



Cigna Healthcare 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

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

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

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

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 This drug list is subject to change and all prior versions are no longer in effect.

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

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What's Inside?	Page
Information about this drug list	3
· Frequently asked questions (FAQs)	3
· Words you may need to know	10
· About this drug list	12
· How to read this drug list	12
· How to find your medication	15
List of prescription medications	18
Exclusions and limitations for coverage	165
Index of medications	166

View your drug list online

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

- As soon as your new plan year starts, log into the **myCigna® App¹ or myCigna.com[®]**. Use the Price a Medication tool to get real-time information about the medications your plan covers.
- You can also view a pdf of this document online at **Cigna.com/PDL**. Click on the dropdown next to "Drug Lists for Employer Plans." Scroll down to the section for California Employer Drug Lists; then click on **California Performance 4 Tier (all specialty medications covered on tier 4) (CDI) [PDF]**.

Questions?

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

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

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

Next planned update: 11/01/2024, for changes starting 01/01/2025

Information about this drug list

Frequently asked questions (FAQs)

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

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

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

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

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

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

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

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

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

Q. How do you decide which medications to cover?

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

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

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

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

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

Information about this drug list

Frequently asked questions (FAQs) (cont.)

Q. What types of medications typically need approval?

A. Medications that:

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

Q. What types of medications typically have quantity limits?

A. Medications that are often:

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

Q. What types of medications require Step Therapy?

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

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

Q. Why does my medication have an age requirement?

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

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

A. Ask your doctor's office to contact Cigna Healthcare to start the coverage review process. They know how the review process works and will take care of everything for you. In case the office asks, they can download a request form from

the Cigna Healthcare provider portal at cignaforhcp.com.

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

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

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

Information about this drug list

Frequently asked questions (FAQs) (cont.)

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

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

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

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

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

medication and/or the reviewing doctor.

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

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

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

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

- **For non-urgent requests,** Cigna Healthcare will let you and your doctor know within 72 hours of the decision. If approved, coverage will be provided until the prescription runs out (including refills).
- **For urgent requests based on exigent circumstances,** Cigna Healthcare will let you and your doctor know within 24 hours of the decision. 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

Information about this drug list

Frequently asked questions (FAQs) (cont.)

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:

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

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

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

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

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

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

A. Yes.

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

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

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

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

Q. What are preventive medications?

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

Information about this drug list

Frequently asked questions (FAQs) (cont.)

prenatal nutrient deficiency and stroke.

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

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

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

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

Q. What's a cost-share?

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

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

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

Q. What's a generic medication?

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

or scientific name, instead of the manufacturer's patented brand name.

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

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

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

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

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

Q. 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®

Information about this drug list

Frequently asked questions (FAQs) (cont.)

Pharmacy and/or specialty medications through Accredo®'s specialty pharmacy for them to be covered.⁴ Log in to the [myCigna App](#) or [myCigna.com](#), or check your plan materials, to find out what your plan requires.

Q. Can I fill my prescriptions by mail?

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

[Express Scripts® Pharmacy for maintenance medications](#)

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

- Easily order, manage, track and pay for your medications on your phone or online
- Standard shipping at no extra cost⁵
- Automatic refills or refill reminders
- Fill up to a 90-day supply at one time⁶
- Helpful pharmacists available 24/7
- Flexible payment options

Here are three easy ways to get started.

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

[Accredo for specialty medications](#)

If you're taking a specialty medication to treat a complex medical condition, Accredo's team of specially-trained pharmacists and nurses can help. They'll fill and ship your specialty medication to your

home (or location of your choice).⁷ They'll also provide you with the personalized care and support you need to manage your therapy – at no extra cost.

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

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

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

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

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

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

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

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

Information about this drug list

Frequently asked questions (FAQs) (cont.)

Q. How do I fill my prescription?

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

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

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

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

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

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

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

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

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

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

Information about this drug list

Frequently asked questions (FAQs) (cont.)

pay your plan deductible first. After that, these medications will be covered at 100%, or no cost-share (\$0) to you.

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

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

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

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

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

Words you may need to know

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

Information about this drug list

Words you may need to know (cont.)

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

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

Information about this drug list

About this drug list

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

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

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

Information about this drug list

How to read this drug list (cont.)

Letters (acronyms) next to medication names

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

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

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

Information about this drug list

How to read this drug list (cont.)

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

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

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

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

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

Prescription drug name is the name of the medication

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

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

Generic medications are in **lowercase italics**

This chart is just a sample. It may not show how these medications are actually covered on the Cigna Healthcare 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)	18-23	Anti-Infectives/Miscellaneous (Infections)	47, 48
Analgesics (Urinary Tract Conditions)	23	Anti-Infectives/Miscellaneous (Miscellaneous)	48
Anesthetics (Miscellaneous)	23	Anti-Infectives/Miscellaneous (Skin Conditions)	48
Anesthetics (Pain Relief and Inflammatory Disease)	23	Anti-Inflammatory Tumor Necrosis Factor Inhibiting Agents (Pain Relief and Inflammatory Disease)	49, 50
Anesthetics (Urinary Tract Conditions)	24	Anti-Neoplastics (Cancer)	50-56
Anti-Allergy (Allergy and Nasal Sprays)	24	Anti-Neoplastics (Skin Conditions)	56, 57
Anti-Arthritis (Pain Relief and Inflammatory Disease)	24-27	Anti-Obesity Drugs (Weight Management)	57
Anti-Asthmatics (Asthma/COPD/Respiratory)	27-30	Anti-Parasitics (Infections)	58
Antibiotics (Allergy/Nasal Sprays)	30	Anti-Parkinson's Drugs (Parkinson's Disease)	58-60
Antibiotics (Ear Medications)	30	Anti-Platelet Drugs (Blood Thinners/Anti-Clotting)	60
Antibiotics (Eye Conditions)	30-32	Antivirals (Aids/Hiv)	60-63
Antibiotics (Infections)	32-37	Antivirals (Eye Conditions)	63
Antibiotics (Skin Conditions)	37, 38	Antivirals (Infections)	63-65
Anti-Coagulants (Blood Thinners/Anti-Clotting)	38-40	Antivirals (Skin Conditions)	65
Antidotes (Gastrointestinal/Heartburn)	40	Autonomic Drugs (Allergy/Nasal Sprays)	65
Antidotes (Substance Abuse)	40, 41	Autonomic Drugs (Alzheimer's Disease)	66, 67
Anti-Fungals (Eye Conditions)	41	Autonomic Drugs (Attention Deficit Hyperactivity Disorder)	62, 63
Anti-Fungals (Feminine Products)	41	Autonomic Drugs (Blood Pressure/Heart Medications)	67
Anti-Fungals (Infections)	41	Autonomic Drugs (Urinary Tract Conditions)	67
Anti-Fungals (Skin Conditions)	42	Biologicals (Allergy/Nasal Sprays)	67, 68
Antihistamine and Decongestant Combination (Allergy/Nasal Sprays)	42	Biologicals (Blood Pressure/Heart Medications)	68
Antihistamines (Allergy/Nasal Sprays)	42, 43	Biologicals (Miscellaneous)	68
Antihistamines (Eye Conditions)	43	Biologicals (Vaccines)	68-70
Anti-Hyperglycemics (Diabetes)	43-47	Blood (Blood Modifiers/Bleeding Disorders)	70, 71
Anti-Infectives (Feminine Products)	47	Blood (Blood Thinners/Anti-Clotting)	71
Anti-Infectives (Infections)	47		

Information about this drug list

How to find your medication (cont.)

Condition	Page	Condition	Page
Cardiac Drugs (Blood Pressure/Heart Medications)	71-74	Gastrointestinal (Pain Relief and Inflammatory Disease)	I09
Cardiovascular (Allergy/Nasal Sprays)	74	Hormones (Hormonal Agents)	I09-I15
Cardiovascular (Asthma/COPD/Respiratory)	75	Hormones (Infertility)	I15
Cardiovascular (Blood Pressure/Heart Medications)	75-81	Hormones (Miscellaneous)	I15
Cardiovascular (Cholesterol Medications)	81-84	Hormones (Osteoporosis Products)	I15, I16
Cardiovascular (Miscellaneous)	84	Immunosuppressants (Pain Relief and Inflammatory Disease)	I16
CNS Drugs (Alzheimer's Disease)	84, 85	Immunosuppressants (Skin Conditions)	I16
CNS Drugs (Miscellaneous)	85, 86	Immunosuppressants (Transplant Medications)	I17
CNS Drugs (Multiple Sclerosis)	86	Miscellaneous Medical Supplies, Devices, Non-Drug (Diabetes)	I17-I29
CNS Drugs (Pain Relief and Inflammatory Disease)	86, 87	Miscellaneous Medical Supplies, Devices, Non-Drug (Miscellaneous)	I29-I34
CNS Drugs (Seizure Disorders)	87-89	Muscle Relaxants (Pain Relief and Inflammatory Disease)	I35
CNS Drugs (Sleep Disorders/Sedatives)	90	Prenatal Vitamins (Nutritional/Dietary)	I35, I36
Colony Stimulating (Blood Modifiers/Bleeding Disorders)	90	Psychotherapeutic Drugs (Anxiety/Depression/Bipolar Disorder)	I36-I40
Colony Stimulating Factors (Cancer)	90	Psychotherapeutic Drugs (Attention Deficit Hyperactivity Disorder)	I40, I42
Contraceptives (Contraception Products)	90-92	Psychotherapeutic Drugs (Miscellaneous)	I42
Cough/Cold Preparations (Allergy/Nasal Sprays)	92	Psychotherapeutic Drugs (Schizophrenia/Anti-Psychotics)	I42-I45
Cough/Cold Preparations (Cough/Cold Medications)	93	Psychotherapeutic Drugs (Sleep Disorders/Sedatives)	I45, I46
Diagnostic (Miscellaneous)	93, 94	Skin Preps (Miscellaneous)	I46
Diuretics (Diuretics)	95, 96	Skin Preps (Pain Relief and Inflammatory Disease)	I47
EENT Preps (Allergy/Nasal Sprays)	96	Skin Preps (Skin Conditions)	I47-I54
EENT Preps (Ear Medications)	96, 97	Smoking Deterrents (Smoking Cessation)	I54
EENT Preps (Eye Conditions)	97-100	Thyroid Prep (Hormonal Agents)	I54, I55
Elect/Caloric/H2O (Cholesterol Medications)	100	Unclassified Drug Products (Aids/Hiv)	I55
Elect/Caloric/H2O (Diabetes)	100, 101	Unclassified Drug Products (Asthma/COPD/Respiratory)	I55, I56
Elect/Caloric/H2O (Miscellaneous)	101	Unclassified Drug Products (Blood Modifiers/Bleeding Disorders)	I56
Elect/Caloric/H2O (Nutritional/Dietary)	101, 102	Unclassified Drug Products (Blood Pressure/Heart Medications)	I56
Gastrointestinal (Cholesterol Medications)	103		
Gastrointestinal (Gastrointestinal/Heartburn)	103-109		

Information about this drug list

How to find your medication (cont.)

Condition	Page	Condition	Page
Unclassified Drug Products (Cancer)	I57	Unclassified Drug Products (Pain Relief and Inflammatory Disease)	I62, I63
Unclassified Drug Products (Dental Products)	I57	Unclassified Drug Products (Substance Abuse)	I62
Unclassified Drug Products (Erectile Dysfunction)	I57, I58	Unclassified Drug Products (Transplant Medications)	I62
Unclassified Drug Products (Gastrointestinal/Heartburn)	I58	Unclassified Drug Products (Urinary Tract Conditions)	I62, I63
Unclassified Drug Products (Hormonal Agents)	I58	Unclassified Drug Products (Weight Management)	I63
Unclassified Drug Products (Miscellaneous)	I58-I61	Vitamins (Nutritional/Dietary)	I63, I64
Unclassified Drug Products (Osteoporosis Products)	I61		

List of Prescription Medications

ANALGESICS (Pain Relief and Inflammatory Disease)			
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits	
ANALGESIC, NON-SALICYLATE AND BARBITURATE COMBINAT			
butalbital/acetaminophen	T1		
ANALGESIC, SALICYLATE, BARBITURATE, XANTHINE COMB.			
butalb-aspirin-caff 50-325-40	T1	QL (6 tabs/day)	
butalbital-asa-caffeine cap (Fiorinal)	T1	QL (6 caps/day)	
FIORINAL (butalbital-aspirin-caffeine)	T3	QL (6 caps/day)	
ANALGESIC, NON-SALICYLATE, BARBITURATE, XANTHINE COMB.			
butalb/acetaminophen/caffeine	T3		
butalb/acetaminophen/caffeine (Esgic)	T3	QL (6 caps/day)	
butalb-acetamin-caff 50-300-40 (Fioricet)	T1	QL (6 caps/day)	
butalb-acetamin-caff 50-325-40 (Esgic)	T1	QL (6 tabs/day)	
ESGIC 50-325-40 MG TABLET (butalbital-acetaminophen-caff)	T3	QL (6 tabs/day)	
ESGIC CAPSULE (zebutal)	T3	QL (6 caps/day)	
FIORICET (phrenilin forte)	T1	QL (6 caps/day)	
ANALGESIC/ANTIPYRETICS, SALICYLATES			
choline salicyl/mag salicylate	T1	HD	
diflunisal	T1	HD	
ANALGESICS, NON-OPIOID			
JOURNAVX	T3	QL (30 tabs/90 days)	
ANTI-MIGRAINE PREPARATIONS			
AIMOVIG AUTOINJECTOR	T2	PA	
AJOVY AUTOINJECTOR	T2	PA	
AJOVY SYRINGE	T2	PA	
almotriptan malate	T1	QL (12 tabs/30 days)	
CAFERGOT (ergotamine-caffeine)	T3	QL (40 tabs/28 days)	
dihydroergotamine 1 mg/ml amp	T1	QL (10 amps/30 days)	
eletriptan hydrobromide	T1	QL (6 tabs/30 days)	
EMGALITY PEN	T2	PA	
EMGALITY SYRINGE	T2	PA	
ergotamine tartrate/caffeine (Cafergot)	T1	QL (40 tabs/28 days)	
frovatriptan succinate	T1	QL (18 tabs/30 days)	
isomethept/dichlphn/acetaminop	T1		
isomethepten/caf/acetaminophen	T1		
naratriptan hcl	T1	QL (9 tabs/30 days)	
NURTEC ODT	T2	PA QL (16 tabs/30 days)	
rizatriptan 10 mg odt (Maxalt Mlt)	T1	QL(12 tabs/30 days)	

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

T4 – Specialty Medications

PA – Prior Authorization

QL – Quantity Limit

ST – Step Therapy

AGE – Age Requirement

SP – Specialty Medication

HD – May require home delivery pharmacy

PPACA – No Cost-Share Preventive Medication

CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

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

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ANTI-MIGRAINE PREPARATIONS (cont.)		
<i>rizatriptan 10 mg tablet (Maxalt)</i>	T1	QL(12 tabs/30 days)
<i>rizatriptan 5 mg odt</i>	T1	QL(12 tabs/30 days)
<i>rizatriptan 5 mg tablet</i>	T1	QL(12 tabs/30 days)
<i>rizatriptan ODT(Maxalt Mlt)</i>	T1	QL(12 tabs/30 days)
<i>rizatriptan tablet (Maxalt)</i>	T1	QL(12 tabs/30 days)
<i>sumatriptan</i>	T1	QL (2 boxes/30 days)
<i>sumatriptan 4 mg/0.5 ml cart</i>	T1	QL (4ml/30 days)
<i>sumatriptan 4 mg/0.5 ml inject</i>	T1	QL (4ml/30 days)
<i>sumatriptan 6 mg/0.5 ml cart</i>	T1	QL (4ml/30 days)
<i>sumatriptan 6 mg/0.5 ml inject</i>	T1	QL (4ml/30 days)
<i>sumatriptan 6 mg/0.5 ml syrng</i>	T1	QL (4ml/30 days)
<i>sumatriptan 6 mg/0.5 ml vial</i>	T1	QL (5ml/30 days)
<i>sumatriptan succ 100 mg tablet</i>	T1	QL (18 tabs/28 days)
<i>sumatriptan succ 25 mg tablet</i>	T1	QL (18 tabs/28 days)
<i>sumatriptan succ 50 mg tablet</i>	T1	QL (9 tabs/30 days)
<i>sumatriptan succ/naproxen sod</i>	T1	QL (18 tabs/30 days)
<i>UBRELVY</i>	T2	PA QL (0.67 tabs/day)
<i>ZAVZPRET</i>	T2	PA QL(6 units/30 days)
<i>zolmitriptan</i>	T1	QL (12 tabs/30 days)
NSAIDS, CYCLOOXYGENASE INHIBITOR-TYPE ANALGESICS		
<i>diclofenac potassium</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

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

T4 – Specialty Medications

PA – Prior Authorization

QL – Quantity Limit

ST – Step Therapy

AGE – Age Requirement

SP – Specialty Medication

HD – May require home delivery pharmacy

PPACA – No Cost-Share Preventive Medication

CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

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

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
OPIOID ANALGESIC AND NON-SALICYLATE ANALGESICS		
acetamin-codein 300-30 mg/12.5	T1	
acetaminop-codeine 120-12 mg/5	T1	
acetaminophen-cod #2 tablet	T1	PA
acetaminophen-cod #3 tablet	T1	PA
acetaminophen-cod #4 tablet	T1	PA
APADAZ	T3	
BENZHYDROCODONE-ACETAMINOPHEN	T1	
hydrocodone/acetaminophen	T1	PA
hydrocodone/acetaminophen (Hydrocodone-acetaminophen)	T1	PA
hydrocodone/acetaminophen (Norco)	T1	PA
HYDROCODONE-ACETAMINOPHEN	T1	PA
LORTAB	T1	PA
NALOCET	T1	PA
NORCO (loracet hd)	T3	PA
NORCO (loracet plus)	T3	PA
NORCO (loracet)	T3	PA
oxycodone hcl/acetaminophen (Nalocet)	T1	PA
oxycodone hcl/acetaminophen (Percocet)	T1	PA
oxycodone hcl/acetaminophen (Primlev)	T1	PA
PERCOCET (oxycodone-acetaminophen)	T3	PA
PRIMLEV	T1	PA
tramadol hcl/acetaminophen (Ultracet)	T1	
ULTRACET (tramadol hcl-acetaminophen)	T3	
OPIOID ANALGESIC AND NSAID COMBINATION		
hydrocodone/ibuprofen	T1	PA
hydrocodone/ibuprofen (Ibudone)	T1	PA
IBUDONE	T1	PA
ibuprofen/oxycodone hcl	T1	PA
OPIOID ANALGESIC AND NON-SALICYLATE XANTHINE COMB		
ACETAMIN-CAFF-DIHYDROCODEINE	T1	PA
acetaminophen/caff/dihydrocod (Acetamin-caff-dihydrocodeine)	T1	PA
acetaminophen/caff/dihydrocod (Trezix)	T1	PA

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

T4 – Specialty Medications

PA – Prior Authorization

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ST – Step Therapy

AGE – Age Requirement

SP – Specialty Medication

HD – May require home delivery pharmacy

PPACA – No Cost-Share Preventive Medication

CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

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

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
OPIOID ANALGESIC AND NON-SALICYLATE XANTHINE COMB (cont.)		
TREZIX	T3	PA
OPIOID ANALGESICS		
ACTIQ (<i>fentanyl citrate</i>)	T3	PA
ARYMO ER	T3	PA
BELBUCA	T2	QL (2 films/day)
BUPRENEX	T3	
<i>buprenorphine</i> (Butrans)	T1	QL (4 patches/28 days)
<i>butorphanol tartrate</i>	T1	PA QL (6 bots/30 days)
BUTRANS (buprenorphine)	T3	QL (4 patches/28 days)
<i>codeine sulfate</i>	T1	PA
DURAGESIC (fentanyl)	T3	PA
<i>fentanyl</i>	T1	PA
<i>fentanyl</i> (Duragesic)	T1	PA
FENTANYL 25 MCG/0.5 ML SYRINGE	T3	PA
<i>fentanyl</i> 1,000mcg/50-0.9% nacl	T1	
<i>fentanyl citrate</i> (Actiq)	T1	PA
<i>fentanyl citrate/pf</i>	T1	PA
<i>fentanyl/ropivacaine/ns/pf</i>	T1	
FENTORA	T3	PA
<i>hydrocodone bitartrate</i> (Hysingla Er)	T1	PA
<i>hydrocodone bitartrate</i> (Zohydro Er)	T1	PA
HYDROMORPHONE 0.25 MG/0.5 ML	T3	PA
<i>hydromorphone hcl</i>	T1	PA
<i>hydromorphone hcl</i> (Dilaudid)	T1	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
MORPHABOND ER	T2	PA
<i>morpheine sulf</i> 1,000 mg/20 ml	T1	PA
<i>morpheine sulf</i> 1,000 mg/20 ml	T1	PA

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

T4 – Specialty Medications

PA – Prior Authorization

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AGE – Age Requirement

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HD – May require home delivery pharmacy

PPACA – No Cost-Share Preventive Medication

CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

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

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
OPIOID ANALGESICS (cont.)		
morphine sulfate	T1	PA
morphine sulfate (Kadian)	T1	PA
morphine sulfate (Ms Contin)	T1	PA
MS CONTIN (morphine sulfate er)	T3	PA
NUCYNTA	T2	PA
NUCYNTA ER	T3	PA
opium/belladonna alkaloids	T1	PA
OXAYDO	T3	PA
oxycodone hcl	T1	PA
OXYCODONE HCL ER	T1	PA
oxymorphone hcl	T1	PA
pentazocine hcl/naloxone hcl	T1	PA
ROXYBOND	T3	PA
TRAMADOL HCL 75 MG TABLET	T3	QL(< 18 yo 5 tabs/day)
tramadol er 100 mg tablet	T1	QL (1 tab/day)
tramadol er 200 mg tablet	T1	QL (1 tab/day)
tramadol er 300 mg tablet	T1	QL (1 tab/day)
tramadol hcl (Ultram)	T1	QL (8 tabs/day)
TRAMADOL HCL ER 100 MG CAPSULE	T1	QL (1 cap/day)
tramadol hcl er 100 mg tablet	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)
tramadol hcl er 200 mg tablet	T1	QL (1 tab/day)
TRAMADOL HCL ER 300 MG CAPSULE	T1	QL (1 cap/day)
tramadol hcl er 300 mg tablet	T1	QL (1 tab/day)
ULTRAM (tramadol hcl)	T3	QL (8 tabs/day)
XTAMPZA ER	T2	PA
ZOHYDRO ER (hydrocodone bitartrate er)	T3	PA
OPIOID AND SALICYLATE ANALGESICS, BARBIT, XANTHINE		
codeine/butalbital/asa/caffein (Fiorinal With Codeine #3)	T1	PA
FIORINAL WITH CODEINE #3 (butalbital compound-codeine)	T3	PA
OPIOID, NON-SALICYL. ANALGESIC, BARBITUATE, XANTHINE		
butalbit/acetamin/caff/codeine	T1	PA
butalbit/acetamin/caff/codeine (Fioricet With Codeine)	T1	PA
FIORICET WITH CODEINE (butalb-acetaminoph-caff-codein)	T3	PA

