



# Cigna Healthcare Legacy (Performance) 4-Tier Prescription Drug List

**Coverage as of January 1, 2025**

## **For the State of California**

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

[Cigna.com/PDL](http://Cigna.com/PDL)

800.Cigna24 (800.244.6224)

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 This drug list is subject to change and all prior versions are no longer in effect.

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### View your drug list online

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

- As soon as your new plan year starts, log into the **myCigna® App<sup>1</sup> or myCigna.com<sup>®</sup>**. Use the Price a Medication tool to get real-time information about the medications your plan covers.
- You can also view a pdf of this document online at **Cigna.com/PDL**. Click on the dropdown next to "Drug Lists for Employer Plans." Scroll down to the section for California Employer Drug Lists; then click on **California Legacy (Performance) 4 Tier (all specialty medications covered on tier 4) (CDI) [PDF]**.

### Questions?

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

\* Drug list created: originally created 01/01/2004

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

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# Information about this drug list

## Frequently asked questions (FAQs)

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

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

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

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

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

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

**A.** There are certain medications and products that can't be covered by your plan for any reason because they're considered to be a "plan or benefit exclusion." This means the medication or product isn't on your plan's drug list, and there's no option to ask Cigna Healthcare to consider approving it through the coverage review process. For example, your plan doesn't cover, or "excludes," medications that aren't approved by the U.S. Food and Drug Administration (FDA).

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

**A.** The Cigna Healthcare Prescription Drug List is developed with the help of the Cigna Healthcare Pharmacy and Therapeutics (P&T) Committee, which is a group of practicing doctors and pharmacists,

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

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

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

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

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

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

**A.** Medications that:

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

## Information about this drug list

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

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

A. Medications that are often:

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

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

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

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

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

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

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

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

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

If your medication isn't approved, your doctor can send us more information to review, using the same

process as before. We're happy to review the request again. Depending on what your doctor sends this time, we may be able to approve coverage. Or, you and your doctor can appeal the decision by sending Cigna Healthcare a written request explaining why the medication should be covered.

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

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

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

Cigna Healthcare will review information your doctor sends us to make sure you meet coverage

## Information about this drug list

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

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

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

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

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

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

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

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

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

#### **Your Step Therapy rights under California State law:**

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

## Information about this drug list

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

by a prescription drug provided that the drug is appropriately prescribed and is considered safe and effective. A new policy can impose a prior authorization requirement for the continued coverage of a prescription drug prescribed pursuant to step therapy imposed by the former policy. A new policy must also allow a prescribing provider to prescribe another drug covered by the new policy that is medically appropriate for the insured.

3. A carrier shall provide coverage for the medically necessary dosage and quantity of the drug prescribed for the treatment of a medical condition consistent with professionally recognized standards of practice.

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

A. When your pharmacist tries to fill your prescription, he or she will see that the medication needs preapproval from Cigna Healthcare. Because you didn't get approval ahead of time, your plan won't cover the cost of your medication. You should ask your doctor to contact Cigna Healthcare to start the coverage review process. Or, you can choose to pay the medication's full cost out-of-pocket directly to the pharmacy (the cost can't be applied to your annual deductible or out-of-pocket maximum).

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

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

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

A. Yes.

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

A. We review all recently approved medications and products to see if they should be covered – and if so, at what cost-share (tier). It can take up to six months from the date the FDA approved them to make a

decision. These include, but are not limited to, medications, medical supplies and/or devices covered under standard pharmacy benefits. If your doctor wants you to use a recently approved medication, he or she can ask Cigna Healthcare to consider approving it through the coverage review process.

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

A. The Patient Protection and Affordable Care Act (PPACA), commonly referred to as "health care reform," was signed into law on March 23, 2010. Under this law, certain preventive medications (including some over-the-counter products) may be available to you at no cost-share (\$0), depending on your plan. Log in to the [myCigna App](#) or [myCigna.com](#), or check your plan materials, to learn more about how your plan covers preventive medications. You can also view the PPACA No Cost-Share Preventive Medications drug list at [Cigna.com/PDL](#). For more information about health care reform, go to [informedonreform.com](#) or [CignaHealthcare.com](#).

#### **Q. What are preventive medications?**

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

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

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

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

A. When you and your doctor are considering the right medication for your treatment, knowing how much it costs, what lower-cost alternatives are available and which pharmacies offer the best prices

## Information about this drug list

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

can help you avoid surprises. Log in to the **myCigna App** or **myCigna.com** and use the Price a Medication tool to see how much your medication costs before you get to the pharmacy counter – or, even before you leave your doctor’s office.<sup>2</sup>

#### Q. What's a cost-share?

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

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

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

#### Q. What's a generic medication?

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

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

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

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

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

different than their brand-name versions, but they're just as safe and effective.

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

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

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

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

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

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

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

#### Q. Can I fill my prescriptions by mail?

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

#### Express Scripts® Pharmacy for maintenance medications

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

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

## Information about this drug list

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

- Standard shipping at no extra cost<sup>5</sup>
- Automatic refills or refill reminders
- Fill up to a 90-day supply at one time<sup>6</sup>
- Helpful pharmacists available 24/7
- Flexible payment options

Here are three easy ways to get started.

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

#### Accredo for specialty medications

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

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

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

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

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

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

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

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

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

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

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

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

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

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

**A.** Managing a complex condition isn't easy. As part of your pharmacy benefits, you have access to Accredo. Accredo's team of specialty-trained pharmacists

## Information about this drug list

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

## Information about this drug list

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

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

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

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

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

### Words you may need to know

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

## Information about this drug list

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

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

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

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

# Information about this drug list

## About this drug list

This is a list of the most commonly prescribed medications covered on the Cigna Healthcare Legacy (Performance) 4-Tier Prescription Drug List as of January 1, 2025. Medications are listed alphabetically by their generic and brand names within their therapeutic category and class.

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

## How to read this drug list

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

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

## Tiers

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

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

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

## Information about this drug list

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

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

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

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

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

# Information about this drug list

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

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

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

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

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

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

**Prescription drug name** is the name of the medication

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

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

Generic medications are in **lowercase italics**

This chart is just a sample. It may not show how these medications are actually covered on the Cigna Healthcare Legacy (Performance) 4-Tier Prescription Drug List.

## Information about this drug list

### How to find your medication

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

Condition	Page	Condition	Page
Analgesics (Pain Relief and Inflammatory Disease)	18-25	Anti-Infectives (Feminine Products)	63
Analgesics (Urinary Tract Conditions)	25	Anti-Infectives (Infections)	63
Anesthetics (Miscellaneous)	25, 26	Anti-Infectives/Miscellaneous (Feminine Products)	63
Anesthetics (Pain Relief and Inflammatory Disease)	26-29	Anti-Infectives/Miscellaneous (Infections)	63-65
Anesthetics (Urinary Tract Conditions)	30	Anti-Infectives/Miscellaneous (Miscellaneous)	65
Anti-Allergy (Allergy and Nasal Sprays)	30	Anti-Infectives/Miscellaneous (Skin Conditions)	65
Anti-Arthritis (Pain Relief and Inflammatory Disease)	30-33	Anti-Inflammatory Tumor Necrosis Factor Inhibiting Agents (Pain Relief and Inflammatory Disease)	65, 66
Anti-Asthmatics (Asthma/COPD/Respiratory)	34-36	Anti-Neoplastics (Cancer)	67-79
Antibiotics (Allergy/Nasal Sprays)	36	Anti-Neoplastics (Skin Conditions)	79, 80
Antibiotics (Ear Medications)	36, 37	Anti-Parasitics (Infections)	80
Antibiotics (Eye Conditions)	37, 38	Anti-Parkinson's Drugs (Parkinson's Disease)	80-82
Antibiotics (Infections)	38-49	Anti-Platelet Drugs (Blood Thinners/Anti-Clotting)	82, 83
Antibiotics (Miscellaneous)	50	Antivirals (Aids/Hiv)	83-87
Antibiotics (Skin Conditions)	50, 51	Antivirals (Eye Conditions)	87
Anti-Coagulants (Blood Thinners/Anti-Clotting)	51-53	Antivirals (Infections)	87-89
Antidotes (Gastrointestinal/Heartburn)	53	Antivirals (Skin Conditions)	89
Antidotes (Substance Abuse)	53, 54	Autonomic Drugs (Allergy/Nasal Sprays)	90
Anti-Fungals (Eye Conditions)	54	Autonomic Drugs (Alzheimer's Disease)	90, 91
Anti-Fungals (Feminine Products)	54	Autonomic Drugs (Attention Deficit Hyperactivity Disorder)	91, 92
Anti-Fungals (Infections)	54, 55	Autonomic Drugs (Blood Pressure/Heart Medications)	92
Anti-Fungals (Skin Conditions)	55, 56	Autonomic Drugs (Miscellaneous)	92-93
Antihistamine and Decongestant Combination (Allergy/Nasal Sprays)	56, 57	Autonomic Drugs (Urinary Tract Conditions)	93, 94
Antihistamines (Allergy/Nasal Sprays)	57	Biologicals (Allergy/Nasal Sprays)	94
Antihistamines (Eye Conditions)	57, 58	Biologicals (Blood Pressure/Heart Medications)	94
Anti-Hyperglycemics (Diabetes)	58-63	Biologicals (Miscellaneous)	94

## Information about this drug list

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

Condition	Page	Condition	Page
Biologicals (Vaccines)	94-96	Elect/Caloric/H2O (Dental Products)	I40, I41
Blood (Blood Modifiers/Bleeding Disorders)	96-98	Elect/Caloric/H2O (Diabetes)	I41
Blood (Miscellaneous)	98	Elect/Caloric/H2O (Miscellaneous)	I41-I43
Cardiac Drugs (Blood Pressure/Heart Medications)	98-I03	Elect/Caloric/H2O (Nutritional/Dietary)	I43-I46
Cardiovascular (Allergy/Nasal Sprays)	I03, I04	Elect/Caloric/H2O (Urinary Tract Conditions)	I47
Cardiovascular (Asthma/COPD/Respiratory)	I04, I05	Gastrointestinal (Cholesterol Medications)	I47
Cardiovascular (Blood Pressure/Heart Medications)	I05-II2	Gastrointestinal (Gastrointestinal/Heartburn)	I47-I57
Cardiovascular (Cholesterol Medications)	II2-II6	Gastrointestinal (Pain Relief and Inflammatory Disease)	I57, I58
Cardiovascular (Miscellaneous)	II6	Hematopoietic Growth Factors (Miscellaneous)	I58
CNS Drugs (Alzheimer's Disease)	II6	Hormones (Hormonal Agents)	I58-I66
CNS Drugs (Miscellaneous)	II7, II8	Hormones (Infertility)	I67
CNS Drugs (Multiple Sclerosis)	II8, II9	Hormones (Miscellaneous)	I67
CNS Drugs (Pain Relief and Inflammatory Disease)	II9	Hormones (Osteoporosis Products)	I67, I68
CNS Drugs (Seizure Disorders)	II9-II24	Immunosuppressants (Pain Relief and Inflammatory Disease)	I68
Colony Stimulating Factors (Blood Modifiers/Bleeding Disorders)	I24, I25	Immunosuppressants (Transplant Medications)	I68-I70
Colony Stimulating Factors (Cancer)	I25	Miscellaneous Medical Supplies, Devices, Non-Drug (Diabetes)	I70-I82
Contraceptives (Contraception Products)	I25-I27	Miscellaneous Medical Supplies, Devices, Non-Drug (Miscellaneous)	I82-I86
Cough/Cold Preparations (Allergy/Nasal Sprays)	I27, I28	Muscle Relaxants (Pain Relief and Inflammatory Disease)	I86-I88
Cough/Cold Preparations (Cough/Cold Medications)	I28	Prenatal Vitamins (Nutritional/Dietary)	I88
Diagnostic (Diabetes)	I28	Psychotherapeutic Drugs (Anxiety/Depression/Bipolar Disorder)	I89-I95
Diagnostic (Miscellaneous)	I28-I32	Psychotherapeutic Drugs (Attention Deficit Hyperactivity Disorder)	I95-I97
Diuretics (Diuretics)	I32-I34	Psychotherapeutic Drugs (Miscellaneous)	I97
EENT Preps (Allergy/Nasal Sprays)	I34, I35	Psychotherapeutic Drugs (Schizophrenia/Anti-Psychotics)	I98-202
EENT Preps (Ear Medications)	I35		
EENT Preps (Eye Conditions)	I35-I40		
Elect/Caloric/H2O (Cholesterol Medications)	I40		

## Information about this drug list

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

Condition	Page	Condition	Page
Psychotherapeutic Drugs (Sleep Disorders/Sedatives)	202	Unclassified Drug Products (Gastrointestinal/Heartburn)	221
Sedative/Hypnotics (Sleep Disorders/Sedatives)	202-204	Unclassified Drug Products (Hormonal Agents)	221, 222
Skin Preps (Miscellaneous)	204	Unclassified Drug Products (Miscellaneous)	222-227
Skin Preps (Pain Relief and Inflammatory Disease)	204, 205	Unclassified Drug Products (Multiple Sclerosis)	227
Skin Preps (Skin Conditions)	205-216	Unclassified Drug Products (Nutritional/Dietary)	227
Smoking Deterrents (Smoking Cessation)	216	Unclassified Drug Products (Osteoporosis Products)	228
Thyroid Prep (Hormonal Agents)	216, 217	Unclassified Drug Products (Pain Relief and Inflammatory Disease)	228, 229
Unclassified Drug Products (Asthma/COPD/Respiratory)	218	Unclassified Drug Products (Seizure Disorders)	229
Unclassified Drug Products (Blood Modifiers/Bleeding Disorders)	219	Unclassified Drug Products (Skin Conditions)	229
Unclassified Drug Products (Blood Pressure/Heart Medications)	219	Unclassified Drug Products (Substance Abuse)	229
Unclassified Drug Products (Cancer)	219, 220	Unclassified Drug Products (Transplant Medications)	230
Unclassified Drug Products (Dental Products)	220	Unclassified Drug Products (Urinary Tract Conditions)	230, 231
Unclassified Drug Products (Diabetes)	220	Unclassified Drug Products (Weight Management)	231
Unclassified Drug Products (Erectile Dysfunction)	220, 221	Vitamins (Nutritional/Dietary)	231-233
Unclassified Drug Products (Eye Conditions)	221		

## List of Prescription Medications

ANALGESICS (Pain Relief and Inflammatory Disease)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>ANALGESIC, NON-SALICYLATE AND BARBITURATE COMBINAT</b>		
ALLZITAL	T3	PA
BUPAP ( <i>butalbital-acetaminophen</i> )	T1	PA
<i>butalbital/acetaminophen</i>	T1	
<i>butalbital-acetaminophen 25-325 (Allzital)</i>	T1	PA
<i>butalbital-acetaminophen 50-300</i>	T1	
<i>butalbital-acetaminophen 50-300 (Bupap)</i>	T1	PA
<i>butalbital-acetaminophen 50-325</i>	T1	
<b>ANALGESIC, SALICYLATE, BARBITURATE, XANTHINE COMB.</b>		
butalb-aspirin-caff 50-325-40	T1	QL (6 tabs/day)
butalbital-asa-caffeine cap (Fiorinal)	T1	QL (6 caps/day)
FIORINAL (butalbital-aspirin-caffeine)	T3	QL (6 caps/day)
<b>ANALGESIC, NON-SALICYLATE, BARBITURATE, XANTHINE COMB.</b>		
<i>butalb/acetaminophen/caffeine (Esgic)</i>	T3	QL (6 caps/day)
<i>butalb/acetaminophen/caffeine (Vanatol S)</i>	T3	
<i>butalb-acetamin-caff 50-300-40 (Fioricet)</i>	T1	QL (6 caps/day)
<i>butalb-acetamin-caff 50-325-40 (Esgic)</i>	T1	QL (6 tabs/day)
ESGIC 50-325-40 MG TABLET ( <i>butalbital-acetaminophen-caff</i> )	T3	PA QL (6 tabs/day)
ESGIC CAPSULE (zebutal)	T3	PA QL (6 caps/day)
FIORICET ( <i>phrenilin forte</i> )	T3	PA QL (6 caps/day)
VANATOL LQ	T3	PA
VANATOL S	T3	PA
VTOL	T1	PA
<b>ANALGESIC/ANTIPYRETICS, SALICYLATES</b>		
<i>choline salicyl/mag salicylate</i>	T1	HD
diflunisal	T1	HD
<b>ANALGESICS, NON-OPIOID</b>		
JOURNAVX	T3	QL (30 tabs/90 days)
<b>ANALGESIC/ANTIPYRETICS, NON-SALICYLATE</b>		
ACETAMINOPHEN 1000MG/100ML BAG	T3	
<i>acetaminophen 1,000mg/100ml v1 (Ofirmev)</i>	T1	
OFIRMEV ( <i>acetaminophen</i> )	T3	
<b>ANALGESICS, NEURONAL-TYPE CALCIUM CHANNEL BLOCKERS</b>		
PRIALT	T4	SP
<i>clonidine 1,000 mcg/10 ml vial (Duraclon)</i>	T1	

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

T4 – Specialty Medications

PA – Prior Authorization

QL – Quantity Limit

ST – Step Therapy

AGE – Age Requirement

SP – Specialty Medication

HD – May require home delivery pharmacy

PPACA – No Cost-Share Preventive Medication

CSL – Oral cancer medication subject to cost-share limits

## List of Prescription Medications

### ANALGESICS (Pain Relief And Inflammatory Disease) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>ANTI-MIGRAINE PREPARATIONS (cont.)</b>		
clonidine 5,000 mcg/10 ml vial	T1	
DURACLON (clonidine hcl)	T3	
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)
CAMBIA (diclofenac potassium)	T3	PA
D.H.E.45 (dihydroergotamine mesylate)	T3	PA QL (10 amps/30 days)
diclofenac pot 50 mg powdr pkt (Cambia)	T1	PA
dihydroergotamine 1 mg/ml amp (D.h.e.45)	T1	QL (10 amps/30 days)
dihydroergotamine 4 mg/ml spry (Migranal)	T1	QL (8/30 days)
eletriptan hydrobromide (Relpx)	T1	QL (6 tabs/30 days)
ELYXYB	T3	PA QL (9 bottles/30 days)
EMGALITY PEN	T2	PA
EMGALITY SYRINGE	T2	PA
ERGOMAR	T3	PA
ergotamine tartrate/caffeine	T1	
ergotamine tartrate/caffeine (Cafergot)	T1	QL (40 tabs/28 days)
frovatriptan succinate (Frova)	T1	QL (18 tabs/30 days)
IMITREX 100 MG TABLET (sumatriptan succinate)	T3	PA QL (9 tabs/30 days)
IMITREX 20 MG NASAL SPRAY (sumatriptan)	T3	PA QL (2 boxes/30 days)
IMITREX 25 MG TABLET (sumatriptan succinate)	T3	PA QL (9 tabs/30 days)
IMITREX 4 MG/0.5 ML CARTRIDGES (sumatriptan succinate)	T3	PA QL (4ml/30 days)
IMITREX 4 MG/0.5 ML PEN INJECT (sumatriptan succinate)	T3	PA QL (4ml/30 days)
IMITREX 5 MG NASAL SPRAY (sumatriptan)	T3	PA QL (2 boxes/30 days)
IMITREX 50 MG TABLET (sumatriptan succinate)	T3	PA QL (9 tabs/30 days)
IMITREX 6 MG/0.5 ML CARTRIDGES (sumatriptan succinate)	T3	PA QL (4ml/30 days)
IMITREX 6 MG/0.5 ML PEN INJECT (sumatriptan succinate)	T3	PA QL (4ml/30 days)
IMITREX 6 MG/0.5 ML VIAL (sumatriptan succinate)	T3	PA QL (5ml/30 days)
isomethept/dichlphn/acetaminop	T1	
isomethepten/caf/acetaminophen	T1	
MAXALT (rizatriptan)	T3	PA QL (12 tabs/30 days)
MAXALT MLT (rizatriptan)	T3	PA QL (12 tabs/30 days)

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

T4 – Specialty Medications

PA – Prior Authorization

QL – Quantity Limit

ST – Step Therapy

AGE – Age Requirement

SP – Specialty Medication

HD – May require home delivery pharmacy

PPACA – No Cost-Share Preventive Medication

CSL – Oral cancer medication subject to cost-share limits

## List of Prescription Medications

### ANALGESICS (Pain Relief And Inflammatory Disease) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>ANTI-MIGRAINE PREPARATIONS (cont.)</b>		
MIGRANAL ( <i>dihydroergotamine mesylate</i> )	T3	PA QL (8/30 days)
<i>naratriptan hcl</i>	T1	QL(9 tabs/30 days)
NURTEC ODT	T2	PA QL (16 tabs/30 days)
ONZETRA XSAIL	T3	PA QL (1 box/30 days)
RELPAX ( <i>eletriptan hbr</i> )	T3	PA QL (6 tabs/30 days)
REYVOW	T3	PA QL (8 tabs/30 days)
<i>rizatriptan</i> (Maxalt Mlt)	T1	QL (12 tabs/30 days)
<i>rizatriptan</i> (Maxalt)	T1	QL (12 tabs/30 days)
<i>rizatriptan</i>	T1	QL (12 tabs/30 days)
QULIPTA	T3	PA QL (1 set/day)
<i>sumatriptan</i> (Imitrex)	T1	QL (2 boxes/30 days)
<i>sumatriptan</i> 4 mg/0.5 ml cart (Imitrex)	T1	QL (4ml/30 days)
<i>sumatriptan</i> 4 mg/0.5 ml inject (Imitrex)	T1	QL (4ml/30 days)
<i>sumatriptan</i> 6 mg/0.5 ml cart (Imitrex)	T1	QL (4ml/30 days)
<i>sumatriptan</i> 6 mg/0.5 ml inject (Imitrex)	T1	QL (4ml/30 days)
<i>sumatriptan</i> 6 mg/0.5 ml syrng	T1	QL (4ml/30 days)
<i>sumatriptan</i> 6 mg/0.5 ml vial (Imitrex)	T1	QL (5ml/30 days)
<i>sumatriptan</i> succ 100 mg tablet (Imitrex)	T1	QL (9 tabs/30 days)
<i>sumatriptan</i> succ 25 mg tablet (Imitrex)	T1	QL (18 tabs/28 days)
<i>sumatriptan</i> succ 50 mg tablet (Imitrex)	T1	QL (9 tabs/30 days)
<i>sumatriptan</i> succ/naproxen sod (Trexiomet)	T1	QL (18 tabs/30 days)
SUMAVEL DOSEPRO	T3	QL (12 injectors/30 days)
TOSYMRA	T3	PA QL (2 boxes/30 days)
TREXIMET 10-60 MG TABLET	T3	PA QL (18 tabs/30 days)
TREXIMET 85-500 MG TABLET ( <i>sumatriptan succ-naproxen sod</i> )	T3	PA QL (18 tabs/28 days)
TRUDHESA	T2	PA QL (2 pkgs/30 days)
UBRELVY	T2	PA QL (0.67 tabs/day)
VYEPTI	T3	PA SP
ZAVAPRET	T2	PA QL(6 units/30 days)
ZEMBRACE SYMTOUCH	T3	PA QL (16 injectors/30 days)
<i>zolmitriptan</i> (Zomig Zmt)	T1	QL (12 tabs/30 days)
<i>zolmitriptan</i> 2.5 mg tablet (Zomig)	T1	QL (12 tabs/30 days)
ZOLMITRIPTAN 5 MG NASAL SPRAY	T3	PA QL (6 spray/22 days)
<i>zolmitriptan</i> 5 mg tablet (Zomig)	T1	QL (12 tabs/30 days)

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

T4 – Specialty Medications

PA – Prior Authorization

QL – Quantity Limit

ST – Step Therapy

AGE – Age Requirement

SP – Specialty Medication

HD – May require home delivery pharmacy

PPACA – No Cost-Share Preventive Medication

CSL – Oral cancer medication subject to cost-share limits

## List of Prescription Medications

ANALGESICS (Pain Relief And Inflammatory Disease) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>ANTI-MIGRAINE PREPARATIONS (cont.)</b>		
ZOMIG 2.5 MG TABLET ( <i>zolmitriptan</i> )	T3	PA QL (12 tabs/30 days)
ZOMIG 5 MG TABLET ( <i>zolmitriptan</i> )	T3	PA QL (12 tabs/30 days)
ZOMIG ZMT ( <i>zolmitriptan odt</i> )	T3	PA QL (12 tabs/30 days)
<b>NASAL NSAIDS, COX NON-SELECTIVE, SYSTEMIC ANALGESIC</b>		
SPRIX	T3	PA QL (10 bots/30 days)
<b>NSAIDS, CYCLOOXYGENASE INHIBITOR-TYPE ANALGESICS</b>		
<i>diclofenac pot 25 mg tablet</i>	T1	PA HD
<i>diclofenac potassium</i>	T1	HD
<i>INDOCIN (indomethacin)</i>	T3	PA HD
<i>indomethacin 50 mg suppository (Indocin)</i>	T1	HD
<i>ketorolac 10 mg tablet</i>	T1	QL (20 tabs/25 days)
<i>ketorolac 15 mg/ml syringe</i>	T1	QL (40 ml/30 days)
<i>ketorolac 15 mg/ml vial</i>	T1	QL (40 ml/30 days)
<i>ketorolac 30 mg/ml carpuject</i>	T1	
<i>ketorolac 30 mg/ml isecure syr</i>	T1	QL (20ml/30 days)
<i>ketorolac 30 mg/ml syringe</i>	T1	QL (20ml/30 days)
<i>ketorolac 30 mg/ml vial</i>	T1	QL (20ml/30 days)
<i>ketorolac 300 mg/10 ml vial</i>	T1	
<i>ketorolac 60 mg/2 ml carpuject</i>	T1	QL (20ml/30 days)
<i>ketorolac 60 mg/2 ml syringe</i>	T1	QL (20ml/30 days)
<i>ketorolac 60 mg/2 ml vial</i>	T1	QL (20ml/30 days)
<i>mefenamic acid</i>	T1	HD
<i>ZIPSOR</i>	T3	PA HD
<b>OPIOID ANALGESIC AND NON-SALICYLATE ANALGESICS</b>		
<i>acetamin-codein 300-30 mg/12.5</i>	T1	
<i>acetaminop-codeine 120-12 mg/5</i>	T1	
<i>acetaminophen-cod #2 tablet</i>	T1	PA
<i>acetaminophen-cod #3 tablet</i>	T1	PA
<i>acetaminophen-cod #4 tablet</i>	T1	PA
<i>APADAZ</i>	T3	
<i>BENZHYDROCODONE-ACETAMINOPHEN</i>	T1	
<i>CAPITAL W-CODEINE</i>	T3	
<i>hydrocodone/acetaminophen</i>	T1	PA

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

T4 – Specialty Medications

PA – Prior Authorization

QL – Quantity Limit

ST – Step Therapy

AGE – Age Requirement

SP – Specialty Medication

HD – May require home delivery pharmacy

PPACA – No Cost-Share Preventive Medication

CSL – Oral cancer medication subject to cost-share limits

## List of Prescription Medications

### ANALGESICS (Pain Relief And Inflammatory Disease) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>OPIOID ANALGESIC AND NON-SALICYLATE ANALGESICS (cont.)</b>		
hydrocodone/acetaminophen (Hydrocodone-acetaminophen)	T1	PA
hydrocodone/acetaminophen (Norco)	T1	PA
HYDROCODONE-ACETAMINOPHEN	T1	PA
LORTAB	T1	PA
NALOCET	T1	PA
NORCO ( <i>loracet hd</i> )	T3	PA
NORCO ( <i>loracet plus</i> )	T3	PA
NORCO ( <i>loracet</i> )	T3	PA
oxycodone hcl/acetaminophen (Nalocet)	T1	PA
oxycodone hcl/acetaminophen (Percocet)	T1	PA
oxycodone hcl/acetaminophen (Primlev)	T1	PA
PERCOSET (oxycodone-acetaminophen)	T3	PA
PRIMLEV	T1	PA
tramadol hcl/acetaminophen (Ultracet)	T1	
ULTRACET (tramadol hcl-acetaminophen)	T3	
<b>OPIOID ANALGESIC AND NSAID COMBINATION</b>		
hydrocodone(ibuprofen	T1	PA
hydrocodone(ibuprofen (Ibudone)	T1	PA
IBUDONE	T1	PA
ibuprofen/oxycodone hcl	T1	PA
SEGLENTIS	T3	PA QL (4 tabs/day)
<b>OPIOID ANALGESIC, ANESTHETIC ADJUNCT AGENTS</b>		
alfentanil 1,000 mcg/2 ml amp (Alfentanil Hcl)	T1	PA
alfentanil 500 mcg/ml ampul (Alfentanil Hcl)	T1	PA
ALFENTANIL 500 MCG/ML AMPULE ( <i>alfentanil hcl</i> )	T3	PA
fentanyl citrate/pf	T1	
FENTANYL 25 MCG/0.5 ML SYRINGE	T2	
fentanyl 50 mcg/ml vial	T1	
fentanyl 100 mcg/2 ml ampul	T1	
fentanyl 100 mcg/2 ml vial	T1	
fentanyl 250 mcg/5 ml	T1	
fentanyl 500 mcg/10 ml vial	T1	

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

T4 – Specialty Medications

PA – Prior Authorization

QL – Quantity Limit

ST – Step Therapy

AGE – Age Requirement

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## List of Prescription Medications

### ANALGESICS (Pain Relief And Inflammatory Disease) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>OPIOID ANALGESIC, ANESTHETIC ADJUNCT AGENTS (cont.)</b>		
fentanyl 1,000 mcg/20 ml vial	T1	
FENTANYL 2,500 MCG/50 ML BAG	T1	
fentanyl 2,500 mcg/50 ml vial	T1	
FENTANYL 5,000 MCG/100 ML BAG	T1	
remifentanil hcl (Ultiva)	T1	PA
sufentanil citrate	T1	PA
ULTIVA (remifentanil hcl)	T3	PA
<b>OPIOID ANALGESIC AND NON-SALICYLATE XANTHINE COMB</b>		
ACETAMIN-CAFF-DIHYDROCODEINE	T1	PA
acetaminophen/caff/dihydrocod (Acetamin-caff-dihydrocodeine)	T1	PA
acetaminophen/caff/dihydrocod (Trexix)	T1	PA
TREXIX	T3	PA
<b>OPIOID ANALGESICS</b>		
ACTIQ (fentanyl citrate)	T3	PA
ARYMO ER	T3	PA
BELBUCA	T2	QL (2 films/day)
BUPRENEX	T3	
buprenorphine (Butrans)	T1	QL (4 patches/28 days)
butorphanol tartrate	T1	PA QL (6 bots/30 days)
BUTRANS (buprenorphine)	T3	QL (4 patches/28 days)
codeine sulfate	T1	PA
DILAUDID 0.2 MG/ML SYRINGE	T3	PA
DILAUDID 0.5 MG/0.5 ML SYRINGE	T3	PA
DILAUDID 1 MG/ML SYRINGE	T3	PA
DILAUDID 2 MG TABLET (hydromorphone hcl)	T3	PA
DILAUDID 2 MG/ML SYRINGE	T3	PA
DILAUDID 4 MG TABLET (hydromorphone hcl)	T3	PA
DILAUDID 4 MG/ML SYRINGE	T3	
DILAUDID 5 MG/5 ML ORAL LIQUID (hydromorphone hcl)	T3	PA
DILAUDID 8 MG TABLET (hydromorphone hcl)	T3	PA
DURAGESIC (fentanyl)	T3	PA
FENTANYL/BUPIVACAINE/NS	T3	
fentanyl (Duragesic)	T1	PA

T1 – Typically Generics

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T3 – Typically Non-Preferred Brands

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## List of Prescription Medications

### ANALGESICS (Pain Relief And Inflammatory Disease) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>OPIOID ANALGESICS (cont.)</b>		
FENTANYL CITRATE/NAACL/ML-NS	T1	PA
<i>fentanyl citrate</i>	T1	PA
FENTORA	T3	PA
<i>hydrocodone bitartrate</i> (Hysingla Er)	T1	PA
<i>hydrocodone bitartrate</i> (Zohydro Er)	T1	PA
<i>hydromorphone 0.5 mg/0.5ml syrup</i>	T1	PA
<i>hydromorphone hcl</i>	T1	PA
<i>hydromorphone hcl</i> (Dilaudid)	T1	PA
HYDROMORPHONE 0.25 MG/0.5 ML	T3	PA
HYSINGLA ER ( <i>hydrocodone bitartrate er</i> )	T2	PA
KADIAN ( <i>morphine sulfate er</i> )	T3	PA
LAZANDA	T3	PA
<i>meperidine hcl</i>	T1	PA
<i>methadone hcl</i>	T1	PA
MITIGO	T1	PA
MORPHABOND ER	T2	PA
morphine sulfate	T1	PA
<i>morphine sulfate</i> (Kadian)	T1	PA
<i>morphine sulfate</i> (Ms Contin)	T1	PA
MS CONTIN ( <i>morphine sulfate er</i> )	T3	PA
<i>nalbuphine hcl</i>	T1	
NUCYNTA	T2	PA
NUCYNTA ER	T3	PA
<i>opium/belladonna alkaloids</i>	T1	PA
OXAYDO	T3	PA
<i>oxycodone hcl</i>	T1	PA
OXYCODONE HCL ER	T1	PA
<i>oxymorphone hcl</i>	T1	PA
<i>pentazocine hcl/naloxone hcl</i>	T1	PA
ROXICODONE ( <i>oxycodone hcl</i> )	T3	PA
ROXYBOND	T3	PA
SUBSYS	T3	PA
tramadol hcl (Ultram)	T1	QL (8 tabs/day)
TRAMADOL HCL 25 MG TABLET	T3	PA QL(>= 18 yo 4 tabs/day)

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

T4 – Specialty Medications

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## List of Prescription Medications

### ANALGESICS (Pain Relief And Inflammatory Disease) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>OPIOID ANALGESICS (cont.)</b>		
TRAMADOL HCL 75 MG TABLET	T3	QL(< 18 yo 5 tabs/day)
<i>tramadol er 100 mg tablet</i>	T1	QL (1 tab/day)
<i>tramadol er 200 mg tablet</i>	T1	QL (1 tab/day)
<i>tramadol er 300 mg tablet</i>	T1	QL (1 tab/day)
TRAMADOL HCL ER 100 MG CAPSULE	T1	QL (1 cap/day)
<i>tramadol hcl er 100 mg tablet</i>	T1	QL (1 tab/day)
TRAMADOL HCL ER 150 MG CAPSULE	T1	QL (1 cap/day)
TRAMADOL HCL ER 200 MG CAPSULE	T1	QL (1 cap/day)
<i>tramadol hcl er 200 mg tablet</i>	T1	QL (1 tab/day)
TRAMADOL HCL ER 300 MG CAPSULE	T1	QL (1 cap/day)
<i>tramadol hcl er 300 mg tablet</i>	T1	QL (1 tab/day)
ULTRAM ( <i>tramadol hc</i> )	T3	QL (8 tabs/day)
XTAMPZA ER	T2	PA
ZOHYDRO ER ( <i>hydrocodone bitartrate er</i> )	T3	PA
<b>OPIOID AND SALICYLATE ANALGESICS, BARBIT, XANTHINE</b>		
codeine/butalbital/asa/caffein (Fiorinal With Codeine #3)	T1	PA
FIORINAL WITH CODEINE #3 ( <i>butalbital compound-codeine</i> )	T3	PA
<b>OPIOID, NON-SALICYL. ANALGESIC, BARBITUATE, XANTHINE</b>		
butalbit/acetamin/caff/codeine	T1	PA
butalbit/acetamin/caff/codeine (Fioricet With Codeine)	T1	PA
FIORICET WITH CODEINE ( <i>butalb-acetaminoph-caff-codein</i> )	T3	PA
<b>SKELETAL MUSCLE RELAXANT, SALICYLAT, OPIOID ANALGESC</b>		
carisoprodol/aspirin/codeine	T1	PA
<b>ANALGESICS (Urinary Tract Conditions)</b>		
<b>URINARY TRACT ANALGESIC AGENTS</b>		
ELMIRON	T2	
RIMSO-50	T2	
<b>ANESTHETICS (Miscellaneous)</b>		
<b>GENERAL ANESTHETICS, INHALANT</b>		
desflurane (Suprane)	T1	
isoflurane	T1	
isoflurane	T3	
sevoflurane (Ultane)	T1	

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

T4 – Specialty Medications

PA – Prior Authorization

QL – Quantity Limit

ST – Step Therapy

AGE – Age Requirement

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HD – May require home delivery pharmacy

PPACA – No Cost-Share Preventive Medication

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## List of Prescription Medications

ANESTHETICS (Miscellaneous) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>GENERAL ANESTHETICS, INHALANT (cont.)</b>		
SUPRANE	T3	
ULTANE ( <i>sevoflurane</i> )	T3	
<b>GENERAL ANESTHETICS, INJECTABLE</b>		
AMIDATE	T3	
AMIDATE ( <i>etomidate</i> )	T3	
BREVITAL SODIUM	T3	
DIPRIVAN ( <i>propofol</i> )	T3	
<i>etomidate</i> (Amidate)	T1	
KETALAR	T3	
KETALAR ( <i>ketamine hcl</i> )	T3	
KETAMINE HCL	T1	
<i>ketamine hcl</i> (Ketalar)	T1	
<i>ketamine hcl in 0.9 % nacl</i>	T1	
<i>ketamine hcl in 0.9 % nacl</i> (Ketamine Hcl-0.9% Nacl)	T1	
KETAMINE HCL-0.9% NAACL	T1	
KETAMINE HCL-0.9% NAACL ( <i>ketamine hcl-0.9% nacl</i> )	T1	
METHOHEXITAL-STERILE WATER	T1	
PROPOFOL	T1	
<i>propofol</i> (Diprivan)	T1	
<b>GENERAL ANESTHETICS, INJECTABLE-BENZODIAZEPINE TYPE</b>		
<i>midazolam hcl/hcl pf</i>	T1	
ANESTHETICS (Pain Relief And Inflammatory Disease)		
<b>LOCAL ANESTHETICS</b>		
ARTICADENT DENTAL	T3	
BUFFERED LIDOCAINE	T1	
BUPIVACAINE HCL	T1	
<i>bupivacaine hcl</i> (Marcaine)	T1	
<i>bupivacaine hcl</i> (Sensorcaine)	T1	
<i>bupivacaine hcl in dextrose/pf</i> (Sensorcaine With Dextrose)	T1	
<i>bupivacaine hcl/epinephrine</i> (Marcaine-epinephrine)	T1	
<i>bupivacaine hcl/epinephrine/pf</i> (Sensorcaine-mpf Epinephrine)	T1	
<i>bupivacaine hcl/pf</i> (Marcaine)	T1	
<i>bupivacaine hcl/pf</i> (Sensorcaine-mpf)	T1	

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

T4 – Specialty Medications

PA – Prior Authorization

QL – Quantity Limit

ST – Step Therapy

AGE – Age Requirement

SP – Specialty Medication

HD – May require home delivery pharmacy

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## List of Prescription Medications

### ANESTHETICS (Pain Relief And Inflammatory Disease) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>LOCAL ANESTHETICS (cont.)</b>		
BUPIVACAINE HCL-0.9% NACL	T1	
CARBOCAINE ( <i>polocaine</i> )	T3	
CARBOCAINE ( <i>polocaine-mpf</i> )	T3	
<i>chloroprocaine hcl/pf</i> (Nesacaine-mpf)	T1	
CITANEST FORTE DENTAL	T3	
CITANEST PLAIN DENTAL	T3	
CLOROTEKAL	T3	
EXPAREL	T3	
<i>lidocaine hcl</i> (Xylocaine)	T1	
<i>lidocaine hcl 1% vial</i> (Xylocaine-mpf)	T1	
<i>lidocaine hcl 1.5% ampul</i> (Xylocaine-mpf)	T1	
<i>lidocaine hcl 10 mg/ml syringe, 100 mg/10 ml/syr</i>	T1	
<i>lidocaine hcl 2% 100 mg/5 ml</i> (Xylocaine-mpf)	T1	
<i>lidocaine hcl 2% 40 mg/2 ml</i> (Xylocaine-mpf)	T1	
<i>lidocaine hcl 2% 40 mg/2 ml vl</i> (Xylocaine-mpf)	T1	
<i>lidocaine hcl 2% ampul</i> (Xylocaine-mpf)	T1	
<i>lidocaine hcl 2% jel urojet ac</i>	T1	
<i>lidocaine hcl 2% jelly</i>	T1	
<i>lidocaine hcl 2% jelly uro-jet</i>	T1	
<i>lidocaine hcl 2% vial</i> (Xylocaine)	T1	
<i>lidocaine hcl 2% vial</i> (Xylocaine-mpf)	T1	
LIDOCAINE HCL 200 MG/10 ML SYR	T1	
LIDOCAINE HCL 30 MG/3 ML SYR	T1	
<i>lidocaine hcl 4% ampul, 4% solution</i>	T1	
<i>lidocaine hcl/dextrose 7.5%/pf</i>	T1	
<i>lidocaine hcl/epinephrine</i> (Xylocaine With Epinephrine)	T1	
<i>lidocaine hcl/epinephrine bit</i> (Lidocaine-epinephrine)	T3	
<i>lidocaine hcl/epinephrine/pf</i> (Xylocaine With Epinephrine)	T1	
<i>lidocaine hcl/epinephrine/pf</i> (Xylocaine-mpf With Epinephrine)	T1	
LIDOCANE HCL-0.9% NACL	T1	
LIDOCANE-EPINEPHRINE	T1	
LIDOCAN II ( <i>lidocaine</i> )	T1	
MARCAINE ( <i>bupivacaine hcl</i> )	T3	

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

T4 – Specialty Medications

PA – Prior Authorization

QL – Quantity Limit

ST – Step Therapy

AGE – Age Requirement

SP – Specialty Medication

HD – May require home delivery pharmacy

PPACA – No Cost-Share Preventive Medication

CSL – Oral cancer medication subject to cost-share limits

## List of Prescription Medications

### ANESTHETICS (Pain Relief And Inflammatory Disease) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>LOCAL ANESTHETICS (cont.)</b>		
MARCAINE ( <i>sensorcaine</i> )	T3	
MARCAINE ( <i>sensorcaine-mpf</i> )	T3	
MARCAINE SPINAL	T3	
MARCAINE-EPINEPHRINE	T3	
MARCAINE-EPINEPHRINE ( <i>bupivacaine hcl-epinephrine</i> )	T3	
MARCAINE-EPINEPHRINE ( <i>sensorcaine-epinephrine</i> )	T3	
<i>mepivacaine hcl</i> (Carbocaine)	T1	
<i>mepivacaine hcl/pf</i>	T1	
<i>mepivacaine hcl/pf</i>	T3	
<i>mepivacaine hcl/pf</i> (Carbocaine)	T1	
NAROPIN	T3	
NESACAIN	T3	
NESACAIN-MPF ( <i>chloroprocaine hcl</i> )	T3	
ORABLOC	T3	
POLOCAINE	T1	
<i>ropivacaine 0.2% 20 mg/10 ml</i> (Naropin)	T1	
<i>ropivacaine 0.2% 200 mg/100 ml</i> (Naropin)	T1	
<i>ropivacaine 0.2% 40 mg/20 ml</i> (Naropin)	T1	
<i>ropivacaine 0.2% 400 mg/200 ml</i> (Naropin)	T1	
ROPIVACAIN 0.2% SYRINGE	T1	
<i>ropivacaine 0.5% 100 mg/20 ml</i> (Naropin)	T1	
ROPIVACAIN 0.5% 1000 MG/200ML	T3	
<i>ropivacaine 0.5% 150 mg/30 ml</i> (Naropin)	T1	
ROPIVACAIN 0.5% 500 MG/100 ML	T3	
ROPIVACAIN 0.5% BAG	T1	
<i>ropivacaine 0.75% 150 mg/20 ml</i> (Naropin)	T1	
<i>ropivacaine 1% 100 mg/10 ml v1</i> (Naropin)	T1	
<i>ropivacaine 1% 200 mg/20 ml v1</i> (Naropin)	T1	
ROPIVACAIN 50 MG/10 ML SYRNG	T1	
ROPIVACAIN HCL 0.2% ON-Q PUMP	T1	
ROPIVACAIN HCL 0.5% SYRINGE	T1	
ROPIVACAIN HCL-0.9% NAACL	T1	
ROPIVACAIN HCL-NAACL	T1	
SENSORC MPF 0.75%-EPI 1:200000	T3	

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

T4 – Specialty Medications

PA – Prior Authorization

QL – Quantity Limit

ST – Step Therapy

AGE – Age Requirement

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## List of Prescription Medications

### ANESTHETICS (Pain Relief And Inflammatory Disease) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>LOCAL ANESTHETICS (cont.)</b>		
SENSORCAINE 0.25% VIAL ( <i>bupivacaine hcl</i> )	T3	
<i>sensorcaine 0.5% vial</i> (Marcaine)	T1	
SENSORCAINE WITH DEXTROSE	T1	
SENSORCAINE-MPF 0.25% AMPUL ( <i>bupivacaine hcl</i> )	T3	
SENSORCAINE-MPF 0.25% VIAL ( <i>bupivacaine hcl</i> )	T3	
SENSORCAINE-MPF 0.5% AMPUL ( <i>bupivacaine hcl</i> )	T3	
<i>sensorcaine-mpf 0.5% vial</i> (Marcaine)	T1	
SENSORCAINE-MPF 0.75% AMPUL ( <i>bupivacaine hcl</i> )	T1	
SENSORCAINE-MPF 0.75% VIAL ( <i>marcaine</i> )	T3	
SENSORC-MPF 0.25%-EPI 1:200000 ( <i>bupivacaine hcl-epinephrine</i> )	T1	
SENSORCN-MPF 0.5%-EPI 1:200000 ( <i>bupivacaine hcl-epinephrine</i> )	T3	
<i>tetracaine hcl/pf</i>	T1	
XYLOCAINE ( <i>lidocaine hcl</i> )	T3	
XYLOCAINE WITH EPINEPHRINE ( <i>lidocaine hcl-epinephrine</i> )	T3	
XYLOCAINE-MPF	T3	
XYLOCAINE-MPF ( <i>lidocaine hcl</i> )	T3	
XYLOCAINE-MPF WITH EPINEPHRINE	T3	
XYLOCAINE-MPF WITH EPINEPHRINE ( <i>lidocaine hcl-epinephrine</i> )	T3	
ZINGO	T3	
<b>TOPICAL LOCAL ANESTHETICS</b>		
L.E.T. (LIDO-EPINEPH-TETRA)	T3	
<i>lidocaine 5% ointment</i>	T1	QL (145gm/30 days)
<i>lidocaine 5% patch</i> (Lidoderm)	T1	
<i>lidocaine</i> (Lidocan II)	T1	
<i>lidocaine</i> (Lidoderm)	T1	
<i>lidocaine hcl</i>	T1	
<i>lidocaine/prilocaine</i>	T1	
LIDODERM ( <i>lidocaine</i> )	T3	
PAIN EASE MEDIUM STREAM SPRAY	T3	
SYNERA	T3	PA
ZTLIDO	T2	

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

T4 – Specialty Medications

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## List of Prescription Medications

ANESTHETICS (Urinary Tract Conditions)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>URINARY TRACT ANESTHETIC/ANALGESIC AGNT (AZO-DYE)</b>		
phenazopyridine hcl (Pyridium)	T1	
PYRIDIUM (phenazopyridine hcl)	T3	
<b>ANTI-ALLERGY (Allergy/Nasal Sprays)</b>		
<b>MAST CELL STABILIZERS</b>		
cromolyn 100 mg/5 ml oral conc (Gastrocrom)	T1	
GASTROCROM (cromolyn sodium)	T3	
<b>ANTI-ARTHRITICS (Pain Relief and Inflammatory Disease)</b>		
<b>ANALGESIC/ANTIPYRETICS, SALICYLATES</b>		
DISALCID (salsalate)	T3	HD
salsalate (Disalcid)	T1	HD
<b>ANTI-ARTHRITIC AND CHELATING AGENTS</b>		
CUPRIMINE (penicillamine)	T4	PA SP
DEPEN (penicillamine)	T4	PA SP
penicillamine	T4	PA SP
penicillamine (Depen)	T4	PA SP
<b>ANTI-ARTHRITIC, FOLATE ANTAGONIST AGENTS</b>		
OTREXUP	T2	PA
RASUVO	T3	PA
<b>ANTI-INFLAM. INTERLEUKIN-1 RECEPTOR ANTAGONIST</b>		
KINERET	T4	PA QL (28 syringes/28 days) SP
<b>ANTI-INFLAMMATORY, PYRIMIDINE SYNTHESIS INHIBITOR</b>		
ARAVA (leflunomide)	T3	HD
leflunomide (Arava)	T1	HD
<b>ANTI-INFLAMMATORY, PHOSPHODIESTERASE-4(PDE4) INHIB.</b>		
OTEZLA 28 DAY STARTER PACK	T4	PA QL (1 pack/180 days) SP HD
OTEZLA TABLET	T4	PA QL (2 tabs/day) SP HD
<b>ANTI-INFLAMMATORY/ANTIARTHRITICS AGENTS, MISC.</b>		
DUROLANE	T4	PA SP HD
EUFLEXXA	T4	PA SP HD
GEL-ONE	T4	PA SP HD
GELSYN-3	T4	PA SP HD
GENVISC 850	T4	PA SP
HYALGAN	T4	PA SP HD
HYMOVIS	T4	PA SP HD

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

T4 – Specialty Medications

PA – Prior Authorization

QL – Quantity Limit

ST – Step Therapy

AGE – Age Requirement

SP – Specialty Medication

HD – May require home delivery pharmacy

PPACA – No Cost-Share Preventive Medication

CSL – Oral cancer medication subject to cost-share limits

## List of Prescription Medications

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

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>ANTI-INFLAMMATORY/ANTIARTHRITICS AGENTS, MISC. (cont.)</b>		
MONOVISC	T4	PA SP HD
ORTHOVISC	T4	PA SP HD
SODIUM HYALURONATE	T4	PA SP
SUPARTZ FX	T4	PA SP HD
SYNOJOINT	T4	PA SP
SYNVISC	T4	PA SP HD
SYNVISC-ONE	T4	PA SP HD
TRILURON	T4	PA SP HD
TRIVISC	T4	PA SP
VISCO-3	T4	PA SP HD
<b>ANTI-INFLAMMATORY, SEL.COSTIM.MOD., T-CELL INHIBITOR</b>		
ORENCIA	T3	PA QL (4 syringes/28 days) SP HD
ORENCIA CLICKJECT	T3	PA QL (4 injectors/28 days) SP HD
<b>COLCHICINE</b>		
colchicine 0.6mg capsule	T1	HD
colchicine 0.6 mg capsule (Mitigare)	T1	HD
colchicine 0.6 mg tablet (Colcrys)	T3	HD
GLOPERBA	T3	PA QL (10ml/day) HD
MITIGARE (colchicine)	T3	
<b>GOLD SALTS</b>		
RIDAURA	T2	
<b>HYPERURICEMIA TX - URATE-OXIDASE ENZYME-TYPE</b>		
ELITEK	T4	SP
KRYSTEXXA	T4	PA SP
<b>HYPURICEMIA TX - XANTHINE OXIDASE INHIBITORS</b>		
allopurinol (Zyloprim)	T1	PA HD
febuxostat 40 mg tablet (Uloric)	T1	QL (1 tab/day) HD
febuxostat 80 mg tablet (Uloric)	T1	HD
ULORIC 40 MG TABLET (febuxostat)	T3	QL (1 tab/day) HD
ULORIC 80 MG TABLET (febuxostat)	T3	HD
ZYLOPRIM (allopurinol)	T3	HD
<b>JANUS KINASE (JAK) INHIBITORS</b>		
CIBINQO	T4	PA QL (30 tabs/30 days) SP
LITFULO	T4	PA QL(1 cap/day) SP HD

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

T4 – Specialty Medications

PA – Prior Authorization

QL – Quantity Limit

ST – Step Therapy

AGE – Age Requirement

SP – Specialty Medication

HD – May require home delivery pharmacy

PPACA – No Cost-Share Preventive Medication

CSL – Oral cancer medication subject to cost-share limits

## List of Prescription Medications

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

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>JANUS KINASE (JAK) INHIBITORS (cont.)</b>		
OLUMIANT	T4	PA QL (1 tab/day) SP HD
RINVOQ	T4	PA QL (1 tab/day) SP HD
RINVOQ LQ	T4	PA QL(12 mls/day) SP HD
XELJANZ 1 MG/ML SOLUTION	T4	PA QL (480ML/22 Days) SP HD
XELJANZ 10 MG TABLET	T4	PA QL (2 tabs/day) SP HD
XELJANZ 5 MG TABLET	T4	PA QL (2 tabs/day) SP HD
XELJANZ XR	T4	PA QL (1 tab/day) SP HD
<b>NSAID ANALGESIC AND NON-SALICYLATE ANALGESIC COMB</b>		
COMBOGESIC IV	T3	PA HD
<b>NSAID AND HISTAMINE H2 RECEPTOR ANTAGONIST COMB.</b>		
DUEXIS	T3	PA HD
<b>NSAIDS (COX NON-SPEC.INHIB) AND PROSTAGLANDIN ANALOG</b>		
ARTHROTEC 50 ( <i>diclofenac sodium-misoprostol</i> )	T3	ST HD
ARTHROTEC 75 ( <i>diclofenac sodium-misoprostol</i> )	T3	ST HD
<i>diclofenac sodium-misoprostol</i> (Arthrotec 50)	T1	HD
<i>diclofenac sodium-misoprostol</i> (Arthrotec 75)	T1	HD
<b>NSAIDS, CYCLOOXYGENASE INHIBITOR - TYPE ANALGESICS</b>		
ANAPROX DS ( <i>naproxen sodium ds</i> )	T3	ST HD
CALDOLOR	T3	
COXANTO	T3	PA 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
etodolac	T1	HD
etodolac (Lodine)	T1	HD
FELDENE ( <i>piroxicam</i> )	T3	ST HD
FENOPROFEN	T3	PA HD
<i>fenoprofen calcium</i> (Nalfon)	T1	HD

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

T4 – Specialty Medications

PA – Prior Authorization

QL – Quantity Limit

ST – Step Therapy

AGE – Age Requirement

SP – Specialty Medication

HD – May require home delivery pharmacy

PPACA – No Cost-Share Preventive Medication

CSL – Oral cancer medication subject to cost-share limits

## List of Prescription Medications

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

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>NSAIDS, CYCLOOXYGENASE INHIBITOR - TYPE ANALGESICS (cont.)</b>		
<i>flurbiprofen</i>	T1	HD
<i>ibuprofen</i>	T1	HD
<i>indomethacin</i>	T1	HD
<i>ketoprofen 25 mg, 75 mg capsule</i>	T1	PA HD
<i>LODINE (etodolac)</i>	T3	ST HD
<i>meclofenamate sodium</i>	T1	HD
<i>meloxicam (Mobic)</i>	T1	HD
<i>MOBIC (meloxicam)</i>	T3	ST HD
<i>nabumetone</i>	T1	HD
<i>NALFON 600 MG TABLET (profeno)</i>	T1	ST HD
<i>NAPROSYN TABLET (naproxen)</i>	T3	ST HD
<i>naproxen (Ec-naprosyn)</i>	T1	HD
<i>naproxen (Naprosyn)</i>	T1	HD
<i>naproxen sodium (Anaprox Ds)</i>	T1	HD
<i>oxaprozin 600 mg caplet (Daypro)</i>	T1	HD
<i>oxaprozin 600 mg tablet (Daypro)</i>	T1	HD
<i>OXAPROZIN 300 MG CAPSULE</i>	T3	PA HD
<i>piroxicam</i>	T1	HD
<i>QMIIZ ODT 15 MG TABLET</i>	T3	ST HD
<i>QMIIZ ODT 7.5 MG TABLET</i>	T3	QL (1 tab/day) ST HD
<i>sulindac</i>	T1	HD
<i>TOLECTIN 600 (tolmetin sodium)</i>	T3	PA HD
<i>tolmetin sodium (Tolectin 600)</i>	T1	HD
<b>NSAIDS, CYCLOOXYGENASE-2(COX-2) SELECTIVE INHIBITOR</b>		
<i>CELEBREX 100 MG, 200 MG CAPSULE (celecoxib)</i>	T3	QL (2 caps/day) ST HD
<i>CELEBREX 400 MG CAPSULE (celecoxib)</i>	T3	QL (1 cap/day) ST HD
<i>CELEBREX 50 MG CAPSULE (celecoxib)</i>	T3	QL (2 caps/day) ST HD
<i>celecoxib 100 mg capsule (Celebrex)</i>	T1	QL(2 caps/day) HD
<i>celecoxib 200 mg capsule (Celebrex)</i>	T1	QL (2 caps/day) HD
<i>celecoxib 400 mg capsule (Celebrex)</i>	T1	QL (1 cap/day) HD
<i>celecoxib 50 mg capsule (Celebrex)</i>	T1	QL (2 caps/day) HD
<b>URICOSURIC AGENTS</b>		
<i>probencid</i>	T1	HD
<i>probencid/colchicine</i>	T1	HD

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

T4 – Specialty Medications

PA – Prior Authorization

QL – Quantity Limit

ST – Step Therapy

AGE – Age Requirement

SP – Specialty Medication

HD – May require home delivery pharmacy

PPACA – No Cost-Share Preventive Medication

CSL – Oral cancer medication subject to cost-share limits

## List of Prescription Medications

### ANTI-ASTHMATICS (Asthma/COPD/Respiratory)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits	
<b>5-LIPOXYGENASE INHIBITORS</b>			
zileuton	T1	HD	
<b>ANTICHOLINERGICS, ORALLY INHALED LONG ACTING</b>			
INCRUSE ELLIPTA	T2	HD	
SPIRIVA RESPIMAT	T2	HD	
<b>ANTICHOLINERGICS, ORALLY INHALED SHORT ACTING</b>			
ATROVENT HFA	T2	HD	
<i>ipratropium bromide</i>	T1	HD	
<b>BETA-ADRENERGIC AGENTS</b>			
<i>albuterol sulf 2 mg/5 ml syrup</i>	T1	HD	
<i>albuterol sulfate tab</i>	T1	HD	
<i>albuterol sulfate er 4 mg tab</i>	T1	HD	
<i>albuterol sulfate er 8 mg tab</i>	T1	HD	
<i>metaproterenol sulfate</i>	T1	HD	
<i>terbutaline sulfate</i>	T1	HD	
<b>BETA-ADRENERGIC AGENTS, INHALED, SHORT ACTING</b>			
<i>albuterol 100 mg/20 ml soln</i>	T1		
<i>albuterol 2.5 mg/0.5 ml sol</i>	T1		
<i>albuterol 5 mg/ml solution</i>	T1		
<i>albuterol sul 0.63 mg/3 ml sol</i>	T1		
<i>albuterol sul 1.25 mg/3 ml sol</i>	T1		
<i>albuterol sul 2.5 mg/3 ml soln</i>	T1		
<i>albuterol sulfate (Albuterol Sulfate Hfa)</i>	T1	QL (18gm/30 days)	
ALBUTEROL SULFATE HFA	T1	QL (18gm/30 days)	
<i>levalbuterol hcl (Xopenex Concentrate)</i>	T1		
<i>levalbuterol hcl (Xopenex)</i>	T1		
XOPENEX ( <i>levalbuterol hcl</i> )	T3		
XOPENEX CONCENTRATE ( <i>levalbuterol concentrate</i> )	T3		
<b>BETA-ADRENERGIC AGENTS, INHALED, ULTRA-LONG ACTING</b>			
ARCAPTA NEOHALER	T3	HD	
STRIVERDI RESPIMAT	T2	QL(1 inhaler/30 days) HD	
<b>BETA-ADRENERGIC AGENTS, ORALLY INHALED, LONG ACTING</b>			
BROVANA ( <i>arformoterol tartrate</i> )			
SEREVENT DISKUS	T3	ST QL(1 blister/30 days) HD	
<b>BETA-ADRENERGIC AND ANTICHOLINERGIC COMBO, INHALED</b>			
ANORO ELLIPTA	T2	HD	
T1 – Typically Generics	T4 – Specialty Medications	ST – Step Therapy	HD – May require home delivery pharmacy
T2 – Typically Preferred Brands	PA – Prior Authorization	AGE – Age Requirement	PPACA – No Cost-Share Preventive Medication
T3 – Typically Non-Preferred Brands	QL – Quantity Limit	SP – Specialty Medication	CSL – Oral cancer medication subject to cost-share limits

## List of Prescription Medications

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

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>BETA-ADRENERGIC AND ANTICHOLINERGIC COMBO, INHALED (cont.)</b>		
BEVESPI AEROSPHERE	T3	PA QL(1 inhaler/30 days) HD
COMBIVENT RESPIMAT	T2	HD
<i>ipratropium/albuterol sulfate</i>	T1	HD
STIOLTO RESPIMAT INHAL SPRAY	T2	HD
<b>BETA-ADRENERGIC AGENTS AND GLUCOCORTICOID COMBO, INHALED</b>		
ADVAIR HFA	T2	HD
AIRDUO DIGIHALER	T3	ST HD
AIRSUPRA	T2	PA QL(1 gm/28 days) HD
BREO ELLIPTA	T2	QL(1 inhaler/30 days) HD
<i>budesonide/formoterol fumarate (Symbicort)</i>	T1	QL HD
DULERA	T2	HD
<i>fluticasone propion/salmeterol (Advair Diskus)</i>	T1	QL(1 inhaler/30 days)
<i>fluticasone-salmeterol 100-50 (Advair Diskus)</i>	T3	QL(1 inhaler/30 days) HD
<i>fluticasone-salmeterol 250-50 (Advair Diskus)</i>	T3	QL(1 inhaler/30 days) HD
<i>fluticasone-salmeterol 500-50 (Advair Diskus)</i>	T3	QL(1 inhaler/30 days) HD
FLUTICASONE-SALMETEROL 113-14	T1	QL(1 inhaler/30 days) HD
FLUTICASONE-SALMETEROL 232-14	T1	QL(1 inhaler/30 days) HD
FLUTICASONE-SALMETEROL 55-14	T1	QL(1 inhaler/30 days) HD
SYMBICORT	T3	ST QL(1 inhaler/30 days) HD
<b>BETA-ADRENERGIC-ANTICHOLINERGIC-GLUCOCORT, INHALED</b>		
BREZTRI AEROSPHERE	T2	
TRELEGY ELLIPTA	T2	
<b>GLUCOCORTICOIDS, ORALLY INHALED</b>		
ALVESCO	T2	HD
<i>budesonide (Pulmicort)</i>	T1	HD
FLOVENT DISKUS	T3	PA QL(1 inhalers/30 days) HD
FLOVENT HFA	T2	PA QL(1 inhalers/30 days) HD
FLUTICASONE PROP DISKUS	T3	PA QL(1 inhaler/30 days) HD
PULMICORT ( <i>budesonide</i> )	T3	HD
PULMICORT FLEXHALER	T3	PA HD
QVAR REDIHALER	T2	HD
<b>INTERLEUKIN-5(IL-5) RECEPTOR ALPHA ANTAGONIST, MAB</b>		
FASENRA PEN	T4	PA SP HD

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

T4 – Specialty Medications

PA – Prior Authorization

QL – Quantity Limit

ST – Step Therapy

AGE – Age Requirement

SP – Specialty Medication

HD – May require home delivery pharmacy

PPACA – No Cost-Share Preventive Medication

CSL – Oral cancer medication subject to cost-share limits

## List of Prescription Medications

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

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits	
<b>LEUKOTRIENE RECEPTOR ANTAGONISTS</b>			
ACCOLATE (zaflurkast)	T3	HD	
montelukast sodium (Singulair)	T1	HD	
SINGULAIR (montelukast sodium)	T3	HD	
zaflurkast (Accolate)	T1	HD	
<b>MAST CELL STABILIZERS, ORALLY INHALED</b>			
cromolyn 20 mg/2 ml neb soln	T1	QL (480ml/30 days) HD	
<b>MONOCLONAL ANTIBODIES TO IMMUNOGLOBULIN E (IGE)</b>			
XOLAIR	T4	PA SP HD	
<b>MONOCLONAL ANTIBODY - INTERLEUKIN-5 ANTAGONISTS</b>			
NUCALA	T4	PA SP HD	
<b>MUCOLYTICS</b>			
acetylcysteine	T1		
<b>PHOSPHODIESTERASE-4 (PDE4) INHIBITORS</b>			
DALIRESP 250 MCG TABLET	T3	QL (28 tabs/180 days) HD	
DALIRESP 500 MCG TABLET	T3	QL (2 tabs/day) HD	
roflumilast 250 mcg tablet (Daliresp)	T3	QL (28 tabs/180 days) HD	
roflumilast 500 mcg tablet (Daliresp)	T3	QL (2 tabs/day) HD	
<b>XANTHINES</b>			
aminophylline	T1		
THEO-24	T2	HD	
theophylline anhydrous	T1	HD	
<b>ANTIBIOTICS (Allergy/Nasal Sprays)</b>			
<b>NOSE PREPARATIONS ANTIBIOTICS</b>			
BACTROBAN NASAL	T2		
<b>ANTIBIOTICS (Ear Medications)</b>			
<b>EAR PREPARATIONS, ANTIBIOTICS</b>			
ciprofloxacin hcl	T1		
CORTISPORIN-TC	T3		
neomycin/polymyxin b/hydrocort	T1		
ofloxacin	T1		
<b>OTIC PREPARATIONS, ANTI-INFLAMMATORY-ANTIBIOTICS</b>			
CIPRO HC	T2		
CIPRODEX (ciprofloxacin-dexamethasone)	T3	PA	
ciprofloxacin hcl/dexameth (Ciprodex)	T1		
T1 – Typically Generics	T4 – Specialty Medications	ST – Step Therapy	HD – May require home delivery pharmacy
T2 – Typically Preferred Brands	PA – Prior Authorization	AGE – Age Requirement	PPACA – No Cost-Share Preventive Medication
T3 – Typically Non-Preferred Brands	QL – Quantity Limit	SP – Specialty Medication	CSL – Oral cancer medication subject to cost-share limits

## List of Prescription Medications

### ANTIBIOTICS (Ear Medications) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>OTIC PREPARATIONS, ANTI-INFLAMMATORY-ANTIBIOTICS (cont.)</b>		
CIPROFLOXACIN HCL-FLUOCINOLONE	T3	
OTOVEL	T3	
<b>ANTIBIOTICS (Eye Conditions)</b>		
<b>EYE ANTIBIOTIC AND GLUCOCORTICOID COMBINATIONS</b>		
MAXITROL ( <i>neomycin-polymyxin-dexameth</i> )	T3	PA
<i>neomycin/bacit/p-myx/hydrocort</i>	T1	
<i>neomycin/polymyxin b/dexametha</i> (Maxitrol)	T1	
<i>neomycin/polymyxin b/hydrocort</i>	T1	
TOBRADEX EYE DROPS ( <i>tobramycin-dexamethasone</i> )	T3	PA
TOBRADEX EYE OINTMENT	T2	
TOBRADEX ST	T3	
<i>tobramycin/dexamethasone</i> (Tobradex)	T1	
ZYLET	T3	
<b>EYE SULFONAMIDES</b>		
BLEPH-10 ( <i>sulfacetamide sodium</i> )	T3	
BLEPHAMIDE	T2	
<i>sulfacetamide sodium</i>	T1	
<i>sulfacetamide sodium</i> (Bleph-10)	T1	
<i>sulfacetamide/prednisolone sp</i>	T1	
<b>OPHTHALMIC ANTIBIOTICS</b>		
AZASITE	T2	
BACIGUENT ( <i>bacitracin</i> )	T3	
<i>bacitracin</i> (Baciguent)	T1	
<i>bacitracin/polymyxin b sulfate</i>	T1	
BESIVANCE	T2	
CILOXAN	T2	
<i>erythromycin base</i>	T1	
<i>gatifloxacin</i>	T1	
<i>gentamicin sulfate</i>	T1	
<i>levofloxacin</i>	T1	
MOXEZA ( <i>moxifloxacin</i> )	T3	
<i>moxifloxacin hcl</i> (Moxeza)	T1	
<i>moxifloxacin hcl</i> (Vigamox)	T1	
<i>neomycin sulf/bacitracin/poly</i>	T1	

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

T4 – Specialty Medications

PA – Prior Authorization

QL – Quantity Limit

ST – Step Therapy

AGE – Age Requirement

SP – Specialty Medication

HD – May require home delivery pharmacy

PPACA – No Cost-Share Preventive Medication

CSL – Oral cancer medication subject to cost-share limits

## List of Prescription Medications

### ANTIBIOTICS (Eye Conditions) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>OPHTHALMIC ANTIBIOTICS (cont.)</b>		
<i>neomycin/polymyxin b/gramicidin</i>	T1	
OCUFLOX ( <i>ofloxacin</i> )	T3	PA
<i>ofloxacin</i> (Ocuflax)	T1	
<i>polymyxin b sulf(trimethoprim</i>	T1	
<i>tobramycin 0.3% eye drop (Tobrex)</i>	T1	
TOBREX	T3	PA
VIGAMOX ( <i>moxifloxacin</i> )	T3	PA

### ANTIBIOTICS (Infections)

<b>2ND GEN. ANAEROBIC ANTIprotozoal-ANTIBACTERIAL</b>		
SOLOSEC	T2	
<b>ABSORBABLE SULFONAMIDE ANTIBACTERIAL AGENTS</b>		
<i>BACTRIM (sulfamethoxazole-trimethoprim)</i>	T3	
<i>BACTRIM DS (sulfamethoxazole-trimethoprim)</i>	T3	
<i>sulfadiazine</i>	T1	
<i>sulfamethoxazole(trimethoprim</i>	T1	
<i>sulfamethoxazole(trimethoprim</i>	T3	
<i>sulfamethoxazole(trimethoprim (Bactrim Ds)</i>	T1	
<i>sulfamethoxazole(trimethoprim (Bactrim)</i>	T1	
<b>AMINOGLYCOSIDE ANTIBIOTICS</b>		
<i>amikacin sulfate</i>	T1	
ARIKAYCE	T4	PA SP
<i>BETHKIS (tobramycin)</i>	T4	PA QL (8ml/day) SP HD
<i>gentamicin in nacl, iso-osm</i>	T1	
<i>gentamicin sulfate</i>	T1	
GENTAMICIN SULFATE IN NS	T1	
<i>gentamicin sulfate/pf</i>	T1	
KITABIS PAK	T4	PA QL (10ml/day) SP HD
<i>neomycin sulfate</i>	T1	
STREPTOMYcin SULFATE	T1	
TOBI ( <i>tobramycin</i> )	T4	PA QL (10ml/day) SP HD
TOBI PODHALER	T4	PA QL (8 caps/day) SP HD
<i>tobramycin 300 mg/4 ml ampule (Bethkis)</i>	T4	PA QL (28 Therapy/56 Days) SP HD
<i>tobramycin 300 mg/5 ml ampule (Tobi)</i>	T4	PA QL (10ml/day) SP HD
TOBRAMYCIN PAK 300 MG/5 ML	T4	PA QL (10ml/day) SP HD

