



Cigna Healthcare National Preferred 3-Tier Prescription Drug List

Coverage as of July 1, 2025

For the State of California

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

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 This drug list is subject to change and all prior versions are no longer in effect.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

951801 h CA NPF 3-Tier 07/25 © 2025 Cigna Healthcare.





What's Inside?	Page
Information about this drug list	3
· Frequently asked questions (FAQs)	3
· Words you may need to know	II
· About this drug list	I2
· How to read this drug list	I2
· How to find your medication	I6
List of prescription medications	I9
Exclusions and limitations for coverage	I71
Index of medications	I72

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® App¹ or myCigna.com[®].** As soon as your new plan year starts, log into your account and use the Price a Medication tool.

Questions?

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

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

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

Next planned update: 10/01/2025, for changes starting 01/01/2026

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.

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

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

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

Information about this drug list

Frequently asked questions (FAQs) (cont.)

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

A. If your doctor feels that your medication is necessary for your treatment and an alternative isn't right for you, he or she can ask Cigna Healthcare to consider approving coverage of your medication. Ask your doctor's office to contact Cigna Healthcare to start the coverage review process. They know how the review process works and will take care of everything for you. In case the office asks, they can download a request form from the Cigna Healthcare provider portal at cignaforhcp.com.

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

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

- **For non-urgent requests,** Cigna Healthcare will let you and your doctor know within 72 hours of the decision. If approved, coverage will be provided until the prescription runs out (including refills).
- **For urgent requests based on exigent circumstances,** Cigna Healthcare will let you and your doctor know within 24 hours of the decision. If approved, coverage will be provided for the duration of the exigency. **It's important to know that when medications are approved, it's typically for one year of coverage.** If your medication is approved for less time, it's

because there's a clinical reason based on Cigna Healthcare coverage requirements for the medication and/or the reviewing doctor.

Q. My medication was just taken off the drug list. My doctor still wants me to take it. What do I have to do to get it covered?

A. You don't need to do anything. If your doctor continues to prescribe the medication, we'll continue to cover it. If your medication already requires prior authorization, your doctor just has to continue to request (and receive) approval from Cigna Healthcare for the medication to be covered.

Q. My medication is part of the Step Therapy program. I don't want to try an alternative. How do I get approval (prior authorization) for my medication?

A. If you and your doctor feel an alternative medication won't work for you, your doctor can ask Cigna Healthcare to consider approving coverage of your current medication. Ask your doctor's office to contact Cigna Healthcare to start the coverage review process. They know how the review process works and will take care of everything for you. In case the office asks, they can download a request form from the Cigna Healthcare provider portal at cignaforhcp.com.

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

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

Information about this drug list

Frequently asked questions (FAQs) (cont.)

- **For non-urgent requests,** Cigna Healthcare will let you and your doctor know within 72 hours of the decision. If approved, coverage will be provided until the prescription runs out (including refills).
- **For urgent requests based on exigent circumstances,** Cigna Healthcare will let you and your doctor know within 24 hours of the decision. If approved, coverage will be provided for the duration of the exigency. If Cigna Healthcare doesn't respond to a completed prior authorization exception request within 72 hours of receiving a non-urgent request and 24 hours of receiving a request based on exigent circumstances, the request will be considered approved and your plan can't deny coverage of the medication.

Your Step Therapy rights under California State law:

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

Information about this drug list

Frequently asked questions (FAQs) (cont.)

this law, certain preventive medications (including some over-the-counter products) may be available to you at no cost-share (\$0), depending on your plan. Log in to the [myCigna App](#) or [myCigna.com](#), or check your plan materials, to learn more about how your plan covers preventive medications. You can also view the PPACA No Cost-Share Preventive Medications drug list at [Cigna.com/PDL](#). For more information about health care reform, go to [informedonreform.com](#) or [CignaHealthcare.com](#).

Q. What are preventive medications?

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

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

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

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

A. When you and your doctor are considering the right medication for your treatment, knowing how much it costs, what lower-cost alternatives are available and which pharmacies offer the best prices can help you avoid surprises. Log in to the [myCigna App](#) or [myCigna.com](#) and use the Price a Medication tool to see how much your medication costs before you get to the pharmacy counter – or, even before you leave your doctor's office.²

Q. What's a cost-share?

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

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

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

Q. What's a generic medication?

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

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

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

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

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

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

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

A. It depends. Some plans only allow fills at certain in-network pharmacies or through home delivery. Log in

Information about this drug list

Frequently asked questions (FAQs) (cont.)

to the **myCigna App** or **myCigna.com**, or check your plan materials, to learn more about the pharmacies in your plan's network.

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

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

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

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

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

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

Q. Can I fill my prescriptions by mail?

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

Express Scripts® Pharmacy for maintenance medications

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

- Easily order, manage, track and pay for your medications on your phone or online
- Standard shipping at no extra cost⁵
- Automatic refills or refill reminders

- Fill up to a 90-day supply at one time⁶
- Helpful pharmacists available 24/7
- Flexible payment options

Here are three easy ways to get started.

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

Accredo for specialty medications

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

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

To get started using Accredo, call **877.826.7657**, Monday–Friday, 7:00 am–10:00 pm CST and Saturdays, 7:00 am–4:00 pm CST. To learn more about Accredo, go to **Cigna.com/specialty**.

Information about this drug list

Frequently asked questions (FAQs) (cont.)

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

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

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

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

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

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

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

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

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

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

You may also be able to use Accredo, to fill your prescription. Accredo has access to most specialty

medications. Call **877.826.7657** for more information. Representatives are available Monday–Friday, 7:00 am–10:00 pm CST and on Saturdays, 7:00 am–4:00 pm CST.

Q. How do I fill my prescription?

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

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

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

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

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

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

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

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

A. Covered medications are divided into tiers (or cost-share levels). Typically, the higher the tier, the

Information about this drug list

Frequently asked questions (FAQs) (cont.)

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

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

Information about this drug list

Frequently asked questions (FAQs) (cont.)

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

Words you may need to know

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

Information about this drug list

Words you may need to know (cont.)

A generic drug is listed in bold and italicized lowercase letters.

- **Non-formulary drug:** A prescription drug that is not listed on the health plan's formulary.
- **Out-of-pocket costs:** Copayments, coinsurance, and the applicable deductible, plus all costs for health care services that are not covered by the health plan.
- **Prescribing provider:** A health care provider authorized to write a prescription to treat a medical condition for a health plan enrollee.
- **Prescription:** An oral, written, or electronic order by a prescribing provider for a specific enrollee that contains the name of the prescription drug, the quantity of the prescribed drug, the date of issue, the name and contact information of the prescribing provider, the signature of the prescribing provider if the prescription is in writing, and if requested by the enrollee, the medical condition or purpose for which the drug is being prescribed.
- **Prescription drug:** A drug that is prescribed by the enrollee's prescribing provider and requires a prescription under applicable law.

- **Prior Authorization:** A health plan's requirement that the enrollee or the enrollee's prescribing provider obtain the health plan's authorization for a prescription drug before the health plan will cover the drug. The health plan shall grant a prior authorization when it is medically necessary for the enrollee to obtain the drug.
- **Step Therapy:** A process specifying the sequence in which different prescription drugs for a given medical condition and medically appropriate for a particular patient are prescribed. The health plan may require the enrollee to try one or more drugs to treat the enrollee's medical condition before the health plan will cover a particular drug for the condition pursuant to a step therapy request. If the enrollee's prescribing provider submits a request for step therapy exception, the health plans shall make exceptions to step therapy when the criteria is met.
- **Subscriber:** The person who is responsible for payment to a plan or whose employment or other status, except for family dependency, is the basis for eligibility for membership in the plan.

About this drug list

This is a list of the most commonly prescribed medications covered on the Cigna Healthcare 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 in ***bold, lowercase italicized*** letters next to the brand-name medication.

Information about this drug list

How to read this drug list (cont.)

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

Tiers

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

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

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

Information about this drug list

How to read this drug list (cont.)

Letters (acronyms) next to medication names

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

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

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

Information about this drug list

How to read this drug list (cont.)

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

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

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
Analgesics (Pain Relief and Inflammatory Disease)	19-25	Anti-Infectives/Miscellaneous (Miscellaneous)	50
Analgesics (Urinary Tract Conditions)	25	Anti-Infectives/Miscellaneous (Skin Conditions)	51
Anesthetics (Miscellaneous)	25	Anti-Inflammatory Tumor Necrosis Factor Inhibiting Agents	51
Anesthetics (Pain Relief and Inflammatory Disease)	25, 26	(Pain Relief and Inflammatory Disease)	
Anesthetics (Urinary Tract Conditions)	26	Anti-Neoplastics (Cancer)	51-58
Anti-Allergy (Allergy and Nasal Sprays)	26	Anti-Neoplastics (Skin Conditions)	58
Anti-Arthritis (Pain Relief and Inflammatory Disease)	26-29	Anti-Obesity Drugs (Weight Management)	58, 59
Anti-Asthmatics (Asthma/COPD/Respiratory)	29-31	Anti-Parasitics (Eye Conditions)	59
Antibiotics (Ear Medications)	31, 32	Anti-Parasitics (Infections)	59
Antibiotics (Eye Conditions)	32, 33	Anti-Parkinson's Drugs (Parkinson's Disease)	59, 60
Antibiotics (Infections)	33-39	Anti-Platelet Drugs (Blood Thinners/Anti-Clotting)	60, 61
Antibiotics (Skin Conditions)	39-41	Antivirals (AIDS/HIV)	61-63
Anti-Coagulants (Blood Thinners/Anti-Clotting)	41, 42	Antivirals (Eye Conditions)	64
Antidotes (Gastrointestinal/Heartburn)	42	Antivirals (Infections)	64, 65
Antidotes (Substance Abuse)	42, 43	Antivirals (Skin Conditions)	65
Anti-Fungals (Eye Conditions)	43	Autonomic Drugs (Allergy/Nasal Sprays)	66
Anti-Fungals (Feminine Products)	43	Autonomic Drugs (Alzheimer's Disease)	66
Anti-Fungals (Infections)	43, 44	Autonomic Drugs (Attention Deficit Hyperactivity Disorder)	66, 67
Anti-Fungals (Skin Conditions)	44, 45	Autonomic Drugs (Blood Pressure/Heart Medications)	67
Antihistamine and Decongestant Combination (Allergy/Nasal Sprays)	45	Autonomic Drugs (Urinary Tract Conditions)	67
Antihistamines (Allergy/Nasal Sprays)	45, 46	Biologicals (Allergy/Nasal Sprays)	67
Antihistamines (Eye Conditions)	46	Biologicals (Blood Pressure/Heart Medications)	68
Anti-Hyperglycemics (Diabetes)	46-49	Biologicals (Miscellaneous)	68
Anti-Infectives/Miscellaneous (Feminine Products)	49	Biologicals (Vaccines)	68-70
Anti-Infectives/Miscellaneous (Infections)	49, 50	Blood (Blood Modifiers/Bleeding Disorders)	70, 71
		Blood (Blood Thinners/Anti-Clotting)	71
		Cardiac Drugs (Blood Pressure/Heart Medications)	71-74

Information about this drug list

How to find your medication (cont.)

Condition	Page	Condition	Page
Cardiovascular (Asthma/COPD/Respiratory)	74, 75	Hormones (Hormonal Agents)	I14-I19
Cardiovascular (Blood Pressure/Heart Medications)	75-79	Hormones (Infertility)	I19
Cardiovascular (Cholesterol Medications)	79-81	Hormones (Miscellaneous)	I19
CNS Drugs (Alzheimer's Disease)	81	Hormones (Osteoporosis Products)	I19
CNS Drugs (Miscellaneous)	81, 82	Immunosuppressants (Pain Relief and Inflammatory Disease)	I20
CNS Drugs (Multiple Sclerosis)	82, 83	Immunosuppressants (Skin Conditions)	I20, I21
CNS Drugs (Pain Relief and Inflammatory Disease)	83	Immunosuppressants (Transplant Medications)	I21
CNS Drugs (Seizure Disorders)	83-87	Miscellaneous Medical Supplies, Devices, Non-Drug (Diabetes)	I21-I32
CNS Drugs (Sleep Disorders/Sedatives)	87	Miscellaneous Medical Supplies, Devices, Non-Drug (Miscellaneous)	I32, I33
Colony Stimulating Factors (Blood Modifiers/Bleeding Disorders)	87	Muscle Relaxants (Pain Relief and Inflammatory Disease)	I33, I34
Colony Stimulating Factors (Cancer)	87	Prenatal Vitamins (Nutritional/Dietary)	I34, I35
Contraceptives (Contraception Products)	87-93	Psychotherapeutic Drugs (Anxiety/Depression/Bipolar Disorder)	I36-I38
Contraceptives (Miscellaneous)	93	Psychotherapeutic Drugs (Attention Deficit Hyperactivity Disorder)	I38-I40
Cough/Cold Preparations (Cough/Cold Medications)	93, 94	Psychotherapeutic Drugs (Schizophrenia/Anti-Psychotics)	I40, I41
Diagnostic (Diabetes)	95	Psychotherapeutic Drugs (Sleep Disorders/Sedatives)	I41
Diagnostic (Miscellaneous)	95, 96	Sedative/Hypnotics (Sleep Disorders/Sedatives)	I41, I42
Diuretics (Diuretics)	96-97	Skin Preps (Miscellaneous)	I43
EENT Preps (Allergy/Nasal Sprays)	98	Skin Preps (Pain Relief and Inflammatory Disease)	I43
EENT Preps (Ear Medications)	99	Skin Preps (Skin Conditions)	I43-I50
EENT Preps (Eye Conditions)	99-I03	Smoking Deterrents (Smoking Cessation)	I50, I51
Elect/Caloric/H2O (Dental Products)	I03, I04	Thyroid Prep (Hormonal Agents)	I51
Elect/Caloric/H2O (Diabetes)	I04	Unclassified Drug Products (AIDS/HIV)	I51
Elect/Caloric/H2O (Miscellaneous)	I05	Unclassified Drug Products (Asthma/COPD/Respiratory)	I51, I52
Elect/Caloric/H2O (Nutritional/Dietary)	I05-I07	Unclassified Drug Products (Blood Pressure/Heart Medications)	I52
Elect/Caloric/H2O (Urinary Tract Conditions)	I07, I08	Unclassified Drug Products (Cancer)	I52, I53
Gastrointestinal (Cholesterol Medications)	I08	Unclassified Drug Products (Dental Products)	I53
Gastrointestinal (Gastrointestinal/Heartburn)	I08-II4		
Gastrointestinal (Pain Relief and Inflammatory Disease)	II4		
Hormones (Gastrointestinal/Heartburn)	II4		

Information about this drug list

How to find your medication (cont.)

Condition	Page	Condition	Page
Unclassified Drug Products (Erectile Dysfunction)	I53	Unclassified Drug Products (Pain Relief and Inflammatory Disease)	I59
Unclassified Drug Products (Eye Conditions)	I53	Unclassified Drug Products (Skin Conditions)	I59
Unclassified Drug Products (Gastrointestinal/Heartburn)	I53, I54	Unclassified Drug Products (Substance Abuse)	I59
Unclassified Drug Products (Hormonal Agents)	I54, I55	Unclassified Drug Products (Transplant Medications)	I59
Unclassified Drug Products (Miscellaneous)	I55-I57	Unclassified Drug Products (Urinary Tract Conditions)	I60, I61
Unclassified Drug Products (Multiple Sclerosis)	I58	Unclassified Drug Products (Weight Management)	I61
Unclassified Drug Products (Nutritional/Dietary)	I58	Vitamins (Nutritional/Dietary)	I61-I70
Unclassified Drug Products (Osteoporosis Products)	I58	Vitamins (Vitamins)	I70

List of Prescription Medications

ANALGESICS (Pain Relief and Inflammatory Disease)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ANALGESIC, NON-SALICYLATE AND BARBITURATE COMBINAT		
acetaminophen w/butalbital	T1	
ALLZITAL	T3	PA
tencon	T1	
ANALGESIC, SALICYLATE, BARBITURATE, XANTHINE COMB.		
butalbital-asp-caffeine (Fiorinal)	T1	
FIORINAL (butalbital-aspirin-caffeine)	T3	PA
ANALGESIC, NON-SALICYLATE, BARBITURATE, XANTHINE COMB.		
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	
ANALGESIC/ANTIPYRETICS, SALICYLATES		
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
ANALGESICS, NON-OPIOID		
JOURNAVX	T3	QL (30 tabs/90 days)
ANTI-MIGRAINE PREPARATIONS		
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
ANTI-MIGRAINE PREPARATIONS (cont.)		
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)
NASAL NSAIDS, COX NON-SELECTIVE, SYSTEMIC ANALGESIC		
SPRIX	T3	ST QL
NSAIDS, CYCLOOXYGENASE INHIBITOR-TYPE ANALGESICS		
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
NSAIDS, CYCLOOXYGENASE INHIBITOR-TYPE ANALGESICS (cont.)		
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	
OPIOID ANALGESIC AND NON-SALICYLATE ANALGESICS		
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
OPIOID ANALGESIC AND NSAID COMBINATION		
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

AGE – Age Requirement

SP – Specialty Medication

HD – May require home delivery pharmacy

PPACA – No Cost-Share Preventive Medication

CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

ANALGESICS (Pain Relief and Inflammatory Disease) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
OPIOID ANALGESIC AND NON-SALICYLATE XANTHINE COMB		
apap-caffeine-dihydrocodeine (Trezix)	T1	PA QL
dvorah	T1	PA QL
TREZIX	T3	PA QL
OPIOID ANALGESICS		
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

SP – Specialty Medication

HD – May require home delivery pharmacy

PPACA – No Cost-Share Preventive Medication

CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

ANALGESICS (Pain Relief and Inflammatory Disease) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
OPIOID ANALGESICS (cont.)		
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 (hydrocodone bitartrate)	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

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
OPIOID ANALGESICS (cont.)		
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
OPIOID AND SALICYLATE ANALGESICS, BARBIT, XANTHINE		
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

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
OPIOID, NON-SALICYL, ANALGESIC, BARBITUATE, XANTHINE		
<i>butalbital/caff/apap/codeine</i> (Fioricet With Codeine)	T1	PA QL
<i>FIORICET WITH CODEINE (butalb-acetaminoph-caff-codein)</i>	T3	PA QL
SKELETAL MUSCLE RELAXANT, SALICYLAT, OPIOID ANALGES		
<i>carisoprodol-aspirin-codeine</i>	T1	PA QL
ANALGESICS (Urinary Tract Conditions)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
URINARY TRACT ANALGESIC AGENTS		
<i>ELMIRON</i>	T2	
<i>RIMSO-50</i>	T3	
ANESTHETICS (Miscellaneous)		
GENERAL ANESTHETICS, INHALANT		
<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)		
LOCAL ANESTHETICS		
<i>glydo</i>	T1	QL (60 ml/23 days)
<i>lidocaine</i>	T1	
<i>lidocaine hcl</i>	T1	QL (60 ml/23 days)
TOPICAL LOCAL ANESTHETICS		
<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	

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

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

PPACA – No Cost-Share Preventive Medication

CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

ANTI-ARTHRITICS (Pain Relief and Inflammatory Disease) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
COLCHICINE (cont.)		
MITIGARE (<i>colchicine</i>)	T2	ST
GOLD SALTS		
AURANOFIN	T2	
febuxostat (Uloric)	T1	HD
RIDAURA	T2	
ZYLOPRIM (<i>allopurinol</i>)	T3	HD
HYPURICEMIA TX - XANTHINE OXIDASE INHIBITORS		
<i>allopurinol</i>	T1	HD
<i>allopurinol</i> (Zyloprim)	T1	HD
JANUS KINASE (JAK) INHIBITORS		
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
NSAIDS (COX NON-SPEC.INHIB) AND PROSTAGLANDIN ANALOG		
ARTHROTEC (<i>diclofenac -misoprostol</i>)	T3	ST HD
<i>diclofenac -misoprostol</i> (Arthrotec 50)	T1	HD
<i>diclofenac -misoprostol</i> (Arthrotec 75)	T1	HD
NSAIDS, CYCLOOXYGENASE INHIBITOR - TYPE ANALGESICS		
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

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-ARTHRITICS (Pain Relief and Inflammatory Disease) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
NSAIDS, CYCLOOXYGENASE INHIBITOR - TYPE ANALGESICS (cont.)		
<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
NSAIDS, CYCLOOXYGENASE-2(COX-2) SELECTIVE INHIBITOR		
<i>celecoxib</i> (Celebrex)	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

ANTI-ARTHRITICS (Pain Relief and Inflammatory Disease) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
NSAIDS, CYCLOOXYGENASE-2(COX-2) SELECTIVE INHIBITOR (cont.)		
celecoxib	T1	HD
URICOSURIC AGENTS		
probenecid	T1	HD
probenecid w/colchicine	T1	HD
ANTI-ASTHMATICS (Asthma/COPD/Respiratory)		
ANTICHOLINERGICS, ORALLY INHALED LONG ACTING		
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
ANTICHOLINERGICS, ORALLY INHALED SHORT ACTING		
ATROVENT HFA	T3	QL HD
<i>ipratropium bromide</i>	T1	HD
BETA-ADRENERGIC AGENTS		
albuterol 2 mg/5 ml syrup cup	T1	HD
albuterol 8 mg/20 ml syrup cup	T1	HD
metaproterenol	T1	HD
terbutaline	T1	HD
BETA-ADRENERGIC AGENTS, INHALED, SHORT ACTING		
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	
levalbuterol hcl (Xopenex Concentrate)	T1	
levalbuterol hcl (Xopenex)	T1	
XOPENEX (<i>levalbuterol concentrate</i>)	T3	
XOPENEX (<i>levalbuterol hcl</i>)	T3	
BETA-ADRENERGIC AGENTS, INHALED, ULTRA-LONG ACTING		
ARCAPTA NEOHALER	T3	QL (30 units/30 days) HD
STRIVERDI RESPIMAT	T2	QL (1 inhaler/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

ANTI-ASTHMATICS (Asthma/COPD/Respiratory) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
BETA-ADRENERGIC AGENTS, ORALLY INHALED, LONG ACTING		
BROVANA	T3	QL HD
FORMOTEROL FUMARATE-NEBULIZER	T2	QL (120 mls/30 days) HD
PERFOROMIST	T3	QL HD
BETA-ADRENERGIC AND ANTICHOLINERGIC COMBO, INHALED		
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
BETA-ADRENERGIC AND GLUCOCORTICOID COMBO, INHALED		
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
BETA-ADRENERGIC-ANTICHOLINERGIC-GLUCOCORT, INHALED		
TRELEGY ELLIPTA	T2	QL
GLUCOCORTICOIDS, ORALLY INHALED		
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

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-ASTHMATICS (Asthma/COPD/Respiratory) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
GLUCOCORTICOIDS, ORALLY INHALED (cont.)		
QVAR REDIHALER 40 MCG	T2	QL (11 gms/30 days)
QVAR REDIHALER 80 MCG	T2	QL (22 gms/30 days)
INTERLEUKIN-5(IL-5) RECEPTOR ALPHA ANTAGONIST, MAB		
FASENRA PEN	T2	PA ST QL (1 pen/56 days) SP HD
LEUKOTRIENE RECEPTOR ANTAGONISTS		
ACCOLATE (zaflukast)	T3	HD
montelukast (Singulair)	T1	HD
zaflukast (Accolate)	T1	HD
MAST CELL STABILIZERS, ORALLY INHALED		
cromolyn	T1	HD
MONOCLONAL ANTIBODIES TO IMMUNOGLOBULIN E (IGE)		
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
MONOCLONAL ANTIBODY - INTERLEUKIN-5 ANTAGONISTS		
NUCALA	T2	PA QL (1 unit/21 days) SP HD
MUCOLYTICS		
acetylcysteine	T1	
PHOSPHODIESTERASE (PDE) INHIBITORS		
roflumilast 250 mcg tablet (Daliresp)	T1	PA QL (30 tabs/30 days) HD
roflumilast 500 mcg tablet (Daliresp)	T1	PA HD
XANTHINES		
ELIXOPHYLLIN	T3	HD
THEO-24	T3	HD
theophylline anhydrous	T1	HD
theophylline anhydrous (Elixophyllin)	T1	HD
ANTIBIOTICS (Ear Medications)		
EAR PREPARATIONS, ANTIBIOTICS		
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

