



Cigna Healthcare Legacy (Standard) 4-Tier Prescription Drug List

Coverage as of January 1, 2025

For the State of California

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

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

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

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

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 This drug list is subject to change and all prior versions are no longer in effect.

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

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View your drug list online

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

- As soon as your new plan year starts, log into the **myCigna® App¹ or myCigna.com[®]**. Use the Price a Medication tool to get real-time information about the medications your plan covers.
- You can also view a pdf of this document online at **Cigna.com/PDL**. Click on the dropdown next to "Drug Lists for Employer Plans." Scroll down to the section for California Employer Drug Lists; then click on **California Legacy (Standard) 4 Tier (injectable specialty medications covered on tier 4) (DHMC) [PDF]**.

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. There are 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.

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

Information about this drug list

Frequently asked questions (FAQs) (cont.)

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).

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

Information about this drug list

Frequently asked questions (FAQs) (cont.)

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

Your Step Therapy rights under California State law:

- I. A carrier may impose prior authorization requirements on prescription drug benefits.
2. When there is more than one drug that is appropriate for the treatment of a medical condition, a carrier may require step therapy.
 - a. In circumstances where an insured is changing policies, the new policy shall not require a repeat of step therapy when that insured is already being treated for a medical condition

Information about this drug list

Frequently asked questions (FAQs) (cont.)

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, 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

Information about this drug list

Frequently asked questions (FAQs) (cont.)

can help you avoid surprises. Log in to the **myCigna App** or **myCigna.com** and use the Price a Medication tool to see how much your medication costs before you get to the pharmacy counter – or, even before you leave your doctor’s office.²

Q. What's a cost-share?

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

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

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

Q. What's a generic medication?

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

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

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

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

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

different than their brand-name versions, but they're just as safe and effective.

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

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

A. It depends. Some plans only allow fills at certain in-network pharmacies or through home delivery. Log in to the **myCigna App** or **myCigna.com**, or check your plan materials, to learn more about the pharmacies in your plan's network.

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

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

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

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

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

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

Q. Can I fill my prescriptions by mail?

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

Information about this drug list

Frequently asked questions (FAQs) (cont.)

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

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

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

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

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

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

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

To get started using Accredo, call **877.826.7657**, Monday–Friday, 7:00 am–10:00 pm CST and Saturdays, 7:00 am–4:00 pm CST. Be sure to call Accredo about two weeks before your next refill so

Information about this drug list

Frequently asked questions (FAQs) (cont.)

they have time to get a new prescription from your doctor's office.

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

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

You may also be able to use Accredo, to fill your prescription. Accredo has access to most specialty medications. Call **877.826.7657** for more information. Representatives are available Monday–Friday, 7:00 am–10:00 pm CST and on Saturdays, 7:00 am–4:00 pm CST.

Q. How do I fill my prescription?

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

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

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

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

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

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

A. You can use the online tools and resources on the **myCigna App** or **myCigna.com** to help you better

understand your pharmacy coverage. You can find out how much your medication costs, see which medications your plan covers, find an in-network pharmacy, ask a pharmacist a question, see your pharmacy claims and coverage details and more. You can also manage your Express Scripts® Pharmacy orders.

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

A. Covered medications are divided into tiers (or cost-share levels). Typically, the higher the tier, the 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 I, Tier 2, Tier 3 and Tier 4 medications.
2. **Log in to the myCigna App or myCigna.com to view your pharmacy coverage information.** You can also use the Price a Medication tool to find out how much your medication may cost you at the different pharmacies in your plan's network.
3. **Check your Summary of Benefits** coverage document.

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

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

Information about this drug list

Frequently asked questions (FAQs) (cont.)

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

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

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

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

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

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

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

Words you may need to know

- **Brand name drug:** A drug that is marketed under a proprietary, trademark-protected name. The brand name drug shall be listed in all CAPITAL letters.
- **Coinsurance:** A percentage of the cost of a covered health care benefit that an enrollee

Information about this drug list

Words you may need to know (cont.)

- pays after the enrollee has paid the deductible, if a deductible applies to the health care benefit, such as the prescription drug benefit.
- **Copayment:** A fixed dollar amount that an enrollee pays for a covered health care benefit after the enrollee has paid the deductible, if a deductible applies to the health care benefit, such as the prescription drug benefit.
 - **Deductible:** The amount an enrollee pays for covered health care benefits before the enrollee's health plan begins payment for all or part of the cost of the health care benefit under the terms of the policy.
 - **Drug tier:** A group of prescription drugs that corresponds to a specified cost sharing tier in the health plan's prescription drug coverage. The tier in which a prescription drug is placed determines the enrollee's portion of the cost for the drug.
 - **Enrollee:** A person enrolled in a health plan who is entitled to receive services from the plan.
 - **Exception request:** A request for coverage of a prescription drug. If an enrollee, his or her designee, or prescribing health care provider submits an exception request for coverage of a prescription drug, the health plan must cover the prescription drug when the drug is determined to be medically necessary to treat the enrollee's condition.
 - **Exigent circumstances:** When an enrollee is suffering from a health condition that may seriously jeopardize the enrollee's life, health, or ability to regain maximum function, or when an enrollee is undergoing a current course of treatment using a nonformulary drug.
 - **Formulary:** The complete list of drugs preferred for use and eligible for coverage under a health plan product, and includes all drugs covered under the outpatient prescription drug benefit of the health plan product. Formulary is also known as a prescription drug list.
 - **Generic drug:** The same drug as its brand name equivalent in dosage, safety, strength, how it is taken, quality, performance, and intended use. A generic drug is listed in bold and italicized

lowercase letters.

- **Non-formulary drug:** A prescription drug that is not listed on the health plan's formulary.
- **Out-of-pocket costs:** Copayments, coinsurance, and the applicable deductible, plus all costs for health care services that are not covered by the health plan.
- **Prescribing provider:** A health care provider authorized to write a prescription to treat a medical condition for a health plan enrollee.
- **Prescription:** An oral, written, or electronic order by a prescribing provider for a specific enrollee that contains the name of the prescription drug, the quantity of the prescribed drug, the date of issue, the name and contact information of the prescribing provider, the signature of the prescribing provider if the prescription is in writing, and if requested by the enrollee, the medical condition or purpose for which the drug is being prescribed.
- **Prescription drug:** A drug that is prescribed by the enrollee's prescribing provider and requires a prescription under applicable law.
- **Prior Authorization:** A health plan's requirement that the enrollee or the enrollee's prescribing provider obtain the health plan's authorization for a prescription drug before the health plan will cover the drug. The health plan shall grant a prior authorization when it is medically necessary for the enrollee to obtain the drug.
- **Step Therapy:** A process specifying the sequence in which different prescription drugs for a given medical condition and medically appropriate for a particular patient are prescribed. The health plan may require the enrollee to try one or more drugs to treat the enrollee's medical condition before the health plan will cover a particular drug for the condition pursuant to a step therapy request. If the enrollee's prescribing provider submits a request for step therapy exception, the health plans shall make exceptions to step therapy when the criteria is met.

Information about this drug list

Words you may need to know (cont.)

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

About this drug list

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

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

How to read this drug list

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

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

Tiers

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

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

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

Information about this drug list

How to read this drug list (cont.)

Letters (acronyms) next to medication names

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

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

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

Information about this drug list

How to read this drug list (cont.)

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

| Prescription Drug Name | Drug Tier | Coverage Requirements and Limits |
|---|-----------|----------------------------------|
| ANALGESICS (Pain Relief and Inflammatory Disease) | | |
| butalbital/acetaminophen | T1 | |
| ANALGESIC, NON-SALICYLATE AND BARBITURATE COMBINAT | | |
| 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, 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 Legacy (Standard) 4-Tier Prescription Drug List.

Information about this drug list

How to find your medication

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

| Condition | Page | Condition | Page |
|--|--------|--|--------|
| Analgesics (Pain Relief and Inflammatory Disease) | 18-22 | Anti-Infectives/Miscellaneous (Feminine Products) | 50 |
| Analgesics (Urinary Tract Conditions) | 23 | Anti-Infectives/Miscellaneous (Infections) | 50-52 |
| Anesthetics (Miscellaneous) | 23 | Anti-Infectives/Miscellaneous (Skin Conditions) | 52 |
| Anesthetics (Pain Relief and Inflammatory Disease) | 23 | Anti-Inflammatory Tumor Necrosis Factor Inhibiting Agents (Pain Relief and Inflammatory Disease) | 52, 53 |
| Anesthetics (Urinary Tract Conditions) | 23 | Anti-Neoplastics (Cancer) | 54-60 |
| Anti-Allergy (Allergy and Nasal Sprays) | 23, 24 | Anti-Neoplastics (Skin Conditions) | 60 |
| Anti-Arthritis (Pain Relief and Inflammatory Disease) | 23-26 | Anti-Obesity Drugs (Weight Management) | 60, 61 |
| Anti-Asthmatics (Asthma/COPD/Respiratory) | 26-29 | Anti-Parasitics (Infections) | 61, 62 |
| Antibiotics (Allergy/Nasal Sprays) | 29 | Anti-Parkinson's Drugs (Parkinson's Disease) | 62-64 |
| Antibiotics (Ear Medications) | 29, 30 | Anti-Platelet Drugs (Blood Thinners/Anti-Clotting) | 64 |
| Antibiotics (Eye Conditions) | 30, 31 | Antivirals (AIDS/HIV) | 65-68 |
| Antibiotics (Infections) | 31- 38 | Antivirals (Eye Conditions) | 68 |
| Antibiotics (Skin Conditions) | 38, 39 | Antivirals (Infections) | 68-70 |
| Anti-Coagulants (Blood Thinners/Anti-Clotting) | 39-41 | Antivirals (Skin Conditions) | 70, 71 |
| Antidotes (Gastrointestinal/Heartburn) | 41 | Autonomic Drugs (Allergy/Nasal Sprays) | 71 |
| Antidotes (Substance Abuse) | 41 | Autonomic Drugs (Alzheimer's Disease) | 71, 72 |
| Anti-Fungals (Eye Conditions) | 41 | Autonomic Drugs (Attention Deficit Hyperactivity Disorder) | 72, 73 |
| Anti-Fungals (Feminine Products) | 41 | Autonomic Drugs (Blood Pressure/Heart Medications) | 73 |
| Anti-Fungals (Infections) | 41, 42 | Autonomic Drugs (Urinary Tract Conditions) | 73 |
| Anti-Fungals (Skin Conditions) | 42, 43 | Biologicals (Allergy/Nasal Sprays) | 73 |
| Antihistamine and Decongestant Combination (Allergy/Nasal Sprays) | 44 | Biologicals (Blood Pressure/Heart Medications) | 74 |
| ANTIHISTAMINES (Allergy/Nasal Sprays) | 44 | Biologicals (Miscellaneous) | 74 |
| Antihistamines (Eye Conditions) | 44, 45 | Biologicals (Vaccines) | 74-76 |
| Anti-Hyperglycemics (Diabetes) | 45-50 | Blood (Blood Modifiers/Bleeding Disorders) | 76, 77 |
| Anti-Infectives (Feminine Products) | 50 | Blood (Blood Thinners/Anti-Clotting) | 77 |
| Anti-Infectives (Infections) | 50 | Cardiac Drugs (Blood Pressure/Heart Medications) | 77-80 |

Information about this drug list

How to find your medication (cont.)

| Condition | Page | Condition | Page |
|---|----------|--|----------|
| Cardiovascular (Asthma/COPD/Respiratory) | 80, 8I | Gastrointestinal (Pain Relief and Inflammatory Disease) | I2I |
| Cardiovascular (Blood Pressure/Heart Medications) | 8I-87 | Hormones (Hormonal Agents) | I2I-I28 |
| Cardiovascular (Cholesterol Medications) | 87-9I | Hormones (Infertility) | I28, I29 |
| CARDIOVASCULAR (Miscellaneous) | 9I | Hormones (Miscellaneous) | I29 |
| CNS Drugs (Alzheimer's Disease) | 9I, 92 | Hormones (Osteoporosis Products) | I29 |
| CNS Drugs (Miscellaneous) | 92 | Immunosuppressants (Pain Relief and Inflammatory Disease) | I29, I30 |
| CNS Drugs (Multiple Sclerosis) | 92, 93 | Immunosuppressants (Skin Conditions) | I30 |
| CNS Drugs (Pain Relief and Inflammatory Disease) | 93 | Immunosuppressants (Transplant Medications) | I30, I3I |
| CNS Drugs (Seizure Disorders) | 93-98 | Miscellaneous Medical Supplies, Devices, Non-Drug (Diabetes) | I3I-I40 |
| CNS Drugs (Sleep Disorders/Sedatives) | 98 | Miscellaneous Medical Supplies, Devices, Non-Drug (Miscellaneous) | I40, I4I |
| Colony Stimulating Factors (Blood Modifiers/Bleeding Disorders) | 98, 99 | Muscle Relaxants (Pain Relief and Inflammatory Disease) | I4I-I43 |
| Contraceptives (Contraception Products) | 99-I0I | Prenatal Vitamins (Nutritional/Dietary) | I43 |
| Cough/Cold Preparations (Allergy/Nasal Sprays) | I0I | Psychotherapeutic Drugs (Anxiety/Depression/Bipolar Disorder) | I43-I49 |
| Cough/Cold Preparations (Cough/Cold Medications) | I0I, I02 | Psychotherapeutic Drugs (Attention Deficit Hyperactivity Disorder) | I49-I52 |
| CXCR4 CHEMOKINE RECEPTOR ANTAGONIST | I02 | Psychotherapeutic Drugs (Miscellaneous) | I53 |
| Diagnostic (Diabetes) | I02, I03 | Psychotherapeutic Drugs (Schizophrenia/Anti-Psychotics) | I53-I56 |
| Diagnostic (Miscellaneous) | I03-I05 | Psychotherapeutic Drugs (Sleep Disorders/Sedatives) | I56 |
| Diuretics (Diuretics) | I05 | Skin Preps (Miscellaneous) | I56, I57 |
| EENT Preps (Allergy/Nasal Sprays) | I06 | Skin Preps (Pain Relief and Inflammatory Disease) | I57, I58 |
| EENT Preps (Ear Medications) | I06-II0 | Skin Preps (Skin Conditions) | I58, I59 |
| EENT Preps (Eye Conditions) | II0 | Smoking Deterrents (Smoking Cessation) | I59-I68 |
| Elect/Caloric/H2O (Cholesterol Medications) | II0 | Thyroid Prep (Hormonal Agents) | I68 |
| Elect/Caloric/H2O (Dental Products) | III | Unclassified Drug Products (AIDS/HIV) | I69 |
| Elect/Caloric/H2O (Diabetes) | III | Unclassified Drug Products (Asthma/COPD/Respiratory) | I70 |
| Elect/Caloric/H2O (Miscellaneous) | III, II2 | Unclassified Drug Products (Blood Modifiers/Bleeding Disorders) | I70 |
| Elect/Caloric/H2O (Nutritional/Dietary) | II2, II3 | Unclassified Drug Products (Blood Pressure/Heart Medications) | I70, I7I |
| Elect/Caloric/H2O (Urinary Tract Conditions) | II3 | Unclassified Drug Products (Cancer) | I7I |
| Gastrointestinal (Cholesterol Medications) | II3-I2I | | |
| Gastrointestinal (Gastrointestinal/Heartburn) | I2I | | |
| Gastrointestinal (Gastrointestinal/Heartburn) | I08-II4 | | |

Information about this drug list

How to find your medication (cont.)

| Condition | Page | Condition | Page |
|--|----------|--|----------|
| Unclassified Drug Products (Blood Pressure/Heart Medications) | I61, I62 | Unclassified Drug Products (Pain Relief and Inflammatory Disease) | I76 |
| Unclassified Drug Products (Dental Products) | I71 | Unclassified Drug Products (Seizure Disorders) | I77 |
| Unclassified Drug Products (Erectile Dysfunction) | I71, I72 | Unclassified Drug Products (Skin Conditions) | I77 |
| Unclassified Drug Products (Gastrointestinal/Heartburn) | I72 | Unclassified Drug Products (Substance Abuse) | I77 |
| Unclassified Drug Products (Hormonal Agents) | I72, I73 | Unclassified Drug Products (Transplant Medications) | I77 |
| Unclassified Drug Products (Miscellaneous) | I73-I75 | Unclassified Drug Products (Urinary Tract Conditions) | I77-I78 |
| Unclassified Drug Products (Nutritional/Dietary) | I76 | Unclassified Drug Products (Weight Management) | I78 |
| Unclassified Drug Products (Osteoporosis Products) | I76 | Vitamins (Nutritional/Dietary) | I78, I79 |

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-acetamin-caff 50-300-40 (Fioricet) | T1 | QL (6 caps/day) |
| butalb-acetamin-caff 50-325-40 | T1 | QL (6 tabs/day) |
| ESGIC (butalbital-acetaminophen-caff) | T3 | PA QL (6 tabs/day) |
| ESGIC CAPSULE (zebutal) | T3 | PA QL (6 caps/day) |
| FIORICET (phrenilin forte) | T3 | PA 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) |
| frovatriptan succinate | T1 | QL (18 tabs/30 days) |
| isomethept/dichlphn/acetaminop | T1 | |
| isomethepten/caf/acetaminophen | T1 | |
| naratriptan hcl | T1 | QL (9 tabs/30 days) |
| NURTEC ODT | T2 | PA QL (16 tabs/30 days) |
| rizatriptan benzoate | T1 | QL(12 tabs/30 days) |

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

T4 – Injectable Specialty Medications

PA – Prior Authorization

QL – Quantity Limit

ST – Step Therapy

AGE – Age Requirement

SP – Specialty Medication

HD – May require home delivery pharmacy

PPACA – No Cost-Share Preventive Medication

CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

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

| Prescription Drug Name | Drug Tier | Coverage Requirements and Limits |
|---|-----------|----------------------------------|
| ANTI-MIGRAINE PREPARATIONS (cont.) | | |
| rizatriptan benzoate (Maxalt Mlt) | T1 | QL (12 tabs/30 days) |
| rizatriptan benzoate (Maxalt) | T1 | QL (12 tabs/30 days) |
| sumatriptan | T1 | QL (2 boxes/30 days) |
| sumatriptan 4 mg/0.5 ml cart | T1 | QL (4ml/30 days) |
| sumatriptan 4 mg/0.5 ml inject | T1 | QL (4ml/30 days) |
| sumatriptan 6 mg/0.5 ml cart | T1 | QL (4ml/30 days) |
| sumatriptan 6 mg/0.5 ml inject | T1 | QL (4ml/30 days) |
| sumatriptan 6 mg/0.5 ml syring | T1 | QL (4ml/30 days) |
| sumatriptan 6 mg/0.5 ml vial | T1 | QL (5ml/30 days) |
| sumatriptan succ 100 mg tablet | T1 | QL (18 tabs/28 days) |
| sumatriptan succ 25 mg tablet | T1 | QL (18 tabs/28 days) |
| sumatriptan succ 50 mg tablet | T1 | QL (9 tabs/30 days) |
| sumatriptan succ/naproxen sod | T1 | QL (18 tabs/30 days) |
| TRUDHESA | T3 | PA QL (2 pkgs/30 days) |
| UBRELVY | T2 | PA QL (0.67 tabs/day) |
| zolmitriptan | T1 | QL (12 tabs/30 days) |
| ZOMIG 2.5 MG NASAL SPRAY | T3 | PA QL(12 units/30 days) |
| ZAVZPRET | T2 | PA QL(6 units/30 days) |
| NSAIDS, CYCLOOXYGENASE INHIBITOR-TYPE ANALGESICS | | |
| diclofenac potassium | T1 | HD |
| INDOCIN (indomethacin) | T3 | PA HD |
| ketoprofen | T1 | PA HD |
| ketorolac 10 mg tablet | T1 | QL (20 tabs/25 days) HD |
| ketorolac 15 mg/ml syringe | T1 | QL (40 ml/30 days) HD |
| ketorolac 15 mg/ml vial | T1 | QL (40 ml/30 days) HD |
| ketorolac 30 mg/ml carpuject | T1 | HD |
| ketorolac 30 mg/ml isecure syr | T1 | QL (20ml/30 days) HD |
| ketorolac 30 mg/ml syringe | T1 | QL (20ml/30 days) HD |
| ketorolac 30 mg/ml vial | T1 | QL (20ml/30 days) HD |
| ketorolac 300 mg/10 ml vial | T1 | HD |
| ketorolac 60 mg/2 ml carpuject | T1 | QL (20ml/30 days) HD |
| ketorolac 60 mg/2 ml syringe | T1 | QL (20ml/30 days) HD |
| ketorolac 60 mg/2 ml vial | T1 | QL (20ml/30 days) HD |
| mefenamic acid | T1 | HD |
| TOLECTIN 600 (tolmetin sodium) | T3 | PA HD |

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

T4 – Injectable Specialty Medications

PA – Prior Authorization

QL – Quantity Limit

ST – Step Therapy

AGE – Age Requirement

SP – Specialty Medication

HD – May require home delivery pharmacy

PPACA – No Cost-Share Preventive Medication

CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

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

| Prescription Drug Name | Drug Tier | Coverage Requirements and Limits |
|---|-----------|----------------------------------|
| ANALGESICS, NON-OPIOID | | |
| JOURNAVX | T2 | QL (30 tabs/90 days) |
| OPIOID ANALGESIC AND NON-SALICYLATE ANALGESICS | | |
| <i>acetamin-codein 300-30 mg/12.5</i> | T1 | |
| <i>acetaminop-codeine 120-12 mg/5</i> | T1 | |
| <i>acetaminophen-cod #2 tablet</i> | T1 | PA |
| <i>acetaminophen-cod #3 tablet</i> | T1 | PA |
| <i>acetaminophen-cod #4 tablet</i> | T1 | PA |
| APADAZ | T3 | |
| BENZHYDROCODONE-ACETAMINOPHEN | T1 | |
| <i>hydrocodone/acetaminophen</i> | T1 | PA |
| <i>hydrocodone/acetaminophen</i> (Hydrocodone-acetaminophen) | T1 | PA |
| <i>hydrocodone/acetaminophen</i> (Norco) | T1 | PA |
| HYDROCODONE-ACETAMINOPHEN | T1 | PA |
| LORTAB | T1 | PA |
| NALOCET | T1 | PA |
| NORCO (<i>lorcet hd</i>) | T3 | PA |
| NORCO (<i>lorcet plus</i>) | T3 | PA |
| NORCO (<i>lorcet</i>) | T3 | PA |
| <i>oxycodone hcl/acetaminophen</i> (Nalocet) | T1 | PA |
| <i>oxycodone hcl/acetaminophen</i> (Percocet) | T1 | PA |
| <i>oxycodone hcl/acetaminophen</i> (Primlev) | T1 | PA |
| PERCOCET (<i>oxycodone-acetaminophen</i>) | T3 | PA |
| PRIMLEV | T1 | PA |
| <i>tramadol hcl/acetaminophen</i> (Ultrace) | T1 | |
| ULTRACET (<i>tramadol hcl-acetaminophen</i>) | T3 | |
| OPIOID ANALGESIC AND NSAID COMBINATION | | |
| <i>hydrocodone/ibuprofen</i> | T1 | PA |
| <i>hydrocodone/ibuprofen</i> (Ibudone) | T1 | PA |
| IBUDONE | T1 | PA |
| <i>ibuprofen/oxycodone hcl</i> | T1 | PA |
| OPIOID ANALGESIC AND NON-SALICYLATE XANTHINE COMB | | |
| ACETAMIN-CAFF-DIHYDROCODEINE | T1 | PA |
| <i>acetaminophen/caff/dihydrocod</i> (Acetamin-caff-dihydrocodeine) | T1 | PA |
| <i>acetaminophen/caff/dihydrocod</i> (Trexiz) | T1 | PA |

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

T4 – Injectable Specialty Medications

PA – Prior Authorization

QL – Quantity Limit

ST – Step Therapy

AGE – Age Requirement

SP – Specialty Medication

HD – May require home delivery pharmacy

PPACA – No Cost-Share Preventive Medication

CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

| ANALGESICS (Pain Relief and Inflammatory Disease) (cont.) | | |
|--|-----------|----------------------------------|
| Prescription Drug Name | Drug Tier | Coverage Requirements and Limits |
| 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) |
| <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 |
| DILAUDID 2 MG TABLET (<i>hydromorphone hcl</i>) | T3 | PA |
| DILAUDID 4 MG TABLET (<i>hydromorphone hcl</i>) | T3 | PA |
| DILAUDID 5 MG/5 ML ORAL LIQUID (<i>hydromorphone hcl</i>) | T3 | PA |
| DILAUDID 8 MG TABLET (<i>hydromorphone hcl</i>) | T3 | PA |
| DURAGESIC (<i>fentanyl</i>) | T3 | PA |
| <i>fentanyl</i> | T1 | PA |
| <i>fentanyl</i> (Duragesic) | T1 | PA |
| FENTANYL CITRATE | T1 | PA |
| <i>fentanyl citrate</i> (Actiq) | T1 | PA |
| FENTORA | T3 | PA |
| <i>hydrocodone bitartrate</i> (Hysingla Er) | T1 | PA |
| <i>hydrocodone bitartrate</i> (Zohydro Er) | T1 | PA |
| <i>hydromorphone hcl</i> | T1 | PA |
| <i>hydromorphone hcl</i> (Dilaudid) | T1 | PA |
| HYSINGLA ER (<i>hydrocodone bitartrate er</i>) | T2 | PA |
| KADIAN (<i>morphine sulfate er</i>) | T3 | PA |
| LAZANDA | T3 | PA |
| <i>meperidine hcl</i> | T1 | PA |
| <i>methadone hcl</i> | T1 | PA |
| MORPHABOND ER | T2 | PA |
| <i>morphine sulfate</i> | T1 | PA |
| <i>morphine sulfate</i> (Kadian) | T1 | PA |
| <i>morphine sulfate</i> (Ms Contin) | T1 | PA |
| MS CONTIN (<i>morphine sulfate er</i>) | T3 | PA |
| NUCYNTA | T2 | PA |

T1 – Typically Generics

T2 – Typically Preferred Brands

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T4 – Injectable Specialty Medications

PA – Prior Authorization

QL – Quantity Limit

ST – Step Therapy

AGE – Age Requirement

SP – Specialty Medication

HD – May require home delivery pharmacy

PPACA – No Cost-Share Preventive Medication

CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

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

| Prescription Drug Name | Drug Tier | Coverage Requirements and Limits |
|--|-----------|----------------------------------|
| OPIOID ANALGESICS (cont.) | | |
| NUCYNTA ER | T3 | PA |
| <i>opium/belladonna alkaloids</i> | T1 | PA |
| OXAYDO | T3 | PA |
| <i>oxycodone hcl</i> | T1 | PA |
| OXYCODONE HCL 5 MG, 15 MG, 30 MG TABLET | T3 | PA |
| OXYCODONE HCL 10 MG TABLET | T3 | |
| OXYCODONE HCL ER | T1 | PA |
| <i>oxymorphone hcl</i> | T1 | PA |
| <i>pentazocine hcl/naloxone hcl</i> | T1 | PA |
| ROXYBOND | T3 | PA |
| <i>tramadol er 100 mg tablet</i> | T1 | QL (1 tab/day) |
| <i>tramadol er 200 mg tablet</i> | T1 | QL (1 tab/day) |
| <i>tramadol er 300 mg tablet</i> | T1 | QL (1 tab/day) |
| tramadol hcl (Ultram) | T1 | QL (8 tabs/day) |
| TRAMADOL HCL 25 MG TABLET | T3 | PA QL(>= 18 yo 4 tabs/day) |
| TRAMADOL HCL 75 MG TABLET | T3 | QL(< 18 yo 5 tabs/day) |
| TRAMADOL HCL ER 100 MG CAPSULE | T1 | QL (1 cap/day) |
| <i>tramadol hcl er 100 mg tablet</i> | 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) |
| <i>tramadol hcl er 200 mg tablet</i> | T1 | QL (1 tab/day) |
| TRAMADOL HCL ER 300 MG CAPSULE | T1 | QL (1 cap/day) |
| <i>tramadol hcl er 300 mg tablet</i> | T1 | QL (1 tab/day) |
| ULTRAM (<i>tramadol hcl</i>) | T3 | QL (8 tabs/day) |
| XTAMPZA ER | T2 | PA |
| ZOHYDRO ER (<i>hydrocodone bitartrate er</i>) | T3 | PA |
| OPIOID AND SALICYLATE ANALGESICS, BARBIT, XANTHINE | | |
| <i>codeine/butalbital/asa/caffein</i> (Fiorinal With Codeine #3) | T1 | PA |
| FIORINAL WITH CODEINE #3 (<i>butalbital compound-codeine</i>) | T3 | PA |
| OPIOID, NON-SALICYL. ANALGESIC, BARBITUATE, XANTHINE | | |
| <i>butalbit/acetamin/caff/codeine</i> | T1 | PA |
| <i>butalbit/acetamin/caff/codeine</i> (Fioricet With Codeine) | T1 | PA |
| FIORICET WITH CODEINE (<i>butalb-acetaminoph-caff-codein</i>) | T3 | PA |
| SKELETAL MUSCLE RELAXANT, SALICYLAT, OPIOID ANALGESIC | | |
| <i>carisoprodol/aspirin/codeine</i> | T1 | PA |

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List of Prescription Medications

| ANALGESICS (Urinary Tract Conditions) | | |
|--|-----------|----------------------------------|
| Prescription Drug Name | Drug Tier | Coverage Requirements and Limits |
| URINARY TRACT ANALGESIC AGENTS | | |
| ELMIRON | T2 | |
| RIMSO-50 | T2 | |
| ANESTHETICS (Miscellaneous) | | |
| GENERAL ANESTHETICS, INHALANT | | |
| desflurane (Suprane) | T1 | |
| isoflurane | T1 | |
| isoflurane | T3 | |
| sevoflurane (Ultane) | T1 | |
| SUPRANE | T3 | |
| ULTANE (sevoflurane) | T3 | |
| lidocaine hcl | T1 | |
| ANESTHETICS (Pain Relief and Inflammatory Disease) | | |
| TOPICAL LOCAL ANESTHETICS | | |
| HURRICAIN (benzocaine) | T1 | |
| L.E.T. (LIDO-EPINEPH-TETRA) | T3 | |
| lidocaine 5% ointment | T1 | QL (145gm/30 days) |
| lidocaine hcl | T1 | |
| lidocaine hcl | T3 | |
| lidocaine/prilocaine | T1 | |
| lidocaine (Lidocan li) | T1 | PA |
| LIDOCAN II (lidocaine) | T3 | PA |
| LIDODERM (lidocaine) | T3 | |
| PAIN EASE MEDIUM STREAM SPRAY | T3 | |
| SYNERA | T3 | PA |
| ZTLIDO | T2 | |
| ANESTHETICS (Urinary Tract Conditions) | | |
| URINARY TRACT ANESTHETIC/ANALGESIC AGNT (AZO-DYE) | | |
| phenazopyridine hcl (Pyridium) | T1 | |
| PYRIDIUM (phenazopyridine hcl) | T3 | PA |

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List of Prescription Medications

| ANTI-ALLERGY (Allergy/Nasal Sprays) | | |
|---|-----------|-----------------------------------|
| Prescription Drug Name | Drug Tier | Coverage Requirements and Limits |
| MAST CELL STABILIZERS | | |
| cromolyn 100 mg/5 ml oral conc (Gastrocrom) | T1 | |
| GASTROCROM (cromolyn sodium) | T3 | PA |
| ANTI-ARTHRITICS (Pain Relief and Inflammatory Disease) | | |
| ANALGESIC/ANTIPYRETICS, SALICYLATES | | |
| DISALCID (<i>salsalate</i>) | T3 | HD |
| <i>salsalate</i> (Disalcid) | T1 | HD |
| ANTI-ARTHRITIC AND CHELATING AGENTS | | |
| DEPEN (<i>penicillamine</i>) | T3 | PA SP |
| penicillamine (Depen) | T1 | PA SP |
| ANTI-ARTHRITIC, FOLATE ANTAGONIST AGENTS | | |
| OTREXUP | T2 | PA |
| ANTI-INFLAM. INTERLEUKIN-1 RECEPTOR ANTAGONIST | | |
| KINERET | T4 | PA QL (28 syringes/28 days) SP |
| ANTI-INFLAMMATORY, PYRIMIDINE SYNTHESIS INHIBITOR | | |
| ARAVA (<i>leflunomide</i>) | T3 | HD |
| <i>leflunomide</i> (Arava) | T1 | HD |
| ANTI-INFLAMMATORY, PHOSPHODIESTERASE-4(PDE4) INHIB. | | |
| OTEZLA 28 DAY STARTER PACK | T2 | PA QL (1 pack/180 days) SP HD |
| OTEZLA 30 MG TABLET | T2 | PA QL (2 tabs/day) SP HD |
| ANTI-INFLAMMATORY, SEL.COSTIM.MOD., T-CELL INHIBITOR | | |
| ORENCIA | T4 | PA QL (4 syringes/28 days) SP HD |
| ORENCIA CLICKJECT | T4 | PA QL (4 injectors/28 days) SP HD |
| COLCHICINE | | |
| colchicine 0.6 mg capsule (Mitigare) | T1 | HD |
| colchicine 0.6 mg tablet (Colcrys) | T1 | HD |
| COLCRYS (<i>colchicine</i>) | T3 | HD |
| MITIGARE (<i>colchicine</i>) | T2 | HD |
| GOLD SALTS | | |
| AURANOFIN | T3 | PA |
| RIDAURA | T2 | |
| HYPURICEMIA TX - XANTHINE OXIDASE INHIBITORS | | |
| allopurinol 200 mg tablet | T1 | PA HD |
| febuxostat 40 mg tablet (Uloric) | T1 | QL (1 tab/day) HD |
| febuxostat 80 mg tablet (Uloric) | T1 | HD |
| ULORIC 40 MG TABLET (febuxostat) | T3 | QL (1 tab/day) HD |

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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 |
| HYPURICEMIA TX - XANTHINE OXIDASE INHIBITORS (cont.) | | |
| 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 |
| COXANTO | T3 | PA 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 |
| DAYPRO (<i>oxaprozin</i>) | T3 | ST HD |
| <i>diclofenac sod dr 25 mg tab</i> | T1 | HD |
| <i>diclofenac sod dr 50 mg tab</i> | T1 | HD |
| <i>diclofenac sod dr 75 mg tab</i> | T1 | HD |
| <i>diclofenac sod ec 25 mg tab</i> | T1 | HD |
| <i>diclofenac sod ec 50 mg tab</i> | T1 | HD |
| <i>diclofenac sod ec 75 mg tab</i> | T1 | HD |
| <i>diclofenac sodium</i> | T1 | HD |
| EC-NAPROSYN (<i>naproxen</i>) | T3 | ST HD |
| <i>etodolac</i> | T1 | HD |
| <i>etodolac (Lodine)</i> | T1 | HD |
| FELDENE (<i>piroxicam</i>) | T3 | ST HD |
| <i>fenoprofen calcium</i> (Nalfon) | T1 | HD |
| FENOPRON | T3 | PA HD |
| <i>flurbiprofen</i> | T1 | HD |
| <i>ibuprofen</i> | 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 INHIBITOR - TYPE ANALGESICS (cont.) | | |
| <i>indomethacin</i> | T1 | HD |
| <i>ketoprofen 25 mg, 75 mg capsule</i> | T1 | HD |
| <i>LODINE (etodolac)</i> | T3 | ST HD |
| <i>meclofenamate sodium</i> | T1 | HD |
| <i>meloxicam (Mobic)</i> | T1 | HD |
| <i>MOBIC (meloxicam)</i> | T3 | ST HD |
| <i>nabumetone</i> | T1 | HD |
| <i>NALFON 600 MG TABLET (profeno)</i> | T1 | ST HD |
| <i>NAPROSYN TABLET (naproxen)</i> | T3 | ST HD |
| <i>naproxen tablet</i> | T1 | HD |
| <i>naproxen (Ec-naprosyn)</i> | T1 | HD |
| <i>naproxen (Naprosyn)</i> | T1 | HD |
| <i>naproxen sodium (Anaprox Ds)</i> | T1 | HD |
| <i>oxaprozin (Daypro)</i> | T1 | HD |
| <i>OXAPROZIN 300 MG CAPSULE</i> | T3 | PA HD |
| <i>piroxicam (Feldene)</i> | T1 | HD |
| <i>QMIIZ ODT 15 MG TABLET</i> | T3 | ST HD |
| <i>QMIIZ ODT 7.5 MG TABLET</i> | T3 | QL (1 tab/day) ST HD |
| <i>sulindac</i> | T1 | HD |
| <i>tolmetin sodium (Tolectin 600)</i> | T1 | HD |
| NSAIDS, CYCLOOXYGENASE-2(COX-2) SELECTIVE INHIBITOR | | |
| <i>CELEBREX 100 MG CAPSULE (celecoxib)</i> | T3 | PA QL (2 caps/day) ST HD |
| <i>CELEBREX 200 MG CAPSULE (celecoxib)</i> | T3 | PA QL (2 caps/day) ST HD |
| <i>CELEBREX 400 MG CAPSULE (celecoxib)</i> | T3 | PA QL (1 cap/day) ST HD |
| <i>CELEBREX 50 MG CAPSULE (celecoxib)</i> | T3 | PA QL (2 caps/day) ST HD |
| <i>celecoxib 100 mg capsule (Celebrex)</i> | T1 | QL(2 caps/day) HD |
| <i>celecoxib 200 mg capsule (Celebrex)</i> | T1 | QL (2 caps/day) HD |
| <i>celecoxib 400 mg capsule (Celebrex)</i> | T1 | QL (1 cap/day) HD |
| <i>celecoxib 50 mg capsule (Celebrex)</i> | T1 | QL (2 caps/day) HD |
| URICOSURIC AGENTS | | |
| <i>probencid</i> | T1 | HD |
| <i>probencid/colchicine</i> | T1 | HD |

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List of Prescription Medications

| ANTI-ASTHMATICS (Asthma/COPD/Respiratory) | | |
|---|-----------|----------------------------------|
| Prescription Drug Name | Drug Tier | Coverage Requirements and Limits |
| 5-LIPOXYGENASE INHIBITORS | | |
| zileuton | 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 INHALED SHORT ACTING | | |
| ATROVENT HFA | T2 | HD |
| <i>ipratropium bromide</i> | T1 | HD |
| BETA-ADRENERGIC AGENTS | | |
| albuterol sulf 2 mg/5 ml syrup | T1 | HD |
| albuterol 8 mg/20 ml syrup cup | T1 | HD |
| albuterol sulfate 2 mg tab | T1 | HD |
| albuterol sulfate 4 mg tab | T1 | HD |
| albuterol sulfate er 4 mg tab | T1 | HD |
| albuterol sulfate er 8 mg tab | T1 | HD |
| metaproterenol sulfate | T1 | HD |
| terbutaline sulfate | T1 | HD |
| BETA-ADRENERGIC AGENTS, INHALED, SHORT ACTING | | |
| albuterol 100 mg/20 ml soln | T1 | |
| albuterol 15 mg/3 ml solution | T1 | |
| albuterol 75 mg/15 ml soln | T1 | |
| albuterol 2.5 mg/0.5 ml sol | T1 | |
| 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 sulfate (Albuterol Sulfate Hfa) | T1 | QL (18gm/30 days) |
| ALBUTEROL SULFATE HFA | T1 | QL (18gm/30 days) |
| <i>levalbuterol hcl</i> (Xopenex Concentrate) | T1 | |
| <i>levalbuterol hcl</i> (Xopenex) | T1 | |
| XOPENEX (<i>levalbuterol hcl</i>) | T3 | |
| XOPENEX CONCENTRATE (<i>levalbuterol concentrate</i>) | T3 | |
| BETA-ADRENERGIC AGENTS, INHALED, ULTRA-LONG ACTING | | |
| ARCAPTA NEOSHALER | T3 | HD |

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List of Prescription Medications

| ANTI-ASTHMATICS (Asthma/COPD/Respiratory) (cont.) | | |
|---|-----------|----------------------------------|
| Prescription Drug Name | Drug Tier | Coverage Requirements and Limits |
| BETA-ADRENERGIC AGENTS, INHALED, ULTRA-LONG ACTING (cont.) | | |
| STRIVERDI RESPIMAT | T2 | QL(1 inhaler/30 days) HD |
| BETA-ADRENERGIC AGENTS, ORALLY INHALED, LONG ACTING | | |
| arformoterol tartrate (Brovana) | T1 | QL(4 mls/day) HD |
| BROVANA | T3 | HD |
| BETA-ADRENERGIC AGENTS, ORALLY INHALED, LONG ACTING | | |
| SEREVENT DISKUS | T3 | ST QL(1 blister/30 days) HD |
| BETA-ADRENERGIC AND ANTICHOLINERGIC COMBO, INHALED | | |
| ANORO ELLIPTA | T2 | HD |
| BEVESPI AEROSPHERE | T3 | PA QL(1 inhaler/30 days) HD |
| COMBIVENT RESPIMAT | T2 | QL(2 inhalers/30 days) |
| <i>ipratropium/albuterol sulfate</i> | T1 | HD |
| STILOTO RESPIMAT INHAL SPRAY | T2 | HD |
| BETA-ADRENERGIC AGENTS AND GLUCOCORTICOID COMBO, INHALED | | |
| ADVAIR HFA | T2 | HD |
| AIRDUO DIGIHALER | T3 | ST HD |
| AIRSUPRA | T3 | PA QL(1 gm/28 days) HD |
| BREO ELLIPTA | T2 | QL(1 inhaler/30 days) HD |
| <i>budesonide/formoterol fumarate (Symbicort)</i> | T1 | QL HD |
| DULERA | T2 | HD |
| <i>fluticasone propion/salmeterol (Advair Diskus)</i> | T1 | QL(1 inhaler/30 days) HD |
| FLUTICASONE-SALMETEROL | T1 | PA QL(1 inhaler/30 days) HD |
| SYMBICORT | T2 | ST QL(1 inhaler/30 days) HD |
| BETA-ADRENERGIC-ANTICHOLINERGIC-GLUCOCORT, INHALED | | |
| BREZTRI AEROSPHERE | T2 | |
| TRELEGY ELLIPTA | T2 | |
| GLUCOCORTICOIDS, ORALLY INHALED | | |
| ALVESCO | T2 | HD |
| ARNUITY ELLIPTA | T3 | ST |
| <i>budesonide (Pulmicort)</i> | T1 | HD |
| COMBIVENT RESPIMAT | T2 | QL(2 inhalers/30 days) |
| FLOVENT DISKUS | T3 | PA QL(1 inhaler/30 days) HD |
| FLOVENT HFA | T3 | PA QL(1 inhaler/30 days) HD |
| FLUTICASONE PROP 100MCG DISKUS | T3 | PA QL(1 inhaler/30 days) HD |
| FLUTICASONE PROP 250 MCG DISK | T3 | PA QL(4 inhalers/30 days) HD |
| FLUTICASONE PROP 50 MCG DISKUS | T3 | PA QL(1 inhaler/30 days) HD |
| PULMICORT (<i>budesonide</i>) | T3 | PA QL(2 mls/day) HD |
| PULMICORT FLEXHALER | T2 | PA HD |
| QVAR REDIHALER | T2 | |

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List of Prescription Medications

| ANTI-ASTHMATICS (Asthma/COPD/Respiratory) (cont.) | | |
|---|-----------|----------------------------------|
| Prescription Drug Name | Drug Tier | Coverage Requirements and Limits |
| INTERLEUKIN-5(IL-5) RECEPTOR ALPHA ANTAGONIST, MAB | | |
| FASENRA PEN | T4 | PA SP HD |
| LEUKOTRIENE RECEPTOR ANTAGONISTS | | |
| ACCOLATE (zafirlukast) | T3 | HD |
| montelukast sodium (Singulair) | T1 | HD |
| SINGULAIR (montelukast sodium) | T3 | PA HD |
| zafirlukast (Accolate) | T1 | HD |
| MAST CELL STABILIZERS, ORALLY INHALED | | |
| cromolyn 20 mg/2 ml neb soln | T1 | QL (480ml/30 days) HD |
| MONOCLONAL ANTIBODIES TO IMMUNOGLOBULIN E (IGE) | | |
| XOLAIR | T4 | PA SP HD |
| MONOCLONAL ANTIBODY - INTERLEUKIN-5 ANTAGONISTS | | |
| NUCALA | T4 | PA SP HD |
| MUCOLYTICS | | |
| acetylcysteine | 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 |
| OHTUVAYRE | T4 | PA QL SP |
| XANTHINES | | |
| THEO-24 | T2 | HD |
| theophylline anhydrous | T1 | HD |
| ANTIBIOTICS (Allergy/Nasal Sprays) | | |
| NOSE PREPARATIONS ANTIBIOTICS | | |
| BACTROBAN NASAL | T2 | |
| ANTIBIOTICS (Ear Medications) | | |
| EAR PREPARATIONS, ANTIBIOTICS | | |
| ciprofloxacin hd | T1 | |
| CORTISPORIN-TC | T3 | |
| neomycin/polymyxin b/hydrocort | T1 | |
| ofloxacin | T1 | |
| OTIC PREPARATIONS, ANTI-INFLAMMATORY-ANTIBIOTICS | | |
| CIPRO HC | T2 | |
| CIPRODEX (ciprofloxacin-dexamethasone) | T3 | |
| ciprofloxacin hcl/dexameth (Ciprodex) | T1 | |
| CIPROFLOXACIN HCL-FLUOCINOLONE | T3 | |

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

T4 – Injectable Specialty Medications

PA – Prior Authorization

QL – Quantity Limit

ST – Step Therapy

AGE – Age Requirement

SP – Specialty Medication

HD – May require home delivery pharmacy

PPACA – No Cost-Share Preventive Medication

CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

| ANTIBIOTICS (Ear Medications) (cont.) | | |
|---|-----------|----------------------------------|
| Prescription Drug Name | Drug Tier | Coverage Requirements and Limits |
| OTIC PREPARATIONS, ANTI-INFLAMMATORY-ANTIBIOTICS (cont.) | | |
| OTOVEL | T3 | |
| ANTIBIOTICS (Eye Conditions) | | |
| EYE ANTIBIOTIC AND GLUCOCORTICOID COMBINATIONS | | |
| MAXITROL (<i>neomycin-polymyxin-dexameth</i>) | T3 | PA |
| <i>neomycin/bacit/p-myx/hydrocort</i> | T1 | |
| <i>neomycin/polymyxin b/dexametha</i> (Maxitrol) | T1 | |
| <i>neomycin/polymyxin b/hydrocort</i> | T1 | |
| TOBRADEX EYE DROPS (<i>tobramycin-dexamethasone</i>) | T3 | PA |
| 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 | T3 | PA |
| <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 | |

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List of Prescription Medications

ANTIBIOTICS (Eye Conditions) (cont.)

| Prescription Drug Name | Drug Tier | Coverage Requirements and Limits |
|--|-----------|----------------------------------|
| OPHTHALMIC ANTIBIOTICS (cont.) | | |
| <i>neomycin/polymyxin b/gramicidin</i> | T1 | |
| <i>OCUFLOX (ofloxacin)</i> | T3 | PA |
| <i>ofloxacin (Ocuflax)</i> | T1 | |
| <i>polymyxin b sulf(trimethoprim</i> | T1 | |
| <i>tobramycin 0.3% eye drop (Tobrex)</i> | T1 | |
| <i>TOBREX</i> | T3 | PA |
| <i>VIGAMOX (moxifloxacin)</i> | T3 | PA |
| <i>ZYMAXID (gatifloxacin)</i> | T3 | PA |

ANTIBIOTICS (Infections)

| | | |
|---|----|----------------------------------|
| 2ND GEN. ANAEROBIC ANTIprotozoal-ANTIBACTERIAL | | |
| <i>SOLOSEC</i> | T2 | |
| ABSORBABLE SULFONAMIDE ANTIBACTERIAL AGENTS | | |
| <i>BACTRIM (sulfamethoxazole-trimethoprim)</i> | T3 | |
| <i>BACTRIM DS (sulfamethoxazole-trimethoprim)</i> | T3 | |
| <i>sulfadiazine</i> | T1 | |
| <i>sulfamethoxazole(trimethoprim</i> | T1 | |
| <i>sulfamethoxazole(trimethoprim</i> | T3 | |
| <i>sulfamethoxazole(trimethoprim (Bactrim Ds)</i> | T1 | |
| <i>sulfamethoxazole(trimethoprim (Bactrim)</i> | T1 | |
| AMINOGLYCOSIDE ANTIBIOTICS | | |
| <i>ARIKAYCE</i> | T3 | PA SP |
| <i>BETHKIS (tobramycin)</i> | T3 | PA QL (8ml/day) SP HD |
| <i>gentamicin sulfate</i> | T1 | |
| <i>gentamicin sulfate/pf</i> | T1 | |
| <i>KITABIS PAK</i> | T3 | PA QL (10ml/day) SP HD |
| <i>neomycin sulfate</i> | T1 | |
| <i>TOBI (tobramycin)</i> | T3 | PA QL (10ml/day) SP HD |
| <i>TOBI PODHALER</i> | T2 | PA QL (8 caps/day) SP HD |
| <i>tobramycin 1, 200 mg/30 ml vial</i> | T1 | |
| <i>tobramycin 1.2 gm vial</i> | T4 | PA |
| <i>tobramycin 1.2 gram/30 ml vial</i> | T1 | |
| <i>tobramycin 20 mg/2 ml vial</i> | T1 | |
| <i>tobramycin 300 mg/4 ml ampule (Bethkis)</i> | T1 | PA QL (28 Therapy/56 days) SP HD |
| <i>tobramycin 300 mg/5 ml ampule (Tobi)</i> | T1 | PA QL (10ml/day) SP HD |

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List of Prescription Medications

| ANTIBIOTICS (Infections) (cont.) | | |
|---|-----------|----------------------------------|
| Prescription Drug Name | Drug Tier | Coverage Requirements and Limits |
| AMINOGLYCOSIDE ANTIBIOTICS (cont.) | | |
| 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 (<i>metronidazole</i>) | T3 | |
| LIKMEZ | T3 | PA |
| <i>metronidazole</i> (Flagyl) | T1 | |
| METRONIDAZOLE 125 MG TABLET | T3 | PA |
| 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 | |
| PRIMSOL | T2 | |
| <i>trimethoprim</i> | T1 | |
| UTA | T3 | |
| ANTILEPROTICS | | |
| <i>dapsone</i> 100 mg tablet | T1 | |
| <i>dapsone</i> 25 mg tablet | T1 | |
| THALOMID | T2 | PA SP HD |
| ANTI-MYCOBACTERIUM AGENTS | | |
| <i>ethambutol hcl</i> | T1 | HD |
| <i>isoniazid</i> | T1 | HD |

