



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 This drug list is subject to change and all prior versions are no longer in effect.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

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View your drug list online

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

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

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Information about this drug list

Frequently asked questions (FAQs)

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

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

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

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

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

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

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

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

Cigna Healthcare to consider approving it through the coverage review process. For example, your plan doesn't cover, or "excludes:"

- Prescription medications used to treat heartburn/stomach acid conditions (such as Nexium, Prilosec OTC and any generics) and allergies (such as Allegra, Clarinex, Xyzal and any generics). These are available over-the-counter without a prescription.
- Medications used to treat lifestyle conditions such as infertility, erectile dysfunction and smoking cessation.²
- 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

Information about this drug list

Frequently asked questions (FAQs) (cont.)

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

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

Information about this drug list

Frequently asked questions (FAQs) (cont.)

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 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.

Information about this drug list

Frequently asked questions (FAQs) (cont.)

decision. If approved, coverage will be provided for the duration of the exigency. If Cigna Healthcare doesn't respond to a completed prior authorization exception request within 72 hours of receiving a non-urgent request and 24 hours of receiving a request based on exigent circumstances, the request will be considered approved and your plan can't deny coverage of the medication.

Your Step Therapy rights under California State law:

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

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

A. When your pharmacist tries to fill your prescription, he or she will see that the medication needs preapproval from Cigna Healthcare. Because you didn't get approval ahead of time, your plan won't cover the cost of your medication. You should ask your doctor to contact Cigna Healthcare to start the coverage review process. Or, you can choose to

pay the medication's full cost out-of-pocket directly to the pharmacy (the cost can't be applied to your annual deductible or out-of-pocket maximum).

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

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

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

A. Yes.

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

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

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

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

Information about this drug list

Frequently asked questions (FAQs) (cont.)

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

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

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

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

A. When you and your doctor are considering the right medication for your treatment, knowing how much it costs, what lower-cost alternatives are available and which pharmacies offer the best prices can help you avoid surprises. Log in to the **myCigna App** or **myCigna.com** and use the Price a Medication tool to see how much your medication costs before you get to the pharmacy counter – or, even before you leave your doctor's office.³

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.⁴ 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.

Information about this drug list

Frequently asked questions (FAQs) (cont.)

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.⁵ Log in to the [myCigna App](#) or [myCigna.com](#), or check your plan materials, to find out what your plan requires.

Q. Can I fill my prescriptions by mail?

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

Express Scripts® Pharmacy for maintenance medications

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

- Easily order, manage, track and pay for your medications on your phone or online
- Standard shipping at no extra cost⁶
- Automatic refills or refill reminders
- Fill up to a 90-day supply at one time⁷
- 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).⁸ 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

Information about this drug list

Frequently asked questions (FAQs) (cont.)

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

Q. How do I fill my prescription?

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

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

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

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

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

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

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

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

A. Covered medications are divided into tiers (or

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

1. **Check your Cigna Healthcare ID card.** It lists your cost-share for Tier 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

Information about this drug list

Frequently asked questions (FAQs) (cont.)

first. After that, these medications will be covered at 100%, or no cost-share (\$0) to you. This is because of a federal HSA requirement.

- **For plans with a combined deductible [including Health Reimbursements Accounts (HRAs) with a combined deductible]:** You'll pay your plan deductible first. After that, these medications will be covered at 100%, or no cost-share (\$0) to you.
- **For plans with a split deductible [including Health Reimbursements Accounts (HRAs) with a split deductible]:** These medications will be covered at 100%, or no cost-share (\$0) to you.

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

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

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

- **Generic preventive care medications:** Covered at 100%, or no cost-share (\$0) to you before you meet your deductible. You'll pay your deductible and applicable cost-share to fill a preferred brand and/or non-preferred brand preventive care medication.
- **Diabetic supplies:** Covered at their applicable cost-share.
- **Growth Hormones:** Need approval from Cigna Healthcare before your plan will cover them (prior authorization). If 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

Information about this drug list

Words you may need to know (cont.)

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

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

Information about this drug list

About this drug list

This is a list of the most commonly prescribed medications covered on the Cigna Healthcare Value 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.

Prescription medications used to treat allergies (ex. Allegra, Clarinex, Xyzal and generics) and heartburn/stomach acid conditions (ex. Nexium, Prilosec and generics) aren't covered on this drug list. These medications are considered plan (or benefit) exclusions. You can buy these medications at the pharmacy without a prescription.

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 Value 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 (Infections)	46
Analgesics (Urinary Tract Conditions)	22	Anti-Infectives/Miscellaneous (Miscellaneous)	47
Anesthetics (Miscellaneous)	23	Anti-Infectives/Miscellaneous (Skin Conditions)	47
Anesthetics (Pain Relief and Inflammatory Disease)	23	Anti-Inflammatory Tumor Necrosis Factor Inhibiting Agents (Pain Relief and Inflammatory Disease)	47, 48
Anesthetics (Urinary Tract Conditions)	23	Anti-Neoplastics (Cancer)	48-55
Anti-Allergy (Allergy and Nasal Sprays)	23	Anti-Neoplastics (Skin Conditions)	55
Anti-Arthritis (Pain Relief and Inflammatory Disease)	24-27	Anti-Obesity Drugs (Weight Management)	56
Anti-Asthmatics (Asthma/COPD/Respiratory)	27-29	Anti-Parasitics (Eye Conditions)	56
Antibiotics (Allergy/Nasal Sprays)	29	Anti-Parasitics (Infections)	57
Antibiotics (Ear Medications)	29, 30	Anti-Parkinson's Drugs (Parkinson's Disease)	57-59
Antibiotics (Eye Conditions)	30, 31	Anti-Platelet Drugs (Blood Thinners/Anti-Clotting)	59
Antibiotics (Infections)	31-36	Antivirals (AIDS/HIV)	59-62
Antibiotics (Skin Conditions)	36, 37	Antivirals (Eye Conditions)	62
Anti-Coagulants (Blood Thinners/Anti-Clotting)	37-39	Antivirals (Infections)	62-64
Antidotes (Gastrointestinal/Heartburn)	39	Antivirals (Skin Conditions)	64
Antidotes (Substance Abuse)	39	Autonomic Drugs (Allergy/Nasal Sprays)	64
Anti-Fungals (Eye Conditions)	39	Autonomic Drugs (Alzheimer's Disease)	64
Anti-Fungals (Feminine Products)	39	Autonomic Drugs (Attention Deficit Hyperactivity Disorder)	65
Anti-Fungals (Infections)	40	Autonomic Drugs (Blood Pressure/Heart Medications)	65
Anti-Fungals (Skin Conditions)	40, 41	Autonomic Drugs (Urinary Tract Conditions)	65
Antihistamine and Decongestant Combination (Allergy/Nasal Sprays)	41	Biologicals (Allergy/Nasal Sprays)	65, 66
Antihistamines (Allergy/Nasal Sprays)	41	Biologicals (Blood Pressure/Heart Medications)	66
Antihistamines (Eye Conditions)	41, 42	Biologicals (Miscellaneous)	66
Anti-Hyperglycemics (Diabetes)	42-45	Biologicals (Vaccines)	66-68
Anti-Infectives (Feminine Products)	45	Blood (Blood Modifiers/Bleeding Disorders)	68, 69
Anti-Infectives (Infections)	45	Blood (Blood Thinners/Anti-Clotting)	70
Anti-Infectives/Miscellaneous (Feminine Products)	45	Cardiac Drugs (Blood Pressure/Heart Medications)	70-72

Information about this drug list

How to find your medication (cont.)

Condition	Page	Condition	Page
Cardiovascular (Asthma/COPD/Respiratory)	72, 73	Hormones (Hormonal Agents)	I04-I09
Cardiovascular (Blood Pressure/Heart Medications)	73-77	Hormones (Infertility)	I09, I10
Cardiovascular (Cholesterol Medications)	77-80	Hormones (Miscellaneous)	I10
CNS Drugs (Alzheimer's Disease)	80	Hormones (Osteoporosis Products)	I10
CNS Drugs (Miscellaneous)	80, 81	Immunosuppressants (Pain Relief and Inflammatory Disease)	I10, I11
CNS Drugs (Multiple Sclerosis)	81, 82	Immunosuppressants (Skin Conditions)	I11
CNS Drugs (Pain Relief and Inflammatory Disease)	82	Immunosuppressants (Transplant Medications)	I11, I12
CNS Drugs (Seizure Disorders)	82-85	Miscellaneous Medical Supplies, Devices, Non-Drug (Diabetes)	I12-I20
CNS Drugs (Sleep Disorders/Sedatives)	85	Miscellaneous Medical Supplies, Devices, Non-Drug (Miscellaneous)	I20, I21
Colony Stimulating Factors (Blood Modifiers/Bleeding Disorders)	85	Muscle Relaxants (Pain Relief and Inflammatory Disease)	I22
Colony Stimulating Factors (Cancer)	86	Prenatal Vitamins (Nutritional/Dietary)	I22, I23
Contraceptives (Contraception Products)	86, 87	Psychotherapeutic Drugs (Anxiety/Depression/Bipolar Disorder)	I23-I27
Cough/Cold Preparations (Allergy/Nasal Sprays)	88	Psychotherapeutic Drugs (Attention Deficit Hyperactivity Disorder)	I27-I29
Cough/Cold Preparations (Cough/Cold Medications)	88	Psychotherapeutic Drugs (Miscellaneous)	I29
Diagnostic (Miscellaneous)	88, 89	Psychotherapeutic Drugs (Schizophrenia/Anti-Psychotics)	I29-I31
Diuretics (Diuretics)	90, 91	Psychotherapeutic Drugs (Sleep Disorders/Sedatives)	I31
EENT Preps (Allergy/Nasal Sprays)	91	Sedative/Hypnotics (Sleep Disorders/Sedatives)	I31, I32
EENT Preps (Ear Medications)	91	Skin Preps (Miscellaneous)	I32, I33
EENT Preps (Eye Conditions)	91-94	Skin Preps (Pain Relief and Inflammatory Disease)	I33-I34
Elect/Caloric/H2O (Cholesterol Medications)	95	Skin Preps (Skin Conditions)	I34-I41
Elect/Caloric/H2O (Dental Products)	95	Smoking Deterrents (Smoking Cessation)	I41
Elect/Caloric/H2O (Diabetes)	95, 96	Thyroid Prep (Hormonal Agents)	I41, I42
Elect/Caloric/H2O (Miscellaneous)	96	Unclassified Drug Products (AIDS/HIV)	I42
Elect/Caloric/H2O (Nutritional/Dietary)	96, 97	Unclassified Drug Products (Asthma/COPD/Respiratory)	I42, I43
Elect/Caloric/H2O (Urinary Tract Conditions)	98	Unclassified Drug Products (Blood Modifiers/Bleeding Disorders)	I43
Gastrointestinal (Cholesterol Medications)	98	Unclassified Drug Products (Blood Pressure/Heart Medications)	I43
Gastrointestinal (Gastrointestinal/Heartburn)	98-103		
Gastrointestinal (Pain Relief and Inflammatory Disease)	103		

Information about this drug list

How to find your medication (cont.)

Condition	Page	Condition	Page
Unclassified Drug Products (Cancer)	I44	Unclassified Drug Products (Pain Relief and Inflammatory Disease)	I49
Unclassified Drug Products (Dental Products)	I44	Unclassified Drug Products (Skin Conditions)	I49
Unclassified Drug Products (Erectile Dysfunction)	I44	Unclassified Drug Products (Substance Abuse)	I49
Unclassified Drug Products (Gastrointestinal/Heartburn)	I45	Unclassified Drug Products (Transplant Medications)	I49
Unclassified Drug Products (Hormonal Agents)	I45	Unclassified Drug Products (Urinary Tract Conditions)	I49, I50
Unclassified Drug Products (Miscellaneous)	I45-I48	Unclassified Drug Products (Weight Management)	I51
Unclassified Drug Products (Nutritional/Dietary)	I48	Vitamins (Nutritional/Dietary)	I51
Unclassified Drug Products (Osteoporosis Products)	I48		

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		
<i>butalbital/acetaminophen</i>	T1	
ANALGESIC, SALICYLATE, BARBITURATE, XANTHINE COMB.		
<i>butalb-aspirin-caff 50-325-40</i>	T1	QL (6 tabs/day)
<i>butalbital-asa-caffeine cap (Fiorinal)</i>	T1	QL (6 caps/day)
<i>FIORINAL (butalbital-aspirin-caffeine)</i>	T3	QL (6 caps/day)
ANALGESIC, NON-SALICYLATE, BARBITURATE, XANTHINE COMB.		
<i>butalb/acetaminophen/caffeine</i>	T3	
<i>butalb-acetamin-caff 50-300-40 (Fioricet)</i>	T1	QL (6 caps/day)
<i>butalb-acetamin-caff 50-325-40</i>	T1	QL (6 tabs/day)
<i>ESGIC 50-325-40 MG TABLET (butalbital-acetaminophen-caff)</i>	T3	QL (6 tabs/day)
<i>ESGIC CAPSULE (zebutal)</i>	T3	QL (6 caps/day)
ANALGESIC/ANTIPYRETICS, SALICYLATES		
<i>choline salicyl/mag salicylate</i>	T1	HD
<i>diflunisal</i>	T1	HD
ANTI-MIGRAINE PREPARATIONS		
<i>AIMOVIG AUTOINJECTOR</i>	T2	PA
<i>AJOVY AUTOINJECTOR</i>	T2	PA
<i>AJOVY SYRINGE</i>	T2	PA
<i>almotriptan malate</i>	T1	QL (12 tabs/30 days)
<i>CAFERGOT (ergotamine-caffeine)</i>	T3	QL (40 tabs/28 days)
<i>dihydroergotamine 1 mg/ml amp</i>	T1	QL (10 amps/30 days)
<i>eletriptan hydrobromide</i>	T1	QL (6 tabs/30 days)
<i>EMGALITY PEN</i>	T2	PA
<i>EMGALITY SYRINGE</i>	T2	PA
<i>ergotamine tartrate/caffeine</i>	T1	
<i>ergotamine tartrate/caffeine (Cafergot)</i>	T1	QL (40 tabs/28 days)
<i>frovatriptan succinate</i>	T1	QL (18 tabs/30 days)
<i>isomethept/dichlphn/acetaminop</i>	T1	
<i>isomethepten/caf/acetaminophen</i>	T1	
<i>naratriptan hcl</i>	T1	QL (9 tabs/30 days)
<i>NURTEC ODT</i>	T2	PA QL (16 tabs/30 days)
<i>rizatriptan 10 mg odt (Maxalt Mlt)</i>	T1	QL(12 tabs/30 days)
<i>rizatriptan 10 mg tablet (Maxalt)</i>	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 5 mg odt	T1	QL(12 tabs/30 days)
rizatriptan 5 mg tablet	T1	QL(12 tabs/30 days)
rizatriptan benzoate	T1	QL (12 tabs/30 days)
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 (9 tabs/30 days)
sumatriptan succ 25 mg tablet	T1	QL (9 tabs/30 days)
sumatriptan succ 50 mg tablet	T1	QL (9 tabs/30 days)
sumatriptan succ/naproxen sod	T1	QL (18 tabs/30 days)
UBRELVY	T2	PA QL (0.67 tabs/day)
ZAVZPRET	T2	PA QL(6 units/30 days)
zolmitriptan	T1	QL (12 tabs/30 days)
NSAIDS, CYCLOOXYGENASE INHIBITOR-TYPE ANALGESICS		
diclofenac potassium	T1	HD
ketorolac 10 mg tablet	T1	QL (20 tabs/25 days)
ketorolac 15 mg/ml syringe	T1	QL (40 ml/30 days)
ketorolac 15 mg/ml vial	T1	QL (40mg/30 days)
ketorolac 30 mg/ml carpuject	T1	
ketorolac 30 mg/ml isecure syr	T1	QL (20ml/30 days)
ketorolac 30 mg/ml syringe	T1	QL (20ml/30 days)
ketorolac 30 mg/ml vial	T1	QL(4 mls/day)
ketorolac 300 mg/10 ml vial	T1	
ketorolac 60 mg/2 ml carpuject	T1	QL (20ml/30 days)
ketorolac 60 mg/2 ml syringe	T1	QL (20ml/30 days)
ketorolac 60 mg/2 ml vial	T1	QL (20ml/30 days)
mefenamic acid	T1	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
OPIOID ANALGESIC AND NON-SALICYLATE ANALGESICS		
acetamin-codein 300-30 mg/12.5	T1	
acetaminop-codeine 120-12 mg/5	T1	
acetaminophen-cod #2 tablet	T1	PA
acetaminophen-cod #3 tablet	T1	PA
acetaminophen-cod #4 tablet	T1	PA
APADAZ	T3	
BENZHYDROCODONE-ACETAMINOPHEN	T1	
hydrocodone/acetaminophen	T1	PA
hydrocodone/acetaminophen (Hydrocodone-acetaminophen)	T1	PA
hydrocodone/acetaminophen (Norco)	T1	PA
HYDROCODONE-ACETAMINOPHEN	T1	PA
LORTAB	T1	PA
NALOCET	T1	PA
NORCO (lorcet hd)	T3	PA
NORCO (lorcet plus)	T3	PA
NORCO (lorcet)	T3	PA
oxycodone hcl/acetaminophen (Nalocet)	T1	PA
oxycodone hcl/acetaminophen (Percocet)	T1	PA
oxycodone hcl/acetaminophen (Primlev)	T1	PA
PRIMLEV	T1	PA
tramadol hcl/acetaminophen (Ultrace)	T1	
ULTRACET (tramadol hcl-acetaminophen)	T3	
OPIOID ANALGESIC AND NSAID COMBINATION		
hydrocodone(ibuprofen	T1	PA
hydrocodone(ibuprofen (Ibudone)	T1	PA
IBUDONE	T1	PA
ibuprofen/oxycodone hcl	T1	PA
OPIOID ANALGESIC AND NON-SALICYLATE XANTHINE COMB		
ACETAMIN-CAFF-DIHYDROCODEINE	T1	PA
acetaminophen/caff/dihydrocod (Acetamin-caff-dihydrocodeine)	T1	PA
acetaminophen/caff/dihydrocod (Trezix)	T1	PA
TREZIX	T3	PA

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

T4 – Specialty Medications

PA – Prior Authorization

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AGE – Age Requirement

SP – Specialty Medication

HD – May require home delivery pharmacy

PPACA – No Cost-Share Preventive Medication

CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

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

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
OPIOID ANALGESICS		
ACTIQ (fentanyl citrate)	T3	PA
ARYMO ER	T3	PA
BELBUCA	T2	QL (2 films/day)
buprenorphine (Butrans)	T1	QL (4 patches/28 days)
butorphanol tartrate	T1	PA QL (6 bots/30 days)
BUTRANS (buprenorphine)	T3	QL (4 patches/28 days)
codeine sulfate	T1	PA
DURAGESIC (fentanyl)	T3	PA
fentanyl	T1	PA
fentanyl (Duragesic)	T1	PA
FENTANYL CITRATE	T1	PA
fentanyl citrate (Actiq)	T1	PA
FENTORA	T3	PA
hydrocodone bitartrate (Hysingla Er)	T1	PA
hydrocodone bitartrate (Zohydro Er)	T1	PA
hydromorphone hcl	T1	PA
hydromorphone hcl (Dilaudid)	T1	PA
HYSINGLA ER (hydrocodone bitartrate er)	T2	PA
KADIAN (morphine sulfate er)	T3	PA
LAZANDA	T3	PA
meperidine hcl	T1	PA
MORPHABOND ER	T2	PA
morphine sulfate	T1	PA
morphine sulfate (Kadian)	T1	PA
morphine sulfate (Ms Contin)	T1	PA
MS CONTIN (morphine sulfate er)	T3	PA
NUCYNTA	T2	PA
NUCYNTA ER	T3	PA
opium/belladonna alkaloids	T1	PA
OXAYDO	T3	PA
oxycodone hcl (ir) 10 mg tab	T1	PA
oxycodone hcl (ir) 15 mg tab (Roxicodone)	T1	PA
oxycodone hcl (ir) 20 mg tab	T1	PA
oxycodone hcl (ir) 30 mg tab (Roxicodone)	T1	PA

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

T4 – Specialty Medications

PA – Prior Authorization

QL – Quantity Limit

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CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

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

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
OPIOID ANALGESICS (cont.)		
oxycodone hcl (ir) 5 mg cap	T1	PA
oxycodone hcl (ir) 5 mg tablet (Roxicodone)	T1	PA
oxycodone hcl 100 mg/5 ml conc	T1	PA
oxycodone hcl 5 mg/5 ml cup	T1	PA
oxycodone hcl 5 mg/5 ml soln	T1	PA
OXCODONE HCL ER	T1	PA
oxymorphone hcl	T1	PA
pentazocine hcl/naloxone hcl	T1	PA
ROXYBOND	T3	PA
tramadol 50 mg tablet	T1	QL(8 tabs/day)
TRAMADOL 75 MG TABLET	T3	QL(< 18 yo 5 tabs/day)
TRAMADOL ER 100 MG CAPSULE	T1	QL (1 cap/day)
tramadol er 100 mg, 200mg, 300mg tablet	T1	QL (1 tab/day)
TRAMADOL HCL ER 150 MG, 200 MG, 300 MG CAPSULE	T1	QL (1 cap/day)
tramadol hcl er 200 mg, 300 mg tablet	T1	QL (1 tab/day)
tramadol hcl er 200 mg, 300 mg tablet	T1	QL (1 tab/day)
ULTRAM (tramadol hcl)	T3	QL (8 tabs/day)
XTAMPZA ER	T2	PA
ZOHYDRO ER (hydrocodone bitartrate er)	T3	PA
OPIOID AND SALICYLATE ANALGESICS, BARBIT, XANTHINE		
codeine/butalbital/asa/caffein (Fiorinal With Codeine #3)	T1	PA
FIORINAL WITH CODEINE #3 (butalbital compound-codeine)	T3	PA
OPIOID, NON-SALICYL. ANALGESIC, BARBITUATE, XANTHINE		
butalbit/acetamin/caff/codeine	T1	PA
butalbit/acetamin/caff/codeine (Fioricet With Codeine)	T1	PA
FIORICET WITH CODEINE (butalb-acetaminoph-caff-codein)	T3	PA
SKELETAL MUSCLE RELAXANT, SALICYLAT, OPIOID ANALGESC		
carisoprodol/aspirin/codeine	T1	PA
ANALGESICS (Urinary Tract Conditions)		
URINARY TRACT ANALGESIC AGENTS		
ELMIRON	T3	
RIMSO-50	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

ANESTHETICS (Miscellaneous)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
GENERAL ANESTHETICS, INHALANT		
<i>desflurane</i> (Suprane)	T1	
<i>isoflurane</i>	T1	
<i>isoflurane</i>	T3	
<i>sevoflurane</i> (Ultane)	T1	
ULTANE (sevoflurane)	T3	
LOCAL ANESTHETICS		
<i>lidocaine hcl</i>	T1	
ANESTHETICS (Pain Relief and Inflammatory Disease)		
TOPICAL LOCAL ANESTHETICS		
<i>desflurane</i> (Suprane)	T1	
<i>isoflurane</i>	T1	
<i>isoflurane</i>	T3	
<i>sevoflurane</i> (Ultane)	T1	
SUPRANE	T3	
ULTANE (sevoflurane)	T3	
<i>lidocaine 5% ointment</i>	T1	QL (145gm/30 days)
<i>lidocaine 5% patch</i> (Lidocan II)	T1	
<i>lidocaine 5% patch</i> (Lidoderm)	T1	
<i>lidocaine hcl</i>	T1	
<i>lidocaine/prilocaine</i>	T1	
LIDODERM (<i>lidocaine</i>)	T3	
PAIN EASE MEDIUM STREAM SPRAY	T3	
ZTLIDO	T2	
ANESTHETICS (Urinary Tract Conditions)		
URINARY TRACT ANESTHETIC/ANALGESIC AGNT (AZO-DYE)		
<i>phenazopyridine hcl</i> (Pyridium)	T1	
ANTI-ALLERGY (Allergy/Nasal Sprays)		
MAST CELL STABILIZERS		
<i>cromolyn 100 mg/5 ml oral conc</i> (Gastrocrom)	T1	

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

T4 – Specialty Medications

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ST – Step Therapy

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List of Prescription Medications

ANTI-ARTHRITICS (Pain Relief and Inflammatory Disease)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ANALGESIC/ANTIPYRETICS, SALICYLATES		
DISALCID (<i>salsalate</i>)	T3	HD
<i>salsalate</i> (Disalcid)	T1	HD
ANTI-ARTHRITIC AND CHELATING AGENTS		
DEPEN (<i>penicillamine</i>)	T4	PA SP
<i>penicillamine</i>	T4	PA SP
<i>penicillamine</i> (Depen)	T4	PA SP
ANTI-ARTHRITIC, FOLATE ANTAGONIST AGENTS		
OTREXUP	T2	PA
ANTI-INFLAMMATORY, PYRIMIDINE SYNTHESIS INHIBITOR		
ARAVA (<i>leflunomide</i>)	T3	HD
<i>leflunomide</i> (Arava)	T1	HD
ANTI-INFLAMMATORY, PHOSPHODIESTERASE-4(PDE4) INHIB.		
OTEZLA 10-20 MG STARTER 28 DAY	T4	PA QL(55 tabs/365 days) SP HD
OTEZLA 10-20-30MG START 28 DAY	T4	PA QL(55 tabs/365 days) SP HD
OTEZLA 20 MG TABLET	T4	PA QL(2 tabs/day) 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		
<i>colchicine</i> 0.6 mg capsule	T1	HD
COLCHICINE	T1	HD
<i>colchicine</i> 0.6 mg capsule (Mitigare)	T1	HD
<i>colchicine</i> 0.6 mg tablet (Colcrys)	T1	HD
COLCRYS (<i>colchicine</i>)	T3	HD
MITIGARE	T2	HD
GOLD SALTS		
RIDAURA	T3	
HYPERURICEMIA TX - XANTHINE OXIDASE INHIBITORS		
<i>allopurinol</i> (Zyloprim)	T1	HD
febuxostat 80 mg tablet (Uloric)	T1	HD
ULORIC 40 MG TABLET (<i>febuxostat</i>)	T3	QL (1 tab/day) HD
ULORIC 80 MG TABLET (<i>febuxostat</i>)	T3	HD
ZYLOPRIM (<i>allopurinol</i>)	T3	HD

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

T4 – Specialty Medications

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ST – Step Therapy

AGE – Age Requirement

SP – Specialty Medication

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List of Prescription Medications

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

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
JANUS KINASE (JAK) INHIBITORS		
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 AND TOPICAL IRRITANT COUNTER-IRRITANT COMB.		
COMFORT PAC-IBUPROFEN	T3	
COMFORT PAC-MELOXICAM	T3	
COMFORT PAC-NAPROXEN	T3	
NSAIDS(COX NON-SPEC.INHIB) AND PROSTAGLANDIN ANALOG		
ARTHROTEC 50 (<i>diclofenac sodium-misoprostol</i>)	T3	ST HD
ARTHROTEC 75 (<i>diclofenac sodium-misoprostol</i>)	T3	ST HD
<i>diclofenac sodium/misoprostol</i> (Arthrotec 50)	T1	HD
<i>diclofenac sodium/misoprostol</i> (Arthrotec 75)	T1	HD
NSAIDS, CYCLOOXYGENASE INHIBITOR- TYPE ANALGESICS		
ANAPROX DS (<i>naproxen sodium 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>flurbiprofen</i>	T1	HD
<i>ibuprofen</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

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List of Prescription Medications

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

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
NSAIDS, CYCLOOXYGENASE INHIBITOR- TYPE ANALGESICS (cont.)		
indomethacin	T1	HD
indomethacin 25 mg/5 ml susp	T1	HD
LODINE (etodolac)	T3	ST HD
meclofenamate sodium	T1	HD
meloxicam 15 mg tablet	T1	HD
meloxicam 7.5 mg tablet (Mobic)	T1	HD
meloxicam (Mobic)	T1	HD
MOBIC (meloxicam)	T3	ST HD
nabumetone	T1	HD
NALFON 600 MG TABLET (profeno)	T1	ST HD
NAPROSYN TABLET (naproxen)	T3	ST HD
naproxen dr 375 mg tablet (Ec-Naprosyn)	T1	HD
naproxen dr 500 mg tablet (Ec-Naprosyn)	T1	HD
naproxen tablet	T1	HD
naproxen (Ec-naprosyn)	T1	HD
naproxen (Naprosyn)	T1	HD
naproxen sodium (Anaprox Ds)	T1	HD
oxaprozin 600 mg caplet (Daypro)	T1	HD
oxaprozin 600 mg tablet (Daypro)	T1	HD
OXAPROZIN 300 MG CAPSULE	T3	HD
piroxicam (Feldene)	T1	HD
QMIIZ ODT 15 MG TABLET	T3	ST HD
QMIIZ ODT 7.5 MG TABLET	T3	QL (1 tab/day) ST HD
tolmetin sodium	T1	HD
tolmetin sodium (Tolectin 600)	T1	HD
NSAIDS, CYCLOOXYGENASE-2(COX-2) SELECTIVE INHIBITOR		
celecoxib 100 mg capsule (Celebrex)	T1	QL (2 caps/day) HD
celecoxib 200 mg capsule (Celebrex)	T1	QL (2 caps/day) HD
celecoxib 400 mg capsule (Celebrex)	T1	QL (1 cap/day) HD
celecoxib 50 mg capsule (Celebrex)	T1	QL (2 caps/day) HD

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

T4 – Specialty Medications

PA – Prior Authorization

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ST – Step Therapy

AGE – Age Requirement

SP – Specialty Medication

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PPACA – No Cost-Share Preventive Medication

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List of Prescription Medications

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

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
URICOSURIC AGENTS		
probenecid	T1	HD
probenecid/colchicine	T1	HD
ANTI-ASTHMATICS (Asthma/COPD/Respiratory)		
5-LIPOXYGENASE INHIBITORS		
zileuton	T1	HD
ANTICHOLINERGICS, ORALLY INHALED LONG ACTING		
INCRUSE ELLIPTA	T2	HD
LONHALA MAGNAIR STARTER & REFILL	T3	PA HD
STRIVERDI RESPIMAT	T2	QL(1 inhaler/30 days) HD
SPIRIVA RESPIMAT	T2	HD
ANTICHOLINERGICS, ORALLY INHADED SHORT ACTING		
ATROVENT HFA	T2	HD
ipratropium bromide	T1	HD
BETA-ADRENERGIC AGENTS		
albuterol sulf 2 mg/5 ml syrup	T1	HD
albuterol 8 mg/20 ml syrup cup	T1	HD
BETA-ADRENERGIC AGENTS, INHALED, SHORT ACTING		
albuterol 15 mg/3 ml solution	T1	
albuterol 75 mg/15 ml soln	T1	
albuterol sulfate 2 mg, 4 mg tab	T1	HD
albuterol sulfate er 8 mg tab	T1	HD
metaproterenol sulfate	T1	HD
terbutaline sulfate	T1	HD
albuterol 2.5 mg/0.5 ml sol	T1	
albuterol 5 mg/ml solution	T1	
albuterol sul 0.63 mg/3 ml sol	T1	
albuterol sul 1.25 mg/3 ml sol	T1	
albuterol sul 2.5 mg/3 ml soln	T1	
albuterol hfa 90 mcg inhaler (Albuterol Sulfate Hfa)	T1	QL (8.5gm/30 days)
ALBUTEROL SULFATE HFA	T1	QL (8.5gm/30 days)
levalbuterol hcl (Xopenex Concentrate)	T1	
levalbuterol hcl (Xopenex)	T1	
XOPENEX (levalbuterol hcl)	T3	
XOPENEX CONCENTRATE (levalbuterol concentrate)	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