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
SKELETAL MUSCLE RELAXANT, SALICYLAT, OPIOID ANALGESIC		
<i>carisoprodol/aspirin/codeine</i>	T1	PA
ANALGESICS (Urinary Tract Conditions)		
URINARY TRACT ANALGESIC AGENTS		
ELMIRON	T2	
RIMSO-50	T2	
ANESTHETICS (Miscellaneous)		
GENERAL ANESTHETICS, INHALANT		
<i>desflurane</i> (Suprane)	T1	
<i>isoflurane</i>	T1	
<i>isoflurane</i>	T3	
<i>sevoflurane</i> (Ultane)	T1	
SUPRANE	T3	
ULTANE (sevoflurane)	T3	
<i>lidocaine hcl</i> (Xylocaine)	T1	
<i>lidocaine hcl/pf</i>		
ANESTHETICS (Pain Relief and Inflammatory Disease)		
LOCAL ANESTHETICS		
<i>lidocaine hcl 2% 200 mg/10 ml</i> (Xylocaine-Mpf)	T1	
<i>lidocaine hcl 4% 200 mg/5 ml</i>	T1	
MARCAINE-EPINEPHRINE	T3	
TOPICAL LOCAL ANESTHETICS		
L.E.T. (LIDO-EPINEPH-TETRA)	T3	
<i>lidocaine 5% ointment</i>	T1	QL (145gm/30 days)
<i>lidocaine 5% patch</i> (Lidocan II)	T1	
<i>lidocaine 5% patch</i> (Lidoderm)	T1	
<i>lidocaine hcl</i>	T1	
<i>lidocaine hcl</i>	T3	
<i>lidocaine/prilocaine</i>	T1	
LIDODERM (<i>lidocaine</i>)	T3	
PAIN EASE MEDIUM STREAM SPRAY	T3	
SYNERA	T3	
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
URINARY TRACT ANESTHETIC/ANALGESIC AGNT (AZO-DYE)		
phenazopyridine hcl (Pyridium)	T1	
PYRIDIUM (phenazopyridine hcl)	T3	
ANTI-ALLERGY (Allergy/Nasal Sprays)		
MAST CELL STABILIZERS		
cromolyn 100 mg/5 ml oral conc (Gastrocrom)	T1	
GASTROCROM (cromolyn sodium)	T3	
ANTI-ARTHRITICS (Pain Relief and Inflammatory Disease)		
ANALGESIC/ANTIPYRETICS, SALICYLATES		
DISALCID (salsalate)	T3	HD
salsalate (Disalcid)	T1	HD
ANTI-ARTHRITIC AND CHELATING AGENTS		
DEPEN (penicillamine)	T4	PA SP
penicillamine	T4	PA SP
penicillamine (Depen)	T4	PA SP
ANTI-ARTHRITIC, FOLATE ANTAGONIST AGENTS		
OTREXUP	T2	PA
ANTI-INFLAM. INTERLEUKIN-1 RECEPTOR ANTAGONIST		
KINERET	T4	PA QL (28 syringes/28 days) SP
ANTI-INFLAMMATORY/ANTIARTHRITICS AGENTS, MISC.		
GEL-ONE	T4	PA SP HD
GENVISC 850	T4	PA SP
SUPARTZ FX	T4	PA SP HD
TRIVISC	T4	PA SP
VISCO-3	T4	PA SP HD
ANTI-INFLAMMATORY, PYRIMIDINE SYNTHESIS INHIBITOR		
ARAVA (leflunomide)	T3	HD
leflunomide (Arava)	T1	HD
ANTI-INFLAMMATORY, PHOSPHODIESTERASE-4(PDE4) INHIB.		
OTEZLA 28 DAY STARTER PACK	T4	PA QL (1 pack/180 days) SP HD
OTEZLA 30 MG TABLET	T4	PA QL (2 tabs/day) SP HD
ANTI-INFLAMMATORY, SEL.COSTIM.MOD., T-CELL INHIBITOR		
ORENCIA	T4	PA QL (4 syringes/28 days) SP HD
ORENCIA CLICKJECT	T4	PA QL (4 injectors/28 days) SP HD

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

T4 – Specialty Medications

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List of Prescription Medications

ANTI-ARTHRITICS (Pain Relief and Inflammatory Disease) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
COLCHICINE		
colchicine 0.6 mg capsule (Mitigare)	T1	HD
colchicine 0.6 mg tablet (Colcrys)	T1	HD
COLCRYS (colchicine)	T3	HD
MITIGARE (colchicine)	T2	HD
GOLD SALTS		
RIDAURA	T2	
HYPERURICEMIA TX - XANTHINE OXIDASE INHIBITORS		
allopurinol	T1	
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
JANUS KINASE (JAK) INHIBITORS		
CIBINQO	T4	PA QL (30 tabs/30 days) SP
LITFULO	T4	PA QL(1 cap/day) SP HD
OLUMIANT	T4	PA QL (1 tab/day) SP HD
RINVOQ	T4	PA QL (1 tab/day) SP HD
RINVOQ LQ	T4	PA QL(12 mls/day) SP HD
XELJANZ 1 MG/ML SOLUTION	T4	PA QL (480ml/22 days) SP HD
XELJANZ 10 MG TABLET	T4	PA QL (2 tabs/day) SP HD
XELJANZ 5 MG TABLET	T4	PA QL (2 tabs/day) SP HD
XELJANZ XR	T4	PA QL (1 tab/day) SP HD
NSAIDS (COX NON-SPEC.INHIB) AND PROSTAGLANDIN ANALOG		
ARTHROTEC 50 (diclofenac sodium-misoprostol)	T3	ST HD
ARTHROTEC 75 (diclofenac sodium-misoprostol)	T3	ST HD
diclofenac sodium-misoprostol (Arthrotec 50)	T1	HD
diclofenac sodium-misoprostol (Arthrotec 75)	T1	HD
NSAIDS, CYCLOOXYGENASE INHIBITOR - TYPE ANALGESICS		
ANAPROX DS (naproxen sodium ds)	T3	ST HD
CALDOLOR	T3	
DAYPRO (oxaprozin)	T3	ST 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-ARTHRITICS (Pain Relief and Inflammatory Disease) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
NSAIDS, CYCLOOXYGENASE INHIBITOR - TYPE ANALGESICS (cont.)		
<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
<i>EC-NAPROSYN (naproxen)</i>	T3	ST HD
<i>etodolac</i>	T1	HD
<i>etodolac (Lodine)</i>	T1	HD
<i>FELDENE (piroxicam)</i>	T3	ST HD
<i>fenoprofen calcium (Nalfon)</i>	T1	HD
<i>flurbiprofen</i>	T1	HD
<i>ibuprofen</i>	T1	HD
<i>indomethacin</i>	T1	HD
<i>ketoprofen 25 mg, 75 mg capsule</i>	T1	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	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>tolmetin sodium (Tolectin 600)</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-ARTHRITICS (Pain Relief and Inflammatory Disease) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
NSAIDS, CYCLOOXYGENASE-2(COX-2) SELECTIVE INHIBITOR		
CELEBREX 100 MG CAPSULE (<i>celecoxib</i>)	T3	QL (2 caps/day) ST HD
CELEBREX 200 MG CAPSULE (<i>celecoxib</i>)	T3	QL (2 caps/day) ST HD
CELEBREX 400 MG CAPSULE (<i>celecoxib</i>)	T3	QL (1 cap/day) ST HD
CELEBREX 50 MG CAPSULE (<i>celecoxib</i>)	T3	QL (2 caps/day) ST HD
<i>celecoxib 100 mg capsule</i> (Celebrex)	T1	QL(2 caps/day) HD
<i>celecoxib 200 mg capsule</i> (Celebrex)	T1	QL (2 caps/day) HD
<i>celecoxib 400 mg capsule</i> (Celebrex)	T1	QL (1 cap/day) HD
<i>celecoxib 50 mg capsule</i> (Celebrex)	T1	QL (2 caps/day) HD
URICOSURIC AGENTS		
<i>probenecid</i>	T1	HD
<i>probenecid/colchicine</i>	T1	HD
ANTI-ASTHMATICS (Asthma/COPD/Respiratory)		
5-LIPOXYGENASE INHIBITORS		
<i>zileuton</i>	T1	HD
ANTICHOLINERGICS, ORALLY INHALED LONG ACTING		
INCRUSE ELLIPTA	T2	HD
LONHALA MAGNAIR REFILL	T3	PA HD
LONHALA MAGNAIR STARTER	T3	PA HD
SPIRIVA RESPIMAT	T2	HD
ANTICHOLINERGICS, ORALLY INHADED SHORT ACTING		
ATROVENT HFA	T2	HD
<i>ipratropium bromide</i>	T1	HD
BETA-ADRENERGIC AGENTS		
<i>albuterol sulf 2 mg/5 ml syrup</i>	T1	HD
<i>albuterol sulfate 2 mg tab</i>	T1	HD
<i>albuterol sulfate 4 mg 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
BETA-ADRENERGIC AGENTS, INHALED, SHORT ACTING		
<i>albuterol 15 mg/3 ml solution</i>	T1	
<i>albuterol 75 mg/15 ml soln</i>	T1	
<i>albuterol 100 mg/20 ml soln</i>	T1	
<i>albuterol 2.5 mg/0.5 ml sol</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

ANTI-ASTHMATICS (Asthma/COPD/Respiratory) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
BETA-ADRENERGIC AGENTS, INHALED, SHORT ACTING (cont.)		
albuterol 5 mg/ml solution	T1	
albuterol sul 0.63 mg/3 ml sol	T1	
albuterol sul 1.25 mg/3 ml sol	T1	
albuterol sul 2.5 mg/3 ml soln	T1	
albuterol hfa 90 mcg inhaler (Proair Hfa)	T1	QL (18gm/30 days)
ALBUTEROL SULFATE HFA	T1	QL (18gm/30 days)
levalbuterol hcl (Xopenex Concentrate)	T1	
levalbuterol hcl (Xopenex)	T1	
XOPENEX (levalbuterol hcl)	T3	
XOPENEX CONCENTRATE (levalbuterol concentrate)	T3	
BETA-ADRENERGIC AGENTS, INHALED, ULTRA-LONG ACTING		
ARCAPTA NEOHALER	T3	HD
STRIVERDI RESPIMAT	T2	QL(1 inhaler/30 days) HD
BETA-ADRENERGIC AGENTS, ORALLY INHALED, LONG ACTING		
SEREVENT DISKUS	T2	HD
BETA-ADRENERGIC AND ANTICHOLINERGIC COMBO, INHALED		
ANORO ELLIPTA	T2	HD
BEVESPI AEROSPHERE	T2	HD
COMBIVENT RESPIMAT	T2	HD
ipratropium/albuterol sulfate	T1	HD
STIOLTO RESPIMAT INHAL SPRAY	T2	HD
BETA-ADRENERGIC AGENTS AND GLUCOCORTICOID COMBO, INHALED		
ADVAIR HFA	T2	HD
AIRDUO DIGIHALER	T3	ST HD
AIRSUPRA	T2	PA QL(1 gm/28 days) HD
BREO ELLIPTA 100-25 MCG INHALR	T2	HD
BREO ELLIPTA 100-25 MCG INHALR	T2	QL(1 inhaler/30 days) HD
BREO ELLIPTA 200-25 MCG INHALR	T2	HD
BREO ELLIPTA 200-25 MCG INHALR	T2	QL(1 inhaler/30 days) HD
BREO ELLIPTA 50-25 MCG INHALER	T2	QL(1 inhaler/30 days) HD
budesonide/formoterol fumarate (Symbicort)	T1	QL HD
DULERA	T2	HD
fluticasone propion/salmeterol	T1	HD
fluticasone-salmeterol 100-50 (Advair Diskus)	T1	QL(1 inhaler/30 days)
fluticasone-salmeterol 250-50 (Advair Diskus)	T1	QL(1 Inhaler/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

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

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
BETA-ADRENERGIC AGENTS AND GLUCOCORTICOID COMBO, INHALED (cont.)		
fluticasone-salmeterol 500-50 (Advair Diskus)	T1	QL(1 inhaler/30 days)
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	T2	HD
BETA-ADRENERGIC-ANTICHOLINERGIC-GLUCOCORT, INHALED		
BREZTRI AEROSPHERE	T2	
TRELEGY ELLIPTA	T2	
GLUCOCORTICOIDS, ORALLY INHALED		
ALVESCO	T2	HD
ASMANEX HFA	T2	QL(1 Inhaler/30 days) HD
ASMANEX TWISTHALER 110 MCG #30	T2	QL(1 inhaler/30 days) HD
ASMANEX TWISTHALER 220 MCG #14	T2	HD
ASMANEX TWISTHALER 220 MCG #30	T2	QL(1 inhaler/30 days) HD
ASMANEX TWISTHALER 220 MCG #60	T2	QL(1 inhaler/30 days) HD
ASMANEX TWISTHALER 220 MCG #120	T2	QL(1 inhaler/30 days) HD
budesonide (Pulmicort)	T1	HD
FLOVENT DISKUS	T2	HD
FLOVENT HFA	T2	HD
FLUTICASONE PROP 100MCG DISKUS	T3	QL HD
FLUTICASONE PROP 250 MCG DISK	T3	QL HD
FLUTICASONE PROP 50 MCG DISKUS	T3	QL HD
PULMICORT (budesonide)	T3	HD
PULMICORT FLEXHALER	T2	HD
QVAR REDIHALER	T2	HD
INTERLEUKIN-5(IL-5) RECEPTOR ALPHA ANTAGONIST, MAB		
FASENRA PEN	T4	PA SP HD
LEUKOTRIENE RECEPTOR ANTAGONISTS		
ACCOLATE (zafirlukast)	T3	HD
montelukast sodium (Singulair)	T1	HD
SINGULAIR (montelukast sodium)	T3	HD
zafirlukast (Accolate)	T1	HD
MAST CELL STABILIZERS, ORALLY INHALED		
cromolyn 20 mg/2 ml neb soln	T1	QL (480ml/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

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List of Prescription Medications

ANTI-ASTHMATICS (Asthma/COPD/Respiratory) (cont.)			
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits	
MONOCLONAL ANTIBODIES TO IMMUNOGLOBULIN E (IGE)			
XOLAIR	T4	PA SP HD	
MONOCLONAL ANTIBODY - INTERLEUKIN-5 ANTAGONISTS			
NUCALA	T4	PA SP HD	
MUCOLYTICS			
<i>acetylcysteine</i>	T1		
PHOSPHODIESTERASE-4 (PDE4) INHIBITORS			
DALIRESP 250 MCG TABLET	T3	QL (28 tabs/180 days) HD	
DALIRESP 500 MCG TABLET	T3	QL (2 tabs/day) HD	
<i>roflumilast 250 mcg tablet (Daliresp)</i>	T3	QL (28 tabs/180 days) HD	
<i>roflumilast 500 mcg tablet (Daliresp)</i>	T3	QL (2 tabs/day) HD	
XANTHINES			
<i>aminophylline</i>	T1		
THEO-24	T2	HD	
<i>theophylline anhydrous</i>	T1		
ANTIBIOTICS (Allergy/Nasal Sprays)			
NOSE PREPARATIONS ANTIBIOTICS			
BACTROBAN NASAL	T2		
ANTIBIOTICS (Ear Medications)			
EAR PREPARATIONS, ANTIBIOTICS			
<i>ciprofloxacin hcl</i>	T1		
CORTISPORIN-TC	T3		
<i>neomycin/polymyxin b/hydrocort</i>	T1		
<i>ofloxacin</i>	T1		
OTIC PREPARATIONS, ANTI-INFLAMMATORY-ANTIBIOTICS			
CIPRO HC	T2		
<i>ciprofloxacin hcl/dexameth (Ciprodex)</i>	T1		
CIPROFLOXACIN HCL-FLUOCINOLONE	T3		
OTOVEL	T3		
ANTIBIOTICS (Eye Conditions)			
EYE ANTIBIOTIC AND GLUCOCORTICOID COMBINATIONS			
MAXITROL (<i>neomycin-polymyxin-dexameth</i>)	T3		
<i>neomycin/bacit/p-myx/hydrocort</i>	T1		
<i>neomycin/polymyxin b/dexametha (Maxitrol)</i>	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

ANTIBIOTICS (Eye Conditions) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
EYE ANTIBIOTIC AND GLUCOCORTICOID COMBINATIONS (cont.)		
<i>neomycin/polymyxin b/hydrocort</i>	T1	
TOBRADEX EYE DROPS (<i>tobramycin-dexamethasone</i>)	T3	
TOBRADEX EYE OINTMENT	T2	
TOBRADEX ST	T2	
<i>tobramycin/dexamethasone</i> (Tobradex)	T1	
ZYLET	T3	
EYE SULFONAMIDES		
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	
OPHTHALMIC ANTIBIOTICS		
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	
<i>neomycin/polymyxn b/gramicidin</i>	T1	
OCUFLOX (<i>ofloxacin</i>)	T3	
<i>ofloxacin</i> (Ocuflax)	T1	
<i>polymyxin b sulf(trimethoprim</i>	T1	
<i>tobramycin 0.3% eye drop</i> (Tobrex)	T1	
TOBREX	T2	
VIGAMOX (<i>moxifloxacin</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

ANTIBIOTICS (Eye Conditions) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
OPHTHALMIC ANTIBIOTICS (cont.)		
ZYMAXID (<i>gatifloxacin</i>)	T3	
ANTIBIOTICS (Infections)		
2ND GEN. ANAEROBIC ANTIprotozoal-ANTIBACTERIAL		
SOLSEC	T2	
ABSORBABLE SULFONAMIDE ANTIBACTERIAL AGENTS		
BACTRIM (<i>sulfamethoxazole-trimethoprim</i>)	T3	
BACTRIM DS (<i>sulfamethoxazole-trimethoprim</i>)	T3	
ABSORBABLE SULFONAMIDE ANTIBACTERIAL AGENTS		
<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	
AMINOGLYCOSIDE ANTIBIOTICS		
ARIKAYCE	T4	PA SP
<i>gentamicin sulfate</i>	T1	
<i>gentamicin sulfate/pf</i>	T1	
KITABIS PAK	T4	PA QL (10ml/day) SP HD
<i>neomycin sulfate</i>	T1	
TOBI PODHALER	T4	PA QL (28 days therapy/56 days) SP HD
<i>tobramycin 1,200 mg/30 ml vial</i>	T1	
<i>tobramycin 1.2 gm vial</i>	T1	PA
<i>tobramycin 1.2 gram/30 ml vial</i>	T1	
<i>tobramycin 10 mg/ml vial</i>	T1	
<i>tobramycin 300 mg/4 ml ampule</i>	T4	QL (8 ml/day) SP HD
<i>tobramycin 300 mg/5 ml ampule</i>	T4	PA QL (10ml/day) SP HD
<i>tobramycin 40 mg/ml vial</i>	T1	
<i>tobramycin 80 mg/2 ml vial</i>	T1	
TOBRAMYCIN PAK 300 MG/5 ML	T4	PA QL (10ml/day) SP HD
ANAEROBIC ANTIprotozoal-ANTIBACTERIAL AGENTS		
FLAGYL (<i>metronidazole</i>)	T3	
LIKMEZ		
<i>metronidazole (Flagyl)</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 (Infections) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ANTIBIOTIC, ANTIBACTERIAL, MISC.		
<i>fosfomycin tromethamine</i> (Monurol)	T1	
<i>methenamine hippurate</i>	T1	
<i>methenamine mandelate</i>	T1	
MONUROL (<i>fosfomycin tromethamine</i>)	T3	
PRIMSOL	T2	
<i>trimethoprim</i>	T1	
URIBEL	T3	
URIBEL TABS (<i>methenam/m.blue/salicyl/hyoscy</i>)	T3	
UTA	T3	
ANTILEPROTICS		
<i>dapsone</i>	T1	
THALOMID	T3	PA SP HD
ANTI-MYCOBACTERIUM AGENTS		
<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
PASER	T2	HD
<i>pyrazinamide</i>	T1	HD
<i>rifabutin</i>	T1	HD
TRECATOR	T2	HD
ANTI-TUBERCULAR ANTIBIOTICS		
<i>cycloserine</i>	T1	
PRETOMANID	T3	PA QL (1 tab/day)
PRIFTIN	T3	
RIFAMATE	T2	
<i>rifampin</i>	T1	
RIFATER	T2	
ANTI-TUBERCULAR ANTIBIOTICS (cont.)		
SIRTURO	T4	SP
BETALACTAMS		
CAYSTON	T4	PA QL (3ml/day) SP HD

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

T4 – Specialty Medications

PA – Prior Authorization

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ST – Step Therapy

AGE – Age Requirement

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List of Prescription Medications

ANTIBIOTICS (Infections) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
CARBAPENEM ANTIBIOTICS (THIENAMYCINS)		
<i>imipenem/cilastatin sodium</i> (Primaxin)	T1	
<i>meropenem iv 1 gm vial</i>	T1	
<i>meropenem iv 500 mg vial</i>	T1	
<i>meropenem</i>	T1	
PRIMAXIN (<i>imipenem/cilastatin sodium</i>)	T3	
RECARBRILO	T3	
VABOMERE	T3	
CEPHALOSPORIN ANTIBIOTICS - 1ST GENERATION		
<i>cefadroxil</i>	T1	
CEFAZOLIN 3 GM VIAL	T3	
<i>cephalexin</i>	T1	
<i>cephalexin</i> (Keflex)	T1	
DAXBIA	T3	
KEFLEX (<i>cephalexin</i>)	T3	
CEPHALOSPORIN ANTIBIOTICS - 2ND GENERATION		
<i>cefaclor</i>	T1	
<i>cefprozil</i>	T1	
<i>cefuroxime axetil</i>	T1	
CEPHALOSPORIN ANTIBIOTICS - 3RD GENERATION		
<i>cefdinir</i>	T1	
<i>cefixime</i>	T1	
<i>cefixime</i> (Suprax)	T1	
<i>cefpodoxime proxetil</i>	T1	
<i>ceftriaxone sodium</i>	T1	
SUPRAX (<i>cefixime</i>)	T3	
CEPHALOSPORIN ANTIBIOTICS - 4TH GENERATION		
<i>cefepime hcl</i>	T1	
CEPHALOSPORIN ANTIBIOTICS - 5TH GENERATION		
ZERBAXA	T3	
LINCOSAMIDE ANTIBIOTICS		
CLEOCIN HCL 150 MG CAPSULE (<i>clindamycin hcl</i>)	T3	
CLEOCIN HCL 300 MG CAPSULE (<i>clindamycin hcl</i>)	T3	
CLEOCIN HCL 75 MG CAPSULE (<i>clindamycin hcl</i>)	T2	