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

T4 – Specialty Medications

PA – Prior Authorization

QL – Quantity Limit

ST – Step Therapy

AGE – Age Requirement

SP – Specialty Medication

HD – May require home delivery pharmacy

PPACA – No Cost-Share Preventive Medication

CSL – Oral cancer medication subject to cost-share limits

## List of Prescription Medications

ANTIBIOTICS (Infections) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>AMINOGLYCOSIDE ANTIBIOTICS (cont.)</b>		
<i>tobramycin sulfate</i>	T1	
<i>tobramycin/sodium chloride</i>	T1	
ZEMDRI	T3	
<b>ANAEROBIC ANTIPROTOZOAL-ANTIBACTERIAL AGENTS</b>		
FLAGYL ( <i>metronidazole</i> )	T3	
LIKMEZ	T3	PA
<i>metronidazole</i> (Flagyl)	T1	
<i>metronidazole/sodium chloride</i>	T1	
<b>ANTIBIOTIC, ANTIBACTERIAL, MISC.</b>		
<i>fosfomycin tromethamine</i> (Monurol)	T1	
HIPREX ( <i>methenamine hippurate</i> )	T3	
<i>methenamine hippurate</i>	T1	
<i>methenamine mandelate</i>	T1	
MONUROL ( <i>fosfomycin tromethamine</i> )	T3	
PRIMSOL	T3	
<i>trimethoprim</i>	T1	
UTA	T3	
<b>ANTIBIOTICS, MISCELLANEOUS, OTHER</b>		
<i>bacitracin</i>	T1	
<b>ANTILEPROTICS</b>		
<i>dapsone 100 mg tablet</i>	T1	
<i>dapsone 25 mg tablet</i>	T1	
THALOMID	T4	PA SP HD
<b>ANTI-MYCOBACTERIUM AGENTS</b>		
<i>ethambutol hcl</i>	T1	HD
<i>ethambutol hcl</i> (Myambutol)	T1	HD
<i>isoniazid</i>	T1	HD
MYAMBUTOL ( <i>ethambutol hcl</i> )	T3	HD

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

T4 – Specialty Medications

PA – Prior Authorization

QL – Quantity Limit

ST – Step Therapy

AGE – Age Requirement

SP – Specialty Medication

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## List of Prescription Medications

ANTIBIOTICS (Infections) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>ANTI-MYCOBACTERIUM AGENTS (cont.)</b>		
PASER	T2	HD
<i>pyrazinamide</i>	T1	HD
<i>rifabutin</i> (Mycobutin)	T1	HD
TRECATOR	T2	HD
<b>ANTI-TUBERCULAR ANTIBIOTICS</b>		
CAPASTAT SULFATE	T3	
CYCLOSERINE	T1	
<i>cycloserine</i>	T1	
PRETOMANID	T3	PA QL (1 tab/day)
PRIFTIN	T3	
RIFADIN ( <i>rifampin</i> )	T3	
RIFAMATE	T2	
<i>rifampin</i>	T1	
<i>rifampin</i> (Rifadin)	T1	
RIFATER	T2	
SIRTURO	T3	SP
<b>BETALACTAMS</b>		
AZACTAM ( <i>aztreonam</i> )	T3	
<i>aztreonam</i> (Azactam)	T1	
CAYSTON	T4	PA QL (3ml/day) SP HD
<b>CARBAPENEM ANTIBIOTICS (THIENAMYCINS)</b>		
<i>ertapenem sodium</i> (Invanz)	T1	
<i>imipenem/cilastatin sodium</i>	T1	
<i>imipenem/cilastatin sodium</i> (Primaxin)	T1	
INVANZ ( <i>ertapenem</i> )	T3	
<i>meropenem</i> (Merrem)	T1	
MEROPENEM-0.9% NaCl	T1	
PRIMAXIN ( <i>imipenem-cilastatin sodium</i> )	T3	
RECARBIRIO	T3	
VABOMERE	T3	
<b>CEPHALOSPORIN ANTIBIOTICS - 1ST GENERATION</b>		
<i>cefadroxil</i>	T1	
<i>cefazolin sodium</i>	T1	

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

T4 – Specialty Medications

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## List of Prescription Medications

### ANTIBIOTICS (Infections) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>CEPHALOSPORIN ANTIBIOTICS - 1ST GENERATION (cont.)</b>		
<i>cefazolin sodium/dextrose, iso</i>	T1	
<i>cefazolin 3 gm vial</i>	T1	
CEFAZOLIN SODIUM-0.9% NAACL	T1	
CEFAZOLIN SODIUM-D5W	T1	
CEFAZOLIN SODIUM-DEXTROSE	T1	
CEFAZOLIN SODIUM-STERILE WATER	T1	
<i>cephalexin</i>	T1	
<i>cephalexin (Keflex)</i>	T1	
DAXBIA	T3	
KEFLEX ( <i>cephalexin</i> )	T3	
<b>CEPHALOSPORIN ANTIBIOTICS - 2ND GENERATION</b>		
<i>cefaclor</i>	T1	
CEFOTAN	T3	
<i>cefotetan disodium</i>	T1	
<i>cefotetan disodium (Cefotan)</i>	T1	
<i>cefoxitin sodium</i>	T1	
<i>cefoxitin sodium/dextrose, iso</i>	T1	
<i>cefprozil</i>	T1	
<i>cefuroxime axetil</i>	T1	
<i>cefuroxime sodium (Zinacef)</i>	T1	
ZINACEF ( <i>cefuroxime sodium</i> )	T3	
<b>CEPHALOSPORIN ANTIBIOTICS - 3RD GENERATION</b>		
AVYCAZ	T3	
<i>cefdinir</i>	T1	
<i>cefixime (Suprax)</i>	T1	
<i>cefotaxime sodium</i>	T1	
<i>cefpodoxime proxetil</i>	T1	
<i>ceftazidime</i>	T1	
<i>ceftazidime (Fortaz)</i>	T1	
CEFTRIAXONE	T1	
<i>ceftriaxone in is-osm dextrose</i>	T1	

T1 – Typically Generics

T2 – Typically Preferred Brands

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## List of Prescription Medications

ANTIBIOTICS (Infections) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>CEPHALOSPORIN ANTIBIOTICS - 3RD GENERATION (con't)</b>		
ceftriaxone sodium	T1	
CLAFORAN	T3	
FORTAZ	T3	
FORTAZ (tazicef)	T3	
FORTAZ IN ISO-OSMOTIC DEXTROSE	T3	
SUPRAX	T3	
SUPRAX (cefixime)	T3	
<b>CEPHALOSPORIN ANTIBIOTICS - 4TH GENERATION</b>		
CEFEPIME HCL	T1	
cefepime hcl (Maxipime)	T1	
cefepime in iso-osm dextrose	T1	
CEFEPIME-DEXTROSE	T1	
MAXIPIME	T3	
MAXIPIME (cefepime hcl)	T3	
<b>CEPHALOSPORIN ANTIBIOTICS - SIDEROPHORE</b>		
FETROJA	T3	
<b>CEPHALOSPORINS - 5TH GENERATION</b>		
TEFLARO	T3	
ZERBAXA	T3	
<b>CHLORAMPHENICOL ANTIBIOTICS AND DERIVATIVES</b>		
chloramphenicol sod succinate	T1	
<b>GLYCYLCYCLINES</b>		
tigecycline (Tygacil)	T1	
TYGACIL (tigecycline)	T3	
<b>LINCOSAMIDE ANTIBIOTICS</b>		
CLEOCIN HCL 150 MG CAPSULE (clindamycin hcl)	T3	
CLEOCIN HCL 300 MG CAPSULE (clindamycin hcl)	T3	
CLEOCIN HCL 75 MG CAPSULE (clindamycin hcl)	T2	
CLEOCIN PEDIATRIC (clindamycin (pediatric))	T3	
CLEOCIN PHOS 150 MG/ML VIAL (clindamycin phosphate)	T3	
CLEOCIN PHOS 300 MG/2 ML VIAL (clindamycin phosphate)	T3	
cleocin phos 300 mg/2ml addvan	T1	
CLEOCIN PHOS 600 MG/4 ML VIAL (clindamycin phosphate)	T3	
CLEOCIN PHOS 600 MG/4ML ADDVAN (clindamycin phosphate)	T3	

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

T4 – Specialty Medications

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## List of Prescription Medications

### ANTIBIOTICS (Infections) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>LINCOSAMIDE ANTIBIOTICS (con't)</b>		
CLEOCIN PHOS 9 G/60 ML VIAL ( <i>clindamycin phosphate</i> )	T3	
CLEOCIN PHOS 900 MG/6 ML VIAL ( <i>clindamycin phosphate</i> )	T3	
CLEOCIN PHOS 900 MG/6ML ADDVAN ( <i>clindamycin phosphate</i> )	T3	
CLIN SINGLE USE	T3	
<i>clindamycin hcl</i> (Cleocin Hcl)	T1	
<i>clindamycin palmitate hcl</i> (Cleocin Pediatric)	T1	
<i>clindamycin phosphate</i>	T1	
<i>clindamycin phosphate</i> (Cleocin Phosphate)	T1	
<i>clindamycin phosphate/d5w</i>	T3	
CLINDAMYCIN-0.9% NACL	T1	
LINCOCIN	T3	
<i>lincomycin hcl</i> (Lincocin)	T1	
<b>LIPOGLYCOPEPTIDE ANTIBIOTICS</b>		
DALVANCE	T3	
ORBACTIV	T3	
VIBATIV	T3	
<b>MACROLIDE ANTIBIOTICS</b>		
<i>azithromycin 1 gm pwd packet</i> (Zithromax)	T1	
<i>azithromycin 100 mg/5 ml susp</i> (Zithromax)	T1	
<i>azithromycin 200 mg/5 ml susp</i> (Zithromax)	T1	
<i>azithromycin 200 mg/5 ml susp</i> (Zithromax)	T1	
<i>azithromycin 250 mg tablet</i> (Zithromax)	T1	
<i>azithromycin 500 mg add-van v1</i>	T1	
<i>azithromycin 500 mg tablet</i> (Zithromax Tri-pak)	T1	
<i>azithromycin 600 mg tablet</i>	T1	
<i>azithromycin i.v. 500 mg vial</i> (Zithromax)	T1	
<i>clarithromycin</i>	T1	
DIFICID 200 MG TABLET	T3	QL (28 tabs/28 days)
DIFICID 40 MG/ML SUSPENSION	T3	QL (5ml/Day)
E.E.S. 200 ( <i>erythromycin ethylsuccinate</i> )	T3	PA
ERYPED 200 ( <i>erythromycin ethylsuccinate</i> )	T3	
ERYPED 400 ( <i>erythromycin ethylsuccinate</i> )	T3	PA
ERY-TAB ( <i>erythromycin</i> )	T3	
ERYTHROCIN LACTOBIONATE	T3	

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

T4 – Specialty Medications

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## List of Prescription Medications

### ANTIBIOTICS (Infections) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>MACROLIDE ANTIBIOTICS (cont.)</b>		
erythromycin base	T1	
erythromycin base	T3	
erythromycin base (Ery-tab)	T1	
erythromycin ethylsuccinate	T1	
erythromycin ethylsuccinate	T3	
erythromycin ethylsuccinate (Eryped 200)	T1	
erythromycin ethylsuccinate (Eryped 400)	T1	
erythromycin stearate	T1	
PCE	T3	
ZITHROMAX 1 GM POWDER PACKET ( <i>azithromycin</i> )	T3	
ZITHROMAX 100 MG/5 ML SUSP ( <i>azithromycin</i> )	T3	
ZITHROMAX 200 MG/5 ML SUSP ( <i>azithromycin</i> )	T3	
ZITHROMAX 200 MG/5 ML SUSP ( <i>azithromycin</i> )	T3	
ZITHROMAX 250 MG TABLET ( <i>azithromycin</i> )	T3	
ZITHROMAX 250 MG Z-PAK TABLET ( <i>azithromycin</i> )	T3	QL (15 tabs/90 days)
ZITHROMAX 500 MG TABLET ( <i>azithromycin</i> )	T3	QL (15 tabs/90 days)
ZITHROMAX I.V. 500 MG VIAL ( <i>azithromycin</i> )	T3	
ZITHROMAX TRI-PAK ( <i>azithromycin</i> )	T3	QL (15 tabs/90 days)
<b>NITROFURAN DERIVATIVES ANTIBACTERIAL AGENTS</b>		
FURADANTIN ( <i>nitrofurantoin</i> )	T3	
MACROBID ( <i>nitrofurantoin mono-macro</i> )	T3	
MACRODANTIN ( <i>nitrofurantoin</i> )	T3	
<i>nitrofurantoin</i> 25 mg/5 ml susp (Furadantin)	T1	
<i>nitrofurantoin</i> 25 mg/5 ml susp (Furadantin)	T1	
<i>nitrofurantoin mcr</i> 100 mg cap (Macrodantin)	T1	
<i>nitrofurantoin mcr</i> 25 mg cap (Macrodantin)	T1	
<i>nitrofurantoin mcr</i> 50 mg cap (Macrodantin)	T1	
<i>nitrofurantoin monohyd/m-cryst</i> (Macrobid)	T1	
<b>OXAZOLIDINONE ANTIBIOTICS</b>		
<i>linezolid</i> in 0.9% sodium chlor	T1	
<i>linezolid</i> in dextrose 5% (Zyvox)	T1	
SIVEXTRO 200 MG TABLET	T3	PA
SIVEXTRO 200 MG VIAL	T3	
ZYVOX 100 MG/5 ML SUSPENSION ( <i>linezolid</i> )	T3	PA

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

T4 – Specialty Medications

PA – Prior Authorization

QL – Quantity Limit

ST – Step Therapy

AGE – Age Requirement

SP – Specialty Medication

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## List of Prescription Medications

### ANTIBIOTICS (Infections) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>OXAZOLIDINONE ANTIBIOTICS (con't)</b>		
ZYVOX 200 MG/100 ML-D5W	T3	
ZYVOX 600 MG TABLET ( <i>linezolid</i> )	T3	PA
ZYVOX 600 MG/300 ML-D5W	T3	
<b>PENICILLIN ANTIBIOTICS</b>		
<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 sodium</i>	T1	
<i>ampicillin sodium/sulbactam na</i>	T1	
<i>ampicillin sodium/sulbactam na (Unasyn)</i>	T1	
<i>ampicillin trihydrate</i>	T1	
AUGMENTIN ( <i>amoxicillin-clavulanate potass</i> )	T3	PA
AUGMENTIN XR ( <i>amoxicillin-clavulanate pot er</i> )	T3	PA
BICILLIN C-R	T3	
BICILLIN L-A	T3	
<i>dicloxacillin sodium</i>	T1	
EXTENCILLINE	T3	
LETOCILIN S	T3	
MOXATAG	T3	
<i>nafcillin in dextrose, iso-osm</i>	T1	
<i>nafcillin sodium</i>	T1	
<i>oxacillin in dextrose (iso-osm)</i>	T1	
<i>oxacillin sodium</i>	T1	
<i>penicillin g potassium</i>	T1	
<i>penicillin g sodium</i>	T1	
PENICILLIN GK-ISO-OSM DEXTROSE	T1	
<i>penicillin v potassium</i>	T1	
<i>piperacillin sodium/tazobactam</i>	T1	
<i>piperacillin sodium/tazobactam (Piperacillin-tazobactam)</i>	T1	
<i>piperacillin sodium/tazobactam (Zosyn)</i>	T1	
PIPERACILLIN-TAZOBACTAM	T1	
UNASYN ( <i>ampicillin-sulbactam</i> )	T3	
ZOSYN	T3	

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

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## List of Prescription Medications

ANTIBIOTICS (Infections) (cont.)			
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits	
<b>PENICILLIN ANTIBIOTICS (con't)</b>			
ZOSYN ( <i>piperacillin-tazobactam</i> )	T3		
<b>PLEUROMUTILIN DERIVATIVES</b>			
XENLETA 150 MG/15 ML VIAL	T3		
XENLETA 600 MG TABLET	T3	PA QL (10 tabs/30 days)	
<b>POLYMYXIN ANTIBIOTICS AND DERIVATIVES</b>			
<i>colistin (colistimethate na)</i> ( <i>Coly-mycin M Parenteral</i> )	T1		
COLY-MYCIN M PARENTERAL ( <i>colistimethate</i> )	T3		
<i>polymyxin b sulfate</i>	T1		
<b>QUINOLONE ANTIBIOTICS</b>			
AVELOX ( <i>moxifloxacin hcl</i> )	T3		
AVELOX IV ( <i>moxifloxacin</i> )	T2		
BAXDELA 300 MG VIAL	T3		
BAXDELA 450 MG TABLET	T3	PA	
CIPRO 10% SUSPENSION ( <i>ciprofloxacin</i> )	T2		
CIPRO 250 MG TABLET ( <i>ciprofloxacin hcl</i> )	T3		
CIPRO 5% SUSPENSION ( <i>ciprofloxacin</i> )	T2		
CIPRO 500 MG TABLET ( <i>ciprofloxacin hcl</i> )	T3		
CIPRO I.V. ( <i>ciprofloxacin-d5w</i> )	T3		
<i>ciprofloxacin</i> (Cipro)	T1		
<i>ciprofloxacin hcl</i>	T1		
<i>ciprofloxacin hcl</i> (Cipro)	T1		
<i>ciprofloxacin in 5 % dextrose</i>	T1		
<i>ciprofloxacin in 5 % dextrose</i> (Cipro l.v.)	T1		
<i>ciprofloxacin lactate</i>	T1		
<i>ciprofloxacin/ciprofloxacin hcl</i>	T1		
FACTIVE	T3		
<i>levofloxacin</i>	T1		
<i>levofloxacin in dextrose 5 %</i>	T1		
MOXIFLOXACIN	T1		
<i>moxifloxacin hcl</i> (Avelox)	T1		
<i>moxifloxacin-sod.chloride (iso)</i> (Avelox Iv)	T1		
<i>ofloxacin</i>	T1		
<b>RIFAMYCINS AND RELATED DERIVATIVE ANTIBIOTICS</b>			
AEMCOLO	T3	QL (12 tabs/3 days)	

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

T4 – Specialty Medications

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QL – Quantity Limit

ST – Step Therapy

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## List of Prescription Medications

### ANTIBIOTICS (Infections) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>RIFAMYCINS AND RELATED DERIVATIVE ANTIBIOTICS</b>		
XIFAXAN 200 MG TABLET	T2	
XIFAXAN 550 MG TABLET	T2	QL (42 tabs/14 days)
<b>STREPTOGRAMIN ANTIBIOTICS</b>		
SYNERCID	T3	
<b>TETRACYCLINE ANTIBIOTICS</b>		
ACTICLATE ( <i>doxycycline hyclate</i> )	T3	ST
<i>coremino er 135 mg tablet</i>	T1	
<i>coremino er 45 mg tablet</i>	T1	QL (1 tab/day)
<i>coremino er 90 mg tablet</i>	T1	
<i>demeclacycline hcl</i>	T1	
DORYX ( <i>doxycycline hyclate</i> )	T3	PA
DORYX MPC	T3	PA
<i>doxycycline 50 mg tablet (Targadox)</i>	T1	PA
<i>doxycycline hyc dr 100 mg tab</i>	T1	PA
<i>doxycycline hyc dr 150 mg tab</i>	T1	PA
<i>doxycycline hyc dr 200 mg tab (Doryx)</i>	T1	PA
<i>doxycycline hyc dr 50 mg tab</i>	T1	PA
<i>doxycycline hyc dr 75 mg tab</i>	T1	PA
DOXYCYCLINE HYC DR 80 MG TAB	T3	PA
<i>doxycycline hyclate</i>	T1	
<i>doxycycline hyclate (Vibramycin)</i>	T1	
<i>doxycycline hyclate 100 mg cap</i>	T1	
<i>doxycycline hyclate 100 mg tab</i>	T1	
<i>doxycycline hyclate 100 mg vl</i>	T1	
<i>doxycycline hyclate 150 mg tab (Acticlate)</i>	T1	
<i>doxycycline hyclate 50 mg cap</i>	T1	
<i>doxycycline hyclate 75 mg tab (Acticlate)</i>	T1	
<i>doxycycline monohydrate</i>	T1	
<i>doxycycline monohydrate (Oracea)</i>	T1	PA
<i>doxycycline monohydrate (Monodox)</i>	T1	
EMROSI	T3	PA
MINOCIN 100 MG VIAL	T3	
MINOCIN 75 MG PELLETIZED CAP ( <i>minocycline hcl</i> )	T3	PA
MINOCYCLINE ER	T3	ST

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

T4 – Specialty Medications

PA – Prior Authorization

QL – Quantity Limit

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AGE – Age Requirement

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## List of Prescription Medications

### ANTIBIOTICS (Infections) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>TETRACYCLINE ANTIBIOTICS (con't.)</b>		
minocycline er 105 mg tablet (Solodyn)	T1	
minocycline er 115 mg tablet (Solodyn)	T1	
minocycline er 135 mg tablet	T1	
minocycline er 45 mg tablet	T1	QL (1 tab/day)
minocycline er 55 mg tablet	T1	
minocycline er 65 mg tablet (Solodyn)	T1	
minocycline er 80 mg tablet (Solodyn)	T1	
minocycline er 90 mg tablet	T1	
minocycline hcl (Minocin)	T1	
MINOLIRA ER	T3	ST
MONODOX (monodoxine nl)	T3	
MONODOX (okebo)	T3	
NUZYRA 100 MG VIAL	T3	PA SP
NUZYRA 150 MG TABLET	T3	PA QL (30 tablets/28 days) SP
ORACEA (doxycycline monohydrate)	T3	PA
SEYSARA	T3	PA
SOLODYN (minocycline hcl er)	T3	PA
SOLOXIDE	T1	PA
TARGADOX	T3	PA
tetracycline hcl	T1	
tetracycline capsule	T1	
tetracycline tablet	T3	PA
XERAVA	T3	
XIMINO	T3	ST
<b>VAGINAL ANTIBIOTICS</b>		
CLEOCIN	T3	PA
CLEOCIN (clindamycin phosphate)	T3	PA
clindamycin phosphate (Cleocin)	T1	
CLINDESSE	T3	
METROGEL-VAGINAL (vandazole)	T3	PA
metronidazole (Metrogel-vaginal)	T1	
NUVESSA	T3	PA

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

T4 – Specialty Medications

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SP – Specialty Medication

HD – May require home delivery pharmacy

PPACA – No Cost-Share Preventive Medication

CSL – Oral cancer medication subject to cost-share limits

## List of Prescription Medications

### ANTIBIOTICS (Infections) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>VAGINAL ANTIBIOTICS (con't)</b>		
XACIATO	T3	
<b>VANCOMYCIN ANTIBIOTICS AND DERIVATIVES</b>		
FIRVANQ ( <i>vancomycin hcl</i> )	T2	PA
VANCOCIN HCL ( <i>vancomycin hcl</i> )	T3	PA
VANCOMYCIN 25 MG/ML SOLUTION <i>vancomycin 50 mg/ml solution</i>	T3	PA
VANCOMYCIN <i>vancomycin 1 gm vial</i>	T1	
VANCOMYCIN 1 GRAM/200 ML BAG	T3	
VANCOMYCIN 1.25 GM/250 ML BAG	T1	
VANCOMYCIN 1.5 GRAM/300 ML BAG	T3	
VANCOMYCIN 1.75 GM/350 ML BAG	T3	
VANCOMYCIN 2 GRAM/400 ML BAG	T3	
VANCOMYCIN 1.25 GRAM/250ML-D5W	T1	
VANCOMYCIN 1.5 GRAM/250 ML-D5W	T1	
VANCOMYCIN 1.5 GRAM/300 ML-D5W	T3	
VANCOMYCIN-D5W 500 MG/100 ML <i>vancomycin 250 mg/5 ml soln (Firvanq)</i>	T1	
<i>vancomycin 50 mg/5 ml soln (Firvanq)</i>	T1	
<i>vancomycin 500 mg vial</i>	T1	
VANCOMYCIN 500 MG/100 ML BAG	T3	
VANCOMYCIN 750 MG/150 ML BAG	T3	
VANCOMYCIN HCL 1.25 GRAM VIAL	T1	
VANCOMYCIN HCL 1.5 GRAM VIAL	T1	
VANCOMYCIN HCL 1.75 GRAM VIAL	T3	
VANCOMYCIN HCL 2 GRAM VIAL <i>vancomycin hcl 10 gm vial</i>	T3	
<i>vancomycin hcl 125 mg capsule (Vancocin Hcl)</i>	T1	
VANCOMYCIN HCL 1G/200 ML BAG <i>vancomycin hcl 250 mg capsule (Vancocin Hcl)</i>	T1	
VANCOMYCIN HCL 250 MG VIAL <i>vancomycin hcl 5 gm vial</i>	T1	
<i>vancomycin hcl 750 mg vial</i>	T1	
VANCOMYCIN HCL-0.9% NAACL	T1	

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

T4 – Specialty Medications

PA – Prior Authorization

QL – Quantity Limit

ST – Step Therapy

AGE – Age Requirement

SP – Specialty Medication

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## List of Prescription Medications

ANTIBIOTICS (Miscellaneous)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>CYCLIC LIPOPEPTIDES</b>		
CUBICIN ( <i>daptomycin</i> )	T3	
DAPTOMYCIN	T1	
ANTIBIOTICS (Skin Conditions)		
<b>TOPICAL ANTIBIOTIC AND ANTI-INFLAMMATORY STEROID</b>		
NEO-SYNALAR	T3	
<b>TOPICAL ANTIBIOTICS</b>		
AMZEEQ	T3	PA
BENZAMYCIN ( <i>erythromycin-benzoyl peroxide</i> )	T3	
CENTANY	T3	
CENTANY AT	T3	
CLEOCIN T ( <i>clindamycin phosphate</i> )	T3	
<i>clindacin etz 1% ppledget</i> (Cleocin T)	T1	
CLINDACIN ETZ KIT	T3	
CLINDACIN PAC	T3	
CLINDAGEL	T3	PA
<i>clindamycin phosphate</i>	T1	
<i>clindamycin phosphate</i> (Cleocin T)	T1	
<i>clindamycin phosphate</i> (Evoclin)	T1	
<i>erythromycin base in ethanol</i>	T1	
<i>erythromycin base in ethanol</i>	T3	
<i>erythromycin/benzoyl peroxide</i> (Benzamycin)	T1	
EVOCLIN ( <i>clindamycin phosphate</i> )	T3	
<i>gentamicin sulfate</i>	T1	
<i>mupirocin</i> (Centany)	T1	PA
<i>mupirocin calcium</i>	T1	
XEPI	T3	
ZILXI	T3	PA
<b>TOPICAL SULFONAMIDES</b>		
AVAR 9.5-5% CLEANSING PADS	T3	PA
<i>avar cleanser</i> (Rosanil)	T1	
AVAR LS	T3	

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

T4 – Specialty Medications

PA – Prior Authorization

QL – Quantity Limit

ST – Step Therapy

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SP – Specialty Medication

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## List of Prescription Medications

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

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>TOPICAL SULFONAMIDES (cont.)</b>		
AVAR-E	T3	PA
AVAR-E GREEN	T3	PA
<i>mafenide acetate</i> (Sulfamylon)	T1	
ROSANIL (sodium sulfacetamide-sulfur)	T1	
SILVADENE (ssd)	T3	
<i>silver sulfadiazine</i> (Silvadene)	T1	
<i>sulfacetamide sod/sulfur/urea</i>	T1	
<i>sulfacetamide sodium/sulfur</i>	T1	
<i>sulfacetamide sodium/sulfur</i> (Avar-e Green)	T1	
<i>sulfacetamide sodium/sulfur</i> (Rosanil)	T1	
<i>sulfacetamide/sulfur/cleansr23</i>	T1	
<i>sulfact sod/sulur/avob/otn/oct</i>	T1	
SULFAMYLYON ( <i>mafenide acetate</i> )	T3	

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

<b>ANTI-COAGULANTS, COUMARIN TYPE</b>		
warfarin sodium	T1	HD
<b>CITRATES AS ANTI-COAGULANTS</b>		
ACD SOLUTION A	T3	
ACD-A	T3	
ANTICOAG SODIUM CITRATE 4% SYR	T1	
CITRATE PHOSPHATE DEXTROSE	T1	
TRICITRASOL	T3	
<b>DIRECT FACTOR XA INHIBITORS</b>		
BEVYXXA	T3	QL (42 caps/42 days)
ELIQUIS	T2	
SAVAYSA 15 MG TABLET	T3	PA QL (1 tab/day)
SAVAYSA 30 MG TABLET	T3	PA QL (1 tab/day)
SAVAYSA 60 MG TABLET	T3	PA
XARELTO	T2	
<b>HEPARIN AND RELATED PREPARATIONS</b>		
ARIXTRA ( <i>fondaparinux sodium</i> )	T4	QL (1 syringe/day) SP
enoxaparin 100 mg/ml syringe (Lovenox)	T4	QL (2 syringes/day) SP
enoxaparin 120 mg/0.8 ml/syr (Lovenox)	T4	QL (2 syringes/day) SP
enoxaparin 150 mg/ml syringe (Lovenox)	T4	QL (2 syringes/day) SP

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

T4 – Specialty Medications

PA – Prior Authorization

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## List of Prescription Medications

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

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>HEPARIN AND RELATED PREPARATIONS (cont.)</b>		
enoxaparin 30 mg/0.3 ml/syr (Lovenox)	T4	QL (2 syringes/day) SP
enoxaparin 300 mg/3 ml vial (Lovenox)	T4	QL (1 vial/day) SP
enoxaparin 40 mg/0.4 ml/syr (Lovenox)	T4	QL (2 syringes/day) SP
enoxaparin 60 mg/0.6 ml/syr (Lovenox)	T4	QL (2 syringes/day) SP
enoxaparin 80 mg/0.8 ml/syr (Lovenox)	T4	QL (2 syringes/day) SP
fondaparinux sodium (Arixtra)	T4	QL (1 syringe/day) SP
FRAGMIN	T4	QL (2ml/day) SP
heparin 1,000 unit/500 ml-ns	T1	
HEPARIN 2,000 UNIT/1,000 ML-NS (heparin sodium,porcine/ns/pf)	T3	
heparin 2,000 unit/1,000 ml-ns (Heparin Sodium-0.9% NaCl)	T1	
HEPARIN 2,500 UNIT/500 ML-NS	T1	
HEPARIN 30,000 UNIT/1,000-NS	T1	
HEPARIN 5,000 UNIT/1,000 ML-NS	T1	
HEPARIN 5,000 UNIT/500 ML-NS	T1	
heparin 10,000 unit/10 ml vial	T1	
heparin 2,000 unit/2 ml vial	T1	
heparin 30,000 unit/30 ml vial	T1	
heparin 40,000 unit/4 ml vial	T1	
heparin 5,000 unit/ml carpuject	T1	
heparin 50,000 unit/10 ml vial	T1	
heparin 50,000 unit/5 ml vial	T1	
heparin sod 1,000 unit/ml vial	T1	
heparin sod 10,000 unit/ml vl	T1	
heparin sod 20,000 unit/ml vl	T1	
heparin sod 5,000 unit/0.5 ml	T1	
HEPARIN SOD 5,000 UNIT/0.5 ML	T3	
heparin sod 5,000 unit/0.5 ml (Heparin Sodium)	T1	
heparin sod 5,000 unit/ml syrg	T3	
heparin sod 5,000 unit/ml vial	T1	
heparin sod, porcine/0.9 % nacl	T1	
heparin sod, pork in 0.45% nacl	T1	
heparin sodium, porcine	T1	
heparin sodium, porcine/d5w	T1	
heparin sodium, porcine/pf	T1	

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

T4 – Specialty Medications

PA – Prior Authorization

QL – Quantity Limit

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AGE – Age Requirement

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## List of Prescription Medications

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

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>HEPARIN AND RELATED PREPARATIONS (cont.)</b>		
HEPARIN SODIUM-0.45% NACL	T1	
LOVENOX 100 MG/ML SYRINGE ( <i>enoxaparin sodium</i> )	T4	QL (2 syringes/day) SP
LOVENOX 120 MG/0.8 ML SYRINGE ( <i>enoxaparin sodium</i> )	T4	QL (2 syringes/day) SP
LOVENOX 150 MG/ML SYRINGE ( <i>enoxaparin sodium</i> )	T4	QL (2 syringes/day) SP
LOVENOX 30 MG/0.3 ML SYRINGE ( <i>enoxaparin sodium</i> )	T4	QL (2 syringes/day) SP
LOVENOX 300 MG/3 ML VIAL ( <i>enoxaparin sodium</i> )	T4	QL (1 vial/day) SP
LOVENOX 40 MG/0.4 ML SYRINGE ( <i>enoxaparin sodium</i> )	T4	QL (2 syringes/day) SP
LOVENOX 60 MG/0.6 ML SYRINGE ( <i>enoxaparin sodium</i> )	T4	QL (2 syringes/day) SP
LOVENOX 80 MG/0.8 ML SYRINGE ( <i>enoxaparin sodium</i> )	T4	QL (2 syringes/day) SP
<b>THROMBIN INHIBITORS, SELECTIVE, DIRECT, REVERSIBLE</b>		
ARGATROBAN	T4	SP
ARGATROBAN-0.9% NACL	T4	SP
<i>dabigatran etexilate</i>	T1	
<b>THROMBIN INHIBITORS, SEL, DIRECT, REVERS-HIRUDIN TYPE</b>		
ANGIOMAX ( <i>bivalirudin</i> )	T3	
BIVALIRUDIN 250 MG ADD-VANT VL	T1	
<i>bivalirudin 250 mg vial (Angiomax)</i>	T1	
BIVALIRUDIN RTU 250 MG/50 ML	T3	
BIVALIRUDIN-0.9% NACL	T1	
<b>ANTIDOTES (Gastrointestinal/Heartburn)</b>		
<b>MU-OPIOID RECEPTOR ANTAGONISTS, PERIPHERALLY-ACTING</b>		
MOVANTIK	T2	PA
RELISTOR	T3	PA
SYMPROIC	T2	PA
<b>ANTIDOTES (Substance Abuse)</b>		
<b>OPIOID ANTAGONISTS</b>		
EVZIO	T3	PA QL (0.8ml/day)
KLOXXADO	T2	PA QL (2 sprays/30 days)
<i>naloxone 0.4 mg/ml carpuject</i>	T1	
<i>naloxone 0.4 mg/ml vial</i>	T1	
NALOXONE 2 MG AUTO-INJECTOR	T3	QL (0.8ml/day)

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

T4 – Specialty Medications

PA – Prior Authorization

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ST – Step Therapy

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## List of Prescription Medications

ANTIDOTES (Substance Abuse) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>OPIOID ANTAGONISTS (cont.)</b>		
<i>naloxone 0.4 mg/ml vial</i>	T1	
NALOXONE 2 MG AUTO-INJECTOR	T3	QL (0.8ml/day)
<i>naloxone 2 mg/2 ml syringe</i>	T1	
<i>naloxone 4 mg/10 ml vial</i>	T1	
<i>naltrexone hcl</i>	T1	QL(180 tabs/30 days)
NARCAN	T2	QL (2 units/30 days)
OPVEE	T3	QL(2 units/30 days)
REXTOVY	T2	QL(2 units/30 days)
ZIMHI	T3	QL (2 inj/month)
<b>ANTI-FUNGALS (Eye Conditions)</b>		
<b>OPHTHALMIC ANTI-FUNGAL AGENTS</b>		
NATACYN	T2	
<b>ANTI-FUNGALS (Feminine Products)</b>		
<b>VAGINAL ANTI-FUNGALS</b>		
GYNAZOLE 1	T1	
<i>miconazole nitrate</i>	T1	
<i>terconazole</i>	T1	
<b>ANTI-FUNGALS (Infections)</b>		
<b>ANTI-FUNGAL AGENTS</b>		
ANCOBON ( <i>flucytosine</i> )	T3	
<i>clotrimazole</i>	T1	
CRESEMDA CAPSULE	T3	PA
CRESEMDA 372 MG VIAL	T3	
DIFLUCAN ( <i>fluconazole</i> )	T3	PA
<i>fluconazole (Diflucan)</i>	T1	
<i>fluconazole in nacl, iso-osm</i>	T1	
<i>flucytosine (Ancobon)</i>	T1	
FULVICIN P-G 165 MG TABLET	T3	PA QL (4 tabs/day)
<i>itraconazole (Sporanox)</i>	T1	
<i>ketoconazole</i>	T1	
NOXAFL 300 MG/16.7 ML VIAL ( <i>posaconazole</i> )	T3	PA
NOXAFL 40 MG/ML SUSPENSION ( <i>posaconazole</i> )	T3	PA
NOXAFL DR 100 MG TABLET ( <i>posaconazole</i> )	T3	PA

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

T4 – Specialty Medications

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AGE – Age Requirement

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## List of Prescription Medications

### ANTI-FUNGALS (Infections) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>ANTI-FUNGAL ANTIBIOTICS</b>		
ORAVIG	T3	
<i>posaconazole</i> (Noxafil)	T1	
SPORANOX ( <i>itraconazole</i> )	T3	PA
<i>terbinafine hcl</i>	T1	
TOLSURA	T3	
VFEND ( <i>voriconazole</i> )	T3	PA
VFEND IV ( <i>voriconazole</i> )	T3	
VIVJOA	T3	PA
<i>voriconazole 200 mg tablet</i> (Vfend)	T1	PA
<i>voriconazole 200 mg vial</i> (Vfend lv)	T1	
<i>voriconazole 40 mg/ml susp</i> (Vfend)	T1	PA
<i>voriconazole 50 mg tablet</i> (Vfend)	T1	PA
ABELCET	T3	
AMBISOME	T3	
<i>amphotericin b</i>	T1	
BREXFEMME	T3	PA
CANCIDAS ( <i>caspofungin acetate</i> )	T3	
<i>caspofungin acetate</i> (Cancidas)	T1	
ERAXIS	T3	
<i>griseofulvin ultramicrosize</i> (Gris-peg)	T1	
<i>griseofulvin, microsize</i>	T1	
GRIS-PEG ( <i>griseofulvin ultramicrosize</i> )	T3	
<i>micafungin sodium</i> (Mycamine)	T1	
MICAFUNGIN-0.9% NACL	T3	
MYCAMINE ( <i>micafungin</i> )	T3	
<i>nystatin</i>	T1	

### ANTI-FUNGALS (Skin Conditions)

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

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

T4 – Specialty Medications

PA – Prior Authorization

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AGE – Age Requirement

SP – Specialty Medication

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## List of Prescription Medications

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

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>TOPICAL ANTI-FUNGALS (con't.)</b>		
ciclopirox olamine (Loprox)	T1	
econazole nitrate	T1	
ECOZA	T3	
ERTACZO	T3	PA
EXELDERM	T3	PA
EXODERM	T1	
EXTINA ( <i>ketodan</i> )	T3	PA
JUBLIA	T3	PA
KERYDIN ( <i>tavaborole</i> )	T3	PA
<i>ketoconazole</i>	T1	
<i>ketoconazole/skin cleanser 28</i>	T1	
LOPROX 0.77% CREAM ( <i>ciclopirox</i> )	T3	PA
LOPROX 0.77% TOPICAL SUSP ( <i>ciclopirox</i> )	T3	
LOPROX 1% SHAMPOO ( <i>ciclopirox</i> )	T3	PA
LULICONAZOLE	T1	
LUZU	T3	PA
MICONAZOLE-ZINC OXIDE-PETROLT <sup>TM</sup>	T1	PA
<i>naftifine hcl</i>	T1	
<i>naftifine hcl</i> (Naftin)	T1	
NAFTIN ( <i>naftifine hcl</i> )	T2	
<i>nystatin</i>	T1	
<i>nystatin/triamcinolone acet</i>	T1	
<i>oxiconazole nitrate</i> (Oxistat)	T1	
OXISTAT 1% CREAM ( <i>oxiconazole nitrate</i> )	T3	PA
OXISTAT 1% LOTION	T2	PA
SULCONAZOLE NITRATE	T3	PA
<i>tavaborole</i> (Kerydin)	T1	PA
VUSION	T3	PA
XOLEGEL	T3	PA

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

#### 1ST GEN ANTIHISTAMINE AND DECONGESTANT COMBINATION

phenylephrine hcl/prometh hcl	T1
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T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

T4 – Specialty Medications

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## List of Prescription Medications

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

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>2ND GEN ANTIHISTAMINE AND DECONGESTANT COMBINATION</b>		
CLARINEX-D 12 HOUR	T3	
<b>ANTIHISTAMINES (Allergy/Nasal Sprays)</b>		
<b>ANTIHISTAMINES - 1ST GENERATION</b>		
carbinoxamine 4 mg/5 ml liquid	T1	
carbinoxamine maleate 4 mg tab	T1	
carbinoxamine maleate 6 mg tab (Ryvent)	T1	PA
clemastine fumarate	T1	
cycloheptadine hcl (Cyproheptadine Hcl)	T1	
dexchlorpheniramine maleate (Ryclora)	T1	
diphenhydramine hcl	T1	
hydroxyzine hcl	T1	
hydroxyzine pamoate	T1	
hydroxyzine pamoate (Vistaril)	T1	
KARBINAL ER	T3	PA
PHENERGAN (promethazine hcl)	T3	
promethazine hcl	T1	
promethazine hcl (Phenergan)	T1	
RYCLORA (dexchlorpheniramine maleate)	T3	
RYVENT	T3	PA
VISTARIL (hydroxyzine pamoate)	T3	
<b>ANTIHISTAMINES - 2ND GENERATION</b>		
cetirizine hcl	T1	HD
CLARINEX (desloratadine)	T3	HD
desloratadine 2.5 mg odt	T1	QL (1 tab/day) HD
desloratadine 5 mg odt	T1	HD
desloratadine 5 mg tablet (Clarinex)	T1	HD
QUZYTIR	T3	
<b>ANTIHISTAMINES (Eye Conditions)</b>		
<b>EYE ANTIHISTAMINES</b>		
azelastine hcl 0.05% drops	T1	
BEPREVE	T3	PA
epinastine hcl	T1	

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

T4 – Specialty Medications

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## List of Prescription Medications

### ANTIHISTAMINES (Eye Conditions) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>EYE ANTIHISTAMINES (con't.)</b>		
LASTACFT	T3	
olopatadine hcl 0.1% eye drops	T1	
olopatadine hcl 0.2% eye drop (Pataday)	T1	
PATADAY (olopatadine hcl)	T3	
PATANOL 0.1%	T3	PA
PAZEO	T2	
ZERVIATE	T2	
<b>ANTI-HYPERGLYCEMICS (Diabetes)</b>		
<b>ANTIHYPERGLY, DPP-4 ENZYME INHIB.-THIAZOLIDINEDIONE</b>		
ALOGLIPTIN-PIOGLITAZONE	T3	PA QL (1 tab/day) HD
OSENI	T3	PA QL (1 tab/day) HD
<b>ANTIHYPERGLY, INCRETIN MIMETIC (GLP-1 RECEPT.AGONIST)</b>		
BYDUREON	T2	QL (4 vials/28 days) ST HD
BYDUREON BCISE	T2	QL (4 pens/28 days) ST
BYDUREON PEN	T2	QL (4 pens/28 days) ST HD
BYETTA	T2	QL (1 pen/30 days) ST
LIRAGLUTIDE	T3	QL(3 pens/30 days) HD
OZEMPI 0.25-0.5 MG DOSE PEN	T2	QL (2 pens/28 days) ST HD
OZEMPI 1 MG DOSE PEN (1.5 ML)	T2	QL (2 pens/28 days) ST HD
OZEMPI 1 MG DOSE PEN (3 ML)	T2	QL (3ML/21 Days) ST HD
REZVOGLAR KWIKPEN	T2	PA
RYBELSUS	T2	QL (1 tab/day) ST
TRULICITY 0.75 MG/0.5 ML PEN	T2	QL (4 pens/28 days) ST
TRULICITY 1.5 MG/0.5 ML PEN	T2	QL (4 pens/28 days) ST
TRULICITY 3 MG/0.5 ML PEN	T2	QL (2 ml/28 Days) ST
TRULICITY 4.5 MG/0.5 ML PEN	T2	QL (2 ml/28 Days) ST
VICTOZA 2-PAK	T3	QL (3 pens/30 days) ST
VICTOZA 3-PAK	T3	QL (3 pens/30 days) ST
<b>ANTI-HYPERGLY, INSULIN, LONG ACT-GLP-1 RECEPT.AGONIST</b>		
SOLIQUA 100-33	T2	HD
XULTOPHY 100-3.6	T3	PA HD
<b>ANTI-HYPERGLYCEMIC-SOD/GLUC COTRANSORT2(SGLT2) INHIB</b>		
FARXIGA	T2	ST QL(1 tab/day) HD
INVOKANA	T2	QL (1 tab/day) ST HD

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

T4 – Specialty Medications

PA – Prior Authorization

QL – Quantity Limit

ST – Step Therapy

AGE – Age Requirement

SP – Specialty Medication

HD – May require home delivery pharmacy

PPACA – No Cost-Share Preventive Medication

CSL – Oral cancer medication subject to cost-share limits

## List of Prescription Medications

### ANTI-HYPERGLYCEMICS (Diabetes) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits	
<b>ANTI-HYPERGLYCEMIC-SOD/GLUC COTRANSPORT2(SGLT2) INHIB (cont.)</b>			
JARDIANCE	T2	QL (1 tab/day) ST HD	
STEGLATRO	T2	QL (1 tab/day) ST HD	
<b>ANTI-HYPERGLYCEMIC-DOPAMINE RECEPTOR AGONISTS</b>			
CYCLOSET	T3	HD	
<b>ANTI-HYPERGLYCEMIC, ALPHA-GLUCOSIDASE INHIBITORS</b>			
acarbose (Precose)	T1	HD	
GLYSET (miglitol)	T3	HD	
miglitol (Glyset)	T1	HD	
PRECOSE (acarbose)	T3	HD	
<b>ANTI-HYPERGLYCEMIC, AMYLIN ANALOG-TYPE</b>			
SYMLINPEN 120	T2	HD	
SYMLINPEN 60	T2		
<b>ANTI-HYPERGLYCEMIC, BIGUANIDE TYPE</b>			
FORTAMET (metformin er osmotic)	T3	PA HD	
GLUCOPHAGE XR (metformin hcl er)	T3	HD	
GLUMETZA (metformin er gastric)	T3	PA	
metformin hcl (Fortamet)	T1	PA HD	
metformin hcl (Glucophage Xr)	T1	HD	
metformin hcl (Glumetza)	T1	PA HD	
metformin hcl (Riomet)	T1	HD	
METFORMIN HCL 750 MG TABLET	T3	PA HD	
RIOMET (metformin hcl)	T3	HD	
RIOMET ER	T3	HD	
<b>ANTI-HYPERGLYCEMIC, DPP-4 INHIBITORS</b>			
ALOGLIPTIN	T3	PA QL (1 tab/day) HD	
JANUVIA	T2	QL (1 tab/day) ST HD	
NESINA	T3	PA QL (1 tab/day) HD	
ONGLYZA	T3	PA QL (1 tab/day) HD	
SITAGLIPTIN	T3	PA QL(1 tab/day) HD	
TRADJENTA	T3	PA QL (2 tabs/day) HD	
ZITUVO	T3	PA QL(1 tab/day) HD	
<b>ANTI-HYPERGLYCEMIC, INSULIN-RELEASE STIMULANT TYPE</b>			
AMARYL (glimepiride)	T3	HD	
chlorpropamide	T1	HD	
glimepiride (Amaryl)	T1	HD	
T1 – Typically Generics	T4 – Specialty Medications	ST – Step Therapy	HD – May require home delivery pharmacy
T2 – Typically Preferred Brands	PA – Prior Authorization	AGE – Age Requirement	PPACA – No Cost-Share Preventive Medication
T3 – Typically Non-Preferred Brands	QL – Quantity Limit	SP – Specialty Medication	CSL – Oral cancer medication subject to cost-share limits

## List of Prescription Medications

### ANTI-HYPERGLYCEMICS (Diabetes) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>ANTI-HYPERGLYCEMIC, INSULIN-RELEASE STIMULANT TYPE (con't.)</b>		
GLIMEPIRIDE 3 MG TABLET	T3	HD
<i>glipizide</i> (Glucotrol) (Glucotrol XI)	T1	HD
GLUCOTROL ( <i>glipizide</i> )	T3	HD
GLUCOTROL XL ( <i>glipizide xl</i> )	T3	HD
<i>glyburide</i>	T1	HD
GLYNASE ( <i>glyburide micronized</i> )	T3	HD
<i>nateglinide</i> (Starlix)	T1	HD
<i>repaglinide</i>	T1	HD
STARLIX ( <i>nateglinide</i> )	T3	HD
<i>tolbutamide</i>	T1	HD
<b>ANTI-HYPERGLYCEMIC, SGLT-2 AND DPP-4 INHIBITOR COMB</b>		
GLYXAMBI	T2	QL (1 tab/day) ST HD
QTERN	T3	QL (1 tab/day) ST HD
STEGLUJAN	T3	QL (1 tab/day) ST HD
<b>ANTI-HYPERGLYCEMIC, THIAZOLIDINEDIONE AND BIGUANIDE</b>		
ACTOPLUS MET ( <i>pioglitazone-metformin</i> )	T3	HD
<i>pioglitazone hcl/metformin hcl</i> (Actoplus Met)	T1	HD
<b>ANTI-HYPERGLYCEMIC, THIAZOLIDINEDIONE-SULFONYLUREA</b>		
DUETACT ( <i>pioglitazone-glimepiride</i> )	T3	HD
<i>pioglitazone hcl/glimepiride</i> (Duetact)	T1	HD
<b>ANTI-HYPERGLYCEMIC, DPP-4 INHIBITOR-BIGUANIDE COMBS.</b>		
ALOGLIPTIN-METFORMIN	T3	PA QL (2 tabs/day) HD
JANUMET	T2	QL (2 tabs/day) ST HD
JANUMET XR 100-1,000 MG TABLET	T2	QL (1 tab/day) ST HD
JANUMET XR 50-1,000 MG TABLET	T2	QL (2 tabs/day) ST HD
JANUMET XR 50-500 MG TABLET	T2	QL (1 tab/day) ST HD
JENTADUETO	T3	PA QL (4 tabs/day) HD
JENTADUETO XR 2.5 MG-1,000 MG	T3	PA QL (2 tabs/day) HD
JENTADUETO XR 5 MG-1,000 MG TB	T3	PA QL (1 tab/day) HD
KAZANO	T3	PA QL (2 tabs/day) HD
KOMBIGLYZE XR 2.5-1,000 MG TAB	T3	PA QL (2 tabs/day) HD
KOMBIGLYZE XR 5-1,000 MG TAB	T3	PA QL (1 tab/day) HD
KOMBIGLYZE XR 5-500 MG TABLET	T3	PA QL (1 tab/day) HD
SITAGLIPTIN-METFORMIN	T3	HD

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

T4 – Specialty Medications

PA – Prior Authorization

QL – Quantity Limit

ST – Step Therapy

AGE – Age Requirement

SP – Specialty Medication

HD – May require home delivery pharmacy

PPACA – No Cost-Share Preventive Medication

CSL – Oral cancer medication subject to cost-share limits

## List of Prescription Medications

ANTI-HYPERGLYCEMICS (Diabetes) (cont.)			
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits	
<b>ANTI-HYPERGLYCEMIC, INSULIN-RELEASE STIM.-BIGUANIDE</b>			
glipizide/metformin hcl	T1	HD	
glyburide/metformin hcl	T1	HD	
repaglinide/metformin hcl	T1	HD	
<b>ANTI-HYPERGLYCEMIC, THIAZOLIDINEDIONE (PPARG AGONIST)</b>			
ACTOS (pioglitazone hcl)	T3	HD	
AVANDIA	T3	HD	
pioglitazone hcl (Actos)	T1	HD	
<b>ANTI-HYPERGLYCEMIC-GLUCOCORTICOID RECEPTOR BLOCKER</b>			
KORLYM (mifepristone)	T4	PA SP	
mifepristone 300 mg tablet (Korlym)	T4	PA SP	
<b>ANTI-HYPERGLYCEMIC-SGLT2 INHIBITOR-BIGUANIDE COMBS.</b>			
DAPAGLIFLOZIN-METFO ER 10-1000	T3	PA QL(1 tab/day) HD	
DAPAGLIFLOZIN-METFOR ER 5-1000	T3	PA QL(2 tabs/day) HD	
INVOKAMET	T2	QL (2 tabs/day) ST HD	
INVOKAMET XR	T2	QL (2 tabs/day) ST HD	
SEGLUROMET	T2	QL (2 tabs/day) ST HD	
SYNJARDY	T2	QL (2 tabs/day) ST HD	
SYNJARDY XR 10-1,000 MG TABLET	T2	QL (2 tabs/day) ST HD	
SYNJARDY XR 12.5-1,000 MG TAB	T2	QL (2 tabs/day) ST HD	
SYNJARDY XR 25-1,000 MG TABLET	T2	QL (1 tab/day) ST HD	
SYNJARDY XR 5-1,000 MG TABLET	T2	QL (2 tabs/day) ST HD	
XIGDUO XR 10 MG-1,000 MG TAB	T2	QL (1 tab/day) ST HD	
XIGDUO XR 10 MG-500 MG TABLET	T2	QL (1 tab/day) ST HD	
XIGDUO XR 2.5 MG-1,000 MG TAB	T2	QL (2 tabs/day) ST HD	
XIGDUO XR 5 MG-1,000 MG TABLET	T2	QL (2 tabs/day) ST HD	
XIGDUO XR 5 MG-500 MG TABLET	T2	QL (1 tab/day) ST HD	
<b>ANTI-HYPERGLY-SGLT-2 INHIB, DPP-4 INHIB, BIGUANIDE CB</b>			
TRIJARDY XR	T2	QL (1 tab/day) ST HD	
<b>ANTIHYPERGLYCEMIC-SOD/GLUC COTRANSPORT2(SGLT2) INH</b>			
BRENZAVVY	T3	PA QL(1 tabs/day) HD	
DAPAGLIFLOZIN	T3	PA QL(1 tab/day) HD	
<b>INSULINS</b>			
ADMELOG	T3	QL (1.5ml/day) HD	
ADMELOG SOLOSTAR	T3	QL (1.5ml/day) HD	

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

T4 – Specialty Medications

PA – Prior Authorization

QL – Quantity Limit

ST – Step Therapy

AGE – Age Requirement

SP – Specialty Medication

HD – May require home delivery pharmacy

PPACA – No Cost-Share Preventive Medication

CSL – Oral cancer medication subject to cost-share limits

## List of Prescription Medications

### ANTI-HYPERGLYCEMICS (Diabetes) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>INSULINS (con't.)</b>		
AFREZZA 12 UNIT CARTRIDGE	T3	PA QL (12 cartridges/day) HD
AFREZZA 4 UNIT CARTRIDGE	T3	PA QL (36 cartridges/day) HD
AFREZZA 4 UNIT/8 UNIT/12 UNIT	T3	PA QL (6 cartridges/day) HD
AFREZZA 8 UNIT CARTRIDGE	T3	PA QL (18 cartridges/day) HD
AFREZZA 90-4 UNIT / 90-8 UNIT	T3	PA QL (12 cartridges/day) HD
AFREZZA 90-8 UNIT / 90-12 UNIT	T3	PA QL (6 cartridges/day) HD
APIDRA	T3	QL (1.5ml/day) HD
APIDRA SOLOSTAR	T3	QL (1.5ml/day) HD
BASAGLAR KWIKPEN U-100	T2	QL (1.5ml/day) HD
FIASP	T2	QL (1.5ml/day) HD
FIASP FLEXTOUCH	T2	QL (1.5ml/day) HD
FIASP PENFILL	T2	QL (1.5ml/day) HD
HUMALOG	T2	QL (1.5ml/day) HD
HUMALOG JUNIOR KWIKPEN	T2	QL (1.5ml/day) HD
HUMALOG KWIKPEN U-100	T2	QL (1.5ML/DAY) HD
HUMALOG KWIKPEN U-200	T2	QL (1ML/DAY) HD
HUMALOG MIX 50-50 KWIKPEN	T2	QL (2ml/day) HD
HUMALOG MIX 75-25	T2	QL (2ml/day) HD
HUMALOG MIX 75-25 KWIKPEN	T2	QL (2ml/day) HD
HUMULIN R U-500	T2	QL (1ML/DAY) HD
HUMULIN R U-500 KWIKPEN	T2	QL (1ml/day) HD
INSULIN ASPART	T2	QL (1.5ml/day) HD
INSULIN ASPART FLEXPEN	T2	QL (1.5ml/day) HD
INSULIN ASPART PENFILL	T2	QL (1.5ml/day) HD
INSULIN ASPART PROT-INSULN ASP	T2	QL (2ml/day) HD
INSULIN GLARGINE MAX SOLOSTAR	T3	PA QL(0.6 mls/day) HD
INSULIN GLARGINE SOLOSTAR U100	T3	PA QL(1.5 mls/day) HD
INSULIN GLARGINE SOLOSTAR U300	T3	PA QL(0.6 mls/day) HD
INSULIN GLARGINE-YFGN	T3	QL (1.5ml/day) HD
INSULIN LISPRO	T2	QL (1.5ml/day) HD
INSULIN LISPRO PROTAMINE MIX	T2	QL (2ml/day) HD
LANTUS	T3	PA QL (1.5ml/day) HD
LANTUS SOLOSTAR	T3	PA QL (1.5ml/day) HD
LEVEMIR	T3	PA QL (1.5ml/day) HD

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

T4 – Specialty Medications

PA – Prior Authorization

QL – Quantity Limit

ST – Step Therapy

AGE – Age Requirement

SP – Specialty Medication

HD – May require home delivery pharmacy

PPACA – No Cost-Share Preventive Medication

CSL – Oral cancer medication subject to cost-share limits

## List of Prescription Medications

### ANTI-HYPERGLYCEMICS (Diabetes) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>INSULINS (con't.)</b>		
LEVEMIR FLEXTOUCH	T3	PA QL (1.5ml/day) HD
LYUMJEV	T2	QL (1.5ml/day) HD
LYUMJEV KWIKPEN U-100	T2	QL (1.5ml/day) HD
LYUMJEV KWIKPEN U-200	T2	QL (1ml/day) HD
NOVOLOG	T2	QL (1.5ml/day) HD
NOVOLOG FLEXPEN	T2	QL (1.5ml/day) HD
NOVOLOG MIX 70-30	T2	QL (2ml/day) HD
NOVOLOG MIX 70-30 FLEXPEN	T2	QL (2ml/day) HD
SEMGLEE (YFGN)	T3	PA QL (1.5ml/day) HD
SEMGLEE PEN	T3	PA QL (1.5ml/day) HD
TOUJEO MAX SOLOSTAR	T3	PA QL (0.6ml/day) HD
TOUJEO SOLOSTAR	T3	PA QL (0.6ml /day) HD
TRESIBA	T2	QL (1.5ml/day) HD
TRESIBA FLEXTOUCH U-100	T2	QL (1.5ml/day) HD
TRESIBA FLEXTOUCH U-200	T2	QL (0.9ml/day) HD

### ANTI-INFECTIVES (Feminine Products)

<b>VAGINAL SULFONAMIDES</b>		
AVC	T3	

### ANTI-INFECTIVES (Infections)

<b>PENICILLIN ANTIBIOTICS</b>		
amoxicillin	T1	
amoxicillin/potassium clav (Augmentin Es-600)	T1	
ampicillin sodium	T1	
AUGMENTIN ES-600 (amoxicillin/potassium clav)	T3	PA
nafcillin sodium	T1	

### ANTI-INFECTIVES/MISCELLANEOUS (Feminine Products)

<b>VAGINAL ANTISEPTICS</b>		
acetic acid/oxyquinoline (Relagard)	T1	
RELAGARD (fem ph)	T3	
TRIMO-SAN	T3	

### ANTI-INFECTIVES/MISCELLANEOUS (Infections)

<b>2ND GEN. ANAEROBIC ANTI-PROTOZOAL-ANTIBACTERIAL</b>			
TINDAMAX (tinidazole)	T3		
T1 – Typically Generics	T4 – Specialty Medications	ST – Step Therapy	HD – May require home delivery pharmacy
T2 – Typically Preferred Brands	PA – Prior Authorization	AGE – Age Requirement	PPACA – No Cost-Share Preventive Medication
T3 – Typically Non-Preferred Brands	QL – Quantity Limit	SP – Specialty Medication	CSL – Oral cancer medication subject to cost-share limits

## List of Prescription Medications

ANTI-INFECTIVES/MISCELLANEOUS (Infections) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>2ND GEN. ANAEROBIC ANTI-PROTOZOAL-ANTIBACTERIAL (con't.)</b>		
<i>tinidazole</i>	T1	
<i>tinidazole</i> (Tindamax)	T1	
<b>AMEBICIDES</b>		
<i>paromomycin sulfate</i>	T1	
<b>ANTHELMINTICS</b>		
<i>albendazole</i> (Albenza)	T1	
ALBENZA ( <i>albendazole</i> )	T3	
BILTRICIDE ( <i>praziquantel</i> )	T3	
EMVERM	T1	
<i>ivermectin</i> (Stromectol)	T1	PA
<i>praziquantel</i> (Biltricide)	T1	
STROMECTOL ( <i>ivermectin</i> )	T3	PA
<b>ANTI-MALARIAL DRUGS</b>		
ARAKODA	T3	PA
<i>atovaquone/proguanil hcl</i> (Malarone)	T1	
<i>chloroquine ph 250 mg tablet</i>	T1	QL (56 Tabs/365 days)
<i>chloroquine ph 500 mg tablet</i>	T1	
COARTEM	T3	PA QL (24 tabs/30 days)
DARAPRIM ( <i>pyrimethamine</i> )	T3	PA SP
<i>hydroxychloroquine sulfate</i> (Plaquenil)	T1	
KRINTAFEL	T3	PA QL (2 tabs/30 days)
MALARONE ( <i>atovaquone-proguanil hcl</i> )	T3	PA
<i>mefloquine hcl</i>	T1	
PLAQUENIL ( <i>hydroxychloroquine sulfate</i> )	T3	PA
<i>primaquine phosphate</i> (Primaquine)	T1	
PRIMAQUINE ( <i>primaquine phosphate</i> )	T1	
<i>pyrimethamine 25 mg tablet</i> (Daraprim)	T1	PA
<i>pyrimethamine 25 mg tablet</i> (Daraprim)	T4	PA SP
QUALAQUIN ( <i>quinine sulfate</i> )	T3	PA
<i>quinine sulfate</i> (Qualaquin)	T1	
<b>ANTI-PROTOZOAL DRUGS, MISCELLANEOUS</b>		
<i>atovaquone</i> (Mepron)	T1	
BENZNIDAZOLE	T3	
IMPAVIDO	T3	PA

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

T4 – Specialty Medications

PA – Prior Authorization

QL – Quantity Limit

ST – Step Therapy

AGE – Age Requirement

SP – Specialty Medication

HD – May require home delivery pharmacy

PPACA – No Cost-Share Preventive Medication

CSL – Oral cancer medication subject to cost-share limits

## List of Prescription Medications

### ANTI-INFECTIVES/MISCELLANEOUS (Infections) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>ANTI-PROTOZOAL DRUGS, MISCELLANEOUS (cont.)</b>		
LAMPIT	T3	
MEPRON	T3	PA
MEPRON ( <i>atovaquone</i> )	T3	PA
NEBUPENT ( <i>pentamidine isethionate</i> )	T3	
PENTAM 300 ( <i>pentamidine isethionate</i> )	T3	
<i>pentamidine isethionate</i> (Nebupent)	T1	
<i>pentamidine isethionate</i> (Pentam 300)	T1	
<b>ANTI-INFECTIVES/MISCELLANEOUS (Miscellaneous)</b>		
<b>ANTIBACTERIAL AGENTS, MISCELLANEOUS</b>		
<i>glycine urologic solution</i>	T1	
<i>glycine urologic solution</i>	T3	
<b>ANTI-INFECTIVES/MISCELLANEOUS (Skin Conditions)</b>		
<b>TOPICAL ANTI-FUNGALS</b>		
CICLODAN 8% KIT	T3	
<i>ciclopirox/urea/camph/men/euc</i> (Ciclodan)	T1	
<b>ANTI-INFLAM.TUMOR NECROSIS FACTOR INHIBITING AGENTS (Pain Relief And Inflammatory Disease)</b>		
<b>ANTI-INFLAMMATORY TUMOR NECROSIS FACTOR INHIBITOR</b>		
ABRILADA(CF)	T4	PA QL(2 pens/syringes/28 days) SP
ADALIMUMAB-AAC(F)CF	T4	PA QL(2 pens/syringes/28 days) SP
ADALIMUMAB-AAC(F) PEN	T4	PA SP
ADALIMUMAB-AATY(CF)	T4	PA QL SP
ADALIMUMAB-AATY(CF) AUTOINJECT	T4	PA QL SP
ADALIMUMAB-ADBM(CF)	T4	PA QL(2 pens/syringes/28 days) SP HD
ADALIMUMAB-ADBM(CF) PEN CROHNS	T4	PA QL(1 starter kit/365 days) SP HD
ADALIMUMAB-ADAZ	T4	PA QL (2 doses/ 28 days) SP
ADALIMUMAB-FKJP(CF)	T4	PA QL(2 pens/syringes/28 days) SP
ADALIMUMAB-RYVK(CF) AUTOINJECT	T4	PA QL (2 auto-injs/28 days) SP
AMJEVITA(CF)	T4	PA QL(2 syringes/28 days) SP HD
AMJEVITA(CF) AUTOINJECTOR	T4	PA QL(2 auto-injs/28 days) SP HD
AVSOLA	T4	PA SP
CIMZIA 200 MG VIAL KIT	T4	PA QL (1 kit/28 days) SP HD
CIMZIA 2X200 MG/ML SYRINGE KIT	T4	PA QL (1 kit/28 days) SP HD
CIMZIA 2X200 MG/ML (X3) START KT	T4	PA QL (1 kit/year) SP HD
CYLTEZO (CF)	T4	PA QL(2 pens/syringes/28 days) SP
I1 – Typically Generics	I4 – Specialty Medications	SI – Step Therapy
T2 – Typically Preferred Brands	PA – Prior Authorization	AGE – Age Requirement
T3 – Typically Non-Preferred Brands	QL – Quantity Limit	SP – Specialty Medication
		HD – May require home delivery pharmacy
		PPACA – No Cost-Share Preventive Medication
		CSL – Oral cancer medication subject to cost-share limits

## List of Prescription Medications

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

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>ANTI-INFLAMMATORY TUMOR NECROSIS FACTOR INHIBITOR (cont.)</b>		
CYLTEZO(CF) PEN	T4	PA QL(2 pens/28 days) SP HD
CYLTEZO(CF) PEN CRH-UC-HS	T4	PA QL(1 starter kit/365 days) SP
CYLTEZO(CF) PEN PSORIA-UV	T4	PA QL(1 starter kit/365 days) SP
ENBREL 25 MG KIT	T4	PA QL (8 vials/28 days) SP HD
ENBREL 25 MG/0.5 ML SYRINGE	T4	PA QL (8 syringes/28 days) SP HD
ENBREL 25 MG/0.5 ML VIAL	T4	PA QL (4ml/28 days) SP HD
ENBREL 50 MG/ML SYRINGE	T4	PA QL (4 syringes/28 days) SP HD
ENBREL MINI	T4	PA QL (4 cartridges/28 days) SP HD
ENBREL SURECLICK	T4	PA QL (4 syringes/28 days) SP HD
HADLIMA	T4	PA QL (2 doses/ 28 days) SP HD
HADLIMA (CF-citrate free)	T4	PA QL (2 doses/ 28 days) SP HD
HULIO(CF)	T4	PA QL(2 pens/syringes/28 days) SP
HUMIRA	T4	PA QL (2 syringes/28 days) SP
HUMIRA PEN	T4	PA QL (2 pens/28 days) SP
HUMIRA (CF)	T4	PA QL (2 syringes/28 days) SP HD
HUMIRA (CF) PEN 40 MG/0.4 ML	T4	PA QL (2 pens/28 days) SP HD
HUMIRA (CF) PEN 80 MG/0.8 ML	T4	PA QL (1 kit/year) SP HD
HUMIRA (CF) PEN CROHN'S-UC-HS	T4	PA QL (1 kit/year) SP HD
HUMIRA (CF) PEN PEDIATRIC UC	T4	PA QL (4 kits/365 days) SP HD
HUMIRA (CF) PEN PSOR-UV-ADOL HS	T4	PA QL (1 kit/year) SP HD
HYRIMoz	T4	PA QL (2 doses/ 28 days) SP
IDACIO (CF)	T4	PA QL (2 doses/ 28 days) SP
INFLECTRA	T4	PA SP HD
REMICADE	T4	PA SP HD
RENFLEXIS	T4	PA SP HD
SIMLANDI(CF) AUTOINJECTOR	T4	PA QL(2 auto-injs/28 days) SP HD
SIMPONI 100 MG/ML PEN INJECTOR	T4	PA QL (1 injector/28 days) SP HD
SIMPONI 100 MG/ML SYRINGE	T4	PA QL (1 syringe/28 days) SP HD
SIMPONI 50 MG/0.5 ML PEN INJEC	T4	PA QL (1 injector/28 days) SP HD
SIMPONI 50 MG/0.5 ML SYRINGE	T4	PA QL (1 syringe/28 days) SP HD
SIMPONI ARIA	T4	PA SP HD
YUFLYMA	T4	PA QL(2 pens/syringes/28 days) SP
YUSIMRY (CF)	T4	PA QL (2 doses/ 28 days) SP