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List of Prescription Medications

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

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
BETA-ADRENERGIC AND ANTICHOLINERGIC COMBO, INHALED		
AIRSUPRA	T2	QL(1 gm/28 days) HD
ANORO ELLIPTA	T2	HD
COMBIVENT RESPIMAT	T2	QL(2 inhalers/30 days)
<i>ipratropium/albuterol sulfate</i>	T2	HD
STILOTO RESPIMAT INHAL SPRAY	T2	HD
BETA-ADRENERGIC AGENTS AND GLUCOCORTICOID COMBO, INHALED		
AIRDUO DIGIHALER	T3	ST HD
<i>budesonide/formoterol fumarate (Symbicort)</i>	T1	QL HD
DULERA	T2	HD
<i>fluticasone propion/salmeterol (Advair Diskus)</i>	T1	QL(1 inhaler/30 days)
<i>fluticasone-salmeterol 100-50 (Advair Diskus)</i>	T1	QL(1 inhaler/30 days) HD
<i>fluticasone-salmeterol 250-50 (Advair Diskus)</i>	T1	QL(1 inhaler/30 days) HD
<i>fluticasone-salmeterol 500-50 (Advair Diskus)</i>	T1	QL(1 inhaler/30 days) HD
FLUTICASONE-SALMETEROL 113-14	T1	QL(1 inhaler/30 days) HD
FLUTICASONE-SALMETEROL 232-14	T1	QL(1 inhaler/30 days) HD
FLUTICASONE-SALMETEROL 55-14	T1	QL(1 inhaler/30 days) HD
BETA-ADRENERGIC AGENTS, ORALLY INHALED, LONG ACTING		
<i>arformoterol tartrate (Brovana)</i>	T1	QL(4 mls/day) HD
<i>formoterol fumarate (Perforomist)</i>	T1	QL(240 mls/30 days) HD
BETA-ADRENERGIC-ANTICHOLINERGIC-GLUCOCORT, INHALED		
BREZTRI AEROSPHERE	T2	
TRELEGY ELLIPTA	T2	
GLUCOCORTICOIDS, ORALLY INHALED		
ALVESCO	T2	QL(1 inhaler/30 days) HD
ASMANEX HFA	T3	QL(1 inhaler/30 days) HD
ASMANEX TWISTHALER	T2	QL
ASMANEX TWISTHALER 110 MCG #30	T2	QL(1 inhaler/30 days) HD
ASMANEX TWISTHALER 220 MCG #14	T2	HD
ASMANEX TWISTHALER 220 MCG #30	T2	QL(1 inhaler/30 days) HD
ASMANEX TWISTHALER 220 MCG #60	T2	QL(1 Inhaler/30 days) HD
ASMANEX TWISTHALR 220 MCG #120	T2	QL(1 Inhaler/30 days) HD
<i>budesonide (Pulmicort)</i>	T1	HD
FLOVENT DISKUS	T2	HD
FLOVENT HFA	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

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

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
GLUCOCORTICOIDS, ORALLY INHALED (cont.)		
FLUTICASONE PROP 100MCG DISKUS	T3	QL HD
FLUTICASONE PROP 250 MCG DISK	T3	QL HD
FLUTICASONE PROP 50 MCG DISKUS	T3	QL HD
QVAR REDIHALER	T2	
INTERLEUKIN-5(IL-5) RECEPTOR ALPHA ANTAGONIST, MAB		
FASENRA PEN	T4	PA SP HD
LEUKOTRIENE RECEPTOR ANTAGONISTS		
ACCOLATE (zaflurkast)	T3	HD
montelukast sodium (Singulair)	T1	HD
zaflurkast (Accolate)	T1	HD
MAST CELL STABILIZERS, ORALLY INHALED		
cromolyn 20 mg/2 ml neb soln	T1	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
roflumilast 250 mcg tablet (Daliresp)	T3	QL (28 tabs/180 days) HD
roflumilast 500 mcg tablet (Daliresp)	T3	QL (2 tabs/day) HD
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 hc	T1	
CORTISPORIN-TC	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

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List of Prescription Medications

ANTIBIOTICS (Ear Medications) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
EAR PREPARATIONS, ANTIBIOTICS (cont.)		
<i>neomycin/polymyxin b/hydrocort</i>	T1	
<i>ofloxacin</i>	T1	
OTIC PREPARATIONS, ANTI-INFLAMMATORY-ANTIBIOTICS		
<i>ciprofloxacin hcl/dexameth</i>	T1	
OTOVEL	T3	
ANTIBIOTICS (Eye Conditions)		
EYE ANTIBIOTIC AND GLUCOCORTICOID COMBINATIONS		
<i>neomycin/bacit/p-myx/hydrocort</i>	T1	
<i>neomycin/polymyxin b/dexametha (Maxitrol)</i>	T1	
<i>neomycin/polymyxin b/hydrocort</i>	T1	
TOBRADEX	T3	
TOBRADEX (<i>tobramycin-dexamethasone</i>)	T3	
TOBRADEX EYE OINTMENT	T3	
TOBRADEX ST	T2	
TOBRADEX ST 0.3-0.05% DROP	T2	
<i>tobramycin/dexamethasone (Tobradex)</i>	T1	
ZYLET	T3	
EYE SULFONAMIDES		
<i>BLEPH-10 (sulfacetamide sodium)</i>	T3	
BLEPHAMIDE	T3	
<i>sulfacetamide sodium</i>	T1	
<i>sulfacetamide sodium (Bleph-10)</i>	T1	
<i>sulfacetamide/prednisolone sp</i>	T1	
OPHTHALMIC ANTIBIOTICS		
AZASITE	T2	
AZASITE 1% EYEDROPS	T2	
BACIGUENT (<i>bacitracin</i>)	T3	
<i>bacitracin</i>	T1	
<i>bacitracin (Baciguent)</i>	T1	
<i>bacitracin/polymyxin b sulfate</i>	T1	
BESIVANCE	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

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List of Prescription Medications

ANTIBIOTICS (Eye Conditions) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
OPHTHALMIC ANTIBIOTICS (cont.)		
BESIVANCE 0.6% SUSP	T2	
erythromycin base	T1	
gatifloxacin	T1	
gentamicin sulfate	T1	
levofloxacin	T1	
metronidazole (Flagyl)	T1	
MOXEZA (moxifloxacin)	T3	
moxifloxacin hcl (Moxeza)	T1	
moxifloxacin hcl (Vigamox)	T1	
neomycin sulf/bacitracin/poly	T1	
neomycin/polymyxn b/gramicidin	T1	
ofloxacin (Ocuflax)	T1	
tobramycin 0.3% eye drop	T1	

ANTIBIOTICS (Infections)

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

AMINOGLYCOSIDE ANTIBIOTICS		
ARIKAYCE	T4	PA SP
gentamicin sulfate	T1	
gentamicin sulfate/pf	T1	
KITABIS PAK	T4	PA QL (10ml/day) SP HD
neomycin sulfate	T1	
TOBI PODHALER	T4	PA QL (8 caps/day) SP HD
tobramycin 20 mg/2 ml vial	T1	
tobramycin 300 mg/4 ml ampule	T4	QL (28ml/day) SP HD
tobramycin 300 mg/5 ml ampule	T4	PA QL (10ml/day) SP HD
tobramycin 40 mg/ml vial	T1	
tobramycin 80 mg/2 ml vial	T1	
tobramycin 1.2 gm vial	T1	PA

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

T4 – Specialty Medications

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List of Prescription Medications

ANTIBIOTICS (Infections) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
AMINOGLYCOSIDE ANTIBIOTICS (cont.)		
tobramycin 1.2 gram/30 ml vial	T1	
TOBRAMYCIN PAK 300 MG/5 ML	T4	PA QL (10ml/day) SP HD
tobramycin 300 mg/5 ml ampule	T4	PA QL (10ml/day) SP HD
tobramycin 40 mg/ml vial	T1	
tobramycin 80 mg/2 ml vial	T1	
TOBRAMYCIN PAK 300 MG/5 ML	T4	PA QL (10ml/day) SP HD
ANAEROBIC ANTIPROTOZOAL-ANTIBACTERIAL AGENTS		
FLAGYL (metronidazole)	T3	
LIKMEZ	T3	PA
ANTIBIOTIC, ANTIBACTERIAL, MISC.		
fosfomycin tromethamine (Monurol)	T1	
methen/mblue/sal/sod phos/hyos	T1	
methenam/m.blue/salicyl/hyosc	T1	
methenamine hippurate	T1	
methenamine mandelate	T1	
MONUROL (fosfomycin tromethamine)	T3	
PRIMSOL	T3	
trimethoprim	T1	
UTA	T3	
ANTILEPROTICS		
dapsone	T1	
THALOMID	T4	PA SP HD
ANTI-MYCOBACTERIUM AGENTS		
ethambutol hcl	T1	HD
isoniazid	T1	HD
PASER	T3	HD
pyrazinamide	T1	HD
rifabutin	T1	HD
TRECATOR	T3	HD
ANTI-TUBERCULAR ANTIBIOTICS		
cycloserine	T1	
CYCLOSERINE	T1	
PRETOMANID	T3	PA QL (1 tab/day)
PRIFTIN	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
ANTI-TUBERCULAR ANTIBIOTICS (cont.)		
RIFAMATE	T3	
rifampin	T1	
RIFATER	T3	
SIRTURO	T4	SP
BETALACTAMS		
CAYSTON	T4	PA QL (3ml/day) SP HD
CEPHALOSPORIN ANTIBIOTICS - 1ST GENERATION		
cefadroxil	T1	
cephalexin	T1	
cephalexin (Keflex)	T1	
DAXBIA	T3	
KEFLEX (cephalexin)	T3	
CEPHALOSPORIN ANTIBIOTICS - 2ND GENERATION		
cefaclor	T1	
cefprozil	T1	
cefuroxime axetil	T1	
CEPHALOSPORIN ANTIBIOTICS - 3RD GENERATION		
cefixime (Suprax)	T1	
cefpodoxime proxetil	T1	
LINCOSAMIDE ANTIBIOTICS		
CLEOCIN PEDIATRIC (<i>clindamycin (pediatric)</i>)	T3	
<i>clindamycin hcl</i> (Cleocin Hcl)	T1	
<i>clindamycin palmitate hcl</i> (Cleocin Pediatric)	T1	
MACROLIDE ANTIBIOTICS		
azithromycin (Zithromax)	T1	
azithromycin 1 gm pwd packet (Zithromax)	T1	
azithromycin 100 mg/5 ml susp (Zithromax)	T1	
azithromycin 200 mg/5 ml susp (Zithromax)	T1	
azithromycin 200 mg/5 ml susp (Zithromax)	T1	
azithromycin 250 mg tablet (Zithromax)	T1	
azithromycin 500 mg tablet (Zithromax Tri-pak)	T1	
azithromycin 600 mg tablet	T1	
<i>clarithromycin</i>	T1	

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

T4 – Specialty Medications

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List of Prescription Medications

ANTIBIOTICS (Infections) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
MACROLIDE ANTIBIOTICS (cont.)		
DIFICID 200 MG TABLET	T3	QL (28 tabs/28 days)
DIFICID 40 MG/ML SUSPENSION	T3	QL (5ml/day)
ERYPED 200 (<i>erythromycin ethylsuccinate</i>)	T3	
ERY-TAB (<i>erythromycin</i>)	T3	
<i>erythromycin base</i>	T1	
<i>erythromycin base</i>	T3	
<i>erythromycin base</i> (Ery-tab)	T1	
<i>erythromycin ethylsuccinate</i>	T1	
<i>erythromycin ethylsuccinate</i>	T3	
<i>erythromycin ethylsuccinate</i> (Eryped 200)	T1	
<i>erythromycin stearate</i>	T1	
PCE	T3	
ZITHROMAX 1 GM POWDER PACKET (<i>azithromycin</i>)	T3	
ZITHROMAX 100 MG/5 ML SUSP (<i>azithromycin</i>)	T3	
ZITHROMAX 200 MG/5 ML SUSP (<i>azithromycin</i>)	T3	
ZITHROMAX 200 MG/5 ML SUSP (<i>azithromycin</i>)	T3	
ZITHROMAX 250 MG TABLET (<i>azithromycin</i>)	T3	
ZITHROMAX 250 MG Z-PAK TABLET (<i>azithromycin</i>)	T3	
ZITHROMAX 500 MG TABLET (<i>azithromycin</i>)	T3	
ZITHROMAX TRI-PAK (<i>azithromycin</i>)	T3	
NITROFURAN DERIVATIVES ANTIBACTERIAL AGENTS		
FURADANTIN (<i>nitrofurantoin</i>)	T3	
MACROBID (<i>nitrofurantoin mono-macro</i>)	T3	
<i>nitrofurantoin</i> 25 mg/5 ml susp (Furadantin)	T1	
<i>nitrofurantoin monohyd/m-cryst</i> (Macrobid)	T1	
<i>nitrofurantoin</i> suspension	T1	
<i>nitrofurantoin</i> macrocrystal	T1	
<i>nitrofurantoin monohyd/m-cryst</i> (Macrobid)	T1	
OXAZOLIDINONE ANTIBIOTICS		
linezolid (Zyvox)	T1	PA
SIVEXTRO	T3	PA
ZYVOX (<i>linezolid</i>)	T3	PA

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

T4 – Specialty Medications

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List of Prescription Medications

ANTIBIOTICS (Infections) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
PENICILLIN ANTIBIOTICS		
<i>amoxicillin</i>	T1	
<i>amoxicillin/potassium clav</i> (Augmentin Es-600)	T1	
<i>ampicillin trihydrate</i>	T1	
<i>dicloxacillin sodium</i>	T1	
MOXATAG	T3	
<i>penicillin v potassium</i>	T1	
PLEUROMUTILIN DERIVATIVES		
XENLETA	T3	PA QL (10 tabs/30 days)
QUINOLONE ANTIBIOTICS		
AVELOX (<i>moxifloxacin hcl</i>)	T3	
BAXDELA	T3	PA
CIPRO (<i>ciprofloxacin hcl</i>)	T3	
CIPRO (<i>ciprofloxacin</i>)	T3	
<i>ciprofloxacin</i> (Cipro)	T1	
<i>ciprofloxacin hcl</i>	T1	
<i>ciprofloxacin hcl</i> (Cipro)	T1	
<i>ciprofloxacin/ciprofloxacin hcl</i>	T1	
FACTIVE	T3	
<i>levofloxacin</i>	T1	
<i>moxifloxacin hcl</i> (Avelox)	T1	
<i>ofloxacin</i>	T1	
RIFAMYCINS AND RELATED DERIVATIVE ANTIBIOTICS		
AEMCOLO	T3	QL (12 tabs/3 days)
XIFAXAN 200 MG TABLET	T2	
XIFAXAN 550 MG TABLET	T2	QL (126 tabs/year)
TETRACYCLINE ANTIBIOTICS		
<i>coremino er 135 mg tablet</i>	T1	
<i>coremino er 45 mg tablet</i>	T1	QL (1 tab/day)
<i>coremino er 90 mg tablet</i>	T1	
<i>demeclocycline hcl</i>	T1	
<i>doxycycline 50 mg tablet</i> (Targadox)	T1	
<i>doxycycline hyclate</i>	T1	
<i>minocycline er 115 mg tablet</i>	T1	

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

T4 – Specialty Medications

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List of Prescription Medications

ANTIBIOTICS (Infections) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
TETRACYCLINE ANTIBIOTICS (cont.)		
minocycline er 45 mg tablet	T1	QL (1 tab/day)
minocycline er 55 mg, 65 mg, 80 mg, 90mg tablet	T1	
minocycline hcl	T1	
NUZYRA	T4	PA QL (30 tablets/28 days) SP
tetracycline 250 mg capsule	T1	
tetracycline 500 mg capsule	T1	
VIBRAMYCIN	T3	
VIBRAMYCIN (doxycycline monohydrate)	T3	
VAGINAL ANTIBIOTICS		
CLEOCIN	T3	
CLEOCIN (<i>clindamycin phosphate</i>)	T3	
<i>clindamycin phosphate</i> (Cleocin)	T1	
metronidazole (Metrogel-vaginal)	T1	
VANCOMYcin ANTIBIOTICS AND DERIVATIVES		
vancomycin 250 mg/5 ml soln	T1	
vancomycin 50 mg/ml solution	T1	
vancomycin hcl 125 mg capsule (Vancocin Hcl)	T1	
vancomycin hcl 250 mg capsule (Vancocin Hcl)	T1	
vancomycin hcl (Firvanq)	T1	

ANTIBIOTICS (Skin Conditions)

TOPICAL ANTIBIOTIC AND ANTI-INFLAMMATORY STEROID		
NEO-SYNALAR	T3	
TOPICAL ANTIBIOTICS		
BENZAMYCIN (<i>erythromycin-benzoyl peroxide</i>)	T3	
CENTANY	T3	
CENTANY AT	T3	
CLEOCIN T (<i>clindamycin phosphate</i>)	T3	
CLINDACIN ETZ KIT	T3	
CLINDACIN PAC	T3	
<i>clindamycin phosphate</i>	T1	
<i>clindamycin phosphate</i> (Cleocin T)	T1	
<i>clindamycin phosphate</i> (Evoclin)	T1	
<i>erythromycin base in ethanol</i>	T1	
<i>erythromycin/benzoyl peroxide</i> (Benzamycin)	T1	

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

T4 – Specialty Medications

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List of Prescription Medications

ANTIBIOTICS (Skin Conditions) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
TOPICAL ANTIBIOTICS (cont.)		
EOCLIN (<i>clindamycin phosphate</i>)	T3	
gentamicin sulfate	T1	
mupirocin (Centany)	T1	
mupirocin calcium	T1	
XEPI	T3	
TOPICAL SULFONAMIDES		
AVAR 9.5-5% CLEANSING PADS	T3	
avar cleanser (Rosanil)	T1	
AVAR LS	T3	
mafенide acetate	T1	
ROSANIL (<i>sodium sulfacetamide-sulfur</i>)	T1	
SILVADENE (ssd)	T3	
silver sulfadiazine (Silvadene)	T1	
sulfacetamide sod/sulfur/urea	T1	
sulfacetamide sodium/sulfur	T1	
sulfacetamide sodium/sulfur (Avar-e Green)	T1	
sulfacetamide sodium/sulfur (Rosanil)	T1	
sulfacetamide/sulfur/cleansr23	T1	
sulfact sod/sulur/avob/otn/oct	T1	
SULFAMYLYON	T3	

ANTI-COAGULANTS (Blood Thinners/Anti-Clotting)

ANTI-COAGULANTS, COUMARIN TYPE		
warfarin sodium	T1	HD
CITRATES AS ANTI-COAGULANTS		
ACD SOLUTION A	T3	
ACD-A SOLUTION	T3	
ANTICOAGULANT SODIUM CITRATE	T3	
CITRATE PHOSPHATE DEXTROSE	T1	
SODIUM CITRATE	T1	
DIRECT FACTOR XA INHIBITORS		
BEVYXXA	T3	QL (42 caps/42 days)
ELIQUIS	T2	
rivaroxaban	T1	

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

T4 – Specialty Medications

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ST – Step Therapy

AGE – Age Requirement

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List of Prescription Medications

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

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
DIRECT FACTOR XA INHIBITORS (cont.)		
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
THROMBIN INHIBITORS, SELECTIVE, DIRECT, REVERSIBLE		
dabigatran etexilate	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

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List of Prescription Medications

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

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
HEPARIN AND RELATED PREPARATIONS (cont.)		
LOVENOX 300 MG/3 ML VIAL (enoxaparin sodium)	T4	QL (1 vial/day) SP
LOVENOX 40 MG/0.4 ML SYRINGE (enoxaparin sodium)	T4	QL (2 syringes/day) SP
LOVENOX 60 MG/0.6 ML SYRINGE (enoxaparin sodium)	T4	QL (2 syringes/day) SP
LOVENOX 80 MG/0.8 ML SYRINGE (enoxaparin sodium)	T4	QL (2 syringes/day) SP

ANTIDOTES (Gastrointestinal/Heartburn)

MU-OPIOID RECEPTOR ANTAGONISTS, PERIPHERALLY-ACTING		
MOVANTIK	T2	PA
RELISTOR 12 MG/0.6 ML SYRINGE	T3	PA
RELISTOR 12 MG/0.6 ML VIAL	T3	PA
RELISTOR 8 MG/0.4 ML SYRINGE	T3	PA
SYMPROIC	T2	PA

ANTIDOTES (Substance Abuse)

OPIOID ANTAGONISTS		
naloxone 0.4 mg/ml carpject	T1	
naloxone 0.4 mg/ml vial	T1	
NALOXONE 2 MG AUTO-INJECTOR	T3	QL (0.8ml/day)
naloxone 2 mg/2 ml syringe	T1	
naloxone 4 mg/10 ml vial	T1	
naltrexone hcl	T1	QL(180 tabs/30 days)
NARCAN	T2	QL (2 units/30 days)
OPVEE	T3	QL(2 units/30 days)
REXTOVY	T2	QL(2 units/30 days)
ZIMHI	T3	QL (2 units/30 days)

ANTI-FUNGALS (Eye Conditions)

OPHTHALMIC ANTI-FUNGAL AGENTS		
NATACYN	T3	

ANTI-FUNGALS (Feminine Products)

VAGINAL ANTI-FUNGALS		
GYNAZOLE 1	T1	
miconazole nitrate	T1	
terconazole	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

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List of Prescription Medications

ANTI-FUNGALS (Infections)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ANTI-FUNGAL AGENTS		
ANCOBON (<i>flucytosine</i>)	T3	
<i>clotrimazole</i>	T1	
CRESEMDA	T3	PA
fluconazole	T1	
<i>flucytosine</i> (Ancobon)	T1	
<i>itraconazole</i>	T1	
<i>ketoconazole</i>	T1	
NOXAFL	T3	
NOXAFL 40 MG/ML SUSPENSION (<i>posaconazole</i>)	T3	
ORAVIG	T3	
<i>posaconazole</i> (Noxafil)	T1	
<i>terbinafine hcl</i>	T1	
VFEND (<i>voriconazole</i>)	T3	PA
VIVJOA	T4	PA SP
<i>voriconazole</i> (Vfend)	T1	PA
ANTI-FUNGAL ANTIBIOTICS		
GRIS-PEG (<i>griseofulvin ultramicrosize</i>)	T3	
<i>griseofulvin ultramicrosize</i> (Gris-peg)	T1	
<i>griseofulvin ultra 125 mg tab</i>	T1	
<i>griseofulvin ultra 165 mg tab</i>	T1	QL(4 tabs/day)
<i>griseofulvin ultra 250 mg tab</i>	T1	
<i>nystatin</i>	T1	

ANTI-FUNGALS (Skin Conditions)

TOPICAL ANTI-FUNGAL/ANTI-INFLAMMATORY, STEROID AGENT		
<i>clotrimazole/betamethasone dip</i>	T1	
TOPICAL ANTI-FUNGALS		
<i>ciclodan 0.77% cream</i>	T1	
<i>CICLODAN 0.77% CREAM KIT</i>	T3	
<i>CICLODAN 8% KIT</i>	T3	
<i>ciclodan 8% solution</i>	T1	
<i>ciclopirox</i>	T1	
<i>ciclopirox olamine</i>	T1	
<i>ciclopirox olamine</i> (Loprox)	T1	
<i>ciclopirox/urea/camph/men/euc</i>	T1	

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

T4 – Specialty Medications

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List of Prescription Medications

ANTI-FUNGALS (Skin Conditions) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
TOPICAL ANTI-FUNGALS (cont.)		
econazole nitrate	T1	
ECOZA	T3	
EXODERM	T1	
ketoconazole	T1	
ketoconazole/skin cleanser 2%	T1	
LOPROX	T3	
LOPROX (ciclopirox)	T3	
LULICONAZOLE	T1	
naftifine hcl	T1	
naftifine hcl (Naftin)	T1	
NAFTIN (naftifine hcl)	T3	
nystatin	T1	
nystatin/triamcinolone acet	T1	

ANTIHISTAMINE AND DECONGESTANT COMBINATION (Allergy/Nasal Sprays)

1ST GEN ANTIHISTAMINE AND DECONGESTANT COMBINATION

phenylephrine hcl/prometh hcl	T1	
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2ND GEN ANTIHISTAMINE AND DECONGESTANT COMBINATION

CLARINEX-D 12 HOUR	T3	
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ANTIHISTAMINES (Allergy/Nasal Sprays)

ANTIHISTAMINES - 1ST GENERATION

carboxamine maleate	T1	
clemastine fumarate	T1	
cyproheptadine hcl	T1	
hydroxyzine hcl	T1	
hydroxyzine pamoate	T1	
hydroxyzine pamoate (Vistaril)	T1	
promethazine hcl	T1	
VISTARIL (hydroxyzine pamoate)	T3	

ANTIHISTAMINES - 2ND GENERATION

cetirizine hcl	T1	HD
desloratadine 2.5 mg odt	T1	QL (1 tab/day) HD
desloratadine 5 mg odt	T1	HD
desloratadine 5 mg tablet	T1	HD
levocetirizine dihydrochloride	T1	HD

I1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

I4 – Specialty Medications

PA – Prior Authorization

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S1 – Step Therapy

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List of Prescription Medications

ANTIHISTAMINES (Eye Conditions)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
EYE ANTIHISTAMINES		
azelastine hcl 0.05% drops	T1	
bepotastine besilate	T1	
epinastine hcl	T1	
olopatadine hcl 0.1% eye drops	T1	
olopatadine hcl 0.2% eye drop	T1	

ANTI-HYPERGLYCEMICS (Diabetes)

ANTIHYPERGLY, INCRETIN MIMETIC (GLP-I RECEPT.AGONIST)		
BYDUREON	T2	QL (4 vials/28 days) ST HD
BYDUREON BCISE	T2	PA QL(4 mls/28 days)
BYDUREON PEN	T2	QL (4 pens/28 days) ST HD
BYETTA	T2	PA QL(3 mls/30 days)
exenatide	T1	PA QL(3 mls/30 days)
OZEMPI 0.25-0.5 MG DOSE PEN	T2	QL (2 pens/28 days) ST HD
OZEMPI 1 MG DOSE PEN (1.5 ML)	T2	QL (2 pens/28 days) ST HD
OZEMPI 1 MG DOSE PEN (3 ML)	T2	QL (3 ml/21 days) ST HD
REZVOGLAR KWIKPEN	T2	QL
RYBELSUS	T2	PA QL(1 tab/day)
TRULICITY 0.75 MG/0.5 ML PEN	T2	PA QL (4 pens/28 days)
TRULICITY 1.5 MG/0.5 ML PEN	T2	PA QL (4 pens/28 days)
TRULICITY 3 MG/0.5 ML PEN	T2	PA QL (2 ml/28 days)
TRULICITY 4.5 MG/0.5 ML PEN	T2	PA QL (2 ml/28 days)

ANTI-HYPERGLY, INSULIN, LONG ACT-GLP-I RECEP.TAGONIST

SOLIQUA 100-33	T2	HD
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ANTI-HYPERGLYCEMIC-SOD/GLUC COTRANSPORT2(SGLT2) INHIB

FARXIGA	T2	ST QL(1 tab/day)
JARDIANCE	T2	QL (1 tab/day) ST HD

ANTI-HYPERGLYCEMIC-DOPAMINE RECEPTOR AGONISTS

CYCLOSET	T3	HD
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ANTI-HYPERGLYCEMIC, ALPHA-GLUCOSIDASE INHIBITORS

acarbose (Precose)	T1	HD
GLYSET (miglitol)	T3	HD
miglitol (Glyset)	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

ANTI-HYPERGLYCEMICS (Diabetes) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ANTI-HYPERGLYCEMIC, ALPHA-GLUCOSIDASE INHIBITORS		
PRECOSE (<i>acarbose</i>)	T3	HD
ANTI-HYPERGLYCEMIC, AMYLIN ANALOG-TYPE		
SYMLINPEN 60	T2	
SYMLINPEN 120	T2	HD
ANTI-HYPERGLYCEMIC, BIGUANIDE TYPE		
GLUCOPHAGE XR (<i>metformin hcl er</i>)	T3	HD
<i>metformin hcl 850 mg tablet</i>	T1	HD
<i>metformin hcl 1,000 mg tablet</i>	T1	HD
<i>metformin hcl (Glucophage Xr)</i>	T1	HD
RIOMET (<i>metformin hcl</i>)	T3	HD
RIOMET ER	T3	HD
ANTI-HYPERGLYCEMIC, DPP-4 INHIBITORS		
JANUVIA	T2	QL (1 tab/day) ST HD
ANTI-HYPERGLYCEMIC, INSULIN-RELEASE STIMULANT TYPE		
AMARYL (<i>glimepiride</i>)	T3	HD
<i>chlorpropamide</i>	T1	HD
<i>glimepiride (Amaryl)</i>	T1	HD
<i>glimepiride 1 mg tablet (Amaryl)</i>	T1	HD
<i>glimepiride 2 mg tablet</i>	T1	HD
GLIMEPIRIDE 3 MG TABLET	T3	HD
<i>glimepiride 4 mg tablet</i>	T1	HD
GLIPIZIDE 2.5 MG TABLET	T3	HD
<i>glipizide 10 mg tablet</i>	T1	HD
<i>glipizide 5 mg tablet</i>	T1	HD
<i>glipizide (Glucotrol XI)</i>	T1	HD
<i>glipizide (Glucotrol)</i>	T1	HD
GLUCOTROL (<i>glipizide</i>)	T3	HD
GLUCOTROL XL (<i>glipizide xl</i>)	T3	HD
<i>glyburide</i>	T1	HD
<i>glyburide, micronized (Glynase)</i>	T1	HD
GLYNASE (<i>glyburide micronized</i>)	T3	HD
<i>nateglinide (Starlix)</i>	T1	HD
<i>repaglinide</i>	T1	HD
STARLIX (<i>nateglinide</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-HYPERGLYCEMICS (Diabetes) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ANTI-HYPERGLYCEMIC, INSULIN-RELEASE STIMULANT TYPE (cont.)		
<i>tolbutamide</i>	T1	HD
ANTI-HYPERGLYCEMIC, SGLT-2 AND DPP-4 INHIBITOR COMB		
GLYXAMBI	T2	QL (1 tab/day) ST HD
ANTI-HYPERGLYCEMIC, THIAZOLIDINEDIONE AND BIGUANIDE		
ACTOPLUS MET (<i>pioglitazone-metformin</i>)	T3	HD
<i>pioglitazone hcl/metformin hcl</i> (Actoplus Met)	T1	HD
ANTI-HYPERGLYCEMIC, THIAZOLIDINEDIONE-SULFONYLUREA		
DUETACT (<i>pioglitazone-glimepiride</i>)	T3	HD
<i>pioglitazone hcl/glimepiride</i> (Duetact)	T1	HD
ANTI-HYPERGLYCEMIC, DPP-4 INHIBITOR-BIGUANIDE COMBS.		
JANUMET	T2	QL (2 tabs/day) ST HD
JANUMET XR 100-1,000 MG TABLET	T2	QL (1 tab/day) ST HD
JANUMET XR 50-1,000 MG TABLET	T2	QL (2 tabs/day) ST HD
JANUMET XR 50-500 MG TABLET	T2	QL (1 tab/day) ST HD
ANTI-HYPERGLYCEMIC, INSULIN-RELEASE STIM.-BIGUANIDE		
<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		
<i>mifepristone 300 mg tablet</i>	T4	PA SP
ANTI-HYPERGLYCEMIC-SGLT2 INHIBITOR-BIGUANIDE COMBS.		
SYNJARDY	T2	QL (2 tabs/day) ST HD
SYNJARDY XR 10-1,000 MG TABLET	T2	QL (2 tabs/day) ST HD
SYNJARDY XR 12.5-1,000 MG TAB	T2	QL (2 tabs/day) ST HD
SYNJARDY XR 25-1,000 MG TABLET	T2	QL (1 tab/day) ST HD
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