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

ANTIBIOTICS (Infections) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
LINCOSSAMIDE ANTIBIOTICS (cont.)		
CLEOCIN PEDIATRIC (<i>clindamycin (pediatric)</i>)	T3	
<i>clindamycin hcl</i> (Cleocin Hcl)	T1	
<i>clindamycin palmitate hcl</i> (Cleocin Pediatric)	T1	
CLINDAMYCIN PHOSPHATEL-D5W	T3	
MACROLIDE ANTIBIOTICS		
<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 250 mg tablet</i> (Zithromax)	T1	
<i>azithromycin 500 mg tablet</i> (Zithromax Tri-pak)	T1	
<i>azithromycin 600 mg tablet</i>	T1	
<i>clarithromycin</i>	T1	
DIFICID 200 MG TABLET	T3	QL (28 tabs/28 days)
DIFICID 40 MG/ML SUSPENSION	T3	QL (5ml/day)
ERYPED 200 (<i>erythromycin ethylsuccinate</i>)	T3	
<i>ery-tab dr 250 mg tablet</i>	T3	
<i>ery-tab dr 333 mg tablet</i>	T2	
ERY-TAB DR 500 MG TABLET (<i>erythromycin</i>)	T3	
<i>erythromycin base</i> (Ery-tab)	T1	
<i>erythromycin ethylsuccinate</i>	T1	
<i>erythromycin ethylsuccinate</i> (Eryped 200)	T1	
<i>erythromycin stearate</i>	T1	
PCE	T3	
ZITHROMAX 1 GM POWDER PACKET (<i>azithromycin</i>)	T3	
ZITHROMAX SUSP (<i>azithromycin</i>)	T3	
ZITHROMAX 250 MG TABLET (<i>azithromycin</i>)	T3	
ZITHROMAX 250 MG Z-PAK TABLET (<i>azithromycin</i>)	T3	
ZITHROMAX 500 MG TABLET (<i>azithromycin</i>)	T3	
ZITHROMAX TRI-PAK (<i>azithromycin</i>)	T3	
NITROFURAN DERIVATIVES ANTIBACTERIAL AGENTS		
FURADANTIN (<i>nitrofurantoin</i>)	T3	
MACROBID (<i>nitrofurantoin mono-macro</i>)	T3	
MACRODANTIN (<i>nitrofurantoin</i>)	T3	
<i>nitrofurantoin</i> (Furadantin)	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 (Infections) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
NITROFURAN DERIVATIVES ANTIBACTERIAL AGENTS (cont.)		
<i>nitrofurantoin macrocrystal</i> (Macrodantin)	T1	
<i>nitrofurantoin monohyd/m-cryst</i> (Macrobid)	T1	
OXAZOLIDINONE ANTIBIOTICS		
<i>linezolid</i> (Zyvox)	T1	PA
SIVEXTRO	T3	PA
ZYVOX (<i>linezolid</i>)	T3	PA
PENICILLIN ANTIBIOTICS		
<i>amoxicillin</i>	T1	
<i>amoxicillin/potassium clav</i>	T1	
<i>ampicillin trihydrate</i>	T1	
<i>dicloxacillin sodium</i>	T1	
EXTENCILLINE	T3	
LETOCILIN S	T3	
MOXATAG	T3	
<i>penicillin v potassium</i>	T1	
PLEUROMUTILIN DERIVATIVES		
XENLETA	T3	PA QL (10 tabs/30 days)
QUINOLONE ANTIBIOTICS		
<i>AVELOX (moxifloxacin hcl)</i>	T3	
BAXDELA	T3	PA
<i>CIPRO 10% SUSPENSION (ciprofloxacin)</i>	T2	
<i>CIPRO 250 MG TABLET (ciprofloxacin hcl)</i>	T3	
<i>CIPRO 5% SUSPENSION (ciprofloxacin)</i>	T2	
<i>CIPRO 500 MG TABLET (ciprofloxacin hcl)</i>	T3	
<i>ciprofloxacin hcl</i> (Cipro)	T1	
<i>ciprofloxacin/ciprofloxacin hcl</i>	T1	
FACTIVE	T3	
<i>levofloxacin</i>	T1	
<i>moxifloxacin hcl</i> (Avelox)	T1	
<i>ofloxacin</i>	T1	
RIFAMYCINS AND RELATED DERIVATIVE ANTIBIOTICS		
AEMCOLO	T3	QL (12 tabs/3 days)
XIFAXAN 200 MG TABLET	T2	
XIFAXAN 550 MG TABLET	T2	QL (126 tabs/year)

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
TETRACYCLINE ANTIBIOTICS		
coremino er 135 mg tablet	T1	
coremino er 45 mg tablet	T1	QL (1 tab/day)
coremino er 90 mg tablet	T1	
demeclacycline hcl	T1	
doxycycline hydiate	T1	
doxycycline monohydrate	T1	
minocycline er 115 mg tablet	T1	
minocycline er 45 mg tablet	T1	QL (1 tab/day)
minocycline er 55 mg tablet	T1	
minocycline er 65 mg tablet	T1	
minocycline er 80 mg tablet	T1	
minocycline er 90 mg tablet	T1	
minocycline hcl	T1	
NUZYRA	T4	PA QL (30 tablets/28 days) SP
tetracycline hcl	T1	
VIBRAMYCIN 50 MG/5 ML SYRUP	T2	
VAGINAL ANTIBIOTICS		
clindamycin phosphate (Cleocin)	T1	
metronidazole (Metrogel-vaginal)	T1	
VANCOMYCIN ANTIBIOTICS AND DERIVATIVES		
vancomycin 50 mg/ml solution	T1	
vancomycin 250 mg/5ml oral sol (Firvanq)	T1	
vancomycin hcl 125 mg capsule	T1	
vancomycin hcl 250 mg capsule	T1	
VANCOMYCIN HCL 1.75 GRAM VIAL	T3	
VANCOMYCIN HCL 2 GRAM VIAL	T3	
vancomycin hcl (Firvanq)	T1	

ANTIBIOTICS (Skin Conditions)

TOPICAL ANTIBIOTIC AND ANTI-INFLAMMATORY STEROID		
CORTISPORIN	T3	
NEO-SYNALAR	T3	
TOPICAL ANTIBIOTICS		
BENZAMYCIN (erythromycin-benzoyl peroxide)	T3	
CENTANY	T3	
CENTANY AT	T3	

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

T4 – Specialty Medications

PA – Prior Authorization

QL – Quantity Limit

ST – Step Therapy

AGE – Age Requirement

SP – Specialty Medication

HD – May require home delivery pharmacy

PPACA – No Cost-Share Preventive Medication

CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

ANTIBIOTICS (Skin Conditions) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
TOPICAL ANTIBIOTICS (cont.)		
CLEOCIN T (<i>clindamycin phosphate</i>)	T3	
CLINDACIN ETZ KIT	T3	
CLINDACIN PAC	T3	
<i>clindamycin phosphate</i>	T1	
<i>clindamycin phosphate</i> (Cleocin T)	T1	
<i>clindamycin phosphate</i> (Evoclin)	T1	
<i>erythromycin base in ethanol</i>	T1	
<i>erythromycin/benzoyl peroxide</i> (Benzamycin)	T1	
EVOCLIN (<i>clindamycin phosphate</i>)	T3	
<i>gentamicin sulfate</i>	T1	
<i>mupirocin</i> (Centany)	T1	
<i>mupirocin calcium</i>	T1	
XEPI	T3	
TOPICAL SULFONAMIDES		
AVAR 9.5-5% CLEANSING PADS	T3	
<i>avar cleanser</i> (Rosanil)	T1	
AVAR LS	T3	
<i>mafенide acetate</i>	T1	
ROSANIL (<i>sodium sulfacetamide-sulfur</i>)	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 8.5% CREAM	T2	
SULFAMYLYON POWDER PACKET (<i>mafенide acetate</i>)	T3	

ANTI-COAGULANTS (Blood Thinners/Anti-Clotting)

ANTI-COAGULANTS, COUMARIN TYPE	T1	HD
warfarin sodium	T1	HD

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

T4 – Specialty Medications

PA – Prior Authorization

QL – Quantity Limit

ST – Step Therapy

AGE – Age Requirement

SP – Specialty Medication

HD – May require home delivery pharmacy

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List of Prescription Medications

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

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
CITRATES AS ANTI-COAGULANTS		
ACD SOLUTION A	T3	
ACD-A	T3	
ANTICOAG SODIUM CITRATE 4% SOL	T3	
CITRATE PHOSPHATE DEXTROSE	T1	
SODIUM CITRATE	T1	
DIRECT FACTOR XA INHIBITORS		
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	
HEPARIN AND RELATED PREPARATIONS		
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 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
<i>fondaparinux sodium</i> (Arixtra)	T4	QL (1 syringe/day) SP
FRAGMIN	T4	QL (2 ml/day) SP
heparin 10,000 unit/10 ml vial	T1	
heparin 30,000 unit/30 ml vial	T1	
heparin 40,000 unit/4 ml vial	T1	
heparin 50,000 unit/10 ml vial	T1	
heparin 1,000 unit/500 ml-ns	T1	
HEPARIN 2,000 UNIT/1,000 ML-NS (<i>heparin sodium, porcine/ns/pf</i>)	T3	
heparin 2,000 unit/1,000 ml-ns (<i>Heparin Sodium-0.9% NaCl</i>)	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	

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

T4 – Specialty Medications

PA – Prior Authorization

QL – Quantity Limit

ST – Step Therapy

AGE – Age Requirement

SP – Specialty Medication

HD – May require home delivery pharmacy

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List of Prescription Medications

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

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
HEPARIN AND RELATED PREPARATIONS (cont.)		
heparin 50,000 unit/5 ml vial	T1	
heparin sod 1,000 unit/ml vial	T1	
heparin sod 10,000 unit/ml vial	T1	
heparin sod 20,000 unit/ml vial	T1	
heparin sod 2,000 unit/ml vial	T1	
heparin sod 5,000 unit/0.5 ml	T1	
HEPARIN SOD 5,000 UNIT/0.5 ML	T1	
heparin sod 5,000 unit/0.5 ml (Heparin Sodium)	T1	
heparin sod 5,000 unit/ml syring	T3	
heparin sod 5,000 unit/ml vial	T1	
LOVENOX 100 MG/ML SYRINGE (enoxaparin sodium)	T4	QL (2 syringes/day) SP
LOVENOX 120 MG/0.8 ML SYRINGE (enoxaparin sodium)	T4	QL (2 syringes/day) SP
LOVENOX 150 MG/ML SYRINGE (enoxaparin sodium)	T4	QL (2 syringes/day) SP
LOVENOX 30 MG/0.3 ML SYRINGE (enoxaparin sodium)	T4	QL (2 syringes/day) SP
LOVENOX 300 MG/3 ML VIAL (enoxaparin sodium)	T4	QL (1 vial/day) SP
LOVENOX 40 MG/0.4 ML SYRINGE (enoxaparin sodium)	T4	QL (2 syringes/day) SP
LOVENOX 60 MG/0.6 ML SYRINGE (enoxaparin sodium)	T4	QL (2 syringes/day) SP
LOVENOX 80 MG/0.8 ML SYRINGE (enoxaparin sodium)	T4	QL (2 syringes/day) SP
THROMBIN INHIBITORS, SELECTIVE, DIRECT, REVERSIBLE		
ARGATROBAN 250MG/2.5ML VIAL	T4	SP
dabigatran etexilate	T1	

ANTIDOTES (Gastrointestinal/Heartburn)

MU-OPIOID RECEPTOR ANTAGONISTS, PERIPHERALLY-ACTING	Tier	Coverage Requirements
MOVANTIK	T2	PA
RELISTOR	T3	PA
SYMPROIC	T3	PA

ANTIDOTES (Substance Abuse)

OPIOID ANTAGONISTS	Tier	Coverage Requirements
KLOXXADO	T2	PA QL (2 sprays/30 days)
naloxone 0.4 mg/ml carpuject, vial	T1	
NALOXONE 2 MG AUTO-INJECTOR	T3	QL (0.8ml/day)
naloxone 2 mg/2 ml syringe	T1	
naloxone 4 mg/10 ml vial	T1	
naltrexone hcl	T1	QL(180 tabs/30 days)

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

ANTIDOTES (Substance Abuse) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
OPIOID ANTAGONISTS (cont.)		
OPVEE		
	T3	QL(2 units/30 days)
NARCAN	T2	QL (2 units/30 days)
REXTOVY	T2	QL(2 units/30 days)
ZIMHI	T3	QL (2 inj/day)
ANTI-FUNGALS (Eye Conditions)		
OPHTHALMIC ANTI-FUNGAL AGENTS		
NATACYN	T2	
ANTI-FUNGALS (Feminine Products)		
VAGINAL ANTI-FUNGALS		
GYNAZOLE 1	T1	
<i>miconazole nitrate</i>	T1	
<i>terconazole</i>	T1	
ANTI-FUNGALS (Infections)		
ANTI-FUNGAL AGENTS		
ANCOBON (<i>flucytosine</i>)	T3	
<i>clotrimazole</i>	T1	
CRESEMPA	T3	PA
CRESEMPA 74.5 MG CAPSULE	T3	PA
<i>fluconazole</i>	T1	
<i>flucytosine (Ancobon)</i>	T1	
<i>itraconazole</i>	T1	
<i>ketoconazole</i>	T1	
NOXAFIL 300 MG/16.7 ML VIAL	T3	
ORAVIG	T3	
<i>terbinafine hcl</i>	T1	
VFEND (<i>voriconazole</i>)	T3	PA
VIVJOA	T4	PA SP
<i>voriconazole (Vfend)</i>	T1	PA
ANTI-FUNGAL ANTIBIOTICS		
<i>griseofulvin ultramicrosize (Gris-peg)</i>	T1	
<i>griseofulvin, microsize</i>	T1	
GRIS-PEG (<i>griseofulvin ultramicrosize</i>)	T3	
<i>nystatin</i>	T1	
MICAFUNGIN	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-FUNGALS (Skin Conditions)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
TOPICAL ANTI-FUNGAL/ANTI-INFLAMMATORY, STEROID AGENT		
<i>clotrimazole/betamethasone dip</i>	T1	
TOPICAL ANTI-FUNGALS		
<i>cyclodan 0.77% cream</i>	T1	
<i>CICLODAN 0.77% CREAM KIT</i>	T3	
<i>cyclodan 8% solution</i>	T1	
<i>ciclopirox</i>	T1	
<i>ciclopirox olamine</i>	T1	
<i>ciclopirox olamine (Loprox)</i>	T1	
<i>econazole nitrate</i>	T1	
<i>ECOZA</i>	T3	
<i>EXODERM</i>	T1	
<i>ketoconazole</i>	T1	
<i>ketoconazole/skin cleanser 28</i>	T1	
<i>LOPROX (ciclopirox)</i>	T3	
<i>LULICONAZOLE</i>	T1	
<i>naftifine hcl</i>	T1	
<i>naftifine hcl (Naftin)</i>	T1	
<i>NAFTIN (naftifine hcl)</i>	T2	
<i>nystatin</i>	T1	
<i>nystatin/triamcinolone acet</i>	T1	
ANTIHISTAMINE AND DECONGESTANT COMBINATION (Allergy/Nasal Sprays)		
1ST GEN ANTIHISTAMINE AND DECONGESTANT COMBINATION		
<i>phenylephrine hcl/prometh hcl</i>	T1	
2ND GEN ANTIHISTAMINE AND DECONGESTANT COMBINATION		
<i>CLARINEX-D 12 HOUR</i>	T3	
ANTIHISTAMINES (Allergy/Nasal Sprays)		
ANTIHISTAMINES - 1ST GENERATION		
<i>carboxoxamine maleate</i>	T1	
<i>clemastine fumarate</i>	T1	
<i>hydroxyzine hcl</i>	T1	
<i>hydroxyzine pamoate</i>	T1	
<i>hydroxyzine pamoate (Vistaril)</i>	T1	

T1 – Typically Generics

T2 – Typically Preferred Brands

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T4 – Specialty Medications

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List of Prescription Medications

ANTIHISTAMINES (Allergy/Nasal Sprays) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ANTIHISTAMINES - 1ST GENERATION (cont.)		
<i>promethazine hcl</i>	T1	
VISTARIL (<i>hydroxyzine pamoate</i>)	T3	
ANTIHISTAMINES - 2ND GENERATION		
<i>cetirizine hcl</i>	T1	HD
CLARINEX (<i>desloratadine</i>)	T3	HD
<i>desloratadine 2.5 mg odt</i>	T1	QL (1 tab/day) HD
<i>desloratadine 5 mg tablet (Claritin)</i>	T1	HD
ANTIHISTAMINES (Eye Conditions)		
EYE ANTIHISTAMINES		
<i>azelastine hcl 0.05% drops</i>	T1	
BEPREVE	T3	
<i>epinastine hcl</i>	T1	
LASTACAFT	T3	
<i>olopatadine hcl 0.1% eye drops</i>	T1	
<i>olopatadine hcl 0.2% eye drop (Pataday)</i>	T1	
PATADAY (<i>olopatadine hcl</i>)	T3	
PAZEO	T2	
ZERVIADE	T2	
ANTI-HYPERGLYCEMICS (Diabetes)		
ANTIHYPERGLY. INCRETIN MIMETIC (GLP-I RECEPTOR AGONIST)		
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
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
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 (2ML/28 Days) ST
TRULICITY 4.5 MG/0.5 ML PEN	T2	QL (2ML/28 Days) ST

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

T4 – Specialty Medications

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List of Prescription Medications

ANTI-HYPERGLYCEMICS (Diabetes) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ANTI-HYPERGLY, INSULIN, LONG ACT-GLP-I RECEPT.AGONIST		
SOLIQUA 100-33	T2	HD
ANTIHYPERGLYCEMIC-GLUCOCORTICOID RECEPTOR BLOCKER		
mifepristone 300 mg tablet (Korlym)	T2	HD
ANTI-HYPERGLYCEMIC-SOD/GLUC COTRANSPORT2(SGLT2) INHIB		
FARXIGA	T2	QL (1 tab/day) ST
JARDIANC	T2	QL (1 tab/day) ST HD
ANTI-HYPERGLYCEMIC-DOPAMINE RECEPTOR AGONISTS		
CYCLOSET	T3	HD
ANTI-HYPERGLYCEMIC, ALPHA-GLUCOSIDASE INHIBITORS		
acarbose (Precose)	T1	HD
GLYSET (miglitol)	T3	HD
miglitol (Glyset)	T1	HD
PRECOSE (acarbose)	T3	HD
ANTI-HYPERGLYCEMIC, AMYLIN ANALOG-TYPE		
SYMLINPEN 60	T2	
SYMLINPEN 120	T2	HD
ANTI-HYPERGLYCEMIC, BIGUANIDE TYPE		
GLUCOPHAGE XR (metformin hcl er)	T3	HD
metformin hcl	T1	HD
metformin hcl (Glucophage Xr)	T1	HD
metformin hcl (Riomet)	T1	HD
RIOMET (metformin hcl)	T3	HD
RIOMET ER	T3	HD
ANTI-HYPERGLYCEMIC, DPP-4 INHIBITORS		
JANUVIA	T2	QL (1 tab/day) ST HD
ANTI-HYPERGLYCEMIC, INSULIN-RELEASE STIMULANT TYPE		
AMARYL (glimepiride)	T3	HD
chlorpropamide	T1	HD
glimepiride (Amaryl)	T1	HD
glipizide 5 mg tablet	T1	HD
glipizide 10 mg tablet	T1	HD
GLIPIZIDE 2.5 MG TABLET	T3	HD
GLUCOTROL (glipizide)	T3	HD
GLUCOTROL XL (glipizide xl)	T3	HD

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List of Prescription Medications

ANTI-HYPERGLYCEMICS (Diabetes) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ANTI-HYPERGLYCEMIC, INSULIN-RELEASE STIMULANT TYPE (cont.)		
glyburide	T1	HD
glyburide, micronized (Glynase)	T1	HD
GLYNASE (glyburide micronized)	T3	HD
nateglinide (Starlix)	T1	HD
repaglinide	T1	HD
STARLIX (nateglinide)	T3	HD
tolbutamide	T1	HD
ANTI-HYPERGLYCEMIC, SGLT-2 AND DPP-4 INHIBITOR COMB		
GLYXAMBI	T2	QL (1 tab/day) ST HD
ANTI-HYPERGLYCEMIC, THIAZOLIDINEDIONE AND BIGUANIDE		
ACTOPLUS MET (pioglitazone-metformin)	T3	HD
pioglitazone hcl/metformin hcl (Actoplus Met)	T1	HD
ANTI-HYPERGLYCEMIC, THIAZOLIDINEDIONE-SULFONYLUREA		
DUETACT (pioglitazone-glimepiride)	T3	HD
pioglitazone hcl/glimepiride (Duetact)	T1	HD
ANTI-HYPERGLYCEMIC, DPP-4 INHIBITOR-BIGUANIDE COMBS.		
JANUMET	T2	QL (2 tabs/day) ST HD
JANUMET XR 100-1,000 MG TABLET	T2	QL (1 tab/day) ST HD
JANUMET XR 50-1,000 MG TABLET	T2	QL (2 tabs/day) ST HD
JANUMET XR 50-500 MG TABLET	T2	QL (1 tab/day) ST HD
ANTI-HYPERGLYCEMIC, INSULIN-RELEASE STIM.-BIGUANIDE		
glipizide/metformin hcl	T1	HD
glyburide/metformin hcl	T1	HD
repaglinide/metformin hcl	T1	HD
ANTI-HYPERGLYCEMIC, THIAZOLIDINEDIONE (PPARG AGONIST)		
ACTOS (pioglitazone hcl)	T3	HD
AVANDIA	T3	HD
pioglitazone hcl (Actos)	T1	HD
ANTI-HYPERGLYCEMIC-SGLT2 INHIBITOR-BIGUANIDE COMBS.		
SYNJARDY	T2	QL (2 tabs/day) ST HD
SYNJARDY XR 10-1,000 MG TABLET	T2	QL (2 tabs/day) ST HD
SYNJARDY XR 12.5-1,000 MG TAB	T2	QL (2 tabs/day) ST HD
SYNJARDY XR 25-1,000 MG TABLET	T2	QL (1 tab/day) ST HD

T1 – Typically Generics

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List of Prescription Medications

ANTI-HYPERGLYCEMICS (Diabetes) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ANTI-HYPERGLYCEMIC-SGLT2 INHIBITOR-BIGUANIDE COMBS. (cont.)		
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
ANTIHYPERGLY-SGLT-2 INHIB, DPP-4 INHIB, BIGUANIDE CB		
TRIJARDY XR	T2	QL (1 tab/day) ST HD
INSULINS		
BASAGLAR KWIKPEN U-100	T2	QL (1.5ml/day) HD
HUMALOG	T2	QL (1.5ml/day) HD
HUMALOG 100 UNIT/ML VIAL	T2	QL (1.5ml/day) HD
HUMALOG JUNIOR KWIKPEN	T2	QL (1.5ml/day) HD
HUMALOG KWIKPEN U-100	T2	QL (1.5 ml/day) HD
HUMALOG KWIKPEN U-200	T2	QL (1 ml/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 (1 ml/day) HD
HUMULIN R U-500 KWIKPEN	T2	QL (1 ml/day) HD
HUMULIN N 100 UNIT/ML VIAL	T2	QL(1.5 mls/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 (2 ml/day) HD
INSULIN GLARGINE-YFGN	T3	QL(1.5 mls/day) HD
INSULIN LISPRO	T3	QL(1.5 mls/day) HD
INSULIN LISPRO JUNIOR KWIKPEN	T3	QL(1.5 mls/day) HD
INSULIN LISPRO KWIKPEN U-100	T3	QL(1.5 mls/day) HD
INSULIN LISPRO PROTAMINE MIX	T3	QL(2 mls/day) HD
LEVEMIR	T2	QL (1.5ml/day) HD
LEVEMIR FLEXTOUCH	T2	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 (1 ml/day) HD

T1 – Typically Generics

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List of Prescription Medications

ANTI-HYPERGLYCEMICS (Diabetes) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
INSULINS (cont.)		
SEMGLEE (YFGN)	T2	PA QL(1.5 mls/day) HD
TRESIBA	T2	QL (1.5ml/day) HD
TRESIBA FLEXTOUCH U-100	T2	QL (1.5ml/day) HD
TRESIBA FLEXTOUCH U-200	T2	QL (0.9ml/day) HD
ANTI-INFECTIVES (Feminine Products)		
VAGINAL SULFONAMIDES		
AVC	T3	
VAGINAL ANTISEPTICS		
acetic acid/oxyquinoline	T1	
XACIATO	T3	
RELAGARD	T3	
RELAGARD (fem ph)	T3	
TRIMO-SAN	T3	
ANTI-INFECTIVES (Infections)		
PENICILLIN ANTIBIOTICS		
<i>amoxicillin</i>	T1	
<i>amoxicillin/potassium clav</i> (Augmentin Es-600)	T1	
ANTI-INFECTIVES/MISCELLANEOUS (Infections)		
2ND GEN. ANAEROBIC ANTI-PROTOZOAL-ANTIBACTERIAL		
TINDAMAX (<i>tinidazole</i>)	T3	
<i>tinidazole</i>	T1	
<i>tinidazole</i> (Tindamax)	T1	
AMEBICIDES		
<i>paromomycin sulfate</i>	T1	
ANTHELMINTICS		
<i>albendazole</i> (Albenza)	T1	
ALBENZA (<i>albendazole</i>)	T3	
BILTRICIDE (<i>praziquantel</i>)	T3	
EMVERM	T1	
<i>ivermectin</i> (Stromectol)	T1	PA
<i>praziquantel</i> (Biltricide)	T1	
STROMECTOL (<i>ivermectin</i>)	T3	PA

