



Cigna Healthcare National Preferred 5-Tier Specialty 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 This drug list is subject to change and all prior versions are no longer in effect.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.

975751 d CA NPF 5-Tier Specialty 07/25 © 2025 Cigna Healthcare.





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View your drug list online

This document was last updated on 07/01/2025.* Go online to see the most up-to-date list of medications your plan covers.

- **myCigna® Appⁱ or myCigna.com[®].** Click on the Prescriptions tab and select Price a Medication from the dropdown menu. Then type in your medication name.
- **Cigna.com/druglist.** Select **National Preferred 5 Tier Specialty** from the dropdown menu. Then type in your medication name.

Questions?

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

* 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, Tier 3, Tier 4 and Tier 5 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).

Information about this drug list

Frequently asked questions (FAQs) (cont.)

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

Words you may need to know

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

Information about this drug list

Words you may need to know (cont.)

- **Exigent circumstances:** When an enrollee is suffering from a health condition that may seriously jeopardize the enrollee's life, health, or ability to regain maximum function, or when an enrollee is undergoing a current course of treatment using a nonformulary drug.
- **Formulary:** The complete list of drugs preferred for use and eligible for coverage under a health plan product, and includes all drugs covered under the outpatient prescription drug benefit of the health plan product. Formulary is also known as a prescription drug list.
- **Generic drug:** The same drug as its brand name equivalent in dosage, safety, strength, how it is taken, quality, performance, and intended use. A generic drug is listed in bold and italicized lowercase letters.
- **Non-formulary drug:** A prescription drug that is not listed on the health plan's formulary.
- **Out-of-pocket costs:** Copayments, coinsurance, and the applicable deductible, plus all costs for health care services that are not covered by the health plan.
- **Prescribing provider:** A health care provider authorized to write a prescription to treat a medical condition for a health plan enrollee.
- **Prescription:** An oral, written, or electronic order by a prescribing provider for a specific enrollee that contains the name of the prescription drug, the quantity of the prescribed drug, the date of issue, the name and contact information of the prescribing provider, the signature of the prescribing provider if the prescription is in writing, and if requested by the enrollee, the medical condition or purpose for which the drug is being prescribed.
- **Prescription drug:** A drug that is prescribed by the enrollee's prescribing provider and requires a prescription under applicable law.
- **Prior Authorization:** A health plan's requirement that the enrollee or the enrollee's prescribing provider obtain the health plan's authorization for a prescription drug before the health plan will cover the drug. The health plan shall grant a prior authorization when it is medically necessary for the enrollee to obtain the drug.
- **Step Therapy:** A process specifying the sequence in which different prescription drugs for a given medical condition and medically appropriate for a particular patient are prescribed. The health plan may require the enrollee to try one or more drugs to treat the enrollee's medical condition before the health plan will cover a particular drug for the condition pursuant to a step therapy request. If the enrollee's prescribing provider submits a request for step therapy exception, the health plans shall make exceptions to step therapy when the criteria is met.
- **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.

Information about this drug list

About this drug list

This is a list of the most commonly prescribed medications covered on the Cigna Healthcare National Preferred 5-Tier Specialty Prescription Drug List as of January 1, 2025. Medications are listed alphabetically by their generic and brand names within their therapeutic category and class.

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

How to read this drug list

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

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

Tiers

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

Tier 1	Generic Medications. Generics have the same strength and active ingredients as brand-name medications, but often cost much less. These medications are covered at your plan's lowest cost-share.	\$
Tier 2	Preferred Brand Medications. These medications typically have a lower-cost generic alternative available.	\$\$
Tier 3	Non-Preferred Brand Medications. These medications typically have a generic and/or preferred brand alternative.	\$\$\$
Tier 4	Preferred Specialty. These medications typically cost less than non-preferred specialty medications.	\$\$\$\$
Tier 5	Non-Preferred Specialty. These medications are covered at your plan's highest cost-share. Non-preferred specialty medications typically have a preferred 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)		
butalbital/acetaminophen	T1	
ANALGESIC, NON-SALICYLATE AND BARBITURATE COMBINAT		
butalb-aspirin-caff 50-325-40	T1	QL (6 tabs/day)
butalbital-asa-caffeine cap (Fiorinal)	T1	QL (6 caps/day)
FIORINAL (butalbital-aspirin-caffeine)	T3	QL (6 caps/day)
ANALGESIC, SALICYLATE, BARBITURATE, XANTHINE COMB.		
butalb/acetaminophen/caffeine	T3	
butalb/acetaminophen/caffeine (Esgic)	T3	QL (6 caps/day)
butalb-acetamin-caff 50-300-40 (Fioricet)	T1	QL (6 caps/day)
butalb-acetamin-caff 50-325-40 (Esgic)	T1	QL (6 tabs/day)
ESGIC 50-325-40 MG TABLET (butalbital-acetaminophen-caff)	T3	QL (6 tabs/day)
ESGIC CAPSULE (zebutal)	T3	QL (6 caps/day)
FIORICET (phrenilin forte)	T1	QL (6 caps/day)
ANALGESIC/ANTIPYRETICS, SALICYLATES		
choline salicyl/mag salicylate	T1	HD
diflunisal	T1	HD
ANTI-MIGRAINE PREPARATIONS		
AIMOVIG AUTOINJECTOR	T2	PA
AJOVY AUTOINJECTOR	T2	PA
AJOVY SYRINGE	T2	PA
almotriptan malate	T1	QL (12 tabs/30 days)
CAFERGOT (ergotamine-caffeine)	T3	QL (40 tabs/28 days)
dihydroergotamine 1 mg/ml amp	T1	QL (10 amps/30 days)
eletriptan hydrobromide	T1	QL (6 tabs/30 days)
EMGALITY PEN	T2	PA
EMGALITY SYRINGE	T2	PA
ergotamine tartrate/caffeine	T1	
ergotamine tartrate/caffeine (Cafergot)	T1	QL (40 tabs/28 days)

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

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

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

Prescription drug name is the name of the medication

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

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

Generic medications are in **lowercase italics**

This chart is just a sample. It may not show how these medications are actually covered on the Cigna Healthcare National Preferred 5-Tier Specialty 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)	19-24	Anti-Infectives/Miscellaneous (Infections)	52, 53
Analgesics (Urinary Tract Conditions)	24	Anti-Infectives/Miscellaneous (Miscellaneous)	53
Anesthetics (Miscellaneous)	24, 25	Anti-Infectives/Miscellaneous (Skin Conditions)	53
Anesthetics (Pain Relief and Inflammatory Disease)	25	Anti-Inflammatory Tumor Necrosis Factor Inhibiting Agents (Pain Relief and Inflammatory Disease)	53, 54
Anesthetics (Urinary Tract Conditions)	25	Anti-Neoplastics (Cancer)	54-61
Anti-Allergy (Allergy and Nasal Sprays)	25	Anti-Neoplastics (Skin Conditions)	61, 62
Anti-Arthritis (Pain Relief and Inflammatory Disease)	26-29	Anti-Obesity Drugs (Weight Management)	62, 63
Anti-Asthmatics (Asthma/COPD/Respiratory)	29-32	Anti-Parasitics (Eye Conditions)	63
Antibiotics (Ear Medications)	32, 33	Anti-Parasitics (Infections)	63
Antibiotics (Eye Conditions)	33, 34	Anti-Parkinson's Drugs (Parkinson's Disease)	63, 64
Antibiotics (Infections)	34-40	Anti-Platelet Drugs (Blood Thinners/Anti-Clotting)	64, 65
Antibiotics (Skin Conditions)	40-42	Antivirals (AIDS/HIV)	65-68
Anti-Coagulants (Blood Thinners/Anti-Clotting)	42, 43	Antivirals (Eye Conditions)	68
Antidotes (Gastrointestinal/Heartburn)	43	Antivirals (Infections)	68-70
Antidotes (Substance Abuse)	43, 44	Antivirals (Skin Conditions)	70
Anti-Fungals (Eye Conditions)	44	Autonomic Drugs (Allergy/Nasal Sprays)	70
Anti-Fungals (Feminine Products)	44	Autonomic Drugs (Alzheimer's Disease)	70, 71
Anti-Fungals (Infections)	44, 45	Autonomic Drugs (Attention Deficit Hyperactivity Disorder)	71
Anti-Fungals (Skin Conditions)	45, 46	Autonomic Drugs (Blood Pressure/Heart Medications)	72
Antihistamine and Decongestant Combination (Allergy/Nasal Sprays)	46	Autonomic Drugs (Urinary Tract Conditions)	72
Antihistamines (Allergy/Nasal Sprays)	47	Biologicals (Allergy/Nasal Sprays)	72
Antihistamines (Eye Conditions)	47	Biologicals (Blood Pressure/Heart Medications)	72
Anti-Hyperglycemics (Diabetes)	47-51	Biologicals (Miscellaneous)	72
Anti-Infectives (Feminine Products)	51	Biologicals (Vaccines)	73-75
Anti-Infectives/Miscellaneous (Feminine Products)	51	Blood (Blood Modifiers/Bleeding Disorders)	75, 76
		Blood (Blood Thinners/Anti-Clotting)	77

Information about this drug list

How to find your medication (cont.)

Condition	Page	Condition	Page
Cardiac Drugs (Blood Pressure/ Heart Medications)	77, 79	Gastrointestinal (Gastrointestinal/Heartburn)	I17-I23
Cardiovascular (Asthma/COPD/Respiratory)	79, 80	Gastrointestinal (Pain Relief and Inflammatory Disease)	I23
Cardiovascular (Blood Pressure/Heart Medications)	80-84	Hormones (Gastrointestinal/Heartburn)	I24
Cardiovascular (Cholesterol Medications)	84-87	Hormones (Hormonal Agents)	I24-I28
CNS Drugs (Alzheimer's Disease)	87	Hormones (Infertility)	I29
CNS Drugs (Miscellaneous)	87, 88	Hormones (Miscellaneous)	I29
CNS Drugs (Multiple Sclerosis)	88, 89	Hormones (Osteoporosis Products)	I29
CNS Drugs (Pain Relief and Inflammatory Disease)	89	Immunosuppressants (Pain Relief and Inflammatory Disease)	I29, I30
CNS Drugs (Seizure Disorders)	90-93	Immunosuppressants (Skin Conditions)	I30
CNS Drugs (Sleep Disorders/Sedatives)	93	Immunosuppressants (Transplant Medications)	I31
Colony Stimulating Factors (Blood Modifiers/Bleeding Disorders)	93	Miscellaneous Medical Supplies, Devices, Non-Drug (Diabetes)	I32-I54
Colony Stimulating Factors (Cancer)	94	Miscellaneous Medical Supplies, Devices, Non-Drug (Miscellaneous)	I54-I63
Contraceptives (Contraception Products)	94, 95	Muscle Relaxants (Pain Relief and Inflammatory Disease)	I63, I64
Cough/Cold Preparations (Allergy/Nasal Sprays)	95	Prenatal Vitamins (Nutritional/Dietary)	I64-I68
Cough/Cold Preparations (Cough/Cold Medications)	95-97	Psychotherapeutic Drugs (Anxiety/Depression/Bipolar Disorder)	I68-I72
Diagnostic (Diabetes)	97	Psychotherapeutic Drugs (Attention Deficit Hyperactivity Disorder)	I72-I74
Diagnostic (Miscellaneous)	97-99	Psychotherapeutic Drugs (Miscellaneous)	I74
Diuretics (Diuretics)	I00, I01	Psychotherapeutic Drugs (Schizophrenia/Anti-Psychotics)	I74-I76
EENT Preps (Allergy/Nasal Sprays)	I01, I02	Psychotherapeutic Drugs (Seizure Disorders)	I76
EENT Preps (Ear Medications)	I02	Psychotherapeutic Drugs (Sleep Disorders/Sedatives)	I76
EENT Preps (Eye Conditions)	I02-I07	Sedative/Hypnotics (Sleep Disorders/Sedatives)	I76, I77
Elect/Caloric/H2O (Cholesterol Medications)	I07	Skin Preps (Miscellaneous)	I77, I78
Elect/Caloric/H2O (Dental Products)	I07, I08	Skin Preps (Pain Relief and Inflammatory Disease)	I78
Elect/Caloric/H2O (Diabetes)	I08, I09	Skin Preps (Skin Conditions)	I79-I88
Elect/Caloric/H2O (Miscellaneous)	I09	Smoking Deterrents (Smoking Cessation)	I89
Elect/Caloric/H2O (Nutritional/Dietary)	I09-II6	Thyroid Prep (Hormonal Agents)	I89
Elect/Caloric/H2O (Urinary Tract Conditions)	II6, II7		
Gastrointestinal (Cholesterol Medications)	II7		

Information about this drug list

How to find your medication (cont.)

Condition	Page	Condition	Page
Unclassified Drug Products (AIDS/HIV)	189	Unclassified Drug Products (Nutritional/Dietary)	197
Unclassified Drug Products (Asthma/COPD/Respiratory)	189, 190	Unclassified Drug Products (Osteoporosis Products)	197, 198
Unclassified Drug Products (Blood Modifiers/Bleeding Disorders)	190	Unclassified Drug Products (Pain Relief and Inflammatory Disease)	198
Unclassified Drug Products (Blood Pressure/Heart Medications)	191	Unclassified Drug Products (Seizure Disorders)	198
Unclassified Drug Products (Cancer)	191	Unclassified Drug Products (Skin Conditions)	198, 199
Unclassified Drug Products (Dental Products)	191	Unclassified Drug Products (Substance Abuse)	199
Unclassified Drug Products (Erectile Dysfunction)	191, 192	Unclassified Drug Products (Transplant Medications)	199
Unclassified Drug Products (Eye Conditions)	192	Unclassified Drug Products (Urinary Tract Conditions)	199, 200
Unclassified Drug Products (Gastrointestinal/Heartburn)	192, 193	Unclassified Drug Products (Weight Management)	200
Unclassified Drug Products (Hormonal Agents)	193	Vitamins (Nutritional/Dietary)	200-243
Unclassified Drug Products (Miscellaneous)	193-197	Vitamins (Vitamins)	243

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		
ALLZITAL	T3	PA
<i>butalbital/acetaminophen</i>	T1	
<i>butalbital/acetaminophen (Bupap)</i>	T1	
ANALGESIC, SALICYLATE, BARBITURATE, XANTHINE COMB.		
<i>butalbital/aspirin/caffeine</i>	T1	
ANALGESICS, NON-OPIOID		
JOURNAVX	T3	QL (30 tabs/90 days)
ANALGESIC, NON-SALICYLATE, BARBITURATE, XANTHINE COMB		
<i>butalb/acetaminophen/caffeine</i>	T1	
<i>butalb/acetaminophen/caffeine (Esgic)</i>	T1	
<i>butalb/acetaminophen/caffeine (Fioricet)</i>	T1	
<i>ESGIC (butalb/acetaminophen/caffeine)</i>	T3	PA
<i>FIORICET (butalb/acetaminophen/caffeine)</i>	T3	PA
ANALGESIC/ANTIPYRETICS, SALICYLATES		
<i>choline salicyl/mag salicylate</i>	T1	HD
<i>diflunisal</i>	T1	HD
ANTIMIGRAINE PREPARATIONS		
AIMOVIG AUTOINJECTOR	T2	PA QL (1 auto-inj/30 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)
<i>almotriptan malate 12.5 mg tab</i>	T1	QL (12 tabs/30 days)
<i>almotriptan malate 6.25 mg tab</i>	T1	QL (6 tabs/30 days)
<i>AMERGE (naratriptan hcl)</i>	T3	ST QL (9 tabs/fill)
CAMBIA	T3	ST QL (9 packs/fill)
<i>dihydroergotamine 1 mg/ml amp</i>	T1	
<i>dihydroergotamine 4 mg/ml spry (Migranal)</i>	T1	ST QL (8 mls/fill)
<i>eletriptan hydrobromide (Relpax)</i>	T1	QL (6 tabs/fill)
EMGALITY 120 MG/ML SYRINGE	T2	PA QL (1 syringe/30 days)
EMGALITY PEN	T2	PA QL (1 pen/30 days)
ERGOMAR	T3	
<i>ergotamine tartrate/caffeine</i>	T1	
<i>FROVA (frovatriptan succinate)</i>	T3	ST QL (9 tabs/fill)
<i>frovatriptan succinate (Frova)</i>	T1	QL (9 tabs/30 days)

T1 – Generics

T2 – Preferred Brands

T3 – Non-Preferred Brands

T4 – Preferred Specialty

T5 – Non-Preferred Specialty

PA – Prior Authorization

QL – Quantity Limit

ST – Step Therapy

AGE – Age Requirement

SP – Specialty Medication

HD – 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
ANTIMIGRAINE PREPARATIONS (cont.)		
MIGRALAN (<i>dihydroergotamine mesylate</i>)	T3	ST QL (8 mls/fill)
<i>naratriptan hcl</i> (Amerge)	T1	QL (9 tabs/fill)
NURTEC ODT	T2	PA QL (16 tabs/fill)
QULIPTA	T2	PA QL (30 tabs/30 days)
REYVOW 100MG TABLET	T3	PA QL (8 tabs/treatment)
<i>rizatriptan benzoate</i> (Maxalt)	T1	QL (18 tabs/fill)
<i>sumatriptan</i>	T1	QL (6 units/30 days)
<i>sumatriptan</i> (Imitrex)	T1	QL (6 units/fill)
<i>sumatriptan 4 mg/0.5 ml inject</i> (Imitrex)	T1	QL (2 pens/fill)
<i>sumatriptan 6 mg/0.5 ml cart</i> (Imitrex)	T1	QL (1 ml/fill)
<i>sumatriptan 6 mg/0.5 ml inject</i> (Imitrex)	T1	QL (2 pens/fill)
<i>sumatriptan 6 mg/0.5 ml vial</i>	T1	QL (2 vials/fill)
TOSYMRA	T3	ST QL (6 units/fill)
UBRELVY	T2	PA QL (10 tabs/treatment)
ZEMBRACE SYMTOUCH	T3	ST QL (4 pens/fill)
<i>zolmitriptan</i>	T1	QL (6 tabs/30 days)
<i>zolmitriptan 2.5 mg tablet</i> (Zomig)	T1	QL (6 tabs/fill)
<i>zolmitriptan 5 mg nasal spray</i> (Zomig)	T1	ST QL (6 units/fill)
<i>zolmitriptan 5 mg tablet</i> (Zomig)	T1	QL (6 tabs/fill)
ZOLMITRIPTAN 2.5 MG NASAL SPRAY	T3	ST QL (6 units/30 days)
ZOMIG 2.5 MG NASAL SPRAY	T2	ST QL (6 units/30 days)
ZOMIG 5 MG NASAL SPRAY (<i>zolmitriptan</i>)	T3	ST QL (6 units/fill)
NASAL NSAIDS, COX NON-SELECTIVE, SYSTEMIC ANALGESIC		
SPRIX	T3	ST QL (5 units/fill)
NSAIDS, CYCLOOXYGENASE INHIBITOR - TYPE ANALGESICS		
<i>diclofenac pot 25mg tablet</i>	T1	ST HD
<i>diclofenac pot 50 mg tablet</i>	T1	HD
<i>diclofenac pot powder pack</i>	T1	ST QL (9 pkts/30 days)
<i>diclofenac potassium</i>	T1	HD
<i>diclofenac potassium</i>	T1	ST HD
<i>diclofenac potassium 25 mg cap</i> (Zipsor)	T1	ST HD
FENORTHO 200 MG CAPSULE	T3	PA QL
<i>ketorolac 10 mg tablet</i>	T1	QL (20 tabs/fill)
<i>ketorolac 15 mg/ml carpuject</i>	T1	HD

T1 – Generics

T2 – Preferred Brands

T3 – Non-Preferred Brands

T4 – Preferred Specialty

T5 – Non-Preferred Specialty

PA – Prior Authorization

QL – Quantity Limit

ST – Step Therapy

AGE – Age Requirement

SP – Specialty Medication

HD – 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.)		
ketorolac 15 mg/ml syr	T1	HD
ketorolac 15 mg/ml syringe, vial	T1	
ketorolac 30 mg/ml syr	T1	HD
ketorolac 30 mg/ml syringe	T1	
ketorolac 30 mg/ml vial	T1	
ketorolac 300 mg/10 ml vial	T1	
ketorolac 60 mg/2 ml syringe	T1	
ketorolac 60 mg/2 ml vial	T1	
mefenamic acid	T1	HD
piroxicam	T1	HD
TOLECTIN 600 (tolmetin sodium)	T3	ST HD
OPIOID ANALGESIC AND NON-SALICYLATE ANALGESICS		
acetaminophen with codeine	T1	PA QL
hydrocodone-acetamin 10-300 mg	T1	PA QL
hydrocodone-acetamin 10-325 mg	T1	PA QL
hydrocodone-acetamin 10-300/15	T1	PA QL (12 ds/60 days)
hydrocodone-acetamin 10-325/15	T1	PA QL
HYDROCODONE-ACETAMIN 2.5-108/5	T3	PA QL
hydrocodone-acetamin 2.5-325	T1	PA QL (12 ds/60 days)
HYDROCODONE-ACETAMIN 5-217/10	T3	PA QL
hydrocodone-acetamin 5-300 mg	T1	PA QL
hydrocodone-acetamin 5-325 mg	T1	PA QL
hydrocodone-acetamin 7.5-300	T1	PA QL
hydrocodone-acetamin 7.5-325/15	T1	PA QL
HYDROCODONE-ACETAMIN 7.5-325/15	T3	PA QL
LORTAB	T3	PA QL
NALOCET	T3	PA QL
oxycodone hcl/acetaminophen	T1	PA QL
prolate 10-300 mg tablet	T1	PA QL
prolate 5-300 mg tablet	T1	PA QL
prolate 7.5-300 mg tablet	T1	PA QL
tramadol hcl/acetaminophen	T1	PA QL (12 ds/60 days)
OPIOID ANALGESIC AND NSAID COMBINATION		
hydrocodone(ibuprofen	T1	PA

T1 – Generics

T2 – Preferred Brands

T3 – Non-Preferred Brands

T4 – Preferred Specialty

T5 – Non-Preferred Specialty

PA – Prior Authorization

QL – Quantity Limit

ST – Step Therapy

AGE – Age Requirement

SP – Specialty Medication

HD – 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, NON-SALICYLATE, XANTHINE COMB		
acetaminophen/caff/dihydrocod	T1	PA QL
TREZIX	T3	PA QL
OPIOID ANALGESICS		
ABSTRAL	T3	PA QL
ACTIQ (fentanyl citrate)	T3	PA QL
BELBUCA	T2	PA QL (60 films/30 days)
buprenorphine (Butrans)	T1	PA
butorphanol tartrate	T1	PA QL (12 ds/180 days)
codeine sulfate	T1	PA QL
DILAUDID (hydromorphone hcl)	T3	PA QL
fentanyl	T1	PA QL (15 patches/30 days)
fentanyl cit oftc 1,200 mcg	T1	PA QL (90 lozs/30 days)
fentanyl cit oftc 1,600 mcg (Actiq)	T1	PA QL
fentanyl citrate oftc 200 mcg	T1	PA QL (90 lozs/30 days)
fentanyl citrate oftc 400 mcg	T1	PA QL (90 lozs/30 days)
fentanyl citrate oftc 600 mcg	T1	PA QL (90 lozs/30 days)
fentanyl citrate oftc 800 mcg	T1	PA QL (90 lozs/30 days)
hydrocodone er 10 mg capsule	T1	PA QL (90 caps/30 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 15 mg capsule	T1	PA QL (90 caps/30 days)
hydrocodone er 20 mg capsule	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 capsule	T1	PA QL (90 caps/30 days)
hydrocodone er 30 mg tablet (Hysingla Er)	T1	PA QL (60 tabs/30 days)
hydrocodone er 40 mg capsule	T1	PA QL (90 caps/30 days)
hydrocodone er 40 mg tablet (Hysingla Er)	T1	PA QL (60 tabs/30 days)
hydrocodone er 50 mg capsule	T1	PA QL (90 caps/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)
hydromorphone hcl	T1	PA QL
hydromorphone hcl	T1	PA QL (60 tabs/30 days)
hydromorphone hcl (Dilauidid)	T1	PA QL
HYSINGLA ER (hydrocodone bitartrate)	T2	PA QL (60 tabs/30 days)

T1 – Generics

T2 – Preferred Brands

T3 – Non-Preferred Brands

T4 – Preferred Specialty

T5 – Non-Preferred Specialty

PA – Prior Authorization

QL – Quantity Limit

ST – Step Therapy

AGE – Age Requirement

SP – Specialty Medication

HD – 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.)		
KADIAN	T3	ST QL (90 caps/30 days)
KADIAN (<i>morphine sulfate</i>)	T3	ST QL (90 caps/30 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)
<i>levorphanol tartrate</i>	T1	PA QL
<i>methadone hcl</i>	T1	
<i>morphine sulfate 100 mg tablet (Ms Contin)</i>	T1	PA QL (120 tabs/30 days)
<i>morphine sulfate 15 mg tablet (Ms Contin)</i>	T1	PA QL (120 tabs/30 days)
<i>morphine sulfate 200 mg tablet (Ms Contin)</i>	T1	PA QL (120 tabs/30 days)
<i>morphine sulfate 30 mg tablet (Ms Contin)</i>	T1	PA QL (120 tabs/30 days)
<i>morphine sulfate 60 mg tablet (Ms Contin)</i>	T1	PA QL (120 tabs/30 days)
<i>morphine sulfate er 10 mg cap (Kadian)</i>	T1	ST QL (90 caps/30 days)
<i>morphine sulfate er 50 mg cap (Kadian)</i>	T1	ST QL (90 caps/30 days)
<i>morphine sulfate er 60 mg cap (Kadian)</i>	T1	ST QL (90 caps/30 days)
<i>morphine sulfate er 80 mg cap (Kadian)</i>	T1	ST QL (90 caps/30 days)
<i>morphine sulfate er 100 mg cap (Kadian)</i>	T1	ST QL (90 caps/30 days)
<i>morphine sulfate er 10 mg cap</i>	T1	PA QL (90 caps/30 days)
<i>morphine sulfate er 20 mg cap</i>	T1	PA QL (90 caps/30 days)
<i>morphine sulfate er 30 mg cap</i>	T1	PA QL (60 caps/30 days)
<i>morphine sulfate er 30 mg cap</i>	T1	PA QL (90 caps/30 days)
<i>morphine sulfate er 45 mg cap</i>	T1	PA QL (60 caps/30 days)
<i>morphine sulfate er 50 mg cap</i>	T1	PA QL (90 caps/30 days)
<i>morphine sulfate er 60 mg cap</i>	T1	PA QL (60 caps/30 days)
<i>morphine sulfate er 60 mg cap</i>	T1	PA QL (90 caps/30 days)
<i>morphine sulfate er 75 mg cap</i>	T1	PA QL (60 caps/30 days)
<i>morphine sulfate er 90 mg cap</i>	T1	PA QL (90 caps/30 days)
<i>morphine sulfate er 90 mg cap</i>	T1	PA QL (60 caps/30 days)
<i>morphine sulfate er 100 mg cap</i>	T1	PA QL (90 caps/30 days)
<i>morphine sulfate er 120 mg cap</i>	T1	PA QL (60 caps/30 days)
<i>MS CONTIN (morphine sulfate)</i>	T3	PA QL (120 tabs/30 days)
<i>opium/belladonna alkaloids</i>	T1	PA QL
<i>oxycodone hcl (ir) 10 mg tab</i>	T1	PA QL (12 ds/60 days)
<i>oxycodone hcl (ir) 15 mg tab (Roxicodone)</i>	T1	PA QL (12 ds/60 days)
<i>oxycodone hcl (ir) 20 mg tab</i>	T1	PA QL (12 ds/60 days)

T1 – Generics

T2 – Preferred Brands

T3 – Non-Preferred Brands

T4 – Preferred Specialty

T5 – Non-Preferred Specialty

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List of Prescription Medications

ANALGESICS (Pain Relief and Inflammatory Disease) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
OPIOID ANALGESICS (cont.)		
oxycodone hcl (ir) 30 mg tab (Roxicodone)	T1	PA QL (12 ds/60 days)
oxycodone hcl (ir) 5 mg cap	T1	PA QL (12 ds/60 days)
oxycodone hcl (ir) 5 mg tablet (Roxicodone)	T1	PA QL (12 ds/60 days)
oxycodone hcl 100 mg/5 ml conc	T1	PA QL (12 ds/60 days)
oxycodone hcl 5 mg/5 ml cup, soln	T1	PA QL (12 ds/60 days)
OXYCONTIN	T2	PA QL (90 tabs/30 days)
oxymorphone hcl	T1	PA QL (90 tabs/30 days)
pentazocine hcl/naloxone hcl	T1	PA QL
ROXICODONE (oxycodone hcl)	T3	PA QL
SUBSYS	T3	PA QL (90 units/30 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 50 mg tablet	T1	PA QL
tramadol hcl 100 mg tablet	T1	PA QL (12 ds/60 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)
OPIOID AND SALICYLATE ANALGESICS, BARBIT, XANTHINE		
codeine/butalbital/asa/caffein	T1	PA QL
OPIOID, NON-SALICYL ANALGESIC, BARBITURATE, XANTHINE		
butalbit/acetamin/caff/codeine	T1	PA QL
butalbit/acetamin/caff/codeine (Fioricet With Codeine)	T1	PA QL
FIORICET WITH CODEINE (butalbit/acetamin/caff/codeine)	T3	PA QL
SKELETAL MUSCLE RELAXANT, SALICYLAT, OPIOID ANALGESC		
carisoprodol/aspirin/codeine	T1	PA QL
ANALGESICS (Urinary Tract Conditions)		
URINARY TRACT ANALGESIC AGENTS		
ELMIRON	T2	
RIMSO-50	T3	
ANESTHETICS (Miscellaneous)		
GENERAL ANESTHETICS, INHALANT		
desflurane	T1	

T1 – Generics

T2 – Preferred Brands

T3 – Non-Preferred Brands

T4 – Preferred Specialty

T5 – Non-Preferred Specialty

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List of Prescription Medications

ANESTHETICS (Miscellaneous) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
GENERAL ANESTHETICS, INHALANT (cont.)		
<i>isoflurane</i>	T1	
<i>sevoflurane (Ultane)</i>	T1	
SUPRANE	T3	
ULTANE (<i>sevoflurane</i>)	T3	
ANESTHETICS (Pain Relief and Inflammatory Disease)		
LOCAL ANESTHETICS		
<i>lidocaine hcl</i>	T1	QL (60 mls/30 days)
<i>lidocaine hcl</i>	T1	
<i>lidocaine hcl 2% jel urojet ac</i>	T1	QL (60 mls/30 days)
<i>lidocaine hcl 2% jelly uro-jet</i>	T1	QL (60 mls/30 days)
<i>lidocaine hcl 4% solution</i>	T1	
TOPICAL LOCAL ANESTHETICS		
CETACAIN ANESTHETIC	T3	
L.E.T. (LIDO-EPINEPH-TETRA)	T3	
<i>lidocaine (Lidocan li)</i>	T1	PA
<i>lidocaine 5% ointment</i>	T1	QL (50 gms/28 days)
<i>lidocaine 5% patch (Lidocan li)</i>	T1	PA
<i>lidocaine 5% patch (Lidoderm)</i>	T1	PA
<i>lidocaine hcl</i>	T1	
<i>lidocaine hcl 4% solution</i>	T1	
LIDOCAIN-EPINEPHRIN-TETRACAIN	T3	
<i>lidocaine-prilocaine cream</i>	T1	QL (30 gms/30 days)
LIDOCAN II (<i>lidocaine</i>)	T3	PA
SYNERA	T3	PA
ZTLIDO	T2	PA
ANESTHETICS (Urinary Tract Conditions)		
URINARY TRACT ANESTHETIC/ANALGESIC AGNT (AZO-DYE)		
<i>phenazopyridine hcl (Pyridium)</i>	T1	
ANTIALERGY (Allergy/Nasal Sprays)		
MAST CELL STABILIZERS		
<i>cromolyn 100 mg/5 ml oral conc (Gastrocrom)</i>	T1	
<i>GASTROCROM (cromolyn sodium)</i>	T3	

T1 – Generics

T2 – Preferred Brands

T3 – Non-Preferred Brands

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List of Prescription Medications

ANTIARTHRITICS (Pain Relief and Inflammatory Disease)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ANALGESIC/ANTIPYRETICS, SALICYLATES		
DISALCID (<i>salsalate</i>)	T3	HD
<i>salsalate</i> (Disalcid)	T1	HD
ANTI-ARTHRITIC AND CHELATING AGENTS		
DEPEN (penicillamine)	T5	PA SP
<i>penicillamine</i> (Cuprimine)	T1	PA SP
<i>penicillamine</i> (Depen)	T1	PA SP
ANTI-ARTHRITIC, FOLATE ANTAGONIST AGENTS		
RASUVO	T2	ST
ANTI-INFLAMMATORY, PYRIMIDINE SYNTHESIS INHIBITOR		
ARAVA (<i>leflunomide</i>)	T3	QL (30 tabs/fill) HD
<i>leflunomide</i> (Arava)	T1	QL (30 tabs/fill) HD
ANTI-INFLAMMATORY, PHOSPHODIESTERASE-4(PDE4) INHIB.		
OTEZLA 10-20 MG STARTER 28 DAY	T4	PA QL (55 tabs/365 days) SP HD
OTEZLA 10-20-30MG START 28 DAY	T4	PA QL (55 tabs/365 days) SP HD
OTEZLA 20 MG TABLET	T4	PA QL (60 tabs/30 days) SP HD
OTEZLA 30 MG TABLET	T4	PA QL (60 tabs/30 days) SP HD
COLCHICINE		
<i>colchicine</i> 0.6 mg tablet (Colcrys)	T1	HD
<i>colchicine</i> 0.6 mg capsule (MITIGARE)	T2	ST
<i>colchicine</i> 0.6 mg tablet	T1	HD
GLOPERBA	T3	HD
MITIGARE (<i>colchicine</i>)	T2	ST
GOLD SALTS		
AURANOFIN	T3	
RIDAURA	T2	
HYPERURICEMIA TX - XANTHINE OXIDASE INHIBITORS		
<i>allopurinol</i>	T1	HD
<i>allopurinol</i> (Zyloprim)	T1	HD
<i>febuxostat</i> (Uloric)	T1	ST HD
ZYLOPRIM (<i>allopurinol</i>)	T3	HD
JANUS KINASE (JAK) INHIBITORS		
RINVOQ ER 15 MG TABLET	T4	PA QL (30 tabs/fill) SP HD
RINVOQ ER 30 MG TABLET	T4	PA QL (30 tabs/fill) SP HD
RINVOQ ER 45 MG TABLET	T4	PA QL (56 tabs/365 days) SP HD

T1 – Generics

T2 – Preferred Brands

T3 – Non-Preferred Brands

T4 – Preferred Specialty

T5 – Non-Preferred Specialty

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List of Prescription Medications

ANTIARTHRITICS (Pain Relief and Inflammatory Disease) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
JANUS KINASE (JAK) INHIBITORS (cont.)		
RINVOQ LQ	T4	PA QL (360 mls/30 days) SP HD
XELJANZ 1 MG/ML SOLUTION	T4	PA QL (300 mls/fill) SP HD
XELJANZ 10 MG TABLET	T4	PA QL (60 tabs/fill) SP HD
XELJANZ 5 MG TABLET	T4	PA QL (60 tabs/fill) SP HD
XELJANZ XR	T4	PA QL (30 tabs/fill) SP HD
NSAID AND TOPICAL IRRITANT COUNTER-IRRITANT COMB.		
COMFORT PAC-IBUPROFEN	T3	
COMFORT PAC-MELOXICAM	T3	
COMFORT PAC-NAPROXEN	T3	
NSAIDS(COX NON-SPEC.INHIB)AND PROSTAGLANDIN ANALOG		
ARTHROTEC 50 (<i>diclofenac sodium/misoprostol</i>)	T3	ST HD
ARTHROTEC 75 (<i>diclofenac sodium/misoprostol</i>)	T3	ST HD
<i>diclofenac sodium/misoprostol</i> (Arthrotec 50)	T1	HD
NSAIDS, CYCLOOXYGENASE INHIBITOR - TYPE ANALGESICS		
<i>diclofenac sodium/misoprostol</i> (Arthrotec 75)	T1	HD
ANAPROX DS (<i>naproxen sodium</i>)	T3	ST HD
DAYPRO (<i>oxaprozin</i>)	T3	ST HD
<i>diclofenac sod dr 25 mg tab</i>	T1	HD
<i>diclofenac sod dr 50 mg tab</i>	T1	HD
<i>diclofenac sod dr 75 mg tab</i>	T1	HD
<i>diclofenac sod ec 25 mg tab</i>	T1	HD
<i>diclofenac sod ec 50 mg tab</i>	T1	HD
<i>diclofenac sod ec 75 mg tab</i>	T1	HD
<i>diclofenac sodium</i>	T1	HD
EC-NAPROSYN (<i>naproxen</i>)	T3	ST HD
<i>ec-naproxen dr 375 mg tablet</i> (Ec-Naprosyn)	T1	HD
<i>ec-naproxen dr 500 mg tablet</i> (Ec-Naprosyn)	T1	ST HD
etodolac	T1	HD
etodolac (Lodine)	T1	HD
FELDENE (<i>piroxicam</i>)	T3	ST HD
<i>fenoprofen 400 mg capsule</i> (Nalfon)	T1	ST HD
<i>fenoprofen 600 mg tablet</i> (Nalfon)	T1	ST HD
flurbiprofen	T1	HD
ibuprofen	T1	HD

T1 – Generics

T2 – Preferred Brands

T3 – Non-Preferred Brands

T4 – Preferred Specialty

T5 – Non-Preferred Specialty

PA – Prior Authorization

QL – Quantity Limit

ST – Step Therapy

AGE – Age Requirement

SP – Specialty Medication

HD – May require home delivery pharmacy

PPACA – No Cost-Share Preventive Medication

CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

ANTIARTHRITICS (Pain Relief and Inflammatory Disease) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
NSAIDS, CYCLOOXYGENASE INHIBITOR - TYPE ANALGESICS (cont.)		
<i>ibuprofen</i>	T1	HD
<i>indomethacin</i>	T1	HD
INDOMETHACIN 20 MG CAPSULE	T3	ST QL (90 caps/30 days) HD
<i>indomethacin 25 mg, 50 mg capsule</i>	T1	HD
<i>indomethacin 50 mg suppository (Indocin)</i>	T1	HD
<i>indomethacin 25 mg/5 ml susp (Indocin)</i>	T1	ST HD
<i>ketoprofen</i>	T1	ST HD
<i>ketoprofen 25 mg capsule</i>	T1	ST HD
<i>ketoprofen 50 mg, 75 mg capsule</i>	T1	HD
<i>ketoprofen er 200 mg capsule</i>	T1	ST HD
LODINE (etodolac)	T3	ST HD
<i>meclomenamate sodium</i>	T1	HD
<i>meloxicam 10 mg capsule (Vivlodex)</i>	T1	ST QL (30 caps/fill) HD
<i>meloxicam 5 mg capsule (Vivlodex)</i>	T1	ST QL (30 caps/fill) HD
MOBIC (meloxicam)	T3	ST QL (30 tabs/fill) HD
<i>nabumetone (Relafen)</i>	T1	HD
NALFON 600 MG TABLET (<i>fenoprofen calcium</i>)	T3	ST HD
NAPRELAN	T3	ST HD
NAPRELAN (<i>naproxen sodium</i>)	T3	ST HD
NAPROSYN (<i>naproxen</i>)	T3	ST HD
<i>naproxen 125 mg/5 ml suspen (Naprosyn)</i>	T1	ST HD
<i>naproxen 250 mg, 375 mg tablet</i>	T1	HD
<i>naproxen 500 mg kit (Naprosyn)</i>	T1	HD
<i>naproxen 500 mg tablet (Naprosyn)</i>	T1	HD
<i>naproxen dr 375 mg tablet (Ec-Naprosyn)</i>	T1	HD
<i>naproxen dr 500 mg tablet (Ec-Naprosyn)</i>	T1	ST HD
<i>naproxen er 750 mg tablet</i>	T1	ST
<i>naproxen sodium</i>	T1	ST HD
<i>naproxen sodium</i>	T1	HD
<i>naproxen sodium (Anaprox Ds)</i>	T1	HD
<i>naproxen sodium (Naprelan)</i>	T1	ST HD
<i>oxaprozin 600mg caplet (Daypro)</i>	T1	HD
<i>oxaprozin 600mg tablet (Daypro)</i>	T1	HD
<i>piroxicam (Feldene)</i>	T1	HD

T1 – Generics

T2 – Preferred Brands

T3 – Non-Preferred Brands

T4 – Preferred Specialty

T5 – Non-Preferred Specialty

PA – Prior Authorization

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AGE – Age Requirement

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List of Prescription Medications

ANTIARTHRITICS (Pain Relief and Inflammatory Disease) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
NSAIDS, CYCLOOXYGENASE INHIBITOR - TYPE ANALGESICS (cont.)		
RELAFEN (<i>nabumetone</i>)	T3	ST HD
sulindac	T1	HD
TIVORBEX	T3	ST QL (90 caps/30 days) HD
<i>tolmetin sodium 200 mg tab</i>	T1	HD
<i>tolmetin sodium 400 mg cap</i>	T1	ST HD
<i>tolmetin sodium 600 mg tab (Tolectin 600)</i>	T1	ST HD
NSAIDS,(COX-2) SELECTIVE INHIBITOR		
<i>celecoxib (Celebrex)</i>	T1	ST HD
URICOSURIC AGENTS		
<i>probenecid</i>	T1	HD
<i>probenecid/colchicine</i>	T1	HD
ANTIASTHMATICS (Asthma/COPD/Respiratory)		
ANTICHOLINERGICS, ORALLY INHALED LONG ACTING		
INCRUSE ELLIPTA	T2	QL (1 inhaler/30 days) HD
LONHALA MAGNAIR REFILL	T3	QL (60 mls/fill) HD
LONHALA MAGNAIR STARTER	T3	QL (60 mls/fill) HD
SPIRIVA HANDIHALER 18 MCG CAP (<i>tiotropium bromide</i>)	T3	QL (90 caps/30 days) HD
SPIRIVA RESPIMAT	T2	QL (1 inhaler/fill) HD
YUPELRI	T2	QL (30 vls/fill) HD
ANTICHOLINERGICS, ORALLY INHALED SHORT ACTING		
ATROVENT HFA	T3	QL (2 inhalers/fill) HD
<i>ipratropium br 0.02% soln</i>	T1	HD
BETA-ADRENERGIC AGENTS		
<i>albuterol 2 mg/5 ml syrup cup</i>	T1	HD
<i>albuterol 8 mg/20 ml syrup cup</i>	T1	HD
<i>albuterol sulf 2 mg/5 ml syrup</i>	T1	HD
<i>albuterol sulfate 2 mg, 4 mg tab</i>	T1	HD
<i>albuterol sulfate er 4 mg, 8 mg tab</i>	T1	HD
<i>metaproterenol sulfate</i>	T1	HD
<i>terbutaline sulfate</i>	T1	HD
BETA-ADRENERGIC AGENTS, INHALED, SHORT ACTING		
<i>albuterol 100 mg/20 ml soln</i>	T1	
<i>albuterol 2.5 mg/0.5 ml sol</i>	T1	

T1 – Generics

T2 – Preferred Brands

T3 – Non-Preferred Brands

T4 – Preferred Specialty

T5 – Non-Preferred Specialty

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List of Prescription Medications

ANTIASTHMATICS (Asthma/COPD/Respiratory) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
BETA-ADRENERGIC AGENTS, INHALED, SHORT ACTINGS (cont.)		
albuterol 5 mg/ml solution	T1	
albuterol 15 mg/3 ml solution	T1	
albuterol 75 mg/15 ml soln	T1	
albuterol hfa 90 mcg inhaler	T1	QL (2 inhalers/30 days)
albuterol sul 0.63 mg/3 ml sol	T1	
albuterol sul 1.25 mg/3 ml sol	T1	
albuterol sul 2.5 mg/3 ml soln	T1	
levalbuterol hcl (Xopenex Concentrate)	T1	
levalbuterol hcl (Xopenex)	T1	
XOPENEX (levalbuterol hcl)	T3	
XOPENEX CONCENTRATE (levalbuterol hcl)	T3	
BETA-ADRENERGIC AGENTS, INHALED, ULTRA-LONG ACTING		
STRIVERDI RESPIMAT	T2	QL (1 inhaler/30 days) HD
BETA-ADRENERGIC AGENTS, ORALLY INHALED, LONG ACTING		
arformoterol tartrate (Brovana)	T1	QL (120 mls/fill) HD
BROVANA (arformoterol tartrate)	T3	QL (120 mls/fill) HD
formoterol fumarate (Perforomist)	T1	QL (120 mls/fill) HD
FORMOTEROL FUMARATE-NEBULIZER	T2	QL (120 mls/30 days) HD
BETA-ADRENERGIC AND ANTICHOLINERGIC COMBO, INHALED		
ANORO ELLIPTA	T2	QL (1 inhaler/fill) HD
COMBIVENT INHALER	T2	
COMBIVENT RESPIMAT	T2	QL (2 inhalers/30 days)
SEEBRI NEOHALER 15.6MCG INHALER	T3	HD
STIOLTO RESPIMAT	T2	QL (1 inhaler/fill) 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	PA QL (1 inhaler/fill) HD
AIRDUO DIGIHALER	T3	PA QL (1 inhaler/fill) HD
AIRSUPRA	T2	HD
BREO ELLIPTA 50-25 MCG INHALER	T2	PA QL (60 blisters/fill) HD
BREO ELLIPTA 100-25 MCG INH	T2	PA QL (60 blisters/fill) HD
BREO ELLIPTA 100-25 MCG INH	T2	PA QL (28 blisters/fill) HD
BREO ELLIPTA 200-25 MCG INH	T2	PA QL (1 inhaler/fill) HD

T1 – Generics

T2 – Preferred Brands

T3 – Non-Preferred Brands

T4 – Preferred Specialty

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AGE – Age Requirement

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HD – May require home delivery pharmacy

PPACA – No Cost-Share Preventive Medication

CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

ANTIASTHMATICS (Asthma/COPD/Respiratory) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
BETA-ADRENERGIC AND GLUCOCORTICOID COMBO, INHALED (cont.)		
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 100 MCG-5 MCG INHALER	T2	PA QL (1 inhaler/fill) HD
DULERA 200 MCG-5 MCG INHALER	T2	PA QL (1 inhaler/fill) HD
DULERA 50 MCG-5 MCG INHALER	T2	PA QL (13 gms/fill) HD
fluticasone propionate/salmeterol (Advair Diskus)	T1	PA QL (1 inhaler/30 days)
fluticasone-salmeterol 100-50 (Advair Diskus)	T1	PA QL (1 inhaler/fill) HD
fluticasone-salmeterol 250-50 (Advair Diskus)	T1	PA QL (1 inhaler/fill) HD
fluticasone-salmeterol 500-50 (Advair Diskus)	T1	PA QL (1 inhaler/fill) HD
SYMBICORT (budesonide/formoterol fumarate)	T3	PA QL (1 inhaler/30 days) HD
BETA-ADRENERGIC-ANTICHOLINERGIC-GLUCOCORT, INHALED		
BREZTRI AEROSPHERE	T2	QL (1 inhaler/fill)
TRELEGY ELLIPTA 100-62.5-25	T2	QL (60 blisters/fill)
TRELEGY ELLIPTA 100-62.5-25	T2	QL (28 blisters/fill)
TRELEGY ELLIPTA 200-62.5-25	T2	QL (60 blisters/fill)
TRELEGY ELLIPTA 200-62.5-25	T2	QL (28 blisters/fill)
GLUCOCORTICOIDS, ORALLY INHALED		
ALVESCO 80 MCG INHALER	T3	QL (1 inhaler/fill) HD
ALVESCO 160 MCG INHALER	T3	QL (2 inhalers/fill) 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 (1 inhaler/fill) HD
ASMANEX HFA 50 MCG INHALER	T2	QL (13 gms/fill) HD
ASMANEX HFA 100 MCG, 200 MCG INHALER	T2	QL (1 inhaler/fill) HD
budesonide 1 mg/2 ml inh susp (Pulmicort)	T1	QL (60 mls/fill) HD
FLOVENT 50 MCG, 100 MCG DISKUS	T2	QL (1 inhaler/fill) HD
FLOVENT 250 MCG DISKUS	T2	QL (4 inhalers/fill) HD
FLOVENT HFA 110 MCG INHALER	T2	QL (12 gms/fill) HD
FLOVENT HFA 220 MCG INHALER	T2	QL (24 gms/fill) HD
FLOVENT HFA 44 MCG INHALER	T2	QL (11 gms/fill) HD
QVAR REDIHALER 40 MCG	T2	QL (11 gms/30 days)
QVAR REDIHALER 80 MCG	T2	QL (22 gms/30 days)

T1 – Generics

T2 – Preferred Brands

T3 – Non-Preferred Brands

T4 – Preferred Specialty

T5 – Non-Preferred Specialty

PA – Prior Authorization

QL – Quantity Limit

ST – Step Therapy

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List of Prescription Medications

ANTIASTHMATICS (Asthma/COPD/Respiratory) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
INTERLEUKIN-5 (IL-5) ANTAGONISTS, MAB		
NUCALA 100 MG/ML AUTO-INJECTOR	T4	PA QL (1 AUTO-INJ/28 DAYS) SP HD
NUCALA 100 MG/ML SYRINGE	T4	PA QL (1 syringe/28 days) SP HD
NUCALA 40 MG/0.4 ML SYRINGE	T4	PA QL (1 syringe/28 days) SP HD
INTERLEUKIN-5(IL-5) RECEPTOR ALPHA ANTAGONIST, MAB		
FASENRA PEN	T4	PA QL (1 syringe/56 days) SP HD
LEUKOTRIENE RECEPTOR ANTAGONISTS		
ACCOLATE (zaflukast)	T3	HD
montelukast sodium (Singulair)	T1	HD
zaflukast (Accolate)	T1	HD
MAST CELL STABILIZERS, ORALLY INHALED		
cromolyn 20 mg/2 ml neb soln	T1	HD
MONOCLONAL ANTIBODIES TO IMMUNOGLOBULIN E (IGE)		
XOLAIR 75 MG/0.5 ML AUTOINJECT	T4	PA QL (2 auto-injs/28 days) SP HD
XOLAIR 150 MG/ML AUTOINJECTOR	T4	PA QL (2 auto-injs/28 days) SP HD
XOLAIR 150 MG/1.2 ML POWDER VL	T4	PA QL (6 vls/28 days) SP HD
XOLAIR 300 MG/2 ML AUTOINJECT	T4	PA QL (2 auto-injs/28 days) SP HD
XOLAIR 300 MG/2 ML SYRINGE	T4	PA QL (2 syringes/28 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
ANTIBIOTICS (Ear Medications)		
EAR PREPARATIONS, ANTIBIOTICS		
ciprofloxacin hcl	T1	
CORTISPORIN-TC	T3	
neomycin/polymyxin b/hydrocort	T1	
ofloxacin	T1	
OTIPRIO	T3	QL (1 ml/fill)

T1 – Generics

T2 – Preferred Brands

T3 – Non-Preferred Brands

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List of Prescription Medications

ANTIBIOTICS (Ear Medications) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
OTIC PREPARATIONS, ANTI-INFLAMMATORY-ANTIBIOTICS		
ciprofloxacin hcl/dexameth	T1	
OTOVEL	T3	
ANTIBIOTICS (Eye Conditions)		
EYE ANTIBIOTIC AND GLUCOCORTICOID COMBINATIONS		
GATIFLOXACIN-DEXAMETHASONE	T3	
MAXITROL (<i>neomycin/polymyxin b/dexametha</i>)	T3	
<i>neomycin/bacit/p-myx/hydrocort</i>	T1	
<i>neomycin/polymyxin b/dexametha</i> (Maxitrol)	T1	
<i>neomycin/polymyxin b/hydrocort</i>	T1	
PRED-G	T3	
PREDNISOLONE ACET-GATIFLOXACIN	T3	
PREDNISOLONE ACET-MOXIFLOXACIN	T3	
PREDNISOLONE PHOS-GATIFLOXACIN	T3	
PREDNISOLONE PHOS-MOXIFLOXACIN	T3	
TOBRADEX	T3	
<i>tobramycin/dexamethasone</i>	T1	
EYE ANTIBIOTIC AND NSAID COMBINATIONS		
MOXIFLOXACIN-BROMFENAC	T3	
EYE ANTIBIOTIC, GLUCOCORTICOID AND NSAID COMB.		
<i>pred ph-maxi-brom 1-0.5-0.075%</i>	T1	
PRED PH-MOXI-BROM 1-0.5-0.075%	T3	
PREDNISOLONE PH-MOXIFLOX-KETOR	T3	
PREDNISOLONE ACET-GATIFLO-BROM	T3	
PREDNISOLONE AC-MOXIFLO-BROMF	T3	
PREDNISOLONE AC-MOXIFLO-NEPAP	T3	
PREDNISOLONE PHOS-GATIFLO-BROM	T3	
EYE SULFONAMIDES		
BLEPH-10 (<i>sulfacetamide sodium</i>)	T3	
BLEPHAMIDE S.O.P.	T3	
<i>sulfacetamide sodium</i>	T1	
<i>sulfacetamide sodium</i> (Bleph-10)	T1	
<i>sulfacetamide/prednisolone sp</i>	T1	

T1 – Generics

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List of Prescription Medications

ANTIBIOTICS (Eye Conditions) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
OPHTHALMIC ANTIBIOTICS		
AZASITE	T2	
<i>bacitracin</i>	T1	
<i>bacitracin/polymyxin b sulfate</i>	T1	
CEFUROXIME SODIUM-0.9% NACL	T3	PA
CILOXAN 0.3% EYE DROPS (<i>ciprofloxacin hcl</i>)	T3	
<i>ciprofloxacin hcl</i> (Ciloxan)	T1	
<i>erythromycin base</i>	T1	
<i>gatifloxacin</i>	T1	
<i>gentamicin 0.3% eye drop</i>	T1	
<i>gentamicin sulfate</i>	T1	
KLARITY-A(AZITHROMYcin-CHONDR)	T3	
<i>levofloxacin</i>	T1	
<i>neomycin/bacitracin/polymyxinb</i>	T1	
<i>neomycin/polymyxn b/gramicidin</i>	T1	
OCUFLOX (<i>ofloxacin</i>)	T3	
<i>ofloxacin</i> (Ocuflax)	T1	
<i>polymyxin b sulf(trimethoprim) (Polytrim)</i>	T1	
POLYTRIM (<i>polymyxin b sulf(trimethoprim)</i>)	T3	
<i>tobramycin 0.3% eye drop</i> (Tobrex)	T1	
TOBREX	T3	
TOBREX (<i>tobramycin</i>)	T3	
VIGAMOX (<i>moxifloxacin hcl</i>)	T3	
ANTIBIOTICS (Infections)		
2ND GEN. ANAEROBIC ANTIprotozoal-ANTIBACTERIAL		
SOLOSEC	T2	QL (1 pack/fill)
ABSORBABLE SULFONAMIDE ANTIBACTERIAL AGENTS		
BACTRIM (<i>sulfamethoxazole/trimethoprim</i>)	T3	
BACTRIM DS (<i>sulfamethoxazole/trimethoprim</i>)	T3	
<i>sulfadiazine</i>	T1	
<i>sulfamethoxazole/trimethoprim</i>	T1	
<i>sulfamethoxazole/trimethoprim</i> (Bactrim Ds)	T1	
<i>sulfamethoxazole/trimethoprim</i> (Bactrim)	T1	
AMINOGLYCOSIDE ANTIBIOTICS		
ARIKAYCE	T4	PA SP

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List of Prescription Medications

ANTIBIOTICS (Infections) (cont.)			
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits	
AMINOGLYCOSIDE ANTIBIOTICS (cont.)			
BETHKIS (<i>tobramycin</i>)	T5	PA QL (224 mls/fill) SP HD	
<i>gentamicin</i> 80 mg/2 ml vial	T1	PA	
<i>gentamicin</i> 800 mg/20 ml vial	T1	PA	
<i>gentamicin</i> ped 20 mg/2 ml vial	T1	PA	
KITABIS PAK	T4	PA QL (280 mls/fill) SP HD	
<i>neomycin sulfate</i>	T1		
TOBI PODHALER	T4	PA QL (224 caps/fill) SP HD	
<i>tobramycin</i> 300 mg/4 ml ampule (Bethkis)	T1	PA QL (224 mls/fill) SP HD	
<i>tobramycin</i> 300 mg/5 ml ampule (Tobi)	T1	PA QL (280 mls/fill) SP HD	
TOBRAMYCIN PAK 300 MG/5 ML	T5	PA QL (280 mls/fill) SP HD	
<i>tobramycin sulfate</i>	T1	PA	
ANAEROBIC ANTIprotozoal-Antibacterial Agents			
<i>metronidazole</i> 250 mg tablet	T1		
<i>metronidazole</i> 375 mg capsule	T1		
<i>metronidazole</i> 500 mg tablet	T1		
ANTIBIOTIC, ANTIBACTERIAL, MISC.			
<i>fosfomycin tromethamine</i>	T1		
<i>meth/meblue/sod phos/psal/hyos</i>	T1		
<i>methen/mblue/sal/sod phos/hyos</i>	T1		
<i>methenam/m.blue/salicyl/hyosc</i> (Uribel Tabs)	T1		
<i>methenam/sod phos/mblue/hyosc</i>	T1		
<i>methenamine hippurate</i>	T1		
<i>methenamine mandelate</i>	T1		
PRIMSON	T3		
<i>trimethoprim</i>	T1		
TRIMPEX	T3		
URELLE	T3		
URIBEL	T3		
URIBEL TABS (<i>methenam/m.blue/salicyl/hyosc</i>)	T3		
ANTILEPROTICS			
<i>dapsone</i> 100 mg tablet	T1		
<i>dapsone</i> 25 mg tablet	T1		
THALOMID 100 MG CAPSULE	T4	PA QL (30 caps/fill) SP HD	

T1 – Generics

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List of Prescription Medications

ANTIBIOTICS (Infections) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ANTILEPROTICS (cont.)		
THALOMID 200 MG CAPSULE	T4	PA QL (60 caps/fill) SP HD
THALOMID 50 MG CAPSULE	T4	PA QL (30 caps/fill) SP HD
ANTI-MYCOBACTERIUM AGENTS		
<i>ethambutol hcl</i>	T1	HD
<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
ANTITUBERCULAR ANTIBIOTICS		
<i>cycloserine</i>	T1	
PRETOMANID	T3	PA
PRIFTIN	T2	
<i>rifampin</i>	T1	
SIRTURO	T4	PA SP
BETALACTAMS		
CAYSTON	T4	PA QL (84 mls/fill) SP HD
CEPHALOSPORIN ANTIBIOTICS - 1ST GENERATION		
<i>cefadroxil</i>	T1	
<i>cephalexin</i>	T1	
CEPHALOSPORIN ANTIBIOTICS - 2ND GENERATION		
<i>cefaclor</i>	T1	
<i>cefprozil</i>	T1	
<i>cefuroxime axetil</i>	T1	
CEPHALOSPORIN ANTIBIOTICS - 3RD GENERATION		
<i>cefdinir</i>	T1	
<i>cefditoren pivoxil</i> (Spectracef)	T1	
<i>cefixime</i> (Suprax)	T1	
<i>cefpodoxime proxetil</i>	T1	
<i>ceftriaxone sodium</i>	T1	PA
SPECTRACEF (<i>cefditoren pivoxil</i>)	T3	
SUPRAX (<i>cefixime</i>)	T3	

T1 – Generics

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List of Prescription Medications

ANTIBIOTICS (Infections) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
LINCOSEAMIDE ANTIBIOTICS		
CLEOCIN HCL (<i>clindamycin hcl</i>)	T3	
CLEOCIN PEDIATRIC (<i>clindamycin palmitate hcl</i>)	T3	
<i>clindamycin hcl</i> (Cleocin Hcl)	T1	
<i>clindamycin palmitate hcl</i> (Cleocin Pediatric)	T1	
MACROLIDE ANTIBIOTICS		
<i>azithromycin</i>	T1	
<i>azithromycin</i> (Zithromax Tri-Pak)	T1	
<i>azithromycin</i> (Zithromax)	T1	
<i>clarithromycin</i>	T1	
DIFICID 200 MG TABLET	T3	QL (20 tabs/fill)
DIFICID 40 MG/ML SUSPENSION	T3	QL (1 bottle/fill)
E.E.S. 200 (<i>erythromycin ethylsuccinate</i>)	T3	
ERYPED 200 (<i>erythromycin ethylsuccinate</i>)	T3	
ERYPED 400 (<i>erythromycin ethylsuccinate</i>)	T3	
<i>ery-tab dr 250 mg, 333 mg tablet</i>	T1	
ERY-TAB DR 500 MG TABLET (<i>erythromycin base</i>)	T3	
<i>erythromycin base</i>	T1	
<i>erythromycin base</i> (Ery-Tab)	T1	
<i>erythromycin ethylsuccinate</i>	T1	
<i>erythromycin ethylsuccinate</i> (E.E.S. 200)	T1	
<i>erythromycin ethylsuccinate</i> (Eryped 200)	T1	
<i>erythromycin ethylsuccinate</i> (Eryped 400)	T1	
<i>erythromycin stearate</i>	T1	
ZITHROMAX (<i>azithromycin</i>)	T3	
ZITHROMAX TRI-PAK (<i>azithromycin</i>)	T3	
NITROFURAN DERIVATIVES ANTIBACTERIAL AGENTS		
FURADANTIN (<i>nitrofurantoin</i>)	T3	
MACROBID (<i>nitrofurantoin monohyd/m-cryst</i>)	T3	
<i>nitrofurantoin</i> (Furadantin)	T1	
<i>nitrofurantoin mcr 25 mg cap</i>	T1	
<i>nitrofurantoin mcr 100 mg cap</i>	T1	
<i>nitrofurantoin mcr 50 mg cap</i>	T1	
<i>nitrofurantoin monohyd/m-cryst</i> (Macrobid)	T1	

T1 – Generics

T2 – Preferred Brands

T3 – Non-Preferred Brands

T4 – Preferred Specialty

T5 – Non-Preferred Specialty

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List of Prescription Medications

ANTIBIOTICS (Infections) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
OXAZOLIDINONE ANTIBIOTICS		
<i>linezolid (Zyvox)</i>	T1	PA
ZYVOX (<i>linezolid</i>)	T3	PA
PENICILLIN ANTIBIOTICS		
<i>amoxicillin</i>	T1	
<i>amoxicillin/potassium clav</i>	T1	
<i>amoxicillin/potassium clav (Augmentin Xr)</i>	T1	
<i>amoxicillin/potassium clav (Augmentin)</i>	T1	
<i>ampicillin trihydrate</i>	T1	
AUGMENTIN 125-31.25 MG/5 ML	T2	
AUGMENTIN 250-62.5 MG/5 ML (<i>amoxicillin/potassium clav</i>)	T3	
AUGMENTIN XR (<i>amoxicillin/potassium clav</i>)	T3	
<i>dicloxacillin sodium</i>	T1	
MOXATAG	T3	
<i>penicillin v potassium</i>	T1	
PLEUROMUTILIN DERIVATIVES		
XENLETA	T3	
QUINOLONE ANTIBIOTICS		
BAXDELA	T2	QL (28 tabs/fill)
CIPRO (<i>ciprofloxacin hcl</i>)	T3	
CIPRO (<i>ciprofloxacin</i>)	T3	
<i>ciprofloxacin (Cipro)</i>	T1	
<i>ciprofloxacin hcl</i>	T1	
<i>ciprofloxacin hcl (Cipro)</i>	T1	
FACTIVE	T3	
<i>levofloxacin</i>	T1	
<i>moxifloxacin hcl</i>	T1	
<i>ofloxacin</i>	T1	
RIFAMYCINS AND RELATED DERIVATIVE ANTIBIOTICS		
AEMCOLO	T3	QL (12 tabs/fill)
XIFAXAN 200 MG TABLET	T2	QL (9 tabs/fill)
XIFAXAN 550 MG TABLET	T2	QL (60 tabs/fill)
TETRACYCLINE ANTIBIOTICS		
ACTICLATE (<i>doxycycline hyolate</i>)	T3	ST
AVIDOXY DK	T3	ST

T1 – Generics

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T3 – Non-Preferred Brands

T4 – Preferred Specialty

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List of Prescription Medications