PA – Prior Authorization

QL – Quantity Limit

ST – Step Therapy

AGE – Age Requirement

SP – Specialty Medication

HD – May require home delivery pharmacy

PPACA – No Cost-Share Preventive Medication

CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

ANTIBIOTICS (Ear Medications) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
EAR PREPARATIONS, ANTIBIOTICS (cont.)		
OTIPRIO	T3	QL
OTIC PREPARATIONS, ANTI-INFLAMMATORY-ANTIBIOTICS		
ciprofloxacin hcl/dexameth	T1	
CIPRODEX	T2	
ANTIBIOTICS (Eye Conditions)		
EYE ANTIBIOTIC AND GLUCOCORTICOID COMBINATIONS		
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	
EYE ANTIBIOTIC AND NSAID COMBINATIONS		
MOXIFLOXACIN-BROMFENAC	T3	
EYE ANTIBIOTIC, GLUCOCORTICOID AND NSAID COMB.		
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	
EYE SULFONAMIDES		
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	

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

PA – Prior Authorization

QL – Quantity Limit

ST – Step Therapy

AGE – Age Requirement

SP – Specialty Medication

HD – May require home delivery pharmacy

PPACA – No Cost-Share Preventive Medication

CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

ANTIBIOTICS (Eye Conditions) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
OPHTHALMIC ANTIBIOTICS		
<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> (Ocuflax)	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	
ANTIBIOTICS (Infections)		
2ND GEN. ANAEROBIC ANTIprotozoal-ANTIBACTERIAL		
SOLOSEC	T2	QL
ABSORBABLE SULFONAMIDE ANTIBACTERIAL AGENTS		
BACTRIM (<i>sulfamethoxazole-trimethoprim</i>)	T3	
BACTRIM DS (<i>sulfamethoxazole-trimethoprim</i>)	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

ANTIBIOTICS (Infections) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ABSORBABLE SULFONAMIDE ANTIBACTERIAL AGENTS (cont.)		
<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	
AMINOGLYCOSIDE ANTIBIOTICS		
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
ANAEROBIC ANTIprotozoal-ANTIBACTERIAL AGENTS		
<i>metronidazole 250 mg tablet</i>	T1	
<i>metronidazole 375 mg capsule</i>	T1	
<i>metronidazole 500 mg tablet</i>	T1	
ANTIBIOTIC, ANTIBACTERIAL, MISC.		
<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	

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

PA – Prior Authorization

QL – Quantity Limit

ST – Step Therapy

AGE – Age Requirement

SP – Specialty Medication

HD – May require home delivery pharmacy

PPACA – No Cost-Share Preventive Medication

CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

ANTIBIOTICS (Infections) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
AMINOGLYCOSIDE ANTIBIOTICS (cont.)		
<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>vilevem mb</i> (Urelle)	T1	
ANTILEPROTICS		
<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
ANTI-MYCOBACTERIUM AGENTS		
<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
ANTI-TUBERCULAR ANTIBIOTICS		
<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
BETALACTAMS		
CAYSTON	T2	QL 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

PPACA – No Cost-Share Preventive Medication

CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

ANTIBIOTICS (Infections) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
CEPHALOSPORIN ANTIBIOTICS - 1ST GENERATION		
cefadroxil	T1	
CEPHALOSPORIN ANTIBIOTICS - 2ND GENERATION		
cefaclor	T1	
cefaclor er	T1	
cefprozil	T1	
cefuroxime axetil	T1	
CEPHALOSPORIN ANTIBIOTICS - 3RD GENERATION		
cefdinir	T1	
cefixime (Suprax)	T1	
cefpodoxime proxetil	T1	
ceftriaxone	T1	
SPECTRACEF	T3	
LINCOSAMIDE ANTIBIOTICS		
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	
MACROLIDE ANTIBIOTICS		
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	

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

PA – Prior Authorization

QL – Quantity Limit

ST – Step Therapy

AGE – Age Requirement

SP – Specialty Medication

HD – May require home delivery pharmacy

PPACA – No Cost-Share Preventive Medication

CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

ANTIBIOTICS (Infections) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
MACROLIDE ANTIBIOTICS (cont.)		
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)
NITROFURAN DERIVATIVES ANTIBACTERIAL AGENTS		
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	
OXAZOLIDINONE ANTIBIOTICS		
<i>linezolid</i> (Zyvox)	T1	PA
ZYVOX (<i>linezolid</i>)	T3	PA
PENICILLIN ANTIBIOTICS		
<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	
PLEUROMUTILIN DERIVATIVES		
XENLETA	T3	
QUINOLONE ANTIBIOTICS		
BAXDELA	T2	QL
CIPRO (<i>ciprofloxacin</i>)	T3	
<i>ciprofloxacin hcl</i> (Cipro)	T1	
LEVAQUIN (<i>levofloxacin</i>)	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

ANTIBIOTICS (Infections) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
QUINOLONE ANTIBIOTICS (cont.)		
<i>levofloxacin hemihydrate</i>	T1	
<i>moxifloxacin hcl</i>	T1	
<i>ofloxacin</i>	T1	
RIFAMYCINS AND RELATED DERIVATIVE ANTIBIOTICS		
AEMCOLO	T3	QL
XIFAXAN	T2	QL
TETRACYCLINE ANTIBIOTICS		
<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	
<i>MINOCIN (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	
<i>MINOLIRA ER</i>	T3	ST
<i>monodoxine nl</i>	T1	
<i>monodoxine nl 75 mg capsule</i>	T1	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

HD – May require home delivery pharmacy

PPACA – No Cost-Share Preventive Medication

CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

ANTIBIOTICS (Infections) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
TETRACYCLINE ANTIBIOTICS (cont.)		
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	
VAGINAL ANTIBIOTICS		
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	
VANCOMYCIN ANTIBIOTICS AND DERIVATIVES		
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
ANTIBIOTICS (Skin Conditions)		
TOPICAL ANTIBIOTIC AND ANTI-INFLAMMATORY STEROID		
NEO-SYNALAR	T3	
TOPICAL ANTIBIOTICS		
AMZEEQ	T3	ST
BENZAMYCIN (<i>erythromycin-benzoyl peroxide</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

HD – May require home delivery pharmacy

PPACA – No Cost-Share Preventive Medication

CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

ANTIBIOTICS (Skin Conditions) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
TOPICAL ANTIBIOTICS (cont.)		
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)
TOPICAL SULFONAMIDES		
<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

AGE – Age Requirement

SP – Specialty Medication

HD – May require home delivery pharmacy

PPACA – No Cost-Share Preventive Medication

CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

ANTIBIOTICS (Skin Conditions) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
TOPICAL SULFONAMIDES (cont.)		
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

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-COAGULANTS (Blood Thinners/Anti-Clotting) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
CITRATES AS ANTI-COAGULANTS		
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	
DIRECT FACTOR XA INHIBITORS		
BEVYXXA	T3	
ELIQUIS	T2	PA
<i>rivaroxaban</i> (Xarelto)	T1	
XARELTO (<i>rivaroxaban</i>)	T2	
XARELTO	T2	PA
HEPARIN AND RELATED PREPARATIONS		
ARIXTRA (<i>fondaparinux</i>)	T3	SP
<i>enoxaparin</i> (Lovenox)	T1	
<i>fondaparinux</i> (Arixtra)	T1	SP
FRAGMIN	T2	SP
<i>heparin</i>	T1	
ANTIDOTES (Gastrointestinal/Heartburn)		
MU-OPIOID RECEPTOR ANTAGONISTS, PERIPHERALLY-ACTING		
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	
ANTIDOTES (Substance Abuse)		
OPIOID ANTAGONISTS		
<i>naloxone</i>	T1	
<i>naloxone 0.4 mg/ml syringe</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

HD – May require home delivery pharmacy

PPACA – No Cost-Share Preventive Medication

CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

ANTIDOTES (Substance Abuse) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
OPIOID ANTAGONISTS (cont.)		
REXTOVY	T2	QL (2 units/30 days)
<i>naltrexone</i>	T1	
NARCAN (<i>naloxone hc</i>)	T3	QL (2 units/30 days)
ANTI-FUNGALS (Eye Conditions)		
OPHTHALMIC ANTI-FUNGAL AGENTS		
NATACYN	T2	
ANTI-FUNGALS (Feminine Products)		
VAGINAL ANTI-FUNGALS		
GYNAZOLE-1	T3	
<i>miconazole 3</i>	T1	
<i>terconazole</i>	T1	
ANTI-FUNGALS (Infections)		
ANTI-FUNGAL AGENTS		
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 (Diflucan)</i>	T1	QL
<i>flucytosine (Ancobon)</i>	T1	
<i>itraconazole 100mg capsule (Sporanox)</i>	T1	QL (30 units/30 days)
<i>itraconazole 10mg/ml solution (Sporanox)</i>	T1	
<i>ketoconazole</i>	T1	
NOXAFL	T2	PA
NOXAFL 40MG/ML SUSP	T2	PA SP
ORAVIG	T3	
<i>posaconazole (Noxafil)</i>	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

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-FUNGALS (Infections) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ANTI-FUNGAL AGENTS (cont.)		
VIVJOA	T3	PA QL (18 caps/30 days) SP
voriconazole (Vfend)	T1	PA
ANTI-FUNGAL ANTIBIOTICS		
BREXAFEMME 150 MG TABLET	T3	ST QL (4 tabs/treatment)
griseofulvin	T1	
griseofulvin ultramicrosize	T1	
nystatin	T1	QL (60 grams/28 days)
TOPICAL ANTI-FUNGAL/ANTI-INFLAMMATORY, STEROID AGENT		
clotrimazole/betamethasone	T1	QL (45 gm/21 days)
clotrimazole/betamethasone	T1	QL (60 ml/21 days)
ANTI-FUNGALS (Skin Conditions)		
TOPICAL ANTI-FUNGALS		
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)

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-FUNGALS (Skin Conditions) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
TOPICAL ANTI-FUNGALS (cont.)		
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	
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	

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

ANTIHISTAMINES (Allergy/Nasal Sprays) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ANTIHISTAMINES - 2ND GENERATION		
CLARINEX D 24 HOUR TABLET	T3	
<i>desloratadine</i> (Clarinet)	T1	QL (30 units/30 days) HD
ANTIHISTAMINES (Eye Conditions)		
EYE ANTIHISTAMINES		
<i>azelastine hcl</i>	T1	
<i>epinastine hcl</i>	T1	
LASTACRAFT 0.25% EYE DROPS	T3	ST
ANTI-HYPERGLYCEMICS (Diabetes)		
ANTIHYPERGLY,DPP-4 ENZYME INHIB.-THIAZOLIDINEDIONE		
OSENI	T3	QL (30 units/30 days) HD
ANTIHYPERGLY, INCRETIN MIMETIC (GLP-I RECEPT.AGONIST)		
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)
ANTI-HYPERGLY, INSULIN, LONG ACT-GLP-I RECEPT.AGONIST		
SOLIQUA 100-33	T2	QL (15 mls/30 days)
ANTI-HYPERGLYCEMIC-SOD/GLUC COTRANSPORT2(SGLT2) INHIB		
FARXIGA	T2	ST QL (30 tabs/30 days)
JARDIANCE	T2	ST QL (30 units/30 days) HD
ANTI-HYPERGLYCEMIC-DOPAMINE RECEPTOR AGONISTS		
CYCLOSET	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

PPACA – No Cost-Share Preventive Medication

CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

ANTI-HYPERGLYCEMICS (Diabetes) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ANTI-HYPERGLYCEMIC, ALPHA-GLUCOSIDASE INHIBITORS		
acarbose (Precose)	T1	HD
GLYSET (miglitol)	T3	HD
miglitol (Glyset)	T1	HD
PRECOSE (acarbose)	T3	HD
ANTI-HYPERGLYCEMIC, AMYLIN ANALOG-TYPE		
SYMLINPEN 60	T2	PA QL (7 pens/30 days)
SYMLINPEN 120	T2	PA QL HD
ANTI-HYPERGLYCEMIC, BIGUANIDE TYPE		
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
ANTI-HYPERGLYCEMIC, DPP-4 INHIBITORS		
JANUVIA	T2	QL (30 units/30 days) HD
saxagliptin hcl (Onglyza)	T1	ST QL (30 tabs/30 days) HD
ANTI-HYPERGLYCEMIC, INSULIN-RELEASE STIMULANT TYPE		
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

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-HYPERGLYCEMICS (Diabetes) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ANTI-HYPERGLYCEMIC, INSULIN-RELEASE STIMULANT TYPE (cont.)		
STARLIX (<i>nateglinide</i>)	T3	HD
ANTI-HYPERGLYCEMIC, SGLT-2 AND DPP-4 INHIBITOR COMB		
GLYXAMBI	T2	ST QL (30 units/30 days) HD
ANTI-HYPERGLYCEMIC, THIAZOLIDINEDIONE AND BIGUANIDE		
ACTOPLUS MET XR 30 1000MG TABLET	T3	ST
<i>pioglitazone-metformin</i> (Actoplus Met)	T1	QL HD
ANTI-HYPERGLYCEMIC, THIAZOLIDINEDIONE-SULFONYLUREA		
DUETACT (<i>pioglitazone-glimepiride</i>)	T3	QL (30 tabs/30 days) HD
<i>pioglitazone-glimepiride</i> (Duetact)	T1	QL (30 units/30 days) HD
ANTI-HYPERGLYCEMIC, DPP-4 INHIBITOR-BIGUANIDE COMBS.		
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
ANTI-HYPERGLYCEMIC, INSULIN-RELEASE STIM.-BIGUANIDE		
<i>glipizide-metformin</i>	T1	HD
<i>glyburide-metformin hcl</i>	T1	HD
ANTI-HYPERGLYCEMIC, THIAZOLIDINEDIONE (PPARG AGONIST)		
ACTOS (<i>pioglitazone hcl</i>)	T3	QL (30 tabs/30 days) HD
AVANDIA	T3	ST QL HD
ANTIHYPERGLYCEMIC-GLUCOCORTICOID RECEPTOR BLOCKER		
<i>mifepristone 300 mg tablet</i> (Korlym)	T1	PA SP
ANTI-HYPERGLYCEMIC-SGLT2 INHIBITOR-BIGUANIDE COMBS.		
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
INSULINS		
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

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-HYPERGLYCEMICS (Diabetes) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
INSULINS (cont.)		
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
ANTI-INFECTIVES/MISCELLANEOUS (Feminine Products)		
VAGINAL ANTISEPTICS		
fem ph	T1	
ANTI-INFECTIVES/MISCELLANEOUS (Infections)		
2ND GEN. ANAEROBIC ANTI-PROTOZOAL-ANTIBACTERIAL		
tinidazole	T1	QL (20 tabs/23 days)
tinidazole	T1	QL (40 tabs/23 days)
ANTHELMINTICS		
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)

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 (Infections) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ANTI-MALARIAL DRUGS		
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)
ANTI-PROTOZOAL DRUGS, MISCELLANEOUS		
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)
ANTI-INFECTIVES/MISCELLANEOUS (Miscellaneous)		
ANTIBACTERIAL AGENTS, MISCELLANEOUS		
aminoacetic acid (Aminoacetic Acid)	T1	
glycine (Aminoacetic Acid)	T1	
ANTISEPTICS, GENERAL		
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
TOPICAL ANTI-FUNGALS		
CICLODAN	T3	ST
ciclopirox	T1	
ANTI-INFLAM.TUMOR NECROSIS FACTOR INHIBITING AGENTS (Pain Relief And Inflammatory Disease)		
ANTI-INFLAMMATORY TUMOR NECROSIS FACTOR INHIBITOR		
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
ANTI-NEOPLASTICS (Cancer)		
ANP - SELECTIVE RETINOID X RECEPTOR AGONISTS (RXR)		
bexarotene (Targretin)	T1	PA SP HD CSL
ANTI-NEOPLAST, HISTONE DEACETYLASE (HDAC) INHIBITORS		
FARYDAK 10mg, 20mg CAPSULE	T3	PA QL SP HD CSL
FARYDAK 5mg CAPSULE	T3	PA QL
ZOLINZA	T2	PA SP HD CSL
ANTI-NEOPLASTIC - ALKYLYATING AGENTS		
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

QL – Quantity Limit

ST – Step Therapy

AGE – Age Requirement

SP – Specialty Medication

HD – May require home delivery pharmacy

PPACA – No Cost-Share Preventive Medication

CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

ANTI-NEOPLASTICS (Cancer) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ANTI-NEOPLASTIC - ANTI-ANDROGENIC AGENTS		
<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
ANTI-NEOPLASTIC - ANTI-METABOLITES		
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
ANTI-NEOPLASTIC - AROMATASE INHIBITORS		
<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
ANTI-NEOPLASTIC - BRAF KINASE INHIBITORS		
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

PA – Prior Authorization

QL – Quantity Limit

ST – Step Therapy

AGE – Age Requirement

SP – Specialty Medication

HD – May require home delivery pharmacy

PPACA – No Cost-Share Preventive Medication

CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

ANTI-NEOPLASTICS (Cancer) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ANTI-NEOPLASTIC - BRAF KINASE INHIBITORS (cont.)		
ZELBORAF	T2	PA QL SP HD CSL
ANTI-NEOPLASTIC - CAR-T CELL IMMUNOTHERAPY		
BREYANZI	T3	PA
ANTI-NEOPLASTIC - HEDGEHOG PATHWAY INHIBITOR		
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
ANTI-NEOPLASTIC - JANUS KINASE (JAK) INHIBITORS		
JAKAFI	T2	PA QL SP HD CSL
ANTI-NEOPLASTIC - KRAS PROTEIN INHIBITOR		
LUMAKRAS	T3	PA SP QL (8 tabs per day) HD
ANTINEOPLASTIC - MEK KINASE INHIBITORS		
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
ANTI-NEOPLASTIC - MTOR KINASE INHIBITORS		
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
ANTI-NEOPLASTIC - PROTEIN METHYLTRANSFERASE INHIBIT		
TAZVERIK	T3	PA SP CSL
ANTI-NEOPLASTIC - TOPOISOMERASE I INHIBITORS		
HYCAMTIN	T2	PA SP HD CSL
ANTINEOPLASTIC COMB - KINASE AND AROMATASE INHIBIT		
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

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-NEOPLASTICS (Cancer) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ANTI-NEOPLASTIC IMMUNOMODULATOR AGENTS		
POMALYST	T2	PA SP HD CSL
REVLIMID	T2	PA QL (30 caps/30 days) SP HD CSL
SYLATRON	T2	PA
ANTI-NEOPLASTIC LHRH (GNRH) AGONIST, PITUITARY SUPPR.		
<i>leuprolide acetate</i>	T1	PA SP HD
LUPRON DEPOT	T3	PA SP HD
ZOLADEX	T2	SP HD
ANTI-NEOPLASTIC LHRH (GNRH) ANTAGONIST, PITUIT.SUPPRS		
FIRMAGON	T2	PA SP HD
ANTI-NEOPLASTIC SYSTEMIC ENZYME INHIBITORS		
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

PA – Prior Authorization

QL – Quantity Limit

ST – Step Therapy

AGE – Age Requirement

SP – Specialty Medication

HD – May require home delivery pharmacy

PPACA – No Cost-Share Preventive Medication

CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

ANTI-NEOPLASTICS (Cancer) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ANTI-NEOPLASTIC SYSTEMIC ENZYME INHIBITORS (cont.)		
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

PA – Prior Authorization

QL – Quantity Limit

ST – Step Therapy

AGE – Age Requirement

SP – Specialty Medication

HD – May require home delivery pharmacy

PPACA – No Cost-Share Preventive Medication

CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

ANTI-NEOPLASTICS (Cancer) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ANTI-NEOPLASTIC SYSTEMIC ENZYME INHIBITORS (cont.)		
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

QL – Quantity Limit

ST – Step Therapy

AGE – Age Requirement

SP – Specialty Medication

HD – May require home delivery pharmacy

PPACA – No Cost-Share Preventive Medication

CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

ANTI-NEOPLASTICS (Cancer) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ANTI-NEOPLASTIC SYSTEMIC ENZYME INHIBITORS (cont.)		
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
ANTI-NEOPLASTIC, ANTI-PROGRAMMED DEATH-1 (PD-1) MAB		
JEMPERLI 500 MG/10 ML VIAL	T3	PA SP HD
OPDIVO	T2	PA SP HD
ANTI-NEOPLASTIC-B CELL LYMPHOMA-2(BCL-2) INHIBITORS		
VENCLEXTA	T2	PA SP CSL
VENCLEXTA STARTING PACK	T2	PA QL SP CSL
ANTI-NEOPLASTIC-ISOCITRATE DEHYDROGENASE INHIBITOR		
IDHIFA	T2	PA QL (30 units/30 days) SP HD CSL
TIBSOVO	T2	PA SP CSL
VORANIGO	T3	PA SP CSL
ANTI-NEOPLASTICS ANTIBODY/ANTIBODY-DRUG COMPLEXES		
ENHERTU	T3	PA SP HD
ANTI-NEOPLASTICS, MISCELLANEOUS		
<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
CYTOTOXIC T-LYMPHOCYTE ANTIGEN (CTLA-4) RMC ANTIBODY		
YERVOY	T2	PA SP HD

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

PA – Prior Authorization

QL – Quantity Limit

ST – Step Therapy

AGE – Age Requirement

SP – Specialty Medication

HD – May require home delivery pharmacy

PPACA – No Cost-Share Preventive Medication

CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

ANTI-NEOPLASTICS (Cancer) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
IMMUNOMODULATORS		
ACTIMMUNE	T2	SP HD
INTRON A	T2	SP HD
SELECTIVE ESTROGEN RECEPTOR MODULATORS (SERMS)		
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
STEROID ANTI-NEOPLASTICS		
<i>megestrol acetate</i>	T1	CSL
ANTI-NEOPLASTICS (Skin Conditions)		
PHOTOACT, TOPICAL ANTI-NEOPLAST, PREMALIGNANT LESIONS		
LEVULAN	T3	SP
TOPICAL ANTI-NEOPLASTIC PREMALIGNANT LESION AGENTS		
PANRETIN	T3	PA SP HD
PICATO	T2	
TARGRETIN	T2	PA SP HD
VALCHLOR	T2	PA SP HD
ANTI-OBESITY DRUGS (Weight Management)		
ANTI-OBESITY - ANOREXIC AGENTS		
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)
ANTI-OBESITY GLUCAGON-LIKE PEPTIDE-I RECEPTOR AGONIST		
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

SP – Specialty Medication

HD – May require home delivery pharmacy

PPACA – No Cost-Share Preventive Medication

CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

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

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

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ANTI-PARKINSONISM DRUGS, OTHER (cont.)		
<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

ANTI-PLATELET DRUGS (Blood Thinners/Anti-Clotting)

DECARBOXYLASE INHIBITORS

<i>carbidopa</i> (Lodosyn)	T1	
LODOSYN (<i>carbidopa</i>)	T3	

PLATELET AGGREGATION INHIBITORS

<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

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-PLATELET DRUGS (Blood Thinners/Anti-Clotting) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
PLATELET AGGREGATION INHIBITORS (cont.)		
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
PLATELET REDUCING AGENTS		
AGRYLIN (<i>anagrelide hcl</i>)	T3	
<i>anagrelide hydrochloride</i> (Agrylan)	T1	
ANTIVIRALS (AIDS/HIV)		
ANTI-RETROVIRAL - CAPSID INHIBITORS		
SUNLENCA	T3	PA SP
YEZTUGO	T3	PA SP
ANTIRETROVIRAL-INTEGRASE INHIBITOR AND NNRTI COMB		
JULUCA	T2	SP
ANTIRETROVIRAL-INTEGRASE INHIBITOR AND NRTI COMB		
DOVATO	T2	SP
ANTIRETROVIRAL-NRTIS AND INTEGRASE INHIBITORS COMB		
TRIUMEQ	T2	SP
TRIUMEQ PD 60-5-30 MG TAB SUSP	T2	SP
ANTI-RETROVIRAL - NUCLEOSIDE, NUCLEOTIDE, PROTEASE INH.		
SYMTUZA	T2	SP
ANTIVIRALS (AIDS/HIV) (cont.)		
ANTIVIRALS - HIV-SPEC, NON-PEPTIDIC PROTEASE INHIB		
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
ANTIVIRALS - HIV-SPEC, NUCLEOSIDE-NUCLEOTIDE ANALOG		
CIMDUO	T2	SP
DESCOVY	T2	SP 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

ANTIVIRALS (AIDS/HIV) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ANTIVIRALS - HIV-SPEC, NUCLEOSIDE-NUCLEOTIDE ANALOG (cont.)		
TEMIXYS	T2	SP
ANTIVIRALS - HIV-SPEC, NUCLEOSIDE ANALOG, RTI COMB		
<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
ANTIVIRALS - HIV-SPECIFIC, FUSION INHIBITORS		
FUZEON	T2	SP QL (60 vials/30 days)
ANTIVIRALS - HIV-SPECIFIC, NON-NUCLEOSIDE, RTI		
EDURANT	T2	SP
EDURANT PED	T3	SP
<i>efavirenz</i> (Sustiva)	T1	SP
INTELENCE	T3	SP
<i>nevirapine</i> (Viramune)	T1	SP
ANTIVIRALS - HIV-SPECIFIC, NON-NUCLEOSIDE, RTI		
<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
ANTIVIRALS - HIV-SPECIFIC, NUCLEOSIDE ANALOG, RTI		
<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
ANTIVIRALS - HIV-SPECIFIC, NUCLEOTIDE ANALOG, RTI		
<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