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
ANTIHYPERGLY-SGLT-2 INHIB, DPP-4 INHIB, BIGUANIDE CB		
TRIARDY XR	T2	QL (1 tab/day) ST HD
INSULINS		
BASAGLAR KWIKPEN U-100	T2	QL (1.5ml/day) HD
FIASP PENFILL	T3	QL (1.5ml/day) HD
HUMALOG	T2	QL (1.5ml/day) HD
HUMALOG JUNIOR KWIKPEN	T2	QL (1.5ml/day) HD
HUMALOG KWIKPEN U-100	T2	QL (1.5ml/day) HD
HUMALOG KWIKPEN U-200	T2	QL (1ml/day) HD
HUMALOG MIX 50-50 KWIKPEN	T2	QL (2ml/day) HD
HUMALOG MIX 75-25	T2	QL (2ml/day) HD
HUMALOG MIX 75-25 KWIKPEN	T2	QL (2ml/day) HD
HUMULIN N 100 UNIT/ML VIAL	T2	QL (1.5 ml/day) HD
HUMULIN R U-500	T2	QL (1ml/day) HD
HUMULIN R U-500 KWIKPEN	T2	QL (1ml/day) HD
LYUMJEV	T2	QL (1.5ml/day) HD
LYUMJEV KWIKPEN U-100	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
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

ANTI-INFECTIVES/MISCELLANEOUS (Feminine Products)

VAGINAL ANTISEPTICS
acetic acid/oxyquinoline (Relagard)
RELAGARD (fem ph)
TRIMO-SAN

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

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List of Prescription Medications

ANTI-INFECTIVES/MISCELLANEOUS (Infections)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
2ND GEN. ANAEROBIC ANTI-PROTOZOAL-ANTIBACTERIAL		
TINDAMAX (<i>tinidazole</i>)	T3	
<i>tinidazole</i>	T1	
<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>praziquantel</i> (Biltricide)	T1	
STROMECTOL (<i>ivermectin</i>)	T3	
ANTI-MALARIAL DRUGS		
<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)
<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	
PRIMAQUINE (<i>primaquine phosphate</i>)	T1	
primaquine phosphate	T1	
<i>pyrimethamine 25 mg tablet</i> (Daraprim)	T1	PA
<i>pyrimethamine 25 mg tablet</i> (Daraprim)	T4	PA SP
QUALAQUIN (<i>quinine sulfate</i>)	T3	PA
<i>quinine sulfate</i> (Qualaquin)	T1	
ANTI-PROTOZOAL DRUGS, MISCELLANEOUS		
BENZNIDAZOLE	T3	
IMPAVIDO	T3	PA
LAMPIT	T3	
NEBUPENT (<i>pentamidine isethionate</i>)	T3	
<i>pentamidine isethionate</i> (Nebupent)	T1	

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

T4 – Specialty Medications

PA – Prior Authorization

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List of Prescription Medications

ANTI-INFECTIVES/MISCELLANEOUS (Miscellaneous)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ANTIBACTERIAL AGENTS, MISCELLANEOUS		
glycine urologic solution	T1	
glycine urologic solution	T3	
ANTISEPTICS, GENERAL		
ALCOHOL SWABSTICK	T3	
GS ISOPROPYL ALCOHOL 70% SPRAY	T1	
ANTI-INFECTIVES/MISCELLANEOUS (Skin Conditions)		
TOPICAL ANTI-FUNGALS		
CICLODAN 8% KIT	T3	
ciclopirox/urea/camph/men/euc (Ciclodan)	T1	
ANTI-INFLAM.TUMOR NECROSIS FACTOR INHIBITING AGENTS (Pain Relief And Inflammatory Disease)		
ANTI-INFLAMMATORY TUMOR NECROSIS FACTOR INHIBITOR		
ADALIMUMAB-ADAZ PEN	T4	PA QL (2 doses/ 28 days) SP HD
ADALIMUMAB-ADBM(CF)PEN	T4	PA QL(2 pens/28 days) SP HD
ADALIMUMAB-ADBM(CF) PEN CROHNS	T4	PA QL(1 starter kit/365 days) SP HD
ADALIMUMAB-ADBM(CF) PEN PS-UV	T4	PA QL(1 starter kit/365 days) SP HD
ADALIMUMAB-RYVK(CF)	T4	PA QL(2pens/syringes/28 days) SP HD
ADALIMUMAB-RYVK(CF) AUTOINJECT	T4	PA QL SP
AVSOLA	T4	PA SP
CIMZIA	T4	PA QL (1 kit/28 days) SP HD
CIMZIA (2 PACK)	T4	PA QL (1 kit/28 days) SP HD
CYLTEZO (CF)	T4	PA QL(2 pens/syringes/28 days) SP HD
CYLTEZO(CF) PEN	T4	PA QL(2 pens/28 days) SP HD
ENBREL 25 MG KIT	T4	PA QL (8 vials/28 days) SP HD
ENBREL 25 MG/0.5 ML SYRINGE	T4	PA QL (8 syringes/28 days) SP HD
ENBREL 25 MG/0.5 ML VIAL	T4	PA QL (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

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

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List of Prescription Medications

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

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ANTI-INFLAMMATORY TUMOR NECROSIS FACTOR INHIBITOR (cont.)		
ENBREL SURECLICK	T4	PA QL (4 syringes/28 days) SP HD
HUMIRA	T4	PA QL (2 syrings/28 days) SP HD
HUMIRA PEN	T4	PA QL (2 pens/28 days) SP HD
HUMIRA(CF)	T4	PA QL (2 syrings/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
HUMIRA(CF) PEN CROHN'S-UC-HS	T4	PA QL (1 kit/year) SP HD
HUMIRA(CF) PEN PEDIATRIC UC	T4	PA QL(1 starter kit/365 days) SP
HUMIRA(CF) PEN PSOR-UV-ADOL HS	T4	PA QL (1 kit/year) SP HD
HYRIMoz	T4	PA SP
HYRIMoz PEN	T4	PA SP
INFLECTRA	T4	PA SP HD
REMICADE	T4	PA SP HD
SIMLANDI(CF) AUTOINJECTOR	T4	PA QL(2 auto-injs/28 days) SP HD
SIMPONI 100 MG/ML PEN INJECTOR	T4	PA QL (1 injector/28 days) SP HD
SIMPONI 100 MG/ML SYRINGE	T4	PA QL (1 syringe/28 days) SP HD
SIMPONI ARIA	T4	PA SP HD

ANTI-NEOPLASTICS (Cancer)

ANP - SELECTIVE RETINOID X RECEPTOR AGONISTS (RXR)		
bexarotene (Targretin)	T4	PA SP HD
ANTI-NEOPLAST, HISTONE DEACETYLASE (HDAC) INHIBITORS		
FARYDAK	T4	PA SP HD
ZOLINZA	T4	PA SP HD

ANTI-NEOPLASTIC - ALKYLATING AGENTS

ALKERAN (<i>melphalan</i>)	T4	SP
cyclophosphamide	T4	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	
<i>temozolomide</i>	T4	PA 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

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List of Prescription Medications

ANTI-NEOPLASTICS (Cancer) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ANTI-NEOPLASTIC - ANTI-ANDROGENIC AGENTS		
<i>abiraterone 500 mg tablet</i>	T4	SP HD
<i>abiraterone acetate (Zytiga)</i>	T4	SP HD CSL
<i>abiraterone acetate 250 mg tab</i>	T4	PA SP HD
<i>bicalutamide (Casodex)</i>	T1	
<i>CASODEX (bicalutamide)</i>	T3	
<i>ERLEADA</i>	T4	PA SP HD CSL
<i>ERLEADA 240 MG TABLET</i>	T4	PA QL(1 tab/day) SP HD CSL
<i>ERLEADA 60 MG TABLET</i>	T4	PA SP HD CSL
<i>flutamide</i>	T1	
<i>nilutamide</i>	T1	QL (4 tabs/day)
<i>NUBEQA</i>	T4	PA SP HD
<i>XTANDI</i>	T4	PA SP HD
ANTI-NEOPLASTIC - ANTI-METABOLITES		
<i>capecitabine (Xeloda)</i>	T4	PA SP HD
<i>INQOVI</i>	T4	PA SP HD
<i>JYLAMVO</i>	T3	CSL
<i>LONSURF</i>	T4	PA SP HD
<i>mercaptopurine</i>	T1	
<i>methotrexate sodium</i>	T1	
<i>methotrexate sodium/pf</i>	T1	
<i>ONUREG</i>	T4	PA QL (14 Tabs/28 Days) SP
<i>PURIXAN (mercaptopurine)</i>	T4	SP
<i>TABLOID</i>	T3	
<i>TREXALL</i>	T2	
<i>XATMEP</i>	T3	
<i>XELODA (capecitabine)</i>	T4	PA SP HD
ANTI-NEOPLASTIC - AROMATASE INHIBITORS		
<i>anastrozole (Arimidex)</i>	T1	HD PPACA
<i>ARIMIDEX (anastrozole)</i>	T3	HD
<i>AROMASIN (exemestane)</i>	T3	HD
<i>exemestane (Aromasin)</i>	T1	HD PPACA
<i>letrozole (Femara)</i>	T1	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

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List of Prescription Medications

ANTI-NEOPLASTICS (Cancer) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits	
ANTI-NEOPLASTIC - BRAF KINASE INHIBITORS			
OJEMDA 100 MG TAB (400MG DOSE)	T4	PA QL(1 packet/28 days) SP CSL	
OJEMDA 100 MG TAB (500MG DOSE)	T4	PA QL(1 packet/28 days) SP CSL	
OJEMDA 100 MG TAB (600MG DOSE)	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 10 MG TABLET FOR SUSP	T4	PA QL(30 tabs/day) SP HD CSL	
TAFINLAR 50 MG CAPSULE	T4	PA QL(4 caps/day) SP HD CSL	
TAFINLAR 75 MG CAPSULE	T4	PA QL(4 caps/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 CSL	
ANTI-NEOPLASTIC - JANUS KINASE (JAK) INHIBITORS			
JAKIFI	T4	PA SP HD	
ANTI-NEOPLASTIC - KRAS PROTEIN INHIBITOR			
LUMAKRAS 120 MG TABLET	T4	PA QL(8 tabs/day) SP HD CSL	
LUMAKRAS 240 MG TABLET	T4	PA QL(4 tabs/day) SP HD CSL	
LUMAKRAS 320 MG TABLET	T4	PA QL(3 tabs/day) SP HD CSL	
ANTI-NEOPLASTIC - MEK1 AND MEK2 KINASE INHIBITORS			
COTELLIC	T4	PA SP HD	
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	T4	PA SP HD	
MEKINIST 0.05 MG/ML SOLUTION	T4	PA QL(40 mls/day) SP HD CSL	
MEKINIST 0.5 MG TABLET	T4	PA QL(3 tabs/day) SP HD CSL	
MEKINIST 2 MG TABLET	T4	PA QL(1 tab/day) SP HD CSL	
ANTI-NEOPLASTIC - MTOR KINASE INHIBITORS			
AFINITOR 10 MG TABLET	T4	PA SP HD	
AFINITOR 2.5 MG TABLET (<i>everolimus</i>)	T4	PA SP HD	
AFINITOR 5 MG TABLET (<i>everolimus</i>)	T4	PA SP HD	
AFINITOR 7.5 MG TABLET (<i>everolimus</i>)	T4	PA SP HD	
AFINITOR DISPERZ	T4	PA SP	
T1 – Typically Generics	T4 – Specialty Medications	ST – Step Therapy	HD – May require home delivery pharmacy
T2 – Typically Preferred Brands	PA – Prior Authorization	AGE – Age Requirement	PPACA – No Cost-Share Preventive Medication
T3 – Typically Non-Preferred Brands	QL – Quantity Limit	SP – Specialty Medication	CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

ANTI-NEOPLASTICS (Cancer) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ANTI-NEOPLASTIC - MTOR KINASE INHIBITORS (cont.)		
everolimus (Afinitor)	T4	PA QL(1 tab/day) SP CSL
everolimus 2.5 mg tablet	T4	PA SP HD
everolimus 5 mg tablet	T4	PA SP HD
everolimus 7.5 mg tablet	T4	PA QL(1 tab/day) SP HD CSL
everolimus 10 mg tablet	T4	PA QL(1 tab/day) SP HD CSL
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 FEMARA CO-PACK	T4	PA QL(1 tab/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 cap/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
ANTI-NEOPLASTIC LHRH (GNRH) AGONIST, PITUITARY SUPPR.		
leuprolide acetate	T4	PA SP HD
LEUPROLIDE DEPOT	T4	PA SP
LUPRON DEPOT 22.5 MG 3MO KIT	T4	PA SP HD
LUPRON DEPOT 45 MG 6MO KIT	T4	PA SP HD
LUPRON DEPOT 7.5 MG KIT	T4	PA SP HD
LUPRON DEPOT-4 MONTH KIT	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
ANTI-NEOPLASTIC SYSTEMIC ENZYME INHIBITORS		
ALECensa	T4	PA QL(8 tabs/day) SP HD CSL
ALUNBRIG	T4	PA SP HD
AYVAKIT	T4	PA QL (1 tab/day) SP
BALVERSA	T4	PA SP
BOSULIF	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

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List of Prescription Medications

ANTI-NEOPLASTICS (Cancer) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ANTI-NEOPLASTIC SYSTEMIC ENZYME INHIBITORS (cont.)		
BOSULIF 100 MG CAPSULE	T4	PA QL(3 caps/day) SP HD CSL
BOSULIF 50 MG CAPSULE	T4	PA QL SP HD CSL
BRUKINSA	T4	PA QL (4 caps/day) SP
CABOMETYX	T4	PA SP HD
CALQUENCE	T4	PA SP
CAPRELSA	T4	PA SP
COMETRIQ	T4	PA SP HD
COPIKTRA	T4	PA SP
<i>dasatinib 100 mg tablet</i>	T4	PA QL(1 tab/day) SP CSL
<i>dasatinib 140 mg tablet</i>	T4	PA QL(1 tab/day) SP CSL
<i>dasatinib 20 mg tablet</i>	T4	PA QL(3 tabs/day) SP CSL
<i>dasatinib 50 mg tablet</i>	T4	PA QL(1 tab/day) SP CSL
<i>dasatinib 70 mg tablet</i>	T4	PA QL(2 tabs/day) SP CSL
<i>dasatinib 80 mg tablet</i>	T4	PA QL(1 tab/day) SP CSL
DANZTEN	T4	PA SP CSL
<i>erlotinib hcl</i>	T4	PA SP HD CSL
EXKIVITY	T4	PA SP HD
GAVRETO	T4	PA QL(4 caps/day) SP CSL
<i>gefitinib</i>	T4	PA SP HD CSL
GILOTrif	T4	PA SP HD
GLEEVEC (<i>imatinib mesylate</i>)	T4	PA SP HD
IBRANCE 100 MG CAPSULE	T4	PA QL(21 caps/28 days) SP HD CSL
IBRANCE 100 MG TABLET	T4	PA QL(21 tabs/28 days) SP HD CSL
IBRANCE 125 MG CAPSULE	T4	PA QL(21 caps/28 days) SP HD CSL
IBRANCE 125 MG TABLET	T4	PA QL(21 tabs/28 days) SP HD CSL
IBRANCE 75 MG CAPSULE	T4	PA QL(21 caps/28 days) SP HD CSL
IBRANCE 75 MG TABLET	T4	PA QL(21 tabs/28 days) SP HD CSL
<i>imatinib mesylate 100 mg tab (Gleevec)</i>	T4	QL(6 tabs/day) SP HD CSL
<i>imatinib mesylate 400 mg tab (Gleevec)</i>	T4	QL(2 tabs/day) SP HD CSL
<i>imatinib mesylate (Gleevec)</i>	T4	QL(6 tabs/day) SP HD CSL
IMKELDI	T4	PA SP CSL
INLYTA	T4	PA SP HD
INREBIC	T4	PA SP HD
IRESSA	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.)		
ITOVEBI	T4	PA SP HD CSL
IWLFIN	T4	PA QL(8 tabs/day) SP CSL
KISQALI 600mg	T4	PA SP QL(63 tabs/28 days)HD CSL
KISQALI 400mg	T4	PA SP QL(42 tabs/28 days) HD CSL
KISQALI 200mg	T4	PA QL(21 tabs/28 days) SP HD CSL
<i>lapatinib ditosylate</i> (Tykerb)	T4	PA SP HD
LENVIMA	T4	PA SP HD CSL
LORBRENA	T4	PA SP HD
LYNPARZA	T4	PA SP HD
LYTGOBI 12 MG DAILY DOSE (3X 4MG TB)	T4	PA QL(3 tabs/day) SP CSL
LYTGOBI 16 MG DAILY DOSE (4X 4MG TB)	T4	PA QL(4 tabs/day) SP CSL
LYTGOBI 20 MG DAILY DOSE (5X 4MG TB)	T4	PA QL(5 tabs/day) SP CSL
NERLYNX	T4	PA SP HD
NINLARO	T4	PA QL(3 caps/28 days) SP HD CSL
<i>pazopanib hcl</i> (Votrient)	T4	PA QL(4 tabs/day) SP HD CSL
PEMAZYRE	T4	PA QL (14 tabs/21 days) SP
PIQRAY	T4	PA SP HD CSL
OGSIVEO 100 MG TABLET	T4	PA QL SP CSL
OGSIVEO 150 MG TABLET	T4	PA QL SP CSL
OGSIVEO 50 MG TABLET	T4	PA QL(6 tabs/day) SP CSL
OJJAARA	T4	PA QL(1 tab/day) SP CSL
QINLOCK	T4	PA QL (3 tabs/day) SP
SCEMBLIX 20 MG TABLET	T4	PA QL(2 tabs/day) SP HD CSL
SCEMBLIX 40 MG TABLET	T4	PA SP HD CSL
SCEMBLIX 100 MG TABLET	T4	PA SP CSL
TURALIO	T4	PA QL(4 caps/day) SP CSL
TURALIO 125 MG CAPSULE	T4	PA QL(4 caps/day) SP CSL
TURALIO 200 MG CAPSULE	T4	PA SP CSL
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

T1 – Typically Generics

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T4 – Specialty Medications

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AGE – Age Requirement

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List of Prescription Medications

ANTI-NEOPLASTICS (Cancer) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ANTI-NEOPLASTIC SYSTEMIC ENZYME INHIBITORS (cont.)		
ROZLYTREK	T4	PA SP HD
RUBRACA	T4	PA SP
RYDAPT	T4	PA SP HD
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 CSL
TASIGNA	T4	PA SP HD
TEPMETKO	T4	PA QL (2 tabs/day) SP
TRUQAP	T4	PA QL(64 tabs/28 days) SP CSL
TUKYSA	T4	PA SP
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(2 tabs/day) SP HD CSL
VITRAKVI	T4	PA SP HD
VIZIMPRO	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 CAPSULE	T4	PA QL(4 caps/day) SP HD CSL
XALKORI 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
XALKORI	T4	PA SP HD
XOSPATA	T4	PA SP
ZEJULA	T4	PA QL(1 tab/day) SP CSL
ZYDELIG	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

T1 – Typically Generics

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List of Prescription Medications

ANTI-NEOPLASTICS (Cancer) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ANTI-NEOPLASTIC-ISOCITRATE DEHYDROGENASE INHIBITORS		
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
SELECTIVE ESTROGEN RECEPTOR MODULATORS (SERMS)		
FARESTON (<i>toremifene citrate</i>)	T3	QL (2 tabs/day) HD
SOLTAMOX	T2	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>	T3	
ANTI-NEOPLASTICS (Skin Conditions)		
PHOTOACT, TOPICAL ANTI-NEOPLAST, PREMALIGNANT LESIONS		
LEVULAN	T4	SP
TOPICAL ANTI-NEOPLASTIC PREMALIGNANT LESION AGENTS		
EFDUDEX (<i>fluorouracil</i>)	T3	
FLUOROPLEX	T2	
<i>fluorouracil</i>	T1	
<i>fluorouracil</i> (Efudex)	T1	
PANRETIN	T4	SP HD
PICATO	T3	
TARGRETIN 1% GEL	T4	SP HD

T1 – Typically Generics

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T3 – Typically Non-Preferred Brands

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List of Prescription Medications

ANTI-OBESITY DRUGS (Weight Management)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
TOPICAL ANTI-NEOPLASTIC PREMALIGNANT LESION AGENTS (con't.)		
TOLAK	T3	
VALCHLOR	T4	SP HD
ANTI-OBESITY - ANOREXIC AGENTS		
ADIPEX-P (<i>phentermine hcl</i>)	T3	PA
<i>benzphetamine hcl</i>	T1	
<i>benzphetamine hcl</i> (Regimex)	T1	
<i>diethylpropion hcl</i>	T1	
LOMAIRA	T3	
<i>phendimetrazine tartrate</i>	T1	
<i>phentermine hcl</i>	T1	
<i>phentermine hcl</i> (Adipex-p)	T1	
QSYMIA	T3	PA
REGIMEX (<i>benzphetamine hcl</i>)	T3	
VYKAT XR	T4	SP
ANTI-OBESITY - MELANOCORTIN 4 RECEPTOR AGONISTS		
IMCIVREE	T4	PA QL (9 ml/22 days) SP
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 (Eye Conditions)		
OPHTHALMIC (EYE) ANTIPARASITICS		
XDEMVY	T4	PA QL(4 bottles/30 days) SP

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

T4 – Specialty Medications

PA – Prior Authorization

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List of Prescription Medications

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

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

T4 – Specialty Medications

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ST – Step Therapy

AGE – Age Requirement

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List of Prescription Medications

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

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ANTI-PARKINSONISM DRUGS, OTHER (cont.)		
DUOPA	T4	SP HD
<i>entacapone</i>	T1	HD
INBRIJA	T4	PA SP HD
KYNMOBI	T2	PA HD
MIRAPEX ER 0.375 MG TABLET (<i>pramipexole er</i>)	T3	QL (1 tab/day) HD
MIRAPEX ER 0.75 MG TABLET (<i>pramipexole er</i>)	T3	HD
MIRAPEX ER 1.5 MG TABLET (<i>pramipexole er</i>)	T3	QL (1 tab/day) HD
MIRAPEX ER 2.25 MG TABLET (<i>pramipexole er</i>)	T3	QL (1 tab/day) HD
MIRAPEX ER 3 MG TABLET (<i>pramipexole er</i>)	T3	HD
MIRAPEX ER 3.75 MG TABLET (<i>pramipexole er</i>)	T3	HD
NEUPRO	T3	HD
NOURIANZ	T4	PA QL (1 tab/day) SP HD
OSMOLEX ER	T3	QL (1 tab/day) HD
OSMOLEX ER 258 MG TABLET	T3	QL (1 tab/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 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 1.5 mg tablet</i>	T1	QL(1 tab/day) HD
<i>pramipexole er 1.5 mg tablet (Mirapex Er)</i>	T1	QL (1 tab/day) HD
<i>rasagiline mesylate 0.5 mg tab (Azilect)</i>	T1	QL (1 tab/day) HD
RYTARY	T3	HD
<i>selegiline hcl</i>	T1	HD
SINEMET (<i>carbidopa-levodopa</i>)	T3	HD
STALEVO 75 (<i>carbidopa-levodopa-entacapone</i>)	T3	HD
STALEVO 100 (<i>carbidopa-levodopa-entacapone</i>)	T3	HD

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

T4 – Specialty Medications

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AGE – Age Requirement

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List of Prescription Medications

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

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

T1 – Typically Generics

T2 – Typically Preferred Brands

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T4 – Specialty Medications

PA – Prior Authorization

QL – Quantity Limit

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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
ANTI-RETROVIRAL - NUCLEOSIDE, NUCLEOTIDE, PROTEASE INH.		
SYMTUZA	T4	SP
ANTIVIRALS - HIV-SPEC, NON-PEPTIDIC PROTEASE INHIB		
APTIVUS	T4	PA SP
darunavir (Prezista)	T4	SP
darunavir ethanolate (Prezista)	T4	SP
PREZCOBIX	T4	PA SP
PREZISTA 100 MG/ML SUSPENSION	T4	SP
PREZISTA 75 MG, 150 MG TABLET	T4	SP
ANTIVIRALS - HIV-SPEC, NUCLEOSIDE-NUCLEOTIDE ANALOG		
CIMDUO	T4	PA SP
DESCOVY	T4	SP PPACA
emtricitabine-tenofovir 100-150mg	T4	SP
emtricitabine-tenofovir 133-200mg	T4	SP
emtricitabine-tenofovir 167-250mg	T4	SP
emtricitabine-tenofovir 200-300mg	T4	SP PPACA
TEMIXYS	T4	PA SP
ANTIVIRALS - HIV-SPEC, NUCLEOSIDE ANALOG, RTI COMB		
abacavir sulfate/lamivudine	T4	PA SP
abacavir/lamivudine/zidovudine	T4	PA SP
lamivudine/zidovudine	T4	SP
ANTIVIRALS - HIV-SPECIFIC, CCR5 CO-RECEPTOR ANTAG.		
maraviroc (Selzentry)	T4	PA SP
SELZENTRY 20 MG/ML ORAL SOLN	T4	PA SP
SELZENTRY 25 MG TABLET	T4	PA SP
SELZENTRY 75 MG TABLET	T4	PA SP
ANTIVIRALS - HIV-SPECIFIC, CD4 ATTACHMENT INHIBITOR		
RUKOBIA	T4	PA QL (2 syringe/day) SP
ANTIVIRALS - HIV-SPECIFIC, FUSION INHIBITORS		
FUZEON	T4	PA SP
ANTIVIRALS - HIV-SPECIFIC, NON-NUCLEOSIDE, RTI		
EDURANT	T4	PA SP

T1 – Typically Generics

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List of Prescription Medications

ANTIVIRALS (AIDS/HIV) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ANTIVIRALS - HIV-SPECIFIC, NON-NUCLEOSIDE, RTI (cont.)		
efavirenz	T4	PA SP
nevirapine	T4	PA SP
PIFELTRO	T4	PA SP
ANTIVIRALS - HIV-SPECIFIC, NUCLEOSIDE ANALOG, RTI		
abacavir sulfate	T4	PA SP
emtricitabine (Emtriva)	T4	PA SP
EMTRIVA 10 MG/ML SOLUTION	T4	PA SP
lamivudine 10 mg/ml oral soln	T4	SP
lamivudine 150 mg tablet	T4	SP
lamivudine 300 mg tablet	T4	PA SP
zidovudine	T4	SP
tenofovir disoproxil fumarate	T4	PA SP
VIREAD	T4	PA SP
VIREAD POWDER	T4	PA SP
ANTIVIRALS - HIV-SPECIFIC, PROTEASE INHIBITOR COMB		
KALETRA 100-25 MG TABLET	T2	
KALETRA 200-50 MG TABLET	T2	
KALETRA 80-20 MG SOLUTION	T2	
lopinavir/ritonavir	T1	
ANTIVIRALS - HIV-SPECIFIC, PROTEASE INHIBITORS		
atazanavir sulfate	T4	PA SP
EVOTAZ	T4	PA SP
fosamprenavir calcium	T4	PA SP
NORVIR	T4	SP
REYATAZ	T4	PA SP
ritonavir	T4	SP
ANTIVIRALS - HIV-I INTEGRASE STRAND TRANSFER INHIBTR		
APRETUDE	T4	PA SP
ISENTRESS	T4	SP
ISENTRESS HD	T4	PA SP
TIVICAY	T4	SP
TIVICAY PD	T4	SP

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List of Prescription Medications

ANTIVIRALS (AIDS/HIV) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ARTV NUCLEOSIDE, NUCLEOTIDE, NON-NUCLEOSIDE RTI COMB		
COMPLERA	T4	PA SP
DELSTRIGO	T4	PA SP
<i>efavirenz/emtricitabine/tenofovir disop (Symfi)</i>	T4	PA SP
<i>efavirenz/lamivudine/tenofovir disop (Symfi Lo)</i>	T4	SP
<i>efavirenz/lamivudine/tenofovir disop (Symfi)</i>	T4	SP
ODEFSEY	T4	PA SP
ARV-NUCLEOSIDE, NUCLEOTIDE RTI, INTEGRASE INHIBITORS		
BIKTARVY	T4	SP
GENVOYA	T4	SP
STRIKING	T4	PA SP
ANTIVIRALS (Eye Conditions)		
EYE ANTIVIRALS		
<i>trifluridine</i>	T1	
ZIRGAN	T3	
ANTIVIRALS (Infections)		
ANTIVIRALS, GENERAL		
acyclovir	T1	
acyclovir susp	T1	
famciclovir	T1	
FLUMADINE (rimantadine hcl)	T3	
LIVTENCY	T4	PA QL (4 tabs/day) SP
<i>oseltamivir 6 mg/ml suspension (Tamiflu)</i>	T1	QL (180ml/30 days)
<i>oseltamivir phos 30 mg capsule (Tamiflu)</i>	T1	QL (20 caps/30 days)
<i>oseltamivir phos 45 mg capsule (Tamiflu)</i>	T1	QL (10/30 days)
<i>oseltamivir phos 75 mg capsule (Tamiflu)</i>	T1	QL (10/30 days)
PREVYMIS PELLET PACKET	T4	SP
PREVYMIS TABLET	T4	SP HD
RELENZA	T3	QL (20/30 days)
<i>rimantadine hcl (Flumadine)</i>	T1	
TAMIFLU 30 MG CAPSULE (<i>oseltamivir phosphate</i>)	T3	QL (20/30 days)
TAMIFLU 45 MG CAPSULE (<i>oseltamivir phosphate</i>)	T3	QL (10/30 days)
TAMIFLU 6 MG/ML SUSPENSION (<i>oseltamivir phosphate</i>)	T3	QL (180ml/30 days)
TAMIFLU 75 MG CAPSULE (<i>oseltamivir phosphate</i>)	T3	QL (10/30 days)
<i>valganciclovir hcl</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

ANTIVIRALS (Infections) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ANTIVIRALS, GENERAL (cont.)		
VALTREX (<i>valacyclovir</i>)	T3	
XOFLUZA	T3	QL (2 tabs/30 days)
HEP C - NS5A, NS3/4A, NUCLEOTIDE NS5B INHIB COMBO		
VOSEVI	T4	PA SP HD
HEP C VIRUS, NUCLEOTIDE ANALOG NS5B POLYMERASE INH		
SOVALDI 150 MG, 200 MG PELLET PACKET	T4	PA QL (1 tab/day) SP HD
SOVALDI 200 MG, 400 MG TABLET	T4	PA QL (1 tab/day) 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
HEPATITIS B TREATMENT AGENTS		
<i>adefovir dipivoxil</i> (Hepsera)	T4	SP HD
BARACLUDE	T4	SP HD
<i>entecavir</i> 0.5 mg tablet	T4	QL (1 tab/day) SP HD
<i>entecavir</i> 1 mg tablet	T4	SP HD
EPIVIR HBV (<i>lamivudine hbv</i>)	T4	SP
<i>lamivudine</i> (Epivir Hbv)	T4	SP
VEMLIDY	T4	SP HD
HEPATITIS C TREATMENT AGENTS		
PEGASYS	T4	PA SP HD
PEGINTRON	T4	PA SP HD
<i>ribasphere</i> 200 mg capsule	T4	SP HD
<i>ribasphere</i> 200 mg tablet	T4	SP HD
<i>ribasphere</i> 400 mg tablet	T4	SP
<i>ribasphere</i> 600 mg tablet	T4	SP
<i>ribasphere</i> ribapak 200-400 mg	T4	SP HD
<i>ribasphere</i> ribapak 400-400 mg	T4	SP HD
<i>ribasphere</i> ribapak 400-400 mg	T4	SP HD
<i>ribasphere</i> ribapak 600-400 mg	T4	SP HD
<i>ribasphere</i> ribapak 600-400 mg	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