ANTIBIOTICS (Infections) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
TETRACYCLINE ANTIBIOTICS (cont.)		
<i>demeclocycline hcl</i>	T1	
<i>doxycycline 25 mg/5 ml susp (Vibramycin)</i>	T1	
<i>doxycycline 50 mg tablet (Targadox)</i>	T1	ST
<i>doxycycline hyc dr 50 mg, 75 mg tab</i>	T1	ST
<i>doxycycline hyc dr 100 mg tab</i>	T1	ST
<i>doxycycline hyc dr 150 mg tab</i>	T1	ST
<i>doxycycline hyc dr 200 mg tab (Doryx)</i>	T1	ST
<i>doxycycline hyclate 100 mg cap</i>	T1	
<i>doxycycline hyclate 50 mg cap</i>	T1	
<i>doxycycline hyclate 75 mg tab (Acticlate)</i>	T1	ST
<i>doxycycline hyclate 100 mg tab (Lymepak)</i>	T1	
<i>doxycycline hyclate 150 mg tab (Acticlate)</i>	T1	ST
<i>doxycycline mono 75 mg capsule</i>	T1	
<i>doxycycline mono 100 mg cap</i>	T1	
<i>doxycycline mono 50 mg cap</i>	T1	
<i>doxycycline mono 50 mg tablet</i>	T1	
<i>doxycycline mono 75 mg tablet</i>	T1	
<i>doxycycline mono 100 mg tablet</i>	T1	
<i>doxycycline mono 150 mg cap</i>	T1	ST
<i>doxycycline mono 150 mg tablet</i>	T1	
<i>doxycycline monohydrate</i>	T1	
<i>doxycycline monohydrate (Oracea)</i>	T1	ST
<i>LYMEPAK (doxycycline hyclate)</i>	T3	
<i>minocycline hcl (Solodyn)</i>	T1	ST
<i>minocycline 100 mg capsule</i>	T1	
<i>minocycline 50 mg capsule</i>	T1	
<i>minocycline 75 mg capsule</i>	T1	
<i>minocycline hcl 100 mg tablet</i>	T1	ST
<i>minocycline hcl 50 mg, 75 mg tablet</i>	T1	ST
<i>MINOLIRA ER</i>	T3	ST
<i>monodoxine nl 100 mg capsule</i>	T1	
<i>monodoxine nl 75 mg capsule</i>	T1	ST
<i>MORGIDOX 1X50 MG KIT</i>	T3	ST
<i>MORGIDOX 1X100 MG KIT</i>	T3	ST

T1 – Generics

T2 – Preferred Brands

T3 – Non-Preferred Brands

T4 – Preferred Specialty

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List of Prescription Medications

ANTIBIOTICS (Infections) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
TETRACYCLINE ANTIBIOTICS (cont.)		
MORGIDOX 2X100 MG KIT	T3	ST
<i>morgidox 50 mg capsule</i>	T1	
NUZYRA	T5	QL (30 tabs/30 days) SP
SEYSARA	T3	ST
SOLODYN (<i>minocycline hcl</i>)	T3	ST
TARGADOX (<i>doxycycline hydate</i>)	T3	ST
<i>tetracycline 250 mg, 500 mg capsule</i>	T1	
<i>tetracycline 250 mg, 500 mg tablet</i>	T1	ST
VIBRAMYCIN	T3	ST
VIBRAMYCIN (<i>doxycycline monohydrate</i>)	T3	ST
VAGINAL ANTIBIOTICS		
CLEOCIN	T3	
CLEOCIN (<i>clindamycin phosphate</i>)	T3	
<i>clindamycin 2% vaginal cream (Cleocin)</i>	T1	
CLINDESSE	T3	
METROGEL-VAGINAL (<i>metronidazole</i>)	T3	
<i>metronidazole (Metrogel-Vaginal)</i>	T1	
<i>metronidazole vaginal 0.75% gl (Metrogel-Vaginal)</i>	T1	
NUVESSA	T3	
XACIATO	T3	
VANCOMYCYIN ANTIBIOTICS AND DERIVATIVES		
VANCOCIN HCL 125 MG CAPSULE (<i>vancomycin hcl</i>)	T3	PA QL (40 caps/fill)
VANCOCIN HCL 250 MG CAPSULE (<i>vancomycin hcl</i>)	T3	PA QL (80 caps/fill)
<i>vancomycin 250 mg/5 ml soln</i>	T1	QL (450 mls/fill)
ANTIBIOTICS (Skin Conditions)		
TOPICAL ANTIBIOTIC AND ANTI-INFLAMMATORY STEROID		
NEO-SYNALAR	T3	
TOPICAL ANTIBIOTICS		
AKTIPAK	T3	ST
AMZEEQ	T3	ST
BENZAMYCIN (<i>erythromycin/benzoyl peroxide</i>)	T3	ST
CENTANY	T3	ST QL (30 gms/fill)
CENTANY AT	T3	ST QL (1 kit/fill)
CLEOCINT 1% LOTION (<i>clindamycin phosphate</i>)	T3	ST QL (120 mls/30 days)

T1 – Generics

T2 – Preferred Brands

T3 – Non-Preferred Brands

T4 – Preferred Specialty

T5 – Non-Preferred Specialty

PA – Prior Authorization

QL – Quantity Limit

ST – Step Therapy

AGE – Age Requirement

SP – Specialty Medication

HD – 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.)		
CLEOCINT 1% PLEDGETS (<i>clindamycin phosphate</i>)	T3	ST
<i>clindacin etz 1% pledget</i> (Cleocin T)	T1	
CLINDACIN ETZ KIT	T3	ST
CLINDACIN PAC	T3	ST
<i>clindamycin ph 1% gel</i>	T1	QL (120 gms/30 days)
<i>clindamycin ph 1% solution</i>	T1	QL (120 mls/30 days)
<i>clindamycin phos 1% ppledget</i> (Cleocin T)	T1	
<i>clindamycin phosp 1% lotion</i> (Cleocin T)	T1	QL (120 mls/30 days)
<i>clindamycin phosphate</i> (Evoclin)	T1	QL (100 gms/30 days)
<i>clindamycin phosphate</i> (Cleocin T)	T1	
<i>clindamycin phosphate 1% foam</i> (Evoclin)	T1	QL (100 gms/30 days)
<i>clindamycin phosphate 1% gel</i> (Clindagel)	T1	QL (150 mls/30 days)
<i>erythromycin base in ethanol</i>	T1	
<i>erythromycin/benzoyl peroxide</i> (Benzamycin)	T1	
EVOCLIN (<i>clindamycin phosphate</i>)	T3	ST QL (100 gms/30 days)
<i>gentamicin 0.1% cream</i>	T1	QL (60 gms/fill)
gentamicin 0.1% ointment	T1	QL (60 gms/fill)
<i>mupirocin 2% cream</i>	T1	ST QL (30 gms/fill)
<i>mupirocin 2% ointment</i>	T1	QL (44 gms/fill)
<i>mupirocin 2% ointment</i>	T1	QL (1 treatment/30days)
XEPI	T3	ST QL (30 gms/fill)
TOPICAL SULFONAMIDES		
AVAR LS	T3	ST
AVAR-E	T3	ST
AVAR-E GREEN	T3	ST
AVAR-E LS	T3	ST
<i>mafenide acetate</i> (Sulfamylon)	T1	
PLEXION	T3	ST
ROSULA 10%-4.5% WASH	T3	ST
<i>rosula 10%-5% cloths</i>	T1	
SILVADENE (<i>silver sulfadiazine</i>)	T3	
<i>silver sulfadiazine</i> (Silvadene)	T1	
<i>sod sulfase-sulf 9.8-4.8% clsr</i>	T1	ST
<i>sod sulfase-sulfur 9-4.5% wash</i>	T1	ST

T1 – Generics

T2 – Preferred Brands

T3 – Non-Preferred Brands

T4 – Preferred Specialty

T5 – Non-Preferred Specialty

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ST – Step Therapy

AGE – Age Requirement

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List of Prescription Medications

ANTIBIOTICS (Skin Conditions) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
TOPICAL SULFONAMIDES (cont.)		
sod sulfacet-sulfur 9.8-4.8% pad	T1	ST
sod sulfacet-sulfur 10-2% clsr	T1	ST
sod sulfacet-sulfur 10-4% pad (Sumaxin)	T1	
sod sulfacet-sulfur 10-5% clsr	T1	
sod sulfac-sulfur 9.8-4.8% crm, lot	T1	ST
sss 10-5 cream	T1	
sss 10-5 foam	T1	ST
sulfacetamide-sulfur 10-2% crm	T1	ST
sulfacetamide-sulfur 10-5% crm	T1	
sulfacetamide-sulfur 10-5% lot, sus	T1	ST
sulfacetamide-sulfur 8-4% susp	T1	ST
sulfacetamide-sulfur 9-4% clsr	T1	ST
SULFAMYLYON 8.5% CREAM	T2	
SULFAMYLYON POWDER PACKET (<i>mafenide acetate</i>)	T3	
SUMADAN	T3	ST
SUMADAN XLT	T3	ST
SUMAXIN	T3	ST
SUMAXIN (<i>sulfacetamide sodium/sulfur</i>)	T3	ST
SUMAXIN CP	T3	ST
SUMAXIN TS	T3	ST
ANTICOAGULANTS (Blood Thinners/Anti-Clotting)		
CITRATES AS ANTICOAGULANTS		
ACD-A	T2	
ACD SOLUTION A	T2	
ANTICOAGULANT SODIUM CITRATE	T3	
CITRATE PHOSPHATE DEXTROSE	T2	
CRRT TRISODIUM CITRATE	T3	
TRISODIUM CITRATE CRRT	T3	
DIRECT FACTOR XA INHIBITORS		
ELIQUIS	T2	PA
rivaroxaban (Xarelto)	T1	
XARELTO	T2	PA
XARELTO (<i>rivaroxaban</i>)	T2	

T1 – Generics

T2 – Preferred Brands

T3 – Non-Preferred Brands

T4 – Preferred Specialty

T5 – Non-Preferred Specialty

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List of Prescription Medications

ANTICOAGULANTS (Blood Thinners/Anti-Clotting) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
HEPARIN AND RELATED PREPARATIONS		
ARIXTRA (<i>fondaparinux sodium</i>)	T5	SP
enoxaparin sodium (<i>Lovenox</i>)	T1	SP
<i>fondaparinux sodium</i> (<i>Arixtra</i>)	T1	SP
FRAGMIN	T4	SP
<i>heparin 10,000 unit/10 ml vial</i>	T1	
<i>heparin 2,000 unit/2 ml vial</i>	T1	
<i>heparin 30,000 unit/30 ml vial</i>	T1	
<i>heparin 40,000 unit/4 ml vial</i>	T1	
<i>heparin 5,000 unit/ml carpuject</i>	T1	
<i>heparin 50,000 unit/10 ml vial</i>	T1	
<i>heparin 50,000 unit/5 ml vial</i>	T1	
<i>heparin sod 1,000 unit/ml vial</i>	T1	
<i>heparin sod 10,000 unit/ml vial</i>	T1	
<i>heparin sod 20,000 unit/ml vial</i>	T1	
<i>heparin sod 5,000 unit/0.5 ml</i>	T1	
HEPARIN SOD 5,000 UNIT/0.5 ML	T2	
HEPARIN SOD 5,000 UNIT/0.5 ML	T3	
<i>heparin sod 5,000 unit/ml syrg</i>	T1	
HEPARIN SOD 5,000 UNIT/ML SYRG	T3	
<i>heparin sod 5,000 unit/ml vial</i>	T1	

ANTIDOTES (Gastrointestinal/Heartburn)

MU-OPIOID RECEPTOR ANTAGONISTS, PERIPHERALLY-ACTING

MOVANTIK	T2	QL (30 tabs/fill)
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

KLOXXADO	T2	QL (2 units/fill)
<i>naloxone 0.4 mg/ml carpuject</i>	T1	
<i>naloxone 0.4 mg/ml syringe</i>	T1	
<i>naloxone 0.4 mg/ml vial</i>	T1	

T1 – Generics

T2 – Preferred Brands

T3 – Non-Preferred Brands

T4 – Preferred Specialty

T5 – Non-Preferred Specialty

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List of Prescription Medications

ANTIDOTES (Substance Abuse) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
OPIOID ANTAGONISTS (cont.)		
naloxone 2 mg/2 ml syringe	T1	
naloxone 4 mg/10 ml vial	T1	
naloxone hcl 4 mg nasal spray (Narcan)	T1	QL (2 units/fill)
naltrexone hcl	T1	
NARCAN (naloxone hcl)	T3	QL (2 units/30 days)
REXTOVY	T2	QL (2 units/30 days)
ANTIFUNGALS (Eye Conditions)		
OPHTHALMIC ANTIFUNGAL AGENTS		
NATACYN	T2	
ANTIFUNGALS (Feminine Products)		
VAGINAL ANTIFUNGALS		
GYNAZOLE 1	T3	
miconazole nitrate	T1	
terconazole	T1	
ANTIFUNGALS (Infections)		
ANTIFUNGAL AGENTS		
ANCOBON (flucytosine)	T3	PA
clotrimazole	T1	
CRESEMDA	T2	PA
DIFLUCAN 10 MG/ML SUSPENSION (fluconazole)	T3	
DIFLUCAN 100 MG TABLET (fluconazole)	T3	
DIFLUCAN 150 MG TABLET (fluconazole)	T3	QL (2 tabs/episode)
DIFLUCAN 200 MG TABLET (fluconazole)	T3	
DIFLUCAN 40 MG/ML SUSPENSION (fluconazole)	T3	
DIFLUCAN 50 MG TABLET (fluconazole)	T3	
fluconazole 10 mg/ml susp	T1	
fluconazole 40 mg/ml susp (Diflucan)	T1	
fluconazole 100 mg tablet (Diflucan)	T1	
fluconazole 150 mg tablet (Diflucan)	T1	QL (2 tabs/fill)
fluconazole 200 mg tablet	T1	
fluconazole 50 mg tablet (Diflucan)	T1	
flucytosine (Ancobon)	T1	
itraconazole 10 mg/ml solution (Sporanox)	T1	QL (2 bottles/fill)

T1 – Generics

T2 – Preferred Brands

T3 – Non-Preferred Brands

T4 – Preferred Specialty

T5 – Non-Preferred Specialty

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List of Prescription Medications

ANTIFUNGALS (Infections) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ANTIFUNGAL AGENTS (cont.)		
<i>itraconazole 100 mg capsule (Sporanox)</i>	T1	QL (30 caps/fill)
<i>itraconazole 100 mg/10 ml cup (Sporanox)</i>	T1	QL (2 bottles/fill)
<i>ketoconazole 200 mg tablet</i>	T1	
NOXAFL	T2	PA
NOXAFL 300 MG POWDERMIX SUSP	T3	PA
NOXAFL 40 MG/ML SUSPENSION	T2	PA SP
ORAVIG	T3	
POSACONAZOLE 200 MG/5 ML SUSP	T2	PA
<i>posaconazole dr 100 mg tablet (Noxafil)</i>	T1	PA
<i>SPORANOX 10 MG/ML SOLUTION (itraconazole)</i>	T3	QL (2 bottles/fill)
<i>SPORANOX 100 MG CAPSULE (itraconazole)</i>	T3	QL (30 caps/fill)
<i>terbinafine hcl</i>	T1	
<i>VFEND (voriconazole)</i>	T3	PA
VIVJOA	T5	PA QL (18 caps/30 days) SP
<i>voriconazole (Vfend)</i>	T1	PA
ANTIFUNGAL ANTIBIOTICS		
BREXFEMME	T3	ST QL (4 tabs/fill)
<i>griseofulvin ultramicrosize</i>	T1	
<i>griseofulvin, microsize</i>	T1	
<i>nystatin 100,000 unit/ml susp</i>	T1	
<i>nystatin 500,000 unit oral tab</i>	T1	
<i>nystatin 500,000 unit/5 ml cup</i>	T1	
ANTIFUNGALS (Skin Conditions)		
TOPICAL ANTIFUNGAL/ANTI-INFLAMMATORY, STEROID AGENT		
<i>clotrimazole-betamethasone crm</i>	T1	QL (90 gms/28 days)
<i>clotrimazole-betamethasone lot</i>	T1	QL (60 mls/28 days)
TOPICAL ANTIFUNGALS		
<i>ciclodan 0.77% cream (Loprox)</i>	T1	QL (90 gms/28 days)
<i>CICLODAN 0.77% CREAM KIT</i>	T3	
<i>ciclodan 8% solution</i>	T1	
<i>ciclopirox 0.77% cream (Loprox)</i>	T1	QL (90 gms/28 days)
<i>ciclopirox 0.77% gel</i>	T1	QL (100 gms/28 days)
<i>ciclopirox 0.77% topical susp (Loprox)</i>	T1	QL (60 mls/28 days)
<i>ciclopirox 1% shampoo</i>	T1	QL (120 mls/28 days)

T1 – Generics

T2 – Preferred Brands

T3 – Non-Preferred Brands

T4 – Preferred Specialty

T5 – Non-Preferred Specialty

PA – Prior Authorization

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ST – Step Therapy

AGE – Age Requirement

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List of Prescription Medications

ANTIFUNGALS (Skin Conditions) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
TOPICAL ANTIFUNGALS (cont.)		
ciclopirox 8% solution	T1	
econazole nitrate	T1	QL (85 gms/28 days)
EXELDERM 1% CREAM	T3	QL (60 gms/28 days)
EXELDERM 1% SOLUTION	T3	QL (60 mls/28 days)
EXTINA 2% FOAM	T3	ST QL (100 gms/28 days)
JUBLIA	T3	ST
ketoconazole 2% cream	T1	QL (60 gms/28 days)
ketoconazole 2% foam (Extina)	T1	ST QL (100 gms/28 days)
ketodan 2% foam (Extina)	T1	ST QL (100 gms/28 days)
ketodan 2% foam kit	T1	ST
LOPROX 0.77% CREAM (ciclopirox olamine)	T3	QL (90 gms/28 days)
LOPROX 0.77% CREAM KIT	T3	QL (544 gms/30 days)
LOPROX 0.77% SUSPENSION KIT	T3	QL (1 kit/30 days)
LOPROX 0.77% TOPICAL SUSP (ciclopirox olamine)	T3	QL (60 mls/28 days)
naftifine hcl 1% cream	T1	QL (90 gms/28 days)
naftifine hcl 2% cream	T1	QL (60 gms/28 days)
naftifine hcl 2% gel (Naftin)	T1	QL (60 gms/28 days)
NAFTIN	T3	QL (60 gms/28 days)
NAFTIN 1% GEL (naftifine hcl)	T3	QL (90 gms/28 days)
NAFTIN 2% GEL (naftifine hcl)	T3	QL (60 gms/28 days)
nystatin	T1	QL (180 gms/fill)
nystatin 100,000 unit/gm cream	T1	QL (60 gms/28 days)
nystatin 100,000 unit/gm oint	T1	QL (60 gms/28 days)
nystatin/triamcin	T1	QL (60 gms/28 days)
oxiconazole nitrate	T1	QL (60 gms/28 days)
tavaborole	T1	ST
ANTIHISTAMINE AND DECONGESTANT COMBINATION (Allergy/Nasal Sprays)		
1ST GEN ANTIHISTAMINE AND DECONGESTANT COMBINATION		
phenylephrine hcl/prometh hcl	T1	
phenylephrine/chlor-tan	T1	
2ND GEN ANTIHISTAMINE AND DECONGESTANT COMBINATION		
CLARINEX-D 12 HOUR	T3	QL (60 tabs/fill)

T1 – Generics

T2 – Preferred Brands

T3 – Non-Preferred Brands

T4 – Preferred Specialty

T5 – Non-Preferred Specialty

PA – Prior Authorization

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List of Prescription Medications

ANTIHISTAMINES (Allergy/Nasal Sprays)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ANTIHISTAMINES - 1ST GENERATION		
carbinoxamine 4 mg/5 ml liquid	T1	
carbinoxamine maleate 4 mg tab	T1	
carbinoxamine maleate 6 mg tab	T1	ST
ciproheptadine 2 mg/5 ml soln	T1	
ciproheptadine 2 mg/5 ml syrup	T1	
ciproheptadine 4 mg tablet	T1	
CYPROHEPTADINE 4 MG/10 ML SYRP	T3	
dexchlorpheniramine maleate (Ryclora)	T1	
hydroxyzine hcl	T1	
hydroxyzine hcl	T1	
hydroxyzine pamoate	T1	
hydroxyzine pamoate (Vistaril)	T1	
promethazine hcl	T1	
RYCLORA (dexchlorpheniramine maleate)	T3	
RYVENT	T3	ST
VISTARIL (hydroxyzine pamoate)	T3	
ANTIHISTAMINES - 2ND GENERATION		
CLARINEX D 24 HOUR TABLET	T3	
desloratadine	T1	QL (30 tabs/fill) HD
desloratadine (Claritin)	T1	QL (30 tabs/fill) HD
ANTIHISTAMINES (Eye Conditions)		
EYE ANTIHISTAMINES		
azelastine hcl 0.05% drops	T1	
bepotastine besilate (Bepreve)	T1	ST
BEPREVE	T3	
epinastine hcl	T1	
LASTACRAFT 0.25% EYE DROPS	T3	ST
ANTIHYPERGLYCEMICS (Diabetes)		
ANTIHYPERGLY,DPP-4 ENZYME INHIB.-THIAZOLIDINEDIONE		
OSENI	T3	ST QL (30 tabs/fill) HD
ANTIHYPERGLY,INCRETIN MIMETIC(GLP-I RECEPTOR 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)

T1 – Generics

T2 – Preferred Brands

T3 – Non-Preferred Brands

T4 – Preferred Specialty

T5 – Non-Preferred Specialty

PA – Prior Authorization

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List of Prescription Medications

ANTIHYPERGLYCEMICS (Diabetes) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ANTIHYPERGLY, INCRETIN MIMETIC(GLP-1 RECEPT.AGONIST) (cont.)		
BYDUREON BCISE	T2	PA QL (4 auto-injs/28 days)
BYDUREON PEN	T2	PA QL (4 pens/fill) HD
BYETTA	T2	PA QL (1 pen/30 days)
exenatide	T1	PA QL (1 pen/30 days)
liraglutide 2-pak 18 mg/3 ml (Victoza 2-Pak)	T1	PA
liraglutide 2-pak 18 mg/3 ml (Victoza 2-Pak)	T1	PA QL (2 pens/30 days)
liraglutide 2-pak 18 mg/3 ml (Victoza 3-Pak)	T1	PA
liraglutide 2-pak 18 mg/3 ml (Victoza 3-Pak)	T1	PA QL (2 pens/30 days)
liraglutide 3-pak 18 mg/3 ml (Victoza 2-Pak)	T1	PA
liraglutide 3-pak 18 mg/3 ml (Victoza 2-Pak)	T1	PA QL (3 pens/30 days)
liraglutide 3-pak 18 mg/3 ml (Victoza 3-Pak)	T1	PA
liraglutide 3-pak 18 mg/3 ml (Victoza 3-Pak)	T1	PA QL (3 pens/30 days)
OZEMPIC	T2	PA QL (1 pen/28 days) HD
RYBELSUS	T2	PA QL (30 tabs/30 days)
TRULICITY	T2	PA QL (4 pens/28 days)
ANTIHYPERGLY, INSULIN, LONG ACT-GLP-1 RECEPT.AGONIST		
SOLIQUA 100-33	T2	QL (15 mls/30 days)
ANTIHYPERGLYCEMIC - DOPAMINE RECEPTOR AGONISTS		
CYCLOSET	T3	HD
ANTIHYPERGLYCEMIC - INCRETIN MIMETICS COMBINATION		
MOUNJARO	T2	PA QL (4 pens/fill)
ANTIHYPERGLYCEMIC, ALPHA-GLUCOSIDASE INHIBITORS		
acarbose (Precose)	T1	HD
miglitol	T1	HD
PRECOSE (acarbose)	T3	HD
ANTIHYPERGLYCEMIC, AMYLIN ANALOG-TYPE		
SYMLINPEN 120	T2	PA QL (7 pens/fill) HD
SYMLINPEN 60	T2	PA QL (7 pens/30 days)
ANTIHYPERGLYCEMIC, BIGUANIDE TYPE		
metformin er 1,000 mg gastr-tb (Glumetza)	T1	PA QL (60 tabs/fill) HD
metformin er 500 mg gastrc-tb (Glumetza)	T1	PA QL (120 tabs/fill) HD
metformin er 1,000 mg osm-tab	T1	PA QL (60 tabs/30 days) HD
metformin er 500 mg osmotic tb	T1	PA QL (30 tabs/30 days) HD
metformin hcl 750 mg tablet	T1	ST HD

T1 – Generics

T2 – Preferred Brands

T3 – Non-Preferred Brands

T4 – Preferred Specialty

T5 – Non-Preferred Specialty

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List of Prescription Medications

ANTIHYPERGLYCEMICS (Diabetes) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ANTIHYPERGLYCEMIC, BIGUANIDE TYPE (cont.)		
metformin hcl 1,000 mg tablet	T1	HD
metformin hcl 500 mg tablet	T1	HD
metformin hcl 500 mg/5 ml soln (Riomet)	T1	ST HD
metformin hcl 850 mg tablet	T1	HD
metformin hcl er 500 mg tablet	T1	QL (120 tabs/fill) HD
metformin hcl er 750 mg tablet	T1	QL (60 tabs/fill) HD
RIOMET (metformin hcl)	T3	ST HD
ANTIHYPERGLYCEMIC, DPP-4 INHIBITORS		
JANUVIA	T2	ST QL (30 tabs/fill) HD
saxagliptin hcl (Onglyza)	T1	ST QL (30 tabs/30 days) HD
ANTIHYPERGLYCEMIC, INSULIN-RELEASE STIMULANT TYPE		
glimepiride 1 mg tablet	T1	HD
glimepiride 2 mg, 4mg tablet	T1	HD
glipizide	T1	HD
GLUCOTROL XL (glipizide)	T3	HD
glyburide	T1	HD
glyburide,micronized	T1	HD
glyburide,micronized (Glynase)	T1	HD
GLYNASE (glyburide,micronized)	T3	HD
nateglinide	T1	HD
PRANDIN (repaglinide)	T3	HD
repaglinide	T1	HD
repaglinide (Prandin)	T1	HD
ANTIHYPERGLYCEMIC, SGLT-2 AND DPP-4 INHIBITOR COMB		
GLYXAMBI	T2	ST QL (30 tabs/fill) HD
ANTIHYPERGLYCEMIC, THIAZOLIDINEDIONE AND BIGUANIDE		
ACTOPLUS MET (pioglitazone hcl/metformin hcl)	T3	QL (90 tabs/30 days) HD
pioglitazone hcl/metformin hcl	T1	QL (90 tabs/fill) HD
pioglitazone hcl/metformin hcl (Actoplus Met)	T1	QL (90 tabs/fill) HD
ANTIHYPERGLYCEMIC, THIAZOLIDINEDIONE-SULFONYLUREA		
DUETACT (pioglitazone-glimepiride)	T3	QL (30 tabs/30 days) HD
pioglitazone hcl/glimepiride (Duetact)	T1	HD
ANTIHYPERGLYCEMIC, DPP-4 INHIBITOR-BIGUANIDE COMBS.		
JANUMET	T2	ST QL (60 tabs/fill) HD

T1 – Generics

T2 – Preferred Brands

T3 – Non-Preferred Brands

T4 – Preferred Specialty

T5 – Non-Preferred Specialty

PA – Prior Authorization

QL – Quantity Limit

ST – Step Therapy

AGE – Age Requirement

SP – Specialty Medication

HD – May require home delivery pharmacy

PPACA – No Cost-Share Preventive Medication

CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

ANTIHYPERGLYCEMICS (Diabetes) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ANTIHYPERGLYCEMIC, DPP-4 INHIBITOR-BIGUANIDE COMBS. (cont.)		
JANUMET XR 50-500 MG TABLET	T2	ST QL (60 tabs/fill) HD
JANUMET XR 50-1,000 MG TABLET	T2	ST QL (60 tabs/fill) HD
JANUMET XR 100-1,000 MG TABLET	T2	ST QL (30 tabs/fill) HD
saxagliptin-metformin er 5-500 (Kombiglyze Xr)	T1	ST QL (30 tabs/30 days) HD
saxagliptin-metformin er 5-1000 (Kombiglyze Xr)	T1	ST QL (30 tabs/30 days) HD
saxagliptin-metformin er 2.5-1000 (Kombiglyze Xr)	T1	ST QL (60 tabs/30 days) HD
ANTIHYPERGLYCEMIC, INSULIN-RELEASE STIM.-BIGUANIDE		
glipizide/metformin hcl	T1	HD
glyburide/metformin hcl	T1	HD
ANTIHYPERGLYCEMIC, THIAZOLIDINEDIONE (PPARG AGONIST)		
ACTOS (pioglitazone hcl)	T3	QL (30 tabs/30 days) HD
ANTIHYPERGLYCEMIC-GLUCOCORTICOID RECEPTOR BLOCKER		
mifepristone 300 mg tablet (Korlym)	T1	PA SP
ANTIHYPERGLYCEMIC-SGLT2 INHIBITOR-BIGUANIDE COMBS.		
SYNJARDY	T2	ST QL (60 tabs/fill) HD
SYNJARDY XR 10-1,000 MG TABLET	T2	ST QL (30 tabs/fill) HD
SYNJARDY XR 12.5-1,000 MG TAB	T2	ST QL (60 tabs/fill) HD
SYNJARDY XR 25-1,000 MG TABLET	T2	ST QL (30 tabs/fill) HD
SYNJARDY XR 5-1,000 MG TABLET	T2	ST QL (60 tabs/fill) HD
XIGDUO XR 2.5 MG-1,000 MG TAB	T2	ST QL (60 tabs/fill) HD
XIGDUO XR 5 MG-500 MG TABLET	T2	ST QL (30 tabs/fill) HD
XIGDUO XR 5 MG-1,000 MG TABLET	T2	ST QL (60 tabs/fill) HD
XIGDUO XR 10 MG-1,000 MG TAB	T2	ST QL (30 tabs/fill) HD
XIGDUO XR 10 MG-500 MG TABLET	T2	ST QL (30 tabs/fill) HD
ANTIHYPERGLYCEMIC-SOD/GLUC COTRANSORT2(SGLT2) INH		
FARXIGA	T2	ST QL (30 tabs/30 days)
JARDIANCE	T2	ST QL (30 tabs/fill) HD
ANTIHYPERGLYCEMIC-SGLT-2 INHIB, DPP-4 INHIB, BIGUANIDE CB		
TRIJARDY XR	T2	ST HD
INSULINS		
HUMALOG 100 unit/ML CARTRIDGE	T2	HD
HUMALOG JUNIOR KWIKPEN	T2	HD
HUMALOG KWIKPEN U-100	T2	HD
HUMALOG KWIKPEN U-200	T2	HD

T1 – Generics

T2 – Preferred Brands

T3 – Non-Preferred Brands

T4 – Preferred Specialty

T5 – Non-Preferred Specialty

PA – Prior Authorization

QL – Quantity Limit

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SP – Specialty Medication

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PPACA – No Cost-Share Preventive Medication

CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

ANTIHYPERGLYCEMICS (Diabetes) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ANTIHYPERTENSIVE, DPP-4 INHIBITOR-BIGUANIDE COMBS. (cont.)		
HUMALOG MIX 50-50 KWIKPEN	T2	HD
HUMALOG MIX 75-25	T2	HD
HUMALOG MIX 75-25 KWIKPEN	T2	HD
HUMULIN 70/30 KWIKPEN	T2	HD
HUMULIN 70-30	T2	HD
HUMULIN N	T2	HD
HUMULIN N KWIKPEN	T2	HD
HUMULIN R	T2	HD
HUMULIN R U-500	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
LYUMJEV	T2	HD
LYUMJEV KWIKPEN U-100	T2	HD
LYUMJEV KWIKPEN U-200	T2	HD
MYXREDLIN	T3	
SEMGLEE (YFGN)	T2	HD
SEMGLEE (YFGN) PEN	T2	HD
TOUJEO MAX SOLOSTAR	T2	HD
TOUJEO SOLOSTAR	T2	HD
TRESIBA	T2	HD
TRESIBA FLEXTOUCH U-100, U-200	T2	HD
ANTIINFECTIVES (Feminine Products)		
VAGINAL SULFONAMIDES		
AVC	T3	
ANTIINFECTIVES/MISCELLANEOUS (Feminine Products)		
VAGINAL ANTISEPTICS		
acetic acid/oxyquinoline (Relagard)	T1	
RELAGARD (acetic acid/oxyquinoline)	T3	
TRIMO-SAN	T2	

T1 – Generics

T2 – Preferred Brands

T3 – Non-Preferred Brands

T4 – Preferred Specialty

T5 – Non-Preferred Specialty

PA – Prior Authorization

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List of Prescription Medications

ANTIINFECTIVES/MISCELLANEOUS (Infections)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
2ND GEN. ANAEROBIC ANTIPROTOZOAL-ANTIBACTERIAL		
<i>tinidazole 250 mg tablet</i>	T1	QL (40 tabs/30 days)
<i>tinidazole 500 mg tablet</i>	T1	QL (20 tabs/30 days)
AMEBICIDES		
HUMATIN	T3	
ANTHELMINTICS		
<i>albendazole (Albenza)</i>	T1	QL (120 tabs/30 days)
<i>ALBENZA (albendazole)</i>	T3	QL (120 tabs/30 days)
<i>BILTRICIDE (praziquantel)</i>	T3	
EMVERM	T2	QL (6 tabs/30 days)
<i>ivermectin 6 mg tablet</i>	T1	PA QL (8 tabs/30 days)
<i>praziquantel (Biltricide)</i>	T1	
<i>STROMECTOL (ivermectin)</i>	T3	PA QL (14 tabs/30 days)
ANTIMALARIAL DRUGS		
ARAKODA	T3	QL (16 tabs/fill)
<i>atovaquone-proguanil 250-100 (Malarone)</i>	T1	QL (60 tabs/180 days)
<i>atovaquone-proguanil 62.5-25 (Malarone)</i>	T1	QL (180 tabs/180 days)
<i>chloroquine phosphate</i>	T1	
COARTEM	T2	QL (24 tabs/30 days)
DARAPRIM (<i>pyrimethamine</i>)	T5	PA SP
HYDROXYCHLOROQUINE 100 MG TAB	T3	
<i>hydroxychloroquine 200 mg tab (Plaquenil)</i>	T1	
HYDROXYCHLOROQUINE 300 MG TAB	T3	
HYDROXYCHLOROQUINE 400 MG TAB	T3	
KRINTAFEL	T3	QL (2 tabs/30 days)
MALARONE 250-100 MG TABLET (<i>atovaquone/proguanil hcl</i>)	T3	QL (60 tabs/180 days)
MALARONE 62.5-25 MG PED TAB (<i>atovaquone/proguanil hcl</i>)	T3	QL (180 tabs/180 days)
<i>mefloquine hcl</i>	T1	QL (13 tabs/180 days)
PRIMAQUINE 26.3 MG TABLET	T2	QL (120 tabs/180 days)
<i>primaquine 26.3 mg tablet</i>	T1	QL (120 tabs/180 days)
<i>pyrimethamine 25 mg tablet (Daraprim)</i>	T1	PA
<i>pyrimethamine 25 mg tablet (Daraprim)</i>	T1	PA SP
<i>quinine sulfate</i>	T1	QL (42 caps/30 days)
ANTIPROTOZOAL DRUGS, MISCELLANEOUS		
<i>atovaquone (Mepron)</i>	T1	

T1 – Generics

T2 – Preferred Brands

T3 – Non-Preferred Brands

T4 – Preferred Specialty

T5 – Non-Preferred Specialty

PA – Prior Authorization

QL – Quantity Limit

ST – Step Therapy

AGE – Age Requirement

SP – Specialty Medication

HD – May require home delivery pharmacy

PPACA – No Cost-Share Preventive Medication

CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

ANTIINFECTIVES/MISCELLANEOUS (Infections) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ANTIPROTOZOAL DRUGS, MISCELLANEOUS (cont.)		
BENZNIDAZOLE	T2	QL (360 tabs/fill)
IMPAVIDO	T2	PA QL (84 caps/30 days)
MEPRON (<i>atovaquone</i>)	T3	
NEBUPENT (<i>pentamidine isethionate</i>)	T3	QL (1 vfl/28 days)
<i>pentamidine isethionate</i> (Nebupent)	T1	QL (1 vfl/28 days)
ANTIINFECTIVES/MISCELLANEOUS (Miscellaneous)		
ANTIBACTERIAL AGENTS,MISCELLANEOUS		
glycine urologic solution	T1	
ANTISEPTICS,GENERAL		
ALCOHOL SWABSTICK	T3	
CVS ISOPROPYL ALCOHOL 91% SPRY	T3	
GS ISOPROPYL ALCOHOL 70% SPRAY	T3	
ISOPROPYL ALCOHOL 70% SPRAY	T3	
MEDI-FIRST ISOPROPYL ALCOHOL	T3	
TOPICAL ANTISEPTIC DRYING AGENTS		
formaldehyde	T1	
ANTIINFECTIVES/MISCELLANEOUS (Skin Conditions)		
TOPICAL ANTIFUNGALS		
CICLODAN 8% KIT	T3	ST
ciclopirox 8% treatment kit	T1	
ANTIINFLAM.TUMOR NECROSIS FACTOR INHIBITING AGENTS (Pain Relief and Inflammatory Disease)		
ANTI-INFLAMMATORY TUMOR NECROSIS FACTOR INHIBITOR		
ADALIMUMAB-ADAZ (CF)	T4	PA QL (2 syringes/28 days) SP HD
ADALIMUMAB-ADAZ(CF) PEN	T4	PA QL (2 pens/28 days) SP HD
ADALIMUMAB-ADBM(CF)PEN	T4	PA QL (2 kits/28 days) SP HD
ADALIMUMAB-RYVK(CF)	T4	PA QL (2 srnge kits/28 days) SP HD
ADALIMUMAB-RYVK(CF) AUTOINJECT	T4	PA QL (2 auto-injs/28 days) SP HD
CYLTEZO(CF)	T4	PA QL (2 srnge kits/28 days) SP HD
CYLTEZO(CF) PEN	T4	PA QL (2 kits/28 days) SP HD
CYLTEZO(CF) PEN CROHN'S-UC-HS	T4	PA QL (6 pens/365 days) SP HD
CYLTEZO(CF) PEN PSORIASIS-UV	T4	PA QL (4 pens/365 days) SP HD
ENBREL 25 MG KIT	T4	PA QL (8 vls/28 days) SP HD
ENBREL MINI	T4	PA QL SP HD

T1 – Generics

T2 – Preferred Brands

T3 – Non-Preferred Brands

T4 – Preferred Specialty

T5 – Non-Preferred Specialty

PA – Prior Authorization

QL – Quantity Limit

ST – Step Therapy

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List of Prescription Medications

ANTIINFLAM.TUMOR NECROSIS FACTOR INHIBITING AGENTS (Pain Relief and Inflammatory Disease) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ANTI-INFLAMMATORY TUMOR NECROSIS FACTOR INHIBITOR (cont.)		
ENBREL SURECLICK	T4	PA QL SP HD
ENBREL 25 MG/0.5 ML SYRINGE	T4	PA QL (8 syringes/28 days) SP HD
ENBREL 25 MG/0.5 ML VIAL	T4	PA QL (8 vials/28 days) SP HD
ENBREL 50 MG/ML SYRINGE	T4	PA QL SP HD
SIMLANDI(CF)	T4	PA QL (2 srnge kits/28 days) SP HD
SIMLANDI(CF) AUTOINJECTOR	T4	PA QL (2 auto-injs/28 days) SP HD
SIMPONI 100 MG/ML PEN INJECTOR	T4	PA QL (1 pen/30 days) SP HD
SIMPONI 100 MG/ML SYRINGE	T4	PA QL (1 syringe/30 days) SP HD
SIMPONI ARIA	T5	PA SP HD
ANTINEOPLASTICS (Cancer)		
ANP - SELECTIVE RETINOID X RECEPTOR AGONISTS (RXR)		
bexarotene (Targretin)	T1	PA SP HD CSL
ANTINEOPLAST, HISTONE DEACETYLASE (HDAC) INHIBITORS		
FARYDAK	T3	PA QL (6 caps/fill) CSL
ZOLINZA	T4	PA QL (120 caps/fill) SP HD CSL
ANTINEOPLASTIC - ALKYLATING AGENTS		
ALKERAN (<i>melphalan</i>)	T5	SP CSL
cyclophosphamide 25 mg capsule	T1	SP HD CSL
cyclophosphamide 50 mg capsule	T1	SP HD CSL
CYCLOPHOSPHAMIDE 50 MG TABLET	T5	SP HD CSL
GLEOSTINE	T2	CSL
HYDREA (<i>hydroxyurea</i>)	T3	CSL
hydroxyurea (Hydrea)	T1	CSL
LEUKERAN	T2	CSL
MYLERAN	T2	CSL
temozolomide	T1	PA SP HD CSL
ANTINEOPLASTIC - ANTIANDROGENIC AGENTS		
abiraterone acetate (Zytiga)	T1	PA QL (120 tabs/30 days) CSL
abiraterone acetate 250 mg tab (Zytiga)	T1	PA QL (120 tabs/fill) SP HD CSL
abiraterone acetate 500 mg tab (Zytiga)	T1	PA QL (60 tabs/fill) SP HD CSL
bicalutermезаamide (Casodex)	T1	CSL
CASODEX (bicalutamide)	T3	CSL
ERLEADA 240 MG TABLET	T4	PA SP HD QL (30 tabs/30 days) CSL
EULEXIN (<i>flutamide</i>)	T3	CSL

T1 – Generics

T2 – Preferred Brands

T3 – Non-Preferred Brands

T4 – Preferred Specialty

T5 – Non-Preferred Specialty

PA – Prior Authorization

QL – Quantity Limit

ST – Step Therapy

AGE – Age Requirement

SP – Specialty Medication

HD – May require home delivery pharmacy

PPACA – No Cost-Share Preventive Medication

CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

ANTINEOPLASTICS (Cancer) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ANTINEOPLASTIC - ANTIANDROGENIC AGENTS (cont.)		
flutamide (Eulexin)	T1	CSL
NILANDRON (<i>nilutamide</i>)	T3	PA CSL
<i>nilutamide</i> (Nilandron)	T1	PA CSL
NUBEQA	T4	PA QL (120 tabs/fill) SP HD CSL
XTANDI 40 MG CAPSULE	T4	PA QL (120 tabs/caps/fill) SP HD CSL
XTANDI 40 MG TABLET	T4	PA QL (120 tabs/caps/fill) SP HD CSL
XTANDI 80 MG TABLET	T4	PA QL (60 tabs/fill) SP HD CSL
YONSA	T4	PA QL (120 tabs/30 days) SP HD CSL
ANTINEOPLASTIC - ANTIMETABOLITES		
LONSURF	T4	PA SP HD CSL
<i>mercaptopurine</i> 20 mg/ml suspen (Purixan)	T1	SP CSL
<i>mercaptopurine</i> 50 mg tablet	T1	CSL
methotrexate 2.5 mg tablet	T1	CSL
methotrexate 250 mg/10 ml vial	T1	
methotrexate 50 mg/2 ml vial	T1	
methotrexate sodium/pf	T1	
PURIXAN (<i>mercaptopurine</i>)	T4	SP CSL
TABLOID	T3	CSL
TREXALL	T3	CSL
XELODA 150 MG TABLET (<i>capecitabine</i>)	T5	PA QL (56 tabs/30days) SP HD CSL
XELODA 500 MG TABLET (<i>capecitabine</i>)	T5	PA QL (140 tabs/30days) SP HD CSL
ANTINEOPLASTIC - AROMATASE INHIBITORS		
anastrozole (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
ANTINEOPLASTIC - BRAF KINASE INHIBITORS		
BRAFTOVI	T4	PA QL (180 caps/30 days) SP HD CSL
OJEMDA	T4	PA SP CSL
TAFINLAR	T4	PA QL (120 caps/fill) SP HD CSL
ZELBORAF	T4	PA QL (240 tabs/fill) SP HD CSL
ANTINEOPLASTIC - HEDGEHOG PATHWAY INHIBITOR		
DAURISMO 100 MG TABLET	T5	PA QL (30 tabs/fill) SP HD CSL

T1 – Generics

T2 – Preferred Brands

T3 – Non-Preferred Brands

T4 – Preferred Specialty

T5 – Non-Preferred Specialty

PA – Prior Authorization

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ST – Step Therapy

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List of Prescription Medications

ANTINEOPLASTICS (Cancer) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ANTINEOPLASTIC - HEDGEHOG PATHWAY INHIBITOR (cont.)		
DAURISMO 25 MG TABLET	T5	PA QL (60 tabs/fill) SP HD CSL
ERIVEDGE	T4	PA QL (30 caps/fill) SP HD CSL
ODOMZO	T4	PA QL (30 caps/fill) SP HD CSL
ANTINEOPLASTIC - JANUS KINASE (JAK) INHIBITORS		
JAKAFI	T4	PA QL (60 tabs/fill) SP HD CSL
ANTINEOPLASTIC - KRAS PROTEIN INHIBITOR		
LUMAKRAS	T5	PA SP HD CSL
ANTINEOPLASTIC - MEK KINASE INHIBITORS		
COTELLIC	T4	PA QL (63 tabs/30 days) SP HD CSL
GOMEKLI	T4	PA SP CSL
KOSELUGO	T5	PA SP CSL
MEKINIST 0.05 MG/ML SOLUTION	T4	PA QL (1080 mls/30 days) SP HD CSL
MEKINIST 0.5 MG TABLET	T4	PA QL (90 tabs/30 days) SP HD CSL
MEKINIST 2 MG TABLET	T4	PA QL (30 tabs/30 days) SP HD CSL
MEKTOVI	T4	PA QL (180 tabs/30 days) SP HD CSL
TAFINLAR 10 MG TABLET FOR SUSP	T4	SP PA HD QL (840ml/30 days) CSL
ANTINEOPLASTIC - MTOR KINASE INHIBITORS		
everolimus (Afinitor)	T1	PA QL (30 tabs/30 days) SP CSL
everolimus 2 mg tab for susp (Afinitor Disperz)	T1	PA QL (30 tabs/fill) SP CSL
everolimus 3 mg tab for susp (Afinitor Disperz)	T1	PA QL (30 tabs/fill) SP CSL
everolimus 5 mg tab for susp (Afinitor Disperz)	T1	PA QL (30 tabs/fill) SP CSL
ANTINEOPLASTIC - PROTEIN METHYLTRANSFERASE INHIBIT		
TAZVERIK	T5	PA SP CSL
ANTINEOPLASTIC - TOPOISOMERASE I INHIBITORS		
HYCAMTIN	T4	PA SP HD CSL
ANTINEOPLASTIC COMB - KINASE AND AROMATASE INHIBIT		
KISQALI FEMARA 200 MG CO-PACK	T4	PA QL (49 tabs/30 days) SP CSL
KISQALI FEMARA 400 MG CO-PACK	T4	PA QL (70 tabs/30 days) SP CSL
KISQALI FEMARA 600 MG CO-PACK	T4	PA QL (91 tabs/30 days) SP CSL
ANTINEOPLASTIC IMMUNOMODULATOR AGENTS		
lenalidomide	T1	PA QL (30 caps/fill) SP HD CSL
POMALYST	T4	PA SP HD CSL
REVLIMID	T4	PA QL (30 caps/fill) SP HD CSL

T1 – Generics

T2 – Preferred Brands

T3 – Non-Preferred Brands

T4 – Preferred Specialty

T5 – Non-Preferred Specialty

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List of Prescription Medications

ANTINEOPLASTICS (Cancer) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ANTINEOPLASTIC LHRH(GNRH) ANTAGONIST,PITUIT.SUPPRS		
ORGOVYX	T5	PA QL (30 tabs/fill) SP CSL
ANTINEOPLASTIC SYSTEMIC ENZYME INHIBITORS		
ALECensa	T4	PA QL (240 caps/fill) SP HD CSL
ALUNBRIG 30 MG TABLET	T4	PA QL (60 tabs/fill) SP CSL
ALUNBRIG 90 MG, 180 MG TABLET	T4	PA QL (30 tabs/fill) SP CSL
ALUNBRIG 90 MG-180 MG TAB PACK	T4	PA QL (30 tabs/fill) SP CSL
AUGTYRO	T5	PA SP HD CSL
AYVAKIT	T5	PA QL (30 tabs/fill) SP CSL
BALVERSA	T4	PA SP CSL
BOSULIF 50 MG CAPSULE	T4	PA QL (30 caps/fill) SP HD CSL
BOSULIF 100 MG CAPSULE	T4	PA QL (90 tabs/fill) SP HD CSL
BOSULIF 100 MG TABLET	T4	PA QL (90 tabs/fill) SP HD CSL
BOSULIF 400 MG, 500 MG TABLET	T4	PA QL (30 tabs/fill) SP HD CSL
BRUKINSA	T4	PA SP CSL
CALQUENCE	T4	PA QL (60 tabs/caps/fill) SP CSL
CAPRELSA 100 MG TABLET	T4	PA QL (60 tabs/fill) SP CSL
CAPRELSA 300 MG TABLET	T4	PA QL (30 tabs/fill) SP CSL
COMETRIQ 100 MG DAILY-DOSE PK	T4	PA QL (56 caps/fill) SP HD CSL
COMETRIQ 140 MG DAILY-DOSE PK	T4	PA QL (112 caps/fill) SP HD CSL
COMETRIQ 60 MG DAILY-DOSE PACK	T4	PA QL (84 caps/fill) SP HD CSL
COPIKTRA	T5	PA QL (56 caps/fill) SP CSL
DANZITEN	T4	PA SP 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
<i>dasatinib 140 mg tablet (Sprycel)</i>	T1	PA QL (30 tabs/30 days) SP CSL
<i>dasatinib 140 mg tablet (Sprycel)</i>	T1	PA QL (30 tabs/30 days) SP HD 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

T1 – Generics

T2 – Preferred Brands

T3 – Non-Preferred Brands

T4 – Preferred Specialty

T5 – Non-Preferred Specialty

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List of Prescription Medications

ANTINEOPLASTICS (Cancer) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ANTINEOPLASTIC SYSTEMIC ENZYME INHIBITORS (cont.)		
erlotinib hcl 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	T4	PA SP CSL
GAVRETO	T4	PA QL (120 caps/30 days) SP CSL
GILOTrif	T4	PA QL (30 tabs/fill) SP HD CSL
IBRANCE	T4	PA QL (21 tabs/caps/30 days) SP HD CSL
ICLUSIG	T4	PA QL (30 tabs/fill) SP CSL
IWLFIN	T4	PA SP CSL
IMBRUVICA 70 MG CAPSULE	T4	PA QL (30 caps/fill) SP CSL
IMBRUVICA 140 MG CAPSULE	T4	PA QL (120 caps/fill) SP CSL
IMBRUVICA 70 MG/ML SUSPENSION	T4	PA QL (3 bottles/fill) SP CSL
IMBRUVICA 140 MG TABLET	T4	PA QL (30 tabs/fill) SP CSL
IMBRUVICA 280 MG TABLET	T4	PA QL (30 tabs/fill) SP CSL
IMBRUVICA 420 MG TABLET	T4	PA QL (30 tabs/fill) SP CSL
IMKELDI	T4	PA SP CSL
INLYTA 1 MG TABLET	T4	PA QL (180 tabs/fill) SP HD CSL
INLYTA 5 MG TABLET	T4	PA QL (120 tabs/fill) SP HD CSL
IRESSA (<i>gefitinib</i>)	T5	PA QL (30 tabs/30 days) SP HD CSL
KISQALI	T5	PA QL (1 pack/1 time) CSL
KISQALI FEMARA CO-PACK	T5	PA QL (1 PACK/28 DAYS) CSL
LAZCLUZE	T5	PA SP CSL
<i>lapatinib ditosylate</i> (Tykerb)	T1	PA QL (180 tabs/fill) SP HD CSL
LENVIMA 10 MG DAILY DOSE	T4	PA QL (30 caps/fill) SP HD CSL
LENVIMA 12 MG DAILY DOSE	T4	PA QL (90 caps/fill) SP HD CSL
LENVIMA 14 MG DAILY DOSE	T4	PA QL (60 caps/fill) SP HD CSL
LENVIMA 18 MG DAILY DOSE	T4	PA QL (90 caps/fill) SP HD CSL
LENVIMA 20 MG DAILY DOSE	T4	PA QL (60 caps/fill) SP HD CSL
LENVIMA 24 MG DAILY DOSE	T4	PA QL (90 caps/fill) SP HD CSL
LENVIMA 4 MG CAPSULE	T4	PA QL (30 caps/fill) SP HD CSL
LENVIMA 8 MG DAILY DOSE	T4	PA QL (60 caps/fill) SP HD CSL
LORBRENA 100 MG TABLET	T4	PA QL (30 tabs/fill) SP HD CSL
LORBRENA 25 MG TABLET	T4	PA QL (90 tabs/fill) SP HD CSL
LYNPARZA	T4	PA QL (120 tabs/fill) SP HD CSL

T1 – Generics

T2 – Preferred Brands

T3 – Non-Preferred Brands

T4 – Preferred Specialty

T5 – Non-Preferred Specialty

PA – Prior Authorization

QL – Quantity Limit

ST – Step Therapy

AGE – Age Requirement

SP – Specialty Medication

HD – May require home delivery pharmacy

PPACA – No Cost-Share Preventive Medication

CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

ANTINEOPLASTICS (Cancer) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ANTINEOPLASTIC SYSTEMIC ENZYME INHIBITORS (cont.)		
LYTGOBI	T4	PA SP CSL
NERLYNX	T4	PA SP HD CSL
NEXAVAR (<i>sorafenib tosylate</i>)	T5	PA QL (120 tabs/fill) SP HD CSL
<i>nilotinib</i> 150 mg capsule (Tasigna)	T1	PA QL (112 caps/30 days) SP HD CSL
<i>nilotinib</i> 200 mg capsule (Tasigna)	T1	PA QL (112 caps/30 days) SP HD CSL
<i>nilotinib</i> 50 mg capsule (Tasigna)	T1	PA QL (120 caps/30 days) SP HD CSL
NINLARO	T4	PA QL (3 caps/fill) SP HD CSL
OGSIVEO	T5	PA SP CSL
<i>pazopanib hcl</i> (Votrient)	T1	PA QL (120 tabs/30 days) SP HD CSL
PEMAZYRE	T4	PA QL (28 tabs/30 days) SP CSL
PIQRAY	T4	PA SP CSL
RETEVMO 40 MG CAPSULE	T5	PA QL (90 tabs/fill) SP HD CSL
RETEVMO 80 MG CAPSULE	T5	PA QL (60 tabs/fill) SP HD CSL
RETEVMO 120 MG TABLET	T5	PA QL (60 tabs/fill) SP HD CSL
RETEVMO 160 MG TABLET	T5	PA QL (60 tabs/fill) SP HD CSL
REVUFORJ	T4	PA SP CSL
ROMVIMZA	T5	PA QL (8 caps/fill) SP CSL
ROZLYTREK 100 MG CAPSULE	T4	PA QL (30 caps/fill) SP HD CSL
ROZLYTREK 200 MG CAPSULE	T4	PA QL (90 caps/fill) SP HD CSL
ROZLYTREK 50 MG PELLET PACKET	T4	PA QL (42 packs/fill) SP HD CSL
RYDAPT	T4	PA QL (224 caps/fill) SP HD CSL
SCEMBLIX 20 MG TABLET	T4	PA QL (600 tabs/30 days) SP CSL
SCEMBLIX 40 MG TABLET	T4	PA QL (300 tabs/30 days) SP CSL
SCEMBLIX 100 MG TABLET	T4	PA QL (120 tabs/fill) SP CSL
<i>sorafenib tosylate</i> (Nexavar)	T1	PA QL (120 tabs/fill) SP HD CSL
STIVARGA	T4	PA QL (84 tabs/fill) SP HD CSL
<i>sunitinib malate</i> 12.5 mg cap (Sutent)	T1	PA QL (90 caps/fill) SP HD CSL
<i>sunitinib malate</i> 25 mg capsule (Sutent)	T1	PA QL (30 caps/fill) SP HD CSL
<i>sunitinib malate</i> 37.5 mg cap (Sutent)	T1	PA QL (30 caps/fill) SP HD CSL
<i>sunitinib malate</i> 50 mg capsule (Sutent)	T1	PA QL (30 caps/fill) SP HD CSL
SUTENT 12.5 MG CAPSULE (<i>sunitinib malate</i>)	T5	PA QL (90 caps/fill) SP HD CSL
SUTENT 25 MG CAPSULE (<i>sunitinib malate</i>)	T5	PA QL (30 caps/fill) SP HD CSL
SUTENT 37.5 MG CAPSULE (<i>sunitinib malate</i>)	T5	PA QL (30 caps/fill) SP HD CSL
SUTENT 50 MG CAPSULE (<i>sunitinib malate</i>)	T5	PA QL (30 caps/fill) SP HD CSL

T1 – Generics

T2 – Preferred Brands

T3 – Non-Preferred Brands

T4 – Preferred Specialty

T5 – Non-Preferred Specialty

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List of Prescription Medications

ANTINEOPLASTICS (Cancer) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ANTINEOPLASTIC SYSTEMIC ENZYME INHIBITORS (cont.)		
TABRECTA	T4	PA SP HD CSL
TAGRISSO	T4	PA QL (30 tabs/fill) SP HD CSL
TALZENNA 0.1 MG CAPSULE	T4	PA QL (30 caps/fill) SP CSL
TALZENNA 0.1 MG SOFTGEL	T4	PA QL (30 caps/fill) SP CSL
TALZENNA 0.25 MG CAPSULE	T4	PA QL (30 caps/30 days) SP CSL
TALZENNA 0.25 MG SOFTGEL	T4	PA QL (30 caps/30 days) SP CSL
TALZENNA 0.35 MG CAPSULE	T4	PA QL (30 caps/fill) SP CSL
TALZENNA 0.35 MG SOFTGEL	T4	PA QL (30 caps/fill) SP CSL
TALZENNA 0.5 MG CAPSULE	T4	PA QL (30 caps/30 days) SP CSL
TALZENNA 0.5 MG SOFTGEL	T4	PA QL (30 caps/30 days) SP CSL
TALZENNA 0.75 MG CAPSULE	T4	PA QL (30 caps/30 days) SP CSL
TALZENNA 0.75 MG SOFTGEL	T4	PA QL (30 caps/30 days) SP CSL
TALZENNA 1 MG CAPSULE	T4	PA QL (30 caps/30 days) SP CSL
TALZENNA 1 MG SOFTGEL	T4	PA QL (30 caps/30 days) SP CSL
TASIGNA 150 MG CAPSULE (<i>nilotinib hcl</i>)	T4	PA QL (112 caps/30 days) SP HD CSL
TASIGNA 200 MG CAPSULE (<i>nilotinib hcl</i>)	T4	PA QL (112 caps/30 days) SP HD CSL
TASIGNA 50 MG CAPSULE (<i>nilotinib hcl</i>)	T4	PA QL (120 caps/30 days) SP HD CSL
TRUQAP	T4	PA SP CSL
TUKYSA 50 MG TABLET	T5	PA QL (300 tabs/fill) SP CSL
TUKYSA 150 MG TABLET	T5	PA QL (120 tabs/fill) SP CSL
TURALIO	T5	PA QL (120 caps/fill) SP CSL
VERZENIO	T4	PA QL (60 tabs/fill) SP HD CSL
VITRAKVI 100 MG CAPSULE	T4	PA QL (60 caps/fill) SP HD CSL
VITRAKVI 20 MG/ML SOLUTION	T4	PA QL (300 mls/fill) SP HD CSL
VITRAKVI 25 MG CAPSULE	T4	PA QL (180 caps/fill) SP HD CSL
VIZIMPRO	T4	PA QL (30 tabs/fill) SP HD CSL
VONJO	T4	PA QL (120 caps/fill) SP CSL
VOTRIENT (<i>pazopanib hcl</i>)	T5	PA QL (120 tabs/30 days) SP HD CSL
XALKORI 200MG, 250 MG CAPSULE	T4	PA QL (60 caps/30 days) SP HD CSL
XALKORI 20MG PELLET	T4	PA QL (120 caps/fill) SP HD CSL
XALKORI 50MG PELLET	T4	PA QL (120 caps/fill) SP HD CSL
XALKORI 150MG PELLET	T4	PA QL (120 caps/fill) SP HD CSL
XOSPATA	T4	PA QL (90 tabs/fill) SP CSL

T1 – Generics

T2 – Preferred Brands

T3 – Non-Preferred Brands

T4 – Preferred Specialty

T5 – Non-Preferred Specialty

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List of Prescription Medications

ANTINEOPLASTICS (Cancer) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ANTINEOPLASTIC SYSTEMIC ENZYME INHIBITORS (cont.)		
ZYDELIG	T4	PA QL (60 tabs/fill) SP HD CSL
ZYKADIA	T4	PA QL (90 tabs/caps/fill) SP HD CSL
ANTINEOPLASTIC-B CELL LYMPHOMA-2(BCL-2) INHIBITORS		
VENCLEXTA 10 MG TAB (10MG X 2)	T4	PA QL (56 tabs/fill) SP CSL
VENCLEXTA 10 MG TABLET	T4	PA QL (56 tabs/fill) SP CSL
VENCLEXTA 100 MG TABLET	T4	PA QL (180 tabs/fill) SP CSL
VENCLEXTA 50 MG TABLET	T4	PA QL (28 tabs/fill) SP CSL
VENCLEXTA STARTING PACK	T4	PA QL (42 tabs/fill) SP CSL
ANTINEOPLASTIC-HYPOXIA INDUCIBLE FACTOR (HIF) INH		
WELIREG	T5	PA SP CSL
ANTINEOPLASTIC-ISOCITRATE DEHYDROGENASE INHIBITORS		
IDHIFA	T4	PA QL (30 tabs/fill) SP HD CSL
TIBSOVO	T4	PA SP CSL
VORANIGO	T5	PA SP CSL
ANTINEOPLASTICS, MISCELLANEOUS		
<i>etoposide</i>	T1	SP HD CSL
LYSODREN	T2	CSL
MATULANE	T4	SP CSL
<i>tretinoin 10 mg capsule</i>	T1	CSL
IMMUNOMODULATORS		
ACTIMMUNE	T4	PA SP HD
SELECTIVE ESTROGEN RECEPTOR MODULATORS (SERMS)		
FARESTON (<i>toremifene citrate</i>)	T3	HD CSL
SOLTAMOX	T3	HD PPACA CSL
<i>tamoxifen citrate</i>	T1	HD PPACA CSL
<i>toremifene citrate</i> (Fareston)	T1	HD CSL
STEROID ANTOINEPLASTICS		
<i>megestrol 20 mg tablet</i>	T1	CSL
<i>megestrol 40 mg tablet</i>	T1	CSL
ANTINEOPLASTICS (Skin Conditions)		
PHOTOACT, TOPICAL ANTOINEPLAST, PREMALIGNANT LESIONS		
LEVULAN	T5	SP
TOPICAL ANTOINEPLASTIC PREMALIGNANT LESION AGENTS		
<i>bexarotene 1% gel</i> (<i>Targretin</i>)	T1	PA SP HD

T1 – Generics

T2 – Preferred Brands

T3 – Non-Preferred Brands

T4 – Preferred Specialty

T5 – Non-Preferred Specialty

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ST – Step Therapy

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List of Prescription Medications

ANTINEOPLASTICS (Skin Conditions) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
TOPICAL ANTINEOPLASTIC PREMALIGNANT LESION AGENTS (cont.)		
diclofenac sodium 3% gel	T1	PA QL (100 gms/28 days)
EFUDEX (fluorouracil)	T3	
FLUOROPLEX	T3	
fluorouracil 2% topical soln	T1	
fluorouracil 5% cream (Efudex)	T1	
fluorouracil 5% topical soln	T1	
PANRETIN	T5	PA SP HD
TARGRETIN 1% GEL (bexarotene)	T5	PA SP HD
VALCHLOR	T4	PA SP HD
ANTI-OBESITY DRUGS (Weight Management)		
ANTI-OBESITY - ANOREXIC AGENTS		
ADIPEX-P (phentermine hcl)	T3	PA QL (30 tabs/30 days)
benzphetamine hcl	T1	PA QL (90 tabs/fill)
diethylpropion hcl	T1	PA QL (90 tabs/fill)
diethylpropion hcl	T1	PA QL (30 tabs/fill)
LOMAIRA	T3	PA QL (90 tabs/fill)
phendimetrazine tartrate	T1	PA QL (30 caps/fill)
phendimetrazine tartrate	T1	PA QL (180 tabs/fill)
phentermine 15 mg, 30 mg capsule	T1	PA QL (30 caps/fill)
phentermine 37.5 mg capsule	T1	PA QL (30 caps/30 days)
phentermine 37.5 mg tablet (Adipex-P)	T1	PA QL (30 tabs/fill)
phentermine/topiramate (Qsymia)	T1	PA QL (30 caps/30 days)
QSYMIA (phentermine/topiramate)	T3	PA QL (30 caps/30 days)
ANTI-OBESITY - INCRETIN MIMETICS COMBINATION		
ZEPBOUND	T2	PA QL (2 mls/28 days)
ANTI-OBESITY - MELANOCORTIN 4 RECEPTOR AGONISTS		
IMCIVREE	T5	PA QL (6 mls/30 days) SP
ANTI-OBESITY GLUCAGON-LIKE PEPTIDE-1 RECEPTOR AGONIST		
SAXENDA	T3	PA QL (5 pens/30 days)
WEGOVY 0.25 MG/0.5 ML PEN	T2	PA QL (8 pens/year)
WEGOVY 0.5 MG/0.5 ML PEN	T2	PA QL (8 pens/year)
WEGOVY 1 MG/0.5 ML PEN	T2	PA QL (8 pens/year)
WEGOVY 1.7 MG/0.75 ML PEN	T2	PA QL (8 pens/year)
WEGOVY 2.4 MG/0.75 ML PEN	T2	PA QL (4 pens/28 days)