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

ANTIVIRALS (AIDS/HIV) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ANTIVIRALS - HIV-SPECIFIC, NUCLEOTIDE ANALOG, RTI (cont.)		
VIREAD 300 MG TABLET (<i>tenofovir disoproxil fumarate</i>)	T3	SP
ANTIVIRALS - HIV-SPECIFIC, PROTEASE INHIBITORS		
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
ANTIVIRALS - HIV-I INTEGRASE STRAND TRANSFER INHIBTR		
APRETUDE	T2	SP PPACA
ISENTRESS	T2	SP
ISENTRESS HD	T2	SP
TIVICAY	T2	SP
ARTV NUCLEOSIDE, NUCLEOTIDE, NON-NUCLEOSIDE RTI COMB		
<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
ARV-NUCLEOSIDE, NUCLEOTIDE RTI, INTEGRASE INHIB		
BIKTARVY	T2	SP
GENVOYA	T2	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

SP – Specialty Medication

HD – May require home delivery pharmacy

PPACA – No Cost-Share Preventive Medication

CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

ANTIVIRALS (Eye Conditions)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
EYE ANTIVIRALS		
trifluridine	T1	
ZIRGAN	T3	
ANTIVIRALS (Infections)		
ANTIVIRAL - MAIN PROTEASE (MPRO) INHIBITOR		
PAXLOVID 150-100 MG (MODERATE)	T2	QL (20 tabs/180 days)
PAXLOVID 300/150-100MG(SEVERE)	T2	
ANTIVIRAL MONOCLONAL ANTIBODIES		
BEYFORTUS	T2	PPACA
ANTIVIRALS, GENERAL		
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

PA – Prior Authorization

QL – Quantity Limit

ST – Step Therapy

AGE – Age Requirement

SP – Specialty Medication

HD – May require home delivery pharmacy

PPACA – No Cost-Share Preventive Medication

CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

ANTIVIRALS (Infections) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
HEP C - NS5A, NS3/4A, NUCLEOTIDE NS5B INHIB COMBO		
VOSEVI	T2	PA QL (84 tabs/365 days) SP HD
HEP C VIRUS-NS5B POLYMERASE AND NS5A INHIB. COMBO.		
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
HEPATITIS B TREATMENT AGENTS		
<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
HEPATITIS C TREATMENT AGENTS		
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
HEPATITIS C VIRUS- NS5A AND NS3/4A INHIBITOR COMB		
ZEPATIER	T2	PA QL (84 tabs/365 days) SP HD
RNA POLYMERASE INHIBITOR		
MOLNUPIRAVIR	T2	
ANTIVIRALS (Skin Conditions)		
TOPICAL ANTIVIRALS		
<i>acyclovir</i> (Zovirax)	T1	PA QL
DENAVIR	T3	
<i>penciclovir</i>	T1	
ZOVIRAX (<i>acyclovir</i>)	T3	PA QL
TOPICAL GENITAL WART-HPV TREATMENT AGENTS		
VEREGEN	T3	PA QL (30 grams/treatment)

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

AUTONOMIC DRUGS (Allergy/Nasal Sprays)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ANAPHYLAXIS THERAPY AGENTS		
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)		
CHOLINESTERASE INHIBITORS		
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) ⁸		
ADRENERGICS, AROMATIC, NON-CATECHOLAMINE		
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	
ADRENERGICS, AROMATIC, NON-CATECHOLAMINE		
<i>dextroamphetamine</i> (Zenzedi)	T1	
<i>dextroamphetamine er</i> (Dexedrine)	T1	
<i>dextroamphetamine-amphetamine er</i> (Adderall XR)	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

AUTONOMIC DRUGS (Attention Deficit Hyperactivity Disorder) ⁸ (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ADRENERGICS, AROMATIC, NON-CATECHOLAMINE		
<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)		
ADRENERGIC VASOPRESSOR AGENTS		
<i>midodrine hcl</i>	T1	
ALPHA-ADRENERGIC BLOCKING AGENTS		
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)		
PARASYMPATHETIC AGENTS		
<i>bethanechol chloride</i>	T1	HD
<i>cevimeline hcl</i> (Evoxac)	T1	HD
EVOXAC (<i>cevimeline hcl</i>)	T3	HD
<i>guanidine hcl</i>	T1	HD
<i>pilocarpine hcl</i> (Salagen)	T1	HD
SALAGEN (<i>pilocarpine hcl</i>)	T3	HD
<i>URECHOLINE</i> (<i>bethanechol chloride</i>)	T3	
BIOLOGICALS (Allergy/Nasal Sprays)		
ALLERGENIC EXTRACTS, THERAPEUTIC		
GRASTEK	T2	PA
ODACTRA	T2	PA
ORALAIR	T2	PA
RAGWITEK	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

SP – Specialty Medication

HD – May require home delivery pharmacy

PPACA – No Cost-Share Preventive Medication

CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

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

CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

BIOLOGICALS (Vaccines) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
INFLUENZA VIRUS VACCINES (cont.)		
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
TOXIN-PRODUCING BACILLI VACCINES/TOXOIDS		
BCG VACCINE (TICE STRAIN)	T2	SP
VAXCHORA VACCINE	T2	
VACCINE/TOXOID PREPARATIONS, COMBINATIONS		
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

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

BIOLOGICALS (Vaccines) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
VACCINE/TOXOID PREPARATIONS, COMBINATIONS (cont.)		
QUADRACEL DTAP-IPV	T2	PPACA
TENIVAC	T2	PPACA
TETANUS Diphtheria Toxoids	T2	PPACA
VAXELIS	T2	PPACA
VIRAL/TUMORIGENIC VACCINES		
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
BLOOD (Blood Modifiers/Bleeding Disorders)		
AGENTS TO TX THROMBOTIC THROMBOCYTOPENIC PURPURA		
CABLIVI	T2	PA SP
ANTI-FIBRINOLYTIC AGENTS		
AMICAR (<i>aminocaproic acid</i>)	T3	SP HD
<i>aminocaproic acid</i> (Amicar)	T1	SP HD
LYSTEDA (<i>tranexamic acid</i>)	T3	SP
<i>tranexamic acid</i> (Lysteda)	T1	SP
COMPLEMENT INHIBITORS		
EMPAVELI	T2	PA SP
FABHALTA	T2	PA SP
TAVNEOS	T3	PA QL (180 caps/30 days) SP
VOYDEYA	T2	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

SP – Specialty Medication

HD – May require home delivery pharmacy

PPACA – No Cost-Share Preventive Medication

CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

BLOOD (Blood Modifiers/Bleeding Disorders) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
HEMOPHILIA TREATMENT AGENTS, NON-FACTOR REPLACEMENT		
HEMLIBRA	T2	PA SP HD
SICKLE CELL ANEMIA AGENTS		
glutamine	T1	PA
DROXIA	T2	
OXBRYTA	T3	SP
TOPICAL HEMOSTATICS		
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	
BLOOD (Blood Thinners/Anti-Clotting)		
HEMORRHEOLOGIC AGENTS		
pentoxifylline	T1	HD
CARDIAC DRUGS (Blood Pressure/Heart Medications)		
ANTI-ANGINAL, ANTI-ISCHEMIC AGENTS, NON-HEMODYNAMIC		
ranolazine	T1	HD
ranolazine er (Ranexa)	T1	HD
RANEXA (ranolazine)	T3	ST HD
ANTI-ARRHYTHMICS		
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

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

CARDIAC DRUGS (Blood Pressure/Heart Medications) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ANTI-ARRHYTHMICS (cont.)		
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
CALCIUM CHANNEL BLOCKER AND NSAID, COX-2 INHIBITOR		
CONSENSI	T3	
CALCIUM CHANNEL BLOCKING AGENTS		
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

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

CARDIAC DRUGS (Blood Pressure/Heart Medications) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
CALCIUM CHANNEL BLOCKING AGENTS (cont.)		
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
CARDIOPLEGIC SOLUTIONS		
cardioplegic (Plegisol)	T1	
DIGITALIS GLYCOSIDES		
digitek (Lanoxin)	T1	HD
digoxin (Lanoxin)	T1	HD
LANOXIN	T3	HD
LANOXIN (digitek)	T3	HD
HEART RATE REDUCING, SA SELECTIVE I(F) CURRENT INH.		
ivabradine (Corlanor)	T1	PA HD
SOLUBLE GUANYLATE CYCLASE (SGC) STIMULATOR		
VERQUVO	T2	QL (max 30 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

CARDIAC DRUGS (Blood Pressure/Heart Medications) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
VASODILATORS, CORONARY		
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
VASODILATORS, CORONARY (cont.)		
<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
CARDIOVASCULAR (Asthma/COPD/Respiratory)		
PULM ANTI-HTN, SOLUBLE GUANYLATE CYCLASE STIMULATOR		
ADEMPAS	T2	PA QL (90 tabs/30 days) SP HD
PULM ANTI-HTN, SEL.C-GMP PHOSPHODIESTERASE T5 INHIB		
REVATIO (<i>sildenafil</i>)	T3	PA QL SP HD
<i>sildenafil</i> (Revatio)	T1	PA QL SP HD
PULMONARY ANTI-HTN, ENDOTHELIN RECEPTOR ANTAGONIST		
<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

PA – Prior Authorization

QL – Quantity Limit

ST – Step Therapy

AGE – Age Requirement

SP – Specialty Medication

HD – May require home delivery pharmacy

PPACA – No Cost-Share Preventive Medication

CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

CARDIOVASCULAR (Asthma/COPD/Respiratory) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
PULMONARY ANTIHYPER AGENT, ACTRIIA-FC		
WINREVAIR	T2	PA SP HD
WINREVAIR (2 PACK)	T2	PA SP HD
PULMONARY ANTIHYPERTENSIVES, PROSTACYCLIN-TYPE		
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
PULMONARY HTN-ENDOTHELIN RECEPTANT G-CGMP PDE5 INH		
OPSYNVI	T2	PA QL (30 tabs/fill) SP HD
CARDIOVASCULAR (Blood Pressure/Heart Medications)		
ACE INHIBITOR-CALCIUM CHANNEL BLOCKER COMBINATION		
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
ACE INHIBITOR-THIAZIDE OR THIAZIDE-LIKE DIURETIC		
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
ALPHA/BETA-ADRENERGIC BLOCKING AGENTS		
CARDURA (doxazosin mesylate)	T3	QL HD
CARDURA XL	T3	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 (Blood Pressure/Heart Medications) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ALPHA/BETA-ADRENERGIC BLOCKING AGENTS (cont.)		
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
ANGIOTEN. RECEPTR ANTAG-CALCIUM CHANL BLKR-THIAZIDE		
amlodipine-valsartan-hctz (Exforge HCT)	T1	HD
olmesartan-amlodipine-hctz (Tribenzor)	T1	HD
ANGIOTENSIN RECEPT-NEPRILYSIN INHIBITOR COMB (ARNI)		
ENTRESTO	T2	QL (60 tabs/30 days)
ENTRESTO SPRINKLE	T2	QL (240 caps/fill) HD
sacubitril/valsartan	T1	QL (60 tabs/30 days) HD
ANGIOTENSIN RECEPTOR ANTAG.-THIAZIDE DIURETIC COMB		
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
ANGIOTENSIN RECEPTOR BLOCKR-CALCIUM CHANNEL BLOCKR		
amlodipine-olmesartan (Azor)	T1	HD
amlodipine-valsartan (Exforge)	T1	HD
telmisartan-amlodipine (Twynsta)	T1	HD
ANTI-HYPERTENSIVES, ACE INHIBITORS		
ACCUPRIL (quinapril hcl)	T3	HD
ALTACE (ramipril)	T3	HD
ANTI-HYPERTENSIVES, ACE INHIBITORS		
benazepril hcl (Lotensin)	T1	HD
captopril	T1	HD
enalapril maleate (Vasotec)	T1	HD
fosinopril	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
ANTI-HYPERTENSIVES, ACE INHIBITORS (cont.)		
<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
ANTI-HYPERTENSIVES, ANGIOTENSIN RECEPTOR ANTAGONIST		
<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
ANTI-HYPERTENSIVES, GANGLIONIC BLOCKERS		
VECAMYL	T3	
ANTI-HYPERTENSIVES, MISCELLANEOUS		
DEMSER	T3	PA HD
ANTI-HYPERTENSIVES, SYMPATHOLYTIC		
<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

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
ANTI-HYPERTENSIVES, VASODILATORS		
hydralazine hcl	T1	HD
minoxidil	T1	HD
BETA-ADRENERGIC BLOCKING AGENTS		
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
BETA-BLOCKERS AND THIAZIDE, THIAZIDE-LIKE DIURETICS		
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
BETA-BLOCKERS AND THIAZIDE, THIAZIDE-LIKE DIURETICS (cont.)		
<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
RENIN INHIBITOR, DIRECT		
<i>aliskiren (Tekturna)</i>	T1	HD
RENIN INHIBITOR, DIRECT AND THIAZIDE DIURETIC COMB		
<i>TEKTURN A HCT</i>	T2	HD
VASODILATORS, COMBINATION		
<i>isosorbide dinit/hydralazine (Bidil)</i>	T1	HD
VASODILATORS, PERIPHERAL		
<i>ergoloid mesylates</i>	T1	
<i>isoxsuprine hcl</i>	T1	
CARDIOVASCULAR (Cholesterol Medications)		
ANTI-HYPERLIP.HMG COA REDUCT INHIB-CHOLEST.AB.INHIB		
<i>ezetimibe-atorvastatin tabs</i>	T1	ST HD QL (30 tabs/30 days)
<i>ezetimibe-simvastatin (Vytorin)</i>	T1	QL (30 units/30 days) HD
ANTI-HYPERLIPID- HMG-COA RI-CALCIUM CHANNEL BLOCKER		
<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
ANTI-HYPERLIPIDEMIC - ANGIOPOIETIN-LIKE 3 INHIBITOR		
<i>EVKEEZA</i>	T3	PA
ANTI-HYPERLIPIDEMIC - APOLIPOPROTEIN INHIBITOR		
<i>TRYNGOLZA</i>	T3	PA SP
ANTI-HYPERLIPIDEMIC - MTP INHIBITOR		
<i>JUXTAPIID</i>	T2	SP HD
ANTI-HYPERLIPIDEMIC - PCSK9 INHIBITORS		
<i>REPATHA</i>	T2	
ANTI-HYPERLIPIDEMIC-HMGCOA REDUCTASE INHIB (STATINS)		
<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
ANTI-HYPERLIPIDEMIC-HMGCOA REDUCTASE INHIB (STATINS) (cont.)		
<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
BILE SALT SEQUESTRANTS		
<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
LIPOTROPICS		
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
LIPOTROPICS (cont.)		
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

memantine hcl	T1	HD
memantine hcl 10 mg/5 ml cup	T1	HD
memantine hcl 5 mg, 10 mg tablet	T1	HD
memantine hcl er (Namenda XR)	T1	HD
NAMENDA	T3	HD
NAMENDA XR	T3	HD

ALZHEIMER'S THX, NMDA RECEPTOR ANTAG-CHOLINES INHIB

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

QL – Quantity Limit

ST – Step Therapy

AGE – Age Requirement

SP – Specialty Medication

HD – May require home delivery pharmacy

PPACA – No Cost-Share Preventive Medication

CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

CNS DRUGS (Miscellaneous) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
DRUGS TO TREAT MOVEMENT DISORDERS (cont.)		
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
XANTHINES		
<i>caffeine d</i>	T1	HD
CNS DRUGS (Multiple Sclerosis)		
AGENTS TO TREAT MULTIPLE SCLEROSIS		
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

PPACA – No Cost-Share Preventive Medication

CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

CNS DRUGS (Multiple Sclerosis) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
AGENTS TO TREAT MULTIPLE SCLEROSIS (cont.)		
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
AGTS TX NEUROMUSC TRANSMISSION DIS, POT-CHAN BLKR		
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
CNS DRUGS (Pain Relief And Inflammatory Disease)		
CALCITONIN GENE-RELATED PEPTIDE (CGRP) INHIBITORS		
EMGALITY SYRINGE	T2	PA QL (1 syr/23 days)
POSTHERPETIC NEURALGIA AGENTS		
gabapentin (Gralise)	T1	ST
GRALISE	T3	ST
GRALISE (gabapentin)	T3	ST
SPHINGOSINE I-PHOSPHATE (SIP) RECEPTOR MODULATOR		
ZEPOSIA STARTER KIT (28-DAY)	T2	
VELSIPITI	T2	PA QL (30 tabs/30 days) SP HD
CNS DRUGS (Seizure Disorders)		
ANTI-CONVULSANT - BENZODIAZEPINE TYPE		
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

PPACA – No Cost-Share Preventive Medication

CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

CNS DRUGS (Seizure Disorders) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ANTI-CONVULSANT - BENZODIAZEPINE TYPE (cont.)		
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
ANTI-CONVULSANT - CANNABINOID TYPE		
EPIDIOLEX	T2	PA SP HD
ANTI-CONVULSANTS		
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

SP – Specialty Medication

HD – May require home delivery pharmacy

PPACA – No Cost-Share Preventive Medication

CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

CNS DRUGS (Seizure Disorders) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ANTI-CONVULSANTS (cont.)		
<i>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

QL – Quantity Limit

ST – Step Therapy

AGE – Age Requirement

SP – Specialty Medication

HD – May require home delivery pharmacy

PPACA – No Cost-Share Preventive Medication

CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

CNS DRUGS (Seizure Disorders) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ANTI-CONVULSANTS (cont.)		
<i>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

QL – Quantity Limit

ST – Step Therapy

AGE – Age Requirement

SP – Specialty Medication

HD – May require home delivery pharmacy

PPACA – No Cost-Share Preventive Medication

CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

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

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
CONTRACEPTIVES, ORAL (cont.)		
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

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
CONTRACEPTIVES, ORAL (cont.)		
<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

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
CONTRACEPTIVES, ORAL (cont.)		
<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

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
CONTRACEPTIVES, ORAL (cont.)		
<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

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
CONTRACEPTIVES, ORAL (cont.)		
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
CONTRACEPTIVES, TRANSDERMAL		
norelgestromin/ethinestradiol	T1	PPACA
xulane	T1	HD PPACA
DIAPHRAGMS/CERVICAL CAP		
CAYA CONTOURED	T3	PPACA
FEMCAP	T2	PPACA
WIDE SEAL DIAPHRAGM	T3	PPACA
INTRA-UTERINE DEVICES (IUDS)		
KYLEENA	T2	SP
LILETTA	T3	SP
MIRENA	T2	SP
PARAGARD T 380-A	T3	SP
SKYLA	T2	SP
CONTRACEPTIVES (Miscellaneous)		
CONDOMS		
FC2 FEMALE CONDOM	T2	PPACA
COUGH/COLD PREPARATIONS (Cough/Cold Medications)		
ANTI-TUSSIVES, NON-OPIOID		
benzonatate (Tessalon Perle)	T1	
TESSALON PERLE (benzonatate)	T3	
NON-OPIOID ANTI-TUS-IST GEN.ANTIHISTAMINE-DECONGEST		
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

PA – Prior Authorization

QL – Quantity Limit

ST – Step Therapy

AGE – Age Requirement

SP – Specialty Medication

HD – May require home delivery pharmacy

PPACA – No Cost-Share Preventive Medication

CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

COUGH/COLD PREPARATIONS (Cough/Cold Medications) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
NON-OPIOID ANTI-TUSSIVE-1ST GEN ANTIHISTAMINE COMB.		
<i>promethazine w/dm</i>	T1	
OPIOID ANTITUSSIVE-1ST GEN. ANTIHISTAMINE-DECONGEST		
CAPCOF	T3	
HISTEX-AC	T3	
MAXI-TUSS CD	T3	
POLY-TUSSIN AC	T3	
<i>promethazine vc w/codeine</i>	T1	
OPIOID ANTI-TUSSIVE-1ST GENERATION ANTIHISTAMINE		
<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	
OPIOID ANTI-TUSSIVE-ANTI-CHOLINERGIC COMBINATIONS		
<i>hydrocodone compound</i>	T1	
<i>hydrocodone/homatropine</i>	T1	
<i>hydromet</i>	T1	
OPIOID ANTITUSSIVE-DECONGESTANT-EXPECTORANT COMB		
CODITUSSIN DAC	T3	
<i>guaifenesin dac</i>	T1	
<i>lortuss ex</i>	T1	
<i>virtussin dac</i>	T1	
OPIOID ANTI-TUSSIVE-EXPECTORANT COMBINATION		
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	

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

DIAGNOSTIC (Diabetes)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
BLOOD SUGAR DIAGNOSTICS		
FREESTYLE TEST STRIPS	T2	
FREESTYLE PRECISION NEO	T2	
ONE TOUCH ULTRA TEST STRIPS	T2	
ONE TOUCH VERIO	T2	
PRECISION XTRA	T2	
URINE GLUCOSE TEST AIDS		
DASTIX REAGENT	T2	
DIAGNOSTIC (Miscellaneous)		
BLOOD TESTING PREPARATIONS		
FORA GTEL KETONE TEST STRIP	T3	
NOVAMAX PLUS	T2	
PRECISION XTRA	T2	
CARDIOVASCULAR DIAGNOSTICS-RADIOPAQUE		
OMNIPAQ	T3	
DIAGNOSTIC PREPARATIONS, MISCELLANEOUS		
ARIDOL	T3	
PROVOCHOLINE	T3	
TC 99M SULFUR COLLOID PREP	T3	
TOXICOLOGY SALIVA COLLECTION	T3	
VUEBLU	T3	
DIAGNOSTIC TEST DEVICES AND SUPPLIES		
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	

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

DIAGNOSTIC (Miscellaneous) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
DIAGNOSTIC TEST DEVICES AND SUPPLIES (cont.)		
SOFIA2 FLU-SARS ANTIGEN FIA	T2	
VERITOR SARS-COV-2 AND FLU A-B	T2	
EYE DIAGNOSTIC AGENTS		
<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	
GASTROINTESTINAL RADIOPAQUE DIAGNOSTICS		
SITZMARKS FOR KIDS	T3	
RADIOACTIVE METABOLIC FUNCTION DIAGNOSTICS		
SODIUM IODIDE I-123	T3	
DIURETICS (Diuretics)		
ARGININE VASOPRESSIN (AVP) RECEPTOR ANTAGONISTS		
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
CARBONIC ANHYDRASE INHIBITORS		
<i>acetazolamide</i>	T1	HD
<i>methazolamide</i>	T1	HD
LOOP DIURETICS		
<i>bumetanide</i>	T1	HD
EDECRIN (<i>ethacrynic acid</i>)	T3	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	
OSMOTIC DIURETICS		
RESECTISOL	T2	
POLYCYSTIC KIDNEY DISEASE AGENT, AVP RECEP. ANTAG		
<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

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

DIURETICS (Diuretics) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
POLYCYSTIC KIDNEY DISEASE AGENT, AVP RECEP. ANTAG (cont.)		
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
POTASSIUM SPARING DIURETICS		
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)
<i>spironolactone</i>	T1	HD
<i>spironolactone</i> 100 mg tablet (Aldactone)	T1	HD
<i>spironolactone</i> 25 mg tablet (Aldactone)	T1	HD
<i>spironolactone</i> 25 mg/5 ml susp (Carospir)	T1	
<i>spironolactone</i> 50 mg tablet (Aldactone)	T1	HD
<i>triamterene</i> (Dyrenium)	T1	HD
POTASSIUM SPARING DIURETICS IN COMBINATION		
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
<i>spironolact/hctz</i>	T1	HD
<i>spironolactone</i> w/hctz (Aldactazide)	T1	HD
<i>triamterene</i> 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

AGE – Age Requirement

SP – Specialty Medication

HD – May require home delivery pharmacy

PPACA – No Cost-Share Preventive Medication

CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

DIURETICS (Diuretics) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
THIAZIDE AND RELATED DIURETICS		
<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
EENT PREPS (Allergy/Nasal Sprays)		
NASAL ANTIHISTAMINE		
<i>azelastine hcl</i>	T1	QL HD
<i>olopatadine hcl (Patanase)</i>	T1	QL HD
<i>PATANASE (olopatadine hcl)</i>	T3	QL HD
NASAL ANTIHISTAMINE AND ANTI-INFLAM. STEROID COMB.		
<i>RYALTRIS 665-25MCG SPRAY</i>	T3	ST QL HD
NASAL ANTI-INFLAMMATORY STEROIDS		
<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
NOSE PREPARATIONS, MISCELLANEOUS (RX)		
<i>COCAINE HCL</i>	T3	
<i>GOPRELTO</i>	T3	
<i>ipratropium bromide</i>	T1	QL (30 units/30 days) HD
<i>NUMBRINO</i>	T3	
NOSE PREPARATIONS, VASOCONSTRICATORS (RX)		
<i>ADRENALIN CHLORIDE</i>	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

