



# Cigna Healthcare Standard 4-Tier Prescription Drug List

**Coverage as of January 1, 2025**

**For the State of California**

Health Maintenance Organization (HMO), Network, Network Point of Service (POS)

View your drug list online: [Cigna.com/PDL](https://www.cigna.com/PDL)

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

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

Last updated: 07/01/2025. This drug list is subject to change and all prior versions are no longer in effect.

Offered by: Cigna Health and Life Insurance Company or its affiliates.

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## View your drug list online

This document was last updated on 07/01/2025.\*

- As soon as your new plan year starts, log into the **myCigna® App<sup>1</sup>** or **myCigna.com<sup>®</sup>**. Use the Price a Medication tool to get real-time information about the medications your plan covers.
- You can also view a pdf of this document online at **Cigna.com/PDL**. Click on the dropdown next to "Drug Lists for Employer Plans." Scroll down to the section for California Employer Drug Lists; then click on **California Standard 4 Tier (injectable specialty medications covered on tier 4) (DHMC) [PDF]**.

## Questions?

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

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

Last updated: 07/01/2025, for changes starting 01/01/2025

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# Information about this drug list

## Frequently asked questions (FAQs)

Understanding your prescription medication coverage can be confusing. Here are answers to some commonly asked questions.

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

A. We regularly review and update your plan's drug list to make sure you're getting coverage for low-cost, safe, clinically effective medications. We make changes for many reasons – like when new medications become available or are no longer available, or when medication prices change. These changes may include:

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

When we make a change that affects the coverage of a medication you're taking, we let you know before it happens. This way, you have time to talk with your doctor about your options. Only you and your doctor can decide what's best for your treatment.

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

A. To help lower your overall health care costs, your plan doesn't cover certain high-cost brand-name medications that have lower-cost alternatives. That's because these lower-cost options work the same as, or similar to, the non-covered medication. If you're taking a medication that isn't covered and your doctor feels a different medication isn't right for you, he or she can ask Cigna Healthcare to consider approving your medication through the coverage review process.

There are also certain medications and products that can't be covered by your plan for any reason because they're considered to be a "plan or benefit exclusion." This means the medication or product isn't on your plan's drug list, and there's no option to ask

Cigna Healthcare to consider approving it through the coverage review process. For example, your plan doesn't cover, or "excludes," medications that aren't approved by the U.S. Food and Drug Administration (FDA).

### Q. How do you decide which medications to cover?

A. The Cigna Healthcare Prescription Drug List is developed with the help of the Cigna Healthcare Pharmacy and Therapeutics (P&T) Committee, which is a group of practicing doctors and pharmacists, most of whom work outside of Cigna Healthcare. The group meets regularly to review medical evidence and information provided by federal agencies, drug manufacturers, medical professional associations, national organizations and peer-reviewed journals about the safety and effectiveness of medications that are newly approved by the FDA and medications already on the market. The Cigna Healthcare Health Plan Commercial Value Assessment Committee (HVAC) then looks at the results of the P&T Committee's clinical review, as well as the medication's overall value and other factors before adding it to, or removing it from, the drug list.

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

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

### Q. How do I know if I'm taking a medication that needs approval?

A. Log in to the **myCigna App** or **myCigna.com**, or check your plan materials, to learn more about how your plan covers your medications. If your medication has a **PA** or **ST** next to it, your medication needs approval before your plan will cover it. If it has a **QL** next to it, you may need approval depending on the amount you're filling. If it has **AGE** next to it, you may need approval depending on the covered age range for the medication.

## Information about this drug list

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

#### Q. What types of medications typically need approval?

A. Medications that:

- May be unsafe when combined with other medications
- Have lower-cost, equally effective alternatives available
- Should only be used for certain health conditions
- Are often misused or abused

#### Q. What types of medications typically have quantity limits?

A. Medications that are often:

- Taken in amounts larger than (or for longer than) may be appropriate
- Misused or abused

#### Q. What types of medications require Step Therapy?

A. High-cost medications that are used to treat many conditions, such as:

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

#### Q. Why does my medication have an age requirement?

A. The FDA considers certain medication to only be clinically appropriate for people of a certain age or within a certain age range.

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

A. Ask your doctor's office to contact Cigna Healthcare to start the coverage review process. They know how the review process works and will take care of everything for you. In case the office asks, they can download a request form from

the Cigna Healthcare provider portal at [cignaforhcp.com](http://cignaforhcp.com).

Cigna Healthcare will review information your doctor sends us to make sure you meet coverage requirements for the medication. We'll send you and your doctor a letter with the decision and next steps. It can take up to five (5) business days to hear from us. You can always check with your doctor's office to find out if a decision's been made. You can also log in to the **myCigna App** or **myCigna.com** to check the status of your approval.

If your medication isn't approved, your doctor can send us more information to review, using the same process as before. We're happy to review the request again. Depending on what your doctor sends this time, we may be able to approve coverage. Or, you and your doctor can appeal the decision by sending Cigna Healthcare a written request explaining why the medication should be covered.

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

## Information about this drug list

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

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

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

Cigna Healthcare will review information your doctor sends us to make sure you meet coverage requirements for the medication. We'll send you and your doctor a letter with the decision and next steps. It can take up to five (5) business days to hear from us. You can always check with your doctor's office to find out if a decision's been made. You can also log in to the **myCigna App** or **myCigna.com** to check the status of your approval.

If your medication isn't approved, your doctor can send us more information to review, using the same process as before. We're happy to review the request again. Depending on what your doctor sends this time, we may be able to approve coverage. Or, you and your doctor can appeal the decision by sending Cigna Healthcare a written request explaining why the medication should be covered.

- **For non-urgent requests,** Cigna Healthcare will let you and your doctor know within 72 hours of the decision. If approved, coverage will be provided until the prescription runs out (including refills).
- **For urgent requests based on exigent circumstances,** Cigna Healthcare will let you and your doctor know within 24 hours of the decision. If approved, coverage will be provided for the duration of the exigency. **It's important to know that when medications are approved, it's typically for one year of coverage.** If your medication is approved for less time, it's

because there's a clinical reason based on Cigna Healthcare coverage requirements for the medication and/or the reviewing doctor.

**Q. My medication was just taken off the drug list. My doctor still wants me to take it. What do I have to do to get it covered?**

A. You don't need to do anything. If your doctor continues to prescribe the medication, we'll continue to cover it. If your medication already requires prior authorization, your doctor just has to continue to request (and receive) approval from Cigna Healthcare for the medication to be covered.

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

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

Cigna Healthcare will review information your doctor sends us to make sure you meet coverage requirements for the medication. We'll send you and your doctor a letter with the decision and next steps. It can take up to five (5) business days to hear from us. You can always check with your doctor's office to find out if a decision's been made. You can also log in to the **myCigna App** or **myCigna.com** to check the status of your approval.

If your medication isn't approved, your doctor can send us more information to review, using the same process as before. We're happy to review the request again. Depending on what your doctor sends this time, we may be able to approve coverage. Or, you and your doctor can appeal the decision by sending Cigna Healthcare a written request explaining why the medication should be covered.

## Information about this drug list

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

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

#### Your Step Therapy rights under California State law:

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

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

A. When your pharmacist tries to fill your prescription, he or she will see that the medication needs preapproval from Cigna Healthcare. Because you didn't get approval ahead of time, your plan won't cover the cost of your medication. You should ask your doctor to contact Cigna Healthcare to start the coverage review process. Or, you can choose to pay the medication's full cost out-of-pocket directly to the pharmacy (the cost can't be applied to your annual deductible or out-of-pocket maximum).

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

A. Your pharmacist will only fill the amount your plan covers. If you want to fill more than what's allowed, your doctor's office will have to contact Cigna Healthcare and ask us to approve a larger amount.

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

A. Yes.

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

A. We review all recently approved medications and products to see if they should be covered – and if so, at what cost-share (tier). It can take up to six months from the date the FDA approved them to make a decision. These include, but are not limited to, medications, medical supplies and/or devices covered under standard pharmacy benefits. If your doctor wants you to use a recently approved medication, he or she can ask Cigna Healthcare to consider approving it through the coverage review process.

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

A. The Patient Protection and Affordable Care Act (PPACA), commonly referred to as "health care reform," was signed into law on March 23, 2010. Under

## Information about this drug list

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

this law, certain preventive medications (including some over-the-counter products) may be available to you at no cost-share (\$0), depending on your plan. Log in to the [myCigna App](#) or [myCigna.com](#), or check your plan materials, to learn more about how your plan covers preventive medications. You can also view the PPACA No Cost-Share Preventive Medications drug list at [Cigna.com/PDL](#). For more information about health care reform, go to [informedonreform.com](#) or [CignaHealthcare.com](#).

#### Q. What are preventive medications?

**A.** Preventive medications are used to keep certain conditions from developing or from coming back. These conditions include, but are not limited to asthma, depression, diabetes, heart attack, high blood pressure, high cholesterol, osteoporosis, prenatal nutrient deficiency and stroke.

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

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

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

**A.** When you and your doctor are considering the right medication for your treatment, knowing how much it costs, what lower-cost alternatives are available and which pharmacies offer the best prices can help you avoid surprises. Log in to the [myCigna App](#) or [myCigna.com](#) and use the Price a Medication tool to see how much your medication costs before you get to the pharmacy counter – or, even before you leave your doctor's office.<sup>2</sup>

#### Q. What's a cost-share?

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

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

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

#### Q. What's a generic medication?

**A.** A generic medication is the same as its brand-name version in safety, effectiveness, quality, strength and dosage, as well as in the way it's taken and used.<sup>3</sup> Brand-name medications are protected by patents. Patents keep other manufacturers from selling generic versions of the brand-name medication. Once a patent ends, other companies can make and sell a generic version of the brand-name medication. Generics are typically sold under their chemical or scientific name, instead of the manufacturer's patented brand name.

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

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

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

**A.** The medications may look different. For example, generics may have a different shape, size or color than their brand-name versions. They may also have a different flavor, have different preservatives, come in different packaging and/or with different labeling and may expire at different times. Generics may look different than their brand-name versions, but they're just as safe and effective.

Generics typically cost much less than brand-name medications – in some cases, up to 85% less. Just because generics cost less, it doesn't mean they're lower quality.

#### Q. Can I fill my prescription at any pharmacy in my network?

**A.** It depends. Some plans only allow fills at certain in-network pharmacies or through home delivery. Log in

## Information about this drug list

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

to the **myCigna App** or **myCigna.com**, or check your plan materials, to learn more about the pharmacies in your plan's network.

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

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

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

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

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

**A.** It depends on your plan. Some plans require you to fill maintenance medications through Express Scripts® Pharmacy and/or specialty medications through Accredo®'s specialty pharmacy for them to be covered.<sup>4</sup> Log in to the **myCigna App** or **myCigna.com**, or check your plan materials, to find out what your plan requires.

#### Q. Can I fill my prescriptions by mail?

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

#### Express Scripts® Pharmacy for maintenance medications

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

- Easily order, manage, track and pay for your medications on your phone or online
- Standard shipping at no extra cost<sup>5</sup>
- Automatic refills or refill reminders
- Fill up to a 90-day supply at one time<sup>6</sup>

- Helpful pharmacists available 24/7
- Flexible payment options

#### Here are three easy ways to get started.

1. Log in to the **myCigna App** or **myCigna.com** to move your prescription electronically. Click on the Prescriptions tab and select My Medications from the dropdown menu. Then click the button next to your medication name to move your prescription(s). Or,
2. Call your doctor's office. Ask them to send a 90-day prescription (with refills) electronically to Express Scripts home delivery. Or,
3. Call Express Scripts® Pharmacy at **800.835.3784**. They'll contact your doctor's office to help transfer your prescription. Have your Cigna Healthcare ID card, doctor's contact information and medication name(s) ready when you call.

#### Accredo for specialty medications

If you're taking a specialty medication to treat a complex medical condition, Accredo's team of specially-trained pharmacists and nurses can help. They'll fill and ship your specialty medication to your home (or location of your choice).<sup>7</sup> They'll also provide you with the personalized care and support you need to manage your therapy – at no extra cost.

- 24/7 access to specially-trained pharmacists and nurses
- Personalized care services such as training on how to administer your medication
- Help you find ways to pay for your medications
- Fast shipping at no extra cost
- Easy refills and reminders
- Easily manage your medications online and track your orders

To get started using Accredo, call **877.826.7657**, Monday–Friday, 7:00 am–10:00 pm CST and Saturdays, 7:00 am–4:00 pm CST. To learn more about Accredo, go to **Cigna.com/specialty**.

## Information about this drug list

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

**Q. I take a medication every day to treat diabetes. My plan requires me to fill my medication through Express Scripts® Pharmacy. How do I get started?**

**A.** Some plans allow one or more fills at a retail pharmacy before switching to home delivery. Check your plan materials to find out if your plan allows retail fills. Here are three easy ways to get started.

**1. Log in to the myCigna App or myCigna.com to move your prescription electronically.** Click on the Prescriptions tab and select My Medications from the dropdown menu. Then click the button next to your medication name to move your prescription(s). Or,

**2. Call your doctor's office.** Ask them to send a 90-day prescription (with refills) electronically to Express Scripts® Home Delivery. Or,

**3. Call Express Scripts® Pharmacy at 800.835.3784.** They'll contact your doctor's office to help transfer your prescription. Have your Cigna Healthcare ID card, doctor's contact information and medication name(s) ready when you call.

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

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

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

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

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

You may also be able to use Accredo, to fill your prescription. Accredo has access to most specialty

medications. Call **877.826.7657** for more information. Representatives are available Monday–Friday, 7:00 am–10:00 pm CST and on Saturdays, 7:00 am–4:00 pm CST.

**Q. How do I fill my prescription?**

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

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

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

**A.** Managing a complex condition isn't easy. As part of your pharmacy benefits, you have access to Accredo. Accredo's team of specialty-trained pharmacists and nurses will provide you with the personalized care and support you need to manage your complex medical condition. They'll help you work through side effects, check in with you and your doctor to see how your therapy's going, help you get your medications approved for coverage, and more.

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

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

**A.** You can use the online tools and resources on the **myCigna App** or **myCigna.com** to help you better understand your pharmacy coverage. You can find out how much your medication costs, see which medications your plan covers, find an in-network pharmacy, ask a pharmacist a question, see your pharmacy claims and coverage details and more. You can also manage your Express Scripts® Pharmacy orders.

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

**A.** Covered medications are divided into tiers (or cost-share levels). Typically, the higher the tier, the

## Information about this drug list

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

higher the price you'll pay to fill the prescription. Here are three places you can go to find out how much you'll pay for your medication based on the tier it's listed in, including the maximum cost-share amount allowed:

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

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

A. Some medications are covered under the pharmacy benefit, some are covered under the medical benefit, and others are covered under both benefits. Typically, medications that are injected or infused are covered under the medical benefit. These are given to you at a doctor's office, an infusion center or at home. Typically, medications that you take yourself and can be filled at a retail pharmacy or through home delivery are covered under the pharmacy benefit. Check your medical summary of benefits coverage to learn more about how your plan covers these medications.

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

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

- **For copay plans:** These medications will be covered at 100%, or no cost-share (\$0) to you.

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

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

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

- **Preventive care medications and products covered under the Patient Protection and Affordable Care Act (PPACA), also known as "health care reform":**
  - **Contraceptives:** Covered at 100%, or no cost-share (\$0) to you. Certain prescription contraceptives are available at their applicable cost-share.
  - **Tobacco cessation products:** Up to two (2) 90-day courses of treatment per plan year are covered at 100%, or no cost-share (\$0) to you. Certain prescription tobacco cessation products are available at their applicable cost-share.
  - **Certain vitamins:** Covered at 100%, or no cost-share (\$0) to you. All other prescription vitamins are available at their applicable cost-share and deductible (if applicable).

## Information about this drug list

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

- **Certain over-the-counter (OTC) products:** If you have a prescription from your doctor, these are covered at 100%, or no cost-share (\$0) to you. All other OTC products are excluded from coverage.
- **Oral fertility medications:** Covered at their applicable tier cost-share. For some plans, injectable fertility medications are covered under the medical benefit.
- **Generic preventive care medications:** Covered at 100%, or no cost-share (\$0) to you before you meet your deductible. You'll pay your deductible and applicable cost-share to fill a preferred brand and/or non-preferred brand preventive care medication.
- **Diabetic supplies:** Covered at their applicable cost-share.
- **Growth Hormones:** Need approval from Cigna Healthcare before your plan will cover them (prior authorization). If you receive approval for coverage, you'll pay your applicable tier cost-share to fill the medication.
- **Vaccines:** Vaccines are now covered under the pharmacy benefit. Not all plans cover vaccines in the same way. Log in to the **myCigna App** or **myCigna.com**, or check your plan materials, to find out how your specific plan covers them.
- **Compounded medications:** If the medication is more than \$200, you'll need approval from Cigna Healthcare before your plan will cover them (prior authorization). coverage, you'll pay your applicable tier cost-share to fill the medication.

### Words you may need to know

- **Brand name drug:** A drug that is marketed under a proprietary, trademark-protected name. The brand name drug shall be listed in all CAPITAL letters.
- **Coinsurance:** A percentage of the cost of a covered health care benefit that an enrollee pays after the enrollee has paid the deductible, if a deductible applies to the health care benefit, such as the prescription drug benefit.
- **Copayment:** A fixed dollar amount that an enrollee pays for a covered health care benefit after the enrollee has paid the deductible, if a deductible applies to the health care benefit, such as the prescription drug benefit.
- **Deductible:** The amount an enrollee pays for covered health care benefits before the enrollee's health plan begins payment for all or part of the cost of the health care benefit under the terms of the policy.
- **Drug tier:** A group of prescription drugs that corresponds to a specified cost sharing tier in the health plan's prescription drug coverage. The tier in which a prescription drug is placed determines the enrollee's portion of the cost for the drug.
- **Enrollee:** A person enrolled in a health plan who is entitled to receive services from the plan.
- **Exception request:** A request for coverage of a prescription drug. If an enrollee, his or her designee, or prescribing health care provider submits an exception request for coverage of a prescription drug, the health plan must cover the prescription drug when the drug is determined to be medically necessary to treat the enrollee's condition.
- **Exigent circumstances:** When an enrollee is suffering from a health condition that may seriously jeopardize the enrollee's life, health, or ability to regain maximum function, or when an enrollee is undergoing a current course of treatment using a nonformulary drug.

## Information about this drug list

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

- **Formulary:** The complete list of drugs preferred for use and eligible for coverage under a health plan product, and includes all drugs covered under the outpatient prescription drug benefit of the health plan product. Formulary is also known as a prescription drug list.
- **Generic drug:** The same drug as its brand name equivalent in dosage, safety, strength, how it is taken, quality, performance, and intended use. A generic drug is listed in bold and italicized lowercase letters.
- **Non-formulary drug:** A prescription drug that is not listed on the health plan's formulary.
- **Out-of-pocket costs:** Copayments, coinsurance, and the applicable deductible, plus all costs for health care services that are not covered by the health plan.
- **Prescribing provider:** A health care provider authorized to write a prescription to treat a medical condition for a health plan enrollee.
- **Prescription:** An oral, written, or electronic order by a prescribing provider for a specific enrollee that contains the name of the prescription drug, the quantity of the prescribed drug, the date of issue, the name and contact information of the prescribing provider, the signature of the prescribing provider if the prescription is in writing, and if requested by the enrollee, the medical condition or purpose for which the drug is being prescribed.
- **Prescription drug:** A drug that is prescribed by the enrollee's prescribing provider and requires a prescription under applicable law.
- **Prior Authorization:** A health plan's requirement that the enrollee or the enrollee's prescribing provider obtain the health plan's authorization for a prescription drug before the health plan will cover the drug. The health plan shall grant a prior authorization when it is medically necessary for the enrollee to obtain the drug.
- **Step Therapy:** A process specifying the sequence in which different prescription drugs for a given medical condition and medically appropriate for a particular patient are prescribed. The health plan may require the enrollee to try one or more drugs to treat the enrollee's medical condition before the health plan will cover a particular drug for the condition pursuant to a step therapy request. If the enrollee's prescribing provider submits a request for step therapy exception, the health plans shall make exceptions to step therapy when the criteria is met.
- **Subscriber:** The person who is responsible for payment to a plan or whose employment or other status, except for family dependency, is the basis for eligibility for membership in the plan.

# Information about this drug list

## About this drug list

This is a list of the most commonly prescribed medications covered on the Cigna Healthcare Standard 4-Tier Prescription Drug List as of January 1, 2025. Medications are listed alphabetically by their generic and brand names within their therapeutic category and class.

**The drug list is updated on a regular basis, so this document doesn't show all of the medications your plan covers.** Also, your plan may not cover every medication on this list. Log in to the [myCigna App](#) or [myCigna.com](#) to see the most up-to-date list of covered medications.

## How to read this drug list

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

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

## Tiers

Covered medications are divided into tiers or cost-share levels. Typically, the higher the tier, the higher the price you'll pay to fill the prescription.

<b>Tier 1</b>	<b>Generic Medications.</b> Generics have the same strength and active ingredients as brand-name medications, but often cost much less. <b>These medications are covered at your plan's lowest cost-share.</b>	\$
<b>Tier 2</b>	<b>Preferred Brand Medications.</b> These medications typically have a lower-cost generic alternative available.	\$\$
<b>Tier 3</b>	<b>Non-Preferred Brand Medications.</b> These medications typically have a generic and/or preferred brand alternative.	\$\$\$
<b>Tier 4</b>	<b>Injectable Specialty Medications.</b> Oral specialty medications are covered on a lower tier (tiers 1-3).	\$\$\$\$

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

## Information about this drug list

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

#### Letters (acronyms) next to medication names

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

PA	<b>Prior Authorization*</b> – This medication needs approval from Cigna Healthcare before your plan will cover it. Your doctor's office will have to send us information to review to make sure you meet coverage requirements for the medication.
QL	<b>Quantity Limit*</b> – Your plan will only cover a certain amount of this medication at one time. If your doctor wants you to fill more than what's allowed, your doctor's office can ask Cigna Healthcare to approve more.
ST	<b>Step Therapy*</b> – Your plan doesn't cover this high-cost medication until you try at least one lower-cost option first (typically a generic or preferred brand) and it didn't work for you. If your doctor feels a different medication isn't right for you, your doctor's office can ask Cigna Healthcare to approve coverage of this medication.
AGE	<b>Age Requirement*</b> – Your plan will only cover this medication if you're a certain age or within a certain age range. If you're not within the allowed age range and your doctor wants you to take this medication, your doctor's office can ask Cigna Healthcare to approve coverage.
SP	This is a <b>specialty medication</b> , which is used to treat a complex medical condition. Some plans may limit coverage to a 30-day supply and/or require you to use a preferred specialty pharmacy to receive coverage.
HD	<b>Home Delivery Medications</b> – Some plans only cover certain maintenance medications if they're filled through home delivery with Express Scripts® Pharmacy. Depending on your plan, you may be able to get coverage for one, two or three fills at an in-network retail pharmacy before switching to home delivery.
PPACA	Health care reform under the <b>Patient Protection and Affordable Care Act (PPACA)</b> requires plans to cover this preventive medication/product at 100%, or no cost-share (\$0), to you
CSL	<b>Oral Cancer Medications Subject to Cost-Share Limits</b> – State law in California limits the cost-share (or amount you pay out-of-pocket) for certain oral chemotherapy medications.

\* These coverage requirements may not apply to your specific plan. Log in to the myCigna App or myCigna.com, or check your plan materials, to find out if your plan includes prior authorization, quantity limits, Step Therapy and/or age requirements.

## Information about this drug list

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

Use the chart below to understand how medications are covered.\*

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

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

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

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

**Prescription drug name** is the name of the medication

Medications are listed in **alphabetical order** within each column

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

Generic medications are in **lowercase italics**

This chart is just a sample. It may not show how these medications are actually covered on the Cigna Healthcare Standard 4-Tier Prescription Drug List.

# Information about this drug list

## How to find your medication

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

Condition	Page	Condition	Page
<b>Analgesics</b> (Pain Relief and Inflammatory Disease)	18-22	<b>Anti-Infectives/Miscellaneous (Infections)</b>	44, 45
<b>Analgesics (Urinary Tract Conditions)</b>	22	<b>Anti-Infectives/Miscellaneous (Miscellaneous)</b>	45, 46
<b>Anesthetics (Miscellaneous)</b>	22	<b>Anti-Infectives/Miscellaneous (Skin Conditions)</b>	46
<b>Anesthetics</b> (Pain Relief and Inflammatory Disease)	23	<b>Anti-Inflammatory Tumor Necrosis Factor Inhibiting Agents</b> (Pain Relief and Inflammatory Disease)	46, 47
<b>Anesthetics (Urinary Tract Conditions)</b>	23	<b>Anti-Neoplastics (Cancer)</b>	47-52
<b>Anti-Allergy (Allergy and Nasal Sprays)</b>	23	<b>Anti-Neoplastics (Skin Conditions)</b>	52, 53
<b>Anti-Arthritis</b> (Pain Relief and Inflammatory Disease)	23-26	<b>Anti-Obesity Drugs (Weight Management)</b>	53
<b>Anti-Asthmatics (Asthma/COPD/Respiratory)</b>	26-28	<b>Anti-Parasitics (Infections)</b>	54
<b>Antibiotics (Allergy/Nasal Sprays)</b>	28	<b>Anti-Parkinson's Drugs (Parkinson's Disease)</b>	54-56
<b>Antibiotics (Ear Medications)</b>	29	<b>Anti-Platelet Drugs</b> (Blood Thinners/Anti-Clotting)	56
<b>Antibiotics (Eye Conditions)</b>	29, 30	<b>Antivirals (AIDS/HIV)</b>	56-59
<b>Antibiotics (Infections)</b>	30-35	<b>Antivirals (Eye Conditions)</b>	59
<b>Antibiotics (Skin Conditions)</b>	36	<b>Antivirals (Infections)</b>	59-61
<b>Anti-Coagulants (Blood Thinners/Anti-Clotting)</b>	36-38	<b>Antivirals (Skin Conditions)</b>	61
<b>Antidotes (Gastrointestinal/Heartburn)</b>	38	<b>Autonomic Drugs (Allergy/Nasal Sprays)</b>	61
<b>Antidotes (Substance Abuse)</b>	38	<b>Autonomic Drugs (Alzheimer's Disease)</b>	61
<b>Anti-Fungals (Eye Conditions)</b>	38	<b>Autonomic Drugs</b> (Attention Deficit Hyperactivity Disorder)	62
<b>Anti-Fungals (Feminine Products)</b>	38	<b>Autonomic Drugs</b> (Blood Pressure/Heart Medications)	62
<b>Anti-Fungals (Infections)</b>	38, 39	<b>Autonomic Drugs (Urinary Tract Conditions)</b>	63
<b>Anti-Fungals (Skin Conditions)</b>	39, 40	<b>Biologicals (Allergy/Nasal Sprays)</b>	63
<b>Antihistamine and Decongestant Combination (Allergy/Nasal Sprays)</b>	40	<b>Biologicals</b> (Blood Pressure/Heart Medications)	63
<b>Antihistamines (Eye Conditions)</b>	40	<b>Biologicals (Miscellaneous)</b>	63
<b>Anti-Hyperglycemics (Diabetes)</b>	41-44	<b>Biologicals (Vaccines)</b>	63-65
<b>Anti-Infectives (Feminine Products)</b>	44	<b>Blood (Blood Modifiers/Bleeding Disorders)</b>	65, 66
<b>Anti-Infectives (Infections)</b>	44	<b>Blood (Blood Thinners/Anti-Clotting)</b>	66
<b>Anti-Infectives/Miscellaneous (Feminine Products)</b>	44	<b>Cardiac Drugs</b> (Blood Pressure/Heart Medications)	66-69

## Information about this drug list

### How to find your medication (cont.)

Condition	Page	Condition	Page
<b>Cardiovascular</b> (Asthma/COPD/Respiratory)	69, 70	<b>Hormones</b> (Infertility)	I08
<b>Cardiovascular</b> (Blood Pressure/Heart Medications)	70-76	<b>Hormones</b> (Miscellaneous)	I08
<b>Cardiovascular</b> (Cholesterol Medications)	76-78	<b>Hormones</b> (Osteoporosis Products)	I08
<b>CNS Drugs</b> (Alzheimer's Disease)	78, 79	<b>Immunosuppressants</b> (Pain Relief and Inflammatory Disease)	I08, I09
<b>CNS Drugs</b> (Miscellaneous)	79	<b>Immunosuppressants</b> (Skin Conditions)	I09
<b>CNS Drugs</b> (Multiple Sclerosis)	79, 80	<b>Immunosuppressants</b> (Transplant Medications)	I09, I10
<b>CNS Drugs</b> (Pain Relief and Inflammatory Disease)	80	<b>Miscellaneous Medical Supplies, Devices, Non-Drug</b> (Diabetes)	I10, I11
<b>CNS Drugs</b> (Seizure Disorders)	80-83	<b>Miscellaneous Medical Supplies, Devices, Non-Drug</b> (Miscellaneous)	I11-I18
<b>CNS Drugs</b> (Sleep Disorders/Sedatives)	83	<b>Muscle Relaxants</b> (Pain Relief and Inflammatory Disease)	I18
<b>Colony Stimulating Factors</b> (Blood Modifiers/Bleeding Disorders)	83, 84	<b>Prenatal Vitamins</b> (Nutritional/Dietary)	I19
<b>Contraceptives</b> (Contraception Products)	84-86	<b>Psychotherapeutic Drugs</b> (Anxiety/Depression/Bipolar Disorder)	I19-I23
<b>Cough/Cold Preparations</b> (Allergy/Nasal Sprays)	86	<b>Psychotherapeutic Drugs</b> (Attention Deficit Hyperactivity Disorder)	I24, I25
<b>Cough/Cold Preparations</b> (Cough/Cold Medications)	86, 87	<b>Psychotherapeutic Drugs</b> (Miscellaneous)	I25
<b>Diagnostic</b> (Miscellaneous)	87, 88	<b>Psychotherapeutic Drugs</b> (Schizophrenia/Anti-Psychotics)	I26-I28
<b>Diuretics</b> (Diuretics)	89, 90	<b>Psychotherapeutic Drugs</b> (Sleep Disorders/Sedatives)	I28, I29
<b>EENT Preps</b> (Allergy/Nasal Sprays)	90	<b>Skin Preps</b> (Miscellaneous)	I29
<b>EENT Preps</b> (Ear Medications)	90	<b>Skin Preps</b> (Pain Relief and Inflammatory Disease)	I29
<b>EENT Preps</b> (Eye Conditions)	91-93	<b>Skin Preps</b> (Skin Conditions)	I29-I36
<b>Elect/Caloric/H2O</b> (Cholesterol Medications)	93	<b>Smoking Deterrents</b> (Smoking Cessation)	I36
<b>Elect/Caloric/H2O</b> (Dental Products)	93, 94	<b>Thyroid Prep</b> (Hormonal Agents)	I37, I38
<b>Elect/Caloric/H2O</b> (Diabetes)	94	<b>Unclassified Drug Products</b> (AIDS/HIV)	I38
<b>Elect/Caloric/H2O</b> (Miscellaneous)	94	<b>Unclassified Drug Products</b> (Asthma/COPD/Respiratory)	I37
<b>Elect/Caloric/H2O</b> (Nutritional/Dietary)	95	<b>Unclassified Drug Products</b> (Blood Modifiers/Bleeding Disorders)	I37
<b>Elect/Caloric/H2O</b> (Urinary Tract Conditions)	96	<b>Unclassified Drug Products</b> (Blood Pressure/Heart Medications)	I37, I38
<b>Gastrointestinal</b> (Cholesterol Medications)	96	<b>Unclassified Drug Products</b> (Cancer)	I38
<b>Gastrointestinal</b> (Gastrointestinal/Heartburn)	96-102	<b>Unclassified Drug Products</b> (Dental Products)	I38
<b>Gastrointestinal</b> (Pain Relief and Inflammatory Disease)	102		
<b>Hormones</b> (Hormonal Agents)	102-107		

## Information about this drug list

### How to find your medication (cont.)

Condition	Page	Condition	Page
Unclassified Drug Products (Erectile Dysfunction)	I39, I40	Unclassified Drug Products (Pain Relief and Inflammatory Disease)	I43
Unclassified Drug Products (Gastrointestinal/Heartburn)	I40	Unclassified Drug Products (Substance Abuse)	I44
Unclassified Drug Products (Hormonal Agents)	I40	Unclassified Drug Products (Transplant Medications)	I44
Unclassified Drug Products (Miscellaneous)	I40-I43	Unclassified Drug Products (Urinary Tract Conditions)	I45, I46
Unclassified Drug Products (Nutritional/Dietary)	I43	Unclassified Drug Products (Weight Management)	I46
Unclassified Drug Products (Osteoporosis Products)	I43	Vitamins (Nutritional/Dietary)	I47, I48

## List of Prescription Medications

ANALGESICS (Pain Relief and Inflammatory Disease)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>ANALGESIC, NON-SALICYLATE AND BARBITURATE COMBINAT</b>		
<i>butalbital/acetaminophen</i>	T1	
<b>ANALGESIC, SALICYLATE, BARBITURATE, XANTHINE COMB.</b>		
<i>butalb-aspirin-caff 50-325-40</i>	T1	QL (6 tabs/day)
<i>butalb-as-a-caffeine cap (Fiorinal)</i>	T1	QL (6 caps/day)
<i>FIORINAL (butalbital-aspirin-caffeine)</i>	T3	QL (6 caps/day)
<b>ANALGESIC, NON-SALICYLATE, BARBITURATE, XANTHINE COMB.</b>		
<i>butalb/acetaminophen/caffeine</i>	T3	
<i>butalb/acetaminophen/caffeine (Esgic)</i>	T3	QL (6 caps/day)
<i>butalb-acetamin-caff 50-300-40 (Fioricet)</i>	T1	QL (6 caps/day)
<i>butalb-acetamin-caff 50-325-40 (Esgic)</i>	T1	QL (6 tabs/day)
<b>ANALGESIC/ANTIPYRETICS, SALICYLATES</b>		
<i>choline salicyl/mag salicylate</i>	T1	HD
<i>diflunisal</i>	T1	HD
<b>ANALGESICS, NON-OPIOID</b>		
JOURNAVX	T3	QL
<b>ANTI-MIGRAINE PREPARATIONS</b>		
<i>AIMOVIG AUTOINJECTOR</i>	T2	PA
<i>AJOVY AUTOINJECTOR</i>	T2	PA
<i>AJOVY SYRINGE</i>	T2	PA
<i>almotriptan malate</i>	T1	QL (12 tabs/30 days)
<i>CAFERGOT (ergotamine-caffeine)</i>	T3	QL (40 tabs/28 days)
<i>dihydroergotamine 1 mg/ml amp</i>	T1	QL (10 amps/30 days)
<i>eletriptan hydrobromide</i>	T1	QL (6 tabs/30 days)
<i>EMGALITY PEN</i>	T2	PA
<i>EMGALITY SYRINGE</i>	T2	PA
<i>ergotamine tartrate/caffeine</i>	T1	
<i>ergotamine tartrate/caffeine (Cafergot)</i>	T1	QL (40 tabs/28 days)
<i>frovatriptan succinate</i>	T1	QL (18 tabs/30 days)
<i>isomethept/dichlphn/acetaminop</i>	T1	
<i>isomethepten/caf/acetaminophen</i>	T1	
<i>naratriptan hcl (Amerge)</i>	T1	QL (9 tabs/30 days)
<i>NURTEC ODT</i>	T2	PA QL (16 tabs/30 days)
<i>REYVOW</i>	T3	PA QL(8 tabs/30 days)
<i>rizatriptan ODT(Maxalt Mlt)</i>	T1	QL(12 tabs/30 days)
<i>rizatriptan tablet (Maxalt)</i>	T1	QL(12 tabs/30 days)

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

T4 – Injectable Specialty Medications

PA – Prior Authorization

QL – Quantity Limit

ST – Step Therapy

AGE – Age Requirement

SP – Specialty Medication

HD – May require home delivery pharmacy

PPACA – No Cost-Share Preventive Medication

CSL – Oral cancer medication subject to cost-share limits

## List of Prescription Medications

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

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>ANTI-MIGRAINE PREPARATIONS (cont.)</b>		
sumatriptan	T1	QL (2 boxes/30 days)
sumatriptan 4 mg/0.5 ml inject	T1	QL (4ml/30 days)
sumatriptan 6 mg/0.5 ml cart	T1	QL (4ml/30 days)
sumatriptan 6 mg/0.5 ml inject	T1	QL (4ml/30 days)
sumatriptan 6 mg/0.5 ml syrng	T1	QL (4ml/30 days)
sumatriptan 6 mg/0.5 ml vial	T1	QL (5ml/30 days)
sumatriptan succ 25 mg tablet	T1	QL (18 tabs/28 days)
sumatriptan succ 50 mg tablet	T1	QL (9 tabs/30 days)
sumatriptan succ 100 mg tablet	T1	QL (18 tabs/28 days)
sumatriptan succ/naproxen sod	T1	QL (18 tabs/30 days)
UBRELVY	T2	PA QL (0.67 TABS/DAY)
zolmitriptan	T1	QL (12 tabs/30 days)
<b>NSAIDS, CYCLOOXYGENASE INHIBITOR-TYPE ANALGESICS</b>		
diclofenac potassium	T1	HD
ketorolac 10 mg tablet	T1	QL (20 tabs/25 days)
ketorolac 15 mg/ml syringe	T1	QL (40 ml/30 days)
ketorolac 15 mg/ml vial	T1	QL (40 ml/30 days)
ketorolac 30 mg/ml carpuject	T1	
ketorolac 30 mg/ml isecure syr	T1	QL (20ml/30 days)
ketorolac 30 mg/ml syringe	T1	QL (20ml/30 days)
ketorolac 30 mg/ml vial	T1	QL (20ml/30 days)
ketorolac 300 mg/10 ml vial	T1	
ketorolac 60 mg/2 ml carpuject	T1	QL (20ml/30 days)
ketorolac 60 mg/2 ml syringe	T1	QL (20ml/30 days)
ketorolac 60 mg/2 ml vial	T1	QL (20ml/30 days)
mefenamic acid	T1	
<b>OPIOID ANALGESIC AND NON-SALICYLATE ANALGESICS</b>		
acetamin-codein 300-30 mg/12.5	T1	
acetaminop-codeine 120-12 mg/5	T1	
acetaminophen-cod #2 tablet	T1	PA
acetaminophen-cod #3 tablet	T1	PA
acetaminophen-cod #4 tablet	T1	PA
APADAZ	T3	

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

T4 – Injectable Specialty Medications

PA – Prior Authorization

QL – Quantity Limit

ST – Step Therapy

AGE – Age Requirement

SP – Specialty Medication

HD – May require home delivery pharmacy

PPACA – No Cost-Share Preventive Medication

CSL – Oral cancer medication subject to cost-share limits

## List of Prescription Medications

ANALGESICS (Pain Relief and Inflammatory Disease) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>OPIOID ANALGESIC AND NON-SALICYLATE ANALGESICS (cont.)</b>		
BENZHYDROCODONE-ACETAMINOPHEN	T1	
<i>hydrocodone/acetaminophen</i>	T1	PA
<i>hydrocodone/acetaminophen</i> (Hydrocodone-acetaminophen)	T1	PA
<i>hydrocodone/acetaminophen</i> (Norco)	T1	PA
HYDROCODONE-ACETAMINOPHEN	T1	PA
LORTAB	T1	PA
NALOCET	T1	PA
NORCO ( <i>loracet hd</i> )	T3	PA
NORCO ( <i>loracet plus</i> )	T3	PA
NORCO ( <i>loracet</i> )	T3	PA
<i>oxycodone hcl/acetaminophen</i> (Nalocet)	T1	PA
<i>oxycodone hcl/acetaminophen</i> (Percocet)	T1	PA
<i>oxycodone hcl/acetaminophen</i> (Primlev)	T1	PA
PRIMLEV	T1	PA
<i>tramadol hcl/acetaminophen</i> (Ultrace)	T1	
ULTRACET ( <i>tramadol hcl-acetaminophen</i> )	T3	
<b>OPIOID ANALGESIC AND NSAID COMBINATION</b>		
<i>hydrocodone/ibuprofen</i>	T1	PA
<i>hydrocodone/ibuprofen</i> (Ibudone)	T1	PA
IBUDONE	T1	PA
<i>ibuprofen/oxycodone hcl</i>	T1	PA
<b>OPIOID ANALGESIC AND NON-SALICYLATE XANTHINE COMB</b>		
ACETAMIN-CAFF-DIHYDROCODEINE	T1	PA
<i>acetaminophen/caff/dihydrocod</i> (Acetamin-caff-dihydrocodeine)	T1	PA
<i>acetaminophen/caff/dihydrocod</i> (Trezix)	T1	PA
TREZIX	T3	PA
<b>OPIOID ANALGESICS</b>		
ACTIQ ( <i>fentanyl citrate</i> )	T3	PA
ARYMO ER	T3	PA
BELBUCA	T2	QL (2 films/day)
<i>buprenorphine</i> (Butrans)	T1	QL (4 patches/28 days)

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

T4 – Injectable Specialty Medications

PA – Prior Authorization

QL – Quantity Limit

ST – Step Therapy

AGE – Age Requirement

SP – Specialty Medication

HD – May require home delivery pharmacy

PPACA – No Cost-Share Preventive Medication

CSL – Oral cancer medication subject to cost-share limits

## List of Prescription Medications

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

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>OPIOID ANALGESICS (cont.)</b>		
<i>butorphanol tartrate</i>	T1	PA QL (6 bots/30 days)
BUTTRANS ( <i>buprenorphine</i> )	T3	QL (4 patches/28 days)
<i>codeine sulfate</i>	T1	PA
DILAUDID 2 MG TABLET ( <i>hydromorphone hcl</i> )	T3	PA
DILAUDID 4 MG TABLET ( <i>hydromorphone hcl</i> )	T3	PA
DILAUDID 5 MG/5 ML ORAL LIQUID ( <i>hydromorphone hcl</i> )	T3	PA
DILAUDID 8 MG TABLET ( <i>hydromorphone hcl</i> )	T3	PA
DURAGESIC ( <i>fentanyl</i> )	T3	PA
<i>fentanyl</i>	T1	PA
<i>fentanyl</i> (Duragesic)	T1	PA
FENTANYL CITRATE	T1	PA
<i>fentanyl citrate</i> (Actiq)	T1	PA
FENTORA	T3	PA
<i>hydrocodone bitartrate</i> (Hysingla Er)	T1	PA
<i>hydrocodone bitartrate</i> (Zohydro Er)	T1	PA
<i>hydromorphone hcl</i>	T1	PA
<i>hydromorphone hcl</i> (Dilaudid)	T1	PA
HYSINGLA ER ( <i>hydrocodone bitartrate er</i> )	T2	PA
KADIAN ( <i>morphine sulfate er</i> )	T3	PA
LAZANDA	T3	PA
<i>meperidine hcl</i>	T1	PA
MORPHABOND ER	T2	PA
<i>morphine sulfate</i>	T1	PA
<i>morphine sulfate</i> (Kadian)	T1	PA
<i>morphine sulfate</i> (Ms Contin)	T1	PA
MS CONTIN ( <i>morphine sulfate er</i> )	T3	PA
NUCYNTA	T2	PA
NUCYNTA ER	T3	PA
<i>opium/belladonna alkaloids</i>	T1	PA
OXAYDO	T3	PA
<i>oxycodone hcl</i>	T1	PA
OXYCODONE HCL ER	T1	PA
<i>oxymorphone hcl</i>	T1	PA
<i>pentazocine hcl/naloxone hcl</i>	T1	PA

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## List of Prescription Medications