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

T4 – Specialty Medications

PA – Prior Authorization

QL – Quantity Limit

ST – Step Therapy

AGE – Age Requirement

SP – Specialty Medication

HD – May require home delivery pharmacy

PPACA – No Cost-Share Preventive Medication

CSL – Oral cancer medication subject to cost-share limits

## List of Prescription Medications

ANTI-NEOPLASTICS (Cancer)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>ANP - SELECTIVE RETINOID X RECEPTOR AGONISTS (RXR)</b>		
bexarotene (Targretin)	T3	PA SP HD
TARGRETIN 75 MG CAPSULE (bexarotene)	T3	PA SP HD
<b>ANTIBIOTIC ANTOINEOPLASTICS</b>		
adriamycin 10 mg vial	T4	PA SP
adriamycin 20 mg/10 ml vial	T4	PA SP
ADRIAMYCIN (doxorubicin hcl)	T4	PA SP
bleomycin sulfate	T4	PA SP
dactinomycin (Cosmegen)	T4	PA SP
daunorubicin hcl	T4	PA SP
DOXIL (lipodox 50)	T4	PA SP
doxorubicin hcl	T4	PA SP
doxorubicin hcl peg-liposomal (Doxil)	T4	PA SP
ELLENCE (epirubicin hcl)	T4	PA SP
epirubicin vial (Ellence)	T4	PA SP
epirubicin hcl 200 mg vial	T4	SP
IDAMYCIN PFS (idarubicin hcl)	T4	PA SP
idarubicin hcl (Idamycin Pfs)	T4	PA SP
mitomycin (Mutamycin)	T4	PA SP
MUTAMYCIN (mitomycin)	T4	PA SP
valrubicin (Valstar)	T4	SP
VALSTAR (valrubicin)	T4	SP
ZANOSAR	T4	PA SP
<b>ANTI-CD20 (B LYMPHOCYTE) MONOCLONAL ANTIBODY</b>		
GAZYVA	T4	PA SP
RIABNI	T4	PA SP
RITUXAN	T4	PA SP
RITUXAN HYCELA	T4	PA SP
RUXIENCE	T4	PA SP
TRUXIMA	T4	PA SP
<b>ANTINEOPLAST HUM VEGF INHIBITOR RECOMB MC ANTIBODY</b>		
AVASTIN	T4	PA SP
MVASI	T4	PA SP
VEGZELMA	T4	PA SP

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

T4 – Specialty Medications

PA – Prior Authorization

QL – Quantity Limit

ST – Step Therapy

AGE – Age Requirement

SP – Specialty Medication

HD – May require home delivery pharmacy

PPACA – No Cost-Share Preventive Medication

CSL – Oral cancer medication subject to cost-share limits

## List of Prescription Medications

### ANTI-NEOPLASTICS (Cancer) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>ANTINEOPLAST HUM VEGF INHIBITOR RECOMB MC ANTIBODY (cont.)</b>		
ZIRABEV	T4	PA SP
<b>ANTI-NEOPLAST, HISTONE DEACETYLASE (HDAC) INHIBITORS</b>		
BELEODAQ	T4	PA SP
FARYDAK	T4	PA SP HD
ISTODAX	T4	PA SP
ROMIDEPSEN 10 MG KIT	T4	PA SP
ROMIDEPSEN 27.5 MG/5.5 ML VIAL	T4	PA SP
ZOLINZA	T4	PA SP HD
<b>ANTI-NEOPLASTIC - ALKYLATING AGENTS</b>		
ALKERAN 2 MG TABLET ( <i>melphalan</i> )	T4	SP
ALKERAN 50 MG VIAL ( <i>melphalan hcl</i> )	T4	PA SP
BELRAPZO	T4	PA SP HD
BENDAMUSTINE 100 MG/4ML VIAL	T4	PA SP HD
BENDEKA	T4	PA SP HD
<i>bendamustine 25 mg vial</i> (Treanda)	T4	PA SP
<i>bendamustine 100 mg vial</i> (Treanda)	T4	PA SP
BICNU ( <i>carmustine</i> )	T4	SP
<i>busulfan</i> (Busulfex)	T4	SP
BUSULFEX ( <i>busulfan</i> )	T4	SP
<i>carboplatin</i>	T4	PA SP
<i>carmustine</i> (Bicnu)	T4	SP
<i>cisplatin</i>	T4	PA SP
<i>cyclophosphamide 1 gm vial</i>	T4	SP
CYCLOPHOSPHAMIDE 1 GM/5 ML VL	T4	SP
CYCLOPHOSPHAMIDE 2 GM/20 ML VL	T4	SP
CYCLOPHOSPHAMIDE 500 MG/5ML VL	T4	SP
<i>cyclophosphamide 2 gm vial</i>	T4	SP
<i>cyclophosphamide 25 mg capsule</i>	T4	SP HD
<i>cyclophosphamide 50 mg capsule</i>	T4	SP HD
CYCLOPHOSPHAMIDE 50 MG TABLET	T4	PA SP HD
<i>cyclophosphamide 500 mg vial</i>	T4	SP
CYCLOPHOSPHAMIDE 500 MG/2.5 ML	T4	SP
EVOMELA	T4	PA SP

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

T4 – Specialty Medications

PA – Prior Authorization

QL – Quantity Limit

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## List of Prescription Medications

### ANTI-NEOPLASTICS (Cancer) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>ANTI-NEOPLASTIC - ALKYLATING AGENTS (con't.)</b>		
GLEOSTINE	T2	
GLIADEL	T4	SP
HYDREA ( <i>hydroxyurea</i> )	T3	
<i>hydroxyurea</i> (Hydrea)	T1	
IFEX ( <i>ifosfamide</i> )	T4	PA SP
<i>ifosfamide</i>	T4	PA SP
<i>ifosfamide</i> (Ifex)	T4	PA SP
LEUKERAN	T2	
<i>melphalan hcl</i> (Alkeran)	T3	PA CSL
MYLERAN	T2	
<i>oxaliplatin</i>	T4	PA SP
PEPAXTO	T4	PA SP
TEMODAR	T4	PA SP
<i>temozolomide</i>	T4	PA SP HD
TEPADINA	T4	PA SP
TEPADINA ( <i>thiotepa</i> )	T4	PA SP
<i>thiotepa</i> (Tepadina)	T4	PA SP
TREANDA ( <i>bendamustine hcl</i> )	T4	PA SP
YONDELIS	T4	PA SP
ZEPZELCA	T4	PA SP
<b>ANTI-NEOPLASTIC - ANTI-ANDROGENIC AGENTS</b>		
<i>abiraterone acetate</i> (Zytiga)	T4	PA SP HD
<i>bicalutamide</i> (Casodex)	T1	
CASODEX ( <i>bicalutamide</i> )	T3	
ERLEADA 240 MG TABLET	T4	PA QL(1 tab/day) SP HD CSL
ERLEADA 60 MG TABLET	T4	PA SP HD CSL
<i>flutamide</i>	T1	
NILANDRON ( <i>nilutamide</i> )	T3	PA QL (4 tabs/day)
<i>nilutamide</i> (Nilandron)	T1	QL (4 tabs/day)
NUBEQA	T4	PA SP HD
XTANDI	T4	PA SP HD
YONSA	T4	PA SP HD
ZYTIGA ( <i>abiraterone acetate</i> )	T4	PA SP HD

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

T4 – Specialty Medications

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## List of Prescription Medications

### ANTI-NEOPLASTICS (Cancer) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>ANTI-NEOPLASTICS ANTI-BODY/ANTI-BODY-DRUG COMPLEXES</b>		
ZIHERA	T3	
<b>ANTINEOPLASTIC - ANTIBIOTIC AND ANTIMETABOLITE</b>		
VYXEOS	T4	PA SP
<b>ANTINEOPLASTIC - ANTI-CD38 MONOCLONAL ANTIBODY</b>		
DARZALEX	T4	PA SP HD
DARZALEX FASPRO	T4	PA SP
SARCLISA	T4	PA SP
<b>ANTI-NEOPLASTIC - ANTI-METABOLITES</b>		
ALIMTA	T4	PA SP
ARRANON	T4	PA SP
<i>azacitidine</i> (Vidaza)	T4	PA SP
<i>capecitabine</i> (Xeloda)	T4	PA SP HD
<i>cladribine</i>	T4	PA SP
<i>clofarabine</i>	T4	PA SP
<i>cytarabine</i>	T4	PA SP
<i>cytarabine/pf</i>	T4	PA SP
DACOGEN ( <i>decitabine</i> )	T4	PA SP
<i>decitabine</i> (Dacogen)	T4	PA SP
<i>flouxuridine</i>	T4	PA SP
<i>fludarabine phosphate</i>	T4	PA SP
<i>fluorouracil</i>	T4	PA SP
<i>fluorouracil 1,000 mg/20 ml vfl</i>	T4	PA SP
<i>fluorouracil 2,500 mg/50 ml vfl</i>	T4	PA SP
<i>fluorouracil 2.5 gm/50 ml btl</i>	T4	PA SP
<i>fluorouracil 2.5 gm/50 ml vial</i>	T4	PA SP
<i>fluorouracil 5 gm/100 ml btl</i>	T4	PA SP
<i>fluorouracil 5 gm/100 ml vial</i>	T4	PA SP
<i>fluorouracil 5,000 mg/100 ml</i>	T4	PA SP
FOLOTYN 20 MG/ML VIAL	T4	PA SP
FOLOTYN 40 MG/2 ML VIAL	T4	PA SP
<i>gemcitabine hcl</i>	T4	PA SP
INFUGEM	T4	PA SP HD
INQOVI	T4	PA SP HD
LONSURF	T4	PA SP HD

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

T4 – Specialty Medications

PA – Prior Authorization

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## List of Prescription Medications

### ANTI-NEOPLASTICS (Cancer) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits	
<b>ANTI-NEOPLASTIC - ANTI-METABOLITES (cont.)</b>			
mercaptopurine	T1		
methotrexate sodium	T1		
methotrexate sodium/pf	T1		
NIPENT	T4	PA SP	
ONUREG	T4	PA QL (14 tabs/28 days) SP	
PEMRYDI RTU	T3	PA	
PURIXAN	T4	SP	
TABLOID	T3		
TREXALL	T2		
VIDAZA ( <i>azacitidine</i> )	T4	PA SP	
XATMEP	T3		
XELODA ( <i>capecitabine</i> )	T4	PA SP HD	
ZYNYZ	T4	PA SP	
<b>ANTINEOPLASTIC - ANTI-SLAMF7 MONOCLONAL ANTIBODY</b>			
EMPLICITI	T4	PA SP HD	
<b>ANTI-NEOPLASTIC - AROMATASE INHIBITORS</b>			
<i>anastrozole</i> (Arimidex)	T1	HD PPACA	
ARIMIDEX ( <i>anastrozole</i> )	T3	HD	
AROMASIN ( <i>exemestane</i> )	T3	HD	
<i>exemestane</i> (Aromasin)	T1	HD PPACA	
FEMARA ( <i>letrozole</i> )	T3	HD	
<i>letrozole</i> (Femara)	T1	HD	
<b>ANTI-NEOPLASTIC - BRAF KINASE INHIBITORS</b>			
BRAFTOVI	T3	PA SP HD	
OJEMDA TABLET	T4	PA QL(1 packet/28 Days) SP CSL	
OJEMDA 25 MG/ML ORAL SUSP	T4	PA QL(8 bottles/28 days) SP CSL	
TAFINLAR 10 MG TABLET FOR SUSP	T4	PA QL(30 tabs/day) SP HD CSL	
TAFINLAR 50 MG, 75 MG CAPSULE	T4	PA QL(4 caps/day) SP HD CSL	
ZELBORAF	T4	PA SP HD	
<b>ANTINEOPLASTIC - CD19 (B LYMPHOCYTE) MC ANTIBODY</b>			
MONJUVI	T4	PA SP	
<b>ANTINEOPLASTIC - EPOTHILONES AND ANALOGS</b>			
IXEMPRA	T4	PA SP	
<b>ANTI-NEOPLASTIC - HEDGEHOG PATHWAY INHIBITOR</b>			
CYCLOPHOSPHAMIDE 25 MG TABLET	T4	PA SP HD	
T1 – Typically Generics	T4 – Specialty Medications	ST – Step Therapy	HD – May require home delivery pharmacy
T2 – Typically Preferred Brands	PA – Prior Authorization	AGE – Age Requirement	PPACA – No Cost-Share Preventive Medication
T3 – Typically Non-Preferred Brands	QL – Quantity Limit	SP – Specialty Medication	CSL – Oral cancer medication subject to cost-share limits

## List of Prescription Medications

### ANTI-NEOPLASTICS (Cancer) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits	
<b>ANTI-NEOPLASTIC - HEDGEHOG PATHWAY INHIBITOR (cont.)</b>			
cyclophosphamide 50 mg capsule	T4	SP HD	
CYCLOPHOSPHAMIDE 50 MG TABLET	T4	PA SP HD	
cyclophosphamide 500 mg vial	T4	SP	
CYCLOPHOSPHAMIDE 500 MG/2.5 ML	T4	SP	
DAURISMO	T4	PA SP HD	
ERIVEDGE	T4	PA SP HD	
EVOMELA	T4	PA SP	
ODOMZO	T4	PA SP HD CSL	
<b>ANTI-NEOPLASTIC - JANUS KINASE (JAK) INHIBITORS</b>			
JAKAFI	T3	PA SP HD	
<b>ANTI-NEOPLASTIC - KRAS PROTEIN INHIBITOR</b>			
KRAZATI	T4	PA QL(6 tabs/day) SP CSL	
LUMAKRAS 120 MG TABLET	T4	PA QL(8 tabs/day) SP HD CSL	
LUMAKRAS 240 MG TABLET	T3	PA QL(4 tabs/day) SP HD CSL	
LUMAKRAS 320 MG TABLET	T4	PA QL(3 tabs/day) SP HD CSL	
<b>ANTI-NEOPLASTIC - MEK1 AND MEK2 KINASE INHIBITORS</b>			
COTELLIC	T4	PA SP HD	
GOMEKLI	T4	PA SP HD	
KOSELUGO 10 MG CAPSULE	T4	PA QL (10 capsules/day) SP	
KOSELUGO 25 MG CAPSULE	T4	PA QL (4 caps/day) SP	
MEKINIST 0.05 MG/ML SOLUTION	T4	PA QL(40 mls/day) SP HD CSL	
MEKINIST 0.5 MG TABLET	T4	PA QL(3 tabs/day) SP HD CSL	
MEKINIST 2 MG TABLET	T4	PA QL(1 tab/day) SP HD CSL	
MEKTOVI	T4	PA SP HD	
<b>ANTINEOPLASTIC - MICROTUBULE INHIBITORS</b>			
eribulin mesylate (Halaven)	T4	PA SP	
HALAVEN (eribulin mesylate)	T4	PA SP	
<b>ANTI-NEOPLASTIC - MTOR KINASE INHIBITORS</b>			
AFINITOR (everolimus)	T4	PA SP HD	
everolimus (Afinitor)	T4	PA QL(1 tab/day) SP CSL	
temsirolimus (Torisel)	T4	PA SP	
TORISEL (temsirolimus)	T4	PA SP	
<b>ANTI-NEOPLASTIC - PROTEIN METHYLTRANSFERASE INHIBIT</b>			
TAZVERIK	T4	PA SP	
<b>ANTI-NEOPLASTIC - TOPOISOMERASE I INHIBITORS</b>			
T1 – Typically Generics	T4 – Specialty Medications	ST – Step Therapy	HD – May require home delivery pharmacy
T2 – Typically Preferred Brands	PA – Prior Authorization	AGE – Age Requirement	PPACA – No Cost-Share Preventive Medication
T3 – Typically Non-Preferred Brands	QL – Quantity Limit	SP – Specialty Medication	CSL – Oral cancer medication subject to cost-share limits

## List of Prescription Medications

ANTI-NEOPLASTICS (Cancer) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>ANTI-NEOPLASTIC - TOPOISOMERASE I INHIBITORS (cont.)</b>		
CAMPTOSAR 100 MG/5 ML VIAL ( <i>irinotecan hcl</i> )	T4	PA SP
CAMPTOSAR 300 MG/15 ML VIAL	T4	PA SP
CAMPTOSAR 40 MG/2 ML VIAL ( <i>irinotecan hcl</i> )	T4	PA SP
HYCAMTIN 0.25 MG CAPSULE	T4	PA SP HD CSL
HYCAMTIN 1 MG CAPSULE	T4	PA SP HD CSL
HYCAMTIN 4 MG VIAL ( <i>topotecan hcl</i> )	T4	PA SP HD CSL
<i>irinotecan hcl</i>	T4	PA SP
<i>irinotecan hcl</i> (Camptosar)	T4	PA SP
ONIVYDE	T4	PA SP
<i>topotecan hcl</i>	T4	PA SP HD
<i>topotecan hcl</i> (Hycamtin)	T4	PA SP HD
<b>ANTINEOPLASTIC - VEGF-A, B AND PLGF INHIBITORS</b>		
ZALTRAP	T4	PA SP
<b>ANTINEOPLASTIC - VEGFR ANTAGONIST</b>		
CYRAMZA	T4	PA SP
<b>ANTINEOPLASTIC - VINCA ALKALOIDS</b>		
MARQIBO	T4	PA SP
NAVELBINE ( <i>vinorelbine tartrate</i> )	T4	PA SP
<i>vinblastine sulfate</i>	T4	PA SP
<i>vincristine sulfate</i>	T4	PA SP
<i>vinorelbine tartrate</i> (Navelbine)	T4	PA SP
<b>ANTINEOPLASTIC- CD22 ANTIBODY-CYTOTOXIC ANTIBIOTIC</b>		
BESPONSA	T4	PA SP
<b>ANTINEOPLASTIC- CD33 ANTIBODY-CYTOTOXIC ANTIBIOTIC</b>		
MYLOTARG	T4	PA SP
<b>ANTI-NEOPLASTIC COMB - KINASE AND AROMATASE INHIBIT</b>		
KISQALI FEMARA CO-PACK	T4	PA QL(1 tab/28 days) SP CSL
<b>ANTI-NEOPLASTIC EGF RECEPTOR BLOCKER MCLON ANTIBODY</b>		
ERBITUX	T4	PA SP
HERCEPTIN	T4	PA SP
HERCEPTIN HYLECTA	T4	PA SP
HERZUMA	T4	PA SP
KANJINTI	T4	PA SP
MARGENZA	T4	PA SP

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

T4 – Specialty Medications

PA – Prior Authorization

QL – Quantity Limit

ST – Step Therapy

AGE – Age Requirement

SP – Specialty Medication

HD – May require home delivery pharmacy

PPACA – No Cost-Share Preventive Medication

CSL – Oral cancer medication subject to cost-share limits

## List of Prescription Medications

### ANTI-NEOPLASTICS (Cancer) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits	
<b>ANTI-NEOPLASTIC EGF RECEPTOR BLOCKER MCLON ANTIBODY (cont.)</b>			
OGIVRI	T4	PA SP	
ONTRUZANT	T4	PA SP	
PERJETA	T4	PA SP	
PHESGO	T4	PA SP HD	
PORTRAZZA	T4	PA SP	
TRAZIMERA	T4	PA SP	
VECTIBIX	T4	PA SP	
<b>ANTI-NEOPLASTIC IMMUNOMODULATOR AGENTS</b>			
lenalidomide	T4	PA QL(1 tab/day) SP HD CSL	
POMALYST	T4	PA QL(21 caps/28 days) SP HD CSL	
REVLIMID	T4	PA QL(1 tab/day) SP HD CSL	
<b>ANTI-NEOPLASTIC LHRH (GNRH) AGONIST, PITUITARY SUPPR.</b>			
ELIGARD	T4	SP HD	
<i>leuprolide acetate</i>	T4	PA SP HD	
LEUPROLIDE DEPOT	T4	PA SP	
LUPRON DEPOT	T4	PA SP HD	
TRELSTAR	T4	SP HD	
ZOLADEX	T4	PA SP HD	
<b>ANTI-NEOPLASTIC LHRH (GNRH) ANTAGONIST, PITUIT.SUPPRS</b>			
FIRMAGON	T4	PA SP HD	
ORGOVYX	T4	PA SP	
<b>ANTI-NEOPLASTIC SYSTEMIC ENZYME INHIBITORS</b>			
ALECensa	T4	PA QL(8 tabs/day) SP HD CSL	
ALIqopa	T4	PA SP	
ALUNBRIG	T4	PA SP HD	
AUGTYRO	T4	PA QL(8 caps/day) SP HD CSL	
AYVAKIT	T4	PA QL (1 tab/day) SP	
BALVERSA	T4	PA SP	
BORTEZOMIB	T4	PA SP	
BORUZU	T3	PA SP	
BOSULIF	T4	PA QL(3 caps/day) SP HD	
BORUZU	T3	PA SP	
BRUKINSA	T4	PA QL (4 caps/day) SP	
CABOMETYX	T4	PA SP HD	
CALQUENCE	T4	PA SP	
T1 – Typically Generics	T4 – Specialty Medications	ST – Step Therapy	HD – May require home delivery pharmacy
T2 – Typically Preferred Brands	PA – Prior Authorization	AGE – Age Requirement	PPACA – No Cost-Share Preventive Medication
T3 – Typically Non-Preferred Brands	QL – Quantity Limit	SP – Specialty Medication	CSL – Oral cancer medication subject to cost-share limits

## List of Prescription Medications

### ANTI-NEOPLASTICS (Cancer) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>ANTI-NEOPLASTIC SYSTEMIC ENZYME INHIBITORS (cont.)</b>		
CAPRELSA	T4	PA SP
COMETRIQ	T4	PA SP HD
COPIKTRA	T4	PA SP
<i>dasatinib</i> 20 mg tablet	T4	PA QL(3 tabs/day) SP HD CSL
<i>dasatinib</i> 70 mg tablet	T4	PA QL(2 tabs/day) SP HD CSL
<i>dasatinib</i> 50 mg, 80 mg, 100 mg, 140 mg tablet	T4	PA QL(1 tab/day) SP HD CSL
<i>erlotinib hcl</i> (Tarceva)	T4	PA SP HD
EXKIVITY	T4	PA SP HD
FOTIVDA	T4	PA QL (30 caps/30 days) SP HD
FRUZAQLA 1 MG CAPSULE	T4	PA QL(84 caps/28 days) SP CSL
FRUZAQLA 5 MG CAPSULE	T4	PA QL(21 caps/28 days) SP CSL
GAVRETO	T4	PA QL (4 tabs/day) SP
<i>gefitinib</i>	T4	PA SP HD CSL
GILOTrif	T4	PA SP HD
GLEEVEC ( <i>imatinib mesylate</i> )	T4	PA SP HD
IBRANCE	T4	PA QL (21/30 days) SP HD
ICLUSIG	T4	PA SP
<i>imatinib mesylate</i> (Gleevec)	T4	PA SP HD
IMBRUVICA	T4	PA SP
IMKELDI	T2	PA SP CSL
INLYTA	T4	PA SP HD
INREBIC	T4	PA SP HD
IRESSA	T4	PA SP HD
ITOVEBI	T4	PA SP HD CSL
OGSIVEO 50 MG, 100 MG, 150 MG TABLET	T4	PA QL SP CSL
OJJAARA	T4	PA QL(1 Tab/day) SP CSL
IWLFIN	T4	PA QL(8 tabs/day) SP CSL
KISQALI 200 MG	T4	PA QL (21 per 28 days) SP HD CSL
KISQALI 400 MG	T4	PA QL (42 per 28 days) SP HD CSL
KISQALI 800 MG	T4	PA QL (63 per 28 days) SP HD CSL
KISQALI FEMARA CO-PACK	T4	PA QL (1 pack per 28 days) SP HD CSL
KYPROLIS	T4	PA SP HD
<i>lapatinib ditosylate</i> (Tykerb)	T4	PA SP HD
LENVIMA	T4	PA SP HD CSL
LORBRENA	T4	PA SP HD

Typically Preferred

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

Specialty Medications

PA – Prior Authorization

QL – Quantity Limit

Step Therapy

AGE – Age Requirement

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May require home delivery pharmacy

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CSL – Oral cancer medication subject to cost-share limits

## List of Prescription Medications

### ANTI-NEOPLASTICS (Cancer) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>ANTI-NEOPLASTIC SYSTEMIC ENZYME INHIBITORS (cont.)</b>		
LYNPARZA	T4	PA SP HD
LYTGOBI 12 MG DOSE (3X 4MG TB)	T4	PA QL(3 tabs/day) SP CSL
LYTGOBI 16 MG DOSE PACK (4X 4MG TB)	T4	PA QL(4 tabs/day) SP CSL
LYTGOBI 20 MG DOSE PACK (5X 4MG TB)	T4	PA QL(5 tabs/day) SP CSL
NERLYNX	T4	PA SP HD
NEXAVAR	T4	PA QL(4 tabs/day) SP HD CSL
NINLARO	T4	PA SP HD
PEMAZYRE	T4	PA QL (14 tabs/21 days) SP
PIQRAY	T4	PA SP HD CSL
<i>pazopanib</i> (Votrient)	T4	PA QL(4 tabs/day) SP HD CSL
QINLOCK	T4	PA QL (3 tabs/day) SP
RETEVMO 40 MG CAPSULE	T4	PA QL (6 caps/day) SP HD
RETEVMO 80 MG CAPSULE	T4	PA QL (4 tabs/day) SP HD
REVUFORJ 25 MG, 110 MG TABLET	T4	PA SP CSL
REVUFORJ 160 MG TABLET	T4	PA QL(2 tabs/day) SP CSL
ROZLYTREK	T4	PA SP HD
RUBRACA	T4	PA SP
RYDAPT	T4	PA SP HD
RYTELO	T4	PA SP
SCEMBLIX	T4	PA QL (2 tablets/day) SP HD
SPRYCEL	T4	PA SP HD
STIVARGA	T4	PA QL(84 tabs/28 days) SP HD CSL
SUTENT	T4	PA SP HD
TABRECTA	T4	PA QL (4 tabs/day) SP HD
TAGRISSO	T4	PA SP HD
TRUQAP	T4	PA QL(64 TABS/28 DAYS) SP CSL
TALZENNA	T4	PA QL(1 cap/day) SP HD CSL
TARCEVA ( <i>erlotinib hcl</i> )	T4	PA SP HD
TASIGNA	T4	PA QL(4 caps/day) SP HD CSL
TEPMETKO	T4	PA SP QL (2 tabs/day)
TUKYSA	T4	PA SP
TURALIO	T4	PA QL(4 caps/day) SP CSL
TYKERB ( <i>lapatinib</i> )	T4	PA SP HD
UKONIQ	T4	PA QL (4 tabs/day) SP
VANFLYTA	T4	PA QL(2 tabs/day) SP CSL

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

PA – Specialty Medications

QL – Quantity Limit

SP – Step Therapy

AGE – Age Requirement

SP – Specialty Medication

PPACA – No Cost-Share Preventive Medication

CSL – Oral cancer medication subject to cost-share limits

## List of Prescription Medications

ANTI-NEOPLASTICS (Cancer) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>ANTI-NEOPLASTIC SYSTEMIC ENZYME INHIBITORS (cont.)</b>		
VELCADE	T4	PA SP
VERZENIO	T4	PA QL (120mg/day) SP HD
VITRAKVI	T4	PA SP HD
VIZIMPRO	T4	PA SP HD
VOTRIENT ( <i>pazopanib hcl</i> )	T4	PA QL(4 tabs/day) SP HD CSL
XALKORI	T4	PA SP HD
XOSPATA	T4	PA SP
ZEJULA	T4	PA QL(1 tab/day) SP CSL
ZYDELIG	T4	PA SP HD
ZYKADIA	T4	PA SP HD
<b>ANTI-NEOPLASTIC, ANTI-PROGRAMMED DEATH-1 (PD-1) MAB</b>		
KEYTRUDA	T4	PA SP
LIBTAYO	T4	PA SP
LOQTORZI	T4	PA SP
OPDIVO	T4	PA SP HD
TEVIMBRA	T4	PA SP
<b>ANTI-NEOPLASTIC-B CELL LYMPHOMA-2(BCL-2) INHIBITORS</b>		
VENCLEXTA	T4	PA SP
VENCLEXTA STARTING PACK	T4	PA SP
<b>ANTI-NEOPLASTIC-ENZYME INHIB, ANTIANDROGEN COMB.</b>		
AKEEGA	T4	PA QL(2 tabs/day) SP CSL
<b>ANTINEOPLASTIC-CD22 DIRECT ANTIBODY/CYTOTOXIN CONJ</b>		
LUMOXITI	T4	PA SP
<b>ANTINEOPLASTIC-INTERLEUKIN-6 (IL-6) INHIB, ANTIBODY</b>		
SYLVANT	T4	PA SP
<b>ANTI-NEOPLASTIC-ISOCITRATE DEHYDROGENASE INHIBITORS</b>		
IDHIFA	T4	PA SP HD
REZLIDHIA	T4	PA QL(2 caps/day) SP CSL
TIBSOVO	T4	PA SP
<b>ANTI-NEOPLASTICS ANTIBODY/ANTIBODY-DRUG COMPLEXES</b>		
ADCETRIS	T4	PA SP
BLENREP	T3	PA
BLINCYTO	T4	PA SP
ENHERTU	T4	PA SP HD

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

T4 – Specialty Medications

PA – Prior Authorization

QL – Quantity Limit

ST – Step Therapy

AGE – Age Requirement

SP – Specialty Medication

HD – May require home delivery pharmacy

PPACA – No Cost-Share Preventive Medication

CSL – Oral cancer medication subject to cost-share limits

## List of Prescription Medications

### ANTI-NEOPLASTICS (Cancer) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>ANTI-NEOPLASTICS ANTIBODY/ANTIBODY-DRUG COMPLEXES (cont.)</b>		
IMDELLTRA	T4	PA SP
KADCYLA	T4	PA SP
LUNSUMIO	T4	PA SP
PADCEV	T4	PA SP
POLIVY	T4	PA SP HD
POTELIGEO	T4	PA SP
TRODELVY	T4	PA SP
UNITUXIN	T4	PA SP
VYLOY	T4	PA SP
ZEVALIN	T4	PA SP
ZIIHERA	T3	
<b>ANTI-NEOPLASTICS, MISCELLANEOUS</b>		
ABRAXANE	T4	PA SP
ARSENIC TRIOXIDE	T4	PA SP
<i>arsenic trioxide</i> (Trisenox)	T4	PA SP
ASPARLAS	T4	SP
BCG (TICE STRAIN)	T4	SP
<i>dacarbazine</i>	T4	PA SP
DOCEFREZ	T4	PA SP
<i>docetaxel 160 mg/16 ml vial</i>	T4	PA SP
<i>docetaxel 160 mg/8 ml vial</i>	T4	PA SP HD
<i>docetaxel 20 mg/2 ml vial</i>	T4	PA SP
<i>docetaxel 20 mg/ml vial</i>	T4	PA SP
<i>docetaxel 80 mg/4 ml vial</i>	T4	PA SP
<i>docetaxel 80 mg/8 ml vial</i>	T4	PA SP
DOCIVYX	T4	PA SP
ERWINAZE	T4	PA SP
ETOPOPHOS	T4	PA SP
<i>etoposide</i>	T4	PA SP
<i>etoposide vial</i>	T4	PA SP
<i>etoposide 50 mg capsule</i>	T4	SP HD
<i>etoposide 500 mg/25 ml vial</i>	T4	PA SP
JEVTANA	T4	PA SP HD
LYSODREN	T3	

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

T4 – Specialty Medications

PA – Prior Authorization

QL – Quantity Limit

ST – Step Therapy

AGE – Age Requirement

SP – Specialty Medication

HD – May require home delivery pharmacy

PPACA – No Cost-Share Preventive Medication

CSL – Oral cancer medication subject to cost-share limits

## List of Prescription Medications

ANTI-NEOPLASTICS (Cancer) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>ANTI-NEOPLASTICS, MISCELLANEOUS (con't.)</b>		
MATULANE	T4	SP
<i>mitoxantrone hcl</i>	T4	PA SP
ONCASPAR	T4	PA SP
<i>paclitaxel</i>	T4	PA SP
TAXOTERE ( <i>docetaxel</i> )	T4	PA SP
<i>tretinoiin 10 mg capsule</i>	T1	PA
TRISENOX ( <i>arsenic trioxide</i> )	T4	PA SP
<b>ANTI-NEOPLASTIC-SELECT INHIB OF NUCLEAR EXP (SINE)</b>		
XPOVIO	T4	PA SP
<b>ANTI-PROGRAMMED CELL DEATH-LIGAND I (PD-L1) MAB</b>		
BAVENCIO	T4	PA SP
IMFINZI	T4	PA SP
TECENTRIQ	T4	PA SP HD
<b>CYTOTOXIC T-LYMPHOCYTE ANTIGEN (CTLA-4) RMC ANTIBODY</b>		
IMJUDO	T4	PA SP HD
YERVOY	T4	PA SP HD
<b>IMMUNOMODULATORS</b>		
ACTIMMUNE	T4	PA SP HD
ALFERON N	T4	PA SP HD
BESREMI	T4	PA QL (2 syringes/28 days) SP
PROLEUKIN	T4	PA SP
<b>PHOTOACTIVATED, ANTINEOPLASTIC AGENTS (SYSTEMIC)</b>		
PHOTOFIRIN	T4	SP
UVADEX	T2	
<b>RADIOACTIVE THERAPEUTIC AGENTS</b>		
AZEDRA DOSIMETRIC	T4	PA SP
AZEDRA THERAPEUTIC	T4	PA SP
<b>SELECTIVE ESTROGEN RECEPTOR MODULATORS (SERMS)</b>		
FARESTON ( <i>toremifene citrate</i> )	T3	QL (2 tabs/day) HD
FASLODEX ( <i>fulvestrant</i> )	T4	PA SP HD
<i>fulvestrant</i> (Faslodex)	T4	PA SP HD
SOLTAMOX	T2	HD
<i>tamoxifen citrate</i>	T1	HD PPACA
<i>toremifene citrate</i> (Fareston)	T1	QL (2 tabs/day) HD

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

T4 – Specialty Medications

PA – Prior Authorization

QL – Quantity Limit

ST – Step Therapy

AGE – Age Requirement

SP – Specialty Medication

HD – May require home delivery pharmacy

PPACA – No Cost-Share Preventive Medication

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## List of Prescription Medications

### ANTI-NEOPLASTICS (Cancer) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>STEROID ANTI-NEOPLASTICS</b>		
EMCYT	T4	SP HD
<i>megestrol acetate</i>	T1	
<b>ANTI-NEOPLASTICS (Skin Conditions)</b>		
<b>PHOTOACT, TOPICAL ANTI-NEOPLAST, PREMALIGNANT LESIONS</b>		
LEVULAN	T4	SP
<b>TOPICAL ANTI-NEOPLASTIC PREMALIGNANT LESION AGENTS</b>		
CARAC	T3	PA
<i>diclofenac sodium 3% gel</i>	T1	PA
EFUDEX ( <i>fluorouracil</i> )	T3	
FLUOROPLEX	T2	
FLUOROURACIL 0.5% CREAM	T1	
<i>fluorouracil 2% topical soln</i>	T1	
<i>fluorouracil 5% cream (Efudex)</i>	T1	
<i>fluorouracil 5% topical soln</i>	T1	
KLISYRI	T3	PA QL (5 packs/30 Days)
PANRETIN	T4	SP HD
PICATO	T2	
TARGRETIN 1% GEL	T4	PA SP HD
TOLAK	T3	
VALCHLOR	T4	SP HD
<b>ANTI-PARASITICS (Infections)</b>		
<b>ANTI-PARASITICS</b>		
ALINIA ( <i>nitazoxanide</i> )	T3	
<i>nitazoxanide (Alinia)</i>	T1	
<b>OPHTHALMIC (EYE) ANTIPARASITICS</b>		
XDEMVY	T4	PA QL(4 bottles/30 days) SP
<b>TOPICAL ANTI-PARASITICS</b>		
<i>crotamiton (Eurax)</i>	T1	
ELIMITE ( <i>permethrin</i> )	T3	
EURAX 10% CREAM	T2	
EURAX 10% LOTION	T3	
NATROBA ( <i>spinosad</i> )	T3	
<i>permethrin (Elimite)</i>	T1	
SKLICE ( <i>ivermectin</i> )	T3	

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

T4 – Specialty Medications

PA – Prior Authorization

QL – Quantity Limit

ST – Step Therapy

AGE – Age Requirement

SP – Specialty Medication

HD – May require home delivery pharmacy

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CSL – Oral cancer medication subject to cost-share limits

## List of Prescription Medications

ANTI-PARASITICS (Infections) (con't.)		
TOPICAL ANTI-PARASITICS (con't.)		
<i>spinossad</i> (Natroba)	T1	
ULESFIA	T3	
ANTI-PARKINSON DRUGS (Parkinson's Disease)		
ANTI-PARKINSONISM DRUGS, ANTI-CHOLINERGIC		
<i>benztropine mesylate</i>	T1	HD
ANTI-PARKINSON DRUGS (Parkinson's Disease) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ANTI-PARKINSONISM DRUGS, ANTI-CHOLINERGIC (cont.)		
<i>trihexyphenidyl hcl</i>	T1	HD
ANTI-PARKINSONISM DRUGS, OTHER		
<i>amantadine hcl</i>	T1	HD
APOKYN	T4	PA SP HD
AZILECT 0.5 MG TABLET ( <i>rasagiline mesylate</i> )	T3	QL (1 tab/day) HD
AZILECT 1 MG TABLET ( <i>rasagiline mesylate</i> )	T3	HD
<i>bromocriptine mesylate</i>	T1	HD
<i>carbidopa/levodopa</i>	T1	HD
<i>carbidopa/levodopa</i> (Sinemet 10-100)	T1	HD
<i>carbidopa/levodopa</i> (Sinemet 25-100)	T1	HD
<i>carbidopa/levodopa</i> (Sinemet 25-250)	T1	HD
<i>carbidopa/levodopa/entacapone</i> (Stalevo 100)	T1	HD
<i>carbidopa/levodopa/entacapone</i> (Stalevo 125)	T1	HD
<i>carbidopa/levodopa/entacapone</i> (Stalevo 150)	T1	HD
<i>carbidopa/levodopa/entacapone</i> (Stalevo 200)	T1	HD
<i>carbidopa/levodopa/entacapone</i> (Stalevo 50)	T1	HD
<i>carbidopa/levodopa/entacapone</i> (Stalevo 75)	T1	HD
COMTAN ( <i>entacapone</i> )	T3	HD
DHIVY	T3	PA
DUOPA	T4	SP HD
<i>entacapone</i> (Comtan)	T1	HD
GOCOVRI	T3	HD
INBRIJA	T4	PA SP HD
KYNMOBI	T2	PA HD
MIRAPEX ER 1.5 MG TABLET ( <i>pramipexole er</i> )	T3	QL (1 tab/day) HD

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

T4 – Specialty Medications

PA – Prior Authorization

QL – Quantity Limit

ST – Step Therapy

AGE – Age Requirement

SP – Specialty Medication

HD – May require home delivery pharmacy

PPACA – No Cost-Share Preventive Medication

CSL – Oral cancer medication subject to cost-share limits

## List of Prescription Medications

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

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>ANTI-PARKINSONISM DRUGS, OTHER (cont.)</b>		
NEUPRO	T3	HD
NOURIANZ	T4	PA QL (1 tab/day) SP HD
ONGENTYS	T3	PA QL (1 caps/day) HD
OSMOLEX ER	T3	QL (1 tab/day) HD
PARLODEL ( <i>bromocriptine mesylate</i> )	T3	HD
<i>pramipexole di-hcl</i>	T1	HD
<i>pramipexole er 0.375 mg tablet</i>	T1	QL (1 tab/day) HD
<i>pramipexole er 0.75 mg tablet</i>	T1	HD
<i>pramipexole er 1.5 mg tablet (Mirapex Er)</i>	T1	QL (1 tab/day) HD
<i>pramipexole er 2.25 mg tablet</i>	T1	QL (1 tab/day) HD
<i>pramipexole er 3 mg tablet</i>	T1	HD
<i>pramipexole er 3.75 mg tablet</i>	T1	HD
<i>rasagiline mesylate 0.5 mg tab (Azilect)</i>	T1	QL (1 tab/day) HD
<i>rasagiline mesylate 1 mg tab (Azilect)</i>	T1	HD
<i>ropinirole hcl</i>	T1	HD
RYTARY	T3	HD
<i>selegiline hcl</i>	T1	HD
SINEMET 10-100 ( <i>carbidopa-levodopa</i> )	T3	HD
SINEMET 25-100 ( <i>carbidopa-levodopa</i> )	T3	HD
SINEMET 25-250 ( <i>carbidopa-levodopa</i> )	T3	HD
STALEVO 100 ( <i>carbidopa-levodopa-entacapone</i> )	T3	HD
STALEVO 125 ( <i>carbidopa-levodopa-entacapone</i> )	T3	HD
STALEVO 150 ( <i>carbidopa-levodopa-entacapone</i> )	T3	HD
STALEVO 200 ( <i>carbidopa-levodopa-entacapone</i> )	T3	HD
STALEVO 50 ( <i>carbidopa-levodopa-entacapone</i> )	T3	HD
STALEVO 75 ( <i>carbidopa-levodopa-entacapone</i> )	T3	HD
TASMAR ( <i>tolcapone</i> )	T3	HD
<i>tolcapone (Tasmar)</i>	T1	HD
VYALEV	T4	PA SP HD
XADAGO	T3	ST HD
ZELAPAR	T3	PA HD

### DECARBOXYLASE INHIBITORS

<i>carbidopa (Lodosyn)</i>	T1	
<i>LODOSYN (carbidopa)</i>	T3	PA
T1 – Typically Generics		HD – May require home delivery pharmacy
T2 – Typically Preferred Brands		PPACA – No Cost-Share Preventive Medication
T3 – Typically Non-Preferred Brands		CSL – Oral cancer medication subject to cost-share limits
T4 – Specialty Medications		
PA – Prior Authorization		
QL – Quantity Limit		
ST – Step Therapy		
AGE – Age Requirement		
SP – Specialty Medication		

## List of Prescription Medications

ANTI-PLATELET DRUGS (Blood Thinners/Anti-Clotting)		
PLATELET AGGREGATION INHIBITORS		
AGGRASTAT	T3	
<i>aspirin/dipyridamole</i>	T1	HD
ANTI-PLATELET DRUGS (Blood Thinners/Anti-Clotting) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
PLATELET AGGREGATION INHIBITORS (con't.)		
ASPIRIN-OMEPRAZOLE	T3	PA HD
BRILINTA	T2	HD
<i>cilostazol</i>	T1	HD
<i>clopidogrel bisulfate</i> (Plavix)	T1	HD
<i>dipyridamole 25 mg tablet</i>	T1	HD
<i>dipyridamole 50 mg tablet</i>	T1	HD
<i>dipyridamole 75 mg tablet</i>	T1	HD
EFFIENT (prasugrel hcl)	T3	HD
EPTIFIBATIDE	T1	HD
<i>eptifibatide</i> (Integrilin)	T1	
INTEGRILIN (eptifibatide)	T3	HD
PLAVIX (clopidogrel)	T3	HD
<i>prasugrel hcl</i> (Effient)	T1	HD
<i>ticlopidine hcl</i>	T1	HD
<i>tirofiban-0.9% sodium chloride</i>	T1	
YOSPRALA DR 325-40 MG TABLET	T3	PA
YOSPRALA DR 81-40 MG TABLET	T3	PA HD
ZONTIVITY	T3	HD
PLATELET REDUCING AGENTS		
AGRYLIN (anagrelide hcl)	T3	
<i>anagrelide hcl</i> (Agrylin)	T1	
ANTIVIRALS (AIDS/HIV)		
ANTIRETROVIRAL - ANTI-CD4 DOMAIN 2 MONOCLONAL AB		
TROGARZO	T4	PA SP
ANTI-RETROVIRAL - CAPSID INHIBITORS		
SUNLENCA 463.5 MG/1.5 ML VIAL	T4	PA SP
SUNLENCA TABLET	T4	PA QL(5 tabs/180 days) SP
ANTI-RETROVIRAL - INTEGRASE INHIBITOR AND NNRTI COMB.		
CABENUVA	T4	PA SP
JULUCA	T4	SP

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

T4 – Specialty Medications

PA – Prior Authorization

QL – Quantity Limit

ST – Step Therapy

AGE – Age Requirement

SP – Specialty Medication

HD – May require home delivery pharmacy

PPACA – No Cost-Share Preventive Medication

CSL – Oral cancer medication subject to cost-share limits

## List of Prescription Medications

### ANTIVIRALS (AIDS/HIV) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits	
<b>ANTI-RETROVIRAL - INTEGRASE INHIBITOR AND NRTI COMB.</b>			
DOVATO	T4	SP	
<b>ANTI-RETROVIRAL - NRTIS AND INTEGRASE INHIBITORS COMB</b>			
TRIUMEQ	T4	QL(6 tabs/day) SP	
<b>ANTI-RETROVIRAL - NUCLEOSIDE, NUCLEOTIDE, PROTEASE INH.</b>			
SYMTUZA	T4	SP	
<b>ANTIVIRALS - HIV-SPEC, NON-PEPTIDIC PROTEASE INHIB</b>			
APTVUS	T4	PA SP	
<i>darunavir (Prezista)</i>	T4	SP	
PREZCOBIX	T4	PA SP	
PREZISTA	T4	PA SP	
<b>ANTIVIRALS - HIV-SPEC, NUCLEOSIDE-NUCLEOTIDE ANALOG</b>			
CIMDUO	T4	PA SP	
DESCOVY	T4	SP PPACA	
<i>emtricitabine-tenofovir 100-150mg (Truvada)</i>	T4	SP	
<i>emtricitabine-tenofovir 133-200mg (Truvada)</i>	T4	SP	
<i>emtricitabine-tenofovir 167-250mg (Truvada)</i>	T4	SP	
<i>emtricitabine-tenofovir 200-300mg (Truvada)</i>	T4	SP PPACA	
TEMIXYS	T4	PA SP	
TRUVADA ( <i>emtricitabine-tenofovir disop</i> )	T4	PA SP	
<b>ANTIVIRALS - HIV-SPEC, NUCLEOSIDE ANALOG, RTI COMB</b>			
<i>abacavir sulfate/lamivudine (Epzicom)</i>	T4	PA SP	
<i>abacavir/lamivudine/zidovudine</i>	T4	PA SP	
<i>COMBIVIR (lamivudine-zidovudine)</i>	T4	PA SP	
<i>EPZICOM (abacavir-lamivudine)</i>	T4	PA SP	
<i>lamivudine/zidovudine (Combivir)</i>	T4	SP	
<b>ANTIVIRALS - HIV-SPECIFIC, CCR5 CO-RECEPTOR ANTAG.</b>			
SELZENTRY 150 MG TABLET (maraviroc)	T4	PA SP	
SELZENTRY 20 MG/ML ORAL SOLN	T4	PA SP	
SELZENTRY 25 MG TABLET	T4	PA SP	
SELZENTRY 300 MG TABLET (maraviroc)	T4	PA SP	
SELZENTRY 75 MG TABLET	T4	PA SP	
<b>ANTIVIRALS - HIV-SPECIFIC, CD4 ATTACHMENT INHIBITOR</b>			
RUKOBIA	T4	PA QL (2 syringes/day) SP	
<b>ANTIVIRALS - HIV-SPECIFIC, FUSION INHIBITORS</b>			
FUZEON	T4	PA SP	
T1 – Typically Generics	T4 – Specialty Medications	ST – Step Therapy	HD – May require home delivery pharmacy
T2 – Typically Preferred Brands	PA – Prior Authorization	AGE – Age Requirement	PPACA – No Cost-Share Preventive Medication
T3 – Typically Non-Preferred Brands	QL – Quantity Limit	SP – Specialty Medication	CSL – Oral cancer medication subject to cost-share limits

## List of Prescription Medications

### ANTIVIRALS (AIDS/HIV) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>ANTIVIRALS - HIV-SPECIFIC, NON-NUCLEOSIDE, RTI (cont.)</b>		
EDURANT	T4	PA SP
efavirenz	T4	PA SP
INTELENCE	T4	PA SP
<b>ANTIVIRALS - HIV-SPECIFIC, NUCLEOSIDE ANALOG, RTI</b>		
abacavir sulfate	T4	PA SP
nevirapine	T4	PA SP
nevirapine (Viramune Xr)	T4	PA SP
nevirapine (Viramune)	T4	PA SP
PIFELTRO	T4	PA SP
SUSTIVA (efavirenz)	T4	PA SP
VIRAMUNE (nevirapine)	T4	PA SP
VIRAMUNE XR (nevirapine er)	T4	PA SP
didanosine (Videx Ec)	T4	PA SP
emtricitabine (Emtriva)	T4	PA SP
EMTRIVA 10 MG/ML SOLUTION	T4	PA SP
EMTRIVA 200 MG CAPSULE (emtricitabine)	T4	PA SP
EPIVIR (lamivudine)	T4	PA SP
lamivudine 10 mg/ml oral soln (Epivir)	T4	SP
lamivudine 150 mg tablet (Epivir)	T4	SP
lamivudine 300 mg tablet (Epivir)	T4	PA SP
RETROVIR (zidovudine)	T4	PA SP
stavudine	T4	PA SP
VIDEX EC	T4	PA SP
VIDEX EC (didanosine)	T4	PA SP
ZIAGEN (abacavir)	T4	PA SP
zidovudine	T4	SP
zidovudine (Retrovir)	T4	SP
<b>ANTIVIRALS, HIV-SPECIFIC, NUCLEOTIDE ANALOG, RTI</b>		
tenofovir disoproxil fumarate (Viread)	T4	PA SP
VIREAD 150 MG TABLET	T4	PA SP
VIREAD 200 MG TABLET	T4	PA SP
VIREAD 250 MG TABLET	T4	PA SP
VIREAD 300 MG TABLET (tenofovir disoproxil fumarate)	T4	PA SP
VIREAD POWDER	T4	PA SP

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

T4 – Specialty Medications

PA – Prior Authorization

QL – Quantity Limit

ST – Step Therapy

AGE – Age Requirement

SP – Specialty Medication

HD – May require home delivery pharmacy

PPACA – No Cost-Share Preventive Medication

CSL – Oral cancer medication subject to cost-share limits

## List of Prescription Medications

### ANTIVIRALS (AIDS/HIV) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>ANTIVIRALS - HIV-SPECIFIC, PROTEASE INHIBITOR COMB</b>		
KALETRA 100-25 MG TABLET	T4	SP
KALETRA 200-50 MG TABLET	T4	SP
KALETRA 80 MG-20 MG/ML SOLN ( <i>lopinavir-ritonavir</i> )	T4	PA SP
<i>lopinavir/ritonavir</i> (Kaletra)	T4	SP
<b>ANTIVIRALS - HIV-SPECIFIC, PROTEASE INHIBITORS</b>		
<i>atazanavir sulfate</i> (Reyataz)	T4	PA SP
CRIXIVAN	T4	PA SP
EVOTAZ	T4	PA SP
<i>fosamprenavir calcium</i> (Lexiva)	T4	PA SP
LEXIVA 50 MG/ML SUSPENSION	T4	PA SP
LEXIVA 700 MG TABLET ( <i>fosamprenavir calcium</i> )	T4	PA SP
NORVIR 100 MG POWDER PACKET	T4	SP
NORVIR 100 MG TABLET ( <i>ritonavir</i> )	T4	PA SP
REYATAZ 150 MG CAPSULE ( <i>atazanavir sulfate</i> )	T4	PA SP
REYATAZ 200 MG CAPSULE ( <i>atazanavir sulfate</i> )	T4	PA SP
REYATAZ 300 MG CAPSULE ( <i>atazanavir sulfate</i> )	T4	PA SP
REYATAZ 50 MG POWDER PACKET	T4	PA SP
<i>ritonavir</i> (Norvir)	T4	SP
VIRACEPT	T4	PA SP
<b>ANTIVIRALS - HIV-I INTEGRASE STRAND TRANSFER INHIBTR</b>		
APRETUDE	T4	PA SA
ISENTRESS	T4	SP
ISENTRESS HD	T4	PA SP
TIVICAY	T4	SP
TIVICAY PD	T4	SP
<b>ARTV NUCLEOSIDE, NUCLEOTIDE, NON-NUCLEOSIDE RTI COMB</b>		
ATRIPLA ( <i>efavirenz-emtric-tenofovir disop</i> )	T4	PA SP
COMPLERA	T4	PA SP
DELSTRIGO	T4	PA SP
<i>efavirenz/emtricit/tenofovir df</i> (Atripla)	T4	PA SP
<i>efavirenz/lamivu/tenofovir disop</i> (Symfi Lo)	T4	SP
<i>efavirenz/lamivu/tenofovir disop</i> (Symfi)	T4	SP
ODEFSEY	T4	PA SP
SYMF1 ( <i>efavirenz-lamivu-tenofovir disop</i> )	T4	SP

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

T4 – Specialty Medications

PA – Prior Authorization

QL – Quantity Limit

ST – Step Therapy

AGE – Age Requirement

SP – Specialty Medication

HD – May require home delivery pharmacy

PPACA – No Cost-Share Preventive Medication

CSL – Oral cancer medication subject to cost-share limits

## List of Prescription Medications

ANTIVIRALS (AIDS/HIV) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>ARTV NUCLEOSIDE, NUCLEOTIDE, NON-NUCLEOSIDE RTI COMB (cont.)</b>		
SYMFI LO ( <i>efavirenz-lamivu-tenofovi disop</i> )	T4	SP
<b>ARV-NUCLEOSIDE, NUCLEOTIDE RTI, INTEGRASE INHIBITORS</b>		
BIKTARVY	T4	SP
GENVOYA	T4	SP
STRIBILD	T4	PA SP
ANTIVIRALS (Eye Conditions)		
<b>EYE ANTIVIRALS</b>		
trifluridine	T1	
ZIRGAN	T3	
ANTIVIRALS (Infections)		
<b>ANTIVIRAL MONOCLONAL ANTIBODIES</b>		
SYNAGIS	T4	PA SP HD
<b>ANTIVIRALS, GENERAL</b>		
acyclovir 200 mg capsule	T1	
acyclovir 200 mg/5 ml susp (Zovirax)	T1	
acyclovir 400 mg tablet	T1	
acyclovir 800 mg tablet	T1	
acyclovir sodium	T1	
cidofovir	T4	SP
CYTOVENE ( <i>ganciclovir sodium</i> )	T4	SP
famciclovir	T1	
FLUMADINE ( <i>rimantadine hcl</i> )	T3	
foscarnet sodium (Foscavir)	T1	
FOSCAVIR	T3	
FOSCAVIR ( <i>foscarnet sodium</i> )	T3	
GANCICLOVIR	T4	SP
<i>ganciclovir sodium</i>	T4	SP
<i>ganciclovir sodium</i> (Cytovene)	T4	SP
LIVTENCITY	T4	PA QL (4 tabs/day) SP
oseltamivir 6 mg/ml suspension (Tamiflu)	T1	QL (180ml/30 days)
oseltamivir phos 30 mg capsule (Tamiflu)	T1	QL (20 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)

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

T4 – Specialty Medications

PA – Prior Authorization

QL – Quantity Limit

ST – Step Therapy

AGE – Age Requirement

SP – Specialty Medication

HD – May require home delivery pharmacy

PPACA – No Cost-Share Preventive Medication

CSL – Oral cancer medication subject to cost-share limits

## List of Prescription Medications

### ANTIVIRALS (Infections) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>ANTIVIRALS, GENERAL (cont.)</b>		
PREVYMIS 240 MG TABLET	T4	SP HD
PREVYMIS 240 MG/12 ML VIAL	T4	SP
PREVYMIS 480 MG TABLET	T4	SP HD
PREVYMIS 480 MG/24 ML VIAL	T4	SP
RAPIVAB	T3	
RELENZA	T3	QL (20/30 days)
<i>rimantadine hcl</i> (Flumadine)	T1	
SITAVIG	T3	PA QL (2 tabs/Rx)
TAMIFLU 30 MG CAPSULE ( <i>oseltamivir phosphate</i> )	T3	QL (20/30 days)
TAMIFLU 45 MG CAPSULE ( <i>oseltamivir phosphate</i> )	T3	QL (10/30 days)
TAMIFLU 6 MG/ML SUSPENSION ( <i>oseltamivir phosphate</i> )	T3	QL (180ml/30 days)
TAMIFLU 75 MG CAPSULE ( <i>oseltamivir phosphate</i> )	T3	QL (10/30 days)
<i>valacyclovir hcl</i> (Valtrex)	T1	
VALCYTE ( <i>valganciclovir hcl</i> )	T3	PA
<i>valganciclovir hcl</i> (Valcyte)	T1	
VALTREX ( <i>valacyclovir</i> )	T3	
XOFLUZA	T3	QL (2 tabs/30 days)
ZOVIRAX 200 MG/5 ML SUSP ( <i>acyclovir</i> )	T3	PA
<b>HEP C - NS5A, NS3/4A, NON-NUCLEO.NS5B INHIB COMB.</b>		
VOSEVI	T4	PA SP HD
<b>HEP C VIRUS, NUCLEOTIDE ANALOG NS5B POLYMERASE INH</b>		
SOVALDI 150 MG PELLET PACKET	T4	PA QL (1 tab/day) SP HD
SOVALDI 200 MG PELLET PACKET	T4	PA QL (1 tab/day) SP HD
SOVALDI 200 MG TABLET	T4	PA QL (1 tab/day) SP HD
SOVALDI 400 MG TABLET	T4	PA SP HD
EPCLUSA 200 MG-50 MG TABLET	T4	PA QL (1 tab/Day) SP HD
EPCLUSA 400 MG-100 MG TABLET	T4	PA SP HD
HARVONI 33.75-150 MG PELLET PK	T4	PA QL (1 tab/day) SP HD
HARVONI 45-200 MG PELLET PACKT	T4	PA QL (1 tab/day) SP HD
HARVONI 45-200 MG TABLET	T4	PA QL (1 tab/day) SP HD
HARVONI 90-400 MG TABLET	T4	PA SP HD
LEDIPASVIR-SOFOSBUVIR	T4	PA QL(1 tab/day) SP HD
<b>HEP C VIRUS-NS5B POLYMERASE AND NS5A INHIB. COMBO.</b>		
SOFOSBUVIR-VELPATASVIR	T4	PA QL(1 tab/day) SP HD

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

T4 – Specialty Medications

PA – Prior Authorization

QL – Quantity Limit

ST – Step Therapy

AGE – Age Requirement

SP – Specialty Medication

HD – May require home delivery pharmacy

PPACA – No Cost-Share Preventive Medication

CSL – Oral cancer medication subject to cost-share limits

## List of Prescription Medications

### ANTIVIRALS (Infections) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>HEPATITIS B TREATMENT AGENTS</b>		
adefovir dipivoxil	T4	SP HD
BARACLUDE 0.05 MG/ML SOLUTION	T4	SP HD
BARACLUDE 0.5 MG TABLET ( <i>entecavir</i> )	T4	PA QL (1 tab/day) SP HD
BARACLUDE 1 MG TABLET ( <i>entecavir</i> )	T4	PA SP HD
<i>entecavir 0.5 mg tablet</i> (Baraclude)	T4	QL (1 tab/day) SP HD
<i>entecavir 1 mg tablet</i> (Baraclude)	T4	SP HD
EPIVIR HBV 100 MG TABLET ( <i>lamivudine hbv</i> )	T4	SP
EPIVIR HBV 25 MG/5 ML SOLN	T4	SP
<i>lamivudine</i> (Epivir Hbv)	T4	SP
VEMLIDY	T4	SP HD
<b>HEPATITIS C TREATMENT AGENTS</b>		
PEGASYS	T4	PA SP HD
PEGINTRON	T4	PA SP HD
<i>ribasphere 200 mg capsule</i>	T4	SP HD
<i>ribasphere 200 mg tablet</i>	T4	SP HD
<i>ribasphere 400 mg tablet</i>	T4	SP
<i>ribasphere 600 mg tablet</i>	T4	SP
<i>ribasphere ribapak 200-400 mg</i>	T4	SP HD
<i>ribasphere ribapak 400-400 mg</i>	T4	SP HD
<i>ribasphere ribapak 600-400 mg</i>	T4	SP HD
<i>ribasphere ribapak 600-600 mg</i>	T4	SP HD
<i>ribavirin</i>	T4	SP HD
<b>HEPATITIS C VIRUS- NS5A AND NS3/4A INHIBITOR COMB</b>		
MAVYRET 100-40 MG TABLET	T4	PA QL(3 tabs/day) SP HD
MAVYRET 50-20 MG PELLET PACKET	T4	PA QL(5 packs/day) SP HD
ZEPATIER	T4	PA SP HD
<b>RNA POLYMERASE INHIBITOR</b>		
LAGEVRIO (EUA)	T2	QL (1 pkg/120 days)
MOLNUPIRAVIR	T3	QL (1 pkg/120 days)

### ANTIVIRALS (Skin Conditions)

#### TOPICAL GENITAL WART-HPV TREATMENT AGENTS

VEREGEN	T3	PA
T1 – Typically Generics	T4 – Specialty Medications	ST – Step Therapy
T2 – Typically Preferred Brands	PA – Prior Authorization	AGE – Age Requirement
T3 – Typically Non-Preferred Brands	QL – Quantity Limit	SP – Specialty Medication
		HD – May require home delivery pharmacy PPACA – No Cost-Share Preventive Medication CSL – Oral cancer medication subject to cost-share limits

## List of Prescription Medications

### AUTONOMIC DRUGS (Allergy/Nasal Sprays)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>ANAPHYLAXIS THERAPY AGENTS</b>		
ADYPHREN	T1	
ADYPHREN AMP	T1	
AUVI-Q	T3	PA QL (2 packs/30 days)
EPINEPHRINE 0.15 MG AUTO-INJECT	T3	PA QL (2 packs/30 days)
<i>epinephrine 0.15 mg auto-inject</i> (Epipen Jr 2-pak)	T1	QL (2 packs/30 days)
EPINEPHRINE 0.3 MG AUTO-INJECT	T1	QL (2 packs/30 days)
<i>epinephrine 0.3 mg auto-inject</i> (Epipen 2-pak)	T1	QL (2 packs/30 days)
EPINEPHRINE PROFESSIONAL EMS	T3	
EPINEPHRINE PROFESSIONAL KIT	T3	
EPINEPHRINESNAP-EMS	T3	
EPINEPHRINESNAP-V	T3	
EPIPEN ( <i>epinephrine</i> )	T3	PA QL (4 pens/22 days)
EPIPEN 2-PAK ( <i>epinephrine</i> )	T3	PA QL (2 packs/30 days)
EPIPEN JR ( <i>epinephrine</i> )	T3	PA QL (4 pens/22 days)
EPIPEN JR 2-PAK ( <i>epinephrine</i> )	T3	PA QL (2 packs/30 days)
SYMJEPI	T3	PA QL (4 syringes/30 days)

### AUTONOMIC DRUGS (Alzheimer's Disease)

CHOLINESTERASE INHIBITORS		
ARICEPT ( <i>donepezil hcl</i> )	T3	HD
BLOXIVERZ ( <i>neostigmine methylsulfate</i> )	T3	
<i>donepezil hcl</i>	T1	HD
<i>donepezil hcl</i> (Aricept)	T1	HD
EXELON ( <i>rivastigmine</i> )	T3	HD
<i>galantamine er 16 mg capsule</i> (Razadyne Er)	T1	HD
<i>galantamine er 24 mg capsule</i> (Razadyne Er)	T1	HD
<i>galantamine er 8 mg capsule</i> (Razadyne Er)	T1	QL (1 cap/day) HD
<i>galantamine hbr</i>	T1	HD
MESTINON ( <i>pyridostigmine bromide</i> )	T3	HD
NEOSTIGMINE METHYLSULFATE	T1	
<i>neostigmine methylsulfate</i> (Bloxiverz)	T1	
<i>neostigmine methylsulfate</i> (Neostigmine Methylsulfate)	T1	
NEOSTIGMINE-STERILE WATER	T1	HD
<i>physostigmine salicylate</i>	T1	
<i>pyridostigmine 60 mg/5 ml soln</i> (Mestinon)	T1	

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

T4 – Specialty Medications

PA – Prior Authorization

QL – Quantity Limit

ST – Step Therapy

AGE – Age Requirement

SP – Specialty Medication

HD – May require home delivery pharmacy

PPACA – No Cost-Share Preventive Medication

CSL – Oral cancer medication subject to cost-share limits

## List of Prescription Medications

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

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>CHOLINESTERASE INHIBITORS (cont.)</b>		
PYRIDOSTIGMINE BR 30 MG TABLET	T3	PA QL (20 tabs/day) HD
<i>pyridostigmine br 60 mg tablet (Mestinon)</i>	T1	HD
<i>pyridostigmine bromide</i>	T3	HD
<i>pyridostigmine bromide (Mestinon)</i>	T1	HD
RAZADYNE ER 16 MG CAPSULE ( <i>galantamine er</i> )	T3	HD
RAZADYNE ER 24 MG CAPSULE ( <i>galantamine er</i> )	T3	HD
RAZADYNE ER 8 MG CAPSULE ( <i>galantamine er</i> )	T3	QL (1 cap/day) HD
<i>rivastigmine (Exelon)</i>	T1	HD
<i>rivastigmine tartrate</i>	T1	HD

### AUTONOMIC DRUGS (Attention Deficit Hyperactivity Disorder)<sup>8</sup>

#### ADRENERGICS, AROMATIC, NON-CATECHOLAMINE

ADDERALL ( <i>dextroamphetamine-amphetamine</i> )	T3	PA ST
ADDERALL XR 10 MG CAPSULE ( <i>dextroamphetamine-amphet er</i> )	T3	PA QL (1 cap/day) ST
ADDERALL XR 15 MG CAPSULE ( <i>dextroamphetamine-amphet er</i> )	T3	PA QL (1 cap/day) ST
ADDERALL XR 20 MG CAPSULE ( <i>dextroamphetamine-amphet er</i> )	T3	PA QL (1 cap/day) ST
ADDERALL XR 25 MG CAPSULE ( <i>dextroamphetamine-amphet er</i> )	T3	PA QL (1 per day) ST
ADDERALL XR 30 MG CAPSULE ( <i>dextroamphetamine-amphet er</i> )	T3	PA QL (1 cap/day) ST
ADDERALL XR 5 MG CAPSULE ( <i>dextroamphetamine-amphet er</i> )	T3	PA QL (1 cap/day) ST
ADZENYS ER	T3	PA QL (15ml/day)
ADZENYS XR-ODT	T3	PA QL (1 tab/day)
AMPHETAMINE	T3	PA QL (15ml/day)
<i>amphetamine sulfate (Evekeo)</i>	T1	PA
DESOXYN ( <i>methamphetamine hcl</i> )	T3	PA
DESOXYN 5 MG TABLET ( <i>methamphetamine hcl</i> )	T3	PA QL(5 tabs/day)
DEXEDRINE ( <i>dextroamphetamine sulfate er</i> )	T3	PA QL (1 cap/day)
<i>dextroamphetamine er 10 mg cap (Dexedrine)</i>	T1	PA QL (1 cap/day)
<i>dextroamphetamine er 15 mg cap (Dexedrine)</i>	T1	PA QL (3/day)
<i>dextroamphetamine/amphetamine (Adderall Xr)</i>	T1	PA QL(1 cap/day)
<i>dextroamphetamine/amphetamine (Mydayis)</i>	T1	PA QL(1 cap/day)
<i>dextroamphetamine er 5 mg cap (Dexedrine)</i>	T1	PA QL (1 cap/day)
<i>dextroamphetamine sulfate</i>	T1	PA

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

T4 – Specialty Medications

PA – Prior Authorization

QL – Quantity Limit

ST – Step Therapy

AGE – Age Requirement

SP – Specialty Medication

HD – May require home delivery pharmacy

PPACA – No Cost-Share Preventive Medication

CSL – Oral cancer medication subject to cost-share limits

## List of Prescription Medications

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

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>ADRENERGICS, AROMATIC, NON-CATECHOLAMINE (cont.)</b>		
<i>dextroamphetamine sulfate</i>	T3	PA ST
DYANAVEL XR	T3	PA QL (8ml/day)
EVEKEO ( <i>amphetamine sulfate</i> )	T3	PA ST
EVEKEO ODT	T3	PA
<i>methamphetamine hcl</i> (Desoxyn)	T1	PA
MYDAYIS ( <i>dextroamphetamine/amphetamine</i> )	T3	PA QL (1 cap/day) ST
XELTRYM	T3	PA QL(1 patch/day)
ZENZEDI	T3	PA ST

### AUTONOMIC DRUGS (Blood Pressure/Heart Medications)

ADRENERGIC VASOPRESSOR AGENTS		
<i>droxidopa</i> (Northera)	T4	SP HD
<i>midodrine hcl</i>	T1	
NORTHERA ( <i>droxidopa</i> )	T4	PA SP HD
ALPHA-ADRENERGIC BLOCKING AGENTS		
DIBENZYLINE ( <i>phenoxybenzamine hcl</i> )	T3	HD
<i>phenoxybenzamine hcl</i> (Dibenzyline)	T1	HD
<i>phentolamine mesylate</i>	T1	HD
<i>prazosin hcl</i>	T1	HD

### AUTONOMIC DRUGS (Miscellaneous)

ADRENERGIC AGENTS, CATECHOLAMINES		
<i>dopamine hcl</i>	T1	
<i>dopamine hcl</i> in dextrose 5 %	T1	
<i>epinephrine</i>	T3	
<i>epinephrine 0.1 mg/ml syringe</i>	T1	
<i>epinephrine 1 mg/10 ml abbojct</i>	T1	
<i>epinephrine 1 mg/10 ml luerjet</i>	T1	
<i>epinephrine 1 mg/ml vial</i>	T1	
<i>epinephrine 1 mg/ml ampul</i>	T1	
<i>epinephrine 30 mg/30 ml vial</i>	T1	
<i>epinephrine hcl</i> in 0.9 % nacl	T1	
<i>epinephrine hcl</i> in 0.9 % nacl (Epinephrine Hcl-0.9% Nacl)	T1	
<i>epinephrine hcl</i> in dextrose 5%	T1	
<i>epinephrine hcl</i> in dextrose 5% (Epinephrine Hcl-d5w)	T1	

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

T4 – Specialty Medications

PA – Prior Authorization

QL – Quantity Limit

ST – Step Therapy

AGE – Age Requirement

SP – Specialty Medication

HD – May require home delivery pharmacy

PPACA – No Cost-Share Preventive Medication

CSL – Oral cancer medication subject to cost-share limits

## List of Prescription Medications

### AUTONOMIC DRUGS (Miscellaneous) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>ADRENERGIC AGENTS, CATECHOLAMINES (cont.)</b>		
EPINEPHRINE HCL-0.9% NaCl	T1	
EPINEPHRINE HCL-0.9% NaCl ( <i>epinephrine hcl-0.9% nacl</i> )	T1	
EPINEPHRINE HCL-D5W	T1	
EPINEPHRINE HCL-D5W ( <i>epinephrine hcl-d5w</i> )	T1	
<i>isoproterenol hcl</i>	T1	
<i>isoproterenol hcl</i> (Isuprel)	T1	
ISUPREL	T3	
LEVOPHED ( <i>norepinephrine bitartrate</i> )	T3	
LEVOPHED BITARTRATE ( <i>norepinephrine bitartrate</i> )	T3	
<i>norepinephrine bit/0.9 % nacl</i>	T1	
<i>norepinephrine bitartrate</i> (Levophed Bitartrate)	T1	
<i>norepinephrine bitartrate</i> (Levophed)	T1	
<i>norepinephrine bitartrate/d5w</i>	T1	
NOREPINEPHRINE BITARTRATE-D5W	T1	
<b>NEUROMUSCULAR BLOCKING AGENTS</b>		
<i>atracurium besylate</i>	T1	
BOTOX 100 UNIT VIAL	T4	PA SP
BOTOX 200 UNIT VIAL	T4	PA SP HD
<i>cisatracurium besylate</i> (Nimbex)	T1	
DAXXIFY	T4	PA SP
DYSPORT	T4	PA SP HD
MIVACRON	T3	
MYOBLOC	T4	PA SP
NIMBEX ( <i>cisatracurium besylate</i> )	T3	
<i>pancuronium bromide</i>	T1	
<b>NEUROMUSCULAR BLOCKING AGENTS</b>		
QUELICIN ( <i>succinylcholine chloride</i> )	T3	
<i>rocuronium bromide</i>	T1	
<i>rocuronium bromide</i> (Rocuronium Bromide)	T1	
SUCCINYLCHOLINE CHLORIDE	T1	
<i>succinylcholine chloride</i> (Quelicin)	T1	

