



Cigna Healthcare Performance 3-Tier Prescription Drug List

Coverage as of January 1, 2025

For the State of California

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

View your drug list online: [Cigna.com/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 This drug list is subject to change and all prior versions are no longer in effect.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.

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What's Inside?	Page
Information about this drug list	3
· Frequently asked questions (FAQs)	3
· Words you may need to know	10
· About this drug list	12
· How to read this drug list	12
· How to find your medication	15
List of prescription medications	18
Exclusions and limitations for coverage	165
Index of medications	166

View your drug list online

This document was last updated on 07/01/2025.* Go online to get real-time information about the medications your plan covers.

- **Cigna.com/druglist.** Select **Performance 3 Tier** from the dropdown menu. Then type in your medication name or view the full list.
- **myCigna® App¹ or myCigna.com[®].** As soon as your new plan year starts, log into your account and use the Price a Medication tool.

Questions?

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

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

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

Next planned update: 11/01/2024, for changes starting 01/01/2025

Information about this drug list

Frequently asked questions (FAQs)

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

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

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

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

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

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

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

There are also certain medications and products that can't be covered by your plan for any reason because they're considered to be a "plan or benefit exclusion." This means the medication or product isn't

on your plan's drug list, and there's no option to ask Cigna Healthcare to consider approving it through the coverage review process. For example, your plan doesn't cover, or "excludes," medications that aren't approved by the U.S. Food and Drug Administration (FDA).

Q. How do you decide which medications to cover?

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

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

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

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

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

Information about this drug list

Frequently asked questions (FAQs) (cont.)

Q. What types of medications typically need approval?

A. Medications that:

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

Q. What types of medications typically have quantity limits?

A. Medications that are often:

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

Q. What types of medications require Step Therapy?

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

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

Q. Why does my medication have an age requirement?

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

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

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

the Cigna Healthcare provider portal at cignaforhcp.com.

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 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.

- **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

Information about this drug list

Frequently asked questions (FAQs) (cont.)

hours of receiving a request based on exigent circumstances, the request will be considered approved and your plan can't deny coverage of the medication.

Your Step Therapy rights under California State law:

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

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

A. When your pharmacist tries to fill your prescription, 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 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,

Information about this drug list

Frequently asked questions (FAQs) (cont.)

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. 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®

Information about this drug list

Frequently asked questions (FAQs) (cont.)

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](#).

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.

Information about this drug list

Frequently asked questions (FAQs) (cont.)

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 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 and Tier 3 medications.

2. **Log in to the myCigna App or myCigna.com to view your pharmacy coverage information.**

You can also use the Price a Medication tool to find out how much your medication may cost you at the different pharmacies in your plan's network.

3. **Check your Summary of Benefits coverage document.**

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

A. Some medications are covered under the pharmacy benefit, some are covered under the medical benefit, and others are covered under both benefits. 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

Information about this drug list

Frequently asked questions (FAQs) (cont.)

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).

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

Words you may need to know

- **Brand name drug:** A drug that is marketed under a proprietary, trademark-protected name. A brand name drug is listed in this formulary in all CAPITAL letters.
- **Coinsurance:** A percentage of the cost of a covered health care benefit that you pay after you have paid the deductible, if a deductible applies to the health care benefit.
- **Copayment:** A fixed dollar amount that you pay for a covered health care benefit after you have paid the deductible, if a deductible applies to the health care benefit.
- **Deductible:** The amount you pay for covered health care benefits that are subject to the deductible before your health insurer begins to pay. If your health insurance policy has a

Information about this drug list

Words you may need to know (cont.)

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

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

Information about this drug list

About this drug list

This is a list of the most commonly prescribed medications covered on the Cigna Healthcare Performance 3-Tier Prescription Drug List as of January 1, 2025. Medications are listed alphabetically by their generic and brand names within their therapeutic category and class.

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

How to read this drug list

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

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

Tiers

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.	\$\$\$

* 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.*

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

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

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

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

Prescription drug name is the name of the medication

Medications are listed in **alphabetical order** 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 Performance 3-Tier Prescription Drug List.

Information about this drug list

How to find your medication

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

Condition	Page	Condition	Page
Analgesics (Pain Relief and Inflammatory Disease)	18-23	Anti-Infectives/Miscellaneous (Infections)	47, 48
Analgesics (Urinary Tract Conditions)	23	Anti-Infectives/Miscellaneous (Miscellaneous)	48
Anesthetics (Miscellaneous)	23	Anti-Infectives/Miscellaneous (Skin Conditions)	48
Anesthetics (Pain Relief and Inflammatory Disease)	23	Anti-Inflammatory Tumor Necrosis Factor Inhibiting Agents (Pain Relief and Inflammatory Disease)	49, 50
Anesthetics (Urinary Tract Conditions)	24	Anti-Neoplastics (Cancer)	50-56
Anti-Allergy (Allergy and Nasal Sprays)	24	Anti-Neoplastics (Skin Conditions)	56, 57
Anti-Arthritis (Pain Relief and Inflammatory Disease)	24-27	Anti-Obesity Drugs (Weight Management)	57
Anti-Asthmatics (Asthma/COPD/Respiratory)	27-30	Anti-Parasitics (Infections)	58
Antibiotics (Allergy/Nasal Sprays)	30	Anti-Parkinson's Drugs (Parkinson's Disease)	58-60
Antibiotics (Ear Medications)	30	Anti-Platelet Drugs (Blood Thinners/Anti-Clotting)	60
Antibiotics (Eye Conditions)	30-32	Antivirals (Aids/Hiv)	60-63
Antibiotics (Infections)	32-37	Antivirals (Eye Conditions)	63
Antibiotics (Skin Conditions)	37, 38	Antivirals (Infections)	63-65
Anti-Coagulants (Blood Thinners/Anti-Clotting)	38-40	Antivirals (Skin Conditions)	65
Antidotes (Gastrointestinal/Heartburn)	40	Autonomic Drugs (Allergy/Nasal Sprays)	65
Antidotes (Substance Abuse)	40, 41	Autonomic Drugs (Alzheimer's Disease)	66, 67
Anti-Fungals (Eye Conditions)	41	Autonomic Drugs (Attention Deficit Hyperactivity Disorder)	62, 63
Anti-Fungals (Feminine Products)	41	Autonomic Drugs (Blood Pressure/Heart Medications)	67
Anti-Fungals (Infections)	41	Autonomic Drugs (Urinary Tract Conditions)	67
Anti-Fungals (Skin Conditions)	42	Biologicals (Allergy/Nasal Sprays)	67, 68
Antihistamine and Decongestant Combination (Allergy/Nasal Sprays)	42	Biologicals (Blood Pressure/Heart Medications)	68
Antihistamines (Allergy/Nasal Sprays)	42, 43	Biologicals (Miscellaneous)	68
Antihistamines (Eye Conditions)	43	Biologicals (Vaccines)	68-70
Anti-Hyperglycemics (Diabetes)	43-47	Blood (Blood Modifiers/Bleeding Disorders)	70, 71
Anti-Infectives (Feminine Products)	47	Blood (Blood Thinners/Anti-Clotting)	71
Anti-Infectives (Infections)	47	Cardiac Drugs (Blood Pressure/Heart Medications)	66-69

Information about this drug list

How to find your medication (cont.)

Condition	Page	Condition	Page
Cardiac Drugs (Blood Pressure/Heart Medications)	71-74	Gastrointestinal (Pain Relief and Inflammatory Disease)	I09
Cardiovascular (Allergy/Nasal Sprays)	74	Hormones (Hormonal Agents)	I09-II5
Cardiovascular (Asthma/COPD/Respiratory)	75	Hormones (Infertility)	II5
Cardiovascular (Blood Pressure/Heart Medications)	75-81	Hormones (Miscellaneous)	II5
Cardiovascular (Cholesterol Medications)	81-84	Hormones (Osteoporosis Products)	II5, II6
Cardiovascular (Miscellaneous)	84	Immunosuppressants (Pain Relief and Inflammatory Disease)	II6
CNS Drugs (Alzheimer's Disease)	84, 85	Immunosuppressants (Skin Conditions)	II6
CNS Drugs (Miscellaneous)	85, 86	Immunosuppressants (Transplant Medications)	II7
CNS Drugs (Multiple Sclerosis)	86	Miscellaneous Medical Supplies, Devices, Non-Drug (Diabetes)	II7-I29
CNS Drugs (Pain Relief and Inflammatory Disease)	86, 87	Miscellaneous Medical Supplies, Devices, Non-Drug (Miscellaneous)	I29-I34
CNS Drugs (Seizure Disorders)	87-89	Muscle Relaxants (Pain Relief and Inflammatory Disease)	I35
CNS Drugs (Sleep Disorders/Sedatives)	90	Prenatal Vitamins (Nutritional/Dietary)	I35, I36
Colony Stimulating (Blood Modifiers/Bleeding Disorders)	90	Psychotherapeutic Drugs (Anxiety/Depression/Bipolar Disorder)	I36-I40
Colony Stimulating Factors (Cancer)	90	Psychotherapeutic Drugs (Attention Deficit Hyperactivity Disorder)	I40, I42
Contraceptives (Contraception Products)	90-92	Psychotherapeutic Drugs (Miscellaneous)	I42
Cough/Cold Preparations (Allergy/Nasal Sprays)	92	Psychotherapeutic Drugs (Schizophrenia/Anti-Psychotics)	I42-I45
Cough/Cold Preparations (Cough/Cold Medications)	93	Psychotherapeutic Drugs (Sleep Disorders/Sedatives)	I45, I46
Diagnostic (Miscellaneous)	93, 94	Skin Preps (Miscellaneous)	I46
Diuretics (Diuretics)	95, 96	Skin Preps (Pain Relief and Inflammatory Disease)	I47
EENT Preps (Allergy/Nasal Sprays)	96	Skin Preps (Skin Conditions)	I47-I54
EENT Preps (Ear Medications)	96, 97	Smoking Deterrents (Smoking Cessation)	I54
EENT Preps (Eye Conditions)	97-100	Thyroid Prep (Hormonal Agents)	I54, I55
Elect/Caloric/H2O (Cholesterol Medications)	100	Unclassified Drug Products (Aids/Hiv)	I55
Elect/Caloric/H2O (Diabetes)	100, 101	Unclassified Drug Products (Asthma/COPD/Respiratory)	I55, I56
Elect/Caloric/H2O (Miscellaneous)	101	Unclassified Drug Products (Blood Modifiers/Bleeding Disorders)	I56
Elect/Caloric/H2O (Nutritional/Dietary)	101, 102	Unclassified Drug Products (Blood Pressure/Heart Medications)	I56
Gastrointestinal (Cholesterol Medications)	103		
Gastrointestinal (Gastrointestinal/Heartburn)	103-109		

Information about this drug list

How to find your medication (cont.)

Condition	Page	Condition	Page
Unclassified Drug Products (Cancer)	I57	Unclassified Drug Products (Pain Relief and Inflammatory Disease)	I62, I63
Unclassified Drug Products (Dental Products)	I57	Unclassified Drug Products (Substance Abuse)	I62
Unclassified Drug Products (Erectile Dysfunction)	I57, I58	Unclassified Drug Products (Transplant Medications)	I62
Unclassified Drug Products (Gastrointestinal/Heartburn)	I58	Unclassified Drug Products (Urinary Tract Conditions)	I62, I63
Unclassified Drug Products (Hormonal Agents)	I58	Unclassified Drug Products (Weight Management)	I63
Unclassified Drug Products (Miscellaneous)	I58-I61	Vitamins (Nutritional/Dietary)	I63, I64
Unclassified Drug Products (Osteoporosis Products)	I61		

List of Prescription Medications

ANALGESICS (Pain Relief and Inflammatory Disease)			
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits	
ANALGESIC, NON-SALICYLATE AND BARBITURATE COMBINAT			
butalbital/acetaminophen	T1		
ANALGESIC, SALICYLATE, BARBITURATE, XANTHINE COMB.			
butalb-aspirin-caff 50-325-40	T1	QL (6 tabs/day)	
butalbital-asa-caffeine cap (Fiorinal)	T1	QL (6 caps/day)	
FIORINAL (butalbital-aspirin-caffeine)	T3	QL (6 caps/day)	
ANALGESIC, NON-SALICYLATE, BARBITURATE, XANTHINE COMB.			
butalb/acetaminophen/caffeine	T3		
butalb/acetaminophen/caffeine (Esgic)	T3	QL (6 caps/day)	
butalb-acetamin-caff 50-300-40 (Fioricet)	T1	QL (6 caps/day)	
butalb-acetamin-caff 50-325-40 (Esgic)	T1	QL (6 tabs/day)	
ESGIC 50-325-40 MG TABLET (butalbital-acetaminophen-caff)	T3	QL (6 tabs/day)	
ESGIC CAPSULE (zebutal)	T3	QL (6 caps/day)	
FIORICET (phrenilin forte)	T1	QL (6 caps/day)	
ANALGESIC/ANTIPYRETICS, SALICYLATES			
choline salicyl/mag salicylate	T1	HD	
diflunisal	T1	HD	
ANALGESICS, NON-OPIOID			
JOURNAVX	T3	QL (30 tabs/90 days)	
ANTI-MIGRAINE PREPARATIONS			
AIMOVIG AUTOINJECTOR	T2	PA	
AJOVY	T2	PA	
almotriptan malate	T1	QL (12 tabs/30 days)	
CAFERGOT (ergotamine-caffeine)	T3	QL (40 tabs/28 days)	
dihydroergotamine 1 mg/ml amp	T1	QL (10 amps/30 days)	
eletriptan hydrobromide	T1	QL (6 tabs/30 days)	
EMGALITY PEN	T2	PA	
EMGALITY SYRINGE	T2	PA	
ergotamine tartrate/caffeine	T1		
ergotamine tartrate/caffeine (Cafergot)	T1	QL (40 tabs/28 days)	
frovatriptan succinate	T1	QL (18 tabs/30 days)	
isomethept/dichlphn/acetaminop	T1		
isomethepten/caf/acetaminophen	T1		
naratriptan hcl	T1	QL (9 tabs/30 days)	

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

PA – Prior Authorization

QL – Quantity Limit

ST – Step Therapy

AGE – Age Requirement

SP – Specialty Medication

HD – May require home delivery pharmacy

PPACA – No Cost-Share Preventive Medication

CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

NURTEC ODT	T2	PA QL (16 tabs/30 days)
<i>rizatriptan 10 mg odt (Maxalt Mlt)</i>	T1	QL(12 tabs/30 days)
ANALGESICS (Pain Relief and Inflammatory Disease) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ANTI-MIGRAINE PREPARATIONS (cont.)		
<i>rizatriptan 10 mg tablet (Maxalt)</i>	T1	QL(12 tabs/30 days)
<i>rizatriptan 5 mg odt</i>	T1	QL(12 tabs/30 days)
<i>rizatriptan 5 mg tablet</i>	T1	QL(12 tabs/30 days)
<i>rizatriptan ODT(Maxalt Mlt)</i>	T1	QL(12 tabs/30 days)
<i>rizatriptan tablet (Maxalt)</i>	T1	QL(12 tabs/30 days)
<i>sumatriptan</i>	T1	QL (2 boxes/30 days)
<i>sumatriptan 4 mg/0.5 ml cart</i>	T1	QL (4ml/30 days)
<i>sumatriptan 4 mg/0.5 ml inject</i>	T1	QL (4ml/30 days)
<i>sumatriptan 6 mg/0.5 ml cart</i>	T1	QL (4ml/30 days)
<i>sumatriptan 6 mg/0.5 ml inject</i>	T1	QL (4ml/30 days)
<i>sumatriptan 6 mg/0.5 ml syrng</i>	T1	QL (4ml/30 days)
<i>sumatriptan 6 mg/0.5 ml vial</i>	T1	QL (5ml/30 days)
<i>sumatriptan succ 100 mg tablet</i>	T1	QL (18 tabs/28 days)
<i>sumatriptan succ 25 mg tablet</i>	T1	QL (18 tabs/28 days)
<i>sumatriptan succ 50 mg tablet</i>	T1	QL (9 tabs/30 days)
<i>sumatriptan succ/naproxen sod</i>	T1	QL (18 tabs/30 days)
<i>UBRELVY</i>	T2	PA QL (0.67 tabs/day)
<i>ZAVZPRET</i>	T2	PA QL(6 units/30 days)
<i>zolmitriptan</i>	T1	QL (12 tabs/30 days)
NSAIDS, CYCLOOXYGENASE INHIBITOR-TYPE ANALGESICS		
<i>diclofenac potassium</i>	T1	HD
<i>ketorolac 10 mg tablet</i>	T1	QL (20 tabs/25 days)
<i>ketorolac 15 mg/ml syringe</i>	T1	QL (40 ml/30 days)
<i>ketorolac 15 mg/ml vial</i>	T1	QL (40 ml/30 days)
<i>ketorolac 30 mg/ml carpuject</i>	T1	
<i>ketorolac 30 mg/ml isecure syr</i>	T1	QL (20ml/30 days)
<i>ketorolac 30 mg/ml syringe</i>	T1	QL (20ml/30 days)
<i>ketorolac 30 mg/ml vial</i>	T1	QL (20ml/30 days)
<i>ketorolac 300 mg/10 ml vial</i>	T1	
<i>ketorolac 60 mg/2 ml carpuject</i>	T1	QL (20ml/30 days)
<i>ketorolac 60 mg/2 ml syringe</i>	T1	QL (20ml/30 days)
<i>ketorolac 60 mg/2 ml vial</i>	T1	QL (20ml/30 days)
<i>mefenamic acid</i>	T1	HD

T1 – Typically Generics

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T3 – Typically Non-Preferred Brands

PA – Prior Authorization

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HD – May require home delivery pharmacy

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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 AND NON-SALICYLATE ANALGESICS		
acetamin-codein 300-30 mg/12.5	T1	
acetaminop-codeine 120-12 mg/5	T1	
acetaminophen-cod #2 tablet	T1	PA
acetaminophen-cod #3 tablet	T1	PA
acetaminophen-cod #4 tablet	T1	PA
APADAZ	T3	
BENZHYDROCODONE-ACETAMINOPHEN	T1	
hydrocodone/acetaminophen	T1	PA
hydrocodone/acetaminophen (Hydrocodone-acetaminophen)	T1	PA
hydrocodone/acetaminophen (Norco)	T1	PA
HYDROCODONE-ACETAMINOPHEN	T1	PA
LORTAB	T1	PA
NALOCET	T1	PA
NORCO (lorcet hd)	T3	PA
NORCO (lorcet plus)	T3	PA
NORCO (lorcet)	T3	PA
oxycodone hcl/acetaminophen (Nalocet)	T1	PA
oxycodone hcl/acetaminophen (Percocet)	T1	PA
oxycodone hcl/acetaminophen (Primlev)	T1	PA
PERCOSET (oxycodone-acetaminophen)	T3	PA
PRIMLEV	T1	PA
tramadol hcl/acetaminophen (Ultrace)	T1	
ULTRACET (tramadol hcl-acetaminophen)	T3	
OPIOID ANALGESIC AND NSAID COMBINATION		
hydrocodone/ibuprofen	T1	PA
hydrocodone/ibuprofen (Ibdone)	T1	PA
IBUDONE	T1	PA
ibuprofen/oxycodone hcl	T1	PA
OPIOID ANALGESIC AND NON-SALICYLATE XANTHINE COMB		
ACETAMIN-CAFF-DIHYDROCODEINE	T1	PA
acetaminophen/caff/dihydrocod (Acetamin-caff-dihydrocodeine)	T1	PA
acetaminophen/caff/dihydrocod (Trexiz)	T1	PA

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T3 – Typically Non-Preferred Brands

PA – Prior Authorization

QL – Quantity Limit

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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 ANALGESIC AND NON-SALICYLATE XANTHINE COMB (cont.)		
TREZIX	T3	PA
OPIOID ANALGESICS		
ACTIQ (<i>fentanyl citrate</i>)	T3	PA
ARYMO ER	T3	PA
BELBUCA	T2	QL (2 films/day)
BUPRENEX	T3	
<i>buprenorphine</i> (Butrans)	T1	QL (4 patches/28 days)
<i>butorphanol tartrate</i>	T1	PA QL (6 bots/30 days)
BUTRANS (buprenorphine)	T3	QL (4 patches/28 days)
<i>codeine sulfate</i>	T1	PA
DURAGESIC (<i>fentanyl</i>)	T3	PA
<i>fentanyl</i>	T1	PA
<i>fentanyl</i> (Duragesic)	T1	PA
FENTANYL 25 MCG/0.5 ML SYRINGE	T3	PA
<i>fentanyl</i> 1,000mcg/50-0.9% nacl	T1	
<i>fentanyl citrate</i> (Actiq)	T1	PA
<i>fentanyl citrate/pf</i>	T1	PA
<i>fentanyl/ropivacaine/ns/pf</i>	T1	
FENTORA	T3	PA
<i>hydrocodone bitartrate</i> (Hysingla Er)	T1	PA
<i>hydrocodone bitartrate</i> (Zohydro Er)	T1	PA
HYDROMORPHONE 0.25 MG/0.5 ML	T3	PA
<i>hydromorphone hcl</i>	T1	PA
<i>hydromorphone hcl</i> (Dilaudid)	T1	PA
HYSINGLA ER (<i>hydrocodone bitartrate er</i>)	T2	PA
KADIAN (<i>morphine sulfate er</i>)	T3	PA
LAZANDA	T3	PA
<i>meperidine hcl</i>	T1	PA
<i>methadone hcl</i>	T1	PA
MORPHABOND ER	T2	PA
<i>morpheine sulf</i> 1,000 mg/20 ml	T1	PA
<i>morpheine sulf</i> 1,000 mg/20 ml	T1	PA

T1 – Typically Generics

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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.)		
morphine sulfate	T1	PA
morphine sulfate (Kadian)	T1	PA
morphine sulfate (Ms Contin)	T1	PA
MS CONTIN (morphine sulfate er)	T3	PA
NUCYNTA	T2	PA
NUCYNTA ER	T3	PA
opium/belladonna alkaloids	T1	PA
OXAYDO	T3	PA
oxycodone hcl	T1	PA
OXYCODONE HCL ER	T1	PA
oxymorphone hcl	T1	PA
pentazocine hcl/naloxone hcl	T1	PA
ROXYBOND	T3	PA
TRAMADOL HCL 75 MG TABLET	T3	QL(< 18 yo 5 tabs/day)
tramadol er 100 mg tablet	T1	QL (1 tab/day)
tramadol er 200 mg tablet	T1	QL (1 tab/day)
tramadol er 300 mg tablet	T1	QL (1 tab/day)
TRAMADOL HCL ER 100 MG CAPSULE	T1	QL (1 cap/day)
tramadol hcl er 100 mg tablet	T1	QL (1 tab/day)
TRAMADOL HCL ER 150 MG CAPSULE	T1	QL (1 cap/day)
TRAMADOL HCL ER 200 MG CAPSULE	T1	QL (1 cap/day)
tramadol hcl er 200 mg tablet	T1	QL (1 tab/day)
TRAMADOL HCL ER 300 MG CAPSULE	T1	QL (1 cap/day)
tramadol hcl er 300 mg tablet	T1	QL (1 tab/day)
tramadol hcl er 300 mg tablet	T1	QL (1 tab/day)
ULTRAM (tramadol hcl)	T3	QL (8 tabs/day)
XTAMPZA ER	T2	PA
ZOHYDRO ER (hydrocodone bitartrate er)	T3	PA
OPIOID AND SALICYLATE ANALGESICS, BARBIT, XANTHINE		
codeine/butalbital/asa/caffein (Fiorinal With Codeine #3)	T1	PA
FIORINAL WITH CODEINE #3 (butalbital compound-codeine)	T3	PA
OPIOID, NON-SALICYL. ANALGESIC, BARBITUATE, XANTHINE		
butalbit/acetamin/caff/codeine	T1	PA
butalbit/acetamin/caff/codeine (Fioricet With Codeine)	T1	PA
FIORICET WITH CODEINE (butalb-acetaminoph-caff-codein)	T3	PA

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

PA – Prior Authorization

QL – Quantity Limit

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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
SKELETAL MUSCLE RELAXANT, SALICYLAT, OPIOID ANALGESIC		
<i>carisoprodol/aspirin/codeine</i>	T1	PA
ANALGESICS (Urinary Tract Conditions)		
URINARY TRACT ANALGESIC AGENTS		
ELMIRON	T2	
RIMSO-50	T2	
ANESTHETICS (Miscellaneous)		
GENERAL ANESTHETICS, INHALANT		
<i>desflurane</i> (Suprane)	T1	
<i>isoflurane</i>	T1	
<i>isoflurane</i>	T3	
<i>sevoflurane</i> (Ultane)	T1	
SUPRANE	T3	
ULTANE (<i>sevoflurane</i>)	T3	
<i>lidocaine hcl</i> (Xylocaine)	T1	
<i>lidocaine hcl/pf</i>		
ANESTHETICS (Pain Relief and Inflammatory Disease)		
LOCAL ANESTHETICS		
<i>lidocaine hcl 2% 200 mg/10 ml</i> (Xylocaine-Mpf)	T1	
<i>lidocaine hcl 4% 200 mg/5 ml</i>	T1	
MARCAINE-EPINEPHRINE	T3	
TOPICAL LOCAL ANESTHETICS		
L.E.T. (LIDO-EPINEPH-TETRA)	T3	
<i>lidocaine 5% ointment</i>	T1	QL (145gm/30 days)
<i>lidocaine hcl</i>	T1	
<i>lidocaine hcl</i>	T3	
<i>lidocaine/prilocaine</i>	T1	
LIDODERM (<i>lidocaine</i>)	T3	
PAIN EASE MEDIUM STREAM SPRAY	T3	
SYNERA	T3	
ZTLIDO	T2	

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List of Prescription Medications

ANESTHETICS (Urinary Tract Conditions)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
URINARY TRACT ANESTHETIC/ANALGESIC AGNT (AZO-DYE)		
phenazopyridine hcl (Pyridium)	T1	
PYRIDIUM (phenazopyridine hcl)	T3	
ANTI-ALLERGY (Allergy/Nasal Sprays)		
MAST CELL STABILIZERS		
cromolyn 100 mg/5 ml oral conc (Gastrocrom)	T1	
GASTROCROM (cromolyn sodium)	T3	
ANTI-ARTHRITICS (Pain Relief and Inflammatory Disease)		
ANALGESIC/ANTIPYRETICS, SALICYLATES		
DISALCID (salsalate)	T3	HD
salsalate (Disalcid)	T1	HD
ANTI-ARTHRITIC AND CHELATING AGENTS		
DEPEN (penicillamine)	T3	PA SP
penicillamine	T3	PA SP
penicillamine (Depen)	T3	PA SP
ANTI-ARTHRITIC, FOLATE ANTAGONIST AGENTS		
OTREXUP	T2	PA
ANTI-INFLAM. INTERLEUKIN-1 RECEPTOR ANTAGONIST		
KINERET	T3	PA QL (28 syringes/28 days) SP
ANTI-INFLAMMATORY/ANTIARTHRITICS AGENTS, MISC.		
GEL-ONE	T3	PA SP HD
GENVISC 850	T3	PA SP
SUPARTZ FX	T3	PA SP HD
TRIVISC	T3	PA SP
VISCO-3	T3	PA SP HD
ANTI-INFLAMMATORY, PYRIMIDINE SYNTHESIS INHIBITOR		
ARAVA (leflunomide)	T3	HD
leflunomide (Arava)	T1	HD
ANTI-INFLAMMATORY, PHOSPHODIESTERASE-4(PDE4) INHIB.		
OTEZLA 28 DAY STARTER PACK	T3	PA QL (1 pack/180 days) SP HD
OTEZLA 30 MG TABLET	T3	PA QL (2 tabs/day) SP HD
ANTI-INFLAMMATORY, SEL.COSTIM.MOD., T-CELL INHIBITOR		
ORENCIA	T3	PA QL (4 syringes/28 days) SP HD
ORENCIA CLICKJECT	T3	PA QL (4 injectors/28 days) SP HD

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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
COLCHICINE		
colchicine 0.6 mg capsule (<i>Mitigare</i>)	T1	HD
colchicine 0.6 mg tablet (<i>Colcrys</i>)	T1	HD
COLCRYS (<i>colchicine</i>)	T3	HD
MITIGARE (<i>colchicine</i>)	T2	HD
GOLD SALTS		
RIDAURA	T2	
HYPURICEMIA TX - XANTHINE OXIDASE INHIBITORS		
allopurinol	T1	
febuxostat 40 mg tablet (<i>Uloric</i>)	T1	QL (1 tab/day) HD
febuxostat 80 mg tablet (<i>Uloric</i>)	T1	HD
ULORIC 40 MG TABLET (<i>febuxostat</i>)	T3	QL (1 tab/day) HD
ULORIC 80 MG TABLET (<i>febuxostat</i>)	T3	HD
ZYLOPRIM (<i>allopurinol</i>)	T3	HD
JANUS KINASE (JAK) INHIBITORS		
CIBINQO	T2	PA QL (30 tabs/30 days) SP
LITFULO	T3	PA QL(1 cap/day) SP HD
OLUMIANT	T3	PA QL (1 tab/day) SP HD
RINVOQ	T2	PA QL (1 tab/day) SP HD
RINVOQ LQ	T2	PA QL(12 mls/day) SP HD
XELJANZ 1 MG/ML SOLUTION	T2	PA QL (480ml/22 days) SP HD
XELJANZ 10 MG TABLET	T2	PA QL (2 tabs/day) SP HD
XELJANZ 5 MG TABLET	T2	PA QL (2 tabs/day) SP HD
XELJANZ XR	T2	PA QL (1 tab/day) SP HD
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 ds</i>)	T3	ST HD
CALDOLOR	T3	
DAYPRO (<i>oxaprozin</i>)	T3	ST HD

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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.)		
diclofenac sod dr 25 mg tab	T1	HD
diclofenac sod dr 50 mg tab	T1	HD
diclofenac sod dr 75 mg tab	T1	HD
diclofenac sod ec 25 mg tab	T1	HD
diclofenac sod ec 50 mg tab	T1	HD
diclofenac sod ec 75 mg tab	T1	HD
diclofenac sodium	T1	HD
EC-NAPROSYN (naproxen)	T3	ST HD
etodolac	T1	HD
etodolac (Lodine)	T1	HD
FELDENE (piroxicam)	T3	ST HD
fenoprofen calcium (Nalfon)	T1	HD
flurbiprofen	T1	HD
ibuprofen	T1	HD
indomethacin	T1	HD
ketoprofen 25 mg. 75 mg capsule	T1	HD
LODINE (etodolac)	T3	ST HD
meclofenamate sodium	T1	HD
meloxicam (Mobic)	T1	HD
MOBIC (meloxicam)	T3	ST HD
nabumetone	T1	HD
NALFON 600 MG TABLET (profeno)	T1	ST HD
NAPROSYN TABLET (naproxen)	T3	ST HD
naproxen (Ec-naprosyn)	T1	HD
naproxen (Naprosyn)	T1	HD
naproxen sodium (Anaprox Ds)	T1	HD
oxaprozin 600 mg caplet (Daypro)	T1	HD
oxaprozin 600 mg tablet (Daypro)	T1	HD
OXAPROZIN 300 MG CAPSULE	T3	HD
piroxicam	T1	HD
QMIIZ ODT 15 MG TABLET	T3	ST HD
QMIIZ ODT 7.5 MG TABLET	T3	QL (1 tab/day) ST HD
sulindac	T1	HD
tolmetin sodium (Tolectin 600)	T1	HD

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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-2(COX-2) SELECTIVE INHIBITOR		
CELEBREX 100 MG CAPSULE (<i>celecoxib</i>)	T3	QL (2 caps/day) ST
CELEBREX 200 MG CAPSULE (<i>celecoxib</i>)	T3	QL (2 caps/day) ST
CELEBREX 400 MG CAPSULE (<i>celecoxib</i>)	T3	QL (1 cap/day) ST
CELEBREX 50 MG CAPSULE (<i>celecoxib</i>)	T3	QL (2 caps/day) ST
<i>celecoxib 100 mg capsule</i> (Celebrex)	T1	QL(2 caps/day) HD
<i>celecoxib 200 mg capsule</i> (Celebrex)	T1	QL (2 caps/day) HD
<i>celecoxib 400 mg capsule</i> (Celebrex)	T1	QL (1 cap/day) HD
<i>celecoxib 50 mg capsule</i> (Celebrex)	T1	QL (2 caps/day) HD
URICOSURIC AGENTS		
<i>probenecid</i>	T1	HD
<i>probenecid/colchicine</i>	T1	HD
ANTI-ASTHMATICS (Asthma/COPD/Respiratory)		
5-LIPOXYGENASE INHIBITORS		
<i>zileuton</i>	T1	HD
ANTICHOLINERGICS, ORALLY INHALED LONG ACTING		
INCRUSE ELLIPTA	T2	HD
LONHALA MAGNAIR REFILL	T3	PA HD
LONHALA MAGNAIR STARTER	T3	PA HD
SPIRIVA RESPIMAT	T2	HD
ANTICHOLINERGICS, ORALLY INHADED SHORT ACTING		
ATROVENT HFA	T2	HD
<i>ipratropium bromide</i>	T1	HD
BETA-ADRENERGIC AGENTS		
<i>albuterol sulf 2 mg/5 ml syrup</i>	T1	HD
<i>albuterol sulfate 2 mg tab</i>	T1	HD
<i>albuterol sulfate 4 mg tab</i>	T1	HD
<i>albuterol sulfate er 4 mg tab</i>	T1	HD
<i>albuterol sulfate er 8 mg tab</i>	T1	HD
<i>metaproterenol sulfate</i>	T1	HD
<i>terbutaline sulfate</i>	T1	HD
BETA-ADRENERGIC AGENTS, INHALED, SHORT ACTING		
<i>albuterol 15 mg/3 ml solution</i>	T1	
<i>albuterol 75 mg/15 ml soln</i>	T1	
<i>albuterol 100 mg/20 ml soln</i>	T1	
<i>albuterol 2.5 mg/0.5 ml sol</i>	T1	

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

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AGE – Age Requirement

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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, INHALED, SHORT ACTING (cont.)		
albuterol 5 mg/ml solution	T1	
albuterol sul 0.63 mg/3 ml sol	T1	
albuterol sul 1.25 mg/3 ml sol	T1	
albuterol sul 2.5 mg/3 ml soln	T1	
albuterol hfa 90 mcg inhaler (Proair Hfa)	T1	QL (18gm/30 days)
ALBUTEROL SULFATE HFA	T1	QL (18gm/30 days)
levalbuterol hcl (Xopenex Concentrate)	T1	
levalbuterol hcl (Xopenex)	T1	
XOPENEX (levalbuterol hcl)	T3	
XOPENEX CONCENTRATE (levalbuterol concentrate)	T3	
BETA-ADRENERGIC AGENTS, INHALED, ULTRA-LONG ACTING		
ARCAPTA NEOHALER	T3	HD
STRIVERDI RESPIMAT	T2	QL(1 inhaler/30 days) HD
BETA-ADRENERGIC AGENTS, ORALLY INHALED, LONG ACTING		
SEREVENT DISKUS	T2	HD
BETA-ADRENERGIC AND ANTICHOLINERGIC COMBO, INHALED		
ANORO ELLIPTA	T2	HD
BEVESPI AEROSPHERE	T2	HD
COMBIVENT RESPIMAT	T2	
ipratropium/albuterol sulfate	T1	HD
STIOLTO RESPIMAT INHAL SPRAY	T2	HD
BETA-ADRENERGIC AGENTS AND GLUCOCORTICOID COMBO, INHALED		
ADVAIR HFA	T2	HD
AIRDUO DIGIHALER	T3	ST HD
AIRSUPRA	T2	PA QL(1 gm/28 days) HD
BREO ELLIPTA 100-25 MCG INHALR	T2	HD
BREO ELLIPTA 100-25 MCG INHALR	T2	QL(1 inhaler/30 days) HD
BREO ELLIPTA 200-25 MCG INHALR	T2	HD
BREO ELLIPTA 200-25 MCG INHALR	T2	QL(1 inhaler/30 days) HD
BREO ELLIPTA 50-25 MCG INHALER	T2	QL(1 inhaler/30 days) HD
budesonide/formoterol fumarate (Symbicort)	T1	QL HD
DULERA	T2	HD
fluticasone propion/salmeterol	T1	HD
fluticasone-salmeterol 100-50 (Advair Diskus)	T1	QL(1 inhaler/30 days)
fluticasone-salmeterol 250-50 (Advair Diskus)	T1	QL(1 Inhaler/30 days)

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

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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 AND GLUCOCORTICOID COMBO, INHALED (cont.)		
fluticasone-salmeterol 500-50 (Advair Diskus)	T1	QL(1 inhaler/30 days)
FLUTICASONE-SALMETEROL 113-14	T1	QL(1 inhaler/30 days) HD
FLUTICASONE-SALMETEROL 232-14	T1	QL(1 inhaler/30 days) HD
FLUTICASONE-SALMETEROL 55-14	T1	QL(1 inhaler/30 days) HD
SYMBICORT	T2	HD
BETA-ADRENERGIC-ANTICHOLINERGIC-GLUCOCORT, INHALED		
BREZTRI AEROSPHERE	T2	
TRELEGY ELLIPTA	T2	
GLUCOCORTICOIDS, ORALLY INHALED		
ALVESCO	T2	HD
ASMANEX HFA	T2	QL(1 Inhaler/30 days) HD
ASMANEX TWISTHALER 110 MCG #30	T2	QL(1 inhaler/30 days) HD
ASMANEX TWISTHALER 220 MCG #14	T2	HD
ASMANEX TWISTHALER 220 MCG #30	T2	QL(1 inhaler/30 days) HD
ASMANEX TWISTHALER 220 MCG #60	T2	QL(1 inhaler/30 days) HD
ASMANEX TWISTHALER 220 MCG #120	T2	QL(1 inhaler/30 days) HD
budesonide (Pulmicort)	T1	HD
FLOVENT DISKUS	T2	HD
FLOVENT HFA	T2	HD
FLUTICASONE PROP 100MCG DISKUS	T3	QL HD
FLUTICASONE PROP 250 MCG DISK	T3	QL HD
FLUTICASONE PROP 50 MCG DISKUS	T3	QL HD
PULMICORT (budesonide)	T3	HD
PULMICORT FLEXHALER	T2	HD
QVAR REDIHALER	T2	
INTERLEUKIN-5(IL-5) RECEPTOR ALPHA ANTAGONIST, MAB		
FASENRA PEN	T3	PA SP HD
LEUKOTRIENE RECEPTOR ANTAGONISTS		
ACCOLATE (zafirlukast)	T3	HD
montelukast sodium (Singulair)	T1	HD
SINGULAIR (montelukast sodium)	T3	
zafirlukast (Accolate)	T1	HD
MAST CELL STABILIZERS, ORALLY INHALED		
cromolyn 20 mg/2 ml neb soln	T1	QL (480ml/30 days) HD

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List of Prescription Medications

ANTI-ASTHMATICS (Asthma/COPD/Respiratory) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
MONOCLONAL ANTIBODIES TO IMMUNOGLOBULIN E (IGE)		
XOLAIR	T2	PA SP HD
MONOCLONAL ANTIBODY - INTERLEUKIN-5 ANTAGONISTS		
NUCALA	T2	PA SP HD
MUCOLYTICS		
<i>acetylcysteine</i>	T1	
PHOSPHODIESTERASE-4 (PDE4) INHIBITORS		
DALIRESP 250 MCG TABLET	T3	QL (28 tabs/180 days) HD
DALIRESP 500 MCG TABLET	T3	QL (2 tabs/day) HD
<i>roflumilast 250 mcg tablet (Daliresp)</i>	T3	QL (28 tabs/180 days) HD
<i>roflumilast 500 mcg tablet (Daliresp)</i>	T3	QL (2 tabs/day) HD
XANTHINES		
<i>aminophylline</i>	T1	
THEO-24	T2	HD
<i>theophylline anhydrous</i>	T1	
ANTIBIOTICS (Allergy/Nasal Sprays)		
NOSE PREPARATIONS ANTIBIOTICS		
BACTROBAN NASAL	T2	
ANTIBIOTICS (Ear Medications)		
EAR PREPARATIONS, ANTIBIOTICS		
<i>ciprofloxacin hcl</i>	T1	
CORTISPORIN-TC	T3	
<i>neomycin/polymyxin b/hydrocort</i>	T1	
<i>ofloxacin</i>	T1	
OTIC PREPARATIONS, ANTI-INFLAMMATORY-ANTIBIOTICS		
CIPRO HC	T2	
<i>ciprofloxacin hcl/dexameth (Ciprodex)</i>	T1	
CIPROFLOXACIN HCL-FLUOCINOLONE	T3	
OTOVEL	T3	
ANTIBIOTICS (Eye Conditions)		
EYE ANTIBIOTIC AND GLUCOCORTICOID COMBINATIONS		
<i>MAXITROL (neomycin-polymyxin-dexameth)</i>	T3	
<i>neomycin/bacit/p-myx/hydrocort</i>	T1	
<i>neomycin/polymyxin b/dexametha (Maxitrol)</i>	T1	

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List of Prescription Medications

ANTIBIOTICS (Eye Conditions) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
EYE ANTIBIOTIC AND GLUCOCORTICOID COMBINATIONS (cont.)		
<i>neomycin/polymyxin b/hydrocort</i>	T1	
TOBRADEX EYE DROPS (<i>tobramycin-dexamethasone</i>)	T3	
TOBRADEX EYE OINTMENT	T2	
TOBRADEX ST	T2	
<i>tobramycin/dexamethasone</i> (Tobradex)	T1	
ZYLET	T3	
EYE SULFONAMIDES		
BLEPH-10 (<i>sulfacetamide sodium</i>)	T3	
BLEPHAMIDE	T2	
<i>sulfacetamide sodium</i>	T1	
<i>sulfacetamide sodium</i> (Bleph-10)	T1	
<i>sulfacetamide/prednisolone sp</i>	T1	
OPHTHALMIC ANTIBIOTICS		
AZASITE	T2	
BACIGUENT (<i>bacitracin</i>)	T3	
<i>bacitracin</i> (Baciguent)	T1	
<i>bacitracin/polymyxin b sulfate</i>	T1	
BESIVANCE	T2	
CILOXAN	T2	
<i>erythromycin base</i>	T1	
<i>gatifloxacin</i>	T1	
<i>gentamicin sulfate</i>	T1	
<i>levofloxacin</i>	T1	
MOXEZA (<i>moxifloxacin</i>)	T3	
<i>moxifloxacin hcl</i> (Moxeza)	T1	
<i>moxifloxacin hcl</i> (Vigamox)	T1	
<i>neomycin sulf/bacitracin/poly</i>	T1	
<i>neomycin/polymyxn b/gramicidin</i>	T1	
OCUFLOX (<i>ofloxacin</i>)	T3	
<i>ofloxacin</i> (Ocuflax)	T1	
<i>polymyxin b sulf(trimethoprim</i>	T1	
<i>tobramycin 0.3% eye drop</i> (Tobrex)	T1	
TOBREX	T2	
VIGAMOX (<i>moxifloxacin</i>)	T3	

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List of Prescription Medications

ANTIBIOTICS (Eye Conditions) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
OPHTHALMIC ANTIBIOTICS (cont.)		
ZYMAXID (gatifloxacin)	T3	
ANTIBIOTICS (Infections)		
2ND GEN. ANAEROBIC ANTIprotozoal-ANTIBACTERIAL		
SOLOSEC	T2	
ABSORBABLE SULFONAMIDE ANTIBACTERIAL AGENTS		
BACTRIM (sulfamethoxazole-trimethoprim)	T3	
BACTRIM DS (sulfamethoxazole-trimethoprim)	T3	
ABSORBABLE SULFONAMIDE ANTIBACTERIAL AGENTS		
sulfadiazine	T1	
sulfamethoxazole(trimethoprim	T1	
sulfamethoxazole(trimethoprim	T3	
sulfamethoxazole(trimethoprim (Bactrim Ds)	T1	
sulfamethoxazole(trimethoprim (Bactrim)	T1	
AMINOGLYCOSIDE ANTIBIOTICS		
ARIKAYCE	T3	PA SP
gentamicin sulfate	T1	
gentamicin sulfate/pf	T1	
KITABIS PAK	T3	PA QL (10ml/day) SP HD
neomycin sulfate	T1	
TOBI PODHALER	T2	PA QL (28 days therapy/56 days) SP HD
tobramycin 1,200 mg/30 ml vial	T1	
tobramycin 1.2 gm vial	T1	PA
tobramycin 1.2 gram/30 ml vial	T1	
tobramycin 10 mg/ml vial	T1	
tobramycin 300 mg/4 ml ampule	T3	QL (8 ml/day) SP HD
tobramycin 300 mg/5 ml ampule	T3	PA QL (10ml/day) SP HD
tobramycin 40 mg/ml vial	T1	
tobramycin 80 mg/2 ml vial	T1	
TOBRAMYCIN PAK 300 MG/5 ML	T3	PA QL (10ml/day) SP HD
ANAEROBIC ANTIprotozoal-ANTIBACTERIAL AGENTS		
FLAGYL (metronidazole)	T3	
LIKMEZ		
metronidazole (Flagyl)	T1	

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

PA – Prior Authorization

QL – Quantity Limit

ST – Step Therapy

AGE – Age Requirement

SP – Specialty Medication

HD – May require home delivery pharmacy

PPACA – No Cost-Share Preventive Medication

CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

ANTIBIOTICS (Infections) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ANTIBIOTIC, ANTIBACTERIAL, MISC.		
<i>fosfomycin tromethamine</i> (Monurol)	T1	
<i>methenamine hippurate</i>	T1	
<i>methenamine mandelate</i>	T1	
MONUROL (<i>fosfomycin tromethamine</i>)	T3	
PRIMSONL	T2	
<i>trimethoprim</i>	T1	
URIBEL	T3	
URIBEL TABS (<i>methenam/m.blue/salicyl/hyosc</i>)	T3	
UTA	T3	
ANTILEPROTICS		
<i>dapsone</i>	T1	
THALOMID	T3	PA SP HD
ANTI-MYCOBACTERIUM AGENTS		
<i>ethambutol hcl</i>	T1	HD
<i>isoniazid</i>	T1	HD
PASER	T2	HD
<i>pyrazinamide</i>	T1	HD
<i>rifabutin</i>	T1	HD
TRECATOR	T2	HD
ANTI-TUBERCULAR ANTIBIOTICS		
<i>cycloserine</i>	T1	
PRETOMANID	T3	PA QL (1 tab/day)
PRIFTIN	T3	
RIFAMATE	T2	
<i>rifampin</i>	T1	
RIFATER	T2	
ANTI-TUBERCULAR ANTIBIOTICS (cont.)		
SIRTURO	T3	SP
BETALACTAMS		
CAYSTON	T3	PA QL (3ml/day) SP HD

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

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List of Prescription Medications

ANTIBIOTICS (Infections) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
CARBAPENEM ANTIBIOTICS (THIENAMYCINS)		
<i>imipenem/cilastatin sodium</i> (Primaxin)	T1	
<i>meropenem iv 1 gm vial</i>	T1	
<i>meropenem iv 500 mg vial</i>	T1	
<i>meropenem</i>	T1	
PRIMAXIN (<i>imipenem/cilastatin sodium</i>)	T3	
RECARBRIOL	T3	
VABOMERE	T3	
CEPHALOSPORIN ANTIBIOTICS - 1ST GENERATION		
<i>cefadroxil</i>	T1	
<i>cefazin-dextrose</i>	T1	
CEFAZOLIN 3 GM VIAL	T3	
<i>cephalexin</i>	T1	
<i>cephalexin</i> (Keflex)	T1	
DAXBIA	T3	
KEFLEX (<i>cephalexin</i>)	T3	
CEPHALOSPORIN ANTIBIOTICS - 2ND GENERATION		
<i>cefaclor</i>	T1	
<i>cefotaxime</i>	T1	
<i>cefprozil</i>	T1	
<i>cefuroxime axetil</i>	T1	
CEPHALOSPORIN ANTIBIOTICS - 3RD GENERATION		
<i>cefdinir</i>	T1	
<i>cefixime</i>	T1	
<i>cefixime</i> (Suprax)	T1	
<i>cefpodoxime proxetil</i>	T1	
<i>ceftriaxone sodium</i>	T1	
SUPRAX (<i>cefixime</i>)	T3	
CEPHALOSPORIN ANTIBIOTICS - 4TH GENERATION		
<i>cefepime hcl</i>	T1	
CEPHALOSPORIN ANTIBIOTICS - 5TH GENERATION		
ZERBAXA	T3	
LINCOSAMIDE ANTIBIOTICS		
CLEOCIN HCL 150 MG CAPSULE (<i>clindamycin hcl</i>)	T3	
CLEOCIN HCL 300 MG CAPSULE (<i>clindamycin hcl</i>)	T3	
CLEOCIN HCL 75 MG CAPSULE (<i>clindamycin hcl</i>)	T2	

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

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List of Prescription Medications