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

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>OPIOID ANALGESICS (cont.)</b>		
ROXYBOND	T3	PA
tramadol er 100 mg tablet	T1	QL (1 tab/day)
tramadol er 200 mg tablet	T1	QL (1 tab/day)
tramadol er 300 mg tablet	T1	QL (1 tab/day)
tramadol hcl 50 mg tablet (Ultram)	T1	QL (8 tabs/day)
tramadol hcl 100 mg tablet	T1	QL (4 tabs/day)
TRAMADOL HCL 75 MG TABLET	T3	QL(< 18 yo 5 tabs/day)
TRAMADOL HCL ER 100 MG CAPSULE	T1	QL (1 cap/day)
tramadol hcl er 100 mg tablet	T1	QL (1 tab/day)
TRAMADOL HCL ER 150 MG CAPSULE	T1	QL (1 cap/day)
TRAMADOL HCL ER 200 MG CAPSULE	T1	QL (1 cap/day)
tramadol hcl er 200 mg tablet	T1	QL (1 tab/day)
TRAMADOL HCL ER 300 MG CAPSULE	T1	QL (1 cap/day)
tramadol hcl er 300 mg tablet	T1	QL (1 tab/day)
ULTRAM (tramadol hcl)	T3	QL (8 tabs/day)
XTAMPZA ER	T2	PA
ZOHYDRO ER (hydrocodone bitartrate er)	T3	PA
<b>OPIOID AND SALICYLATE ANALGESICS, BARBIT, XANTHINE</b>		
codeine/butalbital/asa/caffein (Fiorinal With Codeine #3)	T1	PA
FIORINAL WITH CODEINE #3 (butalbital compound-codeine)	T3	PA
<b>OPIOID, NON-SALICYL. ANALGESIC, BARBITUATE, XANTHINE</b>		
butalbit/acetamin/caff/codeine	T1	PA
butalbit/acetamin/caff/codeine (Fioricet With Codeine)	T1	PA
<b>SKELETAL MUSCLE RELAXANT, SALICYLAT, OPIOID ANALGESC</b>		
carisoprodol/aspirin/codeine	T1	PA
<b>ANALGESICS (Urinary Tract Conditions)</b>		
<b>URINARY TRACT ANALGESIC AGENTS</b>		
ELMIRON	T2	
RIMSO-50	T2	
<b>ANESTHETICS (Miscellaneous)</b>		
<b>GENERAL ANESTHETICS, INHALANT</b>		
desflurane (Suprane)	T1	
isoflurane	T1	
isoflurane	T3	
sevoflurane (Ultane)	T1	

T1 – Typically Generics

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## List of Prescription Medications

ANESTHETICS (Pain Relief and Inflammatory Disease) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>GENERAL ANESTHETICS, INHALANT (cont.)</b>		
ULTANE (sevoflurane)	T3	
<b>LOCAL ANESTHETICS</b>		
<i>lidocaine hcl</i>	T1	
<b>TOPICAL LOCAL ANESTHETICS</b>		
<i>lidocaine 5% ointment</i>	T1	QL (145gm/30 days)
<i>lidocaine hcl</i>	T1	
<i>lidocaine hcl</i>	T3	
<i>lidocaine/prilocaine</i>	T1	
LIDODERM ( <i>lidocaine</i> )	T3	
PAIN EASE MEDIUM STREAM SPRAY	T3	
ZTLIDO	T2	
ANESTHETICS (Urinary Tract Conditions)		
<b>URINARY TRACT ANESTHETIC/ANALGESIC AGNT (AZO-DYE)</b>		
<i>phenazopyridine hcl</i> (Pyridium)	T1	
ANTI-ALLERGY (Allergy/Nasal Sprays)		
<b>MAST CELL STABILIZERS</b>		
<i>cromolyn 100 mg/5 ml oral conc</i> (Gastrocrom)	T1	
ANTI-ARTHRITICS (Pain Relief and Inflammatory Disease)		
<b>ANALGESIC/ANTIPYRETICS, SALICYLATES</b>		
<i>DISALCID (salsalate)</i>	T3	HD
<i>salsalate</i> (Disalcid)	T1	HD
<b>ANTI-ARTHRITIC AND CHELATING AGENTS</b>		
<i>DEPEN (penicillamine)</i>	T3	PA SP
<i>penicillamine</i>	T1	PA SP
<i>penicillamine</i> (Depen)	T1	PA SP
<b>ANTI-ARTHRITIC, FOLATE ANTAGONIST AGENTS</b>		
RASUVO	T2	ST
<b>ANTI-INFLAM. INTERLEUKIN-1 RECEPTOR ANTAGONIST</b>		
KINERET	T4	PA QL (28 syringes/28 days) SP

T1 – Typically Generics

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## List of Prescription Medications

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

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>ANTI-INFLAMMATORY, PYRIMIDINE SYNTHESIS INHIBITOR</b>		
ARAVA ( <i>leflunomide</i> )	T3	HD
<i>leflunomide</i> (Arava)	T1	HD
<b>ANTI-INFLAMMATORY, PHOSPHODIESTERASE-4(PDE4) INHIB.</b>		
OTEZLA 28 DAY STARTER PACK	T2	PA QL (55 tabs/365 days) SP HD
OTEZLA 30 MG TABLET	T2	PA QL (2 tabs/day) SP HD
<b>ANTI-INFLAMMATORY, SEL.COSTIM.MOD., T-CELL INHIBITOR</b>		
ORENCIA	T4	PA QL (4 syringes/28 days) SP HD
ORENCIA CLICKJECT	T4	PA QL (4 injectors/28 days) SP HD
<b>COLCHICINE</b>		
COLCHICINE	T1	HD
<i>colchicine</i> 0.6 mg capsule (Mitigare)	T1	HD
colchicine 0.6 mg tablet (Colcrys)	T1	HD
COLCRYS ( <i>colchicine</i> )	T3	HD
MITIGARE ( <i>colchicine</i> )	T3	
<b>GOLD SALTS</b>		
RIDAURA	T2	
<b>HYPURICEMIA TX - XANTHINE OXIDASE INHIBITORS</b>		
<i>allopurinol</i>	T1	HD
febuxostat 40 mg tablet (Uloric)	T1	QL (1 tab/day) HD
febuxostat 80 mg tablet (Uloric)	T1	HD
ULORIC 40 MG TABLET (febuxostat)	T3	QL (1 tab/day) HD
ULORIC 80 MG TABLET (febuxostat)	T3	HD
ZYLOPRIM ( <i>allopurinol</i> )	T3	HD
<b>JANUS KINASE (JAK) INHIBITORS</b>		
febuxostat 40 mg tablet (Uloric)	T1	QL (1 tab/day) HD
febuxostat 80 mg tablet (Uloric)	T1	HD
LITFULO	T3	PA QL(1 cap/day) SP HD
RINVOQ LQ	T2	PA QL SP HD
ULORIC 40 MG TABLET (febuxostat)	T3	QL (1 tab/day) HD
ULORIC 80 MG TABLET (febuxostat)	T3	HD
ZYLOPRIM ( <i>allopurinol</i> )	T3	HD
XELJANZ 5 MG TABLET	T2	PA QL (2 tabs/day) SP HD
XELJANZ XR	T2	PA QL (1 tab/day) SP HD

T1 – Typically Generics

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T3 – Typically Non-Preferred Brands

T4 – Injectable Specialty Medications

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## List of Prescription Medications

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

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>NSAIDS (COX NON-SPEC.INHIB) AND PROSTAGLANDIN ANALOG</b>		
ARTHROTEC 50 ( <i>diclofenac sodium-misoprostol</i> )	T3	ST HD
ARTHROTEC 75 ( <i>diclofenac sodium-misoprostol</i> )	T3	ST HD
<i>diclofenac sodium/misoprostol</i> (Arthrotec 50)	T1	HD
<i>diclofenac sodium/misoprostol</i> (Arthrotec 75)	T1	HD
<b>NSAIDS, CYCLOOXYGENASE INHIBITOR - TYPE ANALGESICS</b>		
ANAPROX DS ( <i>naproxen sodium ds</i> )	T3	ST HD
DAYPRO ( <i>oxaprozin</i> )	T3	ST HD
<i>diclofenac sod dr 25 mg tab</i>	T1	HD
<i>diclofenac sod dr 50 mg tab</i>	T1	HD
<i>diclofenac sod dr 75 mg tab</i>	T1	HD
<i>diclofenac sod ec 25 mg tab</i>	T1	HD
<i>diclofenac sod ec 50 mg tab</i>	T1	HD
<i>diclofenac sod ec 75 mg tab</i>	T1	HD
<i>diclofenac sodium</i>	T1	HD
EC-NAPROSYN ( <i>naproxen</i> )	T3	ST HD
<i>etodolac</i>	T1	HD
<i>etodolac</i> (Lodine)	T1	HD
FELDENE ( <i>piroxicam</i> )	T3	ST HD
FENOPROFEN 600 MG TABLET (Nalfon)	T1	HD
<i>flurbiprofen</i>	T1	HD
<i>ibuprofen</i>	T1	HD
<i>indomethacin</i>	T1	HD
<i>ketoprofen 25 mg. 75 mg capsule</i>	T1	HD
LODINE ( <i>etodolac</i> )	T3	ST HD
<i>meclofemate sodium</i>	T1	HD
<i>meloxicam</i> (Mobic)	T1	HD
MOBIC ( <i>meloxicam</i> )	T3	ST HD
<i>nabumetone</i>	T1	HD
NALFON 600 MG TABLET ( <i>profeno</i> )	T1	ST HD
NAPROSYN TABLET ( <i>naproxen</i> )	T3	ST HD
<i>naproxen tablet</i>	T1	HD
<i>naproxen</i> (Ec-naprosyn)	T1	HD
<i>naproxen</i> (Naprosyn)	T1	HD
<i>naproxen DR</i> (Ec-Naprosyn)	T1	HD

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

T4 – Injectable Specialty Medications

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## List of Prescription Medications

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

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>NSAIDS, CYCLOOXYGENASE INHIBITOR - TYPE ANALGESICS (cont.)</b>		
<i>naproxen sodium</i> (Anaprox Ds)	T1	HD
<i>oxaprozin</i> (Daypro)	T1	HD
OXAPROZIN 300 MG CAPSULE	T3	HD
<i>piroxicam</i>	T1	HD
QMIIZ ODT 15 MG TABLET	T3	ST HD
QMIIZ ODT 7.5 MG TABLET	T3	QL (1 tab/day) ST HD
<i>tolmetin</i> (Tolectin 600)	T1	HD
<b>NSAIDS, CYCLOOXYGENASE-2(COX-2) SELECTIVE INHIBITOR</b>		
<i>arformoterol tartrate</i> (Brovana)	T1	QL(4 mls/day) HD
<i>celecoxib 100 mg capsule</i> (Celebrex)	T1	QL (2 caps/day) HD
<i>celecoxib 200 mg capsule</i> (Celebrex)	T1	QL (2 caps/day) HD
<i>celecoxib 400 mg capsule</i> (Celebrex)	T1	QL (1 cap/day) HD
<i>celecoxib 50 mg capsule</i> (Celebrex)	T1	QL (2 caps/day) HD
<i>formoterol fumarate</i> (Perforomist)	T1	QL(240 mls/30 days) HD
<b>URICOSURIC AGENTS</b>		
<i>probencid</i>	T1	HD
<i>probencid/colchicine</i>	T1	HD
<b>ANTI-ASTHMATICS (Asthma/COPD/Respiratory)</b>		
<b>5-LIPOXYGENASE INHIBITORS</b>		
<i>zileuton</i>	T1	HD
<b>ANTICHOLINERGICS, ORALLY INHALED LONG ACTING</b>		
INCRUSE ELLIPTA	T2	HD
LONHALA MAGNAIR REFILL	T3	PA HD
LONHALA MAGNAIR STARTER	T3	PA HD
SPIRIVA RESPIMAT	T2	HD
<b>ANTICHOLINERGICS, ORALLY INHADED SHORT ACTING</b>		
ATROVENT HFA	T2	HD
<i>ipratropium bromide</i>	T1	HD
<b>BETA-ADRENERGIC AGENTS</b>		
<i>albuterol 2 mg/5 ml syrup</i>	T1	HD
<i>albuterol 8 mg/20 ml syrup cup</i>	T1	HD
<i>albuterol sulfate 2 mg tab</i>	T1	HD

T1 – Typically Generics

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## List of Prescription Medications

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

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>BETA-ADRENERGIC AGENTS (cont.)</b>		
albuterol sulfate 4 mg tab	T1	HD
albuterol sulfate er 4 mg tab	T1	HD
albuterol sulfate er 8 mg tab	T1	HD
metaproterenol sulfate	T1	HD
terbutaline sulfate	T1	HD
<b>BETA-ADRENERGIC AGENTS, INHALED, SHORT ACTING</b>		
albuterol 2.5 mg/0.5 ml sol	T1	
albuterol 5 mg/ml solution	T1	
albuterol 15 mg/3 ml solution	T1	
albuterol 75 mg/15 ml soln	T1	
albuterol sul 0.63 mg/3 ml sol	T1	
albuterol sul 1.25 mg/3 ml sol	T1	
albuterol sul 2.5 mg/3 ml soln	T1	
albuterol hfa 90 mcg inhale (Albuterol Sulfate Hfa)	T1	QL (18gm/30 days)
ALBUTEROL SULFATE HFA	T1	QL (18gm/30 days)
levalbuterol hcl (Xopenex Concentrate)	T1	
levalbuterol hcl (Xopenex)	T1	
XOPENEX (levalbuterol hcl)	T3	
XOPENEX CONCENTRATE (levalbuterol concentrate)	T3	
<b>BETA-ADRENERGIC AGENTS, INHALED, ULTRA-LONG ACTING</b>		
ARCAPTA NEOHALER	T3	HD
STRIVERDI RESPIMAT	T2	QL HD
<b>BETA-ADRENERGIC AGENTS, ORALLY INHALED, LONG ACTING</b>		
BROVANA	T3	HD
<b>BETA-ADRENERGIC AND ANTICHOLINERGIC COMBO, INHALED</b>		
ANORO ELLIPTA	T2	HD
COMBIVENT RESPIMAT	T2	
ipratropium/albuterol sulfate	T1	HD
STILOTO RESPIMAT INHAL SPRAY	T2	HD
<b>BETA-ADRENERGIC AGENTS AND GLUCOCORTICOID COMBO, INHALED</b>		
ADVAIR HFA	T2	HD
AIRDUO DIGIHALER	T3	ST HD
AIRSUPRA	T2	QL(1 gm/28 days) HD
BREO ELLIPTA	T2	HD
budesonide/formoterol fumarate (Symbicort)	T2	QL HD

T1 – Typically Generics

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## List of Prescription Medications

ANTI-ASTHMATICS (Asthma/COPD/Respiratory) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>BETA-ADRENERGIC AGENTS AND GLUCOCORTICOID COMBO, INHALED (cont.)</b>		
DULERA <i>fluticasone propionate/salmeterol</i>	T2 T1	HD QL (1 Inhaler/30 days)
<b>BETA-ADRENERGIC-ANTICHOLINERGIC-GLUCOCORT, INHALED</b>		
BREZTRI AEROSPHERE	T2	
TRELEGY ELLIPTA	T2	
<b>GLUCOCORTICOIDS, ORALLY INHALED</b>		
ARNUITY ELLIPTA	T2	
ASMANEX HFA/TWISTHALER	T2	QL
<i>budesonide (Pulmicort)</i>	T1	HD
<i>deflazacort (Emflaza)</i>	T1	PA SP HD
FLOVENT DISKUS	T2	HD
FLUTICASONE PROP DISKUS	T3	QL HD
QVAR REDIHALER	T2	
<b>INTERLEUKIN-5(IL-5) RECEPTOR ALPHA ANTAGONIST, MAB</b>		
FASENRA PEN	T4	PA SP HD
<b>LEUKOTRIENE RECEPTOR ANTAGONISTS</b>		
ACCOLATE (zafirlukast)	T3	HD
<i>montelukast sodium (Singulair)</i>	T1	HD
<i>zafirlukast (Accolate)</i>	T1	HD
<b>MAST CELL STABILIZERS, ORALLY INHALED</b>		
<i>cromolyn 20 mg/2 ml neb soln</i>	T1	QL (480ml/30 days) HD
<b>MONOCLONAL ANTIBODIES TO IMMUNOGLOBULIN E (IGE)</b>		
XOLAIR	T4	PA SP HD
<b>MONOCLONAL ANTIBODY - INTERLEUKIN-5 ANTAGONISTS</b>		
NUCALA	T4	PA SP HD
<b>MUCOLYTICS</b>		
<i>acetylcysteine</i>	T1	
<b>PHOSPHODIESTERASE-4 (PDE4) INHIBITORS</b>		
DALIRESP 250 MCG TABLET	T3	QL (28 tabs/180 days) HD
DALIRESP 500 MCG TABLET	T3	QL (2 tabs/day) HD
<i>roflumilast 250 mcg tablet (Daliresp)</i>	T1	QL (28 tabs/180 days) HD

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## List of Prescription Medications

ANTI-ASTHMATICS (Asthma/COPD/Respiratory) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>PHOSPHODIESTERASE-4 (PDE4) INHIBITORS (cont.)</b>		
roflumilast 500 mcg tablet (Daliresp)	T1	QL (2 tabs/day) HD
<b>XANTHINES</b>		
THEO-24	T2	HD
theophylline anhydrous	T1	HD
ANTIBIOTICS (Allergy/Nasal Sprays)		
<b>NOSE PREPARATIONS ANTIBIOTICS</b>		
BACTROBAN NASAL	T2	
ANTIBIOTICS (Ear Medications)		
<b>EAR PREPARATIONS, ANTIBIOTICS</b>		
ciprofloxacin hcl	T1	
CORTISPORIN-TC	T3	
neomycin/polymyxin b/hydrocort	T1	
ofloxacin	T1	
<b>OTIC PREPARATIONS, ANTI-INFLAMMATORY-ANTIBIOTICS</b>		
ciprofloxacin hcl/dexameth	T1	
OTOVEL	T3	
ANTIBIOTICS (Eye Conditions)		
<b>EYE ANTIBIOTIC AND GLUCOCORTICOID COMBINATIONS</b>		
neomycin/bacit/p-myx/hydrocort	T1	
neomycin/polymyxin b/dexametha (Maxitrol)	T1	
neomycin/polymyxin b/hydrocort	T1	
TOBRADEX ST 0.3-0.05% EYE DROP	T3	
tobramycin/dexamethasone (Tobradex)	T1	
<b>EYE SULFONAMIDES</b>		
BLEPH-10 (sulfacetamide sodium)	T3	
BLEPHAMIDE	T2	
sulfacetamide sodium	T1	
sulfacetamide sodium (Bleph-10)	T1	
sulfacetamide/prednisolone sp	T1	
<b>OPHTHALMIC ANTIBIOTICS</b>		
AZASITE	T2	

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

T4 – Injectable Specialty Medications

PA – Prior Authorization

QL – Quantity Limit

ST – Step Therapy

AGE – Age Requirement

SP – Specialty Medication

HD – May require home delivery pharmacy

PPACA – No Cost-Share Preventive Medication

CSL – Oral cancer medication subject to cost-share limits

## List of Prescription Medications

### ANTIBIOTICS (Eye Conditions) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>OPHTHALMIC ANTIBIOTICS (cont.)</b>		
<i>bacitracin</i> (Baciguent)	T1	
<i>bacitracin/polymyxin b sulfate</i>	T1	
BESIVANCE	T2	
<i>ciprofloxacin hcl</i> (Ciloxan)	T1	
<i>erythromycin base</i>	T1	
<i>gatifloxacin</i>	T1	
<i>gentamicin sulfate</i>	T1	
<i>levofloxacin</i>	T1	
MOXEZA (moxifloxacin)	T3	
<i>moxifloxacin hcl</i> (Moxeza)	T1	
<i>moxifloxacin hcl</i> (Vigamox)	T1	
<i>neomycin sulf/bacitracin/poly</i>	T1	
<i>neomycin/polymyxn b/gramicidin</i>	T1	
<i>ofloxacin</i> (Ocuflax)	T1	
<i>tobramycin 0.3% eye drop</i>	T1	
TOBREX 0.3% EYE OINTMENT	T2	

### ANTIBIOTICS (Infections)

ABSORBABLE SULFONAMIDE ANTIBACTERIAL AGENTS		
BACTRIM ( <i>sulfamethoxazole-trimethoprim</i> )	T3	
BACTRIM DS ( <i>sulfamethoxazole-trimethoprim</i> )	T3	
<i>sulfadiazine</i>	T1	
<i>sulfamethoxazole(trimethoprim</i>	T1	
<i>sulfamethoxazole(trimethoprim</i>	T3	
<i>sulfamethoxazole(trimethoprim</i> (Bactrim Ds)	T1	
<i>sulfamethoxazole(trimethoprim</i> (Bactrim)	T1	

AMINOGLYCOSIDE ANTIBIOTICS		
ARIKAYCE	T3	PA SP
<i>gentamicin sulfate</i>	T1	
<i>gentamicin sulfate/pf</i>	T1	
KITABIS PAK	T3	PA QL (10ml/day) SP HD
<i>neomycin sulfate</i>	T1	
TOBI PODHALER	T2	PA QL (28 days therapy/56 days) SP HD
<i>tobramycin 1,200 mg/30 ml vial</i>	T1	
<i>tobramycin 1.2 gm vial</i>	T1	PA

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

T4 – Injectable Specialty Medications

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CSL – Oral cancer medication subject to cost-share limits

## List of Prescription Medications

ANTIBIOTICS (Infections) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>AMINOGLYCOSIDE ANTIBIOTICS (cont.)</b>		
<i>tobramycin 1.2 gram/30 ml vial</i>	T1	
<i>tobramycin 20 mg/2 ml vial</i>	T1	
<i>tobramycin 300 mg/4 ml ampule</i>	T1	QL (8 ml/day) SP HD
<i>tobramycin 300 mg/5 ml ampule</i>	T1	PA QL (10ml/day) SP HD
<i>tobramycin 40 mg/ml vial</i>	T1	
<i>tobramycin 80 mg/2 ml vial</i>	T1	
TOBRAMYCIN PAK 300 MG/5 ML	T3	PA QL (10ml/day) SP HD
<b>ANAEROBIC ANTIprotozoal-ANTIBACTERIAL AGENTS</b>		
LIKMEZ	T3	PA
<i>metronidazole</i>	T1	
<b>ANTIBIOTIC, ANTIBACTERIAL, MISC.</b>		
<i>fosfomycin tromethamine</i>	T1	
<i>methenamine hippurate</i>	T1	
<i>methenamine mandelate</i>	T1	
PRIMSOL	T2	
<i>trimethoprim</i>	T1	
TRIMPEX	T2	
URIBEL ( <i>methenam/m.blue/salicyl/hyosc</i> )	T3	
UTA	T3	
<b>ANTILEPROTICS</b>		
<i>dapsone</i>	T1	
THALOMID	T2	PA SP HD
<b>ANTI-MYCOBACTERIUM AGENTS</b>		
<i>ethambutol hcl</i>	T1	HD
<i>isoniazid</i>	T1	HD

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

T4 – Injectable Specialty Medications

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## List of Prescription Medications

ANTIBIOTICS (Infections) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>ANTI-MYCOBACTERIUM AGENTS (cont.)</b>		
PASER	T2	HD
<i>pyrazinamide</i>	T1	HD
<i>rifabutin</i>	T1	HD
TRECATOR	T2	HD
<b>ANTI-TUBERCULAR ANTIBIOTICS</b>		
CYCLOSERINE	T1	
PRETOMANID	T3	PA QL (1 tab/day)
PRIFTIN	T3	
RIFAMATE	T2	
<i>rifampin</i>	T1	
RIFATER	T2	
SIRTURO	T3	SP
<b>BETALACTAMS</b>		
CAYSTON	T3	PA QL (3ml/day) SP HD
<b>CEPHALOSPORIN ANTIBIOTICS - 1ST GENERATION</b>		
<i>cefadroxil</i>	T1	
<i>cephalexin</i>	T1	
<i>cephalexin (Keflex)</i>	T1	
DAXBIA	T3	
KEFLEX ( <i>cephalexin</i> )	T3	
<b>CEPHALOSPORIN ANTIBIOTICS - 2ND GENERATION</b>		
<i>cefaclor</i>	T1	
<i>cefpazil</i>	T1	
<i>cefuroxime axetil</i>	T1	
<b>CEPHALOSPORIN ANTIBIOTICS - 3RD GENERATION</b>		
<i>cefdinir</i>	T1	
<i>cefditoren pivoxil</i>	T1	
<i>cefixime (Suprax)</i>	T1	
<i>cefpodoxime proxetil</i>	T1	
<i>ceftriaxone sodium</i>	T1	
SUPRAX	T3	
SUPRAX ( <i>cefixime</i> )	T3	
<b>LINCOSAMIDE ANTIBIOTICS</b>		
CLEOCIN HCL 150 MG CAPSULE ( <i>clindamycin hcl</i> )	T3	

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

T4 – Injectable Specialty Medications

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## List of Prescription Medications

### ANTIBIOTICS (Infections) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>LINCOSSAMIDE ANTIBIOTICS (cont.)</b>		
CLEOCIN HCL 300 MG CAPSULE ( <i>clindamycin hcl</i> )	T3	
CLEOCIN HCL 75 MG CAPSULE ( <i>clindamycin hcl</i> )	T2	
CLEOCIN PEDIATRIC ( <i>clindamycin (pediatric)</i> )	T3	
<i>clindamycin hcl</i> (Cleocin Hcl)	T1	
<i>clindamycin palmitate hcl</i> (Cleocin Pediatric)	T1	
<b>MACROLIDE ANTIBIOTICS</b>		
<i>azithromycin 1 gm pwd packet</i> (Zithromax)	T1	
<i>azithromycin 100 mg/5 ml susp</i> (Zithromax)	T1	
<i>azithromycin 200 mg/5 ml susp</i> (Zithromax)	T1	
<i>azithromycin 200 mg/5 ml susp</i> (Zithromax)	T1	
<i>azithromycin 250 mg tablet</i> (Zithromax)	T1	
<i>azithromycin 500 mg tablet</i> (Zithromax Tri-pak)	T1	
<i>azithromycin 600 mg tablet</i>	T1	
<i>clarithromycin</i>	T1	
DIFICID 200 MG TABLET	T3	QL (28 tabs/28 days)
DIFICID 40 MG/ML SUSPENSION	T3	QL (5ml/Day)
ERYPED 200 ( <i>erythromycin ethylsuccinate</i> )	T3	
<i>ery-tab dr 250 mg tablet</i>	T3	
<i>ery-tab dr 333 mg tablet</i>	T2	
ERY-TAB DR 500 MG TABLET ( <i>erythromycin</i> )	T3	
<i>erythromycin base</i>	T1	
<i>erythromycin base</i> (Ery-tab)	T1	
<i>erythromycin ethylsuccinate</i>	T1	
<i>erythromycin ethylsuccinate</i>	T2	
<i>erythromycin ethylsuccinate</i> (Eryped 200)	T1	
<i>erythromycin stearate</i>	T1	
PCE	T3	
ZITHROMAX 1 GM POWDER PACKET ( <i>azithromycin</i> )	T3	
ZITHROMAX 100 MG/5 ML SUSP ( <i>azithromycin</i> )	T3	
ZITHROMAX 200 MG/5 ML SUSP ( <i>azithromycin</i> )	T3	
ZITHROMAX 200 MG/5 ML SUSP ( <i>azithromycin</i> )	T3	
ZITHROMAX 250 MG TABLET ( <i>azithromycin</i> )	T3	
ZITHROMAX 250 MG Z-PAK TABLET ( <i>azithromycin</i> )	T3	
ZITHROMAX 500 MG TABLET ( <i>azithromycin</i> )	T3	

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

T4 – Injectable Specialty Medications

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## List of Prescription Medications

### ANTIBIOTICS (Infections) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>MACROLIDE ANTIBIOTICS (cont.)</b>		
ZITHROMAX TRI-PAK ( <i>azithromycin</i> )	T3	
<b>NITROFURAN DERIVATIVES ANTIBACTERIAL AGENTS</b>		
FURADANTIN ( <i>nitrofurantoin</i> )	T3	
MACROBID ( <i>nitrofurantoin mono-macro</i> )	T3	
<i>nitrofurantoin 25 mg/5 ml susp</i> (Furadantin)	T1	
<i>nitrofurantoin monohyd/m-cryst</i>	T1	
<b>OXAZOLIDINONE ANTIBIOTICS</b>		
<i>linezolid</i> (Zyvox)	T1	PA
SIVEXTRO	T3	PA
ZYVOX ( <i>linezolid</i> )	T3	PA
<b>PENICILLIN ANTIBIOTICS</b>		
<i>amoxicillin</i>	T1	
<i>ampicillin trihydrate</i>	T1	
<i>dicloxacillin sodium</i>	T1	
MOXATAG	T3	
<i>penicillin v potassium</i>	T1	
<b>PLEUROMUTILIN DERIVATIVES</b>		
XENLETA	T3	PA QL (10 tabs/30 days)
<b>QUINOLONE ANTIBIOTICS</b>		
AVELOX ( <i>moxifloxacin hcl</i> )	T3	
BAXDELA	T3	PA
CIPRO 10% SUSPENSION ( <i>ciprofloxacin</i> )	T2	
CIPRO 250 MG TABLET ( <i>ciprofloxacin hcl</i> )	T3	
CIPRO 5% SUSPENSION ( <i>ciprofloxacin</i> )	T2	
CIPRO 500 MG TABLET ( <i>ciprofloxacin hcl</i> )	T3	
<i>ciprofloxacin</i> (Cipro)	T1	
<i>ciprofloxacin hcl</i>	T1	
<i>ciprofloxacin hcl</i> (Cipro)	T1	
<i>ciprofloxacin/ciprofloxacin hcl</i>	T1	
FACTIVE	T3	
<i>levofloxacin</i>	T1	
<i>moxifloxacin hcl</i> (Avelox)	T1	

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

T4 – Injectable Specialty Medications

PA – Prior Authorization

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ST – Step Therapy

AGE – Age Requirement

SP – Specialty Medication

HD – May require home delivery pharmacy

PPACA – No Cost-Share Preventive Medication

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## List of Prescription Medications

ANTIBIOTICS (Infections) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>QUINOLONE ANTIBIOTICS (cont.)</b>		
<i>ofloxacin</i>	T1	
<b>RIFAMYCINS AND RELATED DERIVATIVE ANTIBIOTICS</b>		
AEMCOLO	T3	QL (12 tabs/3 days)
XIFAXAN 200 MG TABLET	T2	
XIFAXAN 550 MG TABLET	T2	QL (126 tabs/year)
<b>TETRACYCLINE ANTIBIOTICS</b>		
<i>coremino er 135 mg tablet</i>	T1	
<i>coremino er 45 mg tablet</i>	T1	QL (1 tab/day)
<i>coremino er 90 mg tablet</i>	T1	
<i>doxycycline 50 mg tablet (Targadox)</i>	T1	
<i>doxycycline hyclate</i>	T1	
<i>minocycline er 135 mg tablet</i>	T1	
<i>minocycline er 45 mg tablet</i>	T1	QL (1 tab/day)
<i>minocycline er 55 mg tablet</i>	T1	
<i>minocycline er 65 mg tablet</i>	T1	
<i>minocycline er 80 mg tablet</i>	T1	
<i>minocycline er 90 mg tablet</i>	T1	
<i>minocycline hcl</i>	T1	
NUZYRA	T3	PA QL (30 tablets/28 days) SP
<i>tetracycline hcl</i>	T1	
VIBRAMYCIN 50 MG/5 ML SYRUP	T2	
<b>VAGINAL ANTIBIOTICS</b>		
<i>clindamycin phosphate (Cleocin)</i>	T1	
<i>metronidazole (Metrogel-vaginal)</i>	T1	
<b>VANCOMYCIN ANTIBIOTICS AND DERIVATIVES</b>		
<i>vancomycin hcl</i>	T1	
<i>vancomycin hcl (Firvanq)</i>	T1	
ANTIBIOTICS (Skin Conditions)		
<b>TOPICAL ANTIBIOTIC AND ANTI-INFLAMMATORY STEROID</b>		
CORTISPORIN	T3	
NEO-SYNALAR	T3	
<b>TOPICAL ANTIBIOTICS</b>		
BENZAMYCIN ( <i>erythromycin-benzoyl peroxide</i> )	T3	
CENTANY	T3	

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

T4 – Injectable Specialty Medications

PA – Prior Authorization

QL – Quantity Limit

ST – Step Therapy

AGE – Age Requirement

SP – Specialty Medication

HD – May require home delivery pharmacy

PPACA – No Cost-Share Preventive Medication

CSL – Oral cancer medication subject to cost-share limits

## List of Prescription Medications

### ANTIBIOTICS (Skin Conditions) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>TOPICAL ANTIBIOTICS (cont.)</b>		
CENTANY AT	T3	
CLEOCIN T ( <i>clindamycin phosphate</i> )	T3	
CLINDACIN ETZ KIT	T3	
CLINDACIN PAC	T3	
<i>clindamycin phosphate</i>	T1	
<i>clindamycin phosphate</i> (Cleocin T)	T1	
<i>clindamycin phosphate</i> (Evoclin)	T1	
<i>erythromycin base in ethanol</i>	T1	
<i>erythromycin base in ethanol</i>	T3	
<i>erythromycin/benzoyl peroxide</i> (Benzamycin)	T1	
EVOCLIN ( <i>clindamycin phosphate</i> )	T3	
<i>gentamicin sulfate</i>	T1	
<i>mupirocin</i> (Centany)	T1	
<i>mupirocin calcium</i>	T1	
XEPI	T3	
<b>TOPICAL SULFONAMIDES</b>		
AVAR 9.5-5% CLEANSING PADS	T3	
<i>avar cleanser</i> (Rosanil)	T1	
AVAR LS	T3	
AVAR-E	T1	
<i>mafénide acetate</i>	T1	
<i>mafénide acetate</i> (Sulfamylon)	T1	
ROSANIL ( <i>sodium sulfacetamide-sulfur</i> )	T1	
SILVADENE ( <i>ssd</i> )	T3	
<i>silver sulfadiazine</i> (Silvadene)	T1	
<i>sulfacetamide sod/sulfur/urea</i>	T1	
<i>sulfacetamide sodium/sulfur</i>	T1	
<i>sulfacetamide sodium/sulfur</i> (Avar-e Green)	T1	
<i>sulfacetamide sodium/sulfur</i> (Rosanil)	T1	
<i>sulfacetamide/sulfur/cleansr23</i>	T1	
<i>sulfact sod/sulur/avob/otn/oct</i>	T1	
SULFAMYLYON	T2	

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

T4 – Injectable Specialty Medications

PA – Prior Authorization

QL – Quantity Limit

ST – Step Therapy

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## List of Prescription Medications

ANTI-COAGULANTS (Blood Thinners/Anti-Clotting)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>ANTI-COAGULANTS, COUMARIN TYPE</b>		
<i>warfarin sodium</i>	T1	HD
<b>CITRATES AS ANTI-COAGULANTS</b>		
ACD SOLUTION A	T3	
ACD-A	T3	
ANTICOAG SODIUM CITRATE 4% SOL	T3	
CITRATE PHOSPHATE DEXTROSE	T1	
<b>DIRECT FACTOR XA INHIBITORS</b>		
BEVYXXA	T3	QL (42 caps/42 days)
ELIQUIS	T2	
<i>rivaroxaban (Xarelto)</i>	T1	
XARELTO	T2	
<b>HEPARIN AND RELATED PREPARATIONS</b>		
<i>ARIXTRA (fondaparinux sodium)</i>	T3	QL (1 syringe/day) SP
<i>enoxaparin 100 mg/ml syringe (Lovenox)</i>	T1	QL (2 syringes/day) SP
<i>enoxaparin 120 mg/0.8 ml/syr (Lovenox)</i>	T1	QL (2 syringes/day) SP
<i>enoxaparin 150 mg/ml syringe (Lovenox)</i>	T1	QL (2 syringes/day) SP
<i>enoxaparin 30 mg/0.3 ml/syr (Lovenox)</i>	T1	QL (2 syringes/day) SP
<i>enoxaparin 300 mg/3 ml vial (Lovenox)</i>	T1	QL (1 vial/day) SP
<i>enoxaparin 40 mg/0.4 ml/syr (Lovenox)</i>	T1	QL (2 syringes/day) SP
<i>enoxaparin 60 mg/0.6 ml/syr (Lovenox)</i>	T1	QL (2 syringes/day) SP
<i>enoxaparin 80 mg/0.8 ml/syr (Lovenox)</i>	T1	QL (2 syringes/day) SP
<i>fondaparinux sodium (Arixtra)</i>	T1	QL (1 syringe/day) SP
<i>heparin 10,000 unit/10 ml vial</i>	T1	
<i>heparin 30,000 unit/30 ml vial</i>	T1	
<i>heparin 40,000 unit/4 ml vial</i>	T1	
<i>heparin 50,000 unit/10 ml vial</i>	T1	
<i>heparin 50,000 unit/5 ml vial</i>	T1	
<i>heparin sod 1,000 unit/ml vial</i>	T1	
<i>heparin sod 10,000 unit/ml vial</i>	T1	
<i>heparin sod 2,000 unit/2ml vial</i>	T1	
<i>heparin sod 20,000 unit/ml vial</i>	T1	
<i>heparin sod 5,000 unit/0.5 ml</i>	T1	

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

T4 – Injectable Specialty Medications

PA – Prior Authorization

QL – Quantity Limit

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AGE – Age Requirement

SP – Specialty Medication

HD – May require home delivery pharmacy

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## List of Prescription Medications

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

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>HEPARIN AND RELATED PREPARATIONS (cont.)</b>		
HEPARIN SOD 5,000 UNIT/0.5 ML	T1	
<i>heparin sod 5,000 unit/0.5 ml</i> (Heparin Sodium)	T1	
<i>heparin sod 5,000 unit/ml syrg</i>	T3	
<i>heparin sod 5,000 unit/ml vial</i>	T1	
LOVENOX 100 MG/ML SYRINGE ( <i>enoxaparin sodium</i> )	T3	QL (2 syringes/day) SP
LOVENOX 120 MG/0.8 ML SYRINGE ( <i>enoxaparin sodium</i> )	T3	QL (2 syringes/day) SP
LOVENOX 150 MG/ML SYRINGE ( <i>enoxaparin sodium</i> )	T3	QL (2 syringes/day) SP
LOVENOX 30 MG/0.3 ML SYRINGE ( <i>enoxaparin sodium</i> )	T3	QL (2 syringes/day) SP
LOVENOX 300 MG/3 ML VIAL ( <i>enoxaparin sodium</i> )	T3	QL (1 vial/day) SP
LOVENOX 40 MG/0.4 ML SYRINGE ( <i>enoxaparin sodium</i> )	T3	QL (2 syringes/day) SP
LOVENOX 60 MG/0.6 ML SYRINGE ( <i>enoxaparin sodium</i> )	T3	QL (2 syringes/day) SP
LOVENOX 80 MG/0.8 ML SYRINGE ( <i>enoxaparin sodium</i> )	T3	QL (2 syringes/day) SP
<b>THROMBIN INHIBITORS, SELECTIVE, DIRECT, REVERSIBLE</b>		
dabigatran etexilate	T1	HD
<b>ANTIDOTES (Gastrointestinal/Heartburn)</b>		
<b>MU-OPIOID RECEPTOR ANTAGONISTS, PERIPHERALLY-ACTING</b>		
MOVANTIK	T2	PA
RELISTOR	T3	PA
SYMPROIC	T2	PA
<b>ANTIDOTES (Substance Abuse)</b>		
<b>OPIOID ANTAGONISTS</b>		
KLOXXADO	T2	PA QL (2 sprays/30 days)
<i>naloxone 0.4 mg/ml carpuject</i>	T1	
<i>naloxone 0.4 mg/ml vial</i>	T1	
NALOXONE 2 MG AUTO-INJECTOR	T3	QL (0.8ml/day)
<i>naloxone 2 mg/2 ml syringe</i>	T1	
<i>naloxone 4 mg/10 ml vial</i>	T1	
naltrexone	T1	QL (180 tabs/30 days)
NARCAN	T2	QL (2 units/30 days)
OPVEE	T3	QL (2 units/30 days)
REXTOVY	T2	QL(2 units/30 days)
ZIMHI	T3	QL (2 units/30 days)

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

T4 – Injectable Specialty Medications

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## List of Prescription Medications

ANTI-FUNGALS (Eye Conditions)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>OPHTHALMIC ANTI-FUNGAL AGENTS</b>		
NATACYN	T2	
ANTI-FUNGALS (Feminine Products)		
<b>VAGINAL ANTI-FUNGALS</b>		
GYNAZOLE 1	T1	
<i>miconazole nitrate</i>	T1	
<i>terconazole</i>	T1	
ANTI-FUNGALS (Infections)		
<b>ANTI-FUNGAL AGENTS</b>		
ANCOBON ( <i>flucytosine</i> )	T3	
<i>clotrimazole</i>	T1	
CRESEMDA	T3	PA
<i>fluconazole</i>	T1	
<i>flucytosine (Ancobon)</i>	T1	
<i>itraconazole</i>	T1	
<i>ketoconazole</i>	T1	
ORAVIG	T3	
<i>posaconazole (Noxafil)</i>	T1	
<i>terbinafine hcl</i>	T1	
VFEND ( <i>voriconazole</i> )	T3	PA
VIVJOA	T4	PA SP
<i>voriconazole (Vfend)</i>	T1	PA
<b>ANTI-FUNGAL ANTIBIOTICS</b>		
GRIS-PEG ( <i>griseofulvin ultramicrosize</i> )	T3	
<i>griseofulvin ultra 125 mg tab</i>	T1	
<i>griseofulvin ultra 165 mg tab</i>	T1	QL(4 tabs/day)
<i>griseofulvin ultra 250 mg tab</i>	T1	
<i>nystatin</i>	T1	
ANTI-FUNGALS (Skin Conditions)		
<b>TOPICAL ANTI-FUNGAL/ANTI-INFLAMMATORY, STEROID AGENT</b>		
<i>clotrimazole/betamethasone dip</i>	T1	
<b>TOPICAL ANTI-FUNGALS</b>		
<i>ciclodan 0.77% cream</i>	T1	
CICLODAN 0.77% CREAM KIT	T3	
<i>ciclodan 8% solution</i>	T1	

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

T4 – Injectable Specialty Medications

PA – Prior Authorization

QL – Quantity Limit

ST – Step Therapy

AGE – Age Requirement

SP – Specialty Medication

HD – May require home delivery pharmacy

PPACA – No Cost-Share Preventive Medication

CSL – Oral cancer medication subject to cost-share limits

## List of Prescription Medications

ANTI-FUNGALS (Skin Conditions) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>TOPICAL ANTI-FUNGALS (cont.)</b>		
ciclopirox	T1	
ciclopirox/urea/camph/men/euc (Ciclodan)	T1	
econazole nitrate	T1	
ECOZA	T3	
EXODERM	T1	
ketoconazole	T1	
ketoconazole/skin cleanser 28	T1	
LOPROX	T3	
LOPROX (ciclopirox)	T3	
LULICONAZOLE	T1	
naftifine hcl	T1	
naftifine hcl (Naftin)	T1	
NAFTIN (naftifine hcl)	T2	
nystatin	T1	
nystatin/triamcinolone acet	T1	
<b>ANTIHISTAMINE AND DECONGESTANT COMBINATION (Allergy/Nasal Sprays)</b>		
<b>1ST GEN ANTIHISTAMINE AND DECONGESTANT COMBINATION</b>		
phenylephrine hcl/prometh hcl	T1	
<b>2ND GEN ANTIHISTAMINE AND DECONGESTANT COMBINATION</b>		
CLARINEX-D 12 HOUR	T3	
<b>ANTIHISTAMINES - 1ST GENERATION</b>		
carbinoxamine maleate	T1	
CARBINOXAMINE MALEATE ER	T3	
clemastine fumarate	T1	
cyproheptadine hcl (Cyproheptadine Hcl)	T1	
hydroxyzine hcl	T1	
hydroxyzine pamoate	T1	
hydroxyzine pamoate (Vistaril)	T1	
promethazine hcl	T1	
VISTARIL (hydroxyzine pamoate)	T3	
<b>ANTIHISTAMINES - 2ND GENERATION</b>		
cetirizine hcl	T1	HD
CLARINEX (desloratadine)	T3	HD
desloratadine 2.5 mg odt	T1	QL (1 tab/day) HD

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

T4 – Injectable Specialty Medications

PA – Prior Authorization

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## List of Prescription Medications

ANTIHISTAMINES (Eye Conditions)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>ANTIHISTAMINES - 2ND GENERATION (con't.)</b>		
desloratadine 5 mg odt	T1	HD
desloratadine 5 mg tablet (Claritin)	T1	HD
<b>EYE ANTIHISTAMINES</b>		
azelastine hcl 0.05% drops	T1	
bepotastine besilate (Bepreve)	T1	
epinastine hcl	T1	
LASTACRAFT	T3	
olopatadine hcl 0.1% eye drops	T1	
olopatadine hcl 0.2% eye drop (Pataday)	T1	
PATADAY (olopatadine hcl)	T3	
PAZEO	T2	
ANTI-HYPERGLYCEMICS (Diabetes)		
<b>ANTIHYPERGLY, INCRETIN MIMETIC (GLP-I RECEPT.AGONIST)</b>		
BYDUREON	T2	QL (4 vials/28 days) ST HD
BYDUREON BCISE	T2	QL (4 pens/28 days) ST
BYDUREON PEN	T2	QL (4 pens/28 days) ST HD
BYETTA	T2	QL (1 pen/30 days) ST
exenatide	T1	PA QL(3 mls/30 days)
OZEMPIC 0.25-0.5 MG DOSE PEN	T2	QL (2 pens/28 days) ST HD
OZEMPIC 1 MG DOSE PEN (1.5 ML)	T2	QL (2 pens/28 days) ST HD
OZEMPIC 1 MG DOSE PEN (3 ML)	T2	QL (3ML/21 Days) ST HD
RYBELSUS	T2	QL (1 tab/day) ST
TRULICITY 0.75 MG/0.5 ML PEN	T2	QL (4 pens/28 days) ST
TRULICITY 1.5 MG/0.5 ML PEN	T2	QL (4 pens/28 days) ST
TRULICITY 3 MG/0.5 ML PEN	T2	QL (2ML/28 Days) ST
TRULICITY 4.5 MG/0.5 ML PEN	T2	QL (2ML/28 Days) ST
<b>ANTI-HYPERGLY, INSULIN, LONG ACT-GLP-I RECEPT.AGONIST</b>		
SOLIQUA 100-33	T2	
<b>ANTI-HYPERGLYCEMIC-SOD/GLUC COTRANSPORT2(SGLT2) INHIB</b>		
FARXIGA	T2	QL (1 tab/day) ST
<b>ANTI-HYPERGLYCEMIC, ALPHA-GLUCOSIDASE INHIBITORS</b>		
acarbose (Precose)	T1	HD
GLYSET (miglitol)	T3	HD