### AUTONOMIC DRUGS (Urinary Tract Conditions)

#### PARASYMPATHETIC AGENTS

*bethanechol chloride*

T1

HD

T1 – Typically Generics

T4 – Specialty Medications

ST – Step Therapy

HD – May require home delivery pharmacy

T2 – Typically Preferred Brands

PA – Prior Authorization

AGE – Age Requirement

PPACA – No Cost-Share Preventive Medication

T3 – Typically Non-Preferred Brands

QL – Quantity Limit

SP – Specialty Medication

CSL – Oral cancer medication subject to cost-share limits

## List of Prescription Medications

AUTONOMIC DRUGS (Urinary Tract Conditions) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>PARASYMPATHETIC AGENTS (cont.)</b>		
cevimeline hcl (Evoxac)	T1	HD
EVOXAC (cevimeline hcl)	T3	HD
guanidine hcl	T1	HD
pilocarpine hcl (Salagen)	T1	HD
SALAGEN (pilocarpine hcl)	T3	HD
<b>BIOLOGICALS (Allergy/Nasal Sprays)</b>		
<b>ALLERGENIC EXTRACTS, THERAPEUTIC</b>		
GRASTEK	T3	PA QL (1 tab/day)
ODACTRA	T3	PA QL (1 tab/day)
ORALAIR	T3	PA QL (1 tab/day)
PALFORZIA	T3	PA SP
RAGWITEK	T3	PA QL (1 tab/day)
<b>BIOLOGICALS (Blood Pressure/Heart Medications)</b>		
<b>PLASMA KALLIKREIN INHIBITORS</b>		
TAKHZYRO	T4	PA SP HD
<b>BIOLOGICALS (Miscellaneous)</b>		
<b>ANTISERA</b>		
HYPERRHO S-D	T4	SP
MICRHOGAM ULTRA-FILTERED PLUS	T4	SP
RHOGAM ULTRA-FILTERED PLUS	T4	SP
RHOPHYLAC	T4	SP
WINRHO SDF	T4	SP HD
<b>PKU TREATMENT AGENTS - PHENYLALANINE AMMONIA LYASE</b>		
PALYNZIQ	T4	PA SP HD
<b>BIOLOGICALS (Vaccines)</b>		
<b>COVID-19 VACCINES</b>		
COMIRNATY	T3	PPACA
JANSSEN COVID-19 VACCINE (EUA)	T3	PPACA
MODERNA COVID-19 VACCINE (EUA)	T3	PPACA
NOVAVAX COVID (EUA)	T3	PPACA
PFIZER COVID-19 VACCINE (EUA)	T3	PPACA
SPIKEVAX	T3	PPACA

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

T4 – Specialty Medications

PA – Prior Authorization

QL – Quantity Limit

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HD – May require home delivery pharmacy

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## List of Prescription Medications

BIOLOGICALS (Vaccines) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>ENTERIC VIRUS VACCINES</b>		
IPOL	T3	PPACA
ROTARIX	T3	PPACA
ROTAVERSE	T3	PPACA
<b>GRAM NEGATIVE COCCI VACCINES</b>		
BEXSERO	T3	PPACA
MENACTRA	T3	PPACA
MENQUADFI	T3	PPACA
MENVEO A-C-Y-W-135-DIP	T3	PPACA
PENBRAYA	T3	PPACA
TRUMENBA	T3	PPACA
<b>GRAM POSITIVE COCCI VACCINES</b>		
CAPVAXIVE	T3	PPACA
PNEUMOVAX 23	T3	PPACA
PREVNAR 13	T3	PPACA
PREVNAR 20	T3	PPACA
<b>INFLUENZA VIRUS VACCINES</b>		
AFLURIA TRIVALENT	T3	PPACA
FLUAD TRIVALENT	T3	PPACA
FLUARIX TRIVALENT	T3	PPACA
FLUARIX TRIVALENT	T3	PPACA
FLUBLOK TRIVALENT	T3	PPACA
FLUCELVAX TRIVALENT	T3	PPACA
FLULAVAL TRIVALENT	T3	PPACA
FLUMIST TRIVALENT	T3	PPACA
FLUZONE TRIVALENT	T3	PPACA
FLUZONE TRIVALENT	T3	PPACA
<b>VACCINE/TOXOID PREPARATIONS, COMBINATIONS</b>		
ACTHIB	T3	PPACA
ADACEL TDAP	T3	PPACA
BOOSTRIX TDAP	T3	PPACA
DAPTACEL DTAP	T3	PPACA
DIPHTHERIA-TETANUS TOXOIDS-PED	T3	PPACA
HIBERIX	T3	PPACA

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

T4 – Specialty Medications

PA – Prior Authorization

QL – Quantity Limit

ST – Step Therapy

AGE – Age Requirement

SP – Specialty Medication

HD – May require home delivery pharmacy

PPACA – No Cost-Share Preventive Medication

CSL – Oral cancer medication subject to cost-share limits

## List of Prescription Medications

### BIOLOGICALS (Vaccines) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>VACCINE/TOXOID PREPARATIONS, COMBINATIONS (con't)</b>		
INFANRIX DTaP	T3	PPACA
KINRIX	T3	PPACA
M-M-R II VACCINE	T3	PPACA
PEDVAXHIB	T3	PPACA
PENTACEL	T3	PPACA
PROQUAD	T3	PPACA
QUADRACEL DTaP-IPV	T3	PPACA
TDVAX	T3	PPACA
TENIVAC	T3	PPACA
VAXELIS	T3	PPACA
<b>VIRAL/TUMORIGENIC VACCINES</b>		
ACAM2000	T3	
ENGERIX-B ADULT	T3	PPACA
ENGERIX-B PEDIATRIC-ADOLESCENT	T3	PPACA
ERVEBO (NATIONAL STOCKPILE)	T3	
GARDASIL 9	T3	PPACA
HEPLISAV-B	T3	PPACA
IXCHIQ	T3	PPACA
JYNNEOS	T3	
MRESVIA	T3	PPACA
PEDIARIX	T3	PPACA
RECOMBIVAX HB	T3	PPACA
SHINGRIX	T3	QL (2 doses/lifetime) PPACA
TWINRIX	T3	PPACA
VARIVAX VACCINE	T3	PPACA
ZOSTAVAX	T3	PPACA

### BLOOD (Blood Modifiers/Bleeding Disorders)

<b>AGENTS TO TX THROMBOTIC THROMBOCYTOPENIC PURPURA</b>		
ADZYNMA	T4	PA SP
CABLIVI	T4	PA SP
<b>ANTI-FIBRINOLYTIC AGENTS</b>		
AMICAR ( <i>aminocaproic acid</i> )	T4	SP HD
<i>aminocaproic acid</i>	T4	SP HD
CYKLOKAPRON ( <i>tranexamic acid</i> )	T4	SP

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

T4 – Specialty Medications

PA – Prior Authorization

QL – Quantity Limit

ST – Step Therapy

AGE – Age Requirement

SP – Specialty Medication

HD – May require home delivery pharmacy

PPACA – No Cost-Share Preventive Medication

CSL – Oral cancer medication subject to cost-share limits

## List of Prescription Medications

BLOOD (Blood Modifiers/Bleeding Disorders) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>ANTI-FIBRINOLYTIC AGENTS (cont.)</b>		
FIBRYGA	T4	PA SP
LYSTEDA ( <i>tranexamic acid</i> )	T4	SP
RIASTAP	T4	PA SP
<i>tranexamic acid</i> (Cyklokapron) (Lysteda)	T4	SP
<i>tranexamic 1,000 mg/100ml-nacl</i>	T4	SP
TRANEXAMIC 1,000 MG/100ML-NACL	T4	SP
<b>ANTI-HEMOPHILIC FACTORS</b>		
ALTUVIIO	T4	PA SP HD
<b>COMPLEMENT (C3) INHIBITORS</b>		
EMPAVELI	T4	PA SP
FABHALTA	T4	PA QL(2 caps/day) SP
<b>COAGULANTS</b>		
<i>protamine sulfate</i>	T1	
<b>COMPLEMENT(C5) INHIBITOR</b>		
TAVNEOS	T4	PA QL (6 caps/day)SP HD
<b>FACTOR IX COMPLEX (PCC) PREPARATIONS</b>		
KCENTRA	T4	SP
<b>FACTOR X PREPARATIONS</b>		
COAGADEX	T4	PA SP
<b>FACTOR XIII PREPARATIONS</b>		
CORIFACT	T4	PA SP
TRETEN	T4	PA SP
<b>HEMOPHILIA TREATMENT AGENTS, NON-FACTOR REPLACEMENT</b>		
ALHEMO PEN	T3	PA SP
HEMLIBRA	T4	PA SP HD
HYMPAVZI PEN	T4	PA SP
<b>HUMAN MONOCLONAL ANTIBODY COMPLEMENT (C5) INHIBITOR</b>		
SOLIRIS	T4	PA SP
ULTOMIRIS	T4	PA SP HD
<b>PROTEIN C PREPARATIONS</b>		
CEPROTIN	T4	PA SP
<b>SICKLE CELL ANEMIA AGENTS</b>		
ADAKVEO	T4	PA SP
DROXIA	T2	

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

T4 – Specialty Medications

PA – Prior Authorization

QL – Quantity Limit

ST – Step Therapy

AGE – Age Requirement

SP – Specialty Medication

HD – May require home delivery pharmacy

PPACA – No Cost-Share Preventive Medication

CSL – Oral cancer medication subject to cost-share limits

## List of Prescription Medications

BLOOD (Blood Modifiers/Bleeding Disorders) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>SICKLE CELL ANEMIA AGENTS</b>		
SIKLOS	T3	PA
<b>TOPICAL HEMOSTATICS</b>		
ASTRINGYN	T3	
AVITENE	T3	
ENDO-AVITENE	T3	
EVICEL	T3	
<i>gelatin sponge, absorb/porcine (Gelfoam)</i>	T1	
GELFOAM	T3	
GELFOAM ( <i>surgifoam</i> )	T3	
GELFOAM COMPRESSED	T3	
MONSEL'S	T3	
RAPLIXA	T3	
RECOTHROM	T3	
SURGIFOAM	T1	
SYRINGE AVITENE	T3	
TACHOSIL	T3	
THROMBI-GEL	T3	
THROMBIN-JMI	T3	
THROMBI-PAD	T3	
ULTRAFOAM	T3	
<b>ANTICOAGULANT REVERSAL AGENT FOR FACTOR XA INHIB.</b>		
ANDEXXA	T4	SP
<b>ANTICOAGULANT REVERSAL AGENT, DIRECT THROMBIN INHIB</b>		
PRAXBIND	T4	SP
<b>HEMORRHEOLOGIC AGENTS</b>		
<i>pentoxifylline</i>	T1	HD
<b>THROMBOLYTIC - NUCLEOTIDE TYPE</b>		
DEFITELIO	T4	PA SP
<b>THROMBOLYTIC ENZYMES</b>		
ACTIVASE	T3	
CATHFLO ACTIVASE	T3	
RETAVASE	T3	
TNKASE	T3	

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

T4 – Specialty Medications

PA – Prior Authorization

QL – Quantity Limit

ST – Step Therapy

AGE – Age Requirement

SP – Specialty Medication

HD – May require home delivery pharmacy

PPACA – No Cost-Share Preventive Medication

CSL – Oral cancer medication subject to cost-share limits

## List of Prescription Medications

BLOOD (Miscellaneous)			
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits	
<b>CELL/GENE THERAPY AGENTS - HEMATOPOIETIC</b>			
OMISRGE	T3		
<b>CARDIAC DRUGS (Blood Pressure/Heart Medications)</b>			
<b>ANTI-ANGINAL, ANTI-ISCHEMIC AGENTS, NON-HEMODYNAMIC</b>			
RANEXA ( <i>ranolazine er</i> )	T3	PA QL (4 tabs/day) HD	
<i>ranolazine</i>	T1	QL(4 tabs/day) hD	
<i>ranolazine</i> (Ranexa)	T1	QL (4 tabs/day) HD	
<b>ANTI-ARRHYTHMICS</b>			
<i>adenosine</i>	T1	HD	
<i>amiodarone hcl</i>	T1	HD	
AMIODARONE HCL-D5W	T1	HD	
<i>bretlyium tosylate</i>	T1		
CORVERT ( <i>ibutilide fumarate</i> )	T3	PA	
<i>disopyramide phosphate</i> (Norpace)	T1	HD	
<i>dofetilide 125 mcg capsule</i> (Tikosyn)	T1	QL (8 caps/day) HD	
<i>dofetilide 250 mcg capsule</i> (Tikosyn)	T1	QL (4 caps/day) HD	
<i>dofetilide 500 mcg capsule</i> (Tikosyn)	T1	QL (2 caps/day) HD	
<i>flecainide acetate</i>	T1	HD	
<i>ibutilide fumarate</i> (Convert)	T1	HD	
<i>lidocaine hcl 1% abboject</i>	T1		
<i>lidocaine hcl 1% syringe</i>	T1		
<i>lidocaine hcl 2% abboject</i>	T1		
<i>lidocaine hcl 2% luer-jet</i>	T1		
<i>lidocaine hcl 2% syringe</i>	T1		
<i>lidocaine hcl 2% vial</i>	T1		
<i>lidocaine hcl/dextrose 5 %/pf</i>	T1		
<i>mexiletine hcl</i>	T1		
MULTAQ	T2	HD	
NEXTERONE	T3		
NORPACE ( <i>disopyramide phosphate</i> )	T3	PA HD	
NORPACE CR	T3	HD	
<i>pacerone 100 mg tablet</i>	T3	PA HD	
<i>pacerone 200 mg tablet</i>	T1	HD	
<i>pacerone 400 mg tablet</i>	T3	PA HD	
<i>procainamide hcl</i>	T1	HD	
<small>I1 – Typically Generics</small>	<small>I4 – Specialty Medications</small>	<small>S1 – Step Therapy</small>	<small>HD – May require home delivery pharmacy</small>
<small>T2 – Typically Preferred Brands</small>	<small>PA – Prior Authorization</small>	<small>AGE – Age Requirement</small>	<small>PPACA – No Cost-Share Preventive Medication</small>
<small>T3 – Typically Non-Preferred Brands</small>	<small>QL – Quantity Limit</small>	<small>SP – Specialty Medication</small>	<small>CSL – Oral cancer medication subject to cost-share limits</small>

## List of Prescription Medications

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

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>ANTI-ARRHYTHMICS (cont.)</b>		
<i>propafenone hcl</i>	T1	HD
<i>propafenone hcl (Rythmol Sr)</i>	T1	HD
<i>quinidine gluconate</i>	T1	HD
<i>quinidine sulfate</i>	T1	HD
RYTHMOL SR ( <i>propafenone hcl er</i> )	T3	PA HD
TIKOSYN 125 MCG CAPSULE ( <i>dofetilide</i> )	T3	PA QL (8 caps/day) HD
TIKOSYN 250 MCG CAPSULE ( <i>dofetilide</i> )	T3	PA QL (4 caps/day) HD
TIKOSYN 500 MCG CAPSULE ( <i>dofetilide</i> )	T3	PA QL (2 caps/day) HD
XYLOCAINE IV	T3	
<b>CALCIUM CHANNEL BLOCKER AND NSAID, COX-2 INHIBITOR</b>		
CONSENSI	T3	PA QL (1 tab/day)
<b>CALCIUM CHANNEL BLOCKING AGENTS</b>		
ADALAT CC ( <i>nifedipine er</i> )	T3	HD
<i>amlodipine besylate (Norvasc)</i>	T1	HD
CALAN SR ( <i>verapamil er</i> )	T3	HD
CAMZYOS	T4	PA QL (30 caps/30 days) SP
CARDENE I.V. ( <i>nicardipine hcl</i> )	T3	
CARDIZEM ( <i>diltiazem hcl</i> )	T3	PA HD
CARDIZEM CD ( <i>diltiazem 24hr er (cd)</i> )	T3	PA HD
CARDIZEM LA 120 MG TABLET ( <i>diltiazem hcl</i> )	T3	PA QL (1 tab/day) HD
CARDIZEM LA 180 MG TABLET ( <i>matzim la</i> )	T3	PA HD
CARDIZEM LA 240 MG TABLET ( <i>matzim la</i> )	T3	PA HD
CARDIZEM LA 300 MG TABLET ( <i>matzim la</i> )	T3	PA HD
CARDIZEM LA 360 MG TABLET ( <i>matzim la</i> )	T3	PA HD
CARDIZEM LA 420 MG TABLET ( <i>matzim la</i> )	T3	PA HD
CLEVIPREX	T3	
CONJUPRI	T3	PA HD
<i>diltiazem hcl</i>	T1	HD
<i>diltiazem hcl (Cardizem Cd)</i>	T1	HD
<i>diltiazem 24h er(la) 120 mg tb (Cardizem La)</i>	T1	QL(1 tab/day) HD
<i>diltiazem 24h er(la) 180 mg tb (Cardizem La)</i>	T1	HD
<i>diltiazem 24h er(la) 240 mg tb (Cardizem La)</i>	T1	HD
<i>diltiazem 24h er(la) 300 mg tb (Cardizem La)</i>	T1	HD
<i>diltiazem 24h er(la) 360 mg tb (Cardizem La)</i>	T1	HD

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

T4 – Specialty Medications

PA – Prior Authorization

QL – Quantity Limit

ST – Step Therapy

AGE – Age Requirement

SP – Specialty Medication

HD – May require home delivery pharmacy

PPACA – No Cost-Share Preventive Medication

CSL – Oral cancer medication subject to cost-share limits

## List of Prescription Medications

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

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>CALCIUM CHANNEL BLOCKING AGENTS (cont.)</b>		
diltiazem 24h er(la) 420 mg tb (Cardizem La)	T1	HD
diltiazem hcl (Cardizem La)	T1	HD
diltiazem hcl (Cardizem)	T1	
diltiazem hcl (Tiazac)	T1	HD
DILTIAZEM HCL-0.7% NACL	T3	
DILTIAZEM HCL-0.9% NACL	T1	
<i>felodipine</i>	T1	HD
<i>isradipine</i>	T1	HD
KATERZIA	T3	PA QL (10ml/day) HD
NICARDIPIN 20MG/200ML-0.9%NACL	T3	
NICARDIPIN 40MG/200ML-0.9%NACL	T3	
NICARDIPINE 1 MG/10 ML-NS SYRG	T1	
<i>nicardipine hcl</i>	T1	
<i>nicardipine hcl</i> (Cardene l.v.)	T1	
NICARDIPINE HCL-D5W	T1	
<i>nifedipine</i>	T1	HD
<i>nifedipine</i> (Adalat Cc)	T1	HD
<i>nifedipine</i> (Procardia XI)	T1	HD
<i>nifedipine</i> (Procardia)	T1	HD
<i>nimodipine</i>	T1	HD
<i>nisoldipine er</i> 17 mg tablet (Sular)	T1	HD
<i>nisoldipine er</i> 20 mg tablet	T1	QL (1 tab/day) HD
<i>nisoldipine er</i> 25.5 mg tablet	T1	HD
<i>nisoldipine er</i> 30 mg tablet	T1	HD
<i>nisoldipine er</i> 34 mg tablet (Sular)	T1	HD
<i>nisoldipine er</i> 40 mg tablet	T1	HD
<i>nisoldipine er</i> 8.5 mg tablet (Sular)	T1	HD
NORVASC ( <i>amlodipine besylate</i> )	T3	HD
NORLIQVA	T2	PA QL (10ml/day) HD
NYMALIZE	T3	
PROCARDIA ( <i>nifedipine</i> )	T3	PA HD
PROCARDIA XL ( <i>nifedipine er</i> )	T3	HD
SULAR ( <i>nisoldipine</i> )	T3	HD
TIAZAC ( <i>tiadylt er</i> )	T3	HD

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

T4 – Specialty Medications

PA – Prior Authorization

QL – Quantity Limit

ST – Step Therapy

AGE – Age Requirement

SP – Specialty Medication

HD – May require home delivery pharmacy

PPACA – No Cost-Share Preventive Medication

CSL – Oral cancer medication subject to cost-share limits

## List of Prescription Medications

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

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>CALCIUM CHANNEL BLOCKING AGENTS (cont.)</b>		
<i>verapamil hcl</i>	T1	HD
<i>verapamil hcl</i> (Calan Sr)	T1	HD
<i>verapamil hcl</i> (Verelan Pm)	T1	HD
<i>verapamil hcl</i> (Verelan)	T1	HD
VERELAN ( <i>verapamil hcl</i> )	T3	HD
VERELAN PM ( <i>verapamil er pm</i> )	T3	HD
<b>CARDIOPLEGIC SOLUTIONS</b>		
CARDIOPLEGIA DEL NIDO FORMULA	T3	
CARDIOPLEGIA HIGH POTASSIUM	T3	
CARDIOPLEGIA IND 8:1 NON-ENRCH	T3	
CARDIOPLEGIA INDUCTION 4:1	T3	
CARDIOPLEGIA INDUCTION 8:1	T3	
CARDIOPLEGIA MAINTENANCE 4:1	T3	
CARDIOPLEGIA MAINTENANCE 8:1	T3	
CARDIOPLEGIA REPERFUSATE 4:1	T3	
<i>cardioplegic solution no.1</i> (Plegisol)	T1	
PLEGISOL	T3	
<b>DIGITALIS GLYCOSIDES</b>		
<i>digoxin</i>	T1	HD
<i>digoxin</i> (Lanoxin)	T1	HD
LANOXIN 125 MCG TABLET ( <i>digoxin</i> )	T3	PA HD
LANOXIN 187.5 MCG TABLET	T3	PA HD
LANOXIN 250 MCG TABLET ( <i>digoxin</i> )	T3	PA HD
LANOXIN 500 MCG/2 ML AMPULE ( <i>digoxin</i> )	T3	HD
LANOXIN 500 MCG/2 ML VIAL	T3	HD
LANOXIN 62.5 MCG TABLET	T3	PA HD
LANOXIN PEDIATRIC	T3	HD
<b>HEART RATE REDUCING, SA SELECTIVE I(F) CURRENT INH.</b>		
CORLANOR TABLET ( <i>ivabradine hcl</i> )	T2	PA HD
CORLANOR SOLUTION ( <i>ivabradine hcl</i> )	T4	PA SP HD
<i>ivabradine hcl</i> (Corlanor)	T1	PA HD
<b>INOTROPIC DRUGS</b>		
<i>dobutamine hcl</i>	T1	
<i>dobutamine hcl</i> in dextrose 5 %	T1	

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

T4 – Specialty Medications

PA – Prior Authorization

QL – Quantity Limit

ST – Step Therapy

AGE – Age Requirement

SP – Specialty Medication

HD – May require home delivery pharmacy

PPACA – No Cost-Share Preventive Medication

CSL – Oral cancer medication subject to cost-share limits

## List of Prescription Medications

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

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>INOTROPIC DRUGS (cont.)</b>		
<i>milrinone lactate</i>	T1	
<i>milrinone lactate/d5w</i>	T1	
<b>VASODILATORS, CORONARY</b>		
DILATRATE-SR	T3	HD
GONITRO	T3	HD
ISORDIL ( <i>isosorbide dinitrate</i> )	T3	PA HD
ISORDIL TITRADOSE ( <i>isosorbide dinitrate</i> )	T3	PA HD
<i>isosorbide dinitrate 10 mg tab</i>	T1	HD
<i>isosorbide dinitrate 20 mg tab</i>	T1	HD
<i>isosorbide dinitrate 30 mg tab</i>	T1	HD
<i>isosorbide dinitrate 40 mg tab (Isordil)</i>	T1	PA HD
<i>isosorbide dinitrate 5 mg tab (Isordil Titradose)</i>	T1	HD
<i>isosorbide mononitrate</i>	T1	HD
MINITRAN	T1	HD
NITRO-DUR 0.1, 0.2, 0.3, 0.4, 0.6, 0.8 MG/HR PATCH	T3	HD
<i>nitroglycerin</i>	T1	HD
<i>nitroglycerin (Nitro-dur)</i>	T1	HD
<i>nitroglycerin (Nitrolingual)</i>	T1	HD
<i>nitroglycerin (Nitromist)</i>	T1	HD
<i>nitroglycerin (Nitrostat)</i>	T1	HD
<i>nitroglycerin in 5 % dextrose</i>	T1	
NITROLINGUAL ( <i>nitroglycerin</i> )	T3	HD
NITROMIST ( <i>nitroglycerin</i> )	T3	HD
NITROSTAT ( <i>nitroglycerin</i> )	T3	HD

### CARDIOVASCULAR (Allergy/Nasal Sprays)

<b>SYMPATHOMIMETIC AGENTS</b>		
AKOVAZ	T3	
BIORPHEN	T3	
EPHEDRINE SULFATE	T1	
<i>ephedrine sulfate (Akovaz)</i>	T1	
EPHEDRINE SULFATE-0.9% NACL	T1	
EPHEDRINE SULFATE-NACL	T1	
<i>phenylephrine hcl (Vazculep)</i>	T1	
<i>phenylephrine hcl in 0.9% nacl (Phenylephrine Hcl-0.9% Nacl)</i>	T1	

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

I4 – Specialty Medications

PA – Prior Authorization

QL – Quantity Limit

SI – Step Therapy

AGE – Age Requirement

SP – Specialty Medication

HD – 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 (Allergy/Nasal Sprays) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits	
<b>SYMPATHOMIMETIC AGENTS (cont.)</b>			
phenylephrine hcl/dextrose 5 %	T1		
PHENYLEPHRINE HCL-0.9% NAACL ( <i>phenylephrine hcl-0.9% nacl</i> )	T1		
PHENYLEPHRINE HCL-D5W	T1		
REZIPRES	T3		
VAZCULEP ( <i>phenylephrine hcl</i> )	T3		
<b>CARDIOVASCULAR (Asthma/COPD/Respiratory)</b>			
<b>PULM ANTI-HTN, SOLUBLE GUANYLATE CYCLASE STIMULATOR</b>			
ADEMPAS	T4	PA SP HD	
VERQUVO	T4	PA QL (1 tab/day)	
<b>PULM.ANTI-HTN, SEL.C-GMP PHOSPHODIESTERASE T5 INHIB</b>			
ADCIRCA ( <i>tadalafil</i> )	T4	PA SP HD	
LIQREV	T4	PA SP HD	
REVATIO	T4	PA SP HD	
REVATIO ( <i>sildenafil citrate</i> )	T4	PA SP HD	
TADLIQ	T4	PA SP HD	
<i>sildenafil</i> 10 mg/12.5 ml vial (Revatio)	T4	PA SP HD	
<i>sildenafil</i> 10 mg/ml oral susp (Revatio)	T4	PA SP HD	
<i>sildenafil</i> 20 mg tablet (Revatio)	T4	PA SP HD	
<i>tadalafil</i> (Adcirca)	T4	PA SP HD	
<i>tadalafil</i> 20 mg tablet (Adcirca)	T4	PA SP HD	
<b>PULMONARY ANTI-HTN, ENDOTHELIN RECEPTOR ANTAGONIST</b>			
ambrisentan (Letairis)	T4	PA SP HD	
bosentan (Tracleer)	T4	PA SP HD	
LETAIRIS ( <i>ambrisentan</i> )	T4	PA SP HD	
OPSUMIT	T4	PA SP HD	
TRACLEER 125 MG TABLET ( <i>bosentan</i> )	T4	PA SP HD	
TRACLEER 32 MG TABLET FOR SUSP	T4	PA SP HD	
TRACLEER 62.5 MG TABLET ( <i>bosentan</i> )	T4	PA SP HD	
<b>PULMONARY ANTIHYPER AGENT, ACTRIIA-FC</b>			
WINREVAIR	T4	PA SP HD	
<b>PULMONARY ANTIHYPERTENSIVES, PROSTACYCLIN-TYPE</b>			
<i>epoprostenol</i> sodium	T4	PA SP HD	
<i>epoprostenol</i> sodium 0.5 mg v/ <i>l</i>	T4	PA SP HD	
<i>epoprostenol</i> sodium 0.5 mg v/ <i>l</i> (Flolan)	T4	PA SP	
T1 – Typically Generics	T4 – Specialty Medications	ST – Step Therapy	HD – May require home delivery pharmacy
T2 – Typically Preferred Brands	PA – Prior Authorization	AGE – Age Requirement	PPACA – No Cost-Share Preventive Medication
T3 – Typically Non-Preferred Brands	QL – Quantity Limit	SP – Specialty Medication	CSL – Oral cancer medication subject to cost-share limits

## List of Prescription Medications

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

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>PULMONARY ANTIHYPERTENSIVES, PROSTACYCLIN-TYPE (cont.)</b>		
epoprostenol sodium 1.5 mg v/ (Flolan)	T4	PA SP
FLOLAN	T4	PA SP
ORENITRAM MONTH 1 TITRATION KT	T4	PA QL(168 tabs/180 days) SP HD
ORENITRAM MONTH 2 TITRATION KT	T4	PA QL(336 tabs/180 days) SP HD
ORENITRAM MONTH 3 TITRATION KT	T4	PA QL(252 tabs/180 days) SP HD
ORENITRAM ER	T4	PA SP HD
REMODULIN ( <i>treprostinil</i> )	T4	PA SP HD
<i>treprostinil</i> sodium (Remodulin)	T4	PA SP HD
TYVASO DPI	T4	PA SP HD
TYVASO INSTITUTIONAL START KIT	T4	PA SP HD
TYVASO REFILL KIT	T4	PA SP HD
TYVASO STARTER KIT	T4	PA SP HD
UPTRAVI	T4	PA SP HD
VELETRI VIAL	T4	PA SP
VENTAVIS	T4	PA SP HD
<b>PULMONARY HTN-ENDOTHELIN RECEPT ANTG-CGMP PDE5 INH</b>		
OPSYNVI	T4	PA QL(1 tab/day) SP HD
<b>CARDIOVASCULAR (Blood Pressure/Heart Medications)</b>		
<b>ACE INHIBITOR-CALCIUM CHANNEL BLOCKER COMBINATION</b>		
PRESTALIA 3.5 MG-2.5 MG TABLET	T3	QL (1 tab/day) HD
PRESTALIA 7 MG-5 MG TABLET	T3	QL (1 tab/day) HD
TARKA ( <i>trandolapril-verapamil er</i> )	T3	HD
<i>trandolapril-verapamil hcl</i>	T1	HD
<i>trandolapril-verapamil hcl</i> (Tarka)	T1	HD
<b>ACE INHIBITOR-THIAZIDE OR THIAZIDE-LIKE DIURETIC</b>		
ACCURETIC ( <i>quinapril-hydrochlorothiazide</i> )	T3	ST HD
<i>benazepril-hydrochlorothiazide</i>	T1	HD
<i>benazepril-hydrochlorothiazide</i> (Lotensin Hct)	T1	HD
<i>captopril-hctz</i> 25-15 mg tablet	T1	QL (3 tabs/day) HD
<i>captopril-hctz</i> 25-25 mg tablet	T1	QL (2 tabs/day) HD
<i>captopril-hctz</i> 50-15 mg tablet	T1	QL (3 tabs/day) HD
<i>captopril-hctz</i> 50-25 mg tablet	T1	QL (2 tabs/day) HD
<i>enalapril-hydrochlorothiazide</i>	T1	HD

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

T4 – Specialty Medications

PA – Prior Authorization

QL – Quantity Limit

ST – Step Therapy

AGE – Age Requirement

SP – Specialty Medication

HD – May require home delivery pharmacy

PPACA – No Cost-Share Preventive Medication

CSL – Oral cancer medication subject to cost-share limits

## List of Prescription Medications

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

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>ACE INHIBITOR-THIAZIDE OR THIAZIDE-LIKE DIURETIC (cont.)</b>		
enalapril/hydrochlorothiazide (Vaseretic)	T1	HD
fosinopril/hydrochlorothiazide	T1	HD
lisinopril/hydrochlorothiazide (Zestoretic)	T1	HD
LOTENSIN HCT (benazepril-hydrochlorothiazide)	T3	ST HD
quinapril/hydrochlorothiazide (Accuretic)	T1	HD
VASERETIC (enalapril-hydrochlorothiazide)	T3	ST HD
ZESTORETIC (lisinopril-hydrochlorothiazide)	T3	ST HD
<b>ALPHA/BETA-ADRENERGIC BLOCKING AGENTS</b>		
carvedilol (Coreg)	T1	HD
carvedilol er 10 mg capsule (Coreg Cr)	T1	QL (1 cap/day) HD
carvedilol er 20 mg capsule (Coreg Cr)	T1	QL (1 cap/day) HD
carvedilol er 40 mg capsule (Coreg Cr)	T1	QL (1 cap/day) HD
carvedilol er 80 mg capsule (Coreg Cr)	T1	HD
COREG (carvedilol)	T3	ST HD
COREG CR 10 MG CAPSULE (carvedilol er)	T3	QL (1 cap/day) ST HD
COREG CR 20 MG CAPSULE (carvedilol er)	T3	QL (1 cap/day) ST HD
COREG CR 40 MG CAPSULE (carvedilol er)	T3	QL (1 cap/day) ST HD
COREG CR 80 MG CAPSULE (carvedilol er)	T3	ST HD
LABETALOL HCL 10 MG/2 ML SYRNG	T3	
labetalol hcl 100 mg tablet	T1	
labetalol hcl 100 mg/20 ml vl	T1	
labetalol hcl 20 mg/4 ml crpj	T1	
labetalol hcl 20 mg/4 ml syrng	T1	
labetalol hcl 20 mg/4 ml vial	T1	
labetalol hcl 200 mg tablet	T1	HD
labetalol hcl 200 mg/40 ml vl	T1	HD
labetalol hcl 300 mg tablet	T1	HD
<b>ALPHA-ADRENERGIC BLOCKING AGENTS</b>		
CARDURA (doxazosin mesylate)	T3	HD
CARDURA XL	T3	HD
doxazosin mesylate (Cardura)	T1	HD
MINIPRESS (prazosin hcl)	T3	HD
prazosin hcl (Minipress)	T1	HD
terazosin hcl	T1	HD

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

T4 – Specialty Medications

PA – Prior Authorization

QL – Quantity Limit

ST – Step Therapy

AGE – Age Requirement

SP – Specialty Medication

HD – May require home delivery pharmacy

PPACA – No Cost-Share Preventive Medication

CSL – Oral cancer medication subject to cost-share limits

## List of Prescription Medications

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

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>ANGIOTEN.RECEPTR ANTAG-CALCIUM CHANL BLKR-THIAZIDE</b>		
amlodipine/valsartan/hcthiazid (Exforge Hct)	T1	HD
EXFORGE HCT (amlodipine-valsartan-hctz)	T3	PA HD
olmesartan/amlodipin/hcthiazid (Tribenzor)	T1	HD
TRIBENZOR (olmesartan-amlodipine-hctz)	T3	HD
<b>ANGIOTENSIN RECEPTE-NEPRILYSIN INHIBITOR COMB (ARNI)</b>		
ENTRESTO	T2	HD
<b>ANGIOTENSIN RECEPTOR ANTAG.-THIAZIDE DIURETIC COMB</b>		
ATACAND HCT (candesartan-hydrochlorothiazid)	T3	ST HD
AVALIDE (irbesartan-hydrochlorothiazide)	T3	ST HD
ATACAND HCT (candesartan-hydrochlorothiazid)	T3	ST HD
AVALIDE (irbesartan-hydrochlorothiazide)	T3	ST HD
BENICAR HCT 20-12.5 MG TABLET (olmesartan-hydrochlorothiazide)	T3	QL (1 tab/day) ST HD
BENICAR HCT 40-12.5 MG TABLET (olmesartan-hydrochlorothiazide)	T3	ST HD
BENICAR HCT 40-25 MG TABLET (olmesartan-hydrochlorothiazide)	T3	ST HD
candesartan/hydrochlorothiazid (Atacand Hct)	T1	HD
DIOVAN HCT (valsartan-hydrochlorothiazide)	T3	ST HD
EDARBYCLOR	T3	ST HD
HYZAAR (losartan-hydrochlorothiazide)	T3	ST HD
irbesartan/hydrochlorothiazide (Avalide)	T1	HD
losartan/hydrochlorothiazide (Hyzaar)	T1	HD
MICARDIS HCT 40-12.5 MG TABLET (telmisartan-hydrochlorothiazid)	T3	QL (1 tab/day) ST HD
MICARDIS HCT 80-12.5 MG TABLET (telmisartan-hydrochlorothiazid)	T3	ST HD
MICARDIS HCT 80-25 MG TABLET (telmisartan-hydrochlorothiazid)	T3	ST HD
olmesartan-hctz 20-12.5 mg tab (Benicar Hct)	T1	QL (1 tab/day) HD
olmesartan-hctz 40-12.5 mg tab (Benicar Hct)	T1	HD
telmisartan-hctz 40-12.5 mg tb (Micardis Hct)	T1	QL (1 tab/day) HD
telmisartan-hctz 80-12.5 mg tb (Micardis Hct)	T1	HD
telmisartan-hctz 80-25 mg tab (Micardis Hct)	T1	HD
valsartan/hydrochlorothiazide (Diovan Hct)	T1	HD
<b>ANGIOTENSIN RECEPTOR BLOCKR-CALCIUM CHANNEL BLOCKR</b>		
amlodipine besylate/valsartan (Exforge)	T1	HD
amlodipine-olmesartan 10-20 mg (Azor)	T1	HD
amlodipine-olmesartan 10-40 mg (Azor)	T1	HD
amlodipine-olmesartan 5-20 mg (Azor)	T1	QL (1 tab/day) HD

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

T4 – Specialty Medications

PA – Prior Authorization

QL – Quantity Limit

ST – Step Therapy

AGE – Age Requirement

SP – Specialty Medication

HD – May require home delivery pharmacy

PPACA – No Cost-Share Preventive Medication

CSL – Oral cancer medication subject to cost-share limits

## List of Prescription Medications

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

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>ANGIOTENSIN RECEPTOR BLOCKER-CALCIUM CHANNEL BLOCKER (cont.)</b>		
<i>amlodipine-olmesartan 5-40 mg (Azor)</i>	T1	HD
AZOR 10-20 MG TABLET ( <i>amlodipine-olmesartan</i> )	T3	HD
AZOR 10-40 MG TABLET ( <i>amlodipine-olmesartan</i> )	T3	HD
AZOR 5-20 MG TABLET ( <i>amlodipine-olmesartan</i> )	T3	QL (1 tab/day) HD
AZOR 5-40 MG TABLET ( <i>amlodipine-olmesartan</i> )	T3	HD
EXFORGE ( <i>amlodipine-valsartan</i> )	T3	PA HD
<i>telmisartan-amlodipine 40-10</i>	T1	HD
<i>telmisartan-amlodipine 40-5 mg</i>	T1	QL (1 tab/day) HD
<i>telmisartan-amlodipine 80-10</i>	T1	HD
<i>telmisartan-amlodipine 80-5 mg</i>	T1	HD
<b>ANTI-HYPERTENSIVES, ACE INHIBITORS</b>		
<i>ACCUPRIL (quinapril hcl)</i>	T3	ST HD
<i>benazepril hcl</i>	T1	HD
<i>benazepril hcl (Lotensin)</i>	T1	HD
<i>captopril</i>	T1	HD
<i>enalapril maleate (Vasotec)</i>	T1	HD
<i>enalaprilat dihydrate</i>	T1	
<i>EPANED</i>	T3	PA HD
<i>fosinopril sodium</i>	T1	HD
<i>lisinopril (Zestril)</i>	T1	HD
<i>LOTENSIN (benazepril hcl)</i>	T3	ST HD
<i>moexipril hcl</i>	T1	HD
<i>perindopril erbumine</i>	T1	HD
<i>PRINIVIL (lisinopril)</i>	T3	ST HD
<i>QBRELIS</i>	T3	PA HD
<i>quinapril hcl (Accupril)</i>	T1	HD
<i>ramipril (Altace)</i>	T1	HD
<i>trandolapril</i>	T1	HD
<i>VASOTEC (enalapril maleate)</i>	T3	ST HD
<i>ZESTRIL (lisinopril)</i>	T3	PA HD
<b>ANTI-HYPERTENSIVES, ANGIOTENSIN RECEPTOR ANTAGONIST</b>		
<i>ATACAND (candesartan cilexetil)</i>	T3	ST HD
<i>AVAPRO (irbesartan)</i>	T3	PA HD

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

T4 – Specialty Medications

PA – Prior Authorization

QL – Quantity Limit

ST – Step Therapy

AGE – Age Requirement

SP – Specialty Medication

HD – May require home delivery pharmacy

PPACA – No Cost-Share Preventive Medication

CSL – Oral cancer medication subject to cost-share limits

## List of Prescription Medications

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

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>ANTI-HYPERTENSIVES, ANGIOTENSIN RECEPTOR ANTAGONIST (cont.)</b>		
BENICAR 20 MG TABLET ( <i>olmesartan medoxomil</i> )	T3	QL (1 tab/day) ST HD
BENICAR 40 MG TABLET ( <i>olmesartan medoxomil</i> )	T3	ST HD
BENICAR 5 MG TABLET ( <i>olmesartan medoxomil</i> )	T3	ST HD
<i>candesartan cilexetil</i> (Atacand)	T1	HD
COZAAR ( <i>losartan potassium</i> )	T3	PA HD
DIOVAN ( <i>valsartan</i> )	T3	ST HD
EDARBI 40 MG TABLET	T3	QL (1 tab/day) ST HD
EDARBI 80 MG TABLET	T3	ST HD
<i>eprosartan mesylate</i>	T1	HD
<i>irbesartan</i> (Avapro)	T1	HD
<i>losartan potassium</i> (Cozaar)	T1	HD
MICARDIS 20 MG TABLET ( <i>telmisartan</i> )	T3	QL (1 tab/day) ST HD
MICARDIS 40 MG TABLET ( <i>telmisartan</i> )	T3	QL (1 tab/day) ST HD
MICARDIS 80 MG TABLET ( <i>telmisartan</i> )	T3	ST HD
<i>olmesartan medoxomil 20 mg tab</i> (Benicar)	T1	QL (1 tab/day) HD
<i>olmesartan medoxomil 40 mg tab</i> (Benicar)	T1	HD
<i>olmesartan medoxomil 5 mg tab</i> (Benicar)	T1	HD
<i>telmisartan 20 mg tablet</i> (Micardis)	T1	QL (1 tab/day) HD
<i>telmisartan 40 mg tablet</i> (Micardis)	T1	QL (1 tab/day) HD
<i>telmisartan 80 mg tablet</i> (Micardis)	T1	HD
<i>valsartan</i> (Diovan)	T1	HD
VALSARTAN 20 MG/5 ML SOLUTION	T3	ST HD
<b>ANTIHYPERTENSIVES, GANGLIONIC BLOCKERS</b>		
VECAMYL	T1	
<b>ANTI-HYPERTENSIVES, MISCELLANEOUS</b>		
DEMSER ( <i>metyrosine</i> )	T3	HD
<i>metyrosine</i> (Demser)	T1	HD
<i>nitroprusside sodium</i> (Nitropress)	T1	
<b>ANTI-HYPERTENSIVES, SYMPATHOLYTIC</b>		
CATAPRES-TTS 1 ( <i>clonidine</i> )	T3	HD
CATAPRES-TTS 2 ( <i>clonidine</i> )	T3	HD
CATAPRES-TTS 3 ( <i>clonidine</i> )	T3	HD

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

T4 – Specialty Medications

PA – Prior Authorization

QL – Quantity Limit

ST – Step Therapy

AGE – Age Requirement

SP – Specialty Medication

HD – May require home delivery pharmacy

PPACA – No Cost-Share Preventive Medication

CSL – Oral cancer medication subject to cost-share limits

## List of Prescription Medications

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

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>ANTI-HYPERTENSIVES, SYMPATHOLYTIC (cont.)</b>		
<i>clonidine</i> (Catapres-tts 1)	T1	HD
<i>clonidine</i> (Catapres-tts 2)	T1	HD
<i>clonidine</i> (Catapres-tts 3)	T1	HD
<i>clonidine hcl 0.1 mg tablet</i> (Catapres)	T1	HD
<i>clonidine hcl 0.2 mg tablet</i>	T1	HD
<i>clonidine hcl 0.3 mg tablet</i> (Catapres)	T1	HD
<i>guanfacine hcl</i>	T1	HD
<i>methyldopa</i>	T1	HD
<i>methyldopa/hydrochlorothiazide</i>	T1	HD
<i>methyldopate hcl</i>	T1	
<b>ANTI-HYPERTENSIVES, VASODILATORS</b>		
<i>CORLOPAM</i>	T3	HD
<i>hydralazine hcl</i>	T1	HD
<i>minoxidil</i>	T1	HD
<b>BETA-ADRENERGIC BLOCKING AGENTS</b>		
<i>acebutolol hcl</i>	T1	HD
<i>atenolol</i> (Tenormin)	T1	HD
<i>BETAPACE (sotalol af)</i>	T3	PA HD
<i>BETAPACE (sotalol)</i>	T3	PA HD
<i>BETAPACE AF (sotalol af)</i>	T3	PA HD
<i>betaxolol hcl</i>	T1	HD
<i>bisoprolol fumarate</i>	T1	HD
<i>BREVIBLOC</i>	T3	HD
<i>BYSTOLIC 10 MG TABLET</i>	T3	PA QL (1 tab/day) HD
<i>BYSTOLIC 2.5 MG TABLET</i>	T3	PA QL (1 tab/day) HD
<i>BYSTOLIC 20 MG TABLET</i>	T3	PA HD
<i>BYSTOLIC 5 MG TABLET</i>	T2	QL (1 tab/day) ST HD
<i>CORGARD (nadolol)</i>	T3	PA HD
<i>esmolol hcl</i>	T1	
<i>esmolol hcl (Brevibloc)</i>	T1	
<i>ESMOLOL HCL-WATER</i>	T1	
<i>esmolol in sodium chloride, iso (Brevibloc)</i>	T1	HD
<i>HEMANGEOL</i>	T3	PA HD
<i>INDERAL LA (propranolol hcl er)</i>	T3	PA HD

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

T4 – Specialty Medications

PA – Prior Authorization

QL – Quantity Limit

ST – Step Therapy

AGE – Age Requirement

SP – Specialty Medication

HD – May require home delivery pharmacy

PPACA – No Cost-Share Preventive Medication

CSL – Oral cancer medication subject to cost-share limits

## List of Prescription Medications

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

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>BETA-ADRENERGIC BLOCKING AGENTS (cont.)</b>		
INDERAL XL	T3	PA HD
INNOPRAN XL	T3	ST HD
KAPSPARGO SPRINKLE	T3	PA HD
LOPRESSOR ( <i>metoprolol tartrate</i> )	T3	PA HD
<i>metoprolol succinate</i> (Toprol XL)	T1	HD
<i>metoprolol tartrate</i>	T1	HD
<i>metoprolol tartrate</i> (Lopressor)	T1	HD
<i>nadolol</i>	T1	HD
<i>pindolol</i>	T1	HD
<i>propranolol hcl</i>	T1	HD
<i>propranolol hcl</i> (Inderal La)	T1	HD
SOTALOL HCL	T1	
<i>sotalol hcl</i> (Betapace Af)	T1	HD
<i>sotalol hcl</i> (Betapace)	T1	HD
SOTYLIZE	T3	HD
TENORMIN ( <i>atenolol</i> )	T3	PA HD
<i>timolol maleate</i>	T1	HD
TOPROL XL ( <i>metoprolol succinate</i> )	T3	PA HD
<b>BETA-BLOCKERS AND THIAZIDE, THIAZIDE-LIKE DIURETICS</b>		
<i>atenolol/chlorthalidone</i> (Tenoretic 100)	T1	HD
<i>atenolol/chlorthalidone</i> (Tenoretic 50)	T1	HD
<i>bisoprolol/hydrochlorothiazide</i> (Ziac)	T1	HD
DUTOPROL	T3	PA
<i>metoprolol/hydrochlorothiazide</i>	T1	HD
<i>nadolol/bendroflumethiazide</i>	T1	HD
<i>propranolol/hydrochlorothiazide</i>	T1	HD
TENORETIC 100 ( <i>atenolol-chlorthalidone</i> )	T3	PA HD
TENORETIC 50 ( <i>atenolol-chlorthalidone</i> )	T3	PA HD
ZIAC ( <i>bisoprolol-hydrochlorothiazide</i> )	T3	PA HD
<b>MUSCARINIC RECEPTOR ANTAGONISTS (ANTICHOLINERGIC)</b>		
ATROPEN	T3	
<b>PATENT DUCTUS ARTERIOSUS TREAT. AGENTS, NSAID-TYPE</b>		
<i>ibuprofen lysine/pf</i> (Neoprofen)	T1	
<i>indomethacin 1 mg vial</i>	T1	

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

T4 – Specialty Medications

PA – Prior Authorization

QL – Quantity Limit

ST – Step Therapy

AGE – Age Requirement

SP – Specialty Medication

HD – May require home delivery pharmacy

PPACA – No Cost-Share Preventive Medication

CSL – Oral cancer medication subject to cost-share limits

## List of Prescription Medications

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

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>PATENT DUCTUS ARTERIOSUS TREAT. AGENTS, NSAID-TYPE (cont.)</b>		
NEOPROFEN ( <i>ibuprofen lysine</i> )	T3	
<b>RENIN INHIBITOR, DIRECT</b>		
aliskiren 150 mg tablet (Tekturna)	T1	QL (1 tab/day) HD
aliskiren 300 mg tablet (Tekturna)	T1	HD
TEKTURN A 150 MG TABLET ( <i>aliskiren</i> )	T3	PA QL (1 tab/day) HD
TEKTURN A 300 MG TABLET ( <i>aliskiren</i> )	T3	PA HD
<b>RENIN INHIBITOR, DIRECT AND THIAZIDE DIURETIC COMB</b>		
TEKTURN A HCT	T2	HD
<b>VASODILATORS, COMBINATION</b>		
BIDIL ( <i>isosorbide dinit/hydralazine</i> )	T3	PA QL (6 tabs/day) HD
<i>isosorbide-dinit hydralazine</i> (Bidil)	T1	QL (6 tabs/day) HD
<b>VASODILATORS, PERIPHERAL</b>		
ergoloid mesylates	T1	
isoxsuprine hcl	T1	
papaverine hcl	T1	

### CARDIOVASCULAR (Cholesterol Medications)

<b>ANTI-HYPERLIP.HMG COA REDUCT INHIB-CHOLEST.AB.INHIB</b>		
ezetimibe/simvastatin (Vytorin)	T1	HD
ROSZET	T3	PA HD
VYTORIN (ezetimibe-simvastatin)	T3	ST HD
<b>ANTI-HYPERLIPID- HMG-COA RI-CALCIUM CHANNEL BLOCKER</b>		
amlodipine-atorvast 10-10 mg (Caduet)	T1	HD
amlodipine-atorvast 10-20 mg (Caduet)	T1	HD
amlodipine-atorvast 10-40 mg (Caduet)	T1	HD
amlodipine-atorvast 10-80 mg (Caduet)	T1	HD
amlodipine-atorvast 2.5-10 mg	T1	HD
amlodipine-atorvast 2.5-20 mg	T1	QL (1 tab/day) HD
amlodipine-atorvast 2.5-40 mg	T1	QL (1 tab/day) HD
amlodipine-atorvast 5-10 mg (Caduet)	T1	HD
amlodipine-atorvast 5-20 mg (Caduet)	T1	QL (1 tab/day) HD
amlodipine-atorvast 5-40 mg (Caduet)	T1	QL (1 tab/day) HD
amlodipine-atorvast 5-80 mg (Caduet)	T1	HD
CADUET 10 MG-10 MG TABLET ( <i>amlodipine-atorvastatin</i> )	T3	HD
CADUET 10 MG-20 MG TABLET ( <i>amlodipine-atorvastatin</i> )	T3	HD

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

T4 – Specialty Medications

PA – Prior Authorization

QL – Quantity Limit

ST – Step Therapy

AGE – Age Requirement

SP – Specialty Medication

HD – May require home delivery pharmacy

PPACA – No Cost-Share Preventive Medication

CSL – Oral cancer medication subject to cost-share limits

## List of Prescription Medications

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

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>ANTI-HYPERLIPID- HMG-COA RI-CALCIUM CHANNEL BLOCKER (cont.)</b>		
CADUET 10 MG-40 MG TABLET ( <i>amlodipine-atorvastatin</i> )	T3	HD
CADUET 10 MG-80 MG TABLET ( <i>amlodipine-atorvastatin</i> )	T3	HD
CADUET 5 MG-10 MG TABLET ( <i>amlodipine-atorvastatin</i> )	T3	HD
CADUET 5 MG-20 MG TABLET ( <i>amlodipine-atorvastatin</i> )	T3	QL (1 tab/day) HD
CADUET 5 MG-40 MG TABLET ( <i>amlodipine-atorvastatin</i> )	T3	QL (1 tab/day) HD
CADUET 5 MG-80 MG TABLET ( <i>amlodipine-atorvastatin</i> )	T3	HD
<b>ANTIHYPOLIPIDEMIC - ANGIOPOIETIN-LIKE 3 INHIBITOR</b>		
EVKEEZA	T4	PA SP
<b>ANTI-HYPERLIPIDEMIC - APO B-100 SYNTHESIS INHIBITOR</b>		
KYNAMRO	T4	PA SP
<b>ANTI-HYPERLIPIDEMIC - APOLIPOPROTEIN INHIBITOR</b>		
TRYNGOLZA	T3	PA QL SP
<b>ANTI-HYPERLIPIDEMIC - ATP CITRATE LYASE INHIBITOR</b>		
NEXLETOL	T2	PA QL (1 tab/day)
<b>ANTI-HYPERLIPIDEMIC - MTP INHIBITOR</b>		
JUXTAPID	T4	PA SP HD
<b>ANTI-HYPERLIPIDEMIC - PCSK9 INHIBITORS</b>		
PRALUENT PEN	T3	PA
REPATHA PUSHTRONEX	T2	PA
REPATHA SURECLICK	T2	PA
REPATHA SYRINGE	T2	PA
<b>ANTI-HYPERLIPIDEMIC-ACLY AND CHOLEST ABSORP INHIB</b>		
NEXLIZET	T2	PA QL (1 syringe/day)
<b>ANTI-HYPERLIPIDEMIC-HMGCOA REDUCTASE INHIB (Statins)</b>		
ALTOPREV 20 MG TABLET	T3	QL (1 tab/day) ST HD
ALTOPREV 40 MG TABLET	T3	ST HD
ALTOPREV 60 MG TABLET	T3	ST HD
<i>atorvastatin 10 mg tablet (Lipitor)</i>	T1	HD PPACA
<i>atorvastatin 20 mg tablet (Lipitor)</i>	T1	HD PPACA
<i>atorvastatin 40 mg tablet (Lipitor)</i>	T1	HD
<i>atorvastatin 80 mg tablet (Lipitor)</i>	T1	HD
CRESTOR 10 MG TABLET ( <i>rosuvastatin calcium</i> )	T3	QL (1 tab/day) ST HD
CRESTOR 20 MG TABLET ( <i>rosuvastatin calcium</i> )	T3	QL (1 tab/day) ST HD
CRESTOR 40 MG TABLET ( <i>rosuvastatin calcium</i> )	T3	ST HD

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

T4 – Specialty Medications

PA – Prior Authorization

QL – Quantity Limit

ST – Step Therapy

AGE – Age Requirement

SP – Specialty Medication

HD – May require home delivery pharmacy

PPACA – No Cost-Share Preventive Medication

CSL – Oral cancer medication subject to cost-share limits

## List of Prescription Medications

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

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>ANTI-HYPERLIPIDEMIC-HMGCOA REDUCTASE INHIB (Statins) (cont.)</b>		
CRESTOR 5 MG TABLET ( <i>rosuvastatin calcium</i> )	T3	QL (1 tab/day) ST HD
EZALLOR SPRINKLE 10 MG CAPSULE	T3	QL (1 tab/day) ST HD
EZALLOR SPRINKLE 20 MG CAPSULE	T3	QL (1 tab/day) ST HD
EZALLOR SPRINKLE 40 MG CAPSULE	T3	ST HD
EZALLOR SPRINKLE 5 MG CAPSULE	T3	QL (1 tab/day) ST HD
FLOLIPID	T3	ST HD
<i>fluvastatin sodium</i>	T1	HD PPACA
<i>fluvastatin sodium (Lescol XL)</i>	T1	HD PPACA
LESCOL XL ( <i>fluvastatin er</i> )	T3	PA HD
LIPITOR ( <i>atorvastatin calcium</i> )	T3	PA HD
LIVALO 1 MG TABLET	T2	QL (1 tab/day) ST HD
LIVALO 2 MG TABLET	T2	QL (1 tab/day) ST HD
LIVALO 4 MG TABLET	T2	PA HD
<i>lovastatin 10 mg tablet</i>	T1	HD
<i>lovastatin 20 mg tablet</i>	T1	HD PPACA
<i>lovastatin 40 mg tablet</i>	T1	HD PPACA
<i>pitavastatin tablet</i>	T1	QL (1 tab/day) HD PPACA
PRAVACHOL ( <i>pravastatin sodium</i> )	T3	PA HD
<i>pravastatin sodium</i>	T1	HD PPACA
<i>pravastatin sodium (Pravachol)</i>	T1	HD PPACA
<i>rosuvastatin calcium 10 mg tab (Crestor)</i>	T1	QL (1 tab/day) HD PPACA
<i>rosuvastatin calcium 20 mg tab (Crestor)</i>	T1	QL (1 tab/day) HD
<i>rosuvastatin calcium 40 mg tab (Crestor)</i>	T1	HD
<i>rosuvastatin calcium 5 mg tab (Crestor)</i>	T1	QL (1 tab/day) HD PPACA
<i>simvastatin 10 mg tablet (Zocor)</i>	T1	HD PPACA
<i>simvastatin 20 mg tablet (Zocor)</i>	T1	HD PPACA
SIMVASTATIN 20 MG/5 ML SUSP	T3	ST HD
<i>simvastatin 40 mg tablet (Zocor)</i>	T1	HD PPACA
<i>simvastatin 5 mg tablet</i>	T1	HD
ZOCOR	T3	PA HD
ZYPITAMAG	T3	ST HD

### BILE SALT SEQUESTRANTS

<i>cholestyramine (with sugar) (Questran)</i>	T1	HD
<i>cholestyramine/aspartame</i>	T1	HD

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

T4 – Specialty Medications

PA – Prior Authorization

QL – Quantity Limit

ST – Step Therapy

AGE – Age Requirement

SP – Specialty Medication

HD – May require home delivery pharmacy

PPACA – No Cost-Share Preventive Medication

CSL – Oral cancer medication subject to cost-share limits

## List of Prescription Medications

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

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>BILE SALT SEQUESTRANTS (con't.)</b>		
COLESTID	T3	HD
COLESTID ( <i>colestipol hcl</i> )	T3	HD
<i>colestipol hcl</i> (Colestid)	T1	HD
QUESTRAN ( <i>cholestyramine</i> )	T3	HD
QUESTRAN LIGHT ( <i>prevalite</i> )	T3	HD
WELCHOL ( <i>colesevelam hcl</i> )	T3	PA HD
<b>LIPOTROPICS</b>		
ANTARA	T3	PA HD
<i>ezetimibe</i> (Zetia)	T1	HD
<i>fenofibrate 120 mg tablet</i> (Fenoglide)	T1	HD
<i>fenofibrate 130 mg capsule</i>	T1	HD
<i>fenofibrate 134 mg capsule</i>	T1	HD
<i>fenofibrate 145 mg tablet</i> (Tricor)	T1	HD
FENOFIBRATE 150 MG CAPSULE	T1	HD
<i>fenofibrate 160 mg tablet</i>	T1	HD
FENOFIBRATE 160 MG TABLET	T3	PA HD
<i>fenofibrate 200 mg capsule</i>	T1	HD
<i>fenofibrate 40 mg tablet</i> (Fenoglide)	T1	HD
<i>fenofibrate 43 mg capsule</i>	T1	HD
<i>fenofibrate 48 mg tablet</i> (Tricor)	T1	HD
FENOFIBRATE 50 MG CAPSULE	T1	HD
<i>fenofibrate 54 mg tablet</i>	T1	HD
<i>fenofibrate 67 mg capsule</i>	T1	HD
<i>fenofibric acid (choline)</i> (Trilipix)	T1	HD
<i>fenofibric acid</i> (Fibrincor)	T1	HD
FENOGLIDE ( <i>fenofibrate</i> )	T3	PA HD
FIBRICOR ( <i>fenofibric acid</i> )	T3	ST HD
<i>gemfibrozil</i> (Lopid)	T1	HD
LIPOFEN	T3	ST HD
LOPID ( <i>gemfibrozil</i> )	T3	HD
<i>niacin</i> (Niacor)	T1	HD
<i>niacin</i> (Niaspan)	T1	HD
NIACOR	T1	HD
NIASPAN ( <i>niacin er</i> )	T3	HD

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

T4 – Specialty Medications

PA – Prior Authorization

QL – Quantity Limit

ST – Step Therapy

AGE – Age Requirement

SP – Specialty Medication

HD – May require home delivery pharmacy

PPACA – No Cost-Share Preventive Medication

CSL – Oral cancer medication subject to cost-share limits

## List of Prescription Medications

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

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>LIPOTROPICS (con't.)</b>		
TRICOR ( <i>fenofibrate</i> )	T3	ST HD
TRIGLIDE	T3	ST HD
TRILIPIX ( <i>fenofibric acid</i> )	T3	ST HD
ZETIA ( <i>ezetimibe</i> )	T3	HD
<b>ENDOTHELIN-ANGIOTENSIN RECEPTOR ANTAGONIST</b>		
FILSPARI	T4	PA QL(1 tab/day) SP HD
<b>CARDIOVASCULAR (Miscellaneous)</b>		
<b>VENOSCLEROSING AGENTS</b>		
ASCLERA	T4	PA SP
ETHAMOLIN	T3	
<i>sodium tetradecyl sulfate</i> (Sotradecol)	T1	
SOTRADECOL ( <i>sodium tetradecyl sulfate</i> )	T3	
<b>CNS DRUGS (Alzheimer's Disease)</b>		
<b>ALZHEIMER'S THERAPY, NMDA RECEPTOR ANTAGONISTS</b>		
memantine hcl	T1	HD
memantine hcl er 7 mg capsule (Namenda Xr)	T1	QL (1 cap/day) HD
memantine hcl er 14 mg capsule (Namenda Xr)	T1	QL (1 cap/day) HD
memantine hcl er 21 mg, 28 mg capsule (Namenda Xr)	T1	HD
NAMENDA 10 MG TABLET ( <i>memantine hcl</i> )	T3	HD
NAMENDA 5 MG TABLET ( <i>memantine hcl</i> )	T3	HD
NAMENDA 5-10 MG TITRATION PK	T2	HD
NAMENDA XR 14 MG CAPSULE ( <i>memantine hcl er</i> )	T3	QL (1 cap/day) HD
NAMENDA XR 21 MG CAPSULE ( <i>memantine hcl er</i> )	T3	HD
NAMENDA XR 28 MG CAPSULE ( <i>memantine hcl er</i> )	T3	HD
NAMENDA XR 7 MG CAPSULE ( <i>memantine hcl er</i> )	T3	QL (1 cap/day) HD
NAMENDA	T2	HD
NAMENDA XR TITRATION PACK	T3	QL (112/365 days) HD
<b>ALZHEIMER'S THX, NMDA RECEPTOR ANTAG-CHOLINES INHIB</b>		
NAMZARIC 14 MG-10 MG CAPSULE	T3	QL (2 caps/day) HD
NAMZARIC 21 MG-10 MG CAPSULE	T3	QL (2 caps/day) HD
NAMZARIC 28 MG-10 MG CAPSULE	T3	QL (2 caps/day) HD
NAMZARIC 7 MG-10 MG CAPSULE	T3	QL (2 caps/day) HD
NAMZARIC TITRATION PACK	T3	QL (112/365 days) HD

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

T4 – Specialty Medications

PA – Prior Authorization

QL – Quantity Limit

ST – Step Therapy

AGE – Age Requirement

SP – Specialty Medication

HD – May require home delivery pharmacy

PPACA – No Cost-Share Preventive Medication

CSL – Oral cancer medication subject to cost-share limits

## List of Prescription Medications

CNS DRUGS (Miscellaneous)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>AMYLOID DIRECTED MONOCLONAL ANTIBODY</b>		
KISUNLA	T4	PA SP
<b>ALCOHOL, SYSTEMIC USE</b>		
ALCOHOL, DEHYDRATED	T1	
<b>AMYLOID DIRECTED MONOCLONAL ANTIBODY</b>		
ADUHELM	T4	PA SP
<b>AMYOTROPHIC LATERAL SCLEROSIS AGENTS</b>		
edaravone	T4	PA SP
RADICAVA	T4	PA SP
RADICAVA ORS	T4	PA QL (50ml/28 days) SP
RELYVRIQ	T4	PA QL(2 packs/day) SP
RILUTEK ( <i>riluzole</i> )	T4	PA SP HD
<i>riluzole</i> (Rilutek)	T4	SP HD
TIGLUTIK	T4	PA SP
QALSODY	T3	
<b>CENTRAL NERVOUS SYSTEM STIMULANTS</b>		
DOPRAM	T3	
<i>doxapram hcl</i> (Dopram)	T1	
<b>DRUGS TO TREAT MOVEMENT DISORDERS</b>		
AUSTEDO XR TABLET	T4	PA QL SP HD
AUSTEDO XR 6 MG TABLET	T4	PA QL (90 tabs/30 days) SP HD
AUSTEDO XR 12 MG TABLET	T4	PA QL (30 tabs/30 days) SP HD
AUSTEDO XR 18 MG TABLET	T4	PA QL(1 tab/day) SP HD
AUSTEDO XR 24 MG TABLET	T4	PA QL (60 tabs/30 days) SP HD
AUSTEDO XR TITRATION KT (WK1-4)	T4	PA QL(1 kit/180 days) SP HD
HORIZANT	T3	PA
INGREZZA	T4	PA QL(1 caps/day) SP
INGREZZA INITIATION PK(TARDIV)	T4	PA QL(28 caps/365 days) SP
INGREZZA SPRINKLE	T4	PA QL SP
<i>tetrabenazine</i> (Xenazine)	T4	PA SP HD
XENAZINE ( <i>tetrabenazine</i> )	T4	PA SP HD
<b>PSEUDOBULBAR AFFECT (PBA) AGENTS, NMDA ANTAGONISTS</b>		
NUEDEXTA	T3	QL (4 caps/day)
<b>XANTHINES</b>		
CAFCIT ( <i>caffeine citrate</i> )	T3	HD

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

T4 – Specialty Medications

PA – Prior Authorization

QL – Quantity Limit

ST – Step Therapy

AGE – Age Requirement

SP – Specialty Medication

HD – May require home delivery pharmacy

PPACA – No Cost-Share Preventive Medication

CSL – Oral cancer medication subject to cost-share limits

## List of Prescription Medications

### CNS DRUGS (Miscellaneous) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>XANTHINES (cont.)</b>		
CAFFEINE AND SODIUM BENZOATE	T1	HD
<i>caffeine citrate</i> (Cafcit)	T1	HD
<i>caffeine/sodium benzoate</i> (Caffeine And Sodium Benzoate)	T1	HD

### CNS DRUGS (Multiple Sclerosis)

AGENTS TO TREAT MULTIPLE SCLEROSIS
AUBAGIO ( <i>teriflunomide</i> )
AVONEX
AVONEX PEN
BAFIERTAM
BETASERON
BRIUMVI
COPAXONE ( <i>glatopa</i> )
<i>dimethyl fumarate</i> (Tecfidera)
GILENYA 0.25 MG CAPSULE
GILENYA 0.5 MG CAPSULE ( <i>fingolimod hc</i> )
<i>glatiramer</i>
<i>glatopa</i>
<i>glatiramer acetate</i> (Copaxone)
KESIMPTA PEN
LEMTRADA
MAVENCLAD
MAYZENT
OCREVUS
PLEGRIDY
PLEGRIDY PEN
PONVORY
REBIF
REBIF REBIDOSE
TASCENO ODT
TECFIDERA ( <i>dimethyl fumarate</i> )

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

T4 – Specialty Medications

PA – Prior Authorization

QL – Quantity Limit

ST – Step Therapy

AGE – Age Requirement

SP – Specialty Medication

HD – May require home delivery pharmacy

PPACA – No Cost-Share Preventive Medication

CSL – Oral cancer medication subject to cost-share limits

## List of Prescription Medications

### CNS DRUGS (Multiple Sclerosis) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits	
<b>AGENTS TO TREAT MULTIPLE SCLEROSIS (con't.)</b>			
teriflunomide (Aubagio)	T4	SP HD	
VELSIPITY	T4	PA QL(30 tabs/30 days) SP HD	
VUMERTY	T4	PA SP HD	
ZEPOSIA	T4	PA SP HD	
<b>AGTS TX NEUROMUSC TRANSMISSION DIS, POT-CHAN BLKR</b>			
AMPYRA (dalfampridine er)	T4	PA SP HD	
dalfampridine (Ampyra)	T4	PA SP HD	
FIRDAPSE	T4	PA QL (8 tabs/day) SP	
RUZURGI	T4	PA SP	
<b>CNS DRUGS (Pain Relief And Inflammatory Disease)</b>			
<b>CALCITONIN GENE-RELATED PEPTIDE (CGRP) INHIBITORS</b>			
EMGALITY SYRINGE	T2	PA	
<b>GLYPROMATE (GPE) ANALOGS</b>			
DAYBUE	T4	PA QL (120 ml/day) SP	
<b>POSTHERPETIC NEURALGIA AGENTS</b>			
GRALISE (gabapentin)	T3	PA	
<b>SPHINGOSINE I-PHOSPHATE (SIP) RECEPTOR MODULATOR</b>			
ZEPOSIA	T2	PA SP HD	
<b>CNS DRUGS (Seizure Disorders)</b>			
<b>ANTI-CONVULSANT - BENZODIAZEPINE TYPE</b>			
clobazam (Onfi)	T1	HD	
clonazepam (Klonopin)	T1	HD	
diazepam 10 mg rectal gel syst	T1	HD	
diazepam 2.5 mg rectal gel sys (Diastat)	T1	HD	
diazepam 20 mg rectal gel syst (Diastat Acudial)	T1	HD	
diazepam 20 mg rectal gel syst (Diastat Acudial)	T1	HD	
KLONOPIN (clonazepam)	T3	PA HD	
LIBERVANT	T3	PA QL(10 films/30 days) HD	
NAYZILAM	T2	PA QL (5 kits/30 days) HD	
ONFI (clobazam)	T3	PA HD	
SYMPAZAN	T3	PA HD	
VALTOCO	T3	PA QL (5 boxes/30 days) HD	
I1 – Typically Generics	I4 – Specialty Medications	SI – Step Therapy	HD – May require home delivery pharmacy
T2 – Typically Preferred Brands	PA – Prior Authorization	AGE – Age Requirement	PPACA – No Cost-Share Preventive Medication
T3 – Typically Non-Preferred Brands	QL – Quantity Limit	SP – Specialty Medication	CSL – Oral cancer medication subject to cost-share limits