ANTIBIOTICS (Infections) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
LINCOSAMIDE ANTIBIOTICS (cont.)		
CLEOCIN PEDIATRIC (<i>clindamycin (pediatric)</i>)	T3	
<i>clindamycin hcl</i> (Cleocin Hcl)	T1	
<i>clindamycin palmitate hcl</i> (Cleocin Pediatric)	T1	
CLINDAMYCIN PHOSPHATEL-D5W	T3	
MACROLIDE ANTIBIOTICS		
<i>azithromycin 1 gm pwd packet</i> (Zithromax)	T1	
<i>azithromycin 100 mg/5 ml susp</i> (Zithromax)	T1	
<i>azithromycin 200 mg/5 ml susp</i> (Zithromax)	T1	
<i>azithromycin 250 mg tablet</i> (Zithromax)	T1	
<i>azithromycin 500 mg tablet</i> (Zithromax Tri-pak)	T1	
<i>azithromycin 600 mg tablet</i>	T1	
<i>clarithromycin</i>	T1	
DIFICID 200 MG TABLET	T3	QL (28 tabs/28 days)
DIFICID 40 MG/ML SUSPENSION	T3	QL (5ml/day)
ERYPED 200 (<i>erythromycin ethylsuccinate</i>)	T3	
<i>ery-tab dr 250 mg tablet</i>	T3	
<i>ery-tab dr 333 mg tablet</i>	T2	
ERY-TAB DR 500 MG TABLET (<i>erythromycin</i>)	T3	
<i>erythromycin base</i> (Ery-tab)	T1	
<i>erythromycin ethylsuccinate</i>	T1	
<i>erythromycin ethylsuccinate</i> (Eryped 200)	T1	
<i>erythromycin stearate</i>	T1	
PCE	T3	
ZITHROMAX 1 GM POWDER PACKET (<i>azithromycin</i>)	T3	
ZITHROMAX SUSP (<i>azithromycin</i>)	T3	
ZITHROMAX 250 MG TABLET (<i>azithromycin</i>)	T3	
ZITHROMAX 250 MG Z-PAK TABLET (<i>azithromycin</i>)	T3	
ZITHROMAX 500 MG TABLET (<i>azithromycin</i>)	T3	
ZITHROMAX TRI-PAK (<i>azithromycin</i>)	T3	
NITROFURAN DERIVATIVES ANTIBACTERIAL AGENTS		
FURADANTIN (<i>nitrofurantoin</i>)	T3	
MACROBID (<i>nitrofurantoin mono-macro</i>)	T3	
<i>nitrofurantoin</i> (Furadantin)	T1	

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

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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.)		
<i>nitrofurantoin macrocrystal</i>	T1	
<i>nitrofurantoin monohyd/m-cryst (Macrobid)</i>	T1	
OXAZOLIDINONE ANTIBIOTICS		
<i>linezolid (Zyvox)</i>	T1	PA
SIVEXTRO	T3	PA
ZYVOX (<i>linezolid</i>)	T3	PA
PENICILLIN ANTIBIOTICS		
<i>amoxicillin</i>	T1	
<i>amoxicillin/potassium clav</i>	T1	
<i>ampicillin trihydrate</i>	T1	
<i>dicloxacillin sodium</i>	T1	
EXTENCILLINE	T3	
LETOCILIN S	T3	
MOXATAG	T3	
<i>penicillin v potassium</i>	T1	
PLEUROMUTILIN DERIVATIVES		
XENLETA	T3	PA QL (10 tabs/30 days)
QUINOLONE ANTIBIOTICS		
AVELOX (<i>moxifloxacin hcl</i>)	T3	
BAXDELA	T3	PA
CIPRO 10% SUSPENSION (<i>ciprofloxacin</i>)	T2	
CIPRO 250 MG TABLET (<i>ciprofloxacin hcl</i>)	T3	
CIPRO 5% SUSPENSION (<i>ciprofloxacin</i>)	T2	
CIPRO 500 MG TABLET (<i>ciprofloxacin hcl</i>)	T3	
<i>ciprofloxacin hcl (Cipro)</i>	T1	
<i>ciprofloxacin/ciprofloxa hcl</i>	T1	
FACTIVE	T3	
<i>levofloxacin</i>	T1	
<i>moxifloxacin hcl (Avelox)</i>	T1	
<i>ofloxacin</i>	T1	
RIFAMYCINS AND RELATED DERIVATIVE ANTIBIOTICS		
AEMCOLO	T3	QL (12 tabs/3 days)
XIFAXAN 200 MG TABLET	T2	
XIFAXAN 550 MG TABLET	T2	QL (126 tabs/year)

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

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List of Prescription Medications

ANTIBIOTICS (Infections) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
TETRACYCLINE ANTIBIOTICS		
coremino er 135 mg tablet	T1	
coremino er 45 mg tablet	T1	QL (1 tab/day)
coremino er 90 mg tablet	T1	
demeclacycline hcl	T1	
doxycycline hydiate	T1	
doxycycline monohydrate	T1	
minocycline er 115 mg tablet	T1	
minocycline er 45 mg tablet	T1	QL (1 tab/day)
minocycline er 55 mg tablet	T1	
minocycline er 65 mg tablet	T1	
minocycline er 80 mg tablet	T1	
minocycline er 90 mg tablet	T1	
minocycline hcl	T1	
NUZYRA	T3	PA QL (30 tablets/28 days) SP
tetracycline hcl	T1	
VIBRAMYCIN 50 MG/5 ML SYRUP	T2	
VAGINAL ANTIBIOTICS		
clindamycin phosphate (Cleocin)	T1	
metronidazole (Metrogel-vaginal)	T1	
VANCOMYCIN ANTIBIOTICS AND DERIVATIVES		
vancomycin 50 mg/ml solution	T1	
vancomycin 250 mg/5ml oral sol (Firvanq)	T1	
vancomycin hcl 125 mg capsule	T1	
vancomycin hcl 250 mg capsule	T1	
VANCOMYCIN HCL 1.75 GRAM VIAL	T3	
VANCOMYCIN HCL 2 GRAM VIAL	T3	
vancomycin hcl (Firvanq)	T1	
ANTIBIOTICS (Skin Conditions)		
TOPICAL ANTIBIOTIC AND ANTI-INFLAMMATORY STEROID		
CORTISPORIN	T3	
NEO-SYNALAR	T3	
TOPICAL ANTIBIOTICS		
BENZAMYCIN (erythromycin-benzoyl peroxide)	T3	
CENTANY	T3	
CENTANY AT	T3	

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

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List of Prescription Medications

ANTIBIOTICS (Skin Conditions) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
TOPICAL ANTIBIOTICS (cont.)		
CLEOCINT (<i>clindamycin phosphate</i>)	T3	
CLINDACIN ETZ KIT	T3	
CLINDACIN PAC	T3	
<i>clindamycin phosphate</i>	T1	
<i>clindamycin phosphate</i> (Cleocin T)	T1	
<i>clindamycin phosphate</i> (Evoclin)	T1	
<i>erythromycin base in ethanol</i>	T1	
<i>erythromycin/benzoyl peroxide</i> (Benzamycin)	T1	
EVOCLIN (<i>clindamycin phosphate</i>)	T3	
<i>gentamicin sulfate</i>	T1	
<i>mupirocin</i> (Centany)	T1	
<i>mupirocin calcium</i>	T1	
XEPI	T3	
TOPICAL SULFONAMIDES		
AVAR 9.5-5% CLEANSING PADS	T3	
<i>avar cleanser</i> (Rosanil)	T1	
AVAR LS	T3	
<i>mafenide acetate</i>	T1	
ROSANIL (<i>sodium sulfacetamide-sulfur</i>)	T1	
SILVADENE (ssd)	T3	
<i>silver sulfadiazine</i> (Silvadene)	T1	
<i>sulfacetamide sod/sulfur/urea</i>	T1	
<i>sulfacetamide sodium/sulfur</i>	T1	
<i>sulfacetamide sodium/sulfur</i> (Avar-e Green)	T1	
<i>sulfacetamide sodium/sulfur</i> (Rosanil)	T1	
<i>sulfacetamide/sulfur/cleansr23</i>	T1	
<i>sulfact sod/sulur/avob/otn/oct</i>	T1	
SULFAMYLYON 8.5% CREAM	T2	
SULFAMYLYON POWDER PACKET (<i>mafenide acetate</i>)	T3	

ANTI-COAGULANTS (Blood Thinners/Anti-Clotting)

ANTI-COAGULANTS, COUMARIN TYPE	T1	HD
<i>warfarin sodium</i>	T1	HD

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

PA – Prior Authorization

QL – Quantity Limit

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AGE – Age Requirement

SP – Specialty Medication

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List of Prescription Medications

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

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
CITRATES AS ANTI-COAGULANTS		
ACD SOLUTION A	T3	
ACD-A	T3	
ANTICOAG SODIUM CITRATE 4% SOL	T3	
CITRATE PHOSPHATE DEXTROSE	T1	
SODIUM CITRATE	T1	
DIRECT FACTOR XA INHIBITORS		
BEVYXXA	T3	QL (42 caps/42 days)
ELIQUIS	T2	
SAVAYSA 15 MG TABLET	T3	PA QL (1 tab/day)
SAVAYSA 30 MG TABLET	T3	PA QL (1 tab/day)
SAVAYSA 60 MG TABLET	T3	PA
XARELTO	T2	
HEPARIN AND RELATED PREPARATIONS		
ARIXTRA (<i>fondaparinux sodium</i>)	T3	QL (1 syringe/day) SP
enoxaparin 100 mg/ml syringe (Lovenox)	T1	QL (2 syringes/day) SP
enoxaparin 120 mg/0.8 ml syr (Lovenox)	T1	QL (2 syringes/day) SP
enoxaparin 30 mg/0.3 ml syr (Lovenox)	T1	QL (2 syringes/day) SP
enoxaparin 300 mg/3 ml vial (Lovenox)	T1	QL (1 vial/day) SP
enoxaparin 40 mg/0.4 ml syr (Lovenox)	T1	QL (2 syringes/day) SP
enoxaparin 60 mg/0.6 ml syr (Lovenox)	T1	QL (2 syringes/day) SP
enoxaparin 80 mg/0.8 ml syr (Lovenox)	T1	QL (2 syringes/day) SP
<i>fondaparinux sodium</i> (Arixtra)	T1	QL (1 syringe/day) SP
FRAGMIN	T1	QL (2 ml/day) SP
heparin 10,000 unit/10 ml vial	T1	
heparin 30,000 unit/30 ml vial	T1	
heparin 40,000 unit/4 ml vial	T1	
heparin 50,000 unit/10 ml vial	T1	
heparin 1,000 unit/500 ml-ns	T1	
HEPARIN 2,000 UNIT/1,000 ML-NS (<i>heparin sodium,porcine/ns/pf</i>)	T3	
heparin 2,000 unit/1,000 ml-ns (<i>Heparin Sodium-0.9% NaCl</i>)	T1	
HEPARIN 2,500 UNIT/500 ML-NS	T1	
HEPARIN 30,000 UNIT/1,000-NS	T1	
HEPARIN 5,000 UNIT/1,000 ML-NS	T1	
HEPARIN 5,000 UNIT/500 ML-NS	T1	

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

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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 50,000 unit/5 ml vial	T1	
heparin sod 1,000 unit/ml vial	T1	
heparin sod 10,000 unit/ml vial	T1	
heparin sod 20,000 unit/ml vial	T1	
heparin sod 2,000 unit/ml vial	T1	
heparin sod 5,000 unit/0.5 ml	T1	
HEPARIN SOD 5,000 UNIT/0.5 ML	T1	
heparin sod 5,000 unit/0.5 ml (Heparin Sodium)	T1	
heparin sod 5,000 unit/ml syrg	T3	
heparin sod 5,000 unit/ml vial	T1	
LOVENOX 100 MG/ML SYRINGE (enoxaparin sodium)	T3	QL (2 syringes/day) SP
LOVENOX 120 MG/0.8 ML SYRINGE (enoxaparin sodium)	T3	QL (2 syringes/day) SP
LOVENOX 150 MG/ML SYRINGE (enoxaparin sodium)	T3	QL (2 syringes/day) SP
LOVENOX 30 MG/0.3 ML SYRINGE (enoxaparin sodium)	T3	QL (2 syringes/day) SP
LOVENOX 300 MG/3 ML VIAL (enoxaparin sodium)	T3	QL (1 vial/day) SP
LOVENOX 40 MG/0.4 ML SYRINGE (enoxaparin sodium)	T3	QL (2 syringes/day) SP
LOVENOX 60 MG/0.6 ML SYRINGE (enoxaparin sodium)	T3	QL (2 syringes/day) SP
LOVENOX 80 MG/0.8 ML SYRINGE (enoxaparin sodium)	T3	QL (2 syringes/day) SP
THROMBIN INHIBITORS, SELECTIVE, DIRECT, REVERSIBLE		
ARGATROBAN 250MG/2.5ML VIAL	T3	SP
dabigatran etexilate	T1	

ANTIDOTES (Gastrointestinal/Heartburn)

MU-OPIOID RECEPTOR ANTAGONISTS, PERIPHERALLY-ACTING	Tier	Coverage Requirements
MOVANTIK	T2	PA
RELISTOR	T3	PA
SYMPROIC	T3	PA

ANTIDOTES (Substance Abuse)

OPIOID ANTAGONISTS	Tier	Coverage Requirements
KLOXXADO	T2	PA QL (2 sprays/30 days)
naloxone 0.4 mg/ml carpuject, vial	T1	
NALOXONE 2 MG AUTO-INJECTOR	T3	QL (0.8ml/day)
naloxone 2 mg/2 ml syringe	T1	
naloxone 4 mg/10 ml vial	T1	
naltrexone hcl	T1	QL(180 tabs/30 days)

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

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QL – Quantity Limit

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List of Prescription Medications

ANTIDOTES (Substance Abuse) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
OPIOID ANTAGONISTS (cont.)		
OPVEE	T3	QL(2 units/30 days)
NARCAN	T2	QL (2 units/30 days)
REXTOVY	T2	QL(2 units/30 days)
ZIMHI	T3	QL (2 inj/day)
ANTI-FUNGALS (Eye Conditions)		
OPHTHALMIC ANTI-FUNGAL AGENTS		
NATACYN	T2	
ANTI-FUNGALS (Feminine Products)		
VAGINAL ANTI-FUNGALS		
GYNAZOLE 1	T1	
<i>miconazole nitrate</i>	T1	
<i>terconazole</i>	T1	
ANTI-FUNGALS (Infections)		
ANTI-FUNGAL AGENTS		
ANCOBON (<i>flucytosine</i>)	T3	
<i>clotrimazole</i>	T1	
CRESEMBA	T3	PA
CRESEMBA 74.5 MG CAPSULE	T3	PA
<i>fluconazole</i>	T1	
<i>flucytosine (Ancobon)</i>	T1	
<i>itraconazole</i>	T1	
<i>ketoconazole</i>	T1	
NOXAFIL 300 MG/16.7 ML VIAL	T3	
ORAVIG	T3	
<i>terbinafine hcl</i>	T1	
VFEND (<i>voriconazole</i>)	T3	PA
VIVJOA	T3	PA SP
<i>voriconazole (Vfend)</i>	T1	PA
ANTI-FUNGAL ANTIBIOTICS		
<i>griseofulvin ultramicrosize (Gris-peg)</i>	T1	
<i>griseofulvin, microsize</i>	T1	
GRIS-PEG (<i>griseofulvin ultramicrosize</i>)	T3	
<i>nystatin</i>	T1	
MICAFUNGIN	T3	

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

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List of Prescription Medications

ANTI-FUNGALS (Skin Conditions)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
TOPICAL ANTI-FUNGAL/ANTI-INFLAMMATORY, STEROID AGENT		
<i>clotrimazole/betamethasone dip</i>	T1	
TOPICAL ANTI-FUNGALS		
<i>cyclodan 0.77% cream</i>	T1	
CICLODAN 0.77% CREAM KIT	T3	
<i>cyclodan 8% solution</i>	T1	
<i>ciclopirox</i>	T1	
<i>ciclopirox olamine</i>	T1	
<i>ciclopirox olamine (Loprox)</i>	T1	
<i>econazole nitrate</i>	T1	
ECOZA	T3	
EXODERM	T1	
<i>ketoconazole</i>	T1	
<i>ketoconazole/skin cleanser 28</i>	T1	
LOPROX (cyclopirox)	T3	
LULICONAZOLE	T1	
<i>naftifine hcl</i>	T1	
<i>naftifine hcl (Naftin)</i>	T1	
NAFTIN (naftifine hcl)	T2	
<i>nystatin</i>	T1	
<i>nystatin/triamcinolone acet</i>	T1	
ANTIHISTAMINE AND DECONGESTANT COMBINATION (Allergy/Nasal Sprays)		
1ST GEN ANTIHISTAMINE AND DECONGESTANT COMBINATION		
<i>phenylephrine hcl/prometh hcl</i>	T1	
2ND GEN ANTIHISTAMINE AND DECONGESTANT COMBINATION		
CLARINEX-D 12 HOUR	T3	
ANTIHISTAMINES (Allergy/Nasal Sprays)		
ANTIHISTAMINES - 1ST GENERATION		
<i>carbinoxamine maleate</i>	T1	
<i>clemastine fumarate</i>	T1	
<i>hydroxyzine hcl</i>	T1	
<i>hydroxyzine pamoate</i>	T1	
<i>hydroxyzine pamoate (Vistaril)</i>	T1	

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

PA – Prior Authorization

QL – Quantity Limit

ST – Step Therapy

AGE – Age Requirement

SP – Specialty Medication

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List of Prescription Medications

ANTIHISTAMINES (Allergy/Nasal Sprays) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ANTIHISTAMINES - 1ST GENERATION (cont.)		
<i>promethazine hcl</i>	T1	
VISTARIL (<i>hydroxyzine pamoate</i>)	T3	
ANTIHISTAMINES - 2ND GENERATION		
<i>cetirizine hcl</i>	T1	HD
CLARINEX (<i>desloratadine</i>)	T3	HD
<i>desloratadine 2.5 mg odt</i>	T1	QL (1 tab/day) HD
<i>desloratadine 5 mg tablet (Claritin)</i>	T1	HD

ANTIHISTAMINES (Eye Conditions)

EYE ANTIHISTAMINES		
<i>azelastine hcl 0.05% drops</i>	T1	
BEPREVE	T3	
<i>epinastine hcl</i>	T1	
LASTACAFT	T3	
<i>olopatadine hcl 0.1% eye drops</i>	T1	
<i>olopatadine hcl 0.2% eye drop (Pataday)</i>	T1	
PATADAY (<i>olopatadine hcl</i>)	T3	
PAZEO	T2	
ZERVIADE	T2	

ANTI-HYPERGLYCEMICS (Diabetes)

ANTIHYPERGLY, INCRETIN MIMETIC (GLP-1 RECEPTOR AGONIST)		
BYDUREON	T2	QL (4 vials/28 days) ST HD
BYDUREON BCISE	T2	QL (4 pens/28 days) ST
BYDUREON PEN	T2	QL (4 pens/28 days) ST HD
BYETTA	T2	QL (1 pen/30 days) ST
OZEMPIC 0.25-0.5 MG DOSE PEN	T2	QL (2 pens/28 days) ST HD
OZEMPIC 1 MG DOSE PEN (1.5 ML)	T2	QL (2 pens/28 days) ST HD
OZEMPIC 1 MG DOSE PEN (3 ML)	T2	QL (3ml/21 days) ST HD
RYBELSUS	T2	QL (1 tab/day) ST
TRULICITY 0.75 MG/0.5 ML PEN	T2	QL (4 pens/28 days) ST
TRULICITY 1.5 MG/0.5 ML PEN	T2	QL (4 pens/28 days) ST
TRULICITY 3 MG/0.5 ML PEN	T2	QL (2ML/28 Days) ST
TRULICITY 4.5 MG/0.5 ML PEN	T2	QL (2ML/28 Days) ST

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List of Prescription Medications

ANTI-HYPERGLYCEMICS (Diabetes) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ANTI-HYPERGLY, INSULIN, LONG ACT-GLP-1 RECEPT.AAGONIST		
SOLIQUA 100-33	T2	HD
ANTIHYPERGLYCEMIC-GLUCOCORTICOID RECEPTOR BLOCKER		
mifepristone 300 mg tablet (Korlym)	T2	HD
ANTI-HYPERGLYCEMIC-SOD/GLUC COTRANSPORT2(SGLT2) INHIB		
FARXIGA	T2	QL (1 tab/day) ST
JARDIANCE	T2	QL (1 tab/day) ST HD
ANTI-HYPERGLYCEMIC-DOPAMINE RECEPTOR AGONISTS		
CYCLOSET	T3	HD
ANTI-HYPERGLYCEMIC, ALPHA-GLUCOSIDASE INHIBITORS		
acarbose (Precose)	T1	HD
GLYSET (miglitol)	T3	HD
miglitol (Glyset)	T1	HD
PRECOSE (acarbose)	T3	HD
ANTI-HYPERGLYCEMIC, AMYLIN ANALOG-TYPE		
SYMLINPEN 60	T2	
SYMLINPEN 120	T2	HD
ANTI-HYPERGLYCEMIC, BIGUANIDE TYPE		
GLUCOPHAGE XR (metformin hcl er)	T3	HD
metformin hcl	T1	HD
metformin hcl (Glucophage Xr)	T1	HD
metformin hcl (Riomet)	T1	HD
RIOMET (metformin hcl)	T3	HD
RIOMET ER	T3	HD
ANTI-HYPERGLYCEMIC, DPP-4 INHIBITORS		
JANUVIA	T2	QL (1 tab/day) ST HD
ANTI-HYPERGLYCEMIC, INSULIN-RELEASE STIMULANT TYPE		
AMARYL (glimepiride)	T3	HD
chlorpropamide	T1	HD
glimepiride (Amaryl)	T1	HD
glipizide 5 mg tablet	T1	HD
glipizide 10 mg tablet	T1	HD
GLIPIZIDE 2.5 MG TABLET	T3	HD
GLUCOTROL (glipizide)	T3	HD
GLUCOTROL XL (glipizide xl)	T3	HD

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ANTI-HYPERGLYCEMICS (Diabetes) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ANTI-HYPERGLYCEMIC, INSULIN-RELEASE STIMULANT TYPE (cont.)		
glyburide	T1	HD
glyburide, micronized (Glynase)	T1	HD
GLYNASE (glyburide micronized)	T3	HD
nateglinide (Starlix)	T1	HD
repaglinide	T1	HD
STARLIX (nateglinide)	T3	HD
tolbutamide	T1	HD
ANTI-HYPERGLYCEMIC, SGLT-2 AND DPP-4 INHIBITOR COMB		
GLYXAMBI	T2	QL (1 tab/day) ST HD
ANTI-HYPERGLYCEMIC, THIAZOLIDINEDIONE AND BIGUANIDE		
ACTOPLUS MET (pioglitazone-metformin)	T3	HD
pioglitazone hcl/metformin hcl (Actoplus Met)	T1	HD
ANTI-HYPERGLYCEMIC, THIAZOLIDINEDIONE-SULFONYLUREA		
DUETACT (pioglitazone-glimepiride)	T3	HD
pioglitazone hcl/glimepiride (Duetact)	T1	HD
ANTI-HYPERGLYCEMIC, DPP-4 INHIBITOR-BIGUANIDE COMBS.		
JANUMET	T2	QL (2 tabs/day) ST HD
JANUMET XR 100-1,000 MG TABLET	T2	QL (1 tab/day) ST HD
JANUMET XR 50-1,000 MG TABLET	T2	QL (2 tabs/day) ST HD
JANUMET XR 50-500 MG TABLET	T2	QL (1 tab/day) ST HD
ANTI-HYPERGLYCEMIC, INSULIN-RELEASE STIM.-BIGUANIDE		
glipizide/metformin hcl	T1	HD
glyburide/metformin hcl	T1	HD
repaglinide/metformin hcl	T1	HD
ANTI-HYPERGLYCEMIC, THIAZOLIDINEDIONE (PPARG AGONIST)		
ACTOS (pioglitazone hcl)	T3	HD
AVANDIA	T3	HD
pioglitazone hcl (Actos)	T1	HD
ANTI-HYPERGLYCEMIC-SGLT2 INHIBITOR-BIGUANIDE COMBS.		
SYNJARDY	T2	QL (2 tabs/day) ST HD
SYNJARDY XR 10-1,000 MG TABLET	T2	QL (2 tabs/day) ST HD
SYNJARDY XR 12.5-1,000 MG TAB	T2	QL (2 tabs/day) ST HD
SYNJARDY XR 25-1,000 MG TABLET	T2	QL (1 tab/day) ST HD

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ANTI-HYPERGLYCEMICS (Diabetes) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ANTI-HYPERGLYCEMIC-SGLT2 INHIBITOR-BIGUANIDE COMBS. (cont.)		
SYNJARDY XR 5-1,000 MG TABLET	T2	QL (2 tabs/day) ST HD
XIGDUO XR 10 MG-1,000 MG TAB	T2	QL (1 tab/day) ST HD
XIGDUO XR 10 MG-500 MG TABLET	T2	QL (1 tab/day) ST HD
XIGDUO XR 2.5 MG-1,000 MG TAB	T2	QL (2 tabs/day) ST HD
XIGDUO XR 5 MG-1,000 MG TABLET	T2	QL (2 tabs/day) ST HD
XIGDUO XR 5 MG-500 MG TABLET	T2	QL (1 tab/day) ST HD
ANTIHYPERGLY-SGLT-2 INHIB, DPP-4 INHIB, BIGUANIDE CB		
TRIJARDY XR	T2	QL (1 tab/day) ST HD
INSULINS		
BASAGLAR KWIKPEN U-100	T2	QL (1.5ml/day) HD
HUMALOG	T2	QL (1.5ml/day) HD
HUMALOG 100 UNIT/ML VIAL	T2	QL (1.5ml/day) HD
HUMALOG JUNIOR KWIKPEN	T2	QL (1.5ml/day) HD
HUMALOG KWIKPEN U-100	T2	QL (1.5 ml/day) HD
HUMALOG KWIKPEN U-200	T2	QL (1 ml/day) HD
HUMALOG MIX 50-50 KWIKPEN	T2	QL (2ml/day) HD
HUMALOG MIX 75-25	T2	QL (2ml/day) HD
HUMALOG MIX 75-25 KWIKPEN	T2	QL (2ml/day) HD
HUMULIN N 100 UNIT/ML VIAL	T2	QL(1.5 mls/day) HD
HUMULIN R U-500	T2	QL (1 ml/day) HD
HUMULIN R U-500 KWIKPEN	T2	QL (1 ml/day) HD
INSULIN ASPART	T2	QL (1.5ml/day) HD
INSULIN ASPART FLEXPEN	T2	QL (1.5ml/day) HD
INSULIN ASPART PENFILL	T2	QL (1.5ml/day) HD
INSULIN ASPART PROT-INSULN ASP	T2	QL (2 ml/day) HD
INSULIN GLARGINE-YFGN	T3	QL(1.5 mls/day) HD
INSULIN LISPRO	T3	QL(1.5 mls/day) HD
INSULIN LISPRO JUNIOR KWIKPEN	T3	QL(1.5 mls/day) HD
INSULIN LISPRO KWIKPEN U-100	T3	QL(1.5 mls/day) HD
INSULIN LISPRO PROTAMINE MIX	T3	QL(2 mls/day) HD
LEVEMIR	T2	QL (1.5ml/day) HD
LEVEMIR FLEXTOUCH	T2	QL (1.5ml/day) HD
LYUMJEV	T2	QL (1.5ml/day) HD
LYUMJEV KWIKPEN U-100	T2	QL (1.5ml/day) HD
LYUMJEV KWIKPEN U-200	T2	QL (1 ml/day) HD

T1 – Typically Generics

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List of Prescription Medications

ANTI-HYPERGLYCEMICS (Diabetes) (cont.)					
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits			
INSULINS (cont.)					
SEMGLEE (YFGN)	T2	PA	QL(1.5 mls/day) HD		
TRESIBA	T2	QL	(1.5ml/day) HD		
TRESIBA FLEXTOUCH U-100	T2	QL	(1.5ml/day) HD		
TRESIBA FLEXTOUCH U-200	T2	QL	(0.9ml/day) HD		
ANTI-INFECTIVES (Feminine Products)					
VAGINAL SULFONAMIDES					
AVC	T3				
VAGINAL ANTISEPTICS					
acetic acid/oxyquinoline	T1				
XACIATO	T3				
RELAGARD	T3				
RELAGARD (fem ph)	T3				
TRIMO-SAN	T3				
ANTI-INFECTIVES (Infections)					
PENICILLIN ANTIBIOTICS					
amoxicillin	T1				
amoxicillin/potassium clav (Augmentin Es-600)	T1				
ANTI-INFECTIVES/MISCELLANEOUS (Infections)					
2ND GEN. ANAEROBIC ANTI-PROTOZOAL-ANTIBACTERIAL					
TINDAMAX (tinidazole)	T3				
tinidazole	T1				
tinidazole (Tindamax)	T1				
AMEBICIDES					
paromomycin sulfate	T1				
ANTHELMINTICS					
albendazole (Albenza)	T1				
ALBENZA (albendazole)	T3				
BILTRICIDE (praziquantel)	T3				
EMVERM	T1				
ivermectin (Stromectol)	T1	PA			
praziquantel (Biltricide)	T1				
STROMECTOL (ivermectin)	T3	PA			

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List of Prescription Medications

ANTI-INFECTIVES/MISCELLANEOUS (Infections) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ANTI-MALARIAL DRUGS		
atovaquone/proguanil hcl (Malarone)	T1	
chloroquine ph 250 mg tablet	T1	QL (56 tabs/365 days)
chloroquine ph 500 mg tablet	T1	
COARTEM	T3	PA QL (24 tabs/30 days)
hydroxychloroquine sulfate (Plaquenil)	T1	
KRINTAFEL	T3	PA QL (2 tabs/30 days)
MALARONE (atovaquone-proguanil hcl)	T3	PA
mefloquine hcl	T1	
PLAQUENIL (hydroxychloroquine sulfate)	T3	PA QL (30 tabs/365 days)
PRIMAQUINE (primaquine phosphate)	T1	
primaquine phosphate (Primaquine)	T1	
pyrimethamine 25 mg tablet (Daraprim)	T1	PA
QUALAQUIN (quinine sulfate)	T3	PA
quinine sulfate (Qualaquin)	T1	
ANTI-PROTOZOAL DRUGS, MISCELLANEOUS		
atovaquone	T1	
BENZNIDAZOLE	T3	
IMPAVIDO	T3	PA
LAMPIT	T3	
NEBUPENT (pentamidine isethionate)	T3	
pentamidine isethionate (Nebupent)	T1	
ANTI-INFECTIVES/MISCELLANEOUS (Miscellaneous)		
ANTIBACTERIAL AGENTS, MISCELLANEOUS		
glycine urologic solution	T1	
glycine urologic solution	T3	
TOPICAL ANTISEPTIC DRYING AGENTS		
formaldehyde	T1	
ANTI-INFECTIVES/MISCELLANEOUS (Skin Conditions)		
TOPICAL ANTI-FUNGALS		
CICLODAN 8% KIT	T3	
ciclopiprox/urea/camph/men/euc (Ciclodan)	T1	

T1 – Typically Generics

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T3 – Typically Non-Preferred Brands

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List of Prescription Medications

ANTI-INFLAM.TUMOR NECROSIS FACTOR INHIBITING AGENTS (Pain Relief And Inflammatory Disease)			
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits	
ANTI-INFLAMMATORY TUMOR NECROSIS FACTOR INHIBITOR			
ADALIMUMAB-AACF(CF)	T3	QL(2 pens/syringes/28 days) SP	
ADALIMUMAB-ADBM(CF)	T2	PA QL(2 pens/syringes/28 days) SP HD	
ADALIMUMAB-ADAZ	T2	PA QL 2 (doses/ 28 days) SP	
ADALIMUMAB-RYVK(CF) AUTOINJECT	T2	PA QL(2 pens/syringes/28 days) SP HD	
AMJEVITA(CF)	T3	PA QL(2 Syringes/28 days) SP HD	
AMJEVITA(CF) AUTOINJECTOR	T3	PA QL(2 auto-injs/28 days) SP HD	
AVSOLA	T2	PA SP	
CIMZIA 200 MG VIAL KIT	T2	PA QL (1 kit/28 days) SP HD	
CIMZIA 2X200 MG/ML SYRINGE KIT	T2	PA QL (1 kit/28 days) SP HD	
CIMZIA 2X200 MG/ML(X3) START KT	T2	PA QL (1 kit/year) SP HD	
CYLTEZO (CF)	T2	PA QL(1 starter kit/365 days) SP	
CYLTEZO(CF) PEN	T2	PA QL(2 pens/28 days) SP	
CYLTEZO(CF) PEN CROHN'S-UC-HS	T2	PA QL(1 starter kit/365 days) SP	
ENBREL 25 MG KIT	T2	PA QL (8 vials/28 days) SP HD	
ENBREL 25 MG/0.5 ML SYRINGE	T2	PA QL (8 syringes/28 days) SP HD	
ENBREL 25 MG/0.5 ML VIAL	T2	PA QL (4 ml/28 days) SP HD	
ENBREL 50 MG/ML SYRINGE	T2	PA QL (4 syringes/28 days) SP HD	
ENBREL MINI	T2	PA QL (4 cartridges/28 days) SP HD	
ENBREL SURECLICK	T2	PA QL (4 syringes/28 days) SP HD	
HUMIRA	T2	PA QL (2 syrings/28 days) SP HD	
HUMIRA PEN	T2	PA QL (2 pens/28 days) SP HD	
HUMIRA PEN PSOR-UVEITS-ADOL HS	T2	PA QL (1 kit/year) SP HD	
HUMIRA(CF)	T2	PA QL (2 syrings/28 days) SP HD	
HUMIRA(CF) PEDIATRIC CROHN'S	T2	PA QL (1 kit/year) SP	
HUMIRA(CF) PEN 40 MG/0.4 ML	T2	PA QL (2 pens/28 days) SP HD	
HUMIRA(CF) PEN 80 MG/0.8 ML	T2	PA QL (1 kit/year) SP HD	
HUMIRA(CF) PEN PEDIATRIC UC	T2	PA QL (4 kits/365 dayS) SP HD	
INFLECTRA	T3	PA SP HD	
REMICADE	T2	PA SP HD	
SIMLANDI(CF) AUTOINJECTOR	T2	PA QL(2 auto-injs/28 days) SP HD	
SIMPONI 100 MG/ML PEN INJECTOR	T2	PA QL (1 injector/28 days) SP HD	
SIMPONI 100 MG/ML SYRINGE	T3	PA QL (1 syringe/28 days) SP HD	
SIMPONI 50 MG/0.5 ML PEN INJEC	T3	PA QL (1 injector/28 days) SP HD	

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ANTI-INFLAM.TUMOR NECROSIS FACTOR INHIBITING AGENTS (Pain Relief And Inflammatory Disease) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ANTI-INFLAMMATORY TUMOR NECROSIS FACTOR INHIBITOR (cont.)		
SIMPONI 50 MG/0.5 ML SYRINGE	T3	PA QL (1 syringe/28 days) SP HD
SIMPONI ARIA	T2	PA SP HD
ANP - SELECTIVE RETINOID X RECEPTOR AGONISTS (RXR)		
bexarotene (Targretin)	T1	PA SP HD
ANTI-NEOPLASTICS (Cancer)		
ANTIBIOTIC ANTOINEPLASTICS		
ADRIAMYCIN (<i>doxorubicin hcl</i>)	T3	PA SP
ANTI-NEOPLAST, HISTONE DEACETYLASE (HDAC) INHIBITORS		
FARYDAK	T3	PA SP HD
ZOLINZA	T3	PA SP HD
ANTINEOPLAST HUM VEGF INHIBITOR RECOMB MC ANTIBODY		
VEGZELMA	T3	PA SP
ANTI-NEOPLASTIC - ALKYLATING AGENTS		
ALKERAN (<i>melphalan</i>)	T3	SP
bendamustine 100 mg vial (<i>Treanda</i>)	T1	PA SP HD
bendamustine 25 mg vial (<i>Treanda</i>)	T1	PA SP HD
BENDAMUSTINE 100 MG/4 ML VIAL	T3	PA HD
cisplatin	T1	PA SP
CISPLATIN 50MG VIAL	T3	PA SP
CYCLOPHOSPHAMIDE	T3	
cyclophosphamide	T1	SP HD
GLEOSTINE	T3	
HYDREA (<i>hydroxyurea</i>)	T3	
hydroxyurea (<i>Hydrea</i>)	T1	
LEUKERAN	T2	
<i>melphalan hcl</i> (<i>Alkeran</i>)	T3	PA CSL
MYLERAN	T2	
TEMODAR 100 MG VIAL	T3	PA SP
TEMODAR 140 MG CAPSULE (<i>temozolomide</i>)	T3	PA SP HD CSL
<i>temozolomide</i>	T1	PA SP HD
VIVIMUSTA	T3	PA SP
ANTI-NEOPLASTIC - ANTI-ANDROGENIC AGENTS		
abiraterone acetate	T1	PA SP HD
bicalutamide (<i>Casodex</i>)	T1	
CASODEX (<i>bicalutamide</i>)	T3	

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List of Prescription Medications

ANTI-NEOPLASTICS (Cancer) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ANTI-NEOPLASTIC - ANTI-ANDROGENIC AGENTS (cont.)		
ERLEADA 240MG TABLET	T3	PA SP HD
ERLEADA 60MG TABLET	T3	PA SP HD CSL
<i>flutamide</i>	T1	
<i>nilutamide</i>	T1	QL (4 tabs/day)
NUBEQA	T3	PA SP HD
TREANDA (<i>bendamustine hcl</i>)	T3	PA SP
XTANDI	T3	PA SP HD
ANTI-NEOPLASTICS ANTI-BODY/ANTI-BODY-DRUG COMPLEXES		
ZIIHERA	T3	
ANTI-NEOPLASTIC - ANTI-METABOLITES		
<i>capecitabine</i> (Xeloda)	T1	PA SP HD
<i>clofarabine</i>	T3	PA SP
DACOGEN 50 MG VIAL	T3	PA SP
<i>gemcitabine</i>	T3	PA SP
GEMCITABINE 1MG/10ML	T3	PA SP
GEMCITABINE 1.5MG/15ML	T3	PA SP
GEMCITABINE 2MG/20ML	T3	PA SP
GEMCITABINE 200MG/2ML VIAL	T3	PA SP
INQOVI	T3	PA SP HD
JYLAMVO	T3	CSL
LONSURF	T3	PA SP HD
<i>mercaptopurine</i>	T1	
<i>methotrexate sodium</i>	T1	
ONUREG	T3	PA QL (14 tabs/28 Days) SP
PEMRYDI RTU	T3	PA
PURIXAN	T3	SP
TABLOID	T3	
TREXALL	T2	
VIDAZA	T3	PA
XATMEP	T3	
XELODA (<i>capecitabine</i>)	T3	PA SP HD
ANTI-NEOPLASTIC, ANTI PROGRAMMED DEATH-1 (PD-I) MAB		
LOQTORZI	T3	SP
TECENTRIQ HYBREZA	T3	PA SP
ZYNYZ	T3	PA SP
ANTI-NEOPLASTIC - AROMATASE INHIBITORS		
<i>anastrozole</i> (Arimidex)	T1	HD PPACA

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ANTI-NEOPLASTICS (Cancer) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ANTI-NEOPLASTIC - AROMATASE INHIBITORS (cont.)		
ARIMIDEX (<i>anastrozole</i>)	T3	HD
AROMASIN (<i>exemestane</i>)	T3	HD
<i>exemestane</i> (Aromasin)	T1	HD PPACA
FEMARA (<i>letrozole</i>)	T3	HD
<i>letrozole</i> (Femara)	T1	HD
ANTI-NEOPLASTIC - BRAF KINASE INHIBITORS		
TAFINLAR 10 MG TABLET FOR SUSP	T2	PA QL(30 tabs/day) SP HD CSL
TAFINLAR CAPSULES	T3	PA QL(4 caps/day) SP HD CSL
OJEMDA TABLET	T3	PA QL(1 packet/28 Days) SP CSL
OJEMDA 25 MG/ML ORAL SUSP	T3	PA QL(8 bottles/28 days) SP CSL
ZELBORAF	T3	PA SP HD
ANTI-NEOPLASTIC-ENZYME INHIB, ANTIANDROGEN COMB.		
AKEEGA	T3	PA QL(2 TABS/DAY) SP CSL
DAURISMO	T3	PA SP HD
ERIVEDGE	T3	PA SP HD
ODOMZO	T3	PA SP HD CSL
ANTI-NEOPLASTIC - JANUS KINASE (JAK) INHIBITORS		
JAKAFI	T1	PA SP HD
ANTI-NEOPLASTIC - KRAS PROTEIN INHIBITOR		
LUMAKRAS 120 MG TABLET	T3	PA QL(8 tabs/day) SP HD CSL
LUMAKRAS 240 MG TABLET	T3	PA QL(4 tabs/day) SP HD CSL
LUMAKRAS 320 MG TABLET	T3	PA QL(3 tabs/day) SP HD CSL
ANTI-NEOPLASTIC - MEK1 AND MEK2 KINASE INHIBITORS		
COTELLIC	T3	PA SP HD
GOMEKLI	T3	PA SP HD
KOSELUGO 10 MG CAPSULE	T3	PA QL (10 capsules/day) SP
KOSELUGO 25 MG CAPSULE	T3	PA QL (4 caps/day) SP
MEKINIST	T3	PA SP HD
ANTINEOPLASTIC - MICROTUBULE INHIBITORS		
eribulin mesylate (Halaven)	T1	PA SP
HALAVEN (eribulin mesylate)	T3	PA SP
ANTI-NEOPLASTIC - MTOR KINASE INHIBITORS		
AFINITOR (<i>everolimus</i>)	T3	PA SP HD
AFINITOR DISPERZ	T3	PA SP
<i>everolimus</i> 2.5 mg tablet	T1	PA SP HD
<i>everolimus</i> 5 mg tablet	T1	PA SP HD
<i>everolimus</i> 7.5 mg tablet	T1	PA SP HD

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

PA – Prior Authorization

QL – Quantity Limit

ST – Step Therapy

AGE – Age Requirement

SP – Specialty Medication

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List of Prescription Medications

ANTI-NEOPLASTICS (Cancer) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ANTI-NEOPLASTIC - PROTEIN METHYLTRANSFERASE INHIBIT		
TAZVERIK	T3	PA SP
ANTI-NEOPLASTIC - TOPOISOMERASE I INHIBITORS		
HYCAMTIN	T3	PA SP HD
ANTI-NEOPLASTIC COMB - KINASE AND AROMATASE INHIBIT		
KISQALI FEMARA CO-PACK	T3	PA QL (1 pack/28 days) SP HD CSL
KISQALI 600MG	T3	PA QL(63/28 days) SP HD CSL
KISQALI 400MG	T3	PA QL(42/28 days) SP HD CSL
KISQALI 200MG	T3	PA QL(21/28 days) SP HD CSL
ANTI-NEOPLASTIC EGF RECEPTOR BLOCKER MCLON ANTIBODY		
OGIVRI	T3	PA SP
PHESGO	T3	PA SP HD
ANTI-NEOPLASTIC IMMUNOMODULATOR AGENTS		
lenalidomide	T1	PA QL(1 cap/day) SP HD CSL
ANTI-NEOPLASTIC LHRH (GNRH) AGONIST, PITUITARY SUPPR.		
POMALYST	T2	PA SP HD
REVLIMID	T3	PA SP HD
leuprolide acetate	T1	PA SP HD
ZOLADEX	T3	PA SP HD
ANTI-NEOPLASTIC LHRH (GNRH) ANTAGONIST, PITUIT.SUPPRS		
FIRMAGON	T3	PA SP HD
ORGOVYX	T3	PA SP
ANTI-NEOPLASTIC SYSTEMIC ENZYME INHIBITORS		
ALECensa	T2	PA QL(8 tabs/day) SP HD CSL
AYVAKIT	T3	PA QL (1 tab/day) SP
BALVERSA	T3	PA SP
BOSULIF	T3	PA QL(3 caps/day) SP HD CSL
BORTEZOMIB 3.5MG IV VIAL	T3	PA SP
BORUZU	T3	PA SP
BRUKINSA	T3	PA QL (4 caps/day) SP
CABOMETYX	T3	PA SP HD
CALQUENCE	T3	PA SP
CAPRELSA	T3	PA SP
COMETRIQ	T3	PA SP HD
COPIKTRA	T3	PA SP
dasatinib 20 mg tablet	T1	PA QL(3 tabs/day) SP CSL
dasatinib 70 mg tablet	T1	PA QL(2 tabs/day) SP CSL

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List of Prescription Medications

ANTI-NEOPLASTICS (Cancer) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ANTI-NEOPLASTIC SYSTEMIC ENZYME INHIBITORS (cont.)		
dasatinib 50 mg, 80 mg, 100 mg, 140 mg tablet	T1	PA QL(1 tab/day) SP CSL
DANZITEN	T2	PA SP CSL
erlotinib hcl	T3	PA SP HD
EXKIVITY	T3	PA SP HD
FOTIVDA	T3	PA QL (30 caps/30 days) SP HD
GAVRETO	T3	PA QL (4 tabs/Day) SP CSL
gefitinib	T3	PA SP HD CSL
GILOTrif	T3	PA SP HD
GLEEVEC (<i>imatinib mesylate</i>)	T3	PA SP HD
IBRANCE	T3	PA QL (21 caps/28 days) SP HD
<i>imatinib mesylate</i> (Gleevec)	T3	SP HD
IMBRUVICA	T3	PA SP
IMKELDI	T3	PA SP HD
INLYTA	T3	PA SP HD
INREBIC	T3	PA SP HD
IRESSA	T3	PA SP HD
ITOVEBI	T3	PA SP HD CSL
IWLFIN	T3	PA QL(8 tabs/day) SP CSL
KISQALI 200 MG DAILY DOSE	T3	PA QL(21 tabs/28 days) SP HD CSL
KISQALI 400 MG DAILY DOSE	T3	PA QL(42 tabs/28 days) SP HD CSL
KISQALI 600 MG DAILY DOSE	T3	PA QL(63 tabs/28 days) SP HD CSL
<i>lapatinib ditosylate</i> (Tykerb)	T3	PA SP HD
LENVIMA	T3	PA SP HD
LORBRENA	T2	PA SP HD
LYNPARZA	T2	PA SP HD
LYTGOBI 12 MG DAILY DOSE (3X 4MG TB)	T3	PA QL(3 tabs/day) SP CSL
LYTGOBI 16 MG DAILY DOSE (4X 4MG TB)	T3	PA QL(4 tabs/day) SP CSL
LYTGOBI 20 MG DAILY DOSE (5X 4MG TB)	T3	PA QL(5 tabs/day) SP CSL
NERLYNX	T3	PA SP HD
NINLARO	T3	PA SP HD
OGSIVEO	T3	PA QL(6 tabs/day) SP CSL
OJJAARA	T3	PA QL(1 tab/day) SP CSL
<i>pazopanib hcl</i> (Votrient)	T1	PA QL(4 tabs/day) SP HD CSL
PEMAZYRE	T3	PA QL (14 tabs/21 days) SP
PIQRAY	T2	PA SP HD
QINLOCK	T3	PA QL (3 tabs/day) SP
RETEVMO 40 MG CAPSULE	T3	PA QL (6 caps/day) SP HD

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List of Prescription Medications

ANTI-NEOPLASTICS (Cancer) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ANTI-NEOPLASTIC SYSTEMIC ENZYME INHIBITORS (cont.)		
RETEVMO 80 MG CAPSULE	T3	PA QL (4 tabs/day) SP HD
REVUFORJ	T3	PA QL(2 tabs/day) SP CSL
ROZLYTREK	T3	PA SP HD
RUBRACA	T2	PA SP
RYDAPT	T3	PA SP HD
SCEMBLIX 20 MG TABLET	T2	PA QL(2 tabs/day) SPCSL
SCEMBLIX 40 MG, 100 MG TABLET	T2	PA SP CSL
STIVARGA	T3	PA SP HD CSL
SUTENT	T3	PA SP HD
TALZENNA	T3	PA QL(1 cap/day) SP HD
TABRECTA	T3	PA QL (4 tabs/day) SP HD
TAGRISSO	T3	PA SP HD
TURALIO 125 MG CAPSULE	T3	PA QL(4 caps/day) SP CSL
TURALIO 200 MG CAPSULE	T3	PA SP CSL
TASIGNA	T2	PA SP HD
TEPMETKO	T3	PA QL (2 tabs/day) SP
TRUQAP	T3	PA QL(64 tabs/28 days) SP CSL
TUKYSA	T3	PA SP
TYKERB (<i>lapatinib</i>)	T3	PA SP HD
UKONIQ	T3	PA QL (4 tabs/day) SP
VANFLYTA	T3	PA QL(2 tabs/day) SP CSL
VERZENIO	T3	PA QL (2 tabs/day) SP HD
VITRAKVI	T3	PA SP HD
VIZIMPRO	T3	PA SP HD
XALKORI 150 MG PELLET	T3	PA QL(4 pellets/day) SP HD CSL
XALKORI 20 MG PELLET	T3	PA QL(4 pellets/day) SP HD CSL
XALKORI 200 MG CAPSULE	T3	PA QL(4 caps/day) SP HD CSL
XALKORI 50 MG PELLET	T3	PA QL(4 pellets/day) SP HD CSL
XOSPATA	T3	PA SP
ZEJULA	T2	PA QL(1 tab/day) SP CSL
ZYDELIG	T2	PA SP HD
ANTI-NEOPLASTIC, ANTI-PROGRAMMED DEATH-1 (PD-1) MAB		
LOQTORZI	T3	PA SP
OPDIVO	T3	PA SP HD
TECENTRIQ HYBREZA	T3	PA SP HD
TEVIMBRA	T3	PA SP

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List of Prescription Medications

ANTI-NEOPLASTICS (Cancer) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ANTI-NEOPLASTIC-B CELL LYMPHOMA-2(BCL-2) INHIBITORS		
VENCLEXTA	T3	PA SP
VENCLEXTA STARTING PACK	T3	PA SP
ANTI-NEOPLASTIC-ISOCITRATE DEHYDROGENASE INHIBITORS		
IDHIFA	T3	PA SP HD
REZLIDHIA	T3	PA QL(2 CAPS/DAY) SP CSL
TIBSOVO	T3	PA SP
ANTI-NEOPLASTICS ANTIBODY/ANTIBODY-DRUG COMPLEXES		
ENHERTU	T3	PA SP HD
IMDELLTRA	T3	PA SP
VYLOY	T3	PA SP
ANTI-NEOPLASTICS, MISCELLANEOUS		
<i>docetaxel vial</i> (Docivyx)	T1	PA SP
MATULANE	T3	SP
<i>paclitaxel protein-bound 100mg</i>	T1	PA SP
PACLITAXEL PROTEIN-BOUND 100MG	T2	PA SP
<i>tretinoin 10 mg capsule</i>	T3	PA
ANTI-NEOPLASTIC-SELECT INHIB OF NUCLEAR EXP (SINE)		
XPOVIO	T3	PA SP
CYTOTOXIC T-LYMPHOCYTE ANTIGEN (CTLA-4) RMC ANTIBODY		
IMJUDO	T3	PA SP HD
YERVOY	T3	PA SP HD
IMMUNOMODULATORS		
ACTIMMUNE	T3	PA SP HD
INTRON A	T3	PA SP HD
SELECTIVE ESTROGEN RECEPTOR MODULATORS (SERMS)		
<i>FARESTON (toremifene citrate)</i>	T3	QL (2 tabs/day) HD
SOLTAMOX	T3	HD
<i>tamoxifen citrate</i>	T1	HD PPACA
<i>toremifene citrate</i> (Fareston)	T1	QL (2 tabs/day) HD
ANTI-NEOPLASTICS (Skin Conditions)		
STEROID ANTI-NEOPLASTICS		
EMCYT	T3	SP HD
<i>megestrol acetate</i>	T1	
PHOTOACT, TOPICAL ANTI-NEOPLAST, PREMALIGNANT LESIONS		
LEVULAN	T3	SP