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

T4 – Injectable Specialty Medications

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## List of Prescription Medications

ANTI-HYPERGLYCEMICS (Diabetes) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>ANTI-HYPERGLYCEMIC, ALPHA-GLUCOSIDASE INHIBITORS (cont.)</b>		
miglitol (Glyset)	T1	HD
PRECOSE (acarbose)	T3	HD
<b>ANTI-HYPERGLYCEMIC, AMYLIN ANALOG-TYPE</b>		
SYMLINPEN 120	T2	HD
SYMLINPEN 60	T2	
<b>ANTI-HYPERGLYCEMIC, BIGUANIDE TYPE</b>		
GLUCOPHAGE XR (metformin hcl er)	T3	HD
metformin hcl	T1	HD
metformin hcl (Glucophage Xr)	T1	HD
RIOMET (metformin hcl)	T3	HD
RIOMET ER	T3	HD
<b>ANTI-HYPERGLYCEMIC, DPP-4 INHIBITORS</b>		
JANUVIA	T2	QL (1 tab/day) ST HD
<b>ANTIHYPERGLYCEMIC-GLUCOCORTICOID RECEPTOR BLOCKER</b>		
mifepristone 300 mg tablet (Korlym)	T1	PA SP
<b>ANTI-HYPERGLYCEMIC, INSULIN-RELEASE STIMULANT TYPE</b>		
AMARYL (glimepiride)	T3	HD
chlorpropamide	T1	HD
glimepiride (Amaryl)	T1	HD
GLIMEPIRIDE 3 MG TABLET	T3	HD
glipizide (Glucotrol XL)	T1	HD
GLIPIZIDE 2.5 MG TABLET	T3	HD
GLUCOTROL (glipizide)	T3	HD
GLUCOTROL XL (glipizide xl)	T3	HD
glyburide	T1	HD
GLYNASE (glyburide micronized)	T3	HD
repaglinide (Prandin)	T1	HD
STARLIX (nateglinide)	T3	HD
tolbutamide	T1	HD
<b>ANTI-HYPERGLYCEMIC, SGLT-2 AND DPP-4 INHIBITOR COMB</b>		
GLYXAMBI	T2	QL (1 tab/day) ST HD
<b>ANTI-HYPERGLYCEMIC, THIAZOLIDINEDIONE AND BIGUANIDE</b>		
ACTOPLUS MET (pioglitazone-metformin)	T3	HD

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

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## List of Prescription Medications

ANTI-HYPERGLYCEMICS (Diabetes) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>ANTI-HYPERGLYCEMIC, THIAZOLIDINEDIONE AND BIGUANIDE (cont.)</b>		
pioglitazone hcl/metformin hcl (Actoplus Met)	T1	HD
<b>ANTI-HYPERGLYCEMIC, THIAZOLIDINEDIONE-SULFONYLUREA</b>		
DUETACT (pioglitazone-glimepiride)	T3	HD
pioglitazone hcl/glimepiride (Duetact)	T1	HD
<b>ANTI-HYPERGLYCEMIC, DPP-4 INHIBITOR-BIGUANIDE COMBS.</b>		
JANUMET	T2	QL (2 tabs/day) ST HD
JANUMET XR 100-1,000 MG TABLET	T2	QL (1 tab/day) ST HD
JANUMET XR 50-1,000 MG TABLET	T2	QL (2 tabs/day) ST HD
JANUMET XR 50-500 MG TABLET	T2	QL (1 tab/day) ST HD
<b>ANTI-HYPERGLYCEMIC, INSULIN-RELEASE STIM.-BIGUANIDE</b>		
glipizide/metformin hcl	T1	HD
glyburide/metformin hcl	T1	HD
pioglitazone hcl (Actos)	T1	HD
repaglinide/metformin hcl	T1	HD
SITAGLIPTIN-METFORMIN	T3	HD
<b>ANTI-HYPERGLYCEMIC, THIAZOLIDINEDIONE (PPARG AGONIST)</b>		
ACTOS (pioglitazone hcl)	T3	HD
AVANDIA	T3	HD
pioglitazone hcl (Actos)	T1	HD
<b>ANTI-HYPERGLYCEMIC-SGLT2 INHIBITOR-BIGUANIDE COMBS.</b>		
INVOKAMET	T2	QL (2 tabs/day) ST HD
SYNJARDY	T2	QL (2 tabs/day) ST HD
SYNJARDY XR 10-1,000 MG TABLET	T2	QL (2 tabs/day) ST HD
SYNJARDY XR 12.5-1,000 MG TAB	T2	QL (2 tabs/day) ST HD
SYNJARDY XR 25-1,000 MG TABLET	T2	QL (1 tab/day) ST HD
SYNJARDY XR 5-1,000 MG TABLET	T2	QL (2 tabs/day) ST HD
XIGDUO XR 10 MG-1,000 MG TAB	T2	QL (1 tab/day) ST HD
XIGDUO XR 10 MG-500 MG TABLET	T2	QL (1 tab/day) ST HD
XIGDUO XR 2.5 MG-1,000 MG TAB	T2	QL (2 tabs/day) ST HD
XIGDUO XR 5 MG-1,000 MG TABLET	T2	QL (2 tabs/day) ST HD
XIGDUO XR 5 MG-500 MG TABLET	T2	QL (1 tab/day) ST HD
<b>ANTIHYPERGLY-SGLT-2 INHIB, DPP-4 INHIB, BIGUANIDE CB</b>		
TRIJARDY XR	T2	QL (1 tab/day) ST HD

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

T4 – Injectable Specialty Medications

PA – Prior Authorization

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## List of Prescription Medications

ANTI-HYPERGLYCEMICS (Diabetes) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>INSULINS</b>		
BASAGLAR KWIKPEN U-100	T2	QL (1.5ml/day) HD
HUMALOG	T2	QL (1.5ml/day) HD
HUMALOG JUNIOR KWIKPEN	T2	QL (1.5ml/day) HD
HUMALOG KWIKPEN U-100	T2	QL (1.5 ml/day) HD
HUMALOG KWIKPEN U-200	T2	QL (1 ml/day) HD
HUMALOG MIX 50-50	T2	QL (2ml/day) HD
HUMALOG MIX 50-50 KWIKPEN	T2	QL (2ml/day) HD
HUMALOG MIX 75-25	T2	QL (2ml/day) HD
HUMALOG MIX 75-25 KWIKPEN	T2	QL (2ml/day) HD
HUMULIN R U-500	T2	QL (1 ml/day) HD
HUMULIN R U-500 KWIKPEN	T2	QL (1 ml/day) HD
INSULIN ASPART	T2	QL (1.5ml/day) HD
INSULIN ASPART FLEXPEN	T2	QL (1.5ml/day) HD
INSULIN ASPART PENFILL	T2	QL (1.5ml/day) HD
INSULIN ASPART PROT-INSULN ASP	T2	QL (2 ml/day) HD
INSULIN GLARGINE YFGN (SEMGLEE-YFGN), VIAL, PEN	T2	QL (1.5ml/day) HD
INSULIN LISPRO (HUMALOG) (U-100 VIAL)	T2	QL (1.5ml/day) HD
INSULIN LISPRO PROTAMINE MIX	T2	QL (2 ml/day) HD
LYUMJEV	T2	QL (1.5ml/day) HD
LYUMJEV KWIKPEN U-100	T2	QL (1.5ml/day) HD
LYUMJEV KWIKPEN U-200	T2	QL (1 ml/day) HD
SEMGLEE	T2	PA QL(1.5 mls/day) HD
TRESIBA	T2	QL (1.5ml/day) HD
TRESIBA FLEXTOUCH U-100	T2	QL (1.5ml/day) HD
TRESIBA FLEXTOUCH U-200	T2	QL (0.9ml/day) HD
ANTI-INFECTIVES (Feminine Products)		
<b>VAGINAL SULFONAMIDES</b>		
AVC	T3	
ANTI-INFECTIVES (Infections)		
<b>PENICILLIN ANTIBIOTICS</b>		
amoxicillin	T1	

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

T4 – Injectable Specialty Medications

PA – Prior Authorization

QL – Quantity Limit

ST – Step Therapy

AGE – Age Requirement

SP – Specialty Medication

HD – May require home delivery pharmacy

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## List of Prescription Medications

ANTI-INFECTIVES/MISCELLANEOUS (Feminine Products)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>VAGINAL ANTISEPTICS</b>		
<i>acetic acid/oxyquinoline</i> (Relagard)	T1	
RELAGARD ( <i>fem ph</i> )	T3	
TRIMO-SAN	T3	
ANTI-INFECTIVES/MISCELLANEOUS (Infections)		
<b>2ND GEN. ANAEROBIC ANTI-PROTOZOAL-ANTIBACTERIAL</b>		
TINDAMAX ( <i>tinidazole</i> )	T3	
<i>tinidazole</i>	T1	
<i>tinidazole</i> (Tindamax)	T1	
<b>ANTHELMINTICS</b>		
<i>albendazole</i> (Albenza)	T1	
ALBENZA ( <i>albendazole</i> )	T3	
BILTRICIDE ( <i>praziquantel</i> )	T3	
EMVERM	T1	
<i>ivermectin</i> (Stromectol)	T1	
<i>praziquantel</i> (Biltricide)	T1	
STROMECTOL ( <i>ivermectin</i> )	T3	PA
<b>ANTI-MALARIAL DRUGS</b>		
<i>atovaquone/proguanil hcl</i> (Malarone)	T1	
<i>chloroquine ph 250 mg tablet</i>	T1	
<i>chloroquine ph 500 mg tablet</i>	T1	QL (28 tabs/365 days)
COARTEM	T3	PA QL (24 tabs/30 days)
<i>hydroxychloroquine sulfate</i> (Sovuna)	T1	
KRINTAFEL	T3	PA QL (2 tabs/30 days)
MALARONE ( <i>atovaquone-proguanil hcl</i> )	T3	PA
<i>mefloquine hcl</i>	T1	
PRIMAQUINE ( <i>primaquine phosphate</i> )	T1	
<i>primaquine phosphate</i> (Primaquine)	T1	
<i>pyrimethamine 25 mg tablet</i> (Daraprim)	T1	PA
<i>pyrimethamine 25 mg tablet</i> (Daraprim)	T1	PA SP

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

T4 – Injectable Specialty Medications

PA – Prior Authorization

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## List of Prescription Medications

ANTI-INFECTIVES/MISCELLANEOUS (Infections) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>ANTI-MALARIAL DRUGS (cont.)</b>		
quinine sulfate	T1	
<b>ANTI-PROTOZOAL DRUGS, MISCELLANEOUS</b>		
atovaquone	T1	
BENZNIDAZOLE	T3	
IMPAVIDO	T3	PA
LAMPIT	T3	
NEBUPENT ( <i>pentamidine isethionate</i> )	T3	
<i>pentamidine isethionate</i> (Nebupent)	T1	
ANTI-INFECTIVES/MISCELLANEOUS (Miscellaneous)		
<b>ANTIBACTERIAL AGENTS, MISCELLANEOUS</b>		
glycine urologic solution	T3	
<b>ANTISEPTICS, GENERAL</b>		
ALCOHOL SWABSTICK	T3	
GS ISOPROPYL ALCOHOL 70% SPRAY	T1	
<b>TOPICAL ANTISEPTIC DRYING AGENTS</b>		
formaldehyde	T1	
ANTI-INFLAM.TUMOR NECROSIS FACTOR INHIBITING AGENTS (Pain Relief And Inflammatory Disease)		
<b>ANTI-INFLAMMATORY TUMOR NECROSIS FACTOR INHIBITOR</b>		
ADALIMUMAB-ADAZ	T2	PA QL 2 (doses/ 28 days) SP
ADALIMUMAB-ADBM(CF)	T4	PA QL(2 pens/syringes/28 days) SP HD
ADALIMUMAB-ADBM(CF) PEN CROHNS	T4	PA QL(1 starter kit/365 days) SP HD
ADALIMUMAB-RYVK(CF)	T4	PA QL(2 pens/syringes/28 days) SP HD
ADALIMUMAB-RYVK(CF) AUTOINJECT	T4	PA QL SP HD
AVSOLA	T2	PA SP
CIMZIA	T2	PA QL(1 starter kit/365 days) SP HD
CIMZIA (2 PACK)	T3	PA QL (1 kit/28 days) SP HD
CYLTEZO	T4	PA QL (2 doses/ 28 days) SP HD

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

T4 – Injectable Specialty Medications

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## List of Prescription Medications

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

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>ANTI-INFLAMMATORY TUMOR NECROSIS FACTOR INHIBITOR (cont.)</b>		
CYLTEZO (CF) PEN	T4	PA QL(2 kit/28 days) SP
CYLTEZO(CF) PEN CROHN'S-UC-HS	T4	PA QL(1 starter kit/365 days) SP HD
CYLTEZO(CF) PEN PSORIASIS-UV	T4	PA QL(1 starter kit/365 days) SP HD
ENBREL 25 MG KIT	T4	PA QL (8 vials/28 days) SP HD
ENBREL 25 MG/0.5 ML SYRINGE	T4	PA QL (8 syringes/28 days) SP HD
ENBREL 25 MG/0.5 ML VIAL	T4	PA QL (4 ml/28 Days) SP HD
ENBREL 50 MG/ML SYRINGE	T4	PA QL (4 syringes/28 days) SP HD
ENBREL MINI	T4	PA QL (4 cartridges/28 days) SP HD
ENBREL SURECLICK	T4	PA QL (4 syringes/28 days) SP HD
HUMIRA	T4	PA QL (2 syringes/28 days) SP HD
HUMIRA PEN	T4	PA QL (2 pens/28 days) SP HD
HUMIRA(CF)	T4	PA QL (2 syringes/28 days) SP HD
HUMIRA(CF) PEDIATRIC CROHN'S	T4	PA QL (1 kit/year) SP HD
HUMIRA(CF) PEN 40 MG/0.4 ML	T4	PA QL (2 pens/28 days) SP HD
HUMIRA(CF) PEN 80 MG/0.8 ML	T4	PA QL (1 kit/year) SP HD
HUMIRA(CF) PEN PSOR-UV-ADOL HS	T4	PA QL (1 kit/year) SP HD
INFLECTRA	T2	PA SP HD
REMICADE	T3	PA SP HD
SIMLANDI(CF) AUTOINJECTOR	T4	PA QL(2 auto-injs/28 days) SP HD
SIMPONI 100 MG/ML PEN INJECTOR	T4	PA QL (1 injector/28 days) SP HD
SIMPONI 100 MG/ML SYRINGE	T4	PA QL (1 syringe/28 days) SP HD
SIMPONI 50 MG/0.5 ML PEN INJEC	T4	PA QL (1 injector/28 days) SP HD
SIMPONI 50 MG/0.5 ML SYRINGE	T4	PA QL (1 syringe/28 days) SP HD
SIMPONI ARIA	T4	PA SP HD

### ANTI-NEOPLASTICS (Cancer)

<b>ANP - SELECTIVE RETINOID X RECEPTOR AGONISTS (RXR)</b>		
bexarotene (Targretin)	T1	PA SP HD
<b>ANTI-NEOPLAST, HISTONE DEACETYLASE (HDAC) INHIBITORS</b>		
FARYDAK	T3	PA SP HD
ZOLINZA	T2	PA SP HD
<b>ANTI-NEOPLASTIC - ALKYLATING AGENTS</b>		
ALKERAN ( <i>melphalan</i> )	T3	SP
cyclophosphamide	T1	SP HD
GLEOSTINE	T2	

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

T4 – Injectable Specialty Medications

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## List of Prescription Medications

### ANTI-NEOPLASTICS (Cancer) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>ANTI-NEOPLASTIC - ALKYLATING AGENTS (cont.)</b>		
HYDREA ( <i>hydroxyurea</i> )	T3	
<i>hydroxyurea</i> (Hydrea)	T1	
LEUKERAN	T2	
<i>melphalan</i> (Alkeran)	T1	SP CSL
MYLERAN	T2	
<i>temozolomide</i>	T1	PA SP HD
<b>ANTI-NEOPLASTIC - ANTI-ANDROGENIC AGENTS</b>		
<i>abiraterone acetate</i>	T1	PA SP HD CSL
<i>bicalutamide</i> (Casodex)	T1	
CASODEX ( <i>bicalutamide</i> )	T3	
ERLEADA 240 MG TABLET	T2	PA QL(1 tab/day) SP HD CSL
ERLEADA 60 MG TABLET	T2	PA SP HD CSL
<i>flutamide</i>	T1	
<i>nilutamide</i>	T1	QL (4 tabs/day)
NUBEQA	T2	PA SP HD
XTANDI	T2	PA SP HD
<b>ANTI-NEOPLASTIC - ANTI-METABOLITES</b>		
<i>capecitabine</i> (Xeloda)	T1	PA SP HD
INQOVI	T3	PA SP HD
JYLMAMVO	T3	CSL
LONSURF	T3	PA SP HD
<i>mercaptopurine</i>	T1	
<i>methotrexate sodium</i>	T1	
<i>methotrexate sodium/pf</i>	T1	
ONUREG	T3	PA QL (14 tabs/28 Days) SP
PURIXAN	T3	SP
TABLOID	T3	
TREXALL	T2	
XATMEP	T3	
XELODA ( <i>capecitabine</i> )	T3	PA SP HD
<b>ANTI-NEOPLASTIC - AROMATASE INHIBITORS</b>		
<i>anastrozole</i> (Arimidex)	T1	HD PPACA
ARIMIDEX ( <i>anastrozole</i> )	T3	HD
AROMASIN ( <i>exemestane</i> )	T3	HD
<i>exemestane</i> (Aromasin)	T1	HD PPACA

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

T4 – Injectable Specialty Medications

PA – Prior Authorization

QL – Quantity Limit

ST – Step Therapy

AGE – Age Requirement

SP – Specialty Medication

HD – May require home delivery pharmacy

PPACA – No Cost-Share Preventive Medication

CSL – Oral cancer medication subject to cost-share limits

## List of Prescription Medications

### ANTI-NEOPLASTICS (Cancer) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>ANTI-NEOPLASTIC - AROMATASE INHIBITORS (con't.)</b>		
letrozole (Femara)	T1	HD
<b>ANTI-NEOPLASTIC - BRAF KINASE INHIBITORS</b>		
OJEMDA TABLET	T3	PA QL(1 packet/28 Days) SP CSL
OJEMDA 25 MG/ML ORAL SUSP	T3	PA QL(8 bottles/28 days) SP CSL
TAFINLAR CAPSULE	T2	PA QL(4 caps/day) SP HD CSL
TAFINLAR TABLET	T2	PA QL(30 tabs/day) SP HD CSL
ZELBORAF	T3	PA SP HD
<b>ANTI-NEOPLASTIC - HEDGEHOG PATHWAY INHIBITOR</b>		
DAURISMO	T3	PA SP HD
ERIVEDGE	T2	PA SP HD
ODOMZO	T2	PA SP HD CSL
<b>ANTI-NEOPLASTIC - JANUS KINASE (JAK) INHIBITORS</b>		
JAKAFI	T3	PA SP HD
<b>ANTI-NEOPLASTIC - KRAS PROTEIN INHIBITOR</b>		
LUMAKRAS 120 MG TABLET	T3	PA QL (8 tabs per day) SP HD
LUMAKRAS 240 MG TABLET	T3	PA QL(4 tabs/day) SP HD CSL
LUMAKRAS 320 MG TABLET	T3	PA QL (3 tabs per day) SP HD
<b>ANTI-NEOPLASTIC LHRH(GNRH) AGONIST,PITUITARY SUPPR.</b>		
LUPRON DEPOT	T4	PA SP HD
<b>ANTI-NEOPLASTIC - MEK KINASE INHIBITORS</b>		
COTELLIC	T3	PA SP HD
GOMEKLI	T3	PA SP HD
KOSELUGO 10 MG CAPSULE	T3	PA QL (10 capsules/day) SP
KOSELUGO 25 MG CAPSULE	T3	PA QL (4 caps/day) SP
MEKINIST 0.05 MG/ML SOLUTION	T2	PA QL(40 mls/day) SP HD CSL
MEKINIST 0.5 MG TABLET	T2	PAQL(3 tabs/day) SP HD CSL
MEKINIST 2 MG TABLET	T2	PA QL(1 tab/day) SP HD CSL
<b>ANTI-NEOPLASTIC - MTOR KINASE INHIBITORS</b>		
AFINITOR (everolimus)	T3	PA SP HD
everolimus (Afinitor)	T1	PA QL(1 tab/day) SP HD CSL
<b>ANTI-NEOPLASTIC - PROTEIN METHYLTRANSFERASE INHIBIT</b>		
TAZVERIK	T3	PA SP
<b>ANTI-NEOPLASTIC - TOPOISOMERASE I INHIBITORS</b>		
HYCAMTIN	T3	PA SP HD
<b>ANTI-NEOPLASTIC COMB - KINASE AND AROMATASE INHIBIT</b>		
KISQALI 200 MG DAILY DOSE	T2	PA QL (21 per 28 days) SP HD

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

T4 – Injectable Specialty Medications

PA – Prior Authorization

QL – Quantity Limit

ST – Step Therapy

AGE – Age Requirement

SP – Specialty Medication

HD – May require home delivery pharmacy

PPACA – No Cost-Share Preventive Medication

CSL – Oral cancer medication subject to cost-share limits

## List of Prescription Medications

### ANTI-NEOPLASTICS (Cancer) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>ANTI-NEOPLASTIC COMB - KINASE AND AROMATASE INHIBIT (cont.)</b>		
KISQALI 400 MG DAILY DOSE	T2	PA QL (42 per 28 days) SP HD
KISQALI 600 MG DAILY DOSE	T2	PA QL (63 per 28 days) SP HD
KISQALI Femara Co-Pack- One pack	T2	PA QL (63 per 28 days) SP
<b>ANTI-NEOPLASTIC EGF RECEPTOR BLOCKER MCLON ANTIBODY</b>		
PHESGO	T3	PA SP HD
<b>ANTI-NEOPLASTIC IMMUNOMODULATOR AGENTS</b>		
lenalidomide	T1	PA QL(1 tab/day) SP HD CSL
POMALYST	T2	PA QL(21 caps/28 days) SP HD CSL
REVLIMID	T2	PA QL(1 tab/day) SP HD CSL
<b>ANTI-NEOPLASTIC LHRH (GNRH) AGONIST, PITUITARY SUPPR.</b>		
leuprolide acetate	T1	PA SP
LEUPROLIDE DEPOT	T4	PA SP HD
LUTRATE DEPOT	T4	PA SP
ZOLADEX	T2	PA SP HD
<b>ANTI-NEOPLASTIC LHRH (GNRH) ANTAGONIST, PITUIT.SUPPRS</b>		
FIRMAGON	T3	PA SP HD
ORGOVYX	T3	PA SP
<b>ANTI-NEOPLASTIC SYSTEMIC ENZYME INHIBITORS</b>		
ALECensa	T2	PA QL(8 tabs/day) SP HD CSL
AYVAKIT	T3	PA QL (1 tab/day) SP
BALVERSA	T3	PA SP
BOSULIF	T3	PA QL(3 caps/day) SP HD CSL
BRUKINSA	T2	PA QL (4 caps/day) SP
CABOMETYX	T3	PA SP HD
CALQUENCE	T3	PA SP
CAPRELSA	T3	PA SP
COMETRIQ	T3	PA SP HD
COPIKTRA	T3	PA SP
dasatinib 20 mg tablet	T1	PA QL(3 tabs/day) SP CSL
dasatinib 70 mg tablet	T1	PA QL(2 tabs/day) SP CSL
dasatinib 50 mg, 80 mg, 100 mg, 140 mg tablet	T1	PA QL(1 tab/day) SP CSL
EXKIVITY	T3	PA SP HD
FOTIVDA	T3	PA QL (30 caps/30 days) SP HD
GAVRETO	T3	PA QL (4 tabs/Day) SP HD CSL
gefitinib	T1	PA SP HD CSL

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

T4 – Injectable Specialty Medications

PA – Prior Authorization

QL – Quantity Limit

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AGE – Age Requirement

SP – Specialty Medication

HD – May require home delivery pharmacy

PPACA – No Cost-Share Preventive Medication

CSL – Oral cancer medication subject to cost-share limits

## List of Prescription Medications

### ANTI-NEOPLASTICS (Cancer) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>ANTI-NEOPLASTIC SYSTEMIC ENZYME INHIBITORS (cont.)</b>		
GILOTRIF	T3	PA SP HD
GLEEVEC ( <i>imatinib mesylate</i> )	T3	PA SP HD
IBRANCE	T3	PA QL(21 caps/28 days) SP HD CSL
<i>imatinib mesylate 100 mg tab (Gleevec)</i>	T1	QL (6 tabs/day) SP HD CSL
<i>imatinib mesylate 400 mg tab (Gleevec)</i>	T1	QL (2 tabs/day) SP HD CSL
IMBRUVICA	T2	PA SP
IMKELDI	T2	PA SP CSL
INLYTA	T3	PA SP HD
INREBIC	T3	PA SP HD
IRESSA	T3	PA SP HD
ITOVEBI	T3	PA SP HD CSL
IWLFIN	T3	PA QL(8 tabs/day) SP CSL
KISQALI 200 MG DAILY DOSE	T2	PA QL(21 tabs/28 days) SP HD CSL
KISQALI 400 MG DAILY DOSE	T2	PA QL(42 tabs/28 days) SP HD CSL
KISQALI 600 MG DAILY DOSE	T2	PA QL(63 tabs/28 days) SP HD CSL
<i>lapatinib ditosylate (Tykerb)</i>	T1	PA SP HD
LENVIMA	T3	PA SP HD
LORBRENA	T3	PA SP HD
LYNPARZA	T2	PA SP HD
LYTGOBI 12 MG DAILY DOSE PACK	T3	PA QL(3 tabs/day) SP CSL
LYTGOBI 16 MG DAILY DOSE PACK	T3	PA QL(4 tabs/day) SP CSL
LYTGOBI 20 MG DAILY DOSE PACK	T3	PA QL(5 tabs/day) SP CSL
NERLYNX	T3	PA SP HD
<i>nilotinib</i>	T1	PA QL (4 caps/day) SP HD CSL
NILOTINIB	T3	PA SP CSL
NINLARO	T3	PA QL(3 caps/28 days) SP HD CSL
OGSIVEO	T3	PA QL(6 TABS/DAY) SP CSL
OJJAARA	T3	PA QL(1 TAB/DAY) SP CSL
<i>pazopanib 200 mg tablet (Votrient)</i>	T1	PA QL (4 tabs/day) SP HD CSL
PEMAZYRE	T3	PA QL (14 tabs/21 days) SP
PIQRAY	T2	PA SP CSL
QINLOCK	T3	PA QL (3 tabs/day) SP
RETEVMO 40 MG CAPSULE	T3	PA QL (6 caps/day) SP HD
RETEVMO 80 MG CAPSULE	T3	PA QL (4 tabs/day) SP HD
RETEVMO 120 MG, 160 MG TABLET	T3	PA QL (2 tabs/day) SP HD CSL

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

T4 – Injectable Specialty Medications

PA – Prior Authorization

QL – Quantity Limit

ST – Step Therapy

AGE – Age Requirement

SP – Specialty Medication

HD – May require home delivery pharmacy

PPACA – No Cost-Share Preventive Medication

CSL – Oral cancer medication subject to cost-share limits

## List of Prescription Medications

### ANTI-NEOPLASTICS (Cancer) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>ANTI-NEOPLASTIC SYSTEMIC ENZYME INHIBITORS (cont.)</b>		
REVUFORJ 25 MG, 110 MG TABLET	T3	PA SP CSL
REVUFORJ 160 MG TABLET	T3	PA QL(2 tabs/day) SP CSL
ROZLYTREK	T3	PA SP HD
RUBRACA	T2	PA SP
RYDAPT	T3	PA SP HD
SCEMBLIX 20 MG TABLET	T2	PA QL(2 tabs/day) SP HD CSL
SCEMBLIX 40 MG TABLET	T2	PA SP HD CSL
SCEMBLIX 100 MG TABLET	T2	PA SP CSL
STIVARGA	T2	PA QL(84 tabs/28 days) SP HD CSL
TABRECTA	T3	PA QL (4 tabs/day) SP HD
TAGRISSO	T3	PA SP HD
TALZENNA 0.1 MG SOFTGEL	T3	PA QL(1 cap/day) SP HD CSL
TALZENNA 0.25 MG SOFTGEL	T3	PA QL(1 cap/day) SP HD CSL
TALZENNA 0.35 MG SOFTGEL	T3	PA QL(1 cap/day) SP HD CSL
TALZENNA 0.5 MG SOFTGEL	T3	PA SP HD CSL
TALZENNA 0.75 MG SOFTGEL	T3	PA SP HD CSL
TALZENNA 1 MG SOFTGEL	T3	PA QL(1 cap/day) SP HD CSL
TASIGNA ( <i>nilotinib hcl</i> )	T2	PA QL(4 caps/day) SP HD CSL
TEPMETKO	T3	PA QL (2 tabs/day) SP
TRUQAP	T3	PA QL(64 tabs/28 days) SP CSL
TUKYSA	T3	PA SP
TURALIO	T3	PA QL(4 caps/day) SP CSL
TYKERB ( <i>lapatinib</i> )	T3	PA SP HD
UKONIQ	T3	PA QL (4 tabs/day) SP
VANFLYTA	T3	PA QL(2 tabs/day) SP CSL
VERZENIO	T2	PA QL(2 tabs/day) SP HD CSL
VITRAKVI	T3	PA SP HD
VIZIMPRO	T3	PA SP HD
XALKORI	T3	PA QL(4 caps/day) SP HD CSL
XOSPATA	T3	PA SP
ZEJULA	T2	PA QL(1 tab/day) SP CSL
ZYDELIG	T3	PA SP HD
<b>ANTI-NEOPLASTIC, ANTI-PROGRAMMED DEATH-1 (PD-1) MAB</b>		
OPDIVO	T3	PA SP HD

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

T4 – Injectable Specialty Medications

PA – Prior Authorization

QL – Quantity Limit

ST – Step Therapy

AGE – Age Requirement

SP – Specialty Medication

HD – May require home delivery pharmacy

PPACA – No Cost-Share Preventive Medication

CSL – Oral cancer medication subject to cost-share limits

## List of Prescription Medications

ANTI-NEOPLASTICS (Cancer) (cont.)			
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits	
<b>ANTI-NEOPLASTIC-B CELL LYMPHOMA-2(BCL-2) INHIBITORS</b>			
VENCLEXTA	T3	PA SP	
VENCLEXTA STARTING PACK	T3	PA SP	
<b>ANTI-NEOPLASTIC-ENZYME INHIB, ANTIANDROGEN COMB.</b>			
AKEEGA	T3	PA QL(2 tabs/day) SP CSL	
<b>ANTI-NEOPLASTIC-ISOCITRATE DEHYDROGENASE INHIBITORS</b>			
IDHIFA	T3	PA SP HD	
<b>ANTI-NEOPLASTIC-ISOCITRATE DEHYDROGENASE INHIBITORS (cont.)</b>			
REZLIDHIA	T3	PA QL(2 caps/day) SP CSL	
TIBSOVO	T3	PA SP	
<b>ANTI-NEOPLASTICS ANTIBODY/ANTIBODY-DRUG COMPLEXES</b>			
ENHERTU	T3	PA SP HD	
<b>ANTI-NEOPLASTICS, MISCELLANEOUS</b>			
<i>etoposide</i>	T1	SP HD	
LYSODREN	T2		
MATULANE	T2	SP	
<i>tretinoin 10 mg capsule</i>	T1	PA	
<b>ANTI-NEOPLASTIC-SELECT INHIB OF NUCLEAR EXP (SINE)</b>			
XPOVIO	T3	PA SP	
<b>CYTOTOXIC T-LYMPHOCYTE ANTIGEN (CTLA-4) RMC ANTIBODY</b>			
YEROVY	T3	PA SP HD	
<b>IMMUNOMODULATORS</b>			
ACTIMMUNE	T4	PA SP HD	
ANTI-NEOPLASTICS (Skin Conditions)			
<b>SELECTIVE ESTROGEN RECEPTOR MODULATORS (SERMS)</b>			
FARESTON ( <i>toremifene citrate</i> )	T3	QL (2 tabs/day) HD	
SOLTAMOX	T3	HD	
<i>tamoxifen citrate</i>	T1	HD PPACA	
<i>toremifene citrate</i> (Fareston)	T1	QL (2 tabs/day) HD	
<b>STEROID ANTI-NEOPLASTICS</b>			
EMCYT	T2	SP HD	
<i>megestrol acetate</i>	T1		
<b>PHOTOACT, TOPICAL ANTI-NEOPLAST, PREMALIGNANT LESIONS</b>			
LEVULAN	T3	SP	
<b>TOPICAL ANTI-NEOPLASTIC PREMALIGNANT LESION AGENTS</b>			
EFUDEX ( <i>fluorouracil</i> )	T3		

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

T4 – Injectable Specialty Medications

PA – Prior Authorization

QL – Quantity Limit

ST – Step Therapy

AGE – Age Requirement

SP – Specialty Medication

HD – May require home delivery pharmacy

PPACA – No Cost-Share Preventive Medication

CSL – Oral cancer medication subject to cost-share limits

## List of Prescription Medications

### ANTI-NEOPLASTICS (Skin Conditions) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>TOPICAL ANTI-NEOPLASTIC PREMALIGNANT LESION AGENTS (cont.)</b>		
FLUOROPLEX	T2	
<i>fluorouracil</i> (Efudex)	T1	
PANRETIN	T3	SP HD
PICATO	T2	
VALCHLOR	T3	SP HD

### ANTI-OBESITY DRUGS (Weight Management)

ANTI-OBESITY - ANOREXIC AGENTS	T3	PA
ADIPEX-P ( <i>phentermine hcl</i> )	T3	PA
<i>benzphetamine hcl</i>	T1	
<i>benzphetamine hcl</i> (Regimex)	T1	
<i>diethylpropion hcl</i>	T1	
LOMAIRA	T1	PA
<i>phendimetrazine tartrate</i>	T1	
<i>phentermine hcl</i>	T1	
<i>phentermine hcl</i> (Adipex-p)	T1	
QSYMIA	T3	PA
REGIMEX ( <i>benzphetamine hcl</i> )	T3	

### ANTI-OBESITY - MELANOCORTIN 4 RECEPTOR AGONISTS

IMCIVREE	T3	PA QL (9 ml/22 days) SP
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### ANTI-OBESITY GLUCAGON-LIKE PEPTIDE-1 RECEPTOR AGONIST

SAXENDA	T3	PA
WEGOVY	T2	PA QL (1 box/month)

### ANTI-OBESITY SEROTONIN 2C RECEPTOR AGONISTS

BELVIQ	T3	PA
BELVIQ XR	T3	PA

### ANTI-OBESITY - OPIOID ANTAG-NOREPI, DOPAMINE RU INHIB

CONTRAVE	T3	PA
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### FAT ABSORPTION DECREASING AGENTS

XENICAL	T3	PA
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### ANTI-PARASITICS (Eye Conditions)

OPHTHALMIC (EYE) ANTIPARASITICS	T2	PA QL(4 bottles/30 days) SP
XDEMVK	T2	PA QL(4 bottles/30 days) SP

### ANTI-PARASITICS (Infections)

ANTI-PARASITICS	T3	
ALINIA 100 MG/5 ML SUSPENSION		
T1 – Typically Generics	T4 – Injectable Specialty Medications	HD – May require home delivery pharmacy
T2 – Typically Preferred Brands	PA – Prior Authorization	PPACA – No Cost-Share Preventive Medication
T3 – Typically Non-Preferred Brands	QL – Quantity Limit	CSL – Oral cancer medication subject to cost-share limits
	ST – Step Therapy	
	AGE – Age Requirement	
	SP – Specialty Medication	

## List of Prescription Medications

ANTI-PARASITICS (Infections) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>ANTI-PARASITICS (cont.)</b>		
ALINIA ( <i>nitazoxanide</i> )	T3	
<i>nitazoxanide</i> (Alinia)	T1	
<b>TOPICAL ANTI-PARASITICS</b>		
<i>crotamiton</i> (Eurax)	T1	
ELIMITE ( <i>permethrin</i> )	T3	
EURAX 10% CREAM	T2	
EURAX 10% LOTION	T3	
<i>permethrin</i> (Elimite)	T1	
SKLICE ( <i>ivermectin</i> )	T3	
<i>spinosad</i> (Natroba)	T1	
ULESFIA	T3	
<b>ANTI-PARKINSON DRUGS (Parkinson's Disease)</b>		
<b>ANTI-PARKINSONISM DRUGS, ANTI-CHOLINERGIC</b>		
<i>benztropine mesylate</i>	T1	HD
<i>trihexyphenidyl hcl</i>	T1	HD
<i>amantadine hcl</i>	T1	HD
APOKYN	T4	PA SP HD
<b>ANTI-PARKINSONISM DRUGS, OTHER</b>		
<i>bromocriptine mesylate</i>	T1	HD
<i>carbidopa/levodopa</i>	T1	HD
<i>carbidopa/levodopa (Sinemet)</i>	T1	HD
<i>carbidopa/levodopa/entacapone</i>	T1	HD
DUOPA	T3	SP HD
<i>entacapone</i>	T1	HD

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

T4 – Injectable Specialty Medications

PA – Prior Authorization

QL – Quantity Limit

ST – Step Therapy

AGE – Age Requirement

SP – Specialty Medication

HD – May require home delivery pharmacy

PPACA – No Cost-Share Preventive Medication

CSL – Oral cancer medication subject to cost-share limits

## List of Prescription Medications

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

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>ANTI-PARKINSONISM DRUGS, OTHER (cont.)</b>		
INBRIJA	T3	PA SP HD
KYNMOBI	T2	PA HD
NEUPRO	T3	HD
NOURIANZ	T3	PA QL (1 tab/day) SP HD
<i>pramipexole di-hcl</i>	T1	HD
<i>pramipexole er 0.375 mg tablet</i>	T1	QL (1 tab/day) HD
<i>pramipexole er 0.75 mg tablet</i>	T1	HD
<i>pramipexole er 1.5 mg tablet</i>	T1	QL (1 tab/day) HD
<i>pramipexole er 2.25 mg tablet</i>	T1	QL (1 tab/day) HD
<i>pramipexole er 3 mg tablet</i>	T1	HD
<i>pramipexole er 3.75 mg tablet</i>	T1	HD
<i>rasagiline mesylate 0.5 mg tab (Azilect)</i>	T1	QL (1 tab/day) HD
RYTARY	T3	HD
<i>selegiline hcl</i>	T1	HD
SINEMET ( <i>carbidopa-levodopa</i> )	T3	HD
STALEVO 100 ( <i>carbidopa-levodopa-entacapone</i> )	T3	HD
STALEVO 125 ( <i>carbidopa-levodopa-entacapone</i> )	T3	HD
STALEVO 50 ( <i>carbidopa-levodopa-entacapone</i> )	T3	HD
STALEVO 75 ( <i>carbidopa-levodopa-entacapone</i> )	T3	HD
TASMAR ( <i>tolcapone</i> )	T3	HD
<i>tolcapone (Tasmar)</i>	T1	HD
XADAGO	T3	ST HD

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

T4 – Injectable Specialty Medications

PA – Prior Authorization

QL – Quantity Limit

ST – Step Therapy

AGE – Age Requirement

SP – Specialty Medication

HD – May require home delivery pharmacy

PPACA – No Cost-Share Preventive Medication

CSL – Oral cancer medication subject to cost-share limits

## List of Prescription Medications

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

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>DECARBOXYLASE INHIBITORS</b>		
carbidopa	T1	
<b>ANTI-PLATELET DRUGS (Blood Thinners/Anti-Clotting)</b>		
<b>PLATELET AGGREGATION INHIBITORS</b>		
aspirin/dipyridamole	T1	HD
BRILINTA (ticagrelor)	T2	HD
cilostazol	T1	HD
clopidogrel bisulfate	T1	HD
clopidogrel bisulfate (Plavix)	T1	HD
dipyridamole	T1	HD
EFFIENT (prasugrel hcl)	T3	HD
prasugrel hcl (Effient)	T1	HD
ticagrelor (Brilinta)	T1	HD
ticlopidine hcl	T1	HD
<b>PLATELET REDUCING AGENTS</b>		
AGRYLIN (anagrelide hcl)	T3	
anagrelide hcl	T1	
anagrelide hcl (Agrylin)	T1	
<b>ANTIVIRALS (AIDS/HIV)</b>		
<b>ANTI-RETROVIRAL - CAPSID INHIBITORS</b>		
SUNLENCA 463.5 MG/1.5 ML VIAL	T4	PA SP
SUNLENCA TABLET	T3	PA QL(5 tabs/180 days) SP
YEZTUGO 300 MG TABLET	T3	PA QL SP
YEZTUGO 463.5 MG/1.5 ML VIAL	T4	PA SP
<b>ANTI-RETROVIRAL - INTEGRASE INHIBITOR AND NNRTI COMB.</b>		
CABENUVA	T3	PA SP
JULUCA	T2	SP
<b>ANTI-RETROVIRAL - INTEGRASE INHIBITOR AND NRTI COMB.</b>		
DOVATO	T2	SP
<b>ANTI-RETROVIRAL - NRTIS AND INTEGRASE INHIBITORS COMB</b>		
TRIUMEQ	T2	SP
TRIUMEQ PD	T2	QL(6 tabs/day) SP
<b>ANTI-RETROVIRAL - NUCLEOSIDE, NUCLEOTIDE, PROTEASE INH.</b>		
SYMTUZA	T2	SP
<b>ANTIVIRALS - HIV-SPEC, NON-PEPTIDIC PROTEASE INHIB</b>		
APTVUS	T2	PA SP

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

T4 – Injectable Specialty Medications

PA – Prior Authorization

QL – Quantity Limit

ST – Step Therapy

AGE – Age Requirement

SP – Specialty Medication

HD – May require home delivery pharmacy

PPACA – No Cost-Share Preventive Medication

CSL – Oral cancer medication subject to cost-share limits

## List of Prescription Medications

ANTIVIRALS (AIDS/HIV) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>ANTIVIRALS - HIV-SPEC, NON-PEPTIDIC PROTEASE INHIB (cont.)</b>		
<i>darunavir</i> (Prezista)	T2	SP
PREZCOBIX	T3	PA SP
PREZISTA	T2	SP
<b>ANTIVIRALS - HIV-SPEC, NUCLEOSIDE-NUCLEOTIDE ANALOG</b>		
CIMDUO	T3	PA SP
DESCOVY	T2	PPACA
<i>emtricitabine-tenofovir 100-150mg</i>	T1	SP PPACA
<i>emtricitabine-tenofovir 133-200mg</i>	T1	SP PPACA
<i>emtricitabine-tenofovir 167-250mg</i>	T1	SP PPACA
<i>emtricitabine-tenofovir 200-300mg (Truvada)</i>	T1	SP PPACA
TEMIXYS	T3	PA SP
<b>ANTIVIRALS - HIV-SPEC, NUCLEOSIDE ANALOG, RTI COMB</b>		
<i>abacavir sulfate/lamivudine</i>	T1	PA SP
<i>abacavir/lamivudine/zidovudine</i>	T1	PA SP
<i>lamivudine/zidovudine</i>	T1	SP
<b>ANTIVIRALS - HIV-SPECIFIC, CCR5 CO-RECEPTOR ANTAG.</b>		
<i>maraviroc</i> (Selzentry)	T1	PA SP
SELZENTRY	T2	PA SP
<b>ANTIVIRALS - HIV-SPECIFIC, CD4 ATTACHMENT INHIBITOR</b>		
RUKOBIA	T3	PA QL (2 syringe/day) SP
<b>ANTIVIRALS - HIV-SPECIFIC, FUSION INHIBITORS</b>		
FUZEON	T4	PA SP
<b>ANTIVIRALS - HIV-SPECIFIC, NON-NUCLEOSIDE, RTI</b>		
EDURANT	T3	PA SP
<i>efavirenz</i>	T1	PA SP
INTELENCE	T3	PA SP
<i>nevirapine</i>	T1	PA SP
PIFELTRO	T3	PA SP
<b>ANTIVIRALS - HIV-SPECIFIC, NUCLEOSIDE ANALOG, RTI</b>		
<i>abacavir sulfate</i>	T1	PA SP
<i>emtricitabine</i> (Emtriva)	T1	PA SP
EMTRIVA 10 MG/ML SOLUTION	T2	PA SP
EMTRIVA 200 MG CAPSULE ( <i>emtricitabine</i> )	T3	PA SP
<i>lamivudine 10 mg/ml oral soln</i>	T1	SP
<i>lamivudine 150 mg tablet</i>	T1	SP