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

T4 – Specialty Medications

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List of Prescription Medications

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

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ANTI-MALARIAL DRUGS		
atovaquone/proguanil hcl (Malarone)	T1	
chloroquine ph 250 mg tablet	T1	QL (56 tabs/365 days)
chloroquine ph 500 mg tablet	T1	
COARTEM	T3	PA QL (24 tabs/30 days)
hydroxychloroquine sulfate (Plaquenil)	T1	
KRINTAFEL	T3	PA QL (2 tabs/30 days)
MALARONE (atovaquone-proguanil hcl)	T3	PA
mefloquine hcl	T1	
PLAQUENIL (hydroxychloroquine sulfate)	T3	PA QL (30 tabs/365 days)
PRIMAQUINE (primaquine phosphate)	T1	
primaquine phosphate (Primaquine)	T1	
pyrimethamine 25 mg tablet (Daraprim)	T1	PA
QUALAQUIN (quinine sulfate)	T3	PA
quinine sulfate (Qualaquin)	T1	
ANTI-PROTOZOAL DRUGS, MISCELLANEOUS		
atovaquone	T1	
BENZNIDAZOLE	T3	
IMPAVIDO	T3	PA
LAMPIT	T3	
NEBUPENT (pentamidine isethionate)	T3	
pentamidine isethionate (Nebupent)	T1	
ANTI-INFECTIVES/MISCELLANEOUS (Miscellaneous)		
ANTIBACTERIAL AGENTS, MISCELLANEOUS		
glycine urologic solution	T1	
glycine urologic solution	T3	
TOPICAL ANTISEPTIC DRYING AGENTS		
formaldehyde	T1	
ANTI-INFECTIVES/MISCELLANEOUS (Skin Conditions)		
TOPICAL ANTI-FUNGALS		
CICLODAN 8% KIT	T3	
ciclopirox/urea/camph/men/euc (Ciclodan)	T1	

T1 – Typically Generics

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T3 – Typically Non-Preferred Brands

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List of Prescription Medications

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

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ANTI-INFLAMMATORY TUMOR NECROSIS FACTOR INHIBITOR		
ADALIMUMAB-AACF(CF)	T4	QL(2 pens/syringes/28 days) SP
ADALIMUMAB-ADBM(CF)	T4	PA QL(2 pens/syringes/28 days) SP HD
ADALIMUMAB-ADAZ	T4	PA QL 2 (doses/ 28 days) SP
ADALIMUMAB-RYVK(CF) AUTOINJECT	T4	PA QL(2 pens/syringes/28 days) SP HD
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(1 starter kit/365 days) SP
CYLTEZO(CF) PEN	T4	PA QL(2 pens/28 days) SP
CYLTEZO(CF) PEN CROHN'S-UC-HS	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 (4 ml/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
HUMIRA	T4	PA QL (2 syringes/28 days) SP HD
HUMIRA PEN	T4	PA QL (2 pens/28 days) SP HD
HUMIRA PEN CROHN'S-UC-HS	T4	PA QL (1 kit/year) SP HD
HUMIRA PEN PSOR-UVEITS-ADOL HS	T4	PA QL (1 kit/year) SP HD
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 PEDIATRIC UC	T4	PA QL (4 kits/365 dayS) SP HD
INFLECTRA	T4	PA SP HD
REMICADE	T4	PA SP HD
SIMLANDI(CF) AUTOINJECTOR	T4	PA QL(2 pens/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

T1 – Typically Generics

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List of Prescription Medications

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

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ANTI-INFLAMMATORY TUMOR NECROSIS FACTOR INHIBITOR (cont.)		
SIMPONI 50 MG/0.5 ML SYRINGE	T4	PA QL (1 syringe/28 days) SP HD
SIMPONI ARIA	T4	PA SP HD
ANP - SELECTIVE RETINOID X RECEPTOR AGONISTS (RXR)		
bexarotene (Targretin)	T4	PA SP HD
ANTI-NEOPLASTICS (Cancer)		
ANTIBIOTIC ANTOINEPLASTICS		
ADRIAMYCIN (doxorubicin hcl)	T4	PA SP
ANTI-NEOPLAST, HISTONE DEACETYLASE (HDAC) INHIBITORS		
FARYDAK	T4	PA SP HD
ZOLINZA	T4	PA SP HD
ANTINEOPLAST HUM VEGF INHIBITOR RECOMB MC ANTIBODY		
VEGZELMA	T4	PA SP
ANTI-NEOPLASTIC - ALKYLATING AGENTS		
ALKERAN (melphalan)	T4	SP
bendamustine 100 mg vial (Treanda)	T4	PA SP HD
bendamustine 25 mg vial (Treanda)	T4	PA SP HD
BENDAMUSTINE 100 MG/4 ML VIAL	T3	PA HD
cisplatin	T4	PA SP
CISPLATIN 50MG VIAL	T4	PA SP
CYCLOPHOSPHAMIDE	T3	
cyclophosphamide	T4	SP HD
GLEOSTINE	T3	
HYDREA (hydroxyurea)	T3	
hydroxyurea (Hydrea)	T1	
LEUKERAN	T2	
melphalan hcl (Alkeran)	T3	PA CSL
MYLERAN	T2	
TEMODAR 100 MG VIAL	T4	PA SP
TEMODAR 140 MG CAPSULE (temozolomide)	T4	PA SP HD CSL
temozolomide	T4	PA SP HD
VIVIMUSTA	T4	PA SP
ANTI-NEOPLASTIC - ANTI-ANDROGENIC AGENTS		
abiraterone acetate	T4	PA SP HD
bicalutamide (Casodex)	T1	
CASODEX (bicalutamide)	T3	

T1 – Typically Generics

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List of Prescription Medications

ANTI-NEOPLASTICS (Cancer) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ANTI-NEOPLASTIC - ANTI-ANDROGENIC AGENTS (cont.)		
ERLEADA 240MG TABLET	T4	PA SP HD
ERLEADA 60MG TABLET	T4	PA SP HD CSL
<i>flutamide</i>	T1	
<i>nilutamide</i>	T1	QL (4 tabs/day)
NUBEQA	T4	PA SP HD
TREANDA (<i>bendamustine hcl</i>)	T4	PA SP
XTANDI	T4	PA SP HD
ANTI-NEOPLASTICS ANTI-BODY/ANTI-BODY-DRUG COMPLEXES		
ZIIHERA	T3	
ANTI-NEOPLASTIC - ANTI-METABOLITES		
<i>capecitabine</i> (Xeloda)	T4	PA SP HD
<i>clofarabine</i>	T4	PA SP
DACOGEN 50 MG VIAL	T4	PA SP
<i>gemcitabine</i>	T4	PA SP
GEMCITABINE 1MG/10ML	T4	PA SP
GEMCITABINE 1.5MG/15ML	T4	PA SP
GEMCITABINE 2MG/20ML	T4	PA SP
GEMCITABINE 200MG/2ML VIAL	T4	PA SP
INQOVI	T4	PA SP HD
JYLAMVO	T3	CSL
LONSURF	T4	PA SP HD
<i>mercaptopurine</i>	T1	
<i>methotrexate sodium</i>	T1	
ONUREG	T3	PA QL (14 tabs/28 Days) SP
PEMRYDI RTU	T3	PA
PURIXAN	T3	SP
TABLOID	T3	
TREXALL	T2	
VIDAZA	T3	PA
XATMEP	T3	
XELODA (<i>capecitabine</i>)	T4	PA SP HD
ANTI-NEOPLASTIC, ANTI PROGRAMMED DEATH-1 (PD-1) MAB		
LOQTORZI	T4	SP
ZYNYZ	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
ANTI-NEOPLASTIC - AROMATASE INHIBITORS (cont.)		
<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
ANTI-NEOPLASTIC - BRAF KINASE INHIBITORS		
TAFINLAR 10 MG TABLET FOR SUSP	T4	PA QL(30 tabs/day) SP HD CSL
TAFINLAR CAPSULES	T4	PA QL(4 caps/day) SP HD CSL
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
ZELBORAF	T4	PA SP HD
ANTI-NEOPLASTIC-ENZYME INHIB, ANTIANDROGEN COMB.		
AKEEGA	T4	PA QL(2 TABS/DAY) SP CSL
DAURISMO	T4	PA SP HD
ERIVEDGE	T4	PA SP HD
ODOMZO	T4	PA SP HD CSL
ANTI-NEOPLASTIC - JANUS KINASE (JAK) INHIBITORS		
JAKAFI	T4	PA SP HD
ANTI-NEOPLASTIC - KRAS PROTEIN INHIBITOR		
LUMAKRAS 120 MG TABLET	T4	PA QL(8 tabs/day) SP HD CSL
LUMAKRAS 240 MG TABLET	T4	PA QL(4 tabs/day) SP HD CSL
LUMAKRAS 320 MG TABLET	T4	PA QL(3 tabs/day) SP HD CSL
ANTI-NEOPLASTIC - MEKI AND MEK2 KINASE INHIBITORS		
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	T4	PA SP HD
ANTINEOPLASTIC - MICROTUBULE INHIBITORS		
<i>eribulin mesylate</i> (Halaven)	T4	PA SP
HALAVEN (<i>eribulin mesylate</i>)	T4	PA SP
ANTI-NEOPLASTIC - MTOR KINASE INHIBITORS		
AFINITOR (<i>everolimus</i>)	T4	PA SP HD
AFINITOR DISPERZ	T4	PA SP
<i>everolimus</i>	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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ST – Step Therapy

AGE – Age Requirement

SP – Specialty Medication

HD – May require home delivery pharmacy

PPACA – No Cost-Share Preventive Medication

CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

ANTI-NEOPLASTICS (Cancer) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ANTI-NEOPLASTIC - PROTEIN METHYLTRANSFERASE INHIBIT		
TAZVERIK	T4	PA SP
ANTI-NEOPLASTIC - TOPOISOMERASE I INHIBITORS		
HYCAMTIN	T4	PA SP HD
ANTI-NEOPLASTIC COMB - KINASE AND AROMATASE INHIBIT		
KISQALI FEMARA CO-PACK	T4	PA QL (1 pack/28 days) SP CSL
KISQALI 600MG	T4	PA QL(63/28 days) SP HD CSL
KISQALI 400MG	T4	PA QL(42/28 days) SP HD CSL
KISQALI 200MG	T4	PA QL(21/28 days) SP HD CSL
ANTI-NEOPLASTIC EGF RECEPTOR BLOCKER MCLON ANTIBODY		
OGIVRI	T4	PA SP
PHESGO	T4	PA SP HD
ANTI-NEOPLASTIC IMMUNOMODULATOR AGENTS		
<i>lenalidomide</i>	T4	PA QL(1 cap/day) SP HD CSL
ANTI-NEOPLASTIC LHRH (GNRH) AGONIST, PITUITARY SUPPR.		
POMALYST	T4	PA SP HD
REVLIMID	T4	PA SP HD
<i>leuprolide acetate</i>	T4	PA SP HD
ZOLADEX	T4	PA SP HD
ANTI-NEOPLASTIC LHRH (GNRH) ANTAGONIST, PITUIT.SUPPRS		
FIRMAGON	T4	PA SP HD
ORGOVYX	T4	PA SP
ANTI-NEOPLASTIC SYSTEMIC ENZYME INHIBITORS		
ALECensa	T4	PA QL(8 tabs/day) SP HD CSL
AYVAKIT	T4	PA QL (1 tab/day) SP
BALVERSA	T4	PA SP
BOSULIF	T4	PA QL(3 caps/day) SP HD CSL
BORTEZOMIB 3.5MG IV VIAL	T4	PA SP
BORUZU	T4	PA SP
BRUKINSA	T4	PA QL (4 caps/day) SP
CABOMETYX	T4	PA SP HD
CALQUENCE	T4	PA SP
CAPRELSA	T4	PA SP
COMETRIQ	T4	PA SP HD
COPIKTRA	T4	PA SP
DANZITEN	T4	PA SP CSL
<i>dasatinib 20 mg tablet</i>	T4	PA QL(3 tabs/day) SP HD CSL

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

ANTI-NEOPLASTICS (Cancer) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ANTI-NEOPLASTIC SYSTEMIC ENZYME INHIBITORS (cont.)		
dasatinib 70 mg tablet	T1	PA QL(2 tabs/day) SP HD CSL
dasatinib 50 mg, 80 mg, 100 mg, 140 mg tablet	T4	PA QL(1 tab/day) SP HD CSL
erlotinib hcl	T4	PA SP HD
EXKIVITY	T4	PA SP HD
FOTIVDA	T4	PA QL (30 caps/30 days) SP HD
GAVRETO	T4	PA QL (4 tabs/Day) SP CSL
gefitinib	T4	PA SP HD CSL
GILOTRIF	T4	PA SP HD
GLEEVEC (imatinib mesylate)	T4	PA SP HD
IBRANCE	T4	PA QL (21 caps/28 days) SP HD
imatinib mesylate (Gleevec)	T4	SP HD
IMBRUVICA	T4	PA SP
IMKELDI	T4	PA SP HD
INLYTA	T4	PA SP HD
INREBIC	T4	PA SP HD
IRESSA	T4	PA SP HD
ITOVEBI	T4	PA SP HD CSL
IWLFIN	T4	PA QL(8 tabs/day) SP CSL
KISQALI 200 MG DAILY DOSE	T4	PA QL(21 tabs/28 days) SP HD CSL
KISQALI 400 MG DAILY DOSE	T4	PA QL(42 tabs/28 days) SP HD CSL
KISQALI 600 MG DAILY DOSE	T4	PA QL(63 tabs/28 days) SP HD CSL
lapatinib ditosylate (Tykerb)	T4	PA SP HD
LENVIMA	T4	PA SP HD
LORBRENA	T4	PA SP HD
LYNPARZA	T4	PA SP HD
LYTGOBI 12 MG DAILY DOSE (3X 4MG TB)	T4	PA QL(3 tabs/day) SP CSL
LYTGOBI 16 MG DAILY DOSE (4X 4MG TB)	T4	PA QL(4 tabs/day) SP CSL
LYTGOBI 20 MG DAILY DOSE (5X 4MG TB)	T4	PA QL(5 tabs/day) SP CSL
NERLYNX	T4	PA SP HD
NINLARO	T4	PA SP HD
OGSIVEO	T4	PA QL(6 tabs/day) SP CSL
OJJAARA	T4	PA QL(1 tab/day) SP CSL
pazopanib hcl (Votrient)	T4	PA QL(4 tabs/day) SP HD CSL
PEMAZYRE	T4	PA QL (14 tabs/21 days) SP
PIQRAY	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
ANTI-NEOPLASTIC SYSTEMIC ENZYME INHIBITORS (cont.)		
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	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 QL(4 caps/day) SP CSL
SCEMBLIX 20 MG TABLET	T4	PA QL(2 tabs/day) SPCSL
SCEMBLIX 40 MG, 100 MG TABLET	T4	PA SP CSL
SPRYCEL	T4	PA SP HD
STIVARGA	T4	PA SP HD CSL
SUTENT	T4	PA SP HD
TALZENNA	T4	PA QL(1 cap/day) SP HD
TABRECTA	T4	PA QL (4 tabs/day) SP HD
TAGRISSO	T4	PA SP HD
TURALIO 125 MG CAPSULE	T4	PA QL(4 caps/day) SP CSL
TURALIO 200 MG CAPSULE	T4	PA SP CSL
TASIGNA	T4	PA SP HD
TEPMETKO	T4	PA QL (2 tabs/day) SP
TRUQAP	T4	PA QL(64 tabs/28 days) SP CSL
TUKYSA	T4	PA SP
TYKERB (<i>lapatinib</i>)	T4	PA SP HD
UKONIQ	T4	PA QL (4 tabs/day) SP
VANFLYTA	T4	PA QL(2 tabs/day) SP CSL
VERZENIO	T4	PA QL (2 tabs/day) SP HD
VITRAKVI	T4	PA SP HD
VIZIMPRO	T4	PA SP HD
XALKORI 150 MG PELLET	T4	PA QL(4 pellets/day) SP HD CSL
XALKORI 20 MG PELLET	T4	PA QL(4 pellets/day) SP HD CSL
XALKORI 200 MG CAPSULE	T4	PA QL(4 caps/day) SP HD CSL
XALKORI 50 MG PELLET	T4	PA QL(4 pellets/day) SP HD CSL
XOSPATA	T4	PA SP
ZEJULA	T4	PA QL(1 tab/day) SP CSL
ZYDELIG	T4	PA SP HD

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

T4 – Specialty Medications

PA – Prior Authorization

QL – Quantity Limit

ST – Step Therapy

AGE – Age Requirement

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List of Prescription Medications

ANTI-NEOPLASTICS (Cancer) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ANTI-NEOPLASTIC, ANTI-PROGRAMMED DEATH-1 (PD-1) MAB		
LOQTORZI	T4	PA SP
OPDIVO	T4	PA SP HD
TEVIMBRA	T4	PA SP
ANTI-NEOPLASTIC-B CELL LYMPHOMA-2(BCL-2) INHIBITORS		
VENCLEXTA	T4	PA SP
VENCLEXTA STARTING PACK	T4	PA SP
ANTI-NEOPLASTIC-ISOCITRATE DEHYDROGENASE INHIBITORS		
IDHIFA	T4	PA SP HD
REZLIDHIA	T4	PA QL(2 caps/day) SP CSL
TIBSOVO	T4	PA SP
ANTI-NEOPLASTICS ANTIBODY/ANTIBODY-DRUG COMPLEXES		
ENHERTU	T4	PA SP HD
IMDELLTRA	T4	PA SP
VYLOY	T4	PA SP
ANTI-NEOPLASTICS, MISCELLANEOUS		
<i>docetaxel vial (Docivyx)</i>	T4	PA SP
MATULANE	T4	SP
<i>tretinoin 10 mg capsule</i>	T3	PA
ANTI-NEOPLASTIC-SELECT INHIB OF NUCLEAR EXP (SINE)		
XPOVIO	T4	PA SP
CYTOTOXIC T-LYMPHOCYTE ANTIGEN (CTLA-4) RMC ANTIBODY		
IMJUDO	T4	PA SP HD
YERVOY	T4	PA SP HD
IMMUNOMODULATORS		
ACTIMMUNE	T4	PA SP HD
INTRON A	T4	PA SP HD
SELECTIVE ESTROGEN RECEPTOR MODULATORS (SERMS)		
<i>FARESTON (toremifene citrate)</i>	T3	QL (2 tabs/day) HD
SOLTAMOX	T3	HD
<i>tamoxifen citrate</i>	T1	HD PPACA
<i>toremifene citrate (Fareston)</i>	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

CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

ANTI-NEOPLASTICS (Skin Conditions)			
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits	
STEROID ANTI-NEOPLASTICS			
EMCYT	T4	SP HD	
<i>megestrol acetate</i>	T1		
PHOTOACT, TOPICAL ANTI-NEOPLAST, PREMALIGNANT LESIONS			
LEVULAN	T4	SP	
TOPICAL ANTI-NEOPLASTIC PREMALIGNANT LESION AGENTS			
EFUDEX (<i>fluorouracil</i>)	T3		
FLUOROPLEX	T2		
<i>fluorouracil</i>	T1		
<i>fluorouracil</i> (Efudex)	T1		
PANRETIN	T4	SP HD	
PICATO	T2		
TOLAK	T3		
VALCHLOR	T4	SP HD	
ANTI-OBESITY DRUGS (Weight Management)			
ANTI-OBESITY - ANOREXIC AGENTS			
ADIPEX-P (<i>phentermine hcl</i>)	T3	PA	
<i>benzphetamine hcl</i> (Regimex)	T1		
<i>diethylpropion hcl</i>	T1		
LOMAIRA	T1		
<i>phendimetrazine tartrate</i>	T1		
<i>phentermine hcl</i> (Adipex-p)	T1		
QSYMIA	T3	PA	
REGIMEX (<i>benzphetamine hcl</i>)	T3		
ANTI-OBESITY - MELANOCORTIN 4 RECEPTOR AGONISTS			
IMCIVREE	T4	PA QL (9 ml/22 days) SP	
ANTI-OBESITY GLUCAGON-LIKE PEPTIDE-1 RECEPTOR AGONIST			
SAXENDA	T3	PA	
ANTI-OBESITY - ANOREXIC AGENTS			
WEGOVY	T2	PA QL (1 box/month))	
ANTI-OBESITY SEROTONIN 2C RECEPTOR AGONISTS			
BELVIQ	T3	PA	
BELVIQ XR	T3	PA	
ANTI-OBESITY - OPIOID ANTAG-NOREPI, DOPAMINE RU INHIB			
CONTRAVE	T3	PA	
FAT ABSORPTION DECREASING AGENTS			
XENICAL	T3	PA	
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-PARASITICS (Infections)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ANTI-PARASITICS		
ALINIA (<i>nitazoxanide</i>)	T3	
<i>nitazoxanide</i> (Alinia)	T1	
OPHTHALMIC (EYE) ANTIPARASITICS		
XDEMVY	T4	PA QL(4 bottles/30 days) SP
TOPICAL ANTI-PARASITICS		
<i>crotamiton</i> (Eurax)	T1	
ELIMITE (<i>permethrin</i>)	T3	
EURAX 10% CREAM	T2	
EURAX 10% LOTION	T3	
<i>permethrin</i> (Elimite)	T1	
SKLICE (<i>ivermectin</i>)	T3	
<i>spinosad</i> (Natroba)	T1	
ULESFIA	T3	
ANTI-PARKINSON DRUGS (Parkinson's Disease)		
ANTI-PARKINSONISM DRUGS, ANTI-CHOLINERGIC		
<i>benztropine mesylate</i>	T1	HD
<i>trihexyphenidyl hcl</i>	T1	HD
ANTI-PARKINSONISM DRUGS, OTHER		
<i>amantadine hcl</i>	T1	HD
APOKYN	T4	PA SP HD
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> (<i>Sinemet 10-100</i>)	T1	HD
<i>carbidopa/levodopa</i> (<i>Sinemet 25-100</i>)	T1	HD
<i>carbidopa/levodopa</i> (<i>Sinemet 25-250</i>)	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 50)	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-PARKINSON DRUGS (Parkinson's Disease) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ANTI-PARKINSONISM DRUGS, OTHER (cont.)		
<i>carbidopa/levodopa/entacapone (Stalevo 75)</i>	T1	HD
DUOPA	T4	SP HD
<i>entacapone</i>	T1	HD
INBRIJA	T4	PA SP HD
KYNMOBI	T4	PA HD
NEUPRO	T3	HD
NOURIANZ	T3	PA QL (1 tab/day) SP HD
OSMOLEX ER	T3	QL (1 tab/day) 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</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 (<i>carbidopa-levodopa-entacapone</i>)	T3	HD
TASMAR (<i>tolcapone</i>)	T3	HD

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

T4 – Specialty Medications

PA – Prior Authorization

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ST – Step Therapy

AGE – Age Requirement

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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
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ANTI-PARKINSONISM DRUGS, OTHER (cont.)