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List of Prescription Medications

ANTI-NEOPLASTICS (Skin Conditions) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
TOPICAL ANTI-NEOPLASTIC PREMALIGNANT LESION AGENTS		
EFUDEX (<i>fluorouracil</i>)	T3	
FLUOROPLEX	T2	
<i>fluorouracil</i>	T1	
<i>fluorouracil</i> (Efudex)	T1	
PANRETIN	T3	SP HD
PICATO	T2	
TOLAK	T3	
VALCHLOR	T3	SP HD
ANTI-OBESITY DRUGS (Weight Management)		
ANTI-OBESITY - ANOREXIC AGENTS		
ADIPEX-P (<i>phentermine hcl</i>)	T3	PA
<i>benzphetamine hcl</i>	T1	
<i>benzphetamine hcl</i> (Regimex)	T1	
<i>diethylpropion hcl</i>	T1	
LOMAIRA	T1	
<i>phendimetrazine tartrate</i>	T1	
<i>phentermine hcl</i>	T1	
<i>phentermine hcl</i> (Adipex-p)	T1	
QSYMIA	T3	PA
REGIMEX (<i>benzphetamine hcl</i>)	T3	
ANTI-OBESITY - MELANOCORTIN 4 RECEPTOR AGONISTS		
IMCIVREE	T3	PA QL (9 ml/22 days) SP
ANTI-OBESITY GLUCAGON-LIKE PEPTIDE-1 RECEPTOR AGONIST		
SAXENDA	T3	PA
ANTI-OBESITY - ANOREXIC AGENTS		
WEGOVY	T2	PA QL (1 box/month))
ANTI-OBESITY SEROTONIN 2C RECEPTOR AGONISTS		
BELVIQ	T3	PA
BELVIQ XR	T3	PA
ANTI-OBESITY - OPIOID ANTAG-NOREPI, DOPAMINE RU INHIB		
CONTRAVE	T3	PA
FAT ABSORPTION DECREASING AGENTS		
XENICAL	T3	PA

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

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List of Prescription Medications

ANTI-PARASITICS (Infections)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ANTI-PARASITICS		
ALINIA (<i>nitazoxanide</i>)	T3	
<i>nitazoxanide</i> (Alinia)	T1	
OPHTHALMIC (EYE) ANTIPARASITICS		
XDEMVY	T3	PA QL(4 bottles/30 days) SP
TOPICAL ANTI-PARASITICS		
<i>crotamiton</i> (Eurax)	T1	
ELIMITE (<i>permethrin</i>)	T3	
EURAX 10% CREAM	T2	
EURAX 10% LOTION	T3	
<i>permethrin</i> (Elimite)	T1	
SKLICE (<i>ivermectin</i>)	T3	
<i>spinosad</i> (Natroba)	T1	
ULESFIA	T3	
ANTI-PARKINSON DRUGS (Parkinson's Disease)		
ANTI-PARKINSONISM DRUGS, ANTI-CHOLINERGIC		
<i>benztropine mesylate</i>	T1	HD
<i>trihexyphenidyl hcl</i>	T1	HD
ANTI-PARKINSONISM DRUGS, OTHER		
<i>amantadine hcl</i>	T1	HD
APOKYN	T3	PA SP HD
AZILECT 0.5 MG TABLET (<i>rasagiline mesylate</i>)	T3	QL (1 tab/day) HD
AZILECT 1 MG TABLET (<i>rasagiline mesylate</i>)	T3	HD
<i>bromocriptine mesylate</i>	T1	HD
<i>carbidopa/levodopa</i>	T1	HD
<i>carbidopa/levodopa</i> (<i>Sinemet 10-100</i>)	T1	HD
<i>carbidopa/levodopa</i> (<i>Sinemet 25-100</i>)	T1	HD
<i>carbidopa/levodopa</i> (<i>Sinemet 25-250</i>)	T1	HD
<i>carbidopa/levodopa/entacapone</i> (<i>Stalevo 100</i>)	T1	HD
<i>carbidopa/levodopa/entacapone</i> (<i>Stalevo 125</i>)	T1	HD
<i>carbidopa/levodopa/entacapone</i> (<i>Stalevo 50</i>)	T1	HD

T1 – Typically Generics

T2 – Typically Preferred Brands

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List of Prescription Medications

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

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ANTI-PARKINSONISM DRUGS, OTHER (cont.)		
<i>carbidopa/levodopa/entacapone</i> (Stalevo 75)	T1	HD
DUOPA	T3	SP HD
<i>entacapone</i>	T1	HD
INBRIJA	T3	PA SP HD
KYNMOBI	T2	PA HD
NEUPRO	T3	HD
NOURIANZ	T3	PA QL (1 tab/day) SP HD
OSMOLEX ER	T3	QL (1 tab/day) HD
<i>pramipexole di-hcl</i>	T1	HD
<i>pramipexole er 0.375 mg tablet</i>	T1	QL (1 tab/day) HD
<i>pramipexole er 0.75 mg tablet</i>	T1	HD
<i>pramipexole er 1.5 mg tablet</i>	T1	QL (1 tab/day) HD
<i>pramipexole er 2.25 mg tablet</i>	T1	QL (1 tab/day) HD
<i>pramipexole er 3 mg tablet</i>	T1	HD
<i>pramipexole er 3.75 mg tablet</i>	T1	HD
<i>rasagiline mesylate 0.5 mg tab</i> (Azilect)	T1	QL (1 tab/day) HD
<i>rasagiline mesylate 1 mg tab</i> (Azilect)	T1	HD
<i>ropinirole hcl</i>	T1	HD
RYTARY	T3	HD
<i>selegiline hcl</i>	T1	HD
SINEMET 10-100 (<i>carbidopa-levodopa</i>)	T3	HD
SINEMET 25-100 (<i>carbidopa-levodopa</i>)	T3	HD
SINEMET 25-250 (<i>carbidopa-levodopa</i>)	T3	HD
STALEVO (<i>carbidopa-levodopa-entacapone</i>)	T3	HD
TASMAR (<i>tolcapone</i>)	T3	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
ANTI-PARKINSONISM DRUGS, OTHER (cont.)		
<i>tolcapone</i> (Tasmar)	T1	HD
XADAGO	T3	ST HD
DECARBOXYLASE INHIBITORS		
<i>carbidopa</i>	T1	
ANTI-PLATELET DRUGS (Blood Thinners/Anti-Clotting)		
PLATELET AGGREGATION INHIBITORS		
AGGRASTAT	T3	
<i>aspirin/dipyridamole</i>	T1	HD
BRILINTA	T2	HD
<i>cilostazol</i>	T1	HD
<i>clopidogrel bisulfate</i>	T1	HD
<i>clopidogrel bisulfate</i> (Plavix)	T1	HD
<i>dipyridamole 50 mg/10 ml vial</i>	T1	HD
EFFIENT (prasugrel hcl)	T3	HD
<i>eptifibatide</i>	T1	
PLAVIX (clopidogrel)	T3	HD
<i>prasugrel hcl</i> (Effient)	T1	HD
<i>ticlopidine hcl</i>	T1	HD
<i>tirofiban-0.9% sodium chloride</i>	T1	
ZONTIVITY	T3	HD
PLATELET REDUCING AGENTS		
AGRYLIN (<i>anagrelide hcl</i>)	T3	
<i>anagrelide hcl</i>	T1	
<i>anagrelide hcl</i> (Agrylin)	T1	
ANTIVIRALS (AIDS/HIV)		
ANTI-RETROVIRAL - CAPSID INHIBITORS		
SUNLENCA 463.5 MG/1.5 ML VIAL	T3	PA SP
SUNLENCA TABLET	T3	PA QL(5 tabs/180 days) SP
ANTI-RETROVIRAL - INTEGRASE INHIBITOR AND NNRTI COMB.		
CABENUVA	T3	PA SP
JULUCA	T3	SP
ANTI-RETROVIRAL - INTEGRASE INHIBITOR AND NRTI COMB.		
DOVATO	T3	SP

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ANTIVIRALS (AIDS/HIV) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ANTI-RETROVIRAL - NRTIS AND INTEGRASE INHIBITORS COMB		
TRIUMEQ PD	T3	SP
ANTI-RETROVIRAL - NUCLEOSIDE, NUCLEOTIDE, PROTEASE INH.		
SYMTUZA	T3	SP
ANTIVIRALS - HIV-SPEC, NON-PEPTIDIC PROTEASE INHIB		
APTIVUS	T3	PA SP
<i>darunavir</i> (Prezista)	T1	PA SP
PREZCOBIX	T3	PA SP
PREZISTA	T3	SP
ANTIVIRALS - HIV-SPEC, NUCLEOSIDE-NUCLEOTIDE ANALOG		
CIMDUO	T3	PA SP
DESCOVY	T3	SP PPACA
<i>emtricitabine-tenofovir</i> 100-150mg	T1	SP
<i>emtricitabine-tenofovir</i> 133-200mg	T1	SP
<i>emtricitabine-tenofovir</i> 167-250mg	T1	SP
<i>emtricitabine-tenofovir</i> 200-300mg	T1	SP PPACA
TEMIXYS	T3	PA SP
ANTIVIRALS - HIV-SPEC, NUCLEOSIDE ANALOG, RTI COMB		
<i>abacavir sulfate/lamivudine</i>	T1	PA SP
<i>abacavir/lamivudine/zidovudine</i>	T1	PA SP
<i>lamivudine/zidovudine</i>	T1	SP
ANTIVIRALS - HIV-SPECIFIC, CCR5 CO-RECEPTOR ANTAG.		
SELZENTRY	T2	PA SP
ANTIVIRALS - HIV-SPECIFIC, CD4 ATTACHMENT INHIBITOR		
RUKOBIA	T3	PA QL (2 syringe/day) SP
ANTIVIRALS - HIV-SPECIFIC, FUSION INHIBITORS		
FUZEON	T3	PA SP
ANTIVIRALS - HIV-SPECIFIC, NON-NUCLEOSIDE, RTI		
EDURANT	T3	PA SP
<i>efavirenz</i>	T1	PA SP
<i>nevirapine</i>	T1	PA SP
PIFELTRO	T3	PA SP
ANTIVIRALS - HIV-SPECIFIC, NUCLEOSIDE ANALOG, RTI		
<i>abacavir sulfate</i>	T1	PA SP
<i>emtricitabine</i> (Emtriva)	T1	PA SP

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ANTIVIRALS (AIDS/HIV) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ANTIVIRALS - HIV-SPECIFIC, NUCLEOSIDE ANALOG, RTI (cont.)		
EMTRIVA 10 MG/ML SOLUTION	T3	PA SP
<i>lamivudine 10 mg/ml oral soln</i>	T1	SP
<i>lamivudine tablet</i>	T1	PA SP
<i>zidovudine</i>	T1	SP
ANTIVIRALS - HIV-SPECIFIC, NUCLEOTIDE ANALOG, RTI		
<i>tenofovir disoproxil fumarate</i>	T1	PA SP
VIREAD	T3	PA SP
VIREAD POWDER	T3	PA SP
ANTIVIRALS - HIV-SPECIFIC, PROTEASE INHIBITOR COMB		
<i>lopinavir/ritonavir</i>	T1	
ANTIVIRALS - HIV-SPECIFIC, PROTEASE INHIBITORS		
atazanavir sulfate	T1	PA SP
EVOTAZ	T3	PA SP
<i>fosamprenavir calcium</i>	T1	PA SP
NORVIR	T3	SP
APRETUDE	T3	PA SP
REYATAZ	T3	PA SP
<i>ritonavir</i>	T3	SP
ANTIVIRALS - HIV-I INTEGRASE STRAND TRANSFER INHIBTR		
ISENTRESS	T3	SP
ISENTRESS HD	T3	PA SP
TIVICAY	T3	SP
TIVICAY PD	T3	SP
ANTIVIRAL - RNA POLYMERASE INHIBITOR		
LAGEVRIO 200 MG CAP (EUA)	T2	QL(1 pack/120 days)
ARTV NUCLEOSIDE, NUCLEOTIDE, NON-NUCLEOSIDE RTI COMB		
COMPLERA	T3	PA SP
DELSTRIGO	T3	PA SP
<i>efavirenz/emtricitabine/tenofovir df (Atripla)</i>	T3	PA SP
<i>efavirenz/lamivudine/tenofovir disop (Symfi Lo)</i>	T3	SP
<i>efavirenz/lamivudine/tenofovir disop (Symfi)</i>	T3	SP
ODEFSEY	T3	PA SP

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

PA – Prior Authorization

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ST – Step Therapy

AGE – Age Requirement

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List of Prescription Medications

ANTIVIRALS (AIDS/HIV) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ARV-NUCLEOSIDE, NUCLEOTIDE RTI, INTEGRASE INHIBITORS		
BIKTARVY	T3	SP
GENVOYA	T3	SP
STRIBILD	T3	PA SP
ANTIVIRALS (Eye Conditions)		
EYE ANTIVIRALS		
trifluridine	T1	
ZIRGAN	T3	
ANTIVIRALS (Infections)		
ANTIVIRALS, GENERAL		
acyclovir	T1	
famciclovir	T1	
FLUMADINE (rimantadine hcl)	T3	
GANCICLOVIR	T3	SP
LIVTENCITY	T3	PA QL (4 tabs/day) SP
oseltamivir 6 mg/ml suspension (Tamiflu)	T1	QL (180ml/30 days)
oseltamivir phos 30 mg capsule (Tamiflu)	T1	QL (20/30 days)
oseltamivir phos 45 mg capsule (Tamiflu)	T1	QL (10 caps/30 days)
oseltamivir phos 75 mg capsule (Tamiflu)	T1	QL (10/30 days)
PREVYMIS	T3	SP HD
RELENZA	T3	QL (20/30 days)
ribavirin (Virazole)	T1	SP HD
rimantadine hcl (Flumadine)	T1	
TAMIFLU 30 MG CAPSULE (oseltamivir phosphate)	T3	QL (20/30 days)
TAMIFLU 45 MG CAPSULE (oseltamivir phosphate)	T3	QL (10/30 days)
TAMIFLU 6 MG/ML SUSPENSION (oseltamivir phosphate)	T3	QL (180ml/30 days)
TAMIFLU 75 MG CAPSULE (oseltamivir phosphate)	T3	QL (10/30 days)
valacyclovir hcl (Valtrex)	T1	
valganciclovir hcl	T1	
VALTREX (valacyclovir)	T3	
VIRAZOLE	T3	SP HD
XOFLUZA	T3	QL (2 tabs/30 days)
HEP C - NS5A, NS3/4A, NUCLEOTIDE NS5B INHIB COMBO		
VOSEVI	T3	PA SP HD

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List of Prescription Medications

ANTIVIRALS (Infections) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
HEP C VIRUS, NUCLEOTIDE ANALOG NS5B POLYMERASE INH		
SOVALDI 150 MG PELLET PACKET	T3	PA QL (1 tab/day) SP HD
SOVALDI 200 MG PELLET PACKET	T3	PA QL (1 tab/day) SP HD
SOVALDI 200 MG TABLET	T3	PA QL (1 tab/day) SP HD
SOVALDI 400 MG TABLET	T3	PA SP HD
HEP C VIRUS-NS5B POLYMERASE AND NS5A INHIB. COMBO.		
EPCLUSA 200 MG-50 MG TABLET	T3	PA QL (1 tab/Day) SP HD
EPCLUSA 400 MG-100 MG TABLET	T3	PA SP HD
HARVONI 33.75-150 MG PELLET PK	T3	PA QL (1 tab/day) SP HD
HARVONI 45-200 MG PELLET PACKT	T3	PA QL (1 tab/day) SP HD
HARVONI 45-200 MG TABLET	T3	PA QL (1 tab/day) SP HD
HARVONI 90-400 MG TABLET	T3	PA SP HD
LEDIPASVIR-SOFOSBUVIR	T3	PA SP HD
HEPATITIS B TREATMENT AGENTS		
<i>adefovir dipivoxil</i>	T1	SP HD
BARACLUDÉ	T3	SP HD
<i>entecavir 0.5 mg tablet</i>	T1	QL (1 tab/day) SP HD
<i>entecavir 1 mg tablet</i>	T1	SP HD
EPIVIR HBV (<i>lamivudine hbv</i>)	T3	SP
<i>lamivudine</i> (Epivir Hbv)	T1	SP
VEMLIDY	T3	SP HD
HEPATITIS C TREATMENT AGENTS		
PEGASYS	T3	PA SP HD
PEGINTRON	T3	PA SP HD
<i>ribasphere 200 mg capsule</i>	T1	SP HD
<i>ribasphere 200 mg tablet</i>	T1	SP HD
<i>ribasphere 400 mg tablet</i>	T1	SP
<i>ribasphere 600 mg tablet</i>	T1	SP
<i>ribasphere ribapak 200-400 mg</i>	T1	SP HD
<i>ribasphere ribapak 400-400 mg</i>	T1	SP HD
<i>ribasphere ribapak 400-400 mg</i>	T1	SP HD
<i>ribasphere ribapak 600-400 mg</i>	T1	SP HD
<i>ribasphere ribapak 600-400 mg</i>	T1	SP HD
<i>ribasphere ribapak 600-600 mg</i>	T1	SP HD
<i>ribasphere ribapak 600-600 mg</i>	T1	SP HD

T1 – Typically Generics

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List of Prescription Medications

ANTIVIRALS (Infections) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
HEPATITIS C TREATMENT AGENTS (cont.)		
RIBASPHERE RIBAPAK	T1	SP HD
<i>ribavirin</i>	T1	SP HD
HEPATITIS C VIRUS- NS5A AND NS3/4A INHIBITOR COMB		
ZEPATIER	T3	PA SP HD
ANTIVIRALS (Infections)		
MAIN PROTEASE (MPRO) INHIBITOR		
PAXLOVID	T2	QL (1 pkg/120 days)
RNA POLYMERASE INHIBITOR		
MOLNUPIRAVIR	T3	QL (1 pkg/120 days)
ANTIVIRALS (Skin Conditions)		
TOPICAL GENITAL WART-HPV TREATMENT AGENTS		
VEREGEN	T3	
AUTONOMIC DRUGS (Allergy/Nasal Sprays)		
ANAPHYLAXIS THERAPY AGENTS		
<i>epinephrine</i> (Epinephrine)	T1	QL (2 packs/30 days)
NEFFY	T2	4 units/30 days
AUTONOMIC DRUGS (Alzheimer's Disease)		
CHOLINESTERASE INHIBITORS		
ARICEPT (<i>donepezil hcl</i>)	T3	HD
BLOXIVERZ (<i>neostigmine methylsulfate</i>)	T3	
<i>donepezil hcl</i>	T1	HD
<i>donepezil hcl</i> (Aricept)	T1	HD
EXELON (<i>rivastigmine</i>)	T3	HD
<i>galantamine er 16 mg capsule</i> (Razadyne Er)	T1	HD
<i>galantamine er 24 mg capsule</i> (Razadyne Er)	T1	HD
<i>galantamine er 8 mg capsule</i> (Razadyne Er)	T1	QL (1 cap/day) HD
<i>galantamine hbr</i>	T1	HD
<i>neostigmine methylsulfate</i> (Bloxiverz)	T1	
<i>pyridostigmine bromide</i> (Mestinon)	T1	HD
<i>physostigmine salicylate</i>	T1	
RAZADYNE ER 16 MG CAPSULE (<i>galantamine er</i>)	T3	HD
RAZADYNE ER 24 MG CAPSULE (<i>galantamine er</i>)	T3	HD
RAZADYNE ER 8 MG CAPSULE (<i>galantamine er</i>)	T3	QL (1 cap/day) HD
<i>rivastigmine</i> (Exelon)	T1	HD

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List of Prescription Medications

AUTONOMIC DRUGS (Attention Deficit Hyperactivity Disorder)⁸

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ADRENERGICS, AROMATIC, NON-CATECHOLAMINE		
ADDERALL (<i>dextroamphetamine-amphetamine</i>)	T3	PA ST
ADZENYS ER	T3	PA QL (15ml/day)
ADZENYS XR-ODT	T3	PA QL (1 tab/day)
AMPHETAMINE	T3	PA QL (15ml/day)
<i>amphetamine sulfate</i> (Evekeo)	T1	PA
<i>dextroamp-amphet er 10 mg cap</i>	T1	PA QL (1 cap/ day)
<i>dextroamp-amphet er 15 mg cap</i>	T1	PA QL (1 cap/day)
<i>dextroamp-amphet er 20 mg cap</i>	T1	PA QL (1 cap/day)
<i>dextroamp-amphet er 25 mg cap</i>	T1	PA QL (1 per day)
<i>dextroamp-amphet er 30 mg cap</i>	T1	PA QL (1 cap/day)
<i>dextroamp-amphet er 5 mg cap</i>	T1	PA QL (1 cap/day)
<i>dextroamphetamine er 10 mg cap</i>	T1	PA QL (1 cap/day)
<i>dextroamphetamine er 15 mg cap</i>	T1	PA QL (3/day)
<i>dextroamphetamine er 5 mg cap</i>	T1	PA QL (1 cap/day)
<i>dextroamphetamine sulfate</i>	T1	PA
<i>dextroamphetamine sulfate</i>	T3	PA ST
<i>dextroamphetamine/amphetamine</i> (Adderall Xr)	T1	PA QL(1 cap/day)
<i>dextroamphetamine/amphetamine</i> (Adderall)	T1	PA
<i>dextroamphetamine/amphetamine</i> (Mydayis)	T1	PA QL(1 cap/day)
DYANAVEL XR	T3	PA QL (8ml/day)
EVEKEO (<i>amphetamine sulfate</i>)	T3	PA ST
EVEKEO ODT	T3	PA
<i>lisdexamfetamine 10 mg capsule</i> (Vyvanse)	T1	PA QL(1 cap/day)
<i>lisdexamfetamine 20 mg capsule</i> (Vyvanse)	T1	PA QL(1 cap/day)
<i>lisdexamfetamine 30 mg capsule</i> (Vyvanse)	T1	PA QL(1 cap/day)
<i>lisdexamfetamine 40 mg capsule</i> (Vyvanse)	T1	PA QL(1 cap/day)
<i>lisdexamfetamine 50 mg capsule</i> (Vyvanse)	T1	PA QL(1 cap/day)
<i>lisdexamfetamine 60 mg capsule</i> (Vyvanse)	T1	PA QL(1 cap/day)
<i>lisdexamfetamine 70 mg capsule</i> (Vyvanse)	T1	PA QL(1 cap/day)
<i>methamphetamine hcl</i>	T1	PA
MYDAYIS (<i>dextroamphetamine/amphetamine</i>)	T3	PA QL(1 cap/day)
VYVANSE 10 MG CAPSULE (<i>lisdexamfetamine dimesylate</i>)	T2	PA QL(1 cap/day)
VYVANSE 20 MG CAPSULE (<i>lisdexamfetamine dimesylate</i>)	T2	PA QL(1 cap/day)
VYVANSE 30 MG CAPSULE (<i>lisdexamfetamine dimesylate</i>)	T2	PA QL(1 cap/day)

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

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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.)		
VYVANSE 40 MG CAPSULE (<i>lisdexamfetamine dimesylate</i>)	T2	PA QL(1 cap/day)
VYVANSE 50 MG CAPSULE (<i>lisdexamfetamine dimesylate</i>)	T2	PA QL(1 cap/day)
VYVANSE 60 MG CAPSULE (<i>lisdexamfetamine dimesylate</i>)	T2	PA QL(1 cap/day)
VYVANSE 70 MG CAPSULE (<i>lisdexamfetamine dimesylate</i>)	T2	PA QL(1 cap/day)
XELTRYM	T3	PA QL(1 patch/day)
ZENZEDI	T3	PA ST
AUTONOMIC DRUGS (Blood Pressure/Heart Medications)		
ADRENERGIC VASOPRESSOR AGENTS		
<i>droxidopa</i> (Northera)	T3	SP HD
<i>midodrine hcl</i>	T1	
ADRENERGIC AGENTS, CATECHOLAMINES		
<i>epinephrine 1 mg/10 ml luerjet</i>	T1	
<i>epinephrine 1 mg/ml vial</i>	T1	
ALPHA-ADRENERGIC BLOCKING AGENTS		
DIBENZYLINE (<i>phenoxybenzamine hcl</i>)	T3	HD
<i>phenoxybenzamine hcl</i> (Dibenzyline)	T1	HD
AUTONOMIC DRUGS (Miscellaneous)		
NEUROMUSCULAR BLOCKING AGENTS		
DAXXIFY	T3	PA SP
MYOBLOC	T3	PA SP HD
AUTONOMIC DRUGS (Urinary Tract Conditions)		
PARASYMPATHETIC AGENTS		
<i>bethanechol chloride</i>	T1	HD
<i>cevimeline hcl</i> (Evoxac)	T1	HD
EVOXAC (<i>cevimeline hcl</i>)	T3	HD
<i>guanidine hcl</i>	T1	HD
<i>pilocarpine hcl</i> (Salagen)	T1	HD
SALAGEN (<i>pilocarpine hcl</i>)	T3	HD
URECHOLINE (<i>bethanechol chloride</i>)	T3	HD
BIOLOGICALS (Allergy/Nasal Sprays)		
ALLERGENIC EXTRACTS, THERAPEUTIC		
GRASTEK	T2	PA QL (1 tab/day)
ODACTRA	T2	PA QL (1 tab/day)

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

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List of Prescription Medications

BIOLOGICALS (Allergy/Nasal Sprays) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ALLERGENIC EXTRACTS, THERAPEUTIC (cont.)		
ORALAIR	T3	PA QL (1 tab/day)
RAGWITEK	T3	PA QL (1 tab/day)
BIOLOGICALS (Blood Pressure/Heart Medications)		
PLASMA KALLIKREIN INHIBITORS		
TAKHZYRO	T3	PA SP HD
BIOLOGICALS (Miscellaneous)		
PKU TREATMENT AGENTS - PHENYLALANINE AMMONIA LYASE		
PALYNZIQ	T3	PA SP HD
BIOLOGICALS (Vaccines)		
COVID-19 VACCINES		
COMIRNATY	T3	PPACA
JANSSEN	T2	PPACA
MODERNA	T2	PPACA
NOVAVAX	T3	PPACA
PFIZER	T2	PPACA
SPIKEVAX	T3	PPACA
ENTERIC VIRUS VACCINES		
IPOL	T2	PPACA
ROTARIX	T3	PPACA
ROTAQE	T3	PPACA
GRAM NEGATIVE COCCI VACCINES		
BEXSERO	T2	PPACA
MENACTRA	T2	
MENQUADFI	T2	PPACA
MENVEO A-C-Y-W-135-DIP	T2	PPACA
PENBRAYA	T3	PPACA
TRUMENBA	T2	PPACA
GRAM POSITIVE COCCI VACCINES		
CAPVAXIVE	T3	PPACA
PNEUMOVAX 23	T2	PPACA
PREVNAR	T2	
INFLUENZA VIRUS VACCINES		
AFLURIA TRIVALENT	T2	PPACA

T1 – Typically Generics

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List of Prescription Medications

BIOLOGICALS (Vaccines) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
INFLUENZA VIRUS VACCINES (cont.)		
EZ FLU 2	T2	PPACA
FLUAD TRIVALENT	T2	PPACA
FLUARIX TRIVALENT	T2	PPACA
FLUBLOK TRIVALENT	T2	PPACA
FLUCELVAX TRIVALENT	T2	PPACA
FLULALVAL TRIVALENT	T2	PPACA
FLUMIST QUAD TRIVALENT	T3	PPACA
FLUVIRIN	T2	PPACA
FLUZONE HIGH-DOSE TRIVALENT	T2	PPACA
FLUZONE TRIVALENT	T2	PPACA
TOXIN-PRODUCING BACILLI VACCINES/TOXOIDS		
BCG VACCINE (TICE STRAIN)	T2	SP
VACCINE/TOXOID PREPARATIONS, COMBINATIONS		
ACTHIB	T2	PPACA
ADACEL TDAP	T2	PPACA
BOOSTRIX TDAP	T2	PPACA
DAPTACEL DTAP	T2	PPACA
DIPHTHERIA-TETANUS TOXOIDS-PED	T2	
HIBERIX	T2	PPACA
INFANRIX DTAP	T2	PPACA
KINRIX	T2	PPACA
M-M-R II VACCINE	T2	PPACA
PEDVAXHIB	T2	PPACA
PENTACEL	T2	PPACA
PROQUAD	T2	PPACA
QUADRACEL DTAP-IPV	T2	PPACA
TDVAX	T2	PPACA
TENIVAC	T2	PPACA
VAXELIS	T2	PPACA
VIRAL/TUMORIGENIC VACCINES		
ACAM2000	T3	

T1 – Typically Generics

T2 – Typically Preferred Brands

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List of Prescription Medications

BIOLOGICALS (Vaccines) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
VIRAL/TUMORIGENIC VACCINES (cont.)		
ENGERIX-B ADULT	T2	PPACA
ENGERIX-B PEDIATRIC-ADOLESCENT	T2	PPACA
ERVEBO (NATIONAL STOCKPILE)	T3	
GARDASIL 9	T2	PPACA
HEPLISAV-B	T2	PPACA
IXCHIQ	T3	PPACA
JYNNEOS	T3	
MRESVIA	T3	PPACA
PEDIARIX	T2	PPACA
RECOMBIVAX HB	T2	PPACA
SHINGRIX	T2	QL (2 doses/lifetime) PPACA
TWINRIX	T2	PPACA
VARIVAX VACCINE	T2	PPACA
ZOSTAVAX	T2	PPACA
BLOOD (Blood Modifiers/Bleeding Disorders)		
AGENTS TO TX THROMBOTIC THROMBOCYTOPENIC PURPURA		
ADZYNMA	T3	PA SP
CABLIVI	T3	PA SP
ANTI-FIBRINOLYTIC AGENTS		
AMICAR (<i>aminocaproic acid</i>)	T3	SP HD
<i>aminocaproic acid</i> (Amicar)	T1	SP HD
LYSTEDA (<i>tranexamic acid</i>)	T3	SP
<i>tranexamic acid</i> (Lysteda)	T1	SP
TRANEXAMIC ACID-NACL	T3	SP
TRANEXAMIC 1,000 MG/100ML-NACL	T3	SP
ANTI-HEMOPHILIC FACTORS		
ALTUULLO	T3	PA SP HD
COMPLEMENT (C3) INHIBITORS		
EMPAVELI	T3	PA SP
FABHALTA	T2	PA QL(2 caps/day) SP
TAVNEOS	T3	PA QL(6 caps/day) SP
VEOPOZ	T3	SP
VOYDEYA	T2	PA QL(1 packet/28 days) SP
HEMOPHILIA TREATMENT AGENTS, NON-FACTOR REPLACEMENT		
HEMLIBRA	T3	PA SP HD

T1 – Typically Generics

T2 – Typically Preferred Brands

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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		
DROXIA	T3	
OXBRYTA 300MG TAB for SUSP	T3	QL (5 tabs/day) SP
SIKLOS	T3	PA
TOPICAL HEMOSTATICS		
ASTRINGYN	T3	
AVITENE	T3	
ENDO-AVITENE	T3	
EVICEL	T3	
<i>gelatin sponge, absorb/porcine (Gelfoam)</i>	T1	
GELFOAM	T3	
GELFOAM (<i>surgifoam</i>)	T3	
GELFOAM COMPRESSED	T3	
MONSEL'S	T3	
RAPLIXA	T3	
RECOTHROM	T3	
SURGIFOAM	T1	
SYRINGE AVITENE	T3	
TACHOSIL	T3	
THROMBIN-JMI	T3	
THROMBI-PAD	T3	
ULTRAFOAM	T3	
BLOOD (Blood Thinners/Anti-Clotting)		
HEMORRHOLOGIC AGENTS		
pentoxifylline	T1	HD
BLOOD (Miscellaneous)		
CELL/GENE THERAPY AGENTS - HEMATOPOIETIC		
OMISRIGE	T3	
CARDIAC DRUGS (Blood Pressure/Heart Medications)		
ANTI-ANGINAL, ANTI-ISCHEMIC AGENTS, NON-HEMODYNAMIC		
ranolazine (Ranexa)	T1	QL (4 tabs/day) HD
ANTI-ARRHYTHMICS		
adenosine	T1	
amiodarone hcl	T1	HD

T1 – Typically Generics

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List of Prescription Medications

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

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ANTI-ARRHYTHMICS (cont.)		
bretlyium tosylate	T1	HD
CORVERT (ibutilide fumarate)	T3	PA
disopyramide phosphate (Norpace)	T1	HD
dofetilide 125 mcg capsule (Tikosyn)	T1	QL (8 caps/day) HD
dofetilide 250 mcg capsule (Tikosyn)	T1	QL (4 caps/day) HD
dofetilide 500 mcg capsule (Tikosyn)	T1	QL (2 caps/day) HD
flecainide acetate	T1	HD
ibutilide fumarate (Corvert)	T1	
mexiletine hcl	T1	HD
MULTAQ	T2	HD
NEXTERONE	T3	
NORPACE (disopyramide phosphate)	T3	PA HD
NORPACE CR	T3	HD
pacerone 100 mg, 400 mg tablet	T3	PA HD
pacerone 200 mg tablet	T1	HD
propafenone hcl (Rythmol Sr)	T1	HD
quinidine	T1	HD
RYTHMOL SR (propafenone hcl er)	T3	PA HD
TIKOSYN 125 MCG CAPSULE (dofetilide)	T3	PA QL (8 caps/day) HD
TIKOSYN 250 MCG CAPSULE (dofetilide)	T3	PA QL (4 caps/day) HD
TIKOSYN 500 MCG CAPSULE (dofetilide)	T3	PA QL (2 caps/day) HD
XYLOCAINE	T3	
CALCIUM CHANNEL BLOCKING AGENTS		
ADALAT CC (nifedipine er)	T3	HD
amlodipine besylate (Norvasc)	T1	HD
CALAN SR (verapamil er)	T3	HD
CAMZYOS	T3	PA QL (30 caps/30 days) SP
CARDENE I.V. (nicardipine hcl)	T3	

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

PA – Prior Authorization

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ST – Step Therapy

AGE – Age Requirement

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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.)		
CLEVIPREX	T3	
<i>diltiazem hcl</i>	T1	
<i>diltiazem 24h er(la) 120 mg tb (Cardizem La)</i>	T1	QL(1 tab/day) HD
<i>diltiazem 24h er(la) 180 mg tb (Cardizem La)</i>	T1	HD
<i>diltiazem 24h er(la) 240 mg tb (Cardizem La)</i>	T1	HD
<i>diltiazem 24h er(la) 300 mg tb (Cardizem La)</i>	T1	HD
<i>diltiazem 24h er(la) 360 mg tb (Cardizem La)</i>	T1	HD
<i>diltiazem 24h er(la) 420 mg tb (Cardizem La)</i>	T1	HD
<i>diltiazem hcl (Cardizem La)</i>	T1	HD
<i>diltiazem hcl (Tiazac)</i>	T1	HD
<i>felodipine</i>	T1	HD
<i>isradipine</i>	T1	
<i>nicardipine hcl</i>	T1	HD
<i>nifedipine (Adalat Cc)</i>	T1	HD
<i>nifedipine (Procardia)</i>	T1	HD
<i>nimodipine</i>	T1	HD
<i>nisoldipine er 17 mg tablet (Sular)</i>	T1	HD
<i>nisoldipine er 20 mg tablet</i>	T1	QL (1 tab/day) HD
<i>nisoldipine er 25.5 mg tablet</i>	T1	HD
<i>nisoldipine er 30 mg tablet</i>	T1	HD
<i>nisoldipine er 34 mg tablet (Sular)</i>	T1	HD
<i>nisoldipine er 40 mg tablet</i>	T1	HD
<i>nisoldipine er 8.5 mg tablet (Sular)</i>	T1	HD
NORLIQVA	T3	QL(10 mls/day) HD
NORLIQVA ORAL SOLN	T2	PA QL
NORVASC (<i>amlodipine besylate</i>)	T3	
NYMALIZE	T3	
PROCARDIA (<i>nifedipine</i>)	T3	HD
SULAR (<i>nisoldipine</i>)	T3	HD
TIAZAC (<i>tiadylt er</i>)	T3	HD
<i>verapamil hcl</i>	T1	HD
<i>verapamil hcl (Calan Sr)</i>	T1	HD
<i>verapamil hcl (Verelan Pm)</i>	T1	HD
<i>verapamil hcl (Verelan)</i>	T1	HD

T1 – Typically Generics

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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.)		
VERELAN (verapamil hc)	T3	HD
VERELAN (verapamil sr)	T3	HD
VERELAN PM (verapamil er pm)	T3	HD
DIGITALIS GLYCOSIDES		
<i>digoxin</i>	T1	HD
HEART RATE REDUCING, SA SELECTIVE I(F) CURRENT INH.		
CORLANOR 5 MG TABLET (ivabradine hcl)	T2	PA HD
CORLANOR 5 MG/5 ML ORAL SOLN	T2	PA SP HD
CORLANOR 7.5 MG TABLET (ivabradine hcl)	T2	PA HD
<i>ivabradine hcl</i> (Corlanor)	T1	PA HD
SOLUBLE GUANYLATE CYCLASE (SGC) STIMULATOR		
VERQUVO	T2	QL(1 tab/day)
VASODILATORS, CORONARY		
DILATRATE-SR	T3	HD
<i>isosorbide dinitrate 5mg tab</i>	T1	HD
<i>isosorbide mononitrate</i>	T1	HD
MINITRAN	T1	HD
NITRO-DUR 0.1 MG/HR PATCH	T3	HD
NITRO-DUR 0.2 MG/HR PATCH	T3	HD
NITRO-DUR 0.3 MG/HR PATCH	T2	HD
NITRO-DUR 0.4 MG/HR PATCH	T3	HD
NITRO-DUR 0.6 MG/HR PATCH	T3	HD
NITRO-DUR 0.8 MG/HR PATCH	T2	HD
<i>nitroglycerin</i> (Nitrostat)	T1	HD
<i>nitroglycerin</i> (Nitro-dur)	T1	HD
<i>nitroglycerin</i> (Nitromist)	T1	HD
<i>nitroglycerin 400 mcg spray</i> (Nitrolingual)	T1	HD
NITROLINGUAL	T3	HD
NITROMIST	T3	HD
NITROSTAT	T3	HD
CARDIOVASCULAR (Allergy/Nasal Spray)		
SYMPATHOMIMETIC AGENTS		
IMMPHENТИV	T3	
REZIPRES	T3	

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List of Prescription Medications

CARDIOVASCULAR (Asthma/COPD/Respiratory)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
PULM ANTI-HTN, SOLUBLE GUANYLATE CYCLASE STIMULATOR		
ADEMPAS	T3	PA SP HD
PULM.ANTI-HTN, SEL.C-GMP PHOSPHODIESTERASE T5 INHIB		
sildenafil 10 mg/ml oral susp (Revatio)	T1	PA SP HD
sildenafil 20 mg tablet (Revatio)	T1	PA SP HD
REVATIO 10 MG/12.5 ML VIAL	T3	PA SP HD
tadalafil (Adcirca)	T1	PA SP HD
tadalafil 20 mg tablet (Adcirca)	T1	PA SP HD
PULMONARY ANTI-HTN, ENDOTHELIN RECEPTOR ANTAGONIST		
ambrisentan (Letairis)	T1	PA SP HD
bosentan (Tracleer)	T1	PA SP HD
LETAIRIS (ambrisentan)	T3	PA SP HD
OPSUMIT	T3	PA SP HD
TRACLEER 125 MG TABLET (bosentan)	T3	PA SP HD
TRACLEER 32 MG TABLET FOR SUSP	T3	PA SP HD
TRACLEER 62.5 MG TABLET (bosentan)	T3	PA SP HD
PULMONARY ANTIHYPER AGENT, ACTRIIA-FC		
WINREVAIR	T3	PA SP HD
PULMONARY ANTIHYPERTENSIVES, PROSTACYCLIN-TYPE		
ORENITRAM ER	T3	PA SP HD
ORENITRAM MONTH 1 TITRATION KT	T3	PA QL(168 tabs/180 days) SP HD
ORENITRAM MONTH 2 TITRATION KT	T3	PA QL(336 tabs/180 days) SP HD
ORENITRAM MONTH 3 TITRATION KT	T3	PA QL(252 tabs/180 days) SP HD
TYVASO DPI	T2	PA SP HD
TYVASO INSTITUTIONAL START KIT	T3	PA SP HD
TYVASO REFILL KIT	T3	PA SP HD
TYVASO STARTER KIT	T3	PA SP HD
UPTRAVI	T3	PA SP HD
VELETRI VIAL	T3	PA SP
VENTAVIS	T3	PA SP HD
PULMONARY HTN-ENDOTHELIN RECEPTANT-CGMP PDE5 INH		
OPSYNVI	T3	PA QL(1 tab/day) SP HD

CARDIOVASCULAR (Blood Pressure/Heart Medications)

ACE INHIBITOR-CALCIUM CHANNEL BLOCKER COMBINATION		
amlodipine besylate/benazepril	T1	HD
amlodipine besylate/benazepril (Lotrel)	T1	HD
LOTREL (amlodipine besylate-benazepril)	T3	HD

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List of Prescription Medications

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

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ACE INHIBITOR-CALCIUM CHANNEL BLOCKER COMBINATION (cont.)		
PRESTALIA 14 MG-10 MG TABLET	T3	HD
PRESTALIA 3.5 MG-2.5 MG TABLET	T3	QL (1 tab/day) HD
PRESTALIA 7 MG-5 MG TABLET	T3	QL (1 tab/day) HD
TARKA (<i>trandolapril-verapamil er</i>)	T3	HD
<i>trandolapril-verapamil hcl</i>	T1	HD
<i>trandolapril-verapamil hcl</i> (Tarka)	T1	HD
ACE INHIBITOR-THIAZIDE OR THIAZIDE-LIKE DIURETIC		
ACCURETIC (<i>quinapril-hydrochlorothiazide</i>)	T3	ST HD
<i>benazepril/hydrochlorothiazide</i>	T1	HD
<i>benazepril/hydrochlorothiazide</i> (Lotensin Hct)	T1	HD
<i>captopril-hctz 25-15 mg tablet</i>	T1	QL (3 tabs/day) HD
<i>captopril-hctz 25-25 mg tablet</i>	T1	QL (2 tabs/day) HD
<i>captopril-hctz 50-15 mg tablet</i>	T1	QL (3 tabs/day) HD
<i>captopril-hctz 50-25 mg tablet</i>	T1	QL (2 tabs/day) HD
<i>enalapril/hydrochlorothiazide</i>	T1	HD
<i>enalapril/hydrochlorothiazide</i> (Vaseretic)	T1	HD
<i>fosinopril/hydrochlorothiazide</i>	T1	HD
<i>lisinopril/hydrochlorothiazide</i> (Zestoretic)	T1	HD
LOTENSIN HCT (<i>benazepril-hydrochlorothiazide</i>)	T3	ST HD
<i>quinapril/hydrochlorothiazide</i> (Accuretic)	T1	HD
VASERETIC (<i>enalapril-hydrochlorothiazide</i>)	T3	ST HD
ZESTORETIC (<i>lisinopril-hydrochlorothiazide</i>)	T3	ST HD
ALPHA/BETA-ADRENERGIC BLOCKING AGENTS		
<i>carvedilol</i> (Coreg)	T1	HD
<i>carvedilol er 10 mg capsule</i> (Coreg Cr)	T1	QL (1 cap/day) HD
<i>carvedilol er 20 mg capsule</i> (Coreg Cr)	T1	QL (1 cap/day) HD
<i>carvedilol er 40 mg capsule</i> (Coreg Cr)	T1	QL (1 cap/day) HD
<i>carvedilol er 80 mg capsule</i> (Coreg Cr)	T1	HD
COREG (<i>carvedilol</i>)	T3	ST HD
COREG CR 10 MG CAPSULE (<i>carvedilol er</i>)	T3	QL (1 cap/day) ST HD
COREG CR 20 MG CAPSULE (<i>carvedilol er</i>)	T3	QL (1 cap/day) ST HD
COREG CR 40 MG CAPSULE (<i>carvedilol er</i>)	T3	QL (1 cap/day) ST HD
COREG CR 80 MG CAPSULE (<i>carvedilol er</i>)	T3	ST HD
ALPHA-ADRENERGIC BLOCKING AGENTS		
CARDURA (<i>doxazosin mesylate</i>)	T3	HD

T1 – Typically Generics

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List of Prescription Medications

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

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ALPHA-ADRENERGIC BLOCKING AGENTS (cont.)		
CARDURA XL	T3	HD
doxazosin mesylate (Cardura)	T1	HD
LABETALOL HCL 10 MG/2 ML SYRNG	T3	
labetalol hcl 100 mg tablet	T1	
labetalol hcl 100 mg/20 ml vl	T1	
labetalol hcl 20 mg/4 ml crpj	T1	
labetalol hcl 20 mg/4 ml syrng	T1	
labetalol hcl 20 mg/4 ml vial	T1	
labetalol hcl 200 mg tablet	T1	
labetalol hcl 200 mg/40 ml vl	T1	
labetalol hcl 300 mg tablet	T1	
MINIPRESS (prazosin hcl)	T3	HD
prazosin hcl (Minipress)	T1	HD
terazosin hcl	T1	HD
ANGIOTEN. RECEPTR ANTAG-CALCIUM CHANL BLKR-THIAZIDE		
amlodipine/valsartan/hcthiazid (Exforge Hct)	T1	HD
EXFORGE HCT (amlodipine-valsartan-hctz)	T3	HD
olmesartan/amlodipin/hcthiazid (Tribenzor)	T1	HD
TRIBENZOR (olmesartan-amlodipine-hctz)	T3	HD
ANGIOTENSIN RECEPT-NEPRILYSIN INHIBITOR COMB (ARNI)		
ENTRESTO	T2	QL(2 tabs/day)
ENTRESTO SPRINKLE	T2	HD
ANGIOTENSIN RECEPTOR ANTAG.-THIAZIDE DIURETIC COMB		
ATACAND HCT (candesartan-hydrochlorothiazid)	T3	ST HD
AVALIDE (irbesartan-hydrochlorothiazide)	T3	ST HD
BENICAR HCT 20-12.5 MG TABLET (olmesartan-hydrochlorothiazide)	T3	QL (1 tab/day) ST HD
BENICAR HCT 40-12.5 MG TABLET (olmesartan-hydrochlorothiazide)	T3	ST HD
BENICAR HCT 40-25 MG TABLET (olmesartan-hydrochlorothiazide)	T3	ST HD
candesartan/hydrochlorothiazid (Atacand Hct)	T1	HD
DIOVAN HCT (valsartan-hydrochlorothiazide)	T3	ST HD
HYZAAR (losartan-hydrochlorothiazide)	T3	ST HD
irbesartan/hydrochlorothiazide (Avalide)	T1	HD
losartan/hydrochlorothiazide (Hyzaar)	T1	HD
MICARDIS HCT 40-12.5 MG TABLET (telmisartan-hydrochlorothiazid)	T3	QL (1 tab/day) ST HD
MICARDIS HCT 80-12.5 MG TABLET (telmisartan-hydrochlorothiazid)	T3	ST HD

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List of Prescription Medications

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

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ANGIOTENSIN RECEPTOR ANTAG.-THIAZIDE DIURETIC COMB (cont.)		
MICARDIS HCT 80-25 MG TABLET (<i>telmisartan-hydrochlorothiazide</i>)	T3	ST HD
<i>olmesartan-hctz 20-12.5 mg tab</i> (Benicar Hct)	T1	QL (1 tab/day) HD
<i>olmesartan-hctz 40-12.5 mg tab</i> (Benicar Hct)	T1	HD
<i>olmesartan-hctz 40-25 mg tab</i> (Benicar Hct)	T1	HD
<i>telmisartan-hctz 40-12.5 mg tb</i> (Micardis Hct)	T1	QL (1 tab/day) HD
<i>telmisartan-hctz 80-12.5 mg tb</i> (Micardis Hct)	T1	HD
<i>telmisartan-hctz 80-25 mg tab</i> (Micardis Hct)	T1	HD
<i>valsartan/hydrochlorothiazide</i> (Diovan Hct)	T1	HD
ANGIOTENSIN RECEPTOR BLOCKR-CALCIUM CHANNEL BLOCKR		
<i>amlodipine besylate/valsartan</i> (Exforge)	T1	HD
<i>amlodipine-olmesartan 10-20 mg</i> (Azor)	T1	HD
<i>amlodipine-olmesartan 10-40 mg</i> (Azor)	T1	HD
<i>amlodipine-olmesartan 5-20 mg</i> (Azor)	T1	QL (1 tab/day) HD
<i>amlodipine-olmesartan 5-40 mg</i> (Azor)	T1	HD
AZOR 10-20 MG TABLET (<i>amlodipine-olmesartan</i>)	T3	HD
AZOR 10-40 MG TABLET (<i>amlodipine-olmesartan</i>)	T3	HD
AZOR 5-20 MG TABLET (<i>amlodipine-olmesartan</i>)	T3	QL (1 tab/day) HD
AZOR 5-40 MG TABLET (<i>amlodipine-olmesartan</i>)	T3	HD
EXFORGE (<i>amlodipine-valsartan</i>)	T3	HD
<i>telmisartan-amlodipine 40-10</i>	T1	HD
<i>telmisartan-amlodipine 40-5 mg</i>	T1	QL (1 tab/day) HD
<i>telmisartan-amlodipine 80-10</i>	T1	HD
<i>telmisartan-amlodipine 80-5 mg</i>	T1	HD
ANTI-HYPERTENSIVES, ACE INHIBITORS		
ACCUPRIL (<i>quinapril hcl</i>)	T3	ST HD
<i>benazepril hcl</i>	T1	HD
<i>benazepril hcl</i> (Lotensin)	T1	HD
<i>captopril</i>	T1	HD
<i>enalaprilat dihydrate</i>	T1	
<i>enalapril maleate</i> (Vasotec)	T1	HD
<i>fosinopril sodium</i>	T1	HD
<i>lisinopril</i> (Zestril)	T1	HD