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

T4 – Injectable Specialty Medications

PA – Prior Authorization

QL – Quantity Limit

ST – Step Therapy

AGE – Age Requirement

SP – Specialty Medication

HD – May require home delivery pharmacy

PPACA – No Cost-Share Preventive Medication

CSL – Oral cancer medication subject to cost-share limits

## List of Prescription Medications

ANTIVIRALS (AIDS/HIV) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>ANTIVIRALS - HIV-SPECIFIC, NUCLEOSIDE ANALOG, RTI (cont.)</b>		
<i>lamivudine 300 mg tablet</i>	T1	PA SP
<i>lamivudine 300 mg/30ml sol cup (Epivir)</i>	T1	SP
<i>zidovudine</i>	T1	SP
<b>ANTIVIRALS - HIV-SPECIFIC, NUCLEOTIDE ANALOG, RTI</b>		
<i>tenofovir disoproxil fumarate</i>	T1	PA SP
VIREAD	T2	PA SP
<b>ANTIVIRALS - HIV-SPECIFIC, PROTEASE INHIBITOR COMB</b>		
<i>lopinavir/ritonavir</i>	T1	SP
<b>ANTIVIRALS - HIV-SPECIFIC, PROTEASE INHIBITORS</b>		
<i>atazanavir sulfate</i>	T1	PA SP
<i>efavirenz</i>		
EVOTAZ	T3	PA SP
<i>fosamprenavir calcium</i>	T1	PA SP
REYATAZ	T2	PA SP
<i>ritonavir</i>	T1	SP
<b>ANTIVIRALS - HIV-I INTEGRASE STRAND TRANSFER INHIBTR</b>		
APRETUDE	T3	PA SP
ISENTRESS	T2	SP
ISENTRESS HD	T2	PA SP
TIVICAY	T2	SP
TIVICAY PD	T2	SP
<b>ARTV NUCLEOSIDE, NUCLEOTIDE, NON-NUCLEOSIDE RTI COMB</b>		
<i>ATRIPLA (efavirenz-emtric-tenofovir disop)</i>	T3	PA SP
COMPLERA	T3	PA SP
DELSTRIGO	T3	PA SP
<i>efavirenz/emtricitabine/tenofovir disop</i>	T1	PA SP
<i>efavirenz/lamivudine/tenofovir disop (Symfi Lo)</i>	T1	SP
<i>efavirenz/lamivudine/tenofovir disop (Symfi)</i>	T1	SP
ODEFSEY	T3	PA SP
<b>ARV-NUCLEOSIDE, NUCLEOTIDE RTI, INTEGRASE INHIBITORS</b>		
BIKTARVY	T2	SP
GENVOYA	T2	SP
STRIBILD	T3	PA SP

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

T4 – Injectable Specialty Medications

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## List of Prescription Medications

ANTIVIRALS (Eye Conditions)			
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits	
<b>EYE ANTIVIRALS</b>			
<i>trifluridine</i>	T1		
ZIRGAN	T3		
ANTIVIRALS (Infections)			
<b>ANTIVIRALS, GENERAL</b>			
<i>acyclovir</i>	T1		
<i>famciclovir</i>	T1		
FLUMADINE ( <i>rimantadine hcl</i> )	T3		
LIVTENCITY	T3	PA QL (4 tabs/day) SP	
<i>oseltamivir 6 mg/ml suspension</i> (Tamiflu)	T1	QL (180ml/30 days)	
<i>oseltamivir phos 30 mg capsule</i> (Tamiflu)	T1	QL (20/30 days)	
<i>oseltamivir phos 45 mg capsule</i> (Tamiflu)	T1	QL (10 caps/30 days)	
<i>oseltamivir phos 75 mg capsule</i> (Tamiflu)	T1	QL (10/30 days)	
PREVYMIS	T3	SP HD	
RELENZA	T3	QL (20/30 days)	
<i>ribavirin</i> (Virazole)	T1	SP HD	
<i>rimantadine hcl</i> (Flumadine)	T1		
TAMIFLU 30 MG CAPSULE ( <i>oseltamivir phosphate</i> )	T3	QL (20/30 days)	
TAMIFLU 45 MG CAPSULE ( <i>oseltamivir phosphate</i> )	T3	QL (10/30 days)	
TAMIFLU 6 MG/ML SUSPENSION ( <i>oseltamivir phosphate</i> )	T3	QL (180ml/30 days)	
TAMIFLU 75 MG CAPSULE ( <i>oseltamivir phosphate</i> )	T3	QL (10/30 days)	
<i>valacyclovir hcl</i> (Valtrex)	T1		
<i>valganciclovir hcl</i>	T1		
VALTREX ( <i>valacyclovir</i> )	T3		
VIRAZOLE	T3	SP HD	
XOFLUZA	T3	QL (2 tabs/30 days)	
<b>HEP C - NS5A, NS3/4A, NON-NUCLEO.NS5B INHIB COMB.</b>			
VIEKIRA PAK	T3	PA SP HD	
<b>HEP C - NS5A, NS3/4A, NUCLEOTIDE NS5B INHIB COMBO</b>			
VOSEVI	T2	PA SP HD	

T1 – Typically Generics

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T3 – Typically Non-Preferred Brands

T4 – Injectable Specialty Medications

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## List of Prescription Medications

ANTIVIRALS (Infections) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>HEP C VIRUS-NS5B POLYMERASE AND NS5A INHIB. COMBO.</b>		
EPCLUSA 200 MG-50 MG TABLET	T2	PA QL (1 tab/Day) SP HD
EPCLUSA 400 MG-100 MG TABLET	T2	PA SP HD
HARVONI 33.75-150 MG PELLET PK	T2	PA QL (1 tab/day) SP HD
HARVONI 45-200 MG PELLET PACKT	T2	PA QL (1 tab/day) SP HD
HARVONI 45-200 MG TABLET	T2	PA QL (1 tab/day) SP HD
HARVONI 90-400 MG TABLET	T2	PA SP HD
<b>HEPATITIS B TREATMENT AGENTS</b>		
EPIVIR HBV ( <i>lamivudine</i> )	T3	SP
HEPSERA (adefovir dipivoxil)	T3	SP HD
PEGASYS	T4	PA SP HD
PEGINTRON	T3	PA SP HD
<i>ribasphere</i> 200 mg capsule	T1	SP HD
<i>ribasphere</i> 200 mg tablet	T1	SP HD
<i>ribasphere</i> 400 mg tablet	T1	SP
<i>ribasphere</i> 600 mg tablet	T1	SP
<i>ribasphere</i> ribapak 200-400 mg	T1	SP HD
<i>ribasphere</i> ribapak 400-400 mg	T1	SP HD
<i>ribasphere</i> ribapak 600-400 mg	T1	SP HD
<i>ribasphere</i> ribapak 600-600 mg	T1	SP HD
<i>ribavirin</i>	T1	SP HD
<b>HEPATITIS C VIRUS- NS5A AND NS3/4A INHIBITOR COMB</b>		
MAVYRET	T2	PA SP HD
ZEPATIER	T2	PA QL(1 tab/day) SP HD
<b>RNA POLYMERASE INHIBITOR</b>		
LAGEVRIO (EUA)	T2	QL (1 pack/120 days)
MOLNUPIRAVIR	T3	QL (1 pkg/120 days)
ANTIVIRALS (Skin Conditions)		
<b>TOPICAL GENITAL WART-HPV TREATMENT AGENTS</b>		
VEREGEN	T3	
AUTONOMIC DRUGS (Allergy/Nasal Sprays)		
<b>ANAPHYLAXIS THERAPY AGENTS</b>		
<i>epinephrine</i>	T1	QL (2 packs/30 days)
<i>epinephrine</i> (Epinephrine)	T1	QL (2 packs/30 days)

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

T4 – Injectable Specialty Medications

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## List of Prescription Medications

AUTONOMIC DRUGS (Alzheimer's Disease)		
CHOLINESTERASE INHIBITORS		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>ADLARITY</b>		
ARICEPT ( <i>donepezil hcl</i> )	T3	HD
<i>donepezil hcl</i>	T1	HD
<i>donepezil hcl</i> (Aricept)	T1	HD
EXELON ( <i>rivastigmine</i> )	T3	HD
<i>galantamine er 16 mg capsule</i> (Razadyne Er)	T1	HD
<i>galantamine er 24 mg capsule</i> (Razadyne Er)	T1	HD
<i>galantamine er 8 mg capsule</i> (Razadyne Er)	T1	QL (1 cap/day) HD
<i>galantamine hbr</i>	T1	HD
MESTINON ( <i>pyridostigmine bromide er</i> )	T3	HD
<i>pyridostigmine bromide</i> (Mestinon)	T1	HD
RAZADYNE ER 16 MG CAPSULE ( <i>galantamine er</i> )	T3	HD
RAZADYNE ER 24 MG CAPSULE ( <i>galantamine er</i> )	T3	HD
RAZADYNE ER 8 MG CAPSULE ( <i>galantamine er</i> )	T3	QL (1 cap/day) HD
<i>rivastigmine</i> (Exelon)	T1	HD
<i>rivastigmine tartrate</i>	T1	HD
AUTONOMIC DRUGS (Attention Deficit Hyperactivity Disorder) <sup>8</sup>		
<b>ADRENERGICS, AROMATIC, NON-CATECHOLAMINE</b>		
ADDERALL ( <i>dextroamphetamine-amphetamine</i> )	T3	PA ST
ADZENYS ER	T3	PA QL (15ml/day)
ADZENYS XR-ODT	T3	PA QL (1 tab/day)
AMPHETAMINE	T3	PA QL (15ml/day)
<i>amphetamine sulfate</i> (Evekeo)	T1	PA
<i>dextroamp-amphet er 10 mg cap</i> (Adderall XR)	T1	PA QL (1 per day)
<i>dextroamp-amphet er 12.5mg cp</i> (Mydayis)	T1	PA QL (1 per day)
<i>dextroamp-amphet er 15 mg cap</i> (Adderall XR)	T1	PA QL (1 cap/day)
<i>dextroamp-amphet er 20 mg cap</i> (Adderall XR)	T1	PA QL (1 cap/day)
<i>dextroamp-amphet er 25 mg cap</i> (Mydayis)	T1	PA QL (1 per day)
<i>dextroamp-amphet er 30 mg cap</i> (Adderall XR)	T1	PA QL (1 cap/day)
<i>dextroamp-amphet er 37.5mg cp</i> (Mydayis)	T1	PA QL (1 cap/day)
<i>dextroamp-amphet er 5 mg cap</i> (Adderall XR)	T1	PA QL (1 cap/day)
<i>dextroamp-amphet er 50 mg cap</i> (Mydayis)	T1	PA QL (1 cap/day)
<i>dextroamphetamine er 10 mg cap</i>	T1	PA QL (1 cap/day)

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

T4 – Injectable Specialty Medications

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SP – Specialty Medication

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CSL – Oral cancer medication subject to cost-share limits

## List of Prescription Medications

AUTONOMIC DRUGS (Attention Deficit Hyperactivity Disorder) <sup>8</sup> (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>ADRENERGICS, AROMATIC, NON-CATECHOLAMINE (cont.)</b>		
<i>dextroamphetamine er 15 mg cap</i>	T1	PA QL (3/day)
<i>dextroamphetamine er 5 mg cap</i>	T1	PA QL (1 cap/day)
<i>dextroamphetamine sulfate</i>	T1	PA
<i>dextroamphetamine sulfate</i>	T3	PA ST
DYANAVEL XR	T3	PA QL (8ml/day)
EVEKEO ( <i>amphetamine sulfate</i> )	T3	PA ST
EVEKEO ODT	T3	PA
MYDAYIS ( <i>dextroamphetamine/amphetamine</i> )	T3	PA QL(1 cap/day)
<i>methamphetamine hcl</i>	T1	PA
XELSTRYM	T3	PA QL(1 PATCH/DAY)
ZENZEDI	T3	PA ST
AUTONOMIC DRUGS (Blood Pressure/Heart Medications)		
<b>ADRENERGIC VASOPRESSOR AGENTS</b>		
<i>droxidopa</i> (Northera)	T1	SP HD
<i>midodrine hcl</i>	T1	
<b>ALPHA-ADRENERGIC BLOCKING AGENTS</b>		
<i>DIBENZYLINE (phenoxybenzamine hcl)</i>	T3	HD
<i>phenoxybenzamine hcl</i> (Dibenzyline)	T1	HD
AUTONOMIC DRUGS (Urinary Tract Conditions)		
<b>PARASYMPATHETIC AGENTS</b>		
<i>cevimeline hcl</i> (Evoxac)	T1	HD
<i>guanidine hcl</i>	T1	HD
<i>pilocarpine hcl</i> (Salagen)	T1	HD
<i>SALAGEN (pilocarpine hcl)</i>	T3	HD
<i>URECHOLINE (bethanechol chloride)</i>	T3	HD
BIOLOGICALS (Allergy/Nasal Sprays)		
<b>ALLERGENIC EXTRACTS, THERAPEUTIC</b>		
GRASTEK	T2	PA QL (1 tab/day)
ODACTRA	T2	PA QL (1 tab/day)
ORALAIR	T3	PA QL (1 tab/day)
RAGWITEK	T3	PA QL (1 tab/day)

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

T4 – Injectable Specialty Medications

PA – Prior Authorization

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## List of Prescription Medications

BIOLOGICALS (Blood Pressure/Heart Medications)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>PLASMA KALLIKREIN INHIBITORS</b>		
TAKHYRO	T4	PA SP HD
BIOLOGICALS (Miscellaneous)		
<b>PKU TREATMENT AGENTS - PHENYLALANINE AMMONIA LYASE</b>		
PALYNZIQ	T4	PA SP HD
BIOLOGICALS (Vaccines)		
<b>COVID-19 VACCINES</b>		
COMIRNATY	T2	PPACA
JANSSEN COVID-19 VACCINE (EUA)	T2	PPACA
MODERNA COVID-19 VACCINE (EUA)	T2	PPACA
NOVAVAX	T2	PPACA
PFIZER COVID-19 VACCINE (EUA)	T2	PPACA
<b>ENTERIC VIRUS VACCINES</b>		
IPOL	T2	PPACA
ROTARIX	T3	PPACA
ROTATEQ	T3	PPACA
<b>GRAM NEGATIVE COCCI VACCINES</b>		
BEXSERO	T2	
MENACTRA	T2	
MENQUADFI	T2	PPACA
MENVEO A-C-Y-W-135-DIP	T2	PPACA
PENBRAYA	T2	PPACA
TRUMENBA	T2	PPACA
<b>GRAM POSITIVE COCCI VACCINES</b>		
CAPVAXIVE	T3	PPACA
PNEUMOVAX 23	T2	PPACA
PREVNAR 13	T2	PPACA
PREVNAR 20	T2	PPACA
<b>INFLUENZA VIRUS VACCINES</b>		
AFLURIA TRIVALENT		
FLUAD TRIVALENT	T2	PPACA
FLUARIX TRIVALENT	T2	PPACA
FLUBLOK TRIVALENT	T2	PPACA
FLUBLOK TRIVALENT	T2	PPACA
FLUCELVAX TRIVALENT	T2	PPACA

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

T4 – Injectable Specialty Medications

PA – Prior Authorization

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## List of Prescription Medications

BIOLOGICALS (Vaccines) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>INFLUENZA VIRUS VACCINES (cont.)</b>		
FLULAVAL TRIVALENT	T2	PPACA
FLUMIST TRIVALENT	T3	PPACA
FLUZONE TRIVALENT	T2	PPACA
<b>TOXIN-PRODUCING BACILLI VACCINES/TOXOIDS</b>		
BCG VACCINE (TICE STRAIN)	T2	SP
<b>VACCINE/TOXOID PREPARATIONS, COMBINATIONS</b>		
ACTHIB	T2	PPACA
ADACEL TDAP	T2	PPACA
BOOSTRIX TDAP	T2	PPACA
DAPTACEL DTAP	T2	PPACA
DIPHTHERIA-TETANUS TOXOIDS-PED	T2	PPACA
HIBERIX	T2	PPACA
INFANRIX DTAP	T2	PPACA
KINRIX	T2	PPACA
M-M-R II VACCINE	T2	PPACA
PEDVAXHIB	T2	PPACA
PENTACEL	T2	PPACA
PENTACEL ACTHIB COMPONENT	T2	PPACA
PROQUAD	T2	PPACA
QUADRACEL DTAP-IPV	T2	PPACA
TDVAX	T2	PPACA
TENIVAC	T2	PPACA
VAXELIS	T2	PPACA
<b>VIRAL/TUMORIGENIC VACCINES</b>		
ABRYSVO	T3	PPACA
ACAM2000 (NATIONAL STOCKPILE)	T3	PPACA
ENGERIX-B ADULT	T2	PPACA
ENGERIX-B PEDIATRIC-ADOLESCENT	T2	PPACA
ERVEBO (NATIONAL STOCKPILE)	T3	
GARDASIL 9	T2	PPACA
HEPLISAV-B	T2	PPACA
IXCHIQ	T3	PPACA

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

T4 – Injectable Specialty Medications

PA – Prior Authorization

QL – Quantity Limit

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AGE – Age Requirement

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## List of Prescription Medications

### BIOLOGICALS (Vaccines) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>VIRAL/TUMORIGENIC VACCINES (cont.)</b>		
JYNNEOS	T3	PPACA
MRESVIA	T3	PPACA
PEDIARIX	T2	PPACA
RECOMBIVAX HB	T2	PPACA
SHINGRIX	T2	QL (2 doses/lifetime) PPACA
TWINRIX	T2	PPACA
VARIVAX VACCINE	T2	PPACA
ZOSTAVAX	T2	PPACA
<b>BLOOD (Blood Modifiers/Bleeding Disorders)</b>		
<b>AGENTS TO TX THROMBOTIC THROMBOCYTOPENIC PURPURA</b>		
CABLIVI	T3	PA SP
<b>ANTI-FIBRINOLYTIC AGENTS</b>		
AMICAR ( <i>aminocaproic acid</i> )	T3	SP HD
<i>aminocaproic acid</i> (Amicar)	T1	SP HD
LYSTEDA ( <i>tranexamic acid</i> )	T3	SP
<i>tranexamic acid</i> (Lysteda)	T1	SP
<b>ANTI-HEMOPHILIC FACTORS</b>		
ALTUVIIIO	T2	PA SP HD
<b>COMPLEMENT (C3) INHIBITORS</b>		
EMPAVELI	T2	PA SP
FABHALTA	T2	PA QL(2 caps/day) SP
TAVNEOS	T3	PA QL(6 caps/day) SP
VOYDEYA	T2	PA QL(1 Packet/28 Days) SP
<b>HEMOPHILIA TREATMENT AGENTS, NON-FACTOR REPLACEMENT</b>		
HEMLIBRA	T4	PA SP HD
<b>SICKLE CELL ANEMIA AGENTS</b>		
DROXIA	T2	
SIKLOS	T3	PA
<b>TOPICAL HEMOSTATICS</b>		
ASTRINGYN	T3	
AVITENE	T3	
ENDO-AVITENE	T3	
EVICEL	T3	
<i>gelatin sponge, absorb/porcine</i> (Gelfoam)	T1	
GELFOAM ( <i>surgifoam</i> )	T3	

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

T4 – Injectable Specialty Medications

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## List of Prescription Medications

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

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>TOPICAL HEMOSTATICS (cont.)</b>		
GELFOAM COMPRESSED	T3	
MONSEL'S	T3	
RAPLIXA	T3	
RECOTHROM	T3	
SURGIFOAM	T1	
SYRINGE AVITENE	T3	
THROMBI-GEL	T3	
THROMBIN-JMI	T3	
THROMBI-PAD	T3	
ULTRAFOAM	T3	
<b>BLOOD (Blood Thinners/Anti-Clotting)</b>		
<b>HEMORRHEOLOGIC AGENTS</b>		
<i>pentoxifylline</i>	T1	HD
<b>CARDIAC DRUGS (Blood Pressure/Heart Medications)</b>		
<b>ANTI-ANGINAL, ANTI-ISCHEMIC AGENTS, NON-HEMODYNAMIC</b>		
<i>ranolazine</i> (Ranexa)	T1	QL (4 tabs/day) HD
<b>ANTI-ARRHYTHMICS</b>		
<i>amiodarone hcl</i>	T1	HD
<i>disopyramide phosphate</i> (Norpace)	T1	HD
<i>dofetilide 125 mcg capsule</i> (Tikosyn)	T1	QL (8 caps/day) HD
<i>dofetilide 250 mcg capsule</i> (Tikosyn)	T1	QL (4 caps/day) HD
<i>dofetilide 500 mcg capsule</i> (Tikosyn)	T1	QL (2 caps/day) HD
<i>flecainide acetate</i>	T1	HD
<i>mexiletine hcl</i>	T1	HD
MULTAQ	T2	HD
<i>NORPACE (disopyramide phosphate)</i>	T3	PA HD
NORPACE CR	T3	HD
<i>pacerone 100 mg tablet</i>	T3	PA HD
<i>pacerone 200 mg tablet</i>	T1	HD
<i>pacerone 400 mg tablet</i>	T3	PA HD
<i>propafenone hcl</i>	T1	HD
<i>propafenone hcl</i> (Rythmol Sr)	T1	HD

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

T4 – Injectable Specialty Medications

PA – Prior Authorization

QL – Quantity Limit

ST – Step Therapy

AGE – Age Requirement

SP – Specialty Medication

HD – May require home delivery pharmacy

PPACA – No Cost-Share Preventive Medication

CSL – Oral cancer medication subject to cost-share limits

## List of Prescription Medications

CARDIAC DRUGS (Blood Pressure/Heart Medications) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>ANTI-ARRHYTHMICS (cont.)</b>		
<i>quinidine sulfate</i>	T1	HD
RYTHMOL SR ( <i>propafenone hcl er</i> )	T3	PA HD
TIKOSYN 125 MCG CAPSULE ( <i>dofetilide</i> )	T3	PA QL (8 caps/day) HD
TIKOSYN 250 MCG CAPSULE ( <i>dofetilide</i> )	T3	PA QL (4 caps/day) HD
TIKOSYN 500 MCG CAPSULE ( <i>dofetilide</i> )	T3	PA QL (2 caps/day) HD
<b>CALCIUM CHANNEL BLOCKING AGENTS</b>		
ADALAT CC ( <i>nifedipine er</i> )	T3	HD
<i>amlodipine besylate</i> (Norvasc)	T1	HD
CALAN SR ( <i>verapamil er</i> )	T3	HD
CAMZYOS	T3	PA QL (30caps/30days) SP
<i>diltiazem hcl</i>	T1	HD
<i>diltiazem hcl</i> (Cardizem La)	T1	QL(1 TAB/DAY) HD
<i>diltiazem hcl</i> (Tiazac)	T1	HD
<i>felodipine</i>	T1	HD
<i>isradipine</i>	T1	
<i>nicardipine hcl</i>	T1	HD
<i>nifedipine</i>	T1	HD
<i>nifedipine</i> (Adalat Cc)	T1	HD
<i>nifedipine</i> (Procardia XI)	T1	HD
<i>nifedipine</i> (Procardia)	T1	HD
<i>nisoldipine er 17 mg tablet</i> (Sular)	T1	HD
<i>nisoldipine er 20 mg tablet</i>	T1	QL (1 tab/day) HD
<i>nisoldipine er 25.5 mg tablet</i>	T1	HD
<i>nisoldipine er 30 mg tablet</i>	T1	HD
<i>nisoldipine er 34 mg tablet</i> (Sular)	T1	HD
<i>nisoldipine er 40 mg tablet</i>	T1	HD
<i>nisoldipine er 8.5 mg tablet</i> (Sular)	T1	HD
NORLIQVA ORAL SOLN	T2	PA QL(10 mls/day) HD

T1 – Typically Generics

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T4 – Injectable Specialty Medications

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## List of Prescription Medications

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

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>CALCIUM CHANNEL BLOCKING AGENTS (cont.)</b>		
NYMALIZE	T3	
PROCARDIA ( <i>nifedipine</i> )	T3	HD
SULAR ( <i>nisoldipine</i> )	T3	HD
TIAZAC ( <i>tiadylter</i> )	T3	HD
<i>verapamil hcl</i>	T1	HD
<i>verapamil hcl</i> (Calan Sr)	T1	HD
<i>verapamil hcl</i> (Verelan Pm)	T1	HD
<i>verapamil hcl</i> (Verelan)	T1	HD
VERELAN ( <i>verapamil hcl</i> )	T3	HD
VERELAN ( <i>verapamil sr</i> )	T3	HD
VERELAN PM ( <i>verapamil er pm</i> )	T3	HD
<b>DIGITALIS GLYCOSIDES</b>		
<i>digoxin</i>	T1	HD
<b>HEART RATE REDUCING, SA SELECTIVE I(F) CURRENT INH.</b>		
CORLANOR	T2	PA HD
CORLANOR 5 MG/5 ML ORAL SOLN	T2	PA HD
<i>ivabradine hcl</i> (Corlanor)		
<b>SOLUBLE GUANYLATE CYCLASE (SGC) STIMULATOR</b>		
VERQUVO	T2	PA QL (1 tab/day) HD
<b>VASODILATORS, CORONARY</b>		
DILATRATE-SR	T3	HD
<i>isosorbide dinitrate</i>	T1	HD
MINITRAN	T1	HD
NITRO-DUR 0.1 MG/HR PATCH	T3	HD
NITRO-DUR 0.2 MG/HR PATCH	T3	HD
NITRO-DUR 0.3 MG/HR PATCH	T2	HD
NITRO-DUR 0.4 MG/HR PATCH	T3	HD
NITRO-DUR 0.6 MG/HR PATCH	T3	HD
NITRO-DUR 0.8 MG/HR PATCH	T2	HD
<i>nitroglycerin</i> (Nitro-dur)	T1	HD
<i>nitroglycerin</i> (Nitrolingual)	T1	HD
<i>nitroglycerin</i> (Nitromist)	T1	HD
<i>nitroglycerin</i> (Nitrostat)	T1	HD
NITROLINGUAL ( <i>nitroglycerin</i> )	T3	HD
NITROMIST ( <i>nitroglycerin</i> )	T3	HD

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

T4 – Injectable Specialty Medications

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## List of Prescription Medications

CARDIAC DRUGS (Blood Pressure/Heart Medications) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>VASODILATORS, CORONARY (cont.)</b>		
NITROSTAT ( <i>nitroglycerin</i> )	T3	HD
<b>CARDIOVASCULAR (Asthma/COPD/Respiratory)</b>		
<b>PULM ANTI-HTN, SOLUBLE GUANYLATE CYCLASE STIMULATOR</b>		
ADEMPAS	T3	PA SP HD
<b>PULM ANTI-HTN, SEL.C-GMP PHOSPHODIESTERASE T5 INHIB</b>		
<i>sildenafil</i> 10 mg/ml oral susp (Revatio)	T1	PA SP HD
<i>sildenafil</i> 20 mg tablet (Revatio)	T1	PA SP HD
<i>tadalafil</i> (Adcirca)	T1	PA SP HD
<i>tadalafil</i> 20 mg tablet (Adcirca)	T1	PA SP HD
<b>PULMONARY ANTI-HTN, ENDOTHELIN RECEPTOR ANTAGONIST</b>		
<i>ambrisentan</i> (Letairis)	T1	PA SP HD
<i>bosentan</i> (Tracleer)	T1	PA SP HD
LETAIRIS ( <i>ambrisentan</i> )	T3	PA SP HD
OPSUMIT	T2	PA SP HD
TRACLEER 125 MG TABLET ( <i>bosentan</i> )	T3	PA SP HD
TRACLEER 32 MG TABLET FOR SUSP	T2	PA SP HD
TRACLEER 62.5 MG TABLET ( <i>bosentan</i> )	T3	PA SP HD
<b>PULMONARY ANTIHYPER AGENT, ACTRIIA-FC</b>		
WINREVAIR	T4	PA SP HD
<b>PULMONARY ANTIHYPERTENSIVES, PROSTACYCLIN-TYPE</b>		
ORENITRAM ER	T3	PA SP HD
ORENITRAM MONTH 1 TITRATION KT	T3	PA QL(168 tabs/180 days) SP HD
ORENITRAM MONTH 2 TITRATION KT	T3	PA QL(336 tabs/180 days) SP HD
ORENITRAM MONTH 3 TITRATION KT	T3	PA QL(252 tabs/180 days) SP HD
TYVASO	T3	PA SP HD
TYVASO DPI	T3	PA SP HD
TYVASO INSTITUTIONAL START KIT	T3	PA SP HD
TYVASO REFILL KIT	T3	PA SP HD
TYVASO STARTER KIT	T3	PA SP HD
UPTRAVI	T2	PA SP HD
VENTAVIS	T3	PA SP HD
<b>PULMONARY HTN-ENDOTHELIN RECEPTANT-CGMP PDE5 INH</b>		
OPSYNVI	T2	PA QL(1 tab/day) SP HD

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

T4 – Injectable Specialty Medications

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## List of Prescription Medications

CARDIOVASCULAR (Blood Pressure/Heart Medications)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>ACE INHIBITOR-CALCIUM CHANNEL BLOCKER COMBINATION</b>		
<i>amlodipine besylate/benazepril</i>	T1	HD
<i>amlodipine besylate/benazepril (Lotrel)</i>	T1	HD
<i>LOTREL (amlodipine besylate-benazepril)</i>	T3	HD
<i>PRESTALIA 14 MG-10 MG TABLET</i>	T3	HD
<i>PRESTALIA 3.5 MG-2.5 MG TABLET</i>	T3	QL (1 tab/day) HD
<i>PRESTALIA 7 MG-5 MG TABLET</i>	T3	QL (1 tab/day) HD
<i>TARKA (trandolapril-verapamil er)</i>	T3	HD
<i>trandolapril/verapamil hcl</i>	T1	HD
<i>trandolapril/verapamil hcl (Tarka)</i>	T1	HD
<b>ACE INHIBITOR-THIAZIDE OR THIAZIDE-LIKE DIURETIC</b>		
<i>ACCURETIC (quinapril-hydrochlorothiazide)</i>	T3	ST HD
<i>benazepril/hydrochlorothiazide (Lotensin Hct)</i>	T1	HD
<i>captopril-hctz 25-15 mg tablet</i>	T1	QL (3 tabs/day) HD
<i>captopril-hctz 25-25 mg tablet</i>	T1	QL (2 tabs/day) HD
<i>captopril-hctz 50-15 mg tablet</i>	T1	QL (3 tabs/day) HD
<i>captopril-hctz 50-25 mg tablet</i>	T1	QL (2 tabs/day) HD
<i>enalapril/hydrochlorothiazide</i>	T1	HD
<i>enalapril/hydrochlorothiazide (Vaseretic)</i>	T1	HD
<i>fosinopril/hydrochlorothiazide</i>	T1	HD
<i>lisinopril/hydrochlorothiazide (Zestoretic)</i>	T1	HD
<i>LOTENSIN HCT (benazepril-hydrochlorothiazide)</i>	T3	ST HD
<i>quinapril/hydrochlorothiazide (Accuretic)</i>	T1	HD
<i>VASERETIC (enalapril-hydrochlorothiazide)</i>	T3	ST HD
<i>ZESTORETIC (lisinopril-hydrochlorothiazide)</i>	T3	ST HD
<b>ALPHA-ADRENERGIC BLOCKING AGENTS</b>		
<i>CARDURA (doxazosin mesylate)</i>	T3	HD
<i>CARDURA XL</i>	T3	HD
<i>doxazosin mesylate (Cardura)</i>	T1	HD
<i>MINIPRESS (prazosin hcl)</i>	T3	HD
<i>prazosin</i>	T1	HD
<i>terazosin hcl</i>	T1	HD

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

T4 – Injectable Specialty Medications

PA – Prior Authorization

QL – Quantity Limit

ST – Step Therapy

AGE – Age Requirement

SP – Specialty Medication

HD – May require home delivery pharmacy

PPACA – No Cost-Share Preventive Medication

CSL – Oral cancer medication subject to cost-share limits

## List of Prescription Medications

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

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>ALPHA/BETA-ADRENERGIC BLOCKING AGENTS</b>		
carvedilol (Coreg)	T1	HD
carvedilol er 10 mg capsule (Coreg Cr)	T1	QL (1 cap/day) HD
carvedilol er 40 mg capsule (Coreg Cr)	T1	QL (1 cap/day) HD
carvedilol er 80 mg capsule (Coreg Cr)	T1	HD
COREG (carvedilol)	T3	ST HD
COREG CR 10 MG CAPSULE (carvedilol er)	T3	QL (1 cap/day) ST HD
COREG CR 20 MG CAPSULE (carvedilol er)	T3	QL (1 cap/day) ST HD
COREG CR 40 MG CAPSULE (carvedilol er)	T3	QL (1 cap/day) ST HD
COREG CR 80 MG CAPSULE (carvedilol er)	T3	ST HD
labetalol hcl	T1	HD
<b>ANGIOTEN. RECEPTR ANTAG-CALCIUM CHANL BLKR-THIAZIDE</b>		
amlodipine/valsartan/hcthiazid (Exforge Hct)	T1	HD
olmesartan/amlodipin/hcthiazid (Tribenzor)	T1	HD
TRIBENZOR (olmesartan-amlodipine-hctz)	T3	HD
<b>ANGIOTENSIN RECEPT-NEPRILYSIN INHIBITOR COMB (ARNI)</b>		
ENTRESTO	T2	QL(2 tabs/day) HD
<b>ANGIOTENSIN RECEPTOR ANTAG.-THIAZIDE DIURETIC COMB</b>		
ATACAND HCT (candesartan-hydrochlorothiazid)	T3	ST HD
AVALIDE (irbesartan-hydrochlorothiazide)	T3	ST HD
candesartan/hydrochlorothiazid (Atacand Hct)	T1	HD
HYZAAR (losartan-hydrochlorothiazide)	T3	ST HD
irbesartan/hydrochlorothiazide (Avalide)	T1	HD
losartan/hydrochlorothiazide (Hyzaar)	T1	HD
MICARDIS HCT 40-12.5 MG TABLET (telmisartan-hydrochlorothiazid)	T3	QL (1 tab/day) ST HD
MICARDIS HCT 80-12.5 MG TABLET (telmisartan-hydrochlorothiazid)	T3	ST HD
MICARDIS HCT 80-25 MG TABLET (telmisartan-hydrochlorothiazid)	T3	ST HD
olmesartan-hctz 20-12.5 mg tab (Benicar Hct)	T1	QL (1 tab/day) HD
olmesartan-hctz 40-12.5 mg tab (Benicar Hct)	T1	HD
olmesartan-hctz 40-25 mg tab (Benicar Hct)	T1	HD

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

T4 – Injectable Specialty Medications

PA – Prior Authorization

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ST – Step Therapy

AGE – Age Requirement

SP – Specialty Medication

HD – May require home delivery pharmacy

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## List of Prescription Medications

CARDIOVASCULAR (Blood Pressure/Heart Medications) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>ANGIOTENSIN RECEPTOR ANTAG.-THIAZIDE DIURETIC COMB</b>		
telmisartan-hctz 40-12.5 mg tb (Micardis Hct)	T1	QL (1 tab/day) HD
telmisartan-hctz 80-12.5 mg tb (Micardis Hct)	T1	HD
telmisartan-hctz 80-25 mg tab (Micardis Hct)	T1	HD
valsartan/hydrochlorothiazide (Diovan Hct)	T1	HD
<b>ANGIOTENSIN RECEPTOR BLOCKR-CALCIUM CHANNEL BLOCKR</b>		
amlodipine besylate/valsartan (Exforge)	T1	HD
amlodipine-olmesartan 10-20 mg (Azor)	T1	HD
amlodipine-olmesartan 10-40 mg (Azor)	T1	HD
amlodipine-olmesartan 5-20 mg (Azor)	T1	QL (1 tab/day) HD
amlodipine-olmesartan 5-40 mg (Azor)	T1	HD
AZOR 10-20 MG TABLET (amlodipine-olmesartan)	T3	HD
AZOR 10-40 MG TABLET (amlodipine-olmesartan)	T3	HD
AZOR 5-20 MG TABLET (amlodipine-olmesartan)	T3	QL (1 tab/day) HD
AZOR 5-40 MG TABLET (amlodipine-olmesartan)	T3	HD
EXFORGE (amlodipine-valsartan)	T3	HD
telmisartan-amlodipine 40-10	T1	HD
telmisartan-amlodipine 40-5 mg	T1	QL (1 tab/day) HD
telmisartan-amlodipine 80-10	T1	HD
telmisartan-amlodipine 80-5 mg	T1	HD
<b>ANTI-HYPERTENSIVES, ACE INHIBITORS</b>		
ACCUPRIL (quinapril hcl)	T3	ST HD
benazepril hcl	T1	HD
benazepril hcl (Lotensin)	T1	HD
captopril	T1	HD
enalapril maleate (Vasotec)	T1	HD
fosinopril sodium	T1	HD
lisinopril (Zestril)	T1	HD
LOTENSIN (benazepril hcl)	T3	ST HD
moexipril hcl	T1	HD
perindopril erbumine	T1	HD
PRINIVIL (lisinopril)	T3	ST HD
quinapril hcl (Accupril)	T1	HD
ramipril (Altace)	T1	HD
trandolapril	T1	HD
VASOTEC (enalapril maleate)	T3	ST HD

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

T4 – Injectable Specialty Medications

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## List of Prescription Medications

CARDIOVASCULAR (Blood Pressure/Heart Medications) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>ANTI-HYPERTENSIVES, ANGIOTENSIN RECEPTOR ANTAGONIST</b>		
ATACAND ( <i>candesartan cilexetil</i> )	T3	ST HD
<i>candesartan cilexetil</i> (Atacand)	T1	HD
DIOVAN ( <i>valsartan</i> )	T3	ST HD
EDARBI 40 MG TABLET	T3	QL (1 tab/day) ST HD
EDARBI 80 MG TABLET	T3	ST HD
<i>eprosartan mesylate</i>	T1	HD
<i>irbesartan</i> (Avapro)	T1	HD
<i>losartan potassium</i> (Cozaar)	T1	HD
MICARDIS 40 MG TABLET ( <i>telmisartan</i> )	T3	QL (1 tab/day) ST HD
MICARDIS 80 MG TABLET ( <i>telmisartan</i> )	T3	ST HD
<i>olmesartan medoxomil 20 mg tab</i> (Benicar)	T1	QL (1 tab/day) HD
<i>olmesartan medoxomil 40 mg tab</i> (Benicar)	T1	HD
<i>olmesartan medoxomil 5 mg tab</i> (Benicar)	T1	HD
<i>telmisartan 20 mg tablet</i>	T1	QL (1 tab/day) HD
<i>telmisartan 40 mg tablet</i> (Micardis)	T1	QL (1 tab/day) HD
<i>telmisartan 80 mg tablet</i> (Micardis)	T1	HD
<i>valsartan</i> (Diovan)	T1	ST HD
<b>ANTI-HYPERTENSIVES, GANGLIONIC BLOCKERS</b>		
VECAMYL	T1	
<b>ANTI-HYPERTENSIVES, MISCELLANEOUS</b>		
DEMSER ( <i>metyrosine</i> )	T3	HD
<i>metyrosine</i> (Demser)	T1	HD
<b>ANTI-HYPERTENSIVES, SYMPATHOLYTIC</b>		
CATAPRES-TTS 1 ( <i>clonidine</i> )	T3	HD
CATAPRES-TTS 2 ( <i>clonidine</i> )	T3	HD
CATAPRES-TTS 3 ( <i>clonidine</i> )	T3	HD
<i>clonidine</i> (Catapres-tts 1)	T1	HD

T1 – Typically Generics

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T3 – Typically Non-Preferred Brands

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## List of Prescription Medications

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

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>ANTI-HYPERTENSIVES, SYMPATHOLYTIC (cont.)</b>		
<i>clonidine (Catapres-tts 2)</i>	T1	HD
<i>clonidine (Catapres-tts 3)</i>	T1	HD
<i>clonidine hcl (Catapres)</i>	T1	HD
<i>guanfacine hcl</i>	T1	HD
<i>methyldopa</i>	T1	HD
<i>methyldopa/hydrochlorothiazide</i>	T1	HD
<b>ANTI-HYPERTENSIVES, VASODILATORS</b>		
<i>hydralazine hcl</i>	T1	HD
<i>minoxidil</i>	T1	HD
<b>BETA-ADRENERGIC BLOCKING AGENTS</b>		
<i>acebutolol hcl</i>	T1	HD
<i>atenolol (Tenormin)</i>	T1	HD
<i>betaxolol hcl</i>	T1	HD
<i>bisoprolol fumarate</i>	T1	HD
BYSTOLIC 10 MG TABLET	T2	QL (1 tab/day) ST HD
BYSTOLIC 2.5 MG TABLET	T2	QL (1 tab/day) ST HD
BYSTOLIC 20 MG TABLET	T2	ST HD
BYSTOLIC 5 MG TABLET	T2	QL (1 tab/day) ST HD
INDERAL LA ( <i>propranolol hcl er</i> )	T3	ST HD
INDERAL XL	T3	ST HD
INNOPRAN XL	T3	ST HD
<i>metoprolol succinate (Toprol XL)</i>	T1	HD
<i>metoprolol tartrate</i>	T1	HD
<i>metoprolol tartrate (Lopressor)</i>	T1	HD
<i>nadolol</i>	T1	HD
<i>pindolol</i>	T1	HD
<i>propranolol hcl</i>	T1	HD
<i>propranolol hcl (Inderal La)</i>	T1	HD
<i>sotalol hcl</i>	T1	HD
<i>sotalol hcl (Betapace Af)</i>	T1	HD
SOTYLIZE	T3	HD
TENORMIN ( <i>atenolol</i> )	T3	ST HD
<i>timolol maleate</i>	T1	HD

T1 – Typically Generics

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T3 – Typically Non-Preferred Brands

T4 – Injectables Specialty Medications

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## List of Prescription Medications

CARDIOVASCULAR (Blood Pressure/Heart Medications) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>BETA-BLOCKERS AND THIAZIDE, THIAZIDE-LIKE DIURETICS</b>		
atenolol/chlorthalidone (Tenoretic 100)	T1	HD
atenolol/chlorthalidone (Tenoretic 50)	T1	HD
bisoprolol/hydrochlorothiazide (Ziac)	T1	HD
METOPROLOL SUCCINATE ER-HCTZ	T1	HD
metoprolol/hydrochlorothiazide	T1	HD
nadolol/bendroflumethiazide	T1	HD
propranolol/hydrochlorothiazide	T1	HD
<b>RENIN INHIBITOR, DIRECT</b>		
aliskiren 150 mg tablet (Tekturna)	T1	QL (1 tab/day) HD
aliskiren 300 mg tablet (Tekturna)	T1	HD
<b>RENIN INHIBITOR, DIRECT AND THIAZIDE DIURETIC COMB</b>		
TEKTURN A HCT	T2	HD
<b>VASODILATORS, COMBINATION</b>		
isosorbide-hydralazine (Bidil)	T1	QL(6 tabs/day) HD
<b>VASODILATORS, PERIPHERAL</b>		
ergoloid mesylates	T1	
isoxsuprine hcl	T1	
CARDIOVASCULAR (Cholesterol Medications)		
<b>ANTI-HYPERLIP.HMG COA REDUCT INHIB-CHOLEST.AB.INHIB</b>		
ezetimibe/simvastatin (Vytorin)	T1	HD
ROSZET	T3	PA HD
<b>ANTI-HYPERLIPID- HMG-COA RI-CALCIUM CHANNEL BLOCKER</b>		
amlodipine-atorvast 10-10 mg (Caduet)	T1	HD
amlodipine-atorvast 10-20 mg (Caduet)	T1	HD
amlodipine-atorvast 10-40 mg (Caduet)	T1	HD
amlodipine-atorvast 10-80 mg (Caduet)	T1	HD
amlodipine-atorvast 2.5-10 mg	T1	HD
amlodipine-atorvast 2.5-20 mg	T1	QL (1 tab/day) HD
amlodipine-atorvast 2.5-40 mg	T1	QL (1 tab/day) HD
amlodipine-atorvast 5-10 mg (Caduet)	T1	HD
amlodipine-atorvast 5-20 mg (Caduet)	T1	QL (1 tab/day) HD
amlodipine-atorvast 5-40 mg (Caduet)	T1	QL (1 tab/day) HD