T1 – Generics

T2 – Preferred Brands

T3 – Non-Preferred Brands

T4 – Preferred Specialty

T5 – Non-Preferred Specialty

PA – Prior Authorization

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ST – Step Therapy

AGE – Age Requirement

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List of Prescription Medications

ANTI-OBESITY DRUGS (Weight Management) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ANTI-OBESITY SEROTONIN 2C RECEPTOR AGONISTS		
BELVIQ	T3	PA
BELVIQ XR	T3	PA
ANTI-OBESITY-OPIOID ANTAG-NOREPI, DOPAMINE RU INHIB		
CONTRAVE	T3	PA QL (120 tabs/fill)
FAT ABSORPTION DECREASING AGENTS		
ORLISTAT	T3	PA QL (90 caps/fill)
XENICAL	T3	PA QL (90 caps/fill)
ANTIPARASITICS (Eye Conditions)		
OPHTHALMIC (EYE) ANTIPARASITICS		
XDEMVY	T4	QL (10 mgs/30 days) SP
ANTIPARASITICS (Infections)		
ANTIPARASITICS		
ALINIA 100 MG/5 ML SUSPENSION	T2	QL (180 mls/30 days)
TOPICAL ANTIPARASITICS		
crotamiton	T1	
ELIMITE (<i>permethrin</i>)	T3	
EURAX	T3	
<i>permethrin</i> (Elimite)	T1	
spinosad (Natroba)	T1	
ULESFIA	T3	
ANTIPARKINSON DRUGS (Parkinson's Disease)		
ANTIPARKINSONISM DRUGS, ANTICHOLINERGIC		
benztropine mesylate	T1	HD
trihexyphenidyl hcl	T1	HD
ANTIPARKINSONISM DRUGS, OTHER		
amantadine hcl	T1	HD
apomorphine hcl	T1	PA QL (30 mls/30 days) SP
AZILECT (<i>rasagiline mesylate</i>)	T3	ST HD
bromocriptine mesylate	T1	HD
carbidopa/levodopa	T1	HD
carbidopa/levodopa (Sinemet)	T1	HD
carbidopa/levodopa/entacapone	T1	HD
carbidopa/levodopa/entacapone (Stalevo 100)	T1	HD

T1 – Generics

T2 – Preferred Brands

T3 – Non-Preferred Brands

T4 – Preferred Specialty

T5 – Non-Preferred Specialty

PA – Prior Authorization

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ST – Step Therapy

AGE – Age Requirement

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List of Prescription Medications

ANTIPARKINSON DRUGS (Parkinson's Disease) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ANTIPARKINSONISM DRUGS, OTHER (cont.)		
<i>carbidopa/levodopa/entacapone</i>	T1	HD
<i>carbidopa/levodopa/entacapone (Stalevo 75)</i>	T1	HD
CREXONT	T3	ST HD
DUOPA	T5	PA SP HD
<i>entacapone</i>	T1	HD
INBRIJA	T4	PA QL (300 caps/fill) SP HD
KYNMOBI	T2	PA QL (150 films/30 days) HD
NEUPRO	T3	HD
NOURIANZ	T5	PA QL (30 tabs/fill) SP HD
ONGENTYS	T3	PA QL (30 caps/30 days) HD
<i>pramipexole di-hcl</i>	T1	HD
<i>rasagiline mesylate (Azilect)</i>	T1	HD
<i>ropinirole hcl</i>	T1	HD
RYTARY	T3	ST HD
<i>selegiline hcl</i>	T1	HD
SINEMET (<i>carbidopa/levodopa</i>)	T3	HD
STALEVO 75 (<i>carbidopa/levodopa/entacapone</i>)	T3	HD
STALEVO 100 (<i>carbidopa/levodopa/entacapone</i>)	T3	HD
TASMAR (<i>tolcapone</i>)	T3	PA HD
<i>tolcapone (Tasmar)</i>	T1	PA HD

DECARBOXYLASE INHIBITORS

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

ANTIPLATELET DRUGS (Blood Thinners/Anti-Clotting)

PLATELET AGGREGATION INHIBITORS

ASPIRIN-OMEPRAZOLE	T3	PA HD
<i>aspirin/dipyridamole</i>	T1	HD
BRILINTA (ticagrelor)	T3	HD
<i>cilostazol</i>	T1	HD
<i>clopidogrel bisulfate</i>	T1	HD
<i>clopidogrel bisulfate (Plavix)</i>	T1	HD
<i>dipyridamole</i>	T1	HD
EFFIENT (<i>prasugrel hcl</i>)	T3	HD

T1 – Generics

T2 – Preferred Brands

T3 – Non-Preferred Brands

T4 – Preferred Specialty

T5 – Non-Preferred Specialty

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List of Prescription Medications

ANTIPLATELET DRUGS (Blood Thinners/Anti-Clotting) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
PLATELET AGGREGATION INHIBITORS (cont.)		
prasugrel hcl (Effient)	T1	HD
ticagrelor (Brilinta)	T1	HD
ZONTIVITY	T3	PA HD
PLATELET REDUCING AGENTS		
AGRYLIN (anagrelide hcl)	T3	
anagrelide hcl	T1	
anagrelide hcl (Agrylin)	T1	
ANTIVIRALS (AIDS/HIV)		
ANTIRETROVIRAL - CAPSID INHIBITORS		
SUNLENCA	T5	PA SP
YEZTUGO	T5	PA SP
ANTIRETROVIRAL-INTEGRASE INHIBITOR AND NNRTI COMB.		
JULUCA	T4	SP
DOVATO	T4	SP
TRIUMEQ	T4	SP
TRIUMEQ PD	T4	SP
ANTIRETROVIRAL-NUCLEOSIDE, NUCLEOTIDE, PROTEASE INH.		
SYMTUZA	T4	SP
ANTIVIRALS, HIV-SPEC, NON-PEPTIDIC PROTEASE INHIB		
APTVUS	T4	SP
darunavir (Prezista)	T1	SP
PREZISTA 600MG, 800MG TABLET (darunavir)	T5	SP
ANTIVIRALS, HIV-SPEC, NUCLEOSIDE-NUCLEOTIDE ANALOG		
CIMDUO	T4	SP
DESCOVY	T4	SP
emtricitabine-tenofovir 100-150mg (Truvada)	T1	SP
emtricitabine-tenofovir 133-200mg (Truvada)	T1	SP
emtricitabine-tenofovir 167-250mg (Truvada)	T1	SP
emtricitabine-tenofovir 200-300mg (Truvada)	T1	SP PPACA
TEMIXYS	T4	SP
ANTIVIRALS, HIV-SPEC., NUCLEOSIDE ANALOG, RTI COMB		
abacavir sulfate/lamivudine (Epzicom)	T1	SP
COMBIVIR (lamivudine/zidovudine)	T5	SP

T1 – Generics

T2 – Preferred Brands

T3 – Non-Preferred Brands

T4 – Preferred Specialty

T5 – Non-Preferred Specialty

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List of Prescription Medications

ANTIVIRALS (AIDS/HIV) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ANTIVIRALS, HIV-SPEC., NUCLEOSIDE ANALOG, RTI COMB (cont.)		
EPZICOM (<i>abacavir sulfate/lamivudine</i>)	T5	SP
<i>lamivudine/zidovudine</i> (Combivir)	T1	SP
ANTIVIRALS, HIV-SPECIFIC, CCR5 CO-RECEPTOR ANTAG.		
<i>maraviroc</i> (Selzentry)	T1	SP
SELZENTRY 20 MG/ML ORAL SOLN	T4	SP
SELZENTRY 150 MG TABLET (<i>maraviroc</i>)	T5	SP
SELZENTRY 300 MG TABLET (<i>maraviroc</i>)	T5	SP
ANTIVIRALS, HIV-SPECIFIC, FUSION INHIBITORS		
FUZEON	T4	PA QL (60 vials/30 days) SP
ANTIVIRALS, HIV-SPECIFIC, NON-NUCLEOSIDE, RTI		
EDURANT	T4	SP
EDURANT PED	T5	SP
<i>efavirenz</i> (Sustiva)	T1	SP
<i>etravirine</i> (Intelence)	T1	SP
INTELENCE 25 MG TABLET	T4	SP
INTELENCE 100 MG TABLET (<i>etravirine</i>)	T5	SP
INTELENCE 200 MG TABLET (<i>etravirine</i>)	T5	SP
<i>nevirapine</i>	T1	SP
<i>nevirapine</i> (Viramune Xr)	T1	SP
SUSTIVA (<i>efavirenz</i>)	T5	SP
VIRAMUNE XR (<i>nevirapine</i>)	T5	SP
ANTIVIRALS, HIV-SPECIFIC, NUCLEOSIDE ANALOG, RTI		
<i>abacavir sulfate</i>	T1	SP
<i>abacavir sulfate</i> (Ziagen)	T1	SP
<i>didanosine</i>	T1	SP
<i>emtricitabine</i> (Emtriva)	T1	SP
EMTRIVA 10 MG/ML SOLUTION	T4	SP
EMTRIVA 200 MG CAPSULE (<i>emtricitabine</i>)	T5	SP
EPIVIR (<i>lamivudine</i>)	T5	SP
<i>lamivudine</i> (Epivir)	T1	SP
RETROVIR (<i>zidovudine</i>)	T5	SP
<i>stavudine</i>	T1	SP
ZIAGEN (<i>abacavir sulfate</i>)	T5	SP
<i>zidovudine</i>	T1	SP

T1 – Generics

T2 – Preferred Brands

T3 – Non-Preferred Brands

T4 – Preferred Specialty

T5 – Non-Preferred Specialty

PA – Prior Authorization

QL – Quantity Limit

ST – Step Therapy

AGE – Age Requirement

SP – Specialty Medication

HD – 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, NUCLEOSIDE ANALOG, RTI (cont.)		
<i>zidovudine</i> (Retrovir)	T1	SP
ANTIVIRALS, HIV-SPECIFIC, NUCLEOTIDE ANALOG, RTI		
<i>tenofovir disoproxil fumarate</i> (Viread)	T1	SP
VIREAD 150 MG TABLET	T4	SP
VIREAD 200 MG TABLET	T4	SP
VIREAD 250 MG TABLET	T4	SP
VIREAD 300 MG TABLET (<i>tenofovir disoproxil fumarate</i>)	T5	SP
VIREAD POWDER	T4	SP
ANTIVIRALS, HIV-SPECIFIC, PROTEASE INHIBITOR COMB		
KALETRA	T5	SP
<i>lopinavir/ritonavir</i>	T1	SP
ANTIVIRALS, HIV-SPECIFIC, PROTEASE INHIBITORS		
<i>atazanavir sulfate</i> (Reyataz)	T1	SP
EVOTAZ	T5	SP
<i>fosamprenavir calcium</i>	T1	SP
NORVIR 100 MG POWDER PACKET	T4	SP
NORVIR 100 MG TABLET (<i>ritonavir</i>)	T5	SP
REYATAZ 150 MG CAPSULE (<i>atazanavir sulfate</i>)	T5	SP
REYATAZ 200 MG CAPSULE (<i>atazanavir sulfate</i>)	T5	SP
REYATAZ 300 MG CAPSULE (<i>atazanavir sulfate</i>)	T5	SP
REYATAZ 50 MG POWDER PACKET	T4	SP
<i>ritonavir</i> (Norvir)	T1	SP
VIRACEPT	T4	SP
ANTIVIRALS, HIV-I INTEGRASE STRAND TRANSFER INHIBTR		
APRETUDE	T4	SP PPACA
ISENTRESS	T4	SP
ISENTRESS HD	T4	SP
TIVICAY	T4	SP
TIVICAY PD	T4	SP
ARTV NUCLEOSIDE, NUCLEOTIDE, NON-NUCLEOSIDE RTI COMB		
<i>efavirenz/emtricitabine/tenofovir df</i>	T1	SP
<i>efavirenz/lamivudine/tenofovir disop (Symfi Lo)</i>	T1	SP
<i>efavirenz/lamivudine/tenofovir disop (Symfi)</i>	T1	SP
<i>emtricitabine/rilpivirine/tenofovir df</i>	T1	SP

T1 – Generics

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List of Prescription Medications

ANTIVIRALS (AIDS/HIV) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ARTV NUCLEOSIDE, NUCLEOTIDE, NON-NUCLEOSIDE RTI COMB (cont.)		
ODEFSEY	T4	SP
SYMFY (efavirenz/lamivu/tenofovir disop)	T4	SP
SYMFY LO (efavirenz/lamivu/tenofovir disop)	T4	SP
ARV-NUCLEOSIDE, NUCLEOTIDE RTI, INTEGRASE INHIBITORS		
BIKTARVY	T4	SP
GENVOYA	T4	SP
ANTIVIRALS (Eye Conditions)		
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 200 mg capsule	T1	
acyclovir 200 mg/5 ml susp cup	T1	
acyclovir 800 mg/20ml susp cup	T1	
acyclovir 200 mg/5 ml susp (Zovirax)	T1	
acyclovir 400 mg tablet	T1	
acyclovir 800 mg tablet	T1	
famciclovir 125 mg tablet	T1	QL (21 tabs/fill)
famciclovir 250 mg tablet	T1	QL (60 tabs/fill)
famciclovir 500 mg tablet	T1	QL (21 tabs/fill)
FLUMADINE (rimantadine hcl)	T3	
LIVTENCITY	T5	PA QL (112 tabs/28 days) SP
oseltamivir 6 mg/ml suspension (Tamiflu)	T1	QL (180ml/30 days)
oseltamivir phos 30 mg capsule (Tamiflu)	T1	QL (20 caps/30 days)
oseltamivir phos 45 mg capsule (Tamiflu)	T1	QL (10 caps/30 days)
oseltamivir phos 75 mg capsule (Tamiflu)	T1	QL (10 caps/30 days)
PREVYMIS 120 MG PELLET PACKET	T4	SP

T1 – Generics

T2 – Preferred Brands

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T4 – Preferred Specialty

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List of Prescription Medications

ANTIVIRALS (Infections) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ANTIVIRALS, GENERAL (cont.)		
PREVYMIS 20 MG PELLET PACKET	T4	SP
PREVYMIS 240 MG TABLET	T4	QL (30 tabs/28 days) SP HD
PREVYMIS 480 MG TABLET	T4	QL (30 tabs/28 days) SP HD
RELENZA 5MG	T3	QL (20 blisters/10 days)
<i>rimantadine hcl</i> (Flumadine)	T1	
SITAVIG	T3	PA QL (2 tabs/30 days)
TAMIFLU 30 MG CAPSULE (<i>oseltamivir phosphate</i>)	T3	QL (20 caps/fill)
TAMIFLU 45 MG CAPSULE (<i>oseltamivir phosphate</i>)	T3	QL (10 caps/fill)
TAMIFLU 75 MG CAPSULE (<i>oseltamivir phosphate</i>)	T3	QL (10 caps/fill)
TAMIFLU 6 MG/ML SUSPENSION (<i>oseltamivir phosphate</i>)	T3	QL (180 mls/fill)
<i>valacyclovir hcl</i> (Valtrex)	T1	QL (30 tabs/fill)
VALCYTE (<i>valganciclovir hcl</i>)	T3	
<i>valganciclovir hcl</i> (Valcyte)	T1	
XOFLUZA	T3	QL (1 tab/fill)
ZOVIRAX 200 MG/5 ML SUSP (<i>acyclovir</i>)	T3	
HEP C - NS5A, NS3/4A, NUCLEOTIDE NS5B INHIB COMBO		
VOSEVI	T4	PA QL (28 tabs/fill) SP HD
HEP C VIRUS-NS5B POLYMERASE AND NS5A INHIB. COMBO.		
EPCLUSIA 150-37.5 MG PELLET PKT	T4	PA QL (28 packs/fill) SP HD
EPCLUSIA 200 MG-50 MG TABLET	T4	PA QL (28 tabs/fill) SP HD
EPCLUSIA 200-50 MG PELLET PACK	T4	PA QL (28 pkts/28 days) SP HD
EPCLUSIA 400 MG-100 MG TABLET	T4	PA QL (28 tabs/fill) SP HD
HARVONI 33.75-150 MG PELLET PK	T4	PA QL (28 packs/fill) SP HD
HARVONI 45-200 MG PELLET PACKT	T4	PA QL (56 packs/fill) SP HD
HARVONI 45-200 MG TABLET	T4	PA QL (56 tabs/fill) SP HD
HARVONI 90-400 MG TABLET	T4	PA QL (>= 18 yo 28 tabs/fill) SP HD
HEPATITIS B TREATMENT AGENTS		
<i>adefovir dipivoxil</i>	T1	SP HD
BARACLUDE 0.05 MG/ML SOLUTION	T4	SP HD
<i>entecavir</i> (Baraclude)	T1	SP HD
<i>lamivudine</i>	T1	SP
VEMLIDY	T4	SP HD
PEGASYS 180MCG/0.5ML SYRINGE KIT	T4	SP HD
PEGASYS PROCLICK 180MCG/0.5ML	T4	SP HD

T1 – Generics

T2 – Preferred Brands

T3 – Non-Preferred Brands

T4 – Preferred Specialty

T5 – Non-Preferred Specialty

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List of Prescription Medications

ANTIVIRALS (Infections) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
HEPATITIS B TREATMENT AGENTS (cont.)		
ribasphere 200 mg capsule	T1	ST SP HD
ribasphere 600 mg tablet	T1	ST SP
HEPATITIS C TREATMENT AGENTS		
ribavirin	T1	PA SP HD
HEPATITIS C VIRUS- NS5A AND NS3/4A INHIBITOR COMB		
ZEPATIER	T4	PA QL (28 tabs/fill) SP HD
ANTIVIRALS (Skin Conditions)		
TOPICAL ANTIVIRALS		
acyclovir 5% cream (Zovirax)	T1	PA QL (5 gms/fill)
acyclovir 5% ointment (Zovirax)	T1	PA QL (30 gms/fill)
DENAVIR	T3	
penciclovir	T1	
ZOVIRAX 5% CREAM (acyclovir)	T3	PA QL (5 gms/fill)
AUTONOMIC DRUGS (Allergy/Nasal Sprays)		
ANAPHYLAXIS THERAPY AGENTS		
AUVI-Q	T2	QL (2 auto-injs/30 days)
epinephrine 0.15 mg auto-injct (Epipen Jr 2-Pak)	T1	QL (2 auto-injs/fill)
epinephrine 0.15 mg auto-injct (Epipen Jr)	T1	QL (2 auto-injs/fill)
epinephrine 0.3 mg auto-inject (Epipen 2-Pak)	T1	QL (2 auto-injs/fill)
epinephrine 0.3 mg auto-inject (Epipen)	T1	QL (2 auto-injs/fill)
EPIPEN (epinephrine)	T2	PA QL (2 auto-injs/fill)
EPIPEN 2-PAK (epinephrine)	T2	PA QL (2 auto-injs/fill)
EPIPEN JR (epinephrine)	T2	PA QL (2 auto-injs/fill)
EPIPEN JR 2-PAK (epinephrine)	T2	PA QL (2 auto-injs/fill)
NEFFY	T2	QL (4 units/fill)
SYMJEPI	T2	QL (2 syringes/fill)
AUTONOMIC DRUGS (Alzheimer's Disease)		
CHOLINESTERASE INHIBITORS		
ADALRITY	T3	ST HD
ARICEPT (donepezil hcl)	T3	ST HD
donepezil hcl	T1	HD
donepezil hcl 10 mg tablet (Aricept)	T1	HD
donepezil hcl 23 mg tablet (Aricept)	T1	ST HD

T1 – Generics

T2 – Preferred Brands

T3 – Non-Preferred Brands

T4 – Preferred Specialty

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List of Prescription Medications

AUTONOMIC DRUGS (Alzheimer's Disease) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
CHOLINESTERASE INHIBITORS (cont.)		
<i>donepezil hcl 5 mg tablet (Aricept)</i>	T1	HD
<i>EXELON (rivastigmine)</i>	T3	ST HD
<i>galantamine hbr</i>	T1	HD
<i>galantamine hbr (Razadyne Er)</i>	T1	HD
<i>pyridostigmine 60 mg/5 ml soln (Mestinon)</i>	T1	HD
<i>PYRIDOSTIGMINE BR 30 MG TABLET</i>	T3	HD
<i>pyridostigmine br 60 mg tablet (Mestinon)</i>	T1	HD
<i>pyridostigmine bromide (Mestinon)</i>	T1	HD
<i>RAZADYNE ER (galantamine hbr)</i>	T3	ST HD
<i>rivastigmine (Exelon)</i>	T1	HD
<i>rivastigmine tartrate</i>	T1	HD

AUTONOMIC DRUGS (Attention Deficit Hyperactivity Disorder)⁸

ADRENERGICS, AROMATIC, NON-CATECHOLAMINE

<i>ADZENYS XR-ODT</i>	T3	ST
<i>amphetamine sulfate (Evekeo)</i>	T1	
<i>DESOXYN (methamphetamine hcl)</i>	T3	
<i>DEXEDRINE (dextroamphetamine sulfate)</i>	T3	ST
<i>dextroamphetamine sulfate</i>	T1	
<i>dextroamphetamine sulfate (Dexedrine)</i>	T1	
<i>dextroamphetamine sulfate (Zenzedi)</i>	T1	
<i>dextroamphetamine/amphetamine (Adderall Xr)</i>	T1	
<i>dextroamphetamine/amphetamine (Adderall)</i>	T1	
<i>dextroamphetamine/amphetamine (Mydayis)</i>	T1	
<i>EVEKEO ODT</i>	T3	
<i>methamphetamine hcl (Desoxyn)</i>	T1	
<i>MYDAYIS (dextroamphetamine/amphetamine)</i>	T3	ST
<i>ZENZEDI 15 MG TABLET (dextroamphetamine sulfate)</i>	T3	
<i>ZENZEDI 2.5 MG TABLET</i>	T3	
<i>ZENZEDI 7.5 MG TABLET (dextroamphetamine sulfate)</i>	T3	
<i>zenzedi 10 mg tablet</i>	T1	
<i>ZENZEDI 20 MG TABLET (dextroamphetamine sulfate)</i>	T3	
<i>ZENZEDI 30 MG TABLET (dextroamphetamine sulfate)</i>	T3	
<i>zenzedi 5 mg tablet</i>	T1	

T1 – Generics

T2 – Preferred Brands

T3 – Non-Preferred Brands

T4 – Preferred Specialty

T5 – Non-Preferred Specialty

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List of Prescription Medications

AUTONOMIC DRUGS (Blood Pressure/Heart Medications)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ADRENERGIC VASOPRESSOR AGENTS		
droxidopa (Northera)	T1	PA SP HD
midodrine hcl	T1	
DIBENZYLINE (phenoxybenzamine hcl)	T3	PA HD
phenoxybenzamine hcl (Dibenzyline)	T1	PA HD
AUTONOMIC DRUGS (Urinary Tract Conditions)		
PARASYMPATHETIC AGENTS		
bethanechol chloride	T1	HD
bethanechol chloride (Urecholine)	T1	HD
cevimeline hcl (Evoxac)	T1	HD
EVOXAC (cevimeline hcl)	T3	HD
pilocarpine hcl (Salagen)	T1	HD
SALAGEN (pilocarpine hcl)	T3	HD
URECHOLINE (bethanechol chloride)	T3	HD
BIOLOGICALS (Allergy/Nasal Sprays)		
ALLERGENIC EXTRACTS, THERAPEUTIC		
GRASTEK	T2	PA
ODACTRA	T2	PA
ORALAIR	T2	PA
RAGWITEK	T2	PA
BIOLOGICALS (Blood Pressure/Heart Medications)		
PLASMA KALLIKREIN INHIBITORS		
ORLADEYO 110MG CAPSULE	T5	PA QL (28 caps/28 days) SP
ORLADEYO 150MG CAPSULE	T5	PA QL (28 caps/28 days) SP
TAKHYRO	T4	PA SP HD
TAKHYRO 300MG/2ML	T4	PA QL (2 units/28 days) SP HD
BIOLOGICALS (Miscellaneous)		
PKU TREATMENT AGENTS - PHENYLALANINE AMMONIA LYASE		
PALYNZIQ 10 MG/0.5 ML SYRINGE	T4	PA QL (30 syringes/fill) SP HD
PALYNZIQ 2.5 MG/0.5 ML SYRINGE	T4	PA QL (8 syringes/fill) SP HD
PALYNZIQ 20 MG/ML SYRINGE	T4	PA QL (60 syringes/fill) SP HD

T1 – Generics

T2 – Preferred Brands

T3 – Non-Preferred Brands

T4 – Preferred Specialty

T5 – Non-Preferred Specialty

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List of Prescription Medications

BIOLOGICALS (Vaccines)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
COVID-19 VACCINES		
COMIRNATY	T2	PPACA
JANSSEN COVID-19 VACCINE (EUA)	T2	PPACA
MODERNA COVID VAC(EUA)	T2	PPACA
MODERNA COVID-19 BOOSTER (EUA)	T2	PPACA
NOVAVAX COVID-19 (EUA)	T2	PPACA
PFIZER COVID EUA	T2	PPACA
PFIZER COVID-19 VACCINE (EUA)	T2	PPACA
SPIKEVAX	T2	PPACA
ENTERIC VIRUS VACCINES		
IPOL	T2	PPACA
ROTARIX	T2	HD PPACA
ROTAQE	T2	PPACA
GRAM NEGATIVE COCCI VACCINES		
BEXSERO	T2	PPACA
MENACTRA	T2	
MENQUADFI	T2	PPACA
MENVEO A-C-Y-W-135-DIP	T2	PPACA
PENBRAYA	T2	PPACA
TRUMENBA	T2	PPACA
GRAM POSITIVE COCCI VACCINES		
CAPVAXIVE	T2	PPACA
PNEUMOVAX 23	T2	PPACA
PREVNAR 13	T2	
PREVNAR 20	T2	PPACA
VAXNEUVANCE	T2	PPACA
INFLUENZA VIRUS VACCINES		
AFLURIA QUAD	T2	PPACA
AFLURIA TRIV	T2	PPACA
AFLURIA TRIVALENT	T2	PPACA
AUDENZ (NATIONAL STOCKPILE)	T2	
FLUAD	T2	PPACA
FLUAD QUAD	T2	PPACA
FLUAD TRIVALENT	T2	PPACA
FLUARIX QUAD	T2	PPACA

T1 – Generics

T2 – Preferred Brands

T3 – Non-Preferred Brands

T4 – Preferred Specialty

T5 – Non-Preferred Specialty

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List of Prescription Medications

BIOLOGICALS (Vaccines) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
INFLUENZA VIRUS VACCINES (cont.)		
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	T3	PPACA
FLUMIST TRIVALENT	T3	PPACA
FLUZONE HIGH-DOSE	T2	PPACA
FLUZONE HIGH-DOSE TRIV	T2	PPACA
FLUZONE QUAD	T2	PPACA
FLUZONE QUAD PEDI	T2	PPACA
FLUZONE TRIVALENT	T2	PPACA
NEUROTOXIC VIRUS VACCINES		
DENGVAXIA	T2	PPACA
TOXIN-PRODUCING BACILLI VACCINES/TOXOIDS		
BCG VACCINE (TICE STRAIN)	T4	SP
VACCINE/TOXOID PREPARATIONS, COMBINATIONS		
ACTHIB	T2	PPACA
ADACEL TDAP	T2	PPACA
BOOSTRIX TDAP	T2	PPACA
DAPTACEL DTAP	T2	PPACA
DIPHTHERIA-TETANUS TOXOIDS-PED	T2	
HIBERIX	T2	PPACA
INFANRIX DTAP	T2	PPACA
KINRIX	T2	PPACA
M-M-R II VACCINE	T2	PPACA
PEDVAXHIB	T2	PPACA
PENTACEL	T2	PPACA
PENTACEL ACTHIB COMPONENT	T2	PPACA
PRIORIX	T2	PPACA
PROQUAD	T2	PPACA
QUADRACEL DTAP-IPV	T2	PPACA

T1 – Generics

T2 – Preferred Brands

T3 – Non-Preferred Brands

T4 – Preferred Specialty

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List of Prescription Medications

BIOLOGICALS (Vaccines) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
VACCINE/TOXOID PREPARATIONS, COMBINATIONS (cont.)		
TDVAX	T2	PPACA
TENIVAC	T2	PPACA
VAXELIS	T2	PPACA
VIRAL/TUMORIGENIC VACCINES		
ABRYSVO	T2	PPACA
ACAM2000	T2	
AREXVY VIAL KIT	T2	PPACA
ENGERIX-B ADULT	T2	PPACA
ENGERIX-B PEDIATRIC-ADOLESCENT	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
PREHEVBRIOD	T2	PPACA
RECOMBIVAX HB	T2	PPACA
SHINGRIX	T2	PPACA
TWINRIX	T2	PPACA
VAQTA	T2	PPACA
VARIVAX VACCINE	T2	PPACA
BLOOD (Blood Modifiers/Bleeding Disorders)		
ANTIFIBRINOLYTIC AGENTS		
AMICAR (<i>aminocaproic acid</i>)	T5	SP HD
<i>aminocaproic acid</i> (Amicar)	T1	SP HD
LYSTEDA (<i>tranexamic acid</i>)	T5	SP
<i>tranexamic acid</i> (Lysteda)	T1	SP
COMPLEMENT INHIBITORS		
EMPAVELI	T4	PA SP
FABHALTA	T4	PA SP
TAVNEOS	T5	PA QL (180 caps/30 days) SP
VOYDEYA	T4	PA SP

T1 – Generics

T2 – Preferred Brands

T3 – Non-Preferred Brands

T4 – Preferred Specialty

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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	T4	PA SP HD
PYRUVATE KINASE ACTIVATORS		
PYRUKYND 5 MG, 20 MG TABLET	T5	PA QL (56 tabs/28 days) SP
PYRUKYND 20-5 MG TAPER PACK	T5	PA QL (14 tabs/365 days) SP
PYRUKYND 5 MG TAPER PACK	T5	PA QL (7 tabs/365 days) SP
PYRUKYND 50 MG TABLET	T5	PA QL (56 tabs/28 days) SP
PYRUKYND 50-20 MG TAPER PACK	T5	PA QL (14 tabs/365 days) SP
SICKLE CELL ANEMIA AGENTS		
DROXIA	T2	
ENDARI	T3	PA
glutamine	T1	PA
OXBRYTA	T5	SP
TOPICAL HEMOSTATICS		
ASTRINGYN	T3	
AVITENE	T3	
ENDO-AVITENE	T3	
EVICEL	T3	
GEL-FLOW	T3	
GEL-FLOW NT	T3	
GELFOAM	T3	
GELFOAM (<i>gelatin sponge,absorb/porcine</i>)	T3	
GELFOAM COMPRESSED	T3	
GELFOAM JMI	T3	
MONSEL'S	T2	
RECOTHROM	T3	
SURGICEL	T3	
SURGIFOAM SPONGE SIZE 100	T3	
SURGIFOAM SPONGE SIZE 100C	T3	
<i>surgifoam sponge size 12-7 (Gelfoam)</i>	T1	
SYRINGE AVITENE	T3	
THROMBI-GEL (<i>thrombin/cal/cmc/gel/dress,hem</i>)	T3	
THROMBIN-JMI	T3	
THROMBI-PAD	T3	
ULTRAFOAM	T3	

T1 – Generics

T2 – Preferred Brands

T3 – Non-Preferred Brands

T4 – Preferred Specialty

T5 – Non-Preferred Specialty

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List of Prescription Medications

BLOOD (Blood Thinners/Anti-Clotting)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
HEMORRHOELOGIC AGENTS		
<i>pentoxifylline</i>	T1	HD
CARDIAC DRUGS (Blood Pressure/Heart Medications)		
ANTIANGINAL, ANTI-ISCHEMIC AGENTS, NON-HEMODYNAMIC		
RANEXA (<i>ranolazine</i>)	T3	ST HD
<i>ranolazine</i>	T1	HD
<i>ranolazine</i> (Ranexa)	T1	HD
ANTIARRHYTHMICS		
<i>amiodarone hcl</i>	T1	HD
<i>disopyramide phosphate</i> (Norpace)	T1	HD
<i>dofetilide</i> (Tikosyn)	T1	HD
<i>flecainide acetate</i>	T1	HD
<i>mexiletine hcl</i>	T1	HD
MULTAQ	T2	HD
<i>propafenone hcl</i>	T1	HD
<i>quinidine gluconate</i>	T1	HD
<i>quinidine sulfate</i>	T1	HD
CALCIUM CHANNEL BLOCKER AND NSAID, COX-2 INHIBITOR		
CONSENSI	T3	
CALCIUM CHANNEL BLOCKING AGENTS		
<i>amlodipine besylate</i> (Norvasc)	T1	HD
CALAN SR (<i>verapamil hcl</i>)	T3	ST HD
CARDIZEM (<i>diltiazem hcl</i>)	T3	HD
CARDIZEM CD (<i>diltiazem hcl</i>)	T3	HD
CARDIZEM LA	T3	HD
CARDIZEM LA (<i>diltiazem hcl</i>)	T3	HD
<i>diltiazem hcl</i>	T1	HD
<i>diltiazem hcl</i>	T1	HD
<i>diltiazem hcl</i> (Cardizem Cd)	T1	HD
<i>diltiazem hcl</i> (Cardizem La)	T1	HD
<i>diltiazem hcl</i> (Cardizem)	T1	HD
<i>felodipine</i>	T1	HD
<i>isradipine</i>	T1	
<i>nicardipine hcl</i>	T1	HD
<i>nifedipine</i>	T1	HD

T1 – Generics

T2 – Preferred Brands

T3 – Non-Preferred Brands

T4 – Preferred Specialty

T5 – Non-Preferred Specialty

PA – Prior Authorization

QL – Quantity Limit

ST – Step Therapy

AGE – Age Requirement

SP – Specialty Medication

HD – May require home delivery pharmacy

PPACA – No Cost-Share Preventive Medication

CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

CARDIAC DRUGS (Blood Pressure/Heart Medications) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
CALCIUM CHANNEL BLOCKING AGENTS (cont.)		
<i>nifedipine</i> (Procardia XL)	T1	HD
<i>nifedipine</i> (Procardia)	T1	HD
<i>nimodipine</i> 30 mg capsule	T1	HD
<i>nimodipine</i> 60 mg/20 ml soln	T1	
<i>nisoldipine</i>	T1	HD
<i>nisoldipine</i> (Sular)	T1	HD
NYMALIZE	T3	
PROCARDIA (<i>nifedipine</i>)	T3	ST HD
PROCARDIA XL (<i>nifedipine</i>)	T3	ST HD
SULAR (<i>nisoldipine</i>)	T3	ST HD
TIAZAC (<i>diltiazem hcl</i>)	T3	HD
verapamil hcl	T1	HD
verapamil hcl (Calan Sr)	T1	HD
verapamil hcl (Verelan Pm)	T1	ST HD
verapamil hcl (Verelan)	T1	HD
VERELAN (<i>verapamil hcl</i>)	T3	ST HD
VERELAN PM (<i>verapamil hcl</i>)	T3	ST HD
CARDIAC MYOSIN INHIBITOR		
CAMZYOS	T4	PA QL (30 caps/fill) SP HD
DIGITALIS GLYCOSIDES		
<i>digoxin</i>	T1	HD
<i>digoxin</i> (Lanoxin)	T1	HD
LANOXIN	T3	HD
LANOXIN (<i>digoxin</i>)	T3	HD
HEART RATE REDUCING, SA SELECTIVE I(F) CURRENT INH.		
<i>ivabradine hcl</i> (Corlanor)	T1	PA HD
SOLUBLE GUANYLATE CYCLASE (SGC) STIMULATOR		
VERQUVO		
VASODILATORS, CORONARY		
GONITRO	T3	HD
ISORDIL (<i>isosorbide dinitrate</i>)	T3	HD
ISORDIL TITRADOSE (<i>isosorbide dinitrate</i>)	T3	HD
<i>isosorbide dinitrate</i>	T1	HD
<i>isosorbide dinitrate</i> (Isordil Titradoser)	T1	HD

T1 – Generics

T2 – Preferred Brands

T3 – Non-Preferred Brands

T4 – Preferred Specialty

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List of Prescription Medications

CARDIAC DRUGS (Blood Pressure/Heart Medications) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
VASODILATORS, CORONARY (cont.)		
<i>isosorbide dinitrate (Isordil)</i>	T1	HD
<i>isosorbide mononitrate</i>	T1	HD
MINITRAN	T3	HD
NITRO-DUR	T3	HD
<i>nitroglycerin</i>	T1	HD
<i>nitroglycerin 0.3 mg tablet sl (Nitrostat)</i>	T1	HD
<i>nitroglycerin 0.4 mg tablet sl (Nitrostat)</i>	T1	HD
<i>nitroglycerin 0.6 mg tablet sl (Nitrostat)</i>	T1	HD
<i>nitroglycerin 400 mcg spray (Nitrolingual)</i>	T1	HD
NITROLINGUAL (<i>nitroglycerin</i>)	T3	HD
NITROMIST (<i>nitroglycerin</i>)	T3	HD
NITROSTAT (<i>nitroglycerin</i>)	T3	HD
CARDIOVASCULAR (Asthma/COPD/Respiratory)		
PULM ANTI-HTN, SOLUBLE GUANYLATE CYCLASE STIMULATOR		
ADEMPAS	T4	PA QL (90 tabs/fill) SP HD
PULM.ANTI-HTN, SEL.C-GMP PHOSPHODIESTERASE T5 INHIB		
REVATIO 10 MG/ML ORAL SUSP (<i>sildenafil citrate</i>)	T5	PA QL (112 mls/fill) SP HD
REVATIO 20 MG TABLET (<i>sildenafil citrate</i>)	T5	PA QL (90 tabs/fill) SP HD
<i>sildenafil 20 mg tablet (Revatio)</i>	T1	PA QL (90 tabs/fill) SP HD
<i>tadalafil 20 mg tablet (Adcirca)</i>	T1	PA QL (60 tabs/fill) SP HD
PULMONARY ANTI-HTN, ENDOTHELIN RECEPTOR ANTAGONIST		
<i>ambrisentan (Letairis)</i>	T1	PA QL (30 tabs/fill) SP HD
<i>bosentan (Tracleer)</i>	T1	PA QL (60 tabs/fill) SP HD
OPSUMIT	T4	PA QL (30 tabs/fill) SP HD
TRACLEER 125 MG TABLET (<i>bosentan</i>)	T5	PA QL (60 tabs/fill) SP HD
TRACLEER 32 MG TABLET FOR SUSP	T4	PA QL (120 tabs/fill) SP HD
TRACLEER 62.5 MG TABLET (<i>bosentan</i>)	T5	PA QL (60 tabs/fill) SP HD
PULMONARY ANTIHYPER AGENT, ACTRIIA-FC		
WINREVAIR	T4	PA SP HD
WINREVAIR (2 PACK)	T4	PA SP HD
PULMONARY ANTIHYPERTENSIVES, PROSTACYCLIN-TYPE		
ORENITRAM ER	T5	PA QL (90 tabs/fill) SP HD
ORENITRAM TITRATION KT MONTH 1	T5	PA QL (30 tabs/30 days)
ORENITRAM TITRATION KT MONTH 2	T5	PA QL (336 tabs/28 days) SP

T1 – Generics

T2 – Preferred Brands

T3 – Non-Preferred Brands

T4 – Preferred Specialty

T5 – Non-Preferred Specialty

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ST – Step Therapy

AGE – Age Requirement

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List of Prescription Medications

CARDIOVASCULAR (Asthma/COPD/Respiratory) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
PULMONARY ANTIHYPERTENSIVES, PROSTACYCLIN-TYPE (cont.)		
ORENITRAM TITRATION KT MONTH 3	T5	PA QL (252 tabs/28 days) SP
TYVASO	T4	PA SP HD
TYVASO DPI	T4	PA SP HD
TYVASO INSTITUTIONAL START KIT	T4	PA SP HD
TYVASO REFILL KIT	T4	PA SP HD
TYVASO STARTER KIT	T4	PA SP HD
UPTRAVI 200 MCG, 400 MCG TABLET	T4	PA QL (60 tabs/fill) SP HD
UPTRAVI 600 MCG TABLET	T4	PA QL (60 tabs/fill) SP HD
UPTRAVI 800 MCG TABLET	T4	PA QL (60 tabs/fill) SP HD
UPTRAVI 1,000 MCG TABLET	T4	PA QL (60 tabs/fill) SP HD
UPTRAVI 1,200 MCG TABLET	T4	PA QL (60 tabs/fill) SP HD
UPTRAVI 1,400 MCG TABLET	T4	PA QL (60 tabs/fill) SP HD
UPTRAVI 1,600 MCG TABLET	T4	PA QL (60 tabs/fill) SP HD
VENTAVIS	T5	PA SP HD
PULMONARY HTN-ENDOTHELIN RECEPT ANTG-CGMP PDE5 INH		
OPSYNVI	T4	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	ST HD
trandolapril/verapamil hcl	T1	HD
ACE INHIBITOR-THIAZIDE OR THIAZIDE-LIKE DIURETIC		
ACCURETIC (quinapril/hydrochlorothiazide)	T3	HD
benazepril/hydrochlorothiazide	T1	HD
benazepril/hydrochlorothiazide (Lotensin Hct)	T1	HD
captopril/hydrochlorothiazide	T1	HD
enalapril/hydrochlorothiazide	T1	HD
enalapril/hydrochlorothiazide (Vaseretic)	T1	HD
fosinopril/hydrochlorothiazide	T1	HD
lisinopril/hydrochlorothiazide (Zestoretic)	T1	HD
LOTENSIN HCT (benazepril/hydrochlorothiazide)	T3	HD
quinapril/hydrochlorothiazide (Accuretic)	T1	HD
VASERETIC (enalapril/hydrochlorothiazide)	T3	HD

T1 – Generics

T2 – Preferred Brands

T3 – Non-Preferred Brands

T4 – Preferred Specialty

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List of Prescription Medications

CARDIOVASCULAR (Blood Pressure/Heart Medications) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ACE INHIBITOR-THIAZIDE OR THIAZIDE-LIKE DIURETIC (cont.)		
ZESTORETIC (<i>lisinopril/hydrochlorothiazide</i>)	T3	HD
carvedilol (Coreg)	T1	HD
carvedilol phosphate (Coreg Cr)	T1	HD
COREG CR (<i>carvedilol phosphate</i>)	T3	ST HD
labetalol hcl	T1	HD
ALPHA-ADRENERGIC BLOCKING AGENTS		
CARDURA 1 MG TABLET (<i>doxazosin mesylate</i>)	T3	ST QL (30 tabs/fill) HD
CARDURA 2 MG TABLET (<i>doxazosin mesylate</i>)	T3	ST QL (30 tabs/fill) HD
CARDURA 4 MG TABLET (<i>doxazosin mesylate</i>)	T3	ST QL (30 tabs/fill) HD
CARDURA 8 MG TABLET (<i>doxazosin mesylate</i>)	T3	ST QL (60 tabs/fill) HD
CARDURA XL	T3	ST QL (30 tabs/fill) HD
<i>doxazosin mesylate 1 mg tab</i> (Cardura)	T1	QL (30 tabs/fill) HD
<i>doxazosin mesylate 2 mg tab</i> (Cardura)	T1	QL (30 tabs/fill) HD
<i>doxazosin mesylate 4 mg tab</i> (Cardura)	T1	QL (30 tabs/fill) HD
ALPHA/BETA-ADRENERGIC BLOCKING AGENTS		
<i>doxazosin mesylate 8 mg tab</i> (Cardura)	T1	QL (60 tabs/fill) HD
<i>labetalol hcl 100 mg tablet</i>	T1	HD
<i>labetalol hcl 200 mg tablet</i>	T1	HD
<i>labetalol hcl 300 mg tablet</i>	T1	HD
MINIPRESS (<i>prazosin hcl</i>)	T3	HD
<i>prazosin hcl</i>	T1	HD
<i>prazosin hcl</i> (Minipress)	T1	HD
<i>terazosin 1 mg, 2 mg capsule</i>	T1	QL (30 caps/fill) HD
<i>terazosin 10 mg capsule</i>	T1	QL (60 caps/fill) HD
<i>terazosin 5 mg capsule</i>	T1	QL (30 caps/fill) HD
ANGIOTEN. RECEPTR ANTAG-CALCIUM CHANL BLKR-THIAZIDE		
<i>amlodipine/valsartan/hcthiazid</i> (Exforge Hct)	T1	HD
<i>olmesartan/amlodipin/hcthiazid</i> (Tribenzor)	T1	HD
ANGIOTENSIN RECEPT-NEPRILYSIN INHIBITOR COMB (ARNI)		
ENTRESTO	T2	QL (60 tabs/fill) HD
ENTRESTO SPRINKLE	T2	QL (240 caps/fill) HD
<i>sacubitriil/valsartan</i>	T1	QL (60 tabs/30 days) HD
ANGIOTENSIN RECEPTOR ANTAG.-THIAZIDE DIURETIC COMB		
<i>candesartan/hydrochlorothiazid</i> (Atacand Hct)	T1	HD

T1 – Generics

T2 – Preferred Brands

T3 – Non-Preferred Brands

T4 – Preferred Specialty

T5 – Non-Preferred Specialty

PA – Prior Authorization

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ST – Step Therapy

AGE – Age Requirement

SP – Specialty Medication

HD – May require home delivery pharmacy

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List of Prescription Medications

CARDIOVASCULAR (Blood Pressure/Heart Medications) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ANGIOTENSIN RECEPTOR ANTAG.-THIAZIDE DIURETIC COMB (cont.)		
irbesartan/hydrochlorothiazide (Avalide)	T1	HD
losartan/hydrochlorothiazide (Hyzaar)	T1	HD
olmesartan/hydrochlorothiazide (Benicar Hct)	T1	HD
telmisartan/hydrochlorothiazide (Micardis Hct)	T1	HD
valsartan/hydrochlorothiazide (Diovan Hct)	T1	HD
ANGIOTENSIN RECEPTOR BLOCKR-CALCIUM CHANNEL BLOCKR		
amlodipine bes/olmesartan med (Azor)	T1	HD
amlodipine besylate/valsartan (Exforge)	T1	HD
telmisartan/amlodipine	T1	HD
ANTIHYPERTENSIVES, ACE INHIBITORS		
ACCUPRIL (quinapril hcl)	T3	HD
ALTACE (ramipril)	T3	HD
benazepril hcl	T1	HD
benazepril hcl (Lotensin)	T1	HD
captopril	T1	HD
enalapril maleate (Epaned)	T1	HD
enalapril maleate (Vasotec)	T1	HD
fosinopril sodium	T1	HD
lisinopril (Zestril)	T1	HD
LOTENSIN (benazepril hcl)	T3	HD
moexipril hcl	T1	HD
perindopril erbumine	T1	HD
quinapril hcl (Accupril)	T1	HD
ramipril (Altace)	T1	HD
trandolapril	T1	HD
VASOTEC (enalapril maleate)	T3	HD
ZESTRIL (lisinopril)	T3	HD
ANTIHYPERTENSIVES, ANGIOTENSIN RECEPTOR ANTAGONIST		
candesartan cilexetil (Atacand)	T1	HD
eprosartan mesylate	T1	HD
irbesartan	T1	HD
irbesartan (Avapro)	T1	HD
losartan potassium (Cozaar)	T1	HD
olmesartan medoxomil (Benicar)	T1	HD

T1 – Generics

T2 – Preferred Brands

T3 – Non-Preferred Brands

T4 – Preferred Specialty

T5 – Non-Preferred Specialty

PA – Prior Authorization

QL – Quantity Limit

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AGE – Age Requirement

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List of Prescription Medications

CARDIOVASCULAR (Blood Pressure/Heart Medications) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ANTIHYPERTENSIVES, ANGIOTENSIN RECEPTOR ANTAGONIST (cont.)		
telmisartan	T1	HD
telmisartan (Micardis)	T1	HD
valsartan 20 mg/5 ml solution	T1	HD
valsartan 160 mg tablet (Diovan)	T1	HD
valsartan 320 mg tablet (Diovan)	T1	HD
valsartan 40 mg tablet (Diovan)	T1	HD
valsartan 80 mg tablet (Diovan)	T1	HD
ANTIHYPERTENSIVES, GANGLIONIC BLOCKERS		
VECAMYL	T3	PA
ANTIHYPERTENSIVES, MISCELLANEOUS		
DEMSER (metyrosine)	T3	PA HD
metyrosine (Demser)	T1	PA HD
ANTIHYPERTENSIVES, SYMPATHOLYTIC		
CATAPRES-TTS 1 (clonidine)	T3	QL (4 patches/28 days) HD
CATAPRES-TTS 2 (clonidine)	T3	QL (4 patches/28 days) HD
CATAPRES-TTS 3 (clonidine)	T3	QL (4 patches/28 days) HD
clonidine (Catapres-Tts 1)	T1	QL (4 patches/28 days) HD
clonidine (Catapres-Tts 2)	T1	QL (4 patches/28 days) HD
clonidine (Catapres-Tts 3)	T1	QL (4 patches/28 days) HD
guanfacine hcl	T1	HD
methyldopa	T1	HD
methyldopa/hydrochlorothiazide	T1	HD
ANTIHYPERTENSIVES, VASODILATORS		
hydralazine hcl	T1	HD
minoxidil	T1	HD
BETA-ADRENERGIC BLOCKING AGENTS		
acebutolol hcl	T1	HD
atenolol (Tenormin)	T1	HD
BETAPACE (sotalol hcl)	T3	ST HD
BETAPACE AF (sotalol hcl)	T3	ST HD
betaxolol hcl	T1	HD
bisoprolol fumarate 5 mg tab	T1	HD
bisoprolol fumarate 10 mg tab	T1	HD
HEMANGEOL	T2	PA

T1 – Generics

T2 – Preferred Brands

T3 – Non-Preferred Brands

T4 – Preferred Specialty

T5 – Non-Preferred Specialty

PA – Prior Authorization

QL – Quantity Limit

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AGE – Age Requirement

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List of Prescription Medications

CARDIOVASCULAR (Blood Pressure/Heart Medications) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
BETA-ADRENERGIC BLOCKING AGENTS (cont.)		
LOPRESSOR (<i>metoprolol tartrate</i>)	T3	ST HD
<i>metoprolol succinate</i> (Toprol XL)	T1	HD
<i>metoprolol tartrate</i>	T1	HD
<i>metoprolol tartrate</i> (Lopressor)	T1	HD
<i>nebivolol hcl</i> (Bystolic)	T1	HD
<i>pindolol</i>	T1	HD
<i>propranolol hcl</i>	T1	HD
<i>propranolol hcl</i> (Inderal La)	T1	HD
<i>sotalol hcl</i> (Betapace Af)	T1	HD
<i>sotalol hcl</i> (Betapace)	T1	HD
SOTYLIZE	T2	HD
TENORMIN (<i>atenolol</i>)	T3	ST HD
<i>timolol maleate</i> 5 mg, 10 mg, 20 mg tablet	T1	HD
BETA-BLOCKERS AND THIAZIDE, THIAZIDE-LIKE DIURETICS		
<i>atenolol/chlorthalidone</i> (Tenoretic 100)	T1	HD
<i>atenolol/chlorthalidone</i> (Tenoretic 50)	T1	HD
<i>bisoprolol/hydrochlorothiazide</i>	T1	HD
METOPROLOL SUCCINATE ER-HCTZ	T3	ST HD
<i>metoprolol/hydrochlorothiazide</i>	T1	HD
<i>propranolol/hydrochlorothiazide</i>	T1	HD
TENORETIC 50 (<i>atenolol/chlorthalidone</i>)	T3	ST HD
TENORETIC 100 (<i>atenolol/chlorthalidone</i>)	T3	ST HD
RENIN INHIBITOR, DIRECT		
<i>aliskiren hemifumarate</i> (Tekturna)	T1	HD
RENIN INHIBITOR, DIRECT AND THIAZIDE DIURETIC COMB		
TEKTURN A HCT	T2	HD
VASODILATORS, COMBINATION		
<i>isosorbide dinit/hydralazine</i> (Bidil)	T1	
VASODILATORS, PERIPHERAL		
<i>ergoloid mesylates</i>	T1	
<i>isoxsuprine hcl</i>	T1	
CARDIOVASCULAR (Cholesterol Medications)		
ANTIHYPERLIP.HMG COA REDUCT INHIB-CHOEST.AB.INHIB		
ezetimibe-atorvastatin tabs	T1	ST QL (30 tabs/30 days) HD

T1 – Generics

T2 – Preferred Brands

T3 – Non-Preferred Brands

T4 – Preferred Specialty

T5 – Non-Preferred Specialty

PA – Prior Authorization

QL – Quantity Limit

ST – Step Therapy

AGE – Age Requirement

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List of Prescription Medications

CARDIOVASCULAR (Cholesterol Medications) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ANTIHYPERLIP.HMG COA REDUCT INHIB-CHOEST.AB.INHIB (cont.)		
ezetimibe/simvastatin (Vytorin)	T1	QL (30 tabs/fill) HD
ROSZET	T3	ST QL (30 tabs/fill) HD
ANTIHYPERLIPID- HMG-COA RI-CALCIUM CHANNEL BLOCKER		
amlodipine/atorvastatin	T1	QL (30 tabs/fill) HD
amlodipine/atorvastatin (Caduet)	T1	QL (30 tabs/fill) HD
CADUET (amlodipine/atorvastatin)	T3	ST QL (30 tabs/fill) HD
ANTIHYPERLIPIDEMIC - ATP CITRATE LYASE INHIBITOR		
NEXLETOL	T2	PA
ANTIHYPERLIPIDEMIC - MTP INHIBITOR		
JUXTAPID	T4	PA SP HD
ANTIHYPERLIPIDEMIC - PCSK9 INHIBITORS		
REPATHA PUSHTRONEX	T2	PA
REPATHA SURECLICK	T2	PA
REPATHA SYRINGE	T2	PA
ANTIHYPERLIPIDEMIC-ACLY AND CHOLEST ABSORP INHIB		
NEXLIZET	T2	PA
ANTIHYPERLIPIDEMIC - APOLIPOPROTEIN INHIBITOR		
TRYNGOLZA	T5	PA SP
ANTIHYPERLIPIDEMIC-HMGCOA REDUCTASE INHIB (STATINS)		
FLOLIPID	T3	ST QL (150 mls/fill) HD
fluvastatin sodium (Lescol XL)	T1	QL (30 tabs/fill) HD PPACA
fluvastatin sodium 20 mg cap	T1	QL (30 caps/fill) HD PPACA
fluvastatin sodium 40 mg cap	T1	QL (60 caps/fill) HD PPACA
LESCOL XL (fluvastatin sodium)	T3	ST QL (30 tabs/fill) HD
lovastatin 10 mg tablet	T1	QL (30 tabs/fill) HD PPACA
lovastatin 20 mg tablet	T1	QL (60 tabs/fill) HD PPACA
lovastatin 40 mg tablet	T1	QL (60 tabs/fill) HD PPACA
pitavastatin calcium (Livalo)	T1	QL (30 tabs/30 days) HD PPACA
pravastatin sodium	T1	QL (30 tabs/fill) HD PPACA
simvastatin 10 mg tablet (Zocor)	T1	QL (30 tabs/fill) HD PPACA
simvastatin 20 mg tablet (Zocor)	T1	QL (30 tabs/fill) HD PPACA
SIMVASTATIN 20 MG/5 ML SUSP	T3	ST QL (150 mls/fill) HD
simvastatin 40 mg tablet (Zocor)	T1	QL (30 tabs/fill) HD PPACA
simvastatin 5 mg tablet	T1	QL (30 tabs/fill) HD PPACA

T1 – Generics

T2 – Preferred Brands

T3 – Non-Preferred Brands

T4 – Preferred Specialty

T5 – Non-Preferred Specialty

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List of Prescription Medications

CARDIOVASCULAR (Cholesterol Medications) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ANTIHYPERLIPIDEMIC-HMGCOA REDUCTASE INHIB (STATINS) (cont.)		
<i>simvastatin 80 mg tablet (Zocor)</i>	T1	QL (30 tabs/fill) HD
ZYPITAMAG	T3	ST QL (30 tabs/fill) HD
BILE SALT SEQUESTRANTS		
<i>cholestyramine</i>	T1	HD
<i>cholestyramine (with sugar) (Questran)</i>	T1	HD
<i>cholestyramine/aspartame</i>	T1	HD
<i>cholestyramine (Questran Light)</i>	T1	HD
<i>colesevelam hcl (Welchol)</i>	T1	HD
COLESTID	T3	ST HD
COLESTID (<i>colestipol hcl</i>)	T3	ST HD
<i>colestipol hcl</i>	T1	HD
<i>colestipol hcl (Colestid)</i>	T1	HD
QUESTRAN (<i>cholestyramine (with sugar)</i>)	T3	ST HD
QUESTRAN LIGHT (<i>cholestyramine</i>)	T3	ST HD
LIPOTROPICS		
ANTARA	T3	ST HD
<i>ezetimibe (Zetia)</i>	T1	HD
<i>fenofibrate 120 mg tablet (Fenoglide)</i>	T1	ST HD
<i>fenofibrate 130 mg capsule</i>	T1	ST HD
<i>fenofibrate 43 mg, 67 mg, 134 mg, 200 mg capsule</i>	T1	HD
<i>fenofibrate 54 mg, 160 mg tablet</i>	T1	HD
<i>fenofibrate 40 mg tablet (Fenoglide)</i>	T1	ST HD
<i>fenofibrate 48 mg tablet (Tricor)</i>	T1	HD
<i>fenofibrate 145 mg tablet (Tricor)</i>	T1	HD
<i>fenofibric acid</i>	T1	HD
<i>fenofibric acid (choline)</i>	T1	HD
<i>fenofibric acid (choline) (Trilipix)</i>	T1	HD
<i>fenofibric acid (Fibrincor)</i>	T1	HD
FENOGLIDE (<i>fenofibrate</i>)	T3	ST HD
FIBRICOR (<i>fenofibric acid</i>)	T3	ST HD
<i>gemfibrozil (Lopid)</i>	T1	HD
LOPID (<i>gemfibrozil</i>)	T3	HD
<i>niacin</i>	T1	HD
<i>niacin 500 mg tablet</i>	T1	HD

T1 – Generics

T2 – Preferred Brands

T3 – Non-Preferred Brands

T4 – Preferred Specialty

T5 – Non-Preferred Specialty

PA – Prior Authorization

QL – Quantity Limit

ST – Step Therapy

AGE – Age Requirement

SP – Specialty Medication

HD – 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.)		
NIACOR	T3	HD
TRILIPIX (<i>fenofibric acid (choline)</i>)	T3	ST HD
CNS DRUGS (Alzheimer's Disease)		
ALZHEIMER'S THERAPY, NMDA RECEPTOR ANTAGONISTS		
MEMANTINE 5-10 MG TITRATION PK	T3	HD
<i>memantine hcl</i>	T1	HD
<i>memantine hcl 10 mg/5 ml cup</i>	T1	HD
<i>memantine hcl (Namenda Xr)</i>	T1	HD
<i>memantine hcl 2 mg/ml solution</i>	T1	HD
<i>memantine hcl 5 mg tablet</i>	T1	HD
<i>memantine hcl 10 mg tablet</i>	T1	HD
NAMENDA	T3	HD
NAMENDA XR TITRATION PACK	T3	HD
NAMZARIC	T2	ST HD
ALZHEIMER'S THX,NMDA RECEPTOR ANTAG-CHOLINES INHIB		
<i>memantine hcl</i>	T1	HD
<i>memantine hcl 10 mg/5 ml cup</i>	T1	HD
<i>memantine hcl/donepezil hcl (Namzaric)</i>	T1	ST HD
<i>NAMZARIC (memantine hcl/donepezil hcl)</i>	T2	ST HD
CNS DRUGS (Miscellaneous)		
AMYOTROPHIC LATERAL SCLEROSIS AGENTS		
RADICAVA ORS	T4	PA SP HD
RILUTEK (<i>riluzole</i>)	T5	PA SP HD
<i>riluzole (Rilutek)</i>	T1	PA SP HD
TEGLUTIK	T5	PA SP
TIGLUTIK	T5	PA SP
DRUGS TO TREAT MOVEMENT DISORDERS		
AUSTEDO 6 MG TABLET	T4	PA QL (60 tabs/fill) SP HD
AUSTEDO 9 MG, 12 MG TABLET	T4	PA QL (120 tabs/fill) SP HD
AUSTEDO XR 6 MG TABLET	T4	PA SP HD QL (210 tabs/30 days)
AUSTEDO XR 12 MG TABLET	T4	PA SP HD QL (90 tabs/30 days)
AUSTEDO XR 18 MG TABLET	T4	PA QL (30 tabs/fill) SP HD
AUSTEDO XR 24 MG TABLET	T4	PA SP HD QL (60 tabs/30 days)

T1 – Generics

T2 – Preferred Brands

T3 – Non-Preferred Brands

T4 – Preferred Specialty

T5 – Non-Preferred Specialty

PA – Prior Authorization

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AGE – Age Requirement

SP – Specialty Medication

HD – May require home delivery pharmacy

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List of Prescription Medications

CNS DRUGS (Miscellaneous) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
DRUGS TO TREAT MOVEMENT DISORDERS (cont.)		
AUSTEDO XR 30 MG TABLET	T4	PA QL (30 tabs/fill) SP HD
AUSTEDO XR 36 MG TABLET	T4	PA QL (30 tabs/fill) SP HD
AUSTEDO XR 42 MG, 48 MG TABLET	T4	PA QL (30 tabs/fill) SP HD
AUSTEDO XR TITRATION KT(WK1-4)	T4	PA QL (28 tabs/fill) SP HD
HORIZANT	T3	ST
INGREZZA	T5	PA QL (30 caps/fill) SP
INGREZZA INITIATION PK (TARDIV)	T5	PA QL (28 caps/30 days) SP
INGREZZA SPRINKLE	T5	PA QL (30 caps/fill) SP
tetrabenazine 12.5 mg tablet (Xenazine)	T1	PA QL (120 tabs/fill) SP HD
tetrabenazine 25 mg tablet (Xenazine)	T1	PA QL (60 tabs/fill) SP HD
PSEUDOBULBAR AFFECT (PBA) AGENTS, NMDA ANTAGONISTS		
NUEDEXTA	T2	PA
XANTHINES		
caffeine citrate	T1	HD
CNS DRUGS (Multiple Sclerosis)		
AGENTS TO TREAT MULTIPLE SCLEROSIS		
AVONEX (4 PACK)	T4	PA QL (1 kit/28 days) SP HD
AVONEX PEN (4 PACK)	T4	PA QL (4 pens/28 days) SP HD
BAFIERTAM	T4	PA QL (120 caps/fill) SP HD
BETASERON	T4	PA QL (14 kits/30 days) SP HD
glatiramer 20 mg/ml syringe (Copaxone)	T1	PA QL (30 syringes/30 days) SP HD
glatiramer 40 mg/ml syringe (Copaxone)	T1	PA QL (12 syringes/30 days) SP HD
glatopa 20 mg/ml syringe (Copaxone)	T1	PA QL (30 syringes/30 days) SP HD
glatopa 40 mg/ml syringe (Copaxone)	T1	PA QL (12 syringes/30 days) SP HD
KESIMPTA PEN	T5	PA QL (1 pen/28 days) SP HD
MAVENCLAD 10 MG X 10 TABLET PK	T5	PA QL (10 tabs/fill) SP HD
MAVENCLAD 10 MG X 4 TABLET PK	T5	PA QL (4 tabs/fill) SP HD
MAVENCLAD 10 MG X 5 TABLET PK	T5	PA QL (5 tabs/fill) SP HD
MAVENCLAD 10 MG X 6 TABLET PK	T5	PA QL (6 tabs/fill) SP HD
MAVENCLAD 10 MG X 7 TABLET PK	T5	PA QL (7 tabs/fill) SP HD
MAVENCLAD 10 MG X 8 TABLET PK	T5	PA QL (8 tabs/fill) SP HD
MAVENCLAD 10 MG X 9 TABLET PK	T5	PA QL (9 tabs/fill) SP HD
MAYZENT 0.25 MG TABLET	T4	PA QL (30 tabs/fill) SP HD