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List of Prescription Medications

ANTIVIRALS (Infections) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
HEPATITIS C TREATMENT AGENTS (cont.)		
ribasphere ribapak 600-600 mg	T4	SP HD
ribasphere ribapak 600-600 mg	T4	SP HD
ribavirin	T4	SP HD
HEPATITIS C VIRUS- NS5A AND NS3/4A INHIBITOR COMB		
ZEPATIER	T4	PA QL(1 tab/day) SP HD
RNA POLYMERASE INHIBITOR		
LAGEVRIO (EUA)	T2	QL(1 pack/120 days)
LAGEVRIO 200 MG CAP (EUA)	T2	QL(1 pack/120 days)
MOLNUPIRAVIR	T3	QL (1 pkg/120 days)
ANTIVIRALS (Skin Conditions)		
TOPICAL GENITAL WART-HPV TREATMENT AGENTS		
VEREGEN	T3	
AUTONOMIC DRUGS (Allergy/Nasal Sprays)		
ANAPHYLAXIS THERAPY AGENTS		
epinephrine	T1	QL (2 packs/30 days)
epinephrine (Epinephrine)	T1	QL (2 packs/30 days)
AUTONOMIC DRUGS (Alzheimer's Disease)		
CHOLINESTERASE INHIBITORS		
ARICEPT (donepezil hcl)	T3	HD
donepezil hcl	T1	HD
donepezil hcl (Aricept)	T1	HD
EXELON (rivastigmine)	T3	HD
galantamine er 16 mg capsule (Razadyne Er)	T1	HD
galantamine er 24 mg capsule (Razadyne Er)	T1	HD
galantamine er 8 mg capsule (Razadyne Er)	T1	QL (1 cap/day) HD
galantamine hbr	T1	HD
MESTINON (pyridostigmine bromide er)	T3	HD
pyridostigmine bromide (Mestinon)	T1	HD
RAZADYNE ER 16 MG CAPSULE (galantamine er)	T3	HD
RAZADYNE ER 24 MG CAPSULE (galantamine er)	T3	HD
RAZADYNE ER 8 MG CAPSULE (galantamine er)	T3	QL (1 cap/day) HD
rivastigmine (Exelon)	T1	HD
rivastigmine tartrate	T1	HD

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

T4 – Specialty Medications

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List of Prescription Medications

AUTONOMIC DRUGS (Attention Deficit Hyperactivity Disorder)⁹

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ADRENERGICS, AROMATIC, NON-CATECHOLAMINE		
ADDERALL (<i>dextroamphetamine-amphetamine</i>)	T3	PA ST
<i>amphetamine sulfate</i> (Evekeo)	T1	PA
<i>dextroamphetamine/amphetamine</i> (Adderall Xr)	T1	PA QL(1 cap/day)
<i>dextroamphetamine/amphetamine</i> (Mydayis)	T1	PA QL(1 cap/day)
<i>dextroamphetamine er</i> 10 mg cap	T1	PA QL (1 cap/day)
<i>dextroamphetamine er</i> 15 mg cap	T1	PA QL (3/day)
<i>dextroamphetamine er</i> 5 mg cap	T1	PA QL (1 cap/day)
<i>dextroamphetamine sulfate</i>	T1	PA
<i>dextroamphetamine sulfate</i>	T3	PA ST
EVEKEO (<i>amphetamine sulfate</i>)	T3	PA ST
<i>lisdexamfetamine capsule</i> (Vyvanse)	T1	PA QL(1 cap/day)
<i>lisdexamfetamine tb chew</i> (Vyvanse)	T1	PA QL(1 tab/day)
<i>methamphetamine hcl</i>	T1	PA
XELTRYM	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
<i>midodrine hcl</i>	T1	

ALPHA-ADRENERGIC BLOCKING AGENTS		
<i>DIBENZYLINE (phenoxybenzamine hcl)</i>	T3	HD
<i>phenoxybenzamine hcl</i> (Dibenzyline)	T1	HD

AUTONOMIC DRUGS (Urinary Tract Conditions)

PARASYMPATHETIC AGENTS		
<i>bethanechol chloride</i>	T1	HD
<i>cevimeline hcl</i> (Evoxac)	T1	HD
<i>guanidine hcl</i>	T1	HD
<i>pilocarpine hcl</i> (Salagen)	T1	HD
SALAGEN (<i>pilocarpine hcl</i>)	T3	HD

BIOLOGICALS (Allergy/Nasal Sprays)

ALLERGENIC EXTRACTS, THERAPEUTIC		
GRASTEK	T3	PA QL (1 tab/day)

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

T4 – Specialty Medications

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List of Prescription Medications

BIOLOGICALS (Allergy/Nasal Sprays) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ALLERGENIC EXTRACTS, THERAPEUTIC (cont.)		
ODACTRA	T3	PA QL (1 tab/day)
ORALAIR	T3	PA QL (1 tab/day)
RAGWITEK	T3	PA QL (1 tab/day)
BIOLOGICALS (Blood Pressure/Heart Medications)		
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 COVID-19 VACCINE	T2	PPACA
JANSSEN COVID-19 VACCINE	T2	PPACA
MODERNA COVID-19 VACCINE	T2	PPACA
NOVAVAX COVID-19 VACCINE	T2	PPACA
PFIZER COVID-19 VACCINE	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	T2	PPACA
PNEUMOVAX 23	T2	PPACA
PREVNAR 13	T2	
PREVNAR 20	T2	

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

T4 – Specialty Medications

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List of Prescription Medications

BIOLOGICALS (Vaccines) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
INFLUENZA VIRUS VACCINES		
AFLURIA	T2	PPACA
AFLURIA QUAD	T2	PPACA
AFLURIA TRIV	T2	PPACA
AFLURIA TRIVALENT	T2	PPACA
EZ FLU	T2	PPACA
FLUAD QUAD	T2	PPACA
FLUAD TRIVALENT	T2	PPACA
FLUARIX QUAD	T2	PPACA
FLUARIX TRIVALENT	T2	PPACA
FLUBLOK	T2	PPACA
FLUBLOK QUAD	T2	PPACA
FLUBLOK TRIVALENT	T2	PPACA
FLUCELVAX QUAD	T2	PPACA
FLUCELVAX TRIVALENT	T2	PPACA
FLULAVAL QUAD	T2	PPACA
FLULAVAL TRIVALENT	T2	PPACA
FLUMIST QUAD	T3	PPACA
FLUMIST TRIVALENT	T3	PPACA
FLUVIRIN	T2	PPACA
FLUZONE	T2	PPACA
FLUZONE HIGH-DOSE	T2	PPACA
FLUZONE HIGH-DOSE TRIV	T2	PPACA
FLUZONE INTRADERM QUAD	T2	PPACA
FLUZONE QUAD	T2	PPACA
FLUZONE QUAD PEDI	T2	PPACA
FLUZONE TRIVALENT	T2	PPACA
TOXIN-PRODUCING BACILLI VACCINES/TOXOIDS		
BCG VACCINE (TICE STRAIN)	T4	SP
VACCINE/TOXOID PREPARATIONS, COMBINATIONS		
ACTHIB	T2	PPACA
ADACEL TDAP	T2	PPACA
BOOSTRIX TDAP	T2	PPACA
DAPTACEL DTAP	T2	PPACA
DIPHTHERIA-TETANUS TOXOIDS-PED	T2	PPACA

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

T4 – Specialty Medications

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List of Prescription Medications

BIOLOGICALS (Vaccines) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
VACCINE/TOXOID PREPARATIONS, COMBINATIONS (cont.)		
ERVEBO (NATIONAL STOCKPILE)	T3	
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
ACAM2000	T3	
ENGERIX-B ADULT	T2	PPACA
ENGERIX-B PEDIATRIC-ADOLESCENT	T2	PPACA
GARDASIL 9	T2	PPACA
HEPLISAV-B	T2	PPACA
IXCHIQ	T3	PPACA
JYNNEOS	T3	
MRESVIA	T3	PPACA
PEDIARIX	T2	PPACA
RECOMBIVAX HB	T2	PPACA
SHINGRIX	T2	QL (2 doses/lifetime) PPACA
TWINRIX	T2	PPACA
VARIVAX VACCINE	T2	PPACA
ZOSTAVAX	T2	PPACA
BLOOD (Blood Modifiers/Bleeding Disorders)		
AGENTS TO TX THROMBOTIC THROMBOCYTOPENIC PURPURA		
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

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List of Prescription Medications

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

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ANTI-FIBRINOLYTIC AGENTS		
AMICAR (<i>aminocaproic acid</i>)	T4	SP HD
<i>aminocaproic acid</i> (Amicar)	T4	SP HD
LYSTEDA (<i>tranexamic acid</i>)	T4	SP
<i>tranexamic acid</i> (Lysteda)	T4	SP
ANTI-HEMOPHILIC FACTORS		
ALTUVIIO	T4	PA SP HD
COMPLEMENT INHIBITORS		
FABHALTA	T4	PA QL(2 caps/day) SP
TAVNEOS	T4	PA QL(6 caps/day) SP
VOYDEYA	T4	PA QL(1 packet/28 days) SP
HEMOPHILIA TREATMENT AGENTS, NON-FACTOR REPLACEMENT		
HEMLIBRA	T4	PA SP HD
SICKLE CELL ANEMIA AGENTS		
DROXIA	T2	
ENDARI	T3	
SIKLOS	T3	PA
TOPICAL HEMOSTATICS		
ASTRINGYN	T3	
AVITENE	T3	
ENDO-AVITENE	T3	
EVICEL	T3	
<i>gelatin sponge, absorb/porcine</i> (Gelfoam)	T1	
GELFOAM (<i>surgifoam</i>)	T3	
GELFOAM COMPRESSED	T3	
MONSEL'S	T3	
RAPLIXA	T3	
RECOTHROM	T3	
SURGIFOAM	T1	
SYRINGE AVITENE	T3	
THROMBI-GEL	T3	
THROMBIN-JMI	T3	
THROMBI-PAD	T3	
ULTRAFOAM	T3	

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

T4 – Specialty Medications

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List of Prescription Medications

BLOOD (Blood Thinners/Anti-Clotting)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
HEMORRHEOLOGIC AGENTS		
pentoxifylline	T1	HD
CARDIAC DRUGS (Blood Pressure/Heart Medications)		
ANTI-ANGINAL, ANTI-ISCHEMIC AGENTS, NON-HEMODYNAMIC		
ranolazine (Ranexa)	T1	QL (4 tabs/day) HD
ANTI-ARRHYTHMICS		
amiodarone hcl	T1	HD
MULTAQ	T2	HD
NORPACE (<i>disopyramide phosphate</i>)	T3	PA HD
NORPACE CR	T3	HD
pacerone 100 mg tablet	T3	PA HD
pacerone 200 mg tablet	T1	HD
pacerone 400 mg tablet	T3	PA HD
propafenone hcl	T1	HD
propafenone hcl (Rythmol Sr)	T1	HD
quinidine gluconate	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 BLOCKING AGENTS		
ADALAT CC (<i>nifedipine er</i>)	T3	HD
amlodipine besylate (Norvasc)	T1	HD
CALAN SR (<i>verapamil er</i>)	T3	HD
CAMZYOS	T3	PA QL (30caps/30days) SP
CARDIZEM LA 180 MG TABLET (<i>matzim la</i>)	T3	HD
CARDIZEM LA 240 MG TABLET (<i>matzim la</i>)	T3	HD
CARDIZEM LA 300 MG TABLET (<i>matzim la</i>)	T3	HD
CARDIZEM LA 360 MG TABLET (<i>matzim la</i>)	T3	HD
CARDIZEM LA 420 MG TABLET (<i>matzim la</i>)	T3	HD
diltiazem 24h er(<i>la</i>) 120 mg tb (Cardizem La)	T1	QL(1 tab/day) HD
diltiazem 24h er(<i>la</i>) 180 mg tb (Cardizem La)	T1	HD
diltiazem 24h er(<i>la</i>) 240 mg tb (Cardizem La)	T1	HD
diltiazem 24h er(<i>la</i>) 300 mg tb (Cardizem La)	T1	HD

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

T4 – Specialty Medications

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List of Prescription Medications

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

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
CALCIUM CHANNEL BLOCKING AGENTS (cont.)		
diltiazem 24h er(la) 360 mg tb (Cardizem La)	T1	HD
diltiazem 24h er(la) 420 mg tb (Cardizem La)	T1	HD
diltiazem hcl	T1	HD
diltiazem hcl (Cardizem La)	T1	HD
diltiazem hcl (Tiazac)	T1	HD
felodipine	T1	HD
isradipine	T1	
KATERZIA	T3	QL (10ml/day) HD
nicardipine hcl	T1	HD
nifedipine	T1	HD
nifedipine (Adalat Cc)	T1	HD
nifedipine (Procardia XI)	T1	HD
nifedipine (Procardia)	T1	HD
nisoldipine er 17 mg tablet (Sular)	T1	HD
nisoldipine er 20 mg tablet	T1	QL (1 tab/day) HD
nisoldipine er 25.5 mg tablet	T1	HD
nisoldipine er 30 mg tablet	T1	HD
nisoldipine er 34 mg tablet (Sular)	T1	HD
nisoldipine er 40 mg tablet	T1	HD
nisoldipine er 8.5 mg tablet (Sular)	T1	HD
NORLIQVA	T2	PA QL(10 mls/day) HD
NYMALIZE	T3	HD
PROCARDIA (nifedipine)	T3	HD
SULAR (nisoldipine)	T3	HD
TIAZAC (tiadylt er)	T3	HD
verapamil hcl	T1	HD
VERELAN (verapamil hcl)	T3	HD
VERELAN (verapamil sr)	T3	HD
VERELAN PM (verapamil er pm)	T3	HD
DIGITALIS GLYCOSIDES		
digoxin	T1	HD
HEART RATE REDUCING, SA SELECTIVE I(F) CURRENT INH.		
CORLANOR 5 MG TABLET (ivabradine hcl)	T2	PA HD

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

T4 – Specialty Medications

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List of Prescription Medications

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

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
HEART RATE REDUCING, SA SELECTIVE I(F) CURRENT INH. (cont.)		
CORLANOR 7.5 MG TABLET (<i>ivabradine hcl</i>)	T2	PA HD
CORLANOR 5 MG/5 ML ORAL SOLN	T4	PA SP HD
<i>ivabradine hcl</i> (Corlanor)	T1	PA.HD
VASODILATORS, CORONARY		
DILATRATE-SR	T3	HD
<i>isosorbide dinitrate</i>	T1	HD
MINITRAN	T1	HD
NITRO-DUR	T3	HD
<i>nitroglycerin 0.3 mg tablet sl (Nitrostat)</i>	T1	HD
<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</i> (Nitro-dur)	T1	HD
<i>nitroglycerin</i> (Nitromist)	T1	HD
NITROLINGUAL (<i>nitroglycerin</i>)	T3	HD
NITROMIST (<i>nitroglycerin</i>)	T3	HD
NITROSTAT (<i>nitroglycerin</i>)	T3	HD

CARDIOVASCULAR (Asthma/COPD/Respiratory)

PULM ANTI-HTN, SOLUBLE GUANYLATE CYCLASE STIMULATOR		
ADEMPAS	T4	PA SP HD
VERQUVO	T3	QL(1 tab/day)

PULM.ANTI-HTN, SEL.C-GMP PHOSPHODIESTERASE T5 INHIB		
<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</i> (Adcirca)	T4	PA SP HD
<i>tadalafil 20 mg tablet (Adcirca)</i>	T4	PA SP HD

PULMONARY ANTI-HTN, ENDOTHELIN RECEPTOR ANTAGONIST		
<i>ambrisentan</i> (Letairis)	T4	PA SP HD
<i>bosentan</i> (Tracleer)	T4	PA SP HD
OPSUMIT	T4	PA SP HD
TRACLEER 125 MG TABLET (<i>bosentan</i>)	T4	PA SP HD
TRACLEER 32 MG TABLET FOR SUSP	T4	PA SP HD
TRACLEER 62.5 MG TABLET (<i>bosentan</i>)	T4	PA SP HD

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

T4 – Specialty Medications

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List of Prescription Medications

CARDIOVASCULAR (Asthma/COPD/Respiratory) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits	
PULMONARY ANTIHYPER AGENT, ACTRIIA-FC			
WINREVAIR	T4	PA SP HD	
PULMONARY ANTIHYPERTENSIVES, PROSTACYCLIN-TYPE			
ORENITRAM ER	T4	PA SP HD	
ORENITRAM MONTH 1 TITRATION KT	T4	PA QL(168 tabs/180 days) SP HD	
ORENITRAM MONTH 2 TITRATION KT	T4	PA QL(336 tabs/180 days) SP HD	
ORENITRAM MONTH 3 TITRATION KT	T4	PA QL(252 tabs/180 days) SP HD	
TYVASO	T4	PA SP HD	
TYVASO DPI	T4	PA SP HD	
TYVASO INSTITUTIONAL START KIT	T4	PA SP HD	
TYVASO REFILL KIT	T4	PA SP HD	
TYVASO STARTER KIT	T4	PA SP HD	
UPTRAVI	T4	PA SP HD	
VENTAVIS	T4	PA SP HD	
PULMONARY ANTIHYPERTENSIVES, PROSTACYCLIN-TYPE			
OPSYNVI	T4	PA QL(1 tab/day) SP HD	
SOLUBLE GUANYLATE CYCLASE (SGC) STIMULATOR			
VERQUVO	T2	PA QL(1 tab/day)	
CARDIOVASCULAR (Blood Pressure/Heart Medications)			
ACE INHIBITOR-CALCIUM CHANNEL BLOCKER COMBINATION			
amlodipine besylate/benazepril	T1	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	
trandolapril/verapamil hcl	T1	HD	
ACE INHIBITOR-THIAZIDE OR THIAZIDE-LIKE DIURETIC			
benazepril/hydrochlorothiazide	T1	HD	
captopril-hctz 25-15 mg tablet	T1	QL (3 tabs/day) HD	
captopril-hctz 25-25 mg tablet	T1	QL (2 tabs/day) HD	
captopril-hctz 50-15 mg tablet	T1	QL (3 tabs/day) HD	
captopril-hctz 50-25 mg tablet	T1	QL (2 tabs/day) HD	
enalapril/hydrochlorothiazide	T1	HD	
fosinopril/hydrochlorothiazide	T1	HD	
lisinopril/hydrochlorothiazide	T1	HD	
quinapril/hydrochlorothiazide	T1	HD	
T1 – Typically Generics	T4 – Specialty Medications	ST – Step Therapy	HD – May require home delivery pharmacy
T2 – Typically Preferred Brands	PA – Prior Authorization	AGE – Age Requirement	PPACA – No Cost-Share Preventive Medication
T3 – Typically Non-Preferred Brands	QL – Quantity Limit	SP – Specialty Medication	CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

CARDIOVASCULAR (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 40 mg capsule (Coreg Cr)	T1	QL (1 cap/day) HD
carvedilol er 80 mg capsule (Coreg Cr)	T1	HD
COREG (carvedilol)	T3	ST HD
COREG CR 10 MG CAPSULE (carvedilol er)	T3	QL (1 cap/day) ST HD
COREG CR 20 MG CAPSULE (carvedilol er)	T3	QL (1 cap/day) ST HD
COREG CR 40 MG CAPSULE (carvedilol er)	T3	QL (1 cap/day) ST HD
COREG CR 80 MG CAPSULE (carvedilol er)	T3	ST HD
labetalol hcl	T1	HD
CARDURA (doxazosin mesylate)	T3	HD
CARDURA XL	T3	HD
MINIPRESS (prazosin hcl)	T3	HD
prazosin hcl	T1	HD
terazosin hcl	T1	HD
ANGIOTEN. RECEPTR ANTAG-CALCIUM CHANL BLKR-THIAZIDE		
amlodipine/valsartan/hcthiazid	T1	HD
olmesartan/amlodipin/hcthiazid	T1	HD
valsartan/hydrochlorothiazide (Diovan Hct)	T1	HD
ANGIOTENSIN RECEPT-NEPRILYSIN INHIBITOR COMB (ARNI)		
ENTRESTO	T2	QL(2 tabs/day)
ANGIOTENSIN RECEPTOR ANTAG.-THIAZIDE DIURETIC COMB		
candesartan/hydrochlorothiazid	T1	HD
irbesartan/hydrochlorothiazide	T1	HD
losartan/hydrochlorothiazide	T1	HD
olmesartan-hctz 20-12.5 mg tab	T1	QL (1 tab/day) HD
olmesartan-hctz 40-12.5 mg tab	T1	HD
olmesartan-hctz 40-25 mg tab	T1	HD
telmisartan-hctz 40-12.5 mg tb	T1	QL (1 tab/day) HD
telmisartan-hctz 80-12.5 mg tb	T1	HD
telmisartan-hctz 80-25 mg tab	T1	HD
valsartan/hydrochlorothiazide	T1	HD
ANGIOTENSIN RECEPTOR BLOCKR-CALCIUM CHANNEL BLOCKR		
amlodipine besylate/valsartan	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
ANGIOTENSIN RECEPTOR BLOCKER-CALCIUM CHANNEL BLOCKER (cont.)		
amlodipine-olmesartan 10-20 mg	T1	HD
amlodipine-olmesartan 10-40 mg	T1	HD
amlodipine-olmesartan 5-20 mg	T1	QL (1 tab/day) HD
amlodipine-olmesartan 5-40 mg	T1	HD
telmisartanamlodipine 40-10	T1	HD
telmisartanamlodipine 40-5 mg	T1	QL (1 tab/day) HD
telmisartanamlodipine 80-10	T1	HD
telmisartanamlodipine 80-5 mg	T1	HD
ANTI-HYPERTENSIVES, ACE INHIBITORS		
benazepril hcl	T1	HD
captopril	T1	HD
enalapril maleate (Vasotec)	T1	HD
EPANED	T3	HD
fosinopril sodium	T1	HD
lisinopril (Zestril)	T1	HD
moexipril hcl	T1	HD
perindopril erbumine	T1	HD
quinapril hcl	T1	HD
ramipril	T1	HD
trandolapril	T1	HD
ANTI-HYPERTENSIVES, ANGIOTENSIN RECEPTOR ANTAGONIST		
candesartan cilexetil	T1	HD
eprosartan mesylate	T1	HD
irbesartan	T1	HD
losartan potassium	T1	HD
olmesartan medoxomil 20 mg tab (Benicar)	T1	QL (1 tab/day) HD
olmesartan medoxomil 40 mg tab (Benicar)	T1	HD
olmesartan medoxomil 5 mg tab (Benicar)	T1	HD
telmisartan 20 mg tablet	T1	QL (1 tab/day) HD
telmisartan 40 mg tablet	T1	QL (1 tab/day) HD
telmisartan 80 mg tablet	T1	HD
valsartan	T1	HD
ANTI-HYPERTENSIVES, GANGLIONIC BLOCKERS		
VECAMYL	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

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

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ANTI-HYPERTENSIVES, MISCELLANEOUS		
DEMSER (<i>metyrosine</i>)	T3	HD
<i>metyrosine</i> (Demser)	T1	HD
ANTI-HYPERTENSIVES, SYMPATHOLYTIC		
CATAPRES-TTS 1 (<i>clonidine</i>)	T3	HD
CATAPRES-TTS 2 (<i>clonidine</i>)	T3	HD
CATAPRES-TTS 3 (<i>clonidine</i>)	T3	HD
<i>clonidine</i> (Catapres-tts 1)	T1	HD
<i>clonidine</i> (Catapres-tts 2)	T1	HD
<i>clonidine</i> (Catapres-tts 3)	T1	HD
<i>guanfacine hcl</i>	T1	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</i> (Tenormin)	T1	HD
<i>betaxolol hcl</i>	T1	HD
<i>bisoprolol fumarate</i>	T1	HD
INNOPRAN XL	T3	ST HD
<i>metoprolol succinate</i> (Toprol XL)	T1	HD
<i>metoprolol tartrate</i>	T1	HD
<i>metoprolol tartrate</i> (Lopressor)	T1	HD
<i>nadolol</i>	T1	HD
<i>pindolol</i>	T1	HD
<i>propranolol hcl</i>	T1	HD
<i>propranolol hcl</i> (Inderal La)	T1	HD
<i>sotalol hcl</i>	T1	HD
<i>sotalol hcl</i> (Betapace Af)	T1	HD
SOTYLIZE	T3	HD
<i>timolol maleate</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 (Blood Pressure/Heart Medications) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
BETA-BLOCKERS AND THIAZIDE, THIAZIDE-LIKE DIURETICS		
atenolol/chlorthalidone (Tenoretic 100)	T1	HD
atenolol/chlorthalidone (Tenoretic 50)	T1	HD
bisoprolol/hydrochlorothiazide (Ziac)	T1	HD
metoprolol/hydrochlorothiazide	T1	HD
nadolol/bendroflumethiazide	T1	HD
propranolol/hydrochlorothiazide	T1	HD
RENIN INHIBITOR, DIRECT		
aliskiren 150 mg tablet	T1	QL (1 tab/day) HD
aliskiren 300 mg tablet	T1	HD
VASODILATORS, COMBINATION		
isosorbide-hydralazine 20-37.5 (Bidil)	T1	QL(6 tabs/day) HD
isosorbide-hydralazine (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/simvastatin	T1	HD
ANTI-HYPERLIPID- HMG-COA RI-CALCIUM CHANNEL BLOCKER		
amlodipine-atorvast 10-40 mg (Caduet)	T1	HD
amlodipine-atorvast 10-80 mg (Caduet)	T1	HD
amlodipine-atorvast 2.5-10 mg	T1	HD
amlodipine-atorvast 2.5-20 mg	T1	QL (1 tab/day) HD
amlodipine-atorvast 2.5-40 mg	T1	QL (1 tab/day) HD
amlodipine-atorvast 5-10 mg (Caduet)	T1	HD
amlodipine-atorvast 5-20 mg (Caduet)	T1	QL (1 tab/day) HD
amlodipine-atorvast 5-40 mg (Caduet)	T1	QL (1 tab/day) HD
amlodipine-atorvast 5-80 mg (Caduet)	T1	HD
CADUET 10 MG-10 MG TABLET (amlodipine-atorvastatin)	T3	HD
CADUET 10 MG-20 MG TABLET (amlodipine-atorvastatin)	T3	HD
CADUET 10 MG-40 MG TABLET (amlodipine-atorvastatin)	T3	HD
CADUET 10 MG-80 MG TABLET (amlodipine-atorvastatin)	T3	HD
CADUET 5 MG-10 MG TABLET (amlodipine-atorvastatin)	T3	HD
CADUET 5 MG-20 MG TABLET (amlodipine-atorvastatin)	T3	QL (1 tab/day) HD

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-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
ANTI-HYPERLIPIDEMIC - APO B-100 SYNTHESIS INHIBITOR		
KYNAMRO	T4	PA SP
ANTIHYPERLIPIDEMIC - APOLIPOPROTEIN INHIBITOR		
TRYNGOLZA	T4	PA QL SP
ANTI-HYPERLIPIDEMIC - PCSK9 INHIBITORS		
REPATHA PUSHTRONEX	T2	PA
REPATHA SURECLICK	T2	PA
ANTI-HYPERLIPIDEMIC-HMGCOA REDUCTASE INHIB (Statins)		
<i>atorvastatin 10 mg tablet</i>	T1	HD PPACA
<i>atorvastatin 20 mg tablet</i>	T1	HD PPACA
<i>atorvastatin 40 mg tablet</i>	T1	HD
<i>atorvastatin 80 mg tablet</i>	T1	HD
<i>fluvastatin sodium</i>	T1	HD PPACA
<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 1 mg tablet</i>	T1	QL(1 tab/day) HD PPACA
<i>pitavastatin 2 mg tablet</i>	T1	QL(1 tab/day) HD PPACA
<i>pitavastatin 4 mg tablet</i>	T1	HD PPACA
<i>pravastatin sodium</i>	T1	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 10 mg tab</i>	T1	QL (1 tab/day) HD PPACA
<i>rosuvastatin calcium 20 mg tab</i>	T1	QL (1 tab/day) HD
<i>rosuvastatin calcium 40 mg tab</i>	T1	HD
<i>rosuvastatin calcium 5 mg tab</i>	T1	QL (1 tab/day) HD PPACA
<i>simvastatin 10 mg tablet</i>	T1	HD PPACA
<i>simvastatin 20 mg tablet</i>	T1	HD PPACA
<i>amlodipine-atorvast 2.5-10 mg</i>	T1	HD
<i>amlodipine-atorvast 2.5-20 mg</i>	T1	QL (1 tab/day) HD
<i>amlodipine-atorvast 2.5-40 mg</i>	T1	QL (1 tab/day) HD
<i>amlodipine-atorvast 5-10 mg (Caduet)</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
ANTI-HYPERLIPIDEMIC-HMGCOA REDUCTASE INHIB (Statins) (cont.)		
amlodipine-atorvast 5-20 mg (Caduet)	T1	QL (1 tab/day) HD
amlodipine-atorvast 5-40 mg (Caduet)	T1	QL (1 tab/day) HD
amlodipine-atorvast 5-80 mg (Caduet)	T1	HD
CADUET 10 MG-10 MG TABLET (amlodipine-atorvastatin)	T3	HD
CADUET 10 MG-20 MG TABLET (amlodipine-atorvastatin)	T3	HD
CADUET 10 MG-40 MG TABLET (amlodipine-atorvastatin)	T3	HD
CADUET 10 MG-80 MG TABLET (amlodipine-atorvastatin)	T3	HD
CADUET 5 MG-10 MG TABLET (amlodipine-atorvastatin)	T3	HD
CADUET 5 MG-20 MG TABLET (amlodipine-atorvastatin)	T3	QL (1 tab/day) HD
CADUET 5 MG-40 MG TABLET (amlodipine-atorvastatin)	T3	QL (1 tab/day) HD
CADUET 5 MG-80 MG TABLET (amlodipine-atorvastatin)	T3	HD
CADUET 10 MG-40 MG TABLET (amlodipine-atorvastatin)	T3	HD
CADUET 10 MG-80 MG TABLET (amlodipine-atorvastatin)	T3	HD
CADUET 5 MG-10 MG TABLET (amlodipine-atorvastatin)	T3	QL (1 tab/day) HD
CADUET 5 MG-40 MG TABLET (amlodipine-atorvastatin)	T3	QL (1 tab/day) HD
CADUET 5 MG-80 MG TABLET (amlodipine-atorvastatin)	T3	HD
simvastatin 40 mg tablet	T1	HD PPACA
simvastatin 5 mg tablet	T1	HD
simvastatin 80 mg tablet	T1	QL (1 tab/day) HD
BILE SALT SEQUESTRANTS		
cholestyramine (with sugar) (Questran)	T1	HD
cholestyramine/aspartame	T1	HD
cholestyramine/aspartame (Questran Light)	T1	HD
colesevelam hcl (Welchol)	T1	HD
COLESTID (colestipol hcl)	T3	HD
colestipol hcl (T1	HD
QUESTRAN (cholestyramine)	T3	HD
QUESTRAN LIGHT (prevalite)	T3	HD
LIPOTROPICS		
ezetimibe (Zetia)	T1	HD
ezetimibe (Zetia)	T1	HD
fenofibrate 40 mg, 120 mg tablet (Fenoglide)	T1	HD
fenofibrate	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>fenofibrate nanocrystallized</i> (Tricor)	T1	HD
<i>fenofibrate, micronized</i>	T1	HD
<i>fenofibric acid (choline)</i> (Trilipix)	T1	HD
<i>fenofibric acid</i> (Fibrincor)	T1	HD
FIBRICOR (<i>fenofibric acid</i>)	T3	ST HD
<i>gemfibrozil</i> (Lopid)	T1	HD
LIPOFEN	T3	ST HD
LOPID (<i>gemfibrozil</i>)	T3	HD
<i>niacin</i> (Niaspan)	T1	HD
NIASPAN (<i>niacin er</i>)	T3	HD
TRICOR (<i>fenofibrate</i>)	T3	ST HD
TRIGLIDE	T3	ST HD
TRILIPIX (<i>fenofibric acid</i>)	T3	ST HD