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

T4 – Injectable Specialty Medications

PA – Prior Authorization

QL – Quantity Limit

ST – Step Therapy

AGE – Age Requirement

SP – Specialty Medication

HD – May require home delivery pharmacy

PPACA – No Cost-Share Preventive Medication

CSL – Oral cancer medication subject to cost-share limits

## List of Prescription Medications

### CARDIOVASCULAR (Cholesterol Medications) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>ANTI-HYPERLIPID- HMG-COA RI-CALCIUM CHANNEL BLOCKER (cont.)</b>		
amlodipine-atorvast 5-80 mg (Caduet)	T1	HD
CADUET 10 MG-10 MG TABLET (amlodipine-atorvastatin)	T3	HD
CADUET 10 MG-20 MG TABLET (amlodipine-atorvastatin)	T3	HD
CADUET 10 MG-40 MG TABLET (amlodipine-atorvastatin)	T3	HD
CADUET 10 MG-80 MG TABLET (amlodipine-atorvastatin)	T3	HD
CADUET 5 MG-10 MG TABLET (amlodipine-atorvastatin)	T3	HD
CADUET 5 MG-20 MG TABLET (amlodipine-atorvastatin)	T3	QL (1 tab/day) HD
CADUET 5 MG-40 MG TABLET (amlodipine-atorvastatin)	T3	QL (1 tab/day) HD
CADUET 5 MG-80 MG TABLET (amlodipine-atorvastatin)	T3	HD
<b>ANTI-HYPERLIPIDEMIC - APO B-100 SYNTHESIS INHIBITOR</b>		
KYNAMRO	T3	PA SP
<b>ANTIHYPERLIPIDEMIC - APOLIPOPROTEIN INHIBITOR</b>		
TRYNGOLZA	T3	PA QL SP
<b>ANTI-HYPERLIPIDEMIC - ATP CITRATE LYASE INHIBITOR</b>		
NEXLETOL	T2	PA QL (1 tab/day)
<b>ANTI-HYPERLIPIDEMIC - PCSK9 INHIBITORS</b>		
REPATHA PUSHTRONEX	T2	PA
REPATHA SURECLICK	T2	PA
REPATHA SYRINGE	T2	PA
<b>ANTI-HYPERLIPIDEMIC-ACLY AND CHOLEST ABSORP INHIB</b>		
NEXLIZET	T2	PA QL (1 syringe/day)
<b>ANTI-HYPERLIPIDEMIC-HMGCOA REDUCTASE INHIB (Statins)</b>		
ALTOPREV 20 MG TABLET	T3	QL (1 tab/day) ST HD
ALTOPREV 40 MG TABLET	T3	ST HD
ALTOPREV 60 MG TABLET	T3	ST HD
atorvastatin 10 mg tablet	T1	HD PPACA
atorvastatin 20 mg tablet	T1	HD PPACA
atorvastatin 40 mg tablet	T1	HD
atorvastatin 80 mg tablet	T1	HD
fluvastatin sodium	T1	HD PPACA
fluvastatin sodium (Lescol XL)	T1	HD PPACA
LIVALO (pitavastatin calcium)	T2	ST QL(1 tab/day) HD
lovastatin 10 mg tablet	T1	HD
lovastatin 20 mg tablet	T1	HD PPACA
lovastatin 40 mg tablet	T1	HD PPACA
pitavastatin (Livalo) 1 mg tablet	T1	QL HD PPACA

T1 – Typically Generics

T4 – Injectable Specialty Medications

ST – Step Therapy

HD – May require home delivery pharmacy

T2 – Typically Preferred Brands

PA – Prior Authorization

AGE – Age Requirement

PPACA – No Cost-Share Preventive Medication

T3 – Typically Non-Preferred Brands

QL – Quantity Limit

SP – Specialty Medication

CSL – Oral cancer medication subject to cost-share limits

## List of Prescription Medications

### CARDIOVASCULAR (Cholesterol Medications) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>ANTI-HYPERLIPIDEMIC-HMGCOA REDUCTASE INHIB (Statins) (cont.)</b>		
<i>pitavastatin (Livalo) 2 mg tablet</i>	T1	QL HD PPACA
<i>pitavastatin (Livalo) 4 mg tablet</i>	T1	HD PPACA
<i>pravastatin sodium</i>	T1	HD PPACA
<i>pravastatin sodium (Pravachol)</i>	T1	HD PPACA
<i>rosuvastatin calcium 10 mg tab (Crestor)</i>	T1	QL (1 tab/day) HD PPACA
<i>rosuvastatin calcium 20 mg tab (Crestor)</i>	T1	QL (1 tab/day) HD
<i>rosuvastatin calcium 40 mg tab (Crestor)</i>	T1	HD
<i>rosuvastatin calcium 5 mg tab (Crestor)</i>	T1	QL (1 tab/day) HD PPACA
<i>simvastatin 10 mg tablet (Zocor)</i>	T1	HD PPACA
<i>simvastatin 20 mg tablet (Zocor)</i>	T1	HD PPACA
<i>simvastatin 40 mg tablet (Zocor)</i>	T1	HD PPACA
<i>simvastatin 5 mg tablet</i>	T1	HD
<b>BILE SALT SEQUESTRANTS</b>		
<i>cholestyramine (with sugar) (Questran)</i>	T1	HD
<i>cholestyramine/aspartame</i>	T1	HD
<i>cholestyramine/aspartame (Questran Light)</i>	T1	HD
<i>colesevelam hcl (Welchol)</i>	T1	HD
<b>COLESTID</b>	T3	HD
<b>COLESTID (colestipol hcl)</b>	T3	HD
<i>colestipol hcl (Colestid)</i>	T1	HD
<b>QUESTRAN (cholestyramine)</b>	T3	HD
<b>QUESTRAN LIGHT (prevalite)</b>	T3	HD
<b>LIPOTROPICS</b>		
<i>ezetimibe (Zetia)</i>	T1	HD
<i>fenofibrate</i>	T1	HD
<i>fenofibrate nanocrystallized (Tricor)</i>	T1	HD
<i>fenofibrate, micronized</i>	T1	HD
<i>fenofibric acid (choline) (Trilipix)</i>	T1	HD
<i>fenofibric acid (Fibrincor)</i>	T1	HD
<b>FIBRICOR (fenofibric acid)</b>	T3	ST HD
<i>gemfibrozil (Lopid)</i>	T1	HD
<b>LIPOFEN</b>	T3	ST HD
<b>LOPID (gemfibrozil)</b>	T3	HD
<i>niacin (Niaspan)</i>	T1	HD

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

T4 – Injectable Specialty Medications

PA – Prior Authorization

QL – Quantity Limit

ST – Step Therapy

AGE – Age Requirement

SP – Specialty Medication

HD – May require home delivery pharmacy

PPACA – No Cost-Share Preventive Medication

CSL – Oral cancer medication subject to cost-share limits

## List of Prescription Medications

CARDIOVASCULAR (Cholesterol Medications) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>LIPOTROPICS (cont.)</b>		
NIASPAN ( <i>niacin er</i> )	T3	HD
TRICOR ( <i>fenofibrate</i> )	T3	ST HD
TRIGLIDE	T3	ST HD
TRILIPIX ( <i>fenofibric acid</i> )	T3	ST HD
<b>CNS DRUGS (Alzheimer's Disease)</b>		
<b>ALZHEIMER'S THERAPY, NMDA RECEPTOR ANTAGONISTS</b>		
memantine hcl	T1	HD
memantine hcl er 14 mg capsule (Namenda Xr)	T1	QL (1 cap/day) HD
memantine hcl er 21 mg capsule	T1	HD
memantine hcl er 28 mg capsule (Namenda Xr)	T1	HD
NAMENDA	T3	HD
NAMENDA XR 14 MG CAPSULE ( <i>memantine hcl er</i> )	T3	QL (1 cap/day) HD
NAMENDA XR 28 MG CAPSULE ( <i>memantine hcl er</i> )	T3	HD
NAMENDA XR 7 MG CAPSULE ( <i>memantine hcl er</i> )	T3	QL (1 cap/day) HD
NAMENDA XR TITRATION PACK	T3	QL (112/365 days) HD
<b>ALZHEIMER'S THX, NMDA RECEPTOR ANTAG-CHOLINES INHIB</b>		
NAMZARIC 14 MG-10 MG CAPSULE	T3	QL (2 caps/day) HD
NAMZARIC 21 MG-10 MG CAPSULE ( <i>memantine hcl/donepezil hcl</i> )	T3	QL (2 caps/day) HD
NAMZARIC 28 MG-10 MG CAPSULE	T3	QL (2 caps/day) HD
NAMZARIC 7 MG-10 MG CAPSULE	T3	QL (2 caps/day) HD
NAMZARIC TITRATION PACK	T3	QL (112/365 days) HD
<b>CNS DRUGS (Miscellaneous)</b>		
<b>AMYOTROPHIC LATERAL SCLEROSIS AGENTS</b>		
RADICAVA ORS	T3	PA QL (50ml/28 days) SP
RILLUTEK ( <i>riluzole</i> )	T3	SP HD
<i>riluzole</i> (Rilutek)	T1	SP HD
TIGLUTIK	T3	PA SP
<b>DRUGS TO TREAT MOVEMENT DISORDERS</b>		
AUSTEDO	T3	PA SP HD
AUSTEDO XR	T3	PA QL SP HD
AUSTEDO XR 12 MG TABLET	T3	PA QL(1 tab/day) SP HD
AUSTEDO XR 24 MG TABLET	T3	PA QL(2 tabs/day) SP HD

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

T4 – Injectable Specialty Medications

PA – Prior Authorization

QL – Quantity Limit

ST – Step Therapy

AGE – Age Requirement

SP – Specialty Medication

HD – May require home delivery pharmacy

PPACA – No Cost-Share Preventive Medication

CSL – Oral cancer medication subject to cost-share limits

## List of Prescription Medications

CNS DRUGS (Miscellaneous) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>DRUGS TO TREAT MOVEMENT DISORDERS (cont.)</b>		
AUSTEDO XR 6 MG TABLET	T3	PA QL(3 tabs/day) SP HD
AUSTEDO XR TITRATION KT(WK1-4)	T3	PA QL(1 kit/180 days) SP HD
INITIATION PK(TARDIV)	T3	PA QL(28 caps/365 days) SP
INGREZZA SPRINKLE	T3	PA QL (1 tab/day) SP
<i>tetrabenazine</i>	T1	PA SP HD
<b>PSEUDOBULBAR AFFECT (PBA) AGENTS, NMDA ANTAGONISTS</b>		
NUEDEXTA	T3	QL (4 caps/day)
<b>XANTHINES</b>		
<i>caffeine citrate</i>	T1	HD
CNS DRUGS (Multiple Sclerosis)		
<b>AGENTS TO TREAT MULTIPLE SCLEROSIS</b>		
AVONEX	T4	PA SP HD
AVONEX PEN	T4	PA SP HD
BAFIERTAM	T2	PA SP HD
BETASERON	T4	PA SP HD
<i>dimethyl fumarate</i>	T1	PA HD
GILENYA	T2	PA SP HD
<i>glatiramer acetate</i>	T4	HD
glatopa	T4	HD
KESIMPTA PEN	T4	PA SP HD
MAVENCLAD	T3	PA SP HD
MAYZENT	T2	PA SP HD
PLEGRIDY	T4	PA SP HD
PLEGRIDY PEN	T4	PA SP HD
REBIF	T4	PA SP HD
REBIF REBIDOSE	T4	PA SP HD
<i>teriflunomide</i> (Aubagio)	T1	SP HD
VUMERTY	T2	PA SP HD
<b>AGTS TX NEUROMUSC TRANSMISSION DIS, POT-CHAN BLKR</b>		
<i>dalfampridine</i>	T1	PA SP HD
FIRDAPSE	T3	PA QL (8 tabs/day) SP
RUZURGI	T3	PA SP

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

T4 – Injectable Specialty Medications

PA – Prior Authorization

QL – Quantity Limit

ST – Step Therapy

AGE – Age Requirement

SP – Specialty Medication

HD – May require home delivery pharmacy

PPACA – No Cost-Share Preventive Medication

CSL – Oral cancer medication subject to cost-share limits

## List of Prescription Medications

CNS DRUGS (Pain Relief And Inflammatory Disease)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>CALCITONIN GENE-RELATED PEPTIDE (CGRP) INHIBITOR</b>		
EMGALITY SYRINGE	T2	PA
<b>SPHINGOSINE I-PHOSPHATE (SIP) RECEPTOR MODULATOR</b>		
VELSIPITY	T2	PA QL(30 tabs/30 days) SP HD
<b>SPHINGOSINE I-PHOSPHATE (SIP) RECEPTOR MODULATOR</b>		
ZEPOSIA	T2	PA SP HD
CNS DRUGS (Seizure Disorders)		
<b>ANTI-CONVULSANT - BENZODIAZEPINE TYPE</b>		
<i>clobazam (Onfi)</i>	T1	HD
<i>clonazepam</i>	T1	HD
<i>clonazepam (Klonopin)</i>	T1	HD
<i>DIASTAT (diazepam)</i>	T3	PA HD
<i>diazepam 10 mg rectal gel syst</i>	T1	HD
<i>diazepam 2.5 mg rectal gel sys (Diastat)</i>	T1	HD
<i>diazepam 20 mg rectal gel syst (Diastat Acudial)</i>	T1	HD
<i>KLONOPIN (clonazepam)</i>	T3	PA HD
NAYZILAM	T2	PA QL (5 kits/30 days) HD
<i>ONFI (clobazam)</i>	T3	PA HD
VALTOCO	T3	PA QL (5 boxes/30 Days) HD
<b>ANTI-CONVULSANT - CANNABINOID TYPE</b>		
EPIDIOLEX	T3	PA SP HD
<b>ANTI-CONVULSANTS</b>		
APTIOM 200 MG TABLET	T3	PA QL (1 tab/day) HD
APTIOM 400 MG TABLET	T3	PA QL (1 tab/day) HD
APTIOM 600 MG TABLET	T3	PA HD
APTIOM 800 MG TABLET	T3	PA HD
BRIVIACT	T3	PA HD
<i>carbamazepine</i>	T1	HD
CARBAMAZEPINE 200 MG TAB CHEW	T3	HD
<i>carbamazepine (Carbatrol)</i>	T1	HD
<i>carbamazepine (Tegretol Xr)</i>	T1	HD
<i>carbamazepine (Tegretol)</i>	T1	HD
CARBATROL ( <i>carbamazepine er</i> )	T3	PA HD

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

T4 – Injectable Specialty Medications

PA – Prior Authorization

QL – Quantity Limit

ST – Step Therapy

AGE – Age Requirement

SP – Specialty Medication

HD – May require home delivery pharmacy

PPACA – No Cost-Share Preventive Medication

CSL – Oral cancer medication subject to cost-share limits

## List of Prescription Medications

### CNS DRUGS (Seizure Disorders) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>ANTI-CONVULSANTS (cont.)</b>		
CELONTIN	T2	HD
DIACOMIT	T3	PA SP HD
DILANTIN 100 MG CAPSULE ( <i>phenytoin sodium extended</i> )	T3	PA HD
DILANTIN 30 MG CAPSULE	T2	PA HD
DILANTIN 50 MG INFATAB ( <i>phenytoin</i> )	T3	PA HD
DILANTIN-125 ( <i>phenytoin</i> )	T3	PA HD
<i>divalproex sodium</i> (Depakote Er)	T1	HD
<i>divalproex sodium</i> (Depakote Sprinkle)	T1	HD
<i>divalproex sodium</i> (Depakote)	T1	HD
<i>ethosuximide</i> (Zarontin)	T1	HD
<i>eslicarbazepine</i> 200 mg, 400 mg tablet	T1	PA QL HD
<i>eslicarbazepine</i> 600 mg, 800 mg tablet	T1	PA HD
<i>felbamate</i>	T1	HD
FINTEPLA	T3	PA SP HD
FYCOMPA 0.5 MG/ML ORAL SUSP	T2	PA HD
FYCOMPA 10 MG TABLET	T2	PA HD
FYCOMPA 12 MG TABLET	T2	PA HD
FYCOMPA 2 MG TABLET	T2	PA HD
FYCOMPA 4 MG TABLET	T2	PA QL (1 tab/day) HD
FYCOMPA 6 MG TABLET	T2	PA QL (1 tab/day) HD
FYCOMPA 8 MG TABLET	T2	PA HD
<i>gabapentin</i> (Gralise)	T1	HD
<i>gabapentin</i> (Neurontin)	T1	HD
<i>lamotrigine</i>	T1	HD
LYRICA ( <i>pregabalin</i> )	T3	PA HD
NEURONTIN ( <i>gabapentin</i> )	T3	PA HD
<i>oxcarbazepine</i> (Oxtellar Xr)	T1	HD
OXTELLAR XR ( <i>oxcarbazepine</i> )	T3	PA HD
PEGANONE	T2	HD
PHENYTEK ( <i>phenytoin sodium extended</i> )	T3	PA HD
<i>phenytoin</i> (Dilantin)	T1	HD
<i>phenytoin</i> (Dilantin-125)	T1	HD
<i>phenytoin sodium extended</i> (Dilantin)	T1	HD
<i>phenytoin sodium extended</i> (Phenytek)	T1	HD
<i>pregabalin</i>	T1	HD

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

T4 – Injectable Specialty Medications

PA – Prior Authorization

QL – Quantity Limit

ST – Step Therapy

AGE – Age Requirement

SP – Specialty Medication

HD – May require home delivery pharmacy

PPACA – No Cost-Share Preventive Medication

CSL – Oral cancer medication subject to cost-share limits

## List of Prescription Medications

### CNS DRUGS (Seizure Disorders) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>ANTI-CONVULSANTS (cont.)</b>		
pregabalin (Lyrica)	T1	HD
primidone (Mysoline)	T1	HD
rufinamide 200 mg tablet (Banzel)	T1	PA QL(16 tabs/day) HD
rufinamide 400 mg tablet (Banzel)	T1	PA QL (80ml/day) HD
SPRITAM	T3	PA HD
TEGRETOL (carbamazepine)	T3	PA HD
TEGRETOL (epitol)	T3	PA HD
TEGRETOL XR (carbamazepine er)	T3	PA HD
tiagabine hcl 12 mg tablet (Gabitril)	T1	QL (8 tabs/day) HD
tiagabine hcl 16 mg tablet (Gabitril)	T1	QL (6 tabs/day) HD
tiagabine hcl 2 mg tablet (Gabitril)	T1	HD
tiagabine hcl 4 mg tablet (Gabitril)	T1	HD
topiramate	T1	HD
topiramate (Qudexy Xr)	T1	HD
topiramate er (Trokendi XR)	T1	QL(1 cap/day) HD
valproic acid	T1	HD
valproic acid (as sodium salt)	T1	HD
vigabatrin	T1	SP HD
VIMPAT	T2	PA HD
XCOPRI 25 MG TABLET	T3	PA HD
XCOPRI 100 MG TABLET	T3	PA QL (1 tab/day) HD
XCOPRI 12.5-25 MG TITRATION PK	T3	PA QL (1/28 Days) HD
XCOPRI 150 MG TABLET	T3	PA QL (1/Day) HD
XCOPRI 150-200 MG TITRATION PK	T3	PA QL (1/28 Days) HD
XCOPRI 200 MG TABLET	T3	PA QL (2/Day) HD
XCOPRI 250 MG DAILY DOSE PACK	T3	PA QL (1/28 Days) HD
XCOPRI 350 MG DAILY DOSE PACK	T3	PA QL (1/28 Days) HD
XCOPRI 50 MG TABLET	T3	PA QL (1/Day) HD
XCOPRI 50-100 MG TITRATION PAK	T3	PA QL (1/28 Days) HD
ZARONTIN (ethosuximide)	T3	PA HD
zonisamide	T1	HD
ZTALMY	T3	PA QL (1800mg/day) SP

### CNS DRUGS (Sleep Disorders/Sedatives)

#### NARCOLEPSY TX-H3-RECEPT.ANTAGONIST/INVERSE AGONIST

WAKIX	T3	PA QL (2 tabs/day) SP HD
T1 – Typically Generics	T4 – Injectable Specialty Medications	ST – Step Therapy
T2 – Typically Preferred Brands	PA – Prior Authorization	AGE – Age Requirement
T3 – Typically Non-Preferred Brands	QL – Quantity Limit	SP – Specialty Medication
		HD – May require home delivery pharmacy
		PPACA – No Cost-Share Preventive Medication
		CSL – Oral cancer medication subject to cost-share limits

## List of Prescription Medications

### COLONY STIMULATING FACTORS (Blood Modifiers/Bleeding Disorders)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>CXCR4 CHEMOKINE RECEPTOR ANTAGONIST</b>		
XOLREMDI	T3	PA QL(4 caps/day) SP CSL
<b>ERYTHROPOEISIS-STIMULATING AGENTS</b>		
ARANESP	T2	PA SP
EPOGEN	T2	PA SP
MIRCERA	T3	PA SP
PROCRIT	T2	PA SP
RETACRIT	T2	PA SP
<b>LEUKOCYTE (WBC) STIMULANTS</b>		
FULPHILA	T4	PA SP
GRANIX	T3	PA SP
LEUKINE	T2	SP
NEULASTA	T4	PA SP
NEULASTA ONPRO	T4	PA SP HD
NEUPOGEN	T3	PA SP
NIVESTYM	T4	SP
NYPOZI	T3	PA SP
NYVEPRIA	T4	PA SP
STIMUFEND	T4	PA SP
UDENYCA	T4	PA SP
ZARXIO	T2	SP HD
ZIEXTENZO	T4	PA SP
<b>THROMBOPOIETIN RECEPTOR AGONISTS</b>		
DOPTELET	T3	PA SP HD
MULPLETA	T3	PA SP HD
PROMACTA	T3	PA SP HD

### CONTRACEPTIVES (Contraception Products)

<b>CONTRACEPTIVES, INTRAVAGINAL, SYSTEMIC</b>		
etonogestrel	T3	
etonogestrel/ethynodiol dihydrogen phosphate (Nuvaring)	T1	PPACA
NUVARING VAGINAL RING (etonogestrel-ethynodiol dihydrogen phosphate)	T3	
<b>CONTRACEPTIVES, IMPLANTABLE</b>		
NEXPLANON	T3	SP PPACA
<b>CONTRACEPTIVES, INJECTABLE</b>		
DEPO-PROVERA 150 MG/ML SYRINGE (medroxyprogesterone acetate)	T3	PPACA
DEPO-SUBQ PROVERA 104	T2	PPACA

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

T4 – Injectable Specialty Medications

PA – Prior Authorization

QL – Quantity Limit

ST – Step Therapy

AGE – Age Requirement

SP – Specialty Medication

HD – May require home delivery pharmacy

PPACA – No Cost-Share Preventive Medication

CSL – Oral cancer medication subject to cost-share limits

## List of Prescription Medications

CONTRACEPTIVES (Contraception Products) (cont.)		
<b>CONTRACEPTIVES, ORAL (cont.)</b>		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>desog-e.estradiol/e.estradiol</b>		
<i>desogestrel-ethinyl estradiol</i>	T1	HD PPACA
<i>drospir/eth estra/levomefola (Beyaz)</i>	T1	HD PPACA
<i>drospir/eth estra/levomefola (Safyral)</i>	T1	HD PPACA
<i>ELLA</i>	T3	HD PPACA
<i>ESTROSTEP FE (tri-legest fe)</i>	T3	HD
<i>ethinyl estradiol/drospirenone (Yasmin 28)</i>	T1	HD PPACA
<i>ethinyl estradiol/drospirenone (Yaz)</i>	T1	HD PPACA
<i>ethynodiol d-ethinyl estradiol</i>	T1	HD PPACA
<i>levonorgestrel/ethinestradiol</i>	T1	HD PPACA
<i>I-norgest/e.estradiol-e.estrad</i>	T1	HD PPACA
<i>I-norgest/e.estradiol-e.estrad (Quartette)</i>	T1	HD PPACA
<i>LO LOESTRIN FE</i>	T2	HD
<i>LOESTRIN FE (tarina fe 1-20 eq)</i>	T3	HD
<i>MICROGESTIN 24 FE (tarina 24 fe)</i>	T3	HD
<i>noreth-ethinyl estradiol/iron</i>	T1	HD PPACA
<i>noreth-ethinyl estradiol/iron (Generess Fe)</i>	T1	HD PPACA
<i>noreth-ethinyl estradiol/iron (Generess Fe)</i>	T3	HD PPACA
<i>norethind-eth estrad 1-0.02 mg (Loestrin)</i>	T1	HD PPACA
<i>norethindrone (Ortho Micronor)</i>	T1	HD PPACA
<i>norethindrone ac-eth estradiol (Loestrin)</i>	T1	HD PPACA
<i>norethindrone-e.estradiol-iron (Estrostep Fe)</i>	T1	HD PPACA
<i>norethindrone-e.estradiol-iron (Loestrin Fe)</i>	T1	HD PPACA
<i>norethindrone-e.estradiol-iron (Microgestin 24 Fe)</i>	T1	HD PPACA
<i>norethindrone-e.estradiol-iron (Taytulla)</i>	T1	HD PPACA
<i>norethindrone-ethin. estradiol</i>	T1	HD PPACA

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

T4 – Injectable Specialty Medications

PA – Prior Authorization

QL – Quantity Limit

ST – Step Therapy

AGE – Age Requirement

SP – Specialty Medication

HD – May require home delivery pharmacy

PPACA – No Cost-Share Preventive Medication

CSL – Oral cancer medication subject to cost-share limits

## List of Prescription Medications

CONTRACEPTIVES (Contraception Products) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>CONTRACEPTIVES, ORAL (cont.)</b>		
norethindrone 1.5-0.03 mg(21) tb (Loestrin)	T1	HD PPACA
norgestrel-ethynodiol diacetate	T1	HD PPACA
ORTHO MICRONOR (tulane)	T3	HD
QUARTETTE (rivelsa)	T3	HD
<b>CONTRACEPTIVES, TRANSDERMAL</b>		
norelgestromin/ethynodiol diacetate	T1	HD PPACA
<b>DIAPHRAGMS/CERVICAL CAP</b>		
CAYA CONTOURED	T2	PPACA
FEMCAP	T2	PPACA
WIDE SEAL DIAPHRAGM	T3	PPACA
<b>INTRA-UTERINE DEVICES (IUDS)</b>		
KYLEENA	T3	SP PPACA
LILETTA	T3	SP PPACA
MIRENA	T3	SP PPACA
MIUDELLA	T3	SP PPACA
PARAGARD T 380-A	T3	SP PPACA
SKYLA	T3	SP PPACA
<b>COUGH/COLD PREPARATIONS (Allergy/Nasal Sprays)</b>		
<b>1ST GEN ANTIHIST-DECONGEST-ANTICHOLINERGIC COMB</b>		
RESPA A.R.	T3	
<b>COUGH/COLD PREPARATIONS (Cough/Cold Medications)</b>		
<b>ANTI-TUSSIVES, NON-OPIOID</b>		
benzonatate	T1	
benzonatate (Tessalon Perle)	T1	
TESSALON PERLE (benzonatate)	T3	
<b>NON-OPIOID ANTI-TUS-1ST GEN.ANTIHISTAMINE-DECONGEST</b>		
brompheniramine/pseudoephed/dm (Bromfed Dm)	T1	
<b>NON-OPIOID ANTI-TUSSIVE-1ST GEN ANTIHISTAMINE COMB.</b>		
promethazine/dextromethorphan	T1	
<b>OPIOID ANTI-TUSSIV-1ST GEN. ANTIHISTAMINE-DECONGEST</b>		
hydrocodone/cpm/pseudoephed	T1	PA
promethazine/phenyleph/codeine	T1	PA QL (480ml/30 days)

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

T4 – Injectable Specialty Medications

PA – Prior Authorization

QL – Quantity Limit

ST – Step Therapy

AGE – Age Requirement

SP – Specialty Medication

HD – May require home delivery pharmacy

PPACA – No Cost-Share Preventive Medication

CSL – Oral cancer medication subject to cost-share limits

## List of Prescription Medications

COUGH/COLD PREPARATIONS (Cough/Cold Medications) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>OPIOID ANTI-TUSSIVE-1ST GENERATION ANTIHISTAMINE</b>		
hydrocodone/chlorphen p-stirex	T1	PA
promethazine-codeine solution	T1	PA QL (480ML/22 Days)
promethazine-codeine syrup	T1	PA QL (480ml/30 days)
TUXARIN ER	T3	PA QL (2 tabs/day)
TUZISTRA XR	T3	PA QL (960ml/30 days)
<b>OPIOID ANTI-TUSSIVE-ANTI-CHOLINERGIC COMBINATIONS</b>		
HYCODAN ( <i>hydromet</i> )	T3	PA QL (480ML/22 DAYS)
hydrocodone bit/homatrop me-br (Hycodan)	T1	PA QL (480ML/22 DAYS)
hydrocodone-homatropine 5-1.5	T1	PA QL (180 tabs/30 days)
hydrocodone-homatropine soln (Hycodan)	T1	PA QL (480ml/30 days)
HYDROCODONE-HOMATROPINE SYRUP	T1	PA QL (480ml/30 days)
<b>OPIOID ANTI-TUSSIVE-EXPECTORANT COMBINATION</b>		
HYDROCODONE-GUAIFENESIN	T1	PA QL (960ml/30 days)
OBREDON	T3	PA QL (960ml/30 days)
DIAGNOSTIC (Diabetes)		
<b>BLOOD SUGAR DIAGNOSTICS</b>		
FREESTYLE INSULINX	T2	
FREESTYLE INSULINX TEST STRIPS	T2	
FREESTYLE LITE TEST STRIP	T2	
FREESTYLE PRECISION NEO	T2	
FREESTYLE TEST STRIPS	T2	
<b>DIAGNOSTIC PREPARATIONS, MISCELLANEOUS</b>		
ADVANCED DNA MEDICATED COLLECT	T3	
ARIDOL	T3	
<i>lidocaine hcl/glycerin</i> (Advanced Dna Medicated Collect)	T1	
PROVOCHOLINE	T3	
TC99M SULFUR COLLOID PREP	T1	
<b>EYE DIAGNOSTIC AGENTS</b>		
<i>fluorescein sodium</i>	T1	
<i>ful-glo 1 mg oph strip</i>	T1	
FUL-GLO EYE STRIPS	T3	
<i>lissamine green</i>	T1	
<b>GASTROINTESTINAL RADIOPAQUE DIAGNOSTICS</b>		
ENTEROVU	T3	

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

T4 – Injectable Specialty Medications

PA – Prior Authorization

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## List of Prescription Medications

DIAGNOSTIC (Miscellaneous) (cont.)			
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits	
<b>GASTROINTESTINAL RADIOPAQUE DIAGNOSTICS (cont.)</b>			
E-Z DISK	T3		
E-Z-HD	T3		
E-Z-PAQUE	T3		
E-Z-PASTE	T3		
GASTROMARK	T3		
LIQUID E-Z PAQUE	T3		
LIQUID POLIBAR PLUS	T3		
NEULUMEX	T3		
POLIBAR ACB	T3		
READI-CAT 2	T3		
SITZMARKS	T3		
TAGITOL V	T3		
VARIBAR HONEY	T3		
VARIBAR NECTAR	T3		
VARIBAR PUDDING	T3		
VARIBARTHIN HONEY	T3		
VARIBARTHIN LIQUID	T3		
<b>METABOLIC FUNCTION DIAGNOSTICS</b>			
METOPIRONE	T2		
<b>RADIOPHARMACEUTICALS ELEMENTS</b>			
INDICLOR	T3		
<b>URINARY TRACT RADIOPAQUE DIAGNOSTICS</b>			
CYSTO-CONRAY II	T3		
CYSTOGRAFIN	T3		
CYSTOGRAFIN-DILUTE	T3		
<i>diatrizoate meglumine, sodium (Gastrografin)</i>	T1		
GASTROGRAFIN ( <i>md-gastroview</i> )	T3		
DIURETICS (Diuretics)			
<b>ARGININE VASOPRESSIN (AVP) RECEPTOR ANTAGONISTS</b>			
TOLVAPTA 15 MG TABLET	T3	SP	
<i>tolvaptan 30 mg tablet (Samsca)</i>	T1	SP	
<b>CARBONIC ANHYDRASE INHIBITORS</b>			
<i>acetazolamide</i>	T1	HD	
<i>methazolamide</i>	T1	HD	

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

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## List of Prescription Medications

DIURETICS (Diuretics) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>LOOP DIURETICS</b>		
<i>bumetanide</i>	T1	HD
<i>furosemide</i>	T1	HD
<i>furosemide (Lasix)</i>	T1	HD
<i>torsemide</i>	T1	HD
<b>POLYCYSTIC KIDNEY DISEASE AGENT, AVP RECEP. ANTAG</b>		
JYNARQUE 15 MG TABLET	T3	SP
JYNARQUE 15 MG-15 MG TABLET	T3	PA SP
JYNARQUE 30 MG TABLET	T3	SP
JYNARQUE 30 MG-15 MG TABLET	T3	PA SP
JYNARQUE 45 MG-15 MG TABLET	T3	PA SP
JYNARQUE 60 MG-30 MG TABLET	T3	PA SP
JYNARQUE 90 MG-30 MG TABLET	T3	PA SP
<b>POTASSIUM SPARING DIURETICS</b>		
<i>amiloride hcl</i>	T1	HD
CAROSPIR ( <i>spironolactone</i> )	T2	PA
<i>eplerenone (Inspira)</i>	T1	HD
INSPRA ( <i>eplerenone</i> )	T3	HD
KERENDIA	T2	PA QL (30 tabs/30 days)
<i>spironolactone (Aldactone)</i>	T1	HD
<i>spironolactone (Carospir)</i>	T1	HD
<i>triamterene (Dyrenium)</i>	T1	HD
<b>POTASSIUM SPARING DIURETICS IN COMBINATION</b>		
ALDACTAZIDE	T3	HD
ALDACTAZIDE ( <i>spironolactone-hctz</i> )	T3	HD
<i>amiloride/hydrochlorothiazide</i>	T1	HD
DYAZIDE ( <i>triamterene-hydrochlorothiazid</i> )	T3	HD
<i>spironolact/hydrochlorothiazid</i>	T1	HD
<i>triamterene/hydrochlorothiazid (Dyazide)</i>	T1	HD
<b>THIAZIDE AND RELATED DIURETICS</b>		
<i>chlorthalidone</i>	T1	HD
DIURIL	T2	HD
HEMICLOR	T3	HD
<i>hydrochlorothiazide</i>	T1	HD
<i>indapamide</i>	T1	HD
<i>metolazone</i>	T1	HD

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

T4 – Injectable Specialty Medications

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## List of Prescription Medications

EENT PREPS (Allergy/Nasal Sprays)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>NASAL ANTIHISTAMINE</b>		
azelastine 0.1% (137 mcg) spry	T1	HD
azelastine 0.15% nasal spray	T1	HD
olopatadine 665 mcg nasal spry (Patanase)	T1	HD
PATANASE (olopatadine hcl)	T3	HD
<b>NASAL ANTIHISTAMINE AND ANTI-INFLAM. STEROID COMB.</b>		
azelastine/fluticasone	T1	HD
<b>NASAL ANTI-INFLAMMATORY STEROIDS</b>		
flunisolide	T1	HD
fluticasone prop 50 mcg spray	T1	HD
mometasone furoate 50 mcg spry	T1	QL (4 bots/30 days) HD
<b>NOSE PREPARATIONS, MISCELLANEOUS (RX)</b>		
ipratropium bromide	T1	HD
<b>NOSE PREPARATIONS, VASOCONSTRICATORS (RX)</b>		
ADRENALIN CHLORIDE	T3	
epinephrine hcl (Adrenalin Chloride)	T1	
EENT PREPS (Ear Medications)		
<b>EAR PREPARATIONS ANTI-INFLAMMATORY</b>		
DERMOTIC (fluocinolone acetonide oil)	T3	
fluocinolone acetonide oil (Dermotic)	T1	
<b>EAR PREPARATIONS, MISC. ANTI-INFECTIVES</b>		
acetic acid	T1	
hydrocortisone/acetic acid	T1	
EENT PREPS (Eye Conditions)		
<b>ARTIFICIAL TEARS</b>		
LACRISERT	T2	
MIEBO	T2	QL(4 bottles/30 days)
<b>EYE ANTI-INFECTIVES (RX ONLY)</b>		
BETADINE	T2	
<b>EYE ANTI-INFLAMMATORY AGENTS</b>		
dexamethasone sodium phosphate	T1	

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

T4 – Injectable Specialty Medications

PA – Prior Authorization

QL – Quantity Limit

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## List of Prescription Medications

ENT PREPS (Eye Conditions) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>EYE ANTI-INFLAMMATORY AGENTS (cont.)</b>		
<i>diclofenac 0.1% eye drops</i>	T1	
EYSUVIS	T2	QL (8.3ML/14 DAYS)
<i>fluorometholone (Fml)</i>	T1	
<i>flurbiprofen sodium</i>	T1	
ILEVRO	T3	
INVELTYS	T3	
<i>ketorolac 0.4% ophth solution (Acular Ls)</i>	T1	
<i>ketorolac 0.5% ophth solution (Acular)</i>	T1	
LOTEMAX 0.5% EYE OINT	T3	
<i>loteprednol etabonate (Lotemax; Alrex)</i>	T1	
OMNIPRED (prednisolone acetate)	T3	
<i>prednisolone acetate (Pred Forte)</i>	T1	
<i>prednisolone sodium phosphate</i>	T1	
PROLENSA	T3	
<b>EYE LOCAL ANESTHETICS</b>		
AKTEN	T3	
ALCAINE ( <i>proparacaine hcl</i> )	T3	
ALTAFLUOR BENOX ( <i>flurox</i> )	T3	
<i>benoxinate hcl/fluorescein sod (Altafluor Benox)</i>	T1	
<i>benoxinate hcl/fluorescein sod (Altafluor Benox)</i>	T3	
<i>proparacaine hcl (Alcaine)</i>	T1	
<i>proparacaine/fluorescein sod</i>	T1	
<i>proparacaine/fluorescein sod</i>	T2	
<i>tetracaine hcl</i>	T1	
TETRAVISC	T2	
TETRAVISC FORTE	T2	
<b>EYE MAST CELL STABILIZERS</b>		
<i>cromolyn 4% eye drops</i>	T1	
<b>EYE PREPARATIONS, MISCELLANEOUS (OTC)</b>		
GELFILM	T3	
<b>EYE VASOCONSTRICATORS</b>		
<i>phenylephrine hcl</i>	T1	

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

T4 – Injectable Specialty Medications

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## List of Prescription Medications

### EENT PREPS (Eye Conditions) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>MIOTICS AND OTHER INTRAOCULAR PRESSURE REDUCERS</b>		
<i>apraclonidine hcl</i> (lopidine)	T1	HD
<i>betaxolol hcl</i>	T1	HD
BETOPTIC S	T3	HD
<i>bimatoprost</i>	T1	QL (10 gm/30 days) HD
<i>brimonidine tartrate</i>	T1	HD
<i>brimonidine tartrate</i> (Alphagan P)	T1	HD
<i>brinzolamide</i> (Azopt)	T1	HD
<i>carteolol hcl</i>	T1	HD
<i>dorzolamide hcl</i> (Trusopt)	T1	HD
<i>dorzolamide hcl/timolol maleat</i> (Cosopt)	T1	HD
<i>dorzolamide/timolol/pf</i> (Cosopt Pf)	T1	HD
IOPIDINE 0.5% EYE DROPS ( <i>apraclonidine hcl</i> )	T3	HD
ISOPTO CARPINE ( <i>pilocarpine hcl</i> )	T3	HD
<i>latanoprost</i>	T1	HD
<i>levobunolol hcl</i>	T1	HD
PHOSPHOLINE IODIDE	T2	HD
<i>pilocarpine hcl</i> (Isopto Carpine)	T1	HD
RHOPRESSA	T3	
ROCKLATAN	T3	
SIMBRINZA	T3	HD
<i>timolol maleate</i> (Istalol)	T1	HD
<i>timolol maleate</i> (Timoptic)	T1	HD
<i>timolol maleate</i> (Timoptic-xe)	T1	HD
<i>timolol maleate/pf</i> (Timoptic Ocudose)	T1	HD
<i>travoprost</i>	T1	HD
TRUSOPT ( <i>dorzolamide hcl</i> )	T3	HD
<b>MYDRIATICS</b>		
<i>atropine</i> (Isopto Atropine)	T1	HD
CYCLOGYL 0.5% EYE DROPS ( <i>cyclopentolate hcl</i> )	T2	HD
CYCLOGYL 1% EYE DROPS ( <i>cyclopentolate hcl</i> )	T3	HD
CYCLOGYL 2% EYE DROPS ( <i>cyclopentolate hcl</i> )	T3	HD
CYCLOMYDRIL	T2	HD
<i>cyclopentolate hcl</i> (Cyclogyl)	T1	HD
<i>homatropine hbr</i>	T1	HD

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

T4 – Injectable Specialty Medications

PA – Prior Authorization

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AGE – Age Requirement

SP – Specialty Medication

HD – May require home delivery pharmacy

PPACA – No Cost-Share Preventive Medication

CSL – Oral cancer medication subject to cost-share limits

## List of Prescription Medications

### EENT PREPS (Eye Conditions) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>MYDRIATICS (cont.)</b>		
MYDRIACYL ( <i>tropicamide</i> )	T3	HD
PAREMYD	T3	HD
<i>tropicamide</i>	T1	HD
<i>tropicamide</i> (Mydriacyl)	T1	HD
<b>OPHTHALMIC ANTI-FIBROTIC AGENTS</b>		
MITOSOL	T3	
<b>OPHTHALMIC ANTI-INFLAMMATORY IMMUNOMODULATOR-TYPE</b>		
CEQUA	T3	
RESTASIS	T2	HD
RESTASIS MULTIDOSE	T2	HD
VEVYE	T3	QL HD
XIIDRA	T2	HD
<b>OPHTHALMIC CYSTINE DEPLETING AGENTS</b>		
CYSTADROPS	T3	PA QL (20ML/21 DAYS) SP
CYSTARAN	T3	PA QL (120ml/28 days) SP
<b>OPHTHALMIC HUMAN NERVE GROWTH FACTOR (HNGF)</b>		
OXERVATE	T3	PA SP HD
<b>ELECT/CALORIC/H2O (Cholesterol Medications)</b>		
<b>ORAL LIPID SUPPLEMENTS</b>		
DOJOLVI	T3	PA SP HD
<b>ELECT/CALORIC/H2O (Dental Products)</b>		
<b>FLUORIDE PREPARATIONS</b>		
CLINPRO 5000	T3	
FRAICHE 5000 PREVI	T3	
<i>fluoride</i> (sodium) (Prevident)	T1	
FLUORIDEX	T1	
FLUORIDEX SENSITIVITY RELIEF	T3	
PREVIDENT 0.2% RINSE	T2	
PREVIDENT 1.1% GEL ( <i>sodium fluoride</i> )	T3	

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

T4 – Injectable Specialty Medications

PA – Prior Authorization

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## List of Prescription Medications

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

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>FLUORIDE PREPARATIONS (cont.)</b>		
PREVENTID 5000	T3	
PREVENTID 5000 BOOSTER PLUS	T3	
PREVENTID 5000 ENAMEL PROTECT	T3	
PREVENTID 5000 ORTHO DEFENSE	T3	
PREVENTID 5000 PLUS ( <i>sodium fluoride 5000 plus</i> )	T3	
PREVENTID 5000 SENSITIVE	T3	
PREVENTID DENTAL RINSE	T2	
PREVENTID KIDS	T3	
<i>sodium fluoride/potassium nit</i> (Preventid 5000 Sensitive)	T1	

### ELECT/CALORIC/H2O (Diabetes)

<b>AGENTS TO TREAT HYPOGLYCEMIA (HYPERGLYCEMICS)</b>		
BAQSIMI	T2	QL (2 units/30 days)
<i>diazoxide</i> (Proglycem)	T1	
<i>glucagon 1 mg emergency kit</i> (Glucagon Emergency Kit)	T1	QL (2 pens/30 days)
GVOKE HYPOPEN 1-PACK	T2	QL (2 packs/22 days)
GVOKE HYPOPEN 2-PACK	T2	QL (2 packs/22 days)
GVOKE PFS 1-PACK SYRINGE	T2	QL (2 syrings/30 days)
GVOKE PFS 2-PACK SYRINGE	T2	QL (2 syrings/30 days)
PROGLYCEM ( <i>diazoxide</i> )	T3	

### ELECT/CALORIC/H2O (Miscellaneous)

<b>NUCLEIC ACID/NUCLEOTIDE SUPPLEMENTS</b>		
XURIDEN	T3	PA SP

### ELECT/CALORIC/H2O (Nutritional/Dietary)

<b>ELECTROLYTE DEPLETERS</b>		
AURYXIA	T3	QL (12 tabs/day)
<i>calcium acetate</i>	T1	
<i>lanthanum carbonate</i> (Fosrenol)	T1	
LOKELMA	T2	
PHOSLYRA	T3	
<i>sevelamer carbonate</i> (Renvela)	T1	

