



Cigna Healthcare National Preferred 4-Tier Specialty Prescription Drug List

Coverage as of July 1, 2025

For the State of California

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

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

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 This drug list is subject to change and all prior versions are no longer in effect.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.

975749 d CA NPF 4-Tier Specialty 07/25 © 2025 Cigna Healthcare.





What's Inside?	Page
Information about this drug list	3
· Frequently asked questions (FAQs)	3
· Words you may need to know	II
· About this drug list	I3
· How to read this drug list	I3
· How to find your medication	I6
List of prescription medications	I9
Exclusions and limitations for coverage	246
Index of medications	247

View your drug list online

This document was last updated on 07/01/2025.* Go online to see the most up-to-date list of medications your plan covers.

- **myCigna® Appⁱ or myCigna.com[®].** Click on the Prescriptions tab and select Price a Medication from the dropdown menu. Then type in your medication name.
- **Cigna.com/druglist.** Select **National Preferred 4 Tier Specialty** from the dropdown menu. Then type in your medication name.

Questions?

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

* Drug list created: originally created 01/01/2023

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

Next planned update: 10/01/2025, for changes starting 01/01/2026

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 July 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.

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.

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.

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.²

Q. What's a cost-share?

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

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

A. 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.³ 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.⁴ 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 cost⁵
- Automatic refills or refill reminders

- Fill up to a 90-day supply at one time⁶
- 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).⁷ 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.

Information about this drug list

Words you may need to know (cont.)

- **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.
- **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 National Preferred 4-Tier Specialty 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.

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

* 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	Prior Authorization* – This medication needs approval from Cigna Healthcare before your plan will cover it. Your doctor's office will have to send us information to review to make sure you meet coverage requirements for the medication.
QL	Quantity Limit* – 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	Step Therapy* – 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	Age Requirement* – Your plan will only cover this medication if you're a certain age or within a certain age range. If you're not within the allowed age range and your doctor wants you to take this medication, your doctor's office can ask Cigna Healthcare to approve coverage.
SP	This is a specialty medication , 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	Home Delivery Medications – Some plans only cover certain maintenance medications if they're filled through home delivery with Express Scripts® Pharmacy. Depending on your plan, you may be able to get coverage for one, two or three fills at an in-network retail pharmacy before switching to home delivery.
PPACA	Health care reform under the Patient Protection and Affordable Care Act (PPACA) requires plans to cover this preventive medication/product at 100%, or no cost-share (\$0), to you
CSL	Oral Cancer Medications Subject to Cost-Share Limits – State law in California limits the cost-share (or amount you pay out-of-pocket) for certain oral chemotherapy medications.

* 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	
ANALGESICS (Pain Relief and Inflammatory Disease)			
ANALGESIC, NON-SALICYLATE AND BARBITURATE COMBINAT	T1		
<i>butalbital/acetaminophen</i>	T1		
ANALGESIC, SALICYLATE, BARBITURATE, XANTHINE COMB.			
<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)	
ANALGESIC, NON-SALICYLATE, BARBITURATE, XANTHINE COMB.			
<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)	
ANALGESIC/ANTIPYRETICS, SALICYLATES			
<i>choline salicyl/mag salicylate</i>	T1	HD	
<i>diflunisal</i>	T1	HD	←
ANTI-MIGRAINE PREPARATIONS			
<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 National Preferred 4-Tier Specialty 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
Analgesics (Pain Relief and Inflammatory Disease)	19-24	Anti-Infectives/Miscellaneous (Feminine Products)	52
Analgesics (Urinary Tract Conditions)	24	Anti-Infectives/Miscellaneous (Infections)	52, 53
Anesthetics (Miscellaneous)	24, 25	Anti-Infectives/Miscellaneous (Miscellaneous)	53
Anesthetics (Pain Relief and Inflammatory Disease)	25	Anti-Infectives/Miscellaneous (Skin Conditions)	54
Anesthetics (Urinary Tract Conditions)	25	Anti-Inflammatory Tumor Necrosis Factor Inhibiting Agents (Pain Relief and Inflammatory Disease)	54
Anti-Allergy (Allergy and Nasal Sprays)	25	Anti-Neoplastics (Cancer)	54-62
Anti-Arthritis (Pain Relief and Inflammatory Disease)	26-29	Anti-Neoplastics (Skin Conditions)	62
Anti-Asthmatics (Asthma/COPD/Respiratory)	29-32	Anti-Obesity Drugs (Weight Management)	62, 63
Antibiotics (Ear Medications)	33	Anti-Parasitics (Eye Conditions)	63
Antibiotics (Eye Conditions)	33, 34	Anti-Parasitics (Infections)	63, 64
Antibiotics (Infections)	34-40	Anti-Parkinson's Drugs (Parkinson's Disease)	64, 65
Antibiotics (Skin Conditions)	41, 42	Anti-Platelet Drugs (Blood Thinners/Anti-Clotting)	65
Anti-Coagulants (Blood Thinners/Anti-Clotting)	43, 44	Antivirals (AIDS/HIV)	65-68
Antidotes (Gastrointestinal/Heartburn)	44	Antivirals (Eye Conditions)	68
Antidotes (Substance Abuse)	44	Antivirals (Infections)	68-70
Anti-Fungals (Eye Conditions)	44	Antivirals (Skin Conditions)	70
Anti-Fungals (Feminine Products)	44	Autonomic Drugs (Allergy/Nasal Sprays)	70, 71
Anti-Fungals (Infections)	44-46	Autonomic Drugs (Alzheimer's Disease)	71
Anti-Fungals (Skin Conditions)	46, 47	Autonomic Drugs (Attention Deficit Hyperactivity Disorder)	71, 72
Antihistamine and Decongestant Combination (Allergy/Nasal Sprays)	47	Autonomic Drugs (Blood Pressure/Heart Medications)	72
Antihistamines (Allergy/Nasal Sprays)	47, 48	Autonomic Drugs (Urinary Tract Conditions)	72
Antihistamines (Eye Conditions)	48	Biologicals (Allergy/Nasal Sprays)	73
Anti-Hyperglycemics (Diabetes)	48-52	Biologicals (Blood Pressure/Heart Medications)	73
Anti-Infectives (Feminine Products)	52	Biologicals (Miscellaneous)	73
		Biologicals (Vaccines)	73-76

Information about this drug list

How to find your medication (cont.)

Condition	Page	Condition	Page
Blood (Blood Modifiers/Bleeding Disorders)	76, 77	Gastrointestinal (Cholesterol Medications)	II8
Blood (Blood Thinners/Anti-Clotting)	77	Gastrointestinal (Gastrointestinal/Heartburn)	II8-II4
Cardiac Drugs (Blood Pressure/Heart Medications)	77-80	Gastrointestinal (Pain Relief and Inflammatory Disease)	I24
Cardiovascular (Asthma/COPD/Respiratory)	80, 81	Hormones (Gastrointestinal/Heartburn)	I24
Cardiovascular (Blood Pressure/Heart Medications)	81-85	Hormones (Hormonal Agents)	I25-I29
Cardiovascular (Cholesterol Medications)	85-87	Hormones (Infertility)	I29, I30
CNS Drugs (Alzheimer's Disease)	88	Hormones (Miscellaneous)	I30
CNS Drugs (Miscellaneous)	88, 89	Hormones (Osteoporosis Products)	I30
CNS Drugs (Multiple Sclerosis)	89, 90	Immunosuppressants (Pain Relief and Inflammatory Disease)	I30, I31
CNS Drugs (Pain Relief and Inflammatory Disease)	90	Immunosuppressants (Skin Conditions)	I31, I32
CNS Drugs (Seizure Disorders)	90-94	Immunosuppressants (Transplant Medications)	I32, I33
CNS Drugs (Sleep Disorders/Sedatives)	94	Miscellaneous Medical Supplies, Devices, Non-Drug (Diabetes)	I33-I55
Colony Stimulating Factors (Blood Modifiers/Bleeding Disorders)	94	Miscellaneous Medical Supplies, Devices, Non-Drug (Miscellaneous)	I55-I64
Colony Stimulating Factors (Cancer)	94	Muscle Relaxants (Pain Relief and Inflammatory Disease)	I64, I65
Contraceptives (Contraception Products)	94-96	Prenatal Vitamins (Nutritional/Dietary)	I65-I69
Cough/Cold Preparations (Allergy/Nasal Sprays)	96	Psychotherapeutic Drugs (Anxiety/Depression/Bipolar Disorder)	I70-I73
Cough/Cold Preparations (Cough/Cold Medications)	96, 97	Psychotherapeutic Drugs (Attention Deficit Hyperactivity Disorder)	I73-I75
Diagnostic (Diabetes)	98	Psychotherapeutic Drugs (Miscellaneous)	I75
Diagnostic (Miscellaneous)	98-100	Psychotherapeutic Drugs (Schizophrenia/Anti-Psychotics)	I75, I76
Diuretics (Diuretics)	100-102	Psychotherapeutic Drugs (Seizure Disorders)	I77
EENT Preps (Allergy/Nasal Sprays)	102	Psychotherapeutic Drugs (Sleep Disorders/Sedatives)	I78
EENT Preps (Ear Medications)	103	Sedative/Hypnotics (Sleep Disorders/Sedatives)	I78, I79
EENT Preps (Eye Conditions)	103-107	Skin Preps (Miscellaneous)	I79
Elect/Caloric/H2O (Cholesterol Medications)	107	Skin Preps (Pain Relief and Inflammatory Disease)	I79, I80
Elect/Caloric/H2O (Dental Products)	108	Skin Preps (Skin Conditions)	I80-I90
Elect/Caloric/H2O (Diabetes)	108-II0	Smoking Deterrents (Smoking Cessation)	I90
Elect/Caloric/H2O (Miscellaneous)	II0	Thyroid Prep (Hormonal Agents)	I90, I91
Elect/Caloric/H2O (Nutritional/Dietary)	II0-II7		
Elect/Caloric/H2O (Urinary Tract Conditions)	II7		

Information about this drug list

How to find your medication (cont.)

Condition	Page	Condition	Page
Unclassified Drug Products (AIDS/HIV)	191	Unclassified Drug Products (Nutritional/Dietary)	199
Unclassified Drug Products (Asthma/COPD/Respiratory)	191, 192	Unclassified Drug Products (Osteoporosis Products)	199, 200
Unclassified Drug Products (Blood Modifiers/Bleeding Disorders)	192	Unclassified Drug Products (Pain Relief and Inflammatory Disease)	200
Unclassified Drug Products (Blood Pressure/Heart Medications)	192	Unclassified Drug Products (Seizure Disorders)	200
Unclassified Drug Products (Cancer)	193	Unclassified Drug Products (Skin Conditions)	200
Unclassified Drug Products (Dental Products)	193	Unclassified Drug Products (Substance Abuse)	201
Unclassified Drug Products (Erectile Dysfunction)	193, 194	Unclassified Drug Products (Transplant Medications)	201
Unclassified Drug Products (Eye Conditions)	194	Unclassified Drug Products (Urinary Tract Conditions)	201, 202
Unclassified Drug Products (Gastrointestinal/Heartburn)	194, 195	Unclassified Drug Products (Weight Management)	202
Unclassified Drug Products (Hormonal Agents)	195	Vitamins (Nutritional/Dietary)	202-244
Unclassified Drug Products (Miscellaneous)	195-199	Vitamins (Vitamins)	244, 245

List of Prescription Medications

ANALGESICS (Pain Relief and Inflammatory Disease)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ANALGESICS, NON-OPIOID		
JOURNAVX	T3	QL (30 tabs/90 days)
ANALGESIC, NON-SALICYLATE AND BARBITURATE COMBINAT		
ALLZITAL	T3	PA
butalbital/acetaminophen	T1	
butalbital/acetaminophen (Bupap)	T1	
ANALGESIC, SALICYLATE, BARBITURATE, XANTHINE COMB.		
butalbital/aspirin/caffeine	T1	
ANALGESIC, NON-SALICYLATE, BARBITURATE, XANTHINE COMB.		
butalb/acetaminophen/caffeine	T1	
butalb/acetaminophen/caffeine (Esgic)	T1	
butalb/acetaminophen/caffeine (Fioricet)	T1	
ESGIC (butalb/acetaminophen/caffeine)	T3	PA
FIORICET (butalb/acetaminophen/caffeine)	T3	PA
ANALGESIC/ANTIPYRETICS, SALICYLATES		
choline salicyl/mag salicylate	T1	HD
diflunisal	T1	HD
ANTIMIGRAINE PREPARATIONS		
AIMOVIG AUTOINJECTOR	T2	PA QL (1 auto-inj/30 days)
AJOVY 225 MG/1.5 ML AUTOINJECT	T2	PA QL (1 auto-inj/30 days)
AJOVY 225 MG/1.5 ML AUTOINJECT	T2	PA QL (3 auto-injs/90 days)
AJOVY SYRINGE	T2	PA QL (1 syringe/30 days)
almotriptan malate 12.5 mg tab	T1	ST QL (12 tabs/30 days)
almotriptan malate 6.25 mg tab	T1	ST QL (6 tabs/30 days)
AMERGE (naratriptan hcl)	T3	ST QL (9 tabs/fill)
CAMBIA	T3	ST QL (9 packs/fill)
DICLOFENAC POT 50 MG POWDR PKT	T1	ST QL (9 pkts/30 days)
dihydroergotamine 1 mg/ml amp	T1	
dihydroergotamine 4 mg/ml spry (Migranal)	T1	ST QL (8 mls/fill)
eletriptan hydrobromide (Relpax)	T1	QL (6 tabs/fill)
EMGALITY 120 MG/ML SYRINGE	T2	PA QL (1 syringe/30 days)
EMGALITY PEN	T2	PA QL (1 pen/30 days)
ERGOMAR	T3	
ergotamine tartrate/caffeine	T1	
FROVA (frovatriptan succinate)	T3	ST QL (9 tabs/fill)

T1 – Generics

T2 – Preferred Brands

T3 – Non-Preferred Brands

T4 – Brand Specialty

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
ANTIMIGRAINE PREPARATIONS (cont.)		
frovatriptan succinate (Frova)	T1	ST QL (9 tabs/30 days)
MIGRAL (dihydroergotamine mesylate)	T3	ST QL (8 mls/fill)
naratriptan hcl (Amerge)	T1	QL (9 tabs/fill)
NURTEC ODT	T2	PA QL (16 tabs/fill)
QULIPTA	T2	PA QL (30 tabs/30 days)
REYVOW 100MG TABLET	T3	PA QL (8 tabs/treatment)
rizatriptan benzoate (Maxalt)	T1	QL (18 tabs/fill)
sumatriptan	T1	QL (6 units/30 days)
sumatriptan (Imitrex)	T1	QL (6 units/fill)
sumatriptan 4 mg/0.5 ml inject (Imitrex)	T1	QL (2 pens/fill)
sumatriptan 6 mg/0.5 ml cart (Imitrex)	T1	QL (1 ml/fill)
sumatriptan 6 mg/0.5 ml inject (Imitrex)	T1	QL (2 pens/fill)
sumatriptan 6 mg/0.5 ml vial	T1	QL (2 vials/fill)
TOSYMRA	T3	ST QL (6 units/fill)
UBRELVY 50MG TABLET	T2	PA QL (10 tabs/treatment)
UBRELVY 100MG TABLET	T2	PA QL (10 tabs/treatment)
ZEMBRACE SYMTOUCH	T3	ST QL (4 pens/fill)
zolmitriptan	T1	QL (6 tabs/30 days)
zolmitriptan (Zomig Zmt)	T1	QL (6 tabs/fill)
zolmitriptan 5 mg nasal spray (Zomig)	T1	ST QL (6 units/fill)
zolmitriptan 2.5 mg tablet (Zomig)	T1	QL (6 tabs/fill)
zolmitriptan 5 mg tablet (Zomig)	T1	QL (6 tabs/fill)
ZOLMITRIPTAN 2.5MG NASAL SPRAY	T3	ST QL (6 units/30 days)
ZOMIG 2.5 MG NASAL SPRAY	T2	ST QL (6 units/30 days)
ZOMIG 5 MG NASAL SPRAY (zolmitriptan)	T3	ST QL (6 units/fill)
NASAL NSAIDS, COX NON-SELECTIVE, SYSTEMIC ANALGESIC		
SPRIX	T3	ST QL (5 units/fill)
NSAIDS, CYCLOOXYGENASE INHIBITOR - TYPE ANALGESICS		
diclofenac pot 25mg tablet	T1	ST HD
diclofenac pot 50 mg tablet	T1	HD
diclofenac potassium	T1	HD
diclofenac potassium	T1	ST HD
diclofenac potassium 25 mg cap (Zipsor)	T1	ST HD
ketorolac 10 mg tablet	T1	QL (20 tabs/fill)

T1 – Generics

T2 – Preferred Brands

T3 – Non-Preferred Brands

T4 – Brand Specialty

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
NSAIDS, CYCLOOXYGENASE INHIBITOR - TYPE ANALGESICS (cont.)		
ketorolac 15 mg/ml carpuject	T1	HD
ketorolac 15 mg/ml syr	T1	HD
ketorolac 15 mg/ml syringe	T1	
ketorolac 15 mg/ml vial	T1	
ketorolac 30 mg/ml syr	T1	HD
ketorolac 30 mg/ml syringe	T1	
ketorolac 30 mg/ml vial	T1	
ketorolac 300 mg/10 ml vial	T1	
ketorolac 60 mg/2 ml syringe	T1	
ketorolac 60 mg/2 ml vial	T1	
mefenamic acid	T1	HD
OPIOID ANALGESIC AND NON-SALICYLATE ANALGESICS		
acetaminophen with codeine	T1	PA QL
hydrocodone-acetamin 10-300 mg	T1	PA QL
hydrocodone-acetamin 10-300/15	T1	PA QL (12 ds/60 days)
hydrocodone-acetamin 10-325 mg	T1	PA QL
hydrocodone-acetamin 10-325/15	T1	PA QL
HYDROCODONE-ACETAMIN 2.5-108/5	T3	PA QL
hydrocodone-acetamin 2.5-325	T1	PA QL (12 ds/60 days)
HYDROCODONE-ACETAMIN 5-217/10	T3	PA QL
hydrocodone-acetamin 5-300 mg	T1	PA QL
hydrocodone-acetamin 5-325 mg	T1	PA QL
hydrocodone-acetamin 7.5-300	T1	PA QL
hydrocodone-acetamin 7.5-325/15	T1	PA QL
HYDROCODONE-ACETAMIN 7.5-325/15	T3	PA QL
LORTAB	T3	PA QL
NALOCET	T3	PA QL
oxycodone hcl/acetaminophen	T1	PA QL
prolate 10-300 mg tablet	T1	PA QL
prolate 5-300 mg tablet	T1	PA QL
prolate 7.5-300 mg tablet	T1	PA QL
tramadol hcl/acetaminophen	T1	PA QL (12 ds/60 days)
OPIOID ANALGESIC AND NSAID COMBINATION		
hydrocodone(ibuprofen	T1	PA

T1 – Generics

T2 – Preferred Brands

T3 – Non-Preferred Brands

T4 – Brand Specialty

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
OPIOID ANALGESIC, NON-SALICYLATE, XANTHINE COMB		
acetaminophen/caff/dihydrocod	T1	PA QL
TREZIX	T3	PA QL
OPIOID ANALGESICS		
ABSTRAL	T3	PA QL
ACTIQ (fentanyl citrate)	T3	PA QL
BELBUCA	T2	PA QL (60 films/30 days)
buprenorphine (Butrans)	T1	PA
butorphanol	T1	PA QL (12 ds/180 days)
codeine sulfate	T1	PA QL
DILAUDID (hydromorphone hcl)	T3	PA QL
fentanyl	T1	PA QL (15 patches/30 days)
fentanyl cit oftc 1,200 mcg	T1	PA QL (90 lozs/30 days)
fentanyl cit oftc 1,600 mcg (Actiq)	T1	PA QL
fentanyl citrate oftc 200 mcg	T1	PA QL (90 lozs/30 days)
fentanyl citrate oftc 400 mcg	T1	PA QL (90 lozs/30 days)
fentanyl citrate oftc 600 mcg	T1	PA QL (90 lozs/30 days)
fentanyl citrate oftc 800 mcg	T1	PA QL (90 lozs/30 days)
hydrocodone er 10 mg capsule	T1	PA QL (90 caps/30 days)
hydrocodone er 100 mg tablet (Hysingla Er)	T1	PA QL (60 tabs/30 days)
hydrocodone er 120 mg tablet (Hysingla Er)	T1	PA QL (60 tabs/30 days)
hydrocodone er 15 mg capsule	T1	PA QL (90 caps/30 days)
hydrocodone er 20 mg capsule	T1	PA QL (90 caps/30 days)
hydrocodone er 20 mg tablet (Hysingla Er)	T1	PA QL (60 tabs/30 days)
hydrocodone er 30 mg capsule	T1	PA QL (90 caps/30 days)
hydrocodone er 30 mg tablet (Hysingla Er)	T1	PA QL (60 tabs/30 days)
hydrocodone er 40 mg capsule	T1	PA QL (90 caps/30 days)
hydrocodone er 40 mg tablet (Hysingla Er)	T1	PA QL (60 tabs/30 days)
hydrocodone er 50 mg capsule	T1	PA QL (90 caps/30 days)
hydrocodone er 60 mg tablet (Hysingla Er)	T1	PA QL (60 tabs/30 days)
hydrocodone er 80 mg tablet (Hysingla Er)	T1	PA QL (60 tabs/30 days)
hydromorphone hcl	T1	PA QL
hydromorphone hcl	T1	PA QL (60 tabs/30 days)
hydromorphone hcl (Dilauidid)	T1	PA QL
HYSINGLA ER (hydrocodone bitartrate)	T2	PA QL (60 tabs/30 days)

T1 – Generics

T2 – Preferred Brands

T3 – Non-Preferred Brands

T4 – Brand Specialty

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
OPIOID ANALGESICS (cont.)		
KADIAN	T3	ST QL (90 caps/30 days)
KADIAN (morphine sulfate)	T3	ST QL (90 caps/30 days)
LAZANDA 100 MCG NASAL SPRAY	T3	PA QL (23 units/30 days)
LAZANDA 400 MCG NASAL SPRAY	T3	PA QL (23 units/30 days)
<i>methadone hcl</i>	T1	
<i>morphine sulfate 100 mg tablet (Ms Contin)</i>	T1	PA QL (120 tabs/30 days)
<i>morphine sulfate 15 mg tablet (Ms Contin)</i>	T1	PA QL (120 tabs/30 days)
<i>morphine sulfate 200 mg tablet (Ms Contin)</i>	T1	PA QL (120 tabs/30 days)
<i>morphine sulfate 30 mg tablet (Ms Contin)</i>	T1	PA QL (120 tabs/30 days)
<i>morphine sulfate 60 mg tablet (Ms Contin)</i>	T1	PA QL (120 tabs/30 days)
<i>morphine sulfate er 10 mg cap (Kadian)</i>	T1	ST QL (90 caps/30 days)
<i>morphine sulfate er 100 mg cap (Kadian)</i>	T1	ST QL (90 caps/30 days)
<i>morphine sulfate er 120 mg cap</i>	T1	PA QL (60 caps/30 days)
<i>morphine sulfate er 20 mg cap</i>	T1	PA QL (90 caps/30 days)
<i>morphine sulfate er 30 mg cap</i>	T1	PA QL (60 caps/30 days)
<i>morphine sulfate er 30 mg cap</i>	T1	PA QL (90 caps/30 days)
<i>morphine sulfate er 45 mg cap</i>	T1	PA QL (60 caps/30 days)
<i>morphine sulfate er 50 mg cap</i>	T1	PA QL (90 caps/30 days)
<i>morphine sulfate er 50 mg cap (Kadian)</i>	T1	ST QL (90 caps/30 days)
<i>morphine sulfate er 60 mg cap</i>	T1	PA QL (60 caps/30 days)
<i>morphine sulfate er 60 mg cap</i>	T1	PA QL (90 caps/30 days)
<i>morphine sulfate er 75 mg cap</i>	T1	PA QL (60 caps/30 days)
<i>morphine sulfate er 80 mg cap</i>	T1	PA QL (90 caps/30 days)
<i>morphine sulfate er 80 mg cap (Kadian)</i>	T1	ST QL (90 caps/30 days)
<i>morphine sulfate er 90 mg cap</i>	T1	PA QL (60 caps/30 days)
MS CONTIN (morphine sulfate)	T3	PA QL (120 tabs/30 days)
<i>opium/belladonna alkaloids</i>	T1	PA QL
<i>oxycodone hcl (ir) 5 mg cap</i>	T1	PA QL (12 ds/60 days)
<i>oxycodone hcl 100 mg/5 ml conc</i>	T1	PA QL (12 ds/60 days)
<i>oxycodone hcl 5 mg/5 ml cup</i>	T1	PA QL (12 ds/60 days)
<i>oxycodone hcl 5 mg/5 ml soln</i>	T1	PA QL (12 ds/60 days)
<i>oxycodone hcl (ir) 10 mg tab</i>	T1	PA QL (12 ds/60 days)
<i>oxycodone hcl (ir) 15 mg tab (Roxicodone)</i>	T1	PA QL (12 ds/60 days)

T1 – Generics

T2 – Preferred Brands

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List of Prescription Medications

ANALGESICS (Pain Relief and Inflammatory Disease) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
OPIOID ANALGESICS (cont.)		
oxycodone hcl (ir) 20 mg tab	T1	PA QL (12 ds/60 days)
oxycodone hcl (ir) 30 mg tab (Roxicodone)	T1	PA QL (12 ds/60 days)
oxycodone hcl (ir) 5 mg tablet (Roxicodone)	T1	PA QL (12 ds/60 days)
OXYCONTIN	T2	PA QL (90 tabs/30 days)
oxymorphone hcl	T1	PA QL (90 tabs/30 days)
pentazocine hcl/naloxone hcl	T1	PA QL
ROXICODONE (oxycodone hcl)	T3	PA QL
SUBSYS	T3	PA QL (90 units/30 days)
tramadol 100 mg tablet	T1	PA QL (12 ds/60 days)
tramadol er 100 mg tablet	T1	PA QL (30 tabs/30 days)
tramadol er 200 mg tablet	T1	PA QL (30 tabs/30 days)
tramadol er 300 mg tablet	T1	PA QL (30 tabs/30 days)
tramadol hcl er 100 mg tablet	T1	PA QL (30 tabs/30 days)
tramadol hcl er 200 mg tablet	T1	PA QL (30 tabs/30 days)
tramadol hcl er 300 mg tablet	T1	PA QL (30 tabs/30 days)
OPIOID AND SALICYLATE ANALGESICS, BARBIT, XANTHINE		
codeine/butalbital/asa/caffein	T1	PA QL
OPIOID, NON-SALICYL ANALGESIC, BARBITURATE, XANTHINE		
butalbit/acetamin/caff/codeine	T1	PA QL
butalbit/acetamin/caff/codeine (Fioricet With Codeine)	T1	PA QL
FIORICET WITH CODEINE (butalbit/acetamin/caff/codeine)	T3	PA QL
SKELETAL MUSCLE RELAXANT, SALICYLAT, OPIOID ANALGESC		
carisoprodol/aspirin/codeine	T1	PA QL
ANALGESICS (Urinary Tract Conditions)		
URINARY TRACT ANALGESIC AGENTS		
ELMIRON	T2	
RIMSO-50	T3	
ANALGESICS (Miscellaneous)		
GENERAL ANESTHETICS, INHALANT		
desflurane	T1	
isoflurane	T1	
sevoflurane (Ultane)	T1	
SUPRANE	T3	

T1 – Generics

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List of Prescription Medications

ANALGESICS (Miscellaneous) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
GENERAL ANESTHETICS, INHALANT (cont.)		
ULTANE (<i>sevoflurane</i>)	T3	
ANESTHETICS (Pain Relief And Inflammatory Disease)		
LOCAL ANESTHETICS		
<i>lidocaine hcl</i>	T1	QL (60 mls/30 days)
<i>lidocaine hcl</i>	T1	
<i>lidocaine hcl 2% jel urojet ac</i>	T1	QL (60 mls/30 days)
<i>lidocaine hcl 2% jelly uro-jet</i>	T1	QL (60 mls/30 days)
<i>lidocaine hcl 4% solution</i>	T1	
TOPICAL LOCAL ANESTHETICS		
CETACAIN ANESTHETIC	T3	
L.E.T. (LIDO-EPINEPH-TETRA)	T3	
<i>lidocaine 5% ointment</i>	T1	QL (50 gms/28 days)
<i>lidocaine 5% patch (Lidocan li)</i>	T1	PA
<i>lidocaine 5% patch (Lidoderm)</i>	T1	PA
<i>lidocaine (Lidocan li)</i>	T1	PA
<i>lidocaine hcl</i>	T1	
<i>lidocaine hcl 4% solution</i>	T1	
LIDOCAN II (<i>lidocaine</i>)	T3	PA
<i>lidocaine-prilocaine cream</i>	T1	QL (30 gms/30 days)
<i>lidocaine-prilocaine cream</i>	T1	
LIDOCAIN-EPINEPHRIN-TETRACAIN	T3	
SYNERA	T3	
ZTLIDO	T2	PA
ANESTHETICS (Urinary Tract Conditions)		
URINARY TRACT ANESTHETIC/ANALGESIC AGNT (AZO-DYE)		
<i>phenazopyridine hcl</i> (Pyridium)	T1	
ANTI-ALLERGY (Allergy/Nasal Sprays)		
MAST CELL STABILIZERS		
<i>cromolyn 100 mg/5 ml oral conc</i> (Gastrocrom)	T1	
GASTROCROM (<i>cromolyn sodium</i>)	T3	

T1 – Generics

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List of Prescription Medications

ANTI-ARTHRITICS (Pain Relief And Inflammatory Disease)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ANALGESIC/ANTIPYRETICS, SALICYLATES		
DISALCID (<i>salsalate</i>)	T3	HD
<i>salsalate</i> (Disalcid)	T1	HD
ANTI-ARTHRITIC AND CHELATING AGENTS		
DEPEN (penicillamine)	T4	PA SP
<i>penicillamine</i> (Cuprimine)	T1	PA SP
<i>penicillamine</i> (Depen)	T1	PA SP
ANTI-ARTHRITIC, FOLATE ANTAGONIST AGENTS		
RASUVO	T2	ST
ANTI-INFLAMMATORY, PYRIMIDINE SYNTHESIS INHIBITOR		
ARAVA (<i>leflunomide</i>)	T3	QL (30 tabs/fill) HD
<i>leflunomide</i> (Arava)	T1	QL (30 tabs/fill) HD
ANTI-INFLAMMATORY, PHOSPHODIESTERASE-4(PDE4) INHIB.		
OTEZLA 10-20 MG STARTER 28 DAY	T4	PA QL (55 tabs/365 days) SP HD
OTEZLA 10-20-30MG START 28 DAY	T4	PA QL (55 tabs/365 days) SP HD
OTEZLA 20 MG TABLET	T4	PA QL (60 tabs/30 days) SP HD
OTEZLA 30 MG TABLET	T4	PA QL (60 tabs/30 days) SP HD
COLCHICINE		
<i>colchicine</i> 0.6 mg capsule (Mitigare)	T1	ST
<i>colchicine</i> 0.6 mg tablet (Colcrys)	T1	HD
GLOPERBA	T3	HD
MITIGARE (<i>colchicine</i>)	T2	ST HD
GOLD SALTS		
AURANOFIN	T2	
RIDAURA	T2	
HYPURICEMIA TX - XANTHINE OXIDASE INHIBITORS		
<i>allopurinol</i>	T1	HD
<i>allopurinol</i> (Zyloprim)	T1	HD
<i>febuxostat</i> (Uloric)	T1	ST HD
ZYLOPRIM (<i>allopurinol</i>)	T3	HD
JANUS KINASE (JAK) INHIBITORS		
RINVOQ ER 15 MG TABLET	T4	PA QL (30 tabs/fill) SP HD
RINVOQ ER 30 MG TABLET	T4	PA QL (30 tabs/fill) SP HD
RINVOQ ER 45 MG TABLET	T4	PA QL (56 tabs/365 days) SP HD
RINVOQ LQ	T4	PA QL (360 mls/30 days) SP HD

T1 – Generics

T2 – Preferred Brands

T3 – Non-Preferred Brands

T4 – Brand Specialty

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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
JANUS KINASE (JAK) INHIBITORS (CONT.)		
XELJANZ 1 MG/ML SOLUTION	T4	PA QL (300 mls/fill) SP HD
XELJANZ 10 MG TABLET	T4	PA QL (60 tabs/fill) SP HD
XELJANZ 5 MG TABLET	T4	PA QL (60 tabs/fill) SP HD
XELJANZ XR	T4	PA QL (30 tabs/fill) SP HD
NSAID AND TOPICAL IRRITANT COUNTER-IRRITANT COMB.		
COMFORT PAC-IBUPROFEN	T3	
COMFORT PAC-MELOXICAM	T3	
COMFORT PAC-NAPROXEN	T3	
NSAIDS(COX NON-SPEC.INHIB)AND PROSTAGLANDIN ANALOG		
ARTHROTEC 50 (<i>diclofenac sodium/misoprostol</i>)	T3	ST HD
ARTHROTEC 75 (<i>diclofenac sodium/misoprostol</i>)	T3	ST HD
<i>diclofenac sodium/misoprostol</i> (Arthrotec 50)	T1	HD
<i>diclofenac sodium/misoprostol</i> (Arthrotec 75)	T1	HD
NSAIDS, CYCLOOXYGENASE INHIBITOR - TYPE ANALGESICS		
ANAPROX DS (<i>naproxen sodium</i>)	T3	ST HD
DAYPRO (oxaprozin)	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>ec-naproxen dr 375 mg tablet</i> (Ec-Naprosyn)	T1	HD
<i>ec-naproxen dr 500 mg tablet</i> (Ec-Naprosyn)	T1	ST HD
<i>etodolac</i>	T1	HD
<i>etodolac</i> (Lodine)	T1	HD
FELDENE (<i>piroxicam</i>)	T3	ST HD
<i>fenoprofen 400 mg capsule</i> (Nalfon)	T1	ST HD
<i>fenoprofen 600 mg tablet</i> (Nalfon)	T1	ST HD
FENORTHO 200 MG CAPSULE	T3	ST HD
<i>flurbiprofen</i>	T1	HD
<i>ibuprofen</i>	T1	HD

T1 – Generics

T2 – Preferred Brands

T3 – Non-Preferred Brands

T4 – Brand Specialty

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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
NSAIDS, CYCLOOXYGENASE INHIBITOR - TYPE ANALGESICS (cont.)		
<i>ibuprofen</i>	T1	HD
<i>indomethacin</i>	T1	HD
INDOMETHACIN 20 MG CAPSULE	T3	ST QL (90 caps/30 days) HD
<i>indomethacin 25 mg capsule</i>	T1	HD
<i>indomethacin 50 mg capsule</i>	T1	HD
<i>indomethacin 50 mg suppository (Indocin)</i>	T1	HD
<i>indomethacin 25 mg/5 ml susp (Indocin)</i>	T1	ST HD
<i>ketoprofen</i>	T1	ST HD
<i>ketoprofen 25 mg capsule</i>	T1	ST HD
<i>ketoprofen 50 mg capsule</i>	T1	HD
<i>ketoprofen 75 mg capsule</i>	T1	HD
<i>ketoprofen er 200 mg capsule</i>	T1	ST HD
LODINE (etodolac)	T3	ST HD
<i>meclofenamate sodium</i>	T1	HD
<i>meloxicam 5 mg capsule (Vivlodex)</i>	T1	ST QL (30 caps/fill) HD
<i>meloxicam 10 mg capsule (Vivlodex)</i>	T1	ST QL (30 caps/fill) HD
MOBIC (meloxicam)	T3	ST QL (30 tabs/fill) HD
<i>nabumetone (Relafen)</i>	T1	HD
NALFON 600 MG TABLET (<i>fenoprofen calcium</i>)	T3	ST HD
NAPRELAN	T3	ST HD
NAPRELAN (<i>naproxen sodium</i>)	T3	ST HD
NAPROSYN (<i>naproxen</i>)	T3	ST HD
<i>naproxen (Ec-Naprosyn)</i>	T1	HD
<i>naproxen 125 mg/5 ml suspen (Naprosyn)</i>	T1	ST HD
<i>naproxen 250 mg tablet</i>	T1	HD
<i>naproxen 375 mg tablet</i>	T1	HD
<i>naproxen 500 mg kit (Naprosyn)</i>	T1	HD
<i>naproxen 500 mg tablet (Naprosyn)</i>	T1	HD
<i>naproxen dr 375 mg tablet (Ec-Naprosyn)</i>	T1	HD
<i>naproxen dr 500 mg tablet (Ec-Naprosyn)</i>	T1	ST HD
<i>naproxen er 750mg tablet</i>	T1	ST HD
<i>naproxen sodium</i>	T1	ST HD
<i>naproxen sodium</i>	T1	HD
<i>naproxen sodium (Anaprox Ds)</i>	T1	HD

T1 – Generics

T2 – Preferred Brands

T3 – Non-Preferred Brands

T4 – Brand Specialty

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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
NSAIDS, CYCLOOXYGENASE INHIBITOR - TYPE ANALGESICS (cont.)		
naproxen sodium (Naprelan)	T1	ST HD
oxaprozin 600 mg caplet (Daypro)	T1	HD
oxaprozin 600 mg tablet (Daypro)	T1	HD
piroxicam	T1	HD
piroxicam (Feldene)	T1	HD
RELAFEN (nabumetone)	T3	ST HD
sulindac	T1	HD
TIVORBEX	T3	ST QL (90 caps/30 days) HD
TOLECTIN 600 (tolmetin sodium)	T3	ST HD
tolmetin sodium 200 mg tab	T1	HD
tolmetin sodium 400 mg cap	T1	ST HD
tolmetin sodium 600 mg tab (Tolectin 600)	T1	ST HD
NSAIDS, CYCLOOXYGENASE-2(COX-2) SELECTIVE INHIBITOR		
celecoxib (Celebrex)	T1	HD
URICOSURIC AGENTS		
probenecid	T1	HD
probenecid/colchicine	T1	HD
ANTIASTHMATICS (Asthma/COPD/Respiratory)		
ANTICHOLINERGICS, ORALLY INHALED LONG ACTING		
INCRUSE ELLIPTA	T2	QL (1 inhaler/30 days) HD
LONHALA MAGNAIR REFILL	T3	QL (60 mls/fill) HD
LONHALA MAGNAIR STARTER	T3	QL (60 mls/fill) HD
SPIRIVA HANDIHALER 18 MCG CAP (tiotropium bromide)	T3	QL (90 caps/30 days) HD
SPIRIVA RESPIMAT	T2	QL (1 inhaler/fill) HD
YUPELRI	T2	QL (30 vls/fill) HD
ANTICHOLINERGICS, ORALLY INHALED SHORT ACTING		
ATROVENT HFA	T3	QL (2 inhalers/fill) HD
ipratropium br 0.02% soln	T1	HD
BETA-ADRENERGIC AGENTS		
albuterol 2 mg/5 ml syrup cup	T1	HD
albuterol 8 mg/20 ml syrup cup	T1	HD
albuterol sulf 2 mg/5 ml syrup	T1	HD
albuterol sulfate 2 mg tab	T1	HD
albuterol sulfate 4 mg tab	T1	HD

T1 – Generics

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List of Prescription Medications

ANTI-ASTHMATICS (Asthma/COPD/Respiratory) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
BETA-ADRENERGIC AGENTS (cont.)		
albuterol sulfate er 4 mg tab	T1	HD
albuterol sulfate er 8 mg tab	T1	HD
metaproterenol sulfate	T1	HD
terbutaline sulfate	T1	HD
BETA-ADRENERGIC AGENTS, INHALED, SHORT ACTING		
albuterol 2.5 mg/0.5 ml sol	T1	
albuterol 100 mg/20 ml soln	T1	
albuterol 5 mg/ml solution	T1	
albuterol 15 mg/3 ml solution	T1	
albuterol 75 mg/15 ml soln	T1	
albuterol hfa 90 mcg inhaler	T1	QL (2 inhalers/30 days)
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	
levalbuterol hcl (Xopenex Concentrate)	T1	
levalbuterol hcl (Xopenex)	T1	
XOPENEX (levalbuterol hcl)	T3	
XOPENEX CONCENTRATE (levalbuterol hcl)	T3	
BETA-ADRENERGIC AGENTS, INHALED, ULTRA-LONG ACTING		
STRIVERDI RESPIMAT	T2	QL (1 inhaler/30 days) HD
BETA-ADRENERGIC AGENTS, ORALLY INHALED, LONG ACTING		
arformoterol tartrate (Brovana)	T1	QL (120 mls/fill) HD
BROVANA (arformoterol tartrate)	T3	QL (120 mls/fill) HD
FORMOTEROL FUMARATE-NEBULIZER	T2	QL (120 mls/30 days) HD
formoterol fumarate (Performist)	T1	QL (120 mls/fill) HD
BETA-ADRENERGIC AND ANTICHOLINERGIC COMBO, INHALED		
ANORO ELLIPTA	T2	QL (1 inhaler/fill) HD
COMBIVENT INHALER	T2	
COMBIVENT RESPIMAT	T2	QL (2 inhalers/30 days)
SEEBRI NEOHALER 15.6MCG INHALER	T3	HD
UTIBRON NEOHALER 27.5, 15.6MCG (PS 6)	T3	HD
UTIBRON NEOHALER 27.5, 15.6 MCG (PS 60)	T3	HD
STIOLTO RESPIMAT	T2	QL (1 inhaler/fill) HD

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List of Prescription Medications

ANTI-ASTHMATICS (Asthma/COPD/Respiratory) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
BETA-ADRENERGIC AND GLUCOCORTICOID COMBO, INHALED		
ADVAIR HFA	T2	PA QL (1 inhaler/fill) HD
AIRDUO DIGITALER	T3	PA QL (1 inhaler/fill) HD
AIRSUPRA	T2	HD
BREO ELLIPTA 50-25 MCG INHALER	T2	PA QL (60 blisters/fill) HD
BREO ELLIPTA 100-25 MCG INH	T2	PA QL (60 blisters/fill) HD
BREO ELLIPTA 100-25 MCG INH	T2	PA QL (28 blisters/fill) HD
BREO ELLIPTA 200-25 MCG INH	T2	PA QL (1 inhaler/fill) HD
<i>breyna 80-4.mcg, 160-4.5 mcg inhaler</i>	T1	PA
<i>budesonide-formoterol 160-4.5, 80-4.5</i>	T1	PA HD QL (1 inhaler/30 days)
DULERA 100 MCG-5 MCG INHALER	T2	PA QL (1 inhaler/fill) HD
DULERA 200 MCG-5 MCG INHALER	T2	PA QL (1 inhaler/fill) HD
DULERA 50 MCG-5 MCG INHALER	T2	PA QL (13 gms/fill) HD
<i>fluticasone propionate/salmeterol (Advair Diskus)</i>	T1	PA QL (1 inhaler/30 days)
<i>fluticasone-salmeterol 100-50 (Advair Diskus)</i>	T1	PA QL (1 inhaler/fill) HD
<i>fluticasone-salmeterol 250-50 (Advair Diskus)</i>	T1	PA QL (1 inhaler/fill) HD
<i>fluticasone-salmeterol 500-50 (Advair Diskus)</i>	T1	PA QL (1 inhaler/fill) HD
SYMBICORT (budesonide/formoterol fumarate)	T3	PA QL (1 inhaler/30 days)HD
BETA-ADRENERGIC-ANTICHOLINERGIC-GLUCOCORT, INHALED		
BREZTRI AEROSPHERE	T2	QL (1 inhaler/fill)
TRELEGY ELLIPTA 100-62.5-25	T2	QL (60 blisters/fill)
TRELEGY ELLIPTA 100-62.5-25	T2	QL (28 blisters/fill)
TRELEGY ELLIPTA 200-62.5-25	T2	QL (60 blisters/fill)
TRELEGY ELLIPTA 200-62.5-25	T2	QL (28 blisters/fill)
GLUCOCORTICOIDS, ORALLY INHALED		
ALVESCO 160 MCG INHALER	T3	QL (2 inhalers/fill) HD
ALVESCO 80 MCG INHALER	T3	QL (1 inhaler/fill) HD
ARNUITY ELLIPTA 100 MCG INH	T2	QL (1 inhaler/30 days)
ARNUITY ELLIPTA 200 MCG INH	T2	QL (1 inhaler/30 days)
ARNUITY ELLIPTA 50 MCG INH	T2	QL (30 blisters/30 days)
ASMANEX	T2	QL (1 inhaler/fill) HD
ASMANEX HFA 100 MCG INHALER	T2	QL (1 inhaler/fill) HD
ASMANEX HFA 200 MCG INHALER	T2	QL (1 inhaler/fill) HD
ASMANEX HFA 50 MCG INHALER	T2	QL (13 gms/fill) HD
<i>budesonide 1 mg/2 ml inh susp (Pulmicort)</i>	T1	QL (60 mls/fill) HD

T1 – Generics

T2 – Preferred Brands

T3 – Non-Preferred Brands

T4 – Brand Specialty

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-ASTHMATICS (Asthma/COPD/Respiratory) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
GLUCOCORTICOIDS, ORALLY INHALED (cont.)		
FLOVENT 50 MCG, 100 MCG DISKUS	T2	QL (1 inhaler/fill) HD
FLOVENT 250 MCG DISKUS	T2	QL (4 inhalers/fill) HD
FLOVENT HFA 110 MCG INHALER	T2	QL (12 gms/fill) HD
FLOVENT HFA 220 MCG INHALER	T2	QL (24 gms/fill) HD
FLOVENT HFA 44 MCG INHALER	T2	QL (11 gms/fill) HD
QVAR REDIHALER 40 MCG	T2	QL (11 gms/30 days)
QVAR REDIHALER 80 MCG	T2	QL (22 gms/30 days)
INTERLEUKIN-5 (IL-5) ANTAGONISTS, MAB		
NUCALA 100 MG/ML AUTO-INJECTOR	T4	PA QL (1 auto-inj/28 days) SP HD
NUCALA 100 MG/ML SYRINGE	T4	PA QL (1 syringe/28 days) SP HD
NUCALA 40 MG/0.4 ML SYRINGE	T4	PA QL (1 syringe/28 days) SP HD
INTERLEUKIN-5(IL-5) RECEPTOR ALPHA ANTAGONIST, MAB		
FASENRA PEN	T4	PA QL (1 syringe/56 days) SP HD
LEUKOTRIENE RECEPTOR ANTAGONISTS		
ACCOLATE (zaflurkast)	T3	HD
montelukast sodium (Singulair)	T1	HD
zaflurkast (Accolate)	T1	HD
MAST CELL STABILIZERS, ORALLY INHALED		
cromolyn 20 mg/2 ml neb soln	T1	HD
MONOCLONAL ANTIBODIES TO IMMUNOGLOBULIN E (IGE)		
XOLAIR 300 MG/2 ML AUTOINJECT	T4	PA QL (2 auto-injs/28 days) SP HD
XOLAIR 75 MG/0.5 ML AUTOINJECT	T4	PA QL (2 auto-injs/28 days) SP HD
XOLAIR 150 MG/ML AUTOINJECTOR	T4	PA QL (2 auto-injs/28 days) SP HD
XOLAIR 150 MG/1.2 ML POWDER VL	T4	PA QL (6 vls/28 days) SP HD
XOLAIR 300 MG/2 ML SYRINGE	T4	PA QL (2 syringes/28 days) SP HD
MUCOLYTICS		
acetylcysteine	T1	
PHOSPHODIESTERASE (PDE) INHIBITORS		
roflumilast 250 mcg tablet (Daliresp)	T1	PA QL (30 tabs/30 days) HD
roflumilast 500 mcg tablet (Daliresp)	T1	PA HD
XANTHINES		
ELIXOPHYLLIN	T3	HD
THEO-24	T3	HD
theophylline anhydrous	T1	HD

T1 – Generics

T2 – Preferred Brands

T3 – Non-Preferred Brands

T4 – Brand Specialty

PA – Prior Authorization

QL – Quantity Limit

ST – Step Therapy

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List of Prescription Medications

ANTIBIOTICS (Ear Medications)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
EAR PREPARATIONS, ANTIBIOTICS		
ciprofloxacin hcl	T1	
CORTISPORIN-TC	T3	
neomycin/polymyxin b/hydrocort	T1	
ofloxacin	T1	
OTIPRIO	T3	QL (1 ml/fill)
OTIC PREPARATIONS, ANTI-INFLAMMATORY-ANTIBIOTICS		
ciprofloxacin hcl/dexameth	T1	
OTOVEL	T3	
ANTIBIOTICS (Eye Conditions)		
EYE ANTIBIOTIC AND GLUCOCORTICOID COMBINATIONS		
GATIFLOXACIN-DEXAMETHASONE	T3	
MAXITROL (neomycin/polymyxin b/dexametha)	T3	
neomycin/bacit/p-myx/hydrocort	T1	
neomycin/polymyxin b/dexametha (Maxitrol)	T1	
neomycin/polymyxin b/hydrocort	T1	
pred ph-moxi-brom 1-0.5-0.075%	T1	
PRED PH-MOXI-BROM 1-0.5-0.075%	T3	
PRED-G	T3	
PREDNISOLONE ACET-GATIFLOXACIN	T3	
PREDNISOLONE ACET-MOXIFLOXACIN	T3	
PREDNISOLONE PHOS-GATIFLOXACIN	T3	
PREDNISOLONE PH-MOXIFLOX-KETOR	T3	
PREDNISOLONE PHOS-MOXIFLOXACIN	T3	
TOBRADEX	T3	
tobramycin/dexamethasone	T1	
EYE ANTIBIOTIC AND NSAID COMBINATIONS		
MOXIFLOXACIN-BROMFENAC	T3	
EYE ANTIBIOTIC, GLUCOCORTICOID AND NSAID COMB.		
PREDNISOLONE ACET-GATIFLO-BROM	T3	
PREDNISOLONE AC-MOXIFLO-BROMF	T3	
PREDNISOLONE AC-MOXIFLO-NEPAF	T3	
PREDNISOLONE PHOS-GATIFLO-BROM	T3	
PREDNISOLONE PHOS-MOXIFLO-BROM	T3	

T1 – Generics

T2 – Preferred Brands

T3 – Non-Preferred Brands

T4 – Brand Specialty

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List of Prescription Medications

ANTIBIOTICS (Eye Conditions) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
EYE SULFONAMIDES		
BLEPH-10 (<i>sulfacetamide sodium</i>)	T3	
BLEPHAMIDE S.O.P.	T3	
<i>sulfacetamide sodium</i>	T1	
<i>sulfacetamide sodium</i> (Bleph-10)	T1	
<i>sulfacetamide/prednisolone sp</i>	T1	
OPHTHALMIC ANTIBIOTICS		
AZASITE	T2	
<i>bacitracin</i>	T1	
<i>bacitracin/polymyxin b sulfate</i>	T1	
CEFURONIME SODIUM-0.9% NACL	T3	PA
CILOXAN 0.3% EYE DROPS (<i>ciprofloxacin hcl</i>)	T3	
<i>ciprofloxacin hcl</i> (Ciloxan)	T1	
<i>erythromycin base</i>	T1	
<i>gatifloxacin</i>	T1	
<i>gentamicin 0.3% eye drop</i>	T1	
<i>gentamicin sulfate</i>	T1	
KLARITY-A(AZITHROMYCIN-CHONDR)	T3	
<i>levofloxacin</i>	T1	
<i>moxifloxacin hcl</i>	T1	
<i>moxifloxacin hcl</i> (Vigamox)	T1	
<i>neomycin/bacitracin/polymyxinb</i>	T1	
<i>neomycin/polymyxn b/gramicidin</i>	T1	
OCUFLOX (<i>ofloxacin</i>)	T3	
<i>ofloxacin</i> (Ocuflor)	T1	
<i>polymyxin b sulf(trimethoprim</i> (Polytrim)	T1	
POLYTRIM (<i>polymyxin b sulf(trimethoprim</i>)	T3	
<i>tobramycin 0.3% eye drop</i> (Tobrex)	T1	
TOBREX	T3	
TOBREX (<i>tobramycin</i>)	T3	
VIGAMOX (<i>moxifloxacin hcl</i>)	T3	
ANTIBIOTICS (Infections)		
2ND GEN. ANAEROBIC ANTIprotozoal-ANTIBACTERIAL		
SOLOSEC	T2	QL (1 pack/fill)

T1 – Generics

T2 – Preferred Brands

T3 – Non-Preferred Brands

T4 – Brand Specialty

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List of Prescription Medications

ANTIBIOTICS (Infections) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
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> (Bactrim Ds)	T1	
<i>sulfamethoxazole/trimethoprim</i> (Bactrim)	T1	
AMINOGLYCOSIDE ANTIBIOTICS		
ARIKAYCE	T4	PA SP
BETHKIS (<i>tobramycin</i>)	T4	PA QL (224 mls/fill) SP HD
gentamicin 80 mg/2 ml vial	T1	PA
<i>gentamicin</i> 800 mg/20 ml vial	T1	PA
<i>gentamicin</i> ped 20 mg/2 ml vial	T1	PA
KITABIS PAK	T4	PA QL (280 mls/fill) SP HD
<i>neomycin sulfate</i>	T1	
TOBI PODHALER	T4	PA QL (224 caps/fill) SP HD
<i>tobramycin</i> 300 mg/4 ml ampule (Bethkis)	T1	PA QL (224 mls/fill) SP HD
<i>tobramycin</i> 300 mg/5 ml ampule (Tobi)	T1	PA QL (280 mls/fill) SP HD
TOBRAMYCIN PAK 300 MG/5 ML	T4	PA QL (280 mls/fill) SP HD
<i>tobramycin sulfate</i>	T1	PA
ANAEROBIC ANTIprotozoal-ANTIBACTERIAL AGENTS		
<i>metronidazole</i> 250 mg tablet	T1	
<i>metronidazole</i> 375 mg capsule	T1	
<i>metronidazole</i> 500 mg tablet	T1	
ANTIBIOTIC, ANTIBACTERIAL, MISC.		
<i>fosfomycin tromethamine</i>	T1	PA
<i>meth/meblue/sod phos/psal/hyos</i>	T1	
<i>methen/mblue/sal/sod phos/hyos</i>	T1	
<i>methenam/m.blue/salicyl/hyosc</i> (Uribel Tabs)	T1	
<i>methenam/sod phos/mblue/hyosc</i>	T1	
<i>methenamine hippurate</i>	T1	
<i>methenamine mandelate</i>	T1	
PRIMSOL	T3	
<i>trimethoprim</i>	T1	
TRIMPEX	T3	

T1 – Generics

T2 – Preferred Brands

T3 – Non-Preferred Brands

T4 – Brand Specialty

PA – Prior Authorization

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List of Prescription Medications

ANTIBIOTICS (Infections) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ANTIBIOTIC, ANTIBACTERIAL, MISC. (cont.)		
URELLE	T3	
URIBEL	T3	
URIBEL TABS (<i>methenam/m.blue/salicyl/hyoscy</i>)	T3	
ANTILEPROTICS		
<i>dapsone 100 mg tablet</i>	T1	
<i>dapsone 25 mg tablet</i>	T1	
THALOMID 100 MG CAPSULE	T4	PA QL (30 caps/fill) SP HD
THALOMID 200 MG CAPSULE	T4	PA QL (60 caps/fill) SP HD
THALOMID 50 MG CAPSULE	T4	PA QL (30 caps/fill) SP HD
ANTI-MYCOBACTERIUM AGENTS		
<i>ethambutol hcl (Myambutol)</i>	T1	HD
<i>isoniazid</i>	T1	HD
MYCOBUTIN (<i>rifabutin</i>)	T3	HD
PASER	T3	HD
<i>pyrazinamide</i>	T1	HD
<i>rifabutin (Mycobutin)</i>	T1	HD
TRECATOR	T3	HD
ANTITUBERCULAR ANTIBIOTICS		
<i>cycloserine</i>	T1	
PRETOMANID	T3	PA
PRIFTIN	T2	
<i>rifampin</i>	T1	
SIRTURO	T4	PA SP
BETALACTAMS		
CAYSTON	T4	PA QL (84 mls/fill) SP HD
CEPHALOSPORIN ANTIBIOTICS - 1ST GENERATION		
<i>cefadroxil</i>	T1	
<i>cephalexin (Keflex)</i>	T1	
CEPHALOSPORIN ANTIBIOTICS - 2ND GENERATION		
<i>cefaclor</i>	T1	
<i>cefpazil</i>	T1	
<i>cefuroxime axetil</i>	T1	
CEPHALOSPORIN ANTIBIOTICS - 3RD GENERATION		
<i>cefdinir</i>	T1	

T1 – Generics

T2 – Preferred Brands

T3 – Non-Preferred Brands

T4 – Brand Specialty

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List of Prescription Medications

ANTIBIOTICS (Infections) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
CEPHALOSPORIN ANTIBIOTICS - 3RD GENERATION (cont.)		
<i>cefditoren pivoxil</i> (Spectracef)	T1	
<i>cefixime</i> (Suprax)	T1	
<i>cefpodoxime proxetil</i>	T1	
<i>ceftriaxone sodium</i>	T1	PA
SPECTRACEF (<i>cefditoren pivoxil</i>)	T3	
LINCOSAMIDE ANTIBIOTICS		
CLEOCIN HCL (<i>clindamycin hcl</i>)	T3	
CLEOCIN PEDIATRIC (<i>clindamycin palmitate hcl</i>)	T3	
<i>clindamycin hcl</i> (Cleocin Hcl)	T1	
<i>clindamycin palmitate hcl</i> (Cleocin Pediatric)	T1	
MACROLIDE ANTIBIOTICS		
<i>azithromycin</i>	T1	
<i>azithromycin</i> (Zithromax Tri-Pak)	T1	
<i>azithromycin</i> (Zithromax)	T1	
<i>clarithromycin</i>	T1	
DIFICID 200 MG TABLET	T3	QL (20 tabs/fill)
DIFICID 40 MG/ML SUSPENSION	T3	QL (1 bottle/fill)
E.E.S. 200 (<i>erythromycin ethylsuccinate</i>)	T3	
ERYPED 200 (<i>erythromycin ethylsuccinate</i>)	T3	
ERYPED 400 (<i>erythromycin ethylsuccinate</i>)	T3	
<i>ery-tab dr 250 mg tablet</i>	T1	
<i>ery-tab dr 333 mg tablet</i>	T1	
ERY-TAB DR 500 MG TABLET (<i>erythromycin base</i>)	T3	
<i>erythromycin base</i>	T1	
<i>erythromycin base</i> (Ery-Tab)	T1	
<i>erythromycin ethylsuccinate</i>	T1	
<i>erythromycin ethylsuccinate</i> (E.E.S. 200)	T1	
<i>erythromycin ethylsuccinate</i> (Eryped 200)	T1	
<i>erythromycin ethylsuccinate</i> (Eryped 400)	T1	
<i>erythromycin stearate</i>	T1	
ZITHROMAX (<i>azithromycin</i>)	T3	
ZITHROMAX TRI-PAK (<i>azithromycin</i>)	T3	
NITROFURAN DERIVATIVES ANTIBACTERIAL AGENTS		
FURADANTIN (<i>nitrofurantoin</i>)	T3	

T1 – Generics

T2 – Preferred Brands

T3 – Non-Preferred Brands

T4 – Brand Specialty

PA – Prior Authorization

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ST – Step Therapy

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List of Prescription Medications

ANTIBIOTICS (Infections) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
NITROFURAN DERIVATIVES ANTIBACTERIAL AGENTS (cont.)		
MACROBID (<i>nitrofurantoin monohyd/m-cryst</i>)	T3	
<i>nitrofurantoin</i> (Furadantin)	T1	
<i>nitrofurantoin mcr 25 mg cap</i>	T1	
<i>nitrofurantoin mcr 50 mg cap</i>	T1	
<i>nitrofurantoin mcr 100 mg cap</i>	T1	
<i>nitrofurantoin monohyd/m-cryst</i> (Macrobid)	T1	
OXAZOLIDINONE ANTIBIOTICS		
<i>linezolid</i> (Zyvox)	T1	PA
ZYVOX (<i>linezolid</i>)	T3	PA
PENICILLIN ANTIBIOTICS		
<i>amoxicillin</i>	T1	
<i>amoxicillin/potassium clav</i>	T1	
<i>amoxicillin/potassium clav</i> (Augmentin Xr)	T1	
<i>amoxicillin/potassium clav</i> (Augmentin)	T1	
<i>ampicillin trihydrate</i>	T1	
AUGMENTIN 125-31.25 MG/5 ML	T2	
AUGMENTIN 250-62.5 MG/5 ML (<i>amoxicillin/potassium clav</i>)	T3	
AUGMENTIN XR (<i>amoxicillin/potassium clav</i>)	T3	
<i>dicloxacillin sodium</i>	T1	
MOXATAG	T3	
<i>penicillin v potassium</i>	T1	
PLEUROMUTILIN DERIVATIVES		
XENLETA	T3	
QUINOLONE ANTIBIOTICS		
BAXDELA	T2	QL (28 tabs/fill)
CIPRO (<i>ciprofloxacin hcl</i>)	T3	
CIPRO (<i>ciprofloxacin</i>)	T3	
<i>ciprofloxacin</i> (Cipro)	T1	
<i>ciprofloxacin hcl</i>	T1	
<i>ciprofloxacin hcl</i> (Cipro)	T1	
FACTIVE	T3	
<i>levofloxacin</i>	T1	
<i>moxifloxacin hcl</i>	T1	
<i>ofloxacin</i>	T1	

T1 – Generics

T2 – Preferred Brands

T3 – Non-Preferred Brands

T4 – Brand Specialty

PA – Prior Authorization

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ST – Step Therapy

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List of Prescription Medications

ANTIBIOTICS (Infections) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
RIFAMYCINS AND RELATED DERIVATIVE ANTIBIOTICS		
AEMCOLO	T3	QL (12 tabs/fill)
XIFAXAN 200 MG TABLET	T2	QL (9 tabs/fill)
XIFAXAN 550 MG TABLET	T2	QL (60 tabs/fill)
TETRACYCLINE ANTIBIOTICS		
ACTICLATE (<i>doxycycline hydrate</i>)	T3	ST
AVIDOXY DK	T3	ST
<i>demeclacycline hcl</i>	T1	
<i>doxycycline 25 mg/5 ml susp (Vibramycin)</i>	T1	
<i>doxycycline 50 mg tablet (Targadox)</i>	T1	ST
<i>doxycycline hyc dr 50 mg tab</i>	T1	ST
<i>doxycycline hyc dr 75 mg tab</i>	T1	ST
<i>doxycycline hyc dr 100 mg tab</i>	T1	ST
<i>doxycycline hyc dr 150 mg tab</i>	T1	ST
<i>doxycycline hyc dr 200 mg tab (Doryx)</i>	T1	ST
<i>doxycycline hydrate 50 mg cap</i>	T1	
<i>doxycycline hydrate 75 mg tab (Acticlate)</i>	T1	ST
<i>doxycycline hydrate 100 mg cap</i>	T1	
<i>doxycycline hydrate 100 mg tab (Lymepak)</i>	T1	
<i>doxycycline hydrate 150 mg tab (Acticlate)</i>	T1	ST
<i>doxycycline mono 50 mg cap</i>	T1	
<i>doxycycline mono 50 mg, 75 mg tablet</i>	T1	
<i>doxycycline mono 100 mg cap</i>	T1	
<i>doxycycline mono 75 mg capsule</i>	T1	
<i>doxycycline mono 100 mg tablet</i>	T1	
<i>doxycycline mono 150 mg cap</i>	T1	ST
<i>doxycycline mono 150 mg tablet</i>	T1	
<i>doxycycline monohydrate</i>	T1	
<i>doxycycline monohydrate (Oracea)</i>	T1	ST
LYMPEAK (<i>doxycycline hydrate</i>)	T3	
<i>minocycline hcl (Solodyn)</i>	T1	ST
<i>minocycline 100 mg capsule</i>	T1	
<i>minocycline 50 mg capsule</i>	T1	
<i>minocycline 75 mg capsule</i>	T1	
<i>minocycline hcl 100 mg tablet</i>	T1	ST

T1 – Generics

T2 – Preferred Brands

T3 – Non-Preferred Brands

T4 – Brand Specialty

PA – Prior Authorization

QL – Quantity Limit

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List of Prescription Medications

ANTIBIOTICS (Infections) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
TETRACYCLINE ANTIBIOTICS (cont.)		
minocycline hcl 50 mg tablet	T1	ST
minocycline hcl 75 mg tablet	T1	ST
MINOLIRA ER	T3	ST
monodoxe nl 100 mg capsule	T1	
monodoxe nl 75 mg capsule	T1	ST
MORGIDOX 1X100 MG KIT	T3	ST
MORGIDOX 1X50 MG KIT	T3	ST
MORGIDOX 2X100 MG KIT	T3	ST
morgidox 50 mg capsule	T1	
NUZYRA	T4	QL (30 tabs/30 days) SP
SEYSARA	T3	ST
SOLODYN (minocycline hcl)	T3	ST
TARGADOX (doxycycline hydiate)	T3	ST
tetracycline 250 mg, 500 mg capsule	T1	
tetracycline 250 mg, 500 mg tablet	T1	ST
VIBRAMYCIN	T3	ST
VIBRAMYCIN (doxycycline monohydrate)	T3	ST
VAGINAL ANTIBIOTICS		
CLEOCIN	T3	
CLEOCIN (clindamycin phosphate)	T3	
clindamycin 2% vaginal cream (Cleocin)	T1	
CLINDESSE	T3	
METROGEL-VAGINAL (metronidazole)	T3	
metronidazole (Metrogel-Vaginal)	T1	
metronidazole vaginal 0.75% gl (Metrogel-Vaginal)	T1	
NUVESSA	T3	
XACIATO	T2	
VANCOMYCIN ANTIBIOTICS AND DERIVATIVES		
VANCOCIN HCL 125 MG CAPSULE (vancomycin hcl)	T3	PA QL (40 caps/fill)
VANCOCIN HCL 250 MG CAPSULE (vancomycin hcl)	T3	PA QL (80 caps/fill)
vancomycin 250 mg/5 ml soln	T1	QL (450 mls/fill)
vancomycin 125 mg capsule	T1	PA QL (40 caps/30 days)
vancomycin 250 mg capsule	T1	PA QL (80 caps/30 days)

T1 – Generics

T2 – Preferred Brands

T3 – Non-Preferred Brands

T4 – Brand Specialty

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)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
TOPICAL ANTIBIOTIC AND ANTI-INFLAMMATORY STEROID		
NEO-SYNALAR	T3	
TOPICAL ANTIBIOTICS		
AKTIPAK	T3	ST
AMZEEQ	T3	ST
BENZAMYCIN (<i>erythromycin/benzoyl peroxide</i>)	T3	ST
CENTANY	T3	ST QL (30 gms/fill)
CENTANY AT	T3	ST QL (1 KIT/FILL)
CLEOCINT 1% LOTION (<i>clindamycin phosphate</i>)	T3	ST QL (120 mls/30 days)
CLEOCINT 1% PLEDGETS (<i>clindamycin phosphate</i>)	T3	ST
<i>clindacin etz 1% plegget</i> (Cleocin T)	T1	
CLINDACIN ETZ KIT	T3	ST
CLINDACIN PAC	T3	ST
<i>clindamycin ph 1% gel</i>	T1	QL (120 gms/30 days)
<i>clindamycin ph 1% solution</i>	T1	QL (120 mls/30 days)
<i>clindamycin phos 1% plegget</i> (Cleocin T)	T1	
<i>clindamycin phosp 1% lotion</i> (Cleocin T)	T1	QL (120 mls/30 days)
<i>clindamycin phosphate</i> (Cleocin T)	T1	
<i>clindamycin phosphate</i> (Evoclin)	T1	ST QL (100 gms/30 days)
<i>clindamycin phosphate 1% foam</i> (Evoclin)	T1	ST QL (100 gms/30 days)
<i>clindamycin phosphate 1% gel</i> (Clindagel)	T1	QL (150 mls/30 days)
<i>erythromycin base in ethanol</i>	T1	
<i>erythromycin/benzoyl peroxide</i> (Benzamycin)	T1	
EVOCLIN (<i>clindamycin phosphate</i>)	T3	ST QL (100 gms/30 days)
<i>gentamicin 0.1% cream</i>	T1	QL (60 gms/fill)
<i>gentamicin 0.1% ointment</i>	T1	QL (60 gms/fill)
<i>mupirocin 2% cream</i>	T1	ST QL (30 gms/fill)
<i>mupirocin 2% ointment</i>	T1	QL (44 gms/fill)
<i>mupirocin 2% ointment</i>	T1	QL (30 gms/fill)
XEPI	T3	ST QL (30 gms/fill)
TOPICAL SULFONAMIDES		
AVAR LS	T3	ST
AVAR-E	T3	ST
AVAR-E GREEN	T3	ST
AVAR-E LS	T3	ST

T1 – Generics

T2 – Preferred Brands

T3 – Non-Preferred Brands

T4 – Brand Specialty

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List of Prescription Medications

ANTIBIOTICS (Skin Conditions) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
TOPICAL SULFONAMIDES (cont.)		
ketoconazole 2% shampoo	T1	
mafenide acetate (Sulfamylon)	T1	
nystatin 100,000 unit/gm powd	T1	
PLEXION	T3	ST
ROSULA 10%-4.5% WASH	T3	ST
rosula 10%-5% cloths	T1	
SILVADENE (<i>silver sulfadiazine</i>)	T3	
silver sulfadiazine (Silvadene)	T1	
sod sulfase-sulf 9.8-4.8% clsr	T1	ST
sod sulfase-sulfur 9-4.5% wash	T1	ST
sod sulfacet-sulfr 9.8-4.8%pad	T1	ST
sod sulfacet-sulfur 10-2% clsr	T1	ST
sod sulfacet-sulfur 10-4% pad (Sumaxin)	T1	
sod sulfacet-sulfur 10-5% clsr	T1	
sod sulfac-sulfur 9.8-4.8% crm	T1	ST
sod sulfac-sulfur 9.8-4.8% lot	T1	ST
sss 10-5 cream	T1	
sss 10-5 foam	T1	ST
sulfacetamide sodium/sulfur	T1	ST
sulfacetamide-sulfur 10-2% crm	T1	ST
sulfacetamide-sulfur 10-5% crm	T1	
sulfacetamide-sulfur 10-5% lot	T1	ST
sulfacetamide-sulfur 10-5% sus	T1	ST
sulfacetamide-sulfur 8-4% susp	T1	ST
sulfacetamide-sulfur 9-4% clsr	T1	ST
SULFAMYRON 8.5% CREAM	T2	
SULFAMYRON POWDER PACKET (<i>mafenide acetate</i>)	T3	
SUMADAN	T3	ST
SUMADAN XLT	T3	ST
SUMAXIN	T3	ST
SUMAXIN (<i>sulfacetamide sodium/sulfur</i>)	T3	ST
SUMAXIN CP	T3	ST
SUMAXIN TS	T3	ST

T1 – Generics

T2 – Preferred Brands

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List of Prescription Medications

ANTI-COAGULANTS (Blood Thinners/Anti-Clotting)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
CITRATES AS ANTI-COAGULANTS		
ACD SOLUTION A	T2	
ACD-A	T2	
ANTICOAGULANT SODIUM CITRATE	T3	
CITRATE PHOSPHATE DEXTROSE	T2	
CRRT TRISODIUM CITRATE	T3	
<i>sodium citrate 4% lock flush</i>	T1	
SODIUM CITRATE 4% LOCK FLUSH	T3	
SODIUM CITRATE 4% SOLN	T3	
SODIUM CITRATE 4% SYRINGE	T3	
SODIUM CITRATE 4% VIAL	T3	
TRISODIUM CITRATE CRRT	T3	
DIRECT FACTOR XA INHIBITORS		
ELIQUIS	T2	PA
<i>rivaroxaban (Xarelto)</i>	T1	
XARELTO	T2	PA
XARELTO (<i>rivaroxaban</i>)	T2	
HEPARIN AND RELATED PREPARATIONS		
ARIXTRA (<i>fondaparinux sodium</i>)	T4	SP
<i>enoxaparin sodium (Lovenox)</i>	T1	SP
<i>fondaparinux sodium (Arixtra)</i>	T1	SP
FRAGMIN	T4	SP
<i>heparin 10,000 unit/10 ml vial</i>	T1	
<i>heparin 2,000 unit/2 ml vial</i>	T1	
<i>heparin 30,000 unit/30 ml vial</i>	T1	
<i>heparin 40,000 unit/4 ml vial</i>	T1	
<i>heparin 5,000 unit/ml carpufcjt</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 vfl</i>	T1	
<i>heparin sod 20,000 unit/ml vfl</i>	T1	
<i>heparin sod 5,000 unit/0.5 ml</i>	T1	
HEPARIN SOD 5,000 UNIT/0.5 ML	T2	
HEPARIN SOD 5,000 UNIT/0.5 ML	T3	

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List of Prescription Medications

ANTI-COAGULANTS (Blood Thinners/Anti-Clotting) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
HEPARIN AND RELATED PREPARATIONS (cont.)		
heparin sod 5,000 unit/ml syrg	T1	
HEPARIN SOD 5,000 UNIT/ML SYRG	T3	
heparin sod 5,000 unit/ml vial	T1	
ANTIDOTES (Gastrointestinal/Heartburn)		
MU-OPIOID RECEPTOR ANTAGONISTS, PERIPHERALLY-ACTING		
MOVANTIK	T2	QL (30 tabs/fill)
RELISTOR 12 MG/0.6 ML SYRINGE	T2	ST
RELISTOR 8 MG/0.4 ML SYRINGE	T2	ST
RELISTOR 12 MG/0.6 ML VIAL	T2	ST
SYMPROIC	T2	
ANTIDOTES (Substance Abuse)		
OPIOID ANTAGONISTS		
KLOXXADO	T2	QL (2 units/fill)
naloxone 0.4 mg/ml carpuject, syringe, vial	T1	
naloxone 2 mg/2 ml syringe	T1	
naloxone 4 mg/10 ml vial	T1	
naloxone hcl 4 mg nasal spray (Narcan)	T1	QL (2 units/fill)
naltrexone hcl	T1	
NARCAN (naloxone hcl)	T3	QL (2 units/30 days)
REXTOVY	T2	QL (2 units/30 days)
ANTI-FUNGALS (Eye Conditions)		
OPHTHALMIC ANTIFUNGAL AGENTS		
NATACYN	T2	
ANTI-FUNGALS (Feminine Products)		
VAGINAL ANTI-FUNGALS		
GYNAZOLE 1	T3	
miconazole nitrate	T1	
terconazole	T1	
ANTI-FUNGALS (Infections)		
ANTIFUNGAL AGENTS		
ANCOBON (flucytosine)	T3	PA
clotrimazole	T1	

T1 – Generics

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List of Prescription Medications

ANTI-FUNGALS (Infections) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ANTIFUNGAL AGENTS (cont.)		
CRESEMBA	T2	PA
DIFLUCAN 10 MG/ML SUSPENSION (<i>fluconazole</i>)	T3	
DIFLUCAN 40 MG/ML SUSPENSION (<i>fluconazole</i>)	T3	
DIFLUCAN 50 MG TABLET (<i>fluconazole</i>)	T3	
DIFLUCAN 100 MG TABLET (<i>fluconazole</i>)	T3	
DIFLUCAN 150 MG TABLET (<i>fluconazole</i>)	T3	QL (2 tabs/episode)
DIFLUCAN 200 MG TABLET (<i>fluconazole</i>)	T3	
<i>fluconazole 10 mg/ml susp</i>	T1	
<i>fluconazole 40 mg/ml susp (Diflucan)</i>	T1	
<i>fluconazole 50 mg tablet (Diflucan)</i>	T1	
<i>fluconazole 100 mg tablet (Diflucan)</i>	T1	
<i>fluconazole 150 mg tablet (Diflucan)</i>	T1	QL (2 tabs/fill)
<i>fluconazole 200 mg tablet</i>	T1	
<i>flucytosine (Ancobon)</i>	T1	
<i>itraconazole 10 mg/ml solution (Sporanox)</i>	T1	QL (2 bottles/fill)
<i>itraconazole 100 mg capsule (Sporanox)</i>	T1	QL (30 caps/fill)
<i>itraconazole 100 mg/10 ml cup (Sporanox)</i>	T1	QL (2 bottles/fill)
<i>ketoconazole 200 mg tablet</i>	T1	
NOXAFL 300 MG POWDERMIX SUSP	T2	PA
NOXAFL 40 MG/ML SUSPENSION	T2	PA SP
ORAVIG	T3	
POSACONAZOLE 200 MG/5 ML SUSP	T2	PA
<i>posaconazole dr 100 mg tablet (Noxafil)</i>	T1	PA
<i>SPORANOX 10 MG/ML SOLUTION (itraconazole)</i>	T3	QL (2 bottles/fill)
<i>SPORANOX 100 MG CAPSULE (itraconazole)</i>	T3	QL (30 caps/fill)
<i>terbinafine hcl</i>	T1	
<i>VFEND (voriconazole)</i>	T3	PA
VIVJOA	T4	PA QL (18 caps/30 days) SP
<i>voriconazole (Vfend)</i>	T1	PA
ANTIFUNGAL ANTIBIOTICS		
BREXFEMME	T3	ST QL (4 tabs/fill)
<i>griseofulvin ultramicrosize</i>	T1	
<i>griseofulvin, microsize</i>	T1	
<i>nystatin 100,000 unit/ml susp</i>	T1	

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List of Prescription Medications

ANTI-FUNGALS (Infections) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ANTIFUNGAL ANTIBIOTICS (cont.)		
nystatin 500,000 unit oral tab	T1	
nystatin 500,000 unit/5 ml cup	T1	
ANTI-FUNGALS (Skin Conditions)		
TOPICAL ANTIFUNGAL/ANTI-INFLAMMATORY, STEROID AGENT		
clotrimazole-betamethasone crm	T1	QL (90 gms/28 days)
clotrimazole-betamethasone lot	T1	QL (60 mls/28 days)
ciclodan 0.77% cream (Loprox)	T1	QL (90 gms/28 days)
CICLODAN 0.77% CREAM KIT	T3	
ciclodan 8% solution	T1	
TOPICAL ANTI-FUNGALS		
ciclopirox 0.77% cream (Loprox)	T1	QL (90 gms/28 days)
ciclopirox 0.77% gel	T1	QL (100 gms/28 days)
ciclopirox 0.77% topical susp (Loprox)	T1	QL (60 mls/28 days)
ciclopirox 1% shampoo	T1	QL (120 mls/28 days)
ciclopirox 8% solution	T1	
econazole nitrate	T1	QL (85 gms/28 days)
EXELDERM 1% CREAM	T3	QL (60 gms/28 days)
EXELDERM 1% SOLUTION	T3	QL (60 mls/28 days)
EXTINA (ketoconazole)	T3	ST QL (100 gms/28 days)
JUBLIA	T3	ST
ketoconazole 2% cream	T1	QL (60 gms/28 days)
ketoconazole 2% foam (Extina)	T1	ST QL (100 gms/28 days)
ketodan 2% foam (Extina)	T1	ST QL (100 gms/28 days)
ketodan 2% foam kit	T1	ST
LOPROX 0.77% CREAM (ciclopirox olamine)	T3	QL (90 gms/28 days)
LOPROX 0.77% CREAM KIT	T3	QL (544 gms/30 days)
LOPROX 0.77% SUSPENSION KIT	T3	QL (1 kit/30 days)
LOPROX 0.77% TOPICAL SUSP (ciclopirox olamine)	T3	QL (60 mls/28 days)
naftifine hcl 1% cream	T1	QL (90 gms/28 days)
naftifine hcl 2% cream	T1	QL (60 gms/28 days)
naftifine hcl 2% gel (Naftin)	T1	QL (60 gms/28 days)
NAFTIN	T3	QL (60 gms/28 days)
NAFTIN 1% GEL (naftifine hcl)	T3	QL (90 gms/28 days)

T1 – Generics

T2 – Preferred Brands

T3 – Non-Preferred Brands

T4 – Brand Specialty

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List of Prescription Medications

