



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

Coverage as of January 1, 2025

For the State of California

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

View your drug list online: [Cigna.com/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 This drug list is subject to change and all prior versions are no longer in effect.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.
927837 m CA Legacy (Standard) 4-Tier Specialty 07/25 © 2024 Cigna Healthcare.





What's Inside?	Page
Information about this drug list	3
· Frequently asked questions (FAQs)	3
· Words you may need to know	10
· About this drug list	12
· How to read this drug list	12
· How to find your medication	15
List of prescription medications	18
Exclusions and limitations for coverage	180
Index of medications	181

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 (all specialty medications covered on tier 4) (CDI) [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. How do I know which pharmacies are in my plan's network?

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

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

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

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

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

Q. Can I fill my prescriptions by mail?

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

Express Scripts® Pharmacy for maintenance medications

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

- Easily order, manage, track and pay for your medications on your phone or online

Information about this drug list

Frequently asked questions (FAQs) (cont.)

- Standard shipping at no extra cost⁵
- Automatic refills or refill reminders
- Fill up to a 90-day supply at one time⁶
- Helpful pharmacists available 24/7
- Flexible payment options

Here are three easy ways to get started.

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

Accredo for specialty medications

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

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

To get started using Accredo, call **877.826.7657**, Monday–Friday, 7:00 am–10:00 pm CST and

Saturdays, 7:00 am–4:00 pm CST. To learn more about Accredo, go to Cigna.com/specialty.

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

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

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

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

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

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

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

Information about this drug list

Frequently asked questions (FAQs) (cont.)

and nurses will provide you with the personalized care and support you need to manage your complex medical condition. They'll help you work through side effects, check in with you and your doctor to see how your therapy's going, help you get your medications approved for coverage, and more.

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

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

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

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

A. Covered medications are divided into tiers (or cost-share levels). Typically, the higher the tier, the higher the price you'll pay to fill the prescription. Here are three places you can go to find out how much you'll pay for your medication based on the tier it's listed in, including the maximum cost-share amount allowed.

1. **Check your Cigna Healthcare ID card.** It lists your cost-share for Tier 1, Tier 2, Tier 3 and Tier 4 medications.

2. **Log in to the myCigna App or myCigna.com to view your pharmacy coverage information.** You can also use the Price a Medication tool to find out how much your medication may cost you at the different pharmacies in your plan's network.

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

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

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

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

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

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

Information about this drug list

Frequently asked questions (FAQs) (cont.)

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

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

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

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

Words you may need to know

- **Brand name drug:** A drug that is marketed under a proprietary, trademark-protected name. A brand name drug is listed in this formulary in all CAPITAL letters.
- **Coinsurance:** A percentage of the cost of a covered health care benefit that you pay after you have paid the deductible, if a deductible applies to the health care benefit.
- **Copayment:** A fixed dollar amount that you pay for a covered health care benefit after you have paid the deductible, if a deductible applies to the health care benefit.
- **Deductible:** The amount you pay for covered health care benefits that are subject to the deductible before your health insurer begins to pay. If your health insurance policy has a deductible, it may have either one deductible or separate deductibles for medical benefits and prescription drug benefits. After you pay your deductible, you usually pay only a copayment or coinsurance for covered health care benefits. Your insurance company pays the rest.
- **Drug tier:** A group of prescription drugs that correspond to a specified cost sharing tier in your

Information about this drug list

Words you may need to know (cont.)

health insurance policy. The drug tier in which a prescription drug is placed determines your portion of the cost for the drug.

- **Exception request:** A request for coverage of a non-formulary drug. If you, your designee, or your prescribing health care provider submits a request for coverage of a non-formulary drug, your insurer must cover the non-formulary drug when it is medically necessary for you to take the drug.
- **Exigent circumstances:** When you are suffering from a medical condition that may seriously jeopardize your life, health, or ability to regain maximum function, or when you are undergoing a current course of treatment using a non-formulary drug.
- **Formulary or prescription drug list:** The list of drugs that is covered by your health insurance policy under the prescription drug benefit of the policy.
- **Generic drug:** A drug that is the same as its brand name drug equivalent in dosage, strength, effect, how it is taken, quality, safety, and intended use. A generic drug is listed in this formulary in italicized lowercase letters.
- **Medically Necessary:** Health care benefits needed to diagnose, treat, or prevent a medical condition or its symptoms and that meet accepted standards of medicine. Health insurance usually does not cover health care benefits that are not medically necessary.
- **Non-formulary drug:** A prescription drug that is not listed on this formulary.
- **Out-of-pocket costs:** Your expenses for health care benefits that aren't reimbursed by your health insurance. Out-of-pocket costs include deductibles, copayments, and coinsurance for covered health care benefits, plus all costs for health care benefits that are not covered.
- **Prescribing provider:** A health care provider who can write a prescription for a drug to diagnose, treat, or prevent a medical condition.

- **Prescription:** An oral, written, or electronic order from a prescribing provider authorizing a prescription drug to be provided to a specific individual.
- **Prescription drug:** A drug that by law requires a prescription.
- **Prior Authorization:** A decision by your health insurer that a health care benefit is medically necessary for you. If a prescription drug is subject to prior authorization in this formulary, your prescribing provider must request approval from your health insurer to cover the drug before you fill your prescription. Your health insurer must grant a prior authorization request when it is medically necessary for you to take the drug.
- **Step Therapy:** A specific sequence in which prescription drugs for a particular medical condition must be tried. If a drug is subject to step therapy in this formulary, you may have to try one or more other drugs before your health insurance policy will cover that drug for your medical condition. If your prescribing provider submits a request for an exception to the step therapy requirement, your health insurer must grant the request when it is medically necessary for you to take the drug.
- **Quantity Limits:** For some medications, your plan will only cover up to a certain amount over a certain length of time. For example, 30mg per day for 30 days. Quantity limits help to make sure you're receiving coverage for the right medication, in the right amount, and for the right situation. Your plan will only cover a larger amount if your doctor requests and receives approval from Cigna Healthcare.
- **Age Requirements:** For certain medications, you must be within a specific age range for your plan to cover them. This is because some medications aren't considered clinically appropriate for individuals who aren't within that age range.

Information about this drug list

About this drug list

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

Tiers

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

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

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

Information about this drug list

How to read this drug list (cont.)

Letters (acronyms) next to medication names

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

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

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

Information about this drug list

How to read this drug list (cont.)

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

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

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

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

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

Prescription drug name is the name of the medication

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

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

Generic medications are in **lowercase italics**

This chart is just a sample. It may not show how these medications are actually covered on the Cigna Healthcare 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)	48
Analgesics (Urinary Tract Conditions)	22	Anti-Infectives/Miscellaneous (Infections)	48, 49
Anesthetics (Miscellaneous)	22, 23	Anti-Infectives/Miscellaneous (Miscellaneous)	49, 50
Anesthetics (Pain Relief and Inflammatory Disease)	23	Anti-Infectives/Miscellaneous (Skin Conditions)	50
Anesthetics (Urinary Tract Conditions)	23	Anti-Inflammatory Tumor Necrosis Factor Inhibiting Agents (Pain Relief and Inflammatory Disease)	50, 51
Anti-Allergy (Allergy and Nasal Sprays)	23	Anti-Neoplastics (Cancer)	51-57
Anti-Arthritis (Pain Relief and Inflammatory Disease)	23-26	Anti-Neoplastics (Skin Conditions)	57
Anti-Asthmatics (Asthma/COPD/Respiratory)	26-28	Anti-Obesity Drugs (Weight Management)	57, 58
Antibiotics (Allergy/Nasal Sprays)	28	Anti-Parasitics (Infections)	58
Antibiotics (Ear Medications)	29	Anti-Parkinson's Drugs (Parkinson's Disease)	58-60
Antibiotics (Eye Conditions)	29, 30	Anti-Platelet Drugs (Blood Thinners/Anti-Clotting)	61
Antibiotics (Infections)	30-37	Antivirals (AIDS/HIV)	61-64
Antibiotics (Skin Conditions)	38	Antivirals (Eye Conditions)	64
Anti-Coagulants (Blood Thinners/Anti-Clotting)	38, 39	Antivirals (Infections)	64-67
Antidotes (Gastrointestinal/Heartburn)	39	Antivirals (Skin Conditions)	67
Antidotes (Substance Abuse)	39, 40	Autonomic Drugs (Allergy/Nasal Sprays)	67
Anti-Fungals (Eye Conditions)	40	Autonomic Drugs (Alzheimer's Disease)	67, 68
Anti-Fungals (Feminine Products)	40	Autonomic Drugs (Attention Deficit Hyperactivity Disorder)	68, 69
Anti-Fungals (Infections)	40-41	Autonomic Drugs (Blood Pressure/Heart Medications)	69
Anti-Fungals (Skin Conditions)	41, 42	Autonomic Drugs (Urinary Tract Conditions)	69
Antihistamine and Decongestant Combination (Allergy/Nasal Sprays)	42, 43	Biologicals (Allergy/Nasal Sprays)	69
Antihistamines (Allergy/Nasal Sprays)	43	Biologicals (Blood Pressure/Heart Medications)	70
Antihistamines (Eye Conditions)	43	Biologicals (Miscellaneous)	70
Anti-Hyperglycemics (Diabetes)	43-48	Biologicals (Vaccines)	70, 71
Anti-Infectives (Feminine Products)	48	Blood (Blood Modifiers/Bleeding Disorders)	71, 72
Anti-Infectives (Infections)	49, 50	Blood (Blood Thinners/Anti-Clotting)	73

Information about this drug list

How to find your medication (cont.)

Condition	Page	Condition	Page
Cardiac Drugs (Blood Pressure/Heart Medications)	73-76	Gastrointestinal (Pain Relief and Inflammatory Disease)	II4
Cardiovascular (Asthma/COPD/Respiratory)	76	Hormones (Hormonal Agents)	II5-II1
Cardiovascular (Blood Pressure/Heart Medications)	77-82	Hormones (Infertility)	I21
Cardiovascular (Cholesterol Medications)	82-86	Hormones (Miscellaneous)	I21
CNS Drugs (Alzheimer's Disease)	86, 87	Hormones (Osteoporosis Products)	I22
CNS Drugs (Miscellaneous)	87	Immunosuppressants (Pain Relief and Inflammatory Disease)	I22
CNS Drugs (Multiple Sclerosis)	87, 88	Immunosuppressants (Skin Conditions)	I22
CNS Drugs (Pain Relief and Inflammatory Disease)	88	Immunosuppressants (Transplant Medications)	I23
CNS Drugs (Seizure Disorders)	89-92	Miscellaneous Medical Supplies, Devices, Non-Drug (Diabetes)	I24-I32
CNS Drugs (Sleep Disorders/Sedatives)	92	Miscellaneous Medical Supplies, Devices, Non-Drug (Miscellaneous)	I32, I33
Colony Stimulating Factors (Blood Modifiers/Bleeding Disorders)	93	Muscle Relaxants (Pain Relief and Inflammatory Disease)	I34
Contraceptives (Contraception Products)	93-95	Prenatal Vitamins (Nutritional/Dietary)	I35
Cough/Cold Preparations (Allergy/Nasal Sprays)	95	Psychotherapeutic Drugs (Anxiety/Depression/Bipolar Disorder)	I35-I41
Cough/Cold Preparations (Cough/Cold Medications)	95, 96	Psychotherapeutic Drugs (Attention Deficit Hyperactivity Disorder)	I41-I44
Diagnostic (Diabetes)	96, 97	Psychotherapeutic Drugs (Miscellaneous)	I44
Diagnostic (Miscellaneous)	98	Psychotherapeutic Drugs (Schizophrenia/Anti-Psychotics)	I44-I47
Diuretics (Diuretics)	98, 99	Psychotherapeutic Drugs (Sleep Disorders/Sedatives)	I45-I49
EENT Preps (Allergy/Nasal Sprays)	99	Skin Preps (Miscellaneous)	I49
EENT Preps (Ear Medications)	100	Skin Preps (Pain Relief and Inflammatory Disease)	I49, I50
EENT Preps (Eye Conditions)	100-104	Skin Preps (Skin Conditions)	I50-I59
Elect/Caloric/H2O (Cholesterol Medications)	104	Smoking Deterrents (Smoking Cessation)	I59
Elect/Caloric/H2O (Dental Products)	104	Thyroid Prep (Hormonal Agents)	I59, I60
Elect/Caloric/H2O (Diabetes)	105	Unclassified Drug Products (AIDS/HIV)	I61
Elect/Caloric/H2O (Miscellaneous)	105	Unclassified Drug Products (Asthma/COPD/Respiratory)	I61
Elect/Caloric/H2O (Nutritional/Dietary)	105, 106	Unclassified Drug Products (Blood Modifiers/Bleeding Disorders)	I61
Elect/Caloric/H2O (Urinary Tract Conditions)	106	Unclassified Drug Products (Blood Pressure/Heart Medications)	I61, I62
Gastrointestinal (Cholesterol Medications)	107		
Gastrointestinal (Gastrointestinal/Heartburn)	108-II4		

Information about this drug list

How to find your medication (cont.)

Condition	Page	Condition	Page
Unclassified Drug Products (Cancer)	I62	Unclassified Drug Products (Seizure Disorders)	I67
Unclassified Drug Products (Dental Products)	I62	Unclassified Drug Products (Skin Conditions)	I67
Unclassified Drug Products (Erectile Dysfunction)	I62, I63	Unclassified Drug Products (Substance Abuse)	I67
Unclassified Drug Products (Gastrointestinal/Heartburn)	I60	Unclassified Drug Products (Transplant Medications)	I67
Unclassified Drug Products (Hormonal Agents)	I63	Unclassified Drug Products (Urinary Tract Conditions)	I67-I69
Unclassified Drug Products (Miscellaneous)	I64-I66	Unclassified Drug Products (Weight Management)	I69
Unclassified Drug Products (Nutritional/Dietary)	I66	Vitamins (Nutritional/Dietary)	I69
Unclassified Drug Products (Osteoporosis Products)	I66		
Unclassified Drug Products (Pain Relief and Inflammatory Disease)	I67		

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 – 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 syrng	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 – 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 (Hydrocodone-acetaminophen)</i>	T1	PA
<i>hydrocodone/acetaminophen (Norco)</i>	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 (Nalocet)</i>	T1	PA
<i>oxycodone hcl/acetaminophen (Percocet)</i>	T1	PA
<i>oxycodone hcl/acetaminophen (Primlev)</i>	T1	PA
PERCOSET (<i>oxycodone-acetaminophen</i>)	T3	PA
PRIMLEV	T1	PA
<i>tramadol hcl/acetaminophen (Ultracet)</i>	T1	
ULTRACET (<i>tramadol hcl-acetaminophen</i>)	T3	
OPIOID ANALGESIC AND NSAID COMBINATION		
<i>hydrocodone/ibuprofen</i>	T1	PA
<i>hydrocodone/ibuprofen (Ibudone)</i>	T1	PA
IBUDONE	T1	PA
<i>ibuprofen/oxycodone hcl</i>	T1	PA
OPIOID ANALGESIC AND NON-SALICYLATE XANTHINE COMB		
ACETAMIN-CAFF-DIHYDROCODEINE	T1	PA

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

T4 – 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

acetaminophen/caff/dihydrocod (Acetamin-caff-dihydrocodeine)	T1	PA
acetaminophen/caff/dihydrocod (Trezix)	T1	PA

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

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

T4 – 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

MS CONTIN (<i>morphine sulfate er</i>)	T3	PA
NUCYNTA	T2	PA
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

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

T4 – 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

SKELETAL MUSCLE RELAXANT, SALICYLAT, OPIOID ANALGESC		
<i>carisoprodol/aspirin/codeine</i>	T1	PA
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		
<i>desflurane</i> (Suprane)	T1	
<i>isoflurane</i>	T1	
<i>isoflurane</i>	T3	
<i>sevoflurane</i> (Ultane)	T1	
SUPRANE	T3	
ULTANE (<i>sevoflurane</i>)	T3	
<i>lidocaine hcl</i>	T1	
ANESTHETICS (Pain Relief and Inflammatory Disease)		
TOPICAL LOCAL ANESTHETICS		
HURRICANE (<i>benzocaine</i>)	T1	
L.E.T. (LIDO-EPINEPH-TETRA)	T3	
<i>lidocaine 5% ointment</i>	T1	QL (145gm/30 days)
<i>lidocaine hcl</i>	T1	
<i>lidocaine hcl</i>	T3	
<i>lidocaine/prilocaine</i>	T1	
<i>lidocaine (Lidocan li)</i>	T1	PA
LIDOCAN II (<i>lidocaine</i>)	T3	PA
LIDODERM (<i>lidocaine</i>)	T3	
PAIN EASE MEDIUM STREAM SPRAY	T3	
SYNERA	T3	PA
ZTLIDO	T2	
ANESTHETICS (Urinary Tract Conditions)		
URINARY TRACT ANESTHETIC/ANALGESIC AGNT (AZO-DYE)		
<i>phenazopyridine hcl</i> (Pyridium)	T1	

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

T4 – 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

PYRIDIUM (<i>phenazopyridine hcl</i>)	T3	PA
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 (<i>cromolyn sodium</i>)	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>)	T4	PA SP
penicillamine (Depen)	T4	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	T4	PA QL (1 pack/180 days) SP HD
OTEZLA 30 MG TABLET	T4	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

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

T4 – 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

febuxostat 80 mg tablet (Uloric) ULORIC 40 MG TABLET (febuxostat)	T1 T3	HD QL (1 tab/day) HD
ANTI-ARTHRITICS (Pain Relief and Inflammatory Disease) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
HYPERURICEMIA TX - XANTHINE OXIDASE INHIBITORS (cont.)		
ULORIC 80 MG TABLET (febuxostat)	T3	HD
ZYLOPRIM (<i>allopurinol</i>)	T3	HD
JANUS KINASE (JAK) INHIBITORS		
CIBINQO	T4	PA QL (30 tabs/30 days) SP
LITFULO	T4	PA QL(1 cap/day) SP HD
OLUMIANT	T4	PA QL (1 tab/day) SP HD
RINVOQ	T4	PA QL (1 tab/day) SP HD
RINVOQ LQ	T4	PA QL(12 mls/day) SP HD
XELJANZ 1 MG/ML SOLUTION	T4	PA QL (480ML/22 Days) SP HD
XELJANZ 10 MG TABLET	T4	PA QL (2 tabs/day) SP HD
XELJANZ 5 MG TABLET	T4	PA QL (2 tabs/day) SP HD
XELJANZ XR	T4	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

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

T4 – 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

<i>flurbiprofen</i>	T1	HD
<i>ibuprofen</i>	T1	HD
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
LODINE (<i>etodolac</i>)	T3	ST HD
<i>meclofenamate sodium</i>	T1	HD
<i>meloxicam (Mobic)</i>	T1	HD
MOBIC (<i>meloxicam</i>)	T3	ST HD
<i>nabumetone</i>	T1	HD
NALFON 600 MG TABLET (<i>profeno</i>)	T1	ST HD
NAPROSYN TABLET (<i>naproxen</i>)	T3	ST HD
<i>naproxen tablet</i>	T1	HD
<i>naproxen (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
OXAPROZIN 300 MG CAPSULE	T3	PA HD
<i>piroxicam (Feldene)</i>	T1	HD
QMIIZ ODT 15 MG TABLET	T3	ST HD
QMIIZ ODT 7.5 MG TABLET	T3	QL (1 tab/day) ST HD
<i>sulindac</i>	T1	HD
<i>tolmetin sodium (Tolectin 600)</i>	T1	HD
NSAIDS, CYCLOOXYGENASE-2(COX-2) SELECTIVE INHIBITOR		
CELEBREX 100 MG CAPSULE (<i>celecoxib</i>)	T3	PA QL (2 caps/day) ST HD
CELEBREX 200 MG CAPSULE (<i>celecoxib</i>)	T3	PA QL (2 caps/day) ST HD
CELEBREX 400 MG CAPSULE (<i>celecoxib</i>)	T3	PA QL (1 cap/day) ST HD
CELEBREX 50 MG CAPSULE (<i>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		

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

T4 – 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

<i>probencid</i>	T1	HD
<i>probencid/colchicine</i>	T1	HD
ANTI-ASTHMATICS (Asthma/COPD/Respiratory)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
5-LIPOXYGENASE INHIBITORS		
<i>zileuton</i>	T1	HD
ANTICHOLINERGICS, ORALLY INHALED LONG ACTING		
INCRUSE ELLIPTA	T2	HD
LONHALA MAGNAIR REFILL	T3	PA HD
LONHALA MAGNAIR STARTER	T3	PA HD
SPIRIVA RESPIMAT	T2	HD
ANTICHOLINERGICS, ORALLY INHADED SHORT ACTING		
ATROVENT HFA	T2	HD
<i>ipratropium bromide</i>	T1	HD
BETA-ADRENERGIC AGENTS		
<i>albuterol sulf 2 mg/5 ml syrup</i>	T1	HD
<i>albuterol 8 mg/20 ml syrup cup</i>	T1	HD
<i>albuterol sulfate 2 mg tab</i>	T1	HD
<i>albuterol sulfate 4 mg tab</i>	T1	HD
<i>albuterol sulfate er 4 mg tab</i>	T1	HD
<i>albuterol sulfate er 8 mg tab</i>	T1	HD
<i>metaproterenol sulfate</i>	T1	HD
<i>terbutaline sulfate</i>	T1	HD
BETA-ADRENERGIC AGENTS, INHALED, SHORT ACTING		
<i>albuterol 100 mg/20 ml soln</i>	T1	
<i>albuterol 15 mg/3 ml solution</i>	T1	
<i>albuterol 75 mg/15 ml soln</i>	T1	
<i>albuterol 2.5 mg/0.5 ml sol</i>	T1	
<i>albuterol 5 mg/ml solution</i>	T1	
<i>albuterol sul 0.63 mg/3 ml sol</i>	T1	
<i>albuterol sul 1.25 mg/3 ml sol</i>	T1	
<i>albuterol sul 2.5 mg/3 ml soln</i>	T1	
<i>albuterol sulfate (Albuterol Sulfate Hfa)</i>	T1	QL (18gm/30 days)
<i>ALBUTEROL SULFATE HFA</i>	T1	QL (18gm/30 days)
<i>levalbuterol hcl (Xopenex Concentrate)</i>	T1	
<i>levalbuterol hcl (Xopenex)</i>	T1	
<i>XOPENEX (levalbuterol hcl)</i>	T3	
<i>XOPENEX CONCENTRATE (levalbuterol concentrate)</i>	T3	

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

T4 – 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

BETA-ADRENERGIC AGENTS, INHALED, ULTRA-LONG ACTING		
ARCAPTA NEOHALER	T3	HD
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)
ipratropium/albuterol sulfate	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
budesonide/formoterol fumarate (Symbicort)	T1	QL HD
DULERA	T2	HD
fluticasone propion/salmeterol (Advair Diskus)	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
budesonide (Pulmicort)	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 (budesonide)	T3	PA QL(2 mls/day) HD

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

T4 – 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

PULMICORT FLEXHALER	T2	PA HD
QVAR REDIHALER	T2	
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 hcl	T1	
CORTISPORIN-TC	T3	
neomycin/polymyxin b/hydrocort	T1	
ofloxacin	T1	
OTIC PREPARATIONS, ANTI-INFLAMMATORY-ANTIBIOTICS		
CIPRO HC	T2	
CIPRODEX (ciprofloxacin-dexamethasone)	T3	

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

T4 – 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

ciprofloxacin hcl/dexameth (Ciprodex)	T1	
CIPROFLOXACIN HCL-FLUOCINOLONE	T3	
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	

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

T4 – 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

<i>neomycin sulf/bacitracin/poly</i>	T1	
ANTIBIOTICS (Eye Conditions) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
OPHTHALMIC ANTIBIOTICS (cont.)		
<i>neomycin/polymyxn 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>	T4	PA SP
<i>BETHKIS (tobramycin)</i>	T4	PA QL (8ml/day) SP HD
<i>gentamicin sulfate</i>	T1	
<i>gentamicin sulfate/pf</i>	T1	
<i>KITABIS PAK</i>	T4	PA QL (10ml/day) SP HD
<i>neomycin sulfate</i>	T1	
<i>TOBI (tobramycin)</i>	T4	PA QL (10ml/day) SP HD
<i>TOBI PODHALER</i>	T4	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>	T4	PA QL (28 Therapy/56 days) SP HD
<i>tobramycin 300 mg/5 ml ampule (Tobi)</i>	T1	PA QL (10ml/day) SP HD

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

T4 – 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 (Infections) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
AMINOGLYCOSIDE ANTIBIOTICS (cont.)		
<i>tobramycin 40 mg/ml vial</i>	T1	
<i>tobramycin 80 mg/2 ml vial</i>	T1	
TOBRAMYCIN PAK 300 MG/5 ML	T4	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 100 mg tablet</i>	T1	
<i>dapsone 25 mg tablet</i>	T1	
THALOMID	T4	PA SP HD
ANTI-MYCOBACTERIUM AGENTS		
<i>ethambutol hcl</i>	T1	HD
<i>isoniazid</i>	T1	HD

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

T4 – 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 (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	T4	SP
BETALACTAMS		
CAYSTON	T4	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	

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

T4 – 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 (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	