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

T4 – Injectable Specialty Medications

PA – Prior Authorization

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SP – Specialty Medication

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## List of Prescription Medications

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

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>ELECTROLYTE DEPLETERS (cont.)</b>		
<i>sevelamer hcl</i>	T1	
<i>sevelamer hcl (Renagel)</i>	T1	
<i>sodium polystyrene sulfon/sorb</i>	T1	
<i>sodium polystyrene sulfonate</i>	T1	
<i>sps 15 gm/60 ml suspension</i>	T1	
<i>sps 30 gm/120 ml enema susp</i>	T3	
VELPHORO	T2	
VELTASSA	T2	
<b>IODINE CONTAINING AGENTS</b>		
<i>potassium iodide/iodine</i>	T1	
SSKI	T1	
<b>IRON REPLACEMENT</b>		
CITRANATAL BLOOM	T3	
mv-mins no.73/iron fum/folic (Hemocyte Plus)	T1	
<b>POTASSIUM REPLACEMENT</b>		
EFFER-K 10 MEQ TABLET EFF	T3	
EFFER-K 20 MEQ TABLET EFF	T3	
<i>effer-k 25 meq tablet eff</i>	T1	
<i>klor-con 10 meq tablet (K-tab Er)</i>	T1	
<i>klor-con 10 meq tablet (K-tab Er)</i>	T3	
<i>klor-con 8 meq tablet</i>	T1	
<i>klor-con 8 meq tablet</i>	T3	
K-TAB (potassium chloride)	T3	
<i>potassium bicarbonate/cit ac</i>	T1	
<i>potassium chloride</i>	T1	
<i>potassium chloride</i>	T2	
<i>potassium chloride</i>	T3	
<i>potassium chloride (K-tab Er)</i>	T1	
<b>PROTEIN REPLACEMENT</b>		
AQNEURSA	T3	PA SP
<b>ELECT/CALORIC/H2O (Urinary Tract Conditions)</b>		
<b>DIALYSIS SOLUTIONS</b>		
PRISMASOL	T3	
<b>URINARY PH MODIFIERS</b>		
K-PHOS NO.2	T2	HD

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

T4 – Injectable Specialty Medications

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## List of Prescription Medications

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

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>URINARY PH MODIFIERS (cont.)</b>		
K-PHOS ORIGINAL	T2	HD
ORACIT	T3	HD
<i>potassium citrate</i> (Urocit-k)	T1	HD
<i>potassium citrate/citric acid</i>	T1	HD
RENACIDIN	T3	HD
UROCIT-K ( <i>potassium citrate er</i> )	T3	HD
UROQID-ACID NO.2	T2	HD

### GASTROINTESTINAL (Cholesterol Medications)

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

### GASTROINTESTINAL (Gastrointestinal/Heartburn)

AMMONIA INHIBITORS		
<i>lactulose</i>	T1	HD
<i>lactulose 10 gm/15 ml solution</i>	T1	HD
LITHOSTAT	T2	HD
OLPRUVA	T3	PA SP HD
PHEBURANE	T2	PA QL(8 Bottles/30 Days) SP HD
<i>sodium phenylbutyrate</i> (Buphenyl)	T1	SP HD

### ANTI-CHOLINERGICS, QUATERNARY AMMONIUM

<i>chlordiazepoxide/clidinium br</i>	T1	
CUVPOSA	T3	
GLYCATE	T3	
<i>glycopyrrolate</i> (Glycate)	T1	
<i>glycopyrrolate</i> (Robinul Forte)	T1	
<i>glycopyrrolate</i> (Robinul)	T1	
<i>propantheline bromide</i>	T1	
ROBINUL ( <i>glycopyrrolate</i> )	T3	
ROBINUL FORTE ( <i>glycopyrrolate</i> )	T3	

### ANTI-CHOLINERGICS/ANTI-SPASMODICS

<i>dicyclomine hcl</i>	T1	
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### ANTI-DIARRHEAL - G.I. CHLORIDE CHANNEL INHIBITORS

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

## List of Prescription Medications

GASTROINTESTINAL (Gastrointestinal/Heartburn) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>ANTI-DIARRHEAL - TRYPTOPHAN HYDROXYLASE INHIBITOR</b>		
XERMELO	T3	PA SP
<b>ANTI-DIARRHEALS</b>		
diphenoxylate hcl/atropine	T1	
diphenoxylate hcl/atropine (Lomotil)	T1	
loperamide hcl	T1	
MOTOFEN	T3	
opium tincture	T1	PA
paregoric	T1	
<b>ANTI-EMETIC, CANNABINOID-TYPE</b>		
dronabinol	T1	
<b>ANTI-EMETIC/ANTI-VERTIGO AGENTS</b>		
AKYNZE	T3	PA QL (4 caps/28 days)
ANZEMET	T3	PA QL (5 tabs/30 days) SP
aprepitant 125 mg capsule	T1	QL (4 caps/28 days)
aprepitant 125-80-80 mg pack (Emend)	T1	QL (12 caps/28 days)
aprepitant 40 mg capsule	T1	QL (1 cap/28 days)
aprepitant 80 mg capsule (Emend)	T1	QL (8 caps/28 days)
BONJESTA	T3	
COMPAZINE (prochlorperazine)	T3	
doxylamine succinate/vit b6 (Diclegis)	T1	QL(4 tabs/day)
EMEND 125 MG POWDER PACKET	T3	PA QL (12 caps/28 days)
EMEND 150 MG VIAL (fosaprepitant dimeglumine)	T3	
fosaprepitant dimeglumine (Emend)	T1	
granisetron hcl	T1	
granisetron hcl/pf	T1	
ondansetron	T1	
ondansetron hcl	T1	
ondansetron hcl/pf	T1	
ONDANSETRON ODT 16 MG TABLET	T3	

T1 – Typically Generics

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T4 – Injectable Specialty Medications

PA – Prior Authorization

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ST – Step Therapy

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## List of Prescription Medications

GASTROINTESTINAL (Gastrointestinal/Heartburn) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>ANTI-EMETIC/ANTI-VERTIGO AGENTS (cont.)</b>		
<i>prochlorperazine</i> (Compazine)	T1	
<i>prochlorperazine maleate</i> (Compazine)	T1	
<i>promethazine hcl</i>	T1	
<i>promethazine hcl</i>	T3	
SANCUSO	T3	PA QL (4 patches/30 days)
<i>scopolamine</i> (Transderm-scop)	T1	
TIGAN ( <i>trimethobenzamide hcl</i> )	T3	
TRANSDERM-SCOP ( <i>scopolamine</i> )	T3	
<i>trimethobenzamide hcl</i> (Tigan)	T1	
VARUBI	T3	PA QL (4 tabs/28 days)
<b>ANTI-ULCER PREPARATIONS</b>		
CYTOTEC ( <i>misoprostol</i> )	T3	HD
<i>misoprostol</i> (Cytotec)	T1	HD
<i>sucralfate</i> (Carafate)	T1	HD
<b>ANTI-ULCER-H.PYLORI AGENTS</b>		
<i>bismuth/metronid/tetracycline</i> (Pylera)	T1	
<i>lansoprazole/amoxiciln/clarith</i>	T1	
<b>BELLADONNA ALKALOIDS</b>		
DONNATAL	T3	HD
DONNATAL ( <i>phenohytro</i> )	T3	HD
<i>hyoscyamine sulfate</i>	T1	HD
<i>hyoscyamine sulfate</i> (Levbid)	T1	HD
<i>hyoscyamine sulfate</i> (Levsin)	T1	HD
<i>hyoscyamine sulfate</i> (Levsin-sl)	T1	HD
<i>hyoscyamine sulfate</i> (Nulev)	T1	HD
<i>hyoscyamine sulfate</i> (Nulev)	T3	HD
LEVSIN ( <i>oscimin</i> )	T3	HD
<i>methscopolamine bromide</i>	T1	HD
NULEV ( <i>symax</i> )	T1	HD
<i>phenobarb/hyoscy/atropine/scop</i> (Donnatal)	T1	HD
<i>phenobarb/hyoscy/atropine/scop</i> (Phenobarbital-belladonna)	T1	HD

T1 – Typically Generics

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T4 – Injectable Specialty Medications

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## List of Prescription Medications

GASTROINTESTINAL (Gastrointestinal/Heartburn) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>BELLADONNA ALKALOIDS (cont.)</b>		
phenobarbital-belladonna elixr (Donnatal)	T1	HD
phenobarbital-belladonna elixr (Phenobarbital-belladonna)	T1	HD
PHENOBARBITAL-BELLADONNA ELIXR ( <i>phenoxytrop</i> )	T3	HD
SYMAX DUOTAB	T2	HD
<b>BILE SALTS</b>		
ACTIGALL ( <i>ursodiol</i> )	T3	HD
CHENODAL	T3	SP HD
CHOLBAM	T3	PA SP HD
URSO FORTE ( <i>ursodiol</i> )	T3	HD
<i>ursodiol</i> (Actigall)	T1	HD
<i>ursodiol</i> (Urso Forte)	T1	HD
<i>ursodiol</i>	T1	HD
<b>CHRONIC INFLAM. COLON DX, 5-A-SALICYLAT, RECTAL TX</b>		
mesalamine 1,000 mg supp (Canasa)	T1	
mesalamine 4 gm/60 ml enema (Sfrowasa)	T1	
mesalamine 4 gm/60 ml kit	T1	
SFROWASA (mesalamine)	T3	
<b>DRUG TX-CHRONIC INFLAM. COLON DX, 5-AMINOSALICYLAT</b>		
APRISO (mesalamine er)	T3	HD
AZULFIDINE (sulfasalazine dr)	T3	HD
balsalazide disodium	T1	HD
mesalamine	T1	HD
mesalamine (Apriso)	T1	HD
mesalamine 800 mg dr tablet	T1	HD
mesalamine dr 1.2 gm tablet (Lialda)	T1	HD
PENTASA 500 MG CAPSULE (mesalamine)	T3	HD
sulfasalazine (Azulfidine)	T1	HD
<b>FARNESOID X RECEPTOR (FXR) AGONIST, BILE AC ANALOG</b>		
OCALIVA	T3	PA SP HD
<b>FECAL MICROBIOTA TRANSPLANTATION (FMT)</b>		
VOWST	T3	PA QL(12 caps/56 days) SP
<b>GASTRIC ENZYMEs</b>		
SUCRAID	T3	PA SP

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## List of Prescription Medications

GASTROINTESTINAL (Gastrointestinal/Heartburn) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>HISTAMINE H2-RECEPTOR INHIBITORS</b>		
cimetidine	T1	HD
cimetidine hcl	T1	HD
famotidine	T1	HD
nizatidine	T1	HD
ranitidine hcl	T1	HD
<b>IBS AGENTS, MIXED OPIOID RECEP AGONISTS/ANTAGONISTS</b>		
VIBERZI	T2	HD
<b>IBS-C/CIC AGENTS, GUANYLATE CYCLASE-C AGONIST</b>		
LINZESS	T2	
TRULANCE	T2	
<b>INTESTINAL MOTILITY STIMULANTS</b>		
metoclopramide hcl	T1	
metoclopramide hcl (Reglan)	T1	
REGLAN (metoclopramide hcl)	T3	
<b>IRRITABLE BOWEL SYNDROME AGENTS, 5-HT3 ANTAGONIST</b>		
alosetron hcl	T1	SP HD
<b>LAXATIVES AND CATHARTICS</b>		
bisac/nacl/nahco3/kcl/peg 3350	T1	PPACA
lactulose	T1	
lactulose 10 gm/15 ml solution	T1	
lactulose 20 gm/30 ml solution	T1	
lubiprostone (Amitiza)	T1	
NULYTELY	T3	PPACA
peg3350/sod sul/nacl/kcl/asb/c	T1	PPACA
peg3350/sod sulf, bicarb, cl/kcl	T1	PPACA
PREPOPIK	T2	PPACA
sodium chloride/nahco3/kcl/peg	T1	PPACA
<b>LOCAL ANORECTAL NITRATE PREPARATIONS</b>		
nitroglycerin 0.4% ointment (Rectiv)	T1	
RECTIV (nitroglycerin)	T3	

T1 – Typically Generics

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## List of Prescription Medications

GASTROINTESTINAL (Gastrointestinal/Heartburn) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>PANCREATIC ENZYMES</b>		
PANCREAZE	T2	HD
VIOKACE	T3	HD
ZENPEP	T2	HD
<b>POTASSIUM-COMPETITIVE ACID BLOCKERS (PCABS)</b>		
VOQUEZNA	T3	PA QL(1 tab/day)
<b>PROTON-PUMP INHIBITORS</b>		
<i>dexlansoprazole dr 30 mg cap (Dexilant)</i>	T1	QL(2 caps/day)
<i>esomeprazole dr 10 mg packet</i>	T1	QL (4 packets/day) HD
<i>esomeprazole dr 20 mg packet</i>	T1	QL (2 packs/day) HD
<i>esomeprazole dr 40 mg packet</i>	T1	QL (1 packet/day) HD
<i>esomeprazole mag dr 20 mg cap</i>	T1	QL (20ml/day) HD
<i>esomeprazole mag dr 40 mg cap</i>	T1	QL (1 cap/day) HD
ESOMEPRAZOLE STRONTIUM	T3	QL (1 cap/day) HD
<i>lansoprazole dr 15 mg capsule (Prevacid)</i>	T1	QL (2 caps/day) HD
<i>lansoprazole dr 30 mg capsule (Prevacid)</i>	T1	QL (30 caps/30 days) HD
<i>lansoprazole odt 15 mg tablet</i>	T1	QL (2 tabs/day) HD
<i>lansoprazole odt 30 mg tablet</i>	T1	QL (30 tabs/30 days) HD
NEXIUM DR 2.5 MG PACKET	T2	QL (480 packs/30 days) HD
NEXIUM DR 5 MG PACKET	T2	QL (240 packs/30 days) HD
<i>omeprazole dr 10 mg capsule</i>	T1	QL (120 caps/30 days) HD
<i>omeprazole dr 20 mg capsule</i>	T1	HD
<i>omeprazole dr 40 mg capsule</i>	T1	QL (1 cap/day) HD
<i>pantoprazole 40 mg suspension (Protonix)</i>	T1	QL (1 dose/day) HD
<i>pantoprazole sod dr 20 mg tab (Protonix)</i>	T1	QL (2 tabs/day) HD
<i>pantoprazole sod dr 40 mg tab (Protonix)</i>	T1	QL (1 tab/day) HD
PREVACID DR 15 MG CAPSULE ( <i>lansoprazole</i> )	T3	QL (60 caps/30 days) ST
PREVACID DR 30 MG CAPSULE ( <i>lansoprazole</i> )	T3	QL (30 caps/30 days) ST
PRILOSEC DR 10 MG SUSPENSION	T3	QL (120 packs/30 days) HD
PRILOSEC DR 2.5 MG SUSPENSION	T3	QL (480 packs/30 days) HD
PROTONIX 40 MG SUSPENSION ( <i>pantoprazole sodium</i> )	T3	QL (30 packs/30 days) ST
PROTONIX DR 20 MG TABLET ( <i>pantoprazole sodium</i> )	T3	QL (60 tabs/30 days) ST
PROTONIX DR 40 MG TABLET ( <i>pantoprazole sodium</i> )	T3	QL (30 tabs/30 days) ST

T1 – Typically Generics

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T3 – Typically Non-Preferred Brands

T4 – Injectable Specialty Medications

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## List of Prescription Medications

GASTROINTESTINAL (Gastrointestinal/Heartburn) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>PROTON-PUMP INHIBITORS (cont.)</b>		
rabeprazole sodium (AcipHex)	T1	QL (30 tabs/30 days) HD
<b>RECTAL PREPARATIONS</b>		
hydrocortisone ac 25 mg supp	T1	
<b>SBS - GLUCAGON-LIKE PEPTIDE-2 (GLP-2) ANALOGS</b>		
GATTEX	T4	PA SP HD
GASTROINTESTINAL (Pain Relief And Inflammatory Disease)		
<b>HEMORRHOID PREP, ANTI-INFLAM STEROID-LOCAL ANESTHET</b>		
ANA-LEX	T1	
ANALPRAM HC 1% CREAM	T3	
hydrocortisone/lidocaine/aloe	T1	
hydrocortisone/pramoxine (Analpram Hc)	T1	
lidocaine/hydrocortisone ac	T1	
LIDOCAINE-HYDROCORTISONE	T1	
PROCORT	T3	
PROCTOFOAM-HC	T2	
<b>RECTAL/LOWER BOWEL PREP., GLUCOCORT. (NON-HEMORR)</b>		
budesonide 2 mg rectal foam	T1	QL(2 KITS/180 DAYS)
CORTENEMA (hydrocortisone)	T3	
hydrocortisone (Cortenema)	T1	
HORMONES (Hormonal Agents)		
<b>ANDROGEN/ESTROGEN PREPS FOR FEMALE SEXUAL DYSFUNC</b>		
INTRAROSA	T3	
<b>ANDROGENIC AGENTS</b>		
ANADROL-50	T2	PA
DEPO-TESTOSTERONE	T3	
DEPO-TESTOSTERONE ( <i>testosterone cypionate</i> )	T3	
METHITEST	T1	

T1 – Typically Generics

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T4 – Injectable Specialty Medications

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## List of Prescription Medications

### HORMONES (Hormonal Agents) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>ANDROGENIC AGENTS (cont.)</b>		
methyltestosterone	T1	
oxandrolone	T1	PA
testosterone 1% (25mg/2.5g) pk (Androgel)	T1	PA QL (150gm/30 days)
testosterone 1% (50 mg/5 g) pk (Testosterone)	T1	PA QL (2 packs/day)
testosterone 1.62% (2.5 g) pkt (Androgel)	T1	PA QL (150gm/30 days)
testosterone 1.62% gel pump (Androgel)	T1	PA QL (150gm/30 days)
testosterone 1.62%(1.25 g) pkt (Androgel)	T1	PA QL (2 packs/day)
testosterone 10 mg gel pump	T1	PA QL (120 gm/30 days)
TESTOSTERONE 12.5 MG/1.25 GRAM	T1	PA QL (150gm/30 days)
testosterone 12.5 mg/1.25 gram (Testosterone)	T1	PA QL (150gm/30 days)
testosterone 30 mg/1.5 ml pump	T1	PA QL (180ml/30 days)
testosterone 50 mg/5 gram gel	T1	PA QL (2 tubes/day)
TESTOSTERONE 50 MG/5 GRAM PKT	T1	PA QL (2 packs/day)
XYOSTED	T3	PA QL(2 ML/28 DAYS)
<b>ANTI-DIURETIC AND VASOPRESSOR HORMONES</b>		
desmopressin (nonrefrigerated)	T1	HD
desmopressin acetate	T1	HD
NOCTIVA	T3	PA
STIMATE	T2	SP
<b>ESTROGEN AND PROGESTIN COMBINATIONS</b>		
BIJUVA	T3	
<b>ESTROGEN/ANDROGEN COMBINATIONS</b>		
estrogen, ester/me-testosterone (Estratest H.S.)	T1	HD
<b>ESTROGENIC AGENTS</b>		
ACTIVELLA (mimvey lo)	T3	HD
ACTIVELLA (mimvey)	T3	HD
ALORA	T3	QL (16 patches/28 days) HD
CLIMARA (estradiol (once weekly))	T3	HD
CLIMARA PRO	T3	HD
COMBIPATCH	T2	HD
DEPO-ESTRADOL	T3	HD
DIVIGEL	T2	HD
ELESTRIN	T3	HD

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## List of Prescription Medications

### HORMONES (Hormonal Agents) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>ESTROGENIC AGENTS (cont.)</b>		
estradiol (Climara)	T1	HD
estradiol 0.06% 1.25g gel pump (Estrogel)	T1	HD
estradiol 0.5 mg tablet (Estrace)	T1	HD
estradiol 1 mg tablet (Estrace)	T1	HD
estradiol 2 mg tablet (Estrace)	T1	HD
estradiol valerate	T1	HD
estradiol/norethindrone acet (Activella)	T1	HD
EVAMIST	T3	HD
FEMHRT ( <i>norethindron-ethinyl estradiol</i> )	T3	HD
MENEST	T3	HD
MENOSTAR	T3	QL (8 patches/28 days) HD
MINIVELLE ( <i>lyllana</i> )	T3	QL (16 patches/28 days) HD
<i>norethind-eth estrad 0.5-2.5</i> (Femhrt)	T1	HD
<i>norethindrone ac-eth estradiol</i>	T1	HD
<i>norethindrone ac-eth estradiol</i> (Femhrt)	T1	HD
<i>norethin-eth estrad 1 mg-5 mcg</i>	T1	HD
PREMARIN	T2	HD
PREMPHASE	T2	HD
PREMPRO	T2	HD
VIVELLE-DOT ( <i>lyllana</i> )	T3	QL (16 patches/28 days) HD
<b>ESTROGEN-PROGESTIN WITH ANTI-MINERALOCORTICOID COMB</b>		
ANGELIQ	T3	HD
<b>ESTROGEN-SELECTIVE ESTROGEN RECEPTOR MOD (SERM) COMB</b>		
DUAVEE	T2	
<b>GLUCOCORTICOIDS</b>		
budesonide	T1	PA QL (56 tabs/180 days)
budesonide (Entocort Ec)	T1	
cortisone acetate	T1	
dexamethasone	T1	
EMFLAZA	T3	PA SP HD

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## List of Prescription Medications

### HORMONES (Hormonal Agents) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>GLUCOCORTICOIDS (cont.)</b>		
ENTOCORT EC ( <i>budesonide ec</i> )	T3	
<i>hydrocortisone</i> (Cortef)	T1	
LOCORT	T1	
MEDROL 16 MG TABLET ( <i>methylprednisolone</i> )	T3	
MEDROL 2 MG TABLET	T2	
MEDROL 32 MG TABLET ( <i>methylprednisolone</i> )	T3	
MEDROL 4 MG DOSEPAK ( <i>methylprednisolone</i> )	T3	
MEDROL 4 MG TABLET ( <i>methylprednisolone</i> )	T3	
MEDROL 8 MG TABLET ( <i>methylprednisolone</i> )	T3	
<i>methylprednisolone</i> (Medrol)	T1	
MILLIPRED 10 MG/5 ML SOLUTION ( <i>prednisolone sodium phosphate</i> )	T3	
<i>millipred 5 mg tablet</i>	T1	
ORAPRED ODT ( <i>prednisolone sodium phos odt</i> )	T3	
<i>prednisolone</i>	T1	
<i>prednisolone sodium phosphate</i>	T1	
<i>prednisolone sodium phosphate</i> (Millipred)	T1	
<i>prednisolone sodium phosphate</i> (Orapred Odt)	T1	
<i>prednisone</i>	T1	
<b>GROWTH HORMONE RELEASING HORMONE (GHRH) AND ANALOGS</b>		
EGRIFTA	T4	PA SP HD
EGRIFTA SV	T4	PA SP HD
<b>GROWTH HORMONES</b>		
GENOTROPIN	T4	PA SP HD
NGENLA	T4	PA SP
NORDITROPIN FLEXPRO	T4	PA SP HD
OMNITROPE	T4	PA SP HD
SEROSTIM	T4	PA SP
SOGROYA	T4	PA SP
<b>INSULIN-LIKE GROWTH FACTOR-I (IGF-I) HORMONES</b>		
INCRELEX	T4	PA SP HD
<b>LHRH (GNRH) AGONIST ANALOG AND PROGESTIN COMB</b>		
LUPANETA PACK	T3	PA SP HD

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

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## List of Prescription Medications

### HORMONES (Hormonal Agents) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>LHRH (GNRH) AGONIST ANALOG PITUITARY SUPPRESSANTS</b>		
LUPRON DEPOT	T4	PA SP HD
<b>LHRH (GNRH) ANTAGONIST, ESTROGEN AND PROGESTIN COMB</b>		
MYFEMBREE	T2	PA QL (24 MONTH THERAPY)
ORIAHNN	T2	PA QL (2 CAPSULES/DAY)
<b>LHRH (GNRH) ANTAGONIST, PITUITARY SUPPRESSANT AGENTS</b>		
CETROTIDE	T2	PA SP
<i>ganirelix acet 250 mcg/0.5 ml (Ganirelix Acetate)</i>	T1	PA SP
GANIRELIX ACET 250 MCG/0.5 ML ( <i>ganirelix acetate</i> )	T2	PA SP
ORILISSA 150 MG TABLET	T2	PA QL (1 tab/day)
ORILISSA 200 MG TABLET	T2	PA QL (6 months therapy/lifetime)
<b>LHRH (GNRH) AGNST PIT.SUP-CENTRAL PRECOCIOUS PUBERTY</b>		
FENSOLVI	T3	PA SP
LUPRON DEPOT-PED	T2	PA SP HD
<b>MINERALOCORTICOIDS</b>		
<i>fludrocortisone acetate</i>	T1	HD
<b>OXYTOCICS</b>		
CERVIDIL	T3	
<i>methylergonovine maleate</i>	T1	
PREPIDIL	T3	
PROSTIN E2 VAGINAL SUPPOSITORY	T3	
<b>PITUITARY SUPPRESSIVE AGENTS</b>		
<i>cabergoline</i>	T1	QL (16 tabs/28 days) HD
CRENESSITY 50 MG CAPSULE	T3	PA QL(2 caps/day) SP
CRENESSITY 100 MG CAPSULE	T3	PA QL SP
CRENESSITY 50 MG/ML SOLUTION	T3	PA QL(8 mls/day) SP
<i>danazol</i>	T1	HD
<b>PROGESTATIONAL AGENTS</b>		
CRINONE 4% GEL	T3	PA HD
DEPO-PROVERA 400 MG/ML VIAL	T3	HD
<i>medroxyprogesterone 10 mg tab (Provera)</i>	T1	HD
<i>medroxyprogesterone 2.5 mg tab (Provera)</i>	T1	HD
<i>medroxyprogesterone 5 mg tab (Provera)</i>	T1	HD
<i>norethindrone acetate</i>	T1	HD
<i>progesterone, micronized (Prometrium)</i>	T1	HD

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

T4 – Injectable Specialty Medications

PA – Prior Authorization

QL – Quantity Limit

ST – Step Therapy

AGE – Age Requirement

SP – Specialty Medication

HD – May require home delivery pharmacy

PPACA – No Cost-Share Preventive Medication

CSL – Oral cancer medication subject to cost-share limits

## List of Prescription Medications

HORMONES (Hormonal Agents) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>SOMATOSTATIC AGENTS</b>		
SANDOSTATIN ( <i>octreotide acetate</i> )	T3	PA SP HD
SANDOSTATIN LAR DEPOT	T2	PA SP
SIGNIFOR	T3	PA SP
SIGNIFOR LAR	T3	PA SP
SOMATULINE DEPOT	T2	PA SP HD
<b>VAGINAL ESTROGEN FOR SEXUAL DYSFUNCTION</b>		
IMVEXXY 10 MCG MAINTENANCE PAK	T3	QL (16/28 days) HD
IMVEXXY 10 MCG STARTER PACK	T3	QL (36/28 days) HD
IMVEXXY 4 MCG MAINTENANCE PACK	T3	QL (16/28 days) HD
IMVEXXY 4 MCG STARTER PACK	T3	QL (36/28 days) HD
<b>VAGINAL ESTROGEN PREPARATIONS</b>		
ESTRACE ( <i>estradiol</i> )	T3	HD
<i>estradiol</i> (Vagifem)	T1	QL (36 tabs/28 days) HD
<i>estradiol</i> 0.01% cream (Estrace)	T1	HD
<i>estradiol</i> 10 mcg vaginal insrt (Vagifem)	T1	QL (36 tabs/28 days) HD
FEMRING	T3	HD
PREMARIN	T2	HD
VAGIFEM ( <i>yuvafem</i> )	T3	QL (36 tabs/28 days) HD
HORMONES (Infertility)		
<b>FERTILITY STIMULATING PREPARATIONS, NON-FSH</b>		
<i>clomiphene citrate</i>	T1	
<b>FOLLICLE-STIMULATING AND LUTEINIZING HORMONES</b>		
MENOPUR	T2	PA SP
<b>FOLLICLE-STIMULATING HORMONE (FSH)</b>		
FOLLISTIM AQ	T3	PA SP
GONAL-F	T2	PA SP
GONAL-F RFF	T2	PA SP
GONAL-F RFF REDI-JECT	T2	PA SP
<b>HUMAN CHORIONIC GONADOTROPIN (HCG)</b>		
CHORIONIC GONADOTROPIN	T3	PA SP
CHORIONIC GONAD VIAL	T1	SP

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

T4 – Injectable Specialty Medications

PA – Prior Authorization

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## List of Prescription Medications

HORMONES (Infertility) (cont.)					
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits			
<b>HUMAN CHORIONIC GONADOTROPIN (HCG) (cont.)</b>					
NOVAREL	T2	PA SP			
OVIDREL	T2	PA SP			
PREGNYL	T2	PA SP			
<b>PREGNANCY FACILITATING/MAINTAINING AGENT, HORMONAL</b>					
CRINONE 8% GEL	T3	PA			
ENDOMETRIN	T2				
HORMONES (Miscellaneous)					
<b>LEPTIN HORMONE ANALOGS</b>					
MYALEPT	T3	PA SP HD			
HORMONES (Osteoporosis Products)					
<b>BONE FORMATION STIM. AGENTS - PARATHYROID HORMONE</b>					
teriparatide 600 mcg/2.4ml pen	T1	PA QL(0.09 mls/day) SP HD			
TERIPARATIDE 620 MCG/2.48 ML	T3	PA QL(0.09 mls/day) SP HD			
<b>BONE RESORPTION INHIBITORS</b>					
<i>ibandronate sodium</i>	T1	HD			
<i>calcitonin, salmon, synthetic</i>	T1	HD			
MIACALCIN	T2	HD			
IMMUNOSUPPRESSANTS (Pain Relief And Inflammatory Disease)					
<b>INTERLEUKIN-4(IL-4) RECEPTOR ALPHA ANTAGONIST, MAB</b>					
DUPIXENT PEN	T4	PA SP HD			
DUPIXENT SYRINGE	T4	PA SP HD			
<b>INTERLEUKIN-6 (IL-6) RECEPTOR INHIBITORS</b>					
TYENNE	T4	PA QL(3.6 ml/28 days) SP			
TYENNE AUTOINJECTOR	T4	PA QL(3.6 ml/28 days) SP			
<b>IL-23 RECEPTOR ANTAGONIST, MONOCLONAL ANTIBODY</b>					
OMVOH 100 MG/ML PEN	T2	PA QL(2 pens/28 days) SP HD			
OMVOH 100 MG/ML SYRINGE	T2	PA QL(2 syringes/28 days) SP HD			
OMVOH 300 MG DOSE - 2 PENS	T2	PA QL(3 mls/28 days) SP HD			
ACTEMRA	T4	PA QL (4 syringes/28 days) SP HD			
ACTEMRA ACTPEN	T4	PA QL (4 pens/28 days) SP HD			
ENSPRYNG	T4	PA SP HD			
KEVZARA 150 MG/1.14 ML PEN INJ	T4	PA QL (2 pens/28 days) SP HD			
KEVZARA 150 MG/1.14 ML SYRINGE	T4	PA QL (2 syringes/28 days) SP HD			
KEVZARA 200 MG/1.14 ML PEN INJ	T4	PA QL (2 pens/28 days) SP HD			

T1 – Typically Generics

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T4 – Injectable Specialty Medications

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## List of Prescription Medications

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

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>IL-23 RECEPTOR ANTAGONIST, MONOCLONAL ANTIBODY (con't.)</b>		
KEVZARA 200 MG/1.14 ML SYRINGE	T4	PA QL (2 syrings/28 days) SP HD
<b>MONOCLONAL ANTIBODY-HUMAN INTERLEUKIN I2/23 INHIB</b>		
STELARA 45 MG/0.5 ML SYRINGE	T4	PA QL (1 syringe/84 days) SP HD
STELARA 45 MG/0.5 ML VIAL	T4	PA QL (1 vial/84 days) SP HD
STELARA 90 MG/ML SYRINGE	T4	PA QL (1 syringe/84 days) SP HD
SELARSDI	T4	PA QL(1 syringe/84 days) SP
USTEKINUMAB-TTWE	T2	PA QL(1 syringe/84 days) SP HD
YESINTEK	T2	PA QL(1 syringe/84 days) SP

### IMMUNOSUPPRESSANTS (Skin Conditions)

TOPICAL IMMUNOSUPPRESSIVE AGENTS
ELIDEL ( <i>pimecrolimus</i> )
<i>pimecrolimus</i> (Elidel)
PROTOPIC ( <i>tacrolimus</i> )
<i>tacrolimus</i> 0.03% ointment
<i>tacrolimus</i> 0.1% ointment

### IMMUNOSUPPRESSANTS (Transplant Medications)

IMMUNOSUPPRESSIVES
ASTAGRAF XL
AZASAN
<i>azathioprine</i> (Imuran)
<i>cyclosporine</i> (Sandimmune)
<i>cyclosporine, modified</i>
<i>cyclosporine, modified</i> (Neoral)
ENVARSUS XR
<i>everolimus</i> 0.25 mg tablet (Zortress)
<i>everolimus</i> 0.5 mg tablet (Zortress)
<i>everolimus</i> 0.75 mg tablet (Zortress)
LUPKYNIS
<i>mycophenolate mofetil</i> (Cellcept)
NEORAL ( <i>gengraf</i> )
PROGRAF
PROGRAF ( <i>tacrolimus</i> )
<i>sirolimus</i> (Rapamune)
<i>tacrolimus</i>

T1 – Typically Generics

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## List of Prescription Medications

IMMUNOSUPPRESSANTS (Transplant Medications) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>IMMUNOSUPPRESSIVES (cont.)</b>		
ZORTRESS (everolimus)	T3	SP HD
MISCELLANEOUS MEDICAL SUPPLIES, DEVICES, NON-DRUG (Diabetes)		
<b>DIABETIC SUPPLIES</b>		
AGAMATRIX CONTROL SOLUTION	T1	
AUTOLET LITE	T1	
CARESENS	T1	
CARETOUCH CONTROL SOLUTION	T1	
CEQUR SIMPLICITY	T2	
CHOSEN LANCING DEVICE	T1	
DEXCOM G6 RECEIVER	T2	PA QL (1 syringe/365 days)
DEXCOM G6 SENSOR	T2	PA QL (3/30 days)
DEXCOM G6 TRANSMITTER	T2	PA QL (1 syringe/67 days)
DEXCOM G7 RECEIVER	T2	PA QL(1 unit/365 days)
DEXCOM G7 SENSOR	T2	PA QL(3 sensors/30 days)
EASY TOUCH BLU LINK CTRL SOLN	T1	
EASY TRAK II CONTROL SOLUTION	T1	
ENLITE SERTER	T1	
FREESTYLE LIBRE 2 PLUS SENSOR	T2	PA QL(2 units/30 days)
FREESTYLE LIBRE 2 READER	T2	PA QL (1 reader/day)
FREESTYLE LIBRE 2 SENSOR	T2	PA QL (2 Sensors/21 days)
FREESTYLE LIBRE 3 PLUS SENSOR	T2	PA QL(2 units/28 days)
FREESTYLE LIBRE 10 DAY READER	T2	PA QL (1 reader/day)
FREESTYLE LIBRE 10 DAY SENSOR	T2	PA QL (3/30 days)
FREESTYLE LIBRE 14 DAY READER	T2	PA QL (1 reader/day))
FREESTYLE LIBRE 14 DAY SENSOR	T2	PA QL (2/28 days)
FORA TN'GO ADVANCE MULTIFN MTR	T3	
GLUCOCOM AUTOLINK	T1	
GUARDIAN RT CHARGER	T1	
GUARDIAN RT STARTER KIT	T1	
GUARDIAN TEST PLUG	T1	
HUMAPEN LUXURA HD	T1	
IHEALTH CONTROL SOLN LEVEL 2	T1	
INPEN (FOR HUMALOG)	T1	
INPEN (FOR NOVOLOG OR FIASP)	T1	
LITE TOUCH LANCING PEN	T1	

T1 – Typically Generics  
T2 – Typically Preferred Brands  
T3 – Typically Non-Preferred Brands

T4 – Injectable Specialty Medications  
PA – Prior Authorization  
QL – Quantity Limit

ST – Step Therapy  
AGE – Age Requirement  
SP – Specialty Medication

HD – May require home delivery pharmacy  
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## List of Prescription Medications

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

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>DIABETIC SUPPLIES (cont.)</b>		
NOVOPEN ECHO	T1	
OMNIPOD 5 G6-G7 INTRO KT(GEN5)	T2	QL
OMNIPOD 5 (G6/LIBRE 2 PLUS)	T2	QL(30 crtgs/30 days)
OMNIPOD 5 (GEN 5) KIT	T2	QL (1 kit/365 days)
OMNIPOD 5 (GEN 5) PODS	T2	QL (30 pods/30 days)
OMNIPOD 5 G6-G7 PODS (GEN 5)	T2	QL
OMNIPOD CLASSIC (GEN 3) KIT	T2	QL (1 kit/365 days)
OMNIPOD CLASSIC (GEN 4) KIT	T2	QL (1 kit/365 days)
OMNIPOD CLASSIC (GEN 3) PODS	T2	QL (30 pods/30 days)
OMNIPOD CLASSIC (GEN 4) PODS	T2	QL (30 pods/30 days)
OMNIPOD DASH 5 PACK POD	T2	PA QL (6 boxes/30 days)
OMNIPOD 5 DEXG7G6 INTRO(GEN 5)	T2	QL(1 unit/365 days)
OMNIPOD 5 DEXG7G6 PODS (GEN 5)	T2	QL(30 crtgs/30 days)
OMNIPOD DASH 5 PACK POD	T2	PA QL (6 boxes/30 days)
ONETOUCH DELICA PLUS LANC DEV	T1	
ONETOUCH ULTRA CONTROL SOLN	T1	
ONETOUCH VERIO HIGH CNTRL SOLN	T1	
ONETOUCH VERIO MID CNTRL SOLN	T1	
REPLACEMENT PEDIATRIC MONITOR	T1	
SEN-SERTER	T1	
V-GO 20, 30, 40	T2	

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

DURABLE MEDICAL EQUIPMENT, MISC (GROUP I)		
2-IN-1 LANCET DEVICE	T1	
ACCU-CHEK FASTCLIX LANCET DRUM	T1	
ACCU-CHEK SAFE-T-PRO	T1	
ACCU-CHEK SAFE-T-PRO PLUS	T1	
ACCU-CHEK SOFTCLIX	T1	
ACTI-LANCE	T1	
ADVANCED TRAVEL LANCETS	T1	
ADVOCATE LANCET	T1	
ADVOCATE SAFETY LANCET	T1	
ALTERNATE SITE LANCETS	T1	
ASSURE HAEMOLANCE PLUS	T1	
ASSURE LANCE	T1	

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

## List of Prescription Medications

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

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>DURABLE MEDICAL EQUIPMENT, MISC (GROUP I) (cont.)</b>		
ASSURE LANCE PLUS	T1	
BD MICROTAINER LANCETS	T1	
BD ULTRA-FINE	T1	
BD ULTRA-FINE II	T1	
BULLSEYE MINI SAFETY LANCETS	T1	
BUTTERFLY TOUCH LANCET	T1	
CAREONE	T1	
CARESENS LANCET	T1	
CARETOUCH SAFETY LANCETS	T1	
CARETOUCH TWIST LANCET	T1	
CHOSEN LANCET	T1	
CHOSEN SAFETY LANCET	T1	
CLEVER CHEK LANCETS	T1	
COAGUCHEK	T1	
COLOR LANCETS	T1	
COMFORT EZ	T1	
COMFORT LANCETS	T1	
COMFORT TOUCH PLUS SAFETY LANCET	T1	
COMFORT TOUCH ULT THIN LANCET	T1	
DROPLET LANCETS	T1	
EASY COMFORT LANCETS	T1	
EASY TOUCH	T1	
EASY TWIST & CAP LANCETS	T1	
EMBRACE 30G LANCETS	T1	
EMBRACE SAFETY LANCET	T1	
EZ SMART LANCETS	T1	
EZ-LETS	T1	
FIFTY50 SAFETY SEAL LANCETS	T1	
FINE 30 UNIVERSAL LANCETS	T1	
FINGERSTIX	T1	
FORA LANCETS	T1	
FORACARE LANCETS	T1	
FREESTYLE LANCETS	T1	
FREESTYLE UNISTIK 2	T1	
GLUCOCOM	T1	
GOJJI LANCETS	T1	

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

T4 – Injectable Specialty Medications

PA – Prior Authorization

QL – Quantity Limit

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## List of Prescription Medications

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

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>DURABLE MEDICAL EQUIPMENT, MISC (GROUP I) (cont.)</b>		
HEALTHY ACCENTS UNILET LANCET	T1	
INCONTROL SUPER THIN LANCETS	T1	
INCONTROL ULTRA THIN LANCETS	T1	
INJECT EASE LANCETS	T1	
INVACARE LANCETS	T1	
lancets	T1	
LANCETS	T1	
LANCETS THIN	T1	
LANCETS ULTRA THIN	T1	
LITE TOUCH	T1	
LITE TOUCH INSULIN 0.5 ML SYR	T1	
LITE TOUCH INSULIN 1 ML SYR	T1	
LITE TOUCH INSULIN SYR 0.3 ML	T1	
LITE TOUCH INSULIN SYR 0.5 ML	T1	
LITE TOUCH INSULIN SYR 1 ML	T1	
MEDISENSE THIN LANCETS	T1	
MEDLANCE PLUS	T1	
MICRO THIN LANCET	T1	
MICRO THIN LANCETS	T1	
MICROLET	T1	
MOBILE LANCETS	T1	
MONOLET LANCETS	T1	
MONOLET THIN LANCETS	T1	
MYGLUCOHEALTH LANCETS	T1	
NOVA SAFETY LANCETS	T1	
NOVA SUREFLEX	T1	
ON CALL LANCET	T1	
ON CALL PLUS LANCET	T1	
ONETOUCH DELICA PLUS LANCET	T1	
ONETOUCH DELICA SAFETY LANCET	T1	
ONETOUCH LANCETS	T1	
ONETOUCH SURESOFT	T1	
ONETOUCH ULTRASOFT 2 LANCET	T1	
ON-THE-GO	T1	
PERFECT POINT SAFETY LANCETS	T1	

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T4 – Injectable Specialty Medications

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## List of Prescription Medications

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

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>DURABLE MEDICAL EQUIPMENT, MISC (GROUP I) (cont.)</b>		
PIP LANCET	T1	
PRESSURE ACTIVATED LANCETS	T1	
PRO COMFORT LANCET	T1	
PRO COMFORT SAFETY LANCET	T1	
PRODIGY LANCETS	T1	
PRODIGY TWIST TOP LANCET	T1	
PURE COMFORT LANCETS	T1	
PURE COMFORT SAFETY LANCETS	T1	
PUSH BUTTON SAFETY LANCETS	T1	
READYLANCE SAFETY LANCETS	T1	
RELIAMED	T1	
RELIAMED SAFETY SEAL LANCETS	T1	
RIGHTEST GL300 LANCETS	T1	
SAFETY LANCETS	T1	
SAFETY SEAL LANCETS	T1	
SAFETY-LET	T1	
SINGLE-LET	T1	
SMART SENSE	T1	
SMART SENSE LANCETS	T1	
SMARTEST LANCET	T1	
SOLUS V2	T1	
SOLUS V2 LANCETS	T1	
STERILANCE TL	T1	
STERILE LANCETS	T1	
SUPER THIN LANCETS	T1	
SURE COMFORT 0.3 ML SYRINGE	T1	
SURE COMFORT 0.5 ML SYRINGE	T1	
SURE COMFORT 1 ML SYRINGE	T1	
SURE COMFORT 3/10 ML SYRINGE	T1	
SURE COMFORT LANCETS	T1	
SURE-LANCE	T1	
SURE-TOUCH	T1	
TECHLITE LANCETS	T1	
TEL CARE ULTRA THIN 30G LANCETS	T1	

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## List of Prescription Medications

