



# Cigna Healthcare National Preferred 3-Tier Prescription Drug List

**Coverage as of July 1, 2025**

## **For the State of California**

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

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

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

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

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 This drug list is subject to change and all prior versions are no longer in effect.

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

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### View your drug list online

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

- **Cigna.com/druglist.** Select **National Preferred 3 Tier** from the dropdown menu. Then type in your medication name.
- **myCigna® App<sup>1</sup> or myCigna.com<sup>®</sup>.** As soon as your new plan year starts, log into your account and use the Price a Medication tool.

### Questions?

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

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

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

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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 July 1.
- **Adding extra coverage requirements** to a medication.

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

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

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

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

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

### Q. How do you decide which medications to cover?

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

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

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

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

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

## Information about this drug list

### Frequently asked questions (FAQs) (cont.)

#### Q. What types of medications typically need approval?

A. Medications that:

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

#### Q. What types of medications typically have quantity limits?

A. Medications that are often:

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

#### Q. What types of medications require Step Therapy?

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

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

#### Q. Why does my medication have an age requirement?

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

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

A. Ask your doctor's office to contact Cigna Healthcare to start the coverage review process. They know how the review process works and will take care of everything for you. In case the office asks, they can download a request form from the Cigna Healthcare provider portal at [cignaforhcp.com](http://cignaforhcp.com).

Cigna Healthcare will review information your doctor sends us to make sure you meet coverage requirements for the medication. We'll send you and your doctor a letter with the decision and next steps. It can take up to five (5) business days to hear from us. You can always check with your doctor's office to find out if a decision's been made. You can also log in to the [myCigna App](#) or [myCigna.com](#) to check the status of your approval.

If your medication isn't approved, your doctor can send us more information to review, using the same process as before. We're happy to review the request again. Depending on what your doctor sends this time, we may be able to approve coverage. Or, you and your doctor can appeal the decision by sending Cigna Healthcare a written request explaining why the medication should be covered.

- **For non-urgent requests,** Cigna Healthcare will let you and your doctor know within 72 hours of the decision. If approved, coverage will be provided until the prescription runs out (including refills).
- **For urgent requests based on exigent circumstances,** Cigna Healthcare will let you and your doctor know within 24 hours of the decision. If approved, coverage will be provided for the duration of the exigency. If Cigna Healthcare doesn't respond to a completed prior authorization exception request within 72 hours of receiving a non-urgent request and 24 hours of receiving a request based on exigent circumstances, the request will be considered approved and your plan can't deny coverage of the medication. Also, if you've already received approval from Cigna Healthcare for your plan to cover your medication, Cigna Healthcare can't limit or exclude coverage for that medication if your doctor continues to prescribe it to treat your condition (as long as the medication is appropriately prescribed and is safe and effective in treating your condition).

#### Q. My plan doesn't cover my medication. I need to take it because it's medically necessary for my treatment. How do I get approval (prior authorization) for my medication?

A. If your doctor feels that your medication is

## Information about this drug list

### Frequently asked questions (FAQs) (cont.)

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](http://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](http://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.

## Information about this drug list

### Frequently asked questions (FAQs) (cont.)

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 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.

## Information about this drug list

### Frequently asked questions (FAQs) (cont.)

**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.<sup>2</sup>

**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.<sup>3</sup> Brand-name medications are protected by patents. Patents keep other manufacturers from selling generic versions of the brand-name medication. Once a patent ends, other companies can make and sell a generic version of the brand-name medication. Generics are typically sold under their chemical or scientific name, instead of the manufacturer's patented brand name.

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

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

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

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

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

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

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

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

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

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

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

## Information about this drug list

### Frequently asked questions (FAQs) (cont.)

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](http://Cigna.com/homedelivery).

- Easily order, manage, track and pay for your medications on your phone or online
- Standard shipping at no extra cost<sup>5</sup>
- Automatic refills or refill reminders
- Fill up to a 90-day supply at one time<sup>6</sup>
- 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).<sup>7</sup> 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](http://Cigna.com/specialty).

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

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

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

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

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

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

## Information about this drug list

### Frequently asked questions (FAQs) (cont.)

#### Q. How do I fill my prescription?

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

## Information about this drug list

### Frequently asked questions (FAQs) (cont.)

medications will be covered at 100%, or no cost-share (\$0) to you.

- **For plans with a split deductible [including Health Reimbursements Accounts (HRAs) with a split deductible]:** These medications will be covered at 100%, or no cost-share (\$0) to you.

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

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

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

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

### Words you may need to know

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

## Information about this drug list

### Words you may need to know (cont.)

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

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

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

# Information about this drug list

## About this drug list

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

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

## How to read this drug list

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

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

## Tiers

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

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

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

## Information about this drug list

### How to read this drug list (cont.)

#### Letters (acronyms) next to medication names

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

PA	<b>Prior Authorization*</b> – 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	<b>Quantity Limit*</b> – 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	<b>Step Therapy*</b> – 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	<b>Age Requirement*</b> – 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 <b>specialty medication</b> , 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	<b>Home Delivery Medications</b> – 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 <b>Patient Protection and Affordable Care Act (PPACA)</b> requires plans to cover this preventive medication/product at 100%, or no cost-share (\$0), to you.
CSL	<b>Oral Cancer Medications Subject to Cost-Share Limits</b> – State law in California limits the cost-share (or amount you pay out-of-pocket) for certain oral chemotherapy medications.

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

## Information about this drug list

### How to read this drug list (cont.)

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

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>ANALGESICS (Pain Relief and Inflammatory Disease)</b>		
ANALGESIC, NON-SALICYLATE AND BARBITURATE COMBINAT	T1	
<b>ANALGESIC, SALICYLATE, BARBITURATE, XANTHINE COMB.</b>		
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)
<b>ANALGESIC, NON-SALICYLATE, BARBITURATE, XANTHINE COMB.</b>		
butalbacetaminophen/caffeine	T3	
butalbacetaminophen/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)
<b>ANALGESIC/ANTIPYRETICS, SALICYLATES</b>		
choline salicyl/mag salicylate	T1	HD
diflunisal	T1	HD
<b>ANTI-MIGRAINE PREPARATIONS</b>		
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 National Preferred 3-Tier Prescription Drug List.

# Information about this drug list

## How to find your medication

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

Condition	Page	Condition	Page
<b>Analgesics</b> (Pain Relief and Inflammatory Disease)	18-24	<b>Anti-Infectives/Miscellaneous (Miscellaneous)</b>	49
<b>Analgesics (Urinary Tract Conditions)</b>	24	<b>Anti-Infectives/Miscellaneous (Skin Conditions)</b>	50
<b>Anesthetics (Miscellaneous)</b>	24	<b>Anti-Inflammatory Tumor Necrosis Factor Inhibiting Agents</b>	50
<b>Anesthetics</b> (Pain Relief and Inflammatory Disease)	24, 25	<b>(Pain Relief and Inflammatory Disease)</b>	
<b>Anesthetics (Urinary Tract Conditions)</b>	25	<b>Anti-Neoplastics (Cancer)</b>	50-57
<b>Anti-Allergy (Allergy and Nasal Sprays)</b>	25	<b>Anti-Neoplastics (Skin Conditions)</b>	57
<b>Anti-Arthritis</b> (Pain Relief and Inflammatory Disease)	25-28	<b>Anti-Obesity Drugs (Weight Management)</b>	57, 58
<b>Anti-Asthmatics (Asthma/COPD/Respiratory)</b>	28-30	<b>Anti-Parasitics (Eye Conditions)</b>	58
<b>Antibiotics (Ear Medications)</b>	30, 31	<b>Anti-Parasitics (Infections)</b>	58
<b>Antibiotics (Eye Conditions)</b>	31, 32	<b>Anti-Parkinson's Drugs (Parkinson's Disease)</b>	58, 59
<b>Antibiotics (Infections)</b>	32-38	<b>Anti-Platelet Drugs</b> (Blood Thinners/Anti-Clotting)	59, 60
<b>Antibiotics (Skin Conditions)</b>	38-40	<b>Antivirals (AIDS/HIV)</b>	60-62
<b>Anti-Coagulants (Blood Thinners/Anti-Clotting)</b>	40, 41	<b>Antivirals (Eye Conditions)</b>	63
<b>Antidotes (Gastrointestinal/Heartburn)</b>	41	<b>Antivirals (Infections)</b>	63, 64
<b>Antidotes (Substance Abuse)</b>	41, 42	<b>Antivirals (Skin Conditions)</b>	64
<b>Anti-Fungals (Eye Conditions)</b>	42	<b>Autonomic Drugs (Allergy/Nasal Sprays)</b>	65
<b>Anti-Fungals (Feminine Products)</b>	42	<b>Autonomic Drugs (Alzheimer's Disease)</b>	65
<b>Anti-Fungals (Infections)</b>	42, 43	<b>Autonomic Drugs</b> (Attention Deficit Hyperactivity Disorder)	65, 66
<b>Anti-Fungals (Skin Conditions)</b>	43, 44	<b>Autonomic Drugs</b> (Blood Pressure/Heart Medications)	66
<b>Antihistamine and Decongestant Combination (Allergy/Nasal Sprays)</b>	44	<b>Autonomic Drugs (Urinary Tract Conditions)</b>	66
<b>Antihistamines (Allergy/Nasal Sprays)</b>	44, 45	<b>Biologicals (Allergy/Nasal Sprays)</b>	66
<b>Antihistamines (Eye Conditions)</b>	45	<b>Biologicals</b> (Blood Pressure/Heart Medications)	67
<b>Anti-Hyperglycemics (Diabetes)</b>	45-48	<b>Biologicals (Miscellaneous)</b>	67
<b>Anti-Infectives/Miscellaneous</b> (Feminine Products)	48,	<b>Biologicals (Vaccines)</b>	67-69
		<b>Blood (Blood Modifiers/Bleeding Disorders)</b>	69, 70
		<b>Blood (Blood Thinners/Anti-Clotting)</b>	70

## Information about this drug list

### How to find your medication (cont.)

Condition	Page	Condition	Page
<b>Cardiac Drugs</b> (Blood Pressure/Heart Medications)	70-73	<b>Gastrointestinal</b> (Pain Relief and Inflammatory Disease)	II3
<b>Cardiovascular</b> (Asthma/COPD/Respiratory)	73, 74	<b>Hormones</b> (Gastrointestinal/Heartburn)	II3
<b>Cardiovascular</b> (Blood Pressure/Heart Medications)	74-78	<b>Hormones</b> (Hormonal Agents)	II3-II8
<b>Cardiovascular</b> (Cholesterol Medications)	78-80	<b>Hormones</b> (Infertility)	II8
<b>CNS Drugs</b> (Alzheimer's Disease)	80	<b>Hormones</b> (Miscellaneous)	II8
<b>CNS Drugs</b> (Miscellaneous)	80, 81	<b>Hormones</b> (Osteoporosis Products)	II8
<b>CNS Drugs</b> (Multiple Sclerosis)	81, 82	<b>Immunosuppressants</b> (Pain Relief and Inflammatory Disease)	II9
<b>CNS Drugs</b> (Pain Relief and Inflammatory Disease)	82	<b>Immunosuppressants</b> (Skin Conditions)	II9, I20
<b>CNS Drugs</b> (Seizure Disorders)	82-86	<b>Immunosuppressants</b> (Transplant Medications)	I20
<b>CNS Drugs</b> (Sleep Disorders/Sedatives)	86	<b>Miscellaneous Medical Supplies, Devices, Non-Drug</b> (Diabetes)	I20-I31
<b>Colony Stimulating Factors</b> (Blood Modifiers/Bleeding Disorders)	86	<b>Miscellaneous Medical Supplies, Devices, Non-Drug</b> (Miscellaneous)	I31, I32
<b>Colony Stimulating Factors</b> (Cancer)	86	<b>Muscle Relaxants</b> (Pain Relief and Inflammatory Disease)	I32, I33
<b>Contraceptives</b> (Contraception Products)	86-92	<b>Prenatal Vitamins</b> (Nutritional/Dietary)	I33, I34
<b>Contraceptives</b> (Miscellaneous)	92	<b>Psychotherapeutic Drugs</b> (Anxiety/Depression/Bipolar Disorder)	I35-I37
<b>Cough/Cold Preparations</b> (Cough/Cold Medications)	92, 93	<b>Psychotherapeutic Drugs</b> (Attention Deficit Hyperactivity Disorder)	I37-I39
<b>Diagnostic</b> (Diabetes)	94	<b>Psychotherapeutic Drugs</b> (Schizophrenia/Anti-Psychotics)	I39, I40
<b>Diagnostic</b> (Miscellaneous)	94, 95	<b>Psychotherapeutic Drugs</b> (Sleep Disorders/Sedatives)	I40
<b>Diuretics</b> (Diuretics)	95-97	<b>Sedative/Hypnotics</b> (Sleep Disorders/Sedatives)	I40, I41
<b>EENT Preps</b> (Allergy/Nasal Sprays)	97	<b>Skin Preps</b> (Miscellaneous)	I42
<b>EENT Preps</b> (Ear Medications)	98	<b>Skin Preps</b> (Pain Relief and Inflammatory Disease)	I42
<b>EENT Preps</b> (Eye Conditions)	98-102	<b>Skin Preps</b> (Skin Conditions)	I42-I49
<b>Elect/Caloric/H2O</b> (Dental Products)	I02, I03	<b>Smoking Deterrents</b> (Smoking Cessation)	I49, I50
<b>Elect/Caloric/H2O</b> (Diabetes)	I03	<b>Thyroid Prep</b> (Hormonal Agents)	I50
<b>Elect/Caloric/H2O</b> (Miscellaneous)	I04	<b>Unclassified Drug Products</b> (AIDS/HIV)	I50
<b>Elect/Caloric/H2O</b> (Nutritional/Dietary)	I04-I06	<b>Unclassified Drug Products</b> (Asthma/COPD/Respiratory)	I50, I51
<b>Elect/Caloric/H2O</b> (Urinary Tract Conditions)	I06, I07		
<b>Gastrointestinal</b> (Cholesterol Medications)	I07		
<b>Gastrointestinal</b> (Gastrointestinal/Heartburn)	I07-II3		

## Information about this drug list

### How to find your medication (cont.)

Condition	Page	Condition	Page
Unclassified Drug Products (Blood Pressure/Heart Medications)	I51	Unclassified Drug Products (Osteoporosis Products)	I57
Unclassified Drug Products (Cancer)	I51, I52	Unclassified Drug Products (Pain Relief and Inflammatory Disease)	I58
Unclassified Drug Products (Dental Products)	I52	Unclassified Drug Products (Skin Conditions)	I58
Unclassified Drug Products (Erectile Dysfunction)	I52	Unclassified Drug Products (Substance Abuse)	I58
Unclassified Drug Products (Eye Conditions)	I52	Unclassified Drug Products (Transplant Medications)	I58
Unclassified Drug Products (Gastrointestinal/Heartburn)	I52, I53	Unclassified Drug Products (Urinary Tract Conditions)	I59, I60
Unclassified Drug Products (Hormonal Agents)	I53, I54	Unclassified Drug Products (Weight Management)	I60
Unclassified Drug Products (Miscellaneous)	I54-I56	Vitamins (Nutritional/Dietary)	I60-I69
Unclassified Drug Products (Multiple Sclerosis)	I57	Vitamins (Vitamins)	I69
Unclassified Drug Products (Nutritional/Dietary)	I57		

## List of Prescription Medications

ANALGESICS (Pain Relief and Inflammatory Disease)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>ANALGESIC, NON-SALICYLATE AND BARBITURATE COMBINAT</b>		
acetaminophen w/butalbital	T1	
ALLZITAL	T3	PA
tencon	T1	
<b>ANALGESIC, SALICYLATE, BARBITURATE, XANTHINE COMB.</b>		
butalbital-asp-caffeine (Fiorinal)	T1	
FIORINAL (butalbital-aspirin-caffeine)	T3	PA
<b>ANALGESIC, NON-SALICYLATE, BARBITURATE, XANTHINE COMB.</b>		
butalb/acetaminophen/caffeine	T1	
butalbital/apap/caffeine	T1	
butalbital/apap/caffeine (Esgic)	T1	
ESGIC (butalbital-acetaminophen-caff)	T3	PA
FIORICET (butalbital-acetaminophen-caff)	T3	PA
VANATOL LQ	T3	PA
VANATOL S	T3	PA
vtol lq (Vanatol Lq)	T1	
zebutal (Esgic)	T1	
<b>ANALGESIC/ANTIPYRETICS, SALICYLATES</b>		
aspirin	T1	HD PPACA
aspirin e.c. (Ecotrin)	T1	HD PPACA
buffered aspirin	T1	HD PPACA
bufferin	T1	HD PPACA
choline mag trisalicylate	T1	
diflunisal	T1	HD
ecotrin (Ecotrin)	T1	HD PPACA
ecpirin (Ecotrin)	T1	HD PPACA
tri-buffered aspirin	T1	HD PPACA
<b>ANALGESICS, NON-OPIOID</b>		
JOURNAVX	T3	QL (30 tabs/90 days)
<b>ANTI-MIGRAINE PREPARATIONS</b>		
AIMOVIG AUTOINJECTOR	T2	PA QL (1 inj/23 days)
AJOVY 225 MG/1.5 ML AUTOINJECT	T2	PA QL (1 auto-inj/30 days)
AJOVY 225 MG/1.5 ML AUTOINJECT	T2	PA QL (3 auto-injs/90 days)
AJOVY SYRINGE	T2	PA QL (1 syringe/30 days)
almotriptan malate 12.5 mg tab	T1	ST QL (12 tabs/30 days)

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

PA – Prior Authorization

QL – Quantity Limit

ST – Step Therapy

AGE – Age Requirement

SP – Specialty Medication

HD – May require home delivery pharmacy

PPACA – No Cost-Share Preventive Medication

CSL – Oral cancer medication subject to cost-share limits

## List of Prescription Medications

ANALGESICS (Pain Relief and Inflammatory Disease) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>ANTI-MIGRAINE PREPARATIONS (cont.)</b>		
almotriptan malate 6.25 mg tab	T1	ST QL (6 tabs/30 days)
AMERGE (naratriptan hcl)	T3	ST QL
CAFERGOT (cafergot)	T3	
CAMBIA	T3	ST QL
D.H.E.45 (dihydroergotamine mesylate)	T3	
diclofenac pot powder pack (CAMBIA)	T1	ST QL (9 pkts/30 days)
dihydroergotamine mesylate (D.H.E.45)	T1	
dihydroergotamine mesylate (Migranal)	T1	QL
eletriptan hbr (Relpax)	T1	QL
EMGALITY	T2	PA QL (1 unit/23 days)
EMGALITY SYRINGE	T2	PA QL (1 unit/23 days)
ERGOMAR	T3	
frovatriptan succinate (Frova)	T1	ST QL (9 tabs/30 days)
migergot	T1	
MIGRAL (dihydroergotamine mesylate)	T3	ST QL
naratriptan hcl (Amerge)	T1	QL
NURTEC ODT	T2	PA QL
QULIPTA	T2	PA QL
REYVOW 100MG TABLET	T3	PA QL (8 tabs/treatment)
rizatriptan (Maxalt)	T1	QL
sumatriptan	T1	QL (6 units/30 days)
TOSYMRA	T3	ST QL
UBRELVY 50MG TABLET	T2	PA QL (10 tabs/treatment)
UBRELVY 100MG TABLET	T2	PA QL (10 tabs/treatment)
ZEMBRACE SYMTOUCH	T3	ST QL
zolmitriptan	T1	QL (6 tabs/30 days)
zolmitriptan odt (Zomig ZMT)	T1	QL
ZOMIG 2.5 MG NASAL SPRAY	T2	ST QL (6 units/30 days)
ZOLMITRIPTAN 2.5 MG NASAL SPRY	T3	ST QL (6 units/30 days)
<b>NASAL NSAIDS, COX NON-SELECTIVE, SYSTEMIC ANALGESIC</b>		
SPRIX	T3	ST QL
<b>NSAIDS, CYCLOOXYGENASE INHIBITOR-TYPE ANALGESICS</b>		
diclofenac	T1	QL HD
diclofenac	T1	

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

PA – Prior Authorization

QL – Quantity Limit

ST – Step Therapy

AGE – Age Requirement

SP – Specialty Medication

HD – May require home delivery pharmacy

PPACA – No Cost-Share Preventive Medication

CSL – Oral cancer medication subject to cost-share limits

## List of Prescription Medications

ANALGESICS (Pain Relief and Inflammatory Disease) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>NSAIDS, CYCLOOXYGENASE INHIBITOR-TYPE ANALGESICS (cont.)</b>		
diclofenac pot 25mg tablet	T1	ST HD
diclofenac potassium 25 mg cap (Zipsor)	T1	ST HD
ketorolac 15 mg/ml syringe	T1	
ketorolac 300 mg/10 ml vial	T1	
ketorolac 60 mg/2 ml syringe	T1	
ketorolac 30 mg/ml syringe	T1	
ketorolac 60 mg/2 ml vial	T1	
ketorolac 15 mg/ml vial	T1	
ketorolac 30 mg/ml vial	T1	
mefenamic acid	T1	HD
mefenamic acid	T1	
<b>OPIOID ANALGESIC AND NON-SALICYLATE ANALGESICS</b>		
acetaminophen w/codeine	T1	PA QL
endocet (Endocet)	T1	PA QL
endocet (Percocet)	T1	PA QL
hydrocodone-acetamin 2.5-325	T1	PA QL (12 ds/60 days)
hydrocodone-acetamin 10--300/15	T1	PA QL (12 ds/60 days)
hydrocodone w/acetaminophen (Norco)	T1	PA QL
lorcet (Norco)	T1	PA QL
lorcet hd (Norco)	T1	PA QL
lorcet plus (Norco)	T1	PA QL
LORTAB	T3	PA QL
NALOCET	T3	PA QL
oxycodone w/acetaminophen (Endocet)	T1	PA QL
oxycodone w/acetaminophen (Percocet)	T1	PA QL
tramadol hcl/acetaminophen	T1	PA QL (12 ds/60 days)
tramadol hcl-acetaminophen (Ultracet)	T1	PA QL
TYLENOL W/CODEINE (acetaminophen-codeine)	T3	PA QL
ULTRACET (tramadol hcl-acetaminophen)	T3	PA QL
vicodin hp	T1	PA QL
<b>OPIOID ANALGESIC AND NSAID COMBINATION</b>		
hydrocodone bit-ibuprofen	T1	PA QL
oxycodone hcl-ibuprofen	T1	PA QL

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

PA – Prior Authorization

QL – Quantity Limit

ST – Step Therapy

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HD – 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
<b>OPIOID ANALGESIC AND NON-SALICYLATE XANTHINE COMB</b>		
apap-caffeine-dihydrocodeine (Trezix)	T1	PA QL
dvorah	T1	PA QL
TREZIX	T3	PA QL
<b>OPIOID ANALGESICS</b>		
ACTIQ (fentanyl)	T3	ST QL (90 units/63 days)
ARYMO ER	T3	ST QL (120 tabs/23 days)
BELBUCA	T2	PA QL (60 films/30 days)
belladonna & opium	T1	PA QL
buprenorphine (Butrans)	T1	PA
butorphanol	T1	PA QL (12 ds/180 days)
codeine	T1	PA QL
CONZIP	T3	ST QL (30 units/30 days)
DILAUDID (hydromorphone hcl)	T3	PA QL
diskets	T1	
DOLOPHINE HCL (methadone hcl)	T3	ST
fentanyl	T1	PA QL (15 patches/30 days)
fentanyl (Actiq)	T1	QL (90 units/63 days)
fentanyl (Duragesic)	T1	QL (15 patches/23 days)
fentanyl cit otfc 1,200 mcg	T1	PA QL (90 lozs/30 days)
fentanyl citrate otfc 200 mcg	T1	PA QL (90 lozs/30 days)
fentanyl citrate otfc 400 mcg	T1	PA QL (90 lozs/30 days)
fentanyl citrate otfc 600 mcg	T1	PA QL (90 lozs/30 days)
fentanyl citrate otfc 800 mcg	T1	PA QL (90 lozs/30 days)
hydrocodone bitartrate (Zohydro ER)	T1	QL (90 units/23 days)
hydrocodone er 100 mg tablet (Hysingla ER)	T1	PA QL (60 tabs/30 days)
hydrocodone er 120 mg tablet (Hysingla ER)	T1	PA QL (60 tabs/30 days)
hydrocodone er 20 mg capsule (Zohydro ER)	T1	PA QL (90 caps/30 days)
hydrocodone er 20 mg tablet (Hysingla ER)	T1	PA QL (60 tabs/30 days)
hydrocodone er 30 mg tablet (Hysingla ER)	T1	PA QL (60 tabs/30 days)
hydrocodone er 40 mg tablet (Hysingla ER)	T1	PA QL (60 tabs/30 days)
hydrocodone er 60 mg tablet (Hysingla ER)	T1	PA QL (60 tabs/30 days)
hydrocodone er 80 mg tablet (Hysingla ER)	T1	PA QL (60 tabs/30 days)
hydrocodone er 10 mg capsule	T1	PA QL (90 caps/30 days)
hydrocodone er 15 mg capsule	T1	PA QL (90 caps/30 days)

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

PA – Prior Authorization

QL – Quantity Limit

ST – Step Therapy

AGE – Age Requirement

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## List of Prescription Medications

ANALGESICS (Pain Relief and Inflammatory Disease) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>OPIOID ANALGESICS (cont.)</b>		
hydrocodone er 20 mg capsule	T1	PA QL (90 caps/30 days)
hydrocodone er 30 mg capsule	T1	PA QL (90 caps/30 days)
hydrocodone er 40 mg capsule	T1	PA QL (90 caps/30 days)
hydrocodone er 50 mg capsule	T1	PA QL (90 caps/30 days)
hydromorphone	T1	QL (60 tabs/23 days)
hydromorphone er	T1	QL (60 tabs/23 days)
hydromorphone hcl (Dilauidid)	T1	PA QL
HYSINGLA ER	T2	ST QL (60 units/23 days)
HYSINGLA ER ( <i>hydrocodone bitartrate</i> )	T2	PA QL (60 tabs/30 days)
KADIAN (morphine er)	T3	ST QL (90 caps/23 days)
LAZANDA 100 MCG NASAL SPRAY	T3	PA QL (23 units/30 days)
LAZANDA 400 MCG NASAL SPRAY	T3	PA QL (23 units/30 days)
levorphanol tartrate	T1	PA QL
methadone hcl	T1	
methadone hcl (Dolophine Hcl)	T1	
methadose	T1	
morphine	T1	PA QL (12 ds/60 days)
MORPHINE	T3	PA QL
morphine cr (Ms Contin)	T1	QL (120 tabs/23 days)
morphine er 10 mg cap	T1	PA QL (90 caps/30 days)
morphine er 20 mg cap	T1	PA QL (90 caps/30 days)
morphine er 30 mg cap	T1	PA QL (90 caps/30 days)
morphine er 30 mg cap	T1	PA QL (60 caps/30 days)
morphine er 45 mg cap	T1	PA QL (60 caps/30 days)
morphine er 60 mg cap	T1	PA QL (60 caps/30 days)
morphine er 50 mg cap	T1	PA QL (90 caps/30 days)
morphine er 60 mg cap	T1	PA QL (90 caps/30 days)
morphine er 100 mg cap	T1	PA QL (90 caps/30 days)
morphine er 75 mg cap	T1	PA QL (60 caps/30 days)
morphine er 90 mg cap	T1	PA QL (60 caps/30 days)
morphine er 120 mg cap	T1	PA QL (60 caps/30 days)
morphine er (Kadian)	T1	QL (90 caps/23 days)
morphine er 15 mg tablet (Ms Contin)	T1	PA QL (120 tabs/30 days)
morphine er 30 mg tablet (Ms Contin)	T1	PA QL (120 tabs/30 days)

T1 – Typically Generics

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## List of Prescription Medications

ANALGESICS (Pain Relief and Inflammatory Disease) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>OPIOID ANALGESICS (cont.)</b>		
morphine er 60 mg tablet (Ms Contin)	T1	PA QL (120 tabs/30 days)
morphine er 100 mg tablet (Ms Contin)	T1	PA QL (120 tabs/30 days)
morphine er 200 mg tablet (Ms Contin)	T1	PA QL (120 tabs/30 days)
morphine er (MS Contin)	T1	QL (120 tabs/23 days)
MS CONTIN (morphine)	T3	PA QL (120 tabs/30 days)
MS CONTIN (morphine cr, morphine er)	T3	ST QL (120 tabs/23 days)
MS CONTIN (morphine er)	T3	ST QL (120 tabs/23 days)
oxycodone (ir) 5 mg cap	T1	PA QL (12 ds/60 days)
oxycodone 100 mg/5 ml conc	T1	PA QL (12 ds/60 days)
oxycodone 5 mg/5 ml cup, soln	T1	PA QL (12 ds/60 days)
oxycodone (ir) 10 mg tab	T1	PA QL (12 ds/60 days)
oxycodone (ir) 20 mg tab	T1	PA QL (12 ds/60 days)
oxycodone (ir) 5 mg tablet (Roxicodone)	T1	PA QL (12 ds/60 days)
oxycodone (ir) 15 mg tab (Roxicodone)	T1	PA QL (12 ds/60 days)
oxycodone (ir) 30 mg tab (Roxicodone)	T1	PA QL (12 ds/60 days)
OXYCONTIN	T2	PA QL (90 tabs/30 days)
oxymorphone	T1	PA QL (90 tabs/30 days)
oxymorphone er	T1	QL (90 tabs/23 days)
pentazocine and naloxone hcl	T1	PA QL
ROXICODONE (oxycodone hcl)	T3	PA QL
SUBSYS	T3	PA QL (90 units/30 days)
tramadol hcl 100 mg tablet	T1	PA QL (12 ds/60 days)
tramadol er 100 mg tablet	T1	PA QL (30 tabs/30 days)
tramadol er 200 mg tablet	T1	PA QL (30 tabs/30 days)
tramadol er 300 mg tablet	T1	PA QL (30 tabs/30 days)
tramadol hcl er 100 mg tablet	T1	PA QL (30 tabs/30 days)
tramadol hcl er 200 mg tablet	T1	PA QL (30 tabs/30 days)
tramadol hcl er 300 mg tablet	T1	PA QL (30 tabs/30 days)
ULTRAM (tramadol hcl)	T3	PA QL
<b>OPIOID AND SALICYLATE ANALGESICS, BARBIT, XANTHINE</b>		
asa-butalb-caff-cod (Fiorinal With Codeine #3)	T1	PA QL
ascomp with codeine (Fiorinal With Codeine #3)	T1	PA QL
butalbital compound w/codeine (Fiorinal With Codeine #3)	T1	PA QL
FIORINAL W/CODEINE (asa-butalb-caffeine-codeine)	T3	PA QL

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## List of Prescription Medications

ANALGESICS (Pain Relief and Inflammatory Disease) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>OPIOID, NON-SALICYL, ANALGESIC, BARBITUATE, XANTHINE</b>		
<i>butalbital/caff/apap/codeine</i> (Fioricet With Codeine)	T1	PA QL
<i>FIORICET WITH CODEINE (butalb-acetaminoph-caff-codein)</i>	T3	PA QL
<b>SKELETAL MUSCLE RELAXANT, SALICYLAT, OPIOID ANALGES</b>		
<i>carisoprodol-aspirin-codeine</i>	T1	PA QL
ANALGESICS (Urinary Tract Conditions)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>URINARY TRACT ANALGESIC AGENTS</b>		
<i>ELMIRON</i>	T2	
<i>RIMSO-50</i>	T3	
ANESTHETICS (Miscellaneous)		
<b>GENERAL ANESTHETICS, INHALANT</b>		
<i>desflurane</i> (Suprane)	T1	
<i>forane</i> (Forane)	T1	
<i>isoflurane</i> (Forane)	T1	
<i>sevoflurane</i> (Ultane)	T1	
<i>SUPRANE</i>	T3	
<i>terrell</i> (Forane)	T1	
<i>ULTANE (sevoflurane)</i>	T3	
ANESTHETICS (Pain Relief and Inflammatory Disease)		
<b>LOCAL ANESTHETICS</b>		
<i>glydo</i>	T1	QL (60 ml/23 days)
<i>lidocaine</i>	T1	
<i>lidocaine hcl</i>	T1	QL (60 ml/23 days)
<b>TOPICAL LOCAL ANESTHETICS</b>		
<i>CETACAINE ANESTHETIC</i>	T3	
<i>L.E.T. (LIDO-EPINEPH-TETRA)</i>	T3	
<i>lidocaine</i> (Lidocan li)	T1	PA
<i>lidocaine</i> (Lidoderm)	T1	PA
<i>lidocaine 5% ointment</i>	T1	QL (50 gm/21 days)
<i>lidocaine 5% patch</i> (Lidocan li)	T1	PA
<i>lidocaine hcl</i>	T1	
<i>LIDOCAIN-EPINEPHRIN-TETRACAIN</i>	T3	

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## List of Prescription Medications

ANESTHETICS (Pain Relief and Inflammatory Disease) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>TOPICAL LOCAL ANESTHETICS (cont.)</b>		
<i>lidocaine-prilocaine</i>	T1	QL (30 gm/23 days)
LIDOCAN II ( <i>lidocaine</i> )	T3	PA
SYNERA	T3	
ZTLIDO	T2	PA
<b>ANESTHETICS (Urinary Tract Conditions)</b>		
<b>URINARY TRACT ANESTHETIC/ANALGESIC AGNT (AZO-DYE)</b>		
<i>phenazopyridine hcl</i> (Pyridium)	T1	
PYRIDIUM ( <i>phenazopyridine hcl</i> )	T3	
<b>ANTI-ALLERGY (Allergy/Nasal Sprays)</b>		
<b>MAST CELL STABILIZERS</b>		
<i>cromolyn</i> (Gastrocrom)	T1	
GASTROCROM ( <i>cromolyn</i> )	T3	
<b>ANTI-ARTHRITICS (Pain Relief and Inflammatory Disease)</b>		
<b>ANALGESIC/ANTIPYRETICS, SALICYLATES</b>		
<i>salsalate</i>	T1	HD
<b>ANTI-ARTHRITIC AND CHELATING AGENTS</b>		
DEPEN ( <i>penicillamine</i> )	T3	PA SP
penicillamine (Cuprimine)	T1	PA SP
penicillamine (Depen)	T1	PA SP
<b>ANTI-ARTHRITIC, FOLATE ANTAGONIST AGENTS</b>		
RASUVO	T2	ST
<b>ANTI-INFLAMMATORY, PYRIMIDINE SYNTHESIS INHIBITOR</b>		
<i>ARAVA</i> ( <i>leflunomide</i> )	T3	QL (30 units/30 days) HD
<i>leflunomide</i> (Arava)	T1	QL (30 units/30 days) HD
<b>ANTI-INFLAMMATORY, PHOSPHODIESTERASE-4(PDE4) INHIB.</b>		
OTEZLA 10-20 MG STARTER 28 DAY	T2	PA QL (55 tabs/365 days) SP HD
OTEZLA 10-20-30 MG START 28 DAY	T2	PA QL (55 tabs/365 days) SP HD
OTEZLA 20 MG TABLET	T2	PA QL (60 tabs/30 days) SP HD
OTEZLA 30 MG TABLET	T2	PA QL (60 tabs/23 days) SP HD
<b>COLCHICINE</b>		
<i>colchicine</i> (Colcrys)	T1	HD
<i>colchicine 0.6 mg capsule</i> (Mitigare)	T1	ST
GLOPERBA	T3	HD

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## List of Prescription Medications

ANTI-ARTHRITICS (Pain Relief and Inflammatory Disease) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>COLCHICINE (cont.)</b>		
MITIGARE ( <i>colchicine</i> )	T2	ST
<b>GOLD SALTS</b>		
AURANOFIN	T2	
febuxostat (Uloric)	T1	HD
RIDAURA	T2	
ZYLOPRIM ( <i>allopurinol</i> )	T3	HD
<b>HYPURICEMIA TX - XANTHINE OXIDASE INHIBITORS</b>		
<i>allopurinol</i>	T1	HD
<i>allopurinol</i> (Zyloprim)	T1	HD
<b>JANUS KINASE (JAK) INHIBITORS</b>		
RINVOQ ER 15 MG, 30 MG TABLET	T2	PA QL (30 tabs/30 days) SP
RINVOQ LQ	T2	PA QL (360 mls/30 days) SP HD
XELJANZ	T2	PA QL SP HD
XELJANZ 1mg/ml ORAL SOLUTION	T2	QL (300ml/30 Days)
XELJANZ XR	T2	PA QL (30 units/30 days) SP HD
<b>NSAIDS (COX NON-SPEC.INHIB) AND PROSTAGLANDIN ANALOG</b>		
ARTHROTEC ( <i>diclofenac -misoprostol</i> )	T3	ST HD
<i>diclofenac -misoprostol</i> (Arthrotec 50)	T1	HD
<i>diclofenac -misoprostol</i> (Arthrotec 75)	T1	HD
<b>NSAIDS, CYCLOOXYGENASE INHIBITOR - TYPE ANALGESICS</b>		
ANAPROX DS ( <i>naproxen</i> )	T3	ST HD
DAYPRO ( <i>oxaprozin</i> )	T3	ST HD
EC-NAPROSYN ( <i>ec-naproxen</i> )	T3	ST HD
<i>ec-naproxen dr 375 mg tablet</i> ( <i>Ec-Naprosyn</i> )	T1	HD
<i>ec-naproxen dr 500 mg tablet</i> ( <i>Ec-Naprosyn</i> )	T1	ST HD
etodolac (Lodine)	T1	HD
etodolac (Lodine)	T1	
etodolac er	T1	HD
FELDENE ( <i>piroxicam</i> )	T3	ST HD
FENORTHO 200 MG CAPSULE	T3	ST HD
<i>fenoprofen</i>	T1	HD
<i>flurbiprofen</i>	T1	HD
<i>ibu</i>	T1	HD
<i>ibuprofen</i>	T1	HD

T1 – Typically Generics

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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
<b>NSAIDS, CYCLOOXYGENASE INHIBITOR - TYPE ANALGESICS (cont.)</b>		
<i>ibuprofen</i> (Children'S Advil)	T1	HD
INDOCIN	T3	ST HD
<i>indomethacin</i>	T1	HD
INDOMETHACIN 20 MG CAPSULE	T3	ST QL (90 caps/30 days) HD
<i>indomethacin 25 mg/5 ml susp</i> (Indocin)	T1	ST HD
<i>indomethacin 50 mg suppository</i> (Indocin)	T1	HD
<i>ketoprofen</i>	T1	ST HD
LODINE ( <i>etodolac</i> )	T3	ST HD
<i>meclofenamate</i>	T1	HD
<i>meloxicam 15mg tablet</i> (Mobic)	T1	HD
MOBIC 7.5 MG TABLET ( <i>meloxicam</i> )	T3	ST QL (30 units/30 days) HD
MOBIC 15 MG TABLET ( <i>meloxicam</i> )	T3	ST QL (30 tabs/30 days) HD
<i>nabumetone</i> (Relafen)	T1	HD
NALFON ( <i>fenoprofen</i> )	T3	ST HD
NAPRELAN ( <i>naproxen cr</i> )	T3	ST HD
NAPROSYN ( <i>naproxen</i> )	T3	ST HD
<i>naproxen</i>	T1	ST HD
<i>naproxen dr 500 mg tablet</i> (Ec-Naprosyn)	T1	ST HD
<i>naproxen er 750mg tablet</i> (Naprelan)	T1	ST
<i>naproxen</i> (Anaprox DS)	T1	HD
<i>naproxen</i> (EC-Naprosyn)	T1	HD
<i>naproxen</i> (Naprosyn)	T1	HD
<i>oxaprozin 600 mg caplet, tablet</i> (Daypro)	T1	HD
<i>piroxicam</i>	T1	HD
<i>piroxicam</i> (Feldene)	T1	HD
QMIIZ ODT 7.5MG TABLET	T3	ST QL (30 units/30 days)
QMIIZ ODT 15 MG TABLET	T3	ST
<i>sulindac</i>	T1	HD
TIVORBEX	T3	ST QL (90 caps/30 days) HD
TOLECTIN 600 ( <i>tolmetin sodium</i> )	T3	ST HD
<i>tolmetin</i>	T1	HD
<i>tolmetin sodium 600 mg tab</i> (Tolectin 600)	T1	ST HD
<b>NSAIDS, CYCLOOXYGENASE-2(COX-2) SELECTIVE INHIBITOR</b>		
<i>celecoxib</i> (Celebrex)	T1	HD

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T2 – Typically Preferred Brands

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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
<b>NSAIDS, CYCLOOXYGENASE-2(COX-2) SELECTIVE INHIBITOR (cont.)</b>		
celecoxib	T1	HD
<b>URICOSURIC AGENTS</b>		
probenecid	T1	HD
probenecid w/colchicine	T1	HD
<b>ANTI-ASTHMATICS (Asthma/COPD/Respiratory)</b>		
<b>ANTICHOLINERGICS, ORALLY INHALED LONG ACTING</b>		
INCRUSE ELLIPTA	T2	QL (1 inhaler/30 days) HD
LONHALA MAGNAIR REFILL	T3	QL HD
LONHALA MAGNAIR STARTER	T3	QL HD
SEEBRI NEOHALER	T3	QL HD
SPIRIVA HANDIHALER 18 MCG CAP ( <i>tiotropium bromide</i> )	T3	QL (90 caps/30 days) HD
SPIRIVA RESPIMAT	T2	QL HD
YUPELRI	T2	QL (30 units/30 days) HD
<b>ANTICHOLINERGICS, ORALLY INHALED SHORT ACTING</b>		
ATROVENT HFA	T3	QL HD
<i>ipratropium bromide</i>	T1	HD
<b>BETA-ADRENERGIC AGENTS</b>		
albuterol 2 mg/5 ml syrup cup	T1	HD
albuterol 8 mg/20 ml syrup cup	T1	HD
metaproterenol	T1	HD
<i>terbutaline</i>	T1	HD
<b>BETA-ADRENERGIC AGENTS, INHALED, SHORT ACTING</b>		
albuterol	T1	
albuterol hfa 90 mcg inhaler	T1	QL (2 inhalers/30 days)
albuterol 15 mg/3 ml solution	T1	
albuterol 75 mg/15 ml soln	T1	
<i>levalbuterol hcl</i> (Xopenex Concentrate)	T1	
<i>levalbuterol hcl</i> (Xopenex)	T1	
XOPENEX ( <i>levalbuterol concentrate</i> )	T3	
XOPENEX ( <i>levalbuterol hcl</i> )	T3	
<b>BETA-ADRENERGIC AGENTS, INHALED, ULTRA-LONG ACTING</b>		
ARCAPTA NEOHALER	T3	QL (30 units/30 days) HD
STRIVERDI RESPIMAT	T2	QL (1 inhaler/30 days) HD

T1 – Typically Generics

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## List of Prescription Medications

ANTI-ASTHMATICS (Asthma/COPD/Respiratory) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>BETA-ADRENERGIC AGENTS, ORALLY INHALED, LONG ACTING</b>		
BROVANA	T3	QL HD
FORMOTEROL FUMARATE-NEBULIZER	T2	QL (120 mls/30 days) HD
PERFOROMIST	T3	QL HD
<b>BETA-ADRENERGIC AND ANTICHOLINERGIC COMBO, INHALED</b>		
ANORO ELLIPTA	T2	QL HD
COMBIVENT INHALER	T2	
COMBIVENT RESPIMAT	T2	QL (2 inhalers/30 days)
SEEBRI NEOHALER 15.6MCG INHALER	T3	HD
STIOLTO RESPIMAT	T2	QL HD
UTIBRON NEOHALER 27.5, 15.6MCG (PS 6)	T3	HD
UTIBRON NEOHALER 27.5, 15.6 MCG (PS 60)	T3	HD
<b>BETA-ADRENERGIC AND GLUCOCORTICOID COMBO, INHALED</b>		
ADVAIR HFA	T2	ST QL HD
AIRDUO DIGIHALER	T3	PA QL HD
AIRSUPRA	T2	HD
BREO ELLIPTA 50-25 MCG INHALER	T2	PA QL (60 blisters/fill) HD
BREO ELLIPTA	T2	ST QL HD
breyna 80-4.mcg, 160-4.5 mcg inhaler	T1	PA
budesonide-formoterol 160-4.5, 80-4.5	T1	PA HD QL (1 inhaler/30 days)
DULERA	T2	ST QL HD
fluticasone-salmeterol (Advair Diskus)	T1	PA QL (1 inhaler/30 days)
SYMBICORT (budesonide/formoterol fumarate)	T3	PA QL (1 inhaler/30 days) HD
wixela inhuhub (Advair Diskus)	T1	QL HD
<b>BETA-ADRENERGIC-ANTICHOLINERGIC-GLUCOCORT, INHALED</b>		
TRELEGY ELLIPTA	T2	QL
<b>GLUCOCORTICOIDS, ORALLY INHALED</b>		
ALVESCO	T3	QL HD
ARNUITY ELLIPTA 50 MCG INH	T2	QL (30 blisters/30 days)
ARNUITY ELLIPTA 100 MCG INH	T2	QL (1 inhaler/30 days)
ARNUITY ELLIPTA 200 MCG INH	T2	QL (1 inhaler/30 days)
ASMANEX	T2	QL HD
ASMANEX HFA	T2	QL HD
FLOVENT DISKUS	T2	QL HD
FLOVENT HFA	T2	QL HD

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## List of Prescription Medications