EENT PREPS (Ear Medications)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
EAR PREPARATIONS ANTI-INFLAMMATORY		
DERMOTIC (<i>flac otic oil</i>)	T3	
<i>flac otic oil</i> (Dermotic)	T1	
<i>fluocinolone acetonide oil</i> (Dermotic)	T1	
EAR PREPARATIONS, MISC. ANTI-INFECTIVES		
<i>acetic acid</i>	T1	
<i>acetic acid/hydrocortisone</i>	T1	
CORTANE-B (<i>hc pramoxine</i>)	T3	
EENT PREPS (Eye Conditions)		
AGENTS FOR CORNEAL COLLAGEN CROSS-LINKING		
PHOTREXA CROSS-LINKING	T3	
PHOTREXA VISCOS	T3	
ARTIFICIAL TEARS		
KLARITY (CHONDROITIN)	T3	
LACRISERT	T3	PA
MIEBO	T2	PA QL (3 mls/fill)
EYE ANTI-INFECTIVES (RX ONLY)		
BETADINE	T3	
<i>povidone-iodine</i>	T1	
EYE ANTI-INFLAMMATORY AGENTS		
<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

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

EENT PREPS (Eye Conditions) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
EYE ANTI-INFLAMMATORY AGENTS (cont.)		
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
EYE IRRIGATIONS		
<i>balanced salt (BSS)</i>	T1	
EYE LOCAL ANESTHETICS		
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	
EYE MAST CELL STABILIZERS		
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

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

EENT PREPS (Eye Conditions) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
EYE MAST CELL STABILIZERS (cont.)		
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
EYE MYDRIATIC AND NSAID COMBINATIONS		
MYDRIATIC4 (TROP-PROP-PE-KTRLC)	T3	
EYE PREPARATIONS, MISCELLANEOUS (OTC)		
GELFILM	T3	
EYE VASOCONSTRICATORS		
<i>phenylephrine hcl</i>	T1	
MIOTICS AND OTHER INTRAOCULAR PRESSURE REDUCERS		
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

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

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

SP – Specialty Medication

HD – May require home delivery pharmacy

PPACA – No Cost-Share Preventive Medication

CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

EENT PREPS (Eye Conditions) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
OPHTH. VEGF-A RECEPTOR ANTAG. RCMB MC ANTIBODY		
LUCENTIS	T3	PA SP
OPHTHALMIC ANTI-FIBROTIC AGENTS		
MITOMYCIN-WATER	T3	
MITOSOL	T3	
OPHTHALMIC ANTI-INFLAMMATORY IMMUNOMODULATOR-TYPE		
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
OPHTHALMIC CYSTINE DEPLETING AGENTS		
CYSTARAN	T2	SP
OPHTHALMIC HUMAN NERVE GROWTH FACTOR (HNGF)		
OXERVATE	T2	PA SP HD
OPHTHALMIC PREPARATIONS, MISCELLANEOUS		
biolon	T1	SP
OPHTHALMIC PROTEOLYTIC ENZYME AGENTS		
JETREA	T2	
OPHTHALMIC SURGICAL AIDS		
ocucoat (Cellugel)	T1	
ELECT/CALORIC/H2O (Dental Products)		
FLUORIDE PREPARATIONS		
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

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

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

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
FLUORIDE PREPARATIONS (cont.)		
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

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

ELECT/CALORIC/H2O (Miscellaneous)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
NUCLEIC ACID/NUCLEOTIDE SUPPLEMENTS		
XURIDEN	T2	SP
ELECT/CALORIC/H2O (Nutritional/Dietary)		
CARBOHYDRATES		
ENFAMIL	T2	
GLUTOL	T2	
ELECTROLYTE DEPLETERS		
<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)
FLUORIDE PREPARATIONS		
PREVENTID KIDS	T3	
IODINE CONTAINING AGENTS		
<i>Jugol's</i>	T1	
SSKI	T3	
<i>strong iodine</i>	T1	
IRON REPLACEMENT		
cvs iron 27 mg tablet (Fergon)	T1	
cvs iron 65 mg tablet	T1	
eql iron 65 mg tablet	T1	
<i>ferrous fum/vit c/b12-if/folic</i>	T1	PPACA
FERROUS SULF 300 MG/5 ML CUP	T3	
<i>ferrous sulf 15 mg iron/ml drp</i> (Fer-In-Sol)	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

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

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
IRON REPLACEMENT (cont.)		
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	
------------------------	----	--

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

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

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
POTASSIUM REPLACEMENT (cont.)		
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	
PROTEIN REPLACEMENT		
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

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

ELECT/CALORIC/H2O (Urinary Tract Conditions) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
URINARY PH MODIFIERS (cont.)		
RENACIDIN	T2	HD
UROCIT-K (<i>potassium er</i>)	T3	HD
GASTROINTESTINAL (Cholesterol Medications)		
LIPOTROPICS		
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
GASTROINTESTINAL (Gastrointestinal/Heartburn)		
AMMONIA INHIBITORS		
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
ANTI-CHOLINERGICS, QUATERNARY AMMONIUM		
<i>clidinium w/chlordiazepoxide</i> (Librax)	T1	
CUVPOSA	T3	
GLYCATE	T3	
<i>glycopyrrrolate</i> (Glycate)	T1	
<i>propantheline bromide</i>	T1	
ANTI-CHOLINERGICS/ANTI-SPASMODICS		
<i>dicyclomine hcl</i>	T1	
ANTI-DIARRHEAL - TRYPTOPHAN HYDROXYLASE INHIBITOR		
XERMELO	T2	PA QL (84 tabs/28 days) SP
ANTI-DIARRHEALS		
<i>diphenoxylate w/atropine</i> (Lomotil)	T1	
LOMOTIL (<i>diphenoxylate-atropine</i>)	T3	
MOTOFEN	T3	
<i>opium</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

HD – May require home delivery pharmacy

PPACA – No Cost-Share Preventive Medication

CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

GASTROINTESTINAL (Gastrointestinal/Heartburn) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ANTI-EMETIC, CANNABINOID-TYPE		
dronabinol (Marinol)	T1	PA
SYNDROS	T3	PA
ANTI-EMETIC/ANTI-VERTIGO AGENTS		
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
ANTI-ULCER PREPARATIONS		
CYTOTEC (misoprostol)	T3	HD
misoprostol (Cytotec)	T1	HD
sucralfate (Carafate)	T1	HD
ANTI-ULCER-H.PYLORI AGENTS		
lansoprazole-amoxicil-clarithro	T1	QL
OMECLAMOX-PAK	T3	QL
TALICIA	T2	QL
VOQUEZNA DUAL PAK	T3	
VOQUEZNA TRIPLE PAK	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

GASTROINTESTINAL (Gastrointestinal/Heartburn) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
BELLADONNA ALKALOIDS		
<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>LEVVID (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
BILE SALTS		
<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
CHRONIC INFLAM. COLON DX, 5-A-SALICYLAT, RECTAL TX		
<i>mesalamine (Canasa)</i>	T1	
<i>mesalamine (Rowasa)</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

HD – May require home delivery pharmacy

PPACA – No Cost-Share Preventive Medication

CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

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

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

PA – Prior Authorization

QL – Quantity Limit

ST – Step Therapy

AGE – Age Requirement

SP – Specialty Medication

HD – May require home delivery pharmacy

PPACA – No Cost-Share Preventive Medication

CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

GASTROINTESTINAL (Gastrointestinal/Heartburn) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
INTESTINAL MOTILITY STIMULANTS		
<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	
IRRITABLE BOWEL SYND. AGENT, 5-HT4 PARTIAL AGO		
ZELNORM	T3	
IRRITABLE BOWEL SYNDROME AGENTS, 5-HT3 ANTAGONIST		
<i>alosetron hcl</i> (Lotronex)	T1	SP HD
LAXATIVES AND CATHARTICS		
<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	

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

GASTROINTESTINAL (Gastrointestinal/Heartburn) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
LAXATIVES AND CATHARTICS (cont.)		
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
LOCAL ANORECTAL NITRATE PREPARATIONS		
<i>nitroglycerin</i> 0.4% ointment (Rectiv)	T1	
RECTIV (<i>nitroglycerin</i>)	T2	
MU-OPIOID RECEPTOR ANTAGONISTS, PERIPHERALLY-ACTING		
ENTEREG	T3	
PANCREATIC ENZYMES		
CREON	T2	HD
VIOKACE	T2	HD
ZENPEP	T2	HD
POTASSIUM-COMPETITIVE ACID BLOCKERS (PCABS)		
VOQUEZNA	T3	ST
PROTON-PUMP INHIBITORS		
<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

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

GASTROINTESTINAL (Gastrointestinal/Heartburn) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
PROTON-PUMP INHIBITORS (cont.)		
<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
RECTAL PREPARATIONS		
<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
SBS - GLUCAGON-LIKE PEPTIDE-2 (GLP-2) ANALOGS		
GATTEX	T3	SP HD
GASTROINTESTINAL (Pain Relief And Inflammatory Disease)		
HEMORRHOID PREP, ANTI-INFLAM STEROID-LOCAL ANESTHET		
<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	
HORMONES (Gastrointestinal/Heartburn)		
RECTAL/LOWER BOWEL PREP., GLUCOCORT. (NON-HEMORR)		
<i>colocort</i> (Cortenema)	T1	
<i>CORTENEMA (hydrocortisone)</i>	T3	
<i>hydrocortisone</i> (Cortenema)	T1	
<i>UCERIS (budesonide)</i>	T3	
HORMONES (Hormonal Agents)		
ADRENOCORTICOTROPHIC HORMONES		
ACTHAR SELFJECT	T3	PA SP HD

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

PA – Prior Authorization

QL – Quantity Limit

ST – Step Therapy

AGE – Age Requirement

SP – Specialty Medication

HD – May require home delivery pharmacy

PPACA – No Cost-Share Preventive Medication

CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

HORMONES (Hormonal Agents) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ADRENOCORTICOTROPHIC HORMONES		
ACTHAR SELFJECT	T3	PA SP HD
ANDROGENIC AGENTS		
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)
ANTI-DIURETIC AND VASOPRESSOR HORMONES		
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	
ESTROGEN/ANDROGEN COMBINATIONS		
covaryx	T1	HD
covaryx h.s.	T1	HD
eemt	T1	HD
eemt hs	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

HORMONES (Hormonal Agents) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ESTROGEN/ANDROGEN COMBINATIONS (cont.)		
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 & methyltestosterone</i>	T1	HD
ESTROGENIC AGENTS		
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
ESTROGEN-PROGESTIN WITH ANTI-MINERALOCORTICOID COMB		
ANGELIQ	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

PPACA – No Cost-Share Preventive Medication

CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

HORMONES (Hormonal Agents) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ESTROGEN-SELECTIVE ESTROGEN RECEPTOR MOD (SERM) COMB		
DUAVEE	T2	
GLUCOCORTICOIDS		
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	
<i>decadron</i>	T1	
<i>deflazacort</i>	T1	PA SP HD
<i>deflazacort</i> (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

ST – Step Therapy

AGE – Age Requirement

SP – Specialty Medication

HD – May require home delivery pharmacy

PPACA – No Cost-Share Preventive Medication

CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

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

HORMONES (Hormonal Agents) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
PROGESTATIONAL AGENTS		
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
SOMATOSTATIC AGENTS		
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
VAGINAL ESTROGEN PREPARATIONS		
<i>estradiol (Estrace)</i>	T1	HD
<i>estradiol (Vagifem)</i>	T1	
<i>yuvafem (Vagifem)</i>	T1	HD
HORMONES (Infertility)		
HUMAN CHORIONIC GONADOTROPIN (HCG)		
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
PREGNANCY FACILITATING/MAINTAINING AGENT,HORMONAL		
ENDOMETRIN	T3	ST
HORMONES (Miscellaneous)		
LEPTIN HORMONE ANALOGS		
MYALEPT	T2	PA SP HD
HORMONES (Osteoporosis Products)		
BONE FORMATION STIMULATING AGTS - PTH REL PEPTIDES		
TYMLOS	T2	PA QL SP HD
BONE RESORPTION INHIBITORS		
<i>calcitonin-salmon</i>	T1	HD
MIACALCIN	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

PPACA – No Cost-Share Preventive Medication

CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

IMMUNOSUPPRESSANTS (Pain Relief And Inflammatory Disease)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
HUMAN INTERLEUKIN I2/23 (IL-12/13) INHIBITORS, MAB		
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
IL-23 RECEPTOR ANTAGONIST, MONOCLONAL ANTIBODY		
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
INTERLEUKIN-4(IL-4) RECEPTOR ALPHA ANTAGONIST, MAB		
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
INTERLEUKIN-6 (IL-6) RECEPTOR INHIBITORS		
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
MONOCLONAL ANTIBODY-HUMAN INTERLEUKIN I2/23 INHIB		
STELARA	T2	PA QL SP HD
IMMUNOSUPPRESSANTS (Skin Conditions)		
INTERLEUKIN-31(IL-31)RECEPTOR ALPHA ANTAGONIST,MAB		
NEMLUVIO	T2	PA QL (2 pens/28 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

PPACA – No Cost-Share Preventive Medication

CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

IMMUNOSUPPRESSANTS (Skin Conditions) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
TOPICAL IMMUNOSUPPRESSIVE AGENTS		
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	

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

PA – Prior Authorization

QL – Quantity Limit

ST – Step Therapy

AGE – Age Requirement

SP – Specialty Medication

HD – May require home delivery pharmacy

PPACA – No Cost-Share Preventive Medication

CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

MISCELLANEOUS MEDICAL SUPPLIES, DEVICES, NON-DRUG (Diabetes) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
DIABETIC SUPPLIES (cont.)		
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

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

PA – Prior Authorization

QL – Quantity Limit

ST – Step Therapy

AGE – Age Requirement

SP – Specialty Medication

HD – May require home delivery pharmacy

PPACA – No Cost-Share Preventive Medication

CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

MISCELLANEOUS MEDICAL SUPPLIES, DEVICES, NON-DRUG (Diabetes) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
DIABETIC SUPPLIES (cont.)		
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	

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

PA – Prior Authorization

QL – Quantity Limit

ST – Step Therapy

AGE – Age Requirement

SP – Specialty Medication

HD – May require home delivery pharmacy

PPACA – No Cost-Share Preventive Medication

CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

MISCELLANEOUS MEDICAL SUPPLIES, DEVICES, NON-DRUG (Diabetes) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
DIABETIC SUPPLIES (cont.)		
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	

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

PA – Prior Authorization

QL – Quantity Limit

ST – Step Therapy

AGE – Age Requirement

SP – Specialty Medication

HD – May require home delivery pharmacy

PPACA – No Cost-Share Preventive Medication

CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

MISCELLANEOUS MEDICAL SUPPLIES, DEVICES, NON-DRUG (Diabetes) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
DIABETIC SUPPLIES (cont.)		
TWIIST RFL(INFUS-CSST-NDL-SYR)	T2	
TWIIST STARTER KIT	T2	
ULTI-LANCE	T2	
VGO 20	T2	
VGO 30	T2	
VGO 40	T2	
DURABLE MEDICAL EQUIPMENT,MISC (GROUP I)		
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	

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

PA – Prior Authorization

QL – Quantity Limit

ST – Step Therapy

AGE – Age Requirement

SP – Specialty Medication

HD – May require home delivery pharmacy

PPACA – No Cost-Share Preventive Medication

CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

MISCELLANEOUS MEDICAL SUPPLIES, DEVICES, NON-DRUG (Diabetes) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
DURABLE MEDICAL EQUIPMENT,MISC (GROUP I) (cont.)		
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	

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

PA – Prior Authorization

QL – Quantity Limit

ST – Step Therapy

AGE – Age Requirement

SP – Specialty Medication

HD – May require home delivery pharmacy

PPACA – No Cost-Share Preventive Medication

CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

MISCELLANEOUS MEDICAL SUPPLIES, DEVICES, NON-DRUG (Diabetes) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
DURABLE MEDICAL EQUIPMENT,MISC (GROUP I) (cont.)		
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

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

PA – Prior Authorization

QL – Quantity Limit

ST – Step Therapy

AGE – Age Requirement

SP – Specialty Medication

HD – May require home delivery pharmacy

PPACA – No Cost-Share Preventive Medication

CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

MISCELLANEOUS MEDICAL SUPPLIES, DEVICES, NON-DRUG (Diabetes) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
DURABLE MEDICAL EQUIPMENT,MISC (GROUP I) (cont.)		
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

SP – Specialty Medication

HD – May require home delivery pharmacy

PPACA – No Cost-Share Preventive Medication

CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

MISCELLANEOUS MEDICAL SUPPLIES, DEVICES, NON-DRUG (Diabetes) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
DURABLE MEDICAL EQUIPMENT,MISC (GROUP I) (cont.)		
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	

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

PA – Prior Authorization

QL – Quantity Limit

ST – Step Therapy

AGE – Age Requirement

SP – Specialty Medication

HD – May require home delivery pharmacy

PPACA – No Cost-Share Preventive Medication

CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

MISCELLANEOUS MEDICAL SUPPLIES, DEVICES, NON-DRUG (Diabetes) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
DURABLE MEDICAL EQUIPMENT,MISC (GROUP I) (cont.)		
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	
NEEDLES/NEEDLELESS DEVICES		
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	

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

PA – Prior Authorization

QL – Quantity Limit

ST – Step Therapy

AGE – Age Requirement

SP – Specialty Medication

HD – May require home delivery pharmacy

PPACA – No Cost-Share Preventive Medication

CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

MISCELLANEOUS MEDICAL SUPPLIES, DEVICES, NON-DRUG (Diabetes) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
NEEDLES/NEEDLELESS DEVICES (cont.)		
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	
SYRINGES AND ACCESSORIES		
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	

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

PA – Prior Authorization

QL – Quantity Limit

ST – Step Therapy

AGE – Age Requirement

SP – Specialty Medication

HD – May require home delivery pharmacy

PPACA – No Cost-Share Preventive Medication

CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

MISCELLANEOUS MEDICAL SUPPLIES, DEVICES, NON-DRUG (Diabetes) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
SYRINGES AND ACCESSORIES (cont.)		
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	
MISCELLANEOUS MEDICAL SUPPLIES, DEVICES, NON-DRUG (Miscellaneous)		
DURABLE MEDICAL EQUIPMENT,MISC (GROUP I)		
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	
PARENTERAL ADMINISTRATION SETS		
ACCU-CHEK	T3	
RESPIRATORY AIDS, DEVICES, EQUIPMENT		
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	

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

PA – Prior Authorization

QL – Quantity Limit

ST – Step Therapy

AGE – Age Requirement

SP – Specialty Medication

HD – May require home delivery pharmacy

PPACA – No Cost-Share Preventive Medication

CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

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

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
RESPIRATORY AIDS, DEVICES, EQUIPMENT (cont.)		
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

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

MUSCLE RELAXANTS (Pain Relief And Inflammatory Disease) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
SKELETAL MUSCLE RELAXANTS (cont.)		
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

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

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

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
PRENATAL VITAMIN PREPARATIONS (cont.)		
<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

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

PSYCHOTHERAPEUTIC DRUGS (Anxiety/Depression/Bipolar Disorder) ⁸		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ALPHA-2 RECEPTOR ANTAGONIST ANTI-DEPRESSANTS		
<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
ANTI-ANXIETY - BENZODIAZEPINES		
<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	
ANTI-ANXIETY DRUGS		
<i>buspirone hcl</i>	T1	HD
<i>meprobamate</i>	T1	
ANTIDEPRESSANT - POSTPARTUM DEPRESSION (PPD)		
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
BIPOLAR DISORDER DRUGS		
EQUETRO	T3	HD
<i>lithium</i>	T1	HD
<i>lithium carbonate</i> (Lithobid)	T1	HD
LITHOBID (<i>lithium carbonate er</i>)	T3	HD
MAOIS -NON-SELECTIVE, IRREVERSIBLE ANTI-DEPRESSANTS		
MARPLAN	T3	
NARDIL (phenelzine)	T3	
PARNATE (tranylcypromine)	T3	
<i>phenelzine</i> (Nardil)	T1	
<i>tranylcypromine</i> (Parnate)	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

PSYCHOTHERAPEUTIC DRUGS (Anxiety/Depression/Bipolar Disorder) ⁸ (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
MONOAMINE OXIDASE (MAO) INHIBITOR ANTI-DEPRESSANTS		
EMSAM	T3	
NDMA RECEPTOR ANTAGONIST AND NDRI COMB		
AUVELITY	T3	ST QL (60 tabs/30 days)
NOREPINEPHRINE AND DOPAMINE REUPTAKE INHIB (NDRIs)		
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
SELECTIVE SEROTONIN 5-HT2A INVERSE AGONISTS (SSIAs)		
NUPLAZID	T3	PA QL SP HD
SELECTIVE SEROTONIN REUPTAKE INHIBITOR (SSRIs)		
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
SEROTONIN-2 ANTAGONIST/REUPTAKE INHIBITORS (SARIs)		
nefazodone hcl	T1	HD
trazodone hcl	T1	HD
SEROTONIN-NOREPINEPHRINE REUPTAKE-INHIB (SNRIs)		
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)

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

PSYCHOTHERAPEUTIC DRUGS (Anxiety/Depression/Bipolar Disorder) ⁸ (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
SEROTONIN-NOREPINEPHRINE REUPTAKE-INHIB (SNRIs) (cont.)		
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
SSRI, SEROTONIN RECEPTOR MODULATOR ANTI-DEPRESSANTS		
TRINTELLIX	T3	ST QL (30 tabs/30 days)
TRICYCLIC ANTI-DEPRESSANT-BENZODIAZEPINE COMBINATNS		
<i>amitriptyline/chlordiazepoxide</i>	T1	HD
<i>amitriptyline-perphenazine</i>	T1	HD
TRICYCLIC ANTI-DEPRESSANTS, REL.NON-SEL.REUPT-INHIB		
<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
PSYCHOTHERAPEUTIC DRUGS (Attention Deficit Hyperactivity Disorder)⁸		
ADRENERGICS, AROMATIC, NON-CATECHOLAMINE		
<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

HD – May require home delivery pharmacy

PPACA – No Cost-Share Preventive Medication

CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

PSYCHOTHERAPEUTIC DRUGS (Attention Deficit Hyperactivity Disorder) ⁸ (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ADRENERGICS, AROMATIC, NON-CATECHOLAMINE (cont.)		
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
TX FOR ADHD - SELECTIVE ALPHA-2 RECEPTOR AGONIST		
clonidine hcl er (Kapvay)	T1	
guanfacine hcl (Intuniv)	T1	HD
guanfacine hcl er (Intuniv)	T1	
KAPVAY (clonidine hcl er)	T3	ST
TX FOR ATTENTION DEFICIT-HYPERACT (ADHD)/NARCOLEPSY		
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

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

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

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
TX FOR ATTENTION DEFICIT-HYPERACT (ADHD)/NARCOLEPSY (cont.)		
<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)⁸

ANTI-PSYCH, DOPAMINE ANTAG., DIPHENYLBUTYLPIPERIDINES

<i>pimozide</i>	T1	
-----------------	----	--

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

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

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

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

PA – Prior Authorization

QL – Quantity Limit

ST – Step Therapy

AGE – Age Requirement

SP – Specialty Medication

HD – May require home delivery pharmacy

PPACA – No Cost-Share Preventive Medication

CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

SEDATIVE/HYPNOTICS (Sleep Disorders/Sedatives)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ANTI-NARCOLEPSY, ANTI-CATAPLEXY, SEDATIVE-TYPE AGENT (cont.)		
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)
BARBITURATES		
<i>phenobarbital</i>	T1	
<i>seconal (Seconal Sodium)</i>	T1	QL (30 units/30 days)
HYPNOTICS, MELATONIN MT1/MT2 RECEPTOR AGONISTS		
HETLIOZ	T3	PA QL (30 units/30 days) SP HD
<i>ramelteon (Rozerem)</i>	T1	QL (30 units/30 days)
SEDATIVE-HYPNOTICS - BENZODIAZEPINES		
<i>estazolam</i>	T1	QL (15 tabs/fill)
<i>flurazepam hcl</i>	T1	
<i>HALCION (triazolam)</i>	T3	
<i>midazolam hcl</i>	T1	
<i>RESTORIL (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)
SEDATIVE-HYPNOTICS, NON-BARBITURATE		
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)
<i>INTERMEZZO (zolpidem tartrate)</i>	T3	ST QL (30 units/30 days)
MKO (MIDAZOLAM-KETAMINE-ONDAN)	T3	
QUVIVIQ	T3	ST QL (30 tabs/fill)
<i>SILENOR (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