CNS DRUGS (Alzheimer's Disease)

ALZHEIMER'S THERAPY, NMDA RECEPTOR ANTAGONISTS		
<i>memantine hcl</i>	T1	HD
<i>memantine hcl er 14 mg capsule</i> (Namenda Xr)	T1	QL (1 cap/day) HD
<i>memantine hcl er 28 mg capsule</i> (Namenda Xr)	T1	HD
NAMENDA	T3	HD
NAMENDA XR 14 MG CAPSULE (<i>memantine hcl er</i>)	T3	QL (1 cap/day) HD
NAMENDA XR 28 MG CAPSULE (<i>memantine hcl er</i>)	T3	HD
NAMENDA XR 7 MG CAPSULE (<i>memantine hcl er</i>)	T3	QL (1 cap/day) HD
NAMENDA XR TITRATION PACK	T3	QL (112/365 days) HD

ALZHEIMER'S THX, NMDA RECEPTOR ANTAG-CHOLINES INHIB

NAMZARIC 14 MG-10 MG CAPSULE	T3	QL (2 caps/day) HD
NAMZARIC 21 MG-10 MG CAPSULE	T3	QL (2 caps/day) HD
NAMZARIC 28 MG-10 MG CAPSULE	T3	QL (2 caps/day) HD
NAMZARIC 7 MG-10 MG CAPSULE	T3	QL (2 caps/day) HD
NAMZARIC TITRATION PACK	T3	QL (112/365 days) HD

CNS DRUGS (Miscellaneous)

AMYOTROPHIC LATERAL SCLEROSIS AGENTS		
RILUTEK (<i>riluzole</i>)	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

CNS DRUGS (Miscellaneous) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
AMYOTROPHIC LATERAL SCLEROSIS AGENTS (cont.)		
RADICAVA ORS	T4	PA QL (50ml/28days) SP
riluzole (Rilutek)	T4	SP HD
TIGLUTIK	T4	PA SP
DRUGS TO TREAT MOVEMENT DISORDERS		
AUSTEDO	T4	PA SP HD
AUSTEDO XR 6MG	T4	PA QL(3 tabs/day) SP HD
AUSTEDO XR 12MG	T4	PA QL(1 tab/day) SP HD
AUSTEDO XR 18MG	T4	PA QL(1 tab/day) SP HD
AUSTEDO XR 24MG	T4	PA QL(2 tabs/day) SP HD
AUSTEDO XR 48 MG TABLET	T4	PA QL SP HD
AUSTEDO XR TITRATION KT(WK1-4)	T4	PA QL(1 kit/180 days) SP HD
INGREZZA INITIATION PK(TARDIV)	T4	PA QL(28 caps/365 days) SP
INGREZZA	T4	PA QL(1 cap/day) SP
tetrabenazine	T4	PA SP HD
PSEUDOBULBAR AFFECT (PBA) AGENTS, NMDA ANTAGONISTS		
NUEDEXTA	T3	QL (4 caps/day)
XANTHINES		
caffeine citrate	T1	HD
CNS DRUGS (Multiple Sclerosis)		
AGENTS TO TREAT MULTIPLE SCLEROSIS		
AVONEX	T4	PA SP HD
AVONEX PEN	T4	PA SP HD
BAFIERTAM	T4	PA SP HD
BETASERON	T4	PA SP HD
dimethyl fumarate	T1	HD
glatiramer	T1	HD
glatiramer acetate	T4	PA SP HD
glatopa	T1	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
REBIF	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.)		
REBIF REBIDOSE	T4	PA SP HD
teriflunomide (Aubagio)	T4	SP HD
VUMERTY	T4	PA SP HD
AGTS TX NEUROMUSC TRANSMISSION DIS, POT-CHAN BLKR		
dalfampridine	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
SPHINGOSINE I-PHOSPHATE (SIP) RECEPTOR MODULATOR		
VELSIPITY	T4	PA QL(30 tabs/30 days) SP HD
SPHINGOSINE I-PHOSPHATE (SIP) RECEPTOR MODULATOR		
ZEPOSIA	T4	PA SP HD
POSTHERPETIC NEURALGIA AGENTS		
gabapentin (Gralise)	T1	

CNS DRUGS (Seizure Disorders)

ANTI-CONVULSANT - BENZODIAZEPINE TYPE		
clobazam (Onfi)	T1	HD
clonazepam (Klonopin)	T1	HD
DIASTAT (diazepam)	T3	PA HD
diazepam 10 mg rectal gel syst	T1	HD
diazepam 2.5 mg rectal gel sys (Diastat)	T1	HD
diazepam 20 mg rectal gel syst	T1	HD
KLONOPIN (clonazepam)	T3	PA HD
LIBERVANT	T3	QL(10 films/30 days) HD
NAYZILAM	T2	PA QL (5 kits/30 days) HD
ONFI (clobazam)	T3	PA HD
VALTOCO	T3	PA QL (10 packs/22 days) HD
ANTI-CONVULSANT - CANNABINOID TYPE		
EPIDIOLEX	T3	PA SP HD
ANTI-CONVULSANTS		
APTIOM 200 MG, 400 MG TABLET	T3	PA QL (1 tab/day) HD
APTIOM 600 MG, 800 MG TABLET	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.)		
BANZEL 200 MG TABLET	T3	PA QL (16 tabs/day) HD
BANZEL 400 MG TABLET	T3	PA QL (8 tabs/day) HD
BRIVIACT	T3	PA HD
<i>carbamazepine</i>	T1	HD
CARBAMAZEPINE 200 MG TAB CHEW	T3	HD
<i>carbamazepine</i> (Carbatrol)	T1	HD
<i>carbamazepine</i> (Tegretol Xr)	T1	HD
<i>carbamazepine</i> (Tegretol)	T1	HD
CARBATROL (<i>carbamazepine er</i>)	T3	PA HD
CELONTIN	T2	HD
DIACOMIT	T4	PA SP HD
DILANTIN 100 MG CAPSULE (<i>phenytoin sodium extended</i>)	T3	PA HD
DILANTIN 30 MG CAPSULE	T2	PA HD
DILANTIN 50 MG INFATAB (<i>phenytoin</i>)	T3	PA HD
DILANTIN-125 (<i>phenytoin</i>)	T3	PA HD
<i>divalproex sodium</i> (Depakote Er)	T1	HD
<i>divalproex sodium</i> (Depakote Sprinkle)	T1	HD
<i>divalproex sodium</i> (Depakote)	T1	HD
<i>ethosuximide</i> (Zarontin)	T1	HD
<i>eslicarbazepine</i> 200 mg, 400 mg tablet	T1	PA QL HD
<i>eslicarbazepine</i> 600 mg, 800 mg tablet	T1	PA HD
<i>felbamate</i>	T1	HD
FINTEPLA	T3	PA SP HD
FYCOMPA 0.5 MG/ML ORAL SUSP	T2	PA HD
FYCOMPA 10 MG, 12 MG, 2 MG, 4MG TABLET	T2	PA HD
FYCOMPA 6 MG TABLET	T2	PA QL (1 tab/day) HD
FYCOMPA 8 MG TABLET	T2	PA HD
<i>gabapentin</i>	T1	HD
<i>gabapentin</i> (Neurontin)	T1	HD
<i>lamotrigine</i>	T1	HD
LYRICA (<i>pregabalin</i>)	T3	PA HD
NEURONTIN (<i>gabapentin</i>)	T3	PA HD
<i>oxcarbazepine</i> (Oxtellar Xr)	T1	PA HD
OXTELLAR XR	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.)		
PEGANONE	T2	HD
PHENYTEK (phenytoin sodium extended)	T3	PA HD
<i>phenytoin</i> (Dilantin)	T1	HD
<i>phenytoin</i> (Dilantin-125)	T1	HD
<i>phenytoin sodium extended</i> (Dilantin)	T1	HD
<i>phenytoin sodium extended</i> (Phenytek)	T1	HD
<i>pregabalin</i>	T1	HD
<i>pregabalin</i> (Lyrica)	T1	HD
<i>primidone</i>	T1	HD
<i>primidone 250 mg tablet</i> (Mysoline)	T1	HD
<i>primidone 50 mg tablet</i> (Mysoline)	T1	HD
<i>rufinamide</i> (Banzel)	T1	PA QL (80ml/day) HD
<i>rufinamide 200 mg tablet</i> (Banzel)	T1	PA QL(16 tabs/day) HD
<i>rufinamide 400 mg tablet</i> (Banzel)	T1	PA QL(8 tabs/day) HD
SPRITAM	T3	PA HD
TEGRETOL (carbamazepine)	T3	PA HD
TEGRETOL (epitol)	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 tablet</i>	T1	HD
<i>tiagabine hcl 4 mg tablet</i>	T1	HD
<i>topiramate</i> (Qudexy Xr)	T1	HD
<i>topiramate er 200 mg capsule</i> (Trokendi Xr)	T1	HD
<i>topiramate er 100 mg capsule</i> (Trokendi Xr)	T1	QL(1 cap/day) HD
<i>topiramate er 50 mg capsule</i> (Trokendi Xr)	T1	HD
<i>topiramate er 25 mg capsule</i> (Trokendi Xr)	T1	QL(1 cap/day) HD
<i>valproic acid</i>	T1	HD
<i>valproic acid</i> (as sodium salt)	T1	HD
<i>vigabatrin</i>	T4	SP HD
VIMPAT	T2	PA HD
XCOPRI 25 MG TABLET	T3	PA QL 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

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.)		
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, 300 MG DAILY DOSE PACK	T3	PA QL (1/28 Days) HD
XCOPRI 50 MG TABLET	T3	PA QL (1/Day) HD
XCOPRI 50-100 MG TITRATION PAK	T3	PA QL (1/28 Days) HD
ZARONTIN (ethosuximide)	T3	PA HD
zonisamide	T1	HD

CNS DRUGS (Sleep Disorders/Sedatives)

NARCOLEPSY TX-H3-RECEPT.ANTAGONIST/INVERSE AGONIST		
WAKIX	T4	PA QL (2 tabs/day) SP HD

COLONY STIMULATING FACTORS (Blood Modifiers/Bleeding Disorders)

ERYTHROPOIESIS-STIMULATING AGENTS		
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	SP HD
NYPOZI	T4	PA SP
NYVEPRIA	T4	PA SP
STIMUFEND	T4	PA SP
UDENYCA	T4	PA SP
UDENYCA AUTOINJECTOR	T4	PA SP
ZARXIO	T4	SP HD
ZIEXTENZO	T4	PA SP

THROMBOPOIETIN RECEPTOR AGONISTS		
DOPTELET	T4	PA SP HD
MULPLETA	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

COLONY STIMULATING FACTORS (Blood Modifiers/Bleeding Disorders) (con't.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
THROMBOPOIETIN RECEPTOR AGONISTS		
PROMACTA	T4	PA SP HD
COLONY STIMULATING FACTORS (Cancer)		
CXCR4 CHEMOKINE RECEPTOR ANTAGONIST		
XOLREMDI	T4	PA QL(4 caps/day) SP CSL
CONTRACEPTIVES (Contraception Products)		
CONTRACEPTIVES, INTRAVAGINAL, SYSTEMIC		
etonogestrel/ethynodiol (Nuvaring)	T1	PPACA
NUVARING (etonogestrel-ethynodiol)	T3	
CONTRACEPTIVES, IMPLANTABLE		
NEXPLANON	T4	SP PPACA
CONTRACEPTIVES, INJECTABLE		
DEPO-PROVERA (<i>medroxyprogesterone acetate</i>)	T3	
DEPO-PROVERA 150 MG/ML SYRINGE (<i>medroxyprogesterone acetate</i>)	T3	
DEPO-PROVERA 150 MG/ML VIAL (<i>medroxyprogesterone acetate</i>)	T3	
DEPO-SUBQ PROVERA 104	T2	
CONTRACEPTIVES, ORAL		
desog-e.estradol/e.estradol	T1	HD PPACA
desogestrel-ethynodiol estradiol	T1	HD PPACA
drospirenone/eth estra/levomefet ca (Beyaz)	T1	HD PPACA
drospirenone/eth estra/levomefet ca (Safyral)	T1	HD PPACA
ELLA	T3	HD PPACA
ESTROSTEP FE (<i>tri-legest fe</i>)	T3	HD
ethynodiol d-ethynodiol estradiol	T1	HD PPACA
ethynodiol d-ethynodiol estradiol (Yaz)	T1	HD PPACA
GENERESSE FE (<i>norethindrone ac/eth estradiol fum</i>)	T3	HD
levonorgestrel/ethinodiol estradiol	T1	HD PPACA
levonorgestrel/eth.estradiol/iron (Balcoltra)	T1	HD PPACA
l-norgestrel/eth.estradiol-e.estrad	T1	HD PPACA
l-norgestrel/eth.estradiol-e.estrad (Quartette)	T1	HD PPACA
LOESTRIN (<i>norethindrone ac/eth estradiol</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

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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 (cont.)		
LOESTRIN FE (tarina fe 1-20 eq)	T3	HD
LOSEASONIQUE (lojaimies)	T3	HD
MICROGESTIN 24 FF (tarina 24 fe)	T3	HD
noreth-ethinyl estradiol/iron	T1	HD PPACA
noreth-ethinyl estradiol/iron (Generess Fe)	T1	HD PPACA
noreth-ethinyl estradiol/iron (Generess Fe)	T3	HD PPACA
norethind-eth estrad 1-0.02 mg (Loestrin)	T1	HD PPACA
norethindrone (Ortho Micronor)	T1	HD PPACA
norethindrone ac/eth estradiol (Loestrin)	T1	HD PPACA
norethindrone-e.estriadiol-iron	T1	HD PPACA
norethindrone-e.estriadiol-iron (Estrostep Fe)	T1	HD PPACA
norethindrone-e.estriadiol-iron (Loestrin Fe)	T1	HD PPACA
norethindrone-e.estriadiol-iron (Microgestin 24 Fe)	T1	HD PPACA
norethindrone-e.estriadiol-iron (Minastrin 24 Fe)	T1	HD PPACA
norethindrone-ethin. estradiol	T1	HD PPACA
norethin-ee 1.5-0.03 mg(21) tb (Loestrin)	T1	HD PPACA
norgestrel-ethinyl estradiol	T1	HD PPACA
ORTHO MICRONOR (tulana)	T3	HD
QUARTETTE (rivelsa)	T3	HD
CONTRACEPTIVES, TRANSDERMAL		
norelgestromin/ethin.estriadiol	T1	HD PPACA
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

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

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List of Prescription Medications

COUGH/COLD PREPARATIONS (Allergy/Nasal Sprays)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
1ST GEN ANTIHIST-DECONGEST-ANTICHOLINERGIC COMB		
RESPA A.R.	T3	
COUGH/COLD PREPARATIONS (Cough/Cold Medications)		
ANTI-TUSSIVES, NON-OPIOID		
benzonatate	T1	
benzonatate (Tessalon Perle)	T1	
TESSALON PERLE (benzonatate)	T3	
NON-OPIOID ANTI-TUS-1ST GEN. ANTIHISTAMINE-DECONGEST		
brompheniramine/pseudoephed/dm (Bromfed Dm)	T1	
NON-OPIOID ANTI-TUSSIVE-1ST GEN ANTIHISTAMINE COMB.		
promethazine/dextromethorphan	T1	
OPIOID ANTI-TUSSIV-1ST GEN. ANTIHISTAMINE-DECONGEST		
hydrocodone/cpm/pseudoephed	T1	PA
promethazine/phenyleph/codeine	T1	PA QL (480ml/22 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)
TUXARIN ER	T3	PA QL (2 tabs/day)
TUZISTRA XR	T3	PA QL (960ml/30 days)
OPIOID ANTI-TUSSIVE-ANTI-CHOLINERGIC COMBINATIONS		
HYCODAN (hydromet)	T3	PA QL (480ml/22 days)
hydrocodone bit/homatrop me-br (Hycodan)	T1	PA QL (480ml/22 days)
hydrocodone-homatropine 5-1.5	T1	PA QL (180 tabs/30 days)
hydrocodone-homatropine soln (Hycodan)	T1	PA QL (480ml/30 days)
HYDROCODONE-HOMATROPINE SYRUP	T1	PA QL (480ml/30 days)
OPIOID ANTI-TUSSIVE-EXPECTORANT COMBINATION		
HYDROCODONE-GUAIFENESIN	T1	PA QL (960ml/30 days)
OBREDON	T3	PA QL (960ml/30 days)
DIAGNOSTIC (Miscellaneous)		
DIAGNOSTIC PREPARATIONS, MISCELLANEOUS		
ADVANCED DNA MEDICATED COLLECT	T3	
ARIDOL	T3	
lidocaine hcl/glycerin (Advanced Dna Medicated Collect)	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

DIAGNOSTIC (Miscellaneous) (cont.)

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

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

T4 – Specialty Medications

PA – Prior Authorization

QL – Quantity Limit

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SP – Specialty Medication

HD – May require home delivery pharmacy

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List of Prescription Medications

DIURETICS (Diuretics)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ARGININE VASOPRESSIN (AVP) RECEPTOR ANTAGONISTS		
TOLVAPTAN 15 MG TABLET	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
<i>furosemide</i>	T1	HD
<i>torsemide</i>	T1	HD
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 60 MG-30 MG TABLET	T4	PA SP
JYNARQUE 90 MG-30 MG TABLET	T4	PA SP
POTASSIUM SPARING DIURETICS		
<i>amiloride hcl</i>	T1	HD
CAROSPIR (<i>spironolactone</i>)	T2	PA HD
<i>eplerenone (Inspira)</i>	T1	HD
INSPRA (<i>eplerenone</i>)	T3	HD
KERENDIA	T2	PA QL (1 tab/day)
<i>spironolactone</i>	T1	HD
<i>spironolact/hydrochlorothiazid</i>	T1	HD
<i>triamterene (Dyrenium)</i>	T1	HD
POTASSIUM SPARING DIURETICS IN COMBINATION		
ALDACTAZIDE	T3	HD
<i>amiloride/hydrochlorothiazide</i>	T1	HD
DYAZIDE (<i>triamterene-hydrochlorothiazid</i>)	T3	HD
<i>spironolact/hydrochlorothiazid (Aldactazide)</i>	T1	HD
<i>triamterene/hydrochlorothiazid (Dyazide)</i>	T1	HD
THIAZIDE AND RELATED DIURETICS		
<i>chlorthalidone</i>	T1	HD
DIURIL	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

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List of Prescription Medications

DIURETICS (Diuretics) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
THIAZIDE AND RELATED DIURETICS (cont.)		
HEMICLOR	T3	HD
<i>hydrochlorothiazide</i>	T1	HD
<i>indapamide</i>	T1	HD
<i>metolazone</i>	T1	HD

EENT PREPS (Allergy/Nasal Sprays)

NASAL ANTIHISTAMINE		
<i>azelastine 0.1% (137 mcg) spry</i>	T1	HD
<i>azelastine 0.15% nasal spray</i>	T1	HD
<i>olopatadine 665 mcg nasal spry (Patanase)</i>	T1	HD
PATANASE (<i>olopatadine hcl</i>)	T3	HD

NASAL ANTIHISTAMINE AND ANTI-INFLAM. STEROID COMB.

<i>azelastine/fluticasone</i>	T1	HD
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NASAL ANTI-INFLAMMATORY STEROIDS

<i>flunisolide</i>	T1	HD
<i>fluticasone prop 50 mcg spray</i>	T1	HD
<i>mometasone furoate 50 mcg spry</i>	T1	QL (4 bots/30 days) HD

NOSE PREPARATIONS, MISCELLANEOUS (RX)

<i>ipratropium bromide</i>	T1	HD
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NOSE PREPARATIONS, VASOCONSTRICATORS (RX)

ADRENALIN CHLORIDE	T3	
<i>epinephrine hcl</i> (Adrenalin Chloride)	T1	

EENT PREPS (Ear Medications)

EAR PREPARATIONS ANTI-INFLAMMATORY		
<i>DERMOTIC (fluocinolone acetonide oil)</i>	T3	
<i>fluocinolone acetonide oil (Dermotic)</i>	T1	

EAR PREPARATIONS, MISC. ANTI-INFECTIVES

<i>hydrocortisone/acetic acid</i>	T1	
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EENT PREPS (Eye Conditions)

ARTIFICIAL TEARS		
LACRISERT	T3	
EYE ANTI-INFECTIVES (RX ONLY)		
BETADINE	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

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List of Prescription Medications

EENT PREPS (Eye Conditions) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
EYE ANTI-INFLAMMATORY AGENTS (cont.)		
ACULAR (<i>ketorolac tromethamine</i>)	T3	
ACULAR LS (<i>ketorolac tromethamine</i>)	T3	
<i>bromfenac sodium</i>	T1	
<i>bromfenac sodium (Bromsite)</i>	T1	
BROMSITE .075%	T2	
<i>dexamethasone sodium phosphate</i>	T1	
<i>diclofenac 0.1% eye drops</i>	T1	
EYSUVIS	T2	QL (8.3ml/14 days)
<i>fluorometholone (FmL)</i>	T1	
<i>flurbiprofen sodium</i>	T1	
ILEVRO	T3	
<i>kotorolac 0.4% ophth solution (Acular Ls)</i>	T1	
<i>kotorolac 0.5% ophth solution (Acular)</i>	T1	
<i>Ioteprednol etabonate (Alrex)</i>	T1	
<i>Ioteprednol etabonate (Lotemax)</i>	T1	
MIEBO	T2	QL(4 bottles/30 days)
OMNIPRED (<i>prednisolone acetate</i>)	T3	
<i>prednisolone acetate (Pred Forte)</i>	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 (Altafluor Benox)</i>	T1	
<i>benoxinate hcl/fluorescein sod (Altafluor Benox)</i>	T3	
<i>proparacaine hcl (Alcaine)</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

EENT PREPS (Eye Conditions) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
EYE LOCAL ANESTHETICS (cont.)		
<i>proparacaine/fluorescein sod</i>	T1	
<i>proparacaine/fluorescein sod</i>	T3	
<i>tetracaine hcl</i>	T1	
TETRAVISC	T3	
TETRAVISC FORTE	T3	
EYE MAST CELL STABILIZERS		
<i>cromolyn 4% eye drops</i>	T1	
EYE PREPARATIONS, MISCELLANEOUS (OTC)		
GELFILM	T3	
EYE VASOCONSTRICATORS		
<i>phenylephrine hcl</i>	T1	
MIOTICS AND OTHER INTRAOCULAR PRESSURE REDUCERS		
<i>apraclonidine hcl (Iopidine)</i>	T1	HD
<i>betaxolol hcl</i>	T1	HD
BETIMOL	T3	HD
BETOPTIC S	T2	HD
BETOPTIC S 0.25% DROPS	T2	HD
<i>bimatoprost</i>	T1	QL (10 gm/30 days) HD
<i>bimatoprost 0.03% eye drops</i>	T1	QL(10 mls/30 days) HD
<i>brimonidine tartrate</i>	T1	HD
<i>brimonidine tartrate (Alphagan P)</i>	T1	HD
<i>brimonidine tartrate/timolol (Combigan)</i>	T1	HD
<i>brinzolamide (Azopt)</i>	T1	HD
<i>carteolol hcl</i>	T1	HD
COMBIGAN	T2	HD
<i>dorzolamide hcl (Trusopt)</i>	T1	HD
<i>dorzolamide hcl/timolol maleat (Cosopt)</i>	T1	HD
<i>dorzolamide/timolol/pf (Cosopt Pf)</i>	T1	HD
IOPIDINE	T3	HD
ISOPTO CARPINE (<i>pilocarpine hcl</i>)	T3	HD
<i>latanoprost</i>	T1	HD
<i>levobunolol hcl</i>	T1	HD
PHOSPHOLINE IODIDE	T3	HD
<i>pilocarpine hcl (Isopto Carpine)</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

EENT PREPS (Eye Conditions) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
MIOTICS AND OTHER INTRAOCULAR PRESSURE REDUCERS (cont.)		
RHOPRESSA	T3	
ROCKLATAN	T3	
SIMBRINZA	T2	HD
<i>timolol maleate</i>	T1	HD
<i>timolol maleate</i> (Timoptic)	T1	HD
<i>timolol maleate/pf</i> (Timoptic Ocudose)	T1	HD
<i>travoprost</i>	T1	HD
TRUSOPT (dorzolamide hcl)	T3	HD
MYDRIATICS		
<i>atropine sulfate</i>	T1	HD
<i>atropine sulfate</i> (Isotopto Atropine)	T1	HD
CYCLOGYL	T3	HD
CYCLOGYL (<i>cyclopentolate hcl</i>)	T3	HD
CYCLOMYDRIL	T3	HD
<i>cyclopentolate hcl</i> (Cyclogyl)	T1	HD
<i>homatropine hbr</i>	T1	HD
MYDRIACYL (<i>tropicamide</i>)	T3	HD
PAREMYD	T3	HD
<i>tropicamide</i>	T1	HD
<i>tropicamide</i> (Mydriacyl)	T1	HD
OPHTHALMIC ANTI-FIBROTIC AGENTS		
MITOSOL	T3	
OPHTHALMIC ANTI-INFLAMMATORY IMMUNOMODULATOR-TYPE		
CEQUA	T2	
RESTASIS	T2	HD
VEVYE	T3	QL 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

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

T4 – Specialty Medications

PA – Prior Authorization

QL – Quantity Limit

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HD – May require home delivery pharmacy

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List of Prescription Medications

ELECT/CALORIC/H2O (Cholesterol Medications)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ORAL LIPID SUPPLEMENTS		
DOJOLVI	T4	PA SP HD
ELECT/CALORIC/H2O (Dental Products)		
FLUORIDE PREPARATIONS		
FLUORIDEX	T1	
FLUORIDEX SENSITIVITY RELIEF	T3	
FRAICHE 5000 PREVI	T3	
PREVENTID	T3	
PREVENTID (<i>sodium fluoride</i>)	T3	
PREVENTID 5000 ENAMEL PROTECT	T3	
PREVENTID 5000 ORTHO DEFENSE	T3	
PREVENTID 5000 PLUS (<i>sodium fluoride 5000 plus</i>)	T3	
PREVENTID 5000 SENSITIVE	T3	
PREVENTID KIDS	T3	
<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>	T1	QL (2 pens/30 days)
GLUCAGON 1 MG EMERGENCY KIT	T3	QL (2 pens/30 days)
PROGLYCEM (<i>diazoxide</i>)	T3	
BAQSIMI	T2	QL (2/30 days)
<i>diazoxide</i> (Proglycem)	T1	
<i>glucagon 1 mg emergency kit</i>	T1	QL (2 pens/30 days)
GLUCAGON 1 MG EMERGENCY KIT	T3	QL (2 pens/30 days)
PROGLYCEM (<i>diazoxide</i>)	T3	
BAQSIMI	T2	QL (2/30 days)
<i>diazoxide</i> (Proglycem)	T1	
<i>glucagon 1 mg emergency kit</i>	T1	QL (2 pens/30 days)
GLUCAGON 1 MG EMERGENCY KIT	T3	QL (2 pens/30 days)
PROGLYCEM (<i>diazoxide</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 (Diabetes) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
AGENTS TO TREAT HYPOGLYCEMIA (HYPERGLYCEMICS) (cont.)		
BAQSIMI	T2	QL (2/30 days)
<i>diazoxide</i> (Proglycem)	T1	
<i>glucagon 1 mg emergency kit</i>	T1	QL (2 pens/30 days)
GLUCAGON 1 MG EMERGENCY KIT	T3	QL (2 pens/30 days)
PROGLYCEM (<i>diazoxide</i>)	T3	
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	
<i>lanthanum carbonate</i> (Fosrenol)	T1	
LOKELMA	T2	
PHOSLYRA	T3	
<i>sevelamer carbonate</i> (Renvela)	T1	
<i>sevelamer hcl</i>	T1	
<i>sevelamer hcl</i> (Renagel)	T1	
<i>sodium polystyrene sulfon/sorb</i>	T1	
<i>sodium polystyrene sulfonate</i>	T1	
<i>sps 15 gm/60 ml suspension</i>	T1	
<i>sps 30 gm/120 ml enema susp</i>	T3	
VELPHORO	T2	
VELTASSA	T2	
PHOSLYRA	T3	
<i>sevelamer carbonate</i> (Renvela)	T1	
<i>sevelamer hcl</i>	T1	
<i>sevelamer hcl</i> (Renagel)	T1	
<i>sodium polystyrene sulfon/sorb</i>	T1	
<i>sodium polystyrene sulfonate</i>	T1	
<i>sps 15 gm/60 ml suspension</i>	T1	
<i>sps 30 gm/120 ml enema susp</i>	T3	

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.)			
VELPHORO	T2		
VELTASSA	T2		
IODINE CONTAINING AGENTS			
potassium iodide/iodine	T1		
SSKI	T1		
IRON REPLACEMENT			
mv-mins no.73/iron fum/folic (Hemocyte Plus)	T1		
CITRANATAL BLOOM	T3		
POTASSIUM REPLACEMENT			
EFFER-K 10 MEQ TABLET EFF	T3		
EFFER-K 20 MEQ TABLET EFF	T3		
effer-k 25 meq tablet eff	T1		
klor-con 10 meq tablet (K-tab Er)	T1		
klor-con 10 meq tablet (K-tab Er)	T3		
klor-con 8 meq tablet	T1		
klor-con 8 meq tablet	T3		
K-TAB ER (potassium chloride)	T3		
potassium bicarbonate/cit ac	T1		
potassium chloride	T1		
potassium cl 10% (20 meq/15ml)	T1		
potassium cl 10% (40 meq/30ml)	T1		
potassium cl 20 meq packet	T1		
potassium cl 20% (40 meq/15ml)	T1		
potassium cl er 10 meq	T1		
potassium cl er 15 meq tablet	T1		
POTASSIUM CL ER 15 MEQ TABLET	T3		
potassium cl er 20 meq tablet (K-Tab Er)	T1		
potassium cl er 8 meq capsule	T1		
potassium cl er 8 meq tablet	T1		
potassium cl10%(20meq/15ml)cup	T1		
potassium cl10%(40meq/30ml)cup	T1		
potassium cl20%(40meq/15ml)cup	T1		
PROTEIN REPLACEMENT			
AQNEURSA	T4	PA SP	
T1 – Typically Generics	T4 – Specialty Medications	ST – Step Therapy	HD – May require home delivery pharmacy
T2 – Typically Preferred Brands	PA – Prior Authorization	AGE – Age Requirement	PPACA – No Cost-Share Preventive Medication
T3 – Typically Non-Preferred Brands	QL – Quantity Limit	SP – Specialty Medication	CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