ANTI-ASTHMATICS (Asthma/COPD/Respiratory) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>GLUCOCORTICOIDS, ORALLY INHALED (cont.)</b>		
QVAR REDIHALER 40 MCG	T2	QL (11 gms/30 days)
QVAR REDIHALER 80 MCG	T2	QL (22 gms/30 days)
<b>INTERLEUKIN-5(IL-5) RECEPTOR ALPHA ANTAGONIST, MAB</b>		
FASENRA PEN	T2	PA ST QL (1 pen/56 days) SP HD
<b>LEUKOTRIENE RECEPTOR ANTAGONISTS</b>		
ACCOLATE (zaflunast)	T3	HD
montelukast (Singulair)	T1	HD
zaflunast (Accolate)	T1	HD
<b>MAST CELL STABILIZERS, ORALLY INHALED</b>		
cromolyn	T1	HD
<b>MONOCLONAL ANTIBODIES TO IMMUNOGLOBULIN E (IGE)</b>		
XOLAIR 75MG/0.5 ML AUTOINJECT	T2	PA QL (2 auto-injs/28 days) SP HD
XOLAIR 300 MG/2 ML AUTOINJECT	T2	PA QL (2 auto-injs/28 days) SP HD
XOLAIR 150 MG/ML AUTOINJECTOR	T2	PA QL (2 auto-injs/28 days) SP HD
XOLAIR 300 MG/2 ML SYRINGE	T2	PA QL (2 syringes/28 days) SP HD
XOLAIR 150 MG VIAL	T2	PA QL (6 vials/21 days) SP HD
<b>MONOCLONAL ANTIBODY - INTERLEUKIN-5 ANTAGONISTS</b>		
NUCALA	T2	PA QL (1 unit/21 days) SP HD
<b>MUCOLYTICS</b>		
acetylcysteine	T1	
<b>PHOSPHODIESTERASE (PDE) INHIBITORS</b>		
roflumilast 250 mcg tablet (Daliresp)	T1	PA QL (30 tabs/30 days) HD
roflumilast 500 mcg tablet (Daliresp)	T1	PA HD
<b>XANTHINES</b>		
ELIXOPHYLLIN	T3	HD
THEO-24	T3	HD
theophylline anhydrous	T1	HD
theophylline anhydrous (Elixophyllin)	T1	HD
<b>ANTIBIOTICS (Ear Medications)</b>		
<b>EAR PREPARATIONS, ANTIBIOTICS</b>		
ciprofloxacin hcl (Cetraxal)	T1	
COLY-MYCIN S	T3	
neomycin/polymyxin/hc	T1	
ofloxacin	T1	

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

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## List of Prescription Medications

ANTIBIOTICS (Ear Medications) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>EAR PREPARATIONS, ANTIBIOTICS (cont.)</b>		
OTIPRIO	T3	QL
<b>OTIC PREPARATIONS, ANTI-INFLAMMATORY-ANTIBIOTICS</b>		
ciprofloxacin hcl/dexameth	T1	
CIPRODEX	T2	
ANTIBIOTICS (Eye Conditions)		
<b>EYE ANTIBIOTIC AND GLUCOCORTICOID COMBINATIONS</b>		
MAXITROL ( <i>neomycin-polymyxin-dexameth</i> )	T3	
<i>neo/polymyxin/dexamethasone</i> (Maxitrol)	T1	
<i>neomycin/bacitracin/poly/hc</i>	T1	
<i>neomycin/polymyxin/hc</i>	T1	
<i>neomycin-polymyxin-dexamethaso</i> (Maxitrol)	T1	
PRED-G	T3	
PREDNISOLONE ACET-MOXIFLOXACIN	T3	
PREDNISOLONE PHOS-MOXIFLOXACIN	T3	
PREDNISOLONE-GATIFLOXACIN	T3	
TOBRADEX EYE OINTMENT	T3	
<i>tobramycin/dexamethasone</i>	T1	
<b>EYE ANTIBIOTIC AND NSAID COMBINATIONS</b>		
MOXIFLOXACIN-BROMFENAC	T3	
<b>EYE ANTIBIOTIC, GLUCOCORTICOID AND NSAID COMB.</b>		
PREDNISOLONE AC-MOXIFLOX-BROMF	T3	
PREDNISOLONE AC-MOXIFLOX-NEPAF	T3	
PREDNISOLONE PH-MOXIFLOX-KETOR	T3	
PREDNISOLONE-GATIFLOX-BROMFENC	T3	
<i>pred ph-moxi-brom 1-0.5-0.075%</i>	T1	
PRED PH-MOXI-BROM 1-0.5-0.075%	T3	
<b>EYE SULFONAMIDES</b>		
BLEPH-10 ( <i>sulfacetamide</i> )	T3	
BLEPHAMIDE	T3	
BLEPHAMIDE S.O.P.	T3	
<i>sulfacetamide</i>	T1	
<i>sulfacetamide</i> (Bleph-10)	T1	
<i>sulfacetamide w/prednisolone</i>	T1	

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## List of Prescription Medications

ANTIBIOTICS (Eye Conditions) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>OPHTHALMIC ANTIBIOTICS</b>		
<i>ak-poly-bac</i>	T1	
AZASITE	T2	
<i>bacitracin</i>	T1	
<i>bacitracin/polymyxin</i>	T1	
CILOXAN ( <i>ciprofloxacin hcl</i> )	T3	
<i>ciprofloxacin hcl</i> (Ciloxan)	T1	
<i>erythromycin</i>	T1	
<i>gatifloxacin</i>	T1	
<i>gentak</i>	T1	
<i>gentamicin</i>	T1	QL (300ml/30 days)
KLARITY-A (AZITHROMYCIN-CHONDR)	T3	
<i>levofloxacin hemihydrate</i>	T1	
MOXEZA ( <i>moxifloxacin</i> )	T3	
<i>moxifloxacin hcl</i>	T1	
<i>moxifloxacin hcl</i> (Moxeza)	T1	
<i>moxifloxacin hcl</i> (Vigamox)	T1	
<i>neomycin/bacitracin/polymyxin</i>	T1	
<i>neomycin/polymyxin/gramicidin</i>	T1	
<i>neo-polycin</i>	T1	
OCUFLOX ( <i>ofloxacin</i> )	T3	
<i>ofloxacin</i> (Ocuflor)	T1	
<i>polycin</i>	T1	
<i>polymyxin b sul-trimethoprim</i> (Polytrim)	T1	
POLYTRIM ( <i>polymyxin b sul-trimethoprim</i> )	T3	
<i>tobramycin</i> (Tobrex)	T1	
TOBREX ( <i>tobramycin</i> )	T3	
VIGAMOX ( <i>moxifloxacin</i> )	T3	
<b>ANTIBIOTICS (Infections)</b>		
<b>2ND GEN. ANAEROBIC ANTIprotozoal-ANTIBACTERIAL</b>		
SOLOSEC	T2	QL
<b>ABSORBABLE SULFONAMIDE ANTIBACTERIAL AGENTS</b>		
BACTRIM ( <i>sulfamethoxazole-trimethoprim</i> )	T3	
BACTRIM DS ( <i>sulfamethoxazole-trimethoprim</i> )	T3	

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## List of Prescription Medications

ANTIBIOTICS (Infections) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>ABSORBABLE SULFONAMIDE ANTIBACTERIAL AGENTS (cont.)</b>		
<i>sulfadiazine</i>	T1	
<i>sulfamethoxazole/trimethoprim (Bactrim DS)</i>	T1	
<i>sulfamethoxazole/trimethoprim (Bactrim)</i>	T1	
<i>sulfamethoxazole/trimethoprim (Sulfatrim)</i>	T1	
<i>sulfatrim (Sulfatrim)</i>	T1	
<b>AMINOGLYCOSIDE ANTIBIOTICS</b>		
ARIKAYCE	T2	PA SP
BETHKIS	T2	PA QL SP HD
<i>gentamicin</i>	T1	QL (300 ml/30 days)
KITABIS PAK	T2	PA QL SP HD
<i>neomycin</i>	T1	
TOBI PODHALER	T2	PA QL
<i>tobramycin</i>	T1	
TOBRAMYCIN	T3	PA QL SP HD
<i>tobramycin (Tobi)</i>	T1	PA QL SP HD
<b>ANAEROBIC ANTIprotozoal-ANTIBACTERIAL AGENTS</b>		
<i>metronidazole 250 mg tablet</i>	T1	
<i>metronidazole 375 mg capsule</i>	T1	
<i>metronidazole 500 mg tablet</i>	T1	
<b>ANTIBIOTIC, ANTIBACTERIAL, MISC.</b>		
<i>fosfomycin tromethamine</i>	T1	
<i>hyophen</i>	T1	
<i>me-naphos-mb-hyo 1 (Urogesic-Blue)</i>	T1	
<i>methenam/m.blue/salicyl/hyosc (Uribel Tabs)</i>	T1	
<i>methenamine hippurate</i>	T1	
<i>methenamine mandelate</i>	T1	
MONUROL	T3	
<i>phosphasal (Uretron D-S)</i>	T1	
PRIMSOL	T3	
<i>trimethoprim</i>	T1	
URELLE	T3	
<i>uretron d-s (Uretron D-S)</i>	T1	
URIBEL TABS ( <i>methenam/m.blue/salicyl/hyosc</i> )	T3	
<i>urimar-t</i>	T1	

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ANTIBIOTICS (Infections) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>AMINOGLYCOSIDE ANTIBIOTICS (cont.)</b>		
<i>urin d.s.</i> (Uretron D-S)	T1	
<i>uro-458</i> (Urelle)	T1	
<i>uroav-b</i> (Uribel)	T1	
<i>urogesic</i> (Urogesic-Blue)	T1	
<i>uro-mp</i> (Uribel)	T1	
<i>uryl</i> (Urogesic-Blue)	T1	
<i>ustell</i>	T1	
<i>utira-c</i> (Uretron D-S)	T1	
<i>vilamit mb</i> (Uribel)	T1	
<i>vilevев mb</i> (Urelle)	T1	
<b>ANTILEPROTICS</b>		
<i>dapsone 25 mg tablet</i>	T1	
<i>dapsone 100 mg tablet</i>	T1	
THALOMID 50mg CAPSULES	T2	PA QL (30 caps/30 day) SP HD
THALOMID 100mg CAPSULES	T2	PA QL (30 caps/30 day) SP HD
THALOMID 200mg CAPSULES	T2	PA QL (60 caps/30 day) SP HD
<b>ANTI-MYCOBACTERIUM AGENTS</b>		
<i>isoniazid</i>	T1	HD
MYCOBUTIN ( <i>rifabutin</i> )	T3	HD
PASER	T3	HD
<i>pyrazinamide</i>	T1	HD
<i>rifabutin</i> (Mycobutin)	T1	HD
TRECATOR	T3	HD
<b>ANTI-TUBERCULAR ANTIBIOTICS</b>		
<i>cycloserine</i>	T1	
PRETOMANID	T3	PA
PRIFTIN	T2	
RIFADIN ( <i>rifadin</i> )	T3	
RIFADIN ( <i>rifampin</i> )	T3	
<i>rifampin</i> (Rifadin)	T1	
SIRTURO	T2	PA SP
<b>BETALACTAMS</b>		
CAYSTON	T2	QL SP HD

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## List of Prescription Medications

ANTIBIOTICS (Infections) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>CEPHALOSPORIN ANTIBIOTICS - 1ST GENERATION</b>		
cefadroxil	T1	
<b>CEPHALOSPORIN ANTIBIOTICS - 2ND GENERATION</b>		
cefaclor	T1	
cefaclor er	T1	
cefprozil	T1	
cefuroxime axetil	T1	
<b>CEPHALOSPORIN ANTIBIOTICS - 3RD GENERATION</b>		
cefdinir	T1	
cefixime (Suprax)	T1	
cefpodoxime proxetil	T1	
ceftriaxone	T1	
SPECTRACEF	T3	
<b>LINCOSAMIDE ANTIBIOTICS</b>		
CLEOCIN HCL ( <i>clindamycin hcl</i> )	T3	
CLEOCIN PALMITATE ( <i>clindamycin (pediatric)</i> )	T3	
<i>clindamycin hcl</i> (Cleocin Hcl)	T1	
<i>clindamycin palmitate hcl</i> (Cleocin Pediatric)	T1	
<i>clindamycin pediatric</i> (Cleocin Pediatric)	T1	
<b>MACROLIDE ANTIBIOTICS</b>		
azithromycin 100mg/5 ml suspension (Zithromax)	T1	QL (195 ml/68 days)
azithromycin 1gm powder packet (Zithromax)	T1	QL (2 packets/68 days)
azithromycin 200mg/5 ml suspension (Zithromax)	T1	QL (120 ml/68 days)
azithromycin 250mg, 500mg tablet (Zithromax)	T1	QL (15 tabs/ 68 days)
azithromycin 600mg tablet	T1	QL (24 tabs/68 days)
clarithromycin	T1	
clarithromycin er	T1	
DIFICID	T3	QL (60 caps/30 days)
e.e.s.	T1	
E.E.S. ( <i>erythromycin ethyl</i> )	T3	
ERYPED ( <i>erythromycin ethyl</i> )	T3	
ery-tab	T1	
erythrocin stearate	T1	
erythromycin	T1	
erythromycin (Ery-Tab)	T1	

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## List of Prescription Medications

ANTIBIOTICS (Infections) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>MACROLIDE ANTIBIOTICS (cont.)</b>		
erythromycin ethylsuccinate	T1	
erythromycin ethylsuccinate (E.E.S. 200)	T1	
erythromycin ethylsuccinate (Eryped 400)	T1	
erythromycin stearate	T1	
ZITHROMAX 1 GM POWDER PACKET ( <i>azithromycin</i> )	T3	QL (2 packets/68 days)
ZITHROMAX 100MG/5 ML SUSPENSION ( <i>azithromycin</i> )	T3	QL (195 ml/68 days)
ZITHROMAX 200 MG/5 ML SUSPENSION ( <i>azithromycin</i> )	T3	QL (120 ml/68 days)
ZITHROMAX 250MG, 500MG TABLET ( <i>azithromycin</i> )	T3	QL (15 tabs/ 68 days)
<b>NITROFURAN DERIVATIVES ANTIBACTERIAL AGENTS</b>		
MACROBID ( <i>nitrofurantoin mono-macro</i> )	T3	
MACRODANTIN ( <i>nitrofurantoin</i> )	T3	
<i>nitrofurantoin mcr 25 mg, 50 mg cap</i>	T1	
<i>nitrofurantoin mcr 100 mg cap</i>	T1	
<b>OXAZOLIDINONE ANTIBIOTICS</b>		
<i>linezolid</i> (Zyvox)	T1	PA
ZYVOX ( <i>linezolid</i> )	T3	PA
<b>PENICILLIN ANTIBIOTICS</b>		
<i>amoxicillin</i>	T1	
<i>amoxicillin-clavulanate pot er</i>	T1	
<i>amoxicillin-clavulanate potass</i>	T1	
<i>amoxicillin-clavulanate potass</i> (Augmentin ES-600)	T1	
<i>amoxicillin-clavulanate potass</i> (Augmentin)	T1	
<i>ampicillin trihydrate</i>	T1	
AUGMENTIN 125-31.25 MG/5ML	T2	
AUGMENTIN 250-62.5 MG/ML SUSP, 500 MG TAB ( <i>amoxicillin-clavulanate potass</i> )	T3	
<i>dicloxacillin</i>	T1	
<i>penicillin V</i>	T1	
<b>PLEUROMUTILIN DERIVATIVES</b>		
XENLETA	T3	
<b>QUINOLONE ANTIBIOTICS</b>		
BAXDELA	T2	QL
CIPRO ( <i>ciprofloxacin</i> )	T3	
<i>ciprofloxacin hcl</i> (Cipro)	T1	
LEVAQUIN ( <i>levofloxacin</i> )	T3	

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## List of Prescription Medications

ANTIBIOTICS (Infections) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>QUINOLONE ANTIBIOTICS (cont.)</b>		
<i>levofloxacin hemihydrate</i>	T1	
<i>moxifloxacin hcl</i>	T1	
<i>ofloxacin</i>	T1	
<b>RIFAMYCINS AND RELATED DERIVATIVE ANTIBIOTICS</b>		
AEMCOLO	T3	QL
XIFAXAN	T2	QL
<b>TETRACYCLINE ANTIBIOTICS</b>		
<i>ACTICLATE (doxycycline hydiate)</i>	T3	ST
<i>avidoxy</i>	T1	
AVIDOXY DK	T3	ST
<i>coremino</i>	T1	
<i>demeclacycline hcl</i>	T1	
<i>doxycycline 50 mg tablet (Targadox)</i>	T1	ST
<i>doxycycline hyc dr 50 mg tab</i>	T1	ST
<i>doxycycline hydiate (Acticlate)</i>	T1	
<i>doxycycline hydiate (Doryx)</i>	T1	
<i>doxycycline hydiate 100 mg cap</i>	T1	
<i>doxycycline mono 75 mg capsule</i>	T1	ST
<i>doxycycline mono 100 mg cap</i>	T1	
<i>doxycycline mono 50 mg cap</i>	T1	
<i>doxycycline monohydrate (Oracea)</i>	T1	ST
<i>doxycycline monohydrate (Vibramycin)</i>	T1	
MINOCIN ( <i>minocycline hcl</i> )	T3	ST
<i>minocycline 50 mg capsule</i>	T1	
<i>minocycline 75 mg capsule</i>	T1	
<i>minocycline 100 mg capsule</i>	T1	
<i>minocycline hcl 50 mg tablet</i>	T1	ST
<i>minocycline hcl 75 mg tablet</i>	T1	ST
<i>minocycline hcl 100 mg tablet</i>	T1	ST
<i>minocycline hcl er</i>	T1	
<i>minocycline hcl er (Solodyn)</i>	T1	
MINOLIRA ER	T3	ST
<i>monodoxine nl</i>	T1	
<i>monodoxine nl 75 mg capsule</i>	T1	ST

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## List of Prescription Medications

ANTIBIOTICS (Infections) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>TETRACYCLINE ANTIBIOTICS (cont.)</b>		
monodoxine nl 100 mg capsule	T1	
morgidox	T1	
MORGIDOX	T3	ST
NUZYRA	T3	QL (30 tabs/30 days) SP
okebo	T1	
ORACEA	T3	ST
SEYSARA	T3	ST
SOLODYN ( <i>minocycline hcl er</i> )	T3	ST
TARGADOX ( <i>doxycycline hyclate</i> )	T3	ST
tetracycline 250 mg capsule	T1	
tetracycline 250 mg tablet	T1	ST
tetracycline 500 mg capsule	T1	
tetracycline 500 mg tablet	T1	ST
VIBRAMYCIN ( <i>doxycycline monohydrate</i> )	T3	
<b>VAGINAL ANTIBIOTICS</b>		
CLEOCIN PHOSPHATE ( <i>clindamycin phosphate</i> )	T3	
<i>clindamycin phosphate</i> (Cleocin)	T1	
CLINDESSE	T3	
metronidazole	T1	
<i>metronidazole vaginal 0.75% gl</i> (Metrogel-Vaginal)	T1	
NUVESSA	T3	
vandazole	T1	
XACIATO	T3	
<b>VANCOMYCIN ANTIBIOTICS AND DERIVATIVES</b>		
VANCOCIN HCL ( <i>vancomycin hcl</i> )	T3	QL
<i>vancomycin 125mg capsule</i>	T1	PA QL (40 caps/30 days)
<i>vancomycin 250mg capsule</i>	T1	PA QL (80 caps/30 days)
<i>vancomycin hcl</i> (Firvanq)	T1	QL
<b>ANTIBIOTICS (Skin Conditions)</b>		
<b>TOPICAL ANTIBIOTIC AND ANTI-INFLAMMATORY STEROID</b>		
NEO-SYNALAR	T3	
<b>TOPICAL ANTIBIOTICS</b>		
AMZEEQ	T3	ST
BENZAMYCIN ( <i>erythromycin-benzoyl peroxide</i> )	T3	ST

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## List of Prescription Medications

ANTIBIOTICS (Skin Conditions) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>TOPICAL ANTIBIOTICS (cont.)</b>		
CENTANY	T3	ST QL (30 units/30 days)
CENTANY AT	T3	ST QL
CLEOCINT ( <i>clindamycin phosphate</i> )	T3	ST QL (120 gm/23 days)
CLEOCINT ( <i>clindamycin phosphate</i> )	T3	ST QL (120 ml/23 days)
CLINDACIN ETZ	T3	ST
<i>clindacin etz</i>	T1	
<i>clindacin p</i>	T1	
CLINDACIN PAC	T3	ST
<i>clindamycin</i> (Evoclin)	T1	ST QL (100 gms/30 days)
<i>clindamycin 1% foam</i> (Evoclin)	T1	ST QL (100 gms/30 days)
<i>clindamycin 1% gel</i>	T1	
<i>clindamycin 1% lotion</i> (Cleocin T)	T1	QL (120 ml/23 days)
<i>clindamycin 1% solution</i>	T1	QL (120 ml/23 days)
<i>clindamycin capsule</i>	T1	
<i>ery</i>	T1	
<i>erygel</i> (Erygel)	T1	
<i>erythromycin</i>	T1	
<i>erythromycin</i> (Erygel)	T1	
<i>erythromycin-benzoyl peroxide</i> (Benzamycin)	T1	
EVOCLIN ( <i>clindamycin phosphate</i> )	T3	ST QL (100 gm/23 days)
<i>gentamicin</i>	T1	QL (300 ml/30 days)
<i>mupirocin 2% oint.</i>	T1	QL (1 treatment/30 days)
<i>mupirocin</i> (Centany)	T1	QL
XEPI	T3	ST QL (30 units/30 days)
<b>TOPICAL SULFONAMIDES</b>		
<i>avar</i>	T1	
AVAR LS	T3	ST
AVAR-E	T3	ST
AVAR-E LS CREAM	T3	ST
<i>mafenide acetate</i> (Sulfamylon)	T1	
PLEXION	T3	ST
SILVADENE ( <i>silver sulfadiazine</i> )	T3	
<i>silver sulfadiazine</i> (Silvadene)	T1	
<i>sod sulfac-sulfur 9.8-4.8% crm</i>	T1	ST

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

PA – Prior Authorization

QL – Quantity Limit

ST – Step Therapy

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## List of Prescription Medications

### ANTIBIOTICS (Skin Conditions) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>TOPICAL SULFONAMIDES (cont.)</b>		
sod sulfac-sulfur 9.8-4.8% lot	T1	ST
sod sulfase-sulf 9.8-4.8% clsr	T1	ST
sod sulfase-sulfur 9-4.5% wash	T1	ST
sod sulfacet-sulfr 9.8-4.8%pad	T1	ST
sod sulfacet-sulfur 10-2% clsr	T1	ST
ss 10-2 (Avar Ls)	T1	
ssd (Silvadene)	T1	
sss 10-5 cream	T1	
sss 10-5 foam	T1	ST
sulfacetamide sodium/sulfur		
sulfacetamide -sulfur	T1	
sulfacetamide-sulfur 9-4% dlsr	T1	ST
sulfacetamide-sulfur 10-2% crm	T1	ST
sulfacetamide-sulfur 10-5% lot	T1	ST
sulfacetamide-sulfur 10-5% sus	T1	ST
sulfacetamide-sulfur 8-4% susp	T1	ST
sulfacetamide/sulfur (Avar LS)	T1	
sulfacetamide/sulfur (Avar-E LS)	T1	
sulfacetamide/sulfur (Plexion)	T1	
sulfacetamide/sulfur (Sumadan)	T1	
sulfacetamide/sulfur (Sumaxin)	T1	
sulfacleanse 8/4	T1	
SULFAMYLYN 8.5% CREAM	T2	
SULFAMYLYN POWDER PACKET ( <i>mafenide</i> )	T3	
SUMADAN	T3	ST
SUMADAN XLT	T3	ST
SUMAXIN ( <i>sulfacetamide-sulfur</i> )	T3	ST
SUMAXIN CP	T3	ST

### ANTI-COAGULANTS (Blood Thinners/Anti-Clotting)

#### ANTI-COAGULANTS, COUMARIN TYPE

COUMADIN ( <i>jantoven</i> )	T3	
COUMADIN ( <i>warfarin</i> )	T3	
<i>jantoven</i>	T1	HD

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## List of Prescription Medications

ANTI-COAGULANTS (Blood Thinners/Anti-Clotting) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>CITRATES AS ANTI-COAGULANTS</b>		
ACD	T2	
ACD-A	T2	
ANTICOAGULANT SODIUM CITRATE	T3	
CRRT TRISODIUM CITRATE	T3	
<i>sodium citrate 4% lock flush</i>	T1	
SODIUM CITRATE 4% LOCK FLUSH	T3	
SODIUM CITRATE 4% SOLN	T3	
SODIUM CITRATE 4% SYRINGE	T3	
SODIUM CITRATE 4% VIAL	T3	
TRISODIUM CITRATE CRRT	T3	
<b>DIRECT FACTOR XA INHIBITORS</b>		
BEVYXXA	T3	
ELIQUIS	T2	PA
<i>rivaroxaban</i> (Xarelto)	T1	
XARELTO ( <i>rivaroxaban</i> )	T2	
XARELTO	T2	PA
<b>HEPARIN AND RELATED PREPARATIONS</b>		
ARIXTRA ( <i>fondaparinux</i> )	T3	SP
<i>enoxaparin</i> (Lovenox)	T1	
<i>fondaparinux</i> (Arixtra)	T1	SP
FRAGMIN	T2	SP
<i>heparin</i>	T1	
<b>ANTIDOTES (Gastrointestinal/Heartburn)</b>		
<b>MU-OPIOID RECEPTOR ANTAGONISTS, PERIPHERALLY-ACTING</b>		
MOVANTIK	T2	QL (30 units/30 days)
RELISTOR 12 MG/0.6 ML SYRINGE	T2	ST
RELISTOR 12 MG/0.6 ML VIAL	T2	ST
RELISTOR 8 MG/0.4 ML SYRINGE	T2	ST
SYMPROIC	T2	
<b>ANTIDOTES (Substance Abuse)</b>		
<b>OPIOID ANTAGONISTS</b>		
<i>naloxone</i>	T1	
<i>naloxone 0.4 mg/ml syringe</i>	T1	

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## List of Prescription Medications

ANTIDOTES (Substance Abuse) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>OPIOID ANTAGONISTS (cont.)</b>		
REXTOVY	T2	QL (2 units/30 days)
<i>naltrexone</i>	T1	
NARCAN ( <i>naloxone hc</i> )	T3	QL (2 units/30 days)
<b>ANTI-FUNGALS (Eye Conditions)</b>		
<b>OPHTHALMIC ANTI-FUNGAL AGENTS</b>		
NATACYN	T2	
<b>ANTI-FUNGALS (Feminine Products)</b>		
<b>VAGINAL ANTI-FUNGALS</b>		
GYNAZOLE-1	T3	
<i>miconazole 3</i>	T1	
<i>terconazole</i>	T1	
<b>ANTI-FUNGALS (Infections)</b>		
<b>ANTI-FUNGAL AGENTS</b>		
ANCOBON ( <i>flucytosine</i> )	T3	PA
<i>clotrimazole</i>	T1	QL (60 ml/28 days)
CRESEMDA	T2	PA
DIFLUCAN ( <i>fluconazole</i> )	T3	
DIFLUCAN 150MG TABLET ( <i>fluconazole</i> )	T3	QL (2 tabs/episode)
<i>fluconazole 10 mg/ml susp</i>	T1	
<i>fluconazole 200 mg tablet</i>	T1	
<i>fluconazole 150 mg tablet</i> (Diflucan)	T1	QL
<i>flucytosine</i> (Ancobon)	T1	
<i>itraconazole 100mg capsule</i> (Sporanox)	T1	QL (30 units/30 days)
<i>itraconazole 10mg/ml solution</i> (Sporanox)	T1	
<i>ketoconazole</i>	T1	
NOXAFL	T2	PA
NOXAFL 40MG/ML SUSP	T2	PA SP
ORAVIG	T3	
<i>posaconazole</i> (Noxafil)	T1	PA
SPORANOX 100MG CAPSULE ( <i>itraconazole</i> )	T3	QL (300 ml/1 treatment)
SPORANOX 10MG/ML SOLUTION ( <i>itraconazole</i> )	T3	
<i>terbinafine</i>	T1	
VFEND ( <i>voriconazole</i> )	T3	PA

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## List of Prescription Medications

ANTI-FUNGALS (Infections) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>ANTI-FUNGAL AGENTS (cont.)</b>		
VIVJOA	T3	PA QL (18 caps/30 days) SP
voriconazole (Vfend)	T1	PA
<b>ANTI-FUNGAL ANTIBIOTICS</b>		
BREXAFEMME 150 MG TABLET	T3	ST QL (4 tabs/treatment)
griseofulvin	T1	
griseofulvin ultramicrosize	T1	
nystatin	T1	QL (60 grams/28 days)
<b>TOPICAL ANTI-FUNGAL/ANTI-INFLAMMATORY, STEROID AGENT</b>		
clotrimazole/betamethasone	T1	QL (45 gm/21 days)
clotrimazole/betamethasone	T1	QL (60 ml/21 days)
<b>ANTI-FUNGALS (Skin Conditions)</b>		
<b>TOPICAL ANTI-FUNGALS</b>		
ciclodan	T1	
ciclopirox 0.77% cream (Loprox)	T1	QL (90 gm/21 days)
ciclopirox 0.77% gel	T1	QL (100 grams/30 days)
ciclopirox 0.77% topical solution (Loprox)	T1	QL (60 ml/21 days)
ciclopirox 1% shampoo	T1	QL (120 mls/28 days)
ciclopirox 8% solution, treatment kit	T1	
econazole nitrate	T1	QL (85 gm/21 days)
ERTACZO	T3	QL (60 gm/21 days)
EXELDERM	T3	QL (60 units/21 days)
EXTINA (ketoconazole)	T3	ST QL (100 gm/21 days)
JUBLIA	T3	ST
ketoconazole 2% cream	T1	QL (60 gm/21 days)
ketoconazole 2% foam (Extina)	T1	ST QL (100 gm/21 days)
ketodan (Extina)	T1	ST QL (100 gm/21 days)
ketodan (Ketodan)	T1	
LOPROX 0.77% CREAM (ciclopirox)	T3	QL (90 gm/21 days)
LOPROX 0.77% CREAM KIT	T3	QL (544 gm/23 days)
LOPROX 0.77% SUSPENSION KIT	T3	QL (1 kit/23 days)
LOPROX 0.77% TOPICAL SOLUTION (ciclopirox)	T3	QL (60 ml/21 days)
LOPROX 1% SHAMPOO (ciclopirox)	T3	QL (120 ml/21 days)
LOTRISONE CREAM	T3	QL (90 grams/28 days)

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## List of Prescription Medications

### ANTI-FUNGALS (Skin Conditions) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>TOPICAL ANTI-FUNGALS (cont.)</b>		
MICONAZOLE-ZINC OXIDE-PETROLTM	T3	QL (50 gm/21 days)
<i>naftifine hcl 1% cream</i>	T1	QL (90 gms/28 days)
<i>naftifine hcl 2% cream</i>	T1	QL (60 gms/28 days)
<i>naftifine hcl 2% gel (Naftin)</i>	T1	QL (60 gms/28 days)
NAFTIN 1% GEL ( <i>naftifine hcl</i> )	T3	QL (90 gms/28 days)
NAFTIN 2% GEL ( <i>naftifine hcl</i> )	T3	QL (60 gms/28 days)
NIZORAL ( <i>ketonconazole</i> )	T3	QL (120 ml/21 days)
<i>nyamyc</i>	T1	QL
<i>nystatin</i>	T1	QL
<i>nystatin w/triamcinolone</i>	T1	QL
<i>nystatin/triamcinolone</i>	T1	QL
<i>nystop</i>	T1	QL
<i>oxiconazole nitrate (Oxistat)</i>	T1	QL (60 units/21 days)
OXISTAT	T3	QL (90 grams/28 days)
VUSION	T3	QL (100 grams/28 days)

### ANTIHISTAMINE AND DECONGESTANT COMBINATION (Allergy/Nasal Sprays)

#### 1ST GEN ANTIHISTAMINE AND DECONGESTANT COMBINATION

<i>promethazine vc</i>	T1	
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#### 2ND GEN ANTIHISTAMINE AND DECONGESTANT COMBINATION

CLARINEX-D 12 HOUR	T3	QL
SEMPREX-D	T3	

### ANTIHISTAMINES (Allergy/Nasal Sprays)

#### ANTIHISTAMINES - 1ST GENERATION

<i>carbinoxamine</i>	T1	
<i>carbinoxamine (Ryvent)</i>	T1	
<i>ciproheptadine hcl</i>	T1	
<i>dexchlorpheniramine maleate (Ryclora)</i>	T1	
<i>hydroxyzine hcl</i>	T1	
<i>hydroxyzine pamoate (Vistaril)</i>	T1	
<i>promethazine hcl</i>	T1	
<i>RYCLORA (dexchlorpheniramine maleate)</i>	T3	
<i>RYVENT</i>	T3	ST
<i>VISTARIL (hydroxyzine pamoate)</i>	T3	

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## List of Prescription Medications

ANTIHISTAMINES (Allergy/Nasal Sprays) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>ANTIHISTAMINES - 2ND GENERATION</b>		
CLARINEX D 24 HOUR TABLET	T3	
<i>desloratadine</i> (Clarinet)	T1	QL (30 units/30 days) HD
<b>ANTIHISTAMINES (Eye Conditions)</b>		
<b>EYE ANTIHISTAMINES</b>		
<i>azelastine hcl</i>	T1	
<i>epinastine hcl</i>	T1	
LASTACRAFT 0.25% EYE DROPS	T3	ST
<b>ANTI-HYPERGLYCEMICS (Diabetes)</b>		
<b>ANTIHYPERGLY,DPP-4 ENZYME INHIB.-THIAZOLIDINEDIONE</b>		
OSENI	T3	QL (30 units/30 days) HD
<b>ANTIHYPERGLY, INCRETIN MIMETIC (GLP-I RECEPT.AGONIST)</b>		
ADLYXIN 10-20 MCG STARTER PACK	T3	PA HD QL (1 kit/28 days)
ADLYXIN 20 MCG MAINTENANCE PK	T3	PA HD QL (1 kit/28 days)
BYDUREON BCISE	T2	PA QL (4 auto-injs/28 days)
BYDUREON PEN	T2	PA QL HD
BYETTA	T2	PA QL (1 pen/30 days)
<i>exenatide</i>	T1	PA QL (1 pen/30 days)
<i>liraglutide</i> 2-pak 18 mg/3 ml (Victoza 2-Pak)	T1	PA
<i>liraglutide</i> 2-pak 18 mg/3 ml (Victoza 3-Pak)	T1	PA
<i>liraglutide</i> 3-pak 18 mg/3 ml (Victoza 2-Pak)	T1	PA
<i>liraglutide</i> 3-pak 18 mg/3 ml (Victoza 3-Pak)	T1	PA
MOUNJARO	T2	PA QL
OZEMPIC	T2	PA QL (1 pen/28 days)
RYBELSUS	T2	PA QL (30 tabs/30 days)
TRULICITY	T2	PA QL (4 pens/28 days)
<b>ANTI-HYPERGLY, INSULIN, LONG ACT-GLP-I RECEPT.AGONIST</b>		
SOLIQUA 100-33	T2	QL (15 mls/30 days)
<b>ANTI-HYPERGLYCEMIC-SOD/GLUC COTRANSPORT2(SGLT2) INHIB</b>		
FARXIGA	T2	ST QL (30 tabs/30 days)
JARDIANCE	T2	ST QL (30 units/30 days) HD
<b>ANTI-HYPERGLYCEMIC-DOPAMINE RECEPTOR AGONISTS</b>		
CYCLOSET	T3	HD

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## List of Prescription Medications

ANTI-HYPERGLYCEMICS (Diabetes) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>ANTI-HYPERGLYCEMIC, ALPHA-GLUCOSIDASE INHIBITORS</b>		
acarbose (Precose)	T1	HD
GLYSET (miglitol)	T3	HD
miglitol (Glyset)	T1	HD
PRECOSE (acarbose)	T3	HD
<b>ANTI-HYPERGLYCEMIC, AMYLIN ANALOG-TYPE</b>		
SYMLINPEN 60	T2	PA QL (7 pens/30 days)
SYMLINPEN 120	T2	PA QL HD
<b>ANTI-HYPERGLYCEMIC, BIGUANIDE TYPE</b>		
FORTAMET ( <i>metformin er osmotic</i> )	T3	PA QL HD
<i>metformin hcl</i>	T1	HD
<i>metformin hcl er</i>	T1	QL HD
<i>metformin er 1,000 mg osm-tab</i>	T1	PA QL (60 tabs/30 days) HD
<i>metformin er 500 mg osmotic tb</i>	T1	PA QL (30 tabs/30 days) HD
<i>metformin hcl 750 mg tablet</i>	T1	ST HD
<i>metformin hcl er</i> (Glumetza)	T1	PA QL
RIOMET ( <i>metformin hcl</i> )	T3	ST HD
<b>ANTI-HYPERGLYCEMIC, DPP-4 INHIBITORS</b>		
JANUVIA	T2	QL (30 units/30 days) HD
saxagliptin hcl (Onglyza)	T1	ST QL (30 tabs/30 days) HD
<b>ANTI-HYPERGLYCEMIC, INSULIN-RELEASE STIMULANT TYPE</b>		
glimepiride 1 mg tablet	T1	HD
glimepiride 2 mg tablet	T1	HD
glimepiride 4 mg tablet	T1	HD
glipizide (Glucotrol)	T1	HD
glipizide er (Glucotrol XL)	T1	HD
glipizide xl (Glucotrol XL)	T1	HD
GLUCOTROL (glipizide)	T3	HD
GLUCOTROL XL (glipizide er)	T3	HD
glyburide	T1	HD
glyburide,micronized	T1	HD
glyburide micronized (Glynase)	T1	HD
GLYNASE (glyburide micronized)	T3	HD
nateglinide (Starlix)	T1	HD
repaglinide	T1	HD

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## List of Prescription Medications

ANTI-HYPERGLYCEMICS (Diabetes) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>ANTI-HYPERGLYCEMIC, INSULIN-RELEASE STIMULANT TYPE (cont.)</b>		
STARLIX ( <i>nateglinide</i> )	T3	HD
<b>ANTI-HYPERGLYCEMIC, SGLT-2 AND DPP-4 INHIBITOR COMB</b>		
GLYXAMBI	T2	ST QL (30 units/30 days) HD
<b>ANTI-HYPERGLYCEMIC, THIAZOLIDINEDIONE AND BIGUANIDE</b>		
ACTOPLUS MET XR 30 1000MG TABLET	T3	ST
<i>pioglitazone-metformin</i> (Actoplus Met)	T1	QL HD
<b>ANTI-HYPERGLYCEMIC, THIAZOLIDINEDIONE-SULFONYLUREA</b>		
DUETACT ( <i>pioglitazone-glimepiride</i> )	T3	QL (30 tabs/30 days) HD
<i>pioglitazone-glimepiride</i> (Duetact)	T1	QL (30 units/30 days) HD
<b>ANTI-HYPERGLYCEMIC, DPP-4 INHIBITOR-BIGUANIDE COMBS.</b>		
JANUMET	T2	QL HD
JANUMET XR	T2	QL HD
<i>saxagliptin-metformin er 2.5-1000</i> (Kombiglyze Xr)	T1	ST QL (60 tabs/30 days) HD
<i>saxagliptin-metformin er 5-500</i> (Kombiglyze Xr)	T1	ST QL (30 tabs/30 days) HD
<i>saxagliptin-metformin er 5-1000</i> (Kombiglyze Xr)	T1	ST QL (30 tabs/30 days) HD
<b>ANTI-HYPERGLYCEMIC, INSULIN-RELEASE STIM.-BIGUANIDE</b>		
<i>glipizide-metformin</i>	T1	HD
<i>glyburide-metformin hcl</i>	T1	HD
<b>ANTI-HYPERGLYCEMIC, THIAZOLIDINEDIONE (PPARG AGONIST)</b>		
ACTOS ( <i>pioglitazone hcl</i> )	T3	QL (30 tabs/30 days) HD
AVANDIA	T3	ST QL HD
<b>ANTIHYPERGLYCEMIC-GLUCOCORTICOID RECEPTOR BLOCKER</b>		
<i>mifepristone 300 mg tablet</i> (Korlym)	T1	PA SP
<b>ANTI-HYPERGLYCEMIC-SGLT2 INHIBITOR-BIGUANIDE COMBS.</b>		
INVOKAMET	T2	ST QL HD
SYNJARDY	T2	ST QL (30 tabs/30 days) HD
SYNJARDY XR	T2	ST QL HD
XIGDUO XR	T2	ST QL HD
<b>INSULINS</b>		
HUMALOG 100 unit/ML CARTRIDGE	T2	HD
HUMALOG JUNIOR KWIKPEN	T2	HD
HUMALOG MIX 75-25	T2	HD
HUMULIN 70/30 KWIKPEN	T2	HD
HUMULIN 70-30	T2	HD

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ANTI-HYPERGLYCEMICS (Diabetes) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>INSULINS (cont.)</b>		
HUMULIN N	T2	HD
HUMULIN N KWIKPEN	T2	HD
HUMULIN R	T2	HD
HUMULIN R U-500 KWIKPEN	T2	HD
INSULIN GLARGINE-YFGN	T2	HD
INSULIN LISPRO 100 UNIT/ML VIAL	T2	HD
INSULIN LISPRO JUNIOR KWIKPEN	T2	HD
INSULIN LISPRO KWIKPEN U-100	T2	HD
INSULIN LISPRO PROTAMINE MIX	T2	HD
LANTUS SOLOSTAR	T2	HD
MYXREDLIN	T3	
SEMGLEE	T2	HD
TOUJEO MAX SOLOSTAR	T2	HD
TOUJEO SOLOSTAR	T2	HD
TRESIBA	T2	HD
TRESIBA FLEXTOUCH U-100, U-200	T2	HD
<b>ANTI-INFECTIVES/MISCELLANEOUS (Feminine Products)</b>		
<b>VAGINAL ANTISEPTICS</b>		
fem ph	T1	
<b>ANTI-INFECTIVES/MISCELLANEOUS (Infections)</b>		
<b>2ND GEN. ANAEROBIC ANTI-PROTOZOAL-ANTIBACTERIAL</b>		
tinidazole	T1	QL (20 tabs/23 days)
tinidazole	T1	QL (40 tabs/23 days)
<b>ANTHELMINTICS</b>		
albendazole (Albenza)	T1	QL (120 tabs/23 days)
ALBENZA (albendazole)	T3	QL (120 tabs/23 days)
BILTRICIDE (praziquantel)	T3	
EMVERM	T2	QL (6 tabs/23 days)
ivermectin 6 mg tablet	T1	PA QL (8 tabs/30 days)
ivermectin (Stromectol)	T1	PA QL (20 tabs/23 days)
praziquantel (Biltricide)	T1	
STROMECTOL (ivermectin)	T3	QL (20 tabs/23 days)

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## List of Prescription Medications

ANTI-INFECTIVES/MISCELLANEOUS (Infections) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>ANTI-MALARIAL DRUGS</b>		
ARAKODA	T3	QL (20 tabs/365 days)
ARAKODA 100mg tablets	T3	QL (32 tabs/180 days)
atovaquone-proguanil 250-100mg tablet (Malarone)	T1	QL (60 tabs/180 days)
atovaquone-proguanil 62.5-25mg tablet (Malarone)	T1	QL (180 tabs/180 days)
chloroquine 250mg tablet	T1	QL (56 tabs/274 days)
chloroquine 500mg tablet	T1	QL (28 tabs/274 days)
COARTEM	T2	QL (24 tabs/23 days)
DARAPRIM (pyrimethamine)	T3	PA SP
hydroxychloroquine (Plaquenil)	T1	QL
KRINTAFEL	T3	QL (2 tabs/23 days)
MALARONE 250-100MG TABLET (atovaquone-proguanil hcl)	T3	QL (60 tabs/180 days)
MALARONE 62.5-25MG TABLET (atovaquone-proguanil hcl)	T3	QL (180 tabs/180 days)
mefloquine hcl	T1	QL (13 tabs/180 days)
PRIMAQUINE BRAND	T2	QL (120 tabs/180 days)
primaquine generic	T1	QL (120 tabs/180 days)
quinine sulfate	T1	QL (42 caps/30 days)
<b>ANTI-PROTOZOAL DRUGS, MISCELLANEOUS</b>		
atovaquone (Mepron)	T1	
BENZNIDAZOLE	T2	QL (720 tabs/365 days)
IMPAVIDO	T2	QL (84 caps/23 days)
MEPRON (atovaquone)	T3	
NEBUPENT	T3	QL (1 vial/21 days)
pentamidine isethionate (Nebupent)	T1	QL (1 vial/21 days)
<b>ANTI-INFECTIVES/MISCELLANEOUS (Miscellaneous)</b>		
<b>ANTIBACTERIAL AGENTS, MISCELLANEOUS</b>		
aminoacetic acid (Aminoacetic Acid)	T1	
glycine (Aminoacetic Acid)	T1	
<b>ANTISEPTICS, GENERAL</b>		
ALCOHOL SWABSTICK	T3	
GS ISOPROPYL ALCOHOL 70% SPRAY	T3	
ISOPROPYL ALCOHOL	T3	