<i>tolcapone</i> (Tasmar)	T1	HD
XADAGO	T3	ST HD

DECARBOXYLASE INHIBITORS

<i>carbidopa</i>	T1	
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ANTI-PLATELET DRUGS (Blood Thinners/Anti-Clotting)

PLATELET AGGREGATION INHIBITORS

AGGRASTAT	T3	
<i>aspirin/dipyridamole</i>	T1	HD
BRILINTA	T2	HD
<i>cilostazol</i>	T1	HD
<i>clopidogrel bisulfate</i>	T1	HD
<i>clopidogrel bisulfate</i> (Plavix)	T1	HD
<i>dipyridamole 50 mg/10 ml vial</i>	T1	HD
EFFIENT (<i>prasugrel hcl</i>)	T3	HD
<i>eptifibatide</i>	T1	
PLAVIX (<i>clopidogrel</i>)	T3	HD
<i>prasugrel hcl</i> (Effient)	T1	HD
<i>ticlopidine hcl</i>	T1	HD
<i>tirofiban-0.9% sodium chloride</i>	T1	
ZONTIVITY	T3	HD

PLATELET REDUCING AGENTS

AGRYLIN (<i>anagrelide hcl</i>)	T3	
<i>anagrelide hcl</i>	T1	
<i>anagrelide hcl</i> (Agrylin)	T1	

ANTIVIRALS (AIDS/HIV)

ANTI-RETROVIRAL - CAPSID INHIBITORS

SUNLENCA 463.5 MG/1.5 ML VIAL	T3	PA SP
SUNLENCA TABLET	T4	PA QL(5 tabs/180 days) SP

ANTI-RETROVIRAL - INTEGRASE INHIBITOR AND NNRTI COMB.

CABENUVA	T4	PA SP
JULUCA	T3	SP

ANTI-RETROVIRAL - INTEGRASE INHIBITOR AND NRTI COMB.

DOVATO	T4	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
ANTI-RETROVIRAL - NRTIS AND INTEGRASE INHIBITORS COMB		
TRIUMEQ PD 60-5-30 MG TAB SUSP	T4	SP
ANTI-RETROVIRAL - NUCLEOSIDE, NUCLEOTIDE, PROTEASE INH.		
SYMTUZA	T4	SP
ANTIVIRALS - HIV-SPEC, NON-PEPTIDIC PROTEASE INHIB		
APTIVUS	T4	PA SP
<i>darunavir (Prezista)</i>	T4	PA SP
PREZCOBIX	T4	PA SP
PREZISTA	T4	SP
ANTIVIRALS - HIV-SPEC, NUCLEOSIDE-NUCLEOTIDE ANALOG		
CIMDUO	T4	PA SP
DESCOVY	T4	SP PPACA
<i>emtricitabine-tenofovir 100-150mg</i>	T4	SP
<i>emtricitabine-tenofovir 133-200mg</i>	T4	SP
<i>emtricitabine-tenofovir 167-250mg</i>	T4	SP
<i>emtricitabine-tenofovir 200-300mg</i>	T4	SP PPACA
TEMIXYS	T4	PA SP
ANTIVIRALS - HIV-SPEC, NUCLEOSIDE ANALOG, RTI COMB		
<i>abacavir sulfate/lamivudine</i>	T4	PA SP
<i>abacavir/lamivudine/zidovudine</i>	T4	PA SP
<i>lamivudine/zidovudine</i>	T4	SP
ANTIVIRALS - HIV-SPECIFIC, CCR5 CO-RECEPTOR ANTAG.		
SELZENTRY	T4	PA SP
ANTIVIRALS - HIV-SPECIFIC, CD4 ATTACHMENT INHIBITOR		
RUKOBIA	T4	PA QL (2 syringe/day) SP
ANTIVIRALS - HIV-SPECIFIC, FUSION INHIBITORS		
FUZEON	T4	PA SP
ANTIVIRALS - HIV-SPECIFIC, NON-NUCLEOSIDE, RTI		
EDURANT	T4	PA SP
<i>efavirenz</i>	T4	PA SP
<i>nevirapine</i>	T4	PA SP
PIFELTRO	T4	PA SP
ANTIVIRALS - HIV-SPECIFIC, NUCLEOSIDE ANALOG, RTI		
<i>abacavir sulfate</i>	T4	PA SP
<i>emtricitabine (Emtriva)</i>	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
ANTIVIRALS - HIV-SPECIFIC, NUCLEOSIDE ANALOG, RTI (cont.)		
EMTRIVA 10 MG/ML SOLUTION	T4	PA SP
<i>lamivudine 10 mg/ml oral soln</i>	T4	SP
<i>lamivudine tablet</i>	T4	PA SP
<i>zidovudine</i>	T4	SP
ANTIVIRALS - HIV-SPECIFIC, NUCLEOTIDE ANALOG, RTI		
<i>tenofovir disoproxil fumarate</i>	T4	PA SP
VIREAD	T4	PA SP
VIREAD POWDER	T4	PA SP
ANTIVIRALS - HIV-SPECIFIC, PROTEASE INHIBITOR COMB		
<i>lopinavir/ritonavir</i>	T1	
ANTIVIRALS - HIV-SPECIFIC, PROTEASE INHIBITORS		
<i>atazanavir sulfate</i>	T4	PA SP
EVOTAZ	T4	PA SP
<i>fosamprenavir calcium</i>	T4	PA SP
LEXIVA	T4	PA SP
NORVIR	T4	SP
APRETUDE	T4	PA SP
REYATAZ	T4	PA SP
<i>ritonavir</i>	T4	SP
ANTIVIRALS - HIV-I INTEGRASE STRAND TRANSFER INHIBTR		
ISENTRESS	T4	SP
ISENTRESS HD	T4	PA SP
TIVICAY	T4	SP
TIVICAY PD	T4	SP
ANTIVIRAL - RNA POLYMERASE INHIBITOR		
LAGEVRIO 200 MG CAP (EUA)	T2	QL(1 pack/120 days)
ARTV NUCLEOSIDE, NUCLEOTIDE, NON-NUCLEOSIDE RTI COMB		
COMPLERA	T4	PA SP
DELSTRIGO	T4	PA SP
<i>efavirenz/emtricitabine/tenofovir df (Atripla)</i>	T4	PA SP
<i>efavirenz/lamivudine/tenofovir disop (Symfi Lo)</i>	T4	SP
<i>efavirenz/lamivudine/tenofovir disop (Symfi)</i>	T4	SP
ODEFSEY	T4	PA SP

T1 – Typically Generics

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T4 – Specialty Medications

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ST – Step Therapy

AGE – Age Requirement

SP – Specialty Medication

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PPACA – No Cost-Share Preventive Medication

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List of Prescription Medications

ANTIVIRALS (AIDS/HIV) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ARV-NUCLEOSIDE, NUCLEOTIDE RTI, INTEGRASE INHIBITORS		
BIKTARVY	T4	SP
GENVOYA	T4	SP
STRIBILD	T4	PA SP
ANTIVIRALS (Eye Conditions)		
EYE ANTIVIRALS		
trifluridine	T1	
ZIRGAN	T3	
ANTIVIRALS (Infections)		
ANTIVIRALS, GENERAL		
acyclovir	T1	
famciclovir	T1	
FLUMADINE (rimantadine hcl)	T3	
GANCICLOVIR	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 (20/30 days)
oseltamivir phos 45 mg capsule (Tamiflu)	T1	QL (10 caps/30 days)
oseltamivir phos 75 mg capsule (Tamiflu)	T1	QL (10/30 days)
PREVYMIS	T4	SP HD
RELENZA	T3	QL (20/30 days)
ribavirin (Virazole)	T4	SP HD
rimantadine hcl (Flumadine)	T1	
TAMIFLU 30 MG CAPSULE (oseltamivir phosphate)	T3	QL (20/30 days)
TAMIFLU 45 MG CAPSULE (oseltamivir phosphate)	T3	QL (10/30 days)
TAMIFLU 6 MG/ML SUSPENSION (oseltamivir phosphate)	T3	QL (180ml/30 days)
TAMIFLU 75 MG CAPSULE (oseltamivir phosphate)	T3	QL (10/30 days)
valacyclovir hcl (Valtrex)	T1	
valganciclovir hcl	T1	
VALTREX (valacyclovir)	T3	
VIRAZOLE	T4	SP HD
XOFLUZA	T3	QL (2 tabs/30 days)
HEP C - NS5A, NS3/4A, NUCLEOTIDE NS5B INHIB COMBO		
VOSEVI	T4	PA SP HD

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List of Prescription Medications

ANTIVIRALS (Infections) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
HEP C VIRUS, NUCLEOTIDE ANALOG NS5B POLYMERASE INH		
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
HEP C VIRUS-NS5B POLYMERASE AND NS5A INHIB. COMBO.		
EPCLUSA 200 MG-50 MG TABLET	T4	PA QL (1 tab/Day) SP HD
EPCLUSA 400 MG-100 MG TABLET	T4	PA SP HD
HARVONI 33.75-150 MG PELLET PK	T4	PA QL (1 tab/day) SP HD
HARVONI 45-200 MG PELLET PACKT	T4	PA QL (1 tab/day) SP HD
HARVONI 45-200 MG TABLET	T4	PA QL (1 tab/day) SP HD
HARVONI 90-400 MG TABLET	T4	PA SP HD
LEDIPASVIR-SOFOSBUVIR	T4	PA SP HD
HEPATITIS B TREATMENT AGENTS		
adefovir dipivoxil	T4	SP HD
BARACLUDE	T4	SP HD
entecavir 0.5 mg tablet	T4	QL (1 tab/day) SP HD
entecavir 1 mg tablet	T4	SP HD
EPIVIR HBV (lamivudine hbv)	T4	SP
lamivudine (Epivir Hbv)	T4	SP
VEMLIDY	T4	SP HD
HEPATITIS C TREATMENT AGENTS		
PEGASYS	T4	PA SP HD
PEGINTRON	T4	PA SP HD
ribasphere 200 mg capsule	T4	SP HD
ribasphere 200 mg tablet	T4	SP HD
ribasphere 400 mg tablet	T4	SP
ribasphere 600 mg tablet	T4	SP
ribasphere ribapak 200-400 mg	T4	SP HD
ribasphere ribapak 400-400 mg	T4	SP HD
ribasphere ribapak 400-400 mg	T4	SP HD
ribasphere ribapak 600-400 mg	T4	SP HD
ribasphere ribapak 600-400 mg	T4	SP HD
ribasphere ribapak 600-600 mg	T4	SP HD
ribasphere ribapak 600-600 mg	T4	SP HD

T1 – Typically Generics

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List of Prescription Medications

ANTIVIRALS (Infections) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
HEPATITIS C TREATMENT AGENTS (cont.)		
RIBASPHERE RIBAPAK	T4	SP HD
ribavirin	T4	SP HD
HEPATITIS C VIRUS- NS5A AND NS3/4A INHIBITOR COMB		
ZEPATIER	T4	PA SP HD
ANTIVIRALS (Infections)		
MAIN PROTEASE (MPRO) INHIBITOR		
PAXLOVID	T2	QL (1 pkg/120 days)
RNA POLYMERASE INHIBITOR		
MOLNUPIRAVIR	T3	QL (1 pkg/120 days)
ANTIVIRALS (Skin Conditions)		
TOPICAL GENITAL WART-HPV TREATMENT AGENTS		
VEREGEN	T3	
AUTONOMIC DRUGS (Allergy/Nasal Sprays)		
ANAPHYLAXIS THERAPY AGENTS		
epinephrine (Epinephrine)	T1	QL (2 packs/30 days)
NEFFY	T2	4 units/30 days
AUTONOMIC DRUGS (Alzheimer's Disease)		
CHOLINESTERASE INHIBITORS		
ARICEPT (donepezil hcl)	T3	HD
BLOXIVERZ (neostigmine methylsulfate)	T3	
donepezil hcl	T1	HD
donepezil hcl (Aricept)	T1	HD
EXELON (rivastigmine)	T3	HD
galantamine er 16 mg capsule (Razadyne Er)	T1	HD
galantamine er 24 mg capsule (Razadyne Er)	T1	HD
galantamine er 8 mg capsule (Razadyne Er)	T1	QL (1 cap/day) HD
galantamine hbr	T1	HD
neostigmine methylsulfate (Bloxiverz)	T1	
pyridostigmine bromide (Mestinon)	T1	HD
physostigmine salicylate	T1	
RAZADYNE ER 16 MG CAPSULE (galantamine er)	T3	HD
RAZADYNE ER 24 MG CAPSULE (galantamine er)	T3	HD
RAZADYNE ER 8 MG CAPSULE (galantamine er)	T3	QL (1 cap/day) HD
rivastigmine (Exelon)	T1	HD

T1 – Typically Generics

T2 – Typically Preferred Brands

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List of Prescription Medications

AUTONOMIC DRUGS (Attention Deficit Hyperactivity Disorder)⁸

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ADRENERGICS, AROMATIC, NON-CATECHOLAMINE		
ADDERALL (<i>dextroamphetamine-amphetamine</i>)	T3	PA 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</i> (Evekeo)	T1	PA
<i>dextroamp-amphet er 10 mg cap</i>	T1	PA QL (1 cap/day)
<i>dextroamp-amphet er 15 mg cap</i>	T1	PA QL (1 cap/day)
<i>dextroamp-amphet er 20 mg cap</i>	T1	PA QL (1 cap/day)
<i>dextroamp-amphet er 25 mg cap</i>	T1	PA QL (1 per day)
<i>dextroamp-amphet er 30 mg cap</i>	T1	PA QL (1 cap/day)
<i>dextroamp-amphet er 5 mg cap</i>	T1	PA QL (1 cap/day)
<i>dextroamphetamine er 10 mg cap</i>	T1	PA QL (1 cap/day)
<i>dextroamphetamine er 15 mg cap</i>	T1	PA QL (3/day)
<i>dextroamphetamine er 5 mg cap</i>	T1	PA QL (1 cap/day)
<i>dextroamphetamine sulfate</i>	T1	PA
<i>dextroamphetamine sulfate</i>	T3	PA ST
<i>dextroamphetamine/amphetamine</i> (Adderall Xr)	T1	PA QL(1 cap/day)
<i>dextroamphetamine/amphetamine</i> (Adderall)	T1	PA
<i>dextroamphetamine/amphetamine</i> (Mydayis)	T1	PA QL(1 cap/day)
DYANAVEL XR	T3	PA QL (8ml/day)
EVEKEO (<i>amphetamine sulfate</i>)	T3	PA ST
EVEKEO ODT	T3	PA
<i>lisdexamfetamine 10 mg capsule</i> (Vyvanse)	T1	PA QL(1 cap/day)
<i>lisdexamfetamine 20 mg capsule</i> (Vyvanse)	T1	PA QL(1 cap/day)
<i>lisdexamfetamine 30 mg capsule</i> (Vyvanse)	T1	PA QL(1 cap/day)
<i>lisdexamfetamine 40 mg capsule</i> (Vyvanse)	T1	PA QL(1 cap/day)
<i>lisdexamfetamine 50 mg capsule</i> (Vyvanse)	T1	PA QL(1 cap/day)
<i>lisdexamfetamine 60 mg capsule</i> (Vyvanse)	T1	PA QL(1 cap/day)
<i>lisdexamfetamine 70 mg capsule</i> (Vyvanse)	T1	PA QL(1 cap/day)
<i>methamphetamine hcl</i>	T1	PA
MYDAYIS (<i>dextroamphetamine/amphetamine</i>)	T3	PA QL(1 cap/day)
VYVANSE 10 MG CAPSULE (<i>lisdexamfetamine dimesylate</i>)	T2	PA QL(1 cap/day)
VYVANSE 20 MG CAPSULE (<i>lisdexamfetamine dimesylate</i>)	T2	PA QL(1 cap/day)
VYVANSE 30 MG CAPSULE (<i>lisdexamfetamine dimesylate</i>)	T2	PA QL(1 cap/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

SP – Specialty Medication

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List of Prescription Medications

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

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ADRENERGICS, AROMATIC, NON-CATECHOLAMINE (cont.)		
VYVANSE 40 MG CAPSULE (<i>lisdexamfetamine dimesylate</i>)	T2	PA QL(1 cap/day)
VYVANSE 50 MG CAPSULE (<i>lisdexamfetamine dimesylate</i>)	T2	PA QL(1 cap/day)
VYVANSE 60 MG CAPSULE (<i>lisdexamfetamine dimesylate</i>)	T2	PA QL(1 cap/day)
VYVANSE 70 MG CAPSULE (<i>lisdexamfetamine dimesylate</i>)	T2	PA QL(1 cap/day)
XELTRYM	T3	PA QL(1 patch/day)
ZENZEDI	T3	PA ST
AUTONOMIC DRUGS (Blood Pressure/Heart Medications)		
ADRENERGIC VASOPRESSOR AGENTS		
<i>droxidopa</i> (Northera)	T3	SP HD
<i>midodrine hcl</i>	T1	
ADRENERGIC AGENTS, CATECHOLAMINES		
<i>epinephrine 1 mg/10 ml luerjet</i>	T1	
<i>epinephrine 1 mg/ml vial</i>	T1	
ALPHA-ADRENERGIC BLOCKING AGENTS		
DIBENZYLINE (<i>phenoxybenzamine hcl</i>)	T3	HD
<i>phenoxybenzamine hcl</i> (Dibenzyline)	T1	HD
AUTONOMIC DRUGS (Miscellaneous)		
NEUROMUSCULAR BLOCKING AGENTS		
DAXXIFY	T4	PA SP
MYOBLOC	T4	PA SP HD
AUTONOMIC DRUGS (Urinary Tract Conditions)		
PARASYMPATHETIC AGENTS		
<i>bethanechol chloride</i>	T1	HD
<i>cevimeline hcl</i> (Evoxac)	T1	HD
EVOXAC (<i>cevimeline hcl</i>)	T3	HD
<i>guanidine hcl</i>	T1	HD
<i>pilocarpine hcl</i> (Salagen)	T1	HD
SALAGEN (<i>pilocarpine hcl</i>)	T3	HD
URECHOLINE (<i>bethanechol chloride</i>)	T3	HD
BIOLOGICALS (Allergy/Nasal Sprays)		
ALLERGENIC EXTRACTS, THERAPEUTIC		
GRASTEK	T2	PA QL (1 tab/day)
ODACTRA	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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List of Prescription Medications

BIOLOGICALS (Allergy/Nasal Sprays) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ALLERGENIC EXTRACTS, THERAPEUTIC (cont.)		
ORALAIR	T3	PA QL (1 tab/day)
RAGWITEK	T3	PA QL (1 tab/day)
BIOLOGICALS (Blood Pressure/Heart Medications)		
PLASMA KALLIKREIN INHIBITORS		
TAKHZYRO	T4	PA SP HD
BIOLOGICALS (Miscellaneous)		
PKU TREATMENT AGENTS - PHENYLALANINE AMMONIA LYASE		
PALYNZIQ	T4	PA SP HD
BIOLOGICALS (Vaccines)		
COVID-19 VACCINES		
COMIRNATY	T3	PPACA
JANSSEN	T2	PPACA
MODERNA	T2	PPACA
NOVAVAX	T3	PPACA
PFIZER	T2	PPACA
SPIKEVAX	T3	PPACA
ENTERIC VIRUS VACCINES		
IPOL	T2	PPACA
ROTARIX	T3	PPACA
ROTATEQ	T3	PPACA
GRAM NEGATIVE COCCI VACCINES		
BEXSERO	T2	PPACA
MENACTRA	T2	
MENQUADFI	T2	PPACA
MENVEO A-C-Y-W-135-DIP	T2	PPACA
PENBRAYA	T3	PPACA
TRUMENBA	T2	PPACA
GRAM POSITIVE COCCI VACCINES		
CAPVAXIVE	T3	PPACA
PNEUMOVAX 23	T2	PPACA
PREVNAR	T2	
INFLUENZA VIRUS VACCINES		
AFLURIA TRIVALENT	T2	PPACA

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

T4 – Specialty Medications

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List of Prescription Medications

BIOLOGICALS (Vaccines) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
INFLUENZA VIRUS VACCINES (cont.)		
EZ FLU 2	T2	PPACA
FLUAD TRIVALENT	T2	PPACA
FLUARIX TRIVALENT	T2	PPACA
FLUBLOK TRIVALENT	T2	PPACA
FLUCELVAX TRIVALENT	T2	PPACA
FLULALVAL TRIVALENT	T2	PPACA
FLUMIST QUAD TRIVALENT	T3	PPACA
FLUVIRIN	T2	PPACA
FLUZONE HIGH-DOSE TRIVALENT	T2	PPACA
FLUZONE TRIVALENT	T2	PPACA
TOXIN-PRODUCING BACILLI VACCINES/TOXOIDS		
BCG VACCINE (TICE STRAIN)	T4	SP
VACCINE/TOXOID PREPARATIONS, COMBINATIONS		
ACTHIB	T2	PPACA
ADACEL TDAP	T2	PPACA
BOOSTRIX TDAP	T2	PPACA
DAPTACEL DTAP	T2	PPACA
DIPHTHERIA-TETANUS TOXOIDS-PED	T2	
HIBERIX	T2	PPACA
INFANRIX DTAP	T2	PPACA
KINRIX	T2	PPACA
M-M-R II VACCINE	T2	PPACA
PEDVAXHIB	T2	PPACA
PENTACEL	T2	PPACA
PROQUAD	T2	PPACA
QUADRACEL DTAP-IPV	T2	PPACA
TDVAX	T2	PPACA
TENIVAC	T2	PPACA
VAXELIS	T2	PPACA
VIRAL/TUMORIGENIC VACCINES		
ACAM2000	T3	

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

T4 – Specialty Medications

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List of Prescription Medications

BIOLOGICALS (Vaccines) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
VIRAL/TUMORIGENIC VACCINES (cont.)		
ENGERIX-B ADULT	T2	PPACA
ENGERIX-B PEDIATRIC-ADOLESCENT	T2	PPACA
ERVEBO (NATIONAL STOCKPILE)	T3	
GARDASIL 9	T2	PPACA
HEPLISAV-B	T2	PPACA
IXCHIQ	T3	PPACA
JYNNEOS	T3	
MRESVIA	T3	PPACA
PEDIARIX	T2	PPACA
RECOMBIVAX HB	T2	PPACA
SHINGRIX	T2	QL (2 doses/lifetime) PPACA
TWINRIX	T2	PPACA
VARIVAX VACCINE	T2	PPACA
ZOSTAVAX	T2	PPACA

BLOOD (Blood Modifiers/Bleeding Disorders)

AGENTS TO TX THROMBOTIC THROMBOCYTOPENIC PURPURA		
ADZYNMA	T4	PA SP
CABLIVI	T4	PA SP
ANTI-FIBRINOLYTIC AGENTS		
AMICAR (<i>aminocaproic acid</i>)	T4	SP HD
<i>aminocaproic acid</i> (Amicar)	T4	SP HD
LYSTEDA (<i>tranexamic acid</i>)	T4	SP
<i>tranexamic acid</i> (Lysteda)	T4	SP
<i>tranexamic 1,000 mg/100ml-nacl</i>	T4	SP
<i>tranexamic acid in nacl,iso-os</i>	T4	SP
TRANEXAMIC ACID-NACL	T4	SP
TRANEXAMIC 1,000 MG/100ML-NACL	T4	SP
ANTI-HEMOPHILIC FACTORS		
ALTUVILLO	T4	PA SP HD
COMPLEMENT (C3) INHIBITORS		
EMPAVELI	T4	PA SP
FABHALTA	T4	PA QL(2 caps/day) SP
PIASKY	T4	PA SP
TAVNEOS	T3	PA QL(6 caps/day) SP
VEOPOZ	T4	SP

T1 – Typically Generics

T2 – Typically Preferred Brands

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List of Prescription Medications