T1 – Generics

T2 – Preferred Brands

T3 – Non-Preferred Brands

T4 – Preferred Specialty

T5 – Non-Preferred Specialty

PA – Prior Authorization

QL – Quantity Limit

ST – Step Therapy

AGE – Age Requirement

SP – Specialty Medication

HD – May require home delivery pharmacy

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List of Prescription Medications

CNS DRUGS (Multiple Sclerosis) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
AGENTS TO TREAT MULTIPLE SCLEROSIS (cont.)		
MAYZENT 0.25MG START-1MG MAINT	T4	PA QL (7 tabs/fill) SP HD
MAYZENT 0.25MG START-2MG MAINT	T4	PA QL (12 tabs/fill) SP HD
MAYZENT 1 MG TABLET	T4	PA QL (30 tabs/fill) SP HD
MAYZENT 2 MG TABLET	T4	PA QL (30 tabs/fill) SP HD
PLEGRIDY 125 MCG/0.5 ML PEN	T4	PA QL (1 ml/28 days) SP HD
PLEGRIDY 125 MCG/0.5 ML SYRING	T4	PA QL (1 ml/28 days) SP HD
PLEGRIDY PEN INJ STARTER PACK	T4	PA QL (1 ml/365 days) SP HD
PLEGRIDY SYRINGE STARTER PACK	T4	PA QL (1 ml/365 days) SP HD
REBIF 22 MCG/0.5 ML SYRINGE	T4	PA QL (6 mls/28 days) SP HD
REBIF 44 MCG/0.5 ML SYRINGE	T4	PA QL (6 mls/28 days) SP HD
REBIF REBIDOSE 22 MCG/0.5 ML	T4	PA QL (6 mls/28 days) SP HD
REBIF REBIDOSE 44 MCG/0.5 ML	T4	PA QL (6 mls/28 days) SP HD
REBIF REBIDOSE TITRATION PACK	T4	PA QL (4.2 mls/28 days) SP HD
REBIF TITRATION PACK	T4	PA QL (4.2 mls/28 days) SP HD
VUMERTY	T4	PA QL (120 caps/fill) SP HD
AGTS TX NEUROMUSC TRANSMISSION DIS, POT-CHAN BLKR		
FIRDAPSE	T4	PA SP
RUZURGI	T2	PA
CNS DRUGS (Pain Relief and Inflammatory Disease)		
CALCITONIN GENE-RELATED PEPTIDE (CGRP) INHIBITORS		
EMGALITY 100 MG/ML SYR(1 OF 3)	T2	PA QL (3 mls/30 days)
EMGALITY 300 MG (100 MG X3SYR)	T2	PA QL (3 mls/30 days)
POSTHERPETIC NEURALGIA AGENTS		
gabapentin (Gralise)	T1	ST
GRALISE	T3	ST
GRALISE (gabapentin)	T3	ST
SPHINGOSINE I-PHOSPHATE (SIP) RECEPTOR MODULATOR		
VELSIPITY	T4	PA QL (30 tabs/30 days) SP HD
ZEPOSIA 0.23-0.46 MG START PCK	T4	PA QL (7 caps/fill) SP HD
ZEPOSIA 0.23-0.46-0.92 MG KIT	T4	PA QL (37 caps/fill) SP HD
ZEPOSIA 0.92 MG CAPSULE	T4	PA QL (30 caps/fill) SP HD
ZEPOSIA STARTER KIT (28-DAY)	T4	

T1 – Generics

T2 – Preferred Brands

T3 – Non-Preferred Brands

T4 – Preferred Specialty

T5 – Non-Preferred Specialty

PA – Prior Authorization

QL – Quantity Limit

ST – Step Therapy

AGE – Age Requirement

SP – Specialty Medication

HD – 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)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ANTICONVULSANT - BENZODIAZEPINE TYPE		
clobazam (Onfi)	T1	PA HD
clonazepam	T1	HD
clonazepam (Klonopin)	T1	HD
DIASTAT (diazepam)	T3	HD
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
NAYZILAM	T2	PA QL (2 units/fill) HD
SYMPAZAN	T3	PA HD
VALTOCO	T2	PA QL (2 units/30 days) HD
ANTICONVULSANT - CANNABINOID TYPE		
EPIDIOLEX	T4	PA SP HD
ANTICONVULSANTS		
APTIOM (eslicarbazepine acetate)	T3	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 (Carbatrol)	T1	HD
carbamazepine (Tegretol Xr)	T1	HD
carbamazepine (Tegretol)	T1	HD
CARBATROL (carbamazepine)	T3	HD
CELONTIN (methsuximide)	T3	HD
DEPAKOTE (divalproex sodium)	T3	ST HD
DEPAKOTE ER (divalproex sodium)	T3	ST HD
DEPAKOTE SPRINKLE (divalproex sodium)	T3	ST HD
DIACOMIT	T4	PA SP HD
DILANTIN 100 MG CAPSULE (phenytoin sodium extended)	T3	HD

T1 – Generics

T2 – Preferred Brands

T3 – Non-Preferred Brands

T4 – Preferred Specialty

T5 – Non-Preferred Specialty

PA – Prior Authorization

QL – Quantity Limit

ST – Step Therapy

AGE – Age Requirement

SP – Specialty Medication

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List of Prescription Medications

CNS DRUGS (Seizure Disorders) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ANTICONVULSANTS (cont.)		
DILANTIN 30 MG CAPSULE	T2	HD
DILANTIN 50 MG INFATAB (<i>phenytoin</i>)	T3	HD
DILANTIN-125 (<i>phenytoin</i>)	T3	HD
<i>divalproex sodium</i> (Depakote Er)	T1	HD
<i>divalproex sodium</i> (Depakote Sprinkle)	T1	HD
<i>divalproex sodium</i> (Depakote)	T1	HD
ELEPSIA XR	T3	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>	T1	HD
<i>gabapentin</i> (Neurontin)	T1	HD
<i>gabapentin</i> (Neurontin)	T1	HD
<i>lacosamide</i> (Vimpat)	T1	HD
LAMICTAL XR (BLUE)	T3	ST HD
LAMICTAL XR (GREEN)	T3	ST HD
LAMICTAL XR (ORANGE)	T3	ST HD
<i>lamotrigine</i> (Lamictal (Blue))	T1	HD
<i>lamotrigine</i> (Lamictal (Green))	T1	HD
<i>lamotrigine</i> (Lamictal (Orange))	T1	HD
<i>lamotrigine</i> (Lamictal Odt (Blue))	T1	HD
<i>lamotrigine</i> (Lamictal Odt (Green))	T1	HD
<i>lamotrigine</i> (Lamictal Odt (Orange))	T1	HD
<i>lamotrigine</i> (Lamictal Odt)	T1	HD
<i>lamotrigine</i> (Lamictal Xr)	T1	HD
<i>lamotrigine</i> (Lamictal)	T1	HD
<i>lamotrigine</i> (Lamictal)	T1	HD
<i>levetiracetam</i> 1,000 mg tablet (Keppra)	T1	HD
<i>levetiracetam</i> 1,000mg/10ml cup (Keppra)	T1	HD
<i>levetiracetam</i> 100 mg/ml soln (Keppra)	T1	HD
<i>levetiracetam</i> 250 mg tablet (Keppra)	T1	HD

T1 – Generics

T2 – Preferred Brands

T3 – Non-Preferred Brands

T4 – Preferred Specialty

T5 – Non-Preferred Specialty

PA – Prior Authorization

QL – Quantity Limit

ST – Step Therapy

AGE – Age Requirement

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List of Prescription Medications

CNS DRUGS (Seizure Disorders) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ANTICONVULSANTS (cont.)		
levetiracetam 500 mg tablet (Keppra)	T1	HD
levetiracetam 500 mg/5 ml cup	T1	HD
levetiracetam 500 mg/5 ml soln	T1	HD
levetiracetam 750 mg tablet (Keppra)	T1	HD
LEVETIRACETAM 250 MG TAB SUSP	T3	ST HD
levetiracetam (Keppra Xr)	T1	HD
levetiracetam (Keppra)	T1	HD
MY SOLINE (primidone)	T3	HD
oxcarbazepine (Oxtellar Xr)	T1	HD
oxcarbazepine (Trileptal)	T1	HD
OXTELLAR XR (oxcarbazepine)	T3	ST HD
perampanel (Fycompa)	T1	HD
PHENYTEK (phenytoin sodium extended)	T3	HD
phenytoin	T1	HD
phenytoin (Dilantin)	T1	HD
phenytoin (Dilantin-125)	T1	HD
phenytoin sodium extended (Dilantin)	T1	HD
phenytoin sodium extended (Phenytek)	T1	HD
pregabalin (Lyrica)	T1	HD
primidone (Mysoline)	T1	HD
QUDEXY XR (topiramate)	T3	ST HD
rufinamide (Banzel)	T1	PA HD
SPRITAM	T3	ST HD
TEGRETOL (carbamazepine)	T3	HD
TEGRETOL XR (carbamazepine)	T3	HD
tiagabine hcl	T1	HD
topiramate (Qudexy Xr)	T1	ST HD
topiramate (Topamax)	T1	HD
topiramate (Topamax)	T1	HD
topiramate er 25mg (Trokendi XR)	T1	ST HD
topiramate er 50mg (Trokendi XR)	T1	ST HD
topiramate 100 mg tablet (Topamax)	T1	HD
topiramate 15 mg sprinkle cap (Topamax)	T1	HD
topiramate 200 mg tablet (Topamax)	T1	HD

T1 – Generics

T2 – Preferred Brands

T3 – Non-Preferred Brands

T4 – Preferred Specialty

T5 – Non-Preferred Specialty

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List of Prescription Medications

CNS DRUGS (Seizure Disorders) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ANTICONVULSANTS (cont.)		
topiramate 25 mg sprinkle cap (Topamax)	T1	HD
topiramate 25 mg tablet (Topamax)	T1	HD
topiramate 50 mg tablet (Topamax)	T1	HD
topiramate er 100mg	T1	ST HD
TROKENDI XR	T3	ST HD
valproic acid	T1	HD
valproic acid (as sodium salt)	T1	HD
vigabatrin (Sabril)	T1	PA QL (150 packs/30 days) SP HD
VIGADRON	T1	PA QL (150 pkts/30 days) SP HD
XCOPRI 250 MG DAILY DOSE PACK	T3	QL (56 tabs/fill) HD
XCOPRI 350 MG DAILY DOSE PACK	T3	QL (56 tabs/fill) HD
XCOPRI 25 MG, 50 MG TABLET	T3	QL (30 tabs/fill) HD
XCOPRI 100 MG, 150 MG TABLET	T3	QL (30 tabs/fill) HD
XCOPRI 200 MG TABLET	T3	QL (30 tabs/fill) HD
XCOPRI 12.5-25 MG TITRATION PK	T3	QL (28 tabs/fill) HD
XCOPRI 50-100 MG TITRATION PAK	T3	QL (28 tabs/fill) HD
XCOPRI 150-200 MG TITRATION PK	T3	QL (28 tabs/fill) HD
ZARONTIN (ethosuximide)	T3	HD
zonisamide	T1	HD
zonisamide (Zonegran)	T1	HD
CNS DRUGS (Sleep Disorders/Sedatives)		
NARCOLEPSY TX-H3-RECEPT.ANTAGONIST/INVERSE AGONIST		
WAKIX 17.8 MG TABLET	T5	PA QL (60 tabs/fill) SP HD
WAKIX 4.45 MG TABLET	T5	PA QL (30 tabs/fill) SP HD
COLONY STIMULATING FACTORS (Blood Modifiers/Bleeding Disorders)		
LEUKOCYTE (WBC) STIMULANTS		
FULPHILA	T4	PA QL (1.2 mls/30 days) SP
LEUKINE	T4	PA SP
NIVESTYM	T4	PA SP HD
THROMBOPOIETIN RECEPTOR AGONISTS		
DOPTELET	T4	PA QL (15 tabs/fill) SP HD
eltrombopag olamine (Promacta)	T1	PA SP HD
PROMACTA (eltrombopag olamine)	T4	PA SP HD

T1 – Generics

T2 – Preferred Brands

T3 – Non-Preferred Brands

T4 – Preferred Specialty

T5 – Non-Preferred Specialty

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List of Prescription Medications

COLONY STIMULATING FACTORS (Cancer)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
CXCR4 CHEMOKINE RECEPTOR ANTAGONIST		
XOLREMDI	T5	PA SP CSL
CONTRACEPTIVES (Contraception Products)		
CONTRACEPTIVES, INTRAVAGINAL, SYSTEMIC		
ANNOVERA	T3	ST QL (1 ring/365 days) PPACA
etongestrel/ethinyl estradiol (Nuvaring)	T1	PPACA
CONTRACEPTIVES, INJECTABLE		
DEPO-PROVERA (<i>medroxyprogesterone acetate</i>)	T3	QL (1 ml/90 days) PPACA
DEPO-SUBQ PROVERA 104	T3	QL (1 ml/90 days) PPACA
<i>medroxyprogesterone 150 mg/ml</i> (Depo-Provera)	T1	QL (1 ml/90 days) PPACA
CONTRACEPTIVES, ORAL		
BEYAZ (<i>drosipir/eth estra/levomefol ca</i>)	T3	ST HD PPACA
<i>desog-e.estriadiol/e.estriadiol</i>	T1	HD PPACA
<i>desog-e.estriadiol/e.estriadiol</i>	T1	PPACA
<i>desogestrel-ethinyl estradiol</i>	T1	HD PPACA
<i>drosipir/eth estra/levomefol ca</i> (Beyaz)	T1	HD PPACA
<i>drosipir/eth estra/levomefol ca</i> (Safyral)	T1	HD PPACA
ELLA	T2	QL (1 tab/fill) HD PPACA
<i>ethinyl estradiol/dospirenone</i> (Yasmin 28)	T1	PPACA
<i>ethinyl estradiol/dospirenone</i> (Yaz)	T1	HD PPACA
<i>ethynodiol d-ethinyl estradiol</i>	T1	HD PPACA
<i>levonorgestrel/ethin.estriadiol</i>	T1	HD PPACA
<i>I-norgest/e.estriadiol-e.estrad</i>	T1	HD PPACA
<i>noreth-ethinyl estradiol/iron</i>	T1	HD PPACA
<i>noreth-ethinyl estradiol/iron</i> (Generess Fe)	T1	HD PPACA
<i>norethind-eth estrad 1-0.02 mg</i> (Loestrin)	T1	HD PPACA
<i>norethindrone</i>	T1	HD PPACA
<i>norethindrone ac/eth estradiol</i> (Loestrin)	T1	HD PPACA
<i>norelgestromin/ethin.estriadiol</i>	T1	PPACA
<i>norethindrone-e.estriadiol-iron</i>	T1	HD PPACA
<i>norethindrone-e.estriadiol-iron</i> (Loestrin Fe)	T1	HD PPACA
<i>norethindrone-e.estriadiol-iron</i> (Taytulla)	T1	HD PPACA
<i>norethindrone-ethin. estradiol</i>	T1	HD PPACA
<i>norethin-ee 1.5-0.03 mg(21) tb</i> (Loestrin)	T1	HD PPACA
<i>norgestimate-ethinyl estradiol</i>	T1	HD PPACA

T1 – Generics

T2 – Preferred Brands

T3 – Non-Preferred Brands

T4 – Preferred Specialty

T5 – Non-Preferred Specialty

PA – Prior Authorization

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List of Prescription Medications

CONTRACECTIVES (Contraception Products) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
CONTRACECTIVES, ORAL (cont.)		
NORGESTREL-ETHINYL ESTRADIOL	T1	HD PPACA
YAZ (ethinyl estradiol/drospirenone)	T3	ST HD PPACA
CONTRACECTIVES, TRANSDERMAL		
norelgestromin/ethinestradiol	T1	HD PPACA
INTRA-UTERINE DEVICES (IUDS)		
KYLEENA	T4	SP PPACA
LILETTA	T5	SP PPACA
MIRENA	T4	SP PPACA
SKYLA	T4	SP PPACA
COUGH/COLD PREPARATIONS (Allergy/Nasal Sprays)		
1ST GEN ANTIHIST-DECONGEST-ANTICHOLINERGIC COMB		
RESPA A.R. (pseudoephed/chlor-mal/bell alk)	T3	
COUGH/COLD PREPARATIONS (Cough/Cold Medications)		
ANTITUSSIVES, NON-OPIOID		
benzonatate	T1	
DECONGESTANT-EXPECTORANT COMBINATIONS		
guaifenesin/phenylephrine hcl	T1	
NON-OPIOID ANTITUS-1ST GEN.ANTIHISTAMINE-DECONGEST		
BROMFED DM (brompheniramine/pseudoephed/dm)	T3	
brompheniramine/pseudoephed/dm (Bromfed Dm)	T1	
NON-OPIOID ANTITUSSIVE-1ST GEN ANTIHISTAMINE COMB.		
promethazine/dextromethorphan	T1	
OPIOID ANTITUSSIV-1ST GEN. ANTIHISTAMINE-DECONGEST		
CAPCOF	T3	
HISTEX-AC	T3	
MAXI-TUSS CD	T3	
POLY-TUSSIN AC	T3	
promethazine/phenyleph/codeine	T1	
ZODRYL DAC 25	T3	
ZODRYL DAC 30	T3	
ZODRYL DAC 35	T3	
ZODRYL DAC 40	T3	
ZODRYL DAC 50	T3	

T1 – Generics

T2 – Preferred Brands

T3 – Non-Preferred Brands

T4 – Preferred Specialty

T5 – Non-Preferred Specialty

PA – Prior Authorization

QL – Quantity Limit

ST – Step Therapy

AGE – Age Requirement

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PPACA – No Cost-Share Preventive Medication

CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

COUGH/COLD PREPARATIONS (Cough/Cold Medications) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
OPIOID ANTITUSSIV-IST GEN. ANTIHISTAMINE-DECONGEST (cont.)		
ZODRYL DAC 60	T3	
ZODRYL DAC 80	T3	
OPIOID ANTITUSSIVE-IST GENERATION ANTIHISTAMINE		
hydrocodone/chlorphen p-stirex	T1	
promethazine hcl/codeine	T1	
TUSSICAPS	T3	PA
UXARIN ER	T3	
TUZISTRA XR	T3	PA
ZODRYL AC 25	T3	
ZODRYL AC 30	T3	
ZODRYL AC 35	T3	
ZODRYL AC 40	T3	
ZODRYL AC 50	T3	
ZODRYL AC 60	T3	
ZODRYL AC 80	T3	
OPIOID ANTITUSSIVE-ANTICHOLINERGIC COMBINATIONS		
HYCODAN	T3	
HYCODAN (hydrocodone bit/homatrop me-br)	T3	
OPIOID ANTITUSSIVE-ANTICHOLINERGIC COMBINATIONS		
hydrocodone bit/homatrop me-br	T1	
hydrocodone bit/homatrop me-br (Hycodan)	T1	
OPIOID ANTITUSSIVE-DECONGESTANT-EXPECTORANT COMB		
CODITUSSIN DAC	T3	
pseudoephed/codeine/guaififen	T1	
ZODRYL DEC 25	T3	
ZODRYL DEC 30	T3	
ZODRYL DEC 35	T3	
ZODRYL DEC 40	T3	
ZODRYL DEC 50	T3	
ZODRYL DEC 60	T3	
ZODRYL DEC 80	T3	
OPIOID ANTITUSSIVE-EXPECTORANT COMBINATION		
codeine phosphate/guaifenesin	T1	
CODITUSSIN AC	T3	

T1 – Generics

T2 – Preferred Brands

T3 – Non-Preferred Brands

T4 – Preferred Specialty

T5 – Non-Preferred Specialty

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List of Prescription Medications

COUGH/COLD PREPARATIONS (Cough/Cold Medications) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
OPIOID ANTITUSSIVE-EXPECTORANT COMBINATION (cont.)		
GUAIFEN-CODEINE 100-10 MG/5 ML	T3	
guaiifен-codeine 100-10 mg/5 ml	T1	
GUAIFEN-CODEINE 200-20 MG/10ML	T3	
MAR-COF CG	T3	
NINJACOF-XG	T3	
OBREDON	T3	PA
DIAGNOSTIC (Diabetes)		
BLOOD SUGAR DIAGNOSTICS		
FREESTYLE INSULINX	T2	
FREESTYLE INSULINX TEST STRIPS	T2	
FREESTYLE LITE TEST STRIP	T2	
FREESTYLE PRECISION NEO	T2	
FREESTYLE TEST STRIPS	T2	
ONETOUCH ULTRA TEST STRIP	T2	
ONETOUCH VERO TEST STRIP	T2	
PRECISION XTRA	T2	
URINE GLUCOSE TEST AIDS		
DIASTIX REAGENT	T2	
DIAGNOSTIC (Miscellaneous)		
BLOOD TESTING PREPARATIONS		
FORA GTEL KETONE TEST STRIP	T3	
GOJJI BLOOD KETONE TEST STRIP	T3	
NOVAMAX PLUS	T2	
PRECISION XTRA	T2	
CARDIOVASCULAR DIAGNOSTICS-RADIOPAQUE		
OMNIPAQ	T3	
DIAGNOSTIC PREPARATIONS, MISCELLANEOUS		
ARIDOL	T3	
METHACHOLINE CHLORIDE	T3	
PROVOCHOLINE	T3	
TC 99M SULFUR COLLOID PREP	T3	
TOXICOLOGY SALIVA COLLECTION	T3	
VUEBLU	T3	

T1 – Generics

T2 – Preferred Brands

T3 – Non-Preferred Brands

T4 – Preferred Specialty

T5 – Non-Preferred Specialty

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List of Prescription Medications

DIAGNOSTIC (Miscellaneous) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
EYE DIAGNOSTIC AGENTS		
fluorescein sodium	T1	
ful-glo 1 mg oph strip	T1	
FUL-GLO EYE STRIPS	T3	
FLUORESCENCE IMAGING AGENTS - MALIGNANT TISSUE		
GLEOLAN	T3	
GASTROINTESTINAL RADIOPAQUE DIAGNOSTICS		
<i>diatrizoate meglumine, sodium (Gastrografin)</i>	T1	
ENTERO VU	T3	
E-Z DISK	T3	
E-Z-HD	T3	
E-Z-PAQUE	T3	
E-Z-PASTE	T3	
GASTROGRAFIN (<i>diatrizoate meglumine, sodium</i>)	T3	
GASTROMARK	T3	
LIQUID E-Z PAQUE	T3	
LIQUID POLIBAR PLUS	T3	
NEULUMEX	T3	
POLIBAR ACB	T3	
READI-CAT 2	T3	
SITZMARKS	T3	
SITZMARKS FOR KIDS	T3	
TAGITOL	T3	
VANILLA SILQ	T3	
VARIBAR HONEY	T3	
VARIBAR NECTAR	T3	
VARIBAR PUDDING	T3	
VARIBAR THIN HONEY	T3	
VARIBAR THIN LIQUID	T3	
VOLUMEN	T3	
METABOLIC FUNCTION DIAGNOSTICS		
METOPIRONE	T3	
RADIOACTIVE DIAGNOSTICS, GENERAL		
XENON XE-133	T3	

T1 – Generics

T2 – Preferred Brands

T3 – Non-Preferred Brands

T4 – Preferred Specialty

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List of Prescription Medications

DIAGNOSTIC (Miscellaneous) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
RADIOACTIVE METABOLIC FUNCTION DIAGNOSTICS		
SODIUM IODIDE I-123	T3	
RADIOPHARMACEUTICALS ELEMENTS		
INDICLOR	T3	
URINARY TRACT RADIOPAQUE DIAGNOSTICS		
CYSTO-CONRAY II	T3	
CYSTOGRAFIN	T3	
CYSTOGRAFIN-DILUTE	T3	
KETONE CARE TEST STRIP	T2	
KETONE TEST STRIP	T2	
KETOSTIX REAGENT	T2	
TRUEPLUS KETONE TEST STRIP	T2	
URINE GLUCOSE/ACETONE TEST AIDS,STRIPS		
KETO-DIASTIX REAGENT	T2	
URINE MULTIPLE TEST AIDS		
CHEK-STIX	T2	
CHEMSTRIP	T2	
CHEMSTRIP 10 WITH SG	T2	
CHEMSTRIP 2 GP	T2	
CHEMSTRIP 50B	T2	
CHEMSTRIP 7,9	T2	
COMBISTIX REAGENT	T2	
HEMA-COMBISTIX	T2	
KETO-DIASTIX REAGENT	T2	
LABSTIX REAGENT	T2	
MULTISTIX	T2	
MULTISTIX 10 SG	T2	
MULTISTIX 5,7	T2	
MULTISTIX 8 SG	T2	
MULTISTIX 9	T2	
MULTISTIX 9 SG	T2	
URISTIX 4	T2	
URISTIX REAGENT	T2	

T1 – Generics

T2 – Preferred Brands

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List of Prescription Medications

DIURETICS (Diuretics)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ARGININE VASOPRESSIN (AVP) RECEPTOR ANTAGONISTS		
tolvaptan 15 mg tablet (Samsca)	T1	PA QL (30 tabs/fill) SP
tolvaptan 30 mg tablet (Samsca)	T1	PA QL (60 tabs/fill) SP
CARBONIC ANHYDRASE INHIBITORS		
acetazolamide	T1	HD
methazolamide	T1	HD
LOOP DIURETICS		
bumetanide	T1	HD
EDECRIN (ethacrynic acid)	T3	ST
ethacrynic acid (Edecrin)	T1	
furosemide	T1	HD
POLYCYSTIC KIDNEY DISEASE AGENT, AVP RECEP. ANTAG		
furosemide (Lasix)	T1	HD
LASIX (furosemide)	T3	ST HD
torsemide	T1	HD
JYNARQUE 15 MG TABLET (tolvaptan)	T5	PA SP HD
JYNARQUE 15 MG-15 MG TABLET (tolvaptan)	T5	PA SP HD
JYNARQUE 30 MG TABLET (tolvaptan)	T5	PA SP HD
JYNARQUE 30 MG-15 MG TABLET (tolvaptan)	T5	PA SP HD
JYNARQUE 45 MG-15 MG TABLET (tolvaptan)	T5	PA SP HD
JYNARQUE 60 MG-30 MG TABLET (tolvaptan)	T5	PA SP HD
JYNARQUE 90 MG-30 MG TABLET (tolvaptan)	T5	PA SP HD
tolvaptan 15 mg tablet (Jynarque)	T1	PA SP HD
tolvaptan 15 mg-15 mg tablet (Jynarque)	T1	PA SP HD
tolvaptan 30 mg tablet (Jynarque)	T1	PA SP HD
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
POTASSIUM SPARING DIURETICS		
ALDACTONE (spironolactone)	T3	HD
amiloride hcl	T1	HD
DYRENIUM (triamterene)	T3	HD
eplerenone (Inspra)	T1	HD
INSPRA (eplerenone)	T3	HD

T1 – Generics

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T3 – Non-Preferred Brands

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List of Prescription Medications

DIURETICS (Diuretics) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
POTASSIUM SPARING DIURETICS (cont.)		
KERENDIA	T2	PA QL (30 tabs/30 days)
spironolactone 100 mg tablet (Aldactone)	T1	HD
spironolactone 25 mg tablet (Aldactone)	T1	HD
spironolactone 25 mg/5 ml susp (Carospir)	T1	
spironolactone 50 mg tablet (Aldactone)	T1	HD
triamterene (Dyrenium)	T1	HD
POTASSIUM SPARING DIURETICS IN COMBINATION		
amiloride/hydrochlorothiazide	T1	HD
DYAZIDE (triamterene/hydrochlorothiazid)	T3	HD
spironolact/hydrochlorothiazid	T1	HD
triamterene/hydrochlorothiazid (Dyazide)	T1	HD
THIAZIDE AND RELATED DIURETICS		
chlorthalidone	T1	HD
DIURIL	T3	HD
hydrochlorothiazide	T1	HD
indapamide	T1	HD
metolazone	T1	HD
EENT PREPS (Allergy/Nasal Sprays)		
NASAL ANTIHISTAMINE		
azelastine 0.1% (137 mcg) spry	T1	QL (60 mls/fill) HD
azelastine 0.15% nasal spray	T1	HD
olopatadine hcl (Patanase)	T1	QL (31 gms/fill) HD
PATANASE (olopatadine hcl)	T3	QL (31 gms/fill) HD
NASAL ANTIHISTAMINE AND ANTI-INFLAM. STEROID COMB.		
azelastine/fluticasone (Dymista)	T1	ST QL (23 gms/fill) HD
RYALTRIS	T3	ST QL (1 bottle/fill) HD
NASAL ANTI-INFLAMMATORY STEROIDS		
flunisolide	T1	ST QL (50 mls/fill) HD
fluticasone prop 50 mcg spray	T1	QL (16 gms/fill) HD
mometasone furoate 50 mcg spry (Nasonex)	T1	ST QL (17 gms/fill) HD
XHANCE	T2	ST QL (32 mls/30 days) HD
NOSE PREPARATIONS, MISCELLANEOUS (RX)		
COCAINE HCL	T3	
GOPRELTO	T3	

T1 – Generics

T2 – Preferred Brands

T3 – Non-Preferred Brands

T4 – Preferred Specialty

T5 – Non-Preferred Specialty

PA – Prior Authorization

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List of Prescription Medications

EENT PREPS (Allergy/Nasal Sprays) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
NOSE PREPARATIONS, MISCELLANEOUS (RX)		
ipratropium 0.03% spray	T1	QL (30 mls/fill) HD
ipratropium 0.06% spray	T1	QL (30 mls/fill) HD
NUMBRINO	T3	HD
NOSE PREPARATIONS, VASOCONSTRICATORS (RX)		
ADRENALIN CHLORIDE	T3	
epinephrine hcl	T1	
EENT PREPS (Ear Medications)		
EAR PREPARATIONS ANTI-INFLAMMATORY		
DERMOTIC (<i>fluocinolone acetonide oil</i>)	T3	
<i>fluocinolone acetonide oil</i> (Dermotic)	T1	
EAR PREPARATIONS, MISC. ANTI-INFECTIVES		
acetic acid	T1	
CORTANE-B (<i>hydrocort/pramoxine/chloroxyd</i>)	T3	
<i>hydrocortisone/acetic acid</i>	T1	
EENT PREPS (Eye Conditions)		
AGENTS FOR CORNEAL COLLAGEN CROSS-LINKING		
PHOTREXA CROSS-LINKING	T3	
PHOTREXA VISCOSU	T3	
ARTIFICIAL TEARS		
KLARITY (CHONDROITIN)	T3	
LACRISERT	T3	PA QL (60 inserts/fill)
MIEBO	T2	PA QL (3 mls/fill)
EYE ANTI-INFECTIVES (RX ONLY)		
BETADINE	T3	
<i>povidone-iodine</i>	T1	
EYE ANTI-INFLAMMATORY AGENTS		
ACULAR (<i>ketorolac tromethamine</i>)	T3	ST
ACULAR LS (<i>ketorolac tromethamine</i>)	T3	ST
<i>bromfenac sodium</i>	T1	
<i>bromfenac sodium</i> (Bromsite)	T1	
<i>bromfenac sodium</i> (Prolensa)	T1	
<i>dexamethasone sodium phosphate</i>	T1	
DEXTENZA	T3	

T1 – Generics

T2 – Preferred Brands

T3 – Non-Preferred Brands

T4 – Preferred Specialty

T5 – Non-Preferred Specialty

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List of Prescription Medications

EENT PREPS (Eye Conditions) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
EYE ANTI-INFLAMMATORY AGENTS (cont.)		
diclofenac 0.1% eye drops	T1	
dilflurprednate (Durezol)	T1	
EYSUVIS	T2	PA QL (8.3 mls/30 days)
fluorometholone (Fml)	T1	
flurbiprofen sodium	T1	
FML (fluorometholone)	T3	ST
ILEVRO	T3	
INVELTYS	T3	ST
ketorolac 0.4% ophth solution (Acular Ls)	T1	
ketorolac 0.5% ophth solution (Acular)	T1	
KLARITY-B(BETAMETHASONE-CHOND)	T3	
KLARITY-L (LOTEPREDNOL-CHONDR)	T3	
LOTEMAX 0.5% EYE DROPS (<i>loteprednol etabonate</i>)	T3	
LOTEMAX 0.5% EYE OINTMENT	T3	ST
LOTEMAX 0.5% OPHTHALMIC GEL (<i>loteprednol etabonate</i>)	T3	ST
LOTEMAX SM	T3	ST
<i>loteprednol etabonate</i> (Alrex)	T1	PA SP HD
<i>loteprednol etabonate</i> (Lotemax)	T1	PA SP HD
PRED FORTE (<i>prednisolone acetate</i>)	T3	
<i>prednisolone ac</i> 1% eye drop (Pred Forte)	T1	
PREDNISOLONE ACET 1% EYE DROP	T3	
<i>prednisolone sod ph/bromfenac</i>	T1	
<i>prednisolone sodium phosphate</i>	T1	
PREDNISOLONE-BROMFENAC	T3	
PREDNISOLONE-NEPAFENAC	T3	
PROLENZA (<i>bromfenac sodium</i>)	T3	ST
EYE LOCAL ANESTHETICS		
AKTEN	T3	
ALCAINE (<i>proparacaine hcl</i>)	T3	
ALTAFLUOR BENOX (<i>benoxinate hcl/fluorescein sod</i>)	T3	
FLUORESCIN-BENOXINATE	T3	
<i>proparacaine hcl</i> (Alcaine)	T1	
<i>proparacaine/fluorescein sod</i>	T1	
<i>tetracaine</i> 0.5% eye drop	T1	

T1 – Generics

T2 – Preferred Brands

T3 – Non-Preferred Brands

T4 – Preferred Specialty

T5 – Non-Preferred Specialty

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List of Prescription Medications

EENT PREPS (Eye Conditions) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
EYE LOCAL ANESTHETICS (cont.)		
TETRACAIN 0.5% STERI-UNIT SOL	T3	
<i>tetracaine hcl</i>	T1	
TETRAVISC	T3	
TETRAVISC FORTE	T3	
EYE MAST CELL STABILIZERS		
ALOCRIL	T3	ST
<i>cromolyn 4% eye drops</i>	T1	
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	T3	ST HD
ALPHAGAN P (<i>brimonidine tartrate</i>)	T3	ST HD
<i>apraclonidine hcl</i>	T1	HD
betaxolol hcl	T1	HD
BETOPTIC S	T3	HD
<i>bimatoprost</i>	T1	PA HD
<i>brimonidine tartrate</i>	T1	HD
<i>brimonidine tartrate</i> (Alphagan P)	T1	HD
<i>brimonidine tartrate/timolol</i> (Combigan)	T1	HD
BRIMONIDINE 0.1%-DORZOLAM 2%	T3	
BRIMONIDINE 0.15%-DORZOLAM 2%	T3	HD
BRIMONIDINE-DORZOLAMIDE	T3	HD
<i>brinzolamide</i> (Azopt)	T1	HD
<i>carteolol hcl</i>	T1	HD
COMBIGAN (<i>brimonidine tartrate/timolol</i>)	T3	ST HD
DORZOLAMIDE	T3	HD
<i>dorzolamide hcl</i>	T1	HD
<i>dorzolamide hcl/timolol maleat</i> (Cosopt)	T1	HD
<i>dorzolamide/timolol/pf</i> (Cosopt Pf)	T1	HD
IOPIDINE	T3	ST HD

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List of Prescription Medications

EENT PREPS (Eye Conditions) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
MIOTICS AND OTHER INTRAOCULAR PRESSURE REDUCERS (cont.)		
IISOPTO CARPINE (<i>pilocarpine hcl</i>)	T3	HD
LATANOPROST 0.005% EYE DROP	T3	HD
<i>latanoprost 0.005% eye drops</i> (Xalatan)	T1	PA HD
<i>levobunolol hcl</i>	T1	HD
PHOSPHOLINE IODIDE	T4	SP HD
<i>pilocarpine hcl</i>	T1	HD
<i>pilocarpine hcl</i> (Isopto Carpine)	T1	HD
RHOPRESSA	T3	
ROCKLATAN	T3	PA
SIMBRINZA	T3	HD
<i>timolol</i> (Betimol)	T1	ST HD
<i>timolol 0.5% eye drop</i> (Istalol)	T1	ST HD
<i>timolol maleate 0.25% eye drop</i>	T1	ST HD
<i>timolol maleate 0.25% eye drop</i> (Timoptic)	T1	HD
<i>timolol maleate 0.5% eye drop</i> (Timoptic Ocudose)	T1	ST HD
<i>timolol maleate 0.5% eye drops</i> (Timoptic)	T1	HD
<i>timolol 0.25% gel-solution</i> (Timoptic-Xe)	T1	ST HD
<i>timolol 0.5% gel-solution</i> (Timoptic-Xe)	T1	ST HD
<i>timolol 0.5% gfs gel-solution</i> (Timoptic-Xe)	T1	ST HD
TIMOLOL-BRIMONIDIN-DORZOLAMIDE	T3	HD
TIMOLOL-BRIMONI-DORZOL-BIMATOP	T3	HD
TIMOLOL-BRIMONI-DORZOL-LATANOP	T3	HD
TIMOLOL-DORZOLAMIDE	T3	HD
TIMOLOL-DORZOLAMIDE-BIMATOPRST	T3	HD
TIMOLOL-DORZOLAMIDE-LATANOPRST	T3	HD
TIMOLOL-LATANOPROST	T3	HD
TIMOPTIC (<i>timolol maleate</i>)	T3	ST HD
TIMOPTIC-XE (<i>timolol maleate</i>)	T3	ST HD
<i>travoprost</i> (Travatan Z)	T1	PA HD
MYDRIATICS		
<i>atropine 1% eye drop</i>	T1	PA SP HD
<i>atropine sulfate 0.01% eye drp</i>	T1	PA SP HD
<i>atropine 1% eye drops, ointment</i>	T1	HD
ATROPINE SULF 0.025% EYE DROP	T3	HD

T1 – Generics

T2 – Preferred Brands

T3 – Non-Preferred Brands

T4 – Preferred Specialty

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ST – Step Therapy

AGE – Age Requirement

SP – Specialty Medication

HD – May require home delivery pharmacy

PPACA – No Cost-Share Preventive Medication

CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

EENT PREPS (Eye Conditions) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
MYDRIATICS (cont.)		
ATROPINE SULFATE 0.05% EYE DRP	T3	HD
ATROPINE SULFATE-0.9% NACL	T3	HD
CYCLOGYL	T3	HD
CYCLOGYL (cyclopentolate hcl)	T3	HD
CYCLOMYDRIL	T3	HD
cyclopentolat/tropic/phenyleph	T1	HD
cyclopentolate hcl (Cyclogyl)	T1	HD
CYCLOPENTOLATE-TROPICAMIDE-PE	T3	HD
homatropine hbr	T1	HD
MYDCOMBI	T3	HD
MYDRIACYL (tropicamide)	T3	HD
PAREMYD	T3	HD
tropicamide	T1	HD
tropicamide (Mydriacyl)	T1	HD
TROPICAMIDE-CYCLOPENTOLATE-PE	T3	HD
TROPICAMIDE-CYCLOPENT-PE-KTRLC	T3	
tropicamide 1%-phenylephr 2.5%	T1	
TROPICAMIDE 1%-PHENYLEPHR 2.5%	T3	
TROPIC-CYCLOPENT-PE-KTRLC-PROP	T3	HD
OPHTH. VEGF-A RECEPTOR ANTAG. RCMB MC ANTIBODY		
LUCENTIS	T5	PA SP
OPHTHALMIC ANTIFIBROTIC AGENTS		
MITOMYCIN	T3	
MITOMYCIN-WATER	T3	
MITOSOL	T3	
OPHTHALMIC ANTI-INFLAMMATORY IMMUNOMODULATOR-TYPE		
CEQUA	T3	PA QL (60 vls/30 days)
cyclosporine 0.05% eye emuls (Restasis)	T1	PA QL (60 vials/fill) HD
CYCLOSPORINE IN KLARITY	T3	HD
RESTASIS (cyclosporine)	T3	PA QL (60 vials/fill) HD
RESTASIS MULTIDOSE	T2	PA QL (6 mls/fill) HD
XIIDRA	T2	PA QL (60 vls/fill) HD
VEVYE	T3	PA QL (2 mls/fill) HD

T1 – Generics

T2 – Preferred Brands

T3 – Non-Preferred Brands

T4 – Preferred Specialty

T5 – Non-Preferred Specialty

PA – Prior Authorization

QL – Quantity Limit

ST – Step Therapy

AGE – Age Requirement

SP – Specialty Medication

HD – May require home delivery pharmacy

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List of Prescription Medications

EENT PREPS (Eye Conditions) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
OPHTHALMIC CYSTINE DEPLETING AGENTS		
CYSTARAN	T4	PA SP
OPHTHALMIC HUMAN NERVE GROWTH FACTOR (HNGF)		
OXERVATE	T4	PA SP HD
OPHTHALMIC PREPARATIONS, MISCELLANEOUS		
HEALON GV	T3	
ELECT/CALORIC/H2O (Cholesterol Medications)		
ORAL LIPID SUPPLEMENTS		
DOJOLVI	T5	PA SP HD
ELECT/CALORIC/H2O (Dental Products)		
FLUORIDE PREPARATIONS		
CLINPRO 5000	T3	
FLORIVA	T3	
fluoride (sodium)	T1	
fluoride (sodium) (Prevident 5000 Plus)	T1	
fluoride (sodium) (Prevident)	T1	
FLUORIDEX	T3	
FLUORIDEX SENSITIVITY RELIEF	T3	
FRAICHE 5000 PREVI	T3	
JUSTRIGHT 5000	T3	
PREVIDENT	T3	
PREVIDENT (fluoride (sodium))	T3	
PREVIDENT KIDS	T3	
PREVIDENT 5000 DRY MOUTH	T3	
PREVIDENT 5000 ENAMEL PROTECT	T3	
PREVIDENT 5000 ORTHO DEFENSE	T3	
PREVIDENT 5000 PLUS (fluoride (sodium))	T3	
PREVIDENT 5000 SENSITIVE	T3	
sodium fluoride 0.2% rinse (Prevident)	T1	
sodium fluoride 1.1% cream (Prevident 5000 Plus)	T1	
sodium fluoride 1.1% gel (Prevident)	T1	
sodium fluoride 5000 ppm cream (Prevident 5000 Plus)	T1	
sodium fluoride 5000 ppm paste	T1	
sodium fluoride/potassium nit	T1	

T1 – Generics

T2 – Preferred Brands

T3 – Non-Preferred Brands

T4 – Preferred Specialty

T5 – Non-Preferred Specialty

PA – Prior Authorization

QL – Quantity Limit

ST – Step Therapy

AGE – Age Requirement

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List of Prescription Medications

ELECT/CALORIC/H2O (Dental Products) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
PEDIATRIC VITAMIN PREPARATIONS		
fluoride (sodium)	T1	PPACA
FLURA-DROPS	T3	
sodium fluoride 0.25 (0.55) mg	T1	PPACA
sodium fluoride 0.5 mg(1.1 mg)	T1	PPACA
sodium fluoride 0.5 mg/ml drop	T1	PPACA
sodium fluoride 1 mg (2.2 mg)	T1	PPACA
ELECT/CALORIC/H2O (Diabetes)		
AGENTS TO TREAT HYPOGLYCEMIA (HYPERGLYCEMICS)		
cvs glucose 4 gram tablet chew (Trueplus Glucose)	T1	
CVS GLUCOSE LIQUID SHOT	T3	
DEX4 GLUCOSE 15 GM GEL PACKET	T3	
dex4 glucose 4 gm tablet chew (Trueplus Glucose)	T1	
DEX4 GLUCOSE LIQUID	T3	
DEX4 GLUCOSE LIQUID BLAST	T3	
dex4 glucose tab pouch pack (Trueplus Glucose)	T1	
dex4 quick dissolve tab chew (Trueplus Glucose)	T1	
dextrose	T1	
dextrose (Glutose-15)	T1	
dextrose (Glutose-45)	T1	
dextrose/vitamin d3	T1	
diazoxide (Proglycem)	T1	
drug mart glucose 4 gm tab chw (Trueplus Glucose)	T1	
GLUCO SHOT	T3	
GLUCOSE 2 GM GUMMY	T3	
glucose 3.75 gram tablet chew (Trueplus Glucose)	T1	
glucose 4 gram tablet chew (Trueplus Glucose)	T1	
GLUCOSE LIQUID	T3	
GLUTOSE-15 (dextrose)	T2	
GLUTOSE-45 (dextrose)	T2	
gnp glucose 3.75 gram tab chew (Trueplus Glucose)	T1	
gnp glucose 4 gram tablet chew (Trueplus Glucose)	T1	
gnp quick dissolve glucose tab (Trueplus Glucose)	T1	
gs glucose 4 gram tablet chew (Trueplus Glucose)	T1	
GVOKE	T2	QL (2 vials/fill)

T1 – Generics

T2 – Preferred Brands

T3 – Non-Preferred Brands

T4 – Preferred Specialty

T5 – Non-Preferred Specialty

PA – Prior Authorization

QL – Quantity Limit

ST – Step Therapy

AGE – Age Requirement

SP – Specialty Medication

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List of Prescription Medications

ELECT/CALORIC/H2O (Diabetes) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
AGENTS TO TREAT HYPOGLYCEMIA (HYPERGLYCEMICS) (cont.)		
GVOKE HYPOPEN 1-PACK, 2-PACK	T2	QL (2 auto-injs/fill)
GVOKE PFS 1-PACK, 2-PACK SYRINGE	T2	QL (2 syringes/fill)
INSTA-GLUCOSE	T3	
kro glucose 4 gram tablet chew (Trueplus Glucose)	T1	
kroger glucose 4 gram tab chew (Trueplus Glucose)	T1	
leader glucose 4 gm tab chew (Trueplus Glucose)	T1	
leader quick dissolve gluc tab (Trueplus Glucose)	T1	
longs glucose 4 gram tab chew (Trueplus Glucose)	T1	
meijer glucose 4 gram tab chew (Trueplus Glucose)	T1	
ms glucose 4 gram tablet chew (Trueplus Glucose)	T1	
ms quick dissolve glucose tab (Trueplus Glucose)	T1	
preferred plus glucose tab chw (Trueplus Glucose)	T1	
PROGLYCEM (diazoxide)	T3	
pub glucose 4 gram tablet chew (Trueplus Glucose)	T1	
ra glucose 4 gram tablet chew (Trueplus Glucose)	T1	
relion glucose 4 gram tab chew (Trueplus Glucose)	T1	
reli-on glucose 4 gram tab chw (Trueplus Glucose)	T1	
RELION GLUCOSE LIQUID	T3	
sm glucose 4 gram tab chew (Trueplus Glucose)	T1	
smart sense glucose 4 gram tab (Trueplus Glucose)	T1	
TRUEPLUS GLUCOSE	T3	
TRUEPLUS GLUCOSE (dextrose)	T3	
upup glucose 4 gram tab chew (Trueplus Glucose)	T1	
ELECT/CALORIC/H2O (Miscellaneous)		
NUCLEIC ACID/NUCLEOTIDE SUPPLEMENTS		
XURIDEN	T4	PA SP
ELECT/CALORIC/H2O (Nutritional/Dietary)		
CARBOHYDRATES		
ENFAMIL	T2	
GLUTOL	T2	
ELECTROLYTE DEPLETERS		
AURYXIA	T3	
calcium acetate 667 mg capsule, gelcap, tablet	T1	QL (360 caps/fill)

T1 – Generics

T2 – Preferred Brands

T3 – Non-Preferred Brands

T4 – Preferred Specialty

T5 – Non-Preferred Specialty

PA – Prior Authorization

QL – Quantity Limit

ST – Step Therapy

AGE – Age Requirement

SP – Specialty Medication

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List of Prescription Medications

ELECT/CALORIC/H2O (Nutritional/Dietary) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ELECTROLYTE DEPLETERS (cont.)		
<i>lanthanum carbonate (Fosrenol)</i>	T1	QL (90 tabs/fill)
LOKELMA	T2	QL (30 packs/fill)
REVELA 0.8 GM POWDER PACKET (<i>sevelamer carbonate</i>)	T3	QL (180 packs/fill)
REVELA 2.4 GM POWDER PACKET (<i>sevelamer carbonate</i>)	T3	QL (90 packs/fill)
REVELA 800 MG TABLET (<i>sevelamer carbonate</i>)	T3	QL (270 tabs/fill)
<i>sodium polystyrene sulfon/sorb</i>	T1	
<i>sodium polystyrene sulfonate</i>	T1	
VELPHORO	T2	QL (120 tabs/fill)
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		
CLINPRO 5000	T3	
<i>fluoride (sodium)</i>	T1	
<i>fluoride (sodium) (Prevident 5000 Plus)</i>	T1	
<i>fluoride (sodium) (Prevident)</i>	T1	
FLUORIDEX	T3	
JUSTRIGHT 5000	T3	
PREVIDENT	T3	
PREVIDENT (<i>fluoride (sodium)</i>)	T3	
PREVIDENT KIDS	T3	
PREVIDENT 5000 DRY MOUTH	T3	
PREVIDENT 5000 ORTHO DEFENSE	T3	
PREVIDENT 5000 PLUS (<i>fluoride (sodium)</i>)	T3	
<i>sodium fluoride 0.2% rinse (Prevident)</i>	T1	
<i>sodium fluoride 1.1% cream (Prevident 5000 Plus)</i>	T1	
<i>sodium fluoride 1.1% gel (Prevident)</i>	T1	
<i>sodium fluoride 5000 ppm cream (Prevident 5000 Plus)</i>	T1	
<i>sodium fluoride 5000 ppm paste</i>	T1	
IODINE CONTAINING AGENTS		
<i>potassium iodide</i>	T1	
<i>potassium iodide/iodine</i>	T1	
SSKI	T3	

T1 – Generics

T2 – Preferred Brands

T3 – Non-Preferred Brands

T4 – Preferred Specialty

T5 – Non-Preferred Specialty

PA – Prior Authorization

QL – Quantity Limit

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List of Prescription Medications

ELECT/CALORIC/H2O (Nutritional/Dietary) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
IRON REPLACEMENT		
ABATRON	T3	
ABATRON AF	T3	
ACCRUFER	T3	
ACTIVE FE	T3	
APETIGEN-PLUS	T2	
BENTIVITE BX	T3	
CHROMAGEN	T3	
CITRANATAL BLOOM	T3	
CORVITE 150	T3	
CORVITE FE	T3	
cvs iron 27 mg tablet (Fergon)	T1	
cvs iron 65 mg tablet	T1	
CVS SLOW RELEASE IRON 45 MG TB	T3	
cvs slow release iron 45 mg tb	T1	
cvs slow release iron tablet	T1	
eql iron 65 mg tablet	T1	
eql slow release iron 45 mg, 50 mg tab	T1	
FEOSOL 45 MG CAPLET (iron,carbonyl)	T2	
feosol 65 mg tablet	T1	
FEOSOL BIFERA 28 MG CAPLET	T2	
FERAHEME (ferumoxytol)	T3	PA
FERGON 27 MG TABLET	T3	
FERGON 27 MG TABLET (ferrous gluconate)	T2	
FERGON TABLET	T3	
FER-IN-SOL (ferrous sulfate)	T2	
FERIVA 21-7	T3	
FERIVA FA	T3	
FERRACTIV IRON	T3	
FERRALET 90	T3	
FERRETTS IPS 18 MG CAP	T3	
FERRETTS IPS 40 MG/15 ML LIQ	T2	
FERRIMIN 150	T2	
FERRLECIT (sodium ferric gluconat/sucrose)	T3	PA
FERRO-SEQUELS	T3	

T1 – Generics

T2 – Preferred Brands

T3 – Non-Preferred Brands

T4 – Preferred Specialty

T5 – Non-Preferred Specialty

PA – Prior Authorization

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SP – Specialty Medication

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List of Prescription Medications

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

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
IRON REPLACEMENT (cont.)		
ferrous fum/vit c/b12-if/folic	T1	PPACA
ferrous fumarate	T1	
ferrous fumarate (Hemocyte)	T1	
FERROUS FUMARATE 29 MG TAB	T3	
ferrous fumarate 324 mg tab (Hemocyte)	T1	
ferrous fumarate/folic acid (Hemocyte-F)	T1	
ferrous gluconate	T1	
ferrous gluconate (Fergon)	T1	
ferrous sulf 15 mg iron/ml drp (Fer-In-Sol)	T1	
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 liq	T1	
ferrous sulf ec 324 mg tablet	T1	
ferrous sulf ec 325 mg tablet	T1	
ferrous sulfate 325 mg tablet	T1	
FERROUS SULF 300 MG/5 ML CUP	T3	
ferrous sulfate	T1	
ferrous sulfate (Fer-In-Sol)	T1	
ferrous sulfate/vit c/folic ac	T1	PPACA
ferumoxytol (Feraheme)	T1	PA
ft iron 65 mg tablet	T1	
FT IRON 45 MG TABLET	T3	
FUSION	T3	
FUSION PLUS	T3	
FUSION SPRINKLES	T3	
GENTLE IRON	T3	
gnp iron 45 mg tablet	T1	
gnp iron 65 mg tablet	T1	
HEMATEX	T3	
HEMATEX (iron polysaccharide complex)	T3	
HEMATOGEN	T3	
HEMATRON-AF	T3	

T1 – Generics

T2 – Preferred Brands

T3 – Non-Preferred Brands

T4 – Preferred Specialty

T5 – Non-Preferred Specialty

PA – Prior Authorization

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List of Prescription Medications

ELECT/CALORIC/H2O (Nutritional/Dietary) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
IRON REPLACEMENT(cont.)		
HEMAX	T3	
HEMOCYTE (<i>ferrous fumarate</i>)	T2	
HEMOCYTE PLUS (<i>iron fum/folic acid/mv,min 15</i>)	T3	
HEMOCYTE-F (<i>ferrous fumarate/folic acid</i>)	T3	
<i>hm iron 65 mg tablet</i>	T1	
<i>hm slow release iron tablet</i>	T1	
I.L.X. B-12	T2	
ICAR	T2	
ICAR-C (<i>iron,carbonyl/ascorbic acid</i>)	T2	
ICAR-C PLUS (<i>iron,carb/vit c/vit b12/folic</i>)	T3	
INFED	T2	PA
INJECTAFER	T3	PA
INTEGRA	T2	
INTEGRA F (<i>iron fum,ps/folic acid/vitc/b3</i>)	T3	
INTEGRA PLUS (<i>iron fum,ps/folic/bcomp,c no.9</i>)	T3	
<i>iron 27 mg tablet</i>	T1	
<i>iron 27 mg tablet (Fergon)</i>	T1	
<i>iron 28 mg tablet</i>	T1	
<i>iron 45 mg tablet</i>	T1	
<i>iron 65 mg tablet</i>	T1	
<i>iron aspgly,ps/c/b12/fa/ca/suc</i>	T1	
<i>iron aspgly,ps/c/succinic acid</i>	T1	
<i>iron aspgly/c/b12/fa/ca-th/suc</i>	T1	
<i>iron bg,ps/vitc/b12/fa/calcium</i>	T1	
IRON BISGLYCINATE	T3	
<i>iron-vitamin c 100-250 mg tab (Icar-C)</i>	T1	PA SP HD
IRON-VITAMIN C 65-125 MG TAB	T2	PA SP HD
<i>iron fum,ag/c/b12/folic/ca/suc</i>	T1	
<i>iron fum,ps/folic acid/vitc/b3 (Integra F)</i>	T1	
<i>iron fum,ps/folic/bcomp,c no.9 (Integra Plus)</i>	T1	
<i>iron fum/folic acid/mv,min 15 (Hemocyte Plus)</i>	T1	
<i>iron fumarate/vit c/vit b12/fa</i>	T1	
<i>iron polysaccharide complex</i>	T1	
<i>iron polysaccharide complex (Nu-Iron 150)</i>	T1	

T1 – Generics

T2 – Preferred Brands

T3 – Non-Preferred Brands

T4 – Preferred Specialty

T5 – Non-Preferred Specialty

PA – Prior Authorization

QL – Quantity Limit

ST – Step Therapy

AGE – Age Requirement

SP – Specialty Medication

HD – May require home delivery pharmacy

PPACA – No Cost-Share Preventive Medication

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List of Prescription Medications

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

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
IRON REPLACEMENT (cont.)		
iron ps complex/b12/folic acid	T1	
iron,carb/vit c/vit b12/folic (Icar-C Plus)	T1	
iron,carbonyl	T1	
iron,carbonyl (Feosol)	T1	
iron,carbonyl/ascorbic acid (Icar-C)	T1	
iron/c/b12/calciu/stomach conc	T1	
iron/c/folic acd/mv cmb 11/calc	T1	
iron/folic ac/vit bcomp,c/min	T1	
iron/folic acid/b12/c/docusate	T1	
iron/folic acid/c/b6/b12/zinc	T1	
iron/vit c/fructooligosaccharid	T1	
IRONUP	T3	
iron-vitamin c 100-250 mg tab (Icar-C)	T1	PA SP HD
IRON-VITAMIN C 65-125 MG TAB	T2	PA SP HD
IRO-PLEX	T3	
IROSPAN	T3	
LIQUID IRON	T3	
LYDIA PINKHAM HERBAL	T3	
MAXFE	T3	
MONOFERRIC	T3	PA
NEONATAL FE	T3	
NIFEREX	T3	
NOVAFERRUM ALL GOOD	T3	PA SP HD
NOVAFERRUM WOW	T3	PA SP HD
NOVAFERRUM YUMMY PEDIATRIC	T2	PA SP HD
NUFERA	T3	
NU-IRON 150 (iron polysaccharide complex)	T2	
PARVLEX	T3	
PERFECT IRON	T3	
PRO FE	T2	
PROFERRIN	T2	
PROFERRIN-FORTE	T3	
PROTECT IRON	T3	

T1 – Generics

T2 – Preferred Brands

T3 – Non-Preferred Brands

T4 – Preferred Specialty

T5 – Non-Preferred Specialty

PA – Prior Authorization

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ST – Step Therapy

AGE – Age Requirement

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List of Prescription Medications

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

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
IRON REPLACEMENT (cont.)		
ra high potency iron 27 mg tab	T1	
RA HIGH POTENCY IRON 27 MG TAB	T3	
ra iron 65 mg tablet	T1	
RA SLOW RELEASE IRON 45 MG TAB	T2	
SIDEROL	T3	
SLOW FE	T2	
slow release iron 160 mg tab	T1	
SLOW RELEASE IRON 45 MG TAB	T2	
SLOW RELEASE IRON 45 MG TABLET	T2	
slow release iron 45 mg tablet	T1	
SLOW RELEASE IRON 45 MG TABLET	T3	
SLOW RELEASE IRON TABLET	T2	
sm iron 65 mg tablet	T1	
sm iron 160 mg tablet sa	T1	
sm iron 325 mg tablet	T1	
SM SLOW RELEASE IRON 45 MG TAB	T2	
sodium ferric gluconat/sucrose (Ferrlecit)	T1	PA
sv iron 65 mg tablet	T1	
SV SLOW RELEASE IRON 45 MG TAB	T2	
TANDEM DUAL ACTION	T2	
TL-HEM 150	T3	
TRIFERIC	T3	
true ferrous sulf ec 324 mg tb	T1	
TULIVITE	T3	
VENOFER	T2	PA
VIRT-FEFA PLUS CAPSULE	T3	
virt-fefa plus capsule (Integra Plus)	T1	
VITABEX IRON	T3	
VITAFOL	T3	
VITRON-C	T2	

PEDIATRIC VITAMIN PREPARATIONS

fluoride (sodium)	T1	PPACA
FLURA-DROPS	T3	
sodium fluoride 0.25 (0.55) mg	T1	PPACA

T1 – Generics

T2 – Preferred Brands

T3 – Non-Preferred Brands

T4 – Preferred Specialty

T5 – Non-Preferred Specialty

PA – Prior Authorization

QL – Quantity Limit

ST – Step Therapy

AGE – Age Requirement

SP – Specialty Medication

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List of Prescription Medications

ELECT/CALORIC/H2O (Nutritional/Dietary) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
PEDIATRIC VITAMIN PREPARATIONS (cont.)		
sodium fluoride 0.5 mg(1.1 mg)	T1	PPACA
sodium fluoride 0.5 mg/ml drop	T1	PPACA
sodium fluoride 1 mg (2.2 mg)	T1	PPACA
POTASSIUM REPLACEMENT		
EFFER-K 10 MEQ TABLET EFF	T3	
EFFER-K 20 MEQ TABLET EFF	T3	
effer-k 25 meq tablet eff	T1	
K-TAB ER 20 MEQ TABLET (<i>potassium chloride</i>)	T3	
k-tab er 8 meq tablet	T1	
potassium bicarbonate/cit ac	T1	
potassium chloride	T1	
potassium chloride	T1	
potassium chloride (K-Tab Er)	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	T1	
potassium cl er 10 meq 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	T1	
potassium cl er 8 meq tablet	T1	
potassium cl10%(20meq/15ml)cup	T1	
potassium cl10%(40meq/30ml)cup	T1	
potassium cl20%(40meq/15ml)cup	T1	
POTASSIUM CL ER 15 MEQ TABLET	T1	
PROTEIN REPLACEMENT		
AQNEURSA	T4	PA SP
ELECT/CALORIC/H2O (Urinary Tract Conditions)		
DIALYSIS SOLUTIONS		
PRISMASOL	T3	
URINARY PH MODIFIERS		
citric acid/sodium citrate	T1	HD

T1 – Generics

T2 – Preferred Brands

T3 – Non-Preferred Brands

T4 – Preferred Specialty

T5 – Non-Preferred Specialty

PA – Prior Authorization

QL – Quantity Limit

ST – Step Therapy

AGE – Age Requirement

SP – Specialty Medication

HD – May require home delivery pharmacy

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CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

ELECT/CALORIC/H2O (Urinary Tract Conditions) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
URINARY PH MODIFIERS (cont.)		
K-PHOS NO.2	T3	HD
K-PHOS ORIGINAL	T2	HD
ORACIT	T3	HD
<i>potassium citrate</i>	T1	HD
<i>potassium citrate</i> (Urocit-K)	T1	HD
RENACIDIN	T2	HD
UROCIT-K (<i>potassium citrate</i>)	T3	HD
UROQID-ACID NO.2	T3	HD

GASTROINTESTINAL (Cholesterol Medications)

LIPOTROPICS

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

GASTROINTESTINAL (Gastrointestinal/Heartburn)

AMMONIA INHIBITORS

BUPHENYL (<i>sodium phenylbutyrate</i>)	T5	PA SP HD
<i>lactulose</i>	T1	HD
<i>lactulose 10 gm/15 ml solution</i>	T1	HD
LITHOSTAT	T3	HD
OLPRUVA DOSE KIT, DOSE ENVELOPE	T5	SP PA HD
PHEBURANE	T4	PA SP
RAVICTI	T4	PA SP HD
<i>sodium phenylbutyrate</i> (Buphenyl)	T1	PA SP HD

ANTICHOLINERGICS, QUATERNARY AMMONIUM

<i>chlor diazepoxide/clidinium br</i> (Librax)	T1	
GLYCATE	T3	
<i>glycopyrrrolate</i>	T1	
<i>glycopyrrrolate</i> (Cuvposa)	T1	
<i>glycopyrrrolate</i> (Robinul Forte)	T1	
<i>glycopyrrrolate</i> (Robinul)	T1	
ROBINUL (<i>glycopyrrrolate</i>)	T3	
ROBINUL FORTE (<i>glycopyrrrolate</i>)	T3	
<i>dicyclomine hcl</i>	T1	

T1 – Generics

T2 – Preferred Brands

T3 – Non-Preferred Brands

T4 – Preferred Specialty

T5 – Non-Preferred Specialty

PA – Prior Authorization

QL – Quantity Limit

ST – Step Therapy

AGE – Age Requirement

SP – Specialty Medication

HD – 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
ANTIDIARRHEAL - TRYPTOPHAN HYDROXYLASE INHIBITOR		
XERMELO	T4	PA QL (84 tabs/28 days) SP
ANTIDIARRHEALS		
diphenoxylate hcl/atropine	T1	
diphenoxylate hcl/atropine (Lomotil)	T1	
LOMOTIL (diphenoxylate hcl/atropine)	T3	
MOTOFEN	T3	
opium tincture	T1	
paregoric	T1	
ANTIEMETIC, CANNABINOID-TYPE		
dronabinol (Marinol)	T1	PA
MARINOL (dronabinol)	T3	PA
SYNDROS	T3	PA
ANTIEMETIC/ANTIVERTIGO AGENTS		
aprepitant 125 mg capsule	T1	QL (1 cap/fill)
aprepitant 125-80-80 mg pack (Emend)	T1	QL (3 caps/fill)
aprepitant 40 mg capsule (Emend)	T1	QL (1 cap/fill)
aprepitant 80 mg capsule (Emend)	T1	QL (2 caps/fill)
COMPAZINE (prochlorperazine maleate)	T3	
COMPAZINE (prochlorperazine)	T3	
DICLEGIS (doxylamine succinate/vit b6)	T3	QL (120 tabs/fill)
fosaprepitant dimeglumine (Emend)	T1	
granisetron hcl 0.1 mg/ml vial	T1	
granisetron hcl 1 mg tablet	T1	QL (6 tabs/fill)
granisetron hcl 1 mg/ml vial	T1	
granisetron hcl 4 mg/4 ml vial	T1	
meclizine 50 mg tablet	T1	
ondansetron 4 mg/2 ml	T1	
ondansetron 40 mg/20 ml vial	T1	
ondansetron hcl 4 mg tablet	T1	QL (9 tabs/fill)
ondansetron hcl 4 mg/2 ml syr, vial	T1	
ondansetron hcl 8 mg tablet	T1	QL (9 tabs/fill)
ondansetron odt 4 mg tablet	T1	QL (9 tabs/30 days)
ondansetron odt 8 mg tablet	T1	QL (9 tabs/30 days)
prochlorperazine (Compazine)	T1	