ANTI-FUNGALS (Skin Conditions) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
TOPICAL ANTI-FUNGALS (cont.)		
NAFTIN 2% GEL (naftifine hcl)	T3	QL (60 gms/28 days)
nystatin	T1	QL (180 gms/fill)
nystatin 100,000 unit/gm cream	T1	QL (60 gms/28 days)
nystatin 100,000 unit/gm oint	T1	QL (60 gms/28 days)
nystatin/triamcin	T1	QL (60 gms/28 days)
oxiconazole nitrate	T1	QL (60 gms/28 days)
tavaborole	T1	ST
ANTIHISTAMINE AND DECONGESTANT COMBINATION (Allergy/Nasal Sprays)		
1ST GEN ANTIHISTAMINE AND DECONGESTANT COMBINATION		
phenylephrine hcl/prometh hcl	T1	
phenylephrine/chlor-tan	T1	
ANTIHISTAMINES (Allergy/Nasal Sprays)		
2ND GEN ANTIHISTAMINE AND DECONGESTANT COMBINATION		
CLARINEX-D 12 HOUR	T3	QL (60 tabs/fill)
ANTIHISTAMINES - 1ST GENERATION		
carbinoxamine 4 mg/5 ml liquid	T1	
carbinoxamine maleate 4 mg tab	T1	
carbinoxamine maleate 6 mg tab	T1	ST
ciproheptadine 2 mg/5 ml soln	T1	
ciproheptadine 2 mg/5 ml syrup	T1	
ciproheptadine 4 mg tablet	T1	
CYPROHEPTADINE 4 MG/10 ML SYRP	T3	
dexchlorpheniramine maleate (Ryclora)	T1	
hydroxyzine hcl	T1	
hydroxyzine hcl	T1	
hydroxyzine pamoate	T1	
hydroxyzine pamoate (Vistaril)	T1	
promethazine hcl	T1	
RYCLORA (dexchlorpheniramine maleate)	T3	
RYVENT	T3	ST
VISTARIL (hydroxyzine pamoate)	T3	
ANTIHISTAMINES - 2ND GENERATION		
CLARINEX D 24 HOUR TABLET	T3	

T1 – Generics

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List of Prescription Medications

ANTIHISTAMINES (Allergy/Nasal Sprays) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ANTIHISTAMINES - 2ND GENERATION (cont.)		
desloratadine	T1	QL (30 tabs/fill) HD
desloratadine (Claritin)	T1	QL (30 tabs/fill) HD
ANTIHISTAMINES (Eye Conditions)		
EYE ANTIHISTAMINES		
azelastine hcl 0.05% drops	T1	
bepotastine besilate (Bepreve)	T1	ST
BEPREVE	T3	
epinastine hcl	T1	
LASTACRAFT 0.25% EYE DROPS	T3	ST
ANTI-HYPERGLYCEMICS (Diabetes)		
ANTIHYPERGLY,DPP-4 ENZYME INHIB.-THIAZOLIDINEDIONE		
OSENI	T3	ST QL (30 tabs/fill) HD
ANTIHYPERGLY,INCRETIN MIMETIC(GLP-1 RECEPT.AGONIST)		
ADLYXIN 10-20 MCG STARTER PACK	T3	PA HD QL (1 kit/28 days)
ADLYXIN 20 MCG MAINTENANCE PK	T3	PA HD QL (1 kit/28 days)
BYDUREON BCISE	T2	PA QL (4 auto-injs/28 days)
BYDUREON PEN	T2	PA QL (4 pens/fill) HD
BYETTA	T2	PA QL (1 pen/30 days)
exenatide	T1	PA QL (1 pen/30 days)
liraglutide 2-pak 18 mg/3 ml (Victoza 2-Pak)	T1	PA
liraglutide 2-pak 18 mg/3 ml (Victoza 3-Pak)	T1	PA
liraglutide 3-pak 18 mg/3 ml (Victoza 2-Pak)	T1	PA
liraglutide 3-pak 18 mg/3 ml (Victoza 3-Pak)	T1	PA
OZEMPIC	T2	PA QL (1 pen/28 days)
RYBELSUS	T2	PA QL (30 tabs/30 days)
TRULICITY	T2	PA QL (4 pens/28 days)
ANTIHYPERGLY, INSULIN, LONG ACT-GLP-1 RECEPT.AGONIST		
SOLIQUA 100-33	T2	QL (15 mls/30 days)
ANTIHYPERGLYCEMIC - DOPAMINE RECEPTOR AGONISTS		
CYCLOSET	T3	HD
ANTIHYPERGLYCEMIC - INCRETIN MIMETICS COMBINATION		
MOUNJARO	T2	PA QL (4 pens/fill)

T1 – Generics

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List of Prescription Medications

ANTI-HYPERGLYCEMICS (Diabetes) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ANTIHYPERGLYCEMIC, ALPHA-GLUCOSIDASE INHIBITORS		
acarbose (Precose)	T1	HD
miglitol	T1	HD
PRECOSE (acarbose)	T3	HD
ANTIHYPERGLYCEMIC, AMYLIN ANALOG-TYPE		
SYMLINPEN 60	T2	PA QL (7 pens/30 days)
SYMLINPEN 120	T2	PA QL (7 pens/fill) HD
ANTIHYPERGLYCEMIC, BIGUANIDE TYPE		
metformin hcl 500 mg/5 ml soln (Riomet)	T1	ST HD
metformin hcl 750 mg tablet	T1	ST HD
metformin hcl 1,000 mg tablet	T1	HD
metformin hcl 500 mg tablet	T1	HD
metformin hcl 850 mg tablet	T1	HD
metformin er 1,000 mg gastr-tb (Glumetza)	T1	PA QL (60 tabs/fill) HD
metformin er 500 mg gastrc-tb (Glumetza)	T1	PA QL (120 tabs/fill) HD
metformin er 1,000 mg osm-tab	T1	PA QL (60 tabs/30 days) HD
metformin er 500 mg osmotic tb	T1	PA QL (30 tabs/30 days) HD
metformin hcl er 500 mg tablet	T1	QL (120 tabs/fill) HD
metformin hcl er 750 mg tablet	T1	QL (60 tabs/fill) HD
RIOMET (metformin hcl)	T3	ST HD
ANTIHYPERGLYCEMIC, DPP-4 INHIBITORS		
JANUVIA	T2	ST QL (30 tabs/fill) HD
saxagliptin hcl (Onglyza)	T1	ST QL (30 tabs/30 days) HD
ANTIHYPERGLYCEMIC, INSULIN-RELEASE STIMULANT TYPE		
glimepiride 1 mg tablet	T1	HD
glimepiride 2 mg tablet	T1	HD
glimepiride 4 mg tablet	T1	HD
glipizide	T1	HD
GLUCOTROL XL (glipizide)	T3	HD
glyburide	T1	HD
glyburide,micronized	T1	HD
glyburide,micronized (Glynase)	T1	HD
GLYNASE (glyburide,micronized)	T3	HD
nateglinide	T1	HD
PRANDIN (repaglinide)	T3	HD

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List of Prescription Medications

ANTI-HYPERGLYCEMICS (Diabetes) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ANTIHYPERGLYCEMIC, INSULIN-RELEASE STIMULANT TYPE (cont.)		
repaglinide	T1	HD
repaglinide (Prandin)	T1	HD
ANTIHYPERGLYCEMIC, SGLT-2 AND DPP-4 INHIBITOR COMB		
GLYXAMBI	T2	ST QL (30 tabs/fill) HD
ANTIHYPERGLYCEMIC, THIAZOLIDINEDIONE AND BIGUANIDE		
ACTOPLUS MET XR 30 1000MG TABLET	T3	ST
pioglitazone hcl/metformin hcl	T1	QL (90 tabs/fill) HD
pioglitazone hcl/metformin hcl (Actoplus Met)	T1	QL (90 tabs/fill) HD
ANTIHYPERGLYCEMIC, THIAZOLIDINEDIONE-SULFONYLUREA		
DUETACT (pioglitazone hcl/glimepiride)	T3	QL (30 tabs/30 days) HD
pioglitazone hcl/glimepiride (Duetact)	T1	HD
ANTIHYPERGLYCEMIC, DPP-4 INHIBITOR-BIGUANIDE COMBS.		
JANUMET	T2	ST QL (60 tabs/fill) HD
JANUMET XR 100-1,000 MG TABLET	T2	ST QL (30 tabs/fill) HD
JANUMET XR 50-1,000 MG TABLET	T2	ST QL (60 tabs/fill) HD
JANUMET XR 50-500 MG TABLET	T2	ST QL (60 tabs/fill) HD
saxagliptin-metformin er 5-500 (Kombiglyze Xr)	T1	ST QL (30 tabs/30 days) HD
saxagliptin-metformin er 5-1000 (Kombiglyze Xr)	T1	ST QL (30 tabs/30 days) HD
saxagliptin-metformin er 2.5-1000 (Kombiglyze Xr)	T1	ST QL (60 tabs/30 days) HD
ANTIHYPERGLYCEMIC, INSULIN-RELEASE STIM.-BIGUANIDE		
glipizide/metformin hcl	T1	HD
glyburide/metformin hcl	T1	HD
ANTIHYPERGLYCEMIC, THIAZOLIDINEDIONE (PPARG AGONIST)		
ACTOS (pioglitazone hcl)	T3	QL (30 tabs/30 days) HD
ANTIHYPERGLYCEMIC-GLUCOCORTICOID RECEPTOR BLOCKER		
mifepristone 300 mg tablet (Korlym)	T1	PA SP
ANTIHYPERGLYCEMIC-SGLT2 INHIBITOR-BIGUANIDE COMBS.		
SYNJARDY	T2	ST QL (60 tabs/fill) HD
SYNJARDY XR 10-1,000 MG TABLET	T2	ST QL (30 tabs/fill) HD
SYNJARDY XR 12.5-1,000 MG TAB	T2	ST QL (60 tabs/fill) HD
SYNJARDY XR 25-1,000 MG TABLET	T2	ST QL (30 tabs/fill) HD
SYNJARDY XR 5-1,000 MG TABLET	T2	ST QL (60 tabs/fill) HD
XIGDUO XR 10 MG-1,000 MG TAB	T2	ST QL (30 tabs/fill) HD
XIGDUO XR 10 MG-500 MG TABLET	T2	ST QL (30 tabs/fill) HD

T1 – Generics

T2 – Preferred Brands

T3 – Non-Preferred Brands

T4 – Brand Specialty

PA – Prior Authorization

QL – Quantity Limit

ST – Step Therapy

AGE – Age Requirement

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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-HYPERGLYCEMICS (Diabetes) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ANTIHYPERGLYCEMIC-SGLT2 INHIBITOR-BIGUANIDE COMBS. (cont.)		
XIGDUO XR 2.5 MG-1,000 MG TAB	T2	ST QL (60 tabs/fill) HD
XIGDUO XR 5 MG-1,000 MG TABLET	T2	ST QL (60 tabs/fill) HD
XIGDUO XR 5 MG-500 MG TABLET	T2	ST QL (30 tabs/fill) HD
ANTIHYPERGLYCEMIC-SOD/GLUC COTRANSORT2(SGLT2) INH		
FARXIGA	T2	ST QL (30 tabs/30 days)
JARDIANCE	T2	ST QL (30 tabs/fill) HD
ANTIHYPERGLY-SGLT-2 INHIB, DPP-4 INHIB, BIGUANIDE CB		
TRIJARDY XR	T2	ST HD
INSULINS		
HUMALOG 100 unit/ML CARTRIDGE	T2	HD
HUMALOG JUNIOR KWIKPEN	T2	HD
HUMALOG KWIKPEN U-100	T2	HD
HUMALOG KWIKPEN U-200	T2	HD
HUMALOG MIX 50-50 KWIKPEN	T2	HD
HUMALOG MIX 75-25	T2	HD
HUMALOG MIX 75-25 KWIKPEN	T2	HD
HUMULIN 70/30 KWIKPEN	T2	HD
HUMULIN 70-30	T2	HD
HUMULIN N	T2	HD
HUMULIN N KWIKPEN	T2	HD
HUMULIN R	T2	HD
HUMULIN R U-500	T2	HD
HUMULIN R U-500 KWIKPEN	T2	HD
INSULIN GLARGINE-YFGN	T2	HD
INSULIN LISPRO 100 UNIT/ML VIAL	T2	HD
INSULIN LISPRO JUNIOR KWIKPEN	T2	HD
INSULIN LISPRO KWIKPEN U-100	T2	HD
INSULIN LISPRO PROTAMINE MIX	T2	HD
LYUMJEV	T2	HD
LYUMJEV KWIKPEN U-100	T2	HD
LYUMJEV KWIKPEN U-200	T2	HD
MYXREDLIN	T3	
SEMGLEE (YFGN)	T2	HD
SEMGLEE (YFGN) PEN	T2	HD

T1 – Generics

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List of Prescription Medications

ANTI-HYPERGLYCEMICS (Diabetes) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
INSULINS (cont.)		
TOUJEO MAX SOLOSTAR	T2	HD
TOUJEO SOLOSTAR	T2	HD
TRESIBA	T2	HD
TRESIBA FLEXTOUCH U-100	T2	HD
TRESIBA FLEXTOUCH U-200	T2	HD
ANTI-INFECTIVES (Feminine Products)		
VAGINAL SULFONAMIDES		
AVC	T3	
ANTI-INFECTIVES/MISCELLANEOUS (Feminine Products)		
VAGINAL ANTISEPTICS		
acetic acid/oxyquinoline (Relagard)	T1	
RELAGARD (acetic acid/oxyquinoline)	T3	
TRIMO-SAN	T2	
ANTI-INFECTIVES/MISCELLANEOUS (Infections)		
2ND GEN. ANAEROBIC ANTIprotozoal-ANTIBACTERIAL		
tinidazole 250 mg tablet	T1	QL (40 tabs/30 days)
tinidazole 500 mg tablet	T1	QL (20 tabs/30 days)
AMEBICIDES		
HUMATIN	T3	
ANTHELMINTICS		
albendazole (Albenza)	T1	QL (120 tabs/30 days)
ALBENZA (albendazole)	T3	QL (120 tabs/30 days)
BILTRICIDE (praziquantel)	T3	
EMVERM	T2	QL (6 tabs/30 days)
ivermectin 6 mg tablet	T1	PA QL (8 tabs/30 days)
praziquantel (Biltricide)	T1	
STROMECTOL (ivermectin)	T3	PA QL (14 tabs/30 days)
ANTIMALARIAL DRUGS		
ARAKODA	T3	QL (16 tabs/fill)
atovaquone-proguanil 250-100 (Malarone)	T1	QL (60 tabs/180 days)
atovaquone-proguanil 62.5-25 (Malarone)	T1	QL (180 tabs/180 days)
chloroquine phosphate	T1	
COARTEM	T2	QL (24 tabs/30 days)

T1 – Generics

T2 – Preferred Brands

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List of Prescription Medications

ANTI-INFECTIVES/MISCELLANEOUS (Infections) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ANTIMALARIAL DRUGS (cont.)		
DARAPRIM (<i>pyrimethamine</i>)	T4	PA SP
HYDROXYCHLOROQUINE 100 MG TAB	T3	
<i>hydroxychloroquine 200 mg tab (Plaquenil)</i>	T1	
HYDROXYCHLOROQUINE 300 MG , 400 MG TAB	T3	
KRINTAFEL	T3	QL (2 tabs/30 days)
MALARONE 250-100 MG TABLET (<i>atovaquone/proguanil hcl</i>)	T3	QL (60 tabs/180 days)
MALARONE 62.5-25 MG PED TAB (<i>atovaquone/proguanil hcl</i>)	T3	QL (180 tabs/180 days)
<i>mefloquine hcl</i>	T1	QL (13 tabs/180 days)
PRIMAQUINE 26.3 MG TABLET	T2	QL (120 tabs/180 days)
<i>primaquine 26.3 mg tablet</i>	T1	QL (120 tabs/180 days)
<i>pyrimethamine 25 mg tablet (Daraprim)</i>	T1	PA
<i>pyrimethamine 25 mg tablet (Daraprim)</i>	T1	PA SP
<i>quinine sulfate</i>	T1	QL (42 caps/30 days)
ANTIPROTOZOAL DRUGS, MISCELLANEOUS		
<i>atovaquone (Mepron)</i>	T1	
BENZNIDAZOLE	T2	QL (360 tabs/fill)
IMPAVIDO	T2	PA QL (84 caps/30 days)
MEPRON (<i>atovaquone</i>)	T3	
NEBUPENT (<i>pentamidine isethionate</i>)	T3	QL (1 vfl/28 days)
<i>pentamidine isethionate (Nebupent)</i>	T1	QL (1 vfl/28 days)
ANTI-INFECTIVES/MISCELLANEOUS (Miscellaneous)		
ANTIBACTERIAL AGENTS,MISCELLANEOUS		
<i>glycine urologic solution</i>	T1	
ANTISEPTICS,GENERAL		
ALCOHOL SWABSTICK	T3	
CVS ISOPROPYL ALCOHOL 91% SPRY	T3	
GS ISOPROPYL ALCOHOL 70% SPRAY	T3	
ISOPROPYL ALCOHOL 70% SPRAY	T3	
MEDI-FIRST ISOPROPYL ALCOHOL	T3	
TOPICAL ANTISEPTIC DRYING AGENTS		
<i>formaldehyde</i>	T1	

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List of Prescription Medications

ANTI-INFECTIVES/MISCELLANEOUS (Skin Conditions)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
TOPICAL ANTI-FUNGALS		
CICLODAN 8% KIT <i>ciclopiprox 8% treatment kit</i>	T3 T1	ST
ANTI-INFLAM.TUMOR NECROSIS FACTOR INHIBITING AGENTS (Pain Relief And Inflammatory Disease)		
ANTI-INFLAMMATORY TUMOR NECROSIS FACTOR INHIBITOR		
ADALIMUMAB-ADAZ(CF)	T4	PA QL (2 syringes/28 days) SP HD
ADALIMUMAB-ADAZ(CF) PEN	T4	PA QL (2 pens/28 days) SP HD
ADALIMUMAB-ADBM(CF)PEN	T4	PA QL (2 kits/28 days) SP HD
ADALIMUMAB-RYVK(CF)	T4	PA QL (2 srnge kits/28 days) SP HD
ADALIMUMAB-RYVK(CF) AUTOINJECT	T4	PA QL (2 auto-injs/28 days) SP HD
CYLTEZO(CF)	T4	PA QL (2 srnge kits/28 days) SP HD
CYLTEZO(CF) PEN	T4	PA QL (2 kits/28 days) SP HD
CYLTEZO(CF) PEN CROHN'S-UC-HS	T4	PA QL (6 pens/365 days) SP HD
CYLTEZO(CF) PEN PSORIASIS-UV	T4	PA QL (4 pens/365 days) SP HD
ENBREL 25 MG KIT	T4	PA QL (8 vls/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 (8 vials/28 days) SP HD
ENBREL 50 MG/ML SYRINGE	T4	PA QL SP HD
ENBREL MINI	T4	PA QL SP HD
ENBREL SURECLICK	T4	PA QL SP HD
SIMLANDI(CF) AUTOINJECTOR	T4	PA QL (2 auto-injs/28 days) SP HD
SIMLANDI(CF)	T4	PA QL (2 srnge kits/28 days) SP HD
SIMPONI 100 MG/ML PEN INJECTOR	T4	PA QL (1 pen/30 days) SP HD
SIMPONI 100 MG/ML SYRINGE	T4	PA QL (1 syringe/30 days) SP HD
SIMPONI ARIA	T4	PA SP HD
ANTI-NEOPLASTICS (Cancer)		
ANP - SELECTIVE RETINOID X RECEPTOR AGONISTS (RXR)		
bevacizumab (Targretin)	T1	PA SP HD CSL
ANTINEOPLAST. HISTONE DEACETYLASE (HDAC) INHIBITORS		
FARYDAK	T3	PA QL (6 caps/fill) CSL
ZOLINZA	T4	PA QL (120 caps/fill) SP HD CSL
ANTINEOPLASTIC - ALKYLATING AGENTS		
ALKERAN (melphalan)	T4	SP CSL
cyclophosphamide 25 mg capsule	T1	SP HD CSL

T1 – Generics

T2 – Preferred Brands

T3 – Non-Preferred Brands

T4 – Brand Specialty

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List of Prescription Medications

ANTI-NEOPLASTICS (Cancer) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ANTINEOPLASTIC - ALKYLATING AGENTS (cont.)		
cyclophosphamide 50 mg capsule	T1	SP HD CSL
CYCLOPHOSPHAMIDE 50 MG TABLET	T4	SP HD CSL
GLEOSTINE	T2	CSL
HYDREA (<i>hydroxyurea</i>)	T3	CSL
<i>hydroxyurea</i> (Hydrea)	T1	CSL
LEUKERAN	T2	CSL
MYLERAN	T2	CSL
temozolomide	T1	PA SP HD CSL
ANTINEOPLASTIC - ANTIANDROGENIC AGENTS		
abiraterone acetate	T1	
abiraterone acetate (Zytiga)	T1	PA QL (120 tabs/30 days) CSL
abiraterone acetate 250 mg tab (Zytiga)	T1	PA QL (120 tabs/fill) SP HD CSL
abiraterone acetate 500 mg tab (Zytiga)	T1	PA QL (60 tabs/fill) SP HD CSL
bicalutamide (Casodex)	T1	CSL
CASODEX (bicalutamide)	T3	CSL
ERLEADA 240 MG TABLET	T4	PA SP HD QL (30 tabs/30 days) CSL
EULEXIN (<i>flutamide</i>)	T3	CSL
<i>flutamide</i> (Eulexin)	T1	CSL
NILANDRON (<i>nilutamide</i>)	T3	PA CSL
<i>nilutamide</i> (Nilandron)	T1	PA CSL
NUBEQA	T4	PA QL (120 tabs/fill) SP HD CSL
XTANDI 40 MG CAPSULE, TABLET	T4	PA QL (120 tabs/caps/fill) SP HD CSL
XTANDI 80 MG TABLET	T4	PA QL (60 tabs/fill) SP HD CSL
YONSA	T4	PA QL (120 tabs/30 days) SP HD CSL
ANTINEOPLASTIC - ANTIMETABOLITES		
LONSURF	T4	PA SP HD CSL
mercaptopurine 20 mg/ml suspen (Purixan)	T1	SP CSL
mercaptopurine 50 mg tablet	T1	CSL
methotrexate 2.5 mg tablet	T1	CSL
methotrexate 250 mg/10 ml vial	T1	
methotrexate 50 mg/2 ml vial	T1	
methotrexate sodium/pf	T1	
PURIXAN (mercaptopurine)	T4	SP CSL
TABLOID	T3	CSL

T1 – Generics

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T4 – Brand Specialty

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List of Prescription Medications

ANTI-NEOPLASTICS (Cancer) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ANTINEOPLASTIC - ANTIMETABOLITES (cont.)		
TREXALL	T3	CSL
XELODA 150 MG TABLET (<i>capecitabine</i>)	T4	PA QL (56 tabs/fill) SP HD CSL
XELODA 500 MG TABLET (<i>capecitabine</i>)	T4	PA QL (140 tabs/fill) SP HD CSL
ANTINEOPLASTIC - AROMATASE INHIBITORS		
<i>anastrozole</i> (Arimidex)	T1	HD PPACA CSL
AROMASIN (<i>exemestane</i>)	T3	HD CSL
<i>exemestane</i> (Aromasin)	T1	HD PPACA CSL
FEMARA (<i>letrozole</i>)	T3	HD CSL
<i>letrozole</i> (Femara)	T1	HD CSL
ANTINEOPLASTIC - BRAF KINASE INHIBITORS		
BRAFTOVI	T4	PA QL (180 caps/30 days) SP HD CSL
OJEMDA	T4	PA SP CSL
TAFINLAR 10 MG TABLET FOR SUSP	T4	SP PA HD QL (840ml/30 days) CSL
ZELBORAF	T4	PA QL (240 tabs/fill) SP HD CSL
ANTINEOPLASTIC - HEDGEHOG PATHWAY INHIBITOR		
DAURISMO 100 MG TABLET	T4	PA QL (30 tabs/fill) SP HD CSL
DAURISMO 25 MG TABLET	T4	PA QL (60 tabs/fill) SP HD CSL
ERIVEDGE	T4	PA QL (30 caps/fill) SP HD CSL
ODOMZO	T4	PA QL (30 caps/fill) SP HD CSL
ANTINEOPLASTIC - JANUS KINASE (JAK) INHIBITORS		
JAKIFI	T4	PA QL (60 tabs/fill) SP HD CSL
ANTINEOPLASTIC - KRAS PROTEIN INHIBITOR		
LUMAKRAS	T4	PA SP HD CSL
ANTINEOPLASTIC - MEK KINASE INHIBITORS		
COTELLIC	T4	PA QL (63 tabs/30 days) SP HD CSL
GOMEKLI	T4	PA SP CSL
KOSELUGO	T4	PA SP CSL
MEKINIST 0.05 MG/ML SOLUTION	T4	PA QL (1080 mls/30 days) SP HD CSL
MEKINIST 0.5 MG TABLET	T4	PA QL (90 tabs/30 days) SP HD CSL
MEKINIST 2 MG TABLET	T4	PA QL (30 tabs/30 days) SP HD CSL
MEKTOVI	T4	PA QL (180 tabs/30 days) SP HD CSL
ANTINEOPLASTIC - MTOR KINASE INHIBITORS		
<i>everolimus</i> (Afinitor)	T1	PA QL (30 tabs/30 days) SP CSL
<i>everolimus</i> 2 mg tab for susp (Afinitor Disperz)	T1	PA QL (30 tabs/fill) SP CSL

T1 – Generics

T2 – Preferred Brands

T3 – Non-Preferred Brands

T4 – Brand Specialty

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List of Prescription Medications

ANTI-NEOPLASTICS (Cancer) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ANTINEOPLASTIC - MTOR KINASE INHIBITORS (cont.)		
everolimus 3 mg tab for susp (Afinitor Disperz)	T1	PA QL (30 tabs/fill) SP CSL
everolimus 5 mg tab for susp (Afinitor Disperz)	T1	PA QL (30 tabs/fill) SP CSL
ANTINEOPLASTIC - PROTEIN METHYLTRANSFERASE INHIBIT		
TAZVERIK	T4	PA SP CSL
ANTINEOPLASTIC - TOPOISOMERASE I INHIBITORS		
HYCAMTIN	T4	PA SP HD CSL
ANTINEOPLASTIC COMB - KINASE AND AROMATASE INHIBIT		
KISQALI FEMARA 200 MG CO-PACK	T4	PA QL (49 tabs/30 days) SP CSL
KISQALI FEMARA 400 MG CO-PACK	T4	PA QL (70 tabs/30 days) SP CSL
KISQALI FEMARA 600 MG CO-PACK	T4	PA QL (91 tabs/30 days) SP CSL
ANTINEOPLASTIC IMMUNOMODULATOR AGENTS		
lenalidomide	T1	PA QL (30 caps/fill) SP HD CSL
POMALYST	T4	PA SP HD CSL
REVLIMID	T4	PA QL (30 caps/fill) SP HD CSL
ANTINEOPLASTIC LHRH(GNRH) ANTAGONIST,PITUIT.SUPPRS		
ORGOVYX	T4	PA QL (30 tabs/fill) SP CSL
ANTINEOPLASTIC SYSTEMIC ENZYME INHIBITORS		
ALECensa	T4	PA QL (240 caps/fill) SP HD CSL
ALUNBRIG 180 MG TABLET	T4	PA QL (30 tabs/fill) SP CSL
ALUNBRIG 30 MG TABLET	T4	PA QL (60 tabs/fill) SP CSL
ALUNBRIG 90 MG TABLET	T4	PA QL (30 tabs/fill) SP CSL
ALUNBRIG 90 MG-180 MG TAB PACK	T4	PA QL (30 tabs/fill) SP CSL
AUGTYRO	T4	PA SP HD CSL
AYVAKIT	T4	PA QL (30 tabs/fill) SP CSL
BALVERSA	T4	PA SP CSL
BOSULIF 50 MG CAPSULE	T4	PA QL (30 caps/fill) SP HD CSL
BOSULIF 100 MG CAPSULE	T4	PA QL (90 tabs/fill) SP HD CSL
BOSULIF 100 MG TABLET	T4	PA QL (90 tabs/fill) SP HD CSL
BOSULIF 400 MG TABLET	T4	PA QL (30 tabs/fill) SP HD CSL
BOSULIF 500 MG TABLET	T4	PA QL (30 tabs/fill) SP HD CSL
BRUKINSA	T4	PA SP CSL
CALQUENCE	T4	PA QL (60 tabs/caps/fill) SP CSL
CAPRELSA 100 MG TABLET	T4	PA QL (60 tabs/fill) SP CSL
CAPRELSA 300 MG TABLET	T4	PA QL (30 tabs/fill) SP CSL

T1 – Generics

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List of Prescription Medications

ANTI-NEOPLASTICS (Cancer) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ANTINEOPLASTIC SYSTEMIC ENZYME INHIBITORS (cont.)		
COMETRIQ 100 MG DAILY-DOSE PK	T4	PA QL (56 caps/fill) SP HD CSL
COMETRIQ 140 MG DAILY-DOSE PK	T4	PA QL (112 caps/fill) SP HD CSL
COMETRIQ 60 MG DAILY-DOSE PACK	T4	PA QL (84 caps/fill) SP HD CSL
COPIKTRA	T4	PA QL (56 caps/fill) SP CSL
DANZITEN	T4	PA SP CSL
<i>dasatinib 20 mg tablet (Sprycel)</i>	T1	PA QL (90 tabs/30 days) SP CSL
<i>dasatinib 20 mg tablet (Sprycel)</i>	T1	PA QL (90 tabs/30 days) SP HD CSL
<i>dasatinib 50 mg tablet (Sprycel)</i>	T1	PA QL (30 tabs/30 days) SP CSL
<i>dasatinib 50 mg tablet (Sprycel)</i>	T1	PA QL (30 tabs/30 days) SP HD CSL
<i>dasatinib 70 mg tablet (Sprycel)</i>	T1	PA QL (60 tabs/30 days) SP CSL
<i>dasatinib 70 mg tablet (Sprycel)</i>	T1	PA QL (60 tabs/30 days) SP HD CSL
<i>dasatinib 80 mg tablet (Sprycel)</i>	T1	PA QL (30 tabs/30 days) SP CSL
<i>dasatinib 80 mg tablet (Sprycel)</i>	T1	PA QL (30 tabs/30 days) SP HD CSL
<i>dasatinib 100 mg tablet (Sprycel)</i>	T1	PA QL (30 tabs/30 days) SP CSL
<i>dasatinib 100 mg tablet (Sprycel)</i>	T1	PA QL (30 tabs/30 days) SP HD CSL
<i>dasatinib 140 mg tablet (Sprycel)</i>	T1	PA QL (30 tabs/30 days) SP CSL
<i>dasatinib 140 mg tablet (Sprycel)</i>	T1	PA QL (30 tabs/30 days) SP HD CSL
<i>erlotinib hcl 25 mg tablet</i>	T1	PA QL (60 tabs/30 days) SP HD CSL
<i>erlotinib hcl 100 mg tablet</i>	T1	PA QL (30 tabs/30 days) SP HD CSL
<i>erlotinib hcl 150 mg tablet</i>	T1	PA QL (30 tabs/30 days) SP HD CSL
FRUZAQLA	T4	PA SP CSL
GAVRETO	T4	PA QL (120 caps/30 days) SP CSL
GILOTRIF	T4	PA QL (30 tabs/fill) SP HD CSL
IBRANCE	T4	PA QL (21 tabs/caps/30 days) SP HD CSL
ICLUSIG	T4	PA QL (30 tabs/fill) SP CSL
IMBRUVICA 70 MG CAPSULE	T4	PA QL (30 caps/fill) SP CSL
IMBRUVICA 140 MG CAPSULE	T4	PA QL (120 caps/fill) SP CSL
IMBRUVICA 140 MG TABLET	T4	PA QL (30 tabs/fill) SP CSL
IMBRUVICA 280 MG TABLET	T4	PA QL (30 tabs/fill) SP CSL
IMBRUVICA 420 MG TABLET	T4	PA QL (30 tabs/fill) SP CSL
IMBRUVICA 70 MG/ML SUSPENSION	T4	PA QL (3 bottles/fill) SP CSL
IMKELDI	T4	PA SP CSL
INLYTA 1 MG TABLET	T4	PA QL (180 tabs/fill) SP HD CSL

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ANTI-NEOPLASTICS (Cancer) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ANTINEOPLASTIC SYSTEMIC ENZYME INHIBITORS (cont.)		
INLYTA 5 MG TABLET	T4	PA QL (120 tabs/fill) SP HD CSL
IRESSA	T4	PA QL (30 tabs/fill) SP HD CSL
IRESSA (<i>gefitinib</i>)	T4	PA QL (30 tabs/30 days) SP HD CSL
IWLFIN	T4	PA SP CSL
KISQALI	T4	PA SP HD QL (1 pack/1 time) CSL
KISQALI FEMARA CO-PACK	T4	PA SP HD QL (1 pack/28 days) CSL
<i>lapatinib ditosylate</i> (Tykerb)	T1	PA QL (180 tabs/fill) SP HD CSL
LAZCLUZE	T4	PA SP CSL
LENVIMA 8 MG DAILY DOSE	T4	PA QL (60 caps/fill) SP HD CSL
LENVIMA 10 MG DAILY DOSE	T4	PA QL (30 caps/fill) SP HD CSL
LENVIMA 12 MG DAILY DOSE	T4	PA QL (90 caps/fill) SP HD CSL
LENVIMA 14 MG DAILY DOSE	T4	PA QL (60 caps/fill) SP HD CSL
LENVIMA 18 MG DAILY DOSE	T4	PA QL (90 caps/fill) SP HD CSL
LENVIMA 20 MG DAILY DOSE	T4	PA QL (60 caps/fill) SP HD CSL
LENVIMA 24 MG DAILY DOSE	T4	PA QL (90 caps/fill) SP HD CSL
LENVIMA 4 MG CAPSULE	T4	PA QL (30 caps/fill) SP HD CSL
LORBRENA 100 MG TABLET	T4	PA QL (30 tabs/fill) SP HD CSL
LORBRENA 25 MG TABLET	T4	PA QL (90 tabs/fill) SP HD CSL
LYNPARZA	T4	PA QL (120 tabs/fill) SP HD CSL
LYTGEOBI	T4	PA SP CSL
NERLYNX	T4	PA SP HD CSL
NEXAVAR (<i>sorafenib tosylate</i>)	T4	PA QL (120 tabs/fill) SP HD CSL
<i>nilotinib</i> 150 mg capsule (Tasigna)	T1	PA QL (112 caps/30 days) SP HD CSL
<i>nilotinib</i> 200 mg capsule (Tasigna)	T1	PA QL (112 caps/30 days) SP HD CSL
<i>nilotinib</i> 50 mg capsule (Tasigna)	T1	PA QL (120 caps/30 days) SP HD CSL
NINLARO	T4	PA QL (3 caps/fill) SP HD CSL
OGSIVEO	T4	PA SP CSL
<i>pazopanib hcl</i> (Votrient)	T1	PA QL (120 tabs/30 days) SP HD CSL
PEMAZYRE 4.5MG, 9MG, 13.5MG TAB	T4	PA QL (28 tabs/30 days) SP CSL
PIQRAY	T4	PA SP CSL
RETEVMO 40 MG CAPSULE	T4	PA SP HD CSL
RETEVMO 80 MG CAPSULE	T4	PA SP HD CSL
RETEVMO 40 MG TABLET	T4	PA QL (90 tabs/fill) SP HD CSL
RETEVMO 80 MG TABLET	T4	PA QL (60 tabs/fill) SP HD CSL

T1 – Generics

T2 – Preferred Brands

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T4 – Brand Specialty

PA – Prior Authorization

QL – Quantity Limit

ST – Step Therapy

AGE – Age Requirement

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List of Prescription Medications

ANTI-NEOPLASTICS (Cancer) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ANTINEOPLASTIC SYSTEMIC ENZYME INHIBITORS (cont.)		
RETEVMO 120 MG TABLET	T4	PA QL (60 tabs/fill) SP HD CSL
RETEVMO 160 MG TABLET	T4	PA QL (60 tabs/fill) SP HD CSL
REVUFORJ	T4	PA SP CSL
ROMVIMZA	T4	PA QL (8 caps/fill) SP CSL
ROZLYTREK 100 MG CAPSULE	T4	PA QL (30 caps/fill) SP HD CSL
ROZLYTREK 200 MG CAPSULE	T4	PA QL (90 caps/fill) SP HD CSL
ROZLYTREK 50 MG PELLET PACKET	T4	PA QL (42 packs/fill) SP HD CSL
RYDAPT	T4	PA QL (224 caps/fill) SP HD CSL
SCEMBLIX 20 MG TABLET	T4	PA QL (600 tabs/30 days) SP CSL
SCEMBLIX 40 MG TABLET	T4	PA QL (300 tabs/30 days) SP CSL
SCEMBLIX 100 MG TABLET	T4	PA QL (120 tabs/fill) SP CSL
<i>sorafenib tosylate</i> (Nexavar)	T1	PA QL (120 tabs/fill) SP HD CSL
STIVARGA	T4	PA QL (84 tabs/fill) SP HD CSL
<i>sunitinib malate</i> 12.5 mg cap (Sutent)	T1	PA QL (90 caps/fill) SP HD CSL
<i>sunitinib malate</i> 25 mg capsule (Sutent)	T1	PA QL (30 caps/fill) SP HD CSL
<i>sunitinib malate</i> 37.5 mg cap (Sutent)	T1	PA QL (30 caps/fill) SP HD CSL
<i>sunitinib malate</i> 50 mg capsule (Sutent)	T1	PA QL (30 caps/fill) SP HD CSL
SUTENT 12.5 MG CAPSULE (<i>sunitinib malate</i>)	T4	PA QL (90 caps/fill) SP HD CSL
SUTENT 25 MG CAPSULE (<i>sunitinib malate</i>)	T4	PA QL (30 caps/fill) SP HD CSL
SUTENT 37.5 MG CAPSULE (<i>sunitinib malate</i>)	T4	PA QL (30 caps/fill) SP HD CSL
SUTENT 50 MG CAPSULE (<i>sunitinib malate</i>)	T4	PA QL (30 caps/fill) SP HD CSL
TABRECTA	T4	PA SP HD CSL
TAGRISSO	T4	PA QL (30 tabs/fill) SP HD CSL
TALZENNA	T4	PA QL (30 caps/fill) SP HD CSL
TALZENNA 0.1 MG CAPSULE, SOFTGEL	T4	PA QL (30 caps/fill) SP CSL
TALZENNA 0.25 MG CAPSULE, SOFTGEL	T4	PA QL (30 caps/30 days) SP CSL
TALZENNA 0.35 MG CAPSULE, SOFTGEL	T4	PA QL (30 caps/fill) SP CSL
TALZENNA 0.5 MG CAPSULE, SOFTGEL	T4	PA QL (30 caps/30 days) SP CSL
TALZENNA 0.75 MG CAPSULE, SOFTGEL	T4	PA QL (30 caps/30 days) SP CSL
TALZENNA 1 MG CAPSULE, SOFTGEL	T4	PA QL (30 caps/30 days) SP CSL
TARCEVA (<i>erlotinib hcl</i>)	T4	PA QL (30 tabs/30 days) SP HD CSL
TASIGNA 150 MG CAPSULE (<i>nilotinib hcl</i>)	T4	PA QL (112 caps/30 days) SP HD CSL
TASIGNA 200 MG CAPSULE (<i>nilotinib hcl</i>)	T4	PA QL (112 caps/30 days) SP HD CSL

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ANTI-NEOPLASTICS (Cancer) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ANTINEOPLASTIC SYSTEMIC ENZYME INHIBITORS (cont.)		
TASIGNA 50 MG CAPSULE (<i>nilotinib hcl</i>)	T4	PA QL (120 caps/30 days) SP HD CSL
TRUQAP	T4	PA SP CSL
TUKYSA 150 MG TABLET	T4	PA QL (120 tabs/fill) SP CSL
TUKYSA 50 MG TABLET	T4	PA QL (300 tabs/fill) SP CSL
TURALIO	T4	PA QL (120 caps/fill) SP CSL
VERZENIO	T4	PA QL (60 tabs/fill) SP HD CSL
VITRAKVI 25 MG CAPSULE	T4	PA QL (180 caps/fill) SP HD CSL
VITRAKVI 100 MG CAPSULE	T4	PA QL (60 caps/fill) SP HD CSL
VITRAKVI 20 MG/ML SOLUTION	T4	PA QL (300 mls/fill) SP HD CSL
VIZIMPRO	T4	PA QL (30 tabs/fill) SP HD CSL
VONJO	T4	PA QL (120 caps/fill) SP CSL
VOTRIENT (<i>pazopanib hcl</i>)	T4	PA QL (120 tabs/30 days) SP HD CSL
XALKORI 200MG, 250MG CAPSULE	T4	PA QL (60 caps/30 days) SP HD CSL
XALKORI 20 MG, 50 MG, 150 MG PELLET	T4	PA QL (120 caps/fill) SP HD CSL
XOSPATA	T4	PA QL (90 tabs/fill) SP CSL
ZYDELIG	T4	PA QL (60 tabs/fill) SP HD CSL
ZYKADIA	T4	PA QL (90 tabs/caps/fill) SP HD CSL
ANTINEOPLASTIC-B CELL LYMPHOMA-2(BCL-2) INHIBITORS		
VENCLEXTA 10 MG TAB (10MG X 2)	T4	PA QL (56 tabs/fill) SP CSL
VENCLEXTA 10 MG TABLET	T4	PA QL (56 tabs/fill) SP CSL
VENCLEXTA 50 MG TABLET	T4	PA QL (28 tabs/fill) SP CSL
VENCLEXTA 100 MG TABLET	T4	PA QL (180 tabs/fill) SP CSL
VENCLEXTA STARTING PACK	T4	PA QL (42 tabs/fill) SP CSL
ANTINEOPLASTIC-HYPOXIA INDUCIBLE FACTOR (HIF) INH		
WELIREG	T4	PA SP CSL
ANTINEOPLASTIC-ISOCITRATE DEHYDROGENASE INHIBITORS		
IDHIFA	T4	PA QL (30 tabs/fill) SP HD CSL
TIBSOVO	T4	PA SP CSL
VORANIGO	T4	PA SP CSL
ANTI-NEOPLASTICS, MISCELLANEOUS		
<i>etoposide</i>	T1	SP HD CSL
LYSODREN	T2	CSL
MATULANE	T4	SP CSL
<i>tretinoin 10 mg capsule</i>	T1	CSL

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List of Prescription Medications

ANTI-NEOPLASTICS (Cancer) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
IMMUNOMODULATORS		
ACTIMMUNE	T4	PA SP HD
SELECTIVE ESTROGEN RECEPTOR MODULATORS (SERMS)		
FARESTON (<i>toremifene citrate</i>)	T3	HD CSL
SOLTAMOX	T3	HD PPACA CSL
<i>tamoxifen citrate</i>	T1	HD PPACA CSL
<i>toremifene citrate</i> (Fareston)	T1	HD CSL
STEROID ANTI-NEOPLASTICS		
<i>megestrol 20 mg, 40 mg tablet</i>	T1	CSL
ANTI-NEOPLASTICS (Skin Conditions)		
PHOTOACT, TOPICAL ANTINEOPLAST, PREMALIGNANT LESIONS		
LEVULAN	T4	SP
TOPICAL ANTINEOPLASTIC PREMALIGNANT LESION AGENTS		
<i>bexarotene 1% gel</i> (Targretin)	T1	PA SP HD
<i>diclofenac sodium 3% gel</i>	T1	PA QL (100 gms/28 days)
EFDUDEX (<i>fluorouracil</i>)	T3	
FLUOROPLEX	T3	
<i>fluorouracil 2% topical soln</i>	T1	
<i>fluorouracil 5% cream</i> (Efudex)	T1	
<i>fluorouracil 5% topical soln</i>	T1	
PANRETIN	T4	PA SP HD
TARGRETIN 1% GEL (<i>bexarotene</i>)	T4	PA SP HD
VALCHLOR	T4	PA SP HD
ANTI-OBESITY DRUGS (Weight Management)		
ANTI-OBESITY - ANOREXIC AGENTS		
ADIPEX-P (<i>phentermine hcl</i>)	T3	PA QL (30 tabs/30 days)
<i>benzphetamine hcl</i>	T1	PA QL (90 tabs/fill)
<i>diethylpropion hcl</i>	T1	PA QL (90 tabs/fill)
<i>diethylpropion hcl</i>	T1	PA QL (30 tabs/fill)
LOMAIR	T3	PA QL (90 tabs/fill)
<i>phendimetrazine tartrate</i>	T1	PA QL (30 caps/fill)
<i>phendimetrazine tartrate</i>	T1	PA QL (180 tabs/fill)
<i>phentermine 15 mg, 30 mg capsule</i>	T1	PA QL (30 caps/fill)
<i>phentermine 37.5 mg capsule</i>	T1	PA QL (30 caps/30 days)

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List of Prescription Medications

ANTI-OBESITY DRUGS (Weight Management) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ANTI-OBESITY - ANOREXIC AGENTS (cont.)		
phentermine 37.5 mg tablet (Adipex-P)	T1	PA QL (30 tabs/fill)
phentermine/topiramate (Qsymia)	T1	PA QL (30 caps/30 days)
QSYMIA (phentermine/topiramate)	T3	PA QL (30 caps/30 days)
ANTI-OBESITY - MELANOCORTIN 4 RECEPTOR AGONISTS		
IMCIVREE	T4	PA QL (6 mls/30 days) SP
ANTI-OBESITY GLUCAGON-LIKE PEPTIDE-1 RECEPTOR AGONIST		
SAXENDA	T3	PA QL (5 pens/30 days)
WEGOVY 0.25 MG/0.5 ML PEN	T2	PA QL (8 pens/year)
WEGOVY 0.5 MG/0.5 ML PEN	T2	PA QL (8 pens/year)
WEGOVY 1 MG/0.5 ML PEN	T2	PA QL (8 pens/year)
WEGOVY 1.7 MG/0.75 ML PEN	T2	PA QL (8 pens/year)
WEGOVY 2.4 MG/0.75 ML PEN	T2	PA QL (4 pens/28 days)
ANTI-OBESITY - INCRETIN MIMETICS COMBINATION		
ZEPBOUND	T2	PA QL (2 mls/28 days)
ANTI-OBESITY SEROTONIN 2C RECEPTOR AGONISTS		
BELVIQ	T3	PA
BELVIQ XR	T3	PA
ANTI-OBESITY-OPPIOID ANTAG-NOREPI, DOPAMINE RU INHIB		
CONTRAVE	T3	PA QL (120 tabs/fill)
FAT ABSORPTION DECREASING AGENTS		
ORLISTAT	T3	PA QL (90 caps/fill)
XENICAL	T3	PA QL (90 caps/fill)
ANTI-PARASITICS (Eye Conditions)		
OPHTHALMIC (EYE) ANTIPARASITICS		
XDEMVY	T4	QL (10 mgs/30 days) SP
ANTI-PARASITICS (Infections)		
ANTIPARASITICS		
ALINIA 100 MG/5 ML SUSPENSION	T2	QL (180ml/30 days)
TOPICAL ANTIPARASITICS		
crotamiton	T1	
ELIMITE (permethrin)	T3	
EURAX	T3	
permethrin (Elimite)	T1	

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List of Prescription Medications

ANTI-PARASITICS (Infections) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
TOPICAL ANTIPARASITICS (cont.)		
<i>spinossad (Natroba)</i>	T1	
<i>ULESFA</i>	T3	
ANTI-PARKINSON DRUGS (Parkinson's Disease)		
ANTIPARKINSONISM DRUGS, ANTICHOLINERGIC		
<i>benztropine mesylate</i>	T1	HD
<i>trihexyphenidyl hcl</i>	T1	HD
ANTIPARKINSONISM DRUGS, OTHER		
<i>amantadine hcl</i>	T1	HD
<i>apomorphine hcl</i>	T1	PA QL (30 mls/30 days) SP
<i>AZILECT (rasagiline mesylate)</i>	T3	ST HD
<i>bromocriptine mesylate</i>	T1	HD
<i>carbidopa/levodopa</i>	T1	HD
<i>carbidopa/levodopa/entacapone</i>	T1	HD
<i>carbidopa/levodopa/entacapone (Stalevo 100)</i>	T1	HD
<i>carbidopa/levodopa/entacapone (Stalevo 75)</i>	T1	HD
<i>CREXONT</i>	T3	ST HD
<i>DUOPA</i>	T4	PA SP HD
<i>entacapone</i>	T1	HD
<i>INBRIJA</i>	T4	PA QL (300 caps/fill) SP HD
<i>KYNMOBI</i>	T2	PA QL (150 films/30 days) HD
<i>NEUPRO</i>	T3	HD
<i>NOURIANZ</i>	T4	PA QL (30 tabs/fill) SP HD
<i>ONGENTYS</i>	T3	PA QL (30 caps/30 days) HD
<i>pramipexole di-hcl</i>	T1	HD
<i>rasagiline mesylate (Azilect)</i>	T1	HD
<i>ropinirole hcl</i>	T1	HD
<i>RYTARY</i>	T3	ST HD
<i>selegiline hcl</i>	T1	HD
<i>STALEVO 200 (carbidopa/levodopa/entacapone)</i>	T3	HD
<i>STALEVO 75 (carbidopa/levodopa/entacapone)</i>	T3	HD
<i>TASMAR (tolcapone)</i>	T3	PA HD
<i>tolcapone (Tasmar)</i>	T1	PA HD

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List of Prescription Medications

ANTI-PARKINSON DRUGS (Parkinson's Disease) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
DECARBOXYLASE INHIBITORS		
<i>carbidopa</i> (Lodosyn)	T1	PA
LODOSYN (<i>carbidopa</i>)	T3	PA
ANTI-PLATELET DRUGS (Blood Thinners/Anti-Clotting)		
PLATELET AGGREGATION INHIBITORS		
ASPIRIN-OMEPRAZOLE	T3	PA HD
<i>aspirin/dipyridamole</i>	T1	HD
BRILINTA (<i>ticagrelor</i>)	T3	HD
<i>cilostazol</i>	T1	HD
<i>cilostazol</i>	T1	HD
<i>clopidogrel bisulfate</i>	T1	HD
<i>clopidogrel bisulfate</i> (Plavix)	T1	HD
<i>dipyridamole</i>	T1	HD
EFFIENT (<i>prasugrel hcl</i>)	T3	HD
<i>prasugrel hcl</i> (Effient)	T1	HD
<i>ticagrelor</i> (Brilinta)	T1	HD
ZONTIVITY	T3	PA HD
PLATELET REDUCING AGENTS		
AGRYLIN (<i>anagrelide hcl</i>)	T3	
<i>anagrelide hcl</i>	T1	
<i>anagrelide hcl</i> (Agrylan)	T1	
ANTIVIRALS (AIDS/HIV)		
ANTIRETROVIRAL - CAPSID INHIBITORS		
SUNLENCA	T4	PA SP
YEZTUGO	T4	PA SP
ANTIRETROVIRAL-INTEGRASE INHIBITOR AND NNRTI COMB.		
JULUCA	T4	SP
DOVATO	T4	SP
TRIUMEQ	T4	SP
TRIUMEQ PD	T4	SP
ANTIRETROVIRAL-NUCLEOSIDE, NUCLEOTIDE, PROTEASE INH.		
SYMTUZA	T4	SP
ANTIVIRALS, HIV-SPEC, NON-PEPTIDIC PROTEASE INHIB		
APTVUS	T4	SP

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List of Prescription Medications

ANTIVIRALS (AIDS/HIV) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ANTIVIRALS, HIV-SPEC, NON-PEPTIDIC PROTEASE INHIB (cont.)		
darunavir (Prezista)	T1	SP
PREZISTA 600 MG TABLET (darunavir)	T4	SP
PREZISTA 800 MG TABLET (darunavir)	T4	SP
ANTIVIRALS, HIV-SPEC, NUCLEOSIDE-NUCLEOTIDE ANALOG		
CIMDUO	T4	SP
DESCOVY	T4	SP
emtricitabine-tenofovir 100-150mg (Truvada)	T1	SP
emtricitabine-tenofovir 133-200mg (Truvada)	T1	SP
emtricitabine-tenofovir 167-250mg (Truvada)	T1	SP
emtricitabine-tenofovir 200-300mg (Truvada)	T1	SP PPACA
TEMIXYS	T4	SP
ANTIVIRALS, HIV-SPEC., NUCLEOSIDE ANALOG, RTI COMB		
abacavir sulfate/lamivudine (Epzicom)	T1	SP
COMBIVIR (lamivudine/zidovudine)	T4	SP
EPZICOM (abacavir sulfate/lamivudine)	T4	SP
lamivudine/zidovudine (Combivir)	T1	SP
ANTIVIRALS, HIV-SPECIFIC, CCR5 CO-RECEPTOR ANTAG.		
maraviroc (Selzentry)	T1	SP
SELZENTRY 150 MG TABLET (maraviroc)	T4	SP
SELZENTRY 20 MG/ML ORAL SOLN	T4	SP
SELZENTRY 300 MG TABLET (maraviroc)	T4	SP
ANTIVIRALS, HIV-SPECIFIC, FUSION INHIBITORS		
FUZEON	T4	SP QL (60 vials/30 days)
ANTIVIRALS, HIV-SPECIFIC, NON-NUCLEOSIDE, RTI		
EDURANT	T4	SP
EDURANT PED	T4	SP
efavirenz (Sustiva)	T1	SP
etravirine (Intelence)	T1	SP
INTELENCE 100 MG TABLET (etravirine)	T4	SP
INTELENCE 200 MG TABLET (etravirine)	T4	SP
INTELENCE 25 MG TABLET	T4	SP
nevirapine	T1	SP
nevirapine (Viramune Xr)	T1	SP
SUSTIVA (efavirenz)	T4	SP

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ANTIVIRALS (AIDS/HIV) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ANTIVIRALS, HIV-SPECIFIC, NON-NUCLEOSIDE, RTI (cont.)		
VIRAMUNE XR (<i>nevirapine</i>)	T4	SP
ANTIVIRALS, HIV-SPECIFIC, NUCLEOSIDE ANALOG, RTI		
<i>abacavir sulfate</i>	T1	SP
<i>abacavir sulfate (Ziagen)</i>	T1	SP
<i>didanosine</i>	T1	SP
<i>emtricitabine (Emtriva)</i>	T1	SP
EMTRIVA 10 MG/ML SOLUTION	T4	SP
EMTRIVA 200 MG CAPSULE (<i>emtricitabine</i>)	T4	SP
EPIVIR (<i>lamivudine</i>)	T4	SP
<i>lamivudine (Epivir)</i>	T1	SP
RETROVIR (zidovudine)	T4	SP
<i>stavudine</i>	T1	SP
ZIAGEN (<i>abacavir sulfate</i>)	T4	SP
<i>zidovudine</i>	T1	SP
<i>zidovudine (Retrovir)</i>	T1	SP
ANTIVIRALS, HIV-SPECIFIC, NUCLEOTIDE ANALOG, RTI		
<i>tenofovir disoproxil fumarate (Viread)</i>	T1	SP
VIREAD 150 MG TABLET	T4	SP
VIREAD 200 MG TABLET	T4	SP
VIREAD 250 MG TABLET	T4	SP
VIREAD 300 MG TABLET (<i>tenofovir disoproxil fumarate</i>)	T4	SP
VIREAD POWDER	T4	SP
ANTIVIRALS, HIV-SPECIFIC, PROTEASE INHIBITOR COMB		
KALETRA	T4	SP
KALETRA (<i>lopinavir/ritonavir</i>)	T4	SP
<i>lopinavir/ritonavir</i>	T1	SP
<i>lopinavir/ritonavir (Kaletra)</i>	T1	SP
ANTIVIRALS, HIV-SPECIFIC, PROTEASE INHIBITORS		
<i>atazanavir sulfate (Reyataz)</i>	T1	SP
EVOTAZ	T4	SP
<i>foscamprenavir calcium</i>	T1	SP
NORVIR 100 MG POWDER PACKET	T4	SP
NORVIR 100 MG TABLET (<i>ritonavir</i>)	T4	SP
REYATAZ 150 MG CAPSULE (<i>atazanavir sulfate</i>)	T4	SP

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List of Prescription Medications

ANTIVIRALS (AIDS/HIV) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ANTIVIRALS, HIV-SPECIFIC, PROTEASE INHIBITORS (cont.)		
REYATAZ 200 MG CAPSULE (<i>atazanavir sulfate</i>)	T4	SP
REYATAZ 300 MG CAPSULE (<i>atazanavir sulfate</i>)	T4	SP
REYATAZ 50 MG POWDER PACKET	T4	SP
<i>ritonavir</i> (Norvir)	T1	SP
VIRACEPT	T4	SP
ANTIVIRALS, HIV-I INTEGRASE STRAND TRANSFER INHIBTR		
APRETUDE	T4	SP PPACA
ISENTRESS	T4	SP
ISENTRESS HD	T4	SP
TIVICAY	T4	SP
TIVICAY PD	T4	SP
ARTV NUCLEOSIDE, NUCLEOTIDE, NON-NUCLEOSIDE RTI COMB		
<i>efavirenz/emtricitabine/tenofovir disop (Symfi Lo)</i>	T1	SP
<i>efavirenz/lamivudine/tenofovir disop (Symfi Lo)</i>	T1	SP
<i>efavirenz/lamivudine/tenofovir disop (Symfi)</i>	T1	SP
<i>emtricitabine/rilpivirine/tenofovir disop</i>	T1	SP
ODEFSEY	T4	SP
SYMFY (efavirenz/lamivudine/tenofovir disop)	T4	SP
SYMFY LO (efavirenz/lamivudine/tenofovir disop)	T4	SP
ARV-NUCLEOSIDE, NUCLEOTIDE RTI, INTEGRASE INHIBITORS		
BIKTARVY	T4	SP
GENVOYA	T4	SP
ANTIVIRALS (Eye Conditions)		
EYE ANTIVIRALS		
<i>trifluridine</i>	T1	
ZIRGAN	T3	
ANTIVIRALS (Infections)		
ANTIVIRAL - MAIN PROTEASE (MPRO) INHIBITOR		
PAXLOVID 150-100 MG (MODERATE)	T2	QL (20 tabs/180 days)
PAXLOVID 300/150-100MG(SEVERE)	T2	
ANTIVIRAL MONOCLONAL ANTIBODIES		
BEYFORTUS	T2	PPACA

T1 – Generics

T2 – Preferred Brands

T3 – Non-Preferred Brands

T4 – Brand Specialty

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

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List of Prescription Medications

ANTIVIRALS (Infections) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ANTIVIRALS, GENERAL		
acyclovir 200 mg capsule	T1	
acyclovir 200 mg/5 ml susp cup	T1	
acyclovir 800 mg/20ml susp cup	T1	
acyclovir 200 mg/5 ml susp (Zovirax)	T1	
acyclovir 400 mg tablet	T1	
acyclovir 800 mg tablet	T1	
famciclovir 125 mg tablet	T1	QL (21 tabs/fill)
famciclovir 250 mg tablet	T1	QL (60 tabs/fill)
famciclovir 500 mg tablet	T1	QL (21 tabs/fill)
FLUMADINE (rimantadine hcl)	T3	
LIVTENCY	T4	PA QL (112 tabs/28 days) SP
oseltamivir 6 mg/ml suspension	T1	QL (180ml/30 days)
oseltamivir phos 30 mg capsule	T1	QL (20 caps/30 days)
oseltamivir phos 45 mg capsule	T1	QL (10 caps/30 days)
oseltamivir phos 75 mg capsule	T1	QL (10 caps/30 days)
PREVYMIS 120 MG PELLET PACKET	T4	SP
PREVYMIS 20 MG PELLET PACKET	T4	SP
PREVYMIS 240 MG TABLET	T4	QL (30 tabs/28 days) SP HD
PREVYMIS 480 MG TABLET	T4	QL (30 tabs/28 days) SP HD
RELENZA	T3	QL (20 blisters/10 days)
rimantadine hcl (Flumadine)	T1	
SITAVIG	T3	PA QL (2 tabs/30 days)
TAMIFLU 30 MG CAPSULE (oseltamivir phosphate)	T3	QL (20 caps/fill)
TAMIFLU 45 MG CAPSULE (oseltamivir phosphate)	T3	QL (10 caps/fill)
TAMIFLU 6 MG/ML SUSPENSION (oseltamivir phosphate)	T3	QL (180 mls/fill)
TAMIFLU 75 MG CAPSULE (oseltamivir phosphate)	T3	QL (10 caps/fill)
valacyclovir hcl (Valtrex)	T1	QL (30 tabs/fill)
VALCYTE (valganciclovir hcl)	T3	
valganciclovir hcl (Valcyte)	T1	
XOFLUZA	T3	QL (1 tab/fill)
ZOVIRAX 200 MG/5 ML SUSP (acyclovir)	T3	
HEP C - NS5A, NS3/4A, NUCLEOTIDE NS5B INHIB COMBO		
VOSEVI	T4	PA QL (28 tabs/fill) SP HD

T1 – Generics

T2 – Preferred Brands

T3 – Non-Preferred Brands

T4 – Brand Specialty

PA – Prior Authorization

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List of Prescription Medications

ANTIVIRALS (Infections) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
HEP C VIRUS-NS5B POLYMERASE AND NS5A INHIB. COMBO.		
EPCLUSA 150-37.5 MG PELLET PKT	T4	PA SP HD QL (28 pkts/28 days)
EPCLUSA 200 MG-50 MG TABLET	T4	PA QL (28 tabs/fill) SP HD
EPCLUSA 200-50 MG PELLET PACK	T4	PA QL (56 packs/fill) SP HD
EPCLUSA 400 MG-100 MG TABLET	T4	PA QL (28 tabs/fill) SP HD
HARVONI 33.75-150 MG PELLET PK	T4	PA QL (28 Packs/fill) SP HD
HARVONI 45-200 MG PELLET PACKT	T4	PA QL (56 Packs/fill) SP HD
HARVONI 45-200 MG TABLET	T4	PA QL (56 tabs/fill) SP HD
HARVONI 90-400 MG TABLET	T4	PA QL (>= 18 yo 28 tabs/fill) SP HD
HEPATITIS B TREATMENT AGENTS		
<i>adefovir dipivoxil</i>	T1	SP HD
BARACLUDE 0.05 MG/ML SOLUTION	T4	SP HD
<i>entecavir</i> (Baraclude)	T1	SP HD
<i>lamivudine</i>	T1	SP
PEGASYS 180MCG/0.5ML SYRINGE KIT	T4	SP HD
PEGASYS 180 MCG/ML VIAL	T4	QL (4 mls/28 days) SP HD
PEGASYS PROCLICK 180MCG/0.5ML	T4	SP HD
<i>ribasphere 200 mg capsule</i>	T1	ST SP HD
<i>ribasphere 600 mg tablet</i>	T1	ST SP
VEMLIDY	T4	SP HD
HEPATITIS C TREATMENT AGENTS		
<i>ribavirin</i>	T1	PA SP HD
HEPATITIS C VIRUS- NS5A AND NS3/4A INHIBITOR COMB		
ZEPATIER	T4	PA QL (28 tabs/fill) SP HD
ANTIVIRALS (Skin Conditions)		
TOPICAL ANTIVIRALS		
<i>acyclovir 5% cream</i> (Zovirax)	T1	PA QL (5 gms/fill)
<i>acyclovir 5% ointment</i> (Zovirax)	T1	PA QL (30 gms/fill)
DENAVIR	T3	
<i>penciclovir</i>	T1	
ZOVIRAX 5% CREAM (<i>acyclovir</i>)	T3	PA QL (5 gms/fill)
AUTONOMIC DRUGS (Allergy/Nasal Sprays)		
ANAPHYLAXIS THERAPY AGENTS		
AUVI-Q	T2	PA QL (2 auto-injs/30 days)

T1 – Generics

T2 – Preferred Brands

T3 – Non-Preferred Brands

T4 – Brand Specialty

PA – Prior Authorization

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List of Prescription Medications

AUTONOMIC DRUGS (Allergy/Nasal Sprays) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ANAPHYLAXIS THERAPY AGENTS (cont.)		
epinephrine 0.15 mg auto-injct (Epipen Jr 2-Pak)	T1	QL (2 auto-injs/fill)
epinephrine 0.15 mg auto-injct (Epipen Jr)	T1	QL (2 auto-injs/fill)
epinephrine 0.3 mg auto-inject (Epipen 2-Pak)	T1	QL (2 auto-injs/fill)
epinephrine 0.3 mg auto-inject (Epipen)	T1	QL (2 auto-injs/fill)
EPIPEN (epinephrine)	T2	PA QL (2 auto-injs/fill)
EPIPEN 2-PAK (epinephrine)	T2	PA QL (2 auto-injs/fill)
EPIPEN JR (epinephrine)	T2	PA QL (2 auto-injs/fill)
EPIPEN JR 2-PAK (epinephrine)	T2	PA QL (2 auto-injs/fill)
NEFFY	T2	QL (4 units/fill)
SYMJEPI	T2	QL (2 syringes/fill)

AUTONOMIC DRUGS (Alzheimer's Disease)

CHOLINESTERASE INHIBITORS

ADLARITY	T3	ST HD
ARICEPT (donepezil hcl)	T3	ST HD
donepezil hcl	T1	HD
donepezil hcl 10 mg tablet (Aricept)	T1	HD
donepezil hcl 23 mg tablet (Aricept)	T1	ST HD
donepezil hcl 5 mg tablet (Aricept)	T1	HD
EXELON (rivastigmine)	T3	ST HD
galantamine hbr	T1	HD
galantamine hbr (Razadyne Er)	T1	HD
pyridostigmine 60 mg/5 ml soln (Mestinon)	T1	HD
PYRIDOSTIGMINE BR 30 MG TABLET	T3	HD
pyridostigmine br 60 mg tablet (Mestinon)	T1	HD
pyridostigmine bromide (Mestinon)	T1	HD
RAZADYNE ER (galantamine hbr)	T3	ST HD
rivastigmine (Exelon)	T1	HD
rivastigmine tartrate	T1	HD

AUTONOMIC DRUGS (Attention Deficit Hyperactivity Disorder)⁸

ADRENERGICS, AROMATIC, NON-CATECHOLAMINE

ADZENYS XR-ODT	T3	ST
amphetamine sulfate (Evekeo)	T1	
DESOXYN (methamphetamine hcl)	T3	

T1 – Generics

T2 – Preferred Brands

T3 – Non-Preferred Brands

T4 – Brand Specialty

PA – Prior Authorization

QL – Quantity Limit

ST – Step Therapy

AGE – Age Requirement

SP – Specialty Medication

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List of Prescription Medications

AUTONOMIC DRUGS (Attention Deficit Hyperactivity Disorder)⁸ (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ADRENERGICS, AROMATIC, NON-CATECHOLAMINE (cont.)		
DEXEDRINE (<i>dextroamphetamine sulfate</i>)	T3	ST
<i>dextroamphetamine sulfate</i>	T1	
<i>dextroamphetamine sulfate</i> (Dexedrine)	T1	
<i>dextroamphetamine sulfate</i> (Zenzedi)	T1	
<i>dextroamphetamine/amphetamine</i> (Adderall Xr)	T1	
<i>dextroamphetamine/amphetamine</i> (Adderall)	T1	
<i>dextroamphetamine/amphetamine</i> (Mydayis)	T1	
EVEKEO ODT	T3	
<i>methamphetamine hcl</i> (Desoxyn)	T1	
MYDAYIS (<i>dextroamphetamine/amphetamine</i>)	T3	ST
ZENZEDI 2.5 MG TABLET	T3	
<i>zenzedi 5 mg tablet</i>	T1	
<i>zenzedi 10 mg tablet</i>	T1	
ZENZEDI 7.5 MG TABLET (<i>dextroamphetamine sulfate</i>)	T3	
ZENZEDI 15 MG TABLET (<i>dextroamphetamine sulfate</i>)	T3	
ZENZEDI 20 MG TABLET (<i>dextroamphetamine sulfate</i>)	T3	
ZENZEDI 30 MG TABLET (<i>dextroamphetamine sulfate</i>)	T3	

AUTONOMIC DRUGS (Blood Pressure/Heart Medications)

ADRENERGIC VASOPRESSOR AGENTS

<i>droxidopa</i> (Northera)	T1	PA SP HD
<i>midodrine hcl</i>	T1	
DIBENZYLINE (<i>phenoxybenzamine hcl</i>)	T3	PA HD
<i>phenoxybenzamine hcl</i> (Dibenzyline)	T1	PA HD

AUTONOMIC DRUGS (Urinary Tract Conditions)

PARASYMPATHETIC AGENTS

<i>bethanechol chloride</i>	T1	HD
<i>bethanechol chloride</i> (Urecholine)	T1	HD
<i>cevimeline hcl</i> (Evoxac)	T1	HD
EVOXAC (<i>cevimeline hcl</i>)	T3	HD
<i>pilocarpine hcl</i> (Salagen)	T1	HD
SALAGEN (<i>pilocarpine hcl</i>)	T3	HD
URECHOLINE (<i>bethanechol chloride</i>)	T3	HD

T1 – Generics

T2 – Preferred Brands

T3 – Non-Preferred Brands

T4 – Brand Specialty

PA – Prior Authorization

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List of Prescription Medications

BIOLOGICALS (Allergy/Nasal Sprays)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ALLERGENIC EXTRACTS, THERAPEUTIC		
GRASTEK	T2	PA
ODACTRA	T2	PA
ORALAIR	T2	PA
RAGWITEK	T2	PA
BIOLOGICALS (Blood Pressure/Heart Medications)		
PLASMA KALLIKREIN INHIBITORS		
TAKHYRO	T4	PA SP HD
BIOLOGICALS (Miscellaneous)		
PKU TREATMENT AGENTS - PHENYLALANINE AMMONIA LYASE		
PALYNZIQ 10 MG/0.5 ML SYRINGE	T4	PA QL (30 syringes/fill) SP HD
PKU TREATMENT AGENTS - PHENYLALANINE AMMONIA LYASE (cont.)		
PALYNZIQ 2.5 MG/0.5 ML SYRINGE	T4	PA QL (8 syringes/fill) SP HD
PALYNZIQ 20 MG/ML SYRINGE	T4	PA QL (60 syringes/fill) SP HD
BIOLOGICALS (Vaccines)		
COVID-19 VACCINES		
COMIRNATY	T2	PPACA
JANSSEN COVID-19 VACCINE (EUA)	T2	PPACA
MODERNA COVID VAC(EUA)	T2	PPACA
COMIRNATY	T2	PPACA
MODERNA COVID EUA	T2	PPACA
NOVAVAX COVID (EUA)	T2	PPACA
NOVAVAX COVID-19 VACC,ADJ(EUA)	T2	PPACA
PFIZER COVID EUA	T2	PPACA
PFIZER COVID-19 VACCINE (EUA)	T2	PPACA
SPIKEVAX	T2	PPACA
SPIKEVAX COVID VACC	T2	PPACA
ENTERIC VIRUS VACCINES		
IPOV	T2	PPACA
ROTARIX	T2	PPACA
ROTATEQ	T2	PPACA
GRAM NEGATIVE COCCI VACCINES		
BEXSERO	T2	PPACA
MENACTRA	T2	

T1 – Generics

T2 – Preferred Brands

T3 – Non-Preferred Brands

T4 – Brand Specialty

PA – Prior Authorization

QL – Quantity Limit

ST – Step Therapy

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List of Prescription Medications

BIOLOGICALS (Vaccines) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
GRAM NEGATIVE COCCI VACCINES (cont.)		
MENQUADFI	T2	PPACA
MENVEO A-C-Y-W-135-DIP	T2	PPACA
PENBRAYA	T2	PPACA
TRUMENBA	T2	PPACA
GRAM POSITIVE COCCI VACCINES		
CAPVAXIVE	T2	PPACA
PNEUMOVAX 23	T2	PPACA
PREVNAR 13	T2	
PREVNAR 20	T2	PPACA
VAXNEUVANCE	T2	PPACA
INFLUENZA VIRUS VACCINES		
AFLURIA QUAD	T2	PPACA
AFLURIA TRIV	T2	PPACA
AFLURIA TRIVALENT	T2	PPACA
AUDENZ (NATIONAL STOCKPILE)	T2	
FLUAD QUAD	T2	PPACA
FLUAD TRIVALENT	T2	PPACA
FLUARIX QUAD	T2	PPACA
FLUARIX TRIVALENT	T2	PPACA
FLUBLOK QUAD	T2	PPACA
FLUBLOK TRIVALENT	T2	PPACA
FLUCELVAX QUAD	T2	PPACA
FLUCELVAX TRIVALENT	T2	PPACA
FLULALVAL QUAD	T2	PPACA
FLUMIST QUAD	T2	PPACA
FLULALVAL TRIVALENT 2024-2025	T2	PPACA
FLUMIST TRIVALENT 2024-2025	T2	PPACA
FLUZONE HIGH-DOSE TRIV 2024-25	T2	PPACA
FLUZONE TRIVALENT 2024-2025	T2	PPACA
FLUZONE HIGH-DOSE	T2	PPACA
FLUZONE HIGH-DOSE QUAD	T2	PPACA
FLUZONE QUAD	T2	PPACA
FLUZONE QUAD PEDI	T2	PPACA

T1 – Generics

T2 – Preferred Brands

T3 – Non-Preferred Brands

T4 – Brand Specialty

PA – Prior Authorization

QL – Quantity Limit

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List of Prescription Medications

BIOLOGICALS (Vaccines) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ENTERIC VIRUS VACCINES		
ROTARIX VACCINE	T2	HD PPACA
NEUROTOXIC VIRUS VACCINES		
DENGVAXIA	T2	PPACA
TOXIN-PRODUCING BACILLI VACCINES/TOXOIDS		
BCG VACCINE (TICE STRAIN)	T4	SP
VACCINE/TOXOID PREPARATIONS, COMBINATIONS		
ACTHIB	T2	PPACA
ADACEL TDAP	T2	PPACA
BOOSTRIXTDAP	T2	PPACA
DACTACEL DTAP	T2	PPACA
DIPHTHERIA-TETANUS TOXOIDS-PED	T2	
HIBERIX	T2	PPACA
INFANRIX DTAP	T2	PPACA
KINRIX	T2	PPACA
M-M-R II VACCINE	T2	PPACA
PEDVAXHIB	T2	PPACA
PENTACEL	T2	PPACA
PENTACEL ACTHIB COMPONENT	T2	PPACA
PRIORIX	T2	PPACA
PROQUAD	T2	PPACA
QUADRACEL DTAP-IPV	T2	PPACA
TDVAX	T2	PPACA
TENIVAC	T2	PPACA
VAXELIS	T2	PPACA
VIRAL/TUMORIGENIC VACCINES		
ABRYSVO	T2	PPACA
ACAM2000	T2	
AREXVY VIAL KIT	T2	PPACA
ENGERIX-B ADULT	T2	PPACA
ENGERIX-B PEDIATRIC-ADOLESCENT	T2	PPACA
ERVEBO (NATIONAL STOCKPILE)	T2	
GARDASIL 9	T2	PPACA
HAVRIX	T2	PPACA
HEPLISAV-B	T2	PPACA

T1 – Generics

T2 – Preferred Brands

T3 – Non-Preferred Brands

T4 – Brand Specialty

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List of Prescription Medications

BIOLOGICALS (Vaccines) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
VIRAL/TUMORIGENIC VACCINES (cont.)		
JYNNEOS	T2	
MRESVIA	T2	PPACA
PEDIARIX	T2	PPACA
PREHEVBRIOP	T2	PPACA
RECOMBIVAX HB	T2	PPACA
SHINGRIX	T2	PPACA
TWINRIX	T2	PPACA
VAQTA	T2	PPACA
VARIVAX VACCINE	T2	PPACA
BLOOD (Blood Modifiers/Bleeding Disorders)		
ANTIFIBRINOLYTIC AGENTS		
AMICAR (<i>aminocaproic acid</i>)	T4	SP HD
<i>aminocaproic acid</i> (Amicar)	T1	SP HD
LYSTEDA (<i>tranexamic acid</i>)	T4	SP
<i>tranexamic acid</i> (Lysteda)	T1	SP
COMPLEMENT INHIBITORS		
EMPAVELI	T4	PA SP
FABHALTA	T4	PA SP
TAVNEOS	T4	PA QL (180 caps/30 days) SP
VOYDEYA	T4	PA SP
HEMOPHILIA TREATMENT AGENTS, NON-FACTOR REPLACEMENT		
HEMLIBRA	T4	PA SP HD
PYRUVATE KINASE ACTIVATORS		
PYRUKYND 20 MG TABLET	T4	PA QL (56 tabs/28 days) SP
PYRUKYND 20-5 MG TAPER PACK	T4	PA QL (14 tabs/365 days) SP
PYRUKYND 5 MG TABLET	T4	PA QL (56 tabs/28 days) SP
PYRUKYND 5 MG TAPER PACK	T4	PA QL (7 tabs/365 days) SP
PYRUKYND 50 MG TABLET	T4	PA QL (56 tabs/28 days) SP
PYRUKYND 50-20 MG TAPER PACK	T4	PA QL (14 tabs/365 days) SP
SICKLE CELL ANEMIA AGENTS		
glutamine	T1	PA
DROXIA	T2	
ENDARI	T3	PA

T1 – Generics

T2 – Preferred Brands

T3 – Non-Preferred Brands

T4 – Brand Specialty

PA – Prior Authorization

QL – Quantity Limit

ST – Step Therapy

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List of Prescription Medications

BLOOD (Blood Modifiers/Bleeding Disorders) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
SICKLE CELL ANEMIA AGENTS (cont.)		
OXBRYTA	T4	SP
TOPICAL HEMOSTATICS		
ASTRINGYN	T3	
AVITENE	T3	
ENDO-AVITENE	T3	
EVICEL	T3	
GEL-FLOW	T3	
GEL-FLOW NT	T3	
GELFOAM	T3	
GELFOAM (<i>gelatin sponge,absorb/porcine</i>)	T3	
GELFOAM COMPRESSED	T3	
GELFOAM JMI	T3	
MONSEL'S	T2	
RECOTHROM	T3	
SURGICEL	T3	
SURGIFOAM SPONGE SIZE 100	T3	
SURGIFOAM SPONGE SIZE 100C	T3	
<i>surgifoam sponge size 12-7 (Gelfoam)</i>	T1	
SYRINGE AVITENE	T3	
THROMBI-GEL (<i>thrombin/cal/cmc/gel/dress,hem</i>)	T3	
THROMBIN-JMI	T3	
THROMBI-PAD	T3	
ULTRAFOAM	T3	
BLOOD (Blood Thinners/Anti-Clotting)		
HEMORRHOELOGIC AGENTS		
pentoxifylline	T1	HD
CARDIAC DRUGS (Blood Pressure/Heart Medications)		
ANTIANGINAL, ANTI-ISCHEMIC AGENTS, NON-HEMODYNAMIC		
ranolazine	T1	HD
ranolazine (Ranexa)	T1	HD
RANEXA (<i>ranolazine</i>)	T3	ST HD
ANTIARRHYTHMICS		
amiodarone hcl	T1	HD

T1 – Generics

T2 – Preferred Brands

T3 – Non-Preferred Brands

T4 – Brand Specialty

PA – Prior Authorization

QL – Quantity Limit

ST – Step Therapy

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List of Prescription Medications

CARDIAC DRUGS (Blood Pressure/Heart Medications) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ANTIARRHYTHMICS (cont.)		
<i>disopyramide phosphate (Norpace)</i>	T1	HD
<i>dofetilide (Tikosyn)</i>	T1	HD
<i>flecainide acetate</i>	T1	HD
<i>mexiletine hcl</i>	T1	HD
MULTAQ	T2	HD
<i>propafenone hcl</i>	T1	HD
<i>quinidine gluconate</i>	T1	HD
<i>quinidine sulfate</i>	T1	HD
CALCIUM CHANNEL BLOCKER AND NSAID, COX-2 INHIBITOR		
CONSENSI	T3	
CALCIUM CHANNEL BLOCKING AGENTS		
<i>amlodipine besylate (Norvasc)</i>	T1	HD
CALAN SR (<i>verapamil hcl</i>)	T3	ST HD
CARDIZEM (<i>diltiazem hcl</i>)	T3	HD
CARDIZEM CD (<i>diltiazem hcl</i>)	T3	HD
CARDIZEM LA	T3	HD
CARDIZEM LA (<i>diltiazem hcl</i>)	T3	HD
<i>diltiazem hcl</i>	T1	HD
<i>diltiazem hcl (Cardizem Cd)</i>	T1	HD
<i>diltiazem hcl (Cardizem La)</i>	T1	HD
<i>diltiazem hcl (Cardizem)</i>	T1	HD
<i>felodipine</i>	T1	HD
<i>isradipine</i>	T1	
<i>nicardipine hcl</i>	T1	HD
<i>nifedipine</i>	T1	HD
<i>nifedipine (Procardia XL)</i>	T1	HD
<i>nifedipine (Procardia)</i>	T1	HD
<i>nimodipine 30 mg capsule</i>	T1	HD
<i>nimodipine 60 mg/20 ml soln</i>	T1	
<i>nisoldipine</i>	T1	HD
<i>nisoldipine (Sular)</i>	T1	HD
NYMALIZE	T3	
PROCARDIA (<i>nifedipine</i>)	T3	ST HD
PROCARDIA XL (<i>nifedipine</i>)	T3	ST HD