ELECT/CALORIC/H2O (Urinary Tract Conditions)

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

GASTROINTESTINAL (Cholesterol Medications)

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

GASTROINTESTINAL (Gastrointestinal/Heartburn)

AMMONIA INHIBITORS		
<i>lactulose</i>	T1	HD
<i>lactulose 10 gm/15 ml solution</i>	T1	HD
LITHOSTAT	T3	HD
<i>sodium phenylbutyrate</i> (Buphenyl)	T4	SP HD

ANTI-CHOLINERGICS, QUATERNARY AMMONIUM

<i>chlordiazepoxide/clidinium br</i>	T1	
CUVPOSA	T3	
GLYCATE	T3	
<i>glycopyrrolate</i> (Glycate)	T1	
<i>glycopyrrolate</i> (Robinul Forte)	T1	
<i>glycopyrrolate</i> (Robinul)	T1	
PHEBURANE	T4	PA QL(8 Bottles/30 Days) SP HD
<i>propantheline bromide</i>	T1	
ROBINUL (<i>glycopyrrolate</i>)	T3	
ROBINUL FORTE (<i>glycopyrrolate</i>)	T3	
OLPRUVA	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
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 (Lomotil)</i>	T1	
<i>loperamide hcl</i>	T1	
MOTOFEN	T3	
<i>opium tincture</i>	T1	PA
<i>paregoric</i>	T1	
ANTI-EMETIC, CANNABINOID-TYPE		
<i>dronabinol</i>	T1	
ANTI-EMETIC/ANTI-VERTIGO AGENTS		
AKYNZEO	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 (Emend)</i>	T1	QL (12 caps/28 days)
<i>aprepitant 40 mg capsule</i>	T1	QL (1 cap/28 days)
<i>aprepitant 80 mg capsule (Emend)</i>	T1	QL (8 caps/28 days)
BONJESTA	T3	
COMPAZINE (<i>prochlorperazine maleate</i>)	T3	
COMPAZINE (<i>prochlorperazine</i>)	T3	
DICLEGIS (<i>doxylamine succ-pyridoxine hcl</i>)	T3	
<i>doxylamine succinate/vit b6 (Diclegis)</i>	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	
<i>fosaprepitant dimeglumine (Emend)</i>	T1	
<i>gransetron hcl</i>	T1	
<i>gransetron hcl/pf</i>	T1	
<i>ondansetron hcl</i>	T1	
<i>ondansetron hcl/pf</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

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List of Prescription Medications

GASTROINTESTINAL (Gastrointestinal/Heartburn) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ANTI-EMETIC/ANTI-VERTIGO AGENTS (cont.)		
<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</i>	T1	
VARUBI	T3	PA QL (4 tabs/28 days)
ANTI-ULCER PREPARATIONS		
CYTOTEC (<i>misoprostol</i>)	T3	HD
<i>misoprostol</i> (Cytotec)	T1	HD
<i>sucralfate</i> (Carafate)	T1	HD
ANTI-ULCER-H.PYLORI AGENTS		
<i>bismuth/metronid/tetracycline</i> (Pylera)	T1	
<i>lansoprazole/amoxiciln/clarith</i>	T1	
BELLADONNA ALKALOIDS		
<i>methscopolamine bromide</i>	T1	HD
NULEV (<i>symax</i>)	T1	HD
<i>phenobarb/hyoscy/atropine/scop</i> (Donnatal)	T1	HD
<i>phenobarb/hyoscy/atropine/scop</i> (Phenobarbital-belladonna)	T1	HD
<i>phenobarbital-belladonna elixr</i> (Donnatal)	T1	HD
<i>phenobarbital-belladonna elixr</i> (Phenobarbital-belladonna)	T1	HD
PHENOBARBITAL-BELLADONNA ELIXR (<i>phenohytro</i>)	T3	HD
SYMAX DUOTAB	T3	HD
BILE SALTS		
ACTIGALL (<i>ursodiol</i>)	T3	HD
CHENODAL	T4	SP HD
CHOLBAM	T3	PA SP HD
URSO FORTE (<i>ursodiol</i>)	T3	HD
<i>ursodiol</i>	T1	HD
<i>ursodiol</i> (Actigall)	T1	HD
<i>ursodiol</i> (Urso Forte)	T1	HD

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

T4 – Specialty Medications

PA – Prior Authorization

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ST – Step Therapy

AGE – Age Requirement

SP – Specialty Medication

HD – May require home delivery pharmacy

PPACA – No Cost-Share Preventive Medication

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List of Prescription Medications

GASTROINTESTINAL (Gastrointestinal/Heartburn) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
CHRONIC INFLAM. COLON DX, 5-A-SALICYLAT, RECTAL TX		
mesalamine 1,000 mg supp (Canasa)	T1	
mesalamine 4 gm/60 ml enema (Sfrowasa)	T1	
mesalamine 4 gm/60 ml kit	T1	
SFROWASA (mesalamine)	T3	
DRUG TX-CHRONIC INFLAM. COLON DX, 5-AMINOSALICYLAT		
APRISO (mesalamine er)	T3	HD
balsalazide disodium	T1	HD
balsalazide disodium (Colazal)	T1	HD
mesalamine	T1	HD
mesalamine (Apriso)	T1	HD
mesalamine 800 mg dr tablet	T1	HD
mesalamine dr 1.2 gm tablet (Lialda)	T1	HD
PENTASA 500 MG CAPSULE (mesalamine)	T3	HD
sulfasalazine (Azulfidine)	T1	HD
FARNESOID X RECEPTOR (FXR) AGONIST, BILE AC ANALOG		
OCALIVA	T4	PA SP HD
FECAL MICROBIOTA TRANSPLANTATION (FMT)		
VOWST	T4	PA QL(12 caps/56 days) SP
GASTRIC ENZYMES		
SUCRAID	T4	PA SP
HISTAMINE H2-RECEPTOR INHIBITORS		
cimetidine hcl	T1	HD
famotidine	T1	HD
ranitidine hcl	T1	HD
IBS AGENTS, MIXED OPIOID RECEP AGONISTS/ANTAGONISTS		
VIBERZI	T2	HD
IBS-C/CIC AGENTS, GUANYLATE CYCLASE-C AGONIST		
TRULANCE	T2	
INTESTINAL MOTILITY STIMULANTS		
metoclopramide hcl	T1	
metoclopramide hcl (Reglan)	T1	
REGLAN (metoclopramide hcl)	T3	
IRRITABLE BOWEL SYNDROME AGENTS, 5-HT3 ANTAGONIST		
alosetron hcl	T4	SP HD

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

T4 – Specialty Medications

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ST – Step Therapy

AGE – Age Requirement

SP – Specialty Medication

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List of Prescription Medications

GASTROINTESTINAL (Gastrointestinal/Heartburn) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
LAXATIVES AND CATHARTICS		
bisac/nacl/nahco3/kcl/peg 3350	T1	PPACA
lactulose	T1	
lactulose 10 gm/15 ml solution	T1	
lactulose 20 gm/30 ml solution	T1	
lubiprostone (Amitiza)	T1	
NULYTELY	T3	PPACA
peg3350/sod sul-nacl/kcl/asb/c	T1	PPACA
peg3350/sod sulf, bicarb, cl/kcl	T1	PPACA
PREPOPIK	T2	PPACA
sodium chloride/nahco3/kcl/peg	T1	PPACA
LOCAL ANORECTAL NITRATE PREPARATIONS		
nitroglycerin 0.4% ointment (Rectiv)	T1	
RECTIV (nitroglycerin)	T3	
PANCREATIC ENZYMES		
PANCREAZE	T2	HD
VIOKACE	T3	HD
ZENPEP	T2	HD
POTASSIUM-COMPETITIVE ACID BLOCKERS (PCABS)		
VOQUEZNA	T3	PA QL(1 tab/day)
PROTON-PUMP INHIBITORS		
dexlansoprazole dr 30 mg cap	T1	QL(2 caps/day) HD
dexlansoprazole dr 60 mg cap	T1	QL(1 cap/day) HD
esomeprazole dr 10 mg packet	T1	QL (4 packets/day) HD
esomeprazole dr 20 mg packet	T1	QL (2 packs/day) HD
esomeprazole dr 40 mg packet	T1	QL (1 packet/day) HD
esomeprazole dr 20 mg packet (Nexium)	T1	QL(2 packs/day) HD
esomeprazole dr 40 mg packet (Nexium)	T1	QL(1 pack/day) HD
esomeprazole mag dr 20 mg cap	T1	QL(2 caps/day) HD
esomeprazole mag dr 40 mg cap	T1	QL(1 cap/day) HD
esomeprazole sodium	T1	HD
lansoprazole dr 15 mg capsule	T1	QL (2 caps/day) HD
lansoprazole dr 30 mg capsule	T1	QL (1 cap/day) HD
lansoprazole odt 15 mg tablet	T1	QL (2 tabs/day) HD
lansoprazole odt 30 mg tablet	T1	QL (30 tabs/30 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

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CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

GASTROINTESTINAL (Gastrointestinal/Heartburn) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
PROTON-PUMP INHIBITORS (cont.)		
NEXIUM DR 2.5 MG PACKET	T2	QL (480 packs/30 days) HD
NEXIUM DR 5 MG PACKET	T2	QL (240 packs/30 days) HD
omeppi 20 mg-1, 100 mg capsule	T1	PA QL (60 caps/30 days) HD
omeppi 40 mg-1, 100 mg capsule	T1	PA QL (30 caps/30 days) HD
omeprazole dr 10 mg capsule	T1	QL (120 caps/30 days) HD
omeprazole dr 20 mg capsule	T1	QL (60 caps/30 days) HD
omeprazole dr 40 mg capsule	T1	QL (30 caps/30 days) HD
omeprazole-bicarb 20-1, 100 cap	T1	PA QL (60 caps/30 days) HD
omeprazole-bicarb 20-1, 680 pkt	T1	PA QL (60 packs/30 days) HD
omeprazole-bicarb 40-1, 100 cap	T1	PA QL (1 cap/day) HD
omeprazole-bicarb 40-1, 680 pkt	T1	PA QL (30 packs/30 days) HD
pantoprazole 40 mg suspension	T1	QL (1 dose/day) HD
pantoprazole sod dr 20 mg tab	T1	QL (2 tabs/day) HD
pantoprazole sod dr 40 mg tab	T1	QL (1 tab/day) HD
pantoprazole sodium 40 mg vial	T1	HD
rabeprazole sodium	T1	QL (30 tabs/30 days) HD

SBS - GLUCAGON-LIKE PEPTIDE-2 (GLP-2) ANALOGS

GATTEX	T4	PA SP HD
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GASTROINTESTINAL (Pain Relief And Inflammatory Disease)

HEMORRHOID PREP, ANTI-INFLAM STEROID-LOCAL ANESTHET

ANA-LEX	T1	
ANALPRAM HC 1% CREAM	T3	
hydrocortisone/lidocaine/aloe	T1	
hydrocortisone/pramoxine (Analpram Hc)	T1	

HEMORRHOID PREP, ANTI-INFLAM STEROID-LOCAL ANESTHET

lidocaine/hydrocortisone ac	T1	
LIDOCAINE-HYDROCORTISONE	T1	
PROCORT	T3	
PROTOFOAM-HC	T3	

RECTAL/LOWER BOWEL PREP., GLUCOCORT. (NON-HEMORR)

budesonide 2 mg rectal foam	T1	QL(2 kits/180 days)
CORTENEMA (hydrocortisone)	T3	
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

HORMONES (Hormonal Agents)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ADRENAL STEROID INHIBITORS		
ISTURISA	T4	PA QL (2 tabs/day) SP
ANDROGEN/ESTROGEN PREPS FOR FEMALE SEXUAL DYSFUNC		
INTRAROSA	T3	
ANDROGENIC AGENTS		
ANADROL-50	T3	PA
DEPO-TESTOSTERONE	T3	
DEPO-TESTOSTERONE (<i>testosterone cypionate</i>)	T3	
METHITEST	T1	
<i>methyltestosterone</i>	T1	
<i>oxandrolone</i>	T1	PA
<i>testosterone 1% (25mg/2.5g) pk (Androgel)</i>	T1	PA QL (150gm/30 days)
<i>testosterone 1% (50 mg/5 g) pk (Testosterone)</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%(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 (Testosterone)</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</i>	T1	PA QL (2 tubes/day)
TESTOSTERONE 50 MG/5 GRAM PKT	T1	PA QL (2 packs/day)
<i>testosterone cypionate (Depo-testosterone)</i>	T1	
<i>testosterone enanthate</i>	T1	
XYOSTED	T3	PA QL(2 ml/28 days)
ANTI-DIURETIC AND VASOPRESSOR HORMONES		
<i>desmopressin 0.01% solution</i>	T1	HD
<i>desmopressin 10 mcg/0.1 ml spr</i>	T1	HD
<i>desmopressin (nonrefrigerated)</i>	T1	
<i>desmopressin 0.01% solution (Ddavp)</i>	T1	
<i>desmopressin 10 mcg/0.1 ml spr (Ddavp)</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
ANTI-DIURETIC AND VASOPRESSOR HORMONES (cont.)		
desmopressin 40 mcg/10 ml vial (Ddavp)	T4	SP
desmopressin ac 4 mcg/ml ampul (Ddavp)	T4	SP
desmopressin ac 4 mcg/ml vial (Ddavp)	T4	SP
desmopressin acetate	T1	
desmopressin acetate 0.1 mg tb (Ddavp)	T1	
desmopressin acetate 0.2 mg tb (Ddavp)	T1	
NOCTIVA	T3	PA
STIMATE	T4	SP
ESTROGEN AND PROGESTIN COMBINATIONS		
BIJUVA	T3	
ESTROGEN/ANDROGEN COMBINATIONS		
estrogen, ester/me-testosterone (Estratest F.S.)	T1	HD
ESTROGENIC AGENTS		
ACTIVELLA (mimvey lo)	T3	HD
ACTIVELLA (mimvey)	T3	HD
ALORA	T3	QL (16 patches/28 days) HD
CLIMARA (estradiol (once weekly))	T3	HD
CLIMARA PRO	T3	HD
COMBIPATCH	T3	
DEPO-ESTRADOL	T3	HD
DIVIGEL	T3	HD
ELESTRIN	T3	HD
ESTRACE (estradiol)	T3	HD
estradiol (Climara)	T1	HD
estradiol (Vivelle-dot)	T1	QL (8 patches/21 days) HD
estradiol 0.06% 1.25g gel pump (Estrogel)	T1	HD
estradiol 0.5 mg tablet (Estrace)	T1	HD
estradiol 1 mg tablet (Estrace)	T1	HD
estradiol 2 mg tablet (Estrace)	T1	HD
estradiol 0.025 mg patch(2/wk) (Minivelle)	T1	QL(16 patches/28 days) HD
estradiol 0.025 mg patch(2/wk) (Vivelle-Dot)	T1	QL(16 patches/28 days) HD
estradiol 0.0375mg patch(2/wk) (Minivelle)	T1	QL(16 patches/28 days) HD

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

T4 – Specialty Medications

PA – Prior Authorization

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ST – Step Therapy

AGE – Age Requirement

SP – Specialty Medication

HD – May require home delivery pharmacy

PPACA – No Cost-Share Preventive Medication

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List of Prescription Medications

HORMONES (Hormonal Agents) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ESTROGENIC AGENTS (cont.)		
estradiol 0.0375mg patch(2/wk) (Vivelle-Dot)	T1	QL(16 patches/28 days) HD
estradiol 0.05 mg patch (2/wk) (Minivelle)	T1	QL(16 patches/28 days) HD
estradiol 0.05 mg patch (2/wk) (Vivelle-Dot)	T1	QL(16 patches/28 days) HD
estradiol 0.075 mg patch(2/wk) (Minivelle)	T1	QL(16 patches/28 days) HD
estradiol 0.075 mg patch(2/wk) (Vivelle-Dot)	T1	QL(16 patches/28 days) HD
estradiol 0.1 mg patch (2/wk) (Minivelle)	T1	QL(16 patches/28 days) HD
estradiol 0.1 mg patch (2/wk) (Vivelle-Dot)	T1	QL(16 patches/28 days) HD
estradiol 0.1% (0.5mg) gel pkt (Divigel)	T1	HD
estradiol valerate (Delestrogen)	T1	HD
estradiol/norethindrone acet	T1	HD
estradiol/norethindrone acet (Activella)	T1	HD
ESTROGEL	T3	HD
EVAMIST	T3	HD
FEMHRT (norethindron-ethinyl estradiol)	T3	HD
MENEST	T3	HD
MENOSTAR	T3	QL (8 patches/28 days) HD
MINIVELLE (Jyllana)	T3	QL (16 patches/28 days) HD
norethind-eth estrad 0.5-2.5 (Femhrt)	T1	HD
norethindrone ac/eth estradiol	T1	HD
norethindrone ac-eth estradiol (Femhrt)	T1	HD
norethin-eth estrad 1 mg-5 mcg	T1	HD
PREMARIN	T2	HD
PREMPHASE	T2	HD
PREMPRO	T2	HD
VIVELLE-DOT (Jyllana)	T3	QL (16 patches/28 days) HD
ESTROGEN-PROGESTIN WITH ANTI-MINERALOCORTICOID COMB		
ANGELIQ	T3	HD
ESTROGEN-SELECTIVE ESTROGEN RECEPTOR MOD (SERM) COMB		
DUAVEE	T2	
GLUCOCORTICOIDS		
budesonide	T1	PA QL (1 tab/day)
budesonide (Entocort Ec)	T1	
cortisone acetate	T1	
deflazacort	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

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List of Prescription Medications

HORMONES (Hormonal Agents) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
GLUCOCORTICOIDS (cont.)		
deflazacort (Emflaza)	T4	PA SP HD
dexamethasone	T1	
dexamethasone 1.5 mg tablet	T1	
dexamethasone 2 mg tablet	T1	
dexamethasone 4 mg tablet	T1	
dexamethasone 6 mg tablet	T1	
ENTOCORT EC (budesonide ec)	T3	
hydrocortisone (Cortef)	T1	
LOCORT	T1	
MEDROL	T3	
MEDROL (methylprednisolone)	T3	
methylprednisolone (Medrol)	T1	
MILLIPRED 10 MG/5 ML SOLUTION (prednisolone sodium phosphate)	T3	
millipred 5 mg tablet	T1	
ORAPRED ODT (prednisolone sodium phos odt)	T3	
prednisolone	T1	
prednisolone sodium phosphate	T1	
prednisolone sodium phosphate (Millipred)	T1	
prednisolone sodium phosphate (Orapred Odt)	T1	
prednisone	T1	
GROWTH HORMONE RELEASING HORMONE (GHRH) AND ANALOGS		
EGRIFTA	T4	PA SP HD
EGRIFTA SV	T4	PA SP HD
GROWTH HORMONES		
GENOTROPIN	T4	PA SP HD
NORDITROPIN FLEXPRO	T4	PA SP HD
OMNITROPE	T4	PA SP HD
SEROSTIM	T4	PA SP HD
SKYTROFA	T4	PA SP HD
SOGROYA	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

HORMONES (Hormonal Agents) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits	
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 3.75 MG KIT	T4	PA SP HD	
LUPRON DEPOT 11.25 MG 3MO KIT	T4	PA SP HD	
SYNAREL	T4	PA SP HD	
LHRH (GNRH) ANTAGONIST, ESTROGEN AND PROGESTIN COMB			
ORIAHNN	T2	PA QL (2 capsules/day)	
LHRH (GNRH) ANTAGONIST, PITUITARY SUPPRESSANT AGENTS			
CETROTIDE	T4	PA SP	
<i>ganirelix acet</i> 250 mcg/0.5 ml (Ganirelix Acetate)	T4	PA SP	
GANIRELIX ACET 250 MCG/0.5 ML (<i>ganirelix acetate</i>)	T4	PA SP	
ORILISSA 150 MG TABLET	T2	PA QL (1 tab/day)	
ORILISSA 200 MG TABLET	T2	PA QL (2 tabs/day)	
LHRH (GNRH) AGNST PIT.SUP-CENTRAL PRECOCIOUS PUBERTY			
FENSOLVI	T4	PA SP	
LUPRON DEPOT-PED	T4	PA SP HD	
MINERALOCORTICOIDS			
<i>fludrocortisone acetate</i>	T1	HD	
OXYTOCICS			
CERVIDIL	T3		
<i>methylergonovine maleate</i>	T1		
PREPIDIL	T3		
PROSTIN E2 VAGINAL SUPPOSITORY	T3		
PITUITARY SUPPRESSIVE AGENTS			
<i>cabergoline</i>	T1	QL (16 tabs/28 days) HD	
CRENESSITY 50 MG CAPSULE	T4	PA QL(2 caps/day) SP	
CRENESSITY 100 MG CAPSULE	T4	PA QL SP	
CRENESSITY 50 MG/ML SOLUTION	T4	PA QL(8 mls/day) SP	
<i>danazol</i>	T1	HD	
PROGESTATIONAL AGENTS			
CRINONE 4% GEL	T3	PA HD	
DEPO-PROVERA 400 MG/ML VIAL	T3	HD	
<i>medroxyprogesterone 10 mg tab</i> (Provera)	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 (cont.)		
medroxyprogesterone 2.5 mg tab (Provera)	T1	HD
medroxyprogesterone 5 mg tab (Provera)	T1	HD
norethindrone acetate	T1	HD
progesterone, micronized (Prometrium)	T1	HD
PROMETRIUM (progesterone)	T3	HD
SOMATOSTATIC AGENTS		
lanreotide 120 mg/0.5 ml syrng	T4	PA SP HD
LANREOTIDE 120 MG/0.5 ML SYRNG	T4	PA SP HD
octreotide acetate	T4	PA SP HD
octreotide acetate (Sandostatin)	T4	PA SP HD
SANDOSTATIN (octreotide acetate)	T4	PA SP HD
SANDOSTATIN LAR DEPOT	T4	PA SP
SIGNIFOR	T4	PA SP
SIGNIFOR LAR	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 (estradiol)	T3	HD
estradiol (Vagifem)	T1	QL (36 tabs/28 days)
estradiol 0.01% cream (Estrace)	T1	HD
estradiol 10 mcg vaginal insrt (Vagifem)	T1	QL (36 tabs/28 days) HD
FEMRING	T3	HD
PREMARIN	T2	HD
VAGIFEM (yuvalfem)	T3	QL (36 tabs/28 days) HD

HORMONES (Infertility)

FERTILITY STIMULATING PREPARATIONS, NON-FSH		
clomiphene citrate	T1	
FOLLICLE-STIMULATING AND LUTEINIZING HORMONES		
MENOPUR	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

HORMONES (Infertility) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
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 GONADOTROPIN	T3	PA SP
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	T2	PA SP
PREGNANCY FACILITATING/MAINTAINING AGENT, HORMONAL		
CRINONE 8% GEL	T2	
ENDOMETRIN	T2	
HORMONES (Miscellaneous)		
LEPTIN HORMONE ANALOGS		
MYALEPT	T4	PA SP HD
HORMONES (Osteoporosis Products)		
BONE FORMATION STIM. AGENTS - PARATHYROID HORMONE		
teriparatide 560mcg/2.4ml pen	T4	PA QL(0.09 mls/day) SP HD
TERIPARATIDE 620 MCG/2.48 ML	T4	PA QL(0.09 mls/day) SP HD
BONE RESORPTION INHIBITORS		
calcitonin, salmon, synthetic	T1	HD
ibandronate sodium	T1	HD
MIACALCIN	T2	HD
IMMUNOSUPPRESSANTS (Pain Relief And Inflammatory Disease)		
IL-23 RECEPTOR ANTAGONIST, MONOCLONAL ANTIBODY		
OMVOH	T4	PA QL SP HD
OMVOH PEN	T4	PA QL(2 pens/28 days) SP HD
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
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
TYENNE AUTOINJECTOR	T4	PA QL(3.6 ml/28 days) SP
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
SELARSDI	T4	PA QL(1 syringe/84 days) SP
USTEKINUMAB-TTWE	T4	PA QL(1 syringe/84 days) SP HD
YESINTEK	T4	PA QL(1 syringe/84 days) SP

IMMUNOSUPPRESSANTS (Skin Conditions)

TOPICAL IMMUNOSUPPRESSIVE AGENTS		
ELIDEL (<i>pimecrolimus</i>)	T3	
<i>pimecrolimus</i> (Elidel)	T1	
PROTOPIC (<i>tacrolimus</i>)	T3	
<i>tacrolimus</i> 0.03% ointment	T1	
<i>tacrolimus</i> 0.1% ointment	T1	

IMMUNOSUPPRESSANTS (Transplant Medications)

IMMUNOSUPPRESSIVES		
ASTAGRAF XL	T4	SP HD
AZASAN	T4	SP HD
<i>azathioprine</i> (Imuran)	T4	SP HD
<i>cyclosporine</i> (Sandimmune)	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.)		
cyclosporine, modified	T4	SP HD
cyclosporine, modified (Neoral)	T4	SP HD
ENVARSUS XR	T4	SP HD
everolimus 0.25 mg tablet (Zortress)	T4	SP HD
everolimus 0.5 mg tablet (Zortress)	T4	SP HD
everolimus 0.75 mg tablet (Zortress)	T4	SP HD
LUPKYNIS	T4	PA QL(6 caps/day) SP
mycophenolate mofetil (Cellcept)	T4	SP HD
PROGRAF (tacrolimus)	T4	SP HD
sirolimus (Rapamune)	T4	SP HD
tacrolimus 0.5 mg capsule (ir) (Prograf)	T4	SP HD
tacrolimus 1 mg capsule (ir) (Prograf)	T4	SP HD
tacrolimus 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	
CARESENS	T1	
CARETOUCH CONTROL SOLUTION	T1	
CEQUR SIMPLICITY	T2	
CEQUR SIMPLICITY INSERTER	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 RECIEVER	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	T2	PA QL(2 units/30 days)

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

T4 – Specialty Medications

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List of Prescription Medications

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

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits	
DIABETIC SUPPLIES (cont.)			
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)	
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)	
GLUCOCOM AUTOLINK	T1		
GUARDIAN RT CHARGER	T1		
GUARDIAN RT STARTER KIT	T1		
GUARDIAN TEST PLUG	T1		
FORA TN'GO ADV MOBILE MULTIFN MTR	T3		
FORA TN'GO ADVANCE MULTIFN MTR	T3		
HUMAPEN LUXURA HD	T1		
IHEALTH CONTROL SOLN LEVEL 2	T1		
INPEN (FOR HUMALOG)	T1		
INPEN (FOR NOVOLOG OR FIASP)	T1		
LITE TOUCH LANCING PEN	T1		
MOBILE LANCETS	T1		
NOVOPEN ECHO	T1		
OMNIPOD 5 (G6/LIBRE 2 PLUS)	T2	QL(30 crtgs/30 days)	
OMNIPOD 5 (GEN 5) KIT	T2	QL (1 kit/365 days)	
OMNIPOD 5 (GEN 5) PODS	T2	QL (30 pods/30 days)	
OMNIPOD 5 G6-G7 PODS (GEN 5)	T2	QL	
OMNIPOD CLASSIC (GEN 3) KIT	T2	QL (1 kit/365 days)	
OMNIPOD CLASSIC (GEN 4) KIT	T2	QL (1 kit/365 days)	
OMNIPOD CLASSIC (GEN 3) PODS	T2	QL (30 pods/30 days)	
OMNIPOD CLASSIC (GEN 4) PODS	T2	QL (30 pods/30 days)	
OMNIPOD DASH 5 PACK POD	T2	PA QL (6 boxes/30 days)	
OMNIPOD 5 DEXG7G6 INTRO(GEN 5)	T2	QL(1 unit/365 days)	
OMNIPOD 5 DEXG7G6 PODS (GEN 5)	T2	QL(30 crtgs/30 days)	
ONETOUCH DELICA PLUS LANCET	T1		
ONETOUCH DELICA PLUS LANC DEV	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	
DIABETIC SUPPLIES (cont.)			
ONETOUCH ULTRA CONTROL SOLN	T1		
ONETOUCH ULTRA TEST STRIP	T2		
ONETOUCH ULTRASOFT 2 LANCET	T1		
ONETOUCH VERIO HIGH CNTRL SOLN	T1		
ONETOUCH VERIO MID CNTRL SOLN	T1		
ONETOUCH VERIO TEST STRIP	T2		
PRO COMFORT SAFETY LANCET	T1		
REPLACEMENT PEDIATRIC MONITOR	T1		
SEN-SERTER	T1		
UNIFINE SAFECONTROL	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 LANCET	T1		
ADVOCATE SAFETY LANCET	T1		
ALTERNATE SITE LANCETS	T1		
ASSURE HAEMOLANCE PLUS	T1		
ASSURE LANCE	T1		
ASSURE LANCE PLUS	T1		
BD MICROTAINER LANCETS	T1		
BD ULTRA-FINE	T1		
BD ULTRA-FINE II	T1		
BLOOD LANCETS	T1		
BULLSEYE MINI SAFETY LANCETS	T1		
BUTTERFLY TOUCH LANCET	T1		
CAREONE	T1		
CARESENS LANCET	T1		
T1 – Typically Generics	T4 – Specialty Medications	ST – Step Therapy	HD – May require home delivery pharmacy
T2 – Typically Preferred Brands	PA – Prior Authorization	AGE – Age Requirement	PPACA – No Cost-Share Preventive Medication
T3 – Typically Non-Preferred Brands	QL – Quantity Limit	SP – Specialty Medication	CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

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

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
DURABLE MEDICAL EQUIPMENT, MISC (GROUP I) (cont.)		
CARETOUCH SAFETY LANCETS	T1	
CARETOUCH TWIST LANCE	T1	
CHOSEN LANCE	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 LANCE	T1	
DROPLET LANCETS	T1	
EASY COMFORT LANCETS	T1	
EASY TOUCH	T1	
EASY TWIST & CAP LANCETS	T1	
EMBRACE 30G LANCETS	T1	
EMBRACE SAFETY LANCE	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	
GOJJI LANCETS	T1	
HEALTHY ACCENTS UNILET LANCE	T1	
INCONTROL SUPERTHIN LANCETS	T1	
INCONTROL ULTRA THIN LANCETS	T1	
INJECT EASE 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.)		
INVACARE LANCETS	T1	
LANCETS	T1	
LANCETS THIN	T1	
LANCETS ULTRA THIN	T1	
LITE TOUCH	T1	
LITE TOUCH 28G LANCETS	T1	
LITE TOUCH 30G LANCETS	T1	
LITE TOUCH 33G LANCETS	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	
PRO COMFORT SAFETY LANCET	T1	
PRODIGY 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.)		
PRODIGY TWIST TOP LANCET	T1	
PURE COMFORT LANCETS	T1	
PURE COMFORT SAFETY LANCETS	T1	
PUSH BUTTON SAFETY LANCETS	T1	
READYLANCE SAFETY LANCETS	T1	
RELIAMED	T1	
RELIAMED SAFETY SEAL LANCETS	T1	
RIGHTEST GL300 LANCETS	T1	
SAFETY LANCETS	T1	
SAFETY SEAL LANCETS	T1	
SAFETY-LET	T1	
SINGLE-LET	T1	
SMART SENSE	T1	
SMART SENSE LANCETS	T1	
SMARTEST LANCET	T1	
SOLUS V2	T1	
SOLUS V2 LANCETS	T1	
STERILANCE TL	T1	
STERILE LANCETS	T1	
SUPER THIN LANCETS	T1	
SURE COMFORT LANCETS	T1	
SURE-LANCE	T1	
SURE-TOUCH	T1	
TECHLITE LANCETS	T1	
TEL CARE ULTRA THIN 30G LANCETS	T1	
THIN LANCETS	T1	
TOP CARE UNIVERSAL1 LANCET	T1	
TOP CARE UNIVERSAL1 THIN LANCET	T1	
TRUE COMFORT LANCET	T1	
TRUE COMFORT SAFETY LANCET	T1	
TRUEPLUS LANCET	T1	
TRUEPLUS LANCETS	T1	
TWIST LANCETS	T1	
TWIST TOP LANCET	T1	