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

T4 – 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 (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)

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

T4 – 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 (Infections) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
QUINOLONE ANTIBIOTICS (cont.)		
AVELOX (moxifloxacin hcl)	T3	
BAXDELA	T3	PA
CIPRO 10% SUSPENSION (ciprofloxacin)	T2	
CIPRO 250 MG TABLET (ciprofloxacin hcl)	T3	
CIPRO 5% SUSPENSION (ciprofloxacin)	T2	
CIPRO 500 MG TABLET (ciprofloxacin hcl)	T3	
ciprofloxacin hcl	T1	
ciprofloxacin hcl (Cipro)	T1	
ciprofloxacin/ciprofloxacin hcl	T1	
FACTIVE	T3	
levofloxacin	T1	
moxifloxacin hcl (Avelox)	T1	
ofloxacin	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 (doxycycline hydiate)	T3	ST
coremino er 135 mg tablet	T1	
coremino er 45 mg tablet	T1	QL (1 tab/day)
coremino er 90 mg tablet	T1	
demeclcycline hcl	T1	
DORYX	T3	PA
DORYX (doxycycline hydiate)	T3	PA
DORYX MPC	T3	PA
doxycycline 50 mg tablet (Targadox)	T1	PA
doxycycline hyc dr 100 mg tab	T1	PA
doxycycline hyc dr 150 mg tab	T1	PA
doxycycline hyc dr 200 mg tab (Doryx)	T1	PA
doxycycline hyc dr 50 mg tab	T1	PA
doxycycline hyc dr 75 mg tab	T1	PA
DOXYCYCLINE HYC DR 80 MG TAB	T3	PA
doxycycline hydiate	T1	

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

T4 – 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 (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

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

T4 – 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 (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	
CLEOCIN T (<i>clindamycin phosphate</i>)	T3	
<i>clindacin etz 1% pdegt</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 – 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>mafénide acetate</i>	T1	
ROSANIL (<i>sodium sulfacetamide-sulfur</i>)	T1	
SILVADENE (<i>ssd</i>)	T3	
<i>silver sulfadiazine</i> (Silvadene)	T1	
<i>sulfacetamide sod/sulfur/urea</i>	T1	
<i>sulfacetamide sodium/sulfur</i>	T1	
<i>sulfacetamide sodium/sulfur</i> (Avar-e Green)	T1	
<i>sulfacetamide sodium/sulfur</i> (Rosanil)	T1	
<i>sulfacetamide/sulfur/cleansr23</i>	T1	
<i>sulfact sod/sulur/avob/otn/oct</i>	T1	
SULFAMYLYON	T2	
ANTI-COAGULANTS (Blood Thinners/Anti-Clotting)		
ANTI-COAGULANTS, COUMARIN TYPE		
warfarin sodium	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	
rivaroxaban	T1	
SAVAYSA 15 MG TABLET	T3	PA QL (1 tab/day)

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

T4 – 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-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 (fondaparinux sodium)	T4	QL (1 syringe/day) SP
enoxaparin 100 mg/ml syringe (Lovenox)	T4	QL (2 syringes/day) SP
enoxaparin 120 mg/0.8 ml syr (Lovenox)	T4	QL (2 syringes/day) SP
enoxaparin 150 mg/ml syringe (Lovenox)	T4	QL (2 syringes/day) SP
enoxaparin 30 mg/0.3 ml syr (Lovenox)	T4	QL (2 syringes/day) SP
enoxaparin 300 mg/3 ml vial (Lovenox)	T4	QL (1 vial/day) SP
enoxaparin 40 mg/0.4 ml syr (Lovenox)	T4	QL (2 syringes/day) SP
enoxaparin 60 mg/0.6 ml syr (Lovenox)	T4	QL (2 syringes/day) SP
enoxaparin 80 mg/0.8 ml syr (Lovenox)	T4	QL (2 syringes/day) SP
fondaparinux sodium (Arixtra)	T4	QL (1 syringe/day) SP
FRAGMIN	T4	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 (enoxaparin sodium)	T4	QL (2 syringes/day) SP
LOVENOX 120 MG/0.8 ML SYRINGE (enoxaparin sodium)	T4	QL (2 syringes/day) SP
LOVENOX 150 MG/ML SYRINGE (enoxaparin sodium)	T4	QL (2 syringes/day) SP
LOVENOX 30 MG/0.3 ML SYRINGE (enoxaparin sodium)	T4	QL (2 syringes/day) SP
LOVENOX 300 MG/3 ML VIAL (enoxaparin sodium)	T4	QL (1 vial/day) SP

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

T4 – 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-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>)	T4	QL (2 syringes/day) SP
LOVENOX 60 MG/0.6 ML SYRINGE (<i>enoxaparin sodium</i>)	T4	QL (2 syringes/day) SP
LOVENOX 80 MG/0.8 ML SYRINGE (<i>enoxaparin sodium</i>)	T4	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	

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

T4 – Specialty Medications

PA – Prior Authorization

QL – Quantity Limit

ST – Step Therapy

AGE – Age Requirement

SP – Specialty Medication

HD – May require home delivery pharmacy

PPACA – No Cost-Share Preventive Medication

CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

ANTI-FUNGALS (Infections)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ANTI-FUNGAL AGENTS		
ANCOBON (<i>flucytosine</i>)	T3	
<i>clotrimazole</i>	T1	
CRESEMBIA	T3	PA
DIFLUCAN (<i>fluconazole</i>)	T3	PA
<i>fluconazole</i> (Diflucan)	T1	
<i>flucytosine</i> (Ancobon)	T1	
<i>itraconazole</i> (Sporanox)	T1	
<i>ketoconazole</i>	T1	
NOXAFL 40 MG/ML SUSPENSION	T3	PA
NOXAFL 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
<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>	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

T3 – Typically Non-Preferred Brands

T4 – Specialty Medications

PA – Prior Authorization

QL – Quantity Limit

ST – Step Therapy

AGE – Age Requirement

SP – Specialty Medication

HD – May require home delivery pharmacy

PPACA – No Cost-Share Preventive Medication

CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

ANTI-FUNGALS (Skin Conditions) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
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

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

T4 – Specialty Medications

PA – Prior Authorization

QL – Quantity Limit

ST – Step Therapy

AGE – Age Requirement

SP – Specialty Medication

HD – May require home delivery pharmacy

PPACA – No Cost-Share Preventive Medication

CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

ANTI-FUNGALS (Skin Conditions) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
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	
ciproheptadine hcl	T1	
ciproheptadine hcl (Ciproheptadine 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 (Clarinex)	T1	HD
ANTIHISTAMINES (Eye Conditions)		
EYE ANTIHISTAMINES		
azelastine hcl 0.05% drops	T1	
BEPREVE	T3	PA
epinastine hcl	T1	

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

T4 – 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

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-1 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-1 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

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

T4 – 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-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	

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

T4 – 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, INSULIN-RELEASE STIMULANT TYPE (cont.)		
chlorpropamide	T1	HD
glimepiride (Amaryl)	T1	HD
GLIMEPIRIDE 3 MG TABLET	T3	HD
GLIPIZIDE	T3	HD
glipizide (Glucotrol XL)	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 – 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		
<i>glipizide/metformin hcl</i>	T1	HD
<i>glyburide/metformin hcl</i>	T1	HD
<i>repaglinide/metformin hcl</i>	T1	HD
ANTI-HYPERGLYCEMIC, THIAZOLIDINEDIONE (PPARG AGONIST)		
ACTOS (<i>pioglitazone hcl</i>)	T3	HD
AVANDIA	T3	HD
<i>pioglitazone hcl</i> (Actos)	T1	HD
ANTI-HYPERGLYCEMIC-GLUCOCORTICOID RECEPTOR BLOCKER		
KORLYM (<i>mifepristone</i>)	T3	PA SP
<i>mifepristone 300 mg tablet</i> (Korlym)	T3	PA SP
ANTI-HYPERGLYCEMIC-SGLT2 INHIBITOR-BIGUANIDE COMBS.		
DAPAGLIFLOZIN-METFO 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 COTRANSPORT2(SGLT2) INH		
BRENZAVVY	T3	PA QL(1 tabs/day) HD

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

T4 – 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
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

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

T4 – 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
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
SEMGLEE (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 (tinidazole)	T3	
tinidazole	T1	

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

T4 – 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-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 – 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-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	T4	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

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

T4 – 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-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	T4	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	T4	PA SP HD
REMICADE	T4	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)	T4	PA SP HD
------------------------	----	----------

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

T4 – 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
ANP - SELECTIVE RETINOID X RECEPTOR AGONISTS (RXR) (cont.)		
TARGRETIN 75 MG CAPSULE (<i>bexarotene</i>)	T4	PA SP HD
ANTI-NEOPLAST, HISTONE DEACETYLASE (HDAC) INHIBITORS		
FARYDAK	T4	PA SP HD
ZOLINZA	T4	PA SP HD
ANTINEOPLASTIC - ALKYLATING AGENTS		
ALKERAN (<i>melphalan</i>)	T4	SP
<i>cyclophosphamide</i> 25 mg capsule	T4	SP HD
<i>cyclophosphamide</i> 50 mg capsule	T4	SP HD
CYCLOPHOSPHAMIDE 50 MG TABLET	T4	PA SP HD
GLEOSTINE	T2	
HYDREA (<i>hydroxyurea</i>)	T3	
<i>hydroxyurea</i> (Hydrea)	T1	
LEUKERAN	T2	
<i>melphalan</i> (Alkeran)	T4	SP CSL
MYLERAN	T2	
ANTI-NEOPLASTIC - ANTI-ANDROGENIC AGENTS		
CASODEX (<i>bicalutamide</i>)	T3	
ERLEADA	T4	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	T4	PA SP HD
XTANDI	T4	PA SP HD
YONSA	T4	PA SP HD
ZYTIGA (<i>abiraterone acetate</i>)	T4	PA SP HD
ANTI-NEOPLASTIC - ANTI-METABOLITES		
<i>capecitabine</i> (Xeloda)	T4	PA SP HD
INQOVI	T4	PA SP HD
JYLAMVO	T4	CSL
LONSURF	T4	PA SP HD
<i>mercaptopurine</i> 20 mg/ml suspen (Purixan)	T4	SP CSL
<i>mercaptopurine</i> 50 mg tablet	T1	CSL
<i>methotrexate sodium</i>	T1	
<i>methotrexate sodium/pf</i>	T1	
ONUREG	T4	PA QL (14 Tabs/28 Days) SP

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

T4 – 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 - ANTI-METABOLITES (cont.)		
PURIXAN	T4	SP
TABLOID	T3	
TREXALL	T2	
XATMEP	T3	
XELODA (<i>capecitabine</i>)	T4	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	T4	PA SP HD
OJEMDA TABLET	T4	PA QL(1 packet/28 Days) SP CSL
OJEMDA 25 MG/ML ORAL SUSP	T4	PA QL(8 bottles/28 days) SP CSL
TAFINLAR CAPSULE	T4	PA QL(4 caps/day) SP HD CSL
TAFINLAR TABLET	T4	PA QL(30 tabs/day) SP HD CSL
ZELBORAF	T4	PA SP HD
ANTI-NEOPLASTIC - ENZYME INHIB, ANTIANDROGEN COMB.		
AKEEGA	T4	PA QL(2 Tabs/Day) SP CSL
ANTI-NEOPLASTIC - HEDGEHOG PATHWAY INHIBITOR		
DAURISMO	T4	PA SP HD
ERIVEDGE	T4	PA SP HD
ODOMZO	T4	PA SP HD
ANTI-NEOPLASTIC - JANUS KINASE (JAK) INHIBITORS		
JAKAFI	T4	PA SP HD
ANTI-NEOPLASTIC - KRAS PROTEIN INHIBITOR		
KRAZATI	T4	PA QL(6 TABS/DAY) SP CSL
LUMAKRAS	T4	PA SP QL (4 tabs per day) HD
ANTI-NEOPLASTIC - MEKI AND MEK2 KINASE INHIBITORS		
COTELLIC	T4	PA SP HD
FULVICIN P-G 165 MG TABLET	T3	PA QL (4 tabs/day)
GOMEKLI	T3	PA SP HD
KOSELUGO 10 MG CAPSULE	T4	PA QL (10 capsules/day) SP
KOSELUGO 25 MG CAPSULE	T4	PA QL (4 caps/day) SP
MEKINIST 0.05 MG/ML SOLUTION	T4	PA QL(40 mls/day) SP HD CSL

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

T4 – 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

MEKINIST 0.5 MG TABLET	T4	PA QL(3 tabs/day) SP HD CSL
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	T4	PA QL(1 tab/day) SP HD CSL
MEKTOVI	T4	PA SP HD
ANTI-NEOPLASTIC - MTOR KINASE INHIBITORS		
AFINITOR	T4	PA SP HD
AFINITOR (everolimus)	T4	PA SP HD
AFINITOR DISPERZ	T4	PA SP
everolimus (Afinitor)	T4	PA SP HD
ANTI-NEOPLASTIC - PROTEIN METHYLTRANSFERASE INHIBIT		
TAZVERIK	T4	PA SP
ANTI-NEOPLASTIC - TOPOISOMERASE I INHIBITORS		
HYCAMTIN	T4	PA SP HD
ANTI-NEOPLASTIC COMB - KINASE AND AROMATASE INHIBIT		
KISQALI 200 MG	T4	PA QL (21 per 28 days) SP HD
KISQALI 400 MG	T4	PA QL (42 per 28 days) SP HD
KISQALI 800 MG	T4	PA QL (63 per 28 days) SP HD
KISQALI FEMARA CO-PACK	T4	PA QL (1 pack per 28 days) SP CSL
ANTI-NEOPLASTIC EGF RECEPTOR BLOCKER MCLON ANTIBODY		
PHESGO	T4	PA SP HD
ANTI-NEOPLASTIC IMMUNOMODULATOR AGENTS		
lenalidomide	T4	PA QL(1 tab/day) SP HD CSL
POMALYST	T4	PA QL(21 caps/28 days) SP HD CSL
REVLIMID	T4	PA QL(1 tab/day) SP HD CSL
pazopanib hcl (Votrient)	T4	PA QL(4 tabs/day) SP HD CSL
ANTI-NEOPLASTIC LHRH (GNRH) AGONIST, PITUITARY SUPPR.		
leuprolide acetate	T4	PA SP HD
LEUPROLIDE DEPOT	T4	PA SP
LUPRON DEPOT	T4	PA SP HD
ZOLADEX	T4	PA SP HD
ANTI-NEOPLASTIC LHRH (GNRH) ANTAGONIST, PITUIT.SUPPRS		
FIRMAGON	T4	PA SP HD
ORGOVYX	T4	PA SP

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

T4 – 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 SYSTEMIC ENZYME INHIBITORS		
ALECensa	T4	PA QL(8 tabs/day) SP HD CSL
ALUNBRIG	T4	PA SP HD
AUGTYRO	T4	PA QL(2 caps/day) SP HD CSL
AYVAKIT	T4	PA QL (1 tab/day) SP
BALVERSA	T4	PA SP
BOSULIF	T4	PA QL (3 caps/day) SP HD CSL
CABOMETYX	T4	PA SP HD
CALQUENCE	T4	PA SP
CAPRELSA	T4	PA SP
COMETRIQ	T4	PA SP HD
COPIKTRA	T4	PA SP
DANZITEN	T4	PA SP CSL
<i>dasatinib 20 mg tablet (Sprycel)</i>	T4	PA QL(3 tabs/day) SP HD CSL
<i>dasatinib 70 mg tablet (Sprycel)</i>	T4	PA QL(2 tabs/day) SP HD CSL
<i>dasatinib 50 mg, 80 mg, 100 mg, 140 mg tablet (Sprycel)</i>	T4	PA QL(1 tab/day) SP HD CSL
<i>erlotinib hcl</i>	T4	PA SP HD
EXKIVITY	T4	PA SP HD
FOTIVDA	T4	PA QL (30 caps/30 days) SP HD
FRUZAQLA 1 MG CAPSULE	T4	PA QL(84 caps/28 days) SP CSL
FRUZAQLA 5 MG CAPSULE	T4	PA QL(21 caps/28 days) SP CSL
GAVRETO	T4	PA QL (4 Tabs/Day) SP CSL
GILOTrif	T4	PA SP HD
GLEEVEC (<i>imatinib mesylate</i>)	T4	PA SP HD
IBRANCE	T4	PA QL (21 caps/28 days) SP HD
ICLUSIG	T4	PA SP
<i>imatinib mesylate (Gleevec)</i>	T4	PA SP HD
IMBRUVICA	T4	PA SP
IMKELDI	T4	PA SP CSL
INLYTA	T4	PA SP HD
INREBIC	T4	PA SP HD
IRESSA	T4	PA SP HD
ITOVEBI	T4	PA SP HD CSL
IWLFIN	T4	PA QL(8 tabs/day) SP CSL
<i>lapatinib ditosylate (Tykerb)</i>	T4	PA SP HD
LENVIMA	T4	PA SP HD
LORBRENA	T4	PA SP HD

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

T4 – 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 SYSTEMIC ENZYME INHIBITORS (cont.)		
LYNPARZA	T4	PA SP HD
LYTGOBI 12 MG DAILY DOSE PACK	T4	PA QL(3 tabs/day) SP CSL
LYTGOBI 16 MG DAILY DOSE PACK	T4	PA QL(4 tabs/day) SP CSL
LYTGOBI 20 MG DAILY DOSE PACK	T4	PA QL(5 tabs/day) SP CSL
NERLYNX	T4	PA SP HD
NEXAVAR	T4	PA SP HD
NINLARO	T4	PA QL(3 caps/28 days) SP HD CSL
OGSIVEO	T4	PA QL(6 tabs/day) SP CSL
OJJAARA	T4	PA QL(1 TAB/DAY) SP CSL
pazopanib 200 mg tablet (Votrient)	T4	PA QL SP HD CSL
PEMAZYRE	T4	PA QL (14 tabs/21 days) SP
PIQRAY	T4	PA SP HD
QINLOCK	T4	PA QL (3 tabs/day) SP
RETEVMO 40 MG CAPSULE	T4	PA QL (6 caps/day) SP HD
RETEVMO 80 MG CAPSULE	T4	PA QL (4 tabs/day) SP HD
RETEVMO 120 MG, 160 MG TABLET	T4	PA QL (2 tabs/day) SP HD CSL
REVUFORJ 25 MG, 110 MG TABLET	T4	PA SP CSL
REVUFORJ 160 MG TABLET	T4	PA QL(2 tabs/day) SP CSL
ROZLYTREK	T4	PA SP HD
RUBRACA	T4	PA SP
RYDAPT	T4	PA SP HD
SCEMBLIX 20 MG TABLET	T4	PA QL (2 tablets/day) SP HD
SCEMBLIX 40 MG TABLET	T4	PA SP HD CSL
SPRYCEL 20 MG	T4	PA QL(3 tab/day) SP HD CSL
SPRYCEL 50 MG, 80 MG, 100 MG, 140 MG TABLET	T4	PA QL(1 tab/day) SP HD CSL
SPRYCEL 70 MG TABLET	T4	PA QL(2 tab/day) SP HD CSL
STIVARGA	T4	PA QL(84 tabs/28 days) SP HD CSL
SUTENT	T4	PA SP HD
TABRECTA	T4	PA QL (4 tabs/day) SP HD
TAGRISSO	T4	PA SP HD
TALZENNA	T4	PA QL (1 cap/day) SP HD
TARCEVA (erlotinib hcl)	T4	PA SP HD
TASIGNA	T4	PA QL(4 caps/day) SP HD
TEPMETKO	T4	PA QL (2 tabs/day) SP
TRUQAP	T4	PA QL(64 tabs/28 days) SP CSL
TUKYSA	T4	PA SP
TURALIO 125 MG CAPSULE	T4	PA QL(4 CAPS/DAY) SP CSL

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

T4 – 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 SYSTEMIC ENZYME INHIBITORS (cont.)		
TURALIO 200 MG CAPSULE	T4	PA QL(4 caps/day) SP CSL
TYKERB (<i>lapatinib</i>)	T4	PA SP HD
UKONIQ	T4	PA QL (4 tabs/day) SP
VANFLYTA	T4	PA QL(2 tabs/day) SP CSL
VERZENIO	T4	PA QL (120mg/day) SP HD
VITRAKVI	T4	PA SP HD
VIZIMPRO	T4	PA SP HD
VOTRIENT (<i>pazopanib hcl</i>)	T4	PA SP HD
XALKORI 150 MG PELLET	T4	PA QL(4 pellets/day) SP HD CSL
XALKORI 20 MG PELLET	T4	PA QL(4 pellets/day) SP HD CSL
XALKORI 200 MG, 250 MG CAPSULE	T4	PA QL(4 caps/day) SP HD CSL
XALKORI 50 MG PELLET	T4	PA QL(4 pellets/day) SP HD CSL
XOSPATA	T4	PA SP
ZEJULA	T4	PA SP
ZYDELIG	T4	PA SP HD
ZYKADIA	T4	PA SP HD
ANTI-NEOPLASTIC, ANTI-PROGRAMMED DEATH-1 (PD-1) MAB		
OPDIVO	T4	PA SP HD
ANTI-NEOPLASTIC-B CELL LYMPHOMA-2(BCL-2) INHIBITORS		
VENCLEXTA	T4	PA SP
VENCLEXTA STARTING PACK	T4	PA SP
ANTI-NEOPLASTIC-ISOCITRATE DEHYDROGENASE INHIBITORS		
IDHIFA	T4	PA SP HD
REZLIDHIA	T4	PA QL(2 CAPS/DAY) SP CSL
TIBSOVO	T4	PA SP
ANTI-NEOPLASTICS ANTIBODY/ANTIBODY-DRUG COMPLEXES		
ENHERTU	T4	PA SP HD
ANTI-NEOPLASTICS, MISCELLANEOUS		
<i>etoposide</i>	T4	SP HD
LYSODREN	T2	
MATULANE	T4	SP
<i>tretinoin 10 mg capsule</i>	T1	PA
ANTI-NEOPLASTIC-SELECT INHIB OF NUCLEAR EXP (SINE)		
XPOVIO	T4	PA SP
CYTOTOXIC T-LYMPHOCYTE ANTIGEN (CTLA-4) RMC ANTIBODY		
YERVOY	T4	PA SP HD
IMMUNOMODULATORS		
ACTIMMUNE	T4	PA SP HD

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

T4 – 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
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	T4	SP HD
<i>megestrol acetate</i>	T1	
ANTI-NEOPLASTICS (Skin Conditions)		
PHOTOACT, TOPICAL ANTI-NEOPLAST, PREMALIGNANT LESIONS		
LEVULAN	T4	SP
TOPICAL ANTI-NEOPLASTIC PREMALIGNANT LESION AGENTS		
CARAC	T3	PA
<i>diclofenac sodium 3% gel</i>	T1	PA
EFUDEX (<i>fluorouracil</i>)	T3	
FLUOROPLEX	T2	
<i>fluorouracil</i>	T1	
<i>fluorouracil</i> (Efudex)	T1	
KLISYRI	T3	PA QL (5 packs/30 Days)
PANRETIN	T4	SP HD
PICATO	T2	
TARGRETIN 1% GEL (<i>bexarotene</i>)	T4	PA SP HD
TOLAK	T3	
VALCHLOR	T4	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>phendimetrazine tartrate</i>	T1	
<i>phentermine hcl</i> (Adipex-p)	T1	
QSYMIA	T3	PA
REGIMEX (<i>benzphetamine hcl</i>)	T3	
VYKAT XR	T4	SP

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

T4 – 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-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	T4	PA QL (9 ml/22 days) SP
ANTI-OBESITY GLUCAGON-LIKE PEPTIDE-1 RECEP AGONIST		
SAXENDA	T2	PA
WEGOVY	T2	PA QL (1 box/month)
ANTI-OBESITY SEROTONIN 2C RECEPTOR AGONISTS		
BELVIQ	T3	PA
BELVIQ XR	T3	PA
ANTI-OBESITY - OPIOID ANTAG-NOREPI, DOPAMINE RU INHIB		
CONTRAVE	T3	PA
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	T4	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	

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

T4 – 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-PARASITICS (Infections) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
TOPICAL ANTI-PARASITICS (cont.)		
ULESFIA	T3	
ANTI-PARKINSON DRUGS (Parkinson's Disease)		
ANTI-PARKINSONISM DRUGS, ANTI-CHOLINERGIC		
benztropine mesylate	T1	HD
trihexyphenidyl hcl	T1	HD
ANTI-PARKINSONISM DRUGS, OTHER		
amantadine hcl	T1	HD
APOKYN	T4	PA SP HD
AZILECT 0.5 MG TABLET (rasagiline mesylate)	T3	QL (1 tab/day) HD
AZILECT 1 MG TABLET (rasagiline mesylate)	T3	HD
bromocriptine mesylate	T1	HD
carbidopa/levodopa	T1	HD
carbidopa/levodopa (Sinemet)	T1	HD
carbidopa/levodopa/entacapone (Stalevo 100)	T1	HD
carbidopa/levodopa/entacapone (Stalevo 75)	T1	HD
DHIVY	T3	PA
DUOPA	T4	SP HD
entacapone	T1	HD
GOCOVRI	T3	HD
INBRIJA	T4	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