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List of Prescription Medications

| ANTIBIOTICS (Infections) (cont.) | | |
|---|-----------|----------------------------------|
| Prescription Drug Name | Drug Tier | Coverage Requirements and Limits |
| ANTI-MYCOBACTERIUM AGENTS (cont.) | | |
| MYCOBUTIN (<i>rifabutin</i>) | T3 | PA HD |
| PASER | T2 | HD |
| <i>pyrazinamide</i> | T1 | HD |
| <i>rifabutin</i> (Mycobutin) | T1 | HD |
| TRECATOR | T2 | HD |
| ANTI-TUBERCULAR ANTIBIOTICS | | |
| CYCLOSERINE | T1 | |
| PRETOMANID | T3 | PA QL (1 tab/day) |
| PRIFTIN | T3 | |
| RIFAMATE | T2 | |
| <i>rifampin</i> | T1 | |
| RIFATER | T2 | |
| SIRTURO | T3 | SP |
| BETALACTAMS | | |
| CAYSTON | T3 | PA QL (3ml/day) SP HD |
| CEPHALOSPORIN ANTIBIOTICS - 1ST GENERATION | | |
| <i>cefadroxil</i> | T1 | |
| <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>cefprozil</i> | T1 | |
| <i>cefuroxime axetil</i> | T1 | |
| CEPHALOSPORIN ANTIBIOTICS - 3RD GENERATION | | |
| <i>cefdinir</i> | T1 | |
| <i>cefixime</i> (Suprax) | T1 | |
| <i>cefpodoxime proxetil</i> | T1 | |
| <i>ceftriaxone sodium</i> | T1 | |
| SPECTRACEF (<i>cefditoren pivoxil</i>) | T3 | |
| SUPRAX | T3 | |

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List of Prescription Medications

ANTIBIOTICS (Infections) (cont.)

| Prescription Drug Name | Drug Tier | Coverage Requirements and Limits |
|---|-----------|----------------------------------|
| CEPHALOSPORIN ANTIBIOTICS - 3RD GENERATION (cont.) | | |
| SUPRAX (cefixime) | 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 | |
| CLEOCIN PEDIATRIC (<i>clindamycin (pediatric)</i>) | T3 | |
| <i>clindamycin hcl</i> (Cleocin Hcl) | T1 | |
| <i>clindamycin palmitate hcl</i> (Cleocin Pediatric) | T1 | |
| 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 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) |
| E.E.S. 200 (<i>erythromycin ethylsuccinate</i>) | T3 | PA |
| ERYPED 200 (<i>erythromycin ethylsuccinate</i>) | T3 | |
| ERYPED 400 (<i>erythromycin ethylsuccinate</i>) | T3 | PA |
| <i>ery-tab dr 250 mg tablet</i> | T3 | |
| <i>ery-tab dr 333 mg tablet</i> | T2 | |
| ERY-TAB DR 500 MG TABLET (<i>erythromycin</i>) | T3 | |
| <i>erythromycin base</i> | T1 | |
| <i>erythromycin base</i> (Ery-tab) | T1 | |
| <i>erythromycin ethylsuccinate</i> | T1 | |
| <i>erythromycin ethylsuccinate</i> | T2 | |
| <i>erythromycin ethylsuccinate</i> (Eryped 200) | T1 | |
| <i>erythromycin ethylsuccinate</i> (Eryped 400) | T1 | |
| <i>erythromycin stearate</i> | T1 | |
| PCE | T3 | |
| ZITHROMAX 1 GM POWDER PACKET (<i>azithromycin</i>) | T3 | |

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List of Prescription Medications

| ANTIBIOTICS (Infections) (cont.) | | |
|--|-----------|----------------------------------|
| Prescription Drug Name | Drug Tier | Coverage Requirements and Limits |
| MACROLIDE ANTIBIOTICS (cont.) | | |
| ZITHROMAX 100 MG/5 ML SUSP (<i>azithromycin</i>) | T3 | |
| ZITHROMAX 200 MG/5 ML SUSP (<i>azithromycin</i>) | T3 | |
| ZITHROMAX 200 MG/5 ML SUSP (<i>azithromycin</i>) | T3 | |
| ZITHROMAX 250 MG TABLET (<i>azithromycin</i>) | T3 | |
| ZITHROMAX 250 MG Z-PAK TABLET (<i>azithromycin</i>) | T3 | |
| ZITHROMAX 500 MG TABLET (<i>azithromycin</i>) | T3 | |
| ZITHROMAX TRI-PAK (<i>azithromycin</i>) | T3 | |
| NITROFURAN DERIVATIVES ANTIBACTERIAL AGENTS | | |
| FURADANTIN (<i>nitrofurantoin</i>) | T3 | |
| MACROBID (<i>nitrofurantoin mono-macro</i>) | T3 | |
| MACRODANTIN (<i>nitrofurantoin</i>) | T3 | |
| <i>nitrofurantoin</i> 25 mg/5 ml susp (Furadantin) | T1 | |
| <i>nitrofurantoin</i> mcr 100 mg cap (Macrodantin) | T1 | |
| <i>nitrofurantoin</i> mcr 25 mg cap | T1 | |
| <i>nitrofurantoin</i> mcr 50 mg cap (Macrodantin) | T1 | |
| <i>nitrofurantoin</i> monohyd/m-cryst (Macrobid) | T1 | |
| OXAZOLIDINONE ANTIBIOTICS | | |
| <i>linezolid</i> (Zyvox) | T3 | PA |
| SIVEXTRO | T3 | PA |
| ZYVOX (<i>linezolid</i>) | T3 | PA |
| PENICILLIN ANTIBIOTICS | | |
| <i>amoxicillin</i> | T1 | |
| <i>amoxicillin/potassium clav</i> | T1 | |
| <i>amoxicillin/potassium clav</i> (Augmentin Xr) | T1 | |
| <i>amoxicillin/potassium clav</i> (Augmentin) | T1 | |
| <i>ampicillin trihydrate</i> | T1 | |
| AUGMENTIN 125-31.25 MG/5 ML | T2 | PA |
| AUGMENTIN 250-62.5 MG/5 ML (<i>amoxicillin-clavulanate potass</i>) | T3 | PA |
| AUGMENTIN XR (<i>amoxicillin-clavulanate pot er</i>) | T3 | PA |
| <i>dicloxacillin sodium</i> | T1 | |
| MOXATAG | T3 | |
| PLEUROMUTILIN DERIVATIVES | | |
| XENLETA | T3 | PA QL (10 tabs/30 days) |

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List of Prescription Medications

ANTIBIOTICS (Infections) (cont.)

| Prescription Drug Name | Drug Tier | Coverage Requirements and Limits |
|--|-----------|----------------------------------|
| QUINOLONE ANTIBIOTICS (cont.) | | |
| 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</i> | T1 | |
| <i>ciprofloxacin hcl</i> (Cipro) | T1 | |
| <i>ciprofloxacin/ciprofloxacin hcl</i> | T1 | |
| FACTIVE | T3 | |
| <i>levofloxacin</i> | T1 | |
| <i>moxifloxacin hcl</i> (Avelox) | T1 | |
| <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) |
| TETRACYCLINE ANTIBIOTICS | | |
| ACTICLATE (<i>doxycycline hydiate</i>) | T3 | ST |
| <i>coremino er 135 mg tablet</i> | T1 | |
| <i>coremino er 45 mg tablet</i> | T1 | QL (1 tab/day) |
| <i>coremino er 90 mg tablet</i> | T1 | |
| <i>demeclercycline hcl</i> | T1 | |
| DORYX | T3 | PA |
| DORYX (<i>doxycycline hydiate</i>) | T3 | PA |
| DORYX MPC | T3 | PA |
| <i>doxycycline 50 mg tablet</i> (Targadox) | T1 | PA |
| <i>doxycycline hyc dr 100 mg tab</i> | T1 | PA |
| <i>doxycycline hyc dr 150 mg tab</i> | T1 | PA |
| <i>doxycycline hyc dr 200 mg tab</i> (Doryx) | T1 | PA |
| <i>doxycycline hyc dr 50 mg tab</i> | T1 | PA |
| <i>doxycycline hyc dr 75 mg tab</i> | T1 | PA |
| DOXYCYCLINE HYC DR 80 MG TAB | T3 | PA |
| <i>doxycycline hydiate</i> | T1 | |

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List of Prescription Medications

ANTIBIOTICS (Infections) (cont.)

| Prescription Drug Name | Drug Tier | Coverage Requirements and Limits |
|---|-----------|----------------------------------|
| TETRACYCLINE ANTIBIOTICS (cont.) | | |
| <i>doxycycline hyclate 100 mg cap</i> | T1 | |
| <i>doxycycline hyclate 100 mg tab</i> | T1 | |
| <i>doxycycline hyclate 150 mg tab (Acticlate)</i> | T1 | |
| <i>doxycycline hyclate 50 mg cap</i> | T1 | |
| <i>doxycycline hyclate 75 mg tab (Acticlate)</i> | T1 | |
| DOXYCYCLINE IR-DR | T1 | PA |
| <i>doxycycline monohydrate</i> | T1 | PA |
| <i>doxycycline monohydrate (Vibramycin)</i> | T1 | |
| EMROSI | T3 | PA |
| MINOCIN (<i>minocycline hcl</i>) | T3 | PA |
| MINOCYCLINE ER | T3 | ST |
| <i>minocycline er 105 mg tablet (Solodyn)</i> | T1 | |
| <i>minocycline er 115 mg tablet (Solodyn)</i> | T1 | |
| <i>minocycline er 135 mg tablet</i> | T1 | |
| <i>minocycline er 45 mg tablet</i> | T1 | QL (1 tab/day) |
| <i>minocycline er 55 mg tablet</i> | T1 | |
| <i>minocycline er 65 mg tablet (Solodyn)</i> | T1 | |
| <i>minocycline er 80 mg tablet (Solodyn)</i> | T1 | |
| <i>minocycline er 90 mg tablet</i> | T1 | |
| <i>minocycline hcl (Minocin)</i> | T1 | |
| MINOLIRA ER | T3 | ST |
| NUZYRA | T3 | PA QL (30 tablets/28 days) SP |
| ORACEA (<i>doxycycline monohydrate</i>) | T3 | PA |
| SEYSARA | T3 | PA |
| SOLODYN (<i>minocycline hcl er</i>) | T3 | PA |
| SOLOXIDE | T1 | PA |
| TARGADOX | T3 | PA |
| <i>tetracycline 250 mg capsule</i> | T1 | |
| <i>tetracycline 250 mg tablet</i> | T1 | PA |
| <i>tetracycline 500 mg capsule</i> | T1 | |
| <i>tetracycline 500 mg tablet</i> | T1 | PA |

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| ANTIBIOTICS (Infections) (cont.) | | |
|---|-----------|----------------------------------|
| Prescription Drug Name | Drug Tier | Coverage Requirements and Limits |
| TETRACYCLINE ANTIBIOTICS (cont.) | | |
| VIBRAMYCIN 100 MG CAPSULE (<i>morgidox</i>) | T3 | PA |
| VIBRAMYCIN 50 MG/5 ML SYRUP | T2 | |
| XIMINO | T3 | ST |
| VAGINAL ANTIBIOTICS | | |
| CLEOCIN (<i>clindamycin phosphate</i>) | T3 | PA |
| <i>clindamycin phosphate</i> (Cleocin) | T1 | |
| CLINDESSE | T3 | |
| METROGEL-VAGINAL (<i>vandazole</i>) | T3 | PA |
| <i>metronidazole</i> (Metrogel-vaginal) | T1 | |
| NUVESSA | T3 | PA |
| VANCOMYCIN ANTIBIOTICS AND DERIVATIVES | | |
| FIRVANQ (<i>vancomycin hcl</i>) | T3 | PA |
| VANCOCIN HCL (<i>vancomycin hcl</i>) | T3 | PA |
| <i>vancomycin hcl</i> (Firvanq) | T1 | |
| ANTIBIOTICS (Skin Conditions) | | |
| TOPICAL ANTIBIOTIC AND ANTI-INFLAMMATORY STEROID | | |
| NEO-SYNALAR | T3 | |
| TOPICAL ANTIBIOTICS | | |
| AMZEEQ | T3 | PA |
| BENZAMYCIN (<i>erythromycin-benzoyl peroxide</i>) | T3 | |
| CENTANY | T3 | |
| CENTANY AT | T3 | |
| CLEOCINT (<i>clindamycin phosphate</i>) | T3 | |
| <i>clindacin etz 1% ppledget</i> (Cleocin T) | T1 | PA |
| CLINDACIN ETZ KIT | T3 | |
| CLINDACIN PAC | T3 | |
| CLINDAGEL | T3 | PA |
| <i>clindamycin phosphate</i> | T1 | |
| <i>clindamycin phosphate</i> (Cleocin T) | T1 | |
| <i>clindamycin phosphate</i> (Evoclin) | T1 | |
| <i>erythromycin base in ethanol</i> | T3 | |
| <i>erythromycin/benzoyl peroxide</i> (Benzamycin) | T1 | |

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

T4 – Injectable Specialty Medications

PA – Prior Authorization

QL – Quantity Limit

ST – Step Therapy

AGE – Age Requirement

SP – Specialty Medication

HD – May require home delivery pharmacy

PPACA – No Cost-Share Preventive Medication

CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

| ANTIBIOTICS (Skin Conditions) (cont.) | | |
|---|-----------|----------------------------------|
| Prescription Drug Name | Drug Tier | Coverage Requirements and Limits |
| TOPICAL ANTIBIOTICS (cont.) | | |
| EVOCLIN (<i>clindamycin phosphate</i>) | T3 | |
| gentamicin sulfate | T1 | |
| mupirocin (Centany) | T1 | PA |
| mupirocin calcium | T1 | PA |
| XEPI | T3 | |
| ZILXI | T3 | PA |
| TOPICAL SULFONAMIDES | | |
| AVAR 9.5-5% CLEANSING PADS | T3 | |
| <i>avar cleanser</i> (Rosanil) | T1 | |
| AVAR LS | T3 | PA |
| AVAR-E | T3 | PA |
| AVAR-E GREEN | T2 | PA |
| <i>mafenide acetate</i> | T1 | |
| ROSANIL (sodium sulfacetamide-sulfur) | T1 | |
| SILVADENE (ssd) | T3 | |
| <i>silver sulfadiazine</i> (Silvadene) | T1 | |
| sulfacetamide sod/sulfur/urea | T1 | |
| sulfacetamide sodium/sulfur | T1 | |
| sulfacetamide sodium/sulfur (Avar-e Green) | T1 | |
| sulfacetamide sodium/sulfur (Rosanil) | T1 | |
| sulfacetamide/sulfur/cleansr23 | T1 | |
| sulfact sod/sulur/avob/otn/oct | T1 | |
| SULFAMYLYON | T2 | |
| ANTI-COAGULANTS (Blood Thinners/Anti-Clotting) | | |
| ANTI-COAGULANTS, COUMARIN TYPE | | |
| <i>warfarin sodium</i> | T1 | HD |
| CITRATES AS ANTI-COAGULANTS | | |
| ACD-A | T3 | |
| ANTICOAG SODIUM CITRATE 4% SOL | T3 | |
| CITRATE PHOSPHATE DEXTROSE | T1 | |
| DIRECT FACTOR XA INHIBITORS | | |
| BEVYXXA | T3 | QL (42 caps/42 days) |
| ELIQUIS | T2 | |
| <i>rivaroxaban</i> | T1 | |
| SAVAYSA 15 MG TABLET | T3 | PA QL (1 tab/day) |

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List of Prescription Medications

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

| Prescription Drug Name | Drug Tier | Coverage Requirements and Limits |
|--|-----------|----------------------------------|
| DIRECT FACTOR XA INHIBITORS (cont.) | | |
| 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 150 mg/ml syringe (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 | T2 | QL (2ml/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 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 (<i>enoxaparin sodium</i>) | T3 | QL (2 syringes/day) SP |
| LOVENOX 120 MG/0.8 ML SYRINGE (<i>enoxaparin sodium</i>) | T3 | QL (2 syringes/day) SP |
| LOVENOX 150 MG/ML SYRINGE (<i>enoxaparin sodium</i>) | T3 | QL (2 syringes/day) SP |
| LOVENOX 30 MG/0.3 ML SYRINGE (<i>enoxaparin sodium</i>) | T3 | QL (2 syringes/day) SP |
| LOVENOX 300 MG/3 ML VIAL (<i>enoxaparin sodium</i>) | T3 | QL (1 vial/day) SP |

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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.) | | |
| LOVENOX 40 MG/0.4 ML SYRINGE (<i>enoxaparin sodium</i>) | T3 | QL (2 syringes/day) SP |
| LOVENOX 60 MG/0.6 ML SYRINGE (<i>enoxaparin sodium</i>) | T3 | QL (2 syringes/day) SP |
| LOVENOX 80 MG/0.8 ML SYRINGE (<i>enoxaparin sodium</i>) | T3 | QL (2 syringes/day) SP |
| THROMBIN INHIBITORS, SELECTIVE, DIRECT, REVERSIBLE | | |
| <i>dabigatran etexilate mesylate</i> (Pradaxa) | T1 | HD |
| PRADAXA 110 MG CAPSULE (<i>dabigatran etexilate mesylate</i>) | T3 | PA HD |
| ANTIDOTES (Gastrointestinal/Heartburn) | | |
| MU-OPIOID RECEPTOR ANTAGONISTS, PERIPHERALLY-ACTING | | |
| MOVANTIK | T2 | PA |
| RELISTOR | T3 | PA |
| SYMPROIC | T2 | PA |
| ANTIDOTES (Substance Abuse) | | |
| OPIOID ANTAGONISTS | | |
| EVZIO | T3 | PA QL (0.8ml/day) |
| KLOXXADO | T2 | PA QL (2 sprays/30 days) |
| <i>naloxone 0.4 mg/ml carpuject</i> | T1 | |
| <i>naloxone 0.4 mg/ml vial</i> | T1 | |
| NALOXONE 2 MG AUTO-INJECTOR | T3 | QL (0.8ml/day) |
| <i>naloxone 2 mg/2 ml syringe</i> | T1 | |
| <i>naloxone 4 mg/10 ml vial</i> | T1 | |
| <i>naltrexone</i> | T1 | QL (180 tabs/30 days) |
| OPVEE | T3 | QL |
| NARCAN | T3 | QL (2 units/30 days) |
| REXTOVY | T2 | QL(2 units/30 days) |
| ZIMHI | T3 | QL (2 inj/month) |
| 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 | |

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List of Prescription Medications

| ANTI-FUNGALS (Infections) | | |
|---|-----------|----------------------------------|
| Prescription Drug Name | Drug Tier | Coverage Requirements and Limits |
| ANTI-FUNGAL AGENTS | | |
| ANCOBON (<i>flucytosine</i>) | T3 | |
| <i>clotrimazole</i> | T1 | |
| CRESEMBA | T3 | PA |
| DIFLUCAN (<i>fluconazole</i>) | T3 | PA |
| <i>fluconazole</i> (Diflucan) | T1 | |
| <i>flucytosine</i> (Ancobon) | T1 | |
| itraconazole (Sporanox) | T1 | |
| <i>ketoconazole</i> | T1 | |
| NOXAFIL 40 MG/ML SUSPENSION | T3 | PA |
| NOXAFIL DR 100 MG TABLET (<i>posaconazole</i>) | T3 | PA |
| ORAVIG | T3 | |
| <i>posaconazole</i> (Noxafil) | T1 | |
| SPORANOX (<i>itraconazole</i>) | T3 | PA |
| <i>terbinafine hcl</i> | T1 | |
| TOLSURA | T3 | |
| VFEND (<i>voriconazole</i>) | T3 | PA |
| VIVJOA | T4 | PA SP |
| <i>voriconazole</i> (Vfend) | T1 | PA |
| ANTI-FUNGAL ANTIBIOTICS | | |
| BREXFEMME | T3 | PA |
| FULVICIN P-G 165 MG TABLET | T3 | PA QL (4 tabs/day) |
| <i>griseofulvin ultramicrosize</i> (Gris-peg) | T1 | QL(4 tabs/day) |
| <i>griseofulvin, microsize</i> | T1 | |
| GRIS-PEG (<i>griseofulvin ultramicrosize</i>) | T3 | |
| <i>nystatin</i> | T1 | |
| ANTI-FUNGALS (Skin Conditions) | | |
| TOPICAL ANTI-FUNGAL/ANTI-INFLAMMATORY, STEROID AGENT | | |
| <i>clotrimazole/betamethasone dip</i> | T1 | |
| TOPICAL ANTI-FUNGALS | | |
| <i>ciclodan 0.77% cream</i> (Loprox) | T1 | |
| CICLODAN 0.77% CREAM KIT | T3 | |
| CICLODAN 8% KIT | T3 | |
| <i>ciclodan 8% solution</i> | T1 | |
| <i>ciclopirox</i> (Loprox) | T1 | |
| <i>ciclopirox olamine</i> (Loprox) | T1 | |
| <i>ciclopirox/urea/camph/men/euc</i> (Ciclodan) | T1 | |
| DIFMETIOXRIME | T3 | |

T1 – Typically Generics

T2 – Typically Preferred Brands

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T4 – Injectable Specialty Medications

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ST – Step Therapy

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List of Prescription Medications

ANTI-FUNGALS (Skin Conditions) (cont.)

| Prescription Drug Name | Drug Tier | Coverage Requirements and Limits |
|---|-----------|----------------------------------|
| TOPICAL ANTI-FUNGALS (cont.) | | |
| econazole nitrate | T1 | |
| ECOZA | T3 | |
| ERTACZO | T3 | PA |
| EXELDERM | T3 | PA |
| EXODERM | T1 | |
| EXTINA (<i>ketodan</i>) | T3 | PA |
| FLUCONAZ-IBU-ITRACONAZ-TERBINA | T3 | |
| HEXIOUNYL | T3 | |
| JUBLIA | T3 | PA |
| KERYDIN | T3 | PA |
| KERYDIN (<i>tavaborole</i>) | T3 | PA |
| <i>ketoconazole</i> | T1 | |
| <i>ketoconazole</i> (Extina) | T1 | |
| <i>ketoconazole/skin cleanser 28</i> | T1 | |
| LOPROX 0.77% CREAM (<i>ciclopirox</i>) | T3 | PA |
| LOPROX 0.77% SUSPENSION KIT | T3 | |
| LOPROX 0.77% TOPICAL SUSP (<i>ciclopirox</i>) | T3 | |
| LOPROX 1% SHAMPOO (<i>ciclopirox</i>) | T3 | PA |
| LULICONAZOLE | T1 | |
| LUZU | T3 | PA |
| MICONAZOLE-ZINC OXIDE-PETROLTM | T1 | PA |
| <i>naftifine hcl</i> | T1 | |
| <i>naftifine hcl</i> (Naftin) | T1 | |
| NAFTIN | T2 | |
| NAFTIN (<i>naftifine hcl</i>) | T2 | |
| <i>nystatin</i> | T1 | |
| <i>nystatin/triamcinolone acet</i> | T1 | |
| <i>oxiconazole nitrate</i> (Oxistat) | T1 | PA |
| OXISTAT 1% CREAM (<i>oxiconazole nitrate</i>) | T3 | PA |
| OXISTAT 1% LOTION | T2 | PA |
| RIMI | T3 | |
| SULCONAZOLE NITRATE | T3 | PA |
| <i>tavaborole</i> (Kerydin) | T1 | PA |
| VUSION | T3 | PA |

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List of Prescription Medications

| ANTI-FUNGALS (Skin Conditions) (cont.) | | |
|--|-----------|----------------------------------|
| Prescription Drug Name | Drug Tier | Coverage Requirements and Limits |
| TOPICAL ANTI-FUNGALS (cont.) | | |
| XOLEGEL | T3 | PA |
| ANTIHISTAMINE AND DECONGESTANT COMBINATION (Allergy/Nasal Sprays) | | |
| 1ST GEN ANTIHISTAMINE AND DECONGESTANT COMBINATION | | |
| phenylephrine hcl/prometh hcl | T1 | |
| 2ND GEN ANTIHISTAMINE AND DECONGESTANT COMBINATION | | |
| CLARINEX-D 12 HOUR | T3 | |
| ANTIHISTAMINES (Allergy/Nasal Sprays) | | |
| ANTIHISTAMINES - 1ST GENERATION | | |
| carbinoxamine 4 mg/5 ml liquid | T1 | |
| carbinoxamine maleate 4 mg tab | T1 | |
| carbinoxamine maleate 6 mg tab (Ryvent) | T1 | PA |
| CARBINOXAMINE MALEATE ER | T3 | PA |
| clemastine fumarate | T1 | |
| cyproheptadine hcl | T1 | |
| cyproheptadine hcl (Cyroheptadine Hcl) | T1 | |
| dexchlorpheniramine maleate (Ryclora) | T1 | PA |
| hydroxyzine hcl | T1 | |
| hydroxyzine pamoate | T1 | |
| hydroxyzine pamoate (Vistaril) | T1 | |
| KARBINAL ER | T3 | PA |
| promethazine hcl | T1 | |
| RYCLORA (dexchlorpheniramine maleate) | T3 | PA |
| RYVENT | T3 | PA |
| VISTARIL (hydroxyzine pamoate) | T3 | |
| cetirizine hcl | T1 | HD |
| CLARINEX (desloratadine) | T3 | HD |
| desloratadine 2.5 mg odt | T1 | QL (1 tab/day) HD |
| desloratadine 5 mg odt | T1 | HD |
| desloratadine 5 mg tablet (Claritin) | T1 | HD |
| ANTIHISTAMINES (Eye Conditions) | | |
| EYE ANTIHISTAMINES | | |
| azelastine hcl 0.05% drops | T1 | |
| BEPREVE | T3 | PA |
| epinastine hcl | T1 | |

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List of Prescription Medications

| ANTIHISTAMINES (Eye Conditions) (cont.) | | |
|--|-----------|----------------------------------|
| Prescription Drug Name | Drug Tier | Coverage Requirements and Limits |
| EYE ANTIHISTAMINES (cont.) | | |
| LASTACRAFT | T3 | |
| olopatadine hcl 0.1% eye drops | T1 | |
| olopatadine hcl 0.2% eye drop (Pataday) | T1 | |
| PATADAY (olopatadine hcl) | T3 | |
| PAZEO | T2 | |
| ZERVIATE | T3 | PA |
| ANTI-HYPERGLYCEMICS (Diabetes) | | |
| ANTIHYPERGLY, DPP-4 ENZYME INHIB.-THIAZOLIDINEDIONE | | |
| ALOGLIPTIN-PIOGLITAZONE | T3 | PA QL (1 tab/day) HD |
| OSENI | T3 | PA QL (1 tab/day) HD |
| ANTIHYPERGLY, INCRETIN MIMETIC (GLP-I RECEPT.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 |
| exenatide | T1 | PA QL(3 mls/30 days) |
| LIRAGLUTIDE | T3 | PA QL(3 pens/30 days) HD |
| 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 |
| REZVOGLAR KWIKPEN | T2 | PA QL |
| 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 (2 ML/28 Days) ST |
| TRULICITY 4.5 MG/0.5 ML PEN | T2 | QL (2 ML/28 Days) ST |
| VICTOZA 2-PAK | T3 | QL (3 pens/30 days) ST |
| VICTOZA 3-PAK | T3 | QL (3 pens/30 days) ST |
| ANTI-HYPERGLY, INSULIN, LONG ACT-GLP-I RECEPT.AGONIST | | |
| SOLIQUA 100-33 | T2 | HD |
| XULTOPHY 100-3.6 | T3 | PA HD |
| ANTI-HYPERGLYCEMIC-SOD/GLUC COTRANSPORT2(SGLT2) INHIB | | |
| FARXIGA | T2 | ST QL (1 tab/day) HD |
| INPEFA 200 MG TABLET | T3 | PA QL(1 tab/day) HD |
| INPEFA 400 MG TABLET | T3 | PA QL(1 tab/day) HD |

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List of Prescription Medications

| ANTI-HYPERGLYCEMICS (Diabetes) (cont.) | | |
|--|-----------|----------------------------------|
| Prescription Drug Name | Drug Tier | Coverage Requirements and Limits |
| ANTI-HYPERGLYCEMIC-SOD/GLUC COTRANSPORT2(SGLT2) INHIB (cont.) | | |
| INVOKANA | T3 | PA QL (1 tab/day) ST HD |
| JARDIANCE | T2 | QL (1 tab/day) ST HD |
| STEGLATRO | T3 | PA QL (1 tab/day) ST HD |
| ANTI-HYPERGLYCEMIC-DOPAMINE RECEPTOR AGONISTS | | |
| CYCLOSET | T3 | HD |
| ANTI-HYPERGLYCEMIC, ALPHA-GLUCOSIDASE INHIBITORS | | |
| acarbose (Precose) | T1 | HD |
| GLYSET (<i>miglitol</i>) | T3 | HD |
| <i>miglitol</i> (Glyset) | T1 | HD |
| PRECOSE (acarbose) | T3 | HD |
| ANTI-HYPERGLYCEMIC, AMYLIN ANALOG-TYPE | | |
| SYMLINPEN 120 | T2 | HD |
| SYMLINPEN 60 | T2 | |
| ANTI-HYPERGLYCEMIC, BIGUANIDE TYPE | | |
| FORTAMET (<i>metformin er osmotic</i>) | T3 | PA HD |
| GLUCOPHAGE XR (<i>metformin hcl er</i>) | T3 | HD |
| GLUMETZA (<i>metformin er gastric</i>) | T3 | PA |
| <i>metformin hcl</i> | T1 | HD |
| <i>metformin hcl</i> (Fortamet) | T1 | PA HD |
| <i>metformin hcl</i> (Glucophage Xr) | T1 | HD |
| <i>metformin hcl</i> (Glumetza) | T1 | PA HD |
| <i>metformin hcl</i> (Riomet) | T1 | HD |
| METFORMIN HCL 750 MG TABLET | T3 | PA HD |
| RIOMET (<i>metformin hcl</i>) | T3 | HD |
| RIOMET ER | T3 | HD |
| ANTI-HYPERGLYCEMIC, DPP-4 INHIBITORS | | |
| ALOGLIPTIN | T3 | PA QL (1 tab/day) HD |
| JANUVIA | T2 | QL (1 tab/day) ST HD |
| NESINA | T3 | PA QL (1 tab/day) HD |
| ONGLYZA | T3 | PA QL (1 tab/day) HD |
| SITAGLIPTIN | T3 | PA QL(1 tab/day) HD |
| TRADJENTA | T3 | PA QL (2 tabs/day) HD |
| ZITUVIO | T3 | PA QL(1 TAB/DAY) HD |
| ANTI-HYPERGLYCEMIC, INSULIN-RELEASE STIMULANT TYPE | | |
| AMARYL (<i>glimepiride</i>) | T3 | |

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List of Prescription Medications

| ANTI-HYPERGLYCEMICS (Diabetes) (cont.) | | |
|---|-----------|----------------------------------|
| Prescription Drug Name | Drug Tier | Coverage Requirements and Limits |
| ANTI-HYPERGLYCEMIC, INSULIN-RELEASE STIMULANT TYPE (cont.) | | |
| chlorpropamide | T1 | HD |
| glimepiride (Amaryl) | T1 | HD |
| GLIMEPIRIDE 3 MG TABLET | T3 | HD |
| GLIPIZIDE | T3 | HD |
| glipizide (Glucotrol XI) | T1 | HD |
| glipizide (Glucotrol) | T1 | HD |
| GLUCOTROL (glipizide) | T3 | HD |
| GLUCOTROL XL (glipizide xl) | T3 | HD |
| 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 |
| QTERN | T3 | ST QL(1 TAB/DAY) HD |
| STEGLUJAN | T3 | 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. | | |
| ALOGLIPTIN-METFORMIN | T3 | PA QL (2 tabs/day) HD |
| 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 |
| JENTADUETO | T3 | PA QL (4 tabs/day) HD |
| JENTADUETO XR 2.5 MG-1,000 MG | T3 | PA QL (2 tabs/day) HD |
| JENTADUETO XR 5 MG-1,000 MG TB | T3 | PA QL (1 tab/day) HD |
| KAZANO | T3 | PA QL (2 tabs/day) HD |

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

T4 – Injectable Specialty Medications

PA – Prior Authorization

QL – Quantity Limit

ST – Step Therapy

AGE – Age Requirement

SP – Specialty Medication

HD – May require home delivery pharmacy

PPACA – No Cost-Share Preventive Medication

CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

| ANTI-HYPERGLYCEMICS (Diabetes) (cont.) | | |
|--|-----------|----------------------------------|
| Prescription Drug Name | Drug Tier | Coverage Requirements and Limits |
| ANTI-HYPERGLYCEMIC, DPP-4 INHIBITOR-BIGUANIDE COMBS.(cont.) | | |
| KOMBIGLYZE XR 2.5-1,000 MG TAB | T3 | PA QL (2 tabs/day) HD |
| KOMBIGLYZE XR 5-1,000 MG TAB | T3 | PA QL (1 tab/day) HD |
| KOMBIGLYZE XR 5-500 MG TABLET | T3 | PA QL (1 tab/day) HD |
| SITAGLIPTIN-METFORMIN | T3 | PA QL(2 tabs/day) 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-GLUCOCORTICOID RECEPTOR BLOCKER | | |
| KORLYM (mifepristone) | T3 | PA SP |
| mifepristone 300 mg tablet (Korlym) | T3 | PA SP |
| ANTI-HYPERGLYCEMIC-SGLT2 INHIBITOR-BIGUANIDE COMBS. | | |
| DAPAGLIFLOZIN-METO ER 10-1000 | T3 | PA QL(1 tab/day) HD |
| DAPAGLIFLOZIN-METFOR ER 5-1000 | T3 | PA QL(2 tabs/day) HD |
| INVOKAMET | T3 | PA QL (2 tabs/day) ST HD |
| INVOKAMET XR | T3 | PA QL (2 tabs/day) ST HD |
| SEGLUROMET | T3 | PA QL (2 tabs/day) ST HD |
| SYNJARDY | T2 | QL (2 tabs/day) ST HD |
| SYNJARDY XR 10-1,000 MG TABLET | T2 | QL (2 tabs/day) ST HD |
| SYNJARDY XR 12.5-1,000 MG TAB | T2 | QL (2 tabs/day) ST HD |
| SYNJARDY XR 25-1,000 MG TABLET | T2 | QL (1 tab/day) ST HD |
| SYNJARDY XR 5-1,000 MG TABLET | T2 | QL (2 tabs/day) ST HD |
| XIGDUO XR 10 MG-1,000 MG TAB | T2 | QL (1 tab/day) ST HD |
| XIGDUO XR 10 MG-500 MG TABLET | T2 | QL (1 tab/day) ST HD |
| XIGDUO XR 2.5 MG-1,000 MG TAB | T2 | QL (2 tabs/day) ST HD |
| XIGDUO XR 5 MG-1,000 MG TABLET | T2 | QL (2 tabs/day) ST HD |
| XIGDUO XR 5 MG-500 MG TABLET | T2 | QL (1 tab/day) ST HD |
| ANTIHYPERGLY-SGLT-2 INHIB, DPP-4 INHIB, BIGUANIDE CB | | |
| TRIJARDY XR | T2 | QL (1 tab/day) ST HD |
| ANTIHYPERGLYCEMIC-SOD/GLUC COTRANSORT2(SGLT2) INH | | |
| BRENZAVVY | T3 | PA QL(1 tabs/day) HD |

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List of Prescription Medications

| ANTI-HYPERGLYCEMICS (Diabetes) (cont.) | | |
|---|-----------|----------------------------------|
| Prescription Drug Name | Drug Tier | Coverage Requirements and Limits |
| ANTIHYPERGLYCEMIC-SOD/GLUC COTRANSPORT2(SGLT2) INH (cont.) | | |
| DAPAGLIFLOZIN | T3 | PA QL(1 tab/day) HD |
| INSULINS | | |
| ADMELOG | T3 | PA QL (1.5ml/day) HD |
| ADMELOG SOLOSTAR | T3 | QL (1.5ml/day) HD |
| AFREZZA 12 UNIT CARTRIDGE | T3 | PA QL (12 cartridges/day) HD |
| AFREZZA 4 UNIT CARTRIDGE | T3 | PA QL (36 cartridges/day) HD |
| AFREZZA 4 UNIT/8 UNIT/12 UNIT | T3 | PA QL (6 cartridges/day) HD |
| AFREZZA 8 UNIT CARTRIDGE | T3 | PA QL (18 cartridges/day) HD |
| AFREZZA 90-4 UNIT / 90-8 UNIT | T3 | PA QL (12 cartridges/day) HD |
| AFREZZA 90-8 UNIT / 90-12 UNIT | T3 | PA QL (6 cartridges/day) HD |
| APIDRA | T3 | PA QL (1.5ml/day) HD |
| APIDRA SOLOSTAR | T3 | PA QL (1.5ml/day) HD |
| BASAGLAR KWIKPEN U-100 | T2 | QL (1.5ml/day) HD |
| FIASP FLEXTOUCH | T3 | PA QL (1.5ml/day) HD |
| FIASP PENFILL | T3 | PA QL (1.5ml/day) HD |
| HUMALOG | T3 | PA QL (1.5ml/day) HD |
| HUMALOG JUNIOR KWIKPEN | T2 | QL (1.5ml/day) HD |
| HUMALOG KWIKPEN U-100 | T2 | QL (1.5ml/day) HD |
| HUMALOG KWIKPEN U-200 | T2 | QL (1ml/day) HD |
| HUMALOG MIX 50-50 KWIKPEN | T2 | QL (1ml/day) HD |
| HUMALOG MIX 75-25 | T2 | QL (2ml/day) HD |
| HUMALOG MIX 75-25 KWIKPEN | T2 | QL (2ml/day) HD |
| HUMULIN R U-500 | T2 | QL (1ml/day) HD |
| HUMULIN R U-500 KWIKPEN | T2 | QL (1ml/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 (2ml/day) HD |
| INSULIN GLARGINE MAX SOLOSTAR | T3 | PA QL(1.5 mls/day) HD |
| INSULIN GLARGINE-YFGN U100 PEN | T3 | PA QL(1.5 mls/day) HD |
| INSULIN GLARGINE-YFGN U100 VL | T3 | PA QL(1.5 mls/day) HD |
| INSULIN LISPRO | T2 | PA QL (1.5ml/day) HD |
| INSULIN LISPRO JUNIOR KWIKPEN | T2 | QL (1.5ml/day) HD |
| INSULIN LISPRO KWIKPEN U-100 | T2 | QL (1.5ml/day) HD |

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List of Prescription Medications

| ANTI-HYPERGLYCEMICS (Diabetes) (cont.) | | |
|--|-----------|----------------------------------|
| Prescription Drug Name | Drug Tier | Coverage Requirements and Limits |
| INSULINS (cont.) | | |
| INSULIN LISPRO PROTAMINE MIX | T2 | QL (2ml/day) HD |
| LANTUS | T3 | PA QL (1.5ml/day) HD |
| LANTUS SOLOSTAR | T3 | PA QL (1.5ml/day) HD |
| LEVEMIR | T3 | PA QL (1.5ml/day) HD |
| LEVEMIR FLEXTOUCH | T3 | PA 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 (1ml/day) HD |
| NOVOLOG | T3 | PA QL (1.5ml/day) HD |
| NOVOLOG FLEXPEN | T2 | QL (1.5ml/day) HD |
| NOVOLOG MIX 70-30 | T2 | QL (2ml/day) HD |
| NOVOLOG MIX 70-30 FLEXPEN | T2 | QL (2ml/day) HD |
| SEMLEE (YFGN) | T3 | PA QL (1.5ml/day) HD |
| TOUJEO MAX SOLOSTAR | T3 | PA QL (0.6ml/day) HD |
| TOUJEO SOLOSTAR | T3 | PA QL (0.6ml/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 | |
| ANTI-INFECTIVES (Infections) | | |
| PENICILLIN ANTIBIOTICS | | |
| amoxicillin | T1 | |
| ANTI-INFECTIVES/MISCELLANEOUS (Feminine Products) | | |
| VAGINAL ANTISEPTICS | | |
| acetic acid/oxyquinoline (Relagard) | T1 | |
| RELAGARD (fem ph) | T3 | |
| TRIMO-SAN | T3 | |
| ANTI-INFECTIVES/MISCELLANEOUS (Infections) | | |
| 2ND GEN. ANAEROBIC ANTI-PROTOZOAL-ANTIBACTERIAL | | |
| TINDAMAX (<i>tinidazole</i>) | T3 | |
| <i>tinidazole</i> | T1 | |

T1 – Typically Generics

T2 – Typically Preferred Brands

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T4 – Injectable Specialty Medications

PA – Prior Authorization

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PPACA – No Cost-Share Preventive Medication

CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

| ANTI-INFECTIVES/MISCELLANEOUS (Infections) (cont.) | | |
|--|-----------|----------------------------------|
| Prescription Drug Name | Drug Tier | Coverage Requirements and Limits |
| 2ND GEN. ANAEROBIC ANTI-PROTOZOAL-ANTIBACTERIAL (cont.) | | |
| <i>tinidazole</i> (Tindamax) | T1 | |
| AMEBICIDES | | |
| <i>paromomycin sulfate</i> | T1 | |
| ANTHELMINTICS | | |
| <i>albendazole</i> (Albenza) | T1 | |
| ALBENZA (<i>albendazole</i>) | T3 | |
| BILTRICIDE (<i>praziquantel</i>) | T3 | |
| EMVERM | T1 | |
| <i>ivermectin</i> (Stromectol) | T1 | PA |
| <i>praziquantel</i> (Biltricide) | T1 | |
| STROMECTOL (<i>ivermectin</i>) | T3 | PA |
| ANTI-MALARIAL DRUGS | | |
| ARAKODA | T3 | PA |
| <i>atovaquone/proguanil hcl</i> (Malarone) | T1 | |
| <i>chloroquine ph 250 mg tablet</i> | T1 | QL (56 Tabs/365 Days) |
| <i>chloroquine ph 500 mg tablet</i> | T1 | |
| COARTEM | T3 | PA QL (24 tabs/30 days) |
| DARAPRIM (<i>pyrimethamine</i>) | T3 | PA SP |
| <i>hydroxychloroquine sulfate</i> (Plaquenil) | T1 | |
| KRINTAFEL | T3 | PA QL (2 tabs/30 days) |
| MALARONE (<i>atovaquone-proguanil hcl</i>) | T3 | PA |
| <i>mefloquine hcl</i> | T1 | |
| PLAQUENIL (<i>hydroxychloroquine sulfate</i>) | T3 | PA QL (30 tabs/365 days) |
| PRIMAQUINE | T1 | |
| <i>primaquine phosphate</i> (Primaquine) | T1 | |
| <i>pyrimethamine 25 mg tablet</i> (Daraprim) | T1 | PA |
| QUALAQUIN (<i>quinine sulfate</i>) | T3 | PA |
| <i>quinine sulfate</i> (Qualaquin) | T1 | |
| SOVUNA | T3 | PA |
| ANTI-PROTOZOAL DRUGS, MISCELLANEOUS | | |
| <i>atovaquone</i> (Mepron) | T1 | |
| BENZNIDAZOLE | T3 | |
| IMPAVIDO | T3 | PA |
| LAMPIT | T3 | |

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

T4 – Injectable Specialty Medications

PA – Prior Authorization

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ST – Step Therapy

AGE – Age Requirement

SP – Specialty Medication

HD – May require home delivery pharmacy

PPACA – No Cost-Share Preventive Medication

CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

| ANTI-INFECTIVES/MISCELLANEOUS (Miscellaneous) (cont.) | | |
|--|-----------|--------------------------------------|
| Prescription Drug Name | Drug Tier | Coverage Requirements and Limits |
| ANTI-PROTOZOAL DRUGS, MISCELLANEOUS (cont.) | | |
| MEPRON | T3 | PA |
| MEPRON (<i>atovaquone</i>) | T3 | PA |
| NEBUPENT (<i>pentamidine isethionate</i>) | T3 | |
| <i>pentamidine isethionate</i> (Nebupent) | T1 | |
| ANTIBACTERIAL AGENTS, MISCELLANEOUS | | |
| <i>glycine urologic solution</i> | T3 | |
| ANTISEPTICS, GENERAL | | |
| ALCOHOL SWABSTICK | T3 | |
| TOPICAL ANTISEPTIC DRYING AGENTS | | |
| <i>formaldehyde</i> | T1 | |
| ANTI-INFECTIVES/MISCELLANEOUS (Skin Conditions) | | |
| TOPICAL ANTIANDROGENIC AGENTS | | |
| WINLEVI | T3 | PA |
| TOPICAL ANTI-FUNGALS | | |
| CICLODAN 8% KIT | T3 | |
| <i>ciclopirox/urea/camph/men/euc</i> (Ciclodan) | T1 | |
| ANTI-INFLAM.TUMOR NECROSIS FACTOR INHIBITING AGENTS (Pain Relief And Inflammatory Disease) | | |
| ANTI-INFLAMMATORY TUMOR NECROSIS FACTOR INHIBITOR | | |
| ABRILADA(CF) | T4 | PA QL(2 pens/syringes/28 days) SP |
| ADALIMUMAB-AACF(CF) | T4 | PA QL(2 pens/syringes/28 days) SP HD |
| ADALIMUMAB-AACF(CF) PEN CROHNS | T4 | PA QL(1 starter kit/365 days) SP HD |
| ADALIMUMAB-AACF(CF) PEN PS-UV | T4 | PA QL(2 kits/365 days) SP HD |
| ADALIMUMAB-AATY(CF) AUTOINJ(2) | T4 | PA QL(2 auto-injs/28 days) SP |
| ADALIMUMAB-AACF(CF) PEN CROHNS | T4 | PA QL(1 starter kit/365 days) SP HD |
| ADALIMUMAB-AATY(CF) | T4 | PA QL(2 auto-injs/28 days) SP |
| ADALIMUMAB-ADAZ | T4 | PA QL (2 pens/ 28 days) SP |
| ADALIMUMAB-ADBM(CF) | T4 | PA QL(2 pens/syringes/28 days) SP HD |
| ADALIMUMAB-ADBM(CF) PEN CROHNS | T4 | PA QL(1 starter kit/365 days) SP HD |
| ADALIMUMAB-FKJP (CF) | T4 | PA QL (2 doses/ 28 days) SP |
| ADALIMUMAB-RYVK(CF) AUTOINJECT | T4 | PA QL SP |
| AMJEVITA SLP | T4 | PA QL (2 syringes/28 days) SP HD |
| AVSOLA | T2 | PA SP |
| CDV HYRIMOZ(CF) 40MG/0.4ML SYR | T4 | SP HD |
| CDV HYRIMOZ(CF) PEN 40MG/0.4ML | T4 | SP HD |
| CIMZIA 200 MG VIAL KIT | T4 | PA QL (1 kit/28 days) SP HD |
| CIMZIA 2X200 MG/ML SYRINGE KIT | T4 | PA QL (1 kit/28 days) SP HD |
| CIMZIA 2X200 MG/ML (X3) START KT | T4 | PA QL (1 kit/year) SP HD |

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List of Prescription Medications

| ANTI-INFLAM.TUMOR NECROSIS FACTOR INHIBITING AGENTS (Pain Relief And Inflammatory Disease) (cont.) | | |
|--|-----------|-------------------------------------|
| Prescription Drug Name | Drug Tier | Coverage Requirements and Limits |
| ANTI-INFLAMMATORY TUMOR NECROSIS FACTOR INHIBITOR (cont.) | | |
| CYLTEZO(CF) PEN PSORIASIS-UV | T4 | PA QL (2 doses/ 28 days) SP |
| CYLTEZO(CF) PEN CRH-UC-HS 40MG | T4 | PA QL(1 starter kit/365 days) SP |
| ENBREL 25 MG KIT | T4 | PA QL (8 vials/28 days) SP HD |
| ENBREL 25 MG/0.5 ML SYRINGE | T4 | PA QL (8 syringes/28 days) SP HD |
| ENBREL 25 MG/0.5 ML VIAL | T4 | PA QL (4ml/28 days) SP HD |
| ENBREL 50 MG/ML SYRINGE | T4 | PA QL (4 syringes/28 days) SP HD |
| ENBREL MINI | T4 | PA QL (4 cartridges/28 days) SP HD |
| ENBREL SURECLICK | T4 | PA QL (4 syringes/28 days) SP HD |
| HADLIMA | T4 | PA QL (2 doses/ 28 days) SP HD |
| HADLIMA (CF-citrate free) | T4 | PA QL (2 doses/ 28 days) SP HD |
| HULIO(CF) | T4 | PA QL(2 pens/syringes/28 days) SP |
| HULIO(CF) PEN | T4 | PA QL(2 pens/28 days) SP |
| HUMIRA | T4 | PA QL (2 syringes/28 days) SP |
| HUMIRA PEN | T4 | PA QL (2 pens/28 days) SP HD |
| HUMIRA (CF) | T4 | PA QL (2 syringes/28 days) SP HD |
| HUMIRA (CF) PEN 40 MG/0.4 ML | T4 | PA QL (2 pens/28 days) SP HD |
| HUMIRA (CF) PEN 80 MG/0.8 ML | T4 | PA QL (1 kit/year) SP HD |
| HYRIMoz | T4 | PA QL (2 doses/ 28 days) SP |
| HYRIMoz(CF) PEN | T2 | PA QL(2 pens/28 days) SP HD |
| IDACIO (CF) | T4 | PA QL (2 doses/ 28 days) SP |
| IDACIO(CF) PEN CROHN'S-UC | T4 | PA QL(1 starter kit/365 days) SP HD |
| IDACIO(CF) PEN PSORIASIS | T4 | PA QL(2 kits/365 days) SP HD |
| INFLECTRA | T2 | PA SP HD |
| REMICADE | T3 | PA SP HD |
| SIMLANDI(CF) AUTOINJECTOR | T4 | PA QL SP |
| SIMPONI 100 MG/ML PEN INJECTOR | T4 | PA QL (1 injector/28 days) SP HD |
| SIMPONI 100 MG/ML SYRINGE | T4 | PA QL (1 syringe/28 days) SP HD |
| SIMPONI 50 MG/0.5 ML PEN INJEC | T4 | PA QL (1 injector/28 days) SP HD |
| SIMPONI 50 MG/0.5 ML SYRINGE | T4 | PA QL (1 syringe/28 days) SP HD |
| SIMPONI ARIA | T4 | PA SP HD |
| YUFLYMA(CF) | T4 | PA QL(2 auto-injs/28 days) SP |
| YUSIMRY (CF) | T4 | PA QL (2 doses/ 28 days) SP |
| ANTI-NEOPLASTICS (Cancer) | | |
| ANP - SELECTIVE RETINOID X RECEPTOR AGONISTS (RXR) | | |
| bexarotene (Targretin) | T1 | PA SP HD |