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List of Prescription Medications

GASTROINTESTINAL (Gastrointestinal/Heartburn) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ANTIEMETIC/ANTIVERTIGO AGENTS (cont.)		
<i>prochlorperazine maleate</i> (Compazine)	T1	
<i>promethazine hcl</i>	T1	
SANCUSO	T3	QL (1 patch/fill)
<i>scopolamine</i> (Transderm-Scop)	T1	
<i>trimethobenzamide hcl</i>	T1	
VARUBI	T2	QL (2 tabs/fill)
ANTI-ULCER PREPARATIONS		
CYTOTEC (<i>misoprostol</i>)	T3	HD
<i>misoprostol</i> (Cytotec)	T1	HD
<i>sucralfate</i> (Carafate)	T1	HD
ANTI-ULCER-H.PYLORI AGENTS		
<i>lansoprazole/amoxiciln/clarith</i>	T1	QL (112 units/fill)
OMECLAMOX-PAK	T3	QL (80 units/fill)
TALICIA	T2	QL (168 caps/fill)
VOQUEZNA DUAL PAK	T3	
VOQUEZNA TRIPLE PAK	T3	
BELLADONNA ALKALOIDS		
DONNATAL	T3	HD
DONNATAL (<i>phenobarb/hyoscy/atropine/scop</i>)	T3	HD
<i>hyoscyamine sulfate</i>	T1	HD
<i>hyoscyamine sulfate</i> (Levbid)	T1	HD
<i>hyoscyamine sulfate</i> (Levsin)	T1	HD
<i>hyoscyamine sulfate</i> (Levsin-SI)	T1	HD
<i>hyoscyamine sulfate</i> (Nulev)	T1	HD
LEVBID (<i>hyoscyamine sulfate</i>)	T3	HD
LEVSIN (<i>hyoscyamine sulfate</i>)	T3	HD
LEVSIN-SL (<i>hyoscyamine sulfate</i>)	T3	HD
<i>methscopolamine bromide</i>	T1	HD
NULEV (<i>hyoscyamine sulfate</i>)	T3	HD
<i>phenobarb/hyoscy/atropine/scop</i>	T1	HD
<i>phenobarb/hyoscy/atropine/scop</i> (Donnatal)	T1	HD
<i>phenobarb/hyoscy/atropine/scop</i> (Phenobarbital-Belladonna)	T1	HD
PHENOBARBITAL-BELLADONNA (<i>phenobarb/hyoscy/atropine/scop</i>)	T3	HD
SYMAX DUOTAB	T3	HD

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List of Prescription Medications

GASTROINTESTINAL (Gastrointestinal/Heartburn) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
BILE SALTS		
CHENODAL	T4	PA SP HD
CHOLBAM 50 MG CAPSULE	T4	PA QL (120 caps/fill) SP HD
CHOLBAM 250 MG CAPSULE	T4	PA SP HD
CTEXLI	T4	PA SP
URSO FORTE (<i>ursodiol</i>)	T3	HD
<i>ursodiol</i>	T1	HD
<i>ursodiol</i> (Urso Forte)	T1	HD
CHRONIC INFLAM. COLON DX, 5-A-SALICYLAT, RECTAL TX		
mesalamine 1,000 mg supp (Canasa)	T1	
mesalamine 4 gm/60 ml enema (Sfrowasa)	T1	
mesalamine 4 gm/60 ml kit (Rowasa)	T1	
ROWASA (mesalamine w/cleansing wipes)	T3	
SFROWASA (mesalamine)	T3	
DRUG TX-CHRONIC INFLAM. COLON DX, 5-AMINOSALICYLAT		
APRISO (mesalamine)	T3	HD
ASACOL HD (mesalamine)	T3	HD
AZULFIDINE (sulfasalazine)	T3	HD
balsalazide disodium (Colazal)	T1	HD
COLAZAL (balsalazide disodium)	T3	HD
mesalamine (Apriso)	T1	HD
mesalamine (Delzicol)	T1	HD
mesalamine (Pentasa)	T1	HD
mesalamine 800 mg dr tablet (Asacol Hd)	T1	HD
mesalamine dr 1.2 gm tablet (Lialda)	T1	HD
PENTASA 250 MG CAPSULE	T2	HD
PENTASA 500 MG CAPSULE (mesalamine)	T3	HD
sulfasalazine (Azulfidine)	T1	HD
FARNESOID X RECEPTOR (FXR) AGONIST, BILE AC ANALOG		
OCALIVA	T4	PA QL (30 tabs/fill) SP HD
FECAL MICROBIOTA TRANSPLANTATION (FMT)		
VOWST CAPSULE	T5	SP
GASTRIC ENZYMEs		
SUCRAID	T4	PA SP

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List of Prescription Medications

GASTROINTESTINAL (Gastrointestinal/Heartburn) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
HISTAMINE H2-RECEPTOR INHIBITORS		
cimetidine	T1	HD
famotidine	T1	HD
famotidine (Pepcid)	T1	HD
nizatidine	T1	HD
PEPCID (famotidine)	T3	HD
ranitidine hcl	T1	HD
IBS AGENTS, MIXED OPIOID RECEPTOR AGONISTS/ANTAGONISTS		
VIBERZI	T2	HD
IBS-C/CIC AGENTS, GUANYLATE CYCLASE-C AGONIST		
LINZESS	T2	QL (30 caps/fill)
TRULANCE	T2	
ILEAL BILE ACID TRANSPORTER (IBAT) INHIBITOR		
BYLVAY 1,200 MCG CAPSULE	T5	PA QL (60 caps/fill) SP HD
BYLVAY 200 MCG PELLET	T5	PA QL (120 pellets/fill) SP HD
BYLVAY 400 MCG CAPSULE	T5	PA QL (150 caps/fill) SP HD
BYLVAY 600 MCG PELLET	T5	PA QL (30 pellets/fill) SP HD
LIVMARLI	T5	PA SP
INTESTINAL MOTILITY STIMULANTS		
metoclopramide hcl	T1	
metoclopramide hcl (Reglan)	T1	
prucalopride succinate	T1	QL (30 tabs/30 days)
REGLAN (metoclopramide hcl)	T3	
IRRITABLE BOWEL SYND. AGENT, 5-HT4 PARTIAL AGONIST		
ZELNORM	T3	
IRRITABLE BOWEL SYNDROME AGENTS, 5-HT3 ANTAGONIST		
alosetron hcl (Lotronex)	T1	SP HD
LAXATIVES AND CATHARTICS		
bisac/nacl/nahco3/kcl/peg 3350	T1	PPACA
GIALAX	T3	PPACA
GOLYTELY (peg3350/sod sulf,bicarb,cl/kcl)	T3	
KRISTALOSE	T3	
lactulose	T1	
lactulose 10 gm packet	T1	
lactulose 10 gm/15 ml solution	T1	

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List of Prescription Medications

GASTROINTESTINAL (Gastrointestinal/Heartburn) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
LAXATIVES AND CATHARTICS (cont.)		
lactulose 20 gm/30 ml solution	T1	
lubiprostone	T1	QL (60 caps/30 days)
NULYTLY	T3	
NULYTLY WITH FLAVOR PACKS (sodium chloride/nahco3/kcl/peg)	T3	
OSMOPREP	T3	PPACA
peg3350/sod sul/nacl/kcl/asb/c (Moviprep)	T1	PPACA
peg3350/sod sulf,bicarb,cl/kcl	T1	PPACA
peg3350/sod sulf,bicarb,cl/kcl (Golytely)	T1	PPACA
sodium chloride/nahco3/kcl/peg (Nulytely With Flavor Packs)	T1	PPACA
sodium, potassium,mag sulfates (Suprep)	T1	PPACA
LOCAL ANORECTAL NITRATE PREPARATIONS		
nitroglycerin 0.4% ointment (Rectiv)	T1	
RECTIV (nitroglycerin)	T2	
MU-OPIOID RECEPTOR ANTAGONISTS,PERIPHERALLY-ACTING		
alvimopan	T1	
ENTEREG	T3	
PANCREATIC ENZYMES		
CREON	T2	HD
PANCREAZE	T2	HD
VIOKACE	T2	HD
ZENPEP	T2	HD
POTASSIUM-COMPETITIVE ACID BLOCKERS (PCABS)		
VOQUEZNA	T3	ST
PROTON-PUMP INHIBITORS		
dexlansoprazole dr 30 mg cap	T1	ST QL
dexlansoprazole dr 60 mg cap	T1	ST HD
esomeprazole dr 2.5 mg packet (Nexium)	T1	ST QL (30 packs/30 days) HD
esomeprazole dr 5 mg packet (Nexium)	T1	ST QL (30 packs/30 days) HD
esomeprazole dr 10 mg packet (Nexium)	T1	ST QL (30 packs/fill) HD
esomeprazole dr 40 mg packet (Nexium)	T1	ST HD
ESOMEPRAZOLE DR 49.3 MG CAP	T3	ST HD
esomeprazole mag dr 40 mg cap (Nexium)	T1	HD
lansoprazole dr 30 mg capsule (Prevacid)	T1	HD
lansoprazole odt 15 mg tablet (Prevacid)	T1	ST QL (30 tabs/fill) HD

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List of Prescription Medications

GASTROINTESTINAL (Gastrointestinal/Heartburn) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
PROTON-PUMP INHIBITORS (cont.)		
<i>lansoprazole odt 30 mg tablet (Prevacid)</i>	T1	ST HD
<i>omeprazole dr 10 mg capsule</i>	T1	QL (30 caps/fill) HD
<i>omeprazole dr 40 mg capsule</i>	T1	HD
<i>omeprazole/sodium bicarbonate (Zegerid)</i>	T1	PA HD
<i>omeprazole-bicarb 20-1,680 pkt (Zegerid)</i>	T1	ST QL (30 packs/30 days) HD
<i>omeprazole-bicarb 40-1,100 cap (Zegerid)</i>	T1	ST HD
<i>omeprazole-bicarb 40-1,680 pkt (Zegerid)</i>	T1	ST HD
<i>pantoprazole 40 mg suspension (Protonix)</i>	T1	ST HD
<i>pantoprazole sod dr 40 mg tab (Protonix)</i>	T1	HD
<i>rabeprazole sod dr 20 mg tab (Aciphenx)</i>	T1	HD
RECTAL PREPARATIONS		
<i>hydrocortisone acetate (Anusol-Hc)</i>	T1	
<i>hydrocortisone acetate (Proctocort)</i>	T1	
<i>PROCTOCORT (hydrocortisone acetate)</i>	T3	ST
SBS - GLUCAGON-LIKE PEPTIDE-2 (GLP-2) ANALOGS		
GATTEX	T5	PA SP HD
GASTROINTESTINAL (Pain Relief and Inflammatory Disease)		
HEMORRHOID PREP, ANTI-INFLAM STEROID-LOCAL ANESTHET		
<i>ANA-LEX</i>	T3	
<i>ANALPRAM HC 1% CREAM</i>	T3	
<i>ANALPRAM HC 2.5%-1% CREAM (hydrocortisone/pramoxine)</i>	T3	ST
<i>ANALPRAM HC 2.5%-1% CRM SINGLE (hydrocortisone/pramoxine)</i>	T3	ST
<i>hydrocort-pramoxine 1%-1% crm</i>	T1	
<i>hydrocort-pramoxine 2.5%-1% cm (Analpram Hc)</i>	T1	ST
<i>hydrocort-pramoxine 2.5-1% crm (Analpram Hc)</i>	T1	ST
<i>LIDOCAINE-HC 3-2.5% GEL KIT</i>	T3	
<i>lidocaine-hc 2.8-0.55% gel</i>	T1	
<i>lidocaine-hc 2-2% cream kit</i>	T1	
<i>lidocaine-hc 3-0.5% cream</i>	T1	
<i>lidocaine-hc 3-0.5% cream kit</i>	T1	
<i>lidocaine-hc 3-2.5% gel kit</i>	T1	
<i>LIDOCAINE-HYDROCORT 3-2.5% GEL</i>	T3	
<i>PROCORT</i>	T3	

T1 – Generics

T2 – Preferred Brands

T3 – Non-Preferred Brands

T4 – Preferred Specialty

T5 – Non-Preferred Specialty

PA – Prior Authorization

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ST – Step Therapy

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List of Prescription Medications

HORMONES (Gastrointestinal/Heartburn)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
RECTAL/LOWER BOWEL PREP.,GLUCOCORT. (NON-HEMORR)		
CORTENEMA (<i>hydrocortisone</i>)	T3	
<i>hydrocortisone</i> (Cortenema)	T1	
UCERIS (<i>budesonide</i>)	T3	
HORMONES (Hormonal Agents)		
ADRENOCORTICOTROPHIC HORMONES		
ACTHAR SELFJECT	T5	PA SP HD
ANDROGENIC AGENTS		
DEPO-TESTOSTERONE	T3	PA
DEPO-TESTOSTERONE (<i>testosterone cypionate</i>)	T3	PA
JATENZO 158 MG, 198 MG CAPSULE	T3	PA QL (120 caps/30 days)
METHITEST	T2	
<i>methyltestosterone</i>	T1	
<i>oxandrolone</i>	T1	
<i>testosterone 1% (25mg/2.5g) pk (Androgel)</i>	T1	PA QL (75 gms/fill)
<i>testosterone 1% (50 mg/5 g) pk (Androgel)</i>	T1	PA QL (300 gms/fill)
<i>testosterone 1.62% (2.5 g) pkt (Androgel)</i>	T1	PA QL (60 packs/fill)
<i>testosterone 1.62% gel pump (Androgel)</i>	T1	PA QL (150 gms/fill)
<i>testosterone 1.62%(1.25 g) pkt (Androgel)</i>	T1	PA QL (30 packs/fill)
<i>testosterone 10 mg gel pump</i>	T1	QL (120 gms/30 days)
TESTOSTERONE 12.5 MG/1.25 GRAM	T3	PA QL (300 gms/fill)
<i>testosterone 12.5 mg/1.25 gram</i>	T1	PA QL (300 gms/fill)
<i>testosterone 30 mg/1.5 ml pump</i>	T1	PA QL (180 mls/fill)
<i>testosterone 50 mg/5 gram gel (Testim)</i>	T1	PA QL (60 tubes/fill)
<i>testosterone 50 mg/5 gram gel (Vogelxo)</i>	T1	PA QL (60 tubes/fill)
TESTOSTERONE 50 MG/5 GRAM PKT	T3	PA QL (300 gms/fill)
<i>testosterone cypionate</i>	T1	PA
<i>testosterone cypionate (Depo-Testosterone)</i>	T1	PA
<i>testosterone enanthate</i>	T1	PA
VOGELXO 12.5 MG/1.25 GRAM PUMP	T3	PA QL (300 gms/fill)
VOGELXO 50 MG/5 GRAM GEL (<i>testosterone</i>)	T3	PA QL (60 tubes/fill)
VOGELXO 50 MG/5 GRAM GEL PACKT	T3	PA QL (60 packs/fill)
XYOSTED	T2	QL (2 mls/28 days)
ANTIDIURETIC AND VASOPRESSOR HORMONES		
DDAVP (<i>desmopressin (nonrefrigerated)</i>)	T3	

T1 – Generics

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T3 – Non-Preferred Brands

T4 – Preferred Specialty

T5 – Non-Preferred Specialty

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List of Prescription Medications

HORMONES (Hormonal Agents) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ANTIDIURETIC AND VASOPRESSOR HORMONES (cont.)		
DDAVP 0.1 MG, 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 (Ddavp)</i>	T1	HD
<i>desmopressin acetate 0.2 mg tb (Ddavp)</i>	T1	HD
NOCTIVA	T3	
ESTROGEN/ANDROGEN COMBINATIONS		
ESTRATEST F.S. (<i>estrogen,ester/me-testosterone</i>)	T3	HD
ESTRATEST H.S. (<i>estrogen,ester/me-testosterone</i>)	T3	HD
<i>estrogen,ester/me-testosterone</i> (Estratest F.S.)	T1	HD
<i>estrogen,ester/me-testosterone</i> (Estratest H.S.)	T1	HD
ESTROGENIC AGENTS		
ACTIVELLA (<i>estradiol/norethindrone acet</i>)	T3	HD
CLIMARA (<i>estradiol</i>)	T3	QL (4 patches/28 days) HD
COMBIPATCH	T2	
DELESTROGEN	T3	HD
DELESTROGEN (<i>estradiol valerate</i>)	T3	HD
DEPO-ESTRADIOL	T2	HD
ESTRACE 0.5 MG TABLET (<i>estradiol</i>)	T3	HD
ESTRACE 1 MG TABLET (<i>estradiol</i>)	T3	HD
ESTRACE 2 MG TABLET (<i>estradiol</i>)	T3	HD
<i>estradiol</i> (Climara)	T1	QL (4 patches/28 days) HD
<i>estradiol 0.1% (0.25mg) gel pk</i> (Divigel)	T1	QL (30 packs/fill) HD
<i>estradiol 0.1% (0.75mg) gel pk</i> (Divigel)	T1	QL (30 packs/fill) HD
<i>estradiol 0.1% (1 mg) gel pkt</i> (Divigel)	T1	QL (30 packs/fill) HD
<i>estradiol 0.1% (1.25mg) gel pk</i>	T1	QL (30 packs/fill) HD
<i>estradiol 0.06% 1.25g gel pump</i> (Estrogel)	T1	QL (50 gms/30 days) HD
<i>estradiol 0.5 mg tablet</i> (Estrace)	T1	HD
<i>estradiol 1 mg tablet</i> (Estrace)	T1	HD
<i>estradiol 2 mg tablet</i> (Estrace)	T1	HD
<i>estradiol valerate</i> (Delestrogen)	T1	HD
<i>estradiol/norethindrone acet</i>	T1	HD
<i>estradiol/norethindrone acet</i> (Activella)	T1	HD

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List of Prescription Medications

HORMONES (Hormonal Agents) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ESTROGENIC AGENTS (cont.)		
EVAMIST	T3	QL (17 mls/30 days) HD
MENOSTAR	T3	QL (4 patches/28 days) HD
<i>norethind-eth estrad 0.5-2.5</i>	T1	HD
<i>norethindrone ac/eth estradiol</i>	T1	HD
<i>norethin-eth estrad 1 mg-5 mcg</i>	T1	HD
ESTROGEN-PROGESTIN WITH ANTIMINERALOCORTICOID COMB		
ANGELIQ	T3	HD
ESTROGEN-SELECTIVE ESTROGEN RECEPTOR MOD (SERM) COMB		
DUAVEE	T2	
GLUCOCORTICOIDS		
ASMALPRED PLUS	T3	
<i>budesonide</i>	T1	
<i>budesonide (Uceris)</i>	T1	
CORTEF (hydrocortisone)	T3	
<i>cortisone acetate</i>	T1	
<i>deflazacort</i>	T1	PA SP HD
<i>deflazacort (Emflaza)</i>	T1	PA SP HD
<i>dexamethasone</i>	T1	PA
<i>dexamethasone</i>	T1	
<i>dexamethasone 0.5 mg tablet</i>	T1	
<i>dexamethasone 0.5 mg/5 ml elx</i>	T1	
<i>dexamethasone 0.5 mg/5 ml liq</i>	T1	
<i>dexamethasone 0.75 mg tablet</i>	T1	
<i>dexamethasone 1 mg tablet</i>	T1	
<i>dexamethasone 1.5 mg tablet</i>	T1	
<i>dexamethasone 6 day 1.5 mg tab</i>	T1	PA
<i>dexamethasone 10 day 1.5 mg tb</i>	T1	PA
<i>dexamethasone 13 day 1.5 mg tb</i>	T1	PA
<i>dexamethasone 2 mg tablet</i>	T1	
<i>dexamethasone 4 mg tablet</i>	T1	
<i>dexamethasone 6 mg tablet</i>	T1	
DEXONTO	T3	
DXEVO	T3	PA
<i>hydrocortisone (Cortef)</i>	T1	

T1 – Generics

T2 – Preferred Brands

T3 – Non-Preferred Brands

T4 – Preferred Specialty

T5 – Non-Preferred Specialty

PA – Prior Authorization

QL – Quantity Limit

ST – Step Therapy

AGE – Age Requirement

SP – Specialty Medication

HD – May require home delivery pharmacy

PPACA – No Cost-Share Preventive Medication

CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

HORMONES (Hormonal Agents) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
GLUCOCORTICOIDS (cont.)		
MEDROL	T3	
MEDROL (<i>methylprednisolone</i>)	T3	
<i>methylprednisolone</i>	T1	
<i>methylprednisolone</i> (Medrol)	T1	
ORAPRED ODT (<i>prednisolone sodium phosphate</i>)	T3	
<i>prednisolone</i>	T1	
<i>prednisolone sodium phosphate</i>	T1	
<i>prednisolone sodium phosphate</i> (Orapred Odt)	T1	
<i>prednisone</i>	T1	
<i>prednisone</i>	T1	
RAYOS	T3	PA
TAPERDEX	T3	PA
TARPEYO	T5	PA QL (28 caps/30 days) SP
UCERIS (<i>budesonide</i>)	T3	
UCERIS 9 MG ER TABLET (<i>budesonide</i>)	T3	
ZCORT	T3	PA
GROWTH HORMONE RELEASING HORMONE (GHRH) AND ANALOGS		
EGRIFTA SV	T4	PA SP HD
GROWTH HORMONES		
GENOTROPIN	T4	PA SP HD
OMNITROPE	T4	PA SP
SEROSTIM	T4	PA SP HD
ZORBTIVE	T5	PA SP HD
INSULIN-LIKE GROWTH FACTOR-I (IGF-I) HORMONES		
INCRELEX	T4	PA SP
LHRH (GNRH) AGONIST ANALOG PITUITARY SUPPRESSANTS		
SYNAREL	T4	PA SP HD
LHRH (GNRH) ANTAGONIST, ESTROGEN AND PROGESTIN COMB		
MYFEMBREE	T2	PA
ORIAHNN	T2	PA
LHRH (GNRH) ANTAGONIST, PITUITARY SUPPRESSANT AGENTS		
<i>cetrorelix acetate</i>	T1	SP
CETROTIDE	T4	SP
GANIRELIX ACET 250 MCG/0.5 ML (<i>ganirelix acetate</i>)	T5	ST SP

T1 – Generics

T2 – Preferred Brands

T3 – Non-Preferred Brands

T4 – Preferred Specialty

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List of Prescription Medications

HORMONES (Hormonal Agents) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
LHRH (GNRH) ANTAGONIST, PITUITARY SUPPRESSANT AGENTS (cont.)		
ganirelix acet 250 mcg/0.5 ml (Ganirelix Acetate)	T1	ST SP
ganirelix acetate (Ganirelix Acetate)	T1	SP
ORILISSA 150 MG TABLET	T2	PA QL (30 tabs/fill)
ORILISSA 200 MG TABLET	T2	PA QL (60 tabs/fill)
MINERALOCORTICOIDS		
fludrocortisone acetate	T1	HD
OXYTOCICS		
CERVIDIL	T3	
methylergonovine maleate	T1	QL (240 tabs/30 days)
PREPIDIL	T3	
PARATHYROID HORMONES		
NATPARA	T4	PA SP HD
YORVIPATH	T5	PA SP
PITUITARY SUPPRESSIVE AGENTS		
cabergoline	T1	QL (8 tabs/28 days) HD
CRENESSITY	T5	PA SP
danazol	T1	HD
PROGESTATIONAL AGENTS		
CRINONE 8% GEL	T2	
medroxyprogesterone 10 mg tab (Provera)	T1	HD
medroxyprogesterone 2.5 mg tab (Provera)	T1	HD
medroxyprogesterone 5 mg tab (Provera)	T1	HD
norethindrone acetate	T1	HD
progesterone, micronized (Prometrium)	T1	HD
PROMETRIUM (progesterone, micronized)	T3	HD
PROVERA (medroxyprogesterone acetate)	T3	HD
SOMATOSTATIC AGENTS		
MYCAPSSA	T5	PA SP
MYCAPSSA DR 20MG CAPSULE	T5	PA QL (56 caps/28 days) SP
SIGNIFOR	T4	PA SP
VAGINAL ESTROGEN PREPARATIONS		
estradiol (Vagifem)	T1	
estradiol 0.01% cream (Estrace)	T1	HD
estradiol 10 mcg vaginal insrt (Vagifem)	T1	HD
PREMARIN VAGINAL CREAM-APPL	T2	HD

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List of Prescription Medications

HORMONES (Infertility)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
FERTILITY STIMULATING PREPARATIONS, NON-FSH		
clomiphene citrate	T1	
FOLLICLE-STIMULATING AND LUTEINIZING HORMONES		
MENOPUR	T4	SP
FOLLICLE-STIMULATING HORMONE (FSH)		
FOLLISTIM AQ	T5	ST SP
GONAL-F	T4	ST SP
GONAL-F RFF REDI-JEKT	T4	ST SP
HUMAN CHORIONIC GONADOTROPIN (HCG)		
CHORIONIC GONAD 10,000 UNIT VL	T5	ST QL (3 vials/30 days) SP
CHORIONIC GONAD 50,000 UNIT VL	T5	ST SP
CHORIONIC GONAD 6,000 UNIT VL	T5	ST SP
NOVAREL	T5	ST QL (6 vls/30 days) SP
OVIDREL	T4	SP
PREGNYL	T4	QL (3 vials/30 days) SP
PREGNANCY FACILITATING/MAINTAINING AGENT, HORMONAL		
CRINONE	T3	
ENDOMETRIN	T3	ST
HORMONES (Miscellaneous)		
LEPTIN HORMONE ANALOGS		
MYALEPT	T4	PA SP HD
HORMONES (Osteoporosis Products)		
BONE FORMATION STIMULATING AGTS - PTH REL PEPTIDES		
TYMLOS	T4	PA QL (1 pen/fill) SP HD
BONE RESORPTION INHIBITORS		
calcitonin, salmon, synthetic	T1	HD
calcitonin, salmon, synthetic (Miacalcin)	T1	HD
MIACALCIN (calcitonin, salmon, synthetic)	T3	HD
IMMUNOSUPPRESSANTS (Pain Relief and Inflammatory Disease)		
HUMAN INTERLEUKIN 12/23 (IL-12/13) INHIBITORS, MAB		
SELARSDI 45 MG/0.5 ML SYRINGE	T4	PA QL (1 syringe/84 days) SP
SELARSDI 90 MG/ML SYRINGE	T4	PA QL (1 syringe/56 days) SP
STELARA	T4	PA QL SP HD
USTEKINUMAB-TTWE 45MG/0.5ML SY	T4	PA SP HD

T1 – Generics

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List of Prescription Medications

IMMUNOSUPPRESSANTS (Pain Relief and Inflammatory Disease) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
HUMAN INTERLEUKIN I2/23 (IL-12/13) INHIBITORS, MAB (cont.)		
USTEKINUMAB-TTWE 90 MG/ML SYR	T4	PA SP HD
YESINTEK 45 MG/0.5 ML SYRINGE, VIAL	T4	PA SP HD
YESINTEK 90 MG/ML SYRINGE	T4	PA SP HD
IL-23 RECEPTOR ANTAGONIST, MONOCLONAL ANTIBODY		
OMVOH 100 MG/ML PEN	T4	PA QL (2 mls/28 days) SP HD
OMVOH 300 MG DOSE - 2 PENS	T4	PA QL (3 mls/28 days) SP HD
OMVOH 100 MG/ML SYRINGE	T4	PA QL (2 mls/28 days) SP HD
OMVOH 300 MG DOSE - 2 SYRINGES	T4	PA QL (3 mls/28 days) SP HD
SKYRIZI ON-BODY	T4	PA QL (1 cartridge/56 days) SP HD
TREMFYA 100 MG/ML PEN	T4	PA SP HD
TREMFYA 200 MG/2 ML PEN	T4	PA SP HD
TREMFYA ONE-PRESS	T4	PA SP HD
TREMFYA PEN INDUCTION PK-CROHN	T4	PA QL (200 mgs/28 days) SP HD
TREMFYA 100 MG/ML SYRINGE	T4	PA QL (1 syringe/56 days) SP HD
TREMFYA 200 MG/2 ML SYRINGE	T4	PA QL (200 mgs/28 days) SP HD
INTERLEUKIN-4(IL-4) RECEPTOR ALPHA ANTAGONIST, MAB		
DUPIXENT 100 MG/0.67 ML SYRING	T4	PA QL (2 syringes/28 days) SP HD
DUPIXENT 200 MG/1.14 ML PEN	T4	PA QL (400 mgs/28 days) SP HD
DUPIXENT 200 MG/1.14 ML SYRING	T4	PA QL (400 mgs/28 days) SP HD
DUPIXENT 300 MG/2 ML PEN	T4	PA QL (600 mgs/28 days) SP HD
DUPIXENT 300 MG/2 ML SYRINGE	T4	PA QL (600 mgs/28 days) SP HD
INTERLEUKIN-6 (IL-6) RECEPTOR INHIBITORS		
ACTEMRA	T4	PA QL (3.6 mls/28 days) SP HD
ACTEMRA ACTPEN	T4	PA QL (2 pens/28 days) SP HD
ENSPRYNG	T4	PA SP HD
TYENNE	T4	PA QL (3.6 mls/28 days) SP
TYENNE AUTOINJECTOR	T4	PA QL (2 pens/28 days) SP
IMMUNOSUPPRESSANTS (Skin Conditions)		
INTERLEUKIN-31(IL-31)RECEPTOR ALPHA ANTAGONIST,MAB		
NEMLUVIO	T4	PA QL (2 pens/28 days) SP HD
TOPICAL IMMUNOSUPPRESSIVE AGENTS		
HYFTOR	T5	PA SP
pimecrolimus (Elidel)	T1	ST QL (120 gms/30 days)
tacrolimus 0.03%, 0.1% ointment	T1	ST QL (120 gms/30 days)

T1 – Generics
 T2 – Preferred Brands
 T3 – Non-Preferred Brands
 T4 – Preferred Specialty

T5 – Non-Preferred Specialty
 PA – Prior Authorization
 QL – Quantity Limit

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

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

List of Prescription Medications

IMMUNOSUPPRESSANTS (Transplant Medications)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
IMMUNOSUPPRESSIVES		
ASTAGRAF XL	T5	PA SP HD
AZASAN (<i>azathioprine</i>)	T5	SP HD
<i>azathioprine</i> (Azasan)	T1	SP HD
<i>azathioprine</i> (Imuran)	T1	SP HD
CELLCEPT (<i>mycophenolate mofetil</i>)	T5	SP HD
<i>cyclosporine 100 mg capsule</i> (Sandimmune)	T1	SP HD
<i>cyclosporine 25 mg capsule</i> (Sandimmune)	T1	SP HD
<i>cyclosporine, modified</i>	T1	SP HD
<i>cyclosporine, modified</i> (Neoral)	T1	SP HD
<i>everolimus 0.25 mg tablet</i> (Zortress)	T1	SP HD
<i>everolimus 0.5 mg tablet</i> (Zortress)	T1	SP HD
<i>everolimus 0.75 mg tablet</i> (Zortress)	T1	SP HD
<i>everolimus 1 mg tablet</i> (Zortress)	T1	SP HD
IMURAN (<i>azathioprine</i>)	T5	SP HD
LUPKYNIS	T5	PA QL (180 caps/30 days) SP
<i>mycophenolate mofetil</i> (Cellcept)	T1	SP HD
<i>mycophenolate sodium</i> (Myfortic)	T1	SP HD
MYFORTIC (<i>mycophenolate sodium</i>)	T5	SP HD
MYHIBBIN	T4	SP
NEORAL (<i>cyclosporine, modified</i>)	T5	SP HD
PROGRAF 0.2 MG, 1 MG GRANULE PACKET	T4	SP HD
PROGRAF 0.5 MG CAPSULE (<i>tacrolimus</i>)	T5	SP HD
PROGRAF 1 MG CAPSULE (<i>tacrolimus</i>)	T5	SP HD
PROGRAF 5 MG CAPSULE (<i>tacrolimus</i>)	T5	SP HD
RAPAMUNE (<i>sirolimus</i>)	T5	SP HD
SANDIMMUNE 100 MG CAPSULE (<i>cyclosporine</i>)	T5	SP HD
SANDIMMUNE 100 MG/ML SOLN	T4	SP HD
SANDIMMUNE 25 MG CAPSULE (<i>cyclosporine</i>)	T5	SP HD
<i>sirolimus</i>	T1	SP HD
<i>sirolimus</i> (Rapamune)	T1	SP HD
<i>tacrolimus 0.5 mg capsule (ir)</i> (Prograf)	T1	SP HD
<i>tacrolimus 1 mg capsule (ir)</i> (Prograf)	T1	SP HD
<i>tacrolimus 5 mg capsule (ir)</i> (Prograf)	T1	SP HD
ZORTRESS (<i>everolimus</i>)	T5	SP HD

T1 – Generics

T2 – Preferred Brands

T3 – Non-Preferred Brands

T4 – Preferred Specialty

T5 – Non-Preferred Specialty

PA – Prior Authorization

QL – Quantity Limit

ST – Step Therapy

AGE – Age Requirement

SP – Specialty Medication

HD – 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)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
DIABETIC SUPPLIES		
2TEK	T3	
ACCU-CHEK	T3	
ACCU-CHEK COMPACT PLUS CONTROL	T3	
ACCU-CHEK FASTCLIX LANCING DEV	T2	
ACCU-CHEK GUIDE CONTROL SOLN	T3	
ACCU-CHEK SMARTVIEW CONTRL SOL	T3	
ACCU-CHEK SOFTCLIX	T2	
ACCUTREND GLUCOSE CONTROL	T3	
ADJUSTABLE LANCING DEVICE	T2	
ADVANCED LANCING DEVICE	T2	
ADVOCATE CONTROL SOLUTION	T3	
ADVOCATE LANCING DEVICE	T2	
ADVOCATE RAPID-SAFE LANCING DV	T2	
ADVOCATE REDI-CODE+ CTRL SOLN	T3	
AGAMATRIX CONTROL	T3	
AGAMATRIX CONTROL SOLUTION	T3	
ALKALINE BATTERIES	T3	
ALTERNATE SITE LANCING DEVICE	T2	
AQUA LANCE LANCING DEVICE	T2	
ASSURE 4 CONTROL SOLUTION	T3	
ASSURE DOSE	T3	
ASSURE PRISM	T3	
AT HOME A1C	T3	
AUTOLET LITE	T2	
AUTOJECT 2	T2	
AUTO-LANCET MINI	T2	
AUTOLET IMPRESSION	T2	
AUTOLET LANCING DEVICE	T2	
AUTOLET PLUS	T2	
AUTOPEN	T2	
AUTOSOFT 30	T2	
AUTOSOFT 90	T2	
AUTOSOFT 30 INFUSION SET PACK	T3	
AUTOSOFT XC	T2	

T1 – Generics

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List of Prescription Medications

MISCELLANEOUS MEDICAL SUPPLIES, DEVICES, NON-DRUG (Diabetes) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
DIABETIC SUPPLIES (cont.)		
AUTOSOFT XC INFUSION SET PACK	T3	
BLOOD GLUCOSE CONTROL	T3	
BLOOD-GLUCOSE CONTROL	T3	
BREEZE 2	T3	
CAREONE	T2	
CARESENS	T3	
CARETOUCH CONTROL SOLUTION	T3	
CARETOUCH LANCING DEVICE	T2	
CEQUR SIMPLICITY	T2	
CEQUR SIMPLICITY INSERTER	T2	
CHEMSTRIP BG DIARY	T3	
CHOSEN LANCING DEVICE	T2	
CLEVER CHOICE CONTROL SOLUTION	T3	
CONTOUR	T3	
CONTOUR NEXT CONTROL SOLUTION	T3	
CONTROL SOLUTION	T3	
COOL CONTROL SOLUTION	T3	
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 RECEIVER	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)
DIATRUE	T3	
DROPLET GENTEE LANCING DEVICE	T2	
DROPLET LANCING DEVICE	T2	
EASY MINI EJECT LANCING DEVICE	T2	
EASY PLUS II CONTROL SOLN HIGH	T3	
EASY PLUS II CONTROL SOLN LOW	T3	

T1 – Generics

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List of Prescription Medications

MISCELLANEOUS MEDICAL SUPPLIES, DEVICES, NON-DRUG (Diabetes) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
DIABETIC SUPPLIES (cont.)		
EASY STEP CONTROL SOLUTION	T3	
EASY TALK CONTROL SOLN LOW	T3	
EASY TALK HIGH CONTROL SOLN	T3	
EASY TALK PLUS II HIGH CONTROL	T3	
EASY TALK PLUS II LOW CTRL SLN	T3	
EASY TOUCH BLULINK CTRL SOLN	T3	
EASY TOUCH CONTROL SOLUTION	T3	
EASY TOUCH LANCING DEVICE	T2	
EASY TRAK CONTROL SOLN HIGH	T3	
EASY TRAK CONTROL SOLN LOW	T3	
EASY TRAK II CONTROL SOLUTION	T3	
EASYGLUCO PLUS CONTROL NORMAL	T3	
EASymax 15 LEVEL 2 SOLUTION	T3	
EASymax NORMAL CONTROL SOLN	T3	
ELEMENT COMPACT CONTROL SOLN	T3	
ELEMENT CONTROL SOLUTION	T3	
EMBRACE EVO LEVEL 1 CTRL SOLN	T3	
EMBRACE GLUC CONTROL SOLN HIGH	T3	
EMBRACE GLUCOSE CONTROL SOLN	T3	
EMBRACE LANCING DEVICE	T2	
EMBRACE PRO	T3	
EMBRACE TALK CONTROL SOLUTION	T3	
ENLITE SERTER	T3	
EVENCARE G2 , G3 CONTROL SOLUTION	T3	
EVOLUTION CONTROL SOLUTION	T3	
FORA CONTROL SOLUTION	T3	
FORA GTel MULTIFUNCTN MONITOR	T3	
FORA KETONE CONTROL SOLUTION	T3	
FORA LANCING DEVICE	T2	
FORA TN'GO ADV MOBILE MULT MTR	T3	
FORA TN'GO ADVANCE MULTIFN MTR	T3	
FORA TN'G ADVANCE PRO MONITOR	T3	
FORACARE GDH	T3	
FORTISCARE	T3	

T1 – Generics

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List of Prescription Medications

MISCELLANEOUS MEDICAL SUPPLIES, DEVICES, NON-DRUG (Diabetes) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
DIABETIC SUPPLIES (cont.)		
FREESTYLE CONTROL SOLUTION	T2	
FREESTYLE LIBRE 2 READER	T2	PA QL (1 unit/365 days)
FREESTYLE LIBRE 2 SENSOR	T2	PA QL (2 sensors/28 days)
FREESTYLE LIBRE 2 PLUS SENSOR	T2	PA QL (2 units/30 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 READER	T2	PA
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	
GE100 CONTROL SOLUTION NORMAL	T3	
GENTEEL VACUUM LANCING DEVICE	T3	
GLUCOCARD 01 CONTROL	T3	
GLUCOCARD EXPRESSION CNTRL SLN	T3	
GLUCOCARD SHINE CONTROL SOLN	T3	
GLUCOCOM AUTOLINK	T3	
GLUCOCOM CONTROL SOLUTION	T3	
GLUCOSE CONTROL	T3	
GLUCOSE CONTROL SOLUTION	T3	
GOJJI GLUCOSE CONTROL SOLUTION	T3	
GOJJI KETONE CONTROL SOLUTION	T3	
GOJJI LANCING DEVICE	T2	
GOJJI MULTI-FUNCTIONAL METER	T3	
GUARDIAN 4 GLUCOSE SENSOR	T3	PA QL (5 sensors/30 days)
GUARDIAN 4 TRANSMITTER	T3	PA QL (1 transmitter/273 days)
GUARDIAN LINK 3 TRANSMITTER	T3	PA QL (1 transmitter/273 days)
GUARDIAN RT CHARGER	T3	
GUARDIAN RT STARTER KIT	T3	
GUARDIAN TEST PLUG	T3	
GUARDIAN TRANSMITTER TAPE	T3	
HEALTHPRO GLUCOSE CONTROL SOLN	T3	
HEALTHY ACCENTS AUTOLET	T2	

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MISCELLANEOUS MEDICAL SUPPLIES, DEVICES, NON-DRUG (Diabetes) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
DIABETIC SUPPLIES (cont.)		
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	
INFINITY CONTROL SOLUTION	T3	
INFINITY VOICE CONTROL SOLN	T3	
INPEN (FOR HUMALOG)	T3	
INPEN (FOR NOVOLOG OR FIASP)	T3	
INSUL-CAP	T3	
INSUL-EZE	T3	
LANCING DEVICE	T2	
LANCING SYSTEM	T2	
LANZO	T2	
LITE TOUCH LANCING PEN	T2	
MEDISENSE	T2	
MEDISENSE GLUCOSE KETONE	T2	
MEDISENSE GLUCOSE KETONE CONTR	T2	
MEDTRONIC EXT INFUSION SET	T2	
MEDTRONIC REMOTE CONTROL	T2	
MICRODOT HIGH-LOW CONTROL SOL	T3	
MICRODOT NORMAL CONTROL SOLUT	T3	
MICROLET 2	T2	
MICROLET NEXT LANCING DEVICE	T2	
MINI LANCING DEVICE	T2	
MINIMED	T2	
MINIMED MIO ADVANCE	T2	
MINIMED QUICK SET	T2	
MINIMED QUICK-SERTER	T3	
MINIMED QUICK-SERTER	T2	
MINIMED SILHOUETTE	T2	
MINIMED SURET	T2	
MULTI-LANCET	T2	

T1 – Generics

T2 – Preferred Brands

T3 – Non-Preferred Brands

T4 – Preferred Specialty

T5 – Non-Preferred Specialty

PA – Prior Authorization

QL – Quantity Limit

ST – Step Therapy

AGE – Age Requirement

SP – Specialty Medication

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List of Prescription Medications

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

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
DIABETIC SUPPLIES (cont.)		
MYGLUCOHEALTH CONTROL SOLUTION	T3	
NOVA MAX PLUS GLUC-KETON METER	T3	
NOVAMAX PLUS GLU-KET	T3	
NOVOPEN 3	T2	
NOVOPEN ECHO	T3	
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 CLASSIC PDM KIT(GEN 3)	T2	
OMNIPOD 5 G6-G7 PODS (GEN 5)	T2	QL (15 crtgs/30 days)
OMNIPOD CLASSIC PODS (GEN 3)	T2	
OMNIPOD DASH INTRO KIT (GEN 4)	T2	QL (1 kit/720 days)
OMNIPOD DASH PODS (GEN 4)	T2	QL (15 pods/28 days)
OMNIPOD GO PODS	T2	QL (10 crtgs/30 days)
ON CALL EXPRESS CONTROL SOLN	T3	
ON CALL LANCING DEVICE	T2	
ON CALL PLUS CONTROL	T3	
ON CALL PLUS LANCING DEVICE	T2	
ON CALL VIVID CONTROL	T3	
ONETOUCH DELICA	T2	
ONETOUCH DELICA PLUS LANC DEV	T2	
ONETOUCH ULTRA CONTROL SOLN	T2	
ONETOUCH VERIO HIGH CNTRL SOLN	T2	
ONETOUCH VERIO MID CNTRL SOLN	T2	
OPTUMRX GLUCOSE CONTROL SOLN	T3	
OVAL TAPE	T3	
PIP GLUCOSE CONTROL SOLUTION	T3	
PRECISION XTRA KETONE-GLUCOSE	T2	
PRODIGY CONTROL SOLUTION	T3	
PRODIGY LANCING DEVICE	T2	
QUICK RELEASE SOFT TEFILON	T2	

T1 – Generics

T2 – Preferred Brands

T3 – Non-Preferred Brands

T4 – Preferred Specialty

T5 – Non-Preferred Specialty

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

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
DIABETIC SUPPLIES (cont.)		
REFUAH PLUS GLUCOSE CONTROL	T3	
RELIAMED MINI LANCING DEVICE	T2	
REPLACEMENT PEDIATRIC MONITOR	T3	
RIGHTEST CONTROL SOLUTION	T3	
RIGHTEST GD500	T2	
SAFE-CLIP	T2	
SEN-SERTER	T3	
SILHOUETTE	T2	
SIL-SERTER	T2	
SMARTDIABETES VANTAGE	T2	
SMARTEST	T3	
SOF-SERTER	T2	
SOF-SET	T2	
SOF-SET MICRO	T2	
SOLUS V2 CONTROL SOLUTION	T3	
SOLUS V2 LANCING DEVICE	T2	
SURE COMFORT LANCING PEN	T2	
SUREFLEX	T2	
SURE-PEN	T2	
SURE-TEST EASYPLUS MINI SOLN	T3	
T:FLEX	T2	
T:SLIM X2	T2	
TANDEM MOBI AUTOSOFT 30	T2	PA SP HD
TANDEM MOBI AUTOSOFT XC	T2	PA SP HD
TANDEM MOBI AUTOSOFT XC SUPPLY	T2	
TANDEM MOBI AUTOSOFT 30 SUPPLY	T2	
TANDEM MOBI CARTRIDGE	T2	
TANDEM MOBI TRUSTEEL SUPPLY	T2	
TEL CARE CONTROL SOLUTION	T3	
TRUE METRIX	T3	
TRUECONTROL	T3	
TRUEDRAW	T2	
TRUSTEEL INFUSION SET	T2	
TRUSTEEL INFUSION SET PACK	T3	

T1 – Generics

T2 – Preferred Brands

T3 – Non-Preferred Brands

T4 – Preferred Specialty

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MISCELLANEOUS MEDICAL SUPPLIES, DEVICES, NON-DRUG (Diabetes) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
DIABETIC SUPPLIES (cont.)		
TWIIST REFILL KT(CSST-NDL-SYR)	T2	
TWIIST RFL(INFUS-CSST-NDL-SYR)	T2	
TWIIST STARTER KIT	T2	
ULTI-LANCE	T2	
ULTRATRAK CONTROL SOL NORMAL	T3	
ULTRATRAK CONTROL SOLUTION	T3	
ULTRATRAK ULTIMATE CNTRL SOLN	T3	
UNISTIK 2	T2	
UNISTRIP	T3	
VARISOFT INFUSION SET	T2	
V-GO 20	T2	
V-GO 30	T2	
V-GO 40	T2	
VIVAGUARD INO CONTROL SOLUTION	T3	
VIVAGUARD LANCING DEVICE	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	

T1 – Generics

T2 – Preferred Brands

T3 – Non-Preferred Brands

T4 – Preferred Specialty

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

T1 – Generics

T2 – Preferred Brands

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T5 – Non-Preferred Specialty

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List of Prescription Medications

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

T1 – Generics

T2 – Preferred Brands

T3 – Non-Preferred Brands

T4 – Preferred Specialty

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List of Prescription Medications

MISCELLANEOUS MEDICAL SUPPLIES, DEVICES, NON-DRUG (Diabetes) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
DURABLE MEDICAL EQUIPMENT,MISC(GROUP I) (cont.)		
medlance plus lite 25g lancets	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	
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	

T1 – Generics

T2 – Preferred Brands

T3 – Non-Preferred Brands

T4 – Preferred Specialty

T5 – Non-Preferred Specialty

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List of Prescription Medications

MISCELLANEOUS MEDICAL SUPPLIES, DEVICES, NON-DRUG (Diabetes) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
DURABLE MEDICAL EQUIPMENT,MISC(GROUP I) (cont.)		
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	
STERILANCE TL	T2	
STERILE LANCETS	T2	
SUPERTHIN 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	

T1 – Generics

T2 – Preferred Brands

T3 – Non-Preferred Brands

T4 – Preferred Specialty

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MISCELLANEOUS MEDICAL SUPPLIES, DEVICES, NON-DRUG (Diabetes) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
DURABLE MEDICAL EQUIPMENT,MISC(GROUP I) (cont.)		
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	
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 ECLIPSE NEEDLE 21GX1"	T2	

T1 – Generics

T2 – Preferred Brands

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T4 – Preferred Specialty

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MISCELLANEOUS MEDICAL SUPPLIES, DEVICES, NON-DRUG (Diabetes) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
NEEDLES/NEEDLELESS DEVICES (cont.)		
BD ECLIPSE NEEDLE 22GX1"	T2	
BD ECLIPSE NEEDLE 23GX1"	T3	
BD ECLIPSE NEEDLE 25G 16MM	T3	
BD ECLIPSE NEEDLE 25G 25MM	T3	
BD ECLIPSE NEEDLE 25GX1"	T2	
BD ECLIPSE NEEDLE 25GX1.5"	T2	
BD ECLIPSE NEEDLE 25GX5/8"	T3	
BD ECLIPSE NEEDLE 27GX1/2"	T3	
BD ECLIPSE NEEDLES 21GX1.5"	T2	
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	
BLUNT NEEDLE	T2	
CAREPOINT PRECISION NEEDLE	T3	
CARETOUCH HYPODERMIC NEEDLE	T3	
CHEMO TRANSFER PIN	T2	
DROPSAFE SICURA SAFETY NEEDLE	T3	
EASY TOUCH FLIPLOCK NEEDLE	T3	
EASY TOUCH FLIPLOCK NEEDLES	T3	
EASY TOUCH HYPODERMIC NEEDLE	T3	
EASYPPOINT NEEDLE	T3	
EXEL HUBER NEEDLE	T2	
EXEL HYPODERMIC NEEDLE	T2	
EXEL MTI DRAWING NEEDLE	T2	
FILTER ASPIRATOR NEEDLE	T2	
FILTER NEEDLE	T2	
FLOW-EZE	T2	
HURRICANE LUER-LOCK	T2	
HYPODERMIC NEEDLE	T2	

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MISCELLANEOUS MEDICAL SUPPLIES, DEVICES, NON-DRUG (Diabetes) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
NEEDLES/NEEDLELESS DEVICES (cont.)		
INTEGRA NEEDLE	T2	
INTEGRA PRECISIONGLIDE NEEDLE	T3	
LIFESHIELD BLUNT CANNULA	T2	
MINI TRANSFER PIN	T2	
MONOJECT BLOOD COLLECTION	T2	
MONOJECT FILTER NEEDLE	T3	
NANO 2ND GEN PEN NEEDLE	T2	
NANO PEN NEEDLE	T2	
NEEDLES	T2	
needles,safety huber,disposabl	T1	
NOKOR ADMIX NEEDLE	T2	
NOKOR NEEDLE	T2	
PEN NEEDLE 30G X 8MM	T3	
PERFECT POINT SAFETY NEEDLE	T3	
PHASEAL PROTECTOR	T3	
POLY HUB NEEDLE	T2	
PRECISIONGLIDE	T2	
PRECISIONGLIDE NEEDLE	T2	
QUINCE SPINAL NEEDLE	T2	
RAYA SURE PEN NEEDLE 29G 12MM	T3	
RAYA SURE PEN NEEDLE 31G 5MM	T3	
RAYA SURE PEN NEEDLE 31G 6MM	T3	
REGULAR BEVEL NEEDLES	T2	
SAFETYGLIDE NEEDLE	T2	
SHORT BEVEL NEEDLES	T2	
SPECIALTY USE NEEDLES	T2	
TERUMO SURGUARD2	T2	
THIN WALL NEEDLES	T2	
TRANSFER NEEDLE	T2	
TRANSFER PIN	T2	
ULTRA-FINE MICRO PEN NEEDLE	T2	
ULTRA-FINE MINI PEN NEEDLE	T2	
ULTRA-FINE NANO PEN NEEDLE	T2	
ULTRA-FINE ORIGINAL PEN NEEDLE	T2	

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MISCELLANEOUS MEDICAL SUPPLIES, DEVICES, NON-DRUG (Diabetes) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
NEEDLES/NEEDLELESS DEVICES (cont.)		
ULTRA-FINE SHORT PEN NEEDLE	T2	
ULTRA-FINE PEN NEEDLE	T2	
YALE NEEDLE	T2	
YALE NEEDLES	T2	
SYRINGES AND ACCESSORIES		
ALLERGIST TRAY	T3	
ALLERGIST TRAY SYR-DETACH NDL	T2	
ALLERGIST TRAY SYR-PERM NEEDLE	T2	
ALLERGY SYRINGE 1 ML 27GX1/2"	T3	
ALLERGY SYRINGE 1 ML 27GX3/8"	T3	
BD ALLERGY SYRINGE-NEEDLE 1 ML	T2	
BD ECLIPSE LUER-LOK SYR 1 ML	T2	
BD ECLIPSE LUER-LOK SYR 3 ML	T2	
BD ECLIPSE SYR 3 ML 22GX1-1/2"	T3	
BD INS SYR 0.3 ML 8MMX31G(1/2)	T2	
BD INS SYR UF 0.3ML 12.7MMX30G	T2	
BD INS SYR UF 0.5ML 12.7MMX30G	T2	
BD INS SYRN UF 1 ML 12.7MMX30G	T2	
BD INS SYRNG 0.3 ML 29GX12.7MM	T2	
BD INS SYRNG 0.5 ML 29GX12.7MM	T2	
BD INS SYRNG UF 0.3 ML 8MMX31G	T2	
BD INS SYRNG UF 0.5 ML 8MMX31G	T2	
BD INSULIN SYR 0.5 ML 28GX1/2"	T2	
BD INSULIN SYR 1 ML 25GX1"	T2	
BD INSULIN SYR 1 ML 25GX5/8"	T2	
BD INSULIN SYR 1 ML 26GX1/2"	T2	
BD INSULIN SYR 1 ML 27GX12.7MM	T2	
BD INSULIN SYR 1 ML 27GX5/8"	T2	
BD INSULIN SYR 1 ML 28GX1/2"	T2	
BD INSULIN SYR 1 ML 29GX1/2"	T2	
BD INSULIN SYR 1 ML 29GX12.7MM	T2	
BD INSULIN SYR UF 1 ML 8MMX31G	T2	
BD INSULIN SYRINGE 1 ML	T2	
BD SAFETYGLIDE 3 ML SYRINGE	T2	

T1 – Generics

T2 – Preferred Brands

T3 – Non-Preferred Brands

T4 – Preferred Specialty

T5 – Non-Preferred Specialty

PA – Prior Authorization

QL – Quantity Limit

ST – Step Therapy

AGE – Age Requirement

SP – Specialty Medication

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List of Prescription Medications

MISCELLANEOUS MEDICAL SUPPLIES, DEVICES, NON-DRUG (Diabetes) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
SYRINGES AND ACCESSORIES (cont.)		
BD SAFETYGLIDE SYR 22GX1.5"	T2	
BD SAFETYGLIDE SYR 3 ML 25GX1"	T3	
BD SAFETYGLIDE SYRINGE 27GX5/8	T2	
BD SAFETYGLIDE TB 1 ML SYR	T2	
BD SAFETYGLIDE TB 1ML 27G 10MM	T3	
BD SAFETYGLIDE TUBERCULIN SYR	T2	
BD SYRINGE-SAFETY GLIDE	T2	
BD UF INS SYR 1 ML 30GX1/2"	T2	
BULK SYRINGE	T2	
CANNULA	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	
CAREPOINT LUER SLIP SYRINGE	T3	
CAREPOINT LUER SLIP SYRING-NDL	T3	
CARETOUCH LUER LOCK	T2	
CARETOUCH LUER LOCK SYRINGE	T3	
CARETOUCH LUER SLIP SYRINGE	T3	
CORNWALL SYRINGE TIP CONNECTOR	T2	
DAVOL IRRIGATION SYRINGE	T2	
DOVER BULB SYRINGE	T3	
EASY GLIDE CATHETER TIP SYRING	T3	
EASY GLIDE LUER LOCK SYRINGE	T3	
EASY GLIDE LUER SLIP TB SYRING	T3	
EASY TOUCH FLIPLK 10ML 20GX1.5	T3	
EASY TOUCH FLIPLK 10ML 21GX1.5	T3	
EASY TOUCH FLIPLK 10ML 22GX1.5	T3	
EASY TOUCH FLIPLK 5 ML 20GX1.5	T3	
EASY TOUCH FLIPLK 5 ML 21GX1.5	T3	
EASY TOUCH FLIPLK 5 ML 22GX1.5	T3	
EASY TOUCH FLIPLOCK	T3	
EASY TOUCH FLIPLOCK 1 ML 25GX1	T2	

T1 – Generics

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

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
SYRINGES AND ACCESSORIES (cont.)		
EASY TOUCH FLIPLOCK 10ML 21GX1	T3	
EASY TOUCH FLIPLOCK 3 ML 18GX1	T3	
EASY TOUCH FLIPLOCK 3 ML 20GX1	T3	
EASY TOUCH FLIPLOCK 3 ML 21GX1	T3	
EASY TOUCH FLIPLOCK 5 ML 18GX1	T3	
EASY TOUCH FLIPLOCK 5 ML 21GX1	T3	
EASY TOUCH FLIPLOCK SYRINGE	T3	
EASY TOUCH FLIPLOK 10 ML 20GX1	T3	
EASY TOUCH FLIPLOK 10 ML 25GX1	T3	
EASY TOUCH FLIPLOK 1ML 26GX3/8	T2	
EASY TOUCH FLIPLOK 1ML 27GX0.5	T2	
EASY TOUCH FLIPLOK 3ML 18GX1.5	T3	
EASY TOUCH FLIPLOK 3ML 20GX1.5	T3	
EASY TOUCH FLIPLOK 3ML 21GX1.5	T3	
EASY TOUCH FLURINGE	T2	
EASY TOUCH FLURINGE FLIPLOCK	T2	
EASY TOUCH FLURINGE FLUTRAY	T3	
EASY TOUCH FLURINGE SHEATHLOCK	T2	
EASY TOUCH LUER LOCK INSULIN	T3	
EASY TOUCH LUER LOCK SYRINGE	T3	
EASY TOUCH SHEATHLOCK SYRG-NDL	T3	
EASY TOUCH SHEATHLOCK SYRINGE	T3	
EASY TOUCH SYR 1 ML 25GX5/8"	T2	
EASY TOUCH SYR 3 ML 22GX1-1/2"	T2	
EASY TOUCH SYR 3 ML 25GX5/8"	T2	
EASY TOUCH SYR ALLERGY TRAY	T3	
EASY TOUCH SYRINGE 1 ML 25GX1"	T2	
EASY TOUCH SYRINGE 3 ML 20GX1"	T2	
EASY TOUCH SYRINGE 3 ML 21GX1"	T2	
EASY TOUCH SYRINGE 3 ML 22GX1"	T2	
EASY TOUCH SYRINGE 3 ML 23GX1"	T2	
EASY TOUCH SYRINGE 3 ML 25GX1"	T2	
EASY TOUCH TUBERCULIN FLIPLOCK	T2	
EASY TOUCH TUBERCULIN SHEATHLK	T2	

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MISCELLANEOUS MEDICAL SUPPLIES, DEVICES, NON-DRUG (Diabetes) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
SYRINGES AND ACCESSORIES (cont.)		
EASY TOUCH UNI-SLIP	T3	
ECLIPSE SYRINGE	T2	
ECLIPSE SYRINGE-NEEDLE	T2	
ENFIT SYRINGE	T3	
ENFIT SYRINGE STERILE	T3	
ENFIT THUMB CONTROL RING SYRIN	T3	
EXEL SYRINGE	T2	
EXEL TB WITH NEEDLE	T2	
EXEL TUBERCULIN SYRINGE	T2	
EXTENDED RESERVOIR	T3	
FILTER, MILLEX-OR SYRINGE	T3	
FINGER GRIP EXTENDER	T3	
INJECT-EASE	T2	
INSULIN CARTRIDGE	T2	
INSULIN SYR 0.5 ML 28G 12.7MM	T2	
INSULIN SYR 0.5 ML 28G 12.7MM	T3	
INSULIN SYRINGE 1 ML 27G 16MM	T2	
INSULIN SYRINGE 1ML 28G 12.7MM	T2	
INSULIN SYRINGE U-500	T2	
INTEGRA SYRINGE	T2	
INTERLINK SYRINGE	T2	
INTERLINK SYRINGE W-CANNULA	T3	
KENDALL DISINFECTANT CAP	T3	
LEVER LOCK CANNULA	T3	
LIFESHIELD BLUNT CANNULA	T2	
LUER LOCK SYRINGE-NEEDLE	T2	
LUER LOCK SYRINGE	T2	
LUER SLIP TIP SYRINGE TRAY	T3	
LUER TIP CAP TRAY	T3	
LUER-LOK SYRINGE	T2	
LUER-LOCK SYRINGE-NEEDLE	T2	PA SP HD
LUER-LOK TIP SYRINGE	T2	
LUERSLIP SYRINGE	T2	
MAGELLAN SAFETY SYRINGE	T2	

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MISCELLANEOUS MEDICAL SUPPLIES, DEVICES, NON-DRUG (Diabetes) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
SYRINGES AND ACCESSORIES (cont.)		
MAGELLAN TB SAFETY SYRINGE	T2	
MAGELLAN TUBERCULIN SYRINGE	T2	
MINIMED RESERVOIR 1.8 ML	T3	
MINIMED RESERVOIR 3 ML	T2	
MONOJECT 3 ML SYRINGE 25GX1"	T2	
MONOJECT 6CC SAFETY SYRINGE	T2	
MONOJECT ALLERGY TRAY-NEEDLE	T2	
MONOJECT CONTROL SYRINGE	T2	
MONOJECT ENFIT SYRINGE	T3	
MONOJECT ENFIT SYRINGE CAP	T3	
MONOJECT LUER LOCK TB SYRINGE	T2	
MONOJECT MAGELLAN	T2	
MONOJECT PHARMACY TRAY	T2	
MONOJECT SAFETY SYRTIP CAP	T3	
MONOJECT SAFETY SYRINGE	T2	
MONOJECT SMARTIP CANNULA	T3	
MONOJECT SYRINGE	T2	
MONOJECT SYRINGE 140 ML	T3	
MONOJECT SYRINGE 35 ML	T2	
MONOJECT SYRINGE PHARMACY TRAY	T2	
MONOJECT TB	T2	
MONOJECT TB SYRINGE	T2	
MONOJECT TB SAFETY SYRINGE	T2	
MONOJECT TUBERCULIN SYRINGE	T2	
NORM-JECT SYRINGE	T3	
NORM-JECT TUBERKULIN SYRINGE	T3	
PARADIGM	T2	
PISTON ENFIT SYRINGE	T3	
PRECISIONGLIDE	T2	
PRODIGY COUNT-A-Dose	T2	
SAFESNAP ALLERGY SYRINGE	T3	
SAFESNAP SYRINGE 10 ML	T2	
SAFESNAP SYRINGE 10 ML	T3	
SAFESNAP SYRINGE 3 ML	T2	

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

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
SYRINGES AND ACCESSORIES (cont.)		
SAFESNAP SYRINGE 5 ML	T2	
SAFESNAP SYRINGE 5 ML	T3	
SAFESNAP TUBERCULIN SYRINGE	T3	
SAFETY SYRINGE WITH SHIELD	T2	
SAFETY SYRINGE-NEEDLE	T3	
SAFETYGLIDE ALLERGY	T2	
SAFETYGLIDE ALLERGY SYRINGE	T3	
SAFETYGLIDE INSULIN SYRINGE	T2	
SAFETY-LOK SAFETY SYRINGE	T2	
SAFETY-LOK SAFETY SYRINGES	T2	
SAFETY-LOK SYRINGES	T2	
SLIP-TIP SYRINGE	T3	
SUPOR	T3	
SYRINGE	T2	
SYRINGE BULK	T2	
SYRINGE CATHETER TIP	T2	
SYRINGE CATHETER TIP NON-STER	T2	
SYRINGE FILTER, MILLEX-GP	T3	
SYRINGE FILTER, MILLEX-GS	T3	
SYRINGE LUER LOCK	T2	PA SP HD
SYRINGE LUER-LOK	T2	
SYRINGE LUER-LOK NON-STERILE	T2	
SYRINGE LUER-LOK STERILE	T2	
SYRINGE SLIP TIP NON-STERILE	T2	
SYRINGE SLIP TIP	T2	
SYRINGE STORAGE BIN	T3	
SYRINGE TIP CAP	T2	
SYRINGE WITH NEEDLE	T2	
SYRINGE WITH NEEDLE DISP	T2	
SYRINGE WITHOUT NEEDLE	T2	
SYRINGE-LUERTIP CAP	T2	
SYRINGE-NEEDLE	T2	
SYRINGE-PRECISIONGLIDE NEEDLE	T2	
TB SYRINGE	T2	