T1 – Generics

T2 – Preferred Brands

T3 – Non-Preferred Brands

T4 – Brand Specialty

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
CALCIUM CHANNEL BLOCKING AGENTS (cont.)		
SULAR (<i>nisoldipine</i>)	T3	ST HD
TIAZAC (<i>diltiazem hcl</i>)	T3	HD
verapamil hcl	T1	HD
verapamil hcl (<i>Calan Sr</i>)	T1	HD
verapamil hcl (<i>Verelan Pm</i>)	T1	ST HD
verapamil hcl (<i>Verelan</i>)	T1	HD
VERELAN (<i>verapamil hcl</i>)	T3	ST HD
VERELAN PM (<i>verapamil hcl</i>)	T3	ST HD
CARDIAC MYOSIN INHIBITOR		
CAMZYOS	T4	PA QL (30 caps/fill) SP HD
DIGITALIS GLYCOSIDES		
<i>digoxin</i>	T1	HD
<i>digoxin</i> (<i>Lanoxin</i>)	T1	HD
LANOXIN	T3	HD
LANOXIN (<i>digoxin</i>)	T3	HD
HEART RATE REDUCING, SA SELECTIVE I(F) CURRENT INH.		
ivabradine hcl (<i>Corlanor</i>)	T1	PA HD
SOLUBLE GUANYLATE CYCLASE (SGC) STIMULATOR		
VERQUVO	T2	
VASODILATORS, CORONARY		
GONITRO	T3	HD
ISORDIL (<i>isosorbide dinitrate</i>)	T3	HD
ISORDIL TITRADOSE (<i>isosorbide dinitrate</i>)	T3	HD
<i>isosorbide dinitrate</i>	T1	HD
<i>isosorbide dinitrate</i> (<i>Isordil Ttradose</i>)	T1	HD
<i>isosorbide dinitrate</i> (<i>Isordil</i>)	T1	HD
<i>isosorbide mononitrate</i>	T1	HD
MINITRAN	T3	HD
NITRO-DUR	T3	HD
<i>nitroglycerin</i>	T1	HD
<i>nitroglycerin 400 mcg spray</i> (<i>Nitrolingual</i>)	T1	HD
<i>nitroglycerin 0.3 mg tablet sl</i> (<i>Nitrostat</i>)	T1	HD
<i>nitroglycerin 0.4 mg tablet sl</i> (<i>Nitrostat</i>)	T1	HD
<i>nitroglycerin 0.6 mg tablet sl</i> (<i>Nitrostat</i>)	T1	HD

T1 – Generics

T2 – Preferred Brands

T3 – Non-Preferred Brands

T4 – Brand Specialty

PA – Prior Authorization

QL – Quantity Limit

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HD – May require home delivery pharmacy

PPACA – No Cost-Share Preventive Medication

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List of Prescription Medications

CARDIAC DRUGS (Blood Pressure/Heart Medications) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
VASODILATORS, CORONARY (cont.)		
NITROLINGUAL (<i>nitroglycerin</i>)	T3	HD
NITROMIST (<i>nitroglycerin</i>)	T3	HD
NITROSTAT (<i>nitroglycerin</i>)	T3	HD
CARDIOVASCULAR (Asthma/COPD/Respiratory)		
PULM ANTI-HTN, SOLUBLE GUANYLATE CYCLASE STIMULATOR		
ADEMPAS	T4	PA QL (90 tabs/fill) SP HD
PULM. ANTI-HTN, SEL.C-GMP PHOSPHODIESTERASE T5 INHIB		
REVATIO 10 MG/ML ORAL SUSP (<i>sildenafil citrate</i>)	T4	PA QL (112 mls/fill) SP HD
REVATIO 20 MG TABLET (<i>sildenafil citrate</i>)	T4	PA QL (90 tabs/fill) SP HD
<i>sildenafil</i> 20 mg tablet (Revatio)	T1	PA QL (90 tabs/fill) SP HD
<i>tadalafil</i> 20 mg tablet (Adcirca)	T1	PA QL (60 tabs/fill) SP HD
PULMONARY ANTI-HTN, ENDOTHELIN RECEPTOR ANTAGONIST		
ambrisentan (Letairis)	T1	PA QL (30 tabs/fill) SP HD
bosentan (Tracleer)	T1	PA QL (60 tabs/fill) SP HD
OPSUMIT	T4	PA QL (30 tabs/fill) SP HD
TRACLEER 125 MG TABLET (<i>bosentan</i>)	T4	PA QL (60 tabs/fill) SP HD
TRACLEER 32 MG TABLET FOR SUSP	T4	PA QL (120 tabs/fill) SP HD
TRACLEER 62.5 MG TABLET (<i>bosentan</i>)	T4	PA QL (60 tabs/fill) SP HD
PULMONARY ANTIHYPER AGENT, ACTRIIA-FC		
WINREVAIR	T4	PA SP HD
WINREVAIR (2 PACK)	T4	PA SP HD
PULMONARY ANTIHYPERTENSIVES, PROSTACYCLIN-TYPE		
ORENITRAM ER	T4	PA QL (90 tabs/fill) SP HD
ORENITRAM TITRATION KT MONTH 1	T4	PA SP QL (168 tabs/28 days)
ORENITRAM TITRATION KT MONTH 2	T4	PA SP QL (336 tabs/28 days)
ORENITRAM TITRATION KT MONTH 3	T4	PA SP QL (252 tabs/28 days)
TYVASO	T4	PA SP HD
TYVASO DPI	T4	PA SP HD
TYVASO INSTITUTIONAL START KIT	T4	PA SP HD
TYVASO REFILL KIT	T4	PA SP HD
TYVASO STARTER KIT	T4	PA SP HD
UPTRAVI 1,000 MCG TABLET	T4	PA QL (60 tabs/fill) SP HD
UPTRAVI 1,200 MCG TABLET	T4	PA QL (60 tabs/fill) SP HD
UPTRAVI 1,400 MCG TABLET	T4	PA QL (60 tabs/fill) SP HD

T1 – Generics

T2 – Preferred Brands

T3 – Non-Preferred Brands

T4 – Brand Specialty

PA – Prior Authorization

QL – Quantity Limit

ST – Step Therapy

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List of Prescription Medications

CARDIOVASCULAR (Asthma/COPD/Respiratory) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
PULMONARY ANTIHYPERTENSIVES, PROSTACYCLIN-TYPE (cont.)		
UPTRAVI 1,600 MCG TABLET	T4	PA QL (60 tabs/fill) SP HD
UPTRAVI 200 MCG, 400 MCG TABLET	T4	PA QL (60 tabs/fill) SP HD
UPTRAVI 600 MCG TABLET	T4	PA QL (60 tabs/fill) SP HD
UPTRAVI 800 MCG TABLET	T4	PA QL (60 tabs/fill) SP HD
VENTAVIS	T4	PA SP HD
PULMONARY HTN-ENDOTHELIN RECEPTANT G-CAMP PDE5 INH		
OPSYNVI	T4	PA QL (30 tabs/fill) SP HD
CARDIOVASCULAR (Blood Pressure/Heart Medications)		
ACE INHIBITOR-CALCIUM CHANNEL BLOCKER COMBINATION		
amlodipine besylate/benazepril	T1	HD
amlodipine besylate/benazepril (Lotrel)	T1	HD
PRESTALIA	T3	ST HD
trandolapril/verapamil hcl	T1	HD
ACE INHIBITOR-THIAZIDE OR THIAZIDE-LIKE DIURETIC		
ACCURETIC (quinapril/hydrochlorothiazide)	T3	HD
benazepril/hydrochlorothiazide	T1	HD
benazepril/hydrochlorothiazide (Lotensin Hct)	T1	HD
captopril/hydrochlorothiazide	T1	HD
enalapril/hydrochlorothiazide	T1	HD
enalapril/hydrochlorothiazide (Vaseretic)	T1	HD
flosinopril/hydrochlorothiazide	T1	HD
lisinopril/hydrochlorothiazide (Zestoretic)	T1	HD
LOTENSIN HCT (benazepril/hydrochlorothiazide)	T3	HD
quinapril/hydrochlorothiazide (Accuretic)	T1	HD
VASERETIC (enalapril/hydrochlorothiazide)	T3	HD
ZESTORETIC (lisinopril/hydrochlorothiazide)	T3	HD
ALPHA/BETA-ADRENERGIC BLOCKING AGENTS		
carvedilol (Coreg)	T1	HD
carvedilol phosphate (Coreg Cr)	T1	HD
COREG CR (carvedilol phosphate)	T3	ST HD
labetalol hcl	T1	HD
CARDURA 1 MG TABLET (doxazosin mesylate)	T3	ST QL (30 tabs/fill) HD
CARDURA 2 MG TABLET (doxazosin mesylate)	T3	ST QL (30 tabs/fill) HD
CARDURA 4 MG TABLET (doxazosin mesylate)	T3	ST QL (30 tabs/fill) HD

T1 – Generics

T2 – Preferred Brands

T3 – Non-Preferred Brands

T4 – Brand Specialty

PA – Prior Authorization

QL – Quantity Limit

ST – Step Therapy

AGE – Age Requirement

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List of Prescription Medications

CARDIOVASCULAR (Blood Pressure/Heart Medications) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ALPHA/BETA-ADRENERGIC BLOCKING AGENTS (cont.)		
CARDURA 8 MG TABLET (doxazosin mesylate)	T3	ST QL (60 tabs/fill) HD
CARDURA XL	T3	ST QL (30 tabs/fill) HD
doxazosin mesylate 1 mg tab (Cardura)	T1	QL (30 tabs/fill) HD
doxazosin mesylate 2 mg tab (Cardura)	T1	QL (30 tabs/fill) HD
doxazosin mesylate 4 mg tab (Cardura)	T1	QL (30 tabs/fill) HD
doxazosin mesylate 8 mg tab (Cardura)	T1	QL (60 tabs/fill) HD
labetalol hcl 100 mg tablet	T1	HD
labetalol hcl 200 mg tablet	T1	HD
labetalol hcl 300 mg tablet	T1	HD
MINIPRESS (prazosin hcl)	T3	HD
prazosin hcl (Minipress)	T1	HD
terazosin 1 mg capsule	T1	QL (30 caps/fill) HD
terazosin 10 mg capsule	T1	QL (60 caps/fill) HD
terazosin 2 mg, 5 mg capsule	T1	QL (30 caps/fill) HD
ALPHA-ADRENERGIC BLOCKING AGENTS		
prazosin	T1	HD
ANGIOTEN. RECEPTR ANTAG-CALCIUM CHANL BLKR-THIAZIDE		
amlodipine/valsartan/hcthiazid (Exforge Hct)	T1	HD
olmesartan/amlodipin/hcthiazid (Tribenzor)	T1	HD
ANGIOTENSIN RECEPT-NEPRILYSIN INHIBITOR COMB (ARNI)		
ENTRESTO	T2	QL (60 tabs/30 days)
ENTRESTO SPRINKLE	T2	QL (240 caps/fill) HD
sacubitril/valsartan	T1	QL (60 tabs/30 days) HD
ANGIOTENSIN RECEPTOR ANTAG.-THIAZIDE DIURETIC COMB		
candesartan/hydrochlorothiazid (Atacand Hct)	T1	HD
irbesartan/hydrochlorothiazide (Avalide)	T1	HD
losartan/hydrochlorothiazide (Hyzaar)	T1	HD
olmesartan/hydrochlorothiazide (Benicar Hct)	T1	HD
telmisartan/hydrochlorothiazid (Micardis Hct)	T1	HD
valsartan/hydrochlorothiazide (Diovan Hct)	T1	HD
ANGIOTENSIN RECEPTOR BLOCKR-CALCIUM CHANNEL BLOCKR		
amlodipine bes/olmesartan med (Azor)	T1	HD
amlodipine besylate/valsartan (Exforge)	T1	HD
telmisartan/amlodipine	T1	HD

T1 – Generics

T2 – Preferred Brands

T3 – Non-Preferred Brands

T4 – Brand Specialty

PA – Prior Authorization

QL – Quantity Limit

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List of Prescription Medications

CARDIOVASCULAR (Blood Pressure/Heart Medications) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ANTIHYPERTENSIVES, ACE INHIBITORS		
ACCUPRIL (<i>quinapril hcl</i>)	T3	HD
ALTACE (<i>ramipril</i>)	T3	HD
<i>benazepril hcl</i>	T1	HD
<i>benazepril hcl</i> (Lotensin)	T1	HD
<i>captopril</i>	T1	HD
<i>enalapril maleate</i> (Epaned)	T1	HD
<i>enalapril maleate</i> (Vasotec)	T1	HD
<i>fosinopril sodium</i>	T1	HD
<i>lisinopril</i> (Zestril)	T1	HD
LOTENSIN (<i>benazepril hcl</i>)	T3	HD
<i>moexipril hcl</i>	T1	HD
<i>perindopril erbumine</i>	T1	HD
<i>quinapril hcl</i> (Accupril)	T1	HD
<i>ramipril</i> (Altace)	T1	HD
<i>trandolapril</i>	T1	HD
VASOTEC (<i>enalapril maleate</i>)	T3	HD
ZESTRIL (<i>lisinopril</i>)	T3	HD
ANTIHYPERTENSIVES, ANGIOTENSIN RECEPTOR ANTAGONIST		
<i>candesartan cilexetil</i> (Atacand)	T1	HD
<i>eprosartan mesylate</i>	T1	HD
<i>irbesartan</i>	T1	HD
<i>irbesartan</i> (Avapro)	T1	HD
<i>losartan potassium</i> (Cozaar)	T1	HD
<i>olmesartan medoxomil</i> (Benicar)	T1	HD
<i>telmisartan</i>	T1	HD
<i>telmisartan</i> (Micardis)	T1	HD
<i>valsartan 20 mg/5 ml solution</i>	T1	HD
<i>valsartan 160 mg tablet</i> (Diovan)	T1	HD
<i>valsartan 320 mg tablet</i> (Diovan)	T1	HD
<i>valsartan 40 mg tablet</i> (Diovan)	T1	HD
<i>valsartan 80 mg tablet</i> (Diovan)	T1	HD
ANTIHYPERTENSIVES, GANGLIONIC BLOCKERS		
VECAMYL	T3	PA

T1 – Generics

T2 – Preferred Brands

T3 – Non-Preferred Brands

T4 – Brand Specialty

PA – Prior Authorization

QL – Quantity Limit

ST – Step Therapy

AGE – Age Requirement

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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
ANTIHYPERTENSIVES, MISCELLANEOUS		
DEMSER (<i>metyrosine</i>)	T3	PA HD
<i>metyrosine</i> (Demser)	T1	PA HD
ANTIHYPERTENSIVES, SYMPATHOLYTIC		
CATAPRES-TTS 1 (<i>clonidine</i>)	T3	QL (4 patches/28 days)) HD
CATAPRES-TTS 2 (<i>clonidine</i>)	T3	QL (4 patches/28 days)) HD
CATAPRES-TTS 3 (<i>clonidine</i>)	T3	QL (4 patches/28 days)) HD
<i>clonidine</i> (Catapres-Tts 1)	T1	QL (4 patches/28 days)) HD
<i>clonidine</i> (Catapres-Tts 2)	T1	QL (4 patches/28 days)) HD
<i>clonidine</i> (Catapres-Tts 3)	T1	QL (4 patches/28 days)) HD
<i>guanfacine hcl</i>	T1	HD
<i>methyldopa</i>	T1	HD
<i>methyldopa/hydrochlorothiazide</i>	T1	HD
ANTIHYPERTENSIVES, VASODILATORS		
<i>hydralazine hcl</i>	T1	HD
<i>minoxidil</i>	T1	HD
BETA-ADRENERGIC BLOCKING AGENTS		
<i>acebutolol hcl</i>	T1	HD
<i>atenolol</i> (Tenormin)	T1	HD
BETAPACE (<i>sotalol hcl</i>)	T3	ST HD
BETAPACE AF (<i>sotalol hcl</i>)	T3	ST HD
<i>betaxolol hcl</i>	T1	HD
<i>bisoprolol fumarate 10 mg tab</i>	T1	HD
<i>bisoprolol fumarate 5 mg tab</i>	T1	HD
HEMANGEOL	T2	PA
LOPRESSOR (<i>metoprolol tartrate</i>)	T3	ST HD
<i>metoprolol succinate</i> (Toprol XL)	T1	HD
<i>metoprolol tartrate</i>	T1	HD
<i>metoprolol tartrate</i> (Lopressor)	T1	HD
<i>nebivolol hcl</i> (Bystolic)	T1	HD
<i>pindolol</i>	T1	HD
<i>propranolol hcl</i>	T1	HD
<i>propranolol hcl</i> (Inderal La)	T1	HD
<i>sotalol hcl</i> (Betapace Af)	T1	HD
<i>sotalol hcl</i> (Betapace)	T1	HD

T1 – Generics

T2 – Preferred Brands

T3 – Non-Preferred Brands

T4 – Brand Specialty

PA – Prior Authorization

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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
BETA-ADRENERGIC BLOCKING AGENTS (cont.)		
SOTYLIZE	T2	HD
TENORMIN (atenolol)	T3	ST HD
<i>timolol maleate 10 mg tablet</i>	T1	HD
<i>timolol maleate 20 mg tablet</i>	T1	HD
<i>timolol maleate 5 mg tablet</i>	T1	HD
BETA-BLOCKERS AND THIAZIDE, THIAZIDE-LIKE DIURETICS		
<i>atenolol/chlorthalidone</i> (Tenoretic 100)	T1	HD
<i>atenolol/chlorthalidone</i> (Tenoretic 50)	T1	HD
<i>bisoprolol/hydrochlorothiazide</i>	T1	HD
METOPROLOL SUCCINATE ER-HCTZ	T3	ST HD
<i>metoprolol/hydrochlorothiazide</i>	T1	HD
<i>propranolol/hydrochlorothiazide</i>	T1	HD
TENORETIC 100 (<i>atenolol/chlorthalidone</i>)	T3	ST HD
TENORETIC 50 (<i>atenolol/chlorthalidone</i>)	T3	ST HD
RENIN INHIBITOR, DIRECT		
<i>aliskiren hemifumarate</i> (Tekturna)	T1	HD
RENIN INHIBITOR, DIRECT AND THIAZIDE DIURETIC COMB		
TEKTURNNA HCT	T2	HD
VASODILATORS, COMBINATION		
<i>isosorbide dinit/hydralazine</i> (Bidil)	T1	HD
VASODILATORS, PERIPHERAL		
<i>ergoloid mesylates</i>	T1	
<i>isoxsuprine hc</i>	T1	
CARDIOVASCULAR (Cholesterol Medications)		
ANTIHYPERLIP.HMG COA REDUCT INHIB-CHOLEST.AB.INHIB		
<i>ezetimibe/atorvastatin</i>	T1	ST HD QL (30 tabs/30 days)
<i>ezetimibe/simvastatin</i> (Vytorin)	T1	QL (30 tabs/fill) HD
ROSZET	T3	ST QL (30 tabs/fill) HD
ANTIHYPERLIPID- HMG-COA RI-CALCIUM CHANNEL BLOCKER		
<i>amlodipine/atorvastatin</i>	T1	QL (30 tabs/fill) HD
<i>amlodipine/atorvastatin</i> (Caduet)	T1	QL (30 tabs/fill) HD
CADUET (<i>amlodipine/atorvastatin</i>)	T3	ST QL (30 tabs/fill) HD
ANTIHYPERLIPIDEMIC - APOLIPOPROTEIN INHIBITOR		
TRYNGOLZA	T4	PA SP

T1 – Generics

T2 – Preferred Brands

T3 – Non-Preferred Brands

T4 – Brand Specialty

PA – Prior Authorization

QL – Quantity Limit

ST – Step Therapy

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List of Prescription Medications

CARDIOVASCULAR (Cholesterol Medications) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ANTIHYPERLIPIDEMIC - ATP CITRATE LYASE INHIBITOR		
NEXLETOL	T2	PA
ANTIHYPERLIPIDEMIC - MTP INHIBITOR		
JUXTAPID	T4	PA SP HD
ANTIHYPERLIPIDEMIC - PCSK9 INHIBITORS		
REPATHA PUSHTRONEX	T2	PA
REPATHA SURECLICK	T2	PA
REPATHA SYRINGE	T2	PA
ANTIHYPERLIPIDEMIC-ACLY AND CHOLEST ABSORP INHIB		
NEXLIZET	T2	PA
ANTIHYPERLIPIDEMIC-HMGCOA REDUCTASE INHIB (STATINS)		
FLOLIPID	T3	ST QL (150 mls/fill) HD
<i>fluvastatin sodium (Lescol XL)</i>	T1	QL (30 tabs/fill) HD PPACA
<i>fluvastatin sodium 20 mg cap</i>	T1	QL (30 caps/fill) HD PPACA
<i>fluvastatin sodium 40 mg cap</i>	T1	QL (60 caps/fill) HD PPACA
<i>LESCOL XL (fluvastatin sodium)</i>	T3	ST QL (30 tabs/fill) HD
<i>lovastatin 10 mg tablet</i>	T1	QL (30 tabs/fill) HD PPACA
<i>lovastatin 20 mg tablet</i>	T1	QL (60 tabs/fill) HD PPACA
<i>lovastatin 40 mg tablet</i>	T1	QL (60 tabs/fill) HD PPACA
<i>pitavastatin</i>	T1	
<i>pitavastatin (Livalo)</i>	T1	QL (30 tabs/30 days) HD PPACA
<i>pravastatin sodium</i>	T1	QL (30 tabs/fill) HD PPACA
<i>simvastatin 10 mg tablet (Zocor)</i>	T1	QL (30 tabs/fill) HD PPACA
<i>simvastatin 20 mg tablet (Zocor)</i>	T1	QL (30 tabs/fill) HD PPACA
<i>SIMVASTATIN 20 MG/5 ML SUSP</i>	T3	ST QL (150 mls/fill) HD
<i>simvastatin 40 mg tablet (Zocor)</i>	T1	QL (30 tabs/fill) HD PPACA
<i>simvastatin 5 mg tablet</i>	T1	QL (30 tabs/fill) HD PPACA
<i>simvastatin 80 mg tablet (Zocor)</i>	T1	QL (30 tabs/fill) HD
ZYPITAMAG	T3	ST QL (30 tabs/fill) HD
BILE SALT SEQUESTRANTS		
<i>cholestyramine (with sugar) (Questran)</i>	T1	HD
<i>cholestyramine/aspartame</i>	T1	HD
<i>cholestyramine</i>	T1	HD
<i>cholestyramine (Questran Light)</i>	T1	HD
<i>colesevelam hcl (Welchol)</i>	T1	HD

T1 – Generics

T2 – Preferred Brands

T3 – Non-Preferred Brands

T4 – Brand Specialty

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List of Prescription Medications

CARDIOVASCULAR (Cholesterol Medications) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
BILE SALT SEQUESTRANTS (cont.)		
COLESTID	T3	ST HD
COLESTID (<i>colestipol hcl</i>)	T3	ST HD
<i>colestipol hcl</i>	T1	HD
<i>colestipol hcl</i> (Colestid)	T1	HD
QUESTRAN (<i>cholestyramine (with sugar)</i>)	T3	ST HD
QUESTRAN LIGHT (<i>cholestyramine</i>)	T3	ST HD
LIPOTROPICS		
ANTARA	T3	ST HD
<i>ezetimibe</i> (Zetia)	T1	HD
<i>fenofibrate 120 mg tablet</i> (Fenoglide)	T1	ST HD
<i>fenofibrate 130 mg capsule</i>	T1	ST HD
<i>fenofibrate 134 mg capsule</i>	T1	HD
<i>fenofibrate 145 mg tablet</i> (Tricor)	T1	HD
<i>fenofibrate 160 mg tablet</i>	T1	HD
<i>fenofibrate 200 mg capsule</i>	T1	HD
<i>fenofibrate 40 mg tablet</i> (Fenoglide)	T1	ST HD
<i>fenofibrate 43 mg capsule</i>	T1	HD
<i>fenofibrate 48 mg tablet</i> (Tricor)	T1	HD
<i>fenofibrate 54 mg tablet</i>	T1	HD
<i>fenofibrate 67 mg capsule</i>	T1	HD
<i>fenofibric acid</i>	T1	HD
<i>fenofibric acid (choline)</i>	T1	HD
<i>fenofibric acid (choline)</i> (Trilipix)	T1	HD
<i>fenofibric acid (Fibrincor)</i>	T1	HD
FENOGLIDE (<i>fenofibrate</i>)	T3	ST HD
FIBRICOR (<i>fenofibric acid</i>)	T3	ST HD
<i>gemfibrozil</i> (Lopid)	T1	HD
LOPID (<i>gemfibrozil</i>)	T3	HD
<i>niacin</i>	T1	HD
<i>niacin 500 mg tablet</i>	T1	HD
NIACOR	T3	HD
TRILIPIX (<i>fenofibric acid (choline)</i>)	T3	ST HD

T1 – Generics

T2 – Preferred Brands

T3 – Non-Preferred Brands

T4 – Brand Specialty

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 (Alzheimer's Disease)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ALZHEIMER'S THERAPY, NMDA RECEPTOR ANTAGONISTS		
memantine hcl	T1	HD
memantine hcl (Namenda Xr)	T1	HD
memantine hcl 10 mg/5 ml cup	T1	HD
memantine hcl 2 mg/ml solution	T1	HD
memantine hcl 5 mg tablet	T1	HD
memantine hcl 10 mg tablet	T1	HD
MEMANTINE 5-10 MG TITRATION PK	T3	HD
NAMENDA	T3	HD
NAMENDA XR TITRATION PACK	T3	HD
NAMZARIC	T2	ST HD
ALZHEIMER'S THX,NMDA RECEPTOR ANTAG-CHOLINES INHIB		
memantine hcl/donepezil hcl (Namzaric)	T1	ST HD
NAMZARIC (memantine hcl/donepezil hcl)	T2	ST HD
CNS DRUGS (Miscellaneous)		
AMYOTROPHIC LATERAL SCLEROSIS AGENTS		
RADICAVA ORS	T4	PA SP HD
RILUTEK (riluzole)	T4	PA SP HD
riluzole (Rilutek)	T1	PA SP HD
TEGLUTIK	T4	PA SP
TIGLUTIK	T4	PA SP
DRUGS TO TREAT MOVEMENT DISORDERS		
AUSTEDO 12 MG TABLET	T4	PA QL (120 tabs/fill) SP HD
AUSTEDO 6 MG TABLET	T4	PA QL (60 tabs/fill) SP HD
AUSTEDO 9 MG TABLET	T4	PA QL (120 tabs/fill) SP HD
AUSTEDO XR 6 MG TABLET	T4	PA SP HD QL (210 tabs/30 days)
AUSTEDO XR 12 MG TABLET	T4	PA SP HD QL (90 tabs/30 days)
AUSTEDO XR 18 MG TABLET	T4	PA QL (30 tabs/fill) SP HD
AUSTEDO XR 24 MG TABLET	T4	PA SP HD QL (60 tabs/30 days)
AUSTEDO XR 30 MG TABLET	T4	PA QL (30 tabs/fill) SP HD
AUSTEDO XR 36 MG TABLET	T4	PA QL (30 tabs/fill) SP HD
AUSTEDO XR 42 MG TABLET	T4	PA QL (30 tabs/fill) SP HD
AUSTEDO XR 48 MG TABLET	T4	PA QL (30 tabs/fill) SP HD
AUSTEDO XR TITRATION KT(WK1-4)	T4	PA QL (28 tabs/fill) SP HD

T1 – Generics

T2 – Preferred Brands

T3 – Non-Preferred Brands

T4 – Brand Specialty

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
DRUGS TO TREAT MOVEMENT DISORDERS (cont.)		
HORIZANT	T3	ST
INGREZZA	T4	PA QL (30 caps/fill) SP
INGREZZA SPRINKLE	T4	PA QL (30 caps/fill) SP
INGREZZA INITIATION PK(TARDIV)	T4	PA QL (28 caps/30 days) SP
tetrabenazine 12.5 mg tablet (Xenazine)	T1	PA QL (120 tabs/fill) SP HD
tetrabenazine 25 mg tablet (Xenazine)	T1	PA QL (60 tabs/fill) SP HD
PSEUDOBULBAR AFFECT (PBA) AGENTS, NMDA ANTAGONISTS		
NUEDEXTA	T2	PA
XANTHINES		
caffeine citrate	T1	HD
CNS DRUGS (Multiple Sclerosis)		
AGENTS TO TREAT MULTIPLE SCLEROSIS		
AVONEX (4 PACK)	T4	PA QL (1 kit/28 days) SP HD
AVONEX PEN (4 PACK)	T4	PA QL (4 pens/28 days) SP HD
BAFIERTAM	T4	PA QL (120 caps/fill) SP HD
BETASERON	T4	PA QL (14 kits/30 days) SP HD
dimethyl fumarate (Tecfidera)	T1	PA QL (60 caps/fill) SP HD
glatiramer 20 mg/ml syringe (Copaxone)	T1	PA QL (30 syringes/30 days) SP HD
glatiramer 40 mg/ml syringe (Copaxone)	T1	PA QL (12 syringes/30 days) SP HD
glatopa 20 mg/ml syringe (Copaxone)	T1	PA QL (30 syringes/30 days) SP HD
glatopa 40 mg/ml syringe (Copaxone)	T1	PA QL (12 syringes/30 days) SP HD
KESIMPTA PEN	T4	PA QL (1 pen/28 days) SP HD
MAVENCLAD 10 MG X 10 TABLET PK	T4	PA QL (10 tabs/fill) SP HD
MAVENCLAD 10 MG X 4 TABLET PK	T4	PA QL (4 tabs/fill) SP HD
MAVENCLAD 10 MG X 5 TABLET PK	T4	PA QL (5 tabs/fill) SP HD
MAVENCLAD 10 MG X 6 TABLET PK	T4	PA QL (6 tabs/fill) SP HD
MAVENCLAD 10 MG X 7 TABLET PK	T4	PA QL (7 tabs/fill) SP HD
MAVENCLAD 10 MG X 8 TABLET PK	T4	PA QL (8 tabs/fill) SP HD
MAVENCLAD 10 MG X 9 TABLET PK	T4	PA QL (9 tabs/fill) SP HD
MAYZENT 0.25 MG TABLET	T4	PA QL (30 tabs/fill) SP HD
MAYZENT 0.25MG START-1MG MAINT	T4	PA QL (7 tabs/fill) SP HD
MAYZENT 0.25MG START-2MG MAINT	T4	PA QL (12 tabs/fill) SP HD
MAYZENT 1 MG TABLET	T4	PA QL (30 tabs/fill) SP HD
MAYZENT 2 MG TABLET	T4	PA QL (30 tabs/fill) SP HD

T1 – Generics

T2 – Preferred Brands

T3 – Non-Preferred Brands

T4 – Brand Specialty

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 (Multiple Sclerosis) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
AGENTS TO TREAT MULTIPLE SCLEROSIS (cont.)		
PLEGRIDY 125 MCG/0.5 ML PEN	T4	PA QL (1 ml/28 days) SP HD
PLEGRIDY 125 MCG/0.5 ML SYRING	T4	PA QL (1 ml/28 days) SP HD
PLEGRIDY PEN INJ STARTER PACK	T4	PA QL (1 ml/365 days) SP HD
PLEGRIDY SYRINGE STARTER PACK	T4	PA QL (1 ml/365 days) SP HD
REBIF 22 MCG/0.5 ML SYRINGE	T4	PA QL (6 mls/28 days) SP HD
REBIF 44 MCG/0.5 ML SYRINGE	T4	PA QL (6 mls/28 days) SP HD
REBIF REBIDOSE 22 MCG/0.5 ML	T4	PA QL (6 mls/28 days) SP HD
REBIF REBIDOSE 44 MCG/0.5 ML	T4	PA QL (6 mls/28 days) SP HD
REBIF REBIDOSE TITRATION PACK	T4	PA QL (4.2 mls/28 days) SP HD
REBIF TITRATION PACK	T4	PA QL (4.2 mls/28 days) SP HD
VUMERTY	T4	PA QL (120 caps/fill) SP HD
AGTS TX NEUROMUSC TRANSMISSION DIS, POT-CHAN BLKR		
dalfampridine (Ampyra)	T1	PA QL (60 tabs/fill) SP HD
FIRDAPSE	T4	PA SP
RUZURGI	T2	PA
CNS DRUGS (Pain Relief And Inflammatory Disease)		
CALCITONIN GENE-RELATED PEPTIDE (CGRP) INHIBITORS		
EMGALITY 100 MG/ML SYR(1 OF 3)	T2	PA QL (3 mls/30 days)
EMGALITY 300 MG (100 MG X3SYR)	T2	PA QL (3 mls/30 days)
gabapentin (Gralise)	T1	ST
GRALISE (gabapentin)	T3	ST
SPHINGOSINE I-PHOSPHATE (SIP) RECEPTOR MODULATOR		
VELSIPITY	T4	PA QL (30 tabs/30 days) SP HD
ZEPOSIA 0.23-0.46 MG START PCK	T4	PA QL (7 caps/fill) SP HD
ZEPOSIA 0.92 MG CAPSULE	T4	PA QL (30 caps/fill) SP HD
ZEPOSIA STARTER KIT (28-DAY)	T4	
CNS DRUGS (Seizure Disorders)		
ANTICONVULSANT - BENZODIAZEPINE TYPE		
clobazam (Onfi)	T1	PA HD
clonazepam	T1	HD
clonazepam (Klonopin)	T1	HD
DIASTAT (diazepam)	T3	HD
diazepam 10 mg rectal gel syrg	T1	HD

T1 – Generics

T2 – Preferred Brands

T3 – Non-Preferred Brands

T4 – Brand Specialty

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
ANTICONVULSANT - BENZODIAZEPINE TYPE (cont.)		
diazepam 10mg rectal gel (2pk)	T1	HD
diazepam 2.5mg rectal gel(2pk) (Diastat)	T1	HD
diazepam 20 mg rectal gel syrg	T1	HD
diazepam 20mg rectal gel (2pk)	T1	HD
NAYZILAM	T2	PA QL (2 units/fill) HD
SYMPAZAN	T3	PA HD
VALTOCO	T2	PA QL (2 units/30 days) HD
ANTICONVULSANT - CANNABINOID TYPE		
EPIDIOLEX	T4	PA SP HD
ANTICONVULSANTS		
APTIOM (<i>eslicarbazepine acetate</i>)	T3	HD
BRIVIACT	T3	ST HD
carbamazepine 100 mg/5 ml cup	T1	HD
carbamazepine 200 mg/10 ml cup	T1	HD
carbamazepine 100 mg/5 ml susp (Tegretol)	T1	HD
carbamazepine 100 mg tab chew	T1	HD
CARBAMAZEPINE 200 MG TAB CHEW	T3	HD
carbamazepine 200 mg tablet (Tegretol)	T1	HD
carbamazepine (Carbatrol)	T1	HD
carbamazepine (Tegretol Xr)	T1	HD
carbamazepine (Tegretol)	T1	HD
CARBATROL (carbamazepine)	T3	HD
CELONTIN	T2	HD
CELONTIN (<i>methylsuximide</i>)	T3	HD
DEPAKOTE (<i>divalproex sodium</i>)	T3	ST HD
DEPAKOTE ER (<i>divalproex sodium</i>)	T3	ST HD
DEPAKOTE SPRINKLE (<i>divalproex sodium</i>)	T3	ST HD
DIACOMIT	T4	PA SP HD
DILANTIN 100 MG CAPSULE (<i>phenytoin sodium extended</i>)	T3	HD
DILANTIN 30 MG CAPSULE	T2	HD
DILANTIN 50 MG INFATAB (<i>phenytoin</i>)	T3	HD
DILANTIN-125 (<i>phenytoin</i>)	T3	HD
<i>divalproex sodium</i> (Depakote Er)	T1	HD
<i>divalproex sodium</i> (Depakote Sprinkle)	T1	HD

T1 – Generics

T2 – Preferred Brands

T3 – Non-Preferred Brands

T4 – Brand Specialty

PA – Prior Authorization

QL – Quantity Limit

ST – Step Therapy

AGE – Age Requirement

SP – Specialty Medication

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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
ANTICONVULSANTS (cont.)		
<i>divalproex sodium (Depakote)</i>	T1	HD
ELEPSIA XR	T3	ST HD
<i>eslicarbazepine acetate (Aptiom)</i>	T1	HD
<i>ethosuximide (Zarontin)</i>	T1	HD
<i>felbamate (Felbatol)</i>	T1	HD
FELBATOL (<i>felbamate</i>)	T3	HD
FYCOMPA	T2	HD
FYCOMPA (<i>perampanel</i>)	T2	HD
<i>gabapentin</i>	T1	HD
<i>gabapentin (Neurontin)</i>	T1	HD
<i>gabapentin (Neurontin)</i>	T1	HD
<i>lacosamide (Vimpat)</i>	T1	HD
LAMICTAL XR (BLUE)	T3	ST HD
LAMICTAL XR (GREEN)	T3	ST HD
LAMICTAL XR (ORANGE)	T3	ST HD
<i>lamotrigine (Lamictal (Blue))</i>	T1	HD
<i>lamotrigine (Lamictal (Green))</i>	T1	HD
<i>lamotrigine (Lamictal (Orange))</i>	T1	HD
<i>lamotrigine (Lamictal Odt (Blue))</i>	T1	HD
<i>lamotrigine (Lamictal Odt (Green))</i>	T1	HD
<i>lamotrigine (Lamictal Odt (Orange))</i>	T1	HD
<i>lamotrigine (Lamictal Odt)</i>	T1	HD
<i>lamotrigine (Lamictal Xr)</i>	T1	HD
<i>lamotrigine (Lamictal)</i>	T1	HD
<i>lamotrigine (Lamictal)</i>	T1	HD
<i>levetiracetam 1,000 mg tablet (Keppra)</i>	T1	HD
<i>levetiracetam 1,000mg/10ml cup (Keppra)</i>	T1	HD
<i>levetiracetam 100 mg/ml soln (Keppra)</i>	T1	HD
<i>levetiracetam 250 mg tablet (Keppra)</i>	T1	HD
<i>levetiracetam 500 mg tablet (Keppra)</i>	T1	HD
<i>levetiracetam 500 mg/5 ml cup</i>	T1	HD
<i>levetiracetam 500 mg/5 ml soln</i>	T1	HD
<i>levetiracetam 750 mg tablet (Keppra)</i>	T1	HD
LEVENTIRACETAM 250 MG TAB SUSP	T3	ST HD

T1 – Generics

T2 – Preferred Brands

T3 – Non-Preferred Brands

T4 – Brand Specialty

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
ANTICONVULSANTS (cont.)		
<i>levetiracetam</i> (Keppra Xr)	T1	HD
<i>levetiracetam</i> (Keppra)	T1	HD
MYSOLINE (<i>primidone</i>)	T3	HD
<i>oxcarbazepine</i> (Oxtellar Xr)	T1	HD
<i>oxcarbazepine</i> (Trileptal)	T1	HD
OXTELLAR XR (<i>oxcarbazepine</i>)	T3	HD
<i>perampanel</i> (Fycompa)	T1	HD
PHENYTEK (<i>phenytoin sodium extended</i>)	T3	HD
<i>phenytoin</i>	T1	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> (Lyrica)	T1	HD
<i>primidone</i> (Mysoline)	T1	HD
QUDEXY XR (<i>topiramate</i>)	T3	ST HD
<i>rufinamide</i> (Banzel)	T1	PA HD
SPRITAM	T3	ST HD
TEGRETOL (<i>carbamazepine</i>)	T3	HD
TEGRETOL XR (<i>carbamazepine</i>)	T3	HD
<i>tiagabine hcl</i>	T1	HD
<i>topiramate</i> (Qudexy Xr)	T1	ST HD
<i>topiramate 100 mg tablet</i> (Topamax)	T1	HD
<i>topiramate 15 mg sprinkle cap</i> (Topamax)	T1	HD
<i>topiramate 200 mg tablet</i> (Topamax)	T1	HD
<i>topiramate 25 mg sprinkle cap</i> (Topamax)	T1	HD
<i>topiramate 25 mg tablet</i> (Topamax)	T1	HD
<i>topiramate 50 mg tablet</i> (Topamax)	T1	HD
<i>topiramate er 25mg, 50mg, 100mg capsule</i>	T1	ST
<i>topiramate er</i> (Trokendi XR)	T1	ST HD
TROKENDI XR	T3	ST HD
<i>valproic acid</i>	T1	HD
<i>valproic acid</i> (as sodium salt)	T1	HD
VIGADRONE	T1	PA SP HD QL (150 pkts/30 days)

T1 – Generics

T2 – Preferred Brands

T3 – Non-Preferred Brands

T4 – Brand Specialty

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
ANTICONVULSANTS (cont.)		
XCOPRI 250 MG DAILY DOSE PACK	T3	QL (56 tabs/fill) HD
XCOPRI 350 MG DAILY DOSE PACK	T3	QL (56 tabs/fill) HD
XCOPRI 25 MG, 50 MG TABLET	T3	QL (30 tabs/fill) HD
XCOPRI 100 MG TABLET	T3	QL (30 tabs/fill) HD
XCOPRI 150 MG TABLET	T3	QL (30 tabs/fill) HD
XCOPRI 200 MG TABLET	T3	QL (30 tabs/fill) HD
XCOPRI 12.5-25 MG TITRATION PK	T3	QL (28 tabs/fill) HD
XCOPRI 50-100 MG TITRATION PAK	T3	QL (28 tabs/fill) HD
XCOPRI 150-200 MG TITRATION PK	T3	QL (28 tabs/fill) HD
ZARONTIN (<i>ethosuximide</i>)	T3	HD
<i>zonisamide</i>	T1	HD
<i>zonisamide</i> (Zonegran)	T1	HD
CNS DRUGS (Sleep Disorders/Sedatives)		
NARCOLEPSY TX-H3-RECEPT.ANTAGONIST/INVERSE AGONIST		
WAKIX 17.8 MG TABLET	T4	PA QL (60 tabs/fill) SP HD
WAKIX 4.45 MG TABLET	T4	PA QL (30 tabs/fill) SP HD
COLONY STIMULATING FACTORS (Blood Modifiers/Bleeding Disorders)		
LEUKOCYTE (WBC) STIMULANTS		
FULPHILA	T4	PA QL (1.2 mls/30 days) SP
LEUKINE	T4	PA SP
NIVESTYM	T4	PA SP HD
THROMBOPOIETIN RECEPTOR AGONISTS		
<i>eltrombopag olamine</i> (Promacta)	T1	PA SP HD
DOPTELET	T4	PA QL (15 tabs/fill) SP HD
PROMACTA (<i>eltrombopag olamine</i>)	T4	PA SP HD
COLONY STIMULATING FACTORS (Cancer)		
CXCR4 CHEMOKINE RECEPTOR ANTAGONIST		
XOLREMDI	T4	PA SP CSL
CONTRACEPTIVES (Contraception Products)		
CONTRACEPTIVES, INTRAVAGINAL, SYSTEMIC		
ANNOVERA	T3	ST QL (1 ring/365 days) PPACA
<i>etonogestrel/ethynodiol dihydrogesterone</i> (Nuvaring)	T1	PPACA

T1 – Generics

T2 – Preferred Brands

T3 – Non-Preferred Brands

T4 – Brand Specialty

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
CONTRACEPTIVES, INJECTABLE		
DEPO-PROVERA (<i>medroxyprogesterone acetate</i>)	T3	QL (1 ml/90 days) PPACA
DEPO-SUBQ PROVERA 104	T3	QL (1 ml/90 days) PPACA
<i>medroxyprogesterone 150 mg/ml</i> (Depo-Provera)	T1	QL (1 ml/90 days) PPACA
CONTRACEPTIVES, ORAL		
BEYAZ (<i>drosipr/eth estra/levomefol ca</i>)	T3	ST HD PPACA
<i>desog-e.estradiol/e.estradiol</i>	T1	HD PPACA
<i>desog-e.estradiol/e.estradiol</i>	T1	HD PPACA
<i>desogestrel-ethinyl estradiol</i>	T1	HD PPACA
<i>drosipr/eth estra/levomefol ca</i> (Beyaz)	T1	HD PPACA
<i>drosipr/eth estra/levomefol ca</i> (Safyral)	T1	HD PPACA
ELLA	T2	QL (1 tab/fill) HD PPACA
<i>ethinyl estradiol/dospirenone</i> (Yasmin 28)	T1	PPACA
<i>ethinyl estradiol/dospirenone</i> (Yaz)	T1	HD PPACA
<i>ethynodiol d-ethinyl estradiol</i>	T1	HD PPACA
<i>levonorgestrel/ethin.estradiol</i>	T1	HD PPACA
<i>I-norgest/e.estradiol-e.estrad</i>	T1	HD PPACA
<i>noreth-ethinyl estradiol/iron</i>	T1	HD PPACA
<i>noreth-ethinyl estradiol/iron</i> (Generess Fe)	T1	HD PPACA
<i>norethind-eth estrad 1-0.02 mg</i> (Loestrin)	T1	HD PPACA
<i>norethindrone</i>	T1	HD PPACA
<i>norethindrone ac/eth estradiol</i> (Loestrin)	T1	PPACA
<i>norethindrone-e.estradiol-iron</i>	T1	HD PPACA
<i>norethindrone-e.estradiol-iron</i> (Loestrin Fe)	T1	HD PPACA
<i>norethindrone-e.estradiol-iron</i> (Taytulla)	T1	HD PPACA
<i>norethindrone-ethin. estradiol</i>	T1	HD PPACA
<i>norethin-ee 1.5-0.03 mg(21) tb</i> (Loestrin)	T1	HD PPACA
<i>norgestimate-ethinyl estradiol</i>	T1	HD PPACA
<i>NORGESTREL-ETHINYL ESTRADIOL</i>	T1	HD PPACA
YAZ (<i>ethinyl estradiol/dospirenone</i>)	T3	ST HD PPACA
CONTRACEPTIVES, TRANSDERMAL		
<i>norelgestromin/ethin.estradiol</i>	T1	PPACA
INTRA-UTERINE DEVICES (IUDS)		
KYLEENA	T4	SP PPACA
LILETTA	T4	SP PPACA

T1 – Generics

T2 – Preferred Brands

T3 – Non-Preferred Brands

T4 – Brand Specialty

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

CONTRACEPTIVES (Contraception Products) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
INTRA-UTERINE DEVICES (IUDS) (cont.)		
MIRENA	T4	SP PPACA
SKYLA	T4	SP PPACA
COUGH/COLD PREPARATIONS (Allergy/Nasal Sprays)		
1ST GEN ANTIHIST-DECONGEST-ANTICHOLINERGIC COMB		
RESPA A.R. (<i>pseudoephed/chlor-mal/bell alk</i>)	T3	
COUGH/COLD PREPARATIONS (Cough/Cold Medications)		
ANTITUSSIVES, NON-OPIOID		
<i>benzonatate</i>	T1	
DECONGESTANT-EXPECTORANT COMBINATIONS		
<i>guaifenesin/phenylephrine hcl</i>	T1	
NON-OPIOID ANTITUS-1ST GEN.ANTIHISTAMINE-DECONGEST		
BROMFED DM (<i>brompheniramine/pseudoephed/dm</i>)	T3	
<i>brompheniramine/pseudoephed/dm</i> (Bromfed Dm)	T1	
NON-OPIOID ANTITUSSIVE-1ST GEN ANTIHISTAMINE COMB.		
<i>promethazine/dextromethorphan</i>	T1	
OPIOID ANTITUSSIV-1ST GEN. ANTIHISTAMINE-DECONGEST		
CAPCOF	T3	
HISTEX-AC	T3	
MAXI-TUSS CD	T3	
POLY-TUSSIN AC	T3	
<i>promethazine/phenyleph/codeine</i>	T1	
ZODRYL DAC 25	T3	
ZODRYL DAC 30	T3	
ZODRYL DAC 35	T3	
ZODRYL DAC 40	T3	
ZODRYL DAC 50	T3	
ZODRYL DAC 60	T3	
ZODRYL DAC 80	T3	
OPIOID ANTITUSSIVE-1ST GENERATION ANTIHISTAMINE		
<i>hydrocodone/chlorphen p-stirex</i>	T1	
<i>promethazine hcl/codeine</i>	T1	
TUSSICAPS	T3	PA
TUXARIN ER	T3	

T1 – Generics

T2 – Preferred Brands

T3 – Non-Preferred Brands

T4 – Brand Specialty

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
OPIOID ANTITUSSIVE-1ST GENERATION ANTIHISTAMINE (cont.)		
TUZISTRA XR	T3	PA
ZODRYL AC 25	T3	
ZODRYL AC 30	T3	
ZODRYL AC 35	T3	
ZODRYL AC 40	T3	
ZODRYL AC 50	T3	
ZODRYL AC 60	T3	
ZODRYL AC 80	T3	
OPIOID ANTITUSSIVE-ANTICHOLINERGIC COMBINATIONS		
HYCODAN	T3	
HYCODAN (<i>hydrocodone bit/homatrop me-br</i>)	T3	
OPIOID ANTITUSSIVE-ANTICHOLINERGIC COMBINATIONS		
<i>hydrocodone bit/homatrop me-br</i>	T1	
<i>hydrocodone bit/homatrop me-br</i> (Hycodan)	T1	
OPIOID ANTITUSSIVE-DECONGESTANT-EXPECTORANT COMB		
CODITUSSIN DAC	T3	
<i>pseudoephed/codeine/guaififen</i>	T1	
ZODRYL DEC 25	T3	
ZODRYL DEC 30	T3	
ZODRYL DEC 35	T3	
ZODRYL DEC 40	T3	
ZODRYL DEC 50	T3	
ZODRYL DEC 60	T3	
ZODRYL DEC 80	T3	
OPIOID ANTITUSSIVE-EXPECTORANT COMBINATION		
<i>codeine phosphate/guaifenesin</i>	T1	
CODITUSSIN AC	T3	
GUAIFEN-CODEINE 100-10 MG/5 ML	T3	
<i>guaifen-codeine 100-10 mg/5 ml</i>	T1	
GUAIFEN-CODEINE 200-20 MG/10ML	T3	
MAR-COF CG	T3	
NINJACOF-XG	T3	
OBREDON	T3	PA

T1 – Generics

T2 – Preferred Brands

T3 – Non-Preferred Brands

T4 – Brand Specialty

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

DIAGNOSTIC (Diabetes)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
BLOOD SUGAR DIAGNOSTICS		
FREESTYLE INSULINX	T2	
FREESTYLE INSULINX TEST STRIPS	T2	
FREESTYLE LITE TEST STRIP	T2	
FREESTYLE PRECISION NEO	T2	
FREESTYLE TEST STRIPS	T2	
ONETOUCH ULTRA TEST STRIP	T2	
ONETOUCH VERIO TEST STRIP	T2	
PRECISION XTRA	T2	
URINE GLUCOSE TEST AIDS		
DIASTIX REAGENT	T2	
DIAGNOSTIC (Miscellaneous)		
BLOOD TESTING PREPARATIONS		
FORA GTEL KETONE TEST STRIP	T3	
GOJJI BLOOD KETONE TEST STRIP	T3	
NOVAMAX PLUS	T2	
PRECISION XTRA	T2	
CARDIOVASCULAR DIAGNOSTICS-RADIOPAQUE		
OMNIPAQ	T3	
DIAGNOSTIC PREPARATIONS, MISCELLANEOUS		
ARIDOL	T3	
METHACHOLINE CHLORIDE	T3	
PROVOCHOLINE	T3	
TC 99M SULFUR COLLOID PREP	T3	
TOXICOLOGY SALIVA COLLECTION	T3	
VUEBLU	T3	
EYE DIAGNOSTIC AGENTS		
fluorescein sodium	T1	
ful-glo 1 mg oph strip	T1	
FUL-GLO EYE STRIPS	T3	
FLUORESCENCE IMAGING AGENTS - MALIGNANT TISSUE		
GLEOLAN	T3	
GASTROINTESTINAL RADIOPAQUE DIAGNOSTICS		
diatrizoate meglumine, sodium (Gastrografin)	T1	
ENTEROVU	T3	

T1 – Generics

T2 – Preferred Brands

T3 – Non-Preferred Brands

T4 – Brand Specialty

PA – Prior Authorization

QL – Quantity Limit

ST – Step Therapy

AGE – Age Requirement

SP – Specialty Medication

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List of Prescription Medications

DIAGNOSTIC (Miscellaneous) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
GASTROINTESTINAL RADIOPAQUE DIAGNOSTICS (cont.)		
E-Z DISK	T3	
E-Z-HD	T3	
E-Z-PAQUE	T3	
E-Z-PASTE	T3	
GASTROGRAFIN (<i>diatrizoate meglumine, sodium</i>)	T3	
GASTROMARK	T3	
LIQUID E-Z PAQUE	T3	
LIQUID POLIBAR PLUS	T3	
NEULUMEX	T3	
POLIBAR ACB	T3	
READI-CAT 2	T3	
SITZMARKS	T3	
SITZMARKS FOR KIDS	T3	
TAGITOL	T3	
VANILLA SILQ	T3	
VARIBAR HONEY	T3	
VARIBAR NECTAR	T3	
VARIBAR PUDDING	T3	
VARIBAR THIN HONEY	T3	
VARIBAR THIN LIQUID	T3	
VOLUMEN	T3	
METABOLIC FUNCTION DIAGNOSTICS		
METOPIRONE	T3	
RADIOACTIVE DIAGNOSTICS, GENERAL		
XENON XE-133	T3	
RADIOACTIVE METABOLIC FUNCTION DIAGNOSTICS		
SODIUM IODIDE I-123	T3	
RADIOPHARMACEUTICALS ELEMENTS		
INDICLOR	T3	
URINARY TRACT RADIOPAQUE DIAGNOSTICS		
CYSTO-CONRAY II	T3	
CYSTOGRAFIN	T3	
CYSTOGRAFIN-DILUTE	T3	
KETONE CARE TEST STRIP	T2	

T1 – Generics

T2 – Preferred Brands

T3 – Non-Preferred Brands

T4 – Brand Specialty

PA – Prior Authorization

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List of Prescription Medications

DIAGNOSTIC (Miscellaneous) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
URINARY TRACT RADIOPAQUE DIAGNOSTICS (cont.)		
KETONE TEST STRIP	T2	
KETOSTIX REAGENT	T2	
TRUEPLUS KETONE TEST STRIP	T2	
URINE GLUCOSE/ACETONE TEST AIDS,STRIPS		
KETO-DIASTIX REAGENT	T2	
URINE MULTIPLE TEST AIDS		
CHEK-STIX	T2	
CHEMSTRIP	T2	
CHEMSTRIP 10 WITH SG	T2	
CHEMSTRIP 2 GP	T2	
CHEMSTRIP 50B	T2	
CHEMSTRIP 7	T2	
CHEMSTRIP 9	T2	
COMBISTIX REAGENT	T2	
HEMA-COMBISTIX	T2	
KETO-DIASTIX REAGENT	T2	
LABSTIX REAGENT	T2	
MULTISTIX	T2	
MULTISTIX 10 SG	T2	
MULTISTIX 5	T2	
MULTISTIX 7	T2	
MULTISTIX 8 SG	T2	
MULTISTIX 9	T2	
MULTISTIX 9 SG	T2	
URISTIX 4	T2	
URISTIX REAGENT	T2	
DIURETICS (Diuretics)		
ARGININE VASOPRESSIN (AVP) RECEPTOR ANTAGONISTS		
tolvaptan 15 mg tablet (Samsca)	T1	PA QL (30 tabs/fill) SP
tolvaptan 30 mg tablet (Samsca)	T1	PA QL (60 tabs/fill) SP
CARBONIC ANHYDRASE INHIBITORS		
acetazolamide	T1	HD
methazolamide	T1	HD

T1 – Generics

T2 – Preferred Brands

T3 – Non-Preferred Brands

T4 – Brand Specialty

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List of Prescription Medications

DIURETICS (Diuretics) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
LOOP DIURETICS		
bumetanide	T1	HD
EDECRIN (ethacrynic acid)	T3	ST
ethacrynic acid (Edecrin)	T1	
furosemide	T1	HD
furosemide (Lasix)	T1	HD
LASIX (furosemide)	T3	ST HD
torsemide	T1	HD
POLYCYSTIC KIDNEY DISEASE AGENT, AVP RECEPTOR ANTAGONIST		
tolvaptan 15 mg tablet (Jynarque)	T1	PA SP HD
tolvaptan 15 mg-15 mg tablet (Jynarque)	T1	PA SP HD
tolvaptan 30 mg tablet (Jynarque)	T1	PA SP HD
tolvaptan 30 mg-15 mg tablet (Jynarque)	T1	PA SP HD
tolvaptan 45 mg-15 mg tablet (Jynarque)	T1	PA SP HD
tolvaptan 60 mg-30 mg tablet (Jynarque)	T1	PA SP HD
tolvaptan 90 mg-30 mg tablet (Jynarque)	T1	PA SP HD
JYNARQUE 15 MG TABLET (tolvaptan)	T4	PA SP HD
JYNARQUE 15 MG-15 MG TABLET (tolvaptan)	T4	PA SP HD
JYNARQUE 30 MG TABLET (tolvaptan)	T4	PA SP HD
JYNARQUE 30 MG-15 MG TABLET (tolvaptan)	T4	PA SP HD
JYNARQUE 45 MG-15 MG TABLET (tolvaptan)	T4	PA SP HD
JYNARQUE 60 MG-30 MG TABLET (tolvaptan)	T4	PA SP HD
JYNARQUE 90 MG-30 MG TABLET (tolvaptan)	T4	PA SP HD
POTASSIUM SPARING DIURETICS		
ALDACTONE (spironolactone)	T3	HD
amiloride hcl	T1	HD
DYRENium (triamterene)	T3	HD
eplerenone (Inspra)	T1	HD
INSPIRA (eplerenone)	T3	HD
KERENDIA	T2	PA QL (30 tabs/30 days)
spironolactone 25 mg/5 ml susp (Carospir)	T1	
spironolactone 25 mg tablet (Aldactone)	T1	HD
spironolactone 50 mg tablet (Aldactone)	T1	HD
spironolactone 100 mg tablet (Aldactone)	T1	HD
triamterene (Dyrenium)	T1	HD

T1 – Generics

T2 – Preferred Brands

T3 – Non-Preferred Brands

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List of Prescription Medications

DIURETICS (Diuretics) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
POTASSIUM SPARING DIURETICS IN COMBINATION		
<i>amiloride/hydrochlorothiazide</i>	T1	HD
DYAZIDE (triamterene/hydrochlorothiazid)	T3	HD
<i>spironolact/hydrochlorothiazid</i>	T1	HD
triamterene/hydrochlorothiazid (Dyazide)	T1	HD
THIAZIDE AND RELATED DIURETICS		
<i>chlorthalidone</i>	T1	HD
THIAZIDE AND RELATED DIURETICS		
DIURIL	T3	HD
<i>hydrochlorothiazide</i>	T1	HD
<i>indapamide</i>	T1	HD
<i>metolazone</i>	T1	HD
EENT PREPS (Allergy/Nasal Sprays)		
NASAL ANTIHISTAMINE		
<i>azelastine 0.1% (137 mcg) spry</i>	T1	QL (60 mls/fill) HD
<i>azelastine 0.15% nasal spray</i>	T1	HD
<i>olopatadine hcl (Patanase)</i>	T1	QL (31 gms/fill) HD
PATANASE (olopatadine hcl)	T3	QL (31 gms/fill) HD
NASAL ANTIHISTAMINE AND ANTI-INFLAM. STEROID COMB.		
<i>azelastine/fluticasone (Dymista)</i>	T1	ST QL (23 gms/fill) HD
RYALTRIS	T3	ST QL (1 bottle/fill) HD
NASAL ANTI-INFLAMMATORY STEROIDS		
<i>flunisolide</i>	T1	ST QL (50 mls/fill) HD
<i>fluticasone prop 50 mcg spray</i>	T1	QL (16 gms/fill) HD
<i>mometasone furoate 50 mcg spry (Nasonex)</i>	T1	ST QL (17 gms/fill) HD
XHANCE	T2	ST QL (32 mls/30 days) HD
NOSE PREPARATIONS, MISCELLANEOUS (RX)		
COCAINE HCL	T3	
GOPRELTO	T3	
<i>ipratropium 0.03% spray</i>	T1	QL (30 mls/fill) HD
<i>ipratropium 0.06% spray</i>	T1	QL (30 mls/fill) HD
NUMBRINO	T3	
NOSE PREPARATIONS, VASOCONSTRICATORS (RX)		
ADRENALIN CHLORIDE	T3	
<i>epinephrine hcl</i>	T1	

T1 – Generics

T2 – Preferred Brands

T3 – Non-Preferred Brands

T4 – Brand Specialty

PA – Prior Authorization

QL – Quantity Limit

ST – Step Therapy

AGE – Age Requirement

SP – Specialty Medication

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List of Prescription Medications

EENT PREPS (Ear Medications)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
EAR PREPARATIONS ANTI-INFLAMMATORY		
DERMOTIC (<i>fluocinolone acetonide oil</i>)	T3	
<i>fluocinolone acetonide oil</i> (Dermotic)	T1	
EAR PREPARATIONS, MISC. ANTI-INFECTIVES		
acetic acid	T1	
CORTANE-B (<i>hydrocort/pramoxine/chloroxyli</i>)	T3	
<i>hydrocortisone/acetic acid</i>	T1	
EENT PREPS (Eye Conditions)		
AGENTS FOR CORNEAL COLLAGEN CROSS-LINKING		
PHOTREXA CROSS-LINKING	T3	
PHOTREXA VISCOS	T3	
ARTIFICIAL TEARS		
KLARITY (CHONDROITIN)	T3	
LACRISERT	T3	PA QL (60 inserts/fill)
MIEBO	T2	PA QL (3 mls/fill)
EYE ANTI-INFECTIVES (RX ONLY)		
BETADINE	T3	
<i>povidone-iodine</i>	T1	
EYE ANTI-INFLAMMATORY AGENTS		
ACULAR (<i>ketorolac tromethamine</i>)	T3	ST
ACULAR LS (<i>ketorolac tromethamine</i>)	T3	ST
<i>bromfenac sodium</i>	T1	
<i>bromfenac sodium</i> (Bromsite)	T1	
<i>bromfenac sodium</i> (Prolensa)	T1	
<i>dexamethasone sodium phosphate</i>	T1	
DEXTENZA	T3	
<i>diclofenac 0.1% eye drops</i>	T1	
<i>difluprednate</i> (Durezol)	T1	
EYSUVIS	T2	PA QL (8.3 mls/30 days)
<i>fluorometholone</i> (Fml)	T1	
<i>flurbiprofen sodium</i>	T1	
FML (<i>fluorometholone</i>)	T3	ST
ILEVRO	T3	
INVELTYS	T3	ST
<i>ketorolac 0.4% ophth solution</i> (Acular Ls)	T1	

T1 – Generics

T2 – Preferred Brands

T3 – Non-Preferred Brands

T4 – Brand Specialty

PA – Prior Authorization

QL – Quantity Limit

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List of Prescription Medications

EENT PREPS (Eye Conditions) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
EYE ANTI-INFLAMMATORY AGENTS (cont.)		
ketorolac 0.5% ophth solution (Acular)	T1	
KLARITY-B(BETAMETHASONE-CHOND)	T3	
KLARITY-L (LOTEPREDNOL-CHONDR)	T3	
LOTEMAX 0.5% EYE DROPS (<i>loteprednol etabonate</i>)	T3	
LOTEMAX 0.5% EYE OINTMENT	T3	ST
LOTEMAX 0.5% OPHTHALMIC GEL (<i>loteprednol etabonate</i>)	T3	ST
LOTEMAX SM	T3	ST
<i>loteprednol etabonate</i> (Alrex)	T1	PA SP HD
<i>loteprednol etabonate</i> (Lotemax)	T1	PA SP HD
PRED FORTE (<i>prednisolone acetate</i>)	T3	
<i>prednisolone ac</i> 1% eye drop (Pred Forte)	T1	
PREDNISOLONE ACET 1% EYE DROP	T3	
<i>prednisolone sod ph/bromfenac</i>	T1	
<i>prednisolone sodium phosphate</i>	T1	
PREDNISOLONE-BROMFENAC	T3	
PREDNISOLONE-NEPAFENAC	T3	
PROLENZA (<i>bromfenac sodium</i>)	T3	ST
EYE LOCAL ANESTHETICS		
AKTEN	T3	
ALCAINE (<i>proparacaine hcl</i>)	T3	
ALTAFLUOR BENOX (<i>benoxinate hcl/fluorescein sod</i>)	T3	
FLUORESCEIN-BENOXINATE	T3	
<i>proparacaine hcl</i> (Alcaine)	T1	
<i>proparacaine/fluorescein sod</i>	T1	
tetracaine 0.5% eye drop	T1	
TETRACAIN 0.5% STERI-UNIT SOL	T3	
<i>tetracaine hcl</i>	T1	
TETRAVISC	T3	
TETRAVISC FORTE	T3	
EYE MAST CELL STABILIZERS		
ALOCRIL	T3	ST
cromolyn 4% eye drops	T1	
EYE MYDRIATIC AND NSAID COMBINATIONS		
MYDRIATIC4(TROP-PROP-PE-KTRLC)	T3	

T1 – Generics

T2 – Preferred Brands

T3 – Non-Preferred Brands

T4 – Brand Specialty

PA – Prior Authorization

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AGE – Age Requirement

SP – Specialty Medication

HD – May require home delivery pharmacy

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List of Prescription Medications

EENT PREPS (Eye Conditions) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
EYE PREPARATIONS, MISCELLANEOUS (OTC)		
GELFILM	T3	
EYE VASOCONSTRICATORS		
<i>phenylephrine hcl</i>	T1	
MIOTICS AND OTHER INTRAOCULAR PRESSURE REDUCERS		
ALPHAGAN P	T3	ST HD
ALPHAGAN P (<i>brimonidine tartrate</i>)	T3	ST HD
<i>apraclonidine hcl</i>	T1	HD
betaxolol hcl	T1	HD
BETOPTIC S	T3	HD
<i>bimatoprost</i>	T1	PA HD
<i>brimonidine tartrate</i>	T1	HD
<i>brimonidine tartrate</i> (Alphagan P)	T1	HD
<i>brimonidine tartrate/timolol</i> (Combigan)	T1	HD
BRIMONIDINE 0.1%-DORZOLAM 2%	T3	
BRIMONIDINE 0.15%-DORZOLAM 2%	T3	HD
<i>brinzolamide</i> (Azopt)	T1	HD
<i>carteolol hcl</i>	T1	HD
COMBIGAN (<i>brimonidine tartrate/timolol</i>)	T3	ST HD
DORZOLAMIDE	T3	HD
<i>dorzolamide hcl</i>	T1	HD
<i>dorzolamide hcl/timolol maleat</i> (Cosopt)	T1	HD
<i>dorzolamide/timolol/pf</i> (Cosopt Pf)	T1	HD
IOPIDINE	T3	ST HD
ISOPTO CARPINE (<i>pilocarpine hcl</i>)	T3	HD
LATANOPROST 0.005% EYE DROP	T3	HD
<i>latanoprost 0.005% eye drops</i> (Xalatan)	T1	PA HD
<i>levobunolol hcl</i>	T1	HD
PHOSPHOLINE IODIDE	T4	SP HD
<i>pilocarpine hcl</i>	T1	HD
<i>pilocarpine hcl</i> (Isopto Carpine)	T1	HD
RHOPRESSA	T3	
ROCKLATAN	T3	PA
SIMBRINZA	T3	HD
<i>timolol</i> (Betimol)	T1	ST HD

T1 – Generics

T2 – Preferred Brands

T3 – Non-Preferred Brands

T4 – Brand Specialty

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List of Prescription Medications

EENT PREPS (Eye Conditions) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
MIOTICS AND OTHER INTRAOCCULAR PRESSURE REDUCERS (cont.)		
timolol 0.25% gel-solution (Timoptic-Xe)	T1	ST HD
timolol 0.5% eye drop (Istalol)	T1	ST HD
timolol 0.5% gel-solution (Timoptic-Xe)	T1	ST HD
timolol 0.5% gfs gel-solution (Timoptic-Xe)	T1	ST HD
timolol maleate 0.25% eye drop	T1	ST HD
timolol maleate 0.25% eye drop (Timoptic)	T1	HD
timolol maleate 0.5% eye drop (Timoptic Ocudose)	T1	ST HD
timolol maleate 0.5% eye drops (Timoptic)	T1	HD
TIMOLOL-BRIMONIDIN-DORZOLAMIDE	T3	HD
TIMOLOL-BRIMONI-DORZOL-BIMATOP	T3	HD
TIMOLOL-BRIMONI-DORZOL-LATANOP	T3	HD
TIMOLOL-DORZOLAMIDE	T3	HD
TIMOLOL-DORZOLAMIDE-BIMATOPRST	T3	HD
TIMOLOL-DORZOLAMIDE-LATANOPRST	T3	HD
TIMOLOL-LATANOPROST	T3	HD
TIMOPTIC (timolol maleate)	T3	ST HD
TIMOPTIC-XE (timolol maleate)	T3	ST HD
travoprost (Travatan Z)	T1	PA HD
MYDRIATICS		
atropine 1% eye drops	T1	PA SP HD
atropine sulfate 0.01% eye drp	T1	PA SP HD
atropine 1% eye ointment	T1	HD
ATROPINE SULF 0.025% EYE DROP	T3	HD
ATROPINE SULFATE 0.01% EYE DRP	T3	HD
ATROPINE SULFATE 0.05% EYE DRP	T3	HD
ATROPINE SULFATE-0.9% NACL	T3	HD
CYCLOGYL	T3	HD
CYCLOGYL (cyclopentolate hcl)	T3	HD
CYCLOMYDRIL	T3	HD
cyclopentolat/tropic/phenyleph	T1	HD
cyclopentolate hcl (Cyclogyl)	T1	HD
CYCLOPENTOLATE-TROPICAMIDE-PE	T3	HD
homatropine hbr	T1	HD
MYDCOMBI	T3	HD

T1 – Generics

T2 – Preferred Brands

T3 – Non-Preferred Brands

T4 – Brand Specialty

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List of Prescription Medications

EENT PREPS (Eye Conditions) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
MYDRIATICS (cont.)		
MYDRIACYL (<i>tropicamide</i>)	T3	HD
PAREMYD	T3	HD
<i>tropicamide</i>	T1	HD
<i>tropicamide 1%-phenylephr 2.5%</i>	T1	
<i>tropicamide (Mydriacyl)</i>	T1	HD
TROPICAMIDE-CYCLOPENTOLATE-PE	T3	HD
TROPICAMIDE-CYCLOPENT-PE-KTRLC	T3	
TROPIC-CYCLOPENT-PE-KTRLC-PROP	T3	HD
TROPICAMIDE 1%-PHENYLEPHR 2.5%	T3	
OPHTH. VEGF-A RECEPTOR ANTAG. RCMB MC ANTIBODY		
LUCENTIS	T4	PA SP
OPHTHALMIC ANTIFIBROTIC AGENTS		
MITOMYCIN	T3	
MITOMYCIN-WATER	T3	
MITOSOL	T3	
OPHTHALMIC ANTI-INFLAMMATORY IMMUNOMODULATOR-TYPE		
CEQUA	T3	PA QL (60 vls/30 days)
<i>cyclosporine 0.05% eye emuls (Restasis)</i>	T1	PA QL (60 vials/fill) HD
CYCLOSPORINE IN KLARITY	T3	HD
RESTASIS (<i>cyclosporine</i>)	T3	PA QL (60 vials/fill) HD
RESTASIS MULTIDOSE	T2	PA QL (6 mls/fill) HD
XIIDRA	T2	PA QL (60 vls/fill) HD
VEVYE	T3	PA QL (2 mls/fill) HD
OPHTHALMIC CYSTINE DEPLETING AGENTS		
CYSTARAN	T4	PA SP
OPHTHALMIC HUMAN NERVE GROWTH FACTOR (HNFG)		
OXERVATE	T4	PA SP HD
OPHTHALMIC PREPARATIONS, MISCELLANEOUS		
HEALON GV	T3	
ELECT/CALORIC/H2O (Cholesterol Medications)		
ORAL LIPID SUPPLEMENTS		
DOJOLVI	T4	PA SP HD

T1 – Generics

T2 – Preferred Brands

T3 – Non-Preferred Brands

T4 – Brand Specialty

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

ELECT/CALORIC/H2O (Dental Products)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
FLUORIDE PREPARATIONS		
CLINPRO 5000	T3	
FLORIVA	T3	
<i>fluoride (sodium)</i>	T1	
<i>fluoride (sodium) (Prevident 5000 Plus)</i>	T1	
<i>fluoride (sodium) (Prevident)</i>	T1	
FLUORIDEX	T3	
FLUORIDEX SENSITIVITY RELIEF	T3	
FRAICHE 5000 PREVI	T3	
JUSTRIGHT 5000	T3	
PREVIDENT	T3	
PREVIDENT (<i>fluoride (sodium)</i>)	T3	
PREVIDENT 5000 DRY MOUTH	T3	
PREVIDENT 5000 ENAMEL PROTECT	T3	
PREVIDENT 5000 ORTHO DEFENSE	T3	
PREVIDENT 5000 PLUS (<i>fluoride (sodium)</i>)	T3	
PREVIDENT 5000 SENSITIVE	T3	
PREVIDENT KIDS	T3	
<i>sodium fluoride 0.2% rinse (Prevident)</i>	T1	
<i>sodium fluoride 1.1% cream (Prevident 5000 Plus)</i>	T1	
<i>sodium fluoride 1.1% gel (Prevident)</i>	T1	
<i>sodium fluoride 5000 ppm cream (Prevident 5000 Plus)</i>	T1	
<i>sodium fluoride 5000 ppm paste</i>	T1	
<i>sodium fluoride/potassium nit</i>	T1	
PEDIATRIC VITAMIN PREPARATIONS		
<i>fluoride (sodium)</i>	T1	PPACA
FLURA-DROPS	T3	
<i>sodium fluoride 0.25 (0.55) mg</i>	T1	PPACA
<i>sodium fluoride 0.5 mg(1.1 mg)</i>	T1	PPACA
<i>sodium fluoride 0.5 mg/ml drop</i>	T1	PPACA
<i>sodium fluoride 1 mg (2.2 mg)</i>	T1	PPACA
ELECT/CALORIC/H2O (Diabetes)		
AGENTS TO TREAT HYPOGLYCEMIA (HYPERGLYCEMICS)		
cvs glucose 4 gram tablet chew (Trueplus Glucose)	T1	

T1 – Generics

T2 – Preferred Brands

T3 – Non-Preferred Brands

T4 – Brand Specialty

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

ELECT/CALORIC/H2O (Diabetes) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
AGENTS TO TREAT HYPOGLYCEMIA (HYPERGLYCEMICS) (cont.)		
CVS GLUCOSE LIQUID SHOT	T3	
DEX4 GLUCOSE 15 GM GEL PACKET	T3	
<i>dex4 glucose 4 gm tablet chew (Trueplus Glucose)</i>	T1	
DEX4 GLUCOSE LIQUID	T3	
DEX4 GLUCOSE LIQUID BLAST	T3	
<i>dex4 glucose tab pouch pack (Trueplus Glucose)</i>	T1	
<i>dex4 quick dissolve tab chew (Trueplus Glucose)</i>	T1	
<i>dextrose</i>	T1	
<i>dextrose (Glutose-15)</i>	T1	
<i>dextrose (Glutose-45)</i>	T1	
<i>dextrose/vitamin d3</i>	T1	
<i>diazoxide (Proglycem)</i>	T1	
<i>drug mart glucose 4 gm tab chw (Trueplus Glucose)</i>	T1	
GLUCO SHOT	T3	
GLUCOSE 2 GRAM GUMMY	T2	QL (2 vials/fill)
<i>glucose 3.75 gram tablet chew (Trueplus Glucose)</i>	T1	
<i>glucose 4 gram tablet chew (Trueplus Glucose)</i>	T1	
GLUCOSE LIQUID	T3	
GLUTOSE-15 (<i>dextrose</i>)	T2	
GLUTOSE-45 (<i>dextrose</i>)	T2	
<i>gnp glucose 3.75 gram tab chew (Trueplus Glucose)</i>	T1	
<i>gnp glucose 4 gram tablet chew (Trueplus Glucose)</i>	T1	
<i>gnp quick dissolve glucose tab (Trueplus Glucose)</i>	T1	
<i>gs glucose 4 gram tablet chew (Trueplus Glucose)</i>	T1	
GVOKE	T2	QL (2 vials/fill)
GVOKE HYPOPEN 1-PACK	T2	QL (2 auto-injs/fill)
GVOKE HYPOPEN 2-PACK	T2	QL (2 auto-injs/fill)
GVOKE PFS 1-PACK SYRINGE	T2	QL (2 syringes/fill)
GVOKE PFS 2-PACK SYRINGE	T2	QL (2 syringes/fill)
INSTA-GLUCOSE	T3	
<i>kro glucose 4 gram tablet chew (Trueplus Glucose)</i>	T1	
<i>kroger glucose 4 gram tab chew (Trueplus Glucose)</i>	T1	
<i>leader glucose 4 gm tab chew (Trueplus Glucose)</i>	T1	
<i>leader quick dissolve gluc tab (Trueplus Glucose)</i>	T1	

T1 – Generics

T2 – Preferred Brands

T3 – Non-Preferred Brands

T4 – Brand Specialty

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

ELECT/CALORIC/H2O (Diabetes) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
AGENTS TO TREAT HYPOGLYCEMIA (HYPERGLYCEMICS) (cont.)		
longs glucose 4 gram tab chew (Trueplus Glucose)	T1	
meijer glucose 4 gram tab chew (Trueplus Glucose)	T1	
ms glucose 4 gram tablet chew (Trueplus Glucose)	T1	
ms quick dissolve glucose tab (Trueplus Glucose)	T1	
preferred plus glucose tab chw (Trueplus Glucose)	T1	
PROGLYCEM (diazoxide)	T3	
pub glucose 4 gram tablet chew (Trueplus Glucose)	T1	
ra glucose 4 gram tablet chew (Trueplus Glucose)	T1	
relion glucose 4 gram tab chew (Trueplus Glucose)	T1	
reli-on glucose 4 gram tab chw (Trueplus Glucose)	T1	
RELION GLUCOSE LIQUID	T3	
sm glucose 4 gram tab chew (Trueplus Glucose)	T1	
smart sense glucose 4 gram tab (Trueplus Glucose)	T1	
TRUEPLUS GLUCOSE	T3	
TRUEPLUS GLUCOSE (dextrose)	T3	
upup glucose 4 gram tab chew (Trueplus Glucose)	T1	
ELECT/CALORIC/H2O (Miscellaneous)		
NUCLEIC ACID/NUCLEOTIDE SUPPLEMENTS		
XURIDEN	T4	PA SP
ELECT/CALORIC/H2O (Nutritional/Dietary)		
CARBOHYDRATES		
ENFAMIL	T2	
GLUTOL	T2	
ELECTROLYTE DEPLETERS		
AURYXIA	T3	
calcium acetate 667 mg capsule, gelcap	T1	QL (360 caps/fill)
calcium acetate 667 mg tablet	T1	QL (360 tabs/fill)
lanthanum carbonate (Fosrenol)	T1	QL (90 tabs/fill)
LOKELMA	T2	QL (30 packs/fill)
RENELA 0.8 GM POWDER PACKET (sevelamer carbonate)	T3	QL (180 packs/fill)
RENELA 2.4 GM POWDER PACKET (sevelamer carbonate)	T3	QL (90 packs/fill)
RENELA 800 MG TABLET (sevelamer carbonate)	T3	QL (270 tabs/fill)
sodium polystyrene sulfon/sorb	T1	