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List of Prescription Medications

| ANTI-NEOPLASTICS (Cancer) (cont.) | | |
|---|-----------|----------------------------------|
| Prescription Drug Name | Drug Tier | Coverage Requirements and Limits |
| ANP - SELECTIVE RETINOID X RECEPTOR AGONISTS (RXR) (cont.) | | |
| TARGETIN 75 MG CAPSULE (<i>bexarotene</i>) | T3 | PA SP HD |
| ANTI-NEOPLAST, HISTONE DEACETYLASE (HDAC) INHIBITORS | | |
| FARYDAK | T3 | PA SP HD |
| ZOLINZA | T2 | PA SP HD |
| ANTINEOPLASTIC - ALKYLATING AGENTS | | |
| ALKERAN (<i>melphalan</i>) | T3 | SP |
| cyclophosphamide 25 mg capsule | T1 | SP HD |
| cyclophosphamide 50 mg capsule | T1 | SP HD |
| CYCLOPHOSPHAMIDE 50 MG TABLET | T3 | PA SP HD |
| GLEOSTINE | T2 | |
| HYDREA (<i>hydroxyurea</i>) | T3 | |
| <i>hydroxyurea</i> (Hydrea) | T1 | |
| LEUKERAN | T2 | |
| <i>melphalan</i> (Alkeran) | T1 | SP CSL |
| MYLERAN | T2 | |
| ANTI-NEOPLASTIC - ANTI-ANDROGENIC AGENTS | | |
| CASODEX (<i>bicalutamide</i>) | T3 | |
| ERLEADA | T2 | PA SP HD CSL |
| <i>flutamide</i> | T1 | |
| NILANDRON (<i>nilutamide</i>) | T3 | PA QL (4 tabs/day) |
| <i>nilutamide</i> (Nilandron) | T1 | QL (4 tabs/day) |
| NUBEQA | T2 | PA SP HD |
| XTANDI | T2 | PA SP HD |
| YONSA | T3 | PA SP HD |
| ZYTIGA (<i>abiraterone acetate</i>) | T3 | PA SP HD |
| ANTI-NEOPLASTIC - ANTI-METABOLITES | | |
| <i>capecitabine</i> (Xeloda) | T1 | PA SP HD |
| INQOVI | T3 | PA SP HD |
| JYLAMVO | T3 | CSL |
| LONSURF | T3 | PA SP HD |
| <i>mercaptopurine</i> 20 mg/ml suspen (Purixan) | T1 | SP CSL |
| <i>mercaptopurine</i> 50 mg tablet | T1 | CSL |
| <i>methotrexate sodium</i> | T1 | |
| <i>methotrexate sodium/pf</i> | T1 | |
| ONUREG | T3 | PA QL (14 Tabs/28 Days) SP |

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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

ANTI-NEOPLASTICS (Cancer) (cont.)

| Prescription Drug Name | Drug Tier | Coverage Requirements and Limits |
|---|-----------|----------------------------------|
| ANTI-NEOPLASTIC - ANTI-METABOLITES (cont.) | | |
| PURIXAN | T3 | SP |
| TABLOID | T3 | |
| TREXALL | T2 | |
| XATMEP | T3 | |
| XELODA (<i>capecitabine</i>) | T3 | PA SP HD |
| ANTI-NEOPLASTIC - AROMATASE INHIBITORS | | |
| <i>anastrozole</i> (Arimidex) | T1 | HD PPACA |
| ARIMIDEX (<i>anastrozole</i>) | T3 | HD |
| AROMASIN (<i>exemestane</i>) | T3 | HD |
| <i>exemestane</i> (Aromasin) | T1 | HD PPACA |
| FEMARA (<i>letrozole</i>) | T3 | PA HD CSL |
| <i>letrozole</i> (Femara) | T1 | HD |
| ANTI-NEOPLASTIC - BRAF KINASE INHIBITORS | | |
| BRAFTOVI | T3 | PA SP HD |
| OJEMDA TABLET | T3 | PA QL(1 packet/28 Days) SP CSL |
| OJEMDA 25 MG/ML ORAL SUSP | T3 | PA QL(8 bottles/28 days) SP CSL |
| TAFINLAR CAPSULE | T2 | PA QL(4 caps/day) SP HD CSL |
| TAFINLAR TABLET | T2 | PA QL(30 tabs/day) SP HD CSL |
| ZELBORAF | T3 | PA SP HD |
| ANTI-NEOPLASTIC - ENZYME INHIB, ANTIANDROGEN COMB. | | |
| AKEEGA | T3 | PA QL(2 Tabs/Day) SP CSL |
| ANTI-NEOPLASTIC - HEDGEHOG PATHWAY INHIBITOR | | |
| DAURISMO | T3 | PA SP HD |
| ERIVEDGE | T2 | PA SP HD |
| ODOMZO | T2 | PA SP HD |
| ANTI-NEOPLASTIC - JANUS KINASE (JAK) INHIBITORS | | |
| JAKAFI | T3 | PA SP HD |
| ANTI-NEOPLASTIC - KRAS PROTEIN INHIBITOR | | |
| KRAZATI | T3 | PA QL(6 TABS/DAY) SP CSL |
| LUMAKRAS | T3 | PA SP QL (4 tabs per day) HD |
| ANTI-NEOPLASTIC - MEKI 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 0.05 MG/ML SOLUTION | T2 | PA QL(40 mls/day) SP HD CSL |
| MEKINIST 0.5 MG TABLET | T2 | PA QL(3 tabs/day) SP HD CSL |

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

T4 – Injectable Specialty Medications

PA – Prior Authorization

QL – Quantity Limit

ST – Step Therapy

AGE – Age Requirement

SP – Specialty Medication

HD – May require home delivery pharmacy

PPACA – No Cost-Share Preventive Medication

CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

| ANTI-NEOPLASTICS (Cancer) (cont.) | | |
|---|-----------|-----------------------------------|
| Prescription Drug Name | Drug Tier | Coverage Requirements and Limits |
| ANTI-NEOPLASTIC - MEKI AND MEK2 KINASE INHIBITORS (con't.) | | |
| MEKINIST 2 MG TABLET | T2 | PA QL(1 tab/day) SP HD CSL |
| MEKTOVI | T3 | PA SP HD |
| ANTI-NEOPLASTIC - MTOR KINASE INHIBITORS | | |
| AFINITOR | T3 | PA SP HD |
| AFINITOR (<i>everolimus</i>) | T3 | PA SP HD |
| AFINITOR DISPERZ | T3 | PA SP |
| <i>everolimus</i> (Afinitor) | T1 | PA SP HD |
| 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 200 MG | T2 | PA QL (21 per 28 days) SP HD |
| KISQALI 400 MG | T2 | PA QL (42 per 28 days) SP HD |
| KISQALI 800 MG | T2 | PA QL (63 per 28 days) SP HD |
| KISQALI FEMARA CO-PACK | T2 | PA QL (1 pack per 28 days) SP CSL |
| ANTI-NEOPLASTIC EGF RECEPTOR BLOCKER MCLON ANTIBODY | | |
| PHESGO | T3 | PA SP HD |
| ANTI-NEOPLASTIC IMMUNOMODULATOR AGENTS | | |
| lenalidomide | T1 | PA QL(1 tab/day) SP HD CSL |
| POMALYST | T2 | PA QL(21 caps/28 days) SP HD CSL |
| REVLIMID | T2 | PA QL(1 tab/day) SP HD CSL |
| <i>pazopanib hcl</i> (Votrient) | T1 | PA QL(4 tabs/day) SP HD CSL |
| ANTI-NEOPLASTIC LHRH (GNRH) AGONIST, PITUITARY SUPPR. | | |
| <i>leuprolide acetate</i> | T1 | PA SP HD |
| LEUPROLIDE DEPOT | T4 | PA SP |
| LUPRON DEPOT | T2 | PA SP HD |
| ZOLADEX | T2 | PA SP HD |
| ANTI-NEOPLASTIC LHRH (GNRH) ANTAGONIST, PITUIT.SUPPRS | | |
| FIRMAGON | T3 | PA SP HD |
| ORGOVYX | 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 SYSTEMIC ENZYME INHIBITORS | | |
| ALECensa | T2 | PA QL(8 tabs/day) SP HD CSL |
| Alunbrig | T3 | PA SP HD |
| Augtyro | T3 | PA QL(2 caps/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 |
| Cabometyx | T3 | PA SP HD |
| Calquence | T3 | PA SP |
| Caprelsa | T3 | PA SP |
| Cometriq | T3 | PA SP HD |
| copiktra | T3 | PA SP |
| DanzitEN | T2 | PA SP CSL |
| <i>dasatinib 20 mg tablet (Sprycel)</i> | T1 | PA QL(3 tabs/day) SP HD CSL |
| <i>dasatinib 70 mg tablet (Sprycel)</i> | T1 | PA QL(2 tabs/day) SP HD CSL |
| <i>dasatinib 50 mg, 80 mg, 100 mg, 140 mg tablet (Sprycel)</i> | T1 | PA QL(1 tab/day) SP HD CSL |
| <i>erlotinib hcl</i> | T1 | PA SP HD |
| Exkivity | T3 | PA SP HD |
| Fotivda | T3 | PA QL (30 caps/30 days) SP HD |
| Fruzaqla 1 MG Capsule | T3 | PA QL(84 caps/28 days) SP CSL |
| Fruzaqla 5 MG Capsule | T3 | PA QL(21 caps/28 days) SP CSL |
| Gavreto | T3 | PA QL (4 Tabs/Day) SP CSL |
| Giotorif | T3 | PA SP HD |
| Gleevec (<i>imatinib mesylate</i>) | T3 | PA SP HD |
| Ibrance | T3 | PA QL (21 caps/28 days) SP HD |
| Inclusig | T3 | PA SP |
| <i>imatinib mesylate (Gleevec)</i> | T1 | PA SP HD |
| Imbruvica | T2 | PA SP |
| Imkealdi | T2 | PA SP CSL |
| Inlyta | T3 | PA SP HD |
| Inrebic | T3 | PA SP HD |
| Iressa | T3 | PA SP HD |
| Itovebi | T3 | PA SP HD CSL |
| Iwilfin | T3 | PA QL(8 tabs/day) SP CSL |
| <i>lapatinib ditosylate (Tykerb)</i> | T1 | PA SP HD |
| Lenvima | T2 | PA SP HD |
| Lorbrena | T3 | PA 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.) | | |
| LYNPARZA | T2 | PA SP HD |
| LYTGOBI 12 MG DAILY DOSE PACK | T3 | PA QL(3 tabs/day) SP CSL |
| LYTGOBI 16 MG DAILY DOSE PACK | T3 | PA QL(4 tabs/day) SP CSL |
| LYTGOBI 20 MG DAILY DOSE PACK | T3 | PA QL(5 tabs/day) SP CSL |
| NERLYNX | T3 | PA SP HD |
| NEXAVAR | T3 | PA SP HD |
| NINLARO | T3 | PA QL(3 caps/28 days) SP HD CSL |
| OGSIVEO | T3 | PA QL(6 tabs/day) SP CSL |
| OJJAARA | T3 | PA QL(1 TAB/DAY) SP CSL |
| pazopanib 200 mg tablet (Votrient) | T1 | PA QL 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 |
| RETEVMO 80 MG CAPSULE | T3 | PA QL (4 tabs/day) SP HD |
| RETEVMO 120 MG, 160 MG TABLET | T3 | PA QL (2 tabs/day) SP HD CSL |
| REVUFORJ 25 MG, 110 MG TABLET | T3 | PA SP CSL |
| REVUFORJ 160 MG TABLET | T3 | PA QL(2 tabs/day) SP CSL |
| ROZLYTREK | T3 | PA SP HD |
| RUBRACA | T2 | PA SP |
| RYDAPT | T3 | PA SP HD |
| SCEMBLIX 20 MG TABLET | T3 | PA QL (2 tablets/day) SP HD |
| SCEMBLIX 40 MG TABLET | T3 | PA SP HD CSL |
| SPRYCEL 20 MG | T3 | PA QL(3 tab/day) SP HD CSL |
| SPRYCEL 50 MG, 80 MG, 100 MG, 140 MG TABLET | T3 | PA QL(1 tab/day) SP HD CSL |
| SPRYCEL 70 MG TABLET | T3 | PA QL(2 tab/day) SP HD CSL |
| STIVARGA | T2 | PA QL(84 tabs/28 days) SP HD CSL |
| SUTENT | T2 | PA SP HD |
| TABRECTA | T3 | PA QL (4 tabs/day) SP HD |
| TAGRISSO | T3 | PA SP HD |
| TALZENNA | T3 | PA QL (1 cap/day) SP HD |
| TARCEVA (<i>erlotinib hc</i>) | T3 | PA SP HD |
| TASIGNA | T2 | PA QL(4 caps/day) SP HD |
| TEPMETKO | T3 | PA QL (2 tabs/day) SP |
| TRUQAP | T3 | PA QL(64 tabs/28 days) SP CSL |
| TUKYSA | T3 | PA SP |
| TURALIO 125 MG CAPSULE | T3 | PA QL(4 CAPS/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.) | | |
| TURALIO 200 MG CAPSULE | T3 | PA QL(4 CAPS/DAY) SP CSL |
| TYKERB (<i>lapatinib</i>) | T3 | PA SP HD |
| UKONIQ | T3 | PA QL (4 tabs/day) SP |
| VANFLYTA | T3 | PA QL(2 tabs/day) SP CSL |
| VERZENIO | T2 | PA QL (120mg/day) SP HD |
| VITRAKVI | T3 | PA SP HD |
| VIZIMPRO | T3 | PA SP HD |
| VOTRIENT (<i>pazopanib hcl</i>) | 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, 250 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 SP |
| ZYDELIG | T3 | PA SP HD |
| ZYKADIA | T3 | PA SP HD |
| ANTI-NEOPLASTIC, ANTI-PROGRAMMED DEATH-1 (PD-1) MAB | | |
| OPDIVO | T3 | PA SP HD |
| 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 |
| ANTI-NEOPLASTICS, MISCELLANEOUS | | |
| <i>etoposide</i> | T1 | SP HD |
| LYSODREN | T2 | |
| MATULANE | T2 | SP |
| <i>tretinoin 10 mg capsule</i> | T1 | PA |
| ANTI-NEOPLASTIC-SELECT INHIB OF NUCLEAR EXP (SINE) | | |
| XPOVIO | T3 | PA SP |
| CYTOTOXIC T-LYMPHOCYTE ANTIGEN (CTLA-4) RMC ANTIBODY | | |
| YERVOY | T3 | PA SP HD |
| IMMUNOMODULATORS | | |
| ACTIMMUNE | T4 | PA SP HD |

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List of Prescription Medications

| ANTI-NEOPLASTICS (Cancer) (cont.) | | |
|--|-----------|----------------------------------|
| Prescription Drug Name | Drug Tier | Coverage Requirements and Limits |
| IMMUNOMODULATORS (con't.) | | |
| BESREMI | T4 | PA QL (2 syringes/28 days) SP |
| SELECTIVE ESTROGEN RECEPTOR MODULATORS (SERMS) | | |
| FARESTON (<i>toremifene citrate</i>) | T3 | QL (2 tabs/day) HD |
| SOLTAMOX | T3 | HD |
| <i>tamoxifen citrate</i> | T1 | HD PPACA |
| <i>toremifene citrate</i> (Fareston) | T1 | QL (2 tabs/day) HD |
| STEROID ANTI-NEOPLASTICS | | |
| EMCYT | T2 | SP HD |
| <i>megestrol acetate</i> | T1 | |
| ANTI-NEOPLASTICS (Skin Conditions) | | |
| PHOTOACT, TOPICAL ANTI-NEOPLAST, PREMALIGNANT LESIONS | | |
| LEVULAN | T3 | SP |
| TOPICAL ANTI-NEOPLASTIC PREMALIGNANT LESION AGENTS | | |
| CARAC | T3 | PA |
| <i>diclofenac sodium 3% gel</i> | T1 | PA |
| EFDUDEX (<i>fluorouracil</i>) | T3 | |
| FLUOROPLEX | T2 | |
| <i>fluorouracil</i> | T1 | |
| <i>fluorouracil</i> (Efudex) | T1 | |
| KLISYRI | T3 | PA QL (5 packs/30 Days) |
| PANRETIN | T3 | SP HD |
| PICATO | T2 | |
| TARGRETIN 1% GEL (<i>bexarotene</i>) | T3 | PA SP HD |
| 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> (Regimex) | T1 | |
| <i>diethylpropion hcl</i> | T1 | |
| LOMAIRA | T3 | PA |
| <i>phenidimetrazine tartrate</i> | T1 | |
| <i>phentermine hcl</i> (Adipex-p) | T1 | |
| QSYMIA | T3 | PA |
| REGIMEX (<i>benzphetamine hcl</i>) | T3 | |
| VYKAT XR | T3 | SP |

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List of Prescription Medications

| ANTI-OBESITY DRUGS (Weight Management) (cont.) | | |
|--|-----------|----------------------------------|
| Prescription Drug Name | Drug Tier | Coverage Requirements and Limits |
| ANTI-OBESITY - INCRETIN MIMETICS COMBINATION | | |
| ZEPBOUND 7.5 MG/0.5 ML PEN | T2 | PA QL(2 mls/30 days) |
| ZEPBOUND 10 MG/0.5 ML PEN | T2 | PA QL(2 mls/30 days) |
| ZEPBOUND 12.5 MG/0.5 ML PEN | T2 | PA QL(2 mls/30 days) |
| ZEPBOUND 15 MG/0.5 ML PEN | T2 | PA QL(2 mls/30 days) |
| ANTI-OBESITY - MELANOCORTIN 4 RECEPTOR AGONISTS | | |
| IMCIVREE | T3 | PA QL (9 ml/22 days) SP |
| ANTI-OBESITY GLUCAGON-LIKE PEPTIDE-I RECEP AGONIST | | |
| SAXENDA | T2 | PA |
| WEGOZY | 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 |
| ANTI-PARASITICS (Infections) | | |
| ANTI-PARASITICS | | |
| ALINIA (<i>nitazoxanide</i>) | T3 | |
| <i>nitazoxanide</i> (Alinia) | T1 | |
| OPHTHALMIC (EYE) ANTIPARASITICS | | |
| XDEMVY | T2 | 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>ivermectin</i> (Sklice) | T1 | |
| NATROBA (<i>spinosad</i>) | T3 | PA |
| <i>permethrin</i> (Elimite) | T1 | |
| SKLICE (<i>ivermectin</i>) | T3 | |
| <i>spinosad</i> (Natroba) | T1 | |

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List of Prescription Medications

| ANTI-PARASITICS (Infections) (cont.) | | |
|--|-----------|----------------------------------|
| Prescription Drug Name | Drug Tier | Coverage Requirements and Limits |
| TOPICAL ANTI-PARASITICS (cont.) | | |
| ULESIA | 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 | T4 | 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> (Sinemet) | T1 | HD |
| <i>carbidopa/levodopa/entacapone</i> (Stalevo 100) | T1 | HD |
| <i>carbidopa/levodopa/entacapone</i> (Stalevo 75) | T1 | HD |
| DHIVY | T3 | PA |
| DUOPA | T3 | SP HD |
| <i>entacapone</i> | T1 | HD |
| GOCOVRI | T3 | HD |
| INBRIJA | T3 | PA SP HD |
| KYNMOBI | T2 | PA HD |
| ONGENTYS | T3 | PA QL (1 caps/day) HD |
| OSMOLEX ER 129 MG TABLET | T3 | QL (1 tab/day) HD |
| OSMOLEX ER 193 MG TABLET | T3 | QL (1 tab/day) HD |
| OSMOLEX ER 258 MG TABLET | T3 | QL (1 tab/day) 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.) | | |
| NEUPRO | T3 | HD |
| NOURIANZ | T3 | PA QL (1 tab/day) SP HD |
| OSMOLEX ER 322 MG DAILY DOSE | T3 | QL (2 tabs/day) HD |
| PARLODEL (<i>bromocriptine mesylate</i>) | T3 | 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>pramipexole er 4.5 mg tablet</i> | T1 | HD |
| <i>rasagiline mesylate 0.5 mg tab (Azilect)</i> | T1 | QL (1 tab/day) HD |
| <i>rasagiline mesylate 1 mg tab (Azilect)</i> | 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 125 (<i>carbidopa-levodopa-entacapone</i>) | T3 | HD |
| STALEVO 50 (<i>carbidopa-levodopa-entacapone</i>) | T3 | HD |
| TASMAR (<i>tolcapone</i>) | T3 | HD |

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T3 – Typically Non-Preferred Brands

T4 – Injectable Specialty Medications

PA – Prior Authorization

QL – Quantity Limit

ST – Step Therapy

AGE – Age Requirement

SP – Specialty Medication

HD – May require home delivery pharmacy

PPACA – No Cost-Share Preventive Medication

CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

| ANTI-PARKINSON DRUGS (Parkinson's Disease) (cont.) | | |
|--|-----------|----------------------------------|
| Prescription Drug Name | Drug Tier | Coverage Requirements and Limits |
| ANTI-PARKINSONISM DRUGS, OTHER (cont.) | | |
| <i>tolcapone</i> (Tasmar) | T1 | HD |
| XADAGO | T3 | ST HD |
| VYALEV | T3 | PA SP HD |
| ZELAPAR | T3 | PA HD |
| DECARBOXYLASE INHIBITORS | | |
| <i>carbidopa</i> (Lodosyn) | T1 | |
| LODOSYN (<i>carbidopa</i>) | T3 | PA |
| ANTI-PLATELET DRUGS (Blood Thinners/Anti-Clotting) | | |
| PLATELET AGGREGATION INHIBITORS | | |
| <i>aspirin/dipyridamole</i> | T1 | HD |
| ASPIRIN-OMEPRAZOLE | T3 | PA HD |
| BRILINTA | T2 | HD |
| <i>cilostazol</i> | T1 | HD |
| <i>clopidogrel bisulfate</i> (Plavix) | T1 | HD |
| <i>dipyridamole</i> | T1 | HD |
| EFFIENT (<i>prasugrel hcl</i>) | T3 | HD |
| PLAVIX (<i>clopidogrel</i>) | T3 | PA HD |
| ticagrelor | T1 | HD |
| <i>prasugrel hcl</i> (Effient) | T1 | HD |
| <i>ticlopidine hcl</i> | T1 | HD |
| YOSPRALA | T3 | PA HD |
| ZONTIVITY | T3 | HD |
| PLATELET REDUCING AGENTS | | |
| AGRYLIN (<i>anagrelide hcl</i>) | T3 | |
| <i>anagrelide hcl</i> (Agrylin) | T1 | |
| ANTIVIRALS (AIDS/HIV) | | |
| ANTI-RETROVIRAL - CAPSID INHIBITORS | | |
| SUNLENCA 300 MG TABLET | T3 | PA QL(5 tabs/180 days) SP |
| SUNLENCA 4- 300 MG TABLET | T3 | PA QL(5 TABS/180 DAYS) SP |
| SUNLENCA 463.5 MG/1.5 ML VIAL | T4 | PA SP |
| SUNLENCA 5- 300 MG TABLET | T3 | PA QL(5 TABS/180 DAYS) SP |
| ANTI-RETROVIRAL - INTEGRASE INHIBITOR AND NNRTI COMB. | | |
| CABENUVA | T3 | PA SP |
| JULUCA | T2 | SP |
| ANTI-RETROVIRAL - INTEGRASE INHIBITOR AND NRTI COMB. | | |
| DOVATO | T2 | SP |

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

T4 – Injectable Specialty Medications

PA – Prior Authorization

QL – Quantity Limit

ST – Step Therapy

AGE – Age Requirement

SP – Specialty Medication

HD – May require home delivery pharmacy

PPACA – No Cost-Share Preventive Medication

CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

| ANTIVIRALS (AIDS/HIV) (cont.) | | |
|--|-----------|----------------------------------|
| Prescription Drug Name | Drug Tier | Coverage Requirements and Limits |
| ANTI-RETROVIRAL - NRTIS AND INTEGRASE INHIBITORS COMB | | |
| TRIUMEQ | T2 | SP |
| TRIUMEQ PD | T2 | QL(6 tabs/day) SP |
| ANTI-RETROVIRAL - NUCLEOSIDE, NUCLEOTIDE, PROTEASE INH. | | |
| SYMTUZA | T2 | SP |
| ANTIVIRALS - HIV-SPEC, NON-PEPTIDIC PROTEASE INHIB | | |
| APTIVUS | T2 | PA SP |
| <i>darunavir ethanolate</i> (Prezista) | T1 | PA SP |
| PREZCOBIX | T3 | PA SP |
| PREZISTA 100 MG/ML SUSPENSION | T2 | SP |
| PREZISTA 150 MG TABLET | T2 | SP |
| PREZISTA 600 MG TABLET (darunavir) | T3 | PA SP |
| PREZISTA 75 MG TABLET | T2 | SP |
| PREZISTA 800 MG TABLET (darunavir) | T3 | PA SP |
| ANTIVIRALS - HIV-SPEC, NUCLEOSIDE-NUCLEOTIDE ANALOG | | |
| CIMDUO | T3 | PA SP |
| DESCOVY | T2 | SP PPACA |
| <i>emtricitabine-tenofovir</i> 100-150mg (Truvada) | T1 | SP |
| <i>emtricitabine-tenofovir</i> 133-200mg (Truvada) | T1 | SP |
| <i>emtricitabine-tenofovir</i> 167-250mg (Truvada) | T1 | SP |
| <i>emtricitabine-tenofovir</i> 200-300mg (Truvada) | T1 | SP PPACA |
| TEMIXYS | T3 | PA SP |
| TRUVADA (<i>emtricitabine-tenofovir disop</i>) | T3 | PA SP |
| ANTIVIRALS - HIV-SPEC, NUCLEOSIDE ANALOG, RTI COMB | | |
| <i>abacavir sulfate/lamivudine</i> (Epzicom) | T1 | PA SP |
| <i>abacavir/lamivudine/zidovudine</i> | T1 | PA SP |
| COMBIVIR (<i>lamivudine-zidovudine</i>) | T3 | PA SP |
| EPZICOM (<i>abacavir-lamivudine</i>) | T3 | PA SP |
| <i>lamivudine/zidovudine</i> (Combivir) | T1 | SP |
| ANTIVIRALS - HIV-SPECIFIC, CCR5 CO-RECEPTOR ANTAG. | | |
| AGRYLIN (<i>anagrelide hcl</i>) | T3 | |
| SELZENTRY 150 MG TABLET (maraviroc) | T3 | PA SP |
| SELZENTRY 20 MG/ML ORAL SOLN | T2 | PA SP |
| SELZENTRY 25 MG TABLET | T2 | PA SP |
| SELZENTRY 300 MG TABLET (maraviroc) | T3 | PA SP |

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

T4 – Injectable Specialty Medications

PA – Prior Authorization

QL – Quantity Limit

ST – Step Therapy

AGE – Age Requirement

SP – Specialty Medication

HD – May require home delivery pharmacy

PPACA – No Cost-Share Preventive Medication

CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

| ANTIVIRALS (AIDS/HIV) (cont.) | | |
|---|-----------|----------------------------------|
| Prescription Drug Name | Drug Tier | Coverage Requirements and Limits |
| ANTIVIRALS - HIV-SPECIFIC, CCR5 CO-RECEPTOR ANTAG. (cont.) | | |
| SELZENTRY 75 MG TABLET | T2 | PA SP |
| ANTIVIRALS - HIV-SPECIFIC, CD4 ATTACHMENT INHIBITOR | | |
| RUKOBIA | T3 | PA QL (2 SYRINGE/DAY) |
| ANTIVIRALS - HIV-SPECIFIC, FUSION INHIBITORS | | |
| FUZEON | T4 | PA SP |
| ANTIVIRALS - HIV-SPECIFIC, NON-NUCLEOSIDE, RTI | | |
| EDURANT | T3 | PA SP |
| INTELENCE | T3 | PA SP |
| <i>nevirapine</i> | T1 | PA SP |
| <i>nevirapine</i> (Viramune Xr) | T1 | PA SP |
| <i>nevirapine</i> (Viramune) | T1 | PA SP |
| PIFELTRO | T3 | PA SP |
| VIRAMUNE (<i>nevirapine</i>) | T3 | PA SP |
| VIRAMUNE XR (<i>nevirapine er</i>) | T3 | PA SP |
| <i>abacavir sulfate</i> (Ziagen) | T1 | PA SP |
| <i>didanosine</i> (Videx Ec) | T1 | PA SP |
| <i>emtricitabine</i> (Emtriva) | T1 | PA SP |
| EMTRIVA 10 MG/ML SOLUTION | T2 | PA SP |
| EMTRIVA 200 MG CAPSULE (<i>emtricitabine</i>) | T3 | PA SP |
| EPIVIR (<i>lamivudine</i>) | T3 | PA SP |
| <i>lamivudine</i> 10 mg/ml oral soln (Epivir) | T1 | SP |
| <i>lamivudine</i> 150 mg tablet (Epivir) | T1 | SP |
| <i>lamivudine</i> 300 mg tablet (Epivir) | T1 | PA SP |
| <i>lamivudine</i> 300 mg/30ml sol cup (Epivir) | T1 | SP |
| RETROVIR (<i>zidovudine</i>) | T3 | PA SP |
| <i>stavudine</i> | T1 | PA SP |
| VIDEX EC | T3 | PA SP |
| VIDEX EC (<i>didanosine</i>) | T3 | PA SP |
| ZIAGEN (<i>abacavir</i>) | T3 | PA SP |
| <i>zidovudine</i> | T1 | SP |
| <i>zidovudine</i> (Retrovir) | T1 | SP |
| <i>tenofovir disoproxil fumarate</i> (Viread) | T1 | PA SP |
| VIREAD 150 MG TABLET | T2 | PA SP |
| VIREAD 200 MG TABLET | T2 | PA SP |
| VIREAD 250 MG TABLET | T2 | PA SP |

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

T4 – Injectable Specialty Medications

PA – Prior Authorization

QL – Quantity Limit

ST – Step Therapy

AGE – Age Requirement

SP – Specialty Medication

HD – May require home delivery pharmacy

PPACA – No Cost-Share Preventive Medication

CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

ANTIVIRALS (AIDS/HIV) (cont.)

| Prescription Drug Name | Drug Tier | Coverage Requirements and Limits |
|---|-----------|----------------------------------|
| ANTIVIRALS - HIV-SPECIFIC, NON-NUCLEOSIDE, RTI (cont.) | | |
| VIREAD 300 MG TABLET (<i>tenofovir disoproxil fumarate</i>) | T3 | PA SP |
| VIREAD POWDER | T2 | PA SP |
| ANTIVIRALS - HIV-SPECIFIC, PROTEASE INHIBITOR COMB | | |
| <i>fosamprenavir</i> | T1 | PA SP |
| KALETRA 100-25 MG TABLET | T3 | PA SP |
| KALETRA 200-50 MG TABLET | T3 | PA SP |
| KALETRA 80 MG-20 MG/ML SOLN (<i>lopinavir-ritonavir</i>) | T3 | PA SP |
| <i>lopinavir/ritonavir</i> (Kaletra) | T1 | |
| ANTIVIRALS - HIV-SPECIFIC, PROTEASE INHIBITORS | | |
| <i>atazanavir sulfate</i> (Reyataz) | T1 | PA SP |
| CRIXIVAN | T2 | PA SP |
| EVOTAZ | T3 | PA SP |
| <i>fosamprenavir calcium</i> (Lexiva) | T1 | PA SP |
| LEXIVA (<i>fosamprenavir calcium</i>) | T3 | PA SP |
| NORVIR 100 MG POWDER PACKET | T2 | SP |
| NORVIR 100 MG TABLET (<i>ritonavir</i>) | T3 | PA SP |
| REYATAZ 150 MG CAPSULE (<i>atazanavir sulfate</i>) | T3 | PA SP |
| REYATAZ 200 MG CAPSULE (<i>atazanavir sulfate</i>) | T3 | PA SP |
| REYATAZ 300 MG CAPSULE (<i>atazanavir sulfate</i>) | T3 | PA SP |
| REYATAZ 50 MG POWDER PACKET | T2 | PA SP |
| <i>ritonavir</i> (Norvir) | T1 | SP |
| VIRACEPT | T2 | PA SP |
| ANTIVIRALS - HIV-I INTEGRASE STRAND TRANSFER INHIBTR | | |
| APRETUDE | T3 | PA SP |
| ISENTRESS | T2 | SP |
| ISENTRESS HD | T2 | PA SP |
| TIVICAY | T2 | SP |
| TIVICAY PD | T2 | SP |
| ARTV NUCLEOSIDE, NUCLEOTIDE, NON-NUCLEOSIDE RTI COMB | | |
| COMPLERA | T3 | PA SP |
| DELSTRIGO | T3 | PA SP |
| <i>efavirenz/emtricit/tenofovr df</i> | T1 | PA SP |
| <i>efavirenz/lamivu/tenofov disop</i> (Symfi Lo) | T1 | SP |

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

T4 – Injectable Specialty Medications

PA – Prior Authorization

QL – Quantity Limit

ST – Step Therapy

AGE – Age Requirement

SP – Specialty Medication

HD – May require home delivery pharmacy

PPACA – No Cost-Share Preventive Medication

CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

| ANTIVIRALS (AIDS/HIV) (cont.) | | |
|---|-----------|----------------------------------|
| Prescription Drug Name | Drug Tier | Coverage Requirements and Limits |
| ARTV NUCLEOSIDE, NUCLEOTIDE, NON-NUCLEOSIDE RTI COMB (cont.) | | |
| efavirenz/lamivu/tenofovir disop (Symfi) | T1 | SP |
| ODEFSEY | T3 | PA SP |
| SYMFY (efavirenz-lamivu-tenofovir disop) | T3 | PA SP |
| SYMFY LO (efavirenz-lamivu-tenofovir disop) | T3 | PA SP |
| ARV-NUCLEOSIDE, NUCLEOTIDE RTI, INTEGRASE INHIBITORS | | |
| BIKTARVY | T2 | SP |
| GENVOYA | T2 | SP |
| STRIBILD | T3 | PA SP |
| ANTIVIRALS (Eye Conditions) | | |
| EYE ANTIVIRALS | | |
| trifluridine | T1 | |
| ZIRGAN | T3 | |
| ANTIVIRALS (Infections) | | |
| ANTIVIRALS, GENERAL | | |
| acyclovir 200 mg capsule | T1 | |
| acyclovir 200 mg/5 ml susp (Zovirax) | T1 | |
| acyclovir 400 mg tablet | T1 | |
| acyclovir 800 mg tablet | T1 | |
| acyclovir 800 mg/20ml susp cup | T1 | |
| famciclovir | T1 | |
| FLUMADINE (rimantadine hcl) | T3 | |
| 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 (10/30 days) |
| oseltamivir phos 75 mg capsule (Tamiflu) | T1 | QL (10 caps/30 days) |
| PREVYMIS | T3 | SP HD |
| RELENZA | T3 | QL (20/30 days) |
| rimantadine hcl (Flumadine) | T1 | |
| SITAVIG | T3 | PA QL (2 tabs/Rx) |
| 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) |

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

T4 – Injectable Specialty Medications

PA – Prior Authorization

QL – Quantity Limit

ST – Step Therapy

AGE – Age Requirement

SP – Specialty Medication

HD – May require home delivery pharmacy

PPACA – No Cost-Share Preventive Medication

CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

| ANTIVIRALS (Infections) (cont.) | | |
|---|-----------|----------------------------------|
| Prescription Drug Name | Drug Tier | Coverage Requirements and Limits |
| ANTIVIRALS, GENERAL (cont.) | | |
| valacyclovir hcl (Valtrex) | T1 | |
| VALCYTE (valganciclovir hcl) | T3 | PA |
| valganciclovir hcl (Valcyte) | T1 | |
| VALTREX (valacyclovir) | T3 | |
| XOFLUZA | T3 | QL (2 tabs/30 days) |
| ZOVIRAX 200 MG/5 ML SUSP (acyclovir) | T3 | PA |
| HEP C - NS5A, NS3/4A, NUCLEOTIDE NS5B INHIB COMBO | | |
| VOSEVI | T2 | PA SP HD |
| 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 | T2 | PA QL (1 tab/Day) SP HD |
| EPCLUSA 400 MG-100 MG TABLET | T2 | PA SP HD |
| HARVONI 33.75-150 MG PELLET PK | T2 | PA QL (1 tab/day) SP HD |
| HARVONI 45-200 MG PELLET PACKT | T2 | PA QL (1 tab/day) SP HD |
| HARVONI 45-200 MG TABLET | T2 | PA QL (1 tab/day) SP HD |
| HARVONI 90-400 MG TABLET | T2 | PA SP HD |
| LEDIPASVIR-SOFOSBUVIR | T3 | PA QL(1 tab/day) SP HD |
| SOFOSBUVIR-VELPATASVIR | T3 | PA QL(1 tab/day) SP HD |
| HEPATITIS B TREATMENT AGENTS | | |
| adefovir dipivoxil | T1 | SP HD |
| BARACLUD 0.05 MG/ML SOLUTION | T2 | SP HD |
| BARACLUD 0.5 MG TABLET (entecavir) | T3 | PA QL (1 tab/day) SP HD |
| BARACLUD 1 MG TABLET (entecavir) | T3 | PA SP HD |
| entecavir 0.5 mg tablet (Baraclude) | T1 | QL (1 tab/day) SP HD |
| entecavir 1 mg tablet (Baraclude) | T1 | SP HD |
| EPIVIR HBV 100 MG TABLET (lamivudine hbv) | T3 | SP |
| EPIVIR HBV 25 MG/5 ML SOLN | T2 | SP |
| HEPSERA (adefovir dipivoxil) | T3 | SP HD |
| lamivudine (Epivir Hbv) | T1 | SP |
| VEMLIDY | T2 | SP HD |

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

T4 – Injectable Specialty Medications

PA – Prior Authorization

QL – Quantity Limit

ST – Step Therapy

AGE – Age Requirement

SP – Specialty Medication

HD – May require home delivery pharmacy

PPACA – No Cost-Share Preventive Medication

CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

ANTIVIRALS (Infections) (cont.)

| Prescription Drug Name | Drug Tier | Coverage Requirements and Limits |
|--|-----------|----------------------------------|
| HEPATITIS C TREATMENT AGENTS | | |
| PEGASYS | T4 | PA SP HD |
| PEGINTRON | T2 | PA SP HD |
| ribasphere 200 mg capsule | T1 | SP HD |
| ribasphere 200 mg tablet | T1 | SP HD |
| ribasphere 400 mg tablet | T1 | SP |
| ribasphere 600 mg tablet | T1 | SP |
| ribasphere ribapak 200-400 mg | T1 | SP HD |
| ribasphere ribapak 400-400 mg | T1 | SP HD |
| ribasphere ribapak 400-400 mg | T1 | SP HD |
| ribasphere ribapak 600-400 mg | T1 | SP HD |
| ribasphere ribapak 600-400 mg | T1 | SP HD |
| ribasphere ribapak 600-600 mg | T1 | SP HD |
| ribasphere ribapak 600-600 mg | T1 | SP HD |
| HEPATITIS C VIRUS- NS5A AND NS3/4A INHIBITOR COMB | | |
| MAVYRET 100-40 MG TABLET | T3 | PA QL(3 tabs/day) SP HD |
| MAVYRET 50-20 MG PELLET PACKET | T3 | PA QL(5 packs/day) SP HD |
| HEPATITIS C VIRUS- NS5A AND NS3/4A INHIBITOR COMB | | |
| ZEPATIER | T2 | PA QL(1 tab/day) SP HD |
| MAIN PROTEASE (MPRO) INHIBITOR | | |
| LAGEVRIO (EUA) | T2 | QL(1 pack/120 days) |
| RNA POLYMERASE INHIBITOR | | |
| MOLNUPIRAVIR | T3 | QL (1 pkg/120 days) |
| ANTIVIRALS (Skin Conditions) | | |
| TOPICAL ANTIVIRAL AND ANTI-INFLAMMATORY STEROID | | |
| XERESE | T3 | PA QL (5gm/30 days) |
| TOPICAL ANTIVIRALS | | |
| acyclovir 5% cream (Zovirax) | T1 | PA QL (5gm/30 days) |
| acyclovir 5% ointment (Zovirax) | T1 | PA QL (15gm/30 days) |
| DENAVIR | T3 | QL (10 gm/30 days) |
| ZOVIRAX 5% CREAM (acyclovir) | T3 | PA QL (10 gm/30 days) |
| ZOVIRAX 5% OINTMENT (acyclovir) | T3 | PA QL (15gm/30 days) |
| TOPICAL GENITAL WART-HPV TREATMENT AGENTS | | |
| VEREGEN | T3 | PA |

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CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

AUTONOMIC DRUGS (Allergy/Nasal Sprays)

| Prescription Drug Name | Drug Tier | Coverage Requirements and Limits |
|--|-----------|----------------------------------|
| ANAPHYLAXIS THERAPY AGENTS | | |
| AUVI-Q | T3 | PA QL (2 packs/30 days) |
| EPINEPHRINE | T1 | QL (2 packs/30 days) |
| <i>epinephrine</i> (AUVI-Q) | T3 | PA QL (2 packs/30 days) |
| <i>epinephrine</i> (Epipen 2-pak) | T1 | QL (2 packs/30 days) |
| <i>epinephrine</i> (Epipen Jr 2-pak) | T1 | QL (2 packs/30 days) |
| EPIPEN (<i>epinephrine</i>) | T3 | PA QL (4 pens/22 days) |
| EPIPEN 2-PAK (<i>epinephrine</i>) | T3 | PA QL (2 packs/30 days) |
| EPIPEN JR (<i>epinephrine</i>) | T3 | PA QL (4 pens/22 days) |
| EPIPEN JR 2-PAK (<i>epinephrine</i>) | T3 | PA QL (2 packs/30 days) |
| SYMJEPI | T3 | PA QL (4 syringes/30 days) |

AUTONOMIC DRUGS (Alzheimer's Disease)

| CHOLINESTERASE INHIBITORS | | |
|---|----|------------------------|
| ARICEPT (<i>donepezil hcl</i>) | T3 | HD |
| <i>donepezil hcl</i> | T1 | HD |
| <i>donepezil hcl</i> (Aricept) | T1 | HD |
| EXELON (<i>rivastigmine</i>) | T3 | HD |
| <i>galantamine er</i> 16 mg capsule (Razadyne Er) | T1 | HD |
| <i>galantamine er</i> 24 mg capsule (Razadyne Er) | T1 | HD |
| <i>galantamine er</i> 8 mg capsule (Razadyne Er) | T1 | QL (1 cap/day) HD |
| <i>galantamine hbr</i> | T1 | HD |
| MESTINON (<i>pyridostigmine bromide</i>) | T3 | PA HD |
| <i>pyridostigmine</i> 60 mg/5 ml soln (Mestinon) | T1 | HD |
| PYRIDOSTIGMINE BR 30 MG TABLET | T3 | PA QL (20 tabs/day) HD |
| <i>pyridostigmine br</i> 60 mg tablet (Mestinon) | T1 | HD |
| <i>pyridostigmine bromide</i> (Mestinon) | T1 | HD |
| RAZADYNE ER 16 MG CAPSULE (<i>galantamine er</i>) | T3 | HD |
| RAZADYNE ER 24 MG CAPSULE (<i>galantamine er</i>) | T3 | HD |
| RAZADYNE ER 8 MG CAPSULE (<i>galantamine er</i>) | T3 | QL (1 cap/day) HD |
| <i>rivastigmine</i> (Exelon) | T1 | HD |
| <i>rivastigmine tartrate</i> | T1 | HD |

AUTONOMIC DRUGS (Attention Deficit Hyperactivity Disorder)⁸

| ADRENERGICS, AROMATIC, NON-CATECHOLAMINE | | |
|---|----|-------|
| ADDERALL (<i>dextroamphetamine-amphetamine</i>) | T3 | PA ST |

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

T4 – Injectable Specialty Medications

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ST – Step Therapy

AGE – Age Requirement

SP – Specialty Medication

HD – May require home delivery pharmacy

PPACA – No Cost-Share Preventive Medication

CSL – Oral cancer medication subject to cost-share limits

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.) | | |
| ADDERALL XR (<i>dextroamphetamine-amphetamine</i>) | T3 | PA QL (1 cap/day) 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 |
| DESOXYN | T3 | PA QL(5 TABS/DAY) |
| DEXEDRINE SPANSULE (<i>dextroamphetamine sulfate er</i>) | T3 | PA QL (1 cap/day) |
| <i>dextroamp-amphetamine 10 mg cap</i> (Adderall Xr) | T1 | PA QL (1 per day) |
| <i>dextroamp-amphetamine 15 mg cap</i> (Adderall Xr) | T1 | PA QL (1 per day) |
| <i>dextroamp-amphetamine 20 mg cap</i> (Adderall Xr) | T1 | PA QL (1 cap/day) |
| <i>dextroamp-amphetamine 25 mg cap</i> (Adderall Xr) | T1 | PA QL (1 cap/day) |
| <i>dextroamp-amphetamine 30 mg cap</i> (Adderall Xr) | T1 | PA QL (1 per day) |
| <i>dextroamp-amphetamine 5 mg cap</i> (Adderall Xr) | T1 | PA QL (1 per day) |
| <i>dextroamphetamine er 10 mg cap</i> (Dexedrine) | T1 | PA QL (1 cap/day) |
| <i>dextroamphetamine er 15 mg cap</i> (Dexedrine) | T1 | PA QL (3 caps/day) |
| <i>dextroamphetamine er 5 mg cap</i> (Dexedrine) | T1 | PA QL (1 cap/day) |
| <i>dextroamp-amphetamine 12.5mg cp</i> (Mydayis) | T1 | PA QL |
| <i>dextroamp-amphetamine 25 mg cap</i> (Mydayis) | T1 | PA QL |
| <i>dextroamp-amphetamine 37.5mg cp</i> (Mydayis) | T1 | PA QL |
| <i>dextroamphetamine sulfate</i> | T1 | PA |
| <i>dextroamphetamine sulfate</i> | T3 | PA ST |
| DYANAVEL XR | T3 | PA QL (8ml/day) |
| EVEKEO (<i>amphetamine sulfate</i>) | T3 | PA ST |
| EVEKEO ODT | T3 | PA |
| MYDAYIS (<i>dextroamphetamine/amphetamine</i>) | T3 | PA QL(1 cap/day) |
| <i>methamphetamine hcl</i> (Desoxyn) | T1 | PA |
| XELSTRYM | T3 | PA QL(1 PATCH/DAY) |
| ZENZEDI | T3 | PA ST |

AUTONOMIC DRUGS (Blood Pressure/Heart Medications)

ADRENERGIC VASOPRESSOR AGENTS

| | | |
|-----------------------------|----|-------|
| <i>droxidopa</i> (Northera) | T1 | SP HD |
|-----------------------------|----|-------|

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

T4 – Injectable Specialty Medications

PA – Prior Authorization

QL – Quantity Limit

ST – Step Therapy

AGE – Age Requirement

SP – Specialty Medication

HD – May require home delivery pharmacy

PPACA – No Cost-Share Preventive Medication

CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

| AUTONOMIC DRUGS (Blood Pressure/Heart Medications) (cont.) | | |
|--|-----------|----------------------------------|
| Prescription Drug Name | Drug Tier | Coverage Requirements and Limits |
| ADRENERGIC VASOPRESSOR AGENTS (cont.) | | |
| midodrine hcl | T1 | |
| NORTHERA (droxidopa) | T3 | PA SP HD |
| ALPHA-ADRENERGIC BLOCKING AGENTS | | |
| DIBENZYLINE (phenoxybenzamine hcl) | T3 | HD |
| phenoxybenzamine hcl (Dibenzyline) | T1 | HD |
| AUTONOMIC DRUGS (Urinary Tract Conditions) | | |
| PARASYMPATHETIC AGENTS | | |
| bethanechol chloride | T1 | HD |
| cevimeline hcl (Evoxac) | T1 | HD |
| EVOXAC (cevimeline hcl) | T3 | PA HD |
| guanidine hcl | T1 | HD |
| pilocarpine hcl (Salagen) | T1 | HD |
| SALAGEN (pilocarpine hcl) | T3 | HD |
| BIOLOGICALS (Allergy/Nasal Sprays) | | |
| ALLERGENIC EXTRACTS, THERAPEUTIC | | |
| GRASTEK | T3 | PA QL (1 tab/day) |
| ODACTRA | T3 | PA QL (1 tab/day) |
| ORALAIR | T3 | PA QL (1 tab/day) |
| PALFORZIA | T3 | PA SP |
| BIOLOGICALS (Blood Pressure/Heart Medications) | | |
| ALLERGENIC EXTRACTS, THERAPEUTIC . | | |
| RAGWITEK | T3 | PA QL (1 tab/day) |
| PLASMA KALLIKREIN INHIBITORS | | |
| TAKHZYRO | T4 | PA SP HD |
| BIOLOGICALS (Miscellaneous) | | |
| PKU TREATMENT AGENTS - PHENYLALANINE AMMONIA LYASE | | |
| PALYNZIQ | T4 | PA SP HD |
| BIOLOGICALS (Vaccines) | | |
| COVID-19 VACCINES | | |
| COMIRNATY | T2 | PPACA |
| JANSSEN COVID-19 VACCINE (EUA) | T2 | PPACA |
| NOVAVAX COVID | T2 | PPACA |

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List of Prescription Medications

| BIOLOGICALS (Vaccines) (cont.) | | |
|--|-----------|----------------------------------|
| Prescription Drug Name | Drug Tier | Coverage Requirements and Limits |
| COVID-19 VACCINES (cont.) | | |
| MODERNA COVID-19 VACCINE (EUA) | T2 | PPACA |
| PFIZER COVID-19 VACCINE (EUA) | T2 | PPACA |
| SPIKEVAX | T2 | PPACA |
| ENTERIC VIRUS VACCINES | | |
| IPOL | T2 | PPACA |
| ROTARIX | T3 | PPACA |
| ROTATEQ | T3 | PPACA |
| GRAM NEGATIVE COCCI VACCINES | | |
| BEXSERO | T2 | PPACA |
| MENACTRA | T2 | |
| MENQUADFI | T2 | PPACA |
| MENVEO A-C-Y-W-135-DIP | T2 | PPACA |
| PENBRAYA | T2 | PPACA |
| TRUMENBA | T2 | PPACA |
| GRAM POSITIVE COCCI VACCINES | | |
| CAPVAXIVE | T3 | PPACA |
| PNEUMOVAX 23 | T2 | PPACA |
| PREVNAR | T2 | PPACA |
| INFLUENZA VIRUS VACCINES | | |
| AFLURIA QUAD 2 | T2 | PPACA |
| EZ FLU (FLUCELVAX) | T2 | PPACA |
| FLUAD | T2 | PPACA |
| FLUAD QUAD | T2 | PPACA |
| FLUARIX QUAD | T2 | PPACA |
| FLUBLOK QUAD | T2 | PPACA |
| FLUCELVAX QUAD | T2 | PPACA |
| FLULALVAL QUAD | T2 | PPACA |
| FLUMIST QUAD | T3 | PPACA |
| FLUZONE HIGH-DOSE QUAD | T2 | PPACA |
| FLUZONE QUAD | T2 | PPACA |
| TOXIN-PRODUCING BACILLI VACCINES/TOXOIDS | | |
| BCG VACCINE (TICE STRAIN) | T2 | SP |
| VACCINE/TOXOID PREPARATIONS, COMBINATIONS | | |
| ACTHIB | T2 | PPACA |
| ADACEL TDAP | T2 | PPACA |

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List of Prescription Medications

| BIOLOGICALS (Vaccines) (cont.) | | |
|--|-----------|----------------------------------|
| Prescription Drug Name | Drug Tier | Coverage Requirements and Limits |
| VACCINE/TOXOID PREPARATIONS, COMBINATIONS (cont.) | | |
| 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 |
| PENTACEL ACTHIB COMPONENT | T2 | PPACA |
| PROQUAD | T2 | PPACA |
| QUADRACEL DTAP-IPV | T2 | PPACA |
| TDVAX | T2 | PPACA |
| TENIVAC | T2 | PPACA |
| VAXELIS | T2 | PPACA |
| VIRAL/TUMORIGENIC VACCINES | | |
| ABRYSVO | T3 | PPACA |
| ENGERIX-B ADULT | T2 | PPACA |
| ENGERIX-B PEDIATRIC-ADOLESCENT | T2 | PPACA |
| ERVEBO (NATIONAL STOCKPILE) | T3 | |
| GARDASIL 9 | T2 | PPACA |
| HEPLISAV-B | T2 | PPACA |
| IXCHIQ | T3 | PPACA |
| JYNNEOS | 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 | | |
| aminocaproic acid (Amicar) | T1 | SP HD |
| CABLIVI | T3 | PA SP |