T1 – Typically Generics

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List of Prescription Medications

CARDIOVASCULAR (Blood Pressure/Heart Medications) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ANTI-HYPERTENSIVES, ACE INHIBITORS (cont.)		
LOTENSIN (<i>benazepril hcl</i>)	T3	ST HD
<i>moexipril hcl</i>	T1	HD
<i>perindopril erbumine</i>	T1	HD
PRINIVIL (<i>lisinopril</i>)	T3	ST 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	ST HD
ANTI-HYPERTENSIVES, ANGIOTENSIN RECEPTOR ANTAGONIST		
ATACAND (<i>candesartan cilexetil</i>)	T3	ST HD
BENICAR 20 MG TABLET (<i>olmesartan medoxomil</i>)	T3	QL (1 tab/day) ST HD
BENICAR 40 MG TABLET (<i>olmesartan medoxomil</i>)	T3	ST HD
BENICAR 5 MG TABLET (<i>olmesartan medoxomil</i>)	T3	ST HD
<i>candesartan cilexetil</i> (Atacand)	T1	HD
DIOVAN (<i>valsartan</i>)	T3	ST HD
EDARBI 80 MG TABLET	T3	ST HD
<i>eprosartan mesylate</i>	T1	HD
<i>irbesartan</i> (Avapro)	T1	HD
<i>losartan potassium</i> (Cozaar)	T1	HD
MICARDIS 20 MG TABLET (<i>telmisartan</i>)	T3	QL (1 tab/day) ST HD
MICARDIS 40 MG TABLET (<i>telmisartan</i>)	T3	QL (1 tab/day) ST HD
MICARDIS 80 MG TABLET (<i>telmisartan</i>)	T3	ST HD
<i>olmesartan medoxomil 20 mg tab</i> (Benicar)	T1	QL (1 tab/day) HD
<i>olmesartan medoxomil 40 mg tab</i> (Benicar)	T1	HD
<i>olmesartan medoxomil 5 mg tab</i> (Benicar)	T1	HD
<i>telmisartan 20 mg tablet</i> (Micardis)	T1	QL (1 tab/day) HD
<i>telmisartan 40 mg tablet</i> (Micardis)	T1	QL (1 tab/day) HD
<i>telmisartan 80 mg tablet</i> (Micardis)	T1	HD
<i>valsartan</i> (Diovan)	T1	HD
VALSARTAN 20 MG/5 ML SOLUTION	T3	ST HD

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List of Prescription Medications

CARDIOVASCULAR (Blood Pressure/Heart Medications) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ANTI-HYPERTENSIVES, GANGLIONIC BLOCKERS		
VECAMYL	T1	
ANTI-HYPERTENSIVES, MISCELLANEOUS		
DEMSER (<i>metyrosine</i>)	T3	HD
<i>metyrosine</i> (Demser)	T1	HD
<i>nitroprusside sodium</i> (Nitropress)	T1	
ANTI-HYPERTENSIVES, SYMPATHOLYTIC		
CATAPRES-TTS 1 (<i>clonidine</i>)	T3	HD
CATAPRES-TTS 2 (<i>clonidine</i>)	T3	HD
CATAPRES-TTS 3 (<i>clonidine</i>)	T3	HD
<i>clonidine</i> (Catapres-tts 1)	T1	HD
<i>clonidine</i> (Catapres-tts 2)	T1	HD
<i>clonidine</i> (Catapres-tts 3)	T1	HD
<i>clonidine hcl</i> (Catapres)	T1	HD
<i>guanfacine hcl</i>	T1	HD
<i>methyldopate hcl</i>	T1	
<i>methyldopa</i>	T1	HD
<i>methyldopa/hydrochlorothiazide</i>	T1	HD
ANTI-HYPERTENSIVES, VASODILATORS		
<i>hydralazine hcl</i>	T1	HD
<i>minoxidil</i>	T1	HD
BETA-ADRENERGIC BLOCKING AGENTS		
<i>acebutolol hcl</i>	T1	HD
<i>atenolol</i> (Tenormin)	T1	HD
<i>betaxolol hcl</i>	T1	HD
<i>atenolol</i> (Tenormin)	T1	HD
<i>betaxolol hcl</i>	T1	HD
<i>bisoprolol fumarate</i>	T1	HD
BREVIBLOC	T3	
BYSTOLIC 10 MG TABLET	T2	QL (1 tab/day) ST HD
BYSTOLIC 2.5 MG TABLET	T2	QL (1 tab/day) ST HD
BYSTOLIC 20 MG TABLET	T2	ST HD
BYSTOLIC 5 MG TABLET	T2	QL (1 tab/day) ST HD

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CARDIOVASCULAR (Blood Pressure/Heart Medications) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
BETA-ADRENERGIC BLOCKING AGENTS (cont.)		
<i>esmolol</i>	T1	
INNOPRAN XL	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>nadolol</i>	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>	T1	
<i>sotalol hcl</i> (Betapace Af)	T1	HD
SOTYLIZE	T3	HD
<i>timolol maleate</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> (Ziac)	T1	HD
<i>metoprolol/hydrochlorothiazide</i>	T1	HD
<i>nadolol/bendroflumethiazide</i>	T1	HD
<i>propranolol/hydrochlorothiazide</i>	T1	HD
RENIN INHIBITOR, DIRECT		
<i>aliskiren 150 mg tablet</i> (Tekturna)	T1	QL (1 tab/day) HD
<i>aliskiren 300 mg tablet</i> (Tekturna)	T1	HD
RENIN INHIBITOR, DIRECT AND THIAZIDE DIURETIC COMB		
TEKTURNAL HCT	T2	HD
VASODILATORS, COMBINATION		
<i>isosorbide dinit/hydralazine</i> (Bidil)	T1	QL (6 tabs/day) HD
BIDIL	T3	QL (6 tabs/day) HD
VASODILATORS, PERIPHERAL		
<i>ergoloid mesylates</i>	T1	
<i>isoxsuprine hcl</i>	T1	
CARDIOVASCULAR (Cholesterol Medications)		
ANTI-HYPERLIP.HMG COA REDUCT INHIB-CHOLEST.AB.INHIB		
<i>ezetimibe/simvastatin</i> (Vytorin)	T1	HD

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

PA – Prior Authorization

QL – Quantity Limit

ST – Step Therapy

AGE – Age Requirement

SP – Specialty Medication

HD – May require home delivery pharmacy

PPACA – No Cost-Share Preventive Medication

CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

CARDIOVASCULAR (Cholesterol Medications) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ANTI-HYPERLIP.HMG COA REDUCT INHIB-CHOLEST.AB.INHIB (cont.)		
ROSZET	T3	PA HD
VYTORIN (ezetimibe-simvastatin)	T3	ST HD
ANTI-HYPERLIPID- HMG-COA RI-CALCIUM CHANNEL BLOCKER		
amlodipine-atorvast 10-10 mg (Caduet)	T1	HD
amlodipine-atorvast 10-20 mg (Caduet)	T1	HD
amlodipine-atorvast 10-40 mg (Caduet)	T1	HD
amlodipine-atorvast 10-80 mg (Caduet)	T1	HD
amlodipine-atorvast 2.5-10 mg	T1	HD
amlodipine-atorvast 2.5-20 mg	T1	QL (1 tab/day) HD
amlodipine-atorvast 2.5-40 mg	T1	QL (1 tab/day) HD
amlodipine-atorvast 5-10 mg (Caduet)	T1	HD
amlodipine-atorvast 5-20 mg (Caduet)	T1	QL (1 tab/day) HD
amlodipine-atorvast 5-40 mg (Caduet)	T1	QL (1 tab/day) HD
amlodipine-atorvast 5-80 mg (Caduet)	T1	HD
CADUET 10 MG-10 MG TABLET (amlodipine-atorvastatin)	T3	HD
CADUET 10 MG-20 MG TABLET (amlodipine-atorvastatin)	T3	HD
CADUET 10 MG-40 MG TABLET (amlodipine-atorvastatin)	T3	HD
CADUET 10 MG-80 MG TABLET (amlodipine-atorvastatin)	T3	HD
CADUET 5 MG-10 MG TABLET (amlodipine-atorvastatin)	T3	HD
CADUET 5 MG-20 MG TABLET (amlodipine-atorvastatin)	T3	QL (1 tab/day) HD
CADUET 5 MG-40 MG TABLET (amlodipine-atorvastatin)	T3	QL (1 tab/day) HD
CADUET 5 MG-80 MG TABLET (amlodipine-atorvastatin)	T3	HD
ANTI-HYPERLIPIDEMIC - APO B-100 SYNTHESIS INHIBITOR		
KYNAMRO	T3	PA SP
ANTI-HYPERLIPIDEMIC - ATP CITRATE LYASE INHIBITOR		
NEXLETOL	T2	PA QL (1 tab/day)
ANTI-HYPERLIPIDEMIC - MTP INHIBITOR		
JUXTAPID	T3	PA SP HD
ANTI-HYPERLIPIDEMIC - PCSK9 INHIBITORS		
REPATHA PUSHTRONEX	T2	PA
REPATHA SURECLICK	T2	PA
REPATHA SYRINGE	T2	PA
ANTI-HYPERLIPIDEMIC-ACLY AND CHOLES ABSORP INHIB		
NEXLIZET	T2	PA QL (1 SYRINGE/DAY)

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

PA – Prior Authorization

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ST – Step Therapy

AGE – Age Requirement

SP – Specialty Medication

HD – May require home delivery pharmacy

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List of Prescription Medications

CARDIOVASCULAR (Cholesterol Medications) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ANTI-HYPERLIPIDEMIC-HMGCOA REDUCTASE INHIB (Statins)		
atorvastatin 20 mg tablet	T1	HD PPACA
atorvastatin 40 mg tablet	T1	HD
atorvastatin 80 mg tablet	T1	HD
fluvastatin sodium	T1	HD PPACA
fluvastatin sodium (Lescol XL)	T1	HD PPACA
LIVALO	T2	PA QL ST
LIVALO 1 MG TABLET (<i>pitavastatin calcium</i>)	T2	ST QL(1 tab/day) HD
LIVALO 2 MG TABLET (<i>pitavastatin calcium</i>)	T2	ST QL(1 tab/day) HD
LIVALO 4 MG TABLET (<i>pitavastatin calcium</i>)	T2	ST HD
lovastatin 10 mg tablet	T1	HD
lovastatin 20 mg tablet	T1	HD PPACA
lovastatin 40 mg tablet	T1	HD PPACA
pitavastatin 1 mg tablet	T1	QL HD PPACA
pitavastatin 2 mg tablet	T1	QL HD PPACA
pitavastatin 4 mg tablet (Livalo)	T1	HD PPACA
pitavastatin 1 mg tablet (Livalo)	T1	QL(1 tab/day) HD PPACA
pitavastatin 2 mg tablet (Livalo)	T1	QL(1 tab/day) HD PPACA
pitavastatin 4 mg tablet	T1	HD PPACA
pravastatin sodium	T1	HD PPACA
pravastatin sodium (Pravachol)	T1	HD PPACA
rosuvastatin calcium 10 mg tab (Crestor)	T1	QL (1 tab/day) HD PPACA
rosuvastatin calcium 20 mg tab (Crestor)	T1	QL (1 tab/day) HD
rosuvastatin calcium 40 mg tab (Crestor)	T1	HD
rosuvastatin calcium 5 mg tab (Crestor)	T1	QL (1 tab/day) HD PPACA
simvastatin 10 mg tablet (Zocor)	T1	HD PPACA
simvastatin 20 mg tablet (Zocor)	T1	HD PPACA
simvastatin 40 mg tablet (Zocor)	T1	HD PPACA
simvastatin 5 mg tablet	T1	HD
simvastatin 80 mg tablet	T1	QL (1 tab/day) HD
BILE SALT SEQUESTRANTS		
cholestyramine (with sugar) (Questran)	T1	HD
cholestyramine/aspartame	T1	HD
cholestyramine/aspartame (Questran Light)	T1	HD
colesevelam hcl (Welchol)	T1	HD

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

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List of Prescription Medications

CARDIOVASCULAR (Cholesterol Medications) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
BILE SALT SEQUESTRANTS (con't.)		
COLESTID 1 GM TABLET (<i>colestipol hcl</i>)	T3	HD
COLESTID FLAVORED GRANULES	T2	HD
COLESTID FLAVORED GRANULES	T3	HD
COLESTID GRANULES	T3	HD
COLESTID GRANULES (<i>colestipol hcl</i>)	T3	HD
COLESTID GRANULES PACKET (<i>colestipol hcl</i>)	T3	HD
<i>colestipol hcl</i> (Colestid)	T1	HD
QUESTRAN (<i>cholestyramine</i>)	T3	HD
QUESTRAN LIGHT (<i>prevalite</i>)	T3	HD
LIPOTROPICS		
<i>ezetimibe</i> (Zetia)	T1	HD
<i>fenofibrate nanocrystallized</i> (Tricor)	T1	HD
<i>fenofibrate, micronized</i>	T1	HD
<i>fenofibric acid (choline)</i> (Trilipix)	T1	HD
<i>fenofibric acid</i> (Fibrincor)	T1	HD
FIBRICOR (<i>fenofibric acid</i>)	T3	ST HD
<i>gemfibrozil</i> (Lopid)	T1	HD
LIPOFEN	T3	ST HD
LOPID (<i>gemfibrozil</i>)	T3	HD
<i>niacin</i> (Niaspan)	T1	HD
NIASPAN (<i>niacin er</i>)	T3	HD
TRICOR (<i>fenofibrate</i>)	T3	ST HD
TRIGLIDE	T3	ST HD
TRILIPIX (<i>fenofibric acid</i>)	T3	ST HD
ZETIA (<i>ezetimibe</i>)	T3	HD
CARDIOVASCULAR (Miscellaneous)		
VENOSCLEROSING AGENTS		
<i>sodium tetradeциl sulfate</i>	T1	
CNS DRUGS (Alzheimer's Disease)		
ALZHEIMER'S THERAPY, NMDA RECEPTOR ANTAGONISTS		
<i>memantine hcl</i>	T1	HD
<i>memantine hcl er 14 mg capsule</i> (Namenda Xr)	T1	QL (1 cap/day) HD
<i>memantine hcl er 21 mg capsule</i> (Namenda Xr)	T1	HD

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

PA – Prior Authorization

QL – Quantity Limit

ST – Step Therapy

AGE – Age Requirement

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List of Prescription Medications

CNS DRUGS (Alzheimer's Disease) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ALZHEIMER'S THERAPY, NMDA RECEPTOR ANTAGONISTS (con't.)		
memantine hcl er 28 mg capsule (Namenda Xr)	T1	HD
memantine hcl er 7 mg capsule (Namenda Xr)	T1	QL (1 cap/day) HD
NAMENDA	T2	HD
NAMENDA XR 14 MG CAPSULE (memantine hcl er)	T3	QL (1 cap/day) HD
NAMENDA XR 21 MG CAPSULE (memantine hcl er)	T3	HD
NAMENDA XR 28 MG CAPSULE (memantine hcl er)	T3	HD
NAMENDA XR 7 MG CAPSULE (memantine hcl er)	T3	QL (1 cap/day) HD
NAMENDA XR TITRATION PACK	T3	QL (112/365 days) HD
ALZHEIMER'S THX, NMDA RECEPTOR ANTAG-CHOLINES INHIB		
NAMZARIC 14 MG-10 MG CAPSULE	T3	QL (2 caps/day) HD
NAMZARIC 21 MG-10 MG CAPSULE	T3	QL (2 caps/day) HD
NAMZARIC 28 MG-10 MG CAPSULE	T3	QL (2 caps/day) HD
NAMZARIC 7 MG-10 MG CAPSULE	T3	QL (2 caps/day) HD
NAMZARIC TITRATION PACK	T3	QL (112/365 days) HD
AMYLOID DIRECTED MONOCLONAL ANTIBODY		
ADUHELM	T3	PA SP
CNS DRUGS (Miscellaneous)		
AMYOTROPHIC LATERAL SCLEROSIS AGENTS		
edaravone	T1	PA SP
EDARAVONE VIAL	T3	PA SP
QALSODY	T3	
RADICAVA ORS	T3	PA QL (50ml/28days) SP
RILUTEK (riluzole)	T3	SP HD
riluzole (Rilutek)	T3	SP HD
TIGLUTIK	T3	PA SP
DRUGS TO TREAT MOVEMENT DISORDERS		
AUSTEDO	T3	PA SP HD
AUSTEDO XR	T3	PA QL SP HD
AUSTEDO XR 6 MG TABLET	T3	PA QL(3 tabs/day) SP HD
AUSTEDO XR 12 MG TABLET	T3	PA QL(1 tab/day) SP HD
AUSTEDO XR 18 MG TABLET	T3	PA QL(1 tab/day) SP HD
AUSTEDO XR 24 MG TABLET	T3	PA QL(2 tabs/day) SP HD
AUSTEDO XR TITRATION KT(WK1-4)	T3	PA QL(1 kit/180 days) SP HD
INGREZZA	T3	PA QL (1 tab/day) SP
INGREZZA INITIATION PK (TARDIV)	T3	PA QL (28 caps/year) SP
tetrabenazine	T1	PA SP HD

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

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

CNS DRUGS (Miscellaneous) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
PSEUDOBULBAR AFFECT (PBA) AGENTS, NMDA ANTAGONISTS		
NUEDEXTA	T3	QL (4 caps/day)
CNS DRUGS (Multiple Sclerosis)		
XANTHINES		
<i>caffeine citrate</i>	T1	HD
AGENTS TO TREAT MULTIPLE SCLEROSIS		
AVONEX	T3	PA SP HD
AVONEX PEN	T3	PA SP HD
BAFIERTAM	T3	PA SP HD
BETASERON	T3	PA SP HD
BRIUMVI	T3	PA SP
<i>dimethyl fumarate</i>	T1	HD
GILENYA	T3	PA SP HD
<i>glatopa</i>	T1	HD
<i>glatiramer acetate</i>	T1	PA SP HD
KESIMPTA PEN	T3	PA SP HD
MAVENCLAD	T3	PA SP HD
MAYZENT	T3	PA SP HD
OCREVUS	T2	PA SP
PLEGRIDY	T3	PA SP HD
PLEGRIDY PEN	T3	PA SP HD
PONVORY	T3	PA SP HD
REBIF	T3	PA SP HD
REBIF REBIDOSE	T3	PA SP HD
<i>teriflunomide</i> (Aubagio)	T1	
VUMERTY	T3	PA SP HD
AGTS TX NEUROMUSC TRANSMISSION DIS, POT-CHAN BLKR		
<i>dalfampridine</i>	T1	PA SP HD
FIRDAPSE	T3	PA QL (8 tabs/day) SP
RUZURGI	T3	PA SP
CNS DRUGS (Pain Relief And Inflammatory Disease)		
CALCITONIN GENE-RELATED PEPTIDE (CGRP) INHIBITORS		
EMGALITY SYRINGE	T2	PA

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

PA – Prior Authorization

QL – Quantity Limit

ST – Step Therapy

AGE – Age Requirement

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List of Prescription Medications

CNS DRUGS (Pain Relief And Inflammatory Disease) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
SPHINGOSINE I-PHOSPHATE (SIP) RECEPTOR MODULATOR		
VELSIPITY	T2	PA QL(30 tabs/30 days) SP HD
POSTHERPETIC NEURALGIA AGENTS		
gabapentin (Gralise)	T2	PA SP HD
SPHINGOSINE I-PHOSPHATE (SIP) RECEPTOR MODULATOR		
ZEPOSIA	T2	PA SP HD
CNS DRUGS (Seizure Disorders)		
ANTI-CONVULSANT - BENZODIAZEPINE TYPE		
clobazam (Onfi)	T1	HD
clonazepam (Klonopin)	T1	HD
DIASTAT ACUDIAL (<i>diazepam</i>)	T3	PA HD
<i>diazepam 10 mg rectal gel syst</i> (Diastat Acudial)	T1	HD
<i>diazepam 2.5 mg rectal gel sys</i> (Diastat)	T1	HD
<i>diazepam 20 mg rectal gel syst</i>	T1	HD
KLONOPIN (<i>clonazepam</i>)	T3	PA HD
LIBERVANT	T3	QL(10 films/30 days) HD
NAYZILAM	T2	PA QL (5 kits/30 days) HD
ONFI (<i>clobazam</i>)	T3	PA HD
VALTOCO	T3	PA QL (5 boxes/30 Days) HD
ANTI-CONVULSANT - CANNABINOID TYPE		
EPIDIOLEX	T3	PA SP HD
ANTI-CONVULSANTS		
APTIOM 200 MG TABLET	T3	PA QL (1 tab/day) HD
APTIOM 400 MG TABLET	T3	PA QL (1 tab/day) HD
APTIOM 600 MG TABLET	T3	PA HD
APTIOM 800 MG TABLET	T3	PA HD
BRIVIACT	T3	PA HD
<i>carbamazepine</i>	T1	HD
CARBAMAZEPINE 200 MG TAB CHEW	T3	HD
<i>carbamazepine</i> (Carbatrol)	T1	HD
<i>carbamazepine</i> (Tegretol Xr)	T1	HD
<i>carbamazepine</i> (Tegretol)	T1	HD
CARBATROL (<i>carbamazepine er</i>)	T3	PA HD
CELONTIN	T2	HD
CEREBYX (fosphenytoin sodium)	T3	
DIACOMIT	T3	PA SP HD

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

PA – Prior Authorization

QL – Quantity Limit

ST – Step Therapy

AGE – Age Requirement

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List of Prescription Medications

CNS DRUGS (Seizure Disorders) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ANTI-CONVULSANTS (cont.)		
SPHINGOSINE I-PHOSPHATE (SIP) RECEPTOR MODULATOR		
VELSIPITY	T2	PA QL(30 tabs/30 days) SP HD
DILANTIN 50 MG INFATAB (<i>phenytoin</i>)	T3	PA HD
DILANTIN-125 (<i>phenytoin</i>)	T3	PA HD
<i>divalproex sodium</i> (Depakote Er)	T1	HD
<i>divalproex sodium</i> (Depakote Sprinkle)	T1	HD
<i>divalproex sodium</i> (Depakote)	T1	HD
<i>ethosuximide</i> (Zarontin)	T1	HD
<i>felbamate</i>	T1	HD
FINTEPLA	T3	PA SP HD
<i>fosphénytoïn sodium</i> (Cerebyx)	T1	
FYCOMPA 0.5 MG/ML ORAL SUSP	T2	PA HD
FYCOMPA 10 MG TABLET	T2	PA HD
FYCOMPA 12 MG TABLET	T2	PA HD
FYCOMPA 2 MG TABLET	T2	PA HD
FYCOMPA 4 MG TABLET	T2	PA QL (1 tab/day) HD
FYCOMPA 6 MG TABLET	T2	PA QL (1 tab/day) HD
FYCOMPA 8 MG TABLET	T2	PA HD
<i>gabapentin</i>	T1	HD
<i>gabapentin</i> (Neurontin)	T1	HD
KEPPRA 500 MG/5 ML VIAL	T3	
<i>lamotrigine</i>	T1	HD
<i>levetiracetam</i>	T1	
LYRICA (<i>pregabalin</i>)	T3	PA HD
NEURONTIN (<i>gabapentin</i>)	T3	PA HD
<i>oxcarbazepine</i> (Oxtellar Xr)	T1	HD
OXTELLAR XR	T3	PA HD
PEGANONE	T2	HD
PHENYTEK (<i>phenytoin sodium extended</i>)	T3	PA 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>	T1	HD

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

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List of Prescription Medications

CNS DRUGS (Seizure Disorders) (cont.)

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

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

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List of Prescription Medications

CNS DRUGS (Sleep Disorders/Sedatives)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
NARCOLEPSY TX-H3-RECEPT.ANTAGONIST/INVERSE AGONIST		
WAKIX	T3	PA QL (2 tabs/day) SP HD
COLONY STIMULATING FACTORS (Blood Modifiers/Bleeding Disorders)		
ERYTHROPOIESIS-STIMULATING AGENTS		
ARANESP	T3	PA SP
EPOGEN	T3	PA SP
MIRCERA	T3	PA SP
PROCRIT	T3	PA SP
RETACRIT	T3	PA SP
LEUKOCYTE (WBC) STIMULANTS		
FULPHILA	T3	PA SP
GRANIX	T3	PA SP
LEUKINE	T3	SP
ZIEXTENZO	T3	PA SP
NEULASTA	T3	PA SP
NEULASTA ONPRO	T3	PA SP HD
NEUPOGEN	T3	PA SP
NIVESTYM	T3	SP HD
NYPOZI	T3	PA SP
NYVEPRIA	T3	PA SP
STIMUFEND	T3	PA SP
UDENYCA	T3	PA SP
ZARXIO	T3	SP HD
ZIEXTENZO	T3	PA SP
THROMBOPOIETIN RECEPTOR AGONISTS		
DOPTELET	T2	PA SP HD
MULPLETA	T3	PA SP HD
PROMACTA	T2	PA SP HD
COLONY STIMULATING FACTORS (Cancer)		
CXCR4 CHEMOKINE RECEPTOR ANTAGONIST		
XOLREMDI	T3	PA QL(4 caps/day) SP CSL
CONTRACEPTIVES (Contraception Products)		
CONTRACEPTIVES, INTRAVAGINAL, SYSTEMIC		
ANNOVERA	T3	
etongestrel/ethinyl estradiol (Nuvaring)	T1	PPACA
NUVARING (etongestrel-ethinyl estradiol)	T3	

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

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List of Prescription Medications

CONTRACEPTIVES (Contraception Products) (cont.)			
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits	
CONTRACEPTIVES, IMPLANTABLE			
NEXPLANON	T3	SP PPACA	
CONTRACEPTIVES, INJECTABLE			
DEPO-PROVERA 150 MG/ML SYRINGE (<i>medroxyprogesterone acetate</i>)	T3		
DEPO-PROVERA 150 MG/ML VIAL (<i>medroxyprogesterone acetate</i>)	T3		
DEPO-SUBQ PROVERA 104	T2		
<i>medroxyprogesterone 150 mg/ml</i> (Depo-provera)	T1	PPACA	
CONTRACEPTIVES, ORAL			
BALCOLTRA (<i>levonorgestrel/eth.estradiol/iron</i>)	T3	HD	
BEYAZ (<i>rajanj</i>)	T3	HD	
<i>desog-e.estradiol/e.estradiol</i>	T1	HD PPACA	
<i>desogestrel-ethinyl estradiol</i>	T1	HD PPACA	
<i>drospir/eth estra/levomefola</i> (Beyaz)	T1	HD PPACA	
<i>drospir/eth estra/levomefola</i> (Safyral)	T1	HD PPACA	
ELLA	T3	HD PPACA	
ESTROSTEP FE (<i>tri-legest fe</i>)	T3	HD	
<i>ethinyl estradiol/drospirenone</i> (Yasmin 28)	T1	HD PPACA	
<i>ethinyl estradiol/drospirenone</i> (Yaz)	T1	HD PPACA	
<i>ethynodiol d-ethinyl estradiol</i>	T1	HD PPACA	
GENERESS FE (<i>norethin-eth estra-ferrous fum</i>)	T3	HD	
<i>levonorgestrel/ethin.estradiol</i>	T1	HD PPACA	
<i>levonorgestrel/ethin.estradiol/iron</i> (Balcoltra)	T1	HD PPACA	
<i>l-norgest/e.estradiol-e.estrad</i>	T1	HD PPACA	
<i>l-norgest/e.estradiol-e.estrad</i> (Quartette)	T1	HD PPACA	
LOESTRIN (<i>norethindron-ethinyl estradiol</i>)	T3	HD	
LOESTRIN FE (<i>norethindrone-eth estradiol-fe</i>)	T3	HD	
MICROGESTIN 24 FE (<i>tarina 24 fe</i>)	T3	HD	
NATAZIA	T3	HD	
NEXTSTELLIS	T3	HD	
<i>noreth-ethinyl estradiol/iron</i>	T1	HD PPACA	
<i>noreth-ethinyl estradiol/iron</i> (Generess Fe)	T1	HD PPACA	
<i>noreth-ethinyl estradiol/iron</i> (Generess Fe)	T3	HD PPACA	
<i>norethind-eth estrad 1-0.02 mg</i> (Loestrin)	T1	HD PPACA	
<i>norethindrone</i> (Ortho Micronor)	T1	HD PPACA	

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

PA – Prior Authorization

QL – Quantity Limit

ST – Step Therapy

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List of Prescription Medications

CONTRACEPTIVES (Contraception Products) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
CONTRACEPTIVES, ORAL (cont.)		
norethindrone ac-eth estradiol (Loestrin)	T1	HD PPACA
norethindrone-e.estriadiol-iron (Estrostep Fe)	T1	HD PPACA
norethindrone-e.estriadiol-iron (Loestrin Fe)	T1	HD PPACA
norethindrone-e.estriadiol-iron (Microgestin 24 Fe)	T1	HD PPACA
norethindrone-e.estriadiol-iron (Taytulla)	T1	HD PPACA
norethindrone-ethin. estradiol	T1	HD PPACA
norethin-ee 1.5-0.03 mg(21) tb (Loestrin)	T1	HD PPACA
norgestrel-ethynodiol estradiol	T1	HD PPACA
ORTHO MICRONOR (tulana)	T3	HD
QUARTETTE (rivelsa)	T3	HD
SAFYRAL (tydemy)	T3	HD
SLYND	T3	HD
TAYTULLA (norethin-eth estra-ferrous fum)	T3	HD
TYBLUME	T3	HD
YASMIN 28 (zumandimine)	T3	HD
YAZ (vestura)	T3	HD
CONTRACEPTIVES, TRANSDERMAL		
norelgestromin/ethin.estriadiol	T1	HD PPACA
TWIRLA	T3	HD PPACA
DIAPHRAGMS/CERVICAL CAP		
CAYA CONTOURED	T1	PPACA
FEMCAP	T1	PPACA
WIDE SEAL DIAPHRAGM	T1	PPACA
INTRA-UTERINE DEVICES (IUDS)		
KYLEENA	T3	SP PPACA
LILETTA	T3	SP PPACA
MIRENA	T3	SP PPACA
PARAGARD T 380-A	T3	SP PPACA
SKYLA	T3	SP PPACA
COUGH/COLD PREPARATIONS (Allergy/Nasal Sprays)		
1ST GEN ANTIHIST-DECONGEST-ANTICHOLINERGIC COMB		
RESPA A.R.	T3	

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

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List of Prescription Medications

COUGH/COLD PREPARATIONS (Cough/Cold Medications)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ANTI-TUSSIVES, NON-OPIOID		
benzonatate	T1	
benzonatate (Tessalon Perle)	T1	
TESSALON PERLE (benzonatate)	T3	
NON-OPIOID ANTI-TUS-IST GEN. ANTIHISTAMINE-DECONGEST		
brompheniramine/pseudoephed/dm (Bromfed Dm)	T1	
NON-OPIOID ANTI-TUSSIVE-IST GEN ANTIHISTAMINE COMB.		
promethazine/dextromethorphan	T1	
OPIOID ANTI-TUSSIV-IST GEN. ANTIHISTAMINE-DECONGEST		
hydrocodone/cpm/pseudoephed	T1	PA
promethazine/phenyleph/codeine	T1	PA QL (480ml/22 days)
promethazine/phenyleph/codeine	T1	PA QL (480ml/30 days)
OPIOID ANTI-TUSSIVE-IST GENERATION ANTIHISTAMINE		
hydrocodone/chlorphen p-stirex	T1	PA
promethazine-codeine solution	T1	PA QL (480ML/22 Days)
promethazine-codeine syrup	T1	PA QL (480ml/30 days)
TUXARIN ER	T3	PA QL (2 tabs/day)
TUZISTRA XR	T3	PA QL (960ml/30 days)
OPIOID ANTI-TUSSIVE-ANTI-CHOLINERGIC COMBINATIONS		
HYCODAN (hydromet)	T3	PA QL (480ml/22 days)
hydrocodone bit/homatrop me-br (Hycodan)	T1	PA QL (480ml/22 days)
hydrocodone-homatropine 5-1.5	T1	PA QL (180 tabs/30 days)
hydrocodone-homatropine soln (Hycodan)	T1	PA QL (480ml/30 days)
HYDROCODONE-HOMATROPINE SYRUP	T1	PA QL (480ml/30 days)
OPIOID ANTI-TUSSIVE-EXPECTORANT COMBINATION		
HYDROCODONE-GUAIFENESIN	T1	PA QL (960ml/30 days)
OBREDON	T3	PA QL (960ml/30 days)
DIAGNOSTIC (Miscellaneous)		
CARDIOVASCULAR DIAGNOSTICS, NON-RADIOPAQUE AGENTS		
regadenoson	T1	
DIAGNOSTIC PREPARATIONS, MISCELLANEOUS		
ADVANCED DNA MEDICATED COLLECT	T3	
ARIDOL	T3	
DIAGNOSTIC PREPARATIONS, MISCELLANEOUS		
lidocaine hcl/glycerin (Advanced Dna Medicated Collect)	T1	

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List of Prescription Medications

DIAGNOSTIC (Miscellaneous) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
DIAGNOSTIC PREPARATIONS, MISCELLANEOUS (cont.)		
PROVOCHOLINE	T3	
TC99M SULFUR COLLOID PREP	T1	
EYE DIAGNOSTIC AGENTS		
AK-FLUOR	T3	
<i>fluorescein sodium</i>	T1	
<i>ful-glo 1 mg oph strip</i>	T1	
FUL-GLO EYE STRIPS	T3	
<i>lissamine green</i>	T1	
GASTROINTESTINAL RADIOPAQUE DIAGNOSTICS		
ENTERO VU	T3	
E-Z DISK	T3	
E-Z-HD	T3	
E-Z-PAQUE	T3	
E-Z-PASTE	T3	
GASTROMARK	T3	
LIQUID E-Z PAQUE	T3	
LIQUID POLIBAR PLUS	T3	
NEULUMEX	T3	
POLIBAR ACB	T3	
READI-CAT 2	T3	
SITZMARKS	T3	
TAGITOL V	T3	
VARIBAR HONEY, NECTAR, PUDDING	T3	
VARIBARTHIN HONEY	T3	
VARIBARTHIN LIQUID	T3	
METABOLIC FUNCTION DIAGNOSTICS		
METOPIRONE	T2	
RADIOPHARMACEUTICALS ELEMENTS		
INDICLOR	T3	
URINARY TRACT RADIOPAQUE DIAGNOSTICS		
CYSTO-CONRAY II	T3	
CYSTOGRAFIN	T3	
<i>diatrizoate meglumine, sodium (Gastrografin)</i>	T1	
GASTROGRAFIN (<i>md-gastroview</i>)	T3	

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List of Prescription Medications

DIURETICS (Diuretics)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ARGININE VASOPRESSIN (AVP) RECEPTOR ANTAGONISTS		
TOLVAPTAN 15 MG TABLET	T3	SP
<i>tolvaptan 30 mg tablet (Samsca)</i>	T3	SP
CARBONIC ANHYDRASE INHIBITORS		
<i>acetazolamide</i>	T1	HD
<i>methazolamide</i>	T1	HD
LOOP DIURETICS		
<i>bumetanide</i>	T1	HD
<i>ethacrynat sodium (Sodium Edecrin)</i>	T1	
FUROSCIX	T3	QL(2 kits/30 days) HD
<i>furosemide (Lasix)</i>	T1	HD
<i>torsemide</i>	T1	HD
SODIUM EDECIN (<i>ethacrynat sodium</i>)	T3	
OSMOTIC DIURETICS		
<i>osmitrol 20% (100 gm/500 ml)</i>	T2	
<i>osmitrol 20% (50 gm/250 ml)</i>	T2	
OSMITROL 10% (50 GM/500 ML) (<i>mannitol</i>)	T3	
OSMITROL 5% (50 GM/1,000 ML) (<i>mannitol</i>)	T3	
POLYCYSTIC KIDNEY DISEASE AGENT, AVP RECEP. ANTAG		
JYNARQUE 15 MG TABLET	T3	SP
JYNARQUE 15 MG-15 MG TABLET	T3	PA SP
JYNARQUE 30 MG TABLET	T3	SP
JYNARQUE 30 MG-15 MG TABLET	T3	PA SP
JYNARQUE 45 MG-15 MG TABLET	T3	PA SP
JYNARQUE 60 MG-30 MG TABLET	T3	PA SP
JYNARQUE 90 MG-30 MG TABLET	T3	PA SP
POTASSIUM SPARING DIURETICS		
<i>amiloride hcl</i>	T1	HD
CAROSPIR (<i>Spironolactone</i>)	T2	HD
<i>eplerenone (Inspira)</i>	T1	HD
INSPRA (<i>eplerenone</i>)	T3	HD
KERENDIA	T3	PA QL (30 tabs/30 days) SP
<i>spironolactone (Aldactone)</i>	T1	HD
<i>triamterene (Dyrenium)</i>	T1	HD

T1 – Typically Generics

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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		
ALDACTAZIDE (<i>spironolactone-hctz</i>)	T3	HD
<i>amiloride/hydrochlorothiazide</i>	T1	HD
CAROSPIR SUSP	T2	PA
DYAZIDE (<i>triaterene-hydrochlorothiazid</i>)	T3	HD
THIAZIDE AND RELATED DIURETICS		
<i>spironolact/hydrochlorothiazid</i> (Aldactazide)	T1	HD
<i>triaterene/hydrochlorothiazid</i> (Dyazide)	T1	HD
<i>chlorthalidone</i>	T1	
DIURIL	T2	HD
<i>hydrochlorothiazide</i>	T1	HD
<i>indapamide</i>	T1	HD
<i>metolazone</i>	T1	HD
SODIUM DIURIL (<i>chlorothiazide sodium</i>)		
EENT PREPS (Allergy/Nasal Sprays)		
NASAL ANTIHISTAMINE		
<i>azelastine 0.1%</i> (137 mcg) spry	T1	HD
<i>azelastine 0.15%</i> nasal spray	T1	HD
<i>olopatadine 665 mcg</i> nasal spry (Patanase)	T1	HD
PATANASE (<i>olopatadine hcl</i>)	T3	HD
NASAL ANTIHISTAMINE AND ANTI-INFLAM. STEROID COMB.		
<i>azelastine/fluticasone</i>	T1	HD
NASAL ANTI-INFLAMMATORY STEROIDS		
<i>flunisolide</i>	T1	HD
<i>fluticasone prop 50 mcg</i> spray	T1	HD
<i>mometasone furoate 50 mcg</i> spry	T1	QL (4 bots/30 days) HD
NOSE PREPARATIONS, MISCELLANEOUS (RX)		
<i>ipratropium bromide</i>	T1	HD
NOSE PREPARATIONS, VASOCONSTRICATORS (RX)		
ADRENALIN CHLORIDE	T3	
<i>epinephrine hcl</i> (Adrenalin Chloride)	T1	
EENT PREPS (Ear Medications)		
EAR PREPARATIONS ANTI-INFLAMMATORY		
DERMOTIC (<i>fluocinolone acetonide oil</i>)	T3	
<i>fluocinolone acetonide oil</i> (Dermotic)	T1	

T1 – Typically Generics

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List of Prescription Medications

EENT PREPS (Ear Medications) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
EAR PREPARATIONS, MISC. ANTI-INFECTIVES		
acetic acid	T1	
hydrocortisone/acetic acid	T1	
EENT PREPS (Eye Conditions)		
ARTIFICIAL TEARS		
LACRISERT	T2	
MIEBO	T2	QL(4 bottles/30 days)
EYE ANTI-INFECTIVES (RX ONLY)		
BETADINE	T2	
EYE ANTI-INFLAMMATORY AGENTS		
ACUVAIL	T3	
ALREX	T3	
bromfenac sodium	T1	
BROMSITE (bromfenac sodium)	T2	
dexamethasone sodium phosphate	T1	
diclofenac 0.1% eye drops	T1	
EYSUVIS	T2	QL (8.3ml/14 days)
FLAREX	T2	
fluorometholone (Fml)	T1	
flurbiprofen sodium	T1	
FML (fluorometholone)	T3	
FML FORTE	T2	
ILEVRO	T3	
INVELTYS	T2	
ketorolac 0.4% ophth solution (Acular Ls)	T1	
ketorolac 0.5% ophth solution (Acular)	T1	
LOTEMAX 0.5% EYE OINT	T2	
LOTEMAX SM	T2	
loteprednol etabonate (Alrex)	T1	
loteprednol etabonate (Lotemax)	T1	
MAXIDEX	T2	
OMNIPRED (prednisolone acetate)	T3	
PRED MILD	T2	
prednisolone acetate (Pred Forte)	T1	
prednisolone sodium phosphate	T1	

T1 – Typically Generics

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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.)		
PROLENSA	T3	
AKTEN	T3	
ALCAINE (<i>proparacaine hcl</i>)	T3	
EYE LOCAL ANESTHETICS		
AKTEN	T3	
ALCAINE (<i>proparacaine hcl</i>)	T3	
ALTAFLUOR BENOX (<i>flurox</i>)	T3	
<i>benoxinate hcl/fluorescein sod</i> (Altafluor Benox)	T3	
<i>proparacaine hcl</i> (Alcaine)	T1	
<i>proparacaine/fluorescein sod</i>	T1	
<i>proparacaine/fluorescein sod</i>	T2	
<i>tetracaine hcl</i>	T1	
TETRAVISC	T2	
TETRAVISC FORTE	T2	
EYE MAST CELL STABILIZERS		
ALOCRIL	T3	
ALOMIDE	T2	
<i>cromolyn 4% eye drops</i>	T1	
EYE PREPARATIONS, MISCELLANEOUS (OTC)		
GELFILM	T3	
EYE VASOCONSTRICATORS		
<i>phenylephrine hcl</i>	T1	
MIOTICS AND OTHER INTRAOCULAR PRESSURE REDUCERS		
<i>apraclonidine hcl</i> (lopidine)	T1	HD
<i>betaxolol hcl</i>	T1	HD
BETIMOL	T2	HD
BETOPTIC S	T2	HD
<i>bimatoprost</i>	T1	QL (10 gm/30 days) HD
<i>brimonidine tartrate</i>	T1	HD
<i>brimonidine tartrate</i> (Alphagan P)	T1	HD
<i>brinzolamide</i> (Azopt)	T1	HD
<i>carteolol hcl</i>	T1	HD
<i>dorzolamide hcl</i> (Trusopt)	T1	HD
<i>dorzolamide hcl/timolol maleat</i> (Cosopt)	T1	HD

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

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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.)		
dorzolamide/timolol/pf (Cosopt Pf)	T1	HD
IOPIDINE 0.5% EYE DROPS (apraclonidine hcl)	T3	HD
IOPIDINE 1% EYE DROPS	T2	HD
ISOPTO CARPINE (pilocarpine hcl)	T3	HD
latanoprost	T1	HD
levobunolol hcl	T1	HD
PHOSPHOLINE IODIDE	T2	HD
pilocarpine hcl (Isoptic Carpine)	T1	HD
RHOPRESSA	T3	
ROCKLATAN	T3	
SIMBRINZA	T2	HD
timolol maleate (Istalol)	T1	HD
timolol maleate (Timoptic-xe)	T1	HD
timolol maleate/pf (Timoptic Ocudose)	T1	HD
travoprost	T1	HD
TRUSOPT (dorzolamide hcl)	T3	HD
MYDRIATICS		
atropine 1% eye drops	T1	HD
atropine sulfate	T1	HD
atropine sulfate (Isoptic Atropine)	T1	HD
ATROPINE SULFATE-0.9% NACL	T3	HD
CYCLOGYL 0.5% EYE DROPS (cyclopentolate hcl)	T3	HD
CYCLOGYL 1% EYE DROPS (cyclopentolate hcl)	T3	HD
CYCLOGYL 2% EYE DROPS (cyclopentolate hcl)	T2	HD
CYCLOMYDRIL	T2	HD
cyclopentolate hcl (Cyclogyl)	T1	HD
homatropine hbr	T1	HD
MYDRIACYL (tropicamide)	T3	HD
PAREMYD	T3	HD
tropicamide	T1	HD
tropicamide (Mydriacyl)	T1	HD
OPHTH VASC. ENDOTHELIAL GROWTH FACTOR ANTAGONISTS		
PAVBLU	T3	PA SP
OPHTHALMIC ANTI-FIBROTIC AGENTS		
MITOSOL	T3	

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

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List of Prescription Medications

EENT PREPS (Eye Conditions) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
OPHTHALMIC ANTI-INFLAMMATORY IMMUNOMODULATOR-TYPE		
CEQUA	T3	HD
RESTASIS	T2	HD
RESTASIS MULTIDOSE	T2	HD
VEVYE	T3	QL HD
XIIDRA	T2	HD
OPHTHALMIC CYSTINE DEPLETING AGENTS		
CYSTADROPS	T3	PA QL (20ml/21 days) SP
CYSTARAN	T3	PA QL (120ml/28 days) SP
OPHTHALMIC PREPARATIONS, MISCELLANEOUS		
PROVISC	T3	SP
TOTALVISC	T3	SP
OPHTHALMIC HUMAN NERVE GROWTH FACTOR (HNGF)		
OXERVATE	T3	PA SP HD
ELECT/CALORIC/H2O (Cholesterol Medications)		
ORAL LIPID SUPPLEMENTS		
DOJOLVI	T3	PA SP HD
ELECT/CALORIC/H2O (Dental Products)		
FLUORIDE PREPARATIONS		
FRAICHE 5000 PREVI	T3	
FRAICHE 5000 SENSITIVE	T3	
PREVENTID 1.1% GEL (<i>sodium fluoride</i>)	T3	
PREVENTID 5000 BOOSTER PLUS	T3	
PREVENTID 5000 ENAMEL PROTECT	T3	
PREVENTID 5000 ORTHO DEFENSE	T3	
PREVENTID 5000 PLUS (<i>sodium fluoride 5000 plus</i>)	T3	
PREVENTID 5000 SENSITIVE	T3	
PREVENTID DENTAL RINSE	T2	
PREVENTID KIDS	T2	
<i>sodium fluoride/potassium nit</i> (Prevident 5000 Sensitive)	T1	
ELECT/CALORIC/H2O (Diabetes)		
AGENTS TO TREAT HYPOGLYCEMIA (HYPERGLYCEMICS)		
BAQSIMI	T2	QL (2/30 days)

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

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List of Prescription Medications

ELECT/CALORIC/H2O (Diabetes) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
AGENTS TO TREAT HYPOGLYCEMIA (HYPERGLYCEMICS) (cont.)		
diazoxide (Proglycem)	T1	
GLUCAGEN	T2	QL (2 pens/30 days)
glucagon 1 mg emergency kit (Glucagon Emergency Kit)	T1	QL (2 pens/30 days)
GVOKE HYPOPEN PACK	T3	QL (2 packs/22 days)
GVOKE PFS 1-PACK SYRINGE	T3	QL (2 syringes/30 days)
GVOKE PFS 2-PACK SYRINGE	T3	QL (2 syringes/30 days)
PROGLYCEM (diazoxide)	T3	
ZEGALOGUE	T2	QL (2 units/23 days)

ELECT/CALORIC/H2O (Miscellaneous)

IV SOLUTIONS: DEXTROSE-WATER		
GLUCOSE IN WATER (DEXTROSE 5 % IN WATER)	T1	
NUCLEIC ACID/NUCLEOTIDE SUPPLEMENTS		
XURIDEN	T3	PA SP
NUCLEIC ACID/NUCLEOTIDE SUPPLEMENTS		
AMINO ACID 3.5%-D10W	T3	

ELECT/CALORIC/H2O (Nutritional/Dietary)

CALCIUM REPLACEMENT		
calcium gluc 2,000mg/100ml-nacl	T1	
calcium gluc 1,000mg/50ml-nacl	T1	
ELECTROLYTE DEPLETERS		
AURYXIA	T3	QL (12 tabs/day)
calcium acetate	T1	
lanthanum carbonate (Fosrenol)	T1	
LOKELMA	T2	
PHOSLYRA	T3	
sevelamer carbonate (Renvela)	T1	
sevelamer hcl (Renagel)	T1	
sodium polystyrene sulfon/sorb	T1	
sodium polystyrene sulfonate	T1	
sps 15 gm/60 ml suspension	T1	
sps 30 gm/120 ml enema susp	T3	
VELPHORO	T2	
VELTASSA	T2	
IODINE CONTAINING AGENTS		
potassium iodide/iodine	T1	
SSKI	T1	

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

PA – Prior Authorization

QL – Quantity Limit

ST – Step Therapy

AGE – Age Requirement

SP – Specialty Medication

HD – May require home delivery pharmacy

PPACA – No Cost-Share Preventive Medication

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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		
CITRANATAL BLOOM	T3	
FERAHEME	T3	PA
HEMOCYTE PLUS (mv-mins no.73/iron fum/folic)	T3	
INJECTAFER	T3	PA
MONOFERRIC	T3	PA
<i>mv-mins no.73/iron fum/folic</i> (Hemocyte Plus)	T1	
PARENTERAL AMINO ACID SOLUTIONS AND COMBINATIONS		
AA 3%-D10W-CALCIUM-HEPARIN	T3	
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	
<i>klor-con 10 meq tablet (K-tab Er)</i>	T1	
<i>klor-con 10 meq tablet (K-tab Er)</i>	T3	
<i>klor-con 8 meq tablet</i>	T1	
<i>klor-con 8 meq tablet</i>	T3	
<i>potassium bicarbonate/cit ac</i>	T1	
POTASSIUM CL ER 15 MEQ TABLET	T3	
<i>potassium chloride</i>	T2	
<i>potassium chloride</i>	T3	
<i>potassium chloride (K-tab Er)</i>	T1	
PROTEIN REPLACEMENT		
AQNEURSA	T3	PA SP
ELECT/CALORIC/H2O (Urinary Tract Conditions)		
DIALYSIS SOLUTIONS		
PRISMASOL	T3	
URINARY PH MODIFIERS		
K-PHOS NO.2	T2	HD
K-PHOS ORIGINAL	T2	HD
ORACIT	T3	HD
<i>potassium citrate (Urocit-k)</i>	T1	HD
<i>potassium citrate/citric acid</i>	T1	HD
RENACIDIN	T3	HD
UROCIT-K (<i>potassium citrate er</i>)	T3	HD
UROQID-ACID NO.2	T2	HD
ZINC REPLACEMENT		
<i>zinc sulfate</i>	T1	HD