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

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>DURABLE MEDICAL EQUIPMENT, MISC (GROUP I) (cont.)</b>		
THIN LANCETS	T1	
TOPCARE UNIVERSAL1 LANCET	T1	
TOPCARE UNIVERSAL1 THIN LANCET	T1	
TRUE COMFORT LANCET	T1	
TRUE COMFORT SAFETY LANCET	T1	
TRUEPLUS LANCET	T1	
TRUEPLUS LANCETS	T1	
TWIST LANCETS	T1	
TWIST TOP LANCET	T1	
ULTILET BASIC	T1	
ULTILET CLASSIC	T1	
ULTILET LANCETS	T1	
ULTILET SAFETY	T1	
ULTRA-THIN II 1 ML 31GX5/16"	T1	
ULTRA-THIN II INS 0.3 ML 30G	T1	
ULTRA-THIN II INS 0.3 ML 31G	T1	
ULTRA-THIN II INS 0.5 ML 29G	T1	
ULTRA-THIN II INS 0.5 ML 30G	T1	
ULTRA-THIN II INS 0.5 ML 31G	T1	
ULTRA-THIN II INS SYR 1 ML 29G	T1	
ULTRA-THIN II INS SYR 1 ML 30G	T1	
ULTRA THIN LANCET	T1	
ULTRA THIN LANCETS	T1	
ULTRA THIN PLUS LANCETS	T1	
ULTRA-CARE LANCETS	T1	
ULTRALANCE	T1	
ULTRA-THIN II LANCETS	T1	
ULTRATLC LANCETS	T1	
UNILET COMFORTOUCH	T1	
UNILET EXCELITE	T1	
UNILET EXCELITE II	T1	
UNILET GP LANCET	T1	
UNILET LANCET	T1	
UNILET LANCETS	T1	
UNISTIK 2 COMFORT	T1	
UNISTIK 2 EXTRA	T1	

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## List of Prescription Medications

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

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>DURABLE MEDICAL EQUIPMENT, MISC (GROUP I) (cont.)</b>		
UNISTIK 2 NORMAL	T1	
UNISTIK 3	T1	
UNISTIK 3 COMFORT	T1	
UNISTIK 3 DUAL	T1	
UNISTIK 3 EXTRA	T1	
UNISTIK 3 NORMAL	T1	
UNISTIK COMFORT	T1	
UNISTIK CZT	T1	
UNISTIK EXTRA	T1	
UNISTIK NORMAL	T1	
UNISTIK PRO	T1	
UNISTIK SAFETY	T1	
UNISTIK TOUCH	T1	
UNIVERSAL 1	T1	
VERIFINE SAFETY LANCET MINI	T1	
VERIFINE UNIVERSAL LANCET	T1	
VIVAGUARD LANCET	T1	
VIVAGUARD SAFETY LANCET	T1	
<b>NEEDLES/NEEDLELESS DEVICES</b>		
AUTOSHIELD DUO PEN NEEDLE	T1	
BD NEEDLES	T1	
CAREPOINT PRECISION NEEDLE	T1	
NEEDLES	T1	
PERFECT POINT SAFETY NEEDLE	T1	
ULTRA-FINE PEN NEEDLE	T1	
<b>RESPIRATORY AIDS, DEVICES, EQUIPMENT</b>		
DROPSAFE SICURA SAFETY NEEDLE	T1	
ACE AEROSOL CLOUD ENHANCER	T2	QL (1 unit/year)
AEROCHAMBER MINI	T2	QL (1 unit/year)
AEROCHAMBER MECHANICAL VENT	T2	QL (1 unit/year)
AEROCHAMBER PLUS FLOW-VU	T2	QL (1 unit/year)
AEROCHAMBER WITH FLOWSIGNAL	T2	QL (1 unit/year)
AEROCHAMBER Z-STAT PLUS	T2	QL (1 unit/year)
AEROTRACH PLUS	T2	QL (1 unit/year)
AEROVENT PLUS	T2	QL (1 unit/year)

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

T4 – Injectable Specialty Medications

PA – Prior Authorization

QL – Quantity Limit

ST – Step Therapy

AGE – Age Requirement

SP – Specialty Medication

HD – May require home delivery pharmacy

PPACA – No Cost-Share Preventive Medication

CSL – Oral cancer medication subject to cost-share limits

## List of Prescription Medications

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

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>RESPIRATORY AIDS, DEVICES, EQUIPMENT</b>		
BREATHERITE SPACER-ADULT MASK	T2	QL (1 unit/year)
BREATHERITE SPACER-INFANT MASK	T2	QL (1 unit/year)
BREATHERITE SPACER-LARGE MASK	T2	QL (1 mask/365 days)
BREATHERITE SPACER-LG CHLD MSK	T2	QL (1 unit/year)
BREATHERITE SPACER-MEDIUM MASK	T2	QL (1 mask/365 days)
BREATHERITE SPACER-NEONATE MSK	T2	QL (1 unit/year)
BREATHERITE SPACER-SM CHLD MSK	T2	QL (1 unit/year)
BREATHERITE SPACER-SMALL MASK	T2	QL (1 mask/365 days)
CLEVER CHOICE HOLDING CHAMBER	T2	QL (1 unit/year)
COMFORTSEAL	T2	QL (1 unit/year)
COMPACT SPACE CHAMBER	T2	QL (1 unit/year)
EASIVENT	T2	QL (1 unit/year)
E-Z SPACER	T2	QL (1 unit/year)
FLEXICHAMBER	T2	QL (1 unit/year)
FLEXICHAMBER MASK	T2	QL (1 unit/year)
INSPIRACHAMBER	T2	QL (1 unit/year)
LITEAIRE	T2	QL (1 unit/year)
LITETOUCH	T2	QL (1 unit/year)
MICROCHAMBER	T2	QL (1 unit/year)
MICROSPACER	T2	QL (1 unit/year)
OPTICHAMBER	T2	QL (1 unit/year)
OPTICHAMBER DIAMOND	T2	QL (1 unit/year)
POCKET CHAMBER	T2	QL (1 unit/year)
PRIMEAIRE	T2	QL (1 unit/year)
<b>SYRINGES AND ACCESSORIES</b>		
BD INS SYR 0.3 ML 8MMX31G(1/2)	T1	
BD INS SYR UF 0.3ML 12.7MMX30G	T1	
BD INS SYR UF 0.5ML 12.7MMX30G	T1	
BD INS SYRN UF 1 ML 12.7MMX30G	T1	
BD INS SYRN UF 1 ML 30G 12.7MM	T1	
BD INS SYRNG 0.3 ML 29GX12.7MM	T1	
BD INS SYRNG 0.5 ML 29GX12.7MM	T1	
BD INS SYRNG UF 0.3 ML 8MMX31G	T1	
BD INS SYRNG UF 0.5 ML 8MMX31G	T1	

T1 – Typically Generics

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## List of Prescription Medications

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

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>SYRINGES AND ACCESSORIES (con't.)</b>		
BD INSULIN SYR 0.5 ML 28GX1/2"	T1	
BD INSULIN SYR 1 ML 25GX1"	T1	
BD INSULIN SYR 1 ML 25GX5/8"	T1	
BD INSULIN SYR 1 ML 26GX1/2"	T1	
BD INSULIN SYR 1 ML 27GX12.7MM	T1	
BD INSULIN SYR 1 ML 27GX5/8"	T1	
BD INSULIN SYR 1 ML 28GX1/2"	T1	
BD INSULIN SYR 1 ML 29GX12.7MM	T1	
BD INSULIN SYR UF 1 ML 8MMX31G	T1	
BD INSULIN SYRINGE 1 ML	T1	
DROPLET 0.3 ML 29G 12.7MM(1/2)	T1	
DROPLET 0.3 ML 30G 12.7MM(1/2)	T1	
DROPLET INS 0.3ML 30G 8MM(1/2)	T1	
DROPLET INS 0.3ML 31G 6MM(1/2)	T1	
DROPLET INS 0.3ML 31G 8MM(1/2)	T1	
DROPLET INS 0.5 ML 29G 12.7MM	T1	
DROPLET INS 0.5 ML 30G 12.7MM	T1	
DROPLET INS SYR 0.5 ML 31G 6MM	T1	
DROPLET INS SYR 0.5 ML 31G 8MM	T1	
DROPLET INS SYR 0.5ML 30G 8MM	T1	
DROPLET INS SYR 1 ML 30G 8MM	T1	
DROPLET INS SYR 1 ML 31G 6MM	T1	
DROPLET INS SYR 1 ML 31G 8MM	T1	
DROPLET INS SYR 1ML 29G 12.7MM	T1	
DROPLET INS SYR 1ML 30G 12.7MM	T1	
EASY COMFORT INSULIN SYRINGE	T1	
INSULIN SYR 0.5 ML 28G 12.7MM	T1	
INSULIN SYRINGE 1ML 28G 12.7MM	T1	
INSULIN SYRINGE U-500	T1	
MINIMED RESERVOIR	T1	
PARADIGM	T1	
ULTRA-FINE 0.3 ML 30G 12.7MM	T1	
ULTRA-FINE 0.3ML 31G 6MM (1/2)	T1	

T1 – Typically Generics

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## List of Prescription Medications

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

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>SYRINGES AND ACCESSORIES (con't.)</b>		
ULTRA-FINE 0.3ML 31G 8MM (1/2)	T1	
ULTRA-FINE 0.5 ML 30G 12.7MM	T1	
ULTRA-FINE INS SYR 1ML 31G 6MM	T1	
ULTRA-FINE INS SYR 1ML 31G 8MM	T1	
<b>RESPIRATORY AIDS,DEVICES,EQUIPMENT</b>		
TRUE COMFORT SAFE INSULIN SYRG	T1	
UNIFINE SAFECONTROL	T3	
VERIFINE PEN NEEDLE	T1	
PRO COMFORT SPACER WITH MASK	T2	QL (1 unit/year)
PROCARE SPACER WITH ADULT MASK	T2	QL (1 unit/year)
PROCARE SPACER WITH CHILD MASK	T2	QL (1 unit/year)
PROCHAMBER	T2	QL (1 unit/year)
RITEFLO	T2	QL (1 unit/year)
SILICONE MASK	T2	QL (1 unit/year)
SPACE CHAMBER	T2	QL (1 unit/year)
SPACE CHAMBER-LARGE MASK	T2	QL (1 unit/year)
SPACE CHAMBER-MEDIUM MASK	T2	QL (1 unit/year)
SPACE CHAMBER-SMALL MASK	T2	QL (1 unit/year)
VORTEX	T2	QL (1 unit/year)
VORTEX HOLDING CHAMBER-CHILD	T2	QL (1 unit/year)
VORTEX HOLDING CHAMBER-TODDLER	T2	QL (1 unit/year)
VORTEX VHC FROG MASK	T2	QL (1 unit/year)
VORTEX VHC LADYBUG MASK	T2	QL (1 unit/year)
VORTEX VHC PEDIATRIC MASK	T2	QL(1 spacer/365 days)

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

<b>SKELETAL MUSCLE RELAXANTS</b>		
baclofen	T1	HD
carisoprodol/aspirin	T1	
chlorzoxazone	T1	
cyclobenzaprine hcl	T1	
cyclobenzaprine hcl (Fexmid)	T1	
DANTRIUM (dantrolene sodium)	T3	
dantrolene sodium	T1	
dantrolene sodium (Dantrium)	T1	
FEXMID (cyclobenzaprine hcl)	T3	

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## List of Prescription Medications

MUSCLE RELAXANTS (Pain Relief And Inflammatory Disease)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>SKELETAL MUSCLE RELAXANTS</b>		
<i>metaxalone</i>	T1	
<i>metaxalone (Skelaxin)</i>	T1	
<i>methocarbamol</i>	T1	
<i>methocarbamol (Robaxin-750)</i>	T1	
<i>orphenadrine citrate</i>	T1	
<i>ROBAXIN-750 (methocarbamol)</i>	T3	
<b>PRE-NATAL VITAMINS (Nutritional/Dietary)</b>		
<b>PRENATAL VITAMIN PREPARATIONS</b>		
<i>SKELAXIN (metaxalone)</i>	T3	
<i>SOMA (carisoprodol)</i>	T3	
<i>tizanidine hcl (Zanaflex)</i>	T1	
<i>ZANAFLEX (tizanidine hcl)</i>	T3	
<i>ATABEX EC</i>	T2	
<i>CITRANATAL 90 DHA</i>	T2	
<i>CITRANATAL ASSURE</i>	T2	
<i>CITRANATAL DHA</i>	T2	
<i>CITRANATAL HARMONY</i>	T2	
<i>CITRANATAL RX</i>	T2	
<i>OBSTETRIX EC</i>	T2	
<i>OBTREX DHA</i>	T2	
<i>pnv 22/iron, gluc/folic/dss/dha</i>	T1	
<i>pnv 66/iron/folic/docusate/dha</i>	T1	
<i>pnv 69/iron/folic/docusate/dha</i>	T1	
<i>pnv 80/iron fum/folic/dss/dha</i>	T1	
<i>pnv no.154/iron fum/folic acid</i>	T1	
<i>pnv/ferrous fum/docusate/folic</i>	T1	
<i>pnv/iron, carb/docusat/folic ac</i>	T1	
<i>prenatal 12/iron/folic/dss/om3</i>	T1	
<i>PRENATAL 19</i>	T1	
<i>prenatal 34/iron/folic/dss/dha</i>	T1	
<i>prenatal vits15/iron/folic/dss</i>	T1	
<i>VITAFOL FE+</i>	T2	

T1 – Typically Generics

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## List of Prescription Medications

PSYCHOTHERAPEUTIC DRUGS (Anxiety/Depression/Bipolar Disorder) <sup>8</sup>		
ALPHA-2 RECEPTOR ANTAGONIST ANTI-DEPRESSANTS		
<i>mirtazapine</i>	T1	HD
<i>mirtazapine</i> (Remeron)	T1	HD
ANTI-ANXIETY - BENZODIAZEPINES		
<i>alprazolam</i> (Xanax Xr)	T1	
<i>alprazolam</i> (Xanax)	T1	
<i>chlordiazepoxide hcl</i>	T1	
PSYCHOTHERAPEUTIC DRUGS (Anxiety/Depression/Bipolar Disorder) <sup>8</sup> (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ANTI-ANXIETY - BENZODIAZEPINES (cont.)		
<i>clorazepate dipotassium</i>	T1	
<i>clorazepate dipotassium</i> (Tranxene T-tab)	T1	
<i>diazepam</i> 10 mg tablet (Valium)	T1	
<i>diazepam</i> 2 mg tablet (Valium)	T1	
<i>diazepam</i> 5 mg tablet (Valium)	T1	
<i>diazepam</i> 5 mg/5 ml solution	T1	
<i>diazepam</i> 5 mg/ml oral conc	T1	
<i>lorazepam</i>	T1	
<i>oxazepam</i>	T1	
TRANXENE T-TAB ( <i>clorazepate dipotassium</i> )	T3	
ANTI-ANXIETY DRUGS		
<i>buspirone hcl</i>	T1	HD
<i>meprobamate</i>	T1	
ANTIDEPRESSANT - POSTPARTUM DEPRESSION (PPD)		
ZURZUVAE 20 MG CAPSULE	T4	PA QL(28 caps/270 days) SP HD
ZURZUVAE 25 MG CAPSULE	T4	PA QL(28 caps/270 days) SP HD
ZURZUVAE 30 MG CAPSULE	T4	PA QL(14 caps/270 days) SP HD
BIPOLAR DISORDER DRUGS		
<i>EQUETRO</i>	T3	HD
<i>lithium carbonate</i>	T1	HD
<i>lithium carbonate</i> (Lithobid)	T1	HD
<i>lithium citrate</i>	T1	HD
MAOIS -NON-SELECTIVE, IRREVERSIBLE ANTI-DEPRESSANTS		
MARPLAN	T3	QL (12 tabs/day)
<i>phenelzine sulfate</i> (Nardil)	T1	
<i>tranylcypromine sulfate</i>	T1	

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

T4 – Injectable Specialty Medications

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AGE – Age Requirement

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## List of Prescription Medications

PSYCHOTHERAPEUTIC DRUGS (Anxiety/Depression/Bipolar Disorder) <sup>8</sup> (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>MONOAMINE OXIDASE (MAO) INHIBITOR ANTI-DEPRESSANTS (cont.)</b>		
EMSAM 12 MG/24 HOURS PATCH	T3	QL (1 patch/day)
EMSAM 6 MG/24 HOURS PATCH	T3	QL (2 patches/day)
EMSAM 9 MG/24 HOURS PATCH	T3	QL (1 patch/day)
<b>NOREPINEPHRINE AND DOPAMINE REUPTAKE INHIB (NDRIs)</b>		
bupropion hcl 100 mg tablet	T1	QL (4 tabs/day) HD
bupropion hcl 75 mg tablet	T1	QL (6 tabs/day) HD
bupropion hcl sr 100 mg tablet (Wellbutrin Sr)	T1	QL (4 tabs/day) HD
bupropion hcl sr 150 mg tablet (Wellbutrin Sr)	T1	QL (2 tabs/day) HD
bupropion hcl sr 200 mg tablet (Wellbutrin Sr)	T1	QL (2 tabs/day) HD
bupropion hcl xl 150 mg tablet	T1	QL (3 tabs/day) HD
bupropion hcl xl 300 mg tablet	T1	QL (1 tab/day) HD
BUPROPION HCL XL 450 MG TABLET	T1	QL (1 tab/day) HD
<b>SELECTIVE SEROTONIN 5-HT2A INVERSE AGONISTS (SSIAs)</b>		
NUPLAZID	T3	PA SP HD
<b>SELECTIVE SEROTONIN REUPTAKE INHIBITOR (SSRIs)</b>		
citalopram hbr 10 mg tablet (Celexa)	T1	QL (6 tabs/day) HD
citalopram hbr 10 mg/5 ml soln	T1	QL (30ml/day) HD
citalopram hbr 20 mg tablet (Celexa)	T1	QL (3 tabs/day) HD
citalopram hbr 20 mg/10 ml sol	T1	QL (30ml/day) HD
citalopram hbr 40 mg tablet (Celexa)	T1	QL (1 tab/day) HD
escitalopram 10 mg tablet	T1	QL (2 tabs/day) HD
escitalopram 5 mg tablet	T1	QL (4 tabs/day) HD
escitalopram oxalate 5 mg/5 ml	T1	QL (20ml/day) HD
fluoxetine hcl	T1	QL (4 caps/28 days) HD
fluoxetine hcl 10 mg capsule (Prozac)	T1	QL (8 caps/day) HD
fluoxetine hcl 10 mg tablet (Sarafem)	T1	HD
fluoxetine 20 mg/5 ml soln cup	T1	QL (20 mls/day) HD
fluoxetine hcl 20 mg capsule (Prozac)	T1	QL (4 caps/day) HD
fluoxetine hcl 20 mg tablet	T1	HD
fluoxetine hcl 40 mg capsule (Prozac)	T1	QL (2 caps/day) HD
fluoxetine hcl 60 mg tablet	T1	QL (1 tab/day) HD
fluvoxamine er 100 mg capsule	T1	QL (3 caps/day) HD
fluvoxamine er 150 mg capsule	T1	QL (2 caps/day) HD
fluvoxamine maleate 100 mg tab	T1	QL (3 tabs/day) HD
fluvoxamine maleate 25 mg tab	T1	QL (12 tabs/day) HD

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

T4 – Injectable Specialty Medications

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## List of Prescription Medications

### PSYCHOTHERAPEUTIC DRUGS (Anxiety/Depression/Bipolar Disorder)<sup>8</sup> (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>SELECTIVE SEROTONIN REUPTAKE INHIBITOR (SSRIs) (cont.)</b>		
fluvoxamine maleate 50 mg tab	T1	QL (6 tabs/day) HD
paroxetine cr 12.5 mg tablet (Paxil Cr)	T1	QL (6 tabs/day) HD
paroxetine cr 25 mg tablet (Paxil Cr)	T1	QL (3 tabs/day) HD
paroxetine cr 37.5 mg tablet (Paxil Cr)	T1	QL (2 tabs/day) HD
paroxetine er 12.5 mg tablet (Paxil Cr)	T1	QL (1 tab/day) HD
paroxetine er 25 mg tablet (Paxil Cr)	T1	QL (3 tabs/day) HD
paroxetine er 37.5 mg tablet (Paxil Cr)	T1	QL (2 tabs/day) HD
paroxetine hcl 10 mg tablet (Paxil)	T1	QL (6 tabs/day) HD
paroxetine hcl 20 mg tablet (Paxil)	T1	QL (3 tabs/day) HD
paroxetine hcl 30 mg tablet (Paxil)	T1	QL (2 tabs/day) HD
paroxetine hcl 40 mg tablet (Paxil)	T1	QL (1 tab/day) HD
SARAFEM (fluoxetine hcl)	T3	ST HD
sertraline 20 mg/ml oral conc (Zoloft)	T1	QL (10ml/day) HD
sertraline hcl 100 mg tablet (Zoloft)	T1	QL (2 tabs/day) HD
sertraline hcl 25 mg tablet (Zoloft)	T1	QL (8 tabs/day) HD
sertraline hcl 50 mg tablet (Zoloft)	T1	QL (4 tabs/day) HD
<b>SEROTONIN-2 ANTAGONIST/REUPTAKE INHIBITORS (SARIs)</b>		
nefazodone hcl	T1	HD
trazodone hcl	T1	HD
<b>SEROTONIN-NOREpinephrine REUPTAKE-INHIB (SNRIs)</b>		
desvenlafaxine succnt er 100mg (Pristiq)	T1	QL (4 tabs/day) HD
desvenlafaxine succnt er 25 mg (Pristiq)	T1	QL (16 tabs/day) HD
desvenlafaxine succnt er 50 mg (Pristiq)	T1	QL (1 tab/day) HD
duloxetine hcl dr 20 mg cap	T1	QL (6 caps/day) HD
duloxetine hcl dr 30 mg cap	T1	QL (4 caps/day) HD
duloxetine hcl dr 40 mg cap	T1	QL (3 caps/day) HD
duloxetine hcl dr 60 mg cap	T1	QL (2 caps/day) HD
FETZIMA 20-40 MG TITRATION PAK	T3	QL (28 caps/180 days) ST
FETZIMA ER 120 MG CAPSULE	T3	QL (1 cap/day) ST
FETZIMA ER 20 MG CAPSULE	T3	QL (6 caps/day) ST
FETZIMA ER 40 MG CAPSULE	T3	QL (3 caps/day) ST
FETZIMA ER 80 MG CAPSULE	T3	QL (1 cap/day) ST
PRISTIQ ER 50 MG TABLET (desvenlafaxine succinate er)	T3	QL (1 tab/day) ST HD
venlafaxine hcl 100 mg tablet	T1	QL (3 tabs/day) HD
venlafaxine hcl 25 mg tablet	T1	QL (15 tabs/day) HD

T1 – Typically Generics

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## List of Prescription Medications

### PSYCHOTHERAPEUTIC DRUGS (Anxiety/Depression/Bipolar Disorder)<sup>8</sup> (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>SEROTONIN-NOREPINEPHRINE REUPTAKE-INHIB (SNRIs) (cont.)</b>		
venlafaxine hcl 37.5 mg tablet	T1	QL (10 tabs/day) HD
venlafaxine hcl 50 mg tablet	T1	QL (7 tabs/day) HD
venlafaxine hcl 75 mg tablet	T1	QL (5 tabs/day) HD
venlafaxine hcl er 150 mg cap (Effexor Xr)	T1	QL (2 caps/day) HD
venlafaxine hcl er 150 mg tab	T1	QL (2 tabs/day) HD
venlafaxine hcl er 225 mg tab	T1	QL (1 tab/day) HD
venlafaxine hcl er 37.5 mg cap (Effexor Xr)	T1	QL (8 caps/day) HD
venlafaxine hcl er 37.5 mg tab	T1	QL (8 tabs/day) HD
venlafaxine hcl er 75 mg cap (Effexor Xr)	T1	QL (4 caps/day) HD
venlafaxine hcl er 75 mg tab	T1	QL (4 tabs/day) HD
<b>SSRI AND 5HTIA PARTIAL AGONIST ANTI-DEPRESSANTS</b>		
VIIIBRYD 10 MG TABLET	T3	QL (1 tab/day) ST HD
VIIIBRYD 10-20 MG STARTER PACK	T3	ST HD
VIIIBRYD 20 MG TABLET	T3	QL (1 tab/day) ST HD
VIIIBRYD 40 MG TABLET	T3	ST HD
vilazodone hcl tablet (Viibryd)	T1	QL(1 tab/day) HD
<b>SSRI, SEROTONIN RECEPTOR MODULATOR ANTI-DEPRESSANTS</b>		
TRINTELLIX 10 MG TABLET	T2	QL (1 tab/day) ST
TRINTELLIX 20 MG TABLET	T2	ST
TRINTELLIX 5 MG TABLET	T2	QL (1 tab/day) ST
<b>TRICYCLIC ANTI-DEPRESSANT-BENZODIAZEPINE COMBINATNS</b>		
amitriptyline/chlordiazepoxide	T1	HD
<b>TRICYCLIC ANTI-DEPRESSANT-PHENOTHIAZINE COMBINATNS</b>		
perphenazine/amitriptyline hcl	T1	HD
<b>TRICYCLIC ANTI-DEPRESSANTS, REL.NON-SEL.REUPT-INHIB</b>		
amitriptyline hcl	T1	HD
amoxapine	T1	HD
clomipramine hcl	T1	HD
desipramine hcl	T1	HD
desipramine hcl (Norpramin)	T1	HD
doxepin 10 mg capsule	T1	HD
doxepin 10 mg/ml oral conc	T1	HD
doxepin 100 mg capsule	T1	HD
doxepin 150 mg capsule	T1	HD
doxepin 25 mg capsule	T1	HD

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## List of Prescription Medications

PSYCHOTHERAPEUTIC DRUGS (Anxiety/Depression/Bipolar Disorder) <sup>8</sup> (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>TRICYCLIC ANTI-DEPRESSANTS, REL.NON-SEL.REUPT-INHIB (con't.)</b>		
<i>doxepin 50 mg capsule</i>	T1	HD
<i>doxepin 75 mg capsule</i>	T1	HD
<i>imipramine hcl</i>	T1	HD
<i>imipramine pamoate</i>	T1	HD
<i>maprotiline hcl</i>	T1	HD
<i>nortriptyline hcl</i>	T1	HD
<i>protriptyline hcl</i>	T1	HD
<i>trimipramine maleate</i>	T1	HD
PSYCHOTHERAPEUTIC DRUGS (Attention Deficit Hyperactivity Disorder) <sup>8</sup>		
<b>ADRENERGICS, AROMATIC, NON-CATECHOLAMINE</b>		
<i>lisdexamfetamine (Vyvanse)</i>	T1	PA QL(1 cap/day)
MYDAYIS	T2	QL
<b>TX FOR ADHD - SELECTIVE ALPHA-2 RECEPTOR AGONIST</b>		
<i>clonidine hcl (Kapvay)</i>	T1	
<i>guanfacine hcl (Intuniv)</i>	T1	HD
<b>TX FOR ATTENTION DEFICIT-HYPERACT (ADHD)/NARCOLEPSY</b>		
DAYTRANA 10 MG/9 HR PATCH	T3	PA QL (1 patch/day)
DAYTRANA 15 MG/9 HR PATCH	T3	PA QL (1 per day)
DAYTRANA 20 MG/9 HOUR PATCH	T3	PA QL (1 patch/day)
DAYTRANA 30 MG/9 HOUR PATCH	T3	PA QL (1 patch/day)
<i>dexmethylphenidate hcl</i>	T1	PA QL (1 cap/day)
<i>dexmethylphenidate hcl (Focalin)</i>	T1	PA
FOCALIN ( <i>dexmethylphenidate hcl</i> )	T3	PA ST
METHYLIN ( <i>methylphenidate hcl</i> )	T3	PA
<i>methylphenidate er 10 mg cap</i>	T1	QL (1 per day)
<i>methylphenidate er 10 mg tab</i>	T1	PA QL (2 tabs/day)
<i>methylphenidate er 15 mg cap</i>	T1	QL (1 per day)

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

T4 – Injectable Specialty Medications

PA – Prior Authorization

QL – Quantity Limit

ST – Step Therapy

AGE – Age Requirement

SP – Specialty Medication

HD – May require home delivery pharmacy

PPACA – No Cost-Share Preventive Medication

CSL – Oral cancer medication subject to cost-share limits

## List of Prescription Medications

### PSYCHOTHERAPEUTIC DRUGS (Attention Deficit Hyperactivity Disorder)<sup>8</sup> (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>TX FOR ATTENTION DEFICIT-HYPERACT (ADHD)/NARCOLEPSY (cont.)</b>		
methylphenidate er 18 mg tab	T1	PA QL (1 tab/day)
methylphenidate er 20 mg cap	T1	QL (1 cap/day)
methylphenidate er 20 mg tab	T1	PA QL (3 tabs/day)
methylphenidate er 27 mg tab	T1	PA QL (1 per day)
methylphenidate er 30 mg cap	T1	QL (1 per day)
methylphenidate er 36 mg tab	T1	PA QL (1 per day)
methylphenidate er 40 mg cap	T1	QL (1 per day)
methylphenidate er 50 mg cap	T1	QL (1 per day)
methylphenidate er 54 mg tab	T1	PA QL (1 tab/day)
methylphenidate er 60 mg cap	T1	QL (1 per day)
methylphenidate hcl ptch	T1	PA QL(1 patch/day)
methylphenidate hcl	T1	PA QL (1 cap/day)
methylphenidate hcl (Metadata Cd)	T1	PA QL (1 cap/day)
methylphenidate hcl (Methyltin)	T1	PA
methylphenidate	T1	PA
methylphenidate la 10 mg cap	T1	PA QL (1 cap/day)
methylphenidate la 20 mg cap	T1	PA QL (1 per day)
methylphenidate la 30 mg cap	T1	PA QL (1 per day)
methylphenidate la 40 mg cap	T1	PA QL (1 per day)
methylphenidate la 60 mg cap	T1	PA QL (1 cap/day)
QUILLICHEW ER	T3	PA QL (1 tab/day)
QUILLIVANT XR	T3	PA QL (12ml/day)
RITALIN (methylphenidate hcl)	T3	PA ST
<b>TX FOR ATTENTION DEFICIT-HYPERACT.(ADHD), NRI-TYPE</b>		
atomoxetine hcl 10 mg capsule (Strattera)	T1	HD
atomoxetine hcl 100 mg capsule (Strattera)	T1	HD
atomoxetine hcl 18 mg capsule (Strattera)	T1	HD

T1 – Typically Generics

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T4 – Injectable Specialty Medications

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## List of Prescription Medications

### PSYCHOTHERAPEUTIC DRUGS (Attention Deficit Hyperactivity Disorder)<sup>8</sup> (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>TX FOR ATTENTION DEFICIT-HYPERACT.(ADHD), NRI-TYPE (cont.)</b>		
<i>atomoxetine hcl 25 mg capsule (Strattera)</i>	T1	HD
<i>atomoxetine hcl 40 mg capsule (Strattera)</i>	T1	QL (1 cap/day) HD
<i>atomoxetine hcl 60 mg capsule (Strattera)</i>	T1	HD
<i>atomoxetine hcl 80 mg capsule (Strattera)</i>	T1	HD

### PSYCHOTHERAPEUTIC DRUGS (Miscellaneous)

HYPACTIVE SEXUAL DESIRE DISORDER (HSDD) TX AGENTS		
ADDYI	T3	PA QL (1 tab/day)
VYLEESI	T4	PA QL (8 injectors/30 days) SP

### PSYCHOTHERAPEUTIC DRUGS (Schizophrenia/Anti-Psychotics)<sup>9</sup>

ANTI-PSYCH, DOPAMINE ANTAG., DIPHENYLBUTYLPIPERIDINES		
<i>pimozide</i>	T1	
<b>ANTI-PSYCHOTIC,ATYPICAL,DOPAMINE,SEROTONIN ANTAGNST</b>		
<i>asenapine maleate (Saphris)</i>	T1	
<i>CAPLYTA</i>	T3	QL(1 tabs/caps/day)
<i>clozapine</i>	T1	
<i>clozapine (Clozapine Odt)</i>	T1	
<i>clozapine (Clozaril)</i>	T1	
<i>CLOZAPINE ODT</i>	T1	
<i>CLOZARIL (clozapine)</i>	T3	ST
<i>INVEGA ER 3 MG TABLET (paliperidone er)</i>	T3	QL (1 tab/day) ST
<i>INVEGA ER 6 MG TABLET (paliperidone er)</i>	T3	ST
<i>INVEGA ER 9 MG TABLET (paliperidone er)</i>	T3	ST
<i>lurasidone hcl tablet</i>	T1	QL(1 tab/day)
<i>LYBALVI</i>	T3	QL(1 tab/day)
<i>olanzapine (Zyprexa)</i>	T1	
<i>paliperidone er 1.5 mg tablet</i>	T1	
<i>paliperidone er 3 mg tablet (Invega)</i>	T1	QL (1 tab/day)
<i>paliperidone er 9 mg tablet (Invega)</i>	T1	
<i>quetiapine fumarate (Seroquel Xr)</i>	T1	
<i>quetiapine fumarate (Seroquel)</i>	T1	
<i>risperidone</i>	T1	
<i>risperidone (Risperdal)</i>	T1	

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## List of Prescription Medications

PSYCHOTHERAPEUTIC DRUGS (Schizophrenia/Anti-Psychotics) <sup>9</sup> (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>ANTI-PSYCHOTIC, ATYPICAL, DOPAMINE, SEROTONIN ANTAGNST (cont.)</b>		
SAPHRIS ( <i>asenapine maleate</i> )	T3	ST
SECUADO	T3	ST
SEROQUEL ( <i>quetiapine fumarate</i> )	T3	ST
SEROQUEL XR ( <i>quetiapine fumarate er</i> )	T3	ST
ziprasidone hcl	T1	
<b>ANTI-PSYCHOTIC-ATYPICAL, D3/D2 PARTIAL AG-5HT MIXED</b>		
VRAYLAR 1.5 MG CAPSULE	T3	QL (1 cap/day)
VRAYLAR 3 MG CAPSULE	T3	QL (1 cap/day)
VRAYLAR 4.5 MG CAPSULE	T3	
VRAYLAR 6 MG CAPSULE	T3	
<b>ANTIPSYCHOTICS, ATYP, D2 PARTIAL AGONIST/5HT MIXED</b>		
<i>aripiprazole</i>	T1	
<i>aripiprazole 1 mg/ml solution</i>	T1	
<i>aripiprazole 15 mg tablet</i>	T1	
<i>aripiprazole 2 mg tablet</i>	T1	
<i>aripiprazole 20 mg tablet</i>	T1	
<i>aripiprazole 30 mg tablet</i>	T1	
<i>aripiprazole 5 mg tablet</i>	T1	QL (1 tab/day)
REXULTI 0.25 MG TABLET	T3	QL (1 tab/day)
REXULTI 0.5 MG TABLET	T3	QL (1 tab/day)
REXULTI 1 MG TABLET	T3	QL (1 tab/day)
REXULTI 2 MG TABLET	T3	QL (1 tab/day)
REXULTI 3 MG TABLET	T3	
REXULTI 4 MG TABLET	T3	
<b>ANTI-PSYCHOTICS, DOPAMINE AND SEROTONIN ANTAGONISTS</b>		
<i>loxpiprazole succinate</i>	T1	

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## List of Prescription Medications

PSYCHOTHERAPEUTIC DRUGS (Schizophrenia/Anti-Psychotics) <sup>9</sup> (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>ANTI-PSYCHOTICS, DOPAMINE ANTAGONISTS, BUTYROPHENONES</b>		
<i>haloperidol</i>	T1	
<i>haloperidol lactate</i>	T1	
<b>ANTI-PSYCHOTICS, DOPAMINE ANTAGONIST, DIHYDROINDOLONES</b>		
<i>molindone hcl</i>	T1	
<b>ANTI-PSYCHOTICS, PHENOTHIAZINES</b>		
<i>chlorpromazine hcl</i>	T1	
<i>fluphenazine hcl</i>	T1	
<i>perphenazine</i>	T1	
<i>thioridazine hcl</i>	T1	
<i>trifluoperazine hcl</i>	T1	
<b>SSRI-ANTI-PSYCH, ATYPICAL, DOPAMINE, SEROTONIN ANTAG</b>		
<i>olanzapine/fluoxetine hcl</i>	T1	
<i>olanzapine/fluoxetine hcl</i> (Symbax)	T1	
PSYCHOTHERAPEUTIC DRUGS (Sleep Disorders/Sedatives)		
<b>NARCOLEPSY AND SLEEP DISORDER THERAPY AGENTS</b>		
<i>armodafinil</i>	T1	PA
<i>modafinil</i> (Provigil)	T1	PA
SUNOSI	T2	PA QL (1 tab/day)
SEDATIVE/HYPNOTICS (Sleep Disorders/Sedatives)		
<b>ANTI-NARCOLEPSY, ANTI-CATAPLEXY, SEDATIVE-TYPE AGENT</b>		
LUMRYZ	T4	PA QL (30 pkts/30 days) SP
SODIUM OXYBATE 0.5 G/ML SOLN	T4	PA QL(18 mls/day) SP HD
XYWAV	T4	PA SP HD
<b>BARBITURATES</b>		
<i>phenobarbital</i>	T1	
<i>secobarbital sodium</i>	T3	PA
<b>HYPNOTICS, MELATONIN MT1/MT2 RECEPTOR AGONISTS</b>		
HETLIOZ	T4	PA SP HD
HETLIOZ LQ	T4	PA SP HD
<i>ramelteon</i> (Rozerem)	T4	QL (1 tab/day)
<i>tasimelteon</i>	T4	PA SP HD
<b>SEDATIVE-HYPNOTICS - BENZODIAZEPINES</b>		
DORAL	T3	
<i>estazolam</i>	T1	

T1 – Typically Generics

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## List of Prescription Medications

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

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>SEDATIVE-HYPNOTICS - BENZODIAZEPINES (cont.)</b>		
<i>flurazepam hcl</i>	T1	
<i>HALCION (triazolam)</i>	T3	
<i>midazolam hcl</i>	T1	
<i>QUAZEPAM</i>	T1	
<i>quazepam (Quazepam)</i>	T1	
<i>temazepam</i>	T1	
<i>triazolam</i>	T1	
<i>triazolam (Halcion)</i>	T1	
<b>SEDATIVE-HYPNOTICS, NON-BARBITURATE</b>		
<i>DAYVIGO</i>	T2	QL (1 tab/day) ST
<i>doxepin hcl 3 mg tablet (Silenor)</i>	T1	QL (1 tab/day)
<i>doxepin hcl 6 mg tablet (Silenor)</i>	T1	
<i>eszopiclone (Lunesta)</i>	T1	
<i>SILENOR 6 MG TABLET (doxepin hcl)</i>	T3	ST
<i>zaleplon</i>	T1	
<i>zolpidem tart er 12.5 mg tab</i>	T1	
<i>zolpidem tart er 6.25 mg tab</i>	T1	QL (1 tab/day)
<i>zolpidem tartrate</i>	T1	
<b>SKIN PREPS (Miscellaneous)</b>		
<b>IRRIGANTS</b>		
<i>acetic acid</i>	T1	
<i>neomycin sulf/polymyxin b sulf</i>	T1	
<i>PHYSIOLYTE</i>	T3	
<i>PHYSIOSOL</i>	T3	
<i>ringer's solution</i>	T1	
<i>ringer's solution, lactated</i>	T1	
<i>sod, pot chlor/mag/sod, pot phos</i>	T3	
<i>sodium chloride 0.9% irrig solution</i>	T1	
<i>SORBITOL</i>	T1	
<i>SORBITOL-MANNITOL</i>	T1	
<i>VASHE WOUND</i>	T3	
<i>VASHE WOUND THERAPY</i>	T3	
<i>water for irrigation, sterile</i>	T1	

T1 – Typically Generics

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## List of Prescription Medications

### SKIN PREPS (Miscellaneous) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>OXIDIZING AGENTS</b>		
hydrogen peroxide		
<b>SKIN PREPS (Pain Relief And Inflammatory Disease)</b>		
<b>ANTI-PSORIATIC AGENTS, SYSTEMIC</b>		
acitretin	T1	
BIMZELX	T4	PA QL(2 mls/28 days) SP HD
BIMZELX AUTOINJECTOR	T4	PA QL(10 mls/365 days) SP HD
COSENTYX	T4	PA QL SP
ILUMYA	T4	PA QL (1 syringe/84 days) SP HD
SILIQ	T4	PA QL (2 syringes/15 days) SP
<i>methoxsalen</i> (Oxsoralen-ultra)	T1	
OXSORALEN-ULTRA ( <i>methoxsalen</i> )	T3	
SKYRIZI (2 SYRINGES) KIT	T4	PA QL (1 kit/84 days) SP HD
SOTYKTU	T4	PA QL (1 tab/day) SP
SPEVIGO	T4	PA QL(2 mls/28 days) SP HD
TALTZ AUTOINJECTOR	T4	PA QL (1 injector/28 days) SP HD
TALTZ AUTOINJECTOR (2 PACK)	T4	PA QL (1 injector/28 days) SP HD
TALTZ AUTOINJECTOR (3 PACK)	T4	PA QL (1 injector/28 days) SP HD
TALTZ SYRINGE	T4	PA QL (1 syringe/28 days) SP HD
TREMFYA 100 MG/ML PEN	T2	PA QL (1 ml/56 days) SP HD
TREMFYA 200 MG/2 ML PEN	T2	PA QL(2 syringe/28 days) SP HD
TREMFYA SYRINGE	T4	PA QL (1 syringe/56 days) SP HD
TREMFYA PEN	T4	PA QL(2 syringe/28 days) SP HD
<b>TOPICAL ANTI-INFLAMMATORY, NSAIDS</b>		
DICLAREAL	T3	HD
<i>diclofenac sodium 1% gel</i> (Voltaren)	T1	QL (1000gm/30 days) HD
LICART	T2	PA QL (1 patch/day) HD
<b>SKIN PREPS (Skin Conditions)</b>		
<b>ACNE AGENTS, SYSTEMIC</b>		
ACCUTANE	T1	
AMNESTEEM	T1	
CLARAVIS	T1	
<i>isotretinoin</i> (Absorica)	T1	
MYORISAN	T1	
ZENATANE	T1	

T1 – Typically Generics

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## List of Prescription Medications

### SKIN PREPS (Skin Conditions) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>ACNE AGENTS, TOPICAL</b>		
<i>adapalene/benzoyl peroxide</i>	T1	
<i>clindamycin phos/benzoyl perox</i>	T1	
<i>clindamycin/tretinoin (Veltin)</i>	T1	
<i>dapsone 5% gel (Aczone)</i>	T1	
DAPSONE 7.5% GEL	T3	
KLARON (sulfacetamide sodium)	T3	
<i>sulfacetamide sodium (Klaron)</i>	T1	
<b>ANTI-PERSPIRANTS</b>		
DRYSOL	T2	
<b>ANTI-PRURITICS, TOPICAL</b>		
ALEVICYN PLUS	T3	
<b>ANTI-PSORIATICS AGENTS</b>		
<i>anthralin</i>	T1	
DOVONEX ( <i>calcipotriene</i> )	T3	
<i>tazarotene 0.05% cream</i>	T1	
<i>tazarotene 0.05% gel (Tazorac)</i>	T1	
<b>ANTI-SEBORRHEIC AGENTS</b>		
<i>tazarotene</i>	T1	
VECTICAL ( <i>calcitriol</i> )	T3	QL (800gm/30 days)
OVACE PLUS	T3	
<i>selenium sulfide</i>	T1	
<i>sulfacetamide sodium</i>	T1	
TERSI FOAM	T3	
<b>ANTISEPTICS, MISCELLANEOUS</b>		
GUAIACOL	T1	
<b>DIABETIC ULCER PREPARATIONS, TOPICAL</b>		
REGRANEX	T3	PA QL (2 tubs/30 days)
<b>EMOLLIENTS</b>		
ATOPICLAIR	T3	
<i>emollient combination no.35 (Mimyx)</i>	T1	
<i>emollient combination no.60 (Restizan)</i>	T1	
<i>emollient combination no.60 (Restizan)</i>	T3	
HALUCORT	T3	
MIMYX ( <i>prumyx</i> )	T3	

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## List of Prescription Medications

### SKIN PREPS (Skin Conditions) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>EMOLLIENTS (cont.)</b>		
RESTIZAN	T1	
<i>vite ac/grape/hyaluronic acid</i> (Atopiclair)	T1	
XCLAIR	T3	
<b>IMMUNOMODULATORS</b>		
<i>imiquimod</i>	T1	
<b>IRRITANTS/COUNTER-IRRITANTS</b>		
<i>methyl salicylate</i>	T1	
QUTENZA	T3	
<b>KERATOLYTICS</b>		
BENZEOFAM	T3	
BENZEPRO	T1	
<i>benzoyl peroxide</i>	T1	
<i>benzoyl peroxide</i> (Enzoclear)	T1	
<i>benzoyl peroxide</i> (Pacnex)	T1	
ENZOCLEAR	T3	
HYDRO 35	T3	
HYDRO 40 ( <i>umecta</i> )	T3	
INOVA	T3	
KERAFOAM	T3	
KERALYT 6% GEL ( <i>salicylic acid</i> )	T3	
<i>keralyt 6% shampoo</i>	T1	
KERALYT SCALP	T3	
KERALYT SCALP ( <i>salicylic acid</i> )	T3	
PACNEX ( <i>benzoyl peroxide</i> )	T3	
PODOCON-25	T1	
<i>podofilox</i> (Condyllox)	T1	
PR BENZOYL PEROXIDE	T1	
<i>salicylic acid</i>	T1	
<i>salicylic acid</i>	T3	
<i>salicylic acid</i> (Keralyt Scalp)	T1	
<i>salicylic acid/ceramide comb 1</i>	T1	
SALIMEZ FORTE	T1	
SALKERA	T3	
SALVAX DUO PLUS	T3	