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List of Prescription Medications

| BLOOD (Blood Modifiers/Bleeding Disorders) (cont.) | | |
|---|-----------|----------------------------------|
| Prescription Drug Name | Drug Tier | Coverage Requirements and Limits |
| AGENTS TO TX THROMBOTIC THROMBOCYTOPENIC PURPURA (cont.) | | |
| LYSTEDA (<i>tranexamic acid</i>) | T3 | SP |
| <i>tranexamic acid</i> (Lysteda) | T1 | SP |
| ANTI-FIBRINOLYTIC AGENTS | | |
| AMICAR (<i>aminocaproic acid</i>) | T3 | SP HD |
| ANTI-HEMOPHILIC FACTORS | | |
| ALTUVIIO | T3 | PA SP HD |
| COMPLEMENT (C3) INHIBITORS | | |
| EMPAVELI | T4 | PA SP |
| FABHALTA | T2 | PA QL(2 caps/day) SP |
| VOYDEYA | T2 | PA QL(1 packet/28 days) SP |
| COMPLEMENT(C5) INHIBITOR | | |
| TAVNEOS | T3 | PA QL (6 caps/day)SP HD |
| HEMOPHILIA TREATMENT AGENTS, NON-FACTOR REPLACEMENT | | |
| ALHEMO PEN | T3 | PA SP |
| HEMLIBRA | T4 | PA SP HD |
| HYMPAVZI PEN | T4 | PA SP |
| SICKLE CELL ANEMIA AGENTS | | |
| DROXIA | T2 | |
| SIKLOS | T3 | PA |
| TOPICAL HEMOSTATICS | | |
| ASTRINGYN | T3 | |
| AVITENE | T3 | |
| ENDO-AVITENE | T3 | |
| EVICEL | T3 | |
| <i>gelatin sponge, absorb/porcine</i> (Gelfoam) | T1 | |
| GELFOAM (<i>surgifoam</i>) | T3 | |
| GELFOAM COMPRESSED | T3 | |
| MONSEL's | T3 | |
| RAPLIXA | T3 | |
| RECOTHROM | T3 | |
| SURGIFOAM | T1 | |
| SYRINGE AVITENE | T3 | |
| THROMBI-GE/PADL | T3 | |
| THROMBIN-JMI | T3 | |
| ULTRAFOAM | T3 | |

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List of Prescription Medications

| BLOOD (Blood Thinners/Anti-Clotting) | | |
|--|-----------|----------------------------------|
| Prescription Drug Name | Drug Tier | Coverage Requirements and Limits |
| HEMORRHEOLOGIC AGENTS | | |
| <i>pentoxifylline</i> | T1 | HD |
| CARDIAC DRUGS (Blood Pressure/Heart Medications) | | |
| ANTI-ANGINAL, ANTI-ISCHEMIC AGENTS, NON-HEMODYNAMIC | | |
| RANEXA (<i>ranolazine er</i>) | T3 | PA QL (4 tabs/day) HD |
| <i>ranolazine</i> (Ranexa) | T1 | QL (4 tabs/day) HD |
| ANTI-ARRHYTHMICS | | |
| <i>amiodarone hcl</i> | T1 | HD |
| <i>disopyramide phosphate</i> (Norpace) | T1 | HD |
| <i>dofetilide 125 mcg capsule</i> (Tikosyn) | T1 | QL (8 caps/day) HD |
| <i>dofetilide 250 mcg capsule</i> (Tikosyn) | T1 | QL (4 caps/day) HD |
| <i>dofetilide 500 mcg capsule</i> (Tikosyn) | T1 | QL (2 caps/day) HD |
| <i>flecainide acetate</i> | T1 | HD |
| <i>mexiletine hcl</i> | T1 | HD |
| MULTAQ | T2 | HD |
| NORPACE (<i>disopyramide phosphate</i>) | T3 | PA HD |
| NORPACE CR | T3 | HD |
| <i>pacerone 100 mg tablet</i> | T3 | PA HD |
| <i>pacerone 200 mg tablet</i> | T1 | HD |
| <i>pacerone 400 mg tablet</i> | T3 | PA HD |
| <i>propafenone hcl</i> | T1 | HD |
| <i>propafenone hcl</i> (Rythmol Sr) | T1 | HD |
| <i>quinidine gluconate</i> | T1 | HD |
| <i>quinidine sulfate</i> | T1 | HD |
| RYTHMOL SR (<i>propafenone hcl er</i>) | T3 | PA HD |
| TIKOSYN 125 MCG CAPSULE (<i>dofetilide</i>) | T3 | PA QL (8 caps/day) HD |
| TIKOSYN 250 MCG CAPSULE (<i>dofetilide</i>) | T3 | PA QL (4 caps/day) HD |
| TIKOSYN 500 MCG CAPSULE (<i>dofetilide</i>) | T3 | PA QL (2 caps/day) HD |
| CALCIUM CHANNEL BLOCKER AND NSAID, COX-2 INHIBITOR | | |
| CONSENSI | T3 | PA QL (1 tab/day) |
| CALCIUM CHANNEL BLOCKING AGENTS | | |
| ADALAT CC (<i>nifedipine er</i>) | T3 | HD |
| <i>amlodipine besylate</i> (Norvasc) | T1 | HD |
| CALAN SR (<i>verapamil er</i>) | T3 | HD |
| CARDIZEM (<i>diltiazem hcl</i>) | T3 | PA HD |
| CARDIZEM CD (<i>diltiazem 24hr er (cd)</i>) | T3 | PA HD |

T1 – Typically Generics

T2 – Typically Preferred Brands

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T4 – Injectable Specialty Medications

PA – Prior Authorization

QL – Quantity Limit

ST – Step Therapy

AGE – Age Requirement

SP – Specialty Medication

HD – May require home delivery pharmacy

PPACA – No Cost-Share Preventive Medication

CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

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

| Prescription Drug Name | Drug Tier | Coverage Requirements and Limits |
|--|-----------|----------------------------------|
| CALCIUM CHANNEL BLOCKING AGENTS (cont.) | | |
| CARDIZEM LA 120 MG TABLET | T3 | PA QL (1 tab/day) HD |
| CARDIZEM LA 180 MG TABLET (<i>matzim la</i>) | T3 | PA HD |
| CARDIZEM LA 240 MG TABLET (<i>matzim la</i>) | T3 | PA HD |
| CARDIZEM LA 300 MG TABLET (<i>matzim la</i>) | T3 | PA HD |
| CARDIZEM LA 360 MG TABLET (<i>matzim la</i>) | T3 | PA HD |
| CARDIZEM LA 420 MG TABLET (<i>matzim la</i>) | T3 | PA HD |
| CONJUPRI | T3 | PA HD |
| <i>diltiazem hcl</i> | T1 | HD |
| <i>diltiazem hcl</i> (Cardizem Cd) | T1 | HD |
| <i>diltiazem hcl</i> (Cardizem La) | T1 | HD |
| <i>diltiazem hcl</i> (Cardizem) | T1 | HD |
| <i>diltiazem hcl</i> (Tiazac) | T1 | HD |
| <i>felodipine</i> | T1 | HD |
| <i>isradipine</i> | T1 | |
| KATERZIA | T3 | PA QL (10ml/day) HD |
| <i>nicardipine hcl</i> | T1 | HD |
| <i>nifedipine</i> | T1 | HD |
| <i>nifedipine</i> (Adalat Cc) | T1 | HD |
| <i>nifedipine</i> (Procardia XI) | T1 | HD |
| <i>nifedipine</i> (Procardia) | T1 | HD |
| <i>nimodipine</i> | T1 | HD |
| <i>nisoldipine er</i> 17 mg tablet (Sular) | T1 | HD |
| <i>nisoldipine er</i> 20 mg tablet | T1 | QL (1 tab/day) HD |
| <i>nisoldipine er</i> 25.5 mg tablet | T1 | HD |
| <i>nisoldipine er</i> 30 mg tablet | T1 | HD |
| <i>nisoldipine er</i> 34 mg tablet (Sular) | T1 | HD |
| <i>nisoldipine er</i> 40 mg tablet | T1 | HD |
| <i>nisoldipine er</i> 8.5 mg tablet (Sular) | T1 | HD |
| NORVASC (<i>amlodipine besylate</i>) | T3 | PA |
| NORLIQVA | T2 | PA QL (10ml/day) HD |
| NYMALIZE | T3 | HD |
| PROCARDIA (<i>nifedipine</i>) | T3 | HD |
| PROCARDIA XL (<i>nifedipine er</i>) | T3 | PA HD |
| SULAR (<i>nisoldipine</i>) | T3 | HD |
| TIAZAC (<i>tiadylt er</i>) | T3 | HD |

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T4 – Injectable Specialty Medications

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List of Prescription Medications

| CARDIAC DRUGS (Blood Pressure/Heart Medications) (cont.) | | |
|---|-----------|----------------------------------|
| Prescription Drug Name | Drug Tier | Coverage Requirements and Limits |
| CALCIUM CHANNEL BLOCKING AGENTS (cont.) | | |
| <i>verapamil hcl</i> | T1 | HD |
| <i>verapamil hcl</i> (Verelan Pm) | T1 | HD |
| CAMZYOS | T3 | PA QL (30caps/30days) SP |
| <i>verapamil hcl</i> (Verelan) | T1 | HD |
| VERELAN (<i>verapamil hcl</i>) | T3 | HD |
| VERELAN (<i>verapamil sr</i>) | T3 | HD |
| VERELAN PM (<i>verapamil er pm</i>) | T3 | HD |
| DIGITALIS GLYCOSIDES | | |
| <i>digoxin</i> | T1 | HD |
| <i>digoxin</i> (Lanoxin) | T1 | HD |
| LANOXIN | T3 | PA HD |
| LANOXIN (<i>digoxin</i>) | T3 | PA HD |
| HEART RATE REDUCING, SA SELECTIVE I(F) CURRENT INH. | | |
| CORLANOR | T2 | PA HD |
| SOLUBLE GUANYLATE CYCLASE (SGC) STIMULATOR | | |
| VERQUVO | T2 | PA QL (1 tab/day) |
| VASODILATORS, CORONARY | | |
| DILATRATE-SR | T3 | HD |
| GONITRO | T3 | HD |
| ISORDIL (<i>isosorbide dinitrate</i>) | T3 | PA HD |
| ISORDIL TITRADOSE (<i>isosorbide dinitrate</i>) | T3 | PA HD |
| <i>isosorbide dinitrate</i> 10 mg tab, 20 mg tab, 30 mg tab | T1 | HD |
| <i>isosorbide dinitrate</i> 40 mg tab (Isordil) | T1 | PA HD |
| <i>isosorbide dinitrate</i> 5 mg tab (Isordil Titradose) | 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> | T1 | HD |
| <i>nitroglycerin</i> 0.3 mg tablet sl (Nitrostat) | T1 | HD |

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List of Prescription Medications

| CARDIAC DRUGS (Blood Pressure/Heart Medications) (cont.) | | |
|--|-----------|----------------------------------|
| Prescription Drug Name | Drug Tier | Coverage Requirements and Limits |
| VASODILATORS, CORONARY (cont.) | | |
| <i>nitroglycerin 0.4 mg tablet sl (Nitrostat)</i> | T1 | HD |
| <i>nitroglycerin 0.6 mg tablet sl (Nitrostat)</i> | T1 | HD |
| <i>nitroglycerin 400 mcg spray (Nitrolingual)</i> | T1 | HD |
| <i>nitroglycerin (Nitro-dur)</i> | T1 | HD |
| <i>nitroglycerin (Nitromist)</i> | T1 | HD |
| <i>nitroglycerin (Nitromist)</i> | T1 | HD |
| <i>nitroglycerin (Nitrostat)</i> | T1 | HD |
| <i>NITROLINGUAL (nitroglycerin)</i> | T3 | HD |
| <i>NITROMIST (nitroglycerin)</i> | T3 | HD |
| <i>NITROSTAT (nitroglycerin)</i> | T3 | HD |
| CARDIOVASCULAR (Asthma/COPD/Respiratory) | | |
| PULM ANTI-HTN, SOLUBLE GUANYLATE CYCLASE STIMULATOR | | |
| <i>ADEMPAS</i> | T2 | PA SP HD |
| PULM.ANTI-HTN, SEL.C-GMP PHOSPHODIESTERASE T5 INHIB | | |
| <i>ADCIRCA (tadalafil)</i> | T3 | PA SP HD |
| <i>REVATIO (sildenafil citrate)</i> | T3 | PA SP HD |
| <i>sildenafil 10 mg/ml oral susp (Revatio)</i> | T1 | PA SP HD |
| <i>sildenafil 20 mg tablet (Revatio)</i> | T1 | PA SP HD |
| <i>tadalafil (Adcirca)</i> | T1 | PA SP HD |
| <i>tadalafil 20 mg tablet (Adcirca)</i> | T1 | PA SP HD |
| <i>TADLIQ</i> | T3 | PA SP HD |
| PULMONARY ANTI-HTN, ENDOTHELIN RECEPTOR ANTAGONIST | | |
| <i>ambrisentan (Letairis)</i> | T1 | PA SP HD |
| <i>bosentan (Tracleer)</i> | T1 | PA SP HD |
| <i>LETAIRIS (ambrisentan)</i> | T3 | PA SP HD |
| <i>OPSUMIT</i> | T2 | PA SP HD |
| <i>TRACLEER 125 MG TABLET (bosentan)</i> | T3 | PA SP HD |
| <i>TRACLEER 32 MG TABLET FOR SUSP</i> | T2 | PA SP HD |
| <i>TRACLEER 62.5 MG TABLET (bosentan)</i> | T3 | PA SP HD |
| PULMONARY ANTIHYPERTENSIVES, PROSTACYCLIN-TYPE | | |
| <i>ORENITRAM ER</i> | T3 | PA SP HD |
| <i>TYVASO</i> | T2 | PA SP HD |
| <i>TYVASO INSTITUTIONAL START KIT</i> | T2 | PA SP HD |
| <i>WINREVAIR</i> | T4 | PA SP HD |

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List of Prescription Medications

| CARDIOVASCULAR (Asthma/COPD/Respiratory) (cont.) | | |
|---|-----------|----------------------------------|
| Prescription Drug Name | Drug Tier | Coverage Requirements and Limits |
| PULMONARY ANTIHYPERTENSIVES, PROSTACYCLIN-TYPE (cont.) | | |
| TYVASO REFILL KIT | T3 | PA SP HD |
| TYVASO STARTER KIT | T3 | PA SP HD |
| UPTRAVI | T2 | PA SP HD |
| VENTAVIS | T3 | PA SP HD |
| PULMONARY HTN-ENDOTHELIN RECEPT ANTG-CGMP PDE5 INH | | |
| OPSYNVI | T2 | 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 |
| 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 (trandolapril-verapamil er) | T3 | HD |
| trandolapril/verapamil hcl | T1 | HD |
| trandolapril/verapamil hcl (Tarka) | T1 | HD |
| ACE INHIBITOR-THIAZIDE OR THIAZIDE-LIKE DIURETIC | | |
| ACCURETIC (quinapril-hydrochlorothiazide) | T3 | ST HD |
| benazepril/hydrochlorothiazide | T1 | HD |
| benazepril/hydrochlorothiazide (Lotensin Hct) | T1 | HD |
| captopril-hctz 25-15 mg tablet | T1 | QL (3 tabs/day) HD |
| captopril-hctz 25-25 mg tablet | T1 | QL (2 tabs/day) HD |
| captopril-hctz 50-15 mg tablet | T1 | QL (3 tabs/day) HD |
| captopril-hctz 50-25 mg tablet | T1 | QL (2 tabs/day) HD |
| enalapril/hydrochlorothiazide | T1 | HD |
| enalapril/hydrochlorothiazide (Vaseretic) | T1 | HD |
| fosinopril/hydrochlorothiazide | T1 | HD |
| lisinopril/hydrochlorothiazide (Zestoretic) | T1 | HD |
| LOTENSIN HCT (benazepril-hydrochlorothiazide) | T3 | ST HD |
| quinapril/hydrochlorothiazide (Accuretic) | T1 | HD |
| VASERETIC (enalapril-hydrochlorothiazide) | T3 | ST HD |
| ZESTORETIC (lisinopril-hydrochlorothiazide) | T3 | ST HD |

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

T4 – Injectable Specialty Medications

PA – Prior Authorization

QL – Quantity Limit

ST – Step Therapy

AGE – Age Requirement

SP – Specialty Medication

HD – May require home delivery pharmacy

PPACA – No Cost-Share Preventive Medication

CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

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

| Prescription Drug Name | Drug Tier | Coverage Requirements and Limits |
|--|-----------|----------------------------------|
| ALPHA/BETA-ADRENERGIC BLOCKING AGENTS | | |
| carvedilol (Coreg) | T1 | HD |
| carvedilol er 10 mg capsule (Coreg Cr) | T1 | QL (1 cap/day) HD |
| carvedilol er 20 mg capsule (Coreg Cr) | T1 | QL (1 cap/day) HD |
| carvedilol er 40 mg capsule (Coreg Cr) | T1 | QL (1 cap/day) HD |
| carvedilol er 80 mg capsule (Coreg Cr) | T1 | HD |
| COREG (carvedilol) | T3 | ST HD |
| COREG CR 10 MG CAPSULE (carvedilol er) | T3 | QL (1 cap/day) ST HD |
| COREG CR 20 MG CAPSULE (carvedilol er) | T3 | QL (1 cap/day) ST HD |
| COREG CR 40 MG CAPSULE (carvedilol er) | T3 | QL (1 cap/day) ST HD |
| COREG CR 80 MG CAPSULE (carvedilol er) | T3 | ST HD |
| ALPHA-ADRENERGIC BLOCKING AGENTS | | |
| labetalol hcl | T1 | HD |
| CARDURA (doxazosin mesylate) | T3 | HD |
| CARDURA XL | T3 | HD |
| doxazosin mesylate (Cardura) | T1 | HD |
| 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 (amlodipine besylate/valsartan) | T3 | PA HD |
| EXFORGE HCT (amlodipine-valsartan-hctz) | T3 | PA HD |
| olmesartan/amlodipin/hcthiazid (Tribenzor) | T1 | HD |
| TRIBENZOR (olmesartan-amlodipine-hctz) | T3 | HD |
| ANGIOTENSIN RECEPT-NEPRILYSIN INHIBITOR COMB (ARNI) | | |
| ENTRESTO | 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 | PA QL (1 tab/day) ST HD |
| BENICAR HCT 40-12.5 MG TABLET (olmesartan-hydrochlorothiazide) | T3 | PA HD |
| BENICAR HCT 40-25 MG TABLET (olmesartan-hydrochlorothiazide) | T3 | PA HD |
| candesartan/hydrochlorothiazid (Atacand Hct) | T1 | HD |
| DIOVAN HCT (valsartan-hydrochlorothiazide) | T3 | ST HD |
| EDARBYCLOR | T3 | PA HD |

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

T4 – Injectable Specialty Medications

PA – Prior Authorization

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PPACA – No Cost-Share Preventive Medication

CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

| CARDIOVASCULAR (Blood Pressure/Heart Medications) (cont.) | | |
|--|-----------|----------------------------------|
| Prescription Drug Name | Drug Tier | Coverage Requirements and Limits |
| ANGIOTENSIN RECEPTOR ANTAG.-THIAZIDE DIURETIC COMB (cont.) | | |
| HYZAAR (<i>losartan-hydrochlorothiazide</i>) | T3 | ST HD |
| <i>irbesartan/hydrochlorothiazide</i> (Avalide) | T1 | HD |
| <i>losartan/hydrochlorothiazide</i> (Hyzaar) | T1 | HD |
| MICARDIS HCT 40-12.5 MG TABLET (<i>telmisartan-hydrochlorothiazid</i>) | T3 | QL (1 tab/day) ST HD |
| MICARDIS HCT 80-12.5 MG TABLET (<i>telmisartan-hydrochlorothiazid</i>) | T3 | ST HD |
| MICARDIS HCT 80-25 MG TABLET (<i>telmisartan-hydrochlorothiazid</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 | PA 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 |
| ALTACE (<i>ramipril</i>) | T3 | PA HD |
| <i>benazepril hcl</i> | T1 | HD |
| <i>captopril</i> | T1 | HD |
| <i>enalapril maleate</i> (Vasotec) | T1 | HD |

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T4 – Injectable Specialty Medications

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ST – Step Therapy

AGE – Age Requirement

SP – Specialty Medication

HD – May require home delivery pharmacy

PPACA – No Cost-Share Preventive Medication

CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

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

| Prescription Drug Name | Drug Tier | Coverage Requirements and Limits |
|--|-----------|----------------------------------|
| ANTI-HYPERTENSIVES, ACE INHIBITORS (cont.) | | |
| EPANED | T3 | PA HD |
| <i>fosinopril sodium</i> | T1 | HD |
| <i>lisinopril (Zestril)</i> | T1 | HD |
| 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 |
| QBRELIS | T3 | PA HD |
| <i>quinapril hcl (Accupril)</i> | T1 | HD |
| <i>ramipril (Altace)</i> | T1 | HD |
| <i>trandolapril</i> | T1 | HD |
| VASOTEC (<i>enalapril maleate</i>) | T3 | ST HD |
| ZESTRIL (<i>lisinopril</i>) | T3 | PA HD |
| ANTI-HYPERTENSIVES, ANGIOTENSIN RECEPTOR ANTAGONIST | | |
| ATACAND (<i>candesartan cilexetil</i>) | T3 | ST HD |
| AVAPRO (<i>irbesartan</i>) | T3 | PA HD |
| BENICAR 5 MG TABLET (<i>olmesartan medoxomil</i>) | T3 | PA HD |
| BENICAR 20 MG TABLET (<i>olmesartan medoxomil</i>) | T3 | PA QL (1 tab/day) HD |
| BENICAR 40 MG TABLET (<i>olmesartan medoxomil</i>) | T3 | PA HD |
| <i>candesartan cilexetil (Atacand)</i> | T1 | HD |
| COZAAR (<i>losartan potassium</i>) | T3 | PA HD |
| DIOVAN (<i>valsartan</i>) | T3 | PA HD |
| EDARBI 40 MG TABLET | T3 | PA QL (1 tab/day) HD |
| EDARBI 80 MG TABLET | T3 | PA HD |
| <i>eprosartan mesylate</i> | T1 | HD |
| <i>irbesartan (Avapro)</i> | T1 | HD |
| <i>losartan potassium (Cozaar)</i> | T1 | HD |
| MICARDIS 40 MG TABLET (<i>telmisartan</i>) | T3 | ST QL (1 tab/day) HD |
| MICARDIS 80 MG TABLET (<i>telmisartan</i>) | T3 | ST HD |
| <i>olmesartan medoxomil 20 mg tab (Benicar)</i> | T1 | QL (1 tab/day) HD |
| <i>olmesartan medoxomil 40 mg tab (Benicar)</i> | T1 | HD |
| <i>olmesartan medoxomil 5 mg tab (Benicar)</i> | T1 | HD |
| <i>telmisartan 20 mg tablet</i> | T1 | QL (1 tab/day) HD |

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

T4 – Injectable Specialty Medications

PA – Prior Authorization

QL – Quantity Limit

ST – Step Therapy

AGE – Age Requirement

SP – Specialty Medication

HD – May require home delivery pharmacy

PPACA – No Cost-Share Preventive Medication

CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

| CARDIOVASCULAR (Blood Pressure/Heart Medications) (cont.) | | |
|--|-----------|----------------------------------|
| Prescription Drug Name | Drug Tier | Coverage Requirements and Limits |
| ANTI-HYPERTENSIVES, ANGIOTENSIN RECEPTOR ANTAGONIST (cont.) | | |
| telmisartan 40 mg tablet (Micardis) | T1 | QL (1 tab/day) HD |
| telmisartan 80 mg tablet (Micardis) | T1 | HD |
| valsartan (Diovan) | T1 | HD |
| ANTI-HYPERTENSIVES, GANGLIONIC BLOCKERS | | |
| VECAMYL | T1 | |
| ANTI-HYPERTENSIVES, MISCELLANEOUS | | |
| DEM SER (metyrosine) | T3 | HD |
| metyrosine (Demser) | T1 | HD |
| ANTI-HYPERTENSIVES, SYMPATHOLYTIC | | |
| CATAPRES-TTS 1 (clonidine) | T3 | HD |
| CATAPRES-TTS 2 (clonidine) | T3 | HD |
| CATAPRES-TTS 3 (clonidine) | T3 | HD |
| clonidine (Catapres-tts 1) | T1 | HD |
| clonidine (Catapres-tts 2) | T1 | HD |
| clonidine (Catapres-tts 3) | T1 | HD |
| guanfacine hcl (Intuniv) | T1 | HD |
| INTUNIV (guanfacine hcl) | T3 | PA HD |
| methyldopa | T1 | HD |
| methyldopa/hydrochlorothiazide | T1 | HD |
| ANTI-HYPERTENSIVES, VASODILATORS | | |
| hydralazine hcl | T1 | HD |
| minoxidil | T1 | HD |
| BETA-ADRENERGIC BLOCKING AGENTS | | |
| acebutolol hcl | T1 | HD |
| atenolol (Tenormin) | T1 | HD |
| BETAPACE (sotalol af) | T3 | PA HD |
| BETAPACE AF (sotalol af) | T3 | PA HD |
| betaxolol hcl | T1 | HD |
| bisoprolol fumarate | T1 | HD |
| BYSTOLIC 10 MG TABLET | T3 | PA QL (1 tab/day) HD |
| BYSTOLIC 2.5 MG TABLET | T3 | PA QL (1 tab/day) HD |
| BYSTOLIC 20 MG TABLET | T3 | PA HD |

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

T4 – Injectable Specialty Medications

PA – Prior Authorization

QL – Quantity Limit

ST – Step Therapy

AGE – Age Requirement

SP – Specialty Medication

HD – May require home delivery pharmacy

PPACA – No Cost-Share Preventive Medication

CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

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

| Prescription Drug Name | Drug Tier | Coverage Requirements and Limits |
|--|-----------|----------------------------------|
| BETA-ADRENERGIC BLOCKING AGENTS (cont.) | | |
| BYSTOLIC 5 MG TABLET | T3 | PA QL (1 tab/day) HD |
| HEMANGEOL | T3 | PA HD |
| INDERAL LA (<i>propranolol hcl er</i>) | T3 | PA HD |
| INDERAL XL | T3 | PA HD |
| INNOPRAN XL | T3 | ST HD |
| KAPSPARGO SPRINKLE | T3 | PA HD |
| LOPRESSOR (<i>metoprolol tartrate</i>) | T3 | PA 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> (Betapace Af) | T1 | HD |
| <i>sotalol hcl</i> (Betapace) | T1 | HD |
| SOTYLIZE | T3 | HD |
| TENORMIN (<i>atenolol</i>) | T3 | PA HD |
| <i>timolol maleate</i> | T1 | HD |
| TOPROL XL (<i>metoprolol succinate</i>) | T3 | PA 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 |
| TENORETIC 100 (<i>atenolol-chlorthalidone</i>) | T3 | PA HD |
| TENORETIC 50 (<i>atenolol-chlorthalidone</i>) | T3 | PA HD |
| ZIAC (<i>bisoprolol-hydrochlorothiazide</i>) | T3 | PA HD |
| RENIN INHIBITOR, DIRECT | | |
| <i>aliskiren 150 mg tablet</i> (Tekturna) | T1 | QL (1 tab/day) HD |

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

T4 – Injectable Specialty Medications

PA – Prior Authorization

QL – Quantity Limit

ST – Step Therapy

AGE – Age Requirement

SP – Specialty Medication

HD – May require home delivery pharmacy

PPACA – No Cost-Share Preventive Medication

CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

| CARDIOVASCULAR (Blood Pressure/Heart Medications) (cont.) | | |
|--|-----------|----------------------------------|
| Prescription Drug Name | Drug Tier | Coverage Requirements and Limits |
| RENIN INHIBITOR, DIRECT (cont.) | | |
| aliskiren 300 mg tablet (Tekturna) | T1 | HD |
| TEKTURN A 150 MG TABLET (aliskiren) | T3 | PA QL(1 TAB/DAY) HD |
| TEKTURN A 300 MG TABLET (aliskiren) | T3 | PA HD |
| RENIN INHIBITOR, DIRECT AND THIAZIDE DIURETIC COMB | | |
| TEKTURN A HCT | T2 | HD |
| VASODILATORS, COMBINATION | | |
| BIDIL (isosorbide dinit/hydralazine) | T3 | QL(6 tabs/day) HD |
| isosorbide-hydralazine 20-37.5 (Bidil) | T1 | QL(6 tabs/day) HD |
| VASODILATORS, PERIPHERAL | | |
| ergoloid mesylates | T1 | |
| isoxsuprine hcl | T1 | |
| CARDIOVASCULAR (Cholesterol Medications) | | |
| ANTI-HYPERLIP.HMG COA REDUCT INHIB-CHOLEST.AB.INHIB | | |
| ezetimibe/atorvastatin calcium | T1 | PA HD |
| ezetimibe/simvastatin (Vytorin) | T1 | HD |
| ROSZET | T3 | PA HD |
| VYTORIN (ezetimibe-simvastatin) | T3 | PA 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 |

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

T4 – Injectable Specialty Medications

PA – Prior Authorization

QL – Quantity Limit

ST – Step Therapy

AGE – Age Requirement

SP – Specialty Medication

HD – May require home delivery pharmacy

PPACA – No Cost-Share Preventive Medication

CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

CARDIOVASCULAR (Cholesterol Medications) (cont.)

| Prescription Drug Name | Drug Tier | Coverage Requirements and Limits |
|--|-----------|----------------------------------|
| ANTI-HYPERLIPID- HMG-COA RI-CALCIUM CHANNEL BLOCKER (cont.) | | |
| CADUET 5 MG-10 MG TABLET (<i>amlodipine-atorvastatin</i>) | T3 | HD |
| CADUET 5 MG-20 MG TABLET (<i>amlodipine-atorvastatin</i>) | T3 | QL (1 tab/day) HD |
| CADUET 5 MG-40 MG TABLET (<i>amlodipine-atorvastatin</i>) | T3 | QL (1 tab/day) HD |
| CADUET 5 MG-80 MG TABLET (<i>amlodipine-atorvastatin</i>) | T3 | HD |
| LIVALO | T3 | PA QL |
| ANTI-HYPERLIPIDEMIC - APO B-100 SYNTHESIS INHIBITOR | | |
| KYNAMRO | T3 | PA SP |
| ANTI-HYPERLIPIDEMIC - APOLIPOPROTEIN INHIBITOR | | |
| TRYNGOLZA | T4 | PA QL SP |
| ANTI-HYPERLIPIDEMIC - ATP CITRATE LYASE INHIBITOR | | |
| NEXLETOL | T2 | PA QL (1 tab/day) |
| ANTI-HYPERLIPIDEMIC - MTP INHIBITOR | | |
| JUXTAPID | T3 | PA QL SP HD |
| ANTI-HYPERLIPIDEMIC - PCSK9 INHIBITORS | | |
| PRALUENT PEN | T3 | PA |
| REPATHA PUSHTRONEX | T2 | PA |
| REPATHA SURECLICK | T2 | PA |
| REPATHA SYRINGE | T2 | PA |
| ANTI-HYPERLIPIDEMIC-ACLY AND CHOLEST ABSORP INHIB | | |
| NEXLIZET | T2 | PA QL (1 SYRINGE/DAY) |
| ANTI-HYPERLIPIDEMIC-HMGCOA REDUCTASE INHIB (Statins) | | |
| ALTOPREV 20 MG TABLET | T3 | QL (1 tab/day) ST HD |
| ALTOPREV 40 MG TABLET | T3 | ST HD |
| ALTOPREV 60 MG TABLET | T3 | ST HD |
| <i>atorvastatin 10 mg tablet (Lipitor)</i> | T1 | HD PPACA |
| <i>atorvastatin 20 mg tablet (Lipitor)</i> | T1 | HD PPACA |
| <i>atorvastatin 40 mg tablet (Lipitor)</i> | T1 | HD |
| <i>atorvastatin 80 mg tablet (Lipitor)</i> | T1 | HD |
| CRESTOR 10 MG TABLET (<i>rosuvastatin calcium</i>) | T3 | PA QL (1 tab/day) HD |
| CRESTOR 20 MG TABLET (<i>rosuvastatin calcium</i>) | T3 | PA QL (1 tab/day) HD |
| CRESTOR 40 MG TABLET (<i>rosuvastatin calcium</i>) | T3 | PA HD |
| CRESTOR 5 MG TABLET (<i>rosuvastatin calcium</i>) | T3 | PA QL (1 tab/day) HD |
| EZALLOR SPRINKLE 10 MG CAPSULE | T3 | QL (1 tab/day) ST HD |
| EZALLOR SPRINKLE 20 MG CAPSULE | T3 | QL (1 tab/day) ST HD |
| EZALLOR SPRINKLE 40 MG CAPSULE | T3 | ST HD |
| EZALLOR SPRINKLE 5 MG CAPSULE | T3 | QL (1 tab/day) ST HD |

T1 – Typically Generics

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T4 – Injectable Specialty Medications

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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-HYPERLIPIDEMIC-HMGCOA REDUCTASE INHIB (Statins) (cont.) | | |
| FLOLIPID | T3 | ST HD |
| <i>fluvastatin sodium</i> | T1 | HD PPACA |
| <i>fluvastatin sodium (Lescol XL)</i> | T1 | HD PPACA |
| <i>LESCOL XL (fluvastatin er)</i> | T3 | PA HD |
| <i>LIPITOR (atorvastatin calcium)</i> | T3 | PA HD |
| <i>LIVALO 1 MG TABLET (pitavastatin calcium)</i> | T2 | QL (1 tab/day) ST HD |
| <i>LIVALO 2 MG TABLET (pitavastatin calcium)</i> | T2 | QL (1 tab/day) ST HD |
| <i>LIVALO 4 MG TABLET (pitavastatin calcium)</i> | T2 | PA HD |
| <i>lovastatin 10 mg tablet</i> | T1 | HD |
| <i>lovastatin 20 mg tablet</i> | T1 | HD PPACA |
| <i>lovastatin 40 mg tablet</i> | T1 | HD PPACA |
| <i>pitavastatin tablet</i> | T1 | QL HD PPACA |
| <i>pitavastatin 1 mg tablet (Livalo)</i> | T1 | QL(1 tab/day) HD PPACA |
| <i>pitavastatin 2 mg tablet (Livalo)</i> | T1 | QL(1 tab/day) HD PPACA |
| <i>pitavastatin 4 mg tablet (Livalo)</i> | T1 | HD PPACA |
| <i>PRAVACHOL (pravastatin sodium)</i> | T3 | PA HD |
| <i>pravastatin sodium</i> | T1 | HD PPACA |
| <i>pravastatin sodium (Pravachol)</i> | T1 | HD PPACA |
| <i>rosuvastatin calcium 10 mg tab (Crestor)</i> | T1 | QL (1 tab/day) HD PPACA |
| <i>rosuvastatin calcium 20 mg tab (Crestor)</i> | T1 | QL (1 tab/day) HD |
| <i>rosuvastatin calcium 40 mg tab (Crestor)</i> | T1 | HD |
| <i>rosuvastatin calcium 5 mg tab (Crestor)</i> | T1 | QL (1 tab/day) HD PPACA |
| <i>simvastatin 10 mg tablet (Zocor)</i> | T1 | HD PPACA |
| <i>simvastatin 20 mg tablet (Zocor)</i> | T1 | HD PPACA |
| <i>SIMVASTATIN 20 MG/5 ML SUSP</i> | T3 | ST HD |
| <i>simvastatin 40 mg tablet (Zocor)</i> | T1 | HD PPACA |
| <i>simvastatin 5 mg tablet</i> | T1 | HD |
| <i>simvastatin 80 mg tablet</i> | T1 | QL (1 tab/day) HD |
| <i>ZOCOR</i> | T3 | PA HD |
| <i>ZYPITAMAG</i> | T3 | ST HD |
| BILE SALT SEQUESTRANTS | | |
| <i>cholestyramine (with sugar) (Questran)</i> | T1 | HD |
| <i>cholestyramine (Questran Light)</i> | T1 | HD |

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

T4 – Injectable Specialty Medications

PA – Prior Authorization

QL – Quantity Limit

ST – Step Therapy

AGE – Age Requirement

SP – Specialty Medication

HD – May require home delivery pharmacy

PPACA – No Cost-Share Preventive Medication

CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

CARDIOVASCULAR (Cholesterol Medications) (cont.)

| Prescription Drug Name | Drug Tier | Coverage Requirements and Limits |
|--|-----------|----------------------------------|
| BILE SALT SEQUESTRANTS (cont.) | | |
| <i>colesevelam hcl</i> (Welchol) | T1 | HD |
| COLESTID | T3 | HD |
| COLESTID (colestipol hcl) | T3 | HD |
| <i>colestipol hcl</i> (Colestid) | T1 | HD |
| QUESTRAN (<i>cholestyramine</i>) | T3 | HD |
| QUESTRAN LIGHT (<i>cholestyramine</i>) | T3 | HD |
| WELCHOL (<i>colesevelam hcl</i>) | T3 | PA HD |
| LIPOTROPICS | | |
| ANTARA | T3 | PA HD |
| <i>ezetimibe</i> (Zetia) | T1 | HD |
| <i>fenofibrate 120 mg tablet</i> (Fenoglide) | T1 | HD |
| <i>fenofibrate 130 mg capsule</i> | T1 | HD |
| <i>fenofibrate 134 mg capsule</i> | T1 | HD |
| <i>fenofibrate 145 mg tablet</i> (Tricor) | T1 | HD |
| FENOFIBRATE 150 MG CAPSULE | T1 | HD |
| <i>fenofibrate 160 mg tablet</i> | T1 | HD |
| FENOFIBRATE 160 MG TABLET | T3 | PA HD |
| <i>fenofibrate 200 mg capsule</i> | T1 | HD |
| <i>fenofibrate 40 mg tablet</i> (Fenoglide) | T1 | HD |
| <i>fenofibrate 43 mg capsule</i> | T1 | HD |
| <i>fenofibrate 48 mg tablet</i> (Tricor) | T1 | HD |
| FENOFIBRATE 50 MG CAPSULE | T1 | HD |
| <i>fenofibrate 54 mg tablet</i> | T1 | HD |
| <i>fenofibrate 67 mg capsule</i> | T1 | HD |
| <i>fenofibric acid (choline)</i> (Trilipix) | T1 | HD |
| <i>fenofibric acid</i> (Fibrincor) | T1 | HD |
| FENOGLIDE (<i>fenofibrate</i>) | T3 | PA 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> (Niacor) | T1 | PA HD |
| <i>niacin</i> (Niaspan) | T1 | HD |
| NIACOR | T3 | PA HD |

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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 |
| LIPOTROPICS (cont.) | | |
| 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 | PA HD |
| CARDIOVASCULAR (Miscellaneous) | | |
| ENDOTHELIN-ANGIOTENSIN RECEPTOR ANTAGONIST | | |
| FILSPARI | T3 | PA QL(1 tab/day) SP HD |
| CNS DRUGS (Alzheimer's Disease) | | |
| ALZHEIMER'S THERAPY, NMDA RECEPTOR ANTAGONISTS | | |
| memantine hcl | T1 | HD |
| memantine hcl er 14 mg capsule (Namenda Xr) | T1 | QL (1 cap/day) HD |
| memantine hcl er 21 mg capsule | T1 | HD |
| memantine hcl er 28 mg capsule (Namenda Xr) | T1 | HD |
| memantine hcl er 7 mg capsule (Namenda Xr) | T1 | QL (1 cap/day) HD |
| NAMENDA | T3 | HD |
| NAMENDA XR 14 MG CAPSULE (<i>memantine hcl er</i>) | T3 | QL (1 cap/day) HD |
| NAMENDA XR 28 MG CAPSULE (<i>memantine hcl er</i>) | T3 | HD |
| NAMENDA XR 7 MG CAPSULE (<i>memantine hcl er</i>) | T3 | QL (1 cap/day) HD |
| NAMENDA XR TITRATION PACK | T3 | QL (112/365 days) HD |
| 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 (<i>memantine hcl/donepezil hcl</i>) | T3 | QL (2 caps/day) HD |
| NAMZARIC 28 MG-10 MG CAPSULE | T3 | QL (2 caps/day) HD |
| NAMZARIC 7 MG-10 MG CAPSULE | T3 | QL (2 caps/day) HD |
| NAMZARIC TITRATION PACK | T3 | QL (112/365 days) HD |
| CNS DRUGS (Miscellaneous) | | |
| AMYOTROPHIC LATERAL SCLEROSIS AGENTS | | |
| RADICAVA ORS | T3 | PA QL (50ml/28days) SP |
| RELYVARIO | T3 | PA QL(2 PACKS/DAY) SP |
| RILUTEK (<i>riluzole</i>) | T3 | PA SP HD |
| <i>riluzole</i> (Rilutek) | T1 | SP HD |
| TIGLUTIK | T3 | PA SP |

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List of Prescription Medications

CNS DRUGS (Miscellaneous) (cont.)

| Prescription Drug Name | Drug Tier | Coverage Requirements and Limits |
|---|-----------|----------------------------------|
| DRUGS TO TREAT MOVEMENT DISORDERS | | |
| AUSTEDO XR 6 MG TABLET | T3 | PA QL (90 tabs/30 days) SP HD |
| AUSTEDO XR 12 MG TABLET | T3 | PA QL (30 tabs/30 days) SP HD |
| AUSTEDO XR 18 MG TABLET | T3 | PA QL(1 tab/day) SP HD |
| AUSTEDO XR 24 MG TABLET | T3 | PA QL (50 tabs/30 days) SP HD |
| AUSTEDO XR TITRATION KT(WK1-4) | T3 | PA QL(1 KIT/180 DAYS) SP HD |
| HORIZANT | T3 | PA |
| INGREZZA | T3 | PA SP |
| INGREZZA INITIATION PACK | T3 | PA QL (28 caps/year) SP |
| <i>tetrabenazine</i> (Xenazine) | T1 | PA SP HD |
| XENAZINE (<i>tetrabenazine</i>) | T3 | PA SP HD |
| PSEUDOBULBAR AFFECT (PBA) AGENTS, NMDA ANTAGONISTS | | |
| NUEDEXTA | T3 | QL (4 caps/day) |
| XANTHINES | | |
| <i>caffeine citrate</i> | T1 | HD |
| CNS DRUGS (Multiple Sclerosis) | | |
| AGENTS TO TREAT MULTIPLE SCLEROSIS | | |
| AUBAGIO (<i>teriflunomide</i>) | T3 | PA SP HD |
| AVONEX | T4 | PA SP HD |
| AVONEX PEN | T4 | PA SP HD |
| BAFIERTAM | T2 | PA SP HD |
| BETASERON | T4 | PA SP HD |
| COPAXONE (<i>glatopa</i>) | T4 | PA SP HD |
| <i>dimethyl fumarate</i> (Tecfidera) | T1 | HD |
| GILENYA | T3 | PA SP HD |
| glatiramer | T4 | HD |
| <i>glatiramer acetate</i> (Copaxone) | T1 | PA SP HD |
| <i>glatopa</i> | T4 | HD |
| KESIMPTA PEN | T4 | PA SP HD |
| MAVENCLAD | T3 | PA SP HD |
| MAYZENT | T2 | PA SP HD |
| PLEGRIDY | T4 | PA SP HD |
| PLEGRIDY PEN | T4 | PA SP HD |
| PONVORY | T3 | PA SP HD |
| REBIF | T4 | PA SP HD |
| REBIF REBIDOSE | T4 | PA SP HD |

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T4 – Injectable Specialty Medications

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List of Prescription Medications

CNS DRUGS (Multiple Sclerosis) (cont.)

| Prescription Drug Name | Drug Tier | Coverage Requirements and Limits |
|--|-----------|----------------------------------|
| AGENTS TO TREAT MULTIPLE SCLEROSIS (cont.) | | |
| TASCENO ODT 0.25 MG TABLET | T3 | PA QL(1 TAB/DAY) SP |
| TECFIDERA (<i>dimethyl fumarate</i>) | T3 | PA SP HD |
| <i>teriflunomide</i> (Aubagio) | T1 | SP HD |
| VUMERTY | T2 | PA SP HD |
| ZEPOSIA | T3 | PA SP HD |
| AGTS TX NEUROMUSC TRANSMISSION DIS, POT-CHAN BLKR | | |
| AMPYRA (<i>dalfampridine er</i>) | T3 | PA SP HD |
| <i>dalfampridine</i> (Ampyra) | 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 |
| GLYPROMATE (GPE) ANALOGS | | |
| DAYBUE | T3 | PA QL (120ml/day) SP |
| POSTHERPETIC NEURALGIA AGENTS | | |
| <i>gabapentin</i> (Gralise) | T1 | |
| GRALISE | T3 | PA |
| GRALISE ER (<i>gabapentin</i>) | T3 | PA |
| SPHINGOSINE I-PHOSPHATE (SIP) RECEPTOR MODULATOR | | |
| VELSIPITY | T3 | PA QL(30 TABS/30 DAYS) SP HD |
| ZEPOSIA | T2 | PA SP HD |

CNS DRUGS (Seizure Disorders)

| | | |
|---|----|-------|
| ANTI-CONVULSANT - BENZODIAZEPINE TYPE | | |
| <i>clobazam</i> (Onfi) | T1 | HD |
| <i>clonazepam</i> | T1 | HD |
| <i>clonazepam</i> (Klonopin) | T1 | HD |
| DIASTAT (<i>diazepam</i>) | T3 | PA HD |
| DIASTAT ACUDIAL (<i>diazepam</i>) | T3 | PA HD |
| <i>diazepam</i> 10 mg rectal gel syst | T1 | HD |
| <i>diazepam</i> 2.5 mg rectal gel sys (Diastat) | T1 | HD |
| <i>diazepam</i> 20 mg rectal gel syst | T1 | HD |
| KLONOPIN (<i>clonazepam</i>) | T3 | PA HD |

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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-CONVULSANT - BENZODIAZEPINE TYPE (cont.) | | |
| LIBERVANT | T3 | PA QL(10 films/30 days) HD |
| NAYZILAM | T2 | PA QL (5 kits/30 days) HD |
| ONFI (<i>clobazam</i>) | T3 | PA HD |
| SYMPAZAN | 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 |
| BANZEL 200 MG TABLET | T3 | PA QL (16 tabs/day) HD |
| BANZEL 40 MG/ML SUSPENSION (<i>rufinamide</i>) | T3 | PA QL (80ml/day) HD |
| BANZEL 400 MG TABLET | T3 | PA QL (8 tabs/day) HD |
| BRIVIACT | T3 | PA HD |
| <i>carbamazepine</i> | T1 | HD |
| <i>carbamazepine</i> (Carbatrol) | T1 | HD |
| <i>carbamazepine</i> (Tegretol Xr) | T1 | HD |
| <i>carbamazepine</i> (Tegretol) | T1 | HD |
| CARBAMAZEPINE 200 MG TAB CHEW | T3 | HD |
| CARBATROL (<i>carbamazepine er</i>) | T3 | PA HD |
| CELONTIN | T2 | HD |
| DEPAKOTE (<i>divalproex sodium</i>) | T3 | PA HD |
| DEPAKOTE ER (<i>divalproex sodium er</i>) | T3 | PA HD |
| DEPAKOTE SPRINKLE (<i>divalproex sodium</i>) | T3 | PA HD |
| DIACOMIT | T3 | PA SP HD |
| DILANTIN 100 MG CAPSULE (<i>phenytoin sodium extended</i>) | T3 | PA HD |
| DILANTIN 30 MG CAPSULE | T2 | PA HD |
| DILANTIN 50 MG INFATAB (<i>phenytoin</i>) | T3 | PA HD |
| DILANTIN-125 (<i>phenytoin</i>) | T3 | PA HD |
| <i>divalproex sodium</i> (Depakote Er) | T1 | HD |
| <i>divalproex sodium</i> (Depakote Sprinkle) | T1 | HD |
| <i>divalproex sodium</i> (Depakote) | T1 | HD |
| ELEPSIA XR | T3 | PA |
| EPRONTIA | T3 | PA |
| <i>ethosuximide</i> (Zarontin) | T1 | HD |

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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.) | | |
| eslicarbazepine 200 mg, 400 mg tablet | T1 | PA QL HD |
| eslicarbazepine 600 mg, 800 mg tablet | T1 | PA HD |
| felbamate (Felbatol) | T1 | HD |
| FELBATOL (felbamate) | T3 | PA HD |
| FINTEPLA | T3 | PA SP HD |
| FYCOMPA 0.5 MG/ML ORAL SUSP | T2 | PA HD |
| FYCOMPA 10 MG TABLET | T2 | PA HD |
| FYCOMPA 12 MG TABLET | T2 | PA HD |
| FYCOMPA 2 MG TABLET | T2 | PA HD |
| FYCOMPA 4 MG TABLET | T2 | PA QL (1 tab/day) HD |
| FYCOMPA 6 MG TABLET | T2 | PA QL (1 tab/day) HD |
| FYCOMPA 8 MG TABLET | T2 | PA HD |
| gabapentin | T1 | HD |
| gabapentin (Neurontin) | T1 | HD |
| GABARONE | T3 | PA HD |
| GABITRIL 2 MG TABLET (<i>tiagabine hcl</i>) | T3 | PA HD |
| GABITRIL 4 MG TABLET (<i>tiagabine hcl</i>) | T3 | PA HD |
| KEPPRA (<i>levetiracetam</i>) | T3 | PA HD |
| KEPPRA (<i>roweepra</i>) | T3 | PA HD |
| KEPPRA XR (<i>levetiracetam er</i>) | T3 | PA HD |
| LAMICTAL (BLUE) (<i>subvenite (blue)</i>) | T3 | PA HD |
| LAMICTAL (GREEN) (<i>subvenite (green)</i>) | T3 | PA HD |
| LAMICTAL (<i>lamotrigine</i>) | T3 | PA HD |
| LAMICTAL (ORANGE) (<i>subvenite (orange)</i>) | T3 | PA HD |
| LAMICTAL (<i>subvenite</i>) | T3 | PA HD |
| LAMICTAL ODT (BLUE) (<i>lamotrigine odt (blue)</i>) | T3 | PA HD |
| LAMICTAL ODT (GREEN) (<i>lamotrigine odt (green)</i>) | T3 | PA HD |
| LAMICTAL ODT (<i>lamotrigine odt</i>) | T3 | PA HD |
| LAMICTAL ODT (ORANGE) (<i>lamotrigine odt (orange)</i>) | T3 | PA HD |
| LAMICTAL XR (BLUE) | T3 | PA HD |
| LAMICTAL XR (GREEN) | T3 | PA HD |
| LAMICTAL XR (<i>lamotrigine er</i>) | T3 | PA HD |
| LAMICTAL XR (ORANGE) | T3 | PA HD |
| <i>lamotrigine</i> (Lamictal (blue)) | T1 | HD |
| <i>lamotrigine</i> (Lamictal (green)) | T1 | HD |
| <i>lamotrigine</i> (Lamictal (orange)) | T1 | HD |
| <i>lamotrigine</i> (Lamictal Odt (blue)) | T1 | HD |