T1 – Generics

T2 – Preferred Brands

T3 – Non-Preferred Brands

T4 – Brand Specialty

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AGE – Age Requirement

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List of Prescription Medications

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

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ELECTROLYTE DEPLETERS (cont.)		
sodium polystyrene sulfonate	T1	
VELPHORO	T2	QL (120 tabs/fill)
VELTASSA 1 GM POWDER PACKET	T2	
VELTASSA 8.4 GM POWDER PACKET	T2	QL (30 packs/30 days)
VELTASSA 16.8 GM POWDER PACKET	T2	QL (30 packs/30 days)
VELTASSA 25.2 GM POWDER PACKET	T2	QL (30 packs/30 days)
FLUORIDE PREPARATIONS		
CLINPRO 5000	T3	
fluoride (sodium)	T1	
fluoride (sodium) (Prevident 5000 Plus)	T1	
fluoride (sodium) (Prevident)	T1	
FLUORIDEX	T3	
JUSTRIGHT 5000	T3	
PREVIDENT	T3	
PREVIDENT (fluoride (sodium))	T3	
PREVIDENT 5000 DRY MOUTH	T3	
PREVIDENT 5000 ORTHO DEFENSE	T3	
PREVIDENT 5000 PLUS (fluoride (sodium))	T3	
PREVIDENT KIDS	T3	
sodium fluoride 0.2% rinse (Prevident)	T1	
sodium fluoride 1.1% cream (Prevident 5000 Plus)	T1	
sodium fluoride 1.1% gel (Prevident)	T1	
sodium fluoride 5000 ppm cream (Prevident 5000 Plus)	T1	
sodium fluoride 5000 ppm paste	T1	
IODINE CONTAINING AGENTS		
potassium iodide	T1	
potassium iodide/iodine	T1	
SSKI	T3	
IRON REPLACEMENT		
ABATRON	T3	
ABATRON AF	T3	
ACCRUFER	T3	
ACTIVE FE	T3	
APETIGEN-PLUS	T2	

T1 – Generics

T2 – Preferred Brands

T3 – Non-Preferred Brands

T4 – Brand Specialty

PA – Prior Authorization

QL – Quantity Limit

ST – Step Therapy

AGE – Age Requirement

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PPACA – No Cost-Share Preventive Medication

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List of Prescription Medications

ELECT/CALORIC/H2O (Nutritional/Dietary) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
IRON REPLACEMENT (cont.)		
BENTIVITE BX	T3	
CHROMAGEN	T3	
CITRANATAL BLOOM	T3	
CORVITE 150	T3	
CORVITE FE	T3	
cvs iron 27 mg tablet (Fergon)	T1	
cvs iron 65 mg tablet	T1	
CVS SLOW RELEASE IRON 45 MG TB	T3	
cvs slow release iron 45 mg tb	T1	
cvs slow release iron tablet	T1	
eql iron 65 mg tablet	T1	
eql slow release iron 45 mg tab	T1	
eql slow release iron 50 mg tb	T1	
FEOSOL 45 MG CAPLET (iron,carbonyl)	T2	
feosol 65 mg tablet	T1	
FEOSOL BIFERA 28 MG CAPLET	T2	
FERAHEME (ferumoxytol)	T3	PA
FERGON 27 MG TABLET	T3	
FERGON 27 MG TABLET (ferrous gluconate)	T2	
FERGON TABLET	T3	
FER-IN-SOL (ferrous sulfate)	T2	
FERIVA 21-7	T3	
FERIVA FA	T3	
FERRACTIV IRON	T3	
FERRALET 90	T3	
FERRETTS IPS 18 MG CAP	T3	
FERRETTS IPS 40 MG/15 ML LIQ	T2	
FERRIMIN 150	T2	
FERRLECIT (sodium ferric gluconat/sucrose)	T3	PA
FERRO-SEQUELS	T3	
ferrous fum/vit c/b12-if/folic	T1	PPACA
ferrous fumarate	T1	
ferrous fumarate (Hemocyte)	T1	
FERROUS FUMARATE 29 MG TAB	T3	

T1 – Generics

T2 – Preferred Brands

T3 – Non-Preferred Brands

T4 – Brand Specialty

PA – Prior Authorization

QL – Quantity Limit

ST – Step Therapy

AGE – Age Requirement

SP – Specialty Medication

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PPACA – No Cost-Share Preventive Medication

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List of Prescription Medications

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

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
IRON REPLACEMENT (cont.)		
ferrous fumarate 324 mg tab (Hemocyte)	T1	
ferrous fumarate/folic acid (Hemocyte-F)	T1	
ferrous gluconate	T1	
ferrous gluconate (Fergon)	T1	
ferrous sulf 300 mg/5 ml cup	T1	
FERROUS SULF 300 MG/5 ML CUP	T3	
ferrous sulf 15 mg iron/ml drp (Fer-In-Sol)	T1	
ferrous sulf 220 mg/5 ml elix	T1	
ferrous sulf 220 mg/5 ml liq	T1	
ferrous sulf 44 mg iron/5ml liq	T1	
ferrous sulf 300 mg/6.8ml soln	T1	
ferrous sulf ec 324 mg tablet	T1	
ferrous sulf ec 325 mg tablet	T1	
ferrous sulfate	T1	
ferrous sulfate (Fer-In-Sol)	T1	
ferrous sulfate 325 mg tablet	T1	
ferrous sulfate/vit c/folic ac	T1	PPACA
ferumoxytol (Feraheme)	T1	PA
ft iron 65 mg tablet	T1	
FT IRON 45 MG TABLET	T3	
FUSION	T3	
FUSION PLUS	T3	
FUSION SPRINKLES	T3	
GENTLE IRON	T3	
gnp iron 45 mg tablet	T1	
gnp iron 65 mg tablet	T1	
HEMATEX	T3	
HEMATEX (iron polysaccharide complex)	T3	
HEMATOGEN	T3	
HEMATRON-AF	T3	
HEMAX	T3	
HEMOCYTE (ferrous fumarate)	T2	
HEMOCYTE PLUS (iron fum/folic acid/mv,min 15)	T3	
HEMOCYTE-F (ferrous fumarate/folic acid)	T3	

T1 – Generics

T2 – Preferred Brands

T3 – Non-Preferred Brands

T4 – Brand Specialty

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

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

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
IRON REPLACEMENT (cont.)		
hm iron 65 mg tablet	T1	
hm slow release iron tablet	T1	
ILX. B-12	T2	
ICAR	T2	
ICAR-C (iron,carbonyl/ascorbic acid)	T2	
ICAR-C PLUS (iron,carb/vit c/vit b12/folic)	T3	
INFED	T2	PA
INJECTAFER	T3	PA
INTEGRA	T2	
INTEGRA F (iron fum,ps/folic acid/vitc/b3)	T3	
INTEGRA PLUS (iron fum,ps/folic/bcomp,c no.9)	T3	
iron 27 mg tablet	T1	
iron 27 mg tablet (Fergon)	T1	
iron 28 mg tablet	T1	
iron 45 mg tablet	T1	
iron 65 mg tablet	T1	
iron aspgly,ps/c/b12/fa/ca/suc	T1	
iron aspgly,ps/c/succinic acid	T1	
iron aspgly/c/b12/fa/ca-th/suc	T1	
iron bg,ps/vitc/b12/fa/calcium	T1	
IRON BISGLYCINATE	T3	
iron fum,ag/c/b12/folic/ca/suc	T1	
iron fum,ps/folic acid/vitc/b3 (Integra F)	T1	
iron fum,ps/folic/bcomp,c no.9 (Integra Plus)	T1	
iron fum/folic acid/mv,min 15 (Hemocyte Plus)	T1	
iron fumarate/vit c/vit b12/fa	T1	
iron polysaccharide complex	T1	
iron polysaccharide complex (Nu-Iron 150)	T1	
iron ps complex/b12/folic acid	T1	
iron,carb/vit c/vit b12/folic (Icar-C Plus)	T1	
iron,carbonyl	T1	
iron,carbonyl (Feosol)	T1	
iron,carbonyl/ascorbic acid (Icar-C)	T1	
iron/c/b12/calciu/stomach conc	T1	

T1 – Generics

T2 – Preferred Brands

T3 – Non-Preferred Brands

T4 – Brand Specialty

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

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

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
IRON REPLACEMENT (cont.)		
iron/c/folic acd/mv cmb11/calc	T1	
iron/folic ac/vit bcomp,c/min	T1	
iron/folic acid/b12/c/docusate	T1	
iron/folic acid/c/b6/b12/zinc	T1	
iron/vit c/fructooligosaccharid	T1	
IRON-VITAMIN C 65-125 MG TAB	T2	PA SP HD
iron-vitamin c 100-250 mg tab (lcar-C)	T1	PA SP HD
IRONUP	T3	
IRO-PLEX	T3	
IROSPAN	T3	
LIQUID IRON	T3	
LYDIA PINKHAM HERBAL	T3	
MAXFE	T3	
MONOFERRIC	T3	PA
NEONATAL FE	T3	
NIFEREX	T3	
NOVAFERRUM ALL GOOD	T3	PA SP HD
NOVAFERRUM WOW	T3	PA SP HD
NOVAFERRUM YUMMY PEDIATRIC	T2	PA SP HD
NUFERA	T3	
NU-IRON 150 (iron polysaccharide complex)	T2	
PARVLEX	T3	
PERFECT IRON	T3	
PRO FE	T2	
PROFERRIN	T2	
PROFERRIN-FORTE	T3	
PROTECT IRON	T3	
ra high potency iron 27 mg tab	T1	
RA HIGH POTENCY IRON 27 MG TAB	T3	
ra iron 65 mg tablet	T1	
RA SLOW RELEASE IRON 45 MG TAB	T2	
SIDEROL	T3	
SLOW FE	T2	
slow release iron 160 mg tab	T1	

T1 – Generics

T2 – Preferred Brands

T3 – Non-Preferred Brands

T4 – Brand Specialty

PA – Prior Authorization

QL – Quantity Limit

ST – Step Therapy

AGE – Age Requirement

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
IRON REPLACEMENT (cont.)		
SLOW RELEASE IRON 45 MG TABLET	T2	
<i>slow release iron 45 mg tablet</i>	T1	
SLOW RELEASE IRON 45 MG TABLET	T3	
SLOW RELEASE IRON TABLET	T2	
<i>sm iron 65 mg tablet</i>	T1	
<i>sm iron 160 mg tablet sa</i>	T1	
<i>sm iron 325 mg tablet</i>	T1	
SM SLOW RELEASE IRON 45 MG TAB	T2	
<i>sodium ferric gluconat/sucrose (Ferrlecit)</i>	T1	PA
<i>sv iron 65 mg tablet</i>	T1	
SV SLOW RELEASE IRON 45 MG TAB	T2	
TANDEM DUAL ACTION	T2	
TL-HEM 150	T3	
TRIFERIC	T3	
<i>true ferrous sulf ec 324 mg tb</i>	T1	
TULIVITE	T3	
VENOFER	T2	PA
VIRT-FEFA PLUS CAPSULE	T3	
<i>virt-fefa plus capsule (Integra Plus)</i>	T1	
VITABEX IRON	T3	
VITAFOL	T3	
VITRON-C	T2	
PEDIATRIC VITAMIN PREPARATIONS		
<i>fluoride (sodium)</i>	T1	PPACA
FLURA-DROPS	T3	
<i>sodium fluoride 0.25 (0.55) mg</i>	T1	PPACA
<i>sodium fluoride 0.5 mg(1.1 mg)</i>	T1	PPACA
<i>sodium fluoride 0.5 mg/ml drop</i>	T1	PPACA
<i>sodium fluoride 1 mg (2.2 mg)</i>	T1	PPACA
POTASSIUM REPLACEMENT		
EFFER-K 10 MEQ TABLET EFF	T3	
EFFER-K 20 MEQ TABLET EFF	T3	
<i>effer-k 25 meq tablet eff</i>	T1	
K-TAB ER 20 MEQ TABLET (<i>potassium chloride</i>)	T3	

T1 – Generics

T2 – Preferred Brands

T3 – Non-Preferred Brands

T4 – Brand Specialty

PA – Prior Authorization

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PPACA – No Cost-Share Preventive Medication

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List of Prescription Medications

ELECT/CALORIC/H2O (Nutritional/Dietary) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
POTASSIUM REPLACEMENT (cont.)		
k-tab er 8 meq tablet	T1	
potassium bicarbonate/cit ac	T1	
potassium chloride	T1	
potassium chloride	T1	
potassium cl 10% (20 meq/15ml)	T1	
potassium cl 20% (40 meq/15ml)	T1	
potassium cl 20 meq packet	T1	
potassium cl 10%(20meq/15ml)cup	T1	
potassium cl 10%(40meq/30ml)cup	T1	
potassium cl20%(40meq/15ml)cup	T1	
potassium cl er 8 meq tablet	T1	
potassium cl er 10 meq capsule	T1	
potassium cl er 10 meq tablet	T1	
potassium cl er 15 meq tablet	T1	
POTASSIUM CL ER 15 MEQ TABLET	T1	
potassium cl er 20 meq tablet	T1	
potassium cl er 20 meq tablet (K-Tab Er)	T1	
PROTEIN REPLACEMENT		
AQNEURSA	T4	PA SP
ELECT/CALORIC/H2O (Urinary Tract Conditions)		
DIALYSIS SOLUTIONS		
PRISMASOL	T3	
URINARY PH MODIFIERS		
citric acid/sodium citrate	T1	HD
K-PHOS NO.2	T3	HD
K-PHOS ORIGINAL	T2	HD
ORACIT	T3	HD
potassium citrate	T1	HD
potassium citrate (Urocit-K)	T1	HD
RENACIDIN	T2	HD
UROCIT-K (potassium citrate)	T3	HD
UROQID-ACID NO.2	T3	HD

T1 – Generics

T2 – Preferred Brands

T3 – Non-Preferred Brands

T4 – Brand Specialty

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List of Prescription Medications

GASTROINTESTINAL (Cholesterol Medications)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
LIPOTROPICS		
<i>icosapent ethyl</i> (Vascepa)	T1	PA HD
<i>omega-3 acid ethyl esters</i> (Lovaza)	T1	PA HD
<i>VASCEPA (icosapent ethyl)</i>	T2	PA HD
GASTROINTESTINAL (Gastrointestinal/Heartburn)		
AMMONIA INHIBITORS		
BUPHENYL (<i>sodium phenylbutyrate</i>)	T4	PA SP HD
<i>lactulose</i>	T1	HD
<i>lactulose 10 gm/15 ml solution</i>	T1	HD
LITHOSTAT	T3	HD
ANTICHOLINERGICS, QUATERNARY AMMONIUM		
<i>chlordiazepoxide/clidinium br</i> (Librax)	T1	
GLYCATE	T3	
<i>glycopyrrolate</i>	T1	
<i>glycopyrrolate</i> (Cuvposa)	T1	
<i>glycopyrrolate</i> (Robinul Forte)	T1	
<i>glycopyrrolate</i> (Robinul)	T1	
OLPRUVA DOSE KIT, DOSE ENVELOPE	T4	SP PA HD
PHEBURANE	T4	PA SP
RAVICTI	T4	PA SP HD
ROBINUL (<i>glycopyrrolate</i>)	T3	
ROBINUL FORTE (<i>glycopyrrolate</i>)	T3	
<i>sodium phenylbutyrate</i> (Buphenyl)	T1	PA SP HD
ANTICHOLINERGICS/ANTISPASMODICS		
<i>dicyclomine hcl</i>	T1	
ANTIARRHEAL - TRYPTOPHAN HYDROXYLASE INHIBITOR		
XERMELO	T4	PA QL (84 tabs/28 days) SP
ANTIARRHEALS		
<i>diphenoxylate hcl/atropine</i>	T1	
<i>diphenoxylate hcl/atropine</i> (Lomotil)	T1	
LOMOTIL (<i>diphenoxylate hcl/atropine</i>)	T3	
MOTOFEN	T3	
<i>opium tincture</i>	T1	
<i>paregoric</i>	T1	

T1 – Generics

T2 – Preferred Brands

T3 – Non-Preferred Brands

T4 – Brand Specialty

PA – Prior Authorization

QL – Quantity Limit

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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
ANTIEMETIC, CANNABINOID-TYPE		
dronabinol (Marinol)	T1	PA
MARINOL (dronabinol)	T3	PA
SYNDROS	T3	PA
ANTIEMETIC/ANTIVERTIGO AGENTS		
aprepitant 125 mg capsule	T1	QL (1 cap/fill)
aprepitant 125-80-80 mg pack (Emend)	T1	QL (3 caps/fill)
aprepitant 40 mg capsule (Emend)	T1	QL (1 cap/fill)
aprepitant 80 mg capsule (Emend)	T1	QL (2 caps/fill)
COMPATINE (prochlorperazine maleate)	T3	
COMPATINE (prochlorperazine)	T3	
DICLEGIS (doxylamine succinate/vit b6)	T3	QL (120 tabs/fill)
fosaprepitant dimeglumine (Emend)	T1	
granisetron hcl 0.1 mg/ml vial	T1	
granisetron hcl 1 mg tablet	T1	QL (6 tabs/fill)
granisetron hcl 1 mg/ml vial	T1	
granisetron hcl 4 mg/4 ml vial	T1	
meclizine 50 mg tablet	T1	
ondansetron 4 mg/2 ml	T1	
ondansetron 40 mg/20 ml vial	T1	
ondansetron hcl 4 mg tablet	T1	QL (9 tabs/fill)
ondansetron hcl 4 mg/2 ml syr	T1	
ondansetron hcl 4 mg/2 ml vial	T1	
ondansetron hcl 8 mg tablet	T1	QL (9 tabs/fill)
ondansetron odt 4 mg tablet	T1	QL (9 tabs/30 days)
ondansetron odt 8 mg tablet	T1	QL (9 tabs/30 days)
prochlorperazine (Compazine)	T1	
prochlorperazine maleate (Compazine)	T1	
promethazine hcl	T1	
SANCUSO	T3	QL (1 patch/fill)
scopolamine (Transderm-Scop)	T1	
trimethobenzamide hcl	T1	
VARUBI	T2	QL (2 tabs/fill)
ANTI-ULCER PREPARATIONS		
CYTOTEC (misoprostol)	T3	HD

T1 – Generics

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List of Prescription Medications

GASTROINTESTINAL (Gastrointestinal/Heartburn) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ANTI-ULCER PREPARATIONS (cont.)		
<i>misoprostol</i> (Cytotec)	T1	HD
<i>sucralfate</i> (Carafate)	T1	HD
ANTI-ULCER-H.PYLORI AGENTS		
<i>lansoprazole/amoxiciln/clarith</i>	T1	QL (112 units/fill)
<i>OMECLAMOX-PAK</i>	T3	QL (80 units/fill)
<i>TALICIA</i>	T2	QL (168 caps/fill)
<i>VOQUEZNA DUAL PAK</i>	T3	
<i>VOQUEZNA TRIPLE PAK</i>	T3	
BELLADONNA ALKALOIDS		
<i>DONNATAL</i>	T3	HD
<i>DONNATAL (phenobarb/hyoscy/atropine/scop)</i>	T3	HD
<i>hyoscyamine sulfate</i>	T1	HD
<i>hyoscyamine sulfate (Levbid)</i>	T1	HD
<i>hyoscyamine sulfate (Levsin)</i>	T1	HD
<i>hyoscyamine sulfate (Levsin-SI)</i>	T1	HD
<i>hyoscyamine sulfate (Nulev)</i>	T1	HD
<i>LEVVID (hyoscyamine sulfate)</i>	T3	HD
<i>LEVSIN (hyoscyamine sulfate)</i>	T3	HD
<i>LEVSIN-SL (hyoscyamine sulfate)</i>	T3	HD
<i>methscopolamine bromide</i>	T1	HD
<i>NULEV (hyoscyamine sulfate)</i>	T3	HD
<i>phenobarb/hyoscy/atropine/scop</i>	T1	HD
<i>phenobarb/hyoscy/atropine/scop (Donnatal)</i>	T1	HD
<i>phenobarb/hyoscy/atropine/scop (Phenobarbital-Belladonna)</i>	T1	HD
<i>PHENOBARBITAL-BELLADONNA (phenobarb/hyoscy/atropine/scop)</i>	T3	HD
<i>SYMAX DUOTAB</i>	T3	HD
BILE SALTS		
<i>CHENODAL</i>	T4	PA SP HD
<i>CHOLBAM 250 MG CAPSULE</i>	T4	PA SP HD
<i>CHOLBAM 50 MG CAPSULE</i>	T4	PA QL (120 caps/fill) SP HD
<i>CTEXLI</i>	T4	PA SP
<i>URSO FORTE (ursodiol)</i>	T3	HD
<i>ursodiol</i>	T1	HD

T1 – Generics

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List of Prescription Medications

GASTROINTESTINAL (Gastrointestinal/Heartburn) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
BILE SALTS (cont.)		
<i>ursodiol</i> (Urso Forte)	T1	HD
<i>ursodiol</i> (Urso)	T1	HD
CHRONIC INFLAM. COLON DX, 5-A-SALICYLAT, RECTAL TX		
<i>mesalamine</i> 1,000 mg supp (Canasa)	T1	
<i>mesalamine</i> 4 gm/60 ml enema (Sfrowasa)	T1	
<i>mesalamine</i> 4 gm/60 ml kit (Rowasa)	T1	
ROWASA (<i>mesalamine</i> w/cleansing wipes)	T3	
SFROWASA (<i>mesalamine</i>)	T3	
DRUG TX-CHRONIC INFLAM. COLON DX, 5-AMINOSALICYLAT		
<i>APRISO</i> (<i>mesalamine</i>)	T3	HD
<i>ASACOL HD</i> (<i>mesalamine</i>)	T3	HD
<i>AZULFIDINE</i> (<i>sulfasalazine</i>)	T3	HD
<i>balsalazide disodium</i> (Colazal)	T1	HD
<i>COLAZAL</i> (<i>balsalazide disodium</i>)	T3	HD
<i>mesalamine</i> (Apriso)	T1	HD
<i>mesalamine</i> (Delzicol)	T1	HD
<i>mesalamine</i> (Pentasa)	T1	HD
<i>mesalamine</i> 800 mg dr tablet (Asacol Hd)	T1	HD
<i>mesalamine</i> dr 1.2 gm tablet (Lialda)	T1	HD
PENTASA 250 MG CAPSULE	T2	HD
PENTASA 500 MG CAPSULE (<i>mesalamine</i>)	T3	HD
<i>sulfasalazine</i> (Azulfidine)	T1	HD
FARNESOID X RECEPTOR (FXR) AGONIST, BILE AC ANALOG		
<i>OCALIVA</i>	T4	PA QL (30 tabs/fill) SP HD
FECAL MICROBIOTA TRANSPLANTATION (FMT)		
VOWST CAPSULE	T4	SP
GASTRIC ENZYMEs		
<i>SUCRAID</i>	T4	PA SP
HISTAMINE H2-RECEPTOR INHIBITORS		
<i>cimetidine</i>	T1	HD
<i>cimetidine hcl</i>	T1	HD
<i>famotidine</i>	T1	HD
<i>famotidine</i> (Pepcid)	T1	HD
<i>nizatidine</i>	T1	HD

T1 – Generics

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List of Prescription Medications

GASTROINTESTINAL (Gastrointestinal/Heartburn) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
HISTAMINE H2-RECEPTOR INHIBITORS (cont.)		
PEPCID (<i>famotidine</i>)	T3	HD
ranitidine hcl	T1	HD
IBS AGENTS, MIXED OPIOID RECEPTOR AGONISTS/ANTAGONISTS		
VIBERZI	T2	HD
IBS-C/CIC AGENTS, GUANYLATE CYCLASE-C AGONIST		
LINZESS	T2	QL (30 caps/fill)
TRULANCE	T2	
ILEAL BILE ACID TRANSPORTER (IBAT) INHIBITOR		
BYLVAY 1,200 MCG CAPSULE	T4	PA QL (60 caps/fill) SP HD
BYLVAY 200 MCG PELLET	T4	PA QL (120 pellets/fill) SP HD
BYLVAY 400 MCG CAPSULE	T4	PA QL (150 caps/fill) SP HD
BYLVAY 600 MCG PELLET	T4	PA QL (30 pellets/fill) SP HD
LIVMARLI	T4	PA SP
INTESTINAL MOTILITY STIMULANTS		
<i>metoclopramide hcl</i>	T1	
<i>metoclopramide hcl</i> (Reglan)	T1	
<i>prucalopride</i>	T1	QL (30 tabs/30 days)
REGLAN (<i>metoclopramide hcl</i>)	T3	
IRRITABLE BOWEL SYNDROME AGENTS, 5-HT3 ANTAGONIST		
alosetron hcl (Lotronex)	T1	SP HD
ZELNORM	T3	
LAXATIVES AND CATHARTICS		
bisac/nacl/nahco3/kcl/peg 3350	T1	PPACA
GIALAX	T3	PPACA
GOLYTELY (peg3350/sod sulf,bicarb,cl/kcl)	T3	
KRISTALOSE	T3	
<i>lactulose</i>	T1	
<i>lactulose</i> 10 gm packet	T1	
<i>lactulose</i> 10 gm/15 ml solution	T1	
<i>lactulose</i> 20 gm/30 ml solution	T1	
NULYTLY	T3	
<i>lubiprostone</i>	T1	QL (60 caps/30 days)
NULYTLY WITH FLAVOR Packs (<i>sodium chloride/nahco3/kcl/peg</i>)	T3	
OSMOPREP	T3	PPACA

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List of Prescription Medications

GASTROINTESTINAL (Gastrointestinal/Heartburn) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
LAXATIVES AND CATHARTICS (cont.)		
peg3350/sod sul/nacl/kcl/asb/c (Moviprep)	T1	PPACA
peg3350/sod sulf,bicarb,cl/kcl	T1	PPACA
peg3350/sod sulf,bicarb,cl/kcl (Golytely)	T1	PPACA
sodium chloride/nahco3/kcl/peg (Nulytely With Flavor Packs)	T1	PPACA
sodium, potassium,mag sulfates (Suprep)	T1	PPACA
LOCAL ANORECTAL NITRATE PREPARATIONS		
nitroglycerin 0.4% ointment (Rectiv)	T1	
RECTIV (nitroglycerin)	T2	
MU-OPIOID RECEPTOR ANTAGONISTS, PERIPHERALLY-ACTING		
alvimopan	T1	
ENTEREG	T3	
PANCREATIC ENZYMES		
CREON	T2	HD
PANCREAZE	T2	HD
VIOKACE	T2	HD
ZENPEP	T2	HD
POTASSIUM-COMPETITIVE ACID BLOCKERS (PCABS)		
VOQUEZNA	T3	
PROTON-PUMP INHIBITORS		
dexlansoprazole dr 30 mg cap	T1	ST HD
dexlansoprazole dr 60 mg cap	T1	ST HD
esomeprazole dr 2.5 mg packet (Nexium)	T1	ST QL (30 packs/30 days) HD
esomeprazole dr 5 mg packet (Nexium)	T1	ST QL (30 packs/30 days) HD
esomeprazole dr 10 mg packet (Nexium)	T1	ST QL (30 packs/fill) HD
esomeprazole dr 40 mg packet (Nexium)	T1	ST HD
esomeprazole mag dr 40 mg cap (Nexium)	T1	HD
ESOMEPRAZOLE DR 49.3 MG CAP	T3	ST HD
lansoprazole dr 30 mg capsule (Prevacid)	T1	HD
lansoprazole odt 15 mg tablet (Prevacid)	T1	ST QL (30 tabs/fill) HD
lansoprazole odt 30 mg tablet (Prevacid)	T1	ST HD
omeprazole dr 10 mg capsule	T1	QL (30 caps/fill) HD
omeprazole dr 40 mg capsule	T1	HD
omeprazole/sodium bicarbonate (Zegerid)	T1	PA HD
omeprazole-bicarb 20-1,680 pkt (Zegerid)	T1	ST QL (30 packs/30 days) HD

T1 – Generics

T2 – Preferred Brands

T3 – Non-Preferred Brands

T4 – Brand Specialty

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List of Prescription Medications

GASTROINTESTINAL (Gastrointestinal/Heartburn) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
PROTON-PUMP INHIBITORS (cont.)		
omeprazole-bicarb 40-1,100 cap (Zegerid)	T1	ST HD
omeprazole-bicarb 40-1,680 pkt (Zegerid)	T1	ST HD
pantoprazole 40 mg suspension (Protonix)	T1	ST HD
pantoprazole sod dr 40 mg tab (Protonix)	T1	HD
rabeprazole sod dr 20 mg tab (Aciphenx)	T1	HD
RECTAL PREPARATIONS		
hydrocortisone acetate (Anusol-Hc)	T1	
hydrocortisone acetate (Proctocort)	T1	
PROCTOCORT (hydrocortisone acetate)	T3	ST
SBS - GLUCAGON-LIKE PEPTIDE-2 (GLP-2) ANALOGS		
GATTEX	T4	PA SP HD
GASTROINTESTINAL (Pain Relief And Inflammatory Disease)		
HEMORRHOID PREP, ANTI-INFLAM STEROID-LOCAL ANESTHET		
ANA-LEX	T3	
ANALPRAM HC 1% CREAM	T3	
ANALPRAM HC 2.5%-1% CREAM (hydrocortisone/pramoxine)	T3	ST
ANALPRAM HC 2.5%-1% CRM SINGLE (hydrocortisone/pramoxine)	T3	ST
LIDOCAINE-HC 3-2.5% GEL KIT	T3	
hydrocort-pramoxine 1%-1% crm	T1	
hydrocort-pramoxine 2.5%-1% cm (Analpram Hc)	T1	ST
hydrocort-pramoxine 2.5-1% crm (Analpram Hc)	T1	ST
lidocaine-hc 2.8-0.55% gel	T1	
lidocaine-hc 2-2% cream kit	T1	
lidocaine-hc 3-0.5% cream	T1	
lidocaine-hc 3-0.5% cream kit	T1	
lidocaine-hc 3-2.5% gel kit	T1	
LIDOCAINE-HYDROCORT 3-2.5% GEL	T3	
PROCORT	T3	
HORMONES (Gastrointestinal/Heartburn)		
RECTAL/LOWER BOWEL PREP, GLUCOCORT. (NON-HEMORR)		
CORTENEMA (hydrocortisone)	T3	
hydrocortisone (Cortenema)	T1	
UCERIS (budesonide)	T3	

T1 – Generics

T2 – Preferred Brands

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List of Prescription Medications

HORMONES (Hormonal Agents)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ADRENOCORTICOTROPHIC HORMONES		
ACTHAR SELFJECT	T4	PA SP HD
ANDROGENIC AGENTS		
DEPO-TESTOSTERONE	T3	PA
DEPO-TESTOSTERONE (<i>testosterone cypionate</i>)	T3	PA
JATENZO	T3	PA QL (60 caps/fill)
METHITEST	T2	
<i>methyltestosterone</i>	T1	
<i>oxandrolone</i>	T1	
<i>testosterone 1% (25mg/2.5g) pk (Androgel)</i>	T1	PA QL (75 gms/fill)
<i>testosterone 1% (50 mg/5 g) pk (Androgel)</i>	T1	PA QL (300 gms/fill)
<i>testosterone 1.62% (2.5 g) pkt (Androgel)</i>	T1	PA QL (60 Packs/fill)
<i>testosterone 1.62% gel pump (Androgel)</i>	T1	PA QL (150 gms/fill)
<i>testosterone 1.62%(1.25 g) pkt (Androgel)</i>	T1	PA QL (30 Packs/fill)
<i>testosterone 10 mg gel pump</i>	T1	QL (120 gms/30 days)
TESTOSTERONE 12.5 MG/1.25 GRAM	T3	PA QL (300 gms/fill)
<i>testosterone 12.5 mg/1.25 gram</i>	T1	PA QL (300 gms/fill)
<i>testosterone 30 mg/1.5 ml pump</i>	T1	PA QL (180 mls/fill)
<i>testosterone 50 mg/5 gram gel (Testim)</i>	T1	PA QL (60 tubes/fill)
<i>testosterone 50 mg/5 gram gel (Vogelxo)</i>	T1	PA QL (60 tubes/fill)
TESTOSTERONE 50 MG/5 GRAM PKT	T3	PA QL (300 gms/fill)
<i>testosterone cypionate</i>	T1	PA
<i>testosterone cypionate (Depo-Testosterone)</i>	T1	PA
<i>testosterone enanthate</i>	T1	PA
VOGELXO 12.5 MG/1.25 GRAM PUMP	T3	PA QL (300 gms/fill)
VOGELXO 50 MG/5 GRAM GEL (<i>testosterone</i>)	T3	PA QL (60 tubes/fill)
VOGELXO 50 MG/5 GRAM GEL PACKT	T3	PA QL (60 Packs/fill)
XYOSTED	T2	QL (2 mls/28 days)
ANTIDIURETIC AND VASOPRESSOR HORMONES		
DDAVP (<i>desmopressin (nonrefrigerated)</i>)	T3	
DDAVP 0.1 MG TABLET (<i>desmopressin acetate</i>)	T3	HD
DDAVP 0.2 MG TABLET (<i>desmopressin acetate</i>)	T3	HD
<i>desmopressin 10 mcg/0.1 ml spr</i>	T1	HD
DESMOPRESSIN 1.5 MG/ML SPRAY	T2	HD

T1 – Generics

T2 – Preferred Brands

T3 – Non-Preferred Brands

T4 – Brand Specialty

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List of Prescription Medications

HORMONES (Hormonal Agents) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ANTIDIURETIC AND VASOPRESSOR HORMONES (cont.)		
desmopressin 0.01% solution	T1	HD
desmopressin acetate 0.1 mg tb (Ddavp)	T1	HD
desmopressin acetate 0.2 mg tb (Ddavp)	T1	HD
NOCTIVA	T3	
ESTROGEN/ANDROGEN COMBINATIONS		
ESTRATEST F.S. (estrogen,ester/me-testosterone)	T3	HD
ESTRATEST H.S. (estrogen,ester/me-testosterone)	T3	HD
estrogen,ester/me-testosterone (Estratest F.S.)	T1	HD
estrogen,ester/me-testosterone (Estratest H.S.)	T1	HD
ESTROGENIC AGENTS		
ACTIVELLA (estradiol/norethindrone acet)	T3	HD
CLIMARA (estradiol)	T3	QL (4 patches/28 days)) HD
COMBIPATCH	T2	
DELESTROGEN	T3	HD
DELESTROGEN (estradiol valerate)	T3	HD
DEPO-ESTRADIOL	T2	HD
ESTRACE 0.5 MG TABLET (estradiol)	T3	HD
ESTRACE 1 MG TABLET (estradiol)	T3	HD
ESTRACE 2 MG TABLET (estradiol)	T3	HD
estradiol (Climara)	T1	QL (4 patches/28 days)) HD
estradiol 0.1% (0.25mg) gel pk (Divigel)	T1	QL (30 packs/fill) HD
estradiol 0.1% (0.75mg) gel pk (Divigel)	T1	QL (30 packs/fill) HD
estradiol 0.1% (1 mg) gel pkt (Divigel)	T1	QL (30 packs/fill) HD
estradiol 0.1% (1.25mg) gel pk	T1	QL (30 packs/fill) HD
estradiol 0.5 mg tablet (Estrace)	T1	HD
estradiol 0.06% 1.25g gel pump (Estrogel)	T1	QL (50 gms/30 days) HD
estradiol 1 mg tablet (Estrace)	T1	HD
estradiol 2 mg tablet (Estrace)	T1	HD
estradiol valerate (Delestrogen)	T1	HD
estradiol/norethindrone acet	T1	HD
estradiol/norethindrone acet (Activella)	T1	HD
EVAMIST	T3	QL (17 mls/30 days) HD
MENOSTAR	T3	QL (4 patches/28 days)) HD
norethind-eth estrad 0.5-2.5	T1	HD

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T4 – Brand Specialty

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List of Prescription Medications

HORMONES (Hormonal Agents) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ESTROGENIC AGENTS (cont.)		
<i>norethindrone ac/eth estradiol</i>	T1	HD
<i>norethrin-eth estrad 1 mg-5 mcg</i>	T1	HD
PREFEST	T3	HD
ESTROGEN-PROGESTIN WITH ANTIMINERALOCORTICOID COMB		
ANGELIQ	T3	HD
ESTROGEN-SELECTIVE ESTROGEN RECEPTOR MOD (SERM) COMB		
DUAVEE	T2	
GLUCOCORTICOIDS		
ASMALPRED PLUS	T3	
<i>budesonide</i>	T1	
<i>budesonide (Uceris)</i>	T1	
CORTEF (<i>hydrocortisone</i>)	T3	
<i>cortisone acetate</i>	T1	
<i>deflazacort</i>	T1	PA SP HD
<i>deflazacort (Emflaza)</i>	T1	PA SP HD
<i>dexamethasone</i>	T1	PA
<i>dexamethasone</i>	T1	
<i>dexamethasone 0.5 mg tablet</i>	T1	
<i>dexamethasone 0.5 mg/5 ml elx</i>	T1	
<i>dexamethasone 0.5 mg/5 ml liq</i>	T1	
<i>dexamethasone 0.75 mg tablet</i>	T1	
<i>dexamethasone 1 mg tablet</i>	T1	
<i>dexamethasone 1.5 mg tablet</i>	T1	
<i>dexamethasone 10 day 1.5 mg tb</i>	T1	PA
<i>dexamethasone 13 day 1.5 mg tb</i>	T1	PA
<i>dexamethasone 2 mg tablet</i>	T1	
<i>dexamethasone 4 mg, 6 mg tablet</i>	T1	
<i>dexamethasone 6 day 1.5 mg tab</i>	T1	PA
DEXONTO	T3	
DXEVO	T3	PA
<i>hydrocortisone (Cortef)</i>	T1	
MEDROL	T3	
MEDROL (<i>methylprednisolone</i>)	T3	
<i>methylprednisolone</i>	T1	

T1 – Generics

T2 – Preferred Brands

T3 – Non-Preferred Brands

T4 – Brand Specialty

PA – Prior Authorization

QL – Quantity Limit

ST – Step Therapy

AGE – Age Requirement

SP – Specialty Medication

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List of Prescription Medications

HORMONES (Hormonal Agents) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
GLUCOCORTICOIDS (cont.)		
<i>methylprednisolone</i> (Medrol)	T1	
ORAPRED ODT (<i>prednisolone sodium phosphate</i>)	T3	
<i>prednisolone</i>	T1	
<i>prednisolone sodium phosphate</i>	T1	
<i>prednisolone sodium phosphate</i> (Orapred Odt)	T1	
<i>prednisone</i>	T1	
<i>prednisone</i>	T1	
RAYOS	T3	PA
TAPERDEX	T3	PA
TARPEYO	T4	PA QL (28 caps/30 days) SP
UCERIS (<i>budesonide</i>)	T3	
ZCORT	T3	PA
GROWTH HORMONE RELEASING HORMONE (GHRH) AND ANALOGS		
EGRIFTA SV	T4	PA SP HD
GROWTH HORMONES		
GENOTROPIN	T4	PA SP HD
OMNITROPE	T4	PA SP
SEROSTIM	T4	PA SP HD
ZORBTIVE	T4	PA SP HD
INSULIN-LIKE GROWTH FACTOR-I (IGF-I) HORMONES		
INCRELEX	T4	PA SP
LHRH (GNRH) AGONIST ANALOG PITUITARY SUPPRESSANTS		
SYNAREL	T4	PA SP HD
LHRH (GNRH) ANTAGONIST, ESTROGEN AND PROGESTIN COMB		
MYFEMBREE	T2	PA
ORIAHNN	T2	PA
LHRH (GNRH) ANTAGONIST, PITUITARY SUPPRESSANT AGENTS		
<i>cetorelix acetate</i>	T1	SP
CETROTIDE	T4	SP
GANIRELIX ACET 250 MCG/0.5 ML (<i>ganirelix acetate</i>)	T4	ST SP
<i>ganirelix acet</i> 250 mcg/0.5 ml (Ganirelix Acetate)	T1	ST SP
<i>ganirelix acetate</i> (Ganirelix Acetate)	T1	SP
ORILISSA 150 MG TABLET	T2	PA QL (30 tabs/fill)
ORILISSA 200 MG TABLET	T2	PA QL (60 tabs/fill)

T1 – Generics

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List of Prescription Medications

HORMONES (Hormonal Agents) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
MINERALOCORTICOIDS		
<i>fludrocortisone acetate</i>	T1	HD
OXYTOCICS		
<i>CERVIDIL</i>	T3	
<i>methylergonovine maleate</i>	T1	QL (240 tabs/30 days)
<i>PREPIDIL</i>	T3	
PARATHYROID HORMONES		
<i>NATPARA</i>	T4	PA SP HD
<i>YORVIPATH</i>	T4	PA SP
PITUITARY SUPPRESSIVE AGENTS		
<i>CRENESSITY</i>	T4	PA SP
<i>cabergoline</i>	T1	QL (8 tabs/28 days) HD
<i>danazol</i>	T1	HD
PROGESTATIONAL AGENTS		
<i>medroxyprogesterone 2.5 mg tab (Provera)</i>	T1	HD
<i>medroxyprogesterone 5 mg tab (Provera)</i>	T1	HD
<i>medroxyprogesterone 10 mg tab (Provera)</i>	T1	HD
<i>norethindrone acetate</i>	T1	HD
<i>progesterone, micronized (Prometrium)</i>	T1	HD
<i>PROMETRIUM (progesterone, micronized)</i>	T3	HD
<i>PROVERA (medroxyprogesterone acetate)</i>	T3	HD
SOMATOSTATIC AGENTS		
<i>MYCAPSSA</i>	T4	PA QL (56 caps/28 days) SP
<i>SIGNIFOR</i>	T4	PA SP
VAGINAL ESTROGEN PREPARATIONS		
<i>estradiol (Vagifem)</i>	T1	
<i>estradiol 0.01% cream (Estrace)</i>	T1	HD
<i>estradiol 10 mcg vaginal insrt (Vagifem)</i>	T1	HD
<i>PREMARIN VAGINAL CREAM-APPL</i>	T2	HD
HORMONES (Infertility)		
FERTILITY STIMULATING PREPARATIONS, NON-FSH		
<i>clomiphene citrate</i>	T1	
FOLLICLE-STIMULATING AND LUTEINIZING HORMONES		
<i>MENOPUR</i>	T4	SP

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HORMONES (Infertility) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
FOLLICLE-STIMULATING HORMONE (FSH)		
FOLLISTIM AQ	T4	ST SP
GONAL-F	T4	ST SP
GONAL-F RFF	T4	ST SP
GONAL-F RFF REDI-JECT	T4	ST SP
HUMAN CHORIONIC GONADOTROPIN (HCG)		
CHORIONIC GONAD 10,000 UNIT VL	T4	ST QL (3 vials/30 days) SP
CHORIONIC GONAD 50,000 UNIT VL	T4	ST SP
CHORIONIC GONAD 6,000 UNIT VL	T4	ST SP
NOVAREL	T4	ST QL (6 vls/30 days) SP
OVIDREL	T4	QL (6 vls/30 days) SP
PREGNYL	T4	QL (3 vials/30 days) SP
PREGNANCY FACILITATING/MAINTAINING AGENT, HORMONAL		
CRINONE	T3	
CRINONE 8% GEL	T2	
ENDOMETRIN	T3	ST
HORMONES (Miscellaneous)		
LEPTIN HORMONE ANALOGS		
MYALEPT	T4	PA SP HD
HORMONES (Osteoporosis Products)		
BONE FORMATION STIMULATING AGTS - PTH REL PEPTIDES		
TYMLOS	T4	PA QL (1 pen/fill) SP HD
BONE RESORPTION INHIBITORS		
calcitonin, salmon, synthetic	T1	HD
calcitonin, salmon, synthetic (Miacalcin)	T1	HD
MIACALCIN (calcitonin, salmon, synthetic)	T3	HD
IMMUNOSUPPRESSANTS (Pain Relief And Inflammatory Disease)		
HUMAN INTERLEUKIN 12/23 (IL-12/13) INHIBITORS, MAB		
SELARSDI 45 MG/0.5 ML SYRINGE	T4	PA QL (1 syringe/84 days) SP
SELARSDI 90 MG/ML SYRINGE	T4	PA QL (1 syringe/56 days) SP
STELARA	T4	PA QL SP HD
USTEKINUMAB-TTWE 45MG/0.5ML SY	T4	PA SP HD
USTEKINUMAB-TTWE 90 MG/ML SYR	T4	PA SP HD
YESINTEK 45 MG/0.5 ML SYRINGE	T4	PA SP HD

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List of Prescription Medications

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

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
HUMAN INTERLEUKIN 12/23 (IL-12/13) INHIBITORS, MAB (cont.)		
YESINTEK 45 MG/0.5 ML VIAL	T4	PA SP HD
YESINTEK 90 MG/ML SYRINGE	T4	PA SP HD
IL-23 RECEPTOR ANTAGONIST, MONOCLONAL ANTIBODY		
OMVOH 100 MG/ML PEN	T4	PA QL (2 mls/28 days) SP HD
OMVOH 300 MG DOSE - 2 PENS	T4	PA QL (3 mls/28 days) SP HD
OMVOH 100 MG/ML PEN	T4	PA QL (2 mls/28 days) SP HD
OMVOH 100 MG/ML SYRINGE	T4	PA QL (2 mls/28 days) SP HD
OMVOH 300 MG DOSE - 2 SYRINGES	T4	PA QL (3 mls/28 days) SP HD
SKYRIZI ON-BODY	T4	PA QL (1 cartridge/56 days) SP HD
TREMFYA 100 MG/ML INJECTOR	T4	PA QL (1 auto-inj/56 days) SP HD
TREMFYA PEN INDUCTION PK-CROHN	T4	PA QL (200 mgs/28 days) SP HD
TREMFYA PEN	T4	PA QL (200 mgs/28 days) SP HD
TREMFYA 100 MG/ML PEN	T4	PA SP HD
TREMFYA 200 MG/2 ML PEN	T4	PA SP HD
TREMFYA ONE-PRESS	T4	PA SP HD
TREMFYA 100 MG/ML SYRINGE	T4	PA QL (1 syringe/56 days) SP HD
TREMFYA 200 MG/2 ML SYRINGE	T4	PA QL (200 mgs/28 days) SP HD
INTERLEUKIN-4(IL-4) RECEPTOR ALPHA ANTAGONIST, MAB		
DUPIXENT 100 MG/0.67 ML SYRING	T4	PA QL (2 syringes/28 days) SP HD
DUPIXENT 200 MG/1.14 ML PEN	T4	PA QL (400 mgs/28 days) SP HD
DUPIXENT 200 MG/1.14 ML SYRING	T4	PA QL (400 mgs/28 days) SP HD
DUPIXENT 300 MG/2 ML PEN	T4	PA QL (600 mgs/28 days) SP HD
DUPIXENT 300 MG/2 ML SYRINGE	T4	PA QL (600 mgs/28 days) SP HD
INTERLEUKIN-6 (IL-6) RECEPTOR INHIBITORS		
ACTEMRA	T4	PA QL (3.6 mls/28 days) SP HD
ACTEMRA ACTPEN	T4	PA QL (2 pens/28 days) SP HD
ENSPRYNG	T4	PA SP HD
TYENNE	T4	PA QL (3.6 mls/28 days) SP
TYENNE AUTOINJECTOR	T4	PA QL (2 pens/28 days) SP
IMMUNOSUPPRESSANTS (Skin Conditions)		
INTERLEUKIN-31(IL-31)RECEPTOR ALPHA ANTAGONIST,MAB		
NEMLUVIO	T4	PA QL (2 pens/28 days) SP HD
TOPICAL IMMUNOSUPPRESSIVE AGENTS		
HYFTOR	T4	PA SP

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List of Prescription Medications

IMMUNOSUPPRESSANTS (Skin Conditions) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
TOPICAL IMMUNOSUPPRESSIVE AGENTS (cont.)		
pimecrolimus (Elidel)	T1	ST QL (120 gms/30 days)
tacrolimus 0.03% ointment	T1	ST QL (120 gms/30 days)
tacrolimus 0.1% ointment	T1	ST QL (120 gms/30 days)

IMMUNOSUPPRESSANTS (Transplant Medications)

IMMUNOSUPPRESSIVES

ASTAGRAF XL	T4	PA SP HD
AZASAN (<i>azathioprine</i>)	T4	SP HD
<i>azathioprine</i> (Azasan)	T1	SP HD
<i>azathioprine</i> (Imuran)	T1	SP HD
CELLCEPT (<i>mycophenolate mofetil</i>)	T4	SP HD
cyclosporine 100 mg capsule (Sandimmune)	T1	SP HD
cyclosporine 25 mg capsule (Sandimmune)	T1	SP HD
cyclosporine, modified	T1	SP HD
cyclosporine, modified (Neoral)	T1	SP HD
everolimus 0.25 mg tablet (Zortress)	T1	SP HD
everolimus 0.5 mg tablet (Zortress)	T1	SP HD
everolimus 0.75 mg tablet (Zortress)	T1	SP HD
everolimus 1 mg tablet (Zortress)	T1	SP HD
IMURAN (<i>azathioprine</i>)	T4	SP HD
LUPKYNIS	T4	PA SP QL (180 caps/30 days)
<i>mycophenolate mofetil</i> (Cellcept)	T1	SP HD
<i>mycophenolate sodium</i> (Myfortic)	T1	SP HD
MYFORTIC (<i>mycophenolate sodium</i>)	T4	SP HD
MYHIBBIN	T4	SP
NEORAL (<i>cyclosporine, modified</i>)	T4	SP HD
PROGRAF 0.2 MG GRANULE PACKET	T4	SP HD
PROGRAF 0.5 MG CAPSULE (<i>tacrolimus</i>)	T4	SP HD
PROGRAF 1 MG CAPSULE (<i>tacrolimus</i>)	T4	SP HD
PROGRAF 1 MG GRANULE PACKET	T4	SP HD
PROGRAF 5 MG CAPSULE (<i>tacrolimus</i>)	T4	SP HD
RAPAMUNE (<i>sirolimus</i>)	T4	SP HD
SANDIMMUNE 100 MG CAPSULE (<i>cyclosporine</i>)	T4	SP HD
SANDIMMUNE 100 MG/ML SOLN	T4	SP HD

T1 – Generics

T2 – Preferred Brands

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List of Prescription Medications

IMMUNOSUPPRESSANTS (Transplant Medications) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
IMMUNOSUPPRESSIVES (cont.)		
SANDIMMUNE 25 MG CAPSULE (<i>cyclosporine</i>)	T4	SP HD
<i>sirolimus</i>	T1	SP HD
<i>sirolimus</i> (Rapamune)	T1	SP HD
<i>tacrolimus 0.5 mg capsule (ir)</i> (Prograf)	T1	SP HD
<i>tacrolimus 1 mg capsule (ir)</i> (Prograf)	T1	SP HD
<i>tacrolimus 5 mg capsule (ir)</i> (Prograf)	T1	SP HD
ZORTRESS (everolimus)	T4	SP HD

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

DIABETIC SUPPLIES

2TEK	T3	
ACCU-CHEK	T3	
ACCU-CHEK COMPACT PLUS CONTROL	T3	
ACCU-CHEK FASTCLIX LANCING DEV	T2	
ACCU-CHEK GUIDE CONTROL SOLN	T3	
ACCU-CHEK SMARTVIEW CTRL SOL	T3	
ACCU-CHEK SOFTCLIX	T2	
ACCUTREND GLUCOSE CONTROL	T3	
ADJUSTABLE LANCING DEVICE	T2	
ADVANCED LANCING DEVICE	T2	
ADVOCATE CONTROL SOLUTION	T3	
ADVOCATE LANCING DEVICE	T2	
ADVOCATE RAPID-SAFE LANCING DV	T2	
ADVOCATE REDI-CODE+ CTRL SOLN	T3	
AGAMATRIX CONTROL	T3	
AGAMATRIX CONTROL SOLUTION	T3	
ALKALINE BATTERIES	T3	
ALTERNATE SITE LANCING DEVICE	T2	
AQUA LANCE LANCING DEVICE	T2	
ASSURE 4 CONTROL SOLUTION	T3	
ASSURE DOSE	T3	
ASSURE PRISM	T3	
AT HOME A1C	T3	
AUTOLET LITE	T2	

T1 – Generics

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List of Prescription Medications

MISCELLANEOUS MEDICAL SUPPLIES, DEVICES, NON-DRUG (Diabetes) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
DIABETIC SUPPLIES (cont.)		
AUTOJECT 2	T2	
AUTO-LANCET MINI	T2	
AUTOLET IMPRESSION	T2	
AUTOLET LANCING DEVICE	T2	
AUTOLET PLUS	T2	
AUTOPEN	T2	
AUTOSOFT 30	T2	
AUTOSOFT 90	T2	
AUTOSOFT 30 INFUSION SET PACK	T3	
AUTOSOFT XC	T2	
AUTOSOFT XC INFUSION SET PACK	T3	
BLOOD GLUCOSE CONTROL	T3	
BLOOD-GLUCOSE CONTROL	T3	
BREEZE 2	T3	
CAREONE	T2	
CARESENS	T3	
CARETOUCH CONTROL SOLUTION	T3	
CARETOUCH LANCING DEVICE	T2	
CEQUR SIMPLICITY	T2	
CEQUR SIMPLICITY INSERTER	T2	
CHEMSTRIP BG DIARY	T3	
CHOSEN LANCING DEVICE	T2	
CLEVER CHOICE CONTROL SOLUTION	T3	
CONTOUR	T3	
CONTOUR NEXT CONTROL SOLUTION	T3	
CONTROL SOLUTION	T3	
COOL CONTROL SOLUTION	T3	
DEXCOM RECEIVER	T2	PA
DEXCOM G4 RECEIVER	T2	PA
DEXCOM G4 TRANSMITTER	T2	PA QL (1 kit/180 days)
DEXCOM G5 RECEIVER	T2	PA
DEXCOM G5 TRANSMITTER	T2	PA QL (1 kit/90 days)
DEXCOM G5-G4 SENSOR	T2	PA
DEXCOM G6 RECEIVER	T2	PA QL (1 unit/365 days)

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MISCELLANEOUS MEDICAL SUPPLIES, DEVICES, NON-DRUG (Diabetes) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
DIABETIC SUPPLIES (cont.)		
DEXCOM G6 SENSOR	T2	PA QL (3 kits/30 days)
DEXCOM G6 TRANSMITTER	T2	PA QL (1 kit/90 days)
DEXCOM G7 RECEIVER	T2	PA QL (1 unit/365 days)
DEXCOM G7 SENSOR	T2	PA QL (3 units/30 days)
DIATRUE	T3	
DROPLET GENTEE LANCING DEVICE	T2	
DROPLET LANCING DEVICE	T2	
EASY MINI EJECT LANCING DEVICE	T2	
EASY PLUS II CONTROL SOLN HIGH	T3	
EASY PLUS II CONTROL SOLN LOW	T3	
EASY STEP CONTROL SOLUTION	T3	
EASY TALK CONTROL SOLN LOW	T3	
EASY TALK HIGH CONTROL SOLN	T3	
EASY TALK PLUS II HIGH CONTROL	T3	
EASY TALK PLUS II LOW CTRL SLN	T3	
EASY TOUCH BLULINK CTRL SOLN	T3	
EASY TOUCH CONTROL SOLUTION	T3	
EASY TOUCH LANCING DEVICE	T2	
EASY TRAK CONTROL SOLN HIGH	T3	
EASY TRAK CONTROL SOLN LOW	T3	
EASY TRAK II CONTROL SOLUTION	T3	
EASYGLUCO PLUS CONTROL NORMAL	T3	
EASymax 15 LEVEL 2 SOLUTION	T3	
EASymax NORMAL CONTROL SOLN	T3	
ELEMENT COMPACT CONTROL SOLN	T3	
ELEMENT CONTROL SOLUTION	T3	
EMBRACE EVO LEVEL 1 CTRL SOLN	T3	
EMBRACE GLUC CONTROL SOLN HIGH	T3	
EMBRACE GLUCOSE CONTROL SOLN	T3	
EMBRACE LANCING DEVICE	T2	
EMBRACE PRO	T3	
EMBRACE TALK CONTROL SOLUTION	T3	
ENLITE SERTER	T3	
EVENCARE G2 CONTROL SOLUTION	T3	

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MISCELLANEOUS MEDICAL SUPPLIES, DEVICES, NON-DRUG (Diabetes) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
DIABETIC SUPPLIES (cont.)		
EVENCARE G3 CONTROL SOLUTION	T3	
EVOLUTION CONTROL SOLUTION	T3	
FORA CONTROL SOLUTION	T3	
FORA GTel MULTIFUNCTN MONITOR	T3	
FORA KETONE CONTROL SOLUTION	T3	
FORA LANCING DEVICE	T2	
FORA TN'GO ADV MOBILE MULT MTR	T3	
FORA TN'GO ADVANCE MONITOR	T3	
FORA TN'GO ADVANCE MULTIFN MTR	T3	
FORA TN'G ADVANCE PRO MONITOR	T3	
FORACARE GDH	T3	
FORTISCARE	T3	
FREESTYLE CONTROL SOLUTION	T2	
FREESTYLE LIBRE 2 READER	T2	PA QL (1 unit/365 days)
FREESTYLE LIBRE 2 PLUS SENSOR	T2	PA QL (2 units/30 days)
FREESTYLE LIBRE 2 SENSOR	T2	PA QL (2 sensors/28 days)
FREESTYLE LIBRE 3 PLUS SENSOR	T2	PA QL (2 units/30 days)
FREESTYLE LIBRE 3 READER	T2	PA QL (1 unit/365 days)
FREESTYLE LIBRE 3 SENSOR	T2	PA QL (2 units/28 days)
FREESTYLE LIBRE 10 DAY READER	T2	PA
FREESTYLE LIBRE 10 DAY SENSOR	T2	PA
FREESTYLE LIBRE 14 DAY READER	T2	PA
FREESTYLE LIBRE 14 DAY SENSOR	T2	PA QL (2 kits/30 days)
FREESTYLE NAVIGATOR SENSOR KIT	T2	
GE100 CONTROL SOLUTION NORMAL	T3	
GENTEEL VACUUM LANCING DEVICE	T3	
GLUCOCARD 01 CONTROL	T3	
GLUCOCARD EXPRESSION CNTRL SLN	T3	
GLUCOCARD SHINE CONTROL SOLN	T3	
GLUCOCOM AUTOLINK	T3	
GLUCOCOM CONTROL SOLUTION	T3	
GLUCOSE CONTROL	T3	
GLUCOSE CONTROL SOLUTION	T3	
GOJJI GLUCOSE CONTROL SOLUTION	T3	

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MISCELLANEOUS MEDICAL SUPPLIES, DEVICES, NON-DRUG (Diabetes) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
DIABETIC SUPPLIES (cont.)		
GOJJI KETONE CONTROL SOLUTION	T3	
GOJJI LANCING DEVICE	T2	
GOJJI MULTI-FUNCTIONAL METER	T3	
GUARDIAN LINK 3 TRANSMITTER	T3	PA QL (1 transmitter/273 days)
GUARDIAN 4 TRANSMITTER	T3	PA QL (1 transmitter/273 days)
GUARDIAN 4 GLUCOSE SENSOR	T3	PA QL (5 sensors/30 days)
GUARDIAN RT CHARGER	T3	
GUARDIAN RT STARTER KIT	T3	
GUARDIAN TEST PLUG	T3	
GUARDIAN TRANSMITTER TAPE	T3	
HEALTHPRO GLUCOSE CONTROL SOLN	T3	
HEALTHY ACCENTS AUTOLET	T2	
HYPOLANCE	T2	
IHEALTH CONTROL SOLN LEVEL 2	T3	
ILET INFUSION-CONTACT DETACH	T2	
ILET INFUSION KIT-INSET	T2	
ILET STARTER KIT-INSET	T2	
INCONTROL LANCING DEVICE	T2	
INFINITY CONTROL SOLUTION	T3	
INFINITY VOICE CONTROL SOLN	T3	
INPEN (FOR HUMALOG)	T3	
INPEN (FOR NOVOLOG OR FIASP)	T3	
INSUL-CAP	T3	
INSUL-EZE	T3	
LANCING DEVICE	T2	
LANCING SYSTEM	T2	
LANZO	T2	
LITE TOUCH LANCING PEN	T2	
MEDISENSE	T2	
MEDISENSE GLUCOSE KETONE	T2	
MEDISENSE GLUCOSE KETONE CONTR	T2	
MEDTRONIC EXT INFUSION SET	T2	
MEDTRONIC REMOTE CONTROL	T2	
MICRODOT HIGH-LOW CONTROL SOL	T3	

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MISCELLANEOUS MEDICAL SUPPLIES, DEVICES, NON-DRUG (Diabetes) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
DIABETIC SUPPLIES (cont.)		
MICRODOT NORMAL CONTROL SOLUT	T3	
MICROLET 2	T2	
MICROLET NEXT LANCING DEVICE	T2	
MINI LANCING DEVICE	T2	
MINIMED	T2	
MINIMED MIO ADVANCE	T2	
MINIMED QUICK SET	T2	
MINIMED QUICK-SERTER	T3	
MINIMED QUICK-SERTER	T2	
MINIMED SILHOUETTE	T2	
MINIMED SURET	T2	
MULTI-LANCET	T2	
MYGLUCOHEALTH CONTROL SOLUTION	T3	
NOVA MAX PLUS GLUC-KETON METER	T3	
NOVAMAX PLUS GLU-KET	T3	
NOVOPEN 3	T2	
NOVOPEN ECHO	T3	
OMNIPOD 5 (G6/LIBRE 2 PLUS)	T2	
OMNIPOD 5 DEXG7G6 INTRO(GEN 5)	T2	QL (1 kit/720 days)
OMNIPOD 5 DEXG7G6 PODS (GEN 5)	T2	QL (15 crtgs/30 days)
OMNIPOD 5 DEXG7G6 PODS (GEN 5)	T2	QL (15 pods/28 days)
OMNIPOD 5 INTRO(G6/LIBRE2PLUS)	T2	QL (1 kit/720 days)
OMNIPOD 5 G6-G7 INTRO KT(GEN5)	T2	QL (1 kit/720 days)
OMNIPOD 5 G6-G7 PODS (GEN 5))	T2	QL (15 crtgs/30 days)
OMNIPOD CLASSIC PDM KIT(GEN 3)	T2	
OMNIPOD CLASSIC PODS (GEN 3)	T2	
OMNIPOD DASH INTRO KIT (GEN 4)	T2	QL (1 kit/720 days)
OMNIPOD DASH PODS (GEN 4)	T2	QL (15 pods/28 days)
OMNIPOD GO PODS	T2	QL (10 crtgs/30 days)
ON CALL EXPRESS CONTROL SOLN	T3	
ON CALL LANCING DEVICE	T2	
ON CALL PLUS CONTROL	T3	
ON CALL PLUS LANCING DEVICE	T2	
ON CALL VIVID CONTROL	T3	

T1 – Generics

T2 – Preferred Brands

T3 – Non-Preferred Brands

T4 – Brand Specialty

PA – Prior Authorization

QL – Quantity Limit

ST – Step Therapy

AGE – Age Requirement

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List of Prescription Medications

MISCELLANEOUS MEDICAL SUPPLIES, DEVICES, NON-DRUG (Diabetes) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
DIABETIC SUPPLIES (cont.)		
ONETOUCH DELICA	T2	
ONETOUCH DELICA PLUS LANC DEV	T2	
ONETOUCH ULTRA CONTROL SOLN	T2	
ONETOUCH VERIO HIGH CNTRL SOLN	T2	
ONETOUCH VERIO MID CNTRL SOLN	T2	
OPTUMRX GLUCOSE CONTROL SOLN	T3	
OVAL TAPE	T3	
PIP GLUCOSE CONTROL SOLUTION	T3	
PRECISION XTRA KETONE-GLUCOSE	T2	
PRODIGY CONTROL SOLUTION	T3	
PRODIGY LANCING DEVICE	T2	
QUICK RELEASE SOFT TEFLO	T2	
REFUAH PLUS GLUCOSE CONTROL	T3	
RELIAMED MINI LANCING DEVICE	T2	
REPLACEMENT PEDIATRIC MONITOR	T3	
RIGHTEST CONTROL SOLUTION	T3	
RIGHTEST GD500	T2	
SAFE-CLIP	T2	
SEN-SERTER	T3	
SILHOUETTE	T2	
SIL-SERTER	T2	
SMARTDIABETES VANTAGE	T2	
SMARTEST	T3	
SOF-SERTER	T2	
SOF-SET	T2	
SOF-SET MICRO	T2	
SOLUS V2 CONTROL SOLUTION	T3	
SOLUS V2 LANCING DEVICE	T2	
SURE COMFORT LANCING PEN	T2	
SUREFLEX	T2	
SURE-PEN	T2	
SURE-TEST EASYPLUS MINI SOLN	T3	
T:FLEX	T2	
T:SLIM X2	T2	

T1 – Generics

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MISCELLANEOUS MEDICAL SUPPLIES, DEVICES, NON-DRUG (Diabetes) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
DIABETIC SUPPLIES (cont.)		
TANDEM MOBI AUTOSOFT 30	T2	PA SP HD
TANDEM MOBI AUTOSOFT XC	T2	PA SP HD
TANDEM MOBI AUTOSOFT 30 SUPPLY	T2	
TANDEM MOBI AUTOSOFT XC SUPPLY	T2	
TANDEM MOBI CARTRIDGE	T2	
TANDEM MOBI TRUSTEEL SUPPLY	T2	
TEL CARE CONTROL SOLUTION	T3	
TRUE METRIX	T3	
TRUECONTROL	T3	
TRUEDRAW	T2	
TRUSTEEL INFUSION SET	T2	
TRUSTEEL INFUSION SET PACK	T3	
TWIIST REFILL KT(CSST-NDL-SYR)	T2	
TWIIST RFL(INFUS-CSST-NDL-SYR)	T2	
TWIIST STARTER KIT	T2	
ULTI-LANCE	T2	
ULTRATRAK CONTROL SOL NORMAL	T3	
ULTRATRAK CONTROL SOLUTION	T3	
ULTRATRAK ULTIMATE CNTRL SOLN	T3	
UNISTIK 2	T2	
UNISTRIP	T3	
VARISOFT INFUSION SET	T2	
V-GO 20	T2	
V-GO 30	T2	
V-GO 40	T2	
VIVAGUARD INO CONTROL SOLUTION	T3	
VIVAGUARD LANCING DEVICE	T2	
WAVESENSE CONTROL SOLUTION	T3	
DURABLE MEDICAL EQUIPMENT,MISC(GROUP I)		
1ST TIER UNILET COMFORTOUCH	T2	
2-IN-1 LANCET DEVICE	T2	
ACCU-CHEK FASTCLIX LANCET DRUM	T2	
ACCU-CHEK SAFE-T-PRO	T2	
ACCU-CHEK SAFE-T-PRO PLUS	T2	

T1 – Generics

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MISCELLANEOUS MEDICAL SUPPLIES, DEVICES, NON-DRUG (Diabetes) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
DURABLE MEDICAL EQUIPMENT,MISC(GROUP I) (cont.)		
ACCU-CHEK SOFTCLIX	T2	
<i>acti-lance lite 28g lancets</i>	T1	
<i>acti-lance special 17g lancets</i>	T1	
<i>acti-lance univers 23g lancets</i>	T1	
ACTI-LANCE UNIVERS 23G LANCETS	T2	
ADVANCED TRAVEL LANCETS	T2	
ADVOCATE LANCET	T2	
ADVOCATE LANCETS	T2	
ADVOCATE SAFETY LANCET	T2	
AGAMATRIX ULTRA-THIN LANCET	T2	PA SP HD
ALTERNATE SITE LANCETS	T2	
ASSURE HAEMOLANCE PLUS	T2	
ASSURE LANCE	T2	
ASSURE LANCE PLUS	T2	
BD MICROTAINER LANCETS	T2	
BLOOD LANCETS	T2	
BULLSEYE MINI SAFETY LANCETS	T2	
BUTTERFLY TOUCH LANCET	T2	
CAREONE	T2	
CARESENS LANCET	T2	
CARETOUCH SAFETY LANCETS	T2	
CARETOUCH TWIST LANCET	T2	
CHOSEN LANCET	T2	
CHOSEN SAFETY LANCET	T2	
CLEVER CHEK LANCETS	T2	
COAGUCHEK	T2	
COLOR LANCETS	T2	
COMFORT EZ	T2	
COMFORT LANCETS	T2	
COMFORT TOUCH PLUS SAFETY LANC	T2	
COMFORT TOUCH ULTHIN LANCET	T2	
DROPLET LANCETS	T2	
EASY COMFORT LANCETS	T2	
EASY TOUCH PULL-TOP 26G LANCET	T2	

T1 – Generics

T2 – Preferred Brands

T3 – Non-Preferred Brands

T4 – Brand Specialty

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MISCELLANEOUS MEDICAL SUPPLIES, DEVICES, NON-DRUG (Diabetes) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
DURABLE MEDICAL EQUIPMENT,MISC(GROUP I) (cont.)		
EASY TOUCH PULL-TOP 28G LANCET	T2	
EASY TOUCH PULL-TOP 30G LANCET	T2	
EASY TOUCH PULL-TOP 32G LANCET	T2	
EASY TOUCH SAFETY 21G LANCETS	T2	
EASY TOUCH SAFETY 23G LANCETS	T2	
EASY TOUCH SAFETY 26G LANCETS	T2	
EASY TOUCH SAFETY 28G LANCETS	T2	
EASY TOUCH SAFETY 30G LANCETS	T2	
EASY TOUCH SAFETY 32G LANCETS	T2	
EASY TOUCH TWIST 26G LANCETS	T2	
EASY TOUCH TWIST 28G LANCETS	T2	
EASY TOUCH TWIST 30G LANCETS	T2	
EASY TOUCH TWIST 32G LANCETS	T2	
EASY TOUCH TWIST 33G LANCETS	T2	
EASY TWIST & CAP LANCETS	T2	
EMBRACE 30G LANCETS	T2	
EMBRACE SAFETY LANCET	T2	
EZ SMART LANCETS	T2	
EZ-LETS	T2	
FIFTY50 SAFETY SEAL LANCETS	T2	
FINE 30 UNIVERSAL LANCETS	T2	
FINGERSTIX	T2	
FORA LANCETS	T2	
FORACARE LANCETS	T2	
FREESTYLE LANCETS	T2	
FREESTYLE UNISTIK 2	T2	
GLUCOCOM	T2	
GLUCOCOM LANCETS	T2	
GOJJI LANCETS	T2	
HEALTHY ACCENTS UNILET LANCET	T2	
INCONTROL SUPERTHIN LANCETS	T2	
INCONTROL ULTRA THIN LANCETS	T2	
INJECT EASE LANCETS	T2	
INVACARE LANCETS	T2	

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T2 – Preferred Brands

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MISCELLANEOUS MEDICAL SUPPLIES, DEVICES, NON-DRUG (Diabetes) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
DURABLE MEDICAL EQUIPMENT,MISC(GROUP I) (cont.)		
lancets	T1	
LANCETS	T2	
LANCETS THIN	T2	
LANCETS ULTRA THIN	T2	
LITE TOUCH 28G LANCETS	T2	
LITE TOUCH 30G LANCETS	T2	
LITE TOUCH 33G LANCETS	T2	
MEDISENSE THIN LANCETS	T2	
<i>medlance plus 21g lancets</i>	T1	
MEDLANCE PLUS 21G LANCETS	T2	
<i>medlance plus 30g lancets</i>	T1	
MEDLANCE PLUS 30G LANCETS	T2	
MEDLANCE PLUS EXTRA 21G LANCET	T2	
<i>medlance plus lite 25g lancets</i>	T1	
MEDLANCE PLUS LITE 25G LANCETS	T2	
MICRO THIN LANCET	T2	
MICRO THIN LANCETS	T2	
MICROLET	T2	
MOBILE LANCETS	T2	
MONOLET LANCETS	T2	
MONOLET THIN LANCETS	T2	
MYGLUCOHEALTH LANCETS	T2	
NOVA SAFETY LANCETS	T2	
NOVA SUREFLEX	T2	
ON CALL LANCET	T2	
ON CALL PLUS LANCET	T2	
ONETOUCH DELICA PLUS LANCET	T2	
ONETOUCH DELICA SAFETY LANCET	T2	
ONETOUCH LANCETS	T2	
ONETOUCH SURESOFT	T2	
ONETOUCH ULTRASOFT 2 LANCET	T2	
ON-THE-GO	T2	
PERFECT POINT SAFETY LANCETS	T2	
PIP LANCET	T2	

T1 – Generics

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MISCELLANEOUS MEDICAL SUPPLIES, DEVICES, NON-DRUG (Diabetes) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
DURABLE MEDICAL EQUIPMENT,MISC(GROUP I) (cont.)		
PRESSURE ACTIVATED LANCETS	T2	
PRO COMFORT LANCET	T2	
PRO COMFORT LANCETS	T2	
PRO COMFORT SAFETY LANCET	T2	
PRODIGY LANCETS	T2	
PRODIGY TWIST TOP LANCET	T2	
PURE COMFORT LANCETS	T2	
PURE COMFORT SAFETY LANCETS	T2	
PUSH BUTTON SAFETY LANCETS	T2	
READYLANCE SAFETY LANCETS	T2	
RELIAMED	T2	
RELIAMED SAFETY SEAL LANCETS	T2	
RIGHTEST GL300 LANCETS	T2	
SAFETY LANCETS	T2	
SAFETY SEAL LANCETS	T2	
SAFETY-LET	T2	
SINGLE-LET	T2	
SMART SENSE	T2	
SMART SENSE LANCETS	T2	
SMARTEST LANCET	T2	
SOLUS V2	T2	
SOLUS V2 LANCETS	T2	
STERILANCE TL	T2	
STERILE LANCETS	T2	
SUPERTHIN LANCETS	T2	
SURE COMFORT LANCETS	T2	
SURE-LANCE	T2	
SURE-TOUCH	T2	
TECHLITE LANCETS	T2	
TELCARE ULTRA THIN 30G LANCETS	T2	
THIN LANCETS	T2	
TOPCARE UNIVERSAL1 LANCET	T2	
TOPCARE UNIVERSAL1 THIN LANCET	T2	
TRUE COMFORT LANCET	T2	

T1 – Generics

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List of Prescription Medications

MISCELLANEOUS MEDICAL SUPPLIES, DEVICES, NON-DRUG (Diabetes) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
DURABLE MEDICAL EQUIPMENT,MISC(GROUP I) (cont.)		
TRUE COMFORT SAFETY LANCET	T2	
TRUEPLUS LANCET	T2	
TRUEPLUS LANCETS	T2	
TWIST LANCETS	T2	
TWIST TOP LANCET	T2	
ULTILET BASIC	T2	
ULTILET CLASSIC	T2	
ULTILET LANCETS	T2	
ULTILET SAFETY	T2	
ULTRA THIN LANCET	T2	
ULTRA THIN LANCETS	T2	
ULTRA THIN PLUS LANCETS	T2	
ULTRA-CARE LANCETS	T2	
ULTRALANCE	T2	
ULTRA-THIN II 28G LANCETS	T2	
ULTRA-THIN II 30G LANCETS	T2	
ULTRATLC LANCETS	T2	
UNILET COMFORTOUCH	T2	
UNILET EXCELITE	T2	
UNILET EXCELITE II	T2	
UNILET GP LANCET	T2	
UNILET LANCET	T2	
UNILET LANCETS	T2	
UNISTIK 2 COMFORT	T2	
UNISTIK 2 EXTRA	T2	
UNISTIK 2 NORMAL	T2	
UNISTIK 3	T2	
UNISTIK 3 COMFORT	T2	
UNISTIK 3 DUAL	T2	
UNISTIK 3 EXTRA	T2	
UNISTIK 3 NORMAL	T2	
UNISTIK COMFORT	T2	
UNISTIK CZT	T2	
UNISTIK EXTRA	T2	

T1 – Generics

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T3 – Non-Preferred Brands

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MISCELLANEOUS MEDICAL SUPPLIES, DEVICES, NON-DRUG (Diabetes) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
DURABLE MEDICAL EQUIPMENT,MISC(GROUP I) (cont.)		
UNISTIK NORMAL	T2	
UNISTIK PRO	T2	
UNISTIK SAFETY	T2	
UNISTIK TOUCH	T2	
UNIVERSAL 1	T2	
VERIFINE SAFETY LANCET MINI	T2	
VERIFINE UNIVERSAL LANCET	T2	
VIVAGUARD LANCET	T2	
VIVAGUARD SAFETY LANCET	T2	
NEEDLES/NEEDLELESS DEVICES		
AUTOSHIELD	T2	
AUTOSHIELD DUO PEN NEEDLE	T2	
BD ECLIPSE NEEDLE 18G 40MM	T3	
BD ECLIPSE NEEDLE 21GX1"	T2	
BD ECLIPSE NEEDLE 22GX1"	T2	
BD ECLIPSE NEEDLE 23GX1"	T3	
BD ECLIPSE NEEDLE 25G 16MM	T3	
BD ECLIPSE NEEDLE 25G 25MM	T3	
BD ECLIPSE NEEDLE 25GX1"	T2	
BD ECLIPSE NEEDLE 25GX1.5"	T2	
BD ECLIPSE NEEDLE 25GX5/8"	T3	
BD ECLIPSE NEEDLE 27GX1/2"	T3	
BD ECLIPSE NEEDLES 21GX1.5"	T2	
BD SAFETYGLIDE NEEDLE	T2	
BD SAFETYGLIDE NEEDLE 18GX1.5"	T2	
BD SAFETYGLIDE NEEDLE 21GX1"	T2	
BD SAFETYGLIDE NEEDLE 21GX1.5"	T2	
BD SAFETYGLIDE NEEDLE 22GX1.5"	T2	
BD SAFETYGLIDE NEEDLE 23G 40MM	T3	
BD SAFETYGLIDE NEEDLE 25GX1"	T2	
BD SAFETYGLIDE NEEDLE 27GX5/8"	T2	
BLUNT NEEDLE	T2	
CAREPOINT PRECISION NEEDLE	T3	
CARETOUCH HYPODERMIC NEEDLE	T3	

T1 – Generics

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T3 – Non-Preferred Brands

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MISCELLANEOUS MEDICAL SUPPLIES, DEVICES, NON-DRUG (Diabetes) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
NEEDLES/NEEDLELESS DEVICES (cont.)		
CHEMO TRANSFER PIN	T2	
DROPSAFE SICURA SAFETY NEEDLE	T3	
EASY TOUCH FLIPLOCK NEEDLE	T3	
EASY TOUCH FLIPLOCK NEEDLES	T3	
EASY TOUCH HYPODERMIC NEEDLE	T3	
EASYPPOINT NEEDLE	T3	
EXEL HUBER NEEDLE	T2	
EXEL HYPODERMIC NEEDLE	T2	
EXEL MTI DRAWING NEEDLE	T2	
FILTER ASPIRATOR NEEDLE	T2	
FILTER NEEDLE	T2	
FLOW-EZE	T2	
HURRICANE LUER-LOCK	T2	
HYPODERMIC NEEDLE	T2	
INTEGRA NEEDLE	T2	
INTEGRA PRECISIONGLIDE NEEDLE	T3	
LIFESHIELD BLUNT CANNULA	T2	
MINI TRANSFER PIN	T2	
MONOJECT BLOOD COLLECTION	T2	
MONOJECT FILTER NEEDLE	T3	
NANO 2ND GEN PEN NEEDLE	T2	
NANO PEN NEEDLE	T2	
NEEDLES	T2	
<i>needles, safety huber, disposabl</i>	T1	
NOKOR ADMIX NEEDLE	T2	
NOKOR NEEDLE	T2	
PEN NEEDLE 30G X 8MM	T3	
PERFECT POINT SAFETY NEEDLE	T3	
PHASEAL PROTECTOR	T3	
POLY HUB NEEDLE	T2	
PRECISIONGLIDE	T2	
QUINCE SPINAL NEEDLE	T2	
RAYA SURE PEN NEEDLE 29G 12MM	T3	
RAYA SURE PEN NEEDLE 31G 5MM	T3	