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

T4 – 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.)		
NEUPRO	T3	HD
NOURIANZ	T4	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

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

T4 – 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.)		
tolcapone (Tasmar)	T1	HD
XADAGO	T3	ST HD
VYALEV	T4	PA SP HD
ZELAPAR	T3	PA HD
DECARBOXYLASE INHIBITORS		
carbidopa (Lodosyn)	T1	
LODOSYN (carbidopa)	T3	PA
ANTI-PLATELET DRUGS (Blood Thinners/Anti-Clotting)		
PLATELET AGGREGATION INHIBITORS		
aspirin/dipyridamole	T1	HD
ASPIRIN-OMEPRAZOLE	T3	PA HD
BRILINTA	T2	HD
cilostazol	T1	HD
clopidogrel bisulfate (Plavix)	T1	HD
dipyridamole	T1	HD
EFFIENT (prasugrel hcl)	T3	HD
PLAVIX (clopidogrel)	T3	PA HD
ticagrelor	T1	HD
prasugrel hcl (Effient)	T1	HD
ticlopidine hcl	T1	HD
YOSPRALA	T3	PA HD
ZONTIVITY	T3	HD
PLATELET REDUCING AGENTS		
AGRYLIN (anagrelide hcl)	T3	
anagrelide hcl (Agrylin)	T1	
ANTIVIRALS (AIDS/HIV)		
ANTI-RETROVIRAL - CAPSID INHIBITORS		
SUNLENCA 300 MG TABLET	T4	PA QL(5 tabs/180 days) SP
SUNLENCA 4- 300 MG TABLET	T4	PA QL(5 tabs/180 days) SP
SUNLENCA 463.5 MG/1.5 ML VIAL	T4	PA SP
SUNLENCA 5- 300 MG TABLET	T4	PA QL(5 tabs/180 days) SP
ANTI-RETROVIRAL - INTEGRASE INHIBITOR AND NNRTI COMB.		
CABENUVA	T4	PA SP
JULUCA	T4	SP
ANTI-RETROVIRAL - INTEGRASE INHIBITOR AND NRTI COMB.		
DOVATO	T2	SP

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

T4 – 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	T4	SP
TRIUMEQ PD	T4	QL(6 tabs/day) SP
ANTI-RETROVIRAL - NUCLEOSIDE, NUCLEOTIDE, PROTEASE INH.		
SYMTUZA	T4	SP
ANTIVIRALS - HIV-SPEC, NON-PEPTIDIC PROTEASE INHIB		
APTIVUS	T4	PA SP
<i>darunavir ethanolate</i> (Prezista)	T4	PA SP
PREZCOBIX	T4	PA SP
PREZISTA 100 MG/ML SUSPENSION	T4	SP
PREZISTA 150 MG TABLET	T4	SP
PREZISTA 600 MG TABLET (darunavir)	T4	PA SP
PREZISTA 75 MG TABLET	T4	SP
PREZISTA 800 MG TABLET (darunavir)	T4	PA SP
ANTIVIRALS - HIV-SPEC, NUCLEOSIDE-NUCLEOTIDE ANALOG		
CIMDUO	T4	PA SP
DESCOVY	T4	SP PPACA
<i>emtricitabine-tenofovir 100-150mg</i> (Truvada)	T4	SP
<i>emtricitabine-tenofovir 133-200mg</i> (Truvada)	T4	SP
<i>emtricitabine-tenofovir 167-250mg</i> (Truvada)	T4	SP
<i>emtricitabine-tenofovir 200-300mg</i> (Truvada)	T4	SP PPACA
TEMIXYS	T4	PA SP
TRUVADA (<i>emtricitabine-tenofovir disop</i>)	T4	PA SP
ANTIVIRALS - HIV-SPEC, NUCLEOSIDE ANALOG, RTI COMB		
<i>abacavir sulfate/lamivudine</i> (Epzicom)	T4	PA SP
<i>abacavir/lamivudine/zidovudine</i>	T4	PA SP
COMBIVIR (<i>lamivudine-zidovudine</i>)	T4	PA SP
EPZICOM (<i>abacavir-lamivudine</i>)	T4	PA SP
<i>lamivudine/zidovudine</i> (Combivir)	T4	SP
ANTIVIRALS - HIV-SPECIFIC, CCR5 CO-RECEPTOR ANTAG.		
AGRYLIN (<i>anagrelide hcl</i>)	T3	
SELZENTRY 150 MG TABLET (maraviroc)	T4	PA SP
SELZENTRY 20 MG/ML ORAL SOLN	T4	PA SP
SELZENTRY 25 MG TABLET	T4	PA SP
SELZENTRY 300 MG TABLET (maraviroc)	T4	PA SP

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

T4 – 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	T4	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	T4	PA SP
INTELENCE	T4	PA SP
<i>nevirapine</i>	T4	PA SP
<i>nevirapine</i> (Viramune Xr)	T4	PA SP
<i>nevirapine</i> (Viramune)	T4	PA SP
PIFELTRO	T4	PA SP
VIRAMUNE (<i>nevirapine</i>)	T4	PA SP
VIRAMUNE XR (<i>nevirapine er</i>)	T4	PA SP
<i>abacavir sulfate</i> (Ziagen)	T4	PA SP
<i>didanosine</i> (Videx Ec)	T4	PA SP
<i>emtricitabine</i> (Emtriva)	T4	PA SP
EMTRIVA 10 MG/ML SOLUTION	T4	PA SP
EMTRIVA 200 MG CAPSULE (<i>emtricitabine</i>)	T4	PA SP
EPIVIR (<i>lamivudine</i>)	T4	PA SP
<i>lamivudine</i> 10 mg/ml oral soln (Epivir)	T4	SP
<i>lamivudine</i> 150 mg tablet (Epivir)	T4	SP
<i>lamivudine</i> 300 mg tablet (Epivir)	T4	PA SP
<i>lamivudine</i> 300 mg/30ml sol cup (Epivir)	T4	SP
RETROVIR (<i>zidovudine</i>)	T4	PA SP
<i>stavudine</i>	T4	PA SP
VIDEX EC	T4	PA SP
VIDEX EC (<i>didanosine</i>)	T4	PA SP
ZIAGEN (<i>abacavir</i>)	T4	PA SP
<i>zidovudine</i>	T4	SP
<i>zidovudine</i> (Retrovir)	T4	SP
<i>tenofovir disoproxil fumarate</i> (Viread)	T4	PA SP
VIREAD 150 MG TABLET	T4	PA SP
VIREAD 200 MG TABLET	T4	PA SP
VIREAD 250 MG TABLET	T4	PA SP

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

T4 – 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>)	T4	PA SP
VIREAD POWDER	T4	PA SP
ANTIVIRALS - HIV-SPECIFIC, PROTEASE INHIBITOR COMB		
<i>fosamprenavir</i>	T4	PA SP
KALETRA 100-25 MG TABLET	T4	PA SP
KALETRA 200-50 MG TABLET	T4	PA SP
KALETRA 80 MG-20 MG/ML SOLN (<i>lopinavir-ritonavir</i>)	T4	PA SP
<i>lopinavir/ritonavir</i> (Kaletra)	T1	
ANTIVIRALS - HIV-SPECIFIC, PROTEASE INHIBITORS		
<i>atazanavir sulfate</i> (Reyataz)	T4	PA SP
CRIXIVAN	T4	PA SP
EVOTAZ	T4	PA SP
<i>fosamprenavir calcium</i> (Lexiva)	T4	PA SP
LEXIVA (<i>fosamprenavir calcium</i>)	T4	PA SP
NORVIR 100 MG POWDER PACKET	T4	SP
NORVIR 100 MG TABLET (<i>ritonavir</i>)	T4	PA SP
REYATAZ 150 MG CAPSULE (<i>atazanavir sulfate</i>)	T4	PA SP
REYATAZ 200 MG CAPSULE (<i>atazanavir sulfate</i>)	T4	PA SP
REYATAZ 300 MG CAPSULE (<i>atazanavir sulfate</i>)	T4	PA SP
REYATAZ 50 MG POWDER PACKET	T4	PA SP
<i>ritonavir</i> (Norvir)	T4	SP
VIRACEPT	T4	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	T4	PA SP
DELSTRIGO	T4	PA SP
<i>efavirenz/emtricit/tenofovr df</i>	T4	PA SP
<i>efavirenz/lamivu/tenofov disop</i> (Symfi Lo)	T4	SP

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

T4 – 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)	T4	SP
ODEFSEY	T4	PA SP
SYMFY (efavirenz-lamivu-tenofovir disop)	T4	PA SP
SYMFY LO (efavirenz-lamivu-tenofovir disop)	T4	PA SP
ARV-NUCLEOSIDE, NUCLEOTIDE RTI, INTEGRASE INHIBITORS		
BIKTARVY	T4	SP
GENVOYA	T4	SP
STRIBILD	T4	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	T4	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 – 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	T4	PA QL (1 tab/day) SP HD
SOVALDI 200 MG PELLET PACKET	T4	PA QL (1 tab/day) SP HD
SOVALDI 200 MG TABLET	T4	PA QL (1 tab/day) SP HD
SOVALDI 400 MG TABLET	T4	PA SP HD
HEP C VIRUS-NS5B POLYMERASE AND NS5A INHIB. COMBO.		
EPCLUSA 200 MG-50 MG TABLET	T4	PA QL (1 tab/Day) SP HD
EPCLUSA 400 MG-100 MG TABLET	T4	PA SP HD
HARVONI 33.75-150 MG PELLET PK	T4	PA QL (1 tab/day) SP HD
HARVONI 45-200 MG PELLET PACKT	T4	PA QL (1 tab/day) SP HD
HARVONI 45-200 MG TABLET	T4	PA QL (1 tab/day) SP HD
HARVONI 90-400 MG TABLET	T4	PA SP HD
LEDIPASVIR-SOFOSBUVIR	T4	PA QL(1 tab/day) SP HD
SOFOSBUVIR-VELPATASVIR	T4	PA QL(1 tab/day) SP HD
HEPATITIS B TREATMENT AGENTS		
adefovir dipivoxil	T4	SP HD
BARACLUD 0.05 MG/ML SOLUTION	T4	SP HD
BARACLUD 0.5 MG TABLET (entecavir)	T4	PA QL (1 tab/day) SP HD
BARACLUD 1 MG TABLET (entecavir)	T4	PA SP HD
entecavir 0.5 mg tablet (Baraclude)	T4	QL (1 tab/day) SP HD
entecavir 1 mg tablet (Baraclude)	T4	SP HD
EPIVIR HBV 100 MG TABLET (lamivudine hbv)	T4	SP
EPIVIR HBV 25 MG/5 ML SOLN	T4	SP
HEPSERA (adefovir dipivoxil)	T4	SP HD
lamivudine (Epivir Hbv)	T4	SP
VEMLIDY	T4	SP HD

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

T4 – 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	T4	PA SP HD
ribasphere 200 mg capsule	T4	SP HD
ribasphere 200 mg tablet	T4	SP HD
ribasphere 400 mg tablet	T4	SP
ribasphere 600 mg tablet	T4	SP
ribasphere ribapak 200-400 mg	T4	SP HD
ribasphere ribapak 400-400 mg	T4	SP HD
ribasphere ribapak 400-400 mg	T4	SP HD
ribasphere ribapak 600-400 mg	T4	SP HD
ribasphere ribapak 600-400 mg	T4	SP HD
ribasphere ribapak 600-600 mg	T4	SP HD
ribasphere ribapak 600-600 mg	T4	SP HD
HEPATITIS C VIRUS- NS5A AND NS3/4A INHIBITOR COMB		
MAVYRET 100-40 MG TABLET	T4	PA QL(3 tabs/day) SP HD
MAVYRET 50-20 MG PELLET PACKET	T4	PA QL(5 packs/day) SP HD
HEPATITIS C VIRUS- NS5A AND NS3/4A INHIBITOR COMB		
ZEPATIER	T4	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

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

T4 – 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 (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 16 mg capsule</i> (Razadyne Er)	T1	HD
<i>galantamine er 24 mg capsule</i> (Razadyne Er)	T1	HD
<i>galantamine er 8 mg capsule</i> (Razadyne Er)	T1	QL (1 cap/day) HD
<i>galantamine hbr</i>	T1	HD
MESTINON (<i>pyridostigmine bromide</i>)	T3	PA HD
<i>pyridostigmine 60 mg/5 ml soln</i> (Mestinon)	T1	HD
PYRIDOSTIGMINE BR 30 MG TABLET	T3	PA QL (20 tabs/day) HD
<i>pyridostigmine br 60 mg tablet</i> (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 – 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 (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)	T4	SP HD
-----------------------------	----	-------

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

T4 – 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)	T4	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

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

T4 – 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

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
ROTAVERSE	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
FLULAVAL 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)	T4	SP
VACCINE/TOXOID PREPARATIONS, COMBINATIONS		
ACTHIB	T2	PPACA
ADACEL TDAP	T2	PPACA

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

T4 – 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

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)	T4	SP HD
CABLIVI	T4	PA SP

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

T4 – 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

BLOOD (Blood Modifiers/Bleeding Disorders) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
AGENTS TO TX THROMBOTIC THROMBOCYTOPENIC PURPURA (con't.)		
LYSTEDA (<i>tranexamic acid</i>)	T4	SP
<i>tranexamic acid</i> (Lysteda)	T4	SP
ANTI-FIBRINOLYTIC AGENTS		
AMICAR (<i>aminocaproic acid</i>)	T4	SP HD
ANTI-HEMOPHILIC FACTORS		
ALTUVIIO	T4	PA SP HD
COMPLEMENT (C3) INHIBITORS		
EMPAVELI	T4	PA SP
FABHALTA	T4	PA QL(2 caps/day) SP
VOYDEYA	T4	PA QL(1 packet/28 days) SP
COMPLEMENT(C5) INHIBITOR		
TAVNEOS	T4	PA QL (6 caps/day)SP HD
HEMOPHILIA TREATMENT AGENTS, NON-FACTOR REPLACEMENT		
ALHEMO PEN	T4	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> (<i>Gelfoam</i>)	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	

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

T4 – 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

BLOOD (Blood Thinners/Anti-Clotting)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
HEMORRHOELOGIC 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

T3 – Typically Non-Preferred Brands

T4 – 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

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

T4 – 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.)		
<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

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

T4 – 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
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		
ADEMPAS	T4	PA SP HD
PULM ANTI-HTN, SEL.C-GMP PHOSPHODIESTERASE T5 INHIB		
<i>ADCIRCA (tadalafil)</i>	T4	PA SP HD
<i>REVATIO (sildenafil citrate)</i>	T4	PA SP HD
<i>sildenafil 10 mg/ml oral susp (Revatio)</i>	T4	PA SP HD
<i>sildenafil 20 mg tablet (Revatio)</i>	T4	PA SP HD
<i>tadalafil (Adcirca)</i>	T4	PA SP HD
<i>tadalafil 20 mg tablet (Adcirca)</i>	T4	PA SP HD
TADLIQ	T4	PA SP HD
PULMONARY ANTI-HTN, ENDOTHELIN RECEPTOR ANTAGONIST		
<i>ambrisentan (Letairis)</i>	T4	PA SP HD
<i>bosentan (Tracleer)</i>	T4	PA SP HD
<i>LETAIRIS (ambrisentan)</i>	T4	PA SP HD
OPSUMIT	T4	PA SP HD
<i>TRACLEER 125 MG TABLET (bosentan)</i>	T4	PA SP HD
<i>TRACLEER 32 MG TABLET FOR SUSP</i>	T4	PA SP HD
<i>TRACLEER 62.5 MG TABLET (bosentan)</i>	T4	PA SP HD
PULMONARY ANTIHYPERTENSIVES, PROSTACYCLIN-TYPE		
ORENITRAM ER	T4	PA SP HD
TYVASO	T4	PA SP HD
TYVASO INSTITUTIONAL START KIT	T4	PA SP HD
WINREVAIR	T4	PA SP HD

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

T4 – 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 (Asthma/COPD/Respiratory) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
PULMONARY ANTIHYPERTENSIVES, PROSTACYCLIN-TYPE (cont.)		
TYVASO REFILL KIT	T4	PA SP HD
TYVASO STARTER KIT	T4	PA SP HD
UPTRAVI	T4	PA SP HD
VENTAVIS	T4	PA SP HD
PULMONARY HTN-ENDOTHELIN RECEPT ANTG-CGMP PDE5 INH		
OPSYNVI	T4	PA QL(1 tab/day) SP HD
CARDIOVASCULAR (Blood Pressure/Heart Medications)		
ACE INHIBITOR-CALCIUM CHANNEL BLOCKER COMBINATION		
<i>amlodipine besylate/benazepril</i>	T1	HD
<i>amlodipine besylate/benazepril (Lotrel)</i>	T1	HD
<i>LOTREL (amlodipine besylate-benazepril)</i>	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 (<i>trandolapril-verapamil er</i>)	T3	HD
<i>trandolapril/verapamil hcl</i>	T1	HD
<i>trandolapril/verapamil hcl (Tarka)</i>	T1	HD
ACE INHIBITOR-THIAZIDE OR THIAZIDE-LIKE DIURETIC		
<i>ACCURETIC (quinapril-hydrochlorothiazide)</i>	T3	ST HD
<i>benazepril/hydrochlorothiazide</i>	T1	HD
<i>benazepril/hydrochlorothiazide (Lotensin Hct)</i>	T1	HD
<i>captopril-hctz 25-15 mg tablet</i>	T1	QL (3 tabs/day) HD
<i>captopril-hctz 25-25 mg tablet</i>	T1	QL (2 tabs/day) HD
<i>captopril-hctz 50-15 mg tablet</i>	T1	QL (3 tabs/day) HD
<i>captopril-hctz 50-25 mg tablet</i>	T1	QL (2 tabs/day) HD
<i>enalapril/hydrochlorothiazide</i>	T1	HD
<i>enalapril/hydrochlorothiazide (Vaseretic)</i>	T1	HD
<i>fosinopril/hydrochlorothiazide</i>	T1	HD
<i>lisinopril/hydrochlorothiazide (Zestoretic)</i>	T1	HD
<i>LOTENSIN HCT (benazepril-hydrochlorothiazide)</i>	T3	ST HD
<i>quinapril/hydrochlorothiazide (Accuretic)</i>	T1	HD
<i>VASERETIC (enalapril-hydrochlorothiazide)</i>	T3	ST HD
<i>ZESTORETIC (lisinopril-hydrochlorothiazide)</i>	T3	ST HD

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

T4 – 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 – 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
ANGIOTENSIN RECEPTOR ANTAG.-THIAZIDE DIURETIC COMB (cont.)		
HYZAAR (<i>losartan-hydrochlorothiazide</i>)	T3	ST HD
irbesartan/ <i>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</i> 20-12.5 mg tab (Benicar Hct)	T1	QL (1 tab/day) HD
<i>olmesartan-hctz</i> 40-12.5 mg tab (Benicar Hct)	T1	HD
<i>olmesartan-hctz</i> 40-25 mg tab (Benicar Hct)	T1	HD
<i>telmisartan-hctz</i> 40-12.5 mg tb (Micardis Hct)	T1	QL (1 tab/day) HD
<i>telmisartan-hctz</i> 80-12.5 mg tb (Micardis Hct)	T1	HD
<i>telmisartan-hctz</i> 80-25 mg tab (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</i> 10-20 mg (Azor)	T1	HD
<i>amlodipine-olmesartan</i> 10-40 mg (Azor)	T1	HD
<i>amlodipine-olmesartan</i> 5-20 mg (Azor)	T1	QL (1 tab/day) HD
<i>amlodipine-olmesartan</i> 5-40 mg (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</i> 40-10	T1	HD
<i>telmisartan-amlodipine</i> 40-5 mg	T1	QL (1 tab/day) HD
<i>telmisartan-amlodipine</i> 80-10	T1	HD
<i>telmisartan-amlodipine</i> 80-5 mg	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

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

T4 – 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, 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 – 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.)		
<i>telmisartan 40 mg tablet (Micardis)</i>	T1	QL (1 tab/day) HD
<i>telmisartan 80 mg tablet (Micardis)</i>	T1	HD
<i>valsartan (Diovan)</i>	T1	HD
ANTI-HYPERTENSIVES, GANGLIONIC BLOCKERS		
<i>VECAMYL</i>	T1	
ANTI-HYPERTENSIVES, MISCELLANEOUS		
<i>DEMSER (metyrosine)</i>	T3	HD
<i>metyrosine (Demser)</i>	T1	HD
ANTI-HYPERTENSIVES, SYMPATHOLYTIC		
<i>CATAPRES-TTS 1 (clonidine)</i>	T3	HD
<i>CATAPRES-TTS 2 (clonidine)</i>	T3	HD
<i>CATAPRES-TTS 3 (clonidine)</i>	T3	HD
<i>clonidine (Catapres-tts 1)</i>	T1	HD
<i>clonidine (Catapres-tts 2)</i>	T1	HD
<i>clonidine (Catapres-tts 3)</i>	T1	HD
<i>guanfacine hcl (Intuniv)</i>	T1	HD
<i>INTUNIV (guanfacine hcl)</i>	T3	PA HD
<i>methyldopa</i>	T1	HD
<i>methyldopa/hydrochlorothiazide</i>	T1	HD
ANTI-HYPERTENSIVES, VASODILATORS		
<i>hydralazine hcl</i>	T1	HD
<i>minoxidil</i>	T1	HD
BETA-ADRENERGIC BLOCKING AGENTS		
<i>acebutolol hcl</i>	T1	HD
<i>atenolol (Tenormin)</i>	T1	HD
<i>BETAPACE (sotalol af)</i>	T3	PA HD
<i>BETAPACE AF (sotalol af)</i>	T3	PA HD
<i>betaxolol hcl</i>	T1	HD
<i>bisoprolol fumarate</i>	T1	HD
<i>BYSTOLIC 10 MG TABLET</i>	T3	PA QL (1 tab/day) HD
<i>BYSTOLIC 2.5 MG TABLET</i>	T3	PA QL (1 tab/day) HD
<i>BYSTOLIC 20 MG TABLET</i>	T3	PA HD

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

T4 – 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 – 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 – 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	T4	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	T4	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

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

T4 – 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-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
LESCOL XL (<i>fluvastatin er</i>)	T3	PA HD
LIPITOR (<i>atorvastatin calcium</i>)	T3	PA HD
LIVALO 1 MG TABLET (<i>pitavastatin calcium</i>)	T2	QL (1 tab/day) ST HD
LIVALO 2 MG TABLET (<i>pitavastatin calcium</i>)	T2	QL (1 tab/day) ST HD
LIVALO 4 MG TABLET (<i>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
PRAVACHOL (<i>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
SIMVASTATIN 20 MG/5 ML SUSP	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
ZOCOR	T3	PA HD
ZYPITAMAG	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 – 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

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

T4 – 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
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	T4	PA QL(1 tab/day) SP HD
CNS DRUGS (Alzheimer's Disease)		
ALZHEIMER'S THERAPY, NMDA RECEPTOR ANTAGONISTS		
<i>memantine hcl</i>	T1	HD
<i>memantine hcl er 14 mg capsule (Namenda Xr)</i>	T1	QL (1 cap/day) HD
<i>memantine hcl er 21 mg capsule</i>	T1	HD
<i>memantine hcl er 28 mg capsule (Namenda Xr)</i>	T1	HD
<i>memantine hcl er 7 mg capsule (Namenda Xr)</i>	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	T4	PA QL (50ml/28days) SP
RELYVARIO	T4	PA QL(2 packs/day) SP
RILUTEK (<i>riluzole</i>)	T4	PA SP HD
<i>riluzole</i> (Rilutek)	T4	SP HD
TIGLUTIK	T4	PA SP

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

T4 – Specialty Medications

PA – Prior Authorization

QL – Quantity Limit

ST – Step Therapy

AGE – Age Requirement

SP – Specialty Medication

HD – May require home delivery pharmacy

PPACA – No Cost-Share Preventive Medication

CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

CNS DRUGS (Miscellaneous) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
DRUGS TO TREAT MOVEMENT DISORDERS		
AUSTEDO XR 6 MG TABLET	T4	PA QL (90 tabs/30 days) SP HD
AUSTEDO XR 12 MG TABLET	T4	PA QL (30 tabs/30 days) SP HD
AUSTEDO XR 18 MG TABLET	T4	PA QL(1 tab/day) SP HD
AUSTEDO XR 24 MG TABLET	T4	PA QL (50 tabs/30 days) SP HD
AUSTEDO XR TITRATION KT(WK1-4)	T4	PA QL(1 kit/180 days) SP HD
HORIZANT	T3	PA
INGREZZA	T4	PA SP
INGREZZA INITIATION PACK	T4	PA QL (28 caps/year) SP
<i>tetrabenazine</i> (Xenazine)	T4	PA SP HD
XENAZINE (<i>tetrabenazine</i>)	T4	PA SP HD
PSEUDOLOBULBAR AFFECT (PBA) AGENTS, NMDA ANTAGONISTS		
NUDEXTA	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	T4	PA SP HD
BETASERON	T4	PA SP HD
COPAXONE (<i>glatopa</i>)	T4	PA SP HD
<i>dimethyl fumarate</i> (Tecfidera)	T1	HD
GILENYA	T4	PA SP HD
glatiramer	T4	SP HD
<i>glatiramer acetate</i> (Copaxone)	T4	PA SP HD
<i>glatopa</i>	T4	SP HD
KESIMPTA PEN	T4	PA SP HD
MAVENCLAD	T4	PA SP HD
MAYZENT	T4	PA SP HD
PLEGRIDY	T4	PA SP HD
PLEGRIDY PEN	T4	PA SP HD
PONVORY	T4	PA SP HD
REBIF	T4	PA SP HD
REBIF REBIDOSE	T4	PA SP HD