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

SKIN PREPS (Miscellaneous)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
IRRIGANTS		
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	
OXIDIZING AGENTS		
hydrogen peroxide	T1	
SKIN PREPS (Pain Relief And Inflammatory Disease)		
ANTI-PSORIATIC AGENTS, SYSTEMIC		
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
TOPICAL ANTI-INFLAMMATORY, NSAIDS		
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)		
ACNE AGENTS, SYSTEMIC		
ABSORICA	T2	ST
ABSORICA LD	T3	
amnesteem (Absorica)	T1	
claravis (Absorica)	T1	
isotretinoin (Absorica)	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

SKIN PREPS (Skin Conditions) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ACNE AGENTS, SYSTEMIC (cont.)		
<i>isotretinoin authorized generics by Sun pharmaceuticals</i>	T1	ST
<i>myorisan (Absorica)</i>	T1	
<i>zenatane (Absorica)</i>	T1	
ACNE AGENTS, TOPICAL		
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
ANTI-PRURITICS, TOPICAL		
<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)
ANTI-PSORIATICS AGENTS		
<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

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

SKIN PREPS (Skin Conditions) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ANTI-PSORIATICS AGENTS (cont.)		
VECTICAL (<i>calcitriol</i>)	T3	
VTAMA	T2	PA QL (60 gms/28 days)
ZORYVE 0.3% CREAM	T3	PA QL (60 gms/30 days)
ANTI-SEBORRHEIC AGENTS		
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)
ANTISEPTICS,GENERAL		
GS ALCOHOL 70% SWABS	T2	
DIABETIC ULCER PREPARATIONS, TOPICAL		
REGRANEX	T2	QL
IMMUNOMODULATORS		
ALDARA (<i>imiquimod</i>)	T3	
<i>imiquimod</i> (Aldara)	T1	
IRRITANTS/COOOUNTER-IRRITANTS		
YCANTH	T3	SP
KERATOLYTICS		
<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

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

SKIN PREPS (Skin Conditions) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
PROTECTIVES		
PHARMABASE (<i>pharmabase barrier</i>)	T3	
zinc oxide	T1	
ROSACEA AGENTS, TOPICAL		
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	
TISSUE/WOUND ADHESIVES		
ARTISS	T3	
TISSEEL VHSD	T3	
TOP. ANTI-INFLAM., PHOSPHODIESTERASE-4 (PDE4) INHIB		
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)
TOPICAL AGENTS, MISCELLANEOUS		
HYFTOR 0.2% GEL	T3	PA
L-MESITRAN SOFT	T3	
TOPICAL ANTIBIOTIC PLEUROMUTILIN DERIVATIVES		
ALTABAX	T3	ST QL (30 units/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

SKIN PREPS (Skin Conditions) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
TOPICAL ANTICHOLINERGIC HYPERHIDROSIS TX AGENTS		
QBREXZA	T3	PA
TOPICAL ANTI-INFLAMMATORY STEROIDAL		
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	

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

SKIN PREPS (Skin Conditions) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
TOPICAL ANTI-INFLAMMATORY STEROIDAL (cont.)		
<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

HD – May require home delivery pharmacy

PPACA – No Cost-Share Preventive Medication

CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

SKIN PREPS (Skin Conditions) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
TOPICAL ANTI-INFLAMMATORY STEROIDAL (cont.)		
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
TOPICAL ANTI-INFLAMMATORY STEROID-LOCAL ANESTHETIC		
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
TOPICAL ANTI-PARASITICS		
<i>lindane</i>	T1	
<i>malathion</i> (Ovide)	T1	
OVIDE (<i>malathion</i>)	T3	
TOPICAL PREPARATIONS, ANTIBACTERIALS		
<i>iodine</i>	T1	
<i>iodine</i> (Lugol'S)	T1	
IODOFLEX	T3	
IODOSORB	T3	
TOPICAL VIT D ANALOG/ANTI-INFLAMMATORY STEROID		
<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
TOPICAL/MUCOUS MEMBR./SUBCUT. ENZYMES		
SANTYL	T2	QL
VITAMIN A DERIVATIVES		
<i>adapalene</i> (Differin)	T1	
AKLIEF	T3	PA ST
ALTRENO	T3	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

SP – Specialty Medication

HD – May require home delivery pharmacy

PPACA – No Cost-Share Preventive Medication

CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

SKIN PREPS (Skin Conditions) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
VITAMIN A DERIVATIVES (cont.)		
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
VITAMIN A DERIVATIVES, TOPICAL ACNE AGENTS		
FABIOR	T3	PA
SMOKING DETERRENTS (Smoking Cessation)⁸		
SMOKING DETERRENT AGENTS (GANGLIONIC STIM, OTHERS)		
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	
SMOKING DETERENT-NICOTINIC RECEPT.PARTIAL AGONIST		
CHANTIX	T3	QL (180 Days Supply/365 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

SMOKING DETERRENTS (Smoking Cessation) ⁸ (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
SMOKING DETERRENTS, OTHER		
bupropion sr	T1	QL (180 days supply/365 days) PPACA
THYROID PREPS (Hormonal Agents)		
ANTI-THYROID PREPARATIONS		
methimazole	T1	HD
propylthiouracil	T1	HD
THYROID HORMONES		
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
UNCLASSIFIED DRUG PRODUCTS (AIDS/HIV)		
CYTOCHROME P450 INHIBITORS		
TYBOST	T3	SP
UNCLASSIFIED DRUG PRODUCTS (Asthma/COPD/Respiratory)		
CYSTIC FIBROSIS-CFTR POTENTIATOR-CORRECTOR COMBIN.		
ALYFTREK 10-50-125 MG TABLET	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

QL – Quantity Limit

ST – Step Therapy

AGE – Age Requirement

SP – Specialty Medication

HD – May require home delivery pharmacy

PPACA – No Cost-Share Preventive Medication

CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

UNCLASSIFIED DRUG PRODUCTS (Asthma/COPD/Respiratory) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
CYSTIC FIBROSIS-CFTR POTENTIATOR-CORRECTOR COMBIN. (cont.)		
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)
CYSTIC FIB-TRANSMEMB CONDUCT.REG.(CFTR) POTENTIATOR		
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)
LUNG SURFACTANTS		
CUROSURF	T3	
INFASURF	T3	
SURVANTA	T3	
MUCOLYTICS		
PULMOZYME	T2	SP HD
PULMONARY FIBROSIS - SYSTEMIC ENZYME INHIBITORS		
OFEV	T2	PA QL SP HD
SYSTEMIC ENZYME INHIBITORS		
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)
THYMIC STROMAL LYMPHOPOIETIN (TSLP) INHIBITORS		
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)		
BRADYKININ B2 RECEPTOR ANTAGONISTS		
icatibant (Firazyr)	T1	PA SP HD
PLASMA KALLIKREIN INHIBITORS		
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)		
ANTINEOPLASTIC - ANTIMETABOLITES		
FLUOROURACIL	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

SP – Specialty Medication

HD – May require home delivery pharmacy

PPACA – No Cost-Share Preventive Medication

CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

UNCLASSIFIED DRUG PRODUCTS (Cancer) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
CHEMOTHERAPY RESCUE/ANTIDOTE AGENTS		
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)		
DENTAL AIDS AND PREPARATIONS		
chlorhexidine gluconate	T1	
DENTAL AIDS AND PREPARATIONS (cont.)		
oralone	T1	
PERIDEX (chlorhexidine gluconate)	T3	
periogard	T1	
triamcinolone acetonide	T1	
PERIODONTAL COLLAGENASE INHIBITORS		
doxycycline hyclate	T1	
UNCLASSIFIED DRUG PRODUCTS (Erectile Dysfunction)		
DRUGS TO TREAT ERECTILE DYSFUNCTION (ED)		
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)		
NICOTINIC RECEPT.PARTIAL AGONIST, ALPHA4BETA2 SPEC		
TYRVAYA 0.03 MG NASAL SPRAY	T3	PA
UNCLASSIFIED DRUG PRODUCTS (Gastrointestinal/Heartburn)		
AGENTS FOR STOMATOLOGICAL USE		
PROTHELIAL	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

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

PA – Prior Authorization

QL – Quantity Limit

ST – Step Therapy

AGE – Age Requirement

SP – Specialty Medication

HD – May require home delivery pharmacy

PPACA – No Cost-Share Preventive Medication

CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

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

UNCLASSIFIED DRUG PRODUCTS (Miscellaneous) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
GENERAL INHALATION AGENTS		
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	
GENETIC D/O TX - SMN PROTEIN DEFICIENCY TREATMENT		
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
GLUCOSYLCERAMIDE SYNTHASE (GCS) INHIBITOR		
miglustat (Zavesca)	T1	PA QL (90 caps/30 days) SP
OPFOLDA	T3	PA QL (8 caps/fill) SP HD
MENOPAUSAL SYMPTOMS SUPPRESSANT-NK3 RECEPTOR ANTAG		
VEOZAH	T2	
MENOPAUSAL SYMPTOMS SUPPRESSANT - SSRIs		
paroxetine mesylate (Brisdelle)	T1	QL (30 units/30 days) HD
METABOLIC DISEASE ENZYME REPLACE, HYPOPHOSPHATASIA		
STRENSIQ	T2	PA SP
METABOLIC DISEASE ENZYME REPLACEMENT, MOCD		
NULIBRY 9.5 MG VIAL	T3	PA
METABOLIC DISEASE ENZYME REPLACEMENT, POMPE DISEASE		
NEXVIAZYME 100 MG VIAL	T3	PA
METALLIC POISON, AGENTS TO TREAT		
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

PA – Prior Authorization

QL – Quantity Limit

ST – Step Therapy

AGE – Age Requirement

SP – Specialty Medication

HD – May require home delivery pharmacy

PPACA – No Cost-Share Preventive Medication

CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

UNCLASSIFIED DRUG PRODUCTS (Miscellaneous) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
NATRIURETIC PEPTIDES		
VOXZOGO 0.4 MG VIAL	T3	PA SP
NEONATAL FC RECEPTOR (FCRN) INHIBITORS		
VYVGART HYTRULO	T3	PA SP HD
PHARMACOLOGICAL CHAPERONE-ALPHA-GALACTOSID.A STABZ		
GALAFOLD	T3	PA QL SP HD
PROTEIN STABILIZERS		
ATTRUBY	T2	PA SP
VYNDAMAX	T2	PA SP HD
VYNDAQEL	T2	PA SP HD
RETINOIC ACID RECEPTOR (RAR) AGONISTS		
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
SOLVENTS		
<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	
SUSPENDING AGENTS		
GELFILM	T3	
HYDROXYPROPYLECELLULOSE	T2	
HYPROMELLOSE	T2	
TREATMENT OF HYPERPHAGIA IN PRADER-WILLI SYNDROME		
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

SP – Specialty Medication

HD – May require home delivery pharmacy

PPACA – No Cost-Share Preventive Medication

CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

UNCLASSIFIED DRUG PRODUCTS (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

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

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

UNCLASSIFIED DRUG PRODUCTS (Urinary Tract Conditions)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
BENIGN PROSTATIC HYPERPLASIA/MICTURITION AGENTS		
<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
BPH 5-ALPHA-REDUCTASE INHIB-ALPHAI-ADRENOCEP ANTAG		
<i>dutasteride/tamsulosin hcl</i> (Jalyn)	T1	ST HD
JALYN (<i>dutasteride/tamsulosin hcl</i>)	T3	ST HD
CYSTINE-DEPLETING AGENTS, NEPHROPATHIC CYSTINOSIS		
CYSTAGON	T2	SP
ENDOTHELIN RECEPTOR ANTAGONISTS		
VANRAFIA	T3	PA SP
KIDNEY STONE AGENTS		
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
OVERACTIVE BLADDER AGENTS, BETA-3 ADRENERGIC RECEPTOR ANTAGONISTS		
GEMTESA	T3	
<i>mirabegron</i> (Myrbetriq)	T1	HD
MYRBETRIQ	T2	HD
MYRBETRIQ (<i>mirabegron</i>)	T2	HD
URINARY TRACT ANTI-SPASMODIC, M(3) SELECTIVE ANTAG.		
<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

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

UNCLASSIFIED DRUG PRODUCTS (Urinary Tract Conditions) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
URINARY TRACT ANTI-SPASMODIC/ANTI-INCONTINENCE AGENT		
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
UNCLASSIFIED DRUG PRODUCTS (Weight Management)		
APPETITE STIM. FOR ANOREXIA, CACHEXIA, WASTING SYND.		
<i>megestrol acetate</i>	T1	
VITAMINS (Nutritional/Dietary)		
ANTIOXIDANT MULTIVITAMIN COMBINATIONS		
EYE HEALTH WITH LUTEIN	T3	
LUTEIN PLUS WITH ZEAXANTHIN	T3	
VISION OPTIMIZER	T3	
VITEYES AREDS 2 PLUS MULTIVIT	T3	
BIOFLAVONOIDS		
FLAVOVIT	T3	
LIPO FLAVONOID	T3	
FOLIC ACID PREPARATIONS		
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	

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
MULTIVITAMIN PREPARATIONS		
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	

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
MULTIVITAMIN PREPARATIONS (cont.)		
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	

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
MULTIVITAMIN PREPARATIONS (cont.)		
TRUE MULTIVITAMIN	T3	
VITACORE	T3	
VITAFUSION PRENATAL	T3	
VITAJOY ADULT MULTI	T3	
<i>vitamin b complex with c</i>	T1	HD PPACA
NIACIN PREPARATIONS		
<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	
PANTHENOL PREPARATIONS		
PANTOTHENIC ACID	T3	
PUREVITA VITAMIN B5	T3	
PEDIATRIC VITAMIN PREPARATIONS		
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	

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
PEDIATRIC VITAMIN PREPARATIONS (cont.)		
<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 & fluoride</i>	T1	PPACA
VITAMIN A PREPARATIONS		
FT VITAMIN A 3,000 MCG SOFTGEL	T3	
GNP VITAMIN A 3,000 MCG SOFTGL	T3	
PUREVITA VITAMIN A	T3	
VITAMIN B PREPARATIONS		
<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

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

PA – Prior Authorization

QL – Quantity Limit

ST – Step Therapy

AGE – Age Requirement

SP – Specialty Medication

HD – May require home delivery pharmacy

PPACA – No Cost-Share Preventive Medication

CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

VITAMINS (Nutritional/Dietary) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
VITAMIN B PREPARATIONS (cont.)		
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 & 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
VITAMIN B1 PREPARATIONS		
<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% NAACL	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	
VITAMIN B12 PREPARATIONS		
<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	

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

PA – Prior Authorization

QL – Quantity Limit

ST – Step Therapy

AGE – Age Requirement

SP – Specialty Medication

HD – May require home delivery pharmacy

PPACA – No Cost-Share Preventive Medication

CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

VITAMINS (Nutritional/Dietary) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
VITAMIN B12 PREPARATIONS (cont.)		
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	
VITAMIN B2 PREPARATIONS		
PUREVITA VITAMIN B2	T3	
RIBOFLAVIN 100 MG CAPSULE	T3	
VITAMIN B6 PREPARATIONS		
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
VITAMIN B6 PREPARATIONS (cont.)		
vitamin b-6 250 mg tablet	T1	
vitamin b-6 50 mg tablet	T1	
VITAMIN C PREPARATIONS		
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	
VITAMIN D PREPARATIONS		
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

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

PA – Prior Authorization

QL – Quantity Limit

ST – Step Therapy

AGE – Age Requirement

SP – Specialty Medication

HD – May require home delivery pharmacy

PPACA – No Cost-Share Preventive Medication

CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

VITAMINS (Nutritional/Dietary) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
VITAMIN D PREPARATIONS (cont.)		
<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

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

PA – Prior Authorization

QL – Quantity Limit

ST – Step Therapy

AGE – Age Requirement

SP – Specialty Medication

HD – May require home delivery pharmacy

PPACA – No Cost-Share Preventive Medication

CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

VITAMINS (Nutritional/Dietary) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
VITAMIN E PREPARATIONS		
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	
VITAMIN K PREPARATIONS		
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	
VITAMINS (Vitamins)		
MULTIVITAMIN PREPARATIONS		
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	
PEDIATRIC VITAMIN PREPARATIONS		
ft children's multi gummy	T1	
GNP CHILDREN'S MULTI GUMMY	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

Exclusions and limitations for coverage

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

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

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

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

Index of Medications

Symbols

IST TIER UNILET	125	ADALAT	72
2-IN-1 LANCET	125	ADALIMUMAB	51
A		ADALIMUMAB-ADBM	51
abacavir	62	ADALIMUMAB-RYVK	51
abacavir-lamivudine.....	62	adapalene	144, 149, 150
ABC.....	162	adapalene-benzoyl peroxide	144
ABILIFY.....	141	ADASUVE	141
ABILIFY MYCITE	141	ADBRY	159
abiraterone acetate	52	adefovir dipivoxil	65
ABRYSVO.....	70	ADEMPAS	74
ABSORICA	143	ADIPEX-P	58
ACAM2000.....	70	ADLYXIN	46
acamprosate.....	155	ADRENALIN CHLORIDE	98
acarbose	47	adthyza	151
ACCOLATE	31	ADULT	162, 164, 170
ACCRUFER	104	ADVAIR	30
ACCU-CHEK	121, 125, 132	ADVANCED	125
ACCUPRIL.....	76	ADVOCATE	125, 132
ACCURETIC.....	75	ADZENYS	66
ACD	42	AEMCOLO	38
ACE AEROSOL CLOUD ENHANCER.....	132	AEROCHAMBER	132
acebutolol.....	78	AEROCHAMBER2GO	132
acetaminophen w/butalbital.....	19	AEROTRACH	132
acetaminophen w/codeine	21	AEROVENT	132
acetate ..40, 52, 54, 58, 71, 82, 87, 91, 100, 105, 114, 117, 118, 119, 161		AFINITOR	53
acetazolamide.....	96	AFINITOR DISPERZ 2 MG, 3 MG, 5MG TABLET	53
acetic acid	99, 143	afirmelle	88
acetylcyst	165	AFLURIA	68
acetylcysteine	31	AFTERA	88
acitretin	143	AGAMATRIX	121, 125, 132
ACTEMRA	120	AGRYLIN	61
ACTHAR	114, 115	AIMOVIG	15, 19
ACTHIB	69	AIRDUO DIGIHALER	30
ACTICLATE	38	AIRSUPRA	30
ACTIGALL	110	AJOVY	15, 19
acti-lance	125	AKLIEF	149
ACTI-LANCE	125	ak-poly-bac	33
ACTIMMUNE	58	AKTEN	100
ACTIQ	22	ALA-SCALP HP	147
ACTIVELLA	116	albendazole	49
ACTIVNUTRIENTS	162	ALBENZA	49
ACTONEL	158	albuterol	29
ACTOPLUS MET	48	ALCAINE	100
ACTOS	48	alclometasone dipropionate	147
acyclovir	64, 65	ALCOHOL	50, 157
ACZONE	144	ALDACTONE	97
ADACEL	69	ALDARA	145

Index of Medications

ALECENSA.....	54	amlodipine-valsartan.....	76
alendronate.....	158	amlodipine-valsartan-hctz.....	76
alfuzosin.....	160	amnesteem.....	143
ALINIA	59	amoxapine	138
aliskiren.....	79	amoxicillin	37
ALIVE	162, 164, 170	amoxicillin-clavulanate potass	37
ALKERAN.....	51	amoxicillin-clavulanate pot er.....	37
allopurinol.....	27	amphetamine.....	66, 67
ALLZITAL	19	AMPHETAMINE ER.....	66
almotriptan.....	19, 20	ampicillin trihydrate	37
almotriptan malate.....	15	AMPYRA	83
ALOCRIL.....	100	AMZEEQ.....	39
alophen	112	ANADROL-50	115
ALORA.....	116	ANAFRANIL.....	138
alosetron.....	112	anagrelide hydrochloride	61
ALPHA	31, 47, 67, 75, 76, 120, 136, 139, 157, 160, 162	ANA-LEX.....	114
ALPHAGAN	101	ANALPRAM-HC	114, 149
alprazolam.....	136	ANAPROX DS	27
ALTABAX.....	146	anaspaz	110
altacaine.....	100	anastrozole	52
ALTACE.....	76	ANCOBON	43
ALTAFLUOR BENOX.....	100	ANGELIQ.....	116
altavera.....	88	ANNOVERA.....	87
ALTERNATE.....	125	ANORO ELLIPTA.....	30
ALTRENO.....	149	ANTABUSE	155
ALTRIXA	162	ANTARA	80
ALUNBRIG.....	54	ANTICOAGULANT SODIUM CITRATE.....	42
ALVESCO.....	30	anucort-hc.....	114
alyacen	88, 91	apap-caffeine-dihydrocodeine	22
ALYFTREK.....	151	apexicon e.....	147
amabelz	116	apraclonidine	101
ambrisentan.....	74	aprepitant.....	109
amcinonide	147	APRETUDE.....	63
AMERGE.....	20	apri	88
amethia	88	APRISO	111
amethyst	88	APTENSIO	139
AMICAR	70	APTIOM.....	84
amiloride.....	97	APTIVUS.....	61
aminoacetic acid.....	50	AQNEURSA.....	107
aminocaproic acid.....	70	AQUORAL	154
amiodarone	71	ARAKODA.....	50
amitriptyline.....	138	ARAKODA 100mg tablets	50
amitriptyline/chlordiazepoxide	138	aranelle	88
amitriptyline-perphenazine	138	ARAVA.....	26
amlodipine-atorvastatin.....	79	ARCALYST	159
amlodipine besylate	72, 75	ARCAPTA NEOHALER	29
amlodipine-olmesartan.....	76	AREXVY.....	70

Index of Medications

ARICEPT	66	AUVELITY	137
ARIDOL	95	AUVI-Q	66
ARIKAYCE	34	avanafil	153
ariPIPrazole	141	AVANDIA	48
ARIXTRA	42	avar	40
armodafinil	141	AVAR	40
ARNUITY	30	aviane	88
AROMASIN	52	avidoxy	38
ARRANON	52	AVIDOXY DK	38
ARTHROTEC	27	avita	150
ARTISS	146	AVITA	150
ARYMO ER	22	AVITENE	71
asa-butalb-caff-cod	24	AVONEX	82
ASACOL	III	ayuna	88
ascomp with codeine	24	AYVAKIT	54
ascorbic	168	AZASAN	121
ashlyna	88	AZASITE	33
ASMALPRED	II7	azathioprine	121
ASMANEX	30	azelaic acid	146
aspirin	I9, 25, 60, 61, I34	azelastine	46, 98
ASPIRIN	60	AZELEX	144
ASSURE	I25	azithromycin	36, 37
ASTAGRAF	I21	AZSTARYS	139
atazanavir	63	AZULFIDINE	III
ATELVIA	I58	azurette	88
atenolol	78, 79		
ATIVAN	I36		
atomoxetine	I40		
atorvastatin	79		
atovaquone	50		
atovaquone-proguanil	50		
atropine	I02, I08		
ATROPINE	I02		
ATROVENT HFA	29		
ATTRUBY	I57		
AUBAGIO	82		
aubra	88		
AUDENZ	69		
AUGMENTIN	37		
AUGTYRO	54		
AURANOFIN	27		
aurovela	88		
AURYXIA	I05		
AUSTEDO	81, 82		
AUTOLET	I22, I23		
AUTOSHIELD	I30		
AUTOSOFT	I22		
		B	
		bacitracin	32, 33
		bacitracin/polymyxin	33
		baclofen	I33, I34
		BACTRIM	33
		BAFIERTAM	82
		balance b	I65
		balanced b-complex	I65
		balanced salt	I00
		balsalazide di	III
		BALVERSA	54
		balziva	88
		BANZEL	84
		BARACLUDE	65
		BAXDELA	37
		BCG	69
		b complex	I62, I63, I64, I65, I66
		B-COMPLEX	I65
		b complex w-vitamin c	I62, I65
		BD	95, I25, I30, I31
		BD VERITOR SYSTEM SARS-COV[I]2	95
		bekyree	88