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.)		
ULTILET BASIC	T1	
ULTILET CLASSIC	T1	
ULTILET LANCETS	T1	
ULTILET SAFETY	T1	
ULTRA-THIN II LANCETS	T1	
ULTRA THIN LANCETS	T1	
ULTRA THIN PLUS LANCETS	T1	
ULTRA-CARE LANCETS	T1	
ULTRALANCE	T1	
ULTRA-THIN II	T1	
ULTRATLC LANCETS	T1	
UNILET COMFORTOUCH	T1	
UNILET EXCELITE	T1	
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	
UNISTIK PRO	T1	
UNISTIK SAFETY	T1	
UNISTIK TOUCH	T1	
UNIVERSAL 1	T1	
UNISTIK 2 COMFORT	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 2 EXTRA	T1	
UNISTIK 2 NORMAL	T1	
UNISTIK 3 COMFORT	T1	
UNISTIK 3 DUAL	T1	
VERIFINE SAFETY LANCET MINI	T1	
VERIFINE UNIVERSAL LANCET	T1	
VIVAGUARD LANCET	T1	
VIVAGUARD SAFETY LANCET	T1	
NEEDLES/NEEDLELESS DEVICES		
AUTOSHIELD DUO PEN NEEDLE	T1	
BLUNT NEEDLE	T1	
CAREPOINT PRECISION NEEDLE	T1	
DROPSAFE SICURA SAFETY NEEDLE	T1	
ECLIPSE NEEDLE	T1	
EMBRACE PEN NEEDLE	T1	
FILTER NEEDLE	T1	
HYPODERMIC NEEDLE	T1	
INSUPEN PEN NEEDLE	T1	
MONOJECT BLOOD COLLECTION	T1	
NEEDLES	T1	
PERFECT POINT SAFETY NEEDLE	T1	
PRECISIONGLIDE NEEDLE	T1	
NANO 2ND GEN PEN NEEDLE	T1	
NANO PEN NEEDLE	T1	
ULTRA-FINE PEN NEEDLE	T1	
SYRINGES AND ACCESSORIES		
BD INS SYR 0.3 ML 8MMX31G(1/2)	T1	
BD INS SYR UF 0.3ML 12.7MMX30G	T1	
BD INS SYR UF 0.5ML 12.7MMX30G	T1	
BD INS SYRN UF 1 ML 12.7MMX30G	T1	
BD INS SYRN UF 1 ML 30G 12.7MM	T1	
BD INS SYRNG 0.3 ML 29GX12.7MM	T1	
BD INS SYRNG 0.5 ML 29GX12.7MM	T1	
BD INS SYRNG UF 0.3 ML 8MMX31G	T1	

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	
SYRINGES AND ACCESSORIES (cont.)			
BD INS SYRNG UF 0.5 ML 8MMX31G	T1		
BD INSULIN SYR 0.5 ML 28GX1/2"	T1		
BD INSULIN SYR 1 ML 25GX1"	T1		
BD INSULIN SYR 1 ML 25GX5/8"	T1		
BD INSULIN SYR 1 ML 26GX1/2"	T1		
BD INSULIN SYR 1 ML 27GX12.7MM	T1		
BD INSULIN SYR 1 ML 27GX5/8"	T1		
BD INSULIN SYR 1 ML 28GX1/2"	T1		
BD INSULIN SYR 1 ML 29GX12.7MM	T1		
BD INSULIN SYR UF 1 ML 8MMX31G	T1		
BD INSULIN SYRINGE 1 ML	T1		
DROPLET 0.3 ML 29G 12.7MM(1/2)	T1		
DROPLET 0.3 ML 30G 12.7MM(1/2)	T1		
DROPLET INS 0.3ML 30G 8MM(1/2)	T1		
DROPLET INS 0.3ML 31G 6MM(1/2)	T1		
DROPLET INS 0.3ML 31G 8MM(1/2)	T1		
DROPLET INS 0.5 ML 29G 12.7MM	T1		
DROPLET INS 0.5 ML 30G 12.7MM	T1		
DROPLET INS SYR 0.5 ML 31G 6MM	T1		
DROPLET INS SYR 0.5 ML 31G 8MM	T1		
DROPLET INS SYR 0.5ML 30G 8MM	T1		
DROPLET INS SYR 1 ML 30G 8MM	T1		
DROPLET INS SYR 1 ML 31G 6MM	T1		
DROPLET INS SYR 1 ML 31G 8MM	T1		
DROPLET INS SYR 1ML 29G 12.7MM	T1		
DROPLET INS SYR 1ML 30G 12.7MM	T1		
EASY COMFORT SYR 0.5ML 29G 8MM	T1		
EASY COMFORT SYR 1 ML 29G 8MM	T1		
INSULIN SYRINGE	T1		
INSULIN SYRINGE U-500	T1		
MINIMED RESERVOIR	T1		
PARADIGM	T1		
TRUE COMFORT SAFE INSULIN SYRG	T1		
ULTRA-THIN II 1 ML 31GX5/16"	T1		
ULTRA-THIN II INS 0.3 ML 30G	T1		
I1 – Typically Generics	I4 – Specialty Medications	SI – Step Therapy	HD – May require home delivery pharmacy
T2 – Typically Preferred Brands	PA – Prior Authorization	AGE – Age Requirement	PPACA – No Cost-Share Preventive Medication
T3 – Typically Non-Preferred Brands	QL – Quantity Limit	SP – Specialty Medication	CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

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

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
SYRINGES AND ACCESSORIES (cont.)		
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	
VERIFINE INSULIN SYRINGE	T1	

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

RESPIRATORY AIDS, DEVICES, EQUIPMENT	Tier	Coverage Requirements and Limits
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, INFANT MASK	T2	QL (1 unit/year)
BREATHERITE SPACER-LARGE MASK	T2	QL (1 mask/365 days)
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)

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.)		
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-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)
UNISTIK 3 NORMAL	T1	
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)
SKELETAL MUSCLE RELAX. TOP IRRITANT COUNTER-IRRIT		
COMFORT PAC-CYCLOBENZAPRINE	T3	
COMFORT PAC-TIZANIDINE	T3	
SKELETAL MUSCLE RELAXANTS		
<i>baclofen</i>	T1	HD
<i>carisoprodol/aspirin</i>	T1	
<i>chlorzoxazone</i>	T1	
<i>cyclobenzaprine hcl</i>	T1	
DANTRIUM (<i>dantrolene sodium</i>)	T3	
<i>dantrolene sodium</i>	T1	
FEXMID (<i>cyclobenzaprine hcl</i>)	T3	
<i>metaxalone</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

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List of Prescription Medications

MUSCLE RELAXANTS (Pain Relief And Inflammatory Disease)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
SKELETAL MUSCLE RELAX. TOP IRRITANT COUNTER-IRRIT		
<i>methocarbamol</i>	T1	
<i>methocarbamol 1,000 mg tablet</i>	T1	
<i>orphenadrine citrate</i>	T1	
OZOBAX DS	T3	
ROBAXIN-750 (<i>methocarbamol</i>)	T3	
SKELAXIN (<i>metaxalone</i>)	T3	
SOMA (<i>vanadom</i>)	T3	
<i>tizanidine hcl</i>	T1	
<i>tizanidine hcl</i> (Zanaflex)	T1	
ZANAFLEX (<i>tizanidine hcl</i>)	T3	

PRE-NATAL VITAMINS (Nutritional/Dietary)

PRENATAL VITAMIN PREPARATIONS		
ATABEX EC	T3	
CITRANATAL 90 DHA	T3	
CITRANATAL ASSURE	T3	
CITRANATAL DHA	T3	
CITRANATAL HARMONY	T3	
CITRANATAL RX	T3	
OBSTETRIX EC	T3	
OBTREX DHA	T3	
<i>pnv 22/iron, gluc/folic/dss/dha</i>	T1	
<i>pnv 66/iron/folic/docusate/dha</i>	T1	
<i>pnv 69/iron/folic/docusate/dha</i>	T1	
<i>pnv 80/iron fum/folic/dss/dha</i>	T1	
<i>pnv no.154/iron fum/folic acid</i>	T1	
<i>pnv/ferrous fum/docusate/folic</i>	T1	
<i>pnv/iron, carb/docusat/folic ac</i>	T1	
<i>prenatal 12/iron/folic/dss/om3 (Obtrex Dha)</i>	T1	
PRENATAL 19	T1	
<i>prenatal 34/iron/folic/dss/dha</i>	T1	
<i>prenatal vits15/iron/folic/dss</i>	T1	
VITAFOL FE+	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

PSYCHOTHERAPEUTIC DRUGS (Anxiety/Depression/Bipolar Disorder)⁹

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

PSYCHOTHERAPEUTIC DRUGS (Anxiety/Depression/Bipolar Disorder)⁹ (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
MONOAMINE OXIDASE (MAO) INHIBITOR ANTI-DEPRESSANTS		
EMSAM 12 MG/24 HOURS PATCH	T3	QL (1 patch/day)
EMSAM 6 MG/24 HOURS PATCH	T3	QL (2 patches/day)
EMSAM 9 MG/24 HOURS PATCH	T3	QL (1 patch/day)
NOREPINEPHRINE AND DOPAMINE REUPTAKE INHIB (NDRIs)		
bupropion hcl 100 mg tablet	T1	QL (4 tabs/day) HD
bupropion hcl 75 mg tablet	T1	QL (6 tabs/day) HD
bupropion hcl sr 100 mg tablet (Wellbutrin Sr)	T1	QL (4 tabs/day) HD
bupropion hcl sr 150 mg tablet (Wellbutrin Sr)	T1	QL (2 tabs/day) HD
bupropion hcl sr 200 mg tablet (Wellbutrin Sr)	T1	QL (2 tabs/day) HD
bupropion hcl xl 150 mg tablet	T1	QL (3 tabs/day) HD
bupropion hcl xl 300 mg tablet	T1	QL (1 tab/day) HD
bupropion hcl xl 150 mg tablet (Wellbutrin XI)	T1	QL(3 tabs/day) HD
bupropion hcl xl 300 mg tablet (Wellbutrin XI)	T1	QL(1 tab/day) HD
WELLBUTRIN SR 100 MG TABLET (bupropion hcl sr)	T3	QL (4 tabs/day) ST HD
WELLBUTRIN SR 150 MG TABLET (bupropion hcl sr)	T3	QL (2 tabs/day) ST HD
WELLBUTRIN SR 200 MG TABLET (bupropion hcl sr)	T3	QL (2 tabs/day) ST HD
SELECTIVE SEROTONIN 5-HT2A INVERSE AGONISTS (SSIAs)		
NUPLAZID	T4	PA SP HD
SELECTIVE SEROTONIN REUPTAKE INHIBITOR (SSRIs)		
citalopram hbr 10 mg tablet (Celexa)	T1	QL(6 tabs/day) HD
citalopram hbr 20 mg tablet (Celexa)	T1	QL(3 tabs/day) HD
citalopram hbr 40 mg tablet (Celexa)	T1	QL (1 tab/day) HD
escitalopram oxalate 5 mg/5 ml	T1	QL (20ml/day) HD
escitalopram 5 mg tablet	T1	QL (4 tabs/day) HD
escitalopram 10 mg tablet	T1	QL (2 tabs/day) HD
escitalopram 20 mg tablet	T1	QL (1 tab/day) HD
fluoxetine hcl	T1	QL (4 caps/28 days) HD
fluoxetine hcl 10 mg capsule (Prozac)	T1	QL (8 caps/day) HD
fluoxetine hcl 10 mg tablet (Sarafem)	T1	HD
fluoxetine hcl 20 mg capsule (Prozac)	T1	QL (4 caps/day) HD
fluoxetine 20 mg/5 ml soln cup	T1	QL(20 mls/day) HD
fluoxetine hcl 20 mg tablet	T1	HD
fluoxetine hcl 40 mg capsule (Prozac)	T1	QL (2 caps/day) HD
fluoxetine hcl 60 mg tablet	T1	QL (1 tab/day) HD

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)⁹ (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
SELECTIVE SEROTONIN REUPTAKE INHIBITOR (SSRIs) (cont.)		
fluvoxamine er 100 mg capsule	T1	QL (3 caps/day) HD
fluvoxamine er 150 mg capsule	T1	QL (2 caps/day) HD
fluvoxamine maleate 100 mg tab	T1	QL (3 tabs/day) HD
fluvoxamine maleate 25 mg tab	T1	QL (12 tabs/day) HD
fluvoxamine maleate 50 mg tab	T1	QL (6 tabs/day) HD
paroxetine cr 12.5 mg tablet (Paxil Cr)	T1	QL (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
SARAFEM (fluoxetine hcl)	T3	ST HD
sertraline 20 mg/ml oral conc (Zoloft)	T1	QL (10ml/day) HD
sertraline hcl 100 mg tablet (Zoloft)	T1	QL (2 tabs/day) HD
sertraline hcl 25 mg tablet (Zoloft)	T1	QL (8 tabs/day) HD
sertraline hcl 50 mg tablet (Zoloft)	T1	QL (4 tabs/day) HD
SEROTONIN-2 ANTAGONIST/REUPTAKE INHIBITORS (SARIs)		
nefazodone hcl	T1	HD
trazodone hcl	T1	HD
SEROTONIN-NOREpinephrine REUPTAKE-INHIB (SNRIs)		
desvenlafaxine succnt er 100mg	T1	QL (4 tabs/day) HD
desvenlafaxine succnt er 25 mg	T1	QL (16 tabs/day) HD
desvenlafaxine succnt er 50 mg	T1	QL (1 tab/day) HD
duloxetine hcl dr 20 mg cap	T1	QL (6 caps/day) HD
duloxetine hcl dr 30 mg cap	T1	QL (4 caps/day) HD
duloxetine hcl dr 40 mg cap	T1	QL (3 caps/day) HD
duloxetine hcl dr 60 mg cap	T1	QL (2 caps/day) HD
FETZIMA 20-40 MG TITRATION PAK	T3	QL (28 caps/180 days) ST
FETZIMA ER 120 MG CAPSULE	T3	QL (1 cap/day) ST

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)⁹ (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
SEROTONIN-NOREPINEPHRINE REUPTAKE-INHIB (SNRIs)(con't.)		
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
venlafaxine hcl 100 mg tablet	T1	QL (3 tabs/day) HD
venlafaxine hcl 25 mg tablet	T1	QL (15 tabs/day) HD
venlafaxine hcl 37.5 mg tablet	T1	QL (10 tabs/day) HD
venlafaxine hcl 50 mg tablet	T1	QL (7 tabs/day) HD
venlafaxine hcl 75 mg tablet	T1	QL (5 tabs/day) HD
venlafaxine hcl er 150 mg cap (Effexor Xr)	T1	QL (2 caps/day) HD
venlafaxine hcl er 150 mg tab	T1	QL (2 tabs/day) HD
venlafaxine hcl er 225 mg tab	T1	QL (1 tab/day) HD
venlafaxine hcl er 37.5 mg cap (Effexor Xr)	T1	QL (8 caps/day) HD
venlafaxine hcl er 37.5 mg tab	T1	QL (8 tabs/day) HD
venlafaxine hcl er 75 mg cap (Effexor Xr)	T1	QL (4 caps/day) HD
venlafaxine hcl er 75 mg tab	T1	QL (4 tabs/day) HD
SSRI AND 5HTIA PARTIAL AGONIST ANTI-DEPRESSANTS		
vilazodone hcl 10 mg tablet (Viibryd)	T1	QL(1 tab/day) HD
vilazodone hcl 20 mg tablet (Viibryd)	T1	QL(1 tab/day) HD
vilazodone hcl 40 mg tablet (Viibryd)	T1	HD
VIIBRYD 10 MG TABLET	T3	QL (1 tab/day) ST HD
VIIBRYD 10-20 MG STARTER PACK	T3	ST HD
VIIBRYD 20 MG TABLET	T3	QL (1 tab/day) ST HD
VIIBRYD 40 MG TABLET	T3	ST HD
SSRI, SEROTONIN RECEPTOR MODULATOR ANTI-DEPRESSANTS		
TRINTELLIX 10 MG TABLET	T2	QL(1 tab/day)
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		
amoxapine	T1	HD
clomipramine 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)⁹ (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
TRICYCLIC ANTI-DEPRESSANTS, REL.NON-SEL.REUPT-INHIB		
desipramine hcl	T1	HD
doxepin 10 mg capsule	T1	HD
doxepin 10 mg/ml oral conc	T1	HD
doxepin 100 mg, 150 mg capsule	T1	HD
doxepin 25 mg capsule	T1	HD
doxepin 50 mg capsule	T1	HD
doxepin 75 mg capsule	T1	HD
imipramine hcl	T1	HD
imipramine pamoate	T1	HD
maprotiline hcl	T1	HD
nortriptyline hcl	T1	HD
protriptyline hcl	T1	HD
trimipramine maleate	T1	HD

PSYCHOTHERAPEUTIC DRUGS (Attention Deficit Hyperactivity Disorder)⁹

TX FOR ADHD - SELECTIVE ALPHA-2 RECEPTOR AGONIST		
clonidine hcl (Kapvay)	T1	
guanfacine hcl (Intuniv)	T1	HD

TX FOR ATTENTION DEFICIT-HYPERACT (ADHD)/NARCOLEPSY		
DAYTRANA	T3	PA QL (1 patch/day)
dexamethylphenidate er 10 mg cp	T1	PA QL (1 cap/day)
dexamethylphenidate er 15 mg cp	T1	PA QL (1 per day)
dexamethylphenidate er 20 mg cp	T1	PA QL (1 cap/day)
dexamethylphenidate er 25 mg cp	T1	PA QL (1 cap/day)
dexamethylphenidate er 30 mg cp	T1	PA QL (1 cap/day)
dexamethylphenidate er 35 mg cp	T1	PA QL (1 cap/day)
dexamethylphenidate er 40 mg cp	T1	PA QL (1 cap/day)
dexamethylphenidate hcl (Focalin)	T1	PA
FOCALIN (dexamethylphenidate hcl)	T3	PA ST
METHYLIN (methylphenidate hcl)	T3	PA
methylphenidate hcl (Metadata Cd)	T1	PA QL(1 cap/day)
methylphenidate (Daytrana)	T1	PA QL(1 patch/day)
methylphenidate 10 mg/9hr ptch (Daytrana)	T1	PA QL(1 patch/day)
methylphenidate 15 mg/9hr ptch (Daytrana)	T1	PA QL(1 patch/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

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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)⁹ (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
TX FOR ATTENTION DEFICIT-HYPERACT (ADHD)/NARCOLEPSY (cont.)		
methylphenidate 20 mg/9hr ptch (Daytrana)	T1	PA QL(1 patch/day)
methylphenidate 30 mg/9hr ptch (Daytrana)	T1	PA QL(1 patch/day)
methylphenidate er 10 mg tab	T1	PA QL (2 tabs/day)
methylphenidate er 18 mg tab	T1	PA QL (1 tab/day)
methylphenidate er 18 mg tab (Relexxii)	T1	PA QL (1 tab/day)
methylphenidate er 10, 15, 20 mg cap	T1	QL (1 per day)
methylphenidate er 20 mg tab	T1	PA QL (3/day)
methylphenidate er 27 mg tab	T1	PA QL (1 tab/day)
methylphenidate er 30 mg cap	T1	QL (1 per day)
methylphenidate er 36 mg tab	T1	PA QL (2 tabs/day)
methylphenidate er 40 mg cap	T1	QL (1 per day)
methylphenidate er 50 mg cap	T1	QL (1 per day)
methylphenidate er 54 mg tab	T1	PA QL (1 per day)
methylphenidate er 60 mg cap	T1	QL (1 per day)
methylphenidate hcl	T1	PA QL (1 cap/day)
methylphenidate hcl (Methylin)	T1	PA
methylphenidate hcl (Ritalin)	T1	PA
methylphenidate la 10 mg cap	T1	PA QL (1 cap/day)
methylphenidate la 20 mg cap	T1	PA QL (1 per day)
methylphenidate la 30 mg cap	T1	PA QL (1 per day)
methylphenidate la 40 mg cap	T1	PA QL (1 cap/day)
methylphenidate la 60 mg cap	T1	PA QL (1 cap/day)
QUILLIVANT XR	T3	PA QL (12ml/day)
RITALIN (methylphenidate hcl)	T3	PA ST
TX FOR ATTENTION DEFICIT-HYPERACT.(ADHD), NRI-TYPE		
atomoxetine hcl 10 mg capsule (Strattera)	T1	HD
atomoxetine hcl 100 mg capsule (Strattera)	T1	HD
atomoxetine hcl 18 mg capsule (Strattera)	T1	HD
atomoxetine hcl 25 mg capsule (Strattera)	T1	HD
atomoxetine hcl 40 mg capsule (Strattera)	T1	QL (1 cap/day) HD
atomoxetine hcl 60 mg capsule (Strattera)	T1	HD
atomoxetine hcl 80 mg capsule (Strattera)	T1	HD

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

T4 – Specialty Medications

PA – Prior Authorization

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ST – Step Therapy

AGE – Age Requirement

SP – Specialty Medication

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List of Prescription Medications

PSYCHOTHERAPEUTIC DRUGS (Miscellaneous)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
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)⁹		
ANTI-PSYCH, DOPAMINE ANTAG., DIPHENYLBUTYLPiperidines		
pimozide	T1	
ANTI-PSYCHOTIC,ATYPICAL,DOPAMINE,SEROTONIN ANTAGNST		
asenapine maleate (Saphris)	T1	
CAPLYTA	T3	ST QL(1 tabs/caps/day)
clozapine	T1	
clozapine (Clozapine Odt)	T1	
clozapine (Clozaril)	T1	
CLOZAPINE ODT	T1	
CLOZARIL (clozapine)	T3	ST
INVEGA ER 1.5 MG TABLET (paliperidone er)	T3	ST
INVEGA ER 3 MG TABLET (paliperidone er)	T3	QL (1 tab/day) ST
INVEGA ER 6 MG TABLET (paliperidone er)	T3	ST
INVEGA ER 9 MG TABLET (paliperidone er)	T3	ST
lurasidone hcl 120 mg tablet (Latuda)	T1	
lurasidone hcl 20 mg tablet (Latuda)	T1	
lurasidone hcl 40 mg tablet (Latuda)	T1	QL(1 tab/day)
lurasidone hcl 60 mg tablet (Latuda)	T1	QL(1 tab/day)
lurasidone hcl 80 mg tablet (Latuda)	T1	
olanzapine	T1	
olanzapine (Zyprexa)	T1	
paliperidone er 1.5 mg tablet	T1	
paliperidone er 3 mg tablet (Invega)	T1	QL (1 tab/day)
paliperidone er 9 mg tablet (Invega)	T1	
quetiapine fumarate (Seroquel Xr)	T1	
quetiapine fumarate 400 mg tab (Seroquel)	T1	
quetiapine fumarate (Seroquel)	T1	
risperidone	T1	
risperidone (Risperdal)	T1	
SAPHRIS (asenapine maleate)	T3	ST

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

T4 – Specialty Medications

PA – Prior Authorization

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ST – Step Therapy

AGE – Age Requirement

SP – Specialty Medication

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List of Prescription Medications

PSYCHOTHERAPEUTIC DRUGS (Schizophrenia/Anti-Psychotics)⁹ (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ANTI-PSYCHOTIC,ATYPICAL,DOPAMINE,SEROTONIN ANTAGNST (cont.)		
SECUDO	T3	ST
SEROQUEL (<i>quetiapine fumarate</i>)	T3	ST
SEROQUEL XR (<i>quetiapine fumarate er</i>)	T3	ST
ziprasidone hcl	T1	
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		
aripiprazole	T1	
aripiprazole 1 mg/ml solution	T1	
aripiprazole 2 mg tablet	T1	
aripiprazole 5 mg tablet	T1	QL (1 tab/day)
aripiprazole 10 mg tablet	T1	
aripiprazole 15 mg tablet	T1	
aripiprazole 20 mg tablet	T1	
aripiprazole 30 mg tablet	T1	
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, 4 MG TABLET	T3	ST
ANTI-PSYCHOTICS, DOPAMINE AND SEROTONIN ANTAGONISTS		
loxapine succinate	T1	
ANTI-PSYCHOTICS, DOPAMINE ANTAGONISTS, BUTYROPHENONES		
haloperidol	T1	
haloperidol lactate	T1	
ANTI-PSYCHOTICS, DOPAMINE ANTAGONST, DIHYDROINDOLONES		
molindone hcl	T1	
ANTI-PSYCHOTICS, PHENOTHIAZINES		
chlorpromazine hcl	T1	
fluphenazine hcl	T1	
perphenazine	T1	
thioridazine hcl	T1	

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

T4 – Specialty Medications

PA – Prior Authorization

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ST – Step Therapy

AGE – Age Requirement

SP – Specialty Medication

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List of Prescription Medications

PSYCHOTHERAPEUTIC DRUGS (Schizophrenia/Anti-Psychotics)⁹ (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ANTI-PSYCHOTICS, PHENOTHIAZINES (con't.)		
trifluoperazine hcl	T1	
SSRI-ANTI-PSYCH, ATYPICAL, DOPAMINE, SEROTONIN ANTAG		
olanzapine/fluoxetine hcl	T1	
olanzapine/fluoxetine hcl (Symbyax)	T1	

PSYCHOTHERAPEUTIC DRUGS (Sleep Disorders/Sedatives)

NARCOLEPSY AND SLEEP DISORDER THERAPY AGENTS		
armodafnil	T1	PA
modafnil	T1	PA
modafnil (Provigil)	T1	PA
SUNOSI	T2	PA QL (1 tab/day)

SEDATIVE/HYPNOTICS (Sleep Disorders/Sedatives)

ANTI-NARCOLEPSY, ANTI-CATAPLEXY, SEDATIVE-TYPE AGENT		
LUMRYZ	T4	PA QL(1 pack/day) SP HD
LUMRYZ STARTER PACK	T4	PA SP HD
SODIUM OXYBATE 0.5 G/ML SOLN	T4	PA QL(18 mls/day) SP HD
XYWAV	T4	PA SP HD

BARBITURATES		
phenobarbital	T1	
secobarbital sodium	T3	PA

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
ramelteon (Rozerem)	T1	QL (1 tab/day)
tasimelteon	T4	PA SP

SEDATIVE-HYPNOTICS - BENZODIAZEPINES		
DORAL	T3	
estazolam	T1	
flurazepam hcl	T1	
HALCION (triazolam)	T3	
midazolam hcl	T1	
QUAZEPAM	T1	

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

T4 – Specialty Medications

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List of Prescription Medications

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

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
SEDATIVE-HYPNOTICS - BENZODIAZEPINES (con't.)		
<i>quazepam</i> (Quazepam)	T1	
<i>temazepam</i>	T1	
<i>triazolam</i> (Halcion)	T1	
SEDATIVE-HYPNOTICS, NON-BARBITURATE		
<i>DAYVIGO</i>	T2	QL (1 tab/day) ST
<i>doxepin hcl 3 mg tablet</i> (Silenor)	T1	QL (1 tab/day)
<i>doxepin hcl 6 mg tablet</i> (Silenor)	T1	
<i>eszopiclone</i> (Lunesta)	T1	
<i>DAYVIGO</i>	T2	QL (1 tab/day) ST
<i>doxepin hcl 3 mg tablet</i> (Silenor)	T1	QL (1 tab/day)
<i>doxepin hcl 6 mg tablet</i> (Silenor)	T1	
<i>zaleplon</i>	T1	
<i>zolpidem tart er 12.5 mg tab</i>	T1	
<i>zolpidem tart er 6.25 mg tab</i>	T1	QL (1 tab/day)
<i>zolpidem tartrate</i>	T1	
<i>zolpidem tartrate 5 mg tablet</i> (Ambien)	T1	
<i>zolpidem tartrate 10 mg tablet</i> (Ambien)	T1	

SKIN PREPS (Miscellaneous)

IRRIGANTS		
<i>acetic acid</i>	T1	
<i>neomycin sulf/polymyxin b sulf</i>	T1	
PHYSIOLYTE	T3	
PHYSIOSOL	T3	
<i>ringer's solution</i>	T1	
<i>ringer's solution, lactated</i>	T1	
<i>sod, pot chlor/mag/sod, pot phos</i>	T3	
<i>sodium chloride irrig solution</i>	T1	
SORBITOL	T1	
SORBITOL-MANNITOL	T1	
VASHE WOUND	T3	
VASHE WOUND THERAPY	T3	
<i>water for irrigation, sterile</i>	T1	
OXIDIZING AGENTS		
<i>hydrogen peroxide</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 (Pain Relief And Inflammatory Disease)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ANTI-PSORIATIC AGENTS, SYSTEMIC		
acitretin	T1	
BIMZELX	T4	PA QL(2 mls/28 days) SP HD
BIMZELX AUT ACZONE 7.5% GEL PUMP (dapsoneOINJECTOR	T4	PA QL(2 mls/28 days) SP HD
COSENTYX	T4	PA QL SP
ILUMYA	T4	PA QL (1 syringe/84 days) SP HD
SILIQ	T4	PA QL SP
<i>methoxsalen</i> (Oxsoralen-ultra)	T1	
OXSORALEN-ULTRA (<i>methoxsalen</i>)	T3	
SKYRIZI (2 SYRINGES) KIT	T4	PA QL (1 kit/84 days) SP HD
SOTYKTU	T4	PA QL (1 tab/day) SP HD
SPEVIGO	T4	PA QL(2 mls/28 days) SP HD
TALTZ AUTOINJECTOR	T4	PA QL (1 injector/28 days) SP HD
TALTZ AUTOINJECTOR (2 PACK)	T4	PA QL (1 injector/28 days) SP HD
TALTZ AUTOINJECTOR (3 PACK)	T4	PA QL (1 injector/28 days) SP HD
TALTZ SYRINGE	T4	PA QL (1 syringe/28 days) SP HD
TREMFYA 100 MG/ML PEN	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(2 syringe/28 days) SP HD

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

TOPICAL ANTI-INFLAMMATORY, NSAIDS (cont.)		
DICLAREAL	T3	HD
<i>diclofenac sodium 1% gel</i>	T1	QL (1000gm/30 days) HD

SKIN PREPS (Skin Conditions)

ACNE AGENTS, SYSTEMIC		
ACCUTANE	T1	
AMNESTEEM	T1	
CLARAVIS	T1	
<i>isotretinoin</i>	T1	
<i>isotretinoin (Absorica)</i>	T1	
MYORISAN	T1	
ZENATANE	T1	
ACNE AGENTS, TOPICAL		
<i>adapalene/benzoyl peroxide</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

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List of Prescription Medications