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

T4 – Specialty Medications

PA – Prior Authorization

QL – Quantity Limit

ST – Step Therapy

AGE – Age Requirement

SP – Specialty Medication

HD – May require home delivery pharmacy

PPACA – No Cost-Share Preventive Medication

CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

CNS DRUGS (Multiple Sclerosis) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
AGENTS TO TREAT MULTIPLE SCLEROSIS (cont.)		
TASCIENO ODT 0.25 MG TABLET	T4	PA QL(1 tab/day) SP
TECFIDERA (<i>dimethyl fumarate</i>)	T4	PA SP HD
teriflunomide (Aubagio)	T4	SP HD
VUMERTY	T4	PA SP HD
ZEPOSIA	T4	PA SP HD
AGTS TX NEUROMUSC TRANSMISSION DIS, POT-CHAN BLKR		
AMPYRA (<i>dalfampridine er</i>)	T4	PA SP HD
<i>dalfampridine</i> (Ampyra)	T4	PA SP HD
FIRDAPSE	T4	PA QL (8 tabs/day) SP
RUZURGI	T4	PA SP
CNS DRUGS (Pain Relief And Inflammatory Disease)		
CALCITONIN GENE-RELATED PEPTIDE (CGRP) INHIBITORS		
EMGALITY SYRINGE	T2	PA
GLYPROMATE (GPE) ANALOGS		
DAYBUE	T4	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	T4	PA QL(30 tabs/30 days) SP HD
ZEPOSIA	T4	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 10 mg rectal gel syst</i>	T1	HD
<i>diazepam 2.5 mg rectal gel sys</i> (Diastat)	T1	HD
<i>diazepam 20 mg rectal gel syst</i>	T1	HD
KLONOPIN (<i>clonazepam</i>)	T3	PA HD

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

T4 – Specialty Medications

PA – Prior Authorization

QL – Quantity Limit

ST – Step Therapy

AGE – Age Requirement

SP – Specialty Medication

HD – May require home delivery pharmacy

PPACA – No Cost-Share Preventive Medication

CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

CNS DRUGS (Seizure Disorders) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
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	T4	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

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

T4 – Specialty Medications

PA – Prior Authorization

QL – Quantity Limit

ST – Step Therapy

AGE – Age Requirement

SP – Specialty Medication

HD – May require home delivery pharmacy

PPACA – No Cost-Share Preventive Medication

CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

CNS DRUGS (Seizure Disorders) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
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
lamotrigine (Lamictal (blue))	T1	HD
lamotrigine (Lamictal (green))	T1	HD
lamotrigine (Lamictal (orange))	T1	HD
lamotrigine (Lamictal Odt (blue))	T1	HD

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

T4 – Specialty Medications

PA – Prior Authorization

QL – Quantity Limit

ST – Step Therapy

AGE – Age Requirement

SP – Specialty Medication

HD – May require home delivery pharmacy

PPACA – No Cost-Share Preventive Medication

CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

CNS DRUGS (Seizure Disorders) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
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 (80ml/day) HD
SABRIL (<i>vigabatrin</i>)	T4	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 (topiramate)	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 (oxcarbazepine)	T3	PA HD

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

T4 – Specialty Medications

PA – Prior Authorization

QL – Quantity Limit

ST – Step Therapy

AGE – Age Requirement

SP – Specialty Medication

HD – May require home delivery pharmacy

PPACA – No Cost-Share Preventive Medication

CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

CNS DRUGS (Seizure Disorders) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ANTI-CONVULSANTS (cont.)		
TROKENDI XR 100 MG, 25MG, 50 MG CAPSULE (topiramate)	T3	PA QL(1 cap/day) HD
valproic acid	T1	HD
vigabatrin (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	T4	PA QL (2 tabs/day) SP HD
--	----	--------------------------

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

ERYTHROPOIESIS-STIMULATING AGENTS		
ARANESP	T4	PA SP
EPOGEN	T4	PA SP
MIRCERA	T4	PA SP
PROCRIT	T4	PA SP
RETACRIT	T4	PA SP

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

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

T4 – 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

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	T4	SP HD
ZIEXTENZO	T4	PA SP
THROMBOPOIETIN RECEPTOR AGONISTS		
ALVAIZ 9 MG, 18 MG TABLET	T4	PA QL(1 tab/day) SP
ALVAIZ 36 MG, 54 MG TABLET	T4	PA QL(2 tabs/day) SP
DOPTELET	T4	PA SP HD
MULPLETA	T4	PA SP HD
PROMACTA	T4	PA SP HD
CXCR4 CHEMOKINE RECEPTOR ANTAGONIST		
LEUKOCYTE (WBC) STIMULANTS (cont.)		
XOLREMDI	T4	PA QL(4 caps/day) SP CSL
CONTRACEPTIVES (Contraception Products)		
CONTRACEPTIVES, INTRAVAGINAL, SYSTEMIC		
ANNOVERA	T3	PPACA
etongestrel/ethinyl estradiol (Nuvaring)	T1	PPACA
NUVARING (etonogestrel-ethinyl estradiol)	T3	PPACA
CONTRACEPTIVES, IMPLANTABLE		
NEXPLANON	T4	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>drosipir/eth estra/levomefol ca</i>)	T3	HD PPACA
<i>desogestrel-ethinyl estradiol</i>	T1	HD PPACA
<i>drosipir/eth estra/levomefol ca</i> (Beyaz)	T1	HD PPACA
<i>drosipir/eth estra/levomefol ca</i> (Safyral)	T1	HD PPACA
ELLA	T3	HD PPACA
ESTROSTEP FE (<i>tri-legest fe</i>)	T3	HD

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

T4 – 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 – 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	T4	SP PPACA
LILETTA	T4	SP PPACA
MIRENA	T4	SP PPACA
MIUDELLA	T4	SP PPACA
PARAGARD T 380-A	T4	SP PPACA
SKYLA	T4	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/phenyleph/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 – 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 oph 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 – 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	
VARIBAR THIN HONEY	T3	
VARIBAR THIN 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>)	T4	PA SP
TOLVAPTAN 15 MG TABLET	T4	SP
<i>tolvaptan 30 mg tablet (Samsca)</i>	T4	SP
CARBONIC ANHYDRASE INHIBITORS		
<i>acetazolamide</i>	T1	HD
<i>methazolamide</i>	T1	HD
LOOP DIURETICS		
<i>bumetanide</i>	T1	HD
EDECRRIN (<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 – 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 RECEP. ANTAG		
JYNARQUE 15 MG TABLET	T4	SP
JYNARQUE 15 MG-15 MG TABLET	T4	PA SP
JYNARQUE 30 MG TABLET	T4	SP
JYNARQUE 30 MG-15 MG TABLET	T4	PA SP
JYNARQUE 45 MG-15 MG TABLET	T4	PA SP
JYNARQUE 60 MG-30 MG TABLET	T4	PA SP
JYNARQUE 90 MG-30 MG TABLET	T4	PA SP
POTASSIUM SPARING DIURETICS		
ALDACTONE (<i>spironolactone</i>)	T3	PA HD
<i>amiloride hcl</i>	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
<i>amiloride/hydrochlorothiazide</i>	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		
<i>chlorthalidone</i>	T1	HD
DIURIL	T2	HD
HEMICLOR	T3	HD
<i>hydrochlorothiazide</i>	T1	HD
<i>indapamide</i>	T1	HD
<i>metolazone</i>	T1	HD
THALITONE	T3	PA HD

ENT 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 – 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 – 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.)		
dexamethasone sodium phosphate	T1	
diclofenac 0.1% eye drops	T1	
DUREZOL	T3	PA
EYSUVIS	T2	QL (8.3ml/14 days)
FLAREX	T2	
fluorometholone (Fml)	T1	
flurbiprofen sodium	T1	
FML (fluorometholone)	T3	PA
FML FORTE	T3	PA
ILEVRO	T3	
INVELTYS	T2	PA
ketorolac 0.4% ophth solution (Acular Ls)	T1	
ketorolac 0.5% ophth solution (Acular)	T1	
LOTEMAX 0.5% EYE DROPS	T3	ST
LOTEMAX OINTMENT (<i>loteprednol etabonate</i>)	T3	ST
LOTEMAX SM	T3	PA
<i>loteprednol etabonate</i> (Lotemax)	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</i> (Pred Forte)	T1	
<i>prednisolone sodium phosphate</i>	T1	
PROLENSA	T3	
EYE LOCAL ANESTHETICS		
AKTEN	T3	
ALCAINE (<i>proparacaine hcl</i>)	T3	
ALTAFLUOR BENOX (<i>flurox</i>)	T3	
<i>benoxinate hcl/fluorescein sod</i> (Altafluor Benox)	T1	
<i>benoxinate hcl/fluorescein sod</i> (Altafluor Benox)	T3	
<i>proparacaine hcl</i> (Alcaine)	T1	
<i>proparacaine/fluorescein sod</i>	T1	
<i>proparacaine/fluorescein sod</i>	T2	
<i>tetracaine hcl</i>	T1	
TETRAVISC	T2	

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

T4 – 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 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
apraclonidine hcl (<i>lopidine</i>)	T1	HD
AZOPT (<i>brinzolamide</i>)	T3	PA HD
betaxolol hcl	T1	HD
BETIMOL	T3	PA HD
BETOPTIC S	T2	HD
bimatoprost	T1	QL (10ml/30 days) HD
brimonidine tartrate	T1	HD
brimonidine tartrate (Alphagan P)	T1	HD
brinzolamide (Azopt)	T1	HD
carteolol hcl	T1	HD
COMBIGAN	T3	PA HD
COSOPT (<i>dorzolamide-timolol</i>)	T3	PA HD
COSOPT PF (<i>dorzolamide-timolol</i>)	T3	PA HD
dorzolamide hcl (Trusopt)	T1	HD
dorzolamide hcl/timolol maleat (Cosopt)	T1	HD
dorzolamide/timolol/pf (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
latanoprost (Xalatan)	T1	HD
levobunolol hcl	T1	HD

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

T4 – 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
MIOTICS AND OTHER INTRAOCCULAR PRESSURE REDUCERS (cont.)		
LUMIGAN	T3	PA HD
PHOSPHOLINE IODIDE	T2	HD
<i>pilocarpine hcl</i> (Isopto 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> (Cyclogy)	T1	HD
<i>homatropine hbr</i>	T1	HD
ISOPTO ATROPINE (<i>atropine sulfate</i>)	T3	HD
MYDRIACYL (<i>tropicamide</i>)	T3	HD

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

T4 – 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
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)
VEVYEE	T3	PA HD
XIIDRA	T2	HD
OPHTHALMIC CYSTINE DEPLETING AGENTS		
CYSTADROPS	T4	PA QL (20ml/21 days) SP
CYSTARAN	T4	PA QL (120ml/28 days) SP
OPHTHALMIC HUMAN NERVE GROWTH FACTOR (HNGF)		
OXERVATE	T4	PA SP HD
ELECT/CALORIC/H2O (Cholesterol Medications)		
ORAL LIPID SUPPLEMENTS		
DOJOLVI	T4	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

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

T4 – 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

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	T4	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

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

T4 – 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

ELECT/CALORIC/H2O (Nutritional/Dietary) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ELECTROLYTE DEPLETERS (cont.)		
<i>lanthanum carbonate (Fosrenol)</i>	T1	
LOKELMA	T2	
PHOSLYRA	T3	
RENAGEL (<i>sevelamer hcl</i>)	T3	PA
RENVELA (<i>sevelamer carbonate</i>)	T3	PA
<i>sevelamer carbonate (Renvela)</i>	T1	
<i>sevelamer hcl</i>	T1	
<i>sevelamer hcl (Renagel)</i>	T1	
<i>sodium polystyrene sulfon/sorb</i>	T1	
<i>sodium polystyrene sulfonate</i>	T1	
<i>sps 15 gm/60 ml suspension</i>	T1	
<i>sps 30 gm/120 ml enema susp</i>	T3	
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 (K-tab Er)</i>	T1	
<i>klor-con 10 meq tablet (K-tab Er)</i>	T3	
<i>klor-con 8 meq tablet</i>	T1	
<i>klor-con 8 meq tablet</i>	T3	
K-TAB ER (<i>potassium chloride</i>)	T3	
POKONZA	T3	PA
<i>potassium bicarbonate/cit ac</i>	T1	
<i>potassium chloride</i>	T1	

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

T4 – 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

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	T4	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>)	T4	PA SP HD
<i>lactulose</i>	T1	HD
<i>lactulose 10 gm/15 ml solution</i>	T1	HD
LITHOSTAT	T2	HD
OLPRUVA	T4	PA SP HD
PHEBURANE	T4	PA QL(8 Bottles/30 Days) SP HD
RAVICTI	T4	PA SP HD
<i>sodium phenylbutyrate (Buphenyl)</i>	T4	SP HD
ANTI-CHOLINERGICS, QUATERNARY AMMONIUM		
<i>chlordiazepoxide/clidinium br (Librax)</i>	T1	

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

T4 – 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
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	T4	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	T4	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)

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

T4 – 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
ANTI-EMETIC/ANTI-VERTIGO AGENTS (cont.)		
aprepitant 80 mg capsule (Emend)	T1	QL (8 caps/28 days)
BONJESTA	T3	
COMPAZINE (<i>prochlorperazine maleate</i>)	T3	
COMPAZINE (<i>prochlorperazine</i>)	T3	
DICLEGIS (<i>doxylamine succ-pyridoxine hcl</i>)	T3	PA QL(4 tabs/day)
<i>doxylamine succinate/vit b6</i> (Diclegis)	T1	QL(4 tabs/day)
EMEND 125 MG POWDER PACKET	T3	PA QL (12 caps/28 days)
EMEND 150 MG VIAL (<i>fosaprepitant dimeglumine</i>)	T3	
EMEND 80 MG CAPSULE (<i>aprepitant</i>)	T3	PA QL (8 caps/28 days)
EMEND TRIPACK (<i>aprepitant</i>)	T3	PA QL (12 caps/28 days)
FOCINVEZ	T3	
<i>fosaprepitant dimeglumine</i> (Emend)	T1	
<i>gransetron hcl</i>	T1	
<i>gransetron hcl/pf</i>	T1	
<i>meclizine 50 mg tablet</i>	T1	PA
MECLIZINE 50 MG TABLET	T3	PA
<i>ondansetron</i>	T1	
<i>ondansetron hcl</i>	T1	
<i>ondansetron hcl</i> (Zofran)	T1	
<i>ondansetron hcl/pf</i>	T1	
ONDANSETRON ODT 16 MG TABLET	T3	PA
<i>prochlorperazine</i> (Compazine)	T1	
<i>prochlorperazine maleate</i> (Compazine)	T1	
<i>promethazine hcl</i>	T1	
<i>promethazine hcl</i>	T3	
SANCUSO	T3	PA QL (4 patches/30 days)
<i>scopolamine</i> (Transderm-scop)	T1	
TRANSDERM-SCOP (<i>scopolamine</i>)	T3	
<i>trimethobenzamide hcl</i>	T1	
VARUBI	T3	PA QL (4 tabs/28 days)
ZOFRAN 2 MG/ML VIAL (<i>ondansetron hcl</i>)	T3	
ZOFRAN 4 MG TABLET (<i>ondansetron hcl</i>)	T3	PA
ZOFRAN 8 MG TABLET (<i>ondansetron hcl</i>)	T3	PA
ANTI-ULCER PREPARATIONS		
CARAFATE (<i>sucralfate</i>)	T3	PA HD
CYTOTEC (<i>misoprostol</i>)	T3	HD

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

T4 – 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
ANTI-ULCER PREPARATIONS (cont.)		
<i>misoprostol</i> (Cytotec)	T1	HD
<i>sucralfate</i> (Carafate)	T1	HD
ANTI-ULCER-H.PYLORI AGENTS		
HELDAC	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>phenohytro</i>)	T3	HD
<i>hyoscyamine sulfate</i>	T1	HD
<i>hyoscyamine sulfate</i> (Levbid)	T1	HD
<i>hyoscyamine sulfate</i> (Levsin)	T1	HD
<i>hyoscyamine sulfate</i> (Levsin-sl)	T1	HD
<i>hyoscyamine sulfate</i> (Nulev)	T1	HD
<i>hyoscyamine sulfate</i> (Nulev)	T3	HD
LEVBID (<i>symax-sr</i>)	T3	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/hoscy/atropine/scop</i> (Donnatal)	T1	HD
<i>phenobarb/hoscy/atropine/scop</i> (Phenobarbital-belladonna)	T1	HD
<i>phenobarbital-belladonna elixr</i> (Donnatal)	T1	HD
<i>phenobarbital-belladonna elixr</i> (Phenobarbital-belladonna)	T1	HD
PHENOBARBITAL-BELLADONNA ELIXR (<i>phenohytro</i>)	T3	HD
SYMAX DUOTAB	T2	HD
BILE SALTS		
ACTIGALL (<i>ursodiol</i>)	T3	HD
CHENODAL	T4	SP HD
CHOLBAM	T4	PA SP HD

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

T4 – 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	T4	PA SP HD
FECAL MICROBIOTA TRANSPLANTATION (FMT)		
VOWST	T4	PA QL (12 caps/56 days) SP HD

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

T4 – 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
GASTRIC ENZYMES		
SUCRAID	T4	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 RECEPTOR AGONISTS/ANTAGONISTS		
VIBERZI	T2	HD
IBS-C/CIC AGENTS, GUANYLATE CYCLASE-C AGONIST		
LINZESS	T2	
TRULANCE	T2	
ILEAL BILE ACID TRANSPORTER (IBAT) INHIBITOR		
BYLVAY	T4	PA SP HD
LIVMARLI	T4	PA SP HD
INTEGRIN RECEPTOR ANTAGONIST, MONOCLONAL ANTIBODY		
ENTYVIO	T4	PA SP HD
INTESTINAL MOTILITY STIMULANTS		
GIMOTI	T4	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)	T4	SP HD
LOTRONEX (alosetron hcl)	T4	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

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

T4 – 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
LAXATIVES AND CATHARTICS (cont.)		
GOLYTELY (peg-3350 and electrolytes)	T3	PA PPACA
KRISTALOSE	T3	PA
<i>lactulose 10 gm packet (Kristalose)</i>	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 (Amitiza)</i>	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 (Moviprep)</i>	T1	PPACA
<i>peg3350/sod sulf, bicarb, cl/kcl (Colyte With Flavor Packets)</i>	T1	PPACA
<i>peg3350/sod sulf, bicarb, cl/kcl (Golytely)</i>	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 (Rectiv)</i>	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

T3 – Typically Non-Preferred Brands

T4 – 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
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 – 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
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 (Aciphex)	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
hydrocortisone acetate	T1	
hydrocortisone acetate (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
hydrocortisone/lidocaine/aloe	T1	
hydrocortisone/pramoxine (Analpram Hc)	T1	
lidocaine/hydrocortisone ac	T1	
LIDOCAINE-HYDROCORTISONE	T1	
PROCORT	T3	
PROCTOFOAM-HC	T2	
RECTAL/LOWER BOWEL PREP., GLUCOCORT. (NON-HEMORR)		
CORTENEMA (<i>hydrocortisone</i>)	T3	
CORTIFOAM	T3	PA
hydrocortisone (Cortenema)	T1	

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

T4 – 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	T4	PA QL (2 tabs/day) SP
RECORLEV	T4	PA QL (8 tabs/day) SP
ADRENOCORTICOTROPHIC HORMONES		
ACTHAR SELFJECT	T4	PA SP HD
CORTROPHIN	T4	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

T3 – Typically Non-Preferred Brands

T4 – 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
ANDROGENIC AGENTS (cont.)		
NATESTO	T3	PA QL (3 bots/30 days)
oxandrolone	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	
NOCURNA	T3	PA
NOCTIVA	T3	PA
STIMATE	T4	SP
ESTROGEN AND PROGESTIN COMBINATIONS		
BIJUVA	T3	

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

T4 – 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
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 – 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	T4	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)	T4	PA SP HD
<i>dexamethasone</i> (Dxovo)	T1	
<i>dexamethasone</i> (Taperdex)	T1	PA
<i>dexamethasone 0.5 mg tablet</i>	T1	
<i>dexamethasone 0.5 mg/5 ml elx</i>	T1	
<i>dexamethasone 0.5 mg/5 ml liq</i>	T1	
<i>dexamethasone 0.75 mg tablet</i>	T1	
<i>dexamethasone 1 mg tablet</i>	T1	
<i>dexamethasone 1.5 mg tablet</i>	T1	
<i>dexamethasone 10 day 1.5 mg tb</i>	T1	PA
<i>dexamethasone 13 day 1.5 mg tb</i>	T1	PA
<i>dexamethasone 2 mg tablet</i>	T1	
<i>dexamethasone 4 mg tablet</i>	T1	
<i>dexamethasone 6 day 1.5 mg tab</i> (Taperdex)	T1	PA
<i>dexamethasone 6 mg tablet</i>	T1	
DXEO	T3	
EMFLAZA	T4	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 – 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
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 5 mg tablet</i>	T1	
ORAPRED ODT (<i>prednisolone sodium phos odt</i>)	T3	
<i>prednisolone</i>	T1	
<i>prednisolone sodium phosphate</i>	T1	
<i>prednisolone sodium phosphate</i> (Millipred)	T1	
<i>prednisolone sodium phosphate</i> (Orapred Odt)	T1	
<i>prednisone</i>	T1	
RAYOS	T3	PA
TAPERDEX	T1	PA
TARPEYO	T4	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	T4	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 – 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
GROWTH HORMONES (cont)		
SAIZEN-SAIZENPREP	T4	PA SP HD
SEROSTIM	T4	PA SP HD
SKYTROFA	T4	PA SP HD
SOGROYA	T4	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	T4	PA SP HD
LHRH (GNRH) AGONIST ANALOG PITUITARY SUPPRESSANTS		
LUPRON DEPOT	T4	PA SP HD
SYNAREL	T4	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
ganirelix acet 250 mcg/0.5 ml (Ganirelix Acetate)	T1	PA SP
GANIRELIX ACET 250 MCG/0.5 ML (ganirelix acetate)	T2	PA SP
ORLISSA 150 MG TABLET	T2	PA QL (1 tab/day)
ORLISSA 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		
fludrocortisone acetate	T1	HD
OXYTOCICS		
CERVIDIL	T3	
methylergonovine maleate	T1	
PREPIDIL	T3	
PROSTIN E2 VAGINAL SUPPOSITORY	T3	
PITUITARY SUPPRESSIVE AGENTS		
cabergoline	T1	QL (16 tabs/28 days) HD
danazol	T1	HD

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

T4 – 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 (Provera)</i>	T1	HD
<i>medroxyprogesterone 2.5 mg tab (Provera)</i>	T1	HD
<i>medroxyprogesterone 5 mg tab (Provera)</i>	T1	HD
<i>norethindrone acetate</i>	T1	HD
<i>progesterone, micronized (Prometrium)</i>	T1	HD
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	T4	PA QL (4 caps/day) SP
<i>octreotide acetate</i>	T4	PA SP HD
<i>octreotide acetate (Sandostatin)</i>	T4	PA SP HD
SANDOSTATIN (<i>octreotide acetate</i>)	T4	PA SP HD
SANDOSTATIN LAR DEPOT	T4	PA SP
SIGNIFOR	T4	PA SP
SOMATULINE DEPOT	T4	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 (Vagifem)</i>	T1	QL (36 tabs/28 days)
<i>estradiol 0.01% cream (Estrace)</i>	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 – 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		
clomiphene citrate	T1	
FOLLICLE-STIMULATING AND LUTEINIZING HORMONES		
MENOPUR	T4	PA SP
FOLLICLE-STIMULATING HORMONE (FSH)		
FOLLISTIM AQ	T4	PA SP
GONAL-F	T4	PA SP
GONAL-F RFF	T4	PA SP
GONAL-F RFF REDI-JECT	T4	PA SP
HUMAN CHORIONIC GONADOTROPIN (HCG)		
CHORIONIC GONAD 10,000 UNIT VL	T4	PA SP
CHORIONIC GONAD 12,000 UNIT VL	T4	SP
CHORIONIC GONAD 6,000 UNIT VL	T4	SP
NOVAREL	T4	PA SP
OVIDREL	T4	PA SP
PREGNYL	T4	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		
calcitonin, salmon, synthetic	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 – 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 0.03% ointment</i>	T1	
<i>tacrolimus 0.1% ointment</i>	T1	
IMMUNOSUPPRESSANTS (Transplant Medications)		
IMMUNOSUPPRESSIVES		
ASTAGRAF XL	T4	SP HD
AZASAN	T4	SP HD
<i>azathioprine</i> (Imuran)	T4	PA SP HD
CELLCEPT (<i>mycophenolate mofetil</i>)	T4	PA SP HD
<i>cyclosporine</i> (Sandimmune)	T4	SP HD
<i>cyclosporine, modified</i>	T4	SP HD
<i>cyclosporine, modified</i> (Neoral)	T4	SP HD
ENVARSUS XR	T4	SP HD