Index of Medications

BELBUCA.....	22	BLEPHAMIDE S.O.P.....	32
belladonna & opium	22	blisovi.....	88
belladonna-phenobarbital.....	110	BLOOD.....	70, 71, 95, 125
BELSOMRA	142	BOCASAL	154
benazepril.....	75, 76, 77	BONJESTA	109
BENLYSTA.....	159	BONSITY.....	158
BENZACLIN	144	BOOSTNOW	170
BENZAMYCIN	39	BOOSTRIX	69
benzepro	145	bosentan.....	74
BENZEPRO	145	BOSULIF	54
BENZNIDAZOLE	50	BRAFTOVI	52
benzonatate.....	93	BREO ELLIPTA	30
benzoyl peroxide.....	39, 40, 144, 145	BREXAFEMME	44
benzphetamine hcl.....	58	BREYANZI	53
benztropine mesylate.....	59	breyna.....	30
beser	147	briellyn	88
BETADINE	99	BRILINTA	60
betaine	158	brimonidine	101
betamethasone	44, 147, 149	BRIMONIDINE	101
BETAPACE.....	78	BRIVIACT	84
BETASERON.....	82	BROMFED-DM	93
betaxolol.....	78, 101	bromfenac.....	99, 100
bethanechol chloride	67	bromipheniramin-pseudoephed-dm	93
BETHKIS.....	34	bromocriptine	59
BETOPTIC	101	brompheniramine w/pseudoephed	93
BEVYXXA.....	42	BRONCHITOL	151
bexarotene	51	BROVANA	30
BEXSERO.....	68	BRUKINSA	54
BEYAZ	88	BRYHALI	147
BEYFORTUS.....	64	budesonide	30, 117
bicalutamide	52	budesonide-formoterol	30
Bidil	79	buffered aspirin	19
BIKTARVY	63	bufferin	19
BILTRICIDE.....	49	BULLSEYE	125
bimatoprost	101	bumetanide	96
BINAXNOW COVID AG CARD HOME TST.....	95	BUPHENYL	108
BINAXNOW COVID-I9 AG CARD	95	buprenorphine	22, 159
BINAXNOW COVID-I9 AG SELF TEST.....	95	bupropion	137, 151
BINOSTO	158	BUPROPION	137
bio glo	96	buspirone	136
biolon.....	103	butalb	19, 24, 25
bisacodyl.....	112	butalb-acetamin-caff 50-300-40	15
bisa-lax.....	112	butalb-acetamin-caff 50-325-40	15
bisoprolol.....	78	butalbacetaminophen/caffeine	15
bisoprolol fumarate	78	butalb-aspirin-caff 50-325-40	15
BLEPH-IO	32	butalbitalacetaminophen.....	15
BLEPHAMIDE	32	butalbitalapap/caffeine.....	19

Index of Medications

butalbital-asa-caffeine cap (Fiorinal).....	15	CAREONE.....	125
butalbital-asp-caffeine	19	CAREPOINT.....	130, 131
butalbital/caff/apap/codeine.....	25	CARESENS.....	125, 132
butalbital compound w/codeine.....	24	CARETOUCH.....	125, 132
butorphanol tartrate.....	22	carglumic	155
BUTTERFLY.....	125	carisoprodol	25, 134
BYDUREON.....	46	carisoprodol-aspirin.....	25, 134
BYETTA	46	carisoprodol-aspirin-codeine.....	25
C		CARNITOR.....	158
cabergoline	118	CAROSPIR	97
CABLIVI.....	70	carteolol.....	101
CADUET	79	cartia	72
CAFERGOT	15, 20	CASODEX.....	52
caffeine d.....	82	CATAPRES.....	77
CALAN	72	CAYA CONTOURED	93
calcipotriene.....	144, 149	CAYSTON.....	35
calcitonin-salmon.....	119	caziant	88
calcitriol.....	144, 145, 168, 169	cefaclor.....	36
CALCIUM.....	72, 105	cefadroxil	36
CALQUENCE	54	cefdinir	36
CAMBIA	20	cefixime	36
camila	88	cefpodoxime proxetil.....	36
camrese.....	88	cefprozil	36
CAMZYOS.....	72	ceftriaxone	36
candesartan cilexetil.....	77	cefuroxime axetil.....	36
candesartan-hydrochlorothiazid	76	celecoxib	28, 29
CAPCOF	94	CELLCEPT	121
capecitabine.....	52	CELONTIN.....	84
CAPEX SHAMPOO.....	147	CENTANY	40
CAPHOSOL.....	154	centrum	162
CAPLYTA.....	141	CENTRUM.....	162, 170
CAPRELSA	54	CEQUA	103
captopril	75, 76	CEQUR SIMPLICITY	122
captopril/hydrochlorothiazide.....	75	CERDELGA	155
CAPVAXIVE	68	CEREFOLIN	165
CARBAGLU.....	155	CERVIDIL	118
carbamazepine.....	84, 86	CETACAINE ANESTHETIC.....	25
CARBAMAZEPINE	84	cetrorelix acetate.....	118
CARBATROL.....	84	cevimeline	67
carbidopa	59, 60	CHANTIX.....	150
carbidopa/levodopa	59	chateal	88
carbidopa-levodopa-entacapone	59	CHEMET	156
carbidopa-levodopa er	59	CHENODAL	110
carbinoxamine	45	children's aspirin	60
cardioplegic	73	chlordiazepoxide.....	108, 136, 138
CARDIZEM	72	chlorhexidine gluconate	153
CARDURA.....	75	chloride.....	67, 106, 107, 156, 161

Index of Medications

chloroquine	50	clindamycin pediatric.....	36
chlorpromazine	141	clindamycin phosphate.....	39, 40
chlorthalidone	78, 79, 98	clindamycin/tretinoin	144
chlorzoxazone	134	CLINDESSE.....	39
CHOLBAM	110	CLINPRO 5000	103
cholestyramine	80	clobazam.....	83, 84
choline mag trisalicylate	19	clobetasol.....	147, 148
choline salicyl/mag salicylate	15	clobetasol propionate	147, 148
CHORIONIC GONAD	119	CLOBEX	147
CHOSEN.....	I22, I26, I32	clodan	147
CIALIS	153	CLODAN	147
ciclodan.....	44	CLODERM.....	147
CICLODAN	51	clomipramine	138
ciclopirox.....	44, 51	clonazepam.....	83, 84
cilostazol	60	clonidine.....	77, 139
CILOXAN	33	clopidogrel	60
CIMDUO.....	61	clorazepate di.....	136
cimetidine	III	clotrimazole.....	43, 44
cinacalcet hcl.....	I54	clovique	156
CINRYZE	I55	clozapine	140
CIPRO	37	CLOZAPINE	140
CIPRODEX	32	CLOZARIL	140
ciprofloxacin.....	31, 32, 33, 37	COAGUCHEK	126
ciprofloxacin hcl	31, 33, 37	COARTEM	50
citalopram	I37	COBALEFOL	I61
CITRANATAL	I35	COCAINE	98
citric acid/sodium citrate	I07	codeine	21, 22, 24, 25, 94
citroma	II2	CODITUSSIN AC	94
claravis	I43	CODITUSSIN DAC	94
CLARINEX	45, 46	COLAZAL	III
CLARINEX-D	45	colchicine	26, 27, 29
clarithromycin	36	colesevelam	80
clarithromycin er	36	COLESTID	80
clearlax	II2	colestipol	80
CLEOCIN HCL	36	colocort	II4
CLEOCIN PALMITATE	36	COLOR	126
CLEOCIN PHOSPHATE	39	COLY-MYCIN S	31
CLEOCIN T	40	COMBIGAN	101
CLEVER	I26, I32	COMBIPATCH	II6
CLEVER CHOICE HOLDING CHAMBER	I32	COMBIVENT	30
clidinium w/chlordiazepoxide	I08	COMBIVENT RESPIMAT	30
CLIMARA	II6	COMBIVIR	62
clindacin	40	COMETRIQ	54
CLINDACIN	40	COMFORT	I26, I28, I29, I30, I33
clindamycin	36, 39, 40, I44	COMFORTSEAL	I32
clindamycin hcl	36	COMIRNATY	68
clindamycin palmitate hcl	36	COMPACT SPACE CHAMBER	I32

Index of Medications

COMPLETE.....	I62, I65	CYCLOSET	46
compro.....	I09	cyclosporine.....	I21
CONDYLOX.....	I45	CYCLOSPORINE IN KLARITY.....	I03
CONSENSI.....	72	CYLTEZO	51
constulose.....	I12	ciproheptadine hcl.....	45
CONTOUR.....	I22	cyred.....	89
CONTRAVE.....	59	CYSTADANE.....	I58
CONZIP	22	CYSTAGON	I60
COPIKTRA.....	54	CYSTARAN	I03
CORDRAN.....	I47	CYTOTEC.....	I09
coremino.....	38	D	
CORTANE-B.....	99	DAILY	I03, I62, I63
CORTEF.....	I17	daily prenatal.....	I34
CORTENEMA.....	I14	dalfampridine	83
cortisone acetate	I17	danazol.....	I18
COTELLIC	53	DANTRIUM	I34
COTEMPLA.....	I39	dantrolene	I34
COUMADIN.....	41	DANZITEN	54
covaryx	I15	dapsone	35, I44
COVID19 SPECIMEN COLLECT NCPDP.....	95	DAPSONE	I44
CRENESSITY.....	I18	DAPTACEL	69
CREON.....	I13	DARAPRIM.....	50
CRESEMBA.....	43	darifenacin	I60
CREXONT	59	darunavir	61
CRINONE	I19	dasatinib.....	54, 55
CRIXIVAN.....	63	dasetta.....	89
cromolyn	26, 31, I00	DAURISMO	53
crotan.....	59	DAVIMET	I62, I64, I70
CRRT TRISODIUM CITRATE.....	42	DAVIMET-M	I70
cryoserv.....	I55	DAYPRO	27
cryselle	89	daysee	89
CUROSURF.....	I52	DAYTRANA.....	I39
CUTIVATE.....	I47	DAYVIGO	I42
CUVPOSA	I08	DDAVP	I15
cvs.....	I05, I34, I62, I66, I67, I68	DDAVP SOLUTION	I15
CVS	95, I65, I66, I68	deblitane	89
CVS COVID19 TEST BY PHARMACIST	95	decadron.....	I17
cyanocobalamin	I66, I67	deferasirox	I56
cyclafem	89	deferiprone	I56
cyclobenzaprine	I34	deflazacort.....	I17
CYCLOBENZAPRINE ER.....	I34	DELESTROGEN	I16
CYCLOGYL.....	I02	demeclacycline hcl.....	38
CYCLOMYDRIL.....	I02	DEM SER.....	77
cyclopentolate hcl	I02	DENAVIR	65
CYCLOPENTOLATE-TROPICAMIDE-PE.....	I02	denta 5000 plus.....	I03
cyclophosphamide	51	dentagel	I03
cycloserine	35	DEPAKOTE	84

Index of Medications

DEPEN	26	diclofenac -misoprostol	27
DEPLIN	I6I	dicloxacillin.....	37
DEPO-ESTRADIOL.....	I16	dicyclomine hcl.....	I08
DEPO-PROVERA	87	didanosine	62
DEPO-SUBQ PROVERA.....	87	diethylpropion	58
DEPO-TESTOSTERONE.....	I15	DIFFERIN	I50
DERMACINRX	I68, I70	DIFICID	36
DERMA-SMOOTH-E-FS	I47	DIFLUCAN	43
DERMOTIC	99	diflunisal	I5, I9
DESCOVI	6I	digitek	73
desflurane	25	digoxin.....	73
desipramine	I38	dihydroergotamine	I5
desloratadine	46	dihydroergotamine mesylate	20
desmopressin	I15	DILANTIN.....	84
DESMOPRESSIN.....	I15	DILATRATE-SR.....	74
desog-e.estradiol.....	89	DILAUDID	22
desogestrel-ethinyl estradiol	89	diltiazem.....	72, 73
desogestr-eth estrad eth estra.....	89	dilt-xr	72
DESONATE.....	I47	diphenoxylate w/atropine.....	I08
desonide.....	I47, I49	DIPHTHERIA-TETANUS TOXOIDS-PED	69
DESOWEN.....	I47	DIPROLENE.....	I47
desoximetasone.....	I47, I48	dipyridamole	60
DESOXYN.....	66	diskets.....	22
desvenlafaxine succinate	I37	disopyramide phosphate71, 72
dex4 glucose	I04	disulfiram	I55
dexamethasone.....	32, I17	DITROPAN	I6I
dexchlorpheniramine maleate	45	DIURIL.....	98
DEXCOM.....	I22	divalproex	84, 85
DEXEDRINE	66	dofetilide.....	71
dexlansoprazole	I13	DOLOPHINE HCL.....	22
dexamethylphenidate	I39	donepezil.....	66
DEXONTO.....	I17	DONNATAL	IIO
DEXPAK.....	I17	DOPTELET	87
DEXTENZA	99	dorzolamide.....	I0I
dextroamphetamine	66, 67	DORZOLAMIDE	I00, I0I
D.H.E.45.....	20	dotti	I16
DIABETES.....	I63	DOVATO	6I
DIACOMIT	84	DOVONEX	I44
dalyvite	I65	doxazosin mesylate	75, 76
DIASTAT	83	doxepin.....	I38, I42, I44
DIASTIX REAGENT	95	doxercalciferol	I54
DIATROL.....	I63	doxycycline	38, 39, I53
diazepam.....	83, 84, I36	doxycycline hydiate	38, I53
DIBENZYLINE	67	doxycycline monohydrate	38, 39
dichlorphenamide	I55	doxylamine.....	I09
DICLEGIS	I09	doxylamine succ-pyridoxine hcl.....	I09
diclofenac.....	20, 2I, 27, I43	DRISDOL	I68

Index of Medications

dronabinol	I09	ELEPSIA	85
DROPLET	I26	eletriptan hbr	20
DROPSAFE	I30	eletriptan hydrobromide	I5
drospirenone-eth estra-levomef	88, 89	ELIMITE	59
drospirenone-ethinyl estradiol	89, 93	elinest	89
DROXIA	71	ELIQUIS	42
DUAVEE	II7	ELIXOPHYLLIN	31
ducodyl	II2	ELLA	89
DUET	I35	ELLUME COVID-19 HOME TEST	95
DUETACT	48	ELMIRON	25
DULERA	30	eltrombopag	87
duloxetine	I37	eluryng	87
DUOBRII	I44	EMBRACE	I22, I26
DUOPA	59	EMERGEN	I64, I68
DUPIXENT	I20	EMERGEN-C	I68
DUPIXENT 100MG/0.67ML PREFILLED SYRINGE	I20	EMGALITY	I5, 20, 83
DUREZOL	99	emoquette	89
dutasteride	I60	Empaveli	70
dvorah	22	EMSAM	I37
DXEVO	II7	emtricitabine	63
DYAZIDE	97	EMTRIVA	62
dy-o-derm	I57	EMVERM	49
DYRENium	97	ENABLEX	I60
E		enalapril maleate	75, 76, 77
EASIVENT	I32	enalapril maleate/hctz	75
EASY	I22, I26	ENBREL	51
EASY-C	I68	ENDO-AVITENE	71
EASYMAX	I22	endocet	21
EBGLYSS	I59	ENDOMETRIN	II9
EC-NAPROSYN	27	ENFAMIL	I05
ec-naproxen	27	ENFIT	I31
econazole nitrate	44	ENGERIX-B	70
econtra ez	89	ENHERTU	57
econtra one-step	89	exoxaparin	42
ecotrin	I9, 60	enpresso	89
ecpirin	I9	enskyce	89
EDECIN	96	ENSTILAR	I49
EDLUAR	I42	ENSTILAR FOAM	I49
ed-spaz	I10	entacapone	59, 60
EDURANT	62	entecavir	65
eemt	I15	ENTEREG	II3
e.e.s.	36	enteric coated aspirin	61
E.E.S.	36, 37	ENTOCORT EC	II7
efavirenz	62, 63	ENTRESTO	76
effer-k	I07	ENTYVIO	III
EFFIENT	61	enulose	I08
EGRIFTA	II8	ENZOCLEAR	I45

Index of Medications

EPCLUSA.....	65	estradiol.....	87, 89, 90, 91, 93, II6, II9
EPIDIOLEX.....	84	estradiol/norethindrone.....	II6
EPIDUO FORTE GEL PUMP.....	I44	ESTRATEST	II6
EPIFOAM.....	I49	estrogen.....	II6
epinastine.....	46	estrogen & methyltestosterone.....	II6
epinephrine.....	66	eszopiclone.....	I42
EPIPEN.....	66	ethacrynic acid	96
EPISIL.....	I54	ethinyl.....	87, 89, 91, 93
epitol.....	85	ethosuximide.....	85, 86
EPIVIR.....	62, 65	ethynodiol-ethinyl estradiol.....	89
eplerenone.....	97	etodolac.....	27, 28
eprosartan mesylate.....	77	etonogestrel-ethinyl estradiol.....	87
EPSOLAY	I46	etoposide	57
EPZICOM.....	62	EUCRISA.....	I46
EQ.....	I63	EUTHYROX.....	I51
eqI.....	I05, I67	EVAMIST	II6
EQUETRO.....	I36	EVEKEO.....	67
ergoloid mesylates.....	79	EVENCARE.....	I22
ERGOMAR.....	20	everolimus	53, I21
ergotamine tartrate/caffeine	15	EVERSENSE.....	I22, I23
ERIVEDGE.....	53	EVISTA.....	I58
ERLEADA	52	EVKEEZA	79
erlotinib	55, 56	EVOCLIN	40
erlotinib hcl.....	56	EVOTAZ	63
ERMEZA.....	I51	EVOXAC	67
errin	89	EVRYSDI.....	I56
ERTACZO	44	EXEL	I31
ERVEBO.....	70	EXELDERM	44
ery	36, 40	exel huber.....	I31
erygel.....	40	EXEL HUBER.....	I31
ERYPED	36	EXELON	66
ery-tab	36	exemestane.....	52
erythrocin stearate.....	36	EXTINA.....	44
erythromycin.....	33, 36, 37, 39, 40	EYE.....	32, 46, 59, 64, 96, 99, I00, I01, I02, I61
erythromycin ethylsuccinate.....	37	EYSUVIS	99
erythromycin stearate.....	37	EZ	I26
ESBRIET	I55	ezetimibe	79, 80
escitalopram.....	I37	ezetimibe-atorvastatin.....	79
ESGIC	I5, I9	ezetimibe-simvastatin.....	79
ESKATA	I45	F	
eslicarbazepine.....	84, 85	FABHALTA.....	70
esomeprazole	I13	FABIOR	I50
ESOMEPRAZOLE.....	I13	falmina	89
esomeprazole magnesium	I13	famciclovir	64
estarryla	89, 92	famotidine	I11
estazolam.....	I42	FARESTON.....	58
ESTRACE	I16	FARXIGA	46

Index of Medications

FARYDAK.....	51	FLEVOXIN	I68
FASENRA PEN.....	31	FLEXICHAMBER.....	I33
fayosim.....	89	FLINTSTONES.....	I64
FC2 FEMALE CONDOM.....	93	FLOLIPID.....	79
febuxostat.....	27	FLOMAX.....	I60
felbamate.....	85	FLONASE.....	98
FELBATOL.....	85	FLORAFOL.....	I64
FELDENE.....	27	FLORRAXYL.....	I63
felodipine.....	72	FLOVENT.....	30
FEMARA.....	52	FLOW-EZE	I31
FEMCAP	93	FLOWFLEX COVID-I9 AG HOME TEST	95
FEMHRT.....	I16	FLUAD	69
fem ph.....	49	FLUARIX	69
femynor	89, 92	FLUBLOK.....	69
fenofibrate.....	80	FLUCELVAX	69
fenofibric acid.....	80, 81	fluconazole	43
FENOGLIDE.....	80	flucytosine.....	43
fenoprofen.....	27, 28	fludrocortisone acetate	I18
FENORTHO.....	27	FLULAVAL.....	69
fentanyl.....	22	FLUMIST	69
FERAHHEME	I04	flunisolide	98
FERRIPROX.....	I56	fluocinolone acetonide	99, I47, I48
ferrous.....	91, I05, I06	fluocinolone acetonide oil	99
FERROUS	I05	fluocinonide	I48
fesoterodine.....	I60	fluoride	I06, I65
FETZIMA.....	I37, I38	FLUORIDEX.....	I03
FEXMID.....	I34	fluoritab	I03, I06
FIBRICOR.....	80	fluorometholone	99
FIFTY50.....	I26	FLUOROURACIL	I52
FILSUVÉZ	I59	fluoxetine	I37
FILTER.....	I31	fluphenazine	I41
FINACEA	I46	flurazepam	I42
finasteride.....	I60	flurbiprofen	27, 99
FINAZOL	I63	flutamide.....	52
FINE.....	I26	fluticasone	30, 98, I48
FINGERSTIX	I26	fluticasone propionate	98, I48
fingolimod.....	82	fluticasone-salmeterol	30
FIORICET	I5, I9, 25	fluvastatin	79
FIORINAL	I5, I9, 24	fluvoxamine maleate	I37
FIORINAL W/CODEINE	24	FLUZONE	69
FIRDAPSE	83	FML	99
FIRMAGON	54	FNP	I70
flac otic oil.....	99	FOLAPRIME	I63
FLAVOVIT	I61	FOLETTRA	I61
flavoxate.....	I61	folic acid.....	I61
flecainide acetate.....	71	FOLIKA-BC	I65
FLECTOR	I43	foltabs	I65

Index of Medications

fondaparinux.....	42	GEL-FLOW	71
FORA.....	95, I23, I27	GELFOAM.....	71
FORACARE.....	I23, I27	gemfibrozil.....	.80, 81
FORA GTEL KETONE.....	95	GEMTESA	I60
forane.....	25	generlac.....	.I08
FORFIVO	I37	gengraf.....	I21
FORMOTEROL.....	30	GENOTROPIN.....	II8
FORTAMET	47	gentak.....	33
FORTEO	I54	gentamicin.....	33, 34, 40
FORTISCARE.....	I23	GENTLE DRAW.....	I23
FOSAMAX.....	I58	gentlelax.....	II2
fosamprenavir	63	gentle laxative.....	.II2, II3
fosaprepitant dimeglumine	I09	GENVOYA.....	63
fosfomycin.....	34	GEODONI40
fosinopril	75, 76	gianvi	89
fosinopril-hydrochlorothiazide.....	75	GILOTrif	55
FRAGMIN.....	42	glatiramer acetate.....	82
FRAICHE.....	I03	glatopa.....	82
FREESTYLE.....	95, I23, I27	GLEOSTINE.....	51
fravatriptan succinate.....	20	glimepiride.....	.47, 48
FRUZAQLA.....	55	glipizide47, 48
ft.....	I06, I35, I61, I63, I64, I65, I66, I67, I68, I69, I70	GLOPERBA	26
FT	I06, I57, I63, I65, I67, I68, I69	glostrips.....	96
ful-glo	96	GLUCAGENI04
full spectrum b	I65	GLUCAGONI04
FULPHILA.....	87	GLUCOI04
furosemide.....	96	gluco burst.....	.I04
FUROSEMIDE.....	96	GLUCOCARD	I23
FUZEON.....	62	GLUCOCOM.....	I23, I27
fyavolv.....	II6	glucose.....	.I04
FYCOMPA	85	GLUCOSEI04, I23
fyremadel.....	II8	GLUCOTROL	47
G		glutamine.....	.71
gabapentin	83, 85	GLUTOLI05
GALAFOLD.....	I57	glutoseI04
galantamine.....	66	GLUTOSEI04
GALZIN.....	I56	glyburide47, 48
GARDASIL 9	70	GLYCATEI08
GASTROCROM	26	glycine	50
gatifloxacin.....	33	glycolax.....	II2
GATTEX	II4	glycopyrrolateI08
gavilax.....	II2	glydo	25
gavilyte-g.....	II2	GLYNASE	47
gavilyte-n.....	II2, II3	GLYSET	47
GAVRETO	55	GLYXAMBI	48
GELCLAIR.....	I54	gnp.....	I06, I66, I67, I69, I70
GELFILM.....	.I01, I57	GNPI57, I65, I67, I69, I70