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

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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	HD
LOVAZA (triklo)	T3	HD
<i>omega-3 acid ethyl esters</i> (Lovaza)	T1	HD
VASCEPA	T2	PA HD
GASTROINTESTINAL (Gastrointestinal/Heartburn)		
AMMONIA INHIBITORS		
AMMONUL (sodium phenylacet-sod benzoate)	T3	
<i>lactulose 10 gm/15 ml solution</i>	T1	
LITHOSTAT	T2	HD
OLPRUVA	T3	PA SP HD
PHEBURANE	T2	PA QL(8 Bottles/30 Days) SP HD
<i>sodium phenylbutyrate</i> (Buphenyl)	T3	SP HD
ANTI-CHOLINERGICS, QUATERNARY AMMONIUM		
<i>chlordiazepoxide/clidinium br</i>	T1	
CUVPOSA	T3	
GLYCATE	T3	
<i>glycopyrrolate</i> (Glycate)	T1	
<i>glycopyrrolate</i> (Robinul Forte)	T1	
<i>glycopyrrolate</i> (Robinul)	T1	
<i>propantheline bromide</i>	T1	
ROBINUL (<i>glycopyrrolate</i>)	T3	
ROBINUL FORTE (<i>glycopyrrolate</i>)	T3	
ANTI-CHOLINERGICS/ANTI-SPASMODICS		
<i>dicyclomine hcl</i>	T1	
ANTI-DIARRHEAL - G.I. CHLORIDE CHANNEL INHIBITORS		
MYTESI	T3	
ANTI-DIARRHEAL - TRYPTOPHAN HYDROXYLASE INHIBITOR		
XERMELO	T3	PA SP
ANTI-DIARRHEALS		
<i>diphenoxylate hcl/atropine</i>	T1	
<i>diphenoxylate hcl/atropine</i> (Lomotil)	T1	
<i>loperamide hcl</i>	T1	
MOTOFEN	T3	

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

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List of Prescription Medications

GASTROINTESTINAL (Gastrointestinal/Heartburn) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ANTI-DIARRHEALS (cont.)		
<i>opium tincture</i>	T1	PA
<i>paregoric</i>	T1	
ANTI-EMETIC, CANNABINOID-TYPE		
<i>dronabinol</i>	T1	
ANTI-EMETIC/ANTI-VERTIGO AGENTS		
AKYNZEON	T3	QL (4 caps/28 days)
ANZEMET	T3	PA QL (5 tabs/30 days) SP
<i>aprepitant 125 mg capsule</i>	T1	QL (4 caps/28 days)
<i>aprepitant 125-80-80 mg pack (Emend)</i>	T1	QL (12 caps/28 days)
<i>aprepitant 40 mg capsule</i>	T1	QL (1 cap/28 days)
<i>aprepitant 80 mg capsule (Emend)</i>	T1	QL (8 caps/28 days)
BONJESTA	T3	
CINVANTI	T3	
COMPATINE (prochlorperazine maleate)	T3	
COMPATINE (prochlorperazine)	T3	
<i>doxylamine succinate/vit b6 (Diclegis)</i>	T1	QL(4 tabs/day)
EMEND 125 MG POWDER PACKET	T3	QL (12 caps/28 days)
EMEND 150 MG VIAL (fosaprepitant dimeglumine)	T3	
FOCINVEZ	T3	
<i>fosaprepitant dimeglumine (Emend)</i>	T1	
<i>granisetron hcl</i>	T1	
<i>granisetron hcl/pf</i>	T1	
<i>ondansetron hcl</i>	T1	
<i>ondansetron hcl/pf</i>	T1	
<i>palonosetron hcl (Posfrea)</i>	T1	
POSFREA	T3	
<i>prochlorperazine (Compazine)</i>	T1	
<i>prochlorperazine maleate (Compazine)</i>	T1	
<i>promethazine hcl</i>	T1	
<i>promethazine hcl</i>	T3	
SANCUSO	T3	PA QL (4 patches/30 days)
<i>scopolamine (Transderm-scop)</i>	T1	
SUSTOL	T3	
TIGAN (trimethobenzamide hcl)	T3	
TRANSDERM-SCOP (scopolamine)	T3	

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List of Prescription Medications

<i>trimethobenzamide hcl</i>	T1	
GASTROINTESTINAL (Gastrointestinal/Heartburn) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ANTI-EMETIC/ANTI-VERTIGO AGENTS (cont.)		
<i>trimethobenzamide hcl</i> (Tigan)	T1	
VARUBI	T3	PA QL (4 tabs/28 days)
ANTI-ULCER PREPARATIONS		
<i>CYTOTEC (misoprostol)</i>	T3	HD
<i>misoprostol</i> (Cytotec)	T1	HD
<i>sucralfate</i> (Carafate)	T1	HD
ANTI-ULCER-H.PYLORI AGENTS		
<i>bismuth/metronid/tetracycline</i> (Pylera)	T1	
<i>lansoprazole/amoxiciln/clarith</i>	T1	
BELLADONNA ALKALOIDS		
<i>atropine 0.25 mg/5 ml syringe</i>	T1	
DONNATAL	T3	HD
DONNATAL (<i>phenohytro</i>)	T3	HD
<i>hyoscyamine sulfate</i>	T1	HD
<i>hyoscyamine sulfate</i> (Levbid)	T1	HD
<i>hyoscyamine sulfate</i> (Levsin)	T1	HD
<i>hyoscyamine sulfate</i> (Levsin-sl)	T1	HD
<i>hyoscyamine sulfate</i> (Nulev)	T1	HD
<i>hyoscyamine sulfate</i> (Nulev)	T3	HD
LEVBID (<i>symax-sr</i>)	T3	HD
LEVSIN (<i>oscimin</i>)	T3	HD
LEVSIN-SL (<i>symax-sl</i>)	T3	HD
<i>methscopolamine bromide</i>	T1	HD
NULEV (<i>symax</i>)	T1	HD
<i>phenobarb/hyoscy/atropine/scop</i> (Donnatal)	T1	HD
<i>phenobarb/hyoscy/atropine/scop</i> (Phenobarbital-belladonna)	T1	HD
<i>phenobarbital-belladonna elixr</i> (Donnatal)	T1	HD
<i>phenobarbital-belladonna elixr</i> (Phenobarbital-belladonna)	T1	HD
PHENOBARBITAL-BELLADONNA ELIXR (<i>phenohytro</i>)	T3	HD
SYMAX DUOTAB	T2	HD
BILE SALTS		
ACTIGALL (<i>ursodiol</i>)	T3	HD

T1 – Typically 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.)		
CHENODAL	T3	SP HD
CHOLBAM	T3	PA SP HD
URSO (<i>ursodiol</i>)	T3	HD
URSO FORTE (<i>ursodiol</i>)	T3	HD
<i>ursodiol</i> (Actigall)	T1	HD
<i>ursodiol</i> (Ursø Forte)	T1	HD
<i>ursodiol</i> (Ursø)	T1	HD
CHRONIC INFLAM. COLON DX, 5-A-SALICYLAT, RECTAL TX		
mesalamine 1,000 mg supp (Canasa)	T1	
mesalamine 4 gm/60 ml enema (Sfrowasa)	T1	
mesalamine 4 gm/60 ml kit	T1	
SFROWASA (mesalamine)	T3	
DRUG TX-CHRONIC INFLAM. COLON DX, 5-AMINOSALICYLAT		
APRISO (mesalamine er)	T3	HD
balsalazide disodium	T1	HD
mesalamine	T1	HD
mesalamine (Apriso)	T1	HD
mesalamine 800 mg dr tablet	T1	HD
mesalamine dr 1.2 gm tablet (Lialda)	T1	HD
PENTASA 500 MG CAPSULE (mesalamine)	T3	HD
sulfasalazine (Azulfidine)	T1	HD
FARNESOID X RECEPTOR (FXR) AGONIST, BILE AC ANALOG		
OCALIVA	T3	PA SP HD
FECAL MICROBIOTA TRANSPLANTATION (FMT)		
VOWST	T3	PA QL(12 caps/56 days) SP
GASTRIC ENZYMES		
SUCRAID	T3	PA SP
HISTAMINE H2-RECEPTOR INHIBITORS		
<i>cimetidine</i>	T1	HD
<i>cimetidine hcl</i>	T1	HD
<i>famotidine</i>	T1	HD
<i>nizatidine</i>	T1	HD
<i>ranitidine hcl</i>	T1	HD

T1 – Typically Generics

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List of Prescription Medications

GASTROINTESTINAL (Gastrointestinal/Heartburn) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
IBS AGENTS, MIXED OPIOID RECEPTOR AGONISTS/ANTAGONISTS		
VIBERZI	T2	HD
IBS-C/CIC AGENTS, GUANYLATE CYCLASE-C AGONIST		
LINZESS	T2	
TRULANCE	T2	
INTESTINAL MOTILITY STIMULANTS		
<i>metoclopramide hcl</i>	T1	
<i>metoclopramide hcl</i> (Reglan)	T1	
REGLAN (<i>metoclopramide hcl</i>)	T3	
IRRITABLE BOWEL SYNDROME AGENTS, 5-HT3 ANTAGONIST		
alosetron hcl	T3	SP HD
LAXATIVES AND CATHARTICS		
<i>bisac/nacl/nahco3/kcl/peg 3350</i>	T1	PPACA
<i>lactulose</i>	T1	
<i>lactulose 10 gm/15 ml solution</i>	T1	
<i>lactulose 20 gm/30 ml solution</i>	T1	
<i>lubiprostone</i> (Amitiza)	T1	
NULYTLY	T3	PPACA
<i>peg3350/sod sul/nacl/kcl/asb/c</i>	T1	PPACA
<i>peg3350/sod sulf, bicarb, cl/kcl</i>	T1	PPACA
PREPOPIK	T2	PPACA
<i>sodium chloride/nahco3/kcl/peg</i>	T1	PPACA
LOCAL ANORECTAL NITRATE PREPARATIONS		
<i>nitroglycerin 0.4% ointment</i> (Rectiv)	T1	
RECTIV	T3	
PANCREATIC ENZYMES		
PANCREAZE	T2	HD
VIOKACE	T3	HD
ZENPEP	T2	HD
POTASSIUM-COMPETITIVE ACID BLOCKERS (PCABS)		
VOQUEZNA	T3	PA QL(1 tab/day)

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

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List of Prescription Medications

GASTROINTESTINAL (Gastrointestinal/Heartburn) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
PROTON-PUMP INHIBITORS		
ACIPHEX SPRINKLE DR 10 MG CAP	T3	QL (60 caps/30 days) HD
ACIPHEX SPRINKLE DR 5 MG CAP	T3	QL (120 caps/30 days) HD
DEXILANT DR 60 MG CAPSULE (<i>dexlansoprazole</i>)	T2	QL(1 cap/day) HD
<i>dexlansoprazole dr 30 mg cap</i> (Dexilant)	T1	QL(2 caps/day)
<i>dexlansoprazole dr 60 mg cap</i> (Dexilant)	T1	QL(1 caps/day)
<i>esomeprazole dr 10 mg packet</i>	T1	QL (4 packets/day) HD
<i>esomeprazole dr 20 mg packet</i>	T1	QL (2 packs/day) HD
<i>esomeprazole dr 40 mg packet</i>	T1	QL (1 packet/day) HD
<i>esomeprazole mag dr 20 mg cap</i>	T1	QL (20ml/day) HD
<i>esomeprazole mag dr 40 mg cap</i>	T1	QL (1 cap/day) HD
ESOMEPRAZOLE STRONTIUM	T3	QL (1 cap/day) HD
<i>lansoprazole dr 15 mg capsule</i> (Prevacid)	T1	QL (2 caps/day) HD
<i>lansoprazole dr 30 mg capsule</i> (Prevacid)	T1	QL (30 caps/30 days) HD
<i>lansoprazole odt 15 mg tablet</i>	T1	QL (2 tabs/day) HD
<i>lansoprazole odt 30 mg tablet</i>	T1	QL (30 tabs/30 days) HD
NEXIUM DR 2.5 MG PACKET	T2	QL (480 packs/30 days) HD
NEXIUM DR 5 MG PACKET	T2	QL (240 packs/30 days) HD
NEXIUM I.V. (<i>esomeprazole sodium</i>)	T3	
<i>omeprazole dr 10 mg capsule</i>	T1	QL (120 caps/30 days) HD
<i>omeprazole dr 20 mg capsule</i>	T1	QL (2 caps/day) HD
<i>omeprazole dr 40 mg capsule</i>	T1	QL (1 cap/day) HD
<i>pantoprazole 40 mg suspension</i> (Protonix)	T1	QL (1 dose/day) HD
<i>pantoprazole sod dr 20 mg tab</i> (Protonix)	T1	QL (2 tabs/day) HD
<i>pantoprazole sod dr 40 mg tab</i> (Protonix)	T1	QL (1 tab/day) HD
PANTOPRAZOLE SODIUM-0.9% NaCl	T3	HD
PREVACID DR 15 MG CAPSULE (<i>lansoprazole</i>)	T3	QL (60 caps/30 days) ST
PREVACID DR 30 MG CAPSULE (<i>lansoprazole</i>)	T3	QL (30 caps/30 days) ST
PRILOSEC DR 10 MG SUSPENSION	T3	QL (120 packs/30 days) HD
PRILOSEC DR 2.5 MG SUSPENSION	T3	QL (480 packs/30 days) HD
PROTONIX 40 MG SUSPENSION (<i>pantoprazole sodium</i>)	T3	QL (30 packs/30 days) ST
PROTONIX DR 20 MG TABLET (<i>pantoprazole sodium</i>)	T3	QL (60 tabs/30 days) ST
PROTONIX DR 40 MG TABLET (<i>pantoprazole sodium</i>)	T3	QL (30 tabs/30 days) ST
PROTONIX IV (<i>pantoprazole sodium</i>)	T3	
<i>rabeprazole sodium</i> (Aciphenx)	T1	QL (30 tabs/30 days) HD

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

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List of Prescription Medications

GASTROINTESTINAL (Gastrointestinal/Heartburn) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
RECTAL PREPARATIONS		
<i>hydrocortisone acetate</i>	T1	
SBS - GLUCAGON-LIKE PEPTIDE-2 (GLP-2) ANALOGS		
GATTEX	T3	PA SP HD
GASTROINTESTINAL (Pain Relief And Inflammatory Disease)		
HEMORRHOID PREP, ANTI-INFLAM STEROID-LOCAL ANESTHET		
ANA-LEX	T1	
ANALPRAM HC 1% CREAM	T3	
<i>hydrocortisone/lidocaine/aloe</i>	T1	
<i>hydrocortisone/pramoxine</i> (Analpram Hc)	T1	
<i>lidocaine/hydrocortisone ac</i>	T1	
LIDOCAINE-HYDROCORTISONE	T1	
PROCORT	T3	
PROCTOFOAM-HC	T2	
RECTAL/LOWER BOWEL PREP., GLUCOCORT. (NON-HEMORR)		
<i>budesonide 2 mg rectal foam</i>	T1	QL(2 kits/180 days)
CORTENEMA (<i>hydrocortisone</i>)	T3	
<i>hydrocortisone</i> (Cortenema)	T1	
HORMONES (Hormonal Agents)		
ANDROGEN/ESTROGEN PREPS FOR FEMALE SEXUAL DYSFUNC		
INTRAROSA	T3	
ANDROGENIC AGENTS		
ANADROL-50	T2	PA
ANDROGEL 1% (25 MG/2.5 G) PKT (<i>testosterone</i>)	T3	PA QL (150gm/30 days)
ANDROGEL 1% (50 MG/5 G) PKT (<i>testosterone</i>)	T3	PA QL (2 packs/day)
ANDROGEL 1.62% GEL PUMP (<i>testosterone</i>)	T3	PA QL (150gm/30 days)
ANDROGEL 1.62%(1.25G) GEL PCKT (<i>testosterone</i>)	T3	PA QL (2 packs/day)
ANDROGEL 1.62%(2.5G) GEL PCKT (<i>testosterone</i>)	T3	PA QL (150gm/30 days)
DEPO-TESTOSTERONE	T3	
DEPO-TESTOSTERONE (<i>testosterone cypionate</i>)	T3	
METHITEST	T1	
<i>methyltestosterone</i>	T1	

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

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List of Prescription Medications

HORMONES (Hormonal Agents) (cont.)

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

T1 – Typically Generics

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List of Prescription Medications

HORMONES (Hormonal Agents) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ESTROGENIC AGENTS (cont.)		
estradiol (Climara)	T1	HD
estradiol (Vivelle-dot)	T1	QL (8 patches/21) days HD
estradiol 0.025 mg patch(2/wk) (Minivelle)	T1	QL(16 patches/28 days) HD
estradiol 0.025 mg patch(2/wk) (Vivelle-Dot)	T1	QL(16 patches/28 days) HD
estradiol 0.0375mg patch(2/wk) (Minivelle)	T1	QL(16 patches/28 days) HD
estradiol 0.0375mg patch(2/wk) (Vivelle-Dot)	T1	QL(16 patches/28 days) HD
estradiol 0.05 mg patch (2/wk) (Minivelle)	T1	QL(16 patches/28 days) HD
estradiol 0.05 mg patch (2/wk) (Vivelle-Dot)	T1	QL(16 patches/28 days) HD
estradiol 0.06% 1.25g gel pump (Estrogel)	T1	HD
estradiol 0.075 mg patch(2/wk) (Minivelle)	T1	QL(16 patches/28 days) HD
estradiol 0.075 mg patch(2/wk) (Vivelle-Dot)	T1	QL(16 patches/28 days) HD
estradiol 0.1 mg patch (2/wk) (Minivelle)	T1	QL(16 patches/28 days) HD
estradiol 0.1 mg patch (2/wk) (Vivelle-Dot)	T1	QL(16 patches/28 days) HD
estradiol 0.5 mg tablet (Estrace)	T1	HD
estradiol 1 mg tablet (Estrace)	T1	HD
estradiol 2 mg tablet (Estrace)	T1	HD
estradiol valerate (Delestrogen)	T1	HD
estradiol/norethindrone acet (Activella)	T1	HD
ESTROGEL (estradiol)	T3	HD
EVAMIST	T3	HD
FEMHRT (norethindron-ethinyl estradiol)	T3	HD
MENEST	T3	HD
MENOSTAR	T3	QL (8 patches/28 days) HD
MINIVELLE (Jyllana)	T3	QL (16 patches/28 days) HD
norethind-eth estrad 0.5-2.5 (Femhrt)	T1	HD
norethindrone ac/eth estradiol	T1	HD
norethindrone ac/eth estradiol (Femhrt)	T1	HD
norethin-eth estrad 1 mg-5 mcg	T1	HD
PREMARIN	T2	HD
PREMPHASE	T2	HD
PREMPRO	T2	HD
VIVELLE-DOT (Jyllana)	T3	QL (16 patches/28 days) HD

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

PA – Prior Authorization

QL – Quantity Limit

ST – Step Therapy

AGE – Age Requirement

SP – Specialty Medication

HD – May require home delivery pharmacy

PPACA – No Cost-Share Preventive Medication

CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

HORMONES (Hormonal Agents) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ESTROGEN-PROGESTIN WITH ANTI-MINERALOCORTICOID COMB		
ANGELIQ	T3	HD
ESTROGEN-SELECTIVE ESTROGEN RECEPTOR MOD (SERM) COMB		
DUAVEE	T2	
GLUCOCORTICOIDS		
budesonide	T1	PA QL (56 tabs/180 days)
budesonide (Entocort Ec)	T1	
cortisone acetate	T1	
deflazacort (Emflaza)	T1	PA SP HD
dexamethasone	T1	
dexamethasone sodium phosph/pf	T1	
EMFLAZA	T3	PA SP HD
ENTOCORT EC (budesonide ec)	T3	
hydrocortisone (Cortef)	T1	
LOCORT	T1	
MEDROL 16 MG TABLET (methylprednisolone)	T3	
MEDROL 2 MG TABLET	T2	
MEDROL 32 MG TABLET (methylprednisolone)	T3	
MEDROL 4 MG DOSEPAK (methylprednisolone)	T3	
MEDROL 4 MG TABLET (methylprednisolone)	T3	
MEDROL 8 MG TABLET (methylprednisolone)	T3	
methylprednisolone (Medrol)	T1	
MILLIPRED 10 MG/5 ML SOLUTION (prednisolone sodium phosphate)	T3	
millipred 5 mg tablet	T1	
ORAPRED ODT (prednisolone sodium phos odt)	T3	
prednisolone	T1	
prednisolone sodium phosphate	T1	
prednisolone sodium phosphate (Millipred)	T1	
prednisolone sodium phosphate (Orapred Odt)	T1	
prednisone	T1	
GROWTH HORMONE RELEASING HORMONE (GHRH) AND ANALOGS		
EGRIFTA	T3	PA SP HD
EGRIFTA SV	T3	PA SP HD

T1 – Typically Generics

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List of Prescription Medications

HORMONES (Hormonal Agents) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
GROWTH HORMONES		
GENOTROPIN	T3	PA SP HD
NORDITROPIN FLEXPRO	T3	PA SP HD
OMNITROPE	T3	PA SP HD
SEROSTIM	T3	PA SP
SKYTROFA	T3	SP HD
SOGROYA	T3	PA SP
INSULIN-LIKE GROWTH FACTOR-I (IGF-I) HORMONES		
INCRELEX	T3	PA SP HD
LHRH (GNRH) AGONIST ANALOG AND PROGESTIN COMB		
LUPANETA PACK	T3	PA SP HD
LHRH (GNRH) AGONIST ANALOG PITUITARY SUPPRESSANTS		
LUPRON DEPOT	T3	PA SP HD
TRIPTODUR	T3	PA SP
SYNAREL	T3	PA SP HD
LHRH (GNRH) ANTAGONIST, ESTROGEN AND PROGESTIN COMB		
MYFEMBREE	T2	PA QL (24 month therapy)
ORIAHNN	T2	PA QL (2 capsules/day)
LHRH (GNRH) ANTAGONIST, PITUITARY SUPPRESSANT AGENTS		
CETROTIDE	T3	PA SP
ganirelix acet 250 mcg/0.5 ml (Ganirelix Acetate)	T3	PA SP
GANIRELIX ACET 250 MCG/0.5 ML (ganirelix acetate)	T3	PA SP
ORLISSA 150 MG TABLET	T2	PA QL (1 tab/day)
ORLISSA 200 MG TABLET	T2	PA QL (6 months therapy/lifetime)
LHRH (GNRH) AGNST PIT.SUP-CENTRAL PRECOCIOUS PUBERTY		
FENSOLVI	T3	PA SP
LUPRON DEPOT-PED	T3	PA SP HD
MINERALOCORTICOIDS		
fludrocortisone acetate	T1	HD
OXYTOCICS		
carboprost 250 mcg/ml ampul (Hemabate)	T1	
CARBOPROST 250 MCG/ML SYRINGE	T3	
CERVIDIL	T3	
methylergonovine maleate	T1	
PREPIDIL	T3	

T1 – Typically Generics

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T3 – Typically Non-Preferred Brands

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List of Prescription Medications

HORMONES (Hormonal Agents) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
OXYTOCICS (cont.)		
PROSTIN E2 VAGINAL SUPPOSITORY	T3	
PARATHYROID HORMONES		
YORVIPATH	T3	
PITUITARY SUPPRESSIVE AGENTS		
<i>cabergoline</i>	T1	QL (16 tabs/28 days) HD
CRENESSITY 50 MG CAPSULE	T3	PA QL(2 caps/day) SP
CRENESSITY 100 MG CAPSULE	T3	PA QL SP
CRENESSITY 50 MG/ML SOLUTION	T3	PA QL(8 mls/day) SP
<i>danazol</i>	T1	HD
PROGESTATIONAL AGENTS		
AYGESTIN (<i>norethindrone acetate</i>)	T3	HD
CRINONE 4% GEL	T3	PA HD
DEPO-PROVERA 400 MG/ML VIAL	T3	HD
<i>hydroxyprogesterone</i>	T1	HD
<i>medroxyprogesterone 10 mg tab</i> (Provera)	T1	HD
<i>medroxyprogesterone 2.5 mg tab</i> (Provera)	T1	HD
<i>medroxyprogesterone 5 mg tab</i> (Provera)	T1	HD
<i>norethindrone acetate</i> (Aygestin)	T1	HD
<i>progesterone, micronized</i> (Prometrium)	T1	HD
SOMATOSTATIC AGENTS		
LANREOTIDE	T3	PA SP HD
<i>lanreotide 120 mg/0.5 ml syring</i>	T1	PA SP HD
<i>octreotide acetate</i> (Sandostatin)	T1	PA SP HD
SANDOSTATIN (<i>octreotide acetate</i>)	T3	PA SP HD
SANDOSTATIN LAR DEPOT	T3	PA SP
SIGNIFOR	T3	PA SP
SIGNIFOR LAR	T3	PA SP
SOMATULINE DEPOT	T3	PA SP HD
VAGINAL ESTROGEN FOR SEXUAL DYSFUNCTION		
IMVEXXY 10 MCG MAINTENANCE PAK	T3	QL (16/28 days) HD
IMVEXXY 10 MCG STARTER PACK	T3	QL (36/28 days) HD
IMVEXXY 4 MCG MAINTENANCE PACK	T3	QL (16/28 days) HD
IMVEXXY 4 MCG STARTER PACK	T3	QL (36/28 days) HD

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

PA – Prior Authorization

QL – Quantity Limit

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List of Prescription Medications

HORMONES (Hormonal Agents) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
VAGINAL ESTROGEN PREPARATIONS (cont.)		
ESTRACE (estradiol)	T3	HD
estradiol	T1	QL (36 tabs/28 days) HD
estradiol 0.01% cream	T1	HD
estradiol 10 mcg vaginal insrt	T1	QL (36 tabs/28 days) HD
ESTRING	T2	QL (2 rings/90 days) HD
FEMRING	T3	HD
PREMARIN	T2	HD
VAGIFEM (yuvafem)	T3	QL (36 tabs/28 days)
HORMONES (Infertility)		
FERTILITY STIMULATING PREPARATIONS, NON-FSH		
clomiphene citrate	T1	
FOLLICLE-STIMULATING AND LUTEINIZING HORMONES		
MENOPUR	T3	PA SP
FOLLICLE-STIMULATING HORMONE (FSH)		
FOLLISTIM AQ	T3	PA SP
GONAL-F	T3	PA SP
GONAL-F RFF	T3	PA SP
GONAL-F RFF REDI-JECT	T3	PA SP
HUMAN CHORIONIC GONADOTROPIN (HCG)		
CHORIONIC GONAD 10,000 UNIT VL	T3	PA SP
CHORIONIC GONAD 12,000 UNIT VL	T3	SP
NOVAREL	T3	PA SP
PREGNYL	T3	PA SP
PREGNANCY FACILITATING/MAINTAINING AGENT, HORMONAL		
CRINONE 8% GEL	T2	
ENDOMETRIN	T3	
hydroxyprogesterone 1,250 mg/5 ml	T1	PA
hydroxyprogesterone 250 mg/ml vial	T1	PA
MAKENA	T3	PA
HORMONES (Miscellaneous)		
LEPTIN HORMONE ANALOGS		
MYALEPT	T3	PA SP HD
HORMONES (Osteoporosis Products)		
BONE FORMATION STIMULATING AGTS - PTH REL PEPTIDES		
teriparatide 600 mcg/2.4ml pen	T1	PA QL(0.09 mls/day) SP HD
TERIPARATIDE 620 MCG/2.48 ML	T3	PA QL(0.09 mls/day) SP HD

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

PA – Prior Authorization

QL – Quantity Limit

ST – Step Therapy

AGE – Age Requirement

SP – Specialty Medication

HD – May require home delivery pharmacy

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CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

HORMONES (Osteoporosis Products) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits	
BONE RESORPTION INHIBITORS			
calcitonin, salmon, synthetic			
RECLAST 5 MG/100 ML SOLUTION	T1	HD	
MIACALCIN	T3		
zoledronic acid 4 mg vial	T2	HD	
ZOLEDRONIC ACID 4MG/100ML	T3		
IMMUNOSUPPRESSANTS (Pain Relief And Inflammatory Disease)			
IL-23 RECEPTOR ANTAGONIST, MONOCLONAL ANTIBODY			
OMVOH 100 MG/ML SYRINGE	T2	PA QL SP HD	
OMVOH 300 MG/15 ML VIAL	T2	PA SP HD	
INTERLEUKIN-4(IL-4) RECEPTOR ALPHA ANTAGONIST, MAB			
DUPIXENT PEN	T3	PA SP HD	
DUPIXENT SYRINGE	T3	PA SP HD	
INTERLEUKIN-6 (IL-6) RECEPTOR INHIBITORS			
ACTEMRA	T3	PA QL (4 syringes/28 days) SP HD	
ACTEMRA ACTPEN	T3	PA QL (4 pens/28 days) SP HD	
ENSPRYNG	T3	PA SP HD	
KEVZARA 150 MG/1.14 ML PEN INJ	T3	PA QL (2 pens/28 days) SP HD	
KEVZARA 150 MG/1.14 ML SYRINGE	T3	PA QL (2 syringes/28 days) SP HD	
KEVZARA 200 MG/1.14 ML PEN INJ	T3	PA QL (2 pens/28 days) SP HD	
KEVZARA 200 MG/1.14 ML SYRINGE	T3	PA QL (2 syringes/28 days) SP HD	
TYENNE	T3	PA SP	
TYENNE AUTOINJECTOR	T3	PA QL(3.6 ml/28 days) SP	
MONOCLONAL ANTIBODY-HUMAN INTERLEUKIN 12/23 INHIB			
STELARA 45 MG/0.5 ML SYRINGE	T3	PA QL (1 syringe/84 days) SP HD	
STELARA 45 MG/0.5 ML VIAL	T3	PA QL (1 vial/84 days) SP HD	
STELARA 90 MG/ML SYRINGE	T3	PA QL (1 syringe/84 days) SP HD	
USTEKINUMAB-TTWE	T2	PA QL(1 syringe/84 days) SP HD	
YESINTEK	T2	PA QL(1 syringe/84 days) SP	
IMMUNOSUPPRESSANTS (Skin Conditions)			
TOPICAL IMMUNOSUPPRESSIVE AGENTS			
ELIDEL (<i>pimecrolimus</i>)	T3		
NEMLUVIO	T2	PA SP	
<i>pimecrolimus</i> (Elidel)	T1		
PROTOPIC (<i>tacrolimus</i>)	T3		
<i>tacrolimus ointment</i> (Protopic)	T1		
T1 – Typically Generics	PA – Prior Authorization	AGE – Age Requirement	PPACA – No Cost-Share Preventive Medication
T2 – Typically Preferred Brands	QL – Quantity Limit	SP – Specialty Medication	CSL – Oral cancer medication subject to cost-share limits
T3 – Typically Non-Preferred Brands	ST – Step Therapy	HD – May require home delivery pharmacy	

List of Prescription Medications

IMMUNOSUPPRESSANTS (Transplant Medications)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
IMMUNOSUPPRESSIVES		
ASTAGRAF XL	T3	SP HD
AZASAN	T3	SP HD
<i>azathioprine</i> (Imuran)	T3	SP HD
CELLCEPT (<i>mycophenolate mofetil</i>)	T3	SP HD
<i>cyclosporine</i> (Sandimmune)	T3	SP HD
<i>cyclosporine, modified</i> (Neoral)	T3	SP HD
ENVARSUS XR	T3	SP HD
<i>everolimus 0.25 mg tablet</i> (Zortress)	T3	SP HD
<i>everolimus 0.5 mg tablet</i> (Zortress)	T3	SP HD
<i>everolimus 0.75 mg tablet</i> (Zortress)	T3	SP HD
IMURAN (<i>azathioprine</i>)	T3	SP HD
LUPKYNIS	T3	PA QL(6 caps/day) SP
<i>mycophenolate mofetil</i> (Cellcept)	T3	SP HD
<i>mycophenolate sodium</i> (Myfortic)	T1	SP HD
PROGRAF	T3	SP HD
PROGRAF (<i>tacrolimus</i>)	T3	SP HD
<i>sirolimus</i> (Rapamune)	T1	SP HD
<i>tacrolimus ointment</i>	T1	
<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 (<i>everolimus</i>)	T3	SP HD
IMMUNOSUPP - MONOCLONAL AB INHIBITING T LYMPH FXN		
SIMULECT	T2	SP
MISCELLANEOUS MEDICAL SUPPLIES, DEVICES, NON-DRUG (Diabetes)		
DIABETIC SUPPLIES		
2TEK CONTROL SOLUTION	T1	
2TEK GLUCOSE-WRIST MONITOR KIT	T3	
ACCU-CHEK FASTCLIX LANCING DEV	T1	
ACCU-CHEK GUIDE CONTROL SOLN	T1	
ACCU-CHEK SMARTVIEW CONTRL SOL	T1	
ACCU-CHEK SOFTCLIX	T1	

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

PA – Prior Authorization

QL – Quantity Limit

ST – Step Therapy

AGE – Age Requirement

SP – Specialty Medication

HD – May require home delivery pharmacy

PPACA – No Cost-Share Preventive Medication

CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

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

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
DIABETIC SUPPLIES (cont.)		
ACCUTREND GLUCOSE CONTROL	T1	
ADJUSTABLE LANCING DEVICE	T1	
ADVANCED LANCING DEVICE	T1	
ADVOCATE CONTROL SOLUTION	T1	
ADVOCATE LANCING DEVICE	T1	
ADVOCATE RAPID-SAFE LANCING DV	T1	
ADVOCATE REDI-CODE+ CTRL SOLN	T1	
AGAMATRIX CONTROL	T1	
ALKALINE BATTERIES	T1	
ALTERNATE SITE LANCING DEVICE	T1	
AQUA LANCE LANCING DEVICE	T1	
ASSURE 4 CONTROL SOLUTION	T1	
ASSURE DOSE	T1	
ASSURE PRISM	T1	
AT HOME A1C	T1	
AUTOJECT 2	T1	
AUTO-LANCET MINI	T1	
AUTOLET IMPRESSION	T1	
AUTOLET LANCING DEVICE	T1	
AUTOLET PLUS	T1	
BLOOD GLUCOSE CONTROL	T1	
BLULINK DIABETIC TEST BUNDLE	T3	
BLULINK GLUCOSE MONITOR SYST	T3	
BREEZE 2	T1	
CAREONE	T1	
CARESENS	T1	
CARETOUCH CONTROL SOLUTION	T1	
CARETOUCH LANCING DEVICE	T1	
CEQUR SIMPLICITY	T2	
CHEMSTRIP BG DIARY	T1	
CHOSEN LANCING DEVICE	T1	
CLEVER CHOICE CONTROL SOLUTION	T1	
CONTOUR METER	T3	
CONTOUR PLUS BLUE	T3	

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-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
DIABETIC SUPPLIES (cont.)		
CONTOUR NEXT CONTROL SOLUTION	T1	
CONTOUR SOLUTION	T1	
COOL CONTROL SOLUTION	T1	
DEXCOM G6 RECEIVER	T2	PA QL (1 syringe/365 days)
DEXCOM G6 SENSOR	T2	PA QL (3/30 days)
DEXCOM G6 TRANSMITTER	T2	PA QL (1 syringe/67 days)
DEXCOM G7 RECEIVER	T2	PA QL(1 unit/365 days)
DEXCOM G7 SENSOR	T2	PA QL(3 sensors/30 days)
DIATRUE	T1	
DROPLET GENTEL LANCING DEVICE	T1	
DROPLET LANCING DEVICE	T1	
EASY MINI EJECT LANCING DEVICE	T1	
EASY PLUS II CONTROL SOLN HIGH	T1	
EASY PLUS II CONTROL SOLN LOW	T1	
EASY STEP CONTROL SOLUTION	T1	
EASY TALK CONTROL SOLN LOW	T1	
EASY TALK HIGH CONTROL SOLN	T1	
EASY TALK PLUS II HIGH CONTROL	T1	
EASY TALK PLUS II LOW CTRL SLN	T1	
EASY TOUCH BLULINK CTRL SOLN	T1	
EASY TOUCH CONTROL SOLUTION	T1	
EASY TOUCH LANCING DEVICE	T1	
EASY TRAK CONTROL SOLN HIGH	T1	
EASY TRAK CONTROL SOLN LOW	T1	
EASY TRAK II CONTROL SOLUTION	T1	
EASYGLUCO PLUS CONTROL NORMAL	T1	
EASymax	T1	
EASymax NORMAL CONTROL SOLN	T1	
ELEMENT COMPACT CONTROL SOLN	T1	
ELEMENT CONTROL SOLUTION	T1	
EMBRACE EVO LEVEL 1 CTRL SOLN	T1	
EMBRACE GLUC CONTROL SOLN HIGH	T1	
EMBRACE GLUCOSE CONTROL SOLN	T1	
EMBRACE LANCING DEVICE	T1	

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-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
DIABETIC SUPPLIES (cont.)		
EMBRACE PRO	T1	
EMBRACE TALK CONTROL SOLUTION	T1	
EMBRACE WAVE PLUS GLUCOSE MTR	T3	
ENLITE SERTER	T1	
EVENCARE G2 CONTROL SOLUTION	T1	
EVENCARE G3 CONTROL SOLUTION	T1	
EVOLUTION CONTROL SOLUTION	T1	
EZ-VAC	T1	
FORA CONTROL SOLUTION	T1	
FORA LANCING DEVICE	T1	
FORA TN'GO ADVANCE MULTIFN MTR	T3	
FORACARE GDH	T1	
FORTISCARE	T1	
FREESTYLE CONTROL SOLUTION	T1	
FREESTYLE LIBRE 2 PLUS SENSOR	T2	PA QL(2 units/30 days)
FREESTYLE LIBRE 2 READER	T2	PA QL (1 reader/day)
FREESTYLE LIBRE 2 SENSOR	T2	PA QL (2 sensors/21 days)
FREESTYLE LIBRE 3 PLUS SENSOR	T2	PA QL(2 units/28 days)
FREESTYLE LIBRE 10 DAY READER	T2	PA QL (1 reader/day)
FREESTYLE LIBRE 10 DAY SENSOR	T2	PA QL (3/30 days)
FREESTYLE LIBRE 14 DAY READER	T2	PA QL (1 reader/day)
FREESTYLE LIBRE 14 DAY SENSOR	T2	PA QL (2/28 days)
FREESTYLE TEST STRIP	T2	
GE100 CONTROL SOLUTION NORMAL	T1	
GE333 BLOOD GLUCOSE SYSTEM	T3	
GENTEEL VACUUM LANCING DEVICE	T1	
GLUCOCARD 01 CONTROL	T1	
GLUCOCARD EXPRESSION CNTRL SLN	T1	
GLUCOCARD SHINE CONTROL SOLN	T1	
GLUCOCOM AUTOLINK	T1	
GLUCOCOM CONTROL SOLUTION	T1	
GLUCOSE CONTROL	T1	
GOJJI GLUCOSE CONTROL SOLUTION	T1	
GOJJI LANCING DEVICE	T1	
GUARDIAN RT CHARGER	T1	
GUARDIAN RT STARTER KIT	T1	
GUARDIAN RT SYSTEM	T1	

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-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
DIABETIC SUPPLIES (cont.)		
GUARDIAN TEST PLUG	T1	
GUARDIAN TRANSMITTER TAPE	T1	
HEALTHPRO GLUCOSE CONTROL SOLN	T1	
HEALTHY ACCENTS AUTOLET	T1	
HUMAPEN LUXURA HD	T1	
HYPOLANCE	T1	
IHEALTH CONTROL SOLN LEVEL 2	T1	
IHEALTH GLUCO PLUS METER	T3	
INCONTROL LANCING DEVICE	T1	
INFINITY CONTROL SOLUTION	T1	
INFINITY VOICE CONTROL SOLN	T1	
INPEN (FOR HUMALOG)	T1	
INPEN (FOR NOVOLOG OR FIASP)	T1	
INSUL-CAP	T1	
INSUL-EZE	T1	
LANCING DEVICE	T1	
LANCING SYSTEM	T1	
LANZO	T1	
LITE TOUCH	T1	
MAGNI-GUIDE MAGNIFIER	T1	
MEDISENSE	T1	
MEDISENSE GLUCOSE KETONE	T1	
MEDISENSE GLUCOSE KETONE CONTR	T1	
MEDTRONIC REMOTE CONTROL	T1	
MICRODOT HIGH-LOW CONTROL SOL	T1	
MICRODOT NORMAL CONTROL SOLUT	T1	
MICROLET 2	T1	
MICROLET NEXT LANCING DEVICE	T1	
MINI LANCING DEVICE	T1	
MINIMED QUICK-SERTER	T1	
MOBILE LANCETS	T2	
MULTI-LANCET	T1	
MYGLUCOHEALTH CONTROL SOLUTION	T1	
NOVAMAX PLUS GLU-KET	T1	
NOVOPEN ECHO	T1	
OMNIPOD 5 (G6/LIBRE 2 PLUS)	T2	QL(30 CRTGS/30 DAYS)

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-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
DIABETIC SUPPLIES (cont.)		
OMNIPOD 5 DEXG7G6 INTRO(GEN 5)	T2	QL(1 UNIT/365 DAYS)
OMNIPOD 5 DEXG7G6 PODS (GEN 5)	T2	QL(30 CRTGS/30 DAYS)
OMNIPOD 5 INTRO(G6/LIBRE2PLUS)	T2	QL
ON CALL EXPRESS CONTROL SOLN	T1	
ON CALL LANCING DEVICE	T1	
ON CALL PLUS CONTROL	T1	
ON CALL PLUS LANCING DEVICE	T1	
ON CALL VIVID CONTROL	T1	
ONETOUCH DELICA PLUS LANC DEV	T1	
ONETOUCH ULTRA CONTROL SOLN	T1	
ONETOUCH ULTRASOFT 2 LANCET	T2	
ONETOUCH VERIO HIGH CNTRL SOLN	T1	
ONETOUCH VERIO MID CNTRL SOLN	T1	
OPTUMRX GLUCOSE CONTROL SOLN	T1	
OVAL TAPE	T1	
PIP GLUCOSE CONTROL SOLUTION	T1	
PRO COMFORT SAFETY LANCET	T2	
PRODIGY CONTROL SOLUTION	T1	
PRODIGY LANCING DEVICE	T1	
REFUAH PLUS GLUCOSE CONTROL	T1	
RELIAMED MINI LANCING DEVICE	T1	
REPLACEMENT PEDIATRIC MONITOR	T1	
RIGHTEST CONTROL SOLUTION	T1	
RIGHTEST GD500	T1	
SAFE-CLIP	T1	
SEN-SERTER	T1	
SIL-SERTER	T1	
SMARTDIABETES VANTAGE	T1	
SMARTTEST	T1	
SOLUS V2 CONTROL SOLUTION	T1	
SOLUS V2 LANCING DEVICE	T1	
SURE COMFORT LANCING PEN	T1	
SUREFLEX	T1	
SURE-PEN	T1	

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

PA – Prior Authorization

QL – Quantity Limit

ST – Step Therapy

AGE – Age Requirement

SP – Specialty Medication

HD – May require home delivery pharmacy

PPACA – No Cost-Share Preventive Medication

CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

MISCELLANEOUS MEDICAL SUPPLIES, DEVICES, NON-DRUG (Diabetes) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
DIABETIC SUPPLIES (cont.)		
SURE-TEST EASYPLUS MINI SOLN	T1	
TELCARE CONTROL SOLUTION	T1	
TRUE METRIX	T1	
TRUECONTROL	T1	
TRUEDRAW	T1	
ULTI-LANCE	T1	
ULTRATRAK CONTROL SOLUTION	T1	
ULTRATRAK ULTIMATE CNTRL SOLN	T1	
UNISTIK 2	T1	
UNISTIK 3	T1	
UNISTIK 3 COMFORT	T1	
UNISTIK 3 NEONATAL	T1	
UNISTRIP	T1	
VERASENS CONTROL SOLUTION	T1	
V-GO 20	T2	
V-GO 30	T2	
V-GO 40	T2	
VIVAGUARD INO CONTROL SOLUTION	T1	
VIVAGUARD LANCING DEVICE	T1	
WAVESENSE CONTROL SOLUTION	T1	
DURABLE MEDICAL EQUIPMENT,MISC (GROUP I)		
CHOSEN LANCET	T1	
CHOSEN SAFETY LANCET	T1	
PERFECT POINT SAFETY LANCETS		
NEEDLES/NEEDLELESS DEVICES		
1ST TIER UNIFINE PENTIPS	T1	
1ST TIER UNIFINE PENTIPS PLUS	T1	
ABOUTTIME PEN NEEDLE	T1	
ADVOCATE PEN NEEDLES	T1	
AQINJECT PEN NEEDLE	T1	
ASSURE ID PEN NEEDLE	T1	
AUTOSHIELD DUO PEN NEEDLE	T1	
BLUNT NEEDLE	T1	
CAREFINE PEN NEEDLE	T1	
CARETOUCH HYPODERMIC NEEDLE	T1	

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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
NEEDLES/NEEDLELESS DEVICES (cont.)		
CARETOUCH PEN NEEDLE	T1	
CLICKFINE	T1	
COMFORT EZ PEN NEEDLE	T1	
COMFORT EZ PRO SAFETY PEN NDL	T1	
COMFORT TOUCH PEN NEEDLE	T1	
DROPLET MICRON PEN NEEDLE	T1	
DROPLET PEN NEEDLE	T1	
DROPSAFE PEN NEEDLE	T1	
EASY COMFORT PEN NEEDLE	T1	
EASY COMFORT PEN NEEDLES	T1	
EASY GLIDE PEN NEEDLE	T1	
EASY TOUCH FLIPLOCK NEEDLE	T1	
EASY TOUCH FLIPLOCK NEEDLES	T1	
EASY TOUCH HYPODERMIC NEEDLE	T1	
EASY TOUCH PEN NEEDLE	T1	
EASY TOUCH SAFETY PEN NEEDLE	T1	
EASYPPOINT NEEDLE	T1	
ECLIPSE NEEDLE	T1	
EMBRACE PEN NEEDLE	T1	
EXEL HUBER NEEDLE	T1	
EXEL HYPODERMIC NEEDLE	T1	
FILTER ASPIRATOR NEEDLE	T1	
FILTER NEEDLE	T1	
FLOW-EZE	T1	
HEALTHWISE PEN NEEDLE	T1	
HEALTHY ACCENTS UNIFINE PENTIP	T1	
HYPODERMIC NEEDLE	T1	
INCONTROL PEN NEEDLE	T1	
INSULIN PEN NEEDLE	T1	
INSUPEN	T1	
INSUPEN PEN NEEDLE	T1	
INTEGRA NEEDLE	T1	
INTEGRA PRECISIONGLIDE NEEDLE	T1	
LIFESHIELD BLUNT CANNULA	T1	

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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
NEEDLES/NEEDLELESS DEVICES (cont.)		
LITE TOUCH	T1	
MAXICOMFORT II PEN NEEDLE	T1	
MAXICOMFORT SAFETY PEN NEEDLE	T1	
MICRODOT INSULIN PEN NEEDLE	T1	
MINI PEN NEEDLE	T1	
MINI ULTRA-THIN II	T1	
MONOJECT BLOOD COLLECTION	T1	
MONOJECT FILTER NEEDLE	T1	
NANO 2ND GEN PEN NEEDLE	T1	
NEEDLES	T1	
needles,safety huber,disposable	T1	
NOKOR ADMIX NEEDLE	T1	
NOKOR NEEDLE	T1	
NOVOFINE 32	T1	
NOVOFINE AUTOCOVER	T1	
NOVOFINE PLUS	T1	
NOVOTWIST	T1	
PEN NEEDLES	T1	
PENTIPS	T1	
PHASEAL PROTECTOR	T1	
PIP PEN NEEDLE	T1	
POLY HUB NEEDLE	T1	
PRECISIONGLIDE	T1	
PREVENT DROPSAFE PEN NEEDLE	T1	
PRO COMFORT PEN NEEDLE	T1	
PURE COMFORT PEN NEEDLE	T1	
PURE COMFORT SAFETY PEN NEEDLE	T1	
RAYA SURE PEN NEEDLE	T1	
REGULAR BEVEL NEEDLES	T1	
RELION PEN NEEDLES	T1	
SAFETY PEN NEEDLE	T1	
SAFETYGLIDE NEEDLE	T1	
SECURESAFE PEN NEEDLE	T1	
SHORT BEVEL NEEDLES	T1	

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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.)		
SKY SAFETY PEN NEEDLE	T1	
SPECIALTY USE NEEDLES	T1	
SURE COMFORT	T1	
SURE COMFORT PEN NEEDLE	T1	
SURE COMFORT SAFETY PEN NEEDLE	T1	
SURE-FINE PEN NEEDLES	T1	
TECHLITE PEN NEEDLE	T1	
TERUMO SURGUARD2	T1	
TERUMO SURGUARD2	T1	
THIN WALL NEEDLES	T1	
TOPCARE CLICKFINE	T1	
TRANSFER NEEDLE	T1	
TRUE COMFORT PEN NEEDLE	T1	
TRUE COMFORT PRO PEN NEEDLE	T1	
TRUE COMFORT SAFETY PEN NEEDLE	T1	
TRUEPLUS PEN NEEDLE	T1	
ULTICARE PEN NEEDLE	T1	
ULTICARE SAFETY PEN NEEDLE	T1	
ULTIGUARD SAFEPACK-PEN NEEDLE	T1	
ULTILET PEN NEEDLE	T1	
ULTRA FLO PEN NEEDLE	T1	
ULTRA THIN	T1	
ULTRACARE PEN NEEDLE	T1	
ULTRA-FINE MICRO PEN NEEDLE	T1	
ULTRA-FINE MINI PEN NEEDLE	T1	
ULTRA-FINE NANO PEN NEEDLE	T1	
ULTRA-FINE ORIGINAL PEN NEEDLE	T1	
ULTRA-FINE SHORT PEN NEEDLE	T1	
ULTRA-THIN II	T1	
UNIFINE PEN NEEDLE	T1	
UNIFINE PENTIPS	T1	
UNIFINE PENTIPS PLUS	T1	
UNIFINE PENTIPS PLUS MAXFLOW	T1	
UNIFINE SAFECONTROL	T1	