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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>lamotrigine</i> (Lamictal) | T1 | HD |
| <i>lamotrigine</i> (Lamictal Odt (green)) | T1 | HD |
| <i>lamotrigine</i> (Lamictal Odt (orange)) | T1 | HD |
| <i>lamotrigine</i> (Lamictal Odt) | T1 | HD |
| <i>lamotrigine</i> (Lamictal Xr) | T1 | HD |
| <i>levetiracetam</i> | T1 | HD |
| <i>levetiracetam</i> (Keppra) | T1 | HD |
| <i>levetiracetam</i> (Keppra Xr) | T1 | HD |
| <i>LYRICA (pregabalin)</i> | T3 | PA HD |
| MOTPOLY XR 100 MG CAPSULE | T3 | PA QL(1 cap/day) HD |
| MOTPOLY XR 150 MG CAPSULE | T3 | PA QL(2 caps/day) HD |
| MOTPOLY XR 200 MG CAPSULE | T3 | PA QL(2 caps/day) HD |
| <i>MYSOLINE (primidone)</i> | T3 | PA HD |
| <i>NEURONTIN (gabapentin)</i> | T3 | PA HD |
| <i>oxcarbazepine</i> | T1 | PA HD |
| OXTELLAR XR (<i>oxcarbazepine</i>) | 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> | T1 | HD |
| <i>pregabalin</i> (Lyrica) | T1 | HD |
| <i>primidone</i> (Mysoline) | T1 | HD |
| QUDEXY XR (<i>topiramate er</i>) | T3 | PA HD |
| <i>rufinamide</i> (Banzel) | T1 | PA QL (8ML/DAY) HD |
| SABRIL (<i>vigabatrin</i>) | T3 | PA SP HD |
| SPRITAM | T3 | PA HD |
| TEGRETOL (carbamazepine) | T3 | PA HD |
| TEGRETOL XR (carbamazepine er) | 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, 4 mg tablet</i> | T1 | HD |
| TOPAMAX (<i>topiramate</i>) | T3 | PA HD |
| TOPIRAMATE 50 MG SPRINKLE CAP | T3 | PA HD |
| <i>topiramate</i> (Qudexy Xr) | T1 | HD |
| <i>topiramate er</i> (Trokendi Xr) | T1 | QL(1 CAP/DAY) HD |
| TRILEPTAL (<i>oxcarbazepine</i>) | T3 | PA HD |

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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.) | | |
| TROKENDI XR 100 MG, 25MG, 50 MG CAPSULE (topiramate) | T3 | PA QL(1 CAP/DAY) HD |
| <i>valproic acid</i> | T1 | HD |
| <i>vigabatrin</i> (Sabril) | T1 | SP HD |
| VIGAFYDE | T3 | PA SP |
| VIMPAT | T2 | PA HD |
| XCOPRI 25 MG TABLET | T3 | PA HD |
| XCOPRI 100 MG TABLET | T3 | PA QL (1 tab/day) HD |
| XCOPRI 12.5-25 MG TITRATION PK | T3 | PA QL (1/28 Days) HD |
| XCOPRI 150 MG TABLET | T3 | PA QL (1/Day) HD |
| XCOPRI 150-200 MG TITRATION PK | T3 | PA QL (1/28 Days) HD |
| XCOPRI 200 MG TABLET | T3 | PA QL (2/Day) HD |
| XCOPRI 250 MG DAILY DOSE PACK | T3 | PA QL (1/28 Days) HD |
| XCOPRI 350 MG DAILY DOSE PACK | T3 | PA QL (1/28 Days) HD |
| XCOPRI 50 MG TABLET | T3 | PA QL (1/Day) HD |
| XCOPRI 50-100 MG TITRATION PAK | T3 | PA QL (1/28 Days) HD |
| ZARONTIN (ethosuximide) | T3 | PA HD |
| ZONEGRAN (zonisamide) | T3 | PA HD |
| zonisamide (Zonegran) | T1 | HD |
| ZONISADE | T3 | PA QL(6 bottles/30 days) |

CNS DRUGS (Sleep Disorders/Sedatives)

| | | |
|---|----|--------------------------|
| NARCOLEPSY TX-H3-RECEPT.ANTAGONIST/INVERSE AGONIST | | |
| WAKIX | T3 | PA QL (2 tabs/day) SP HD |

COLONY STIMULATING FACTORS (Blood Modifiers/Bleeding Disorders) (cont.)

| | | |
|--|----|-------|
| ERYTHROPOIESIS-STIMULATING AGENTS | | |
| ARANESP | T2 | PA SP |
| EPOGEN | T2 | PA SP |
| MIRCERA | T3 | PA SP |
| PROCRIT | T2 | PA SP |
| RETACRIT | T2 | PA SP |

| | | |
|-----------------------------------|----|----------|
| LEUKOCYTE (WBC) STIMULANTS | | |
| FULPHILA | T4 | PA SP |
| GRANIX | T3 | PA SP |
| LEUKINE | T2 | SP |
| NEULASTA | T4 | PA SP |
| NEULASTA ONPRO | T4 | PA SP HD |
| NEUPOGEN | T3 | PA SP |
| NIVESTYM | T4 | PA SP |

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

List of Prescription Medications

COLONY STIMULATING FACTORS (Blood Modifiers/Bleeding Disorders) (cont.)

| Prescription Drug Name | Drug Tier | Coverage Requirements and Limits |
|--|-----------|----------------------------------|
| LEUKOCYTE (WBC) STIMULANTS (con't.) | | |
| NYPOZI | T4 | PA SP |
| NYVEPRIA | T4 | PA SP |
| STIMUFEND | T4 | PA SP |
| UDENYCA | T4 | PA SP |
| ZARXIO | T2 | SP HD |
| ZIEXTENZO | T4 | PA SP |
| THROMBOPOIETIN RECEPTOR AGONISTS | | |
| ALVAIZ 9 MG, 18 MG TABLET | T3 | PA QL(1 tab/day) SP |
| ALVAIZ 36 MG, 54 MG TABLET | T3 | PA QL(2 tabs/day) SP |
| DOPTELET | T2 | PA SP HD |
| MULPLETA | T3 | PA SP HD |
| PROMACTA | T2 | PA SP HD |
| CXCR4 CHEMOKINE RECEPTOR ANTAGONIST | | |
| LEUKOCYTE (WBC) STIMULANTS (cont.) | | |
| XOLREMDI | T3 | PA QL(4 caps/day) SP CSL |
| CONTRACEPTIVES (Contraception Products) | | |
| CONTRACEPTIVES, INTRAVAGINAL, SYSTEMIC | | |
| ANNOVERA | T3 | PPACA |
| etongestrel/ethinyl estradiol (Nuvaring) | T1 | PPACA |
| NUVARING (etongestrel-ethinyl estradiol) | T3 | PPACA |
| CONTRACEPTIVES, IMPLANTABLE | | |
| NEXPLANON | T2 | SP PPACA |
| CONTRACEPTIVES, INJECTABLE | | |
| DEPO-PROVERA 150 MG/ML SYRINGE (<i>medroxyprogesterone acetate</i>) | T3 | PPACA |
| DEPO-PROVERA 150 MG/ML VIAL (<i>medroxyprogesterone acetate</i>) | T3 | PPACA |
| DEPO-SUBQ PROVERA 104 | T2 | PPACA |
| <i>medroxyprogesterone 150 mg/ml</i> (Depo-provera) | T1 | PPACA |
| CONTRACEPTIVES, INTRAVAGINAL | | |
| PHEXXI | T3 | PA PPACA |
| CONTRACEPTIVES, ORAL | | |
| BALCOLTRA | T3 | HD PPACA |
| BEYAZ (<i>drospirenone/ethynodiol diacetate/levomefetinol citrate</i>) | T3 | HD PPACA |
| <i>desogestrel-ethinyl estradiol</i> | T1 | HD PPACA |
| <i>drospirenone/ethynodiol diacetate/levomefetinol citrate</i> (Beyaz) | T1 | HD PPACA |
| <i>drospirenone/ethynodiol diacetate/levomefetinol citrate</i> (Safyral) | T1 | HD PPACA |
| ELLA | T3 | HD PPACA |
| ESTROSTEP FE (<i>tri-legestenol</i>) | T3 | HD |

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

T4 – Injectable Specialty Medications

PA – Prior Authorization

QL – Quantity Limit

ST – Step Therapy

AGE – Age Requirement

SP – Specialty Medication

HD – May require home delivery pharmacy

PPACA – No Cost-Share Preventive Medication

CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

CONTRACEPTIVES (Contraception Products) (cont.)

| Prescription Drug Name | Drug Tier | Coverage Requirements and Limits |
|--|-----------|----------------------------------|
| CONTRACEPTIVES, ORAL | | |
| ethinyl estradiol/drospirenone (Yasmin 28) | T1 | HD PPACA |
| ethinyl estradiol/drospirenone (Yaz) | T1 | HD PPACA |
| ethynodiol d-ethinyl estradiol | T1 | HD PPACA |
| FEMLYV | T3 | PA HD PPACA |
| levonorgestrel/ethin estradiol | T1 | HD PPACA |
| levonorgest/eth estradiol/iron (Balcoltra) | T1 | HD PPACA |
| I-norgest/e.estradiol-e.estrad | T1 | HD PPACA |
| I-norgest/e.estradiol-e.estrad (Quartette) | T1 | HD PPACA |
| I-norgest/e.estradiol-e.estrad (Seasonique) | T1 | HD PPACA |
| LO LOESTRIN FE | T3 | PA HD |
| LOESTRIN (norethindron-ethinyl estradiol) | T3 | HD PPACA |
| LOESTRIN FE (norethindrone-eth estradiol-fe) | T3 | HD PPACA |
| MICROGESTIN 24 FE (tarina 24 fe) | T3 | HD |
| NATAZIA | T3 | HD PPACA |
| NEXTSTELLIS | T3 | HD PPACA |
| noreth-ethinyl estradiol/iron | T1 | HD PPACA |
| norethindrone (Ortho Micronor) | T1 | HD PPACA |
| norethindrone ac-eth estradiol (Loestrin) | T1 | HD PPACA |
| norethindrone-e.estradiol-iron (Estrostep Fe) | T1 | HD PPACA |
| norethindrone-e.estradiol-iron (Loestrin Fe) | T1 | HD PPACA |
| norethindrone-e.estradiol-iron (Microgestin 24 Fe) | T1 | HD PPACA |
| norethindrone-e.estradiol-iron (Taytulla) | T1 | HD PPACA |
| norethindrone-ethin. estradiol | T1 | HD PPACA |
| norethin-ee 1.5-0.03 mg (21) tb (Loestrin) | T1 | HD PPACA |
| norgestimate-ethinyl estradiol | T1 | HD PPACA |
| norgestrel-ethinyl estradiol | T1 | HD PPACA |
| ORTHO MICRONOR (tulana) | T3 | HD |
| QUARTETTE (rivelsa) | T3 | HD |
| SAFYRAL (tydemy) | T3 | HD PPACA |
| SEASONIQUE (simpesse) | T3 | HD PPACA |
| SLYND | T3 | HD PPACA |
| TAYTULLA (norethin-eth estra-ferrous fum) | T3 | HD PPACA |
| TYBLUME | T3 | HD PPACA |
| YASMIN 28 (zumandimine) | T3 | HD PPACA |
| YAZ (vestura) | T3 | HD PPACA |
| CONTRACEPTIVES, TRANSDERMAL | | |
| norelgestromin/ethin estradiol | T1 | HD PPACA |
| TWIRLA | T3 | HD PPACA |

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

T4 – Injectable Specialty Medications

PA – Prior Authorization

QL – Quantity Limit

ST – Step Therapy

AGE – Age Requirement

SP – Specialty Medication

HD – May require home delivery pharmacy

PPACA – No Cost-Share Preventive Medication

CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

| CONTRACEPTIVES (Contraception Products) (cont.) | | |
|--|-----------|----------------------------------|
| Prescription Drug Name | Drug Tier | Coverage Requirements and Limits |
| DIAPHRAGMS/CERVICAL CAP | | |
| CAYA CONTOURED | T2 | PPACA |
| FEMCAP | T2 | PPACA |
| WIDE SEAL DIAPHRAGM | T3 | PPACA |
| INTRA-UTERINE DEVICES (IUDS) | | |
| KYLEENA | T3 | SP PPACA |
| LILETTA | T3 | SP PPACA |
| MIRENA | T3 | SP PPACA |
| MIUDELLA | T3 | SP PPACA |
| PARAGARD T 380-A | T3 | SP PPACA |
| SKYLA | T3 | SP PPACA |
| COUGH/COLD PREPARATIONS (Allergy/Nasal Sprays) | | |
| 1ST GEN ANTIHIST-DECONGEST-ANTICHOLINERGIC COMB | | |
| RESPA A.R. | T3 | |
| COUGH/COLD PREPARATIONS (Cough/Cold Medications) | | |
| ANTI-TUSSIVES, NON-OPIOID | | |
| benzonatate 100 mg capsule (Tessalon Perle) | T1 | |
| ANTI-TUSSIVES, NON-OPIOID (cont.) | | |
| benzonatate 150 mg capsule | T1 | PA |
| benzonatate 200 mg capsule | T1 | |
| NON-OPIOID ANTI-TUS-1ST GEN.ANTIHISTAMINE-DECONGEST | | |
| benzonatate perle 100 mg cap (Tessalon Perle) | T1 | |
| TESSALON PERLE (benzonatate) | T3 | |
| NON-OPIOID ANTITUS-1ST GEN.ANTIHISTAMINE-DECONGEST | | |
| BROMFED DM (brompheniramine-pseudoephed-dm) | T3 | PA |
| brompheniramine/pseudoephed/dm (Bromfed Dm) | T1 | |
| NON-OPIOID ANTI-TUSSIVE-1ST GEN ANTIHISTAMINE COMB. | | |
| promethazine/dextromethorphan | T1 | |
| hydrocodone/cpm/pseudoephed | T1 | PA |
| promethazine/phenylephh/codeine | T1 | PA QL (480ml/30 days) |
| OPIOID ANTI-TUSSIVE-1ST 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) |
| TUSSICAPS | T2 | PA |
| TUXARIN ER | T3 | PA QL (2 tabs/day) |
| TUZISTRA XR | T3 | PA QL (960ml/30 days) |

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

T4 – Injectable Specialty Medications

PA – Prior Authorization

QL – Quantity Limit

ST – Step Therapy

AGE – Age Requirement

SP – Specialty Medication

HD – May require home delivery pharmacy

PPACA – No Cost-Share Preventive Medication

CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

| COUGH/COLD PREPARATIONS (Cough/Cold Medications) (cont.) | | |
|--|-----------|----------------------------------|
| Prescription Drug Name | Drug Tier | Coverage Requirements and Limits |
| OPIOID ANTI-TUSSIVE-ANTI-CHOLINERGIC COMBINATIONS | | |
| HYCODAN (<i>hydromet</i>) | T3 | PA QL (480ml/22 days) |
| <i>hydrocodone bit/homatrop me-br</i> (Hycodan) | T1 | PA QL (480ml/22 days) |
| <i>hydrocodone-homatropine 5-1.5</i> | T1 | PA QL (180 tabs/30 days) |
| <i>hydrocodone-homatropine soln</i> (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 (Diabetes) | | |
| BLOOD SUGAR DIAGNOSTICS | | |
| AGAMATRIX JAZZ TEST STRIP | T3 | |
| AGAMATRIX PRESTO | T3 | |
| BLULINK GLUCOSE TEST STRIP | T3 | |
| EASY TOUCH BLU LINK TEST STRIP | T3 | |
| FORA 6CONN-GTEL-TN'G ADV STRIP | T3 | |
| GE333 BLOOD GLUCOSE TEST STRIP | T3 | |
| IHEALTH GLUCOSE TEST STRIP | T3 | |
| PLATINUM TEST STRIP | T3 | |
| DIAGNOSTIC PREPARATIONS, MISCELLANEOUS | | |
| ADVANCED DNA MEDICATED COLLECT | T3 | |
| ARIDOL | T3 | |
| KERENDIA | T2 | PA QL(1 tab/day) |
| <i>lidocaine hcl/glycerin</i> (Advanced Dna Medicated Collect) | T1 | |
| PROVOCHOLINE | T3 | |
| TC99M SULFUR COLLOID PREP | T1 | |
| EYE DIAGNOSTIC AGENTS | | |
| <i>fluorescein sodium</i> | T1 | |
| <i>ful-glo 1 mg ophth strip</i> | T1 | |
| FUL-GLO EYE STRIPS | T3 | |
| <i>lissamine green</i> | T1 | |
| GASTROINTESTINAL RADIOPAQUE DIAGNOSTICS | | |
| ENTEROVU | T3 | |
| E-Z DISK | T3 | |
| E-Z-HD | T3 | |
| E-Z-PAQUE | T3 | |
| E-Z-PASTE | T3 | |
| GASTROMARK | T3 | |

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

T4 – Injectable Specialty Medications

PA – Prior Authorization

QL – Quantity Limit

ST – Step Therapy

AGE – Age Requirement

SP – Specialty Medication

HD – May require home delivery pharmacy

PPACA – No Cost-Share Preventive Medication

CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

| DIAGNOSTIC (Miscellaneous) | | |
|--|-----------|----------------------------------|
| Prescription Drug Name | Drug Tier | Coverage Requirements and Limits |
| GASTROINTESTINAL RADIOPAQUE DIAGNOSTICS | | |
| LIQUID E-Z PAQUE | T3 | |
| LIQUID POLIBAR PLUS | T3 | |
| NEULUMEX | T3 | |
| POLIBAR ACB | T3 | |
| READI-CAT 2 | T3 | |
| SITZMARKS | T3 | |
| TAGITOL | T3 | |
| VARIBAR | 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 | |
| CYSTOGRAFIN-DILUTE | T3 | |
| <i>diatrizoate meglumine, sodium (Gastrografin)</i> | T1 | |
| GASTROGRAFIN (<i>md-gastroview</i>) | T3 | |
| DIURETICS (Diuretics) | | |
| ARGININE VASOPRESSIN (AVP) RECEPTOR ANTAGONISTS | | |
| SAMSCA (<i>tolvaptan</i>) | T3 | PA SP |
| TOLVAPTAN 15 MG TABLET | T3 | SP |
| <i>tolvaptan 30 mg tablet (Samsca)</i> | T1 | SP |
| CARBONIC ANHYDRASE INHIBITORS | | |
| <i>acetazolamide</i> | T1 | HD |
| <i>methazolamide</i> | T1 | HD |
| LOOP DIURETICS | | |
| <i>bumetanide</i> | T1 | HD |
| EDECRIN (<i>ethacrynic acid</i>) | T3 | PA HD |
| <i>ethacrynic acid (Edecrin)</i> | T1 | PA HD |
| FUROSCIX | T3 | PA QL(2 kits/30 days) HD |
| <i>furosemide (Lasix)</i> | T1 | HD |
| LASIX (<i>furosemide</i>) | T3 | PA HD |
| <i>torsemide</i> | T1 | HD |

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

T4 – Injectable Specialty Medications

PA – Prior Authorization

QL – Quantity Limit

ST – Step Therapy

AGE – Age Requirement

SP – Specialty Medication

HD – May require home delivery pharmacy

PPACA – No Cost-Share Preventive Medication

CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

DIURETICS (Diuretics) (cont.)

| Prescription Drug Name | Drug Tier | Coverage Requirements and Limits |
|---|-----------|----------------------------------|
| POLYCYSTIC KIDNEY DISEASE AGENT, AVP RECEPTOR ANTAGONIST | | |
| 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 | | |
| ALDACTONE (<i>spironolactone</i>) | T3 | PA HD |
| amiloride hcl | T1 | HD |
| CAROSPIR (<i>spironolactone</i>) | T2 | PA HD |
| DYRENium (<i>triamterene</i>) | T3 | PA HD |
| POTASSIUM SPARING DIURETICS IN COMBINATION | | |
| ALDACTAZIDE | T3 | HD |
| ALDACTAZIDE (<i>spironolactone-hctz</i>) | T3 | HD |
| amiloride/hydrochlorothiazide | T1 | HD |
| DYAZIDE (<i>triamterene-hydrochlorothiazid</i>) | T3 | HD |
| <i>spironolact/hydrochlorothiazid</i> | T1 | HD |
| <i>spironolactone</i> (Carospir) | T1 | HD |
| <i>spironolact/hydrochlorothiazid</i> (Aldactazide) | T1 | HD |
| <i>triamterene/hydrochlorothiazid</i> (Dyazide) | T1 | HD |
| THIAZIDE AND RELATED DIURETICS | | |
| chlorthalidone | T1 | HD |
| DIURIL | T2 | HD |
| HEMICLOR | T3 | HD |
| hydrochlorothiazide | T1 | HD |
| indapamide | T1 | HD |
| metolazone | T1 | HD |
| THALITONE | T3 | PA HD |

EENT PREPS (Allergy/Nasal Sprays)

| | | |
|---|----|----|
| NASAL ANTIHISTAMINE | | |
| azelastine 0.1% (137 mcg) spry | T1 | HD |
| azelastine 0.15% nasal spray | T1 | HD |
| olopatadine 665 mcg nasal spry (Patanase) | T1 | HD |
| PATANASE (olopatadine hcl) | T3 | HD |
| NASAL ANTIHISTAMINE AND ANTI-INFLAM. STEROID COMB. | | |
| azelastine/fluticasone (Dymista) | T1 | HD |

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

T4 – Injectable Specialty Medications

PA – Prior Authorization

QL – Quantity Limit

ST – Step Therapy

AGE – Age Requirement

SP – Specialty Medication

HD – May require home delivery pharmacy

PPACA – No Cost-Share Preventive Medication

CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

| EENT PREPS (Allergy/Nasal Sprays) (cont.) | | |
|---|-----------|----------------------------------|
| Prescription Drug Name | Drug Tier | Coverage Requirements and Limits |
| NASAL ANTIHISTAMINE AND ANTI-INFLAM. STEROID COMB.(con't.) | | |
| DYMISTA (azelastine-fluticasone) | T3 | ST HD |
| RYALTRIS | T3 | PA QL(1 gm/30 days) HD |
| NASAL ANTI-INFLAMMATORY STEROIDS | | |
| flunisolide | T1 | HD |
| fluticasone prop 50 mcg spray | T1 | HD |
| mometasone furoate 50 mcg spry (Nasonex) | T1 | QL (4 bots/30 days) HD |
| NASONEX (mometasone furoate) | T3 | QL (4 bots/30 days) ST HD |
| OMNARIS | T3 | ST HD |
| QNASL | T3 | ST |
| QNASL CHILDREN | T3 | |
| XHANCE | T3 | ST HD |
| ZETONNA | T3 | ST HD |
| NOSE PREPARATIONS, MISCELLANEOUS (RX) | | |
| ipratropium bromide | T1 | HD |
| NOSE PREPARATIONS, VASOCONSTRICATORS (RX) | | |
| ADRENALIN CHLORIDE | T3 | |
| epinephrine hcl (Adrenalin Chloride) | T1 | |
| EENT PREPS (Ear Medications) | | |
| EAR PREPARATIONS ANTI-INFLAMMATORY | | |
| DERMOTIC (fluocinolone acetonide oil) | T3 | |
| fluocinolone acetonide oil (Dermotic) | T1 | |
| EAR PREPARATIONS, MISC. ANTI-INFECTIVES | | |
| acetic acid | T1 | |
| hydrocortisone/acetic acid | T1 | |
| EENT PREPS (Eye Conditions) | | |
| ARTIFICIAL TEARS | | |
| LACRISERT | T3 | |
| MIEBO | T2 | PA QL(4 bottles/22 days) |
| EYE ANTI-INFECTIVES (RX ONLY) | | |
| BETADINE | T2 | |
| EYE ANTI-INFLAMMATORY AGENTS | | |
| ACULAR (ketorolac tromethamine) | T3 | PA |
| ACULAR LS (ketorolac tromethamine) | T3 | PA |
| ACUVAIL | T3 | PA |
| ALREX (loteprednol etabonate) | T3 | PA |
| bromfenac sodium (Bromsite) | T1 | |
| BROMSITE(bromfenac sodium) | T2 | PA |

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

T4 – Injectable Specialty Medications

PA – Prior Authorization

QL – Quantity Limit

ST – Step Therapy

AGE – Age Requirement

SP – Specialty Medication

HD – May require home delivery pharmacy

PPACA – No Cost-Share Preventive Medication

CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

EENT PREPS (Eye Conditions) (cont.)

| Prescription Drug Name | Drug Tier | Coverage Requirements and Limits |
|---|-----------|----------------------------------|
| EYE ANTI-INFLAMMATORY AGENTS (cont.) | | |
| <i>dexamethasone sodium phosphate</i> | T1 | |
| <i>diclofenac 0.1% eye drops</i> | T1 | |
| DUREZOL | T3 | PA |
| EYSUVIS | T2 | QL (8.3ml/14 days) |
| FLAREX | T2 | |
| <i>fluorometholone (Fml)</i> | T1 | |
| <i>flurbiprofen sodium</i> | T1 | |
| FML (<i>fluorometholone</i>) | T3 | PA |
| FML FORTE | T3 | PA |
| ILEVRO | T3 | |
| INVELTYS | T2 | PA |
| <i>ketorolac 0.4% ophth solution (Acular Ls)</i> | T1 | |
| <i>ketorolac 0.5% ophth solution (Acular)</i> | T1 | |
| LOTEMAX 0.5% EYE DROPS | T3 | ST |
| LOTEMAX OINTMENT (<i>loteprednol etabonate</i>) | T3 | ST |
| LOTEMAX SM | T3 | PA |
| <i>loteprednol etabonate (Lotemax)</i> | T1 | |
| MAXIDEX | T3 | PA |
| NEVANAC | T3 | PA |
| OMNIPRED (<i>prednisolone acetate</i>) | T3 | |
| PRED FORTE (<i>prednisolone acetate</i>) | T3 | PA |
| PRED MILD | T3 | PA |
| <i>prednisolone acetate (Pred Forte)</i> | T1 | |
| <i>prednisolone sodium phosphate</i> | T1 | |
| PROLENZA | T3 | |
| EYE LOCAL ANESTHETICS | | |
| AKTEN | T3 | |
| ALCAINE (<i>proparacaine hcl</i>) | T3 | |
| ALTAFLUOR BENOX (<i>flurox</i>) | T3 | |
| <i>benoxinate hcl/fluorescein sod (Altafluor Benox)</i> | T1 | |
| <i>benoxinate hcl/fluorescein sod (Altafluor Benox)</i> | T3 | |
| <i>proparacaine hcl (Alcaine)</i> | T1 | |
| <i>proparacaine/fluorescein sod</i> | T1 | |
| <i>proparacaine/fluorescein sod</i> | T2 | |
| <i>tetracaine hcl</i> | T1 | |
| TETRAVISC | T2 | |

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

T4 – Injectable Specialty Medications

PA – Prior Authorization

QL – Quantity Limit

ST – Step Therapy

AGE – Age Requirement

SP – Specialty Medication

HD – May require home delivery pharmacy

PPACA – No Cost-Share Preventive Medication

CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

| ENT PREPS (Eye Conditions) (cont.) | | |
|--|-----------|----------------------------------|
| Prescription Drug Name | Drug Tier | Coverage Requirements and Limits |
| EYE LOCAL ANESTHETICS (cont.) | | |
| TETRAVISC FORTE | T2 | |
| EYE MAST CELL STABILIZERS | | |
| ALOCRIL | T3 | PA |
| ALOMIDE | T3 | PA |
| cromolyn 4% eye drops | T1 | |
| EYE PREPARATIONS, MISCELLANEOUS (OTC) | | |
| GELFILM | T3 | |
| EYE VASOCONSTRICATORS | | |
| phenylephrine hcl | T1 | |
| UPNEEQ | T3 | PA |
| MIOTICS AND OTHER INTRAOCULAR PRESSURE REDUCERS | | |
| ALPHAGAN P (<i>brimonidine tartrate</i>) | T3 | HD |
| <i>apraclonidine hcl</i> (Iopidine) | T1 | HD |
| AZOPT (<i>brinzolamide</i>) | T3 | PA HD |
| <i>betaxolol hcl</i> | T1 | HD |
| BETIMOL | T3 | PA HD |
| BETOPTIC S | T2 | HD |
| <i>bimatoprost</i> | T1 | QL (10ml/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 |
| COBIGAN | T3 | PA HD |
| COSOPT (<i>dorzolamide-timolol</i>) | T3 | PA HD |
| COSOPT PF (<i>dorzolamide-timolol</i>) | T3 | PA HD |
| <i>dorzolamide hcl</i> (Trusopt) | T1 | HD |
| <i>dorzolamide hcl/timolol maleat</i> (Cosopt) | T1 | HD |
| <i>dorzolamide/timolol/pf</i> (Cosopt Pf) | T1 | HD |
| IOPIDINE (<i>apraclonidine hcl</i>) | T3 | HD |
| ISOPTO CARPINE (<i>pilocarpine hcl</i>) | T3 | HD |
| ISTALOL (<i>timolol maleate</i>) | T3 | PA HD |
| IFYUZEH | T3 | PA QL(30 vials/30 days) HD |
| <i>latanoprost</i> (Xalatan) | T1 | HD |
| <i>levobunolol hcl</i> | T1 | HD |

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 |
|---|-----------|----------------------------------|
| MIOTICS AND OTHER INTRAOCCULAR PRESSURE REDUCERS (cont.) | | |
| LUMIGAN | T3 | PA HD |
| PHOSPHOLINE IODIDE | T2 | HD |
| <i>pilocarpine hcl</i> (Isotopto Carpine) | T1 | HD |
| RHOPRESSA | T3 | |
| ROCKLATAN | T3 | |
| SIMBRINZA | T2 | HD |
| <i>timolol maleate</i> (Istalol) | T1 | HD |
| <i>timolol maleate</i> (Timoptic) | T1 | HD |
| <i>timolol maleate</i> (Timoptic-xe) | T1 | HD |
| <i>timolol maleate/pf</i> (Timoptic Ocudose) | T1 | HD |
| TIMOPTIC (<i>timolol maleate</i>) | T3 | PA HD |
| TIMOPTIC OCUDOSE | T3 | PA HD |
| TIMOPTIC OCUDOSE (<i>timolol maleate</i>) | T3 | PA HD |
| TIMOPTIC-XE (<i>timolol maleate</i>) | T3 | PA HD |
| TRAVATAN Z (<i>travoprost</i>) | T3 | PA HD |
| <i>travoprost</i> (Travatan Z) | T1 | HD |
| TRUSOPT (<i>dorzolamide hcl</i>) | T3 | HD |
| QLOSI | T3 | PA |
| VUITY | T3 | PA |
| VYZULTA | T3 | PA |
| XALATAN (<i>latanoprost</i>) | T3 | PA HD |
| XELPROS | T3 | PA HD |
| ZIOPTAN (<i>tafluprost/pf</i>) | T3 | PA QL(60 DROPPERS/30 DAYS) HD |
| MYDRIATICS | | |
| <i>atropine sulfate</i> | T1 | HD |
| <i>atropine 1% eye drops</i> | T1 | HD |
| CYCLOGYL 0.5% EYE DROPS (<i>cyclopentolate hcl</i>) | T3 | HD |
| CYCLOGYL 1% EYE DROPS | T3 | HD |
| CYCLOGYL 1% EYE DROPS (<i>cyclopentolate hcl</i>) | T3 | HD |
| CYCLOGYL 2% EYE DROPS (<i>cyclopentolate hcl</i>) | T2 | HD |
| CYCLOMYDRIL | T2 | HD |
| <i>cyclopentolate hcl</i> (Cyclogyl) | T1 | HD |
| <i>homatropine hbr</i> | T1 | HD |
| ISOPTO ATROPINE (<i>atropine sulfate</i>) | T3 | HD |
| MYDRIACYL (<i>tropicamide</i>) | T3 | HD |

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List of Prescription Medications

| EENT PREPS (Eye Conditions) (cont.) | | |
|--|-----------|----------------------------------|
| Prescription Drug Name | Drug Tier | Coverage Requirements and Limits |
| MYDRIATICS (cont.) | | |
| PAREMYD | T3 | HD |
| <i>tropicamide</i> | T1 | HD |
| <i>tropicamide</i> (Mydriacyl) | T1 | HD |
| TROPICAMIDE-CYCLOPENTOLATE-PE | T3 | HD |
| OPHTHALMIC ANTI-FIBROTIC AGENTS | | |
| MITOSOL | T3 | |
| OPHTHALMIC ANTI-INFLAMMATORY IMMUNOMODULATOR-TYPE | | |
| CEQUA | T2 | |
| RESTASIS | T2 | HD |
| RESTASIS MULTIDOSE | T2 | HD |
| VERKAZIA | T3 | PA QL (1 box/month) |
| VEVYE | T3 | PA 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 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 | | |
| CLINPRO 5000 | T3 | |
| FRAICHE 5000 | T3 | |
| <i>fluoride (sodium)</i> (Prevident 5000 Ortho Defense) | T1 | |
| <i>fluoride (sodium)</i> (Prevident 5000 Plus) | T1 | |
| <i>fluoride (sodium)</i> (Prevident 5000) | T1 | |
| <i>fluoride (sodium)</i> (Prevident) | T1 | |
| FLUORIDEX | T1 | |
| FLUORIDEX SENSITIVITY RELIEF | T3 | |
| PREVIDENT 0.2% RINSE | T2 | PA |
| PREVIDENT 1.1% GEL (<i>sodium fluoride</i>) | T3 | PA |

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List of Prescription Medications

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

| Prescription Drug Name | Drug Tier | Coverage Requirements and Limits |
|---|-----------|----------------------------------|
| FLUORIDE PREPARATIONS (cont.) | | |
| PREVENTID 5000 | T3 | PA |
| PREVENTID 5000 BOOSTER PLUS | T3 | PA |
| 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 KIDS | T3 | |
| PREVENTID DENTAL RINSE | T2 | PA |
| <i>sodium fluoride/potassium nit</i> (Preventid 5000 Sensitive) | T1 | |

ELECT/CALORIC/H2O (Diabetes)

| AGENTS TO TREAT HYPOGLYCEMIA (HYPERGLYCEMICS) | | |
|---|----|------------------------|
| BAQSIMI | T2 | QL(2 units/30 days) |
| <i>diazoxide</i> (Proglycem) | T1 | |
| <i>glucagon 1 mg emergency kit</i> (Glucagon Emergency Kit) | T1 | QL (2 pens/30 days) |
| GVOKE HYPOPEN 1-PACK | T2 | QL (2 packs/22 days) |
| GVOKE HYPOPEN 2-PACK | T2 | QL (2 packs/22 days) |
| GVOKE PFS 1-PACK SYRINGE | T2 | QL (2 syrings/30 days) |
| GVOKE PFS 2-PACK SYRINGE | T2 | QL (2 syrings/30 days) |
| PROGLYCEM (<i>diazoxide</i>) | T3 | |
| ZEGALOGUE | T2 | QL (2 units/23 days) |

ELECT/CALORIC/H2O (Miscellaneous)

| NUCLEIC ACID/NUCLEOTIDE SUPPLEMENTS | | |
|-------------------------------------|----|-------|
| XURIDEN | T3 | PA SP |

ELECT/CALORIC/H2O (Nutritional/Dietary)

| ELECTROLYTE DEPLETERS | | |
|--|----|--------------------|
| AURYXIA | T3 | QL (12 tabs/day) |
| <i>calcium acetate</i> | T1 | |
| FERRIC CITRATE | T3 | PA QL(12 tabs/day) |
| FOSRENOL 1,000 MG POWDER PACK | T2 | PA |
| FOSRENOL 1,000 MG TABLET CHEW (<i>lanthanum carbonate</i>) | T3 | |
| FOSRENOL 500 MG TABLET CHEW (<i>lanthanum carbonate</i>) | T3 | |
| FOSRENOL 750 MG POWDER PACKET | T2 | |
| FOSRENOL 750 MG TABLET CHEW (<i>lanthanum carbonate</i>) | T3 | |

T1 – Typically Generics

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List of Prescription Medications

| ELECT/CALORIC/H2O (Nutritional/Dietary) (cont.) | | |
|---|-----------|----------------------------------|
| Prescription Drug Name | Drug Tier | Coverage Requirements and Limits |
| ELECTROLYTE DEPLETERS (cont.) | | |
| <i>lanthanum carbonate</i> (Fosrenol) | T1 | |
| LOKELMA | T2 | |
| PHOSLYRA | T3 | |
| RENAGEL (<i>sevelamer hcl</i>) | T3 | PA |
| RENVELA (<i>sevelamer carbonate</i>) | T3 | PA |
| <i>sevelamer carbonate</i> (Renvela) | T1 | |
| <i>sevelamer hcl</i> | T1 | |
| <i>sevelamer hcl</i> (Renagel) | T1 | |
| <i>sodium polystyrene sulfon/sorb</i> | T1 | |
| <i>sodium polystyrene sulfonate</i> | T1 | |
| <i>sps 15 gm/60 ml suspension</i> | T1 | |
| <i>sps 30 gm/120 ml enema susp</i> | T3 | |
| XPHOZAH | T3 | PA |
| IODINE CONTAINING AGENTS | | |
| VELPHORO | T2 | |
| VELTASSA | T2 | |
| <i>potassium iodide/iodine</i> | T1 | |
| SSKI | T1 | |
| IRON REPLACEMENT | | |
| CITRANATAL BLOOM | T3 | |
| HEMOCYTE PLUS (mv-mins no.73/iron fum/folic) | T1 | |
| mv-mins no.73/iron fum/folic (Hemocyte Plus) | T1 | |
| 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</i> (K-tab Er) | T1 | |
| <i>klor-con 10 meq tablet</i> (K-tab Er) | T3 | |
| <i>klor-con 8 meq tablet</i> | T1 | |
| <i>klor-con 8 meq tablet</i> | T3 | |
| K-TAB ER (<i>potassium chloride</i>) | T3 | |
| POKONZA | T3 | PA |
| <i>potassium bicarbonate/cit ac</i> | T1 | |
| <i>potassium chloride</i> | T1 | |

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PA – Prior Authorization

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List of Prescription Medications

| ELECT/CALORIC/H2O (Nutritional/Dietary) (cont.) | | |
|---|-----------|----------------------------------|
| Prescription Drug Name | Drug Tier | Coverage Requirements and Limits |
| POTASSIUM REPLACEMENT (cont.) | | |
| <i>potassium chloride</i> | T2 | |
| POTASSIUM CL ER 15 MEQ TABLET | 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 |
| GASTROINTESTINAL (Cholesterol Medications) | | |
| LIPOTROPICS | | |
| <i>icosapent ethyl (Vascepa)</i> | T1 | HD |
| LOVAZA (<i>triklo</i>) | T3 | PA HD |
| <i>omega-3 acid ethyl esters (Lovaza)</i> | T1 | HD |
| VASCEPA | T2 | PA HD |
| GASTROINTESTINAL (Gastrointestinal/Heartburn) | | |
| AMMONIA INHIBITORS | | |
| BUPHENYL (<i>sodium phenylbutyrate</i>) | T3 | PA SP HD |
| <i>lactulose</i> | T1 | HD |
| <i>lactulose 10 gm/15 ml solution</i> | T1 | HD |
| LITHOSTAT | T2 | HD |
| OLPRUVA | T3 | PA SP HD |
| PHEBURANE | T2 | PA QL(8 Bottles/30 Days) SP HD |
| RAVICTI | T3 | PA SP HD |
| <i>sodium phenylbutyrate (Buphenyl)</i> | T1 | SP HD |
| ANTI-CHOLINERGICS, QUATERNARY AMMONIUM | | |
| <i>chlordiazepoxide/clidinium br (Librax)</i> | T1 | |

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List of Prescription Medications

| GASTROINTESTINAL (Gastrointestinal/Heartburn) (cont.) | | |
|--|-----------|----------------------------------|
| Prescription Drug Name | Drug Tier | Coverage Requirements and Limits |
| ANTI-CHOLINERGICS, QUATERNARY AMMONIUM (cont.) | | |
| CUVPOSA | T3 | |
| DARTISLA | T3 | PA |
| GLYCATE | T3 | |
| <i>glycopyrrolate</i> (Glycate) | T1 | PA |
| <i>glycopyrrolate</i> (Robinul Forte) | T1 | |
| <i>glycopyrrolate</i> (Robinul) | T1 | |
| LIBRAX (<i>chlordiazepoxide-clidinium</i>) | T3 | PA |
| <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 | |
| LOMOTIL (<i>diphenoxylate-atropine</i>) | T3 | PA |
| <i>loperamide hcl</i> | T1 | |
| MOTOFEN | T3 | |
| <i>opium tincture</i> | T1 | PA |
| <i>paregoric</i> | T1 | |
| ANTI-EMETIC, CANNABINOID-TYPE | | |
| <i>dronabinol</i> (Marinol) | T1 | |
| MARINOL (<i>dronabinol</i>) | T3 | PA |
| SYNDROS | T3 | PA |
| ANTI-EMETIC/ANTI-VERTIGO AGENTS | | |
| AKYNZEON | T3 | PA 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</i> (Emend) | T1 | QL (12 caps/28 days) |
| <i>aprepitant 40 mg capsule</i> | T1 | QL (1 cap/28 days) |

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List of Prescription Medications

GASTROINTESTINAL (Gastrointestinal/Heartburn) (cont.)

| Prescription Drug Name | Drug Tier | Coverage Requirements and Limits |
|--|-----------|----------------------------------|
| ANTI-EMETIC/ANTI-VERTIGO AGENTS (cont.) | | |
| aprepitant 80 mg capsule (Emend) | T1 | QL (8 caps/28 days) |
| BONJESTA | T3 | |
| COMPAZINE (prochlorperazine maleate) | T3 | |
| COMPAZINE (prochlorperazine) | T3 | |
| DICLEGIS (doxylamine succ-pyridoxine hcl) | T3 | PA QL(4 tabs/day) |
| doxylamine succinate/vit b6 (Diclegis) | T1 | QL(4 tabs/day) |
| EMEND 125 MG POWDER PACKET | T3 | PA QL (12 caps/28 days) |
| EMEND 150 MG VIAL (fosaprepitant dimeglumine) | T3 | |
| EMEND 80 MG CAPSULE (aprepitant) | T3 | PA QL (8 caps/28 days) |
| EMEND TRIPACK (aprepitant) | T3 | PA QL (12 caps/28 days) |
| FOCINVEZ | T3 | |
| fosaprepitant dimeglumine (Emend) | T1 | |
| granisetron hcl | T1 | |
| granisetron hcl/pf | T1 | |
| meclizine 50 mg tablet | T1 | PA |
| MECLIZINE 50 MG TABLET | T3 | PA |
| ondansetron | T1 | |
| ondansetron hcl | T1 | |
| ondansetron hcl (Zofran) | T1 | |
| ondansetron hcl/pf | T1 | |
| ONDANSETRON ODT 16 MG TABLET | T3 | PA |
| prochlorperazine (Compazine) | T1 | |
| prochlorperazine maleate (Compazine) | T1 | |
| promethazine hcl | T1 | |
| promethazine hcl | T3 | |
| SANCUSO | T3 | PA QL (4 patches/30 days) |
| scopolamine (Transderm-scop) | T1 | |
| TRANSDERM-SCOP (scopolamine) | T3 | |
| trimethobenzamide hcl | T1 | |
| VARUBI | T3 | PA QL (4 tabs/28 days) |
| ZOFRAN 2 MG/ML VIAL (ondansetron hcl) | T3 | |
| ZOFRAN 4 MG TABLET (ondansetron hcl) | T3 | PA |
| ZOFRAN 8 MG TABLET (ondansetron hcl) | T3 | PA |
| ANTI-ULCER PREPARATIONS | | |
| CARAFATE (sucralfate) | T3 | PA HD |
| CYTOTEC (misoprostol) | T3 | HD |

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List of Prescription Medications

| GASTROINTESTINAL (Gastrointestinal/Heartburn) (cont.) | | |
|--|-----------|----------------------------------|
| Prescription Drug Name | Drug Tier | Coverage Requirements and Limits |
| ANTI-ULCER PREPARATIONS (cont.) | | |
| <i>misoprostol</i> (Cytotec) | T1 | HD |
| <i>sucralfate</i> (Carafate) | T1 | HD |
| ANTI-ULCER-H.PYLORI AGENTS | | |
| HELIDAC | T3 | PA |
| <i>lansoprazole/amoxiciln/clarith</i> | T1 | |
| OMECLAMOX-PAK | T3 | PA |
| PYLERA | T3 | PA |
| TALICIA | T3 | PA |
| VOQUEZNA TRIPLE PAK | T3 | PA |
| VOQUEZNA DUAL PAK | T3 | PA |
| BELLADONNA ALKALOIDS | | |
| DONNATAL | T3 | HD |
| DONNATAL (<i>phenohytrō</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 |
| LEVIBID (<i>symax-sr</i>) | T3 | PA HD |
| LEVSIN (<i>oscimin</i>) | T3 | HD |
| LEVSIN-SL (<i>symax-sl</i>) | T3 | PA 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>phenohytrō</i>) | T3 | HD |
| SYMAX DUOTAB | T2 | HD |
| BILE SALTS | | |
| ACTIGALL (<i>ursodiol</i>) | T3 | HD |
| CHENODAL | T3 | SP HD |
| CHOLBAM | T3 | PA SP HD |

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

T4 – Injectable Specialty Medications

PA – Prior Authorization

QL – Quantity Limit

ST – Step Therapy

AGE – Age Requirement

SP – Specialty Medication

HD – May require home delivery pharmacy

PPACA – No Cost-Share Preventive Medication

CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

GASTROINTESTINAL (Gastrointestinal/Heartburn) (cont.)

| Prescription Drug Name | Drug Tier | Coverage Requirements and Limits |
|---|-----------|----------------------------------|
| BILE SALTS (cont.) | | |
| RELTONE | T3 | PA HD |
| URSO FORTE (<i>ursodiol</i>) | T3 | HD |
| <i>ursodiol</i> (Actigall) | T1 | HD |
| <i>ursodiol</i> (Urso Forte) | T1 | HD |
| <i>ursodiol</i> (Urso) | T1 | HD |
| CHRONIC INFLAM. COLON DX, 5-A-SALICYLAT, RECTAL TX | | |
| CANASA (<i>mesalamine</i>) | T3 | PA |
| <i>mesalamine</i> 1,000 mg supp (Canasa) | T1 | |
| <i>mesalamine</i> 4 gm/60 ml enema (Sfrowasa) | T1 | |
| <i>mesalamine</i> 4 gm/60 ml kit (Rowasa) | T1 | |
| ROWASA (<i>mesalamine</i>) | T3 | PA |
| SFROWASA (<i>mesalamine</i>) | T3 | |
| DRUG TX-CHRONIC INFLAM. COLON DX, 5-AMINOSALICYLAT | | |
| APRISO (<i>mesalamine er</i>) | T3 | ST HD |
| ASACOL HD (<i>mesalamine</i>) | T3 | ST HD |
| AZULFIDINE (<i>sulfasalazine dr</i>) | T3 | PA HD |
| AZULFIDINE (<i>sulfasalazine</i>) | T3 | HD |
| <i>balsalazide disodium</i> (Colazal) | T1 | HD |
| COLAZAL (<i>balsalazide disodium</i>) | T3 | ST HD |
| DELZICOL (<i>mesalamine dr</i>) | T3 | ST HD |
| DIPENTUM | T3 | ST HD |
| LIALDA (<i>mesalamine</i>) | T3 | ST |
| <i>mesalamine</i> (Apriso) | T1 | HD |
| <i>mesalamine</i> (Delzicol) | T1 | HD |
| <i>mesalamine</i> 800 mg dr tablet (Asacol Hd) | T1 | HD |
| <i>mesalamine</i> dr 1.2 gm tablet (Lialda) | T1 | HD |
| PENTASA | T3 | ST HD |
| <i>sulfasalazine</i> (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 HD |

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

T4 – Injectable Specialty Medications

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PPACA – No Cost-Share Preventive Medication

CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

| GASTROINTESTINAL (Gastrointestinal/Heartburn) (cont.) | | |
|--|-----------|----------------------------------|
| Prescription Drug Name | Drug Tier | Coverage Requirements and Limits |
| GASTRIC ENZYMES | | |
| SUCRAID | T3 | PA SP |
| HISTAMINE H2-RECEPTOR INHIBITORS | | |
| cimetidine hcl | T1 | HD |
| famotidine | T1 | HD |
| famotidine (Pepcid) | T1 | HD |
| nizatidine | T1 | HD |
| PEPCID (famotidine) | T1 | PA HD |
| ranitidine hcl | T1 | HD |
| IBS AGENTS, MIXED OPIOID RECEP AGONISTS/ANTAGONISTS | | |
| VIBERZI | T2 | HD |
| IBS-C/CIC AGENTS, GUANYLATE CYCLASE-C AGONIST | | |
| LINZESS | T2 | |
| TRULANCE | T2 | |
| ILEAL BILE ACID TRANSPORTER (IBAT) INHIBITOR | | |
| BYLVAY | T3 | PA SP HD |
| LIVMARLI | T3 | PA SP HD |
| INTEGRIN RECEPTOR ANTAGONIST, MONOCLONAL ANTIBODY | | |
| ENTYVIO | T2 | PA SP HD |
| INTESTINAL MOTILITY STIMULANTS | | |
| GIMOTI | T3 | PA SP |
| metoclopramide hcl | T1 | |
| metoclopramide hcl (Reglan) | T1 | |
| MOTEGRITY | T3 | PA |
| REGLAN (metoclopramide hcl) | T3 | |
| IRRITABLE BOWEL SYND. AGENT, 5-HT4 PARTIAL AGONIST | | |
| ZELNORM | T3 | PA |
| IRRITABLE BOWEL SYNDROME AGENTS, 5-HT3 ANTAGONIST | | |
| alosetron hcl (Lotronex) | T1 | SP HD |
| LOTRONEX (alosetron hcl) | T3 | PA SP HD |
| LAXATIVES AND CATHARTICS | | |
| AMITIZA (lubiprostone) | T3 | PA |
| bisac/nacl/nahco3/kcl/peg 3350 | T1 | PPACA |
| CLENPIQ | T3 | PA PPACA |
| COLYTE WITH FLAVOR PACKETS (peg 3350-electrolyte) | T3 | PPACA |

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List of Prescription Medications

GASTROINTESTINAL (Gastrointestinal/Heartburn) (cont.)