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

PA – Prior Authorization

QL – Quantity Limit

ST – Step Therapy

AGE – Age Requirement

SP – Specialty Medication

HD – May require home delivery pharmacy

PPACA – No Cost-Share Preventive Medication

CSL – Oral cancer medication subject to cost-share limits

## List of Prescription Medications

ANTI-INFECTIVES/MISCELLANEOUS (Skin Conditions)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>TOPICAL ANTI-FUNGALS</b>		
CICLODAN	T3	ST
ciclopirox	T1	
<b>ANTI-INFLAM.TUMOR NECROSIS FACTOR INHIBITING AGENTS (Pain Relief And Inflammatory Disease)</b>		
<b>ANTI-INFLAMMATORY TUMOR NECROSIS FACTOR INHIBITOR</b>		
ADALIMUMAB-ADAZ (CF)	T2	PA QL (2 syringes/28 days) SP HD
ADALIMUMAB-ADAZ(CF) PEN	T2	PA QL (2 pens/28 days) SP HD
ADALIMUMAB-ABDM(CF)PEN	T2	PA QL (2 kits/28 days) SP HD
ADALIMUMAB-RYVK(CF)	T2	PA QL (4 pens/365 days) SP
ADALIMUMAB-RYVK(CF) AUTOINJECT	T2	PA QL (2 auto-injs/28 days) SP HD
CYLTEZO(CF)	T2	PA QL (2 syringe kits/28 days) SP HD
CYLTEZO(CF) PEN	T2	PA QL (2 kits/28 days) SP HD
CYLTEZO(CF) PEN CROHN'S-UC-HS	T2	PA QL (6 pens/365 days) SP HD
CYLTEZO(CF) PEN PSORIASIS-UV	T2	PA QL (4 pens/365 days) SP HD
ENBREL	T2	PA QL SP HD
SIMLANDI(CF) AUTOINJECTOR	T2	PA QL (2 auto-injs/28 days) SP HD
SIMLANDI(CF)	T2	PA QL (2 syringe kits/28 days) SP HD
SIMPONI	T2	PA QL SP HD
SIMPONI ARIA	T3	PA SP HD
<b>ANTI-NEOPLASTICS (Cancer)</b>		
<b>ANP - SELECTIVE RETINOID X RECEPTOR AGONISTS (RXR)</b>		
bexarotene (Targretin)	T1	PA SP HD CSL
<b>ANTI-NEOPLAST, HISTONE DEACETYLASE (HDAC) INHIBITORS</b>		
FARYDAK 10mg, 20mg CAPSULE	T3	PA QL SP HD CSL
FARYDAK 5mg CAPSULE	T3	PA QL
ZOLINZA	T2	PA SP HD CSL
<b>ANTI-NEOPLASTIC - ALKYLYATING AGENTS</b>		
ALKERAN ( <i>melphalan</i> )	T3	SP CSL
cyclophosphamide	T3	SP HD CSL
GLEOSTINE	T2	CSL
HYDREA ( <i>hydroxyurea</i> )	T3	CSL
<i>hydroxyurea</i> (Hydrea)	T1	CSL
LEUKERAN	T2	CSL
MYLERAN	T2	CSL

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

PA – Prior Authorization

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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
<b>ANTI-NEOPLASTIC - ANTI-ANDROGENIC AGENTS</b>		
<i>abiraterone acetate</i> (Zytiga)	T1	PA QL (120 tabs/30 days) CSL
<i>bicalutamide</i> (Casodex)	T1	CSL
<i>CASODEX (bicalutamide)</i>	T3	CSL
ERLEADA 240 MG TABLET	T2	PA SP HD QL (30 tabs/30 days) CSL
<i>flutamide</i>	T1	CSL
<i>NILANDRON (nilutamide)</i>	T3	PA CSL
<i>nilutamide</i> (Nilandron)	T1	PA CSL
NUBEQA	T2	PA QL SP HD CSL
XTANDI	T2	PA QL SP HD CSL
YONSA	T2	PA QL (120 tabs/30 days) SP HD CSL
<b>ANTI-NEOPLASTIC - ANTI-METABOLITES</b>		
ARRANON	T3	
<i>capecitabine</i> (Xeloda)	T1	SP HD CSL
LONSURF	T2	PA SP HD CSL
<i>mercaptopurine 20 mg/ml suspen</i> (Purixan)	T1	SP CSL
<i>mercaptopurine 50 mg tablet</i>	T1	CSL
<i>methotrexate</i>	T1	
<i>methotrexate</i>	T1	CSL
PURIXAN ( <i>mercaptopurine</i> )	T2	SP CSL
TABLOID	T3	CSL
TREXALL	T3	CSL
XELODA (capecitabine)	T3	PA QL ST SP HD CSL
XELODA 150MG tablets	T3	PA SP HD QL (56 tabs/30 days) CSL
XELODA 500MG tablets	T3	PA SP HD QL (140 tabs/30 days) CSL
<b>ANTI-NEOPLASTIC - AROMATASE INHIBITORS</b>		
<i>anastrozole</i> (Arimidex)	T1	HD PPACA CSL
AROMASIN ( <i>exemestane</i> )	T3	HD CSL
<i>exemestane</i> (Aromasin)	T1	HD PPACA CSL
FEMARA ( <i>letrozole</i> )	T3	HD CSL
<i>letrozole</i> (Femara)	T1	HD CSL
<b>ANTI-NEOPLASTIC - BRAF KINASE INHIBITORS</b>		
BRAFTOVI	T2	PA QL (180 caps/30 days) SP HD CSL
OJEMDA	T2	PA SP CSL
TAFINLAR 10 MG TABLET FOR SUSP	T2	SP PA HD QL (840 ml/30 days) CSL

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

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## List of Prescription Medications

ANTI-NEOPLASTICS (Cancer) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>ANTI-NEOPLASTIC - BRAF KINASE INHIBITORS (cont.)</b>		
ZELBORAF	T2	PA QL SP HD CSL
<b>ANTI-NEOPLASTIC - CAR-T CELL IMMUNOTHERAPY</b>		
BREYANZI	T3	PA
<b>ANTI-NEOPLASTIC - HEDGEHOG PATHWAY INHIBITOR</b>		
DAURISMO	T3	PA QL SP HD CSL
ERIVEDGE	T2	PA QL (30 units/30 days) SP HD CSL
ODOMZO	T2	PA QL (30 units/30 days) SP HD CSL
<b>ANTI-NEOPLASTIC - JANUS KINASE (JAK) INHIBITORS</b>		
JAKAFI	T2	PA QL SP HD CSL
<b>ANTI-NEOPLASTIC - KRAS PROTEIN INHIBITOR</b>		
LUMAKRAS	T3	PA SP QL (8 tabs per day) HD
<b>ANTINEOPLASTIC - MEK KINASE INHIBITORS</b>		
COTELLIC	T2	PA QL (63 tabs/30 days) SP HD CSL
GOMEKLI	T2	PA SP CSL
KOSELUGO	T3	PA SP CSL
MEKINIST 0.05 MG/ML SOLUTION	T2	PA QL (1080 mls/30 days) SP HD CSL
MEKINIST 0.5 MG TABLET	T2	PA QL (90 tabs/30 days) SP HD CSL
MEKINIST 2 MG TABLET	T2	PA QL (30 tabs/30 days) SP HD CSL
MEKTOVI	T2	PA QL (180 tabs/30 days) SP HD CSL
<b>ANTI-NEOPLASTIC - MTOR KINASE INHIBITORS</b>		
AFINITOR 10MG TABLET	T2	PA QL (30 tabs/30 days) ST SP HD CSL
AFINITOR DISPERZ 2 MG, 3 MG, 5MG TABLET	T3	PA QL ST SP
AFINITOR 2.5MG, 5MG, 7.5MG TABLET ( <i>everolimus</i> )	T3	PA QL (30 tabs/30 days) ST SP HD CSL
AFINITOR DISPERZ	T2	PA QL (30 tabs/30 days) ST SP CSL
<i>everolimus</i> (Afinitor)	T1	PA QL (30 tabs/30 days) SP CSL
<b>ANTI-NEOPLASTIC - PROTEIN METHYLTRANSFERASE INHIBIT</b>		
TAZVERIK	T3	PA SP CSL
<b>ANTI-NEOPLASTIC - TOPOISOMERASE I INHIBITORS</b>		
HYCAMTIN	T2	PA SP HD CSL
<b>ANTINEOPLASTIC COMB - KINASE AND AROMATASE INHIBIT</b>		
KISQALI FEMARA 200 MG CO-PACK	T2	PA QL (49 tabs/30 days) SP CSL
KISQALI FEMARA 400 MG CO-PACK	T2	PA QL (70 tabs/30 days) SP CSL
KISQALI FEMARA 600 MG CO-PACK	T2	PA QL (91 tabs/30 days) SP CSL

T1 – Typically Generics

T2 – Typically Preferred Brands

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## List of Prescription Medications

ANTI-NEOPLASTICS (Cancer) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>ANTI-NEOPLASTIC IMMUNOMODULATOR AGENTS</b>		
POMALYST	T2	PA SP HD CSL
REVLIMID	T2	PA QL (30 caps/30 days) SP HD CSL
SYLATRON	T2	PA
<b>ANTI-NEOPLASTIC LHRH (GNRH) AGONIST, PITUITARY SUPPR.</b>		
<i>leuprolide acetate</i>	T1	PA SP HD
LUPRON DEPOT	T3	PA SP HD
ZOLADEX	T2	SP HD
<b>ANTI-NEOPLASTIC LHRH (GNRH) ANTAGONIST, PITUIT.SUPPRS</b>		
FIRMAGON	T2	PA SP HD
<b>ANTI-NEOPLASTIC SYSTEMIC ENZYME INHIBITORS</b>		
ALECensa	T2	PA QL SP HD CSL
ALUNBRIG	T2	PA QL SP HD CSL
AUGTYRO	T3	PA SP HD CSL
AYVAKIT	T3	PA QL (30 tabs/30 days) SP CSL
BALVERSA	T2	PA SP CSL
BOSULIF	T2	PA QL SP HD CSL
BOSULIF 50 MG CAPSULE	T2	PA QL (30 caps/fill) SP HD CSL
BOSULIF 100 MG CAPSULE	T2	PA QL (90 tabs/fill) SP HD CSL
BRUKINSA	T2	PA SP CSL
CALQUENCE	T2	SP
CAPRELSA	T2	PA QL SP CSL
COMETRIQ	T2	PA SP HD CSL
COPIKTRA	T3	PA QL (56 caps/28 days) SP CSL
DANZITEN	T2	PA SP CSL
<i>dasatinib 20 mg tablet (Sprycel)</i>	T1	PA QL (90 tabs/30 days) SP CSL
<i>dasatinib 20 mg tablet (Sprycel)</i>	T1	PA QL (90 tabs/30 days) SP HD CSL
<i>dasatinib 50 mg tablet (Sprycel)</i>	T1	PA QL (30 tabs/30 days) SP CSL
<i>dasatinib 50 mg tablet (Sprycel)</i>	T1	PA QL (30 tabs/30 days) SP HD CSL
<i>dasatinib 70 mg tablet (Sprycel)</i>	T1	PA QL (60 tabs/30 days) SP CSL
<i>dasatinib 70 mg tablet (Sprycel)</i>	T1	PA QL (60 tabs/30 days) SP HD CSL
<i>dasatinib 80 mg tablet (Sprycel)</i>	T1	PA QL (30 tabs/30 days) SP CSL
<i>dasatinib 80 mg tablet (Sprycel)</i>	T1	PA QL (30 tabs/30 days) SP HD CSL
<i>dasatinib 100 mg tablet (Sprycel)</i>	T1	PA QL (30 tabs/30 days) SP CSL
<i>dasatinib 100 mg tablet (Sprycel)</i>	T1	PA QL (30 tabs/30 days) SP HD CSL

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

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AGE – Age Requirement

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## List of Prescription Medications

ANTI-NEOPLASTICS (Cancer) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>ANTI-NEOPLASTIC SYSTEMIC ENZYME INHIBITORS (cont.)</b>		
dasatinib 140 mg tablet (Sprycel)	T1	PA QL (30 tabs/30 days) SP CSL
dasatinib 140 mg tablet (Sprycel)	T1	PA QL (30 tabs/30 days) SP HD CSL
erlotinib 25 mg tablet	T1	PA QL (60 tabs/30 days) SP HD CSL
erlotinib hcl 100 mg tablet	T1	PA QL (30 tabs/30 days) SP HD CSL
erlotinib hcl 150 mg tablet	T1	PA QL (30 tabs/30 days) SP HD CSL
FRUZAQLA	T2	PA SP CSL
GAVRETO	T2	PA QL (120 caps/30 days) SP CSL
GILOTrif	T2	PA QL (30 units/30 days) SP HD CSL
IBRANCE	T2	PA QL (21 tabs/caps/30 days) SP HD CSL
ICLUSIG	T2	PA QL SP CSL
IMKELDI	T2	PA SP CSL
INLYTA	T2	PA QL SP HD CSL
IRESSA ( <i>gefitinib</i> )	T3	PA QL (30 tabs/30 days) SP HD CSL
IWLFIN	T2	PA SP CSL
KISQALI	T3	PA SP HD QL (1 pack/1 time) CSL
KISQALI FEMARA CO-PACK	T3	PA SP HD QL (1 pack/28 days) CSL
LAZCLUZE	T3	PA SP CSL
LENVIMA 4MG (five 4 mg capsules per card)	T2	PA QL (30 caps/30 days) SP HD CSL
LENVIMA 8MG (ten 4 mg capsules per card)	T2	PA QL (60 caps/30 days) SP HD CSL
LENVIMA 10MG (five 10 mg capsules per card)	T2	PA QL (30 caps/30 days) SP HD CSL
LENVIMA 12MG (fifteen 4 mg capsules per card)	T2	PA QL (90 caps/30 days) SP HD CSL
LENVIMA 14MG (five 10 mg capsules and five 4 mg capsules per card)	T2	PA QL (60 caps/30 days) SP HD CSL
LENVIMA 18MG (five 10 mg capsules and five 4 mg capsules per card)	T2	PA QL (90 caps/30 days) SP HD CSL
LENVIMA 20MG	T2	PA QL (60 caps/30 days) SP HD CSL
LENVIMA 24MG	T2	PA QL (90 caps/30 days) SP HD
LORBRENA	T2	PA QL SP HD CSL
LYNPARZA	T2	PA QL SP HD CSL
LYTGEOBI	T2	PA SP CSL
NERLYNX	T2	PA SP HD CSL
NEXAVAR	T3	PA QL (120 tabs/30 days) SP HD CSL
nilotinib 150 mg capsule (Tasigna)	T1	PA QL (112 caps/30 days) SP HD CSL
nilotinib 200 mg capsule (Tasigna)	T1	PA QL (112 caps/30 days) SP HD CSL
nilotinib 50 mg capsule (Tasigna)	T1	PA QL (120 caps/30 days) SP HD CSL
NINLARO	T2	PA QL SP HD CSL

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

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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
<b>ANTI-NEOPLASTIC SYSTEMIC ENZYME INHIBITORS (cont.)</b>		
OGSIVEO	T3	PA SP CSL
pazopanib (Votrient)	T1	PA QL (120 tabs/30 days) SP HD CSL
PEMAZYRE 4.5MG, 9MG, 13.5MG TAB	T2	PA QL (28 tabs/30 days) SP
PIQRAY	T2	PA SP CSL
RETEVMO 120 MG TABLET	T3	PA QL (60 tabs/fill) SP HD CSL
RETEVMO 160 MG TABLET	T3	PA QL (60 tabs/fill) SP HD CSL
RETEVMO 40 MG TABLET	T3	PA QL (90 tabs/fill) SP HD CSL
RETEVMO 80 MG TABLET	T3	PA QL (60 tabs/fill) SP HD CSL
REVUFORJ	T2	PA SP CSL
ROMVIMZA	T3	PA QL (8 caps/fill) SP CSL
ROZLYTREK	T2	PA QL SP HD CSL
ROZLYTREK 50 MG PELLET PACKET	T2	PA QL (42 packs/fill) SP HD CSL
RYDAPT	T2	PA QL (224 caps/30 days) SP HD CSL
SCEMBLIX 20MG TABLET	T2	PA QL (600 tabs/30 days) SP CSL
SCEMBLIX 40MG TABLET	T2	PA QL (300 tabs/30 days) SP CSL
SCEMBLIX 100 MG TABLET	T2	PA QL (120 tabs/fill) SP CSL
STIVARGA	T2	PA QL SP HD CSL
SUTENT	T3	PA QL SP CSL
TABRECTA	T2	PA SP
TAGRISSO	T2	PA QL (30 units/30 days) SP HD CSL
TALZENNA	T2	PA QL (30 caps/30 days) SP HD CSL
TALZENNA 0.1 MG CAPSULE, SOFTGEL	T2	PA QL (30 caps/fill) SP CSL
TALZENNA 0.25 MG CAPSULE, SOFTGEL	T2	PA QL (30 caps/30 days) SP CSL
TALZENNA 0.35 MG CAPSULE, SOFTGEL	T2	PA QL (30 caps/fill) SP CSL
TALZENNA 0.5 MG CAPSULE, SOFTGEL	T2	PA QL (30 caps/30 days) SP CSL
TALZENNA 0.75 MG CAPSULE, SOFTGEL	T2	PA QL (30 caps/30 days) SP CSL
TALZENNA 1 MG CAPSULE, SOFTGEL	T2	PA QL (30 caps/30 days) SP CSL
TARCEVA (erlotinib hcl)	T3	PA QL (30 tabs/30 days) SP HD CSL
TASIGNA 150 MG CAPSULE (nilotinib hcl)	T2	PA QL (112 caps/30 days) SP HD CSL
TASIGNA 200 MG CAPSULE (nilotinib hcl)	T2	PA QL (112 caps/30 days) SP HD CSL
TASIGNA 50 MG CAPSULE (nilotinib hcl)	T2	PA QL (120 caps/30 days) SP HD CSL
TRUQAP	T2	PA SP CSL
TURALIO	T3	PA QL SP CSL
UKONIQ	T3	SP

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

PA – Prior Authorization

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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
<b>ANTI-NEOPLASTIC SYSTEMIC ENZYME INHIBITORS (cont.)</b>		
VERZENIO	T2	PA QL SP HD CSL
VIKTRAKVI 100 MG CAPSULE	T2	PA QL (60 caps/30 days) SP HD CSL
VIKTRAKVI 20 MG/ML SOLUTION	T2	PA QL (300ml/30 days) SP HD CSL
VIKTRAKVI 25 MG CAPSULE	T2	PA QL (180 caps/30 days) SP HD CSL
VIZIMPRO	T2	PA QL (30 units/30 days) SP HD CSL
VOTRIENT ( <i>pazopanib hcl</i> )	T3	PA QL (120 tabs/30 days) SP HD CSL
XOSPATA	T2	PA SP CSL
XALKORI 20MG PELLET	T2	PA QL (120 caps/fill) SP HD CSL
XALKORI 50MG PELLET	T2	PA QL (120 caps/fill) SP HD CSL
XALKORI 150MG PELLET	T2	PA QL (120 caps/fill) SP HD CSL
XALKORI 200MG CAPSULE	T2	PA QL (60 caps/30 days) SP HD CSL
XALKORI 250MG CAPSULE	T2	PA QL (60 caps/30 days) SP HD CSL
ZYDELIG	T2	PA QL SP HD CSL
ZYKADIA	T2	PA QL (90 tabs-caps/30 days) SP HD CSL
<b>ANTI-NEOPLASTIC, ANTI-PROGRAMMED DEATH-1 (PD-1) MAB</b>		
JEMPERLI 500 MG/10 ML VIAL	T3	PA SP HD
OPDIVO	T2	PA SP HD
<b>ANTI-NEOPLASTIC-B CELL LYMPHOMA-2(BCL-2) INHIBITORS</b>		
VENCLEXTA	T2	PA SP CSL
VENCLEXTA STARTING PACK	T2	PA QL SP CSL
<b>ANTI-NEOPLASTIC-ISOCITRATE DEHYDROGENASE INHIBITOR</b>		
IDHIFA	T2	PA QL (30 units/30 days) SP HD CSL
TIBSOVO	T2	PA SP CSL
VORANIGO	T3	PA SP CSL
<b>ANTI-NEOPLASTICS ANTIBODY/ANTIBODY-DRUG COMPLEXES</b>		
ENHERTU	T3	PA SP HD
<b>ANTI-NEOPLASTICS, MISCELLANEOUS</b>		
<i>etoposide</i>	T1	SP HD CSL
LYSODREN	T2	CSL
MATULANE	T2	SP CSL
RYLAZE 10 MG/0.5 ML VIAL	T3	PA SP
<i>tretinoin</i>	T1	CSL
<b>CYTOTOXIC T-LYMPHOCYTE ANTIGEN (CTLA-4) RMC ANTIBODY</b>		
YERVOY	T2	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
<b>IMMUNOMODULATORS</b>		
ACTIMMUNE	T2	SP HD
INTRON A	T2	SP HD
<b>SELECTIVE ESTROGEN RECEPTOR MODULATORS (SERMS)</b>		
FARESTON ( <i>toremifene</i> )	T3	HD CSL
SOLTAMOX	T3	HD CSL
<i>tamoxifen</i>	T1	HD PPACA CSL
<i>toremifene</i> (Fareston)	T1	HD CSL
<b>STEROID ANTI-NEOPLASTICS</b>		
<i>megestrol acetate</i>	T1	CSL
<b>ANTI-NEOPLASTICS (Skin Conditions)</b>		
<b>PHOTOACT, TOPICAL ANTI-NEOPLAST, PREMALIGNANT LESIONS</b>		
LEVULAN	T3	SP
<b>TOPICAL ANTI-NEOPLASTIC PREMALIGNANT LESION AGENTS</b>		
PANRETIN	T3	PA SP HD
PICATO	T2	
TARGRETIN	T2	PA SP HD
VALCHLOR	T2	PA SP HD
<b>ANTI-OBESITY DRUGS (Weight Management)</b>		
<b>ANTI-OBESITY - ANOREXIC AGENTS</b>		
ADIPEX-P ( <i>phentermine hcl</i> )	T3	PA QL (30 tabs/30 days)
<i>benzphetamine hcl</i>	T1	PA QL (90 tabs/30 days)
<i>diethylpropion 25 mg tablets</i>	T1	PA QL (90 tabs/30 days)
<i>diethylpropion 75 mg tablets</i>	T1	PA QL (30 tabs/30 days)
LOMAIRA	T1	PA QL (90 tabs/30 days)
<i>phendimetrazine tartrate</i>	T1	PA QL (180 tabs/30 days)
<i>phentermine 37.5 mg capsule</i>	T1	PA QL (30 caps/30 days)
<i>phentermine/topiramate (Qsymia)</i>	T1	PA QL (30 caps/30 days)
QSYMIA ( <i>phentermine/topiramate</i> )	T3	PA QL (30 caps/30 days)
REGIMEX ( <i>benzphetamine hcl</i> )	T3	PA QL (90 tabs/30 days)
<b>ANTI-OBESITY GLUCAGON-LIKE PEPTIDE-I RECEPTOR AGONIST</b>		
SAXENDA	T3	PA QL (5 pens/30 days)
WEGOVY	T2	PA

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

PA – Prior Authorization

QL – Quantity Limit

ST – Step Therapy

AGE – Age Requirement

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## List of Prescription Medications

ANTI-OBESITY DRUGS (Weight Management) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>ANTI-OBESITY - INCRETIN MIMETICS COMBINATION</b>		
ZEPBOUND	T2	PA QL (2 mls/28 days)
<b>ANTI-OBESITY - OPIOID ANTAG-NOREPI, DOPAMINE RU INHIB</b>		
CONTRAVE	T3	PA QL (120 tabs/30 days)
<b>FAT ABSORPTION DECREASING AGENTS</b>		
XENICAL	T3	PA QL (90 tabs/30 days)
<b>ANTI-PARASITICS (Eye Conditions)</b>		
<b>OPHTHALMIC (EYE) ANTIPARASITICS</b>		
XDEMVY	T2	QL (10 mgs/30 days) SP
<b>ANTI-PARASITICS (Infections)</b>		
<b>ANTI-PARASITICS</b>		
ALINIA 100MG/5ML SUSP	T2	QL (180 ml/30 days)
<b>TOPICAL ANTI-PARASITICS</b>		
crotan	T1	
ELIMITE ( <i>permethrin</i> )	T3	
<i>permethrin</i> (Elimite)	T1	
SKLICE	T3	
<i>spinosad</i> (Natroba)	T1	
ULESFIA	T3	
<b>ANTI-PARKINSON DRUGS (Parkinson's Disease)</b>		
<b>ANTI-PARKINSONISM DRUGS, ANTI-CHOLINERGIC</b>		
benztropine mesylate	T1	HD
trihexyphenidyl hcl	T1	HD
<b>ANTI-PARKINSONISM DRUGS, OTHER</b>		
bromocriptine mesylate	T1	HD
carbidopa/levodopa (Sinemet)	T1	HD
carbidopa-levodopa er	T1	HD
carbidopa/levodopa/entacapone	T1	HD
carbidopa-levodopa-entacapone (Stalevo 100)	T1	HD
carbidopa-levodopa-entacapone (Stalevo 150)	T1	HD
carbidopa-levodopa-entacapone (Stalevo 200)	T1	HD
carbidopa-levodopa-entacapone (Stalevo 75)	T1	HD
CREXONT	T3	ST HD
DUOPA	T3	SP HD

T1 – Typically Generics

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## List of Prescription Medications

ANTI-PARKINSON DRUGS (Parkinson's Disease) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>ANTI-PARKINSONISM DRUGS, OTHER (cont.)</b>		
<i>entacapone</i>	T1	HD
<i>entacapone</i> (Comtan)	T1	HD
INBRIJA	T2	PA QL (300 caps/30 days) SP HD
MIRAPEX ER ( <i>pramipexole er</i> )	T3	HD
NEUPRO	T3	HD
NOURIANZ	T3	PA QL (30 units/30 days) SP HD
ONGENTYS	T3	PA QL (30 caps/30 days) HD
<i>pramipexole di-hcl</i>	T1	HD
<i>pramipexole di-hcl</i> (Mirapex)	T1	HD
<i>pramipexole er</i> (Mirapex ER)	T1	HD
<i>rasagiline mesylate</i> (Azilect)	T1	HD
REQUIP XL ( <i>ropinirole er</i> )	T3	HD
<i>ropinirole hcl</i>	T1	HD
<i>ropinirole hcl</i> (Requip XL)	T1	HD
RYTARY	T3	ST HD
<i>selegiline hcl</i>	T1	HD
SINEMET ( <i>carbidopa-levodopa</i> )	T3	HD
TASMAR ( <i>tolcapone</i> )	T3	HD
<i>tolcapone</i> (Tasmar)	T1	HD
<b>ANTI-PLATELET DRUGS (Blood Thinners/Anti-Clotting)</b>		
<b>DECARBOXYLASE INHIBITORS</b>		
<i>carbidopa</i> (Lodosyn)	T1	
LODOSYN ( <i>carbidopa</i> )	T3	
<b>PLATELET AGGREGATION INHIBITORS</b>		
<i>aspirin e.c.</i>	T1	HD PPACA
<i>aspirin-dipyridamole er</i> (Aggrenox)	T1	HD
ASPIRIN-OMEPRAZOLE	T3	PA HD
BRILINTA ( <i>ticagrelor</i> )	T3	HD
<i>children's aspirin</i> (Bayer Chewable Aspirin)	T1	HD PPACA
<i>cilostazol</i>	T1	HD
<i>clopidogrel</i> (Plavix)	T1	HD
<i>dipyridamole</i>	T1	HD
<i>ecotrin</i>	T1	HD PPACA

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## List of Prescription Medications

ANTI-PLATELET DRUGS (Blood Thinners/Anti-Clotting) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>PLATELET AGGREGATION INHIBITORS (cont.)</b>		
EFFIENT ( <i>prasugrel hcl</i> )	T3	HD
<i>enteric coated aspirin</i>	T1	HD PPACA
<i>low dose aspirin</i>	T1	HD PPACA
<i>prasugrel hcl</i> (Effient)	T1	HD
<i>st. joseph aspirin</i>	T1	HD PPACA
<i>ticagrelor</i> (Brilinta)	T1	HD
ZONTIVITY	T3	PA HD
<b>PLATELET REDUCING AGENTS</b>		
AGRYLIN ( <i>anagrelide hcl</i> )	T3	
<i>anagrelide hydrochloride</i> (Agrylan)	T1	
<b>ANTIVIRALS (AIDS/HIV)</b>		
<b>ANTI-RETROVIRAL - CAPSID INHIBITORS</b>		
SUNLENCA	T3	PA SP
YEZTUGO	T3	PA SP
<b>ANTIRETROVIRAL-INTEGRASE INHIBITOR AND NNRTI COMB</b>		
JULUCA	T2	SP
<b>ANTIRETROVIRAL-INTEGRASE INHIBITOR AND NRTI COMB</b>		
DOVATO	T2	SP
<b>ANTIRETROVIRAL-NRTIS AND INTEGRASE INHIBITORS COMB</b>		
TRIUMEQ	T2	SP
TRIUMEQ PD 60-5-30 MG TAB SUSP	T2	SP
<b>ANTI-RETROVIRAL - NUCLEOSIDE, NUCLEOTIDE, PROTEASE INH.</b>		
SYMTUZA	T2	SP
<b>ANTIVIRALS (AIDS/HIV) (cont.)</b>		
<b>ANTIVIRALS - HIV-SPEC, NON-PEPTIDIC PROTEASE INHIB</b>		
APTVUS	T2	SP
<i>darunavir 600mg, 800mg tablet</i>	T1	SP
<i>darunavir</i> (Prezista)	T1	SP
PREZISTA 600MG, 800MG TABLET	T2	SP
PREZISTA 600MG, 800MG TABLET ( <i>darunavir</i> )	T3	SP
<b>ANTIVIRALS - HIV-SPEC, NUCLEOSIDE-NUCLEOTIDE ANALOG</b>		
CIMDUO	T2	SP
DESCOVY	T2	SP PPACA

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## List of Prescription Medications

ANTIVIRALS (AIDS/HIV) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>ANTIVIRALS - HIV-SPEC, NUCLEOSIDE-NUCLEOTIDE ANALOG (cont.)</b>		
TEMIXYS	T2	SP
<b>ANTIVIRALS - HIV-SPEC, NUCLEOSIDE ANALOG, RTI COMB</b>		
<i>abacavir-lamivudine</i> (Epzicom)	T1	SP
<i>COMBIVIR</i> ( <i>lamivudine-zidovudine</i> )	T3	SP
<i>EPZICOM</i> ( <i>abacavir-lamivudine</i> )	T3	SP
<i>lamivudine-zidovudine</i> (Combivir)	T1	SP
<b>ANTIVIRALS - HIV-SPECIFIC, FUSION INHIBITORS</b>		
FUZEON	T2	SP QL (60 vials/30 days)
<b>ANTIVIRALS - HIV-SPECIFIC, NON-NUCLEOSIDE, RTI</b>		
EDURANT	T2	SP
EDURANT PED	T3	SP
<i>efavirenz</i> (Sustiva)	T1	SP
INTELENCE	T3	SP
<i>nevirapine</i> (Viramune)	T1	SP
<b>ANTIVIRALS - HIV-SPECIFIC, NON-NUCLEOSIDE, RTI</b>		
<i>nevirapine er</i>	T1	SP
<i>nevirapine er</i> (Viramune XR)	T1	SP
SUSTIVA ( <i>efavirenz</i> )	T3	SP
VIRAMUNE ( <i>nevirapine</i> )	T3	SP
VIRAMUNE XR ( <i>nevirapine er</i> )	T3	SP
<b>ANTIVIRALS - HIV-SPECIFIC, NUCLEOSIDE ANALOG, RTI</b>		
<i>abacavir</i>	T1	SP
<i>abacavir</i> (Ziagen)	T1	SP
<i>didanosine</i>	T1	SP
EMTRIVA	T2	SP
EPIVIR ( <i>lamivudine</i> )	T3	SP
<i>lamivudine</i> (Epivir)	T1	SP
RETROVIR ( <i>zidovudine</i> )	T3	SP
<i>stavudine</i> (Zerit)	T1	SP
ZIAGEN ( <i>abacavir</i> )	T3	SP
<b>ANTIVIRALS - HIV-SPECIFIC, NUCLEOTIDE ANALOG, RTI</b>		
<i>tenofovir disoproxil fumarate</i> (Viread)	T1	SP
VIREAD POWDER	T2	SP
VIREAD 150 MG, 200 MG, 250 MG TABLET	T2	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
<b>ANTIVIRALS - HIV-SPECIFIC, NUCLEOTIDE ANALOG, RTI (cont.)</b>		
VIREAD 300 MG TABLET ( <i>tenofovir disoproxil fumarate</i> )	T3	SP
<b>ANTIVIRALS - HIV-SPECIFIC, PROTEASE INHIBITORS</b>		
atazanavir ( <i>Reyataz</i> )	T1	SP
CRIXIVAN	T2	SP
EVOTAZ	T3	SP
<i>fosamprenavir calcium</i>	T1	SP
<i>lopinavir/ritonavir</i>	T1	SP
KALETRA	T3	SP
KALETRA 100-25 MG TABLET	T3	QL (2 tabs/day) SP
KALETRA 200-50 MG TABLET	T3	QL (56 tabs/274 days) SP
KALETRA 80-20MG/ML SOLUTION ( <i>lopinavir-ritonavir</i> )	T3	QL (2ml/day) SP
<i>lopinavir-ritonavir</i> (Kaletra)	T1	QL (2ml/day) SP
NORVIR 100 MG TABLET ( <i>ritonavir</i> )	T3	SP
NORVIR 100 MG POWDER PACKET	T2	SP
REYATAZ CAPSULES (atazanavir )	T3	SP
REYATAZ POWDER PACKET	T2	SP
<i>ritonavir</i> (Norvir)	T1	SP
VIRACEPT	T2	SP
<b>ANTIVIRALS - HIV-I INTEGRASE STRAND TRANSFER INHIBTR</b>		
APRETUDE	T2	SP PPACA
ISENTRESS	T2	SP
ISENTRESS HD	T2	SP
TIVICAY	T2	SP
<b>ARTV NUCLEOSIDE, NUCLEOTIDE, NON-NUCLEOSIDE RTI COMB</b>		
<i>efavirenz/emtricitabine/tenofovir disoproxil fumarate</i>	T1	SP
<i>emtricitabine/rilpivirine/tenofovir disoproxil fumarate</i>	T1	SP
ODEFSEY	T2	SP
SYMFY	T2	SP
SYMFY LO	T2	SP
<b>ARV-NUCLEOSIDE, NUCLEOTIDE RTI, INTEGRASE INHIB</b>		
BIKTARVY	T2	SP
GENVOYA	T2	SP

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## List of Prescription Medications

ANTIVIRALS (Eye Conditions)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>EYE ANTIVIRALS</b>		
trifluridine	T1	
ZIRGAN	T3	
ANTIVIRALS (Infections)		
<b>ANTIVIRAL - MAIN PROTEASE (MPRO) INHIBITOR</b>		
PAXLOVID 150-100 MG (MODERATE)	T2	QL (20 tabs/180 days)
PAXLOVID 300/150-100MG(SEVERE)	T2	
<b>ANTIVIRAL MONOCLONAL ANTIBODIES</b>		
BEYFORTUS	T2	PPACA
<b>ANTIVIRALS, GENERAL</b>		
acyclovir (Zovirax)	T1	
acyclovir 200 mg/5 ml susp cup	T1	
acyclovir 800 mg/20ml susp cup	T1	
famciclovir	T1	QL
LIVTENCITY 200 MG TABLET	T3	PA SP
oseltamivir phosphate (Tamiflu)	T1	QL
OSELTAMIVIR 6MG/ML SUSPENSION	T3	QL (180 ml/30 days)
oseltamivir 30mg capsule	T1	QL (20 caps/30 days)
oseltamivir 45mg capsule	T1	QL (10 caps/30 days)
oseltamivir 75mg capsule	T1	QL (10 caps/30 days)
PREVYMIS 20 MG PELLET PACKET	T2	SP
PREVYMIS 120 MG PELLET PACKET	T2	SP
PREVYMIS 240 MG TABLET	T2	QL (30 tabs/28 days) SP HD
PREVYMIS 480 MG TABLET	T2	QL (30 tabs/28 days) SP HD
RELENZA 5 MG	T3	QL (20 blisters/10 days )
ribavirin (Virazole)	T1	SP HD
rimantadine hcl	T1	
SITAVIG	T3	PA QL (2 tabs/30 days)
TAMIFLU (oseltamivir phosphate)	T3	QL
valacyclovir (Valtrex)	T1	QL (30 units/30 days)
VALCYTE (valganciclovir hcl)	T3	
valganciclovir hcl (Valcyte)	T1	
XOFLUZA	T3	QL
ZOVIRAX (acyclovir)	T3	

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

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## List of Prescription Medications

ANTIVIRALS (Infections) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>HEP C - NS5A, NS3/4A, NUCLEOTIDE NS5B INHIB COMBO</b>		
VOSEVI	T2	PA QL (84 tabs/365 days) SP HD
<b>HEP C VIRUS-NS5B POLYMERASE AND NS5A INHIB. COMBO.</b>		
EPCLUSA 200MG/50MG ORAL PELLET PACKET	T2	PA SP HD QL (28 pkts/28 days)
EPCLUSA	T2	PA QL (84 packets/365 days) ST SP HD
HARVONI 45-200 MG TABLET	T2	PA QL (56 tabs/dispense) SP HD
HARVONI 90-400 MG TABLET	T2	PA QL (84 tabs/365 days) SP HD
<b>HEPATITIS B TREATMENT AGENTS</b>		
<i>adefovir dipivoxil</i>	T1	SP HD
BARACLUDE	T2	SP HD
<i>entecavir</i> (Baraclude)	T1	SP HD
EPIVIR	T2	SP
<i>lamivudine</i>	T1	SP
VEMLIDY	T2	SP HD
<b>HEPATITIS C TREATMENT AGENTS</b>		
PEGASYS 180MCG/0.5ML SYRINGE KIT	T2	SP HD
PEGASYS PROCLICK 180MCG/0.5ML	T2	SP HD
PEGASYS SYRINGE	T2	QL (2ml/21 days) SP HD
PEGASYS VIAL	T2	QL (4ml/21 days) SP HD
PEG-INTRON	T3	QL (4 kits/21 days) SP HD
<i>ribavirin</i>	T1	PA SP HD
<b>HEPATITIS C VIRUS- NS5A AND NS3/4A INHIBITOR COMB</b>		
ZEPATIER	T2	PA QL (84 tabs/365 days) SP HD
<b>RNA POLYMERASE INHIBITOR</b>		
MOLNUPIRAVIR	T2	
ANTIVIRALS (Skin Conditions)		
<b>TOPICAL ANTIVIRALS</b>		
<i>acyclovir</i> (Zovirax)	T1	PA QL
DENAVIR	T3	
<i>penciclovir</i>	T1	
ZOVIRAX ( <i>acyclovir</i> )	T3	PA QL
<b>TOPICAL GENITAL WART-HPV TREATMENT AGENTS</b>		
VEREGEN	T3	PA QL (30 grams/treatment)

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## List of Prescription Medications

AUTONOMIC DRUGS (Allergy/Nasal Sprays)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>ANAPHYLAXIS THERAPY AGENTS</b>		
AUVI-Q	T2	QL (2 auto-injs/30 days)
<i>epinephrine</i> (Auvi-Q)	T1	QL
<i>epinephrine</i> (Epipen Jr 2-Pak)	T1	QL
EPIPEN ( <i>epinephrine</i> )	T2	QL
EPIPEN JR. ( <i>epinephrine</i> )	T2	QL
NEFFY	T2	QL (4 units/fill)
SYMJEPI	T2	QL
AUTONOMIC DRUGS (Alzheimer's Disease)		
<b>CHOLINESTERASE INHIBITORS</b>		
ARICEPT ( <i>donepezil hcl</i> )	T3	ST HD
<i>donepezil hcl</i> (Aricept)	T1	HD
EXELON ( <i>rivastigmine</i> )	T3	ST HD
<i>galantamine</i>	T1	HD
<i>galantamine er</i> (Razadyne ER)	T1	HD
<i>pyridostigmine bromide</i> (Mestinon)	T1	HD
<i>pyridostigmine bromide er</i> (Mestinon)	T1	HD
RAZADYNE ( <i>galantamine hbr</i> )	T3	ST
RAZADYNE ER ( <i>galantamine er</i> )	T3	ST HD
<i>rivastigmine</i>	T1	HD
<i>rivastigmine</i> (Exelon)	T1	HD
AUTONOMIC DRUGS (Attention Deficit Hyperactivity Disorder) <sup>8</sup>		
<b>ADRENERGICS, AROMATIC, NON-CATECHOLAMINE</b>		
ADZENYS ER	T3	ST
ADZENYS XR-ODT	T3	ST
<i>amphetamine</i> (Evekeo)	T1	
AMPHETAMINE ER 1.25 MG/ML SUSP	T3	ST
DESOXYN ( <i>methamphetamine hcl</i> )	T3	
DEXEDRINE (dextroamphetamine er)	T3	ST
<i>dextroamphetamine</i>	T1	
<b>ADRENERGICS, AROMATIC, NON-CATECHOLAMINE</b>		
<i>dextroamphetamine</i> (Zenzedi)	T1	
<i>dextroamphetamine er</i> (Dexedrine)	T1	
<i>dextroamphetamine-amphetamine er</i> (Adderall XR)	T1	

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## List of Prescription Medications

AUTONOMIC DRUGS (Attention Deficit Hyperactivity Disorder) <sup>8</sup> (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>ADRENERGICS, AROMATIC, NON-CATECHOLAMINE</b>		
<i>dextroamphetamine-amphetamine</i> (Adderall)	T1	
<i>dextroamphetamine/amphetamine</i> (Mydayis)	T1	
EVEKEO (amphetamine )	T3	
EVEKEO ODT	T3	
<i>methamphetamine hcl</i> (Desoxyn)	T1	
MYDAYIS (dextroamphetamine/amphetamine)	T3	ST
<i>procenutra</i>	T1	
ZENZEDI	T3	
ZENZEDI 7.5 MG TABLET (dextroamphetamine sulfate)	T3	
<i>zenzedi</i> (Zenzedi)	T1	
AUTONOMIC DRUGS (Blood Pressure/Heart Medications)		
<b>ADRENERGIC VASOPRESSOR AGENTS</b>		
<i>midodrine hcl</i>	T1	
<b>ALPHA-ADRENERGIC BLOCKING AGENTS</b>		
DIBENZYLINE ( <i>phenoxybenzamine hcl</i> )	T3	PA HD
<i>prazosin</i>	T1	HD
<i>phenoxybenzamine hcl</i> (Dibenzyline)	T1	PA HD
AUTONOMIC DRUGS (Urinary Tract Conditions)		
<b>PARASYMPATHETIC AGENTS</b>		
<i>bethanechol chloride</i>	T1	HD
<i>cevimeline hcl</i> (Evoxac)	T1	HD
EVOXAC ( <i>cevimeline hcl</i> )	T3	HD
<i>guanidine hcl</i>	T1	HD
<i>pilocarpine hcl</i> (Salagen)	T1	HD
SALAGEN ( <i>pilocarpine hcl</i> )	T3	HD
<i>URECHOLINE</i> ( <i>bethanechol chloride</i> )	T3	
BIOLOGICALS (Allergy/Nasal Sprays)		
<b>ALLERGENIC EXTRACTS, THERAPEUTIC</b>		
GRASTEK	T2	PA
ODACTRA	T2	PA
ORALAIR	T2	PA
RAGWITEK	T2	PA

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## List of Prescription Medications

BIOLOGICALS (Blood Pressure/Heart Medications)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>PLASMA KALLIKREIN INHIBITORS</b>		
ORLADEYO	T3	PA SP
TAKHYRO	T2	PA SP ST HD
<b>BIOLOGICALS (Miscellaneous)</b>		
<b>PKU TREATMENT AGENTS - PHENYLALANINE AMMONIA LYASE</b>		
PALYNZIQ	T2	PA QL (8 syringes/30 days) SP HD
<b>BIOLOGICALS (Vaccines)</b>		
<b>COVID-19 VACCINES</b>		
COMIRNATY	T2	PPACA
MODERNA COVID	T2	PPACA
NOVAVAX COVID	T2	PPACA
PFIZER COVID	T2	PPACA
SPIKEVAX	T2	PPACA
<b>ENTERIC VIRUS VACCINES</b>		
IPOL	T2	PPACA
ROTARIX	T2	HD PPACA
ROTATEQ	T2	PPACA
<b>GRAM (-) BACILLI (NON-ENTERIC) VACCINES</b>		
VIVOTIF	T2	
<b>GRAM NEGATIVE COCCI VACCINES</b>		
BEXSERO	T2	PPACA
MENACTRA	T2	
MENVEO A-C-Y-W-135-DIP	T3	PPACA
MENQUADFI	T2	PPACA
PENBRAYA	T2	PPACA
TRUMENBA	T2	PPACA
<b>GRAM POSITIVE COCCI VACCINES</b>		
CAPVAXIVE	T2	PPACA
PNEUMOVAX 23	T2	PPACA
PREVNAR 13	T2	
<b>INFLUENZA VIRUS VACCINES</b>		
AFLURIA QUAD	T2	PPACA
AFLURIA TRIV	T2	PPACA
AFLURIA TRIVALENT	T2	PPACA

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

PA – Prior Authorization

QL – Quantity Limit

ST – Step Therapy

AGE – Age Requirement

SP – Specialty Medication

HD – May require home delivery pharmacy

PPACA – No Cost-Share Preventive Medication

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## List of Prescription Medications