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

T4 – 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 (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)	T4	SP HD
IMURAN (azathioprine)	T4	PA SP HD
LUPKYNIS 7.9 MG CAPSULE	T4	PA QL (6 caps/day)
mycophenolate mofetil (Cellcept)	T4	SP HD
mycophenolate sodium (Myfortic)	T4	SP HD
MYFORTIC (mycophenolic acid)	T4	PA SP HD
MYHIBBIN	T4	PA SP
NEORAL (gengraf)	T4	PA SP HD
PROGRAF	T4	SP HD
PROGRAF (tacrolimus)	T4	SP HD
RAPAMUNE (sirolimus)	T4	PA SP HD
SANDIMMUNE 100 MG CAPSULE (cyclosporine)	T4	SP HD
SANDIMMUNE 100 MG/ML SOLN	T4	SP HD
SANDIMMUNE 25 MG CAPSULE (cyclosporine)	T4	SP HD
sirolimus (Rapamune)	T4	SP HD
tacrolimus 0.5 mg capsule, 1 mg, 5 mg capsule (ir) (Prograf)	T4	SP HD
ZORTRESS	T4	SP HD
ZORTRESS (everolimus)	T4	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 – 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 – 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 LANC	T1	
COMFORT TOUCH ULT THIN LANCET	T1	
DROPLET LANCETS	T1	
EASY COMFORT LANCETS	T1	
EASY TOUCH	T1	
EASY TWIST & CAP LANCETS	T1	
EMBRACE 30G LANCETS	T1	
EMBRACE SAFETY LANCET	T1	
EZ SMART LANCETS	T1	
EZ-LETS	T1	
FIFTY50 SAFETY SEAL LANCETS	T1	
FINE 30 UNIVERSAL LANCETS	T1	
FINGERSTIX	T1	
FORA LANCETS	T1	
FORACARE LANCETS	T1	
FREESTYLE LANCETS	T1	
FREESTYLE UNISTIK 2	T1	
GLUCOCOM	T1	
GLUCOCOM LANCETS	T1	

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

T4 – 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 SUPERTHIN 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	

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

T4 – 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.)		
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	
SMARTTEST 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

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

T4 – 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.)		
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

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

T4 – 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.)		
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

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

T4 – 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
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	

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

T4 – 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
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

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

T4 – 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
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)

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

T4 – Specialty Medications

PA – Prior Authorization

QL – Quantity Limit

ST – Step Therapy

AGE – Age Requirement

SP – Specialty Medication

HD – May require home delivery pharmacy

PPACA – No Cost-Share Preventive Medication

CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

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

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
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)

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

T4 – Specialty Medications

PA – Prior Authorization

QL – Quantity Limit

ST – Step Therapy

AGE – Age Requirement

SP – Specialty Medication

HD – May require home delivery pharmacy

PPACA – No Cost-Share Preventive Medication

CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

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

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
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
LYVSPA	T3	PA
<i>metaxalone (Skelaxin)</i>	T1	
<i>methocarbamol</i>	T1	

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

T4 – 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

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 – 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	T4	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	T4	PA QL(28 caps/270 days) SP HD
ZURZUVAE 25 MG CAPSULE	T4	PA QL(28 caps/270 days) SP HD

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

T4 – 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 (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ANTIDEPRESSANT- POSTPARTUM DEPRESSION (PPD) (cont.)		
ZURZUVAE 30 MG CAPSULE	T4	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)

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

T4 – 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 (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</i> (<i>escitalopram oxalate</i>)	T3	PA QL (2 tabs/day) HD
<i>LEXAPRO 20 MG TABLET</i> (<i>escitalopram oxalate</i>)	T3	PA QL (1 tab/day) HD
<i>LEXAPRO 5 MG TABLET</i> (<i>escitalopram oxalate</i>)	T3	PA QL (4 tabs/day) HD

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

T4 – 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 (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

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

T4 – 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 (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 (Pristiq)</i>	T1	QL (4 tabs/day) HD
<i>desvenlafaxine succnt er 25 mg (Pristiq)</i>	T1	QL (16 tabs/day) HD
<i>desvenlafaxine succnt er 50 mg (Pristiq)</i>	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 (Cymbalta)</i>	T1	QL (6 caps/day) HD
<i>duloxetine hcl dr 30 mg cap (Cymbalta)</i>	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 (Cymbalta)</i>	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

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

T4 – 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 (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

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

T4 – 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 (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 – 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

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

T4 – 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 (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 (Methyltin)	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)

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

T4 – 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 (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	T4	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 – 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 (Schizophrenia/Anti-Psychotics)⁸ (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ANTI-PSYCHOTIC, ATYPICAL, DOPAMINE, SEROTONIN ANTAGNIST (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 – 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 (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
<i>ziprasidone hcl</i> (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 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 – 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 (Schizophrenia/Anti-Psychotics) ⁸ (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ANTI-PSYCHOTICS, DOPAMINE AND SEROTONIN ANTAGONISTS (cont.)		
<i>loxpipine 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>	T4	PA QL(1 pack/day) SP HD
<i>LUMRYZ STARTER PACK</i>	T4	PA SP HD
<i>XYREM</i>	T4	PA SP HD
<i>XYWAV</i>	T4	PA SP HD
BARBITURATES		
<i>phenobarbital</i>	T1	
<i>secobarbital sodium</i>	T3	PA

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

T4 – 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

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

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
HYPNOTICS, MELATONIN MT1/MT2 RECEPTOR AGONISTS		
HETLIOZ	T4	PA SP HD
HETLIOZ LQ	T4	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-BARBUTURATE		
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

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

T4 – 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

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 syringes/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 – 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	T4	PA QL(2 syringe/28 days) SP HD

TOPICAL ANTI-INFLAMMATORY, NSAIDS

DICLAREAL	T3	HD
<i>diclofenac 1.5% topical soln</i>	T1	PA HD
DICLOFENAC EPOLAMINE	T3	PA QL (2 patches/day) HD
<i>diclofenac sodium 1% gel</i> (Voltaren)	T1	QL (1000gm/30 days) HD
FLECTOR	T2	PA QL (2 patches/day) HD
LICART	T2	PA QL (1 patch/day) HD
PENNSAID	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

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

T4 – 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
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	
BENZAACLIN (<i>clindamycin-benzoyl peroxide</i>)	T3	PA
CABTREO	T3	PA
<i>clindamycin-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)

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

T4 – 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
ANTI-PRURITICS, TOPICAL (cont.)		
doxepin hcl (Zonalon)	T3	PA QL (90gm/30 days)
ZONALON	T3	PA QL (90gm/30 days)
ZONALON (prodoxin)	T3	PA QL (90gm/30 days)
ANTI-PSORIATICS AGENTS		
anthralin	T1	
calcipotriene 0.005% cream (Dovonex)	T1	
CALCIPOTRIENE 0.005% FOAM	T3	PA
calcipotriene 0.005% ointment	T1	
calcipotriene 0.005% solution	T1	
calcitriol 3 mcg/g ointment (Vectical)	T1	QL (800gm/30 days)
DOVONEX (calcipotriene)	T3	
DUOBRII	T3	
RYALTRIS	T3	PA QL (1 tube/30/days)
SORILUX	T3	PA
tazarotene 0.1% cream (Tazorac)	T1	
tazarotene 0.05% cream	T1	
TAZORAC 0.05% CREAM	T2	
TAZORAC 0.05% GEL	T2	
TAZORAC 0.1% CREAM (tazarotene)	T3	
TAZORAC 0.1% GEL	T2	
VECTICAL (calcitriol)	T3	QL (800gm/30 days)
ZORYVE 0.3% CREAM	T2	ST QL(1 gm/30 days)
ANTI-SEBORRHEIC AGENTS		
OVACE PLUS	T3	
selenium sulfide	T1	
sulfacetamide sodium	T1	
TERSI FOAM	T3	
ANTISEPTICS, MISCELLANEOUS		
GUAIACOL	T1	
DIABETIC ULCER PREPARATIONS, TOPICAL		
REGRANEX	T3	PA QL (2 tubs/30 days)
EMOLLIENTS		
ATOPICLAIR	T3	
emollient combination no.35 (Mimyx)	T1	
emollient combination no.60 (Restizan)	T1	

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

T4 – 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
EMOLLIENTS (cont.)		
HALUCORT	T3	
MIMYX (<i>prumyx</i>)	T3	
RESTIZAN	T1	
<i>vite ac/grape/hyaluronic acid</i> (Atopiclair)	T1	
XCLAIR	T3	
IMMUNOMODULATORS		
ALDARA (<i>imiquimod</i>)	T3	PA
<i>imiquimod 3.75% cream</i> (Zyclara)	T1	PA QL(112 packets/67 days)
IMIQUIMOD 3.75% CREAM PUMP	T1	PA
<i>imiquimod 5% cream packet</i> (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 6% shampoo</i>	T1	
KERALYT SCALP	T3	
KERALYT SCALP (<i>salicylic acid</i>)	T3	
PACNEX (<i>benzoyl peroxide</i>)	T3	
PODOCON-25	T1	

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

T4 – 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
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	
SAVAX 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	
<i>metronidazole</i> (Metrocream)	T1	

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

T4 – 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
ROSACEA AGENTS, TOPICAL (cont.)		
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	

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

T4 – 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 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>clodan 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>diflorasone 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	

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

T4 – 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 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

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

T4 – 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 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 – 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 (Taclonex)</i>	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 (Differin)</i>	T1	PA
<i>adapalene (Plixa)</i>	T1	PA
AKLIEF	T3	
ALTRENO	T3	PA
ATRALIN (<i>tretinoin</i>)	T3	PA
<i>avita 0.025% cream (Retin-a)</i>	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 – 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</i> 0.01% gel (Retin-a)	T1	
<i>tretinoin</i> 0.025% cream (Retin-a)	T1	PA
<i>tretinoin</i> 0.025% gel (Retin-a)	T1	
<i>tretinoin</i> 0.05% cream (Retin-a)	T1	PA
<i>tretinoin</i> 0.05% gel (Atralin)	T1	PA
<i>tretinoin</i> 0.1% cream (Retin-a)	T1	PA
<i>tretinoin</i> microspheres (Retin-a Micro Pump)	T1	PA
<i>tretinoin</i> microspheres (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 DETERENT-NICOTINIC RECEPT.PARTIAL AGONIST		
CHANTIX	T2	
<i>varenicline</i> 1 mg cont month bx	T1	PPACA
SMOKING DETERRENTS, OTHER		
<i>bupropion hcl</i> sr 150 mg tablet	T1	PPACA
THYROID PREPS (Hormonal Agents)		
ANTI-THYROID PREPARATIONS		
<i>methimazole</i> (Tapazole)	T1	HD

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

T4 – 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.)		
propylthiouracil	T1	HD
TAPAZOLE (<i>methimazole</i>)	T3	HD
THYROID HORMONES		
adthyza 120 mg tablet	T1	PA HD
ADTHYZA 130 MG TABLET	T3	PA HD
adthyza 15 mg tablet	T1	PA HD
ADTHYZA 16.25 MG TABLET	T3	PA HD
adthyza 30 mg tablet	T1	PA HD
ADTHYZA 32.5 MG TABLET	T3	PA HD
adthyza 60 mg tablet	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
LEVOOTHYROXINE	T3	HD
<i>levothyroxine sodium</i> (Synthroid)	T1	HD
<i>levothyroxine sodium</i> (Synthroid)	T3	HD
<i>liothyronine sodium</i> (Cytomel)	T1	HD
SYNTHROID (<i>unithroid</i>)	T3	HD
THYQUIDITY	T3	PA HD
<i>thyroid, pork</i>	T1	HD
<i>thyroid, pork</i> (Armour Thyroid)	T1	HD
<i>thyroid, pork</i> (Wp Thyroid)	T1	HD
THYROLAR-1	T2	HD
THYROLAR-1/2	T2	HD
THYROLAR-1/4	T2	HD
THYROLAR-2	T2	HD
THYROLAR-3	T2	HD
TIROSINT	T3	HD
TIROSINT-SOL	T3	HD
WP THYROID	T1	HD
WP THYROID (<i>nature-throid</i>)	T1	HD
WP THYROID (<i>westhroid</i>)	T1	HD

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

T4 – 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 (AIDS/HIV)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
CYTOCHROME P450 INHIBITORS		
TYBOST	T4	SP
UNCLASSIFIED DRUG PRODUCTS (Asthma/COPD/Respiratory)		
CYSTIC FIBROSIS-CFTR POTENTIATOR-CORRECTOR COMBIN.		
ALYFTREK 10-50-125 MG TABLET	T4	PA QL(2 tabs/day) SP HD
ALYFTREK 4-20-50 MG TABLET	T4	PA QL(3 tabs/day) SP HD
BRONCHITOL 40 MG INHALE CAP	T4	PA SP
ORKAMBI 100 MG-125 MG TABLET	T4	PA QL (4 tabs/day) SP HD
ORKAMBI 100-125 MG GRANULE PKT	T4	PA QL (2 packs/day) SP HD
ORKAMBI 150-188 MG GRANULE PKT	T4	PA QL (2 packs/day) SP HD
ORKAMBI 200 MG-125 MG TABLET	T4	PA QL (4 tabs/day) SP HD
SYMDEKO	T4	PA QL (2 tabs/day) SP HD
TRIKAFTA	T4	PA QL (3 tabs/day) SP HD
CYSTIC FIB-TRANSMEMB CONDUCT.REG.(CFTR) POTENTIATOR		
KALYDECO 5.8 MG TABLET	T4	PA QL (2 tabs/day) SP HD
KALYDECO 150 MG TABLET	T4	PA QL (2 tabs/day) SP HD
KALYDECO 25 MG GRANULES PACKET	T4	PA QL (2 packs/day) SP HD
KALYDECO 50 MG GRANULES PACKET	T4	PA QL (2 packs/day) SP HD
KALYDECO 75 MG GRANULES PACKET	T4	PA QL (2 packs/day) SP HD
LUNG SURFACTANTS		
CUROSURF	T3	
INFASURF	T3	
SURVANTA	T3	
MUCOLYTICS		
PULMOZYME	T4	PA SP HD
PULMONARY FIBROSIS - SYSTEMIC ENZYME INHIBITORS		
OFEV	T4	PA SP HD
SYSTEMIC ENZYME INHIBITORS		
JOENJA	T4	PA QL SP
VIJOICE 125mg,50 mg	T4	PA QL(PA QL (30tabs/30days) SP
VIJOICE 250mg dose pack	T4	PA QL (2 tabs/30 days)
ZOKINVY	T4	PA QL (4 caps/day) SP
UNCLASSIFIED DRUG PRODUCTS (Blood Modifiers/Bleeding Disorders)		
SPLEEN TYROSINE KINASE INHIBITORS		
TAVALISSE	T4	PA SP

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

T4 – 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		
LODOC	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	T4	PA SP HD
CINRYZE	T4	PA SP HD
HAEGARD	T4	PA SP HD
RUCONEST	T4	PA SP HD
PLASMA KALLIKREIN INHIBITORS		
KALBITOR	T4	PA SP HD
ORLADEYO	T4	PA QL (1 caps/day) SP
UNCLASSIFIED DRUG PRODUCTS (Cancer)		
CHEMOTHERAPY RESCUE/ANTIDOTE AGENTS		
<i>leucovorin calcium</i>	T1	
<i>mesna</i> (Mesnex)	T4	SP CSL
MESNEX	T4	SP
VISTOGARD	T4	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 – 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>vardenafil 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>vardenafil hcl</i>	T1	QL (10 tabs/30 days)
<i>vardenafil 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 (Sensipar)</i>	T4	SP
<i>SENSIPAR (cinacalcet hcl)</i>	T3	PA SP
ORAL MUCOSITIS/STOMATITIS AGENTS		
GELCLAIR	T3	
ORAMAGICRX	T3	
REZDIFRA	T4	PA QL(1 tab/day) SP HD
SALIVA STIMULANT AGENTS		
NUMOISYN	T3	

UNCLASSIFIED DRUG PRODUCTS (Hormonal Agents)

BONE FORMATION STIM. AGENTS - PARATHYROID HORMONE		
FORTEO	T4	PA QL (3ML/21 DAYS) SP HD
<i>teriparatide 600 mcg/2.4ml pen</i>	T4	PA QL(0.09 mls/day) SP HD
TERIPARATIDE 620 MCG/2.48 ML	T4	PA QL(0.09 mls/day) SP HD
TERIPARATIDE	T4	PA QL (1 pen/28 days) SP HD

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

T4 – 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		
<i>doxercalciferol</i>	T1	
<i>paricalcitol</i>	T4	SP HD
<i>paricalcitol</i> (Zemplar)	T4	SP HD
RAYALDEE	T3	
ZEMPLAR (<i>paricalcitol</i>)	T4	SP HD
MENOPAUSAL SYMPT SUPP-SEL ESTROGEN RECEP MODULATOR		
OSPHENA	T3	HD
UNCLASSIFIED DRUG PRODUCTS (Miscellaneous)		
ABORTIFACIENT-PROGESTERONE RECEPTOR ANTAGONISTS		
MIFEPREX	T3	
<i>mifepristone</i> (Mifeprex)	T1	
AGENTS TO TX PERIODIC PARALYSIS - CARBON ANHYD INH		
<i>dichlorphenamide</i> (Keveyis)	T4	PA SP
KEVEYIS	T4	SP
AMMONIA INHIBITORS		
CARBAGLU (<i>carglumic acid</i>)	T4	SP HD
<i>carglumic acid</i> (Carbaglu)	T4	SP HD
AMYLOIDOSIS AGENTS-TRANSTHYRETIN (TTR) SUPPRESSION		
TEGSEDI	T4	PA SP HD
WAINUA	T4	PA QL(1 auto-inj/28 days) SP
ANTI-ALCOHOLIC PREPARATIONS		
<i>acamprosate calcium</i>	T1	
ANTABUSE (<i>disulfiram</i>)	T3	
<i>disulfiram</i> (Antabuse)	T1	
ANTIDOTES, MISCELLANEOUS		
CETYLEV	T3	
ANTI-FIBROTIC THERAPY - PYRIDONE ANALOGS		
ESBRIET	T4	PA SP HD
<i>pirfenidone 267 mg capsule</i>	T4	PA SP HD
COMPLEMENT INHIBITORS		
ZILBRYSQ	T4	PA QL(1 syringe/day) SP

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

T4 – 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
CRYOPRESERVATIVE AGENTS		
<i>dimethyl sulfoxide</i>	T1	
DRUGS TO TREAT HEREDITARY TYROSINEMIA		
<i>nitisinone</i> (Orfadin)	T4	PA SP HD
NITYR	T4	PA SP
ORFADIN (<i>nitisinone</i>)	T4	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)	T4	PA SP HD
GENETIC DISORDER THERAPY - HDAC INHIBITOR		
DUVYZAT	T4	PA SP
GLUCOSYLCERAMIDE SYNTHASE (GCS) INHIBITOR		
CERDELGA	T4	PA SP HD
OPFOLDA	T4	PA QL(8 CAPS/30 DAYS) SP HD
<i>miglustat</i> (Zavesca)	T4	PA SP
ZAVESCA (<i>miglustat</i>)	T4	PA SP HD
GENETIC D/O TX - SMN PROTEIN DEFICIENCY TREATMENT		
MIPLYFFA	T4	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	T4	PA SP
METALLIC POISON, AGENTS TO TREAT		
CHEMET	T3	
CUVRIOR	T4	PA SP
<i>deferasirox</i> (Exjade)	T4	SP HD
<i>deferasirox</i> (Jadenu Sprinkle)	T4	SP HD
<i>deferasirox</i> (Jadenu)	T4	SP HD
<i>deferiprone</i> (Ferriprox)	T4	PA SP
EXJADE (<i>deferasirox</i>)	T4	PA SP HD

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

T4 – 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	T4	PA SP
FERRIPROX (2 TIMES A DAY)	T4	PA SP
GALZIN	T4	SP
JADENU (deferasirox)	T4	PA SP HD
JADENU SPRINKLE (deferasirox)	T4	PA SP HD
RADIOGARDASE	T3	
SYPRINE (trientine hcl)	T4	PA SP HD
trientine hcl (Syprine)	T4	PA SP HD
NATRIURETIC PEPTIDES		
VOXZOGO	T4	PA SP HD
NEONATAL FC RECEPTOR (FCRN) INHIBITORS		
VYVGART HYTRULO	T4	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		
mirabegron er 25 mg tablet (Myrbetriq)	T1	PA QL (1 tab/day) HD
mirabegron er 50 mg tablet (Myrbetriq)	T1	PA HD
MYRBETRIQ ER 25 MG TABLET (mirabegron)	T3	ST QL(1 tab/day) HD
MYRBETRIQ ER 50 MG TABLET	T3	ST HD
OXALOSIS AGENT - OXALATE INHIBITOR, SIRNA BASED		
RIVFLOZA	T4	PA QL(1 syringe/30 days) SP
PHARMACOLOGICAL CHAPERONE-ALPHA-GALACTOSIDASE STAB		
GALAFOLD	T4	PA SP HD
PKU TX AGENT-COFACCTOR OF PHENYLALANINE HYDROXYLASE		
KUVAN (sapropterin dihydrochloride)	T4	PA SP HD
sapropterin dihydrochloride (Kuvan)	T4	PA SP HD
PROTEIN STABILIZERS		
ATTRUBY	T3	PA
VYNDAMAX	T4	PA QL (1 cap/day) SP HD
VYndaQEL	T4	PA QL (4 caps/day) SP HD
RETINOIC ACID RECEPTOR (RAR) AGONISTS		
SOHONOS	T4	PA SP
SOLVENTS		
FT ISOPROPYL ALCOHOL 91%	T1	

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

T4 – 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)	T4	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	T4	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 – 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	T4	PA SP HD
FIBROMYALGIA AGENTS, SEROTONIN-NOREPINEPH RU 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	T4	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	T4	PA SP HD
UNCLASSIFIED DRUG PRODUCTS (Urinary Tract Conditions)		
BENIGN PROSTATIC HYPERSTROPHY/MICTURITION AGENTS		
alfuzosin hcl (Uroxatral)	T1	HD
AVODART (dutasteride)	T3	PA HD

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

T4 – 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
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	T4	SP
PROCYSBI	T4	PA SP HD
KIDNEY STONE AGENTS		
THIOLA	T4	PA SP
THIOLA EC	T4	PA SP
tiopronin	T4	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 – 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.		
megestrol acetate	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 – Specialty Medications

PA – Prior Authorization

QL – Quantity Limit

ST – Step Therapy

AGE – Age Requirement

SP – Specialty Medication

HD – May require home delivery pharmacy

PPACA – No Cost-Share Preventive Medication

CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

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

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

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

T4 – Specialty Medications

PA – Prior Authorization

QL – Quantity Limit

ST – Step Therapy

AGE – Age Requirement

SP – Specialty Medication

HD – May require home delivery pharmacy

PPACA – No Cost-Share Preventive Medication

CSL – Oral cancer medication subject to cost-share limits

Exclusions and limitations for coverage

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

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

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

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

Index of Medications

Symbols

1ST TIER UNIFINE	135
1ST TIER UNILET	130
2-IN-1 LANCET DEVICE.....	130
(mirabegron)	174
A	
abacavir	65, 66
abacavir/lamivudine/zidovudine	65
abacavir sulfate/lamivudine	65
ABILIFY	153
abiraterone	54
ABOUTTIME	135
ABRILADA	52
ABRYSVO	75
ABSORICA	157
acamprosate	172
ACANYA	158
acarbose	46
ACCOLATE	29
ACCU-CHEK	130
ACCUPRIL	83
ACCURETIC	81
ACCUTANE	157
ACD	39
ACE AEROSOL CLOUD ENHANCER	138
acebutolol	85
ACETAMIN-CAFF-DIHYDROCODEINE	20
acetamin-codein 300-30 mg/12.5	20
acetaminop-codeine 120-12 mg/5	20
acetaminophen/caff/dihydrocod	20
acetaminophen-cod	20
acetazolamide	102
acetic acid	50, 104, 156
acetylcysteine	29
ACIOXIA	162
ACIPHEX	117
acitretin	156, 157
ACTEMRA	128
ACTHAR	120
ACTHIB	74, 75
ACTICLATE	36
ACTIGALL	114
ACTI-LANCE	130
ACTIMMUNE	59
ACTIQ	21
ACTIVELLA	122
ACTONEL	175
ACTOPLUS	47
ACTOS	48

ACULAR	104
ACUVAIL	104
acyclovir	68, 69, 70
ACZONE	158
ADACEL	74
ADALAT	77
ADALIMUMAB	52, 181
adapalene	158, 166
ADBRY	176
ADCIRCA	80
ADDERALL	71, 72
ADDYI	151
adefovir	69
ADEMPAS	80
ADHANSIA	149
ADIPEX-P	60
ADMELOG	49
ADRENALIN	104
adthyza	168
ADTHYZA	168
ADVAIR HFA	28
ADVANCED	101, 130
ADVANCED DNA MEDICATED COLLECT	101
ADVOCATE	130, 135, 181
ADZENYS	72
AEMCOLO	36
AEROCHAMBER	138
AEROTRACH	138
AEROVENT	138
AFINITOR	56
AFLURIA	74
AFREZZA	49
AGAMATRIX	101, 129
AGAMREE	123
AGRYLIN	64, 65
AIMOVIG	14, 18
AIRDUO DIGITALER	28
AIRSUPRA	28
AJOVY	14, 18
AKEEGA	55
AKLIEF	166
AKTEN	105
AKYNZEO	112
ALA-SCALP	162
albendazole	51
ALBENZA	51
albuterol	27, 28
ALBUTEROL	27
ALCAINE	105