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

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
COMPLEMENT (C3) INHIBITORS		
VOYDEYA	T4	PA QL(1 packet/28 days) SP
HEMOPHILIA TREATMENT AGENTS, NON-FACTOR REPLACEMENT		
HEMLIBRA	T4	PA SP HD
SICKLE CELL ANEMIA AGENTS		
DROXIA	T3	
OXBRYTA 300MG TAB for SUSP	T4	QL (5 tabs/day) SP
SIKLOS	T3	PA
TOPICAL HEMOSTATICS		
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	
THROMBIN-JMI	T3	
THROMBI-PAD	T3	
ULTRAFOAM	T3	
BLOOD (Blood Thinners/Anti-Clotting)		
HEMORRHOLOGIC AGENTS		
pentoxifylline	T1	HD
BLOOD (Miscellaneous)		
CELL/GENE THERAPY AGENTS - HEMATOPOIETIC		
OMISIRGE	T3	
CARDIAC DRUGS (Blood Pressure/Heart Medications)		
ANTI-ANGINAL, ANTI-ISCHEMIC AGENTS, NON-HEMODYNAMIC		
ranolazine (Ranexa)	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

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

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ANTI-ARRHYTHMICS (cont.)		
adenosine	T1	
amiodarone hcl	T1	HD
bretiyium tosylate	T1	HD
CONVERT (ibutilide fumarate)	T3	PA
disopyramide phosphate (Norpace)	T1	HD
dofetilide 125 mcg capsule (Tikosyn)	T1	QL (8 caps/day) HD
dofetilide 250 mcg capsule (Tikosyn)	T1	QL (4 caps/day) HD
dofetilide 500 mcg capsule (Tikosyn)	T1	QL (2 caps/day) HD
flecainide acetate	T1	HD
ibutilide fumarate (Convert)	T1	
mexiletine hcl	T1	HD
MULTAQ	T2	HD
NEXTERONE	T3	
NORPACE (disopyramide phosphate)	T3	PA HD
NORPACE CR	T3	HD
pacerone 100 mg, 400 mg tablet	T3	PA HD
pacerone 200 mg tablet	T1	HD
propafenone hcl (Rythmol Sr)	T1	HD
quinidine	T1	HD
RYTHMOL SR (propafenone hcl er)	T3	PA HD
TIKOSYN 125 MCG CAPSULE (dofetilide)	T3	PA QL (8 caps/day) HD
TIKOSYN 250 MCG CAPSULE (dofetilide)	T3	PA QL (4 caps/day) HD
TIKOSYN 500 MCG CAPSULE (dofetilide)	T3	PA QL (2 caps/day) HD
XYLOCAINE	T3	
CALCIUM CHANNEL BLOCKING AGENTS		
ADALAT CC (nifedipine er)	T3	HD
amlodipine besylate (Norvasc)	T1	HD
CALAN SR (verapamil er)	T3	HD
CAMZYOS	T3	PA QL (30 caps/30 days) SP
CARDENE I.V. (nicardipine hcl)	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

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

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
CALCIUM CHANNEL BLOCKING AGENTS (cont.)		
CLEVIPREX	T3	
diltiazem hcl	T1	
diltiazem 24h er(la) 120 mg tb (Cardizem La)	T1	QL(1 tab/day) HD
diltiazem 24h er(la) 180 mg tb (Cardizem La)	T1	HD
diltiazem 24h er(la) 240 mg tb (Cardizem La)	T1	HD
diltiazem 24h er(la) 300 mg tb (Cardizem La)	T1	HD
diltiazem 24h er(la) 360 mg tb (Cardizem La)	T1	HD
diltiazem 24h er(la) 420 mg tb (Cardizem La)	T1	HD
diltiazem hcl (Cardizem La)	T1	HD
diltiazem hcl (Tiazac)	T1	HD
felodipine	T1	HD
isradipine	T1	HD
nicardipin	T1	HD
nicardipine hcl	T1	HD
nifedipine (Adalat Cc)	T1	HD
nifedipine (Procardia)	T1	HD
nimodipine	T1	HD
nisoldipine er 17 mg tablet (Sular)	T1	HD
nisoldipine er 20 mg tablet	T1	QL (1 tab/day) HD
nisoldipine er 25.5 mg tablet	T1	HD
nisoldipine er 30 mg tablet	T1	HD
nisoldipine er 34 mg tablet (Sular)	T1	HD
nisoldipine er 40 mg tablet	T1	HD
nisoldipine er 8.5 mg tablet (Sular)	T1	HD
NORLIQVA	T3	QL(10 mls/day) HD
NORLIQVA ORAL SOLN	T2	PA QL
NORVASC (amlodipine besylate)	T3	HD
NYMALIZE	T3	
PROCARDIA (nifedipine)	T3	HD
SULAR (nisoldipine)	T3	HD
TIAZAC (tiadylt er)	T3	HD
verapamil hcl	T1	HD
verapamil hcl (Calan Sr)	T1	HD
verapamil hcl (Verelan Pm)	T1	HD
verapamil hcl (Verelan)	T1	HD

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

T4 – Specialty Medications

PA – Prior Authorization

QL – Quantity Limit

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AGE – Age Requirement

SP – Specialty Medication

HD – May require home delivery pharmacy

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List of Prescription Medications

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

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
CALCIUM CHANNEL BLOCKING AGENTS (cont.)		
VERELAN (verapamil hcl)	T3	HD
VERELAN (verapamil sr)	T3	HD
VERELAN PM (verapamil er pm)	T3	HD
DIGITALIS GLYCOSIDES		
digoxin	T1	HD
HEART RATE REDUCING, SA SELECTIVE I(F) CURRENT INH.		
CORLANOR 5 MG TABLET (ivabradine hcl)	T2	PA HD
CORLANOR 5 MG/5 ML ORAL SOLN	T4	PA SP HD
CORLANOR 7.5 MG TABLET (ivabradine hcl)	T2	PA HD
ivabradine hcl (Corlanor)	T1	PA HD
SOLUBLE GUANYLATE CYCLASE (SGC) STIMULATOR		
VERQUVO	T2	QL(1 tab/day)
VASODILATORS, CORONARY		
DILATRATE-SR	T3	HD
isosorbide dinitrate 5mg tab	T1	HD
isosorbide mononitrate	T1	HD
MINITRAN	T1	HD
NITRO-DUR 0.1 MG/HR PATCH	T3	HD
NITRO-DUR 0.2 MG/HR PATCH	T3	HD
NITRO-DUR 0.3 MG/HR PATCH	T2	HD
NITRO-DUR 0.4 MG/HR PATCH	T3	HD
NITRO-DUR 0.6 MG/HR PATCH	T3	HD
NITRO-DUR 0.8 MG/HR PATCH	T2	HD
nitroglycerin (Nitrostat)	T1	HD
nitroglycerin (Nitro-dur)	T1	HD
nitroglycerin (Nitromist)	T1	HD
nitroglycerin 400 mcg spray (Nitrolingual)	T1	HD
NITROLINGUAL	T3	HD
NITROMIST	T3	HD
NITROSTAT	T3	HD
CARDIOVASCULAR (Allergy/Nasal Spray)		
SYMPATHOMIMETIC AGENTS		
IMMPHENТИV	T3	
REZIPRES	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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PPACA – No Cost-Share Preventive Medication

CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

CARDIOVASCULAR (Asthma/COPD/Respiratory)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
PULM ANTI-HTN, SOLUBLE GUANYLATE CYCLASE STIMULATOR		
ADEMPAS	T4	PA SP HD
PULM.ANTI-HTN, SEL.C-GMP PHOSPHODIESTERASE T5 INHIB		
sildenafil 10 mg/ml oral susp (Revatio)	T4	PA SP HD
sildenafil 20 mg tablet (Revatio)	T4	PA SP HD
REVATIO 10 MG/12.5 ML VIAL	T4	PA SP HD
tadalafil (Adcirca)	T4	PA SP HD
tadalafil 20 mg tablet (Adcirca)	T4	PA SP HD
PULMONARY ANTI-HTN, ENDOTHELIN RECEPTOR ANTAGONIST		
ambrisentan (Letairis)	T4	PA SP HD
bosentan (Tracleer)	T4	PA SP HD
LETAIRIS (ambrisentan)	T4	PA SP HD
OPSUMIT	T4	PA SP HD
TRACLEER 125 MG TABLET (bosentan)	T4	PA SP HD
TRACLEER 32 MG TABLET FOR SUSP	T4	PA SP HD
TRACLEER 62.5 MG TABLET (bosentan)	T4	PA SP HD
PULMONARY ANTIHYPER AGENT, ACTRIIA-FC		
WINREVAIR	T4	PA SP HD
PULMONARY ANTIHYPERTENSIVES, PROSTACYCLIN-TYPE		
ORENITRAM ER	T4	PA SP HD
ORENITRAM MONTH 1 TITRATION KT	T4	PA QL(168 tabs/180 days) SP HD
ORENITRAM MONTH 2 TITRATION KT	T4	PA QL(336 tabs/180 days) SP HD
ORENITRAM MONTH 3 TITRATION KT	T4	PA QL(252 tabs/180 days) SP HD
TYVASO 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
PULMONARY HTN-ENDOTHELIN RECEPT ANTG-CGMP PDE5 INH		
OPSYNVI	T4	PA QL(1 tab/day) SP HD
CARDIOVASCULAR (Blood Pressure/Heart Medications)		
ACE INHIBITOR-CALCIUM CHANNEL BLOCKER COMBINATION		
amlodipine besylate/benazepril	T1	HD

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

T4 – Specialty Medications

PA – Prior Authorization

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ST – Step Therapy

AGE – Age Requirement

SP – Specialty Medication

HD – May require home delivery pharmacy

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List of Prescription Medications

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

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ACE INHIBITOR-CALCIUM CHANNEL BLOCKER COMBINATION (cont.)		
amlodipine besylate/benazepril (Lotrel)	T1	HD
LOTREL (amlodipine besylate-benazepril)	T3	HD
PRESTALIA 14 MG-10 MG TABLET	T3	HD
PRESTALIA 3.5 MG-2.5 MG TABLET	T3	QL (1 tab/day) HD
PRESTALIA 7 MG-5 MG TABLET	T3	QL (1 tab/day) HD
TARKA (trandolapril-verapamil er)	T3	HD
trandolapril/verapamil hcl	T1	HD
trandolapril/verapamil hcl (Tarka)	T1	HD
ACE INHIBITOR-THIAZIDE OR THIAZIDE-LIKE DIURETIC		
ACCURETIC (quinapril-hydrochlorothiazide)	T3	ST HD
benazepril/hydrochlorothiazide	T1	HD
benazepril/hydrochlorothiazide (Lotensin Hct)	T1	HD
captopril-hctz 25-15 mg tablet	T1	QL (3 tabs/day) HD
captopril-hctz 25-25 mg tablet	T1	QL (2 tabs/day) HD
captopril-hctz 50-15 mg tablet	T1	QL (3 tabs/day) HD
captopril-hctz 50-25 mg tablet	T1	QL (2 tabs/day) HD
enalapril/hydrochlorothiazide	T1	HD
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
ALPHA/BETA-ADRENERGIC BLOCKING AGENTS		
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

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
ALPHA-ADRENERGIC BLOCKING AGENTS		
CARDURA (<i>doxazosin mesylate</i>)	T3	HD
CARDURA XL	T3	HD
<i>doxazosin mesylate</i> (Cardura)	T1	HD
LABETALOL HCL 10 MG/2 ML SYRNG	T3	
<i>labetalol hcl 100 mg tablet</i>	T1	
<i>labetalol hcl 100 mg/20 ml vial</i>	T1	
<i>labetalol hcl 20 mg/4 ml crpj</i>	T1	
<i>labetalol hcl 20 mg/4 ml syrng</i>	T1	
<i>labetalol hcl 20 mg/4 ml vial</i>	T1	
<i>labetalol hcl 200 mg tablet</i>	T1	
<i>labetalol hcl 200 mg/40 ml vial</i>	T1	
<i>labetalol hcl 300 mg tablet</i>	T1	
MINIPRESS (<i>prazosin hcl</i>)	T3	HD
<i>prazosin hcl</i> (Minipress)	T1	HD
<i>terazosin hcl</i>	T1	HD
ANGIOTEN. RECEPTR ANTAG-CALCIUM CHANL BLKR-THIAZIDE		
<i>amlodipine/valsartan/hcthiazid</i> (Exforge Hct)	T1	HD
EXFORGE HCT (<i>amlodipine-valsartan-hctz</i>)	T3	HD
<i>olmesartan/amlodipin/hcthiazid</i> (Tribenzor)	T1	HD
TRIBENZOR (<i>olmesartan-amlodipine-hctz</i>)	T3	HD
ANGIOTENSIN RECEPT-NEPRILYSIN INHIBITOR COMB (ARNI)		
ENTRESTO	T2	HD
ANGIOTENSIN RECEPTOR ANTAG.-THIAZIDE DIURETIC COMB		
ATACAND HCT (<i>candesartan-hydrochlorothiazid</i>)	T3	ST HD
AVALIDE (<i>irbesartan-hydrochlorothiazide</i>)	T3	ST HD
BENICAR HCT 20-12.5 MG TABLET (<i>olmesartan-hydrochlorothiazide</i>)	T3	QL (1 tab/day) ST HD
BENICAR HCT 40-12.5 MG TABLET (<i>olmesartan-hydrochlorothiazide</i>)	T3	ST HD
BENICAR HCT 40-25 MG TABLET (<i>olmesartan-hydrochlorothiazide</i>)	T3	ST HD
<i>candesartan/hydrochlorothiazid</i> (Atacand Hct)	T1	HD
DIOVAN HCT (<i>valsartan-hydrochlorothiazide</i>)	T3	ST HD
HYZAAR (<i>losartan-hydrochlorothiazide</i>)	T3	ST HD
<i>irbesartan/hydrochlorothiazide</i> (Avalide)	T1	HD
<i>losartan/hydrochlorothiazide</i> (Hyzaar)	T1	HD
MICARDIS HCT 40-12.5 MG TABLET (<i>telmisartan-hydrochlorothiazid</i>)	T3	QL (1 tab/day) ST HD
MICARDIS HCT 80-12.5 MG TABLET (<i>telmisartan-hydrochlorothiazid</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 (Blood Pressure/Heart Medications) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ANGIOTENSIN RECEPTOR ANTAG.-THIAZIDE DIURETIC COMB (cont.)		
MICARDIS HCT 80-25 MG TABLET (<i>telmisartan-hydrochlorothiazide</i>)	T3	ST HD
<i>olmesartan-hctz 20-12.5 mg tab</i> (Benicar Hct)	T1	QL (1 tab/day) HD
<i>olmesartan-hctz 40-12.5 mg tab</i> (Benicar Hct)	T1	HD
<i>olmesartan-hctz 40-25 mg tab</i> (Benicar Hct)	T1	HD
<i>telmisartan-hctz 40-12.5 mg tb</i> (Micardis Hct)	T1	QL (1 tab/day) HD
<i>telmisartan-hctz 80-12.5 mg tb</i> (Micardis Hct)	T1	HD
<i>telmisartan-hctz 80-25 mg tab</i> (Micardis Hct)	T1	HD
<i>valsartan/hydrochlorothiazide</i> (Diovan Hct)	T1	HD
ANGIOTENSIN RECEPTOR BLOCKR-CALCIUM CHANNEL BLOCKR		
<i>amlodipine besylate/valsartan</i> (Exforge)	T1	HD
<i>amlodipine-olmesartan 10-20 mg</i> (Azor)	T1	HD
<i>amlodipine-olmesartan 10-40 mg</i> (Azor)	T1	HD
<i>amlodipine-olmesartan 5-20 mg</i> (Azor)	T1	QL (1 tab/day) HD
<i>amlodipine-olmesartan 5-40 mg</i> (Azor)	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	HD
<i>telmisartanamlodipine 40-10</i>	T1	HD
<i>telmisartanamlodipine 40-5 mg</i>	T1	QL (1 tab/day) HD
<i>telmisartanamlodipine 80-10</i>	T1	HD
<i>telmisartanamlodipine 80-5 mg</i>	T1	HD
ANTI-HYPERTENSIVES, ACE INHIBITORS		
ACCUPRIL (<i>quinapril hcl</i>)	T3	ST HD
<i>benazepril hcl</i>	T1	HD
<i>benazepril hcl</i> (Lotensin)	T1	HD
<i>captopril</i>	T1	HD
<i>enalaprilat dihydrate</i>	T1	
<i>enalapril maleate</i> (Vasotec)	T1	HD
<i>fosinopril sodium</i>	T1	HD
<i>lisinopril</i> (Zestril)	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
ANTI-HYPERTENSIVES, ACE INHIBITORS (cont.)		
LOTENSIN (<i>benazepril hcl</i>)	T3	ST HD
<i>moexipril hcl</i>	T1	HD
<i>perindopril erbumine</i>	T1	HD
PRINIVIL (<i>lisinopril</i>)	T3	ST HD
<i>quinapril hcl</i> (Accupril)	T1	HD
<i>ramipril</i> (Altace)	T1	HD
<i>trandolapril</i>	T1	HD
VASOTEC (<i>enalapril maleate</i>)	T3	ST HD
ANTI-HYPERTENSIVES, ANGIOTENSIN RECEPTOR ANTAGONIST		
ATACAND (<i>candesartan cilexetil</i>)	T3	ST HD
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
DIOVAN (<i>valsartan</i>)	T3	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

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

T4 – Specialty Medications

PA – Prior Authorization

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ST – Step Therapy

AGE – Age Requirement

SP – Specialty Medication

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PPACA – No Cost-Share Preventive Medication

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List of Prescription Medications

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

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ANTI-HYPERTENSIVES, GANGLIONIC BLOCKERS		
VECAMYL	T1	
ANTI-HYPERTENSIVES, MISCELLANEOUS		
DEMSER (<i>metyrosine</i>)	T3	HD
<i>metyrosine</i> (Demser)	T1	HD
<i>nitroprusside sodium</i> (Nitropress)	T1	
ANTI-HYPERTENSIVES, SYMPATHOLYTIC		
CATAPRES-TTS 1 (<i>clonidine</i>)	T3	HD
CATAPRES-TTS 2 (<i>clonidine</i>)	T3	HD
CATAPRES-TTS 3 (<i>clonidine</i>)	T3	HD
<i>clonidine</i> (Catapres-tts 1)	T1	HD
<i>clonidine</i> (Catapres-tts 2)	T1	HD
<i>clonidine</i> (Catapres-tts 3)	T1	HD
<i>clonidine hcl</i> (Catapres)	T1	HD
<i>guanfacine hcl</i>	T1	HD
<i>methyldopate hcl</i>	T1	
<i>methyldopa</i>	T1	HD
<i>methyldopa/hydrochlorothiazide</i>	T1	HD
ANTI-HYPERTENSIVES, VASODILATORS		
<i>hydralazine hcl</i>	T1	HD
<i>minoxidil</i>	T1	HD
BETA-ADRENERGIC BLOCKING AGENTS		
<i>acebutolol hcl</i>	T1	HD
<i>atenolol</i> (Tenormin)	T1	HD
<i>betaxolol hcl</i>	T1	HD
<i>atenolol</i> (Tenormin)	T1	HD
<i>betaxolol hcl</i>	T1	HD
<i>bisoprolol fumarate</i>	T1	HD
BREVIBLOC	T3	
BYSTOLIC 10 MG TABLET	T2	QL (1 tab/day) ST HD
BYSTOLIC 2.5 MG TABLET	T2	QL (1 tab/day) ST HD
BYSTOLIC 20 MG TABLET	T2	ST HD
BYSTOLIC 5 MG TABLET	T2	QL (1 tab/day) ST HD

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

T4 – Specialty Medications

PA – Prior Authorization

QL – Quantity Limit

ST – Step Therapy

AGE – Age Requirement

SP – Specialty Medication

HD – May require home delivery pharmacy

PPACA – No Cost-Share Preventive Medication

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List of Prescription Medications

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

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
BETA-ADRENERGIC BLOCKING AGENTS (cont.)		
<i>esmolol</i>	T1	
<i>INNOPRAN XL</i>	T3	ST HD
<i>metoprolol succinate (Toprol XL)</i>	T1	HD
<i>metoprolol tartrate</i>	T1	HD
<i>metoprolol tartrate (Lopressor)</i>	T1	HD
<i>nadolol</i>	T1	HD
<i>pindolol</i>	T1	HD
<i>propranolol hcl</i>	T1	HD
<i>propranolol hcl (Inderal La)</i>	T1	HD
<i>sotalol hcl</i>	T1	
<i>sotalol hcl (Betapace Af)</i>	T1	HD
<i>SOTYLIZE</i>	T3	HD
<i>timolol maleate</i>	T1	HD
BETA-BLOCKERS AND THIAZIDE, THIAZIDE-LIKE DIURETICS		
<i>atenolol/chlorthalidone (Tenoretic 100)</i>	T1	HD
<i>atenolol/chlorthalidone (Tenoretic 50)</i>	T1	HD
<i>bisoprolol/hydrochlorothiazide (Ziac)</i>	T1	HD
<i>metoprolol/hydrochlorothiazide</i>	T1	HD
<i>nadolol/bendroflumethiazide</i>	T1	HD
<i>propranolol/hydrochlorothiazide</i>	T1	HD
RENIN INHIBITOR, DIRECT		
<i>aliskiren 150 mg tablet (Tekturna)</i>	T1	QL (1 tab/day) HD
<i>aliskiren 300 mg tablet (Tekturna)</i>	T1	HD
RENIN INHIBITOR, DIRECT AND THIAZIDE DIURETIC COMB		
<i>TEKTURN A HCT</i>	T2	HD
VASODILATORS, COMBINATION		
<i>isosorbide dinit/hydralazine (Bidil)</i>	T1	QL (6 tabs/day) HD
<i>BIDIL</i>	T3	QL (6 tabs/day) HD
VASODILATORS, PERIPHERAL		
<i>ergoloid mesylates</i>	T1	
<i>isoxsuprine hcl</i>	T1	
CARDIOVASCULAR (Cholesterol Medications)		
ANTI-HYPERLIP.HMG COA REDUCT INHIB-CHOEST.AB.INHIB		
<i>ezetimibe/simvastatin (Vytorin)</i>	T1	HD

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

T4 – Specialty Medications

PA – Prior Authorization

QL – Quantity Limit

ST – Step Therapy

AGE – Age Requirement

SP – Specialty Medication

HD – May require home delivery pharmacy

PPACA – No Cost-Share Preventive Medication

CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

CARDIOVASCULAR (Cholesterol Medications) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ANTI-HYPERLIP.HMG COA REDUCT INHIB-CHOLEST.AB.INHIB (cont.)		
ROSZET	T3	PA HD
VYTORIN (ezetimibe-simvastatin)	T3	ST HD
ANTI-HYPERLIPID- HMG-COA RI-CALCIUM CHANNEL BLOCKER		
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 (amlodipine-atorvastatin)	T3	HD
CADUET 10 MG-20 MG TABLET (amlodipine-atorvastatin)	T3	HD
CADUET 10 MG-40 MG TABLET (amlodipine-atorvastatin)	T3	HD
CADUET 10 MG-80 MG TABLET (amlodipine-atorvastatin)	T3	HD
CADUET 5 MG-10 MG TABLET (amlodipine-atorvastatin)	T3	HD
CADUET 5 MG-20 MG TABLET (amlodipine-atorvastatin)	T3	QL (1 tab/day) HD
CADUET 5 MG-40 MG TABLET (amlodipine-atorvastatin)	T3	QL (1 tab/day) HD
CADUET 5 MG-80 MG TABLET (amlodipine-atorvastatin)	T3	HD
ANTI-HYPERLIPIDEMIC - APO B-100 SYNTHESIS INHIBITOR		
KYNAMRO	T4	PA SP
ANTI-HYPERLIPIDEMIC - ATP CITRATE LYASE INHIBITOR		
NEXLETOL	T2	PA QL (1 tab/day)
ANTI-HYPERLIPIDEMIC - MTP INHIBITOR		
JUXTAPID	T4	PA SP HD
ANTI-HYPERLIPIDEMIC - PCSK9 INHIBITORS		
REPATHA	T2	PA
ANTI-HYPERLIPIDEMIC-ACLY AND CHOLES ABSORP INHIB		
NEXLIZET	T2	PA QL (1 syringe/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