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MISCELLANEOUS MEDICAL SUPPLIES, DEVICES, NON-DRUG (Diabetes) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
NEEDLES/NEEDLELESS DEVICES (cont.)		
RAYA SURE PEN NEEDLE 31G 6MM	T3	
REGULAR BEVEL NEEDLES	T2	
SHORT BEVEL NEEDLES	T2	
SPECIALTY USE NEEDLES	T2	
TERUMO SURGUARD2	T2	
THIN WALL NEEDLES	T2	
TRANSFER NEEDLE	T2	
TRANSFER PIN	T2	
ULTRA-FINE MICRO PEN NEEDLE	T2	
ULTRA-FINE MINI PEN NEEDLE	T2	
ULTRA-FINE NANO PEN NEEDLE	T2	
ULTRA-FINE PEN NEEDLE	T2	
ULTRA-FINE ORIGINAL PEN NEEDLE	T2	
ULTRA-FINE SHORT PEN NEEDLE	T2	
YALE NEEDLE	T2	
YALE NEEDLES	T2	
SYRINGES AND ACCESSORIES		
ALLERGIST TRAY	T3	
ALLERGIST TRAY SYR-DETACH NDL	T2	
ALLERGIST TRAY SYR-PERM NEEDLE	T2	
ALLERGY SYRINGE 1 ML 27GX1/2"	T3	
ALLERGY SYRINGE 1 ML 27GX3/8"	T3	
BD ALLERGY SYRINGE-NEEDLE 1 ML	T2	
BD ECLIPSE LUER-LOK SYR 1 ML	T2	
BD ECLIPSE LUER-LOK SYR 3 ML	T2	
BD ECLIPSE SYR 3 ML 22GX1-1/2"	T3	
BD INS SYR 0.3 ML 8MMX31G(1/2)	T2	
BD INS SYR UF 0.3ML 12.7MMX30G	T2	
BD INS SYR UF 0.5ML 12.7MMX30G	T2	
BD INS SYRN UF 1 ML 12.7MMX30G	T2	
BD INS SYRNG 0.3 ML 29GX12.7MM	T2	
BD INS SYRNG 0.5 ML 29GX12.7MM	T2	
BD INS SYRNG UF 0.3 ML 8MMX31G	T2	
BD INS SYRNG UF 0.5 ML 8MMX31G	T2	

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MISCELLANEOUS MEDICAL SUPPLIES, DEVICES, NON-DRUG (Diabetes) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
SYRINGES AND ACCESSORIES (cont.)		
BD INSULIN SYR 0.5 ML 28GX1/2"	T2	
BD INSULIN SYR 1 ML 25GX1"	T2	
BD INSULIN SYR 1 ML 25GX5/8"	T2	
BD INSULIN SYR 1 ML 26GX1/2"	T2	
BD INSULIN SYR 1 ML 27GX12.7MM	T2	
BD INSULIN SYR 1 ML 27GX5/8"	T2	
BD INSULIN SYR 1 ML 28GX1/2"	T2	
BD INSULIN SYR 1 ML 29GX1/2"	T2	
BD INSULIN SYR 1 ML 29GX12.7MM	T2	
BD INSULIN SYR UF 1 ML 8MMX31G	T2	
BD INSULIN SYRINGE 1 ML	T2	
BD SAFETYGLIDE 3 ML SYRINGE	T2	
BD SAFETYGLIDE SYR 22GX1.5"	T2	
BD SAFETYGLIDE SYR 3 ML 25GX1"	T3	
BD SAFETYGLIDE SYRINGE 27GX5/8	T2	
BD SAFETYGLIDE TB 1 ML SYR	T2	
BD SAFETYGLIDE TB 1ML 27G 10MM	T3	
BD SAFETYGLIDE TUBERCULIN SYR	T2	
BD SYRINGE-SAFETY GLIDE	T2	
BD UF INS SYR 1 ML 30GX1/2"	T2	
BULK SYRINGE	T2	
CANNULA	T2	
CAREPOINT LUER LOCK SYRINGE	T3	
CAREPOINT LUER LOCK SYRING-NDL	T2	
CAREPOINT SAFETY LUER LOCK SYR	T2	
CAREPOINT LUER SLIP SYRINGE	T3	
CAREPOINT LUER SLIP SYRING-NDL	T3	
CARETOUCH LUER LOCK	T2	
CARETOUCH LUER LOCK SYRINGE	T3	
CARETOUCH LUER SLIP SYRINGE	T3	
CORNWALL SYRINGETIP CONNECTOR	T2	
DAVOL IRRIGATION SYRINGE	T2	
DOVER BULB SYRINGE	T3	
EASY GLIDE CATHETER TIP SYRING	T3	

T1 – Generics

T2 – Preferred Brands

T3 – Non-Preferred Brands

T4 – Brand Specialty

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 (Diabetes) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
SYRINGES AND ACCESSORIES (cont.)		
EASY GLIDE LUER LOCK SYRINGE	T3	
EASY GLIDE LUER SLIP TB SYRINGE	T3	
EASY TOUCH FLIPLK 10ML 20GX1.5	T3	
EASY TOUCH FLIPLK 10ML 21GX1.5	T3	
EASY TOUCH FLIPLK 10ML 22GX1.5	T3	
EASY TOUCH FLIPLK 5 ML 20GX1.5	T3	
EASY TOUCH FLIPLK 5 ML 21GX1.5	T3	
EASY TOUCH FLIPLK 5 ML 22GX1.5	T3	
EASY TOUCH FLIPLOCK	T3	
EASY TOUCH FLIPLOCK 1 ML 25GX1	T2	
EASY TOUCH FLIPLOCK 10ML 21GX1	T3	
EASY TOUCH FLIPLOCK 3 ML 18GX1	T3	
EASY TOUCH FLIPLOCK 3 ML 20GX1	T3	
EASY TOUCH FLIPLOCK 3 ML 21GX1	T3	
EASY TOUCH FLIPLOCK 5 ML 18GX1	T3	
EASY TOUCH FLIPLOCK 5 ML 21GX1	T3	
EASY TOUCH FLIPLOCK SYRINGE	T3	
EASY TOUCH FLIPLOK 10 ML 20GX1	T3	
EASY TOUCH FLIPLOK 10 ML 25GX1	T3	
EASY TOUCH FLIPLOK 1ML 26GX3/8	T2	
EASY TOUCH FLIPLOK 1ML 27GX0.5	T2	
EASY TOUCH FLIPLOK 3ML 18GX1.5	T3	
EASY TOUCH FLIPLOK 3ML 20GX1.5	T3	
EASY TOUCH FLIPLOK 3ML 21GX1.5	T3	
EASY TOUCH FLURINGE	T2	
EASY TOUCH FLURINGE FLIPLOCK	T2	
EASY TOUCH FLURINGE FLU TRAY	T3	
EASY TOUCH FLURINGE SHEATHLOCK	T2	
EASY TOUCH LUER LOCK INSULIN	T3	
EASY TOUCH LUER LOCK SYRINGE	T3	
EASY TOUCH SHEATHLOCK SYRG-NDL	T3	
EASY TOUCH SHEATHLOCK SYRINGE	T3	
EASY TOUCH SYR 1 ML 25GX5/8"	T2	
EASY TOUCH SYR 3 ML 22GX1-1/2"	T2	

T1 – Generics

T2 – Preferred Brands

T3 – Non-Preferred Brands

T4 – Brand Specialty

PA – Prior Authorization

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List of Prescription Medications

MISCELLANEOUS MEDICAL SUPPLIES, DEVICES, NON-DRUG (Diabetes) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
SYRINGES AND ACCESSORIES (cont.)		
EASY TOUCH SYR 3 ML 25GX5/8"	T2	
EASY TOUCH SYR ALLERGY TRAY	T3	
EASY TOUCH SYRINGE 1 ML 25GX1"	T2	
EASY TOUCH SYRINGE 3 ML 20GX1"	T2	
EASY TOUCH SYRINGE 3 ML 21GX1"	T2	
EASY TOUCH SYRINGE 3 ML 22GX1"	T2	
EASY TOUCH SYRINGE 3 ML 23GX1"	T2	
EASY TOUCH SYRINGE 3 ML 25GX1"	T2	
EASY TOUCH TUBERCULIN FLIPLOCK	T2	
EASY TOUCH TUBERCULIN SHEATHLK	T2	
EASY TOUCH UNI-SLIP	T3	
ECLIPSE SYRINGE	T2	
ECLIPSE SYRINGE-NEEDLE	T2	
ENFIT SYRINGE	T3	
ENFIT SYRINGE STERILE	T3	
ENFIT THUMB CONTROL RING SYRIN	T3	
EXEL SYRINGE	T2	
EXEL TB WITH NEEDLE	T2	
EXEL TUBERCULIN SYRINGE	T2	
EXTENDED RESERVOIR	T3	
FILTER, MILLEX-OR SYRINGE	T3	
FINGER GRIP EXTENDER	T3	
INJECT-EASE	T2	
INSULIN CARTRIDGE	T2	
INSULIN SYR 0.5 ML 28G 12.7MM	T3	
INSULIN SYRINGE 1 ML 27G 16MM	T2	
INSULIN SYRINGE 1ML 28G 12.7MM	T2	
INSULIN SYRINGE U-500	T2	
INTEGRA SYRINGE	T2	
INTERLINK SYRINGE	T2	
INTERLINK SYRINGE W-CANNULA	T3	
KENDALL DISINFECTANT CAP	T3	
LEVER LOCK CANNULA	T3	
LIFESHIELD BLUNT CANNULA	T2	

T1 – Generics

T2 – Preferred Brands

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List of Prescription Medications

MISCELLANEOUS MEDICAL SUPPLIES, DEVICES, NON-DRUG (Diabetes) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
SYRINGES AND ACCESSORIES (cont.)		
LUER LOCK SYRINGE	T2	
LUER LOCK SYRINGE-NEEDLE	T3	PA SP HD
LUER SLIP TIP SYRINGE TRAY	T3	
LUER TIP CAP TRAY	T3	
LUER-LOK SYRINGE	T2	
LUER-LOK SYRINGE-NEEDLE	T2	
LUER-LOK TIP SYRINGE	T2	
LUERSLIP SYRINGE	T2	
MAGELLAN SAFETY SYRINGE	T2	
MAGELLAN TB SAFETY SYRINGE	T2	
MAGELLAN TUBERCULIN SYRINGE	T2	
MINIMED RESERVOIR 1.8 ML	T3	
MINIMED RESERVOIR 3 ML	T2	
MONOJECT 3 ML SYRINGE 25GX1"	T2	
MONOJECT 6CC SAFETY SYRINGE	T2	
MONOJECT ALLERGY TRAY-NEEDLE	T2	
MONOJECT CONTROL SYRINGE	T2	
MONOJECT ENFIT SYRINGE	T3	
MONOJECT ENFIT SYRINGE CAP	T3	
MONOJECT LUER LOCK TB SYRINGE	T2	
MONOJECT MAGELLAN	T2	
MONOJECT PHARMACY TRAY	T2	
MONOJECT SAFETY SYR TIP CAP	T3	
MONOJECT SAFETY SYRINGE	T2	
MONOJECT SMARTIP CANNULA	T3	
MONOJECT SYRINGE	T2	
MONOJECT SYRINGE 140 ML	T3	
MONOJECT SYRINGE 35 ML	T2	
MONOJECT SYRINGE PHARMACY TRAY	T2	
MONOJECT TB	T2	
MONOJECT TB SAFETY SYRINGE	T2	
MONOJECT TB SYRINGE	T2	
MONOJECT TUBERCULIN SYRINGE	T2	
NORM-JECT SYRINGE	T3	

T1 – Generics

T2 – Preferred Brands

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MISCELLANEOUS MEDICAL SUPPLIES, DEVICES, NON-DRUG (Diabetes) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
SYRINGES AND ACCESSORIES (cont.)		
NORM-JECK TUBERKULIN SYRINGE	T3	
PARADIGM	T2	
PISTON ENFIT SYRINGE	T3	
PRECISIONGLIDE	T2	
PRODIGY COUNT-A-DOSE	T2	
SAFESNAP ALLERGY SYRINGE	T3	
SAFESNAP SYRINGE 10 ML	T2	
SAFESNAP SYRINGE 10 ML	T3	
SAFESNAP SYRINGE 3 ML	T2	
SAFESNAP SYRINGE 5 ML	T2	
SAFESNAP SYRINGE 5 ML	T3	
SAFESNAP TUBERCULIN SYRINGE	T3	
SAFETY SYRINGE WITH SHIELD	T2	
SAFETY SYRINGE-NEEDLE	T3	
SAFETYGLIDE ALLERGY	T2	
SAFETYGLIDE ALLERGY SYRINGE	T3	
SAFETYGLIDE INSULIN SYRINGE	T2	
SAFETY-LOK SAFETY SYRINGE	T2	
SAFETY-LOK SAFETY SYRINGES	T2	
SAFETY-LOK SYRINGES	T2	
SLIP-TIP SYRINGE	T3	
SUPOR	T3	
SYRINGE	T2	
SYRINGE BULK	T2	
SYRINGE CATHETER TIP	T2	
SYRINGE CATHETER TIP NON-STER	T2	
SYRINGE FILTER, MILLEX-GP	T3	
SYRINGE FILTER, MILLEX-GS	T3	
SYRINGE LUER LOCK	T2	PA SP HD
SYRINGE LUER-LOK	T2	
SYRINGE LUER-LOK NON-STERILE	T2	
SYRINGE LUER-LOK STERILE	T2	
SYRINGE SLIP TIP	T2	
SYRINGE SLIP TIP NON-STERILE	T2	

T1 – Generics

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MISCELLANEOUS MEDICAL SUPPLIES, DEVICES, NON-DRUG (Diabetes) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
SYRINGES AND ACCESSORIES (cont.)		
SYRINGE STORAGE BIN	T3	
SYRINGE TIP CAP	T2	
SYRINGE WITH NEEDLE	T2	
SYRINGE WITH NEEDLE DISP	T2	
SYRINGE WITHOUT NEEDLE	T2	
SYRINGE-LUERT TIP CAP	T2	
SYRINGE-NEEDLE	T2	
SYRINGE-PRECISIONGLIDE NEEDLE	T2	
TB SYRINGE	T2	
TERUMO ALLERGY SYRINGE	T2	
TERUMO HYPODERMIC NEEDLE-SYRIN	T2	
TERUMO SURGUARD2	T2	
TERUMO SYRINGE	T2	
TOOMEY SYRINGE	T2	
TUBERCULIN SLIP-TIP SYRINGE	T3	
TUBERCULIN SYRINGE	T2	
TUBERCULIN SYRINGE-NEEDLE	T2	
TWINPAK DUAL CANNULA	T2	
ULTICARE LDS SYR 1 ML 22G 1.5"	T3	
ULTICARE LDS SYR 3 ML 22GX1.5"	T2	
ULTICARE SAFETY SYRINGE	T3	
ULTICARE SYRINGE	T3	
ULTICARE TB SAFETY 1 ML 25GX1"	T2	
ULTICARE TB SAFETY 1ML 25GX5/8	T2	
ULTICARE TB SAFETY SYRINGE	T2	
ULTIGUARD SAFE 1ML 30G 12.7MM	T3	
ULTIGUARD SAFEPACK 1ML 31G 8MM	T3	
ULTRA-FINE INSULIN SYRINGE	T2	
UNIVERSAL SYRINGE TIP ADAPTOR	T3	
VANISHPOINT 1 ML TB SYR 25X5/8	T2	
VANISHPOINT 1 ML TB SYR 27X1/2	T2	
VANISHPOINT 20GX1" 3 ML SYRING	T2	
VANISHPOINT 21GX1" 5 ML SYRING	T2	
VANISHPOINT 21GX1.5" 3 ML SYR	T2	

T1 – Generics

T2 – Preferred Brands

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List of Prescription Medications

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

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
SYRINGES AND ACCESSORIES (cont.)		
VANISHPOINT 22GX1" 3 ML SYR	T2	
VANISHPOINT 22GX1-1/2" 5 ML SY	T2	
VANISHPOINT 23GX1" 3 ML SYRING	T2	
VANISHPOINT 23GX1-1/2 3 ML SYR	T2	
VANISHPOINT 25GX1" 3 ML SYRING	T2	
VANISHPOINT 25GX5/8" 3 ML SYR	T2	
VANISHPOINT 3 ML 21GX1" SYRING	T2	
VANISHPOINT 3 ML 22GX1.5" SYRG	T2	
VANISHPOINT SYRINGE	T3	
VANISHPOINT SYRINGE 1 ML 25X1"	T2	
VEO INSULIN SYRINGE	T2	

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

BANDAGES AND RELATED SUPPLIES

ARGLAES FILM	T3	
CONFORMANT 2	T3	
DERMAVIEW	T2	
DERMAVIEW II	T2	
IV 3000	T2	
IV3000 FRAME DELIVERY	T3	
KENDALL	T2	
NEXCARE TEGADERM 2.375"X2.75"	T3	
NEXCARE TEGADERM DRESSING	T2	
OPSITE	T3	
OPSITE IV 3000	T2	
POLYSKIN II	T2	
SURESITE MATRIX	T2	
SURESITE WINDOW	T2	
TEGADERM 1.75X1.75" DRSSNG	T3	
TEGADERM 2"X2.75" DRESSING	T2	
TEGADERM 2.375"X2.75" DRESSING	T2	
TEGADERM 2.375"X4" DRESSING	T2	
TEGADERM 2.375X2.75" DRSSNG	T2	
TEGADERM 3.5" X 4" DRESSING	T2	

T1 – Generics

T2 – Preferred Brands

T3 – Non-Preferred Brands

T4 – Brand Specialty

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MISCELLANEOUS MEDICAL SUPPLIES, DEVICES, NON-DRUG (Miscellaneous) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
BANDAGES AND RELATED SUPPLIES (cont.)		
TEGADERM 3.5"X 10" DRESSING	T3	
TEGADERM 3.5"X 6" DRESSING	T3	
TEGADERM 3.5"X13.75" DRESS	T3	
TEGADERM 3.5"X4.125" DRESS	T2	
TEGADERM 3.5"X8" DRESSING	T3	
TEGADERM 4" X 10" DRESSING	T2	
TEGADERM 4" X 4-3/4" DRESSING	T2	
TEGADERM 4"X4.75" DRESSING	T2	
TEGADERM 6" X 8" DRESSING	T2	
TEGADERM 8" X 12" DRESSING	T2	
TEGADERM ABSORBENT	T3	
TEGADERM HP 4" X 4.5 " DRSSN	T2	
TEGADERM HP 4.5"X4.75" DRSS	T2	
TEGADERM HP DRESSING	T2	
TEGADERM HP DRESSING	T3	
TEGADERM I.V.	T3	
TEGADERM I.V. 2.5"X2.75" DRSSN	T3	
TEGADERM I.V. 4"X4.75" DRSSN	T2	
TRANSPARENT DRESSING	T3	
TRANSPARENT FILM DRESSING	T3	
TRANSPARENT I.V. SITE DRESSING	T2	
TRANSPARENT MEPITEL FILM DRESS	T3	
TRANSPARENT THIN FILM DRESSING	T2	
WINDOW BANDAGES	T3	
DURABLE MEDICAL EQUIPMENT,MISC(GROUP I)		
1ST TIER UNILET COMFORTOUCH	T2	
2-IN-1 LANCET DEVICE	T2	
ACCU-CHEK FASTCLIX LANCET DRUM	T2	
ACCU-CHEK SAFE-T-PRO	T2	
ACCU-CHEK SAFE-T-PRO PLUS	T2	
ACCU-CHEK SOFTCLIX	T2	
<i>acti-lance lite 28g lancets</i>	T1	
<i>acti-lance special 17g lancets</i>	T1	
ACTI-LANCE UNIVERS 23G LANCETS	T2	

T1 – Generics

T2 – Preferred Brands

T3 – Non-Preferred Brands

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MISCELLANEOUS MEDICAL SUPPLIES, DEVICES, NON-DRUG (Miscellaneous) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
DURABLE MEDICAL EQUIPMENT,MISC(GROUP I) (cont.)		
acti-lance univers 23g lancets	T1	
ADVANCED TRAVEL LANCETS	T2	
ADVOCATE LANCET	T2	
ADVOCATE LANCETS	T2	
ADVOCATE SAFETY LANCET	T2	
AEROCHAMBER2GO	T2	PA SP HD
AGAMATRIX ULTRA-THIN LANCET	T2	PA SP HD
ALTERNATE SITE LANCETS	T2	
ASSURE HAEMOLANCE PLUS	T2	
ASSURE LANCE	T2	
ASSURE LANCE PLUS	T2	
BD MICROTAINER LANCETS	T2	
BLOOD LANCETS	T2	
BULLSEYE MINI SAFETY LANCETS	T2	
BUTTERFLY TOUCH LANCET	T2	
CAREONE	T2	
CARESENS LANCET	T2	
CARETOUCH SAFETY LANCETS	T2	
CARETOUCH TWIST LANCET	T2	
CHOSEN LANCET	T2	
CHOSEN SAFETY LANCET	T2	
CLEVER CHEK LANCETS	T2	
COAGUCHEK	T2	
COLOR LANCETS	T2	
COMFORT EZ	T2	
COMFORT LANCETS	T2	
DROPLET LANCETS	T2	
EASY COMFORT LANCETS	T2	
EASY TOUCH BUTTON 30G LANCETS	T2	
EASY TOUCH PULL-TOP 26G LANCET	T2	
EASY TOUCH PULL-TOP 28G LANCET	T2	
EASY TOUCH PULL-TOP 30G LANCET	T2	
EASY TOUCH PULL-TOP 32G LANCET	T2	
EASY TOUCH SAFETY 21G LANCETS	T2	

T1 – Generics

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MISCELLANEOUS MEDICAL SUPPLIES, DEVICES, NON-DRUG (Miscellaneous) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
DURABLE MEDICAL EQUIPMENT,MISC(GROUP I) (cont.)		
EASY TOUCH SAFETY 23G LANCETS	T2	
EASY TOUCH SAFETY 26G LANCETS	T2	
EASY TOUCH SAFETY 28G LANCETS	T2	
EASY TOUCH SAFETY 30G LANCETS	T2	
EASY TOUCH SAFETY 32G LANCETS	T2	
EASY TOUCH TWIST 26G LANCETS	T2	
EASY TOUCH TWIST 28G LANCETS	T2	
EASY TOUCH TWIST 30G LANCETS	T2	
EASY TOUCH TWIST 32G LANCETS	T2	
EASY TOUCH TWIST 33G LANCETS	T2	
EASY TWIST CAP LANCETS	T2	
EMBRACE 30G LANCETS	T2	
EMBRACE SAFETY LANCET	T2	
EZ SMART LANCETS	T2	
EZ-LETS	T2	
FIFTY50 SAFETY SEAL LANCETS	T2	
FINE 30 UNIVERSAL LANCETS	T2	
FINGERSTIX	T2	
FORA LANCETS	T2	
FORACARE LANCETS	T2	
FREESTYLE LANCETS	T2	
FREESTYLE UNISTIK 2	T2	
GLUCOCOM	T2	
GLUCOCOM LANCETS	T2	
GOJJI LANCETS	T2	
HEALTHY ACCENTS UNILET LANCET	T2	
INCONTROL SUPER THIN LANCETS	T2	
INCONTROL ULTRA THIN LANCETS	T2	
INJECT EASE LANCETS	T2	
INVACARE LANCETS	T2	
<i>lancets</i>	T1	
LANCETS	T2	
LANCETS THIN	T2	
LANCETS ULTRA THIN	T2	

T1 – Generics

T2 – Preferred Brands

T3 – Non-Preferred Brands

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MISCELLANEOUS MEDICAL SUPPLIES, DEVICES, NON-DRUG (Miscellaneous) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
DURABLE MEDICAL EQUIPMENT,MISC(GROUP I) (cont.)		
LITE TOUCH 28G LANCETS	T2	
LITE TOUCH 30G LANCETS	T2	
LITE TOUCH 33G LANCETS	T2	
MEDISENSE THIN LANCETS	T2	
MEDLANCE PLUS 21G LANCETS	T2	
<i>medlance plus 21g lancets</i>	T1	
MEDLANCE PLUS 30G LANCETS	T2	
<i>medlance plus 30g lancets</i>	T1	
MEDLANCE PLUS EXTRA 21G LANCET	T2	
MEDLANCE PLUS LITE 25G LANCETS	T2	
<i>medlance plus lite 25g lancets</i>	T1	
MEDLANCE PLUS SPECIAL BLADE	T2	
MICRO THIN LANCET	T2	
MICRO THIN LANCETS	T2	
MICROLET	T2	
MICROTAINER LANCETS	T2	
MONOLET LANCETS	T2	
MONOLET THIN LANCETS	T2	
MYGLUCOHEALTH LANCETS	T2	
NOVA SAFETY LANCETS	T2	
NOVA SUREFLEX	T2	
ON CALL LANCET	T2	
ON CALL PLUS LANCET	T2	
ONETOUCH DELICA	T2	
ONETOUCH DELICA PLUS LANCET	T2	
ONETOUCH DELICA SAFETY LANCET	T2	
ONETOUCH LANCETS	T2	
ONETOUCH SURESOFT	T2	
ON-THE-GO	T2	
PERFECT POINT SAFETY LANCETS	T2	
PIP LANCET	T2	
PRESSURE ACTIVATED LANCETS	T2	
PRO COMFORT LANCET	T2	
PRO COMFORT LANCETS	T2	

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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
DURABLE MEDICAL EQUIPMENT,MISC(GROUP I) (cont.)		
PRODIGY LANCETS	T2	
PRODIGY TWIST TOP LANCET	T2	
PURE COMFORT LANCETS	T2	
PURE COMFORT SAFETY LANCETS	T2	
PUSH BUTTON SAFETY LANCETS	T2	
READYLANCE SAFETY LANCETS	T2	
RELIAMED	T2	
RELIAMED SAFETY SEAL LANCETS	T2	
RIGHTEST GL300 LANCETS	T2	
SAFETY LANCETS	T2	
SAFETY SEAL LANCETS	T2	
SAFETY-LET	T2	
SINGLE-LET	T2	
SMART SENSE	T2	
SMART SENSE LANCETS	T2	
SMARTEST LANCET	T2	
SOLUS V2	T2	
SOLUS V2 LANCETS	T2	
STERILANCE TL	T2	
STERILE LANCETS	T2	
SUPER THIN LANCETS	T2	
SURE COMFORT LANCETS	T2	
SURE-LANCE	T2	
SURE-TOUCH	T2	
TECHLITE LANCETS	T2	
TELCARE ULTRA THIN 30G LANCETS	T2	
THIN LANCETS	T2	
TOPCARE UNIVERSAL1 LANCET	T2	
TOPCARE UNIVERSAL1 THIN LANCET	T2	
TRUE COMFORT LANCET	T2	
TRUEPLUS LANCET	T2	
TRUEPLUS LANCETS	T2	
TWIST LANCETS	T2	
TWIST TOP LANCET	T2	

T1 – Generics

T2 – Preferred Brands

T3 – Non-Preferred Brands

T4 – Brand Specialty

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
DURABLE MEDICAL EQUIPMENT,MISC(GROUP I) (cont.)		
ULTILET BASIC	T2	
ULTILET CLASSIC	T2	
ULTILET LANCETS	T2	
ULTILET SAFETY	T2	
ULTRA THIN LANCET	T2	
ULTRA THIN LANCETS	T2	
ULTRA THIN PLUS LANCETS	T2	
ULTRA-CARE LANCETS	T2	
ULTRALANCE	T2	
ULTRA-THIN II 28G LANCETS	T2	
ULTRA-THIN II 30G LANCETS	T2	
ULTRATLC LANCETS	T2	
UNILET COMFORTOUCH	T2	
UNILET EXCELITE	T2	
UNILET EXCELITE II	T2	
UNILET GP LANCET	T2	
UNILET LANCET	T2	
UNISTIK 3	T2	
UNISTIK 3 EXTRA	T2	
UNISTIK COMFORT	T2	
UNISTIK CZT	T2	
UNISTIK EXTRA	T2	
UNISTIK NORMAL	T2	
UNISTIK PRO	T2	
UNISTIK SAFETY	T2	
UNISTIK TOUCH	T2	
UNISTIK 2 COMFORT	T2	
UNISTIK 2 EXTRA	T2	
UNISTIK 2 NORMAL	T2	
UNISTIK 3 COMFORT	T2	
UNISTIK 3 DUAL	T2	
UNIVERSAL 1	T2	
VIVAGUARD LANCET	T2	
VIVAGUARD SAFETY LANCET	T2	

T1 – Generics

T2 – Preferred Brands

T3 – Non-Preferred Brands

T4 – Brand Specialty

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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
MEDICAL SUPPLIES,MISCELLANEOUS		
ALCOH-GLOVE	T3	
ALCOH-WIPE	T3	
PARENTERAL ADMINISTRATION SETS		
1.5 VOLT BATTERIES #357	T2	
ACCU-CHEK	T3	
ACCU-CHEK RAPID D 10-100	T3	
ACCU-CHEK RAPID D 10-50	T3	
ACCU-CHEK RAPID D 10-70	T2	
ACCU-CHEK RAPID D 6-100	T3	
ACCU-CHEK RAPID D 6-50	T2	
ACCU-CHEK RAPID D 6-70	T3	
ACCU-CHEK RAPID D 8-100	T3	
ACCU-CHEK RAPID D 8-50	T2	
ACCU-CHEK RAPID D 8-70	T2	
ACCU-CHEK SPIRIT	T2	
ACCU-CHEKTENDER	T2	
ACCU-CHEK ULTRAFLEX	T2	
DELTEC COZMO CLEO INFUSION SET	T2	
INSET 30 TUBING	T2	
IV ADMINISTRATION SET	T2	
NERIA	T3	
PARADIGM INFUSION	T2	
POLYFIN QR	T2	
PSV SET	T3	
Q-SYTE	T2	
SILHOUETTE	T2	
SURE-T	T2	
RESPIRATORY AIDS,DEVICES,EQUIPMENT		
ACE AEROSOL CLOUD ENHANCER	T2	
AEROCHAMBER MECHANICAL VENT	T2	
AEROCHAMBER MINI	T2	
AEROCHAMBER MV	T2	
AEROCHAMBER PLUS FLOW-VU	T2	
AEROCHAMBER Z-STAT PLUS	T2	

T1 – Generics

T2 – Preferred Brands

T3 – Non-Preferred Brands

T4 – Brand Specialty

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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
RESPIRATORY AIDS,DEVICES,EQUIPMENT (cont.)		
AEROTRACH PLUS	T2	
AEROVENT PLUS	T2	
BREATHERITE	T2	
BREATHERITE SPACER-ADULT MASK	T2	
BREATHERITE SPACER-INFANT MASK	T2	
BREATHERITE SPACER-LG CHLD MSK	T2	
BREATHERITE SPACER-NEONATE MSK	T2	
BREATHERITE SPACER-SM CHLD MSK	T2	
BREATHRITE	T2	
CLEVER CHOICE HOLDING CHAMBER	T2	
COMFORTSEAL	T2	
COMPACT SPACE CHAMBER	T2	
EASIVENT	T2	
FLEXICHAMBER	T2	
FLEXICHAMBER MASK	T2	
INSPIRACHAMBER	T2	
LITEAIRE	T2	
LITETOUCH	T2	
MICROCHAMBER	T2	
MICROSPACER	T2	
MOUTHPIECE	T2	
ONE WAY MOUTHPIECE	T2	
OPTICHAMBER	T2	
OPTICHAMBER DIAMOND	T2	
PANDA MASK	T2	
PEDIATRIC MASK	T2	
PEDIATRIC PANDA MASK	T2	
POCKET CHAMBER	T2	
PRIMEAIRE	T2	
PRO COMFORT SPACER-ADULT MASK	T2	
PRO COMFORT SPACER-CHILD MASK	T3	
PRO COMFORT SPACER-INFANT MASK	T3	
PROCARE SPACER WITH ADULT MASK	T2	
PROCARE SPACER WITH CHILD MASK	T2	

T1 – Generics

T2 – Preferred Brands

T3 – Non-Preferred Brands

T4 – Brand Specialty

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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
RESPIRATORY AIDS,DEVICES,EQUIPMENT (cont.)		
PROCHAMBER	T2	
PURECOMFORT PEAK FLOW MOUTHPC	T2	
PURE COMFORT SPACER WITH MASK	T3	
RITEFLO	T2	
SIDESTREAM PEDIATRIC	T2	
SILICONE MASK	T2	
SPACE CHAMBER	T2	
SPACE CHAMBER-LARGE MASK	T2	
SPACE CHAMBER-MEDIUM MASK	T2	
SPACE CHAMBER-SMALL MASK	T2	
VORTEX	T2	
VORTEX VHC FROG MASK	T2	
VORTEX VHC LADYBUG MASK	T2	
VORTEX VHC PEDIATRIC MASK	T2	

MUSCLE RELAXANTS (Pain Relief And Inflammatory Disease)

SKELETAL MUSCLE RELAX.-TOP. IRRITANT COUNTER-IRRIT

COMFORT PAC-CYCLOBENZAPRINE	T3	
COMFORT PAC-TIZANIDINE	T3	

SKELETAL MUSCLE RELAXANTS

baclofen 5 mg tablet	T1	HD
baclofen 10 mg tablet	T1	HD
baclofen 15 mg tablet	T1	HD
baclofen 20 mg tablet	T1	HD
baclofen 10 mg/5 ml solution	T1	PA SP HD
baclofen 5 mg/5 ml suspension	T1	HD
baclofen 25 mg/5 ml suspension	T1	ST
baclofen 25 mg/5 ml suspension (Fleqsuvy)	T1	HD
carisoprodol (Soma)	T1	
carisoprodol/aspirin	T1	
chlorzoxazone	T1	
chlorzoxazone (Lorzone)	T1	
cyclobenzaprine hcl	T1	
cyclobenzaprine hcl (Amrix)	T1	PA

T1 – Generics

T2 – Preferred Brands

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T4 – Brand Specialty

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List of Prescription Medications

MUSCLE RELAXANTS (Pain Relief And Inflammatory Disease) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
SKELETAL MUSCLE RELAXANTS (cont.)		
cyclobenzaprine hcl (Fexmid)	T1	
DANTRIUM (dantrolene sodium)	T3	
dantrolene sodium	T1	
dantrolene sodium (Dantrium)	T1	
FEXMID (cyclobenzaprine hcl)	T3	PA
LORZONE (chlorzoxazone)	T3	PA
metaxalone 400 mg tablet	T1	
metaxalone 800 mg tablet	T1	
methocarbamol	T1	
methocarbamol 500 mg tablet	T1	
methocarbamol 750 mg tablet	T1	
methocarbamol 1,000 mg tablet	T1	
NORGESIC (orphenadrine/aspirin/caffeine)	T3	
NORGESIC FORTE (orphenadrine/aspirin/caffeine)	T3	
orphenadrine citrate	T1	
orphenadrine/aspirin/caffeine (Norgesic Forte)	T1	
orphenadrine/aspirin/caffeine (Norgesic)	T1	
SOMA (carisoprodol)	T3	
tizanidine hcl	T1	
tizanidine hcl (Zanaflex)	T1	
ZANAFLEX (tizanidine hcl)	T3	
PRE-NATAL VITAMINS (Nutritional/Dietary)		
PRENATAL VITAMIN PREPARATIONS		
BAL-CARE DHA ESSENTIAL	T3	
BRAINSTRONG PRENATAL	T3	
CADEAU DHA	T3	
CITRANATAL 90 DHA	T3	
CITRANATAL ASSURE	T3	
CITRANATAL DHA	T3	
CITRANATAL HARMONY	T3	
CITRANATAL RX	T3	
cvs prenatal multi-dha softgel	T1	PPACA
cvs prenatal multivit-dha sfgl	T1	PPACA

T1 – Generics

T2 – Preferred Brands

T3 – Non-Preferred Brands

T4 – Brand Specialty

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List of Prescription Medications

PRE-NATAL VITAMINS (Nutritional/Dietary) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
PRENATAL VITAMIN PREPARATIONS (cont.)		
cvs prenatal vitamins tablet	T1	PPACA
DUET DHA BALANCED	T3	
EXPECTA PRENATAL	T2	
ft prenatal tablet	T1	PPACA
gnp prenatal vitamins tablet	T1	PPACA
GS PRENATAL VITAMINS TABLET	T3	
HM ONE DAILY PRENATAL COMBO PK	T2	
hm prenatal tablet	T1	PPACA
KOSHER PRENATAL PLUS IRON	T3	
KPN PRENATAL TABLET	T2	
kpn tablet	T1	PPACA
MARNATAL-F	T3	
MINI PRENATAL	T3	
MTERYTI	T3	
MTERYTI FOLIC 5	T3	
NATACHEW	T3	
NEONATAL COMPLETE	T3	
NEONATAL PLUS	T3	
NEONATAL-DHA	T3	
NESTABS	T3	
NESTABS ABC	T3	
NESTABS DHA	T3	
OB COMPLETE ONE	T3	
OB COMPLETE PETITE	T3	
OB COMPLETE PREMIER	T3	
OB COMPLETE WITH DHA	T3	
OBSTETRIX EC	T3	
OBTREX DHA	T3	
ONE A DAY WOMEN'S PRENATAL DHA	T3	
ONE-A-DAY PRENATAL-1	T3	
pnv 11/iron fum/folic acid/om3	T1	
pnv 119/iron fum/folic acid	T1	
pnv no.154/iron fum/folic acid	T1	
pnv no.52/iron/fa/omega-3/dha	T1	PA SP HD

T1 – Generics

T2 – Preferred Brands

T3 – Non-Preferred Brands

T4 – Brand Specialty

PA – Prior Authorization

QL – Quantity Limit

ST – Step Therapy

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List of Prescription Medications

PRE-NATAL VITAMINS (Nutritional/Dietary) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
PRENATAL VITAMIN PREPARATIONS (cont.)		
pnv 66/iron/folic/docusate/dha	T1	
pnv 69/iron/folic/docusate/dha	T1	
pnv 80/iron fum/folic/dss/dha	T1	
pnv no.118/iron fumarate/fa	T1	
pnv,calcium 72/iron,carb/folic	T1	
pnv,calcium 72/iron/folic acid	T1	
pnv/iron,carb/docusat/folic ac	T1	
pnv19/iron bg,s,p/folic ac/om3	T1	
pnv81/iron ps,edta/folic/omeg3	T1	PA SP HD
PRENATA	T3	
prenatal 105/iron/folic ac/dha	T1	
prenatal 12/iron/folic/dss/om3	T1	
PRENATAL 19 CHEWABLE TABLET	T3	
prenatal 19 chewable tablet	T1	
PRENATAL 19 TABLET	T3	
prenatal 19 tablet	T1	
prenatal 21/iron fu/folic acid	T1	PPACA
prenatal 53/iron/folic ac/omg3	T1	
prenatal 54/iron/folic ac/omg3	T1	
prenatal 93/iron/folate 9/dha	T1	
prenatal,calc 40/iron/folate 1	T1	PA SP HD
prenatal caplet	T1	PPACA
PRENATAL FORMULA	T2	
PRENATAL FORMULA-DHA (prenatal vit 116/iron/fa/dha)	T3	PA SP HD
PRENATAL GUMMIES	T3	
PRENATAL MULTI	T3	
prenatal multi-dha softgel	T1	PPACA
PRENATAL MULTI-DHA SOFTGEL	T2	
PRENATAL MULTI-DHA SOFTGEL	T3	
prenatal multivitamin tablet	T1	PPACA
PRENATAL MULTIVITAMIN TABLET	T3	
PRENATAL MULTIVITAMIN-DHA SFGL	T2	
PRENATAL PLUS VITAMIN-MINERAL	T3	
PRENATAL PLUS-DHA	T3	

T1 – Generics

T2 – Preferred Brands

T3 – Non-Preferred Brands

T4 – Brand Specialty

PA – Prior Authorization

QL – Quantity Limit

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List of Prescription Medications

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

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
PRENATAL VITAMIN PREPARATIONS (cont.)		
<i>prenatal tablet</i>	T1	PPACA
PRENATAL TABLET	T3	
<i>prenatal vit 14/iron fum/folic</i>	T1	
<i>prenatal vit 55/iron/folic/om3</i>	T1	
<i>prenatal vit 91/iron/folic/dha</i>	T1	
<i>prenatal vit no.126/iron/folic</i>	T1	PPACA
<i>prenatal vit no.129/iron/folic</i>	T1	PPACA
<i>prenatal vit,cal 73/iron/folic</i>	T1	
<i>prenatal vit/iron fum/folic ac</i>	T1	
<i>prenatal vit,cal 78/iron/folic</i>	T1	PA SP HD
<i>prenatal vits 86/iron/folic ac</i>	T1	PA SP HD
PRENATAL VITAMIN + DHA	T2	
<i>prenatal vitamin tablet</i>	T1	PPACA
PRENATAL VITAMIN TABLET (<i>prenatal vit no.124/iron/folic</i>)	T3	
<i>prenatal vitamins tablet</i>	T1	PPACA
<i>prenatal vits calc.36/iron/fa</i>	T1	PPACA
<i>prenatal71/iron/folic acid/dha</i>	T1	
PRENATE ENHANCE	T3	
PRENATE RESTORE	T3	
PRIMACARE	T3	
PROVIDA OB	T3	
<i>qc prenatal tablet</i>	T1	PPACA
<i>ra one daily prenatal dha pack</i>	T1	PPACA
<i>ra prenatal tablet</i>	T1	PPACA
SELECT-OB	T3	
SELECT-OB (<i>prenatal vit128/iron/folic acd</i>)	T3	
SELECT-OB + DHA	T3	
SIMILAC PRENATAL	T3	
<i>sm prenatal vitamins tablet</i>	T1	PPACA
STUART ONE (<i>pnv no.63/iron,carb/folic/dha</i>)	T3	
<i>sv prenatal tablet</i>	T1	PPACA
SV PRENATAL VITAMIN TABLET	T3	
THERANATAL	T3	

T1 – Generics

T2 – Preferred Brands

T3 – Non-Preferred Brands

T4 – Brand Specialty

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List of Prescription Medications

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

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
PRENATAL VITAMIN PREPARATIONS (cont.)		
THERANATAL COMPLETE	T3	
THERANATAL ONE	T3	
THERANATAL PLUS	T3	
THRIVITE RX	T3	
TRICARE	T3	
TRICARE PRENATAL DHA ONE	T3	
TRISTART DHA	T3	
VITAFOL FE PLUS	T3	
VITAFOL NANO	T3	
VITAFOL ULTRA	T3	
VITAFOL-OB	T3	
VITAFOL-OB+DHA	T3	
VITAFOL-ONE	T3	
VITAMEDMD ONE RX	T3	
VITAMEDMD REDICHEW RX (<i>prenatal no.42/folic acid</i>)	T3	PA SP HD
VITAPEARL	T3	
VITATRUE	T3	
VP-PNV-DHA	T3	
WOMEN'S PRENATAL PLUS DHA	T2	

PRENATAL VITAMINS WITH LOW OR NO IRON

CITRANATAL B-CALM	T3	PA SP HD
CVS PRENATAL GUMMIES	T3	
DUET DHA 400	T3	PA SP HD
PRENATAL GUMMIES	T3	
PRENATE DHA	T3	PA SP HD
PRENATE ELITE	T3	PA SP HD
PRENATE MINI	T3	PA SP HD
PRENATE PIXIE	T3	PA SP HD
PRENATE STAR	T3	PA SP HD
R-NATAL OB	T3	PA SP HD
THERANATAL OVAVITE	T3	PA SP HD
ULTRA PRENATAL PLUS DHA	T3	PA SP HD
VITAFOL GUMMIES	T3	PA SP HD
TRINAZ	T3	

T1 – Generics

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List of Prescription Medications

PSYCHOTHERAPEUTIC DRUGS (Anxiety/Depression/Bipolar Disorder) ⁸		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ADRENERGICS, AROMATIC, NON-CATECHOLAMINE		
<i>lisdexamphetamine 10 mg tb chew (Vyvanse)</i>	T1	ST
<i>lisdexamphetamine 20 mg tb chew (Vyvanse)</i>	T1	ST
<i>lisdexamphetamine 30 mg tb chew (Vyvanse)</i>	T1	ST
<i>lisdexamphetamine 40 mg tb chew (Vyvanse)</i>	T1	ST
<i>lisdexamphetamine 50 mg tb chew (Vyvanse)</i>	T1	ST
<i>lisdexamphetamine 60 mg tb chew (Vyvanse)</i>	T1	ST
<i>VYVANSE (lisdexamphetamine dimesylate)</i>	T3	ST
ALPHA-2 RECEPTOR ANTAGONIST ANTIDEPRESSANTS		
<i>mirtazapine</i>	T1	HD
<i>mirtazapine (Remeron)</i>	T1	HD
<i>REMERON (mirtazapine)</i>	T3	HD
ANTI-ANXIETY - BENZODIAZEPINES		
<i>alprazolam</i>	T1	
<i>alprazolam (Xanax Xr)</i>	T1	
<i>alprazolam (Xanax)</i>	T1	
<i>ATIVAN (lorazepam)</i>	T3	
<i>chlordiazepoxide hcl</i>	T1	
<i>clorazepate dipotassium</i>	T1	
<i>diazepam 10 mg tablet (Valium)</i>	T1	
<i>diazepam 2 mg tablet (Valium)</i>	T1	
<i>diazepam 25 mg/5 ml oral conc</i>	T1	
<i>diazepam 5 mg tablet (Valium)</i>	T1	
<i>diazepam 5 mg/5 ml oral conc, soln, solution</i>	T1	
<i>lorazepam</i>	T1	
<i>lorazepam (Ativan)</i>	T1	
<i>oxazepam</i>	T1	
ANTI-ANXIETY DRUGS		
<i>buspirone hcl</i>	T1	HD
<i>meprobamate</i>	T1	
ANTIDEPRESSANT - POSTPARTUM DEPRESSION (PPD)		
<i>ZURZUVAE 20 MG CAPSULE</i>	T4	QL (28 caps/365 days) SP HD
<i>ZURZUVAE 25 MG CAPSULE</i>	T4	QL (28 caps/365 days) SP HD
<i>ZURZUVAE 30 MG CAPSULE</i>	T4	QL (14 caps/365 days) SP HD

T1 – Generics

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List of Prescription Medications

PSYCHOTHERAPEUTIC DRUGS (Anxiety/Depression/Bipolar Disorder) ⁸ (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
BIPOLAR DISORDER DRUGS		
EQUETRO	T3	HD
<i>lithium carbonate</i>	T1	HD
<i>lithium carbonate</i> (Lithobid)	T1	HD
LITHOBID (<i>lithium carbonate</i>)	T3	HD
MAOIS -NON-SELECTIVE, IRREVERSIBLE ANTIDEPRESSANTS		
MARPLAN	T3	
NARDIL (<i>phenelzine sulfate</i>)	T3	
PARNATE (<i>tranylcypromine sulfate</i>)	T3	
<i>phenelzine sulfate</i> (Nardil)	T1	
<i>tranylcypromine sulfate</i> (Parnate)	T1	
MONOAMINE OXIDASE (MAO) INHIBITOR ANTIDEPRESSANTS		
EMSAM	T3	
NDMA RECEPTOR ANTAGONIST AND NDRI COMB		
AUVELITY	T3	ST QL (60 tabs/30 days)
NOREPINEPHRINE AND DOPAMINE REUPTAKE INHIB (NDRIS)		
<i>bupropion hcl</i>	T1	HD
SELECTIVE SEROTONIN 5-HT2A INVERSE AGONISTS (SSIA)		
NUPLAZID 10 MG TABLET	T4	PA QL (30 tabs/fill) SP HD
NUPLAZID 34 MG CAPSULE	T4	PA QL (30 caps/fill) SP HD
SELECTIVE SEROTONIN REUPTAKE INHIBITOR (SSRIS)		
<i>citalopram hbr 10 mg/5 ml soln</i>	T1	HD
<i>citalopram hbr 20 mg/10 ml cup</i>	T1	PA SP HD
<i>escitalopram 10 mg/10 ml cup</i>	T1	PA SP HD
<i>escitalopram oxalate 5 mg/5 ml</i>	T1	ST HD
<i>fluoxetine 20 mg/5 ml solution</i>	T1	HD
<i>fluoxetine hcl</i>	T1	ST QL (4 caps/fill) HD
<i>fluoxetine hcl 10 mg tablet</i>	T1	ST QL (30 tabs/fill) HD
<i>fluoxetine hcl 20 mg capsule</i> (Prozac)	T1	HD
<i>fluoxetine hcl 20 mg tablet</i>	T1	ST HD
<i>fluoxetine hcl 60 mg tablet</i>	T1	ST HD
<i>fluvoxamine maleate</i>	T1	ST QL (60 caps/fill) HD
<i>fluvoxamine maleate 100 mg tab</i>	T1	QL (90 tabs/fill) HD
<i>fluvoxamine maleate 25 mg tab</i>	T1	QL (30 tabs/fill) HD
<i>fluvoxamine maleate 50 mg tab</i>	T1	QL (60 tabs/fill) HD

T1 – Generics

T2 – Preferred Brands

T3 – Non-Preferred Brands

T4 – Brand Specialty

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 (Anxiety/Depression/Bipolar Disorder) ⁸ (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
SELECTIVE SEROTONIN REUPTAKE INHIBITOR (SSRIS) (cont.)		
paroxetine hcl (Paxil Cr)	T1	ST QL (60 tabs/fill) HD
paroxetine hcl 10 mg tablet (Paxil)	T1	QL (30 tabs/fill) HD
paroxetine hcl 10 mg/5 ml susp (Paxil)	T1	ST HD
paroxetine hcl 20 mg tablet (Paxil)	T1	QL (60 tabs/fill) HD
paroxetine hcl 30 mg tablet (Paxil)	T1	QL (60 tabs/fill) HD
paroxetine hcl 40 mg tablet (Paxil)	T1	QL (30 tabs/fill) HD
PAXIL 10 MG TABLET (paroxetine hcl)	T3	ST QL (30 tabs/fill) HD
PAXIL 10 MG/5 ML SUSPENSION (paroxetine hcl)	T3	ST HD
PAXIL 20 MG TABLET (paroxetine hcl)	T3	ST QL (60 tabs/fill) HD
PAXIL 30 MG TABLET (paroxetine hcl)	T3	ST QL (60 tabs/fill) HD
PAXIL 40 MG TABLET (paroxetine hcl)	T3	ST QL (30 tabs/fill) HD
PAXIL CR (paroxetine hcl)	T3	ST QL (60 tabs/fill) HD
sertraline 20 mg/ml oral conc (Zoloft)	T1	HD
sertraline hcl 100 mg tablet (Zoloft)	T1	QL (60 tabs/fill) HD
sertraline hcl 25 mg tablet (Zoloft)	T1	QL (45 tabs/fill) HD
sertraline hcl 50 mg tablet (Zoloft)	T1	QL (60 tabs/fill) HD
SEROTONIN-2 ANTAGONIST/REUPTAKE INHIBITORS (SARIS)		
nefazodone hcl	T1	HD
trazodone hcl	T1	HD
SEROTONIN-NOREPINEPHRINE REUPTAKE-INHIB (SNRIS)		
DESVENLAFAXINE ER	T3	ST QL (30 tabs/fill) HD
DESVENLAFAXINE ER	T3	ST QL (30 tabs/fill) HD
desvenlafaxine succinate (Pristiq)	T1	ST QL (30 tabs/fill) HD
duloxetine hcl dr 20 mg cap (Cymbalta)	T1	QL (60 caps/fill) HD
duloxetine hcl dr 30 mg cap (Cymbalta)	T1	QL (30 caps/fill) HD
duloxetine hcl dr 40 mg cap	T1	ST QL (30 caps/fill) HD
duloxetine hcl dr 60 mg cap (Cymbalta)	T1	QL (60 caps/fill) HD
FETZIMA 20-40 MG TITRATION PAK	T2	ST QL (28 caps/30 days)
FETZIMA ER 120 MG CAPSULE	T2	ST QL (30 caps/30 days)
FETZIMA ER 20 MG CAPSULE	T2	ST QL (30 caps/30 days)
FETZIMA ER 40 MG CAPSULE	T2	ST QL (30 caps/30 days)
FETZIMA ER 80 MG CAPSULE	T2	ST QL (30 caps/30 days)
venlafaxine hcl	T1	QL (90 tabs/fill) HD
venlafaxine hcl er 37.5 mg tab	T1	ST QL (30 tabs/fill) HD

T1 – Generics

T2 – Preferred Brands

T3 – Non-Preferred Brands

T4 – Brand Specialty

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 (Anxiety/Depression/Bipolar Disorder) ⁸ (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
SEROTONIN-NOREPINEPHRINE REUPTAKE-INHIB (SNRIS) (cont.)		
<i>venlafaxine hcl er 75 mg tab</i>	T1	ST QL (30 tabs/fill) HD
<i>venlafaxine hcl er 150 mg tab</i>	T1	ST QL (30 tabs/fill) HD
<i>venlafaxine hcl er 225 mg tab</i>	T1	ST QL (30 tabs/fill) HD
SSRI, SEROTONIN RECEPTOR MODULATOR ANTIDEPRESSANTS		
<i>TRINTELLIX</i>	T3	ST QL (30 tabs/30 days)
TRICYCLIC ANTIDEPRESSANT-BENZODIAZEPINE COMBINATNS		
<i>amitriptyline/chlordiazepoxide</i>	T1	HD
<i>perphenazine/amitriptyline hcl</i>	T1	HD
TRICYCLIC ANTIDEPRESSANTS, REL.NON-SEL.REUPT-INHIB		
<i>amitriptyline hcl</i>	T1	HD
<i>amoxapine</i>	T1	HD
<i>ANAFRANIL (clomipramine hcl)</i>	T3	HD
<i>clomipramine hcl (Anafranil)</i>	T1	HD
<i>desipramine hcl</i>	T1	HD
<i>doxepin 10 mg capsule</i>	T1	HD
<i>doxepin 10 mg/ml oral conc</i>	T1	HD
<i>doxepin 100 mg capsule</i>	T1	HD
<i>doxepin 150 mg capsule</i>	T1	HD
<i>doxepin 25 mg capsule</i>	T1	HD
<i>doxepin 50 mg capsule</i>	T1	HD
<i>doxepin 75 mg capsule</i>	T1	HD
<i>imipramine hcl (Tofranil)</i>	T1	HD
<i>imipramine pamoate</i>	T1	HD
<i>maprotiline hcl</i>	T1	HD
<i>nortriptyline hcl</i>	T1	HD
<i>nortriptyline hcl (Pamelor)</i>	T1	HD
<i>PAMELOR (nortriptyline hcl)</i>	T3	HD
<i>protriptyline hcl</i>	T1	HD
<i>SURMONTIL (trimipramine maleate)</i>	T3	HD
<i>TOFRANIL (imipramine hcl)</i>	T3	HD
<i>trimipramine maleate (Surmontil)</i>	T1	HD
PSYCHOTHERAPEUTIC DRUGS (Attention Deficit Hyperactivity Disorder)⁸		
ADRENERGICS, AROMATIC, NON-CATECHOLAMINE		
<i>lisdexamfetamine 10 mg capsule (Vyvanse)</i>	T1	

T1 – Generics

T2 – Preferred Brands

T3 – Non-Preferred Brands

T4 – Brand Specialty

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) ⁸ (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ADRENERGICS, AROMATIC, NON-CATECHOLAMINE (cont.)		
<i>lisdexamfetamine 10 mg tb chew</i>	T1	ST
<i>lisdexamfetamine 20 mg capsule (Vyvanse)</i>	T1	
<i>lisdexamfetamine 20 mg tb chew</i>	T1	ST
<i>lisdexamfetamine 30 mg capsule (Vyvanse)</i>	T1	
<i>lisdexamfetamine 30 mg tb chew</i>	T1	ST
<i>lisdexamfetamine 40 mg capsule (Vyvanse)</i>	T1	
<i>lisdexamfetamine 40 mg tb chew</i>	T1	ST
<i>lisdexamfetamine 50 mg capsule (Vyvanse)</i>	T1	
<i>lisdexamfetamine 50 mg tb chew</i>	T1	ST
<i>lisdexamfetamine 60 mg capsule (Vyvanse)</i>	T1	
<i>lisdexamfetamine 60 mg tb chew</i>	T1	ST
<i>lisdexamfetamine 70 mg capsule (Vyvanse)</i>	T1	
TX FOR ADHD - SELECTIVE ALPHA-2 RECEPTOR AGONIST		
<i>clonidine hcl er 0.1 mg tablet (Kapvay)</i>	T1	
<i>guanfacine hcl (Intuniv)</i>	T1	HD
<i>KAPVAY (clonidine hcl)</i>	T3	ST
TX FOR ATTENTION DEFICIT-HYPERACT (ADHD)/NARCOLEPSY		
<i>APTENSIO XR (methylphenidate hcl)</i>	T3	ST
<i>AZSTARYS</i>	T2	ST
<i>COTEMPLA XR-ODT</i>	T3	ST
<i>DAYTRANA</i>	T2	ST
<i>dexamethylphenidate hcl (Focalin Xr)</i>	T1	
<i>dexamethylphenidate hcl (Focalin)</i>	T1	
<i>JORNAY PM</i>	T3	ST
<i>METADATE CD (methylphenidate hcl)</i>	T3	ST
<i>METHYLIN (methylphenidate hcl)</i>	T3	
<i>methylphenidate</i>	T1	ST
<i>methylphenidate er 10 mg cap (Aptensio Xr)</i>	T1	ST
<i>methylphenidate er 10 mg tab</i>	T1	
<i>methylphenidate er 15 mg cap (Aptensio Xr)</i>	T1	ST
<i>methylphenidate er 18 mg tab (Concerta)</i>	T1	
<i>methylphenidate er 18 mg tab (Relexxii)</i>	T1	
<i>methylphenidate er 20 mg cap (Aptensio Xr)</i>	T1	ST
<i>methylphenidate er 20 mg tab</i>	T1	

T1 – Generics

T2 – Preferred Brands

T3 – Non-Preferred Brands

T4 – Brand Specialty

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) ⁸ (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
TX FOR ATTENTION DEFICIT-HYPERACT (ADHD)/NARCOLEPSY (cont.)		
methylphenidate er 27 mg tab (Concerta)	T1	
methylphenidate er 27 mg tab (Relexxii)	T1	
methylphenidate er 30 mg cap (Aptensio Xr)	T1	ST
methylphenidate er 36 mg tab (Concerta)	T1	
methylphenidate er 36 mg tab (Relexxii)	T1	
methylphenidate er 40 mg cap (Aptensio Xr)	T1	ST
methylphenidate er 50 mg cap (Aptensio Xr)	T1	ST
methylphenidate er 54 mg tab (Concerta)	T1	
methylphenidate er 54 mg tab (Relexxii)	T1	
methylphenidate er 60 mg cap (Aptensio Xr)	T1	ST
methylphenidate er 72 mg tab	T1	
METHYLPHENIDATE ER 72 MG TAB	T3	ST
methylphenidate hcl	T1	
methylphenidate hcl (Metadate Cd)	T1	
methylphenidate hcl (Methylin)	T1	
methylphenidate hcl (Ritalin La)	T1	
methylphenidate hcl (Ritalin)	T1	
QELBREE ER	T3	ST
RELEXXII ER 72 MG TABLET	T3	ST
TX FOR ATTENTION DEFICIT-HYPERACT.(ADHD), NRI-TYPE		
atomoxetine hcl (Strattera)	T1	HD
QELBREE	T3	ST
PSYCHOTHERAPEUTIC DRUGS (Miscellaneous)		
HYPACTIVE SEXUAL DESIRE DISORDER (HSDD) TX AGENTS		
ADDYI	T3	PA
VYLEESI	T4	PA QL (8 auto-injs/fill) SP
PSYCHOTHERAPEUTIC DRUGS (Schizophrenia/Anti-Psychotics)⁸		
ANTIPSYCH, DOPAMINE ANTAG., DIPHENYLBUTYLPIPERIDINES		
pimozide	T1	
ANTIPSYCHOTIC, ATYPICAL, DOPAMINE, SEROTONIN ANTAGNST		
asenapine maleate (Saphris)	T1	QL (60 tabs/fill)
CAPLYTA	T3	QL (30 caps/fill)
clozapine	T1	

T1 – Generics

T2 – Preferred Brands

T3 – Non-Preferred Brands

T4 – Brand Specialty

PA – Prior Authorization

QL – Quantity Limit

ST – Step Therapy

AGE – Age Requirement

SP – Specialty Medication

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List of Prescription Medications

PSYCHOTHERAPEUTIC DRUGS (Schizophrenia/Anti-Psychotics) ⁸ (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ANTIPSYCHOTIC, ATYPICAL, DOPAMINE, SEROTONIN ANTAGNST (cont.)		
<i>clozapine</i> (Clozaril)	T1	
<i>CLOZARIL</i> (<i>clozapine</i>)	T3	
<i>GEODON</i> (<i>ziprasidone hcl</i>)	T3	QL (60 caps/fill)
<i>INVEGA ER 3 MG TABLET</i> (<i>paliperidone</i>)	T3	QL (30 tabs/fill)
<i>INVEGA ER 6 MG TABLET</i> (<i>paliperidone</i>)	T3	QL (60 tabs/fill)
<i>INVEGA ER 9 MG TABLET</i> (<i>paliperidone</i>)	T3	QL (30 tabs/fill)
<i>LYBALVI</i>	T3	QL (30 tabs/30 days)
<i>olanzapine</i>	T1	PA SP HD
<i>olanzapine</i> (Zyprexa Zydis)	T1	QL (30 tabs/fill)
<i>quetiapine er 200 mg tablet</i> (Seroquel Xr)	T1	QL (30 tabs/fill)
<i>quetiapine er 300 mg tablet</i> (Seroquel Xr)	T1	QL (60 tabs/fill)
<i>quetiapine er 400 mg tablet</i> (Seroquel Xr)	T1	QL (60 tabs/fill)
<i>quetiapine er 50 mg tablet</i> (Seroquel Xr)	T1	QL (60 tabs/fill)
<i>quetiapine fumarate 200 mg tab</i> (Seroquel)	T1	QL (90 tabs/fill)
<i>quetiapine fumarate 300 mg tab</i> (Seroquel)	T1	QL (60 tabs/fill)
<i>RISPERDAL 0.5 MG TABLET</i> (<i>risperidone</i>)	T3	QL (60 tabs/fill)
<i>RISPERDAL 1 MG TABLET</i> (<i>risperidone</i>)	T3	QL (60 tabs/fill)
<i>RISPERDAL 1 MG/ML SOLUTION</i> (<i>risperidone</i>)	T3	
<i>RISPERDAL 2 MG TABLET</i> (<i>risperidone</i>)	T3	QL (60 tabs/fill)
<i>RISPERDAL 3 MG TABLET</i> (<i>risperidone</i>)	T3	QL (60 tabs/fill)
<i>RISPERDAL 4 MG TABLET</i> (<i>risperidone</i>)	T3	QL (60 tabs/fill)
<i>risperidone</i>	T1	QL (60 tabs/fill)
<i>risperidone 0.5 mg tablet</i> (Risperdal)	T1	QL (60 tabs/fill)
<i>risperidone 1 mg tablet</i> (Risperdal)	T1	QL (60 tabs/fill)
<i>risperidone 1 mg/ml solution</i> (Risperdal)	T1	
<i>risperidone 2 mg tablet</i> (Risperdal)	T1	QL (60 tabs/fill)
<i>risperidone 3 mg tablet</i> (Risperdal)	T1	QL (60 tabs/fill)
<i>risperidone 4 mg tablet</i> (Risperdal)	T1	QL (60 tabs/fill)
<i>SECUADO</i>	T3	QL (30 patches/fill)
<i>VERSACLOZ</i>	T3	
<i>ziprasidone hcl</i> (Geodon)	T1	QL (60 caps/fill)
<i>ZYPREXA</i> (<i>olanzapine</i>)	T3	QL (30 tabs/fill)
<i>ZYPREXA ZYDIS</i> (<i>olanzapine</i>)	T3	QL (30 tabs/fill)

T1 – Generics

T2 – Preferred Brands

T3 – Non-Preferred Brands

T4 – Brand Specialty

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 (Schizophrenia/Anti-Psychotics) ⁸ (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ANTIPSYCHOTIC-ATYPICAL, D3/D2 PARTIAL AG-5HT MIXED		
VRAYLAR	T3	QL (30 caps/30 days)
ANTIPSYCHOTICS, ATYP, D2 PARTIAL AGONIST/5HT MIXED		
ABILIFY ASIMTUFII 720MG/2.4ML, 960MG/3.2ML	T3	
ABILIFY MYCITE	T3	QL (30 tabs/fill)
<i>ariPIPRAZOLE</i>	T1	QL (60 tabs/fill)
<i>ariPIPRAZOLE 1 mg/ml solution</i>	T1	
<i>ariPIPRAZOLE 2 mg tablet (Abilify)</i>	T1	QL (30 tabs/fill)
<i>ariPIPRAZOLE 10 mg tablet (Abilify)</i>	T1	QL (30 tabs/fill)
<i>ariPIPRAZOLE 20 mg tablet (Abilify)</i>	T1	QL (30 tabs/fill)
<i>ariPIPRAZOLE 30 mg tablet (Abilify)</i>	T1	QL (30 tabs/fill)
REXULTI	T3	QL (30 tabs/fill)
ANTIPSYCHOTICS, DOPAMINE AND SEROTONIN ANTAGONISTS		
<i>loxpiprazine succinate</i>	T1	
ANTIPSYCHOTICS, DOPAMINE ANTAGONISTS, THIOXANTHENES		
<i>thiothixene</i>	T1	
ANTIPSYCHOTICS, DOPAMINE ANTAGONISTS, BUTYROPHENONES		
<i>haloperidol</i>	T1	
<i>haloperidol lactate</i>	T1	
ANTIPSYCHOTICS, DOPAMINE ANTAGONISTS, DIHYDROINDOLONES		
<i>molindone hcl</i>	T1	
ANTIPSYCHOTICS, PHENOTHIAZINES		
<i>chlorpromazine hcl</i>	T1	
<i>fluphenazine hcl</i>	T1	
<i>perphenazine</i>	T1	
<i>thioridazine hcl</i>	T1	
<i>trifluoperazine hcl</i>	T1	
SSRI-ANTIPSYCH, ATYPICAL,DOPAMINE,SEROTONIN ANTAG		
<i>olanzapine/fluoxetine hcl</i>	T1	
PSYCHOTHERAPEUTIC DRUGS (Seizure Disorders)		
NEUROACTIVE STEROID GABA-A RECEPTOR MODULATOR		
ZTALMY	T4	PA SP

T1 – Generics

T2 – Preferred Brands

T3 – Non-Preferred Brands

T4 – Brand Specialty

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 (Sleep Disorders/Sedatives)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
NARCOLEPSY AND SLEEP DISORDER THERAPY AGENTS		
<i>armodafinil</i> (Nuvigil)	T1	PA QL (30 tabs/fill)
<i>modafinil 100 mg tablet</i> (Provigil)	T1	PA QL (30 tabs/fill)
SUNOSI	T2	PA QL (30 tabs/fill)
SEDATIVE/HYPNOTICS (Sleep Disorders/Sedatives)		
ANTI-NARCOLEPSY, ANTI-CATAPLEXY, SEDATIVE-TYPE AGENT		
LUMRYZ STARTER PACK	T4	PA SP HD
LUMRYZ ER	T4	PA SP HD QL (30 packets/30 days)
SODIUM OXYBATE	T4	PA SP HD QL (540ml/30 days)
XYREM	T4	PA QL (540 mls/fill) SP HD
XYWAV	T4	PA QL (540 mls/fill) SP HD
BARBITURATES		
<i>phenobarbital</i>	T1	
<i>secobarbital sodium</i>	T1	QL (30 caps/fill)
HYPNOTICS, MELATONIN MT1/MT2 RECEPTOR AGONISTS		
HETLIOZ	T4	PA QL (30 caps/fill) SP HD
HETLIOZ LQ	T4	PA QL (158 mls/fill) SP HD
<i>ramelteon</i> (Rozerem)	T1	QL (30 tabs/fill)
SEDATIVE-HYPNOTICS - BENZODIAZEPINES		
<i>estazolam</i>	T1	QL (15 tabs/fill)
<i>flurazepam hcl</i>	T1	QL (15 caps/fill)
<i>HALCION (triazolam)</i>	T3	QL (15 tabs/fill)
MIDAZOLAM HCL 10 MG/5 ML SYRUP	T3	
<i>midazolam hcl 2 mg/ml syrup</i>	T1	
RESTORIL (<i>temazepam</i>)	T3	QL (15 caps/fill)
<i>temazepam</i> (Restoril)	T1	QL (15 caps/fill)
<i>triazolam</i>	T1	QL (15 tabs/fill)
<i>triazolam</i> (Halcion)	T1	QL (15 tabs/fill)
SEDATIVE-HYPNOTICS, NON-BARBITURATE		
BELSOMRA	T3	ST QL (30 tabs/fill)
DAYVIGO	T3	ST QL (30 tabs/fill)
<i>doxepin hcl 3 mg tablet</i> (Silenor)	T1	ST QL (30 tabs/fill)
<i>doxepin hcl 6 mg tablet</i> (Silenor)	T1	ST QL (30 tabs/fill)
EDLUAR	T3	ST QL (30 tabs/fill)
<i>eszopiclone</i> (Lunesta)	T1	QL (30 tabs/fill)

T1 – Generics

T2 – Preferred Brands

T3 – Non-Preferred Brands

T4 – Brand Specialty

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

SEDATIVE/HYPNOTICS (Sleep Disorders/Sedatives) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
SEDATIVE-HYPNOTICS, NON-BARBITURATE (cont.)		
IGALMI	T3	
MKO (MIDAZOLAM-KETAMINE-ONDAN)	T3	
SILENOR (<i>doxepin hcl</i>)	T3	ST QL (30 tabs/fill)
QUVIVIQ	T3	ST QL (30 tabs/fill)
<i>zaleplon 10 mg capsule</i>	T1	QL (60 caps/fill)
<i>zaleplon 5 mg capsule</i>	T1	QL (30 caps/fill)
<i>zolpidem tartrate</i>	T1	QL (30 tabs/fill)
<i>zolpidem tartrate (Ambien Cr)</i>	T1	QL (30 tabs/fill)
<i>zolpidem tartrate (Ambien)</i>	T1	QL (30 tabs/fill)
ZOLPIMIST	T3	ST QL (1 canister/30 days)
SKIN PREPS (Miscellaneous)		
IRRIGANTS		
<i>acetic acid</i>	T1	
<i>neomycin sulf/polymyxin b sulf</i>	T1	
PHYSIOLYTE (<i>physiological irrig soln no.1</i>)	T3	
PHYSIOSOL (<i>physiological irrig soln no.1</i>)	T3	
<i>ringer's solution</i>	T1	
<i>ringer's solution,lactated</i>	T1	
<i>sod,pot chlor/mag/sod,pot phos</i>	T1	
<i>sodium chloride irrig solution</i>	T1	
<i>sodium chloride 0.9% irrig</i>	T1	
<i>sodium chloride 0.9% prcss sol</i>	T1	
SODIUM CHLORIDE 0.9% IRRIG.	T3	
SORBITOL	T3	
SORBITOL-MANNITOL	T3	
<i>water for irrigation,sterile</i>	T1	
OXIDIZING AGENTS		
<i>hydrogen peroxide</i>	T1	
PRESERVATIVES		
<i>formaldehyde</i>	T1	
SKIN PREPS (Pain Relief And Inflammatory Disease)		
ANTIPSORIATIC AGENTS, SYSTEMIC		
<i>acitretin</i>	T1	

T1 – Generics

T2 – Preferred Brands

T3 – Non-Preferred Brands

T4 – Brand Specialty

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List of Prescription Medications

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

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ANTIPSORIATIC AGENTS, SYSTEMIC (cont.)		
methoxsalen	T1	
SKYRIZI	T4	PA QL (150 mg/84 days) SP HD
SKYRIZI (2 SYRINGES) KIT	T4	PA QL (150 mg/84 days) SP HD
SKYRIZI PEN	T4	PA QL (150 mg/84 days) SP HD
SOTYKTU	T4	PA QL (30 tabs/30 days) SP HD
SPEVIGO	T4	PA SP HD
TALTZ AUTOINJECTOR	T4	PA QL (1 ml/28 days) SP HD
TALTZ AUTOINJECTOR (2 PACK)	T4	PA QL (1 ml/28 days) SP HD
TALTZ AUTOINJECTOR (3 PACK)	T4	PA QL (1 ml/28 days) SP HD
TALTZ 20 MG/0.25 ML SYRINGE	T4	PA QL (1 syringe/28 days) SP HD
TALTZ 40 MG/0.5 ML SYRINGE	T4	PA QL (1 syringe/28 days) SP HD
TALTZ 80 MG/ML SYRINGE	T4	PA QL (1 ml/28 days) SP HD

TOPICAL ANTI-INFLAMMATORY, NSAIDS

diclofenac sodium 1% gel	T1	QL (500 gms/28 days) HD
FLECTOR	T2	ST QL (60 patches/fill) HD
LICART	T2	ST QL (30 patches/fill) HD

SKIN PREPS (Skin Conditions)

ACNE AGENTS, SYSTEMIC

ABSORICA (isotretinoin)	T3	ST
isotretinoin (Absorica)	T1	

ACNE AGENTS, TOPICAL

ACZONE (dapson)	T3	ST
adapalene/benzoyl peroxide	T1	
adapalene/benzoyl peroxide (Epiduo Forte)	T1	
AZELEX	T3	ST
clindamycin phos/benzoyl perox	T1	
clindamycin phos/benzoyl perox (Acanya)	T1	
clindamycin/tretinoin (Veltin)	T1	
clindamycin/tretinoin (Ziana)	T1	PA
dapsone 5% gel (Aczone)	T1	PA SP HD
dapsone 7.5% gel pump (Aczone)	T1	PA SP HD
DAPSONE 7.5% GEL	T3	PA SP HD
EPIDUO FORTE	T3	ST
EPIDUO FORTE (adapalene/benzoyl peroxide)	T3	ST

T1 – Generics

T2 – Preferred Brands

T3 – Non-Preferred Brands

T4 – Brand Specialty

PA – Prior Authorization

QL – Quantity Limit

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AGE – Age Requirement

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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
ACNE AGENTS, TOPICAL (cont.)		
KLARON (<i>sulfacetamide sodium</i>)	T3	ST
NEUAC 1.2-5% KIT	T3	ST
<i>neuac gel</i>	T1	
ONEXTON	T2	ST
ONEXTON (<i>clindamycin phos/benzoyl perox</i>)	T3	ST
<i>sulfacetamide sodium (Klaron)</i>	T1	
ANTIPRURITICS, TOPICAL		
ZONALON	T3	ST QL (90 gms/30 days)
ZONALON (<i>doxepin hcl</i>)	T3	ST QL (90 gms/30 days)
ANTIPSORIATICS AGENTS		
<i>calcipotriene 0.005% cream (Dovonex)</i>	T1	QL (120 gms/30 days)
<i>calcipotriene 0.005% ointment</i>	T1	QL (120 gms/30 days)
<i>calcipotriene 0.005% solution</i>	T1	QL (120 mls/30 days)
<i>calcitriol 3 mcg/g ointment (Vectical)</i>	T1	
DOVONEX (<i>calcipotriene</i>)	T3	ST QL (120 gms/30 days)
DUOBRII	T3	ST QL (200 gms/30 days)
<i>tazarotene 0.05% gel (Tazorac)</i>	T1	PA
<i>tazarotene 0.1% cream (Tazorac)</i>	T1	PA
<i>sod sulfacetam 10% clnsng gel</i>	T1	
<i>sod sulfacetamide 10% shampoo</i>	T1	
<i>sod sulfacetamide 9.8% shampoo</i>	T1	
SODIUM SULFACETAMIDE 10% WASH	T3	
<i>sodium sulfacetamide 10% wash (Ovace)</i>	T1	
<i>tazarotene 0.05% cream (Tazorac)</i>	T1	PA
<i>tazarotene 0.1% gel (Tazorac)</i>	T1	PA
TERSI FOAM	T3	
TWYNEO	T3	PA ST
VECTICAL (<i>calcitriol</i>)	T3	
VTAMA	T2	PA QL (60 gms/28 days)
ZIANA (<i>clindamycin/tretinoin</i>)	T3	PA ST
ZORYVE 0.3% CREAM	T3	PA QL (60 gms/30 days)
ANTISEBORRHEIC AGENTS		
ESKATA	T3	
OVACE (<i>sulfacetamide sodium</i>)	T3	

T1 – Generics

T2 – Preferred Brands

T3 – Non-Preferred Brands

T4 – Brand Specialty

PA – Prior Authorization

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List of Prescription Medications

SKIN PREPS (Skin Conditions) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ANTISEBORRHEIC AGENTS (cont.)		
OVACE PLUS	T3	
OVACE PLUS WASH	T3	
PLEXION NS	T3	
<i>selenium sulfide</i>	T1	
ANTISEPTICS, GENERAL		
ADVOCATE ALCOHOL 70% PREP PADS	T2	
ALCOHOL 70% PREP PADS	T2	
ALCOHOL 70% SWABS	T2	
<i>alcohol 70% swabs</i>	T1	
ALCOHOL 70% WIPES	T2	
<i>alcohol antiseptic pads</i>	T1	
<i>alcohol prep pads</i>	T1	
<i>alcohol swabs</i>	T1	
CARETOUCH ALCOHOL PREP PAD	T2	
CURITY ALCOHOL PREPS	T2	
CVS ALCOHOL 70% PREP PADS	T2	
<i>cvs isopropyl alcohol 70% wipe</i>	T1	
DROPSAFE PREP PADS	T2	
EASY COMFORT ALCOHOL PAD	T2	
EASY TOUCH ALCOHOL PREP PADS	T2	
<i>fifty50 alcohol prep pads</i>	T1	
GS ALCOHOL 70% SWABS	T2	
HM ALCOHOL 70% PREP PADS	T2	
INCONTROL ALCOHOL PADS	T2	
PHARM CHOICE ALCOHOL PREP PADS	T2	
<i>pharm choice alcohol prep pads</i>	T1	
PRO COMFORT ALCOHOL PADS	T2	
PURE COMFORT ALCOHOL PAD	T2	
<i>qc alcohol 70% swabs</i>	T1	
<i>ra alcohol swabs</i>	T1	
RA ISOPROPYL ALCOHOL 70% WIPES	T2	
RELION ALCOHOL 70% SWABS	T2	
SAPS ALCOHOL 70% PREP PADS	T2	
SINGLE USE SWAB	T2	

T1 – Generics

T2 – Preferred Brands

T3 – Non-Preferred Brands

T4 – Brand Specialty

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List of Prescription Medications

SKIN PREPS (Skin Conditions) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ANTISEPTICS,GENERAL (cont.)		
<i>sm alcohol prep pads</i>	T1	
SURE COMFORT ALCOHOL	T2	
SURE-PREP ALCOHOL PREP PADS	T2	
TRUE COMFORT ALCOHOL PADS	T2	
TRUE COMFORT PRO ALCOHOL PADS	T2	
ULTILET ALCOHOL SWAB	T2	
<i>v-r alcohol prep pads</i>	T1	
WEBCOL	T2	
ANTISEPTICS,MISCELLANEOUS		
GUAIACOL	T2	
DIABETIC ULCER PREPARATIONS, TOPICAL		
REGRANEX	T2	QL (15 gms/fill)
IMMUNOMODULATORS		
<i>imiquimod</i>	T1	
<i>imiquimod (Zyclara)</i>	T1	
IRRITANTS/COUNTER-IRRITANTS		
CANTHARIDIN-ACETONE	T3	
<i>methyl salicylate</i>	T1	
YCANTH	T4	SP
JANUS KINASE (JAK) INHIBITORS		
CIBINQO	T4	PA QL (30 tabs/30 days) SP
KERATOLYTIC-GLUCOCORTICOID COMBINATIONS		
VANOXIDE-HC	T3	ST
KERATOLYTICS		
<i>benzepro 6% foaming cloths</i>	T1	
BENZEPRO 7% CREAMY WASH (<i>benzoyl peroxide microspheres</i>)	T3	ST
<i>benzoyl peroxide</i>	T1	
<i>benzoyl peroxide (Pacnex)</i>	T1	
ENZOCLEAR	T3	ST
INOVA	T3	ST
INOVA 4-1	T3	ST
INOVA 8-2	T3	ST
PACNEX (<i>benzoyl peroxide</i>)	T3	ST
<i>podofilox 0.5% gel (Condyllox)</i>	T1	ST QL (7 gms/30 days)