Index of Medications

alclometasone	162	AMNESTEEM	157
ALCOHOL	52	amoxapine	147
ALDACTAZIDE	103	amoxicillin	35, 50
ALDACTONE	103	amphetamine	71, 72
ALDARA	160	AMPHETAMINE	72
ALECENSA	57	ampicillin	35
alendronate	175	AMPYRA	93
ALEVICYN	158	AMRIX	140
alfuzosin	176, 177	AMZEEQ	38
ALHEMO	76	ANA	119
ALINIA	61	ANADROL	120
aliskiren	86, 87	ANAFRANIL	147
ALKERAN	54	anagrelide	64, 65
ALKINDI	123	ANALPRAM	119, 165
allopurinol	24, 25	ANAPROX DS	25
almotriptan malate	14, 18	anastrozole	55
ALCROL	106	ANCOBON	42
ALOGLIPTIN	45, 46, 47	ANDROGEL	120
ALOGLIPTIN-PIOGLITAZONE	45	ANGELIQ	123
ALOMIDE	106	ANNOVERA	98
ALORA	122	ANORO ELLIPTA	28
alosetron	116	ANTABUSE	172
ALPHAGAN	106	ANTARA	90
alprazolam	142	anthralin	159
ALREX	104	ANTICOAG	39
ALTABAX	162	ANUSOL	119, 162
ALTACE	83	ANZEMET	112
ALTAFLUOR	105	APADAZ	20
ALTERNATE	130	APIDRA	49
ALTOPREV	88	APLENZIN	143
ALTRENO	166	APOKYN	62
ALTUVIPIO	76	apraclonidine	106
ALUNBRIG	57	aprepitant	112, 113
ALVAIZ	98	APRETUDE	67
ALVESCO	28	APRISO	115
ALYFTREK	169	APTENSIO	149
amantadine	62	APTIOM	94
AMARYL	46	APTIVUS	65
AMBIEN	155	AQINJECT	135
ambrisentan	80	AQNEURSA	111
amcinonide	162	AQUA	162
AMICAR	76	ARAKODA	51
amiloride	103	ARANESP	97
aminocaproic	75, 76	ARAVA	24
amiodarone	77	ARAZLO	167
AMITIZA	116	ARCALYST	176
amitriptyline	147	ARCAPTA NEOHALER	27
AMJEVITA	52	arformoterol tartrate	28
amlodipine	77, 78, 81, 82, 83, 87, 88	ARICEPT	71

Index of Medications

ARIDOL.....	101	AVAR.....	39
ARIKAYCE.....	31	AVC.....	50
ARIMIDEX.....	55	AVELOX.....	36
aripiprazole.....	153	avita.....	166
ARIIXTRA.....	40	AVITA.....	166
armodafinil.....	154, 155	AVITENE.....	76
ARMOUR.....	168	AVODART.....	176
ARNUITY.....	28	AVONEX.....	92
AROMASIN.....	55	AVSOLA.....	52
ARTHROTEC.....	25	AYGESTIN.....	126
ARTISS.....	162	AYVAKIT.....	57
ARYMO ER.....	21	AZASAN.....	128
ASACOL.....	115	AZASITE.....	30
asenapine.....	151, 152	azathioprine.....	128, 129
aspirin/dipyridamole.....	64	azelaic.....	161
ASPIRIN-OMEPRAZOLE.....	64	azelastine.....	44, 103, 104
ASSURE.....	130, 135, 141, 183	AZELEX.....	158
ASTAGRAF.....	128	AZILECT.....	62
ASTRINGYN.....	76	azithromycin.....	34, 35
ATABEX.....	141	AZOPT.....	106
ATACAND.....	82, 84	AZOR.....	83
atazanavir.....	67	AZULFIDINE.....	115
ATELVIA.....	175	B	
atenolol.....	85, 86	BACIGUENT.....	30
ATIVAN.....	142	bacitracin.....	30
atomoxetine.....	151	bacitracin/polymyxin b sulfate.....	30
ATOPICLAIR.....	159	baclofen.....	140, 183
atorvastatin.....	87, 88, 89	BACLOFEN.....	140, 183
atovaquone.....	51, 52	BACTRIM.....	31
atovaquone/proguanil.....	51	BACTRIM DS.....	31
ATRALIN.....	166	BAFIERTAM.....	92
atropine.....	107, 112, 114	BALCOLTRA.....	98
ATROPINE.....	107	balsalazide.....	115
ATROVENT HFA.....	27	BALVERSA.....	57
ATTRUBY.....	174	BANZEL.....	94
AUBAGIO.....	92	BAQSIMI.....	109
AUGMENTIN.....	35	BARACLUDÉ.....	69
AUGTYRO.....	57	BASAGLAR.....	49
AURANOFIN.....	24	BAXDELA.....	36
AURYXIA.....	109	BCG.....	74
AUSTEDO.....	92	BD.....	130, 131
AUTOLET.....	129	BELBUCA.....	21
AUVELITY.....	143	BELSOMRA.....	155
AUVI-Q.....	71	BELVIQ.....	61
AVALIDE.....	82	benazepril.....	81, 83, 84
AVANDIA.....	48	benazepril/hydrochlorothiazide.....	81
AVAPRO.....	84	BENICAR.....	82, 84
avar.....	39	BENLYSTA.....	176
		benoxinate.....	105

Index of Medications

BENZACLIN	158	BREATHERITE.....	138, 139
BENZAMYCIN	38	BREATHRITE.....	139
BENZEFOAM.....	160	BRENZAVVY.....	48
BENZEPRO.....	160	BREO ELLIPTA.....	28
BENZHYDROCODONE-ACETAMINOPHEN	20	BREXAFEMME.....	42
BENZNIDAZOLE	51	BREZTRI AEROSPHERE	28
benzonataate	100	BRILINTA.....	64
benzoyl.....	38, 158, 160	brimonidine	106
benzphetamine.....	60	brinzolamide	106
benztropine.....	62	BRIVIACT	94
BEPREVE.....	44	BROMFED.....	100
BERINERT.....	170	bromfenac.....	104
BESIVANCE	30	bromocriptine	62
BESREMI.....	60	brompheniramine	100
BETADINE	104	BROMSITE	104
betaine	175	BRONCHITOL	169
betamethasone.....	42, 162, 163, 164, 166	BROVANA	28
BETAPACE	85	BRYHALI	163
BETASERON	92	budesonide	28, 123, 124
betaxolol	85, 106	BULLSEYE	131
bethanechol	73	bumetanide	102
BETHKIS.....	31	BUNAVAIL	176
BETIMOL.....	106	BUPHENYL	111
BETOPTIC	106	buprenorphine	21, 176
BEVESPI AEROSPHERE	28	bupropion	143, 144, 167
BEVYXXA.....	39	BUPROPION	143
bexarotene	53, 54	butalb-acetamin-caff 50-300-40	14, 18
BEXZERO.....	74	butalb-acetamin-caff 50-325-40	14, 18
BEYAZ	98	butalb/acetaminophen/caffeine	14, 18
bicalutamide	54	butalb-aspirin-caff 50-325-40	14, 18
BIDIL	87	butalbit/acetamin/caff/codeine	22
BIJUVA	121	butalbital/acetaminophen	14, 18
BIKTARVY	68	butalbital-asa-caffeine cap (Fiorinal)	14, 18
BILTRICIDE	51	butorphanol tartrate	21
binatoprost	106	BUTRANS	21
BIMZELX.....	156	BUTTERFLY	131
BINOSTO	175	BYDUREON	45
bisac/nacl/nahco3/kcl/peg	116	BYETTA	45
bisoprolol	85, 86	BYLVAY	116
BLEPH-10.....	30	BYSTOLIC	85, 86
BLEPHAMIDE	30	C	
BLOOD LANCETS	131	CABENUVA	64
BLULINK.....	101, 129	cabergoline	125
BONIVA	175	CABLIVI	75
BONJESTA	113	CABOMETYX	57
BOOSTRIX	75	CABTREO	158
bosentan	80	CADUET	87, 88
BOSULIF	57	CAFERGOT	14, 18
BRAFTOVI	55	caffeine	92, 141

Index of Medications

CALAN.....	.77	cefadroxil.....	33
calcipotriene	159, 166	cefdinir	33
CALCIPOTRIENE.....	159	cefditoren	33
calcitonin.....	127	cefixime.....	33, 34
calcitriol.....	159, 179	cefodoxime	33
calcium.....	39, 67, 88, 89, 109, 170, 172	cefprozil.....	33
CALQUENCE.....	.57	ceftriaxone	33
CAMZYOS.....	.79	cefuroxime	33
CANASA.....	115	CELEBREX.....	26
candesartan82, 84	celecoxib	26
capecitabine.....	.54, 55	CELEXA.....	144
CAPEX.....	163	CELLCEPT	128
CAPLYTA.....	151	CELONTIN	94
CAPRELSA.....	.57	CENTANY	38
captopril.....	.81, 83	cephalexin.....	33
captopril-hctz81	CEQUA	108
CAPVAXIVE.....	.74	CEQUR	129
CARAC.....	.60	CERDELGA	173
CARAFATE.....	113	CERVIDIL.....	125
CARBAGLU.....	.172	cetirizine	44
carbamazepine94, 96	CETROTIDE	125
CARBAMAZEPINE.....	.94	CETYLEV	172
CARBATROL.....	.94	cevimeline73
carbidopa62, 63, 64	CHANTIX	167
carbidopa/levodopa62	CHEMET.....	173
carbinoxamine44	CHENODAL	114
CARBINOXAMINE.....	.44	chlordiazepoxide.....	111, 112, 142, 147
CARDIZEM.....	.77, 78	chlordiazepoxide/clidinium.....	111
CARDURA.....	.82	chlorhexidine	170
CAREFINE.....	.135	chloroquine	51
CAREONE.....	.131	chlorpromazine	154
CAREPOINT.....	.135	chlorpropamide	47
CARESENS131	chlorthalidone	86, 103
CARETOUCH129, 131, 135, 185	chloroxazone	140
carglumic172	CHOLBAM	114
carisoprodol22, 140, 141	cholestyramine89, 90
carisoprodol/aspirin.....	.22	choline salicyl/mag salicylate14, 18
carisoprodol/aspirin/codeine22	CHORIONIC127
CARNITOR.....	.175	CHOSEN129, 131
CAROSPIR.....	.103	CIALIS170
carteolol106	CIBINQO25
carvedilol.....	.82	ciclodan42
CASODEX.....	.54	CICLODAN42, 52
CATAPRES85	ciclopirox42, 43, 52
CAVERJECT170	cilostazol64
CAYA100	CILOXAN30
CAYSTON33	CIMDUO65
CDV HYRIMOZ.....	.52	cimetidine116
cefaclor33	CIMZIA.....	.52

Index of Medications

cinacalcet	171	codeine.....	100
CINRYZE.....	170	codeine/butalbital/asa/caffein	22
CIPRO.....	29, 36, 185	codeine sulfate.....	21
CIPRODEX.....	29	COLAZAL.....	115
ciprofloxacin.....	29, 36	colchicine.....	24, 26
ciprofloxacin hcl.....	29, 36	COLCRYS.....	24
CIPROFLOXACIN HCL-FLUOCINOLONE	29	colesevelam	90
citalopram.....	144	COLESTID.....	90, 186
CITRANATAL.....	110, 141	colestipol.....	90
CITRATE.....	39	COLOR LANCETS.....	131
CITRATE PHOSPHATE DEXTROSE	39	COLYTE.....	116
CLARAVIS.....	157	COMBIGAN.....	106
CLARINEX.....	44	COMBIPATCH.....	122
clarithromycin.....	34	COMBIVENT.....	28
dexamfetamine.....	44	COMBIVENT RESPIMAT	28
CLENPIQ	116	COMBIVIR.....	65
CLEOCIN	34, 38	COMETRIQ.....	57
CLEVER.....	131, 139	COMFORT	131, 132, 133, 134, 135, 136, 137, 138, 139, 186, 201
CLICKFINE.....	135, 137	COMFORTSEAL.....	139
CLIMARA.....	122	COMIRNATY.....	73
clindacin.....	38	COMPACT.....	139
CLINDACIN.....	38	COMPazine.....	113
CLINDAGEL.....	38	COMPLERA.....	67
clindamyc.....	158	CONCEPT	178
clindamycin.....	34, 38, 39, 158	CONCERTA.....	149
clindamycin/tretinoin.....	158	CONDYLOX.....	160
CLINDESSE.....	38	CONJUPRI	78
CLINPRO	108	CONSENSI.....	77
clobazam.....	93, 94	CONTRAVE.....	61
clobetasol.....	163, 165	COPAXONE.....	92
CLOBETASOL.....	163	COPIKTRA.....	57
CLOBEX	163	CORDRAN.....	163
CLOCORTOLONE.....	163	COREG.....	82
clodan	163	coremino	36
CLODAN.....	163	CORLANOR	79
CLODERM	163	CORTEF	123
clomiphene.....	127	CORTENEMA	119
clomipramine.....	147	CORTIFOAM	119
clonazepam.....	93	cortisone	123
clonidine	85, 148	CORTISPORIN	29, 186
clopidogrel	64	CORTROPHIN	120
clorazepate.....	142	COSENTYX	156, 157
clotrimazole	42	COSOPT	106
clozapine	151, 152	COTELLIC	55
CLOZAPINE	151	COTEMPLA	149
CLOZARIL.....	151	COXANTO	25
COAGUCHEK	131	COZAAR	84
COARTEM	51	CREON	117
		CRESEMBA	42

Index of Medications

CRESTOR.....	.88	DAYPRO.....	25
CRINONE.....	126, 127	DAYTRANA.....	149
CRIXIVAN.....	.67	DAYVIGO.....	155
cromolyn.....	24, 29, 106	DDAVP	121
crotamiton.....	.61	deferasirox.....	173, 174
CUROSURF.....	169	deferiprone.....	173
CUTIVATE.....	163	deflazacort.....	123
CUVPOSA.....	112	DELESTROGEN.....	122
CUVRIOR.....	173	DELSTRIGO.....	67
cyanocobalamin.....	178	DELZICOL.....	115
cyclobenzaprine.....	140	demeclacycline.....	36
CYCLOGYL.....	107	DEMSEER.....	85
CYCLOMYDRIL.....	107	DENAVIR.....	70
cyclopentolate.....	107	DEPAKOTE.....	94
cyclophosphamide.....	.54	DEPEN.....	24
CYCLOPHOSPHAMIDE.....	.54	DEPO-ESTRADIOL.....	122
CYCLOSERINE.....	.33	DEPO-PROVERA.....	98, 126
CYCLOSET.....	.46	DEPO-SUBQ.....	98
cyclosporine.....	128, 129	DEPO-TESTOSTERONE.....	120
CYLTEZO.....	.53	DERMA.....	163
CYMBALTA.....	146	DERMATOP.....	163
ciproheptadine.....	.44	dermazene.....	166
CYSTADANE.....	175	DERMAZENE.....	166
CYSTADROPS.....	108	DERMOTIC.....	104
CYSTAGON.....	177	DESCOVY.....	65
CYSTARAN.....	108	desflurane.....	23
CYSTO-CONRAY.....	102	desipramine.....	147
CYSTOGRAFIN.....	102	desloratadine.....	44
CYTOMEL.....	168	desmopressin.....	121
CYTOTEC.....	113	desogestrel-ethinyl.....	98
D		desonide.....	163, 165
dabigatran.....	.41	DESOWEN.....	163
dalfampridine.....	.93	desoximetasone.....	163, 165
DALIRESP.....	.29	DESOXYN.....	72
danazol.....	125	desvenlafaxine.....	146
DANTRIUM.....	140	DESVENLAFAXINE.....	146
dantrolene.....	140	DETROL.....	178
DANZITEN.....	.57	dexamethasone.....	.29, 30, 105, 123
DAPAGLIFLOZIN.....	.48, .49	dexchlorpheniramine.....	44
dapsone.....	32, 158	DEXCOM.....	129
DAPSONE.....	158	DEXEDRINE.....	72
DAPTACEL.....	.75	DEXILANT.....	117
DARAPRIM.....	.51	dexlansoprazole.....	117, 118, 119
darifenacin.....	177	dexamethylphenidate.....	149
DARTISLA.....	112	dextroamp-amphet.....	72
darunavir.....	.65	dextroamp-amphet.....	72
dasatinib.....	.57	dextroamphetamine.....	.71, 72
DAURISMO.....	.55	DHIVY.....	62
DAXBIA.....	.33	DIACOMIT.....	94

Index of Medications

DAISTAT	93	DOPTELET	98
diaztrioate	102	DORAL	155
diazepam	93, 142	DORYX	36
diazoxide	109	dorzolamide	106, 107
DIBENZYLINE	73	DOVATO	64
dichlorphenamide	172	DOVONEX	159
DICLAREAL	157	doxazosin	82
DICLEGIS	113	doxepin	147, 155, 156, 158, 159
diclofenac	60, 105, 157	doxercalciferol	172
DICLOFENAC	157	doxycycline	36, 37, 170
diclofenac potassium	19	DOXYCYCLINE	36, 37
diclofenac sod dr.	25	doxylamine	113
diclofenac sod ec	25	DRIZALMA	146
diclofenac sodium	25	dronabinol	112
diclofenac sodium/misoprostol	25	DROPLET	131, 136, 188
dicloxacillin	35	DROPSAFE	136, 137
dicyclomine	112	drospir/eth estra/levomef ol	98
didanosine	66	DROXIA	76
diethylpropion	60	droxidopa	72, 73
DIFFERIN	166	DRYSOL	158
DIFCID	34	DUAVEE	123
diflorasone	163, 165	DULERA	28
DIFLUCAN	42	duloxetine	146
diflunisal	14, 18	DUOBRII	159
DIFMETIOXRIME	42	DUOPA	62
digoxin	79	DUPIXENT	127
dihydroergotamine	14, 18	DURAGESIC	21
DILANTIN	94	DUREZOL	105
DILATRATE	79	dutasteride	176, 177
DILAUDID	21	DUVYZAT	173
diltiazem	77, 78	DXEVO	123
dimethyl	92, 93, 173	DYANAVEL	72
DIOVAN	82, 84	DYAZIDE	103
DIPENTUM	115	DYMISTA	104
diphenoxylate	112	DYRENium	103
DIPHThERIA	75	E	
DIPROLENE	163	EASIVENT	139
dipyridamole	64	EASY	101, 129, 131, 136, 188
DISALCID	24	EASY TOUCH	101, 129, 131, 136
disopyramide	77	EBGLYSS	176
disulfiram	172	EC-NAPROSYN	25
DITROPAN	178	econazole	43
DIURIL	103	ECOZA	43
divalproex	94	EDARBI	84
DIVIGEL	122	EDARBYCLOR	82
dofetilide	77	EDECRIN	102
DOJOLVI	108	EDEX	171
donepezil	71	EDLUAR	155
DONNATAL	114	EDURANT	66

Index of Medications

E.E.S.....	.34	ENZOCLEAR.....	160
efavirenz.....	.67, 68	EOHILIA	123
effer-k	110	EPANED	84
EFFER-K.....	110	EPCLUSA.....	69
EFFEXOR.....	146	EPIDIOLEX	94
EFFIENT64	EPIDUO.....	158
EFUDEX.....	.60	EPIFOAM	165
EGRIFTA.....	124	epinastine	44
ELEPSIA.....	.94	epinephrine.....	71, 104
ELESTRIN.....	122	EPINEPHRINE.....	71
eletriptan hydrobromide14, 18	EPIPEN	71
ELIDEL	128	EPIVIR.....	66, 69
ELIMITE61	EPOGEN	97
ELIQUIS.....	.39	EPRONTIA.....	94
ELLA98	eprosartan.....	84
ELMIRON.....	.23	EPZICOM.....	65
EMBRACE.....	.131, 136, 188	EQUETRO	143
EMCYT.....	.60	ergocalciferol.....	179
EMEND113	ergoloid.....	87
EMFLAZA	123	ergotamine tartrate/caffeine.....	.14, 18
EMGALITY14, 18, 93	ERIVEDGE	55
emollient combination.....	.159	ERLEADA	54
Empaveli.....	.76	erlotinib.....	.57, 58
EMROSI.....	.37	ERTACZO	43
EMSAM143	ERVEBO	75
emtricitabine.....	.65, 66	ERYPED34
emtricitabine-tenovf65	erythromycin.....	.30, 34, 38
EMTRIVA.....	.66	ESBRIET172
EMVERM51	escitalopram144
ENABLEX177	ESGIC.....	.14, 18
enalapril81, 83, 84	eslicarbazepine95
enalapril/hydrochlorothiazide.....	.81	esomeprazole.....	.118
ENBREL.....	.53	ESOMEPRAZOLE.....	.118
ENDO-AVITENE.....	.76	estazolam.....	.155
ENDOMETRIN127	ESTRACE122, 126
ENGERIX-B75	estradiol98, 99, 122, 126, 187, 189, 194, 198
ENHERTU59	ESTRATEST F.S122
ENLITE129	ESTRING.....	.126
enoxaparin40, 41	ESTROGEL122
ENSPRYNG.....	.128	estrogen122
ENSTILAR.....	.166	ESTROSTEP98
entacapone62, 63	eszopiclone155
ENTADFI.....	.177	ethacrynic102
entecavir.....	.69	ethambutol32
ENTERO.....	.101	ethinyl estradiol98, 99, 122
ENTOCORT123	ethosuximide94, 97
ENTRESTO.....	.82	ethynodiol99
ENTYVIO.....	.116	etodolac25, 26
ENVARSUS.....	.128	etonogestrel/ethinyl estradiol98

Index of Medications

etoposide59	fenofibrate.....	.90, 91
EUCRISA	162	FENOFIBRATE90
EURAX61	fenofibric.....	.90, 91
EVAMIST	122	FENOGLIDE90
EVEKEO72	fenoprofen calcium.....	.25
everolimus.....	.56, 129	FENOPRON25
EVICEL76	FENSOLVI125
EVISTA175	fentanyl.....	.21
EVOCLIN39	FENTORA21
EVOTAZ67	FERRIC109
EVOXAC73	FERRIPROX174
EVRYSDI173	FETZIMA146
EVZIO41	FEXMID.....	.140
EXELDERM.....	.43	FIASP49, 130
EXELON71	FIBRICOR90
exemestane.....	.55	FIFTY50131
exenatide.....	.45	FILSPARI91
EXFORGE82, 83	FILSUVEZ176
EXJADE173	FINACEA161
EXKIVITY57	finasteride.....	.177
EXODERM43	FINE131
EXTINA43	FINGERSTIX131
EYSUVIS105	FINTEPLA95
E-Z101, 102, 139	FIORICET14, 18, 22
EZ74, 131	FIORINAL14, 18
EZALLOR.....	.88	Fiorinal With Codeine #3.....	.22
ezetimibe87, 90, 91	FIORINAL WITH CODEINE #3.....	.22
EZ FLU74	FIRAZYR170
F		FIRDAPSE93
FABHALTA76	FIRMAGON56
FABIOR167	FLAGYL32
FACTIVE36	FLAREX105
famciclovir.....	.68	flavoxate178
famotidine.....	.116	flecainide77
FANAPT151, 152	FLECTOR157
FARESTON60	FLEQSVUY140
FARXIGA45	FLEXICHAMBER139
FARYDAK54	FLOLIPID89
FAZACLO152	FLOMAX177
febuxostat24, 25	FLOVENT28
felbamate95	FLUAD74
FELBATOL95	FLUARIX74
FELDENE25	FLUBLOK74
felodipine78	FLUCELVAX74
FEMARA55, 56	FLUCONAZ-IBU-ITRACONAZ-TERBINA43
FEMCAP100	fluconazole42
FEMHRT122	flucytosine42
FEMLYV99	fludrocortisone125
FEMRING126	FLULALVAL74