## List of Prescription Medications

### CNS DRUGS (Seizure Disorders) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>ANTI-CONVULSANT - CANNABINOID TYPE</b>		
EPIDIOLEX	T4	PA SP HD
<b>ANTI-CONVULSANTS</b>		
APTIOM 200 MG TABLET	T3	PA QL (1 tab/day) HD
APTIOM 400 MG TABLET	T3	PA QL (1 tab/day) HD
APTIOM 600 MG TABLET	T3	PA HD
APTIOM 800 MG TABLET	T3	PA HD
BANZEL 200 MG TABLET	T3	PA QL (16 tabs/day) HD
BANZEL 40 MG/ML SUSPENSION ( <i>rufinamide</i> )	T3	PA QL (80ml/day) HD
BANZEL 400 MG TABLET	T3	PA QL (8 tabs/day) HD
BRIVIACT 10 MG TABLET	T3	PA HD
BRIVIACT 10 MG/ML ORAL SOLN	T3	PA HD
BRIVIACT 100 MG TABLET	T3	PA HD
BRIVIACT 25 MG TABLET	T3	PA HD
BRIVIACT 50 MG TABLET	T3	PA HD
BRIVIACT 50 MG/5 ML VIAL	T3	HD
BRIVIACT 75 MG TABLET	T3	PA HD
<i>carbamazepine</i>	T1	HD
<i>carbamazepine</i> (Carbatrol)	T1	HD
<i>carbamazepine</i> (Tegretol Xr)	T1	HD
<i>carbamazepine</i> (Tegretol)	T1	HD
CARBATROL ( <i>carbamazepine er</i> )	T3	PA HD
CELONTIN	T2	HD
CEREBYX ( <i>fosphenytoin sodium</i> )	T3	
DEPAKOTE ( <i>divalproex sodium</i> )	T3	PA HD
DEPAKOTE ER ( <i>divalproex sodium er</i> )	T3	PA HD
DEPAKOTE SPRINKLE ( <i>divalproex sodium</i> )	T3	PA HD
DIACOMIT	T4	PA SP HD
DILANTIN	T3	PA HD
DILANTIN ( <i>phenytoin sodium extended</i> )	T3	PA HD
DILANTIN ( <i>phenytoin</i> )	T3	PA HD
DILANTIN-125 ( <i>phenytoin</i> )	T3	PA HD
<i>divalproex sodium</i> (Depakote Er)	T1	HD
<i>divalproex sodium</i> (Depakote Sprinkle)	T1	HD
<i>divalproex sodium</i> (Depakote)	T1	HD

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

T4 – Specialty Medications

PA – Prior Authorization

QL – Quantity Limit

ST – Step Therapy

AGE – Age Requirement

SP – Specialty Medication

HD – May require home delivery pharmacy

PPACA – No Cost-Share Preventive Medication

CSL – Oral cancer medication subject to cost-share limits

## List of Prescription Medications

### CNS DRUGS (Seizure Disorders) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>ANTI-CONVULSANTS (cont.)</b>		
ELEPSIA XR	T3	PA
EPRONTIA	T3	PA
<i>ethosuximide</i> (Zarontin)	T1	HD
<i>felbamate</i> (Felbatol)	T1	HD
FELBATOL ( <i>felbamate</i> )	T3	PA HD
FINTEPLA	T4	PA SP HD
<i>fosphenytoin sodium</i> (Cerebyx)	T1	
FYCOMPA 0.5 MG/ML ORAL SUSP	T2	PA HD
FYCOMPA 10 MG TABLET	T2	PA HD
FYCOMPA 12 MG TABLET	T2	PA HD
FYCOMPA 2 MG TABLET	T2	PA HD
FYCOMPA 4 MG TABLET	T2	PA QL (1 tab/day) HD
FYCOMPA 6 MG TABLET	T2	PA QL (1 tab/day) HD
FYCOMPA 8 MG TABLET	T2	PA HD
GABARONE	T3	PA HD
<i>gabapentin</i> (Neurontin)	T1	HD
KEPPRA 1,000 MG TABLET ( <i>roweepra</i> )	T3	PA HD
KEPPRA 100 MG/ML ORAL SOLN ( <i>levetiracetam</i> )	T3	PA HD
KEPPRA 250 MG TABLET ( <i>levetiracetam</i> )	T3	PA HD
KEPPRA 500 MG TABLET ( <i>roweepra</i> )	T3	PA HD
KEPPRA 500 MG/5 ML VIAL ( <i>levetiracetam</i> )	T3	
KEPPRA 750 MG TABLET ( <i>roweepra</i> )	T3	PA HD
KEPPRA XR ( <i>levetiracetam er</i> )	T3	PA HD
LAMICTAL (BLUE) ( <i>subvenite (blue)</i> )	T3	PA HD
LAMICTAL (GREEN) ( <i>subvenite (green)</i> )	T3	PA HD
LAMICTAL ( <i>lamotrigine</i> )	T3	PA HD
LAMICTAL (ORANGE) ( <i>subvenite (orange)</i> )	T3	PA HD
LAMICTAL ( <i>subvenite</i> )	T3	PA HD
LAMICTAL ODT (BLUE) ( <i>lamotrigine odt (blue)</i> )	T3	PA HD
LAMICTAL ODT (GREEN) ( <i>lamotrigine odt (green)</i> )	T3	PA HD
LAMICTAL ODT ( <i>lamotrigine odt</i> )	T3	PA HD
LAMICTAL ODT (ORANGE) ( <i>lamotrigine odt (orange)</i> )	T3	PA HD
LAMICTAL XR (BLUE)	T3	PA HD
LAMICTAL XR (GREEN)	T3	PA HD

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

T4 – Specialty Medications

PA – Prior Authorization

QL – Quantity Limit

ST – Step Therapy

AGE – Age Requirement

SP – Specialty Medication

HD – May require home delivery pharmacy

PPACA – No Cost-Share Preventive Medication

CSL – Oral cancer medication subject to cost-share limits

## List of Prescription Medications

### CNS DRUGS (Seizure Disorders) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>ANTI-CONVULSANTS (cont.)</b>		
LAMICTAL XR ( <i>lamotrigine er</i> )	T3	PA HD
LAMICTAL XR (ORANGE)	T3	PA 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>levetiracetam</i>	T1	HD
<i>levetiracetam</i> (Keppra Xr)	T1	HD
<i>levetiracetam</i> (Keppra)	T1	HD
<i>levetiracetam in nacl (iso-os)</i>	T1	
LYRICA ( <i>pregabalin</i> )	T3	PA HD
MOTPOLY XR 100 MG CAPSULE	T3	PA QL(1 cap/day) HD
MOTPOLY XR 150 MG CAPSULE	T3	PA QL(2 caps/day) HD
MOTPOLY XR 200 MG CAPSULE	T3	PA QL(2 caps/day) HD
MYSOLINE ( <i>primidone</i> )	T3	PA HD
NEURONTIN ( <i> gabapentin</i> )	T3	PA HD
<i>oxcarbazepine</i>	T1	PA HD
OXTELLAR XR	T3	PA HD
PEGANONE	T2	HD
PHENYTEK ( <i>phenytoin sodium extended</i> )	T3	PA HD
<i>phenytoin</i>	T1	HD
<i>phenytoin</i> (Dilantin)	T1	HD
<i>phenytoin</i> (Dilantin-125)	T1	HD
<i>phenytoin sodium</i>	T1	HD
<i>phenytoin sodium extended</i> (Dilantin)	T1	HD
<i>pregabalin</i> (Lyrica)	T1	HD
PRIMIDONE 125 MG TABLET	T3	PA HD
<i>primidone 250 mg tablet</i> (Mysoline)	T1	HD

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

T4 – Specialty Medications

PA – Prior Authorization

QL – Quantity Limit

ST – Step Therapy

AGE – Age Requirement

SP – Specialty Medication

HD – May require home delivery pharmacy

PPACA – No Cost-Share Preventive Medication

CSL – Oral cancer medication subject to cost-share limits

## List of Prescription Medications

### CNS DRUGS (Seizure Disorders) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>ANTI-CONVULSANTS (cont.)</b>		
primidone 50 mg tablet (Mysoline)	T1	HD
QUDEXY XR (topiramate er)	T3	PA HD
rufinamide (Banzel)	T1	PA QL (80ml/day) HD
SABRIL (vigabatrin)	T4	PA SP HD
SABRIL (vigadroner)	T4	PA SP HD
SPRITAM	T3	PA HD
TEGRETOL (carbamazepine)	T3	PA HD
TEGRETOL (epitol)	T3	PA HD
TEGRETOL XR (carbamazepine er)	T3	PA HD
tiagabine hcl 12 mg tablet (Gabitril)	T1	QL (8 tabs/day) HD
tiagabine hcl 16 mg tablet (Gabitril)	T1	QL (6 tabs/day) HD
tiagabine hcl 2 mg tablet (Gabitril)	T1	HD
tiagabine hcl 4 mg tablet (Gabitril)	T1	HD
TOPAMAX (topiramate)	T3	PA HD
topiramate (Qudexy Xr)	T1	HD
topiramate (Topamax)	T1	HD
TOPIRAMATE 50 MG SPRINKLE CAP	T3	PA HD
topiramate er 50 mg capsule (Trokendi Xr)	T1	HD
topiramate er 25 mg capsule (Trokendi Xr)	T1	QL(1 cap/day) HD
topiramate er 100 mg capsule (Trokendi Xr)	T1	QL(1 cap/day) HD
topiramate er 200 mg capsule (Trokendi Xr)	T1	HD
TRILEPTAL (oxcarbazepine)	T3	PA HD
TROKENDI XR 50 MG CAPSULE (topiramate)	T3	PA HD
TROKENDI XR 25 MG CAPSULE (topiramate)	T3	PA QL(1 cap/day) HD
TROKENDI XR 100 MG CAPSULE (topiramate)	T3	PA QL(1 cap/day) HD
TROKENDI XR 200 MG CAPSULE (topiramate)	T3	PA HD
valproic acid	T1	HD
valproic acid (as sodium salt)	T1	HD
vigabatrin (Sabril)	T4	SP HD
VIMPAT 10 MG/ML SOLUTION	T2	PA HD
VIMPAT 100 MG TABLET	T2	PA HD
VIMPAT 150 MG TABLET	T2	PA HD
VIMPAT 200 MG TABLET	T2	PA HD
VIMPAT 200 MG/20 ML VIAL	T3	HD

T1 – Typically Generics

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T3 – Typically Non-Preferred Brands

T4 – Specialty Medications

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## List of Prescription Medications

### CNS DRUGS (Seizure Disorders) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>ANTI-CONVULSANTS (cont.)</b>		
VIMPAT 50 MG TABLET	T2	PA HD
XCOPRI 25 MG TABLET	T3	PA HD
XCOPRI 100 MG TABLET	T3	PA QL (1 tab/day) HD
XCOPRI 12.5-25 MG TITRATION PK	T3	PA QL (1 pack/28 day) HD
XCOPRI 150 MG TABLET	T3	PA QL (1 tab/day) HD
XCOPRI 150-200 MG TITRATION PK	T3	PA QL (1 pack/28 Days) HD
XCOPRI 200 MG TABLET	T3	PA QL (2 tabs/day) HD
XCOPRI 250 MG DAILY DOSE PACK	T3	PA QL (1 pack/28 day) HD
XCOPRI 350 MG DAILY DOSE PACK	T3	PA QL (1 pack/28 day) HD
XCOPRI 50 MG TABLET	T3	PA QL (1 tab/day) HD
XCOPRI 50-100 MG TITRATION PAK	T3	PA QL (1 pack/28 day) HD
ZARONTIN ( <i>ethosuximide</i> )	T3	PA HD
ZONEGRAN ( <i>zonisamide</i> )	T3	PA HD
ZONISADE	T3	PA QL (6 mls/30 days)
<i>zonisamide</i> (Zonegran)	T1	HD

### COLONY STIMULATING FACTORS (Blood Modifiers/Bleeding Disorders)

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

LEUKOCYTE (WBC) STIMULANTS		
FULPHILA	T4	PA SP
GRANIX	T4	PA SP
LEUKINE	T4	SP
NEULASTA	T4	PA SP
NEULASTA ONPRO	T4	PA SP HD
NEUPOGEN	T4	PA SP
NIVESTYM	T4	SP
NYPOZI	T3	PA SP
NYVEPRIA	T4	PA SP
STIMUFEND	T4	PA SP
UDENYCA	T4	PA SP

T1 – Typically Generics

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## List of Prescription Medications

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

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>LEUKOCYTE (WBC) STIMULANTS (cont.)</b>		
ZARXIO	T4	SP HD
ZIEXTENZO	T4	PA SP
<b>THROMBOPOIETIN RECEPTOR AGONISTS</b>		
ALVAIZ 18 MG, 54 MG TABLET	T4	PA QL(1 tab/day) SP
ALVAIZ 36 MG, 54 MG TABLET	T4	PA QL(2 tabs/day) SP
DOPTELET	T4	PA SP HD
MULPLETA	T4	PA SP HD
NPLATE	T4	PA SP
PROMACTA	T4	PA SP HD

### COLONY STIMULATING FACTORS (Cancer)

<b>CXCR4 CHEMOKINE RECEPTOR ANTAGONIST</b>		
APHEXA	T4	PA SP
MOZOBIL	T4	PA SP
XOLREMDI	T4	PA QL(4 caps/day) SP CSL

### CONTRACEPTIVES (Contraception Products)

<b>CONTRACEPTIVES, INTRAVAGINAL, SYSTEMIC</b>		
ANNOVERA	T3	
etonogestrel/ethinyl estradiol (Nuvaring)	T1	PPACA
NUVARING (etonogestrel-ethinyl estradiol)	T3	
<b>CONTRACEPTIVES, IMPLANTABLE</b>		
NEXPLANON	T3	SP PPACA
<b>CONTRACEPTIVES, INJECTABLE</b>		
DEPO-PROVERA 150 MG/ML SYRINGE (medroxyprogesterone acetate)	T3	
DEPO-PROVERA 150 MG/ML VIAL (medroxyprogesterone acetate)	T3	
DEPO-SUBQ PROVERA 104	T3	
medroxyprogesterone 150 mg/ml (Depo-provera)	T1	PPACA
<b>CONTRACEPTIVES, INTRAVAGINAL</b>		
PHEXXI	T3	PA PPACA
<b>CONTRACEPTIVES, ORAL</b>		
BALCOLTRA (levonorgestrel/eth.estradiol/iron)	T3	HD
BEYAZ (rajan)	T3	HD
desog-e.estradiol/e.estriadiol (Mircette)	T1	HD PPACA
desogestrel-ethinyl estradiol	T1	HD PPACA
drospirene/eth estra/levomefet ca	T1	HD PPACA

T1 – Typically Generics

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## List of Prescription Medications

### CONTRACEPTIVES (Contraception Products) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>CONTRACEPTIVES, ORAL (cont.)</b>		
ELLA	T3	HD PPACA
ESTROSTEP FE ( <i>tri-legest fe</i> )	T3	HD
<i>ethinyl estradiol/drospirenone</i> (Yasmin 28)	T1	HD PPACA
<i>ethinyl estradiol/drospirenone</i> (Yaz)	T1	HD PPACA
<i>ethynodiol d-ethinyl estradiol</i>	T1	HD PPACA
<i>levonorgestrel/ethin estradiol</i>	T1	HD PPACA
<i>levonorgest/eth.estriadiol/iron</i> (Balcoltra)	T1	HD PPACA
<i>I-norgest/e.estriadiol-e.estrad</i>	T1	HD PPACA
<i>I-norgest/e.estriadiol-e.estrad</i> (Quartette)	T1	HD PPACA
LO LOESTRIN FE	T3	PA HD
LOESTRIN ( <i>norethindron-ethinyl estradiol</i> )	T3	HD
LOESTRIN FE ( <i>norethindrone-eth estradiol-fe</i> )	T3	HD
MICROGESTIN 24 FE ( <i>tarina 24 fe</i> )	T3	HD
MIRCETTE ( <i>volnea</i> )	T3	HD
NATAZIA	T3	HD
NEXTSTELLIS	T3	HD
<i>noreth-ethinyl estradiol/iron</i>	T1	HD PPACA
<i>norethind-eth estrad 1-0.02 mg</i> (Loestrin)	T1	HD PPACA
<i>norethindrone</i> (Ortho Micronor)	T1	HD PPACA
<i>norethindrone ac-eth estradiol</i> (Loestrin)	T1	HD PPACA
<i>norethindrone-e.estriadiol-iron</i> (Estrostep Fe)	T1	HD PPACA
<i>norethindrone-e.estriadiol-iron</i> (Loestrin Fe)	T1	HD PPACA
<i>norethindrone-e.estriadiol-iron</i> (Microgestin 24 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
<i>norgestrel-ethinyl estradiol</i>	T1	HD PPACA
ORTHO MICRONOR ( <i>tulana</i> )	T3	HD
QUARTETTE ( <i>rivilsa</i> )	T3	HD
SAFYRAL ( <i>tydemy</i> )	T3	HD
SLYND	T3	HD
TAYTULLA ( <i>norethin-eth estra-ferrous fum</i> )	T3	HD
TYBLUME	T3	HD

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

T4 – Specialty Medications

PA – Prior Authorization

QL – Quantity Limit

ST – Step Therapy

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HD – May require home delivery pharmacy

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## List of Prescription Medications

CONTRACEPTIVES (Contraception Products) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>CONTRACEPTIVES, ORAL (cont.)</b>		
YASMIN 28 (zumandimine)	T3	HD
YAZ (vestura)	T3	HD
<b>CONTRACEPTIVES, TRANSDERMAL</b>		
norelgestromin/ethinestradiol	T1	HD PPACA
TWIRLA	T3	HD PPACA
DIAPHRAGMS/CERVICAL CAP		
CAYA CONTOURED	T3	PPACA
FEMCAP	T3	PPACA
WIDE SEAL DIAPHRAGM	T3	PPACA
<b>INTRA-UTERINE DEVICES (IUDS)</b>		
KYLEENA	T4	SP PPACA
LILETTA	T4	SP PPACA
MIRENA	T4	SP PPACA
PARAGARD T 380-A	T4	SP PPACA
SKYLA	T4	SP PPACA
COUGH/COLD PREPARATIONS (Allergy/Nasal Sprays)		
<b>ANTI-TUSSIVES, NON-OPIOID</b>		
benzonatate 100 mg capsule (Tessalon Perle)	T1	
benzonatate 150 mg capsule	T1	PA
benzonatate 200 mg capsule	T1	
benzonatate perle 100 mg cap (Tessalon Perle)	T1	
TESSALON PERLE (benzonatate)	T3	
<b>NON-OPIOID ANTI-TUS-IST GEN. ANTIHISTAMINE-DECONGEST</b>		
BROMFED DM (brompheniramine-pseudoephed-dm)	T3	PA
brompheniramine/pseudoephed/dm (Bromfed Dm)	T1	
<b>NON-OPIOID ANTI-TUSSIVE-IST GEN ANTIHISTAMINE COMB.</b>		
promethazine/dextromethorphan	T1	
<b>OPIOID ANTI-TUSSIV-IST GEN. ANTIHISTAMINE-DECONGEST</b>		
hydrocodone/cpm/pseudoephed	T1	PA
promethazine/phenyleph/codeine	T1	PA QL (480ml/22 days)
hydrocodone/chlorphen p-stirex	T1	PA
promethazine-codeine solution	T1	PA QL (480ml/22 days)
promethazine-codeine syrup	T1	PA QL (480ml/30 days)

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

T4 – Specialty Medications

PA – Prior Authorization

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ST – Step Therapy

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## List of Prescription Medications

### COUGH/COLD PREPARATIONS (Allergy/Nasal Sprays) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>OPIOID ANTI-TUSSIVE-1ST GENERATION ANTIHISTAMINE</b>		
TUSSICAPS	T2	PA
TUXARIN ER	T3	PA QL (2 tabs/day)
TUZISTRA XR	T3	PA QL (960ml/30 days)
<b>OPIOID ANTI-TUSSIVE-ANTI-CHOLINERGIC COMBINATIONS</b>		
HYCODAN ( <i>hydromet</i> )	T3	PA QL (480ml/22 days)
<i>hydrocodone bit/homatrop me-br</i> (Hycodan)	T1	PA QL (480ml/22 days)
<i>hydrocodone-homatropine 5-1.5</i>	T1	PA QL (180 tabs/30 days)
<i>hydrocodone-homatropine soln</i> (Hycodan)	T1	PA QL (480ml/30 days)
HYDROCODONE-HOMATROPINE SYRUP	T1	PA QL (480ml/30 days)
<b>OPIOID ANTI-TUSSIVE-EXPECTORANT COMBINATION</b>		
HYDROCODONE-GUAIFENESIN	T1	PA QL (960ml/30 days)
OBREDON	T3	PA QL (960ml/30 days)

### COUGH/COLD PREPARATIONS (Cough/Cold Medications)

#### 1ST GEN ANTIHIST-DECONGEST-ANTICHOLINERGIC COMB

RESPA A.R.	T3
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### DIAGNOSTIC (Diabetes)

#### BLOOD SUGAR DIAGNOSTICS

ASSURE 4 TEST STRIPS	T3
EASY PLUS TEST STRIP	T3
EASY TALK TEST STRIP	T3
EASY GLUCOSE TEST STRIP	T3
EASymax TEST STRIP	T3
EMBRACE EVO TEST STRIPS	T3
EVENCARE TEST STRIP	T3
FORA 6CONN-GTEL-TN'G ADV STRIP	T3
GLUCOCARD EXPRESSION/SHINE TEST STRP	T3
MICRODOT TEST STRIPS	T3
OPTUMRX TEST STRIP	T3

#### ULTRATRAK TEST STRIP

ADREVIEW	T3
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### DIAGNOSTIC (Miscellaneous)

#### BILIARY DIAGNOSTICS

CHOLETEC	T3
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T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

T4 – Specialty Medications

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ST – Step Therapy

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## List of Prescription Medications

DIAGNOSTIC (Miscellaneous) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>BILIARY DIAGNOSTICS (cont.)</b>		
TC99M MEBROFENIN PREP	T1	
<b>BILIARY DIAGNOSTICS, RADIOPAQUE</b>		
<i>indocyanine green</i>	T1	
SINOGRAPHIN	T3	
<b>CARDIOVASCULAR DIAGNOSTICS - RADIOACTIVE</b>		
AMMONIA N-13	T3	
MYOVIEW	T3	
TC99M PYROPHOSPHATE PREP	T1	
TC99M SESTAMIBI PREP	T1	
THALLOUS CHLORIDE TL-201	T1	
<b>CARDIOVASCULAR DIAGNOSTICS, NON-RADIOPAQUE AGENTS</b>		
<i>adenosine 60 mg/20 ml vial</i>	T1	
<i>adenosine 90 mg/30 ml vial</i>	T1	
DEFINITY	T3	
<i>dipyridamole 50 mg/10 ml vial</i>	T1	
LEXISCAN	T3	
OPTISON	T3	
<i>regadenoson</i>	T1	
<b>CARDIOVASCULAR DIAGNOSTICS-RADIOPAQUE</b>		
ISOVUE-200	T3	
ISOVUE-250	T3	
ISOVUE-300	T3	
ISOVUE-370	T3	
ISOVUE-M 200	T3	
ISOVUE-M 300	T3	
NEUROLITE	T3	
OMNIPAQ	T3	
OPTIRAY 240, 300, 320, 350	T3	
ULTRAVIST	T3	
VISIPAQUE	T3	
<b>CEREBRAL SPINAL RADIOACTIVE DIAGNOSTICS</b>		
CERETEC	T3	
INDIUM IN-111 DTPA	T3	

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

T4 – Specialty Medications

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## List of Prescription Medications

### DIAGNOSTIC (Miscellaneous) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>CEREBRAL SPINAL RADIOPAQUE DIAGNOSTICS</b>		
DOTAREM	T3	
<i>gadoterate meglumine</i> (Dotarem)	T1	
MAGNEVIST	T3	
MULTIHANCE	T3	
MULTIHANCE MULTIPACK	T3	
OMNISCAN	T3	
OMNISCAN PREFILL PLUS	T3	
OPTIMARK	T3	
PROHANCE	T3	
PROHANCE MULTIPACK	T3	
<b>DIAGNOSTIC PREPARATIONS, MISCELLANEOUS</b>		
ADVANCED DNA MEDICATED COLLECT	T3	
ARIDOL	T3	
DMSA	T3	
DRAXIMAGE DTPA	T3	
<i>ful-glo 1 mg oph strip</i>	T1	
FUL-GLO EYE STRIPS	T3	
GADAVIST	T3	
GLUCAGON HCL	T1	
<i>isosulfan blue</i> (Lymphazurin)	T1	
<i>lidocaine hcl/glycerin</i> (Advanced Dna Medicated Collect)	T1	
LIPIODOL	T3	
<i>lissamine green</i>	T1	
LUMASON	T3	
LYMPHAZURIN	T3	
NETSPOT	T3	
PROVOCHOLINE	T3	
TC99M MEDRONATE PREP	T1	
TC99M SULFUR COLLOID PREP	T1	
<b>DIAGNOSTIC RADIOPHARM - AMYLOID/TAU IMAGING</b>		
AMYVID	T3	
VIZAMYL	T3	PA
<b>DIAGNOSTIC RADIOPHARM - DOPAMINE TRANSPORTER (DAT)</b>		
DATSCAN	T3	

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

T4 – Specialty Medications

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## List of Prescription Medications

DIAGNOSTIC (Miscellaneous) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>EYE DIAGNOSTIC AGENTS</b>		
AK-FLUOR	T3	
AK-FLUOR ( <i>fluorescite</i> )	T3	
<i>fluorescein sodium</i>	T1	
<i>fluorescein sodium (Ak-fluor)</i>	T3	
<b>FLUORESCENCE CYSTOSCOPY/OPTICAL IMAGING AGENTS</b>		
CYSVIEW	T3	
<b>GASTROINTESTINAL RADIOPAQUE DIAGNOSTICS</b>		
ENTEROVU	T3	
E-Z DISK	T3	
E-Z-HD	T3	
E-Z-PAQUE	T3	
E-Z-PASTE	T3	
GASTROMARK	T3	
LIQUID E-Z PAQUE	T3	
LIQUID POLIBAR PLUS	T3	
NEULUMEX	T3	
POLIBAR ACB	T3	
READI-CAT 2	T3	
SITZMARKS	T3	
TAGITOL V	T3	
VARIBAR HONEY	T3	
VARIBAR NECTAR	T3	
VARIBAR PUDDING	T3	
VARIBAR THIN HONEY	T3	
VARIBAR THIN LIQUID	T3	
<b>HEPATIC DIAGNOSTICS</b>		
EOVIST	T3	
<b>HISTAMINE PREPARATIONS</b>		
HISTATROL INTRADERMAL	T3	
HISTATROL PERCUTANEOUS	T3	
<b>METABOLIC FUNCTION DIAGNOSTICS</b>		
CHIRHOSTIM	T3	
METOPIRONE	T3	
R-GENE 10	T3	

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T3 – Typically Non-Preferred Brands

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## List of Prescription Medications

DIAGNOSTIC (Miscellaneous) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>NEOPLASM MONOCLONAL DIAGNOSTIC AGENTS</b>		
PROSTASCINT	T3	
<b>RADIOACTIVE DIAGNOSTICS, GENERAL</b>		
OCTREOSCAN	T3	
<b>RADIOACTIVE DX RADIOLABEL OF AUTOLOGOUS LEUKOCYTES</b>		
INDIUM IN-111 OXYQUINOLINE	T1	
<b>RADIOACTIVE DX RADIOLABEL OF SYNTHETIC AMINO ACIDS</b>		
AXUMIN	T3	
<b>RADIOACTIVE METABOLIC FUNCTION DIAGNOSTICS</b>		
FLUDEOXYGLUCOSE F-18	T3	
<b>RADIOPHARMACEUTICALS ELEMENTS</b>		
GA 68 DOTATOC	T3	
INDICLOR	T3	
<b>RENAL FUNCTION DIAGNOSTICS AGENTS</b>		
<i>indigotindisulfonate sodium</i>	T3	
<b>URINARY TRACT RADIOPAQUE DIAGNOSTICS</b>		
CONRAY	T3	
CONRAY-30	T3	
CONRAY-43	T3	
CYSTO-CONRAY II	T3	
CYSTOGRAFIN	T3	
CYSTOGRAFIN-DILUTE	T3	
<i>diatrizoate meglumine, sodium</i>	T3	
<i>diatrizoate meglumine, sodium (Gastrografin)</i>	T1	
GASTROGRAFIN ( <i>md-gastroview</i> )	T3	
DIURETICS (Diuretics)		
<b>ARGININE VASOPRESSIN (AVP) RECEPTOR ANTAGONISTS</b>		
SAMSCA	T4	PA QL SP
SAMSCA ( <i>tolvaptan</i> )	T4	SP
TOLVAPTAN 15 MG TABLET	T4	SP
<i>tolvaptan 30 mg tablet (Samsca)</i>	T4	SP
VAPRISOL-5% DEXTROSE	T3	
<b>CARBONIC ANHYDRASE INHIBITORS</b>		
<i>acetazolamide</i>	T1	HD
<i>acetazolamide sodium</i>	T1	HD

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

T4 – Specialty Medications

PA – Prior Authorization

QL – Quantity Limit

ST – Step Therapy

AGE – Age Requirement

SP – Specialty Medication

HD – May require home delivery pharmacy

PPACA – No Cost-Share Preventive Medication

CSL – Oral cancer medication subject to cost-share limits

## List of Prescription Medications

### DIURETICS (Diuretics) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>CARBONIC ANHYDRASE INHIBITORS (cont.)</b>		
<i>methazolamide</i>	T1	HD
<b>LOOP DIURETICS</b>		
<i>bumetanide</i>	T1	HD
EDECRIN ( <i>ethacrynic acid</i> )	T3	PA
<i>ethacrynat e sodium (Sodium Edecrin)</i>	T1	
FUROSCIX	T3	PA QL(2 kits/30 days)
<i>furosemide</i>	T1	HD
<i>furosemide (Lasix)</i>	T1	HD
FUROSEMIDE-0.9% NaCl	T1	
LASIX ( <i>furosemide</i> )	T3	PA HD
SODIUM EDECRIN ( <i>ethacrynat e sodium</i> )	T3	
<i>torsemide</i>	T1	HD
<b>OSMOTIC DIURETICS</b>		
<i>mannitol</i>	T1	
<i>mannitol (Osmotrol)</i>	T1	
OSMITROL 10% IV SOLUTION ( <i>mannitol</i> )	T3	
<i>osmitrol 15% iv solution</i>	T3	
<i>osmitrol 20% iv solution</i>	T2	
OSMITROL 10% (50 GM/500 ML) ( <i>mannitol</i> )	T3	
<b>POLYCYSTIC KIDNEY DISEASE AGENT, AVP RECEP. ANTAG</b>		
JYNARQUE 15 MG TABLET	T4	SP
JYNARQUE 15 MG-15 MG TABLET	T4	PA SP
JYNARQUE 30 MG TABLET	T4	SP
JYNARQUE 30 MG-15 MG TABLET	T4	PA SP
JYNARQUE 45 MG-15 MG TABLET	T4	PA SP
JYNARQUE 60 MG-30 MG TABLET	T4	PA SP
JYNARQUE 90 MG-30 MG TABLET	T4	PA SP
<b>POTASSIUM SPARING DIURETICS</b>		
ALDACTONE ( <i>spironolactone</i> )	T3	PA HD
<i>amiloride hcl</i>	T1	HD
CAROSPIR	T2	PA
DYRENium ( <i>triamterene</i> )	T3	PA HD
<i>eplerenone (Inspira)</i>	T1	HD
KERENDIA	T2	PA QL(1 tab/day)

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

T4 – Specialty Medications

PA – Prior Authorization

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ST – Step Therapy

AGE – Age Requirement

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CSL – Oral cancer medication subject to cost-share limits

## List of Prescription Medications

### DIURETICS (Diuretics) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>POTASSIUM SPARING DIURETICS (cont.)</b>		
<i>spironolactone</i>	T1	
<b>POTASSIUM SPARING DIURETICS IN COMBINATION</b>		
<i>INSPRA (eplerenone)</i>	T3	HD
<i>spironolactone (Aldactone)</i>	T1	HD
<i>triamterene (Dyrenium)</i>	T1	HD
<i>ALDACTAZIDE</i>	T3	HD
<i>ALDACTAZIDE (spironolactone-hctz)</i>	T3	HD
<i>amiloride/hydrochlorothiazide</i>	T1	HD
<i>DYAZIDE (triamterene-hydrochlorothiazid)</i>	T3	HD
<i>spironolact/hydrochlorothiazid (Aldactazide)</i>	T1	HD
<i>triamterene/hydrochlorothiazid (Dyazide)</i>	T1	HD
<b>THIAZIDE AND RELATED DIURETICS</b>		
<i>chlorothiazide sodium (Sodium Diuril)</i>	T1	
<i>chlorthalidone</i>	T1	HD
<i>DIURIL</i>	T2	HD
<i>hydrochlorothiazide</i>	T1	HD
<i>indapamide</i>	T1	HD
<i>metolazone</i>	T1	HD
<i>SODIUM DIURIL (chlorothiazide sodium)</i>	T2	
<i>THALITONE</i>	T3	PA HD

### EENT PREPS (Allergy/Nasal Sprays)

<b>NASAL ANTIHISTAMINE</b>			
<i>azelastine 0.1% (137 mcg) spry</i>	T1	HD	
<i>azelastine 0.15% nasal spray</i>	T1	HD	
<i>olopatadine 665 mcg nasal spry (Patanase)</i>	T1	HD	
<i>PATANASE (olopatadine hc)</i>	T3	HD	
<b>NASAL ANTIHISTAMINE AND ANTI-INFLAM. STEROID COMB.</b>			
<i>azelastine/fluticasone (Dymista)</i>	T1	HD	
<i>DYMISTA (azelastine-fluticasone)</i>	T3	ST HD	
<i>RYALTRIS</i>	T3	PA QL (1 gm/30 days)	
<b>NASAL ANTI-INFLAMMATORY STEROIDS</b>			
<i>BECONASE AQ</i>	T3	ST HD	
<i>flunisolide</i>	T1	HD	
<i>fluticasone prop 50 mcg spray</i>	T1	HD	
T1 – Typically Generics T2 – Typically Preferred Brands T3 – Typically Non-Preferred Brands	T4 – Specialty Medications PA – Prior Authorization QL – Quantity Limit	ST – Step Therapy AGE – Age Requirement SP – Specialty Medication	HD – May require home delivery pharmacy PPACA – No Cost-Share Preventive Medication CSL – Oral cancer medication subject to cost-share limits

## List of Prescription Medications

### EENT PREPS (Allergy/Nasal Sprays) (con't.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits	
<b>NASAL ANTI-INFLAMMATORY STEROIDS (cont.)</b>			
mometasone furoate 50 mcg spry (Nasonex)	T1	QL (4 bots/30 days) HD	
NASONEX (mometasone furoate)	T3	QL (4 bots/30 days) ST HD	
OMNARIS	T3	ST HD	
QNASL	T3	ST HD	
QNASL CHILDREN	T3	HD	
SINUVA	T4	PA SP	
XHANCE	T3	ST HD	
ZETONNA	T3	ST HD	
<b>NOSE PREPARATIONS, MISCELLANEOUS (RX)</b>			
ipratropium bromide	T1	HD	
<b>NOSE PREPARATIONS, VASOCONSTRICATORS (RX)</b>			
ADRENALIN CHLORIDE	T3		
epinephrine hcl (Adrenalin Chloride)	T1		
<b>EENT PREPS (Ear Medications)</b>			
<b>EAR PREPARATIONS ANTI-INFLAMMATORY</b>			
DERMOTIC (fluocinolone acetonide oil)	T3		
fluocinolone acetonide oil (Dermotic)	T1		
<b>EAR PREPARATIONS, MISC. ANTI-INFECTIVES</b>			
acetic acid	T1		
hydrocortisone/acetic acid	T1		
<b>EENT PREPS (Eye Conditions)</b>			
<b>ARTIFICIAL TEARS</b>			
LACRISERT	T3		
MIEBO	T3	PA QL(4 bottles/22 days)	
<b>EYE ANTI-INFECTIVES (RX ONLY)</b>			
BETADINE	T2		
<b>EYE ANTI-INFLAMMATORY AGENTS</b>			
ACULAR (ketorolac tromethamine)	T3	PA	
ACULAR LS (ketorolac tromethamine)	T3	PA	
ACUVAIL	T3		
ALREX (loteprednol etabonate)	T3		
bromfenac sodium (Bromsite)	T1		
BROMSITE (bromfenac sodium)	T2		
diclofenac 0.1% eye drops	T1		
I1 – Typically Generics	I4 – Specialty Medications	SI – Step Therapy	HD – May require home delivery pharmacy
T2 – Typically Preferred Brands	PA – Prior Authorization	AGE – Age Requirement	PPACA – No Cost-Share Preventive Medication
T3 – Typically Non-Preferred Brands	QL – Quantity Limit	SP – Specialty Medication	CSL – Oral cancer medication subject to cost-share limits

## List of Prescription Medications

### EENT PREPS (Eye Conditions) (con't.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>EYE ANTI-INFLAMMATORY AGENTS (cont.)</b>		
DUREZOL	T3	PA
EYSUVIS	T2	QL (8.3ml/14 days)
FLAREX	T2	
<i>fluorometholone (FmI)</i>	T1	
<i>flurbiprofen sodium</i>	T1	
FML ( <i>fluorometholone</i> )	T3	PA
FML FORTE	T3	PA
ILEVRO	T3	
ILUVIEN	T4	SP
INVELTYS	T2	
<i>ketorolac 0.4% ophth solution (Acular Ls)</i>	T1	
<i>ketorolac 0.5% ophth solution (Acular)</i>	T1	
LOTEMAX 0.5% EYE DROPS	T3	PA
LOTEMAX 0.5% EYE OINTMENT	T2	
LOTEMAX SM 0.38% OPHTH GEL	T3	PA
<i>loteprednol etabonate (Lotemax)</i>	T1	
<i>loteprednol etabonate (Alrex)</i>	T1	
MAXIDEX	T3	PA
MIEBO	T2	QL(4 bottles/30 days)
NEVANAC	T3	PA
OMNIPRED ( <i>prednisolone acetate</i> )	T3	
OZURDEX	T4	SP
PRED FORTE ( <i>prednisolone acetate</i> )	T3	PA
PRED MILD	T3	PA
<i>prednisolone acetate (Pred Forte)</i>	T1	
<i>prednisolone sodium phosphate</i>	T1	
PROLENSA	T3	
TRIESENCE	T3	
<b>EYE IRRIGATIONS</b>		
<i>balanced salt irrig soln no.2</i>	T3	
BSS PLUS	T3	
<b>EYE LOCAL ANESTHETICS</b>		
AKTEN	T3	

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

T4 – Specialty Medications

PA – Prior Authorization

QL – Quantity Limit

ST – Step Therapy

AGE – Age Requirement

SP – Specialty Medication

HD – May require home delivery pharmacy

PPACA – No Cost-Share Preventive Medication

CSL – Oral cancer medication subject to cost-share limits

## List of Prescription Medications

### EENT PREPS (Eye Conditions) (con't.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>EYE LOCAL ANESTHETICS (cont.)</b>		
ALCAINE ( <i>proparacaine hcl</i> )	T3	
ALTAFLUOR BENOX ( <i>flurox</i> )	T3	
<i>benoxinate hcl/fluorescein sod</i> (Altafluor Benox)	T1	
<i>benoxinate hcl/fluorescein sod</i> (Altafluor Benox)	T3	
<i>proparacaine hcl</i> (Alcaine)	T1	
<i>proparacaine/fluorescein sod</i>	T1	
<i>proparacaine/fluorescein sod</i>	T3	
<i>tetracaine hcl</i>	T1	
TETRAVISC	T2	
TETRAVISC FORTE	T2	
<b>EYE MAST CELL STABILIZERS</b>		
ALOCRIL	T3	PA
ALOMIDE	T3	PA
<i>cromolyn 4% eye drops</i>	T1	
<b>EYE MYDRIATIC AND NSAID COMBINATIONS</b>		
OMIDRIA	T3	
<b>EYE PREPARATIONS, MISCELLANEOUS (OTC)</b>		
GELFILM	T3	
<b>EYE VASOCONSTRICATORS</b>		
<i>phenylephrine hcl</i>	T1	
UPNEEQ	T3	PA
<b>MIOTICS AND OTHER INTRAOCULAR PRESSURE REDUCERS</b>		
<i>apraclonidine hcl</i> (lopidine)	T1	HD
ALPHAGAN P ( <i>brimonidine tartrate</i> )	T3	PA HD
AZOPT ( <i>brinzolamide</i> )	T3	PA HD
<i>betaxolol hcl</i>	T1	HD
BETIMOL	T3	PA HD
BETOPTIC S	T2	HD
<i>bimatoprost</i>	T1	QL (10 gm/30 days) HD
<i>brimonidine tartrate</i>	T1	HD
<i>brimonidine tartrate</i> (Alphagan P)	T1	HD
<i>brinzolamide</i> (Azopt)	T1	HD
<i>carbachol</i>	T3	HD
<i>carteolol hcl</i>	T1	HD

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

T4 – Specialty Medications

PA – Prior Authorization

QL – Quantity Limit

ST – Step Therapy

AGE – Age Requirement

SP – Specialty Medication

HD – May require home delivery pharmacy

PPACA – No Cost-Share Preventive Medication

CSL – Oral cancer medication subject to cost-share limits

## List of Prescription Medications

### EENT PREPS (Eye Conditions) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>MIOTICS AND OTHER INTRAOCCULAR PRESSURE REDUCERS (cont.)</b>		
COMBIGAN	T3	PA HD
COSOPT ( <i>dorzolamide-timolol</i> )	T3	PA HD
COSOPT PF ( <i>dorzolamide-timolol</i> )	T3	PA HD
<i>dorzolamide hcl</i> (Trusopt)	T1	HD
<i>dorzolamide hcl/timolol maleat</i> (Cosopt)	T1	HD
<i>dorzolamide/timolol/pf</i> (Cosopt Pf)	T1	HD
DURYSTA	T3	PA SP HD
IOPIDINE 1% EYE DROPS	T3	PA HD
ISOPTO CARPINE ( <i>pilocarpine hcl</i> )	T3	HD
ISTALOL ( <i>timolol maleate</i> )	T3	PA HD
IXYZEH	T3	PA QL(30 vials/30 days) HD
<i>latanoprost</i> (Xalatan)	T1	HD
<i>levobunolol hcl</i>	T1	HD
LUMIGAN	T3	PA HD
MIOCHOL-E	T3	HD
PHOSPHOLINE IODIDE	T2	HD
<i>pilocarpine hcl</i> (Isopto Carpine)	T1	HD
QLOSI	T3	PA
RHOPRESSA	T3	HD
ROCKLATAN	T3	HD
SIMBRINZA	T2	HD
<i>timolol maleate</i> (Istalol)	T1	HD
<i>timolol maleate</i> (Timoptic)	T1	HD
<i>timolol maleate</i> (Timoptic-xe)	T1	HD
<i>timolol maleate/pf</i> (Timoptic Ocudose)	T1	HD
TIMOPTIC ( <i>timolol maleate</i> )	T3	PA HD
TIMOPTIC OCUDOSE ( <i>timolol maleate</i> )	T3	PA HD
TIMOPTIC-XE ( <i>timolol maleate</i> )	T3	PA HD
TRAVATAN Z ( <i>travoprost</i> )	T3	PA HD
<i>travoprost</i> (Travatan Z)	T1	HD
TRUSOPT ( <i>dorzolamide hcl</i> )	T3	PA HD
VUITY	T3	PA
VYZULTA	T3	PA HD
XALATAN ( <i>latanoprost</i> )	T3	PA HD

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

T4 – Specialty Medications

PA – Prior Authorization

QL – Quantity Limit

ST – Step Therapy

AGE – Age Requirement

SP – Specialty Medication

HD – May require home delivery pharmacy

PPACA – No Cost-Share Preventive Medication

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## List of Prescription Medications

### EENT PREPS (Eye Conditions) (con't.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>MIOTICS AND OTHER INTRAOCULAR PRESSURE REDUCERS (cont.)</b>		
XELPROS	T3	PA HD
ZIOPTAN ( <i>tafluprost/pf</i> )	T3	PA QL (60 droppers/30 days) HD
<b>MYDRIATICS</b>		
<i>atropine 1%</i>	T1	HD
ATROPINE SULFATE-0.9% NACL	T1	HD
CYCLOGYL 0.5% EYE DROPS ( <i>cyclopentolate hcl</i> )	T2	HD
CYCLOGYL 1% EYE DROPS ( <i>cyclopentolate hcl</i> )	T3	HD
CYCLOGYL 2% EYE DROPS ( <i>cyclopentolate hcl</i> )	T3	HD
CYCLOMYDRIL	T2	HD
<b>MIOTICS AND OTHER INTRAOCULAR PRESSURE REDUCERS</b>		
<i>cyclopentolate hcl (Cyclogyl)</i>	T1	HD
<i>homatropine hbr</i>	T1	HD
ISOPTO ATROPINE ( <i>atropine sulfate</i> )	T3	HD
MYDRIACYL ( <i>tropicamide</i> )	T3	HD
PAREMYD	T3	HD
<i>tropicamide</i>	T1	HD
<i>tropicamide (Mydriacyl)</i>	T1	HD
TROPICAMIDE-CYCLOPENTOLATE-PE	T3	HD
<b>OPHTH VASC. ENDOTHELIAL GROWTH FACTOR ANTAGONISTS</b>		
PAVBLU	T3	PA SP
<b>OPHTH VASC. ENDOTHELIAL GROWTH FACTOR ANTAGONISTS</b>		
EYLEA	T4	PA SP
<b>OPHTH. VEGF-A RECEPTOR ANTAG. RCMB MC ANTIBODY</b>		
BEOVU	T4	PA SP
LUCENTIS	T4	PA SP
<b>OPHTHALMIC ANTI-FIBROTIC AGENTS</b>		
MITOSOL	T3	
<b>OPHTHALMIC ANTI-INFLAMMATORY IMMUNOMODULATOR-TYPE</b>		
CEQUA	T2	
RESTASIS	T2	HD
RESTASIS MULTIDOSE	T2	HD
VERKAZIA	T3	PA QL (1 box/month)
VEVYE	T3	PA HD
XIIDRA	T2	HD

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

T4 – Specialty Medications

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## List of Prescription Medications

EENT PREPS (Eye Conditions) (con't.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>OPHTHALMIC COMPLEMENT INHIBITORS</b>		
SYFOVRE	T4	PA SP HD
<b>OPHTHALMIC CYSTINE DEPLETING AGENTS</b>		
CYSTADROPS	T4	PA QL (20ml/21 days) SP
CYSTARAN	T4	PA QL (120ml/28 days) SP
<b>OPHTHALMIC HUMAN NERVE GROWTH FACTOR (HNGF)</b>		
OXERVATE	T4	PA SP HD
<b>OPHTHALMIC PREPARATIONS, MISCELLANEOUS</b>		
AMVISC	T4	SP
AMVISC PLUS	T4	SP
DISCOVISC	T3	
DUOVISC	T3	
HEALON ( <i>biolon</i> )	T4	SP
HEALON5	T3	
PROVISC	T4	SP
TOTALVISC	T4	SP
VISCOAT	T3	
<b>OPHTHALMIC SURGICAL AIDS</b>		
CELLUGEL	T3	
<i>hypromellose</i> (Cellugel)	T1	
MEMBRANEBLUE	T3	
VISIONBLUE	T3	
<b>ELECT/CALORIC/H2O (Cholesterol Medications)</b>		
<b>ORAL LIPID SUPPLEMENTS</b>		
DOJOLVI	T4	PA SP HD
<b>ELECT/CALORIC/H2O (Dental Products)</b>		
<b>FLUORIDE PREPARATIONS</b>		
CLINPRO 5000	T3	
<i>fluoride (sodium)</i> (Prevident 5000 Ortho Defense)	T1	
<i>fluoride (sodium)</i> (Prevident 5000 Plus)	T1	
<i>fluoride (sodium)</i> (Prevident 5000)	T1	
<i>fluoride (sodium)</i> (Prevident)	T1	
FLUORIDEX	T1	

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

T4 – Specialty Medications

PA – Prior Authorization

QL – Quantity Limit

ST – Step Therapy

AGE – Age Requirement

SP – Specialty Medication

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## List of Prescription Medications

### ELECT/CALORIC/H2O (Dental Products) (con't.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>FLUORIDE PREPARATIONS (con't.)</b>		
FLUORIDEX SENSITIVITY RELIEF	T3	
FRAICHE 5000 PREVI	T3	
FRAICHE 5000 SENSITIVE	T3	
PREVIDENT 0.2% RINSE	T3	
PREVIDENT 1.1% GEL ( <i>sodium fluoride</i> )	T3	
PREVIDENT 5000	T2	
PREVIDENT 5000 BOOSTER PLUS	T2	
PREVIDENT 5000 ENAMEL PROTECT	T2	
PREVIDENT 5000 ORTHO DEFENSE	T2	
PREVIDENT 5000 PLUS ( <i>sodium fluoride 5000 plus</i> )	T3	
PREVIDENT 5000 SENSITIVE	T2	
PREVIDENT DENTAL RINSE	T3	
PREVIDENT KIDS	T2	
<i>sodium fluoride/potassium nit</i> (Prevident 5000 Sensitive)	T1	

### ELECT/CALORIC/H2O (Diabetes)

#### AGENTS TO TREAT HYPOGLYCEMIA (HYPERGLYCEMICS)

BAQSIMI	T2	QL(2 units/30 days)
<i>diazoxide</i> (Proglycem)	T1	
GLUCAGEN	T2	QL(2 vials/30 days)
GLUCAGON 1 MG EMERGENCY KIT	T3	QL (2 pens/30 days)
<i>glucagon 1 mg emergency kit</i> (Glucagon Emergency Kit)	T1	QL (2 pens/30 days)
GVOKE HYPOPEN 1-PACK	T2	QL (2 packs/22 days)
GVOKE HYPOPEN 2-PACK	T2	QL (2 packs/22 days)
GVOKE PFS 1-PACK SYRINGE	T2	QL (2 syringes/30 days)
GVOKE PFS 2-PACK SYRINGE	T2	QL (2 syringes/30 days)
PROGLYCEM ( <i>diazoxide</i> )	T3	
ZEGALOGUE	T2	QL (2 units/23 days)

### ELECT/CALORIC/H2O (Miscellaneous)

#### BICARBONATE PRODUCING/CONTAINING AGENTS

sodium acetate	T1	
sodium bicarbonate	T1	
sodium bicarbonate in d5w	T1	

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

T4 – Specialty Medications

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## List of Prescription Medications

### ELECT/CALORIC/H2O (Miscellaneous) (con't.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>DRUGS USED TO TREAT ACIDOSIS</b>		
THAM	T3	
<b>IV SOLUTIONS: DEXTROSE AND LACTATED RINGERS</b>		
dextrose 5%-lactated ringers	T1	
<b>IV SOLUTIONS: DEXTROSE-SALINE</b>		
dextrose 10 % and 0.2 % nacl	T1	
dextrose 10 % and 0.45 % nacl	T1	
dextrose 2.5 % and 0.45 % nacl	T1	
dextrose 5 % and 0.3 % nacl	T1	
dextrose 5 % and 0.9 % nacl	T1	
dextrose 5 %-0.2 % sod chlorid	T1	
dextrose 5 %-0.45 % sod chlord	T1	
<b>IV SOLUTIONS: DEXTROSE-WATER</b>		
dextrose 10 % in water	T1	
dextrose 20 % in water	T1	
dextrose 25 % in water	T1	
dextrose 30 % in water	T1	
dextrose 40 % in water	T1	
dextrose 50 % in water	T1	
dextrose 70 % in water	T1	
GLUCOSE IN WATER (dextrose in water)	T1	
<b>NUCLEIC ACID/NUCLEOTIDE SUPPLEMENTS</b>		
XURIDEN	T4	PA SP
<b>PARENTERAL AMINO ACID SOLUTIONS AND COMBINATIONS</b>		
AMINO ACID 3%-D10W-CALCIUM-HEPARIN	T3	
AMINOSYN	T3	
AMINOSYN II	T3	
AMINOSYN II WITH ELECTROLYTES	T3	
AMINOSYN M	T3	
AMINOSYN WITH ELECTROLYTES	T3	
AMINOSYN-PF	T3	
AMINOSYN-RF	T3	
CLINIMIX	T3	
CLINIMIX E	T3	
CLINISOL	T3	

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

T4 – Specialty Medications

PA – Prior Authorization

QL – Quantity Limit

ST – Step Therapy

AGE – Age Requirement

SP – Specialty Medication

HD – May require home delivery pharmacy

PPACA – No Cost-Share Preventive Medication

CSL – Oral cancer medication subject to cost-share limits

## List of Prescription Medications

### ELECT/CALORIC/H2O (Miscellaneous) (con't.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>PARENTERAL AMINO ACID SOLUTIONS AND COMBINATIONS (con't.)</b>		
HEPATAMINE	T3	
KABIVEN	T3	
<i>parenteral amino acid 10% no.4</i>	T3	
<i>parenteral amino acid 10% no.6</i>	T3	
<i>parenteral amino acid 10% no.7</i>	T3	
PERIKABIVEN	T3	
PLENAMINE	T3	
PROCALAMINE	T3	
PROSOL	T3	
TROPHAMINE	T3	

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

CALCIUM REPLACEMENT	Tier	
calcium chloride	T1	
CALCIUM GLU 2,000MG/100ML-NACL	T3	
CALCIUM GLUC 1,000MG/50ML-NACL	T1	
<i>calcium gluconate</i>	T1	
<i>calcium gluconate in 0.9% nadl (Calcium Gluconate-0.9% NaCl)</i>	T1	
CALCIUM GLUCONATE-0.9% NACL	T1	
CALCIUM GLUCONATE-0.9% NACL ( <i>calcium gluconate-0.9% nadl</i> )	T1	
CALCIUM GLUCONATE-D5W	T1	

ELECTROLYTE DEPLETERS	Tier	
AURYXIA	T3	QL (12 tabs/day)
<i>calcium acetate</i>	T1	
FOSRENOL 1,000 MG POWDER PACK	T2	PA
FOSRENOL 1,000 MG TABLET CHEW ( <i>lanthanum carbonate</i> )	T3	PA
FOSRENOL 500 MG TABLET CHEW ( <i>lanthanum carbonate</i> )	T3	PA
FOSRENOL 750 MG POWDER PACKET	T2	PA
FOSRENOL 750 MG TABLET CHEW ( <i>lanthanum carbonate</i> )	T3	PA
<i>lanthanum carbonate</i> (Fosrenol)	T1	
LOKELMA	T2	
PHOSLYRA	T3	
RENAGEL ( <i>sevelamer hcl</i> )	T3	PA
RENVELA ( <i>sevelamer carbonate</i> )	T3	PA

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

T4 – Specialty Medications

PA – Prior Authorization

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## List of Prescription Medications

ELECT/CALORIC/H2O (Nutritional/Dietary) (con't.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>ELECTROLYTE DEPLETERS (con't.)</b>		
<i>sevelamer carbonate (Renvela)</i>	T1	
<i>sevelamer hcl</i>	T1	
<i>sevelamer hcl (Renagel)</i>	T1	
<i>sodium polystyrene sulfon/sorb</i>	T1	
<i>sodium polystyrene sulfonate</i>	T1	
<i>sps 15 gm/60 ml suspension</i>	T1	
<i>sps 30 gm/120 ml enema susp</i>	T3	
VELPHORO	T2	
VELTASSA	T2	
XPHOZAH	T4	PA SP
<b>ELECTROLYTE MAINTENANCE</b>		
<i>electrolyte-48 solution/d5w</i>	T1	
<i>IONOSOL B WITH DEXTROSE 5%</i>	T3	
<i>IONOSOL MB-DEXTROSE 5%</i>	T3	
<i>ISOLYTE P WITH DEXTROSE</i>	T3	
<i>ISOLYTE S</i>	T3	
<i>NORMOSOL-M AND DEXTROSE</i>	T3	
<i>NORMOSOL-R</i>	T3	
<i>NORMOSOL-R AND DEXTROSE</i>	T3	
<i>NORMOSOL-R PH 7.4</i>	T3	
<i>PLASMA-LYTE 148</i>	T3	
<i>PLASMA-LYTE A PH 7.4</i>	T3	
<i>ringer's solution</i>	T1	
<i>ringer's solution, lactated</i>	T1	
<i>TPN ELECTROLYTES</i>	T3	
<i>TPN ELECTROLYTES II</i>	T3	
<b>IODINE CONTAINING AGENTS</b>		
<i>IODOPEN</i>	T3	
<i>potassium iodide/iodine</i>	T1	
<i>SSKI</i>	T1	
<b>IRON REPLACEMENT</b>		
<i>HEMOCYTE PLUS (mv-mins no.73/iron fum/folic)</i>	T3	
<i>mv-mins no.73/iron fum/folic (Hemocyte Plus)</i>	T1	

T1 – Typically Generics

T2 – Typically Preferred Brands

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T4 – Specialty Medications

PA – Prior Authorization

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## List of Prescription Medications

### ELECT/CALORIC/H2O (Nutritional/Dietary) (con't.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>MAGNESIUM SALTS REPLACEMENT</b>		
<i>magnesium chloride</i>	T1	
<i>magnesium sulfate</i>	T1	
<i>magnesium sulfate in water</i>	T1	
MAGNESIUM SULFATE-0.9% NACL	T1	
MAGNESIUM SULFATE-D5W	T1	
MAGNESIUM-LACTATED RINGERS	T1	
<b>MINERAL REPLACEMENT, MISCELLANEOUS</b>		
ADDAMEL N	T3	
<i>chromic chloride</i>	T1	
<i>cupric chloride</i>	T1	
<i>manganese chloride</i>	T1	
<i>manganese sulfate</i>	T1	
MULTITRACE-4 CONC VIAL	T1	
<i>multitrace-4 vial</i>	T3	
MULTITRACE-5	T1	
PEDITRACE	T3	
SELENIOUS ACID	T1	
TRALEMENT	T3	
<b>PHOSPHATE REPLACEMENT</b>		
GLYCOPHOS	T3	
<i>potassium phos, m-basic-d-basic</i>	T1	
POTASSIUM PHOSPHATE-0.9% NACL	T1	
POTASSIUM PHOSPHATES	T3	
<i>sod phosphate, monobasic-dibas</i>	T1	
SODIUM PHOSPHATE-0.9% NACL	T1	
<b>POTASSIUM REPLACEMENT</b>		
EFFER-K 10 MEQ TABLET EFF	T3	
EFFER-K 20 MEQ TABLET EFF	T3	
<i>effer-k 25 meq tablet eff</i>	T1	
<i>klor-con 10 meq tablet (K-tab Er)</i>	T1	
<i>klor-con 10 meq tablet (K-tab Er)</i>	T3	
<i>klor-con 8 meq tablet</i>	T1	
<i>klor-con 8 meq tablet</i>	T3	
K-TAB ( <i>potassium chloride</i> )	T3	

T1 – Typically Generics

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## List of Prescription Medications

ELECT/CALORIC/H2O (Nutritional/Dietary) (con't.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>POTASSIUM REPLACEMENT (con't.)</b>		
<i>potassium bicarbonate/cit ac</i>	T1	
<i>potassium chloride</i>	T3	
<i>potassium chloride (K-tab Er)</i>	T1	
<b>PROTEIN REPLACEMENT</b>		
AQNEURSA	T4	PA SP
<b>SODIUM/SALINE PREPARATIONS</b>		
<i>0.9 % sodium chloride</i>	T1	
KENDALL 0.9% NACL WITH CAP	T1	
<i>sodium chloride</i>	T1	
<i>sodium chloride 0.45 %</i>	T1	
<i>sodium chloride 0.9 % (flush)</i>	T1	
<i>sodium chloride 3 %</i>	T1	
<i>sodium chloride 5 %</i>	T1	
SWABFLUSH	T3	
<b>ZINC REPLACEMENT</b>		
<i>zinc chloride</i>	T1	
<i>zinc sulfate 10 mg/10 ml vial</i>	T1	
<i>zinc sulfate 25 mg/5 ml vial</i>	T1	
ZINC SULFATE 30 MG/10 ML VIAL	T3	
ELECT/CALORIC/H2O (Urinary Tract Conditions)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>DIALYSIS SOLUTIONS</b>		
DELFLEX WITH 1.5% DEXTROSE	T3	
DELFLEX-2.5% DEXTROSE	T3	
DIANEAL PD-2 W-1.5% DEXTROSE	T3	
DIANEAL PD-2 W-2.5% DEXTROSE	T2	
DIANEAL PD-2 W-4.25% DEXTROSE	T3	
DIANEAL WITH 1.5% DEXTROSE	T3	
DIANEAL WITH 2.5% DEXTROSE	T3	

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

T4 – Specialty Medications

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## List of Prescription Medications

ELECT/CALORIC/H2O (Urinary Tract Conditions)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>DIALYSIS SOLUTIONS</b>		
DIANEAL WITH 4.25% DEXTROSE	T3	
EXTRANEAL ICODEXTRIN DIALYSIS	T3	
<i>perit. dialysis no.6-1.5 % dex</i> (Dianeal With 1.5% Dextrose)	T3	
<i>periton.dialysis 7-2.5 % dextr</i> (Dianeal With 2.5% Dextrose)	T3	
<i>periton.dialysis 8-4.25 % dext</i> (Dianeal With 4.25% Dextrose)	T3	
PHOXILLUM	T3	
PRISMASOL	T3	
<b>URINARY PH MODIFIERS</b>		
K-PHOS NO.2	T2	HD
K-PHOS ORIGINAL	T2	HD
ORACIT	T3	HD
<i>potassium citrate</i> (Urocit-k)	T1	HD
<i>potassium citrate/citric acid</i>	T1	HD
RENACIDIN	T3	HD
UROCIT-K ( <i>potassium citrate er</i> )	T3	HD
UROQID-ACID NO.2	T2	HD
<b>GASTROINTESTINAL (Cholesterol Medications)</b>		
<b>LIPOTROPICS</b>		
<i>icosapent ethyl</i> (Vascepa)	T1	HD
LOVAZA (triklo)	T3	PA HD
<i>omega-3 acid ethyl esters</i> (Lovaza)	T1	HD
VASCEPA	T2	PA HD
<b>GASTROINTESTINAL (Gastrointestinal/Heartburn)</b>		
<b>AMMONIA INHIBITORS</b>		
AMMONUL ( <i>sodium phenylacet-sod benzoate</i> )	T3	
CARBAGLU ( <i>carglumic acid</i> )	T4	SP HD

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

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## List of Prescription Medications

### GASTROINTESTINAL (Gastrointestinal/Heartburn) (con't.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>AMMONIA INHIBITORS (con't.)</b>		
<i>carglumic acid</i> (Carbaglu)	T4	SP HD
BUPHENYL ( <i>sodium phenylbutyrate</i> )	T4	SP HD
<i>lactulose</i>	T1	HD
<i>lactulose 10 gm/15 ml solution</i>	T1	
LITHOSTAT	T2	HD
PHEBURANE	T4	PA QL(8 bottles/30 days) SP HD
RAVICTI	T4	PA SP HD
<i>sodium benzoate/sod phenylacet</i> (Ammonul)	T1	
<i>sodium phenylbutyrate</i> (Buphenyl)	T4	SP
<b>ANTI-CHOLINERGICS, QUATERNARY AMMONIUM</b>		
<i>chlordiazepoxide/clidinium br</i> (Librax)	T1	
CUVPOSA	T3	
DARTISLA	T3	PA
GLYCATE	T3	
<i>glycopyrrolate</i>	T1	
<i>glycopyrrolate</i> (Glycate)	T1	
<i>glycopyrrolate</i> (Robinul Forte)	T1	
<i>glycopyrrolate</i> (Robinul)	T1	
GLYCOPYRROLATE-WATER	T1	
LIBRAX ( <i>chlordiazepoxide-clidinium</i> )	T3	PA
<i>propantheline bromide</i>	T1	
ROBINUL ( <i>glycopyrrolate</i> )	T3	
ROBINUL FORTE ( <i>glycopyrrolate</i> )	T3	
<b>ANTI-CHOLINERGICS/ANTI-SPASMODICS</b>		
BENTYL	T3	
<i>dicyclomine hcl</i>	T1	
<i>dicyclomine hcl</i> (Bentyl)	T1	
<b>ANTI-DIARRHEAL - G.I. CHLORIDE CHANNEL INHIBITORS</b>		
MYTESI	T3	
<b>ANTI-DIARRHEAL - TRYPTOPHAN HYDROXYLASE INHIBITOR</b>		
XERMELO	T4	PA SP
<b>ANTI-DIARRHEALS</b>		
<i>diphenoxylate hcl/atropine</i>	T1	
<i>diphenoxylate hcl/atropine</i> (Lomotil)	T1	

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

T4 – Specialty Medications

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## List of Prescription Medications

### GASTROINTESTINAL (Gastrointestinal/Heartburn) (con't.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>ANTI-DIARRHEALS (con't.)</b>		
LOMOTIL ( <i>diphenoxylate-atropine</i> )	T3	PA
<i>loperamide hcl</i>	T1	
MOTOFEN	T3	
<i>opium tincture</i>	T1	PA
<i>paregoric</i>	T1	
<b>ANTI-EMETIC, CANNABINOID-TYPE</b>		
<i>dronabinol</i> (Marinol)	T1	
MARINOL ( <i>dronabinol</i> )	T3	PA
SYNDROS	T3	PA
<b>ANTI-EMETIC/ANTI-VERTIGO AGENTS</b>		
AKYNZEO 235-0.25 MG VIAL	T3	
AKYNZEO 235-0.25 MG/20 ML VIAL	T3	
AKYNZEO 300-0.5 MG CAPSULE	T3	QL (4 caps/28 days)
ALOXI ( <i>palonosetron hcl</i> )	T3	PA
ANZEMET	T4	PA QL (5 tabs/30 days) SP
<i>aprepitant 125 mg capsule</i>	T1	QL (4 caps/28 days)
<i>aprepitant 125-80-80 mg pack</i> (Emend)	T1	QL (12 caps/28 days)
<i>aprepitant 40 mg capsule</i>	T1	QL (1 cap/28 days)
<i>aprepitant 80 mg capsule</i> (Emend)	T1	QL (8 caps/28 days)
BARHEMSYS	T3	
BONJESTA	T3	
CINVANTI	T3	
COMPAZINE ( <i>prochlorperazine maleate</i> )	T3	
COMPAZINE ( <i>prochlorperazine</i> )	T3	
DICLEGIS ( <i>doxylamine succ-pyridoxine hcl</i> )	T3	PA QL(4 tabs/day)
<i>dimenhydrinate</i>	T1	
<i>doxylamine succinate/vit b6</i> (Diclegis)	T1	QL(4 tabs/day)
EMEND 125 MG POWDER PACKET	T3	QL (12 caps/28 days)
EMEND 150 MG VIAL ( <i>fosaprepitant dimeglumine</i> )	T3	
EMEND 80 MG CAPSULE ( <i>aprepitant</i> )	T3	QL (8 caps/28 days)
EMEND TRIPACK ( <i>aprepitant</i> )	T3	QL (12 caps/28 days)
FOCINVEZ	T3	
<i>fosaprepitant dimeglumine</i> (Emend)	T1	
<i>granisetron hcl</i>	T1	

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

T4 – Specialty Medications

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CSL – Oral cancer medication subject to cost-share limits

## List of Prescription Medications

### GASTROINTESTINAL (Gastrointestinal/Heartburn) (con't.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>ANTI-EMETIC/ANTI-VERTIGO AGENTS (con't.)</b>		
<i>granisetron hcl/pf</i>	T1	
<i>ondansetron hcl</i>	T1	
<i>ondansetron hcl (Zofran)</i>	T1	
ONDANSETRON ODT 16 MG TABLET	T3	PA
<i>ondansetron hcl/pf</i>	T1	
ONDANSETRON HCL-0.9% NACL	T1	
ONDANSETRON HCL-D5W	T1	
<i>palonosetron hcl</i>	T1	
<i>palonosetron hcl (Aloxi) (Posfrea)</i>	T1	
POSFREA ( <i>palonosetron hcl</i> )	T3	
<i>prochlorperazine (Compazine)</i>	T1	
<i>prochlorperazine edisylate</i>	T1	
<i>prochlorperazine maleate (Compazine)</i>	T1	
<i>promethazine hcl</i>	T1	
<i>promethazine hcl</i>	T3	
SANCUSO	T3	PA QL (4 patches/30 days)
<i>scopolamine (Transderm-scop)</i>	T1	
SUSTOL	T3	
TIGAN	T3	
TRANSDERM-SCOP ( <i>scopolamine</i> )	T3	
<i>trimethobenzamide hcl (Tigan)</i>	T1	
VARUBI	T3	PA QL (4 tabs/28 days)
ZOFRAN 2 MG/ML VIAL ( <i>ondansetron hcl</i> )	T3	
ZOFRAN 4 MG TABLET ( <i>ondansetron hcl</i> )	T3	PA
ZOFRAN 8 MG TABLET ( <i>ondansetron hcl</i> )	T3	PA
<b>ANTI-ULCER PREPARATIONS</b>		
CARAFATE ( <i>sucralfate</i> )	T3	PA HD
CYTOTEC ( <i>misoprostol</i> )	T3	HD
<i>misoprostol (Cytotec)</i>	T1	HD
<i>sucralfate (Carafate)</i>	T1	HD
<b>ANTI-ULCER-H.PYLORI AGENTS</b>		
<i>bismuth/metronidazole/tetracycline (Pylera)</i>	T1	
HELDAC	T3	PA
<i>lansoprazole/amoxicillin/clarithromycin</i>	T1	

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

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## List of Prescription Medications