BIOLOGICALS (Vaccines) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>INFLUENZA VIRUS VACCINES (cont.)</b>		
AUDENZ (NATIONAL STOCKPILE)	T2	
FLUAD QUAD	T2	PPACA
FLUAD TRIVALENT	T2	PPACA
FLUARIX QUAD	T2	PPACA
FLUARIX TRIVALENT	T2	PPACA
FLUBLOK QUAD	T2	PPACA
FLUBLOK TRIVALENT	T2	PPACA
FLUCELVAX QUAD	T2	PPACA
FLUCELVAX TRIVALENT	T2	PPACA
FLULAVAL QUAD	T2	PPACA
FLULAVAL TRIVALENT	T2	PPACA
FLUMIST QUAD	T2	PPACA
FLUMIST TRIVALENT	T2	PPACA
FLUZONE HIGH-DOSE QUAD	T2	PPACA
FLUZONE HIGH-DOSE TRIV	T2	PPACA
FLUZONE QUAD	T2	PPACA
FLUZONE TRIVALENT	T2	PPACA
<b>TOXIN-PRODUCING BACILLI VACCINES/TOXOIDS</b>		
BCG VACCINE (TICE STRAIN)	T2	SP
VAXCHORA VACCINE	T2	
<b>VACCINE/TOXOID PREPARATIONS, COMBINATIONS</b>		
ACTHIB	T2	PPACA
ADACEL	T2	PPACA
BOOSTRIX	T2	PPACA
DAPTACEL	T2	PPACA
DIPHTHERIA-TETANUS TOXOIDS-PED	T2	
HIBERIX	T2	PPACA
INFANRIX	T2	PPACA
KINRIX	T2	PPACA
M-M-R II VACCINE W/DILUENT	T2	PPACA
PRIORIX VIAL	T2	PPACA
PEDVAXHIB	T2	PPACA
PENTACEL	T2	PPACA
PROQUAD	T2	PPACA

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## List of Prescription Medications

BIOLOGICALS (Vaccines) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>VACCINE/TOXOID PREPARATIONS, COMBINATIONS (cont.)</b>		
QUADRACEL DTAP-IPV	T2	PPACA
TENIVAC	T2	PPACA
TETANUS Diphtheria Toxoids	T2	PPACA
VAXELIS	T2	PPACA
<b>VIRAL/TUMORIGENIC VACCINES</b>		
ABRYSVO	T2	PPACA
ACAM2000	T2	
AREXVY VIAL KIT	T2	PPACA
ENGERIX-B	T2	PPACA
ERVEBO (NATIONAL STOCKPILE)	T2	
GARDASIL 9	T2	PPACA
HAVRIX	T2	PPACA
HEPLISAV-B	T2	PPACA
JYNNEOS	T2	
MRESVIA	T2	PPACA
PEDIARIX	T2	PPACA
RECOMBIVAX HB	T2	PPACA
SHINGRIX	T2	PPACA
TWINRIX	T2	PPACA
VAQTA	T2	PPACA
VARIVAX VACCINE	T2	PPACA
<b>BLOOD (Blood Modifiers/Bleeding Disorders)</b>		
<b>AGENTS TO TX THROMBOTIC THROMBOCYTOPENIC PURPURA</b>		
CABLIVI	T2	PA SP
<b>ANTI-FIBRINOLYTIC AGENTS</b>		
AMICAR ( <i>aminocaproic acid</i> )	T3	SP HD
<i>aminocaproic acid</i> (Amicar)	T1	SP HD
LYSTEDA ( <i>tranexamic acid</i> )	T3	SP
<i>tranexamic acid</i> (Lysteda)	T1	SP
<b>COMPLEMENT INHIBITORS</b>		
EMPAVELI	T2	PA SP
FABHALTA	T2	PA SP
TAVNEOS	T3	PA QL (180 caps/30 days) SP
VOYDEYA	T2	PA SP

T1 – Typically Generics

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## List of Prescription Medications

BLOOD (Blood Modifiers/Bleeding Disorders) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>HEMOPHILIA TREATMENT AGENTS, NON-FACTOR REPLACEMENT</b>		
HEMLIBRA	T2	PA SP HD
<b>SICKLE CELL ANEMIA AGENTS</b>		
glutamine	T1	PA
DROXIA	T2	
OXBRYTA	T3	SP
<b>TOPICAL HEMOSTATICS</b>		
AVITENE	T3	
ENDO-AVITENE	T3	
GEL-FLOW	T3	
GELFOAM	T3	
GELFOAM JMI	T3	
MONSEL'S	T2	
RECOTHROM	T3	
SYRINGE AVITENE	T3	
THROMBI-GEL	T3	
THROMBIN-JMI	T3	
THROMBI-PAD	T3	
ULTRAFOAM	T3	
<b>BLOOD (Blood Thinners/Anti-Clotting)</b>		
<b>HEMORRHEOLOGIC AGENTS</b>		
pentoxifylline	T1	HD
<b>CARDIAC DRUGS (Blood Pressure/Heart Medications)</b>		
<b>ANTI-ANGINAL, ANTI-ISCHEMIC AGENTS, NON-HEMODYNAMIC</b>		
ranolazine	T1	HD
ranolazine er (Ranexa)	T1	HD
RANEXA (ranolazine)	T3	ST HD
<b>ANTI-ARRHYTHMICS</b>		
amiodarone hcl	T1	HD
amiodarone hcl (Pacerone)	T1	HD
disopyramide phosphate (Norpace)	T1	HD
dofetilide (Tikosyn)	T1	HD
flecainide acetate	T1	HD
mexiletine hcl	T1	HD

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## List of Prescription Medications

CARDIAC DRUGS (Blood Pressure/Heart Medications) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>ANTI-ARRHYTHMICS (cont.)</b>		
MULTAQ	T2	HD
NORPACE ( <i>disopyramide phosphate</i> )	T3	HD
NORPACE CR	T3	HD
<i>pacerone</i>	T1	HD
<i>propafenone hcl</i>	T1	HD
<i>quinidine</i>	T1	HD
<i>quinidine gluconate</i>	T1	HD
<b>CALCIUM CHANNEL BLOCKER AND NSAID, COX-2 INHIBITOR</b>		
CONSENSI	T3	
<b>CALCIUM CHANNEL BLOCKING AGENTS</b>		
ADALAT CC ( <i>nifedipine er</i> )	T3	
<i>amlodipine besylate</i> (Norvasc)	T1	
CALAN SR ( <i>verapamil er</i> )	T3	HD
CAMZYOS	T3	PA QL (30 caps/30 days) SP
CARDIZEM ( <i>diltiazem hcl</i> )	T3	HD
CARDIZEM CD ( <i>cartia xt</i> )	T3	HD
CARDIZEM CD ( <i>diltiazem 24hr er (cd)</i> )	T3	HD
CARDIZEM LA	T3	HD
CARDIZEM LA ( <i>diltiazem 24hr er (la)</i> )	T3	HD
CARDIZEM LA ( <i>matzim la</i> )	T3	HD
<i>cartia xt</i> (Cardizem CD)	T1	HD
<i>diltiazem 24hr er (cd)</i> (Cardizem CD)	T1	HD
<i>diltiazem 24hr er (la)</i> (Cardizem La)	T1	HD
<i>diltiazem 24hr er (xr)</i>	T1	HD
<i>diltiazem er</i>	T1	HD
<i>diltiazem er</i> (Tiazac)	T1	HD
<i>diltiazem hcl</i> (Cardizem)	T1	HD
<i>dilt-xr</i>	T1	HD
<i>felodipine er</i>	T1	HD
<i>isradipine</i>	T1	
<i>matzim la</i> (Cardizem La)	T1	HD
<i>nicardipine hcl</i>	T1	HD
<i>nifedipine</i>	T1	HD
<i>nifedipine</i> (Procardia)	T1	HD

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## List of Prescription Medications

CARDIAC DRUGS (Blood Pressure/Heart Medications) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>CALCIUM CHANNEL BLOCKING AGENTS (cont.)</b>		
nifedipine er	T1	HD
nifedipine er (Procardia XI)	T1	HD
nimodipine 30 mg capsule	T1	HD
nimodipine 60 mg/20 ml soln	T1	
nisoldipine	T1	HD
nisoldipine (Sular)	T1	HD
NYMALIZE	T3	
PROCARDIA (nifedipine)	T3	HD
PROCARDIA XL (nifedipine er)	T3	HD
SULAR (nisoldipine)	T3	HD
taztia xt (Tiazac)	T1	HD
tiadylt er (Tiazac)	T1	HD
TAZAC (diltiazem 24hr er)	T3	HD
verapamil er (Calan SR)	T1	HD
verapamil er (Verelan)	T1	HD
verapamil er pm (Verelan PM)	T1	HD
verapamil hcl	T1	HD
verapamil hcl (Verelan)	T1	HD
verapamil hcl (Verelan Pm)	T1	ST HD
VERELAN (verapamil er)	T3	HD
VERELAN (verapamil hcl)	T3	HD
VERELAN PM (verapamil er pm)	T3	HD
<b>CARDIOPLEGIC SOLUTIONS</b>		
cardioplegic (Plegisol)	T1	
<b>DIGITALIS GLYCOSIDES</b>		
digitek (Lanoxin)	T1	HD
digoxin (Lanoxin)	T1	HD
LANOXIN	T3	HD
LANOXIN (digitek)	T3	HD
<b>HEART RATE REDUCING, SA SELECTIVE I(F) CURRENT INH.</b>		
ivabradine (Corlanor)	T1	PA HD
<b>SOLUBLE GUANYLATE CYCLASE (SGC) STIMULATOR</b>		
VERQUVO	T2	QL (max 30 tabs/30 days)

T1 – Typically Generics

T2 – Typically Preferred Brands

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## List of Prescription Medications

CARDIAC DRUGS (Blood Pressure/Heart Medications) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>VASODILATORS, CORONARY</b>		
DILATRATE-SR	T2	HD
GONITRO	T3	
ISORDIL ( <i>isosorbide dinitrate</i> )	T3	HD
<i>isosorbide dinitrate</i>	T1	HD
<i>isosorbide dinitrate</i> (Isordil Ttradose)	T1	HD
<i>isosorbide dinitrate</i> (Isordil)	T1	HD
<i>isosorbide mononitrate</i>	T1	HD
MINITRAN	T3	HD
<i>nitro-bid</i>	T1	HD
NITRO-DUR	T3	HD
<i>nitroglycerin</i>	T1	HD
<b>VASODILATORS, CORONARY (cont.)</b>		
<i>nitroglycerin</i> (Nitro-Dur)	T1	HD
<i>nitroglycerin</i> 400 mcg spray (Nitrolingual)	T1	HD
<i>nitroglycerin</i> 0.3 mg tablet sl (Nitrostat)	T1	HD
<i>nitroglycerin</i> 0.4 mg tablet sl (Nitrostat)	T1	HD
<i>nitroglycerin</i> 0.6 mg tablet sl (Nitrostat)	T1	HD
NITROLINGUAL ( <i>nitroglycerin</i> )	T3	
NITROMIST ( <i>nitroglycerin</i> )	T3	HD
NITROSTAT ( <i>nitroglycerin</i> )	T3	HD
<i>nitro-time</i>	T1	HD
<b>CARDIOVASCULAR (Asthma/COPD/Respiratory)</b>		
<b>PULM ANTI-HTN, SOLUBLE GUANYLATE CYCLASE STIMULATOR</b>		
ADEMPAS	T2	PA QL (90 tabs/30 days) SP HD
<b>PULM ANTI-HTN, SEL.C-GMP PHOSPHODIESTERASE T5 INHIB</b>		
REVATIO ( <i>sildenafil</i> )	T3	PA QL SP HD
<i>sildenafil</i> (Revatio)	T1	PA QL SP HD
<b>PULMONARY ANTI-HTN, ENDOTHELIN RECEPTOR ANTAGONIST</b>		
<i>ambrisentan</i> (Letairis)	T1	PA SP HD
<i>bosentan</i> (Tracleer)	T1	PA SP HD
<i>bosentan</i> (Tracleer)	T1	PA
OPSUMIT	T2	PA QL (30 tabs/30 days) SP HD
TRACLEER 32 MG TABLET FOR SUSPENSION	T2	PA ST QL (120 tabs/30 days) SP HD
TRACLEER 62.5 MG, 125 MG TABLET ( <i>bosentan</i> )	T3	PA QL (60 tabs/30 days) SP HD

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

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## List of Prescription Medications

CARDIOVASCULAR (Asthma/COPD/Respiratory) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>PULMONARY ANTIHYPER AGENT, ACTRIIA-FC</b>		
WINREVAIR	T2	PA SP HD
WINREVAIR (2 PACK)	T2	PA SP HD
<b>PULMONARY ANTIHYPERTENSIVES, PROSTACYCLIN-TYPE</b>		
ORENITRAM ER	T3	PA QL (90 tabs/30 days) SP HD
ORENITRAM TITRATION KT MONTH 1	T3	PA SP QL (168 tabs/28 days)
ORENITRAM TITRATION KT MONTH 2	T3	PA SP QL (336 tabs/28 days)
ORENITRAM TITRATION KT MONTH 3	T3	PA SP QL (252 tabs/28 days)
TYVASO	T2	PA ST SP HD
UPTRAVI	T2	PA QL (60 tabs/30 days) SP HD
VENTAVIS	T3	PA SP HD
<b>PULMONARY HTN-ENDOTHELIN RECEPTANTG-CGMP PDE5 INH</b>		
OPSYNVI	T2	PA QL (30 tabs/fill) SP HD
<b>CARDIOVASCULAR (Blood Pressure/Heart Medications)</b>		
<b>ACE INHIBITOR-CALCIUM CHANNEL BLOCKER COMBINATION</b>		
amlodipine besylate-benazepril	T1	HD
amlodipine besylate-benazepril (Lotrel)	T1	HD
PRESTALIA	T3	HD
TARKA (trandolapril-verapamil er)	T3	HD
trandolapril-verapamil	T1	HD
trandolapril-verapamil (Tarka)	T1	HD
<b>ACE INHIBITOR-THIAZIDE OR THIAZIDE-LIKE DIURETIC</b>		
ACCURETIC (quinapril-hydrochlorothiazide)	T3	HD
benazepril hcl-hctz (Lotensin HCT)	T1	HD
captopril/hydrochlorothiazide	T1	HD
enalapril maleate/hctz (Vaseretic)	T1	HD
fosinopril-hydrochlorothiazide	T1	HD
lisinopril-hctz (Zestoretic)	T1	HD
LOTENSIN HCT (benazepril-hydrochlorothiazide)	T3	HD
quinapril-hydrochlorothiazide (Accuretic)	T1	HD
VASERETIC (enalapril-hydrochlorothiazide)	T3	HD
ZESTORETIC (lisinopril-hydrochlorothiazide)	T3	HD
<b>ALPHA/BETA-ADRENERGIC BLOCKING AGENTS</b>		
CARDURA (doxazosin mesylate)	T3	QL HD
CARDURA XL	T3	QL (30 units/30 days) HD

T1 – Typically Generics

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## List of Prescription Medications

CARDIOVASCULAR (Blood Pressure/Heart Medications) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>ALPHA/BETA-ADRENERGIC BLOCKING AGENTS (cont.)</b>		
doxazosin mesylate (Cardura)	T1	QL HD
labetalol hcl 100 mg tablet	T1	HD
labetalol hcl 200 mg tablet	T1	HD
labetalol hcl 300 mg tablet	T1	HD
MINIPRESS (prazosin hcl)	T3	HD
prazosin hcl (Minipress)	T1	HD
terazosin hcl	T1	QL (30 caps/30 days ) HD
<b>ANGIOTEN. RECEPTR ANTAG-CALCIUM CHANL BLKR-THIAZIDE</b>		
amlodipine-valsartan-hctz (Exforge HCT)	T1	HD
olmesartan-amlodipine-hctz (Tribenzor)	T1	HD
<b>ANGIOTENSIN RECEPT-NEPRILYSIN INHIBITOR COMB (ARNI)</b>		
ENTRESTO	T2	QL (60 tabs/30 days)
ENTRESTO SPRINKLE	T2	QL (240 caps/fill) HD
sacubitril/valsartan	T1	QL (60 tabs/30 days) HD
<b>ANGIOTENSIN RECEPTOR ANTAG.-THIAZIDE DIURETIC COMB</b>		
candesartan-hydrochlorothiazid (Atacand Hct)	T1	HD
irbesartan-hydrochlorothiazide (Avalide)	T1	HD
losartan-hydrochlorothiazide (Hyzaar)	T1	HD
losartan-hydrochlorothiazide (Hyzaar)	T1	
olmesartan-hydrochlorothiazide (Benicar HCT)	T1	HD
telmisartan-hydrochlorothiazid (Micardis HCT)	T1	HD
valsartan-hydrochlorothiazide (Diovan HCT)	T1	HD
<b>ANGIOTENSIN RECEPTOR BLOCKR-CALCIUM CHANNEL BLOCKR</b>		
amlodipine-olmesartan (Azor)	T1	HD
amlodipine-valsartan (Exforge)	T1	HD
telmisartan-amlodipine (Twynsta)	T1	HD
<b>ANTI-HYPERTENSIVES, ACE INHIBITORS</b>		
ACCUPRIL (quinapril hcl)	T3	HD
ALTACE (ramipril)	T3	HD
<b>ANTI-HYPERTENSIVES, ACE INHIBITORS</b>		
benazepril hcl (Lotensin)	T1	HD
captopril	T1	HD
enalapril maleate (Vasotec)	T1	HD
fosinopril	T1	HD

T1 – Typically Generics

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## List of Prescription Medications

CARDIOVASCULAR (Blood Pressure/Heart Medications) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>ANTI-HYPERTENSIVES, ACE INHIBITORS (cont.)</b>		
<i>lisinopril</i> (Prinivil)	T1	HD
<i>lisinopril</i> (Zestril)	T1	HD
LOTENSIN ( <i>benazepril hcl</i> )	T3	HD
<i>moexipril hcl</i>	T1	HD
<i>perindopril erbumine</i>	T1	HD
PRINIVIL ( <i>lisinopril</i> )	T3	HD
<i>quinapril</i> (Accupril)	T1	HD
<i>ramipril</i> (Altace)	T1	HD
<i>trandolapril</i>	T1	HD
VASOTEC ( <i>enalapril maleate</i> )	T3	HD
ZESTRIL ( <i>lisinopril</i> )	T3	HD
<b>ANTI-HYPERTENSIVES, ANGIOTENSIN RECEPTOR ANTAGONIST</b>		
<i>candesartan cilexetil</i> (Atacand)	T1	HD
<i>eprosartan mesylate</i>	T1	
<i>irbesartan</i>	T1	HD
<i>irbesartan</i> (Avapro)	T1	HD
<i>losartan</i> (Cozaar)	T1	HD
<i>telmisartan</i>	T1	HD
<i>olmesartan medoxomil</i> (Benicar)	T1	HD
<i>telmisartan</i> (Micardis)	T1	HD
<i>valsartan</i> (Diovan)	T1	HD
<i>valsartan 20 mg/5 ml solution</i>	T1	HD
<b>ANTI-HYPERTENSIVES, GANGLIONIC BLOCKERS</b>		
VECAMYL	T3	
<b>ANTI-HYPERTENSIVES, MISCELLANEOUS</b>		
DEMSER	T3	PA HD
<b>ANTI-HYPERTENSIVES, SYMPATHOLYTIC</b>		
<i>CATAPRES-TTS (clonidine)</i>	T3	QL (4 patches/21 days) HD
<i>clonidine hcl</i> (Catapres-TTS 1)	T1	QL (4 patches/21 days) HD
<i>clonidine hcl</i> (Catapres-TTS 2)	T1	QL (4 patches/21 days) HD
<i>clonidine hcl</i> (Catapres-TTS 3)	T1	QL (4 patches/21 days) HD
<i>guanfacine hcl</i>	T1	HD
<i>methyldopa</i>	T1	HD
<i>methyldopa/hydrochlorothiazide</i>	T1	HD

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## List of Prescription Medications

CARDIOVASCULAR (Blood Pressure/Heart Medications) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>ANTI-HYPERTENSIVES, VASODILATORS</b>		
hydralazine hcl	T1	HD
minoxidil	T1	HD
<b>BETA-ADRENERGIC BLOCKING AGENTS</b>		
acebutolol hcl	T1	HD
atenolol (Tenormin)	T1	HD
BETAPACE (sorine)	T3	HD
BETAPACE AF (sorine)	T3	HD
betaxolol hcl	T1	HD
bisoprolol fumarate 10 mg tab	T1	HD
bisoprolol fumarate 5 mg tab	T1	HD
HEMANGEOL	T2	PA
LOPRESSOR (metoprolol tartrate)	T3	HD
metoprolol succinate (Toprol XL)	T1	HD
metoprolol tartrate	T1	HD
metoprolol tartrate (Lopressor)	T1	HD
pindolol	T1	HD
propranolol hcl	T1	HD
propranolol hcl er (Inderal La)	T1	HD
sorine	T1	HD
sorine (Betapace)	T1	HD
sotalol	T1	HD
sotalol (Betapace)	T1	HD
sotalol af (Betapace)	T1	HD
SOTYLIZE	T2	HD
TENORMIN (atenolol)	T3	HD
timolol maleate 10 mg tablet	T1	HD
timolol maleate 20 mg tablet	T1	HD
timolol maleate 5 mg tablet	T1	HD
<b>BETA-BLOCKERS AND THIAZIDE, THIAZIDE-LIKE DIURETICS</b>		
atenolol w/chlorthalidone (Tenoretic 100)	T1	HD
atenolol w/chlorthalidone (Tenoretic 50)	T1	
atenolol w/chlorthalidone (Tenoretic 50)	T1	HD
bisoprolol fumarate/hctz (Ziac)	T1	HD
bisoprolol/hydrochlorothiazide	T1	HD

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

PA – Prior Authorization

QL – Quantity Limit

ST – Step Therapy

AGE – Age Requirement

SP – Specialty Medication

HD – May require home delivery pharmacy

PPACA – No Cost-Share Preventive Medication

CSL – Oral cancer medication subject to cost-share limits

## List of Prescription Medications

CARDIOVASCULAR (Blood Pressure/Heart Medications) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>BETA-BLOCKERS AND THIAZIDE, THIAZIDE-LIKE DIURETICS (cont.)</b>		
<i>metoprolol-hydrochlorothiazide</i>	T1	HD
<i>metoprolol-hydrochlorothiazide (Lopressor HCT)</i>	T1	HD
<i>propranolol hcl-hctz</i>	T1	HD
<i>TENORETIC (atenolol-chlorthalidone)</i>	T3	HD
<b>RENIN INHIBITOR, DIRECT</b>		
<i>aliskiren (Tekturna)</i>	T1	HD
<b>RENIN INHIBITOR, DIRECT AND THIAZIDE DIURETIC COMB</b>		
<i>TEKTURN A HCT</i>	T2	HD
<b>VASODILATORS, COMBINATION</b>		
<i>isosorbide dinit/hydralazine (Bidil)</i>	T1	HD
<b>VASODILATORS, PERIPHERAL</b>		
<i>ergoloid mesylates</i>	T1	
<i>isoxsuprine hcl</i>	T1	
<b>CARDIOVASCULAR (Cholesterol Medications)</b>		
<b>ANTI-HYPERLIP.HMG COA REDUCT INHIB-CHOLEST.AB.INHIB</b>		
<i>ezetimibe-atorvastatin tabs</i>	T1	ST HD QL (30 tabs/30 days)
<i>ezetimibe-simvastatin (Vytorin)</i>	T1	QL (30 units/30 days) HD
<b>ANTI-HYPERLIPID- HMG-COA RI-CALCIUM CHANNEL BLOCKER</b>		
<i>amlodipine-atorvastatin (Caduet)</i>	T1	QL (30 units/30 days) HD
<i>CADUET (amlodipine-atorvastatin)</i>	T3	ST QL (30 units/30 days) HD
<b>ANTI-HYPERLIPIDEMIC - ANGIOPOIETIN-LIKE 3 INHIBITOR</b>		
<i>EVKEEZA</i>	T3	PA
<b>ANTI-HYPERLIPIDEMIC - APOLIPOPROTEIN INHIBITOR</b>		
<i>TRYNGOLZA</i>	T3	PA SP
<b>ANTI-HYPERLIPIDEMIC - MTP INHIBITOR</b>		
<i>JUXTAPIID</i>	T2	SP HD
<b>ANTI-HYPERLIPIDEMIC - PCSK9 INHIBITORS</b>		
<i>REPATHA</i>	T2	
<b>ANTI-HYPERLIPIDEMIC-HMGCOA REDUCTASE INHIB (STATINS)</b>		
<i>FLOLIPID</i>	T3	ST QL HD
<i>fluvastatin</i>	T1	QL HD PPACA
<i>fluvastatin</i>	T1	QL (30 units/30 days) HD PPACA
<i>fluvastatin er (Lescol XL)</i>	T1	QL (30 units/30 days) HD PPACA
<i>LESCOL XL (fluvastatin er)</i>	T3	ST QL (30 units/30 days) HD

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

PA – Prior Authorization

QL – Quantity Limit

ST – Step Therapy

AGE – Age Requirement

SP – Specialty Medication

HD – May require home delivery pharmacy

PPACA – No Cost-Share Preventive Medication

CSL – Oral cancer medication subject to cost-share limits

## List of Prescription Medications

CARDIOVASCULAR (Cholesterol Medications) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>ANTI-HYPERLIPIDEMIC-HMGCOA REDUCTASE INHIB (STATINS) (cont.)</b>		
<i>lovastatin</i>	T1	QL HD PPACA
<i>pitavastatin calcium (Livalo)</i>	T1	QL (30 tabs/30 days) HD PPACA
<i>pravastatin (Pravachol)</i>	T1	QL (30 units/30 days) HD PPACA
<i>simvastatin</i>	T1	QL (30 units/30 days) HD
<i>simvastatin (Zocor)</i>	T1	QL (30 units/30 days) HD PPACA
ZYPITAMAG	T3	ST QL (30 units/30 days) HD
<b>BILE SALT SEQUESTRANTS</b>		
<i>cholestyramine</i>	T1	HD
<i>cholestyramine (Questran)</i>	T1	HD
<i>cholestyramine (Questran Light)</i>	T1	HD
<i>cholestyramine light (Questran Light)</i>	T1	HD
<i>colesevelam hcl (Welchol)</i>	T1	HD
COLESTID ( <i>colestipol hcl</i> )	T3	HD
<i>colestipol hcl</i>	T1	HD
<i>colestipol hcl (Colestid)</i>	T1	HD
<i>prevalite</i>	T1	HD
<i>prevalite (Questran Light)</i>	T1	HD
QUESTRAN ( <i>cholestyramine</i> )	T3	HD
QUESTRAN LIGHT ( <i>cholestyramine</i> )	T3	ST HD
QUESTRAN LIGHT ( <i>cholestyramine light</i> )	T3	HD
<b>LIPOTROPICS</b>		
ANTARA	T3	ST HD
<i>ezetimibe (Zetia)</i>	T1	HD
<i>fenofibrate</i>	T1	HD
<i>fenofibrate 130 mg capsule</i>	T1	ST HD
<i>fenofibrate (Fenoglide)</i>	T1	HD
<i>fenofibrate (Tricor)</i>	T1	HD
<i>fenofibric acid</i>	T1	HD
<i>fenofibric acid (choline)</i>	T1	HD
<i>fenofibric acid (Fibrincor)</i>	T1	HD
<i>fenofibric acid (Trilipix)</i>	T1	HD
FENOGLIDE ( <i>fenofibrate</i> )	T3	ST HD
FIBRICOR ( <i>fenofibric acid</i> )	T3	ST HD
<i>gemfibrozil (Lopid)</i>	T1	HD

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

PA – Prior Authorization

QL – Quantity Limit

ST – Step Therapy

AGE – Age Requirement

SP – Specialty Medication

HD – May require home delivery pharmacy

PPACA – No Cost-Share Preventive Medication

CSL – Oral cancer medication subject to cost-share limits

## List of Prescription Medications

### CARDIOVASCULAR (Cholesterol Medications) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>LIPOTROPICS (cont.)</b>		
LIPOFEN	T2	HD
LOPID ( <i>gemfibrozil</i> )	T3	HD
niacin	T1	HD
niacin er (Niaspan)	T1	HD
NIACOR	T3	HD
NIASPAN ( <i>niacin er</i> )	T3	HD
rosuvastatin 5mg, 10mg, 20mg, 40mg tab (Crestor)	T1	
TRIGLIDE	T3	ST
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 10 mg/5 ml cup</i>	T1	HD
<i>memantine hcl 5 mg, 10 mg tablet</i>	T1	HD
<i>memantine hcl er</i> (Namenda XR)	T1	HD
NAMENDA	T3	HD
NAMENDA XR	T3	HD

#### ALZHEIMER'S THX, NMDA RECEPTOR ANTAG-CHOLINES INHIB

<i>memantine hcl/donepezil hcl</i> (Namzaric)	T1	ST HD
<i>NAMZARIC</i> ( <i>memantine hcl/donepezil hcl</i> )	T2	ST HD
NAMZARIC	T2	ST HD

### CNS DRUGS (Miscellaneous)

#### AMYOTROPHIC LATERAL SCLEROSIS AGENTS

RILUTEK ( <i>riluzole</i> )	T3	PA SP HD
<i>riluzole</i> (Rilutek)	T1	PA SP HD
TEGLUTIK	T3	PA SP
TIGLUTIK	T3	PA SP

#### DRUGS TO TREAT MOVEMENT DISORDERS

AUSTEDO XR 6 MG TABLET	T2	PA SP HD QL (210 tabs/30 days)
AUSTEDO XR 12 MG TABLET	T2	PA SP HD QL (90 tabs/30 days)
AUSTEDO XR 18 MG TABLET	T2	PA QL (30 tabs/fill) SP HD
AUSTEDO XR 24 MG TABLET	T2	PA SP HD QL (60 tabs/30 days)
AUSTEDO XR 30 MG TABLET	T2	PA QL (30 tabs/fill) SP HD

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

PA – Prior Authorization

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## List of Prescription Medications

CNS DRUGS (Miscellaneous) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>DRUGS TO TREAT MOVEMENT DISORDERS (cont.)</b>		
AUSTEDO XR 36 MG TABLET	T2	PA QL (30 tabs/fill) SP HD
AUSTEDO XR 42 MG TABLET	T2	PA QL (30 tabs/fill) SP HD
AUSTEDO XR 48 MG TABLET	T2	PA QL (30 tabs/fill) SP HD
AUSTEDO XR TITRATION KT(WK1-4)	T2	PA QL (28 tabs/fill) SP HD
HORIZANT	T3	ST
INGREZZA CAPSULES	T3	PA ST QL (1 cap/1 day) SP HD
INGREZZA SPRINKLE	T3	PA QL (30 caps/fill) SP
INGREZZA INITIATION PK (TARDIV)	T3	PA QL (28 caps/30 days) SP
<i>tetrabenazine (Xenazine)</i>	T1	PA QL SP HD
<b>XANTHINES</b>		
<i>caffeine d</i>	T1	HD
<b>CNS DRUGS (Multiple Sclerosis)</b>		
<b>AGENTS TO TREAT MULTIPLE SCLEROSIS</b>		
AUBAGIO	T3	PA SP HD QL (30 tabs/30 days)
AVONEX (4 PACK)	T2	PA QL (1 kit/28 days) SP HD
AVONEX ADMINISTRATION PACK	T2	PA QL (1 kit/21 days) SP HD
AVONEX PEN (4 PACK)	T2	PA QL (4 pens/28 days) SP HD
BAFIERTAM	T2	PA ST (120 caps/30 days) SP HD
BETASERON	T2	PA QL (14 kits/23 days) SP HD
<i> fingolimod</i>	T1	PA ST QL (30 caps/30 days) SP HD
<i> glatiramer acetate 20 mg/ml syringe (Copaxone)</i>	T1	QL (30 syr/23 days) SP HD
<i> glatiramer acetate 40 mg/ml syringe (Copaxone)</i>	T1	QL (12 ml/23 days) SP HD
<i> glatopa 20 mg/ml syringe (Copaxone)</i>	T1	PA QL (30 syr/23 days) SP HD
<i> glatopa 40 mg/ml syringe (Copaxone)</i>	T1	PA QL (12 ml/23 days) SP HD
KESIMPTA PEN	T2	PA ST QL (1 pen/28 days) SP HD
MAVENCLAD 10 MG X 10 TABLET PACK	T3	PA QL (10 tabs/dispense) SP HD
MAVENCLAD 10 MG X 4 TABLET PACK	T3	PA QL (4 tabs/dispense) SP HD
MAVENCLAD 10 MG X 5 TABLET PACK	T3	PA QL (5 tabs/dispense) SP HD
MAVENCLAD 10 MG X 6 TABLET PACK	T3	PA QL (6 tabs/dispense) SP HD
MAVENCLAD 10 MG X 7 TABLET PACK	T3	PA QL (7 tabs/dispense) SP HD
MAVENCLAD 10 MG X 8 TABLET PACK	T3	PA QL (8 tabs/dispense) SP HD
MAVENCLAD 10 MG X 9 TABLET PACK	T3	PA QL (9 tabs/dispense) SP HD
MAYZENT	T2	PA QL (30 units/30 days) SP HD

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

PA – Prior Authorization

QL – Quantity Limit

ST – Step Therapy

AGE – Age Requirement

SP – Specialty Medication

HD – May require home delivery pharmacy

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## List of Prescription Medications

CNS DRUGS (Multiple Sclerosis) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>AGENTS TO TREAT MULTIPLE SCLEROSIS (cont.)</b>		
PLEGRIDY PEN/SYRINGE	T2	PA QL (1 ml/21 days) SP HD
PLEGRIDY STARTER PACK	T2	PA QL (1 pack/365 days) SP HD
PONVORY	T2	PA ST QL (30 tabs/30 days) SP
REBIF REBIDOSE SYRINGES	T2	PA ST QL (1 pack/28 days) SP HD
REBIF REBIDOSE TITRATION PACK	T2	PA ST QL (1 pack/28 days) SP HD
REBIF SYRINGES	T2	PA QL (6 ml/21 days) SP HD
REBIF TITRATION PACK	T2	PA QL (5 ml/21 c) SP HD
VUMERTY STARTER PACK	T2	PA QL (106 c/30 days) SP HD
VUMERTY	T2	PA QL (120 caps/30 days) SP HD
ZEPOSIA	T2	PA QL SP HD
ZEPOSIA 0.23-0.46 MG START PCK	T2	PA QL (37 v/30 days) SP HD
ZEPOSIA 0.23-0.46-0.92 MG KIT	T2	PA QL (7 v/7 days) SP HD
ZEPOSIA 0.92 MG CAPSULE	T2	PA QL (30 caps/30 Days) SP HD
<b>AGTS TX NEUROMUSC TRANSMISSION DIS, POT-CHAN BLKR</b>		
AMPYRA ER 10 MG TABLET	T3	PA QL (30 caps/30 days) SP HD
dalfampridine er (Ampyra)	T1	PA SP HD
FIRDAPSE	T2	PA SP
RUZURGI	T2	PA SP
<b>CNS DRUGS (Pain Relief And Inflammatory Disease)</b>		
<b>CALCITONIN GENE-RELATED PEPTIDE (CGRP) INHIBITORS</b>		
EMGALITY SYRINGE	T2	PA QL (1 syr/23 days)
<b>POSTHERPETIC NEURALGIA AGENTS</b>		
gabapentin (Gralise)	T1	ST
GRALISE	T3	ST
GRALISE (gabapentin)	T3	ST
<b>SPHINGOSINE I-PHOSPHATE (SIP) RECEPTOR MODULATOR</b>		
ZEPOSIA STARTER KIT (28-DAY)	T2	
VELSIPITI	T2	PA QL (30 tabs/30 days) SP HD
<b>CNS DRUGS (Seizure Disorders)</b>		
<b>ANTI-CONVULSANT - BENZODIAZEPINE TYPE</b>		
clobazam (Onfi)	T1	PA HD
clonazepam (Klonopin)	T1	HD
DIASTAT (diazepam)	T3	HD

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

PA – Prior Authorization

QL – Quantity Limit

ST – Step Therapy

AGE – Age Requirement

SP – Specialty Medication

HD – May require home delivery pharmacy

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## List of Prescription Medications

CNS DRUGS (Seizure Disorders) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>ANTI-CONVULSANT - BENZODIAZEPINE TYPE (cont.)</b>		
diazepam 10 mg rectal gel syrg	T1	HD
diazepam 10mg rectal gel (2pk)	T1	HD
diazepam 2.5mg rectal gel(2pk) (Diastat)	T1	HD
diazepam 20 mg rectal gel syrg	T1	HD
diazepam 20mg rectal gel (2pk)	T1	HD
KLONOPIN (clonazepam)	T3	HD
NAYZILAM	T2	PA QL HD
ONFI (clobazam)	T3	PA HD
SYMPAZAN	T3	PA HD
VALTOCO	T2	PA QL (2 units/30 days) HD
<b>ANTI-CONVULSANT - CANNABINOID TYPE</b>		
EPIDIOLEX	T2	PA SP HD
<b>ANTI-CONVULSANTS</b>		
APTIOM (eslicarbazepine acetate)	T3	HD
BANZEL	T3	PA HD
BRIVIACT	T3	ST HD
carbamazepine 100 mg tab chew	T1	HD
carbamazepine 100 mg/5 ml cup	T1	HD
carbamazepine 100 mg/5 ml susp (Tegretol)	T1	HD
carbamazepine 200 mg tablet (Tegretol)	T1	HD
carbamazepine 200 mg/10 ml cup	T1	HD
CARBAMAZEPINE 200 MG TAB CHEW	T3	HD
carbamazepine (Tegretol)	T1	HD
carbamazepine er (Carbatrol)	T1	HD
carbamazepine er (Tegretol XR)	T1	HD
CARBATROL (carbamazepine er)	T3	HD
CELONTIN (methylsuximide)	T3	HD
DEPAKOTE (divalproex )	T3	ST HD
DEPAKOTE ER (divalproex er)	T3	ST HD
DEPAKOTE SPRINKLE (divalproex )	T3	ST HD
DIACOMIT	T2	PA SP HD
DILANTIN (phenytoin)	T3	HD
DILANTIN 30 MG CAPSULE	T2	HD
divalproex er (Depakote ER)	T1	HD

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

PA – Prior Authorization

QL – Quantity Limit

ST – Step Therapy

AGE – Age Requirement

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## List of Prescription Medications

CNS DRUGS (Seizure Disorders) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>ANTI-CONVULSANTS (cont.)</b>		
<i>divalproex</i> (Depakote Sprinkle)	T1	HD
<i>divalproex</i> (Depakote)	T1	HD
<i>epitol</i> (Tegretol)	T1	HD
ELEPSIA XR	T3	ST HD
<i>eslicarbazepine acetate</i> (Aptiom)	T1	HD
<i>ethosuximide</i> (Zarontin)	T1	HD
<i>felbamate</i> (Felbatol)	T1	HD
FELBATOL ( <i>felbamate</i> )	T3	HD
FYCOMPA	T2	HD
FYCOMPA ( <i>perampanel</i> )	T2	HD
<i>gabapentin</i> (Neurontin)	T1	HD
LAMICTAL XR	T3	ST HD
<i>lamotrigine (blue)</i> (Lamictal (Blue))	T1	HD
<i>lamotrigine (green)</i> (Lamictal (Green))	T1	HD
<i>lamotrigine</i> (Lamictal XR)	T1	HD
<i>lamotrigine</i> (Lamictal)	T1	HD
<i>lamotrigine (orange)</i> (Lamictal (Orange))	T1	HD
<i>lamotrigine odt</i> (Lamictal ODT)	T1	HD
<i>levetiracetam</i> (Keppra XR)	T1	HD
<i>levetiracetam</i> (Keppra)	T1	HD
LEVETIRACETAM 250 MG TAB SUSP	T3	ST HD
<i>levetiracetam 1,000 mg tablet</i> (Keppra)	T1	HD
<i>levetiracetam 1,000mg/10ml cup</i> (Keppra)	T1	HD
<i>levetiracetam 100 mg/ml soln</i> (Keppra)	T1	HD
<i>levetiracetam 250 mg tablet</i> (Keppra)	T1	HD
<i>levetiracetam 500 mg tablet</i> (Keppra)	T1	HD
<i>levetiracetam 500 mg/5 ml cup</i>	T1	HD
<i>levetiracetam 500 mg/5 ml soln</i>	T1	HD
<i>levetiracetam 750 mg tablet</i> (Keppra)	T1	HD
MYSOLINE ( <i>primidone</i> )	T3	HD
<i>oxcarbazepine</i> (Oxtellar Xr)	T1	HD
<i>oxcarbazepine</i> (Trileptal)	T1	HD
OXTELLAR XR ( <i>oxcarbazepine</i> )	T3	ST HD
PEGANONE	T2	HD

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

PA – Prior Authorization

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AGE – Age Requirement

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## List of Prescription Medications

CNS DRUGS (Seizure Disorders) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>ANTI-CONVULSANTS (cont.)</b>		
<i>perampanel</i> (Fycompa)	T1	HD
<i>PHENYTEK</i> ( <i>phenytoin extended</i> )	T3	HD
<i>phenytoin</i>	T1	HD
<i>phenytoin</i> (Dilantin)	T1	HD
<i>phenytoin</i> (Dilantin-125)	T1	HD
<i>phenytoin</i> (Phenytek)	T1	HD
<i>pregabalin</i> (Lyrica)	T1	HD
<i>primidone</i> (Mysoline)	T1	HD
QUDEXY XR	T2	ST HD
<i>roweepra</i> (Keppra)	T1	HD
SABRIL ( <i>vigabatrin</i> )	T3	PA SP HD
SPRITAM	T3	ST HD
<i>subvenite</i> (Lamictal (Blue))	T1	HD
<i>subvenite</i> (Lamictal (Green))	T1	HD
<i>subvenite</i> (Lamictal (Orange))	T1	HD
<i>subvenite</i> (Lamictal)	T1	HD
TEGRETOL ( <i>carbamazepine</i> )	T3	HD
TEGRETOL XR ( <i>carbamazepine er</i> )	T3	HD
<i>tiagabine</i>	T1	HD
<i>topiramate er</i> 25mg, 50mg, 100mg capsule (Trokendi XR)	T1	ST
<i>topiramate</i> 100 mg tablet (Topamax)	T1	HD
<i>topiramate</i> 15 mg sprinkle cap (Topamax)	T1	HD
<i>topiramate</i> 200 mg tablet (Topamax)	T1	HD
<i>topiramate</i> 25 mg sprinkle cap (Topamax)	T1	HD
<i>topiramate</i> 25 mg tablet (Topamax)	T1	HD
<i>topiramate</i> 50 mg tablet (Topamax)	T1	HD
TROKENDI XR	T3	ST HD
<i>valproic acid</i>	T1	HD
VIGADRON	T1	PA SP HD QL (150 pkts/30 days)
<i>vigadron</i> (Sabril)	T1	PA SP HD
VIMPAT	T2	HD
XCOPRI 25 MG TABLET	T3	QL (30 tabs/fill) HD
ZARONTIN ( <i>ethosuximide</i> )	T3	HD
<i>zonisamide</i>	T1	HD

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

PA – Prior Authorization

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## List of Prescription Medications

CNS DRUGS (Seizure Disorders) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>ANTI-CONVULSANTS (cont.)</b>		
zonisamide (Zonegran)	T1	HD
ZTALMY 50 MG/ML SUSPENSION	T2	SP
<b>CNS DRUGS (Sleep Disorders/Sedatives)</b>		
<b>NARCOLEPSY TX-H3-RECEPT.ANTAGONIST/INVERSE AGONIST</b>		
WAKIX	T3	PA QL SP HD
<b>COLONY STIMULATING FACTORS (Blood Modifiers/Bleeding Disorders)</b>		
<b>ERYTHROPOEISIS-STIMULATING AGENTS</b>		
PROCRIT	T2	PA SP
RETACRIT	T2	PA SP
<b>LEUKOCYTE (WBC) STIMULANTS</b>		
FULPHILA	T2	PA QL (2 syr/23 days) SP
LEUKINE	T2	PA SP
NIVESTYM	T2	PA SP HD
ZARXIO	T2	PA SP HD
<b>THROMBOPOIETIN RECEPTOR AGONISTS</b>		
DOPTELET	T2	PA QL SP HD
eltrombopag olamine (Promacta)	T1	PA SP HD
PROMACTA (eltrombopag olamine)	T2	PA SP HD
<b>COLONY STIMULATING FACTORS (Cancer)</b>		
<b>CXCR4 CHEMOKINE RECEPTOR ANTAGONIST</b>		
XOLREMDI	T3	PA SP CSL
<b>CONTRACEPTIVES (Contraception Products)</b>		
<b>CONTRACEPTIVES, INTRAVAGINAL, SYSTEMIC</b>		
ANNOVERA VAGINAL RING	T3	QL (1 ring)
eluryng (Nuvaring)	T1	PPACA
etongestrel-ethinyl estradiol (Nuvaring)	T1	PPACA
NUVARING (eluryng)	T3	
<b>CONTRACEPTIVES, IMPLANTABLE</b>		
NEXPLANON	T2	SP
<b>CONTRACEPTIVES, INJECTABLE</b>		
DEPO-PROVERA ( <i>medroxyprogesterone acetate</i> )	T3	QL (1 ml/90 days) PPACA
DEPO-SUBQ PROVERA	T3	QL (1 ml/68 days)
<i>medroxyprogesterone acetate</i> (Depo-Provera)	T1	QL (1 ml/68 days) PPACA