Index of Medications

FLUMADINE.....	.68	FRUZAQLA.....	57
FLUMIST.....	.74	ful-glo	101
flunisolide104	FUL-GLO.....	101
fluocinolone.....	.104, 163, 164, 165	FULPHILA	97
fluocinonide.....	.164, 165	FULVICIN.....	42
fluorescein.....	.101, 105	FURADANTIN.....	35
fluoride.....	.108, 109	FUROSCIX.....	102
FLUORIDEX.....	.108	furosemide.....	102
fluorometholone.....	.105	FUZEON.....	66
FLUOROPLEX.....	.60	FYCOMPA.....	95
fluorouracil.....	.60	G	
fluoxetine144, 145, 154	gabapentin.....	.93, 95, 96
fluphenazine.....	.154	GABARONE.....	.95
flurandrenolide163, 164	GABITRIL.....	.95
flurazepam hcl.....	.155	GALAFOLD.....	.174
flurbiprofen.....	.25, 105	galantamine.....	.71
flutamide.....	.54	GALZIN174
fluticasone.....	.28, 103, 104, 163, 164	ganirelix125
FLUTICASONE.....	.28	GANIRELIX.....	.125
fluticasone propion/salmeterol.....	.28	GARDASIL 9.....	.75
FLUTICASONE-SALMETEROL.....	.28	GASTROCROM.....	.24
fluvastatin89	GASTROGRAFIN102
fluvoxamine144	GASTROMARK.....	.101
FLUZONE.....	.74	gatifloxacin.....	.30, 31
FML.....	.105	GATTEX.....	.119
FOCALIN.....	.149	GAVRETO57
FOCINVEZ.....	.113	GE333.....	.101
FOLET178	gelatin76
folic.....	.141, 178	GELCLAIR.....	.171
FOLLISTIM.....	.127	GELFILM.....	.106
fondaparinux.....	.40	GELFOAM76
FORA.....	.101, 130, 131	gemfibrozil.....	.90
FORACARE.....	.131	GEMTESA.....	.177
FORFIVO143	GENOTROPIN124
formaldehyde.....	.52	gentamicin.....	.31, 39
FORTAMET.....	.46	gentamicin sulfate.....	.30
FORTEO.....	.171, 190	GENVOYA.....	.68
FOSAMAX.....	.175	GEDON.....	.152
fosamprenavir.....	.67	GILENYA.....	.92
fosaprepitant.....	.113	GILOTrif.....	.57
fosfomycin.....	.32	GIMOTI.....	.116
fosinopril81, 84	glatiramer92
fosinopril/hydrochlorothiazide.....	.81	glatopa92
FOSRENOL.....	.109	GLEEVEC57
Fotivda.....	.57	GLEOSTINE54
FRAGMIN.....	.40	glimepiride.....	.46, 47
FRAICHE108	GLIMEPIRIDE47
FREESTYLE.....	.129, 130, 131	GLIMEPIRIDE 3 MG TABLET.....	.47
frovatriptan succinate.....	.18	glipizide.....	.47, 48

Index of Medications

GLIPIZIDE.....	47	HEMLIBRA.....	76
glucagon.....	109	HEMOCYTE.....	110
GLUCOCOM.....	130, 131	heparin.....	40
GLUCOPHAGE.....	46	HEPARIN.....	40
GLUCOTROL.....	47	HEPLISAV-B.....	75
GLUMETZA.....	46	HEPSERA.....	69
glyburide.....	47, 48	HETLIOZ.....	155
GLYCATE.....	112	HEXIOUNYL.....	43
glycine urologic.....	52	HIBERIX.....	75
glycopyrrolate.....	112	homatropine.....	101, 107
GLYNASE.....	47	HORIZANT.....	92
GLYSET.....	46	HULIO.....	53
GLYXAMBI.....	47	HUMALOG.....	49, 130
GOCOVRI.....	62	HUMAPEN.....	130
GOJJI.....	132	HUMATROPE.....	124
GOLYTELY.....	117	HUMIRA.....	53
GOMEKLI.....	55	HUMULIN.....	49
GONAL.....	127	HURRICAIN.....	23
GONITRO.....	79	HYCAMTIN.....	56
GRALISE.....	93, 191	HYCODAN.....	101
granisetron.....	113	hydralazine.....	85
GRANIX.....	97	HYDREA.....	54
GRASTEK.....	73	HYDRO.....	160
griseofulvin.....	42	hydrochlorothiazide.....	81, 82, 83, 85, 86, 103
GRIS-PEG.....	42	hydrocodone.....	100, 101
GUAIACOL.....	159	HYDROCODONE.....	101
guanfacine.....	85, 148	hydrocodone/acetaminophen.....	20
guanidine.....	73	HYDROCODONE-ACETAMINOPHEN.....	20
GUARDIAN.....	130	hydrocodone bitartrate.....	21, 22
GVOKE.....	109	hydrocodone/ibuprofen.....	20
GYNAZOLE.....	41	hydrocort.....	164
H		hydrocortisone.....	104, 119, 123, 124, 164, 165, 166
HADLIMA.....	53	hydrogen peroxide.....	156
HAEGARDA.....	170	hydromorphone hcl.....	21
halcinonide.....	164	hydroxychloroquine.....	51
HALCION.....	155	hydroxyurea.....	54
halobetasol.....	164	hydroxyzine.....	44
HALOBETASOL.....	164	HYMPAVZI.....	76
HALOG.....	164	hyoscyamine.....	114
haloperidol.....	154	HYPER.....	173
HALUCORT.....	160	HYRIM MOZ.....	52, 53
HARVONI.....	69	HYSINGLA ER.....	21
HEALTHWISE.....	136	HYZAAR.....	83
HEALTHY.....	132, 136, 191	I	
HELIDAC.....	114	ibandronate.....	175
HEMADY.....	123	IBRANCE.....	57
HEMANGEOL.....	86	IBUDONE.....	20
HEMICLOR.....	103		

Index of Medications

ibuprofen.....	20, 25	INSULIN.....	45, 46, 47, 48, 49, 50, 125, 130, 136, 138, 192, 193
ibuprofen/oxycodone hcl	20	INSULIN GLARGINE	49
icatibant	170	INSUPEN.....	136
ICLUSIG.....	57	INTELENCE.....	66
icosapent.....	111	INTRAROSA.....	120
IDACIO	53	INTUNIV.....	85, 148
DAOXIA.....	161	INVACARE.....	132
IDHIFA.....	59	INVEGA.....	152
IFE-BIMIX.....	171	INVELTYS.....	105
IFE-PG20.....	171	INVOKAMET	48
IHEALTH.....	101, 130	INVOKANA	46
ILARIS.....	176	iodine	110, 166
ILEVRO.....	105	IODOFLEX.....	166
ILUMYA.....	157	IODOSORB	166
imatinib.....	57	IOPIDINE.....	106
IMBRUVICA	57	IPOL.....	74
IMCIVREE.....	61	ipratropium	104
imipramine	147	ipratropium/albuterol sulfate	28
imipramine hcl.....	147	ipratropium bromide	27
imiquimod	160	irbesartan.....	82, 83, 84
IMIQUIMOD.....	160	irbesartan/hydrochlorothiazide	83
IMKELDI.....	57	IRESSA.....	57
IMPAVIDO	51	ISENTRESS.....	67
IMPEKLO.....	164	isoflurane	23
IMPOYZ	164	isomethopten/caf/acetaminophen	18
IMURAN	129	isomethopten/caf/acetaminophen	18
IMVEXXY	126	isoniazid	32
INBRIJA.....	62	isopropyl	175
INCONTROL	132, 136, 192	ISOPTO.....	106, 107
INCRELEX.....	125	ISORDIL.....	79
INCURSE ELLIPTA	27	isosorbide	79, 87, 193
indapamide.....	103	isotretinoin	157
INDERAL.....	86	isoxsuprine	87
INDICLOR	102	isradipine	78
INDOCIN	19	ISTALOL	106
indomethacin.....	26	ISTURISA	120
INFANRIX	75	ITOVEBI	57
INFASURF	169	itraconazole	42
INFLECTRA.....	53	ivermectin	51, 61, 161, 162
INGREZZA	92	IWILFIN	57
INJECT.....	132	IXCHIQ	75
INLYTA	57	HYUZEH	106
INNOPRAN.....	86	J	
INOVA	160	JADENU	174
INPEFA	45, 170	JAKAFI	55
INPEN	130	JANSSEN	73
INQOVI.....	54	JANUMET	47
INREBIC	57	JANUVIA	46
INSPIRACHAMBER.....	139	JARDIANCE	46

Index of Medications

JATENZO	120	KRINTAFEL	51
JENTADUETO	47	KRISTALOSE	117
JOENJA	169	K-TAB	110
JORNAY	149	KUVAN	174
JOURNAVX	20	KYLEENA	100
JUBLIA	43	KYNAMRO	88
JULUCA	64	KYNMOBI	62
JUXTAPID	88	KYZATREX	120
JYLMAMVO	54	L	
JYNARQUE	103	labetalol	82
JYNNEOS	75	LACRISERT	104
K		lactulose	111, 117
KADIAN	21	LAGEVRIO (EUA)	70
KALBITOR	170	LAMICTAL	95
KALETRA	67	lamivudine	65, 66, 69
KALYDECO	169	lamivudine/zidovudine	65
KAPSPARGO	86	lamotrigine	95, 96
KAPVAY	148	LAMPIT	51
KARBINAL	44	LANCET	133
KATERZIA	78	lancets	132
KAZANO	47	LANCETS	130, 131, 132, 133, 134
KEFLEX	33	LANOXIN	79
KENALOG	164	lanreotide	126
KEPPRA	95	LANREOTIDE	126
KERAFOAM	160	lansoprazole	114, 118
keralyt	160	lanthanum	109, 110
KERALYT	160	LANTUS	50
KERYDIN	43	lapatinib	57, 59
KESIMPTA	92	LASIX	102
ketoconazole	42, 43	LASTACRAFT	45
ketoprofen	19, 26	latanoprost	106, 107
ketorolac	19, 104, 105	LATUDA	152
KEVEYIS	172	LAZANDA	21
KEVZARA	128	LEDIPASVIR	69
KINERET	24	leflunomide	24
KINRIX	75	lenalidomide	56
KISQALI	56	LENVIMA	57
KISQALI FEMARA	56	LESCOL	89
KITABIS	31	L.E.T.	23
KLARON	158	LETAIRIS	80
KLISYRI	60	letrozole	55
KLONOPIN	93	leucovorin	170
klor-con	110	LEUKERAN	54
Kloxxado	41	LEUKINE	97
KOMBIGLYZE	48	leuprolide	56
KORLYM	48	LEUPROLIDE	56
KOSELUGO	55	levalbuterol hcl	27
K-PHOS	111	LEVIBID	114
KRAZATI	55	LEVEMIR	50

Index of Medications

levetiracetam	95, 96	LOCOID	164
LEVITRA	171	LOCORT	124
levobunolol	106	LODINE	26
levocarnitine	175	LODOC	170
levofloxacin	30, 36	LODOSYN	64
levonorgest/eth.estriol/iron	99	LOESTRIN	99
levonorgestrel/ethin.estriol	99	lofexidine	176
levothyroxine	168	LOKELMA	110
LEVOHYROXINE	168	LOMAIRA	60
LEVSIN	114	LOMOTIL	112
LEVULAN	60	LONHALA MAGNAIR	27
LEXAPRO	144	LONSURF	54
LEXETTE	164	loperamide	112
LEXIVA	67	LOPID	90
LIALDA	115	lopinavir/ritonavir	67
LIBERVANT	94	LOPRESSOR	86
LIBRAX	112	LOPROX	43
LICART	157	lorazepam	142
lidocaine	23, 101, 119, 165	LORBRENA	57
LIDOCAINE	119	LOREEV	142
lidocaine 5% ointment	23	LORTAB	20
lidocaine hcl	23	LORZONE	140
LIDOCAN	23	losartan	83, 84
LIDODERM	23	losartan/hydrochlorothiazide	83
LIKMEZ	32	LOTEMAX	105
LILETTA	100	LOTENSIN	81, 84
linezolid	35	loteprednol	105
LINZESS	116	LOTREL	81
liothyronine	168	LOTRONEX	116
LIPITOR	89	lovastatin	89
LIPOFEN	90	LOVAZA	111
LIQUID	102	LOVENOX	40, 41
LIRAGLUTIDE	45	loxapine	154
lisdexamphetamine	148	lubiprostone	117
lisinopril	81, 84	LUCEMYRA	176
lisinopril/hydrochlorothiazide	81	LULICONAZOLE	43
lissamine	101	Lumakras	55
LITEAIRE	139	LUMIGAN	107
LITE TOUCH	132, 136, 138, 194	LUMRYZ	154
LITETOUCH	139	LUNESTA	155
LITFULO	25	LUPANETA	125
lithium	143	LUPKYNIS	129
LITHOBID	143	LUPRON	56, 125
LITHOSTAT	111	lurasidone	154
LIVALO	88, 89	LUXIQL	164
Livmarli	116	LUZU	43
LIVTENCYCITY	68	LYNPARZA	58
L-MESITRAN	162	LYRICA	96, 176
l-norgest	99	LYSODREN	59

Index of Medications

LYSTEDA76	MESTINON.....	71
LYTGEBI.....	.58	metaxalone.....	140, 141
LYUMJEV.....	.50	metformin.....	46, 47, 48
LYVISPAH.....	.140	METFORMIN.....	46
M		methadone hcl.....	21
MACROBID35	methamphetamine	72
MACRODANTIN35	methazolamide.....	102
mafeneide.....	.39	methenamine	32
MAGELLAN.....	.130	methimazole.....	167, 168
MALARONE.....	.51	METHITEST.....	120
maprotiline148	methocarbamol.....	140, 141
MARINOL.....	.112	methotrexate	54
MARPLAN.....	.143	methoxsalen	157
MATULANE.....	.59	methscopolamine.....	114
MAVENCLAD92	methyldopa.....	85
MAXICOMFORT136	methylergonovine	125
MAXIDEX105	METHYLIN.....	149
MAXITROL30	methylphenidate	149, 150, 151
MAYZENT92	METHYLPHENIDATE.....	150
meclizine.....	.113	methylprednisolone	124
MECLIZINE.....	.113	methyl salicylate.....	160
meclofenamate sodium.....	.26	methyltestosterone.....	120
MEDIHONEY.....	.162	metoclopramide	116
MEDISENSE132	metolazone	103
MEDLANCE.....	.132	METOPIRONE.....	102
MEDROL124	metoprolol	86
medroxyprogesterone98, 126	METROCREAM.....	161
mefenamic acid19	METROGEL	38, 161
mefloquine.....	.51	metronidazole.....	32, 38, 161, 162
megestrol60, 178	METRONIDAZOLE.....	32, 162
MEKINIST.....	.55, 56, 195	metyrosine	85
MEKTOVI.....	.56	mexiletine	77
meloxicam26	MEZPAROX.....	165
melphalan.....	.54	MIACALCIN.....	127
memantine91	MICARDIS.....	.83, 84
MENACTRA.....	.74	miconazole.....	41
MENEST.....	.122	MICONAZOLE-ZINC OXIDE-PETROLTM43
MENOPUR127	MICROCHAMBER.....	.139
MENOSTAR.....	.122	MICROGESTIN.....	.99
MENQUADFI.....	.74	MICROLET.....	.132
MENVEO74	MICROSPACER.....	.139
meperidine hcl.....	.21	MICRO THIN.....	.132
MEPHYTON179	midazolam155
meprobamate142	midodrine73
MEPRON.....	.52	MIEBO.....	.104
mercaptopurine54	MIFEPREX.....	.172
mesalamine115	mifepristone48, 172, 196
mesna.....	.170	miglitol.....	.46
MESNEX.....	.170	milglustat.....	.173

Index of Medications

millipred.....	124	MULPLETA.....	98
MILLIPRED.....	124	MULTAQ.....	77
MIMYX.....	160	mupirocin.....	39
MINI.....	53, 131, 135, 136, 138	MURI-LUBE.....	175
MINIMED.....	130	MUSE.....	171
MINI PEN.....	136	mvn	178
MINIPRESS.....	.82	MYCAPSSA.....	126
MINITRAN.....	.79	MYCOBUTIN.....	33
MINIVELLE.....	122	mycophenolate.....	128, 129
MINOCIN.....	.37	MYDAYIS.....	72
minocycline.....	.37	MYDRIACYL.....	107
MINOCYCLINE.....	.37	Myfembree.....	125
MINOLIRA.....	.37	MYFORTIC.....	129
minoxidil.....	.85	MYGLUCOHEALTH.....	132
MIPLYFFA.....	.173	MYHIBBIN.....	129
mirabegron.....	174, 177	MYLERAN.....	54
MIRCERA.....	.97	MYORISAN.....	158
MIRENA.....	100	MYRBETRIQ.....	174, 177, 197
mirtazapine.....	142	mysoline.....	96
misoprostol.....	25, 113, 114	MYTESI.....	112
MITIGARE.....	.24	N	
MITOSOL.....	108	nabumetone	26
MIUDELLA.....	100	nadolol	86
M-M-R II.....	.75	naftifine	43
MOBIC.....	.26	NAFTIN	43
MOBILE.....	132	NALFON.....	26
modafinil.....	154, 155	NALOCET.....	20
MODERNA.....	.74	naloxone	22, 41, 176
moexipril.....	.84	NALOXONE.....	41
molindone.....	154	naltrexone	41
MOLNUPIRAVIR.....	.70	NAMENDA.....	91
MOMETACURE.....	165	NAMZARIC.....	91
mometasone.....	104, 165	NAPROSYN.....	25, 26
MONOLET.....	132	naproxen	19, 25, 26
MONSEL's.....	.76	naratriptan hcl	18
montelukast sodium.....	.29	NARCAN.....	41
MONUROL.....	32	NARDIL.....	143
MORPHABOND ER.....	.21	NASCOBAL	178
morphine sulfate.....	.21	NASONEX	104
MOTEGRITY.....	.116	NATACYN	41
MOTOFEN	112	NATAZIA	99
MOTPOLY.....	.96	nateglinide	47
MOVANTIK.....	.41	NATESTO	121
MOVIPREP	117	NATROBA	61
MOXATAG.....	.35	NAYZILAM	94
MOXEZA.....	.30	NEBUPENT	52
moxifloxacin.....	.36	nebusal	173
moxifloxacin hcl.....	.30	NEBUSAL	173
MS CONTIN.....	.21	NEEDLES	135, 136, 137, 138

Index of Medications

nefazodone	145	nizatidine	116
neomycin	29, 30, 31, 156, 197	NOCDURNA	121
neomycin/bacit/p-myx/hydrocort.....	30	NOCTIVA	121
neomycin/polymyxin b/dexametha.....	30	NORCO	20
neomycin/polymyxin b/hydrocort.....	30	NORDITROPIN	124
neomycin/polymyxn b/gramicidin	31	norelgestromin/ethin.estriadiol	99
neomycin sulf/bacitracin/poly	30	noreth.....	99
NEORAL	129	norethind	122
NEO-SYNALAR	38	norethindrone	99, 122, 126
NERLYNX	58	norethin-ee	99
NESINA	46	norethrin-eth estrad	122
neuac	158	NORGESIC	141
NEUAC	158	norgestimate	99
NEULASTA	97	norgestrel	99
NEULUMEX	102	NORITATE	162
NEUPOGEN	97	NORLIQVA	78
NEUPRO	63	NORPACE	77
NEURONTIN	96	NORTHERA	73
NEVANAC	105	nortriptyline	148
nevirapine	66	NORVASC	78
NEXAVAR	58	NORVIR	67
NEXIUM	118	NOURIANZ	63
NEXLETOL	88	NOVA	132
NEXLIZET	88	NOVAREL	127
NEXPLANON	98	NOVAVAX	73
Nextstellis	99	NOVOFINE	136
NGENLA	124	NOVOLOG	50, 130
niacin	90, 91	NOVOPEN	130
NIACOR	90	NOXAFIL	42
NIASPAN	91	NUBEQA	54
nicardipine	78	NUCALA	29
NICOTROL	167	NUCORT	165
nifedipine	77, 78	NUCYNTA	21, 22
NILANDRON	54	NUCYNTA ER	22
nilutamide	54	NUDEXTA	92
nimodipine	78	NUJO	128
NINLARO	58	NULEV	114
nisoldipine	78	NULIBRY	173
nitazoxanide	61	NULYTLY	117
nitisinone	173	NUMOISYN	171
NITRO-DUR	79	NUPLAZID	144
nitrofurantoin	35	NURTEC ODT	18
nitroglycerin	79, 80	NUTROPIN	124
nitroglycerin 0.4% ointment	117	NUVARING	98
NITROLINGUAL	80	NUVESSA	38
NITROMIST	80	NUVIGIL	154, 155
NITROSTAT	80	NUZYRA	37
NITYR	173	NYMALIZE	78
NIVESTYM	97	NYPOZI	98

Index of Medications

nystatin	42, 43	opium/belladonna alkaloids	22
NYVEPRIA.....	98	OPSUMIT	80
O		OPSYNVI.....	81
OBREDON	101	OPTICHAMBER	139
OBSTETRIX.....	141, 178	OPVEE.....	41
OBTREX.....	141	ORACEA.....	37
OCALIVA.....	115	ORACIT	111
octreotide	126	ORALAIR	73
OCUFLOX	31	ORAMAGICRX	171
ODACTRA	73	ORAPRED	124
ODEFSEY.....	68	ORAVIG	42
ODOMZO	55	ORENCIA	24
OFEV	169	ORENITRAM	80
ofloxacin.....	29, 31, 36, 198	ORFADIN	173
OGSIVEO	58	ORGOVYX	57
OHTUVAYRE.....	29	ORIAHNN	125
OJEMDA.....	55	ORILISSA	125
OJJAARA.....	58	ORKAMBI	169
olanzapine	152, 153, 154	ORLADEYO	170
olmesartan.....	82, 83, 84	orphenadrine	141
olmesartan/amlodipin/hctiazid	82	ORTHO	99, 109
olmesartan-hctz	83	oseltamivir	68
olopatadine	45, 103	OSENI	45
OLPRUVA	111	OSMOLEX	62, 63
OLUMIANT	25	OSMOPREP	117
OLUX.....	165	OSPHENA	172
OMECLAMOX	114	OTEZLA	24
omega-3	111	OTOVEL	30
omeppi	118	OTREXUP	24
omeprazole	118, 119	OVACE	159
OMNARIS	104	OVIDREL	127
OMNIPOD	130	oxandrolone	121
OMNIPRED	105	oxaprozin	25, 26
OMNITROPE	124	OXAPROZIN	26
OMVOH	128	OXAYDO	22
ON CALL	132	oxazepam	142
ondansetron	113	oxcarbazepine	96
ONDANSETRON	113	OXERVATE	108
ONETOUCH	132	OXIANUJI	128
ONEXTON	158	oxiconazole	43
ONFI	94	OXISTAT	43
ONGENTYS	62	OXSORALEN	157
ONGLYZA	46	OXTELLAR	96
ON-THE-GO	132	oxybutynin	178
ONUREG	54	OXYCODONE	22
OPDIVO	59	oxycodone hcl	20, 22
OPFOLDA	173	oxycodone hcl/acetaminophen	20
OPIPZA	153	OXYCODONE HCL ER	22
opium	22, 112	oxymorphone hcl	22

Index of Medications

OXYTROL.....	178	PERIDEX.....	170
OZEMPIC.....	45	perindopril.....	84
OZOBAX.....	141	permethrin.....	61
P		perphenazine.....	147, 154
pacerone.....	77	PERTZYE.....	117
PACNEX.....	160	PEXEVA.....	145
PAIN EASE MEDIUM STREAM SPRAY.....	23	PFIZER	74
PALFORZIA.....	73	PHARMABASE.....	161
paliperidone.....	152	PHEBURANE.....	111
PALYNZIQ.....	73	phenazopyridine hcl.....	23
PAMELOR.....	148	phendimetrazine.....	60
PANCREAZE.....	117	phenelzine.....	143
PANDEL.....	165	phenobarb.....	114
PANRETIN.....	60	phenobarbital.....	114, 154
pantoprazole.....	118, 119	PHENOBARBITAL.....	114
PAPAVERINE.....	171	phenoxybenzamine.....	73
PARAGARD.....	100	phentermine.....	60
paregoric.....	112	PHENTOLAMINE.....	171
PAREMYD.....	108	phenylephrine.....	44, 106
paricalcitol.....	172	PHENYTEK.....	96
PARLODEL.....	63	phenytoin.....	94, 96
PARNATE.....	143	PHESGO.....	56
paromomycin.....	51	PHEXXI.....	98
paroxetine	145, 173	PHOSLYRA.....	110
PASER.....	33	PHOSPHOLINE.....	107
PATADAY.....	45	PHYSIOLYTE.....	156
PAXIL.....	145	PHYSISOL.....	156
PAZEO.....	45	phytonadione.....	179
pazopanib hcl.....	56, 58, 59, 199	PICATO	60
PCE	34	PIFELTRO.....	66
PEDIARIX.....	75	pilocarpine.....	73, 106, 107
PEDVAXHIB.....	75	pimecrolimus.....	128
peg3350.....	117	pimozide	151
PEGANONE.....	96	pindolol.....	86
PEGASYS.....	70	pioglitazone	47, 48
PEGINTRON.....	70	PIP	132, 136, 200
PEMAZYRE.....	58	PIQRAY	58
PENBRAYA.....	74	pirfenidone	172
penicillamine	24	piroxicam.....	25, 26
PENNSAID	157	pitavastatin	89
PENTACEL.....	75	PLAQUENIL.....	51
pentamidine	52	PLATINUM.....	101
PENTASA	115	PLAVIX.....	64
pentazocine hcl/naloxone hcl	22	PLEGRIDY	92
PENTIPS.....	135, 136, 137	PLENVU	117
pentoxifylline	77	PLIXDA	167
PEPCID.....	116	PNEUMOVAX	74
PERCOSET.....	20	pnv	141
PERFECT	136	POCKET	139