| Prescription Drug Name | Drug Tier | Coverage Requirements and Limits |
|--|-----------|----------------------------------|
| LAXATIVES AND CATHARTICS (cont.) | | |
| GOLYTELY (peg-3350 and electrolytes) | T3 | PA PPACA |
| KRISTALOSE | T3 | PA |
| <i>lactulose 10 gm packet</i> (Kristalose) | T1 | PA |
| <i>lactulose 20 gm packet</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 | |
| MOVIPREP (peg3350-sod sul-nacl-kcl-asb-c) | T3 | PA PPACA |
| NULYTELY | T3 | PA PPACA |
| NULYTELY WITH FLAVOR PACKS (<i>trilyte with flavor packets</i>) | T3 | PA PPACA |
| OSMOPREP | T3 | PA PPACA |
| <i>peg3350/sod sul/nacl/kcl/asb/c</i> (Moviprep) | T1 | PPACA |
| <i>peg3350/sod sulf, bicarb, cl/kcl</i> (Colyte With Flavor Packets) | T1 | PPACA |
| <i>peg3350/sod sulf, bicarb, cl/kcl</i> (Golytely) | T1 | PPACA |
| PLENU | T3 | PA PPACA |
| PREPOPIK | T2 | PPACA |
| <i>sodium chloride/nahco3/kcl/peg</i> | T1 | PPACA |
| SUFLAVE | T3 | PA PPACA |
| SUPREP | T3 | PPACA |
| SUTAB | T3 | PA PPACA |
| LOCAL ANORECTAL NITRATE PREPARATIONS | | |
| <i>nitroglycerin 0.4% ointment</i> (Rectiv) | T1 | |
| RECTIV (<i>nitroglycerin</i>) | T3 | |
| PANCREATIC ENZYMES | | |
| CREON | T3 | PA HD |
| PANCREAZE | T2 | HD |
| PERTZYE | T3 | PA HD |
| VIOKACE | T3 | HD |
| ZENPEP | T2 | HD |
| PROTON-PUMP INHIBITORS | | |
| ACIPHEX (<i>rabeprazole sodium</i>) | T3 | QL (30 tabs/30 days) ST HD |
| 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 30 MG CAPSULE | T3 | QL (2 caps/day) |
| DEXILANT DR 60 MG CAPSULE | T3 | PA QL (30 caps/30 days) |
| <i>dexlansoprazole dr 30 mg cap</i> | T1 | QL(2 caps/day) HD |

T1 – Typically Generics

T2 – Typically Preferred Brands

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T4 – Injectable Specialty Medications

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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

GASTROINTESTINAL (Gastrointestinal/Heartburn) (cont.)

| Prescription Drug Name | Drug Tier | Coverage Requirements and Limits |
|--|-----------|----------------------------------|
| PROTON-PUMP INHIBITORS (cont.) | | |
| dexlansoprazole dr 60 mg cap | T1 | QL(1 caps/day) HD |
| esomeprazole dr 10 mg packet (Nexium) | T1 | QL (4 packets/day) HD |
| esomeprazole dr 20 mg packet (Nexium) | T1 | QL (2 packs/day) HD |
| esomeprazole dr 40 mg packet (Nexium) | T1 | QL (1 packet/day) HD |
| esomeprazole mag dr 20 mg cap (Nexium) | T1 | QL (2/day) HD |
| esomeprazole mag dr 40 mg cap (Nexium) | T1 | QL (30 caps/30 days) HD |
| ESOMEPRAZOLE STRONTIUM | T3 | QL (30 caps/30 days) HD |
| lansoprazole dr 15 mg capsule (Prevacid) | T1 | QL (2 caps/day) HD |
| lansoprazole dr 30 mg capsule (Prevacid) | T1 | QL (30 caps/30 days) HD |
| lansoprazole odt 15 mg tablet (Prevacid) | T1 | QL (2 tabs/day) HD |
| lansoprazole odt 30 mg tablet (Prevacid) | T1 | QL (30 tabs/30 days) HD |
| NEXIUM DR 10 MG PACKET (esomeprazole magnesium) | T3 | PA QL (120 packs/30 days) HD |
| NEXIUM DR 2.5 MG PACKET | T2 | QL (480 packs/30 days) HD |
| NEXIUM DR 20 MG CAPSULE (esomeprazole magnesium) | T3 | PA QL (2 caps/day) HD |
| NEXIUM DR 20 MG PACKET (esomeprazole magnesium) | T3 | PA QL (2 packs/day) HD |
| NEXIUM DR 40 MG CAPSULE (esomeprazole magnesium) | T3 | PA QL (30 caps/30 days) HD |
| NEXIUM DR 40 MG PACKET (esomeprazole magnesium) | T3 | PA QL (30 packs/30 days) HD |
| NEXIUM DR 5 MG PACKET | T2 | QL (240 packs/30 days) HD |
| omeppi 20 mg-1, 100 mg capsule (Zegerid) | T3 | PA QL (60 caps/30 days) HD |
| omeppi 40 mg-1, 100 mg capsule (Zegerid) | T3 | PA QL (30 caps/30 days) HD |
| omeprazole dr 10 mg capsule | T1 | QL (4 caps/day) HD |
| omeprazole dr 20 mg capsule | T1 | QL (60 caps/30 days) HD |
| omeprazole dr 40 mg capsule | T1 | QL (1 cap/day) HD |
| omeprazole-bicarb 20-1, 100 cap (Zegerid) | T1 | PA QL (2 caps/day) HD |
| omeprazole-bicarb 20-1, 680 pkt (Zegerid) | T1 | PA QL (60 packs/30 days) HD |
| omeprazole-bicarb 40-1, 100 cap (Zegerid) | T1 | PA QL (30 caps/30 days) HD |
| omeprazole-bicarb 40-1, 680 pkt (Zegerid) | T1 | PA QL (30 packs/30 days) HD |
| pantoprazole 40 mg suspension (Protonix) | T1 | QL (1 dose/day) HD |
| pantoprazole sod dr 20 mg tab (Protonix) | T1 | QL (60 tabs/30 days) HD |
| pantoprazole sod dr 40 mg tab (Protonix) | T1 | QL (1 tab/day) HD |
| PREVACID 15 MG SOLUTAB (lansoprazole) | T3 | PA QL (2 tabs/day) |
| PREVACID 30 MG SOLUTAB (lansoprazole) | T3 | PA QL (30 tabs/30 days) |
| PREVACID DR 15 MG CAPSULE (lansoprazole) | T3 | QL (60 caps/30 days) ST HD |
| PREVACID DR 30 MG CAPSULE (lansoprazole) | T3 | QL (30 caps/30 days) ST |

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

T4 – Injectable Specialty Medications

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ST – Step Therapy

AGE – Age Requirement

SP – Specialty Medication

HD – May require home delivery pharmacy

PPACA – No Cost-Share Preventive Medication

CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

GASTROINTESTINAL (Gastrointestinal/Heartburn) (cont.)

| Prescription Drug Name | Drug Tier | Coverage Requirements and Limits |
|--|-----------|----------------------------------|
| PROTON-PUMP INHIBITORS (cont.) | | |
| dexlansoprazole dr 60 mg cap | T1 | QL(1 caps/day) 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 |
| RABEPRAZOLE DR 10 MG SPRNKL CP | T3 | QL (2 caps/day) HD |
| rabeprazole sod dr 20 mg tab (Aciphen) | T1 | QL (30 tabs/30 days) HD |
| ZEGERID 20 MG CAPSULE (<i>omeprazole-sodium bicarbonate</i>) | T3 | PA QL (60 caps/30 days) HD |
| ZEGERID 20 MG PACKET (<i>omeprazole-sodium bicarbonate</i>) | T3 | PA QL (60 packs/30 days) HD |
| ZEGERID 40 MG CAPSULE (<i>omeprazole-sodium bicarbonate</i>) | T3 | PA QL (30 caps/30 days) HD |
| ZEGERID 40 MG PACKET (<i>omeprazole-sodium bicarbonate</i>) | T3 | PA QL (30 packs/30 days) HD |
| POTASSIUM-COMPETITIVE ACID BLOCKERS (PCABS) | | |
| VOQUEZNA | T3 | PA QL(1 TAB/DAY) |
| RECTAL PREPARATIONS | | |
| ANUSOL-HC 25 MG SUPPOSITORY (<i>hydrocortisone acetate</i>) | T3 | PA |
| <i>hydrocortisone acetate</i> | T1 | |
| <i>hydrocortisone acetate</i> (Anusol-hc) | T1 | |
| SBS - GLUCAGON-LIKE PEPTIDE-2 (GLP-2) ANALOGS | | |
| GATTEX | T4 | PA SP HD |

GASTROINTESTINAL (Pain Relief And Inflammatory Disease)

| | | |
|--|----|----|
| HEMORRHOID PREP, ANTI-INFLAM STEROID-LOCAL ANESTHET | | |
| ANA-LEX | T1 | |
| ANALPRAM HC | T3 | |
| ANALPRAM HC (<i>hydrocortisone-pramoxine</i>) | T3 | PA |
| <i>hydrocortisone/lidocaine/aloe</i> | T1 | |
| <i>hydrocortisone/pramoxine</i> (Analpram Hc) | T1 | |
| <i>lidocaine/hydrocortisone ac</i> | T1 | |
| LIDOCAINE-HYDROCORTISONE | T1 | |
| PROCORT | T3 | |
| PROTOFOAM-HC | T2 | |
| RECTAL/LOWER BOWEL PREP., GLUCOCORT. (NON-HEMORR) | | |
| CORTENEMA (<i>hydrocortisone</i>) | T3 | |
| CORTIFOAM | T3 | PA |
| <i>hydrocortisone</i> (Cortenema) | T1 | |

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

T4 – Injectable Specialty Medications

PA – Prior Authorization

QL – Quantity Limit

ST – Step Therapy

AGE – Age Requirement

SP – Specialty Medication

HD – May require home delivery pharmacy

PPACA – No Cost-Share Preventive Medication

CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

| GASTROINTESTINAL (Pain Relief And Inflammatory Disease) (cont.) | | |
|--|-----------|----------------------------------|
| Prescription Drug Name | Drug Tier | Coverage Requirements and Limits |
| RECTAL/LOWER BOWEL PREP., GLUCOCORT. (NON-HEMORR) (cont.) | | |
| UCERIS 2 MG RECTAL FOAM | T3 | PA QL (2 kits/180 days) |
| HEMATOPOIETIC GROWTH FACTORS (Miscellaneous) | | |
| HYPOXIA INDUCIBLE FACTOR PROLYL HYDROXYLASE INH. | | |
| VAFSEO 150 MG TABLET | T3 | PA QL(1 tab/day) |
| VAFSEO 300 MG TABLET | T3 | PA QL(2 tabs/day) |
| HORMONES (Hormonal Agents) | | |
| ADRENAL STEROID INHIBITORS | | |
| ISTURISA | T3 | PA QL (2 TABS/DAY) SP |
| RECORLEV | T3 | PA QL (8 tabs/day) SP |
| ADRENOCORTICOTROPHIC HORMONES | | |
| ACTHAR SELFJECT | T3 | PA SP HD |
| CORTROPHIN | T3 | PA SP HD |
| 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) |
| UNDECATREX | T3 | PA QL(4 caps/day) |
| DEPO-TESTOSTERONE | T3 | |
| DEPO-TESTOSTERONE (<i>testosterone cypionate</i>) | T3 | |
| JATENZO 158 MG CAPSULE | T3 | PA QL (4 caps/day) |
| JATENZO 198 MG CAPSULE | T3 | PA QL (4 caps/day) |
| JATENZO 237 MG CAPSULE | T3 | PA QL (2 caps/day) |
| KYZATREX | T3 | PA QL(2 caps/day) |
| METHITEST | T1 | |
| TLANDO | T3 | PA QL (4/day) |
| <i>methyltestosterone</i>) | T1 | |

T1 – Typically Generics

T2 – Typically Preferred Brands

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ST – Step Therapy

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List of Prescription Medications

HORMONES (Hormonal Agents) (cont.)

| Prescription Drug Name | Drug Tier | Coverage Requirements and Limits |
|---|-----------|----------------------------------|
| ANDROGENIC AGENTS (cont.) | | |
| NATESTO | T3 | PA QL (3 bots/30 days) |
| <i>oxandrolone</i> | T1 | PA |
| TESTIM (<i>testosterone</i>) | T3 | PA QL (2 tubes/day) |
| <i>testosterone 1% (25mg/2.5g) pk (Androgel)</i> | T1 | PA QL (150gm/30 days) |
| <i>testosterone 1% (50 mg/5 g) pk (Vogelxo)</i> | T1 | PA QL (2 packs/day) |
| <i>testosterone 1.62% (2.5 g) pkt (Androgel)</i> | T1 | PA QL (150gm/30 days) |
| <i>testosterone 1.62% gel pump (Androgel)</i> | T1 | PA QL (150gm/30 days) |
| <i>testosterone 1.62% (1.25 g) pkt (Androgel)</i> | T1 | PA QL (2 packs/day) |
| <i>testosterone 10 mg gel pump</i> | T1 | PA QL (120 gm/30 days) |
| TESTOSTERONE 12.5 MG/1.25 GRAM | T1 | PA QL (150gm/30 days) |
| <i>testosterone 12.5 mg/1.25 gram (Vogelxo)</i> | T1 | PA QL (150gm/30 days) |
| <i>testosterone 30 mg/1.5 ml pump</i> | T1 | PA QL (180ml/30 days) |
| <i>testosterone 50 mg/5 gram gel (Vogelxo)</i> | T1 | PA QL (2 tubes/day) |
| TESTOSTERONE 50 MG/5 GRAM PKT | T1 | PA QL (2 packs/day) |
| VOGELXO 12.5 MG/1.25 GRAM PUMP | T3 | PA QL (150gm/30 days) |
| VOGELXO 50 MG/5 GRAM GEL (<i>testosterone</i>) | T3 | PA QL (2 tubes/day) |
| VOGELXO 50 MG/5 GRAM GEL PACKT | T3 | PA QL (2 packs/day) |
| XYOSTED | T3 | PA QL (4 injectors/28 days) |
| ANTI-DIURETIC AND VASOPRESSOR HORMONES | | |
| DDAVP 0.1 MG TABLET (<i>desmopressin acetate</i>) | T3 | PA HD |
| DDAVP 0.2 MG TABLET (<i>desmopressin acetate</i>) | T3 | PA HD |
| DDAVP (<i>desmopressin acetate</i>) | T3 | PA |
| <i>desmopressin (nonrefrigerated) (Ddavp)</i> | T1 | |
| <i>desmopressin 0.01% solution</i> | T1 | HD |
| <i>desmopressin 10 mcg/0.1 ml spr</i> | T1 | HD |
| <i>desmopressin acetate 0.1 mg tb (Ddavp)</i> | T1 | HD |
| <i>desmopressin acetate 0.2 mg tb (Ddavp)</i> | T1 | HD |
| <i>desmopressin acetate (Ddavp)</i> | T1 | |
| NOCDURNA | T3 | PA |
| NOCTIVA | T3 | PA |
| STIMATE | T2 | SP |
| ESTROGEN AND PROGESTIN COMBINATIONS | | |
| BIJUVA | T3 | |

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List of Prescription Medications

HORMONES (Hormonal Agents) (cont.)

| Prescription Drug Name | Drug Tier | Coverage Requirements and Limits |
|--|-----------|----------------------------------|
| ESTROGEN/ANDROGEN COMBINATIONS (cont.) | | |
| ESTRATEST F.S. (<i>estrogen,ester/me-testosterone</i>) | T3 | PA HD |
| <i>estrogen, ester/me-testosterone</i> | T1 | HD |
| ESTROGENIC AGENTS | | |
| ACTIVELLA (<i>mimvey lo</i>) | T3 | HD |
| ACTIVELLA (<i>mimvey</i>) | T3 | HD |
| ALORA | T3 | QL (16 patches/28 days) HD |
| CLIMARA (<i>estradiol (once weekly)</i>) | T3 | HD |
| CLIMARA PRO | T3 | HD |
| COMBIPATCH | T3 | |
| DELESTROGEN (<i>estradiol valerate</i>) | T3 | PA HD |
| DEPO-ESTRADOL | T3 | HD |
| DIVIGEL | T2 | HD |
| ELESTRIN | T3 | HD |
| ESTRACE (<i>estradiol</i>) | T3 | HD |
| <i>estradiol</i> (Climara) | T1 | HD |
| <i>estradiol</i> (Vivelle-dot) | T1 | QL (8 PATCHES/21 DAYS) HD |
| <i>estradiol</i> (Vivelle-dot) | T1 | QL (16 patches/28 days) HD |
| <i>estradiol 0.06% 1.25g gel pump</i> | T1 | HD |
| <i>estradiol 0.5 mg tablet</i> (Estrace) | T1 | HD |
| <i>estradiol 1 mg tablet</i> (Estrace) | T1 | HD |
| <i>estradiol 2 mg tablet</i> (Estrace) | T1 | HD |
| <i>estradiol valerate</i> (Delestrogen) | T1 | HD |
| <i>estradiol/norethindrone acet</i> (Activella) | T1 | HD |
| ESTROGEL (<i>estradiol</i>) | T3 | PA HD |
| EVAMIST | T3 | HD |
| FEMHRT (<i>norethindron-ethinyl estradiol</i>) | T3 | HD |
| MENEST | T3 | HD |
| MENOSTAR | T3 | QL (8 patches/28 days) HD |
| MINIVELLE (<i>lyllana</i>) | T3 | QL (16 patches/28 days) HD |
| <i>norethind-eth estrad 0.5-2.5</i> (Femhrt) | T1 | HD |
| <i>norethindrone ac-eth estradiol</i> | T1 | HD |
| <i>norethindrone ac-eth estradiol</i> (Femhrt) | T1 | HD |
| <i>norethin-eth estrad 1 mg-5 mcg</i> | T1 | HD |
| PREMARIN | T2 | HD |

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

T4 – Injectable Specialty Medications

PA – Prior Authorization

QL – Quantity Limit

ST – Step Therapy

AGE – Age Requirement

SP – Specialty Medication

HD – May require home delivery pharmacy

PPACA – No Cost-Share Preventive Medication

CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

HORMONES (Hormonal Agents) (cont.)

| Prescription Drug Name | Drug Tier | Coverage Requirements and Limits |
|---|-----------|----------------------------------|
| ESTROGENIC AGENTS (cont) | | |
| PREMPHASE | T2 | HD |
| PREMPRO | T2 | HD |
| VIVELLE-DOT (<i>lyllana</i>) | T3 | QL (16 patches/28 days) HD |
| ESTROGEN-PROGESTIN WITH ANTI-MINERALOCORTICOID COMB | | |
| ANGELIQ | T3 | HD |
| ESTROGEN-SELECTIVE ESTROGEN RECEPTOR MOD (SERM) COMB | | |
| DUAVEE | T2 | |
| GLUCOCORTICOIDS | | |
| AGAMREE | T3 | PA QL(10 mls/day) SP |
| ALKINDI SPRINKLE | T3 | PA |
| <i>budesonide</i> (Entocort Ec) | T1 | |
| <i>budesonide</i> (Uceris) | T1 | PA QL (56 tabs/180 days) |
| CORTEF (<i>hydrocortisone</i>) | T3 | PA |
| <i>cortisone acetate</i> | T1 | |
| <i>deflazacort</i> (Emflaza) | T1 | PA SP HD |
| <i>dexamethasone</i> (Dxovo) | T1 | |
| <i>dexamethasone</i> (Taperdex) | T1 | PA |
| <i>dexamethasone</i> 0.5 mg tablet | T1 | |
| <i>dexamethasone</i> 0.5 mg/5 ml elx | T1 | |
| <i>dexamethasone</i> 0.5 mg/5 ml liq | T1 | |
| <i>dexamethasone</i> 0.75 mg tablet | T1 | |
| <i>dexamethasone</i> 1 mg tablet | T1 | |
| <i>dexamethasone</i> 1.5 mg tablet | T1 | |
| <i>dexamethasone</i> 10 day 1.5 mg tb | T1 | PA |
| <i>dexamethasone</i> 13 day 1.5 mg tb | T1 | PA |
| <i>dexamethasone</i> 2 mg tablet | T1 | |
| <i>dexamethasone</i> 4 mg tablet | T1 | |
| <i>dexamethasone</i> 6 day 1.5 mg tab (Taperdex) | T1 | PA |
| <i>dexamethasone</i> 6 mg tablet | T1 | |
| DXEO | T3 | |
| EMFLAZA | T3 | PA SP HD |
| ENTOCORT EC (<i>budesonide ec</i>) | T3 | |
| EOHILIA | T3 | PA QL(1800 mls/180 days) |
| HEMADY | T3 | |

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

T4 – Injectable Specialty Medications

PA – Prior Authorization

QL – Quantity Limit

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AGE – Age Requirement

SP – Specialty Medication

HD – May require home delivery pharmacy

PPACA – No Cost-Share Preventive Medication

CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

HORMONES (Hormonal Agents) (cont.)

| Prescription Drug Name | Drug Tier | Coverage Requirements and Limits |
|--|-----------|----------------------------------|
| GLUCOCORTICOIDS (cont.) | | |
| hydrocortisone (Cortef) | T1 | |
| LOCORT | T1 | |
| MEDROL 16 MG TABLET (<i>methylprednisolone</i>) | T3 | |
| MEDROL 2 MG TABLET | T2 | |
| MEDROL 32 MG TABLET (<i>methylprednisolone</i>) | T3 | |
| MEDROL 4 MG DOSEPAK (<i>methylprednisolone</i>) | T3 | |
| MEDROL 4 MG TABLET (<i>methylprednisolone</i>) | T3 | |
| MEDROL 8 MG TABLET (<i>methylprednisolone</i>) | T3 | |
| <i>methylprednisolone</i> (Medrol) | T1 | |
| MILLIPRED 10 MG/5 ML SOLUTION (<i>prednisolone sodium phosphate</i>) | T3 | |
| <i>millipred</i> 5 mg tablet | T1 | |
| ORAPRED ODT (<i>prednisolone sodium phos odt</i>) | T3 | |
| <i>prednisolone</i> | T1 | |
| <i>prednisolone sodium phosphate</i> | T1 | |
| <i>prednisolone sodium phosphate</i> (Millipred) | T1 | |
| <i>prednisolone sodium phosphate</i> (Orapred Odt) | T1 | |
| <i>prednisone</i> | T1 | |
| RAYOS | T3 | PA |
| TAPERDEX | T1 | PA |
| TARPEYO | T3 | PA QL (4 caps/day) SP |
| UCERIS 9 MG ER TABLET (<i>budesonide er</i>) | T3 | PA QL (1 tab/day) |
| ZCORT | T3 | PA |
| ZONACORT | T3 | |

GROWTH HORMONE RELEASING HORMONE (GHRH) AND ANALOGS

| | | |
|------------|----|----------|
| EGRIFTA | T4 | PA SP HD |
| EGRIFTA SV | T4 | PA SP HD |

GROWTH HORMONES

| | | |
|---------------------|----|----------|
| GENOTROPIN | T4 | PA SP HD |
| HUMATROPE | T4 | PA SP HD |
| NGENLA | T3 | PA SP |
| NORDITROPIN FLEXPRO | T4 | PA SP HD |
| NUTROPIN AQ NUSPIN | T4 | PA SP HD |
| OMNITROPE | T4 | PA SP HD |
| SAIZEN-SAIZENPREP | T3 | PA HD |

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

T4 – Injectable Specialty Medications

PA – Prior Authorization

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HD – May require home delivery pharmacy

PPACA – No Cost-Share Preventive Medication

CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

| HORMONES (Hormonal Agents) (cont.) | | |
|---|-----------|----------------------------------|
| Prescription Drug Name | Drug Tier | Coverage Requirements and Limits |
| GROWTH HORMONES (cont.) | | |
| SAIZEN-SAIZENPREP | T4 | PA SP HD |
| SEROSTIM | T4 | PA SP HD |
| SKYTROFA | T4 | PA SP HD |
| SOGROYA | T3 | PA SP HD |
| ZOMACTON | T4 | PA SP HD |
| INSULIN-LIKE GROWTH FACTOR-I (IGF-I) HORMONES | | |
| INCRELEX | T4 | PA SP HD |
| LHRH (GNRH) AGONIST ANALOG AND PROGESTIN COMB | | |
| LUPANETA PACK | T3 | PA SP HD |
| LHRH (GNRH) AGONIST ANALOG PITUITARY SUPPRESSANTS | | |
| LUPRON DEPOT | T2 | PA SP HD |
| 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 | T2 | PA SP |
| <i>ganirelix acet 250 mcg/0.5 ml (Ganirelix Acetate)</i> | T1 | PA SP |
| GANIRELIX ACET 250 MCG/0.5 ML (<i>ganirelix acetate</i>) | T2 | PA SP |
| ORILISSA 150 MG TABLET | T2 | PA QL (1 tab/day) |
| ORILISSA 200 MG TABLET | T2 | PA QL (2 tabs/day) |
| LHRH (GNRH) AGNST PIT.SUP-CENTRAL PRECOCIOUS PUBERTY | | |
| FENSOLVI | T3 | PA SP |
| LUPRON DEPOT-PED | T2 | PA SP HD |
| MINERALOCORTICOIDS | | |
| <i>fludrocortisone acetate</i> | T1 | HD |
| OXYTOCICS | | |
| CERVIDIL | T3 | |
| <i>methylergonovine maleate</i> | T1 | |
| PREPIDIL | T3 | |
| PROSTIN E2 VAGINAL SUPPOSITORY | T3 | |
| PITUITARY SUPPRESSIVE AGENTS | | |
| <i>cabergoline</i> | T1 | QL (16 tabs/28 days) HD |
| <i>danazol</i> | T1 | HD |

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

T4 – Injectable Specialty Medications

PA – Prior Authorization

QL – Quantity Limit

ST – Step Therapy

AGE – Age Requirement

SP – Specialty Medication

HD – May require home delivery pharmacy

PPACA – No Cost-Share Preventive Medication

CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

HORMONES (Hormonal Agents) (cont.)

| Prescription Drug Name | Drug Tier | Coverage Requirements and Limits |
|---|-----------|----------------------------------|
| PROGESTATIONAL AGENTS | | |
| AYGESTIN (<i>norethindrone acetate</i>) | T3 | HD |
| CRINONE 4% GEL | T2 | PA HD |
| DEPO-PROVERA 400 MG/ML VIAL | T3 | 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> | T1 | HD |
| <i>progesterone, micronized</i> (Prometrium) | T1 | HD |
| PROMETRIUM (<i>progesterone</i>) | T3 | PA HD |
| PROVERA (<i>medroxyprogesterone acetate</i>) | T3 | PA HD |
| SOMATOSTATIC AGENTS | | |
| Ianreotide | T4 | PA SP HD |
| LANREOTIDE | T4 | PA SP HD |
| MYCAPSSA | T3 | PA QL (4 caps/day) SP |
| <i>octreotide acetate</i> | T1 | PA SP HD |
| <i>octreotide acetate</i> (Sandostatin) | T4 | PA SP HD |
| SANDOSTATIN (<i>octreotide acetate</i>) | T3 | PA SP HD |
| SANDOSTATIN LAR DEPOT | T2 | PA SP |
| SIGNIFOR | T4 | PA SP |
| SOMATULINE DEPOT | T2 | 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 |
| VAGINAL ESTROGEN PREPARATIONS | | |
| ESTRACE (<i>estradiol</i>) | T3 | HD |
| <i>estradiol</i> (Vagifem) | T1 | QL (36 tabs/28 days) |
| <i>estradiol 0.01% cream</i> (Estrace) | T1 | HD |
| ESTRING | T3 | QL (2 rings/90 days) HD |
| FEMRING | T3 | HD |
| PREMARIN | T2 | HD |
| VAGIFEM (<i>yuvafem</i>) | T3 | QL (36 tabs/28 days) HD |

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

T4 – Injectable Specialty Medications

PA – Prior Authorization

QL – Quantity Limit

ST – Step Therapy

AGE – Age Requirement

SP – Specialty Medication

HD – May require home delivery pharmacy

PPACA – No Cost-Share Preventive Medication

CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

| HORMONES (Infertility) | | |
|---|-----------|----------------------------------|
| Prescription Drug Name | Drug Tier | Coverage Requirements and Limits |
| FERTILITY STIMULATING PREPARATIONS, NON-FSH | | |
| <i>clomiphene citrate</i> | T1 | |
| FOLLICLE-STIMULATING AND LUTEINIZING HORMONES | | |
| MENOPUR | T2 | PA SP |
| FOLLICLE-STIMULATING HORMONE (FSH) | | |
| FOLLISTIM AQ | T2 | PA SP |
| GONAL-F | T2 | PA SP |
| GONAL-F RFF | T2 | PA SP |
| GONAL-F RFF REDI-JECT | T2 | PA SP |
| HUMAN CHORIONIC GONADOTROPIN (HCG) | | |
| CHORIONIC GONAD 10,000 UNIT VL | T3 | PA SP |
| CHORIONIC GONAD 12,000 UNIT VL | T1 | SP |
| CHORIONIC GONAD 6,000 UNIT VL | T1 | SP |
| NOVAREL | T2 | PA SP |
| OVIDREL | T2 | PA SP |
| PREGNYL | T2 | PA SP |
| PREGNANCY FACILITATING/MAINTAINING AGENT, HORMONAL | | |
| CRINONE 8% GEL | T3 | PA |
| ENDOMETRIN | T3 | |
| HORMONES (Miscellaneous) | | |
| LEPTIN HORMONE ANALOGS | | |
| MYALEPT | T4 | PA SP HD |
| HORMONES (Osteoporosis Products) | | |
| BONE FORMATION STIMULATING AGTS - PTH REL PEPTIDES | | |
| TYMLOS | T3 | PA QL(1 PEN/30 DAYS) SP HD |
| BONE RESORPTION INHIBITORS | | |
| <i>calcitonin, salmon, synthetic</i> | T1 | HD |
| MIACALCIN | T2 | HD |
| RECLAST 5 MG/100 ML SOLUTION | T3 | |
| IMMUNOSUPPRESSANTS (Pain Relief And Inflammatory Disease) | | |
| INTERLEUKIN-4(IL-4) RECEPTOR ALPHA ANTAGONIST, MAB | | |
| DUPIXENT PEN | T4 | PA SP HD |
| DUPIXENT SYRINGE | T4 | PA SP HD |

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

T4 – Injectable Specialty Medications

PA – Prior Authorization

QL – Quantity Limit

ST – Step Therapy

AGE – Age Requirement

SP – Specialty Medication

HD – May require home delivery pharmacy

PPACA – No Cost-Share Preventive Medication

CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

| IMMUNOSUPPRESSANTS (Pain Relief And Inflammatory Disease) (cont.) | | | |
|---|---------------------------------------|----------------------------------|---|
| Prescription Drug Name | Drug Tier | Coverage Requirements and Limits | |
| INTERLEUKIN-6 (IL-6) RECEPTOR INHIBITORS | | | |
| ACTEMRA | T4 | PA QL (4 syringes/28 days) | SP HD |
| ACTEMRA ACTPEN | T4 | PA QL (4 pens/28 days) | SP HD |
| ENSPRYNG | T4 | PA SP HD | |
| KEVZARA 150 MG/1.14 ML PEN INJ | T4 | PA QL (2 pens/28 days) | SP HD |
| KEVZARA 150 MG/1.14 ML SYRINGE | T4 | PA QL (2 syringes/28 days) | SP HD |
| KEVZARA 200 MG/1.14 ML PEN INJ | T4 | PA QL (2 pens/28 days) | SP HD |
| KEVZARA 200 MG/1.14 ML SYRINGE | T4 | PA QL (2 syringes/28 days) | SP HD |
| TYENNE | T4 | PA QL(3.6 ml/28 days) | SP |
| IL-23 RECEPTOR ANTAGONIST, MONOCLONAL ANTIBODY | | | |
| OMVOH 100 MG/ML PEN | T4 | PA QL(2 pens/28 days) | SP HD |
| OMVOH 100 MG/ML SYRINGE | T4 | PA QL(2 syringes/28 days) | SP HD |
| OMVOH 300 MG DOSE - 2 PENS | T4 | PA QL(3 mls/28 days) | SP HD |
| TREMFYA 100 MG/ML PEN | T4 | PA QL(1 ml/56 days) | SP HD |
| TREMFYA 200 MG/2 ML PEN | T4 | PA QL(2 syringe/28 days) | SP HD |
| TREMFYA PEN INDUCTION PK-CROHN | T4 | PA QL(12 mls/365 days) | SP HD |
| MONOCLONAL ANTIBODY-HUMAN INTERLEUKIN 12/23 INHIB | | | |
| STELARA 45 MG/0.5 ML SYRINGE | T4 | PA QL (1 syringe/84 days) | SP HD |
| STELARA 45 MG/0.5 ML VIAL | T4 | PA QL (1 vial/84 days) | SP HD |
| STELARA 90 MG/ML SYRINGE | T4 | PA QL (1 syringe/84 days) | SP HD |
| IMMUNOSUPPRESSANTS (Skin Conditions) | | | |
| TOPICAL IMMUNOSUPPRESSIVE AGENTS | | | |
| ELIDEL (<i>pimecrolimus</i>) | T3 | | |
| NUJO | T3 | | |
| OXIANUJI | T3 | | |
| <i>pimecrolimus</i> (Elidel) | T1 | | |
| <i>tacrolimus</i> 0.03% ointment | T1 | | |
| <i>tacrolimus</i> 0.1% ointment | T1 | | |
| IMMUNOSUPPRESSANTS (Transplant Medications) | | | |
| IMMUNOSUPPRESSIVES | | | |
| ASTAGRAF XL | T3 | SP | HD |
| AZASAN | T2 | SP | HD |
| <i>azathioprine</i> (Imuran) | T1 | PA | SP HD |
| CELLCEPT (<i>mycophenolate mofetil</i>) | T3 | PA | SP HD |
| <i>cyclosporine</i> (Sandimmune) | T1 | SP | HD |
| <i>cyclosporine</i> , modified | T1 | SP | HD |
| <i>cyclosporine</i> , modified (Neoral) | T1 | SP | HD |
| ENVARSUS XR | T3 | SP | HD |
| T1 – Typically Generics | T4 – Injectable Specialty Medications | ST – Step Therapy | HD – May require home delivery pharmacy |
| T2 – Typically Preferred Brands | PA – Prior Authorization | AGE – Age Requirement | PPACA – No Cost-Share Preventive Medication |
| T3 – Typically Non-Preferred Brands | QL – Quantity Limit | SP – Specialty Medication | CSL – Oral cancer medication subject to cost-share limits |

List of Prescription Medications

IMMUNOSUPPRESSANTS (Transplant Medications) (cont.)

| Prescription Drug Name | Drug Tier | Coverage Requirements and Limits |
|--|-----------|----------------------------------|
| IMMUNOSUPPRESSIVES (cont.) | | |
| everolimus 0.25, 0.5 mg, 0.75 mg tablet (Zortress) | T1 | SP HD |
| IMURAN (azathioprine) | T3 | PA SP HD |
| LUPKYNIS 7.9 MG CAPSULE | T3 | PA QL (6 caps/day) |
| mycophenolate mofetil (Cellcept) | T1 | SP HD |
| mycophenolate sodium (Myfortic) | T1 | SP HD |
| MYFORTIC (mycophenolic acid) | T3 | PA SP HD |
| MYHIBBIN | T3 | PA SP |
| NEORAL (gengraf) | T3 | PA SP HD |
| PROGRAF | T3 | SP HD |
| PROGRAF (tacrolimus) | T3 | SP HD |
| RAPAMUNE (sirolimus) | T3 | PA SP HD |
| SANDIMMUNE 100 MG CAPSULE (cyclosporine) | T3 | SP HD |
| SANDIMMUNE 100 MG/ML SOLN | T3 | SP HD |
| SANDIMMUNE 25 MG CAPSULE (cyclosporine) | T3 | SP HD |
| sirolimus (Rapamune) | T1 | SP HD |
| tacrolimus 0.5 mg capsule, 1 mg, 5 mg capsule (ir) (Prograf) | T1 | SP HD |
| ZORTRESS | T3 | SP HD |
| ZORTRESS (everolimus) | T3 | SP HD |

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

| DIABETIC SUPPLIES | | |
|-------------------------------|----|----------------------------|
| AGAMATRIX CONTROL SOLUTION | T1 | |
| AUTOLET LITE | T1 | |
| CARETOUCH CONTROL SOLUTION | T1 | |
| CEQUR SIMPLICITY | T2 | |
| CHOSEN LANCING DEVICE | T1 | |
| DEXCOM G6 RECEIVER | T2 | PA QL (1 syringe/365 days) |
| DEXCOM G6 SENSOR | T2 | PA QL (3/30 days) |
| DEXCOM G6 TRANSMITTER | T2 | PA QL (1 syringe/67 days) |
| DEXCOM G7 RECEIVER | T2 | PA QL (1 UNIT/365 DAYS) |
| DEXCOM G7 SENSOR | T2 | PA QL (3 sensors/30 days) |
| EASY TOUCH BLULINK CTRL SOLN | T1 | |
| EASY TRAK II CONTROL SOLUTION | T1 | |
| ENLITE SERTER | T1 | |
| FREESTYLE LIBRE 2 PLUS SENSOR | | |
| 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 3 READER | T2 | PA QL (1 unit/720 days) |

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

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

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

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

List of Prescription Medications

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

| Prescription Drug Name | Drug Tier | Coverage Requirements and Limits |
|---|-----------|----------------------------------|
| DIABETIC SUPPLIES (cont.) | | |
| FREESTYLE LIBRE 10 DAY READER | T2 | PA QL (1 reader/day) |
| FREESTYLE LIBRE 10 DAY SENSOR | T2 | PA QL (3/30 days) |
| FREESTYLE LIBRE 14 DAY READER | T2 | PA QL (1 reader/day) |
| FREESTYLE LIBRE 14 DAY SENSOR | T2 | PA QL (2/28 days) |
| FORA TN'GO ADVANCE MULTIFN MTR | T3 | |
| GLUCOCOM AUTOLINK | T1 | |
| GUARDIAN TRANSMITTER TAPE | T1 | |
| HUMAPEN LUXURA HD | T1 | |
| IHEALTH CONTROL SOLN LEVEL 2 | T1 | |
| INPEN (FOR HUMALOG) | T1 | |
| INPEN (FOR NOVOLOG OR FIASP) | T1 | |
| NOVOPEN ECHO | T1 | |
| MAGELLAN INSULIN SAFETY SYRNG | T1 | |
| MAGELLAN INSULIN SYRINGE | T1 | |
| MINIMED RESERVOIR | T1 | |
| OMNIPOD 5 G6-G7 INTRO KT(GEN5) | T2 | QL(1 unit/365 days) |
| OMNIPOD 5 G6-G7 PODS (GEN 5) | T2 | QL(30 crtgs/30 days) |
| OMNIPOD DASH 5 PACK POD | T2 | PA QL (6 boxes/30 days) |
| REPLACEMENT PEDIATRIC MONITOR | T1 | |
| SEN-SERTER | T1 | |
| V-GO 20 , V-GO 30, V-GO 40 | T2 | |
| 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 | |

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

T4 – Injectable Specialty Medications

PA – Prior Authorization

QL – Quantity Limit

ST – Step Therapy

AGE – Age Requirement

SP – Specialty Medication

HD – May require home delivery pharmacy

PPACA – No Cost-Share Preventive Medication

CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

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

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

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

T4 – Injectable Specialty Medications

PA – Prior Authorization

QL – Quantity Limit

ST – Step Therapy

AGE – Age Requirement

SP – Specialty Medication

HD – May require home delivery pharmacy

PPACA – No Cost-Share Preventive Medication

CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

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

| Prescription Drug Name | Drug Tier | Coverage Requirements and Limits |
|---|-----------|----------------------------------|
| DURABLE MEDICAL EQUIPMENT,MISC (GROUP I) (cont.) | | |
| 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 | |
| <i>lancets</i> | T1 | |
| LANCETS | T1 | |
| LANCETS THIN | T1 | |
| LANCETS ULTRA THIN | T1 | |
| LITE TOUCH | T1 | |
| MEDISENSE THIN LANCETS | T1 | |
| MEDLANCE PLUS | T1 | |
| MICRO THIN LANCET | T1 | |
| MICRO THIN LANCETS | T1 | |
| MICROLET | T1 | |
| MOBILE LANCETS | T1 | |
| MONOLET LANCETS | T1 | |
| MONOLET THIN LANCETS | T1 | |
| MYGLUCOHEALTH LANCETS | T1 | |
| NOVA SAFETY LANCETS | T1 | |
| NOVA SUREFLEX | T1 | |
| ON CALL LANCET | T1 | |
| ON CALL PLUS LANCET | T1 | |
| ONETOUCH DELICA PLUS LANCET | T1 | |
| ONETOUCH DELICA SAFETY LANCET | T1 | |
| ONETOUCH LANCETS | T1 | |
| ONETOUCH SURESOFT | T1 | |
| ONETOUCH ULTRASOFT 2 LANCET | T1 | |
| ON-THE-GO | T1 | |
| PERFECT POINT SAFETY LANCETS | T1 | |
| PIP LANCET | T1 | |
| PRESSURE ACTIVATED LANCETS | T1 | |
| PRO COMFORT LANCET | T1 | |
| PRO COMFORT LANCETS | 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 |
|---|-----------|----------------------------------|
| DURABLE MEDICAL EQUIPMENT,MISC (GROUP I) (cont.) | | |
| PRO COMFORT SAFETY LANCET | T1 | |
| PRODIGY LANCETS | T1 | |
| PRODIGY TWIST TOP LANCET | T1 | |
| PURE COMFORT LANCETS | T1 | |
| PURE COMFORT SAFETY LANCETS | T1 | |
| PUSH BUTTON SAFETY LANCETS | T1 | |
| READYLANCE SAFETY LANCETS | T1 | |
| RELIAMED | T1 | |
| RELIAMED SAFETY SEAL LANCETS | T1 | |
| RIGHTEST GL300 LANCETS | T1 | |
| SAFETY LANCETS | T1 | |
| SAFETY SEAL LANCETS | T1 | |
| SAFETY-LET | T1 | |
| SINGLE-LET | T1 | |
| SMART SENSE | T1 | |
| SMART SENSE LANCETS | T1 | |
| SMARTEST LANCET | T1 | |
| SOLUS V2 | T1 | |
| SOLUS V2 LANCETS | T1 | |
| STERILANCE TL | T1 | |
| STERILE LANCETS | T1 | |
| SUPER THIN LANCETS | T1 | |
| SURE COMFORT LANCETS | T1 | |
| SURE-LANCE | T1 | |
| SURE-TOUCH | T1 | |
| TECHLITE LANCETS | T1 | |
| TELCARE 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 | |

T1 – Typically Generics

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List of Prescription Medications

| MISCELLANEOUS MEDICAL SUPPLIES, DEVICES, NON-DRUG (Diabetes) (cont.) | | |
|--|-----------|----------------------------------|
| Prescription Drug Name | Drug Tier | Coverage Requirements and Limits |
| DURABLE MEDICAL EQUIPMENT,MISC (GROUP I) (cont.) | | |
| TRUEPLUS LANCET | T1 | |
| TRUEPLUS LANCETS | T1 | |
| TWIST LANCETS | T1 | |
| TWIST TOP LANCET | T1 | |
| ULTILET BASIC | T1 | |
| ULTILET CLASSIC | T1 | |
| ULTILET LANCETS | T1 | |
| ULTILET SAFETY | T1 | |
| ULTRA THIN LANCET | T1 | |
| ULTRA THIN LANCETS | T1 | |
| ULTRA-CARE LANCETS | T1 | |
| ULTRALANCE | T1 | |
| ULTRA-THIN II | T1 | |
| ULTRATLC LANCETS | T1 | |
| UNILET COMFORTOUCH | T1 | |
| UNILET EXCELITE | T1 | |
| UNILET EXCELITE II | T1 | |
| UNILET GP LANCET | T1 | |
| UNILET LANCET | T1 | |
| UNILET LANCETS | T1 | |
| UNISTIK 2 COMFORT | T1 | |
| UNISTIK 2 EXTRA | T1 | |
| UNISTIK 2 NORMAL | T1 | |
| UNISTIK 3 | T1 | |
| UNISTIK 3 COMFORT | T1 | |
| UNISTIK 3 DUAL | T1 | |
| UNISTIK 3 EXTRA | T1 | |
| UNISTIK 3 NORMAL | T1 | |
| UNISTIK COMFORT | T1 | |
| UNISTIK CZT | T1 | |
| UNISTIK EXTRA | T1 | |
| UNISTIK NORMAL | T1 | |

T1 – Typically Generics

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List of Prescription Medications

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

| Prescription Drug Name | Drug Tier | Coverage Requirements and Limits |
|---|-----------|----------------------------------|
| DURABLE MEDICAL EQUIPMENT,MISC (GROUP I) (cont.) | | |
| UNISTIK PRO | T1 | |
| UNISTIK SAFETY | T1 | |
| UNISTIK TOUCH | T1 | |
| UNIVERSAL 1 | T1 | |
| VERIFINE SAFETY LANCET MINI | T1 | |
| VERIFINE UNIVERSAL LANCET | T1 | |
| VIVAGUARD LANCET | T1 | |
| VIVAGUARD SAFETY LANCET | T1 | |
| UNISTIK 2 COMFORT | T1 | |
| UNISTIK 2 EXTRA | T1 | |
| UNISTIK 2 NORMAL | T1 | |
| UNISTIK 3 COMFORT | T1 | |
| UNISTIK 3 DUAL | T1 | |
| NEEDLES/NEEDLELESS DEVICES | | |
| 1ST TIER UNIFINE PENTIPS | T1 | PA |
| 1ST TIER UNIFINE PENTIPS PLUS | T1 | PA |
| ABOUTTIME PEN NEEDLE | T1 | PA |
| ADVOCATE PEN NEEDLE | T1 | PA |
| ADVOCATE PEN NEEDLES | T1 | PA |
| AQINJECT PEN NEEDLE | T1 | PA |
| ASSURE ID DUO PRO SFTY PEN NDL | T1 | PA |
| ASSURE ID PEN NEEDLE | T1 | PA |
| ASSURE ID PRO PEN NEEDLE | T1 | PA |
| CAREFINE PEN NEEDLE | T1 | PA |
| CAREPOINT PRECISION NEEDLE | T1 | |
| CARETOUCH PEN NEEDLE | T1 | PA |
| CLICKFINE | T1 | PA |
| COMFORT EZ PEN NEEDLE | T1 | PA |
| COMFORT EZ PRO SAFETY PEN NDL | T1 | PA |
| COMFORT TOUCH PEN NEEDLE | T1 | PA |

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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.) | | |
| DROPLET MICRON PEN NEEDLE | T1 | PA |
| DROPLET PEN NEEDLE | T1 | PA |
| DROPSAFE PEN NEEDLE | T1 | PA |
| DROPSAFE SICURA SAFETY NEEDLE | T1 | |
| EASY COMFORT PEN NEEDLE | T1 | PA |
| EASY COMFORT PEN NEEDLES | T1 | PA |
| EASY COMFORT SAFETY PEN NEEDLE | T1 | PA |
| EASY GLIDE PEN NEEDLE | T1 | PA |
| EASY TOUCH PEN NEEDLE | T1 | PA |
| EASY TOUCH SAFETY PEN NEEDLE | T1 | PA |
| EMBRACE PEN NEEDLE | T1 | PA |
| HEALTHWISE PEN NEEDLE | T1 | PA |
| HEALTHY ACCENTS UNIFINE PENTIP | T1 | PA |
| INCONTROL PEN NEEDLE | T1 | PA |
| INSULIN PEN NEEDLE | T1 | PA |
| INSUPEN | T1 | PA |
| INSUPEN PEN NEEDLE | T1 | PA |
| LITE TOUCH 31GX1/4" PEN NEEDLE | T1 | PA |
| LITE TOUCH PEN NEEDLE 29G | T1 | PA |
| LITE TOUCH PEN NEEDLE 31G | T1 | PA |
| MAXICOMFORT II PEN NEEDLE | T1 | PA |
| MAXICOMFORT SAFETY PEN NEEDLE | T1 | PA |
| MINI PEN NEEDLE | T1 | PA |
| MINI ULTRA-THIN II | T1 | PA |
| NEEDLES | T1 | |
| NOVOFINE 32 | T1 | PA |
| NOVOFINE AUTOCOVER | T1 | PA |
| NOVOFINE PLUS | T1 | PA |
| NOVOTWIST | T1 | PA |
| PEN NEEDLE | T1 | PA |
| PEN NEEDLES | T1 | PA |
| PENTIPS | T1 | PA |
| PERFECT POINT SAFETY NEEDLE | T1 | |
| PIP PEN NEEDLE | T1 | PA |
| PRECISIONGLIDE 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.) | | |
| PREVENT DROPSAFE PEN NEEDLE | T1 | PA |
| PRO COMFORT PEN NEEDLE | T1 | PA |
| PURE COMFORT PEN NEEDLE | T1 | PA |
| PURE COMFORT SAFETY PEN NEEDLE | T1 | PA |
| RAYA SURE PEN NEEDLE | T1 | PA |
| SAFETY PEN NEEDLE | T1 | PA |
| SECURESAFE PEN NEEDLE | T1 | PA |
| SKY SAFETY PEN NEEDLE | T1 | PA |
| SURE COMFORT PEN NEEDLE | T1 | PA |
| SURE COMFORT SAFETY PEN NEEDLE | T1 | PA |
| SURE-FINE PEN NEEDLES | T1 | PA |
| TECHLITE PEN NEEDLE | T1 | PA |
| TOPCARE CLICKFINE | T1 | PA |
| TRUE COMFORT PEN NEEDLE | T1 | PA |
| TRUE COMFORT PRO PEN NEEDLE | T1 | PA |
| TRUE COMFORT SAFETY PEN NEEDLE | T1 | PA |
| TRUEPLUS PEN NEEDLE | T1 | PA |
| ULTICARE PEN NEEDLE | T1 | PA |
| ULTICARE SAFETY PEN NEEDLE | T1 | PA |
| ULTIGUARD SAFEPACK-PEN NEEDLE | T1 | PA |
| ULTILET PEN NEEDLE | T1 | PA |
| ULTRA FLO PEN NEEDLE | T1 | PA |
| ULTRA THIN | T1 | PA |
| ULTRACARE PEN NEEDLE | T1 | PA |
| ULTRA-THIN II PEN NDL | T1 | PA |
| UNIFINE PEN NEEDLE | T1 | PA |
| UNIFINE PENTIPS | T1 | PA |
| UNIFINE PENTIPS MAXFLOW | T1 | PA |
| UNIFINE PENTIPS PLUS | T1 | PA |
| UNIFINE PENTIPS PLUS MAXFLOW | T1 | PA |
| UNIFINE PROTECT | T1 | PA |

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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.) | | |
| UNIFINE ULTRA PEN NEEDLE | T1 | PA |
| VERIFINE PLUS PEN NEEDLE | T1 | PA |
| VERIFINE PLUS PEN NEEDLE-SHARP | T1 | PA |
| SYRINGES AND ACCESSORIES | | |
| LITE TOUCH INSULIN 0.5 ML SYR | T1 | |
| LITE TOUCH INSULIN 1 ML SYR | T1 | |
| LITE TOUCH INSULIN SYR 0.3 ML | T1 | |
| LITE TOUCH INSULIN SYR 0.5 ML | T1 | |
| LITE TOUCH INSULIN SYR 1 ML | T1 | |
| SURE COMFORT 0.3 ML SYRINGE | T1 | |
| SURE COMFORT 0.5 ML SYRINGE | T1 | |
| SURE COMFORT 1 ML SYRINGE | T1 | |
| SURE COMFORT 3/10 ML SYRINGE | T1 | |
| TRUE COMFORT SAFE INSULIN SYRG | T1 | |
| ULTRA-THIN II 1 ML 31GX5/16" | T1 | |
| ULTRA-THIN II INS 0.3 ML 30G | T1 | |
| ULTRA-THIN II INS 0.3 ML 31G | T1 | |
| ULTRA-THIN II INS 0.5 ML 29G | T1 | |
| ULTRA-THIN II INS 0.5 ML 30G | T1 | |
| ULTRA-THIN II INS 0.5 ML 31G | T1 | |
| ULTRA-THIN II INS SYR 1 ML 29G | T1 | |
| ULTRA-THIN II INS SYR 1 ML 30G | T1 | |