T1 – Generics

T2 – Preferred Brands

T3 – Non-Preferred Brands

T4 – Brand Specialty

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List of Prescription Medications

SKIN PREPS (Skin Conditions) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
KERATOLYTICS (cont.)		
<i>podofilox 0.5% topical soln</i>	T1	
PR BENZOYL PEROXIDE (<i>benzoyl peroxide microspheres</i>)	T3	ST
PROTECTIVES		
PHARMABASE BARRIER (<i>zinc oxide</i>)	T3	
<i>zinc oxide 20% ointment</i>	T1	
ZINC OXIDE PASTE	T2	
ROSACEA AGENTS, TOPICAL		
<i>azelaic acid (Finacea)</i>	T1	
EPSOLAY	T3	ST
FINACEA 15% FOAM	T2	ST
FINACEA 15% GEL (<i>azelaic acid</i>)	T3	ST
<i>ivermectin 1% cream (Soolantra)</i>	T1	QL (45 gms/30 days)
METROCREAM (<i>metronidazole</i>)	T3	ST
METROGEL (<i>metronidazole</i>)	T3	ST
<i>metronidazole 0.75% cream (Metrocream)</i>	T1	
<i>metronidazole 0.75% lotion</i>	T1	
<i>metronidazole top 1% gel pump</i>	T1	
<i>metronidazole topical 0.75% gl</i>	T1	
<i>metronidazole topical 1% gel (Metrogel)</i>	T1	
MIRVASO	T2	PA
RHOFADE	T3	PA
<i>rosadan 0.75% cream (Metrocream)</i>	T1	
ROSADAN 0.75% CREAM KIT	T3	ST
<i>rosadan 0.75% gel</i>	T1	
ROSADAN 0.75% GEL KIT	T3	ST
SOOLANTRA (<i>ivermectin</i>)	T3	ST QL (60 gms/30 days)
TISSUE/WOUND ADHESIVES		
ARTISS	T3	
SURGISEAL STYLUS	T3	
SURGISEAL TEARDROP	T3	
SURGISEAL TWIST	T3	
TISSEEL VHSD	T3	
TOP. ANTI-INFLAM., PHOSPHODIESTERASE-4 (PDE4) INHIB		
EUCRISA	T2	ST QL (120 gms/30 days)

T1 – Generics

T2 – Preferred Brands

T3 – Non-Preferred Brands

T4 – Brand Specialty

PA – Prior Authorization

QL – Quantity Limit

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List of Prescription Medications

SKIN PREPS (Skin Conditions) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
TOP. ANTI-INFLAM., PHOSPHODIESTERASE-4 (PDE4) INHIB (cont.)		
ZORYVE 0.15% CREAM	T2	ST QL (60 gms/30 days)
ZORYVE 0.3% FOAM	T3	ST QL (60 gms/30 days)
TOPICAL ACNE AGENT, RETINOIC ACID RECEPTOR AGONIST		
AKLIEF	T3	PA ST
ARAZLO	T3	PA
TOPICAL AGENTS, MISCELLANEOUS		
L-MESITRAN SOFT	T3	
MEDIHONEY	T3	
<i>trichloroacetic acid</i>	T1	
TRICHLOROACETIC ACID 100% (<i>trichloroacetic acid</i>)	T3	
TRICHLOROACETIC ACID 20% (<i>trichloroacetic acid</i>)	T2	
TRICHLOROACETIC ACID 25%	T3	
TRICHLOROACETIC ACID 30%	T2	
TRICHLOROACETIC ACID 35%	T2	
TRICHLOROACETIC ACID 40%	T2	
TRICHLOROACETIC ACID 50%	T2	
TRICHLOROACETIC ACID 75%	T3	
TRICHLOROACETIC ACID 80%	T2	
TRICHLOROACETIC ACID 85%	T2	
TRICHLOROACETIC ACID 90%	T2	
TOPICAL ANTIBIOTIC PLEUROMUTILIN DERIVATIVES		
ALTABAX	T3	ST QL (30 gms/fill)
TOPICAL ANTI-INFLAMMATORY STEROIDAL		
ALA-SCALP (<i>hydrocortisone</i>)	T3	ST
<i>alclometasone dipropionate</i>	T1	
<i>amcinonide</i>	T1	ST
<i>betamethasone dipropionate</i>	T1	
<i>betamethasone va 0.1% cream</i>	T1	
<i>betamethasone va 0.1% lotion</i>	T1	
<i>betamethasone valer 0.1% ointm</i>	T1	
<i>betamethasone valer 0.12% foam</i>	T1	ST
<i>betamethasone/propylene glyc</i>	T1	
<i>betamethasone/propylene glyc</i> (Diprolene)	T1	
BRYHALI	T3	ST

T1 – Generics

T2 – Preferred Brands

T3 – Non-Preferred Brands

T4 – Brand Specialty

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List of Prescription Medications

SKIN PREPS (Skin Conditions) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
TOPICAL ANTI-INFLAMMATORY STEROIDAL (cont.)		
CAPEX SHAMPOO	T3	ST
<i>clobetasol 0.05% cream</i>	T1	QL (120 gms/30 days)
<i>clobetasol 0.05% gel</i>	T1	QL (120 gms/30 days)
<i>clobetasol 0.05% ointment (Temovate)</i>	T1	QL (120 gms/30 days)
<i>clobetasol 0.05% shampoo (Clobex)</i>	T1	ST QL (236 mls/30 days)
<i>clobetasol 0.05% solution</i>	T1	QL (100 mls/30 days)
<i>clobetasol 0.05% topical lotion</i>	T1	ST QL (118 mls/30 days)
<i>clobetasol emollient 0.05% cream</i>	T1	QL (120 gms/30 days)
<i>clobetasol emollient 0.05% foam</i>	T1	ST QL (100 gms/30 days)
<i>clobetasol prop 0.05% foam (Olux)</i>	T1	ST QL (100 gms/30 days)
<i>clobetasol prop 0.05% spray (Clobex)</i>	T1	ST QL (125 mls/30 days)
<i>clobetasol propionate/emollient</i>	T1	ST QL (100 gms/30 days)
CLOBEX 0.05% SHAMPOO (<i>clobetasol propionate</i>)	T3	ST QL (236 mls/30 days)
CLOBEX 0.05% SPRAY (<i>clobetasol propionate</i>)	T3	ST QL (125 mls/30 days)
CLODAN 0.05% KIT	T3	ST QL (2 kits/28 days)
<i>cladan 0.05% shampoo (Clobex)</i>	T1	ST QL (236 mls/30 days)
CLODERM	T3	ST
CLODERM (<i>clo cortolone pivalate</i>)	T3	ST
CORDRAN 0.025% CREAM	T3	ST QL (120 gms/30 days)
CORDRAN 0.05% CREAM (<i>flurandrenolide</i>)	T3	ST QL (120 gms/30 days)
CORDRAN 0.05% LOTION (<i>flurandrenolide</i>)	T3	ST QL (120 mls/30 days)
CORDRAN 0.05% OINTMENT (<i>flurandrenolide</i>)	T3	ST QL (120 gms/30 days)
CORDRAN 4 MCG/SQ CM TAPE LARGE	T3	ST
DERMA-SMOOTH-E-FS (<i>fluocinolone acetonide</i>)	T3	ST
DERMA-SMOOTH-E-FS (<i>fluocinolone/shower cap</i>)	T3	ST
DERMASORB HC	T3	ST
DERMASORB TA	T3	ST
DERMATOP (<i>prednicarbate</i>)	T3	ST
DESONATE (<i>desonide</i>)	T3	ST
desonide (Desonate)	T1	ST
<i>desonide 0.05% cream (Tridesilon)</i>	T1	
<i>desonide 0.05% cream (Desowen)</i>	T1	
<i>desonide 0.05% gel (Desonate)</i>	T1	ST
<i>desonide 0.05% lotion</i>	T1	ST

T1 – Generics

T2 – Preferred Brands

T3 – Non-Preferred Brands

T4 – Brand Specialty

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List of Prescription Medications

SKIN PREPS (Skin Conditions) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
TOPICAL ANTI-INFLAMMATORY STEROIDAL (cont.)		
desonide 0.05% ointment	T1	
desoximetasone (Topicort)	T1	ST
DESOWEN (desonide)	T3	ST
DIPROLENE (betamethasone/propylene glyc)	T3	ST
fluocinolone acetonide	T1	
fluocinolone acetonide (Derma-Smoothe-Fs)	T1	
fluocinolone acetonide (Synalar)	T1	
fluocinolone/shower cap (Derma-Smoothe-Fs)	T1	
fluocinonide 0.05% cream	T1	QL (120 gms/30 days)
fluocinonide 0.05% gel	T1	QL (120 gms/30 days)
fluocinonide 0.05% ointment	T1	QL (120 gms/30 days)
fluocinonide 0.05% solution	T1	QL (120 gms/30 days)
fluocinonide 0.1% cream (Nanos)	T1	ST QL (120 gms/30 days)
fluocinonide/emollient base	T1	QL (120 gms/30 days)
fluticasone prop 0.005% oint	T1	
fluticasone prop 0.05% cream	T1	
fluticasone prop 0.05% lotion	T1	ST
fluticasone propionate	T1	ST
halobetasol prop 0.05% cream	T1	
halobetasol prop 0.05% foam	T1	ST
halobetasol prop 0.05% ointmnt	T1	
halobetasol prop 0.05% cream (Ultravate)	T1	
halobetasol prop 0.05% ointmnt (Ultravate)	T1	
HALOG	T3	ST
HALOG (halcinonide)	T3	ST
hydrocort buty 0.1% lipid crm (Locoid Lipocream)	T1	QL (120 gms/30 days)
hydrocort buty 0.1% lipo cream (Locoid Lipocream)	T1	QL (120 gms/30 days)
hydrocort/min oil/petrolat,wht	T1	
hydrocortisone	T1	
hydrocortisone (Ala-Scalp)	T1	
hydrocortisone (Anusol-Hc)	T1	
hydrocortisone buty 0.1% cream	T1	QL (120 gms/30 days)
hydrocortisone butyr 0.1% lotn	T1	PA SP HD
hydrocortisone butyr 0.1% oint	T1	ST QL (10 gm/28 days)

T1 – Generics

T2 – Preferred Brands

T3 – Non-Preferred Brands

T4 – Brand Specialty

PA – Prior Authorization

QL – Quantity Limit

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List of Prescription Medications

SKIN PREPS (Skin Conditions) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
TOPICAL ANTI-INFLAMMATORY STEROIDAL (cont.)		
hydrocortisone butyr 0.1% soln	T1	ST QL (120 mls/30 days)
hydrocortisone valerate	T1	
IMPEKLO	T3	ST QL (136 gms/28 days)
KENALOG 0.147 MG/GRAM SPRAY (<i>triamcinolone acetonide</i>)	T3	ST QL (100 gms/30 days)
KENALOG 0.147 MG/GRAM SPRAY (<i>triamcinolone acetonide</i>)	T3	ST QL (126 gms/30 days)
mometasone furoate 0.1% cream	T1	
mometasone furoate 0.1% oint	T1	
mometasone furoate 0.1% soln	T1	
LEXETTE	T3	PA SP HD
NUCORT	T3	ST
OLUX (<i>clobetasol propionate</i>)	T3	ST QL (100 gms/30 days)
PANDEL	T3	ST
<i>prednicarbate</i>	T1	
<i>prednicarbate</i> (Dermatop)	T1	
SCALACORT DK	T3	ST
SYNALAR	T3	ST
SYNALAR (<i>fluocinolone acetonide</i>)	T3	ST
SYNALARTS	T3	ST
TEMOVATE (<i>clobetasol propionate</i>)	T3	ST QL (120 gms/30 days)
TEXACORT	T3	ST
TOPICORT 0.05% CREAM (<i>desoximetasone</i>)	T3	ST
TOPICORT 0.05% GEL (<i>desoximetasone</i>)	T3	ST
TOPICORT 0.05% OINTMENT (<i>desoximetasone</i>)	T3	ST
TOPICORT 0.25% CREAM (<i>desoximetasone</i>)	T3	ST
TOPICORT 0.25% OINTMENT (<i>desoximetasone</i>)	T3	ST
triamcinolone 0.025% cream	T1	
triamcinolone 0.025% lotion	T1	
triamcinolone 0.025% oint	T1	
triamcinolone 0.05% ointment	T1	ST
triamcinolone 0.1% cream, lotion	T1	
triamcinolone 0.1% ointment	T1	
triamcinolone 0.147 mg/g spray (Kenalog)	T1	ST QL (126 gms/30 days)
triamcinolone 0.147 mg/g spray (Kenalog)	T1	ST QL (100 gms/30 days)
triamcinolone 0.5% cream	T1	

T1 – Generics

T2 – Preferred Brands

T3 – Non-Preferred Brands

T4 – Brand Specialty

PA – Prior Authorization

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ST – Step Therapy

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List of Prescription Medications

SKIN PREPS (Skin Conditions) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
TOPICAL ANTI-INFLAMMATORY STEROIDAL (cont.)		
triamcinolone 0.5% ointment	T1	
triamcinolone acetonide	T1	ST
triderm 0.1% cream	T1	
triderm 0.5% cream	T1	ST
TRIDESILON (desonide)	T3	ST
ULTRAVATE X	T3	ST
TOPICAL ANTI-INFLAMMATORY STEROID-LOCAL ANESTHETIC		
ANALPRAM HC 2.5%-1% LOTION (<i>hydrocortisone/pramoxine</i>)	T3	ST
EPIFOAM	T3	ST
<i>hydrocort-pramoxine</i> 2.5-1% crm	T1	ST
<i>lidocaine/hydrocortisone ac</i>	T1	
<i>lidocaine-hc</i> 3-0.5% cream	T1	
PRAMOSONE	T3	ST
TOPICAL ANTIPARASITICS		
<i>lindane</i>	T1	
<i>malathion</i> (Ovide)	T1	
OVIDE (<i>malathion</i>)	T3	
TOPICAL JANUS KINASE (JAK) INHIBITORS		
OPZELURA	T3	PA QL (240 gms/28 days)
TOPICAL PREPARATIONS, ANTIBACTERIALS		
<i>iodine/potassium iodide</i>	T1	
<i>iodine/sodium iodide</i>	T1	
IODOFLEX	T3	
IODOSORB	T3	
TOPICAL VIT D ANALOG/ANTI-INFLAMMATORY STEROID		
<i>calcipotriene/betamethasone</i> (Taclonex)	T1	ST QL (60 gms/30 days)
<i>calcipotriene/betamethasone</i> (Taclonex)	T1	QL (60 gms/30 days)
ENSTILAR	T2	ST QL (60 gms/30 days)
WYNZORA	T3	ST QL (60 gms/30 days)
TOPICAL/MUCOUS MEMBR./SUBCUT. ENZYMES		
SANTYL	T2	QL (180 gms/fill)
VITAMIN A DERIVATIVES		
<i>adapalene</i> 0.1% cream (Differin)	T1	
ADAPALENE 0.1% LOTION	T3	ST

T1 – Generics

T2 – Preferred Brands

T3 – Non-Preferred Brands

T4 – Brand Specialty

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

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List of Prescription Medications

SKIN PREPS (Skin Conditions) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
VITAMIN A DERIVATIVES (cont.)		
adapalene 0.1% solution	T1	
adapalene 0.1% swab	T1	ST
adapalene 0.3% gel	T1	
adapalene 0.3% gel pump (Differin)	T1	
ALTRENO	T3	PA
avita 0.025% cream (Retin-A)	T1	PA
AVITA 0.025% GEL	T3	PA
DIFFERIN	T3	ST
DIFFERIN (adapalene)	T3	ST
RETIN-A (tretinoin)	T3	PA
RETIN-A MICRO PUMP 0.06% GEL	T3	PA
RETIN-A MICRO PUMP 0.08% GEL	T3	PA
tretinoin 0.01% gel (Retin-A)	T1	
tretinoin 0.025% cream (Retin-A)	T1	
tretinoin 0.025% gel (Retin-A)	T1	
tretinoin 0.05% cream (Retin-A)	T1	
tretinoin 0.05% gel (Atralin)	T1	
tretinoin 0.1% cream (Retin-A)	T1	
tretinoin microspheres (Retin-A Micro Pump)	T1	PA
tretinoin microspheres (Retin-A Micro)	T1	PA
SMOKING DETERRENTS (Smoking Cessation)⁸		
SMOKING DETERRENT AGENTS (GANGLIONIC STIM, OTHERS)		
NICOTROL	T3	QL (180 ds/365 days) PPACA
NICOTROL NS	T3	QL (180 ds/365 days) PPACA
SMOKING DETERRENT-NICOTINIC RECEPT.PARTIAL AGONIST		
APO-VARENICLINE 0.5 MG TABLET	T2	QL (180 ds/365 days) PPACA
APO-VARENICLINE 1 MG TABLET	T2	QL (180 ds/365 days) PPACA
CHANTIX	T3	QL (180 ds/365 days) PPACA
SMOKING DETERRENTS, OTHER		
bupropion hcl sr 150 mg tablet	T1	QL (180 ds/365 days) PPACA
THYROID PREPS (Hormonal Agents)		
ANTITHYROID PREPARATIONS		
methimazole	T1	HD

T1 – Generics

T2 – Preferred Brands

T3 – Non-Preferred Brands

T4 – Brand Specialty

PA – Prior Authorization

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ST – Step Therapy

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List of Prescription Medications

THYROID PREPS (Hormonal Agents) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ANTITHYROID PREPARATIONS (cont.)		
<i>propylthiouracil</i>	T1	HD
THYROID HORMONES		
<i>adthyza 15 mg tablet</i>	T1	HD
<i>adthyza 30 mg tablet</i>	T1	HD
<i>adthyza 60 mg tablet</i>	T1	HD
<i>adthyza 90 mg tablet</i>	T1	HD
<i>adthyza 120 mg tablet</i>	T1	HD
ARMOUR THYROID	T2	HD
ERMEZA	T3	ST HD
<i>levothyroxine sodium (Synthroid)</i>	T1	HD
<i>liothyronine sodium (Cytomel)</i>	T1	HD
<i>thyroid,pork</i>	T1	HD
UNCLASSIFIED DRUG PRODUCTS (AIDS/HIV)		
CYTOCHROME P450 INHIBITORS		
TYBOST	T4	SP
UNCLASSIFIED DRUG PRODUCTS (Asthma/COPD/Respiratory)		
CYSTIC FIBROSIS - INHALED OSMOTIC AGENTS		
BRONCHITOL	T4	PA SP HD
THYMIC STROMAL LYMPHOPOIETIN (TSLP) INHIBITORS		
TEZSPIRE 210 MG/1.91 ML PEN	T4	SP PA HD QL (1 pen/28 days)
TEZSPIRE 210 MG/1.91 ML SYRING	T4	SP PA HD QL (1 syringe/28 days)
CYSTIC FIBROSIS-CFTR POTENTIATOR-CORRECTOR COMBIN.		
ALYFTREK 10-50-125 MG TABLET	T4	PA QL (56 tabs/fill) SP HD
ALYFTREK 4-20-50 MG TABLET	T4	PA QL (84 tabs/fill) SP HD
ORKAMBI 100 MG-125 MG TABLET	T4	PA QL (112 tabs/fill) SP HD
ORKAMBI 100-125 MG GRANULE PKT	T4	PA QL (56 packs/fill) SP HD
ORKAMBI 150-188 MG GRANULE PKT	T4	PA QL (56 packs/fill) SP HD
ORKAMBI 200 MG-125 MG TABLET	T4	PA QL (112 tabs/fill) SP HD
ORKAMBI 75-94 MG GRANULE PKT	T4	PA QL (56 packs/fill) SP HD
SYMDEKO	T4	PA QL (56 tabs/fill) SP HD
TRIKAFTA 100-50-75 MG/75MG PKT	T4	SP PA HD QL (56 packets/28 days)
TRIKAFTA 80-40-60MG/59.5MG PKT	T4	SP PA HD QL (56 packets/28 days)

T1 – Generics

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List of Prescription Medications

UNCLASSIFIED DRUG PRODUCTS (Asthma/COPD/Respiratory) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
CYSTIC FIB-TRANSMEMB CONDUCT.REG.(CFTR) POTENTIATOR		
KALYDECO 5.8 MG GRANULES PKT	T4	PA QL (56 packs/fill) SP HD
KALYDECO 13.4MG GRANULES PKT	T4	PA SP QL (56 packets/28 days)
KALYDECO 150 MG TABLET	T4	PA QL (56 tabs/fill) SP HD
KALYDECO 25 MG GRANULES PACKET	T4	PA QL (56 packs/fill) SP HD
KALYDECO 50 MG GRANULES PACKET	T4	PA QL (56 packets/fill) SP HD
KALYDECO 75 MG GRANULES PACKET	T4	PA QL (56 packets/fill) SP HD
LUNG SURFACTANTS		
CUROSURF	T3	
INFASURF	T3	
SURVANTA	T3	
MUCOLYTICS		
PULMOZYME	T4	PA SP HD
PULMONARY FIBROSIS - SYSTEMIC ENZYME INHIBITORS		
OFEV	T4	PA QL (60 caps/fill) SP HD
SYSTEMIC ENZYME INHIBITORS		
JOENJA 70 MG TABLET	T4	PA SP QL (60 tabs/30 days)
VIOVICE 250 MG DAILY DOSE PACK	T4	PA QL (56 tabs/28 days) SP
VIOVICE 50 MG GRANULE PACKET	T4	PA QL (28 Packs/28 days) SP
VIOVICE 125 MG TABLET	T4	PA QL (28 tabs/28 days) SP
VIOVICE 50 MG TABLET	T4	PA QL (28 tabs/28 days) SP
ZOKINVY	T4	PA QL (120 caps/fill) SP
UNCLASSIFIED DRUG PRODUCTS (Blood Modifiers/Bleeding Disorders)		
SPLEEN TYROSINE KINASE INHIBITORS		
TAVALISSE	T4	PA QL (60 tabs/fill) SP
UNCLASSIFIED DRUG PRODUCTS (Blood Pressure/Heart Medications)		
BRADYKININ B2 RECEPTOR ANTAGONISTS		
icatibant acetate (Firazyr)	T1	PA SP HD
icatibant acetate (Firazyr)	T1	PA SP
PLASMA KALLIKREIN INHIBITORS		
ORLADEYO	T4	PA SP
TAKHYRO 300MG/2ML	T4	PA QL (2 units/28 days) SP HD

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List of Prescription Medications

UNCLASSIFIED DRUG PRODUCTS (Cancer)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
CHEMOTHERAPY RESCUE/ANTIDOTE AGENTS		
<i>leucovorin calcium</i>	T1	CSL
<i>mesna (Mesnex)</i>	T1	SP CSL
MESNEX (<i>mesna</i>)	T4	SP CSL
VISTOGARD 10GM PKT	T4	PA QL (20 pkts/30 days) SP CSL
UNCLASSIFIED DRUG PRODUCTS (Dental Products)		
DENTAL AIDS AND PREPARATIONS		
<i>chlorhexidine gluconate (Peridex)</i>	T1	
PERIDEX (<i>chlorhexidine gluconate</i>)	T3	
<i>triamcinolone 0.1% paste</i>	T1	
<i>triamcinolone acetonide</i>	T1	
PERIODONTAL COLLAGENASE INHIBITORS		
<i>doxycycline hyclate 20 mg tab</i>	T1	
UNCLASSIFIED DRUG PRODUCTS (Erectile Dysfunction)		
DRUGS TO TREAT ERECTILE DYSFUNCTION (ED)		
<i>avanafil (Stendra)</i>	T1	PA QL (8 tabs/30 days)
CAVERJECT 20 MCG VIAL	T2	PA QL (12 vials/fill)
CAVERJECT 40 MCG VIAL	T2	PA QL (12 vials/fill)
CAVERJECT IMPULSE 10 MCG KIT	T2	PA QL (12 kits/fill)
CAVERJECT IMPULSE 10 MCG SYRNG	T2	PA QL (12 syringes/fill)
CAVERJECT IMPULSE 20 MCG KIT	T2	PA QL (12 kits/fill)
CAVERJECT IMPULSE 20 MCG SYRNG	T2	PA QL (12 syringes/fill)
<i>CIALIS (tadalafil)</i>	T3	PA QL (8 tabs/30 days)
EDEX 10 MCG CARTRIDGE 2-PK KIT	T3	PA QL (6 kits/fill)
EDEX 10 MCG CARTRIDGE 6-PK KIT	T3	PA QL (2 kits/fill)
EDEX 20 MCG CARTRIDGE 2-PK KIT	T3	PA QL (6 kits/fill)
EDEX 20 MCG CARTRIDGE 6-PK KIT	T3	PA QL (2 kits/fill)
EDEX 40 MCG CARTRIDGE 2-PK KIT	T3	PA QL (6 kits/fill)
EDEX 40 MCG CARTRIDGE 6-PK KIT	T3	PA QL (2 kits/fill)
IFE-BIMIX 30/1	T3	
<i>LEVITRA (vardenafil hcl)</i>	T3	PA QL (8 tabs/fill)
MUSE	T2	PA QL (12 supps/fill)
PAPAVERINE-PHENTOLAMINE	T3	
PAPAVERINE-PHENTOLMN-ALPROSTDL	T3	

T1 – Generics

T2 – Preferred Brands

T3 – Non-Preferred Brands

T4 – Brand Specialty

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List of Prescription Medications

UNCLASSIFIED DRUG PRODUCTS (Erectile Dysfunction) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
DRUGS TO TREAT ERECTILE DYSFUNCTION (ED) (cont.)		
sildenafil 25 mg tablet (Viagra)	T1	PA QL (8 tabs/30 days) HD
sildenafil 100 mg tablet (Viagra)	T1	PA QL (8 tabs/30 days) HD
sildenafil 50 mg tablet (Viagra)	T1	PA QL (8 tabs/30 days) HD
STENDRA (avanafil)	T3	PA QL (8 tabs/30 days)
tadalafil 2.5 mg tablet	T1	PA QL (30 tabs/30 days) HD
tadalafil 10 mg tablet (Cialis)	T1	PA QL (8 tabs/30 days) HD
tadalafil 20 mg tablet (Cialis)	T1	PA QL (8 tabs/30 days) HD
tadalafil 5 mg tablet (Cialis)	T1	PA QL (8 tabs/30 days) HD
TRI-MIX (PAPVRN-PHNTLMN-PGE1)	T3	
vardenafil hcl	T1	PA QL (8 tabs/fill)
vardenafil hcl (Levitra)	T1	PA QL (8 tabs/fill)
UNCLASSIFIED DRUG PRODUCTS (Eye Conditions)		
NICOTINIC RECEPT.PARTIAL AGONIST, ALPHA4BETA2 SPEC		
TYRVAYA	T3	PA
UNCLASSIFIED DRUG PRODUCTS (Gastrointestinal/Heartburn)		
AGENTS FOR STOMATOLOGICAL USE		
PROTHELIAL	T3	
SILATRIX	T3	
COMPOUNDING KIT		
FIRST-MOUTHWASH BLM	T3	
ORAL MUCOSITIS/STOMATITIS AGENTS		
GELCLAIR	T3	
GELX	T3	
ORAMAGICRX	T3	
ORAL MUCOSITIS/STOMATITIS ANTI-INFLAMMATORY AGENT		
EPISIL	T3	
PPAR AGONIST		
IQIRVO	T4	PA SP HD
LIVDELZI	T4	PA SP
SALIVA STIMULANT AGENTS		
NUMOISYN	T3	
SALIVA SUBSTITUTE AGENTS		
AQUORAL	T3	

T1 – Generics

T2 – Preferred Brands

T3 – Non-Preferred Brands

T4 – Brand Specialty

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List of Prescription Medications

UNCLASSIFIED DRUG PRODUCTS (Gastrointestinal/Heartburn) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
SALIVA SUBSTITUTE AGENTS (cont.)		
BOCASAL	T3	
CAPHOSOL	T3	
MUCOSITISRX	T3	
NEUTRASAL	T3	
NUMOISYN	T3	
SALIVAMAX	T3	
THYROID HORMONE RECEPTOR (THR) AGONIST		
REZDIFRA	T4	PA QL (30 tabs/30 days) SP HD
UNCLASSIFIED DRUG PRODUCTS (Hormonal Agents)		
GROWTH HORMONE RECEPTOR ANTAGONISTS		
SOMAVERT	T4	PA SP HD
HYPERPARATHYROID TX AGENTS - VITAMIN D ANALOG-TYPE		
doxercalciferol	T1	ST
paricalcitol	T1	ST SP HD
paricalcitol (Zemplar)	T1	ST SP HD
RAYALDEE	T3	ST
ZEMPLAR (paricalcitol)	T4	ST SP HD
UNCLASSIFIED DRUG PRODUCTS (Miscellaneous)		
ABORTIFACIENT-PROGESTERONE RECEPTOR ANTAGONISTS		
MIFEPR	T3	
mifepristone 200 mg tablet	T1	
AGENTS TO TX PERIODIC PARALYSIS - CARBON ANHYD INH		
dichlorphenamide (Keveyis)	T1	PA SP
AMMONIA INHIBITORS		
CARBAGLU (carglumic acid)	T4	PA SP HD
carglumic acid (Carbaglu)	T1	PA SP HD
AMYLOIDOSIS AGENTS-TRANSTHYRETIN (TTR) SUPPRESSION		
TEGSEDI	T4	PA SP HD
ANTI-ALCOHOLIC PREPARATIONS		
acamprosate calcium	T1	
disulfiram	T1	
CI ESTERASE INHIBITORS		
HAEGarda 2,000 UNIT VIAL	T4	PA QL (24 vls/28 days) SP HD
HAEGarda 3,000 UNIT VIAL	T4	PA QL (16 vls/28 days) SP HD

T1 – Generics

T2 – Preferred Brands

T3 – Non-Preferred Brands

T4 – Brand Specialty

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List of Prescription Medications

UNCLASSIFIED DRUG PRODUCTS (Miscellaneous) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
CALCIMIMETIC,PARATHYROID CALCIUM ENHANCER		
<i>cinacalcet hcl (Sensipar)</i>	T1	PA SP
COMPOUNDING KIT		
FIRST-MOUTHWASH BLM	T3	
CRYOPRESERVATIVE AGENTS		
<i>dimethyl sulfoxide</i>	T1	
DRUGS TO TREAT HEREDITARY TYROSINEMIA		
<i>nitisinone (Orfadin)</i>	T1	PA SP HD
NITYR	T4	PA SP
ORFADIN	T4	PA SP
ORFADIN (<i>nitisinone</i>)	T4	PA SP
DRUGS TO TX GAUCHER DX-TYPE I, SUBSTRATE REDUCING		
CERDELGA	T4	PA QL (56 caps/28 days) SP HD
<i>miglustat (Zavesca)</i>	T1	PA QL (90 caps/30 days) SP
ENVIRONMENT ALLERGENS AND IRRITANTS, OTHER		
T.R.U.E. TEST	T3	
GENERAL INHALATION AGENTS		
HYPER-SAL	T3	
<i>nebusal 3% vial</i>	T1	
NEBUSAL 6% VIAL	T3	
<i>sodium chloride for inhalation</i>	T1	
<i>sodium chloride 0.9% inhal vfl</i>	T1	
<i>sodium chloride 10% vial</i>	T1	
<i>sodium chloride 3% vial</i>	T1	
<i>sodium chloride 7% vial</i>	T1	
GENETIC D/O TX - SMN PROTEIN DEFICIENCY TREATMENT		
EVRYSDI 5 MG TABLET	T4	PA QL (30 tabs/30 days) SP HD
EVRYSDI 60 MG/80 ML(0.75MG/ML)	T4	PA QL (240 mls/30 days) SP HD
GLUCOSYL CERAMIDE SYNTHASE (GCS) INHIBITOR		
OPFOLDA	T4	PA QL (8 caps/fill) SP HD
HOMEOPATHIC DRUGS		
VERTIGOHEEL	T3	
MENOPAUSAL SYMPTOMS SUPPRESSANT-NK3 RECEPTOR ANTAG		
VEOZAH	T3	

T1 – Generics

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List of Prescription Medications

UNCLASSIFIED DRUG PRODUCTS (Miscellaneous) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
MENOPAUSAL SYMPTOMS SUPPRESSANT - SSRIS		
paroxetine mesylate (Brisdelle)	T1	ST QL (30 caps/fill) HD
METABOLIC DISEASE ENZYME REPLACE, HYPOPHOSPHATASIA		
STRENSIQ	T4	PA SP
METALLIC POISON, AGENTS TO TREAT		
CHEMET	T2	PA
deferasirox (Exjade)	T1	PA SP HD
deferasirox (Jadenu Sprinkle)	T1	PA SP HD
deferasirox (Jadenu)	T1	PA SP HD
deferiprone (Ferriprox (3 Times A Day))	T1	PA SP HD
FERRIPROX (2 TIMES A DAY)	T4	PA SP
FERRIPROX (3 TIMES A DAY) (deferiprone)	T4	PA SP
FERRIPROX 100 MG/ML SOLUTION	T4	PA SP
FERRIPROX 500 MG TABLET (deferiprone)	T4	PA SP
GALZIN	T4	SP
RADIOGARDASE	T3	
SYPRINE (trientine hcl)	T4	PA SP HD
NATRIURETIC PEPTIDES		
VOXZOGO	T4	PA SP HD
NEONATAL FC RECEPTOR (FCRN) INHIBITORS		
VYVGART HYTRULO	T4	PA SP HD
PHARMACOLOGICAL CHAPERONE-ALPHA-GALACTOSID.A STABZ		
GALAFOLD	T4	PA QL (15 caps/fill) SP HD
PKU TX AGENT-COFACTOR OF PHENYLALANINE HYDROXYLASE		
sapropterin dihydrochloride (Kuvan)	T1	PA SP
sapropterin dihydrochloride (Kuvan)	T1	PA SP HD
PROTEIN STABILIZERS		
ATTRUBY	T4	PA SP
VYNDAMAX	T4	PA SP HD
VYNDAQEL	T4	PA SP HD
RETINOIC ACID RECEPTOR (RAR) AGONISTS		
SOHONOS 1 MG, 1.5 MG CAPSULE	T4	PA QL (112 caps/fill) SP
SOHONOS 10 MG CAPSULE	T4	PA QL (56 caps/fill) SP
SOHONOS 2.5 MG CAPSULE	T4	PA QL (140 caps/fill) SP
SOHONOS 5 MG CAPSULE	T4	PA QL (84 caps/fill) SP

T1 – Generics

T2 – Preferred Brands

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List of Prescription Medications

UNCLASSIFIED DRUG PRODUCTS (Miscellaneous) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
SOLVENTS		
CVS ISOPROPYL ALCOHOL 91%	T3	
<i>cvs isopropyl alcohol 91%</i>	T1	
CVS ISOPROPYL RUB ALCOHOL 70%	T3	
<i>cvs isopropyl rub alcohol 70%</i>	T1	
<i>eql isopropyl alcohol 91%</i>	T1	
<i>eql isopropyl rub alcohol 70%</i>	T1	
FT ISOPROPYL ALCOHOL 91%	T3	
FT ISOPROPYL RUB ALCOHOL 70%	T3	
GNP ISOPROPYL ALCOHOL 70%	T3	
<i>gnp isopropyl alcohol 99%</i>	T1	
<i>hm isopropyl alcohol 70%</i>	T1	
<i>hm isopropyl alcohol 91%</i>	T1	
INSTACLEAN	T2	
ISOPROPANOL	T2	
<i>isopropyl 70% alcohol</i>	T1	
<i>isopropyl alcohol</i>	T1	
ISOPROPYL ALCOHOL	T3	
<i>isopropyl alcohol 70%</i>	T1	
<i>isopropyl alcohol 91%</i>	T1	
<i>isopropyl alcohol 99%</i>	T1	
<i>isopropyl rubbing alcohol 70%</i>	T1	
ISOPROPYL RUBBING ALCOHOL 70%	T3	
ISOPROPYL RUBBING ALCOHOL 91%	T3	
<i>kro isopropyl alcohol 91%</i>	T1	
MURI-LUBE MINERAL OIL	T2	
<i>polyethylene glycol</i>	T1	
<i>qc isopropyl alcohol 91%</i>	T1	
<i>qc isopropyl rubbing alcohol</i>	T1	
<i>ra isopropyl alcohol 70%</i>	T1	
<i>ra isopropyl alcohol 91%</i>	T1	
<i>sm isopropyl alcohol 70%</i>	T1	
<i>swan isopropyl alcohol 70%</i>	T1	
SUSPENDING AGENTS		
GELFILM	T3	

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List of Prescription Medications

UNCLASSIFIED DRUG PRODUCTS (Miscellaneous) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
SUSPENDING AGENTS (cont.)		
HYDROXYPROPYLCELLULOSE	T2	
HYPROMELLOSE	T2	
TREATMENT OF HYPERPHAGIA IN PRADER-WILLI SYNDROME		
VYKAT XR	T4	PA SP
UNCLASSIFIED DRUG PRODUCTS (Nutritional/Dietary)		
METABOLIC DEFICIENCY AGENTS		
<i>betaine</i> (Cystadane)	T1	PA SP
CARNITOR (<i>levocarnitine</i> (with sugar))	T3	
CARNITOR (<i>levocarnitine</i>)	T3	
CARNITOR SF (<i>levocarnitine</i>)	T3	
<i>levocarnitine</i> 4 gm/20 ml vial	T1	
<i>levocarnitine</i> (Carnitor Sf)	T1	
<i>levocarnitine</i> (Carnitor)	T1	
<i>levocarnitine</i> (with sugar) (Carnitor)	T1	
UNCLASSIFIED DRUG PRODUCTS (Osteoporosis Products)		
BONE FORMATION STIM. AGENTS - PARATHYROID HORMONE		
BONSITY (<i>teriparatide</i>)	T4	PA QL (1 pens/28 days) SP
<i>teriparatide</i> 560 mcg/2.24ml pen (Bonsity)	T1	PA QL (1 pens/28 days) SP HD
<i>teriparatide</i> 560 mcg/2.24ml pen (Forteo)	T1	PA QL (1 pen/28 days) SP HD
TERIPARATIDE 560 MCG/2.24 ML	T4	PA QL (1 pens/28 days) SP
BONE RESORPTION INHIBITOR AND VITAMIN D COMBS.		
FOSAMAX PLUS D	T3	ST QL (4 tabs/28 days) HD
BONE RESORPTION INHIBITORS		
ACTONEL 150 MG TABLET (<i>risedronate sodium</i>)	T3	ST QL (1 tab/30 days) HD
ACTONEL 35 MG TABLET (<i>risedronate sodium</i>)	T3	ST QL (4 tabs/28 days) HD
<i>alendronate sod</i> 70 mg/75 ml	T1	QL (300 mls/28 days) HD
<i>alendronate sodium</i> 10 mg tab	T1	QL (30 tabs/fill) HD
<i>alendronate sodium</i> 35 mg tab	T1	QL (4 tabs/28 days) HD
<i>alendronate sodium</i> 40 mg tab	T1	HD
<i>alendronate sodium</i> 5 mg tablet	T1	QL (30 tabs/fill) HD
<i>alendronate sodium</i> 70 mg tab (Fosamax)	T1	QL (4 tabs/28 days) HD
ATELVIA (<i>risedronate sodium</i>)	T3	ST QL (4 tabs/28 days) HD
BINOSTO	T3	ST QL (4 tabs/28 days) HD

T1 – Generics

T2 – Preferred Brands

T3 – Non-Preferred Brands

T4 – Brand Specialty

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 (Osteoporosis Products) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
BONE RESORPTION INHIBITORS (cont.)		
EVISTA (<i>raloxifene hcl</i>)	T3	HD
FOSAMAX (<i>alendronate sodium</i>)	T3	ST QL (4 tabs/28 days) HD
<i>ibandronate sodium</i>	T1	QL (1 tab/30 days) HD
<i>raloxifene hcl</i> (Evista)	T1	HD PPACA
<i>risedronate sodium</i> (Atelvia)	T1	QL (4 tabs/28 days) HD
<i>risedronate sodium 150 mg tab</i> (Actonel)	T1	QL (1 tab/30 days) HD
<i>risedronate sodium 30 mg tab</i>	T1	QL (30 tabs/fill) HD
<i>risedronate sodium 35 mg tab</i> (Actonel)	T1	QL (4 tabs/28 days) HD
<i>risedronate sodium 5 mg tablet</i>	T1	QL (30 tabs/fill) HD
UNCLASSIFIED DRUG PRODUCTS (Pain Relief And Inflammatory Disease)		
ANTI-INFLAM. INTERLEUKIN-1 RECEPTOR ANTAGONIST		
ARCALYST	T4	PA QL (4 vls/28 days) SP HD
FIBROMYALGIA AGENTS, SEROTONIN-NOREPINEPHRINE INHIB		
SAVELLA 100 MG TABLET	T2	ST QL (60 tabs/30 days)
SAVELLA 12.5 MG TABLET	T2	ST QL (60 tabs/30 days)
SAVELLA 25 MG TABLET	T2	ST QL (60 tabs/30 days)
SAVELLA 50 MG TABLET	T2	ST QL (60 tabs/30 days)
SAVELLA TITRATION PACK	T2	ST QL (55 tabs/30 days)
IMMUNOMODULATOR, B-LYMPHOCYTE STIM (BLYS)-SPEC INHIB		
BENLYSTA	T4	PA QL (4 mls/28 days) SP HD
UNCLASSIFIED DRUG PRODUCTS (Seizure Disorders)		
NEUROPATHIC AGENTS		
<i>pregabalin</i> (Lyrica Cr)	T1	PA HD
UNCLASSIFIED DRUG PRODUCTS (Skin Conditions)		
INTERLEUKIN-13 (IL-13) INHIBITORS, MAB		
ADBRY	T4	PA QL (4 syringes/28 days) SP HD
ADBRY AUTOINJECTOR	T4	PA QL (2 auto-injs/28 days) SP HD
EBGLYSS PEN	T4	PA QL (4 mls/28 days) SP
EBGLYSS SYRINGE	T4	PA SP
JANUS KINASE (JAK) INHIBITORS		
LITFULO	T4	PA QL (28 caps/28 days) SP HD
WOUND HEALING AGENTS, LOCAL		
FILSUEZ	T4	PA SP

T1 – Generics

T2 – Preferred Brands

T3 – Non-Preferred Brands

T4 – Brand Specialty

PA – Prior Authorization

QL – Quantity Limit

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List of Prescription Medications

UNCLASSIFIED DRUG PRODUCTS (Substance Abuse)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
OPIOID WITHDRAWAL THER, ALPHA-2 ADRENERGIC AGONIST		
<i>lofexidine hcl</i> (Lucemyra)	T1	PA QL (224 tabs/30 days)
OPIOID WITHDRAWAL THERAPY AGENTS, OPIOID-TYPE		
<i>buprenorphine hcl</i>	T1	
<i>buprenorphine hcl/naloxone hcl</i>	T1	
<i>buprenorphine hcl/naloxone hcl</i> (Suboxone)	T1	
ZUBSOLV	T2	
UNCLASSIFIED DRUG PRODUCTS (Transplant Medications)		
RHO KINASE INHIBITOR		
REZUROCK	T4	PA QL (30 tabs/fill) SP
UNCLASSIFIED DRUG PRODUCTS (Urinary Tract Conditions)		
BENIGN PROSTATIC HYPERPLASIA/MICTURITION AGENTS		
<i>alfuzosin hcl</i> (Uroxatral)	T1	HD
<i>dutasteride</i> (Avodart)	T1	ST HD
<i>finasteride</i> (Proscar)	T1	HD
FLOMAX (<i>tamsulosin hcl</i>)	T3	ST HD
PROSCAR (<i>finasteride</i>)	T3	ST HD
<i>silodosin</i> (Rapaflo)	T1	HD
<i>tamsulosin hcl</i> (Flomax)	T1	HD
BPH 5-ALPHA-REDUCTASE INHIB-ALPHAI-ADRENOCEP ANTAG		
<i>dutasteride/tamsulosin hcl</i> (Jalyn)	T1	ST HD
JALYN (<i>dutasteride/tamsulosin hcl</i>)	T3	ST HD
CYSTINE-DEPLETING AGENTS, NEPHROPATHIC CYSTINOSIS		
CYSTAGON	T4	SP
ENDOTHELIN RECEPTOR ANTAGONISTS		
VANRAFIA	T4	PA SP
KIDNEY STONE AGENTS		
<i>THIOLA EC</i> (<i>tiopronin</i>)	T4	PA SP
<i>tiopronin 100 mg tablet</i> (Thiola)	T1	PA SP
<i>tiopronin</i> (Thiola Ec)	T1	PA SP
<i>tiopronin dr 100 mg tablet</i> (Thiola Ec)	T1	PA SP
<i>tiopronin dr 100 mg tablet</i> (Thiola Ec)	T1	PA SP HD
<i>tiopronin dr 300 mg tablet</i> (Thiola Ec)	T1	PA SP
<i>tiopronin dr 300 mg tablet</i> (Thiola Ec)	T1	PA SP HD

T1 – Generics

T2 – Preferred Brands

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T4 – Brand Specialty

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List of Prescription Medications

UNCLASSIFIED DRUG PRODUCTS (Urinary Tract Conditions) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
OVERACTIVE BLADDER AGENTS, BETA-3 ADRENERGIC RECEPTOR ANTAGONISTS		
GEMTESA	T3	HD
<i>mirabegron</i> (Myrbetriq)	T1	HD
MYRBETRIQ	T2	HD
MYRBETRIQ (<i>mirabegron</i>)	T2	HD
URINARY TRACT ANTISPASMODIC, M(3) SELECTIVE ANTAGONISTS		
<i>darifenacin hydrobromide</i>	T1	HD
<i>solifenacain succinate</i> (Vesicare)	T1	HD
URINARY TRACT ANTISPASMODIC/ANTIINCONTINENCE AGENT		
<i>fesoterodine fumarate</i> (Toviaz)	T1	HD
<i>flavoxate hcl</i>	T1	HD
<i>oxybutynin 5 mg/5 ml soln cup</i>	T1	HD
<i>oxybutynin chloride</i>	T1	HD
OXYTROL	T3	ST QL (8 patches/28 days)) HD
<i>tolterodine tartrate</i> (Detrol La)	T1	HD
<i>tolterodine tartrate</i> (Detrol)	T1	HD
<i>trospium chloride</i>	T1	HD
UNCLASSIFIED DRUG PRODUCTS (Weight Management)		
APPETITE STIM. FOR ANOREXIA, CACHEXIA, WASTING SYND.		
<i>megestrol 625 mg/5 ml susp</i>	T1	
<i>megestrol acet 40 mg/ml susp</i>	T1	
<i>megestrol acet 400 mg/10 ml</i>	T1	
VITAMINS (Nutritional/Dietary)		
ANTIOXIDANT MULTIVITAMIN COMBINATIONS		
50 PLUS ADULT EYE HEALTH	T3	
<i>a/c/e/zinc ox/cupric ox/lutein</i>	T1	
ADULT 50 PLUS EYE HEALTH	T3	
ANTIOXIDANT FORMULA	T3	
EQ VISION FORMULA TABLET	T2	
<i>eql eye health plus lutein tab</i>	T1	
EYE HEALTH AND LUTEIN	T3	
EYE HEALTH WITH LUTEIN	T3	
EYE HEALTH PLUS LUTEIN TABLET	T3	
EYE MULTIVITAMIN	T2	

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List of Prescription Medications

VITAMINS (Nutritional/Dietary) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ANTIOXIDANT MULTIVITAMIN COMBINATIONS (cont.)		
EYE MULTIVITAMIN WITH LUTEIN	T3	
EYEPROTECT	T3	
<i>gnp healthy eyes tablet</i>	T1	
HEALTHY EYES TABLET	T2	
<i>healthy eyes tablet</i>	T1	
I-CAPS	T2	
ICAPS AREDS FORMULA DR TABLET	T3	
ICAPS AREDS2	T3	
LUTEIN PLUS WITH ZEAXANTHIN	T3	
LIPOTRIAD	T3	
LIPOTRIAD VISIONARY	T3	
MACULAR BENEFITS	T3	
MACULAR HEALTH FORMULA	T3	
MACUVEX	T3	
MACUZIN	T3	
MULTI-BETIC	T2	
OCULAR VITAMINS	T3	
OCUVEL	T3	
OCUVITE ADULT 50 PLUS	T2	
OCUVITE WITH LUTEIN	T2	
PRESERVISION AREDS	T2	
PRESERVISION LUTEIN	T2	
VISION OPTIMIZER	T3	
VISION FORMULA TABLET	T3	
VISION FORMULA WITH LUTEIN	T3	
VISTA ADVANCED AREDS2	T3	
<i>vit a/vit c/vit e/zinc/copper</i>	T1	
<i>vits a,c,e/lutein/minerals</i>	T1	
VITEYES AREDS 2 PLUS MULTIVIT	T3	
BIOFLAVONOIDS		
<i>bioflav/lemon/vit bcomp,c</i>	T1	
<i>bioflav/lemon/vit bcomp,c</i> (Lipo-Flavonoid Plus)	T1	
CITRUS BIOFLAVONOIDS	T3	
EAR HEALTH PLUS CAPLET	T3	

T1 – Generics

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List of Prescription Medications

VITAMINS (Nutritional/Dietary) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
BIOFLAVONOIDS (cont.)		
ear health plus caplet (Lipo-Flavonoid Plus)	T1	
FLAVOVIT	T3	
FLOGEN	T3	
INNER EAR PLUS	T3	
LIPO FLAVONOID	T3	
LIPO-FLAVONOID PLUS (<i>bioflav,lemon/vit bcomp,c</i>)	T2	
QUERCETIN	T3	
<i>rutin</i>	T1	
VASCULERA	T3	
VASOFLEX D1	T3	
VENALIV	T3	
FOLIC ACID PREPARATIONS		
COBALEFOL	T3	
cvs folic acid 800 mcg tablet	T1	PPACA
DENOVO	T3	
DEPLIN-ALGAL OIL (<i>levomefolate/algal oil</i>)	T3	
DEPLIN FC	T3	
ENLYTE	T3	
FA-8	T3	
FOLETRA	T3	
<i>folic acid 0.4 mg, 0.8 mg tablet</i>	T1	PPACA
<i>folic acid 1 mg tablet</i>	T1	
<i>folic acid 1,000 mcg tablet</i>	T1	
FOLIC ACID 20 MG CAPSULE	T3	
<i>folic acid 400 mcg tablet</i>	T1	PPACA
FOLIC ACID 5 MG CAPSULE	T3	
<i>folic acid 5 mg/ml vial</i>	T1	
<i>folic acid 50 mg/10 ml vial</i>	T1	
FOLIC ACID 800 MCG CAPSULE	T3	
<i>folic acid 800 mcg tablet</i>	T1	PPACA
<i>folic acid/b6/ca phos/ginger</i>	T1	
<i>ft folic acid 400 mcg, 800 mcg tablet</i>	T1	PPACA
FOLIKA-V	T3	
FOLITE	T3	

T1 – Generics

T2 – Preferred Brands

T3 – Non-Preferred Brands

T4 – Brand Specialty

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List of Prescription Medications

VITAMINS (Nutritional/Dietary) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
FOLIC ACID PREPARATIONS (cont.)		
GENICIN VITA-Q	T3	
gnp folic acid 400 mcg tablet	T1	PPACA
hm folic acid 400 mcg tablet	T1	PPACA
HYLAZINC	T3	
levomefolate calcium	T1	
levomefolate/algal oil (Deplin-Algal Oil)	T1	
METHYLFOLATE	T3	
MI-VITE RX	T3	
PUREVITA FOLIC ACID	T3	
ra folic acid 0.4 mg tablet	T1	PPACA
ra folic acid 800 mcg tablet	T1	PPACA
sm folic acid 0.4 mg tablet	T1	PPACA
sm folic acid 400 mcg tablet	T1	PPACA
sv folic acid 800 mcg tablet	T1	PPACA
true folic acid 1600mcg dfe tb	T1	
true folic acid 667 mcg dfe tb	T1	PPACA
XAQUIL XR	T3	
GERIATRIC VITAMIN PREPARATIONS		
a thru z advanced formula tab (Vision Plus Lutein)	T1	
a thru z select tablet (Vision Plus Lutein)	T1	
CENTRUM SILVER CHEWABLE TABLET	T2	
eldertonic elixir	T1	
ELDERTONIC LIQUID	T3	
GERITOL COMPLETE	T2	
GERITOL TONIC	T2	
multivit with iron,minerals	T1	
multivit with minerals/lutein (Vision Plus Lutein)	T1	
REQ49+	T3	
SPECTRAVITE ADULT 50+	T3	
VISION PLUS LUTEIN (multivit with minerals/lutein)	T2	
MULTIVITAMIN PREPARATIONS		
a thru z advanced formula tab	T1	
A THRU Z MEN'S ULTIMATE TABLET	T2	
A THRU Z MEN'S ULTIMATE TABLET	T2	

T1 – Generics

T2 – Preferred Brands

T3 – Non-Preferred Brands

T4 – Brand Specialty

PA – Prior Authorization

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List of Prescription Medications

VITAMINS (Nutritional/Dietary) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
MULTIVITAMIN PREPARATIONS (cont.)		
A THRU Z SELECT MEN 50+ TABLET	T3	
a thru z select multivit tab	T1	
a thru z select multivit tab (Centrum Silver)	T1	
a thru z select multivit tab (Certavite Senior)	T1	
a thru z select tablet (Centrum Silver)	T1	
a thru z select tablet (Certavite Senior)	T1	
a thru z select women's tablet	T1	
a/c/e/zinc/sod selenate/copper	T1	
ABC COMPLETE ADULT	T2	
ABC COMPLETE MEN'S	T2	
ABC COMPLETE SENIOR WOMEN'S	T3	
ACTVNUTRIENTS	T3	
ACTVNUTRIENTS PERFORMANCE	T3	
ADEK GUMMIES PLUS ZINC	T3	
ADULT MULTI GUMMIES	T3	
ADULT MULTIVITAMIN GUMMIES	T3	
ADULT ONE DAILY GUMMIES	T3	
ADULTS' DAILY FORMULA	T3	
ADULTS MULTI	T3	
ADULTS MULTIVITAMIN	T3	
ADVANCED MULTI EA	T3	
ALIVE ADULT ULTRA POTENCY	T3	
ALIVE COMPLETE PREMIUM PRENATL	T3	
ALIVE DAILY ENERGY	T3	
ALIVE DAILY SUPPORT PRENATAL	T3	
ALIVE HAIR, SKIN AND NAILS	T3	
ALIVE MAX POTENCY	T3	
ALIVE MAX6 POTENCY	T3	
ALIVE MEN'S 50 PLUS GUMMY	T3	
ALIVE MEN'S ENERGY	T3	
ALIVE MEN'S GUMMY	T3	
ALIVE WOMEN'S ULTRA POTENCY	T3	
ALIVE PREMIUM PRENATAL	T3	
ALIVE WOMEN'S 50 PLUS	T3	

T1 – Generics

T2 – Preferred Brands

T3 – Non-Preferred Brands

T4 – Brand Specialty

PA – Prior Authorization

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List of Prescription Medications

VITAMINS (Nutritional/Dietary) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
MULTIVITAMIN PREPARATIONS (cont.)		
ALIVE WOMEN'S 50 PLUS COMPLETE	T3	
ALIVE WOMEN'S 50 PLUS ULTRA	T3	
ALIVE WOMEN'S ENERGY	T3	
ALIVE WOMEN'S GUMMY VITAMIN	T3	
ALIVE WOMEN'S MULTIVITAMIN	T3	
ALPHA BETIC MULTIVITAMIN	T3	
ALTRIXA	T3	
<i>amino acids/mv,tx,iron,mineral</i>	T1	
AMLADEX	T3	
ANIMI-3	T3	
AQUADEKS	T2	
BACMIN	T3	
BARIATRIC MULTIVITAMINS	T3	
<i>b-complex plus vitamin c cplt</i>	T1	
<i>b-complex with vitamin c</i>	T1	
<i>b-complex with vitamin c (Support-500)</i>	T1	
<i>b-complex w-vitamin c caplet</i>	T1	
BEROCCA	T3	
<i>beta-carotene(a)-vits c,e/mins</i>	T1	
BIO-35	T3	
BLADDER 2.2	T2	
BODY, HAIR, SKIN AND NAILS	T3	
CENTRAL-VITE	T3	
CENTRAL-VITE WOMEN'S MATURE (<i>multivit-min/iron/folic/lutein</i>)	T3	
CENTRAVITES ADULTS	T3	
CENTRUM	T2	
CENTRUM ADULT 50 PLUS	T3	
CENTRUM ADULT 50 FRESH-FRUITY	T3	
CENTRUM CHEWABLES ADULTS TAB	T2	
CENTRUM CHEWABLES ADULTS TAB	T3	
CENTRUM COMPLETE	T2	
CENTRUM FLAVOR BURST ADULT	T3	
CENTRUM MEN	T2	
CENTRUM MEN 50 PLUS	T3	

T1 – Generics

T2 – Preferred Brands

T3 – Non-Preferred Brands

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List of Prescription Medications

VITAMINS (Nutritional/Dietary) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
MULTIVITAMIN PREPARATIONS (cont.)		
CENTRUM MEN MULTIGUMMY	T3	
CENTRUM MEN'S TABLET	T2	
CENTRUM MULTI PLUS BEAUTY	T3	
CENTRUM MULTI PLUS OMEGA-3	T3	
CENTRUM MULTIGUMMIES	T3	
CENTRUM WOMEN 50 PLUS	T3	
CENTRUM WOMEN MULTIGUMMY	T3	
<i>centrum women tablet</i> (Certavite-Antioxidant)	T1	
<i>centrum women tablet</i> (Tab-A-Vite Multivit With Iron)	T1	
CENTRUM SILVER MEN	T3	
CENTRUM SILVER TABLET (<i>multivit-min/fa/lycopen/lutein</i>)	T3	
CENTRUM SILVER ULTRA MEN'S (<i>multivit-min/fa/lycopen/lutein</i>)	T2	
CENTRUM SILVER WOMEN (<i>multivit-min/iron/folic/lutein</i>)	T3	
CENTRUM SPECIALIST ENERGY	T3	
CENTRUM SPECIALIST HEART	T2	
CENTRUM ULTRA MEN'S	T2	
CENTRUM WOMEN IMMUNE MINI	T3	
<i>certavite-antioxidant tablet</i> (Certavite-Antioxidant)	T1	
CERTAVITE-ANTIOXIDANT TABLET (<i>multivitamin/iron/folic acid</i>)	T3	
<i>certavite-antioxidant tablet</i> (Tab-A-Vite Multivit With Iron)	T1	
COMPLETE MEN	T2	
COMPLETE MEN 50 PLUS	T3	
COMPLETE MULTIVITAMIN-MINERAL	T3	
CONCEPT DHA (<i>mvn-min75/iron/iron ps/om3/dha</i>)	T3	
CONCEPT OB (<i>mvn-min 74/iron fum/iron/fa</i>)	T3	
CORVITE	T3	
CULTURELLE PROBIOTIC-MULTIVIT	T3	
<i>cvs adult multivitamin gummy</i>	T1	
<i>cvs b-complex-vit c caplet</i>	T1	
<i>cvs hair, skin and nails cplt</i>	T1	
<i>cvs one daily essential tablet</i> (Daily-Vite)	T1	
DAILY GUMMIES	T3	
DAILY MULTIVITAMIN	T3	
<i>daily-vite tablet</i> (Daily-Vite)	T1	

T1 – Generics

T2 – Preferred Brands

T3 – Non-Preferred Brands

T4 – Brand Specialty

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List of Prescription Medications

VITAMINS (Nutritional/Dietary) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
MULTIVITAMIN PREPARATIONS (cont.)		
DAILY-VITE TABLET (<i>multivitamin with folic acid</i>)	T3	
DAYAVITE	T3	
DECUBI VITE	T3	
DEKAS BARIATRIC	T3	
DEKAS ESSENTIAL	T3	
DEKAS PLUS	T3	
DERMACINRX FOLIFLEX	T3	
DERMACINRX FOLITIN-Z	T3	
DERMACINRX MULTITAM	T3	
DERMACINRX RIBOTIN-E	T3	
DERMACINRX VENEXA	T3	
DERMACINRX VENEXA FE	T3	
DERMACINRX VENTRIXYL	T3	
DERMACINRX VENTRIXYL FE	T3	
DERMACINRX VITRAMYN	T3	
DERMACINRX VITRANOL	T3	
DERMACINRX VITRANOL FE	T3	
DERMACINRX VITREXATE	T3	
DERMACINRX VITREXATE FE	T3	
DERMACINRX ZINTREXYL-C	T3	
DIABETES HEALTH FORMULA	T3	
DIABETES HEALTH PACK	T3	
DIABETIC VITAMIN	T3	
DIALYVITE 800 WITH IRON	T3	
DIATROL	T3	
ELON MATRIX 5000 COMPLETE	T3	
ENBRACE HR	T3	
ENDUR-VM IRON-FREE	T3	
ENDUR-VM WITH IRON	T3	
EQ ONE DAILY WOMEN'S HEALTH TB	T3	
EQ ONE DAILY MEN'S TABLET	T2	
EQ ONE DAILY WOMEN'S TABLET	T2	
ESSENTIAL MAN	T3	
ESSENTIAL MAN 50+	T3	

T1 – Generics

T2 – Preferred Brands

T3 – Non-Preferred Brands

T4 – Brand Specialty

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List of Prescription Medications

VITAMINS (Nutritional/Dietary) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
MULTIVITAMIN PREPARATIONS (cont.)		
ESSENTIAL WOMAN 50+	T3	
ESTROVEN MENOPAUSE	T3	
<i>fa/mv,ca,iron,min/lycopene/lut</i>	T1	
FATIGUE RELIEF COMPLEX (<i>bcomp,c/st.jhn wrt/s.gins/gpn</i>)	T3	
FINAZOL	T3	
FLORRAXYL	T3	
FOLAGENT DHA	T3	
FOLAMAX	T3	
FOLAMED DHA	T3	
<i>folic acid/multivit,iron,miner</i>	T1	
<i>folic acid/mv,iron,min/lutein</i>	T1	
FOLIC ACID-VIT B-6-VIT B-12	T3	
<i>folc/mvi ther-min/lycop/lut</i>	T1	
FOLIKA-CI	T3	
FOLIKA-MG	T3	
FORTAVIT	T3	
FREEDAVITE	T3	
<i>ft b complex plus vit c tablet</i>	T1	
FT HAIR, SKIN AND NAILS TABLET	T3	
<i>ft one daily men's tablet</i>	T1	
<i>ft one daily women's tablet</i>	T1	
GENADEK STEP 1	T3	
GENADEK STEP 2	T3	
GERBER GS PRENATAL NOURISH PLS	T3	
GNP B-COMPLEX PLUS VIT C TAB	T3	
<i>gnp one daily tablet</i>	T1	
HAIR FORMULA	T3	
HAIR, SKIN AND NAILS CAPLET	T3	
HAIR, SKIN AND NAILS SOFTGEL	T3	
HAIR, SKIN AND NAILS TABLET (<i>multivitamin/folic acid/biotin</i>)	T3	
HEARTBURN ACID REFLUX	T3	
<i>high potency multivitamin tab</i>	T1	
HIGH POTENCY MULTIVITAMIN TAB	T3	
<i>high potency multivitamin tab (Certavite-Antioxidant)</i>	T1	

T1 – Generics

T2 – Preferred Brands

T3 – Non-Preferred Brands

T4 – Brand Specialty

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
MULTIVITAMIN PREPARATIONS (cont.)		
<i>high potency multivitamin tab (Tab-A-Vite Multivit With Iron)</i>	T1	
HM HAIR, SKIN AND NAILS TABLET	T3	
HM MEN'S ONE DAILY TABLET	T2	
ICAPS MV	T2	
ICAPS TABLET	T2	
IMMUNERX	T3	
INFUVITE ADULT	T3	
K-PAX IMMUNE SUPPORT	T2	
<i>lecithin/pyridoxine/kelp</i>	T1	
<i>lmefolate/b3/copp/zn/sel/chrom</i>	T1	
MAXIMIN	T3	
MEBOLIC	T3	
MEN 50 PLUS ADVANCED ONE DAILY	T3	
MEN 50 PLUS MULTIVITAMIN	T3	
MEN'S 50 PLUS DAILY FORMULA	T3	
MEN'S 50 PLUS MULTIVITAMIN	T3	
MEN'S DAILY FORMULA	T3	
MEN'S DAILY GUMMIES	T3	
MEN'S DAILY PACK	T3	
MEN'S DAILY MULTIVITAMIN	T2	
MEN'S MULTIVITAMIN	T3	
MONOCAPS	T3	
MULTIA DAILY MULTIVITAMIN	T3	
MULTI FOR HER 50 PLUS	T3	
MULTI FOR HER SOFTGEL	T3	
<i>multi for her tablet</i>	T1	
MULTI PRO	T3	
MULTI-DAY PLUS MINERALS	T3	
MULTILEX TABLET	T3	
<i>multilex tablet</i>	T1	
MULTILEXT-M	T3	
<i>multivit 47/iron/folate 1/dha</i>	T1	
<i>multivit infusn,adult 1,vit k</i>	T1	
<i>multivit no.51/iron/folic acid</i>	T1	

T1 – Generics

T2 – Preferred Brands

T3 – Non-Preferred Brands

T4 – Brand Specialty

PA – Prior Authorization

QL – Quantity Limit

ST – Step Therapy

AGE – Age Requirement

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PPACA – No Cost-Share Preventive Medication

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List of Prescription Medications

VITAMINS (Nutritional/Dietary) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
MULTIVITAMIN PREPARATIONS (cont.)		
<i>multivit no.18/iron no.1/folic (Tandem Plus)</i>	T1	
<i>multivit with calcium,iron,min</i>	T1	
<i>multivit,calc,mins/iron/folic</i>	T1	
<i>multivit,iron,minerals/lutein</i>	T1	
<i>multivit-minerals/folic acid</i>	T1	
<i>multivit,stress formula/zinc (Stress Formula With Zinc)</i>	T1	
<i>multivit/iron/folic acid/hb179</i>	T1	
<i>multivitamin</i>	T1	
MULTI-VITAMIN	T3	
MULTIVITAMIN-MULTIMINERAL	T3	
<i>multivitamin combination no.55</i>	T1	
<i>multivitamin combination no.56</i>	T1	
MULTIVITAMIN GUMMIES	T3	
MULTIVITAMIN LIQUID	T3	
<i>multivitamin tablet</i>	T1	
<i>multivitamin with folic acid (Daily-Vite)</i>	T1	
<i>multivitamin with iron</i>	T1	
MULTIVITAMIN WITH MINERALS	T3	
<i>multivitamin with minerals</i>	T1	
<i>multivitamin,stress formula</i>	T1	
<i>multivitamin,ther and minerals</i>	T1	
<i>multivitamin,therapeutic</i>	T1	
<i>multivitamin,therapeutic (Oncovite)</i>	T1	
<i>multivitamin/ferrous gluconate</i>	T1	
<i>multivitamin/iron/folic acid (Certavite-Antioxidant)</i>	T1	
<i>multivitamin/iron/folic acid (Tab-A-Vite Multivit With Iron)</i>	T1	
MULTI-VITE	T3	
<i>multivit-min/fa/lycopen/lutein</i>	T1	
<i>multivit-min/fa/lycopen/lutein (Centrum Silver)</i>	T1	
<i>multivit-min/ferrous gluconate</i>	T1	
<i>multivit-min/folic acid/biotin</i>	T1	
<i>multivit-min/iron fum/folic ac</i>	T1	
<i>multivit-min/iron/folic/lutein (Central-Vite Women'S Mature)</i>	T1	
<i>multivit-min/iron/folic/lutein (Centrum Silver Women)</i>	T1	

T1 – Generics

T2 – Preferred Brands

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T4 – Brand Specialty

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List of Prescription Medications

VITAMINS (Nutritional/Dietary) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
MULTIVITAMIN PREPARATIONS (cont.)		
multivit-min69/iron/folic acid	T1	
multivit-minerals/fa/lycopene	T1	
multivit-minerals/folic acid (One-A-Day)	T1	
multivit-minerals/folic/ginkgo	T1	
multivit-mins no.7/folic acid	T1	
multivit-mins/iron/folic/lycop	T1	
mv,min 59/iron/folic/docusate	T1	
mv,cal,min/iron/folic acid/lut	T1	
mv,iron,min/ginkgo/pan.ginseng	T1	
mv-min 59/iron/folic/docusate	T1	
mv-min/iron/folic ac/vit k/lut	T1	
mv-mins 71/iron/folic no.1/dha	T1	
mv-mins/folic/lycopene/ginkgo	T1	
mv-mn/folic ac/calcium/vit k1	T1	
mv-mn/folic acid/lutein/hrb178	T1	
mvn no.53/iron/folic/dss/dha	T1	
mvn-min 74/iron fum/iron/fa (Concept Ob)	T1	
mvn-min75/iron/iron ps/om3/dha (Concept Dha)	T1	
MVW MODULATR FORM MINI MULTIVT	T3	
NEEVODHA	T3	
NEOVITE	T3	
NESTABS ONE	T3	
NICOMIDE	T3	
NIVA-PLUS (multivit-mins60/iron fum/folic)	T3	
NIVA-PLUS (multivit-min 60/iron fum/folic)	T3	
NUTRALYN	T3	
NUTRIVIT	T2	
OB COMPLETE	T3	
OBSTETRIX ONE	T3	
OCUVITE EYE PLUS MULTI	T3	
om-3/dha/epa/b12/fa/b6/phytost	T1	
OMNIVEX	T3	
ONCOVITE (multivitamin,therapeutic)	T2	
ONE DAILY ESSENTIALS	T3	

T1 – Generics

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List of Prescription Medications

VITAMINS (Nutritional/Dietary) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
MULTIVITAMIN PREPARATIONS (cont.)		
ONE DAILY ESSENTIAL TABLET	T3	
<i>one daily essential tablet</i>	T1	
<i>one daily essential tablet (Daily-Vite)</i>	T1	
ONE DAILY HEALTHY WEIGHT	T3	
ONE DAILY MEN'S 50 PLUS	T3	
ONE DAILY MEN'S 50 PLUS D3	T3	
ONE DAILY MEN'S HEALTH	T3	
ONE DAILY MEN'S MULTIVITAMIN	T3	
<i>one daily multivit-mineral tab</i>	T1	
ONE DAILY MULTIVIT-MINERAL TAB	T3	
<i>one daily multivitamin tab</i>	T1	
ONE DAILY MULTIVITAMIN TABLET	T3	
<i>one daily multivitamin tablet (Daily-Vite)</i>	T1	
<i>one daily tablet</i>	T1	
ONE DAILY WOMEN 50 PLUS TAB	T3	
ONE DAILY WOMEN'S 50 PLUS ADV	T3	
ONE DAILY WOMEN'S 50+	T2	
ONE DAILY WOMEN'S FORMULA	T3	
<i>one daily women's health tab</i>	T1	
ONE DAILY WOMEN'S MULTIVITAMIN	T3	
ONE-A-DAY (<i>multivit-minerals/folic acid</i>)	T3	
ONE-A-DAY ENERGY	T3	
ONE-A-DAY MEN VITACRAVES	T3	
ONE-A-DAY MENOPAUSE FORMULA	T3	
ONE-A-DAY MEN'S	T2	
ONE-A-DAY MEN'S 50 PLUS	T2	
ONE-A-DAY MEN'S 50 PLUS (<i>mv-mins/folic/lycopene/ginkgo</i>)	T2	
ONE-A-DAY MEN'S COMPLETE	T3	
ONE-A-DAY PROACTIVE 65 PLUS	T3	
ONE-A-DAY VITACRAVES	T3	
ONE-A-DAY VITACRAVES IMMUNITY	T3	
ONE-A-DAY VITACRAVES OMEGA-3	T3	
ONE-A-DAY VITACRAVES SOUR	T3	
ONE-A-DAY WEIGHTSMART	T2	

T1 – Generics

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List of Prescription Medications

VITAMINS (Nutritional/Dietary) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
MULTIVITAMIN PREPARATIONS (cont.)		
one-a-day women's 50 plus tab (One-A-Day)	T1	
ONE-A-DAY WOMEN VITACRAVES	T3	
ONE-A-DAY WOMEN'S COMPLETE	T2	
ONE-A-DAY WOMEN'S HEALTHY SKIN	T3	
ONE-A-DAY WOMEN'S PETITES	T3	
ONE-A-DAY WOMEN'S TABLET	T2	
ONE-A-DAY WOMEN'S TABLET	T3	
ONE-DAILY MULTI	T3	
ONE-DAILY MULTI-VITAMIN-IRON	T3	
ONE-DAILY MULTIVITAMIN-MINERAL	T3	
ONEVITE	T3	
OPTIFAST	T3	
OPTISOURCE	T3	
OPURITY MULTIVITAMIN	T3	
POLYVITAMIN-IRON	T3	
PRENATE AM	T3	
PRENATE CHEWABLE	T3	
PRENATE ESSENTIAL	T3	
PRENATAL GUMMIES	T3	
PROCERV HP	T3	
PROFOLA	T3	
PRORENAL QD	T2	
PROTECT CARDIO AF	T3	
PROTECT IRON	T3	
PROTECT PLUS SO	T3	
PUREFE OB PLUS	T3	
PUREFE PLUS	T3	
QUINTABS	T3	
QUINTABS-M	T3	
ra one daily essential tablet (One-A-Day)	T1	
ra one daily women's tablet	T1	
REMEDIENT	T3	
sm b complex with vit c tablet	T1	
sm super b complex-c caplet	T1	

T1 – Generics

T2 – Preferred Brands

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List of Prescription Medications

VITAMINS (Nutritional/Dietary) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
MULTIVITAMIN PREPARATIONS (cont.)		
SOLO	T3	
SPECTRAVITE MEN 50 PLUS	T3	
SPECTRAVITE ULTRA MEN 50+	T3	
SPECTRAVITE ULTRA MEN'S	T3	
STRESS B-COMPLEX	T3	
<i>stress formula tablet</i>	T1	
STRESS FORMULA WITH ZINC TAB (<i>multivit,stress formula/zinc</i>)	T3	
<i>stress formula with zinc tab</i> (Stress Formula With Zinc)	T1	
<i>stress-c with zinc tablet</i> (Stress Formula With Zinc)	T1	
STROVITE FORTE (<i>multivit,iron,min 5/folic acid</i>)	T3	
STROVITE ONE	T3	
SUPER GINSENG MULTIVITAMIN	T3	
SUPER MULTIPLE-LOW IRON	T3	
SUPERIOR MEN'S MULTI	T3	
SUPPORT-500 (<i>b-complex with vitamin c</i>)	T3	
SV HAIR, SKIN AND NAILS CAPLET	T3	
TAB-A-VITE MULTIVIT WITH IRON	T3	
<i>tab-a-vite multivit with iron</i>	T1	
TAB-A-VITE MULTIVIT WITH IRON (<i>multivitamin/iron/folic acid</i>)	T3	
TANDEM PLUS (<i>multivit no.18/iron no.1/folic</i>)	T3	
<i>thera-m caplet</i>	T1	
<i>thera-m tablet</i>	T1	
TERA-M CAPLET	T3	
THERAGRAN-M PREMIER 50 PLUS	T3	
THERAMILL FORTE	T3	
THERANATAL LACTATION SUPPORT	T3	
THEREMS-H	T2	
TOBAKIENT	T3	
TRIVIA COMPLETE	T3	
TRUE MULTIVITAMIN	T3	
TRUEPLUS MULTIVITAMIN (<i>multivit-min/folic acid/vit k1</i>)	T3	
UDAMIN SP	T3	
ULTRA FREEDA	T3	
VITABEX PLUS	T3	

T1 – Generics

T2 – Preferred Brands

T3 – Non-Preferred Brands

T4 – Brand Specialty

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List of Prescription Medications

VITAMINS (Nutritional/Dietary) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
MULTIVITAMIN PREPARATIONS (cont.)		
VITACORE	T3	
VITAFUSION PRENATAL	T3	
VITAJOY ADULT MULTI	T3	
<i>vitamin b complex-vit c cap (Support-500)</i>	T1	
<i>vitamin b complex-vit c caplet</i>	T1	
<i>vitamin b complex-vitamin c tb</i>	T1	
VITAMIN D3-ALOE	T3	
VITAMINS A-D-E	T3	
VITREXYL	T3	
VITREXYL PLUS IRON	T3	
VITRUM 50 PLUS SENIOR	T2	
WELLESSE MULTIVITAMIN PLUS	T3	
WOMEN'S 50 PLUS ADVANCED	T3	
WOMEN'S 50 PLUS DAILY FORMULA	T3	
<i>women's daily formula caplet</i>	T1	
WOMEN'S DAILY FORMULA CAPLET	T2	
WOMEN'S DAILY FORMULA TABLET	T3	
WOMENS DAILY GUMMIES	T3	
WOMEN'S DAILY PACK	T3	
WOMEN'S MULTIVITAMIN	T3	
WOMEN'S MULTIVITAMIN W-BIOTIN	T3	
XYZBAC	T3	
ZYVANA	T3	
ZYVIT	T3	
NIACIN PREPARATIONS		
cvs niacin 400 mg capsule	T1	
ENDUR-AMIDE	T3	
ENDUR-THINE	T3	
<i>ft niacin 400 mg capsule</i>	T1	
<i>gnp niacin 250 mg tablet</i>	T1	
<i>gnp niacin 400 mg capsule</i>	T1	
<i>hm niacin tr 250 mg tablet (Slo-Niacin)</i>	T1	
<i>niacin</i>	T1	
<i>niacin (inositol niacinate)</i>	T1	

T1 – Generics

T2 – Preferred Brands

T3 – Non-Preferred Brands

T4 – Brand Specialty

PA – Prior Authorization

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List of Prescription Medications

VITAMINS (Nutritional/Dietary) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
NIACIN PREPARATIONS (cont.)		
niacin (Slo-Niacin)	T1	
NIACIN 100 MG CAPSULE	T3	
NIACINAMIDE 500 MG CAPSULE	T3	
niacin 100 mg tablet	T1	
niacin 250 mg tablet	T1	
niacin 50 mg tablet	T1	
niacin 500 mg capsule	T1	
niacin 500 mg capsule sa	T1	
NIACIN 500 MG SOFTGEL	T2	
niacin 500 mg tablet	T1	
niacin 750 mg tablet sa (Slo-Niacin)	T1	
NIACIN ER 1,000 MG TABLET	T2	
niacin er 250 mg tablet (Slo-Niacin)	T1	
niacin er 500 mg caplet	T1	
niacin er 500 mg capsule, tablet	T1	
niacin flush free 500 mg cap	T1	
NIACIN FLUSH FREE 750 MG CAP	T2	
niacin sa 250 mg capsule	T1	
niacin tr 250 mg capsule	T1	
niacin tr 250 mg tablet (Slo-Niacin)	T1	
niacin tr 500 mg caplet	T1	
niacin tr 500 mg tablet	T1	
niacinamide 500 mg tablet	T1	
NIACINAMIDE ER 500 MG TABLET	T3	
NO FLUSH NIACIN	T3	
PUREVITA VITAMIN B3	T3	
ra niacin 100 mg tablet	T1	
RA NIACIN 500 MG TABLET	T3	
ra niacin 500 mg tablet	T1	
SLO-NIACIN 250 MG TABLET (niacin)	T2	
slo-niacin 500 mg tablet	T1	
SLO-NIACIN 750 MG TABLET (niacin)	T2	
sv niacin flush free 500 mg	T1	
true vitamin b3 50 mg tablet	T1	

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List of Prescription Medications