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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.)		
UNIFINE ULTRA PEN NEEDLE	T1	
VERIFINE PEN NEEDLE	T1	
VERIFINE PLUS PEN NEEDLE	T1	
YALE NEEDLES	T1	
SYRINGES AND ACCESSORIES		
ADVOCATE SYRINGES	T1	
ASSURE ID INSULIN SAFETY	T1	
CARETOUCH INSULIN SYRINGE	T1	
COMFORT EZ INSULIN SYRINGE	T1	
DROPLET INSULIN SYRINGE	T1	
DROPSAFE INSULIN SYRINGE	T1	
EASY COMFORT INSULIN SYRINGE	T1	
EASY GLIDE INSULIN SYRINGE	T1	
EASY TOUCH	T1	
EASY TOUCH FLIPLOCK INSULIN	T1	
EASY TOUCH INSULIN SAFETY	T1	
EASY TOUCH INSULIN SYRINGE	T1	
EASY TOUCH LUER LOCK INSULIN	T1	
EASY TOUCH SHEATHLOCK INSULIN	T1	
EASY TOUCH UNI-SLIP	T1	
EASY-TOUCH INSULIN SYRINGE	T1	
ECLIPSE SYRINGE	T1	
FREESTYLE PRECISION	T1	
HEALTHWISE INSULIN SYRINGE	T1	
INSULIN SYRINGE	T1	
INSULIN SYRINGE U-500	T1	
LITE TOUCH	T1	
LITETOUCH INSULIN SYRINGE	T1	
LUER-LOK SYRINGE	T1	
MAGELLAN INSULIN SAFETY SYRNG	T1	
MAGELLAN INSULIN SYRINGE	T1	
MAXI-COMFORT	T1	
MAXICOMFORT INSULIN SYRINGE	T1	
MINIMED RESERVOIR 1.8 ML	T1	

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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.)		
MINIMED RESERVOIR 3 ML	T3	
MONOJECT	T1	
MONOJECT INSULIN SAFETY SYRNG	T1	
MONOJECT INSULIN SYRINGE	T1	
PARADIGM RESERVOIR 1.8 ML	T1	
PARADIGM RESERVOIR 3 ML	T3	
PRO COMFORT INSULIN SYRINGE	T1	
PRODIGY INSULIN SYRINGE	T1	
SAFESNAP INSULIN SYRINGE	T1	
SAFETYGLIDE INSULIN SYRINGE	T1	
SECURESAFE INSULIN SYRINGE	T1	
SURE COMFORT	T1	
SURE COMFORT INSULIN SYRINGE	T1	
SURE-JECT INSULIN SYRINGE	T1	
<i>syringe and needle,insulin,1ml</i>	T1	
<i>syringe-needle,insulin,0.5 ml</i>	T1	
<i>syring-needl,disp,insul,0.3 ml</i>	T1	
TECHLITE INSULIN SYRINGE	T1	
TERUMO INSULIN SYRINGE	T1	
THINPRO INSULIN SYRINGE	T1	
TOPCARE ULTRA COMFORT	T1	
TRUE COMFORT INSULIN SYRINGE	T1	
TRUE COMFORT PRO INS SYRINGE	T1	
TRUEPLUS INSULIN SYRINGE	T1	
ULTICARE INSULIN SYRINGE	T1	
ULTIGUARD SAFE 1ML 30G 12.7MM	T3	
ULTIGUARD SAFE0.3ML 30G 12.7MM	T3	
ULTIGUARD SAFE0.5ML 30G 12.7MM	T1	
ULTIGUARD SAFEPACK 1ML 31G 8MM	T3	
ULTIGUARD SAFEPK 0.3ML 31G 8MM	T3	
ULTIGUARD SAFEPK 0.5ML 31G 8MM	T1	
ULTILET INSULIN SYRINGE	T1	
ULTRA COMFORT	T1	
ULTRA FLO INSULIN SYRINGE	T1	

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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.)		
ULTRACARE INSULIN SYRINGE	T1	
ULTRA-THIN II	T1	
VANISHPOINT	T1	
VANISHPOINT INSULIN SYRINGE	T1	
VEO INSULIN SYRINGE	T1	
VERIFINE INSULIN SYRINGE	T1	

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

DURABLE MEDICAL EQUIPMENT,MISC (GROUP I)		
1ST TIER UNILET COMFORTOUCH	T1	
2-IN-1 LANCET DEVICE	T1	
ACCU-CHEK FASTCLIX LANCET DRUM	T1	
ACCU-CHEK SAFE-T-PRO	T1	
ACCU-CHEK SAFE-T-PRO PLUS	T1	
ACCU-CHEK SOFTCLIX	T1	
ACTI-LANCE	T1	
ADVANCED TRAVEL LANCETS	T1	
ADVOCATE LANCETS	T1	
ALTERNATE SITE LANCETS	T1	
ASSURE HAEMOLANCE PLUS	T1	
ASSURE LANCE	T1	
ASSURE LANCE PLUS	T1	
BD MICROTAINER LANCETS	T1	
BD ULTRA-FINE	T1	
BD ULTRA-FINE II	T1	
BLOOD LANCETS	T1	
BLULINK BG SYSTEM REFILL	T3	
BULLSEYE MINI SAFETY LANCETS	T1	
BUTTERFLY TOUCH LANCET	T1	
CAREONE	T1	
CARETOUCH TWIST LANCET	T1	
CLEVER CHEK LANCETS	T1	
COAGUCHEK	T1	
COLOR LANCETS	T1	
COMFORT EZ	T1	

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List of Prescription Medications

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

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
DURABLE MEDICAL EQUIPMENT,MISC (GROUP I) (cont.)		
COMFORT LANCETS	T1	
COMFORT TOUCH PLUS SAFETY LANC	T1	
COMFORT TOUCH ULT THIN LANCET	T1	
DROPLET LANCETS	T1	
EASY COMFORT LANCETS	T1	
EASY TOUCH	T1	
EASY TWIST & CAP LANCETS	T1	
EMBRACE 30G LANCETS	T1	
EMBRACE SAFETY LANCET	T1	
EZ SMART LANCETS	T1	
EZ-LETS	T1	
FIFTY50 SAFETY SEAL LANCETS	T1	
FINE 30 UNIVERSAL LANCETS	T1	
FINGERSTIX	T1	
FORA LANCETS	T1	
FORACARE LANCETS	T1	
FREESTYLE UNISTIK 2	T1	
GLUCOCOM LANCETS	T1	
GOJJI LANCETS	T1	
HEALTHY ACCENTS UNILET LANCET	T1	
INCONTROL SUPER THIN LANCETS	T1	
INCONTROL ULTRA THIN LANCETS	T1	
INJECT EASE LANCETS	T1	
INVACARE LANCETS	T1	
/lancets	T1	
LANCETS	T1	
LANCETS THIN	T1	
LANCETS ULTRA THIN	T1	
LITE TOUCH	T1	
MEDISENSE THIN LANCETS	T1	
MEDLANCE PLUS	T1	
MEDLANCE PLUS SPECIAL BLADE	T1	
MICRO THIN LANCETS	T1	
MICROLET	T1	

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List of Prescription Medications

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

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

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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.)		
SMART SENSE LANCETS	T1	
SMARTEST LANCET	T1	
SOLUS V2 28G LANCETS	T1	
SOLUS V2 LANCETS	T1	
STERILANCE TL	T1	
STERILE LANCETS	T1	
SUPER THIN LANCETS	T1	
SURE COMFORT LANCETS	T1	
SURE-LANCE	T1	
SURE-TOUCH	T1	
TECHLITE LANCETS	T1	
TEL CARE ULTRA THIN 30G LANCETS	T1	
THIN LANCETS	T1	
TOPCARE UNIVERSAL1 LANCET	T1	
TOPCARE UNIVERSAL1 THIN LANCET	T1	
TRUE COMFORT LANCET	T1	
TRUE COMFORT SAFETY LANCET	T1	
TRUEPLUS LANCETS	T1	
TWIST LANCETS	T1	
TWIST TOP LANCET	T1	
ULTILET BASIC	T1	
ULTILET CLASSIC	T1	
ULTILET LANCETS	T1	
ULTILET SAFETY	T1	
ULTRA THIN LANCETS	T1	
ULTRA THIN PLUS LANCETS	T1	
ULTRA-CARE LANCETS	T1	
ULTRALANCE	T1	
ULTRA-THIN II	T1	
ULTRATLC LANCETS	T1	
UNILET COMFORTOUCH	T1	
UNILET EXCELITE	T1	

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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.)		
UNILET EXCELITE II	T1	
UNILET GP LANCET	T1	
UNILET LANCET	T1	
UNISTIK 3	T1	
UNISTIK 3 EXTRA	T1	
UNISTIK 3 NORMAL	T1	
UNISTIK COMFORT	T1	
UNISTIK CZT	T1	
UNISTIK EXTRA	T1	
UNISTIK NORMAL	T1	
UNISTIK PRO	T1	
UNISTIK SAFETY	T1	
UNISTIK TOUCH	T1	
UNIVERSAL 1	T1	
VERIFINE SAFETY LANCET MINI	T1	
VERIFINE UNIVERSAL LANCET	T1	
VIVAGUARD LANCET	T1	
NEEDLES/NEEDLELESS DEVICES		
NEEDLES	T1	
RESPIRATORY AIDS, DEVICES, EQUIPMENT		
ACE AEROSOL CLOUD ENHANCER	T2	QL (1 unit/year)
AEROCHAMBER MINI	T2	QL (1 unit/year)
AEROCHAMBER MV	T2	QL (1 unit/year)
AEROCHAMBER PLUS FLOW-VU	T2	QL (1 unit/year)
AEROCHAMBER WITH FLOWSIGNAL	T2	QL (1 unit/year)
AEROCHAMBER Z-STAT PLUS	T2	QL (1 unit/year)
AEROTRACH PLUS	T2	QL (1 unit/year)
AEROVENT PLUS	T2	QL (1 unit/year)
BREATHERITE	T2	QL (1 unit/year)
BREATHERITE SPACER-ADULT MASK	T2	QL (1 unit/year)
BREATHERITE SPACER-INFANT MASK	T2	QL (1 unit/year)
BREATHERITE SPACER-LARGE MASK	T2	QL (1 mask/365 days)
BREATHERITE SPACER-LG CHLD MSK	T2	QL (1 unit/year)
BREATHERITE SPACER-MEDIUM MASK	T2	QL (1 mask/365 days)
BREATHERITE SPACER-NEONATE MSK	T2	QL (1 unit/year)

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

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
RESPIRATORY AIDS, DEVICES, EQUIPMENT (cont.)		
BREATHERITE SPACER-SM CHLD MSK	T2	QL (1 unit/year)
BREATHERITE SPACER-SMALL MASK	T2	QL (1 mask/365 days)
BREATHRITE	T2	QL (1 unit/year)
CLEVER CHOICE HOLDING CHAMBER	T2	QL (1 unit/year)
COMPACT SPACE CHAMBER	T2	QL (1 unit/year)
EASIVENT	T2	QL (1 unit/year)
E-Z SPACER	T2	QL (1 unit/year)
FLEXICHAMBER	T2	QL (1 unit/year)
FLEXICHAMBER MASK	T2	QL (1 unit/year)
INSPIRACHAMBER	T2	QL (1 unit/year)
LITEAIRE	T2	QL (1 unit/year)
LITETOUCH	T2	QL (1 unit/year)
MICROCHAMBER	T2	QL (1 unit/year)
MICROSPACER	T2	QL (1 unit/year)
OPTICHAMBER	T2	QL (1 unit/year)
OPTICHAMBER DIAMOND	T2	QL (1 unit/year)
POCKET CHAMBER	T2	QL (1 unit/year)
PRIMEAIRE	T2	QL (1 unit/year)
PRO COMFORT SPACER WITH MASK	T2	QL (1 unit/year)
PROCARE SPACER WITH ADULT MASK	T2	QL (1 unit/year)
PROCARE SPACER WITH CHILD MASK	T2	QL (1 unit/year)
PROCHAMBER	T2	QL (1 unit/year)
RITEFLO	T2	QL (1 unit/year)
SILICONE MASK	T2	QL (1 unit/year)
SPACE CHAMBER MASK	T2	QL (1 unit/year)
VORTEX	T2	QL (1 unit/year)
VORTEX HOLDING CHAMBER-CHILD, TODDLER	T2	QL (1 unit/year)
VORTEX VHC FROG MASK	T2	QL (1 unit/year)
VORTEX VHC LADYBUG MASK	T2	QL (1 unit/year)
SYRINGES AND ACCESSORIES		
LITE TOUCH INSULIN SYR	T1	
SURE COMFORT SYRINGE	T1	
ULTRA-THIN II	T1	
TISSUE BULKING IMPLANTS		
BARRIGEL (hyaluronate sodium, stabilized)	T3	PA SP HD

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

PA – Prior Authorization

QL – Quantity Limit

ST – Step Therapy

AGE – Age Requirement

SP – Specialty Medication

HD – May require home delivery pharmacy

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List of Prescription Medications

MUSCLE RELAXANTS (Pain Relief And Inflammatory Disease)		
SKELETAL MUSCLE RELAXANTS		
<i>baclofen</i>	T1	HD
<i>carisoprodol (Soma)</i>	T1	
<i>carisoprodol/aspirin</i>	T1	
<i>chlorzoxazone</i>	T1	
<i>cyclobenzaprine hcl</i>	T1	
<i>cyclobenzaprine hcl (Fexmid)</i>	T1	
<i>DANTRIUM (dantrolene sodium)</i>	T3	
<i>dantrolene sodium</i>	T1	
<i>dantrolene sodium (Dantrium)</i>	T1	
<i>FEXMID (cyclobenzaprine hcl)</i>	T3	
<i>FLEQSUVY (baclofen)</i>	T3	HD
<i>metaxalone</i>	T1	
<i>metaxalone (Skelaxin)</i>	T1	
<i>methocarbamol</i>	T1	
<i>orphenadrine citrate</i>	T1	
<i>OZOBAX DS</i>	T3	
<i>ROBAXIN-750 (methocarbamol)</i>	T3	
<i>SKELAXIN (metaxalone)</i>	T3	
<i>tizanidine hcl (Zanaflex)</i>	T1	
<i>ZANAFLEX (tizanidine hcl)</i>	T3	
PRE-NATAL VITAMINS (Nutritional/Dietary)		
PRENATAL VITAMIN PREPARATIONS		
<i>ATABEX EC</i>	T2	
<i>CITRANATAL 90 DHA</i>	T2	
<i>CITRANATAL ASSURE</i>	T2	
<i>CITRANATAL DHA</i>	T2	
<i>CITRANATAL HARMONY</i>	T2	
<i>CITRANATAL RX</i>	T2	
<i>OBSTETRIX EC</i>	T2	
<i>OBTREX DHA</i>	T2	
<i>pnv 22/iron, gluc/folic/dss/dha</i>	T1	
<i>pnv 66/iron/folic/docusate/dha</i>	T1	
<i>pnv 69/iron/folic/docusate/dha</i>	T1	

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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 80/iron fum/folic/dss/dha	T1	
pnv no.154/iron fum/folic acid	T1	
pnv/ferrous fum/docusate/folic	T1	
pnv/iron, carb/docusat/folic ac	T1	
prenatal 12/iron/folic/dss/om3 (Obtrex Dha)	T1	
PRENATAL 19	T1	
prenatal 34/iron/folic/dss/dha	T1	
prenatal vits15/iron/folic/dss	T1	
VITAFOL FE+	T2	
PSYCHOTHERAPEUTIC DRUGS (Anxiety/Depression/Bipolar Disorder)⁸		
ALPHA-2 RECEPTOR ANTAGONIST ANTI-DEPRESSANTS		
mirtazapine	T1	HD
mirtazapine (Remeron)	T1	HD
ANTI-ANXIETY - BENZODIAZEPINES		
alprazolam	T1	
alprazolam (Xanax Xr)	T1	
alprazolam (Xanax)	T1	
chlordiazepoxide hcl	T1	
clorazepate dipotassium	T1	
clorazepate dipotassium (Tranxene T-tab)	T1	
diazepam 10 mg tablet (Valium)	T1	
diazepam 2 mg tablet (Valium)	T1	
diazepam 5 mg tablet (Valium)	T1	
diazepam 5 mg/5 ml solution	T1	
diazepam 5 mg/ml oral conc	T1	
lorazepam	T1	
oxazepam	T1	
TRANXENE T-TAB (clorazepate dipotassium)	T3	
XANAX XR (alprazolam xr)	T3	
ANTI-ANXIETY DRUGS		
buspirone hcl	T1	
meprobamate	T1	

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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
ANTI-DEPRESSANT - NMDA RECEPTOR ANTAGONIST		
SPRAVATO	T3	PA SP
ANTIDEPRESSANT - POSTPARTUM DEPRESSION (PPD)		
ZURZUVAE 20 MG CAPSULE	T3	PA QL(28 caps/270 days) SP HD
ZURZUVAE 25 MG CAPSULE	T3	PA QL(28 caps/270 days) SP HD
BIPOLAR DISORDER DRUGS		
EQUETRO	T3	HD
<i>lithium carbonate</i> (Lithobid)	T1	HD
<i>lithium citrate</i>	T1	HD
MAOIS -NON-SELECTIVE, IRREVERSIBLE ANTI-DEPRESSANTS		
MARPLAN	T3	QL (12 tabs/day)
<i>phenelzine sulfate</i> (Nardil)	T1	
<i>tranylcypromine sulfate</i>	T1	
MONOAMINE OXIDASE (MAO) INHIBITOR ANTI-DEPRESSANTS		
EMSAM 12 MG/24 HOURS PATCH	T3	QL (1 patch/day)
EMSAM 6 MG/24 HOURS PATCH	T3	QL (2 patches/day)
EMSAM 9 MG/24 HOURS PATCH	T3	QL (1 patch/day)
NOREPINEPHRINE AND DOPAMINE REUPTAKE INHIB (NDRIs)		
<i>bupropion hcl 100 mg tablet</i>	T1	QL (4 tabs/day) HD
<i>bupropion hcl 75 mg tablet</i>	T1	QL (6 tabs/day) HD
<i>bupropion hcl sr 100 mg tablet</i> (Wellbutrin Sr)	T1	QL (4 tabs/day) HD
<i>bupropion hcl sr 150 mg tablet</i> (Wellbutrin Sr)	T1	QL (2 tabs/day) HD
<i>bupropion hcl sr 200 mg tablet</i> (Wellbutrin Sr)	T1	QL (2 tabs/day) HD
<i>bupropion hcl xl 150 mg tablet</i>	T1	QL (3 tabs/day) HD
<i>bupropion hcl xl 300 mg tablet</i>	T1	QL (1 tab/day) HD
SELECTIVE SEROTONIN 5-HT2A INVERSE AGONISTS (SSIAs)		
NUPLAZID	T3	PA SP HD
SELECTIVE SEROTONIN REUPTAKE INHIBITOR (SSRIs)		
<i>citalopram hbr 10 mg tablet</i> (Celexa)	T1	QL (6 tabs/day) HD
<i>citalopram hbr 10 mg/5 ml soln</i>	T1	QL (30ml/day) HD
<i>citalopram hbr 20 mg tablet</i> (Celexa)	T1	QL (3 tabs/day) HD
<i>citalopram hbr 20 mg/10 ml sol</i>	T1	QL (30ml/day) HD
<i>citalopram hbr 40 mg tablet</i> (Celexa)	T1	QL (1 tab/day) HD
<i>escitalopram 10 mg tablet</i>	T1	QL (2 tabs/day) HD
<i>escitalopram 20 mg tablet</i>	T1	QL (1 tab/day) HD

T1 – Typically 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
SELECTIVE SEROTONIN REUPTAKE INHIBITOR (SSRIs) (cont.)		
escitalopram 5 mg tablet	T1	QL (4 tabs/day) HD
escitalopram oxalate 5 mg/5 ml	T1	QL (20ml/day) HD
fluoxetine hcl	T1	QL (4 caps/28 days) HD
fluoxetine 20 mg/5 ml soln cup	T1	QL(20 mls/day) HD
fluoxetine hcl 10 mg capsule (Prozac)	T1	QL (8 caps/day) HD
fluoxetine hcl 20 mg capsule (Prozac)	T1	QL (4 caps/day) HD
fluoxetine hcl 20 mg tablet	T1	HD
fluoxetine hcl 40 mg capsule (Prozac)	T1	QL (2 caps/day) HD
fluoxetine hcl 60 mg tablet	T1	QL (1 tab/day) HD
fluvoxamine er 100 mg capsule	T1	QL (3 caps/day) HD
fluvoxamine er 150 mg capsule	T1	QL (2 caps/day) HD
fluvoxamine maleate 100 mg tab	T1	QL (3 tabs/day) HD
fluvoxamine maleate 25 mg tab	T1	QL (12 tabs/day) HD
fluvoxamine maleate 50 mg tab	T1	QL (6 tabs/day) HD
paroxetine cr 12.5 mg tablet (Paxil Cr)	T1	QL (6 tabs/day) HD
paroxetine cr 25 mg tablet (Paxil Cr)	T1	QL (3 tabs/day) HD
paroxetine cr 37.5 mg tablet (Paxil Cr)	T1	QL (2 tabs/day) HD
paroxetine er 12.5 mg tablet (Paxil Cr)	T1	QL (1 tab/day) HD
paroxetine er 25 mg tablet (Paxil Cr)	T1	QL (3 tabs/day) HD
paroxetine er 37.5 mg tablet (Paxil Cr)	T1	QL (2 tabs/day) HD
paroxetine hcl 10 mg tablet (Paxil)	T1	QL (6 tabs/day) HD
paroxetine hcl 20 mg tablet (Paxil)	T1	QL (3 tabs/day) HD
paroxetine hcl 30 mg tablet (Paxil)	T1	QL (2 tabs/day) HD
paroxetine hcl 40 mg tablet (Paxil)	T1	QL (1 tab/day) HD
SARAFEM (fluoxetine hcl)	T3	ST HD
sertraline 20 mg/ml oral conc (Zoloft)	T1	QL (10ml/day) HD
sertraline hcl 100 mg tablet (Zoloft)	T1	QL (2 tabs/day) HD
sertraline hcl 25 mg tablet (Zoloft)	T1	QL (8 tabs/day) HD
sertraline hcl 50 mg tablet (Zoloft)	T1	QL (4 tabs/day) HD
SEROTONIN-2 ANTAGONIST/REUPTAKE INHIBITORS (SARIs)		
nefazodone hcl	T1	HD
trazodone hcl	T1	HD
SEROTONIN-NOREpinephrine REUPTAKE-INHIB (SNRIs)		
desvenlafaxine succnt er 100mg (Pristiq)	T1	QL (4 tabs/day) HD
desvenlafaxine succnt er 25 mg (Pristiq)	T1	QL (16 tabs/day) HD

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

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AGE – Age Requirement

SP – Specialty Medication

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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
SEROTONIN-NOREPINEPHRINE REUPTAKE-INHIB (SNRIs) (cont.)		
desvenlafaxine succnt er 50 mg (Pristiq)	T1	QL (1 tab/day) HD
duloxetine hcl dr 20 mg cap	T1	QL (6 caps/day) HD
duloxetine hcl dr 30 mg cap	T1	QL (4 caps/day) HD
duloxetine hcl dr 40 mg cap	T1	QL (3 caps/day) HD
duloxetine hcl dr 60 mg cap	T1	QL (2 caps/day) HD
FETZIMA 20-40 MG TITRATION PAK	T3	QL (28 caps/180 days) ST
FETZIMA ER 120 MG CAPSULE	T3	QL (1 cap/day) ST
FETZIMA ER 20 MG CAPSULE	T3	QL (6 caps/day) ST
FETZIMA ER 40 MG CAPSULE	T3	QL (3 caps/day) ST
FETZIMA ER 80 MG CAPSULE	T3	QL (1 cap/day) ST
PRISTIQ ER 100 MG TABLET (desvenlafaxine succinate er)	T3	QL (2 tabs/day) ST HD
PRISTIQ ER 25 MG TABLET (desvenlafaxine succinate er)	T3	QL (16 tabs/day) ST HD
PRISTIQ ER 50 MG TABLET (desvenlafaxine succinate er)	T3	QL (1 tab/day) ST HD
venlafaxine hcl 100 mg tablet	T1	QL (3 tabs/day) HD
venlafaxine hcl 25 mg tablet	T1	QL (15 tabs/day) HD
venlafaxine hcl 37.5 mg tablet	T1	QL (10 tabs/day) HD
venlafaxine hcl 50 mg tablet	T1	QL (7 tabs/day) HD
venlafaxine hcl 75 mg tablet	T1	QL (5 tabs/day) HD
venlafaxine hcl er 150 mg cap (Effexor Xr)	T1	QL (2 caps/day) HD
venlafaxine hcl er 150 mg tab	T1	QL (2 tabs/day) HD
venlafaxine hcl er 225 mg tab	T1	QL (1 tab/day) HD
venlafaxine hcl er 37.5 mg cap (Effexor Xr)	T1	QL (8 caps/day) HD
venlafaxine hcl er 37.5 mg tab	T1	QL (8 tabs/day) HD
venlafaxine hcl er 75 mg cap (Effexor Xr)	T1	QL (4 caps/day) HD
venlafaxine hcl er 75 mg tab	T1	QL (4 tabs/day) HD
SSRI AND 5HTIA PARTIAL AGONIST ANTI-DEPRESSANTS		
VIIBRYD 10 MG TABLET	T3	QL (1 tab/day) ST HD
VIIBRYD 10-20 MG STARTER PACK	T3	ST HD
VIIBRYD 20 MG TABLET	T3	QL (1 tab/day) ST HD
VIIBRYD 40 MG TABLET	T3	ST HD
SSRI, SEROTONIN RECEPTOR MODULATOR ANTI-DEPRESSANTS		
TRINTELLIX 10 MG TABLET	T2	QL (1 tab/day) ST
TRINTELLIX 20 MG TABLET	T2	ST
TRINTELLIX 5 MG TABLET	T2	QL (1 tab/day) ST

T1 – Typically Generics

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T3 – Typically Non-Preferred Brands

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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
TRICYCLIC ANTI-DEPRESSANT-BENZODIAZEPINE COMBINATNS		
amitriptyline/chlordiazepoxide	T1	HD
TRICYCLIC ANTI-DEPRESSANT-PHENOTHIAZINE COMBINATNS		
perphenazine/amitriptyline hcl	T1	HD
TRICYCLIC ANTI-DEPRESSANTS, REL.NON-SEL.REUPT-INHIB		
amitriptyline hcl	T1	HD
amoxapine	T1	HD
clomipramine hcl	T1	HD
desipramine hcl	T1	HD
doxepin 10 mg capsule	T1	HD
doxepin 10 mg/ml oral conc	T1	HD
doxepin 100 mg capsule	T1	HD
doxepin 150 mg capsule	T1	HD
doxepin 25 mg capsule	T1	HD
doxepin 50 mg capsule	T1	HD
doxepin 75 mg capsule	T1	HD
imipramine hcl	T1	HD
imipramine pamoate	T1	HD
maprotiline hcl	T1	HD
nortriptyline hcl	T1	HD
protriptyline hcl	T1	HD
trimipramine maleate	T1	HD
PSYCHOTHERAPEUTIC DRUGS (Attention Deficit Hyperactivity Disorder) ⁸		
ADRENERGICS, AROMATIC, NON-CATECHOLAMINE		
lisdexamfetamine (Vyvanse)	T1	PA QL(1 tab/day)
MYDAYIS	T2	QL
VYVANSE 10 MG CAPSULE (lisdexamfetamine dimesylate)	T3	PA QL (1 cap/day)
VYVANSE 10 MG CHEWABLE TABLET (lisdexamfetamine dimesylate)	T3	PA QL (1 tab/day)
VYVANSE 20 MG CAPSULE (lisdexamfetamine dimesylate)	T3	PA QL (1 cap/day)
VYVANSE 20 MG CHEWABLE TABLET (lisdexamfetamine dimesylate)	T3	PA QL (1 tab/day)
VYVANSE 30 MG CAPSULE (lisdexamfetamine dimesylate)	T3	PA QL (1 cap/day)
VYVANSE 30 MG CHEWABLE TABLET (lisdexamfetamine dimesylate)	T3	PA QL (1 tab/day)
VYVANSE 40 MG CAPSULE (lisdexamfetamine dimesylate)	T3	PA QL (1 cap/day)
VYVANSE 40 MG CHEWABLE TABLET (lisdexamfetamine dimesylate)	T3	PA QL (1 tab/day)
VYVANSE 50 MG CAPSULE (lisdexamfetamine dimesylate)	T3	PA QL (1 cap/day)
VYVANSE 50 MG CHEWABLE TABLET (lisdexamfetamine dimesylate)	T3	PA QL (1 tab/day)

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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.)		
VYVANSE 60 MG CAPSULE	T3	PA QL (1 cap/day)
VYVANSE 60 MG CHEWABLE TABLET	T3	PA QL (1 tab/day)
VYVANSE 70 MG CAPSULE	T3	PA QL (1 cap/day)
TX FOR ADHD - SELECTIVE ALPHA-2 RECEPTOR AGONIST		
clonidine hcl (Kapvay)	T1	
guanfacine hcl (Intuniv)	T1	HD
TX FOR ATTENTION DEFICIT-HYPERACT (ADHD)/NARCOLEPSY		
DAYTRANA (<i>methylphenidate</i>)	T3	PA QL(1 patch/day)
DAYTRANA 10 MG/9 HR PATCH	T3	PA QL (1 patch/day)
DAYTRANA 15 MG/9 HR PATCH	T3	PA QL (1 per day)
DAYTRANA 20 MG/9 HOUR PATCH	T3	PA QL (1 patch/day)
DAYTRANA 30 MG/9 HOUR PATCH	T3	PA QL (1 patch/day)
<i>dexamethylphenidate hcl</i>	T1	PA QL (1 cap/day)
<i>dexamethylphenidate hcl</i> (Focalin)	T1	PA QL (1 cap/day)
FOCALIN (<i>dexamethylphenidate hcl</i>)	T3	PA ST
METHYLIN (<i>methylphenidate hcl</i>)	T3	PA
<i>methylphenidate</i> (Daytrana)	T1	PA QL(1 patch/day)
<i>methylphenidate 10 mg/9hr ptch</i> (Daytrana)	T1	PA QL(1 patch/day)
<i>methylphenidate 15 mg/9hr ptch</i> (Daytrana)	T1	PA QL(1 patch/day)
<i>methylphenidate 20 mg/9hr ptch</i> (Daytrana)	T1	PA QL(1 patch/day)
<i>methylphenidate 30 mg/9hr ptch</i> (Daytrana)	T1	PA QL(1 patch/day)
<i>methylphenidate er 10 mg cap</i>	T1	QL (1 per day)
<i>methylphenidate er 10 mg tab</i>	T1	PA QL (2 tabs/day)
<i>methylphenidate er 15 mg cap</i>	T1	QL (1 per day)
<i>methylphenidate er 18 mg tab</i>	T1	PA QL (1 tab/day)
<i>methylphenidate er 18 mg tab</i> (Relexxii)	T1	PA QL(1 tab/day)
<i>methylphenidate er 20 mg cap</i>	T1	QL (1 cap/day)
<i>methylphenidate er 20 mg tab</i>	T1	PA QL (3 tabs/day)
<i>methylphenidate er 27 mg tab</i>	T1	PA QL (1 tab/day)
<i>methylphenidate er 30 mg cap</i>	T1	QL (1 per day)
<i>methylphenidate er 36 mg tab</i>	T1	PA QL (2 tabs/day)
<i>methylphenidate er 40 mg cap</i>	T1	QL (1 per day)
<i>methylphenidate er 50 mg cap</i>	T1	QL (1 per day)
<i>methylphenidate er 54 mg tab</i>	T1	PA QL (1 tab/day)

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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 60 mg cap	T1	QL (1 per day)
methylphenidate hcl (Metadate CD)	T1	PA QL (1 cap/day)
methylphenidate hcl (Methyltin)	T1	PA
methylphenidate hcl (Ritalin)	T1	PA
methylphenidate la 10 mg cap	T1	PA QL (1 cap/day)
methylphenidate la 20 mg cap	T1	PA QL (1 per day)
methylphenidate la 30 mg cap	T1	PA QL (1 per day)
methylphenidate la 40 mg cap	T1	PA QL (1 per day)
methylphenidate la 60 mg cap	T1	PA QL (1 cap/day)
QUILLICHEW ER	T3	PA QL (1 tab/day)
QUILLIVANT XR	T3	PA QL (12ml/day)
RITALIN (methylphenidate hcl)	T3	PA ST
TX FOR ATTENTION DEFICIT-HYPERACT.(ADHD), NRI-TYPE		
atomoxetine hcl 10 mg capsule (Strattera)	T1	HD
atomoxetine hcl 100 mg capsule (Strattera)	T1	HD
atomoxetine hcl 18 mg capsule (Strattera)	T1	HD
atomoxetine hcl 25 mg capsule (Strattera)	T1	HD
atomoxetine hcl 40 mg capsule (Strattera)	T1	QL (1 cap/day) HD
atomoxetine hcl 60 mg capsule (Strattera)	T1	HD
atomoxetine hcl 80 mg capsule (Strattera)	T1	HD
SUPARTZ FX 25MG/2.5ML SYR	T3	PA SP

PSYCHOTHERAPEUTIC DRUGS (Miscellaneous)

HYPACTIVE SEXUAL DESIRE DISORDER (HSDD) TX AGENTS		
ADDYI	T3	PA QL (1 tab/day)
VYLEESI	T1	PA QL (8 injectors/30 days) SP

PSYCHOTHERAPEUTIC DRUGS (Schizophrenia/Anti-Psychotics)⁸

ANTI-PSYCH, DOPAMINE ANTAG., DIPHENYLBUTYLPIPERIDINES		
pimozide	T1	
ANTI-PSYCHOTIC,ATYPICAL,DOPAMINE,SEROTONIN ANTAGNST		
ABILIFY MAINTENA	T2	
asenapine maleate (Saphris)	T1	
CAPLYTA	T3	ST QL(1 tabs/caps/day)
clozapine	T1	

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

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ST – Step Therapy

AGE – Age Requirement

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List of Prescription Medications

PSYCHOTHERAPEUTIC DRUGS (Schizophrenia/Anti-Psychotics)⁸ (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ANTI-PSYCHOTIC,ATYPICAL,DOPAMINE,SEROTONIN ANTAGNIST (cont.)		
<i>clozapine</i> (Clozapine Odt)	T1	
<i>clozapine</i> (Clozaril)	T1	
CLOZAPINE ODT	T1	
CLOZARIL (clozapine)	T3	ST
ERZOFRI	T3	QL
INVEGA ER 1.5 MG TABLET (<i>paliperidone er</i>)	T2	ST
INVEGA ER 3 MG TABLET (<i>paliperidone er</i>)	T2	QL (1 tab/day) ST
INVEGA ER 6 MG TABLET (<i>paliperidone er</i>)	T2	ST
INVEGA ER 9 MG TABLET (<i>paliperidone er</i>)	T2	ST
INVEGA SUSTENNA 117 MG/0.75 ML	T2	
INVEGA SUSTENNA 156 MG/ML SYRG	T2	
INVEGA SUSTENNA 234 MG/1.5 ML	T2	
INVEGA SUSTENNA 39 MG/0.25 ML	T2	
INVEGA SUSTENNA 78 MG/0.5 ML	T2	
INVEGA TRINZA	T2	
<i>lurasidone hcl</i> 120 mg tablet (Latuda)	T1	
<i>lurasidone hcl</i> 20 mg tablet (Latuda)	T1	
<i>lurasidone hcl</i> 40 mg tablet (Latuda)	T1	QL(1 tab/day)
<i>lurasidone hcl</i> 60 mg tablet (Latuda)	T1	QL(1 tab/day)
<i>lurasidone hcl</i> 80 mg tablet (Latuda)	T1	
<i>olanzapine</i>	T1	
<i>paliperidone er</i> 1.5 mg tablet	T1	
<i>paliperidone er</i> 3 mg tablet (Invega)	T1	QL (1 tab/day)
<i>paliperidone er</i> 6 mg tablet (Invega)	T1	
<i>paliperidone er</i> 9 mg tablet (Invega)	T1	
<i>quetiapine fumarate</i> (Seroquel Xr)	T1	
<i>quetiapine fumarate</i> (Seroquel)	T1	
<i>risperidone</i>	T1	
<i>risperidone microspheres</i>	T1	QL
<i>risperidone microspheres</i> (Risperdal Consta)	T1	QL(4 vials/28 days)
<i>risperidone</i> (Risperdal)	T1	
SAPHRIS (<i>asenapine maleate</i>)	T3	ST
SECUADO	T3	ST

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List of Prescription Medications

PSYCHOTHERAPEUTIC DRUGS (Schizophrenia/Anti-Psychotics)⁸ (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ANTI-PSYCHOTIC,ATYPICAL,DOPAMINE,SEROTONIN ANTAGNIST (cont.)		
SEROQUEL (quetiapine fumarate)	T3	ST
SEROQUEL XR (quetiapine fumarate er)	T3	ST
ziprasidone hcl	T1	
ZYPREXA	T3	
ANTI-PSYCHOTIC-ATYPICAL, D3/D2 PARTIAL AG-5HT MIXED		
VRAYLAR 1.5 MG CAPSULE	T3	QL (1 cap/day) ST
VRAYLAR 3 MG CAPSULE	T3	QL (1 cap/day) ST
VRAYLAR 4.5 MG CAPSULE	T3	ST
VRAYLAR 6 MG CAPSULE	T3	ST
ANTIPSYCHOTICS, ATYP, D2 PARTIAL AGONIST/5HT MIXED		
ABILIFY ASIMTUFII	T3	
ariPIPRAZOLE	T1	
ariPIPRAZOLE 1 mg/ml solution	T1	
ariPIPRAZOLE 10 mg tablet	T1	
ariPIPRAZOLE 15 mg tablet	T1	
ariPIPRAZOLE 2 mg tablet	T1	
ariPIPRAZOLE 20 mg tablet	T1	
ariPIPRAZOLE 30 mg tablet	T1	
ariPIPRAZOLE 5 mg tablet	T1	QL (1 tab/day)
REXULTI 0.25 MG TABLET	T3	QL (1 tab/day) ST
REXULTI 0.5 MG TABLET	T3	QL (1 tab/day) ST
REXULTI 1 MG TABLET	T3	QL (1 tab/day) ST
REXULTI 2 MG TABLET	T3	QL (1 tab/day) ST
REXULTI 3 MG TABLET	T3	ST
REXULTI 4 MG TABLET	T3	ST
ANTI-PSYCHOTICS, DOPAMINE AND SEROTONIN ANTAGONISTS		
loxpiprazole succinate	T1	
ANTI-PSYCHOTICS, DOPAMINE ANTAGONISTS, THIOXANTHENES		
thiothixene	T1	
ANTI-PSYCHOTICS, DOPAMINE ANTAGONISTS, BUTYROPHENONES		
haloperidol	T1	
haloperidol lactate	T1	

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PSYCHOTHERAPEUTIC DRUGS (Schizophrenia/Anti-Psychotics) ⁸ (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ANTI-PSYCHOTICS, DOPAMINE ANTAGONIST, DIHYDROINDOLONES		
<i>molindone hcl</i>	T1	
ANTI-PSYCHOTICS, PHENOTHIAZINES		
<i>chlorpromazine hcl</i>	T1	
<i>fluphenazine hcl</i>	T1	
<i>perphenazine</i>	T1	
<i>thioridazine hcl</i>	T1	
<i>trifluoperazine hcl</i>	T1	
SSRI-ANTI-PSYCH, ATYPICAL, DOPAMINE, SEROTONIN ANTAG		
<i>olanzapine/fluoxetine hcl</i>	T1	
<i>olanzapine/fluoxetine hcl (Symbax)</i>	T1	
PSYCHOTHERAPEUTIC DRUGS (Sleep Disorders/Sedatives)		
NARCOLEPSY AND SLEEP DISORDER THERAPY AGENTS		
<i>armodafinil</i>	T1	PA
<i>modafinil</i>	T1	PA
SUNOSI	T2	PA QL (1 tab/day)
SEDATIVE/HYPNOTICS (Sleep Disorders/Sedatives)		
ANTI-NARCOLEPSY, ANTI-CATAPLEXY, SEDATIVE-TYPE AGENT		
LUMRYZ	T3	PA QL (1 pack/day) SP HD
LUMRYZ STARTER PACK	T3	SP HD
SODIUM OXYBATE 0.5 G/ML SOLN	T3	PA QL(18 mls/day) SP HD
XYWAV	T3	PA SP HD
BARBITURATES		
<i>phenobarbital</i>	T1	
<i>secobarbital sodium</i>	T3	PA
HYPNOTICS, MELATONIN MT1/MT2 RECEPTOR AGONISTS		
HETLIOZ	T3	PA SP HD
HETLIOZ LQ	T3	PA SP HD
<i>ramelteon (Rozerem)</i>	T3	QL (1 tab/day)
<i>tasimelteon</i>	T1	PA SP
SEDATIVE-HYPNOTICS - BENZODIAZEPINES		
DORAL	T3	
<i>estazolam</i>	T1	
HALCION (<i>triazolam</i>)	T3	
<i>midazolam hcl</i>	T1	

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

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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
ANTI-PSORIATICS AGENTS, SYSTEMIC (cont.)		
COSENTYX	T3	PA SP
ILUMYA	T3	PA QL (1 syringe/84 days) SP HD
<i>methoxsalen</i> (Oxsoralen-ultra)	T1	
OXSORALEN-ULTRA (<i>methoxsalen</i>)	T3	
SKYRIZI (2 SYRINGES) KIT	T3	PA QL (1 kit/84 days) SP HD
SILIQ	T3	PA QL (2 inj/15 days) SP HD
SOTYKTU	T2	PA QL (1 tab/day) SP HD
SPEVIGO 150 MG/ML SYRINGE	T3	PA QL(2 mls/28 days) SP HD
SPEVIGO 450 MG/7.5 ML VIAL	T3	PA SP HD
TALTZ AUTOINJECTOR	T3	PA QL (1 injector/28 days) SP HD
TALTZ SYRINGE	T3	PA QL (1 syringe/28 days) SP HD
TREMFYA 200 MG/2 ML SYRINGE	T2	PA QL(2 mls/28 days) SP
TREMFYA PEN	T2	PA QL(2 syringe/28 days) SP HD
TOPICAL ANTI-INFLAMMATORY, NSAIDS		
DICLAREAL	T3	HD
DICLOFENAC EPOLAMINE	T3	PA QL (2 patches/day) HD
<i>diclofenac sodium 1% gel</i> (Voltaren)	T1	QL (1000gm/30 days) HD
FLECTOR	T2	PA QL (2 patches/day) HD
LICART 1.3% PATCH	T2	PA QL (1 patch/day) HD
VOLTAREN (<i>diclofenac sodium</i>)	T3	PA QL (1000gm/30 days) HD
SKIN PREPS (Skin Conditions)		
ACNE AGENTS, SYSTEMIC		
ACUTANE	T1	
AMNESTEEM	T1	
CLARAVIS	T1	
isotretinoin	T1	
MYORISAN	T1	
ZENATANE	T1	
ACNE AGENTS, TOPICAL		
<i>adapalene/benzoyl peroxide</i>	T1	
<i>clindamycin phos/benzoyl perox</i> (Onexton)	T1	
<i>clindamycin phos/benzoyl perox</i>	T1	
<i>clindamycin/tretinoin</i>	T1	

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SKIN PREPS (Skin Conditions) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ACNE AGENTS, TOPICAL (cont.)		
dapsone	T1	
KLARON (sulfacetamide sodium)	T3	
sulfacetamide sodium (Klaron)	T1	
ANTI-PERSPIRANTS		
DRYSOL	T2	
ANTI-PRURITICS, TOPICAL		
ALEVICYN PLUS	T3	
ANTI-PSORIATICS AGENTS		
anthralin	T1	
BIMZELX	T3	PA QL(10 mls/365 days) SP HD
BIMZELX AUTOINJECTOR	T9	PA QL(10 mls/365 days) SP HD
calcipotriene	T1	
calcipotriene 0.005% cream (Dovonex)	T1	
CALCIPOTRIENE 0.005% FOAM	T3	
calcipotriene 0.005% ointment	T1	
calcipotriene 0.005% solution	T1	
calcitriol 3 mcg/g ointment (Vectical)	T1	QL (800gm/30 days)
COSENTYX	T3	SP HD
DOVONEX (calcipotriene)	T3	
tazarotene 0.05% cream (Tazorac)	T1	
ANTISEPTICS, GENERAL		
ALCOHOL SWAB	T1	
CURITY ALCOHOL PREPS	T1	
DROPSAFE PREP PADS	T1	
EASY COMFORT ALCOHOL PAD	T1	
INCONTROL ALCOHOL PADS	T1	
PRO COMFORT ALCOHOL PADS	T1	
PURE COMFORT ALCOHOL PAD	T1	
SINGLE USE SWAB	T1	
SURE COMFORT ALCOHOL	T1	
TRUE COMFORT ALCOHOL PADS	T1	
TRUE COMFORT PRO ALCOHOL PADS	T1	
ULTILET ALCOHOL SWAB	T1	
ALCOHOL PREP PADS		
alcohol antiseptic pads	T1	

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List of Prescription Medications

SKIN PREPS (Skin Conditions) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ALCOHOL PREP PADS (cont.)		
ALCOHOL SWABS	T1	
ALCOHOL WIPES	T1	
CARETOUCH ALCOHOL PREP PAD	T1	
EASY TOUCH ALCOHOL PREP PADS	T1	
GUAIACOL	T1	
SURE-PREP ALCOHOL PREP PADS	T1	
WEBCOL	T1	
ANTI-SEBORRHEIC AGENTS		
tazarotene	T1	
VECTICAL (<i>calcitriol</i>)	T3	QL (800gm/30 days)
OVACE PLUS	T3	
<i>selenium sulfide</i>	T1	
<i>sulfacetamide sodium</i>	T1	
TERSI FOAM	T3	
DIABETIC ULCER PREPARATIONS, TOPICAL		
REGRANEX	T3	PA QL (2 tubs/30 days)
EMOLLIENTS		
<i>emollient combination no.60</i> (Restizan)	T3	
HALUCORT	T3	
MIMYX (<i>prumyx</i>)	T3	
RESTIZAN	T1	
<i>vite ac/grape/hyaluronic acid</i> (Atopiclair)	T1	
XCLAIR	T3	
IMMUNOMODULATORS		
<i>imiquimod</i>	T1	
IRRITANTS/COUNTER-IRRITANTS		
<i>methyl salicylate</i>	T1	
QUTENZA	T3	
KERATOLYTICS		
BENZEOFAM	T3	
BENZEPRO	T1	
<i>benzoyl peroxide</i> (Enzoclear)	T1	
<i>benzoyl peroxide</i> (Pacnex)	T1	
ENZOCLEAR	T3	

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List of Prescription Medications

SKIN PREPS (Skin Conditions) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
KERATOLYTICS (cont.)		
HYDRO 35	T3	
HYDRO 40 (<i>umecta</i>)	T3	
INOVA	T3	
KERAFOAM	T3	
KERALYT 6% GEL (<i>salicylic acid</i>)	T3	
<i>keralyt 6% shampoo</i>	T1	
KERALYT SCALP	T3	
KERALYT SCALP (<i>salicylic acid</i>)	T3	
PACNEX (<i>benzoyl peroxide</i>)	T3	
PODOCON-25	T1	
<i>podofilox</i>	T1	
PR BENZOYL PEROXIDE	T1	
<i>salicylic acid</i>	T1	
<i>salicylic acid</i> (Keralyt Scalp)	T1	
<i>salicylic acid/ceramide comb 1</i>	T1	
SALIMEZ FORTE	T1	
SALICATE	T3	
SALKERA	T3	
SAVAX DUO PLUS	T3	
<i>silver nitrate</i>	T1	
<i>silver nitrate applicator</i>	T1	
URAMAXIN	T3	
URAMAXIN (<i>urea</i>)	T3	
<i>urea</i> (Hydro 35)	T1	
<i>urea</i> (Hydro 40)	T3	
<i>urea</i> (Uramaxin)	T1	
<i>urea</i> (Xurea)	T1	
XUREA	T3	
PROTECTIVES		
PHARMABASE BARRIER	T1	
<i>polydimethylsiloxanes/silicon</i>	T1	
<i>protectives2/ceramide 1,3,6-ii</i>	T1	
RADIAPLEXRX	T3	
<i>zinc oxide</i>	T1	

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SKIN PREPS (Skin Conditions) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ROSACEA AGENTS, TOPICAL		
<i>azelaic acid</i>	T1	
<i>ivermectin</i>	T1	
<i>metronidazole</i>	T1	
<i>SOOLANTRA (ivermectin)</i>	T3	
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	
ZORYVE 0.15% CREAM	T2	PA QL(60 gms/30 days)
TOPICAL AGENTS, MISCELLANEOUS		
GORDON'S UREA	T3	
MEDIHONEY	T3	
L-MESITRAN SOFT	T3	
SAF-CLENS AF	T1	
<i>trichloroacetic acid</i>	T3	
TRICHLOROACETIC ACID	T1	
TOPICAL ANTIBIOTIC PLEUROMUTILIN DERIVATIVES		
ALTABAX	T3	
TOPICAL ANTI-INFLAMMATORY STEROIDAL		
ALA-SCALP (<i>scalacort</i>)	T3	ST
<i>alclometasone dipropionate</i>	T1	
<i>amcinonide 0.1% cream</i>	T1	
<i>amcinonide 0.1% lotion</i>	T1	
AQUA GLYCOLIC HC	T3	
<i>betamethasone dipropionate</i>	T1	
<i>betamethasone valerate</i>	T1	
<i>betamethasone valerate (Luxiq)</i>	T1	
<i>betamethasone/propylene glyc</i>	T1	
<i>betamethasone/propylene glyc (Diprolene)</i>	T1	
BRYHALI	T3	ST
CAPEX SHAMPOO	T3	ST