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MISCELLANEOUS MEDICAL SUPPLIES, DEVICES, NON-DRUG (Diabetes) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
SYRINGES AND ACCESSORIES (cont.)		
TERUMO ALLERGY SYRINGE	T2	
TERUMO HYPODERMIC NEEDLE-SYRIN	T2	
TERUMO SURGUARD2	T2	
TERUMO SYRINGE	T2	
TOOMEY SYRINGE	T2	
TUBERCULIN SLIP-TIP SYRINGE	T3	
TUBERCULIN SYRINGE	T2	
TUBERCULIN SYRINGE-NEEDLE	T2	
TWINPAK DUAL CANNULA	T2	
ULTICARE LDS SYR 1 ML 22G 1.5"	T3	
ULTICARE LDS SYR 3 ML 22GX1.5"	T2	
ULTICARE SAFETY SYRINGE	T3	
ULTICARE SYRINGE	T3	
ULTICARE TB SAFETY 1 ML 25GX1"	T2	
ULTICARE TB SAFETY 1ML 25GX5/8	T2	
ULTICARE TB SAFETY SYRINGE	T2	
ULTIGUARD SAFE 1ML 30G 12.7MM	T3	
ULTIGUARD SAFEPACK 1ML 31G 8MM	T3	
ULTRA-FINE INSULIN SYRINGE	T2	
UNIVERSAL SYRINGE TIP ADAPTOR	T3	
VANISHPOINT 1 ML TB SYR 25X5/8	T2	
VANISHPOINT 1 ML TB SYR 27X1/2	T2	
VANISHPOINT 20GX1" 3 ML SYRING	T2	
VANISHPOINT 21GX1" 5 ML SYRING	T2	
VANISHPOINT 21GX1.5" 3 ML SYR	T2	
VANISHPOINT 22GX1" 3 ML SYR	T2	
VANISHPOINT 22GX1-1/2" 5 ML SY	T2	
VANISHPOINT 23GX1" 3 ML SYRING	T2	
VANISHPOINT 23GX1-1/2 3 ML SYR	T2	
VANISHPOINT 25GX1" 3 ML SYRING	T2	
VANISHPOINT 25GX5/8" 3 ML SYR	T2	
VANISHPOINT 3 ML 21GX1" SYRING	T2	
VANISHPOINT 3 ML 22GX1.5" SYRG	T2	
VANISHPOINT SYRINGE	T3	

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MISCELLANEOUS MEDICAL SUPPLIES, DEVICES, NON-DRUG (Diabetes) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
SYRINGES AND ACCESSORIES (cont.)		
VANISHPOINT SYRINGE 1 ML 25X1"	T2	
VEO INSULIN SYRINGE	T2	
MISCELLANEOUS MEDICAL SUPPLIES, DEVICES, NON-DRUG (Miscellaneous)		
BANDAGES AND RELATED SUPPLIES		
ARGLAES FILM	T3	
CONFORMANT 2	T3	
DERMAVIEW	T2	
DERMAVIEW II	T2	
IV 3000	T2	
IV3000 FRAME DELIVERY	T3	
KENDALL	T2	
NEXCARE TEGADERM 2.375"X2.75"	T3	
NEXCARE TEGADERM DRESSING	T2	
OPSITE	T3	
OPSITE IV 3000	T2	
POLYSKIN II	T2	
SURESITE MATRIX	T2	
SURESITE WINDOW	T2	
TEGADERM 1.75X1.75" DRSSNG	T3	
TEGADERM 2"X2.75" DRESSING	T2	
TEGADERM 2.375"X2.75" DRESSING	T2	
TEGADERM 2.375"X4" DRESSING	T2	
TEGADERM 2.375X2.75" DRSSNG	T2	
TEGADERM 3.5" X 4" DRESSING	T2	
TEGADERM 3.5"X 10" DRESSING	T3	
TEGADERM 3.5"X 6" DRESSING	T3	
TEGADERM 3.5"X13.75" DRESS	T3	
TEGADERM 3.5"X4.125" DRESS	T2	
TEGADERM 3.5"X8" DRESSING	T3	
TEGADERM 4" X 10" DRESSING	T2	
TEGADERM 4" X 4-3/4" DRESSING	T2	
TEGADERM 4"X4.75" DRESSING	T2	
TEGADERM 6" X 8" DRESSING	T2	

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MISCELLANEOUS MEDICAL SUPPLIES, DEVICES, NON-DRUG (Miscellaneous) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
BANDAGES AND RELATED SUPPLIES (cont.)		
TEGADERM 8" X 12" DRESSING	T2	
TEGADERM ABSORBENT	T3	
TEGADERM HP 4" X 4.5 " DRSSN	T2	
TEGADERM HP 4.5"X4.75" DRSS	T2	
TEGADERM HP DRESSING	T2	
TEGADERM HP DRESSING	T3	
TEGADERM I.V.	T3	
TEGADERM I.V. 2.5"X2.75" DRSSN	T3	
TEGADERM I.V. 4"X4.75" DRSSN	T2	
TRANSPARENT DRESSING	T3	
TRANSPARENT FILM DRESSING	T3	
TRANSPARENT I.V. SITE DRESSING	T2	
TRANSPARENT MEPITEL FILM DRESS	T3	
TRANSPARENT THIN FILM DRESSING	T2	
WINDOW BANDAGES	T3	
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	
ACTI-LANCE UNIVERS 23G LANCETS	T2	
<i>acti-lance univers 23g lancets</i>	T1	
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	

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
DURABLE MEDICAL EQUIPMENT,MISC(GROUP I) (cont.)		
ASSURE LANCE PLUS	T2	
BD MICROTAINER LANCETS	T2	
BD ULTRA-FINE	T2	
BD ULTRA-FINE II	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	
CHOSEN LANCET	T2	
CHOSEN SAFETY LANCET	T2	
CLEVER CHEK LANCETS	T2	
COAGUCHEK	T2	
COLOR LANCETS	T2	
COMFORT EZ	T2	
COMFORT LANCETS	T2	
DROPLET LANCETS	T2	
EASY COMFORT LANCETS	T2	
EASY TOUCH BUTTON 30G 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	

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
DURABLE MEDICAL EQUIPMENT,MISC(GROUP I) (cont.)		
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	
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 SUPER THIN 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	
MEDLANCE PLUS 21G LANCETS	T2	
<i>medlance plus 21g lancets</i>	T1	
MEDLANCE PLUS 30G LANCETS	T2	
<i>medlance plus 30g lancets</i>	T1	

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
DURABLE MEDICAL EQUIPMENT,MISC(GROUP I) (cont.)		
MEDLANCE PLUS EXTRA 21G LANCET	T2	
MEDLANCE PLUS LITE 25G LANCETS	T2	
<i>medlance plus lite 25g lancets</i>	T1	
MEDLANCE PLUS SPECIAL BLADE	T2	
MICROTHIN LANCET	T2	
MICROTHIN LANCETS	T2	
MICROLET	T2	
MICROTAINER LANCETS	T2	
MONOLET LANCETS	T2	
MONOLET THIN LANCETS	T2	
MYGLUCOHEALTH LANCETS	T2	
NOVA SAFETY LANCETS	T2	
NOVA SUREFLEX	T2	
ON CALL LANCET	T2	
ON CALL PLUS LANCET	T2	
ONETOUCH DELICA	T2	
ONETOUCH DELICA PLUS LANCET	T2	
ONETOUCH DELICA SAFETY LANCET	T2	
ONETOUCH LANCETS	T2	
ONETOUCH SURESOFT	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	
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	

T1 – Generics

T2 – Preferred Brands

T3 – Non-Preferred Brands

T4 – Preferred Specialty

T5 – Non-Preferred Specialty

PA – Prior Authorization

QL – Quantity Limit

ST – Step Therapy

AGE – Age Requirement

SP – Specialty Medication

HD – 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
DURABLE MEDICAL EQUIPMENT,MISC(GROUP I) (cont.)		
RIGHTEST 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	
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	
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	

T1 – Generics

T2 – Preferred Brands

T3 – Non-Preferred Brands

T4 – Preferred Specialty

T5 – Non-Preferred Specialty

PA – Prior Authorization

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List of Prescription Medications

MISCELLANEOUS MEDICAL SUPPLIES, DEVICES, NON-DRUG (Miscellaneous) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
DURABLE MEDICAL EQUIPMENT,MISC(GROUP I) (cont.)		
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	
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 COMFORT	T2	
UNISTIK CZT	T2	
UNISTIK EXTRA	T2	
UNISTIK NORMAL	T2	
UNISTIK PRO	T2	
UNISTIK SAFETY	T2	
UNISTIK TOUCH	T2	
UNIVERSAL 1	T2	
VIVAGUARD LANCET	T2	
VIVAGUARD SAFETY LANCET	T2	
MEDICAL SUPPLIES,MISCELLANEOUS		
ALCOH-GLOVE	T3	
ALCOH-WIPE	T3	
PARENTERAL ADMINISTRATION SETS		
1.5 VOLT BATTERIES #357	T2	
ACCU-CHEK	T3	
ACCU-CHEK RAPID D 10-100	T3	

T1 – Generics
 T2 – Preferred Brands
 T3 – Non-Preferred Brands
 T4 – Preferred Specialty

T5 – Non-Preferred Specialty
 PA – Prior Authorization
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 ST – Step Therapy
 AGE – Age Requirement
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List of Prescription Medications

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

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
PARENTERAL ADMINISTRATION SETS (cont.)		
ACCU-CHEK RAPID D 10-50	T3	
ACCU-CHEK RAPID D 10-70	T2	
ACCU-CHEK RAPID D 6-100	T3	
ACCU-CHEK RAPID D 6-50	T2	
ACCU-CHEK RAPID D 6-70	T3	
ACCU-CHEK RAPID D 8-100	T3	
ACCU-CHEK RAPID D 8-50	T2	
ACCU-CHEK RAPID D 8-70	T2	
ACCU-CHEK SPIRIT,TENDER	T2	
ACCU-CHEK ULTRAFLEX	T2	
DELTEC COZMO CLEO INFUSION SET	T2	
INSET 30 TUBING	T2	
IV ADMINISTRATION SET	T2	
NERIA	T3	
PARADIGM INFUSION	T2	
POLYFIN QR	T2	
PSV SET	T3	
Q-SYTE	T2	
SILHOUETTE	T2	
SURE-T	T2	
RESPIRATORY AIDS,DEVICES,EQUIPMENT		
ACE AEROSOL CLOUD ENHANCER	T2	
AEROCHAMBER2GO	T2	PA SP HD
AEROCHAMBER MECHANICAL VENT	T2	
AEROCHAMBER MINI	T2	
AEROCHAMBER MV	T2	
AEROCHAMBER PLUS FLOW-VU	T2	
AEROCHAMBER Z-STAT PLUS	T2	
AEROTRACH PLUS	T2	
AEROVENT PLUS	T2	
BREATHERITE	T2	
BREATHERITE SPACER-ADULT MASK	T2	
BREATHERITE SPACER-INFANT MASK	T2	
BREATHERITE SPACER-LG CHLD MSK	T2	

T1 – Generics

T2 – Preferred Brands

T3 – Non-Preferred Brands

T4 – Preferred Specialty

T5 – Non-Preferred Specialty

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List of Prescription Medications

MISCELLANEOUS MEDICAL SUPPLIES, DEVICES, NON-DRUG (Miscellaneous) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
RESPIRATORY AIDS, DEVICES, EQUIPMENT (cont.)		
BREATHERITE SPACER-NEONATE MSK	T2	
BREATHERITE SPACER-SM CHLD MSK	T2	
BREATHRITE	T2	
CLEVER CHOICE HOLDING CHAMBER	T2	
COMFORTSEAL	T2	
COMPACT SPACE CHAMBER	T2	
EASIVENT	T2	
FLEXICHAMBER	T2	
FLEXICHAMBER MASK	T2	
INSPIRACHAMBER	T2	
LITEAIRE	T2	
LITETOUCH	T2	
MICROCHAMBER	T2	
MICROSPACER	T2	
MOUTHPIECE	T2	
ONE WAY MOUTHPIECE	T2	
OPTICHAMBER	T2	
OPTICHAMBER DIAMOND	T2	
PANDA MASK	T2	
PEDIATRIC MASK	T2	
PEDIATRIC PANDA MASK	T2	
POCKET CHAMBER	T2	
PRIMEAIRE	T2	
PRO COMFORT SPACER-ADULT MASK	T2	
PRO COMFORT SPACER-CHILD MASK	T3	
PRO COMFORT SPACER-INFANT MASK	T3	
PROCARE SPACER WITH ADULT MASK	T2	
PROCARE SPACER WITH CHILD MASK	T2	
PROCHAMBER	T2	
PURECOMFORT PEAK FLOW MOUTHPC	T2	
PURE COMFORT SPACER WITH MASK	T3	
RITEFLO	T2	
SIDESTREAM PEDIATRIC	T2	
SILICONE MASK	T2	

T1 – Generics

T2 – Preferred Brands

T3 – Non-Preferred Brands

T4 – Preferred Specialty

T5 – Non-Preferred Specialty

PA – Prior Authorization

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List of Prescription Medications

MISCELLANEOUS MEDICAL SUPPLIES, DEVICES, NON-DRUG (Miscellaneous) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
RESPIRATORY AIDS,DEVICES,EQUIPMENT (cont.)		
SPACE CHAMBER	T2	
SPACE CHAMBER-LARGE MASK	T2	
SPACE CHAMBER-MEDIUM MASK	T2	
SPACE CHAMBER-SMALL MASK	T2	
VORTEX	T2	
VORTEX VHC FROG MASK	T2	
VORTEX VHC LADYBUG MASK	T2	
VORTEX VHC PEDIATRIC MASK	T2	
MUSCLE RELAXANTS (Pain Relief and Inflammatory Disease)		
SKELETAL MUSCLE RELAX.-TOP. IRRITANT COUNTER-IRRIT		
COMFORT PAC-CYCLOBENZAPRINE	T3	
COMFORT PAC-TIZANIDINE	T3	
SKELETAL MUSCLE RELAXANTS		
<i>baclofen 5 mg, 10 mg tablet</i>	T1	HD
<i>baclofen 15 mg, 20 mg tablet</i>	T1	HD
<i>baclofen 10 mg/5 ml solution</i>	T1	PA SP HD
<i>baclofen 5mg/5ml solution</i>	T1	HD
<i>baclofen 25mg/5ml suspension (Fleqsuvy)</i>	T1	HD
<i>carisoprodol (Soma)</i>	T1	
<i>carisoprodol/aspirin</i>	T1	
<i>chlorzoxazone</i>	T1	
<i>chlorzoxazone (Lorzone)</i>	T1	
<i>cyclobenzaprine hcl</i>	T1	
<i>cyclobenzaprine hcl (Amrix)</i>	T1	PA
<i>cyclobenzaprine hcl (Fexmid)</i>	T1	
<i>DANTRIUM (dantrolene sodium)</i>	T3	
<i>dantrolene sodium</i>	T1	
<i>dantrolene sodium (Dantrium)</i>	T1	
<i>FEXMID (cyclobenzaprine hcl)</i>	T3	PA
<i>LORZONE (chlorzoxazone)</i>	T3	PA
<i>metaxalone 400 mg, 800 mg tablet</i>	T1	
<i>methocarbamol</i>	T1	
<i>methocarbamol 500 mg, 750 mg, 1,000 mg tablet</i>	T1	

T1 – Generics

T2 – Preferred Brands

T3 – Non-Preferred Brands

T4 – Preferred Specialty

T5 – Non-Preferred Specialty

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QL – Quantity Limit

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List of Prescription Medications

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

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
SKELETAL MUSCLE RELAXANTS (cont.)		
NORGESIC (<i>orphenadrine/aspirin/caffeine</i>)	T3	
NORGESIC FORTE (<i>orphenadrine/aspirin/caffeine</i>)	T3	
<i>orphenadrine citrate</i>	T1	
<i>orphenadrine/aspirin/caffeine</i> (Norgesic Forte)	T1	
<i>orphenadrine/aspirin/caffeine</i> (Norgesic)	T1	
SOMA (<i>carisoprodol</i>)	T3	
<i>tizanidine hcl</i>	T1	
<i>tizanidine hcl</i> (Zanaflex)	T1	
ZANAFLEX (<i>tizanidine hcl</i>)	T3	

PRE-NATAL VITAMINS (Nutritional/Dietary)

PREGNANT VITAMIN PREPARATIONS

BAL-CARE DHA ESSENTIAL	T3	
BRAINSTRONG PRENATAL	T3	
CADEAU DHA	T3	
CITRANATAL 90 DHA	T3	
CITRANATAL ASSURE	T3	
CITRANATAL DHA	T3	
CITRANATAL HARMONY	T3	
CITRANATAL RX	T3	
<i>cvs prenatal multi-dha softgel</i>	T1	PPACA
<i>cvs prenatal multivit-dha sfgl</i>	T1	PPACA
<i>cvs prenatal vitamins tablet</i>	T1	PPACA
DUET DHA BALANCED	T3	
EXPECTA PRENATAL	T2	
<i>ft prenatal tablet</i>	T1	PPACA
<i>gnp prenatal vitamins tablet</i>	T1	PPACA
GS PRENATAL VITAMINS TABLET	T3	
HM ONE DAILY PRENATAL COMBO PK	T2	
<i>hm prenatal tablet</i>	T1	PPACA
KOSHER PRENATAL PLUS IRON	T3	
KPN PRENATAL TABLET	T2	
<i>kpn tablet</i>	T1	PPACA
MARNATAL-F	T3	

T1 – Generics

T2 – Preferred Brands

T3 – Non-Preferred Brands

T4 – Preferred Specialty

T5 – Non-Preferred Specialty

PA – Prior Authorization

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List of Prescription Medications

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

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
PRENATAL VITAMIN PREPARATIONS (cont.)		
MINI PRENATAL	T3	
MTERYTI	T3	
MTERYTI FOLIC 5	T3	
NATACHEW	T3	
NEONATAL COMPLETE	T3	
NEONATAL PLUS	T3	
NEONATAL-DHA	T3	
NESTABS	T3	
NESTABS ABC	T3	
NESTABS DHA	T3	
OB COMPLETE ONE	T3	
OB COMPLETE PETITE	T3	
OB COMPLETE PREMIER	T3	
OB COMPLETE WITH DHA	T3	
OBSTETRIX EC	T3	
OBTREX DHA	T3	
ONE A DAY WOMEN'S PRENATAL DHA	T3	
ONE-A-DAY PRENATAL-1	T3	
<i>pnv 11/iron fum/folic acid/om3</i>	T1	
<i>pnv 119/iron fum/folic acid</i>	T1	
<i>pnv 66/iron/folic/docusate/dha</i>	T1	
<i>pnv 69/iron/folic/docusate/dha</i>	T1	
<i>pnv 80/iron fum/folic/dss/dha</i>	T1	
<i>pnv no.52/iron/fa/omega-3/dha</i>	T1	PA SP HD
<i>pnv81/iron ps,edta/folic/omeg3</i>	T1	PA SP HD
<i>pnv no.118/iron fumarate/fa</i>	T1	
<i>pnv no.154/iron fum/folic acid</i>	T1	
<i>pnv,calcium 72/iron,carb/folic</i>	T1	
<i>pnv,calcium 72/iron/folic acid</i>	T1	
<i>pnv/iron,carb/docusat/folic ac</i>	T1	
<i>pnv19/iron bg,s,p/folic ac/om3</i>	T1	
<i>pnv81/iron edta,ps/folic/omeg3</i>	T1	
PRENATA	T3	
<i>prenatal 105/iron/folic ac/dha</i>	T1	

T1 – Generics

T2 – Preferred Brands

T3 – Non-Preferred Brands

T4 – Preferred Specialty

T5 – Non-Preferred Specialty

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List of Prescription Medications

PRE-NATAL VITAMINS (Nutritional/Dietary) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
PRENATAL VITAMIN PREPARATIONS (cont.)		
prenatal 12/iron/folic/dss/om3	T1	
prenatal,calc 40/iron/folate 1	T1	PA SP HD
PRENATAL 19 CHEWABLE TABLET	T3	
prenatal 19 chewable tablet	T1	
PRENATAL 19 TABLET	T3	
prenatal 19 tablet	T1	
prenatal 21/iron fu/folic acid	T1	PPACA
prenatal 53/iron/folic ac/omg3	T1	
prenatal 54/iron/folic ac/omg3	T1	
prenatal 93/iron/folate 9/dha	T1	
prenatal caplet	T1	PPACA
PRENATAL FORMULA	T2	
PRENATAL FORMULA-DHA (prenatal vit 116/iron/fa/dha)	T3	PA SP HD
PRENATAL GUMMIES	T3	
PRENATAL MULTI	T3	
prenatal multi-dha softgel	T1	PPACA
PRENATAL MULTI-DHA SOFTGEL	T2	
PRENATAL MULTI-DHA SOFTGEL	T3	
prenatal multivitamin tablet	T1	PPACA
PRENATAL MULTIVITAMIN TABLET	T3	
PRENATAL MULTIVITAMIN-DHA SFGL	T2	
PRENATAL PLUS VITAMIN-MINERAL	T3	
PRENATAL PLUS-DHA	T3	
prenatal tablet	T1	PPACA
PRENATAL TABLET	T3	
prenatal vit 14/iron fum/folic	T1	
prenatal vit 55/iron/folic/om3	T1	
prenatal vit 91/iron/folic/dha	T1	
prenatal vit no.126/iron/folic	T1	PPACA
prenatal vit no.129/iron/folic	T1	PPACA
prenatal vit,cal 73/iron/folic	T1	
prenatal no.42/folic acid (Vitamedmd Redichew Rx)	T1	PA SP HD
prenatal vit 27,calc/iron/fa	T1	PA SP HD
prenatal vit,cal 76/iron/folic	T1	PA SP HD

T1 – Generics

T2 – Preferred Brands

T3 – Non-Preferred Brands

T4 – Preferred Specialty

T5 – Non-Preferred Specialty

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List of Prescription Medications

PRE-NATAL VITAMINS (Nutritional/Dietary) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
PRENATAL VITAMIN PREPARATIONS (cont.)		
prenatal vit,cal 78/iron/folic	T1	PA SP HD
prenatal vits 86/iron/folic ac	T1	PA SP HD
prenatal vit/iron fum/folic ac	T1	
PRENATAL VITAMIN + DHA	T2	
prenatal vitamin tablet	T1	PPACA
PRENATAL VITAMIN TABLET (<i>prenatal vit no.124/iron/folic</i>)	T3	
prenatal vitamins tablet	T1	PPACA
prenatal vits calc.36/iron/fa	T1	PPACA
prenatal71/iron/folic acid/dha	T1	
PRENATE ENHANCE	T3	
PRENATE RESTORE	T3	
PRIMACARE	T3	
PROVIDA OB	T3	
qc prenatal tablet	T1	PPACA
ra one daily prenatal dha pack	T1	PPACA
ra prenatal tablet	T1	PPACA
SELECT-OB	T3	
SELECT-OB (<i>prenatal vit128/iron/folic acd</i>)	T3	
SELECT-OB + DHA	T3	
SIMILAC PRENATAL	T3	
sm prenatal vitamins tablet	T1	PPACA
STUART ONE (<i>pnv no.63/iron,carb/folic/dha</i>)	T3	
sv prenatal tablet	T1	PPACA
SV PRENATAL VITAMIN TABLET	T3	
THERANATAL	T3	
THERANATAL COMPLETE	T3	
THERANATAL ONE	T3	
THERANATAL PLUS	T3	
THRIVITE RX	T3	
TRICARE	T3	
TRICARE PRENATAL DHA ONE	T3	
TRISTART DHA	T3	
VITAFOL FE PLUS	T3	
VITAFOL NANO	T3	

T1 – Generics

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T3 – Non-Preferred Brands

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List of Prescription Medications

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

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
PRENATAL VITAMIN PREPARATIONS (cont.)		
VITAFOL ULTRA	T3	
VITAFOL-OB	T3	
VITAFOL-OB+DHA	T3	
VITAFOL-ONE	T3	
VITAMEDMD ONE RX	T3	
VITAMEDMD REDICHEW RX (<i>pregnatal no.42/folic acid</i>)	T3	PA SP HD
VITAPEARL	T3	
VITATRUE	T3	
VP-PNV-DHA	T3	
WOMEN'S PRENATAL PLUS DHA	T2	

PRENATAL VITAMINS WITH LOW OR NO IRON

CVS PRENATAL GUMMIES	T3	
CITRANATAL B-CALM	T3	PA SP HD
DUET DHA 400	T3	PA SP HD
PRENATAL GUMMIES	T3	
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 OAVITE	T3	PA SP HD
TRINAZ	T3	
ULTRA PRENATAL PLUS DHA	T3	PA SP HD
VITAFOL GUMMIES	T3	PA SP HD

PSYCHOTHERAPEUTIC DRUGS (Anxiety/Depression/Bipolar Disorder)⁸

ALPHA-2 RECEPTOR ANTAGONIST ANTIDEPRESSANTS

mirtazapine	T1	HD
mirtazapine (Remeron)	T1	HD
REMERON (mirtazapine)	T3	HD

ANTI-ANXIETY - BENZODIAZEPINES

alprazolam	T1	
alprazolam (Xanax Xr)	T1	
alprazolam (Xanax)	T1	

T1 – Generics

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T3 – Non-Preferred Brands

T4 – Preferred Specialty

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List of Prescription Medications

PSYCHOTHERAPEUTIC DRUGS (Anxiety/Depression/Bipolar Disorder) ⁸ (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ANTI-ANXIETY - BENZODIAZEPINES (cont.)		
ATIVAN (<i>lorazepam</i>)	T3	
<i>chlordiazepoxide hcl</i>	T1	
<i>clorazepate dipotassium</i>	T1	
<i>diazepam 10 mg tablet (Valium)</i>	T1	
<i>diazepam 2 mg tablet (Valium)</i>	T1	
<i>diazepam 25 mg/5 ml oral conc</i>	T1	
<i>diazepam 5 mg tablet (Valium)</i>	T1	
<i>diazepam 5 mg/5 ml oral soln</i>	T1	
<i>diazepam 5 mg/5 ml solution</i>	T1	
<i>diazepam 5 mg/ml oral conc</i>	T1	
<i>lorazepam</i>	T1	
<i>lorazepam (Ativan)</i>	T1	
<i>oxazepam</i>	T1	
ANTI-ANXIETY DRUGS		
<i>buspirone hcl</i>	T1	HD
<i>meprobamate</i>	T1	
ANTIDEPRESSANT - POSTPARTUM DEPRESSION (PPD)		
ZURZUVAE 20 MG CAPSULE	T4	QL (28 caps/365 days) SP HD
ZURZUVAE 25 MG CAPSULE	T4	QL (28 caps/365 days) SP HD
ZURZUVAE 30 MG CAPSULE	T4	QL (14 caps/365 days) SP HD
BIPOLAR DISORDER DRUGS		
EQUETRO	T3	HD
<i>lithium carbonate</i>	T1	HD
<i>lithium carbonate (Lithobid)</i>	T1	HD
<i>LITHOBID (lithium carbonate)</i>	T3	HD
MAOIS -NON-SELECTIVE, IRREVERSIBLE ANTIDEPRESSANTS		
MARPLAN	T3	
MAOIS -NON-SELECTIVE, IRREVERSIBLE ANTIDEPRESSANTS		
NARDIL (<i>phenelzine sulfate</i>)	T3	
PARNATE (<i>tranylcypromine sulfate</i>)	T3	
<i>phenelzine sulfate (Nardil)</i>	T1	
<i>tranylcypromine sulfate (Parnate)</i>	T1	
MONOAMINE OXIDASE (MAO) INHIBITOR ANTIDEPRESSANTS		
EMSAM	T3	

T1 – Generics

T2 – Preferred Brands

T3 – Non-Preferred Brands

T4 – Preferred Specialty

T5 – Non-Preferred Specialty

PA – Prior Authorization

QL – Quantity Limit

ST – Step Therapy

AGE – Age Requirement

SP – Specialty Medication

HD – 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
NDMA RECEPTOR ANTAGONIST AND NDRI COMB		
AUVELITY	T3	ST QL (60 tabs/30 days)
NOREPINEPHRINE AND DOPAMINE REUPTAKE INHIB (NDRIS)		
bupropion hcl	T1	HD
SELECTIVE SEROTONIN 5-HT2A INVERSE AGONISTS (SSIA)		
NUPLAZID 10 MG TABLET	T5	PA QL (30 tabs/fill) SP HD
NUPLAZID 34 MG CAPSULE	T5	PA QL (30 caps/fill) SP HD
SELECTIVE SEROTONIN REUPTAKE INHIBITOR (SSRIS)		
citalopram hbr 10 mg/5 ml soln	T1	HD
citalopram hbr 20 mg/10 ml cup	T1	PA SP HD
escitalopram oxalate 5 mg/5 ml	T1	ST HD
escitalopram 10 mg/10 ml cup	T1	PA SP HD
fluoxetine hcl	T1	ST QL (4 caps/fill) HD
fluoxetine 20 mg/5 ml solution cup	T1	HD
fluoxetine hcl 10 mg tablet	T1	ST QL (30 tabs/fill) HD
fluoxetine hcl 20 mg capsule (Prozac)	T1	HD
fluoxetine hcl 20 mg, 60 mg tablet	T1	ST HD
fluvoxamine maleate	T1	ST QL (60 caps/fill) HD
fluvoxamine maleate 100 mg tab	T1	QL (90 tabs/fill) HD
fluvoxamine maleate 25 mg tab	T1	QL (30 tabs/fill) HD
fluvoxamine maleate 50 mg tab	T1	QL (60 tabs/fill) HD
paroxetine hcl (Paxil Cr)	T1	ST QL (60 tabs/fill) HD
paroxetine hcl 10 mg tablet (Paxil)	T1	QL (30 tabs/fill) HD
paroxetine hcl 10 mg/5 ml susp (Paxil)	T1	ST HD
paroxetine hcl 20 mg tablet (Paxil)	T1	QL (60 tabs/fill) HD
paroxetine hcl 30 mg tablet (Paxil)	T1	QL (60 tabs/fill) HD
paroxetine hcl 40 mg tablet (Paxil)	T1	QL (30 tabs/fill) HD
PAXIL 10 MG TABLET (paroxetine hcl)	T3	ST QL (30 tabs/fill) HD
PAXIL 10 MG/5 ML SUSPENSION (paroxetine hcl)	T3	ST HD
PAXIL 20 MG TABLET (paroxetine hcl)	T3	ST QL (60 tabs/fill) HD
PAXIL 30 MG TABLET (paroxetine hcl)	T3	ST QL (60 tabs/fill) HD
PAXIL 40 MG TABLET (paroxetine hcl)	T3	ST QL (30 tabs/fill) HD
PAXIL CR (paroxetine hcl)	T3	ST QL (60 tabs/fill) HD
sertraline 20 mg/ml oral conc (Zoloft)	T1	HD
sertraline hcl 25 mg tablet (Zoloft)	T1	QL (45 tabs/fill) HD

T1 – Generics

T2 – Preferred Brands

T3 – Non-Preferred Brands

T4 – Preferred Specialty

T5 – Non-Preferred Specialty

PA – Prior Authorization

QL – Quantity Limit

ST – Step Therapy

AGE – Age Requirement

SP – Specialty Medication

HD – May require home delivery pharmacy

PPACA – No Cost-Share Preventive Medication

CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

PSYCHOTHERAPEUTIC DRUGS (Anxiety/Depression/Bipolar Disorder) ⁸ (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
SEROTONIN-2 ANTAGONIST/REUPTAKE INHIBITORS (SARIS)		
nefazodone hcl	T1	HD
trazodone hcl	T1	HD
SEROTONIN-NOREPINEPHRINE REUPTAKE-INHIB (SNRIS)		
DESVENLAFAXINE ER	T3	ST QL (30 tabs/fill) HD
duloxetine hcl dr 20 mg cap (Cymbalta)	T1	QL (60 caps/fill) HD
duloxetine hcl dr 30 mg cap (Cymbalta)	T1	QL (30 caps/fill) HD
duloxetine hcl dr 40 mg cap	T1	ST QL (30 caps/fill) HD
duloxetine hcl dr 60 mg cap (Cymbalta)	T1	QL (60 caps/fill) HD
FETZIMA 20-40 MG TITRATION PAK	T2	ST QL (28 caps/30 days)
FETZIMA ER 20 MG CAPSULE	T2	ST QL (30 caps/30 days)
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 ER 120 MG CAPSULE	T2	ST QL (30 caps/30 days)
venlafaxine hcl	T1	QL (90 tabs/fill) HD
venlafaxine hcl er 150 mg tab	T1	ST QL (30 tabs/fill) HD
venlafaxine hcl er 225 mg tab	T1	ST QL (30 tabs/fill) HD
venlafaxine hcl er 37.5 mg tab	T1	ST QL (30 tabs/fill) HD
venlafaxine hcl er 75 mg tab	T1	ST QL (30 tabs/fill) HD
SSRI, SEROTONIN RECEPTOR MODULATOR ANTIDEPRESSANTS		
TRINTELLIX	T3	ST QL (30 tabs/30 days)
TRINTELLIX 10 MG TABLET	T3	QL (1 tab/day) ST HD
TRICYCLIC ANTIDEPRESSANT-BENZODIAZEPINE COMBINATNS		
amitriptyline/chlordiazepoxide	T1	HD
perphenazine/amitriptyline hcl	T1	HD
TRICYCLIC ANTIDEPRESSANTS, REL.NON-SEL.REUPT-INHIB		
amitriptyline hcl	T1	HD
amoxapine	T1	HD
ANAFRANIL (clomipramine hcl)	T3	HD
clomipramine hcl (Anafranil)	T1	HD
desipramine hcl	T1	HD
doxepin 10 mg capsule	T1	HD
doxepin 10 mg/ml oral conc	T1	HD
doxepin 25 mg capsule	T1	HD
doxepin 50 mg capsule	T1	HD

T1 – Generics

T2 – Preferred Brands

T3 – Non-Preferred Brands

T4 – Preferred Specialty

T5 – Non-Preferred Specialty

PA – Prior Authorization

QL – Quantity Limit

ST – Step Therapy

AGE – Age Requirement

SP – Specialty Medication

HD – May require home delivery pharmacy

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CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

PSYCHOTHERAPEUTIC DRUGS (Anxiety/Depression/Bipolar Disorder)⁸ (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
TRICYCLIC ANTIDEPRESSANTS, REL.NON-SEL.REUPT-INHIB		
doxepin 75 mg capsule	T1	HD
doxepin 100 mg capsule	T1	HD
doxepin 150 mg capsule	T1	HD
imipramine hcl (Tofranil)	T1	HD
imipramine pamoate	T1	HD
maprotiline hcl	T1	HD
nortriptyline hcl	T1	HD
nortriptyline hcl (Pamelor)	T1	HD
PAMELOR (nortriptyline hcl)	T3	HD
protriptyline hcl	T1	HD
SURMONTIL (trimipramine maleate)	T3	HD
TOFRANIL (imipramine hcl)	T3	HD
trimipramine maleate (Surmontil)	T1	HD

PSYCHOTHERAPEUTIC DRUGS (Attention Deficit Hyperactivity Disorder)⁸

ADRENERGICS, AROMATIC, NON-CATECHOLAMINE

lisdexamfetamine 10 mg capsule (Vyvanse)	T1	
lisdexamfetamine 10 mg tb chew (Vyvanse)	T1	ST
lisdexamfetamine 20 mg capsule (Vyvanse)	T1	
lisdexamfetamine 20 mg tb chew (Vyvanse)	T1	ST
lisdexamfetamine 30 mg capsule (Vyvanse)	T1	
lisdexamfetamine 30 mg tb chew (Vyvanse)	T1	ST
lisdexamfetamine 40 mg capsule (Vyvanse)	T1	
lisdexamfetamine 40 mg tb chew (Vyvanse)	T1	ST
lisdexamfetamine 50 mg capsule (Vyvanse)	T1	
lisdexamfetamine 50 mg tb chew (Vyvanse)	T1	ST
lisdexamfetamine 60 mg capsule (Vyvanse)	T1	
lisdexamfetamine 60 mg tb chew (Vyvanse)	T1	ST
lisdexamfetamine 70 mg capsule (Vyvanse)	T1	
VYVANSE (lisdexamfetamine dimesylate)	T3	ST

TX FOR ADHD - SELECTIVE ALPHA-2 RECEPTOR AGONIST

clonidine hcl er 0.1 mg tablet (Kapvay)	T1	
guanfacine hcl (Intuniv)	T1	HD
KAPVAY (clonidine hcl)	T3	ST

T1 – Generics

T2 – Preferred Brands

T3 – Non-Preferred Brands

T4 – Preferred Specialty

T5 – Non-Preferred Specialty

PA – Prior Authorization

QL – Quantity Limit

ST – Step Therapy

AGE – Age Requirement

SP – Specialty Medication

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CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

PSYCHOTHERAPEUTIC DRUGS (Attention Deficit Hyperactivity Disorder) ⁸ (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
TX FOR ATTENTION DEFICIT-HYPERACT (ADHD)/NARCOLEPSY		
APTENSIO XR (<i>methylphenidate hcl</i>)	T3	ST
AZSTARYS	T2	ST
COTEMPLA XR-ODT	T3	ST
DAYTRANA	T3	ST
<i>dexamethylphenidate hcl</i> (Focalin Xr)	T1	
<i>dexamethylphenidate hcl</i> (Focalin)	T1	
JORNAY PM	T3	ST
METADATE CD (<i>methylphenidate hcl</i>)	T3	ST
METHYLIN (<i>methylphenidate hcl</i>)	T3	
<i>methylphenidate</i>	T1	ST
<i>methylphenidate er 10 mg cap</i> (Aptensio Xr)	T1	ST
<i>methylphenidate er 10 mg, 20 mg tab</i>	T1	
<i>methylphenidate er 15 mg cap</i> (Aptensio Xr)	T1	ST
<i>methylphenidate er 18 mg tab</i> (Relexxii)	T1	
<i>methylphenidate er 18 mg tab</i> (Concerta)	T1	
<i>methylphenidate er 20 mg cap</i> (Aptensio Xr)	T1	ST
<i>methylphenidate er 27 mg tab</i> (Relexxii)	T1	
<i>methylphenidate er 27 mg tab</i> (Concerta)	T1	
<i>methylphenidate er 30 mg cap</i> (Aptensio Xr)	T1	ST
<i>methylphenidate er 36 mg tab</i> (Relexxii)	T1	
<i>methylphenidate er 36 mg tab</i> (Concerta)	T1	
<i>methylphenidate er 40 mg cap</i> (Aptensio Xr)	T1	ST
<i>methylphenidate er 50 mg cap</i> (Aptensio Xr)	T1	ST
<i>methylphenidate er 54 mg tab</i> (Relexxii)	T1	
<i>methylphenidate er 54 mg tab</i> (Concerta)	T1	
<i>methylphenidate er 60 mg cap</i> (Aptensio Xr)	T1	ST
METHYLPHENIDATE ER 72 MG TAB	T3	ST
<i>methylphenidate er 72 mg tab</i>	T1	
<i>methylphenidate hcl</i>	T1	
<i>methylphenidate hcl</i> (Metadate Cd)	T1	
<i>methylphenidate hcl</i> (Methylin)	T1	
<i>methylphenidate hcl</i> (Ritalin La)	T1	
<i>methylphenidate hcl</i> (Ritalin)	T1	
QUELBREE ER	T3	ST

T1 – Generics

T2 – Preferred Brands

T3 – Non-Preferred Brands

T4 – Preferred Specialty

T5 – Non-Preferred Specialty

PA – Prior Authorization

QL – Quantity Limit

ST – Step Therapy

AGE – Age Requirement

SP – Specialty Medication

HD – May require home delivery pharmacy

PPACA – No Cost-Share Preventive Medication

CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

PSYCHOTHERAPEUTIC DRUGS (Attention Deficit Hyperactivity Disorder) ⁸ (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
TX FOR ATTENTION DEFICIT-HYPERACT (ADHD)/NARCOLEPSY (cont.)		
RELEXXII ER 72 MG TABLET	T3	ST
atomoxetine hcl (Strattera)	T1	HD
TX FOR ATTENTION DEFICIT-HYPERACT.(ADHD), NRI-TYPE		
QELBREE	T3	ST
PSYCHOTHERAPEUTIC DRUGS (Miscellaneous)		
HYPOACTIVE SEXUAL DESIRE DISORDER (HSDD) TX AGENTS		
ADDYI	T3	PA
VYLEESI	T5	PA QL (8 auto-injs/fill) SP
PSYCHOTHERAPEUTIC DRUGS (Schizophrenia/Anti-Psychotics)⁸		
ANTIPSYCH, DOPAMINE ANTAG., DIPHENYLBUTYLPIPERIDINES		
pimozide	T1	
ANTIPSYCHOTIC, ATYPICAL, DOPAMINE, SEROTONIN ANTAGNST		
asenapine maleate (Saphris)	T1	QL (60 tabs/fill)
CAPLYTA	T3	QL (30 caps/fill)
clozapine	T1	
clozapine (Clozaril)	T1	
CLOZARIL (clozapine)	T3	
GEODON (ziprasidone hcl)	T3	QL (60 caps/fill)
INVEGA ER 3 MG TABLET (paliperidone)	T3	QL (30 tabs/fill)
INVEGA ER 6 MG TABLET (paliperidone)	T3	QL (60 tabs/fill)
INVEGA ER 9 MG TABLET (paliperidone)	T3	QL (30 tabs/fill)
LYBALVI	T3	QL (30 tabs/30 days)
olanzapine	T1	PA SP HD
olanzapine (Zyprexa Zydis)	T1	QL (30 tabs/fill)
quetiapine er 50 mg tablet (Seroquel Xr)	T1	QL (60 tabs/fill)
quetiapine er 200 mg tablet (Seroquel Xr)	T1	QL (30 tabs/fill)
quetiapine er 300 mg tablet (Seroquel Xr)	T1	QL (60 tabs/fill)
quetiapine er 400 mg tablet (Seroquel Xr)	T1	QL (60 tabs/fill)
quetiapine fumarate 200 mg tab (Seroquel)	T1	QL (90 tabs/fill)
quetiapine fumarate 300 mg tab (Seroquel)	T1	QL (60 tabs/fill)
RISPERDAL 0.5 MG TABLET (risperidone)	T3	QL (60 tabs/fill)
RISPERDAL 1 MG TABLET (risperidone)	T3	QL (60 tabs/fill)
RISPERDAL 1 MG/ML SOLUTION (risperidone)	T3	

T1 – Generics

T2 – Preferred Brands

T3 – Non-Preferred Brands

T4 – Preferred Specialty

T5 – Non-Preferred Specialty

PA – Prior Authorization

QL – Quantity Limit

ST – Step Therapy

AGE – Age Requirement

SP – Specialty Medication

HD – 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
ANTIPSYCHOTIC, ATYPICAL, DOPAMINE, SEROTONIN ANTAGNST (cont.)		
RISPERDAL 2 MG TABLET (<i>risperidone</i>)	T3	QL (60 tabs/fill)
RISPERDAL 3 MG TABLET (<i>risperidone</i>)	T3	QL (60 tabs/fill)
RISPERDAL 4 MG TABLET (<i>risperidone</i>)	T3	QL (60 tabs/fill)
<i>risperidone</i>	T1	QL (60 tabs/fill)
<i>risperidone 0.5 mg tablet (Risperdal)</i>	T1	QL (60 tabs/fill)
<i>risperidone 1 mg tablet (Risperdal)</i>	T1	QL (60 tabs/fill)
<i>risperidone 1 mg/ml solution (Risperdal)</i>	T1	
<i>risperidone 2 mg tablet (Risperdal)</i>	T1	QL (60 tabs/fill)
<i>risperidone 3 mg tablet (Risperdal)</i>	T1	QL (60 tabs/fill)
<i>risperidone 4 mg tablet (Risperdal)</i>	T1	QL (60 tabs/fill)
SECUADO	T3	QL (30 patches/fill)
VERSACLOZ	T3	
<i>ziprasidone hcl (Geodon)</i>	T1	QL (60 caps/fill)
ZYPREXA (<i>olanzapine</i>)	T3	QL (30 tabs/fill)
ZYPREXA ZYDIS (<i>olanzapine</i>)	T3	QL (30 tabs/fill)
ANTIPSYCHOTIC-ATYPICAL, D3/D2 PARTIAL AG-5HT MIXED		
VRAYLAR	T3	QL (30 caps/30 days)
ANTIPSYCHOTICS, ATYP, D2 PARTIAL AGONIST/5HT MIXED		
ABILIFY ASIMTUFI 720MG/2.4ML, 960MG/3.2ML	T3	
ABILIFY MYCITE	T3	QL (30 tabs/fill)
<i>aripiprazole</i>	T1	QL (60 tabs/fill)
<i>aripiprazole 1 mg/ml solution</i>	T1	
<i>aripiprazole 2 mg tablet (Abilify)</i>	T1	QL (30 tabs/fill)
<i>aripiprazole 10 mg tablet (Abilify)</i>	T1	QL (30 tabs/fill)
<i>aripiprazole 20 mg tablet (Abilify)</i>	T1	QL (30 tabs/fill)
<i>aripiprazole 30 mg tablet (Abilify)</i>	T1	QL (30 tabs/fill)
REXULTI	T3	QL (30 tabs/fill)
ANTIPSYCHOTICS, DOPAMINE AND SEROTONIN ANTAGONISTS		
<i>loxapine succinate</i>	T1	
ANTIPSYCHOTICS, DOPAMINE ANTAGONISTS, THIOXANTHENES		
<i>thiothixene</i>	T1	
ANTIPSYCHOTICS, DOPAMINE ANTAGONISTS, BUTYROPHENONES		
<i>haloperidol</i>	T1	
<i>haloperidol lactate</i>	T1	

T1 – Generics

T2 – Preferred Brands

T3 – Non-Preferred Brands

T4 – Preferred Specialty

T5 – Non-Preferred Specialty

PA – Prior Authorization

QL – Quantity Limit

ST – Step Therapy

AGE – Age Requirement

SP – Specialty Medication

HD – 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
ANTIPSYCHOTICS, DOPAMINE ANTAGONIST, DIHYDROINDOLONES		
molindone hcl	T1	
ANTIPSYCHOTICS, PHENOTHIAZINES		
chlorpromazine hcl	T1	
fluphenazine hcl	T1	
perphenazine	T1	
thioridazine hcl	T1	
trifluoperazine hcl	T1	
SSRI-ANTIPSYCH, ATYPICAL,DOPAMINE,SEROTONIN ANTAG		
olanzapine/fluoxetine hcl	T1	
PSYCHOTHERAPEUTIC DRUGS (Seizure Disorders)		
NEUROACTIVE STEROID GABA-A RECEPTOR MODULATOR		
ZTALMY	T4	PA SP
PSYCHOTHERAPEUTIC DRUGS (Sleep Disorders/Sedatives)		
NARCOLEPSY AND SLEEP DISORDER THERAPY AGENTS		
armodafinil (Nuvigil)	T1	PA QL (30 tabs/fill)
modafinil 100 mg tablet (Provigil)	T1	PA QL (30 tabs/fill)
SUNOSI	T2	PA QL (30 tabs/fill)
SEDATIVE/HYPNOTICS (Sleep Disorders/Sedatives)		
ANTI-NARCOLEPSY, ANTI-CATAPLEXY, SEDATIVE-TYPE AGENT		
LUMRYZ STARTER PACK	T4	PA SP HD
LUMRYZ ER	T5	PA SP HD QL (30 packets/30 days)
SODIUM OXYBATE	T4	PA QL (540 mls/30 days)
XYREM	T4	PA QL (540 mls/fill) SP HD
XYWAV	T4	PA QL (540 mls/fill) SP HD
BARBITURATES		
phenobarbital	T1	
secobarbital sodium	T1	QL (30 caps/fill)
HYPNOTICS, MELATONIN MT1/MT2 RECEPTOR AGONISTS		
HETLIOZ	T5	PA QL (30 caps/fill) SP HD
HETLIOZ LQ	T5	PA QL (158 mls/fill) SP HD
ramelteon (Rozerem)	T1	QL (30 tabs/fill)
SEDATIVE-HYPNOTICS - BENZODIAZEPINES		
estazolam	T1	QL (15 tabs/fill)

T1 – Generics

T2 – Preferred Brands

T3 – Non-Preferred Brands

T4 – Preferred Specialty

T5 – Non-Preferred Specialty

PA – Prior Authorization

QL – Quantity Limit

ST – Step Therapy

AGE – Age Requirement

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List of Prescription Medications

SEDATIVE/HYPNOTICS (Sleep Disorders/Sedatives) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
SEDATIVE-HYPNOTICS - BENZODIAZEPINES (cont.)		
<i>flurazepam hcl</i>	T1	QL (15 caps/fill)
HALCION (triazolam)	T3	QL (15 tabs/fill)
MIDAZOLAM HCL 10 MG/5 ML SYRUP	T3	
<i>midazolam hcl 2 mg/ml syrup</i>	T1	
RESTORIL (temazepam)	T3	QL (15 caps/fill)
<i>temazepam (Restoril)</i>	T1	QL (15 caps/fill)
<i>triazolam</i>	T1	QL (15 tabs/fill)
<i>triazolam (Halcion)</i>	T1	QL (15 tabs/fill)
SEDATIVE-HYPNOTICS, NON-BARBITURATE		
BELSOMRA	T3	ST QL (30 tabs/fill)
DAYVIGO	T3	ST QL (30 tabs/fill)
<i>doxepin hcl 3 mg tablet (Silenor)</i>	T1	ST QL (30 tabs/fill)
<i>doxepin hcl 6 mg tablet (Silenor)</i>	T1	ST QL (30 tabs/fill)
EDLUAR	T3	ST QL (30 tabs/fill)
<i>eszopiclone (Lunesta)</i>	T1	QL (30 tabs/fill)
IGALMI	T3	
MKO (MIDAZOLAM-KETAMINE-ONDAN)	T3	
QUVIVIQ	T3	ST QL (30 tabs/fill)
SILENOR (<i>doxepin hcl</i>)	T3	ST QL (30 tabs/fill)
<i>zaleplon 10 mg capsule</i>	T1	QL (60 caps/fill)
<i>zaleplon 5 mg capsule</i>	T1	QL (30 caps/fill)
<i>zolpidem tartrate</i>	T1	QL (30 tabs/fill)
<i>zolpidem tartrate (Ambien Cr)</i>	T1	QL (30 tabs/fill)
<i>zolpidem tartrate (Ambien)</i>	T1	QL (30 tabs/fill)
ZOLPIMIST	T3	ST QL (1 canister/30 days)
SKIN PREPS (Miscellaneous)		
IRRIGANTS		
<i>acetic acid</i>	T1	
<i>neomycin sulf/polymyxin b sulf</i>	T1	
PHYSIOLYTE (<i>physiological irrig soln no.1</i>)	T3	
PHYSIOSOL (<i>physiological irrig soln no.1</i>)	T3	
<i>ringer's solution</i>	T1	
<i>ringer's solution,lactated</i>	T1	

T1 – Generics

T2 – Preferred Brands

T3 – Non-Preferred Brands

T4 – Preferred Specialty

T5 – Non-Preferred Specialty

PA – Prior Authorization

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ST – Step Therapy

AGE – Age Requirement

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List of Prescription Medications

SKIN PREPS (Miscellaneous) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
IRRIGANTS (cont.)		
sod,pot chlor/mag/sod,pot phos	T1	
sodium chloride 0.9% irrig.	T1	
sodium chloride 0.9% prcss sol	T1	
SODIUM CHLORIDE 0.9% IRRIG.	T3	
sodium chloride irrig solution	T1	
SORBITOL	T3	
SORBITOL-MANNITOL	T3	
water for irrigation,sterile	T1	
OXIDIZING AGENTS		
hydrogen peroxide	T1	
PRESERVATIVES		
formaldehyde	T1	
SKIN PREPS (Pain Relief and Inflammatory Disease)		
ANTIPSORIATIC AGENTS, SYSTEMIC		
acitretin	T1	
methoxsalen	T1	
SKYRIZI	T4	PA QL (150 mg/84 days) SP HD
SKYRIZI (2 SYRINGES) KIT	T4	PA QL (150 mg/84 days) SP HD
SKYRIZI PEN	T4	PA QL (150 mg/84 days) SP HD
SOTYKTU	T4	PA QL (30 tabs/30 days) SP HD
SPEVIGO	T5	PA SP HD
TALTZ AUTOINJECTOR	T4	PA QL (1 ml/28 days) SP HD
TALTZ AUTOINJECTOR (2 PACK)	T4	PA QL (1 ml/28 days) SP HD
TALTZ AUTOINJECTOR (3 PACK)	T4	PA QL (1 ml/28 days) SP HD
TALTZ 20 MG/0.25 ML SYRINGE	T4	PA QL (1 syringe/28 days) SP HD
TALTZ 40 MG/0.5 ML SYRINGE	T4	PA QL (1 syringe/28 days) SP HD
TALTZ 80 MG/ML SYRINGE	T4	PA QL (1 ml/28 days) SP HD
TOPICAL ANTI-INFLAMMATORY, NSAIDS		
diclofenac sodium 1% gel	T1	QL (500 gms/28 days) HD
FLECTOR	T2	ST QL (60 patches/fill) HD
LICART	T2	ST QL (30 patches/fill) HD

T1 – Generics

T2 – Preferred Brands

T3 – Non-Preferred Brands

T4 – Preferred Specialty

T5 – Non-Preferred Specialty

PA – Prior Authorization

QL – Quantity Limit

ST – Step Therapy

AGE – Age Requirement

SP – Specialty Medication

HD – 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)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ACNE AGENTS, SYSTEMIC		
ABSORICA (isotretinoin)	T3	ST
isotretinoin (Absorica)	T1	
ACZONE (<i>dapsone</i>)	T3	ST
<i>adapalene/benzoyl peroxide</i>	T1	
<i>adapalene/benzoyl peroxide</i> (Epiduo Forte)	T1	
AZELEX	T3	ST
<i>clindamycin phos/benzoyl perox</i>	T1	
<i>clindamycin phos/benzoyl perox</i> (Acanya)	T1	
<i>clindamycin/tretinoin</i> (Ziana)	T1	PA
<i>dapsone 5% gel</i> (Aczone)	T1	PA SP HD
<i>dapsone 7.5% gel pump</i> (Aczone)	T1	PA SP HD
DAPSONE 7.5% GEL	T3	PA SP HD
EPIDUO FORTE	T3	ST
EPIDUO FORTE (<i>adapalene/benzoyl peroxide</i>)	T3	ST
KLARON (<i>sulfacetamide sodium</i>)	T3	ST
NEUAC 1.2-5% KIT	T3	ST
<i>neuac gel</i>	T1	
ONEXTON	T2	ST
<i>sulfacetamide sodium</i> (Klaron)	T1	
ACNE AGENTS, TOPICAL		
<i>clindamycin/tretinoin</i> (Veltin)	T1	
ONEXTON (<i>clindamycin phos/benzoyl perox</i>)	T3	ST
ANTIPRURITICS, TOPICAL		
ZONALON	T3	ST QL (90 gms/30 days)
ZONALON (<i>doxepin hcl</i>)	T3	ST QL (90 gms/30 days)
ANTIPSORIATICS AGENTS		
<i>calcipotriene 0.005% cream</i> (Dovonex)	T1	QL (120 gms/30 days)
<i>calcipotriene 0.005% ointment</i>	T1	QL (120 gms/30 days)
<i>calcipotriene 0.005% solution</i>	T1	QL (120 mls/30 days)
<i>calcitriol 3 mcg/g ointment</i> (Vectical)	T1	
DOVONEX (<i>calcipotriene</i>)	T3	ST QL (120 gms/30 days)
DUOBRII	T3	ST QL (200 gms/30 days)
<i>tazarotene 0.05% gel</i> (Tazorac)	T1	PA
<i>tazarotene 0.05% cream</i> (Tazorac)	T1	PA

T1 – Generics

T2 – Preferred Brands

T3 – Non-Preferred Brands

T4 – Preferred Specialty

T5 – Non-Preferred Specialty

PA – Prior Authorization

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List of Prescription Medications

SKIN PREPS (Skin Conditions) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ANTIPSORIATICS AGENTS (cont.)		
tazarotene 0.1% cream (Tazorac)	T1	PA
tazarotene 0.1% gel (Tazorac)	T1	PA
TWYNEO	T3	PA ST
VECTICAL (<i>calcitriol</i>)	T3	
VTAMA	T2	PA QL (60 gms/28 days)
ZIANA (<i>clindamycin/tretinoin</i>)	T3	PA ST
ZORYVE 0.3% CREAM	T3	PA QL (60 gms/30 days)
ANTISEBORRHEIC AGENTS		
ESKATA	T3	
OVACE (<i>sulfacetamide sodium</i>)	T3	
OVACE PLUS	T3	
OVACE PLUS WASH	T3	
PLEXION NS	T3	
<i>selenium sulfide</i>	T1	
<i>sod sulfacetam 10% clnsng gel</i>	T1	
<i>sod sulfacetamide 10% shampoo</i>	T1	
<i>sod sulfacetamide 9.8% shampoo</i>	T1	
SODIUM SULFACETAMIDE 10% WASH	T3	
<i>sodium sulfacetamide 10% wash (Ovace)</i>	T1	
TERSI FOAM	T3	
ANTISEPTICS, GENERAL		
ADVOCATE ALCOHOL 70% PREP PADS	T2	
ALCOHOL 70% PREP PADS	T2	
ALCOHOL 70% SWABS	T2	
<i>alcohol 70% swabs</i>	T1	
ALCOHOL 70% WIPES	T2	
<i>alcohol antiseptic pads</i>	T1	
<i>alcohol prep pads</i>	T1	
<i>alcohol swabs</i>	T1	
CARETOUCH ALCOHOL PREP PAD	T2	
CURITY ALCOHOL PREPS	T2	
CVS ALCOHOL 70% PREP PADS	T2	
<i>cvs isopropyl alcohol 70% wipe</i>	T1	
DROPSAFE PREP PADS	T2	

T1 – Generics

T2 – Preferred Brands

T3 – Non-Preferred Brands

T4 – Preferred Specialty

T5 – Non-Preferred Specialty

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List of Prescription Medications

SKIN PREPS (Skin Conditions) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ANTISEPTICS, GENERAL (cont.)		
EASY COMFORT ALCOHOL PAD	T2	
EASY TOUCH ALCOHOL PREP PADS	T2	
<i>fifty50 alcohol prep pads</i>	T1	
GS ALCOHOL 70% SWABS	T2	
HM ALCOHOL 70% PREP PADS	T2	
INCONTROL ALCOHOL PADS	T2	
PHARM CHOICE ALCOHOL PREP PADS	T2	
<i>pharm choice alcohol prep pads</i>	T1	
PRO COMFORT ALCOHOL PADS	T2	
PURE COMFORT ALCOHOL PAD	T2	
<i>qc alcohol 70% swabs</i>	T1	
<i>ra alcohol swabs</i>	T1	
RA ISOPROPYL ALCOHOL 70% WIPES	T2	
RELION ALCOHOL 70% SWABS	T2	
SAPS ALCOHOL 70% PREP PADS	T2	
SINGLE USE SWAB	T2	
<i>sm alcohol prep pads</i>	T1	
SURE COMFORT ALCOHOL	T2	
SURE-PREP ALCOHOL PREP PADS	T2	
TRUE COMFORT ALCOHOL PADS	T2	
TRUE COMFORT PRO ALCOHOL PADS	T2	
ULTILET ALCOHOL SWAB	T2	
<i>v-r alcohol prep pads</i>	T1	
WEBCOL	T2	
ANTISEPTICS, MISCELLANEOUS		
GUAIACOL	T2	
DIABETIC ULCER PREPARATIONS, TOPICAL		
REGRANEX	T2	QL (15 gms/fill)
IMMUNOMODULATORS		
<i>imiquimod</i>	T1	
<i>imiquimod (Zyclara)</i>	T1	
IRRITANTS/COUNTER-IRRITANTS		
CANTHARIDIN-ACETONE	T3	
<i>methyl salicylate</i>	T1	

T1 – Generics

T2 – Preferred Brands

T3 – Non-Preferred Brands

T4 – Preferred Specialty

T5 – Non-Preferred Specialty

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List of Prescription Medications

SKIN PREPS (Skin Conditions) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
IRRITANTS/COUNTER-IRRITANTS (cont.)		
YCANTH	T5	SP
JANUS KINASE (JAK) INHIBITORS		
CIBINQO	T4	PA QL (30 tabs/30 days) SP
KERATOLYTIC-GLUCOCORTICOID COMBINATIONS		
VANOXIDE-HC	T3	ST
KERATOLYTICS		
<i>benzepro 6% foaming cloths</i>	T1	
BENZEPRO 7% CREAMY WASH (<i>benzoyl peroxide microspheres</i>)	T3	ST
<i>benzoyl peroxide</i>	T1	
<i>benzoyl peroxide (Pacnex)</i>	T1	
ENZOCLEAR	T3	ST
INOVA	T3	ST
INOVA 4-1	T3	ST
INOVA 8-2	T3	ST
PACNEX (<i>benzoyl peroxide</i>)	T3	ST
<i>podofilox 0.5% gel (Condyllox)</i>	T1	ST QL (7 gms/30 days)
<i>podofilox 0.5% topical soln</i>	T1	
PR BENZOYL PEROXIDE (<i>benzoyl peroxide microspheres</i>)	T3	ST
PROTECTIVES		
PHARMABASE BARRIER (<i>zinc oxide</i>)	T3	
<i>zinc oxide 20% ointment</i>	T1	
ZINC OXIDE PASTE	T2	
ROSACEA AGENTS, TOPICAL		
<i>azelaic acid (Finacea)</i>	T1	
EPSOLAY	T3	ST
FINACEA 15% FOAM	T2	ST
FINACEA 15% GEL (<i>azelaic acid</i>)	T3	ST
<i>ivermectin 1% cream (Soolantra)</i>	T1	QL (45 gms/30 days)
METROCREAM (<i>metronidazole</i>)	T3	ST
METROGEL (<i>metronidazole</i>)	T3	ST
<i>metronidazole 0.75% cream (Metrocream)</i>	T1	
<i>metronidazole 0.75% lotion</i>	T1	
<i>metronidazole top 1% gel/pump</i>	T1	
<i>metronidazole topical 0.75% gl</i>	T1	

T1 – Generics

T2 – Preferred Brands

T3 – Non-Preferred Brands

T4 – Preferred Specialty

T5 – Non-Preferred Specialty

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List of Prescription Medications

SKIN PREPS (Skin Conditions) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ROSACEA AGENTS, TOPICAL (cont.)		
metronidazole topical 1% gel (Metrogel)	T1	
MIRVASO	T2	PA
RHOFADE	T3	PA
rosadan 0.75% cream (Metrocream)	T1	
ROSADAN 0.75% CREAM KIT	T3	ST
rosadan 0.75% gel	T1	
ROSADAN 0.75% GEL KIT	T3	ST
SOOLANTRA (<i>ivermectin</i>)	T3	ST QL (60 gms/30 days)
TISSUE/WOUND ADHESIVES		
ARTISS	T3	
SURGISEAL STYLUS	T3	
SURGISEAL TEARDROP	T3	
SURGISEAL TWIST	T3	
TISSEEL VHSD	T3	
TOP. ANTI-INFLAM., PHOSPHODIESTERASE-4 (PDE4) INHIB		
EUCRISA	T2	ST QL (120 gms/30 days)
ZORYVE 0.15% CREAM	T2	ST QL (60 gms/30 days)
ZORYVE 0.3% FOAM	T3	ST QL (60 gms/30 days)
TOPICAL ACNE AGENT, RETINOIC ACID RECEPTOR AGONIST		
AKLIEF	T3	PA ST
ARAZLO	T3	PA
TOPICAL AGENTS, MISCELLANEOUS		
L-MESITRAN SOFT	T3	
MEDIHONEY	T3	
<i>trichloroacetic acid</i>	T1	
TRICHLOROACETIC ACID 100% (<i>trichloroacetic acid</i>)	T3	
TRICHLOROACETIC ACID 20% (<i>trichloroacetic acid</i>)	T2	
TRICHLOROACETIC ACID 25%	T3	
TRICHLOROACETIC ACID 30%	T2	
TRICHLOROACETIC ACID 35%	T2	
TRICHLOROACETIC ACID 40%	T2	
TRICHLOROACETIC ACID 50%	T2	
TRICHLOROACETIC ACID 75%	T3	
TRICHLOROACETIC ACID 80%	T2	

T1 – Generics

T2 – Preferred Brands

T3 – Non-Preferred Brands

T4 – Preferred Specialty

T5 – Non-Preferred Specialty

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List of Prescription Medications