### GASTROINTESTINAL (Gastrointestinal/Heartburn) (con't.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>ANTI-ULCER-H.PYLORI AGENTS (con't.)</b>		
OMECLAMOX-PAK	T3	PA
PYLERA ( <i>bismuth/metronidazole/tetracycline</i> )	T3	PA
TALICIA	T3	PA
VOQUEZNA DUAL, TRIPLE PAK	T3	PA
<b>BELLADONNA ALKALOIDS</b>		
<i>atropine 0.4 mg/ml vial</i>	T1	
ATROPINE 0.4 MG/ML VIAL	T3	
<i>atropine 0.5 mg/5 ml abboject</i>	T1	
<i>atropine 1 mg/10 ml abboject</i>	T1	
<i>atropine 1 mg/10 ml syringe</i>	T1	
ATROPINE 1 MG/2.5 ML SYRINGE	T1	
<i>atropine 1 mg/ml vial</i>	T1	
ATROPINE 1 MG/ML VIAL	T3	
ATROPINE 2 MG/5 ML SYRINGE	T3	
ATROPINE SULFATE 0.25 MG/5 ML SYRINGE	T3	
<i>atropine 8 mg/20 ml vial</i>	T1	
DONNATAL	T3	HD
DONNATAL ( <i>phenohydra</i> )	T3	HD
<i>hyoscyamine 0.125 mg odt (Nulev)</i>	T1	HD
<i>hyoscyamine 0.125 mg tab sl (Levsin-sl)</i>	T1	HD
<i>hyoscyamine 0.125 mg/5 ml elix</i>	T1	HD
<i>hyoscyamine 0.125 mg/ml drop</i>	T1	HD
<i>hyoscyamine sulf 0.125 mg tab (Levsin)</i>	T1	HD
<i>hyoscyamine sulfate</i>	T1	HD
<i>hyoscyamine sulfate (Levbid)</i>	T1	HD
<i>hyoscyamine sulfate (Levsin)</i>	T1	HD
<i>hyoscyamine sulfate (Levsin-sl)</i>	T1	HD
<i>hyoscyamine sulfate (Nulev)</i>	T1	HD
<i>hyoscyamine sulfate (Nulev)</i>	T3	HD
HYOSCYAMINE SULFATE 0.5 MG/ML	T3	HD
LEVBID ( <i>symax-sr</i> )	T3	HD
LEVSIN	T3	HD
LEVSIN ( <i>oscimin</i> )	T3	HD

T1 – Typically Generics

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## List of Prescription Medications

### GASTROINTESTINAL (Gastrointestinal/Heartburn) (con't.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>BELLADONNA ALKALOIDS (con't.)</b>		
LEVSIN-SL ( <i>symax-sl</i> )	T3	HD
<i>methscopolamine bromide</i>	T1	HD
NULEV ( <i>symax</i> )	T1	HD
<i>phenobarb/hyoscy/atropine/scop</i> (Donnatal)	T1	HD
<i>phenobarb/hyoscy/atropine/scop</i> (Phenobarbital-belladonna)	T1	HD
<i>phenobarbital-belladonna elixr</i> (Donnatal)	T1	HD
<i>phenobarbital-belladonna elixr</i> (Phenobarbital-belladonna)	T1	HD
PHENOBARBITAL-BELLADONNA ELIXR ( <i>phenohytro</i> )	T3	HD
SYMAX DUOTAB	T2	HD
<b>BILE SALTS</b>		
ACTIGALL ( <i>ursodiol</i> )	T3	HD
CHENODAL	T3	SP HD
CHOLBAM	T3	PA SP HD
RELTONE	T3	PA HD
URSO ( <i>ursodiol</i> )	T3	HD
URSO FORTE ( <i>ursodiol</i> )	T3	HD
<i>ursodiol</i> (Actigall)	T1	HD
<i>ursodiol</i> (Urso Forte)	T1	HD
<i>ursodiol</i> (Urso)	T1	HD
<b>CHOLERETICS</b>		
KINEVAC	T3	
<b>CHRONIC INFLAM. COLON DX, 5-A-SALICYLAT, RECTAL TX</b>		
CANASA ( <i>mesalamine</i> )	T3	PA
<i>mesalamine 1,000 mg supp</i> (Canasa)	T1	
<i>mesalamine 4 gm/60 ml enema</i> (Sfrowasa)	T1	
<i>mesalamine 4 gm/60 ml kit</i> (Rowasa)	T1	
ROWASA ( <i>mesalamine</i> )	T3	PA
SFROWASA ( <i>mesalamine</i> )	T3	
<b>DRUG TX-CHRONIC INFLAM. COLON DX, 5-AMINOSALICYLAT</b>		
APRISO ( <i>mesalamine er</i> )	T3	HD
ASACOL HD ( <i>mesalamine</i> )	T3	ST HD
AZULFIDINE ( <i>sulfasalazine dr</i> )	T3	PA HD
AZULFIDINE ( <i>sulfasalazine</i> )	T3	PA HD
<i>balsalazide disodium</i> (Colazal)	T1	HD

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

T4 – Specialty Medications

PA – Prior Authorization

QL – Quantity Limit

ST – Step Therapy

AGE – Age Requirement

SP – Specialty Medication

HD – May require home delivery pharmacy

PPACA – No Cost-Share Preventive Medication

CSL – Oral cancer medication subject to cost-share limits

## List of Prescription Medications

GASTROINTESTINAL (Gastrointestinal/Heartburn) (con't.)			
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits	
<b>DRUG TX-CHRONIC INFLAM. COLON DX, 5-AMINOSALICYLAT (con't.)</b>			
COLAZAL ( <i>balsalazide disodium</i> )	T3	ST	HD
DELZICOL ( <i>mesalamine dr</i> )	T3	ST	HD
DIPENTUM	T3	ST	HD
LIALDA ( <i>mesalamine</i> )	T3	ST	HD
<i>mesalamine</i> (Apriso)	T1	HD	
<i>mesalamine</i> (Delzicol)	T1	HD	
<i>mesalamine</i> 800 mg dr tablet (Asacol Hd)	T1	HD	
<i>mesalamine</i> dr 1.2 gm tablet (Lialda)	T1	HD	
PENTASA 250 MG CAPSULE	T3	ST	HD
PENTASA 500 MG CAPSULE ( <i>mesalamine</i> )	T3	HD	
<i>sulfasalazine</i> (Azulfidine)	T1	HD	
<b>FARNESOID X RECEPTOR (FXR) AGONIST, BILE AC ANALOG</b>			
OCALIVA	T4	PA	SP HD
<b>FECAL MICROBIOTA TRANSPLANTATION (FMT)</b>			
VOWST CAPSULE	T4	PA	QL (12 caps/8 weeks) SP HD
<b>GASTRIC ENZYMEs</b>			
SUCRAID	T4	PA	SP
<i>cimetidine</i>	T1	HD	
<i>cimetidine hcl</i>	T1	HD	
<i>famotidine</i>	T1	HD	
<i>famotidine</i> (Pepcid)	T1	HD	
FAMOTIDINE-0.9% NACL	T1	HD	
<i>nizatidine</i>	T1	HD	
PEPCID ( <i>famotidine</i> )	T1	PA	HD
<i>ranitidine hcl</i>	T1	HD	
<i>ranitidine hcl</i> (Zantac)	T1	HD	
ZANTAC ( <i>ranitidine hcl</i> )	T3	HD	
<b>IBS AGENTS, MIXED OPIOID RECEP AGONISTS/ANTAGONISTS</b>			
VIBERZI	T2	HD	
<b>IBS-C/CIC AGENTS, GUANYLATE CYCLASE-C AGONIST</b>			
LINZESS	T2		
TRULANCE	T2		
<b>ILEAL BILE ACID TRANSPORTER (IBAT) INHIBITOR</b>			
BYLVAY	T4	PA	SP HD

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

T4 – Specialty Medications

PA – Prior Authorization

QL – Quantity Limit

ST – Step Therapy

AGE – Age Requirement

SP – Specialty Medication

HD – May require home delivery pharmacy

PPACA – No Cost-Share Preventive Medication

CSL – Oral cancer medication subject to cost-share limits

## List of Prescription Medications

GASTROINTESTINAL (Gastrointestinal/Heartburn) (con't.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>IILEAL BILE ACID TRANSPORTER (IBAT) INHIBITOR (con't.)</b>		
LIVMARLI	T4	PA SP HD
<b>INTESTINAL MOTILITY STIMULANTS</b>		
GIMOTI	T4	PA SP
<i>metoclopramide hcl</i>	T1	
<i>metoclopramide hcl (Reglan)</i>	T1	
MOTEGRITY	T3	PA
REGLAN ( <i>metoclopramide hcl</i> )	T3	
<b>IRRITABLE BOWEL SYNDROME AGENTS, 5-HT3 ANTAGONIST</b>		
<i>alosetron hcl</i> (Lotronex)	T4	SP HD
LOTRONEX ( <i>alosetron hcl</i> )	T4	PA SP HD
ZELNORM	T3	PA
<b>IV FAT EMULSIONS</b>		
CLINOLIPID	T3	
<i>fat emulsions</i> (Nutrilipid)	T3	
INTRALIPID	T3	
NUTRILIPID ( <i>intralipid</i> )	T3	
OMEGAVEN	T3	
SMOFLIPID	T3	
<b>LAXATIVES AND CATHARTICS</b>		
AMITIZA ( <i>lubiprostone</i> )	T3	PA
<i>bisac/nacl/nahco3/kcl/peg 3350</i>	T1	PPACA
CLENPIQ	T3	PA PPACA
COLYTE WITH FLAVOR PACKETS ( <i>peg 3350-electrolyte</i> )	T3	PPACA
COLYTE WITH FLAVOR PACKETS ( <i>peg 3350-electrolyte</i> )	T3	PA PPACA
GOLYTELY	T3	PA PPACA
GOLYTELY ( <i>peg-3350 and electrolytes</i> )	T3	PA PPACA
KRISTALOSE	T3	
<i>lactulose</i>	T1	
<i>lactulose 10 gm packet</i> (Kristalose)	T1	
<i>lactulose 10 gm/15 ml solution</i>	T1	
<i>lactulose 20 gm/30 ml solution</i>	T1	
<i>lactulose 10 gm/15 ml solution</i>	T1	
<i>lactulose 20 gm/30 ml solution</i>	T1	
<i>lubiprostone</i>	T1	

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

T4 – Specialty Medications

PA – Prior Authorization

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ST – Step Therapy

AGE – Age Requirement

SP – Specialty Medication

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## List of Prescription Medications

### GASTROINTESTINAL (Gastrointestinal/Heartburn) (con't.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>LAXATIVES AND CATHARTICS (con't.)</b>		
LUBIPROSTONE	T3	PA
MOVIPREP (peg3350-sod sul-nacl-kcl-asb-c)	T3	PA PPACA
NULYTLY	T3	PA PPACA
OSMOPREP	T3	PA PPACA
peg3350/sod sul/nacl/kcl/asb/c (Moviprep)	T1	PPACA
peg3350/sod sulf, bicarb, cl/kcl (Colyte With Flavor Packets)	T1	PPACA
peg3350/sod sulf, bicarb, cl/kcl (Golytely)	T1	PPACA
PLENUV	T3	PA PPACA
PREPOPIK	T2	PPACA
sodium chloride/nahco3/kcl/peg	T1	PPACA
SUFLAVE	T3	PA PPACA
SUPREP	T3	PA PPACA
SUTAB	T3	PA PPACA
<b>LOCAL ANORECTAL NITRATE PREPARATIONS</b>		
nitroglycerin 0.4% ointment (Rectiv)	T1	
RECTIV (nitroglycerin)	T3	
<b>PANCREATIC ENZYMES</b>		
CREON	T3	PA HD
PANCREAZE	T2	HD
PERTZYE	T3	PA HD
VIOKACE	T3	HD
ZENPEP	T3	HD
<b>POTASSIUM-COMPETITIVE ACID BLOCKERS (PCABS)</b>		
VOQUEZNA	T3	PA QL(1 tab/day)
<b>PROTON-PUMP INHIBITORS</b>		
ACIPHEX (rabeprazole sodium)	T3	QL (30 tabs/30 days) ST HD
ACIPHEX SPRINKLE DR 10 MG CAP	T3	QL (60 caps/30 days) HD
ACIPHEX SPRINKLE DR 5 MG CAP	T3	QL (120 caps/30 days) HD
DEXILANT DR 30 MG CAPSULE (dexlansoprazole)	T3	PA QL(2 caps/day)
DEXILANT DR 60 MG CAPSULE	T3	PA QL(1 cap/day)
dexlansoprazole dr 30 mg cap (Dexilant)	T1	QL(2 caps/day)
dexlansoprazole dr 60 mg cap (Dexilant)	T1	QL(1 cap/day)
esomeprazole dr 10 mg packet (Nexium)	T1	QL (4 packets/day) HD
esomeprazole dr 20 mg packet (Nexium)	T1	QL (2 packs/day) HD

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

T4 – Specialty Medications

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## List of Prescription Medications

### GASTROINTESTINAL (Gastrointestinal/Heartburn) (con't.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>PROTON-PUMP INHIBITORS (cont.)</b>		
esomeprazole dr 40 mg packet (Nexium)	T1	QL (1 packet/day) HD
esomeprazole mag dr 20 mg cap (Nexium)	T1	QL (20ml/day) HD
esomeprazole mag dr 40 mg cap (Nexium)	T1	QL (30 caps/30 days) HD
esomeprazole sodium	T1	HD
ESOMEPRAZOLE STRONTIUM	T3	QL (30 caps/30 days) HD
KONVOMEP	T3	PA QL(20 mls/day) HD
lansoprazole dr 15 mg capsule (Prevacid)	T1	QL (2 caps/day) HD
lansoprazole dr 30 mg capsule (Prevacid)	T1	QL (30 caps/30 days) HD
lansoprazole odt 15 mg tablet (Prevacid)	T1	QL (2 tabs/day) HD
lansoprazole odt 30 mg tablet (Prevacid)	T1	QL (30 tabs/30 days) HD
NEXIUM DR 10 MG PACKET (esomeprazole magnesium)	T3	PA QL (120 packs/30 days) HD
NEXIUM DR 2.5 MG PACKET	T2	QL (480 packs/30 days) HD
NEXIUM DR 20 MG CAPSULE (esomeprazole magnesium)	T3	PA QL (2 caps/day) HD
NEXIUM DR 20 MG PACKET (esomeprazole magnesium)	T3	PA QL (2 packs/day) HD
NEXIUM DR 40 MG CAPSULE (esomeprazole magnesium)	T3	PA QL (30 caps/30 days) HD
NEXIUM DR 40 MG PACKET (esomeprazole magnesium)	T3	PA QL (30 packs/30 days) HD
NEXIUM DR 5 MG PACKET	T2	QL (240 packs/30 days) HD
NEXIUM I.V. (esomeprazole sodium)	T3	
omeppi 20 mg-1, 100 mg capsule (Zegerid)	T3	PA QL (60 caps/30 days) HD
omeppi 40 mg-1, 100 mg capsule (Zegerid)	T3	PA QL (30 caps/30 days) HD
omeprazole dr 10 mg capsule	T1	QL (4 caps/day) HD
omeprazole dr 20 mg capsule	T1	QL (60 caps/30 days) HD
omeprazole dr 40 mg capsule	T1	QL (30 caps/30 days) HD
omeprazole-bicarb 20-1, 100 cap (Zegerid)	T1	PA QL (60 caps/30 days) HD
omeprazole-bicarb 20-1, 680 pkt (Zegerid)	T1	PA QL (60 packs/30 days) HD
omeprazole-bicarb 40-1, 100 cap (Zegerid)	T1	PA QL (30 caps/30 days) HD
omeprazole-bicarb 40-1, 680 pkt (Zegerid)	T1	PA QL (30 packs/30 days) HD
pantoprazole 40 mg suspension (Protonix)	T1	QL (1 dose/day) HD
pantoprazole sod dr 20 mg tab (Protonix)	T1	QL (2 tabs/day) HD
pantoprazole sod dr 40 mg tab (Protonix)	T1	QL (30 tabs/30 days) HD
PANTOPRAZOLE SODIUM-0.9% NACL	T3	HD
pantoprazole sodium 40 mg vial (Protonix lv)	T1	
PREVACID 15 MG SOLUTAB (lansoprazole)	T3	PA QL (2 tabs/day) HD
PREVACID 30 MG SOLUTAB (lansoprazole)	T3	PA QL (30 tabs/30 days) HD

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

T4 – Specialty Medications

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ST – Step Therapy

AGE – Age Requirement

SP – Specialty Medication

HD – May require home delivery pharmacy

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## List of Prescription Medications

### GASTROINTESTINAL (Gastrointestinal/Heartburn) (con't.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>PROTON-PUMP INHIBITORS (cont.)</b>		
PREVACID DR 15 MG CAPSULE ( <i>lansoprazole</i> )	T3	QL (60 caps/30 days) ST HD
PREVACID DR 30 MG CAPSULE ( <i>lansoprazole</i> )	T3	QL (30 caps/30 days) ST HD
PRILOSEC DR 10 MG SUSPENSION	T3	QL (120 packs/30 days) HD
PRILOSEC DR 2.5 MG SUSPENSION	T3	QL (480 packs/30 days) HD
PROTONIX 40 MG SUSPENSION ( <i>pantoprazole sodium</i> )	T3	QL (30 packs/30 days) ST HD
PROTONIX DR 20 MG TABLET ( <i>pantoprazole sodium</i> )	T3	QL (60 tabs/30 days) ST HD
PROTONIX DR 40 MG TABLET ( <i>pantoprazole sodium</i> )	T3	QL (30 tabs/30 days) ST HD
PROTONIX IV ( <i>pantoprazole sodium</i> )	T3	HD
RABEPRAZOLE DR 10 MG SPRNKL CP <i>rabeprazole sod dr 20 mg tab (Aciphex)</i>	T3	QL (2 caps/day) HD
ZEGERID 20 MG CAPSULE ( <i>omeprazole-sodium bicarbonate</i> )	T3	PA QL (60 caps/30 days) HD
ZEGERID 20 MG PACKET ( <i>omeprazole-sodium bicarbonate</i> )	T3	PA QL (60 packs/30 days) HD
ZEGERID 40 MG CAPSULE ( <i>omeprazole-sodium bicarbonate</i> )	T3	PA QL (30 caps/30 days) HD
ZEGERID 40 MG PACKET ( <i>omeprazole-sodium bicarbonate</i> )	T3	PA QL (30 packs/30 days) HD
<b>RECTAL PREPARATIONS</b>		
ANUSOL-HC 25 MG SUPPOSITORY ( <i>hydrocortisone acetate</i> )	T3	PA
<i>hydrocortisone acetate</i>	T1	
<b>SBS - GLUCAGON-LIKE PEPTIDE-2 (GLP-2) ANALOGS</b>		
GATTEX	T4	PA SP HD

### GASTROINTESTINAL (Pain Relief And Inflammatory Disease)

HEMORRHOID PREP, ANTI-INFLAM STEROID-LOCAL ANESTHET		
ANA-LEX	T1	
ANALPRAM HC	T3	PA
ANALPRAM HC ( <i>hydrocortisone-pramoxine</i> )	T3	
<i>hydrocortisone/lidocaine/aloe</i>	T1	
<i>hydrocortisone/pramoxine (Analpram Hc)</i>	T1	
<i>lidocaine/hydrocortisone ac</i>	T1	
LIDOCAINE-HYDROCORTISONE	T1	
PROCORT	T3	
PROCTOFOAM-HC	T2	

### KERATINOCYTE GROWTH FACTOR (KGF)

KEPIVANCE	T4	SP
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### RECTAL/LOWER BOWEL PREP., GLUCOCORT. (NON-HEMORR)

budesonide 2 mg rectal foam	T1	QL(2 kits/180 days)
T1 – Typically Generics	T4 – Specialty Medications	ST – Step Therapy
T2 – Typically Preferred Brands	PA – Prior Authorization	AGE – Age Requirement
T3 – Typically Non-Preferred Brands	QL – Quantity Limit	SP – Specialty Medication

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

## List of Prescription Medications

GASTROINTESTINAL (Pain Relief And Inflammatory Disease) (con't.)			
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits	
<b>RECTAL/LOWER BOWEL PREP., GLUCOCORT. (NON-HEMORR) (cont.)</b>			
CORTENEMA ( <i>hydrocortisone</i> )	T3		
CORTIFOAM	T3	PA	
<i>hydrocortisone</i> (Cortenema)	T1		
TARPEYO	T4	PA QL (4 caps/day) SP	
UCERIS 2 MG RECTAL FOAM	T3	PA QL (2 kits/180 days)	
<b>HEMATOPOIETIC GROWTH FACTORS (MISCELLANEOUS)</b>			
<b>HYPOXIA INDUCIBLE FACTOR PROLYL HYDROXYLASE INH.</b>			
VAFSEO 150 MG TABLET	T3	PA QL(1 TAB/DAY)	
VAFSEO 300 MG TABLET	T3	PA QL(2 TABS/DAY)	
<b>HORMONES (Hormonal Agents)</b>			
<b>ADRENAL STEROID INHIBITORS</b>			
ISTURISA	T4	PA QL (2 tabs/day) SP	
RECORLEV	T4	PA QL (8 tabs/day) SP	
<b>ADRENOCORTICOTROPHIC HORMONES</b>			
ACTHAR	T4	PA SP HD	
ACTHREL	T4	SP	
CORTROSYN ( <i>cosyntropin</i> )	T3		
<i>cosyntropin</i> (Cortrosyn)	T1		
<b>ANDROGEN/ESTROGEN PREPS FOR FEMALE SEXUAL DYSFUNC</b>			
INTRAROSA	T3		
<b>ANDROGENIC AGENTS</b>			
ANADROL-50	T2	PA	
ANDRODERM	T2	PA QL (1 patch/day)	
ANDROGEL 1% (25 MG/2.5 G) PKT ( <i>testosterone</i> )	T3	PA QL (150gm/30 days)	
ANDROGEL 1% (50 MG/5 G) PKT ( <i>testosterone</i> )	T3	PA QL (2 packs/day)	
ANDROGEL 1.62% GEL PUMP ( <i>testosterone</i> )	T3	PA QL (150gm/30 days)	
ANDROGEL 1.62% (1.25G) GEL PCKT ( <i>testosterone</i> )	T3	PA QL (2 packs/day)	
ANDROGEL 1.62% (2.5G) GEL PCKT ( <i>testosterone</i> )	T3	PA QL (150gm/30 days)	
AVEED	T3	PA SP	
AZMIRO	T3		
JATENZO 158, 198 MG CAPSULE	T3	PA QL (4 caps/day)	
JATENZO 237 MG CAPSULE	T3	PA QL (2 caps/day)	
KYZATREX	T3	PA QL (60 tabs/30 days)	

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

T4 – Specialty Medications

PA – Prior Authorization

QL – Quantity Limit

ST – Step Therapy

AGE – Age Requirement

SP – Specialty Medication

HD – May require home delivery pharmacy

PPACA – No Cost-Share Preventive Medication

CSL – Oral cancer medication subject to cost-share limits

## List of Prescription Medications

### HORMONES (Hormonal Agents) (con't.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>ANDROGENIC AGENTS (cont.)</b>		
METHITEST	T1	
<i>methyltestosterone</i>	T1	
NATESTO	T3	PA QL (3 bots/30 days)
<i>oxandrolone</i>	T1	PA
TESTIM ( <i>testosterone</i> )	T3	PA QL (2 tubes/day)
TESTOPEL	T3	PA
<i>testosterone 1% (25mg/2.5g) pk (Androgel)</i>	T1	PA QL (150gm/30 days)
<i>testosterone 1% (50 mg/5 g) pk (Vogelxo)</i>	T1	PA QL (2 packs/day)
<i>testosterone 1.62% (2.5 g) pkt (Androgel)</i>	T1	PA QL (150gm/30 days)
<i>testosterone 1.62% gel pump (Androgel)</i>	T1	PA QL (150gm/30 days)
<i>testosterone 1.62% (1.25 g) pkt (Androgel)</i>	T1	PA QL (2 packs/day)
<i>testosterone 10 mg gel pump</i>	T1	PA QL (120 gm/30 days)
TESTOSTERONE 12.5 MG/1.25 GRAM	T1	PA QL (150gm/30 days)
<i>testosterone 12.5 mg/1.25 gram (Vogelxo)</i>	T1	PA QL (150gm/30 days)
<i>testosterone 30 mg/1.5 ml pump</i>	T1	PA QL (180ml/30 days)
<i>testosterone 50 mg/5 gram gel (Vogelxo)</i>	T1	PA QL (2 tubes/day)
TESTOSTERONE 50 MG/5 GRAM PKT	T1	PA QL (2 packs/day)
TESTRED ( <i>methyltestosterone</i> )	T3	
TLANDO	T3	PA QL (4/day)
UNDECATREX	T3	PA
VOGELXO 12.5 MG/1.25 GRAM PUMP	T3	PA QL (150gm/30 days)
VOGELXO 50 MG/5 GRAM GEL ( <i>testosterone</i> )	T3	PA QL (2 tubes/day)
VOGELXO 50 MG/5 GRAM GEL PACKT	T3	PA QL (2 packs/day)
XYOSTED	T3	PA QL (4 injectors/28 days)
<b>ANTI-DIURETIC AND VASOPRESSOR HORMONES</b>		
DDAVP 0.01% NASAL SPRAY ( <i>desmopressin acetate</i> )	T3	PA
DDAVP 0.1 MG TABLET ( <i>desmopressin acetate</i> )	T3	PA HD
DDAVP 0.2 MG TABLET ( <i>desmopressin acetate</i> )	T3	PA HD
DDAVP 10 MCG/0.1 ML SOLUTION	T3	PA
DDAVP 4 MCG/ML AMPUL ( <i>desmopressin acetate</i> )	T4	PA SP
DDAVP 4 MCG/ML VIAL ( <i>desmopressin acetate</i> )	T4	PA SP
<i>desmopressin 0.01% (Ddavp)</i>	T1	HD
<i>desmopressin 10 mcg/0.1 ml spr (Ddavp)</i>	T1	HD
<i>desmopressin 40 mcg/10 ml vial (Ddavp)</i>	T4	SP

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

T4 – Specialty Medications

PA – Prior Authorization

QL – Quantity Limit

ST – Step Therapy

AGE – Age Requirement

SP – Specialty Medication

HD – May require home delivery pharmacy

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## List of Prescription Medications

### HORMONES (Hormonal Agents) (con't.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>ANTI-DIURETIC AND VASOPRESSOR HORMONES (cont.)</b>		
desmopressin ac 4 mcg/ml ampul (Ddavp)	T4	SP
desmopressin ac 4 mcg/ml vial (Ddavp)	T4	SP
desmopressin acetate 0.1 mg tb (Ddavp)	T1	
desmopressin acetate 0.2 mg tb (Ddavp)	T1	
NOCDURNA	T3	PA
NOCTIVA	T3	PA
STIMATE	T4	SP
vasopressin in 0.9 % nacl	T1	
VASOPRESSIN-0.9% NAACL	T3	
VASOPRESSIN-D5W	T1	
VASOSTRICT	T3	
<b>ESTROGEN AND PROGESTIN COMBINATIONS</b>		
BUJUVA	T3	
<b>ESTROGEN/ANDROGEN COMBINATIONS</b>		
ESTRATEST F.S. (estrogen,ester/me-testosterone)	T3	PA HD
estrogen, ester/me-testosterone (Estratest F.S.)	T1	HD
<b>ESTROGENIC AGENTS</b>		
ACTIVELLA (mimvey)	T3	HD
ALORA	T3	QL (16 patches/28 days) HD
CLIMARA (estradiol (once weekly))	T3	HD
CLIMARA PRO	T3	HD
COMBIPATCH	T3	HD
DELESTROGEN (estradiol valerate)	T3	PA HD
DEPO-ESTRADOL	T3	HD
DIVIGEL	T2	HD
ELESTRIN	T3	HD
ESTRACE (estradiol)	T3	HD
estradiol 0.06% 1.25g gel pump (Estrogel)	T1	HD
estradiol (Climara)	T1	HD
estradiol (Vivelle-dot)	T1	QL (16 patches/28 days) HD
estradiol 0.025 mg patch(2/wk) (Minivelle)	T1	QL (16 patches/28 days) HD
estradiol 0.025 mg patch(2/wk) (Vivelle-Dot)	T1	QL (16 patches/28 days) HD
estradiol 0.0375mg patch(2/wk) (Minivelle)	T1	QL (16 patches/28 days) HD
estradiol 0.0375mg patch(2/wk) (Vivelle-Dot)	T1	QL (16 patches/28 days) HD

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

T4 – Specialty Medications

PA – Prior Authorization

QL – Quantity Limit

ST – Step Therapy

AGE – Age Requirement

SP – Specialty Medication

HD – 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) (con't.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>ESTROGENIC AGENTS (cont.)</b>		
estradiol 0.05 mg patch (2/wk) (Minivelle)	T1	QL (16 patches/28 days) HD
estradiol 0.075 mg patch(2/wk) (Minivelle)	T1	QL (16 patches/28 days) HD
estradiol 0.075 mg patch(2/wk) (Vivelle-Dot)	T1	QL (16 patches/28 days) HD
estradiol 0.1 mg patch (2/wk) (Minivelle)	T1	QL (16 patches/28 days) HD
estradiol 0.1 mg patch (2/wk) (Vivelle-Dot)	T1	QL (16 patches/28 days) HD
estradiol 0.5 mg tablet (Estrace)	T1	HD
estradiol 1 mg tablet (Estrace)	T1	HD
estradiol 2 mg tablet (Estrace)	T1	HD
estradiol valerate (Delestrogen)	T1	HD
estradiol/norethindrone acet (Activella)	T1	HD
ESTROGEL (estradiol)	T2	HD
EVAMIST	T3	HD
FEMHRT (norethindron-ethinyl estradiol)	T3	HD
MENEST	T3	HD
MENOSTAR	T3	QL (8 patches/28 days) HD
MINIVELLE (lyllana)	T3	QL (16 patches/28 days) HD
norethind-eth estrad 0.5-2.5 (Femhrt)	T1	HD
norethindrone ac/eth estradiol	T1	HD
norethindrone ac-eth estradiol (Femhrt)	T1	HD
norethin-eth estrad 1 mg-5 mcg	T1	HD
PREMARIN	T2	HD
PREMPHASE	T2	HD
PREMPRO	T2	HD
VIVELLE-DOT (estradiol)	T3	QL (16 patches/28 days) HD
<b>ESTROGEN-PROGESTIN WITH ANTI-MINERALOCORTICOID COMB</b>		
ANGELIQ	T3	HD
<b>ESTROGEN-SELECTIVE ESTROGEN RECEPTOR MOD (SERM) COMB</b>		
DUAVEE	T2	
<b>GLUCOCORTICOIDS</b>		
AGAMREE	T4	PA QL(10 mls/day) SP
ALKINDI SPRINKLE	T3	PA
BETA 1	T3	
betamethasone acetate, sod phos (Celestone)	T1	
BSP 0820	T3	

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

T4 – Specialty Medications

PA – Prior Authorization

QL – Quantity Limit

ST – Step Therapy

AGE – Age Requirement

SP – Specialty Medication

HD – May require home delivery pharmacy

PPACA – No Cost-Share Preventive Medication

CSL – Oral cancer medication subject to cost-share limits

## List of Prescription Medications

### HORMONES (Hormonal Agents) (con't.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>GLUCOCORTICOIDS (cont.)</b>		
budesonide (Entocort Ec)	T1	
budesonide (Uceris)	T1	PA QL (56 tabs/180 days)
CELESTONE (betamethasone sod phos-acetate)	T2	
CORTEF (hydrocortisone)	T3	PA
cortisone acetate	T1	
deflazacort	T4	PA SP HD
DEPO-MEDROL	T3	
dexamethasone (Dxovo)	T1	
dexamethasone 0.5 mg tablet	T1	
dexamethasone 0.5 mg/5 ml elx	T1	
dexamethasone 0.5 mg/5 ml liq	T1	
dexamethasone 0.75 mg tablet	T1	
dexamethasone 1 mg tablet	T1	
dexamethasone 1.5 mg tablet	T1	
dexamethasone 10 day 1.5 mg tb	T1	PA
DEXAMETHASONE 10 MG/ML SYRING	T3	
dexamethasone 10 mg/ml vial	T1	
dexamethasone 100 mg/10 ml vl	T1	
dexamethasone 120 mg/30 ml vl	T1	
dexamethasone 13 day 1.5 mg tb	T1	PA
dexamethasone 2 mg tablet	T1	
dexamethasone 20 mg/5 ml vial	T1	
dexamethasone 4 mg tablet	T1	
dexamethasone 4 mg/ml syringe	T1	
dexamethasone 4 mg/ml vial	T1	
dexamethasone 6 day 1.5 mg tab (Taperdex)	T1	PA
dexamethasone 6 mg tablet	T1	
dexamethasone in 0.9 % sod chl	T1	
DXEVO	T3	
EMFLAZA	T4	PA SP HD
ENTOCORT EC (budesonide ec)	T3	
EOHILIA	T3	PA QL(1800 mls/180 days)
HEMADY	T3	
hydrocortisone (Cortef)	T1	

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

T4 – Specialty Medications

PA – Prior Authorization

QL – Quantity Limit

ST – Step Therapy

AGE – Age Requirement

SP – Specialty Medication

HD – May require home delivery pharmacy

PPACA – No Cost-Share Preventive Medication

CSL – Oral cancer medication subject to cost-share limits

## List of Prescription Medications

### HORMONES (Hormonal Agents) (con't.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>GLUCOCORTICOIDS (cont.)</b>		
KENALOG-10	T3	
KENALOG-40 ( <i>triamcinolone acetonide</i> )	T3	
KENALOG-80	T3	
LOCORT	T1	
MEDROL 16 MG TABLET ( <i>methylprednisolone</i> )	T3	
MEDROL 2 MG TABLET	T2	
MEDROL 32 MG TABLET ( <i>methylprednisolone</i> )	T3	
MEDROL 4 MG DOSEPAK ( <i>methylprednisolone</i> )	T3	
MEDROL 4 MG TABLET ( <i>methylprednisolone</i> )	T3	
MEDROL 8 MG TABLET ( <i>methylprednisolone</i> )	T3	
MEDROLOAN II SUIK	T3	
<i>methylprednisolone</i> (Medrol)	T1	
<i>methylprednisolone acetate</i> (Depo-medrol)	T1	
<i>methylprednisolone sod succ</i>	T1	
<i>methylprednisolone sod succ</i> (Solu-medrol)	T1	
MILLIPRED 10 MG/5 ML SOLUTION ( <i>prednisolone sodium phosphate</i> )	T3	
<i>millipred 5 mg tablet</i>	T1	
NGENLA	T4	PA SP
ORAPRED ODT ( <i>prednisolone sodium phos odt</i> )	T3	
P-CARE D80G	T1	
P-CARE K80	T1	
POD-CARE 100C	T1	
<i>prednisolone</i>	T1	
<i>prednisolone sodium phosphate</i>	T1	
<i>prednisolone sodium phosphate</i> (Millipred)	T1	
<i>prednisolone sodium phosphate</i> (Orapred Odt)	T1	
<i>prednisone</i>	T1	
PRO-C-DURE 5	T3	
PRO-C-DURE 6	T3	
RAYOS	T3	PA
READYSHARP BETAMETHASONE	T1	
SOLU-CORTEF	T3	
SOLU-MEDROL	T3	
TAPERDEX	T1	PA

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

T4 – Specialty Medications

PA – Prior Authorization

QL – Quantity Limit

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## List of Prescription Medications

### HORMONES (Hormonal Agents) (con't.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>GLUCOCORTICOIDS (cont.)</b>		
triamcinolone acetonide (Kenalog-40)	T1	
UCERIS 9 MG ER TABLET (budesonide er)	T3	PA QL (1 tab/day)
ZCORT	T3	PA
ZILRETTA	T3	PA
ZONACORT	T3	
<b>GROWTH HORMONE RELEASING HORMONE (GHRH) AND ANALOGS</b>		
EGRIFTA	T4	PA SP HD
EGRIFTA SV	T4	PA SP HD
<b>GROWTH HORMONES</b>		
GENOTROPIN	T4	PA SP HD
HUMATROPE	T4	PA SP HD
NGENLA	T4	PA SP
NORDITROPIN FLEXPRO	T4	PA SP HD
NUTROPIN AQ NUSPIN	T4	PA SP HD
OMNITROPE	T4	PA SP HD
SAIZEN	T4	PA SP HD
SAIZEN-SAIZENPREP	T4	PA HD
SEROSTIM	T4	PA SP HD
SKYTROFA	T4	PA SP HD
SOGROYA	T4	PA SP
ZOMACTON	T4	PA SP HD
<b>INSULIN-LIKE GROWTH FACTOR-I (IGF-I) HORMONES</b>		
INCRELEX	T4	PA SP HD
<b>LHRH (GNRH) AGONIST ANALOG AND PROGESTIN COMB</b>		
LUPANETA PACK	T4	PA SP HD
<b>LHRH (GNRH) AGONIST ANALOG PITUITARY SUPPRESSANTS</b>		
LUPRON DEPOT	T4	PA SP HD
SYNAREL	T4	PA SP HD
<b>LHRH (GNRH) ANTAGONIST, ESTROGEN AND PROGESTIN COMB</b>		
MYFEMBREE	T2	PA QL (24 month therapy)
ORIAHNN	T2	PA QL (2 caps/day)
<b>LHRH (GNRH) ANTAGONIST, PITUITARY SUPPRESSANT AGENTS</b>		
CETROTIDE	T4	PA SP
ganirelix acet 250 mcg/0.5 ml (Ganirelix Acetate)	T4	PA SP

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

T4 – Specialty Medications

PA – Prior Authorization

QL – Quantity Limit

ST – Step Therapy

AGE – Age Requirement

SP – Specialty Medication

HD – May require home delivery pharmacy

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## List of Prescription Medications

### HORMONES (Hormonal Agents) (con't.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>LHRH (GNRH) ANTAGONIST, PITUITARY SUPPRESSANT AGENTS (con't.)</b>		
GANIRELIX ACET 250 MCG/0.5 ML ( <i>ganirelix acetate</i> )	T4	PA SP
ORILISSA 150 MG TABLET	T2	PA QL (24 months of treatment/lifetime)
ORILISSA 200 MG TABLET	T2	PA QL (2 tabs/day)
<b>LHRH (GNRH) AGAINST PIT.SUP-CENTRAL PRECOCIOUS PUBERTY</b>		
FENSOLVI	T4	PA SP
LUPRON DEPOT-PED	T4	PA SP HD
SUPPRELIN LA	T4	PA SP HD
TRIPTODUR	T4	PA SP
<b>MINERALOCORTICOIDS</b>		
<i>fludrocortisone acetate</i>	T1	HD
<b>OXYTOCICS</b>		
CARBOPROST TROMETHAMINE	T3	
CERVIDIL	T3	
HEMABATE	T3	
<i>methylergonovine maleate</i>	T1	
<i>oxytocin</i> (Pitocin)	T1	
OXYTOCIN-D5-LACTATED RINGERS	T1	
OXYTOCIN-D5W	T1	
OXYTOCIN-LACTATED RINGERS	T1	
PITOCIN ( <i>oxytocin</i> )	T3	
PREPIDIL	T3	
PROSTIN E2 VAGINAL SUPPOSITORY	T3	
<b>PITUITARY SUPPRESSIVE AGENTS</b>		
<i>cabergoline</i>	T1	QL (16 tabs/28 days) HD
CRENESSITY 50 MG CAPSULE	T3	PA QL(2 caps/day) SP
CRENESSITY 100 MG CAPSULE	T3	PA QL SP
CRENESSITY 50 MG/ML SOLUTION	T3	PA QL(8 mls/day) SP
<i>danazol</i>	T1	HD
<b>PROGESTATIONAL AGENTS</b>		
CRINONE 4% GEL	T3	PA HD
DEPO-PROVERA 400 MG/ML VIAL	T2	HD
<i>hydroxyprogesterone caproate/pf</i>	T1	PA
<i>hydroxyprogesterone caproate</i>	T1	PA

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

T4 – Specialty Medications

PA – Prior Authorization

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ST – Step Therapy

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PPACA – No Cost-Share Preventive Medication

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## List of Prescription Medications

### HORMONES (Hormonal Agents) (con't.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>PROGESTATIONAL AGENTS (con't.)</b>		
medroxyprogesterone 2.5 mg, 5 mg, 10 mg tab (Provera)	T1	HD
norethindrone acetate	T1	HD
progesterone capsule (Prometrium)	T1	HD
progesterone 500 mg/10 ml vial	T4	SP HD
PROMETRIUM (progesterone)	T3	PA HD
PROVERA (medroxyprogesterone acetate)	T3	PA HD
<b>RENIN-ANGIOTENSIN-ALDOSTERONE SYS. (RAAS) HORMONES</b>		
GIAPREZA	T4	SP
<b>SOMATOSTATIC AGENTS</b>		
lanreotide 120 mg/0.5 ml syrng	T4	PA SP HD
LANREOTIDE 120 MG/0.5 ML SYRNG	T4	PA SP HD
MYCAPSSA	T4	PA QL (4 caps/day) SP
octreotide acetate (Sandostatin)	T4	PA SP HD
SANDOSTATIN 0.05 MG/ML AMPUL (octreotide acetate)	T4	PA SP HD
SANDOSTATIN 0.1 MG/ML AMPUL (octreotide acetate)	T4	PA SP HD
SANDOSTATIN 0.5 MG/ML AMPUL (octreotide acetate)	T4	PA SP HD
SANDOSTATIN LAR DEPOT	T4	PA SP
SIGNIFOR	T4	PA SP
SIGNIFOR LAR	T4	PA SP
SOMATULINE DEPOT	T4	PA SP HD
<b>VAGINAL ESTROGEN FOR SEXUAL DYSFUNCTION</b>		
IMVEXXY 10 MCG MAINTENANCE PAK	T3	QL (16/28 days) HD
IMVEXXY 10 MCG STARTER PACK	T3	QL (36/28 days) HD
IMVEXXY 4 MCG MAINTENANCE PACK	T3	QL (16/28 days) HD
IMVEXXY 4 MCG STARTER PACK	T3	QL (36/28 days) HD
<b>VAGINAL ESTROGEN PREPARATIONS</b>		
ESTRACE (estradiol)	T3	HD
estradiol (Vagifem)	T1	QL (36 tabs/28 days) HD
estradiol 0.01% cream (Estrace)	T1	HD
estradiol 10 mcg vaginal insrt (Vagifem)	T1	QL (36 tabs/28 days) HD
ESTRING	T2	QL (2 rings/90 days) HD
FEMRING	T3	HD
PREMARIN	T2	HD
VAGIFEM (yuvafem)	T3	QL (36 tabs/28 days) HD

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

T4 – Specialty Medications

PA – Prior Authorization

QL – Quantity Limit

ST – Step Therapy

AGE – Age Requirement

SP – Specialty Medication

HD – May require home delivery pharmacy

PPACA – No Cost-Share Preventive Medication

CSL – Oral cancer medication subject to cost-share limits

## List of Prescription Medications

HORMONES (Infertility)			
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits	
<b>FERTILITY STIMULATING PREPARATIONS, NON-FSH</b>			
<i>clomiphene citrate</i>	T1		
<b>FOLLICLE-STIMULATING AND LUTEINIZING HORMONES</b>			
MENOPUR	T4	PA SP	
<b>FOLLICLE-STIMULATING HORMONE (FSH)</b>			
FOLLISTIM AQ	T4	PA SP	
GONAL-F	T4	PA SP	
GONAL-F RFF	T4	PA SP	
GONAL-F RFF REDI-JECT	T4	PA SP	
<b>HUMAN CHORIONIC GONADOTROPIN (HCG)</b>			
CHORIONIC GONAD 10,000 UNIT VL	T4	PA SP	
CHORIONIC GONAD 12,000 UNIT VL	T4	SP	
CHORIONIC GONAD 6,000 UNIT VL	T4	SP	
NOVAREL 10,000 UNITS VIAL	T4	PA SP	
NOVAREL 5,000 UNIT VIAL	T4	PA SP	
OIDREL	T4	PA SP	
PREGNYL	T4	PA SP	
<b>FACILITATING/MAINTAINING AGENT, HORMONAL</b>			
CRINONE 8% GEL	T2		
ENDOMETRIN	T2		
<b>PREGNANCY FACILITATING/MAINTAINING AGENT, HORMONAL</b>			
<i>hydroxyprogesterone caproate</i>	T1	PA	
<i>hydroxyprogesterone caproate</i>	T1	PA	
MAKENA	T3	PA	
MAKENA ( <i>hydroxyprogesterone caproate</i> )	T4	PA SP	
HORMONES (Miscellaneous)			
<b>LEPTIN HORMONE ANALOGS</b>			
MYALEPT	T4	PA SP HD	
HORMONES (Osteoporosis Products)			
<b>BONE FORMATION STIMULATING AGTS - PTH REL PEPTIDES</b>			
TYMLOS	T4	PA QL (1 pen/30 days) SP HD	
<b>BONE RESORPTION INHIBITORS</b>			
JESDUVROQ 1 MG, 2 MG, 4 MG TABLET	T3	PA QL(1 tab/day)	
JESDUVROQ 6 MG TABLET	T3	PA QL(2 tabs/day)	
JESDUVROQ 8 MG TABLET	T3	PA QL(3 tabs/day)	
T1 – Typically Generics T2 – Typically Preferred Brands T3 – Typically Non-Preferred Brands	T4 – Specialty Medications PA – Prior Authorization QL – Quantity Limit	ST – Step Therapy AGE – Age Requirement SP – Specialty Medication	HD – May require home delivery pharmacy PPACA – No Cost-Share Preventive Medication CSL – Oral cancer medication subject to cost-share limits

## List of Prescription Medications

HORMONES (Osteoporosis Products) (con't.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>BONE RESORPTION INHIBITORS (con't.)</b>		
calcitonin, salmon, synthetic	T1	HD
MIACALCIN	T3	HD
<b>IMMUNOSUPPRESSANTS (Miscellaneous)</b>		
<b>IMMUNOSUPPRESSANT-INTERFERON GAMMA INHIBITOR, MAB</b>		
GAMIFANT	T4	PA SP
<b>IMMUNOSUPPRESSANTS (Pain Relief And Inflammatory Disease)</b>		
<b>ANTI-CD19 (B LYMPHOCYTE) MONOCLONAL ANTIBODY</b>		
UPLIZNA	T4	PA SP
<b>IL-23 RECEPTOR ANTAGONIST, MONOCLONAL ANTIBODY</b>		
OMVOH 100 MG/ML SYRINGE	T4	PA QL SP HD
OMVOH 300 MG/15 ML VIAL	T4	PA SP HD
OMVOH PEN	T4	PA QL(2 pens/28 days) SP HD
<b>INTERLEUKIN-4(IL-4) RECEPTOR ALPHA ANTAGONIST, MAB</b>		
DUPIXENT PEN	T4	PA SP HD
DUPIXENT SYRINGE	T4	PA SP HD
<b>INTERLEUKIN-6 (IL-6) RECEPTOR INHIBITORS</b>		
ACTEMRA 80 MG/4 ML VIAL	T4	PA SP HD
ACTEMRA 162 MG/0.9 ML SYRINGE	T4	PA QL (4 syringes/28 days) SP HD
ACTEMRA 200 MG/10 ML VIAL	T4	PA SP HD
ACTEMRA 400 MG/20 ML VIAL	T4	PA SP HD
ACTEMRA ACTPEN	T4	PA QL (4 pens/28 days) SP HD
ENSPRYNG	T4	PA SP HD
KEVZARA 150 MG/1.14 ML PEN INJ	T4	PA QL (2 pens/28 days) SP HD
KEVZARA 150 MG/1.14 ML SYRINGE	T4	PA QL (2 syringes/28 days) SP HD
KEVZARA 200 MG/1.14 ML PEN INJ	T4	PA QL (2 pens/28 days) SP HD
KEVZARA 200 MG/1.14 ML SYRINGE	T4	PA QL (2 syringes/28 days) SP HD
TOFIDENCE	T4	PA SP
TYENNE	T4	PA QL(3.6 ml/28 days) SP
<b>IMMUNOSUPPRESSANTS (Transplant Medications)</b>		
<b>MONOCLONAL ANTIBODY-HUMAN INTERLEUKIN 12/23 INHIB</b>		
OTULFI	T4	PA QL(1 syringe/84 days) SP
PYZCHIVA	T4	PA QL(1 syringe/84 days) SP
SELARSDI	T4	PA QL(1 syringe/84 days) SP

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

T4 – Specialty Medications

PA – Prior Authorization

QL – Quantity Limit

ST – Step Therapy

AGE – Age Requirement

SP – Specialty Medication

HD – May require home delivery pharmacy

PPACA – No Cost-Share Preventive Medication

CSL – Oral cancer medication subject to cost-share limits

## List of Prescription Medications

### IMMUNOSUPPRESSANTS (Transplant Medications) (con't.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>MONOCLONAL ANTIBODY-HUMAN INTERLEUKIN 12/23 INHIB (con't.)</b>		
STELARA 130 MG/26 ML VIAL	T4	PA SP HD
STELARA 45 MG/0.5 ML SYRINGE	T4	PA QL (1 syringe/84 days) SP HD
STELARA 45 MG/0.5 ML VIAL	T4	PA QL (1 vial/84 days) SP HD
STELARA 90 MG/ML SYRINGE	T4	PA QL (1 syringe/84 days) SP HD
STEQEYMA	T4	PA QL(1 syringe/84 days) SP
USTEKINUMAB-TTWE	T4	PA QL(1 syringe/84 days) SP HD
YESINTEK	T4	PA QL(1 syringe/84 days) SP
<b>TOPICAL IMMUNOSUPPRESSIVE AGENTS</b>		
ELIDEL ( <i>pimecrolimus</i> )	T3	
<i>pimecrolimus</i> (Elidel)	T1	
PROTOPIC ( <i>tacrolimus</i> )	T3	
<i>tacrolimus</i> 0.03% ointment (Protopic)	T1	
<i>tacrolimus</i> 0.1% ointment (Protopic)	T1	
<b>IMMUNOSUPP - MONOCLONAL AB INHIBITING T LYMPH FXN</b>		
SIMULECT	T4	SP
<b>IMMUNOSUPPRESSIVES</b>		
ASTAGRAF XL	T4	SP HD
AZASAN	T4	SP HD
<i>azathioprine</i> (Imuran)	T4	PA SP HD
<i>azathioprine sodium</i>	T1	PA
CELLCEPT 200 MG/ML ORAL SUSP ( <i>mycophenolate mofetil</i> )	T4	PA SP HD
CELLCEPT 250 MG CAPSULE ( <i>mycophenolate mofetil</i> )	T4	PA SP HD
CELLCEPT 500 MG TABLET ( <i>mycophenolate mofetil</i> )	T4	PA SP HD
CELLCEPT 500 MG VIAL ( <i>mycophenolate mofetil</i> )	T4	SP
<i>cyclosporine</i> 100 mg capsule (Sandimmune)	T4	SP HD
<i>cyclosporine</i> 25 mg capsule (Sandimmune)	T4	SP HD
<i>cyclosporine</i> 250 mg/5 ml ampul (Sandimmune)	T4	SP
<i>cyclosporine</i> , modified	T4	SP HD
<i>cyclosporine</i> , modified (Neoral)	T4	SP HD
ENVARSUS XR	T4	SP HD
<i>everolimus</i> 0.25 mg tablet (Zortress)	T4	SP HD
<i>everolimus</i> 0.5 mg tablet (Zortress)	T4	SP HD
<i>everolimus</i> 0.75 mg tablet (Zortress)	T4	SP HD
IMURAN ( <i>azathioprine</i> )	T4	SP HD

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

T4 – Specialty Medications

PA – Prior Authorization

QL – Quantity Limit

ST – Step Therapy

AGE – Age Requirement

SP – Specialty Medication

HD – May require home delivery pharmacy

PPACA – No Cost-Share Preventive Medication

CSL – Oral cancer medication subject to cost-share limits

## List of Prescription Medications

### IMMUNOSUPPRESSANTS (Transplant Medications) (con't.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>IMMUNOSUPPRESSIVES (cont.)</b>		
LUPKYNIS	T4	PA SP QL (6 caps/day)
<i>mycophenolate 200 mg/ml susp (Cellcept)</i>	T4	SP HD
<i>mycophenolate 250 mg capsule (Cellcept)</i>	T4	SP HD
<i>mycophenolate 500 mg tablet (Cellcept)</i>	T4	SP HD
<i>mycophenolate 500 mg vial (Cellcept)</i>	T4	SP
<i>mycophenolate sodium (Myfortic)</i>	T4	SP HD
MYFORTIC ( <i>mycophenolic acid</i> )	T4	PA SP HD
MYHIBBIN	T4	PA SP
NEORAL ( <i>gengraf</i> )	T1	PA SP HD
NULOJIX	T4	SP
PROGRAF 0.2 MG GRANULE PACKET	T4	SP HD
PROGRAF 0.5 MG CAPSULE ( <i>tacrolimus</i> )	T4	SP HD
PROGRAF 1 MG CAPSULE ( <i>tacrolimus</i> )	T4	SP HD
PROGRAF 1 MG GRANULE PACKET	T4	SP HD
PROGRAF 5 MG CAPSULE ( <i>tacrolimus</i> )	T4	SP HD
PROGRAF 5 MG/ML AMPULE	T4	SP
RAPAMUNE ( <i>sirolimus</i> )	T4	PA SP HD
SANDIMMUNE 100 MG CAPSULE ( <i>cyclosporine</i> )	T4	PA SP HD
SANDIMMUNE 100 MG/ML SOLN	T4	SP HD
SANDIMMUNE 25 MG CAPSULE ( <i>cyclosporine</i> )	T1	PA SP HD
SANDIMMUNE 50 MG/ML AMPUL ( <i>cyclosporine</i> )	T4	PA SP
<i>sirolimus (Rapamune)</i>	T4	SP HD
<i>tacrolimus capsule (ir) (Prograf)</i>	T4	SP HD
ZORTRESS	T4	SP HD

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

BLOOD SUGAR DIAGNOSTICS		
BLULINK GLUCOSE TEST STRIP	T3	
CONTOUR PLUS TEST STRIP	T3	
EASY TOUCH BLULINK TEST STRIP	T3	
DIABETIC SUPPLIES		
2TEK CONTROL SOLUTION	T1	
2TEK GLUCOSE-WRIST MONITOR KIT	T3	
ACCU-CHEK	T1	
ACCU-CHEK FASTCLIX LANCING DEV	T1	
11 – Typically Generics	I4 – Specialty Medications	SI – Step Therapy
T2 – Typically Preferred Brands	PA – Prior Authorization	AGE – Age Requirement
T3 – Typically Non-Preferred Brands	QL – Quantity Limit	SP – Specialty Medication
HD – 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) (con't.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>DIABETIC SUPPLIES (cont.)</b>		
ACCU-CHEK GUIDE CONTROL SOLN	T1	
ACCU-CHEK SMARTVIEW CTRL SOL	T1	
ACCU-CHEK SOFTCLIX	T1	
ACCUTREND GLUCOSE CONTROL	T1	
ADJUSTABLE LANCING DEVICE	T1	
ADVANCED LANCING DEVICE	T1	
ADVOCATE CONTROL SOLUTION	T1	
ADVOCATE LANCING DEVICE	T1	
ADVOCATE RAPID-SAFE LANCING DV	T1	
ADVOCATE REDI-CODE+ CTRL SOLN	T1	
AGAMATRIX CONTROL	T1	
ALKALINE BATTERIES	T1	
ALTERNATE SITE LANCING DEVICE	T1	
AQUA LANCE LANCING DEVICE	T1	
ASSURE 4 CONTROL SOLUTION	T1	
ASSURE DOSE	T1	
ASSURE PRISM	T1	
AT HOME A1C	T1	
AUTOJECT 2	T1	
AUTO-LANCET MINI	T1	
AUTOLET IMPRESSION	T1	
AUTOLET LANCING DEVICE	T1	
AUTOLET PLUS	T1	
AUTOPEN	T1	
BLOOD-GLUCOSE CONTROL	T1	
BLULINK DIABETIC TEST BUNDLE	T3	
BLULINK DIABETIC TEST BUNDLE	T3	
BREEZE 2	T1	
CAREONE	T1	
CARESENS	T3	
CARETOUCH CONTROL SOLUTION	T1	
CARETOUCH LANCING DEVICE	T1	
CEQUR SIMPLICITY	T2	
CEQUR SIMPLICITY INSERTER	T2	
I1 – Typically Generics	I4 – Specialty Medications	SI – Step Therapy
T2 – Typically Preferred Brands	PA – Prior Authorization	AGE – Age Requirement
T3 – Typically Non-Preferred Brands	QL – Quantity Limit	SP – Specialty Medication
		HD – 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) (con't.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>DIABETIC SUPPLIES (cont.)</b>		
CHOSEN LANCING DEVICE	T1	
CLEVER CHOICE CONTROL SOLUTION	T1	
CONTOUR	T1	
CONTOUR METER	T1	
CONTOUR NEXT CONTROL SOLUTION	T1	
CONTROL SOLUTION	T1	
COOL CONTROL SOLUTION	T1	
DEXCOM	T3	
DEXCOM G4	T3	
DEXCOM G5	T3	
DEXCOM G5-G4 SENSOR	T3	
DEXCOM G6 RECEIVER	T2	PA QL (1 syringe/365 days)
DEXCOM G6 SENSOR	T2	PA QL (3/30 days)
DEXCOM G6 TRANSMITTER	T2	PA QL (1 syringe/67 days)
DEXCOM G7 SENSOR	T2	PA QL(3 sensors/30 days)
DEXCOM G7 RECEIVER	T2	PA QL(1 unit/365 days)
DIATRUE	T1	
DROPLET GENTEE LANCING DEVICE	T1	
DROPLET LANCING DEVICE	T1	
EASY MINI EJECT LANCING DEVICE	T1	
EASY PLUS II BLOOD GLUCOSE SYS	T1	
EASY PLUS II CONTROL SOLN HIGH	T1	
EASY PLUS II CONTROL SOLN LOW	T1	
EASY STEP CONTROL SOLUTION	T1	
EASY TALK BLOOD GLUCOSE METER	T1	
EASY TALK CONTROL SOLN LOW	T1	
EASY TALK HIGH CONTROL SOLN	T1	
EASY TALK PLUS II HIGH CONTROL	T1	
EASY TALK PLUS II LOW CTRL SLN	T1	
EASY TOUCH BLULINK CTRL SOLN	T1	
EASY TOUCH BLULINK GLUC SYST	T3	
EASY TOUCH CONTROL SOLUTION	T1	
EASY TOUCH LANCING DEVICE	T1	
EASY TRAK BLOOD GLUCOSE METER	T1	

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

T4 – Specialty Medications

PA – Prior Authorization

QL – Quantity Limit

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AGE – Age Requirement

SP – Specialty Medication

HD – May require home delivery pharmacy

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## List of Prescription Medications

### MISCELLANEOUS MEDICAL SUPPLIES, DEVICES, NON-DRUG (Diabetes) (con't.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits	
<b>DIABETIC SUPPLIES (cont.)</b>			
EASY TRAK CONTROL SOLN HIGH	T1		
EASY TRAK CONTROL SOLN LOW	T1		
EASYGLUCO PLUS CONTROL NORMAL	T1		
EASymax 15 LEVEL 2 SOLUTION	T1		
EASymax NORMAL CONTROL SOLN	T1		
ELEMENT COMPACT CONTROL SOLN	T1		
ELEMENT CONTROL SOLUTION	T1		
EMBRACE EVO BLOOD GLUCOSE KIT	T1		
EMBRACE EVO BLOOD GLUCOSE MTR	T1		
EMBRACE EVO LEVEL 1 CTRL SOLN	T1		
EMBRACE GLUC CONTROL SOLN HIGH	T1		
EMBRACE GLUCOSE CONTROL SOLN	T1		
EMBRACE LANCING DEVICE	T1		
EMBRACE PRO	T1		
EMBRACE TALK CONTROL SOLUTION	T1		
EMBRACE WAVE PLUS GLUCOSE MTR	T1		
ENLITE	T1		
ENLITE GLUCOSE SENSOR	T1		
ENLITE SERTER	T1		
EVENCARE G2 BLOOD GLUCOSE SYS	T1		
EVENCARE G2 CONTROL SOLUTION	T1		
EVENCARE G3 BLOOD GLUCOSE SYS	T1		
EVENCARE G3 CONTROL SOLUTION	T1		
EVERSENSE SENSOR-HOLDER	T3		
EVERSENSE SMART TRANSMITTER	T3		
EVOLUTION CONTROL SOLUTION	T1		
EZ-VAC	T1		
FORA CONTROL SOLUTION	T1		
FORA LANCING DEVICE	T1		
FORACARE GDH	T1		
FORA TN'GO ADVANCE MULTIFN MTR	T3		
FORTISCARE	T1		
FREESTYLE CONTROL SOLUTION	T1		
FREESTYLE LIBRE 2 READER	T2	PA QL (1 reader/day)	
T1 – Typically Generics	T4 – Specialty Medications	ST – Step Therapy	HD – May require home delivery pharmacy
T2 – Typically Preferred Brands	PA – Prior Authorization	AGE – Age Requirement	PPACA – No Cost-Share Preventive Medication
T3 – Typically Non-Preferred Brands	QL – Quantity Limit	SP – Specialty Medication	CSL – Oral cancer medication subject to cost-share limits

## List of Prescription Medications

### MISCELLANEOUS MEDICAL SUPPLIES, DEVICES, NON-DRUG (Diabetes) (con't.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>DIABETIC SUPPLIES (cont.)</b>		
FREESTYLE LIBRE 2 SENSOR	T2	PA QL (2 sensors/21 days)
FREESTYLE LIBRE 3 READER	T2	PA QL(1 unit/720 days)
FREESTYLE LIBRE 3 PLUS SENSOR	T2	PA QL(2 units/28 days)
FREESTYLE LIBRE 10 DAY READER	T2	PA QL (1 reader/day)
FREESTYLE LIBRE 10 DAY SENSOR	T2	PA QL (3/30 days)
FREESTYLE LIBRE 14 DAY READER	T2	PA QL (1 reader/day)
FREESTYLE LIBRE 14 DAY SENSOR	T2	PA QL (2/28 days)
FREESTYLE NAVIGATOR	T3	
GE100 CONTROL SOLUTION NORMAL	T1	
GE333 BLOOD GLUCOSE TEST STRIP	T3	
GE333 BLOOD GLUCOSE SYSTEM	T3	
GENTEEL VACUUM LANCING DEVICE	T1	
GLUCOCARD 01 CONTROL	T1	
GLUCOCARD EXPRESSION CNTRL SLN	T1	
GLUCOCARD EXPRESSION METER	T1	
GLUCOCARD EXPRESSION METER KIT	T1	
GLUCOCARD SHINE CONTROL SOLN	T1	
GLUCOCARD SHINE METER	T1	
GLUCOCARD SHINE METER KIT	T1	
GLUCOCOM AUTOLINK	T1	
GLUCOCOM CONTROL SOLUTION	T1	
GLUCOSE CONTROL	T1	
GLUCOSE CONTROL SOLUTION	T1	
GOJJI GLUCOSE CONTROL SOLUTION	T1	
GOJJI LANCING DEVICE	T1	
GUARDIAN CONNECT TRANSMITTER	T3	
GUARDIAN LINK 3	T3	
GUARDIAN REAL-TIME	T3	
GUARDIAN RT CHARGER	T1	
GUARDIAN RT STARTER KIT	T3	
GUARDIAN SENSOR 3	T3	
GUARDIAN TEST PLUG	T1	
HUMAPEN LUXURA HD	T3	
INPEN (FOR HUMALOG)	T1	

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

T4 – Specialty Medications

PA – Prior Authorization

QL – Quantity Limit

ST – Step Therapy

AGE – Age Requirement

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## List of Prescription Medications

### MISCELLANEOUS MEDICAL SUPPLIES, DEVICES, NON-DRUG (Diabetes) (con't.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>DIABETIC SUPPLIES (cont.)</b>		
INPEN (FOR NOVOLOG OR FIASP)	T1	
LITE TOUCH LANCING PEN	T1	
MOBILE LANCETS	T2	
MINILINK REAL-TIME TRANSMITTER	T2	
MINIMED 630G GUARDIAN START KT	T3	
NOVA MAX GLUCOSE CONTROL SOLN	T3	
NOVOPEN ECHO	T3	
ON CALL EXPRESS CONTROL SOLN	T1	
ON CALL LANCING DEVICE	T1	
ON CALL PLUS CONTROL	T1	
ON CALL PLUS LANCING DEVICE	T1	
ON CALL VIVID CONTROL	T1	
ONETOUCH DELICA PLUS LANC DEV	T1	
ONETOUCH ULTRA CONTROL SOLN	T1	
ONETOUCH VERIO HIGH CNTRL SOLN	T1	
ONETOUCH VERIO MID CNTRL SOLN	T1	
OMNIPOD DASH 5 PACK POD	T2	PA QL (6 boxes/30 days)
OMNIPOD 5 G6-G7 INTRO KT(GEN5)	T2	QL
OMNIPOD 5 G6-G7 PODS (GEN 5)	T2	QL
ONETOUCH ULTRASOFT 2 LANCET	T2	
OPTUMRX BLOOD GLUCOSE METER	T3	
OPTUMRX BLOOD GLUCOSE SYSTEM	T3	
OPTUMRX GLUCOSE CONTROL SOLN	T1	
OVAL TAPE	T1	
PARADIGM REAL-TIME	T2	
PIP GLUCOSE CONTROL SOLUTION	T1	
PRODIGY CONTROL SOLUTION	T1	
PRODIGY LANCING DEVICE	T1	
REFUAH PLUS GLUCOSE CONTROL	T1	
RELIAMED MINI LANCING DEVICE	T1	
REPLACEMENT PEDIATRIC MONITOR	T3	
RIGHTEST CONTROL SOLUTION	T1	
RIGHTEST GD500	T1	
SAFE-CLIP	T1	

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

T4 – Specialty Medications

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AGE – Age Requirement

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## List of Prescription Medications

### MISCELLANEOUS MEDICAL SUPPLIES, DEVICES, NON-DRUG (Diabetes) (con't.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>DIABETIC SUPPLIES (cont.)</b>		
SEN-SERTER	T2	
SIL-SERTER	T1	
SMARTDIABETES VANTAGE	T1	
SMARTEST	T1	
SOF-SENSOR	T2	
SOLUS V2 CONTROL SOLUTION	T1	
SOLUS V2 LANCING DEVICE	T1	
SURE COMFORT LANCING PEN	T1	
SUREFLEX	T1	
SURE-PEN	T1	
SURE-TEST EASYPLUS	T1	
TELCARE CONTROL SOLUTION	T1	
TRUE METRIX	T1	
TRUECONTROL	T1	
TRUEDRAW	T1	
ULTI-LANCE	T1	
ULTRATRAK BLOOD GLUCOSE METER	T1	
ULTRATRAK CONTROL SOL NORMAL	T1	
ULTRATRAK CONTROL SOLUTION	T1	
ULTRATRAK ULTIMATE CNTRL SOLN	T1	
ULTRATRAK ULTIMATE GLUCOSE MTR	T3	
UNISTIK 2	T1	
UNISTIK 2 NORMAL	T1	
UNISTIK 3	T1	
UNISTIK 3 COMFORT	T1	
UNISTIK 3 NEONATAL	T1	
UNISTRIP	T1	
V-GO 20	T2	
V-GO 30	T2	
V-GO 40	T2	
VERASENS CONTROL SOLUTION	T1	
VIVAGUARD INO CONTROL SOLUTION	T1	
VIVAGUARD LANCING DEVICE	T1	
WAVENSENSE CONTROL SOLUTION	T1	

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

T4 – Specialty Medications

PA – Prior Authorization

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## List of Prescription Medications

### MISCELLANEOUS MEDICAL SUPPLIES, DEVICES, NON-DRUG (Diabetes) (con't.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>DURABLE MEDICAL EQUIPMENT,MISC (GROUP I)</b>		
ADVOCATE SAFETY LANCET	T1	
BLULINK BG SYSTEM REFILL	T3	
CARESENS LANCET	T1	
CARETOUCH SAFETY LANCETS	T1	
LITE TOUCH LANCETS	T1	
ULTRA-THIN II 28G LANCETS	T1	
<b>NEEDLES/NEEDLELESS DEVICES</b>		
1ST TIER UNIFINE PENTIPS	T1	
1ST TIER UNIFINE PENTIPS PLUS	T1	
ABOUTTIME PEN NEEDLE	T1	
ADVOCATE PEN NEEDLES	T1	
AQINJECT PEN NEEDLE	T1	
ASSURE ID PEN NEEDLE	T1	
AUTOSHIELD DUO PEN NEEDLE	T1	
BLUNT NEEDLE	T1	
CAREFINE PEN NEEDLE	T1	
CARETOUCH HYPODERMIC NEEDLE	T1	
CARETOUCH PEN NEEDLE	T1	
CLICKFINE	T1	
COMFORT EZ PEN NEEDLE	T1	
COMFORT EZ PRO SAFETY PEN NDL	T1	
COMFORT TOUCH PEN NEEDLE	T1	
DROPLET MICRON PEN NEEDLE	T1	
DROPLET PEN NEEDLE	T1	
DROPSAFE PEN NEEDLE	T1	
DROPSAFE SICURA SAFETY NEEDLE	T1	
EASY COMFORT PEN NEEDLES	T1	
EASY GLIDE PEN NEEDLE	T1	
EASY TOUCH FLIPLOCK NEEDLE	T1	
EASY TOUCH FLIPLOCK NEEDLES	T1	
EASY TOUCH HYPODERMIC NEEDLE	T1	
EASY TOUCH PEN NEEDLE	T1	
EASY TOUCH SAFETY PEN NEEDLE	T1	
EASYPPOINT NEEDLE	T1	

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

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## List of Prescription Medications

### MISCELLANEOUS MEDICAL SUPPLIES, DEVICES, NON-DRUG (Diabetes) (con't.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>NEEDLES/NEEDLELESS DEVICES (con't.)</b>		
ECLIPSE NEEDLE	T1	
EMBRACE PEN NEEDLE	T1	
EXEL HUBER NEEDLE	T1	
EXEL HYPODERMIC NEEDLE	T1	
FILTER ASPIRATOR NEEDLE	T1	
FILTER NEEDLE	T1	
FLOW-EZE	T1	
HEALTHWISE PEN NEEDLE	T1	
HEALTHY ACCENTS UNIFINE PENTIP	T1	
HYPODERMIC NEEDLE	T1	
INCONTROL PEN NEEDLE	T1	
INSULIN PEN NEEDLE	T1	
INSUPEN	T1	
INSUPEN PEN NEEDLE	T1	
INTEGRA NEEDLE	T1	
INTEGRA PRECISIONGLIDE NEEDLE	T1	
LIFESHIELD BLUNT CANNULA	T1	
LITE TOUCH	T1	
MAXICOMFORT II PEN NEEDLE	T1	
MAXICOMFORT SAFETY PEN NEEDLE	T1	
MINI PEN NEEDLE	T1	
MINI ULTRA-THIN II	T1	
MONOJECT FILTER NEEDLE	T1	
NANO 2ND GEN PEN NEEDLE	T1	
NEEDLES	T1	
NOKOR ADMIX NEEDLE	T1	
NOKOR NEEDLE	T1	
NOVOFINE 32	T1	
NOVOFINE AUTOCOVER	T1	
NOVOFINE PLUS	T1	
NOVOTWIST	T1	
PEN NEEDLE	T1	