VITAMINS (Nutritional/Dietary) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
NIACIN PREPARATIONS (cont.)		
true vitamin b3 500 mg tablet	T1	
TRUE VITAMIN B3 250 MG TABLET	T3	
PANTHENOL PREPARATIONS		
CALCIUM PANTOTHENATE	T3	
PANTETHINE	T3	
PANTOTHENIC ACID	T3	
PUREVITA VITAMIN B5	T3	
PEDIATRIC VITAMIN PREPARATIONS		
ABDEK MULTIVITAMIN	T3	
ALIVE KIDS MULTIVITAMIN	T3	
ANIMAL SHAPES COMPLETE	T3	
CENTRUM KIDS	T3	
CHILD CHEWABLE VITMN COMPLETE	T3	
CHILD COMPLETE CHEWABLE VITMN	T3	
CHILD COMPLETE MULTIVITAMIN	T3	
CHILD MULTIVITAMIN PLUS IRON	T3	
CHILDREN MULTIVITAMIN	T3	
<i>children multivitamin chew tab</i>	T1	
CHILDREN MULTIVITAMIN GUMMIES	T3	
CHILDREN MULTIVITAMIN GUMMIES (<i>pediatric multivitamin no.120</i>)	T3	
CHILDREN'S CHEW MULTIVIT-IRON (<i>pedi multivit no.91/iron fum</i>)	T3	
<i>childrens chew vitamin tab (Flintstones With Extra C)</i>	T1	
<i>childrens chew vitamin tab (Flintstones)</i>	T1	
CHILDREN'S CHEWABLE	T3	
CHILDREN'S MULTI-VIT GUMMIES	T3	
CHILDREN'S MULTIVITAMIN GUMMY	T3	
CHILD'S CHEWABLE VITAMINTAB	T3	
CHILD'S OMEGA-3 DHA MULTIVITAM	T3	
CULTURELLE KIDS PROBIOTIC-MV	T3	
CULTURELLE KIDS PRO-MV-LUTEIN	T3	
DAVIMET WITH FLUORIDE	T3	
DEKAS PLUS	T3	
EMERGEN-C KIDZ	T3	
EMERGEN-C KIDZ DAILY IMMUNE	T3	

T1 – Generics

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List of Prescription Medications

VITAMINS (Nutritional/Dietary) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
PEDIATRIC VITAMIN PREPARATIONS (cont.)		
EMERGEN-C KIDZ IMMUNE PLUS	T3	
EQ CHILD MULTIVITAMIN GUMMIES	T3	
FLINTSTONES COMPLETE GUMMIES	T3	
FLINTSTONES COMPLETE TABLET (<i>multivit with iron,minerals</i>)	T2	
FLINTSTONES EXTRA C GUMMIES	T3	
FLINTSTONES EXTRA CTAB CHEW (<i>multivitamin</i>)	T2	
FLINTSTONES GUMMIES	T2	
FLINTSTONES GUMMIES CHEW TAB	T3	
FLINTSTONES IMMUNITY SUPPORT	T3	
FLINTSTONES MULTIVIT CHEW TAB (<i>pedi multivit no.25/folic acid</i>)	T3	
FLINTSTONES MULTI-VIT GUMMIES	T2	
FLINTSTONES PLUS CALCIUM	T2	
FLINTSTONES SOUR-GUM CHEW TAB	T3	
FLINTSTONES TAB CHEW	T2	
FLINTSTONES TABLET CHEWABLE (<i>multivitamin</i>)	T2	
FLINTSTONES WITH IRON	T3	
FLORAFOL PEDIATRIC	T3	
FLORAFOL FE PEDIATRIC	T3	
FLORIVA	T3	
FLORIVA PLUS	T3	
GENADEK	T3	
GERBER GROW MIGHTY	T3	
GERBER LIL BRAINIES	T3	
GUMMIES CHILDREN MULTIVITAMIN	T3	
GUMMY	T3	
GUMMY DINOS	T3	
INFANT-TODDLER MULTIVITAMIN	T3	
INFANT-TODDLER MULTIVIT-IRON	T3	
<i>infant-toddler multivit-iron</i>	T1	
INFANT-TODDLER TRI-VITAMIN	T3	
INFUVITE PEDIATRIC	T2	
JUST 4 KIDZ MULTIVIT-PROBIOTIC	T3	
KIDS COD LIVER OIL +D	T3	
KIDS MULTIVITAMIN-MINERALS	T2	

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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

VITAMINS (Nutritional/Dietary) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
PEDIATRIC VITAMIN PREPARATIONS (cont.)		
LITTLE ANIMALS PLUS IRON	T3	
LIVITA FOR CHILDREN	T3	
<i>multivit with iron,minerals</i>	T1	
<i>multivit with iron,minerals (Flintstones Complete)</i>	T1	
<i>multivit with iron,minerals (Scooby-Doo)</i>	T1	
<i>multivitamin (Flintstones With Extra C)</i>	T1	
<i>multivitamin (Flintstones)</i>	T1	
<i>multivitamin with iron</i>	T1	
MULTI-VIT-FLOR	T3	
MULTIVIT-FLUOR 0.25 MG TAB CHW	T3	
MULTIVIT-FLUOR 0.5 MG TAB CHEW	T3	
<i>multivit-fluor 0.25 mg tab chw</i>	T1	PPACA
<i>multivit-fluor 0.5 mg tab chew</i>	T1	PPACA
<i>multivit-fluor 0.25 mg/ml drop</i>	T1	PPACA
<i>multivit-fluor 0.5 mg/ml drop</i>	T1	PPACA
<i>multivit-fluoride 1 mg tab chw</i>	T1	PPACA
MULTIVIT-FLUORIDE 1 MG TAB CHW	T3	
MVV COMPLETE FORMLTN PEDIATRIC	T3	
MVV COMPLETE FORMULATION D3000	T3	
MVV COMPLETE FORMULATION D5000	T3	
MVV COMPLETE FORMULTN MULTIVIT	T3	
MVV MODULATR FORMLTN PEDIATRIC	T3	
NANO VM 1-3	T2	
NANO VM 4-8	T2	
NANOVMT 9-18	T3	
NANOVMT-F	T3	
NOVAFERRUM YUM PEDIATR MV-IRON	T3	
NOVAMV MMM PEDIATRIC MULTIVIT	T3	
ONE-A-DAY KID'S	T3	
ONE-A-DAY TEEN HER VITACRAVES	T3	
ONE-A-DAY TEEN HIM VITACRAVES	T3	
<i>ped mvit a,c,d3 no.21/fluoride</i>	T1	PPACA
<i>pedi multivit 158/iron/vit k1</i>	T1	
<i>pedi multivit 45/fluoride/iron</i>	T1	

T1 – Generics

T2 – Preferred Brands

T3 – Non-Preferred Brands

T4 – Brand Specialty

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

VITAMINS (Nutritional/Dietary) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
PEDIATRIC VITAMIN PREPARATIONS (cont.)		
pedi multivit no.12 w-fluoride	T1	PPACA
pedi multivit no.17 w-fluoride	T1	PPACA
pedi multivit no.159/iron sulf	T1	
pedi multivit no.23/folic acid	T1	
pedi multivit no.25/folic acid (Flintstones)	T1	
pedia poly-vite iron 5mg/0.5ml	T1	
PEDIA POLY-VITE WITH IRON DROP	T3	
PEDIA TRI-VITE	T3	
pediatric multivit no.36/iron	T1	
pediatric multivitamin no.17	T1	
pediatric multivitamin no.111	T1	
pediatric multivitamin no.212	T1	
PEDIATRIC POLY-VITAMIN	T3	
PEDIATRIC POLY-VITAMIN-IRON	T3	
PEDIATRIC POLY-VITE	T3	
PEDIATRIC POLY-VITE WITH IRON	T3	
PEDIATRIC TRI-VITAMIN	T3	
PEDIATRIC TRI-VITE	T3	
POLY-VI-FLOR	T3	
POLY-VI-FLOR WITH IRON	T3	
poly-vi-sol 0.5 ml oral syring	T1	
POLY-VI-SOL 1 ML ENFIT SYRINGE	T3	
POLY-VI-SOL 250MCG-50MG/ML DRP	T3	
POLY-VI-SOL WITH IRON	T3	
POLY-VITA	T3	
POLY-VITA WITH IRON	T3	
QUFLORA	T3	
QUFLORA FE	T3	
SCOODY-DOO ONE A DAY GUMMIES	T3	
SCOODY-DOO ONE A DAY TABLET (<i>multivit with iron,minerals</i>)	T2	
SOLUVITA MULTIVITAMIN FLUORIDE	T3	
SOLUVITA MULTIVITAMIN FLUORIDE (<i>pedi multivit no.82 w-fluoride</i>)	T3	
TRI-VI-FLOR	T3	
TRI-VI-SOL	T3	

T1 – Generics

T2 – Preferred Brands

T3 – Non-Preferred Brands

T4 – Brand Specialty

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List of Prescription Medications

VITAMINS (Nutritional/Dietary) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
PEDIATRIC VITAMIN PREPARATIONS (cont.)		
tri-vit-fluor 0.25 mg/ml drop	T1	PPACA
TRI-VIT-FLUOR 0.25 MG/ML DROP	T3	
tri-vit-fluor 0.5 mg/ml drop	T1	PPACA
TROPICAL LIQUID NUTRITION (pediatric multivitamin no.118)	T3	
vit a palmitate/vit c/vit d3	T1	
ZOO FRIENDS	T3	
ZOO FRIENDS COMPLETE	T3	
VITAMIN A AND D PREPARATIONS		
cod liver oil softgel	T1	
gnp norwegian cod liver oil	T1	
SV COD LIVER OIL SOFTGEL	T3	
VITAMIN A PREPARATIONS		
A-25	T3	
AQUASOL A	T2	
beta-carotene	T1	
cvs vitamin a 2,400 mcg softgl	T1	
FT VITAMIN A 3,000 MCG SOFTGEL	T3	
GNP VITAMIN A 3,000 MCG SOFTGL	T3	
NORWEGIAN COD LIVER OIL SFGL	T3	
PREVENT	T2	
PUREVITA VITAMIN A	T3	
ra vitamin a 10,000 unit softgl	T1	
VITAMIN A - BETA CAROTENE	T3	
vitamin a 10,000 unit capsule	T1	
vitamin a 10,000 unit softgel	T1	
VITAMIN A 10,000 UNIT SOFTGEL	T3	
vitamin a 3,000 mcg softgel	T1	
vitamin a 8,000 unit capsule	T1	
VITAMIN A PALMITATE	T3	
vitamin a/vit c/zinc/propolis	T1	
VITAMINS A D	T3	
VITAMIN B PREPARATIONS		
5-MTHF PLUS B12	T3	HD
acetylcyst/methylb12/levomefol (Cerefolin Brain Wellness)	T1	HD

T1 – Generics

T2 – Preferred Brands

T3 – Non-Preferred Brands

T4 – Brand Specialty

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List of Prescription Medications

VITAMINS (Nutritional/Dietary) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
VITAMIN B PREPARATIONS (cont.)		
ALBA-LYBE	T2	HD
APETEX (<i>vitamin b complex/lysine</i>)	T2	HD
APETIGEN (<i>vitamin b complex/lysine</i>)	T2	HD
ARKALIOX	T3	HD
B ACTIV	T3	HD
<i>b comp no3/folic/c/biotin/zinc</i>	T1	HD
<i>b comp/ferrous gluc/lysin/znox</i>	T1	HD
<i>b complex 11/folic/c/biot/zinc</i>	T1	HD
<i>b complex c no.10/folic acid</i>	T1	HD
<i>b complex, c no.20/folic acid (Virt-Caps)</i>	T1	HD
<i>b complex capsule</i>	T1	HD
<i>b complex tablet</i>	T1	HD
B COMPLEX WITH B-12	T3	HD
B COMPLEX WITH VITAMIN C	T3	HD
B COMPLEX FAST DISSOLVE TABLET	T3	HD
B COMPLEX-FOLIC ACID (<i>cyanocobalamin/folic ac/vit b6</i>)	T3	HD
<i>b12/levomefolate calcium/b-6</i>	T1	HD
B-50 COMPLEX	T3	HD
<i>balanced b-100 complex tab sa</i>	T1	HD
B-COMPLEX 100	T3	HD
<i>b-complex 100 injection</i>	T1	HD
<i>b-complex injection vial</i>	T1	HD
<i>b-complex plus vitamin c cplt (Vita-Bee With C)</i>	T1	HD PPACA
<i>b-complex tablet</i>	T1	HD PPACA
B-COMPLEX WITH B-12	T3	HD
<i>b-complex with b12 tablet</i>	T1	HD
<i>b-complex with vit c caplet (Vita-Bee With C)</i>	T1	HD PPACA
<i>b-complex with vit c tablet (Vita-Bee With C)</i>	T1	HD PPACA
B-COMPLEX-VITAMIN CTR TABLET	T2	HD
BIOTIN 1,000 MCG GUMMIES	T3	HD
<i>biotin 1,000 mcg tablet</i>	T1	HD
BIOTIN 10 MG TABLET	T2	HD
BIOTIN 10,000 MCG SOFTGEL	T3	HD
BIOTIN 10,000 MCG TABLET	T2	HD

T1 – Generics

T2 – Preferred Brands

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T4 – Brand Specialty

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List of Prescription Medications

VITAMINS (Nutritional/Dietary) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
VITAMIN B PREPARATIONS (cont.)		
biotin 2,500 mcg softgel (Hard Nails)	T1	HD
biotin 300 mcg tablet	T1	HD
BIOTIN 5 MG TABLET	T3	HD
biotin 5,000 mcg capsule (Meribin)	T1	HD
BIOTIN 5,000 MCG FAST DISSOLVE	T3	HD
BIOTIN 5,000 MCG QUICK DISSOLV	T3	HD
biotin 5,000 mcg softgel (Meribin)	T1	HD
BIOTIN 5,000 MCG TABLET	T3	HD
biotin 800 mcg tablet	T1	HD
BIOTIN FORTE 3 MG TABLET	T3	HD
BIOTIN FORTE 5 MG TABLET	T2	HD
BREWER'S YEAST	T3	HD
B-STRESS	T3	HD
CARDIOTEK-RX	T3	HD
CEREFOLIN (vit b12/levomefolate/vit b6/b2)	T3	HD
CEREFOLIN BRAIN WELLNESS (acetylcyst/methylb12/levomefol)	T3	HD
CEREFOLIN NAC	T3	HD
COMPLEX B-100 ER CAPLET	T3	HD
complex b-100 tablet sa	T1	HD
COMPLEX B-50	T3	HD
COMPLETE LIVER CLEANSE	T1	HD
CVS BALANCED B-100 TR CAPLET	T3	HD
CVS BIOTIN 10,000 MCG SOFTGEL	T3	HD
cvs biotin 1,000 mcg tablet	T1	HD
CVS BIOTIN 5,000 MCG TABLET	T3	HD
cvs super b-complex-vit c cptl (Vita-Bee With C)	T1	HD PPACA
cyanocobalamin/folic ac/vit b6	T1	HD
cyanocobalamin/folic ac/vit b6	T1	HD PPACA
cyanocobalamin/folic ac/vit b6 (Niva-Fol)	T1	HD
CYTO B7	T3	HD
DIALYVITE 3000	T3	HD
DIALYVITE 5000	T3	HD
DIALYVITE 800 CHEWABLE WAFER	T3	HD

T1 – Generics

T2 – Preferred Brands

T3 – Non-Preferred Brands

T4 – Brand Specialty

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List of Prescription Medications

VITAMINS (Nutritional/Dietary) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
VITAMIN B PREPARATIONS (cont.)		
DIALYVITE 800 PLUS D	T3	HD
<i>dialyvite 800 tablet</i>	T1	HD PPACA
DIALYVITE 800 WITH ZINC	T3	HD
DIALYVITE 800-ULTRA D	T2	HD
DIALYVITE SUPREME D	T3	HD
ELFOLATE PLUS	T3	HD
ENDUR-B COMPLEX	T3	HD
<i>eql b complex 50 tablet</i>	T1	HD
<i>folic acid/b complex c no.17</i>	T1	HD
<i>folic acid/vit b complex and c</i>	T1	HD PPACA
<i>folic acid/vit b complex and c</i>	T1	HD
<i>folic acid/vit b complex and c (Vita-Bee With C)</i>	T1	HD PPACA
<i>folic acid/vit bcomp,c/cu/zinc</i>	T1	HD
FOLIKA-BC	T3	HD
FOLIKA-NC	T3	HD
FOLIKA-T	T3	HD
FOLINIC-PLUS	T3	HD
FOLIX	T3	HD
<i>ft biotin 5,000 mcg capsule (Meribin)</i>	T1	HD
FT BIOTIN 2,500 MCG GUMMY	T2	HD
FT BIOTIN 10,000 MCG TABLET	T3	HD
GENICIN VITA-S	T3	HD
<i>gnp biotin 5,000 mcg capsule (Meribin)</i>	T1	HD
HAIR-SKIN-NAILS	T3	HD
HARD NAILS (<i>biotin</i>)	T3	HD
HM BIOTIN 10,000 MCG TABLET	T3	HD
<i>hm biotin 5,000 mcg capsule (Meribin)</i>	T1	HD
HOMOCYSTEINE FORMULA	T3	HD
HYLAVITE (<i>folic acid/vit b complex and c</i>)	T3	HD
KIDS BRAIN BUILDER	T3	HD
<i>levomefolate/b6/b12/algal oil</i>	T1	HD
LEVOMEFOLATE-NAC-MECOBAL-ALGAL	T3	HD
LEVOMEFOL-PYRIDOXAL-MEC-ALGAL	T3	HD
<i>l-mefol/a-cyst/meb12/algal oil</i>	T1	HD

T1 – Generics

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T4 – Brand Specialty

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List of Prescription Medications

VITAMINS (Nutritional/Dietary) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
VITAMIN B PREPARATIONS (cont.)		
L-METHYLFOL-ALGAL-NAC-ME-CBL	T3	HD
L-METHYLFOL-ALGAL-P5P-ME-CBL	T3	HD
LORID	T3	HD
LORMATE	T3	HD
<i>mecobal/levomefolat ca/b6 phos</i>	T1	HD
MEDTYCHOLL-B COMPLEX W-LIVER	T3	HD
MEGA BIOTIN	T3	HD
MERIBIN (<i>biotin</i>)	T2	HD
METANX	T3	HD
METANX FC	T3	HD
METANX RR	T3	HD
METANXPRO NERVE HEALTH	T3	HD
METHAVER	T3	HD
METHYL PROTECT	T3	HD
MINCORA	T3	HD
MULTIVITAMIN-ZINC-STRESS	T3	HD
NEPHRON FA	T3	HD
NEPHRO-VITE	T2	HD
NIVA-FOL (<i>cyanocobalamin/folic ac/vit b6</i>)	T3	HD
NUFOLA	T3	HD
PODIAPN	T3	HD
POTABA	T3	HD
PRORENAL	T2	HD
PUREVITA SUPER B-COMPLEX	T3	HD
QUIN B STRONG	T3	HD
<i>ra balanced b-100 tablet</i>	T1	HD PPACA
<i>ra b-complex-vitamin b-12 tab</i>	T1	HD
<i>ra biotin 2,500 mcg capsule (Hard Nails)</i>	T1	HD
RELCARE	T3	HD
RENAL VITAMIN	T3	HD
RENAL-VITE	T3	HD
RENAPLEX	T3	HD
RENAPLEX-D	T3	HD
RIBOZEL	T3	HD

T1 – Generics

T2 – Preferred Brands

T3 – Non-Preferred Brands

T4 – Brand Specialty

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List of Prescription Medications

VITAMINS (Nutritional/Dietary) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
VITAMIN B PREPARATIONS (cont.)		
sm biotin 5,000 mcg capsule (Meribin)	T1	HD
sm stress formula+zinc tablet	T1	HD
super b complex-vit c caplet (Vita-Bee With C)	T1	HD PPACA
super quints b-50 tablet	T1	HD PPACA
super quints b-50 tablets	T1	HD
SV BIOTIN 1,000 MCG SOFTGEL	T3	HD
sv biotin 5,000 mcg softgel (Meribin)	T1	HD
TRONVITE	T3	HD
ULTRA B-100 COMPLEX TABLET	T3	HD
ultra b-100 complex tablet	T1	HD
vit b comp c 19/folic acid/d3	T1	HD PPACA
vit b comp no.3/folic/c/biotin	T1	HD
vit b comp/c/fa/iron sulf/vite	T1	HD PPACA
vit b comp/c/folic/iron/vit e	T1	HD PPACA
vit b comp/folic/choline/inosi	T1	HD PPACA
vit b complex 100 combo no.2	T1	HD
vit b12/levomefolate/vit b6/b2 (Cerefolin)	T1	HD
VIRT-CAPS (b complex, c no.20/folic acid)	T3	HD
VITA-BEE WITH C (folic acid/vit b complex and c)	T3	HD
VITAL-D RX	T3	HD
vitamin b complex	T1	HD
vitamin b complex capsule, softgel	T1	HD
vitamin b complex tablet	T1	HD PPACA
vitamin b complex tablet	T1	HD
vitamin b complex/folic acid	T1	HD PPACA
vitamin b complex/lysine (Apetex)	T1	HD
vitamin b complex/lysine (Apetigen)	T1	HD
vitamin b complex-vitamin c tb (Vita-Bee With C)	T1	HD PPACA
vitamin b-complex c caplet	T1	HD PPACA
VITAJOY BIOTIN	T3	HD
VITA-RESPA	T3	HD
VITASURE	T3	HD
XVITE	T3	HD
ZELDANA	T3	HD

T1 – Generics

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List of Prescription Medications

VITAMINS (Nutritional/Dietary) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
VITAMIN B1 PREPARATIONS		
CYTO B-1	T3	
cvs vitamin b-1 100 mg tablet	T1	
ft vitamin b-1 100 mg tablet	T1	
gnp vitamin b-1 100 mg tablet	T1	
PUREVITA VITAMIN B1	T3	
ra vitamin b-1 100 mg tablet	T1	
thiamine hcl	T1	
THIAMINE HCL-0.9% NaCl	T3	
thiamine 100 mg tablet	T1	
thiamine 250 mg tablet	T1	
THIAMINE 500 MG TABLET	T3	
thiamine 200 mg/2 ml vial	T1	
TRUE VITAMIN B-1 50 MG TABLET	T3	
TRUE VITAMIN B-1 250 MG TABLET	T3	
true vitamin b-1 100 mg tablet	T1	
VITAMIN B-1 100 MG CAPSULE	T3	
vitamin b-1 50 mg tablet	T1	
vitamin b-1 100 mg tablet	T1	
vitamin b-1 250 mg tablet	T1	
VITAMIN B12 PREPARATIONS		
ABANEU-SL	T3	
APATATE	T2	
B-12 1,000 MCG FAST DISSOLVE	T3	
B-12 1,000 MCG LOZENGE	T3	
B-12 1,000 MCG QUICK DISSOLVE	T3	
b-12 1,000 mcg tablet	T1	
B-12 1,000 MCG/15 ML LIQUID	T2	
b-12 1,000 mcg/15 ml liquid	T1	
b-12 2,500 mcg microlozenge	T1	
b12 2,500 mcg tablet sl	T1	
b-12 2,500 mcg tablet sl	T1	
B-12 3,000 MCG TABLET SL	T3	
b-12 3,000 mcg/ml subling liq	T1	
B-12 5,000 MCG FAST DISSOLVE	T3	

T1 – Generics

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List of Prescription Medications

VITAMINS (Nutritional/Dietary) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
VITAMIN B12 PREPARATIONS (cont.)		
B12 5,000 MCG MICROLOZENGE	T3	
B-12 5,000 MCG MICROLOZENGE	T2	
B-12 5,000 MCG ODT	T3	
B-12 5,000 MCG QUICK DISSOLVE	T3	
B-12 5,000 MCG SUBLINGUAL TAB	T3	
B-12 5,000 MCG/ML SUBLING LIQ	T3	
B-12 500 MCG QUICK DISSOLVE TB	T3	
b-12 500 mcg tablet	T1	
B12 ACTIVE	T3	
B-12 DUAL SPECTRUM	T3	
b-12 er 1,000 mcg tab	T1	
B-12 WITH FOLIC ACID	T3	
cvs b-12 1,000 mcg tablet	T1	
CVS B-12 5,000 MCG MICROLOZENG	T2	
CVS VIT B-12 500 MCG LOZENGE	T2	
cvs vitamin b12 5,000 mcg chew	T1	
CVS VIT B12 2,500 MCG SOFT CHW	T3	
CVS VITAMIN B12 5,000 MCG TAB	T3	
cvs vit b-12 500 mcg lozenge	T1	
cvs vit b-12 tr 1,000 mcg tab	T1	
cvs vit b-12 tr 2,000 mcg tab	T1	
CVS VITAMIN B-12 500 MCG GUMMY	T3	
cvs vitamin b-12 500 mcg tab	T1	
cyanocobalamin (vitamin b-12) (Nascobal)	T1	ST QL (4 units/30 days)
eq/ vitamin b-12 500 mcg tab	T1	
fn vitamin b-12 1,000 mcg tab	T1	
FOLTRATE	T3	
ft vit b-12 2,500 mcg tab sl	T1	
ft vitamin b-12 500 mcg tablet	T1	
ft vitamin b12 er 1,000 mcg tb	T1	
FT VITAMIN B-12 1500 MCG GUMMY	T3	
FT VITAMIN B-12 5,000 MCG TAB	T2	
gnp b12 2,500 mcg tablet sl	T1	
gnp vit b-12 er 1,000 mcg tab	T1	

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List of Prescription Medications

VITAMINS (Nutritional/Dietary) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
VITAMIN B12 PREPARATIONS (cont.)		
GNP VITAMIN B-12 1500MCG GUMMY	T3	
gnp vitamin b-12 500 mcg tab	T1	
hm vit b-12 tr 1,000 mcg tab	T1	
hm vitamin b-12 500 mcg tablet	T1	
hydroxocobalamin	T1	
INTRINSI B12-FOLATE	T3	
METHYL B-12	T3	
METHYLCOBALAMIN	T3	
METHYLCOBALAMIN 5,000 MCG TAB	T3	
MTX SUPPORT	T3	
NASCOBAL (<i>cyanocobalamin (vitamin b-12)</i>)	T2	ST QL (4 units/30 days)
NEURIN-SL	T3	
OPURITY	T3	
PAXLYTE	T3	
PUREVITA VITAMIN B12	T3	
ra vit b12 1,000 mcg tab sa	T1	
RA VIT B-12 1,000 MCG/ML LIQ	T3	
ra vitamin b-12 100 mcg tablet	T1	
ra vitamin b12 er 2,000 mcg tb	T1	
RAPID B-12 ENERGY	T3	
sm vitamin b12 1,000 mcg tab	T1	
sm vitamin b-12 100 mcg tablet	T1	
sm vitamin b-12 500 mcg tablet	T1	
sv b-12 2,500 mcg microlozenge	T1	
SV B-12 5,000 MCG MICROLOZENGE	T2	
SV VIT B-12 500 MCG LOZENGE	T2	
sv vitamin b-12 500 mcg tablet	T1	
sv vitamin b12 tr 1,000 mcg tb	T1	
true vitamin b-12 1000 mcg tab	T1	
true vitamin b-12 500 mcg tab	T1	
VIT B-12 500 MCG SUBLING TAB	T3	
VITAMIN B-12 1,000 MCG SOFTGEL	T3	
vitamin b-12 1,000 mcg tab sl	T1	
vitamin b-12 1,000 mcg tablet	T1	

T1 – Generics

T2 – Preferred Brands

T3 – Non-Preferred Brands

T4 – Brand Specialty

PA – Prior Authorization

QL – Quantity Limit

ST – Step Therapy

AGE – Age Requirement

SP – Specialty Medication

HD – May require home delivery pharmacy

PPACA – No Cost-Share Preventive Medication

CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

VITAMINS (Nutritional/Dietary) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
VITAMIN B12 PREPARATIONS (cont.)		
vitamin b-12 100 mcg tablet	T1	
vitamin b-12 2,000 mcg tab sa	T1	
VITAMIN B-12 2,000 MCG TABLET	T3	
vitamin b-12 2,500 mcg tab sl	T1	
VITAMIN B-12 250 MCG LOZENGE	T3	
vitamin b-12 250 mcg tablet	T1	
VITAMIN B-12 3,000 MCG SL LOZ	T3	
VITAMIN B-12 3,000 MCG SOFTGEL	T3	
VITAMIN B-12 3,000 MCG TAB SL	T3	
VITAMIN B-12 5,000 MCG ODT	T3	
VITAMIN B-12 5,000 MCG SOFTGEL	T3	
VITAMIN B-12 5,000 MCG TAB SL	T2	
vitamin b-12 5,000 mcg tab sl	T1	
VITAMIN B-12 5,000 MCG TAB SL	T3	
VITAMIN B12 2,500 MCG TABLET	T3	
VITAMIN B-12 5,000 MCG TABLET	T3	
VITAMIN B-12 50 MCG LOZENGE	T3	
vitamin b12 50 mcg tablet	T1	
vitamin b-12 50 mcg tablet	T1	
VITAMIN B-12 500 MCG LOZENGE	T2	
vitamin b12 500 mcg tablet	T1	
vitamin b-12 500 mcg tablet	T1	
vitamin b-12 tr 1,000 mcg tab	T1	
vitamin b-12 tr 2,000 mcg tab	T1	
VITAMIN B12	T3	
VITAMIN B12-FOLIC ACID	T3	
VITAMIN B2 PREPARATIONS		
CYTO B-2	T3	
PUREVITA VITAMIN B2	T3	
riboflavin (vitamin b2)	T1	
RIBOFLAVIN 100 MG CAPSULE	T3	
riboflavin 100 mg tablet	T1	
RIBOFLAVIN 400 MG TABLET	T3	
riboflavin 50 mg tablet	T1	

T1 – Generics

T2 – Preferred Brands

T3 – Non-Preferred Brands

T4 – Brand Specialty

PA – Prior Authorization

QL – Quantity Limit

ST – Step Therapy

AGE – Age Requirement

SP – Specialty Medication

HD – May require home delivery pharmacy

PPACA – No Cost-Share Preventive Medication

CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

VITAMINS (Nutritional/Dietary) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
VITAMIN B6 PREPARATIONS		
cvs vitamin b-6 100 mg tablet	T1	
eq/ vitamin b-6 100 mg tablet	T1	
ft vitamin b-6 100 mg tablet	T1	
gnp vitamin b-6 100 mg tablet	T1	
PUREVITA VITAMIN B6	T3	
pyridoxine 100 mg/ml vial	T1	
pyridoxine 25 mg tablet	T1	
pyridoxine 250 mg tablet	T1	
PYRIDOXINE 50 MG TABLET (pyridoxine hcl (vitamin b6))	T2	
pyridoxine 50 mg tablet (Pyridoxine Hcl)	T1	
PYRIDOXINE 500 MG TABLET (pyridoxine hcl (vitamin b6))	T3	
pyridoxine hcl (vitamin b6)	T1	
pyridoxine hcl (vitamin b6) (Pyridoxine Hcl)	T1	
ra vitamin b-6 100 mg tablet	T1	
ra vitamin b-6 50 mg tablet	T1	
sm vitamin b-6 100 mg tablet	T1	
sv vitamin b-6 100 mg tablet	T1	
true vitamin b-6 25 mg tablet	T1	
true vitamin b-6 50 mg tablet	T1	
true vitamin b-6 100 mg tablet	T1	
TRUE VITAMIN B-6 10 MG TABLET	T3	
VB6 P5P	T3	
vitamin b-6 25 mg tablet	T1	
vitamin b-6 50 mg tablet	T1	
vitamin b-6 100 mg tablet	T1	
vitamin b-6 250 mg tablet	T1	
VITAMIN C PREPARATIONS		
ASCOR	T3	
ascorbate calcium	T1	
ascorbic acid	T1	
ascorbic acid 500 mg/5 ml cup	T1	
ascorbic acid 500 mg tablet	T1	
ascorbic acid 500 mg/ml vial	T1	
ASCORBIC ACID GRANULES	T2	

T1 – Generics

T2 – Preferred Brands

T3 – Non-Preferred Brands

T4 – Brand Specialty

PA – Prior Authorization

QL – Quantity Limit

ST – Step Therapy

AGE – Age Requirement

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List of Prescription Medications

VITAMINS (Nutritional/Dietary) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
VITAMIN C PREPARATIONS (cont.)		
ascorbic acid/ascorbate sodium	T1	
BIO C 1:1	T3	
c-1,000 mg tablet sa	T1	
cod liver oil tab chewable	T1	
cvs vit c-rose hip 1,000 mg tb	T1	
cvs vit c-rose hip 500 mg chew, cptl, tab	T1	
cvs vitamin c 1,000 mg caplet	T1	
CVS VITAMIN C 1,000 MG POWDER	T3	
cvs vitamin c 250 mg tablet	T1	
cvs vitamin c 500 mg caplet, tablet	T1	
CYTO C	T3	
EASY-C IMMUNE HEALTH	T3	
EMERGEN-C	T3	
EMERGEN-C APPLE CIDER VINEGAR	T3	
EMERGEN-C ASHWAGANDHA	T3	
EMERGEN-C ELDERBERRY	T3	
EMERGEN-C IMMUNE PLUS	T3	
EMERGEN-C MSM LITE	T3	
EMERGEN-C TURMERIC GINGER	T3	
eq/vitamin c 1,000 mg tablet	T1	
ESSENCE C	T3	
ESTER-C 1,000 MG TABLET	T3	
ESTER-C 500 MG TABLET	T2	
FRUIT C-100 TABLET CHEWABLE	T3	
fruit c-100 tablet chewable	T1	
FLEVOXIN	T3	
FRUIT C-200	T3	
ft vit c-rose hip 500 mg, 1,000 mg tab	T1	
FT VITAMIN C 500 MG CHEW TAB	T2	
ft vitamin c 1,000 mg tablet	T1	
gnp vit c-rose hips 500 mg tab	T1	
gnp vitamin c 1,000 mg tablet	T1	
gnp vitamin c 250 mg tablet	T1	
gnp vitamin c 500 mg tab chew	T1	

T1 – Generics

T2 – Preferred Brands

T3 – Non-Preferred Brands

T4 – Brand Specialty

PA – Prior Authorization

QL – Quantity Limit

ST – Step Therapy

AGE – Age Requirement

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List of Prescription Medications

VITAMINS (Nutritional/Dietary) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
VITAMIN C PREPARATIONS (cont.)		
gnp vitamin c 500 mg tablet	T1	
gnp vitamin c er 500 mg tablet	T1	
hm vit c-rose hip 1,000 mg tab	T1	
hm vit c-rose hips 500 mg cplt	T1	
hm vitamin c 500 mg tab chew	T1	
LIQUID C	T3	
PAN-C 500	T3	
PERIDIN-C	T2	
PUREVITA VITAMIN C	T3	
ra vit c-rose hips 500 mg tab	T1	
ra vitamin c 1,000 mg tab sa	T1	
ra vitamin c 1,000 mg tablet	T1	
ra vitamin c 250 mg tablet	T1	
ra vitamin c 500 mg chew tab	T1	
ra vitamin c 500 mg tab chew	T1	
ra vitamin c 500 mg tablet	T1	
RA VITAMIN C 53 MG DROP	T3	
ra vitamin c tr 500 mg caplet	T1	
SAMBUCUS ELDERBERRY-VITAMIN C	T3	
sm vit c-rose hips 500 mg tab	T1	
sm vitamin c 1,000 mg tablet	T1	
sm vitamin c 250 mg tablet	T1	
sm vitamin c 500 mg chew tab	T1	
sm vitamin c 500 mg tab chew	T1	
sm vitamin c 500 mg tablet	T1	
sm vitamin c with rose hips	T1	
SPAN C	T3	
sv vit c-rose hip 1,000 mg tab	T1	
sv vit c-rose hips 1,000 mg tb	T1	
sv vit c-rose hips 500 mg tab	T1	
sv vitamin c 500 mg tab chew	T1	
sv vitamin c tr 1,000 mg tab	T1	
true vitamin c 250 mg tablet	T1	
true vitamin c 500 mg tablet	T1	

T1 – Generics

T2 – Preferred Brands

T3 – Non-Preferred Brands

T4 – Brand Specialty

PA – Prior Authorization

QL – Quantity Limit

ST – Step Therapy

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List of Prescription Medications

VITAMINS (Nutritional/Dietary) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
VITAMIN C PREPARATIONS (cont.)		
true vitamin c 1,000 mg tablet	T1	
vit c-rose hips 500 mg capsule	T1	
VIT C-ROSE HIPS 500 MG CAPSULE	T3	
vit c-rose hip 1,000 mg caplet	T1	
vit c-rose hips 1,000 mg cplt	T1	
vit c-rose hips 1,000 mg tab	T1	
VIT C-ROSE HIPS 500 MG CHEW TB	T3	
vit c-rose hips 500 mg tablet	T1	
vit c-rose hips tr 1,000 mg	T1	
vit c-rose hips tr 500 mg cplt	T1	
vit c-rose hips tr 500 mg tab	T1	
VITAJOY DAILY C	T3	
vitamin c 1,000 mg caplet	T1	
vitamin c 1,000 mg tablet	T1	
vitamin c 1,500 mg tablet sa	T1	
vitamin c 100 mg tablet	T1	
VITAMIN C 125 MG GUMMIES	T3	
vitamin c 250 mg tablet	T1	
VITAMIN C 250 MG TABLET CHEW	T3	
vitamin c 250 mg tablet chew	T1	
vitamin c 500 mg capsule sa	T1	
vitamin c 500 mg chew tablet	T1	
VITAMIN C 500 MG POWDER PACKET	T3	
VITAMIN C 500 MG SOFTGEL	T3	
vitamin c 500 mg tablet	T1	
vitamin c 500 mg tablet chew	T1	
VITAMIN C 500 MG WAFER	T3	
VITAMIN C 500 MG/15 ML LIQUID	T3	
vitamin c 500 mg/5 ml liquid	T1	
vitamin c drops	T1	
VITAMIN C FIZZY DRINK	T3	
VITAMIN C POWDER	T3	
vitamin c powder	T1	
vitamin c tr 1,000 mg tablet	T1	

T1 – Generics

T2 – Preferred Brands

T3 – Non-Preferred Brands

T4 – Brand Specialty

PA – Prior Authorization

QL – Quantity Limit

ST – Step Therapy

AGE – Age Requirement

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PPACA – No Cost-Share Preventive Medication

CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

VITAMINS (Nutritional/Dietary) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
VITAMIN C PREPARATIONS (cont.)		
vitamin c tr 500 mg caplet	T1	
vitamin c tr 500 mg tablet	T1	
vitamin c-500 mg tablet	T1	
vitamin c-500 mg tr capsule	T1	
VITAMIN C-BIOFLAVINOIDS-RH	T3	
vitamin c-rose hip 1,000 mg tb	T1	
v-r vitamin c 1,000 mg tablet	T1	
v-r vitamin c 250 mg tab chew	T1	
v-r vitamin c 500 mg tab chew	T1	
well vitamin c 1,000 mg tablet	T1	
well vitamin c 500 mg tablet	T1	
XCELLENT C	T3	
ZINC PLUS	T3	
ZINC-VITAMIN C	T3	
VITAMIN D PREPARATIONS		
AQUA-D CONCENTRATE	T3	HD
BABY DDROPS	T3	HD
BABY VITAMIN D3	T3	HD
BABY'S SUPER DAILY D3	T3	HD
BIO-D-MULSION	T3	HD
BIO-D-MULSION FORTE	T3	HD
calcitriol 0.25 mcg capsule	T1	
calcitriol 0.5 mcg capsule	T1	
calcitriol 1 mcg/ml ampul	T1	
calcitriol 1 mcg/ml solution (Rocaltrol)	T1	
CHOLECAL DF	T3	HD
cholecalciferol (vitamin d3)	T1	HD
cod liver oil	T1	HD
cod liver oil capsule	T1	HD
cvs vit d3 1,000 unit gummies	T1	HD
cvs vit d3 250 mcg softgel	T1	HD
cvs vitamin d3 25 mcg gummies	T1	HD
cvs vitamin d3 400 unit sftgl	T1	HD
cvs vitamin d3 1,000 unit sfgl	T1	HD

T1 – Generics

T2 – Preferred Brands

T3 – Non-Preferred Brands

T4 – Brand Specialty

PA – Prior Authorization

QL – Quantity Limit

ST – Step Therapy

AGE – Age Requirement

SP – Specialty Medication

HD – May require home delivery pharmacy

PPACA – No Cost-Share Preventive Medication

CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

VITAMINS (Nutritional/Dietary) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
VITAMIN D PREPARATIONS (cont.)		
cvs vitamin d3 2,000 unit sfgl	T1	HD
cvs vitamin d3 5,000 unit sfgl	T1	HD
cvs vitamin d3 10 mcg softgel	T1	HD
cvs vitamin d3 25 mcg softgel	T1	HD
cvs vitamin d3 50 mcg softgel	T1	HD
cvs vitamin d3 125 mcg softgel	T1	HD
cvs vitamin d3 50 mcg tablet	T1	HD
CVS VITAMIN D3 250 MCG SOFTGEL	T3	HD
CYFOLEX	T3	HD
D3 LIQUID	T3	HD
D3 PLUS K2 DOTS	T3	HD
D3-50	T2	HD
DDROPS	T3	HD
decara 10,000 unit softgel	T1	HD
DECARA 25,000 UNIT VEGICAP	T2	HD
decara 50,000 unit softgel	T1	HD
DECARA K	T3	HD
DERMACINRX DOTREMIN	T3	HD
DERMACINRX FOLDITAM	T3	HD
DERMACINRX FOLIXAPURE	T3	HD
DERMACINRX FOLIXATE	T3	HD
DERMACINRX FOLTAMIN	T3	HD
DERMACINRX FOLTREXYL	T3	HD
DERMACINRX PUREFOLIX	T3	HD
DIALYVITE VITAMIN D3 MAX	T3	HD
DOSOKAP	T3	HD
DOSOQUIN	T3	HD
eql/vitamin d3 2,000 unit sfgl	T1	HD
eql/vitamin d3 400 unit sftgl	T1	HD
ERGOCAL	T3	HD
ergocalciferol (vitamin d2)	T1	HD
FOLIC D3	T3	HD
FOLIKA-D	T3	HD
FOLVITE-D	T3	HD

T1 – Generics

T2 – Preferred Brands

T3 – Non-Preferred Brands

T4 – Brand Specialty

PA – Prior Authorization

QL – Quantity Limit

ST – Step Therapy

AGE – Age Requirement

SP – Specialty Medication

HD – May require home delivery pharmacy

PPACA – No Cost-Share Preventive Medication

CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

VITAMINS (Nutritional/Dietary) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
VITAMIN D PREPARATIONS (cont.)		
ft vitamin d3 25 mcg softgel	T1	HD
ft vitamin d3 50 mcg softgel	T1	HD
ft vitamin d3 50 mcg tablet	T1	HD
ft vitamin d3 125 mcg softgel	T1	HD
ft vitamin d3 125 mcg tablet	T1	HD
ft vitamin d3 25 mcg tablet	T1	HD
FT VITAMIN D3 250 MCG SOFTGEL	T3	HD
FT VITAMIN D3 250 MCG TABLET	T3	HD
GENICIN VITA-D	T3	HD
gnp vit d3 10mcg(400 unit) chw	T1	HD
gnp vitamin d3 50 mcg softgel	T1	HD
GNP VITAMIN D3 250 MCG SOFTGEL	T3	HD
gnp vitamin d3 1,000 unit tab	T1	HD
gnp vitamin d3 10 mcg tablet	T1	HD
gnp vitamin d3 2,000 unit tab	T1	HD
gnp vitamin d3 25 mcg tablet	T1	HD
gnp vitamin d3 25mcg(1000 unt)	T1	HD
gnp vitamin d3 5,000 unit tab	T1	HD
hm vitamin d3 1,000 unit tab	T1	HD
hm vitamin d3 2,000 unit sftgl	T1	HD
HM VITAMIN D3 4,000 UNIT SFTGL	T3	HD
IS-D-10,000	T3	HD
K2 PLUS D3	T3	HD
K2-D3 10,000	T3	HD
K2-D3 5000	T3	HD
K2-D3 MAX	T3	HD
MAXIMUM D3	T2	HD
NOXIFOL-D3	T3	HD
OPTIMAL D3 M	T3	HD
ORTHO DF	T3	HD
OSTACHOL	T3	HD
PUREVITA VITAMIN D3	T3	HD
qc cod liver oil	T1	HD
ra cod liver oil	T1	HD

T1 – Generics

T2 – Preferred Brands

T3 – Non-Preferred Brands

T4 – Brand Specialty

PA – Prior Authorization

QL – Quantity Limit

ST – Step Therapy

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HD – May require home delivery pharmacy

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List of Prescription Medications

VITAMINS (Nutritional/Dietary) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
VITAMIN D PREPARATIONS (cont.)		
ra cod liver oil softgel	T1	HD
ra vitamin d3 1,000 unit tab	T1	HD
ra vitamin d3 2,000 unit sfgl	T1	HD
ra vitamin d3 2,000 unit sftgl	T1	HD
ra vitamin d3 5,000 unit sftgl	T1	HD
REPLESTA NX	T2	HD
REVESTA	T3	HD
ROCALTROL (<i>calcitriol</i>)	T3	ST
ROXIFOL-D	T3	HD
sm vitamin d3 1,000 unit tab	T1	HD
sm vitamin d3 2,000 unit sftgl	T1	HD
sm vitamin d3 50 mcg softgel	T1	HD
SUPER DAILY D3	T3	HD
sv vitamin d3 1,000 unit gummy	T1	HD
sv vitamin d3 1,000 unit sftgl	T1	HD
sv vitamin d3 2,000 unit sftgl	T1	HD
sv vitamin d3 25mcg(1000 unit)	T1	HD
sv vitamin d3 400 unit softgel	T1	HD
sv vitamin d3 5,000 unit sftgl	T1	HD
thera-d 2000 tablet	T1	HD
Thera-D 4000 TABLET	T3	HD
thera-d rapid repletion tablet	T1	HD
thera-d sport 2,000 unit tab	T1	HD
true vitamin d3 1,250 mcg tab	T1	HD
true vitamin d3 10 mcg capsule	T1	HD
true vitamin d3 10 mcg tablet	T1	HD
true vitamin d3 50 mcg tablet	T1	HD
true vitamin d3 125 mcg cap	T1	HD
true vitamin d3 125 mcg tablet	T1	HD
true vitamin d3 25 mcg capsule	T1	HD
true vitamin d3 50 mcg capsule	T1	HD
true vitamin d3 25 mcg tablet	T1	HD
TRUE VITAMIN D3 1,250 MCG CAP	T3	HD
TRUE VITAMIN D3 250 MCG CAP	T3	HD

T1 – Generics

T2 – Preferred Brands

T3 – Non-Preferred Brands

T4 – Brand Specialty

PA – Prior Authorization

QL – Quantity Limit

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List of Prescription Medications

VITAMINS (Nutritional/Dietary) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
VITAMIN D PREPARATIONS (cont.)		
TRUE VITAMIN D3 250 MCG TABLET	T3	HD
<i>vit d3 125 mcg (5000 unit) tab</i>	T1	HD
VIT D3 5,000 UNIT FAST DISSOLV	T3	HD
<i>vitamin d2 1.25mg(50,000 unit)</i>	T1	HD
VITAMIN D2 2,000 UNITTABLET	T2	HD
<i>vitamin d2 400 unit tablet</i>	T1	HD
VITAMIN D2 50 MCG (2,000 UNIT)	T3	HD
VITAMIN D2-VITAMIN K1	T3	HD
VITAMIN D3-VITAMIN K2	T3	HD
VITAMIN D3 50 MCG DISSOLVE TAB	T3	HD
VITAMIN D3 10 MCG/ML ENFIT SYR	T3	HD
<i>vitamin d3 1,000 unit gummies</i>	T1	HD
<i>vitamin d3 1,000 unit gummy</i>	T1	HD
<i>vitamin d3 1,000 unit softgel</i>	T1	HD
VITAMIN D3 1,000 UNIT SPRAY	T3	HD
<i>vitamin d3 1,000 unit tab chew</i>	T1	HD
<i>vitamin d3 1,000 unit tablet</i>	T1	HD
VITAMIN D3 1,000 UNIT/10 ML LQ	T3	HD
<i>vitamin d3 1,250 mcg capsule</i>	T1	HD
<i>vitamin d3 1.25 mg softgel</i>	T1	HD
<i>vitamin d3 10 mcg tablet</i>	T1	HD
<i>vitamin d3 10 mcg(400 unit)/ml</i>	T1	HD
<i>vitamin d3 10 mcg/ml drop</i>	T1	HD
<i>vitamin d3 10 mcg/ml liquid</i>	T1	HD
VITAMIN D3 10,000 UNIT CAPSULE	T3	HD
<i>vitamin d3 10,000 unit softgel</i>	T1	HD
VITAMIN D3 10,000 UNIT TABLET	T3	HD
VITAMIN D3 62.5 MCG SOFTGEL	T3	HD
<i>vitamin d3 125 mcg (5000 unit)</i>	T1	HD
<i>vitamin d3 125 mcg capsule</i>	T1	HD
<i>vitamin d3 125 mcg softgel</i>	T1	HD
<i>vitamin d3 125 mcg tablet</i>	T1	HD
VITAMIN D3 125 MCG/0.5 ML DROP	T3	HD
<i>vitamin d3 2,000 unit softgel</i>	T1	HD

T1 – Generics

T2 – Preferred Brands

T3 – Non-Preferred Brands

T4 – Brand Specialty

PA – Prior Authorization

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List of Prescription Medications

VITAMINS (Nutritional/Dietary) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
VITAMIN D PREPARATIONS (cont.)		
VITAMIN D3 2,000 UNIT TAB CHEW	T3	HD
<i>vitamin d3 2,000 unit tablet</i>	T1	HD
<i>vitamin d3 25 mcg (1,000 unit)</i>	T1	HD
<i>vitamin d3 25 mcg gummy</i>	T1	HD
<i>vitamin d3 25 mcg softgel</i>	T1	HD
<i>vitamin d3 25 mcg tablet</i>	T1	HD
VITAMIN D3 250 MCG TABLET	T3	HD
VITAMIN D3 3,000 UNIT TABLET	T3	HD
<i>vitamin d3 400 unit softgel</i>	T1	HD
<i>vitamin d3 400 unit tab chew</i>	T1	HD
<i>vitamin d3 400 unit tablet</i>	T1	HD
VITAMIN D3 400 UNIT/5 ML LIQ	T3	HD
<i>vitamin d3 400 unit/ml liquid</i>	T1	HD
<i>vitamin d3 5,000 unit capsule</i>	T1	HD
<i>vitamin d3 5,000 unit softgel</i>	T1	HD
<i>vitamin d3 5,000 unit tablet</i>	T1	HD
<i>vitamin d3 5,000 unit/ml drops</i>	T1	HD
<i>vitamin d3 50 mcg (2,000 unit)</i>	T1	HD
<i>vitamin d3 50 mcg capsule</i>	T1	HD
<i>vitamin d3 50 mcg softgel</i>	T1	HD
<i>vitamin d3 50 mcg tablet</i>	T1	HD
<i>vitamin d3 50,000 unit capsule</i>	T1	HD
<i>v-r cod liver oil capsule</i>	T1	HD
<i>well vitamin d3 125 mcg softgl</i>	T1	HD
<i>well vitamin d3 25 mcg softgel</i>	T1	HD
<i>well vitamin d3 50 mcg softgel</i>	T1	HD
VITAMIN E PREPARATIONS		
AQUA-E	T2	
AQUA-E CONCENTRATE	T3	
<i>cvs vitamin e 180 mg softgel</i>	T1	
<i>cvs vitamin e 200 unit softgel</i>	T1	
CVS VITAMIN E 450 MG SOFTGEL	T3	
<i>cvs vitamin e 90 mg softgel</i>	T1	
<i>eql vitamin e 1,000 unit sftgl</i>	T1	

T1 – Generics

T2 – Preferred Brands

T3 – Non-Preferred Brands

T4 – Brand Specialty

PA – Prior Authorization

QL – Quantity Limit

ST – Step Therapy

AGE – Age Requirement

SP – Specialty Medication

HD – May require home delivery pharmacy

PPACA – No Cost-Share Preventive Medication

CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

VITAMINS (Nutritional/Dietary) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
VITAMIN E PREPARATIONS (cont.)		
eq/ vitamin e 180 mg softgel	T1	
ft vitamin e 180 mg softgel	T1	
gnp vitamin e 180 mg softgel	T1	
gnp vitamin e 400 unit softgel	T1	
GNP VITAMIN E 450 MG SOFTGEL	T3	
gnp vitamin e 90 mg softgel	T1	
hm vitamin e 180 mg softgel	T1	
hm vitamin e 200 unit softgel	T1	
hm vitamin e 400 unit softgel	T1	
MIXED TOCOTRIENOLS	T3	
PUREVITA VITAMIN E	T3	
ra vitamin e 268 mg softgel	T1	
sv vitamin e 180 mg softgel	T1	
sv vitamin e 400 unit softgel	T1	
sv vitamin e 450 mg softgel	T1	
sv vitamin e 670 mg softgel	T1	
true vitamin e 180 mg capsule	T1	
true vitamin e 90 mg capsule	T1	
TRUE VITAMIN E 450 MG CAPSULE	T3	
vitamin e (dl,tocopheryl acet)	T1	
vitamin e 1,000 unit softgel	T1	
VITAMIN E 1,000 UNIT SOFTGEL	T3	
vitamin e 100 unit softgel	T1	
VITAMIN E 100 UNIT TABLET	T3	
vitamin e 15 unit/0.3 ml drop	T1	
vitamin e 180 mg softgel	T1	
vitamin e 180mg(400 unit) sfgl	T1	
vitamin e 200 unit capsule, softgel	T1	
vitamin e 268 mg softgel	T1	
vitamin e 400 unit capsule, softgel	T1	
vitamin e 45 mg softgel	T1	
VITAMIN E 450 MG SOFTGEL	T3	
vitamin e 450 mg softgel	T1	
vitamin e 600 unit capsule	T1	

T1 – Generics

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T4 – Brand Specialty

PA – Prior Authorization

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List of Prescription Medications

VITAMINS (Nutritional/Dietary) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
VITAMIN E PREPARATIONS (cont.)		
vitamin e 90 mg softgel	T1	
VITAMIN E NATURAL OIL DROPS	T2	
VITAMIN E OIL	T3	
VITAMIN E OIL DROPS	T2	
VITAMIN E OIL DROPS	T3	
VITAMIN E-OIL	T2	
WHEAT GERM OIL	T2	
XCELLENT E	T3	
VITAMIN K PREPARATIONS		
AQUA-K CONCENTRATE	T3	
FNP VITAMIN K2 40 MCG TABLET	T3	
ft vitamin k2 100 mcg capsule	T1	
gnp vitamin k2 100 mcg capsule	T1	
K1-1000	T3	
K2 LIQUID	T3	
K2-45	T3	
MEPHYTON (<i>phytonadione (vit k1)</i>)	T3	QL (10 tabs/fill)
<i>phytonadione (vit k1)</i>	T1	
PHYTONADIONE 1 MG/0.5 ML SYR	T2	
<i>phytonadione 1 mg/0.5 ml/syr</i>	T1	
PHYTONADIONE 1 MG/0.5 ML VIAL	T2	
<i>phytonadione 10 mg/ml ampul</i>	T1	
<i>phytonadione 10 mg/ml vial</i>	T1	
VITAMIN K	T2	
VITAMIN K-1	T2	
VITAMIN K2 (MENAQUINONE-4)	T3	
VITAMIN K2 100 MCG SOFTGEL	T3	

VITAMINS (Vitamins)

MULTIVITAMIN PREPARATIONS

ALIVE MEN'S MAX3 POTENCY	T3	
BOOSTNOW IMMUNE SUPPORT	T3	
CENTRUM ADULTS 50 PLUS MINIS	T3	
CENTRUM MEN 50 PLUS MINIS	T3	

T1 – Generics

T2 – Preferred Brands

T3 – Non-Preferred Brands

T4 – Brand Specialty

PA – Prior Authorization

QL – Quantity Limit

ST – Step Therapy

AGE – Age Requirement

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CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

VITAMINS (Vitamins) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
MULTIVITAMIN PREPARATIONS (cont.)		
DAVIMET-M	T3	
DERMACINRX MULTIVITAMIN	T3	
LIVITA FOR ADULT	T3	
MULTITOL-M	T3	
NANOVM ADULT	T3	
SUPERIOR WOMEN'S MULTI	T3	
PEDIATRIC VITAMIN PREPARATIONS		
<i>ft children's multi gummy</i>	T1	
GNP CHILDREN'S MULTI GUMMY	T3	

T1 – Generics

T2 – Preferred Brands

T3 – Non-Preferred Brands

T4 – Brand Specialty

PA – Prior Authorization

QL – Quantity Limit

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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:⁹

- 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,¹⁰ sexual dysfunction, cosmetic purposes, weight loss, smoking cessation,¹⁰ or athletic enhancement.
- Prescription vitamins (other than prenatal vitamins) or dietary supplements unless state or federal law requires coverage of such products.
- Immunization agents, biological products for allergy immunization, biological sera, blood, blood plasma and other blood products or fractions and medications used for travel prophylaxis.
- Replacement of prescription medications and related supplies due to loss or theft.
- Medications which are to be taken by or administered to a covered person while they are a patient in a licensed hospital, skilled nursing facility, rest home or similar institution which operates on its premises or allows to be operated on its premises a facility for dispensing pharmaceuticals.
- Prescriptions more than one year from the date of issue.
- Coverage for prescription medication products for the amount dispensed (days' supply) which is more than the applicable supply limit, or is less than any applicable supply minimum set forth in The Schedule, or which is more than the quantity limit(s) or dosage limit(s) set by the P&T Committee.
- More than one prescription order or refill for a given prescription supply period for the same prescription medication product prescribed by one or more doctors and dispensed by one or more pharmacies.
- Prescription medication products dispensed outside the jurisdiction of the United States, except as required for emergency or urgent care treatment.

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

Index of Medications

Symbols

I.5 VOLT BATTERIES	162	ACTEMRA	131
IST TIER	140, 156	ACTHAR	125
IST TIER UNILET COMFORTOUCH	156	ACTHIB	75
2-IN-1	140, 156	ACTICLATE	39
2-IN-1 LANCET DEVICE	156	acti-lance	141, 156, 157
2TEK	133	ACTI-LANCE	141, 156
5-MTHF	223	acti-lance lite	156
50 PLUS ADULT EYE	202	acti-lance univers	157
A		ACTI-LANCE UNIVERS	156
A-25	223	ACTIMMUNE	62
abacavir	66, 67	ACTIQ	22
abacavir sulfate/lamivudine	66	ACTIVE FE	III
ABANEU-SL	229	ACTIVELLA	126
ABATRON	III	ACTIVNUTRIENTS	206
ABC	166, 206	ACTONEL	199
ABC COMPLETE	206	ACTOPLUS MET	50
ABDEK	219	ACTOS	50
ABILIFY	177	ACULAR	103
abiraterone	55	acyclovir	69, 70
ABRYSVO	75	ACZONE	180
ABSORICA	180	ADACEL TDAP	75
ABSTRAL	22	ADALIMUMAB	54
ACAM2000	75	ADALIMUMAB-ADAZ	54
acamprosate	195	ADALIMUMAB-RYVK	54
acarbose	49	adapalene	180, 189, 190
ACCOLATE	32	ADAPALENE	189
ACCRUFER	III	adapalene/benzoyl peroxide	180
ACCU-CHEK	133, 140, 141, 156, 162	ADBRY	200
ACCUPRIL	83	ADDYI	175
ACCURETIC	81	adefovir	70
ACCUTREND	133	ADEK GUMMIES	206
ACD-A	43	ADEMPAS	80
ACD SOLUTION A	43	ADIPEX-P	62
ACE	81, 82, 83	ADJUSTABLE LANCING DEVICE	133
ACE AEROSOL	162	ADLARTY	71
acebutolol	84	ADLYXIN	48
acetaminophen/caff/dihydrocod	22	ADRENALIN CHLORIDE	102
acetaminophen with codeine	21	adthyza	191
acetazolamide	100	ADULT 50 PLUS EYE HEALTH	202
acetic acid	52, 103, 179	ADULT MULTI	206
acetic acid/oxyquinoline	52	ADULT ONE DAILY	206
acetylcysteine	32	ADULTS' DAILY FORMULA	206
acetylcyst/methylbl2/levomefol	223	ADULTS MULTIVITAMIN	206
a/c/e/zinc ox/cupric ox/lutein	202	ADVAIR HFA	31
a/c/e/zinc/sod selenate/copper	206	ADVANCED	133, 141, 157, 203, 206, 211, 217
acitretin	179	ADVANCED LANCING DEVICE	133

Index of Medications

ADVANCED MULTI EA	206
ADVANCED TRAVEL LANCETS	157
ADVOCATE	133, 141, 157, 182
ADVOCATE CONTROL SOLUTION	133
ADVOCATE LANCET	157
ADVOCATE LANCETS	157
ADVOCATE LANCING DEVICE	133
ADVOCATE RAPID-SAFE LANCING DV	133
ADVOCATE REDI-CODE+ CTRL SOLN	133
ADZENYS	71
AEMCOLO	39
AEROCHAMBER	162
AEROCHAMBER2GO	157
AEROTRACH	163
AEROVENT	163
AFLURIA	74
AFLURIA QUAD	74
AGAMATRIX	133, 141, 157
AGAMATRIX CONTROL	133
AGRYLIN	65
AIMOVIG	15
AIMOVIG AUTOINJECTOR	19
AIRDUO DIGIHALER	31
AIRSUPRA	31
AJOVY	15, 19
AKLIEF	185
AKTEN	104
AKTIPAK	41
ALA-SCALP	185
ALBA-LYBE	224
albendazole	52
ALBENZA	52
albuterol	29, 30
ALCAINE	104
alclometasone	185
ALCOH-GLOVE	162
alcohol	182, 183, 198
ALCOHOL	53, 182, 183, 198
ALCOH-WIPE	162
ALDACTONE	101
ALECENSA	57
alendronate	199, 200
alfuzosin	201
ALINIA	63
aliskiren hemifumarate	85
ALIVE	206, 207, 219, 244
ALIVE DAILY	206
ALIVE PREMIUM	206
ALIVE WOMEN'S	206, 207
ALKALINE BATTERIES	133
ALKERAN	54
ALLERGIST TRAY	148
ALLERGY SYRINGE	148, 153, 154
allopurinol	26
ALLZITAL	19
almotriptan	19
almotriptan malate	15
ALOCRIL	104
alosetron	122
ALPHA	32, 49, 81, 82, 131, 170, 174, 197, 201, 207
ALPHAGAN P	105
alprazolam	170
ALTABAX	185
ALTACE	83
ALTAFLUOR BENOX	104
ALTERNATE	133, 141, 157
ALTERNATE SITE LANCETS	157
ALTERNATE SITE LANCING DEVICE	133
ALTRENO	190
ALTRIXA	207
ALUNBRIG	57
ALVESCO	31
alvimopan	123
ALYFTREK	191
amantadine	64
ambrisentan	80
amcinonide	185
AMERGE	19
AMICAR	76
amiloride	101, 102
amino acids/mv;tx,iron,mineral	207
aminocaproic	76
amiodarone	77
amitriptyline	173
amitriptyline/chlordiazepoxide	173
AMLADEX	207
amlodipine	78, 81, 82, 85
amoxapine	173
amoxicillin	38
amphetamine	71, 72
ampicillin	38
AMZEEQ	41
ANAFRANIL	173
anagrelide	65

Index of Medications

ANA-LEX	124	armodafinil	178
ANALPRAM	124, 189	ARMOUR THYROID	191
ANAPROX DS	27	ARNUITY ELLIPTA	31
anastrozole	56	AROMASIN	56
ANCOBON	44	ARTHROTEC 50	27
ANGELIQ	127	ARTHROTEC 75	27
ANIMAL SHAPES COMPLETE	219	ARTISS	184
ANIMI-3	207	ASACOL	121
ANNOVERA	94	ASCOR	233
ANORO ELLIPTA	30	ascorbate	233, 234
ANTARA	87	ascorbic	114, 233, 234
ANTICOAGULANT SODIUM CITRATE	43	ASCORBIC ACID	233
ANTIOXIDANT FORMULA	202	asenapine	175
APATATE	229	ASMANEX	31
APETEX	224	ASPIRIN	65
APETIGEN	III, 224	aspirin/dipyridamole	65
APETIGEN-PLUS	III	ASSURE	133, 141, 157, 165
apomorphine	64	ASSURE 4 CONTROL SOLUTION	133
APO-VARENICLINE	190	ASSURE DOSE	133
apraclonidine	105	ASSURE HAEMOLANCE PLUS	157
aprepitant	119	ASSURE LANCE	157
APRETUDE	68	ASSURE PRISM	133
APRISO	121	ASTAGRAF	132
APTENSIO	174	ASTRINGYN	77
APTIOM	91	atazanavir	67, 68
APТИВУС	65	ATELVIA	199
AQNEURSA	II7	atenolol	84, 85
AQUA-D	237	AT HOME AIC	133
AQUADEKS	207	a thru z	205, 206
AQUA-E	242	A THRU Z MEN'S ULTIMATE	205
AQUA-K	244	A THRU Z SELECT	206
AQUA LANCE LANCING DEVICE	133	ATIVAN	170
AQUASOL A	223	atomoxetine	175
AQUORAL	194	atorvastatin	85
ARAKODA	52	atovaquone	52, 53
ARAVA	26	atovaquone-proguanil	52
ARAZLO	185	atropine	106, 118, 120
ARCALYST	200	ATROPINE	106
AREXVY	75	ATROVENT HFA	29
arformoterol	30	ATTRUBY	197
ARGLAES FILM	155	AUDENZ	74
ARICEPT	71	AUGMENTIN	38
ARIDOL	98	AUGTYRO	57
ARIKAYCE	35	AURANOFIN	26
ariPIPRAZOLE	177	AURYXIA	110
ARIXTA	43	AUSTEDO	88
ARKALIOX	224	AUSTEDO XR	88

Index of Medications

AUTOJECT	134
AUTO-LANCET	134
AUTOLET	133, 134, 137
AUTOPEN	134
AUTOSHIELD DUO	146
AUTOSOFT	134
AUVELITY	171
AUVI-Q	70
avanafil	193
AVAR-E	41
AVAR LS	41
AVC	52
AVIDOXY	39
avita	190
AVITA	190
AVITENE	77
AVONEX	89
AYVAKIT	57
AZASAN	132
AZASITE	34
azathioprine	132
azelaic acid	184
azelastine	48, 102
AZELEX	180
AZILECT	64
azithromycin	37
AZSTARYS	174
AZULFIDINE	121
B	
b-6	224, 233
b-12	227, 229, 230, 231, 232
bl2	II2, II4, II5, 213, 224, 225, 226, 228, 229, 230, 231, 232
B-I2	II4, 210, 224, 229, 230, 231, 232
Bl2	223, 229, 230, 231, 232
Bl2 ACTIVE	230
b-l2 er	230
bl2/levomefolate calcium/b-6	224
B-50 COMPLEX	224
BABY DDROPS	237
BABY'S SUPER DAILY D3	237
BABY VITAMIN D3	237
bacitracin	34
baclofen	164
BACMIN	207
B ACTIV	224
BACTRIM	35
BAFIERTAM	89
BALANCED B-100	225
balanced b-100 complex tab sa	224
BAL-CARE DHA	165
balsalazide	121
BALVERSA	57
BARACLUDE	70
BARIATRIC MULTIVITAMINS	207
BAXDELA	38
BCG	75
b comp	224, 228
b complex	210, 215, 217, 224, 226, 228
b-complex	207, 208, 216, 224, 225, 227, 228
B COMPLEX	224, 226, 227
B-COMPLEX-VITAMIN C	224
B-COMPLEX WITH B-I2	224
BD	141, 146, 148, 149, 157
BD ECLIPSE	146, 148
BELBUCA	22
BELSOMRA	178
BELVIQ	63
benazepril	81, 83
benazepril/hydrochlorothiazide	81
BENLYSTA	200
BENTIVITE BX	II2
BENZAMYCIN	41
benzepro	183
BENZEPRO	183
BENZNIDAZOLE	53
benzonataate	96
benzoyl peroxide	41, 180, 183, 184
benzphetamine	62
benztropine	64
bepotastine	48
BEPREVE	48
BEROCCA	207
beta-carotene	207, 223
BETADINE	103
betaine	199
betamethasone	46, 185, 187, 189
BETAPACE	84
BETASERON	89
betaxolol	84, 105
bethanechol	72
BETHKIS	35
BETOPTIC S	105
bexarotene	54, 62
BEXZERO	73

Index of Medications

BEYAZ	95	bromocriptine	64
BEYFORTUS	68	brompheniramine/pseudoephed/dm	96
bicalutamide	55	BRONCHITOL	191
BIKTARVY	68	BROVANA	30
BILTRICIDE	52	BRUKINSA	57
bimatoprost	105	BRYHALI	185
BINOSTO	199	B-STRESS	225
BIO-35	207	budesonide	31, 127, 128
BIO C	234	BULK SYRINGE	149
BIO-D-MULSION	237	BULLSEYE	141, 157
bioflav,lemon/vit bcomp,c	203, 204	BULLSEYE MINI SAFETY LANCETS	157
biotin	210, 212, 224, 225, 226, 227, 228	bumetanide	101
BIOTIN	217, 224, 225, 226, 227, 228	BUPHENYL	118
bisac/nacl/nahco3/kcl/peg 3350	122	buprenorphine	22, 201
bisoprolol	84, 85	bupropion	171, 190
BLADDER 2.2	207	buspirone	170
BLEPH-IO	34	butalb-acetamin-caff 50-300-40	15
BLEPHAMIDE S.O.P.	34	butalb-acetamin-caff 50-325-40	15
BLOOD	76, 77, 98, 134, 141, 147, 157	butalb/acetaminophen/caffeine	15, 19
BLOOD GLUCOSE CONTROL	134	butalb-aspirin-caff 50-325-40	15
BLOOD-GLUCOSE CONTROL	134	butalbit/acetamin/caff/codeine	24
BLOOD LANCETS	157	butalbital/acetaminophen	15, 19
BLUNT	146, 147, 151	butalbital-asa-caffeine cap (Fiorinal)	15
BOCASAL	195	butalbital/aspirin/caffeine	19
BODY, HAIR, SKIN AND NAILS	207	butorphanol	22
BONSITY	199	BUTTERFLY	141, 157
BOOSTNOW	244	BUTTERFLY TOUCH LANCET	157
BOOSTRIX TDAP	75	BYDUREON BCISE	48
bosentan	80	BYDUREON PEN	48
BOSULIF	57	BYETTA	48
BRAFTOVI	56	BYLVAY	122
BRAINSTRONG	165	C	
BREATHERITE	163	c-I,000	234
BREATHRITE	163	cabergoline	129
BREEZE 2	134	CADEAU DHA	165
BREO ELLIPTA	31	CADUET	85
BREWER'S YEAST	225	CAFERGOT	15
BREXAFEMME	45	caffeine	19, 89, 165
breyna	31	CALAN	78
BREZTRI AEROSPHERE	31	calcipotriene	181, 189
BRILINTA	65	calcitonin,salmon,synthetic	130
brimonidine	105	calcitriol	181, 237, 240
BRIMONIDINE	105	calcium acetate	110
brinzolamide	105	CALCIUM PANTOTHENATE	219
BRIVIACT	91	CALQUENCE	57
BROMFED DM	96	CAMBIA	19
bromfenac	103	CAMZYOS	79

Index of Medications

candesartan cilexetil	83	celecoxib	29
candesartan/hydrochlorothiazid	82	CELLCEPT	132
CANNULA	147, 149, 151, 152, 154	CELONTIN	91
CANTHARIDIN-ACETONE	183	CENTANY	41
CAPCOF	96	CENTRAL-VITE	207
capecitabine	56	CENTRAVITES	207
CAPEX	186	centrum	208
CAPHOSOL	195	CENTRUM	205, 207, 208, 219, 244
CAPLYTA	175	CENTRUM KIDS	219
CAPRELSA	57	CENTRUM SILVER	205, 208
captopril	81, 83	cephalexin	36
captopril/hydrochlorothiazide	81	CEQUA	107
CAPVAXIVE	74	CEQUR SIMPLICITY	134
CARBAGLU	195	CERDELGA	196
carbamazepine	91, 93	CEREFORIN	225
CARBAMAZEPINE	91	certavite	208
CARBATROL	91	CERTAVITE	208
carbidopa	64, 65	CERVIDIL	129
carbidopa/levodopa	64	CETACAINE ANESTHETIC	25
carbinoxamine	47	cetrorelix	128
CARDOTEK-RX	225	CETROTIDE	128
CARDIZEM	78	cevimeline	72
CARDURA	81, 82	CHANTIX	190
CAREONE	134, 141, 157	CHEK-STIX	100
CAREPOINT	146, 149	CHEMET	197
CARESENS	134, 141	CHEMO TRANSFER PIN	147
CARETOUCH	134, 141, 146, 149, 157, 182	CHEMSTRIP	100, 134
carglumic	195	CHENODAL	120
carisoprodol	24, 164, 165	CHILD CHEWABLE VITAMN	219
carisoprodol/aspirin/codeine	24	CHILD COMPLETE	219
CARNITOR	199	CHILD MULTIVITAMIN PLUS IRON	219
carteolol	105	children multivitamin	219
carvedilol	81	CHILDREN MULTIVITAMIN	219, 220
CASODEX	55	CHILDREN'S	219
CATAPRES	84	CHILDREN'S CHEWABLE	219
CAVERJECT	193	CHILDREN'S CHEW MULTIVIT-IRON	219
CAYSTON	36	childrens chew vitamin	219
cefaclor	36	CHILDREN'S MULTI-VIT	219
cefadroxil	36	CHILDREN'S MULTIVITAMIN GUMMY	219
cefdinir	36	CHILD'S CHEWABLE	219
cefditoren pivoxil	37	CHILD'S OMEGA-3	219
cefixime	37	chlordiazepoxide	118, 170, 173
cefpodoxime proxetil	37	chlordiazepoxide/clidinium br	118
cefprozil	36	chlorhexidine	193
ceftriaxone	37	chloroquine	52
cefuroxime axetil	36	chlorpromazine	177
CEFUROXIME SODIUM-0.9% NACL	34	chlorthalidone	85, 102

Index of Medications

chlorzoxazone	I64, I65
CHOLBAM	I20
cholecalciferol	237
CHOLECAL DF	237
cholestyramine	86, 87
choline salicyl/mag salicylate	I5, I9
CHORIONIC	I30
CHORIONIC GONAD	I30
CHOSEN	I34, I4I, I57
CHROMAGEN	I12
CIALIS	I93
CIBINQO	I83
ciclodan	46
CICLODAN	46, 54
ciclopirox	46, 54
cilostazol	65
CILOXAN	34
CIMDUO	66
cimetidine	I2I
cinacalcet	I96
CIPRO	38
ciprofloxacin	33, 34, 38
citalopram	I7I
CITRANATAL	I12, I65, I69
CITRANATAL BLOOM	I12
CITRATE PHOSPHATE DEXTROSE	43
citric	I17
CITRUS BIOFLAVONOIDS	203
CLARINEX	47
CLARINEX-D	47
clarithromycin	37
CLEOCIN	37, 40, 4I
CLEVER	I34, I4I, I57, I63
CLEVER CHEK LANCETS	I57
CLEVER CHOICE	I63
CLEVER CHOICE CONTROL SOLUTION	I34
CLIMARA	I26
clindacin	4I
CLINDACIN	4I
clindamycin	37, 40, 4I, I80, I8I
CLINDESSE	40
CLINPRO 5000	I08, III
clobazam	90
clobetasol	I86, I88
CLOBEX	I86
clocortolone	I86
clodan	I86
CLODAN	I86
CLODERM	I86
clomiphene	I29
clomipramine	I73
clonazepam	90
clonidine	84, I74
clopidogrel	65
clorazepate	I70
clotrimazole	44, 46
clozapine	I75, I76
CLOZARIL	I76
COAGUCHEK	I4I, I57
COARTEM	52
COBALEFOL	204
COCAINE	I02
codeine	2I, 22, 24, 96, 97
CODITUSSIN AC	97
CODITUSSIN DAC	97
cod liver oil	223, 234, 237, 239, 240, 242
COLAZAL	I2I
colchicine	26, 29
COLCHICINE	26
colesevelam	86
COLESTID	87
colestipol	87
COLOR	I4I, I57
COLOR LANCESTS	I57
COMBIGAN	I05
COMBIPATCH	I26
COMBISTIX REAGENT	I00
COMBIVENT	30
COMBIVENT RESPIMAT	30
COMBIVIR	66
COMETRIQ	58
COMFORT	27, I39, I4I, I44, I45, I57, I59, I60, I6I, I63, I64, I82, I83
COMFORT PAC-IBUPROFEN	27
COMFORT PAC-MELOXICAM	27
COMFORT PAC-NAPROXEN	27
COMFORTSEAL	I63
COMIRNATY	73
COMPACT SPACE CHAMBER	I63
COMPATZINE	I19
COMPLETE	I66, I69, 205, 206, 207, 208, 209, 213, 214, 215, 219, 220, 221, 223, 225
COMPLEX B-50	225
complex b-I00	225

Index of Medications

COMPLEX B-100	225	cvs vitamin b-12	230
CONCEPT	208	cvs vitamin c	234
CONFORMANT 2	155	cvs vitamin d3	237, 238
CONSENSI	78	cvs vitamin e	242
CONTOUR	134	cvs vit c	234
CONTRAVE	63	cvs vit d3	237
CONTROL SOLUTION	I33, I34, I35, I36, I37, I38, I39, I40	cyanocobalamin	224, 225, 227, 230
COOL CONTROL SOLUTION	I34	cyclobenzaprine	I64, I65
COPIKTRA	58	CYCLOGYL	I06
CORDRAN	I86	CYCLOMYDRIL	I06
COREG	81	cyclopentolate	I06
CORNWALL SYRINGE TIP CONNECTOR	I49	CYCLOPENTOLATE-TROPICAMIDE-PE	I06
CORTANE-B	I03	cyclopentolat/tropic/phenyleph	I06
CORTEF	I27	cyclophosphamide	54, 55
CORTENEMA	I24	CYCLOPHOSPHAMIDE	55
cortisone	I27	cycloserine	36
CORTISPORIN	33	CYCLOSET	48
CORVITE	II2, 208	cyclosporine	I07, I32, I33
CORVITE I50	II2	CYCLOSPORINE	I07
CORVITE FE	II2	CYFOLEX	238
COTELLIC	56	CYLTEZO	54
COTEMPLA	I74	cyproheptadine	47
CREON	I23	CYPROHEPTADINE	47
CRESEMBOLA	45	CYSTAGON	201
CREXONT	64	CYSTARAN	I07
CRINONE	I30	CYSTO-CONRAY II	99
cromolyn	25, 32, I04	CYSTOGRAFIN	99
crotamiton	63	CYSTOGRAFIN-DILUTE	99
CRRT TRISODIUM CITRATE	43	CYTO B-I	229
CTEXLI	I20	CYTO B-2	232
CULTURELLE	208, 219	CYTO B7	225
CULTURELLE KIDS	219	CYTO C	234
CURITY ALCOHOL PREPS	I82	CYTOTEC	II9
CUROSURF	I92	D	
cvs	I08, II2, I65, I66, I82, I98, 204, 208, 217, 223, 225, 229, 230, 233, 234, 237, 238, 242	D3	I77, 214, 217, 237, 238, 239, 240, 241, 242
CVS	53, I09, II2, I69, I82, I98, 225, 230, 234, 238, 242	daily-vite	208
CVS ALCOHOL 70% PREP PADS	I82	dalfampridine	90
cvs glucose	I08	danazol	I29
CVS GLUCOSE LIQUID	I09	DANTRIUM	I65
cvs isopropyl alcohol 70% wipe	I82	dantrolene	I65
cvs prenatal	I65, I66	DANZITEN	58
CVS PRENATAL	I69	dapsone	36, I80
cvs slow release iron	II2	DAPSONE	I80
CVS SLOW RELEASE IRON	II2	DAPTACEL DTAP	75
CVS VITAMIN	230, 234, 242	DARAPRIM	53
cvs vitamin a	223	darifenacin	202
		dasatinib	58