SKIN PREPS (Skin Conditions)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ACNE AGENTS, SYSTEMIC		
<i>clindamycin phos/benzoyl perox</i>	T1	
<i>clindamycin-benzoyl perox 1-5% pmp</i>	T1	
<i>clindamycin/tretinoin</i>	T1	
<i>dapsone 5% gel (Aczone)</i>	T1	
DAPSONE 7.5% GEL	T3	
KLARON (sulfacetamide sodium)	T3	
<i>sulfacetamide sodium (Klaron)</i>	T1	
ANTI-PERSPIRANTS		
DRYSOL	T3	
ANTI-PRURITICS, TOPICAL		
ALEVICYN PLUS	T3	
ANTI-PSORIATICS AGENTS		
<i>anthralin</i>	T1	
<i>calcipotriene</i>	T1	
<i>calcipotriene 0.005% cream</i>	T1	
CALCIPOTRIENE 0.005% FOAM	T3	
<i>calcipotriene 0.005% ointment</i>	T1	
<i>calcipotriene 0.005% solution</i>	T1	
<i>calcitriol 3 mcg/g ointment</i>	T1	QL (800gm/30 days)
<i>tazarotene (Tazorac)</i>	T1	
<i>tazarotene 0.05% cream</i>	T1	
<i>tazarotene 0.05% gel (Tazorac)</i>	T1	
<i>tazarotene 0.1% gel (Tazorac)</i>	T1	
ANTI-SEBORRHEIC AGENTS		
OVACE PLUS	T3	
<i>selenium sulfide</i>	T1	
<i>sulfacetamide sodium</i>	T1	
TERSI FOAM	T3	
ANTISEPTICS, MISCELLANEOUS		
GUAIACOL	T1	
DIABETIC ULCER PREPARATIONS, TOPICAL		
REGRANEX	T3	PA QL (2 tubs/30 days)
EMOLLIENTS		
<i>ammonium lactate</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
EMOLLIENTS (con't.)		
ATOPICLAIR	T3	
<i>emollient combination no.35 (Mimyx)</i>	T1	
<i>emollient combination no.60 (Restizan)</i>	T1	
<i>emollient combination no.60 (Restizan)</i>	T3	
HALUCORT	T3	
HPR PLUS-MB HYDROGEL	T1	
MIMYX (<i>prumyx</i>)	T3	
RESTIZAN	T1	
<i>vite ac/grape/hyaluronic acid (Atopiclair)</i>	T1	
XCLAIR	T3	
IMMUNOMODULATORS		
<i>imiquimod</i>	T1	
IRRITANTS/COUNTER-IRRITANTS		
<i>methyl salicylate</i>	T1	
QUTENZA	T3	
JANUS KINASE (JAK) INHIBITORS		
CIBINQO	T4	PA QL(30 tabs/30 days) SP
KERATOLYTICS		
BENZEOFAM	T3	
BENZEPRO	T1	
<i>benzoyl peroxide</i>	T1	
<i>benzoyl peroxide (Enzoclear)</i>	T1	
<i>benzoyl peroxide (Pacnex)</i>	T1	
ENZOCLEAR	T3	
HYDRO 35	T3	
HYDRO 40 (<i>umecta</i>)	T3	
INOVA	T3	
KERAFOAM	T3	
KERALYT 6% GEL (<i>salicylic acid</i>)	T3	
<i>keralyt 6% shampoo</i>	T1	
KERALYT SCALP (<i>salicylic acid</i>)	T3	
PACNEX (<i>benzoyl peroxide</i>)	T3	
PODOCON-25	T1	
<i>podofilox</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

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List of Prescription Medications

SKIN PREPS (Skin Conditions) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
KERATOLYTICS (con't.)		
<i>podofilox</i> (Condylox)	T1	
PR BENZOYL PEROXIDE	T1	
SALICATE	T3	
<i>salicylic acid</i>	T3	
<i>salicylic acid</i> (Keralyt Scalp)	T1	
<i>salicylic acid/ceramide comb 1</i>	T1	
SALIMEZ FORTE	T1	
SALKERA	T3	
SALVAX DUO PLUS	T3	
<i>silver nitrate</i>	T1	
<i>silver nitrate applicator</i>	T1	
URAMAXIN	T3	
URAMAXIN (<i>urea</i>)	T3	
<i>urea</i> (Hydro 35)	T1	
<i>urea</i> (Hydro 40)	T3	
<i>urea</i> (Uramaxin)	T1	
<i>urea</i> (Xurea)	T1	
XUREA	T3	
PROTECTIVES		
BIONECT	T3	
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>	T1	
<i>ivermectin</i>	T1	
<i>metronidazole</i>	T1	
SOOLANTRA (<i>ivermectin</i>)	T3	
TISSUE/WOUND ADHESIVES		
ARTISS	T3	
SURGISEAL STYLUS	T3	
SURGISEAL TEARDROP	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
TISSUE/WOUND ADHESIVES (con't.)		
SURGISEAL TWIST	T3	
TISSEEL VHSD	T3	
TOP. ANTI-INFLAM., PHOSPHODIESTERASE-4 (PDE4) INHIB		
EUCRISA	T2	
ZORYVE 0.15% CREAM	T2	ST QL(60 gms/30 days)
TOPICAL AGENTS, MISCELLANEOUS		
GORDON'S UREA	T3	
HYFTOR	T4	PA SP
L-MESITRAN SOFT	T3	
MEDIHONEY	T3	
SAF-CLENS AF	T1	
trichloroacetic acid	T3	
TRICHLOROACETIC ACID	T1	
urea	T1	
TOPICAL ANTIBIOTIC PLEUROMUTILIN DERIVATIVES		
ALTABAX	T3	
TOPICAL ANTI-INFLAMMATORY STEROIDAL		
ALA-SCALP (<i>scalacort</i>)	T3	ST
alclometasone dipropionate	T1	
amcinonide 0.1% cream	T1	
amcinonide 0.1% lotion	T1	
amcinonide	T1	
AQUA GLYCOLIC HC	T3	
betamethasone dipropionate	T1	
betamethasone valerate	T1	
betamethasone valerate (Luxiq)	T1	
betamethasone/propylene glyc	T1	
betamethasone/propylene glyc (Diprolene)	T1	
BRYHALI	T3	ST
CAPEX SHAMPOO	T3	ST
clobetasol 0.05% cream (Temovate)	T1	
clobetasol 0.05% gel	T1	
clobetasol 0.05% ointment (Temovate)	T1	
clobetasol 0.05% shampoo (Clobex)	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

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List of Prescription Medications

SKIN PREPS (Skin Conditions) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
TOPICAL ANTI-INFLAMMATORY STEROIDAL (cont.)		
clobetasol 0.05% solution	T1	
clobetasol 0.05% topical lotion	T1	
clobetasol prop 0.05% foam (Olux)	T1	
clobetasol prop 0.05% spray (Clobex)	T1	
clobetasol propionate/emollient	T1	
CLOCORTOLONE PIVALATE	T1	
CLODAN 0.05% KIT	T3	ST
clodan 0.05% shampoo	T1	
CLODERM	T3	ST
DERMA-SMOOTH-E-FS (fluocinolone acetonide)	T3	ST
DERMATOP (prednicarbate)	T3	ST
desonide	T1	
desonide (Desowen)	T1	
DESOWEN 0.05% CREAM	T3	ST
desoximetasone (Topicort)	T1	
DIPROLENE (betamethasone diprop augmented)	T3	ST
fluocinolone acetonide (Derma-Smoothe-Fs)	T1	
fluocinolone/shower cap (Derma-Smoothe-Fs)	T1	
fluocinolone acetonide	T1	
fluocinolone acetonide (Derma-smoothe-fs)	T1	
fluocinolone acetonide (Synalar)	T1	
fluocinolone/shower cap (Derma-smoothe-fs)	T1	
fluocinonide	T1	
fluocinonide/emollient base	T1	
fluticasone prop 0.005% oint	T1	
fluticasone prop 0.05% cream	T1	
fluticasone prop 0.05% lotion	T1	
fluticasone propionate	T1	
halcinonide 0.1% solution	T1	
halobetasol prop 0.05% cream	T1	
halobetasol prop 0.05% foam	T1	
halobetasol prop 0.05% ointment	T1	
halobetasol propionate	T1	
halobetasol propionate (Ultravate)	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

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List of Prescription Medications

SKIN PREPS (Skin Conditions) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
TOPICAL ANTI-INFLAMMATORY STEROIDAL (cont.)		
hydrocortisone	T1	
hydrocortisone (Ala-scalp)	T1	
hydrocortisone butyrate	T1	
hydrocortisone valerate	T1	
LUXIQ (betamethasone valerate)	T3	ST
MOMETACURE	T3	
mometasone furoate 0.1%	T1	
mometasone furoate 0.1% soln	T1	
NUCORT	T3	ST
prednicarbate (Dermatop)	T1	
SCALACORT DK	T3	ST
SYNALAR	T3	ST
SYNALAR (fluocinolone acetonide)	T3	ST
SYNALARTS	T3	ST
TEMOVATE (clobetasol propionate)	T3	ST
TEXACORT	T3	ST
TOPICORT (desoximetasone)	T3	ST
ULTRAVATE (halobetasol propionate)	T3	ST
TOPICAL ANTI-INFLAMMATORY STEROID-LOCAL ANESTHETIC		
ANALPRAM HC	T3	
ANALPRAM HC 1% CREAM	T3	
EPIFOAM	T2	
hydrocortisone/pramoxine (Pramosone)	T1	
lidocaine/hydrocortisone ac	T1	
MEZPAROX-HC	T1	
PRAMOSONE	T3	
TOPICAL ANTI-CHOLINERGIC HYPERHIDROSIS TX AGENTS		
QBREXZA	T3	PA
TOPICAL ANTI-PARASITICS		
lindane	T1	
TOPICAL PREPARATIONS, ANTIBACTERIALS		
dermazene cream	T1	
DERMAZENE CREAM PACKET	T3	
hydrocortisone/iodoquinol	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

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List of Prescription Medications

SKIN PREPS (Skin Conditions) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
TOPICAL PREPARATIONS, ANTIBACTERIALS		
hydrocortisone/iodoquinol/aloe	T1	
iodine/potassium iodide	T1	
iodine/sodium iodide	T1	
IODOFLEX	T3	
IODOSORB	T3	
silver nitrate	T1	
TOPICAL VIT D ANALOG/ANTI-INFLAMMATORY STEROID		
calcipotriene/betamethasone	T1	
TOPICAL/MUCOUS MEMBR./SUBCUT. ENZYMES		
SANTYL	T3	QL (60gm/30 days)
VITAMIN A DERIVATIVES		
adapalene (Plixda)	T1	PA
PLIXDA	T1	PA
tretinoin 0.01% gel	T1	
tretinoin 0.025% cream	T1	PA
tretinoin 0.025% gel	T1	
tretinoin 0.05% cream	T1	PA
tretinoin 0.05% gel	T1	PA
tretinoin 0.1% cream	T1	PA
tretinoin microspheres	T1	PA
SMOKING DETERRENTS (Smoking Cessation)⁹		
SMOKING DETERRENT AGENTS (GANGLIONIC STIM, OTHERS)		
NICOTROL	T3	PPACA
NICOTROL NS	T3	PPACA
SMOKING DETERRENT-NICOTINIC RECEPT.PARTIAL AGONIST		
CHANTIX	T3	
varenicline 0.5 mg tablet	T1	PPACA
varenicline 1 mg cont month bx	T1	PPACA
varenicline 1 mg tablet	T1	PPACA
varenicline starting month box	T1	PPACA
SMOKING DETERRENTS, OTHER		
bupropion hcl sr 150 mg tablet	T1	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

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List of Prescription Medications

THYROID PREPS (Hormonal Agents)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ANTI-THYROID PREPARATIONS		
<i>methimazole (Tapazole)</i>	T1	HD
<i>propylthiouracil</i>	T1	HD
<i>TAPAZOLE (methimazole)</i>	T3	HD
THYROID HORMONES		
ARMOUR THYROID	T3	HD
<i>CYTOMEL (liothyronine sodium)</i>	T3	HD
LEVOHYROXINE	T3	PA HD
<i>levothyroxine 100 mcg tablet (Synthroid)</i>	T1	HD
<i>levothyroxine 112 mcg tablet (Synthroid)</i>	T1	HD
<i>levothyroxine 125 mcg tablet (Synthroid)</i>	T1	HD
<i>levothyroxine 137 mcg tablet (Synthroid)</i>	T1	HD
<i>levothyroxine 150 mcg tablet (Synthroid)</i>	T1	HD
<i>levothyroxine 175 mcg tablet (Synthroid)</i>	T1	HD
<i>levothyroxine 200 mcg tablet (Synthroid)</i>	T1	HD
<i>levothyroxine 25 mcg tablet (Synthroid)</i>	T1	HD
<i>levothyroxine 300 mcg tablet (Synthroid)</i>	T1	HD
<i>levothyroxine 50 mcg tablet (Synthroid)</i>	T1	HD
<i>levothyroxine 75 mcg tablet (Synthroid)</i>	T1	HD
<i>levothyroxine 88 mcg tablet (Synthroid)</i>	T1	HD
<i>levothyroxine sodium (Synthroid)</i>	T1	HD
<i>liothyronine sodium (Cytomel)</i>	T1	HD
<i>SYNTHROID (unitriod)</i>	T3	HD
<i>thyroid, pork</i>	T1	HD
<i>thyroid, pork (Armour Thyroid)</i>	T1	HD
<i>thyroid, pork (Wp Thyroid)</i>	T1	HD
THYROLAR-1	T3	HD
THYROLAR-1/2	T3	HD
THYROLAR-1/4	T3	HD
THYROLAR-2	T3	HD
THYROLAR-3	T3	HD
TIROSINT	T3	PA HD
TIROSINT-SOL	T3	PA HD
WP THYROID	T1	HD
<i>WP THYROID (nature-throid) (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

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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 100-50-75 MG/150 MG	T4	PA QL (3 tabs/day) SP HD	
TRIKAFTA 100-50-75 MG/75MG PKT	T4	PA QL(3 tabs/day) SP HD	
TRIKAFTA 50-25-37.5 MG/75 MG	T4	PA QL(3 tabs/day) HD	
TRIKAFTA 80-40-60MG/59.5MG PKT	T4	PA QL(3 tabs/day) SP HD	
CYSTIC FIB-TRANSMEMB CONDUCT.REG.(CFTR) POTENTIATOR			
KALYDECO 5.8 MG GRANULES PKT	T4	PA QL 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(2 tabs/day) SP	
VIJOICE 125mg,50mg	T4	PA QL (30tabs/30days) SP	
VIJOICE 250mg dose pack	T4	PA QL (2 tabs/30days) SP	
ZOKINVY	T4	PA QL (4 caps/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 (Blood Modifiers/Bleeding Disorders)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
SPLEEN TYROSINE KINASE INHIBITORS		
TAVALISSE	T2	PA SP
UNCLASSIFIED DRUG PRODUCTS (Blood Pressure/Heart Medications)		
BRADYKININ B2 RECEPTOR ANTAGONISTS		
<i>icatibant acetate</i>	T4	PA SP HD
CI ESTERASE INHIBITORS		
BERINERT	T4	PA SP HD
CINRYZE	T4	PA SP HD
HAEGARDA	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 (Mesnex)</i>	T4	SP CSL
MESNEX	T4	SP
VISTOGARD	T4	SP

UNCLASSIFIED DRUG PRODUCTS (Dental Products)

DENTAL AIDS AND PREPARATIONS		
<i>chlorhexidine gluconate (Peridex)</i>	T1	
PERIDEX (<i>periogard</i>)	T1	
<i>triamcinolone acetonide</i>	T1	

PERIODONTAL COLLAGENASE INHIBITORS

<i>doxycycline hyclate</i>	T1	
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UNCLASSIFIED DRUG PRODUCTS (Erectile Dysfunction)

DRUGS TO TREAT ERECTILE DYSFUNCTION (ED)		
<i>avanafil (Stendra)</i>	T1	QL(8 tabs/30 days)
CAVERJECT	T3	PA QL (6 injectors/30 days)
CIALIS 10 MG TABLET (<i>tadalafil</i>)	T3	QL (8 tabs/30 days) ST
CIALIS 20 MG TABLET (<i>tadalafil</i>)	T3	QL (8 tabs/30 days) ST
CIALIS 5 MG TABLET (<i>tadalafil</i>)	T3	QL (1 tabs/30 days) ST
EDEX	T3	PA QL (6 injectors/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

UNCLASSIFIED DRUG PRODUCTS (Erectile Dysfunction)

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

UNCLASSIFIED DRUG PRODUCTS (Gastrointestinal/Heartburn)

CALCIMIMETIC, PARATHYROID CALCIUM ENHANCER		
<i>cinacalcet hcl</i>	T4	SP
ORAL MUCOSITIS/STOMATITIS AGENTS		
GELCLAIR	T3	
MUGARD	T3	
ORAMAGICRX	T3	
SALIVA STIMULANT AGENTS		
NUMOISYN	T3	
SALIVA SUBSTITUTE AGENTS		
NEUTRASAL	T3	
THYROID HORMONE RECEPTOR (THR) AGONIST		
REZDIFRA	T4	PA QL(1 tab/day) SP HD

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> (Forteo)	T4	PA QL(0.09 mls/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

UNCLASSIFIED DRUG PRODUCTS (Miscellaneous)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
GROWTH HORMONE RECEPTOR ANTAGONISTS		
SOMAVERT	T4	PA SP HD
HYPERPARATHYROID TX AGENTS - VITAMIN D ANALOG-TYPE		
doxercalciferol	T1	
paricalcitol (Zemplar)	T4	SP HD
RAYALDEE	T3	
ZEMPLAR (paricalcitol)	T4	SP HD
MENOPAUSAL SYMPT SUPP-SEL ESTROGEN RECEP MODULATOR		
OSPHENA	T3	QL(30 tabs/30 days) HD
ABORTIFACIENT-PROGESTERONE RECEPTOR ANTAGONISTS		
MIFEPREX	T3	
mifepristone (Mifeprex)	T1	
mifepristone 200 mg tablet	T1	
mifepristone 300 mg tablet (Korlym)	T4	PA SP
AGENTS TO TX PERIODIC PARALYSIS - CARBON ANHYD INH		
dichlorphenamide (Keveyis)	T4	PA SP
AMMONIA INHIBITORS		
CARBAGLU (carglumic acid)	T4	SP HD
carglumic acid (Carbaglu)	T4	SP HD
AMYLOIDOSIS AGENTS-TRANSTHYRETIN (TTR) SUPPRESSION		
TEGSEDI	T4	PA SP HD
ANTI-ALCOHOLIC PREPARATIONS		
acamprosate calcium	T1	
ANTABUSE (disulfiram)	T3	
disulfiram (Antabuse)	T1	
ANTIDOTES, MISCELLANEOUS		
CETYLEV	T3	
ANTI-FIBROTIC THERAPY - PYRIDONE ANALOGS		
pirfenidone 267 mg capsule (Esbriet)	T4	PA SP HD
pirfenidone 801 mg capsule (Esbriet)	T4	PA SP HD
CRYOPRESERVATIVE AGENTS		
dimethyl sulfoxide	T1	
DRUGS TO TREAT HEREDITARY TYROSINEMIA		
nitisinone (Orfadin)	T4	PA SP HD
NITYR	T4	PA SP

T1 – Typically Generics

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List of Prescription Medications

UNCLASSIFIED DRUG PRODUCTS (Miscellaneous) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
DRUGS TO TREAT HEREDITARY TYROSINEMIA		
ORFADIN	T4	PA SP
ORFADIN (<i>nitisinone</i>)	T4	PA SP
DRUGS TO TX GAUCHER DX-TYPE I, SUBSTRATE REDUCING		
CERDELGA	T4	PA SP HD
<i>miglustat</i> (Zavesca)	T4	PA SP
ZAVESCA (<i>miglustat</i>)	T4	PA SP HD
GENERAL INHALATION AGENTS		
HYPER-SAL	T3	
nebusal 3% vial	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
GLUCOSYLCERAMIDE SYNTHASE (GCS) INHIBITOR		
<i>miglustat</i> (Zavesca)	T4	PA SP HD
OPFOLDA	T4	PA QL(8 caps/30 days) SP HD
INTERLEUKIN-13 (IL-13) INHIBITORS, MAB		
ADBRY	T4	PA SP HD
MENOPAUSAL SYMPTOMS SUPPRESSANT - SSRIs		
<i>paroxetine</i> 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	
<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 HD
EXJADE (<i>deferasirox</i>)	T4	PA SP HD
FERRIPROX	T4	PA SP
FERRIPROX (2 TIMES A DAY)	T4	PA SP

T1 – Typically Generics

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List of Prescription Medications

UNCLASSIFIED DRUG PRODUCTS (Miscellaneous) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
METALLIC POISON, AGENTS TO TREAT		
GALZIN	T4	SP
RADIOGARDASE	T3	
TRIENTINE HCL 500 MG CAPSULE	T4	PA SP HD
<i>trientine hcl</i>	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	T2	QL(8.4 mls/30 days)
OINTMENT/CREAM BASES		
RADIAGEL	T1	
PHARMACOLOGICAL CHAPERONE-ALPHA-GALACTOSID.A STABZ		
GALAFOLD	T4	PA SP HD
PKU TX AGENT-COFAC TOR OF PHENYLALANINE HYDROXYLASE		
<i>javvygor 100 mg powder packet (Kuvan)</i>	T4	PA SP
<i>javvygor 100 mg tablet (Kuvan)</i>	T4	PA SP HD
<i>javvygor 500 mg powder packet (Kuvan)</i>	T4	PA SP
<i>sapropterin dihydrochloride</i>	T4	PA SP HD

UNCLASSIFIED DRUG PRODUCTS (Miscellaneous) (cont.)

PROTEIN STABILIZERS		
ATTRUBY	T3	
VYNDAMAX	T4	PA QL (1 cap/day) SP HD
VYNDAQEL	T4	PA QL (4 caps/day) SP HD
SOLVENTS		
FT ISOPROPYL ALCOHOL 91%	T1	
FT ISOPROPYL RUB ALCOHOL 70%	T3	
GS ISOPROPYL ALCOHOL 70%	T3	
<i>isopropyl alcohol</i>	T1	
MURI-LUBE MINERAL OIL	T1	

UNCLASSIFIED DRUG PRODUCTS (Nutritional/Dietary)

METABOLIC DEFICIENCY AGENTS		
<i>betaine</i> (Cystadane)	T4	SP
CYSTADANE	T4	SP

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

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List of Prescription Medications

UNCLASSIFIED DRUG PRODUCTS (Nutritional/Dietary)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
METABOLIC DEFICIENCY AGENTS		
<i>levocarnitine</i> (Carnitor Sf)	T1	
<i>levocarnitine</i> (Carnitor)	T1	
<i>levocarnitine</i> (with sugar) (Carnitor)	T1	

THYMIC STROMAL LYMPHOPOIETIN (TSLP) INHIBITORS

TEZSPIRE 210 MG/1.91 ML PEN	T4	PA QL(1 pen/28 days) SP HD
TEZSPIRE 210 MG/1.91 ML SYRING	T4	PA SP HD

UNCLASSIFIED DRUG PRODUCTS (Osteoporosis Products)

BONE RESORPTION INHIBITOR AND VITAMIN D COMBS.

FOSAMAX PLUS D	T2	ST HD
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BONE RESORPTION INHIBITORS

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

UNCLASSIFIED DRUG PRODUCTS (Pain Relief And Inflammatory Disease)

ANTI-INFLAM. INTERLEUKIN-I RECEPTOR ANTAGONIST

ARCALYST	T4	PA SP HD
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ANTI-INFLAMMATORY, INTERLEUKIN-I BETA BLOCKERS

ILARIS	T4	PA SP HD
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FIBROMYALGIA AGENTS, SEROTONIN-NOREPINEPHRINE INHIB

SAVELLA	T3	
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IMMUNOMODULATOR, B-LYMPHOCYTE STIM (BLYS)-SPEC INHIB

BENLYSTA	T4	PA SP HD
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UNCLASSIFIED DRUG PRODUCTS (Skin Conditions)

INTERLEUKIN-13 (IL-13) INHIBITORS, MAB

ADBRY AUTOINJECTOR	T4	PA SP HD
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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

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PPACA – No Cost-Share Preventive Medication

CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

UNCLASSIFIED DRUG PRODUCTS (Skin Conditions)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
INTERLEUKIN-13 (IL-13) INHIBITORS, MAB		
EBGLYSS PEN	T4	PA SP
WOUND HEALING AGENTS, LOCAL		
FILSUEZ	T4	PA SP
UNCLASSIFIED DRUG PRODUCTS (Substance Abuse)		
OPIOID WITHDRAWAL THER, ALPHA-2 ADRENERGIC AGONIST		
<i>lofexidine hcl</i> (Lucemyra)	T1	QL(192 tabs/30 days)
LUCEMYRA (<i>lofexidine hcl</i>)	T2	QL (192 tabs/14 days)
OPIOID WITHDRAWAL THER, ALPHA-2 ADRENERGIC AGONIST		
LUCEMYRA	T2	QL (168 tabs/14 days)
OPIOID WITHDRAWAL THERAPY AGENTS, OPIOID-TYPE		
BUNAVAIL	T3	
<i>buprenorphine 2 mg tablet sl</i>	T1	
<i>buprenorphine 8 mg tablet sl</i>	T1	
<i>buprenorphine hcl</i>	T1	
<i>buprenorphine hcl/naloxone hcl</i> (Suboxone)	T1	
SUBOXONE (<i>buprenorphine-naloxone</i>)	T3	
ZUBSOLV	T2	
UNCLASSIFIED DRUG PRODUCTS (Transplant Medications)		
RHO KINASE INHIBITOR		
REZUROCK	T4	PA SP HD
UNCLASSIFIED DRUG PRODUCTS (Urinary Tract Conditions)		
BENIGN PROSTATIC HYPERPLASIA/MICTURITION AGENTS		
<i>alfuzosin hcl</i> (Uroxatral)	T1	HD
<i>dutasteride</i> (Avodart)	T1	HD
BENIGN PROSTATIC HYPERPLASIA/MICTURITION AGENTS (cont.)		
<i>finasteride</i> (Proscar)	T1	HD
PROSCAR (<i>finasteride</i>)	T3	HD
RAPAFLO 4 MG CAPSULE (<i>silodosin</i>)	T3	QL (1 cap/day) HD
RAPAFLO 8 MG CAPSULE (<i>silodosin</i>)	T3	HD
<i>silodosin 4 mg capsule</i> (Rapaflo)	T1	QL (1 cap/day) HD
<i>silodosin 8 mg capsule</i> (Rapaflo)	T1	HD
<i>tamsulosin hcl</i> (Flomax)	T1	HD

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

T4 – Specialty Medications

PA – Prior Authorization

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List of Prescription Medications

UNCLASSIFIED DRUG PRODUCTS (Urinary Tract Conditions)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
BPH 5-ALPHA-REDUCTASE INHIB-ALPHAI-ADRENOCEP ANTAG		
dutasteride/tamsulosin hcl (Jalyn)	T1	HD
CYSTINE-DEPLETING AGENTS, NEPHROPATHIC CYSTINOSIS		
CYSTAGON	T4	SP
KIDNEY STONE AGENTS		
solifenacin 5 mg tablet	T1	QL (1 tab/day) HD
solifenacin 10 mg tablet	T1	HD
THIOLA	T4	SP
tiopronin 100 mg tablet (Thiola)	T4	SP
tiopronin dr tablet	T4	SP
OVERACTIVE BLADDER AGENTS, BETA-3 ADRENERGIC RECEPTOR ANTAGONISTS		
mirabegron er 25 mg tablet (Myrbetriq)	T1	QL(1 tab/day) HD
mirabegron er 50 mg tablet (Myrbetriq)	T1	HD
URINARY TRACT ANTI-SPASMODIC, M(3) SELECTIVE ANTAG.		
darifenacin er 15 mg tablet	T1	HD
darifenacin er 7.5 mg tablet	T1	QL (1 tab/day) HD
URINARY TRACT ANTI-SPASMODIC/ANTI-INCONTINENCE AGENT		
flavoxate hcl	T1	HD
oxybutynin 5 mg/5 ml solution	T1	HD
oxybutynin 5 mg/5 ml syrup	T1	HD
oxybutynin chloride	T1	HD
tolterodine tart er 2 mg cap	T1	QL (1 cap/day) HD
tolterodine tart er 4 mg cap	T1	HD
tolterodine tart er 2 mg cap (Detrol La)	T1	QL(1 cap/day) HD
tolterodine tart er 4 mg cap (Detrol La)	T1	HD
tolterodine tartrate	T1	HD
trospium chloride	T1	HD
UNCLASSIFIED DRUG PRODUCTS (Weight Management)		
APPETITE STIM. FOR ANOREXIA, CACHEXIA, WASTING SYND.		
megestrol acetate	T1	
VITAMINS (Nutritional/Dietary)		
FOLIC ACID PREPARATIONS		
folic acid	T1	
true folic acid 1600mcg dfe tb	T1	

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

T4 – Specialty Medications

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QL – Quantity Limit

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List of Prescription Medications

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

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

T4 – Specialty Medications

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Exclusions and limitations for coverage

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

Plans generally do not provide coverage for the following under the pharmacy benefit, except as required by state or federal law, or by the terms of your specific plan:¹⁰

- 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,¹¹ sexual dysfunction, cosmetic purposes, weight loss, smoking cessation,¹¹ or athletic enhancement.
- Prescription vitamins (other than prenatal vitamins) or dietary supplements unless state or federal law requires coverage of such products.
- Immunization agents, biological products for allergy immunization, biological sera, blood, blood plasma and other blood products or fractions and medications used for travel prophylaxis.
- Replacement of prescription medications and related supplies due to loss or theft.
- Medications which are to be taken by or administered to a covered person while they are a patient in a licensed hospital, skilled nursing facility, rest home or similar institution which operates on its premises or allows to be operated on its premises a facility for dispensing pharmaceuticals.
- Prescriptions more than one year from the date of issue.
- Coverage for prescription medication products for the amount dispensed (days' supply) which is more than the applicable supply limit, or is less than any applicable supply minimum set forth in The Schedule, or which is more than the quantity limit(s) or dosage limit(s) set by the P&T Committee.
- More than one prescription order or refill for a given prescription supply period for the same prescription medication product prescribed by one or more doctors and dispensed by one or more pharmacies.
- Prescription medication products dispensed outside the jurisdiction of the United States, except as required for emergency or urgent care treatment.

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

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

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



1. App/online store terms and mobile phone carrier/data charges apply. Customers under age 13 (and/or their parent/guardian) will not be able to register at myCigna.com.
2. Smoking cessation medications are not typically covered under the plan, except as required by law or by the terms of your specific plan. Costs and complete details of the plan's prescription drug coverage, including a full list of exclusions and limitations, 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.
3. Prices shown on myCigna are not guaranteed and coverage is subject to your plan terms and conditions. Visit myCigna for more information.
4. 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.
5. 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.
6. Standard shipping costs are included as part of your prescription plan.
7. 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.
8. As allowable by law. For medications administered by a health care provider, Accredo will ship the medication directly to your doctor's office.
9. **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.
10. 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.
11. **For plans that must follow state insurance laws, such as Delaware:** Your plan may provide coverage for infertility medications and smoking cessation medications even if this drug list states that your plan may not cover them. To find out if your specific plan covers these medications, log in to the myCigna App or myCigna.com, or check your plan materials.

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

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

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Discrimination is against the law.

Medical coverage

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

Cigna Healthcare:

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

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

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

Cigna Healthcare

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

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

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

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



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Proficiency of Language Assistance Services

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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