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

| | | |
|---|----|-----------------------|
| RESPIRATORY AIDS, DEVICES, EQUIPMENT | | |
| ACE AEROSOL CLOUD ENHANCER | T2 | QL (1 unit/year) |
| AEROCHAMBER MECHANICAL VENT | T2 | QL(1 spacer/365 days) |
| 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) |

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T4 – Injectable Specialty Medications

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List of Prescription Medications

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

| Prescription Drug Name | Drug Tier | Coverage Requirements and Limits |
|---|-----------|----------------------------------|
| RESPIRATORY AIDS, DEVICES, EQUIPMENT (cont.) | | |
| BREATHERITE SPACER-INFANT MASK | T2 | QL (1 unit/year) |
| BREATHERITE SPACER-LARGE MASK | T2 | QL (1 mask/365 days) |
| BREATHERITE SPACER-LG CHLD MSK | T2 | QL (1 unit/year) |
| BREATHERITE SPACER-MEDIUM MASK | T2 | QL (1 mask/365 days) |
| BREATHERITE SPACER-NEONATE MSK | T2 | QL (1 unit/year) |
| BREATHERITE SPACER-SM CHLD MSK | T2 | QL (1 unit/year) |
| BREATHERITE SPACER-SMALL MASK | T2 | QL (1 mask/365 days) |
| BREATHRITE | T2 | QL (1 unit/year) |
| CLEVER CHOICE HOLDING CHAMBER | T2 | QL (1 unit/year) |
| COMFORTSEAL | T2 | QL |
| 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 | T2 | QL (1 unit/year) |
| SPACE CHAMBER-LARGE MASK | T2 | QL (1 unit/year) |
| SPACE CHAMBER-MEDIUM MASK | T2 | QL (1 unit/year) |
| SPACE CHAMBER-SMALL MASK | T2 | QL (1 unit/year) |

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List of Prescription Medications

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

| Prescription Drug Name | Drug Tier | Coverage Requirements and Limits |
|--|-----------|----------------------------------|
| RESPIRATORY AIDS, DEVICES, EQUIPMENT (cont.) | | |
| VORTEX | T2 | QL (1 unit/year) |
| VORTEX HOLDING CHAMBER-CHILD | T2 | QL (1 unit/year) |
| VORTEX HOLDING CHAMBER-TODDLER | T2 | QL (1 unit/year) |
| VORTEX VHC FROG MASK | T2 | QL (1 unit/year) |
| VORTEX VHC LADYBUG MASK | T2 | QL (1 unit/year) |
| MUSCLE RELAXANTS (Pain Relief And Inflammatory Disease) | | |
| SKELETAL MUSCLE RELAXANTS | | |
| AMRIX ER 15 MG CAPSULE (<i>cyclobenzaprine hcl er</i>) | T3 | PA QL (1 cap/day) |
| AMRIX ER 30 MG CAPSULE (<i>cyclobenzaprine hcl er</i>) | T3 | PA |
| <i>baclofen</i> | T1 | HD |
| <i>baclofen 25 mg/5 ml suspension (Fleqsuvy)</i> | T1 | PA HD |
| BACLOFEN 5 MG/5 ML SOLUTION | T3 | PA HD |
| BACLOFEN 10 MG/5 ML SOLUTION | T3 | PA HD |
| BACLOFEN 15 MG TABLET | T1 | PA HD |
| <i>carisoprodol (Soma)</i> | T1 | |
| <i>carisoprodol/aspirin</i> | T1 | |
| <i>chlorzoxazone 250 mg tablet</i> | T1 | PA |
| <i>chlorzoxazone 500 mg tablet</i> | T1 | |
| <i>chlorzoxazone 250 mg, 375 mg, 750 mg tablet (Lorzone)</i> | T1 | PA |
| <i>cyclobenzaprine er 15 mg cap (Amrix)</i> | T1 | PA QL (1 cap/day) |
| <i>cyclobenzaprine er 30 mg cap (Amrix)</i> | T1 | PA |
| <i>cyclobenzaprine hcl</i> | T1 | |
| <i>cyclobenzaprine hcl (Fexmid)</i> | T1 | |
| DANTRIUM (<i>dantrolene sodium</i>) | T3 | |
| <i>dantrolene sodium</i> | T1 | |
| <i>dantrolene sodium (Dantrium)</i> | T1 | |
| FEXMID (<i>cyclobenzaprine hcl</i>) | T3 | |
| FLEQSUVY (<i>baclofen</i>) | T3 | PA HD |
| LORZONE (<i>chlorzoxazone</i>) | T3 | PA |
| LYVISPANH | T3 | PA |
| <i>metaxalone (Skelaxin)</i> | T1 | |
| <i>methocarbamol</i> | T1 | |

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List of Prescription Medications

MUSCLE RELAXANTS (Pain Relief And Inflammatory Disease) (cont.)

| Prescription Drug Name | Drug Tier | Coverage Requirements and Limits |
|---|-----------|----------------------------------|
| SKELETAL MUSCLE RELAXANTS (cont.) | | |
| <i>methocarbamol</i> (Robaxin-750) | T1 | |
| NORGESIC FORTE | T3 | PA |
| <i>orphenadrine citrate</i> | T1 | |
| <i>orphenadrine/aspirin/caffeine</i> (Norgesic Forte) | T1 | PA |
| OZOBAX | T3 | PA HD |
| OZOBAX DS | T3 | PA HD |
| ROBAXIN-750 (<i>methocarbamol</i>) | T3 | |
| SKELAXIN (<i>metaxalone</i>) | T3 | |
| SOMA (<i>carisoprodol</i>) | T3 | PA |
| <i>tizanidine hcl</i> (Zanaflex) | T1 | PA |
| ZANAFLEX (<i>tizanidine hcl</i>) | T3 | |

PRE-NATAL VITAMINS (Nutritional/Dietary)

| PRENATAL VITAMIN PREPARATIONS | |
|--|----|
| ATABEX EC | T2 |
| CITRANATAL 90 DHA | T2 |
| CITRANATAL ASSURE | T2 |
| CITRANATAL DHA | T2 |
| CITRANATAL HARMONY | T2 |
| CITRANATAL RX | T2 |
| OBSTETRIX EC | T2 |
| OBTREX DHA | T2 |
| <i>pnv 22/iron, gluc/folic/dss/dha</i> | T1 |
| <i>pnv 66/iron/folic/docusate/dha</i> | T1 |
| <i>pnv 69/iron/folic/docusate/dha</i> | T1 |
| <i>pnv 80/iron fum/folic/dss/dha</i> | T1 |
| <i>pnv no.154/iron fum/folic acid</i> | |
| <i>pnv/ferrous fum/docusate/folic</i> | T1 |
| <i>pnv/iron, carb/docusat/folic ac</i> | T1 |
| <i>prenatal 12/iron/folic/dss/om3</i> (Obtrex Dha) | T1 |
| PRENATAL 19 | T1 |
| <i>prenatal 12/iron/folic/dss/om3</i> | T1 |
| <i>prenatal 34/iron/folic/dss/dha</i> | T1 |
| <i>prenatal vits15/iron/folic/dss</i> | T1 |
| VITAFOL FE+ | T2 |

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

T4 – Injectable Specialty Medications

PA – Prior Authorization

QL – Quantity Limit

ST – Step Therapy

AGE – Age Requirement

SP – Specialty Medication

HD – May require home delivery pharmacy

PPACA – No Cost-Share Preventive Medication

CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

| PSYCHOTHERAPEUTIC DRUGS (Anxiety/Depression/Bipolar Disorder) ⁸ | | |
|--|-----------|----------------------------------|
| Prescription Drug Name | Drug Tier | Coverage Requirements and Limits |
| ALPHA-2 RECEPTOR ANTAGONIST ANTI-DEPRESSANTS | | |
| mirtazapine | T1 | HD |
| mirtazapine (Remeron) | T1 | HD |
| QELBREE | T3 | PA QL |
| QELBREE ER | T3 | PA QL(2 caps/day) HD |
| REMERON (mirtazapine) | T3 | PA HD |
| ANTI-ANXIETY - BENZODIAZEPINES | | |
| alprazolam (Xanax Xr) | T1 | |
| alprazolam (Xanax) | T1 | |
| ATIVAN (lorazepam) | T3 | PA |
| chlordiazepoxide hcl | T1 | |
| clorazepate dipotassium | T1 | |
| clorazepate dipotassium (Tranxene T-tab) | T1 | |
| diazepam tablet (Valium) | T1 | |
| diazepam 5 mg/5 ml solution | T1 | |
| diazepam 5 mg/ml oral conc | T1 | |
| lorazepam | T1 | |
| lorazepam (Ativan) | T1 | |
| LOREEV XR | T3 | PA QL (30 tabs/30 days) SP |
| oxazepam | T1 | |
| TRANXENET-TAB (clorazepate dipotassium) | T3 | PA |
| VALIUM (diazepam) | T3 | PA |
| XANAX (alprazolam) | T3 | PA |
| XANAX XR (alprazolam xr) | T3 | PA |
| ANTI-ANXIETY DRUGS | | |
| buspirone hcl 10 mg tablet | T1 | HD |
| buspirone hcl 15 mg tablet | T1 | |
| buspirone hcl 15 mg tablet | T1 | HD |
| buspirone hcl 30 mg tablet | T1 | HD |
| buspirone hcl 5 mg tablet | T1 | HD |
| buspirone hcl 7.5 mg tablet | T1 | HD |
| meprobamate | T1 | |
| 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 |

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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 |
| ANTIDEPRESSANT- POSTPARTUM DEPRESSION (PPD) (cont.) | | |
| ZURZUVAE 30 MG CAPSULE | T3 | PA QL(14 caps/270 days) SP HD |
| BIPOLAR DISORDER DRUGS | | |
| EQUETRO | T3 | HD |
| <i>lithium carbonate</i> | T1 | HD |
| <i>lithium carbonate</i> (Lithobid) | T1 | HD |
| <i>lithium citrate</i> | T1 | HD |
| LITHOBID (<i>lithium carbonate er</i>) | T3 | PA HD |
| MAOIS -NON-SELECTIVE, IRREVERSIBLE ANTI-DEPRESSANTS | | |
| MARPLAN | T3 | QL (12 tabs/day) |
| NARDIL (<i>phenelzine sulfate</i>) | T3 | PA |
| PARNATE (<i>tranylcypromine sulfate</i>) | T3 | PA |
| <i>phenelzine sulfate</i> (Nardil) | T1 | |
| <i>tranylcypromine sulfate</i> (Parnate) | 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) |
| NDMA RECEPTOR ANTAGONIST AND NDRI COMB | | |
| AUVELITY | T3 | PA QL(60 tabs/30 days) |
| NOREPINEPHRINE AND DOPAMINE REUPTAKE INHIB (NDRIs) | | |
| APLENZIN ER 174 MG TABLET | T3 | PA QL (3 tabs/day) HD |
| APLENZIN ER 348 MG TABLET | T3 | PA QL (1 tab/day) HD |
| APLENZIN ER 522 MG TABLET | T3 | PA QL (1 tab/day) HD |
| <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> (Wellbutrin XI) | T1 | QL (3 tabs/day) HD |
| <i>bupropion hcl xl 300 mg tablet</i> (Wellbutrin XI) | T1 | QL (1 tab/day) HD |
| BUPROPION HCL XL 450 MG TABLET | T3 | PA QL (1 tab/day) HD |
| FORFIVO XL | T3 | PA QL (1 tab/day) HD |
| WELLBUTRIN SR 100 MG TABLET (<i>bupropion hcl sr</i>) | T3 | PA QL (4 tabs/day) |
| WELLBUTRIN SR 150 MG TABLET (<i>bupropion hcl sr</i>) | T3 | PA QL (2 tabs/day) |

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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 |
|---|-----------|----------------------------------|
| NOREPINEPHRINE AND DOPAMINE REUPTAKE INHIB (NDRIs) (cont.) | | |
| WELLBUTRIN SR 200 MG TABLET (<i>bupropion hcl sr</i>) | T3 | PA QL (2 tabs/day) |
| WELLBUTRIN XL 150 MG TABLET (<i>bupropion xl</i>) | T3 | PA QL (3 tabs/day) |
| WELLBUTRIN XL 300 MG TABLET (<i>bupropion xl</i>) | T3 | PA QL (1 tab/day) |
| SELECTIVE SEROTONIN 5-HT2A INVERSE AGONISTS (SSIAs) | | |
| NUPLAZID | T3 | PA SP HD |
| SELECTIVE SEROTONIN REUPTAKE INHIBITOR (SSRIs) | | |
| CELEXA 10 MG TABLET (<i>citalopram hbr</i>) | T3 | PA QL (6 tabs/day) HD |
| CELEXA 20 MG TABLET (<i>citalopram hbr</i>) | T3 | PA QL (3 tabs/day) HD |
| CELEXA 40 MG TABLET (<i>citalopram hbr</i>) | T3 | PA QL (1 tab/day) HD |
| <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> (Lexapro) | T1 | QL (2 tabs/day) HD |
| <i>escitalopram 20 mg tablet</i> (Lexapro) | T1 | QL (1 tab/day) HD |
| <i>escitalopram 5 mg tablet</i> (Lexapro) | T1 | QL (4 tabs/day) HD |
| <i>escitalopram oxalate 5 mg/5 ml</i> | T1 | QL (20ml/day) HD |
| <i>fluoxetine 20 mg/5 ml solution</i> | T1 | QL (20ml/day) HD |
| <i>fluoxetine hcl</i> | T1 | QL (4 caps/28 days) HD |
| <i>fluoxetine hcl 10 mg capsule</i> (Prozac) | T1 | QL (8 caps/day) HD |
| <i>fluoxetine hcl 10 mg tablet</i> (Sarafem) | T1 | HD |
| <i>fluoxetine hcl 20 mg capsule</i> (Prozac) | T1 | QL (4 caps/day) HD |
| <i>fluoxetine hcl 20 mg tablet</i> | T1 | HD |
| <i>fluoxetine hcl 40 mg capsule</i> (Prozac) | T1 | QL (2 caps/day) HD |
| <i>fluoxetine hcl 60 mg tablet</i> | T1 | QL (1 tab/day) HD |
| <i>fluvoxamine er 100 mg capsule</i> | T1 | QL (3 caps/day) HD |
| <i>fluvoxamine er 150 mg capsule</i> | T1 | QL (2 caps/day) HD |
| <i>fluvoxamine maleate 100 mg tab</i> | T1 | QL (3 tabs/day) HD |
| <i>fluvoxamine maleate 25 mg tab</i> | T1 | QL (12 tabs/day) HD |
| <i>fluvoxamine maleate 50 mg tab</i> | T1 | QL (6 tabs/day) HD |
| <i>LEXAPRO 10 MG TABLET (escitalopram oxalate)</i> | T3 | PA QL (2 tabs/day) HD |
| <i>LEXAPRO 20 MG TABLET (escitalopram oxalate)</i> | T3 | PA QL (1 tab/day) HD |
| <i>LEXAPRO 5 MG TABLET (escitalopram oxalate)</i> | T3 | PA QL (4 tabs/day) HD |

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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.) | | |
| paroxetine cr 12.5 mg tablet (Paxil Cr) | T1 | QL (1 tab/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 |
| PAXIL 10 MG TABLET (paroxetine hcl) | T3 | PA QL (6 tabs/day) HD |
| PAXIL 10 MG/5 ML SUSPENSION | T3 | PA QL (30ml/day) HD |
| PAXIL 20 MG TABLET (paroxetine hcl) | T3 | PA QL (3 tabs/day) HD |
| PAXIL 30 MG TABLET (paroxetine hcl) | T3 | PA QL (2 tabs/day) HD |
| PAXIL 40 MG TABLET (paroxetine hcl) | T3 | PA QL (1 tab/day) HD |
| PAXIL CR 12.5 MG TABLET (paroxetine er) | T3 | PA QL (1 tab/day) HD |
| PAXIL CR 25 MG TABLET (paroxetine er) | T3 | PA QL (3 tabs/day) HD |
| PAXIL CR 37.5 MG TABLET (paroxetine er) | T3 | PA QL (2 tabs/day) HD |
| PEXEVA 30 MG TABLET | T3 | PA QL (2 tabs/day) HD |
| PEXEVA 40 MG TABLET | T3 | PA QL (1 tab/day) HD |
| PROZAC 10 MG PULVULE (fluoxetine hcl) | T3 | PA QL (8 caps/day) |
| PROZAC 20 MG PULVULE (fluoxetine hcl) | T3 | PA QL (4 caps/day) |
| PROZAC 40 MG PULVULE (fluoxetine hcl) | T3 | QL (2 caps/day) ST |
| 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 |
| ZOLOFT 100 MG TABLET (sertraline hcl) | T3 | PA QL (2 tabs/day) |
| ZOLOFT 20 MG/ML ORAL CONC (sertraline hcl) | T3 | PA QL (10ml/day) |
| ZOLOFT 25 MG TABLET (sertraline hcl) | T3 | PA QL (8 tabs/day) |
| ZOLOFT 50 MG TABLET (sertraline hcl) | T3 | PA QL (4 tabs/day) |
| SEROTONIN-2 ANTAGONIST/REUPTAKE INHIBITORS (SARIs) | | |
| nefazodone hcl | T1 | HD |

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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-2 ANTAGONIST/REUPTAKE INHIBITORS (SARIs) (cont.) | | |
| trazodone hcl | T1 | HD |
| SEROTONIN-NOREPINEPHRINE REUPTAKE-INHIB (SNRIs) | | |
| CYMBALTA 20 MG CAPSULE (<i>duloxetine hcl</i>) | T3 | PA QL (6 caps/day) HD |
| CYMBALTA 30 MG CAPSULE (<i>duloxetine hcl</i>) | T3 | PA QL (4 caps/day) HD |
| CYMBALTA 60 MG CAPSULE (<i>duloxetine hcl</i>) | T3 | PA QL (2 caps/day) HD |
| DESVENLAFAKINE ER 100 MG TAB | T3 | PA QL (4 tabs/day) HD |
| DESVENLAFAKINE ER 50 MG TAB | T3 | PA QL (8 tabs/day) HD |
| <i>desvenlafaxine succnt er 100mg</i> (Pristiq) | T1 | QL (4 tabs/day) HD |
| <i>desvenlafaxine succnt er 25 mg</i> (Pristiq) | T1 | QL (16 tabs/day) HD |
| <i>desvenlafaxine succnt er 50 mg</i> (Pristiq) | T1 | QL (1 tab/day) HD |
| DRIZALMA SPRINKLE DR 20 MG CAP | T3 | QL (1 cap/day) ST HD |
| DRIZALMA SPRINKLE DR 30 MG CAP | T3 | QL (1 cap/day) ST HD |
| DRIZALMA SPRINKLE DR 40 MG CAP | T3 | QL (1 cap/day) ST HD |
| DRIZALMA SPRINKLE DR 60 MG CAP | T3 | QL (2 caps/day) ST HD |
| <i>duloxetine hcl dr 20 mg cap</i> (Cymbalta) | T1 | QL (6 caps/day) HD |
| <i>duloxetine hcl dr 30 mg cap</i> (Cymbalta) | T1 | QL (4 caps/day) HD |
| <i>duloxetine hcl dr 40 mg cap</i> | T1 | QL (3 caps/day) HD |
| <i>duloxetine hcl dr 60 mg cap</i> (Cymbalta) | T1 | PA QL (2 caps/day) HD |
| EFFEXOR XR 150 MG CAPSULE (<i>venlafaxine hcl er</i>) | T3 | PA QL (2 caps/day) |
| EFFEXOR XR 37.5 MG CAPSULE (<i>venlafaxine hcl er</i>) | T3 | PA QL (8 caps/day) |
| EFFEXOR XR 75 MG CAPSULE (<i>venlafaxine hcl er</i>) | T3 | QL (4 caps/day) ST |
| 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 (<i>desvenlafaxine succinate er</i>) | T3 | PA QL (4 tabs/day) HD |
| PRISTIQ ER 25 MG TABLET (<i>desvenlafaxine succinate er</i>) | T3 | PA QL (16 tabs/day) HD |
| PRISTIQ ER 50 MG TABLET (<i>desvenlafaxine succinate er</i>) | T3 | PA QL (1 tab/day) HD |
| <i>venlafaxine hcl 100 mg tablet</i> | T1 | QL (3 tabs/day) HD |
| <i>venlafaxine hcl 25 mg tablet</i> | T1 | QL (15 tabs/day) HD |
| <i>venlafaxine hcl 37.5 mg tablet</i> | T1 | QL (10 tabs/day) HD |
| <i>venlafaxine hcl 50 mg tablet</i> | T1 | QL (7 tabs/day) HD |
| <i>venlafaxine hcl 75 mg tablet</i> | T1 | QL (5 tabs/day) HD |

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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.) | | |
| 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 | | |
| VIBRYD 10 MG TABLET | T3 | QL (1 tab/day) PA HD |
| VIBRYD 20 MG TABLET | T3 | PA QL (1 tab/day) HD |
| VIBRYD 40 MG TABLET | T3 | PA HD |
| SSRI, SEROTONIN RECEPTOR MODULATOR ANTI-DEPRESSANTS | | |
| TRINTELLIX 10 MG TABLET | T2 | QL(1 TAB/DAY) |
| TRINTELLIX 20 MG TABLET | T2 | |
| TRINTELLIX 5 MG TABLET | T2 | QL(1 TAB/DAY) |
| 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 |
| ANAFRANIL (clomipramine hcl) | T3 | PA HD |
| clomipramine hcl (Anafranil) | 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 pamoate | T1 | HD |
| imipramine hcl | T1 | HD |

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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-DEPRESSANTS, REL.NON-SEL.REUPT-INHIB (cont.) | | |
| maprotiline hcl | T1 | HD |
| nortriptyline hcl (Pamelor) | T1 | HD |
| PAMELOR (nortriptyline hcl) | T3 | PA HD |
| protriptyline hcl | T1 | HD |
| trimipramine maleate | T1 | HD |
| PSYCHOTHERAPEUTIC DRUGS (Attention Deficit Hyperactivity Disorder)⁸ | | |
| ADRENERGICS, AROMATIC, NON-CATECHOLAMINE | | |
| lisdexamfetamine 10 mg capsule (Vyvanse) | T1 | PA QL (1 cap/day) |
| lisdexamfetamine 20 mg capsule (Vyvanse) | T1 | PA QL (1 tab/day) |
| lisdexamfetamine 30 mg capsule (Vyvanse) | T1 | PA QL (1 per day) |
| lisdexamfetamine 40 mg capsule (Vyvanse) | T1 | PA QL (1 cap/day) |
| lisdexamfetamine 40 mg capsule (Vyvanse) | T1 | PA QL (1 tab/day) |
| lisdexamfetamine 60 mg capsule (Vyvanse) | T1 | PA QL (1 per day) |
| lisdexamfetamine 70 mg capsule (Vyvanse) | T1 | PA QL (1 tab/day) |
| 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 per 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 per day) |
| VYVANSE 50 MG CHEWABLE TABLET (lisdexamfetamine dimesylate) | T3 | PA QL (1 tab/day) |
| 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 per day) |
| TX FOR ADHD - SELECTIVE ALPHA-2 RECEPTOR AGONIST | | |
| clonidine hcl (Kapvay) | T1 | |
| guanfacine hcl (Intuniv) | T1 | |
| INTUNIV (guanfacine hcl er) | T3 | PA |
| KAPVAY (clonidine hcl er) | T3 | PA |

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

T4 – Injectable Specialty Medications

PA – Prior Authorization

QL – Quantity Limit

ST – Step Therapy

AGE – Age Requirement

SP – Specialty Medication

HD – May require home delivery pharmacy

PPACA – No Cost-Share Preventive Medication

CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

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

| Prescription Drug Name | Drug Tier | Coverage Requirements and Limits |
|--|-----------|----------------------------------|
| TX FOR ATTENTION DEFICIT-HYPERACT (ADHD)/NARCOLEPSY | | |
| ADHANSIA XR | T3 | PA QL (1 cap/day) ST |
| APTENSIO XR (<i>methylphenidate er</i>) | T3 | PA QL (1 cap/day) ST |
| CONCERTA (<i>methylphenidate er</i>) | T3 | PA QL (1 tab/day) ST |
| COTEMPLA XR-ODT 17.3 MG TABLET | T3 | PA QL (1 tab/day) |
| COTEMPLA XR-ODT 25.9 MG TABLET | T3 | PA QL (2 tabs/day) |
| COTEMPLA XR-ODT 8.6 MG TABLET | T3 | PA QL (1 tab/day) |
| DAYTRANA (<i>methylphenidate</i>) 10 MG/9 HR PATCH | T3 | PA QL (1 patch/day) |
| DAYTRANA (<i>methylphenidate</i>) 15 MG/9 HR PATCH | T3 | PA QL (1 per day) |
| DAYTRANA (<i>methylphenidate</i>) 20 MG/9 HOUR PATCH | T3 | PA QL (1 patch/day) |
| DAYTRANA (<i>methylphenidate</i>) 30 MG/9 HOUR PATCH | T3 | PA QL (1 patch/day) |
| <i>dexamethylphenidate er 10 mg cp</i> (Focalin Xr) | T1 | PA QL (1 cap/day) |
| <i>dexamethylphenidate er 15 mg cp</i> (Focalin Xr) | T1 | PA QL (1 per day) |
| <i>dexamethylphenidate er 20 mg cp</i> (Focalin Xr) | T1 | PA QL (1 cap/day) |
| <i>dexamethylphenidate er 25 mg cp</i> (Focalin Xr) | T1 | PA QL (1 cap/day) |
| <i>dexamethylphenidate er 30 mg cp</i> (Focalin Xr) | T1 | PA QL (1 cap/day) |
| <i>dexamethylphenidate er 35 mg cp</i> (Focalin Xr) | T1 | PA QL (1 cap/day) |
| <i>dexamethylphenidate er 40 mg cp</i> (Focalin Xr) | T1 | PA QL (1 cap/day) |
| <i>dexamethylphenidate er 5 mg cap</i> (Focalin Xr) | T1 | PA QL (1 cap/day) |
| <i>dexamethylphenidate hcl</i> (Focalin) | T1 | PA |
| FOCALIN (<i>dexamethylphenidate hcl</i>) | T3 | PA ST |
| FOCALIN XR (<i>dexamethylphenidate hcl er</i>) | T3 | PA QL (1 cap/day) ST |
| JORNAY PM | T3 | PA QL (1 cap/day) ST |
| METHYLIN (<i>methylphenidate hcl</i>) | T3 | PA |
| <i>methylphenidate</i> (Daytrana) | T1 | PA QL (1 patch/day) |
| <i>methylphenidate er 10 mg cap</i> (Aptensio Xr) | T1 | PA QL (1 per day) |
| <i>methylphenidate er 10 mg tab</i> | T1 | PA QL (2/day) |
| <i>methylphenidate er 15 mg cap</i> (Aptensio Xr) | T1 | PA QL (1 per day) |

T1 – Typically Generics

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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 18 mg tab (Relexxii) | T1 | PA QL(1 tab/day) |
| methylphenidate er 18 mg tab (Concerta) | T1 | PA QL (1 tab/day) |
| methylphenidate er 20 mg cap (Aptensio Xr) | T1 | PA QL (1 per day) |
| methylphenidate er 20 mg tab | T1 | PA QL (3 tabs/day) |
| methylphenidate er 18 mg tab (Relexxii) | T1 | PA QL(1 tab/day) |
| methylphenidate er 27 mg tab (Concerta) | T1 | PA QL (1 per day) |
| methylphenidate er 27 mg tab (Concerta) | T1 | PA QL (1 per day) |
| methylphenidate er 30 mg cap (Aptensio Xr) | T1 | PA QL (1 per day) |
| methylphenidate er 36 mg tab (Concerta) | T1 | PA QL (1 per day) |
| methylphenidate er 36 mg tab (Relexxii) | T1 | PA QL(2 tabs/day) |
| methylphenidate er 40 mg cap (Aptensio Xr) | T1 | PA QL (1 per day) |
| methylphenidate er 50 mg cap (Aptensio Xr) | T1 | PA QL (1 per day) |
| methylphenidate er 54 mg tab (Concerta) | T1 | PA QL (1 per day) |
| methylphenidate er 54 mg tab (Relexxii) | T1 | PA QL(1 tab/day) |
| methylphenidate er 60 mg cap (Aptensio Xr) | T1 | PA QL (1 per day) |
| METHYLPHENIDATE ER 72 MG TAB | T3 | PA QL (1 tab/day) |
| methylphenidate hcl (Metadata Cd) | T1 | PA QL(1 cap/day) |
| methylphenidate hcl (Methylin) | T1 | PA |
| methylphenidate hcl (Ritalin La) | T1 | PA QL (1 cap/day) |
| methylphenidate hcl (Ritalin) | T1 | PA |
| methylphenidate ptch (Daytrana) | T1 | PA QL(1 patch/day) |
| QUILLICHEW ER | T3 | PA QL (1 tab/day) |
| QUILLIVANT XR | T3 | PA QL (12ml/day) |
| RELEXXII | T3 | PA QL (1 tab/day) |
| RELEXXII ER 18 MG TABLET (methylphenidate hcl) | T3 | PA QL(1 tab/day) |
| RELEXXII ER 27 MG TABLETmethylphenidate hcl) | T3 | PA QL(1 tab/day) |
| RELEXXII ER 36 MG TABLET methylphenidate hcl) | T3 | PA QL(2 tabs/day) |
| RELEXXII ER 45 MG TABLET | T3 | PA QL(1 tab/day) |
| RELEXXII ER 54 MG TABLETmethylphenidate hcl) | T3 | PA QL(1 tab/day) |

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T4 – Injectable Specialty Medications

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ST – Step Therapy

AGE – Age Requirement

SP – Specialty Medication

HD – May require home delivery pharmacy

PPACA – No Cost-Share Preventive Medication

CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

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

| Prescription Drug Name | Drug Tier | Coverage Requirements and Limits |
|--|-----------|----------------------------------|
| TX FOR ATTENTION DEFICIT-HYPERACT (ADHD)/NARCOLEPSY (cont.) | | |
| RELEXXII ER 63 MG TABLET | T3 | PA QL(1 tab/day) |
| RELEXXII ER 72 MG TABLET | T3 | PA QL(1 tab/day) |
| RITALIN (<i>methylphenidate hcl</i>) | T3 | PA ST |
| RITALIN LA (<i>methylphenidate la</i>) | T3 | PA QL (1 cap/day) 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 |
| STRATTERA 100 MG CAPSULE (<i>atomoxetine hcl</i>) | T3 | PA QL HD |
| STRATTERA 18 MG CAPSULE (<i>atomoxetine hcl</i>) | T3 | PA QL HD |
| STRATTERA 25 MG CAPSULE (<i>atomoxetine hcl</i>) | T3 | PA QL HD |
| STRATTERA 40 MG CAPSULE (<i>atomoxetine hcl</i>) | T3 | PA QL (1 cap/day) HD |
| STRATTERA 60 MG CAPSULE (<i>atomoxetine hcl</i>) | T3 | PA QL HD |
| STRATTERA 80 MG CAPSULE (<i>atomoxetine hcl</i>) | T3 | PA QL HD |

PSYCHOTHERAPEUTIC DRUGS (Miscellaneous)

| HYPACTIVE SEXUAL DESIRE DISORDER (HSDD) TX AGENTS | | |
|---|----|--------------------------------|
| ADDYI | T3 | PA QL (1 tab/day) |
| VYLEESI | T3 | 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 | | |
| asenapine maleate (Saphris) | T1 | |
| CAPLYTA | T3 | QL (1 CAPS/DAY) ST |
| clozapine | T1 | |
| clozapine (Clozapine Odt) | T1 | |
| clozapine (Clozaril) | T1 | |
| clozapine (Fazaclor) | T1 | |
| CLOZAPINE ODT | T1 | |
| CLOZARIL (<i>clozapine</i>) | T3 | PA |
| FANAPT 1 MG TABLET | T3 | PA QL (4 tabs/day) ST |

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

T4 – Injectable Specialty Medications

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ST – Step Therapy

AGE – Age Requirement

SP – Specialty Medication

HD – May require home delivery pharmacy

PPACA – No Cost-Share Preventive Medication

CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

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

| Prescription Drug Name | Drug Tier | Coverage Requirements and Limits |
|---|-----------|----------------------------------|
| ANTI-PSYCHOTIC, ATYPICAL, DOPAMINE, SEROTONIN ANTAGNST (cont.) | | |
| FANAPT 10 MG TABLET | T3 | PA QL (4 tabs/day) ST |
| FANAPT 12 MG TABLET | T3 | PA |
| FANAPT 2 MG TABLET | T3 | PA QL (4 tabs/day) ST |
| FANAPT 4 MG TABLET | T3 | PA QL (4 tabs/day) ST |
| FANAPT 6 MG TABLET | T3 | PA QL (4 tabs/day) ST |
| FANAPT 8 MG TABLET | T3 | PA QL (4 tabs/day) ST |
| FANAPT TITRATION PACK | T3 | PA QL (4 packs/year) ST |
| FAZACLO (<i>clozapine odt</i>) | T3 | PA |
| GEODON (<i>ziprasidone hcl</i>) | T3 | PA |
| INVEGA ER 1.5 MG TABLET (<i>paliperidone er</i>) | T3 | ST |
| INVEGA ER 3 MG TABLET (<i>paliperidone er</i>) | T3 | QL (1 tab/day) ST |
| INVEGA ER 6 MG TABLET (<i>paliperidone er</i>) | T3 | ST |
| INVEGA ER 9 MG TABLET (<i>paliperidone er</i>) | T3 | ST |
| LATUDA 120 MG TABLET | T3 | |
| LATUDA 20 MG TABLET | T2 | |
| LATUDA 40 MG TABLET | T2 | QL (1 tab/day) |
| LATUDA 60 MG TABLET | T2 | QL (1 tab/day) |
| LATUDA 80 MG TABLET | T2 | |
| <i>olanzapine</i> (Zyprexa Zydis) | T1 | |
| <i>olanzapine</i> (Zyprexa) | T1 | |
| <i>paliperidone er 1.5 mg tablet</i> | T1 | |
| <i>paliperidone er 1.5 mg tablet</i> (Invega) | T1 | |
| <i>paliperidone er 3 mg tablet</i> (Invega) | T1 | QL (1 tab/day) |
| <i>paliperidone er 6 mg tablet</i> (Invega) | T1 | |
| <i>paliperidone er 9 mg tablet</i> (Invega) | T1 | |
| <i>quetiapine fumarate</i> (Seroquel Xr) | T1 | |
| <i>quetiapine fumarate</i> (Seroquel) | T1 | |
| RISPERDAL (<i>risperidone</i>) | T3 | PA |
| <i>risperidone</i> | T1 | |
| <i>risperidone</i> (Risperdal) | T1 | |
| SAPHRIS (<i>asenapine maleate</i>) | T3 | ST |
| SECUADO | T3 | ST |
| SEROQUEL (<i>quetiapine fumarate</i>) | T3 | ST |

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

T4 – Injectable Specialty Medications

PA – Prior Authorization

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ST – Step Therapy

AGE – Age Requirement

SP – Specialty Medication

HD – May require home delivery pharmacy

PPACA – No Cost-Share Preventive Medication

CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

| PSYCHOTHERAPEUTIC DRUGS (Schizophrenia/Anti-Psychotics) ⁸ (cont.) | | |
|--|-----------|----------------------------------|
| Prescription Drug Name | Drug Tier | Coverage Requirements and Limits |
| ANTI-PSYCHOTIC, ATYPICAL, DOPAMINE, SEROTONIN ANTAGNST (cont.) | | |
| SEROQUEL XR (<i>quetiapine fumarate er</i>) | T3 | ST |
| VERSACLOZ | T3 | PA |
| ziprasidone hcl (Geodon) | T1 | |
| ZYPREXA (<i>olanzapine</i>) | T3 | PA |
| ZYPREXA ZYDIS (<i>olanzapine odt</i>) | T3 | PA |
| 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 10 MG TABLET (<i>aripiprazole</i>) | T3 | ST |
| ABILIFY 15 MG TABLET (<i>aripiprazole</i>) | T3 | ST |
| ABILIFY 2 MG TABLET (<i>aripiprazole</i>) | T3 | ST |
| ABILIFY 20 MG TABLET (<i>aripiprazole</i>) | T3 | ST |
| ABILIFY 30 MG TABLET (<i>aripiprazole</i>) | T3 | ST |
| ABILIFY 5 MG TABLET (<i>aripiprazole</i>) | T3 | QL (1 tab/day) ST |
| ABILIFY MYCITE <i>aripiprazole</i> | T3 | PA |
| <i>aripiprazole</i> | T1 | |
| <i>aripiprazole 1 mg/ml solution</i> | T1 | |
| <i>aripiprazole 10 mg tablet (Abilify)</i> | T1 | |
| <i>aripiprazole 15 mg tablet (Abilify)</i> | T1 | |
| <i>aripiprazole 2 mg tablet (Abilify)</i> | T1 | |
| <i>aripiprazole 20 mg tablet (Abilify)</i> | T1 | |
| <i>aripiprazole 30 mg tablet (Abilify)</i> | T1 | |
| <i>aripiprazole 5 mg tablet (Abilify)</i> | 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 |
| OPIPZA 2 MG FILM | T3 | PA QL(1 film/day) |
| OPIPZA 5 MG FILM | T3 | PA QL(3 films/day) |
| OPIPZA 10 MG FILM | T3 | PA QL(3 films/day) |
| ANTI-PSYCHOTICS, DOPAMINE AND SEROTONIN ANTAGONISTS | | |
| REXULTI 4 MG TABLET | T3 | ST |

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

T4 – Injectable Specialty Medications

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AGE – Age Requirement

SP – Specialty Medication

HD – May require home delivery pharmacy

PPACA – No Cost-Share Preventive Medication

CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

| PSYCHOTHERAPEUTIC DRUGS (Schizophrenia/Anti-Psychotics) ⁸ (cont.) | | |
|--|-----------|----------------------------------|
| Prescription Drug Name | Drug Tier | Coverage Requirements and Limits |
| ANTI-PSYCHOTICS, DOPAMINE AND SEROTONIN ANTAGONISTS (cont.) | | |
| <i>loxapine succinate</i> | T1 | |
| <i>lurasidone hcl</i> | T1 | |
| ANTI-PSYCHOTICS, DOPAMINE ANTAGONISTS, THIOXANTHENES | | |
| <i>thiothixene</i> | T1 | |
| ANTI-PSYCHOTICS, DOPAMINE ANTAGONISTS, BUTYROPHENONES | | |
| <i>haloperidol</i> | T1 | |
| <i>haloperidol lactate</i> | T1 | |
| ANTI-PSYCHOTICS, DOPAMINE ANTAGONISTS, 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 (Symbyax)</i> | T1 | |
| <i>SYMBYAX (olanzapine-fluoxetine hcl)</i> | T3 | PA |
| PSYCHOTHERAPEUTIC DRUGS (Sleep Disorders/Sedatives) | | |
| NARCOLEPSY AND SLEEP DISORDER THERAPY AGENTS | | |
| <i>armodafinil (Nuvigil)</i> | T1 | PA |
| <i>modafinil (Provigil)</i> | T1 | PA |
| <i>NUVIGIL (armodafinil)</i> | T3 | PA |
| <i>PROVIGIL (modafinil)</i> | T3 | PA |
| <i>SUNOSI</i> | T2 | PA QL (1 tab/day) |
| SEDATIVE/HYPNOTICS (Sleep Disorders/Sedatives) | | |
| ANTI-NARCOLEPSY, ANTI-CATAPLEXY, SEDATIVE-TYPE AGENT | | |
| <i>LUMRYZ</i> | T3 | PA QL(1 pack/day) SP HD |
| <i>LUMRYZ STARTER PACK</i> | T3 | PA SP HD |
| <i>XYREM</i> | T3 | PA SP HD |
| <i>XYWAV</i> | T3 | PA SP HD |
| BARBITURATES | | |
| <i>phenobarbital</i> | T1 | |
| <i>secobarbital sodium</i> | T3 | PA |

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List of Prescription Medications

| SEDATIVE/HYPNOTICS (Sleep Disorders/Sedatives) (cont.) | | |
|--|-----------|----------------------------------|
| Prescription Drug Name | Drug Tier | Coverage Requirements and Limits |
| HYPNOTICS, MELATONIN MT1/MT2 RECEPTOR AGONISTS | | |
| HETLIOZ | T3 | PA SP HD |
| HETLIOZ LQ | T3 | PA SP HD |
| <i>ramelteon</i> (Rozerem) | T1 | QL (1 tab/day) |
| ROZEREM (<i>ramelteon</i>) | T3 | PA QL (1 tab/day) |
| DORAL | T3 | |
| <i>estazolam</i> | T1 | |
| HALCION (<i>triazolam</i>) | T3 | |
| <i>midazolam hcl</i> | T1 | |
| QUAZEPAM | T1 | |
| <i>quazepam</i> (Quazepam) | T1 | |
| RESTORIL (<i>temazepam</i>) | T3 | PA |
| NARCOLEPSY AND SLEEP DISORDER THERAPY AGENTS | | |
| <i>armodafinil</i> (Nuvigil) | T1 | PA |
| <i>modafinil</i> (Provigil) | T1 | PA |
| NUVIGIL (<i>armodafinil</i>) | T3 | PA |
| PROVIGIL (<i>modafinil</i>) | T3 | PA |
| SUNOSI | T2 | PA QL (1 tab/day) |
| SEDATIVE-HYPNOTICS - BENZODIAZEPINES | | |
| <i>flurazepam hcl</i> | T1 | |
| <i>temazepam</i> (Restoril) | T1 | |
| <i>triazolam</i> | T1 | |
| <i>triazolam</i> (Halcion) | T1 | |
| SEDATIVE-HYPNOTICS, NON-BARBITURATE | | |
| AMBIEN (<i>zolpidem tartrate</i>) | T3 | PA |
| AMBIEN CR 12.5 MG TABLET (<i>zolpidem tartrate er</i>) | T3 | PA |
| AMBIEN CR 6.25 MG TABLET (<i>zolpidem tartrate er</i>) | T3 | PA QL (1 tab/day) |
| BELSOMRA | T3 | PA |
| 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 | |
| EDLUAR 10 MG SL TABLET | T3 | PA |
| EDLUAR 5 MG SL TABLET | T3 | PA QL (1 tab/day) |
| <i>eszopiclone</i> (Lunesta) | T1 | |
| LUNESTA (<i>eszopiclone</i>) | T3 | PA |

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List of Prescription Medications

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

| Prescription Drug Name | Drug Tier | Coverage Requirements and Limits |
|--|-----------|----------------------------------|
| SEDATIVE-HYPNOTICS, NON-BARBITURATE (cont.) | | |
| QUVIVQ | T3 | PA QL (1 day) |
| SILENOR 3 MG TABLET (<i>doxepin hc</i>) | T3 | PA QL (1 tab/day) |
| SILENOR 6 MG TABLET (<i>doxepin hc</i>) | T3 | PA |
| zaleplon | T1 | |
| zolpidem tart er 12.5 mg tab (Ambien Cr) | T1 | |
| zolpidem tart er 6.25 mg tab (Ambien Cr) | T1 | QL (1 tab/day) |
| zolpidem tartrate | T1 | |
| zolpidem tartrate (Ambien) | T1 | |
| ZOLPIMIST | T3 | PA |

SKIN PREPS (Miscellaneous)

| IRRIGANTS | | |
|----------------------------------|----|--|
| acetic acid | T1 | |
| neomycin sulf/polymyxin b sulf | T1 | |
| PHYSIOLYTE | T3 | |
| PHYSIOSOL | T3 | |
| ringer's solution | T1 | |
| ringer's solution, lactated | T1 | |
| sod, pot chlor/mag/sod, pot phos | T3 | |
| sodium chloride irrig solution | T1 | |
| SODIUM CHLORIDE 0.9% IRRIG. | T3 | |
| SORBITOL | T1 | |
| SORBITOL-MANNITOL | T1 | |
| VASHE WOUND THERAPY | T3 | |
| water for irrigation, sterile | T1 | |

OXIDIZING AGENTS

| | | |
|-------------------|----|--|
| hydrogen peroxide | T1 | |
|-------------------|----|--|

SKIN PREPS (Pain Relief And Inflammatory Disease)

| ANTI-PSORIATIC AGENTS, SYSTEMIC | | |
|---------------------------------|----|---------------------------------|
| acitretin | T1 | |
| acitretin (Soriatane) | T1 | |
| BIMZELX | T4 | PA QL(2 mls/28 days) SP HD |
| COSENTYX (2 SYRINGES) | T4 | PA QL (2 syrings/28 days) SP HD |
| COSENTYX PEN | T4 | PA QL (1 pen/28 days) SP HD |

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

T4 – Injectable Specialty Medications

PA – Prior Authorization

QL – Quantity Limit

ST – Step Therapy

AGE – Age Requirement

SP – Specialty Medication

HD – May require home delivery pharmacy

PPACA – No Cost-Share Preventive Medication

CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

| SKIN PREPS (Pain Relief And Inflammatory Disease) (cont.) | | |
|---|-----------|----------------------------------|
| Prescription Drug Name | Drug Tier | Coverage Requirements and Limits |
| ANTI-PSORIATIC AGENTS, SYSTEMIC (cont.) | | |
| COSENTYX PEN (2 PENS) | T4 | PA QL (2 pens/28 days) SP HD |
| COSENTYX SYRINGE | T4 | PA QL (1 syringe/28 days) SP HD |
| ILUMYA | T4 | PA QL (1 syringe/84 days) SP HD |
| <i>methoxsalen</i> (Oxsoralen-ultra) | T1 | |
| OXSORALEN-ULTRA (<i>methoxsalen</i>) | T3 | |
| SILIQ | T4 | PA QL (2 syringes/28 days) SP HD |
| SKYRIZI (2 SYRINGES) KIT | T4 | PA QL (1 kit/84 days) SP HD |
| SORIATANE (<i>acitretin</i>) | T3 | PA |
| SOTYKTU | T3 | PA QL (1 tab/day) SP |
| SPEVIGO | T4 | PA QL(2 mls/28 days) SP HD |
| TALTZ AUTOINJECTOR | T4 | PA QL (1 injector/28 days) SP HD |
| TALTZ AUTOINJECTOR (2 PACK) | T4 | PA QL (1 injector/28 days) SP HD |
| TALTZ AUTOINJECTOR (3 PACK) | T4 | PA QL (1 injector/28 days) SP HD |
| TALTZ SYRINGE | T4 | PA QL (1 syringe/28 days) SP HD |
| TREMFYA 100 MG/ML INJECTOR | T4 | PA QL (1 injector/56 days) SP HD |
| TREMFYA 100 MG/ML SYRINGE | T4 | PA QL (1 syringe/56 days) SP HD |
| TREMFYA PEN | T2 | PA QL(2 syringe/28 days) SP HD |
| TOPICAL ANTI-INFLAMMATORY, NSAIDS | | |
| DICLAREAL | T3 | HD |
| <i>diclofenac</i> 1.5% topical soln | T1 | PA HD |
| DICLOFENAC EPOLAMINE | T3 | PA QL (2 patches/day) HD |
| <i>diclofenac sodium</i> 1% gel (Voltaren) | T1 | QL (1000gm/30 days) HD |
| FLECTOR | T2 | PA QL (2 patches/day) HD |
| LICART | T2 | PA QL (1 patch/day) HD |
| PENNNSAID | T3 | PA HD |
| VOLTAREN (<i>diclofenac sodium</i>) | T3 | PA QL (1000gm/30 days) HD |
| SKIN PREPS (Skin Conditions) | | |
| ACNE AGENTS, SYSTEMIC | | |
| ABSORICA (<i>isotretinoin</i>) | T3 | PA |
| ABSORICA LD | T3 | ST |
| ACCUTANE | T1 | |
| AMNESTEEM | T1 | |
| CLARAVIS | T1 | |
| <i>isotretinoin</i> (Absorica) | T1 | |

T1 – Typically Generics

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T4 – Injectable Specialty Medications

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CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

| SKIN PREPS (Skin Conditions) (cont.) | | |
|---|-----------|----------------------------------|
| Prescription Drug Name | Drug Tier | Coverage Requirements and Limits |
| ACNE AGENTS, SYSTEMIC (cont.) | | |
| MYORISAN | T1 | |
| ZENATANE | T1 | |
| ACNE AGENTS, TOPICAL | | |
| ACANYA (<i>clindamycin phos-benzoyl perox</i>) | T3 | |
| ACZONE 5% GEL (<i>dapsone</i>) | T3 | |
| ACZONE 7.5% GEL PUMP | T2 | |
| <i>adapalene/benzoyl peroxide</i> | T1 | |
| AZELEX | T2 | |
| BENZACLIN (<i>clindamycin-benzoyl peroxide</i>) | T3 | PA |
| CABTREO | T3 | PA |
| <i>clindamyc-bnz perox 1.2-3.75% (Onexton)</i> | T1 | PA |
| <i>clindamycin-benzoyl perox 1-5%</i> | T1 | |
| <i>clindamycin-bnz perox 1-5% pmp</i> | T1 | |
| <i>clindamycin phos/benzoyl perox (Onexton)</i> | T1 | |
| <i>clindamycin phos/benzoyl perox (Acanya)</i> | T1 | |
| <i>clindamycin phos/benzoyl perox (Benzaclin)</i> | T1 | |
| <i>clindamycin/tretinoin (Ziana)</i> | T1 | |
| <i>clindamycin/tretinoin (Veltin)</i> | T1 | |
| <i>dapsone 5% gel (Aczone)</i> | T1 | |
| DAPSONE 7.5% GEL PUMP | T3 | PA |
| <i>dapsone 7.5% gel pump (Aczone)</i> | T1 | |
| EPIDUO FORTE | T2 | |
| KLARON (<i>sulfacetamide sodium</i>) | T3 | |
| NEUAC 1.2-5% KIT | T3 | |
| <i>neuac gel</i> | T1 | |
| ONEXTON (<i>clindamycin phos/benzoyl perox</i>) | T3 | |
| <i>sulfacetamide sodium (Klaron)</i> | T1 | |
| VELTIN | T3 | PA |
| ZIANA (<i>clindamycin phos-tretinoin</i>) | T3 | PA |
| ANTI-PERSPIRANTS | | |
| DRYSOL | T2 | |
| ANTI-PRURITICS, TOPICAL | | |
| ALEVICYN PLUS | T3 | |
| <i>doxepin 5% cream (Zonalon)</i> | T1 | PA QL (90gm/30 days) |