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## List of Prescription Medications

SKIN PREPS (Skin Conditions) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>KERATOLYTICS (con't.)</b>		
<i>silver nitrate</i>	T1	
<i>silver nitrate applicator</i>	T1	
URAMAXIN	T3	
URAMAXIN ( <i>urea</i> )	T3	
<i>urea</i> (Hydro 35)	T1	
<i>urea</i> (Hydro 40)	T3	
<i>urea</i> (Uramaxin)	T1	
<i>urea</i> (Xurea)	T1	
XUREA	T3	
<b>PROTECTIVES</b>		
PHARMABASE BARRIER	T1	
<i>polydimethylsiloxanes/silicon</i>	T1	
<i>protectives2/ceramide 1,3,6-ii</i>	T1	
RADIAPLEXRX	T3	
<i>zinc oxide</i>	T1	
<b>ROSACEA AGENTS, TOPICAL</b>		
<i>azelaic acid</i>	T1	
<i>ivermectin</i>	T1	
<i>metronidazole</i>	T1	
SOOLANTRA ( <i>ivermectin</i> )	T3	
<b>TISSUE/WOUND ADHESIVES</b>		
ARTISS	T3	
SURGISEAL STYLUS	T3	
SURGISEAL TEARDROP	T3	
SURGISEAL TWIST	T3	
TISSEEL VHSD	T3	
<b>TOP. ANTI-INFLAM., PHOSPHODIESTERASE-4 (PDE4) INHIB</b>		
EUCRISA	T2	
ZORYVE 0.15% CREAM	T2	ST QL(60 gms/30 days)
<b>TOPICAL AGENTS, MISCELLANEOUS</b>		
GORDON'S UREA	T3	
L-MESITRAN SOFT	T3	
MEDIHONEY	T3	
SAF-CLENS AF	T1	
<i>trichloroacetic acid</i>	T3	

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## List of Prescription Medications

### SKIN PREPS (Skin Conditions) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>TOPICAL AGENTS, MISCELLANEOUS (cont.)</b>		
TRICHLOROACETIC ACID	T1	
<b>TOPICAL ANTI-BACTERIAL PLEUROMUTILIN DERIVATIVES</b>		
ALTABAX	T3	
<b>TOPICAL ANTICHOLINERGIC HYPERHIDROSIS TX AGENTS</b>		
QBREXA	T3	PA
<b>TOPICAL ANTI-INFLAMMATORY STEROIDAL</b>		
ALA-SCALP ( <i>scalacort</i> )	T3	ST
<i>alclometasone dipropionate</i>	T1	
<i>amcinonide</i>	T1	
AQUA GLYCOLIC HC	T3	
<i>betamethasone valerate</i>	T1	
<i>betamethasone valerate (Luxiq)</i>	T1	
<i>betamethasone/propylene glyc</i>	T1	
<i>betamethasone/propylene glyc (Diprolene)</i>	T1	
BRYHALI	T3	ST
CAPEX SHAMPOO	T3	ST
<i>clobetasol propionate (Clobex)</i>	T1	
<i>clobetasol propionate (Olux)</i>	T1	
<i>clobetasol propionate (Temovate)</i>	T1	
CLODAN 0.05% KIT	T3	ST
<i>cladan 0.05% shampoo</i>	T1	
CLODERM	T3	ST
DERMA-SMOOTH-E FS ( <i>fluocinolone acetonide</i> )	T3	ST
DERMATOP ( <i>prednicarbate</i> )	T3	ST
DESONATE ( <i>desonide</i> )	T3	ST
<i>desonide</i>	T1	
DESOWEN 0.05% CREAM	T3	ST
<i>desoximetasone (Topicort)</i>	T1	
DIPROLENE ( <i>betamethasone diprop augmented</i> )	T3	ST
<i>fluocinolone acetonide</i>	T1	
<i>fluocinolone acetonide (Derma-smoothe-fs)</i>	T1	
<i>fluocinolone acetonide (Synalar)</i>	T1	
<i>fluocinolone/shower cap (Derma-smoothe-fs)</i>	T1	
<i>fluocinonide</i>	T1	

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

T4 – Injectable Specialty Medications

PA – Prior Authorization

QL – Quantity Limit

ST – Step Therapy

AGE – Age Requirement

SP – Specialty Medication

HD – May require home delivery pharmacy

PPACA – No Cost-Share Preventive Medication

CSL – Oral cancer medication subject to cost-share limits

## List of Prescription Medications

SKIN PREPS (Skin Conditions) (cont.)			
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits	
<b>TOPICAL ANTI-INFLAMMATORY STEROIDAL (cont.)</b>			
<i>fluocinonide/Emollient base</i>	T1		
<i>fluticasone prop 0.005% oint</i>	T1		
<i>fluticasone prop 0.05% cream</i>	T1		
<i>fluticasone prop 0.05% lotion</i>	T1		
<i>fluticasone propionate</i>	T1		
<i>halcinonide 0.1% solution</i>	T1		
<i>halobetasol prop 0.05% foam</i>	T1		
<i>halobetasol prop 0.05% cream</i>	T1		
<i>halobetasol prop 0.05% ointmnt</i>	T1		
<i>hydrocortisone</i>	T1		
<i>hydrocortisone (Ala-scalp)</i>	T1		
<i>hydrocortisone butyrate</i>	T1		
<i>hydrocortisone valerate</i>	T1		
<b>MOMETACURE</b>	T3		
<i>mometasone furoate 0.1% cream</i>	T1		
<i>mometasone furoate 0.1% oint</i>	T1		
<i>mometasone furoate 0.1% soln</i>	T1		
<b>NUCORT</b>	T3	ST	
<i>prednicarbate (Dermatop)</i>	T1		
<b>SCALACORT DK</b>	T3	ST	
<b>SYNALAR</b>	T3	ST	
<i>SYNALAR (fluocinolone acetonide)</i>	T3	ST	
<b>SYNALARTS</b>	T3	ST	
<i>TEMOVATE (clobetasol propionate)</i>	T3	ST	
<b>TEXACORT</b>	T3	ST	
<i>TOPICORT (desoximetasone)</i>	T3	ST	
<b>TOPICAL ANTI-INFLAMMATORY STEROID-LOCAL ANESTHETIC</b>			
<b>ANALPRAM HC</b>	T3		
<b>EPIFOAM</b>	T3		
<i>hydrocortisone/pramoxine (Pramosone)</i>	T1		
<i>lidocaine/hydrocortisone ac</i>	T1		
<b>MEZPAROX-HC</b>	T1		
<b>PRAMOSONE 1% LOTION</b>	T2		
<b>PRAMOSONE 1%-1% CREAM</b>	T2		
<b>PRAMOSONE 1%-1% OINTMENT</b>	T2		

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

T4 – Injectable Specialty Medications

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SP – Specialty Medication

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## List of Prescription Medications

### SKIN PREPS (Skin Conditions) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>TOPICAL ANTI-INFLAMMATORY STEROID-LOCAL ANESTHETIC (cont.)</b>		
PRAMOSONE 2.5%-1% CREAM	T3	
PRAMOSONE 2.5%-1% LOTION	T3	
PRAMOSONE 2.5%-1% OINTMENT	T2	
<b>TOPICAL ANTI-PARASITICS</b>		
<i>lindane</i>	T1	
<b>TOPICAL PREPARATIONS, ANTIBACTERIALS</b>		
<i>dermazene cream</i>	T1	
DERMAZENE CREAM PACKET	T3	
<i>hydrocortisone/iodoquinol</i>	T1	
<i>hydrocortisone/iodoquinol/aloe</i>	T1	
<i>iodine/potassium iodide</i>	T1	
<i>iodine/sodium iodide</i>	T1	
IODOFLEX	T3	
IODOSORB	T3	
<i>silver nitrate</i>	T1	
<b>TOPICAL VIT D ANALOG/ANTI-INFLAMMATORY STEROID</b>		
<i>calcipotriene/betamethasone</i>	T1	
<b>TOPICAL/MUCOUS MEMBR./SUBCUT. ENZYMEs</b>		
SANTYL	T2	QL (60gm/30 days)
<b>VITAMIN A DERIVATIVES</b>		
<i>adapalene</i>	T1	PA
<i>adapalene (Plixda)</i>	T1	PA
PLIXDA	T1	PA
<i>tretinoin 0.01% gel</i>	T1	
<i>tretinoin 0.025% cream</i>	T1	PA
<i>tretinoin 0.025% gel</i>	T1	
<i>tretinoin 0.05% cream</i>	T1	PA
<i>tretinoin 0.05% gel</i>	T1	PA
<i>tretinoin 0.1% cream</i>	T1	PA
<i>tretinoin microspheres</i>	T1	PA

T1 – Typically Generics

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T4 – Injectable Specialty Medications

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## List of Prescription Medications

SMOKING DETERRENTS (Smoking Cessation) <sup>8</sup>		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>SMOKING DETERENT AGENTS (GANGLIONIC STIM, OTHERS)</b>		
NICOTROL	T2	PPACA
NICOTROL NS	T2	PPACA
<b>SMOKING DETERENT-NICOTINIC RECEPT.PARTIAL AGONIST</b>		
CHANTIX	T2	
<i>varenicline</i>	T1	PPACA
<b>SMOKING DETERRENTS, OTHER</b>		
<i>bupropion hcl sr 150 mg tablet</i>	T1	PPACA
THYROID PREPS (Hormonal Agents)		
<b>ANTI-THYROID PREPARATIONS</b>		
<i>methimazole (Tapazole)</i>	T1	HD
<i>propylthiouracil</i>	T1	HD
TAPAZOLE ( <i>methimazole</i> )	T3	HD
<b>THYROID HORMONES</b>		
ARMOUR THYROID	T3	HD
CYTOMEL ( <i>liothyronine sodium</i> )	T3	HD
LEVOTHYROXINE	T3	HD
<i>levothyroxine sodium (Synthroid)</i>	T1	HD
<i>levothyroxine sodium (Synthroid)</i>	T3	HD
<i>liothyronine sodium (Cytomel)</i>	T1	HD
SYNTHROID ( <i>unithroid</i> )	T3	HD
<i>thyroid, pork</i>	T1	HD
<i>thyroid, pork (Armour Thyroid)</i>	T1	HD
<i>thyroid, pork (Wp Thyroid)</i>	T1	HD
THYROLAR-1	T2	HD
THYROLAR-1/2	T2	HD
THYROLAR-1/4	T2	HD
THYROLAR-2	T2	HD
THYROLAR-3	T2	HD
TIROSINT	T3	HD
TIROSINT-SOL	T3	HD
WP THYROID	T1	HD
WP THYROID ( <i>nature-throid</i> )	T1	HD

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

T4 – Injectable Specialty Medications

PA – Prior Authorization

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ST – Step Therapy

AGE – Age Requirement

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## List of Prescription Medications

THYROID PREPS (Hormonal Agents) (cont.)			
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits	
<b>THYROID HORMONES</b>			
WP THYROID ( <i>westhroid</i> )	T1	HD	
<b>UNCLASSIFIED DRUG PRODUCTS (AIDS/HIV)</b>			
<b>CYTOCHROME P450 INHIBITORS</b>			
TYBOST	T4	SP	
<b>UNCLASSIFIED DRUG PRODUCTS (Asthma/COPD/Respiratory)</b>			
<b>CYSTIC FIBROSIS-CFTR POTENTIATOR-CORRECTOR COMBIN.</b>			
ALYFTREK 10-50-125 MG TABLET	T3	PA QL(2 tabs/day) SP HD	
ALYFTREK 4-20-50 MG TABLET	T3	PA QL(3 tabs/day) SP HD	
BRONCHITOL 40 MG INHALE CAP	T4	PA SP HD	
ORKAMBI 100 MG-125 MG TABLET	T4	PA QL (4 tabs/day) SP HD	
ORKAMBI 100-125 MG GRANULE PKT	T4	PA QL (2 packs/day) SP HD	
ORKAMBI 150-188 MG GRANULE PKT	T4	PA QL (2 packs/day) SP HD	
ORKAMBI 200 MG-125 MG TABLET	T4	PA QL (4 tabs/day) SP HD	
SYMDEKO	T4	PA QL (2 tabs/day) SP HD	
TRIKAFTA	T4	PA QL (3 tabs/day) SP HD	
<b>CYSTIC FIB-TRANSMEMB CONDUCT.REG.(CFTR) POTENTIATOR</b>			
KALYDECO 150 MG TABLET	T4	PA QL (2 tabs/day) SP HD	
KALYDECO 25 MG GRANULES PACKET	T4	PA QL (2 packs/day) SP HD	
KALYDECO 50 MG GRANULES PACKET	T4	PA QL (2 packs/day) SP HD	
KALYDECO 75 MG GRANULES PACKET	T4	PA QL (2 packs/day) SP HD	
<b>LUNG SURFACTANTS</b>			
CUROSURF	T3		
INFASURF	T3		
SURVANTA	T3		
<b>MUCOLYTICS</b>			
PULMOZYME	T4	PA SP HD	
<b>PULMONARY FIBROSIS - SYSTEMIC ENZYME INHIBITORS</b>			
OFEV	T4	PA SP HD	
<b>SYSTEMIC ENZYME INHIBITORS</b>			
JOENJA	T4	PA QL (2 tabs/day) SP	
VIJOICE 50 MG GRANULE PACKET	T4	PA SP HD	
VIJOICE 125mg,50mg	T4	PA QL (30tabs/30days) SP	
VIJOICE 250mg	T4	PA QL (2 tabs/30 days) SP	
ZOKINVY	T4	PA QL (4 caps/day) SP	

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

T4 – Injectable Specialty Medications

PA – Prior Authorization

QL – Quantity Limit

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## List of Prescription Medications

UNCLASSIFIED DRUG PRODUCTS (Blood Modifiers/Bleeding Disorders)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>SPLEEN TYROSINE KINASE INHIBITORS</b>		
TAVALISSE	T4	PA SP
UNCLASSIFIED DRUG PRODUCTS (Blood Pressure/Heart Medications)		
<b>BRADYKININ B2 RECEPTOR ANTAGONISTS</b>		
<i>icatibant acetate</i>	T4	PA SP HD
<b>CI ESTERASE INHIBITORS</b>		
BERINERT	T4	PA SP HD
CINRYZE	T4	PA SP HD
HAEGARDA	T4	PA SP HD
RUCONEST	T4	PA SP HD
<b>PLASMA KALLIKREIN INHIBITORS</b>		
KALBITOR	T4	PA SP HD
ORLADEYO	T4	PA QL (1 caps/day) SP
UNCLASSIFIED DRUG PRODUCTS (Cancer)		
<b>CHEMOTHERAPY RESCUE/ANTIDOTE AGENTS</b>		
<i>leucovorin calcium</i>	T1	
<i>mesna (Mesnex)</i>	T1	SP CSL
MESNEX ( <i>mesna</i> )	T3	SP
VISTOGARD	T4	SP
UNCLASSIFIED DRUG PRODUCTS (Dental Products)		
<b>DENTAL AIDS AND PREPARATIONS</b>		
<i>chlorhexidine gluconate (Peridex)</i>	T1	
PERIDEX ( <i>periogard</i> )	T1	
<i>triamcinolone acetonide</i>	T1	
<b>PERIODONTAL COLLAGENASE INHIBITORS</b>		
<i>doxycycline hyclate</i>	T1	
UNCLASSIFIED DRUG PRODUCTS (Erectile Dysfunction)		
<b>DRUGS TO TREAT ERECTILE DYSFUNCTION (ED)</b>		
CAVERJECT	T3	PA QL (6 injectors/30 days)
CIALIS 10 MG TABLET ( <i>tadalafil</i> )	T3	QL (6 tabs/30 days) ST HD
CIALIS 20 MG TABLET ( <i>tadalafil</i> )	T3	QL (6 tabs/30 days) ST HD
CIALIS 5 MG TABLET ( <i>tadalafil</i> )	T3	QL (8 tabs/30 days) ST HD
EDEX	T3	PA QL (6 injectors/30 days)
IFE-BIMIX 30/1	T2	
IFE-PG20	T2	

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

T4 – Injectable Specialty Medications

PA – Prior Authorization

QL – Quantity Limit

ST – Step Therapy

AGE – Age Requirement

SP – Specialty Medication

HD – May require home delivery pharmacy

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CSL – Oral cancer medication subject to cost-share limits

## List of Prescription Medications

### UNCLASSIFIED DRUG PRODUCTS (Erectile Dysfunction) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>DRUGS TO TREAT ERECTILE DYSFUNCTION (ED) (cont.)</b>		
LEVITRA ( <i>vardenafil hcl</i> )	T3	QL (10 tabs/30 days) ST
MUSE	T2	PA QL (6/30 days)
PAPAVERINE-PHENTOLMN-ALPROSTDL	T1	
PHENTOLAMINE-ALPROSTADIL	T1	
<i>sildenafil 100 mg tablet</i> (Viagra)	T1	QL (10 tabs/30 days) HD
<i>sildenafil 25 mg tablet</i> (Viagra)	T1	QL (6 tabs/30 days) HD
<i>sildenafil 50 mg tablet</i> (Viagra)	T1	QL (6 tabs/30 days) HD
STENDRA	T3	QL (8 tabs/30 days) ST
<i>tadalafil 2.5 mg tablet</i>	T1	QL(1 tab/day)
<i>tadalafil</i> (Cialis)	T1	QL (8 tabs/30 days) HD
<i>vardenafil hcl</i> (Levitra)	T1	QL (10 tabs/30 days)
VIAGRA ( <i>sildenafil citrate</i> )	T3	QL (6 tabs/30 days) ST

### UNCLASSIFIED DRUG PRODUCTS (Eye Dysfunction)

ORAL MUCOSITIS/STOMATITIS AGENTS		
TYRVAYA	T2	QL(8.4 mls/30 days)

### UNCLASSIFIED DRUG PRODUCTS (Gastrointestinal/Heartburn)

ORAL MUCOSITIS/STOMATITIS AGENTS		
GELCLAIR	T3	
ORAMAGICRX	T3	
REZDIFRA	T4	PA QL(1 tab/day) SP HD

SALIVA STIMULANT AGENTS		
NUMOISYN	T3	

### UNCLASSIFIED DRUG PRODUCTS (Hormonal Agents)

BONE FORMATION STIM. AGENTS - PARATHYROID HORMONE		
FORTEO	T4	PA QL (3ml/21 day) SP HD
<b>GROWTH HORMONE RECEPTOR ANTAGONISTS</b>		
<b>SOMAVERT</b>		
	T4	PA SP HD

HYPERPARATHYROID TX AGENTS - VITAMIN D ANALOG-TYPE		
<i>doxercalciferol</i>	T1	
<i>paricalcitol</i>	T4	SP HD
<i>paricalcitol</i> (Zemplar)	T4	SP HD
RAYALDEE	T3	
ZEMPLAR ( <i>paricalcitol</i> )	T4	SP HD

MENOPAUSAL SYMPT SUPP-SEL ESTROGEN RECP MODULATOR		
OSPHENA	T3	QL(30 tabs/30 days) HD

T1 – Typically Generics      T4 – Injectable Specialty Medications      ST – Step Therapy  
T2 – Typically Preferred Brands      PA – Prior Authorization      AGE – Age Requirement  
T3 – Typically Non-Preferred Brands      QL – Quantity Limit      SP – Specialty Medication

HD – May require home delivery pharmacy  
PPACA – No Cost-Share Preventive Medication  
CSL – Oral cancer medication subject to cost-share limits

## List of Prescription Medications

UNCLASSIFIED DRUG PRODUCTS (Miscellaneous)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>ABORTIFACIENT-PROGESTERONE RECEPTOR ANTAGONISTS</b>		
MIFEPREX <i>mifepristone (Mifeprex)</i>	T3 T4	PA SP
<b>AGENTS TO TX PERIODIC PARALYSIS - CARBON ANHYD INH</b>		
<i>dichlorphenamide (Keveyis)</i>	T4	PA SP
<b>AMMONIA INHIBITORS</b>		
CARBAGLU <i>carglumic acid (Carbaglu)</i>	T4 T4	SP HD SP HD
<b>AMYLOIDOSIS AGENTS-TRANSTHYRETIN (TTR) SUPPRESSION</b>		
TEGSEDI	T4	PA SP HD
<b>ANTI-ALCOHOLIC PREPARATIONS</b>		
<i>acamprosate calcium</i>	T1	
ANTABUSE ( <i>disulfiram</i> )	T3	
<i>disulfiram</i> (Antabuse)	T1	
<b>ANTIDOTES, MISCELLANEOUS</b>		
CETYLEV	T3	
<b>ANTI-FIBROTIC THERAPY - PYRIDONE ANALOGS</b>		
<i>pirfenidone 267 mg capsule (Esbriet)</i>	T4	PA SP HD
<i>pirfenidone 801 mg tablet (Esbriet)</i>	T4	PA SP HD
<b>CRYOPRESERVATIVE AGENTS</b>		
<i>dimethyl sulfoxide</i>	T1	
<b>DRUGS TO TREAT HEREDITARY TYROSINEMIA</b>		
<i>nitisinone (Orfadin)</i>	T4	PA SP HD
NITYR	T4	PA SP
ORFADIN ( <i>nitisinone</i> )	T4	PA SP
<b>DRUGS TO TX GAUCHER DX-TYPE I, SUBSTRATE REDUCING</b>		
CERDELGA	T4	PA SP HD
<i>miglustat (Zavesca)</i>	T4	PA SP HD
OPFOLDA	T4	PA QL(8 caps/30 days) SP HD
<b>GENERAL INHALATION AGENTS</b>		
HYPER-SAL	T3	
<i>nebusal 3% vial</i>	T1	
NEBUSAL 6% VIAL	T3	
<i>sodium chloride for inhalation</i>	T1	
<i>sodium chloride for inhalation (Hyper-sal)</i>	T1	

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

T4 – Injectable Specialty Medications

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## List of Prescription Medications

### UNCLASSIFIED DRUG PRODUCTS (Miscellaneous) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>GENETIC D/O TX - SMN PROTEIN DEFICIENCY TREATMENT</b>		
EVRYSDI 60 MG/80 ML(0.75MG/ML)	T4	PA SP HD
<b>INTERLEUKIN-13 (IL-13) INHIBITORS, MAB</b>		
ADBRY	T4	PA SP HD
ADBRY AUTOINJECTOR	T4	PA SP HD
EBGLYSS	T4	PA SP
<b>MENOPAUSAL SYMPTOMS SUPPRESSANT-RECEPTOR ANTAG</b>		
VEOZAH	T3	QL(1 tab/day)
<b>MENOPAUSAL SYMPTOMS SUPPRESSANT - SSRIs</b>		
paroxetine mesylate	T1	QL (1 cap/day) HD
<b>METABOLIC DISEASE ENZYME REPLACE, HYPOPHOSPHATASIA</b>		
STRENsiQ	T4	PA SP
<b>METABOLIC DISEASE ENZYME REPLACEMENT, MOCD</b>		
NULIBRY	T4	PA SP
<b>METALLIC POISON, AGENTS TO TREAT</b>		
CHEMET	T3	
deferasirox (Exjade)	T4	SP HD
deferasirox (Jadenu) (Jadenu Sprinkle)	T4	SP HD
deferiprone (Ferriprox)	T4	PA SP HD
EXJADE (deferasirox)	T4	PA SP HD
FERRIPROX	T4	PA SP
FERRIPROX (2 TIMES A DAY)	T4	PA SP
GALZIN	T3	SP
RADIOGARDASE	T3	
trientine hcl	T4	PA SP HD
TRIENTINE HCL	T4	PA SP HD
<b>NATRIURETIC PEPTIDES</b>		
VOXZOGO	T4	PA SP HD
<b>NEONATAL FC RECEPTOR (FCRN) INHIBITORS</b>		
VYVGART HYTRULO	T3	PA SP HD
<b>ointment/cream bases</b>		
RADIAGEL	T1	
<b>PHARMACOLOGICAL CHAPERONE-ALPHA-GALACTOSID.A STABZ</b>		
GALAFOLD	T4	PA SP HD
<b>PKU TX AGENT-COFACTOR OF PHENYLALANINE HYDROXYLASE</b>		
javygtor powder pkt	T4	PA SP
javygtor tablet	T4	PA SP HD

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## List of Prescription Medications

### UNCLASSIFIED DRUG PRODUCTS (Miscellaneous) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>PROTEIN STABILIZERS</b>		
ATTRUBY	T3	
VYNDAMAX	T4	PA QL (1 cap/day) SP HD
VYndaQEL	T4	PA QL (4 caps/day) SP HD
<b>RETINOIC ACID RECEPTOR (RAR) AGONISTS</b>		
SOHONOS	T4	PA SP
<b>SOLVENTS</b>		
FT ISOPROPYL ALCOHOL 91%	T1	
FT ISOPROPYL RUB ALCOHOL 70%	T3	
<i>isopropyl alcohol</i>	T1	
MURI-LUBE MINERAL OIL	T1	
<b>THYMIC STROMAL LYMPHOPOIETIN (TSLP) INHIBITORS</b>		
TEZSPIRE 210 MG/1.91 ML PEN	T4	PA QL(1 pen/28 days) SP HD
TEZSPIRE 210 MG/1.91 ML SYRING	T4	PA SP HD

### UNCLASSIFIED DRUG PRODUCTS (Nutritional/Dietary)

<b>METABOLIC DEFICIENCY AGENTS</b>		
<i>betaine</i> (Cystadane)	T4	SP
CYSTADANE	T4	SP
<i>levocarnitine</i> (Carnitor Sf)	T1	
<i>levocarnitine</i> (Carnitor)	T1	
<i>levocarnitine</i> (with sugar) (Carnitor)	T1	

### UNCLASSIFIED DRUG PRODUCTS (Osteoporosis Products)

<b>BONE RESORPTION INHIBITORS</b>		
ACTONEL ( <i>risedronate sodium</i> )	T3	ST HD
alendronate sodium ( <i>Fosamax</i> )	T1	HD
ATELVIA ( <i>risedronate sodium dr</i> )	T3	ST HD
BINOSTO	T3	ST HD
BONIVA ( <i>ibandronate sodium</i> )	T3	ST HD
EVISTA ( <i>raloxifene hcl</i> )	T3	HD
FOSAMAX ( <i>alendronate sodium</i> )	T3	ST HD
<i>ibandronate sodium</i> (Boniva)	T1	HD
<i>raloxifene hcl</i> (Evista)	T1	HD PPACA
<i>risedronate sodium</i> (Actonel)	T1	HD
<i>risedronate sodium</i> (Atelvia)	T1	HD

### BONE RESORPTION INHIBITOR AND VITAMIN D COMBS.

FOSAMAX PLUS D	T3	ST HD
T1 – Typically Generics	T4 – Injectable Specialty Medications	ST – Step Therapy
T2 – Typically Preferred Brands	PA – Prior Authorization	AGE – Age Requirement
T3 – Typically Non-Preferred Brands	QL – Quantity Limit	SP – Specialty Medication

HD – May require home delivery pharmacy  
 PPACA – No Cost-Share Preventive Medication  
 CSL – Oral cancer medication subject to cost-share limits

## List of Prescription Medications

UNCLASSIFIED DRUG PRODUCTS (Osteoporosis Products) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>BONE FORMATION STIM. AGENTS - PARATHYROID HORMONE</b>		
teriparatide 560mcg/2.4ml pen (Forteo)	T1	HD
UNCLASSIFIED DRUG PRODUCTS (Pain Relief And Inflammatory Disease)		
<b>ANTI-INFLAM. INTERLEUKIN-1 RECEPTOR ANTAGONIST</b>		
ARCALYST	T4	PA SP HD
<b>ANTI-INFLAMMATORY, INTERLEUKIN-1 BETA BLOCKERS</b>		
ILARIS	T4	PA SP HD
<b>FIBROMYALGIA AGENTS, SEROTONIN-NOREPINEPHRINE INHIB</b>		
SAVELLA	T2	
<b>IMMUNOMODULATOR, B-LYMPHOCYTE STIM (BLYS)-SPEC INHIB</b>		
BENLYSTA	T4	PA SP HD
UNCLASSIFIED DRUG PRODUCTS (Skin Conditions)		
<b>WOUND HEALING AGENTS, LOCAL</b>		
FILSUVEZ	T4	PA SP
UNCLASSIFIED DRUG PRODUCTS (Substance Abuse)		
<b>OPIOID WITHDRAWAL THER, ALPHA-2 ADRENERGIC AGONIST</b>		
lofexidine hcl (Lucemyra)	T1	QL(192 tabs/30 days)
LUCEMYRA (lofexidine)	T2	QL (168 tabs/14 days)
<b>OPIOID WITHDRAWAL THERAPY AGENTS, OPIOID-TYPE</b>		
BUNAVAIL	T3	
buprenorphine hcl	T1	
buprenorphine hcl/naloxone hcl	T1	
buprenorphine hcl/naloxone hcl (Suboxone)	T1	
SUBOXONE (buprenorphine-naloxone)	T3	
ZUBSOLV	T2	
UNCLASSIFIED DRUG PRODUCTS (Transplant Medications)		
<b>RHO KINASE INHIBITOR</b>		
REZUROCK	T4	PA SP HD
UNCLASSIFIED DRUG PRODUCTS (Urinary Tract Conditions)		
<b>BENIGN PROSTATIC HYPERPLASIA/MICTURITION AGENTS</b>		
alfuzosin hcl (Uroxatral)	T1	HD
dutasteride (Avodart)	T1	HD
finasteride (Proscar)	T1	HD
PROSCAR (finasteride)	T3	HD

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

T4 – Injectable Specialty Medications

PA – Prior Authorization

QL – Quantity Limit

ST – Step Therapy

AGE – Age Requirement

SP – Specialty Medication

HD – May require home delivery pharmacy

PPACA – No Cost-Share Preventive Medication

CSL – Oral cancer medication subject to cost-share limits

## List of Prescription Medications

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

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>BENIGN PROSTATIC HYPERPLASIA/MICTURITION AGENTS (cont.)</b>		
RAPAFLO 4 MG CAPSULE ( <i>silodosin</i> )	T3	QL (1 cap/day) HD
RAPAFLO 8 MG CAPSULE ( <i>silodosin</i> )	T3	HD
<i>silodosin 4 mg capsule</i> (Rapaflo)	T1	QL (1 cap/day) HD
<i>silodosin 8 mg capsule</i> (Rapaflo)	T1	HD
<i>tamsulosin hcl</i> (Flomax)	T1	HD
<b>BPH 5-ALPHA-REDUCTASE INHIB-ALPHAI-ADRENOCEP ANTAG</b>		
dutasteride/tamsulosin hcl (Jalyn)	T1	HD
<b>CYSTINE-DEPLETING AGENTS, NEPHROPATHIC CYSTINOSIS</b>		
CYSTAGON	T4	SP
<b>KIDNEY STONE AGENTS</b>		
<i>tiopronin</i>	T4	SP
<i>tiopronin dr</i>	T4	SP
<b>OVERACTIVE BLADDER AGENTS, BETA-3 ADRENERGIC RECEPTOR ANTAGONISTS</b>		
<i>mirabegron er 25 mg tablet</i> (Myrbetriq)	T1	QL(1 tab/day) HD
<i>mirabegron er 50 mg tablet</i> (Myrbetriq)	T1	HD
<b>URINARY TRACT ANTI-SPASMODIC, M(3) SELECTIVE ANTAG.</b>		
<i>darifenacin er 15 mg tablet</i>	T1	HD
<i>darifenacin er 7.5 mg tablet</i>	T1	QL (1 tab/day) HD
<i>solifenacin 10 mg tablet</i>	T1	HD
<i>solifenacin 5 mg tablet</i>	T1	QL (1 tab/day) HD
<b>URINARY TRACT ANTI-SPASMODIC/ANTI-INCONTINENCE AGENT</b>		
<i>flavoxate hcl</i>	T1	HD
<i>oxybutynin</i>	T1	HD
<i>tolterodine tart er 2 mg cap</i>	T1	QL (1 cap/day) HD
<i>tolterodine tart er 4 mg cap</i>	T1	HD
<i>tolterodine tartrate</i>	T1	HD
<i>trospium chloride</i>	T1	HD
<b>VITAMINS (Nutritional/Dietary)</b>		
<b>FOLIC ACID PREPARATIONS</b>		
<i>folic acid</i>	T1	

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

T4 – Injectable Specialty Medications

PA – Prior Authorization

QL – Quantity Limit

ST – Step Therapy

AGE – Age Requirement

SP – Specialty Medication

HD – May require home delivery pharmacy

PPACA – No Cost-Share Preventive Medication

CSL – Oral cancer medication subject to cost-share limits

## List of Prescription Medications

### VITAMINS (Nutritional/Dietary) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>MULTIVITAMIN PREPARATIONS</b>		
CITRANATAL MEDLEY	T3	
CONCEPT DHA CAPSULE	T3	
FOLET ONE	T2	
<i>mvn no.53/iron/folic/dss/dha</i>	T1	
OBSTETRIX ONE	T1	
<b>VITAMIN B12 PREPARATIONS</b>		
<i>cyanocobalamin (vitamin b-12)</i>	T1	
<b>VITAMIN D PREPARATIONS</b>		
<i>calcitriol 0.25 mcg capsule</i>	T1	
<i>calcitriol 0.5 mcg capsule</i>	T1	
<i>calcitriol 1 mcg/ml solution (Rocaltrol)</i>	T1	HD
<i>cyanocobalamin (vitamin b-12) (Nascobal)</i>	T1	
<i>ergocalciferol (vitamin d2)</i>	T1	HD
ROCALTROL ( <i>calcitriol</i> )	T3	HD
<b>VITAMIN K PREPARATIONS</b>		
MEPHYTON ( <i>phytonadione</i> )	T3	

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

T4 – Injectable Specialty Medications

PA – Prior Authorization

QL – Quantity Limit

ST – Step Therapy

AGE – Age Requirement

SP – Specialty Medication

HD – May require home delivery pharmacy

PPACA – No Cost-Share Preventive Medication

CSL – Oral cancer medication subject to cost-share limits

## Exclusions and limitations for coverage

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

Plans generally do not provide coverage for the following under the pharmacy benefit, except as required by state or federal law, or by the terms of your specific plan:<sup>9</sup>

- Over-the-counter (OTC) medicines (those that do not require a prescription) except insulin unless state or federal law requires coverage of such medicines.
- Prescription medications or supplies for which there is a prescription or OTC therapeutic equivalent or therapeutic alternative.
- Doctor-administered injectable medications covered under the Plan's medical benefit, unless otherwise covered under the Plan's prescription drug list or approved by Cigna Healthcare.
- Implantable contraceptive devices covered under the Plan's medical benefit.
- Medications that are not medically necessary.
- Experimental or investigational medications, including U.S. Food and Drug Administration (FDA)-approved medications used for purposes other than those approved by the FDA unless the medication is recognized for the treatment of the particular indication.
- Medications that are not approved by the FDA.
- Prescription and non-prescription devices, supplies, and appliances other than those supplies specifically listed as covered.
- Medications used for fertility,<sup>10</sup> sexual dysfunction, cosmetic purposes, weight loss, smoking cessation,<sup>10</sup> or athletic enhancement.
- Prescription vitamins (other than prenatal vitamins) or dietary supplements unless state or federal law requires coverage of such products.
- Immunization agents, biological products for allergy immunization, biological sera, blood, blood plasma and other blood products or fractions and medications used for travel prophylaxis.
- Replacement of prescription medications and related supplies due to loss or theft.
- Medications which are to be taken by or administered to a covered person while they are a patient in a licensed hospital, skilled nursing facility, rest home or similar institution which operates on its premises or allows to be operated on its premises a facility for dispensing pharmaceuticals.
- Prescriptions more than one year from the date of issue.
- Coverage for prescription medication products for the amount dispensed (days' supply) which is more than the applicable supply limit, or is less than any applicable supply minimum set forth in The Schedule, or which is more than the quantity limit(s) or dosage limit(s) set by the P&T Committee.
- More than one prescription order or refill for a given prescription supply period for the same prescription medication product prescribed by one or more doctors and dispensed by one or more pharmacies.
- Prescription medication products dispensed outside the jurisdiction of the United States, except as required for emergency or urgent care treatment.

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

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XOFLUZA .....	61	ZOSTAVAX .....	67
XOLAIR .....	29	ZTALMY .....	84
XOLREMDI .....	85	ZTLIDO .....	24
XOPENEX .....	28	ZUBSOLV .....	146
XOSPATA .....	53	ZURZUVAE .....	122
XPOVIO .....	54	ZYDELIG .....	53
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ZIRGAN .....	61		
ZITHROMAX .....	34, 35		
ZOHYDRO .....	23		

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

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



1. App/online store terms and mobile phone carrier/data charges apply. Customers under age 13 (and/or their parent/guardian) will not be able to register at myCigna.com.
2. Prices shown on myCigna are not guaranteed and coverage is subject to your plan terms and conditions. Visit myCigna for more information.
3. U.S. Food and Drug Administration (FDA) website, "Generic Drugs: Questions and Answers." Last updated 03/16/21. fda.gov/drugs/questions-answers/generic-drugs-questions-answers.
4. Not all plans offer Express Scripts® Pharmacy and Accredo as covered pharmacy options. Log in to the myCigna App or myCigna.com, or check your plan materials, to learn more about the pharmacies in your plan's network. Cigna Healthcare maintains an ownership interest in Express Scripts® Pharmacy's home delivery services and Accredo's specialty pharmacy services. However, you have the right to fill prescriptions at any pharmacy in your plan's network. You won't be penalized regardless of where you fill your prescriptions.
5. Standard shipping costs are included as part of your prescription plan.
6. Some medications aren't available in a 90-day supply and may only be packaged in lesser amounts. For example, three packages of oral contraceptives equal an 84-day supply. Even though it's not a "90-day supply," it's still considered a 90-day prescription.
7. As allowable by law. For medications administered by a health care provider, Accredo will ship the medication directly to your doctor's office.
8. **For insured plans that must follow Delaware's state insurance laws:** Brand-name antidepressants, smoking cessation, attention deficit hyperactivity disorder (ADHD) and anti-psychotic medications that don't have a generic equivalent available will be covered as Tier 2 (preferred brand). This is true even if the medication is listed as Tier 3 (non-preferred brand) on your plan's drug list. To find out how your specific plans covers these medications, log in to the myCigna App or myCigna.com, or call Customer Service using the number on your ID card.
9. Costs and complete details of the plan's prescription drug coverage are set forth in the plan documents. If there are any differences between the information provided here and the plan documents, the information in the plan documents takes complete precedence.
10. **For plans that must follow state insurance laws, such as Delaware:** Your plan may provide coverage for infertility medications and smoking cessation medications even if this drug list states that your plan may not cover them. To find out if your specific plan covers these medications, log in to the myCigna App or myCigna.com, or check your plan materials.

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

Product availability may vary by location and plan type and is subject to change. All group health insurance policies and health benefit plans contain exclusions and limitations. For costs and details of coverage, review your plan documents or contact a Cigna Healthcare representative.

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# Discrimination is against the law.

## Medical coverage

Cigna Healthcare complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Cigna Healthcare does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

### **Cigna Healthcare:**

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

If you need these services, contact customer service at the toll-free number shown on your ID card, and ask a Customer Service Associate for assistance.

If you believe that Cigna Healthcare has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance by sending an email to **ACAGrievance@Cigna.com** or by writing to the following address:

### **Cigna Healthcare**

Nondiscrimination Complaint Coordinator  
P.O. Box 188016  
Chattanooga, TN 37422

If you need assistance filing a written grievance, please call the number on the back of your ID card or send an email to **ACAGrievance@Cigna.com**. You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>, or by mail or phone at:

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

Complaint forms are available at  
<http://www.hhs.gov/ocr/office/file/index.html>



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## Proficiency of Language Assistance Services

**English** – ATTENTION: Language assistance services, free of charge, are available to you. For current Cigna customers, call the number on the back of your ID card. Otherwise, call 1.800.244.6224 (TTY: Dial 711).

**Spanish** – ATENCIÓN: Hay servicios de asistencia de idiomas, sin cargo, a su disposición. Si es un cliente actual de Cigna, llame al número que figura en el reverso de su tarjeta de identificación. Si no lo es, llame al 1.800.244.6224 (los usuarios de TTY deben llamar al 711).

**Chinese** – 注意：我們可為您免費提供語言協助服務。對於 Cigna 的現有客戶，請致電您的 ID 卡背面的號碼。其他客戶請致電 1.800.244.6224（聽障專線：請撥 711）。

**Vietnamese** – XIN LƯU Ý: Quý vị được cung cấp dịch vụ trợ giúp về ngôn ngữ miễn phí. Dành cho khách hàng hiện tại của Cigna, vui lòng gọi số ở mặt sau thẻ Hội viên. Các trường hợp khác xin gọi số 1.800.244.6224 (TTY: Quay số 711).

**Korean** – 주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 현재 Cigna 가입자님들께서는 ID 카드 뒷면에 있는 전화번호로 연락해주십시오. 기타 다른 경우에는 1.800.244.6224 (TTY: 다이얼 711)번으로 전화해주십시오.

**Tagalog** – PAUNAWA: Makakakuha ka ng mga serbisyo sa tulong sa wika nang libre. Para sa mga kasalukuyang customer ng Cigna, tawagan ang numero sa likuran ng iyong ID card. O kaya, tumawag sa 1.800.244.6224 (TTY: I-dial ang 711).

**Russian** – ВНИМАНИЕ: вам могут предоставить бесплатные услуги перевода. Если вы уже участвуете в плане Cigna, позвоните по номеру, указанному на обратной стороне вашей идентификационной карточки участника плана. Если вы не являетесь участником одного из наших планов, позвоните по номеру 1.800.244.6224 (TTY: 711).

**Arabic** – برجاء الانتباه خدمات الترجمة المجانية متاحة لكم. لعملاء Cigna برجاء الاتصال بالرقم المدون على ظهر بطاقتكم الشخصية.  
او اتصل ب 1.800.244.6224 (TTY: اتصل ب 711).

**French Creole** – ATANSYON: Gen sèvis èd nan lang ki disponib gratis pou ou. Pou kliyan Cigna yo, rele nimewo ki dèyè kat ID ou. Sinon, rele nimewo 1.800.244.6224 (TTY: Rele 711).

**French** – ATTENTION: Des services d'aide linguistique vous sont proposés gratuitement. Si vous êtes un client actuel de Cigna, veuillez appeler le numéro indiqué au verso de votre carte d'identité. Sinon, veuillez appeler le numéro 1.800.244.6224 (ATS : composez le numéro 711).

**Portuguese** – ATENÇÃO: Tem ao seu dispor serviços de assistência linguística, totalmente gratuitos. Para clientes Cigna atuais, ligue para o número que se encontra no verso do seu cartão de identificação. Caso contrário, ligue para 1.800.244.6224 (Dispositivos TTY: marque 711).

**Polish** – UWAGA: w celu skorzystania z dostępnej, bezpłatnej pomocy językowej, obecni klienci firmy Cigna mogą dzwonić pod numer podany na odwrocie karty identyfikacyjnej. Wszystkie inne osoby prosimy o skorzystanie z numeru 1 800 244 6224 (TTY: wybierz 711).

**Japanese** – 注意事項:日本語を話される場合、無料の言語支援サービスをご利用いただけます。現在のCignaのお客様は、IDカード裏面の電話番号まで、お電話にてご連絡ください。その他の方は、1.800.244.6224 (TTY: 711)まで、お電話にてご連絡ください。

**Italian** – ATTENZIONE: Sono disponibili servizi di assistenza linguistica gratuiti. Per i clienti Cigna attuali, chiamare il numero sul retro della tessera di identificazione. In caso contrario, chiamare il numero 1.800.244.6224 (utenti TTY: chiamare il numero 711).

**German** – ACHTUNG: Die Leistungen der Sprachunterstützung stehen Ihnen kostenlos zur Verfügung. Wenn Sie gegenwärtiger Cigna-Kunde sind, rufen Sie bitte die Nummer auf der Rückseite Ihrer Krankenversicherungskarte an. Andernfalls rufen Sie 1.800.244.6224 an (TTY: Wählen Sie 711).

**Persian (Farsi)** – توجه: خدمات کمک زبانی، به صورت رایگان به شما ارائه می شود. برای مشتریان فعلی Cigna، لطفاً با شماره‌ای که در پشت کارت شناسایی شماست تماس بگیرید. در غیر اینصورت با شماره 1.800.244.6224 تماس بگیرید (شماره تلفن ویژه ناشنوايان: شماره 711 را شماره‌گیری کنيد).