SKIN PREPS (Skin Conditions) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
TOPICAL AGENTS, MISCELLANEOUS (cont.)		
TRICHLOROACETIC ACID 85%	T2	
TRICHLOROACETIC ACID 90%	T2	
TOPICAL ANTIBIOTIC PLEUROMUTILIN DERIVATIVES		
ALTABAX	T3	ST QL (30 gms/fill)
TOPICAL ANTI-INFLAMMATORY STEROIDAL		
ALA-SCALP (<i>hydrocortisone</i>)	T3	ST
<i>alclometasone dipropionate</i>	T1	
<i>amcinonide</i>	T1	ST
<i>betamethasone dipropionate</i>	T1	
<i>betamethasone va 0.1% cream, lotion</i>	T1	
<i>betamethasone valer 0.1% ointm</i>	T1	
<i>betamethasone valer 0.12% foam</i>	T1	ST
<i>betamethasone/propylene glyc</i>	T1	
<i>betamethasone/propylene glyc (Diprolene)</i>	T1	
BRYHALI	T3	ST
CAPEX SHAMPOO	T3	ST
<i>clobetasol 0.05% cream</i>	T1	QL (120 gms/30 days)
<i>clobetasol 0.05% gel</i>	T1	QL (120 gms/30 days)
<i>clobetasol 0.05% ointment (Temovate)</i>	T1	QL (120 gms/30 days)
<i>clobetasol 0.05% shampoo (Clobex)</i>	T1	ST QL (236 mls/30 days)
<i>clobetasol 0.05% solution</i>	T1	QL (100 mls/30 days)
<i>clobetasol 0.05% topical lotn</i>	T1	ST QL (118 mls/30 days)
<i>clobetasol emollient 0.05% crm</i>	T1	QL (120 gms/30 days)
<i>clobetasol emollient 0.05% foam</i>	T1	ST QL (100 gms/30 days)
<i>clobetasol prop 0.05% foam (Olux)</i>	T1	ST QL (100 gms/30 days)
<i>clobetasol prop 0.05% spray (Clobex)</i>	T1	ST QL (125 mls/30 days)
<i>clobetasol propionate/emoll</i>	T1	ST QL (100 gms/30 days)
CLOBEX 0.05% SHAMPOO (<i>clobetasol propionate</i>)	T3	ST QL (236 mls/30 days)
CLOBEX 0.05% SPRAY (<i>clobetasol propionate</i>)	T3	ST QL (125 mls/30 days)
CLODAN 0.05% KIT	T3	ST QL (2 kits/28 days)
<i>clodan 0.05% shampoo (Clobex)</i>	T1	ST QL (236 mls/30 days)
CLODERM	T3	ST
CLODERM (<i>dicocortolone pivalate</i>)	T3	ST
CORDRAN 0.025% CREAM	T3	ST QL (120 gms/30 days)

T1 – Generics

T2 – Preferred Brands

T3 – Non-Preferred Brands

T4 – Preferred Specialty

T5 – Non-Preferred Specialty

PA – Prior Authorization

QL – Quantity Limit

ST – Step Therapy

AGE – Age Requirement

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PPACA – No Cost-Share Preventive Medication

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List of Prescription Medications

SKIN PREPS (Skin Conditions) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
TOPICAL ANTI-INFLAMMATORY STEROIDAL (cont.)		
CORDRAN 0.05% CREAM (<i>flurandrenolide</i>)	T3	ST QL (120 gms/30 days)
CORDRAN 0.05% LOTION (<i>flurandrenolide</i>)	T3	ST QL (120 mls/30 days)
CORDRAN 0.05% OINTMENT (<i>flurandrenolide</i>)	T3	ST QL (120 gms/30 days)
CORDRAN 4 MCG/SQ CM TAPE LARGE	T3	ST
DERMA-SMOOTH-E-FS (<i>fluocinolone acetonide</i>)	T3	ST
DERMA-SMOOTH-E-FS (<i>fluocinolone/shower cap</i>)	T3	ST
DERMASORB HC	T3	ST
DERMASORB TA	T3	ST
DERMATOP (<i>prednicarbate</i>)	T3	ST
DESONATE (<i>desonide</i>)	T3	ST
<i>desonide</i> (Desonate)	T1	ST
<i>desonide</i> 0.05% cream (Desowen)	T1	
<i>desonide</i> 0.05% cream (Tridesilon)	T1	
<i>desonide</i> 0.05% gel (Desonate)	T1	ST
<i>desonide</i> 0.05% lotion	T1	ST
<i>desonide</i> 0.05% ointment	T1	
<i>desoximetasone</i> (Topicort)	T1	ST
DESOWEN (<i>desonide</i>)	T3	ST
DIPROLENE (<i>betamethasone/propylene glyc</i>)	T3	ST
<i>fluocinolone acetonide</i>	T1	
<i>fluocinolone acetonide</i> (Derma-Smoothe-Fs)	T1	
<i>fluocinolone acetonide</i> (Synalar)	T1	
<i>fluocinolone/shower cap</i> (Derma-Smoothe-Fs)	T1	
<i>fluocinonide</i> 0.05% cream	T1	QL (120 gms/30 days)
<i>fluocinonide</i> 0.05% gel	T1	QL (120 gms/30 days)
<i>fluocinonide</i> 0.05% ointment	T1	QL (120 gms/30 days)
<i>fluocinonide</i> 0.05% solution	T1	QL (120 gms/30 days)
<i>fluocinonide</i> 0.1% cream (Nanos)	T1	ST QL (120 gms/30 days)
<i>fluocinonide/emollient base</i>	T1	QL (120 gms/30 days)
<i>fluticasone prop</i> 0.005% oint	T1	
<i>fluticasone prop</i> 0.05% cream	T1	
<i>fluticasone prop</i> 0.05% lotion	T1	ST
<i>fluticasone propionate</i>	T1	ST
<i>halobetasol prop</i> 0.05% cream	T1	

T1 – Generics

T2 – Preferred Brands

T3 – Non-Preferred Brands

T4 – Preferred Specialty

T5 – Non-Preferred Specialty

PA – Prior Authorization

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List of Prescription Medications

SKIN PREPS (Skin Conditions) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
TOPICAL ANTI-INFLAMMATORY STEROIDAL (cont.)		
halobetasol prop 0.05% foam	T1	ST
halobetasol prop 0.05% ointmnt	T1	
halobetasol prop 0.05% cream (Ultravate)	T1	
halobetasol prop 0.05% ointmnt (Ultravate)	T1	
HALOG	T3	ST
HALOG (halcinonide)	T3	ST
hydrocort buty 0.1% lipid crm (Locoid Lipocream)	T1	QL (120 gms/30 days)
hydrocort buty 0.1% lipo cream (Locoid Lipocream)	T1	QL (120 gms/30 days)
hydrocort/min oil/petrolat,wht	T1	
hydrocortisone	T1	
hydrocortisone (Ala-Scalp)	T1	
hydrocortisone (Anusol-Hc)	T1	
hydrocortisone buty 0.1% cream	T1	QL (120 gms/30 days)
hydrocortisone butyr 0.1% lotn	T1	PA SP HD
hydrocortisone butyr 0.1% oint	T1	ST QL (10 gm/28 days)
hydrocortisone butyr 0.1% soln	T1	ST QL (120 mls/30 days)
hydrocortisone valerate	T1	
IMPEKLO	T3	ST QL (136 gms/28 days)
KENALOG 0.147 MG/GRAM SPRAY (triamcinolone acetonide)	T3	ST QL (100 gms/30 days)
KENALOG 0.147 MG/GRAM SPRAY (triamcinolone acetonide)	T3	ST QL (126 gms/30 days)
LEXETTE	T3	PA SP HD
mometasone furoate 0.1% cream	T1	
mometasone furoate 0.1% oint	T1	
mometasone furoate 0.1% soln	T1	
NUCORT	T3	ST
OLUX (clobetasol propionate)	T3	ST QL (100 gms/30 days)
PANDEL	T3	ST
prednicarbate	T1	
prednicarbate (Dermatop)	T1	
SCALACORT DK	T3	ST
SYNALAR	T3	ST
SYNALAR (fluocinolone acetonide)	T3	ST
SYNALARTS	T3	ST
TEMOVATE (clobetasol propionate)	T3	ST QL (120 gms/30 days)

T1 – Generics

T2 – Preferred Brands

T3 – Non-Preferred Brands

T4 – Preferred Specialty

T5 – Non-Preferred Specialty

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List of Prescription Medications

SKIN PREPS (Skin Conditions) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
TOPICAL ANTI-INFLAMMATORY STEROIDAL (cont.)		
TEXACORT	T3	ST
TOPICORT 0.25% CREAM (<i>desoximetasone</i>)	T3	ST
TOPICORT 0.25% OINTMENT (<i>desoximetasone</i>)	T3	ST
TOPICORT 0.05% CREAM (<i>desoximetasone</i>)	T3	ST
TOPICORT 0.05% GEL (<i>desoximetasone</i>)	T3	ST
TOPICORT 0.05% OINTMENT (<i>desoximetasone</i>)	T3	ST
<i>triamcinolone 0.025% cream</i>	T1	
<i>triamcinolone 0.025% lotion</i>	T1	
<i>triamcinolone 0.025% oint</i>	T1	
<i>triamcinolone 0.5% cream</i>	T1	
<i>triamcinolone 0.05% ointment</i>	T1	ST
<i>triamcinolone 0.1% cream, lotion</i>	T1	
<i>triamcinolone 0.1% ointment</i>	T1	
<i>triamcinolone 0.147 mg/g spray (Kenalog)</i>	T1	ST QL (126 gms/30 days)
<i>triamcinolone 0.147 mg/g spray (Kenalog)</i>	T1	ST QL (100 gms/30 days)
<i>triamcinolone 0.5% ointment</i>	T1	
<i>triamcinolone acetonide</i>	T1	ST
<i>triderm 0.1% cream</i>	T1	
<i>triderm 0.5% cream</i>	T1	ST
TRIDESILON (<i>desonide</i>)	T3	ST
ULTRAVATE X	T3	ST
TOPICAL ANTI-INFLAMMATORY STEROID-LOCAL ANESTHETIC		
ANALPRAM HC 2.5%-1% LOTION (<i>hydrocortisone/pramoxine</i>)	T3	ST
EPIFOAM	T3	ST
<i>hydrocort-pramoxine 2.5-1% crm</i>	T1	ST
<i>lidocaine/hydrocortisone ac</i>	T1	
<i>lidocaine-hc 3-0.5% cream</i>	T1	
PRAMOSONE	T3	ST
TOPICAL ANTIPARASITICS		
<i>lindane</i>	T1	
<i>malathion (Ovide)</i>	T1	
OVIDE (<i>malathion</i>)	T3	
TOPICAL JANUS KINASE (JAK) INHIBITORS		
OPZELURA	T3	PA QL (240 gms/28 days)

T1 – Generics

T2 – Preferred Brands

T3 – Non-Preferred Brands

T4 – Preferred Specialty

T5 – Non-Preferred Specialty

PA – Prior Authorization

QL – Quantity Limit

ST – Step Therapy

AGE – Age Requirement

SP – Specialty Medication

HD – 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 PREPARATIONS, ANTIBACTERIALS		
iodine/potassium iodide	T1	
iodine/sodium iodide	T1	
IODOFLEX	T3	
IODOSORB	T3	
TOPICAL VIT D ANALOG/ANTI-INFLAMMATORY STEROID		
calcipotriene/betamethasone (Taclonex)	T1	ST QL (60 gms/30 days)
calcipotriene/betamethasone (Taclonex)	T1	QL (60 gms/30 days)
ENSTILAR	T2	ST QL (60 gms/30 days)
WYNZORA	T3	ST QL (60 gms/30 days)
TOPICAL/MUCOUS MEMBR./SUBCUT. ENZYMEs		
SANTYL	T2	QL (180 gms/fill)
VITAMIN A DERIVATIVES		
adapalene 0.1% cream (Differin)	T1	
ADAPALENE 0.1% LOTION	T3	ST
adapalene 0.1% solution	T1	
adapalene 0.1% swab	T1	ST
adapalene 0.3% gel	T1	
adapalene 0.3% gel pump (Differin)	T1	
ALTRENO	T3	PA
avita 0.025% cream (Retin-A)	T1	PA
AVITA 0.025% GEL	T3	PA
DIFFERIN	T3	ST
DIFFERIN (adapalene)	T3	ST
RETIN-A (tretinoin)	T3	PA
RETIN-A MICRO PUMP 0.06% GEL	T3	PA
RETIN-A MICRO PUMP 0.08% GEL	T3	PA
tretinoin 0.01% gel (Retin-A)	T1	PA
tretinoin 0.025% cream (Retin-A)	T1	PA
tretinoin 0.025% gel (Retin-A)	T1	PA
tretinoin 0.05% cream (Retin-A)	T1	PA
tretinoin 0.05% gel (Atralin)	T1	PA
tretinoin 0.1% cream (Retin-A)	T1	PA
tretinoin microspheres (Retin-A Micro Pump)	T1	PA
tretinoin microspheres (Retin-A Micro)	T1	PA

T1 – Generics

T2 – Preferred Brands

T3 – Non-Preferred Brands

T4 – Preferred Specialty

T5 – Non-Preferred Specialty

PA – Prior Authorization

QL – Quantity Limit

ST – Step Therapy

AGE – Age Requirement

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List of Prescription Medications

SMOKING DETERRENTS (Smoking Cessation)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
SMOKING DETERRENT AGENTS (GANGLIONIC STIM, OTHERS)		
NICOTROL	T3	QL (180 ds/365 days)PPACA
NICOTROL NS	T3	QL (180 ds/365 days)PPACA
SMOKING DETERRENT-NICOTINIC RECEPT.PARTIAL AGONIST		
APO-VARENICLINE 0.5 MG TABLET	T2	QL (180 ds/365 days)PPACA
APO-VARENICLINE 1 MG TABLET	T2	QL (180 ds/365 days)PPACA
CHANTIX	T3	QL (180 ds/365 days)PPACA
SMOKING DETERRENTS, OTHER		
<i>bupropion hcl sr 150 mg tablet</i>	T1	QL (180 ds/365 days)PPACA
THYROID PREPS (Hormonal Agents)		
ANTITHYROID PREPARATIONS		
<i>methimazole</i>	T1	HD
<i>propylthiouracil</i>	T1	HD
THYROID HORMONES		
<i>adthyza 15 mg tablet</i>	T1	HD
<i>adthyza 30 mg tablet</i>	T1	HD
<i>adthyza 60 mg tablet</i>	T1	HD
<i>adthyza 90 mg tablet</i>	T1	HD
<i>adthyza 120 mg tablet</i>	T1	HD
ARMOUR THYROID	T2	HD
ERMEZA SOLUTION	T3	ST HD
<i>levothyroxine sodium (Synthroid)</i>	T1	HD
<i>liothyronine sodium (Cytomel)</i>	T1	HD
<i>thyroid,pork</i>	T1	HD
UNCLASSIFIED DRUG PRODUCTS (AIDS/HIV)		
CYTOCHROME P450 INHIBITORS		
TYBOST	T5	SP
UNCLASSIFIED DRUG PRODUCTS (Asthma/COPD/Respiratory)		
CYSTIC FIBROSIS - INHALED OSMOTIC AGENTS		
BRONCHITOL	T5	PA SP HD
CYSTIC FIBROSIS-CFTR POTENTIATOR-CORRECTOR COMBIN.		
ALYFTREK 10-50-125 MG TABLET	T4	PA QL (56 tabs/fill) SP HD
ALYFTREK 4-20-50 MG TABLET	T4	PA QL (84 tabs/fill) SP HD
ORKAMBI 100 MG-125 MG TABLET	T4	PA QL (112 tabs/fill) SP HD

T1 – Generics

T2 – Preferred Brands

T3 – Non-Preferred Brands

T4 – Preferred Specialty

T5 – Non-Preferred Specialty

PA – Prior Authorization

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ST – Step Therapy

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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.)		
ORKAMBI 100-125 MG GRANULE PKT	T4	PA QL (56 packs/fill) SP HD
ORKAMBI 150-188 MG GRANULE PKT	T4	PA QL (56 packs/fill) SP HD
ORKAMBI 200 MG-125 MG TABLET	T4	PA QL (112 tabs/fill) SP HD
ORKAMBI 75-94 MG GRANULE PKT	T4	PA QL (56 packs/fill) SP HD
SYMDEKO	T4	PA QL (56 tabs/fill) SP HD
TRIKAFTA 100-50-75 MG/75MG PKT	T4	SP PA HD QL (56 packets/28 days)
TRIKAFTA 80-40-60MG/59.5MG PKT	T4	SP PA HD QL (56 packets/28 days)
CYSTIC FIB-TRANSMEMB CONDUCT.REG.(CFTR) POTENTIATOR		
KALYDECO 150 MG TABLET	T4	PA QL (56 tabs/fill) SP HD
KALYDECO 5.8 MG GRANULES PKT	T4	PA QL (56 packs/fill) SP HD
KALYDECO 13.4MG GRANULES PKT	T4	PA SP QIL (56 packets/28 days)
KALYDECO 25 MG, 50 MG GRANULES PACKET	T4	PA QL (56 packs/fill) SP HD
KALYDECO 75 MG GRANULES PACKET	T4	PA QL (56 packs/fill) SP HD
LUNG SURFACTANTS		
CUROSURF	T3	
INFASURF	T3	
SURVANTA	T3	
MUCOLYTICS		
PULMOZYME	T4	PA SP HD
PULMONARY FIBROSIS - SYSTEMIC ENZYME INHIBITORS		
OFEV	T4	PA QL (60 caps/fill) SP HD
SYSTEMIC ENZYME INHIBITORS		
JOENJA 70 MG TABLET	T5	PA SP QL (60 tabs/30 days)
VIJOICE 250 MG DAILY DOSE PACK	T4	PA QL (56 tabs/28 days) SP
VIJOICE 50 MG GRANULE PACKET	T4	PA QL (28 packs/28 days) SP
VIJOICE 125 MG TABLET	T4	PA QL (28 tabs/28 days) SP
VIJOICE 50 MG TABLET	T4	PA QL (28 tabs/28 days) SP
ZOKINVY	T5	PA QL (120 caps/fill) SP
THYMIC STROMAL LYMPHOPOIETIN (TSLP) INHIBITORS		
TEZSPIRE 210 MG/1.91 ML PEN	T4	SP PA HD QL (1 pen/28 days)
TEZSPIRE 210 MG/1.91 ML SYRING	T4	SP PA HD QL (1 syringe/28 days)
UNCLASSIFIED DRUG PRODUCTS (Blood Modifiers/Bleeding Disorders)		
SPLEEN TYROSINE KINASE INHIBITORS		
TAVALISSE	T4	PA QL (60 tabs/fill) SP

T1 – Generics

T2 – Preferred Brands

T3 – Non-Preferred Brands

T4 – Preferred Specialty

T5 – Non-Preferred Specialty

PA – Prior Authorization

QL – Quantity Limit

ST – Step Therapy

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List of Prescription Medications

UNCLASSIFIED DRUG PRODUCTS (Blood Pressure/Heart Medications)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
BRADYKININ B2 RECEPTOR ANTAGONISTS		
<i>icatibant acetate</i> (Firazyr)	T1	PA SP HD
<i>icatibant acetate</i> (Firazyr)	T1	PA SP
PLASMA KALLIKREIN INHIBITORS		
ORLADEYO	T5	PA SP
UNCLASSIFIED DRUG PRODUCTS (Cancer)		
CHEMOTHERAPY RESCUE/ANTIDOTE AGENTS		
<i>leucovorin calcium</i>	T1	CSL
<i>mesna</i> (Mesnex)	T1	SP CSL
MESNEX (<i>mesna</i>)	T4	SP CSL
VISTOGARD	T4	PA QL (20 packs/30 days) SP CSL
UNCLASSIFIED DRUG PRODUCTS (Dental Products)		
DENTAL AIDS AND PREPARATIONS		
<i>chlorhexidine gluconate</i> (Peridex)	T1	
PERIDEX (<i>chlorhexidine gluconate</i>)	T3	
<i>triamcinolone 0.1% paste</i>	T1	
<i>triamcinolone acetonide</i>	T1	
PERIODONTAL COLLAGENASE INHIBITORS		
<i>doxycycline hyclate 20 mg tab</i>	T1	
UNCLASSIFIED DRUG PRODUCTS (Erectile Dysfunction)		
DRUGS TO TREAT ERECTILE DYSFUNCTION (ED)		
<i>avanafil</i> (Stendra)	T1	PA QL (8 tabs/30 days)
CAVERJECT 20 MCG VIAL	T2	PA QL (12 vials/fill)
CAVERJECT 40 MCG VIAL	T2	PA QL (12 vials/fill)
CAVERJECT IMPULSE 10 MCG KIT	T2	PA QL (12 kits/fill)
CAVERJECT IMPULSE 10 MCG SYRNG	T2	PA QL (12 syringes/fill)
CAVERJECT IMPULSE 20 MCG KIT	T2	PA QL (12 kits/fill)
CAVERJECT IMPULSE 20 MCG SYRNG	T2	PA QL (12 syringes/fill)
<i>CIALIS (tadalafil)</i>	T3	PA QL (8 tabs/30 days)
EDEX 10 MCG CARTRIDGE 2-PK KIT	T3	PA QL (6 kits/fill)
EDEX 10 MCG CARTRIDGE 6-PK KIT	T3	PA QL (2 kits/fill)
EDEX 20 MCG CARTRIDGE 2-PK KIT	T3	PA QL (6 kits/fill)
EDEX 20 MCG CARTRIDGE 6-PK KIT	T3	PA QL (2 kits/fill)
EDEX 40 MCG CARTRIDGE 2-PK KIT	T3	PA QL (6 kits/fill)

T1 – Generics

T2 – Preferred Brands

T3 – Non-Preferred Brands

T4 – Preferred Specialty

T5 – Non-Preferred Specialty

PA – Prior Authorization

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AGE – Age Requirement

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List of Prescription Medications

UNCLASSIFIED DRUG PRODUCTS (Erectile Dysfunction) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
DRUGS TO TREAT ERECTILE DYSFUNCTION (ED) (cont.)		
EDEX 40 MCG CARTRIDGE 6-PK KIT	T3	PA QL (2 kits/fill)
IFE-BIMIX 30/1	T3	
LEVITRA (<i>vardenafil hcl</i>)	T3	PA QL (8 tabs/fill)
MUSE	T2	PA QL (12 supps/fill)
PAPAVERINE-PHENTOLAMINE	T3	
PAPAVERINE-PHENTOLMN-ALPROSTDL	T3	
<i>sildenafil</i> 25 mg tablet (Viagra)	T1	PA QL (8 tabs/30 days) HD
<i>sildenafil</i> 100 mg tablet (Viagra)	T1	PA QL (8 tabs/30 days) HD
<i>sildenafil</i> 50 mg tablet (Viagra)	T1	PA QL (8 tabs/30 days) HD
STENDRA (<i>avanafil</i>)	T3	PA QL (8 tabs/30 days)
<i>tadalafil</i> 2.5 mg tablet	T1	PA QL (30 tabs/30 days) HD
<i>tadalafil</i> 5 mg tablet (Cialis)	T1	PA QL (8 tabs/30 days) HD
<i>tadalafil</i> 10 mg tablet (Cialis)	T1	PA QL (8 tabs/30 days) HD
<i>tadalafil</i> 20 mg tablet (Cialis)	T1	PA QL (8 tabs/30 days) HD
TRI-MIX (PAPVRN-PHNTLMN-PGE1)	T3	
<i>vardenafil hcl</i>	T1	PA QL (8 tabs/fill)
<i>vardenafil hcl</i> (Levitra)	T1	PA QL (8 tabs/fill)
UNCLASSIFIED DRUG PRODUCTS (Eye Conditions)		
NICOTINIC RECEPT.PARTIAL AGONIST, ALPHA4BETA2 SPEC		
TYRVAYA	T3	PA
UNCLASSIFIED DRUG PRODUCTS (Gastrointestinal/Heartburn)		
AGENTS FOR STOMATOLOGICAL USE		
PROTHELIAL	T3	
SILATRIX	T3	
COMPOUNDING KIT		
FIRST-MOUTHWASH BLM	T3	
ORAL MUCOSITIS/STOMATITIS AGENTS		
GELCLAIR	T3	
GELX	T3	
ORAMAGICRX	T3	
ORAL MUCOSITIS/STOMATITIS ANTI-INFLAMMATORY AGENT		
EPISIL	T3	

T1 – Generics

T2 – Preferred Brands

T3 – Non-Preferred Brands

T4 – Preferred Specialty

T5 – Non-Preferred Specialty

PA – Prior Authorization

QL – Quantity Limit

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List of Prescription Medications

UNCLASSIFIED DRUG PRODUCTS (Gastrointestinal/Heartburn) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
PPAR AGONIST		
IQIRVO	T4	PA SP HD
LIVDELZI	T4	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	T4	PA QL (30 tabs/30 days) SP HD
UNCLASSIFIED DRUG PRODUCTS (Hormonal Agents)		
GROWTH HORMONE RECEPTOR ANTAGONISTS		
SOMAVERT	T4	PA SP HD
HYPERPARTHYROID TX AGENTS - VITAMIN D ANALOG-TYPE		
doxercalciferol	T1	ST
paricalcitol	T1	ST SP HD
paricalcitol (Zemplar)	T1	ST SP HD
RAYALDEE	T3	ST
ZEMPLAR (paricalcitol)	T5	ST SP HD
UNCLASSIFIED DRUG PRODUCTS (Miscellaneous)		
ABORTIFACIENT-PROGESTERONE RECEPTOR ANTAGONISTS		
MIFEPREX	T3	
mifepristone 200 mg tablet	T1	
AGENTS TO TX PERIODIC PARALYSIS - CARBON ANHYD INH		
dichlorphenamide (Keveyis)	T1	PA SP
AMMONIA INHIBITORS		
CARBAGLU (carglumic acid)	T4	PA SP HD
carglumic acid (Carbaglu)	T1	PA SP HD

T1 – Generics

T2 – Preferred Brands

T3 – Non-Preferred Brands

T4 – Preferred Specialty

T5 – Non-Preferred Specialty

PA – Prior Authorization

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AGE – Age Requirement

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List of Prescription Medications

UNCLASSIFIED DRUG PRODUCTS (Miscellaneous) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
AMYLOIDOSIS AGENTS-TRANSTHYRETIN (TTR) SUPPRESSION		
TEGSEDI	T4	PA QL (SP HD)
ANTI-ALCOHOLIC PREPARATIONS		
<i>acamprosate calcium</i>	T1	
<i>disulfiram</i>	T1	
ANTIFIBROTIC THERAPY - PYRIDONE ANALOGS		
<i>pirfenidone 267 mg capsules</i>	T1	PA QL (270 caps/30 days) SP HD
CI ESTERASE INHIBITORS		
HAEGARDA	T5	PA SP HD
HAEGARDA 2,000UNIT VIAL	T4	PA QL (24 vls/28 days) SP HD
HAEGARDA 3,000UNIT VIAL	T4	PA QL (16 vls/28 days) SP HD
CALCIMIMETIC,PARATHYROID CALCIUM ENHANCER		
<i>cinacalcet hcl (Sensipar)</i>	T1	PA SP
COMPOUNDING KIT		
FIRST-MOUTHWASH BLM	T3	
CRYOPRESERVATIVE AGENTS		
<i>dimethyl sulfoxide</i>	T1	
DRUGS TO TREAT HEREDITARY TYROSINEMIA		
<i>nitisinone (Orfadin)</i>	T1	PA SP HD
NITYR	T4	PA SP
ORFADIN	T5	PA SP
ORFADIN (<i>nitisinone</i>)	T5	PA SP
DRUGS TO TX GAUCHER DX-TYPE I, SUBSTRATE REDUCING		
CERDELGA	T4	PA QL (56 caps/28 days) SP HD
<i>miglustat (Zavesca)</i>	T1	PA SP HD
ENVIRONMENT ALLERGENS AND IRRITANTS, OTHER		
T.R.U.E. TEST	T3	
GENERAL INHALATION AGENTS		
HYPER-SAL	T3	
<i>nebusal 3% vial</i>	T1	
NEBUSAL 6% VIAL	T3	
<i>sodium chloride for inhalation</i>	T1	
<i>sodium chloride 0.9% inhal vial</i>	T1	
<i>sodium chloride 10% vial</i>	T1	
<i>sodium chloride 3% vial</i>	T1	

T1 – Generics

T2 – Preferred Brands

T3 – Non-Preferred Brands

T4 – Preferred Specialty

T5 – Non-Preferred Specialty

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AGE – Age Requirement

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List of Prescription Medications

UNCLASSIFIED DRUG PRODUCTS (Miscellaneous) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
GENERAL INHALATION AGENTS (cont.)		
sodium chloride 7% vial	T1	
GENETIC D/O TX - SMN PROTEIN DEFICIENCY TREATMENT		
EVRYSDI 5 MG TABLET	T5	PA QL (30 tabs/30 days) SP HD
EVRYSDI 60 MG/80 ML(0.75MG/ML)	T5	PA QL (240 mls/30 days) SP HD
GLUCOSYLCERAMIDE SYNTHASE (GCS) INHIBITOR		
miglustat (Zavesca)	T1	PA QL (90 caps/30 days) SP
OPFOLDA	T5	PA QL (8 caps/fill) SP HD
HOMEOPATHIC DRUGS		
VERTIGOHEEL	T3	
MENOPAUSAL SYMPTOMS SUPPRESSANT-NK3 RECEPTOR ANTAG		
VEOZAH	T3	
MENOPAUSAL SYMPTOMS SUPPRESSANT - SSRIS		
paroxetine mesylate (Brisdelle)	T1	ST QL (30 caps/fill) HD
METABOLIC DISEASE ENZYME REPLACE, HYPOPHOSPHATASIA		
STRENSIQ	T4	PA SP
METALLIC POISON, AGENTS TO TREAT		
CHEMET	T2	PA
deferasirox (Exjade)	T1	PA SP HD
deferasirox (Jadenu Sprinkle)	T1	PA SP HD
deferasirox (Jadenu)	T1	PA SP HD
deferiprone (Ferriprox (3 Times A Day))	T1	PA SP HD
FERRIPROX	T5	PA SP
FERRIPROX (2 TIMES A DAY)	T4	PA SP
FERRIPROX (3 TIMES A DAY) (deferiprone)	T4	PA SP
FERRIPROX 100 MG/ML SOLUTION	T4	PA SP
FERRIPROX 500 MG TABLET (deferiprone)	T5	PA SP
GALZIN	T5	SP
RADIOGARDASE	T3	
SYPRINE (<i>trientine hcl</i>)	T5	PA SP HD
NATRIURETIC PEPTIDES		
VOXZOGO	T5	PA SP HD
NEONATAL FC RECEPTOR (FCRN) INHIBITORS		
VYVGART HYTRULO	T5	PA SP HD

T1 – Generics

T2 – Preferred Brands

T3 – Non-Preferred Brands

T4 – Preferred Specialty

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List of Prescription Medications

UNCLASSIFIED DRUG PRODUCTS (Miscellaneous) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
PHARMACOLOGICAL CHAPERONE-ALPHA-GALACTOSID.A STABZ		
GALAFOLD	T5	PA QL (15 caps/fill) SP HD
PKU TX AGENT-COFACtOR OF PHENYLALANINE HYDROXYLASE		
sapropterin dihydrochloride (Kuvan)	T1	PA SP
sapropterin dihydrochloride (Kuvan)	T1	PA SP HD
PROTEIN STABILIZERS		
ATTRUBY	T4	PA SP
VYNDAMAX	T4	PA SP HD
VYndaQEL	T4	PA SP HD
RETINOIC ACID RECEPTOR (RAR) AGONISTS		
SOHONOS 1 MG CAPSULE	T5	PA QL (112 caps/fill) SP
SOHONOS 1.5 MG CAPSULE	T5	PA QL (112 caps/fill) SP
SOHONOS 10 MG CAPSULE	T5	PA QL (56 caps/fill) SP
SOHONOS 2.5 MG CAPSULE	T5	PA QL (140 caps/fill) SP
SOHONOS 5 MG CAPSULE	T5	PA QL (84 caps/fill) SP
SOLVENTS		
CVS ISOPROPYL ALCOHOL 91%	T3	
cvs isopropyl alcohol 91%	T1	
CVS ISOPROPYL RUB ALCOHOL 70%	T3	
cvs isopropyl rub alcohol 70%	T1	
eql isopropyl alcohol 91%	T1	
eql isopropyl rub alcohol 70%	T1	
FT ISOPROPYL ALCOHOL 91%	T3	
FT ISOPROPYL RUB ALCOHOL 70%	T3	
GNP ISOPROPYL ALCOHOL 70%	T3	
gnp isopropyl alcohol 99%	T1	
hm isopropyl alcohol 70%	T1	
hm isopropyl alcohol 91%	T1	
INSTACLEAN	T2	
ISOPROPANOL	T2	
isopropyl 70% alcohol	T1	
isopropyl alcohol	T1	
ISOPROPYL ALCOHOL 70%	T3	
isopropyl alcohol 70%, 91%	T1	
isopropyl alcohol 99%	T1	

T1 – Generics

T2 – Preferred Brands

T3 – Non-Preferred Brands

T4 – Preferred Specialty

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List of Prescription Medications

UNCLASSIFIED DRUG PRODUCTS (Miscellaneous) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
SOLVENTS (cont.)		
<i>isopropyl rubbing alcohol 70%</i>	T1	
ISOPROPYL RUBBING ALCOHOL 70%	T3	
ISOPROPYL RUBBING ALCOHOL 91%	T3	
<i>kro isopropyl alcohol 91%</i>	T1	
MURI-LUBE MINERAL OIL	T2	
<i>polyethylene glycol</i>	T1	
<i>qc isopropyl alcohol 91%</i>	T1	
<i>qc isopropyl rubbing alcohol</i>	T1	
<i>ra isopropyl alcohol 70%, 91%</i>	T1	
<i>sm isopropyl alcohol 70%</i>	T1	
<i>swan isopropyl alcohol 70%</i>	T1	
SUSPENDING AGENTS		
GELFILM	T3	
HYDROXYPROPYLECELLULOSE	T2	
HYPROMELLOSE	T2	
TREATMENT OF HYPERPHAGIA IN PRADER-WILLI SYNDROME		
VYKAT XR	T5	PA SP
UNCLASSIFIED DRUG PRODUCTS (Nutritional/Dietary)		
METABOLIC DEFICIENCY AGENTS		
<i>betaine (Cystadane)</i>	T1	PA SP
CARNITOR (<i>levocarnitine (with sugar)</i>)	T3	
CARNITOR (<i>levocarnitine</i>)	T3	
CARNITOR SF (<i>levocarnitine</i>)	T3	
<i>levocarnitine 4 gm/20 ml vial</i>	T1	
<i>levocarnitine (Carnitor Sf)</i>	T1	
<i>levocarnitine (Carnitor)</i>	T1	
<i>levocarnitine (with sugar) (Carnitor)</i>	T1	
UNCLASSIFIED DRUG PRODUCTS (Osteoporosis Products)		
BONE FORMATION STIM. AGENTS - PARATHYROID HORMONE		
BONSITY (<i>teriparatide</i>)	T5	PA QL (1 pens/28 days) SP
TERIPARATIDE 560 MCG/2.24 ML	T5	PA QL (1 pens/28 days) SP
<i>teriparatide 560mcg/2.24ml pen (Bonsity)</i>	T1	PA QL (1 pens/28 days) SP HD
<i>teriparatide 560 mcg/2.24ml pen (Forteo)</i>	T1	PA QL (1 pen/28 days) SP HD

T1 – Generics

T2 – Preferred Brands

T3 – Non-Preferred Brands

T4 – Preferred Specialty

T5 – Non-Preferred Specialty

PA – Prior Authorization

QL – Quantity Limit

ST – Step Therapy

AGE – Age Requirement

SP – Specialty Medication

HD – May require home delivery pharmacy

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List of Prescription Medications

UNCLASSIFIED DRUG PRODUCTS (Osteoporosis Products) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
BONE RESORPTION INHIBITOR AND VITAMIN D COMBS.		
FOSAMAX PLUS D	T3	ST QL (4 tabs/28 days) HD
BONE RESORPTION INHIBITORS		
ACTONEL 35 MG TABLET (<i>risedronate sodium</i>)	T3	ST QL (4 tabs/28 days) HD
ACTONEL 150 MG TABLET (<i>risedronate sodium</i>)	T3	ST QL (1 tab/30 days) HD
<i>alendronate sod 70 mg/75 ml</i>	T1	QL (300 mls/28 days) HD
<i>alendronate sodium 5mg, 10mg tablet</i>	T1	QL (30 tabs/fill) HD
<i>alendronate sodium 35 mg tab</i>	T1	QL (4 tabs/28 days) HD
<i>alendronate sodium 40 mg tab</i>	T1	HD
<i>alendronate sodium 70 mg tab (Fosamax)</i>	T1	QL (4 tabs/28 days) HD
ATELVIA (<i>risedronate sodium</i>)	T3	ST QL (4 tabs/28 days) HD
BINOSTO	T3	ST QL (4 tabs/28 days) HD
EVISTA (<i>raloxifene hcl</i>)	T3	HD
FOSAMAX (<i>alendronate sodium</i>)	T3	ST QL (4 tabs/28 days) HD
<i>ibandronate sodium</i>	T1	QL (1 tab/30 days) HD
<i>raloxifene hcl (Evista)</i>	T1	HD PPACA
<i>risedronate sodium (Atelvia)</i>	T1	QL (4 tabs/28 days) HD
<i>risedronate sodium 5 mg, 30 mg tablet</i>	T1	QL (30 tabs/fill) HD
<i>risedronate sodium 35 mg tab (Actonel)</i>	T1	QL (4 tabs/28 days) HD
<i>risedronate sodium 150 mg tab (Actonel)</i>	T1	QL (1 tab/30 days) HD
UNCLASSIFIED DRUG PRODUCTS (Pain Relief and Inflammatory Disease)		
ANTI-INFLAM. INTERLEUKIN-1 RECEPTOR ANTAGONIST		
ARCALYST	T5	PA QL (4 vls/28 days) SP HD
FIBROMYALGIA AGENTS, SEROTONIN-NOREPINEPHRU INHIB		
SAVELLA 12.5MG, 25MG, 50MG, 100MG 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	T4	PA QL (4 mls/28 days) SP HD
UNCLASSIFIED DRUG PRODUCTS (Seizure Disorders)		
NEUROPATHIC AGENTS		
<i>pregabalin (Lyrica Cr)</i>	T1	PA HD
UNCLASSIFIED DRUG PRODUCTS (Skin Conditions)		
INTERLEUKIN-13 (IL-13) INHIBITORS, MAB		
ADBRY	T4	PA QL (4 syringes/28 days) SP HD

T1 – Generics

T2 – Preferred Brands

T3 – Non-Preferred Brands

T4 – Preferred Specialty

T5 – Non-Preferred Specialty

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List of Prescription Medications

UNCLASSIFIED DRUG PRODUCTS (Skin Conditions) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
INTERLEUKIN-13 (IL-13) INHIBITORS, MAB (cont.)		
ADBRY AUTOINJECTOR	T4	PA QL (2 auto-injs/28 days) SP HD
EBGLYSS PEN	T4	PA QL (4 mls/28 days) SP
EBGLYSS SYRINGE	T4	PA SP
JANUS KINASE (JAK) INHIBITORS		
LITFULO	T5	PA QL (28 caps/28 days) SP HD
WOUND HEALING AGENTS, LOCAL		
FILSUVEZ	T5	PA SP
UNCLASSIFIED DRUG PRODUCTS (Substance Abuse)		
OPIOID WITHDRAWAL THER, ALPHA-2 ADRENERGIC AGONIST		
lofexidine hcl (Lucemyra)	T1	PA QL (224 tabs/30 days)
OPIOID WITHDRAWAL THERAPY AGENTS, OPIOID-TYPE		
buprenorphine hcl	T1	
buprenorphine hcl/naloxone hcl	T1	
buprenorphine hcl/naloxone hcl (Suboxone)	T1	
ZUBSOLV	T2	
UNCLASSIFIED DRUG PRODUCTS (Transplant Medications)		
RHO KINASE INHIBITOR		
REZUROCK	T5	PA QL (30 tabs/fill) SP
UNCLASSIFIED DRUG PRODUCTS (Urinary Tract Conditions)		
BENIGN PROSTATIC HYPERPLASIA/MICTURITION AGENTS		
alfuzosin hcl (Uroxatral)	T1	HD
dutasteride (Avodart)	T1	ST HD
finasteride (Proscar)	T1	HD
FLOMAX (tamsulosin hcl)	T3	ST HD
PROSCAR (finasteride)	T3	ST HD
silodosin (Rapaflo)	T1	HD
tamsulosin hcl (Flomax)	T1	HD
BPH 5-ALPHA-REDUCTASE INHIB-ALPHAI-ADRENOCEP ANTAG		
dutasteride/tamsulosin hcl (Jalyn)	T1	ST HD
JALYN (dutasteride/tamsulosin hcl)	T3	ST HD
CYSTINE-DEPLETING AGENTS, NEPHROPATHIC CYSTINOSIS		
CYSTAGON	T4	SP

T1 – Generics

T2 – Preferred Brands

T3 – Non-Preferred Brands

T4 – Preferred Specialty

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List of Prescription Medications

UNCLASSIFIED DRUG PRODUCTS (Urinary Tract Conditions) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ENDOTHELIN RECEPTOR ANTAGONISTS		
VANRAFIA	T5	PA SP
KIDNEY STONE AGENTS		
THIOLA EC (<i>tiopronin</i>)	T5	PA 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
OVERACTIVE BLADDER AGENTS, BETA-3 ADRENERGIC RECEPTOR ANTAGONISTS		
GEMTESA	T3	HD
<i>mirabegron</i> (Myrbetriq)	T1	HD
MYRBETRIQ (<i>mirabegron</i>)	T2	HD
MYRBETRIQ	T2	HD
URINARY TRACT ANTISPASMODIC, M(3) SELECTIVE ANTAGONISTS		
<i>darifenacin hydrobromide</i>	T1	HD
<i>solifenacin succinate</i> (Vesicare)	T1	HD
URINARY TRACT ANTISPASMODIC/ANTIINCONTINENCE AGENT		
<i>fesoterodine fumarate</i> (Toviaz)	T1	HD
<i>flavoxate hcl</i>	T1	HD
<i>oxybutynin 5 mg/5 ml soln cup</i>	T1	HD
<i>oxybutynin chloride</i>	T1	HD
OXYTROL	T3	ST QL (8 patches/28 days) HD
<i>tolterodine tartrate</i> (Detrol La)	T1	HD
<i>tolterodine tartrate</i> (Detrol)	T1	HD
<i>trospium chloride</i>	T1	HD
UNCLASSIFIED DRUG PRODUCTS (Weight Management)		
APPETITE STIM. FOR ANOREXIA, CACHEXIA, WASTING SYND.		
<i>megestrol 625 mg/5 ml susp</i>	T1	
<i>megestrol acet 40 mg/ml susp</i>	T1	
VITAMINS (Nutritional/Dietary)		
ANTIOXIDANT MULTIVITAMIN COMBINATIONS		
50 PLUS ADULT EYE HEALTH	T3	

T1 – Generics

T2 – Preferred Brands

T3 – Non-Preferred Brands

T4 – Preferred Specialty

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List of Prescription Medications

VITAMINS (Nutritional/Dietary) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ANTIOXIDANT MULTIVITAMIN COMBINATIONS (cont.)		
a/c/e/zinc ox/cupric ox/lutein	T1	
ADULT 50 PLUS EYE HEALTH	T3	
ANTIOXIDANT FORMULA	T3	
EQ VISION FORMULA TABLET	T2	
eq/eye health plus lutein tab	T1	
EYE HEALTH AND LUTEIN	T3	
EYE HEALTH WITH LUTEIN	T3	
EYE HEALTH PLUS LUTEIN TABLET	T3	
EYE MULTIVITAMIN	T2	
EYE MULTIVITAMIN WITH LUTEIN	T3	
EYEPROTECT	T3	
gnp healthy eyes tablet	T1	
HEALTHY EYES TABLET	T2	
healthy eyes tablet	T1	
I-CAPS	T2	
ICAPS AREDS FORMULA DR TABLET	T3	
ICAPS AREDS2	T3	
LIPOTRIAD	T3	
LIPOTRIAD VISIONARY	T3	
LUTEIN PLUS WITH ZEAXANTHIN	T3	
MACULAR BENEFITS	T3	
MACULAR HEALTH FORMULA	T3	
MACUVEX	T3	
MACUZIN	T3	
MULTI-BETIC	T2	
OCULAR VITAMINS	T3	
OCUVEL	T3	
OCUVITE ADULT 50 PLUS	T2	
OCUVITE WITH LUTEIN	T2	
PRESERVISION AREDS	T2	
PRESERVISION LUTEIN	T2	
VISION FORMULA TABLET	T3	
VISION FORMULA WITH LUTEIN	T3	
VISION OPTIMIZER	T3	

T1 – Generics

T2 – Preferred Brands

T3 – Non-Preferred Brands

T4 – Preferred Specialty

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List of Prescription Medications

VITAMINS (Nutritional/Dietary) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ANTIOXIDANT MULTIVITAMIN COMBINATIONS (cont.)		
VISTA ADVANCED AREDS2	T3	
<i>vit a/vit c/vit e/zinc/copper</i>	T1	
<i>vits a,c,e/lutein/minerals</i>	T1	
VITEYES AREDS 2 PLUS MULTIVIT	T3	
BIOFLAVONOIDS		
<i>bioflav,lemon/vit bcomp,c</i>	T1	
<i>bioflav,lemon/vit bcomp,c (Lipo-Flavonoid Plus)</i>	T1	
CITRUS BIOFLAVONOIDS	T3	
EAR HEALTH PLUS CAPLET	T3	
<i>ear health plus caplet (Lipo-Flavonoid Plus)</i>	T1	
FLAVOVIT	T3	
FLOGEN	T3	
INNER EAR PLUS	T3	
LIPOL FLAVONOID	T3	
LIPOL-FLAVONOID PLUS (<i>bioflav,lemon/vit bcomp,c</i>)	T2	
QUERCETIN	T3	
<i>rutin</i>	T1	
VASCULERA	T3	
VASOFLEX D1	T3	
VENALIV	T3	
FOLIC ACID PREPARATIONS		
COBALEFOL	T3	
<i>cvs folic acid 800 mcg tablet</i>	T1	PPACA
DENOVO	T3	
DEPLIN-ALGAL OIL (<i>levomefolate/algal oil</i>)	T3	
DEPLIN FC	T3	
ENLYTE	T3	
FA-8	T3	
FOLETRA	T3	
<i>folic acid 0.4 mg, 0.8 mg tablet</i>	T1	PPACA
<i>folic acid 1 mg tablet</i>	T1	
<i>folic acid 1,000 mcg tablet</i>	T1	
FOLIC ACID 20 MG CAPSULE	T3	
<i>folic acid 400 mcg, 800 mcg tablet</i>	T1	PPACA

T1 – Generics

T2 – Preferred Brands

T3 – Non-Preferred Brands

T4 – Preferred Specialty

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List of Prescription Medications

VITAMINS (Nutritional/Dietary) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
FOLIC ACID PREPARATIONS (cont.)		
FOLIC ACID 5 MG CAPSULE	T3	
<i>folic acid 5 mg/ml vial</i>	T1	
<i>folic acid 50 mg/10 ml vial</i>	T1	
FOLIC ACID 800 MCG CAPSULE	T3	
<i>folic acid/b6/ca phos/ginger</i>	T1	
FOLIKA-V	T3	
FOLITE	T3	
<i>ft folic acid 400 mcg, 800 mcg tablet</i>	T1	PPACA
GENICIN VITA-Q	T3	
<i>gnp folic acid 400 mcg tablet</i>	T1	PPACA
<i>hm folic acid 400 mcg tablet</i>	T1	PPACA
HYLAZINC	T3	
<i>levomefolate calcium</i>	T1	
<i>levomefolate/algal oil (Deplin-Algal Oil)</i>	T1	
METHYLFOLATE	T3	
MI-VITE RX	T3	
PUREVITA FOLIC ACID	T3	
<i>ra folic acid 0.4 mg tablet</i>	T1	PPACA
<i>ra folic acid 800 mcg tablet</i>	T1	PPACA
<i>sm folic acid 0.4 mg tablet</i>	T1	PPACA
<i>sm folic acid 400 mcg tablet</i>	T1	PPACA
<i>sv folic acid 800 mcg tablet</i>	T1	PPACA
<i>true folic acid 667 mcg dfe tb</i>	T1	PPACA
<i>true folic acid 1600mcg dfe tb</i>	T1	
XAQUIL XR	T3	
GERIATRIC VITAMIN PREPARATIONS		
<i>a thru z advanced formula tab (Vision Plus Lutein)</i>	T1	
<i>a thru z select tablet (Vision Plus Lutein)</i>	T1	
CENTRUM SILVER CHEWABLE TABLET	T2	
<i>eldertonic elixir</i>	T1	
ELDERTONIC LIQUID	T3	
GERITOL COMPLETE	T2	
GERITOL TONIC	T2	
<i>multivit with iron,minerals</i>	T1	

T1 – Generics

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List of Prescription Medications

VITAMINS (Nutritional/Dietary) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
GERIATRIC VITAMIN PREPARATIONS (cont.)		
multivit with minerals/lutein (Vision Plus Lutein)	T1	
REQ49+	T3	
SPECTRAVITE ADULT 50+	T3	
VISION PLUS LUTEIN (multivit with minerals/lutein)	T2	
MULTIVITAMIN PREPARATIONS		
a thru z advanced formula tab	T1	
A THRU Z MEN'S ULTIMATE TABLET	T2	
A THRU Z SELECT MEN 50+ TABLET	T3	
a thru z select multivit tab	T1	
a thru z select multivit tab (Centrum Silver)	T1	
a thru z select multivit tab (Certavite Senior)	T1	
a thru z select tablet (Centrum Silver)	T1	
a thru z select tablet (Certavite Senior)	T1	
a thru z select women's tablet	T1	
a/c/e/zinc/sod selenate/copper	T1	
ABC COMPLETE ADULT	T2	
ABC COMPLETE MEN'S	T2	
ABC COMPLETE SENIOR WOMEN'S	T3	
ACTIVNUTRIENTS	T3	
ACTIVNUTRIENTS PERFORMANCE	T3	
ADEK GUMMIES PLUS ZINC	T3	
ADULT MULTI GUMMIES	T3	
ADULT MULTIVITAMIN GUMMIES	T3	
ADULT ONE DAILY GUMMIES	T3	
ADULTS' DAILY FORMULA	T3	
ADULTS MULTI	T3	
ADULTS MULTIVITAMIN	T3	
ADVANCED MULTI EA	T3	
ALIVE ADULT ULTRA POTENCY	T3	
ALIVE COMPLETE PREMIUM PRENATL	T3	
ALIVE MAX6 POTENCY	T3	
ALIVE WOMEN'S 50 PLUS COMPLETE	T3	
ALIVE DAILY ENERGY	T3	
ALIVE HAIR, SKIN AND NAILS	T3	

T1 – Generics

T2 – Preferred Brands

T3 – Non-Preferred Brands

T4 – Preferred Specialty

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List of Prescription Medications

VITAMINS (Nutritional/Dietary) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
MULTIVITAMIN PREPARATIONS (cont.)		
ALIVE DAILY SUPPORT PRENATAL	T3	
ALIVE MAX POTENCY	T3	
ALIVE MEN'S 50 PLUS GUMMY	T3	
ALIVE MEN'S 50 PLUS ULTRA	T3	
ALIVE MEN'S ULTRA POTENCY	T3	
ALIVE MEN'S ENERGY	T3	
ALIVE MEN'S GUMMY	T3	
ALIVE PREMIUM ADULT	T3	
ALIVE PREMIUM PRENATAL	T3	
ALIVE WOMEN'S 50 PLUS	T3	
ALIVE WOMEN'S 50 PLUS ULTRA	T3	
ALIVE WOMEN'S ENERGY	T3	
ALIVE WOMEN'S GUMMY VITAMIN	T3	
ALIVE WOMEN'S MULTIVITAMIN	T3	
ALIVE WOMEN'S ULTRA POTENCY	T3	
ALPHA BETIC MULTIVITAMIN	T3	
ALTRIXA	T3	
<i>amino acids/mv,tx,iron,mineral</i>	T1	
AMLADEX	T3	
ANIMI-3	T3	
AQUADEKS	T2	
BACMIN	T3	
BARIATRIC MULTIVITAMINS	T3	
<i>b-complex with vitamin c</i>	T1	
<i>b-complex with vitamin c (Support-500)</i>	T1	
<i>b-complex w-vitamin c caplet</i>	T1	
BEROCCA	T3	
<i>beta-carotene(a)-vits c,e/mins</i>	T1	
BIO-35	T3	
BLADDER 2.2	T2	
BODY, HAIR, SKIN AND NAILS	T3	
CENTRAL-VITE	T3	
CENTRAL-VITE WOMEN'S MATURE (<i>multivit-min/iron/folic/lutein</i>)	T3	
CENTRAVITES ADULTS	T3	

T1 – Generics

T2 – Preferred Brands

T3 – Non-Preferred Brands

T4 – Preferred Specialty

T5 – Non-Preferred Specialty

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List of Prescription Medications

VITAMINS (Nutritional/Dietary) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
MULTIVITAMIN PREPARATIONS (cont.)		
CENTRUM	T2	
CENTRUM ADULT 50 PLUS	T3	
CENTRUM ADULT 50 FRESH-FRUITY	T3	
CENTRUM CHEWABLES ADULTS TAB	T2	
CENTRUM CHEWABLES ADULTS TAB	T3	
CENTRUM COMPLETE	T2	
CENTRUM FLAVOR BURST ADULT	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	
CENTRUM MULTIGUMMIES	T3	
CENTRUM SILVER MEN	T3	
CENTRUM SILVER TABLET (<i>multivit-min/fa/lycopen/lutein</i>)	T3	
CENTRUM SILVER ULTRA MEN'S (<i>multivit-min/fa/lycopen/lutein</i>)	T2	
CENTRUM SILVER WOMEN (<i>multivit-min/iron/folic/lutein</i>)	T3	
CENTRUM SPECIALIST ENERGY	T3	
CENTRUM SPECIALIST HEART	T2	
CENTRUM ULTRA MEN'S	T2	
CENTRUM WOMEN IMMUNE MINIS	T3	
<i>certavite-antioxidant tablet</i> (Certavite-Antioxidant)	T1	
CERTAVITE-ANTIOXIDANT TABLET (<i>multivitamin/iron/folic acid</i>)	T3	
<i>certavite-antioxidant tablet</i> (Tab-A-Vite Multivit With Iron)	T1	
COMPLETE MEN	T2	
COMPLETE MEN 50 PLUS	T3	
COMPLETE MULTIVITAMIN-MINERAL	T3	
CONCEPT DHA (<i>mvn-min75/iron/iron ps/om3/dha</i>)	T3	
CONCEPT OB (<i>mvn-min 74/iron fum/iron/fa</i>)	T3	
CORVITE	T3	

T1 – Generics

T2 – Preferred Brands

T3 – Non-Preferred Brands

T4 – Preferred Specialty

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VITAMINS (Nutritional/Dietary) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
MULTIVITAMIN PREPARATIONS (cont.)		
CULTURELLE PROBIOTIC-MULTIVIT	T3	
cvs adult multivitamin gummy	T1	
cvs b-complex-vit c caplet	T1	
cvs hair, skin and nails cplt	T1	
cvs one daily essential tablet (Daily-Vite)	T1	
DAILY GUMMIES	T3	
DAILY MULTIVITAMIN	T3	
DAILY MULTIPLE	T2	
daily-vite tablet (Daily-Vite)	T1	
DAILY-VITE TABLET (<i>multivitamin with folic acid</i>)	T3	
DAVIMET WITH IRON	T3	
DAYAVITE	T3	
DECUBIVITE	T3	
DEKAS BARIATRIC	T3	
DEKAS ESSENTIAL	T3	
DEKAS PLUS	T3	
DERMACINRX FOLIFLEX	T3	
DERMACINRX FOLITIN-Z	T3	
DERMACINRX MULTITAM	T3	
DERMACINRX RIBOTIN-E	T3	
DERMACINRX VENEXA	T3	
DERMACINRX VENEXA FE	T3	
DERMACINRX VENTRIXYL	T3	
DERMACINRX VENTRIXYL FE	T3	
DERMACINRX VITRAMYN	T3	
DERMACINRX VITRANOL	T3	
DERMACINRX VITRANOL FE	T3	
DERMACINRX VITREXATE	T3	
DERMACINRX VITREXATE FE	T3	
DERMACINRX ZINTREXYL-C	T3	
DIABETES HEALTH FORMULA	T3	
DIABETES HEALTH PACK	T3	
DIABETIC VITAMIN	T3	
DIALYVITE 800 WITH IRON	T3	

T1 – Generics

T2 – Preferred Brands

T3 – Non-Preferred Brands

T4 – Preferred Specialty

T5 – Non-Preferred Specialty

PA – Prior Authorization

QL – Quantity Limit

ST – Step Therapy

AGE – Age Requirement

SP – Specialty Medication

HD – May require home delivery pharmacy

PPACA – No Cost-Share Preventive Medication

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List of Prescription Medications

VITAMINS (Nutritional/Dietary) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
MULTIVITAMIN PREPARATIONS (cont.)		
DIATROL	T3	
ELON MATRIX 5000 COMPLETE	T3	
ENBRACE HR	T3	
ENDUR-VM IRON-FREE	T3	
ENDUR-VM WITH IRON	T3	
EQ ONE DAILY MEN'S TABLET	T2	
EQ ONE DAILY WOMEN'S HEALTH TB	T3	
EQ ONE DAILY WOMEN'S TABLET	T2	
ESSENTIAL MAN	T3	
ESSENTIAL MAN 50+	T3	
ESSENTIAL WOMAN 50+	T3	
ESTROVEN MENOPAUSE	T3	
<i>fa/mv,ca,iron,min/lycopene/lut</i>	T1	
FATIGUE RELIEF COMPLEX (<i>bcomp,c/st,jhn wrt/s.ginsg/pgn</i>)	T3	
FINAZOL	T3	
FLORRAXYL	T3	
FOLAGENT DHA	T3	
FOLAMAX	T3	
FOLAMED DHA	T3	
FOLAPRIME	T3	
<i>folic acid/multivit,iron,miner</i>	T1	
<i>folic acid/mv,iron,min/lutein</i>	T1	
FOLIC ACID-VIT B-6-VIT B-12	T3	
<i>folic/mvi ther-min/lycop/lut</i>	T1	
FOLIKA-CI	T3	
FOLIKA-MG	T3	
FORTAVIT	T3	
FREEDAVITE	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	
GENADEK STEP 1	T3	
GENADEK STEP 2	T3	

T1 – Generics

T2 – Preferred Brands

T3 – Non-Preferred Brands

T4 – Preferred Specialty

T5 – Non-Preferred Specialty

PA – Prior Authorization

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List of Prescription Medications

VITAMINS (Nutritional/Dietary) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
MULTIVITAMIN PREPARATIONS (cont.)		
GERBER GS PRENATAL NOURISH PLS	T3	
GNP B-COMPLEX PLUS VIT C TAB	T3	
<i>gnp one daily tablet</i>	T1	
HAIR FORMULA	T3	
HAIR, SKIN AND NAILS CAPLET	T3	
HAIR, SKIN AND NAILS SOFTGEL	T3	
HAIR, SKIN AND NAILS TABLET (<i>multivitamin/folic acid/biotin</i>)	T3	
HEARTBURN ACID REFLUX	T3	
<i>high potency multivitamin tab</i>	T1	
HIGH POTENCY MULTIVITAMIN TAB	T3	
<i>high potency multivitamin tab (Certavite-Antioxidant)</i>	T1	
<i>high potency multivitamin tab (Tab-A-Vite Multivit With Iron)</i>	T1	
HM HAIR, SKIN AND NAILS TABLET	T3	
HM MEN'S ONE DAILY TABLET	T2	
ICAPS MV	T2	
ICAPS TABLET	T2	
IMMUNERX	T3	
INFUVITE ADULT	T3	
K-PAX IMMUNE SUPPORT	T2	
<i>lecithin/pyridoxine/kelp</i>	T1	
<i>Imefolate/b3/copp/zn/sel/chrom</i>	T1	
MAXIMIN	T3	
MEBOLIC	T3	
MEN 50 PLUS ADVANCED ONE DAILY	T3	
MEN 50 PLUS MULTIVITAMIN	T3	
MEN'S 50 PLUS DAILY FORMULA	T3	
MEN'S 50 PLUS MULTIVITAMIN	T3	
MEN'S DAILY FORMULA	T3	
MEN'S DAILY GUMMIES	T3	
MEN'S DAILY MULTIVITAMIN	T2	
MEN'S DAILY PACK	T3	
MEN'S MULTIVITAMIN	T3	
MEN'S ONE DAILY	T3	
MONOCAPS	T3	

T1 – Generics

T2 – Preferred Brands

T3 – Non-Preferred Brands

T4 – Preferred Specialty

T5 – Non-Preferred Specialty

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List of Prescription Medications

VITAMINS (Nutritional/Dietary) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
MULTIVITAMIN PREPARATIONS (cont.)		
MULTI FOR HER 50 PLUS	T3	
MULTI FOR HER SOFTGEL	T3	
<i>multi for her tablet</i>	T1	
MULTI PRO	T3	
MULTI-DAY PLUS MINERALS	T3	
MULTIA DAILY MULTIVITAMIN	T3	
MULTILEX TABLET	T3	
<i>multilex tablet</i>	T1	
MULTILEX-T-M	T3	
<i>multivit 47/iron/folate 1/dha</i>	T1	
<i>multivit infusn,adult 1,vit k</i>	T1	
<i>multivit no. 18/iron no.1/folic (Tandem Plus)</i>	T1	
<i>multivit no.51/iron/folic acid</i>	T1	
<i>multivit with calcium,iron,min</i>	T1	
<i>multivit,calc,mins/iron/folic</i>	T1	
<i>multivit,iron,minerals/lutein</i>	T1	
<i>multivit,stress formula/zinc (Stress Formula With Zinc)</i>	T1	
<i>multivit/iron/folic acid/hb179</i>	T1	
<i>multivitamin</i>	T1	
MULTI-VITAMIN	T3	
<i>multivitamin combination no.55</i>	T1	
<i>multivitamin combination no.56</i>	T1	
MULTIVITAMIN GUMMIES	T3	
MULTIVITAMIN LIQUID	T3	
<i>multivitamin tablet</i>	T1	
<i>multivitamin with folic acid (Daily-Vite)</i>	T1	
<i>multivitamin with iron</i>	T1	
MULTIVITAMIN WITH MINERALS	T3	
<i>multivitamin with minerals</i>	T1	
<i>multivitamin,stress formula</i>	T1	
<i>multivitamin,ther and minerals</i>	T1	
<i>multivitamin,therapeutic</i>	T1	
<i>multivitamin,therapeutic (Oncovite)</i>	T1	
<i>multivitamin/ferrous gluconate</i>	T1	

T1 – Generics

T2 – Preferred Brands

T3 – Non-Preferred Brands

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List of Prescription Medications

VITAMINS (Nutritional/Dietary) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
MULTIVITAMIN PREPARATIONS (cont.)		
multivitamin/iron/folic acid (Certavite-Antioxidant)	T1	
multivitamin/iron/folic acid (Tab-A-Vite Multivit With Iron)	T1	
MULTIVITAMIN-MULTIMINERAL	T3	
MULTI-VITE	T3	
multivit-min/fa/lycopen/lutein	T1	
multivit-min/fa/lycopen/lutein (Centrum Silver)	T1	
multivit-min/ferrous gluconate	T1	
multivit-min/folic acid/biotin	T1	
multivit-min/iron fum/folic ac	T1	
multivit-min/iron/folic/lutein (Central-Vite Women'S Mature)	T1	
multivit-min/iron/folic/lutein (Centrum Silver Women)	T1	
multivit-min69/iron/folic acid	T1	
multivit-minerals/fa/lycopene	T1	
multivit-minerals/folic acid	T1	
multivit-minerals/folic acid (One-A-Day)	T1	
multivit-minerals/folic/ginkgo	T1	
multivit-mins no.7/folic acid	T1	
multivit-mins/iron/folic/lycop	T1	
mv-min 59/iron/folic/docusate	T1	
mv,cal,min/iron/folic acid/lut	T1	
mv,iron,min/ginkgo/pan.ginseng	T1	
mv-min/iron/folic ac/vit k/lut	T1	
mv-mins 71/iron/folic no.1/dha	T1	
mv-mins/folic/lycopene/ginkgo	T1	
mv-mn/folic ac/calcium/vit k1	T1	
mv-mn/folic acid/lutein/hrb178	T1	
mvn no.53/iron/folic/dss/dha	T1	
mvn-min 74/iron fum/iron/fa (Concept Ob)	T1	
mvn-min75/iron/iron ps/om3/dha (Concept Dha)	T1	
MVW MODULATR FORM MINI MULTIVT	T3	
NEEVODHA	T3	
NEOVITE	T3	
NESTABS ONE	T3	
NICOMIDE	T3	