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SKIN PREPS (Skin Conditions) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
TOPICAL ANTI-INFLAMMATORY STEROIDAL (cont.)		
clobetasol propionate	T1	
clobetasol propionate (Temovate)	T1	
clobetasol propionate/emolll	T1	
CLOCORTOLONE PIVALATE	T1	
CLODAN 0.05% KIT	T3	ST
cladan 0.05% shampoo	T1	
CLODERM	T3	ST
DERMA-SMOOTH-E-FS (fluocinolone acetonide)	T3	ST
DERMATOP (prednicarbate)	T3	ST
desonide (Desowen)	T1	
DESOWEN (desonide)	T3	ST
desoximetasone (Topicort)	T1	
DIPROLENE (betamethasone diprop augmented)	T3	ST
fluocinolone acetonide	T1	
fluocinolone acetonide (Derma-smoothe-fs)	T1	
fluocinolone acetonide (Synalar)	T1	
fluocinolone/shower cap (Derma-smoothe-fs)	T1	
fluocinonide	T1	
fluocinonide/emollient base	T1	
fluticasone prop 0.005% oint	T1	
fluticasone prop 0.05% cream	T1	
fluticasone prop 0.05% lotion	T1	
halobetasol prop 0.05% foam	T1	
halobetasol propionate (Ultravate)	T1	
hydrocortisone	T1	
hydrocortisone (Ala-scalp)	T1	
hydrocortisone butyrate	T1	
hydrocortisone valerate	T1	
LUXIQ (betamethasone valerate)	T3	ST
MOMETACURE	T3	
mometasone furoate 0.1% cream	T1	
mometasone furoate 0.1% oint	T1	
mometasone furoate 0.1% soln	T1	
NUCORT	T3	ST

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SKIN PREPS (Skin Conditions) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
TOPICAL ANTI-INFLAMMATORY STEROIDAL (cont.)		
<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
TEXACORT	T3	ST
TOPICORT (<i>desoximetasone</i>)	T3	ST
ULTRAVATE (<i>halobetasol propionate</i>)	T3	ST
TOPICAL ANTI-INFLAMMATORY STEROID-LOCAL ANESTHETIC		
ANALPRAM HC	T3	
EPIFOAM	T3	
<i>hydrocortisone/pramoxine</i> (Pramosone)	T1	
<i>lidocaine/hydrocortisone ac</i>	T1	
MEZPAROX-HC	T1	
PRAMOSONE 1% LOTION	T2	
PRAMOSONE 1%-1% CREAM	T2	
PRAMOSONE 1%-1% OINTMENT	T2	
PRAMOSONE 2.5%-1% CREAM	T3	
PRAMOSONE 2.5%-1% LOTION	T3	
PRAMOSONE 2.5%-1% OINTMENT	T2	
TOPICAL ANTI-PARASITICS		
<i>malathion</i> (Ovide)	T1	
OVIDE (<i>malathion</i>)	T3	
TOPICAL PREPARATIONS, ANTIBACTERIALS		
<i>dermazene cream</i>	T1	
DERMAZENE CREAM PACKET	T3	
<i>hydrocortisone/iodoquinol</i>	T1	
<i>hydrocortisone/iodoquinol/aloe</i>	T1	
<i>iodine/potassium iodide</i>	T1	
<i>iodine/sodium iodide</i>	T1	
IODOFLEX	T3	
IODOSORB	T3	
<i>silver nitrate</i>	T1	

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

PA – Prior Authorization

QL – Quantity Limit

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 VIT D ANALOG/ANTI-INFLAMMATORY STEROID		
calcipotriene/betamethasone	T1	
TACLONEX 0.005%-0.064% SUSPENS (calcipotriene/betamethasone)	T3	
TOPICAL/MUCOUS MEMBR./SUBCUT. ENZYMES		
SANTYL	T2	QL (60gm/30 days)
VITAMIN A DERIVATIVES		
adapalene 0.1% cream	T1	PA
adapalene 0.3% gel pump	T1	PA
PLIXDA	T1	PA
tretinoin 0.01% gel	T1	
tretinoin 0.025% cream	T1	PA
tretinoin 0.025% gel	T1	
tretinoin 0.05% cream	T1	PA
tretinoin 0.05% gel	T1	PA
tretinoin 0.1% cream	T1	PA
SMOKING DETERRENTS (Smoking Cessation)⁸		
SMOKING DETERRENT AGENTS (GANGLIONIC STIM, OTHERS)		
NICOTROL	T2	PPACA
NICOTROL NS	T2	PPACA
SMOKING DETERENT-NICOTINIC RECEPT.PARTIAL AGONIST		
CHANTIX	T2	
varenicline 1 mg cont month bx	T1	PPACA
SMOKING DETERRENTS, OTHER		
bupropion hcl sr 150 mg tablet	T1	PPACA
THYROID PREPS (Hormonal Agents)		
ANTI-THYROID PREPARATIONS		
methimazole (Tapazole)	T1	HD
propylthiouracil	T1	HD
TAPAZOLE (methimazole)	T3	HD
THYROID HORMONES		
ARMOUR THYROID	T3	HD
CYTOMEL (liothyronine sodium)	T3	HD
LEVOTHYROXINE	T3	HD
levothyroxine sodium (Synthroid)	T1	HD
levothyroxine sodium (Synthroid)	T3	HD

T1 – Typically Generics

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List of Prescription Medications

THYROID PREPS (Hormonal Agents) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
THYROID HORMONES (cont.)		
liothyronine sodium (Cytomel)	T1	HD
SYNTHROID (unithroid)	T3	HD
thyroid, pork	T1	HD
thyroid, pork (Armour Thyroid)	T1	HD
thyroid, pork (Wp Thyroid)	T1	HD
THYROLAR-1	T2	HD
THYROLAR-1/2	T2	HD
THYROLAR-1/4	T2	HD
THYROLAR-2	T2	HD
THYROLAR-3	T2	HD
TIROSINT	T3	HD
TIROSINT-SOL	T3	HD
WP THYROID	T1	HD
WP THYROID (<i>nature-thyroid</i>)	T1	HD
WP THYROID (<i>westhroid</i>)	T1	HD
UNCLASSIFIED DRUG PRODUCTS (AIDS/HIV)		
CYTOCHROME P450 INHIBITORS		
TYBOST	T3	SP
UNCLASSIFIED DRUG PRODUCTS (Asthma/COPD/Respiratory)		
CYSTIC FIBROSIS-CFTR POTENTIATOR-CORRECTOR COMBIN.		
ALYFTREK 10-50-125 MG TABLET	T3	PA QL(2 tabs/day) SP HD
ALYFTREK 4-20-50 MG TABLET	T3	PA QL(3 tabs/day) SP HD
BRONCHITOL 40 MG INHALE CAPSULE	T3	PA SP
ORKAMBI 100 MG-125 MG TABLET	T3	PA QL (4 tabs/day) SP HD
ORKAMBI GRANULE PKT	T3	PA QL (2 packs/day) SP HD
ORKAMBI 200 MG-125 MG TABLET	T3	PA QL (4 tabs/day) SP HD
SYMDEKO	T3	PA QL (2 tabs/day) SP HD
TRIKAFTA 100-50-75 MG/150 MG	T3	PA QL(3 tabs/day) SP HD
TRIKAFTA 100-50-75 MG/75MG PKT	T3	PA QL(3 tabs/day) HD
TRIKAFTA 50-25-37.5 MG/75 MG	T3	PA QL(3 tabs/day) SP HD
TRIKAFTA 80-40-60MG/59.5MG PKT	T3	PA QL(3 tabs/day) HD
CYSTICFIB-TRANSMEMB CONDUCT.REG. (CFTR) POTENTIATOR		
KALYDECO 5.8 MG GRANULES PKT	T3	PA QL SP HD
KALYDECO 150 MG TABLET	T3	PA QL (2 tabs/day) SP HD
KALYDECO 25 MG GRANULES PACKET	T3	PA QL (2 packs/day) SP HD

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UNCLASSIFIED DRUG PRODUCTS (Asthma/COPD/Respiratory) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
CYSTICFIB-TRANSMEMB CONDUCT.REG. (CFTR) POTENTIATOR (cont.)		
KALYDECO 50 MG GRANULES PACKET	T3	PA QL (2 packs/day) SP HD
KALYDECO 75 MG GRANULES PACKET	T3	PA QL (2 packs/day) SP HD
LUNG SURFACTANTS		
CUROSURF	T3	
INFASURF	T3	
SURVANTA	T3	
MUCOLYTICS		
PULMOZYME	T3	PA SP HD
PULMONARY FIBROSIS - SYSTEMIC ENZYME INHIBITORS		
OFEV	T3	PA SP HD
SYSTEMIC ENZYME INHIBITORS		
JOENJA	T3	PA QL(2 tabs/day) SP
PROLASTIN C	T3	PA SP HD
VIJOICE 125mg, 50mg	T3	PA QL (30 tabs/30 days) SP
VIJOICE 250mg	T3	PA QL (2tabs/30 days) SP
ZEMAIRA	T3	PA SP
ZOKINVY	T3	PA QL (4 caps/day) SP
UNCLASSIFIED DRUG PRODUCTS (Blood Modifiers/Bleeding Disorders)		
SPLEEN TYROSINE KINASE INHIBITORS		
TAVALISSE	T2	PA SP
UNCLASSIFIED DRUG PRODUCTS (Blood Pressure/Heart Medications)		
BRADYKININ B2 RECEPTOR ANTAGONISTS		
icatibant acetate	T3	PA SP HD
CI ESTERASE INHIBITORS		
BERINERT	T3	PA SP HD
CINRYZE	T3	PA SP HD
HAEGARDA	T3	PA SP HD
RUCONEST	T3	PA SP HD
PLASMA KALLIKREIN INHIBITORS		
KALBITOR	T3	PA SP HD
ORLADEYO	T3	PA QL (1 caps/day) SP

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UNCLASSIFIED DRUG PRODUCTS (Cancer)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
CHEMOTHERAPY RESCUE/ANTIDOTE AGENTS		
leucovorin calcium	T1	
MESNEX	T3	SP
VISTOGARD	T3	SP
UNCLASSIFIED DRUG PRODUCTS (Dental Products)		
DENTAL AIDS AND PREPARATIONS		
chlorhexidine gluconate (Peridex)	T1	
PERIDEX (periogard)	T1	
triamcinolone acetonide	T1	
PERIODONTAL COLLAGENASE INHIBITORS		
doxycycline hyclate	T1	
UNCLASSIFIED DRUG PRODUCTS (Erectile Dysfunction)		
DRUGS TO TREAT ERECTILE DYSFUNCTION (ED)		
CAVERJECT	T3	PA QL (6 injectors/30 days)
CIALIS 10 MG TABLET (tadalafil)	T3	QL (6 tabs/30 days) ST
CIALIS 20 MG TABLET (tadalafil)	T3	QL (6 tabs/30 days) ST
CIALIS 5 MG TABLET (tadalafil)	T3	QL (8 tabs/30 days) ST
EDEX	T3	PA QL (6 injectors/30 days)
IFE-BIMIX 30/1	T2	
IFE-PG20	T2	
LEVITRA (vardenafil hcl)	T3	QL (10 tabs/30 days) ST
MUSE	T2	PA QL (6/30 days)
PAPAVERINE-ALPROSTADIL	T1	
PAPAVERINE-PHENTOLAMINE	T1	
PAPAVERINE-PHENTOLMN-ALPROSTDL	T1	
PHENTOLAMINE-ALPROSTADIL	T1	
sildenafil 100 mg tablet (Viagra)	T1	QL (10 tabs/30 days) HD
sildenafil 25 mg tablet (Viagra)	T1	QL (6 tabs/30 days) HD
sildenafil 50 mg tablet (Viagra)	T1	QL (6 tabs/30 days) HD
STENDRA (avanafil)	T3	QL (8 tabs/30 days) ST
tadalafil 2.5 mg tablet	T1	QL(1 Tab/day)
tadalafil 5 mg tablet (Cialis)	T1	QL (8 tabs/30 days)
tadalafil 10 mg tablet (Cialis)	T1	QL (10 tabs/30 days)
tadalafil 20 mg tablet (Cialis)	T1	PA QL (10 tabs/30 days)

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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.)		
TRI-MIX (<i>papvrn-phntilmn-pge1</i>)	T3	
vardenafil hcl (Levitra)	T1	QL (10 tabs/30 days)
VIAGRA (<i>sildenafil citrate</i>)	T3	QL (6 tabs/30 days) ST
UNCLASSIFIED DRUG PRODUCTS (Gastrointestinal/Heartburn)		
CALCIMIMETIC, PARATHYROID CALCIUM ENHANCER		
<i>cinacalcet hcl</i>	T3	SP
ORAL MUCOSITIS/STOMATITIS AGENTS		
EBGLYSS	T2	PA SP
ORAMAGICRX	T3	
PPAR AGONIST		
IQIRVO	T2	
SALIVA STIMULANT AGENTS		
NUMOISYN	T3	
THYROID HORMONE RECEPTOR (THR) AGONIST		
REZDIFRA	T3	PA QL(1 tab/day) SP HD
UNCLASSIFIED DRUG PRODUCTS (Hormonal Agents)		
BONE FORMATION STIM. AGENTS - PARATHYROID HORMONE		
<i>teriparatide 600 mcg/2.4ml pen (Forteo)</i>	T1	PA QL(0.09 mls/day) SP HD
GROWTH HORMONE RECEPTOR ANTAGONISTS		
SOMAVERT	T3	PA SP HD
HYPERPARATHYROID TX AGENTS - VITAMIN D ANALOG-TYPE		
<i>doxercalciferol</i>	T1	
PARICALCITOL 10MCG/2ML	T3	SP
PARICALCITOL 2MCG/ML VIAL	T3	SP
PARICALCITOL 5MCG/ML VIAL	T3	SP
RAYALDEE	T3	
ZEMPLAR (<i>paricalcitol</i>)	T3	SP HD
MENOPAUSAL SYMPT SUPP-SEL ESTROGEN RECEP MODULATOR		
OSPHENA	T3	HD
UNCLASSIFIED DRUG PRODUCTS (Miscellaneous)		
ABORTIFACIENT-PROGESTERONE RECEPTOR ANTAGONISTS		
MIFEPREX	T3	
<i>mifepristone (Mifeprex)</i>	T1	
ACID AND ALKALI POISON ANTIDOTES		
METHYLENE BLUE 1%	T3	
<i>methylene blue 1%</i>	T1	

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List of Prescription Medications

UNCLASSIFIED DRUG PRODUCTS (Miscellaneous) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
AGENTS TO TX PERIODIC PARALYSIS - CARBON ANHYD INH		
<i>dichlorphenamide</i> (Keveyis)	T3	PA SP
AMMONIA INHIBITORS		
<i>CARBAGLU</i> (<i>carglumic acid</i>)	T3	SP HD
<i>carglumic acid</i> (Carbaglu)	T1	SP HD
AMYLOIDOSIS AGENTS-TRANSTHYRETIN (TTR) SUPPRESSION		
TEGSEDI	T3	PA SP HD
ANTI-ALCOHOLIC PREPARATIONS		
<i>acamprosate calcium</i>	T1	
<i>ANTABUSE</i> (<i>disulfiram</i>)	T3	
<i>disulfiram</i> (Antabuse)	T1	
ANTIDOTES, MISCELLANEOUS		
CETYLEV	T3	
ANTI-FIBROTIC THERAPY - PYRIDONE ANALOGS		
<i>pirfenidone 267 mg capsule</i> (Esbriet)	T1	PA SP HD
CATHETER LOCK SOLUTIONS		
DEFENCATH	T3	
CRYOPRESERVATIVE AGENTS		
<i>dimethyl sulfoxide</i>	T1	
DRUGS TO TREAT HEREDITARY TYROSINEMIA		
<i>nitisinone</i> (Orfadin)	T3	PA SP HD
NITYR	T3	PA SP
ORFADIN (<i>nitisinone</i>)	T3	PA SP
GENERAL INHALATION AGENTS		
HYPER-SAL	T3	
<i>nebusal 3% vial</i>	T1	
NEBUSAL 6% VIAL	T3	
<i>sodium chloride for inhalation</i> (Hyper-sal)	T1	
GENETIC D/O TX - SMN PROTEIN DEFICIENCY TREATMENT		
EVRYSDI	T3	PA SP HD
GLUCOSYLCERAMIDE SYNTHASE INHIBITOR		
CERDELGA	T3	PA SP HD
<i>miglustat</i> (Zavesca)	T3	PA SP
OPFOLDA	T3	PA QL(8 caps/30 days) SP HD
INTERLEUKIN-13 (IL-13) INHIBITORS, MAB		
ADBRY	T2	PA SP HD

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List of Prescription Medications

UNCLASSIFIED DRUG PRODUCTS (Miscellaneous) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
MENOPAUSAL SYMPTOMS SUPPRESSANT-NK3 RECEPTOR ANTAG		
VEOZAH	T3	QL(1 tab/day)
MENOPAUSAL SYMPTOMS SUPPRESSANT - SSRIs		
paroxetine mesylate	T1	QL(1 cap/day) HD
METABOLIC DX ENZYME REPLACEMENT, ALPHA-MANNOSIDOSIS		
LAMZEDE	T3	PA SP
METABOLIC DISEASE ENZYME REPLACE, HYPOPHOSPHATASIA		
STRENSIQ	T3	PA SP
METABOLIC DISEASE ENZYME REPLACEMENT, MOCD		
NULIBRY	T3	PA SP
METABOLIC DISEASE ENZYME REPLACEMENT, POMPE DISEASE		
ELFABRIO	T3	PA SP
POMBILITI	T3	PA SP HD
METALLIC POISON, AGENTS TO TREAT		
CHEMET	T3	
deferasirox (Exjade)	T1	SP HD
deferasirox (Jadenu Sprinkle)	T1	SP HD
deferasirox (Jadenu)	T1	SP HD
deferiprone (Ferriprox)	T1	PA SP
EXJADE (deferasirox)	T3	PA SP HD
FERRIPROX	T3	PA SP
GALZIN	T3	
RADIOGARDASE	T3	
trientine hcl	T1	PA SP HD
trientine hcl 250 mg capsule (Syprine)	T1	PA SP HD
TRIENTINE HCL 500 MG CAPSULE	T3	PA SP HD
NATRIURETIC PEPTIDES		
VOXZOGO	T3	PA SP HD
NICOTINIC RECEPT.PARTIAL AGONIST, ALPHA4BETA2 SPEC		
TYRVAYA	T2	QL(8.4 mls/30 days)
OINTMENT/CREAM BASES		
RADIAGEL	T1	
PHARMACOLOGICAL CHAPERONE-ALPHA-GALACTOSID.A STABZ		
GALAFOLD	T3	PA SP HD

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List of Prescription Medications

UNCLASSIFIED DRUG PRODUCTS (Miscellaneous) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
PKU TX AGENT-COFACTOR OF PHENYLALANINE HYDROXYLASE		
javvygtor 100 mg tablet (Kuvan)	T3	PA SP HD
javvygtor powder packet (Kuvan)	T3	PA SP
sapropterin dihydrochloride	T3	PA SP HD
PROTEIN STABILIZERS		
ATTRUBY	T3	PA SP
VYNDAMAX	T3	PA QL (1 cap/day) SP HD
VYNDAQEL	T3	PA QL (4 caps/day) SP HD
SOLVENTS		
isopropyl alcohol	T1	
MURI-LUBE MINERAL OIL	T1	
THYMIC STROMAL LYMPHOPOIETIN (TSLP) INHIBITORS		
TEZSPIRE 210 MG/1.91 ML PEN	T3	PA QL(1 pen/28 days) SP HD
TEZSPIRE 210 MG/1.91 ML SYRING	T3	PA SP HD

UNCLASSIFIED DRUG PRODUCTS (SKIN CONDITIONS)

WOUND HEALING AGENTS, LOCAL	T3	PA SP
FILSUVEZ	T3	PA SP

UNCLASSIFIED DRUG PRODUCTS (Osteoporosis Products)

BONE RESORPTION INHIBITOR AND VITAMIN D COMBS.	T3	ST HD
BONE RESORPTION INHIBITORS		
ACTONEL (<i>risedronate sodium</i>)	T3	ST HD
alendronate sodium (FOSAMAX)	T1	HD
ATELVIA (<i>risedronate sodium dr</i>)	T3	ST HD
BINOSTO	T3	ST HD
BONIVA (<i>ibandronate sodium</i>)	T3	ST HD
EVISTA (<i>raloxifene hcl</i>)	T3	HD
FOSAMAX (<i>alendronate sodium</i>)	T3	ST HD
ibandronate sodium (Boniva)	T1	HD
raloxifene hcl (Evista)	T1	HD PPACA
<i>risedronate sodium</i> (Actonel)	T1	HD
<i>risedronate sodium</i> (Atelvia)	T1	HD
PROLIA	T3	PA SP
XGEVA	T3	PA SP

UNCLASSIFIED DRUG PRODUCTS (Pain Relief And Inflammatory Disease)

ANTI-INFLAM. INTERLEUKIN-1 RECEPTOR ANTAGONIST	T3	PA SP HD
ARCALYST	T3	PA SP HD

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List of Prescription Medications

UNCLASSIFIED DRUG PRODUCTS (Pain Relief And Inflammatory Disease) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ANTI-INFLAMMATORY, INTERLEUKIN-1 BETA BLOCKERS		
ILARIS	T3	PA SP HD
FIBROMYALGIA AGENTS, SEROTONIN-NOREPINEPHRINE INHIB		
SAVELLA	T2	HD
IMMUNOMODULATOR, B-LYMPHOCYTE STIM (BLYS)-SPEC INHIB		
BENLYSTA	T3	PA SP HD
UNCLASSIFIED DRUG PRODUCTS (Substance Abuse)		
OPIOID WITHDRAWAL THER, ALPHA-2 ADRENERGIC AGONIST		
<i>lofexidine hcl</i> (Lucemyra)	T1	QL(192 tabs/30 days)
<i>LUCEMYRA (lofexidine hcl)</i>	T2	QL (168 tabs/14 days)
OPIOID WITHDRAWAL THERAPY AGENTS, OPIOID-TYPE		
BUNAVAIL	T3	
<i>buprenorphine hcl</i>	T1	
<i>buprenorphine hcl/naloxone hcl</i>	T1	
<i>buprenorphine hcl/naloxone hcl</i> (Suboxone)	T1	
SUBOXONE (<i>buprenorphine-naloxone</i>)	T3	
ZUBSOLV	T2	
UNCLASSIFIED DRUG PRODUCTS (Transplant Medications)		
RHO KINASE INHIBITOR		
REZUROCK	T3	PA SP HD
UNCLASSIFIED DRUG PRODUCTS (Urinary Tract Conditions)		
BENIGN PROSTATIC HYPERPLASIA/MICTURITION AGENTS		
<i>alfuzosin hcl</i> (Uroxatral)	T1	HD
<i>dutasteride</i> (Avodart)	T1	HD
<i>finasteride</i> (Proscar)	T1	HD
PROSCAR (<i>finasteride</i>)	T3	HD
RAPAFLO 4 MG CAPSULE (<i>silodosin</i>)	T3	QL (1 cap/day) HD
RAPAFLO 8 MG CAPSULE (<i>silodosin</i>)	T3	HD
<i>silodosin 4 mg capsule</i> (Rapaflo)	T1	QL (1 cap/day) HD
<i>silodosin 8 mg capsule</i> (Rapaflo)	T1	HD
<i>tamsulosin hcl</i> (Flomax)	T1	HD
UROXATRAL (<i>alfuzosin hcl</i> er)	T3	HD
BPH 5-ALPHA-REDUCTASE INHIB-ALPHAI-ADRENOCEP ANTAG		
<i>dutasteride/tamsulosin hcl</i>	T1	HD

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UNCLASSIFIED DRUG PRODUCTS (Urinary Tract Conditions) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
CYSTINE-DEPLETING AGENTS, NEPHROPATHIC CYSTINOSIS		
CYSTAGON	T3	SP
KIDNEY STONE AGENTS		
mirabegron er 25 mg tablet (Myrbetriq)	T1	QL(1 tab/day) HD
mirabegron er 50 mg tablet (Myrbetriq)	T1	HD
tiopronin	T1	SP
URINARY TRACT ANTI-SPASMODIC, M(3) SELECTIVE ANTAG.		
darifenacin er 15 mg tablet	T1	HD
darifenacin er 7.5 mg tablet	T1	QL (1 tab/day) HD
solifenacin 10 mg tablet	T1	HD
solifenacin 5 mg tablet	T1	QL (1 tab/day) HD
URINARY TRACT ANTI-SPASMODIC/ANTI-INCONTINENCE AGENT		
flavoxate hcl	T1	HD
oxybutynin 5 mg tablet	T1	HD
oxybutynin 5 mg/5 ml solution	T1	HD
oxybutynin 5 mg/5 ml syrup	T1	HD
oxybutynin chloride	T1	HD
tolterodine tart er 2 mg cap	T1	QL (1 cap/day) HD
tolterodine tart er 4 mg cap	T1	HD
tolterodine tartrate	T1	HD
trospium chloride	T1	HD
UNCLASSIFIED DRUG PRODUCTS (Weight Management)		
APPETITE STIM. FOR ANOREXIA, CACHEXIA, WASTING SYND.		
megestrol acetate	T1	
VITAMINS (Nutritional/Dietary)		
FOLIC ACID PREPARATIONS		
folic acid	T1	
MULTIVITAMIN PREPARATIONS		
CITRANATAL MEDLEY	T3	
FOLET ONE	T2	
mvn no.53/iron/folic/dss/dha	T1	
OBSTETRIX ONE	T1	
VITLIPID N ADULT	T3	
PEDIATRIC VITAMIN PREPARATIONS		
multivit-fluor 0.25 mg/ml drop	T1	PPACA
SOLUVITA MULTIVITAMIN FLUORIDE (pedi multivit no.82 w-fluoride)	T3	PPACA
VITLIPID N INFANT	T3	

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

PA – Prior Authorization

QL – Quantity Limit

ST – Step Therapy

AGE – Age Requirement

SP – Specialty Medication

HD – May require home delivery pharmacy

PPACA – No Cost-Share Preventive Medication

CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

VITAMINS (Nutritional/Dietary) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
VITAMIN B PREPARATIONS		
POTABA	T2	HD
VITAMIN B PREPARATIONS (cont.)		
NIVA-FOL	T1	HD
VITAMIN B12 PREPARATIONS		
cyanocobalamin (vitamin b-12) (Nascobal)	T1	
VITAMIN D PREPARATIONS		
calcitriol 0.25 mcg capsule	T1	
calcitriol 0.5 mcg capsule	T1	
calcitriol 1 mcg/ml solution	T1	HD
calcitriol 1 mcg/ml vial	T1	
DRISDOL	T3	HD
ergocalciferol (vitamin d2)	T1	HD
ROCALTROL	T3	HD
VITAMIN K PREPARATIONS		
MEPHYTON	T3	
phytonadione 5mg tablet	T1	

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

PA – Prior Authorization

QL – Quantity Limit

ST – Step Therapy

AGE – Age Requirement

SP – Specialty Medication

HD – May require home delivery pharmacy

PPACA – No Cost-Share Preventive Medication

CSL – Oral cancer medication subject to cost-share limits

Exclusions and limitations for coverage

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

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

1STTIER.....	123, 129
2TEK.....	117
A	
AA 3%-D10W-CALCIUM-HEPARIN.....	102
abacavir.....	61
abacavir/lamivudine/zidovudine.....	61
abacavir sulfate/lamivudine.....	61
ABILIFY ASIMTUFI.....	144
ABILITY MAINTENA.....	142
abiraterone.....	50
ABOUTIME.....	123
ACAM2000.....	69
acamprosate.....	159
acarbose.....	44
ACCOLATE.....	29
ACCU-CHEK.....	117, 129
ACCUPRIL.....	78
ACCURETIC.....	76
ACCUTANE.....	147
ACCUTREND.....	118
ACD-A.....	39
ACD SOLUTION A.....	39
ACE AEROSOL.....	133
acebutolol.....	80
ACETAMIN-CAFF-DIHYDROCODEINE.....	20
acetamin-codein 300-30 mg/12.5.....	20
acetaminop-codeine 120-12 mg/5.....	20
acetaminophen/caff/dihydrocod.....	20
acetaminophen-cod.....	20
acetazolamide.....	95
acetic.....	97, 146
acetic acid/oxyquinoline.....	47
acetylcysteine.....	30
ACIPHEX.....	108
acitretin.....	146
ACTEMRA.....	116
ACTHIB.....	69
ACTIGALL.....	105
ACTI-LANCE.....	129
ACTIMMUNE.....	56
ACTIQ.....	21
ACTIVELLA.....	110
ACTONEL.....	161
ACTOPLUS MET.....	45
ACTOS.....	45
ACUVAIL.....	97
acyclovir.....	63
ADACEL TDAP.....	69

ADALAT CC	72
ADALIMUMAB.....	49
ADALIMUMAB-ADAZ.....	49
adapalene.....	147, 154
adapalene/benzoyl peroxide.....	147
ADBRY	159
ADDERALL.....	66
ADDYI.....	142
adefovir dipivoxil.....	64
ADEMPAS.....	74, 75
adenosine.....	71
ADIPEX-P.....	57
ADJUSTABLE.....	118
ADRENALIN.....	96
ADRIAMYCIN.....	50
ADUHELM	85
ADVAIR HFA.....	28
ADVANCED.....	93, 118, 129
ADVANCED DNA MEDICATED COLLECT	93
ADVOCATE.....	118, 123, 127, 129
ADZENYS.....	66
ADZYNMA.....	70
AEMCOLO.....	36
AEROCHAMBER.....	133
AEROTRACH	133
AEROVENT.....	133
AFINITOR.....	52
AFINITOR DISPERZ.....	52
AFLURIA.....	68
AGAMATRIX.....	118
AGGRASTAT	60
AGRYLIN.....	60
AIMOVIG.....	14, 18
AIRDUO DIGIHALER.....	28
AIRSUPRA.....	28
AJOVY.....	14, 18
AKEEGA.....	52
AK-FLUOR.....	94
AKTEN	98
AKYNZE	104
ALA-SCALP	151
albendazole.....	47
ALBENZA.....	47
albuterol.....	27, 28
ALBUTEROL.....	28
ALCAINE.....	98
alclometasone	151
ALCOHOL.....	148, 149
ALDACTAZIDE.....	96

Index of Medications

ALECENSA	53
alendronate	161
ALEVICYN PLUS	148
alfuzosin	162
ALINIA	58
aliskiren	81
ALKALINE	118
ALKERAN	50
allopurinol	25
almotriptan malate	14, 18
ALOCRIL	98
ALOMIDE	98
ALORA	110
alosetron	107
alprazolam	136
ALREX	97
ALTABAX	151
ALTAFLUOR BENOX	98
ALTERNATE	118, 129
ALTUVILLO	70
ALVESCO	29
ALYFTREK	155
amantadine	58
AMARYL	44
ambrisentan	75
amcinonide	151
AMICAR	70
amiloride	95, 96
AMINO	101, 102
aminocaproic acid	70
aminophylline	30
amiodarone	71
amitriptyline	140
amitriptyline/chlordiazepoxide	140
AMJEVITA	49
amlodipine	72, 73, 75, 77, 78, 82
amlodipine-atorvast	82
amlodipine besylate/benazepril	75
amlodipine besylate/valsartan	78
amlodipine-olmesartan	78
amlodipine/valsartan/hctiazid	77
AMMONUL	103
AMNESTEEM	147
amoxapine	140
amoxicillin	36, 47
amphetamine	66
AMPHETAMINE	66
ampicillin	36
ANADROL-50	109
anagrelide	60
ANA-LEX	109
ANALPRAM	109, 153
ANALPRAM HC	153
ANAPROX DS	25
anastrozole	51, 52
ANCOBON	41
ANDROGEL	109
ANGELIQ	112
ANNOVERA	90
ANORO ELLIPTA	28
ANTABUSE	159
anthralin	148
ANTICOAG SODIUM CITRATE	39
ANZEMET	104
APADAZ	20
APOKYN	58
apraclonidine	98, 99
aprepitant	104
APRETUDE	62
APRISO	106
APTIOM	87
APTIVUS	61
AQNEURSA	102
AQUA	118, 151
AQUA GLYCOLIC HC	151
ARANESP	90
ARAVA	24
ARCALYST	161
ARCAPTA NEOHALER	28
ARGATROBAN	40
ARICEPT	65
ARIDOL	93
ARIKAYCE	32
ARIMIDEX	52
ariPIPRAZOLE	144
ARIIXTRA	39
armodafnil	145
ARMOUR THYROID	154
AROMASIN	52
ARTHROTEC	25
ARTISS	151
ARYMO ER	21
asenapine	142, 143
ASMANEX HFA	29
ASMANEX TWISTHALER	29
aspirin/dipyridamole	60
ASSURE	118, 123, 127, 129, 135

Index of Medications

ASTAGRAF XL.....	117	BALVERSA	53
ASTRINGYN.....	71	BAQSIMI	100
ATABEX EC.....	135	BARACLUDE.....	64
ATACAND.....	77, 79	BARRIGEL	134
atazanavir.....	62	BASAGLAR KWIKPEN.....	46
ATELVIA	161	BAXDELA.....	36
atenolol	80, 81	BCG.....	69
AT HOME A1C.....	118	BD.....	129
atomoxetine.....	142	BELBUCA	21
atorvastatin.....	82, 83	BELVIQ	57
atovaquone.....	48	BELVIQ XR.....	57
atovaquone/proguanil.....	48	benazepril	75, 76, 78, 79
atropine.....	99, 103, 105	benazepril/hydrochlorothiazide.....	76
ATROPINE	99	bendamustine.....	50
ATROVENT HFA.....	27	BENDAMUSTINE.....	50
ATTRUBY	161	BENICAR	77, 79
AURYXIA.....	101	BENLYSTA	162
AUSTEDO.....	85	benoxinate hcl/fluorescein.....	98
AUTOJECT	118	BENZAMycin	37
AUTO-LANCET.....	118	BENZEFOAM	149
AUTOLET.....	118, 121	BENZEPRO	149
AUTOSHIELD.....	123	BENZHYDROCODONE-ACETAMINOPHEN	20
AVALIDE.....	77	BENZNIDAZOLE	48
AVANDIA	45	benzonatate	93
AVAR.....	38	benzoyl peroxide.....	37, 38, 147, 149, 150
AVC.....	47	benzphetamine.....	57
AVELOX.....	36	benztropine.....	58
AVITENE.....	71	BEPREVE	43
AVONEX.....	86	BERINERT	156
AVSOLA	49	BESIVANCE	31
AYGESTIN.....	114	BETADINE	97
AYVAKIT	53	betamethasone.....	42, 151, 152, 154
AZASAN.....	117	betamethasone/propylene glyc.....	151
azathioprine.....	117	BETASERON	86
azelaic acid.....	151	betaxolol	80, 98
azelastine	43, 96	bethanechol	67
AZILECT	58	BETIMOL	98
azithromycin	35	BETOPTIC S	98
AZOR.....	78	BEVESPI AEROSPHERE	28
B		BEVYXXA	39
BACIGUENT	31	bexarotene	50
bacitracin.....	31	BEXZERO	68
bacitracin/polymyxin b sulfate.....	31	BEYAZ	91
baclofen	135	bicalutamide	50
BACTRIM	32	BIDIL	81
BACTRIM DS.....	32	BIJUVA	110
BAFIERTAM.....	86	BIKTARVY	63
BALCOLTRA.....	91	BILTRICIDE	47
balsalazide	106	batimoprost.....	98

Index of Medications

BIMZELX.....	148	butalb-acetamin-caff 50-300-40.....	14, 18
BINOSTO.....	161	butalb-acetamin-caff 50-325-40.....	14, 18
bisac-nacl/nahco3/kcl/peg.....	107	butalb/acetaminophen/caffeine.....	14, 18
bisoprolol	80, 81	butalb-aspirin-caff 50-325-40	14, 18
BLEPH-10.....	31	butalbit/acetamin/caff/codeine	22
BLEPHAMIDE.....	31	butalbital/acetaminophen	14, 18
BLOOD	70, 71, 118, 120, 125, 129	butalbital-asa-caffeine cap (Fiorinal).....	14, 18
BLOOD GLUCOSE.....	118, 120	butorphanol tartrate.....	21
BLOXIVERZ.....	65	BUTTRANS.....	21
BLU.....	118, 119	BUTTERFLY.....	129
BLULINK.....	118, 119, 129	BYDUREON.....	43
BLUNT.....	123, 124	BYETTA.....	43
BONIVA.....	161	BYSTOLIC.....	80
BONJESTA.....	104	C	
BOOSTRIX TDAP.....	69	CABENUVA.....	60
BORTEZOMIB.....	53	cabergoline	114
BORUZU.....	53	CABLIVI.....	70
bosentan	75	CABOMETYX.....	53
BOSULIF.....	53	CADUET.....	82
BREATHERITE.....	133, 134	CAFERGOT.....	14, 18
BREATHRITE.....	134	caffeine.....	86
BREEZE	118	CALAN SR.....	72
BREO ELLIPTA.....	28	calcipotriene	148, 154
bretyleum.....	72	CALCIPOTRIENE	148
BREVIBLOC	80	calcitriol.....	148, 149, 164
BREZTRI AEROSPHERE	29	calcium acetate	101
BRILINTA.....	60	calcium gluc.....	101
brimonidine	98	CALDOLOR.....	25
brinzolamide	98	CALQUENCE.....	53
BRIUMVI.....	86	CAMZYOS.....	72
BRIVIACT	87	candesartan cilexetil	79
bromfenac	97	candesartan/hydrochlorothiazid	77
bromocriptine	58	capecitabine	51
brompheniramine/pseudoephed/dm	93	CAPEX.....	151
BROMSITE	97	CAPLYTA.....	142
BRONCHITOL	155	CAPRELSA.....	53
BRUKINSA	53	captopril	76, 78
BRYHALI	151	captopril-hctz	76
budesonide	29, 109, 112	CAPVAXIVE.....	68
budesonide/formoterol	28	CARBAGLU.....	159
BULLSEYE.....	129	carbamazepine	87, 89
bumetanide	95	CARBAMAZEPINE	87
BUNAVAIL.....	162	CARBATROL	87
BUPRENEX.....	21	carbidopa	58, 59, 60
buprenorphine	21, 162	carbidopa/levodopa	58, 59
bupropion	137, 154	carbinoxamine	42
buspirone	136	CARDENE.....	72

Index of Medications

CARDURA.....	76, 77	CHENODAL.....	106
CARDURA XL.....	77	chlordiazepoxide.....	103, 136, 140
CAREFINE.....	123	chlordiazepoxide/clidinium br.....	103
CAREONE.....	118, 129	chlorhexidine gluconate.....	157
CARESENS.....	118	chloroquine.....	48
CARETOUCH	118, 123, 124, 127, 129, 149	chlorpromazine.....	145
carglumic.....	159	chlorpropamide.....	44
carisoprodol.....	23, 135	chlorthalidone.....	81, 96
carisoprodol/aspirin.....	23	chlorzoxazone.....	135
carisoprodol/aspirin/codeine.....	23	CHOLBAM.....	106
CAROSPIR.....	95	cholestyramine.....	83, 84
CAROSPIR SUSP	96	choline salicyl/mag salicylate.....	14, 18
carteolol.....	98	CHORIONIC GONAD.....	115
carvedilol.....	76	CHOSEN.....	118, 123
carvedilol er	76	CIALIS.....	157
CASODEX.....	50	CIBINQO.....	25
CATAPRES.....	80	cyclodan.....	42
CAVERJECT	157	CICLODAN.....	42, 48
CAYA CONTOURED.....	92	ciclopirox.....	42, 48
CAYSTON.....	33	cilostazol.....	60
cefaclor.....	34	CILOXAN.....	31
cefadroxil.....	34	CIMDUO.....	61
cefazolin.....	34	cimetidine.....	106
CEFAZOLIN.....	34	CIMZIA.....	49
cefdinir.....	34	cinacalcet	158
cefepime.....	34	CINRYZE.....	156
cefixime.....	34	CINVANTI.....	104
cefotaxime	34	CIPRO.....	36
cefpodoxime proxetil	34	ciprofloxacin.....	30, 36
cefprozil.....	34	ciprofloxacin hcl.....	30
ceftriaxone	34	CIPROFLOXACIN HCL-FLUOCINOLONE	30
cefuroxime	34	cisplatin.....	50
CELEBREX.....	27	CISPLATIN.....	50
celecoxib	27	citalopram.....	137
CELLCEPT.....	117	CITRANATAL.....	102, 135
CELONTIN	87	CITRANATAL BLOOM	102
CENTANY.....	37	CITRANATAL MEDLEY	163
cephalexin.....	34	CITRATE PHOSPHATE DEXTROSE	39
CEQUA.....	100	CLARAVIS	147
CEQR.....	118	CLARINEX.....	42, 43
CERDELGA	159	clarithromycin.....	35
CERVIDIL.....	113	clemastine.....	42
certirizine.....	43	CLEOCIN	34, 35, 38
CETROTIDE.....	113	CLEVER.....	118, 129, 134
CETYLEV.....	159	CLEVER CHOICE HOLDING CHAMBER	134
cevimeline.....	67	CLEVIPREX.....	73
CHANTIX.....	154	CLICKFINE.....	124, 126
CHEMET.....	160	CLIMARA.....	110
CHEMSTRIP	118	CLINDACIN.....	38

Index of Medications

CLINDACIN ETZ.....	38	cortisone	112
clindamycin.....	34, 35, 37, 38, 147	CORTISPORIN.....	37
CLINDAMYCIN	35	CORVERT.....	72
clindamycin palmitate.....	35	COSENTYX.....	147, 148
clobazam.....	87	COTELLIC.....	52
clobetasol.....	152, 153	CRENESSITY.....	114
clobetasol propionate/emoll.....	152	CRESEMBA	41
CLOCORTOLONE	152	CRINONE.....	114, 115
clodan	152	cromolyn.....	24, 29, 98
CLODAN.....	152	crotamiton.....	58
CLODERM	152	CURITY	148
clofarabine	51	CUROSURF.....	156
clomiphene	115	CUVPOSA	103
clomipramine.....	140	cyanocobalamin	164
clonazepam.....	87	cyclobenzaprine	135
clonidine	80, 141	CYCLOGYL.....	99
clopidogrel	60	CYCLOMYDRIL	99
clorazepate dipotassium.....	136	cyclopentolate	99
clotrimazole	41, 42	cyclophosphamide	50
clozapine	142, 143	CYCLOPHOSPHAMIDE	50
CLOZAPINE ODT.....	143	CYCLOSERINE.....	33
CLOZARIL.....	143	CYCLOSET	44
COAGUCHEK	129	cyclosporine	117
COARTEM	48	CYLTEZO	49
codeine/butalbital/asa/caffein	22	CYSTADROPS	100
codeine sulfate.....	21	CYSTAGON	163
colchicine	25, 27	CYSTARAN	100
COLCRYS	25	CYSTO-CONRAY II	94
colesevelam	83	CYSTOGRAFIN	94
COLESTID.....	84	CYTOMEL	154
colestipol.....	84	CYTOTEC	105
COLOR.....	129	D	
COMBIPATCH	110	dabigatran	40
COMBIVENT RESPIMAT	28	DACOGEN	51
COMETRIQ	53	dalfampridine	86
COMFORT	122, 123, 124, 125, 126, 127, 128, 129, 130, 131, 132, 133, 134, 148	DALIRESP	30
COMIRNATY.....	68	danazol.....	114
COMPACT SPACE CHAMBER.....	134	DANTRIUM	135
COMPazine.....	104	dantrolene	135
COMPLERA	62	DANZITEN	54
CONTOUR.....	118, 119	dapsone	33, 148
CONTRAVE.....	57	DAPTACEL DTAP	69
COOL.....	119	darifenacin er	163
COPIKTRA	53	darunavir	61
COREG.....	76	dasatinib	53, 54
COREG CR	76	DAURISMO	52
coremino er	37	DAXBIA	34
CORLANOR	74	DAXXIFY	67
CORTENEMA.....	109	DAYPRO	25

Index of Medications

DAYTRANA	141	DICLOFENAC EPOLAMINE	147
DAYVIGO	146	diclofenac potassium.....	19
DEFENCATH	159	diclofenac sod dr.....	26
deferasirox.....	160	diclofenac sod ec	26
deferiprone.....	160	diclofenac sodium.....	25, 26, 147
deflazacort.....	112	diclofenac sodium/misoprostol.....	25
DELSTRIGO	62	dicloxacillin	36
demeclacycline.....	37	dicyclomine hcl.....	103
DEMSEER.....	80	diethylpropion	57
DEPEN.....	24	DIFICID.....	35
DEPO-ESTRADIOL	110	diflunisal	14, 18
DEPO-PROVERA	91, 114	digoxin	74
DEPO-SUBQ PROVERA	91	dihydroergotamine	14, 18
DEPO-TESTOSTERONE	109	DILANTIN.....	88
DERMA-SMOOTH-E-FS	152	DILATRATE-SR.....	74
DERMATOP	152	diltiazem	73
dermazene	153	dimethyl	86, 159
DERMAZENE	153	DIOVAN.....	77, 79
DERMOTIC	96	diphenoxylate hcl/atropine	103
DESCOVY	61	DIPHThERIA-TETANUS TOXOIDS-PED	69
desflurane	23	DIPROLENE	152
desipramine	140	dipyridamole	60
desloratadine	43	DISALCID	24
desmopressin.....	110	disopyramide	72
desog-e.estradiol/e.estriadiol	91	disulfiram	159
desogestrel-ethinyl estradiol	91	DIURIL.....	96
desonide.....	152	divalproex	88
DESOWEN	152	DIVIGEL	110
desoximetasone	152, 153	docetaxel	56
desvenlafaxine succnt er.....	138, 139	dofetilide	72
dexamethasone	31, 97, 112	DOJOLVI	100
DEXCOM	119	donepezil	65
DEXILANT	108	DONNATAL	105
dexlansoprazole	108	DOPTELET	90
dexmethylphenidate	141	DORAL	145
dextroamp.....	66	dorzolamide	98, 99
dextroamp-amphet er.....	66	DOVATO	60
dextroamphetamine	66	DOVONEX	148
dextroamphetamine er.....	66	doxazosin	76, 77
DIACOMIT	87	doxepin	140, 146
DIASTAT	87	doxercalciferol	158
diatrizoate	94	doxycycline	37, 157
DIATRUE	119	doxylamine succinate/vit b6	104
diazepam	87, 136	DRISDOL	164
diazoxide	101	dronabinol	104
DIBENZYLINE.....	67	DROPLET	119, 124, 127, 130
dichlorphenamide	159	DROPSAFE	124, 125, 127, 148
DICLAREAL	147	drospir/eth estra/levomefol ca	91
diclofenac.....	97, 147	DROXIA	71

Index of Medications

droxidopa67	emollient combination no.60.....	149
DRYSOL	148	Empaveli	70
DUAVEE	112	EMSAM	137
DUETACT.....	.45	emtricitabine.....	61
DULERA.....	.28	emtricitabine-tenovf	61
duloxetine	139	EMTRIVA	62
DUOPA.....	.59	EMVERM	47
DUPIXENT.....	116	enalapril	76, 78, 79
DURAGESIC.....	.21	enalaprilat	78
dutasteride	162	enalapril/hydrochlorothiazide.....	76
dutasteride/tamsulosin	162	ENBREL	49
DYANAVEL XR.....	.66	ENDO-AVITENE	71
DYAZIDE.....	.96	ENDOMETRIN	115
E		ENGERIX	70
EASIVENT	134	ENGERIX-B	70
EASY.....	. 119, 124, 127, 130, 148, 149	ENHERTU	56
EASYGLUCO	119	ENLITE	120
EASYMAX	119	enoxaparin	39, 40
EASYPPOINT	124	ENSPRYNG	116
EBGLYSS	158	entacapone	58, 59
ECLIPSE.....	124, 127	entecavir	64
EC-NAPROSYN.....	.26	ENTEROVU	94
econazole42	ENTOCORT EC	112
ECOZA.....	.42	ENTRESTO	77
edaravone85	ENVARSUS XR.....	117
EDARAVONE85	ENZOCLEAR	149
EDARBI79	EPCLUSA	64
EDEX	157	EPIDIOLEX	87
EDURANT61	EPIFOAM	153
efavirenz.....	.61, 62	epinastine	43
effer-k	102	epinephrine	65, 67, 96
EFFER-K.....	102	EPIVIR	64
EFFIENT60	plererone	95
EFUDEX57	EPOGEN	90
EGRIFTA	112	eprosartan	79
ELEMENT	119	eftifibatide	60
ELESTRIN	110	EQUETRO	137
eletriptan hydrobromide14, 18	ergocalciferol	164
ELFABRIO	160	ergoloid	81
ELIDEL	116	ergotamine tartrate/caffeine14, 18
ELIMITE58	eribulin	52
ELIQUIS.....	.39	ERIVEDGE	52
ELLA91	ERLEADA	51
ELMIRON23	erlotinib	54
EMBRACE119, 120, 124, 130	ERVEBO	70
EMCYT56	ERYPED	35
EMEND104	ery-tab dr	35
EMFLAZA112	ERY-TAB DR	35
EMGALITY14, 18, 86	erythromycin	31