Index of Medications

PODOCON.....	160	PRIFTIN.....	33
podofilox.....	161	PRILOSEC.....	119
POKONZA.....	110	PRIMAQUINE.....	51
POLIBAR.....	102	PRIMEAIRE.....	139
polydimethylsiloxanes.....	161	primidone.....	96
polymyxin	29, 30, 31, 156	PRIMLEV.....	20
POMALYST.....	.56	PRIMSOL.....	32
Ponvory92	PRINVIL.....	84
posaconazole.....	42	PRISMASOL.....	111
POTABA.....	178	PRISTIQ.....	146
potassium	19, 35, 84, 109, 110, 111, 166	probenecid	26
POTASSIUM.....	103, 110, 111, 119	probenecid/colchicine	26
potassium bicarbonate.....	110	PROCARDIA.....	78
potassium iodide/iodine	110	PROCARE.....	139
PRADAXA.....	.41	PROCHAMBER.....	139
PRALUENT.....	.88	prochlorperazine.....	113
pramipexole.....	.63	PRO COMFORT.....	132, 133, 137, 139, 201
PRAMOSONE.....	165, 166	PROCORT.....	119
prasugrel.....	.64	PROCRIT.....	.97
PRAVACHOL.....	.89	PROCTOFOAM.....	119
pravastatin89	PROCYSB.....	177
praziquantel.....	.51	PRODIGY.....	133
prazosin.....	.82	progesterone.....	126
PR BENZOYL PEROXIDE.....	161	PROGLYCEM.....	109
PRECISIONGLIDE	136	PROGRAF.....	129
PRECOSE.....	.46	PROLENSA.....	105
PRED.....	.105	PROMACTA.....	.98
prednicarbate.....	163, 165	promethazine.....	44, 100, 113
prednisolone.....	30, 105, 124	PROMETRIUM.....	126
prednisone124	PRONAL.....	161
pregabalin.....	.96	propafenone.....	.77
PREGNYL.....	.127	propantheline	112
PREMARIN.....	122, 126	proparacaine	105
PREMPHASE.....	.123	propranolol86
PREMPRO.....	.123	propylthiouracil.....	168
prenatal.....	.141	PROQUAD.....	.75
PRENATAL.....	.141	PROSCAR.....	177
PREPIDIL.....	.125	PROSTIN.....	125
PREPOPIK117	protectives2.....	161
PRESSURE.....	.106, 107, 132	PROTONIX.....	119
PRESTALIA.....	.81	protriptyline	148
PRETOMANID33	PROVERA.....	98, 126
PREVACID118	PROVIGIL.....	154, 155
PREVENT137	PROVOCHOLINE.....	101
PREVIDENT108, 109, 200	PROZAC.....	145
PREVNAR.....	.74	PSORCON.....	165
PREVYMIS68	PULMICORT.....	.28
PREZCOBIX.....	.65	PULMOZYME.....	.169
PREZISTA65	PURE.....	133, 137, 201

Index of Medications

PURE COMFORT.....	133	RAPAFLO.....	177
PURIXAN.....	55	RAPAMUNE.....	129
PUSH BUTTON.....	133	RAPLIXA.....	76
PYLERA.....	114	rasagiline.....	62, 63
pyrazinamide.....	33	RAVICTI.....	111
PYRIDIUM.....	23	RAYA.....	137
pyridostigmine.....	71	RAYALDEE.....	172
PYRIDOSTIGMINE.....	71	RAYASAL.....	161
pyrimethamine.....	51	RAYOS.....	124
Q		RAZADYNE.....	71
QBRELIS.....	84	READI.....	102
QBREXA.....	162	READYLANCE.....	133
QELBREE.....	142	REBIF.....	92
QINLOCK.....	58	RECLAST.....	127
QLOSI.....	107	RECOMBIVAX.....	75
QMIIZ ODT.....	26	RECORLEV.....	120
QNDSL.....	104	RECOTHROM.....	76
QSYMIA.....	60	RECTIV.....	117
QTERN.....	47	REGIMEX.....	60
QUADRACEL.....	75	REGLAN.....	116
QUALAQUIN.....	51	REGRANEX.....	159
QUARTETTE.....	99	RELAGARD.....	50
quazepam.....	155	RELENZA.....	68
QUAZEPAM.....	155	RELEXXII.....	150
QUDEXY.....	96	RELIAMED.....	133
QUESTRAN.....	90	RELION.....	202
quetiapine.....	152, 153	RELISTOR.....	41
QUILLICHEW.....	150	RELTONE.....	115
QUILLIVANT.....	150	RELYVRIOS.....	91
quinapril.....	81, 83, 84	REMERON.....	142
quinapril/hydrochlorothiazide.....	81	REMICADE.....	53
quinidine.....	77	RENACIDIN.....	111
quinine.....	51	RENAGEL.....	110
QUVIVQ.....	156	RENVELA.....	110
QVAR.....	28	repaglinide.....	47, 48
R		REPATHA.....	88
rabeprazole.....	117, 119	REPLACEMENT Pediatric MONITOR.....	130
RABEPRAZOLE.....	119	RESPA.....	100
RADIAGEL.....	174	RESTASIS.....	108
RADIAPLEXRX.....	161	RESTIZAN.....	160
RADICAVA ORS.....	91	RESTORIL.....	155
RADIOGARDASE.....	174	RETACRIT.....	97
RAGWITEK.....	73	RETEVMO.....	58
raloxifene.....	175	RETIN.....	167
ramelteon.....	155	RETROVIR.....	66
ramipril.....	83, 84	REVATIO.....	80
RANEXA.....	77	REVLIMID.....	56
ranitidine.....	116	REVUFORJ.....	58
ranolazine.....	77	REXULTI.....	153

Index of Medications

REYATAZ67	RUZURGI93
REZDIFRA.....	171	RYALTRIS	104, 159
REZLIDHIA59	RYBELSUS	45
REZUROCK.....	176	RYCLORA	44
REZVOGLAR.....	.45	RYDAPT	58
RHOPRESSA.....	107	RYTARY	63
ribaspHERE70	RYTHMOL	77
RIDAURA24	RYVENT	44
rifabutin.....	.33	S	
RIFAMATE33	SABRIL.....	.96
rifampin.....	.33	SAF-CLENS	162
RIFATER.....	.33	SAFETY.....	130, 131, 132, 133, 134, 135, 136, 137, 202
RIGHTTEST	133	SAFYRAL99
RILUTEK91	SAIZEN	124, 125
riluzole.....	.91	SALAGEN73
rimantadine68	SALICATE161
RIMI43	salicylic.....	.160, 161
RIMSO-50.....	.23	SALIMEZ161
ringer's.....	156	SALKERA161
RINVOQ25	salsalate24
RIOMET46	SALVAX161
risedronate	175	SAMSCA102
RISPERDAL152	SANCUSO113
risperidone152	SANDIMMUNE129
RITALIN151	SANDOSTATIN126
RITEFLO139	SANTYL166
ritonavir67	SAPHRIS152
rivaroxaban39	sapropterin174
rivastigmine71	SARAFEM145
RIVFLOZA174	SAVAYSA39, 40
rizatriptan benzoate.....	.19	SAVELLA176
ROBAXIN141	SAXENDA61
ROBINUL112	SCALACORT165
ROCALTROL179	SCEMBLIK58, 203
ROCKLATAN107	scopolamine113
ropinirole63	SEASONIQUE99
ROSANIL39	secobarbital154
rosuvastatin.....	.88, 89	SECUADO152
Roszet87	SECURESAFE137
ROTARIX74	SEGLUROMET48
ROTATEQ74	selegiline63
ROWASA115	selenium159
ROXYBOND22	SELZENTRY65, 66
ROZEREM155	SEMGLEE50
ROZLYTREK58	SEN-SERTER130
RUBRACA58	SENSIPAR171
RUCONEST170	SEREVENT DISKUS28
rufinamide94, 96	SERNIVO165
RUKOBIA66	SEROQUEL152, 153

Index of Medications

SEROSTIM.....	125	SOFOSBUVIR	69
sertraline.....	145	SOGROYA.....	125
sevelamer.....	110	SOHONOS.....	174
sevoflurane.....	23	solifenacin.....	177
SEYSARA.....	37	SOLIQUA.....	45
SFROWASA.....	115	SOLIDYN.....	37
SHINGRIX.....	75	SOLESEC.....	31
SIGNIFOR.....	126	SOLOXIDE	37
SIKLOS.....	76	SOLTAMOX.....	60
sildenafil.....	80, 171	SOLUS.....	133
SILENOR.....	156	SOMA	141
SILICONE.....	139	SOMATULINE.....	126
SILIQ.....	157	SOMAVERT.....	172
silodosin.....	177	SOOLANTRA.....	162
SILVADENE.....	39	SORBITOL.....	156
silver.....	39, 161, 166	SORIATANE.....	157
SIMLANDI.....	53	SORILUX.....	159
SIMPONI.....	53	sotalol.....	85, 86
simvastatin.....	87, 89	SOTYKTU.....	157
SIMVASTATIN.....	89	SOTYLIZE.....	86
SINEMET.....	63	SOVALDI.....	69
SINGLE-LET.....	133	SPACE CHAMBER.....	139
SINGULAIR.....	29	SPECTRACEF.....	33
sirolimus.....	129	SPEVIGO.....	157
SIRTURO	33	SPIKEVAX.....	74
SITAGLIPTIN.....	46, 48	spinosad.....	61
SITAVIG.....	68	SPIRIVA RESPIMAT	27
SITZMARKS	102	spironolact.....	103
SIVEXTRO	35	spironolactone	103
SKELAXIN	141	SPORANOX.....	42
SKLICE	61	SPRAVATO.....	142
SKY	137	SPRITAM.....	96
SKYCLARYS.....	174	SPRYCEL.....	58
SKYLA.....	100	sps	110
SKYRIZI.....	157	SSKI	110
SKYTROFA	125	STALEVO.....	63
SLYND.....	99	STARLIX.....	47
SMARTEST.....	133	stavudine.....	66
SMART SENSE	133	STEGLATRO.....	46
sodium chloride.....	117	STEGLUJAN.....	47
SODIUM CHLORIDE.....	156	STELARA.....	128
sodium chloride for inhalation.....	173	STENDRA.....	171
sodium chloride irrig	156	STERILANCE.....	133
SODIUM CITRATE.....	39	STERILE.....	133
sodium fluoride.....	108, 109	STIMATE.....	121
sodium phenylbutyrate.....	111	STIMUFEND.....	98
sodium polystyrene	110	STIOLTO RESPIMAT	28
sod, pot chlor/mag/sod, pot phos	156	STIVARGA.....	58
SOFDRA.....	162	STRATTERA.....	151

Index of Medications

STRENSIQ	173	TABLOID.....	55
STRIBILD.....	.68	TABRECTA.....	58
STRIVERDI.....	.28	TACLONEX.....	166
STROMECTOL51	tacrolimus.....	128, 129
SUBOXONE176	tadalafil.....	80, 170, 171, 204
SUCRAID.....	.116	TADLIQ.....	80
sucralfate.....	.113, 114	TAFINLAR	55
SUFLAVE.....	.117	TAGITOL.....	102
SULAR78	TAGRISSO	58
SULCONAZOLE.....	.43	TAKHZYRO	73
sulfacetamide30, 39, 158, 159	TALICIA.....	114
sulfact sod/sulur/avob/otn/oct.....	.39	TALTZ.....	157
sulfadiazine.....	.31, 39	TALZENNA	58
sulfamethoxazole(trimethoprim.....	.31	TAMIFLU	68
SULFAMYLYON.....	.39	tamoxifen.....	60
sulfasalazine.....	.115	tamsulosin	177
sulindac.....	.26	TAPAZOLE.....	168
sumatriptan19	TAPERDEX.....	124
SUNLENCA64	TARCEVA	58
SUNOSI.....	.154, 155	TARGADOX	37
SUPER THIN.....	.132, 133	TARGRETIN	54, 60
SUPRANE.....	.23	TARKA.....	81
SUPRAX.....	.33, 34	TARPEYO	124
SUPREP.....	.117	TASCENO	93
SURE.....	.133, 137, 138, 204	TASIGNA	58
SURE-TOUCH133	TASMAR	63
SURGIFOAM76	tavaborole	43
SURGISEAL.....	.162	TAVALISSE	169
SURVANTA.....	.169	TAVNEOS	76
SUTAB.....	.117	TAYTULLA.....	99
SUTENT.....	.58	tazarotene	159
SYMAX114	TAZAROTENE	167
SYMBICORT28	TAZORAC	159
SYMBYAX154	TAZVERIK	56
SYMDEKO169	TC99M	101
SYMFY68	TDVAX.....	75
SYMJEPI71	TECFIDERA	93
SYMLINPEN.....	.46	TECHLITE133, 137, 205
SYMPAZAN.....	.94	TEGRETOL96
SYMPROIC.....	.41	TEGSEDI172
SYMTUZA65	TEKTURNA87
SYNALAR.....	.38, 165	TEL CARE133
SYNAREL125	telmisartan.....	.83, 84, 85
SYNDROS.....	.112	telmisartan-hctz.....	.83
SYNERA.....	.23	temazepam155
SYNJARDY.....	.48	TEMIXYS65
SYNTROID168	TEMOVATE165
SYPRINE174	TENIVAC75
T		tenofovir.....	.65, 66, 67

Index of Medications

TENORETIC86	tizanidine	141
TENORMIN.....	.86	TLANDO.....	120
TEPMETKO.....	.58	TOBI	31
terazosin.....	.82	TOBRADEX	30
terbinafine.....	.42	TOBRADEX EYE DROPS.....	30
terconazole.....	.41	tobramycin.....	30, 31, 32
teriflunomide.....	.92, 93	TOBRAMYCIN	32
teriparatide.....	.171	tobramycin/dexamethasone.....	30
TERIPARATIDE.....	.171	TOBREX.....	31
TERS1.....	.159	TOLAK.....	60
TESSALON.....	.100	tolbutamide	47
TESTIM121	tolcapone63, 64
testosterone120, 121, 122	TOLECTIN 600.....	.19
TESTOSTERONE120, 121	tolmetin sodium26
tetrabenazine.....	.92	TOLSURA42
tetracaine105	tolterodine.....	.178
tetracycline.....	.37	tolvaptan102
TETRAVISC.....	.105, 106	TOLVAPTAN.....	.102
TEXACORT.....	.165	TOPAMAX96
TEZSPIRE175	TOPCARE133, 137, 205
THALITONE.....	.103	TOPICORT165
THALOMID.....	.32	topiramate96
THEO-24.....	.29	TOPIRAMATE96
theophylline.....	.29	TOPROL.....	.86
THIN.....	.102, 131, 132, 133, 134	toremifene.....	.60
THIOLA177	torsemide102
thioridazine.....	.154	TOUJOE.....	.50
thiothixene.....	.154	TOVIAZ.....	.178
THROMBI.....	.76	TRACLEER.....	.80
THROMBIN76	TRADJENTA46
THYQUIDITY168	TRAMADOL22
thyroid.....	.168	tramadol er22
THYROID.....	.168	tramadol hcl.....	.20, 22
THYROLAR.....	.168	TRAMADOL HCL.....	.22
tiagabine.....	.95, 96	tramadol hcl/acetaminophen20
TIAZAC.....	.78	trandolapril81, 84
TIBSOVO59	tranexamic76
ticagrelor.....	.64	TRANSDERM113
ticlopidine64	TRANXENE142
TIGLUTIK.....	.91	tranylcypromine143
TIKOSYN77	TRAVATAN107
timolol.....	.86, 106, 107	travoprost107
TIMOPTIC.....	.107	trazodone146
TINDAMAX50	TRECATOR33
tinidazole50, 51	TRELEGY ELLIPTA28
tiopronin177	TREMFYA128, 157
TIROSINT168	TRESIBA50
TISSEEL.....	.162	TRETIN167
TIVICAY.....	.67	tretinoin.....	.59, 158, 166, 167

Index of Medications

TREXALL.....	.55	TYBLUME.....	.99
TREZIX.....	.21	TYBOST.....	.169
triamcinolone.....	.164, 165, 170	TYENNE.....	.128
triamterene.....	.103	TYKERB.....	.59
triazolam.....	.155	TYMLOS.....	.127
TRIBENZOR.....	.82	TYRVAYA.....	.174
trichloroacetic.....	.162	TYVASO.....	.80, 81
TRICHLOROACETIC.....	.162	U	
TRICOR.....	.91	UBRELVY.....	.19
TRIDESILON.....	.165	UCERIS.....	.120, 124
trientine.....	.174	UDENYCA.....	.98
trifluoperazine.....	.154	UKONIQ.....	.59
trifluridine.....	.68	ULESFIA.....	.62
TRIGLIDE.....	.91	ULORIC.....	.24, 25
trihexyphenidyl.....	.62	ULTANE.....	.23
TRIJARDY.....	.48	ULTICARE.....	.137
TRIKAFTA.....	.169	ULTIGUARD.....	.137
TRILEPTAL.....	.96	ULTILET.....	.134, 137, 206
TRILIPIX.....	.91	ULTRA.....	.27, 28, 131, 132, 133, 134, 136, 137, 138, 157, 206
trimethobenzamide.....	.113	ULTRACARE.....	.137
trimethoprim.....	.31, 32	ULTRACET.....	.20
trimipramine.....	.148	ULTRAFOAM.....	.76
TRIMO-SAN.....	.50	ULTRALANCE.....	.134
TRINTELLIX.....	.147	ULTRAM.....	.22
TRIUMEQ.....	.65	ULTRATLC.....	.134
TROKENDI.....	.97	UNDECATREX.....	.120
tropicamide.....	.107, 108	UNIFINE.....	.135, 136, 137, 138
TROPICAMIDE.....	.108	UNILET.....	.130, 132, 134
trospium.....	.178	UNISTIK.....	.131, 134, 135
TRUDHESA.....	.19	UNIVERSAL.....	.131, 135
TRUE.....	.133, 137, 206	UPNEEQ.....	.106
TRUE COMFORT.....	.133, 137, 138	UPTRAVI.....	.81
true folic acid.....	.178	URAMAXIN.....	.161
TRUEPLUS.....	.134, 137, 206	urea39, 42, 52, 161
TRULANCE.....	.116	UROCIT.....	.111
TRULICITY.....	.45	UROQID.....	.111
TRUMENBA.....	.74	UROXATRAL.....	.177
TRUQAP.....	.58	URSO115
TRUSOPT.....	.107	ursodiol114, 115
TRUVADA.....	.65	UTA.....	.32
TRYNGOLZA.....	.88	V	
TUKYSA.....	.58	VAFSEO.....	.120
TURALIO.....	.58, 59	VAGIFEM.....	.126
TUSSICAPS.....	.100	valacyclovir69
TUXARIN.....	.100	VALCHLOR.....	.60
TUZISTRA.....	.100	VALCYTE.....	.69
TWINRIX.....	.75	valganciclovir69
TWIRLA.....	.99	VALIUM142
TWIST.....	.131, 133, 134, 162	valproic.....	.97

Index of Medications

valsartan82, 83, 84, 85	VIIIBRYD	147
valsartan/hydrochlorothiazide83	VIJOICE	169
VALTOCO94	VIMPAT97
VALTREX69	VIOKACE	117
VANCOCIN38	VIRACEPT67
vancomycin38	VIRAMUNE66
VANFLYTA59	VIREAD66, 67
VANOS165	VISTARIL44
vardenafil171	VISTOGARD170
varenicline167	VITAFOL141
VARIBAR102	vite ac/grape/hyaluronic acid160
VARIVAX75	VITRAKVI59
VARUBI113	VIVAGUARD135, 207
VASCEPA111	VIVELLE123
VASERETIC81	VIVJOA42
VASHE156	VIZIMPRO59
VASOTEC84	VOGELXO121
VAXELIS75	VOLTAREN157
VECAMYL85	VOQUEZNA114, 119
VECTICAL159	VOQUEZNA DUAL PAK114
VELPHORO110	VOQUEZNA TRIPLE PAK114
VELSIPITY93	voriconazole42
VELTASSA110	VORTEX140
VELTIN158	VOSEVI69
VEMLIDY69	VOTRIENT59
VENCLEXTA59	VOWST115
venlafaxine146, 147	VOXZOGO174
VENTAVIS81	VOYDEYA76
verapamil77, 79, 81	VRAYLAR153
VERDESO165	VUITY107
VEREGEN70	VUMERTY93
VERELAN79	VUSION43
VERIFINE135, 138, 207	VYALEV64
VERKAZIA108	VYKAT60
VERQUVO79	VYLEESI151
VERSACLOZ153	VYNDAMAX174
VERZENIO59	VYndaQEL174
VESICARE177, 178	VYTORIN87
VEVYE108	VYVANSE148
VFEND42	VYVGART174
V-GO130	VYZULTA107
VIAGRA171	W	
VIBERZI116	WAINUA172
VIBRAMYCIN38	WAKIX97
VICTOZA45	warfarin39
VIDEX66	water for irrigation156
vigabatrin96, 97	Wegovy61
VIGAFYDE97	WELCHOL90
VIGAMOX31	WELLBUTRIN143, 144

Index of Medications

WIDE SEAL DIAPHRAGM	100	YONSA	54
WINLEVI	52	YOSPRAILA	64
WINREVAIR	80	YUFLYMA	53
WYNZORA	166	YUSIMRY	53
X		Z	
XADAGO	64	zafirlukast	29
XALATAN	107	zaleplon	156
XALKORI	59	ZANAFLEX	141
XANAX	142	ZARONTIN	97
XARELTO	40	ZARXIO	98
XATMEP	55	ZAVESCA	173
XCLAIR	160	ZAVZPRET	19
XCOPRI	97, 208	ZCORT	124
XDEMVY	61	Zegalogue	109
XELJANZ	25	ZEGERID	119
XELODA	55	ZEJULA	59
XELPROS	107	ZELAPAR	64
XELSTRYM	72	ZELBORAF	55
XENAZINE	92	ZELNORM	116
XENICAL	61	ZEMPLAR	172
XENLETA	35	ZENATANE	158
XEPI	39	ZENPEP	117
XERESE	70	ZENZEDI	72
XERMELO	112	ZEPATIER	70
XHANCE	104	ZEPBOUND	61
XIFAXAN	36	ZEPOSIA	93
XIGDUO	48	ZERVIA TE	45
XiIDRA	108	ZESTORETIC	81
XIMINO	38	ZESTRIL	84
XOFLUZA	69	ZETIA	91
XOLAIR	29	ZETONNA	104
XOLEGEL	44	ZIAC	86
XOPENEX	27	ZIAGEN	66
XOSPATA	59	ZIANA	158
XPHOZAH	110	zidovudine	65, 66
XPOVIO	59	ZIEXTENZO	98
XTAMPZA ER	22	ZILBRYSQ	172
XTANDI	54	zileuton	27
XULTOPHY	45	ZILXI	39
XUREA	161	ZIMHI	41
XURIDEN	109	zinc	161
XYOSTED	121	ZIOPTAN	107
XYREM	154	ziprasidone	152, 153
XYWAV	154	ZIRGAN	68
Y		ZITHROMAX	34, 35
YASMIN	99	ZITUVIO	46
YAZ	99	ZOCOR	89
YERVOY	59	ZOFTRAN	113

ZOHYDRO ER	22
ZOKINVY.....	169
ZOLADEX.....	56
ZOLINZA.....	54
zolmitriptan	19
ZOLOFT	145
zolpidem.....	155, 156
ZOLPIMIST.....	156
ZOMACTON.....	125
ZOMIG	19
ZONACORT.....	124
ZONALON.....	159
ZONEGRAN.....	97
ZONISADE.....	97
zonisamide.....	97
ZONTIVITY	64
ZORTRESS.....	129
ZORYVE	159
ZOSTAVAX.....	75
ZOVIRAX.....	69, 70
ZTLIDO.....	23
ZUBSOLV.....	176
ZURZUVAE.....	142, 143
ZYCLARA	160
ZYDELIG.....	59
ZYKADIA.....	59
ZYLET.....	30
ZYLOPRIM	25
ZYMAXID	31
ZYPITAMAG.....	89
ZYPREXA	153
ZYTIGA	54
ZYVOX35

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>



Cigna Healthcare products and services are provided exclusively by or through operating subsidiaries of The Cigna Group, including Cigna Health and Life Insurance Company, Connecticut General Life Insurance Company, Evernorth Behavioral Health, Inc., Evernorth Care Solutions, Inc. and HMO or service company subsidiaries of Cigna Health Corporation, including Cigna HealthCare of Arizona, Inc., Cigna HealthCare of California, Inc., Cigna HealthCare of Colorado, Inc., Cigna HealthCare of Connecticut, Inc., Cigna HealthCare of Florida, Inc., Cigna HealthCare of Georgia, Inc., Cigna HealthCare of Illinois, Inc., Cigna HealthCare of Indiana, Inc., Cigna HealthCare of St. Louis, Inc., Cigna HealthCare of North Carolina, Inc., Cigna HealthCare of New Jersey, Inc., Cigna HealthCare of South Carolina, Inc., Cigna HealthCare of Tennessee, Inc., and Cigna HealthCare of Texas, Inc. ATTENTION: If you speak languages other than English, 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). ATENCION: Si usted habla un idioma que no sea inglés, tiene a su disposición servicios gratuitos de asistencia lingüística. 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).

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).