Index of Medications

GOJJI	I27
GOMEKLI	53
GONITRO	74
GOPRELTO	98
GRALISE	83
granisetron.....	I09
GRASTEK	67
griseofulvin.....	44
GS	50
g tussin ac	94
guaifenesin ac	94
guaifenesin dac	94
guaifenesin with codeine	94
guanfacine	77, I39
guanidine	67
GUARDIAN	I23
guiatussin ac	94
GUMMY	I04, I62, I64, I67
GVOKE	I04
GYNAZOLE	43
gynol	88
H	
HAEGARDA	I55
hailey	89
halcinonide	I48
HALCION	I42
halobetasol	I48
HALOG	I48
haloperidol	I41
HARVONI	65
HAVRIX	70
hc pramoxine	99, II4, I49
HEALTHWISE	I31
HEALTHY	I23, I27, I31
HEALTHY ACCENTS	I23, I31
HEALTHY ACCENTS AUTOLET	I23
healthylax	II2
heather	89
HEMANGEOL	78
HEMATOGEN	I06
HEMLIBRA	71
hemmorex-hc	II4
heparin	42
HEPLISAV-B	70
HETLIOZ	I42
HIBERIX	69
hidex	II7
HISTEX-AC	94
homatropaire	I02
HORIZANT	82
HUMALOG	48
HUMULIN48, 49
HURRICAINE LUER-LOCK	I31
HYCAMTIN	53
hydralazine	78
HYDREA	51
hydrochlorothiazide	75, 76, 77, 79, 98
hydrocodone	21, 22, 23, 94
hydrocodone-acetamin	21
hydrocodone bitartrate	22
hydrocodone bit-ibuprofen	21
hydrocodone-chlorpheniramine	94
hydrocodone compound	94
hydrocodone/homatropine	94
hydrocodone w/acetaminophen	21
hydrocortisone	99, II4, II7, I47, I48
hydrocortisone acetate	II4
hydrogen peroxide	I43
hydromet	94
hydromorphone	22, 23
hydroxocobalamin	I67
hydroxychloroquine	50
HYDROXYPROPYLCELLULOSE	I57
hydroxyurea	51
hydroxyzine	45
HYFTOR	I46
hyphen	34
hyoscyamine	II0
hyosyne	II0
HYPER-SAL	I56
HYPOLANCE	I23
HYPROMELLOSE	I57
HYSINGLA ER	23
I	
IBRANCE	55
ibu	27
ibuprofen	21, 27, 28
icatibant	I52
ICLUSIG	55
IDHIFA	57
IHEALTH	I23
ILARIS	I59
ILET	I23
ILEVRO	99

Index of Medications

imipramine	138
imiquimod	145
IMKELDI	55
IMPAVIDO	50
IMPEKLO	148
IMPOYZ	148
IMURAN	121
INBRIJA	60
incassia	89
INCONTROL	123, 127
INCRELEX	118
INCRUSE ELLIPTA	29
indapamide	98
INDOCIN	28
indomethacin	28
INDOMETHACIN	28
INFANRIX	69
INFASURF	152
INFINITY	124
INGREZZA	82
INJECT	127
INLYTA	55
INOVA	145
INSPIRACHAMBER	133
INSPRA	97
INSTA	104
INSTACLEAN	157
INSULIN	46, 47, 48, 49, 118, 131, 132
INSULIN LISPRO	49
INTELENCE	62
INTELISWAB COVID-19 RAPID TEST	95
INTERMEZZO	142
INTRON A	58
introvale	90
INVACARE	127
INVEGA	140
INVELTYS	99
INVOKAMET	48
iodine	105, 149
IODOFLEX	149
IODOSORB	149
IOPIDINE	101
IPOL	68
ipratropium bromide	29, 98
IQIRVO	154
irbesartan	76, 77
irbesartan-hydrochlorothiazide	76
IRESSA	55
iron	105, 106
IRON	104, 105, 106, 162
ISENTRESS	63
isibloom	90
isoflurane	25
isoniazid	35
ISOPROPANOL	157
isopropyl alcohol	157
ISOPROPYL ALCOHOL	50, 157
ISOPTO CARPINE	101
ISORDIL	74
isosorbide	74, 79
isosorbide dinitrate	74
isosorbide mononitrate	74
isotretinoin	143, 144
isoxyprine	79
isradipine	72
itraconazole	43
ivabradine	73
ivermectin	49, 146
IWILFIN	55
J	
JAKAFI	53
JALYN	160
jantoven	41
JANUMET	48
JANUVIA	47
JARDIANC	46
jasmiel	90
JEMPERLI	57
jencycla	90
JETREA	103
jinteli	116
JOENJA	152
jolessa	90
JORNAY	139
JOURNAVX	19
JUBLIA	44
juleber	90
JULUCA	61
junel	90
JUXTAPIID	79
JYNARQUE	96, 97
JYNNEOS	70
K	
K2-D3	169

Index of Medications

KADIAN	23	lanthanum carbonate	105
kaitlib	90	LANTUS.....	49
KALBITOR	152	larin.....	90
KALETRA	63	larissia	90
kalliga	90	LASIX.....	96
KALYDECO	152	LASTACAFT	46
KAPVAY	139	latanoprost	101
kariva	90	LATANOPROST	100, 101
kelnor	90	laxaclear	112
KENALOG	148	laxative	112, 113
KERENDIA	97	layolis	90
KESIMPTA	82	LAZANDA.....	23
KETAMINE	142	LAZCLUZE	55
ketoconazole	43, 44, 45	leena	90
ketodan	44	leflunomide	26
ketoprofen	28	LENVIMA.....	55
ketorolac	21, 99	LESCOL.....	79
KIDS	96, I04, I05, I64, I65	lessina.....	90
KINRIX	69	L.E.T.	25
kionex	I05	letrozole	52
KISQALI.....	53, 55	leucovorin	153
KITABIS PAK	34	LEUKERAN	51
KLARITY	33, 99, I03	LEUKINE	87
KLARITY-A	33	leuprolide acetate	54
KLARON	I44	levalbuterol hcl	29
KLONOPIN	84	LEVAQUIN	37
klor-con	I07	LEVIBID	I10
KOSELUGO	53	levetiracetam	85
K-PHOS	I07	LEVETIRACETAM	85
KRINTAFEL	50	levobunolol	I01
KRISTALOSE	I12	levocarnitine	158
k-tab	I07	levofloxacin hemihydrate	33, 38
K-TAB	I07	levonest	90
KYLEENA	93	levonorgestrel	90
L		levonorg-eth estrad eth estrad	90
labetalol	76	levora	90
LACRISERT	99	levorphanol tartrate	23
lactulose	I08, I12	LEVO-T	I51
LAMICTAL	85	levothyroxine	I51
lamivudine	62, 65	levoxyl	I51
lamivudine-zidovudine	62	LEVSIN	I10
lamotrigine	85	LEVULAN	58
lancets	I25, I27	LEXETTE	I48
LANCETS	I25, I26, I27, I28, I29, I30	lidocaine	25, 26, I49
LANOXIN	73	LIDOCAINE	25, I14
lansoprazol-amoxicil-clarithro	I09	LIDOCAINE-EPINEPHRIN-TETRACAIN	25
lansoprazole	I14	lidocaine-hc	I49

Index of Medications

lidocaine-prilocaine.....	26	LORZONE.....	134
LIDOCAN.....	26	losartan.....	76, 77
LILETTA.....	93	losartan-hydrochlorothiazide.....	76
lillow.....	90	LOTEMAX	99, 100
lindane.....	149	LOTENSIN.....	75, 77
linezolid.....	37	LOTENSIN HCT	75
LINZESS.....	III	loteprednol.....	99, 100
liothyronine.....	151	loteprednol etabonate.....	99
LIPO.....	161	LOTRISONE	44
LIPOFEN	81	lovastatin.....	80
LIQUID	104	LOVAZA.....	108
liraglutide.....	46	low dose aspirin.....	61
lisdexamfetamine	I38, I39	low-ogestrel.....	90
lisinopril.....	75, 77	loxapine succinate.....	141
lisinopril-hctz	75	lo-zumandimine.....	90
LITEAIRE.....	I33	lubiprostone.....	II2
LITE TOUCH	I24, I27, I31	LUCENTIS	I03
LITETOUCH	I33	ludent fluoride	I06
LITFULO.....	I59	LUER	I31, I32
lithium	I36	lugol's	I05
LITHOBID.....	I36	Lumakras	53
LITHOSTAT.....	I08	LUMRYZ	I41, I42
LIVDELZI.....	I54	LUPANETA.....	II8
LIVITA.....	I64, I70	LUPKYNIS	I21
LIVTENCITY.....	64	LUPRON DEPOT.....	54, II8
L-MESITRAN.....	I46	LUTEIN	I61
I-norgest/e.estriadiol-e.estrad	90	lutera.....	91
LODINE.....	28	LYBALVI.....	I40
LODOSYN	60	LYNPARZA.....	55
lofexidine.....	I59	LYSODREN	57
LOKELMA.....	I05	LYSTEDA.....	70
LOMAIRA	58	LYTGOBI	55
LOMOTIL.....	I08	lyza.....	91
LONHALA MAGNAIR	29	M	
LONSURF.....	52	MACROBID	37
LOPID	81	MACRODANTIN.....	37
lopinavir	63	MACUGEN	I02
lopinavir-ritonavir	63	mafénide acetate	40
lopreeza.....	II6	magnesium.....	II2, II3
LOPRESSOR	78	MALARONE	50
LOPROX	44	malathion	I49
lorazepam.....	I36	maprotiline.....	I38
LORBRENA	55	MAR-COF CG.....	94
lorcet.....	21	marlissa.....	91
LORTAB	21	MARPLAN	I36
lortuss ex.....	94	MASK.....	I33
loryna	90	MATULANE.....	57

Index of Medications

matzim.....	72	methergine	II8
MAVENCLAD.....	82	methimazole.....	I5I
MAXITROL.....	32	METHITEST	II5
MAXI-TUSS CD.....	94	methocarbamol.....	I34
MAYZENT.....	82	methotrexate.....	52
m-clear wc	94	methoxsalen.....	I43
meclizine.....	I09	methscopolamine bromide.....	II0
meclofenamate	28	methyldopa.....	77
MEDISENSE.....	I24, I27	methyldopa/hydrochlorothiazide.....	77
medlance.....	I27	methylergonovine maleate.....	II8
MEDLANCE.....	I27	METHYLIN.....	I39
MEDROL.....	I17	methylphenidate.....	I39, I40
medroxyprogesterone acetate.....	87, II9	methylpred dp.....	I17
mefenamic acid	21	methylprednisolone.....	I17
mefloquine hcl.....	50	methyltestosterone	II5, II6
megestrol acetate.....	58, I6I	metoclopramide	II2
MEKINIST.....	53	metolazone.....	98
MEKTOVI.....	53	metoprolol-hydrochlorothiazide	79
melodetta.....	9I	metoprolol succinate.....	78
meloxicam.....	28	metoprolol tartrate	78
melphalan.....	5I	METROCREAM.....	I46
memantine.....	8I	METROGEL	I46
MENACTRA.....	68	METROLOTION	I46
me-naphos-mb-hyo I.....	34	metronidazole.....	34, 39, I46
MENOSTAR.....	I16	mexiletine.....	7I
MENQUADFI.....	68	MIACALCIN	I19
MEN'S.....	I62, I63, I70	miconazole.....	43
MENVEO	68	MICONAZOLE-ZINC OXIDE-PETROLT ^M	45
MEPHYTON.....	I70	MICRO	I27
meprobamate.....	I36	MICROCHAMBER.....	I33
MEPRON.....	50	microgestin	9I
mercaptopurine.....	52	MICROLET	I24, I27
mesalamine	I10, III	MICROSPACER	I33
mesna	I53	midazolam.....	I42
MESNEX	I53	midodrine	67
METADATE	I39	MIEBO.....	99
METANX.....	I66	MIFEPREX	I55
METANXPRO.....	I65	mifepristone	48, I55
metaproterenol.....	29	migergot	20
metaxalone.....	I34	miglitol	47
metformin.....	47, 48	miglustat	I56
methadone hcl.....	22, 23	MIGRAL.....	20
methadose.....	23	mihi.....	9I, 92
methamphetamine.....	66, 67	milk of magnesia	II2
methazolamide.....	96	millipred	I17
methenam.....	34	mimvey	I16
methenamine mandelate	34	MINCORA	I66

Index of Medications

MINI LANCING DEVICE.....	124	MOXEZA.....	33
MINIMED.....	124	MOXIFLOXACIN.....	32
MINIPRESS.....	76	moxifloxacin hcl.....	33, 38
MINITRAN.....	74	MRESVIA.....	70
MINI TRANSFER PIN.....	131	MS CONTIN.....	24
MINOCIN.....	38	MUCOSITISRX.....	154
minocycline	38, 39	MULTAQ.....	72
MINOLIRA ER	38	MULTIA.....	163
minoxidil.....	78	MULTITOL-M	170
miostat	101	multivit.....	134, 163, 164, 165
mirabegron.....	160	MULTIVIT.....	164
miralax.....	113	MULTIVITAMIN-MULTIMINERAL	163
MIRAPEX.....	60	multivitamin with fluoride	165
MIRENA.....	93	mupirocin	40
mirtazapine.....	136	MURI-LUBE MINERAL OIL.....	157
MIRVASO.....	146	mv	163
misoprostol.....	27, 109	mvc-fluoride.....	165
MITIGARE	27	mv-min.....	163
MITOMYCIN-WATER.....	103	MVW.....	163, 164
MITOSOL	103	MYALEPT.....	119
MI-VITE.....	161	MYCAPSSA DR.....	119
MKO.....	142	my choice	91
M-M-R II VACCINE W/DILUENT.....	69	MYCOBUTIN.....	35
MOBIC	28	mycophenolate mofetil.....	121
MOBILE.....	127	mycophenolic acid.....	121
MODERNA	68	MYDAYIS.....	67
moexipril.....	77	MYDCOMBI	102
molindone.....	141	MYDRIACYL.....	102
MOLNUPIRAVIR.....	65	MYDRIATIC4	101
mometasone	98, 148	MYFORTIC	121
monodoxyne	38, 39	MYGLUCOHEALTH	127
monodoxyne nl.....	38	MYHIBBIN	121
MONOJECT.....	132	MYLERAN	51
MONOLET.....	127	myorisan.....	144
mono-linyah	91	MYRBETRIQ.....	160
MONSEL'S.....	71	mysoline.....	85
montelukast.....	31	my way	91
MONUROL	34	MYXREDLIN	49
morgidox.....	39	N	
MORGIDOX	39	nabumetone	28
morphine.....	23, 24	naftifine	45
MORPHINE	23	NAFTIN	45
MOTEGRITY	112	NALFON	28
MOTOFEN.....	108	NALOCET	21
MOUNJARO	46	naloxone.....	24, 42, 43, 159
MOUTHPIECE	133	naltrexone	43
MOVANTIK.....	42	NAMENDA	81

Index of Medications

NAMZARIC	81	NIACOR	81
NANO	I31	NIASPAN	81
NANOVIM	I70	nicardipine	72
NAPRELAN	28	NICODERM	I50
NAPROSYN	27, 28	nicorelief	I50
naproxen	27, 28	NICORETTE	I50
naratriptan hcl	20	nicotine	I50
NARCAN	43	NICOTROL	I50
NARDIL	I36	nifedipine	72, 73
NASACORT	98	nikki	91
NASCOBAL	I67	NILANDRON	52
NASONEX	98	nilotinib	55
NATACYN	43	nilutamide	52
nateglinide	47, 48	nimodipine	73
NATPARA	II8	NINJACOF-XG	94
natura-lax	II3	NINLARO	55
nature-throid	I51	nisoldipine	73
NAYZILAM	84	nitisinone	I55
NEBUPENT	50	nitro-bid	74
nebusal	I56	NITRO-DUR	74
NEBUSAL	I56	nitrofurantoin	37
necon	91	nitrofurantoin macrocrystal	37
NEEDLES	I31	nitroglycerin	74, II3
nefazodone	I37	NITROLINGUAL	74
NEFFY	66	NITROMIST	74
NEMLUVIO	I20	NITROSTAT	74
neomycin	31, 32, 33, 34, I43	nitro-time	74
neomycin/bacitracin/poly/hc	32	NITYR	I55
neomycin/bacitracin/polymyxin	33	NIVA	I63
neomycin-polymyxin-dexamethaso	32	NIVESTYM	87
neomycin/polymyxin/gramicidin	33	nizatidine	III
neomycin/polymyxin/hc	31, 32	NIZORAL	45
neo-polycin	33	NOCTIVA	II5
neo/polymyxin/dexamethasone	32	nora-be	91
NEORAL	I21	norelgestromin	93
NEO-SYNALAR	39	norethindrone	91, II6, II9
NERLYNX	55	norethindrone acetate	91, II9
neuac	I44	norethindrone-ethin estradiol	91, II6
NEUPRO	60	norethrin-eth estra ferrous fum	91
NEUTRASAL	I54	NORGESIC FORTE	I34
nevirapine	62	norgestimate-ethinyl estradiol	91
new day	91	norgestrel-ethiny estra	91
NEXAVAR	55	NORITATE	I46
NEXPLANON	87	norlyda	91
NEXVIAZYME	I56	NORPACE	72
niacin	81	nortrel	91
NIACIN	I64	nortriptyline	I38

Index of Medications

NORVIR	63	olanzapine	140
NOURIANZ	60	olmesartan-amlodipine-hctz.....	76
NOVA	128	olmesartan-hydrochlorothiazide	76
NOVAFERRUM	I06, I64	olmesartan medoxomil.....	77
NOVAMAX	95	olopatadine	98
NOVAMV	I64	OLPRUVA	I08
NOVAREL	I19	OLUX.....	I48
NOVAVAX	68	OMECLAMOX-PAK	I09
NOVOFINE	I31	omega-3 acid ethyl esters.....	I08
NOVOTWIST	I31	omeprazole	I14
NOXAFIL.....	43	omeprazole- bicarbonate	I14
np thyroid.....	I51	OMNIPAQUE	95
NUBEQA	52	OMNIPOD	I24
NUCALA	31	OMNIPOD GO	I24
NUCORT	I48	OMVOH.....	I20
NULEV	I10	ON CALL	I28
NULIBRY	I56	ondansetron	I09
NULYTELY.....	I13	one	89, 91, I63
NUMBRINO	98	ONE.....	92, 95, I24, I33, I63
NUMOISYN	I54	one-a-day.....	I63
NUPLAZID	I37	ONE-A-DAY	I63
NURTEC ODT	20	ONE TOUCH.....	95, I24
NUTRALYN	I63	ONETOUCH.....	I24, I28
NUVARING	87	ONE WAY MOUTHPIECE	I33
NUVESSA	39	ONEXTON	I44
NUZYRA	39	ONFI	84
nyamyc	45	ONGENTYS.....	60
NYMALIZE	73	ON-THE-GO.....	I28
nystatin	44, 45	opcicon one-step	91
nystatin w/triamcinolone	45	OPDIVO.....	57
nystop	45	OPFOLDA	I56
O		opium	22, I08
OCALIVA	III	OPSUMIT	74
ocella	91	OPSYNVI	75
octreotide acetate	I19	OPTICHAMBER	I33
ocucoat	I03	option 2	91
OCUFLOX	33	ORACEA	39
ODACTRA	67	ORACIT	I07
ODEFSEY	63	ORALAIR	67
ODOMZO	53	oralone	I53
OFEV	I52	ORAMAGICRX	I54
ofloxacin.....	31, 33, 38	ORAPRED ODT	I17
of magnesia	I12	ORAVIG	43
ogestrel	90, 91	ORENITRAM	75
OGSIVEO	56	ORFADIN	I55
OJEMDA	52	ORILISSA	I18
okebo	39	ORKAMBI	I51

Index of Medications

ORLADEYO	68, I52	PAREMYD	I02
orphenadrine.....	I34	paricalcitol.....	I54, I55
orphenadrine-aspirin-caffeine	I34	PARNATE	I36
orphengesic forte.....	I34	paroxetine.....	I37, I56
orsythia	91	PASER	35
ORTHO-NOVUM	91	PATANASE	98
oscimin.....	I10	PAXIL	I37
oseltamivir	64	PAXLOVID	64
OSELTAMIVIR	64	PAXLYTE.....	I67
oseltamivir phosphate	64	pazopanib	56
OSENI	46	pedi.....	I64, I65
OSMOPREP	I13	PEDIARIX	70
OTEZLA.....	26	pediatric	36, I64
OTIPRIO.....	32	PEDIATRIC PANDA MASK	I33
OVACE	I45	PEDVAXHIB	69
OVIDE.....	I49	peg.....	I12, I13
oxandrolone.....	I15	PEGANONE	85
oxaprozin.....	27, 28	PEGASYS.....	65
oxazepam.....	I36	PEG-INTRON.....	65
OXBRYTA	71	PEMAZYRE	56
oxcarbazepine.....	85	PENBRAYA	68
OXERVATE	I03	penciclovir.....	65
oxiconazole nitrate.....	45	penicillamine	26
OXISTAT.....	45	penicillin V	37
OXSORALEN-ULTRA.....	I43	PENTACEL	69
OXTELLAR	85	pentamidine isethionate	50
oxybutynin chloride	I61	PENTASA	III
oxycodone	21, 24	pentazocine and naloxone hcl.....	24
oxycodone hcl	21, 24	pentoxifylline.....	71
oxycodone hcl-ibuprofen.....	21	PEPCID	III
oxycodone w/acetaminophen.....	21	perampanel	85, 86
OXYCONTIN.....	24	PERFECT	I28, I31, I32
oxymorphone hcl.....	24	PERFOROMIST	30
oxymorphone hcl er	24	PERIDEX	I53
OXYTROL	I61	perindopril erbumine	77
OZEMPIC.....	46	periogard	I53
P		permethrin.....	59
pacerone	72	perphenazine.....	I38, I41
paliperidone	I40	perry	I35
PALYNZIQ.....	68	PFIZER	68
PAMELOR	I38	PHARMABASE	I46
PANDA MASK.....	I33	PHEBURANE	I08
PANDEL	I48	phenadoz	I09
PANRETIN	58	phenazopyridine hcl.....	26
pantoprazole	I14	phendimetrazine tartrate	58
PANTOTHENIC	I64	phenelzine.....	I36
PARAGARD	93	phenobarbital	I10, I42

Index of Medications

PHENOBARBITAL.....	I10	POTASSIUM	97, I06, I07, II3
phenohydro	I10	povidone-iodine	99
phenoxybenzamine.....	67	powderlax.....	II3
phentermine	58	pramipexole	60
phenylbutyrate	I08	pramipexole di-hcl.....	60
phenylephrine.....	I01	PRAMOSONE	I49
PHENYTEK.....	86	pramoxine hcl w/hydrocortisone.....	II4
phenytoin	84, 86	prasugrel	61
philith.....	91	pravastatin.....	80
phosphasal.....	34	praziquantel	49
PHOSPHOLINE IODIDE	I01	prazosin.....	67, 76
PHOTREXA.....	99	PR BENZOYL PEROXIDE.....	I45
PHYSIOLYTE.....	I43	PRECISION	95
PHYSISOL.....	I43	PRECISIONGLIDE	I31
phytonadione	I70	PRECOSE	47
PICATO	58	PRED FORTE	I00
pilocarpine.....	67, I00, I01	PRED-G.....	32
pimecrolimus.....	I21	prednicarbate	I48
pimozide.....	I40	prednisolone.....	32, I00, II7
pimtrea.....	91	PREDNISOLONE	32, I00
pindolol.....	78	prednisolone acetate	I00
pioglitazone	48	PREDNISOLONE ACET-MOXIFLOXACIN.....	32
pioglitazone-glimepiride.....	48	PREDNISOLONE AC-MOXIFLOX-BROMF	32
pioglitazone-metformin.....	48	PREDNISOLONE AC-MOXIFLOX-NEPAF	32
PIP	I28	PREDNISOLONE-GATIFLOXACIN	32
PIQRAY	56	PREDNISOLONE-GATIFLOX-BROMFENC	32
pirfenidone	I55	PREDNISOLONE-NEPAFENAC	I00
pirmella.....	92	PREDNISOLONE PHOS-MOXIFLOXACIN	32
piroxicam	27, 28	prednisolone phos odt	II7
PLAN B ONE-STEP	92	prednisolone phosphate	I00, II7
PLEGRIDY	83	prednisone	II7
PLEXION	40	pred ph	32
PNEUMOVAX	68	PRED PH	32
pnv	I35	PREFEST	II6
POCKET CHAMBER	I33	pregabalin	86
podofilox.....	I45	PREGNYL	II9
polycin.....	33	prenatal	I34, I35
polyethylene glycol	II3	PRENATAL	I34, I35, I63, I64
polymyxin b sul-trimethoprim.....	33	prenatal complete	I35
polystyrene sulfonate	I05	prenatal formula	I35
POLYTRIM.....	33	prenatal multi + dha	I35
POLY-TUSSIN AC.....	94	prenatal vitamin	I35
POMALYST	54	PRENATE	I35
PONVORY	83	prenavite	I35
portia.....	92	PREPIDIL	II8
posaconazole.....	43	PREPOPIK	II3
potassium.....	I07, I08	PRESSURE	I01, I02, I28