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

PA – Prior Authorization

QL – Quantity Limit

ST – Step Therapy

AGE – Age Requirement

SP – Specialty Medication

HD – May require home delivery pharmacy

PPACA – No Cost-Share Preventive Medication

CSL – Oral cancer medication subject to cost-share limits

## List of Prescription Medications

CONTRACEPTIVES (Contraception Products) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>CONTRACEPTIVES, INTRAVAGINAL</b>		
<i>gynol ii</i>	T1	PPACA
TODAY CONTRACEPTIVE SPONGE	T2	PPACA
<i>vcf</i>	T1	PPACA
<b>CONTRACEPTIVES, ORAL</b>		
<i>afirmelle</i>	T1	HD PPACA
AFTERA ( <i>aftera</i> )	T3	QL HD PPACA
<i>altavera</i>	T1	HD PPACA
<i>alyacen</i>	T1	HD PPACA
<i>amethia</i> (Seasonique)	T1	HD PPACA
<i>amethia lo</i> (Loseasonique)	T1	HD PPACA
<i>amethyst</i>	T1	HD PPACA
<i>apri</i>	T1	HD PPACA
<i>aranelle</i>	T1	HD PPACA
<i>ashlyna</i> (Seasonique)	T1	HD PPACA
<i>aubra</i>	T1	HD PPACA
<i>aubra eq</i>	T1	HD PPACA
<i>aurovela</i> (Loestrin)	T1	HD PPACA
<i>aurovela 24 fe</i>	T1	HD PPACA
<i>aurovela fe</i> (Loestrin Fe)	T1	HD PPACA
<i>aviane</i>	T1	HD PPACA
<i>ayuna</i>	T1	HD PPACA
<i>azurette</i> (Mircette)	T1	HD PPACA
<i>balziva</i>	T1	HD PPACA
<i>bekyree</i> (Mircette)	T1	HD PPACA
BEYAZ ( <i>dospirenone-eth estra-levomef</i> )	T3	HD
<i>blisovi 24 fe</i>	T1	HD PPACA
<i>blisovi fe</i> (Loestrin Fe)	T1	HD PPACA
<i>briellyn</i>	T1	HD PPACA
<i>camila</i>	T1	HD PPACA
<i>camrese</i> (Seasonique)	T1	HD PPACA
<i>camrese lo</i> (Loseasonique)	T1	HD PPACA
<i>caziant</i>	T1	HD PPACA
<i>chateal</i>	T1	HD PPACA
<i>chateal eq</i>	T1	HD PPACA

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## List of Prescription Medications

CONTRACEPTIVES (Contraception Products) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>CONTRACEPTIVES, ORAL (cont.)</b>		
cryselle	T1	HD PPACA
cyclafem	T1	HD PPACA
cyred	T1	HD PPACA
cyred eq	T1	HD PPACA
dasetta	T1	HD PPACA
daysee (Seasonique)	T1	HD PPACA
deblitane	T1	HD PPACA
desog-e.estriadiol/e.estriadiol	T1	HD PPACA
desog-e.estriadiol/e.estriadiol	T1	PPACA
desogestrel-ethinyl estradiol	T1	
desogestrel-eth estrad eth estra (Mircette)	T1	HD PPACA
drospirenone-eth estra-levomef (Beyaz)	T1	HD PPACA
drospirenone-eth estra-levomef (Safyral)	T1	HD PPACA
drospirenone-ethinyl estradiol (Yasmin 28)	T1	HD PPACA
drospirenone-ethinyl estradiol (Yaz)	T1	HD PPACA
econtra ez (Plan B One-Step)	T1	QL HD PPACA
econtra one-step (Plan B One-Step)	T1	QL HD PPACA
elinest	T1	HD PPACA
ELLA	T2	QL HD PPACA
emoquette	T1	HD PPACA
enpresse	T1	HD PPACA
enskyce	T1	HD PPACA
errin	T1	HD PPACA
estarrylla	T1	HD PPACA
ethynodiol-ethinyl estradiol	T1	HD PPACA
ethinyl estradiol/drospirenone (Yasmin 28)	T1	PPACA
falmina	T1	HD PPACA
fayosim (Quartette)	T1	HD PPACA
femynor	T1	HD PPACA
gianvi (Yaz)	T1	HD PPACA
hailey (Loestrin)	T1	HD PPACA
hailey 24 fe	T1	HD PPACA
heather	T1	HD PPACA
incassia	T1	HD PPACA

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## List of Prescription Medications

CONTRACEPTIVES (Contraception Products) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>CONTRACEPTIVES, ORAL (cont.)</b>		
<i>introvale</i>	T1	HD PPACA
<i>isibloom</i>	T1	HD PPACA
<i>jasmiel (Yaz)</i>	T1	HD PPACA
<i>jencycla</i>	T1	
<i>jolessa</i>	T1	HD PPACA
<i>juleber</i>	T1	HD PPACA
<i>junel (Loestrin)</i>	T1	HD PPACA
<i>junel fe</i>	T1	HD PPACA
<i>junel fe (Loestrin Fe)</i>	T1	HD PPACA
<i>kaitlib fe (Generess Fe)</i>	T1	HD PPACA
<i>kalliga</i>	T1	HD PPACA
<i>kariva (Mircette)</i>	T1	HD PPACA
<i>kelnor 1-35</i>	T1	HD PPACA
<i>kelnor 1-50</i>	T1	HD PPACA
<i>I-norgest/e.estradiol-e.estrad</i>	T1	HD PPACA
<i>larin (Loestrin)</i>	T1	HD PPACA
<i>larin fe</i>	T1	HD PPACA
<i>larin fe (Loestrin Fe)</i>	T1	HD PPACA
<i>larissia</i>	T1	HD PPACA
<i>layolis fe (Generess Fe)</i>	T1	HD
<i>leena</i>	T1	HD PPACA
<i>lessina</i>	T1	HD PPACA
<i>levonest</i>	T1	HD PPACA
<i>levonorgestrel (Plan B One-Step)</i>	T1	QL HD PPACA
<i>levonorgestrel-eth estradiol</i>	T1	HD PPACA
<i>levonorgestrel-eth estradiol</i>	T1	
<i>levonorg-eth estrad eth estrad (Loseasonique)</i>	T1	HD PPACA
<i>levonorg-eth estrad eth estrad (Quartette)</i>	T1	HD PPACA
<i>levonorg-eth estrad eth estrad (Seasonique)</i>	T1	HD PPACA
<i>levora</i>	T1	HD PPACA
<i>lillow</i>	T1	HD PPACA
<i>loryna (Yaz)</i>	T1	HD PPACA
<i>low-ogestrel</i>	T1	HD PPACA
<i>lo-zumandimine (Yaz)</i>	T1	HD PPACA

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## List of Prescription Medications

CONTRACEPTIVES (Contraception Products) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>CONTRACEPTIVES, ORAL (cont.)</b>		
<i>lulera</i>	T1	HD PPACA
<i>lyza</i>	T1	HD PPACA
<i>marlissa</i>	T1	HD PPACA
<i>melodetta 24 fe</i> (Minastrin 24 Fe)	T1	HD PPACA
<i>microgestin</i> (Loestrin)	T1	HD PPACA
<i>microgestin fe</i> (Loestrin Fe)	T1	HD PPACA
<i>mili</i>	T1	HD PPACA
<i>mono-linyah</i>	T1	HD PPACA
<i>my choice</i> (Plan B One-Step)	T1	QL HD PPACA
<i>my way</i> (Plan B One-Step)	T1	QL HD PPACA
<i>necon</i>	T1	HD PPACA
<i>new day</i> (Plan B One-Step)	T1	QL HD PPACA
<i>nikki</i> (Yaz)	T1	HD PPACA
<i>nora-be</i>	T1	HD PPACA
<i>norethindrone ac/eth estradiol</i> (Loestrin)	T1	HD PPACA
<i>norethindrone acetate</i>	T1	HD PPACA
<i>norethindrone-ethin estradiol</i> (Loestrin)	T1	HD PPACA
<i>norethin-eth estra ferrous fum</i> (Generess Fe)	T1	HD PPACA
<i>norethin-eth estra ferrous fum</i> (Loestrin Fe)	T1	HD PPACA
<i>norethin-eth estra ferrous fum</i> (Minastrin 24 Fe)	T1	HD PPACA
<i>norethin-eth estra ferrous fum</i> (Minastrin 24 Fe)	T1	
<i>norgestimate-ethynodiol estradiol</i>	T1	HD PPACA
<i>norgestimate-ethynodiol estradiol</i>	T1	
<i>norgestrel-ethinodiol</i>	T1	
<i>norlyda</i>	T1	HD PPACA
<i>nortrel</i>	T1	HD PPACA
<i>ocella</i> (Yasmin 28)	T1	HD PPACA
<i>ogestrel</i>	T1	
<i>opcicon one-step</i> (Plan B One-Step)	T1	QL HD PPACA
<i>option 2</i> (Plan B One-Step)	T1	QL HD PPACA
<i>orsythia</i>	T1	HD PPACA
<i>ORTHO-NOVUM (alyacen)</i>	T3	
<i>philith</i>	T1	HD PPACA
<i>pimtrea</i> (Mircette)	T1	HD PPACA

T1 – Typically Generics

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## List of Prescription Medications

CONTRACEPTIVES (Contraception Products) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>CONTRACEPTIVES, ORAL (cont.)</b>		
<i>pirmella</i>	T1	HD PPACA
PLAN B ONE-STEP ( <i>aftera</i> )	T2	QL HD PPACA
<i>portia</i>	T1	HD PPACA
<i>previfem</i>	T1	HD PPACA
<i>reclipsen</i>	T1	HD PPACA
<i>rivelsa</i> (Quartette)	T1	HD PPACA
<i>setlakin</i>	T1	HD PPACA
<i>sharobel</i>	T1	HD PPACA
<i>simliya</i> (Mircette)	T1	HD PPACA
<i>simpesse</i> (Seasonique)	T1	HD PPACA
<i>sprintec</i>	T1	HD PPACA
<i>sronyx</i>	T1	HD PPACA
<i>syeda</i> (Yasmin 28)	T1	HD PPACA
TAKE ACTION ( <i>aftera</i> )	T3	QL HD PPACA
<i>tarina fe</i>	T1	HD PPACA
<i>tarina fe</i> (Loestrin Fe)	T1	HD PPACA
<i>tilia fe</i> (Estrostep Fe)	T1	HD PPACA
<i>tri-femynor</i>	T1	HD PPACA
<i>tri-estarrylla</i>	T1	HD PPACA
<i>tri-legest fe</i> (Estrostep Fe)	T1	HD PPACA
<i>tri-linyah</i>	T1	HD PPACA
<i>tri-lo-estarrylla</i>	T1	HD PPACA
<i>tri-lo-marzia</i>	T1	HD PPACA
<i>tri-lo-mili</i>	T1	HD PPACA
<i>tri-lo-sprintec</i>	T1	HD PPACA
<i>tri-mili</i>	T1	HD PPACA
<i>tri-previfem</i>	T1	HD PPACA
<i>tri-sprintec</i>	T1	HD PPACA
<i>trivora</i>	T1	HD PPACA
<i>tri-vylibra</i>	T1	HD PPACA
<i>tulana</i>	T1	HD PPACA
<i>tydemy</i> (Safyral)	T1	HD PPACA
<i>velivet</i>	T1	HD PPACA
<i>vienva</i>	T1	HD PPACA

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## List of Prescription Medications

CONTRACEPTIVES (Contraception Products) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>CONTRACEPTIVES, ORAL (cont.)</b>		
viorele (Mircette)	T1	HD PPACA
vyfemla	T1	HD PPACA
vylibra	T1	HD PPACA
wera	T1	HD PPACA
wymzya fe	T1	HD PPACA
YAZ (drospirenone-ethinyl estradiol)	T3	HD
zarah (Yasmin 28)	T1	HD PPACA
zovia	T1	HD PPACA
zumandimine (Yasmin 28)	T1	HD PPACA
<b>CONTRACEPTIVES, TRANSDERMAL</b>		
norelgestromin/ethinestradiol	T1	PPACA
xulane	T1	HD PPACA
<b>DIAPHRAGMS/CERVICAL CAP</b>		
CAYA CONTOURED	T3	PPACA
FEMCAP	T2	PPACA
WIDE SEAL DIAPHRAGM	T3	PPACA
<b>INTRA-UTERINE DEVICES (IUDS)</b>		
KYLEENA	T2	SP
LILETTA	T3	SP
MIRENA	T2	SP
PARAGARD T 380-A	T3	SP
SKYLA	T2	SP
<b>CONTRACEPTIVES (Miscellaneous)</b>		
<b>CONDOMS</b>		
FC2 FEMALE CONDOM	T2	PPACA
<b>COUGH/COLD PREPARATIONS (Cough/Cold Medications)</b>		
<b>ANTI-TUSSIVES, NON-OPIOID</b>		
benzonatate (Tessalon Perle)	T1	
TESSALON PERLE (benzonatate)	T3	
<b>NON-OPIOID ANTI-TUS-IST GEN.ANTIHISTAMINE-DECONGEST</b>		
BROMFED-DM (bromfed dm)	T3	
brompheniramin-pseudoephed-dm	T1	
brompheniramine w/pseudoephed	T1	

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

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## List of Prescription Medications

COUGH/COLD PREPARATIONS (Cough/Cold Medications) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>NON-OPIOID ANTI-TUSSIVE-1ST GEN ANTIHISTAMINE COMB.</b>		
<i>promethazine w/dm</i>	T1	
<b>OPIOID ANTITUSSIVE-1ST GEN. ANTIHISTAMINE-DECONGEST</b>		
CAPCOF	T3	
HISTEX-AC	T3	
MAXI-TUSS CD	T3	
POLY-TUSSIN AC	T3	
<i>promethazine vc w/codeine</i>	T1	
<b>OPIOID ANTI-TUSSIVE-1ST GENERATION ANTIHISTAMINE</b>		
<i>hydrocodone-chlorpheniramine</i>	T1	
<i>promethazine w/codeine</i>	T1	
TUSSICAPS	T3	PA
TUXARIN ER	T3	
TUZISTRA XR	T3	PA
Z-TUSS AC	T3	
<b>OPIOID ANTI-TUSSIVE-ANTI-CHOLINERGIC COMBINATIONS</b>		
<i>hydrocodone compound</i>	T1	
<i>hydrocodone/homatropine</i>	T1	
<i>hydromet</i>	T1	
<b>OPIOID ANTITUSSIVE-DECONGESTANT-EXPECTORANT COMB</b>		
CODITUSSIN DAC	T3	
<i>guaifenesin dac</i>	T1	
<i>lortuss ex</i>	T1	
<i>virtussin dac</i>	T1	
<b>OPIOID ANTI-TUSSIVE-EXPECTORANT COMBINATION</b>		
CODITUSSIN AC	T3	
<i>g tussin ac (Virtussin Ac)</i>	T1	
<i>guaifenesin ac (Virtussin Ac)</i>	T1	
<i>guaifenesin with codeine (Virtussin Ac)</i>	T1	
<i>guiatussin ac (Virtussin Ac)</i>	T1	
MAR-COF CG	T3	
<i>m-clear wc</i>	T1	
NINJACOF-XG	T3	
<i>virtussin ac (Virtussin Ac)</i>	T1	

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## List of Prescription Medications

DIAGNOSTIC (Diabetes)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>BLOOD SUGAR DIAGNOSTICS</b>		
FREESTYLE TEST STRIPS	T2	
FREESTYLE PRECISION NEO	T2	
ONE TOUCH ULTRA TEST STRIPS	T2	
ONE TOUCH VERIO	T2	
PRECISION XTRA	T2	
<b>URINE GLUCOSE TEST AIDS</b>		
DASTIX REAGENT	T2	
DIAGNOSTIC (Miscellaneous)		
<b>BLOOD TESTING PREPARATIONS</b>		
FORA GTEL KETONE TEST STRIP	T3	
NOVAMAX PLUS	T2	
PRECISION XTRA	T2	
<b>CARDIOVASCULAR DIAGNOSTICS-RADIOPAQUE</b>		
OMNIPAQ	T3	
<b>DIAGNOSTIC PREPARATIONS, MISCELLANEOUS</b>		
ARIDOL	T3	
PROVOCHOLINE	T3	
TC 99M SULFUR COLLOID PREP	T3	
TOXICOLOGY SALIVA COLLECTION	T3	
VUEBLU	T3	
<b>DIAGNOSTIC TEST DEVICES AND SUPPLIES</b>		
BD VERTOR SYSTEM SARS-COV[1]2	T2	
BINAXNOW COVID AG CARD HOME TST	T2	
BINAXNOW COVID-19 AG CARD	T2	
BINAXNOW COVID-19 AG SELF TEST	T2	
COVID19 SPECIMEN COLLECT NCPDP	T2	
CVS COVID19 TEST BY PHARMACIST	T2	
ELLUME COVID-19 HOME TEST	T2	
FLOWFLEX COVID-19 AG HOME TEST	T2	
INTELISWAB COVID-19 RAPID TEST	T2	
QUICKVUE AT-HOME COVID-19 TEST	T2	
QUICKVUE SARS ANTIGEN TEST	T2	
RAPID RESPONSE COVID-19 TEST	T2	
SOFIA SARS ANTIGEN FIA TEST	T2	

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## List of Prescription Medications

DIAGNOSTIC (Miscellaneous) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>DIAGNOSTIC TEST DEVICES AND SUPPLIES (cont.)</b>		
SOFIA2 FLU-SARS ANTIGEN FIA	T2	
VERITOR SARS-COV-2 AND FLU A-B	T2	
<b>EYE DIAGNOSTIC AGENTS</b>		
<i>bio glo</i> (Fluor-I-Strip At)	T1	
<i>ful-glo</i> (Fluor-I-Strip At)	T1	
<i>glostrips</i> (Fluor-I-Strip At)	T1	
<b>GASTROINTESTINAL RADIOPAQUE DIAGNOSTICS</b>		
SITZMARKS FOR KIDS	T3	
<b>RADIOACTIVE METABOLIC FUNCTION DIAGNOSTICS</b>		
SODIUM IODIDE I-123	T3	
<b>DIURETICS (Diuretics)</b>		
<b>ARGININE VASOPRESSIN (AVP) RECEPTOR ANTAGONISTS</b>		
JYNARQUE	T3	PA QL SP
SAMSCA 15 MG TABLET	T2	PA QL (30 units/30 days) SP
SAMSCA 30 MG TABLET	T3	PA QL SP
<b>CARBONIC ANHYDRASE INHIBITORS</b>		
<i>acetazolamide</i>	T1	HD
<i>methazolamide</i>	T1	HD
<b>LOOP DIURETICS</b>		
<i>bumetanide</i>	T1	HD
EDECRIN ( <i>ethacrynic acid</i> )	T3	ST
<i>ethacrynic acid</i> (Edecrin)	T1	
<i>furosemide</i>	T1	HD
FUROSEMIDE	T3	HD
<i>furosemide</i> (Lasix)	T1	HD
LASIX ( <i>furosemide</i> )	T3	HD
<i>torsemide</i>	T1	HD
<i>torsemide</i>	T1	
<b>OSMOTIC DIURETICS</b>		
RESECTISOL	T2	
<b>POLYCYSTIC KIDNEY DISEASE AGENT, AVP RECEP. ANTAG</b>		
<i>tolvaptan</i> 15 mg tablet (Jynarque)	T1	PA SP HD
<i>tolvaptan</i> 15 mg-15 mg tablet (Jynarque)	T1	PA SP HD
<i>tolvaptan</i> 30 mg tablet (Jynarque)	T1	PA SP HD

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## List of Prescription Medications

DIURETICS (Diuretics) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>POLYCYSTIC KIDNEY DISEASE AGENT, AVP RECEP. ANTAG (cont.)</b>		
tolvaptan 30 mg-15 mg tablet (Jynarque)	T1	PA SP HD
tolvaptan 45 mg-15 mg tablet (Jynarque)	T1	PA SP HD
tolvaptan 60 mg-30 mg tablet (Jynarque)	T1	PA SP HD
tolvaptan 90 mg-30 mg tablet (Jynarque)	T1	PA SP HD
JYNARQUE 15 MG TABLET ( <i>tolvaptan</i> )	T3	PA SP HD
JYNARQUE 15 MG-15 MG TABLET ( <i>tolvaptan</i> )	T3	PA SP HD
JYNARQUE 30 MG TABLET ( <i>tolvaptan</i> )	T3	PA SP HD
JYNARQUE 30 MG-15 MG TABLET ( <i>tolvaptan</i> )	T3	PA SP HD
JYNARQUE 45 MG-15 MG TABLET ( <i>tolvaptan</i> )	T3	PA SP HD
JYNARQUE 60 MG-30 MG TABLET ( <i>tolvaptan</i> )	T3	PA SP HD
JYNARQUE 90 MG-30 MG TABLET ( <i>tolvaptan</i> )	T3	PA SP HD
<b>POTASSIUM SPARING DIURETICS</b>		
ALDACTONE ( <i>spironolactone</i> )	T3	HD
amiloride hcl	T1	HD
CAROSPIR	T3	PA HD
DYRENium ( <i>triamterene</i> )	T3	HD
eplerenone (Inspira)	T1	HD
INSPRA ( <i>eplerenone</i> )	T3	HD
KERENDIA	T2	PA QL (30 tabs/30 days)
spironolactone	T1	HD
spironolactone 100 mg tablet (Aldactone)	T1	HD
spironolactone 25 mg tablet (Aldactone)	T1	HD
spironolactone 25 mg/5 ml susp (Carospir)	T1	
spironolactone 50 mg tablet (Aldactone)	T1	HD
triamterene (Dyrenium)	T1	HD
<b>POTASSIUM SPARING DIURETICS IN COMBINATION</b>		
amiloride hcl w/hctz	T1	HD
DYAZIDE ( <i>triamterene-hydrochlorothiazid</i> )	T3	HD
JYNARQUE 45-15mg tablets	T3	PA QL (56 tabs/30 days) SP
JYNARQUE 60-30mg tablets	T3	PA QL (56 tabs/30 days) SP
JYNARQUE 90-30mg tablets	T3	PA QL (56 tabs/30 days) SP
spironolact/hctz	T1	HD
spironolactone w/hctz (Aldactazide)	T1	HD
triamterene w/hctz (Dyazide)	T1	HD

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

PA – Prior Authorization

QL – Quantity Limit

ST – Step Therapy

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## List of Prescription Medications

DIURETICS (Diuretics) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>THIAZIDE AND RELATED DIURETICS</b>		
<i>chlorthalidone</i>	T1	HD
<i>DIURIL</i>	T3	HD
<i>hydrochlorothiazide</i>	T1	HD
<i>indapamide</i>	T1	HD
<i>metolazone</i>	T1	HD
<b>EENT PREPS (Allergy/Nasal Sprays)</b>		
<b>NASAL ANTIHISTAMINE</b>		
<i>azelastine hcl</i>	T1	QL HD
<i>olopatadine hcl (Patanase)</i>	T1	QL HD
<i>PATANASE (olopatadine hcl)</i>	T3	QL HD
<b>NASAL ANTIHISTAMINE AND ANTI-INFLAM. STEROID COMB.</b>		
<i>RYALTRIS 665-25MCG SPRAY</i>	T3	ST QL HD
<b>NASAL ANTI-INFLAMMATORY STEROIDS</b>		
<i>FLONASE ALLERGY RELIEF 50mcg NASAL SPRAY (15.8 PS)</i>	T3	
<i>FLONASE ALLERGY RELIEF 50mcg NASAL SPRAY (9.9 PS)</i>	T2	
<i>FLONASE SENSIMIST 27.5mcg (5.9, 9.9)</i>	T2	
<i>FLONASE SENSIMIST 27.5mcg (9.1, 15.8)</i>	T2	
<i>flunisolide</i>	T1	QL HD
<i>fluticasone propionate</i>	T1	QL HD
<i>mometasone (Nasonex)</i>	T1	QL HD
<i>NASACORT ALLERGY 24 hour SPRAY (10.8 PS)</i>	T2	
<i>NASACORT ALLERGY 24 hour SPRAY (16.9 PS)</i>	T2	
<i>NASONEX</i>	T3	ST SP
<i>RHINOCORT ALLERGY RELIEF 50mcg NASAL SPRAY</i>	T2	
<i>RHINOCORT AQUA NASAL SPRAY</i>	T2	
<i>XHANCE</i>	T2	ST QL (32 mls/30 days) HD
<b>NOSE PREPARATIONS, MISCELLANEOUS (RX)</b>		
<i>COCAINE HCL</i>	T3	
<i>GOPRELTO</i>	T3	
<i>ipratropium bromide</i>	T1	QL (30 units/30 days) HD
<i>NUMBRINO</i>	T3	
<b>NOSE PREPARATIONS, VASOCONSTRICATORS (RX)</b>		
<i>ADRENALIN CHLORIDE</i>	T3	

T1 – Typically Generics

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## List of Prescription Medications

EENT PREPS (Ear Medications)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>EAR PREPARATIONS ANTI-INFLAMMATORY</b>		
DERMOTIC ( <i>flac otic oil</i> )	T3	
<i>flac otic oil</i> (Dermotic)	T1	
<i>fluocinolone acetonide oil</i> (Dermotic)	T1	
<b>EAR PREPARATIONS, MISC. ANTI-INFECTIVES</b>		
<i>acetic acid</i>	T1	
<i>acetic acid/hydrocortisone</i>	T1	
CORTANE-B ( <i>hc pramoxine</i> )	T3	
EENT PREPS (Eye Conditions)		
<b>AGENTS FOR CORNEAL COLLAGEN CROSS-LINKING</b>		
PHOTREXA CROSS-LINKING	T3	
PHOTREXA VISCOS	T3	
<b>ARTIFICIAL TEARS</b>		
KLARITY (CHONDROITIN)	T3	
LACRISERT	T3	PA
MIEBO	T2	PA QL (3 mls/fill)
<b>EYE ANTI-INFECTIVES (RX ONLY)</b>		
BETADINE	T3	
<i>povidone-iodine</i>	T1	
<b>EYE ANTI-INFLAMMATORY AGENTS</b>		
<i>bromfenac sodium</i> (Bromsite)	T1	
<i>bromfenac sodium</i> (Prolensa)	T1	
DEXTENZA	T3	
DUREZOL	T3	ST
EYSUVIS	T2	PA QL (8.3 mls/30 days)
<i>fluorometholone</i> (Fml)	T1	
<i>flurbiprofen</i>	T1	
FML ( <i>fluorometholone</i> )	T3	
ILEVRO	T3	
INVELTYS	T3	ST
<i>ketorolac</i> (Acular LS)	T1	
<i>ketorolac</i> (Acular)	T1	
KLARITY-B (BETAMETHASONE-CHOND)	T3	
KLARITY-L (LOTEPREDNOL-CHONDR)	T3	
LOTEMAX DROPS ( <i>loteprednol etabonate</i> )	T3	

T1 – Typically Generics

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## List of Prescription Medications

EENT PREPS (Eye Conditions) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>EYE ANTI-INFLAMMATORY AGENTS (cont.)</b>		
LOTEMAX GEL, OINTMENT	T3	ST
LOTEMAX SM	T3	ST
<i>loteprednol etabonate (Alrex)</i>	T1	PA SP HD
<i>loteprednol etabonate (Lotemax)</i>	T1	PA SP HD
PRED FORTE ( <i>prednisolone</i> )	T3	
<i>prednisolone acetate (Pred Forte)</i>	T1	
PREDNISOLONE-NEPafenac	T3	
<i>prednisolone phosphate</i>	T1	
<i>prednisolone sod ph/bromfenac</i>	T1	
PROLENSA ( <i>bromfenac sodium</i> )	T3	ST
<b>EYE IRRIGATIONS</b>		
<i>balanced salt (BSS)</i>	T1	
<b>EYE LOCAL ANESTHETICS</b>		
AKTEN	T3	
ALCAINE ( <i>proparacaine hcl</i> )	T3	
<i>altacaine</i>	T1	
ALTAFLUOR BENOX	T3	
<i>proparacaine hcl (Alcaine)</i>	T1	
<i>proparacaine-fluorescein</i>	T1	
<i>tetracaine hcl</i>	T1	
<b>EYE MAST CELL STABILIZERS</b>		
ALOCRIL	T3	ST
<i>cromolyn</i>	T1	
<i>pilocarpine hcl (Isoto Carpine)</i>	T1	HD
SIMBRINZA	T3	HD
<i>timolol maleate (Istalol)</i>	T1	HD
<i>timolol maleate (Timoptic)</i>	T1	HD
<i>timolol maleate (Timoptic-XE)</i>	T1	HD
TIMOLOL-BRIMONIDIN-DORZOLAMIDE	T3	HD
TIMOLOL-BRIMONI-DORZOL-LATANOP	T3	HD
TIMOLOL-DORZOLAMIDE-LATANOPRST	T3	HD
TIMOLOL-LATANOPROST	T3	HD
TIMOPTIC ( <i>timolol maleate</i> )	T3	ST HD

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## List of Prescription Medications

EENT PREPS (Eye Conditions) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>EYE MAST CELL STABILIZERS (cont.)</b>		
TIMOPTIC-XE ( <i>timolol maleate</i> )	T3	ST HD
<i>travoprost</i> (Travatan Z)	T1	HD
TRUSOPT ( <i>dorzolamide hcl</i> )	T3	ST HD
VYZULTA	T3	ST HD
<b>EYE MYDRIATIC AND NSAID COMBINATIONS</b>		
MYDRIATIC4 (TROP-PROP-PE-KTRLC)	T3	
<b>EYE PREPARATIONS, MISCELLANEOUS (OTC)</b>		
GELFILM	T3	
<b>EYE VASOCONSTRICATORS</b>		
<i>phenylephrine hcl</i>	T1	
<b>MIOTICS AND OTHER INTRAOCULAR PRESSURE REDUCERS</b>		
ALPHAGAN P 0.1% DROPS	T3	ST HD
ALPHAGAN P 0.15% DROPS ( <i>brimonidine tartrate</i> )	T3	HD
<i>apraclonidine hcl</i>	T1	HD
<i>betaxolol hcl</i>	T1	HD
BETOPTIC S	T3	HD
<i>bimatoprost</i>	T1	HD
BRIMONIDINE 0.1%-DORZOLAM 2%	T3	
BRIMONIDINE 0.15%-DORZOLAM 2%	T3	HD
<i>brimonidine tartrate</i> (Alphagan P)	T1	HD
<i>carteolol hcl</i>	T1	HD
COMBIGAN	T3	HD
DORZOLAMIDE HCL	T3	HD
<i>dorzolamide hcl</i>	T1	HD
DORZOLAMIDE-TIMOLOL	T3	HD
<i>dorzolamide-timolol</i> (Cosopt PF)	T1	HD
<i>dorzolamide-timolol</i> (Cosopt)	T1	HD
IOPIDINE	T3	ST HD
ISOPTO CARPINE ( <i>pilocarpine hcl</i> )	T3	HD
LATANOPROST	T3	HD
<i>latanoprost</i> (Xalatan)	T1	HD
<i>levobunolol hcl</i>	T1	HD
<i>miostat</i> (Miostat)	T1	HD
PHOSPHOLINE IODIDE	T2	HD

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## List of Prescription Medications

EENT PREPS (Eye Conditions) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>MIOTICS AND OTHER INTRAOCCULAR PRESSURE REDUCERS (cont.)</b>		
RHOPRESSA	T3	
ROCKLATAN	T3	PA
<i>timolol</i> (Betimol)	T1	ST HD
TIMOLOL-DORZOLAMIDE-BIMATOPRST	T3	HD
<i>timolol 0.25% gel-solution</i> (Timoptic-Xe)	T1	ST HD
<i>timolol 0.5% eye drop</i> (Istalol)	T1	ST HD
<i>timolol 0.5% gel-solution</i> (Timoptic-Xe)	T1	ST HD
<i>timolol 0.5% gfs gel-solution</i> (Timoptic-Xe)	T1	ST HD
<i>timolol maleate 0.25% eye drop</i>	T1	ST HD
<i>timolol maleate 0.25% eye drop</i> (Timoptic)	T1	HD
<i>timolol maleate 0.5% eye drop</i> (Timoptic Ocudose)	T1	ST HD
<i>timolol maleate 0.5% eye drops</i> (Timoptic)	T1	HD
<b>MYDRIATICS</b>		
<i>atropine</i>	T1	HD
<i>atropine 1% eye drops</i>	T1	PA SP HD
<i>atropine sulfate 0.01% eye drp</i>	T1	PA SP HD
ATROPINE SULF 0.025% EYE DROP	T3	HD
ATROPINE SULFATE 0.05% EYE DRP	T3	HD
CYCLOGYL ( <i>cyclopentolate hcl</i> )	T3	HD
CYCLOMYDRIL	T3	HD
<i>cyclopentolate hcl</i> (Cyclogyl)	T1	HD
CYCLOPENTOLATE-TROPICAMIDE-PE	T3	HD
<i>homatropaire</i>	T1	HD
MYDCOMBI	T3	HD
MYDRIACYL ( <i>tropicamide</i> )	T3	HD
PAREMYD	T3	HD
<i>tropicamide</i>	T1	HD
<i>tropicamide</i> (Mydriacyl)	T1	HD
TROPICAMIDE-CYCLOPENTOLATE-PE	T3	
<i>tropicamide 1%-phenylephr 2.5%</i>	T1	
TROPICAMIDE 1%-PHENYLEPHR 2.5%	T3	
<b>OPHTH VASC. ENDOTHELIAL GROWTH FACTOR ANTAGONISTS</b>		
MACUGEN	T3	PA

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## List of Prescription Medications

EENT PREPS (Eye Conditions) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>OPHTH. VEGF-A RECEPTOR ANTAG. RCMB MC ANTIBODY</b>		
LUCENTIS	T3	PA SP
<b>OPHTHALMIC ANTI-FIBROTIC AGENTS</b>		
MITOMYCIN-WATER	T3	
MITOSOL	T3	
<b>OPHTHALMIC ANTI-INFLAMMATORY IMMUNOMODULATOR-TYPE</b>		
CEQUA	T3	PA QL (60 vls/30 days)
CYCLOSPORINE IN KLARITY	T3	HD
RESTASIS	T3	PA QL HD
RESTASIS MULTIDOSE	T2	PA QL HD
XIIDRA	T2	PA QL
VEVYE	T3	PA QL (2 mls/fill) HD
<b>OPHTHALMIC CYSTINE DEPLETING AGENTS</b>		
CYSTARAN	T2	SP
<b>OPHTHALMIC HUMAN NERVE GROWTH FACTOR (HNGF)</b>		
OXERVATE	T2	PA SP HD
<b>OPHTHALMIC PREPARATIONS, MISCELLANEOUS</b>		
biolon	T1	SP
<b>OPHTHALMIC PROTEOLYTIC ENZYME AGENTS</b>		
JETREA	T2	
<b>OPHTHALMIC SURGICAL AIDS</b>		
ocucoat (Cellugel)	T1	
ELECT/CALORIC/H2O (Dental Products)		
<b>FLUORIDE PREPARATIONS</b>		
CLINPRO 5000	T3	
denta 5000 plus	T1	
dentagel	T1	
FLUORIDEX DAILY DEFENSE	T3	
FLUORIDEX SENSITIVITY RELIEF	T3	
FRAICHE 5000 PREVI	T3	
fluoritab	T1	PPACA
PREVENTID	T3	
PREVENTID 5000 ENAMEL PROTECT	T3	
PREVENTID 5000 ORTHO DEFENSE	T3	
PREVENTID 5000 SENSITIVE	T3	

T1 – Typically Generics

T2 – Typically Preferred Brands

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## List of Prescription Medications

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

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>FLUORIDE PREPARATIONS (cont.)</b>		
PREVENTID KIDS	T3	
<i>sf</i>	T1	
<i>sf 5000 plus</i>	T1	
<i>sodium fluoride</i>	T1	
<i>sodium fluoride 5000 plus</i>	T1	
<i>sodium fluoride enamel protect</i>	T1	
<i>sodium fluoride sensitive</i>	T1	

### IRON REPLACEMENT

ACCRUFER 30 MG CAPSULE	T3	
FERAHEME 510 MG/17 ML VIAL	T3	PA

### ELECT/CALORIC/H2O (Diabetes)

#### AGENTS TO TREAT HYPOGLYCEMIA (HYPERGLYCEMICS)

<i>dex4 glucose</i>	T1	
GLUCAGEN	T2	QL
GLUCAGON EMERGENCY KIT	T2	QL
<i>gluco burst</i>	T1	
GLUCO SHOT	T3	
<i>glucose</i>	T1	
GLUCOSE 2 GRAM GUMMY	T3	
GLUCOSE	T3	
<i>glucose bits</i>	T1	
<i>glucose gel</i>	T1	
<i>glutose</i>	T1	
GLUTOSE ( <i>gluco burst</i> )	T2	
GVOKE	T2	
GVOKE SYRINGE	T2	QL
GLUCOSE 2 GRAM GUMMY	T3	
INSTA-GLUCOSE	T3	
LIQUID IRON	T3	
PROGLYCEM ( <i>diazoxide</i> )	T3	
<i>reliion</i>	T1	
TRUEPLUS	T3	
TRUEPLUS ( <i>dex4 glucose</i> )	T3	

T1 – Typically Generics

T2 – Typically Preferred Brands

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## List of Prescription Medications

ELECT/CALORIC/H2O (Miscellaneous)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>NUCLEIC ACID/NUCLEOTIDE SUPPLEMENTS</b>		
XURIDEN	T2	SP
<b>ELECT/CALORIC/H2O (Nutritional/Dietary)</b>		
<b>CARBOHYDRATES</b>		
ENFAMIL	T2	
GLUTOL	T2	
<b>ELECTROLYTE DEPLETERS</b>		
<i>acetate</i>	T1	
AURYXIA	T3	
CALCIUM 667mg	T3	QL (360 tabs/30 days)
<i>kionex</i>	T1	
<i>lanthanum carbonate</i> (Fosrenol)	T1	QL (90 tabs/30 days)
LOKELMA	T2	QL (30 units/30 days)
<i>polystyrene sulfonate</i>	T1	
RENVELA (sevelamer carbonate)	T3	QL (270 tabs/30 days)
<i>sps</i>	T1	
VELPHORO	T2	QL (120 tabs/20 days)
VELTASSA 1 GM POWDER PACKET	T2	
VELTASSA 16.8 GM POWDER PACKET	T2	QL (30 packs/30 days)
VELTASSA 25.2 GM POWDER PACKET	T2	QL (30 packs/30 days)
VELTASSA 8.4 GM POWDER PACKET	T2	QL (30 packs/30 days)
<b>FLUORIDE PREPARATIONS</b>		
PREVENTID KIDS	T3	
<b>IODINE CONTAINING AGENTS</b>		
<i>Jugol's</i>	T1	
SSKI	T3	
<i>strong iodine</i>	T1	
<b>IRON REPLACEMENT</b>		
cvs iron 27 mg tablet (Fergon)	T1	
cvs iron 65 mg tablet	T1	
eql iron 65 mg tablet	T1	
ferrous fum/vit c/b 12-if/folic	T1	PPACA
FERROUS SULF 300 MG/5 ML CUP	T3	
ferrous sulf 15 mg iron/ml drp (Fer-In-Sol)	T1	

T1 – Typically Generics

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## List of Prescription Medications

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

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>IRON REPLACEMENT (cont.)</b>		
ferrous sulf 220 mg/5 ml elix	T1	
ferrous sulf 220 mg/5 ml liq	T1	
ferrous sulf 300 mg/5 ml cup	T1	
ferrous sulf 300 mg/6.8ml soln	T1	
ferrous sulf 44 mg iron/5ml lq	T1	
ferrous sulf ec 324 mg tablet	T1	
ferrous sulf ec 325 mg tablet	T1	
ferrous sulfate 325 mg tablet	T1	
ft iron 65 mg tablet	T1	
FT IRON 45 MG TABLET	T3	
gnp iron 45 mg tablet	T1	
gnp iron 65 mg tablet	T1	
HEMATOGEN	T3	
iron 27 mg tablet	T1	
iron 27 mg tablet (Fergon)	T1	
iron 28 mg tablet	T1	
iron 45 mg tablet	T1	
iron 65 mg tablet	T1	
iron-vitamin c 100-250 mg tab (lcar-C)	T1	PA SP HD
IRON-VITAMIN C 65-125 MG TAB	T2	PA SP HD
NOVAFERRUM ALL GOOD	T3	PA SP HD
NOVAFERRUM WOW	T3	PA SP HD
NOVAFERRUM YUMMY PEDIATRIC	T2	PA SP HD
ra iron 65 mg tablet	T1	
sm iron 65 mg tablet	T1	
sv iron 65 mg tablet	T1	
true ferrous sulf ec 324 mg tb	T1	
TULIVITE	T3	

### PEDIATRIC VITAMIN PREPARATIONS

fluoride	T1	PPACA
fluoritab	T1	PPACA
ludent fluoride	T1	PPACA

### POTASSIUM REPLACEMENT

chloride (Klor-Con 10)	T1	
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T1 – Typically Generics

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## List of Prescription Medications

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

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>POTASSIUM REPLACEMENT (cont.)</b>		
chloride (Klor-Con 8)	T1	
chloride (K-Tab ER)	T1	
effer-k	T1	
klor-con	T1	
klor-con (Klor-Con 10)	T1	
klor-con (Klor-Con 8)	T1	
klor-con m	T1	
klor-con m (Klor-Con M15)	T1	
klor-con-ef	T1	
K-TAB	T3	
k-tab (Klor-Con 8)	T1	
potassium cl 10% (20 meq/15ml)	T1	
potassium cl 20 meq packet	T1	
potassium cl 20% (40 meq/15ml)	T1	
potassium cl er 10 meq capsule, tablet	T1	
potassium cl er 15 meq tablet	T1	
potassium cl er 20 meq tablet	T1	
potassium cl er 20 meq tablet (K-Tab Er)	T1	
potassium cl er 8 meq capsule, tablet	T1	
potassium cl10%(20meq/15ml)cup	T1	
potassium cl10%(40meq/30ml)cup	T1	
potassium cl20%(40meq/15ml)cup	T1	
POTASSIUM CL ER 15 MEQ TABLET	T1	
<b>PROTEIN REPLACEMENT</b>		
AQNEURSA	T2	PA SP

### ELECT/CALORIC/H2O (Urinary Tract Conditions)

#### URINARY PH MODIFIERS

citric acid/sodium citrate	T1	HD
er (Urocit-K)	T1	HD
K-PHOS NO.2	T3	HD
K-PHOS ORIGINAL	T2	HD
ORACIT	T3	HD
potassium citrate	T1	HD

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## List of Prescription Medications

ELECT/CALORIC/H2O (Urinary Tract Conditions) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>URINARY PH MODIFIERS (cont.)</b>		
RENACIDIN	T2	HD
UROCIT-K ( <i>potassium er</i> )	T3	HD
<b>GASTROINTESTINAL (Cholesterol Medications)</b>		
<b>LIPOTROPICS</b>		
LOVAZA ( <i>omega-3 acid ethyl esters</i> )	T3	PA HD
<i>omega-3 acid ethyl esters</i> (Lovaza)	T1	PA HD
VASCEPA	T2	PA HD
<b>GASTROINTESTINAL (Gastrointestinal/Heartburn)</b>		
<b>AMMONIA INHIBITORS</b>		
BUPHENYL ( <i>phenylbutyrate</i> )	T3	SP HD
<i>enulose</i>	T1	HD
<i>generlac</i>	T1	HD
<i>lactulose</i>	T1	HD
LITHOSTAT	T3	HD
OLPRUVA DOSE KIT, DOSE ENVELOPE	T3	SP PA HD
<i>phenylbutyrate</i> (Buphenyl)	T1	SP HD
PHEBURANE	T2	PA SP
RAVICTI	T2	SP HD
<b>ANTI-CHOLINERGICS, QUATERNARY AMMONIUM</b>		
<i>clidinium w/chlordiazepoxide</i> (Librax)	T1	
CUVPOSA	T3	
GLYCATE	T3	
<i>glycopyrrrolate</i> (Glycate)	T1	
<i>propantheline bromide</i>	T1	
<b>ANTI-CHOLINERGICS/ANTI-SPASMODICS</b>		
<i>dicyclomine hcl</i>	T1	
<b>ANTI-DIARRHEAL - TRYPTOPHAN HYDROXYLASE INHIBITOR</b>		
XERMELO	T2	PA QL (84 tabs/28 days) SP
<b>ANTI-DIARRHEALS</b>		
<i>diphenoxylate w/atropine</i> (Lomotil)	T1	
LOMOTIL ( <i>diphenoxylate-atropine</i> )	T3	
MOTOFEN	T3	
<i>opium</i>	T1	

T1 – Typically Generics

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## List of Prescription Medications

GASTROINTESTINAL (Gastrointestinal/Heartburn) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>ANTI-EMETIC, CANNABINOID-TYPE</b>		
dronabinol (Marinol)	T1	PA
SYNDROS	T3	PA
<b>ANTI-EMETIC/ANTI-VERTIGO AGENTS</b>		
aprepitant	T1	QL
aprepitant (Emend)	T1	QL
BONJESTA	T3	QL (60 tabs/dispense)
compro	T1	
DICLEGIS (doxylamine succ-pyridoxine hcl)	T3	QL (720 tabs/365 days)
doxylamine succ-pyridoxine hcl (Diclegis)	T1	QL (720 tabs/365 days)
fosaprepitant dimeglumine (Emend)	T1	
granisetron hcl	T1	QL
meclizine 50 mg tablet	T1	
ondansetron hcl (Zofran)	T1	QL
ondansetron odt 4 mg tablet	T1	QL (9 tabs/30 days)
ondansetron odt 8 mg tablet	T1	QL (9 tabs/30 days)
phenadoz	T1	
prochlorperazine maleate	T1	
promethazine hcl	T1	
promethegan	T1	
SANCUSO	T3	QL
scopolamine (Transderm-Scop)	T1	
trimethobenzamide hcl	T1	
VARUBI	T2	QL
ZOFRAN (ondansetron hcl)	T3	QL
<b>ANTI-ULCER PREPARATIONS</b>		
CYTOTEC (misoprostol)	T3	HD
misoprostol (Cytotec)	T1	HD
sucralfate (Carafate)	T1	HD
<b>ANTI-ULCER-H.PYLORI AGENTS</b>		
lansoprazole-amoxicil-clarithro	T1	QL
OMECLAMOX-PAK	T3	QL
TALICIA	T2	QL
VOQUEZNA DUAL PAK	T3	
VOQUEZNA TRIPLE PAK	T3	