T1 – Generics

T2 – Preferred Brands

T3 – Non-Preferred Brands

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List of Prescription Medications

VITAMINS (Nutritional/Dietary) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
MULTIVITAMIN PREPARATIONS (cont.)		
NIVA-PLUS NIVA-PLUS (<i>multivit-min 60/iron fum/folic</i>)	T3	
NUTRALYN	T3	
NUTRIVIT	T2	
OB COMPLETE	T3	
OBSTETRIX ONE	T3	
OCUVITE EYE PLUS MULTI	T3	
<i>om-3/dha/epa/b12/fa/b6/phytost</i>	T1	
OMNIVEX	T3	
ONCOVITE (<i>multivitamin,therapeutic</i>)	T2	
ONE DAILY ESSENTIALS	T3	
ONE DAILY ESSENTIAL TABLET	T3	
<i>one daily essential tablet</i>	T1	
<i>one daily essential tablet</i> (Daily-Vite)	T1	
ONE DAILY HEALTHY WEIGHT	T3	
ONE DAILY MEN'S 50 PLUS	T3	
ONE DAILY MEN'S 50 PLUS D3	T3	
ONE DAILY MEN'S HEALTH	T3	
ONE DAILY MEN'S MULTIVITAMIN	T3	
<i>one daily multivitamin tab</i>	T1	
<i>one daily multivitamin tab</i>	T1	
ONE DAILY MULTIVITAMIN TABLET	T3	
<i>one daily multivitamin tablet</i> (Daily-Vite)	T1	
<i>one daily tablet</i>	T1	
ONE DAILY WOMEN 50 PLUS TAB	T3	
ONE DAILY WOMEN'S 50 PLUS ADV	T3	
ONE DAILY WOMEN'S 50+	T2	
ONE DAILY WOMEN'S FORMULA	T3	
<i>one daily women's health tab</i>	T1	
ONE DAILY WOMEN'S MULTIVITAMIN	T3	
ONE-A-DAY (<i>multivit-minerals/folic acid</i>)	T3	
ONE-A-DAY ENERGY	T3	
ONE-A-DAY MEN VITACRAVES	T3	
ONE-A-DAY MENOPAUSE FORMULA	T3	
ONE-A-DAY MEN'S	T2	

T1 – Generics

T2 – Preferred Brands

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List of Prescription Medications

VITAMINS (Nutritional/Dietary) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
MULTIVITAMIN PREPARATIONS (cont.)		
ONE-A-DAY MEN'S 50 PLUS	T2	
ONE-A-DAY MEN'S 50 PLUS (<i>mv-mins/folic/lycopene/ginkgo</i>)	T2	
ONE-A-DAY MEN'S COMPLETE	T3	
ONE-A-DAY PROACTIVE 65 PLUS	T3	
ONE-A-DAY TRIPLE IMMUNE SUPPORT	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-A-DAY VITACRAVES	T3	
ONE-A-DAY VITACRAVES IMMUNITY	T3	
ONE-A-DAY VITACRAVES OMEGA-3	T3	
ONE-A-DAY VITACRAVES SOUR	T3	
ONE-A-DAY WEIGHTSMART	T2	
ONE-A-DAY WOMEN VITACRAVES	T3	
ONE-A-DAY WOMEN'S COMPLETE	T2	
ONE-A-DAY WOMEN'S HEALTHY SKIN	T3	
ONE-A-DAY WOMEN'S PETITES	T3	
ONE-A-DAY WOMEN'S TABLET	T2	
ONE-A-DAY WOMEN'S TABLET	T3	
ONE-DAILY MULTI	T3	
<i>one daily multivit-mineral tab</i>	T1	
ONE DAILY MULTIVIT-MINERAL TAB	T3	
ONE-DAILY MULTI-VITAMIN-IRON	T3	
ONE-DAILY MULTIVITAMIN-MINERAL	T3	
ONEVITE	T3	
OPTIFAST	T3	
OPTISOURCE	T3	
OPURITY MULTIVITAMIN	T3	
POLY VITAMIN-IRON	T3	
PRENATAL GUMMIES	T3	
PRENATE AM	T3	
PRENATE CHEWABLE	T3	
PRENATE ESSENTIAL	T3	
PROCERV HP	T3	
PROFOLA	T3	

T1 – Generics

T2 – Preferred Brands

T3 – Non-Preferred Brands

T4 – Preferred Specialty

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List of Prescription Medications

VITAMINS (Nutritional/Dietary) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
MULTIVITAMIN PREPARATIONS (cont.)		
PRORENAL QD	T2	
PROTECT CARDIO AF	T3	
PROTECT IRON	T3	
PROTECT PLUS SO	T3	
PUREFE OB PLUS	T3	
PUREFE PLUS	T3	
QUINTABS	T3	
QUINTABS-M	T3	
<i>ra one daily essential tablet (One-A-Day)</i>	T1	
<i>ra one daily women's tablet</i>	T1	
REMEDIENT	T3	
<i>sm b complex with vit c tablet</i>	T1	
<i>sm super b complex-c caplet</i>	T1	
SOLO	T3	
SPECTRAVITE MEN 50 PLUS	T3	
SPECTRAVITE ULTRA MEN 50+	T3	
SPECTRAVITE ULTRA MEN'S	T3	
STRESS B-COMPLEX	T3	
<i>stress formula tablet</i>	T1	
STRESS FORMULA WITH ZINC TAB (<i>multivit,stress formula/zinc</i>)	T3	
<i>stress formula with zinc tab (Stress Formula With Zinc)</i>	T1	
<i>stress-c with zinc tablet (Stress Formula With Zinc)</i>	T1	
STROVITE FORTE (<i>multivit,iron,min 5/folic acid</i>)	T3	
STROVITE ONE	T3	
SUPER GINSENG MULTIVITAMIN	T3	
SUPER MULTIPLE-LOW IRON	T3	
SUPERIOR MEN'S MULTI	T3	
SUPPORT-500 (<i>b-complex with vitamin c</i>)	T3	
SV HAIR, SKIN AND NAILS CAPLET	T3	
TAB-A-VITE MULTIVIT WITH IRON	T3	
<i>tab-a-vite multivit with iron</i>	T1	
TAB-A-VITE MULTIVIT WITH IRON (<i>multivitamin/iron/folic acid</i>)	T3	
TANDEM PLUS (<i>multivit no.18/iron no.1/folic</i>)	T3	
THERAGRAN-M PREMIER 50 PLUS	T3	

T1 – Generics

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T3 – Non-Preferred Brands

T4 – Preferred Specialty

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List of Prescription Medications

VITAMINS (Nutritional/Dietary) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
MULTIVITAMIN PREPARATIONS (cont.)		
thera-m caplet	T1	
thera-m tablet	T1	
THERA-M CAPLET	T3	
THERAMIL FORTE	T3	
THERANATAL LACTATION SUPPORT	T3	
THEREMS-H	T2	
TOBAKIENT	T3	
TRIVIA COMPLETE	T3	
TRUE MULTIVITAMIN	T3	
TRUEPLUS MULTIVITAMIN (<i>multivit-min/folic acid/vit k1</i>)	T3	
UDAMIN SP	T3	
ULTRA FREEDA	T3	
VITABEX PLUS	T3	
VITACORE	T3	
VITAFUSION PRENATAL	T3	
VITAJOY ADULT MULTI	T3	
<i>vitamin b complex-vit c cap</i> (Support-500)	T1	
<i>vitamin b complex-vit c caplet</i>	T1	
<i>vitamin b complex-vitamin c tb</i>	T1	
VITAMIN D3-ALOE	T3	
VITAMINS A-D-E	T3	
VITREXYL	T3	
VITREXYL PLUS IRON	T3	
VITRUM 50 PLUS SENIOR	T2	
WELLESSE MULTI VITAMIN PLUS	T3	
WOMEN'S 50 PLUS ADVANCED	T3	
WOMEN'S 50 PLUS DAILY FORMULA	T3	
<i>women's daily formula caplet</i>	T1	
WOMEN'S DAILY FORMULA CAPLET	T2	
WOMEN'S DAILY FORMULA TABLET	T3	
WOMENS DAILY GUMMIES	T3	
WOMEN'S DAILY PACK	T3	
WOMEN'S MULTIVITAMIN	T3	
WOMEN'S MULTIVITAMIN W-BIOTIN	T3	

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List of Prescription Medications

VITAMINS (Nutritional/Dietary) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
MULTIVITAMIN PREPARATIONS (cont.)		
XYZBAC	T3	
ZYVANA	T3	
ZYVIT	T3	
NIACIN PREPARATIONS		
cvs niacin 400 mg capsule	T1	
ENDUR-AMIDE	T3	
ENDUR-THINE	T3	
ft niacin 400 mg capsule	T1	
gnp niacin 250 mg tablet	T1	
gnp niacin 400 mg capsule	T1	
hm niacin tr 250 mg tablet (Slo-Niacin)	T1	
niacin	T1	
niacin (inositol niacinate)	T1	
niacin (Slo-Niacin)	T1	
NIACIN 100 MG CAPSULE	T3	
NIACINAMIDE 500 MG CAPSULE	T3	
niacin 100 mg tablet	T1	
niacin 250 mg tablet	T1	
niacin 50 mg tablet	T1	
niacin 500 mg capsule	T1	
niacin 500 mg capsule sa	T1	
NIACIN 500 MG SOFTGEL	T2	
niacin 500 mg tablet	T1	
niacin 750 mg tablet sa (Slo-Niacin)	T1	
NIACIN ER 1,000 MG TABLET	T2	
niacin er 250 mg tablet (Slo-Niacin)	T1	
niacin er 500 mg caplet	T1	
niacin er 500 mg capsule	T1	
niacin er 500 mg tablet	T1	
niacin flush free 500 mg cap	T1	
NIACIN FLUSH FREE 750 MG CAP	T2	
niacin sa 250 mg capsule	T1	
niacin tr 250 mg capsule	T1	
niacin tr 250 mg tablet (Slo-Niacin)	T1	

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List of Prescription Medications

VITAMINS (Nutritional/Dietary) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
NIACIN PREPARATIONS (cont.)		
niacin tr 500 mg caplet	T1	
niacin tr 500 mg tablet	T1	
niacinamide 500 mg tablet	T1	
NIACINAMIDE ER 500 MG TABLET	T3	
NO FLUSH NIACIN	T3	
PUREVITA VITAMIN B3	T3	
ra niacin 100 mg tablet	T1	
RA NIACIN 500 MG TABLET	T3	
ra niacin 500 mg tablet	T1	
SLO-NIACIN 250 MG TABLET (<i>niacin</i>)	T2	
slo-niacin 500 mg tablet	T1	
SLO-NIACIN 750 MG TABLET (<i>niacin</i>)	T2	
sv niacin flush free 500 mg	T1	
true vitamin b3 50 mg tablet	T1	
true vitamin b3 500 mg tablet	T1	
TRUE VITAMIN B3 250 MG TABLET	T3	
PANTHENOL PREPARATIONS		
CALCIUM PANTOTHENATE	T3	
PANTETHINE	T3	
PANTOTHENIC ACID	T3	
PUREVITA VITAMIN B5	T3	
PEDIATRIC VITAMIN PREPARATIONS		
ABDEK MULTIVITAMIN	T3	
ALIVE KIDS MULTIVITAMIN	T3	
ANIMAL SHAPES COMPLETE	T3	
CENTRUM KIDS	T3	
CHILD CHEWABLE VITAMN COMPLETE	T3	
CHILD COMPLETE CHEWABLE VITAMN	T3	
CHILD COMPLETE MULTIVITAMIN	T3	
CHILD MULTIVITAMIN PLUS IRON	T3	
CHILDREN MULTIVITAMIN	T3	
<i>children multivitamin chew tab</i>	T1	
CHILDREN MULTIVITAMIN GUMMIES	T3	
CHILDREN MULTIVITAMIN GUMMIES (<i>pediatric multivitamin no. 120</i>)	T3	

T1 – Generics

T2 – Preferred Brands

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List of Prescription Medications

VITAMINS (Nutritional/Dietary) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
PEDIATRIC VITAMIN PREPARATIONS (cont.)		
CHILDREN'S CHEW MULTIVIT-IRON (<i>pedi multivit no.91/iron fum</i>)	T3	
<i>childrens chew vitamin tab (Flintstones With Extra C)</i>	T1	
<i>childrens chew vitamin tab (Flintstones)</i>	T1	
CHILDREN'S CHEWABLE	T3	
CHILDREN'S MULTI-VIT GUMMIES	T3	
CHILDREN'S MULTIVITAMIN GUMMY	T3	
CHILD'S CHEWABLE VITAMIN TAB	T3	
CHILD'S OMEGA-3 DHA MULTIVITAM	T3	
CULTURELLE KIDS PROBIOTIC-MV	T3	
CULTURELLE KIDS PRO-MV-LUTEIN	T3	
DAVIMET WITH FLUORIDE	T3	
DEKAS PLUS	T3	
EMERGEN-C KIDZ	T3	
EMERGEN-C KIDZ DAILY IMMUNE	T3	
EMERGEN-C KIDZ IMMUNE PLUS	T3	
EQ CHILD MULTIVITAMIN GUMMIES	T3	
FLINTSTONES COMPLETE GUMMIES	T3	
FLINTSTONES COMPLETE TABLET (<i>multivit with iron,minerals</i>)	T2	
FLINTSTONES EXTRA C GUMMIES	T3	
FLINTSTONES EXTRA C TAB CHEW (<i>multivitamin</i>)	T2	
FLINTSTONES GUMMIES	T2	
FLINTSTONES GUMMIES CHEW TAB	T3	
FLINTSTONES IMMUNITY SUPPORT	T3	
FLINTSTONES MULTIVIT CHEW TAB (<i>pedi multivit no.25/folic acid</i>)	T3	
FLINTSTONES MULTI-VIT GUMMIES	T2	
FLINTSTONES PLUS CALCIUM	T2	
FLINTSTONES SOUR-GUM CHEW TAB	T3	
FLINTSTONES TAB CHEW	T2	
FLINTSTONES TABLET CHEWABLE (<i>multivitamin</i>)	T2	
FLINTSTONES WITH IRON	T3	
FLORAFL PEDIATRIC	T3	
FLORAFL FE PEDIATRIC	T3	
FLORIVA	T3	
FLORIVA PLUS	T3	

T1 – Generics

T2 – Preferred Brands

T3 – Non-Preferred Brands

T4 – Preferred Specialty

T5 – Non-Preferred Specialty

PA – Prior Authorization

QL – Quantity Limit

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List of Prescription Medications

VITAMINS (Nutritional/Dietary) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
PEDIATRIC VITAMIN PREPARATIONS (cont.)		
GENADEK	T3	
GERBER GROW MIGHTY	T3	
GERBER LIL BRAINIES	T3	
GUMMIES CHILDREN MULTIVITAMIN	T3	
GUMMY	T3	
GUMMY DINOS	T3	
INFANT-TODDLER MULTIVITAMIN	T3	
INFANT-TODDLER MULTIVIT-IRON	T3	
infant-toddler multivit-iron	T1	
INFANT-TODDLER TRI-VITAMIN	T3	
INFUVITE PEDIATRIC	T2	
JUST 4 KIDZ MULTIVIT-PROBIOTIC	T3	
KIDS COD LIVER OIL +D	T3	
KIDS MULTIVITAMIN-MINERALS	T2	
LITTLE ANIMALS PLUS IRON	T3	
LIVITA FOR CHILDREN	T3	
<i>multivit with iron,minerals</i>	T1	
<i>multivit with iron,minerals (Flintstones Complete)</i>	T1	
<i>multivit with iron,minerals (Scooby-Doo)</i>	T1	
<i>multivitamin (Flintstones With Extra C)</i>	T1	
<i>multivitamin (Flintstones)</i>	T1	
<i>multivitamin with iron</i>	T1	
MULTI-VIT-FLOR	T3	
MULTIVIT-FLUOR 0.25 MG TAB CHW	T3	
<i>multivit-fluor 0.25 mg tab chw</i>	T1	PPACA
<i>multivit-fluor 0.25 mg/ml drop</i>	T1	PPACA
<i>multivit-fluor 0.5 mg tab chew</i>	T1	PPACA
MULTIVIT-FLUOR 0.5 MG TAB CHEW	T3	
<i>multivit-fluor 0.5 mg/ml drop</i>	T1	PPACA
<i>multivit-fluoride 1 mg tab chw</i>	T1	PPACA
MULTIVIT-FLUORIDE 1 MG TAB CHW	T3	
MVV COMPLETE FORMLTN PEDIATRIC	T3	
MVV COMPLETE FORMULATION D3000, D5000	T3	
MVV COMPLETE FORMULTN MULTIVIT	T3	

T1 – Generics

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VITAMINS (Nutritional/Dietary) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
PEDIATRIC VITAMIN PREPARATIONS (cont.)		
MVW MODULATR FORMLTN PEDIATRIC	T3	
NANO VM 1-3	T2	
NANO VM 4-8	T2	
NANOV M 9-18	T3	
NANOVMT-F	T3	
NOVAFERRUM YUM PEDIATR MV-IRON	T3	
NOVAMV MMM PEDIATRIC MULTIVIT	T3	
ONE-A-DAY KID'S	T3	
ONE-A-DAY TEEN HER VITACRAVES	T3	
ONE-A-DAY TEEN HIM VITACRAVES	T3	
<i>ped mvit a,c,d3 no.21/fluoride</i>	T1	PPACA
<i>pedi multivit 158/iron/vit k1</i>	T1	
<i>pedi multivit 45/fluoride/iron</i>	T1	
<i>pedi multivit no.12 w-fluoride</i>	T1	PPACA
<i>pedi multivit no.17 w-fluoride</i>	T1	PPACA
<i>pedi multivit no.159/iron sulf</i>	T1	
<i>pedi multivit no.23/folic acid</i>	T1	
<i>pedi multivit no.25/folic acid (Flintstones)</i>	T1	
<i>pedia poly-vite iron 5mg/0.5ml</i>	T1	
PEDIA POLY-VITE WITH IRON DROP	T3	
PEDIA TRI-VITE	T3	
<i>pediatric multivit no.36/iron</i>	T1	
<i>pediatric multivitamin no.17</i>	T1	
<i>pediatric multivitamin no.111</i>	T1	
<i>pediatric multivitamin no.212</i>	T1	
PEDIATRIC POLY-VITAMIN	T3	
PEDIATRIC POLY-VITAMIN-IRON	T3	
PEDIATRIC POLY-VITE	T3	
PEDIATRIC POLY-VITE WITH IRON	T3	
PEDIATRIC TRI-VITAMIN	T3	
PEDIATRIC TRI-VITE	T3	
POLY-VI-FLOR	T3	
POLY-VI-FLOR WITH IRON	T3	
poly-vi-sol 0.5 ml oral syring	T1	

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VITAMINS (Nutritional/Dietary) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
PEDIATRIC VITAMIN PREPARATIONS (cont.)		
POLY-VI-SOL 1 ML ENFIT SYRINGE	T3	
POLY-VI-SOL 250MCG-50MG/ML DRP	T3	
POLY-VI-SOL WITH IRON	T3	
POLY-VITA	T3	
POLY-VITA WITH IRON	T3	
QUFLORA	T3	
QUFLORA FE	T3	
SCOOBY-DOO ONE A DAY GUMMIES	T3	
SCOOBY-DOO ONE A DAY TABLET (<i>multivit with iron,minerals</i>)	T2	
SOLUVITA MULTIVITAMIN FLUORIDE	T3	
SOLUVITA MULTIVITAMIN FLUORIDE (<i>pedi multivit no.82 w-fluoride</i>)	T3	
TRI-VI-FLOR	T3	
TRI-VI-SOL	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
TROPICAL LIQUID NUTRITION (<i>pediatric multivitamin no.118</i>)	T3	
<i>vit a palmitate/vit c/vit d3</i>	T1	
ZOO FRIENDS	T3	
ZOO FRIENDS COMPLETE	T3	
VITAMIN A AND D PREPARATIONS		
cod liver oil softgel	T1	
gnp norwegian cod liver oil	T1	
SV COD LIVER OIL SOFTGEL	T3	
VITAMIN A PREPARATIONS		
A-25	T3	
AQUASOL A	T2	
<i>beta-carotene</i>	T1	
<i>cvs vitamin a 2,400 mcg softgl</i>	T1	
FT VITAMIN A 3,000 MCG SOFTGEL	T3	
GNP VITAMIN A 3,000 MCG SOFTGL	T3	
NORWEGIAN COD LIVER OIL SFGL	T3	
PREVENT	T2	
PUREVITA VITAMIN A	T3	

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VITAMINS (Nutritional/Dietary) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
VITAMIN A PREPARATIONS (cont.)		
<i>ra vitamin a 10,000 unit softgel</i>	T1	
VITAMIN A BETA CAROTENE	T3	
<i>vitamin a 10,000 unit capsule</i>	T1	
<i>vitamin a 10,000 unit softgel</i>	T1	
VITAMIN A 10,000 UNIT SOFTGEL	T3	
<i>vitamin a 3,000 mcg softgel</i>	T1	
<i>vitamin a 8,000 unit capsule</i>	T1	
VITAMIN A PALMITATE	T3	
<i>vitamin a/vit c/zinc/propolis</i>	T1	
VITAMINS A D	T3	
VITAMIN B PREPARATIONS		
5-MTHF PLUS B12	T3	HD
<i>acetylcyst/methylb12/levomefol (Cerefolin Brain Wellness)</i>	T1	HD
ALBA-LYBE	T2	HD
APETEX (<i>vitamin b complex/lysine</i>)	T2	HD
APETIGEN (<i>vitamin b complex/lysine</i>)	T2	HD
ARKALIOX	T3	HD
B ACTIV	T3	HD
<i>b comp no3/folic/c/biotin/zinc</i>	T1	HD
<i>b comp/ferrous gluc/lysin/znox</i>	T1	HD
<i>b complex 11/folic/c/biot/zinc</i>	T1	HD
<i>b complex c no.10/folic acid</i>	T1	HD
<i>b complex capsule</i>	T1	HD
<i>b complex tablet</i>	T1	HD
<i>b complex, c no.20/folic acid (Virt-Caps)</i>	T1	HD
B COMPLEX WITH B-12	T3	HD
B COMPLEX WITH VITAMIN C	T3	HD
B COMPLEX-FOLIC ACID (<i>cyanocobalamin/folic ac/vit b6</i>)	T3	HD
<i>b12/levomefolate calcium/b-6</i>	T1	HD
B-50 COMPLEX	T3	HD
<i>balanced b-100 complex tab sa</i>	T1	HD
B-COMPLEX 100	T3	HD
<i>b-complex 100 injection</i>	T1	HD
B COMPLEX FAST DISSOLVE TABLET	T3	HD

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List of Prescription Medications

VITAMINS (Nutritional/Dietary) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
VITAMIN B PREPARATIONS (cont.)		
b-complex injection vial	T1	HD
b-complex plus vitamin c cplt (Vita-Bee With C)	T1	HD PPACA
b-complex tablet	T1	HD PPACA
B-COMPLEX WITH B-12	T3	HD
b-complex with b12 tablet	T1	HD
b-complex with vit c caplet (Vita-Bee With C)	T1	HD PPACA
b-complex with vit c tablet (Vita-Bee With C)	T1	HD PPACA
B-COMPLEX-VITAMIN CTR TABLET	T2	HD
BIOTIN 1,000 MCG GUMMIES	T3	HD
biotin 1,000 mcg tablet	T1	HD
BIOTIN 10 MG TABLET	T2	HD
BIOTIN 10,000 MCG SOFTGEL	T3	HD
BIOTIN 10,000 MCG TABLET	T2	HD
biotin 2,500 mcg softgel (Hard Nails)	T1	HD
biotin 300 mcg tablet	T1	HD
BIOTIN 5 MG TABLET	T3	HD
biotin 5,000 mcg capsule (Meribin)	T1	HD
BIOTIN 5,000 MCG FAST DISSOLVE	T3	HD
BIOTIN 5,000 MCG QUICK DISSOLV	T3	HD
biotin 5,000 mcg softgel (Meribin)	T1	HD
BIOTIN 5,000 MCG TABLET	T3	HD
biotin 800 mcg tablet	T1	HD
BIOTIN FORTE 3 MG TABLET	T3	HD
BIOTIN FORTE 5 MG TABLET	T2	HD
BREWER'S YEAST	T3	HD
B-STRESS	T3	HD
CARDIOTEK-RX	T3	HD
CEREFOLIN (vit b12/levomefolate/vit b6/b2)	T3	HD
CEREFOLIN BRAIN WELLNESS (acetylcyst/methylb12/levomefol)	T3	HD
CEREFOLIN NAC	T3	HD
COMPLEX B-100 ER CAPLET	T3	HD
complex b-100 tablet sa	T1	HD
COMPLEX B-50	T3	HD
COMPLETE LIVER CLEANSE	T3	HD

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List of Prescription Medications

VITAMINS (Nutritional/Dietary) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
VITAMIN B PREPARATIONS (cont.)		
CVS BALANCED B-100 TR CAPLET	T3	HD
<i>cvs biotin 1,000 mcg tablet</i>	T1	HD
CVS BIOTIN 5,000 MCG TABLET	T3	HD
CVS BIOTIN 10,000 MCG SOFTGEL	T3	HD
<i>cvs super b-complex-vit c cpt (Vita-Bee With C)</i>	T1	HD PPACA
<i>cyanocobalamin/folic ac/vit b6</i>	T1	HD
<i>cyanocobalamin/folic ac/vit b6</i>	T1	HD PPACA
<i>cyanocobalamin/folic ac/vit b6 (Niva-Fol)</i>	T1	HD
CYTO B7	T3	HD
DIALYVITE 3000	T3	HD
DIALYVITE 5000	T3	HD
DIALYVITE 800 CHEWABLE WAFER	T3	HD
DIALYVITE 800 PLUS D	T3	HD
<i>dialyvite 800 tablet</i>	T1	HD PPACA
DIALYVITE 800 WITH ZINC	T3	HD
DIALYVITE 800-ULTRA D	T2	HD
DIALYVITE SUPREME D	T3	HD
ELFOLATE PLUS	T3	HD
ENDUR-B COMPLEX	T3	HD
<i>eq/b complex 50 tablet</i>	T1	HD
<i>folic acid/b complex c no.17</i>	T1	HD
<i>folic acid/vit b complex and c</i>	T1	HD PPACA
<i>folic acid/vit b complex and c</i>	T1	HD
<i>folic acid/vit b complex and c (Vita-Bee With C)</i>	T1	HD PPACA
<i>folic acid/vit bcomp,c/cu/zinc</i>	T1	HD
FOLIKA-BC	T3	HD
FOLIKA-NC	T3	HD
FOLIKA-T	T3	HD
FOLINIC-PLUS	T3	HD
FOLTX	T3	HD
<i>ft biotin 5,000 mcg capsule (Meribin)</i>	T1	HD
FT BIOTIN 10,000 MCG TABLET	T2	HD
FT BIOTIN 2,500 MCG GUMMY	T3	HD
GENICIN VITA-S	T3	HD

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VITAMINS (Nutritional/Dietary) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
VITAMIN B PREPARATIONS (cont.)		
gnp biotin 5,000 mcg capsule (Meribin)	T1	HD
HAIR-SKIN-NAILS	T3	HD
HARD NAILS (<i>biotin</i>)	T3	HD
HM BIOTIN 10,000 MCG TABLET	T3	HD
hm biotin 5,000 mcg capsule (Meribin)	T1	HD
HOMOCYSTEINE FORMULA	T3	HD
HYLAVITE (<i>folic acid/vit b complex and c</i>)	T3	HD
KIDS BRAIN BUILDER	T3	HD
<i>levomefolate/b6/b12/algal oil</i>	T1	HD
LEVOMEFOLATE-NAC-MECOBAL-ALGAL	T3	HD
LEVOMEFOL-PYRIDOXAL-MEC-ALGAL	T3	HD
<i>l-mefol/a-cyst/meb12/algal oil</i>	T1	HD
L-METHYLFOL-ALGAL-NAC-ME-CBL	T3	HD
L-METHYLFOL-ALGAL-P5P-ME-CBL	T3	HD
LORID	T3	HD
LORMATE	T3	HD
<i>mecobal/levomefolat ca/b6 phos</i>	T1	HD
MEDTYCHOLL-B COMPLEX W-LIVER	T3	HD
MEGA BIOTIN	T3	HD
MERIBIN (<i>biotin</i>)	T2	HD
METANX	T3	HD
METANX FC	T3	HD
METANX RR	T3	HD
METANXPRO NERVE HEALTH	T3	HD
METHAVER	T3	HD
METHYL PROTECT	T3	HD
MINCORA	T3	HD
MULTIVITAMIN-ZINC-STRESS	T3	HD
NEPHRON FA	T3	HD
NEPHRO-VITE	T2	HD
NIVA-FOL (<i>cyanocobalamin/folic ac/vit b6</i>)	T3	HD
NUFOLA	T3	HD
PODIAPN	T3	HD
POTABA	T3	HD

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VITAMINS (Nutritional/Dietary) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
VITAMIN B PREPARATIONS (cont.)		
PRORENAL	T2	HD
PUREVITA SUPER B-COMPLEX	T3	HD
QUIN B STRONG	T3	HD
<i>ra balanced b-100 tablet</i>	T1	HD PPACA
<i>ra b-complex-vitamin b-12 tab</i>	T1	HD
<i>ra biotin 2,500 mcg capsule (Hard Nails)</i>	T1	HD
RELCARE	T3	HD
RENAL VITAMIN	T3	HD
RENAL-VITE	T3	HD
RENAPLEX	T3	HD
RENAPLEX-D	T3	HD
RIBOZEL	T3	HD
<i>sm biotin 5,000 mcg capsule (Meribin)</i>	T1	HD
<i>sm stress formula+zinc tablet</i>	T1	HD
<i>super b complex-vit c caplet (Vita-Bee With C)</i>	T1	HD PPACA
<i>super quints b-50 tablet</i>	T1	HD PPACA
<i>super quints b-50 tablets</i>	T1	HD
SV BIOTIN 1,000 MCG SOFTGEL	T3	HD
<i>sv biotin 5,000 mcg softgel (Meribin)</i>	T1	HD
TRONVITE	T3	HD
ULTRA B-100 COMPLEX TABLET	T3	HD
<i>ultra b-100 complex tablet</i>	T1	HD
VIRT-CAPS (<i>b complex w-c no.20/folic acid</i>)	T3	HD
VIRT-CAPS (<i>b complex, c no.20/folic acid</i>)	T3	HD
<i>vit b comp c 19/folic acid/d3</i>	T1	HD PPACA
<i>vit b comp no.3/folic/c/biotin</i>	T1	HD
<i>vit b comp/c/fa/iron sulf/vite</i>	T1	HD PPACA
<i>vit b comp/c/folic/iron/vit e</i>	T1	HD PPACA
<i>vit b comp/folic/choline/inosi</i>	T1	HD PPACA
<i>vit b complex 100 combo no.2</i>	T1	HD
<i>vit b12/levomefolate/vit b6/b2 (Cerefolin)</i>	T1	HD
VITA-BEE WITH C (<i>folic acid/vit b complex and c</i>)	T3	HD
VITAL-D RX	T3	HD
VITAJOY BIOTIN	T3	HD

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VITAMINS (Nutritional/Dietary) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
VITAMIN B PREPARATIONS (cont.)		
<i>vitamin b complex</i>	T1	HD
<i>vitamin b complex capsule</i>	T1	HD
<i>vitamin b complex softgel</i>	T1	HD
<i>vitamin b complex tablet</i>	T1	HD PPACA
<i>vitamin b complex tablet</i>	T1	HD
<i>vitamin b complex/folic acid</i>	T1	HD PPACA
<i>vitamin b complex/lysine (Apetex)</i>	T1	HD
<i>vitamin b complex/lysine (Apetigen)</i>	T1	HD
<i>vitamin b complex-vitamin c tb (Vita-Bee With C)</i>	T1	HD PPACA
<i>vitamin b-complex c caplet</i>	T1	HD PPACA
VITA-RESPA	T3	HD
VITASURE	T3	HD
XVITE	T3	HD
ZELDANA	T3	HD
VITAMIN B1 PREPARATIONS		
<i>cvs vitamin b-1 100 mg tablet</i>	T1	
<i>CYTO B-1</i>	T3	
<i>ft vitamin b-1 100 mg tablet</i>	T1	
<i>gnp vitamin b-1 100 mg tablet</i>	T1	
PUREVITA VITAMIN B1	T3	HD
<i>ra vitamin b-1 100 mg tablet</i>	T1	
THIAMINE HCL-0.9% NaCl	T3	
TRUE VITAMIN B-1 250 MG TABLET	T3	
TRUE VITAMIN B-1 50 MG TABLET	T3	
<i>true vitamin b-1 100 mg tablet</i>	T1	
<i>thiamine 100 mg tablet</i>	T1	
<i>thiamine 200 mg/2 ml vial</i>	T1	
<i>thiamine 250 mg tablet</i>	T1	
THIAMINE 500 MG TABLET	T3	
<i>thiamine hcl</i>	T1	
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	

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VITAMINS (Nutritional/Dietary) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
VITAMIN B12 PREPARATIONS		
ABANEU-SL	T3	
APATATE	T2	
B-12 1,000 MCG FAST DISSOLVE	T3	
B-12 1,000 MCG LOZENGE	T3	
B-12 1,000 MCG QUICK DISSOLVE	T3	
<i>b-12 1,000 mcg tablet</i>	T1	
B-12 1,000 MCG/15 ML LIQUID	T2	
<i>b-12 1,000 mcg/15 ml liquid</i>	T1	
<i>b-12 2,500 mcg microlozenge</i>	T1	
<i>b12 2,500 mcg tablet sl</i>	T1	
<i>b-12 2,500 mcg tablet sl</i>	T1	
B-12 3,000 MCG TABLET SL	T3	
<i>b-12 3,000 mcg/ml subling liq</i>	T1	
B-12 5,000 MCG FAST DISSOLVE	T3	
B12 5,000 MCG MICROLOZENGE	T3	
B-12 5,000 MCG MICROLOZENGE	T2	
B-12 5,000 MCG ODT	T3	
B-12 5,000 MCG QUICK DISSOLVE	T3	
B-12 5,000 MCG SUBLINGUAL TAB	T3	
B-12 5,000 MCG/ML SUBLING LIQ	T3	
B-12 500 MCG QUICK DISSOLVE TB	T3	
<i>b-12 500 mcg tablet</i>	T1	
B12 ACTIVE	T3	
B-12 DUAL SPECTRUM	T3	
<i>b-12 er 1,000 mcg tab</i>	T1	
B-12 WITH FOLIC ACID	T3	
<i>cvs b-12 1,000 mcg tablet</i>	T1	
CVS VIT B-12 500 MCG LOZENGE	T2	
<i>cvs vit b-12 500 mcg lozenge</i>	T1	
<i>cvs vit b-12 tr 1,000 mcg tab</i>	T1	
<i>cvs vit b-12 tr 2,000 mcg tab</i>	T1	
CVS VIT B12 2,500 MCG SOFT CHW	T3	
<i>cvs vitamin b12 5,000 mcg chew</i>	T1	
CVS VITAMIN B12 5,000 MCG TAB	T3	

T1 – Generics

T2 – Preferred Brands

T3 – Non-Preferred Brands

T4 – Preferred Specialty

T5 – Non-Preferred Specialty

PA – Prior Authorization

QL – Quantity Limit

ST – Step Therapy

AGE – Age Requirement

SP – Specialty Medication

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List of Prescription Medications

VITAMINS (Nutritional/Dietary) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
VITAMIN B12 PREPARATIONS (cont.)		
CVS VITAMIN B-12 500 MCG GUMMY	T3	
cvs vitamin b-12 500 mcg tab	T1	
cyanocobalamin (vitamin b-12) (Nascobal)	T1	ST QL (4 units/30 days)
eql vitamin b-12 500 mcg tab	T1	
fn vitamin b-12 1,000 mcg tab	T1	
FOLTRATE	T3	
ft vit b-12 2,500 mcg tab sl	T1	
ft vitamin b-12 500 mcg tablet	T1	
ft vitamin b12 er 1,000 mcg tb	T1	
FT VITAMIN B-12 1500 MCG GUMMY	T3	
FT VITAMIN B-12 5,000 MCG TAB	T2	
gnp b12 2,500 mcg tablet sl	T1	
gnp vit b-12 er 1,000 mcg tab	T1	
gnp vitamin b-12 500 mcg tab	T1	
GNP VITAMIN B-12 1500MCG GUMMY	T3	
hm vit b-12 tr 1,000 mcg tab	T1	
hm vitamin b-12 500 mcg tablet	T1	
hydroxocobalamin	T1	
INTRINSI B12-FOLATE	T3	
METHYL B-12	T3	
METHYLCOBALAMIN	T3	
METHYLCOBALAMIN 5,000 MCG TAB	T3	
MTX SUPPORT	T3	
NASCOBAL (cyanocobalamin (vitamin b-12))	T2	ST QL (4 units/30 days)
NEURIN-SL	T3	
OPURITY	T3	
PAXLYTE	T3	
PUREVITA VITAMIN B12	T3	
ra vit b12 1,000 mcg tab sa	T1	
RA VIT B-12 1,000 MCG/ML LIQ	T3	
ra vitamin b-12 100 mcg tablet	T1	
ra vitamin b12 er 2,000 mcg tb	T1	
RAPID B-12 ENERGY	T3	
sm vitamin b12 1,000 mcg tab	T1	

T1 – Generics

T2 – Preferred Brands

T3 – Non-Preferred Brands

T4 – Preferred Specialty

T5 – Non-Preferred Specialty

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List of Prescription Medications

VITAMINS (Nutritional/Dietary) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
VITAMIN B12 PREPARATIONS (cont.)		
sm vitamin b-12 100 mcg tablet	T1	
sm vitamin b-12 500 mcg tablet	T1	
sv b-12 2,500 mcg microlozenge	T1	
SV B-12 5,000 MCG MICROLOZENGE	T2	
SV VIT B-12 500 MCG LOZENGE	T2	
sv vitamin b-12 500 mcg tablet	T1	
sv vitamin b12 tr 1,000 mcg tb	T1	
true vitamin b-12 1000 mcg tab	T1	
true vitamin b-12 500 mcg tab	T1	
VIT B-12 500 MCG SUBLING TAB	T3	
VITAMIN B-12 1,000 MCG SOFTGEL	T3	
vitamin b-12 1,000 mcg tab sl	T1	
vitamin b-12 1,000 mcg tablet	T1	
vitamin b-12 100 mcg tablet	T1	
vitamin b-12 2,000 mcg tab sa	T1	
VITAMIN B-12 2,000 MCG TABLET	T3	
vitamin b-12 2,500 mcg tab sl	T1	
VITAMIN B-12 250 MCG LOZENGE	T3	
vitamin b-12 250 mcg tablet	T1	
VITAMIN B-12 3,000 MCG SL LOZ	T3	
VITAMIN B-12 3,000 MCG SOFTGEL	T3	
VITAMIN B-12 3,000 MCG TAB SL	T3	
VITAMIN B-12 5,000 MCG ODT	T3	
VITAMIN B-12 5,000 MCG SOFTGEL	T3	
VITAMIN B-12 5,000 MCG TAB SL	T2	
vitamin b-12 5,000 mcg tab sl	T1	
VITAMIN B-12 5,000 MCG TAB SL	T3	
VITAMIN B-12 5,000 MCG TABLET	T3	
VITAMIN B-12 50 MCG LOZENGE	T3	
vitamin b12 50 mcg tablet	T1	
vitamin b-12 50 mcg tablet	T1	
VITAMIN B-12 500 MCG LOZENGE	T2	
vitamin b12 500 mcg tablet	T1	
vitamin b-12 500 mcg tablet	T1	

T1 – Generics

T2 – Preferred Brands

T3 – Non-Preferred Brands

T4 – Preferred Specialty

T5 – Non-Preferred Specialty

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List of Prescription Medications

VITAMINS (Nutritional/Dietary) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
VITAMIN B12 PREPARATIONS (cont.)		
vitamin b-12 tr 1,000 mcg tab	T1	
vitamin b-12 tr 2,000 mcg tab	T1	
VITAMIN B12-FOLIC ACID	T3	
VITAMIN B2 PREPARATIONS		
CYTO B-2	T3	
PUREVITA VITAMIN B2	T3	
riboflavin (vitamin b2)	T1	
RIBOFLAVIN 100 MG CAPSULE	T3	
riboflavin 100 mg tablet	T1	
RIBOFLAVIN 400 MG TABLET	T3	
riboflavin 50 mg tablet	T1	
VITAMIN B6 PREPARATIONS		
cvs vitamin b-6 100 mg tablet	T1	
eqv 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 100 mg/ml vial	T1	
pyridoxine 25 mg tablet	T1	
pyridoxine 250 mg tablet	T1	
PYRIDOXINE 50 MG TABLET (pyridoxine hcl (vitamin b6))	T2	
pyridoxine 50 mg tablet (Pyridoxine Hcl)	T1	
PYRIDOXINE 500 MG TABLET (pyridoxine hcl (vitamin b6))	T3	
pyridoxine hcl (vitamin b6)	T1	
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	
vitamin b-6 100 mg tablet	T1	
vitamin b-6 25 mg tablet	T1	

T1 – Generics

T2 – Preferred Brands

T3 – Non-Preferred Brands

T4 – Preferred Specialty

T5 – Non-Preferred Specialty

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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	
TRUE VITAMIN B-6 10 MG TABLET	T3	
VB6 P5P	T3	
VITAMIN C PREPARATIONS		
ASCOR	T3	
ascorbate calcium	T1	
ascorbic acid	T1	
ascorbic acid 500 mg/5 ml cup	T1	
ascorbic acid 500 mg tablet	T1	
ascorbic acid 500 mg/ml vial	T1	
ASCORBIC ACID GRANULES	T2	
ascorbic acid/ascorbate sodium	T1	
BIO C 1:1	T3	
c-1,000 mg tablet sa	T1	
cod liver oil tab chewable	T1	
cvs vit c-rose hip 500 mg cplt	T1	
cvs vit c-rose hip 1,000 mg tb	T1	
cvs vit c-rose hip 500 mg chew	T1	
cvs vit c-rose hips 500 mg tab	T1	
cvs vitamin c 1,000 mg caplet	T1	
CVS VITAMIN C 1,000 MG POWDER	T3	
cvs vitamin c 250 mg, 500 mg tablet	T1	
cvs vitamin c 500 mg caplet	T1	
CYTO C	T3	
EASY-C IMMUNE HEALTH	T3	
EMERGEN-C	T3	
EMERGEN-C APPLE CIDER VINEGAR	T3	
EMERGEN-C ASHWAGANDHA	T3	
EMERGEN-C TURMERIC GINGER	T3	
EMERGEN-C ELDERBERRY	T3	
EMERGEN-C IMMUNE PLUS	T3	
EMERGEN-C MSM LITE	T3	
eql vitamin c 1,000 mg tablet	T1	

T1 – Generics

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T4 – Preferred Specialty

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List of Prescription Medications

VITAMINS (Nutritional/Dietary) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
VITAMIN C PREPARATIONS (cont.)		
ESSENCE C	T3	
ESTER-C 1,000 MG TABLET	T3	
ESTER-C 500 MG TABLET	T2	
FLEVOXIN	T3	
FRUIT C-100 TABLET CHEWABLE	T3	
<i>fruit c-100 tablet chewable</i>	T1	
FRUIT C-200	T3	
<i>ft vit c-rose hip 1,000 mg tab</i>	T1	
<i>ft vit c-rose hips 500 mg tab</i>	T1	
FT VITAMIN C 500 MG CHEW TAB	T2	
<i>ft vitamin c 1,000 mg tablet</i>	T1	
<i>gnp vit c-rose hips 500 mg tab</i>	T1	
<i>gnp vitamin c 1,000 mg tablet</i>	T1	
<i>gnp vitamin c 250 mg tablet</i>	T1	
<i>gnp vitamin c 500 mg tab chew</i>	T1	
<i>gnp vitamin c 500 mg tablet</i>	T1	
<i>gnp vitamin c er 500 mg tablet</i>	T1	
<i>hm vit c-rose hip 1,000 mg tab</i>	T1	
<i>hm vit c-rose hips 500 mg cplt</i>	T1	
<i>hm vitamin c 500 mg tab chew</i>	T1	
LIQUID C	T3	
PAN-C 500	T3	
PERIDIN-C	T2	
PUREVITA VITAMIN C	T3	
<i>ra vit c-rose hips 500 mg tab</i>	T1	
<i>ra vitamin c 1,000 mg tab sa</i>	T1	
<i>ra vitamin c 1,000 mg tablet</i>	T1	
<i>ra vitamin c 250 mg tablet</i>	T1	
<i>ra vitamin c 500 mg chew tab</i>	T1	
<i>ra vitamin c 500 mg tab chew</i>	T1	
<i>ra vitamin c 500 mg tablet</i>	T1	
RA VITAMIN C 53 MG DROP	T3	
<i>ra vitamin c tr 500 mg caplet</i>	T1	
SAMBUCUS ELDERBERRY-VITAMIN C	T3	

T1 – Generics

T2 – Preferred Brands

T3 – Non-Preferred Brands

T4 – Preferred Specialty

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List of Prescription Medications

VITAMINS (Nutritional/Dietary) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
VITAMIN C PREPARATIONS (cont.)		
sm vit c-rose hips 500 mg tab	T1	
sm vitamin c 1,000 mg tablet	T1	
sm vitamin c 250 mg tablet	T1	
sm vitamin c 500 mg chew tab	T1	
sm vitamin c 500 mg tab chew	T1	
sm vitamin c 500 mg tablet	T1	
sm vitamin c with rose hips	T1	
SPAN C	T3	
sv vit c-rose hip 1,000 mg tab	T1	
sv vit c-rose hips 1,000 mg tb	T1	
sv vit c-rose hips 500 mg tab	T1	
sv vitamin c 500 mg tab chew	T1	
sv vitamin c tr 1,000 mg tab	T1	
true vitamin c 250 mg tablet	T1	
true vitamin c 500 mg tablet	T1	
true vitamin c 1,000 mg tablet	T1	
vit c-rose hips 500 mg capsule	T1	
VIT C-ROSE HIPS 500 MG CAPSULE	T3	
vit c-rose hip 1,000 mg caplet	T1	
vit c-rose hips 1,000 mg cplt	T1	
vit c-rose hips 1,000 mg tab	T1	
VIT C-ROSE HIPS 500 MG CHEW TB	T3	
vit c-rose hips 500 mg tablet	T1	
vit c-rose hips tr 1,000 mg	T1	
vit c-rose hips tr 500 mg cplt	T1	
vit c-rose hips tr 500 mg tab	T1	
VITAJOY DAILY C	T3	
vitamin c 1,000 mg caplet	T1	
vitamin c 1,000 mg tablet	T1	
vitamin c 1,500 mg tablet sa	T1	
vitamin c 100 mg tablet	T1	
VITAMIN C 125 MG GUMMIES	T3	
vitamin c 250 mg tablet	T1	
VITAMIN C 250 MG TABLET CHEW	T3	

T1 – Generics

T2 – Preferred Brands

T3 – Non-Preferred Brands

T4 – Preferred Specialty

T5 – Non-Preferred Specialty

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List of Prescription Medications

VITAMINS (Nutritional/Dietary) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
VITAMIN C PREPARATIONS (cont.)		
vitamin c 250 mg tablet chew	T1	
vitamin c 500 mg capsule sa	T1	
vitamin c 500 mg chew tablet	T1	
VITAMIN C 500 MG POWDER PACKET	T3	
VITAMIN C 500 MG SOFTGEL	T3	
vitamin c 500 mg tablet	T1	
vitamin c 500 mg tablet chew	T1	
VITAMIN C 500 MG WAFER	T3	
VITAMIN C 500 MG/15 ML LIQUID	T3	
vitamin c 500 mg/5 ml liquid	T1	
vitamin c drops	T1	
VITAMIN C FIZZY DRINK	T3	
VITAMIN C POWDER	T3	
vitamin c powder	T1	
vitamin c tr 1,000 mg tablet	T1	
vitamin c tr 500 mg caplet	T1	
vitamin c tr 500 mg tablet	T1	
vitamin c-500 mg tablet	T1	
vitamin c-500 mg tr capsule	T1	
VITAMIN C-BIOFLAVINOIDS-RH	T3	
vitamin c-rose hip 1,000 mg tb	T1	
v-r vitamin c 1,000 mg tablet	T1	
v-r vitamin c 250 mg tab chew	T1	
v-r vitamin c 500 mg tab chew	T1	
well vitamin c 1,000 mg tablet	T1	
well vitamin c 500 mg tablet	T1	
XCELLENT C	T3	
ZINC PLUS	T3	
ZINC-VITAMIN C	T3	
VITAMIN D PREPARATIONS		
AQUA-D CONCENTRATE	T3	HD
BABY DDROPS	T3	HD
BABY VITAMIN D3	T3	HD
BABY'S SUPER DAILY D3	T3	HD

T1 – Generics

T2 – Preferred Brands

T3 – Non-Preferred Brands

T4 – Preferred Specialty

T5 – Non-Preferred Specialty

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List of Prescription Medications

VITAMINS (Nutritional/Dietary) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
VITAMIN D PREPARATIONS (cont.)		
BIO-D-MULSION	T3	HD
BIO-D-MULSION FORTE	T3	HD
<i>calcitriol 0.25 mcg capsule</i>	T1	
<i>calcitriol 0.5 mcg capsule</i>	T1	
<i>calcitriol 1 mcg/ml ampul</i>	T1	
<i>calcitriol 1 mcg/ml solution (Rocaltrol)</i>	T1	
CHOLECAL DF	T3	HD
<i>cholecalciferol (vitamin d3)</i>	T1	HD
<i>cod liver oil</i>	T1	HD
<i>cod liver oil capsule</i>	T1	HD
<i>cvs vit d3 1,000 unit gummies</i>	T1	HD
<i>cvs vit d3 250 mcg softgel</i>	T1	HD
<i>cvs vitamin d3 1,000 unit sfgl</i>	T1	HD
<i>cvs vitamin d3 10 mcg softgel</i>	T1	HD
<i>cvs vitamin d3 125 mcg softgel</i>	T1	HD
CVS VITAMIN D3 250 MCG SOFTGEL	T3	HD
<i>cvs vitamin d3 2,000 unit sfgl</i>	T1	HD
<i>cvs vitamin d3 25 mcg gummies</i>	T1	HD
<i>cvs vitamin d3 25 mcg softgel</i>	T1	HD
<i>cvs vitamin d3 400 unit sftgl</i>	T1	HD
<i>cvs vitamin d3 5,000 unit sfgl</i>	T1	HD
<i>cvs vitamin d3 50 mcg softgel</i>	T1	HD
<i>cvs vitamin d3 50 mcg tablet</i>	T1	HD
CYFOLEX	T3	HD
D3 LIQUID	T3	HD
D3 PLUS K2 DOTS	T3	HD
D3-50	T2	HD
DDROPS	T3	HD
<i>decara 10,000 unit softgel</i>	T1	HD
DECARA 25,000 UNIT VEGICAP	T2	HD
<i>decara 50,000 unit softgel</i>	T1	HD
DECARA K	T3	HD
DERMACINRX DOTREMIN	T3	HD
DERMACINRX FOLDITAM	T3	HD

T1 – Generics

T2 – Preferred Brands

T3 – Non-Preferred Brands

T4 – Preferred Specialty

T5 – Non-Preferred Specialty

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List of Prescription Medications

VITAMINS (Nutritional/Dietary) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
VITAMIN D PREPARATIONS (cont.)		
DERMACINRX FOLIXAPURE	T3	HD
DERMACINRX FOLIXATE	T3	HD
DERMACINRX FOLTAMIN	T3	HD
DERMACINRX FOLTREXYL	T3	HD
DERMACINRX PUREFOLIX	T3	HD
DIALYVITE VITAMIN D3 MAX	T3	HD
DOSOKAP	T3	HD
DOSOQUIN	T3	HD
<i>eq/ vitamin d3 2,000 unit softgel</i>	T1	HD
<i>eq/ vitamin d3 400 unit softgel</i>	T1	HD
ERGOCAL	T3	HD
<i>ergocalciferol (vitamin d2)</i>	T1	HD
FOLIC D3	T3	HD
FOLIKA-D	T3	HD
FOLVITE-D	T3	HD
<i>ft vitamin d3 25 mcg softgel</i>	T1	HD
<i>ft vitamin d3 50 mcg softgel</i>	T1	HD
<i>ft vitamin d3 50 mcg tablet</i>	T1	HD
<i>ft vitamin d3 125 mcg softgel</i>	T1	HD
<i>ft vitamin d3 125 mcg tablet</i>	T1	HD
<i>ft vitamin d3 25 mcg tablet</i>	T1	HD
FT VITAMIN D3 250 MCG SOFTGEL	T3	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
GENICIN VITA-D	T3	HD
<i>gnp vit d3 10mcg(400 unit) chw</i>	T1	HD
<i>gnp vitamin d3 1,000 unit tab</i>	T1	HD
<i>gnp vitamin d3 10 mcg tablet</i>	T1	HD
<i>gnp vitamin d3 2,000 unit tab</i>	T1	HD
<i>gnp vitamin d3 25 mcg tablet</i>	T1	HD
<i>gnp vitamin d3 25mcg(1000 unt)</i>	T1	HD
<i>gnp vitamin d3 5,000 unit tab</i>	T1	HD
<i>hm vitamin d3 1,000 unit tab</i>	T1	HD

T1 – Generics

T2 – Preferred Brands

T3 – Non-Preferred Brands

T4 – Preferred Specialty

T5 – Non-Preferred Specialty

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List of Prescription Medications

VITAMINS (Nutritional/Dietary) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
VITAMIN D PREPARATIONS (cont.)		
hm vitamin d3 2,000 unit sftgl	T1	HD
HM VITAMIN D3 4,000 UNIT SFTGL	T3	HD
IS-D-10,000	T3	HD
K2 PLUS D3	T3	HD
K2-D3 10,000	T3	HD
K2-D3 5000	T3	HD
K2-D3 MAX	T3	HD
MAXIMUM D3	T2	HD
NOXIFOL-D3	T3	HD
OPTIMAL D3 M	T3	HD
ORTHO DF	T3	HD
OSTACHOL	T3	HD
PUREVITA VITAMIN D3	T3	HD
qc cod liver oil	T1	HD
ra cod liver oil	T1	HD
ra cod liver oil softgel	T1	HD
ra vitamin d3 1,000 unit tab	T1	HD
ra vitamin d3 2,000 unit sftgl	T1	HD
ra vitamin d3 2,000 unit sftgl	T1	HD
ra vitamin d3 5,000 unit sftgl	T1	HD
REPLESTA NX	T2	HD
REVESTA	T3	HD
ROCALTROL (calcitriol)	T3	ST
ROXIFOL-D	T3	HD
sm vitamin d3 1,000 unit tab	T1	HD
sm vitamin d3 2,000 unit sftgl	T1	HD
sm vitamin d3 50 mcg softgel	T1	HD
SUPER DAILY D3	T3	HD
sv vitamin d3 1,000 unit gummy	T1	HD
sv vitamin d3 1,000 unit sftgl	T1	HD
sv vitamin d3 2,000 unit sftgl	T1	HD
sv vitamin d3 25mcg(1000 unit)	T1	HD
sv vitamin d3 400 unit softgel	T1	HD
sv vitamin d3 5,000 unit sftgl	T1	HD

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T3 – Non-Preferred Brands

T4 – Preferred Specialty

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List of Prescription Medications

VITAMINS (Nutritional/Dietary) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
VITAMIN D PREPARATIONS (cont.)		
thera-d 2000 tablet	T1	HD
THERA-D 4000 TABLET	T3	HD
thera-d rapid repletion tablet	T1	HD
thera-d sport 2,000 unit tab	T1	HD
true vitamin d3 1,250 mcg tab	T1	HD
true vitamin d3 10 mcg capsule	T1	HD
true vitamin d3 10 mcg tablet	T1	HD
true vitamin d3 125 mcg cap	T1	HD
true vitamin d3 125 mcg tablet	T1	HD
true vitamin d3 25 mcg capsule	T1	HD
true vitamin d3 50 mcg capsule	T1	HD
true vitamin d3 25 mcg tablet	T1	HD
true vitamin d3 50 mcg tablet	T1	HD
TRUE VITAMIN D3 1,250 MCG CAP	T1	HD
TRUE VITAMIN D3 250 MCG CAP	T1	HD
TRUE VITAMIN D3 250 MCG TABLET	T1	HD
vit d3 125 mcg (5000 unit) tab	T1	HD
VIT D3 5,000 UNIT FAST DISSOLV	T3	HD
VITAMIN D2 2,000 UNIT TABLET	T2	HD
vitamin d2 1.25mg(50,000 unit)	T1	HD
vitamin d2 400 unit tablet	T1	HD
VITAMIN D2 50 MCG (2,000 UNIT)	T3	HD
VITAMIN D2-VITAMIN K1	T3	HD
VITAMIN D3-VITAMIN K2	T3	HD
VITAMIN D3 10 MCG/ML ENFIT SYR	T3	HD
vitamin d3 1,000 unit gummies	T1	HD
vitamin d3 1,000 unit gummy	T1	HD
vitamin d3 1,000 unit softgel	T1	HD
VITAMIN D3 1,000 UNIT SPRAY	T3	HD
vitamin d3 1,000 unit tab chew	T1	HD
vitamin d3 1,000 unit tablet	T1	HD
VITAMIN D3 1,000 UNIT/10 ML LQ	T3	HD
vitamin d3 1,250 mcg capsule	T1	HD
vitamin d3 1.25 mg softgel	T1	HD

T1 – Generics

T2 – Preferred Brands

T3 – Non-Preferred Brands

T4 – Preferred Specialty

T5 – Non-Preferred Specialty

PA – Prior Authorization

QL – Quantity Limit

ST – Step Therapy

AGE – Age Requirement

SP – Specialty Medication

HD – 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.)		
vitamin d3 10 mcg tablet	T1	HD
vitamin d3 10 mcg(400 unit)/ml	T1	HD
vitamin d3 10 mcg/ml drop	T1	HD
vitamin d3 10 mcg/ml liquid	T1	HD
VITAMIN D3 10,000 UNIT CAPSULE	T3	HD
vitamin d3 10,000 unit softgel	T1	HD
VITAMIN D3 10,000 UNIT TABLET	T3	HD
vitamin d3 125 mcg (5000 unit)	T1	HD
vitamin d3 125 mcg capsule	T1	HD
vitamin d3 125 mcg softgel	T1	HD
vitamin d3 125 mcg tablet	T1	HD
VITAMIN D3 125 MCG/0.5 ML DROP	T3	HD
vitamin d3 2,000 unit softgel	T1	HD
VITAMIN D3 2,000 UNIT TAB CHEW	T3	HD
vitamin d3 2,000 unit tablet	T1	HD
vitamin d3 25 mcg (1,000 unit)	T1	HD
vitamin d3 25 mcg gummy	T1	HD
vitamin d3 25 mcg softgel	T1	HD
vitamin d3 25 mcg tablet	T1	HD
VITAMIN D3 62.5 MCG SOFTGEL	T3	HD
VITAMIN D3 250 MCG TABLET	T3	HD
VITAMIN D3 3,000 UNIT TABLET	T3	HD
vitamin d3 400 unit softgel	T1	HD
vitamin d3 400 unit tab chew	T1	HD
vitamin d3 400 unit tablet	T1	HD
VITAMIN D3 400 UNIT/5 ML LIQ	T3	HD
vitamin d3 400 unit/ml liquid	T1	HD
vitamin d3 5,000 unit capsule	T1	HD
vitamin d3 5,000 unit softgel	T1	HD
vitamin d3 5,000 unit tablet	T1	HD
vitamin d3 5,000 unit/ml drops	T1	HD
vitamin d3 50 mcg (2,000 unit)	T1	HD
vitamin d3 50 mcg capsule	T1	HD
vitamin d3 50 mcg softgel	T1	HD

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List of Prescription Medications

VITAMINS (Nutritional/Dietary) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
VITAMIN D PREPARATIONS (cont.)		
vitamin d3 50 mcg tablet	T1	HD
VITAMIN D3 50 MCG DISSOLVE TAB	T3	HD
vitamin d3 50,000 unit capsule	T1	HD
vitamin d3/folic acid	T1	HD
v-r cod liver oil capsule	T1	HD
well vitamin d3 125 mcg softgel	T1	HD
well vitamin d3 25 mcg softgel	T1	HD
well vitamin d3 50 mcg softgel	T1	HD
VITAMIN E PREPARATIONS		
AQUA-E	T2	
AQUA-E CONCENTRATE	T3	
cvs vitamin e 180 mg softgel	T1	
cvs vitamin e 200 unit softgel	T1	
CVS VITAMIN E 450 MG SOFTGEL	T3	
cvs vitamin e 90 mg softgel	T1	
eql vitamin e 1,000 unit softgel	T1	
eql vitamin e 180 mg softgel	T1	
ft vitamin e 180 mg softgel	T1	
gnp vitamin e 180 mg softgel	T1	
gnp vitamin e 400 unit softgel	T1	
GNP VITAMIN E 450 MG SOFTGEL	T3	
gnp vitamin e 90 mg softgel	T1	
hm vitamin e 180 mg softgel	T1	
hm vitamin e 200 unit softgel	T1	
hm vitamin e 400 unit softgel	T1	
MIXED TOCOTRIENOLS	T3	
PUREVITA VITAMIN E	T3	
ra vitamin e 268 mg softgel	T1	
sv vitamin e 180 mg softgel	T1	
sv vitamin e 400 unit softgel	T1	
sv vitamin e 450 mg softgel	T1	
sv vitamin e 670 mg softgel	T1	
true vitamin e 180 mg capsule	T1	
true vitamin e 90 mg capsule	T1	

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List of Prescription Medications

VITAMINS (Nutritional/Dietary) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
VITAMIN E PREPARATIONS (cont.)		
TRUE VITAMIN E 450 MG CAPSULE	T1	
<i>vitamin e (dl,tocopheryl acet)</i>	T1	
<i>vitamin e 1,000 unit softgel</i>	T1	
VITAMIN E 1,000 UNIT SOFTGEL	T3	
<i>vitamin e 100 unit softgel</i>	T1	
VITAMIN E 100 UNIT TABLET	T3	
<i>vitamin e 15 unit/0.3 ml drop</i>	T1	
<i>vitamin e 180 mg softgel</i>	T1	
<i>vitamin e 180mg(400 unit) sfgl</i>	T1	
<i>vitamin e 200 unit capsule</i>	T1	
<i>vitamin e 200 unit softgel</i>	T1	
<i>vitamin e 268 mg softgel</i>	T1	
<i>vitamin e 400 unit capsule</i>	T1	
<i>vitamin e 400 unit softgel</i>	T1	
<i>vitamin e 45 mg softgel</i>	T1	
VITAMIN E 450 MG SOFTGEL	T3	
<i>vitamin e 450 mg softgel</i>	T1	
<i>vitamin e 600 unit capsule</i>	T1	
<i>vitamin e 90 mg softgel</i>	T1	
VITAMIN E NATURAL OIL DROPS	T2	
VITAMIN E OIL	T3	
VITAMIN E OIL DROPS	T2	
VITAMIN E OIL DROPS	T3	
VITAMIN E-OIL	T2	
WHEAT GERM OIL	T2	
XCELLENT E	T3	
VITAMIN K PREPARATIONS		
AQUA-K CONCENTRATE	T3	
FNP VITAMIN K2 40 MCG TABLET	T3	
<i>ft vitamin k2 100 mcg capsule</i>	T1	
<i>gnp vitamin k2 100 mcg capsule</i>	T1	
K1-1000	T3	
K2 LIQUID	T3	
K2-45	T3	

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List of Prescription Medications

VITAMINS (Nutritional/Dietary) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
VITAMIN K PREPARATIONS (cont.)		
MEPHYTON (<i>phytonadione (vit k1)</i>)	T3	QL (10 tabs/fill)
<i>phytonadione (vit k1)</i>	T1	
<i>phytonadione 1 mg/0.5 ml syr</i>	T1	
PHYTONADIONE 1 MG/0.5 ML SYR	T2	
PHYTONADIONE 1 MG/0.5 ML VIAL	T2	
<i>phytonadione 10 mg/ml ampul</i>	T1	
<i>phytonadione 10 mg/ml vial</i>	T1	
VITAMIN K	T2	
VITAMIN K-1	T2	
VITAMIN K2 (MENAQUINONE-4)	T3	
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		
<i>ft children's multi gummy</i>	T1	
GNP CHILDREN'S MULTI GUMMY	T3	

T1 – Generics

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Exclusions and limitations for coverage

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

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

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

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

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

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



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

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

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Cigna Healthcare

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

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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)

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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).