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List of Prescription Medications

| SKIN PREPS (Skin Conditions) (cont.) | | |
|---|-----------|----------------------------------|
| Prescription Drug Name | Drug Tier | Coverage Requirements and Limits |
| ANTI-PRURITICS, TOPICAL (cont.) | | |
| <i>doxepin hcl</i> (Zonalon) | T3 | PA QL (90gm/30 days) |
| ZONALON | T3 | PA QL (90gm/30 days) |
| ZONALON (<i>prudoxin</i>) | T3 | PA QL (90gm/30 days) |
| ANTI-PSORIATICS AGENTS | | |
| <i>anthralin</i> | T1 | |
| <i>calcipotriene 0.005% cream</i> (Dovonex) | T1 | |
| CALCIPOTRIENE 0.005% FOAM | T3 | PA |
| <i>calcipotriene 0.005% ointment</i> | T1 | |
| <i>calcipotriene 0.005% solution</i> | T1 | |
| <i>calcitriol 3 mcg/g ointment</i> (Vectical) | T1 | QL (800gm/30 days) |
| DOVONEX (<i>calcipotriene</i>) | T3 | |
| DUOBRII | T3 | |
| RYALTRIS | T3 | PA QL (1 tube/30 days) |
| SORILUX | T3 | PA |
| <i>tazarotene 0.1% cream</i> (Tazorac) | T1 | |
| <i>tazarotene 0.05% cream</i> | T1 | |
| TAZORAC 0.05% CREAM | T2 | |
| TAZORAC 0.05% GEL | T2 | |
| TAZORAC 0.1% CREAM (<i>tazarotene</i>) | T3 | |
| TAZORAC 0.1% GEL | T2 | |
| VECTICAL (<i>calcitriol</i>) | T3 | QL (800gm/30 days) |
| ZORYVE 0.3% CREAM | T2 | ST QL(1 gm/30 days) |
| ANTI-SEBORRHEIC AGENTS | | |
| OVACE PLUS | T3 | |
| <i>selenium sulfide</i> | T1 | |
| <i>sulfacetamide sodium</i> | T1 | |
| TERSI FOAM | T3 | |
| ANTISEPTICS, MISCELLANEOUS | | |
| GUAIACOL | T1 | |
| DIABETIC ULCER PREPARATIONS, TOPICAL | | |
| REGRANEX | T3 | PA QL (2 tubs/30 days) |
| EMOLLIENTS | | |
| ATOPICLAIR | T3 | |
| <i>emollient combination no.35</i> (Mimyx) | T1 | |
| <i>emollient combination no.60</i> (Restizan) | T1 | |

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List of Prescription Medications

| SKIN PREPS (Skin Conditions) (cont.) | | |
|--|-----------|----------------------------------|
| Prescription Drug Name | Drug Tier | Coverage Requirements and Limits |
| EMOLLIENTS (cont.) | | |
| HALUCORT | T3 | |
| MIMYX (<i>prumyx</i>) | T3 | |
| RESTIZAN | T1 | |
| vite ac/grape/hyaluronic acid (Atopiclair) | T1 | |
| XCLAIR | T3 | |
| IMMUNOMODULATORS | | |
| ALDARA (<i>imiquimod</i>) | T3 | PA |
| <i>imiquimod</i> 3.75% cream (Zyclara) | T1 | PA QL(112 PACKETS/67 DAYS) |
| IMIQUIMOD 3.75% CREAM PUMP | T1 | PA |
| <i>imiquimod</i> 5% cream packet (Aldara) | T1 | |
| ZYCLARA 2.5% CREAM PUMP | T3 | PA QL (4 bots/30 days) |
| ZYCLARA 3.75% CREAM (<i>imiquimod</i>) | T3 | PA QL (112 packs/30 days) |
| ZYCLARA 3.75% CREAM PUMP | T3 | PA |
| IRRITANTS/COUNTER-IRRITANTS | | |
| <i>methyl salicylate</i> | T1 | |
| KERATOLYTICS | | |
| BENZEFOAM | T3 | |
| BENZEPRO | T1 | |
| <i>benzoyl peroxide</i> (Enzoclear) | T1 | |
| <i>benzoyl peroxide</i> (Pacnex) | T1 | |
| CONDYLOX (<i>podofilox</i>) | T3 | PA |
| ENZOCLEAR | T3 | |
| HYDRO 35 | T3 | |
| HYDRO 40 (<i>umecta</i>) | T3 | |
| INOVA | T3 | |
| KERAFOAM | T3 | |
| KERALYT 6% GEL (<i>salicylic acid</i>) | T3 | |
| <i>keralyt</i> 6% shampoo | T1 | |
| KERALYT SCALP | T3 | |
| KERALYT SCALP (<i>salicylic acid</i>) | T3 | |
| PACNEX (<i>benzoyl peroxide</i>) | T3 | |
| PODOCON-25 | T1 | |

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List of Prescription Medications

SKIN PREPS (Skin Conditions) (cont.)

| Prescription Drug Name | Drug Tier | Coverage Requirements and Limits |
|---|-----------|----------------------------------|
| KERATOLYTICS (cont.) | | |
| <i>podofilox</i> | T1 | |
| PR BENZOYL PEROXIDE | T1 | |
| PRONAL | T3 | |
| RAYASAL | T3 | |
| SALICATE | T3 | |
| <i>salicylic acid</i> | T1 | |
| <i>salicylic acid</i> (Keralyt Scalp) | T1 | |
| <i>salicylic acid/ceramide comb 1</i> | T1 | |
| SALIMEZ FORTE | T1 | |
| SALKERA | T3 | |
| SALVAX DUO PLUS | T3 | |
| <i>silver nitrate</i> | T1 | |
| <i>silver nitrate applicator</i> | T1 | |
| URAMAXIN (urea) | 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 | |
| ROSACEA AGENTS, TOPICAL | | |
| <i>azelaic acid</i> (Finacea) | T1 | |
| FINACEA | T3 | PA |
| FINACEA (<i>azelaic acid</i>) | T3 | PA |
| IDAOXIA | T3 | |
| <i>ivermectin</i> (Soolantra) | T1 | |
| METROCREAM (<i>rosadan</i>) | T3 | PA |
| METROGEL (<i>metronidazole</i>) | T3 | PA |
| <i>metronidazole</i> | T1 | |

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List of Prescription Medications

SKIN PREPS (Skin Conditions) (cont.)

| Prescription Drug Name | Drug Tier | Coverage Requirements and Limits |
|--|-----------|----------------------------------|
| ROSACEA AGENTS, TOPICAL (cont.) | | |
| metronidazole (Metrocream) | T1 | |
| metronidazole (Metrogel) | T1 | |
| METRONIDAZOLE 125 MG TABLET | T2 | QL (30 tabs/90 days) |
| NORITATE | T3 | PA |
| SOOLANTRA | T3 | |
| SOOLANTRA (<i>ivermectin</i>) | T3 | PA |
| 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 | |
| TOPICAL AGENTS, MISCELLANEOUS | | |
| L-MESITRAN SOFT | T3 | |
| MEDIHONEY | T3 | |
| SAF-CLENS AF | T1 | |
| <i>trichloroacetic acid</i> | T3 | |
| TRICHLOROACETIC ACID | T1 | |
| <i>urea</i> | T1 | |
| TOPICAL ANTIBIOTIC PLEUROMUTILIN DERIVATIVES | | |
| ALTABAX | T3 | |
| TOPICAL ANTICHOLINERGIC HYPERHIDROSIS TX AGENTS | | |
| QBREXZA | T3 | |
| SOFDRA | T3 | PA |
| TOPICAL ANTI-INFLAMMATORY STEROIDAL | | |
| ACIOXIA | T3 | |
| ALA-SCALP (<i>scalacort</i>) | T3 | ST |
| <i>alclometasone dipropionate</i> | T1 | |
| <i>amcinonide 0.1%</i> | T1 | |
| ANUSOL-HC 2.5% CREAM (<i>proctozone-hc</i>) | T1 | PA |
| AQUA GLYCOLIC HC | T3 | |
| <i>betamethasone dipropionate</i> | T1 | |
| <i>betamethasone valerate</i> | T1 | |
| <i>betamethasone valerate (Luxiq)</i> | T1 | |

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List of Prescription Medications

SKIN PREPS (Skin Conditions) (cont.)

| Prescription Drug Name | Drug Tier | Coverage Requirements and Limits |
|---|-----------|----------------------------------|
| TOPICAL ANTI-INFLAMMATORY STEROIDAL (cont.) | | |
| <i>betamethasone/propylene glyc</i> | T1 | |
| <i>betamethasone/propylene glyc (Diprolene)</i> | T1 | |
| BRYHALI | T3 | ST |
| CAPEX SHAMPOO | T3 | ST |
| CLOBETASOL 0.025% CREAM | T3 | PA |
| <i>clobetasol propionate</i> | T1 | |
| <i>clobetasol propionate (Clobex)</i> | T1 | |
| <i>clobetasol propionate (Olux)</i> | T1 | |
| <i>clobetasol propionate (Temovate)</i> | T1 | |
| <i>clobetasol propionate/emoll</i> | T1 | |
| <i>clobetasol propionate/emoll (Olux-e)</i> | T1 | |
| CLOBEX (<i>clobetasol propionate</i>) | T3 | PA |
| CLOBEX (<i>clodan</i>) | T3 | PA |
| CLOCORTOLONE PIVALATE | T1 | |
| CLODAN 0.05% KIT | T3 | ST |
| <i>cladan 0.05% shampoo (Clobex)</i> | T1 | |
| CLODERM | T3 | ST |
| CORDRAN (<i>flurandrenolide</i>) | T3 | PA |
| CORDRAN (<i>nolix</i>) | T3 | PA |
| CUTIVATE 0.05% CREAM (<i>fluticasone propionate</i>) | T3 | ST |
| CUTIVATE 0.05% LOTION (<i>fluticasone propionate</i>) | T3 | PA |
| DERMA-SMOOTH-E-FS (<i>fluocinolone acetonide</i>) | T3 | ST |
| DERMATOP (<i>prednicarbate</i>) | T3 | ST |
| <i>desonide</i> | T1 | |
| <i>desonide (Desowen)</i> | T1 | |
| <i>desonide (Tridesilon)</i> | T1 | |
| DESOWEN 0.05% CREAM | T3 | ST |
| <i>desoximetasone (Topicort)</i> | T1 | |
| <i>diflorasone diacetate</i> | T1 | PA |
| <i>diflorasone diacetate (Psorcon)</i> | T1 | PA |
| <i>diflurasone diacetate/emoll</i> | T1 | PA |
| DIPROLENE (<i>betamethasone diprop augmented</i>) | T3 | ST |
| <i>fluocinolone acetonide</i> | T1 | |
| <i>fluocinolone acetonide (Derma-smoothe-fs)</i> | T1 | |
| <i>fluocinolone acetonide (Synalar)</i> | T1 | |

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T4 – Injectable Specialty Medications

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List of Prescription Medications

SKIN PREPS (Skin Conditions) (cont.)

| Prescription Drug Name | Drug Tier | Coverage Requirements and Limits |
|--|-----------|----------------------------------|
| TOPICAL ANTI-INFLAMMATORY STEROIDAL (cont.) | | |
| fluocinolone/shower cap (Derma-smoothe-fs) | T1 | |
| fluocinonide | T1 | |
| fluocinonide (Vanos) | T1 | |
| fluocinonide/emollient base | T1 | |
| flurandrenolide (Cordran) | T1 | PA |
| fluticasone prop 0.005% oint | T1 | |
| fluticasone prop 0.05% cream (Cutivate) | T1 | |
| fluticasone prop 0.05% lotion (Cutivate) | T1 | |
| fluticasone propionate (Cutivate) | T1 | |
| halcinonide (Halog) | T1 | PA |
| halobetasol prop 0.05% foam | T1 | |
| HALOBETASOL PROPIONATE | T3 | PA |
| HALOG (halcinonide) | T3 | PA |
| hydrocort buty 0.1% lipid crm (Locoid Lipocream) | T1 | PA |
| hydrocort buty 0.1% lipo cream (Locoid Lipocream) | T1 | PA |
| hydrocortisone | T1 | |
| hydrocortisone (Ala-scalp) | T1 | |
| hydrocortisone (Anusol-hc) | T1 | |
| hydrocortisone buty 0.1% cream | T1 | |
| hydrocortisone butyr 0.1% lotn (Locoid) | T1 | PA |
| hydrocortisone butyr 0.1% oint (Locoid) | T1 | |
| hydrocortisone butyr 0.1% soln | T1 | |
| hydrocortisone valerate | T1 | |
| IMPEKLO | T3 | PA |
| IMPOYZ | T3 | PA |
| KENALOG (triamcinolone acetonide) | T3 | PA |
| LEXETTE | T3 | PA |
| LOCOID 0.1% LOTION (hydrocortisone butyrate) | T3 | PA |
| LOCOID 0.1% OINTMENT (hydrocortisone butyrate) | T3 | |
| LOCOID LIPOCREAM | T3 | PA |
| LOCOID LIPOCREAM (hydrocortisone butyrate) | T3 | PA |
| LUXIQ (betamethasone valerate) | T3 | ST |

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List of Prescription Medications

SKIN PREPS (Skin Conditions) (cont.)

| Prescription Drug Name | Drug Tier | Coverage Requirements and Limits |
|---|-----------|----------------------------------|
| TOPICAL ANTI-INFLAMMATORY STEROIDAL (cont.) | | |
| MOMETACURE | T3 | |
| <i>mometasone furoate 0.1% cream</i> | T1 | |
| <i>mometasone furoate 0.1% oint</i> | T1 | |
| <i>mometasone furoate 0.1% soln</i> | T1 | |
| NUCORT | T3 | ST |
| OLUX (<i>clobetasol propionate</i>) | T3 | PA |
| OLUX-E (<i>tovet emollient</i>) | T3 | PA |
| PANDEL | T3 | PA |
| <i>prednicarbate (Dermatop)</i> | T1 | |
| PSORCON (<i>diflorasone diacetate</i>) | T3 | PA |
| SCALACORT DK | T3 | ST |
| SERNIVO | T3 | PA |
| 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 |
| <i>triamcinolone acetonide</i> | T1 | |
| <i>triamcinolone acetonide</i> | T1 | PA |
| <i>triamcinolone acetonide (Kenalog)</i> | T1 | PA |
| TRIDESILON (<i>desonide</i>) | T3 | PA |
| VANOS (<i>fluocinonide</i>) | T3 | PA |
| VERDESO | T3 | PA |
| TOPICAL ANTI-INFLAMMATORY STEROID-LOCAL ANESTHETIC | | |
| ANALPRAM HC | T3 | PA |
| EPIFOAM | T3 | |
| <i>hydrocortisone/pramoxine (Pramosone)</i> | 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 | |

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

T4 – Injectable Specialty Medications

PA – Prior Authorization

QL – Quantity Limit

ST – Step Therapy

AGE – Age Requirement

SP – Specialty Medication

HD – May require home delivery pharmacy

PPACA – No Cost-Share Preventive Medication

CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

SKIN PREPS (Skin Conditions) (cont.)

| Prescription Drug Name | Drug Tier | Coverage Requirements and Limits |
|---|-----------|----------------------------------|
| TOPICAL ANTI-INFLAMMATORY STEROID-LOCAL ANESTHETIC (cont.) | | |
| PRAMOSONE 2.5%-1% LOTION | T3 | |
| PRAMOSONE 2.5%-1% OINTMENT | T2 | |
| 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 | |
| TOPICAL VIT D ANALOG/ANTI-INFLAMMATORY STEROID | | |
| <i>calcipotriene/betamethasone</i> (Taclonex) | T1 | |
| ENSTILAR | T3 | PA |
| TACLONEX (<i>calcipotriene/betamethasone</i>) | T3 | |
| WYNZORA | T3 | PA |
| TOPICAL/MUCOUS MEMBR./SUBCUT. ENZYMES | | |
| SANTYL | T2 | QL (60gm/30 days) |
| VITAMIN A DERIVATIVES | | |
| <i>adapalene</i> | T1 | PA |
| <i>adapalene</i> (Differin) | T1 | PA |
| <i>adapalene</i> (Plixa) | T1 | PA |
| AKLIEF | T3 | |
| ALTRENO | T3 | PA |
| ATRALIN (<i>tretinoin</i>) | T3 | PA |
| <i>avita 0.025% cream</i> (Retin-a) | T3 | PA |
| AVITA 0.025% GEL | T3 | |
| DIFFERIN | T3 | PA |
| DIFFERIN (<i>adapalene</i>) | T3 | PA |

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

T4 – Injectable Specialty Medications

PA – Prior Authorization

QL – Quantity Limit

ST – Step Therapy

AGE – Age Requirement

SP – Specialty Medication

HD – May require home delivery pharmacy

PPACA – No Cost-Share Preventive Medication

CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

SKIN PREPS (Skin Conditions) (cont.)

| Prescription Drug Name | Drug Tier | Coverage Requirements and Limits |
|---|-----------|----------------------------------|
| VITAMIN A DERIVATIVES (con't.) | | |
| PLIXDA | T1 | PA |
| RETIN-A 0.01% GEL (<i>tretinoin</i>) | T3 | |
| RETIN-A 0.025% CREAM (<i>tretinoin</i>) | T3 | PA |
| RETIN-A 0.025% GEL (<i>tretinoin</i>) | T3 | |
| RETIN-A 0.05% CREAM (<i>tretinoin</i>) | T3 | PA |
| RETIN-A 0.1% CREAM (<i>tretinoin</i>) | T3 | PA |
| RETIN-A MICRO (<i>tretinoin microsphere</i>) | T3 | PA |
| RETIN-A MICRO PUMP | T3 | PA |
| RETIN-A MICRO PUMP (<i>tretinoin microsphere</i>) | T3 | PA |
| <i>tretinoin 0.01% gel</i> (Retin-a) | T1 | |
| <i>tretinoin 0.025% cream</i> (Retin-a) | T1 | PA |
| <i>tretinoin 0.025% gel</i> (Retin-a) | T1 | |
| <i>tretinoin 0.05% cream</i> (Retin-a) | T1 | PA |
| <i>tretinoin 0.05% gel</i> (Atralin) | T1 | PA |
| <i>tretinoin 0.1% cream</i> (Retin-a) | T1 | PA |
| <i>tretinoin microspheres</i> (Retin-a Micro Pump) | T1 | PA |
| <i>tretinoin microspheres</i> (Retin-a Micro) | T1 | PA |
| TRETIN-X | T3 | PA |
| VITAMIN A DERIVATIVES, TOPICAL ACNE AGENTS | | |
| ARAZLO | T2 | |
| FABIOR | T3 | |
| TAZAROTENE 0.1% FOAM | T3 | |

SMOKING DETERRENTS (Smoking Cessation)⁸

| | | |
|---|----|-------|
| SMOKING DETERRENT AGENTS (GANGLIONIC STIM, OTHERS) | | |
| NICOTROL | T2 | PPACA |
| NICOTROL NS | T2 | PPACA |
| SMOKING DETERRENT-NICOTINIC RECEPT.PARTIAL AGONIST | | |
| CHANTIX | T2 | |
| <i>varenicline 1 mg cont month bx</i> | T1 | PPACA |
| SMOKING DETERRENTS, OTHER | | |
| <i>bupropion hcl sr 150 mg tablet</i> | T1 | PPACA |

THYROID PREPS (Hormonal Agents)

| | | |
|----------------------------------|----|----|
| ANTI-THYROID PREPARATIONS | | |
| <i>methimazole (Tapazole)</i> | T1 | HD |

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

T4 – Injectable Specialty Medications

PA – Prior Authorization

QL – Quantity Limit

ST – Step Therapy

AGE – Age Requirement

SP – Specialty Medication

HD – May require home delivery pharmacy

PPACA – No Cost-Share Preventive Medication

CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

THYROID PREPS (Hormonal Agents) (cont.)

| Prescription Drug Name | Drug Tier | Coverage Requirements and Limits |
|---|-----------|----------------------------------|
| ANTI-THYROID PREPARATIONS (con't.) | | |
| <i>propylthiouracil</i> | T1 | HD |
| TAPAZOLE (<i>methimazole</i>) | T3 | HD |
| THYROID HORMONES | | |
| <i>adthyza 120 mg tablet</i> | T1 | PA HD |
| ADTHYZA 130 MG TABLET | T3 | PA HD |
| <i>adthyza 15 mg tablet</i> | T1 | PA HD |
| ADTHYZA 16.25 MG TABLET | T3 | PA HD |
| <i>adthyza 30 mg tablet</i> | T1 | PA HD |
| ADTHYZA 32.5 MG TABLET | T3 | PA HD |
| <i>adthyza 60 mg tablet</i> | T1 | PA HD |
| ADTHYZA 65 MG TABLET | T3 | PA HD |
| ADTHYZA 97.5 MG TABLET | T3 | PA HD |
| ARMOUR THYROID | T3 | HD |
| CYTOMEL (<i>liothyronine sodium</i>) | T3 | HD |
| LEVOTHYROXINE | T3 | HD |
| <i>levothyroxine sodium (Synthroid)</i> | T1 | HD |
| <i>levothyroxine sodium (Synthroid)</i> | T3 | HD |
| <i>liothyronine sodium (Cytomel)</i> | T1 | HD |
| SYNTHROID (<i>unithroid</i>) | T3 | HD |
| THYQUIDITY | T3 | PA HD |
| <i>thyroid, pork</i> | T1 | HD |
| <i>thyroid, pork (Armour Thyroid)</i> | T1 | HD |
| <i>thyroid, pork (Wp Thyroid)</i> | T1 | HD |
| THYROLAR-1 | T2 | HD |
| THYROLAR-1/2 | T2 | HD |
| THYROLAR-1/4 | T2 | HD |
| THYROLAR-2 | T2 | HD |
| THYROLAR-3 | T2 | HD |
| TIROSINT | T3 | HD |
| TIROSINT-SOL | T3 | HD |
| WP THYROID | T1 | HD |
| WP THYROID (<i>nature-throid</i>) | T1 | HD |
| WP THYROID (<i>westhroid</i>) | T1 | HD |

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

T4 – Injectable Specialty Medications

PA – Prior Authorization

QL – Quantity Limit

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AGE – Age Requirement

SP – Specialty Medication

HD – May require home delivery pharmacy

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CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

| UNCLASSIFIED DRUG PRODUCTS (AIDS/HIV) | | |
|---|-----------|----------------------------------|
| Prescription Drug Name | Drug Tier | Coverage Requirements and Limits |
| 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 CAP | T3 | PA SP |
| ORKAMBI 100 MG-125 MG TABLET | T3 | PA QL (4 tabs/day) SP HD |
| ORKAMBI 100-125 MG GRANULE PKT | T3 | PA QL (2 packs/day) SP HD |
| ORKAMBI 150-188 MG 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 | T3 | PA QL (3 tabs/day) SP HD |
| CYSTIC FIB-TRANSMEMB CONDUCT.REG.(CFTR) POTENTIATOR | | |
| KALYDECO 5.8 MG TABLET | T3 | PA QL (2 tabs/day) 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 |
| 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 | T2 | PA SP HD |
| PULMONARY FIBROSIS - SYSTEMIC ENZYME INHIBITORS | | |
| OFEV | T2 | PA SP HD |
| SYSTEMIC ENZYME INHIBITORS | | |
| JOENJA | T3 | PA QL SP |
| VIVOICE 125mg,50 mg | T3 | PA QL(PA QL (30tabs/30days) SP |
| VIVOICE 250mg dose pack | T3 | PA QL (2 tabs/30 days) |
| ZOKINVY | T3 | PA QL (4 CAPS/DAY) SP |
| UNCLASSIFIED DRUG PRODUCTS (Blood Modifiers/Bleeding Disorders) | | |
| SPLEEN TYROSINE KINASE INHIBITORS | | |
| TAVALISSE | T2 | PA SP |

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

T4 – Injectable Specialty Medications

PA – Prior Authorization

QL – Quantity Limit

ST – Step Therapy

AGE – Age Requirement

SP – Specialty Medication

HD – May require home delivery pharmacy

PPACA – No Cost-Share Preventive Medication

CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

| UNCLASSIFIED DRUG PRODUCTS (Blood Pressure/Heart Medications) | | |
|---|-----------|----------------------------------|
| Prescription Drug Name | Drug Tier | Coverage Requirements and Limits |
| ANTI-INFLAMMATORY-ANTIMITOTICS | | |
| LODOCO | T3 | PA |
| BRADYKININ B2 RECEPTOR ANTAGONISTS | | |
| FIRAZYR (<i>icatibant</i>) | T4 | PA SP |
| <i>icatibant acetate</i> (Firazyr) | T4 | PA SP HD |
| CI ESTERASE INHIBITORS | | |
| BERINERT | T3 | PA SP HD |
| CINRYZE | T3 | PA SP HD |
| HAEGARDA | T4 | PA SP HD |
| RUCONEST | T3 | PA SP HD |
| PLASMA KALLIKREIN INHIBITORS | | |
| KALBITOR | T3 | PA SP HD |
| ORLADEYO | T3 | PA QL (1 CAPS/DAY) SP |
| UNCLASSIFIED DRUG PRODUCTS (Cancer) | | |
| CHEMOTHERAPY RESCUE/ANTIDOTE AGENTS | | |
| <i>leucovorin calcium</i> | T1 | |
| <i>mesna</i> (Mesnex) | T1 | SP CSL |
| MESNEX | T3 | SP |
| VISTOGARD | T3 | SP |
| UNCLASSIFIED DRUG PRODUCTS (Dental Products) | | |
| DENTAL AIDS AND PREPARATIONS | | |
| <i>chlorhexidine gluconate</i> (Peridex) | T1 | |
| PERIDEX (<i>periogard</i>) | T1 | |
| <i>triamcinolone acetonide</i> | T1 | |
| PERIODONTAL COLLAGENASE INHIBITORS | | |
| <i>doxycycline hyclate 20 mg tab</i> | T1 | |
| UNCLASSIFIED DRUG PRODUCTS (Diabetes) | | |
| PERIODONTAL COLLAGENASE INHIBITORS | | |
| INPEFA | T3 | PA QL(1 tab/day) HD |
| UNCLASSIFIED DRUG PRODUCTS (Erectile Dysfunction) | | |
| DRUGS TO TREAT ERECTILE DYSFUNCTION (ED) | | |
| CAVERJECT | T3 | PA QL (6 injectors/30 days) |
| CIALIS 10 MG TABLET (<i>tadalafil</i>) | T3 | QL (1 tab/30 days) ST |
| CIALIS 20 MG TABLET (<i>tadalafil</i>) | T3 | ST QL(8 tabs/30 days) |
| CIALIS 5 MG TABLET (<i>tadalafil</i>) | T3 | ST QL(1 tab/day) |

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

T4 – Injectable Specialty Medications

PA – Prior Authorization

QL – Quantity Limit

ST – Step Therapy

AGE – Age Requirement

SP – Specialty Medication

HD – May require home delivery pharmacy

PPACA – No Cost-Share Preventive Medication

CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

UNCLASSIFIED DRUG PRODUCTS (Erectile Dysfunction) (cont.)

| Prescription Drug Name | Drug Tier | Coverage Requirements and Limits |
|---|-----------|----------------------------------|
| DRUGS TO TREAT ERECTILE DYSFUNCTION (ED) (cont.) | | |
| EDEX | T3 | PA QL (6 injectors/30 days) |
| IFE-BIMIX 30/1 | T2 | |
| IFE-PG20 | T2 | |
| LEVITRA (<i>ildenafil hcl</i>) | T3 | QL (10 tabs/30 days) ST |
| MUSE | T2 | PA QL (6/30 days) |
| PAPAVERINE-ALPROSTADIL | T1 | |
| PHENTOLAMINE-ALPROSTADIL | T1 | |
| <i>sildenafil 100 mg tablet (Viagra)</i> | T1 | QL(8 TABS/30 DAYS) HD |
| <i>sildenafil 25 mg tablet (Viagra)</i> | T1 | QL(8 TABS/30 DAYS) HD |
| <i>sildenafil 50 mg tablet (Viagra)</i> | T1 | QL(8 TABS/30 DAYS) HD |
| STENDRA (<i>avanafil</i>) | T3 | QL (8 tabs/30 days) ST |
| <i>tadalafil 2.5 mg tablet</i> | T1 | QL(1 TAB/DAY) HD |
| <i>tadalafil 5 mg tablet (Cialis)</i> | T1 | QL(1 TAB/DAY) HD |
| <i>tadalafil 10 mg tablet (Cialis)</i> | T1 | QL(8 TABS/30 DAYS) HD |
| <i>tadalafil 20 mg tablet (Cialis)</i> | T1 | QL(8 TABS/30 DAYS) HD |
| <i>ildenafil hcl</i> | T1 | QL (10 tabs/30 days) |
| <i>ildenafil hcl (Levitra)</i> | T1 | QL (10 tabs/30 days) |
| VIAGRA (<i>sildenafil citrate</i>) | T3 | ST QL(8 tabs/30 days) |

UNCLASSIFIED DRUG PRODUCTS (Gastrointestinal/Heartburn)

| | | |
|---|----|------------------------|
| CALCIMIMETIC, PARATHYROID CALCIUM ENHANCER | | |
| <i>cinacalcet hcl</i> (Sensipar) | T1 | SP |
| SENSIPAR (<i>cinacalcet hcl</i>) | T3 | PA SP |
| ORAL MUCOSITIS/STOMATITIS AGENTS | | |
| GELCLAIR | T3 | |
| ORAMAGICRX | T3 | |
| REZDIFRA | T3 | PA QL(1 tab/day) SP HD |
| SALIVA STIMULANT AGENTS | | |
| NUMOISYN | T3 | |

UNCLASSIFIED DRUG PRODUCTS (Hormonal Agents)

| | | |
|--|----|-----------------------------|
| BONE FORMATION STIM. AGENTS - PARATHYROID HORMONE | | |
| FORTEO | T2 | PA QL (3ML/21 DAYS) SP HD |
| <i>teriparatide 600 mcg/2.4ml pen</i> | T1 | PA QL(0.09 mls/day) SP HD |
| TERIPARATIDE 620 MCG/2.48 ML | T3 | PA QL(0.09 mls/day) SP HD |
| TERIPARATIDE | T3 | PA QL (1 pen/28 days) SP HD |

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

T4 – Injectable Specialty Medications

PA – Prior Authorization

QL – Quantity Limit

ST – Step Therapy

AGE – Age Requirement

SP – Specialty Medication

HD – May require home delivery pharmacy

PPACA – No Cost-Share Preventive Medication

CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

| UNCLASSIFIED DRUG PRODUCTS (Hormonal Agents) (con't.) | | |
|---|-----------|----------------------------------|
| Prescription Drug Name | Drug Tier | Coverage Requirements and Limits |
| GROWTH HORMONE RECEPTOR ANTAGONISTS | | |
| SOMAVERT | T4 | PA SP HD |
| HYPERPARATHYROID TX AGENTS - VITAMIN D ANALOG-TYPE | | |
| doxercalciferol | T1 | |
| paricalcitol | T1 | SP HD |
| paricalcitol (Zemplar) | T1 | SP HD |
| RAYALDEE | T3 | |
| ZEMPLAR (paricalcitol) | T3 | SP HD |
| MENOPAUSAL SYMPT SUPP-SEL ESTROGEN RECEP MODULATOR | | |
| OSPHENA | T3 | HD |
| UNCLASSIFIED DRUG PRODUCTS (Miscellaneous) | | |
| ABORTIFACIENT-PROGESTERONE RECEPTOR ANTAGONISTS | | |
| MIFEPREX | T3 | |
| mifepristone (Mifeprex) | T1 | |
| AGENTS TO TX PERIODIC PARALYSIS - CARBON ANHYD INH | | |
| dichlorphenamide (Keveyis) | T1 | PA SP |
| KEVEYIS | T3 | SP |
| AMMONIA INHIBITORS | | |
| CARBAGLU (carglumic acid) | T3 | SP HD |
| carglumic acid (Carbaglu) | T1 | SP HD |
| AMYLOIDOSIS AGENTS-TRANSTHYRETIN (TTR) SUPPRESSION | | |
| TEGSEDI | T3 | PA SP HD |
| WAINUA | T4 | PA QL(1 auto-inj/28 days) SP |
| ANTI-ALCOHOLIC PREPARATIONS | | |
| acamprosate calcium | T1 | |
| ANTABUSE (disulfiram) | T3 | |
| disulfiram (Antabuse) | T1 | |
| ANTIDOTES, MISCELLANEOUS | | |
| CETYLEV | T3 | |
| ANTI-FIBROTIC THERAPY - PYRIDONE ANALOGS | | |
| ESBRIET | T3 | PA SP HD |
| pirfenidone 267 mg capsule | T1 | PA SP HD |
| COMPLEMENT INHIBITORS | | |
| ZILBRYSQ | T4 | PA QL(1 syringe/day) SP |

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T4 – Injectable Specialty Medications

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AGE – Age Requirement

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List of Prescription Medications

UNCLASSIFIED DRUG PRODUCTS (Miscellaneous) (cont.)

| Prescription Drug Name | Drug Tier | Coverage Requirements and Limits |
|---|-----------|----------------------------------|
| CRYOPRESERVATIVE AGENTS | | |
| <i>dimethyl sulfoxide</i> | T1 | |
| DRUGS TO TREAT HEREDITARY TYROSINEMIA | | |
| <i>nitisinone</i> (Orfadin) | T1 | PA SP HD |
| NITYR | T2 | 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> | T1 | |
| <i>sodium chloride for inhalation</i> (Hyper-sal) | T1 | |
| GENETIC D/O TX - SMN PROTEIN DEFICIENCY TREATMENT | | |
| EVRYSDI 60 MG/80 ML(0.75MG/ML) | T3 | PA SP HD |
| GENETIC DISORDER THERAPY - HDAC INHIBITOR | | |
| DUVYZAT | T3 | PA SP |
| GLUCOSYLCERAMIDE SYNTHASE (GCS) INHIBITOR | | |
| CERDELGA | T2 | PA SP HD |
| OPFOLDA | T3 | PA QL(8 CAPS/30 DAYS) SP HD |
| <i>miglustat</i> (Zavesca) | T1 | PA SP |
| ZAVESCA (<i>miglustat</i>) | T3 | PA SP HD |
| GENETIC D/O TX - SMN PROTEIN DEFICIENCY TREATMENT | | |
| MIPLYFFA | T3 | PA SP |
| 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 DISEASE ENZYME REPLACE, HYPOPHOSPHATASIA | | |
| STRENsiQ | T4 | PA SP |
| METABOLIC DISEASE ENZYME REPLACEMENT, MOCD | | |
| NULIBRY | T3 | PA SP |
| METALLIC POISON, AGENTS TO TREAT | | |
| CHEMET | T3 | |
| CUVRIOR | T3 | PA SP |
| <i>deferasirox</i> (Exjade) | T1 | SP HD |
| <i>deferasirox</i> (Jadenu Sprinkle) | T1 | SP HD |
| <i>deferasirox</i> (Jadenu) | T1 | SP HD |
| <i>deferiprone</i> (Ferriprox) | T1 | PA SP |
| EXJADE (<i>deferasirox</i>) | T3 | PA SP HD |

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

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

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

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

List of Prescription Medications

UNCLASSIFIED DRUG PRODUCTS (Miscellaneous) (con't.)

| Prescription Drug Name | Drug Tier | Coverage Requirements and Limits |
|--|-----------|----------------------------------|
| METALLIC POISON, AGENTS TO TREAT (con't.) | | |
| FERRIPROX | T3 | PA SP |
| FERRIPROX (2 TIMES A DAY) | T3 | PA SP |
| GALZIN | T3 | SP |
| JADENU (<i>deferasirox</i>) | T3 | PA SP HD |
| JADENU SPRINKLE (<i>deferasirox</i>) | T3 | PA SP HD |
| RADIOGARDASE | T3 | |
| SYPRINE (<i>trientine hcl</i>) | T3 | PA SP HD |
| <i>trientine hcl</i> (Syprine) | T1 | PA SP HD |
| NATRIURETIC PEPTIDES | | |
| VOXZOGO | T4 | PA SP HD |
| NEONATAL FC RECEPTOR (FCRN) INHIBITORS | | |
| VYVGART HYTRULO | T3 | PA SP HD |
| NICOTINIC RECEPT.PARTIAL AGONIST, ALPHA4BETA2 SPEC | | |
| TYRVAYA | T3 | PA QL (2/month) HD |
| NUCLEAR FACTOR ERYTHROID 2-REL. FACTOR 2 ACTIVATOR | | |
| SKYCLARYS | T1 | |
| ointment/cream bases | | |
| RADIAGEL | T1 | |
| OVERACTIVE BLADDER AGENTS, BETA-3 ADRENERGIC RECEPTOR ANTAGONISTS | | |
| <i>mirabegron er 25 mg tablet</i> (Myrbetriq) | T1 | PA QL (1 tab/day) HD |
| <i>mirabegron er 50 mg tablet</i> (Myrbetriq) | T1 | PA HD |
| MYRBETRIQ ER 25 MG TABLET (<i>mirabegron</i>) | T3 | ST QL(1 TAB/DAY) HD |
| MYRBETRIQ ER 50 MG TABLET | T3 | ST HD |
| OXALOSIS AGENT - OXALATE INHIBITOR, SIRNA BASED | | |
| RIVFOLOZA | T4 | PA QL(1 syringe/30 days) SP |
| PHARMACOLOGICAL CHAPERONE-ALPHA-GALACTOSIDASE STABZ | | |
| GALAFOLD | T3 | PA SP HD |
| PKU TX AGENT-COFACTOR OF PHENYLALANINE HYDROXYLASE | | |
| KUVAN (<i>sapropterin dihydrochloride</i>) | T3 | PA SP HD |
| <i>sapropterin dihydrochloride</i> (Kuvan) | T1 | PA SP HD |
| PROTEIN STABILIZERS | | |
| ATTRUBY | T3 | PA |
| VYNDAMAX | T3 | PA QL (1 cap/day) SP HD |
| VYndaQEL | T3 | PA QL (4 caps/day) SP HD |
| RETINOIC ACID RECEPTOR (RAR) AGONISTS | | |
| SOHONOS | T3 | PA SP |
| SOLVENTS | | |
| FT ISOPROPYL ALCOHOL 91% | T1 | |

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

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

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

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

List of Prescription Medications

| UNCLASSIFIED DRUG PRODUCTS (Miscellaneous) (con't.) | | |
|---|-----------|----------------------------------|
| Prescription Drug Name | Drug Tier | Coverage Requirements and Limits |
| SOLVENTS (con't.) | | |
| FT ISOPROPYL RUB ALCOHOL 70% | T3 | |
| <i>isopropyl alcohol</i> | T1 | |
| MURI-LUBE MINERAL OIL | T1 | |
| THYMIC STROMAL LYMPHOPOIETIN (TSLP) INHIBITORS | | |
| TEZSPIRE | T4 | PA SP |
| UNCLASSIFIED DRUG PRODUCTS (Nutritional/Dietary) | | |
| METABOLIC DEFICIENCY AGENTS | | |
| <i>betaine</i> (Cystadane) | T1 | SP |
| CARNITOR 1 GM/5 ML VIAL | T3 | PA |
| CARNITOR 100 MG/ML ORAL SOLN (<i>levocarnitine</i>) | T3 | PA |
| CARNITOR 330 MG TABLET (<i>levocarnitine</i>) | T3 | PA |
| CARNITOR SF (<i>levocarnitine sf</i>) | T3 | PA |
| CYSTADANE | T2 | SP |
| <i>levocarnitine</i> (Carnitor Sf) | T1 | |
| <i>levocarnitine</i> (Carnitor) | T1 | |
| <i>levocarnitine (with sugar)</i> (Carnitor) | T1 | |
| UNCLASSIFIED DRUG PRODUCTS (Osteoporosis Products) | | |
| BONE RESORPTION INHIBITOR AND VITAMIN D COMBS. | | |
| FOSAMAX PLUS D | T3 | ST HD |
| BONE RESORPTION INHIBITORS | | |
| ACTONEL (<i>risedronate sodium</i>) | T3 | ST HD |
| <i>alendronate sodium</i> | T1 | HD |
| <i>alendronate sodium</i> (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 |
| <i>ibandronate sodium</i> | T1 | HD |
| <i>raloxifene hcl</i> (Evista) | T1 | HD PPACA |
| <i>risedronate sodium</i> | T1 | HD |
| <i>risedronate sodium</i> (Actonel) | T1 | HD |
| <i>risedronate sodium</i> (Atelvia) | T1 | HD |

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

T4 – Injectable Specialty Medications

PA – Prior Authorization

QL – Quantity Limit

ST – Step Therapy

AGE – Age Requirement

SP – Specialty Medication

HD – May require home delivery pharmacy

PPACA – No Cost-Share Preventive Medication

CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

| UNCLASSIFIED DRUG PRODUCTS (Pain Relief And Inflammatory Disease) | | | |
|---|---------------------------------------|----------------------------------|---|
| Prescription Drug Name | Drug Tier | Coverage Requirements and Limits | |
| ANTI-INFLAM. INTERLEUKIN-I RECEPTOR ANTAGONIST | | | |
| ARCALYST | T4 | PA SP HD | |
| ANTI-INFLAMMATORY, INTERLEUKIN-I BETA BLOCKERS | | | |
| ILARIS | T3 | PA SP HD | |
| FIBROMYALGIA AGENTS, SEROTONIN-NOREPINEPHRINE INHIB | | | |
| SAVELLA | T2 | | |
| IMMUNOMODULATOR, B-LYMPHOCYTE STIM (BLYS)-SPEC INHIB | | | |
| BENLYSTA | T4 | PA SP HD | |
| UNCLASSIFIED DRUG PRODUCTS (Seizure Disorders) | | | |
| NEUROPATHIC AGENTS | | | |
| LYRICA CR | T3 | HD | |
| UNCLASSIFIED DRUG PRODUCTS (Skin Conditions) | | | |
| INTERLEUKIN-13 (IL-13) INHIBITORS,MAB | | | |
| ADBRY | T4 | PA SP HD | |
| ADBRY AUTOINJECTOR | T4 | PA SP HD | |
| EBGLYSS PEN | T4 | PA SP | |
| WOUND HEALING AGENTS, LOCAL | | | |
| FILSUVEZ | T3 | PA SP | |
| UNCLASSIFIED DRUG PRODUCTS (Substance Abuse) | | | |
| OPIOID WITHDRAWAL THER, ALPHA-2 ADRENERGIC AGONIST | | | |
| lofexidine hcl | T1 | QL(192 tabs/30 days) | |
| LUCEMYRA | T2 | QL (168 tabs/14 days) | |
| OPIOID WITHDRAWAL THERAPY AGENTS, OPIOID-TYPE | | | |
| BUNAVAIL | T3 | | |
| buprenorphine hcl | T1 | | |
| buprenorphine hcl/naloxone hcl | T1 | | |
| buprenorphine hcl/naloxone hcl (Suboxone) | T1 | | |
| SUBOXONE (buprenorphine-naloxone) | T3 | | |
| ZUBSOLV | T2 | | |
| UNCLASSIFIED DRUG PRODUCTS (Transplant Medications) | | | |
| RHO KINASE INHIBITOR | | | |
| REZUROCK | T3 | PA SP HD | |
| UNCLASSIFIED DRUG PRODUCTS (Urinary Tract Conditions) | | | |
| BENIGN PROSTATIC HYPERPLASIA/MICTURITION AGENTS | | | |
| alfuzosin hcl (Uroxatral) | T1 | HD | |
| AVODART (dutasteride) | T3 | PA HD | |
| T1 – Typically Generics | T4 – Injectable Specialty Medications | ST – Step Therapy | HD – May require home delivery pharmacy |
| T2 – Typically Preferred Brands | PA – Prior Authorization | AGE – Age Requirement | PPACA – No Cost-Share Preventive Medication |
| T3 – Typically Non-Preferred Brands | QL – Quantity Limit | SP – Specialty Medication | CSL – Oral cancer medication subject to cost-share limits |

List of Prescription Medications

| UNCLASSIFIED DRUG PRODUCTS (Urinary Tract Conditions) (con't.) | | |
|--|-----------|----------------------------------|
| Prescription Drug Name | Drug Tier | Coverage Requirements and Limits |
| BENIGN PROSTATIC HYPERPLASIA/MICTURITION AGENTS (con't.) | | |
| dutasteride (Avodart) | T1 | HD |
| finasteride (Proscar) | T1 | HD |
| FLOMAX (tamsulosin hcl) | T3 | PA HD |
| PROSCAR (finasteride) | T3 | HD |
| RAPAFLO 4 MG CAPSULE (silodosin) | T3 | QL (1 cap/day) HD |
| RAPAFLO 8 MG CAPSULE (silodosin) | T3 | HD |
| silodosin 4 mg capsule (Rapaflo) | T1 | QL (1 cap/day) HD |
| silodosin 8 mg capsule (Rapaflo) | T1 | HD |
| tamsulosin hcl (Flomax) | T1 | HD |
| UROXATRAL (alfuzosin hcl er) | T3 | PA HD |
| BPH AGENT-5-ALPHA-REDUCTASE INH AND PDE5 INH COMB | | |
| ENTADFI | T3 | PA QL (30caps/30days) |
| BPH 5-ALPHA-REDUCTASE INHIB-ALPHAI-ADRENOCEP ANTAG | | |
| dutasteride/tamsulosin hcl (Jalyn) | T1 | HD |
| CYSTINE-DEPLETING AGENTS, NEPHROPATHIC CYSTINOSIS | | |
| CYSTAGON | T2 | SP |
| PROCYSB1 | T3 | PA SP HD |
| KIDNEY STONE AGENTS | | |
| THIOLA | T3 | PA SP |
| THIOLA EC | T3 | PA SP |
| tiopronin | T1 | SP |
| OVERACTIVE BLADDER AGENTS, BETA-3 ADRENERGIC RECEPTOR ANTAGONISTS | | |
| GEMTESA | T3 | QL (1 tab/Day) ST HD |
| mirabegron er 25 mg tablet (Myrbetriq) | T1 | QL (1 tab/day) HD |
| mirabegron er 50 mg tablet (Myrbetriq) | T1 | HD |
| MYRBETRIQ ER 25 MG TABLET | T3 | QL (1 tab/day) ST HD |
| MYRBETRIQ ER 50 MG TABLET | T3 | ST HD |
| URINARY TRACT ANTI-SPASMODIC, M(3) SELECTIVE ANTAG. | | |
| darifenacin er 15 mg tablet | T1 | HD |
| darifenacin er 7.5 mg tablet (Enablex) | T1 | QL (1 tab/day) HD |
| ENABLEX (darifenacin er) | T3 | QL (1 tab/day) ST HD |
| solifenacin 10 mg tablet (Vesicare) | T1 | HD |
| solifenacin 5 mg tablet (Vesicare) | T1 | QL (1 tab/day) HD |
| VESICARE 10 MG TABLET (solifenacin succinate) | T3 | ST HD |
| VESICARE 5 MG TABLET (solifenacin succinate) | T3 | QL (1 tab/day) ST HD |

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

T4 – Injectable Specialty Medications

PA – Prior Authorization

QL – Quantity Limit

ST – Step Therapy

AGE – Age Requirement

SP – Specialty Medication

HD – May require home delivery pharmacy

PPACA – No Cost-Share Preventive Medication

CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

| UNCLASSIFIED DRUG PRODUCTS (Urinary Tract Conditions) (con't.) | | |
|--|-----------|----------------------------------|
| Prescription Drug Name | Drug Tier | Coverage Requirements and Limits |
| URINARY TRACT ANTI-SPASMODIC, M(3) SELECTIVE ANTAG. (con't.) | | |
| VESICARE LS | T3 | ST HD |
| URINARY TRACT ANTI-SPASMODIC/ANTI-INCONTINENCE AGENT | | |
| DETROL (<i>tolterodine tartrate</i>) | T3 | ST HD |
| DETROL LA 2 MG CAPSULE (<i>tolterodine tartrate er</i>) | T3 | QL (1 cap/day) ST HD |
| URINARY TRACT ANTI-SPASMODIC/ANTI-INCONTINENCE AGENT (con't.) | | |
| DETROL LA 4 MG CAPSULE (<i>tolterodine tartrate er</i>) | T3 | ST HD |
| DITROPAN XL (<i>oxybutynin chloride er</i>) | T3 | ST HD |
| <i>flavoxate hcl</i> | T1 | HD |
| <i>oxybutynin chloride</i> | T1 | HD |
| <i>oxybutynin chloride</i> (Ditropan XI) | T1 | HD |
| OXYTROL | T3 | ST HD |
| <i>tolterodine tart er 2 mg cap</i> (Detrol La) | T1 | QL (1 cap/day) HD |
| <i>tolterodine tart er 4 mg cap</i> (Detrol La) | T1 | HD |
| <i>tolterodine tartrate</i> (Detrol) | T1 | HD |
| TOVIAZ ER 4 MG TABLET | T2 | QL (1 tab/day) HD |
| TOVIAZ ER 8 MG TABLET | T2 | HD |
| <i>trospium chloride</i> | T1 | HD |
| UNCLASSIFIED DRUG PRODUCTS (Weight Management) | | |
| APPETITE STIM. FOR ANOREXIA, CACHEXIA, WASTING SYND. | | |
| <i>megestrol acetate</i> | T1 | |
| VITAMINS (Nutritional/Dietary) | | |
| FOLIC ACID PREPARATIONS | | |
| <i>folic acid</i> | T1 | |
| <i>true folic acid 1600mcg dfe tb</i> | T1 | |
| MULTIVITAMIN PREPARATIONS | | |
| CONCEPT DHA CAPSULE | T3 | |
| FOLET ONE | T2 | |
| <i>mvn no.53/iron/folic/dss/dha</i> | T1 | |
| OBSTETRIX ONE | T1 | |
| VITAMIN B PREPARATIONS | | |
| POTABA | T2 | HD |
| VITAMIN B12 PREPARATIONS | | |
| <i>cyanocobalamin (vitamin b-12)</i> | T1 | |
| NASCOBAL | T3 | PA |

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

T4 – Injectable Specialty Medications

PA – Prior Authorization

QL – Quantity Limit

ST – Step Therapy

AGE – Age Requirement

SP – Specialty Medication

HD – May require home delivery pharmacy

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CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

VITAMINS (Nutritional/Dietary) (con't.)

| Prescription Drug Name | Drug Tier | Coverage Requirements and Limits |
|--|-----------|----------------------------------|
| VITAMIN D PREPARATIONS | | |
| <i>calcitriol</i> 0.25 mcg capsule | T1 | |
| <i>calcitriol</i> 0.5 mcg capsule | T1 | |
| <i>calcitriol</i> 1 mcg/ml solution | T1 | |
| <i>ergocalciferol</i> (vitamin d2) (Drisdol) | T1 | HD |
| ROCALTROL (<i>calcitriol</i>) | T3 | HD |
| VITAMIN K PREPARATIONS | | |
| MEPHYTON (<i>phytonadione</i>) | T3 | |
| <i>phytonadione</i> (vit k1) (Mephyton) | T1 | |

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

T4 – Injectable Specialty Medications

PA – Prior Authorization

QL – Quantity Limit

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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.

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

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



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

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

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

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

Discrimination is against the law.

Medical coverage

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

Cigna Healthcare:

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

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

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

Cigna Healthcare

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

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

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

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



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Proficiency of Language Assistance Services

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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