CARDIOVASCULAR (Cholesterol Medications) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ANTI-HYPERLIPIDEMIC-HMGCOA REDUCTASE INHIB (Statins)		
atorvastatin 20 mg tablet	T1	HD PPACA
atorvastatin 40 mg tablet	T1	HD
atorvastatin 80 mg tablet	T1	HD
fluvastatin sodium	T1	HD PPACA
fluvastatin sodium (Lescol XL)	T1	HD PPACA
LIVALO	T2	PA QL ST
LIVALO 1 MG TABLET (<i>pitavastatin calcium</i>)	T2	ST QL(1 tab/day) HD
LIVALO 2 MG TABLET (<i>pitavastatin calcium</i>)	T2	ST QL(1 tab/day) HD
LIVALO 4 MG TABLET (<i>pitavastatin calcium</i>)	T2	ST HD
lovastatin 10 mg tablet	T1	HD
lovastatin 20 mg tablet	T1	HD PPACA
lovastatin 40 mg tablet	T1	HD PPACA
pitavastatin 1 mg tablet	T1	QL HD PPACA
pitavastatin 2 mg tablet	T1	QL HD PPACA
pitavastatin 4 mg tablet (Livalo)	T1	HD PPACA
pitavastatin 1 mg tablet (Livalo)	T1	QL(1 tab/day) HD PPACA
pitavastatin 2 mg tablet (Livalo)	T1	QL(1 tab/day) HD PPACA
pitavastatin 4 mg tablet	T1	HD PPACA
pravastatin sodium	T1	HD PPACA
pravastatin sodium (Pravachol)	T1	HD PPACA
rosuvastatin calcium 10 mg tab (Crestor)	T1	QL (1 tab/day) HD PPACA
rosuvastatin calcium 20 mg tab (Crestor)	T1	QL (1 tab/day) HD
rosuvastatin calcium 40 mg tab (Crestor)	T1	HD
rosuvastatin calcium 5 mg tab (Crestor)	T1	QL (1 tab/day) HD PPACA
simvastatin 10 mg tablet (Zocor)	T1	HD PPACA
simvastatin 20 mg tablet (Zocor)	T1	HD PPACA
simvastatin 40 mg tablet (Zocor)	T1	HD PPACA
simvastatin 5 mg tablet	T1	HD
simvastatin 80 mg tablet	T1	QL (1 tab/day) HD
BILE SALT SEQUESTRANTS		
cholestyramine (with sugar) (Questran)	T1	HD
cholestyramine/aspartame	T1	HD
cholestyramine/aspartame (Questran Light)	T1	HD
colesevelam hcl (Welchol)	T1	HD

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

T4 – Specialty Medications

PA – Prior Authorization

QL – Quantity Limit

ST – Step Therapy

AGE – Age Requirement

SP – Specialty Medication

HD – May require home delivery pharmacy

PPACA – No Cost-Share Preventive Medication

CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

CARDIOVASCULAR (Cholesterol Medications) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
BILE SALT SEQUESTRANTS (con't.)		
COLESTID 1 GM TABLET (<i>colestipol hcl</i>)	T3	HD
COLESTID FLAVORED GRANULES	T2	HD
COLESTID FLAVORED GRANULES	T3	HD
COLESTID GRANULES	T3	HD
COLESTID GRANULES (<i>colestipol hcl</i>)	T3	HD
COLESTID GRANULES PACKET (<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
LIPOTROPICS		
<i>ezetimibe</i> (Zetia)	T1	HD
<i>fenofibrate nanocrystallized</i> (Tricor)	T1	HD
<i>fenofibrate, micronized</i>	T1	HD
<i>fenofibric acid (choline)</i> (Trilipix)	T1	HD
<i>fenofibric acid</i> (Fibrincor)	T1	HD
FIBRICOR (<i>fenofibric acid</i>)	T3	ST HD
<i>gemfibrozil</i> (Lopid)	T1	HD
LIPOFEN	T3	ST HD
LOPID (<i>gemfibrozil</i>)	T3	HD
<i>niacin</i> (Niaspan)	T1	HD
NIASPAN (<i>niacin er</i>)	T3	HD
TRICOR (<i>fenofibrate</i>)	T3	ST HD
TRIGLIDE	T3	ST HD
TRILIPIX (<i>fenofibric acid</i>)	T3	ST HD
ZETIA (<i>ezetimibe</i>)	T3	HD
CARDIOVASCULAR (Miscellaneous)		
VENOSCLEROSING AGENTS		
<i>sodium tetradearyl sulfate</i>	T1	
CNS DRUGS (Alzheimer's Disease)		
ALZHEIMER'S THERAPY, NMDA RECEPTOR ANTAGONISTS		
<i>memantine hcl</i>	T1	HD
<i>memantine hcl er 14 mg capsule</i> (Namenda Xr)	T1	QL (1 cap/day) HD
<i>memantine hcl er 21 mg capsule</i> (Namenda Xr)	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 (Alzheimer's Disease) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ALZHEIMER'S THERAPY, NMDA RECEPTOR ANTAGONISTS (con't.)		
memantine hcl er 28 mg capsule (Namenda Xr)	T1	HD
memantine hcl er 7 mg capsule (Namenda Xr)	T1	QL (1 cap/day) HD
NAMENDA	T2	HD
NAMENDA XR 14 MG CAPSULE (memantine hcl er)	T3	QL (1 cap/day) HD
NAMENDA XR 21 MG CAPSULE (memantine hcl er)	T3	HD
NAMENDA XR 28 MG CAPSULE (memantine hcl er)	T3	HD
NAMENDA XR 7 MG CAPSULE (memantine hcl er)	T3	QL (1 cap/day) HD
NAMENDA XR TITRATION PACK	T3	QL (112/365 days) HD
ALZHEIMER'S THX, NMDA RECEPTOR ANTAG-CHOLINES INHIB		
NAMZARIC 14 MG-10 MG CAPSULE	T3	QL (2 caps/day) HD
NAMZARIC 21 MG-10 MG CAPSULE	T3	QL (2 caps/day) HD
NAMZARIC 28 MG-10 MG CAPSULE	T3	QL (2 caps/day) HD
NAMZARIC 7 MG-10 MG CAPSULE	T3	QL (2 caps/day) HD
NAMZARIC TITRATION PACK	T3	QL (112/365 days) HD
AMYLOID DIRECTED MONOCLONAL ANTIBODY		
ADUHELM	T3	PA SP
CNS DRUGS (Miscellaneous)		
AMYOTROPHIC LATERAL SCLEROSIS AGENTS		
edaravone	T4	PA SP
QALSODY	T3	
RADICAVA ORS	T4	PA QL (50ml/28days) SP
RILUTEK (riluzole)	T4	SP HD
riluzole (Rilutek)	T4	SP HD
TIGLUTIK	T4	PA SP
DRUGS TO TREAT MOVEMENT DISORDERS		
AUSTEDO	T4	PA SP HD
AUSTEDO XR	T4	PA QL SP HD
AUSTEDO XR 6 MG TABLET	T4	PA QL(3 tabs/day) SP HD
AUSTEDO XR 12 MG TABLET	T4	PA QL(1 tab/day) SP HD
AUSTEDO XR 18 MG TABLET	T4	PA QL(1 tab/day) SP HD
AUSTEDO XR 24 MG TABLET	T4	PA QL(2 tabs/day) SP HD
AUSTEDO XRTITRATION KT(WK1-4)	T4	PA QL(1 kit/180 days) SP HD
INGREZZA	T4	PA QL (1 tab/day) SP
INGREZZA INITIATION PK (TARDIV)	T4	PA QL (28 caps/year) SP
tetrabenazine	T4	PA SP HD

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

T4 – Specialty Medications

PA – Prior Authorization

QL – Quantity Limit

ST – Step Therapy

AGE – Age Requirement

SP – Specialty Medication

HD – May require home delivery pharmacy

PPACA – No Cost-Share Preventive Medication

CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

CNS DRUGS (Miscellaneous) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
PSEUDOLOBULAR AFFECT (PBA) AGENTS, NMDA ANTAGONISTS		
NUEDEXTA	T3	QL (4 caps/day)
CNS DRUGS (Multiple Sclerosis)		
XANTHINES		
caffeine citrate	T1	HD
AGENTS TO TREAT MULTIPLE SCLEROSIS		
AVONEX	T4	PA SP HD
AVONEX PEN	T4	PA SP HD
BAFIERTAM	T4	PA SP HD
BETASERON	T4	PA SP HD
BRIUMVI	T4	PA SP
<i>dimethyl fumarate</i>	T1	HD
GILENYA	T4	PA SP HD
<i>glatopa</i>	T1	HD
<i>glatiramer acetate</i>	T4	PA SP HD
KESIMPTA PEN	T4	PA SP HD
MAVENCLAD	T4	PA SP HD
MAYZENT	T4	PA SP HD
OCREVUS	T4	PA SP
PLEGRIDY	T4	PA SP HD
PLEGRIDY PEN	T4	PA SP HD
PONVORY	T4	PA SP HD
REBIF	T3	PA SP HD
REBIF REBIDOSE	T4	PA SP HD
<i>teriflunomide</i> (Aubagio)	T1	
VUMERTY	T4	PA SP HD
AGTS TX NEUROMUSC TRANSMISSION DIS, POT-CHAN BLKR		
dalfampridine	T4	PA SP HD
FIRDAPSE	T4	PA QL (8 tabs/day) SP
RUZURGI	T4	PA SP
CNS DRUGS (Pain Relief And Inflammatory Disease)		
CALCITONIN GENE-RELATED PEPTIDE (CGRP) INHIBITORS		
EMGALITY SYRINGE	T2	PA
SPHINGOSINE I-PHOSPHATE (SIP) RECEPTOR MODULATOR		
VELSIPITY	T4	PA QL(30 tabs/30 days) SP HD

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 (Pain Relief And Inflammatory Disease) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
POSTHERPETIC NEURALGIA AGENTS		
<i>gabapentin</i> (Gralise)	T4	PA SP HD
SPHINGOSINE I-PHOSPHATE (SIP) RECEPTOR MODULATOR		
ZEPOSIA	T4	PA SP HD
CNS DRUGS (Seizure Disorders)		
ANTI-CONVULSANT - BENZODIAZEPINE TYPE		
<i>clobazam</i> (Onfi)	T1	HD
<i>clonazepam</i> (Klonopin)	T1	HD
DIASTAT ACUDIAL (<i>diazepam</i>)	T3	PA HD
<i>diazepam 10 mg rectal gel syst</i> (Diastat Acudial)	T1	HD
<i>diazepam 2.5 mg rectal gel sys</i> (Diastat)	T1	HD
<i>diazepam 20 mg rectal gel syst</i>	T1	HD
KLONOPIN (<i>clonazepam</i>)	T3	PA HD
LIBERVANT	T3	QL(10 films/30 days) HD
NAYZILAM	T2	PA QL (5 kits/30 days) HD
ONFI (<i>clobazam</i>)	T3	PA HD
VALTOCO	T3	PA QL (5 boxes/30 Days) HD
ANTI-CONVULSANT - CANNABINOID TYPE		
EPIDIOLEX	T4	PA SP HD
ANTI-CONVULSANTS		
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
BRIVIACT	T3	PA HD
<i>carbamazepine</i>	T1	HD
CARBAMAZEPINE 200 MG TAB CHEW	T3	HD
<i>carbamazepine</i> (Carbatrol)	T1	HD
<i>carbamazepine</i> (Tegretol Xr)	T1	HD
<i>carbamazepine</i> (Tegretol)	T1	HD
CARBATROL (<i>carbamazepine er</i>)	T3	PA HD
CELONTIN	T2	HD
CEREBYX (fosphenytoin sodium)	T3	
DIACOMIT	T4	PA SP HD

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

T4 – Specialty Medications

PA – Prior Authorization

QL – Quantity Limit

ST – Step Therapy

AGE – Age Requirement

SP – Specialty Medication

HD – May require home delivery pharmacy

PPACA – No Cost-Share Preventive Medication

CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

CNS DRUGS (Seizure Disorders) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ANTI-CONVULSANTS (cont.)		
DILANTIN 100 MG CAPSULE (<i>phenytoin sodium extended</i>)	T3	PA HD
DILANTIN 30 MG CAPSULE	T2	PA HD
DILANTIN 50 MG INFATAB (<i>phenytoin</i>)	T3	PA HD
DILANTIN-125 (<i>phenytoin</i>)	T3	PA HD
<i>divalproex sodium</i> (Depakote Er)	T1	HD
<i>divalproex sodium</i> (Depakote Sprinkle)	T1	HD
<i>divalproex sodium</i> (Depakote)	T1	HD
<i>ethosuximide</i> (Zarontin)	T1	HD
<i>felbamate</i>	T1	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
<i> gabapentin</i>	T1	HD
<i> gabapentin</i> (Neurontin)	T1	HD
KEPPRA 500 MG/5 ML VIAL	T3	
<i> lamotrigine</i>	T1	HD
<i> levetiracetam</i>	T1	
LYRICA (<i>pregabalin</i>)	T3	PA HD
NEURONTIN (<i> gabapentin</i>)	T3	PA HD
<i> oxcarbazepine</i>	T1	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 extended</i> (Dilantin)	T1	HD
<i> phenytoin sodium extended</i> (Phenytek)	T1	HD
<i> pregabalin</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

CNS DRUGS (Seizure Disorders) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ANTI-CONVULSANTS (cont.)		
<i>pregabalin</i> (Lyrica)	T1	HD
<i>primidone 250 mg tablet</i> (Mysoline)	T1	HD
<i>primidone 50 mg tablet</i> (Mysoline)	T1	HD
<i>primidone</i>	T1	HD
<i>rufinamide</i> (Banzel)	T1	PA QL (80ml/day HD)
<i>SPRITAM</i>	T3	PA HD
<i>TEGRETOL (carbamazepine)</i>	T3	PA HD
<i>TEGRETOL (epitol)</i>	T3	PA HD
<i>TEGRETOL XR (carbamazepine er)</i>	T3	PA HD
<i>tiagabine hcl 12 mg tablet</i>	T1	QL (8 tabs/day) HD
<i>tiagabine hcl 16 mg tablet</i>	T1	QL (6 tabs/day) HD
<i>tiagabine hcl 2 mg tablet</i>	T1	HD
<i>tiagabine hcl 4 mg tablet</i>	T1	HD
<i>topiramate er 25mg capsule</i> (Trokendi XR)	T1	QL(1 cap/day) HD
<i>topiramate er 50mg capsule</i> (Trokendi XR)	T1	HD
<i>topiramate er 100mg capsule</i> (Trokendi XR)	T1	QL(1 cap/day) HD
<i>topiramate er 200 mg capsule</i> (Trokendi XR)	T1	HD
<i>valproic acid</i> (as sodium salt)	T1	HD
<i>vigabatrin</i>	T4	SP HD
<i>VIMPAT</i>	T2	PA HD
<i>XCOPRI 25 MG TABLET</i>	T3	PA HD
<i>XCOPRI 100 MG TABLET</i>	T3	PA QL (1 tab/day) HD
<i>XCOPRI 12.5-25 MG TITRATION PK</i>	T3	PA QL (1/28 Days) HD
<i>XCOPRI 150 MG TABLET</i>	T3	PA QL (1/Day) HD
<i>XCOPRI 150-200 MG TITRATION PK</i>	T3	PA QL (1/28 Days) HD
<i>XCOPRI 200 MG TABLET</i>	T3	PA QL (2/Day) HD
<i>XCOPRI DAILY DOSE PACK</i>	T3	PA QL (1/28 Days) HD
<i>XCOPRI 50 MG TABLET</i>	T3	PA QL (1/Day) HD
<i>XCOPRI 50-100 MG TITRATION PAK</i>	T3	PA QL (1/28 Days) HD
<i>XCOPRI 25 MG TABLET</i>	T3	PA QL (1/Day) HD
<i>ZARONTIN (ethosuximide)</i>	T3	PA HD
<i>zonisamide</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

CNS DRUGS (Sleep Disorders/Sedatives)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
NARCOLEPSY TX-H3-RECEPT.ANTAGONIST/INVERSE AGONIST		
WAKIX	T4	PA QL (2 tabs/day) SP HD
COLONY STIMULATING FACTORS (Blood Modifiers/Bleeding Disorders)		
ERYTHROPOIESIS-STIMULATING AGENTS		
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
ZIEXTENZO	T4	PA SP
NEULASTA	T4	PA SP
NEULASTA ONPRO	T4	PA SP HD
NEUPOGEN	T4	PA SP
NIVESTYM	T4	SP HD
NYPOZI	T3	PA SP
NYVEPRIA	T4	PA SP
STIMUFEND	T4	PA SP
UDENYCA	T4	PA SP
ZARXIO	T4	SP HD
ZIEXTENZO	T4	PA SP
THROMBOPOIETIN RECEPTOR AGONISTS		
DOPTELET	T4	PA SP HD
MULPLETA	T4	PA SP HD
PROMACTA	T4	PA SP HD
COLONY STIMULATING FACTORS (Cancer)		
CXCR4 CHEMOKINE RECEPTOR ANTAGONIST		
XOLREMDI	T4	PA QL(4 caps/day) SP CSL
CONTRACEPTIVES (Contraception Products)		
CONTRACEPTIVES, INTRAVAGINAL, SYSTEMIC		
ANNOVERA	T3	
etongestrel/ethinyl estradiol (Nuvaring)	T1	PPACA
NUVARING (etongestrel-ethinyl estradiol)	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

CONTRACEPTIVES (Contraception Products) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
CONTRACEPTIVES, IMPLANTABLE		
NEXPLANON	T4	SP PPACA
CONTRACEPTIVES, INJECTABLE		
DEPO-PROVERA 150 MG/ML SYRINGE (<i>medroxyprogesterone acetate</i>)	T3	
DEPO-PROVERA 150 MG/ML VIAL (<i>medroxyprogesterone acetate</i>)	T3	
DEPO-SUBQ PROVERA 104	T2	
<i>medroxyprogesterone 150 mg/ml</i> (Depo-provera)	T1	PPACA
CONTRACEPTIVES, ORAL		
BALCOLTRA (<i>levonorgestrel/eth.estradiol/iron</i>)	T3	HD
BEYAZ (<i>rajanii</i>)	T3	HD
<i>desog-e.estradiol/e.estradiol</i> (Mircette)	T1	HD PPACA
<i>desogestrel-ethinyl estradiol</i>	T1	HD PPACA
<i>drospir/eth estra/levomefola</i> (Beyaz)	T1	HD PPACA
<i>drospir/eth estra/levomefola</i> (Safyral)	T1	HD PPACA
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
GENERESS FE (<i>norethin-eth estra-ferrous fum</i>)	T3	HD
<i>levonorgestrel/ethin.estradiol</i>	T1	HD PPACA
<i>levonorgestrel/eth.estradiol/iron</i> (Balcoltra)	T1	HD PPACA
<i>I-norgest/e.estradiol-e.estrad</i>	T1	HD PPACA
<i>I-norgest/e.estradiol-e.estrad</i> (Quartette)	T1	HD PPACA
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>noreth-ethinyl estradiol/iron</i> (Generess Fe)	T1	HD PPACA
<i>noreth-ethinyl estradiol/iron</i> (Generess Fe)	T3	HD PPACA
<i>norethind-eth estrad 1-0.02 mg</i> (Loestrin)	T1	HD PPACA
<i>norethindrone</i> (Ortho Micronor)	T1	HD 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

CONTRACEPTIVES (Contraception Products) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
CONTRACEPTIVES, ORAL (cont.)		
norethindrone ac-eth estradiol (Loestrin)	T1	HD PPACA
norethindrone-e.estradol-iron (Estrostep Fe)	T1	HD PPACA
norethindrone-e.estradol-iron (Loestrin Fe)	T1	HD PPACA
norethindrone-e.estradol-iron (Microgestin 24 Fe)	T1	HD PPACA
norethindrone-e.estradol-iron (Taytulla)	T1	HD PPACA
norethindrone-ethin. estradiol	T1	HD PPACA
norethin-ee 1.5-0.03 mg(21) tb (Loestrin)	T1	HD PPACA
norgestrel-ethinyl estradiol	T1	HD PPACA
ORTHO MICRONOR (tulana)	T3	HD
QUARTETTE (rivelsa)	T3	HD
SAFYRAL (tydemy)	T3	HD
SLYND	T3	HD
TAYTULLA (norethin-eth estra-ferrous fum)	T3	HD
TYBLUME	T3	HD
YASMIN 28 (zumandimine)	T3	HD
YAZ (vestura)	T3	HD
CONTRACEPTIVES, TRANSDERMAL		
norelgestromin/ethin.estradol	T1	HD PPACA
TWIRLA	T3	HD PPACA
DIAPHRAGMS/CERVICAL CAP		
CAYA CONTOURED	T1	PPACA
FEMCAP	T1	PPACA
WIDE SEAL DIAPHRAGM	T1	PPACA
INTRA-UTERINE DEVICES (IUDS)		
KYLEENA	T3	SP PPACA
LILETTA	T3	SP PPACA
MIRENA	T3	SP PPACA
PARAGARD T 380-A	T3	SP PPACA
SKYLA	T3	SP PPACA
COUGH/COLD PREPARATIONS (Allergy/Nasal Sprays)		
1ST GEN ANTIHIST-DECONGEST-ANTICHOLINERGIC COMB		
RESPA A.R.	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

COUGH/COLD PREPARATIONS (Cough/Cold Medications)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ANTI-TUSSIVES, NON-OPIOID		
benzonatate	T1	
benzonatate (Tessalon Perle)	T1	
TESSALON PERLE (benzonatate)	T3	
NON-OPIOID ANTI-TUSSIVE-IST GEN. ANTIHISTAMINE-DECONGEST		
brompheniramine/pseudoephed/dm (Bromfed Dm)	T1	
NON-OPIOID ANTI-TUSSIVE-IST GEN ANTIHISTAMINE COMB.		
promethazine/dextromethorphan	T1	
OPIOID ANTI-TUSSIVE-IST GEN. ANTIHISTAMINE-DECONGEST		
hydrocodone/cpm/pseudoephed	T1	PA
promethazine/phenyleph/codeine	T1	PA QL (480ml/22 days)
promethazine/phenyleph/codeine	T1	PA QL (480ml/30 days)
OPIOID ANTI-TUSSIVE-IST GENERATION ANTIHISTAMINE		
hydrocodone/chlorphen p-stirex	T1	PA
promethazine-codeine solution	T1	PA QL (480ML/22 Days)
promethazine-codeine syrup	T1	PA QL (480ml/30 days)
TUXARIN ER	T3	PA QL (2 tabs/day)
TUZISTRA XR	T3	PA QL (960ml/30 days)
OPIOID ANTI-TUSSIVE-ANTI-CHOLINERGIC COMBINATIONS		
HYCODAN (hydromet)	T3	PA QL (480ml/22 days)
hydrocodone bit/homatrop me-br (Hycodan)	T1	PA QL (480ml/22 days)
hydrocodone-homatropine 5-1.5	T1	PA QL (180 tabs/30 days)
hydrocodone-homatropine soln (Hycodan)	T1	PA QL (480ml/30 days)
HYDROCODONE-HOMATROPINE SYRUP	T1	PA QL (480ml/30 days)
OPIOID ANTI-TUSSIVE-EXPECTORANT COMBINATION		
HYDROCODONE-GUAIFENESIN	T1	PA QL (960ml/30 days)
OBREDON	T3	PA QL (960ml/30 days)
DIAGNOSTIC (Miscellaneous)		
CARDIOVASCULAR DIAGNOSTICS, NON-RADIOPAQUE AGENTS		
regadenoson	T1	
DIAGNOSTIC PREPARATIONS, MISCELLANEOUS		
ADVANCED DNA MEDICATED COLLECT	T3	
ARIDOL	T3	
DIAGNOSTIC PREPARATIONS, MISCELLANEOUS		
lidocaine hcl/glycerin (Advanced Dna Medicated Collect)	T1	