Index of Medications

PRESTALIA.....	75	propylthiouracil.....	I51
PRETOMANID	35	PROQUAD.....	69
prevalite.....	80	PROSCAR.....	I60
PREVIDENT	I03, I04, I05	PROTHELIAL	I53
previfem	92	protriptyline.....	I38
PREVNAR.....	68	PROVERA.....	.87, II9
PREVYMIS.....	64	PROVOCHOLINE	95
PREZISTA.....	61	prucalopride.....	II2
PRIFTIN	35	prudoxin.....	I44
PRIMAQUINE BRAND.....	50	PSORCON	I48
primaquine generic.....	50	pulmosal.....	I56
PRIMEAIRE.....	I33	PULMOZYME.....	I52
primidone.....	85, 86	PURE	I28
PRIMSOL	34	PURECOMFORT	I33
PRINIVIL	77	purelax.....	II3
PRIORIX VIAL.....	69	PUREVITA.....	I61, I64, I65, I66, I67, I68, I69, I70
probenecid.....	29	PURIXAN	52
PROBUPHINE.....	I59	PUSH.....	I28
PROCARDIA	73	pyrazinamide.....	35
procenutra	67	PYRIDIUM.....	26
PROCHAMBER.....	I33	pyridostigmine bromide.....	66
prochlorperazine maleate.....	I09	pyridoxine.....	I09, I67
PRO COMFORT	I28, I33	Q	
PRO COMFORT SPACER WITH MASK.....	I33	QBREXZA	I47
PROCORT	II4	QELBREE ER	I40
PROCRIT.....	87	QMIZ ODT	28
PROCTOCORT	II4	QSYMIA	58
procto-med hc.....	I48	QUADRACEL	70
procto-pak	I48	QUDEXY	86
proctosol-hc.....	I48	QUESTRAN	80
protozone-hc.....	I48	quetiapine.....	I40
PRODIGY.....	I24, I28	quetiapine fumarate.....	I40
progesterone.....	II9	QUICKVUE AT-HOME COVID-I9 TEST	95
PROGLYCEM.....	I04	QUICKVUE SARS ANTIGEN TEST	95
PROGRAF	I21	quinapril.....	75, 76, 77
PROLENSA.....	I00	quinapril-hydrochlorothiazide.....	75
PROMACTA	87	quinidine	72
promethazine.....	45, 94, I09	quinine.....	50
promethazine vc.....	45, 94	quit.....	I50
promethazine vc w/codeine.....	94	QULIPTA.....	20
promethegan.....	I09	QUVIVIQ	I42
PROMETRIUM.....	II9	QVAR	31
propafenone	72	R	
propantheline bromide	I08	ra.....	I06, I66, I67
proparacaine-fluorescein	I00	rabeprazole	II4
proparacaine hcl.....	I00	RADIOGARDASE	I56
propranolol	78, 79	RAGWITEK	67

Index of Medications

raloxifene.....	158	REYVOW	20
ramelteon.....	142	REZDIFFRA.....	154
ramipril.....	76, 77	REZUROCK	159
RANEXA	71	RHINOCORT.....	98
ranolazine.....	71	RHOFADE	146
RAPAMUNE.....	121	RHOPRESSA	102
RAPID RESPONSE COVID-19 TEST.....	95	ribavirin	64, 65
rasagiline mesylate	60	RIBOFLAVIN.....	167
RASUVO.....	26	RIDAURA.....	27
RAVICTI	108	rifabutin.....	35
RAYALDEE.....	155	RIFADIN	35
RAYOS.....	117	rifampin	35
RAZADYNE.....	66	RIGHTEST.....	128
READYLANCE.....	128	RILUTEK.....	81
REBIF.....	83	riluzole	81
reclipsen.....	92	rimantadine.....	64
RECOMBIVAX HB.....	70	RIMSO-50.....	25
RECOTHROM.....	71	RINVOQ ER.....	27
RECTIV.....	113	RINVOQ ER 30MG TABLET.....	27
REGIMEX.....	58	RIOMET	47
REGLAN	112	risedronate.....	158
REGRANEX.....	145	RISPERDAL	140
RELCARE.....	166	risperidone	140
RELENZA	64	RITALIN	140
RELIAMED.....	128	RITEFLO	133
relion	104	ritonavir.....	63
RELISTOR.....	42	rivaroxaban.....	42
REMERON	136	rivastigmine.....	66
RENACIDIN.....	108	rivelsa	92
rena-vite	166	rizatriptan.....	20
RENVELA.....	105	R-NATAL.....	135
repaglinide.....	47	ROBAXIN	134
REPATHA.....	79	ROCALTROL	169
REQUIP	60	ROCKLATAN.....	102
RESECTISOL.....	96	roflumilast.....	31
RESTASIS	103	ROMVIMZA	56
RESTORIL.....	142	ropinirole	60
RETACRIT	87	rosadan	146
RETEVMO	56	ROSADAN.....	146
RETIN-A.....	150	ROTARIX	68
RETROVIR	62	ROTATEQ	68
REVATIO	74	ROWASA	III
REVLIMID	54	roweepra	86
REVUFORJ	56	ROXICODONE.....	24
REXTOVY	43	ROZLYTREK	56
REXULTI	141	RUCONEST	155
REYATAZ	63	RUZURGI	83

Index of Medications

RYALTRIS	98	SHINGRIX	70
RYBELSUS	46	SIDESTREAM PEDIATRIC	133
RYCLORA	45	SIGNIFOR	II9
RYDAPT	56	sildenafil	74, I53
RYLAZE	57	SILENOR	I42
RYTARY	60	SILICONE MASK	I33
RYVENT	45	silodosin	I60
S		SILVADENE	40
SABRIL	86	silver sulfadiazine	40
sacubitril	76	SIMBRINZA	I00
SAFETY	I25, I26, I28, I29, I30	SIMLANDI	51
SALAGEN	67	simliya	92
SALIVAMAX	I54	simpesse	92
salsalate	26	SIMPONI	51
SAMBUCUS	I68	simvastatin	79, 80
SAMSCA	96	SINEMET	60
SANCUSO	I09	SINGLE	I28
SANDIMMUNE	I21	sirolimus	I21
SANDOSTATIN	II9	SIRTURO	35
SANTYL	I49	SITAVIG	64
SARAFEM	I37	SITZMARKS	96
SAVELLA	I59	SKELAXIN	I34
saxagliptin	47, 48	SKLICE	59
saxagliptn	48	SKYLA	93
SAXENDA	58	SKYRIZI	I43
SCALACORT DK	I48	sm	I06, I67
SCEMBLIX	56	SMART	I23, I26, I28
scopolamine	I09	SMARTEST	I28
seconal	I42	smoothlax	II3
SECUADO	I40	sod	40, 41, I00
SEEBRI	29, 30	sodium	28, 41, 42, 99, I00, I04, I07, I43, I56, I58
SEEBRI NEOHALER	29	SODIUM	42, 96, I42, I43
SELARSDI	I20	SODIUM CITRATE	42
selegiline	60	sodium fluoride	I04
selenium sulfide	I45	SODIUM OXYBATE	I42
SEMGLEE	49	sod sulfacet	40, 41
SEMPREX-D	45	SOFIA2 FLU-SARS ANTIGEN FIA	96
SERNIVO	I48	SOFIA SARS ANTIGEN FIA TEST	95
SEROSTIM	II8	SOHONOS	I57
setlakin	92	solifenacin succinate	I60
sevelamer	I05	SOLIQUA	46
sevelamer carbonate	I05	SOLODYN	39
sevoflurane	25	SOLOSEC	33
SEYSARA	39	SOLTAMOX	58
sf	I04, I58	SOLUS	I28
SFROWASA	III	SOLUVITA	I65
sharobel	92		

Index of Medications

SOMA	134	sulfacetamide.....	32, 41, I44, I45
SOMATULINE DEPOT	I19	sulfacetamide w/prednisolone	32
SOMAVERT	I54	sulfacleanse	41
SORIATANE	I43	sulfadiazine	34, 40
sorine	78	sulfamethoxazole(trimethoprim)	34
sotalol.....	78	SULFAMYLON.....	41
SOTYKTU	I43	sulfasalazine	III
SOTYLIZE	78	sulfatrim.....	34
SPECTRACEF.....	36	sulindac	28
SPEVIGO.....	I43	SUMADAN.....	41
SPIKEVAX	68	sumatriptan.....	20
spinosad.....	59	sumatriptan succ-naproxen sod.....	20
SPIRIVA	29	SUMAXIN.....	41
spironolact.....	97	SUNLENCA	61
spironolactone	97	SUNOSI.....	I41
SPORANOX	43	super	I63, I66
sprintec.....	92	SUPER.....	I27, I29
SPRITAM.....	86	super b complex.....	I66
SPRIX.....	20	super b complex-vitamin c	I66
sps	I05	super b-complex w/vitamin c	I63
sronyx	92	SUPERIOR.....	I63, I70
ss	41	SUPRANE	25
ssd	41	SURE	I29
SSKI	I05	SURVANTA	I52
sss	41	SUSTIVA.....	62
STARLIX	48	SUTENT	56
stavudine	62	sv	I06, I67
STELARA	I20	syeda	92
STENDRA	I53	SYLATRON	54
STERILANCE	I29	SYMAX DUOTAB.....	I10
STERILE	I29	symax-sl	I10
STIMATE	I15	symax-sr	I10
STIOLTO RESPIMAT	30	SYMBICORT	30
STIVARGA	56	SYMDEKO	I52
st. joseph aspirin	61	SYMF.....	63
stop smoking aid	I50	SYMJEPI	66
STRENSIQ	I56	SYMLINPEN	47
STRIANT	I15	SYMPAZAN	84
STRIVERDI	29	SYMPROIC	42
STROMECTOL	49	SYMTUZA	61
strong iodine	I05	SYNALAR	39, I48
SUBOXONE	I59	SYNAREL	I18
SUBSYS	24	SYNDROS	I09
subvenite	86	SYNERA	26
SUCRAID	III	SYNJARDY	48
sucralfate	I09	SYPRINE	I56
SULAR	73	SYRINGE	I5, I9, 20, 31, 42, 65, 71, 83, I04, I20, I31, I32, I43, I59

Index of Medications

SYRINGE AVITENE	71	TENORETIC.....	79
T		TENORMIN	78
TABLOID	52	terazosin	76
TABRECTA.....	56	terbinafine	43
tacrolimus.....	121	terbutaline	29
tadalafil.....	153	terconazole	43
TAFINLAR.....	52	teriparatide	154, 158
TAGRISSO.....	56	TERIPARATIDE.....	154, 158
TAKE ACTION	92	terrell	25
TAKHYRO.....	68, 152	TESSALON PERLE.....	93
TALICIA	109	testosterone.....	115
TALTZ	143	TESTOSTERONE.....	115
TALZENNA.....	56	testosterone cypionate	115
TAMIFLU	64	testosterone enanthate	115
tamoxifen.....	58	TETANUS Diphtheria Toxoids.....	70
tamsulosin	160	tetrabenazine	82
TANDEM.....	124, 163	tetracaine.....	100
TAPERDEX.....	117	tetracycline hcl	39
TARCEVA.....	56	TEXACORT	148
TARGADOX	39	TEZSPIRE.....	152
TARGRETIN	58	T:FLEX	124
tarina fe.....	92	THALOMID	35
TARKA	75	THEO-24	31
TARPEYO.....	117	theophylline anhydrous	31
TASIGNA	56	thera-m.....	163
TASMAR	60	THERA-M	163
TAVNEOS	70	THERANATAL.....	135
tazarotene	144	THIAMINE.....	166
TAZORAC	144	THIN	126, 127, 129
taztia.....	73	THIOLA	160
TAZVERIK	53	thioridazine	141
TC	95	thiothixene	141
TECHLITE.....	129	THROMBI-GEL	71
TEGLUTIK	81	THROMBIN-JMI	71
TEGRETOL	86	THROMBI-PAD	71
TEGSEDI	155	thyroid	151
TEKTURN A	79	tiadylt	73
TEL CARE	129	tiagabine	86
telmisartan.....	76, 77	TIAZAC	73
telmisartan-amlodipine	76	TIBSOVO	57
telmisartan-hydrochlorothiazid	76	ticagrelor	61
temazepam	142	TIGLUTIK	81
TEMIXYS.....	62	tilia fe	92
TEMOVATE	148	timolol	78, 100, 101, 102
tencon	19	TIMOLOL	100, 101, 102
TENIVAC	70	TIMOLOL-BRIMONIDIN-DORZOLAMIDE	100
tenofovir disoproxil fumarate	62, 63	TIMOLOL-BRIMONI-DORZOL-LATANOP	100

Index of Medications

TIMOLOL-DORZOLAMIDE-LATANOPRST	100
TIMOLOL-LATANOPROST	100
timolol maleate.....	100, 101
TIMOPTIC.....	100, 101
tinidazole.....	49
tiopronin.....	160
TISSEEL VHSD	146
TIVICAY	63
TIVORBEX	28
tizanidine	134
TOBI PODHALER.....	34
TOBRADEX EYE OINTMENT.....	32
tobramycin.....	32, 33, 34
TOBRAMYCIN.....	34
tobramycin-dexamethasone	32
TOBREX.....	33
TODAY	88
tolcapone.....	60
TOLECTIN	28
tolmetin.....	28
tolterodine tartrate.....	161
tolvaptan.....	96, 97
TOPCARE.....	129
TOPICORT	148
topiramate.....	86
topiramate er.....	86
toremifene	58
torsemide.....	96
TOSYMRA.....	20
TOUJEO.....	49
tovet emollient.....	149
TOVIAZ.....	161
TOXICOLOGY SALIVA COLLECTION.....	95
TRACLEER	74
tramadol	21, 24
tramadol hcl.....	21, 24
tramadol hcl-acetaminophen.....	21
trandolapril	75, 77
trandolapril-verapamil	75
tranexamic acid	70
TRANXENE	136
tranylcypromine.....	136
travoprost.....	101
trazodone	137
TRECATOR	35
TRELEGY ELLIPTA.....	30
TREMFYA.....	120, 143
TRESIBA.....	49
tretinoin.....	57, 144, 150
TREXALL.....	52
TREZIX.....	22
triamcinolone acetonide.....	148, 149, 153
triамтерене	97
trianex.....	149
triazolam.....	142
tri-buffered aspirin.....	19
triderm	149
TRIDESILON.....	149
tri-estarrylla.....	92
tri-femynor.....	92
trifluoperazine hcl	141
trifluridine.....	64
TRIGLIDE.....	81
trihexyphenidyl hcl	59
TRIKAFTA.....	152
tri-legest fe.....	92
tri-linyah.....	92
TRILIPPIX	81
tri-lo-estarrylla.....	92
tri-lo-marzia.....	92
tri-lo-mili.....	92
tri-lo-sprintec	92
trilyte	113
trimethobenzamide	109
trimethoprim.....	33, 34
tri-mili.....	92
trimipramine maleate	138
TRINTELLIX.....	138
tri-previfem.....	92
TRISODIUM CITRATE CRRT.....	42
tri-sprintec	92
TRIUMEQ	61
TRIVIA	163
tri-vitamin with fluoride	165
tri-vit-fluor	165
TRI-VIT-FLUOR	165
trivora.....	92
tri-vylibra.....	92
TROKENDI	86
tropicamide.....	102
TROPICAMIDE	102
TROPICAMIDE-CYCLOPENTOLATE-PE	102
trospium chloride	161
true	106, 161, 164, 166, 167, 168, 169, 170

Index of Medications

TRUE.....	124, 129, I64, I66, I67, I69, I70	UPTRAVI	75
TRUECONTROL.....	I24	URECHOLINE.....	67
TRUE METRIX.....	I24	URELLE.....	34
TRUEPLUS.....	I04, I29	uretron d-s.....	34
TRULANCE.....	III	URIBEL.....	34
TRULICITY.....	46	urimar-t.....	34
TRUMENBA.....	68	urin d.s.....	35
TRUQAP.....	56	uro-458.....	35
TRUSOPT.....	I01	uroav-b.....	35
TRUSTEEL.....	I24	UROCIT-K.....	I08
TRYNGOLZA.....	79	urogesic.....	35
TUBERCULIN.....	I32	uro-mp.....	35
tulana	92	URSO	I10
TULIVITE.....	I06	ursodiol.....	I10
TURALIO.....	56	uryl	35
TUSSICAPS.....	94	USTEKINUMAB.....	I20
TUXARIN.....	94	ustell	35
TUZISTRA	94	UTIBRON.....	30
TWIIST.....	I24, I25	UTIBRON NEOHALER.....	30
TWINRIX.....	70	utira-c.....	35
TWIST.....	I25, I26, I28, I29	V	
TYBOST.....	I51	valacyclovir	64
tydemy	92	VALCHLOR	58
TYENNE.....	I20	VALCYTE	64
TYLENOL W/CODEINE.....	21	valganciclovir	64
TYMLOS.....	I19	valproic acid	86
TYSABRI.....	I58	valsartan	76, 77
TYVASO	75	valsartan-hydrochlorothiazide	76
U		VALTOCO.....	84
UBRELVY.....	20	VANATOL	I9
UCERIS.....	I14, I17	VANCOCIN	39
UKONIQ.....	56	vancomycin	39
ULESFIA	59	vandazole	39
ULTANE.....	25	VANRAFIA.....	I60
ULTI-LANCE.....	I25	VAQTA.....	70
ULTILET	I29	varenicline.....	I50
ULTRA	29, 95, I24, I25, I27, I29, I31, I32, I35, I43, I62	VARIVAX.....	70
ULTRACET	I21	VARUBI.....	I09
ULTRA-FINE	I31, I32	VASCEPA.....	I08
ULTRAFOAM	71	VASERETIC	75
ULTRAM	24	VASOTEC	77
ULTRATLC.....	I29	VAXCHORA	69
ULTRAVATE	I49	VAXELIS.....	70
UNILET	I25, I27, I29, I30	vcf	88
UNISTIK.....	I27, I30, I33	VECAMYL	77
unithroid.....	I51	VECTICAL	I45
UNIVERSAL.....	I26, I30	velivet	92

Index of Medications

VELPHORO	105
VELSIPITY.....	83
VELTASSA.....	105
VEMLIDY.....	65
VENCLEXTA.....	57
venlafaxine.....	138
VENTAVIS.....	75
VEOZAH.....	156
verapamil.....	72, 73, 75
VEREGEN.....	65
VERELAN.....	73
VERIFINE.....	130
VERITOR SARS-COV-2 AND FLU A-B.....	96
VERQUVO.....	73
VERSACLOZ.....	140
VERZENIO.....	57
VEVYE.....	103
VFEND.....	43
VGO.....	125
VIBERZI.....	III
VIBRAMYCIN.....	39
vicodin hp.....	21
vienna.....	92
vigabatrin.....	86
vigadroner.....	86
VIGADRONE.....	86
VIGAMOX.....	33
VIJOICE.....	152
vilamit mb.....	35
vilevmb.....	35
VIMPAT.....	86
VIOKACE.....	II3
viorele.....	93
VIRACEPT.....	63
VIRAMUNE.....	62
VIREAD.....	62, 63
VIRT-CAPS.....	166
virtussin ac.....	94
virtussin dac.....	94
VISION.....	161
VISTARIL.....	45
VISTOGARD.....	153
vit.....	105, 163, 166, 167, 168
VITACORE.....	164
VITAFOL.....	135
VITAFUSION.....	164
VITAJOY.....	164, 166
VITAMEDMD	135
vitamin.....	135, 162, 163, 164, 165, 166, 167, 168, 169, 170
VITAMINI06, I34, I35, I49, I50, I54, I55, I58, I64, I65, I66, I67, I68, I69, I70	
vitamin b	164, 166, 167, 168
vitamin b complex	164, 166
vitamin b-complex & c.....	166
vitamin b complex with c.....	164
vitamin d2.....	168, 169
vitamin k.....	170
vitamins a, c, d & fluoride.....	165
VITEYES.....	161
VITRAKVI.....	57
VIVAGUARD.....	I30, I32
VIVJOA.....	44
VIVOTIF.....	68
VIZIMPRO.....	57
VOGELXO.....	II5
VOLTAREN.....	143
voriconazole	43, 44
VORTEX.....	I33
VOSEVI.....	65
VOTRIENT.....	57
VOWST.....	III
VOXZOGO	157
VOYDEYA	70
VRAYLAR.....	141
VTAMA.....	145
vtol lq.....	19
VUEBLU.....	95
VUMERTY.....	83
VUSION.....	45
vyfemla.....	93
vylibra	92, 93
VYNDAMAX	157
VYNDAQEL.....	157
VYVANSE.....	I39
VYVGART	157
VYZULTA.....	101
W	
WAKIX	87
warfarin.....	41
WEGOVY	58
well.....	168, 169
wera.....	93
westhroid.....	151
WIDE SEAL DIAPHRAGM.....	93

Index of Medications

WINREVAIR.....	75	ZELBORAF.....	53
wixela inhub	30	ZELNORM.....	112
women's gentle laxative	113	ZEMBRACE SYMTOUCH	20
women's laxative.....	113	ZEMPLAR	155
wymzya fe	93	zenatane.....	144
X		ZENPEP	113
XACIATO	39	zenzedi.....	67
XALKORI	57	ZENZEDI.....	67
XARELTO	42	ZEPATIER	65
XCOPRI	86	ZEPBOUND	59
XDEMVY	59	ZEPOSIA	83
XELJANZ	27	ZESTORETIC	75
XELODA	52	ZESTRIL	77
XENICAL	59	ZIAGEN	62
XENLETA	37	ZIANA	144
XEPI	40	zidovudine	62
XERMELO	108	zinc oxide	146
XHANCE	98	ziprasidone.....	140
XIFAXAN	38	ZIRGAN	64
XIGDUO	48	ZITHROMAX.....	37
XXIIDRA	103	ZOFRAN	109
XOFLUZA	64	ZOKINVY	152
XOLAIR	31	ZOLADEX	54
XOLREMDI	87	ZOLINZA	51
XOPENEX	29	ZOLMITRIPTAN	20
XOSPATA	57	zolmitriptan odt	20
XTANDI.....	52	zolpidem tartrate.....	142
xulane	93	ZOLPIMIST	142
XURIDEN	105	ZOMIG	20
XYOSTED	115	ZONALON	144
XYREM	142	zonisamide	86, 87
XYWAV	142	ZONTIVITY	61
Y		ZORBTIVE	118
YAZ	93	ZORTRESS	121
YCANTH	145	ZORYVE	145, 146
YEROVY	57	zovia	93
YESINTEK	120	ZOVIRAX	64, 65
YEZTUGO	61	ZTALMY	87
YONSA	52	ZTLIDO	26
YUPELRI	29	Z-TUSS AC	94
yuvafem	119	ZUBSOLV	159
Z		zumandimine	90, 93
zafirlukast	31	ZURZUVAE	136
zaleplon	142	ZYDELIG	57
ZANAFLEX	134	ZYKADIA	57
zarah	93	ZYLOPRIM	27
ZARONTIN	86	ZYPITAMAG	80
ZARXIO	87	ZYPREXA	140
zebutal	19	ZYVOX	37

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

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



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

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

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

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

Discrimination is against the law.

Medical coverage

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

Cigna Healthcare:

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

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

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

Cigna Healthcare

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

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

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

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



Cigna Healthcare products and services are provided exclusively by or through operating subsidiaries of The Cigna Group, including Cigna Health and Life Insurance Company, Connecticut General Life Insurance Company, Evernorth Behavioral Health, Inc., Evernorth Care Solutions, Inc. and HMO or service company subsidiaries of Cigna Health Corporation, including Cigna HealthCare of Arizona, Inc., Cigna HealthCare of California, Inc., Cigna HealthCare of Colorado, Inc., Cigna HealthCare of Connecticut, Inc., Cigna HealthCare of Florida, Inc., Cigna HealthCare of Georgia, Inc., Cigna HealthCare of Illinois, Inc., Cigna HealthCare of Indiana, Inc., Cigna HealthCare of St. Louis, Inc., Cigna HealthCare of North Carolina, Inc., Cigna HealthCare of New Jersey, Inc., Cigna HealthCare of South Carolina, Inc., Cigna HealthCare of Tennessee, Inc., and Cigna HealthCare of Texas, Inc. ATTENTION: If you speak languages other than English, language assistance services, free of charge are available to you. For current Cigna customers, call the number on the back of your ID card. Otherwise, call 1.800.244.6224 (TTY: Dial 711). ATENCION: Si usted habla un idioma que no sea inglés, tiene a su disposición servicios gratuitos de asistencia lingüística. Si es un cliente actual de Cigna, llame al número que figura en el reverso de su tarjeta de identificación. Si no lo es, llame al 1.800.244.6224 (los usuarios de TTY deben llamar al 711).

Proficiency of Language Assistance Services

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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