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

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## List of Prescription Medications

### MISCELLANEOUS MEDICAL SUPPLIES, DEVICES, NON-DRUG (Diabetes) (con't.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>NEEDLES/NEEDLELESS DEVICES (con't.)</b>		
PENTIPS	T1	
PIP PEN NEEDLE	T1	
POLY HUB NEEDLE	T1	
PRECISIONGLIDE	T1	
PREVENT DROPSAFE PEN NEEDLE	T1	
PRO COMFORT PEN NEEDLE	T1	
PURE COMFORT PEN NEEDLE	T1	
PURE COMFORT SAFETY PEN NEEDLE	T1	
RAYA SURE PEN NEEDLE	T1	
REGULAR BEVEL NEEDLES	T1	
SAFETY PEN NEEDLE	T1	
SAFETYGLIDE NEEDLE	T1	
SECURESAFE PEN NEEDLE	T1	
SHORT BEVEL NEEDLES	T1	
SKY SAFETY PEN NEEDLE	T1	
SPECIALTY USE NEEDLES	T1	
SURE COMFORT	T1	
SURE COMFORT PEN NEEDLE	T1	
SURE COMFORT SAFETY PEN NEEDLE	T1	
SURE-FINE PEN NEEDLES	T1	
TECHLITE PEN NEEDLE	T1	PA
TERUMO SURGUARD2	T1	
THIN WALL NEEDLES	T1	
TOPCARE CLICKFINE	T1	
TRANSFER NEEDLE	T1	
TRUE COMFORT PEN NEEDLE	T1	
TRUE COMFORT PRO PEN NEEDLE	T1	
TRUE COMFORT SAFETY PEN NEEDLE	T1	
TRUEPLUS PEN NEEDLE	T1	
ULTICARE PEN NEEDLE	T1	
ULTICARE SAFETY PEN NEEDLE	T1	
ULTIGUARD SAFEPACK-PEN NEEDLE	T1	
ULTILET PEN NEEDLE	T1	

T1 – Typically Generics

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T3 – Typically Non-Preferred Brands

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## List of Prescription Medications

### MISCELLANEOUS MEDICAL SUPPLIES, DEVICES, NON-DRUG (Diabetes) (con't.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>NEEDLES/NEEDLELESS DEVICES (con't.)</b>		
ULTRA FLO PEN NEEDLE	T1	
ULTRA THIN	T1	
ULTRACARE PEN NEEDLE	T1	
ULTRA-FINE MICRO PEN NEEDLE	T1	
ULTRA-FINE MINI PEN NEEDLE	T1	
ULTRA-FINE NANO PEN NEEDLE	T1	
ULTRA-FINE ORIGINAL PEN NEEDLE	T1	
ULTRA-FINE SHORT PEN NEEDLE	T1	
ULTRA-THIN II	T1	
UNIFINE PEN NEEDLE	T1	
UNIFINE PENTIPS	T1	
UNIFINE PENTIPS MAXFLOW	T1	
UNIFINE PENTIPS PLUS	T1	
UNIFINE PENTIPS PLUS MAXFLOW	T1	
UNIFINE SAFECONTROL	T1	
UNIFINE ULTRA PEN NEEDLE	T1	
VERIFINE PEN NEEDLE	T1	
VERIFINE PLUS PEN NEEDLE	T1	
YALE NEEDLE	T1	
<b>SYRINGES AND ACCESSORIES</b>		
ASSURE ID INSULIN SAFETY	T1	
CARETOUCH INSULIN SYRINGE	T1	
COMFORT EZ INSULIN SYRINGE	T1	
DROPLET INSULIN SYRINGE	T1	
DROPSAFE INSULIN SYRINGE	T1	
EASY COMFORT INSULIN SYRINGE	T1	
EASY GLIDE INSULIN SYRINGE	T1	
EASY TOUCH	T1	
EASY TOUCH FLIPLOCK INSULIN	T1	
EASY TOUCH INSULIN SAFETY	T1	
EASY TOUCH INSULIN SYRINGE	T1	
EASY TOUCH LUER LOCK INSULIN	T1	
EASY TOUCH SHEATHLOCK INSULIN	T1	
EASY TOUCH UNI-SLIP	T1	

T1 – Typically Generics

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T3 – Typically Non-Preferred Brands

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## List of Prescription Medications

### MISCELLANEOUS MEDICAL SUPPLIES, DEVICES, NON-DRUG (Diabetes) (con't.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>SYRINGES AND ACCESSORIES (con't.)</b>		
EASY-TOUCH INSULIN SYRINGE	T1	
ECLIPSE SYRINGE	T1	
FREESTYLE PRECISION	T1	
HEALTHWISE INSULIN SYRINGE	T1	
INSULIN SYRINGE	T2	
INSULIN SYRINGE U-500	T1	
LITETOUCH INSULIN SYRINGE	T1	
LUER-LOK SYRINGE	T1	
MAGELLAN INSULIN SAFETY SYRNG	T1	
MAGELLAN INSULIN SYRINGE	T1	
MINIMED RESERVOIR	T1	
MONOJECT INSULIN SYRINGE	T1	
PARADIGM	T3	
SECURESAFE INSULIN SYRINGE	T2	
SURE COMFORT INSULIN SYRINGE	T1	
SURE-JECT INSULIN SYRINGE	T1	
<i>syringe and needle,insulin,1ml</i>	T1	
<i>syringe-needle,insulin,0.5 ml</i>	T1	
<i>syring-needl,disp,insul,0.3 ml</i>	T1	
TECHLITE INSULIN SYRINGE	T1	
TERUMO INSULIN SYRINGE	T1	
THINPRO INSULIN SYRINGE	T1	
TOPCARE ULTRA COMFORT	T1	
TRUE COMFORT INSULIN SYRINGE	T1	
TRUEPLUS INSULIN SYRINGE	T1	
ULTICARE INSULIN SYRINGE	T1	
ULTIGUARD SAFE 1ML 30G 12.7MM	T1	
ULTIGUARD SAFE0.3ML 30G 12.7MM	T1	
ULTIGUARD SAFE0.5ML 30G 12.7MM	T1	
ULTIGUARD SAFEPACK 1ML 31G 8MM	T1	
ULTIGUARD SAFEPK 0.3ML 31G 8MM	T1	
ULTIGUARD SAFEPK 0.5ML 31G 8MM	T1	
ULTILET INSULIN SYRINGE	T1	
ULTRA COMFORT	T1	
T1 – Typically Generics	T4 – Specialty Medications	ST – Step Therapy
T2 – Typically Preferred Brands	PA – Prior Authorization	AGE – Age Requirement
T3 – Typically Non-Preferred Brands	QL – Quantity Limit	SP – Specialty Medication
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## List of Prescription Medications

### MISCELLANEOUS MEDICAL SUPPLIES, DEVICES, NON-DRUG (Diabetes) (con't.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>SYRINGES AND ACCESSORIES (con't.)</b>		
ULTRA FLO INSULIN SYRINGE	T1	
ULTRACARE INSULIN SYRINGE	T1	
ULTRA-THIN II	T1	
VANISHPOINT INSULIN SYRINGE	T1	
VEO INSULIN SYRINGE	T1	
VERIFINE INSULIN SYRINGE	T1	

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

DURABLE MEDICAL EQUIPMENT,MISC (GROUP I)	Tier	
1ST TIER UNILET COMFORTOUCH	T1	
2-IN-1 LANCET DEVICE	T1	
ACCU-CHEK FASTCLIX LANCET DRUM	T1	
ACCU-CHEK SAFE-T-PRO	T1	
ACCU-CHEK SAFE-T-PRO PLUS	T1	
ACCU-CHEK SOFTCLIX	T1	
ACTI-LANCE	T1	
ADVANCED TRAVEL LANCETS	T1	
ADVOCATE LANCET	T1	
ADVOCATE LANCETS	T1	
ALTERNATE SITE LANCETS	T1	
ASSURE HAEMOLANCE PLUS	T1	
ASSURE LANCE	T1	
ASSURE LANCE PLUS	T1	
BD MICROTAINER LANCETS	T1	
BD ULTRA-FINE	T1	
BD ULTRA-FINE II	T1	
BLOOD LANCETS	T1	
BULLSEYE MINI SAFETY LANCETS	T1	
BUTTERFLY TOUCH LANCET	T1	
CAREONE	T1	
CARESENS LANCET	T1	
CARETOUCH TWIST LANCET	T1	
CLEVER CHEK LANCETS	T1	
COAGUCHEK	T1	
COLOR LANCETS	T1	

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

T4 – Specialty Medications

PA – Prior Authorization

QL – Quantity Limit

ST – Step Therapy

AGE – Age Requirement

SP – Specialty Medication

HD – May require home delivery pharmacy

PPACA – No Cost-Share Preventive Medication

CSL – Oral cancer medication subject to cost-share limits

## List of Prescription Medications

### MISCELLANEOUS MEDICAL SUPPLIES, DEVICES, NON-DRUG (Miscellaneous) (con't.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>DURABLE MEDICAL EQUIPMENT,MISC (GROUP I) (con't.)</b>		
COMFORT EZ	T1	
COMFORT LANCETS	T1	
COMFORT TOUCH PLUS SAFETY LANC	T1	
COMFORT TOUCH ULT THIN LANCET	T1	
DROPLET LANCETS	T1	
EASY COMFORT LANCETS	T1	
EASY TOUCH	T1	
EASYTWIST & CAP LANCETS	T1	
EMBRACE 30G LANCETS	T1	
EMBRACE SAFETY LANCET	T1	
EZ SMART LANCETS	T1	
EZ-LETS	T1	
FIFTY50 SAFETY SEAL LANCETS	T1	
FINE 30 UNIVERSAL LANCETS	T1	
FINGERSTIX	T1	
FORA LANCETS	T1	
FORACARE LANCETS	T1	
FREESTYLE LANCETS	T1	
FREESTYLE UNISTIK 2	T1	
GLUCOCOM	T1	
GLUCOCOM LANCETS	T1	
GOJJI LANCETS	T1	
HEALTHY ACCENTS UNILET LANCET	T1	
INCONTROL SUPER THIN LANCETS	T1	
INCONTROL ULTRA THIN LANCETS	T1	
INJECT EASE LANCETS	T1	
INVACARE LANCETS	T1	
<i>lancets</i>	T1	
LANCETS	T1	
LANCETS THIN	T1	
LANCETS ULTRA THIN	T1	
LITE TOUCH	T1	
MEDISENSE THIN LANCETS	T1	
MEDLANCE PLUS	T1	

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

T4 – Specialty Medications

PA – Prior Authorization

QL – Quantity Limit

ST – Step Therapy

AGE – Age Requirement

SP – Specialty Medication

HD – May require home delivery pharmacy

PPACA – No Cost-Share Preventive Medication

CSL – Oral cancer medication subject to cost-share limits

## List of Prescription Medications

### MISCELLANEOUS MEDICAL SUPPLIES, DEVICES, NON-DRUG (Miscellaneous) (con't.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>DURABLE MEDICAL EQUIPMENT,MISC (GROUP I) (con't.)</b>		
MEDLANCE PLUS SPECIAL BLADE	T1	
MICRO THIN LANCET	T1	
MICRO THIN LANCETS	T1	
MICROLET	T1	
MICROTAINER LANCETS	T1	
MOBILE LANCETS	T1	
MONOLET LANCETS	T1	
MONOLETTHIN LANCETS	T1	
MYGLUCOHEALTH LANCETS	T1	
NOVA SAFETY LANCETS	T1	
NOVA SUREFLEX	T1	
ON CALL LANCET	T1	
ON CALL PLUS LANCET	T1	
ONETOUCH DELICA PLUS LANCET	T1	
ONETOUCH DELICA SAFETY LANCET	T1	
ONETOUCH LANCETS	T1	
ONETOUCH SURESOFT	T1	
ONETOUCH ULTRASOFT 2 LANCET	T1	
ON-THE-GO	T1	
PIP LANCET	T1	
PRESSURE ACTIVATED LANCETS	T1	
PRO COMFORT LANCET	T1	
PRO COMFORT LANCETS	T1	
PRO COMFORT SAFETY LANCET	T1	
PRODIGY LANCETS	T1	
PRODIGY TWIST TOP LANCET	T1	
PURE COMFORT LANCETS	T1	
PURE COMFORT SAFETY LANCETS	T1	
PUSH BUTTON SAFETY LANCETS	T1	
READYLANCE SAFETY LANCETS	T1	
RELIAMED	T1	
RELIAMED SAFETY SEAL LANCETS	T1	
RIGHTEST GL300 LANCETS	T1	

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

T4 – Specialty Medications

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## List of Prescription Medications

### MISCELLANEOUS MEDICAL SUPPLIES, DEVICES, NON-DRUG (Miscellaneous) (con't.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>DURABLE MEDICAL EQUIPMENT,MISC (GROUP I) (con't.)</b>		
SAFETY LANCETS	T1	
SAFETY SEAL LANCETS	T1	
SAFETY-LET	T1	
SINGLE-LET	T1	
SMART SENSE	T1	
SMART SENSE LANCETS	T1	
SMARTEST LANCET	T1	
SOFT TOUCH	T1	
SOLUS V2 28G LANCETS	T1	
SOLUS V2 LANCETS	T1	
STERILANCE TL	T1	
STERILE LANCETS	T1	
SUPER THIN LANCETS	T1	
SURE COMFORT LANCETS	T1	
SURE-LANCE	T1	
SURE-TOUCH	T1	
TECHLITE LANCETS	T1	
TEL CARE ULTRA THIN 30G LANCETS	T1	
THIN LANCETS	T1	
TOPCARE UNIVERSAL1 LANCET	T1	
TOPCARE UNIVERSAL1 THIN LANCET	T1	
TRUE COMFORT LANCET	T1	
TRUE COMFORT SAFETY LANCET	T1	
TRUEPLUS LANCET	T1	
TRUEPLUS LANCETS	T1	
TWIST LANCETS	T1	
TWIST TOP LANCET	T1	
ULTILET BASIC	T1	
ULTILET CLASSIC	T1	
ULTILET LANCETS	T1	
ULTILET SAFETY	T1	
ULTRA THIN LANCET	T1	
ULTRA THIN LANCETS	T1	

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

T4 – Specialty Medications

PA – Prior Authorization

QL – Quantity Limit

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## List of Prescription Medications

### MISCELLANEOUS MEDICAL SUPPLIES, DEVICES, NON-DRUG (Miscellaneous) (con't.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>DURABLE MEDICAL EQUIPMENT,MISC (GROUP I) (con't.)</b>		
ULTRA-CARE LANCETS	T1	
ULTRALANCE	T1	
ULTRA-THIN II	T1	
ULTRATLC LANCETS	T1	
UNILET COMFORTOUCH	T1	
UNILET EXCELITE	T1	
UNILET EXCELITE II	T1	
UNILET GP LANCET	T1	
UNILET LANCET	T1	
UNILET LANCETS	T1	
UNISTIK 3	T1	
UNISTIK 3 EXTRA	T1	
UNISTIK 3 NORMAL	T1	
UNISTIK COMFORT	T1	
UNISTIK CZT	T1	
UNISTIK EXTRA	T1	
UNISTIK NORMAL	T1	
UNISTIK PRO	T1	
UNISTIK SAFETY	T1	
UNISTIKTOUCH	T1	
UNIVERSAL 1	T1	
VERIFINE SAFETY LANCET MINI	T1	
VERIFINE UNIVERSAL LANCET	T1	
VIVAGUARD LANCET	T1	
<b>TISSUE BULKING IMPLANTS</b>		
BARRIGEL ( <i>hyaluronate sodium, stabilized</i> )	T4	PA SP HD

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

SKELETAL MUSCLE RELAXANTS			
AMRIX ER 15 MG CAPSULE ( <i>cyclobenzaprine hcl er</i> )	T3	PA QL (1 cap/day)	
AMRIX ER 30 MG CAPSULE ( <i>cyclobenzaprine hcl er</i> )	T3	PA	
<i>baclofen</i>	T1	HD	
BACLOFEN 25 MG/5 ML SUSPENSION	T3	PA HD	
BACLOFEN 15 MG TABLET	T1	PA HD	

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

T4 – Specialty Medications

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AGE – Age Requirement

SP – Specialty Medication

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## List of Prescription Medications

### MUSCLE RELAXANTS (Pain Relief And Inflammatory Disease) (con't.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>SKELETAL MUSCLE RELAXANTS (con't.)</b>		
BACLOFEN 10 MG/5 ML SOLUTION	T3	PA HD
<i>baclofen 10 mg tablet</i>	T1	
<i>baclofen 20 mg tablet</i>	T1	
<i>baclofen 25 mg/5 ml suspension (Fleqsuvy)</i>	T1	PA
<i>baclofen 5 mg tablet</i>	T1	
<i>baclofen (Gablofen)</i>	T1	
<i>carisoprodol (Soma)</i>	T1	
<i>carisoprodol/aspirin</i>	T1	
<i>chlorzoxazone 250 mg tablet</i>	T1	PA
<i>chlorzoxazone 375 mg tablet (Lorzone)</i>	T1	PA
<i>chlorzoxazone 500 mg tablet</i>	T1	
<i>chlorzoxazone 750 mg tablet (Lorzone)</i>	T1	PA
<i>cyclobenzaprine er 15 mg cap (Amrix)</i>	T1	PA QL (1 cap/day)
<i>cyclobenzaprine er 30 mg cap (Amrix)</i>	T1	PA
<i>cyclobenzaprine hcl</i>	T1	
<i>cyclobenzaprine hcl (Fexmid)</i>	T1	
DANTRIUM	T3	
DANTRIUM ( <i>dantrolene sodium</i> )	T3	
<i>dantrolene sodium</i>	T1	
<i>dantrolene sodium (Dantrium)</i>	T1	
FEXMID ( <i>cyclobenzaprine hcl</i> )	T3	
FLEQSUVY ( <i>baclofen</i> )	T3	PA HD
GABLOFEN	T3	
GABLOFEN ( <i>baclofen</i> )	T3	
LIORESAL INTRATHECAL	T3	
LORZONE ( <i>chlorzoxazone</i> )	T3	PA
LYVISPAN	T3	PA
<i>metaxalone</i>	T1	
<i>metaxalone (Skelaxin)</i>	T1	
<i>methocarbamol</i>	T1	
<i>methocarbamol (Robaxin)</i>	T1	
<i>methocarbamol (Robaxin-750)</i>	T1	
NORGESIC FORTE	T3	
<i>orphenadrine citrate</i>	T1	

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

T4 – Specialty Medications

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ST – Step Therapy

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SP – Specialty Medication

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## List of Prescription Medications

### MUSCLE RELAXANTS (Pain Relief And Inflammatory Disease) (con't.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>SKELETAL MUSCLE RELAXANTS (con't.)</b>		
orphenadrine/aspirin/caffeine (Norgesic Forte)	T1	
OZOBAX	T3	PA HD
OZOBAX DS	T3	PA HD
ROBAXIN	T3	
ROBAXIN-750 ( <i>methocarbamol</i> )	T3	
RYANODEX	T3	
SKELAXIN ( <i>metaxalone</i> )	T3	
SOMA ( <i>carisoprodol</i> )	T3	PA
tizanidine hcl	T1	PA
tizanidine hcl (Zanaflex)	T1	PA
ZANAFLEX ( <i>tizanidine hcl</i> )	T3	

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

PRENATAL VITAMIN PREPARATIONS		
ATABEX EC	T3	
CITRANATAL 90 DHA	T2	
CITRANATAL ASSURE	T2	
CITRANATAL DHA	T2	
CITRANATAL HARMONY	T2	
CITRANATAL RX	T2	
OBSTETRIX EC	T2	
OBTREX DHA	T3	
<i>pnv 22/iron, gluc/folic/dss/dha</i>	T1	
<i>pnv 66/iron/folic/docusate/dha</i>	T1	
<i>pnv 69/iron/folic/docusate/dha</i>	T1	
<i>pnv 80/iron fum/folic/dss/dha</i>	T1	
<i>pnv/ferrous fum/docusate/folic</i>	T1	
<i>pnv/iron, carb/docusat/folic ac</i>	T1	
<i>prenatal 12/iron/folic/dss/om3 (Obtrex Dha)</i>	T1	
PRENATAL 19	T1	
<i>prenatal 34/iron/folic/dss/dha</i>	T1	
<i>prenatal vits15/iron/folic/dss</i>	T1	
VITAFOL FE+	T2	

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

T4 – Specialty Medications

PA – Prior Authorization

QL – Quantity Limit

ST – Step Therapy

AGE – Age Requirement

SP – Specialty Medication

HD – May require home delivery pharmacy

PPACA – No Cost-Share Preventive Medication

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## List of Prescription Medications

### PSYCHOTHERAPEUTIC DRUGS (Anxiety/Depression/Bipolar Disorder)<sup>8</sup>

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits	
<b>ALPHA-2 RECEPTOR ANTAGONIST ANTI-DEPRESSANTS</b>			
mirtazapine	T1	HD	
mirtazapine (Remeron)	T1	HD	
QELBREE	T3	PA QL	
QELBREE ER	T3	PA QL(2 caps/day) HD	
REMERON (mirtazapine)	T3	PA HD	
<b>ANTI-ANXIETY - BENZODIAZEPINES</b>			
ATIVAN (lorazepam)	T3	PA	
chlordiazepoxide hcl	T1		
clorazepate dipotassium	T1		
clorazepate dipotassium (Tranxene T-tab)	T1		
diazepam 10 mg tablet (Valium)	T1		
diazepam 10 mg/2 ml carpuject	T1		
diazepam 10 mg/2 ml syringe	T1		
diazepam 2 mg tablet (Valium)	T1		
diazepam 5 mg tablet (Valium)	T1		
diazepam 5 mg/5 ml solution	T1		
diazepam 5 mg/ml oral conc	T1		
diazepam 50 mg/10 ml vial	T1		
lorazepam	T1		
lorazepam (Ativan)	T1		
LOREEV XR	T4	PA QL (30 tabs/30 days) SP	
oxazepam	T1		
TRANXENET-TAB (clorazepate dipotassium)	T3	PA	
VALIUM (diazepam)	T3	PA	
XANAX (alprazolam)	T3	PA	
XANAX XR (alprazolam xr)	T3	PA	
<b>ANTI-ANXIETY DRUGS</b>			
buspirone hcl	T1		
meprobamate	T1		
<b>ANTIDEPRESSANT - NMDA RECEPTOR ANTAGONIST</b>			
SPRAVATO	T4	PA SP	
<b>ANTIDEPRESSANT - POSTPARTUM DEPRESSION (PPD)</b>			
ZURZUVAE 20 MG CAPSULE	T4	PA QL(28 caps/270 days) SP HD	
ZURZUVAE 25 MG CAPSULE	T4	PA QL(28 caps/270 day) SP HD	
ZURZUVAE 30 MG CAPSULE	T4	PA QL(14 caps/270 day) SP HD	
I1 – Typically Generics T2 – Typically Preferred Brands T3 – Typically Non-Preferred Brands	I4 – Specialty Medications PA – Prior Authorization QL – Quantity Limit	SI – Step Therapy AGE – Age Requirement SP – Specialty Medication	HD – 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)<sup>8</sup> (con't.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>BIPOLAR DISORDER DRUGS</b>		
EQUETRO	T3	HD
<i>lithium carbonate</i> (Lithobid)	T1	HD
<i>lithium citrate</i>	T1	HD
LITHOBID ( <i>lithium carbonate er</i> )	T3	PA HD
<b>MAOIS -NON-SELECTIVE, IRREVERSIBLE ANTI-DEPRESSANTS</b>		
MARPLAN	T3	QL (12 tabs/day)
NARDIL ( <i>phenelzine sulfate</i> )	T3	PA
PARNATE ( <i>tranylcypromine sulfate</i> )	T3	PA
<i>phenelzine sulfate</i> (Nardil)	T1	
<i>tranylcypromine sulfate</i> (Parnate)	T1	
<b>MONOAMINE OXIDASE (MAO) INHIBITOR ANTI-DEPRESSANTS</b>		
EMSAM 12 MG/24 HOURS PATCH	T3	QL (1 patch/day)
EMSAM 6 MG/24 HOURS PATCH	T3	QL (2 patches/day)
EMSAM 9 MG/24 HOURS PATCH	T3	QL (1 patch/day)
<b>NDMA RECEPTOR ANTAGONIST AND NDRI COMB</b>		
AUVELITY	T3	PA QL (60 tabs/30days)
<b>NOREPINEPHRINE AND DOPAMINE REUPTAKE INHIB (NDRIs)</b>		
APLENZIN ER 174 MG TABLET	T3	PA QL (3 tabs/day) HD
APLENZIN ER 348 MG TABLET	T3	PA QL (1 tab/day) HD
APLENZIN ER 522 MG TABLET	T3	PA QL (1 tab/day) HD
<i>bupropion hcl 100 mg tablet</i>	T1	QL (4 tabs/day) HD
<i>bupropion hcl 75 mg tablet</i>	T1	QL (6 tabs/day) HD
<i>bupropion hcl sr 100 mg tablet</i> (Wellbutrin Sr)	T1	QL (4 tabs/day) HD
<i>bupropion hcl sr 150 mg tablet</i> (Wellbutrin Sr)	T1	QL (2 tabs/day) HD
<i>bupropion hcl sr 200 mg tablet</i> (Wellbutrin Sr)	T1	QL (2 tabs/day) HD
<i>bupropion hcl xl 150 mg tablet</i> (Wellbutrin XI)	T1	QL (3 tabs/day) HD
<i>bupropion hcl xl 300 mg tablet</i> (Wellbutrin XI)	T1	QL (1 tab/day) HD
BUPROPION HCL XL 450 MG TABLET	T1	QL (1 tab/day) HD
FORFIVO XL	T3	QL (1 tab/day) ST HD
WELLBUTRIN SR 100 MG TABLET ( <i>bupropion hcl sr</i> )	T3	PA QL (4 tabs/day) HD
WELLBUTRIN SR 150 MG TABLET ( <i>bupropion hcl sr</i> )	T3	PA QL (2 tabs/day) HD
WELLBUTRIN SR 200 MG TABLET ( <i>bupropion hcl sr</i> )	T3	PA QL (2 tabs/day) HD
WELLBUTRIN XL 150 MG TABLET ( <i>bupropion xl</i> )	T3	PA QL (3 tabs/day) HD
WELLBUTRIN XL 300 MG TABLET ( <i>bupropion xl</i> )	T3	PA QL (1 tab/day) HD

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

T4 – Specialty Medications

PA – Prior Authorization

QL – Quantity Limit

ST – Step Therapy

AGE – Age Requirement

SP – Specialty Medication

HD – May require home delivery pharmacy

PPACA – No Cost-Share Preventive Medication

CSL – Oral cancer medication subject to cost-share limits

## List of Prescription Medications

### PSYCHOTHERAPEUTIC DRUGS (Anxiety/Depression/Bipolar Disorder)<sup>8</sup> (con't.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>SELECTIVE SEROTONIN 5-HT2A INVERSE AGONISTS (SSIAs)</b>		
NUPLAZID	T3	PA SP HD
<b>SELECTIVE SEROTONIN REUPTAKE INHIBITOR (SSRIs)</b>		
CELEXA 10 MG TABLET ( <i>citalopram hbr</i> )	T3	PA QL (6 tabs/day) HD
CELEXA 20 MG TABLET ( <i>citalopram hbr</i> )	T3	PA QL (3 tabs/day) HD
CELEXA 40 MG TABLET ( <i>citalopram hbr</i> )	T3	PA QL (1 tab/day) HD
<i>citalopram hbr 10 mg tablet</i> (Celexa)	T1	QL (6 tabs/day) HD
<i>citalopram hbr 10 mg/5 ml soln</i>	T1	QL (30ml/day) HD
<i>citalopram hbr 20 mg tablet</i> (Celexa)	T1	QL (3 tabs/day) HD
<i>citalopram hbr 20 mg/10 ml sol</i>	T1	QL (30ml/day) HD
<i>citalopram hbr 40 mg tablet</i> (Celexa)	T1	QL (1 tab/day) HD
<i>escitalopram 10 mg tablet</i> (Lexapro)	T1	QL (2 tabs/day) HD
<i>escitalopram 20 mg tablet</i> (Lexapro)	T1	QL (1 tab/day) HD
<i>escitalopram 5 mg tablet</i> (Lexapro)	T1	QL (4 tabs/day) HD
<i>escitalopram oxalate 5 mg/5 ml</i>	T1	QL (20ml/day) HD
<i>fluoxetine 20 mg/5 ml solution</i>	T1	QL (20 mls/day) HD
<i>fluoxetine hcl 10 mg capsule</i> (Prozac)	T1	QL (8 caps/day) HD
<i>fluoxetine hcl 10 mg tablet</i> (Sarafem)	T1	HD
<i>fluoxetine hcl 20 mg capsule</i> (Prozac)	T1	QL (4 caps/day) HD
<i>fluoxetine hcl 20 mg tablet</i>	T1	HD
<i>fluoxetine hcl 40 mg capsule</i> (Prozac)	T1	QL (2 caps/day) HD
<i>fluoxetine hcl 60 mg tablet</i>	T1	QL (1 tab/day) HD
<i>fluvoxamine er 100 mg capsule</i>	T1	QL (3 caps/day) HD
<i>fluvoxamine er 150 mg capsule</i>	T1	QL (2 caps/day) HD
<i>fluvoxamine maleate 100 mg tab</i>	T1	QL (3 tabs/day) HD
<i>fluvoxamine maleate 25 mg tab</i>	T1	QL (12 tabs/day) HD
<i>fluvoxamine maleate 50 mg tab</i>	T1	QL (6 tabs/day) HD
LEXAPRO 10 MG TABLET ( <i>escitalopram oxalate</i> )	T3	PA QL (2 tabs/day) HD
LEXAPRO 20 MG TABLET ( <i>escitalopram oxalate</i> )	T3	PA QL (1 tab/day) HD
LEXAPRO 5 MG TABLET ( <i>escitalopram oxalate</i> )	T3	PA QL (4 tabs/day) HD
<i>paroxetine cr 12.5 mg tablet</i> (Paxil Cr)	T1	QL (1 tab/day) HD
<i>paroxetine cr 25 mg tablet</i> (Paxil Cr)	T1	QL (3 tabs/day) HD
<i>paroxetine cr 37.5 mg tablet</i> (Paxil Cr)	T1	QL (2 tabs/day) HD
<i>paroxetine er 12.5 mg tablet</i> (Paxil Cr)	T1	QL (1 tab/day) HD
<i>paroxetine er 25 mg tablet</i> (Paxil Cr)	T1	QL (3 tabs/day) HD

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

T4 – Specialty Medications

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SP – Specialty Medication

HD – 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)<sup>8</sup> (con't.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>SELECTIVE SEROTONIN REUPTAKE INHIBITOR (SSRIs) (con't.)</b>		
paroxetine er 37.5 mg tablet (Paxil Cr)	T1	QL (2 tabs/day) HD
paroxetine hcl 10 mg tablet (Paxil)	T1	QL (6 tabs/day) HD
paroxetine hcl 20 mg tablet (Paxil)	T1	QL (3 tabs/day) HD
paroxetine hcl 30 mg tablet (Paxil)	T1	QL (2 tabs/day) HD
paroxetine hcl 40 mg tablet (Paxil)	T1	QL (1 tab/day) HD
PAXIL 10 MG TABLET (paroxetine hcl)	T3	PA QL (6 tabs/day) HD
PAXIL 10 MG/5 ML SUSPENSION	T3	PA QL (30ml/day) HD
PAXIL 20 MG TABLET (paroxetine hcl)	T3	PA QL (3 tabs/day) HD
PAXIL 30 MG TABLET (paroxetine hcl)	T3	PA QL (2 tabs/day) HD
PAXIL 40 MG TABLET (paroxetine hcl)	T3	PA QL (1 tab/day) HD
PAXIL CR 12.5 MG TABLET (paroxetine er)	T3	PA QL (1 tab/day) HD
PAXIL CR 25 MG TABLET (paroxetine er)	T3	PA QL (3 tabs/day) ST HD
PAXIL CR 37.5 MG TABLET (paroxetine er)	T3	PA QL (2 tabs/day) ST HD
PROZAC 10 MG PULVULE (fluoxetine hcl)	T3	PA QL (8 caps/day) HD
PROZAC 20 MG PULVULE (fluoxetine hcl)	T3	PA QL (4 caps/day) HD
PROZAC 40 MG PULVULE (fluoxetine hcl)	T3	PA QL (2 caps/day) HD
SARAFEM (fluoxetine hcl)	T3	ST HD
sertraline 20 mg/ml oral conc (Zoloft)	T1	QL (10ml/day) HD
sertraline hcl 100 mg tablet (Zoloft)	T1	QL (2 tabs/day) HD
sertraline hcl 25 mg tablet (Zoloft)	T1	QL (8 tabs/day) HD
sertraline hcl 50 mg tablet (Zoloft)	T1	QL (4 tabs/day) HD
ZOLOFT 100 MG TABLET (sertraline hcl)	T3	PA QL (2 tabs/day) HD
ZOLOFT 20 MG/ML ORAL CONC (sertraline hcl)	T3	PA QL (10ml/day) HD
ZOLOFT 25 MG TABLET (sertraline hcl)	T3	PA QL (8 tabs/day) HD
ZOLOFT 50 MG TABLET (sertraline hcl)	T3	PA QL (4 tabs/day) HD
<b>SEROTONIN-2 ANTAGONIST/REUPTAKE INHIBITORS (SARIs)</b>		
nefazodone hcl	T1	HD
trazodone hcl	T1	HD
<b>SEROTONIN-NOREpinephrine REUPTAKE-INHIB (SNRIs)</b>		
CYMBALTA 20 MG CAPSULE (duloxetine hcl)	T3	PA QL (6 caps/day) HD
CYMBALTA 30 MG CAPSULE (duloxetine hcl)	T3	PA QL (4 caps/day) HD
CYMBALTA 60 MG CAPSULE (duloxetine hcl)	T3	PA QL (2 caps/day) HD
DESVENLAFAKINE ER 100 MG TAB	T3	PA QL (4 tabs/day) HD
DESVENLAFAKINE ER 50 MG TAB	T3	PA QL (8 tabs/day) HD

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

T4 – Specialty Medications

PA – Prior Authorization

QL – Quantity Limit

ST – Step Therapy

AGE – Age Requirement

SP – Specialty Medication

HD – May require home delivery pharmacy

PPACA – No Cost-Share Preventive Medication

CSL – Oral cancer medication subject to cost-share limits

## List of Prescription Medications

### PSYCHOTHERAPEUTIC DRUGS (Anxiety/Depression/Bipolar Disorder)<sup>8</sup> (con't.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>SEROTONIN-NOREPINEPHRINE REUPTAKE-INHIB (SNRIs) (con't.)</b>		
desvenlafaxine succnt er 100mg (Pristiq)	T1	QL (4 tabs/day) HD
desvenlafaxine succnt er 25 mg (Pristiq)	T1	QL (16 tabs/day) HD
desvenlafaxine succnt er 50 mg (Pristiq)	T1	QL (1 tab/day) HD
DRIZALMA SPRINKLE DR 20 MG CAP	T3	QL (1 cap/day) ST HD
DRIZALMA SPRINKLE DR 30 MG CAP	T3	QL (1 cap/day) ST HD
DRIZALMA SPRINKLE DR 40 MG CAP	T3	QL (1 cap/day) ST HD
DRIZALMA SPRINKLE DR 60 MG CAP	T3	QL (2 caps/day) ST HD
duloxetine hcl dr 20 mg cap (Cymbalta)	T1	QL (6 caps/day) HD
duloxetine hcl dr 30 mg cap (Cymbalta)	T1	QL (4 caps/day) HD
duloxetine hcl dr 40 mg cap	T1	QL (3 caps/day) HD
duloxetine hcl dr 60 mg cap (Cymbalta)	T1	QL (2 caps/day) HD
EFFEXOR XR 150 MG CAPSULE (venlafaxine hcl er)	T3	PA QL (2 caps/day) HD
EFFEXOR XR 37.5 MG CAPSULE (venlafaxine hcl er)	T3	PA QL (8 caps/day) HD
EFFEXOR XR 75 MG CAPSULE (venlafaxine hcl er)	T3	PA QL (4 caps/day) HD
FETZIMA 20-40 MG TITRATION PAK	T3	QL (28 caps/180 days) ST HD
FETZIMA ER 120 MG CAPSULE	T3	QL (1 cap/day) ST HD
FETZIMA ER 20 MG CAPSULE	T3	QL (6 caps/day) ST HD
FETZIMA ER 40 MG CAPSULE	T3	QL (3 caps/day) ST HD
FETZIMA ER 80 MG CAPSULE	T3	QL (1 cap/day) ST HD
PRISTIQ ER 100 MG TABLET (desvenlafaxine succinate er)	T3	PA QL (4 tabs/day) HD
PRISTIQ ER 25 MG TABLET (desvenlafaxine succinate er)	T3	PA QL (16 tabs/day) HD
PRISTIQ ER 50 MG TABLET (desvenlafaxine succinate er)	T3	PA QL (1 tab/day) HD
venlafaxine hcl 100 mg tablet	T1	QL (3 tabs/day) HD
venlafaxine hcl 25 mg tablet	T1	QL (15 tabs/day) HD
venlafaxine hcl 37.5 mg tablet	T1	QL (10 tabs/day) HD
venlafaxine hcl 50 mg tablet	T1	QL (7 tabs/day) HD
venlafaxine hcl 75 mg tablet	T1	QL (5 tabs/day) HD
venlafaxine hcl er 150 mg cap (Effexor Xr)	T1	QL (2 caps/day) HD
venlafaxine hcl er 150 mg tab	T1	QL (2 tabs/day) HD
venlafaxine hcl er 225 mg tab	T1	QL (1 tab/day) HD
venlafaxine hcl er 37.5 mg cap (Effexor Xr)	T1	QL (8 caps/day) HD
venlafaxine hcl er 37.5 mg tab	T1	QL (8 tabs/day) HD
venlafaxine hcl er 75 mg cap (Effexor Xr)	T1	QL (4 caps/day) HD
venlafaxine hcl er 75 mg tab	T1	QL (4 tabs/day) HD

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

T4 – Specialty Medications

PA – Prior Authorization

QL – Quantity Limit

ST – Step Therapy

AGE – Age Requirement

SP – Specialty Medication

HD – May require home delivery pharmacy

PPACA – No Cost-Share Preventive Medication

CSL – Oral cancer medication subject to cost-share limits

## List of Prescription Medications

### PSYCHOTHERAPEUTIC DRUGS (Anxiety/Depression/Bipolar Disorder)<sup>8</sup> (con't.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>SSRI AND 5HTIA PARTIAL AGONIST ANTI-DEPRESSANTS</b>		
VIBRYD 10 MG TABLET	T3	PA QL (1 tab/day) HD
VIBRYD 20 MG TABLET	T3	PA QL (1 tab/day) HD
VIBRYD 40 MG TABLET	T3	PA HD
<b>SSRI, SEROTONIN RECEPTOR MODULATOR ANTI-DEPRESSANTS</b>		
TRINTELLIX 10 MG TABLET	T3	QL (1 tab/day) ST HD
TRINTELLIX 20 MG TABLET	T3	HD
TRINTELLIX 5 MG TABLET	T3	QL (1 tab/day) ST HD
<b>TRICYCLIC ANTI-DEPRESSANT-BENZODIAZEPINE COMBINATNS</b>		
<i>amitriptyline/chlordiazepoxide</i>	T1	HD
<b>TRICYCLIC ANTI-DEPRESSANT-PHENOTHIAZINE COMBINATNS</b>		
<i>perphenazine/amitriptyline hcl</i>	T1	HD
<b>TRICYCLIC ANTI-DEPRESSANTS, REL.NON-SEL.REUPT-INHIB</b>		
<i>amitriptyline hcl</i>	T1	HD
<i>amoxapine</i>	T1	HD
<i>ANAFRANIL (clomipramine hcl)</i>	T3	PA HD
<i>clomipramine hcl (Anafranil)</i>	T1	HD
<i>desipramine hcl</i>	T1	HD
<i>desipramine hcl (Norpramin)</i>	T1	HD
<i>doxepin 10 mg capsule</i>	T1	HD
<i>doxepin 10 mg/ml oral conc</i>	T1	HD
<i>doxepin 100 mg capsule</i>	T1	HD
<b>TRICYCLIC ANTI-DEPRESSANTS, REL.NON-SEL.REUPT-INHIB</b>		
<i>PRISTIQ ER 50 MG TABLET (desvenlafaxine succinate er)</i>	T3	PA QL (1 tab/day) HD
<i>venlafaxine hcl 100 mg tablet</i>	T1	QL (3 tabs/day) HD
<i>venlafaxine hcl 25 mg tablet</i>	T1	QL (15 tabs/day) HD
<i>venlafaxine hcl 37.5 mg tablet</i>	T1	QL (10 tabs/day) HD
<i>venlafaxine hcl 50 mg tablet</i>	T1	QL (7 tabs/day) HD
<i>venlafaxine hcl 75 mg tablet</i>	T1	QL (5 tabs/day) HD
<i>imipramine pamoate</i>	T1	HD
<i>maprotiline hcl</i>	T1	HD
<i>NORPRAMIN (desipramine hcl)</i>	T3	PA HD
<i>nortriptyline hcl</i>	T1	HD
<i>nortriptyline hcl (Pamelor)</i>	T1	HD
<i>PAMELOR (nortriptyline hcl)</i>	T3	PA HD

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

T4 – Specialty Medications

PA – Prior Authorization

QL – Quantity Limit

ST – Step Therapy

AGE – Age Requirement

SP – Specialty Medication

HD – May require home delivery pharmacy

PPACA – No Cost-Share Preventive Medication

CSL – Oral cancer medication subject to cost-share limits

## List of Prescription Medications

### PSYCHOTHERAPEUTIC DRUGS (Anxiety/Depression/Bipolar Disorder)<sup>8</sup> (con't.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>TRICYCLIC ANTI-DEPRESSANTS, REL.NON-SEL.REUPT-INHIB (con't.)</b>		
protriptyline hcl	T1	HD
trimipramine maleate	T1	HD
<b>PSYCHOTHERAPEUTIC DRUGS (Attention Deficit Hyperactivity Disorder)<sup>8</sup></b>		
<b>ADRENERGICS, AROMATIC, NON-CATECHOLAMINE</b>		
lisdexamfetamine 10 mg capsule (Vyvanse)	T1	PA QL(1 cap/day)
lisdexamfetamine 20 mg capsule (Vyvanse)	T1	PA QL(1 cap/day)
lisdexamfetamine 30 mg capsule (Vyvanse)	T1	PA QL(1 cap/day)
lisdexamfetamine 40 mg capsule (Vyvanse)	T1	PA QL(1 cap/day)
lisdexamfetamine 50 mg capsule (Vyvanse)	T1	PA QL(1 cap/day)
lisdexamfetamine 60 mg capsule (Vyvanse)	T1	PA QL(1 cap/day)
lisdexamfetamine 70 mg capsule (Vyvanse)	T1	PA QL(1 cap/day)
VYVANSE 10 MG CAPSULE (lisdexamfetamine dimesylate)	T3	PA QL (1 cap/day)
VYVANSE 10 MG CHEWABLE TABLET	T3	PA QL (1 tab/day)
VYVANSE 20 MG CAPSULE (lisdexamfetamine dimesylate)	T3	PA QL (1 per day)
VYVANSE 20 MG CHEWABLE TABLET	T3	PA QL (1 tab/day)
VYVANSE 30 MG CAPSULE (lisdexamfetamine dimesylate)	T3	PA QL (1 per day)
VYVANSE 30 MG CHEWABLE TABLET	T3	PA QL (1 tab/day)
VYVANSE 40 MG CAPSULE (lisdexamfetamine dimesylate)	T3	PA QL (1 cap/day)
VYVANSE 40 MG CHEWABLE TABLET	T3	PA QL (1 tab/day)
VYVANSE 50 MG CAPSULE (lisdexamfetamine dimesylate)	T3	PA QL (1 cap/day)
VYVANSE 50 MG CHEWABLE TABLET	T3	PA QL (1 tab/day)
VYVANSE 60 MG CAPSULE (lisdexamfetamine dimesylate)	T3	PA QL (1 cap/day)
VYVANSE 60 MG CHEWABLE TABLET	T3	PA QL (1 tab/day)
VYVANSE 70 MG CAPSULE (lisdexamfetamine dimesylate)	T3	PA QL (1 cap/day)
<b>TX FOR ADHD - SELECTIVE ALPHA-2 RECEPTOR AGONIST</b>		
clonidine hcl (Kapvay)	T1	
guanfacine hcl (Intuniv)	T1	HD
INTUNIV (guanfacine hcl er)	T3	PA HD
KAPVAY (clonidine hcl er)	T3	PA
<b>TX FOR ATTENTION DEFICIT-HYPERACT (ADHD)/NARCOLEPSY</b>		
ADHANSIA XR	T3	PA QL (1 cap/day) ST
APTENSIO XR (methylphenidate er)	T3	PA QL (1 cap/day) ST
CONCERTA (methylphenidate er)	T3	PA QL (1 tab/day) ST

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

T4 – Specialty Medications

PA – Prior Authorization

QL – Quantity Limit

ST – Step Therapy

AGE – Age Requirement

SP – Specialty Medication

HD – May require home delivery pharmacy

PPACA – No Cost-Share Preventive Medication

CSL – Oral cancer medication subject to cost-share limits

## List of Prescription Medications

### PSYCHOTHERAPEUTIC DRUGS (Attention Deficit Hyperactivity Disorder)<sup>8</sup> (con't.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>TX FOR ATTENTION DEFICIT-HYPERACT (ADHD)/NARCOLEPSY (con't.)</b>		
COTEMPLA XR-ODT 17.3 MG TABLET	T3	PA QL (1 tab/day)
COTEMPLA XR-ODT 25.9 MG TABLET	T3	PA QL (2 tabs/day)
COTEMPLA XR-ODT 8.6 MG TABLET	T3	PA QL (1 tab/day)
DAYTRANA 10 MG/9 HR PATCH ( <i>methylphenidate</i> )	T3	PA QL (1 patch/day)
DAYTRANA 15 MG/9 HR PATCH ( <i>methylphenidate</i> )	T3	PA QL (1 per day)
DAYTRANA 20 MG/9 HOUR PATCH ( <i>methylphenidate</i> )	T3	PA QL (1 patch/day)
DAYTRANA 30 MG/9 HOUR PATCH ( <i>methylphenidate</i> )	T3	PA QL (1 patch/day)
<i>dexamethylphenidate er 10 mg cp</i> (Focalin Xr)	T1	PA QL (1 cap/day)
<i>dexamethylphenidate er 15 mg cp</i> (Focalin Xr)	T1	PA QL (1 per day)
<i>dexamethylphenidate er 20 mg cp</i> (Focalin Xr)	T1	PA QL (1 cap/day)
<i>dexamethylphenidate er 25 mg cp</i> (Focalin Xr)	T1	PA QL (1 cap/day)
<i>dexamethylphenidate er 30 mg cp</i> (Focalin Xr)	T1	PA QL (1 cap/day)
<i>dexamethylphenidate er 35 mg cp</i> (Focalin Xr)	T1	PA QL (1 cap/day)
<i>dexamethylphenidate er 40 mg cp</i> (Focalin Xr)	T1	PA QL (1 cap/day)
<i>dexamethylphenidate er 5 mg cap</i> (Focalin Xr)	T1	PA QL (1 cap/day)
<i>dexamethylphenidate hcl</i> (Focalin)	T1	PA
FOCALIN ( <i>dexamethylphenidate hcl</i> )	T3	PA ST
FOCALIN XR ( <i>dexamethylphenidate hcl er</i> )	T3	PA QL (1 cap/day) ST
JORNAY PM	T3	PA QL (1 cap/day) ST
METADATE CD ( <i>methylphenidate hcl</i> )	T3	PA QL(1 cap/day)
METHYLIN ( <i>methylphenidate hcl</i> )	T3	PA
<i>methylphenidate er 10 mg cap</i> (Aptensio Xr)	T1	PA QL (1 per day)
<i>methylphenidate er 10 mg tab</i>	T1	PA QL (2/day)
<i>methylphenidate er 15 mg cap</i> (Aptensio Xr)	T1	PA QL (1 per day)
<i>methylphenidate er 18 mg tab</i>	T1	PA QL (1 per day)
<i>methylphenidate er 20 mg cap</i> (Aptensio Xr)	T1	PA QL (1 per day)
<i>methylphenidate er 20 mg tab</i>	T1	PA QL (3/day)
<i>methylphenidate er 27 mg tab</i>	T1	PA QL (1 tab/day)
<i>methylphenidate er 30 mg cap</i> (Aptensio Xr)	T1	PA QL (1 per day)
<i>methylphenidate er 36 mg tab</i>	T1	PA QL (1 per day)
<i>methylphenidate er 40 mg cap</i> (Aptensio Xr)	T1	PA QL (1 per day)
<i>methylphenidate er 50 mg cap</i> (Aptensio Xr)	T1	PA QL (1 per day)
<i>methylphenidate er 54 mg tab</i>	T1	PA QL (1 tab/day)
<i>methylphenidate er 60 mg cap</i> (Aptensio Xr)	T1	PA QL (1 per day)

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

T4 – Specialty Medications

PA – Prior Authorization

QL – Quantity Limit

ST – Step Therapy

AGE – Age Requirement

SP – Specialty Medication

HD – May require home delivery pharmacy

PPACA – No Cost-Share Preventive Medication

CSL – Oral cancer medication subject to cost-share limits

## List of Prescription Medications

### PSYCHOTHERAPEUTIC DRUGS (Attention Deficit Hyperactivity Disorder)<sup>8</sup> (con't.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>TX FOR ATTENTION DEFICIT-HYPERACT (ADHD)/NARCOLEPSY (con't.)</b>		
METHYLPHENIDATE ER 72 MG TAB	T1	PA QL (1 tab/day)
<i>methylphenidate hcl</i> (Metadate CD)	T1	PA QL (1 cap/day)
<i>methylphenidate hcl</i> (Methylin)	T1	PA
<i>methylphenidate hcl</i> (Ritalin La)	T1	PA QL (1 cap/day)
<i>methylphenidate hcl</i> (Ritalin)	T1	PA
<i>methylphenidate la</i> 10 mg cap (Ritalin La)	T1	PA QL (1 cap/day)
<i>methylphenidate la</i> 20 mg cap (Ritalin La)	T1	PA QL (1 cap/day)
<i>methylphenidate la</i> 30 mg cap (Ritalin La)	T1	PA QL (1 per day)
<i>methylphenidate la</i> 40 mg cap (Ritalin La)	T1	PA QL (1 cap/day)
<i>methylphenidate la</i> 60 mg cap	T1	PA QL (1 cap/day)
QUILLICHEW ER	T3	PA QL (1 tab/day)
QUILLIVANT XR	T3	PA QL (12ml/day)
RELEXXII	T3	PA QL (1 tab/day)
RITALIN ( <i>methylphenidate hcl</i> )	T3	PA ST
RITALIN LA ( <i>methylphenidate la</i> )	T3	PA QL (1 cap/day) ST
<b>TX FOR ATTENTION DEFICIT-HYPERACT.(ADHD), NRI-TYPE</b>		
atomoxetine hcl 10 mg capsule (Strattera)	T1	HD
atomoxetine hcl 100 mg capsule (Strattera)	T1	HD
atomoxetine hcl 18 mg capsule (Strattera)	T1	HD
atomoxetine hcl 25 mg capsule (Strattera)	T1	HD
atomoxetine hcl 40 mg capsule (Strattera)	T1	QL (1 cap/day) HD
atomoxetine hcl 60 mg capsule (Strattera)	T1	HD
atomoxetine hcl 80 mg capsule (Strattera)	T1	HD
STRATTERA 10 MG CAPSULE ( <i>atomoxetine hcl</i> )	T3	PA HD
STRATTERA 100 MG CAPSULE ( <i>atomoxetine hcl</i> )	T3	PA HD
STRATTERA 18 MG CAPSULE ( <i>atomoxetine hcl</i> )	T3	PA HD
STRATTERA 25 MG CAPSULE ( <i>atomoxetine hcl</i> )	T3	PA HD
STRATTERA 40 MG CAPSULE ( <i>atomoxetine hcl</i> )	T3	PA QL (1 cap/day) HD
STRATTERA 60 MG CAPSULE ( <i>atomoxetine hcl</i> )	T3	PA HD
STRATTERA 80 MG CAPSULE ( <i>atomoxetine hcl</i> )	T3	PA HD

### PSYCHOTHERAPEUTIC DRUGS (Miscellaneous)

#### HYPOACTIVE SEXUAL DESIRE DISORDER (HSDD) TX AGENTS

ADDYI	T3	QL (1 tab/day)
VYLEESI	T3	PA QL (8 injectors/30 days) SP
I1 – Typically Generics	I4 – Specialty Medications	S1 – Step Therapy
T2 – Typically Preferred Brands	PA – Prior Authorization	AGE – Age Requirement
T3 – Typically Non-Preferred Brands	QL – Quantity Limit	SP – Specialty Medication
		HD – 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)<sup>8</sup>

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits	
<b>ANTI-PSYCH, DOPAMINE ANTAG., DIPHENYLBUTYLPIPERIDINES</b>			
pimozide	T1		
<b>ANTI-PSYCHOTIC, ATYPICAL, DOPAMINE, SEROTONIN ANTAGNST</b>			
asenapine maleate (Saphris)	T1		
CAPLYTA	T3	QL (1 caps/day) ST	
clozapine	T1		
clozapine (Clozapine Odt)	T1		
clozapine (Clozaril)	T1		
clozapine (Fazacllo)	T1		
CLOZAPINE ODT	T1		
CLOZARIL (clozapine)	T3	PA	
FANAPT 1 MG TABLET	T3	QL (4 tabs/day) ST	
FANAPT 2 MG TABLET	T3	QL (4 tabs/day) ST	
FANAPT 4 MG TABLET	T3	QL (4 tabs/day) ST	
FANAPT 6 MG TABLET	T3	QL (4 tabs/day) ST	
FANAPT 8 MG TABLET	T3	QL (4 tabs/day) ST	
FANAPT 10 MG TABLET	T3	QL (4 tabs/day) ST	
FANAPT 12 MG TABLET	T3	ST	
FANAPT TITRATION PACK	T3	PA QL (4 packs/year) ST	
FAZACLO (clozapine odt)	T3	PA	
GEODON 20 MG CAPSULE (ziprasidone hcl)	T3	PA	
GEODON 20 MG/ML VIAL	T3		
GEODON 40 MG CAPSULE (ziprasidone hcl)	T3	PA	
GEODON 60 MG CAPSULE (ziprasidone hcl)	T3	PA	
GEODON 80 MG CAPSULE (ziprasidone hcl)	T3	PA	
INVEGA ER 1.5 MG TABLET (paliperidone er)	T3	ST	
INVEGA ER 3 MG TABLET (paliperidone er)	T3	QL (1 tab/day) ST	
INVEGA ER 6 MG TABLET (paliperidone er)	T3	ST	
INVEGA ER 9 MG TABLET (paliperidone er)	T3	ST	
INVEGA SUSTENNA 117 MG/0.75 ML	T3	QL (2 syrings/28 days)	
INVEGA SUSTENNA 156 MG/ML SYRG	T3	QL (1 syringe/28 days)	
INVEGA SUSTENNA 234 MG/1.5 ML	T3	QL (1 syringe/28 days)	
INVEGA SUSTENNA 39 MG/0.25 ML	T3	QL (2 syrings/28 days)	
INVEGA SUSTENNA 78 MG/0.5 ML	T3	QL (2 syrings/28 days)	
INVEGA TRINZA	T3	QL (2 injectors/90 days)	
T1 – Typically Generics	T4 – Specialty Medications	ST – Step Therapy	HD – May require home delivery pharmacy
T2 – Typically Preferred Brands	PA – Prior Authorization	AGE – Age Requirement	PPACA – No Cost-Share Preventive Medication
T3 – Typically Non-Preferred Brands	QL – Quantity Limit	SP – Specialty Medication	CSL – Oral cancer medication subject to cost-share limits

## List of Prescription Medications

### PSYCHOTHERAPEUTIC DRUGS (Schizophrenia/Anti-Psychotics)<sup>8</sup> (con't.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>ANTI-PSYCHOTIC, ATYPICAL, DOPAMINE, SEROTONIN ANTAGNST (con't.)</b>		
LATUDA 120 MG TABLET ( <i>lurasidone hcl</i> )	T3	PA
LATUDA 20 MG TABLET ( <i>lurasidone hcl</i> )	T3	PA
LATUDA 40 MG TABLET ( <i>lurasidone hcl</i> )	T3	PA QL (1 tab/day)
LATUDA 40 MG TABLET ( <i>lurasidone hcl</i> )	T3	PA QL (1 tab/day)
LATUDA 60 MG TABLET ( <i>lurasidone hcl</i> )	T3	PA QL (1 tab/day)
LATUDA 80 MG TABLET ( <i>lurasidone hcl</i> )	T3	
<i>lurasidone hcl 80 mg tablet</i> (Latuda)	T1	
<i>lurasidone hcl 60 mg tablet</i> (Latuda)	T1	QL(1 tab/day)
<i>lurasidone hcl 40 mg tablet</i> (Latuda)	T1	QL(1 tab/day)
<i>lurasidone hcl 20 mg tablet</i> (Latuda)	T1	
<i>lurasidone hcl 120 mg tablet</i> (Latuda)	T1	
<i>olanzapine</i> (Zyprexa Zydis)	T1	
<i>olanzapine</i> (Zyprexa)	T1	
<i>paliperidone er 1.5 mg tablet</i> (Invega)	T1	
<i>paliperidone er 3 mg tablet</i> (Invega)	T1	QL (1 tab/day)
<i>paliperidone er 6 mg tablet</i> (Invega)	T1	
<i>paliperidone er 9 mg tablet</i> (Invega)	T1	
PERSERIS	T3	QL (1 kit/28 days)
<i>quetiapine fumarate</i> (Seroquel Xr)	T1	
<i>quetiapine fumarate</i> (Seroquel)	T1	
RISPERDAL ( <i>risperidone</i> )	T3	PA
RISPERDAL CONSTA	T3	PA QL(4 vials/28 days)
<i>risperidone</i>	T1	
<i>risperidone</i> (Risperdal)	T1	
<i>risperidone microspheres</i>	T1	QL
SAPHRIS ( <i>asenapine maleate</i> )	T3	ST
SECUADO	T3	ST
SEROQUEL ( <i>quetiapine fumarate</i> )	T3	ST
SEROQUEL XR ( <i>quetiapine fumarate er</i> )	T3	ST
VERSACLOZ	T3	PA
<i>ziprasidone hcl</i> (Geodon)	T1	
<i>ziprasidone mesylate</i> (Geodon)	T1	
ZYPREXA 10 MG TABLET ( <i>olanzapine</i> )	T3	PA
ZYPREXA 10 MG VIAL ( <i>olanzapine</i> )	T3	

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

T4 – Specialty Medications

PA – Prior Authorization

QL – Quantity Limit

ST – Step Therapy

AGE – Age Requirement

SP – Specialty Medication

HD – May require home delivery pharmacy

PPACA – No Cost-Share Preventive Medication

CSL – Oral cancer medication subject to cost-share limits

## List of Prescription Medications

### PSYCHOTHERAPEUTIC DRUGS (Schizophrenia/Anti-Psychotics)<sup>8</sup> (con't.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>ANTI-PSYCHOTIC, ATYPICAL, DOPAMINE, SEROTONIN ANTAGNIST (con't.)</b>		
ZYPREXA 15 MG TABLET ( <i>olanzapine</i> )	T3	PA
ZYPREXA 2.5 MG TABLET ( <i>olanzapine</i> )	T3	PA
ZYPREXA 20 MG TABLET ( <i>olanzapine</i> )	T3	PA
ZYPREXA 5 MG TABLET ( <i>olanzapine</i> )	T3	PA
ZYPREXA 7.5 MG TABLET ( <i>olanzapine</i> )	T3	PA
ZYPREXA RELPREVV 210 MG VIAL	T3	QL (4 vials/28 days)
ZYPREXA RELPREVV 210 MG VL KIT	T3	QL (4 vials/28 days)
ZYPREXA RELPREVV 300 MG VIAL	T3	QL (4 vials/28 days)
ZYPREXA RELPREVV 300 MG VL KIT	T3	QL (4 vials/28 days)
ZYPREXA RELPREVV 405 MG VIAL	T3	QL (2 vials/28 days)
ZYPREXA RELPREVV 405 MG VL KIT	T3	QL (2 vials/28 days)
ZYPREXA ZYDIS ( <i>olanzapine odt</i> )	T3	PA
<b>ANTI-PSYCHOTIC-ATYPICAL, D3/D2 PARTIAL AG-5HT MIXED</b>		
VRAYLAR 1.5 MG CAPSULE	T3	QL (1 cap/day) ST
VRAYLAR 3 MG CAPSULE	T3	QL (1 cap/day) ST
VRAYLAR 4.5 MG CAPSULE	T3	ST
VRAYLAR 6 MG CAPSULE	T3	ST
<b>ANTIPSYCHOTICS, ATYP, D2 PARTIAL AGONIST/5HT MIXED</b>		
ABILIFY 10 MG TABLET ( <i>aripiprazole</i> )	T3	ST
ABILIFY 15 MG TABLET ( <i>aripiprazole</i> )	T3	ST
ABILIFY 2 MG TABLET ( <i>aripiprazole</i> )	T3	ST
ABILIFY 20 MG TABLET ( <i>aripiprazole</i> )	T3	ST
ABILIFY 30 MG TABLET ( <i>aripiprazole</i> )	T3	ST
ABILIFY 5 MG TABLET ( <i>aripiprazole</i> )	T3	QL (1 tab/day) ST
ABILIFY ASIMTUFI	T3	
ABILIFY MAINTENA ER 300 MG SYR	T2	QL (2 injectors/30 days)
ABILIFY MAINTENA ER 300 MG VL	T2	QL (2 injectors/30 days)
ABILIFY MAINTENA ER 400 MG SYR	T2	QL (2 injectors/30 days)
ABILIFY MAINTENA ER 400 MG VL	T2	
ABILIFY MYCITE <i>aripiprazole</i>	T3	PA
<i>aripiprazole 1 mg/ml solution</i>	T1	
<i>aripiprazole 10 mg tablet (Abilify)</i>	T1	

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

T4 – Specialty Medications

PA – Prior Authorization

QL – Quantity Limit

ST – Step Therapy

AGE – Age Requirement

SP – Specialty Medication

HD – May require home delivery pharmacy

PPACA – No Cost-Share Preventive Medication

CSL – Oral cancer medication subject to cost-share limits

## List of Prescription Medications

### PSYCHOTHERAPEUTIC DRUGS (Schizophrenia/Anti-Psychotics)<sup>8</sup> (con't.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits	
<b>ANTIPSYCHOTICS, ATYP, D2 PARTIAL AGONIST/5HT MIXED (con't.)</b>			
ariPIPrazole 15 mg tablet (Abilify)	T1		
ariPIPrazole 2 mg tablet (Abilify)	T1		
ariPIPrazole 20 mg tablet (Abilify)	T1		
ariPIPrazole 30 mg tablet (Abilify)	T1		
ariPIPrazole 5 mg tablet (Abilify)	T1	QL (1 tab/day)	
ARISTADA ER 1064 MG/3.9 ML SYR	T3		
ARISTADA ER 441 MG/1.6 ML SYRN	T3	QL (2 syrings/30 days)	
ARISTADA ER 662 MG/2.4 ML SYRN	T3	QL (2 syrings/30 days)	
ARISTADA ER 882 MG/3.2 ML SYRN	T3	QL (2 syrings/30 days)	
ARISTADA INITIO	T3		
COBENFY	T3	PA	
REXULTI 0.25 MG TABLET	T3	QL (1 tab/day) ST	
REXULTI 0.5 MG TABLET	T3	QL (1 tab/day) ST	
REXULTI 1 MG TABLET	T3	QL (1 tab/day) ST	
REXULTI 2 MG TABLET	T3	QL (1 tab/day) ST	
REXULTI 3 MG TABLET	T3	ST	
REXULTI 4 MG TABLET	T3	ST	
OPIPZA 2 MG FILM	T3	PA QL(1 film/day)	
OPIPZA 5 MG, 10 MG FILM	T3	PA QL(3 films/day)	
<b>ANTI-PSYCHOTICS, DOPAMINE AND SEROTONIN ANTAGONISTS</b>			
loxapine succinate	T1		
<b>ANTI-PSYCHOTICS, DOPAMINE ANTAGONISTS, THIOXANTHENES</b>			
thiothixene	T1		
droperidol	T1		
HALDOL (haloperidol lactate)	T3		
haloperidol	T1		
haloperidol decanoate	T1		
haloperidol decanoate (Haldol Decanoate 100)	T1		
haloperidol decanoate (Haldol Decanoate 50)	T1		
haloperidol lactate	T1		
haloperidol lactate (Haldol)	T1		
<b>ANTI-PSYCHOTICS, DOPAMINE ANTAGONST, DIHYDROINDOLONES</b>			
molindone hcl	T1		
<b>ANTI-PSYCHOTICS, PHENOTHIAZINES</b>			
chlorpromazine hcl	T1		
T1 – Typically Generics	T4 – Specialty Medications	ST – Step Therapy	HD – May require home delivery pharmacy
T2 – Typically Preferred Brands	PA – Prior Authorization	AGE – Age Requirement	PPACA – No Cost-Share Preventive Medication
T3 – Typically Non-Preferred Brands	QL – Quantity Limit	SP – Specialty Medication	CSL – Oral cancer medication subject to cost-share limits

## List of Prescription Medications

### PSYCHOTHERAPEUTIC DRUGS (Schizophrenia/Anti-Psychotics)<sup>8</sup> (con't.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>ANTIPSYCHOTICS, ATYP, D2 PARTIAL AGONIST/5HT MIXED (con't.)</b>		
<i>fluphenazine decanoate</i>	T1	
<i>fluphenazine hcl</i>	T1	
<i>perphenazine</i>	T1	
<i>thioridazine hcl</i>	T1	
<i>trifluoperazine hcl</i>	T1	
<b>SSRI-ANTI-PSYCH, ATYPICAL, DOPAMINE, SEROTONIN ANTAG</b>		
<i>olanzapine/fluoxetine hcl</i>	T1	
<i>olanzapine/fluoxetine hcl (Symbax)</i>	T1	
<i>SYMBAX (olanzapine-fluoxetine hcl)</i>	T3	PA

### PSYCHOTHERAPEUTIC DRUGS (Sleep Disorders/Sedatives)

NARCOLEPSY AND SLEEP DISORDER THERAPY AGENTS		
<i>armodafinil (Nuvigil)</i>	T1	PA
<i>modafinil (Provigil)</i>	T1	PA
<i>NUVIGIL (armodafinil)</i>	T3	PA
<i>PROVIGIL (modafinil)</i>	T3	PA
SUNOSI	T2	PA QL (1 tab/day)

### SEDATIVE/HYPNOTICS (Sleep Disorders/Sedatives)

ANTI-NARCOLEPSY, ANTI-CATAPLEXY, SEDATIVE-TYPE AGENT		
SODIUM OXYBATE	T4	PA QL(18 mls/day) SP HD
LUMRYZ	T4	PA QL (30 pkts/30 days) SP
XYREM	T4	PA SP HD
XYWAV	T4	PA SP HD

BARBITURATES		
AMYTAL SODIUM	T3	
NEMBUTAL SODIUM ( <i>pentobarbital sodium</i> )	T3	PA
<i>pentobarbital sodium</i> (Nembutal Sodium)	T1	PA
<i>phenobarbital sodium</i>	T1	
<i>secobarbital sodium</i>	T3	PA

HYPNOTICS, MELATONIN MT1/MT2 RECEPTOR AGONISTS		
HETLIOZ	T4	PA SP HD
HETLIOZ LQ	T4	PA SP HD
<i>ramelteon</i> (Rozerem)	T1	QL (1 tab/day)
<i>ROZEREM (ramelteon)</i>	T3	PA QL (1 tab/day)

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

T4 – Specialty Medications

PA – Prior Authorization

QL – Quantity Limit

ST – Step Therapy

AGE – Age Requirement

SP – Specialty Medication

HD – May require home delivery pharmacy

PPACA – No Cost-Share Preventive Medication

CSL – Oral cancer medication subject to cost-share limits

## List of Prescription Medications

SEDATIVE/HYPNOTICS (Sleep Disorders/Sedatives) (con't.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>HYPNOTICS, MELATONIN MT1/MT2 RECEPTOR AGONISTS (con't.)</b>		
<i>tasimelteon</i>	T4	PA SP
<b>SEDATIVE-HYPNOTICS - BENZODIAZEPINES</b>		
ATIVAN ( <i>lorazepam</i> )	T3	PA
DORAL	T3	
<i>estazolam</i>	T1	
HALCION ( <i>triazolam</i> )	T3	
<i>lorazepam</i>	T1	
<i>lorazepam</i> (Ativan)	T1	
LORAZEPAM-0.9% NACL	T1	
LORAZEPAM-D5W	T1	
QUAZEPAM	T1	
<i>quazepam</i> (Quazepam)	T1	
RESTORIL ( <i>temazepam</i> )	T3	PA
<i>temazepam</i> (Restoril)	T1	
<i>triazolam</i>	T1	
<i>triazolam</i> (Halcion)	T1	
<b>SEDATIVE-HYPNOTICS, NON-BARBITURATE</b>		
AMBIEN ( <i>zolpidem tartrate</i> )	T3	PA
AMBIEN CR 12.5 MG TABLET ( <i>zolpidem tartrate er</i> )	T3	PA
AMBIEN CR 6.25 MG TABLET ( <i>zolpidem tartrate er</i> )	T3	PA QL (1 tab/day)
BELSOMRA	T3	PA
DAYVIGO	T2	QL (1 tab/day) ST
DEXMEDETOMIDINE HCL	T1	
<i>dexmedetomidine hcl</i> (Precedex)	T1	
<i>dexmedetomidine in 0.9 % nacl</i> (Precedex)	T1	
<i>doxepin hcl 3 mg tablet</i> (Silenor)	T1	QL (1 tab/day)
<i>doxepin hcl 6 mg tablet</i> (Silenor)	T1	
EDLUAR 10 MG SL TABLET	T3	PA
EDLUAR 5 MG SL TABLET	T3	PA QL (1 tab/day)
<i>eszopiclone</i> (Lunesta)	T1	
LUNESTA ( <i>eszopiclone</i> )	T3	PA
PRECEDEX	T3	
QUVIVIQ	T3	PA QL (1 tab/day)
SILENOR 3 MG TABLET ( <i>doxepin hcl</i> )	T3	PA QL (1 tab/day)