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## List of Prescription Medications

GASTROINTESTINAL (Gastrointestinal/Heartburn) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>BELLADONNA ALKALOIDS</b>		
<i>anaspaz</i> (Anaspaz)	T1	HD
<i>belladonna-phenobarbital</i> (Donnatal)	T1	HD
<i>DONNATAL (phenohytra)</i>	T3	HD
<i>ed-spaz</i> (Anaspaz)	T1	HD
<i>hyoscyamine</i>	T1	HD
<i>hyoscyamine (Anaspaz)</i>	T1	HD
<i>hyoscyamine (Levbid)</i>	T1	HD
<i>hyoscyamine (Levsin)</i>	T1	HD
<i>hyoscyamine (Levsin-SL)</i>	T1	HD
<i>hyosyne</i>	T1	HD
<i>LEVIBID (hyoscyamine er)</i>	T3	HD
<i>LEVSIN (hyoscyamine )</i>	T3	HD
<i>LEVSIN-SL (hyoscyamine )</i>	T3	HD
<i>methscopolamine bromide</i>	T1	HD
<i>NULEV (ed-spaz)</i>	T3	HD
<i>oscimin (Levsin)</i>	T1	HD
<i>oscimin sl (Levsin-SL)</i>	T1	HD
<i>oscimin sr (Levbid)</i>	T1	HD
<i>PHENOBARBITAL-BELLADONNA (phenobarb/hyoscy/atropine/scop)</i>	T3	HD
<i>phenohytra (Donnatal)</i>	T1	HD
<i>SYMAX DUOTAB</i>	T3	HD
<i>symax-sl (Levsin-SL)</i>	T1	HD
<i>symax-sr (Levbid)</i>	T1	HD
<b>BILE SALTS</b>		
<i>ACTIGALL (ursodiol)</i>	T3	HD
<i>CHENODAL</i>	T2	PA SP HD
<i>CHOLBAM</i>	T2	PA QL SP HD
<i>CTEXLI</i>	T2	PA SP
<i>URSO FORTE (ursodiol)</i>	T3	HD
<i>ursodiol (Actigall)</i>	T1	HD
<i>ursodiol (Urso Forte)</i>	T1	HD
<b>CHRONIC INFLAM. COLON DX, 5-A-SALICYLAT, RECTAL TX</b>		
<i>mesalamine (Canasa)</i>	T1	
<i>mesalamine (Rowasa)</i>	T1	

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## List of Prescription Medications

GASTROINTESTINAL (Gastrointestinal/Heartburn) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>CHRONIC INFLAM. COLON DX, 5-A-SALICYLAT, RECTAL TX (cont.)</b>		
mesalamine (Sfrowasa)	T1	
ROWASA (mesalamine)	T3	
SFROWASA (mesalamine)	T3	
<b>DRUG TX-CHRONIC INFLAM. COLON DX, 5-AMINOSALICYLAT</b>		
APRISO (mesalamine er)	T3	HD
ASACOL HD (mesalamine)	T3	HD
AZULFIDINE (sulfasalazine dr)	T3	HD
AZULFIDINE (sulfasalazine)	T3	HD
balsalazide di (Colazal)	T1	HD
COLAZAL (balsalazide di)	T3	HD
mesalamine (Asacol Hd)	T1	HD
mesalamine (Lialda)	T1	HD
mesalamine dr (Delzicol)	T1	HD
mesalamine er (Apriso)	T1	HD
PENTASA	T2	HD
sulfasalazine (Azulfidine)	T1	HD
<b>FARNESOID X RECEPTOR (FXR) AGONIST, BILE AC ANALOG</b>		
OCALIVA	T2	PA QL (30 units/30 days) SP HD
<b>FECAL MICROBIOTA TRANSPLANTATION (FMT)</b>		
VOWST CAPSULE	T3	SP
<b>GASTRIC ENZYMEs</b>		
SUCRAID	T2	SP
<b>HISTAMINE H2-RECEPTOR INHIBITORS</b>		
cimetidine	T1	HD
famotidine	T1	HD
nizatidine	T1	HD
PEPCID (famotidine)	T3	HD
<b>IBS AGENTS, MIXED OPIOID RECEP AGONISTS/ANTAGONISTS</b>		
VIBERZI	T2	HD
<b>IBS-C/CIC AGENTS, GUANYLATE CYCLASE-C AGONIST</b>		
LINZESS	T2	QL (30 units/30 days)
TRULANCE	T2	
<b>INTEGRIN RECEPTOR ANTAGONIST, MONOCLONAL ANTIBODY</b>		
ENTYVIO	T2	PA SP HD

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## List of Prescription Medications

GASTROINTESTINAL (Gastrointestinal/Heartburn) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>INTESTINAL MOTILITY STIMULANTS</b>		
<i>metoclopramide hcl</i> (Reglan)	T1	
<i>metoclopramide hcl odt</i>	T1	
MOTEGRITY	T3	QL (30 units/30 days)
<i>prucalopride</i>	T1	QL (30 tabs/30 days)
REGLAN ( <i>metoclopramide hcl</i> )	T3	
<b>IRRITABLE BOWEL SYND. AGENT, 5-HT4 PARTIAL AGO</b>		
ZELNORM	T3	
<b>IRRITABLE BOWEL SYNDROME AGENTS, 5-HT3 ANTAGONIST</b>		
<i>alosetron hcl</i> (Lotronex)	T1	SP HD
<b>LAXATIVES AND CATHARTICS</b>		
<i>alophen pills</i> (Dulcolax)	T1	PPACA
<i>bisacodyl</i> (Dulcolax)	T1	PPACA
<i>bisa-lax</i> (Dulcolax)	T1	PPACA
<i>citroma</i> (Citroma)	T1	
<i>clearlax</i> (Miralax)	T1	PPACA
<i>clearlax</i> (Miralax)	T1	
<i>constulose</i>	T1	
<i>ducodyl</i> (Dulcolax)	T1	
<i>gavilax</i> (Miralax)	T1	PPACA
<i>gavilyte-g</i> (Golytely)	T1	PPACA
<i>gavilyte-n</i> (Nulytely)	T1	PPACA
<i>gentle laxative</i> (Correctol)	T1	PPACA
<i>gentle laxative</i> (Dulcolax)	T1	PPACA
<i>gentrelax</i> (Miralax)	T1	PPACA
<i>glycolax</i> (Miralax)	T1	PPACA
<i>healthylax</i> (Miralax)	T1	PPACA
KRISTALOSE	T3	
<i>lactulose</i> (Kristalose)	T1	
<i>laxaclear</i> (Miralax)	T1	PPACA
<i>laxative</i> (Dulcolax)	T1	PPACA
<i>laxative peg 3350</i> (Miralax)	T1	PPACA
<i>lubiprostone</i>	T1	QL (60 caps/30 days)
<i>magnesium</i> (Citroma)	T1	
<i>milk of magnesia</i>	T1	

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## List of Prescription Medications

GASTROINTESTINAL (Gastrointestinal/Heartburn) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>LAXATIVES AND CATHARTICS (cont.)</b>		
miralax	T1	PPACA
natura-lax (Miralax)	T1	PPACA
NULYTLY WITH FLAVOR Packs ( <i>gavilyte-n</i> )	T3	PPACA
OSMOPREP	T3	PPACA
peg 3350-electrolyte (Golytely)	T1	PPACA
peg 3350-electrolyte (Nulytely)	T1	PPACA
peg-prep	T1	PPACA
<i>polyethylene glycol</i> (Miralax)	T1	PPACA
powderlax (Miralax)	T1	
PREPOPIK	T2	
purelax (Miralax)	T1	PPACA
smoothlax (Miralax)	T1	PPACA
trilyte with flavor packets (Nulytely)	T1	PPACA
women's gentle laxative (Dulcolax)	T1	PPACA
women's laxative (Correctol)	T1	PPACA
women's laxative (Dulcolax)	T1	PPACA
<b>LOCAL ANORECTAL NITRATE PREPARATIONS</b>		
<i>nitroglycerin</i> 0.4% ointment (Rectiv)	T1	
RECTIV ( <i>nitroglycerin</i> )	T2	
<b>MU-OPIOID RECEPTOR ANTAGONISTS, PERIPHERALLY-ACTING</b>		
ENTEREG	T3	
<b>PANCREATIC ENZYMES</b>		
CREON	T2	HD
VIOKACE	T2	HD
ZENPEP	T2	HD
<b>POTASSIUM-COMPETITIVE ACID BLOCKERS (PCABS)</b>		
VOQUEZNA	T3	ST
<b>PROTON-PUMP INHIBITORS</b>		
<i>dexlansoprazole</i> dr 30 mg cap	T1	ST QL
<i>esomeprazole</i> dr 2.5 mg packet (Nexium)	T1	ST QL (30 packs/30 days) HD
<i>esomeprazole</i> dr 5 mg packet (Nexium)	T1	ST QL (30 packs/30 days) HD
ESOMEPRAZOLE DR 49.3 MG CAP	T3	ST HD
<i>esomeprazole magnesium</i> (Nexium 24HR)	T1	QL (30 units/30 days) HD
<i>esomeprazole magnesium</i> (Nexium)	T1	HD

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GASTROINTESTINAL (Gastrointestinal/Heartburn) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>PROTON-PUMP INHIBITORS (cont.)</b>		
<i>lansoprazole</i> (Prevacid)	T1	HD
<i>omeprazole</i>	T1	QL (30 caps/30 days) HD
<i>omeprazole-bicarb 20-1,680 pkt</i> (Zegerid)	T1	ST QL (30 packs/30 days) HD
<i>omeprazole-bicarb 40-1,680 pkt</i> (Zegerid)	T1	ST HD
<i>omeprazole-bicarb 40-1,100 cap</i> (Zegerid)	T1	ST HD
<i>omeprazole- bicarbonate</i> (Zegerid)	T1	PA HD
<i>pantoprazole</i> (Protonix)	T1	QL (30 units/30 days) HD
<i>rabeprazole</i> (Aciphex)	T1	HD
<b>RECTAL PREPARATIONS</b>		
<i>anucort-hc</i> (Anucort-HC)	T1	
<i>hemmorex-hc</i> (Anucort-HC)	T1	
<i>hydrocortisone acetate</i> (Anucort-HC)	T1	
<i>hydrocortisone acetate</i> (Proctocort)	T1	
<i>PROCTOCORT (hydrocortisone)</i>	T3	ST
<b>SBS - GLUCAGON-LIKE PEPTIDE-2 (GLP-2) ANALOGS</b>		
GATTEX	T3	SP HD
<b>GASTROINTESTINAL (Pain Relief And Inflammatory Disease)</b>		
<b>HEMORRHOID PREP, ANTI-INFLAM STEROID-LOCAL ANESTHET</b>		
<i>ANA-LEX</i>	T3	
<i>ANALPRAM-HC (hydrocortisone-pramoxine)</i>	T3	ST
<i>hc pramoxine</i> (Analpram HC)	T1	
<i>LIDOCAINE-HC 3-2.5% GEL KIT</i>	T3	
<i>pramoxine hcl w/hydrocortisone</i> (Analpram Hc)	T1	
<i>PROCORT</i>	T3	
<b>HORMONES (Gastrointestinal/Heartburn)</b>		
<b>RECTAL/LOWER BOWEL PREP., GLUCOCORT. (NON-HEMORR)</b>		
<i>colocort</i> (Cortenema)	T1	
<i>CORTENEMA (hydrocortisone)</i>	T3	
<i>hydrocortisone</i> (Cortenema)	T1	
<i>UCERIS (budesonide)</i>	T3	
<b>HORMONES (Hormonal Agents)</b>		
<b>ADRENOCORTICOTROPHIC HORMONES</b>		
ACTHAR SELFJECT	T3	PA SP HD

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## List of Prescription Medications

HORMONES (Hormonal Agents) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>ADRENOCORTICOTROPHIC HORMONES</b>		
ACTHAR SELFJECT	T3	PA SP HD
<b>ANDROGENIC AGENTS</b>		
ANADROL-50	T3	
DEPO-TESTOSTERONE ( <i>testosterone cypionate</i> )	T3	PA
METHITEST	T2	
<i>methyltestosterone</i>	T1	
<i>oxandrolone</i>	T1	
STRIANT	T3	PA QL
<i>testosterone</i>	T1	PA QL
TESTOSTERONE	T3	PA QL
<i>testosterone</i> (Androgel)	T1	PA QL
<i>testosterone</i> (Testim)	T1	PA QL
<i>testosterone</i> (Vogelxo)	T1	PA QL
<i>testosterone cypionate</i> (Depo-Testosterone)	T1	PA
<i>testosterone enanthate</i>	T1	PA
<i>testosterone 10 mg gel pump</i>	T1	QL (120 gms/30 days)
VOGELXO ( <i>testosterone</i> )	T3	PA QL
XYOSTED	T2	QL (2 mls/28 days)
<b>ANTI-DIURETIC AND VASOPRESSOR HORMONES</b>		
DDAVP SOLUTION	T2	
DDAVP 0.1 MG TABLET ( <i>desmopressin acetate</i> )	T3	HD
DDAVP 0.2 MG TABLET ( <i>desmopressin acetate</i> )	T3	HD
<i>desmopressin 0.01% solution</i>	T1	HD
DESMOPRESSIN 1.5 MG/ML SPRAY	T2	HD
<i>desmopressin 10 mcg/0.1 ml spr</i>	T1	HD
<i>desmopressin acetate 0.1 mg tb</i> (Ddavp)	T1	HD
<i>desmopressin acetate 0.2 mg tb</i> (Ddavp)	T1	HD
NOCTIVA	T3	
STIMATE	T2	
<b>ESTROGEN/ANDROGEN COMBINATIONS</b>		
covaryx	T1	HD
covaryx h.s.	T1	HD
eemt	T1	HD
eemt hs	T1	HD

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HORMONES (Hormonal Agents) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>ESTROGEN/ANDROGEN COMBINATIONS (cont.)</b>		
ESTRATEST F.S. (estrogen,ester/me-testosterone)	T3	HD
ESTRATEST H.S. (estrogen,ester/me-testosterone)	T3	HD
<i>estrogen,ester/me-testosterone</i> (Estratest F.S.)	T1	HD
<i>estrogen &amp; methyltestosterone</i>	T1	HD
<b>ESTROGENIC AGENTS</b>		
ACTIVELLA ( <i>amabelz</i> )	T3	HD
ALORA	T3	QL (8 patches/21 days) HD
<i>amabelz</i> (Activella)	T1	HD
CLIMARA ( <i>estradiol (once weekly)</i> )	T3	QL (4 patches/21 days) HD
COMBIPATCH	T2	
DELESTROGEN ( <i>estradiol valerate</i> )	T3	HD
DEPO-ESTRADIOL	T2	HD
<i>dotti</i> (Alora)	T1	QL (8 patches/21 days) HD
<i>dotti</i> (Minivelle)	T1	QL (8 patches/21 days) HD
ESTRACE ( <i>estradiol</i> )	T3	HD
<i>estradiol</i> (Alora)	T1	QL (8 patches/21 days) HD
<i>estradiol</i> (Climara)	T1	QL (4 patches/21 days) HD
<i>estradiol</i> (Delestrogen)	T1	HD
<i>estradiol</i> (Estrace)	T1	HD
<i>estradiol 0.06% 1.25g gel pump</i> (Estrogel)	T1	QL (50 gms/30 days) HD
<i>estradiol/norethindrone acet</i>	T1	HD
<i>estradiol-norethindrone acetat</i> (Activella)	T1	HD
EVAMIST	T3	QL (17 mls/30 days) HD
FEMHRT ( <i>fyavolv</i> )	T3	HD
<i>fyavolv</i> (Femhrt)	T1	HD
<i>jinteli</i>	T1	HD
<i>lopreeza</i> (Activella)	T1	
MENOSTAR	T3	QL (4 patches/21 days) HD
<i>mimvey</i> (Activella)	T1	HD
<i>norethindrone ac/eth estradiol</i>	T1	HD
<i>norethindrone-ethin estradiol</i> (Femhrt)	T1	HD
PREFEST	T3	HD
<b>ESTROGEN-PROGESTIN WITH ANTI-MINERALOCORTICOID COMB</b>		
ANGELIQ	T3	HD

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HORMONES (Hormonal Agents) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>ESTROGEN-SELECTIVE ESTROGEN RECEPTOR MOD (SERM) COMB</b>		
DUAVEE	T2	
<b>GLUCOCORTICOIDS</b>		
ASMALPRED PLUS	T3	
<i>budesonide ec</i> (Entocort EC)	T1	
<i>budesonide er</i> (Uceris)	T1	
CORTEF ( <i>hydrocortisone</i> )	T3	
<i>cortisone acetate</i>	T1	
decadron	T1	
deflazacort	T1	PA SP HD
deflazacort (Emflaza)	T1	PA SP HD
<i>dexamethasone</i>	T1	PA
<i>dexamethasone 0.5 mg/5 ml elx</i>	T1	
DEXONTO	T3	
DEXPAK ( <i>dexamethasone</i> )	T3	PA
DXEVO	T3	PA
ENTOCORT EC ( <i>budesonide ec</i> )	T3	
<i>hidex</i>	T1	PA
<i>hydrocortisone</i> (Cortef)	T1	
MEDROL ( <i>methylpred dp</i> )	T3	
MEDROL ( <i>methylprednisolone</i> )	T3	
<i>methylpred dp</i> (Medrol)	T1	
<i>methylprednisolone</i> (Medrol)	T1	
<i>millipred</i>	T1	
ORAPRED ODT ( <i>prednisolone phos odt</i> )	T3	
<i>prednisolone</i>	T1	
<i>prednisolone phos odt</i> (Orapred ODT)	T1	
<i>prednisolone phosphate</i>	T1	
<i>prednisolone phosphate</i> (Pediapred)	T1	
<i>prednisone</i>	T1	
RAYOS	T3	PA
TAPERDEX	T3	PA
TARPEYO	T3	PA QL (28 caps/30 days) SP
UCERIS ( <i>budesonide</i> )	T3	
UCERIS ( <i>budesonide er</i> )	T3	

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

PA – Prior Authorization

QL – Quantity Limit

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## List of Prescription Medications

HORMONES (Hormonal Agents) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>GROWTH HORMONE RELEASING HORMONE (GHRH) AND ANALOGS</b>		
EGRIFTA SV	T2	PA SP HD
GENOTROPIN	T2	PA SP HD
ZORBTIVE	T3	PA SP HD
<b>GROWTH HORMONES</b>		
OMNITROPE	T2	PA SP
SEROSTIM	T2	PA SP HD
<b>INSULIN-LIKE GROWTH FACTOR-I (IGF-I) HORMONES</b>		
INCRELEX	T2	PA SP
<b>LHRH (GNRH) AGONIST ANALOG AND PROGESTIN COMB</b>		
LUPANETA PACK	T2	PA SP HD
LUPRON DEPOT	T2	PA SP HD
<b>LHRH (GNRH) AGONIST ANALOG PITUITARY SUPPRESSANTS</b>		
SYNAREL	T2	PA SP HD
<b>LHRH (GNRH) ANTAGONIST, PITUITARY SUPPRESSANT AGENTS</b>		
<i>cetorelix acetate</i>	T1	
<i>fyremadel</i> (generic to GANIRELIX)	T1	PA ST
ORILISSA 150 MG TABLET	T2	PA QL (1 tab/day)
ORILISSA 200 MG TABLET	T2	PA QL (360 tabs/365 days)
<b>LHRH (GNRH) AGNST PIT.SUP-CENTRAL PRECOCIOUS PUBERTY</b>		
LUPRON DEPOT-PED	T2	PA SP HD
<b>MINERALOCORTICOIDS</b>		
<i>fludrocortisone acetate</i>	T1	HD
<b>OXYTOCICS</b>		
CERVIDIL	T3	
<i>methergine</i>	T1	PA QL
<i>methylergonovine</i>	T1	QL (240 tabs/30 days)
PREPIDIL	T3	
<b>PARATHYROID HORMONES</b>		
NATPARA	T2	PA SP HD
YORVIPATH	T3	PA SP
<b>PITUITARY SUPPRESSIVE AGENTS</b>		
<i>cabergoline</i>	T1	QL (8 tabs/21 days) HD
CRENESSITY	T3	PA SP
<i>danazol</i>	T1	HD

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## List of Prescription Medications

HORMONES (Hormonal Agents) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>PROGESTATIONAL AGENTS</b>		
CRINONE 8% GEL	T2	
<i>medroxyprogesterone acetate</i>	T1	HD
<i>medroxyprogesterone acetate (Provera)</i>	T1	HD
<i>norethindrone acetate</i>	T1	HD
<i>progesterone (Prometrium)</i>	T1	HD
PROMETRIUM ( <i>progesterone</i> )	T3	HD
PROVERA ( <i>medroxyprogesterone</i> )	T3	HD
<b>SOMATOSTATIC AGENTS</b>		
MYCAPSSA DR 20 MG CAPSULE	T3	PA SP QL (56 caps/28 days)
<i>octreotide acetate</i>	T1	SP HD
SANDOSTATIN ( <i>octreotide</i> )	T3	PA ST SP HD
SIGNIFOR	T2	PA SP HD
SOMATULINE DEPOT	T2	PA SP HD
<b>VAGINAL ESTROGEN PREPARATIONS</b>		
<i>estradiol (Estrace)</i>	T1	HD
<i>estradiol (Vagifem)</i>	T1	
<i>yuvafem (Vagifem)</i>	T1	HD
<b>HORMONES (Infertility)</b>		
<b>HUMAN CHORIONIC GONADOTROPIN (HCG)</b>		
CHORIONIC GONAD 10, 000 UNIT VIAL	T3	ST QL (3 vials/30 days) SP
NOVAREL	T3	ST QL (6 vls/30 days) SP
PREGNYL	T2	QL (3 vials/30 days) SP
<b>PREGNANCY FACILITATING/MAINTAINING AGENT,HORMONAL</b>		
ENDOMETRIN	T3	ST
<b>HORMONES (Miscellaneous)</b>		
<b>LEPTIN HORMONE ANALOGS</b>		
MYALEPT	T2	PA SP HD
<b>HORMONES (Osteoporosis Products)</b>		
<b>BONE FORMATION STIMULATING AGTS - PTH REL PEPTIDES</b>		
TYMLOS	T2	PA QL SP HD
<b>BONE RESORPTION INHIBITORS</b>		
<i>calcitonin-salmon</i>	T1	HD
MIACALCIN	T3	HD

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## List of Prescription Medications

IMMUNOSUPPRESSANTS (Pain Relief And Inflammatory Disease)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>HUMAN INTERLEUKIN I2/23 (IL-12/13) INHIBITORS, MAB</b>		
SELARSDI 45 MG/0.5 ML SYRINGE	T2	PA QL (1 syringe/84 days) SP
SELARSDI 90 MG/ML SYRINGE	T2	PA QL (1 syringe/56 days) SP
USTEKINUMAB-TTWE 45MG/0.5ML SY	T2	PA SP HD
USTEKINUMAB-TTWE 90 MG/ML SYR	T2	PA SP HD
YESINTEK 45 MG/0.5 ML SYRINGE	T2	PA SP HD
YESINTEK 45 MG/0.5 ML VIAL	T2	PA SP HD
YESINTEK 90 MG/ML SYRINGE	T2	PA SP HD
<b>IL-23 RECEPTOR ANTAGONIST, MONOCLONAL ANTIBODY</b>		
OMVOH 100 MG/ML PEN	T2	PA QL (2 mls/28 days) SP HD
OMVOH 300 MG DOSE - 2 PENS	T2	PA QL (3 mls/28 days) SP HD
OMVOH 100 MG/ML SYRINGE	T2	PA QL (2 mls/28 days) SP HD
OMVOH 300 MG DOSE - 2 SYRINGES	T2	PA QL (3 mls/28 days) SP HD
TREMFYA 100 MG/ML INJECTOR	T2	PA QL (1 auto-inj/56 days) SP HD
TREMFYA 100 MG/ML PEN	T2	PA SP HD
TREMFYA 200 MG/2 ML PEN	T2	PA SP HD
TREMFYA ONE-PRESS	T2	PA SP HD
TREMFYA PEN INDUCTION PK-CROHN	T2	PA QL (200 mgs/28 days) SP HD
TREMFYA 100 MG/ML SYRINGE	T2	PA QL (1 syringe/56 days) SP HD
TREMFYA 200 MG/2 ML SYRINGE	T2	PA QL (200 mgs/28 days) SP HD
<b>INTERLEUKIN-4(IL-4) RECEPTOR ALPHA ANTAGONIST, MAB</b>		
DUPIXENT 100MG/0.67ML PREFILLED SYRINGE	T2	PA QL (2 pens/28 days) SP HD
DUPIXENT 200 MG/1.14 ML SYRINGE	T2	PA QL (800 mg/21 days) SP HD
DUPIXENT 300 MG2 ML SYRINGE	T2	PA QL (600 mg/21 days) SP HD
<b>INTERLEUKIN-6 (IL-6) RECEPTOR INHIBITORS</b>		
ACTEMRA	T2	PA QL (2 syr/21 days) SP HD
ACTEMRA ACTPEN	T2	PA QL (2 pens/21 days) SP HD
TYENNE	T2	PA QL (3.6 mls/28 days) SP
TYENNE AUTOINJECTOR	T2	PA QL (2 pens/28 days) SP
<b>MONOCLONAL ANTIBODY-HUMAN INTERLEUKIN I2/23 INHIB</b>		
STELARA	T2	PA QL SP HD
<b>IMMUNOSUPPRESSANTS (Skin Conditions)</b>		
<b>INTERLEUKIN-31(IL-31)RECEPTOR ALPHA ANTAGONIST,MAB</b>		
NEMLUVIO	T2	PA QL (2 pens/28 days) SP HD

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## List of Prescription Medications

### IMMUNOSUPPRESSANTS (Skin Conditions) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>TOPICAL IMMUNOSUPPRESSIVE AGENTS</b>		
pimecrolimus (Elidel)	T1	QL (100 gm/23 days)
tacrolimus 0.1% ointment	T1	ST QL (120 gms/30 days)
tacrolimus 0.03% ointment	T1	ST QL (120 gms/30 days)

### IMMUNOSUPPRESSANTS (Transplant Medications)

#### IMMUNOSUPPRESSIVES

ASTAGRAF XL	T3	PA SP HD
AZASAN	T3	SP HD
azathioprine (Imuran)	T1	SP HD
CELLCEPT (mycophenolate mofetil)	T3	SP HD
cyclosporine (Neoral)	T1	SP HD
cyclosporine (Sandimmune)	T1	SP HD
genraf (Neoral)	T1	SP HD
IMURAN (azathioprine)	T3	SP HD
LUPKYNIS	T3	PA SP QL (180 caps/30 days)
mycophenolate mofetil (Cellcept)	T1	SP HD
mycophenolic acid (Myfortic)	T1	SP HD
MYFORTIC (mycophenolic acid)	T3	SP HD
MYHIBBIN	T2	SP
NEORAL (cyclosporine modified)	T3	SP HD
PROGRAF CAPSULES (tacrolimus)	T3	SP HD
PROGRAF GRANULE PACKETS	T2	SP HD
RAPAMUNE (sirolimus)	T3	SP HD
SANDIMMUNE CAPSULES (cyclosporine)	T3	SP HD
SANDIMMUNE SOLUTION	T2	SP HD
sirolimus	T1	SP HD
sirolimus (Rapamune)	T1	SP HD
tacrolimus (Prograf)	T1	SP HD
ZORTRESS 0.25MG, 0.5MG, 0.75 MG TABLETS (everolimus)	T3	SP HD
ZORTRESS 1 MG TABLET	T3	SP HD

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

#### DIABETIC SUPPLIES

ACCU-CHEK	T3	
AGAMATRIX CONTROL SOLUTION	T3	

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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
<b>DIABETIC SUPPLIES (cont.)</b>		
AUTOLET LITE	T2	
AUTOSOFT 30 INFUSION SET PACK	T3	
AUTOSOFT XC INFUSION SET PACK	T3	
CEQUR SIMPLICITY 2 UNIT PATCH, INSERTER	T2	
CHOSEN LANCING DEVICE	T2	
CONTOUR	T3	
CONTOUR NEXT	T3	
DEXCOM RECEIVER	T2	PA
DEXCOM G4 RECEIVER	T2	PA
DEXCOM G4 TRANSMITTER	T2	PA QL (1 kit/180 days)
DEXCOM G5 RECEIVER	T2	PA
DEXCOM G5 TRANSMITTER	T2	PA QL (1 kit/90 days)
DEXCOM G5-G4 SENSOR	T2	PA
DEXCOM G6 RECEIVER	T2	PA QL (1 unit/365 days)
DEXCOM G6 SENSOR	T2	PA QL (3 kits/30 days)
DEXCOM G6 TRANSMITTER	T2	PA QL (1 kit/90 days)
DEXCOM G7 RECEIVER	T2	PA QL (1 unit/365 days)
DEXCOM G7 SENSOR	T2	PA QL (3 units/30 days)
EASY MINI EJECT LANCING DEVICE	T2	
EASY PLUS II	T3	
EASY STEP CONTROL SOLUTION	T3	
EASY TALK	T3	
EASY TOUCH	T3	
EASY TOUCH BLULINK CTRL SOLN	T3	
EASY TOUCH LANCING DEVICE	T2	
EASY TRAK	T3	
EASymax	T3	
EASymax N	T3	
EMBRACE	T3	
EMBRACE EVO	T3	
EMBRACE PRO	T3	
EVENCARE G2	T3	
EVENCARE G3	T3	
EVERSENSE SENSOR-HOLDER	T3	PA QL

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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
<b>DIABETIC SUPPLIES (cont.)</b>		
EVERSENSE SMART TRANSMITTER	T3	PA QL
FORA	T3	
FORA TN'GO ADV MOBILE MULT MTR	T3	
FORA TN'GO ADVANCE MULTIFN MTR	T3	
FORACARE	T3	
FORTISCARE	T3	
FREESTYLE	T2	
FREESTYLE LIBRE 2 PLUS SENSOR	T2	PA QL (2 units/30 days)
FREESTYLE LIBRE 2 READER	T2	PA QL (1 unit/365 days)
FREESTYLE LIBRE 2 SENSOR	T2	PA QL (2 sensors/28 days)
FREESTYLE LIBRE 3 PLUS SENSOR	T2	PA QL (2 units/30 days)
FREESTYLE LIBRE 3 READER	T2	PA QL (1 unit/365 days)
FREESTYLE LIBRE 3 SENSOR	T2	PA QL (2 units/28 days)
FREESTYLE LIBRE 10 DAY SENSOR	T2	PA
FREESTYLE LIBRE 14 DAY READER	T2	PA
FREESTYLE LIBRE 14 DAY SENSOR	T2	PA QL (2 kits/30 days)
FREESTYLE NAVIGATOR SENSOR KIT	T2	
GENTLE DRAW	T2	
GLUCOCARD	T3	
GLUCOCOM	T3	
GLUCOSE CONTROL	T3	
GLUCOSE CONTROL SOLUTION	T3	
GUARDIAN LINK 3 TRANSMITTER	T3	PA QL (1 transmitter/273 days)
GUARDIAN 4 TRANSMITTER	T3	PA QL (1 transmitter/273 days)
GUARDIAN 4 GLUCOSE SENSOR	T3	PA QL (5 sensors/30 days)
GUARDIAN RT REPLACE MONITOR	T3	
GUARDIAN SENSOR 3	T3	
HEALTHY ACCENTS AUTOLET	T2	
HYPOLANCE	T2	
IHEALTH CONTROL SOLN LEVEL 2	T3	
ILET INFUSION-CONTACT DETACH	T2	
ILET INFUSION KIT-INSET	T2	
ILET STARTER KIT-INSET	T2	
INCONTROL LANCING DEVICE	T2	

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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
<b>DIABETIC SUPPLIES (cont.)</b>		
INFINITY CONTROL SOLUTION	T3	
INFINITY VOICE CONTROL SOLN	T3	
LITE TOUCH	T2	
MEDISENSE	T2	
MICROLET	T2	
MINI LANCING DEVICE	T2	
MINIMED	T2	
OMNIPOD	T2	
OMNIPOD CLASSIC PDM KIT(GEN 3)	T2	
OMNIPOD DASH	T2	QL (15 pods/30 days)
OMNIPOD GO PODS	T2	QL (10 crtgs/30 days)
OMNIPOD 5 (G6/LIBRE 2 PLUS)	T2	QL (15 crtgs/30 days)
OMNIPOD 5 DEXG7G6 INTRO(GEN 5)	T2	QL (1 kit/720 days)
OMNIPOD 5 DEXG7G6 PODS (GEN 5)	T2	QL (15 crtgs/30 days)
OMNIPOD 5 DEXG7G6 PODS (GEN 5)	T2	QL (15 pods/28 days)
OMNIPOD 5 INTRO(G6/LIBRE2PLUS)	T2	QL (1 kit/720 days)
OMNIPOD 5 G6-G7 INTRO KT(GEN5)	T2	QL (1 kit/720 days)
OMNIPOD 5 G6-G7 PODS (GEN 5)	T2	QL (15 crtgs/30 days)
ONE TOUCH DELICA	T2	
ONE TOUCH ULTRA CONTROL SOLN	T2	
ONE TOUCH VERIO	T2	
ONETOUCH DELICA PLUS LANC DEV	T2	
PRODIGY LANCING DEVICE	T2	
T:FLEX	T2	
TANDEM MOBI AUTOSOFT 30	T2	PA SP HD
TANDEM MOBI AUTOSOFT XC	T2	PA SP HD
TANDEM MOBI AUTOSOFT 30 SUPPLY	T2	
TANDEM MOBI AUTOSOFT XC SUPPLY	T2	
TANDEM MOBI CARTRIDGE	T2	
TANDEM MOBI TRUSTEEL SUPPLY	T2	
TRUE METRIX	T3	
TRUECONTROL	T3	
TRUSTEEL INFUSION SET PACK	T3	
TWIIST REFILL KT(CSST-NDL-SYR)	T2	

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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
<b>DIABETIC SUPPLIES (cont.)</b>		
TWIIST RFL(INFUS-CSST-NDL-SYR)	T2	
TWIIST STARTER KIT	T2	
ULTI-LANCE	T2	
VGO 20	T2	
VGO 30	T2	
VGO 40	T2	
<b>DURABLE MEDICAL EQUIPMENT,MISC (GROUP I)</b>		
1ST TIER UNILET COMFORTOUCH	T2	
2-IN-1 LANCET DEVICE	T2	
ACCU-CHEK FASTCLIX LANCET DRUM	T2	
ACCU-CHEK SAFE-T-PRO	T2	
ACCU-CHEK SAFE-T-PRO PLUS	T2	
ACCU-CHEK SOFTCLIX	T2	
<i>acti-lance lite 28g lancets</i>	T1	
<i>acti-lance special 17g lancets</i>	T1	
<i>acti-lance univers 23g lancets</i>	T1	
ACTI-LANCE UNIVERS 23G LANCETS	T2	
ADVANCED TRAVEL LANCETS	T2	
ADVOCATE LANCET	T2	
ADVOCATE LANCETS	T2	
ADVOCATE SAFETY LANCET	T2	
AGAMATRIX ULTRA-THIN LANCET	T2	PA SP HD
ALTERNATE SITE LANCETS	T2	
ASSURE HAEMOLANCE PLUS	T2	
ASSURE LANCE	T2	
ASSURE LANCE PLUS	T2	
BD MICROTAINER LANCETS	T2	
BLOOD LANCETS	T2	
BULLSEYE MINI SAFETY LANCETS	T2	
BUTTERFLY TOUCH LANCET	T2	
CAREONE	T2	
CARESENS LANCET	T2	
CARETOUCH SAFETY LANCETS	T2	
CARETOUCH TWIST LANCET	T2	

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MISCELLANEOUS MEDICAL SUPPLIES, DEVICES, NON-DRUG (Diabetes) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>DURABLE MEDICAL EQUIPMENT,MISC (GROUP I) (cont.)</b>		
CHOSEN LANCET	T2	
CHOSEN SAFETY LANCET	T2	
CLEVER CHEK LANCETS	T2	
COAGUCHEK	T2	
COLOR LANCETS	T2	
COMFORT EZ	T2	
COMFORT LANCETS	T2	
COMFORT TOUCH PLUS SAFETY LANC	T2	
COMFORT TOUCH ULT THIN LANCET	T2	
DROPLET LANCETS	T2	
EASY COMFORT LANCETS	T2	
EASY TOUCH PULL-TOP 26G LANCET	T2	
EASY TOUCH PULL-TOP 28G LANCET	T2	
EASY TOUCH PULL-TOP 30G LANCET	T2	
EASY TOUCH PULL-TOP 32G LANCET	T2	
EASY TOUCH SAFETY 21G LANCETS	T2	
EASY TOUCH SAFETY 23G LANCETS	T2	
EASY TOUCH SAFETY 26G LANCETS	T2	
EASY TOUCH SAFETY 28G LANCETS	T2	
EASY TOUCH SAFETY 30G LANCETS	T2	
EASY TOUCH SAFETY 32G LANCETS	T2	
EASY TOUCH TWIST 26G LANCETS	T2	
EASY TOUCH TWIST 28G LANCETS	T2	
EASY TOUCH TWIST 30G LANCETS	T2	
EASY TOUCH TWIST 32G LANCETS	T2	
EASY TOUCH TWIST 33G LANCETS	T2	
EASY TWIST & CAP LANCETS	T2	
EMBRACE 30G LANCETS	T2	
EMBRACE SAFETY LANCET	T2	
EZ SMART LANCETS	T2	
EZ-LETS	T2	
FIFTY50 SAFETY SEAL LANCETS	T2	
FINE 30 UNIVERSAL LANCETS	T2	
FINGERSTIX	T2	

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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
<b>DURABLE MEDICAL EQUIPMENT,MISC (GROUP I) (cont.)</b>		
FORA LANCETS	T2	
FORACARE LANCETS	T2	
FREESTYLE LANCETS	T2	
FREESTYLE UNISTIK 2	T2	
GLUCOCOM	T2	
GLUCOCOM LANCETS	T2	
GOJJI LANCETS	T2	
HEALTHY ACCENTS UNILET LANCET	T2	
INCONTROL SUPERTHIN LANCETS	T2	
INCONTROL ULTRA THIN LANCETS	T2	
INJECT EASE LANCETS	T2	
INVACARE LANCETS	T2	
<i>lancets</i>	T1	
LANCETS	T2	
LANCETS THIN	T2	
LANCETS ULTRA THIN	T2	
LITE TOUCH 28G LANCETS	T2	
LITE TOUCH 30G LANCETS	T2	
LITE TOUCH 33G LANCETS	T2	
MEDISENSE THIN LANCETS	T2	
<i>medlance plus 21g lancets</i>	T1	
MEDLANCE PLUS 21G LANCETS	T2	
<i>medlance plus 30g lancets</i>	T1	
MEDLANCE PLUS 30G LANCETS	T2	
MEDLANCE PLUS EXTRA 21G LANCET	T2	
<i>medlance plus lite 25g lancets</i>	T1	
MEDLANCE PLUS LITE 25G LANCETS	T2	
MICRO THIN LANCET	T2	
MICRO THIN LANCETS	T2	
MICROLET	T2	
MOBILE LANCETS	T2	
MONOLET LANCETS	T2	
MONOLET THIN LANCETS	T2	
MYGLUCOHEALTH LANCETS	T2	

T1 – Typically Generics

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MISCELLANEOUS MEDICAL SUPPLIES, DEVICES, NON-DRUG (Diabetes) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>DURABLE MEDICAL EQUIPMENT,MISC (GROUP I) (cont.)</b>		
NOVA SAFETY LANCETS	T2	
NOVA SUREFLEX	T2	
ON CALL LANCET	T2	
ON CALL PLUS LANCET	T2	
ONETOUCH DELICA PLUS LANCET	T2	
ONETOUCH DELICA SAFETY LANCET	T2	
ONETOUCH LANCETS	T2	
ONETOUCH SURESOFT	T2	
ONETOUCH ULTRASOFT 2 LANCET	T2	
ON-THE-GO	T2	
PERFECT POINT SAFETY LANCETS	T2	
PIP LANCET	T2	
PRESSURE ACTIVATED LANCETS	T2	
PRO COMFORT LANCET	T2	
PRO COMFORT LANCETS	T2	
PRO COMFORT SAFETY LANCET	T2	
PRODIGY LANCETS	T2	
PRODIGY TWIST TOP LANCET	T2	
PURE COMFORT LANCETS	T2	
PURE COMFORT SAFETY LANCETS	T2	
PUSH BUTTON SAFETY LANCETS	T2	
READYLANCE SAFETY LANCETS	T2	
RELIAMED	T2	
RELIAMED SAFETY SEAL LANCETS	T2	
RIGHTTEST GL300 LANCETS	T2	
SAFETY LANCETS	T2	
SAFETY SEAL LANCETS	T2	
SAFETY-LET	T2	
SINGLE-LET	T2	
SMART SENSE	T2	
SMART SENSE LANCETS	T2	
SMARTEST LANCET	T2	
SOLUS V2	T2	
SOLUS V2 LANCETS	T2	

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

PA – Prior Authorization

QL – Quantity Limit

ST – Step Therapy

AGE – Age Requirement

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## List of Prescription Medications

MISCELLANEOUS MEDICAL SUPPLIES, DEVICES, NON-DRUG (Diabetes) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>DURABLE MEDICAL EQUIPMENT,MISC (GROUP I) (cont.)</b>		
STERILANCE TL	T2	
STERILE LANCETS	T2	
SUPER THIN LANCETS	T2	
SURE COMFORT LANCETS	T2	
SURE-LANCE	T2	
SURE-TOUCH	T2	
TECHLITE LANCETS	T2	
TELCARE ULTRA THIN 30G LANCETS	T2	
THIN LANCETS	T2	
TOPCARE UNIVERSAL1 LANCET	T2	
TOPCARE UNIVERSAL1 THIN LANCET	T2	
TRUE COMFORT LANCET	T2	
TRUE COMFORT SAFETY LANCET	T2	
TRUEPLUS LANCET	T2	
TRUEPLUS LANCETS	T2	
TWIST LANCETS	T2	
TWIST TOP LANCET	T2	
ULTILET BASIC	T2	
ULTILET CLASSIC	T2	
ULTILET LANCETS	T2	
ULTILET SAFETY	T2	
ULTRA THIN LANCET	T2	
ULTRA THIN LANCETS	T2	
ULTRA THIN PLUS LANCETS	T2	
ULTRA-CARE LANCETS	T2	
ULTRALANCE	T2	
ULTRA-THIN II 28G LANCETS	T2	
ULTRA-THIN II 30G LANCETS	T2	
ULTRATLC LANCETS	T2	
UNILET COMFORTOUCH	T2	
UNILET EXCELITE	T2	
UNILET EXCELITE II	T2	
UNILET GP LANCET	T2	
UNILET LANCET	T2	

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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
<b>DURABLE MEDICAL EQUIPMENT,MISC (GROUP I) (cont.)</b>		
UNILET LANCETS	T2	
UNISTIK 2 COMFORT	T2	
UNISTIK 2 EXTRA	T2	
UNISTIK 2 NORMAL	T2	
UNISTIK 3	T2	
UNISTIK 3 COMFORT	T2	
UNISTIK 3 DUAL	T2	
UNISTIK 3 EXTRA	T2	
UNISTIK 3 NORMAL	T2	
UNISTIK COMFORT	T2	
UNISTIK CZT	T2	
UNISTIK EXTRA	T2	
UNISTIK NORMAL	T2	
UNISTIK PRO	T2	
UNISTIK SAFETY	T2	
UNISTIK TOUCH	T2	
UNIVERSAL 1	T2	
VERIFINE SAFETY LANCET MINI	T2	
VERIFINE UNIVERSAL LANCET	T2	
VIVAGUARD LANCET	T2	
VIVAGUARD SAFETY LANCET	T2	
<b>NEEDLES/NEEDLELESS DEVICES</b>		
AUTOSHIELD DUO PEN NEEDLE	T2	
BD ECLIPSE NEEDLE 18G 40MM	T3	
BD SAFETYGLIDE NEEDLE	T2	
BD SAFETYGLIDE NEEDLE 18GX1.5"	T2	
BD SAFETYGLIDE NEEDLE 21GX1"	T2	
BD SAFETYGLIDE NEEDLE 21GX1.5"	T2	
BD SAFETYGLIDE NEEDLE 22GX1.5"	T2	
BD SAFETYGLIDE NEEDLE 23G 40MM	T3	
BD SAFETYGLIDE NEEDLE 25GX1"	T2	
BD SAFETYGLIDE NEEDLE 27GX5/8"	T2	
CAREPOINT PRECISION NEEDLE	T3	
DROPSAFE SICURA SAFETY NEEDLE	T3	