Index of Medications

erythromycin base.....	.35, 38	ezetimibe81, 82, 84
erythromycin ethylsuccinate.....	.35	ezetimibe/simvastatin.....	.81
erythromycin stearate.....	.35	EZ FLU.....	.69
ERZOFRI.....	.143	E-Z-HD94
escitalopram.....	.137, 138	E-Z-PAQUE94
ESGIC.....	.14, 18	E-Z-PASTE94
esmolol81	E-Z SPACER.....	.134
esomeprazole dr.....	.108	EZ-VAC.....	.120
esomeprazole mag dr.....	.108	F	
ESOMEPRAZOLE STRONTIUM.....	.108	FABHALTA.....	.70
estazolam.....	.145	FACTIVE36
ESTRACE.....	.115	famciclovir.....	.63
estradiol90, 91, 92, 110, 111, 115	famotidine.....	.106
ESTRING.....	.115	FARESTON.....	.56
ESTROGEL.....	.111	FARXIGA44
estrogen, ester/me-testosterone110	FARYDAK50
ESTROSTEP FE.....	.91	febuxostat25
eszopiclone146	felbamate88
ethacrynat.....	.95	FELDENE26
ethambutol33	felodipine73
ethinyl estradiol/drospirenone.....	.91	FEMARA52, 53
ethosuximide88, 89	FEMCAP92
etodolac26	FEMHRT111
etonogestrel/ethinyl estradiol.....	.90	FEMRING115
EUCRISA151	fenofibrate84
EURAX.....	.58	fenofibric84
EVAMIST.....	.111	fenoprofen calcium.....	.26
EVEKEO.....	.66	FENSOLVI113
EVENCARE.....	.120	fentanyl21
everolimus.....	.52, 117	FENTANYL21
EVICEL71	FENTORA21
EVISTA.....	.161	FERAHEME102
EVOCLIN38	FERRIPROX160
EVOLUTION.....	.120	FETZIMA139
EVOTAZ.....	.62	FETZIMA ER.....	.139
EVOXAC.....	.67	FEXMID135
EVRYSDI159	FIBRICOR84
EXEL.....	.124	FIFTY50130
EXERLON.....	.65	FILSUVEZ161
exemestane.....	.52	FILTER124, 125
EXFORGE77, 78	finasteride162
EXFORGE HCT.....	.77	FINE126, 129, 130
EXJADE.....	.160	FINGERSTIX130
EXKIVITY.....	.54	FINTEPLA88
EXODERM.....	.42	FIORICET14, 18, 22
EXTENCILLINE.....	.36	FIORINAL14, 18
EYSUVIS97	Fiorinal With Codeine #3.....	.22
EZ.....	.69, 120, 124, 127, 129, 130	FIORINAL WITH CODEINE #3.....	.22
E-Z DISK94	FIRDAPSE86

Index of Medications

FIRMAGON53	fondaparinux.....	39
FLAGYL.....	.32	FORA	120, 130
FLAREX.....	.97	FORACARE.....	120, 130
flavoxate.....	.163	formaldehyde.....	48
flecainide.....	.72	FORTISCARE	120
FLECTOR147	FOSAMAX.....	161
FLEQUSUVY.....	.135	fosamprenavir calcium.....	62
FLEXICHAMBER.....	.134	fosaprepitant.....	104
FLOVENT.....	.29	fosfomycin tromethamine.....	33
FLOW-EZE.....	.124	fosinopril.....	76, 78
FLUAD.....	.69	fosinopril/hydrochlorothiazide.....	76
FLUARIX QUAD.....	.69	fosphenytoin.....	87, 88
FLUBLOK.....	.69	Fotivda.....	54
FLUCELVAX QUAD.....	.69	FRAGMIN.....	39
fluconazole.....	.41	FRAICHE.....	100
flucytosine.....	.41	FREESTYLE.....	120, 127, 130, 175
fludrocortisone.....	.113	FREESTYLE LIBRE	120
FLULALVAL QUAD.....	.69	fravatriptan succinate	18
FLUMADINE.....	.63	ful-glo	94
FLUMIST QUAD69	FUL-GLO.....	94
flunisolide96	FULPHILA	90
fluocinolone acetonide.....	.96, 152, 153	FURADANTIN.....	35
fluocinolone/shower cap.....	.152	FUROSCIX.....	95
fluocinonide152	furosemide	95
fluorescein.....	.94, 98	FUZEON	61
fluoride.....	.100	FYCOMPA.....	88
fluorometholone.....	.97	G	
FLUOROPLEX57	gabapentin.....	87, 88
fluorouracil.....	.57	GALAFOLD.....	160
fluoxetine138, 145	galantamine.....	65
fluphenazine145	galantamine er.....	65
flurbiprofen26, 97	GALZIN	160
flutamide.....	.51	GANCICLOVIR	63
fluticasone.....	.28, 96, 152	ganirelix acet.....	113
FLUTICASONE29	GANIRELIX ACET.....	113
fluticasone propion/salmeterol.....	.28	GARDASIL 9.....	70
fluticasone-salmeterol28, 29	GASTROCROM	24
FLUTICASONE-SALMETEROL29	GASTROGRAFIN	94
fluvastatin83	GASTROMARK	94
FLUVIRIN69	gatifloxacin.....	31, 32
fluvoxamine138	GATTEX	109
FLUZONE HIGH-DOSE.....	.69	GAVRETO	54
FLUZONE QUAD.....	.69	GE100.....	120
FML97	GE333.....	120
FOCALIN141	gefitinib	54
FOCINVEZ104	gelatin sponge, absorb/porcine	71
FOLET ONE.....	.163	GELFILM	98
folic acid.....	.163	GELFOAM	71
FOLLISTIM AQ115	GEL-ONE	24

Index of Medications

gemcitabine.....	.51	H	
GEMCITABINE.....	.51	HAEGARDA.....	156
gemfibrozil.....	.84	HALAVEN.....	52
GENERESS FE.....	.91	HALCION.....	145
GENOTROPIN.....	.113	halobetasol.....	152, 153
gentamicin.....	.32, 38	haloperidol.....	144
gentamicin sulfate.....	.31	HALUCORT.....	149
GENTEEL.....	.119, 120	HARVONI.....	64
GENVISC.....	.24	HEALTHPRO.....	121
GENVOYA.....	.63	HEALTHWISE.....	124, 127
GILENYA.....	.86	HEALTHY.....	121, 124, 130
GILOTrif.....	.54	HEMLIBRA.....	70
glatiramer.....	.86	HEMOCYTE PLUS.....	102
glatopa.....	.86	heparin.....	39, 40
GLEEVEC.....	.54	HEPARIN.....	40
GLEOSTINE.....	.50	HEPLISAV.....	70
glimepiride.....	.44, 45	HEPLISAV-B.....	70
glipizide.....	.44, 45	HETLIOZ.....	145
GLUCAGEN.....	.101	HIBERIX.....	69
glucagon.....	.101	homatropine.....	93, 99
GLUCOCARD.....	.120	HUMALOG.....	46
GLUCOCOM.....	.120, 130	HUMAPEN.....	121
GLUCOPHAGE XR.....	.44	HUMIRA.....	49
GLUCOSE.....	.101, 117, 118, 119, 120, 121, 122	HUMULIN.....	46
GLUCOTROL.....	.44	HUMULIN R.....	46
glyburide.....	.45	HYCAMTIN.....	53
GLYCATE.....	.103	HYCODAN.....	93
glycine.....	.48	hydralazine.....	80
glycopyrrolate.....	.103	HYDREA.....	50
GLYNASE.....	.45	HYDRO 35.....	150
GLYSET.....	.44	HYDRO 40.....	150
GLYXAMBI.....	.45	hydrochlorothiazide.....	76, 77, 78, 80, 81, 96
GOJJI.....	.120, 130	hydrocodone/acetaminophen.....	20
GOMEKLI.....	.52	HYDROCODONE-ACETAMINOPHEN.....	20
GONAL-F.....	.115	hydrocodone bitartrate.....	21, 22
GORDON'S UREA.....	.151	hydrocodone bit/homatrop me-br.....	93
granisetron.....	.104	hydrocodone/chlorphen p-stirex.....	93
GRANIX.....	.90	hydrocodone/cpm/pseudoephed.....	93
GRASTEK.....	.67	HYDROCODONE-GUAIFENESIN.....	93
griseofulvin.....	.41	hydrocodone-homatropine.....	93
GRIS-PEG.....	.41	HYDROCODONE-HOMATROPINE.....	93
GUAIACOL.....	.149	hydrocodone/ibuprofen.....	20
guanfacine.....	.80, 141	hydrocortisone.....	97, 109, 112, 152, 153
guanidine.....	.67	hydrocortisone/acetic acid.....	97
GUARDIAN.....	.120, 121	HYDROMORPHONE.....	21
GVOKE.....	.101	hydromorphone hcl.....	21
GYNAZOLE 1.....	.41	hydroxychloroquine.....	48

Index of Medications

hydroxyprogesterone	115	INJECTAFER	102
hydroxyprogesterone	114	INLYTA	54
hydroxyurea	50	INNOPRAN XL	81
hydroxyzine	42, 43	INOVA	150
hyoscyamine	105	INPEN	121
HYPER-SAL	159	INQOVI	51
HYPODERMIC	123, 124	INREBIC	54
HYPOLANCE	121	INSPIRACHAMBER	134
HYSINGLA ER	21	INSPRA	95
HYZAAR	77	INSUL-CAP	121
I		INSUL-EZE	121
ibandronate	161	INSULIN	44, 45, 46, 113, 124, 125, 127, 128, 129
IBRANCE	54	INSULIN ASPART	46
IBUDONE	20	INSULIN LISPRO	46
ibuprofen	20, 26	INSUPEN	124
ibuprofen/oxycodone hcl	20	INTEGRA	124
ibutilide	72	INTRAROSA	109
icatibant	156	INTRON A	56
icosapent	103	INVEGA	143
IDHIFA	56	INVEGA ER	143
IFE	157	INVELTYS	97
IHEALTH	121	iodine/potassium iodide	153
ILARIS	162	iodine/sodium iodide	153
ILEVRO	97	IODOFLEX	153
ILUMYA	147	IODOSORB	153
imatinib	54	IOPIDINE	99
IMBRUVICA	54	IPOL	68
IMCIVREE	57	ipratropium/albuterol sulfate	28
IMDELLTRA	56	ipratropium bromide	27, 96
imipenem	34	IQIRVO	158
imipramine	140	irbesartan	77, 79
imiquimod	149	irbesartan/hydrochlorothiazide	77
IMKELDI	54	IRESSA	54
IMMPHENITIV	74	ISENTRESS	62
IMPAVIDO	48	isoflurane	23
IMURAN	117	isomethopterin/dichlorphenacetaminophen	18
IMVEXXY	114	isomethopropyl/caf/acetaminophen	18
INBRIJA	59	isoniazid	33
INCONTROL	121, 124, 130, 148	isopropyl alcohol	161
INCRELEX	113	ISOPTO CARPINE	99
INCRUSE ELLIPTA	27	isosorbide	74, 81
indapamide	96	isotretinoin	147
INDICLOR	94	isosuprime	81
indomethacin	26	isradipine	73
INFANRIX DTaP	69	ITOVEBI	54
INFASURF	156	itraconazole	41
INFINITY	121	ivabradine hcl	74
INFLECTRA	49	ivermectin	47, 58, 151
INGREZZA	85	IWILFIN	54

Index of Medications

IXCHIQ70	LAGEVRIO62
J		lamivudine61, 62, 64
JAKAFI52	lamivudine/zidovudine61
JANSSEN COVID-19 VACCINE68	lamotrigine88
JANUMET45	LAMPIT48
JANUMET XR45	LAMZEDE160
JANUVIA44	LANCING117, 118, 119, 120, 121, 122, 123
JARDIANCE44	lanreotide114
javygtor161	LANREOTIDE114
JOENJA156	lansoprazole/amoxiciln/clarith105
JOURNAVX18	lansoprazole dr108
JULUCA60	lansoprazole odt108
JUXTAPID82	lanthanum101
JYLMAMVO51	LANZO121
JYNARQUE95	lapatinib54, 55
JYNNEOS70	LASTACRAFT43
K		latanoprost99
KADIAN21	LAZANDA21
KALBITOR156	LEDIPASVIR-SOFOSBUVIR64
KALYDECO155, 156	leflunomide24
KEFLEX34	lenalidomide53
KEPPRA88	LENTOCILIN36
KERAFOAM150	LENVIMA54
keralyt150	L.E.T.23
KERALYT150	LETAIRIS75
KERENDIA95	letrozole52
KESIMPTA86	leucovorin157
ketoconazole41, 42	LEUKERAN50
ketoprofen26	LEUKINE90
ketorolac19, 97	leuprolide53
KEVZARA116	levalbuterol hcl28
KINERET24	LEVIBID105
KINRIX69	LEVEMIR46
KISQALI53, 54	levetiracetam88
KITABIS PAK32	LEVITRA157
KLARON148	levobunolol99
KLONOPIN87	levofloxacin31, 36
klor-con102	levonorgestrel/ethin.estradiol91
Kloxxado40	levothyroxine154
KOSELUGO52	LEVOHYROXINE154
K-PHOS102	LEVSIN105
KRINTAFEL48	LEVULAN56
KYLEENA92	LIBERVANT87
KYNAMRO82	LICART147
KYNMOBI59	lidocaine23, 93, 109, 153
L		lidocaine 5% ointment23
LABETALOL77	lidocaine hcl23
LACRISERT97	LIDOCAINE-HYDROCORTISONE109
lactulose103, 107	LIFESHIELD124

Index of Medications

LIKMEZ32	LUER127
LILETTA92	LULICONAZOLE42
linezolid36	LUMAKRAS52
LINZESS107	LUMRYZ145
liothyronine154, 155	LUPANETA113
LIPOFEN84	LUPKYNIS117
LIQUID E-Z PAQUE94	LUPRON DEPOT113
LIQUID POLIBAR PLUS94	Iurasidone143
lisdexamfetamine66, 67, 140	LUXIQ152
lisinopril76, 78, 79	LYNPARZA54
lisinopril/hydrochlorothiazide76	LYRICA88
lissamine green94	LYSTEDA70
LITEAIRE134	LYTGOBI54
LITE TOUCH121, 125, 127, 130, 134	LYUMJEV46
LITETOUCH127, 134	M	
LITFULO25	MACROBID35
lithium137	mafenide38
LITHOSTAT103	MAGELLAN127
LIVALO83	MAGNI-GUIDE121
LIVTENCYCITY63	MAKENA115
L-MESITRAN151	MALARONE48
LOCORT112	malathion153
LODINE26	maprotiline140
LOESTRIN91	MARCAINE23
lofexidine162	MARPLAN137
LOKELMA101	MATULANE56
LOMAIRA57	MAVENCLAD86
LONHALA MAGNAIR27	MAXI127
loperamide103	MAXICOMFORT125, 127
LOPID84	MAXIDEX97
lopinavir/ritonavir62	MAYZENT86
LOPROX42	meclofenamate sodium26
LOQTORZI51, 55	MEDIHONEY151
lorazepam136	MEDISENSE121, 130
LORBRENA54	MEDROL112
LORTAB20	medroxyprogesterone91, 114
losartan/hydrochlorothiazide77	mefenamic acid19
losartan potassium79	mefloquine48
LOTEMAX97	megestrol56, 163
LOTENSIN76, 79	MEKINIST52
LOTENSIN HCT76	meloxicam26
loteprednol97	melphalan50
LOTREL75	memantine84, 85
lovastatin83	MENACTRA68
LOVAZA103	MENEST111
LOVENOX40	MENOPUR115
loxapine144	MENOSTAR111
lubiprostone107	MENQUADFI68
LUCEMYRA162	MENVEO A-C-Y-W-135-DIP68

Index of Medications

meperidine hcl.....	.21	midazolam.....	145
MEPHYTON	164	midodrine.....	67
meprobamate	136	MIEBO.....	97
mercaptopurine	51	MIFEPREX.....	158
meropenem	34	mifepristone.....	44, 158
mesalamine	106	miglitol.....	44
MESNEX.....	157	millipred.....	112
metaxalone	135	MILLIPRED.....	112
metformin.....	44, 45	MIMYX.....	149
methadone hcl.....	.21	MINI.....	49, 118, 119, 121, 122, 123, 125, 126, 129, 133
methamphetamine66	MINIMED.....	121, 127, 128
methazolamide.....	.95	MINIPRESS.....	77
methenamine hippurate33	MINITRAN.....	74
methenamine mandelate.....	.33	MINIVELLE.....	111
methimazole.....	.154	minocycline.....	37
METHITEST	109	minocycline er	37
methocarbamol.....	.135	minoxidil.....	80
methotrexate51	mirabegron	163
methoxsalen147	MIRCERA.....	90
methscopolamine.....	.105	MIRENA.....	92
methyldopa.....	.80	mirtazapine.....	136
methyldopate80	misoprostol	25, 105
methylene.....	.158	MITOSOL.....	99
METHYLENE158	M-M-R II VACCINE.....	69
methylergonovine113	MOBIC	26
METHYLIN.....	.141	MOBILE.....	121, 131
methylphenidate141, 142	modafinil.....	145
methylphenidate er141, 142	MODERNA COVID-19 VACCINE	68
methylprednisolone112	moexipril.....	79
methyl salicylate.....	.149	molindone.....	145
methyltestosterone.....	.109	MOLNUPIRAVIR.....	65
metoclopramide107	MOMETACURE.....	152
metolazone96	mometasone	96, 152
METOPIRONE.....	.94	MONOFERRIC	102
metoprolol81	MONOJECT	125, 128
metoprolol/hydrochlorothiazide81	MONSEL'S.....	71
metronidazole.....	.32, 37, 151	montelukast sodium.....	29
metyrosine80	MONUROL.....	33
mexiteline72	MORPHABOND ER.....	21
MEZPAROX-HC.....	.153	morphine sulfate.....	.21, 22
MIACALCIN.....	.116	MOTOFEN	103
MICAFUNGIN.....	.41	MOVANTIK	40
MICARDIS.....	.77, 78, 79	MOXATAG	36
miconazole41	MOXEZA	31
MICROCHAMBER.....	.134	moxifloxacin	36
MICRODOT.....	.121, 125	moxifloxacin hcl	31
MICROGESTIN 24 FE.....	.91	MRESVIA	70
MICROLET.....	.121, 130	MS CONTIN	22
MICROSPACER.....	.134	MULPLETA90

Index of Medications

MULTAQ.....	.72	neomycin/polymyxin b/dexametha	30
MULTI-LANCET.....	121	neomycin/polymyxin b/hydrocort.....	31
multivit-fluor.....	163	neomycin/polymyxn b/gramicidin.....	31
mupirocin.....	38	neomycin sulf/bacitracin/poly	31
mupirocin calcium.....	38	neostigmine.....	65
MURI-LUBE	161	NEO-SYNALAR.....	37
MUSE.....	157	NERLYNX	54
mvn no.53/iron/folic/dss/dha	163	NEULASTA.....	90
MYALEPT.....	115	NEULUMEX.....	94
mycophenolate.....	117	NEUPOGEN.....	90
MYDAYIS.....	66, 140	NEUPRO.....	59
MYDRIACYL.....	.99	NEURONTIN.....	88
Myfembree.....	113	nevirapine.....	61
MYGLUCOHEALTH.....	121, 131	NEXIUM.....	108
MYLERAN.....	.50	NEXIUM DR	108
MYOBLOC67	NEXLETOL.....	82
MYORISAN	147	NEXLIZET.....	82
MYTESI.....	103	NEXPLANON.....	91
N		NEXTERONE.....	72
nabumetone26	Nextstelis.....	91
nadolol81	niacin.....	84
naftifine.....	.42	NIASPAN.....	84
NAFTIN42	nicardipine	73
NALFON.....	.26	NICOTROL	154
NALOCET20	nifedipine	72, 73
naloxone.....	22, 40, 162	nilutamide	51
NALOXONE40	nimodipine	73
naltrexone40	NINLARO	54
NAMENDA.....	.85	nisoldipine er	73
NAMZARIC85	nitazoxanide	58
NANO	125, 126	nitisinone	159
NAPROSYN.....	.26	NITRO-DUR.....	74
naproxen	19, 25, 26	nitrofurantoin	35, 36
naratriptan hcl18	nitroglycerin	74
NARCAN.....	.41	NITROLINGUAL.....	74
NATACYN.....	.41	NITROMIST	74
NATAZIA91	nitroprusside	80
nateglinide45	NITROSTAT	74
NAYZILAM.....	.87	NITYR.....	159
NEBUPENT.....	.48	NIVA-FOL.....	164
nebusal.....	159	NIVESTYM	90
NEBUSAL.....	159	nizatidine	106
needles.....	125	NOCTIVA	110
NEEDLES.....	123, 124, 125, 126, 127, 133	NOKOR.....	125
nefazodone	138	NORCO	20
NEFFY.....	.65	NORDITROPIN FLEXPRO	113
NEMLUVIO.....	116	norelgestromin/ethin.estriadiol	92
neomycin	30, 31, 32, 146	NOREPINEPHRINE	137, 138, 139
neomycin/bacit/p-myx/hydrocort.....	.30	noreth-ethinyl estradiol/iron	91

Index of Medications

norethind-eth estrad.....	91, 111	OJEMDA.....	52
norethindrone.....	91, 92, 111, 114	OJJAARA.....	54
norgestrel-ethinyl estradiol.....	92	olanzapine	143, 145
NORLIQVA.....	73	olmesartan/amlodipin/hctiazid	77
NORPACE.....	72	olmesartan-hctz	78
NORPACE CR.....	72	olmesartan medoxomil	79
nortriptyline.....	140	olopatadine.....	43, 96
NORVASC.....	73	OLPRUVA.....	103
NORVIR.....	62	OLUMIANT.....	25
NOURIANZ.....	59	omega-3 acid ethyl esters.....	103
NOVAMAX.....	121	omeprazole dr.....	108
NOVAREL.....	115	OMISIRGE.....	71
NOVAVAX.....	68	OMNIPOD.....	121, 122
NOVOFINE.....	125	OMNIPRED.....	97
NOVOPEN.....	121	OMNITROPE.....	113
NOVOTWIST.....	125	ON CALL.....	122, 131
NUBEQA.....	51	ondansetron.....	104
NUCORT.....	152	ONETOUCH.....	122, 131
NUCYNTA.....	22	ONFI.....	87
NUCYNTA ER.....	22	ON-THE-GO.....	131
NUEDEXTA.....	86	ONUREG.....	51
NULEV.....	105	OPDIVO.....	55
NULIBRY.....	160	OPFOLDA.....	159
NULYTLY.....	107	opium.....	22, 104
NUMOISYN.....	158	opium/belladonna alkaloids.....	22
NUPLAZID.....	137	OPSUMIT.....	75
NURTEC ODT.....	19	OPSYNVI.....	75
NUVARING.....	90	OPTICHAMBER.....	134
NUZYRA.....	37	OPTUMRX.....	122
NYMALIZE.....	73	OPVEE.....	41
NYPOZI.....	90	ORACIT	102
nystatin	41, 42	ORALAIR.....	68
NYVEPRIA.....	90	ORAMAGICRX.....	158
O		ORAPRED ODT.....	112
OBREDON	93	ORAVIG.....	41
OBSTETRIX EC.....	135	ORENCIA.....	24
OBSTETRIX ONE.....	163	ORENITRAM	75
OBTREX.....	135	ORENITRAM ER	75
OCALIVA.....	106	ORFADIN.....	159
OCREVUS.....	86	ORGOVYX.....	53
octreotide.....	114	ORIAHNN.....	113
OCUFLOX.....	31	ORILISSA.....	113
ODACTRA.....	67	ORKAMBI.....	155
ODEFSEY.....	62	ORLADEYO.....	156
ODOMZO.....	52	orphenadrine	135
OFEV.....	156	ORTHO MICRONOR.....	92
ofloxacin.....	31, 36	oseltamivir	63
OGIVRI.....	53	osmitrol	95
OGSIVEO.....	54	OSMITROL.....	95

Index of Medications

OSMOLEX ER59	PASER	33
OSPHENA	158	PATADAY	43
OTEZLA	24	PATANASE	96
OTOVEL	30	PAVBLU	99
OTREXUP	24	PAXLOVID	65
OVACE PLUS	149	PAZEO	43
OVAL	122	pazopanib	54
OVIDE	153	PCE	35
oxandrolone	110	PEDIARIX	70
oxaprozin	25, 26	PEDVAXHIB	69
OXAPROZIN	26	peg3350/sod sulf, bicarb, cl/kcl	107
OXAYDO	22	peg3350/sod sul/nacl/kcl/asb/c	107
oxazepam	136	PEGANONE	88
oxcarbazepine	88	PEGASYS	64
OXERVATE	100	PEGINTRON	64
OXSORALEN-ULTRA	147	PEMAZYRE	54
OXTELLAR XR	88	PEMRYDI	51
oxybutynin	163	PENBRAYA	68
oxycodone hcl	20, 22	penicillamine	24
oxycodone hcl/acetaminophen	20	penicillin v potassium	36
OXYCODONE HCL ER	22	PEN NEEDLES	123, 124, 125, 126
oxymorphone hcl	22	PENTACEL	69
OZEMPIC	43	pentamidine	48
OZOBAX DS	135	pentazocine hcl/naloxone hcl	22
P		PENTIPS	123, 125, 126
pacerone	72	pentoxifylline	71
paclitaxel	56	PEROCET	20
PACLITAXEL	56	PERFECT POINT	123
PACNEX	150	PERIDEX	157
PAIN EASE MEDIUM STREAM SPRAY	23	perindopril	79
paliperidone er	143	permethrin	58
palonosetron	104	perphenazine	140, 145
PALYNZIQ	68	perphenazine/amitriptyline	140
PANCREAZE	107	PFIZER COVID-19 VACCINE	68
PANRETIN	57	PHARMABASE BARRIER	150
pantoprazole	108	PHASEAL	125
PANTOPRAZOLE	108	PHEBURANE	103
PAPAVERINE-ALPROSTADIL	157	phenazopyridine hcl	24
PAPAVERINE-PHENTOLAMINE	157	phendimetrazine	57
PAPAVERINE-PHENTOLMN-ALPROSTDL	157	phenelzine	137
PARADIGM	128	phenobarb/hyosc/atropine/scop	105
PARAGARD	92	phenobarbital	105, 145
paregoric	104	phenobarbital-belladonna	105
PAREMYD	99	PHENOBARBITAL-BELLADONNA	105
paricalcitol	158	phenoxybenzamine	67
paromomycin	47	phentermine	57
paroxetine	138, 160	PHENTOLAMINE-ALPROSTADIL	157
paroxetine cr	138	phenylephrine	42, 98
paroxetine er	138	phenylephrine hcl/prometh	42

Index of Medications

PHENYTEK.....	.88	potassium iodide/iodine	101
phenytoin.....	.88	pramipexole	59
PHESGO.....	.53	pramipexole er.....	59
PHOSLYRA.....	101	PRAMOSONE.....	153
PHOSPHOLINE IODIDE.....	.99	prasugrel	60
PHYSIOLYTE.....	146	pravastatin	83
PHYSIOSOL.....	146	praziquantel	47
physostigmine65	prazosin.....	77
phytonadione.....	164	PR BENZOYL PEROXIDE.....	150
PICATO57	PRECISIONGLIDE	124, 125
PIFELTRO.....	.61	PRECOSE	44
pilocarpine67, 99	PRED MILD	97
pimecrolimus.....	116	prednircarbate.....	152, 153
pimozide	142	prednisolone	31, 97, 112
pindolol.....	.81	prednisone	112
pioglitazone45	pregabalin88, 89
PIP122, 125, 131	PREGNYL	115
PIQRAY54	PREMARIN	111, 115
pirfenidone	159	PREMPhase	111
piroxicam.....	.26	PREMPRO	111
pitavastatin83	prenatal 12/iron/folic/dss/om3	136
PLAQUENIL.....	.48	PRENATAL 19.....	136
PLAVIX.....	.60	prenatal 34/iron/folic/dss/dha	136
PLEGRIDY86	prenatal vits15/iron/folic/dss.....	136
PLIXDA	154	PREPIDIL	113
PNEUMOVAX 23.....	.68	PREPOPIK	107
pnv	136	PRESTALIA	76
pnv 22/iron, gluc/folic/dss/dha	135	PRETOMANID	33
pnv 66/iron/folic/docusate/dha	135	PREVACID DR	108
pnv 69/iron/folic/docusate/dha	135	PREVENT	125
pnv 80/iron fum/folic/dss/dha	136	PREVIDENT	100
pnv/ferrous fum/docusate/folic	136	PREVNAR 13.....	68
pnv/iron, carb/docusat/folic ac.....	136	PREVYMIS	63
POCKET CHAMBER.....	134	PREZCOBIX	61
PODOCON-25	150	PREZISTA	61
podofilox	150	PRIFTIN	33
POLIBAR ACB.....	.94	PRILOSEC DR	108
polydimethylsiloxanes/silicon.....	150	primaquine	48
POLY HUB	125	PRIMAQUINE	48
POMALYST.....	.53	Primaxin	34
POMBILITI.....	160	PRIMAXIN	34
Ponvory86	PRIMEAIRE	134
POTABA	164	primidone89
potassium19	PRIMLEV	20
POTASSIUM95, 96, 102, 107	PRIMSOL	33
potassium bicarbonate/cit ac.....	102	PRINVIL	79
potassium chloride	102	PRISMASOL	102
potassium citrate	102	PRISTIQ ER	139
potassium citrate/citric acid.....	102	probencid	27

Index of Medications

probenecid/colchicine.....	.27	QUARTETTE.....	.92
PROCARDIA.....	.73	quazepam.....	.146
PROCARE SPACER WITH ADULT MASK.....	.134	QUAZEPAM.....	.146
PROCARE SPACER WITH CHILD MASK.....	.134	QUESTRAN.....	.84
PROCHAMBER.....	.134	quetiapine.....	.143, 144
prochlorperazine.....	.104	QUILLICHEW ER.....	.142
PRO COMFORT.....	.122, 125, 128, 131, 134, 148	QUILLIVANT XR.....	.142
PRO COMFORT SPACER WITH MASK.....	.134	quinapril.....	.76, 78, 79
PROCORT.....	.109	quinapril/hydrochlorothiazide.....	.76
PROCRIT.....	.90	quinidine.....	.72
PROCTOFOAM-HC.....	.109	quinine.....	.48
PRODIGY.....	.122, 128, 131	QUTENZA.....	.149
PROGLYCEM.....	.101	QVAR.....	.29
PROGRAF.....	.117	R	
PROLASTIN.....	.156	rabeprazole.....	.108
PROLENSA.....	.98	RADIAGEL.....	.160
PROLIA.....	.161	RADIAPLEXRX.....	.150
PROMACTA.....	.90	RADICAVA ORS.....	.85
promethazine.....	.43, 93, 104	RADIOGARDASE.....	.160
propafenone.....	.72	RAGWITEK.....	.68
propantheline.....	.103	raloxifene161
proparacaine.....	.98	ramelteon.....	.145
propranolol.....	.81	ramipril.....	.79
propylthiouracil.....	.154	ranitidine.....	.106
PROQUAD.....	.69	ranolazine.....	.71
PROSCAR.....	.162	RAPAFLO.....	.162
PROSTIN E2.....	.114	RAPLIXA.....	.71
protectives2/ceramide 1,3,6-ii.....	.150	rasagiline mesylate.....	.58, 59
PROTONIX.....	.108	RAYA.....	.125
PROTOPIC.....	.116	RAYALDEE.....	.158
protriptyline.....	.140	RAZADYNE ER.....	.65
PROVERA.....	.91, 114	READI-CAT 2.....	.94
PROVISC.....	.100	READYLANCE.....	.131
PROVOCHOLINE.....	.94	REBIF86
PULMICORT.....	.29	RECARBRIIO.....	.34
PULMOZYME.....	.156	RECLAST.....	.116
PURE.....	.125, 131, 148	RECOMBIVAX HB.....	.70
PURIXAN.....	.51	RECOTHROM.....	.71
PUSH.....	.131	RECTIV.....	.107
pyrazinamide.....	.33	REFUAH.....	.122
PYRIDIUM.....	.24	regadenoson.....	.93
pyridostigmine.....	.65	REGIMEX.....	.57
pyrimethamine.....	.48	REGLAN.....	.107
Q		REGRANEX.....	.149
QALSODY.....	.85	REGULAR.....	.125
QINLOCK.....	.54	RELAGARD.....	.47
QMIIZ ODT.....	.26	RELENZA.....	.63
QSYMIA.....	.57	RELIAMED.....	.122, 131
QUALAQUIN.....	.48		

Index of Medications

RELION.....	125	ROCKLATAN.....	99
RELISTOR.....	40	roflumilast.....	30
REMICADE.....	49	ropinirole.....	59
RENACIDIN.....	102	ROSANIL.....	38
repaglinide.....	45	rosuvastatin.....	83
REPATHA.....	82	Roszet.....	82
REPLACEMENT.....	70, 101, 102, 122, 160	ROTARIX.....	68
RESPA A.R.....	92	ROTATEQ.....	68
RESTASIS.....	100	ROXYBOND.....	22
RESTIZAN.....	149	ROZLYTREK.....	55
RETACRIT.....	90	RUBRACA	55
RETEVMO.....	54, 55	RUCONEST.....	156
REVATIO.....	75	rufinamide.....	89
REVLIMID.....	53	RUKOBIA.....	61
REVUFORJ.....	55	RUZURGI.....	86
REXULTI.....	144	RYBELSUS.....	43
REYATAZ.....	62	RYDAPT.....	55
REZDIFRA.....	158	RYTARY.....	59
REZIPRES.....	74	RYTHMOL SR.....	72
REZLIDHIA.....	56	S	
REZUROCK.....	162	SAF-CLENS AF.....	151
RHOPRESSA.....	99	SAFE.....	118, 122, 128, 129
ribaspHERE.....	64	SAFETY.....	122, 124, 125, 126, 127, 128, 129, 130, 131, 132, 133
RIBASPERE.....	65	SAFETYGLIDE.....	125, 128
ribavirin.....	63, 65	SAFYRAL.....	92
RIDAURA.....	25	SALAGEN.....	67
rifabutin.....	33	SALICATE.....	150
RIFAMATE.....	33	salicylic acid.....	150
rifampin.....	33	SALIMEZ FORTE.....	150
RIFATER.....	33	SALKERA.....	150
RIGHTEST.....	122, 131	salsalate.....	24
RILLUTEK.....	85	SALVAX DUO PLUS.....	150
riluzole.....	85	SANCUSO.....	104
rimantadine	63	SANDOSTATIN.....	114
RIMSO-50.....	23	SANTYL.....	154
ringer's solution	146	SAPHRIS.....	143
RINVOQ.....	25	sapropterin.....	161
RIOMET.....	44	SARAFEM	138
RIOMET ER.....	44	SAVAYSA.....	39
risedronate.....	161	SAVELLA.....	162
risperidone.....	143	SAXENDA.....	57
RITALIN.....	142	SCALACORT DK.....	153
RITEFLO.....	134	SCEMBLIX.....	55
ritonavir.....	62	scopolamine.....	104
rivastigmine	65	secobarbital.....	145
rizatriptan.....	19	SECUADO.....	143
ROBAXIN-750.....	135	SECURESAFE.....	125, 128
ROBINUL.....	103	selegiline.....	59
ROCALTROL.....	164	selenium.....	149

Index of Medications

SELZENTRY	61	SODIUM CITRATE.....	39
SEMGLEE	47	SODIUM DIURIL.....	96
SEN-SERTER	122	SODIUM EDECIN.....	95
SEREVENT DISKUS.....	28	sodium fluoride/potassium nit	100
SEROQUEL	144	SODIUM OXYBATE.....	145
SEROQUEL XR.....	144	sodium phenylbutyrate	103
SEROSTIM.....	113	sodium polystyrene	101
sertraline	138	sodium polystyrene sulfon/sorb	101
sevelamer	101	sod, pot chlor/mag/sod, pot phos	146
sevoflurane	23	SOGROYA.....	113
SFROWASA.....	106	solifenacin.....	163
SHINGRIX	70	SOLIQUA.....	44
SHORT	27, 28, 125, 126	SOLOSEC.....	32
SIGNIFOR	114	SOLTAMOX.....	56
SIKLOS	71	SOLUS.....	122, 132
sildenafil	75, 157, 158	SOLUVITA	163
SILICONE MASK	134	SOMATULINE DEPOT	114
SILIQ	147	SOMAVERT	158
silodosin	162	SOOLANTRA	151
SIL-SERTER	122	SORBITOL	146
SILVADENE	38	sotalol	81
silver nitrate	150, 153	SOTYKTU	147
silver sulfadiazine	38	SOTYLIZE	81
SIMBRINZA	99	SOVALDI	64
SIMLANDI	49	SPACE CHAMBER	134
SIMPONI	49, 50	SPEVIGO	147
SIMULECT	117	spinosad	58
simvastatin	81, 82, 83	SPIRIVA RESPIMAT	27
SINEMET	59	spironolact/hydrochlorothiazid	96
SINGLE	131, 148	spironolactone	95, 96
SINGULAIR	29	SPRAVATO	137
sirolimus	117	SPRITAM	89
SIRTURO	33	sps	101
SITZMARKS	94	SSKI	101
SIVEXTRO	36	STALEVO	59
SKELAXIN	135	STARLIX	45
SKLICE	58	STELARA	116
SKYLA	92	STENDRA	157
SKYRIZI	147	STERILANCE	132
SKY SAFETY	126	STERILE	132
SKYTROFA	113	STIMATE	110
SLYND	92	STIMUFEND	90
SMART	130, 131, 132	STIOLTO RESPIMAT	28
SMARTDIABETES	122	STIVARGA	55
SMARTEST	122, 132	STRENSIQ	160
sodium chloride for inhalation	159	STRIBILD	63
sodium chloride irrig solution	146	STRIVERDI RESPIMAT	28
sodium chloride/nahco3/kcl/peg	107	STROMECTOL	47

Index of Medications

SUBOXONE	162	TACHOSIL	71
SUCRAID	106	TACLONEX	154
sucralfate	105	tacrolimus	116, 117
SULAR	73	tadalafil	75, 157
sulfacetamide	31	TAFINLAR	52
sulfacetamide sodium	38, 148, 149	TAGITOL	94
sulfacetamide sod/sulfur/urea	38	TAGRISSO	55
sulfacetamide/sulfur/cleansr23	38	TAKHZYRO	68
sulfact sod/sulur/avob/otn/oct	38	TALTZ	147
sulfadiazine	32, 38	TALZENNA	55
sulfamethoxazole/trimethoprim	32	TAMIFLU	63
SULFAMYLYON	38	tamoxifen	56
sulfasalazine	106	tamsulosin	162
sulindac	26	TAPAZOLE	154
sumatriptan	19	TARKA	76
SUNLENCA	60	TASIGNA	55
SUNOSI	145	tasimelteon	145
SUPARTZ	24, 142	TASMAR	59
SUPER	130, 132	TAVALISSE	156
SUPRANE	23	TAVNEOS	70
SUPRAX	34	TAYTULLA	92
SURE	122, 123, 125, 126, 128, 132, 134, 148, 149	tazarotene	148, 149
SUREFLEX	122, 131	TAZVERIK	53
SURE-PEN	122	TC99M SULFUR COLLOID PREP	94
SURE-TEST	123	TDVAX	69
SURGIFOAM	71	TECENTRIQ	51, 55, 188
SURGISEAL	151	TECHLITE	126, 128, 132
SURVANTA	156	TEGRETOL	89
SUSTOL	104	TEGSEDI	159
SUTENT	55	TEKTURNA	81
SYMAX	105	TEL CARE	123, 132
SYMBICORT	29	telmisartan	77, 78, 79
SYMDEKO	155	telmisartan-amlodipine	78
SYMLINPEN	44	temazepam	146
SYMPROIC	40	TEMIXYS	61
SYMTUZA	61	TEMODAR	50
SYNALAR	37, 153	TEMOVATE	153
SYNAREL	113	temozolomide	50
SYNERA	23	TENIVAC	69
SYNJARDY	45, 46	tenofovir disoproxil fumarate	62
SYNJARDY XR	45, 46	TEPMETKO	55
SYNTHROID	155	terazosin	77
syringe	19, 39, 40, 49, 50, 61, 105, 116, 119, 128, 147	terbinafine	41
SYRINGE AVITENE	71	terconazole	41
syring-needl,disp,insul	128	teriflunomide	86
T		teriparatide	115, 158
TABLOID	51	TERIPARATIDE	115
TABRECTA	55	TERSİ FOAM	149

Index of Medications

TERUMO	126, 128
TESSALON PERLE	93
testosterone	109, 110
TESTOSTERONE	109, 110
tetrabenazine	85
tetracaine	98
tetracycline	37
tetradecyl	84
TETRAVISC	98
TEVIMBRA	55
TEXACORT	153
TEZSPIRE	161
THALOMID	33
THEO-24	30
theophylline	30
THIN	94, 125, 126, 129, 130, 131, 132
THIN WALL	126
thioridazine	145
thiothixene	144
THROMBIN-JMI	71
THROMBI-PAD	71
thyroid, pork	155
THYROLAR	155
tiagabine	89
TIAZAC	73
TIBSOVO	56
ticlopidine	60
TIGAN	104
TIGLUTIK	85
TIKOSYN	72
timolol	81, 98, 99
TINDAMAX	47
tinidazole	47
tiopronin	163
tirofiban-0.9% sodium chloride	60
TIROSINT	155
TISSEEL VHSD	151
TIVICAY	62
tizanidine	135
TOBI PODHALER	32
TOBRADEX	31
TOBRADEX EYE DROPS	31
tobramycin	31, 32
TOBRAMYCIN	32
tobramycin/dexamethasone	31
TOBREX	31
TOLAK	57
tolbutamide	45
tolcapone	.59, 60
tolmetin sodium	26
tolterodine	163
tolterodine tart er	163
tolvaptan	95
TOLVAPTAN	95
TOPCARE	126, 128, 132
TOPICORT	153
topiramate	89
toremifene	56
torsemide	95
TOTALVISC	100
TRACLEER	75
TRAMADOL	22
tramadol er	22
tramadol hcl	20, 22
TRAMADOL HCL	22
tramadol hcl/acetaminophen	20
trandolapril	76, 79
trandolapril/verapamil	76
tranexamic	70
TRANEXAMIC	70
tranexamic acid	70
TRANSDERM-SCOP	104
TRANSFER	62, 126
TRANXENE	136
tranylcypromine	137
travoprost	99
trazodone	138
TREANDA	51
TRECATOR	33
TRELEGY ELLIPTA	29
TREMFYA	147
TRESIBA	47
tretinoin	56, 147, 154
TREXALL	51
TREZIX	21
triamcinolone	157
triamterene	95, 96
triazolam	145, 146
TRIBENZOR	77
trichloroacetic acid	151
TRICHLOROACETIC ACID	151
TRICOR	84
trientine	160
TRIENTINE	160
trifluoperazine	145
trifluridine	63
TRIGLIDE	84
trihexyphenidyl	58

Index of Medications

TRIARDY XR	46
TRIKAFTA	155
TRILIPIX	84
trimethobenzamide	104, 105
trimethoprim	31, 32, 33
trimipramine	140
TRI-MIX	158
TRIMO-SAN	47
TRINTELLIX	139
TRIPTODUR	113
TRIUMEQ	61
TRIVISC	24
tropicamide	99
trospium	163
TRUE	123, 126, 128, 132, 148
TRUECONTROL	123
TRUEDRAW	123
TRUE METRIX	123
TRUEPLUS	126, 128, 132
TRULANCE	107
TRULICITY	43
TRUMENBA	68
TRUQAP	55
TRUSOPT	99
TUKYSA	55
TURALIO	55
TUXARIN ER	93
TUZISTRA XR	93
TWINRIX	70
TWIRLA	92
TWIST	129, 130, 131, 132, 151
TYBLUME	92
TYBOST	155
TYENNE	116
TYKERB	55
TYRVAYA	160
TYVASO	75
U	
UBRELVY	19
UDENYCA	90
UKONIQ	55
ULESFA	58
ULORIC	25
ULTANE	23
ULTI	123
ULTICARE	126, 128
ULTIGUARD	126, 128
ULTILET	126, 128, 132, 148
ULTRA	28, 122, 125, 126, 127, 128, 129, 130, 132, 147
ULTRACET	20
ULTRAFOAM	71
ULTRALANCE	132
ULTRAM	22
ULTRA-THIN	125, 126, 129, 132, 134
ULTRATLC	132
ULTRATRAK	123
ULTRAVATE	153
UNIFINE	123, 124, 126, 127
UNILET	129, 130, 132, 133
UNISTIK	123, 130, 133
UPTRAVI	75
URAMAXIN	150
urea	38, 48, 150
URECHOLINE	67
URIBEL	33
UROCIT-K	102
UROQID-ACID	102
UROXATRAL	162
URSO	106
ursodiol	105, 106
USTEKINUMAB	116
UTA	33
V	
VABOMERE	34
VAGIFEM	115
valacyclovir	63
VALCHLOR	57
valganciclovir	63
valproic	89
valsartan	77, 78, 79
VALSARTAN	79
VALTOCO	87
VALTREX	63
vancomycin	37
VANCOMYCIN	37
VANFLYTA	55
vardenafil	157, 158
VARIBAR	94
VARIVAX VACCINE	70
VARUBI	105
VASCEPA	103
VASERETIC	76
VASHE WOUND	146
VASOPRESSIN	95
VASOTEC	79
VAXELIS	69
VECAMYL	80
VECTICAL	149

Index of Medications

VEGZELMA.....	50	voriconazole.....	41
VELETRI.....	75	VORTEX.....	134
VELPHORO.....	101	VOSEVI.....	63
VELSIPITY.....	87, 88	VOWST.....	106
VELTASSA.....	101	VOXZOGO.....	160
VEMLIDY.....	64	VOYDEYA.....	70
VENCLEXTA.....	56	VRAYLAR.....	144
venlafaxine.....	139	VUMERITY.....	86
VENTAVIS.....	75	VYLEESI.....	142
VEOPOZ.....	70	VYLOY.....	56
VEOZAH.....	160	VYNDAMAX.....	161
verapamil.....	72, 73, 74, 76	VYNDAQEL.....	161
VERASENS.....	123	VYTORIN.....	82
VEREGEN.....	65	VYVANSE.....	66, 67, 140, 141
VERELAN.....	74	W	
VERELAN PM.....	74	WAKIX.....	90
VERIFINE.....	127, 129, 133	warfarin.....	38
VERQUVO.....	74	water for irrigation, sterile.....	146
VERZENIO.....	55	WAVESENSE.....	123
VEVYE.....	100	Wegovy.....	57
VFEND.....	41	WIDE SEAL DIAPHRAGM.....	92
V-GO.....	123	WINREVAIR.....	75
VIAGRA.....	158	WP THYROID.....	155
VIBERZI.....	107	X	
VIBRAMYCIN.....	37	XACIATO.....	47
VIDAZA.....	51	XADAGO.....	60
vigabatrin.....	89	XALKORI.....	55
VIGAMOX.....	31	XANAX.....	136
VIIBRYD.....	139	XARELTO.....	39
VIJOICE.....	156	XATMEP.....	51
VIMPAT.....	89	XCLAIR.....	149
VIOKACE.....	107	XCOPRI.....	89
VIRAZOLE.....	63	XDEMVY.....	58
VIREAD.....	62	XEIJANZ.....	25
VISCO.....	24	XELODA.....	51
VISTARIL.....	43	XELSTRYM.....	67
VISTOGARD.....	157	XENICAL.....	57
VITAFOL FE.....	136	XENLETA.....	36
VITALIPID.....	163	XEPI.....	38
vite ac/grape/hyaluronic acid.....	149	XERMELO.....	103
VITRAKVI.....	55	XGEVA.....	161
VIVAGUARD.....	123, 133	XIFAXAN.....	36
VIVELLE-DOT.....	111	XIGDUO XR.....	46
VIVIMUSTA.....	50	XiIDRA.....	100
VIVJOA.....	41	XOFLUZA.....	63
VIZIMPRO.....	55	XOLAIR.....	30
VOLTAREN.....	147	XOLREMDI.....	90
VOQUEZNA.....	107	XOPENEX.....	28

Index of Medications

XOSPATA.....	55	ZOLEDRONIC ACID.....	116
XPOVIO.....	56	ZOLINZA.....	50
XTAMPZA ER.....	22	zolmitriptan.....	19
XTANDI.....	51	zolpidem.....	146
XUREA.....	150	zolpidem tart er.....	146
XURIDEN.....	101	zonisamide.....	89
XYLOCAINE.....	72	ZONTIVITY.....	60
XYWAV.....	145	ZORTRESS.....	117
Y		ZORYVE.....	151
YALE.....	127	ZOSTAVAX.....	70
YASMIN 28.....	92	ZTLIDO.....	23
YAZ.....	92	ZUBSOLV.....	162
YERVOY.....	56	ZURZUVAE.....	137
YESINTEK.....	116	ZYDELIG.....	55
YORVIPATH.....	114	ZYLET.....	31
Z		ZYLOPRIM.....	25
zaflunast.....	29	ZYNYZ.....	51
zaleplon.....	146	ZYVOX.....	36
ZANAFLEX.....	135		
ZARONTIN.....	89		
ZARXIO.....	90		
ZAVPRET.....	19		
Zeglogue.....	101		
ZEJULA.....	55		
ZELBORAF.....	52		
ZEMAIRA.....	156		
ZEMPLAR.....	158		
ZENATANE.....	147		
ZENPEP.....	107		
ZENZEDI.....	67		
ZEPATIER.....	65		
ZEPOSIA.....	87		
ZERBAXA.....	34		
ZERVIASTE.....	43		
ZESTORETIC.....	76		
ZETIA.....	84		
zidovudine.....	61, 62		
ZIEXTENZO.....	90		
ZIHERA.....	51		
zileuton.....	27		
ZIMHI.....	41		
zinc oxide.....	150		
ziprasidone.....	144		
ZIRGAN.....	63		
ZITHROMAX.....	35		
ZOHYDRO ER.....	22		
ZOKINVY.....	156		
ZOLADEX.....	53		
zoledronic.....	116		

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

Cigna:

- 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 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
Nondiscrimination Complaint Coordinator
PO 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: 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).

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

- توجه: خدمات کمک زبانی، به صورت رایگان به شما ارائه می شود. برای مشتریان فعلی Cigna، لطفاً با شماره‌ای که در پشت کارت شناسایی ثابت شده باشید، در غیر اینصورت با شماره 1.800.244.6224 تماس بگیرید (شماره تلفن ویژه ناشنوایان: شماره 711 شماره مگری کنید).
Persian (Farsi)