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

T4 – Specialty Medications

PA – Prior Authorization

QL – Quantity Limit

ST – Step Therapy

AGE – Age Requirement

SP – Specialty Medication

HD – May require home delivery pharmacy

PPACA – No Cost-Share Preventive Medication

CSL – Oral cancer medication subject to cost-share limits

## List of Prescription Medications

SEDATIVE/HYPNOTICS (Sleep Disorders/Sedatives) (con't.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>SEDATIVE-HYPNOTICS, NON-BARBITURATE (con't.)</b>		
SILENOR 6 MG TABLET ( <i>doxepin hc</i> )	T3	PA
<i>zaleplon</i>	T1	
<i>zolpidem tart er 12.5 mg tab (Ambien Cr)</i>	T1	
<i>zolpidem tart er 6.25 mg tab (Ambien Cr)</i>	T1	QL (1 tab/day)
<i>zolpidem tartrate</i>	T1	
<i>zolpidem tartrate (Ambien)</i>	T1	
ZOLPIMIST	T3	PA
<b>SEDATIVE-HYPNOTICS - BENZODIAZEPINES</b>		
<i>flurazepam hcl</i>	T1	
SKIN PREPS (Miscellaneous)		
<b>IRRIGANTS</b>		
<i>acetic acid</i>	T1	
<i>neomycin sulf/polymyxin b sulf</i>	T1	
PHYSIOLYTE	T3	
PHYSIOSOL	T3	
<i>ringer's solution</i>	T1	
<i>ringer's solution, lactated</i>	T1	
<i>sod, pot chlor/mag/sod, pot phos</i>	T3	
<i>sodium chloride irrig solution</i>	T1	
SORBITOL	T1	
SORBITOL-MANNITOL	T1	
<i>water for irrigation, sterile</i>	T1	
<b>OXIDIZING AGENTS</b>		
<i>hydrogen peroxide</i>	T1	
SKIN PREPS (Pain Relief And Inflammatory Disease)		
<b>ANTI-PSORIATIC AGENTS, SYSTEMIC</b>		
<i>acitretin</i>	T1	
<i>acitretin (Soriatane)</i>	T1	
BIMZELX AUTOINJECTOR	T4	PA QL(2 mls/28 days) SP HD
COSENTYX (2 SYRINGES)	T4	PA QL (2 syrings/28 days) SP HD
COSENTYX PEN	T4	PA QL (1 pen/28 days) SP HD
COSENTYX PEN (2 PENS)	T4	PA QL (2 pens/28 days) SP HD

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

T4 – Specialty Medications

PA – Prior Authorization

QL – Quantity Limit

ST – Step Therapy

AGE – Age Requirement

SP – Specialty Medication

HD – May require home delivery pharmacy

PPACA – No Cost-Share Preventive Medication

CSL – Oral cancer medication subject to cost-share limits

## List of Prescription Medications

### SKIN PREPS (Pain Relief And Inflammatory Disease) (con't.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>ANTI-PSORIATIC AGENTS, SYSTEMIC (con't.)</b>		
COSENTYX SYRINGE	T4	PA QL (1 syringe/28 days) SP HD
ILUMYA	T4	PA QL (1 syringe/84 days) SP HD
<i>methoxsalen</i> (Oxsoralen-ultra)	T1	
OXSORALEN-ULTRA ( <i>methoxsalen</i> )	T3	
SKYRIZI (2 SYRINGES) KIT	T4	PA QL (1 kit/84 days) SP HD
SORIATANE ( <i>acitretin</i> )	T3	PA
SOTYKTU	T4	PA QL(1 tab/day) SP HD
SPEVIGO 150 MG/ML SYRINGE	T4	PA QL(2 mls/28 days) SP HD
SPEVIGO 450 MG/7.5 ML VIAL	T4	PA SP HD
TALTZ AUTOINJECTOR	T4	PA QL (1 injector/28 days) SP HD
TALTZ AUTOINJECTOR (2 PACK)	T4	PA QL (1 injector/28 days) SP HD
TALTZ AUTOINJECTOR (3 PACK)	T4	PA QL (1 injector/28 days) SP HD
TALTZ SYRINGE	T4	PA QL (1 syringe/28 days) SP HD
TREMFYA 100 MG/ML INJECTOR	T4	PA SP HD
TREMFYA 100 MG/ML SYRINGE	T4	PA SP HD
<b>TOPICAL ANTI-INFLAMMATORY, NSAIDS</b>		
DICLAREAL	T3	HD
<i>diclofenac</i> 1.5% topical soln	T1	PA HD
DICLOFENAC EPOLAMINE	T3	PA QL (2 patches/day) HD
<i>diclofenac sodium</i> 1% gel (Voltaren)	T1	QL (1000gm/30 days) HD
FLECTOR	T2	PA QL (2 patches/day) HD
LICART	T2	PA QL (1 patch/day) HD
PENNNSAID	T3	PA HD
VOLTAREN ( <i>diclofenac sodium</i> )	T3	PA QL (1000gm/30 days) HD
<b>SKIN PREPS (Skin Conditions)</b>		
<b>ACNE AGENTS, SYSTEMIC</b>		
ABSORICA	T3	
ABSORICA LD	T3	ST
ACCUTANE	T1	
AMNESTEEM	T1	
CABTREO	T3	PA
CLARAVIS	T1	
isotretinoin	T1	
MYORISAN	T1	

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

T4 – Specialty Medications

PA – Prior Authorization

QL – Quantity Limit

ST – Step Therapy

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HD – May require home delivery pharmacy

PPACA – No Cost-Share Preventive Medication

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## List of Prescription Medications

SKIN PREPS (Skin Conditions) (con't.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>ACNE AGENTS, SYSTEMIC (con't.)</b>		
ZENATANE	T1	
<b>ACNE AGENTS, TOPICAL</b>		
ACANYA ( <i>clindamycin phos-benzoyl perox</i> )	T3	
ACZONE 5% GEL ( <i>dapsone</i> )	T3	
ACZONE 7.5% GEL PUMP	T2	PA
<i>adapalene/benzoyl peroxide</i>	T1	
AZELEX	T2	
BENZAACLIN ( <i>clindamycin-benzoyl peroxide</i> )	T3	PA
<i>clindamycin-bnz perox 1.2-3.75%</i> (Onexton)	T1	PA
<i>clindamycin phos/benzoyl perox</i>	T1	
<i>clindamycin phos/benzoyl perox</i> (Acanya) (Benzacllin)	T1	
<i>clindamycin/tretinoin</i> (Veltin)	T1	
<i>clindamycin/tretinoin</i> (Ziana)	T1	
<i>dapsone 5% gel</i> (Aczone)	T1	
DAPSONE 7.5% GEL PUMP	T3	PA
<i>dapsone 7.5% gel pump</i> (Dapsone)	T1	
KLARON ( <i>sulfacetamide sodium</i> )	T3	
NEUAC 1.2-5% KIT	T3	
<i>neuac gel</i>	T1	
ONEXTON	T3	
<i>sulfacetamide sodium</i> (Klaron)	T1	
VELTIN	T3	PA
ZIANA ( <i>clindamycin phos-tretinoin</i> )	T3	PA
<b>ANTI-PERSPIRANTS</b>		
DRYSOL	T3	
<b>ANTI-PRURITICS, TOPICAL</b>		
<i>doxepin hcl</i> (Zonalon)	T3	PA QL (90gm/30 days)
ZONALON ( <i>prodoxin</i> )	T3	PA QL (90gm/30 days)
<b>ANTI-PSORIATICS AGENTS</b>		
<i>anthralin</i>	T1	
<i>calcipotriene 0.005% cream</i> (Dovonex)	T1	
CALCIPOTRIENE 0.005% FOAM	T3	PA
<i>calcipotriene 0.005% ointment</i>	T1	
<i>calcipotriene 0.005% solution</i>	T1	

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

T4 – Specialty Medications

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AGE – Age Requirement

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## List of Prescription Medications

### SKIN PREPS (Skin Conditions) (con't.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>ANTI-PSORIATICS AGENTS</b>		
<i>calcitriol 3 mcg/g ointment (Vectical)</i>	T1	QL (800gm/30 days)
DOVONEX ( <i>calcipotriene</i> )	T3	
DUOBRII	T3	
SORILUX	T3	PA
<i>tazarotene 0.1% cream (Tazorac)</i>	T1	
TAZORAC 0.05% CREAM	T2	
TAZORAC 0.05% GEL	T2	
TAZORAC 0.1% CREAM ( <i>tazarotene</i> )	T3	
TAZORAC 0.1% GEL	T2	
VECTICAL ( <i>calcitriol</i> )	T3	QL (800gm/30 days)
ZORYVE 0.3% FOAM	T2	PA QL(1 gm/30 days)
<b>ANTI-SEBORRHEIC AGENTS</b>		
OVACE PLUS	T3	
PROMISEB	T2	
<i>selenium sulfide</i>	T1	
<i>sulfacetamide sodium</i>	T1	
TERSI FOAM	T3	
<b>ANTISEPTICS, GENERAL</b>		
<i>alcohol antiseptic pads</i>	T1	
ALCOHOL PREP PADS	T1	
ALCOHOL SWAB	T1	
ALCOHOL WIPES	T1	
CARETOUCH ALCOHOL PREP PAD	T1	
CURITY ALCOHOL PREPS	T1	
DROPSAFE PREP PADS	T1	
EASY COMFORT ALCOHOL PAD	T1	
EASY TOUCH ALCOHOL PREP PADS	T1	
INCONTROL ALCOHOL PADS	T1	
PRO COMFORT ALCOHOL PADS	T1	
PURE COMFORT ALCOHOL PAD	T1	
SINGLE USE SWAB	T1	
SURE COMFORT ALCOHOL	T1	
SURE-PREP ALCOHOL PREP PADS	T1	
TRUE COMFORT ALCOHOL PADS	T1	

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

T4 – Specialty Medications

PA – Prior Authorization

QL – Quantity Limit

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## List of Prescription Medications

SKIN PREPS (Skin Conditions) (con't.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>ANTISEPTICS, GENERAL (con't.)</b>		
TRUE COMFORT PRO ALCOHOL PADS	T1	
ULTILET ALCOHOL SWAB	T1	
WEBCOL	T1	
<b>ANTISEPTICS, MISCELLANEOUS</b>		
GUAIACOL	T3	
<b>DIABETIC ULCER PREPARATIONS, TOPICAL</b>		
REGRANEX	T3	PA QL (2 tubs/30 days)
<b>EMOLLIENTS</b>		
<i>ammonium lactate</i>	T1	
ATOPICLAIR	T3	
BIAFINE ( <i>sonafine</i> )	T3	
<i>emollient combination no.10</i> (Biafine)	T1	
<i>emollient combination no.35</i> (Mimyx)	T1	
<i>emollient combination no.44</i>	T1	
<i>emollient combination no.60</i> (Restizan)	T3	
HALUCORT	T3	
MIMYX ( <i>prumyx</i> )	T3	
RESTIZAN	T1	
<i>vite ac/grape/hyaluronic acid</i> (Atopicclair)	T1	
XCLAIR	T3	
<b>IMMUNOMODULATORS</b>		
ALDARA ( <i>imiquimod</i> )	T3	PA
<i>imiquimod 3.75% cream</i> (Zyclara)	T1	PA QL (112 packets/67 days)
IMIQUIMOD 3.75% CREAM PUMP	T1	PA
<i>imiquimod 5% cream packet</i> (Aldara)	T1	
ZYCLARA 2.5% CREAM PUMP	T3	PA QL (4 bots/30 days)
ZYCLARA 3.75% CREAM ( <i>imiquimod</i> )	T3	PA QL (112 packs/30 days)
ZYCLARA 3.75% CREAM PUMP	T3	PA
<b>IRRITANTS/COUNTER-IRRITANTS</b>		
<i>methyl salicylate</i>	T1	
QUTENZA	T3	
<b>KERATOLYTICS</b>		
BENSAL HP	T1	PA
BENZEOFAM	T3	

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

T4 – Specialty Medications

PA – Prior Authorization

QL – Quantity Limit

ST – Step Therapy

AGE – Age Requirement

SP – Specialty Medication

HD – May require home delivery pharmacy

PPACA – No Cost-Share Preventive Medication

CSL – Oral cancer medication subject to cost-share limits

## List of Prescription Medications

### SKIN PREPS (Skin Conditions) (con't.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>KERATOLYTICS (con't.)</b>		
BENZEPRO	T1	
<i>benzoyl peroxide</i>	T1	
<i>benzoyl peroxide</i> (Enzoclear)	T1	
<i>benzoyl peroxide</i> (Pacnex)	T1	
CONDYLOX ( <i>podofilox</i> )	T3	PA
ENZOCLEAR	T3	
HYDRO 35	T3	
HYDRO 40 ( <i>umecta</i> )	T3	
INOVA	T3	
KERAFOAM	T3	
KERALYT 6% GEL ( <i>salicylic acid</i> )	T3	
<i>keralyt</i> 6% shampoo	T1	
KERALYT SCALP	T3	
KERALYT SCALP ( <i>salicylic acid</i> )	T3	
PACNEX ( <i>benzoyl peroxide</i> )	T3	
PODOCON-25	T1	
<i>podofilox</i>	T1	
PR BENZOYL PEROXIDE	T1	
SALICATE	T3	
<i>salicylic acid</i>	T1	
<i>salicylic acid</i>	T3	
<i>salicylic acid</i> (Keralyt Scalp)	T1	
<i>salicylic acid/ceramide comb</i> 1	T1	
SALIMEZ FORTE	T1	
SALKERA	T3	
SALVAX DUO PLUS	T3	
<i>silver nitrate</i>	T1	
<i>silver nitrate applicator</i>	T1	
URAMAXIN	T3	
URAMAXIN ( <i>urea</i> )	T3	
<i>urea</i>	T1	
<i>urea</i> (Hydro 35)	T1	
<i>urea</i> (Hydro 40)	T3	
<i>urea</i> (Uramaxin)	T1	

T1 – Typically Generics

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## List of Prescription Medications

SKIN PREPS (Skin Conditions) (con't.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>KERATOLYTICS (con't.)</b>		
urea (Xurea)	T1	
XUREA	T3	
<b>PROTECTIVES</b>		
BIONECT	T3	
PHARMABASE BARRIER	T1	
<i>polydimethylsiloxanes/silicon</i>	T1	
<i>protectives2/ceramide 1, 3, 6-ii</i>	T1	
RADIAPLEXRX	T3	
<i>zinc oxide</i>	T1	
<b>ROSACEA AGENTS, TOPICAL</b>		
<i>azelaic acid</i> (Finacea)	T1	
FINACEA	T3	PA
FINACEA ( <i>azelaic acid</i> )	T3	PA
<i>ivermectin</i> (Soolantra)	T1	
METROCREAM ( <i>rosadan</i> )	T3	PA
METROGEL ( <i>metronidazole</i> )	T3	PA
<i>metronidazole</i>	T3	PA
NORITATE	T3	PA
SOOLANTRA ( <i>ivermectin</i> )	T3	
<b>TISSUE/WOUND ADHESIVES</b>		
ARTISS	T3	
SURGISEAL STYLUS	T3	
SURGISEAL TEARDROP	T3	
SURGISEAL TWIST	T3	
TISSEEL VHSD	T3	
<b>TOP. ANTI-INFLAM., PHOSPHODIESTERASE-4 (PDE4) INHIB</b>		
EUCRISA	T2	
<b>TOPICAL AGENTS, MISCELLANEOUS</b>		
GORDON'S UREA	T3	
HYFTOR	T4	PA SP
L-MESITRAN SOFT	T3	
MEDIHONEY	T3	

T1 – Typically Generics

T2 – Typically Preferred Brands

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## List of Prescription Medications

SKIN PREPS (Skin Conditions) (con't.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>TOPICAL AGENTS, MISCELLANEOUS (con't.)</b>		
SAF-CLENS AF	T3	
<i>trichloroacetic acid</i>	T3	
TRICHLOROACETIC ACID	T1	
<b>TOPICAL ANTIANDROGENIC AGENTS</b>		
WINLEVI	T3	PA
<b>TOPICAL ANTIBIOTIC PLEUROMUTILIN DERIVATIVES</b>		
ALTABAX	T3	
<b>TOPICAL ANTICHOLINERGIC HYPERHIDROSIS TX AGENTS</b>		
QBREXZA	T3	
<b>TOPICAL ANTI-INFLAMMATORY STEROIDAL</b>		
ALA-SCALP ( <i>scalacort</i> )	T3	ST
<i>alclometasone dipropionate</i>	T1	
<i>amcinonide 0.1% cream, ointment, lotion</i>	T1	PA
ANUSOL-HC 2.5% CREAM ( <i>proctozone-hc</i> )	T1	PA
AQUA GLYCOLIC HC	T3	
<i>betamethasone dipropionate</i>	T1	
<i>betamethasone valerate</i>	T1	
<i>betamethasone valerate (Luxiq)</i>	T1	
<i>betamethasone/propylene glyc</i>	T1	
<i>betamethasone/propylene glyc (Diprolene)</i>	T1	
BRYHALI	T3	ST
CAPEX SHAMPOO	T3	ST
<i>clobetasol propionate</i>	T1	
<i>clobetasol propionate (Clobex)</i>	T1	
<i>clobetasol propionate (Olux)</i>	T1	
<i>clobetasol propionate (Temovate)</i>	T1	
<i>clobetasol propionate/emoll</i>	T1	
<i>clobetasol propionate/emoll (Olux-e)</i>	T1	
CLOBEX ( <i>clobetasol propionate</i> )	T3	PA
CLOBEX ( <i>cldan</i> )	T3	PA
CLOCORTOLONE PIVALATE	T1	
CLODAN 0.05% KIT	T3	ST
<i>cladan 0.05% shampoo (Clobex)</i>	T1	
CLODERM	T3	ST

T1 – Typically Generics

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T3 – Typically Non-Preferred Brands

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## List of Prescription Medications

### SKIN PREPS (Skin Conditions) (con't.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>TOPICAL ANTI-INFLAMMATORY STEROIDAL (con't.)</b>		
CORDRAN	T3	PA
CORDRAN ( <i>flurandrenolide</i> )	T3	PA
CORDRAN ( <i>nolix</i> )	T3	PA
CUTIVATE 0.05% CREAM ( <i>fluticasone propionate</i> )	T3	ST
CUTIVATE 0.05% LOTION ( <i>fluticasone propionate</i> )	T3	PA
DERMA-SMOOTH-E-FS ( <i>fluocinolone acetonide</i> )	T3	ST
DERMATOP ( <i>prednicarbate</i> )	T3	ST
<i>desonide</i>	T1	
<i>desonide</i> (Desowen)	T1	
<i>desonide</i> (Tridesilon)	T1	
DESOWEN ( <i>desonide</i> )	T3	PA
<i>desoximetasone</i> (Topicort)	T1	
<i>diflorasone diacetate</i>	T1	PA
<i>diflorasone diacetate</i> (Psorcon)	T1	PA
<i>diflorasone diacetate/emoll</i>	T1	PA
DIPROLENE ( <i>betamethasone diprop augmented</i> )	T3	ST
<i>fluocinolone acetonide</i>	T1	
<i>fluocinolone acetonide</i> (Derma-smoothe-fs)	T1	
<i>fluocinolone acetonide</i> (Synalar)	T1	
<i>fluocinolone/shower cap</i> (Derma-smoothe-fs)	T1	
<i>fluocinonide</i>	T1	
<i>fluocinonide</i> (Vanos)	T1	
<i>fluocinonide/emollient base</i>	T1	
<i>flurandrenolide</i> (Cordran)	T1	PA
<i>fluticasone prop 0.005% oint</i>	T1	
<i>fluticasone prop 0.05% cream</i> (Cutivate)	T1	
<i>fluticasone prop 0.05% lotion</i> (Cutivate)	T1	
<i>fluticasone propionate</i> (Cutivate)	T1	
<i>halcinonide</i> (Halog)	T1	PA
HALOBETASOL PROPIONATE	T1	
<i>halobetasol prop 0.05% foam</i>	T1	
<i>halobetasol propionate</i> (Ultravate)	T1	
HALOG 0.1% CREAM ( <i>halcinonide</i> )	T3	PA
HALOG 0.1% OINTMENT	T3	PA

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

T4 – Specialty Medications

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ST – Step Therapy

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SP – Specialty Medication

HD – May require home delivery pharmacy

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## List of Prescription Medications

### SKIN PREPS (Skin Conditions) (con't.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>TOPICAL ANTI-INFLAMMATORY STEROIDAL (con't.)</b>		
HALOG 0.1% SOLUTION	T3	ST
<i>hydrocort buty 0.1% lipid crm (Locoid Lipocream)</i>	T1	PA
<i>hydrocort buty 0.1% lipo cream (Locoid Lipocream)</i>	T1	PA
<i>hydrocortisone</i>	T1	
<i>hydrocortisone (Ala-scalp)</i>	T1	
<i>hydrocortisone (Anusol-hc)</i>	T1	
<i>hydrocortisone buty 0.1% cream</i>	T1	
<i>hydrocortisone butyr 0.1% lotn (Locoid)</i>	T1	PA
<i>hydrocortisone butyr 0.1% oint (Locoid)</i>	T1	
<i>hydrocortisone butyr 0.1% soln</i>	T1	
<i>hydrocortisone valerate</i>	T1	
IMPEKLO	T3	PA
IMPOYZ	T3	PA
KENALOG ( <i>triamcinolone acetonide</i> )	T3	PA
LEXETTE	T3	ST
LOCOID 0.1% LOTION ( <i>hydrocortisone butyrate</i> )	T3	PA
LOCOID 0.1% OINTMENT ( <i>hydrocortisone butyrate</i> )	T3	
LOCOID LIPOCREAM	T3	PA
LOCOID LIPOCREAM ( <i>hydrocortisone butyrate</i> )	T3	PA
LUXIQ ( <i>betamethasone valerate</i> )	T3	ST
MOMETACURE	T3	
<i>mometasone furoate 0.1% cream</i>	T1	
<i>mometasone furoate 0.1% oint</i>	T1	
<i>mometasone furoate 0.1% soln</i>	T1	
NUCORT	T3	ST
OLUX ( <i>clobetasol propionate</i> )	T3	PA
OLUX-E ( <i>tovet emollient</i> )	T3	PA
PANDEL	T3	PA
<i>prednicarbate (Dermatop)</i>	T1	
PSORCON ( <i>diflorasone diacetate</i> )	T3	PA
SCALACORT DK	T3	ST
SERNIVO	T3	PA
SYNALAR ( <i>fluocinolone acetonide</i> )	T3	ST

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

T4 – Specialty Medications

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SP – Specialty Medication

HD – May require home delivery pharmacy

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## List of Prescription Medications

### SKIN PREPS (Skin Conditions) (con't.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>TOPICAL ANTI-INFLAMMATORY STEROIDAL (con't.)</b>		
SYNALARTS	T3	ST
TEMOVATE ( <i>clobetasol propionate</i> )	T3	ST
TEXACORT	T3	ST
TOPICORT ( <i>desoximetasone</i> )	T3	ST
<i>triamcinolone acetonide</i>	T1	
<i>triamcinolone acetonide</i>	T1	PA
<i>triamcinolone acetonide</i> (Kenalog)	T1	
TRIDESILON ( <i>desonide</i> )	T3	PA
ULTRAVATE	T3	ST
VANOS ( <i>fluocinonide</i> )	T3	PA
VERDESO	T3	PA
<b>TOPICAL ANTI-INFLAMMATORY STEROID-LOCAL ANESTHETIC</b>		
ANALPRAM HC	T3	
EPIFOAM	T3	
<i>hydrocortisone/pramoxine</i> (Pramosone)	T1	
<i>lidocaine/hydrocortisone ac</i>	T1	
MEZPAROX-HC	T1	
PRAMOSONE 1% LOTION	T2	
PRAMOSONE 1%-1% CREAM	T2	
PRAMOSONE 1%-1% OINTMENT	T2	
PRAMOSONE 2.5%-1% CREAM	T3	
PRAMOSONE 2.5%-1% LOTION	T3	
PRAMOSONE 2.5%-1% OINTMENT	T2	
<b>TOPICAL ANTI-PARASITICS</b>		
<i>malathion</i> (Ovide)	T1	
OVIDE ( <i>malathion</i> )	T3	
<b>TOPICAL PREPARATIONS, ANTIBACTERIALS</b>		
<i>dermazene cream</i>	T1	
DERMAZENE CREAM PACKET	T3	
<i>hydrocortisone/iodoquinol</i>	T1	
<i>hydrocortisone/iodoquinol/aloe</i>	T1	
<i>iodine/potassium iodide</i>	T1	
<i>iodine/sodium iodide</i>	T1	
IODOFLEX	T3	

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

T4 – Specialty Medications

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## List of Prescription Medications

SKIN PREPS (Skin Conditions) (con't.)			
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits	
<b>TOPICAL PREPARATIONS, ANTIBACTERIALS</b>			
IODOSORB	T3	PA	
<i>silver nitrate</i>	T1		
<b>TOPICAL VIT D ANALOG/ANTI-INFLAMMATORY STEROID</b>			
<i>calcipotriene/betamethasone</i> (Taclonex)	T1	PA	
ENSTILAR	T3		
TACLONEX 0.005%-0.064% SUSPENS ( <i>calcipotriene-betamethasone dp</i> )	T3		
TACLONEX OINTMENT ( <i>calcipotriene-betamethasone</i> )	T3		
WYNZORA	T3	PA	
<b>TOPICAL/MUCOUS MEMBR./SUBCUT. ENZYMES</b>			
AMPHADASE	T3	QL (60gm/30 days)	
SANTYL	T2		
VITRASE	T3		
<b>VITAMIN A DERIVATIVES</b>			
<i>adapalene</i>	T1	PA	
<i>adapalene</i> (Differin)	T1		
<i>adapalene</i> (Plixda)	T1	PA	
AKLIEF	T3		
ALTRENO	T3	PA	
ATRALIN ( <i>tretinoin</i> )	T3		
<i>avita</i> 0.025% cream (Retin-a)	T3	PA	
AVITA 0.025% GEL	T3		
DIFFERIN	T3	PA	
DIFFERIN ( <i>adapalene</i> )	T3		
PLIXDA	T1	PA	
RETIN-A 0.01% GEL ( <i>tretinoin</i> )	T3		
RETIN-A 0.025% CREAM ( <i>tretinoin</i> )	T3	PA	
RETIN-A 0.025% GEL ( <i>tretinoin</i> )	T3		
RETIN-A 0.05% CREAM ( <i>tretinoin</i> )	T3	PA	
RETIN-A 0.1% CREAM ( <i>tretinoin</i> )	T3		
RETIN-A MICRO ( <i>tretinoin microsphere</i> )	T3	PA	
RETIN-A MICRO PUMP	T3		
RETIN-A MICRO PUMP ( <i>tretinoin microsphere</i> )	T3	PA	
<i>tretinoin</i> 0.01% gel (Retin-a)	T1		
<i>tretinoin</i> 0.025% cream (Retin-a)	T1	PA	

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

T4 – Specialty Medications

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## List of Prescription Medications

### SKIN PREPS (Skin Conditions) (con't.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>VITAMIN A DERIVATIVES (con't.)</b>		
tretinoin 0.025% gel (Retin-a)	T1	
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
TRETIN-X	T3	PA

### VITAMIN A DERIVATIVES, TOPICAL ACNE AGENTS

ARAZLO	T2	
FABIOR	T3	
TAZAROTENE 0.1% FOAM	T3	

### SMOKING DETERRENTS (Smoking Cessation)<sup>8</sup>

#### SMOKING DETERRENT AGENTS (GANGLIONIC STIM, OTHERS)

NICOTROL	T2	PPACA
NICOTROL NS	T2	PPACA

#### SMOKING DETERRENT-NICOTINIC RECEPT.PARTIAL AGONIST

CHANTIX	T2	
varenicline 1 mg cont month bx	T1	PPACA

#### SMOKING DETERRENTS, OTHER

bupropion hcl sr 150 mg tablet	T1	PPACA
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### THYROID PREPS (Hormonal Agents)

#### ANTI-THYROID PREPARATIONS

methimazole (Tapazole)	T1	HD
propylthiouracil	T1	HD
TAPAZOLE (methimazole)	T3	HD

#### THYROID FUNCTION DIAGNOSTIC AGENTS

THYROGEN	T4	SP
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#### THYROID HORMONES

ADTHYZA	T3	PA HD
ARMOUR THYROID	T3	HD
CYTOMEL ( <i>liothyronine sodium</i> )	T3	HD
ERMEZA	T3	PA HD
LEVOTHYROXINE 100 MCG CAPSULE	T3	HD
LEVOTHYROXINE 112 MCG CAPSULE	T3	HD

I1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

I4 – Specialty Medications

PA – Prior Authorization

QL – Quantity Limit

S1 – Step Therapy

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## List of Prescription Medications

### THYROID PREPS (Hormonal Agents) (con't.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>THYROID HORMONES (con't.)</b>		
LEVOTHYROXINE 125 MCG CAPSULE	T3	HD
LEVOTHYROXINE 13 MCG CAPSULE	T3	HD
LEVOTHYROXINE 137 MCG CAPSULE	T3	HD
LEVOTHYROXINE 150 MCG CAPSULE	T3	HD
LEVOTHYROXINE 175 MCG CAPSULE	T3	HD
LEVOTHYROXINE 200 MCG CAPSULE	T3	HD
LEVOTHYROXINE 25 MCG CAPSULE	T3	HD
LEVOTHYROXINE 50 MCG CAPSULE	T3	HD
LEVOTHYROXINE 75 MCG CAPSULE	T3	HD
LEVOTHYROXINE 88 MCG CAPSULE	T3	HD
<i>levothyroxine sodium</i>	T1	HD
<i>levothyroxine sodium (Synthroid)</i>	T3	HD
<i>liothyronine sodium (Cytomel)</i>	T1	HD
<i>liothyronine sodium (Triostat)</i>	T1	HD
SYNTHROID ( <i>unithroid</i> )	T3	HD
THYQUIDITY	T3	PA HD
<i>thyroid, pork</i>	T1	HD
<i>thyroid, pork (Armour Thyroid)</i>	T1	HD
<i>thyroid, pork (Wp Thyroid)</i>	T1	HD
THYROLAR-1	T2	HD
THYROLAR-1/2	T2	HD
THYROLAR-1/4	T2	HD
THYROLAR-2	T2	HD
THYROLAR-3	T2	HD
TIROSINT	T3	HD
TIROSINT-SOL	T3	HD
TRIOSTAT ( <i>liothyronine sodium</i> )	T3	
WP THYROID	T1	HD
WP THYROID ( <i>nature-throid</i> )	T1	HD
WP THYROID ( <i>westhroid</i> )	T1	HD
<b>CYTOCHROME P450 INHIBITORS</b>		
TYBOST	T4	SP

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

T4 – Specialty Medications

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## List of Prescription Medications

### UNCLASSIFIED DRUG PRODUCTS (Asthma/COPD/Respiratory)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits	
<b>CYSTIC FIBROSIS-CFTR POTENTIATOR-CORRECTOR COMBIN.</b>			
ALYFTREK 10-50-125 MG TABLET	T4	PA QL(2 tabs/day) SP HD	
ALYFTREK 4-20-50 MG TABLET	T4	PA QL(3 tabs/day) SP HD	
BRONCHITOL	T4	PA SP	
ORKAMBI 100 MG-125 MG TABLET	T4	PA QL (4 tabs/day) SP HD	
ORKAMBI 100-125 MG GRANULE PKT	T4	PA QL (2 packs/day) SP HD	
ORKAMBI 150-188 MG GRANULE PKT	T4	PA QL (2 packs/day) SP HD	
ORKAMBI 200 MG-125 MG TABLET	T4	PA QL (4 tabs/day) SP HD	
SYMDEKO	T4	PA QL (2 tabs/day) SP HD	
TRIKAFTA 100-50-75 MG/150 MG	T4	PA QL(3 tabs/day) SP HD	
TRIKAFTA 100-50-75 MG/75MG PKT	T4	PA QL(3 tabs/day) HD	
TRIKAFTA 50-25-37.5 MG/75 MG	T4	PA QL(3 tabs/day) SP HD	
TRIKAFTA 80-40-60MG/59.5MG PKT	T4	PA QL(3 tabs/day) HD	
<b>CYSTIC FIB-TRANSMEMB CONDUCT.REG.(CFTR) POTENTIATOR</b>			
KALYDECO 150 MG TABLET	T4	PA QL (2 tabs/day) SP HD	
KALYDECO 25 MG GRANULES PACKET	T4	PA QL (2 packs/day) SP HD	
KALYDECO 5.8 MG GRANULES PACKET	T4	PA QL (2 packs/day) SP HD	
KALYDECO 50 MG GRANULES PACKET	T4	PA QL (2 packs/day) SP HD	
KALYDECO 75 MG GRANULES PACKET	T4	PA QL (2 packs/day) SP HD	
<b>LUNG SURFACTANTS</b>			
CUROSURF	T3		
INFASURF	T3		
SURVANTA	T3		
<b>MUCOLYTICS</b>			
PULMOZYME	T4	PA SP HD	
<b>PULMONARY FIBROSIS - SYSTEMIC ENZYME INHIBITORS</b>			
OFEV	T4	PA SP HD	
<b>SYSTEMIC ENZYME INHIBITORS</b>			
ARALAST NP	T4	PA SP	
GLASSIA	T4	PA SP	
PROLASTIN C	T4	PA SP HD	
JOENJA	T4	PA QL(2 tabs/day) SP	
VIJOICE 125mg, 50mg	T4	PA QL (30 tabs/30 days) SP	
VIJOICE 250mg dose pack	T4	PA QL (2 tabs/30 days) SP	
ZEMAIRA	T4	PA SP	
ZOKINVY	T4	PA QL (4 caps/day) SP	
T1 – Typically Generics	T4 – Specialty Medications	ST – Step Therapy	HD – May require home delivery pharmacy
T2 – Typically Preferred Brands	PA – Prior Authorization	AGE – Age Requirement	PPACA – No Cost-Share Preventive Medication
T3 – Typically Non-Preferred Brands	QL – Quantity Limit	SP – Specialty Medication	CSL – Oral cancer medication subject to cost-share limits

## List of Prescription Medications

UNCLASSIFIED DRUG PRODUCTS (Blood Modifiers/Bleeding Disorders)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>ANTI-INFLAMMATORY - ANTIMITOTICS</b>		
LODOCO	T3	PA
<b>ANTIPORPHYRIA FACTORS</b>		
PANHEMATIN	T4	SP
<b>ERYTHROID MATURATION AGENTS</b>		
REBLOZYL	T4	PA SP
UNCLASSIFIED DRUG PRODUCTS (Blood Pressure/Heart Medications)		
<b>SPLEEN TYROSINE KINASE INHIBITORS</b>		
TAVALISSE	T4	PA SP
<b>BRADYKININ B2 RECEPTOR ANTAGONISTS</b>		
FIRAZYR ( <i>icatibant acetate</i> )	T4	PA SP
<i>icatibant acetate</i> (Firazyr)	T4	PA SP HD
<b>CI ESTERASE INHIBITORS</b>		
BERINERT	T4	PA SP HD
CINRYZE	T4	PA SP HD
HAEGARDA	T4	PA SP HD
RUCONEST	T4	PA SP HD
<b>PLASMA KALLIKREIN INHIBITORS</b>		
KALBITOR	T4	PA SP HD
ORLADEYO	T4	PA QL (1 caps/day) SP
UNCLASSIFIED DRUG PRODUCTS (Cancer)		
<b>CHEMOTHERAPY RESCUE/ANTIDOTE AGENTS</b>		
<i>amifostine crystalline</i> (Ethylol)	T4	SP
<i>dexrazoxane hcl</i> (Zinecard)	T4	SP
ETHYOL ( <i>amifostine</i> )	T4	SP
KHAPZORY	T3	PA
<i>leucovorin calcium</i>	T1	
<i>levoleucovorin calcium</i>	T1	PA
<i>mesna</i> (Mesnex)	T4	SP
MESNEX	T4	SP
MESNEX ( <i>mesna</i> )	T4	SP
VISTOGARD	T4	SP
VORAXAZE	T4	PA SP
ZINECARD ( <i>dexrazoxane</i> )	T4	SP

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

T4 – Specialty Medications

PA – Prior Authorization

QL – Quantity Limit

ST – Step Therapy

AGE – Age Requirement

SP – Specialty Medication

HD – May require home delivery pharmacy

PPACA – No Cost-Share Preventive Medication

CSL – Oral cancer medication subject to cost-share limits

## List of Prescription Medications

UNCLASSIFIED DRUG PRODUCTS (Cancer) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>INTRAPLEURAL SCLEROSING AGENTS, ANTINEOPLAST. ADJ.</b>		
SCLEROSOL	T3	
STERILE TALC	T1	
STERITALC	T3	
<b>RADIOACTIVE THERAPEUTIC AGENTS</b>		
LUTATHERA	T4	PA SP
METASTRON	T3	PA
QUADRAMET	T3	PA
<i>strontium-89 chloride</i> (Metastron)	T1	PA
XOFIGO	T3	PA
<b>TISSUE PROTECTIVE TX OF CHEMOTHERAPY EXTRAVASATION</b>		
TOTECT	T3	
UNCLASSIFIED DRUG PRODUCTS (Dental Products)		
<b>DENTAL AIDS AND PREPARATIONS</b>		
<i>chlorhexidine gluconate</i> (Peridex)	T1	
PERIDEX (periogard)	T1	
<i>triamcinolone acetonide</i>	T1	
<b>PERIODONTAL COLLAGENASE INHIBITORS</b>		
<i>doxycycline hyclate 20 mg tab</i>	T1	
UNCLASSIFIED DRUG PRODUCTS (Diabetes)		
<b>ANTIHYPERGLYCEMIC-SOD/GLUC COTRANSPORT2(SGLT2) INH</b>		
INPEFA	T3	PA QL(1 tab/day) HD
UNCLASSIFIED DRUG PRODUCTS (Erectile Dysfunction)		
<b>DRUGS TO TREAT ERECTILE DYSFUNCTION (ED)</b>		
CAVERJECT	T3	QL (6 injectors/30 days)
CIALIS 10 MG TABLET ( <i>tadalafil</i> )	T3	QL (6 tabs/30 days) ST HD
CIALIS 20 MG TABLET ( <i>tadalafil</i> )	T3	QL (6 tabs/30 days) ST HD
CIALIS 5 MG TABLET ( <i>tadalafil</i> )	T3	QL (8 tabs/30 days) ST HD
EDEX	T3	QL (6 injectors/30 days)
LEVITRA ( <i>vardenafil hcl</i> )	T3	QL (10 tabs/30 days) ST
MUSE	T2	QL (6/30 days)
<i>sildenafil 100 mg tablet</i> (Viagra)	T1	QL (6 tabs/30 days) HD
<i>sildenafil 25 mg tablet</i> (Viagra)	T1	QL (10 tabs/30 days) HD
<i>sildenafil 50 mg tablet</i> (Viagra)	T1	QL (6 tabs/30 days) HD

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

T4 – Specialty Medications

PA – Prior Authorization

QL – Quantity Limit

ST – Step Therapy

AGE – Age Requirement

SP – Specialty Medication

HD – May require home delivery pharmacy

PPACA – No Cost-Share Preventive Medication

CSL – Oral cancer medication subject to cost-share limits

## List of Prescription Medications

### UNCLASSIFIED DRUG PRODUCTS (Erectile Dysfunction) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>DRUGS TO TREAT ERECTILE DYSFUNCTION (ED) (cont.)</b>		
STENDRA	T3	QL (8 tabs/30 days) ST
tadalafil 2.5 mg tablet	T1	QL(1 tab/day) HD
tadalafil 10 mg tablet (Cialis)	T1	QL(8 tabs/30 days) HD
tadalafil 20 mg tablet (Cialis)	T1	QL(8 tabs/30 days) HD
tadalafil 5 mg tablet (Cialis)	T1	QL(1 tab/day) HD
vardenafil hcl	T1	QL (10 tabs/30 days)
vardenafil hcl (Levitra)	T1	QL (10 tabs/30 days)
VIAGRA (sildenafil citrate)	T3	QL (6 tabs/30 days) ST HD

### UNCLASSIFIED DRUG PRODUCTS (Eye Conditions)

INSULIN-LIKE GROWTH FACTOR RECEPTOR (IGF-R) INHIB		
TEPEZZA	T4	PA SP HD
<b>OCULAR PHOTOACTIVATED VESSEL-OCLUDING AGENTS</b>		
VISUDYNE	T4	SP

### UNCLASSIFIED DRUG PRODUCTS (Gastrointestinal/Heartburn)

CALCIMIMETIC, PARATHYROID CALCIUM ENHANCER		
cinacalcet hcl (Sensipar)	T4	SP
PARSABIV	T4	PA SP
SENSIPAR (cinacalcet hcl)	T4	PA SP
<b>ORAL MUCOSITIS/STOMATITIS AGENTS</b>		
ORAMAGICRX	T3	
REZDIFRA	T4	PA QL(1 tab/day) SP HD
<b>SALIVA STIMULANT AGENTS</b>		
NUMOISYN	T2	

### UNCLASSIFIED DRUG PRODUCTS (Hormonal Agents)

BONE FORMATION STIM. AGENTS - PARATHYROID HORMONE		
FORTEO	T4	PA QL (3ml/21 days) SP HD
teriparatide 600 mcg/2.4ml pen (Forteo)	T4	PA QL (1 pen/28 days) SP HD
<b>GROWTH HORMONE RECEPTOR ANTAGONISTS</b>		
SOMAVERT	T4	PA SP HD
<b>HYPERPARATHYROID TX AGENTS - VITAMIN D ANALOG-TYPE</b>		
doxercalciferol	T1	
doxercalciferol (Hectorol)	T1	
HECTOROL (doxercalciferol)	T3	

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

T4 – Specialty Medications

PA – Prior Authorization

QL – Quantity Limit

ST – Step Therapy

AGE – Age Requirement

SP – Specialty Medication

HD – May require home delivery pharmacy

PPACA – No Cost-Share Preventive Medication

CSL – Oral cancer medication subject to cost-share limits

## List of Prescription Medications

### UNCLASSIFIED DRUG PRODUCTS (Hormonal Agents) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>HYPERPARATHYROID TX AGENTS - VITAMIN D ANALOG-TYPE (cont.)</b>		
paricalcitol 1 mcg capsule (Zemplar)	T4	SP HD
PARICALCITOL 10 MCG/2 ML VIAL	T4	SP
paricalcitol 10 mcg/2 ml vial (Zemplar)	T4	SP
paricalcitol 2 mcg capsule (Zemplar)	T4	SP HD
PARICALCITOL 2 MCG/ML VIAL	T4	SP
paricalcitol 2 mcg/ml vial (Zemplar)	T4	SP
paricalcitol 4 mcg capsule	T4	SP HD
PARICALCITOL 5 MCG/ML VIAL	T4	SP
paricalcitol 5 mcg/ml vial (Zemplar)	T4	SP
RAYALDEE	T3	
ZEMPLAR 1 MCG CAPSULE (paricalcitol)	T4	SP HD
ZEMPLAR 10 MCG/2 ML VIAL (paricalcitol)	T4	SP
ZEMPLAR 2 MCG CAPSULE (paricalcitol)	T4	SP HD
ZEMPLAR 2 MCG/ML VIAL (paricalcitol)	T4	SP
ZEMPLAR 5 MCG/ML VIAL (paricalcitol)	T4	SP
<b>MENOPAUSAL SYMPT SUPP-SEL ESTROGEN RECEPTOR MODULATOR</b>		
OSPHENA	T3	HD
<b>UNCLASSIFIED DRUG PRODUCTS (Miscellaneous)</b>		
<b>ABORTIFACIENT-PROGESTERONE RECEPTOR ANTAGONISTS</b>		
MIFEPREX	T3	
mifepristone (Mifeprex)	T1	
<b>ACID AND ALKALI POISON ANTIDOTES</b>		
methylene blue (antidotes)	T1	
PROVAYBLUE	T3	
<b>AGENTS TO TX PERIODIC PARALYSIS - CARBON ANHYD INH</b>		
dichlorphenamide (Keveyis)	T4	PA SP
KEVEYIS (dichlorphenamide)	T4	PA SP
<b>AMMONIA INHIBITORS</b>		
CARBAGLU	T4	SP HD
PHEBURANE	T4	PA QL (8 bottles/30days) SP
<b>AMYLOIDOSIS AGENTS-TRANSTHYRETIN (TTR) SUPPRESSION</b>		
ONPATRO	T4	PA SP
TEGSEDI	T4	PA SP HD
WAINUA	T4	PA QL(1 auto-inj/28 days) SP

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

T4 – Specialty Medications

PA – Prior Authorization

QL – Quantity Limit

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AGE – Age Requirement

SP – Specialty Medication

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## List of Prescription Medications

### UNCLASSIFIED DRUG PRODUCTS (Miscellaneous) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>ANTI-ALCOHOLIC PREPARATIONS</b>		
acamprosate calcium	T1	
ANTABUSE ( <i>disulfiram</i> )	T3	
<i>disulfiram</i> (Antabuse)	T1	
VIVITROL	T4	SP HD
<b>ANTIDOTES, MISCELLANEOUS</b>		
ACETADOTE ( <i>acetylcysteine</i> )	T3	
<i>acetylcysteine</i> (Acetadote)	T1	
CETYLEV	T3	
CYANOKIT	T3	
DIGIFAB	T3	
<i>fomepizole</i>	T1	
SODIUM NITRITE	T1	
<b>ANTI-FIBROTIC THERAPY - PYRIDONE ANALOGS</b>		
<i>pirfenidone 267 mg capsule</i> (Esbriet)	T4	PA SP HD
<b>BENZODIAZEPINE ANTAGONISTS</b>		
<i>flumazenil</i>	T1	
<b>CATHETER LOCK SOLUTIONS</b>		
DEFENCATH	T3	
<b>CHOLINESTERASE REACTIVAT.-MUSCARINIC ANTG.ANTIDOTE</b>		
DUODOTE	T3	
<b>CHOLINESTERASE REACTIVATING, ORGANOPHOS. ANTIDOTES</b>		
PRALIDOXIME CHLORIDE	T1	
PROTOPAM CHLORIDE	T3	
<b>COMPLEMENT INHIBITORS</b>		
PIASKY	T4	PA SP
VEOPZOZ	T4	SP
VOYDEYA	T4	PA QL(1 packet/28 days) SP
ZILBRYSQ	T4	PA QL(1 syringe/day) SP
<b>CRYOPRESERVATIVE AGENTS</b>		
<i>dimethyl sulfoxide</i>	T3	
<b>DILUENT SOLUTIONS</b>		
<i>diluent for epoprostenol (glyc)</i>	T1	
DILUENT FOR REMODULIN	T3	
<i>diluent for treprostinil (gly)</i> (Diluent For Remodulin)	T1	
ELLIOTTS B	T3	

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

T4 – Specialty Medications

PA – Prior Authorization

QL – Quantity Limit

ST – Step Therapy

AGE – Age Requirement

SP – Specialty Medication

HD – May require home delivery pharmacy

PPACA – No Cost-Share Preventive Medication

CSL – Oral cancer medication subject to cost-share limits

## List of Prescription Medications

### UNCLASSIFIED DRUG PRODUCTS (Miscellaneous) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>DRUGS TO TREAT ACUTE HEPATIC PORPHYRIA (AHP)</b>		
GIVLAARI	T4	PA SP HD
<b>DRUGS TO TREAT HEREDITARY TYROSINEMIA</b>		
<i>nitisinone</i> (Orfadin)	T4	PA SP HD
NITYR	T4	PA SP
ORFADIN	T4	PA SP
ORFADIN ( <i>nitisinone</i> )	T4	PA SP
<b>GENERAL INHALATION AGENTS</b>		
HYPER-SAL	T3	
<i>nebusal 3% vial</i>	T1	
NEBUSAL 6% VIAL	T3	
<i>sodium chloride for inhalation</i>	T1	
<i>sodium chloride for inhalation</i> (Hyper-sal)	T1	
<b>GENETIC D/O TX - SMN PROTEIN DEFICIENCY TREATMENT</b>		
AMONDYS-45	T4	PA SP
EVRYSDI	T4	PA SP HD
EXONDYS-51	T4	PA SP
SPINRAZA	T4	PA SP HD
VILTEPSO	T4	PA SP
VYONDYS-53	T4	PA SP
<b>GLUCOSYL CERAMIDE SYNTHASE (GCS) INHIBITOR</b>		
CERDELGA	T4	PA SP HD
<i>miglustat</i> (Zavesca)	T4	PA SP HD
OPFOLDA	T4	PA QL(8 caps/30 days) SP HD
ZAVESCA ( <i>miglustat</i> )	T4	PA SP HD
<b>KIDNEY STONE AGENTS</b>		
<i>tiopronin</i>	T4	SP
<b>LEAD POISONING, AGENTS TO TREAT (CHELATING-TYPE)</b>		
CALCIUM DISODIUM VERSENATE	T1	PA
<b>MENOPAUSAL SYMPTOMS SUPPRESSANT - SSRIs</b>		
<i>paroxetine mesylate</i>	T1	QL (1 cap/day) HD
VEOZAH	T3	QL(1 tab/day)
<b>METABOLIC DISEASE ENZYME REPLACE, HYPOPHOSPHATASIA</b>		
STRENSIQ	T4	PA SP

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

T4 – Specialty Medications

PA – Prior Authorization

QL – Quantity Limit

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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

### UNCLASSIFIED DRUG PRODUCTS (Miscellaneous) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>METABOLIC DISEASE ENZYME REPLACEMENT, BATTEN DISEASE</b>		
BRINEURA	T4	PA SP
<b>METABOLIC DISEASE ENZYME REPLACEMENT, FABRY'S DX</b>		
FABRAZYME	T4	PA SP HD
<b>METABOLIC DISEASE ENZYME REPLACEMENT, GAUCHER'S DX</b>		
CEREZYME	T4	PA SP HD
ELELYSO	T4	PA SP
VPRIV	T4	PA SP HD
<b>METABOLIC DISEASE ENZYME REPLACEMENT, MOCD</b>		
NULIBRY	T4	PA SP
<b>METABOLIC DISEASE ENZYME REPLACEMENT, POMPE DISEASE</b>		
LUMIZYME	T4	PA SP
POMBILITI	T4	PA SP HD
<b>METABOLIC DX ENZYME REPLACEMENT, ALPHA-MANNOSIDOSIS</b>		
LAMZED	T4	PA SP
<b>METABOLIC DX ENZYME REPLACE, MUCOPOLYSACCHARIDOSIS</b>		
ALDURAZYME	T4	PA SP HD
ELAPRASE	T4	PA SP
MEPSEVII	T4	PA SP
NAGLAZYME	T4	PA SP
VIMIZIM	T4	PA SP
<b>METABOLIC DX ENZYME REPLACEMENT, LYSO.ACID LIP.DEF.</b>		
KANUMA	T4	PA SP
<b>METABOLIC DX ENZYME REPLACEMT, SEV.COMB.IMMUNE DEF.</b>		
ADAGEN	T4	PA SP
REVCovi	T4	PA SP
<b>METALLIC POISON, AGENTS TO TREAT</b>		
BAL IN OIL	T3	PA
CHEMET	T3	
CUVRIOR	T4	PA SP
deferasirox (Exjade)	T4	SP HD
deferasirox (Jadenu Sprinkle)	T4	SP HD
deferasirox (Jadenu)	T4	SP HD
deferiprone (Ferriprox)	T4	PA SP HD
deferoxamine mesylate	T1	

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

T4 – Specialty Medications

PA – Prior Authorization

QL – Quantity Limit

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AGE – Age Requirement

SP – Specialty Medication

HD – May require home delivery pharmacy

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## List of Prescription Medications

### UNCLASSIFIED DRUG PRODUCTS (Miscellaneous) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>METALLIC POISON, AGENTS TO TREAT (cont.)</b>		
deferoxamine mesylate (Desferal Mesylate)	T1	
DESFERAL MESYLATE (deferoxamine mesylate)	T3	
EXJADE (deferasirox)	T4	PA SP HD
FERRIPROX	T4	PA SP
FERRIPROX (2 TIMES A DAY)	T4	PA SP
GALZIN	T3	
JADENU (deferasirox)	T4	PA SP HD
JADENU SPRINKLE (deferasirox)	T4	PA SP HD
NITHIODOTE	T3	
PENTETATE CALCIUM TRISODIUM	T1	
ZINC TRISODIUM	T1	
RADIOGARDASE	T3	
sodium thiosulf (poison treat)	T1	
SYPRINE (trientine hcl)	T4	PA SP HD
trientine hcl (Syprine)	T4	PA SP HD
TRIENTINE HCL 500 MG CAPSULE	T4	PA SP HD
<b>MISCELLANEOUS AGENTS</b>		
NEXAVIR	T4	SP
<b>NATRIURETIC PEPTIDES</b>		
VOXZOGO	T4	PA SP HD
<b>NICOTINIC RECEPT.PARTIAL AGONIST, ALPHA4BETA2 SPEC</b>		
TYRVAYA	T3	QL (2/month) HD
<b>NUCLEAR FACTOR ERYTHROID 2-REL. FACTOR 2 ACTIVATOR</b>		
SKYCLARYS	T4	PA QL(3 caps/day) SP
<b>OINTMENT/CREAM BASES</b>		
RADIAGEL	T3	
<b>OXALOSIS AGENT - OXALATE INHIBITOR, SIRNA BASED</b>		
RIVFLOZA 128 MG/0.8 ML SYRINGE	T4	PA QL(1 syringe/30 days) SP
RIVFLOZA 160 MG/ML SYRINGE	T4	PA QL(1 syringe/30 days) SP
RIVFLOZA 80 MG/0.5 ML VIAL	T4	PA SP
<b>PHARMACOLOGICAL CHAPERONE-ALPHA-GALACTOSID.A STABZ</b>		
GALAFOLD	T4	PA SP HD
<b>PKU TX AGENT-COFACTOR OF PHENYLALANINE HYDROXYLASE</b>		
javygtor 100 mg powder packet (Kuvan)	T1	

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

T4 – Specialty Medications

PA – Prior Authorization

QL – Quantity Limit

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AGE – Age Requirement

SP – Specialty Medication

HD – May require home delivery pharmacy

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## List of Prescription Medications

### UNCLASSIFIED DRUG PRODUCTS (Miscellaneous) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>PKU TX AGENT-COFACTOR OF PHENYLALANINE HYDROXYLASE (cont.)</b>		
javvygor 100 mg tablet (Kuvan)	T1	
javvygor 500 mg powder packet (Kuvan)	T1	
KUVAN (sapropterin dihydrochloride)	T4	PA SP HD
sapropterin dihydrochloride (Kuvan)	T4	PA SP HD
<b>PROTEIN STABILIZERS</b>		
ATTRUBY	T4	PA QL (4 ml/day) SP HD
VYNDAMAX	T4	PA QL (1 cap/day) SP HD
VYndaQEL	T4	PA QL (4 caps/day) SP HD
<b>RADIOPHARMACEUTICALS ELEMENTS</b>		
TECHNELITE TC-99M GENERATOR	T3	
<b>RETINOIC ACID RECEPTOR (RAR) AGONISTS</b>		
SOHONOS	T4	PA SP
<b>SODIUM/SALINE PREPARATIONS</b>		
bacteriostatic sodium chloride	T1	
<b>SOLVENTS</b>		
isopropyl alcohol	T3	
MURI-LUBE MINERAL OIL	T3	
<b>TOPICAL/MUCOUS MEMBR./SUBCUT. ENZYMES</b>		
HYLENEX	T4	SP HD
<b>WATER</b>		
water for injection, sterile	T1	
water/me-paraben/propylparaben	T1	

### UNCLASSIFIED DRUG PRODUCTS (Multiple Sclerosis)

#### LEUKOCYTE ADHESION INHIB, ALPHA4-MEDIAT IGG4K MC AB

TYSABRI	T4	PA SP HD
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### UNCLASSIFIED DRUG PRODUCTS (Nutritional/Dietary)

#### METABOLIC DEFICIENCY AGENTS

CARNITOR 1 GM/5 ML VIAL	T3	PA
CARNITOR 100 MG/ML ORAL SOLN ( <i>levocarnitine</i> )	T3	PA
CARNITOR 330 MG TABLET ( <i>levocarnitine</i> )	T3	PA
CARNITOR SF ( <i>levocarnitine sf</i> )	T3	PA
CYSTADANE	T4	SP
<i>levocarnitine</i> (Carnitor)	T1	
<i>levocarnitine</i> (with sugar) (Carnitor)	T1	

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

T4 – Specialty Medications

PA – Prior Authorization

QL – Quantity Limit

ST – Step Therapy

AGE – Age Requirement

SP – Specialty Medication

HD – May require home delivery pharmacy

PPACA – No Cost-Share Preventive Medication

CSL – Oral cancer medication subject to cost-share limits

## List of Prescription Medications

UNCLASSIFIED DRUG PRODUCTS (Osteoporosis Products)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>BONE FORMATION AGENTS - SCLEROSTIN INHIBITOR, MONO</b>		
EVENITY	T4	PA QL (2 syrings/month) SP
EVENITY (2 SYRINGES)	T4	PA QL (2 syrings/month) SP
<b>BONE RESORPTION INHIBITOR AND VITAMIN D COMBS.</b>		
FOSAMAX PLUS D	T3	ST HD
<b>BONE RESORPTION INHIBITORS</b>		
ACTONEL ( <i>risedronate sodium</i> )	T3	ST HD
<i>alendronate sodium</i>	T1	HD
<i>alendronate sodium (Fosamax)</i>	T1	HD
ATELVIA ( <i>risedronate sodium dr</i> )	T3	ST HD
BINOSTO	T3	ST HD
BONIVA 150 MG TABLET ( <i>ibandronate sodium</i> )	T3	ST HD
BONIVA 3 MG/3 ML SYRINGE ( <i>ibandronate sodium</i> )	T4	SP HD
EVISTA ( <i>raloxifene hcl</i> )	T3	HD
FOSAMAX ( <i>alendronate sodium</i> )	T3	ST HD
<i>ibandronate 3 mg/3 ml syringe (Boniva)</i>	T4	SP HD
<i>ibandronate 3 mg/3 ml vial</i>	T4	SP HD
<i>ibandronate sodium 150 mg tab (Boniva)</i>	T1	HD
<i>pamidronate disodium</i>	T4	SP HD
PROLIA	T4	PA SP
<i>raloxifene hcl (Evista)</i>	T1	HD PPACA
RECLAST ( <i>zoledronic acid</i> )	T4	SP HD
<i>risedronate sodium</i>	T1	HD
<i>risedronate sodium (Actonel)</i>	T1	HD
<i>risedronate sodium (Atelvia)</i>	T1	HD
XGEVA	T4	PA SP
<i>zoledronic acid</i>	T4	SP HD
<i>zoledronic acid/manitol-water</i>	T4	SP HD
<i>zoledronic acid/manitol-water (Reclast)</i>	T4	SP HD
UNCLASSIFIED DRUG PRODUCTS (Pain Relief And Inflammatory Disease)		
<b>ANTI-INFLAM. INTERLEUKIN-1 RECEPTOR ANTAGONIST</b>		
ARCALYST	T4	PA SP HD
<b>ANTI-INFLAMMATORY, INTERLEUKIN-1 BETA BLOCKERS</b>		
ILARIS	T4	PA SP HD

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

T4 – Specialty Medications

PA – Prior Authorization

QL – Quantity Limit

ST – Step Therapy

AGE – Age Requirement

SP – Specialty Medication

HD – May require home delivery pharmacy

PPACA – No Cost-Share Preventive Medication

CSL – Oral cancer medication subject to cost-share limits

## List of Prescription Medications

### UNCLASSIFIED DRUG PRODUCTS (Pain Relief And Inflammatory Disease) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>FIBROMYALGIA AGENTS, SEROTONIN-NOREPINEPHRINE INHIBITORS</b>		
SAVELLA	T2	HD
<b>IMMUNOMODULATOR, B-LYMPHOCYTE STIM (BLYS)-SPECIFIC INHIBITOR</b>		
BENLYSTA 120 MG VIAL	T4	PA SP
BENLYSTA 200 MG/ML AUTOINJECT	T4	PA SP HD
BENLYSTA 200 MG/ML SYRINGE	T4	PA SP HD
BENLYSTA 400 MG VIAL	T4	PA SP
<b>JOINT CONTRACTURE THERAPY, COLLAGENASE ENZYME</b>		
XIAFLEX	T3	PA SP
<b>UNCLASSIFIED DRUG PRODUCTS (Seizure Disorders)</b>		
<b>NEUROPATHIC AGENTS</b>		
LYRICA CR	T3	HD
<b>UNCLASSIFIED DRUG PRODUCTS (Skin Conditions)</b>		
<b>INTERLEUKIN-13 (IL-13) INHIBITORS, MAB</b>		
EBGLYSS	T4	PA SP
ADBRY	T4	PA SP HD
<b>WOUND HEALING AGENTS, LOCAL</b>		
balsam peruvian/castor oil (Venelex)	T1	
BALSAM PERU-CASTOR OIL	T1	
DERMULCERA	T1	
FILSUVEX	T4	PA SP
VENELEX	T3	
<b>UNCLASSIFIED DRUG PRODUCTS (Substance Abuse)</b>		
<b>OPIOID WITHDRAWAL THERAPY, ALPHA-2 ADRENERGIC AGONIST</b>		
lofexidine hcl (Lucemyra)	T1	QL(192 tabs/30 days)
LUCEMYRA (lofexidine hcl)	T2	QL (168 tabs/14 days)
<b>OPIOID WITHDRAWAL THERAPY AGENTS, OPIOID-TYPE</b>		
BUNAVAIL	T3	
buprenorphine hcl	T1	
buprenorphine hcl/naloxone hcl (Suboxone)	T1	
PROBUPHINE	T3	
SUBLOCADE	T4	SP
SUBOXONE (buprenorphine-naloxone)	T3	
ZUBSOLV	T2	

T1 – Typically Generics

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## List of Prescription Medications

UNCLASSIFIED DRUG PRODUCTS (Transplant Medications)			
RHO KINASE INHIBITOR			
REZUROCK	T4	PA SP HD	
UNCLASSIFIED DRUG PRODUCTS (Urinary Tract Conditions)			
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits	
<b>BENIGN PROSTATIC HYPERPLASIA/MICTURITION AGENTS</b>			
alfuzosin hcl (Uroxatral)	T1	HD	
AVODART (dutasteride)	T3	PA HD	
dutasteride (Avodart)	T1	HD	
finasteride (Proscar)	T1	HD	
FLOMAX (tamsulosin hcl)	T3	HD	
PROSCAR (finasteride)	T3	PA HD	
RAPAFLO 4 MG CAPSULE (silodosin)	T3	QL (1 cap/day) HD	
RAPAFLO 8 MG CAPSULE (silodosin)	T3	HD	
silodosin 4 mg capsule (Rapaflo)	T1	QL (1 cap/day) HD	
silodosin 8 mg capsule (Rapaflo)	T1	HD	
tamsulosin hcl (Flomax)	T1	HD	
UROXATRAL (alfuzosin hcl er)	T3	HD	
<b>BPH AGENT-5-ALPHA-REDUCTASE INH AND PDE5 INH COMB</b>			
ENTADFI	T3	PA QL(1 cap/day)	
<b>BPH 5-ALPHA-REDUCTASE INHIB-ALPHAI-ADRENOCEP ANTAG</b>			
dutasteride/tamsulosin hcl	T1	HD	
<b>CYSTINE-DEPLETING AGENTS, NEPHROPATHIC CYSTINOSIS</b>			
CYSTAGON	T4	SP	
PROCYSBI	T4	PA SP HD	
<b>OVERACTIVE BLADDER AGENTS, BETA-3 ADRENERGIC RECEPTOR ANTAGONISTS</b>			
GEMTESA	T3	QL (1 tab/day) ST HD	
mirabegron er 25 mg tablet (Myrbetriq)	T1	QL(1 tab/day) HD	
mirabegron er 50 mg tablet (Myrbetriq)	T1	HD	
MYRBETRIQ ER 25 MG TABLET (mirabegron)	T3	ST QL(1 tab/day) HD	
MYRBETRIQ ER 50 MG TABLET (mirabegron)	T3	ST HD	
<b>URINARY TRACT ANTI-SPASMODIC, M(3) SELECTIVE ANTAG.</b>			
darifenacin er 15 mg tablet	T1	HD	
darifenacin er 7.5 mg tablet (Enablex)	T1	QL (1 tab/day) HD	
ENABLEX (darifenacin er)	T3	QL (1 tab/day) ST HD	
solifenacin 10 mg tablet (Vesicare)	T1	HD	
solifenacin 5 mg tablet (Vesicare)	T1	QL (1 tab/day) HD	

T1 – Typically Generics

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## List of Prescription Medications

UNCLASSIFIED DRUG PRODUCTS (Urinary Tract Conditions) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>URINARY TRACT ANTI-SPASMODIC, M(3) SELECTIVE ANTAG. (con't.)</b>		
VESICARE TABLET ( <i>solifenacin succinate</i> )	T3	ST QL (1 tab/day) HD
VESICARE LS	T3	ST HD
<b>URINARY TRACT ANTI-SPASMODIC/ANTI-INCONTINENCE AGENT</b>		
DETROL ( <i>tolterodine tartrate</i> )	T3	ST HD
DETROL LA 2 MG CAPSULE ( <i>tolterodine tartrate er</i> )	T3	QL (1 cap/day) ST HD
DETROL LA 4 MG CAPSULE ( <i>tolterodine tartrate er</i> )	T3	ST HD
DITROPAN XL ( <i>oxybutynin chloride er</i> )	T3	ST HD
<i>flavoxate hcl</i>	T1	HD
OXYBUTYNIN 2.5 MG TABLET	T3	PA HD
<i>oxybutynin 5 mg tablet</i>	T1	HD
<i>oxybutynin 5 mg/5 ml solution</i>	T1	HD
<i>oxybutynin 5 mg/5 ml syrup</i>	T1	HD
<i>oxybutynin chloride</i>	T1	HD
<i>oxybutynin chloride (Ditropan XI)</i>	T1	HD
OXYTROL	T3	ST HD
<i>tolterodine tart er 2 mg cap (Detrol La)</i>	T1	QL (1 cap/day) HD
<i>tolterodine tart er 4 mg cap (Detrol La)</i>	T1	HD
<i>tolterodine tartrate (Detrol)</i>	T1	HD
TOVIAZ ER 4 MG TABLET	T2	QL (1 tab/day) HD
TOVIAZ ER 8 MG TABLET	T2	HD
<i>trospium chloride</i>	T1	HD
<b>UNCLASSIFIED DRUG PRODUCTS (Weight Management)</b>		
<b>APPETITE STIM. FOR ANOREXIA, CACHEXIA, WASTING SYND.</b>		
megestrol acetate	T1	
<b>VITAMINS (Nutritional/Dietary)</b>		
<b>FOLIC ACID PREPARATIONS</b>		
<i>folic acid</i>	T1	
<b>MULTIVITAMIN PREPARATIONS</b>		
CITRANATAL MEDLEY	T3	
FOLET ONE	T2	
INFUVITE ADULT	T3	
<i>multivit infusn, adult 1, vit k</i>	T3	

T1 – Typically Generics

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## List of Prescription Medications

VITAMINS (Nutritional/Dietary) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>MULTIVITAMIN PREPARATIONS (con't.)</b>		
<i>mvn no.53/iron/folic/dss/dha</i>	T1	
OBSTETRIX ONE	T1	
<b>PEDIATRIC VITAMIN PREPARATIONS</b>		
INFUVITE PEDIATRIC	T3	
M.V.I. PEDIATRIC	T3	
VITALIPID N INFANT	T3	
VITLIPID N INFANT	T3	
<b>VITAMIN A PREPARATIONS</b>		
AQUASOL A	T3	
<b>VITAMIN B PREPARATIONS</b>		
<i>vitamins b1, b2, b3, b5, and b6</i>	T1	HD
<b>VITAMIN B1 PREPARATIONS</b>		
<i>thiamine hcl</i>	T1	
<b>VITAMIN B12 PREPARATIONS</b>		
B-12 COMPLIANCE	T1	
<i>cyanocobalamin (vitamin b-12)</i>	T1	PA
<i>hydroxocobalamin</i>	T1	
NASCOBAL	T3	PA
PHYSICIANS EZ USE B-12	T3	
<b>VITAMIN C PREPARATIONS</b>		
ASCOR	T3	
<i>ascorbic acid</i>	T1	
<b>VITAMIN D PREPARATIONS</b>		
<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 vial</i>	T1	HD
<i>calcitriol 1 mcg/ml solution (Rocaltrol)</i>	T1	HD
<i>ergocalciferol (vitamin d2)</i>	T1	HD
ROCALTROL ( <i>calcitriol</i> )	T3	
MEPHYTON ( <i>phytonadione</i> )	T3	
PHYTONADIONE	T1	
<i>phytonadione (vit k1)</i>	T1	

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## List of Prescription Medications

### VITAMINS (Nutritional/Dietary) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>VITAMIN K PREPARATIONS</b>		
<i>phytonadione (vit k1) (Mephyton)</i>	T1	
<b>MULTIVITAMIN PREPARATIONS</b>		
VITLIPID N ADULT	T3	

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## Exclusions and limitations for coverage

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

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

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

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

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

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



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

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

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

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

# DISCRIMINATION IS AGAINST THE LAW

## Medical coverage

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

Cigna:

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

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

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

Cigna  
Nondiscrimination Complaint Coordinator  
PO Box 188016  
Chattanooga, TN 37422

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

U.S. Department of Health and Human Services  
200 Independence Avenue, SW  
Room 509F, HHH Building  
Washington, DC 20201  
1.800.368.1019, 800.537.7697 (TDD)  
Complaint forms are available at  
<http://www.hhs.gov/ocr/office/file/index.html>.



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## Proficiency of Language Assistance Services

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

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

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

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

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

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

- توجه: خدمات کمک زبانی، به صورت رایگان به شما ارائه می شود. برای مشتریان فعلی Cigna، لطفاً با شماره‌ای که در پشت کارت شناسایی ثابت شده باشند تماس بگیرید. در غیر اینصورت با شماره 1.800.244.6224 تماس بگیرید (شماره تلفن ویژه ناشنوایان: شماره 711 شماره مگری کنید).  
**Persian (Farsi)**