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MISCELLANEOUS MEDICAL SUPPLIES, DEVICES, NON-DRUG (Diabetes) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>NEEDLES/NEEDLELESS DEVICES (cont.)</b>		
EXEL HUBER NEEDLE	T2	
<i>exel huber needle (V-Go 20)</i>	T1	
EXEL HYPODERMIC NEEDLE	T2	
EXEL MTI DRAWING NEEDLE	T2	
FILTER NEEDLE	T2	
FLOW-EZE	T2	
HEALTHWISE PEN NEEDLE	T3	
HEALTHY ACCENTS UNIFINE PENTIP	T3	
HURRICANE LUER-LOCK	T2	
LITE TOUCH	T3	
MINI TRANSFER PIN	T2	
NANO 2ND GEN PEN NEEDLE	T2	
NANO PEN NEEDLE	T2	
NEEDLES	T2	
NOVOFINE	T2	
NOVOTWIST	T2	
PERFECT POINT SAFETY NEEDLE	T3	
PRECISIONGLIDE NEEDLE	T2	
ULTRA-FINE PEN NEEDLE	T2	
<b>SYRINGES AND ACCESSORIES</b>		
BD SAFETYGLIDE TB 1 ML SYR	T2	
BD SAFETYGLIDE TB 1ML 27G 10MM	T3	
BD SAFETYGLIDE TUBERCULIN SYR	T2	
CAREPOINT LUER LOCK SYRINGE	T3	
CAREPOINT LUER LOCK SYRING-NDL	T2	
CAREPOINT PRECISION LUER LOCK	T3	
CAREPOINT PRECISION SAFETY	T2	
CAREPOINT SAFETY LUER LOCK SYR	T2	
ENFIT SYRINGE	T3	
ENFIT SYRINGE STERILE	T3	
ENFIT THUMB CONTROL RING SYRIN	T3	
INSULIN SYR 0.5 ML 28G 12.7MM	T2	
INSULIN SYRINGE 1 ML 27G 16MM	T2	
INSULIN SYRINGE 1ML 28G 12.7MM	T2	

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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
<b>SYRINGES AND ACCESSORIES (cont.)</b>		
INSULIN SYRINGE U-500	T2	
LUER LOCK SYRINGE-NEEDLE	T3	PA SP HD
MONOJECT TB SAFETY SYRINGE	T2	
SYRINGE LUER LOCK	T2	PA SP HD
SYRINGE SLIP TIP	T2	
SYRINGE WITH NEEDLE	T2	
TUBERCULIN SLIP-TIP SYRINGE	T3	
ULTRA-FINE INSULIN SYRINGE	T2	
<b>MISCELLANEOUS MEDICAL SUPPLIES, DEVICES, NON-DRUG (Miscellaneous)</b>		
<b>DURABLE MEDICAL EQUIPMENT,MISC (GROUP I)</b>		
ADVOCATE SAFETY LANCET	T2	
AEROCHAMBER2GO	T2	PA SP HD
AGAMATRIX ULTRA-THIN LANCET	T2	PA SP HD
CHOSEN LANCET	T2	
CHOSEN SAFETY LANCET	T2	
CARESENS LANCET	T2	
CARETOUCH SAFETY LANCETS	T2	
PERFECT POINT SAFETY LANCETS	T2	
VIVAGUARD SAFETY LANCET	T2	
<b>PARENTERAL ADMINISTRATION SETS</b>		
ACCU-CHEK	T3	
<b>RESPIRATORY AIDS, DEVICES, EQUIPMENT</b>		
ACE AEROSOL CLOUD ENHANCER	T2	
AEROCHAMBER	T2	
AEROCHAMBER MECHANICAL VENT	T2	
AEROCHAMBER PLUS	T2	
AEROCHAMBER Z-STAT PLUS	T2	
AEROTRACH PLUS	T2	
AEROVENT PLUS	T2	
CLEVER CHOICE HOLDING CHAMBER	T2	
COMFORTSEAL	T2	
COMPACT SPACE CHAMBER	T2	
EASIVENT	T2	

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## List of Prescription Medications

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

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>RESPIRATORY AIDS, DEVICES, EQUIPMENT (cont.)</b>		
FLEXICHAMBER	T2	
INSPIRACHAMBER	T2	
LITEAIRE	T2	
LITETOUCH	T2	
MASK	T2	
MICROCHAMBER	T2	
MICROSPACER	T2	
MOUTHPIECE	T2	
ONE WAY MOUTHPIECE	T2	
OPTICHAMBER	T2	
OPTICHAMBER DIAMOND	T2	
PANDA MASK	T2	
PEDIATRIC PANDA MASK	T2	
POCKET CHAMBER	T2	
PRIMEAIRE	T2	
PRO COMFORT SPACER WITH MASK	T2	
PROCHAMBER	T2	
PURECOMFORT PEAK FLOW MOUTHPCE	T2	
RITEFLO	T2	
SIDESTREAM PEDIATRIC	T2	
SILICONE MASK	T2	
UNISTIK 2 COMFORT	T2	
UNISTIK 2 EXTRA	T2	
UNISTIK 2 NORMAL	T2	
UNISTIK 3 COMFORT	T2	
UNISTIK 3 DUAL	T2	
VORTEX	T2	
VORTEX VHC PEDIATRIC MASK	T2	

### MUSCLE RELAXANTS (Pain Relief And Inflammatory Disease)

#### SKELETAL MUSCLE RELAXANTS

baclofen 5 mg/5 ml solution	T1	HD
baclofen 25 mg/5 ml suspension (Fleqsuvy)	T1	HD
baclofen 10 mg/5 ml solution	T1	PA SP HD

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## List of Prescription Medications

MUSCLE RELAXANTS (Pain Relief And Inflammatory Disease) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>SKELETAL MUSCLE RELAXANTS (cont.)</b>		
baclofen 5 mg tablet	T1	HD
baclofen 10 mg tablet	T1	HD
baclofen 15 mg tablet	T1	HD
baclofen 20 mg tablet	T1	HD
carisoprodol (Soma)	T1	
carisoprodol-aspirin	T1	
chlorzoxazone (Lorzone)	T1	
CYCLOBENZAPRINE ER	T1	ST
cyclobenzaprine hcl	T1	
cyclobenzaprine hcl (Amrix)	T1	
cyclobenzaprine hcl (Fexmid)	T1	
DANTRIUM (dantrolene )	T3	
dantrolene (Dantrium)	T1	
FEXMID (cyclobenzaprine hcl)	T3	PA
LORZONE (chlorzoxazone)	T3	PA
metaxalone (Skelaxin)	T1	
metaxalone 400 mg tablet	T1	
metaxalone 800 mg tablet	T1	
methocarbamol	T1	
methocarbamol 1,000 mg tablet	T1	
NORGESIC FORTE	T3	
orphenadrine	T1	
orphenadrine-aspirin-caffeine (Norgesic Forte)	T1	
orphengesic forte (Norgesic Forte)	T1	
ROBAXIN (methocarbamol)	T3	
SKELAXIN (metaxalone)	T3	
SOMA (carisoprodol)	T3	
tizanidine hcl (Zanaflex)	T1	
ZANAFLEX (tizanidine hcl)	T3	

## PRE-NATAL VITAMINS (Nutritional/Dietary)

### PRENATAL VITAMIN PREPARATIONS

cvs prenatal multivit-dha sfgl	T1	PPACA
daily prenatal	T1	PPACA

T1 – Typically Generics

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## List of Prescription Medications

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

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>PRENATAL VITAMIN PREPARATIONS (cont.)</b>		
<i>ft prenatal tablet</i>	T1	PPACA
<i>perry prenatal tablet (Perry Prenatal)</i>	T1	PPACA
<i>pnv no.154/iron fum/folic acid</i>	T1	
<i>prenatal</i>	T1	PPACA
<i>prenatal 12/iron/folic/dss/om3</i>	T1	
<i>prenatal complete</i>	T1	PPACA
<i>prenatal formula</i>	T1	PPACA
<i>prenatal multi + dha</i>	T1	PPACA
PRENATAL MULTIVITAMIN-DHA SFGL	T2	
<i>pnv no.52/iron/fa/omega-3/dha</i>	T1	PA SP HD
<i>pnv 81/iron ps,edta/folic/omeg3</i>	T1	PA SP HD
<i>prenatal no.42/folic acid (Vitamedmd Redicheck Rx)</i>	T1	PA SP HD
<i>prenatal vit 27,calc/iron/fa</i>	T1	PA SP HD
<i>prenatal vit,cal 76/iron/folic</i>	T1	PA SP HD
<i>prenatal vit,cal 78/iron/folic</i>	T1	PA SP HD
<i>prenatal vits 86/iron/folic ac</i>	T1	PA SP HD
<i>prenatal,calc 40/iron/folate 1</i>	T1	PA SP HD
PRENATAL FORMULA-DHA ( <i>prenatal vit 116/iron/fa/dha</i> )	T3	PA SP HD
<i>prenatal vitamin</i>	T1	PPACA
<i>prenavite (Classic Prenatal)</i>	T1	PPACA
VITAMEDMD REDICHEW RX ( <i>prenatal no.42/folic acid</i> )	T3	PA SP HD

### PRENATAL VITAMINS WITH LOW OR NO IRON

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

T1 – Typically Generics

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## List of Prescription Medications

PSYCHOTHERAPEUTIC DRUGS (Anxiety/Depression/Bipolar Disorder) <sup>8</sup>		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>ALPHA-2 RECEPTOR ANTAGONIST ANTI-DEPRESSANTS</b>		
<i>alprazolam</i> (Xanax)	T1	
<i>alprazolam er</i> (Xanax XR)	T1	
<i>alprazolam intensol</i>	T1	
<i>mirtazapine</i>	T1	HD
<i>mirtazapine</i> (Remeron)	T1	HD
REMERON ( <i>mirtazapine</i> )	T3	HD
<b>ANTI-ANXIETY - BENZODIAZEPINES</b>		
<i>alprazolam odt</i>	T1	
<i>alprazolam xr</i> (Xanax XR)	T1	
ATIVAN ( <i>lorazepam</i> )	T3	
<i>chlordiazepoxide hcl</i>	T1	
<i>clorazepate di</i> (Tranxene T-Tab)	T1	
<i>diazepam</i> (Valium)	T1	
<i>lorazepam</i> (Ativan)	T1	
<i>lorazepam intensol</i>	T1	
<i>oxazepam</i>	T1	
TRANXENE T-TAB ( <i>clorazepate dipotassium</i> )	T3	
<b>ANTI-ANXIETY DRUGS</b>		
<i>buspirone hcl</i>	T1	HD
<i>meprobamate</i>	T1	
<b>ANTIDEPRESSANT - POSTPARTUM DEPRESSION (PPD)</b>		
ZURZUVAE 20 MG, 25 MG CAPSULE	T2	QL (28 caps/365 days) SP HD
ZURZUVAE 30 MG CAPSULE	T2	QL (14 caps/365 days) SP HD
<b>BIPOLAR DISORDER DRUGS</b>		
EQUETRO	T3	HD
<i>lithium</i>	T1	HD
<i>lithium carbonate</i> (Lithobid)	T1	HD
LITHOBID ( <i>lithium carbonate er</i> )	T3	HD
<b>MAOIS -NON-SELECTIVE, IRREVERSIBLE ANTI-DEPRESSANTS</b>		
MARPLAN	T3	
NARDIL (phenelzine )	T3	
PARNATE (tranylcypromine )	T3	
<i>phenelzine</i> (Nardil)	T1	
<i>tranylcypromine</i> (Parnate)	T1	

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PSYCHOTHERAPEUTIC DRUGS (Anxiety/Depression/Bipolar Disorder) <sup>8</sup> (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>MONOAMINE OXIDASE (MAO) INHIBITOR ANTI-DEPRESSANTS</b>		
EMSAM	T3	
<b>NDMA RECEPTOR ANTAGONIST AND NDRI COMB</b>		
AUVELITY	T3	ST QL (60 tabs/30 days)
<b>NOREPINEPHRINE AND DOPAMINE REUPTAKE INHIB (NDRIs)</b>		
bupropion hcl	T1	HD
bupropion hcl er (Wellbutrin SR)	T1	QL HD
bupropion hcl xl 300 mg tablet (Wellbutrin SR)	T1	QL (30 tabs/30 days) HD
BUPROPION HCL XL	T3	ST QL (30 units/30 days) HD
FORFIVO XL	T3	ST QL (30 units/30 days) HD
<b>SELECTIVE SEROTONIN 5-HT2A INVERSE AGONISTS (SSIAs)</b>		
NUPLAZID	T3	PA QL SP HD
<b>SELECTIVE SEROTONIN REUPTAKE INHIBITOR (SSRIs)</b>		
citalopram hbr 20 mg/10 ml cup	T1	PA SP HD
escitalopram 10 mg/10 ml cup	T1	PA SP HD
fluoxetine dr	T1	QL ST HD
fluoxetine (Sarafem)	T1	HD
fluoxetine 20 mg/5 ml soln cup	T1	HD
fluvoxamine maleate	T1	QL HD
paroxetine er (Paxil CR)	T1	QL HD
paroxetine hcl (Paxil)	T1	ST HD
PAXIL (paroxetine hcl)	T3	ST QL HD
PAXIL CR (paroxetine cr)	T3	ST QL HD
SARAFEM (fluoxetine hcl)	T3	ST QL (30 units/30 days) HD
vilazodone-hctz tablets	T1	QL ST
<b>SEROTONIN-2 ANTAGONIST/REUPTAKE INHIBITORS (SARIs)</b>		
nefazodone hcl	T1	HD
trazodone hcl	T1	HD
<b>SEROTONIN-NOREPINEPHRINE REUPTAKE-INHIB (SNRIs)</b>		
desvenlafaxine succinate er (Pristiq)	T1	QL (30 units/30 days) HD
duloxetine hcl	T1	QL (30 units/30 days) HD
duloxetine hcl (Cymbalta)	T1	QL HD
FETZIMA 20-40 MG TITRATION PAK	T2	ST QL (28 caps/30 days)
FETZIMA ER 120 MG CAPSULE	T2	ST QL (30 caps/30 days)
FETZIMA ER 20 MG CAPSULE	T2	ST QL (30 caps/30 days)

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PSYCHOTHERAPEUTIC DRUGS (Anxiety/Depression/Bipolar Disorder) <sup>8</sup> (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>SEROTONIN-NOREPINEPHRINE REUPTAKE-INHIB (SNRIs) (cont.)</b>		
FETZIMA ER 40 MG CAPSULE	T2	ST QL (30 caps/30 days)
FETZIMA ER 80 MG CAPSULE	T2	ST QL (30 caps/30 days)
FETZIMA ERTITRATION PACK	T2	ST QL (1 pack/30 days) HD
<i>venlafaxine hcl</i>	T1	QL HD
<i>venlafaxine hcl er</i>	T1	QL (30 units/30 days) HD
<b>SSRI, SEROTONIN RECEPTOR MODULATOR ANTI-DEPRESSANTS</b>		
TRINTELLIX	T3	ST QL (30 tabs/30 days)
<b>TRICYCLIC ANTI-DEPRESSANT-BENZODIAZEPINE COMBINATNS</b>		
<i>amitriptyline/chlordiazepoxide</i>	T1	HD
<i>amitriptyline-perphenazine</i>	T1	HD
<b>TRICYCLIC ANTI-DEPRESSANTS, REL.NON-SEL.REUPT-INHIB</b>		
<i>amitriptyline hcl</i>	T1	HD
<i>amoxapine</i>	T1	HD
<i>ANAFRANIL (clomipramine hcl)</i>	T3	HD
<i>clomipramine hcl (Anafranil)</i>	T1	HD
<i>desipramine hcl</i>	T1	HD
<i>doxepin hcl</i>	T1	HD
<i>imipramine hcl</i>	T1	HD
<i>imipramine pamoate</i>	T1	HD
<i>maprotiline hcl</i>	T1	HD
<i>nortriptyline hcl</i>	T1	HD
<i>nortriptyline hcl (Pamelor)</i>	T1	HD
<i>PAMELOR (nortriptyline hcl)</i>	T3	HD
<i>protriptyline hcl</i>	T1	HD
<i>trimipramine maleate</i>	T1	HD
<b>PSYCHOTHERAPEUTIC DRUGS (Attention Deficit Hyperactivity Disorder)<sup>8</sup></b>		
<b>ADRENERGICS, AROMATIC, NON-CATECHOLAMINE</b>		
<i>lisdexamfetamine 10 mg capsule (Vyvanse)</i>	T1	
<i>lisdexamfetamine 20 mg capsule (Vyvanse)</i>	T1	
<i>lisdexamfetamine 30 mg capsule (Vyvanse)</i>	T1	
<i>lisdexamfetamine 40 mg capsule (Vyvanse)</i>	T1	
<i>lisdexamfetamine 50 mg capsule (Vyvanse)</i>	T1	
<i>lisdexamfetamine 60 mg capsule (Vyvanse)</i>	T1	

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

PA – Prior Authorization

QL – Quantity Limit

ST – Step Therapy

AGE – Age Requirement

SP – Specialty Medication

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## List of Prescription Medications

PSYCHOTHERAPEUTIC DRUGS (Attention Deficit Hyperactivity Disorder) <sup>8</sup> (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>ADRENERGICS, AROMATIC, NON-CATECHOLAMINE (cont.)</b>		
lisdexamfetamine 70 mg capsule (Vyvanse)	T1	
lisdexamfetamine 10 mg tb chew (Vyvanse)	T1	ST
lisdexamfetamine 20 mg tb chew (Vyvanse)	T1	ST
lisdexamfetamine 30 mg tb chew (Vyvanse)	T1	ST
lisdexamfetamine 40 mg tb chew (Vyvanse)	T1	ST
lisdexamfetamine 50 mg tb chew (Vyvanse)	T1	ST
lisdexamfetamine 60 mg tb chew (Vyvanse)	T1	ST
VYVANSE (lisdexamfetamine dimesylate)	T3	ST
<b>TX FOR ADHD - SELECTIVE ALPHA-2 RECEPTOR AGONIST</b>		
clonidine hcl er (Kapvay)	T1	
guanfacine hcl (Intuniv)	T1	HD
guanfacine hcl er (Intuniv)	T1	
KAPVAY (clonidine hcl er)	T3	ST
<b>TX FOR ATTENTION DEFICIT-HYPERACT (ADHD)/NARCOLEPSY</b>		
APTENSIO XR	T3	ST
AZSTARYS	T2	ST
COTEMPLA XR-ODT	T3	ST
DAYTRANA	T2	ST
dexmethylphenidate hcl (Focalin)	T1	
dexmethylphenidate hcl er (Focalin XR)	T1	
JORNAY PM	T3	ST
METADATE CD (methylphenidate hcl)	T3	ST
METHYLIN (methylphenidate hcl)	T3	
methylphenidate er	T1	
methylphenidate er (Concerta)	T1	
methylphenidate er 72 mg tab	T1	
methylphenidate er 18 mg tab (Relexxii)	T1	
methylphenidate er 27 mg tab (Relexxii)	T1	
methylphenidate er 36 mg tab (Relexxii)	T1	
methylphenidate er 54 mg tab (Relexxii)	T1	
methylphenidate er (Ritalin LA)	T1	
methylphenidate hcl	T1	
methylphenidate hcl (Metadate Cd)	T1	
methylphenidate hcl (Methylin)	T1	

T1 – Typically Generics

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## List of Prescription Medications

### PSYCHOTHERAPEUTIC DRUGS (Attention Deficit Hyperactivity Disorder)<sup>8</sup> (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>TX FOR ATTENTION DEFICIT-HYPERACT (ADHD)/NARCOLEPSY (cont.)</b>		
<i>methylphenidate hcl</i> (Ritalin)	T1	
<i>methylphenidate hcl cd</i>	T1	
<i>methylphenidate la</i>	T1	
<i>methylphenidate la</i> (Ritalin La)	T1	
QELBREE ER	T3	ST
RITALIN ( <i>methylphenidate hcl</i> )	T3	
RITALIN LA ( <i>methylphenidate er (la)</i> )	T3	ST

### TX FOR ATTENTION DEFICIT-HYPERACT.(ADHD), NRI-TYPE

<i>atomoxetine hcl</i> (Strattera)	T1	HD
QELBREE	T3	ST

### PSYCHOTHERAPEUTIC DRUGS (Schizophrenia/Anti-Psychotics)<sup>8</sup>

#### ANTI-PSYCH, DOPAMINE ANTAG., DIPHENYLBUTYLPIPERIDINES

<i>pimozide</i>	T1	
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#### ANTI-PSYCHOTIC,ATYPICAL,DOPAMINE,SEROTONIN ANTAGNST

<i>clozapine</i> (Clozaril)	T1	
<i>clozapine odt</i>	T1	
CLOZAPINE ODT	T3	
CLOZARIL ( <i>clozapine</i> )	T3	
GEODON ( <i>ziprasidone hcl</i> )	T3	QL
INVEGA ( <i>paliperidone er</i> )	T3	QL
LYBALVI	T3	QL (30 tabs/30 days)
<i>olanzapine</i>	T1	PA SP HD
<i>olanzapine odt</i> (Zyprexa Zydis)	T1	QL (30 units/30 days)
<i>quetiapine fumarate er</i> (Seroquel XR)	T1	QL
RISPERDAL ( <i>risperidone</i> )	T3	QL
<i>risperidone</i> (Risperdal)	T1	QL
<i>risperidone odt</i>	T1	QL
SECUADO	T3	QL
VERSACLOZ	T3	
<i>ziprasidone hcl</i> (Geodon)	T1	QL
ZYPREXA ( <i>olanzapine</i> )	T3	QL (30 units/30 days)
ZYPREXA ZYDIS ( <i>olanzapine odt</i> )	T3	QL (30 units/30 days)

T1 – Typically Generics

T2 – Typically Preferred Brands

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## List of Prescription Medications

PSYCHOTHERAPEUTIC DRUGS (Schizophrenia/Anti-Psychotics) <sup>8</sup> (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>ANTI-PSYCHOTIC-ATYPICAL, D3/D2 PARTIAL AG-5HT MIXED</b>		
CAPLYTA 10.5MG CAPSULE	T3	QL (30 caps/30 days)
CAPLYTA 21MG CAPSULE	T3	QL (30 caps/30 days)
VRAYLAR	T3	QL (30 caps/30 days)
<b>ANTIPSYCHOTICS, ATYP, D2 PARTIAL AGONIST/5HT MIXED</b>		
ABILIFY ASIMTUFII 720MG/2.4ML, 960MG/3.2ML	T3	
ABILIFY MYCITE	T3	QL (30 units/30 days)
<i>ariPIPRAZOLE</i>	T1	
<i>ariPIPRAZOLE (Abilify)</i>	T1	QL (30 units/30 days)
<i>ariPIPRAZOLE odt</i>	T1	QL
REXULTI	T3	QL (30 units/30 days)
<b>ANTI-PSYCHOTICS, DOPAMINE AND SEROTONIN ANTAGONISTS</b>		
ADASUVE	T3	
<i>loxpiprazole succinate</i>	T1	
<b>ANTI-PSYCHOTICS, DOPAMINE ANTAGONISTS, THIOXANTHENES</b>		
<i>thiothixene</i>	T1	
<b>ANTI-PSYCHOTICS, DOPAMINE ANTAGONISTS, BUTYROPHENONES</b>		
<i>haloperidol</i>	T1	
<i>haloperidol lactate</i>	T1	
<b>ANTI-PSYCHOTICS, DOPAMINE ANTAGONST, DIHYDROINDOLONES</b>		
<i>molindone hcl</i>	T1	
<b>ANTI-PSYCHOTICS, PHENOTHIAZINES</b>		
<i>chlorpromazine hcl</i>	T1	
<i>fluphenazine hcl</i>	T1	
<i>perphenazine</i>	T1	
<i>thioridazine hcl</i>	T1	
<i>trifluoperazine hcl</i>	T1	
PSYCHOTHERAPEUTIC DRUGS (Sleep Disorders/Sedatives)		
<b>NARCOLEPSY AND SLEEP DISORDER THERAPY AGENTS</b>		
<i>armodafinil</i> (Nuvigil)	T1	PA QL (30 units/30 days)
SUNOSI	T2	PA QL (30 units/30 days)
SEDATIVE/HYPNOTICS (Sleep Disorders/Sedatives)		
<b>ANTI-NARCOLEPSY, ANTI-CATAPLEXY, SEDATIVE-TYPE AGENT</b>		
LUMRYZ STARTER PACK	T2	PA SP HD

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## List of Prescription Medications

SEDATIVE/HYPNOTICS (Sleep Disorders/Sedatives)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>ANTI-NARCOLEPSY, ANTI-CATAPLEXY, SEDATIVE-TYPE AGENT (cont.)</b>		
LUMRYZ ER	T3	PA SP HD QL (30 packets/30 days)
SODIUM OXYBATE	T2	PA SP HD QL (540 ml/30 days)
XYREM	T2	QL (540 ml/30 days) SP HD
XYWAV	T2	QL (540 ml/30 days)
<b>BARBITURATES</b>		
<i>phenobarbital</i>	T1	
<i>seconal (Seconal Sodium)</i>	T1	QL (30 units/30 days)
<b>HYPNOTICS, MELATONIN MT1/MT2 RECEPTOR AGONISTS</b>		
HETLIOZ	T3	PA QL (30 units/30 days) SP HD
<i>ramelteon (Rozerem)</i>	T1	QL (30 units/30 days)
<b>SEDATIVE-HYPNOTICS - BENZODIAZEPINES</b>		
<i>estazolam</i>	T1	QL (15 tabs/fill)
<i>flurazepam hcl</i>	T1	
HALCION ( <i>triazolam</i> )	T3	
<i>midazolam hcl</i>	T1	
RESTORIL ( <i>temazepam</i> )	T3	QL (15 caps/fill)
<i>temazepam (Restoril)</i>	T1	QL (15 caps/fill)
<i>triazolam (Halcion)</i>	T1	QL (15 tabs/fill)
<b>SEDATIVE-HYPNOTICS, NON-BARBITURATE</b>		
BELSOMRA	T3	ST QL (30 units/30 days)
<i>doxepin hcl (Silenor)</i>	T1	QL (30 units/30 days)
DAYVIGO	T3	ST QL (30 tabs/fill)
EDLUAR	T3	ST QL (30 units/30 days)
<i>eszopiclone (Lunesta)</i>	T1	QL (30 units/30 days)
INTERMEZZO ( <i>zolpidem tartrate</i> )	T3	ST QL (30 units/30 days)
MKO (MIDAZOLAM-KETAMINE-ONDAN)	T3	
QUVIVIQ	T3	ST QL (30 tabs/fill)
SILENOR ( <i>doxepin hcl</i> )	T3	ST QL (30 units/30 days)
<i>zaleplon</i>	T1	QL
<i>zolpidem tartrate</i>	T1	QL (30 units/30 days)
<i>zolpidem tartrate (Ambien)</i>	T1	QL (30 units/30 days)
<i>zolpidem tartrate (Intermezzo)</i>	T1	QL (30 units/30 days)
<i>zolpidem tartrate er (Ambien CR)</i>	T1	QL (30 units/30 days)
ZOLPIMIST	T3	ST QL (1 canister/30 days)

T1 – Typically Generics

T2 – Typically Preferred Brands

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## List of Prescription Medications

SKIN PREPS (Miscellaneous)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>IRRIGANTS</b>		
acetic acid	T1	
neomycin-polymyxin b	T1	
PHYSIOLYTE	T3	
PHYSIOSOL	T3	
sodium chloride 0.9% irrig	T1	
sodium chloride 0.9% prcss sol	T1	
SODIUM CHLORIDE 0.9% IRRIG.	T3	
<b>OXIDIZING AGENTS</b>		
hydrogen peroxide	T1	
SKIN PREPS (Pain Relief And Inflammatory Disease)		
<b>ANTI-PSORIATIC AGENTS, SYSTEMIC</b>		
acitretin	T1	
methoxsalen (Oxsoralen-Ultra)	T1	
OXSORALEN-ULTRA (methoxsalen)	T3	
SKYRIZI (2 SYRINGES) KIT	T2	PA QL (1 kit/30 days) SP HD
SORIATANE (acitretin)	T3	
SOTYKTU	T2	PA QL (30 tabs/30 days) SP HD
SPEVIGO	T3	PA SP HD
TALTZ 20 MG/0.25 ML SYRINGE	T2	PA QL (1 syringe/28 days) SP HD
TALTZ 40 MG/0.5 ML SYRINGE	T2	PA QL (1 syringe/28 days) SP HD
TALTZ 80 MG/ML SYRINGE	T2	PA QL (1 ml/28 days) SP HD
TREMFYA	T2	PA QL SP HD
<b>TOPICAL ANTI-INFLAMMATORY, NSAIDS</b>		
diclofenac sodium 1% gel	T1	QL (500 gms/28 days) HD
FLECTOR	T2	ST QL
VOLTAREN (arthritis pain)	T3	ST QL (500gm/21 days) HD
SKIN PREPS (Skin Conditions)		
<b>ACNE AGENTS, SYSTEMIC</b>		
ABSORICA	T2	ST
ABSORICA LD	T3	
amnesteem (Absorica)	T1	
claravis (Absorica)	T1	
isotretinoin (Absorica)	T1	

T1 – Typically Generics

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## List of Prescription Medications

SKIN PREPS (Skin Conditions) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>ACNE AGENTS, SYSTEMIC (cont.)</b>		
<i>isotretinoin authorized generics by Sun pharmaceuticals</i>	T1	ST
<i>myorisan (Absorica)</i>	T1	
<i>zenatane (Absorica)</i>	T1	
<b>ACNE AGENTS, TOPICAL</b>		
ACZONE ( <i>dapsone</i> )	T3	ST
adapalene-benzoyl peroxide (Epiduo)	T1	
AZELEX	T3	ST
BENZACLIN ( <i>clindamycin-benzoyl peroxide</i> )	T3	ST
<i>clindamycin phos-tretinoin (Veltin)</i>	T1	PA
<i>clindamycin-benzoyl peroxide</i>	T1	
<i>clindamycin-benzoyl peroxide (Acanya)</i>	T1	
<i>clindamycin-benzoyl peroxide (Benzacllin)</i>	T1	
<i>clindamycin/tretinoin (Veltin)</i>	T1	
<i>dapsone 5% gel (Aczone)</i>	T1	PA SP HD
<i>dapsone 7.5% gel pump (Aczone)</i>	T1	PA SP HD
DAPSONE 7.5% GEL	T3	PA SP HD
EPIDUO FORTE GEL PUMP	T3	ST
KLARON ( <i>sulfacetamide</i> )	T3	ST
<i>neuac</i>	T1	
ONEXTON ( <i>clindamycin phos/benzoyl perox</i> )	T3	ST
ONEXTON	T2	ST
<i>sulfacetamide (Klaron)</i>	T1	
ZIANA ( <i>clindamycin phos-tretinoin</i> )	T3	PA ST
<b>ANTI-PRURITICS, TOPICAL</b>		
<i>doxepin hcl (Prudoxin)</i>	T1	QL (45 gm/23 days)
<i>prudoxin (Prudoxin)</i>	T1	QL (45 gm/23 days)
ZONALON ( <i>doxepin hcl</i> )	T3	ST QL (90 grams/30 days)
<b>ANTI-PSORIATICS AGENTS</b>		
<i>calcipotriene (Dovonex)</i>	T1	QL (120/23 days)
<i>calcitriol (Vectical)</i>	T1	
DOVONEX ( <i>calcipotriene</i> )	T3	QL (120/23 days)
DUOBRII	T3	ST QL (200 gm/23 days)
<i>tazarotene 0.05% cream (Tazorac)</i>	T1	PA
TAZORAC	T2	PA

T1 – Typically Generics

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## List of Prescription Medications

SKIN PREPS (Skin Conditions) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>ANTI-PSORIATICS AGENTS (cont.)</b>		
VECTICAL ( <i>calcitriol</i> )	T3	
VTAMA	T2	PA QL (60 gms/28 days)
ZORYVE 0.3% CREAM	T3	PA QL (60 gms/30 days)
<b>ANTI-SEBORRHEIC AGENTS</b>		
ESKATA	T3	
OVACE ( <i>sulfacetamide</i> )	T3	
OVACE PLUS	T3	
<i>selenium sulfide</i> (Selrx)	T1	
<i>sulfacetamide</i> (Ovace Plus Wash)	T1	
<i>sulfacetamide</i> (Ovace Plus)	T1	
<i>sulfacetamide</i> (Ovace)	T1	
VTAMA	T3	PA QL
ZORYVE	T3	PA QL (60 grams/21 days)
<b>ANTISEPTICS,GENERAL</b>		
GS ALCOHOL 70% SWABS	T2	
<b>DIABETIC ULCER PREPARATIONS, TOPICAL</b>		
REGRANEX	T2	QL
<b>IMMUNOMODULATORS</b>		
ALDARA ( <i>imiquimod</i> )	T3	
<i>imiquimod</i> (Aldara)	T1	
<b>IRRITANTS/COOOUNTER-IRRITANTS</b>		
YCANTH	T3	SP
<b>KERATOLYTICS</b>		
<i>benzepro</i>	T1	
BENZEPRO ( <i>benzepro</i> )	T3	ST
<i>benzoyl peroxide</i>	T1	
CONDYLOX	T3	ST QL (7 grams/30 days)
ENZOCLEAR	T3	ST
INOVA	T3	ST
INOVA 4-1	T3	ST
INOVA 8-2	T3	ST
<i>podofilox 0.5% gel</i> (Condyllox)	T1	ST QL (7 gms/30 days)
<i>podofilox 0.5% topical soln</i>	T1	
PR BENZOYL PEROXIDE ( <i>benzepro</i> )	T3	ST

T1 – Typically Generics

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## List of Prescription Medications

SKIN PREPS (Skin Conditions) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>PROTECTIVES</b>		
PHARMABASE ( <i>pharmabase barrier</i> )	T3	
zinc oxide	T1	
<b>ROSACEA AGENTS, TOPICAL</b>		
azelaic acid (Finacea)	T1	
EPSOLAY	T3	
FINACEA ( <i>azelaic acid</i> )	T3	ST
ivermectin 1% cream (Soolantra)	T1	QL (45 gms/30 days)
METROCREAM ( <i>metronidazole</i> )	T3	ST
METROGEL ( <i>metronidazole</i> )	T3	ST
METROLOTION ( <i>metronidazole</i> )	T3	ST
metronidazole 0.75% cream (Metrocream)	T1	
metronidazole 0.75% lotion	T1	
metronidazole top 1% gel/pump	T1	
metronidazole topical 0.75% gl	T1	
metronidazole topical 1% gel (Metrogel)	T1	
metronidazole ( <i>Metro lotion</i> )	T1	
MIRVASO	T2	PA
NORITATE	T3	ST
RHOFADE	T3	PA
ROSADAN	T3	ST
rosadan (Metrocream)	T1	
<b>TISSUE/WOUND ADHESIVES</b>		
ARTISS	T3	
TISSEEL VHSD	T3	
<b>TOP. ANTI-INFLAM., PHOSPHODIESTERASE-4 (PDE4) INHIB</b>		
EUCRISA	T2	ST QL (120 gms/30 days)
ZORYVE 0.3% FOAM	T3	ST QL (60 GMS/30 DAYS)
ZORYVE 0.15% CREAM	T2	ST QL (60 gms/30 days)
<b>TOPICAL AGENTS, MISCELLANEOUS</b>		
HYFTOR 0.2% GEL	T3	PA
L-MESITRAN SOFT	T3	
<b>TOPICAL ANTIBIOTIC PLEUROMUTILIN DERIVATIVES</b>		
ALTABAX	T3	ST QL (30 units/30 days)

T1 – Typically Generics

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## List of Prescription Medications

SKIN PREPS (Skin Conditions) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>TOPICAL ANTICHOLINERGIC HYPERHIDROSIS TX AGENTS</b>		
QBREXZA	T3	PA
<b>TOPICAL ANTI-INFLAMMATORY STEROIDAL</b>		
ALA-SCALP HP ( <i>hydrocortisone</i> )	T3	ST
<i>alclometasone dipropionate</i>	T1	
<i>amcinonide</i>	T1	
<i>apexicon e</i>	T1	
<i>beser (Cutivate)</i>	T1	
<i>betamethasone</i>	T1	
<i>betamethasone dipropionate</i>	T1	
<i>betamethasone valer 0.12% foam</i>	T1	ST
BRYHALI	T3	ST
CAPEX SHAMPOO	T3	ST
<i>clobetasol e</i>	T1	QL (120gm/23 days)
<i>clobetasol clobetasol 0.05% cream</i>	T1	QL (120 gms/30 days)
<i>clobetasol emollnt 0.05% foam</i>	T1	ST QL (100 gms/30 days)
<i>clobetasol propionate/emoll</i>	T1	ST QL (100 gms/30 days)
<i>clobetasol emulsion (Olux-E)</i>	T1	QL (100 units/23 days)
<i>clobetasol propionate</i>	T1	QL
CLOBEX SHAMPOO ( <i>clobetasol propionate</i> )	T3	ST QL (263ml/23 days)
CLOBEX SPRAY ( <i>clobetasol propionate</i> )	T3	ST QL (125ml/23 days)
CLOBEX TOPICAL LOTION ( <i>clobetasol propionate</i> )	T3	ST QL (118ml/23 days)
CLODAN	T3	ST
<i>clodan (Clobex)</i>	T1	QL (263ml/23 days)
CLODERM	T3	ST
CORDRAN	T3	ST QL
CUTIVATE ( <i>beser</i> )	T3	ST
DERMA-SMOOTH-E-FS ( <i>fluocinolone acetonide</i> )	T3	ST
DESONATE	T3	ST
<i>desonide (Desowen)</i>	T1	
<i>desonide 0.05% cream (Desowen)</i>	T1	
DESOWEN ( <i>desonide</i> )	T3	ST
<i>desoximetasone (Topicort)</i>	T1	
DIPROLENE ( <i>betamethasone diprop augmented</i> )	T3	ST
<i>fluocinolone acetonide</i>	T1	

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## List of Prescription Medications

SKIN PREPS (Skin Conditions) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>TOPICAL ANTI-INFLAMMATORY STEROIDAL (cont.)</b>		
<i>fluocinonide</i>	T1	QL
<i>fluocinonide-e</i>	T1	QL (120 gm/23 days)
<i>fluticasone prop 0.05% cream</i>	T1	
<i>fluticasone prop 0.05% lotion</i>	T1	ST
<i>fluticasone propionate</i>	T1	ST
<i>halobetasol prop 0.05% cream</i>	T1	
<i>halobetasol prop 0.05% foam</i>	T1	ST
<i>halobetasol prop 0.05% ointmnt</i>	T1	
<i>HALOG (halcinonide)</i>	T3	ST
<i>hydrocortisone</i>	T1	
<i>hydrocortisone butyrate</i>	T1	ST QL (10gm/28 days)
<i>hydrocortisone butyrate (Locoid Lipocream)</i>	T1	QL (120gm/23 days)
<i>hydrocortisone butyr 0.1% lotn</i>	T1	PA SP HD
<i>IMPEKLO</i>	T3	ST QL (136 gm/28 days)
<i>IMPOYZ</i>	T3	ST QL (120 gm/23 days)
<i>KENALOG (triamcinolone acetonide)</i>	T3	ST QL
<i>LEXETTE</i>	T3	PA SP HD
<i>mometasone</i>	T1	
<i>NUCORT</i>	T3	ST
<i>OLUX (clobetasol propionate)</i>	T3	ST QL (100 units/23 days)
<i>PANDEL</i>	T3	ST
<i>prednicarbate</i>	T1	
<i>procto-med hc</i>	T1	
<i>procto-pak</i>	T1	
<i>proctosol-hc</i>	T1	
<i>protozozone-hc</i>	T1	
<i>PSORCON (diflorasone di)</i>	T3	ST QL (120gm/23 days)
<i>SCALACORT DK</i>	T3	ST
<i>SERNIVO</i>	T3	ST
<i>SYNALAR (fluocinolone acetonide)</i>	T3	ST
<i>SYNALARTS</i>	T3	ST
<i>TEMOVATE (clobetasol propionate)</i>	T3	ST QL (120 gm/23 days)
<i>TEXACORT</i>	T3	ST
<i>TOPICORT (desoximetasone)</i>	T3	ST

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

PA – Prior Authorization

QL – Quantity Limit

ST – Step Therapy

AGE – Age Requirement

SP – Specialty Medication

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## List of Prescription Medications

SKIN PREPS (Skin Conditions) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>TOPICAL ANTI-INFLAMMATORY STEROIDAL (cont.)</b>		
tovet emollient (Olux-E)	T1	QL (100 units/23 days)
triamcinolone acetonide	T1	
triamcinolone acetonide (Kenalog)	T1	QL
trianex	T1	
triderm	T1	
TRIDESILON (desonide)	T3	ST
ULTRAVATE	T3	ST
<b>TOPICAL ANTI-INFLAMMATORY STEROID-LOCAL ANESTHETIC</b>		
ANALPRAM-HC ( <i>hc pramoxine</i> )	T3	ST
EPIFOAM	T3	ST
EPIFOAM	T3	ST
<i>hc pramoxine</i> (Pramosone)	T1	
<i>lidocaine-hc</i>	T1	
PRAMOSONE	T3	ST
<b>TOPICAL ANTI-PARASITICS</b>		
<i>lindane</i>	T1	
<i>malathion</i> (Ovide)	T1	
OVIDE ( <i>malathion</i> )	T3	
<b>TOPICAL PREPARATIONS, ANTIBACTERIALS</b>		
<i>iodine</i>	T1	
<i>iodine</i> (Lugol'S)	T1	
IODOFLEX	T3	
IODOSORB	T3	
<b>TOPICAL VIT D ANALOG/ANTI-INFLAMMATORY STEROID</b>		
<i>calcipotriene-betamethasone</i> (Taclonex)	T1	QL (60 gm/23 days)
<i>calcipotriene-betamethasone dp</i> (Taclonex)	T1	QL (60 gm/23 days)
ENSTILAR	T2	QL (60 gm/23 days)
ENSTILAR FOAM	T2	QL ST
<b>TOPICAL/MUCOUS MEMBR./SUBCUT. ENZYMES</b>		
SANTYL	T2	QL
<b>VITAMIN A DERIVATIVES</b>		
<i>adapalene</i> (Differin)	T1	
AKLIEF	T3	PA ST
ALTRENO	T3	PA

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

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AGE – Age Requirement

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## List of Prescription Medications

SKIN PREPS (Skin Conditions) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>VITAMIN A DERIVATIVES (cont.)</b>		
AVITA	T3	PA
<i>avita</i> (Avita)	T1	PA
DIFFERIN ( <i>adapalene</i> )	T3	ST
RETIN-A ( <i>tretinoin</i> )	T3	PA
<i>tretinoin</i>	T1	
<i>tretinoin</i> (Atralin)	T1	PA
<i>tretinoin</i> (Avita)	T1	PA
<i>tretinoin microsphere</i> (Retin-A Micro Pump)	T1	PA
<i>tretinoin microsphere</i> (Retin-A Micro)	T1	PA
<b>VITAMIN A DERIVATIVES, TOPICAL ACNE AGENTS</b>		
FABIOR	T3	PA
<b>SMOKING DETERRENTS (Smoking Cessation)<sup>8</sup></b>		
<b>SMOKING DETERRENT AGENTS (GANGLIONIC STIM, OTHERS)</b>		
NICODERM CQ ( <i>nicoderm cq</i> )	T2	QL (180 days supply/365 days) PPACA
NICODERM CQ ( <i>nicotine patch</i> )	T2	QL (180 days supply/365 days) PPACA
<i>nicorelief</i> (Nicorette)	T1	QL (180 days supply/365 days) PPACA
NICORETTE	T2	QL (180 days supply/365 days) PPACA
NICORETTE ( <i>nicorelief</i> )	T2	QL (180 days supply/365 days) PPACA
NICORETTE ( <i>nicotine gum</i> )	T2	QL (180 days supply/365 days) PPACA
<i>nicotine</i>	T1	QL (180 days supply/365 days) PPACA
<i>nicotine</i> (Nicoderm CQ)	T1	QL (180 days supply/365 days) PPACA
<i>nicotine</i> (Nicorette)	T1	QL (180 days supply/365 days) PPACA
<i>nicotine gum</i> (Nicorette)	T1	QL (180 days supply/365 days) PPACA
NICOTROL	T3	QL (180 days supply/365 days)
NICOTROL NS	T3	QL (180 days supply/365 days)
<i>quit 2</i> (Nicorette)	T1	QL (180 days supply/365 days) PPACA
<i>quit 4</i> (Nicorette)	T1	QL (180 days supply/365 days) PPACA
<i>stop smoking aid</i> (Nicorette)	T1	QL (180 days supply/365 days) PPACA
<i>varenicline 0.5 mg tablet</i>	T1	
<i>varenicline 1 mg tablet</i>	T1	
<i>varenicline starting month box</i>	T1	
<b>SMOKING DETERENT-NICOTINIC RECEPT.PARTIAL AGONIST</b>		
CHANTIX	T3	QL (180 Days Supply/365 Days)

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

PA – Prior Authorization

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## List of Prescription Medications