Index of Medications

DAURISMO	56	DESONATE	I86
DAVIMET	219, 245	desonide	I86, I87, I89
DAVIMET-M	245	DESOWEN	I87
DAVOL IRRIGATION SYRINGE	149	desoximetasone	I87, I88
DAYAVITE	209	DESOXYN	71
DAYPRO	27	desvenlafaxine	I72
DAYTRANA	174	DESVENLAFAKINE	I72
DAYVIGO	178	dex4 glucose	I09
DDAVP	125	DEX4 GLUCOSE	I09
DDROPS	237, 238	dex4 quick dissolve tab chew	I09
decara	238	dexamethasone	33, I03, I27
DECARA	238	dexchlorpheniramine	47
DECUBI	209	DEXCOM	I34, I35
deferasirox	197	DEXCOM G6	I34, I35
deferiprone	197	DEXEDRINE	72
deflazacort	127	dexlansoprazole	I23
DEKAS	209, 219	dexmethylphenidate	I74
DEKAS PLUS	209, 219	DEXONTO	I27
DELESTROGEN	126	DEXTENZA	I03
DELTEC COZMO CLEO	162	dextroamphetamine	72
demeclocycline	39	dextrose	I09, I10
DEMSER	84	DIABETES HEALTH	209
DENAVIR	70	DIABETIC VITAMIN	209
DENGVAXIA	75	DIACOMIT	91
DENOVO	204	dialyvite	226
DEPAKOTE	91	DIALYVITE	209, 225, 226, 238
DEPEN	26	DIASTAT	90
DEPLIN	204	DIASTIX REAGENT	98, I00
DEPLIN-ALGAL OIL	204	diatrizoate meglumine	98, 99
DEPO-ESTRADIOL	126	DIATROL	209
DEPO-PROVERA	95	DIATRUE	I35
DEPO-SUBQ PROVERA	95	diazepam	90, 91, I70
DEPO-TESTOSTERONE	125	diazoxide	I09, I10
DERMACINRX	209, 238, 245	DIBENZYLINE	72
DERMA-SMOOTH-E-FS	186	dichlorphenamide	I95
DERMASORB	186	DICLEGIS	I19
DERMATOP	186	diclofenac	20, 27, 62, I03, I80
DERMAVIEW	155	DICLOFENAC	I9
DERMOTIC	I03	dicloxacillin	38
DESCOVI	66	dicyclomine	I18
desflurane	24	didanosine	67
desipramine	173	diethylpropion	62
desloratadine	48	DIFFERIN	I90
desmopressin	125, I26	DIFCID	37
DESMOPRESSIN	125	DIFLUCAN	45
desog-e	95	dilunisal	I5, I9
desogestrel-ethynodiol	95	diluprednate	I03

Index of Medications

digoxin	79	DUET DHA	I66
dihydroergotamine	I5, I9, 20	DULERA	31
DILANTIN	91	duloxetine	I72
DILAUDID	22	DUOBRII	I81
diltiazem	78	DUOPA	64
dimethyl	89, I96	DUPIXENT	I31
dimethyl fumarate	89	dutasteride	201
diphenoxylate hcl/atropine	I18	DXEVO	I27
DIPHTHERIA-TETANUS TOXOIDS-PED	75	DYAZIDE	I02
DIPROLENE	I87	DYRENIUM	I01
dipyridamole	65	E	
DISALCID	26	EAR HEALTH PLUS	203
disopyramide	78	ear health plus caplet	204
disulfiram	I95	EASIVENT	I63
DIURIL	I02	EASY	I35, I41, I42, I47, I49, I50, I51, I57, I58, I82
divalproex	I91, 92	EASY-C	234
dofetilide	78	EASY COMFORT	I41, I57, I82
DOJOLVI	I07	EASY COMFORT ALCOHOL PAD	I82
donepezil	71	EASY COMFORT LANCETS	I57
DONNATAL	I20	EASY GLIDE CATHETER	I49
DOPTELET	94	EASY GLIDE LUER	I50
dorzolamide	I05	EASYGLUCO PLUS	I35
DORZOLAMIDE	I05, I06	EASYMAX I5	I35
DOSOKAP	238	EASYMAX NORMAL	I35
DOSOQUIN	238	EASY MINI EJECT	I35
DOVATO	65	EASY PLUS II	I35
DOVER BULB SYRINGE	I49	EASYPPOINT	I47
DOVONEX	I81	EASY STEP	I35
doxazosin	I81, 82	EASY TALK	I35
doxepin	I73, I78, I79, I81	EASY TOUCH	I35, I41, I42, I47, I50, I51, I57, I58, I82
doxercalciferol	I95	EASY TOUCH FLIPLOCK	I47, I50
doxycycline	39, 40, I93	EASY TRAK	I35
doxylamine succinate/vit b6	I19	EASY TWIST CAP LANCETS	I58
dronabinol	I19	EBGLYSS	200
DROPLET	I35, I41, I57	ECLIPSE SYRINGE	I51
DROPLET GENTEEL LANCING DEVICE	I35	EC-NAPROSYN	27
DROPLET LANCETS	I57	ec-naproxen	27
DROPLET LANCING DEVICE	I35	econazole	46
DROPSAFE	I47, I82	EDECIN	I01
DROPSAFE PREP PADS	I82	EDEX	I93
drospir/eth estra/levomefol	95	EDLUAR	I78
DROXIA	76	EDURANT	66
droxidopa	72	E.E.S. 200	37
drug mart glucose	I09	efavirenz	66, 68
DUAVEE	I27	effer-k	I16
DUET	I66, I69	EFFER-K	I16
DUETACT	50	EFFIENT	65

Index of Medications

EFUDEX	62	ENLITE SERTER	I35
EGRIFTA	I28	ENLYTE	204
eldertonics	205	enoxaparin	43
ELDERTONIC LIQUID	205	ENSPRYNG	I31
ELEMENT COMPACT	I35	ENSTILAR	I89
ELEMENT CONTROL	I35	entacapone	64
ELEPSIA	92	entecavir	70
eletriptan hydrobromide	I5, I9	ENTEREG	I23
ELFOLATE	226	ENTERO VU	98
ELIMITE	63	ENTRESTO	82
ELIQUIS	43	ENZOCLEAR	I83
ELIXOPHYLLIN	32	EPCLUSA	70
ELLA	95	EPIDIOLEX	91
ELMIRON	24	EPIDUO FORTE	I80
ELON	209	EPIFOAM	I89
eltrombopag	94	epinastine	48
EMBRACE	I35, I42, I58	epinephrine	71, I02
EMBRACE EVO LEVEL I	I35	EPIPEN	71
EMBRACE GLUC CONTROL SOLN	I35	EPISIL	I94
EMBRACE LANCING DEVICE	I35	EPIVIR	67
EMBRACE PRO	I35	eplerenone	I01
EMBRACE TALK CONTROL	I35	eprosartan	83
EMERGEN	I19, 220, 234	EPSOLAY	I84
EMERGEN-C	I19, 234	EPZICOM	66
EMERGEN-C KIDZ	I19	EQ	202, 209, 220
EMGALITY	I5, I9, 90	EQ CHILD	220
EMGALITY PEN	I9	eqI	I12, I98, 202, 226, 230, 233, 234, 238, 242, 243
EMPAVELI	76	eqI slow release iron	I12
EMSAM	I71	eqI vitamin	230, 234, 238, 242, 243
emtricitabine	68	EQUETRO	I71
emtricitabine	66, 67	EQ VISION	202
emtricitabine-tenofovir	66	ERGOCAL	238
EMTRIVA	67	ergocalciferol	238
EMVERM	52	ergoloid	85
enalapril	I8, 83	ERGOMAR	I9
enalapril/hydrochlorothiazide	I8I	ergotamine tartrate/caffeine	I5, I9
ENBRACE	209	ERIVEDGE	56
ENBREL	54	ERLEADA	55
ENDARI	76	erlotinib	58
ENDO-AVITENE	77	ERMEZA	I9I
ENDOMETRIN	I30	ERVEBO	75
ENDUR-AMIDE	I27	ERYPED	37
ENDUR-THINE	I27	ERY-TAB	37
ENDUR-VM	209	ery-tab dr	37
ENFAMIL	I10	erythromycin	34, 37, 41
ENFIT	I5I, I52, I53, 222	escitalopram	I71
ENGERIX-B	75	ESGIC	I5, I9

Index of Medications

ESKATA	181	EYE HEALTH AND LUTEIN	202
eslicarbazepine	91, 92	EYE HEALTH PLUS LUTEIN TABLET	202
esomeprazole	123	EYE MULTIVITAMIN	202, 203
ESOMEPRAZOLE	123	EYEPROTECT	203
ESSENCE C	234	EYSUVIS	103
ESSENTIAL	165, 209, 210, 213, 214, 215	EZ	141, 142, 157, 158
estazolam	178	E-Z DISK	99
ESTER-C	234	ezetimibe	85, 87
ESTRACE	126	ezetimibe/simvastatin	85
estradiol	94, 95, 126, 127, 129	E-Z-HD	99
ESTRATEST	126	EZ-LETS	158
estrogen,ester/me-testosterone	126	E-Z-PAQUE	99
ESTROVEN	210	E-Z-PASTE	99
eszopiclone	178	EZ SMART LANCETS	158
ethacrynic	101	F	
ethambutol	36	FA-8	204
ethinyl	94, 95	FABHALTA	76
ethinyl estradiol/drospirenone	95	FACTIVE	38
ethosuximide	92, 94	famciclovir	69
ethynodiol d-ethinyl estradiol	95	famotidine	121, 122
etodolac	27, 28	fa/mv,ca,iron,min/lycopene/lut	210
etonogestrel/ethinyl estradiol	94	FARESTON	62
etoposide	61	FARXIGA	51
etravirine	66	FARYDAK	54
EUCRISA	184	FASENRA	32
EULEXIN	55	FATIGUE RELIEF COMPLEX	210
EURAX	63	febuxostat	26
EVAMIST	126	felbamate	92
EVEKEO	72	FELBATOL	92
EVENCARE	135, 136	FELDENE	27
everolimus	56, 57, 132, 133	felodipine	78
EVICEL	77	FEMARA	56
EVISTA	200	fenofibrate	87
EOCLIN	41	fenofibric	87
EVOLUTION	136	FENOGLIDE	87
EVOTAZ	67	fenoprofen	27, 28
EVOXAC	72	FENORTHO	27
EVRYSDI	196	fentanyl	22
EXEL	147, 151	feosol	112
EXELDERM	46	FEOSOL	112
EXEL HUBER	147	FERAHEME	112
EXELON	71	FERGON	112
exemestane	56	FER-IN-SOL	112
exenatide	48	FERIVA 21-7	112
EXPECTA PRENATAL	166	FERIVA FA	112
EXTENDED RESERVOIR	151	FERRACTIV IRON	112
EXTINA	46	FERRALET	112

Index of Medications

FERRETT'S IPS	II2	FLOVENT	32
FERRIMIN	II2	FLOW-EZE	147
FERRIPROX	197	FLUAD	74
FERRLECIT	II2	FLUAD QUAD	74
FERRO-SEQUELS	II2	FLUARIX	74
ferrous	II2, II3, II6, 212, 224	FLUARIX QUAD	74
FERROUS	II2, II3	FLUBLOK	74
ferrous fumarate	II2, II3	FLUBLOK QUAD	74
FERROUS FUMARATE	II2	FLUCELVAX	74
ferrous fum/vit c/bl2-if/folic	II2	FLUCELVAX QUAD	74
ferrous gluconate	II2, II3, 212	fluconazole	45
ferrous sulfate	II2, II3	flucytosine	44, 45
ferumoxytol	II2, II3	fludrocortisone	129
fesoterodine	202	FLULALVAL	74
FETZIMA	172	FLULALVAL QUAD	74
FEXMID	165	FLUMADINE	69
FIBRICOR	87	FLUMIST	74
FIFTY50	I42, I58	FLUMIST QUAD	74
fifty50 alcohol prep pads	182	flunisolide	I02
FIFTY50 SAFETY SEAL LANCETS	I58	fluocinolone	I03, I86, I87, I88
FILSUVEZ	200	fluocinonide	I87
FILTER	I47, I51, I53	fluorescein	98, I04
FILTER ASPIRATOR	I47	FLUORESCIN-BENOXINATE	I04
FINACEA	I84	fluoride	I08, III, II6, 221, 222
finasteride	201	FLUORIDEX	I08, III
FINAZOL	210	fluorometholone	I03
FINE	I42, I48, I58	FLUOROPLEX	62
FINE 30 UNIVERSAL LANCETS	I58	fluorouracil	62
FINGER GRIP	I51	fluoxetine	I71, I77
FINGERSTIX	I42, I58	fluphenazine	I77
FIORICET	I5, I9, 24	FLURA-DROPS	I08, II6
FIORINAL	I5	flurandrenolide	I86
FIRDAPSE	90	flurazepam	I78
FIRST-MOUTHWASH BLM	I94, I96	flurbiprofen	27, I03
FLAVOVIT	204	flutamide	55
flavoxate	202	fluticasone	3I, I02, I87
flecainide	78	fluticasone propion/salmeterol	3I
FLECTOR	I80	fluticasone-salmeterol	3I
FLEVOXIN	234	fluticasone-salmeterol I00-50	3I
FLEXICHAMBER	I63	fluvastatin	86
FLINTSTONES	220	fluvoxamine	I71
FLOGEN	204	FLUZONE	74
FLOLIPID	86	FLUZONE HIGH-DOSE	74
FLOMAX	201	FLUZONE HIGH-DOSE QUAD	74
FLORAFOIL	220	FLUZONE QUAD	74
FLORIVA	I08, 220	FML	I03
FLORRAXYL	210	FNP	244

Index of Medications

fn vitamin	230	frovatriptan succinate	I9, 20
FOLAGENT	210	FRUIT C	234
FOLAMAX	210	fruit c-I00	234
FOLAMED	210	FRUIT C-I00	234
FOLETRA	204	FRUZAQLA	58
FOLIC	I66, 204, 205, 210, 224, 230, 232, 238	ft	I13, I66, 204, 210, 217, 226, 229, 230, 233, 234, 239, 243, 244, 245
folic acid	I13, I14, I15, I66, I67, I68, 204, 205, 208, 209, 210, 211, 212, 213, 214, 216, 220, 222, 224, 226, 228	FT	I13, I98, 210, 223, 226, 230, 234, 239
folic/mvi ther-min/lycop/lut	210	ful-glo	98
FOLIKA	204, 210, 226, 238	FUL-GLO	98
FOLIKA-BC	226	FULPHILA	94
FOLIKA-D	238	FURADANTIN	37
FOLIKA-NC	226	furosemide	I01
FOLIKA-T	226	FUSION	66, I13
FOLIKA-V	204	FUZEON	66
FOLINIC-PLUS	226	FYCOMPA	92
FOLITE	204	G	
FOLIXAPURE	238	gabapentin	90, 92
FOLLISTIM AQ	I30	GALAFOLD	I97
FOLTRATE	230	galantamine	71
FOLTX	226	GALZIN	I97
FOLVITE-D	238	ganirelix	I28
fondaparinux	43	GANIRELIX	I28
FORA	98, I36, I42, I58	GARDASIL 9	75
FORACARE	I36, I42, I58	GASTROCROM	25
FORACARE LANCETS	I58	GASTROGRAFIN	99
FORA GTEL	98, I36	GASTROMARK	99
FORA LANCETS	I58	gatifloxacin	34
formaldehyde	I79	GATIFLOXACIN-DEXAMETHASONE	33
formoterol	30	GATTEX	I24
FORMOTEROL	30	GAVRETO	58
FORTAVIT	210	GEIOO	I36
FORTISCARE	I36	GELCLAIR	I94
FOSAMAX	I99, 200	GELFILM	I05, I98
FOSAMAX PLUS D	I99	GEL-FLOW	77
fosamprenavir	67	GELFOAM	77
fosaprepitant	I19	GELX	I94
fosfomycin	35	gemfibrozil	87
fosinopril	81, 83	GEMTESA	202
fosinopril/hydrochlorothiazide	81	GENADEK	210, 220
FRAGMIN	43	GENICIN	205, 226, 239
FRAICHE	I08	GENICIN VITA-Q	205
FREEDAVITE	210	GENICIN VITA-S	226
FREESTYLE	98, I36, I42, I58	GENOTROPIN	I28
FREESTYLE INSULINX	98	gentamicin	34, 35, 41
FREESTYLE LITE	98	GENTEEL	I35, I36
FROVA	I9	GENTLE IRON	I13

Index of Medications

GENVOYA	68
GEODON	176
GERBER	210, 220
GERBER GROW MIGHTY	220
GERBER LIL BRAINIES	220
GERITOL	205
GIALAX	122
GILOTTRIF	58
glatiramer	89
glatopa	89
GLEOLAN	98
GLEOSTINE	55
glimepiride	49, 50
glipizide	49, 50
GLOPERBA	26
GLUCAGON	63, 124
GLUCO	109
GLUCOCARD	136
GLUCOCOM	136, 142, 158
glucose	108, 109, 110
GLUCOSE	109
GLUCOSE CONTROL	133, 134, 135, 136, 139
GLUCOSE LIQUID	109, 110
GLUCOTROL	49
glutamine	76
GLUTOL	110
GLUTOSE-15	109
GLUTOSE-45	109
glyburide	49, 50
GLYCATE	118
glycopyrrolate	118
GLYNASE	49
GLYXAMBI	50
gnp	109, 113, 166, 198, 203, 205, 210, 217, 223, 226, 229, 230, 231, 233, 234, 235, 239, 243, 244
GNP	198, 210, 223, 231, 239, 243, 245
GNP B-COMPLEX PLUS VIT C TAB	210
gnp glucose	109
GNP VITAMIN E	243
GOJJI	98, 136, 137, 142, 158
GOLYTELY	122
GOMEKLI	56
GONAL-F	130
GONITRO	79
GOPRELTO	102
GRALISE	90
granisetron	119
GRASTEK	73
griseofulvin	45
gs	109
GS	53, 153, 166, 182, 210
GS PRENATAL	166, 210
GUAIACOL	183
guaifen-codeine	97
GUAIFEN-CODEINE	97
guaifenesin/phenylephrine	96
guanfacine	84, 174
GUARDIAN	137
GUMMIES CHILDREN MULTIVITAMIN	220
GUMMY	207, 219, 220, 230
GVOKE	109
GYNIAZOLE	44
H	
HAEGARDA 2,000UNIT VIAL	195
HAIR FORMULA	210
HAIR, SKIN AND NAILS	207, 210, 211, 216
HAIR-SKIN-NAILS	226
halcinonide	187
HALCION	178
halobetasol	187
HALOG	187
haloperidol	177
HARD NAILS	226
HARVONI	70
HAVRIX	75
HEALON GV	107
HEALTHPRO GLUCOSE CONTROL SOLN	137
HEALTHY	137, 142, 158, 203, 214, 215
HEALTHY ACCENTS AUTOLET	137
HEALTHY ACCENTS UNILET LANCET	158
healthy eyes tablet	203
HEALTHY EYES TABLET	203
HEARTBURN ACID REFLUX	210
HEMA-COMBISTIX	100
HEMANGEOL	84
HEMATEX	113
HEMATOGEN	113
HEMATRON-AF	113
HEMAX	113
HEMLIBRA	76
HEMOCYTE	113
heparin	43, 44
HEPARIN	43, 44
HEPLISAV-B	75

Index of Medications

HETLIOZ	178	HYLAVITE	226
HIBERIX	75	HYLAZINC	205
high potency multivitamin tab	210, 211	hyoscyamine	120
HIGH POTENCY MULTIVITAMIN TAB	210	HYPER-SAL	196
HISTEX-AC	96	HYPODERMIC NEEDLE	146, 147, 154
hm	114, 166, 198, 205, 217, 226, 231, 235, 239, 243	HYPOLANCE	137
HM ALCOHOL 70% PREP PADS	182	HYPROMELLOSE	199
HM BIOTIN	226	HYSINGLA	22
HM HAIR, SKIN AND NAILS TABLET	211		
hm iron	114	ibandronate	200
HM MEN'S ONE DAILY TABLET	211	IBRANCE	58
HM ONE DAILY PRENATAL	166	ibuprofen	21, 27, 28
hm prenatal	166	I-CAPS	203
hm slow release iron	114	ICAPS	203, 211
hm vit	231, 235	ICAPS AREDS2	203
hm vitamin	231, 235, 239, 243	ICAR	114
HM VITAMIN	239	icatibant	192
homatropine	106	ICLUSIG	58
HOMOCYSTEINE	226	icosapent	118
HORIZANT	89	IDHIFA	61
HORMONES	125, 126, 127, 128, 129, 130, 191	IFE-BIMIX	193
HUMALOG	51	IGALMI	179
HUMATIN	52	IHEALTH	137
HUMULIN	51	ILET	137
HURRICANE LUER-LOCK	147	ILEVRO	103
HYCAMTIN	57	I.L.X. B-I2	114
HYCODAN	97	IMBRUVICA	58
hydralazine	84, 85	IMCIVREE	63
HYDREA	55	imipramine	173
hydrochlorothiazide	81, 82, 84, 85, 102	imiquimod	183
hydrocodone	21, 22, 96, 97	IMKELDI	58
hydrocodone-acetamin	21	IMMUNERX	211
HYDROCODONE-ACETAMIN	21	IMPAVIDO	53
hydrocodone/ibuprofen	21	IMEPEKLO	188
hydrocort	33, 103, 124, 187, 189	IMURAN	132
hydrocortisone	103, 124, 127, 185, 187, 188, 189	INBRIJA	64
hydrocortisone/acetic acid	103	INCONTROL	137, 142, 158, 182
hydrocort-pramoxine	124, 189	INCONTROL LANCING DEVICE	137
hydrogen peroxide	179	INCRELEX	128
hydromorphone	22	INCRUSE	29
hydroxocobalamin	231	indapamide	102
hydroxychloroquine	53	INDICLOR	99
HYDROXYCHLOROQUINE	53	indomethacin	28
HYDROXYPROPYLCELLULOSE	199	INDOMETHACIN	28
hydroxyurea	55	INFANRIX DTAP	75
hydroxyzine	47	INFANT-TODDLER MULTIVITAMIN	220
HYFTOR	131	infant-toddler multivit-iron	220

Index of Medications

INFANT-TODDLER MULTIVIT-IRON	220	IRON .III, II2, II3, II4, II5, II6, I66, I69, 209, 2I5, 2I6, 2I7, 2I9, 220, 22I, 222
INFANT-TODDLER TRI-VITAMIN	220	iron bg
INFASURF	I92	II4, I67
INFED	II4	IRON BISGLYCINATE
INFINITY	I37	II4
INFUVITE	2II, 220	iron/c
INGREZZA	89	II4, II5
INJECT	I42, I5I, I58	iron,carbonyl
INJECTAFER	II4	II2, II4
INJECT EASE	I58	iron/folic
INJECT-EASE	I5I	II5, I67, I68, 207, 208, 2II, 2I2, 2I3, 2I6
INLYTA	58, 59	iron fum
INNER EAR PLUS	204	II3, II4, II5, I66, I67, I68, 208, 2I2, 2I3, 2I9
INOVA	I83	iron fumarate
INPEN	I37	II4, I67
INS	I48, I49	iron polysaccharide
INSET	I62	II3, II4, II5
INSET 30	I62	IRONUP
INSET 30 TUBING	I62	II5
INSPIRACHAMBER	I63	IRO-PLEX
INSPRA	I0I	II5
INSTACLEAN	I98	IROSPAN
INSTA-GLUCOSE	I09	II5
INSUL-CAP	I37	IS-D
INSUL-EZE	I37	239
INSULIN	48, 49, 50, 5I, I28, I49, I50, I5I, I53, I55	ISENTRESS
INSULIN CARTRIDGE	I5I	68
INTEGRA	II4, I47, I5I	isoflurane
INTELENCE	66	24
INTERLINK	I5I	isoniazid
INTRINSI	23I	36
INVACARE	I42, I58	ISOPROPANOL
INVEGA	I76	I98
INVELTYS	I03	isopropyl
iodine/potassium iodide	I89	I82, I98
iodine/sodium iodide	I89	isopropyl alcohol
IODOFLEX	I89	I82, I98
IODOSORB	I89	ISOPROPYL ALCOHOL
IOPIDINE	I05	I82, I98
IPOL	73	isopropyl rubbing alcohol
ipratropium	29, I02	I98
IQIRVO	I94	ISOPROPYL RUBBING ALCOHOL
irbesartan	82, 83	I05
irbesartan/hydrochlorothiazide	82	ISOPTO CARPINE
IRESSA	59	I79
iron ..	95, II2, II3, II4, II5, II6, I66, I67, I68, 205, 207, 208, 2I0, 2II, 2I2, 2I3, 2I6, 2I9, 220, 22I, 222, 228	ISORDIL
		79
		isosorbide
		79, 85
		isotretinoin
		I80
		isoxyprine
		85
		isradipine
		78
		itraconazole
		45
		IV 3000
		I55
		IV3000
		I55
		ivabradine
		79
		IV ADMINISTRATION SET
		I62
		ivermectin
		.52, I84
		IWILFIN
		59
		J
		JAKAFI
		56
		JALYN
		20I
		JANSSEN COVID-I9 VACCINE
		73
		JANUMET
		50
		JANUVIA
		49
		JARDIANCE
		5I
		JATENZO
		I25
		JOENJA
		I92
		JORNAY
		I74
		JOURNAVX
		I9

Index of Medications

JUBLIA	46	kro glucose	109
JULUCA	65	kro isopropyl alcohol 91%	198
JUST 4 KIDZ MULTIVIT-PROBIOTIC	220	k-tab	II7
JUSTRIGHT 5000	108, III	K-TAB	II6
JUXTAPID	86	KYLEENA	95
JYNARQUE	101	KYNMOBI	64
JYNNEOS	76	L	
K		labetalol	81, 82
KI-1000	244	LABSTIX REAGENT	100
K2	238, 239, 244	lacosamide	92
KADIAN	23	LACRISERT	103
KALETRA	67	lactulose	II8, I22
KALYDECO	192	LAMICTAL	92
KAPVAY	174	lamivudine	66, 67, 70
KENALOG	188	lamivudine/zidovudine	66
KENDALL	151, 155	lamotrigine	92
KENDALL DISINFECTANT CAP	151	lancets	I43, I56, I57, I58, I59
Keppra	92, 93	LANCETS	I41, I42, I43, I44, I45, I56, I57, I58, I59, I60, I61
KERENDIA	101	LANCETS THIN	I58
KESIMPTA	89	LANCETS ULTRA THIN	I58
KETAMINE	179	LANCING DEVICE	I33, I34, I35, I36, I37, I38, I39, I40
ketoconazole	42, 45, 46	LANCING SYSTEM	I37
ketodan	46	LANOXIN	79
KETO-DIASTIX REAGENT	100	lansoprazole	I20, I23
KETONE CARE TEST STRIP	99	lansoprazole/amoxiciln/clarith	I20
KETONE TEST STRIP	98, 100	lanthanum carbonate	I10
ketoprofen	28	LANZO	I37
ketorolac	20, 21, I03, I04	lapatinib ditosylate	59
KETOSTIX REAGENT	100	LASIX	101
KIDS	99, I08, III, 219, 220, 226	LASTACAFT	48
KIDS COD LIVER OIL	220	latanoprost	I05
KIDS MULTIVITAMIN	220	LATANOPROST	I05, I06
KINRIX	75	LAZANDA	23
KISQALI	57, 59	LAZCLUZE	59
KITABIS PAK	35	leader glucose	109
KLARITY	34, I03, I04, I07	leader quick dissolve gluc	109
KLARITY-A(AZITHROMYCIN-CHONDR)	34	lecithin/pyridoxine/kelp	2II
KLARON	I81	leflunomide	26
KLOXXADO	44	lenalidomide	57
KOSELUGO	56	LENVIMA	59
KOSHER PRENATAL	I66	LESCOL	86
K-PAX	2II	L.E.T.	25
K-PHOS	II7	letrozole	56
KPN PRENATAL	I66	leucovorin	193
KRINTAFEL	53	LEUKERAN	55
KRISTALOSE	I22	LEUKINE	94
kroger glucose	I09	levalbuterol	30

Index of Medications

LEVBID	120	LIVITA	221, 245
LEVER LOCK CANNULA	151	LIVMARLI	122
levetiracetam	92, 93	LIVTENCITY	69
LEVETIRACETAM	92	l-mefol/a-cyst/mebl2/algal oil	226
LEVITRA	193	lmefolate/b3/copp/zn/sel/chrom	211
levobunolol	105	L-MESITRAN	185
levocarnitine	199	L-METHYLFOL	227
levofloxacin	34, 38	l-norgest/e.estradol-e.estrad	95
LEVOMEFOL	226	LODINE	28
levomefolate	204, 205, 224, 225, 226, 228	LODOSYN	65
LEVOMEFOLATE	226	lofexidine	201
levonorgestrel/ethin.estradol	95	LOKELMA	110
levothyroxine	191	LOMAIRA	62
LEVSIN	120	LOMOTIL	118
LEVULAN	62	longs glucose	110
LEXETTE	188	LONHALA MAGNAIR	29
LICART	180	LONSURF	55
lidocaine	25, 124, 189	LOPID	87
LIDOCAINE-EPINEPHRIN-TETRACAIN	25	lopinavir/ritonavir	67
LIDOCAINE-HYDROCORT	124	LOPRESSOR	84
LIDOCAN	25	LOPROX	46
LIFESHIELD BLUNT CANNULA	147, 151	lorazepam	170
LILETTA	95	LORBRENA	59
lindane	189	LORID	227
linezolid	38	LORMATE	227
LINZESS	122	LORTAB	21
liothyronine	191	LORZONE	165
LIPO	204	losartan/hydrochlorothiazide	82
LIPO-FLAVONOID PLUS	204	losartan potassium	83
LIPOTRIAD	203	LOTEMAX	104
LIQUID 99, I09, I10, I15, 205, 212, 223, 229, 235, 236, 238, 244		LOTENSIN	81, 83
LIQUID C	235	LOTENSIN HCT	81
LIQUID E-Z PAQUE	99	loteprednol	104
LIQUID POLIBAR PLUS	99	loteprednol etabonate	104
liraglutide	48	lovastatin	86
lisdexamphetamine	170, 173, 174	loxapine	177
lisinopril	81, 83	lubiprostone	122
lisinopril/hydrochlorothiazide	81	LUCENTIS	107
LITEAIRE	163	LUER LOCK	149, 150, 152
LITE TOUCH	137, 143, 159	LUER-LOK	148, 152, 153
LITETOUGH	163	LUERSLIP	152
LITFULO	200	LUER SLIP TIP	152
lithium	171	LUER TIP CAP	152, 154
LITHOBID	171	LUMAKRAS	56
LITHOSTAT	118	LUMRYZ	178
LITTLE ANIMALS	221	LUPKYNIS	132
LIVDELZI	194	LUTEIN	202, 203, 205, 219

Index of Medications

LYBALVI	176	MEGA BIOTIN	227
LYDIA PINKHAM HERBAL	115	megestrol	62, 202
LYMPEAK	39	meijer glucose	110
LYNPARZA	59	MEKINIST	56
LYSODREN	61	MEKTOVI	56
LYSTEDA	76	meloxicam	28
LYTGOBI	59	melphalan	54
LYUMJEV	51	memantine	88
M			
MACROBID	38	MEMANTINE	88
MACULAR BENEFITS	203	MEN 50	206, 208, 211, 216
MACUVEX	203	MENACTRA	73
MACUZIN	203	MENOPUR	129
mafенide	42	MENOSTAR	126
MAGELLAN	152	MENQUADFI	74
MALARONE	53	MEN'S	205, 206, 208, 209, 211, 214, 216, 244
malathion	189	MEN'S 50 PLUS	211, 214
maprotiline	173	MEN'S DAILY	211
maraviroc	66	MEN'S MULTIVITAMIN	211, 214
MAR-COF CG	97	MENVEO	74
MARINOL	119	MEPHYTON	244
MARNATAL-F	166	meprobamate	170
MARPLAN	171	MEPRON	53
MATULANE	61	mercaptopurine	55
MAVENCLAD	89	MERIBIN	227
MAXFE	115	mesalamine	121
MAXIMIN	211	mesna	193
MAXIMUM D3	239	MESNEX	193
MAXITROL	33	METADATE	174
MAXI-TUSS CD	96	METANX	227
MAYZENT	89	METANXPRO	227
MEBOLIC	211	metaproterenol	30
meclizine	119	metaxalone	165
meclofenamate	28	metformin	49, 50
mecobal/levomefolat ca/b6 phos	227	METHACHOLINE	98
MEDIHONEY	185	methadone	23
MEDISENSE	137, 143, 159	methamphetamine	71, 72
medlance	143, 159	METHAVER	227
MEDLANCE	143, 159	methazolamide	100
medlance plus	159	methenam	35
MEDLANCE PLUS	159	methenamine hippurate	35
MEDROL	127	methenamine mandelate	35
medroxyprogesterone	95, 129	methenam/sod phos/mblue/hyosc	35
MEDTRONIC	137	methen/mblue/sal/sod phos/hyos	35
MEDTYCHOLL-B	227	methimazole	190
mefenamic	21	METHITEST	125
mefloquine	53	meth/meblue/sod phos/psal/hyos	35
		methocarbamol	165

Index of Medications

methotrexate	55	MINIMED	I38, I52
methoxsalen	I80	MINIMED RESERVOIR	I52
methscopolamine	I20	MINI PRENATAL	I66
METHYL B-I2	23I	MINIPRESS	82
METHYLCOBALAMIN	23I	MINITRAN	79
methyldopa	84	minocycline	39, 40
methylergonovine	I29	MINOLIRA	40
METHYLFOLATE	205	minoxidil	84
METHYLIN	I74	mirabegron	202
methylphenidate	I74, I75	MIRENA	96
METHYLPHENIDATE	I75	mirtazapine	I70
methylprednisolone	I27, I28	MIRVASO	I84
METHYL PROTECT	227	misoprostol	27, II9, I20
methyl salicylate	I83	MITIGARE	26
methyltestosterone	I25	MITOMYCIN	I07
metoclopramide	I22	MITOMYCIN-WATER	I07
metolazone	I02	MITOSOL	I07
METOPIRONE	99	MI-VITE	205
metoprolol	84, 85	MIXED TOCOTRIENOLS	243
METOPROLOL SUCCINATE ER-HCTZ	85	MKO	I79
METROCREAM	I84	M-M-R II VACCINE	75
METROGEL	40, I84	MOBIC	28
METROGEL-VAGINAL	40	MOBILE	I43
metronidazole	35, 40, I84	modafinil	I78
metyrosine	84	MODERNA	73
mexiletine	78	MODERNA COVID	73
MIACALCIN	I30	moexipril	83
miconazole	44	molindone	I77
MICRO	I39, I43, I48, I59, I90	mometasone	I02, I88
MICROCHAMBER	I63	mondoxyne	40
MICRODOT	I37, I38	MONOCAPS	2II
MICROLET	I38, I43, I59	MONOFERRIC	I15
MICROSPACER	I63	MONOJECT	I47, I52
MICROTAINER	I57, I59	MONOLET	I43, I59
MICRO THIN LANCET	I59	MONSEL'S	77
MICRO THIN LANCETS	I59	montelukast	32
midazolam	I78	morgidox	40
MIDAZOLAM	I78, I79	MORGIDOX	40
midodrine	72	morphine	23
MIEBO	I03	MOTOFEN	II8
MIFEPREX	I95	MOUNJARO	48
mifepristone	50, I95	MOUTHPIECE	I63
miglitol	49	MOVANTIK	44
miglustat	I96	MOXATAG	38
MIGRALAN	20	moxifloxacin	34, 38
MINCORA	227	MOXIFLOXACIN	33
MINI LANCING DEVICE	I38, I39	MRESVIA	76

Index of Medications

MS CONTIN	23	MYFORTIC	I32
ms glucose	IIO	MYGLUCOHEALTH	I38, I43, I59
ms quick dissolve glucose	IIO	MYHIBBIN	I32
MTERYTI	I66	MYLERAN	55
MTX	23I	MYRBETRIQ	202
MUCOSITISRX	I95	mysoline	93
MULTAQ	78	MYXREDLIN	5I
MULTIA	2II	N	
MULTI-BETIC	203	nabumetone	28, 29
MULTI-DAY PLUS MINERALS	2II	naftifine	46, 47
multi for her	2II	NAFTIN	46, 47
MULTI FOR HER	2II	NALFON	28
MULTI-LANCET	I38	NALOCET	2I
multilex	2II	naloxone	24, 44, 20I
MULTILEX	2II	naltrexone	44
MULTI PRO	2II	NAMENDA	88
MULTISTIX	I00	NAMZARIC	88
MULTITOL-M	245	NANO	I47, I48, I69, 22I
multivit I65, 205, 206, 207, 208, 2I0, 2II, 2I2, 2I3, 2I4, 2I6, 2I9, 220, 22I, 222		NANOVM	22I, 245
multivitamin .I67, 208, 209, 2I0, 2II, 2I2, 2I3, 2I4, 2I6, 2I9, 220, 22I, 222, 223		NAPRELAN	28
MULTIVITAMIN ...I67, 202, 203, 205, 206, 207, 208, 209, 2I0, 2II, 2I2, 2I3, 2I4, 2I5, 2I6, 2I7, 2I9, 220, 227		NAPROSYN	27, 28
MULTIVITAMIN-MULTIMINERAL	2I2	naproxen	27, 28, 29
MULTI-VITE	2I2	naratriptan	I9, 20
MULTI-VIT-FLOR	22I	NARCAN	44
MULTIVIT-FLUOR	22I	NARDIL	I7I
MULTIVIT-FLUORIDE	22I	NASCOBAL	23I
multivit-min/fa/lycopen/lutein	208, 2I2	NATACHEW	I66
mupirocin	4I	NATACYN	44
MURI-LUBE	I98	nateglinide	49
MUSE	I93	NATPARA	I29
mv	I13, I14, I15, 207, 2I0, 2I3, 2I4	NAYZILAM	9I
mv-min	2I3	nebivolol	84
mvn	208, 2I3	NEBUPENT	53
MVW	2I3, 22I	nebusal	I96
MVW COMPLETE	22I	NEBUSAL	I96
MYALEPT	I30	NEEDLE	I46, I47, I48, I5I, I52, I53, I54
MYCAPSSA	I29	needles,safety huber,disposabl	I47
MYCOBUTIN	36	NEEVODHA	2I3
mycophenolate	I32	nefazodone	I72
MYDAYIS	72	NEFFY	7I
MYDCOMBI	I06	NEMLUVIO	I3I
MYDRIACYL	I07	neomycin	33, 34, 35, I79
MYDRIATIC4	I04	neomycin/bacit/p-myx/hydrocort	33
MYFEMBREE	I28	neomycin/bacitracin/polymyxinb	34
		neomycin/polymyxin b/dexametha	33
		neomycin/polymyxin b/hydrocort	33
		neomycin/polymyxin b/gramicidin	34

Index of Medications

neomycin sulfate	35
NEONATAL	I15, I66
NEONATAL FE	I15
NEORAL	I32
NEO-SYNALAR	41
NEOVITE	213
NEPHRON FA	227
NEPHRO-VITE	227
NERIA	I62
NERLYNX	59
NESTABS	I66, 213
NEUAC	I81
neuac gel	I81
NEULUMEX	99
NEUPRO	64
NEURIN-SL	231
NEUTRASAL	I95
nevirapine	66, 67
NEXAVAR	59
NEXCARE TEGADERM	I55
NEXLETOL	86
NEXLIZET	86
niacin	87, 217, 218
NIACIN	217, 218, 219
niacinamide	218
NIACINAMIDE	218
NIACOR	87
nicardipine	78
NICOMIDE	213
NICOTROL	I90
nifedipine	78
NIFEREX	I15
NILANDRON	55
nilotinib	59
nilutamide	55
nimodipine	78
NINJACOF-XG	97
NINLARO	59
nisoldipine	78, 79
nitisinone	I96
NITRO-DUR	79
nitrofurantoin	37, 38
nitroglycerin	79, 80
NITROLINGUAL	80
NITROMIST	80
NITROSTAT	80
NITYR	I96
NIVA-FOL	227
NIVA-PLUS	I23
NIVESTYM	94
nizatidine	I21
NOCTIVA	I26
NO FLUSH NIACIN	218
NOKOR	I47
norelgestromin/ethin.estradiol	95
noreth-ethinyl estradiol/iron	95
norethind-eth estrad	95, I26
norethindrone	95, I26, I27, I29
norethin-ee	95
norethin-eth estrad	I27
NORGESIC	I65
norgestimate-ethinyl estradiol	95
norgestrel-ethinyl estradiol	95
NORM-JECT	I52, I53
nortriptyline	I73
NORVIR	67
NORWEGIAN COD LIVER OIL	223
NOURIANZ	64
NOVA	I38, I43, I59
NOVAFERRUM	I15, 221
NOVAMAX PLUS	98, I38
NOVAMV	221
NOVAREL	I30
NOVAVAX	73
NOVAVAX COVID-I9 VACC,ADJ	73
NOVOPEN 3	I38
NOVOPEN ECHO	I38
NOXAFIL	45
NOXIFOL-D3	239
NUBEQA	55
NUCALA	32
NUCORT	I88
NUEDEXTA	89
NUFERA	I15
NUFOLA	227
NU-IRON	I15
NULEV	I20
NULYTELY	I22
NUMBRINO	I02
NUMOISYN	I94, I95
NUPLAZID	I71
NURTEC ODT	20

Index of Medications

NUTRALYN	213	ONE-A-DAY	I66, 214, 215, 221
NUTRIVIT	213	one daily	I68, 208, 210, 214, 215
NUVESSA	40	ONE DAILY	I66, 206, 209, 211, 213, 214
NUZYRA	40	ONE-DAILY	215
NYMALIZE	78	ONETOUCH	98, I39, I43, I59
nystatin	42, 45, 46, 47	ONETOUCH DELICA	I39, I59
O		ONETOUCH ULTRA	98, I39
OB COMPLETE	I66, 213	ONETOUCH VERIO	98, I39
OBREDON	97	ONEVITE	215
OBSTETRIX EC	I66	ONE WAY MOUTHPIECE	I63
OBSTETRIX ONE	213	ONEXTON	I81
OBTREX DHA	I66	ONGENTYS	64
OCALIVA	I21	ON-THE-GO	I43, I59
OCUFLOX	34	OPFOLDA	I96
OCULAR VITAMINS	203	opium/belladonna	23
OCUVEL	203	opium tincture	I18
OCUVITE	203, 213	OPSITE	I55
ODACTRA	73	OPSUMIT	80
ODEFSEY	68	OPSYNVI	I81
ODOMZO	56	OPTICHAMBER	I63
OFEV	I92	OPTIFAST	215
ofloxacin	33, 34, 38	OPTIMAL D3 M	239
OGSIVEO	59	OPTISOURCE	215
OJEMDA	56	OPTUMRX	I39
olanzapine	I76, I77	OPURITY	I25, 231
olmesartan/amlodipin/hcthiazid	82	OPZELURA	I89
olmesartan/hydrochlorothiazide	82	ORACIT	I17
olmesartan medoxomil	83	ORALAIR	73
olopatadine	I02	ORAMAGICRX	I94
OLPRUVA	I18	ORAPRED ODT	I28
OLUX	I88	ORAVIG	45
om-3	213	ORENITRAM	80
OMECLAMOX-PAK	I20	ORFADIN	I96
omega-3 acid	I18	ORGOVYX	57
omeprazole	I23, I24	ORIAHNN	I28
OMNIPAQ	98	ORILISSA	I28
OMNIPOD	I38	ORKAMBI	I91
OMNITROPE	I28	ORLADEYO	I92
OMNIVEX	213	ORLISTAT	63
OMVOH	I31	orphenadrine	I65
ON CALL	I38, I43, I59	ORTHO DF	239
ONCOVITE	213	oseltamivir	69
ondansetron	I19	OSENI	48
one	I68, 208, 210, 214, 215	OSMOPREP	I22
ONE I63, I66, I68, I69, 206, 209, 211, 213, 214, 215, 216, 221, 222		OSTACHOL	239
one-a-day	215	OTEZLA	26
ONE A DAY	I66, 222	OTIPRIO	33

Index of Medications

OTOVEL	33	PEDIA POLY-VITE	222
OVACE	I81, I82	pedia poly-vite iron	222
OVAL TAPE	I39	PEDIARIX	76
OVIDE	I89	PEDIATRIC MASK	I63
OVIDREL	I30	PEDIATRIC MONITOR	I39
oxandrolone	I25	pediatric multivit	222
oxaprozin	27, 29	pediatric multivitamin	I29, 222, 223
oxazepam	I70	PEDIATRIC PANDA MASK	I63
OXBRYTA	77	PEDIATRIC POLY-VITAMIN	222
oxcarbazepine	93	PEDIATRIC POLY-VITE	222
OXERVATE	I07	PEDIATRIC TRI-VITAMIN	222
oxiconazole	47	PEDIATRIC TRI-VITE	222
OXTELLAR	93	PEDIA TRI-VITE	222
oxybutynin	202	pedi multivit	I29, 220, 221, 222
oxycodone	I21, 23, 24	ped mvit	221
oxycodone hcl/acetaminophen	I21	PEDVAXHIB	75
OXYCONTIN	24	peg3350/sod sulf,bicarb,cl/kcl	I22, I23
oxymorphone	24	peg3350/sod sul/hacl/kcl/asb/c	I23
OXYTROL	202	PEGASYS	70
OZEMPIC	48	PEMAZYRE	59
P		PENBRAYA	74
PACNEX	I83	penciclovir	70
paliperidone	I76	penicillamine	26
PALYNZIQ	73	penicillin	38
PAMELOR	I73	PENTACEL	75
PAN-C	235	pentamidine	53
PANCREAZE	I23	PENTASA	I21
PANDA	I63	pentazocine	24
PANDEL	I88	pentoxifylline	77
PANRETIN	62	PEPCID	I22
PANTETHINE	I29	perampanel	I92, 93
pantoprazole	I24	PERFECT	I15, I43, I47, I59
PANTOTHENIC	I29	PERFECT IRON	I15
PAPAVERINE-PHENTOLAMINE	I93	PERIDEX	I93
PAPAVERINE-PHENTOLMN-ALPROSTDL	I93	PERIDIN-C	235
PARADIGM	I53, I62	perindopril erbumine	83
paregoric	I18	permethrin	63
PAREMYD	I07	perphenazine	I73, I77
paricalcitol	I95	perphenazine/amitriptyline	I73
PARNATE	I71	PFIZER	73
paroxetine	I72, I97	PFIZER COVID	73
PARVLEX	I15	PHARMABASE BARRIER	I84
PASER	36	pharm choice alcohol prep pads	I82
PATANASE	I02	PHARM CHOICE ALCOHOL PREP PADS	I82
PAXIL	I72	PHASEAL	I47
PAXLYTE	23I	PHEBURANE	I18
pazopanib	59	phenazopyridine	25

Index of Medications

phendimetrazine	62	POLY-VITE	222
phenelzine	171	POMALYST	57
phenobarb/hyoscy/atropine/scop	120	POSACONAZOLE	45
phenobarbital	178	posaconazole dr	45
PHENOBARBITAL-BELLADONNA ELIXR	120	POTABA	227
phenoxybenzamine	72	potassium	20, 38, 83, I08, III, II6, II7, I23, I89
phentermine	62, 63	POTASSIUM	I01, I02, II6, II7, I23
phenylephrine	47, 96, I05	potassium bicarbonate/cit ac	II7
PHENYTEK	93	potassium chloride	II6, II7
phenytoin	91, 93	potassium citrate	II7
PHOSPHOLINE IODIDE	I05	potassium iodide	III, I89
PHOTREXA	I03	potassium iodide/iodine	III
PHYSIOLYTE	I79	povidone-iodine	I03
PHYSIOSOL	I79	pramipexole	64
phytonadione	244	PRAMOSONE	189
PHYTONADIONE	244	PRANDIN	49
pilocarpine	72, I05	prasugrel	65
pimecrolimus	I32	pravastatin	86
pimozide	I75	praziquantel	52
pindolol	84	prazosin	82
pioglitazone	50	PR BENZOYL PEROXIDE	I84
PIP	I39, I43, I59	PRECISIONGLIDE	I47, I53, I54
PIP GLUCOSE CONTROL SOLUTION	I39	PRECISION XTRA	98, I39
PIP LANCET	I59	PRECOSE	49
PIQRAY	59	pred	33
piroxicam	27, 29	PRED	33, I04
PISTON ENFIT	I53	PRED FORTE	I04
pitavastatin	86	PRED-G	33
PLEGRIDY	90	prednicarbate	I86, I88
PLEXION	42, I82	prednisolone	34, I04, I28
PNEUMOVAX 23	74	PREDNISOLONE	33, I04
pnv	I66, I67, I68	PREDNISOLONE ACET-GATIFLO-BROM	33
POCKET CHAMBER	I63	PREDNISOLONE ACET-GATIFLOXACIN	33
PODIAPN	227	PREDNISOLONE ACET-MOXIFLOXACIN	33
podofilox	I83, I84	PREDNISOLONE AC-MOXIFLO-BROMF	33
POLIBAR ACB	99	PREDNISOLONE AC-MOXIFLO-NEPAF	33
polyethylene	I98	PREDNISOLONE PHOS-GATIFLO-BROM	33
POLY HUB	I47	PREDNISOLONE PHOS-GATIFLOXACIN	33
polymyxin b sulf(trimethoprim	34	PREDNISOLONE PHOS-MOXIFLO-BROM	33
POLYSKIN II	I55	PREDNISOLONE PHOS-MOXIFLOXACIN	33
POLYTRIM	34	prednisone	I28
POLY-TUSSIN AC	96	preferred plus glucose	I10
POLY-VI-FLOR	222	PREFEST	I27
poly-vi-sol	222	pregabalin	93, 200
POLY-VI-SOL	222	PREGNYL	I30
POLY-VITA	222	PREHEVBRIOP	76
POLY VITAMIN-IRON	215	PREMARIN	I29

Index of Medications

PRENATA	I67	promethazine	47, 96, II9
prenatal	I65, I66, I67, I68	PROMETRIUM	I29
PRENATAL	I65, I66, I67, I68, I69, 206, 210, 215, 217	propafenone	78
prenatal7I	I68	proparacaine	I04
PRENATE	I68, I69, 215	propranolol	84, 85
PREPIDIL	I29	propylthiouracil	I91
PRESERVISION	203	PROQUAD	75
PRESSURE	I05, I06, I44, I59	PRORENAL	215, 227
PRESSURE ACTIVATED LANCETS	I59	PROSCAR	201
PRESTALIA	8I	PROTECT	I08, II5, 215, 227
PRETOMANID	36	PROTECT IRON	II5, 215
PREVENT	223	PROTHELIAL	I94
PREVIDENT	I08, III	PROTOPIC	I32
PREVNAR I3	74	protriptyline	I73
PREVNAR 20	74	PROVERA	95, I29
PREVYMIS	69	PROVIDA OB	I68
PREZISTA	66	PROVOCHOLINE	98
PRIFTIN	36	prucalopride	I22
PRIMACARE	I68	pseudoephed/codeine/guaif'en	97
primaquine	53	PSV SET	I62
PRIMAQUINE	53	pub glucose	II0
PRIMEAIRE	I63	PULMOZYME	I92
primidone	93	PURE	I44, I60, I64, I82
PRIMSOL	35	PURE COMFORT	I60, I64, I82
PRIORIX	75	PURECOMFORT	I64
PRISMASOL	I17	PUREFE	215
probenecid	29	PUREVITA	205, 218, 219, 223, 227, 229, 231, 232, 233, 235, 239, 243
PROCARDIA	78	PURIXAN	55
PROCARE SPACER	I63	PUSH	I44, I60
PROCERV HP	215	PUSH BUTTON	I60
PROCHAMBER	I64	pyrazinamide	36
prochlorperazine	I19	pyridostigmine	71
PRO COMFORT	I44, I59, I63, I82	PYRIDOSTIGMINE	71
PROCORT	I24	pyridoxine	I11, 233
PROCTOCORT	I24	PYRIDOXINE	233
PRODIGY	I39, I44, I53, I60	pyrimethamine	53
PRODIGY COUNT-A-DOSE	I53	PYRUKYND	76
PRO FE	I15	Q	
PROFERRIN	I15	qc	I68, I82, I98, 239
PROFOLA	I25	qc alcohol 70% swabs	I82
progesterone	I29	qc prenatal tablet	I68
PROGLYCEM	I10	QUELBREE	I75
PROGRAF	I32	QSYMIA	63
prolate	2I	Q-SYTE	I62
PROLENSA	I04	QUADRACEL DTAP-IPV	75
PROMACTA	94		

Index of Medications

QUDEXY	93	ra vitamin a	223
QUERCETIN	204	RA VITAMIN C	235
QUESTRAN	87	RAYALDEE	195
quetiapine	176	RAYA SURE	147, 148
QUFLORA	222	RAYOS	128
QUICK RELEASE SOFT TEFLON	139	RAZADYNE	71
quinapril	81, 83	READI-CAT 2	99
quinapril/hydrochlorothiazide	81	READYLANCE	144, 160
QUIN B STRONG	227	REBIF	90
QUINCE SPINAL	147	RECOMBIVAX HB	76
quinidine	78	RECOTHROM	77
quinine	53	RECTIV	123
QUINTABS	215	REFUAH	139
QULIPTA	20	REGLAN	122
QUVIVIQ	179	REGRANEX	183
QVAR REDIHALER	32	REGULAR BEVEL	148
R		RELAFEN	29
ra alcohol swabs	182	RELAGARD	52
ra balanced	227	RELCARE	227
rabeprazole	124	RELENZA	69
RADICAVA ORS	88	RELEXXII	175
RADIOGARDASE	197	RELIAMED	139, 144, 160
ra glucose	110	RELION	110, 182
RAGWITEK	73	reli-on glucose	110
ra high potency iron	115	relion glucose	110
RA HIGH POTENCY IRON	115	RELION GLUCOSE	110
ra isopropyl alcohol 70%	198	RELISTOR	44
RA ISOPROPYL ALCOHOL 70% WIPES	182	REMEDIENT	215
ra isopropyl alcohol 91%	198	REMERON	170
raloxifene	200	RENACIDIN	117
ramelteon	178	RENAL VITAMIN	227
ramipril	83	RENAL-VITE	227
RANEXA	77	RENAPLEX	227
RA NIACIN	218	RENVELA	110
ranitidine	122	repaglinide	49, 50
ranolazine	77	REPATHA	86
ra one daily prenatal dha pack	168	REPLACEMENT	76, III, II2, II3, II4, II5, II6
RAPAMUNE	132	REPLACEMENT PEDIATRIC MONITOR	139
RAPID B-I2 ENERGY	231	REPLESTA	240
ra prenatal tablet	168	REQ49+	205
rasagiline	64	RESPA A.R.	96
RASUVO	26	RESTASIS	107
RAVICTI	118	RESTORIL	178
ra vit	231, 235	RETEVMO	59, 60
RA VIT	231	RETIN-A	190
ra vitamin	223, 231, 235, 240, 243	RETROVIR	67
		REVATIO	80

Index of Medications

REVESTA	240	ROTATEQ	73
REVLIMID	57	ROWASA	121
REVUFORJ	60	ROXICODONE	24
REXULTI	177	ROXIFOL	240
REYATAZ	67, 68	ROZLYTREK	60
REYVOW	20	rufinamide	93
REZDIFRA	195	rutin	204
REZUROCK	201	RUZURGI	90
RHOFADE	184	RYALTRIS	102
RHOPRESSA	105	RYBELSUS	48
ribasphere	70	RYCLORA	47
ribavirin	70	RYDAPT	60
riboflavin	232	RYTARY	64
RIBOFLAVIN	232	RYVENT	47
RIBOZEL	227	S	
RIDAURA	26	sacubitril	82
rifabutin	36	SAFE-CLIP	139
rifampin	36	SAFESNAP	153
RIGHTEST	I39, I44, I60	SAFETY I4I, I42, I43, I44, I45, I46, I49, I52, I53, I54, I57, I58, I59, I60, I6I	
RILUTEK	88	SAFETYGLIDE	I49, I53
riluzole	88	SAFETY LANCETS	I57, I59, I60
rimantadine	69	SAFETY-LET	I60
RIMSO-50	24	SAFETY-LOK	I53
ringer's solution	I79	SAFETY SEAL LANCETS	I58, I60
RINVOQ	26	SAFETY SYRINGE	I52, I53, I54
RIOMET	49	SALAGEN	72
risedronate	I99, 200	SALIVAMAX	I95
RISPERDAL	I76	salsalate	26
risperidone	I76	SAMBUCUS	235
RITEFLO	I64	SANCUSO	I19
ritonavir	67, 68	SANDIMMUNE	I32, I33
rivaroxaban	43	SANTYL	I89
rivastigmine	71	sapropterin	I97
rizatriptan	20	SAPS ALCOHOL 70% PREP PADS	I82
R-NATAL	I69	SAVELLA	200
ROBINUL	I18	saxagliptin	49, 50
ROCALTROL	240	saxagliptn	50
ROCKLATAN	I05	SAXENDA	63
roflumilast	32	SCALACORT	I88
ROMVIMZA	60	SCEMBLIX	60
ropinirole	64	SCOODY-DOO ONE A DAY	222
rosadan	I84	scopolamine	I19
ROSADAN	I84	secobarbital	I78
rosula	42	SECUADO	I76
ROSULA	42	SEEBRI	30
ROSZET	85	SELARSDI	I30
ROTARIX	73, 75		

Index of Medications

SELECT-OB	I68	sm	I10, I16, I68, I83, I98, 205, 215, 228, 231, 233, 235, 240
selegiline	64	sm alcohol prep pads	I83
selenium	I82	SMART	I42, I44, I58, I60
SELZENTRY	66	SMARTDIABETES VANTAGE	I39
SEMGLEE	51	SMARTEST	I39, I44, I60
SEN-SERTER	I39	smart sense	I10
SEROSTIM	I28	SMART SENSE	I60
sertraline	I72	sm iron	I16
sevelamer	I10	sm isopropyl alcohol 70%	I98
sevoflurane	24, 25	sm prenatal vitamins tablet	I68
SEYSARA	40	SM SLOW RELEASE IRON 45 MG TAB	I16
SFROWASA	I21	sm vitamin	231, 235, 240
SHINGRIX	76	sodium	25, 27, 28, 29, 32, 34, 37, 38, 42, 43, 55, 62, 83, 86, 91, 92, 93, 98, 99, I03, I04, I08, I10, I11, I12, I16, I17, I18, I22, I23, I28, I32, I65, I78, I79, I80, I81, I89, I91, I96, I99, 200, 234
SHORT BEVEL	I48	SODIUM	34, 43, 99, I78, I79, I81
SIDEROL	I15	sodium chloride	I22, I23, I79, I96
SIDESTREAM	I64	sodium chloride/nahco3/kcl/peg	I22, I23
SIGNIFOR	I29	SODIUM CITRATE	43
SILATRIX	I94	sodium ferric gluconat/sucrose	I12, I16
sildenafil	80, I94	sodium fluoride	I08, I11, I16
SILENOR	I79	SODIUM OXYBATE	I78
SILHOUETTE	I38, I39, I62	sodium phenylbutyrate	I18
SILICONE MASK	I64	sodium polystyrene sulfonate	I11
silodosin	201	sodium polystyrene sulfon/sorb	I10
SIL-SERTER	I39	sodium, potassium,mag sulfates	I23
SILVADENE	42	sodium sulfacetamide	I81
silver sulfadiazine	42	SODIUM SULFACETAMIDE I0% WASH	I81
SIMBRINZA	I05	sod,pot chlor/mag/sod,pot phos	I79
SIMILAC PRENATAL	I68	sod sulfase-sulf	42
SIMLANDI	54	sod sulfacetam I0% clnsng gel	I81
SIMPONI	54	sod sulfacetamide 9.8% shampoo	I81
simvastatin	85, 86	sod sulfacetamide I0% shampoo	I81
SIMVASTATIN	86	sod sulfacet-sulfr	42
SINGLE	I24, I44, I60, I82	sod sulfacet-sulfur	42
SINGLE-LET	I60	SOF-SERTER	I39
SINGLE USE SWAB	I82	SOF-SET	I39
sirolimus	I32, I33	SOFT	I39
SIRTURO	36	SOHONOS	I97
SITAVIG	69	solifenacin	202
SITZMARKS	99	SOLIQUA	48
SKYLA	96	SOLO	I16
SKYRIZI	I31, I80	SOLODYN	40
SLIP-TIP	I53	SOLOSEC	34
slo-niacin	218	SOLTAMOX	62
SLO-NIACIN	218		
SLOW FE	I15		
slow release iron	I12, I14, I15, I16		
SLOW RELEASE IRON	I12, I15, I16		

Index of Medications

SOLUS	139, 144, 160	STUART ONE	168
SOLUS V2	139, 160	SUBSYS	24
SOLUVITA	222	SUCRAID	121
SOMA	165	sucralfate	120
SOMAVERT	195	SULAR	79
SOOLANTRA	184	sulfacetamide	34, 42, 181
sorafenib tosylate	59, 60	sulfadiazine	35, 42
SORBITOL	179	sulfamethoxazole(trimethoprim)	35
sotalol	84	SULFAMYLON	42
SOTYKTU	180	sulfasalazine	121
SOTYLIZE	85	sulindac	29
SPACE CHAMBER	163, 164	SUMADAN	42
SPAN C	235	sumatriptan	20
SPECIALTY USE NEEDLES	148	SUMAXIN	42
SPECTRACEF	37	sunitinib malate	60
SPECTRAVITE	205, 216	SUNLENCA	65
SPEVIGO	180	SUNOSI	178
SPIKEVAX	73	super	215, 225, 228
SPIKEVAX COVID	73	SUPER	142, 144, 158, 160, 216, 237, 240
spinosad	64	super b complex-vit c	228
SPIRIVA HANDIHALER	29	SUPER DAILY D3	237, 240
SPIRIVA RESPIMAT	29	SUPER GINSENG	216
spironolact/hydrochlorothiazid	102	SUPERIOR	216, 245
spironolactone	101	super quints	228
SPORANOX	45	SUPER THIN LANCETS	158, 160
SPRITAM	93	SUPOR	153
SPRIX	20	SUPPORT-500	216
SSKI	III	SUPRANE	24
sss	42	SURE	138, 139, 144, 147, 148, 160, 162, 183
STALEVO	64	SURE COMFORT	139, 160, 183
stavudine	67	SUREFLEX	139, 159
STELARA	130	SURE-LANCE	160
STENDRA	194	SURE-PEN	139
STERILANCE	144, 160	SURE-PREP ALCOHOL PREP PADS	183
STERILANCE TL	160	SURESITE	155
STERILE	144, 153, 160	SURE-T	162
STERILE LANCETS	160	SURE-TEST EASYPLUS	139
STIOLTO RESPIMAT	30	SURE-TOUCH	160
STIVARGA	60	SURGICEL	77
STRENSIQ	197	surgi foam	77
STRESS B-COMPLEX	216	SURGIFOAM	77
stress-c	216	SURGISEAL	184
stress formula	212, 216, 228	SURMONTIL	173
STRESS FORMULA	216	SURVANTA	192
STROMECTOL	52	SUSTIVA	66
STROVITE	216	SUTENT	60
		sv	116, 168, 205, 218, 228, 231, 233, 235, 240, 243

Index of Medications

sv b-I2	23I	TAGITOL	99
sv biotin	228	TAGRISSO	60
SV BIOTIN	228	TAKHYRO	73, I92
SV COD LIVER OIL	223	TALICIA	I20
sv folic acid	205	TALTZ	I80
SV HAIR, SKIN AND NAILS	216	TALZENNA	60
sv niacin	218	TAMIFLU	69
sv prenatal tablet	I68	tamoxifen	62
SV PRENATAL VITAMINS TABLET	I68	tamsulosin	20I
SV SLOW RELEASE IRON 45 MG TAB	I16	TANDEM	I16, I40, 216
sv vitamin	23I, 235, 240, 243	TANDEM DUAL ACTION	I16
sv vitamin b-I2	23I	TAPERDEX	I28
sv vitamin c	235	TARCEVA	60
SV VIT B	23I	TARGADOX	40
sv vit c	235	TARGETIN	62
SYMAX DUOTAB	I20	TARPEYO	I28
SYMBICORT	3I	TASIGNA	60, 6I
SYMDEKO	I9I	TASMAR	64
SYMFY	68	tavaborole	47
SYMJEPI	7I	TAVALISSE	I92
SYMLINPEN	49	TAVNEOS	76
SYMPAZAN	9I	tazarotene	I8I
SYMPROIC	44	TAZVERIK	57
SYMTUZA	65	TB SYRINGE	I52, I54
SYNALAR	4I, I88	TC99M	98
SYNAREL	I28	TDVAX	75
SYNDROS	I19	TECHLITE	I44, I60
SYNERA	25	TEGADERM	I55, I56
SYNJARDY	50	TEGLUTIK	88
SPRINE	I97	TEGRETOL	93
SYRINGE AVITENE	77	TEGSEDI	I95
SYRINGE BULK	I53	TEKTONA HCT	85
SYRINGE CATHETER	I53	TEL CARE	I40, I44, I60
SYRINGE FILTER	I53	TEL CARE CONTROL SOLUTION	I40
SYRINGE SLIP TIP	I53	TEL CARE ULTRA THIN	I60
SYRINGE STORAGE BIN	I54	telmisartan	82, 83
SYRINGE TIP CAP	I54	telmisartan/amlodipine	82
SYRINGE WITH NEEDLE DISP	I54	telmisartan/hydrochlorothiazid	82
SYRINGE WITHOUT NEEDLE	I54	temazepam	I78
T		TEMIXYS	66
tab-a-vite	216	TEMOVATE	I88
TAB-A-VITE	216	temozolomide	55
TABLOID	55	TENIVAC	75
TABRECTA	60	tenofovir	67
tacrolimus	I32, I33	TENORETIC	85
tadalafil	80, I93, I94	TENORMIN	85
TAFINLAR	56	terazosin	82

Index of Medications

terbinafine	45	timolol	85, I05, I06
terbutaline	30	TIMOLOL	I06
terconazole	44	TIMOLOL-BRIMONIDIN-DORZOLAMIDE	I06
teriparatide	I99	TIMOLOL-BRIMONI-DORZOL-LATANOP	I06
TERIPARATIDE	I99	TIMOLOL-DORZOLAMIDE	I06
TERSI FOAM	I81	TIMOLOL-LATANOPROST	I06
TERUMO	I48, I54	TIMOPTIC	I06
TERUMO SURGUARD2	I48, I54	tinidazole	52
TERUMO SYRINGE	I54	tiopronin	20I
testosterone	I25, I26	TISSEEL VHSD	I84
TESTOSTERONE	I25	TIVICAY	68
tetrabenazine	89	TIVORBEX	29
tetracaine	I04	tizanidine	I65
TETRACAINÉ	I04	TL-HEM I50	I16
tetracycline	40	TOBAKIENT	I26
TETRAVISC	I04	TOBI PODHALER	35
TEXACORT	I88	TOBRADEX	33
T:FLEX	I39	tobramycin	33, 34, 35
THALOMID	36	tobramycin/dexamethasone	33
THEO-24	32	TOBRAMYCIN PAK	35
theophylline anhydrous	32	TOBREX	34
thera-d	240	TOFRANIL	I73
THERA-D	240	tolcapone	64
THERAGRAN	I6	TOLECTIN	29
thera-m	I6	tolmetin	29
THERA-M	I6	tolterodine	202
THERAMIL FORTE	I6	tolvaptan	I00, I0I
THERANATAL	I68, I69, I6	TOOMEY SYRINGE	I54
THEREMS-H	I6	Topamax	93
thiamine	229	TOPCARE	I44, I60
THIAMINE	229	TOPICORT	I88
THIN	99, I4I, I42, I43, I44, I45, I48, I56, I58, I59, I60, I6I	topiramate	93
THIN LANCETS	I58, I59, I60, I6I	topiramate er	93
THIN WALL NEEDLES	I48	toremifene	62
THIOLA EC	20I	torsemide	I0I
thioridazine	I77	TOSYMRA	20
thiothixene	I77	TOUJEO	52
THRIVITE	I69	TOXICOLOGY SALIVA COLLECTION	98
THROMBI-GEL	77	TRACLEER	80
THROMBIN-JMI	77	tramadol	I2, 24
THROMBI-PAD	77	trandolapril	I8I, 83
thyroid,pork	I9I	trandolapril/verapamil	I8I
tiagabine	93	tranexamic	76
TIAZAC	79	TRANSFER	68, I47, I48
TIBSOVO	6I	TRANSPARENT	I56
ticagrelor	65	tranylcypromine	I7I
TIGLUTIK	88	travoprost	I06

Index of Medications

trazodone	172
TRECATOR	36
TRELEGY ELLIPTA	31
TREMFYA	131
TRESIBA	52
tretinoin	61, 180, 181, 190
TREXALL	56
TREZIX	22
triamcinolone	188, 189, 193
triamterene	101, 102
triamterene/hydrochlorothiazid	102
triazolam	178
TRICARE	169
trichloroacetic acid	185
TRICHLOROACETIC ACID	185
triderm	189
TRIDESILON	189
trientine	197
TRIFERIC	116
trifluoperazine	177
trifluridine	68
trihexyphenidyl	64
TRIJARDY	51
TRILIPIX	87
trimethobenzamide	119
trimethoprim	34, 35
trimipramine	173
TRI-MIX	194
TRIMO-SAN	52
TRIMPEX	35
TRINAZ	169
TRINTELLIX	173
TRISODIUM CITRATE CRRT	43
TRISTART	169
TRIUMEQ	65
TRIVIA	216
TRI-VI-FLOR	222
TRI-VI-SOL	222
tri-vit-fluor	223
TRI-VIT-FLUOR	223
TROKENDI	93
TRONVITE	228
TROPICAL LIQUID	223
tropicamide	107
TROPICAMIDE-CYCLOPENTOLATE-PE	107
TROPICAMIDE-CYCLOPENT-PE-KTRLC	107
TROPIC-CYCLOPENT-PE-KTRLC-PROP	107
trospium	202
true	116, 205, 218, 219, 229, 231, 233, 235, 236, 240, 243
TRUE	140, 144, 145, 160, 183, 216, 219, 229, 233, 240, 241, 243
TRUE COMFORT	160, 183
TRUECONTROL	140
TRUEDRAW	140
TRUE METRIX	140
TRUEPLUS	100, 110, 145, 160, 216
TRUEPLUS GLUCOSE	110
TRUEPLUS KETONE TEST STRIP	100
T.R.U.E. TEST	196
TRULANCE	122
TRULICITY	48
TRUMENBA	74
TRUQAP	61
TRUSTEEL INFUSION SET	140
TRYNGOLZA	85
T:SLIM	139
TUBERCULIN SYRINGE	151, 152, 153, 154
TUKYSA	61
TULIVITE	116
TURALIO	61
TUSSICAPS	96
TUXARIN	96
TUZISTRA	97
TWIIST	140
TWINPAK DUAL CANNULA	154
TWINRIX	76
TWIST	141, 142, 144, 145, 157, 158, 160, 184
TWYNEO	181
TYBOST	191
TYENNE	131
TYMLOS	130
TYRVAYA	194
TYVASO	80
U	
UBRELVY	20
UCERIS	124, 128
UDAMIN SP	216
ULESFIA	64
ULTANE	25
ULTICARE LDS SYR	154
ULTICARE SAFETY SYRINGE	154
ULTICARE SYRINGE	154
ULTICARE TB SAFETY	154
ULTIGUARD SAFE	154
ULTIGUARD SAFEPACK	154

Index of Medications

ULTI-LANCE	I40	valsartan	82, 83
ULTILET	I45, I61, I83	valsartan/hydrochlorothiazide	82
ULTRA ... 30, 98, I39, I41, I42, I43, I44, I45, I48, I54, I57, I58, I60, I61, I69, 206, 207, 208, 216, 226, 228		VALTOCO	91
ultra b-100	228	VANCOCIN	40
ULTRA B-100 COMPLEX	228	vancomycin	40
ULTRA-CARE	I61	VANILLA SILQ	99
ULTRA-FINE	I48, I54	VANISHPOINT	I54, I55
ULTRA-FINE MICRO	I48	VANOXIDE-HC	I83
ULTRA-FINE MINI	I48	VANRAFIA	201
ULTRA-FINE NANO	I48	VAQTA	76
ULTRA-FINE ORIGINAL	I48	vardenafil	I93, I94
ULTRA-FINE SHORT	I48	VARIBAR	99
ULTRAFOAM	77	VARISOFT	I40
ULTRA FREEDA	216	VARIVAX VACCINE	76
ULTRALANCE	I45, I61	VARUBI	I19
ULTRA THIN	I58, I60, I61	VASCEPA	I18
ULTRA-THIN II	I61	VASCULERA	204
ULTRA THIN PLUS	I61	VASERETIC	81
ULTRATLC	I45, I61	VASOFLEX	204
ULTRATRAK CONTROL	I40	VASOTEC	83
ULTRATRAK ULTIMATE	I40	VAXELIS	75
ULTRAVATE X	I89	VAXNEUVANCE	74
UNILET	I40, I42, I45, I56, I58, I61	VB6 P5P	233
UNISTIK	I40, I42, I45, I46, I58, I61	VECAMYL	83
UNISTRIP	I40	VECTICAL	I81
UNIVERSAL	I42, I46, I54, I58, I61	VELPHORO	I11
UNIVERSAL I	I61	VELSIPITY	90
UNIVERSAL SYRINGE	I54	VELTASSA	I11
UPTRAVI	80, 81	VEMLIDY	70
upup	I10	VENALIV	204
URECHOLINE	72	VENCLEXTA	61
URELLE	36	venlafaxine	I72, I73
URIBEL	36	VENOFER	I16
URISTIX	I00	VENTAVIS	81
UROCIT-K	I17	VEO INSULIN SYRINGE	I55
UROQID-ACID	I17	VEOZAH	I96
URSO	I20	verapamil	78, 79, 81
ursodiol	I20, I21	VERELAN	79
USTEKINUMAB	I30	VERIFINE	I46
UTIBRON	30	VERQUVO	79
V		VERSACLOZ	I76
valacyclovir	69	VERTIGOHEEL	I96
VALCHLOR	62	VERZENIO	61
VALCYTE	69	VEVYE	I07
valganciclovir	69	VFEND	45
valproic	93	V-GO	I40
		VIBERZI	I22

Index of Medications

VIBRAMYCIN	40	VITAMIN D3	217, 237, 238, 239, 241, 242
VIGADRONE	93	VITAMIN D3-ALOE	217
VIGAMOX	34	vitamin e	242, 243, 244
VIJOICE	192	VITAMIN E	242, 243, 244
VIOKACE	123	VITAMIN K	244
VIRACEPT	68	VITAMIN K2	244
VIRAMUNE	67	VITAMINS A-D	223
VIREAD	67	VITAMINS A-D-E	217
VIRT-CAPS	228	VITAPEARL	169
virt-fefa plus	II6	VITA-RESPA	228
VIRT-FEFA PLUS	II6	VITASURE	228
VISION FORMULA	202, 203	VITATRUE	169
VISION PLUS	205	vit a/vit c/vit e/zinc/copper	203
VISTA ADVANCED AREDS2	203	vit b	226, 228, 230, 231
VISTARIL	47	VIT B-I2	210, 230, 231
VISTOGARD	193	vit b12/levomefolate/vit b6/b2	225, 228
VIT	I89, 210, 219, 220, 221, 230, 231, 236, 241	vit c-rose hip	234, 235, 236
vit a	203, 223	vit c-rose hips	234, 235, 236
VITA-BEE	228	VIT C-ROSE HIPS	236
VITABEX	II6, 216	vit d3	223, 237, 239, 241
VITACORE	217	VIT D3 5,000 UNIT FAST DISSOLV	241
VITAFOL	II6, I69	VITEYES	203
VITAFUSION	217	VITRAKVI	61
VITAJOY	217, 228, 236	VITREXYL	217
VITAL-D	228	VITRON-C	II6
VITAMEDMD	I69	VITRUM 50	217
vitamin	I09, I68, 207, 216, 217, 218, 219, 223, 224, 227, 228, 229, 230, 231, 232, 233, 234, 235, 236, 237, 238, 239, 240, 241, 242, 243, 244	vits a,c,e/lutein/minerals	203
VITAMIN	I08, II6, I65, I66, I67, I68, I69, I89, I90, I95, I99, 205, 207, 209, 212, 215, 217, 219, 220, 221, 222, 223, 224, 225, 226, 227, 228, 229, 230, 231, 232, 233, 234, 235, 236, 237, 238, 239, 240, 241, 242, 243, 244	VIVAGUARD	I40, I46, I61
vitamin a	223	VIVJOA	45
VITAMIN A	I89, I90, 223	VIZIMPRO	61
vitamin b-I2	227, 230, 231, 232	VOGELXO	I25
vitamin bl2	231, 232	VOLUMEN	99
VITAMIN B-I2	230, 231, 232	VONJO	61
VITAMIN BI2	229, 230, 231, 232	VOQUEZNA	I20, I23
vitamin b complex	217, 224, 228	VORANIGO	61
vitamin b-complex	228	voriconazole	45
vitamin c	207, 216, 217, 224, 228, 234, 235, 236, 237	VORTEX	I64
VITAMIN C	224, 233, 234, 235, 236, 237	VOSEVI	69
vitamin d2	238, 241	VOTRIENT	61
VITAMIN D2	241	VOWST	I21
VITAMIN D2-VITAMIN K1	241	VOXZOGO	I97
vitamin d3	I09, 237, 238, 239, 240, 241, 242	VOYDEYA	76
		VP-PNV-DHA	I69
		v-r alcohol prep pads	I83
		VRAYLAR	I77
		VRAYLAR I.5 MG CAPSULE	I77
		v-r cod liver oil capsule	242

Index of Medications

v-r vitamin c	237	XIFAXAN	39
VTAMA	181	XIGDUO	50, 51
VUEBLU	98	IIIDRA	107
VUMERITY	90	XOFLUZA	69
VYKAT	199	XOLAIR	32
VYLEESI	175	XOLREMDI	94
VYNDAMAX	197	XOPENEX	30
VYNDAQEL	197	XOSPATA	61
VYVANSE	170	XTANDI	55
VYVGART	197	XURIDEN	110
W		XVITE	228
WAKIX	94	XYOSTED	125
water	179	XYREM	178
WAVESENSE	140	XYWAV	178
WEBCOL	183	XYZBAC	217
WEGOVY	63	Y	
WELIREG	61	YALE	148
well	237, 242	YAZ	95
WELLESSE	217	YESINTEK	130, 131
WHEAT GERM	244	YEZTUGO	65
WINDOW BANDAGES	156	YONSA	55
WINREVAIR	80	YORVIPATH	129
WOMEN'S 50	206, 207, 214, 217	YUPELRI	29
women's daily	217	Z	
WOMEN'S DAILY	217	zafirlukast	32
WOMENS DAILY GUMMIES	217	zaleplon	179
WOMEN'S MULTIVITAMIN	214, 217	ZANAFLEX	165
WOMEN'S PRENATAL PLUS DHA	169	ZARONTIN	94
WYNZORA	189	ZCORT	128
X		ZELBORAF	56
XACIATO	40	ZELDANA	228
XALKORI	61	ZELNORM	122
XAQUIL	205	ZEMBRACE SYMTOUCH	20
XARELTO	43	ZEMPLAR	195
XCELLENT	237, 244	ZENPEP	123
XCELLENT C	237	zenzedi	72
XCOPRI	94	ZENZEDI	72
XDEMVY	63	ZEPATIER	70
XELJANZ	27	ZEPBOUND	63
XELODA	56	ZEPOSIA	90
XENICAL	63	ZESTORETIC	81
XENLETA	38	ZESTRIL	83
XENON XE-I33	99	ZIAGEN	67
XEPI	41	ZIANA	181
XERMELO	118	zidovudine	66, 67
XHANCE	102	zinc oxide	184
		ZINC OXIDE PASTE	184

List of Prescription Medications

ZINC PLUS	237
ziprasidone	176
ZIRGAN	68
ZITHROMAX	37
ZODRYL AC	97
ZODRYL DAC	96
ZODRYL DEC	97
ZOKINVY	192
ZOLINZA	54
zolmitriptan	20
zolpidem	179
ZOMIG	20
ZONALON	181
zonisamide	94
ZONTIVITY	65
ZOO FRIENDS	223
ZORBTIVE	128
ZORTRESS	133
ZORYVE	181, 185
ZOVIRAX	69, 70
ZTALMY	177
ZTLIDO	25
ZUBSOLV	201
ZYDELIG	61
ZYKADIA	61
ZYLOPRIM	26
ZYPITAMAG	86
ZYPREXA	176
ZYVANA	217
ZYVIT	217
ZYVOX	38

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

T4 – Brand Specialty
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

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.

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

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).