SMOKING DETERRENTS (Smoking Cessation) <sup>8</sup> (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>SMOKING DETERRENTS, OTHER</b>		
bupropion sr	T1	QL (180 days supply/365 days) PPACA
<b>THYROID PREPS (Hormonal Agents)</b>		
<b>ANTI-THYROID PREPARATIONS</b>		
methimazole	T1	HD
propylthiouracil	T1	HD
<b>THYROID HORMONES</b>		
adthyza 15 mg tablet	T1	HD
adthyza 30 mg tablet	T1	HD
adthyza 60 mg tablet	T1	HD
adthyza 90 mg tablet	T1	HD
adthyza 120 mg tablet	T1	HD
ERMEZA SOLUTION	T3	ST HD
EUTHYROX (Ethyroxlevothyroxine )	T1	HD
LEVO-T (Ethyroxlevothyroxine )	T1	HD
LEVO-T (Levo-Tlevothyroxine )	T1	HD
levothyroxine	T1	HD
levoxyl (Ethyrox)	T1	HD
liothyronine (Cytomel)	T1	HD
nature-throid	T1	
np thyroid (Armour Thyroid)	T1	HD
thyroid (Armour Thyroid)	T1	
unithroid (Ethyrox)	T1	HD
unithroid (Levo-T)	T1	HD
westhroid	T1	HD
<b>UNCLASSIFIED DRUG PRODUCTS (AIDS/HIV)</b>		
<b>CYTOCHROME P450 INHIBITORS</b>		
TYBOST	T3	SP
<b>UNCLASSIFIED DRUG PRODUCTS (Asthma/COPD/Respiratory)</b>		
<b>CYSTIC FIBROSIS-CFTR POTENTIATOR-CORRECTOR COMBIN.</b>		
ALYFTREK 10-50-125 MG TABLET	T2	PA QL (56 tabs/fill) SP HD
ALYFTREK 4-20-50 MG TABLET	T2	PA QL (84 tabs/fill) SP HD
BRONCHITOL 40 MG INHALE CAPSULE	T3	PA SP
ORKAMBI	T2	PA QL (56 packets/28 days) SP HD

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

PA – Prior Authorization

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## List of Prescription Medications

UNCLASSIFIED DRUG PRODUCTS (Asthma/COPD/Respiratory) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>CYSTIC FIBROSIS-CFTR POTENTIATOR-CORRECTOR COMBIN. (cont.)</b>		
SYMDEKO	T2	PA QL SP HD
TRIKAFTA 80-40-60MG/59.5MG PKT	T2	SP PA HD QL (56 packets/28 days)
TRIKAFTA 100-50-75 MG/75MG PKT	T2	SP PA HD QL (56 packets/28 days)
<b>CYSTIC FIB-TRANSMEMB CONDUCT.REG.(CFTR) POTENTIATOR</b>		
KALYDECO 5.8 MG GRANULES PKT	T2	PA QL (56 packs/fill) SP HD
KALYDECO 13.4MG GRANULES PKT	T2	PA SP QL (56 packets/28 days)
<b>LUNG SURFACTANTS</b>		
CUROSURF	T3	
INFASURF	T3	
SURVANTA	T3	
<b>MUCOLYTICS</b>		
PULMOZYME	T2	SP HD
<b>PULMONARY FIBROSIS - SYSTEMIC ENZYME INHIBITORS</b>		
OFEV	T2	PA QL SP HD
<b>SYSTEMIC ENZYME INHIBITORS</b>		
JOENJA 70 MG TABLET	T3	PA SP QL (60 tabs/30 days)
VIOJOICE	T2	SP PA QL (28 tabs/30 days)
VIOJOICE 50 MG GRANULE PACKET	T2	PA QL (28 Packs/28 days) SP
ZOKINVY	T3	PA QL (max 120 caps/30 days)
<b>THYMIC STROMAL LYMPHOPOIETIN (TSLP) INHIBITORS</b>		
TEZSPIRE 210 MG/1.91 ML PEN	T2	SP PA HD QL (1 pen/28 days)
TEZSPIRE 210 MG/1.91 ML SYRING	T2	SP PA HD QL (1 syringe/28 days)
UNCLASSIFIED DRUG PRODUCTS (Blood Pressure/Heart Medications)		
<b>BRADYKININ B2 RECEPTOR ANTAGONISTS</b>		
icatibant (Firazyr)	T1	PA SP HD
<b>PLASMA KALLIKREIN INHIBITORS</b>		
KALBITOR	T3	PA SP HD
ORLADEYO 110MG, 150MG CAPSULE	T3	PA SP QL (28 caps/28 days)
TAKHZYRO 300MG/2ML	T2	PA SP HD QL (2 units/28 days)
UNCLASSIFIED DRUG PRODUCTS (Cancer)		
<b>ANTINEOPLASTIC - ANTIMETABOLITES</b>		
FLUOROURACIL	T2	

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

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## List of Prescription Medications

UNCLASSIFIED DRUG PRODUCTS (Cancer) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>CHEMOTHERAPY RESCUE/ANTIDOTE AGENTS</b>		
leucovorin	T1	
mesna (Mesnex)	T1	SP CSL
MESNEX (mesna)	T2	SP CSL
VISTOGARD 10GM PKT	T2	PA QL (20 pkts/30days) SP
UNCLASSIFIED DRUG PRODUCTS (Dental Products)		
<b>DENTAL AIDS AND PREPARATIONS</b>		
chlorhexidine gluconate	T1	
<b>DENTAL AIDS AND PREPARATIONS (cont.)</b>		
oralone	T1	
PERIDEX (chlorhexidine gluconate)	T3	
periogard	T1	
triamcinolone acetonide	T1	
<b>PERIODONTAL COLLAGENASE INHIBITORS</b>		
doxycycline hyclate	T1	
UNCLASSIFIED DRUG PRODUCTS (Erectile Dysfunction)		
<b>DRUGS TO TREAT ERECTILE DYSFUNCTION (ED)</b>		
avanafil (Stendra)	T1	PA QL (8 tabs/30 days)
CIALIS (tadalafil)	T3	PA QL (8 tabs/30 days)
sildenafil 25 mg tablet (Viagra)	T1	PA QL (8 tabs/30 days) HD
sildenafil 50 mg tablet (Viagra)	T1	PA QL (8 tabs/30 days) HD
sildenafil 100 mg tablet (Viagra)	T1	PA QL (8 tabs/30 days) HD
STENDRA (avanafil)	T3	PA QL (8 tabs/30 days)
tadalafil 2.5 mg tablet	T1	PA QL (30 tabs/30 days) HD
tadalafil 5 mg tablet (Cialis)	T1	PA QL (8 tabs/30 days) HD
tadalafil 10 mg tablet (Cialis)	T1	PA QL (8 tabs/30 days) HD
tadalafil 20 mg tablet (Cialis)	T1	PA QL (8 tabs/30 days) HD
UNCLASSIFIED DRUG PRODUCTS (Eye Conditions)		
<b>NICOTINIC RECEPT.PARTIAL AGONIST, ALPHA4BETA2 SPEC</b>		
TYRVAYA 0.03 MG NASAL SPRAY	T3	PA
UNCLASSIFIED DRUG PRODUCTS (Gastrointestinal/Heartburn)		
<b>AGENTS FOR STOMATOLOGICAL USE</b>		
PROTHELIAL	T3	

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

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## List of Prescription Medications

UNCLASSIFIED DRUG PRODUCTS (Gastrointestinal/Heartburn) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>CALCIMIMETIC, PARATHYROID CALCIUM ENHANCER</b>		
<i>cinacalcet hcl</i> (Sensipar)	T1	SP
<b>ORAL MUCOSITIS/STOMATITIS AGENTS</b>		
GELCLAIR	T3	
ORAMAGICRX	T3	
<b>ORAL MUCOSITIS/STOMATITIS ANTI-INFLAMMATORY AGENT</b>		
EPISIL	T3	
<b>PPAR AGONIST</b>		
IQIRVO	T2	PA SP HD
LIVDELZI	T2	PA SP
<b>SALIVA STIMULANT AGENTS</b>		
NUMOISYN	T3	
<b>SALIVA SUBSTITUTE AGENTS</b>		
AQUORAL	T3	
BOCASAL	T3	
CAPHOSOL	T3	
MUCOSITISRX	T3	
NEUTRASAL	T3	
NUMOISYN	T3	
SALIVAMAX	T3	
<b>THYROID HORMONE RECEPTOR (THR) AGONIST</b>		
REZDIFRA	T2	PA QL (30 tabs/30 days) SP HD
UNCLASSIFIED DRUG PRODUCTS (Hormonal Agents)		
<b>BONE FORMATION STIM. AGENTS - PARATHYROID HORMONE</b>		
FORTEO	T2	PA QL (1 pen/21 days) SP HD
<i>teriparatide 600 mcg/2.4ml pen</i>	T1	PA QL (1 pen/28 days) SP HD
TERIPARATIDE 620 MCG/2.48 ML	T3	PA QL (1 pen/28 days) SP
<b>BONE RESORPTION INHIBITORS</b>		
<i>ibandronate</i>	T1	QL (1 tab/30 days) HD
<b>GROWTH HORMONE RECEPTOR ANTAGONISTS</b>		
SOMAVERT	T2	SP HD
<b>HYPERPARTHYROID TX AGENTS - VITAMIN D ANALOG-TYPE</b>		
<i>doxercalciferol</i>	T1	
<i>paricalcitol</i>	T1	SP HD
<i>paricalcitol</i> (Zemplar)	T1	SP HD

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

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## List of Prescription Medications

UNCLASSIFIED DRUG PRODUCTS (Hormonal Agents) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>HYPERPARATHYROID TX AGENTS - VITAMIN D ANALOG-TYPE (cont.)</b>		
RAYALDEE	T3	
ZEMPLAR ( <i>paricalcitol</i> )	T3	SP HD
UNCLASSIFIED DRUG PRODUCTS (Miscellaneous)		
<b>ABORTIFACIENT-PROGESTERONE RECEPTOR ANTAGONISTS</b>		
MIFEPREX	T3	
<i>mifepristone 200 mg tablet</i>	T1	
<i>mifepristone (Mifeprex)</i>	T1	
<b>AGENTS TO TX PERIODIC PARALYSIS - CARBON ANHYD INH</b>		
<i>dichlorphenamide (Keveyis)</i>	T1	PA SP
<b>AMMONIA INHIBITORS</b>		
CARBAGLU ( <i>carglumic acid</i> )	T2	PA SP HD
<i>carglumic acid (Carbaglu)</i>	T1	PA SP HD
<b>AMYLOIDOSIS AGENTS-TRANSTHYRETIN (TTR) SUPPRESSION</b>		
TEGSEDI	T2	PA SP HD QL (4 syr/28 days)
<b>ANTI-ALCOHOLIC PREPARATIONS</b>		
<i>acamprosate</i>	T1	
ANTABUSE ( <i>disulfiram</i> )	T3	
<i>disulfiram (Antabuse)</i>	T1	
<b>ANTI-FIBROTIC THERAPY - PYRIDONE ANALOGS</b>		
ESBRIET	T3	PA QL (90 tabs/30 days) SP ST HD
<i>pirfenidone 267mg capsules</i>	T1	PA SP HD QL (270 caps/30 days)
<b>CI ESTERASE INHIBITORS</b>		
CINRYZE	T2	PA SP HD
HAEGARDA 2,000UNIT VIAL	T2	PA QL (24 vls/28 days) SP HD
HAEGARDA 3,000UNIT VIAL	T2	PA QL (16 vls/28 days) SP HD
RUCONEST	T2	PA SP HD
<b>CRYOPRESERVATIVE AGENTS</b>		
<i>cryoserv</i>	T1	
<b>DRUGS TO TREAT HEREDITARY TYROSINEMIA</b>		
<i>nitisinone (Orfadin)</i>	T1	PA SP HD
NITYR	T2	PA SP
<i>ORFADIN (nitisinone)</i>	T3	PA SP
<b>DRUGS TO TX GAUCHER DX-TYPE I, SUBSTRATE REDUCING</b>		
CERDELGA	T2	PA SP HD QL (56 caps/28 days)

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

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## List of Prescription Medications

UNCLASSIFIED DRUG PRODUCTS (Miscellaneous) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>GENERAL INHALATION AGENTS</b>		
chloride	T1	
HYPER-SAL	T3	
nebusal	T1	
NEBUSAL	T3	
pulmosal	T1	
sodium chloride 0.9% inhal vl	T1	
sodium chloride 10% vial	T1	
sodium chloride 3%, 7% vial	T1	
<b>GENETIC D/O TX - SMN PROTEIN DEFICIENCY TREATMENT</b>		
EVRYSDI 5 MG TABLET	T3	PA QL (30 tabs/30 days) SP HD
EVRYSDI 60 MG/80 ML(0.75MG/ML)	T3	PA QL (240 mls/30 days) SP HD
<b>GLUCOSYLCERAMIDE SYNTHASE (GCS) INHIBITOR</b>		
miglustat (Zavesca)	T1	PA QL (90 caps/30 days) SP
OPFOLDA	T3	PA QL (8 caps/fill) SP HD
<b>MENOPAUSAL SYMPTOMS SUPPRESSANT-NK3 RECEPTOR ANTAG</b>		
VEOZAH	T2	
<b>MENOPAUSAL SYMPTOMS SUPPRESSANT - SSRIs</b>		
paroxetine mesylate (Brisdelle)	T1	QL (30 units/30 days) HD
<b>METABOLIC DISEASE ENZYME REPLACE, HYPOPHOSPHATASIA</b>		
STRENSIQ	T2	PA SP
<b>METABOLIC DISEASE ENZYME REPLACEMENT, MOCD</b>		
NULIBRY 9.5 MG VIAL	T3	PA
<b>METABOLIC DISEASE ENZYME REPLACEMENT, POMPE DISEASE</b>		
NEXVIAZYME 100 MG VIAL	T3	PA
<b>METALLIC POISON, AGENTS TO TREAT</b>		
CHEMET	T2	PA
clovique (Syprine)	T1	PA SP HD
deferasirox (Exjade)	T1	PA SP HD
deferasirox (Jadenu)	T1	PA SP HD
deferiprone (Ferriprox (3 Times A Day)	T1	PA SP HD
FERRIPROX	T3	PA SP
GALZIN	T3	SP
RADIOGARDASE	T3	
SYPRINE (clovique)	T3	PA SP HD

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

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## List of Prescription Medications

UNCLASSIFIED DRUG PRODUCTS (Miscellaneous) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>NATRIURETIC PEPTIDES</b>		
VOXZOGO 0.4 MG VIAL	T3	PA SP
<b>NEONATAL FC RECEPTOR (FCRN) INHIBITORS</b>		
VYVGART HYTRULO	T3	PA SP HD
<b>PHARMACOLOGICAL CHAPERONE-ALPHA-GALACTOSID.A STABZ</b>		
GALAFOLD	T3	PA QL SP HD
<b>PROTEIN STABILIZERS</b>		
ATTRUBY	T2	PA SP
VYNDAMAX	T2	PA SP HD
VYNDAQEL	T2	PA SP HD
<b>RETINOIC ACID RECEPTOR (RAR) AGONISTS</b>		
SOHONOS 1 MG CAPSULE	T3	PA QL (112 caps/fill) SP
SOHONOS 1.5 MG CAPSULE	T3	PA QL (112 caps/fill) SP
SOHONOS 2.5 MG CAPSULE	T3	PA QL (140 caps/fill) SP
SOHONOS 5 MG CAPSULE	T3	PA QL (84 caps/fill) SP
SOHONOS 10 MG CAPSULE	T3	PA QL (56 caps/fill) SP
<b>SOLVENTS</b>		
<i>dy-o-derm</i>	T1	
FT ISOPROPYL ALCOHOL 91%	T3	
FT ISOPROPYL RUB ALCOHOL 70%	T3	
GNP ISOPROPYL ALCOHOL 70%	T3	
INSTACLEAN	T2	
ISOPROPANOL	T2	
<i>isopropyl alcohol</i>	T1	
ISOPROPYL ALCOHOL	T3	
ISOPROPYL ALCOHOL 70%	T3	
MURI-LUBE MINERAL OIL	T2	
<b>SUSPENDING AGENTS</b>		
GELFILM	T3	
HYDROXYPROPYLECELLULOSE	T2	
HYPROMELLOSE	T2	
<b>TREATMENT OF HYPERPHAGIA IN PRADER-WILLI SYNDROME</b>		
VYKAT XR	T3	PA SP

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

PA – Prior Authorization

QL – Quantity Limit

ST – Step Therapy

AGE – Age Requirement

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## List of Prescription Medications

UNCLASSIFIED DRUG PRODUCTS (Multiple Sclerosis)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
LEUKOCYTE ADHESION INHIB,ALPHA4-MEDIAT IGG4K MC AB TYSABRI 300 MG/15 ML VIAL	T2	PA QL (15 mL/30 days) HD
UNCLASSIFIED DRUG PRODUCTS (Nutritional/Dietary)		
METABOLIC DEFICIENCY AGENTS		
betaine ( <i>Cystadane</i> )	T1	PA SP
CARNITOR ( <i>levocarnitine</i> )	T3	
CARNITOR SF ( <i>levocarnitine sf</i> )	T3	
CYSTADANE	T2	PA ST SP
<i>levocarnitine</i> (Carnitor)	T1	
<i>levocarnitine sf</i> (Carnitor SF)	T1	
<i>levocarnitine</i> 4 gm/20 ml vial	T1	
UNCLASSIFIED DRUG PRODUCTS (Osteoporosis Products)		
BONE FORMATION STIM. AGENTS - PARATHYROID HORMONE		
BONSITY ( <i>teriparatide</i> )	T3	PA QL (1 pens/28 days) SP
<i>teriparatide</i> 560mcg/2.24ml pen (Bonsity)	T1	PA QL (1 pens/28 days) SP HD
<i>teriparatide</i> 560mcg/2.24ml pen (Forteo)	T1	PA QL (1 pen/28 days) SP HD
TERIPARATIDE 560 MCG/2.24 ML	T3	PA QL (1 pens/28 days) SP
BONE RESORPTION INHIBITOR AND VITAMIN D COMBS.		
FOSAMAX PLUS D	T3	ST QL (4 tabs/21 days) HD
BONE RESORPTION INHIBITORS		
ACTONEL 150 MG TABLET ( <i>risedronate</i> )	T3	ST QL (1 tab/23 days) HD
ACTONEL 35 MG TABLET ( <i>risedronate</i> )	T3	ST QL (4 tabs/21 days) HD
ACTONEL 5 MG TABLET ( <i>risedronate</i> )	T3	ST QL (30 units/30 days)
<i>alendronate</i> 10mg tablet	T1	QL (30 units/30 days) HD
<i>alendronate sodium</i> 40mg tablet	T1	HD
<i>alendronate</i> 35mg, 70mg tablets (Fosamax)	T1	QL (4 tabs/ 21 days) HD
<i>alendronate</i> 70 mg/75 ml	T1	QL (4 bottles/21 days) HD
ATELVIA ( <i>risedronate dr</i> )	T3	ST QL (4 tabs/21 days) HD
BINOSTO	T3	ST QL (4 tabs/21 days) HD
EVISTA ( <i>raloxifene hcl</i> )	T3	HD
FOSAMAX ( <i>alendronate</i> )	T3	ST QL (4 tabs/21 days) HD
<i>raloxifene hcl</i> (Evista)	T1	HD PPACA
<i>risedronate</i>	T1	QL HD
<i>risedronate dr</i> (Atelvia)	T1	QL (4 tabs/21 days) HD

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## List of Prescription Medications

UNCLASSIFIED DRUG PRODUCTS (Pain Relief And Inflammatory Disease)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>ANTI-INFLAM. INTERLEUKIN-1 RECEPTOR ANTAGONIST</b>		
ARCALYST	T3	PA SP HD
<b>ANTI-INFLAMMATORY, INTERLEUKIN-1 BETA BLOCKERS</b>		
ILARIS	T2	PA SP HD
<b>FIBROMYALGIA AGENTS, SEROTONIN-NOREPINEPHRINE INHIB</b>		
SAVELLA 100 MG TABLET	T2	ST QL (60 tabs/30 days)
SAVELLA 12.5 MG TABLET	T2	ST QL (60 tabs/30 days)
SAVELLA 25 MG TABLET	T2	ST QL (60 tabs/30 days)
SAVELLA 50 MG TABLET	T2	ST QL (60 tabs/30 days)
SAVELLA TITRATION PACK	T2	ST QL (55 tabs/30 days)
<b>IMMUNOMODULATOR, B-LYMPHOCYTE STIM (BLYS)-SPEC INHIB</b>		
BENLYSTA	T2	PA QL (4ml/28 days) SP HD
UNCLASSIFIED DRUG PRODUCTS (Skin Conditions)		
<b>INTERLEUKIN-13 (IL-13) INHIBITORS, MAB</b>		
ADBRY AUTOINJECTOR	T2	PA QL (2 auto-injs/28 days) SP HD
ADBRY 150MG/ML SYRINGE	T2	PA SP
EBGLYSS PEN	T2	PA QL (4 mls/28 days) SP
EBGLYSS SYRINGE	T2	PA SP
<b>JANUS KINASE (JAK) INHIBITORS</b>		
LITFULO	T3	PA QL (28 caps/28 days) SP HD
<b>WOUND HEALING AGENTS, LOCAL</b>		
FILSUVEZ	T3	PA SP
UNCLASSIFIED DRUG PRODUCTS (Substance Abuse)		
<b>OPIOID WITHDRAWAL THER, ALPHA-2 ADRENERGIC AGONIST</b>		
lofexidine (Lucemyra)	T1	PA QL (224 tabs/30 days)
<b>OPIOID WITHDRAWAL THERAPY AGENTS, OPIOID-TYPE</b>		
buprenorphine	T1	
buprenorphine-naloxone (Suboxone)	T1	QL
PROBUPHINE	T3	
SUBOXONE (buprenorphine-naloxone)	T3	QL
ZUBSOLV	T2	QL
UNCLASSIFIED DRUG PRODUCTS (Transplant Medications)		
<b>RHO KINASE INHIBITOR</b>		
REZUROCK 200 MG TABLET	T3	PA QL (30 tabs/30 days)

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## List of Prescription Medications

UNCLASSIFIED DRUG PRODUCTS (Urinary Tract Conditions)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>BENIGN PROSTATIC HYPERPLASIA/MICTURITION AGENTS</b>		
<i>alfuzosin hcl er</i> (Uroxatral)	T1	HD
<i>dutasteride</i> (Avodart)	T1	HD
<i>finasteride</i> (Proscar)	T1	HD
FLOMAX ( <i>tamsulosin hcl</i> )	T3	HD
PROSCAR ( <i>finasteride</i> )	T3	ST HD
<i>silodosin</i> (Rapaflo)	T1	HD
<i>tamsulosin hcl</i> (Flomax)	T1	HD
<b>BPH 5-ALPHA-REDUCTASE INHIB-ALPHAI-ADRENOCEP ANTAG</b>		
<i>dutasteride/tamsulosin hcl</i> (Jalyn)	T1	ST HD
JALYN ( <i>dutasteride/tamsulosin hcl</i> )	T3	ST HD
<b>CYSTINE-DEPLETING AGENTS, NEPHROPATHIC CYSTINOSIS</b>		
CYSTAGON	T2	SP
<b>ENDOTHELIN RECEPTOR ANTAGONISTS</b>		
VANRAFIA	T3	PA SP
<b>KIDNEY STONE AGENTS</b>		
THIOLA	T3	SP
<i>tiopronin 100 mg tablet</i> (Thiola)	T1	PA SP
<i>tiopronin dr 100 mg tablet</i> (Thiola Ec)	T1	PA SP
<i>tiopronin dr 100 mg tablet</i> (Thiola Ec)	T1	PA SP HD
<i>tiopronin dr 300 mg tablet</i> (Thiola Ec)	T1	PA SP
<i>tiopronin dr 300 mg tablet</i> (Thiola Ec)	T1	PA SP HD
<i>tiopronin</i> (Thiola Ec)	T1	PA SP
THIOLA EC ( <i>tiopronin</i> )	T3	PA SP
<b>OVERACTIVE BLADDER AGENTS, BETA-3 ADRENERGIC RECEPTOR ANTAGONISTS</b>		
GEMTESA	T3	
<i>mirabegron</i> (Myrbetriq)	T1	HD
MYRBETRIQ	T2	HD
MYRBETRIQ ( <i>mirabegron</i> )	T2	HD
<b>URINARY TRACT ANTI-SPASMODIC, M(3) SELECTIVE ANTAG.</b>		
<i>darifenacin er</i>	T1	HD
ENABLEX ( <i>darifenacin er</i> )	T3	ST
<i>fesoterodine er tablets</i> (generic)	T1	ST
<i>solifenacin succinate</i> (Vesicare)	T1	HD

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## List of Prescription Medications

UNCLASSIFIED DRUG PRODUCTS (Urinary Tract Conditions) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>URINARY TRACT ANTI-SPASMODIC/ANTI-INCONTINENCE AGENT</b>		
DITROPAN XL ( <i>oxybutynin chloride er</i> )	T3	ST HD
<i>flavoxate hcl</i>	T1	HD
<i>oxybutynin</i>	T1	HD
<i>oxybutynin chloride er</i> (Ditropan XL)	T1	HD
<i>oxybutynin 5 mg/5 ml soln cup</i>	T1	HD
OXYTROL	T3	ST QL (8 patches/21 days) HD
<i>tolterodine tartrate</i> (Detrol)	T1	HD
<i>tolterodine tartrate er</i> (Detrol LA)	T1	HD
TOVIAZ	T3	ST HD
TOVIAZ ER	T3	HD
<i>trospium chloride</i>	T1	HD
<b>UNCLASSIFIED DRUG PRODUCTS (Weight Management)</b>		
<b>APPETITE STIM. FOR ANOREXIA, CACHEXIA, WASTING SYND.</b>		
<i>megestrol acetate</i>	T1	
<b>VITAMINS (Nutritional/Dietary)</b>		
<b>ANTIOXIDANT MULTIVITAMIN COMBINATIONS</b>		
EYE HEALTH WITH LUTEIN	T3	
LUTEIN PLUS WITH ZEAXANTHIN	T3	
VISION OPTIMIZER	T3	
VITEYES AREDS 2 PLUS MULTIVIT	T3	
<b>BIOFLAVONOIDS</b>		
FLAVOVIT	T3	
LIPO FLAVONOID	T3	
<b>FOLIC ACID PREPARATIONS</b>		
COBALEFOL	T3	
FOLETRA	T3	
DEPLIN FC	T3	
<i>folic acid</i>	T1	PPACA
<i>ft folic acid 400 mcg, 800 mcg tablet</i>	T1	PPACA
MI-VITE RX	T3	
PUREVITA FOLIC ACID	T3	
<i>true folic acid 667 mcg dfe tb</i>	T1	PPACA
<i>true folic acid 1600mcg dfe tb</i>	T1	

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## List of Prescription Medications

VITAMINS (Nutritional/Dietary) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>MULTIVITAMIN PREPARATIONS</b>		
ABC COMPLETE ADULT	T2	
ABC COMPLETE MEN'S	T2	
ACTIVNUTRIENTS PERFORMANCE	T3	
ADULT MULTI	T3	
ALIVE ADULT ULTRA POTENCY	T3	
ALIVE COMPLETE PREMIUM PRENATL	T3	
ALIVE MAX6 POTENCY	T3	
ALIVE WOMEN'S 50 PLUS COMPLETE	T3	
ALIVE WOMEN'S MULTIVITAMIN	T3	
ALIVE DAILY ENERGY	T3	
ALIVE HAIR, SKIN AND NAILS	T3	
ALIVE MEN'S 50 PLUS GUMMY	T3	
ALIVE MEN'S 50 PLUS ULTRA	T3	
ALIVE MEN'S ULTRA POTENCY	T3	
ALIVE PREMIUM ADULT	T3	
ALIVE MEN'S ENERGY	T3	
ALIVE MEN'S GUMMY	T3	
ALPHA BETIC MULTIVITAMIN	T3	
ALTRIXA	T3	
<i>b complex w-vitamin c</i>	T1	PPACA
CENTRUM ADULT 50 PLUS	T3	
CENTRUM CENTRUM WOMEN IMMUNE MINIS	T3	
CENTRUM MEN 50 PLUS	T3	
CENTRUM MEN MULTIGUMMY	T3	
CENTRUM MEN'S TABLET	T2	
CENTRUM MULTI PLUS BEAUTY	T3	
CENTRUM MULTI PLUS OMEGA-3	T3	
CENTRUM WOMEN 50 PLUS	T3	
CENTRUM WOMEN MULTIGUMMY	T3	
<i>centrum women tablet</i> (Certavite-Antioxidant)	T1	
<i>centrum women tablet</i> (Tab-A-Vite Multivit With Iron)	T1	
cvs adult multivitamin gummy	T1	
DAILY MULTIPLE	T2	
DAVIMET WITH IRON	T3	

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## List of Prescription Medications

VITAMINS (Nutritional/Dietary) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>MULTIVITAMIN PREPARATIONS (cont.)</b>		
DIABETES HEALTH PACK	T3	
DIATROL	T3	
EQ ONE DAILY MEN'S TABLET	T2	
FINAZOL	T3	
FOLAPRIME	T3	
FLORRAXYL	T3	
<i>ft b complex plus vit c tablet</i>	T1	
FT HAIR, SKIN AND NAILS TABLET	T3	
<i>ft one daily men's tablet</i>	T1	
<i>ft one daily women's tablet</i>	T1	
MEN'S DAILY MULTIVITAMIN	T2	
<i>multivit no.18/iron no.1/folic (Tandem Plus)</i>	T1	
MEN'S ONE DAILY	T2	
MULTIA DAILY MULTIVITAMIN	T3	
<i>multivit-minerals/folic acid</i>	T1	
MULTIVITAMIN-MULTIMINERAL	T3	
<i>mv-mn/folic ac/calcium/vit k1</i>	T1	
<i>mv-min 59/iron/folic/docusate</i>	T1	
MVW MODULATR FORM MINI MULTIVT	T3	
NIVA-PLUS ( <i>multivit-min 60/iron fum/folic</i> )	T3	
NUTRALYN	T3	
ONE-A-DAY TRIPLE IMMUNE SUPRT	T3	
ONE-A-DAY WOMEN'S 50 PLUS TAB	T3	
<i>one-a-day women's 50 plus tab (One-A-Day)</i>	T1	
ONE DAILY ESSENTIALS	T3	
<i>one daily multivit-mineral tab</i>	T1	
ONE DAILY MULTIVIT-MINERAL TAB	T3	
PRENATAL GUMMIES	T3	
<i>super b-complex w/vitamin c</i>	T1	PPACA
SUPERIOR MEN'S MULTI	T3	
TANDEM PLUS ( <i>multivit no.18/iron no.1/folic</i> )	T3	
<i>thera-m caplet, tablett</i>	T1	
THERA-M CAPLET	T3	
TRIVIA COMPLETE	T3	

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## List of Prescription Medications

VITAMINS (Nutritional/Dietary) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>MULTIVITAMIN PREPARATIONS (cont.)</b>		
TRUE MULTIVITAMIN	T3	
VITACORE	T3	
VITAFUSION PRENATAL	T3	
VITAJOY ADULT MULTI	T3	
<i>vitamin b complex with c</i>	T1	HD PPACA
<b>NIACIN PREPARATIONS</b>		
<i>ft niacin 400 mg capsule</i>	T1	
NIACIN 100 MG CAPSULE	T3	
NIACINAMIDE 500 MG CAPSULE	T3	
PUREVITA VITAMIN B3	T3	
<i>true vitamin b3 50 mg tablet</i>	T1	
<i>true vitamin b3 500 mg tablet</i>	T1	
TRUE VITAMIN B3 250 MG TABLET	T3	
<b>PANTHENOL PREPARATIONS</b>		
PANTOTHENIC ACID	T3	
PUREVITA VITAMIN B5	T3	
<b>PEDIATRIC VITAMIN PREPARATIONS</b>		
ALIVE KIDS MULTIVITAMIN	T3	
DAVIMET WITH FLUORIDE	T3	
EMERGEN-C KIDZ DAILY IMMUNE	T3	
EMERGEN-C KIDZ IMMUNE PLUS	T3	
FLINTSTONES IMMUNITY SUPPORT	T3	
FLORAFOL PEDIATRIC	T3	
FLORAFOL FE PEDIATRIC	T3	
GUMMY DINOS	T3	
LIVITA FOR CHILDREN	T3	
MVW MODULATR FORMLTN PEDIATRIC	T3	
NOVAFERRUM YUM PEDIATR MV-IRON	T3	
NOVAMV MMM PEDIATRIC MULTIVIT	T3	
<i>pedi multivit no.17 w-fluoride</i>	T1	PPACA
<i>pediatric multivitamin no.111</i>	T1	
<i>pediatric multivitamin no.212</i>	T1	
MULTIVIT-FLUOR 0.5 MG TAB CHEW	T3	
MULTIVIT-FLUORIDE 1 MG TAB CHW	T3	

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## List of Prescription Medications

VITAMINS (Nutritional/Dietary) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>PEDIATRIC VITAMIN PREPARATIONS (cont.)</b>		
<i>multivitamin with fluoride</i>	T1	PPACA
<i>mvc-fluoride</i>	T1	PPACA
SOLUVITA MULTIVITAMIN FLUORIDE	T3	
SOLUVITA MULTIVITAMIN FLUORIDE (pedi multivit no.82 w-fluoride)	T3	
<i>tri-vit-fluor 0.25 mg/ml drop</i>	T1	PPACA
TRI-VIT-FLUOR 0.25 MG/ML DROP	T3	
<i>tri-vit-fluor 0.5 mg/ml drop</i>	T1	PPACA
<i>tri-vitamin with fluoride</i>	T1	PPACA
<i>vitamins a, c, d &amp; fluoride</i>	T1	PPACA
<b>VITAMIN A PREPARATIONS</b>		
FT VITAMIN A 3,000 MCG SOFTGEL	T3	
GNP VITAMIN A 3,000 MCG SOFTGL	T3	
PUREVITA VITAMIN A	T3	
<b>VITAMIN B PREPARATIONS</b>		
<i>acetylcyst/methylb12/levomefol</i> (Cerefolin Brain Wellness)	T1	HD
<i>b complex</i>	T1	HD PPACA
<i>b complex, c no.20/folic acid</i> (Virt-Caps)	T1	HD
<i>b complex w-vitamin c</i>	T1	HD PPACA
B-COMPLEX 100	T3	HD
B-COMPLEX FAST DISSOLVE TABLET	T3	HD
<i>balance b</i>	T1	HD PPACA
<i>balanced b-complex</i>	T1	HD PPACA
CEREFOLIN BRAIN WELLNESS ( <i>acetylcyst/methylb12/levomefol</i> )	T3	HD
COMPLETE LIVER CLEANSE	T3	HD
CVS BIOTIN 5,000 MCG TABLET	T3	HD
<i>dialyvite 800</i> (Nephro-Vite)	T1	HD PPACA
FOLIKA-BC	T3	HD
<i>foltabs 800</i>	T1	HD PPACA
<i>ft biotin 5,000 mcg capsule</i> (Meribin)	T1	HD
FT BIOTIN 10,000 MCG TABLET	T2	HD
FT BIOTIN 2,500 MCG GUMMY	T3	HD
<i>full spectrum b</i> (Nephro-Vite)	T1	HD PPACA
KIDS BRAIN BUILDER	T3	HD
METANXPRO NERVE HEALTH	T3	HD

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## List of Prescription Medications

VITAMINS (Nutritional/Dietary) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>VITAMIN B PREPARATIONS (cont.)</b>		
METANX FC	T3	HD
METANX RR	T3	HD
MINCORA	T3	HD
PUREVITA SUPER B-COMPLEX	T3	HD
RELCARE	T3	HD
<i>rena-vite</i> (Nephro-Vite)	T1	HD PPACA
<i>vit b comp/folic/choline/inosi</i>	T1	HD PPACA
<i>super b complex-vitamin c</i>	T1	HD PPACA
VIRT-CAPS ( <i>b complex, c no.20/folic acid</i> )	T3	HD
<i>vitamin b complex</i>	T1	HD PPACA
<i>vitamin b-complex &amp; c</i>	T1	HD PPACA
<i>super b-50 complex capsule</i>	T1	HD
<i>super b-50 complex capsule</i>	T1	HD PPACA
<i>vit b comp c 19/folic acid/d3</i>	T1	HD PPACA
VITAJOY BIOTIN	T3	HD
<b>VITAMIN B1 PREPARATIONS</b>		
<i>cvs vitamin b-1 100 mg tablet</i>	T1	
<i>ft vitamin b-1 100 mg tablet</i>	T1	
<i>gnp vitamin b-1 100 mg tablet</i>	T1	
PUREVITA VITAMIN B1	T3	
<i>ra vitamin b-1 100 mg tablet</i>	T1	
THIAMINE HCL-0.9% NACL	T3	
<i>true vitamin b-1 100 mg tablet</i>	T1	
TRUE VITAMIN B-1 250 MG TABLET	T3	
TRUE VITAMIN B-1 50 MG TABLET	T3	
VITAMIN B-1 100 MG CAPSULE	T3	
<i>vitamin b-1 100 mg tablet</i>	T1	
<i>vitamin b-1 250 mg tablet</i>	T1	
<i>vitamin b-1 50 mg tablet</i>	T1	
<b>VITAMIN B12 PREPARATIONS</b>		
<i>cvs vitamin b12 5,000 mcg chew</i>	T1	
CVS VIT B12 2,500 MCG SOFT CHW	T3	
CVS VITAMIN B12 5,000 MCG TAB	T3	
<i>cyanocobalamin</i>	T1	

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## List of Prescription Medications

VITAMINS (Nutritional/Dietary) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>VITAMIN B12 PREPARATIONS (cont.)</b>		
cyanocobalamin (vitamin b-12) (Nascobal)	T1	ST QL (4 units/30 days)
ft vit b-12 2,500 mcg tab sl	T1	
FT VITAMIN B-12 1500 MCG GUMMY	T3	
FT VITAMIN B-12 5,000 MCG TAB	T2	
ft vitamin b-12 500 mcg tablet	T1	
ft vitamin b12 er 1,000 mcg tb	T1	
GNP VITAMIN B-12 1500MCG GUMMY	T3	
hydroxocobalamin	T1	
NASCOBAL (cyanocobalamin (vitamin b-12))	T2	ST QL (4 units/30 days)
PAXLYTE	T3	
PUREVITA VITAMIN B12	T3	
true vitamin b-12 1000 mcg tab	T1	
true vitamin b-12 500 mcg tab	T1	
VITAMIN B12 2,500 MCG TABLET	T3	
<b>VITAMIN B2 PREPARATIONS</b>		
PUREVITA VITAMIN B2	T3	
RIBOFLAVIN 100 MG CAPSULE	T3	
<b>VITAMIN B6 PREPARATIONS</b>		
cvs vitamin b-6 100 mg tablet	T1	
eql vitamin b-6 100 mg tablet	T1	
ft vitamin b-6 100 mg tablet	T1	
gnp vitamin b-6 100 mg tablet	T1	
PUREVITA VITAMIN B6	T3	
pyridoxine hcl (vitamin b6) (Pyridoxine Hcl)	T1	
ra vitamin b-6 100 mg tablet	T1	
ra vitamin b-6 50 mg tablet	T1	
sm vitamin b-6 100 mg tablet	T1	
sv vitamin b-6 100 mg tablet	T1	
true vitamin b-6 100 mg tablet	T1	
true vitamin b-6 25 mg tablet	T1	
true vitamin b-6 50 mg tablet	T1	
TRUE VITAMIN B-6 10 MG TABLET	T3	
vitamin b-6 100 mg tablet	T1	
vitamin b-6 25 mg tablet	T1	

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

PA – Prior Authorization

QL – Quantity Limit

ST – Step Therapy

AGE – Age Requirement

SP – Specialty Medication

HD – May require home delivery pharmacy

PPACA – No Cost-Share Preventive Medication

CSL – Oral cancer medication subject to cost-share limits

## List of Prescription Medications

VITAMINS (Nutritional/Dietary) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>VITAMIN B6 PREPARATIONS (cont.)</b>		
vitamin b-6 250 mg tablet	T1	
vitamin b-6 50 mg tablet	T1	
<b>VITAMIN C PREPARATIONS</b>		
ascorbic acid 500 mg/5 ml cup	T1	
cvs vit c-rose hip 500 mg cplt	T1	
EASY-C IMMUNE HEALTH	T3	
EMERGEN-C APPLE CIDER VINEGAR	T3	
EMERGEN-C ASHWAGANDHA	T3	
EMERGEN-C ELDERBERRY	T3	
EMERGEN-C TURMERIC GINGER	T3	
FLEVOXIN	T3	
ft vit c-rose hip 1,000 mg tab	T1	
ft vit c-rose hips 500 mg tab	T1	
FT VITAMIN C 500 MG CHEW TAB	T2	
ft vitamin c 1,000 mg tablet	T1	
PUREVITA VITAMIN C	T3	
SAMBUCUS ELDERBERRY-VITAMIN C	T3	
true vitamin c 1,000 mg tablet	T1	
true vitamin c 250 mg tablet	T1	
true vitamin c 500 mg tablet	T1	
vit c-rose hips 500 mg capsule	T1	
VIT C-ROSE HIPS 500 MG CAPSULE	T1	
well vitamin c 1,000 mg tablet	T1	
well vitamin c 500 mg tablet	T1	
<b>VITAMIN D PREPARATIONS</b>		
calcitriol (Rocaltrol)	T1	HD
calcitriol 1 mcg/ml ampul	T1	
calcitriol 1 mcg/ml solution (Rocaltrol)	T1	
calcitriol 0.25 mcg capsule	T1	
calcitriol 0.5 mcg capsule	T1	
cvs vitamin d3 50 mcg tablet	T1	HD
CVS VITAMIN D3 250 MCG SOFTGEL	T3	HD
DERMACINRX FOLIXATE	T3	HD
DRISDOL (vitamin d2)	T3	HD

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## List of Prescription Medications

VITAMINS (Nutritional/Dietary) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>VITAMIN D PREPARATIONS (cont.)</b>		
<i>ft vitamin d3 25 mcg softgel</i>	T1	HD
<i>ft vitamin d3 50 mcg softgel</i>	T1	HD
<i>ft vitamin d3 125 mcg softgel</i>	T1	HD
FT VITAMIN D3 250 MCG SOFTGEL	T3	HD
<i>ft vitamin d3 25 mcg tablet</i>	T1	HD
<i>ft vitamin d3 50 mcg tablet</i>	T1	HD
<i>ft vitamin d3 125 mcg tablet</i>	T1	HD
FT VITAMIN D3 250 MCG TABLET	T3	HD
<i>gnp vitamin d3 50 mcg softgel</i>	T1	HD
GNP VITAMIN D3 250 MCG SOFTGEL	T3	HD
K2-D3 MAX	T3	HD
PUREVITA VITAMIN D3	T3	HD
ROCALTROL ( <i>calcitriol</i> )	T3	ST
<i>true vitamin d3 1,250 mcg tab</i>	T1	HD
<i>true vitamin d3 10 mcg capsule</i>	T1	HD
<i>true vitamin d3 10 mcg tablet</i>	T1	HD
<i>true vitamin d3 50 mcg tablet</i>	T1	HD
<i>true vitamin d3 125 mcg cap, tablet</i>	T1	HD
<i>true vitamin d3 25 mcg capsule</i>	T1	HD
<i>true vitamin d3 50 mcg capsule</i>	T1	HD
<i>true vitamin d3 25 mcg tablet</i>	T1	HD
TRUE VITAMIN D3 1,250 MCG CAP	T3	HD
TRUE VITAMIN D3 250 MCG CAP	T3	HD
TRUE VITAMIN D3 250 MCG TABLET	T3	HD
<i>vitamin d2 (Drisdol)</i>	T1	HD
<i>vitamin d2 1.25mg (50,000 unit)</i>	T1	HD
VITAMIN D2-VITAMIN K1	T3	HD
VITAMIN D2-VITAMIN K2	T3	HD
VITAMIN D3 50 MCG DISSOLVE TAB	T3	HD
VITAMIN D3 62.5 MCG SOFTGEL	T3	HD
<i>well vitamin d3 125 mcg softgl</i>	T1	HD
<i>well vitamin d3 25 mcg softgel</i>	T1	HD
<i>well vitamin d3 50 mcg softgel</i>	T1	HD
VITAMIN D3 10 MCG/ML ENFIT SYR	T3	HD

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## List of Prescription Medications

VITAMINS (Nutritional/Dietary) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>VITAMIN E PREPARATIONS</b>		
ft vitamin e 180 mg softgel	T1	
true vitamin e 180 mg capsule	T1	
PUREVITA VITAMIN E	T3	
TRUE VITAMIN E 450 MG CAPSULE	T3	
<b>VITAMIN K PREPARATIONS</b>		
FNP VITAMIN K2 40 MCG TABLET	T3	
ft vitamin k2 100 mcg capsule	T1	
gnp vitamin k2 100 mcg capsule	T1	
MEPHYTON (phytonadione)	T3	QL
phytonadione	T1	
phytonadione 1 mg/0.5 ml syr	T1	
vitamin k	T1	
VITAMIN K2 100 MCG SOFTGEL	T3	
<b>VITAMINS (Vitamins)</b>		
<b>MULTIVITAMIN PREPARATIONS</b>		
ALIVE MEN'S MAX3 POTENCY	T3	
BOOSTNOW IMMUNE SUPPORT	T3	
CENTRUM ADULTS 50 PLUS MINIS	T3	
CENTRUM MEN 50 PLUS MINIS	T3	
DAVIMET-M	T3	
DERMACINRX MULTIVITAMIN	T3	
LIVITA FOR ADULT	T3	
MULTITOL-M	T3	
NANOVM ADULT	T3	
SUPERIOR WOMEN'S MULTI	T3	
<b>PEDIATRIC VITAMIN PREPARATIONS</b>		
ft children's multi gummy	T1	
GNP CHILDREN'S MULTI GUMMY	T3	

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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:<sup>9</sup>

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

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

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

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



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

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

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

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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).