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

T4 – Specialty Medications

PA – Prior Authorization

QL – Quantity Limit

ST – Step Therapy

AGE – Age Requirement

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List of Prescription Medications

DIAGNOSTIC (Miscellaneous) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
DIAGNOSTIC PREPARATIONS, MISCELLANEOUS (cont.)		
PROVOCHOLINE	T3	
TC99M SULFUR COLLOID PREP	T1	
EYE DIAGNOSTIC AGENTS		
AK-FLUOR	T3	
<i>fluorescein sodium</i>	T1	
<i>ful-glo 1 mg oph strip</i>	T1	
FUL-GLO EYE STRIPS	T3	
<i>lissamine green</i>	T1	
GASTROINTESTINAL RADIOPAQUE DIAGNOSTICS		
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, NECTAR, PUDDING	T3	
VARIBARTHIN HONEY	T3	
VARIBARTHIN LIQUID	T3	
METABOLIC FUNCTION DIAGNOSTICS		
METOPIRONE	T2	
RADIOPHARMACEUTICALS ELEMENTS		
INDICLOR	T3	
URINARY TRACT RADIOPAQUE DIAGNOSTICS		
CYSTO-CONRAY II	T3	
CYSTOGRAFIN	T3	
<i>diatrizoate meglumine, sodium (Gastrografin)</i>	T1	
GASTROGRAFIN (<i>md-gastroview</i>)	T3	

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

DIURETICS (Diuretics)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ARGININE VASOPRESSIN (AVP) RECEPTOR ANTAGONISTS		
TOLVAPTAN 15 MG TABLET	T4	SP
<i>tolvaptan 30 mg tablet (Samsca)</i>	T4	SP
CARBONIC ANHYDRASE INHIBITORS		
<i>acetazolamide</i>	T1	HD
<i>methazolamide</i>	T1	HD
LOOP DIURETICS		
<i>bumetanide</i>	T1	HD
<i>ethacrynat sodium (Sodium Edecrin)</i>	T1	
FUROSCIX	T3	QL(2 kits/30 days) HD
<i>furosemide (Lasix)</i>	T1	HD
<i>torsemide</i>	T1	HD
SODIUM EDECRIN (<i>ethacrynat sodium</i>)	T3	
OSMOTIC DIURETICS		
<i>osmitrol 20% (100 gm/500 ml)</i>	T2	
<i>osmitrol 20% (50 gm/250 ml)</i>	T2	
OSMITROL 10% (50 GM/500 ML) (<i>mannitol</i>)	T3	
POLYCYSTIC KIDNEY DISEASE AGENT, AVP RECEP. ANTAG		
JYNARQUE 15 MG TABLET	T4	SP
JYNARQUE 15 MG-15 MG TABLET	T4	PA SP
JYNARQUE 30 MG TABLET	T4	SP
JYNARQUE 30 MG-15 MG TABLET	T4	PA SP
JYNARQUE 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
POTASSIUM SPARING DIURETICS		
<i>amiloride hcl</i>	T1	HD
CAROSPIR (<i>Spironolactone</i>)	T2	HD
<i>eplerenone (Inspira)</i>	T1	HD
INSPRA (<i>eplerenone</i>)	T3	HD
KERENDIA	T4	PA QL (30 tabs/30 days) SP
<i>spironolactone (Aldactone)</i>	T1	HD
<i>triamterene (Dyrenium)</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

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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
POTASSIUM SPARING DIURETICS IN COMBINATION		
ALDACTAZIDE (spironolactone-hctz)	T3	HD
amiloride/hydrochlorothiazide	T1	HD
CAROSPIR SUSP	T2	PA
DYAZIDE (triamterene-hydrochlorothiazid)	T3	HD
THIAZIDE AND RELATED DIURETICS		
spironolact/hydrochlorothiazid (Aldactazide)	T1	HD
triamterene/hydrochlorothiazid (Dyazide)	T1	HD
chlorthalidone	T1	
DIURIL	T2	HD
hydrochlorothiazide	T1	HD
indapamide	T1	HD
metolazone	T1	HD
SODIUM DIURIL (chlorothiazide sodium)		
EENT PREPS (Allergy/Nasal Sprays)		
NASAL ANTIHISTAMINE		
azelastine 0.1% (137 mcg) spry	T1	HD
azelastine 0.15% nasal spray	T1	HD
olopatadine 665 mcg nasal spry (Patanase)	T1	HD
PATANASE (olopatadine hc)	T3	HD
NASAL ANTIHISTAMINE AND ANTI-INFLAM. STEROID COMB.		
azelastine/fluticasone	T1	HD
NASAL ANTI-INFLAMMATORY STEROIDS		
flunisolide	T1	HD
fluticasone prop 50 mcg spray	T1	HD
mometasone furoate 50 mcg spry	T1	QL (4 bots/30 days) HD
NOSE PREPARATIONS, MISCELLANEOUS (RX)		
ipratropium bromide	T1	HD
NOSE PREPARATIONS, VASOCONSTRICATORS (RX)		
ADRENALIN CHLORIDE	T3	
epinephrine hcl (Adrenalin Chloride)	T1	
EENT PREPS (Ear Medications)		
EAR PREPARATIONS ANTI-INFLAMMATORY		
DERMOTIC (fluocinolone acetonide oil)	T3	
fluocinolone acetonide oil (Dermotic)	T1	

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

T4 – Specialty Medications

PA – Prior Authorization

QL – Quantity Limit

ST – Step Therapy

AGE – Age Requirement

SP – Specialty Medication

HD – May require home delivery pharmacy

PPACA – No Cost-Share Preventive Medication

CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

EENT PREPS (Ear Medications) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
EAR PREPARATIONS, MISC. ANTI-INFECTIVES		
acetic acid	T1	
hydrocortisone/acetic acid	T1	
EENT PREPS (Eye Conditions)		
ARTIFICIAL TEARS		
LACRISERT	T2	
MIEBO	T2	QL(4 bottles/30 days)
EYE ANTI-INFECTIVES (RX ONLY)		
BETADINE	T2	
EYE ANTI-INFLAMMATORY AGENTS		
ACUVAIL	T3	
ALREX	T3	
bromfenac sodium	T1	
BROMSITE (bromfenac sodium)	T2	
dexamethasone sodium phosphate	T1	
diclofenac 0.1% eye drops	T1	
EYSUVIS	T2	QL (8.3ml/14 days)
FLAREX	T2	
fluorometholone (Fml)	T1	
flurbiprofen sodium	T1	
FML (fluorometholone)	T3	
FML FORTE	T2	
ILEVRO	T3	
INVELTYS	T2	
ketorolac 0.4% ophth solution (Acular Ls)	T1	
ketorolac 0.5% ophth solution (Acular)	T1	
LOTEMAX 0.5% EYE OINT	T2	
LOTEMAX SM	T2	
loteprednol etabonate (Alrex)	T1	
loteprednol etabonate (Lotemax)	T1	
MAXIDEX	T2	
OMNIPRED (prednisolone acetate)	T3	
PRED MILD	T2	
prednisolone acetate (Pred Forte)	T1	
prednisolone sodium phosphate	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

EENT PREPS (Eye Conditions) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
EYE ANTI-INFLAMMATORY AGENTS (cont.)		
PROLENSA	T3	
AKTEN	T3	
ALCAINE (<i>proparacaine hcl</i>)	T3	
EYE LOCAL ANESTHETICS		
AKTEN	T3	
ALCAINE (<i>proparacaine hcl</i>)	T3	
ALTAFLUOR BENOX (<i>flurox</i>)	T3	
<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>	T2	
<i>tetracaine hcl</i>	T1	
TETRAVISC	T2	
TETRAVISC FORTE	T2	
EYE MAST CELL STABILIZERS		
ALOCRIL	T3	
ALOMIDE	T2	
<i>cromolyn 4% eye drops</i>	T1	
EYE PREPARATIONS, MISCELLANEOUS (OTC)		
GELFILM	T3	
EYE VASOCONSTRICATORS		
<i>phenylephrine hcl</i>	T1	
MIOTICS AND OTHER INTRAOCULAR PRESSURE REDUCERS		
<i>apraclonidine hcl</i> (<i>lopidine</i>)	T1	HD
<i>betaxolol hcl</i>	T1	HD
BETIMOL	T2	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> (<i>Alphagan P</i>)	T1	HD
<i>brinzolamide</i> (<i>Azopt</i>)	T1	HD
<i>carteolol hcl</i>	T1	HD
<i>dorzolamide hcl</i> (<i>Trusopt</i>)	T1	HD
<i>dorzolamide hcl/timolol maleat</i> (<i>Cosopt</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

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List of Prescription Medications

EENT PREPS (Eye Conditions) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
MIOTICS AND OTHER INTRAOCULAR PRESSURE REDUCERS (cont.)		
dorzolamide/timolol/pf (Cosopt Pf)	T1	HD
IOPIDINE 0.5% EYE DROPS (<i>apraclonidine hcl</i>)	T3	HD
IOPIDINE 1% EYE DROPS	T2	HD
ISOPTO CARPINE (<i>pilocarpine hcl</i>)	T3	HD
latanoprost	T1	HD
levobunolol hcl	T1	HD
PHOSPHOLINE IODIDE	T2	HD
pilocarpine hcl (Isopto Carpine)	T1	HD
RHOPRESSA	T3	HD
ROCKLATAN	T3	HD
SIMBRINZA	T2	HD
timolol maleate (Istalol)	T1	HD
timolol maleate (Timoptic-xe)	T1	HD
timolol maleate/pf (Timoptic Ocudose)	T1	HD
travoprost	T1	HD
TRUSOPT (dorzolamide hcl)	T3	HD
MYDRIATICS		
atropine 1% eye drops	T1	HD
atropine sulfate	T1	HD
atropine sulfate (Isopto Atropine)	T1	HD
ATROPINE SULFATE-0.9% NACL	T3	HD
CYCLOGYL 0.5% EYE DROPS (<i>cyclopentolate hcl</i>)	T3	HD
CYCLOGYL 1% EYE DROPS (<i>cyclopentolate hcl</i>)	T3	HD
CYCLOGYL 2% EYE DROPS (<i>cyclopentolate hcl</i>)	T2	HD
CYCLOMYDRIL	T2	HD
cyclopentolate hcl (Cyclogyl)	T1	HD
homatropine hbr	T1	HD
MYDRIACYL (<i>tropicamide</i>)	T3	HD
PAREMYD	T3	HD
tropicamide	T1	HD
tropicamide (Mydriacyl)	T1	HD
OPHTH VASC. ENDOTHELIAL GROWTH FACTOR ANTAGONISTS		
PAVBLU	T3	PA SP
OPHTHALMIC ANTI-FIBROTIC AGENTS		
MITOSOL	T3	

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

T4 – Specialty Medications

PA – Prior Authorization

QL – Quantity Limit

ST – Step Therapy

AGE – Age Requirement

SP – Specialty Medication

HD – May require home delivery pharmacy

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List of Prescription Medications

EENT PREPS (Eye Conditions) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
OPHTHALMIC ANTI-INFLAMMATORY IMMUNOMODULATOR-TYPE		
CEQUA	T3	HD
RESTASIS	T2	HD
RESTASIS MULTIDOSE	T2	HD
VEVYE	T3	QL HD
XIIDRA	T2	HD
OPHTHALMIC CYSTINE DEPLETING AGENTS		
CYSTADROPS	T4	PA QL (20ml/21 days) SP
CYSTARAN	T4	PA QL (120ml/28 days) SP
OPHTHALMIC PREPARATIONS, MISCELLANEOUS		
PROVISC	T4	SP
TOTALVISC	T4	SP
OPHTHALMIC HUMAN NERVE GROWTH FACTOR (HNGF)		
OXERVATE	T4	PA SP HD
ELECT/CALORIC/H2O (Cholesterol Medications)		
ORAL LIPID SUPPLEMENTS		
DOJOLVI	T4	PA SP HD
ELECT/CALORIC/H2O (Dental Products)		
FLUORIDE PREPARATIONS		
FRAICHE 5000 PREVI	T3	
FRAICHE 5000 SENSITIVE	T3	
PREVENTD 1.1% GEL (<i>sodium fluoride</i>)	T3	
PREVENTD 5000 BOOSTER PLUS	T3	
PREVENTD 5000 ENAMEL PROTECT	T3	
PREVENTD 5000 ORTHO DEFENSE	T3	
PREVENTD 5000 PLUS (<i>sodium fluoride 5000 plus</i>)	T3	
PREVENTD 5000 SENSITIVE	T3	
PREVENTD DENTAL RINSE	T2	
PREVENTD KIDS	T2	
<i>sodium fluoride/potassium nit</i> (Preventd 5000 Sensitive)	T1	
ELECT/CALORIC/H2O (Diabetes)		
AGENTS TO TREAT HYPOGLYCEMIA (HYPERGLYCEMICS)		
BAQSIMI	T2	QL (2/30 days)

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 (Diabetes) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
AGENTS TO TREAT HYPOGLYCEMIA (HYPERGLYCEMICS) (cont.)		
diazoxide (Proglycem)	T1	
GLUCAGEN	T2	QL (2 pens/30 days)
glucagon 1 mg emergency kit (Glucagon Emergency Kit)	T1	QL (2 pens/30 days)
GVOKE HYPOPEN PACK	T3	QL (2 packs/22 days)
GVOKE PFS 1-PACK SYRINGE	T3	QL (2 syringes/30 days)
GVOKE PFS 2-PACK SYRINGE	T3	QL (2 syringes/30 days)
PROGLYCEM (diazoxide)	T3	
ZEGALOGUE	T2	QL (2 units/23 days)

ELECT/CALORIC/H2O (Miscellaneous)

IV SOLUTIONS: DEXTROSE-WATER		
GLUCOSE IN WATER (DEXTROSE 5 % IN WATER)	T1	
NUCLEIC ACID/NUCLEOTIDE SUPPLEMENTS		
XURIDEN	T4	PA SP

ELECT/CALORIC/H2O (Nutritional/Dietary)

CALCIUM REPLACEMENT		
calcium gluc 2,000mg/100ml-nacl	T1	
calcium gluc 1,000mg/50ml-nacl	T1	
ELECTROLYTE DEPLETERS		
AURYXIA	T3	QL (12 tabs/day)
calcium acetate	T1	
lanthanum carbonate (Fosrenol)	T1	
LOKELMA	T2	
PHOSLYRA	T3	
sevelamer carbonate (Renvela)	T1	
sevelamer hcl (Renagel)	T1	
sodium polystyrene sulfon/sorb	T1	
sodium polystyrene sulfonate	T1	
sps 15 gm/60 ml suspension	T1	
sps 30 gm/120 ml enema susp	T3	
VELPHORO	T2	
VELTASSA	T2	
IODINE CONTAINING AGENTS		
potassium iodide/iodine	T1	
SSKI	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

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

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits	
IRON REPLACEMENT			
CITRANATAL BLOOM	T3		
FERAHEME	T3	PA	
HEMOCYTE PLUS (mv-mins no.73/iron fum/folic)	T3		
INJECTAFER	T3	PA	
MONOFERRIC	T3	PA	
<i>mv-mins no.73/iron fum/folic</i> (Hemocyte Plus)	T1		
PARENTERAL AMINO ACID SOLUTIONS AND COMBINATIONS			
AMINO ACID 3%-D10W-CALCIUM-HEPARIN	T3		
POTASSIUM REPLACEMENT			
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>	T3		
<i>klor-con 8 meq tablet</i>	T3		
<i>potassium bicarbonate/cit ac</i>	T1		
POTASSIUM CL ER 15 MEQ TABLET	T3		
<i>potassium chloride</i>	T1		
<i>potassium chloride</i>	T2		
<i>potassium chloride</i>	T3		
<i>potassium chloride (K-tab Er)</i>	T1		
PROTEIN REPLACEMENT			
AQNEURSA	T3	PA SP	
ELECT/CALORIC/H2O (Urinary Tract Conditions)			
DIALYSIS SOLUTIONS			
PRISMASOL	T3		
URINARY PH MODIFIERS			
K-PHOS NO.2	T2	HD	
K-PHOS ORIGINAL	T2	HD	
ORACIT	T3	HD	
<i>potassium citrate (Urocit-k)</i>	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	
ZINC REPLACEMENT			
<i>zinc sulfate</i>	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

GASTROINTESTINAL (Cholesterol Medications)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
LIPOTROPICS		
<i>icosapent ethyl</i> (Vascepa)	T1	HD
LOVAZA (<i>triklo</i>)	T3	HD
<i>omega-3 acid ethyl esters</i> (Lovaza)	T1	HD
VASCEPA	T2	PA HD
GASTROINTESTINAL (Gastrointestinal/Heartburn)		
AMMONIA INHIBITORS		
AMMONUL (<i>sodium phenylacet-sod benzoate</i>)	T3	
<i>lactulose 10 gm/15 ml solution</i>	T1	
LITHOSTAT	T2	HD
OLPRUVA	T4	PA SP HD
PHEBURANE	T4	PA QL(8 Bottles/30 Days) SP HD
<i>sodium phenylbutyrate</i> (Buphenyl)	T4	SP HD
ANTI-CHOLINERGICS, QUATERNARY AMMONIUM		
<i>chlordiazepoxide/clidinium br</i>	T1	
CUVPOSA	T3	
GLYCATE	T3	
<i>glycopyrrrolate</i> (Glycate)	T1	
<i>glycopyrrrolate</i> (Robinul Forte)	T1	
<i>glycopyrrrolate</i> (Robinul)	T1	
<i>propantheline bromide</i>	T1	
ROBINUL (<i>glycopyrrrolate</i>)	T3	
ROBINUL FORTE (<i>glycopyrrrolate</i>)	T3	
ANTI-CHOLINERGICS/ANTI-SPASMODICS		
<i>dicyclomine hcl</i>	T1	
ANTI-DIARRHEAL - G.I. CHLORIDE CHANNEL INHIBITORS		
MYTESI	T3	
ANTI-DIARRHEAL - TRYPTOPHAN HYDROXYLASE INHIBITOR		
XERMELO	T4	PA SP
ANTI-DIARRHEALS		
<i>diphenoxylate hcl/atropine</i>	T1	
<i>diphenoxylate hcl/atropine</i> (Lomotil)	T1	
<i>loperamide hcl</i>	T1	
MOTOFEN	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

GASTROINTESTINAL (Gastrointestinal/Heartburn) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ANTI-DIARRHEALS (cont.)		
<i>opium tincture</i>	T1	PA
<i>paregoric</i>	T1	
ANTI-EMETIC, CANNABINOID-TYPE		
<i>dronabinol</i>	T1	
ANTI-EMETIC/ANTI-VERTIGO AGENTS		
AKYNZEO	T3	QL (4 caps/28 days)
ANZEMET	T4	PA QL (5 tabs/30 days) SP
<i>aprepitant 125 mg capsule</i>	T1	QL (4 caps/28 days)
<i>aprepitant 125-80-80 mg pack (Emend)</i>	T1	QL (12 caps/28 days)
<i>aprepitant 40 mg capsule</i>	T1	QL (1 cap/28 days)
<i>aprepitant 80 mg capsule (Emend)</i>	T1	QL (8 caps/28 days)
BONJESTA	T3	
CINVANTI	T3	
COMPAZINE (<i>prochlorperazine maleate</i>)	T3	
COMPAZINE (<i>prochlorperazine</i>)	T3	
<i>doxylamine succinate/vit b6 (Diclegis)</i>	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	
<i>fosaprepitant dimeglumine (Emend)</i>	T1	
<i>granisetron hcl</i>	T1	
<i>granisetron hcl/pf</i>	T1	
<i>ondansetron hcl</i>	T1	
<i>ondansetron hcl/pf</i>	T1	
<i>palonosetron hcl (Posfrea)</i>	T1	
<i>prochlorperazine (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 (<i>trimethobenzamide hcl</i>)	T3	
TRANSDERM-SCOP (<i>scopolamine</i>)	T3	
<i>trimethobenzamide hcl</i>	T1	

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

T4 – Specialty Medications

PA – Prior Authorization

QL – Quantity Limit

ST – Step Therapy

AGE – Age Requirement

SP – Specialty Medication

HD – May require home delivery pharmacy

PPACA – No Cost-Share Preventive Medication

CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

GASTROINTESTINAL (Gastrointestinal/Heartburn) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ANTI-EMETIC/ANTI-VERTIGO AGENTS (cont.)		
<i>trimethobenzamide hcl</i> (Tigan)	T1	
VARUBI	T3	PA QL (4 tabs/28 days)
ANTI-ULCER PREPARATIONS		
CYTOTEC (<i>misoprostol</i>)	T3	HD
<i>misoprostol</i> (Cytotec)	T1	HD
<i>sucralfate</i> (Carafate)	T1	HD
ANTI-ULCER-H.PYLORI AGENTS		
<i>bismuth/metronidazole/tetracycline</i> (Pylera)	T1	
<i>lansoprazole/amoxicillin/clarithromycin</i>	T1	
BELLADONNA ALKALOIDS		
<i>atropine 0.25 mg/5 ml syringe</i>	T1	
DONNATAL	T3	HD
DONNATAL (<i>phenohytrio</i>)	T3	HD
<i>hyoscyamine sulfate</i>	T1	HD
<i>hyoscyamine sulfate</i> (Levbid)	T1	HD
<i>hyoscyamine sulfate</i> (Levsin)	T1	HD
<i>hyoscyamine sulfate</i> (Levsin-sl)	T1	HD
<i>hyoscyamine sulfate</i> (Nulev)	T1	HD
<i>hyoscyamine sulfate</i> (Nulev)	T3	HD
LEVIBID (<i>symax-sr</i>)	T3	HD
LEVSIN (<i>oscimin</i>)	T3	HD
LEVSIN-SL (<i>symax-sl</i>)	T3	HD
<i>methscopolamine bromide</i>	T1	HD
NULEV (<i>symax</i>)	T1	HD
<i>phenobarb/hyoscy/atropine/scopolamine</i> (Donnatal)	T1	HD
<i>phenobarb/hyoscy/atropine/scopolamine</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>phenohytrio</i>)	T3	HD
SYMAX DUOTAB	T2	HD
BILE SALTS		
ACTIGALL (<i>ursodiol</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

GASTROINTESTINAL (Gastrointestinal/Heartburn) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
BILE SALTS (cont.)		
CHENODAL	T4	SP HD
CHOLBAM	T4	PA SP HD
URSO FORTE (<i>ursodiol</i>)	T3	HD
<i>ursodiol</i> (Actigall)	T1	HD
<i>ursodiol</i> (Urso Forte)	T1	HD
CHRONIC INFLAM. COLON DX, 5-A-SALICYLAT, RECTAL TX		
mesalamine 1,000 mg supp (Canasa)	T1	
mesalamine 4 gm/60 ml enema (Sfrowasa)	T1	
mesalamine 4 gm/60 ml kit	T1	
SFROWASA (mesalamine)	T3	
DRUG TX-CHRONIC INFLAM. COLON DX, 5-AMINOSALICYLAT		
APRISO (mesalamine er)	T3	HD
balsalazide disodium	T1	HD
mesalamine	T1	HD
mesalamine (Apriso)	T1	HD
mesalamine 800 mg dr tablet	T1	HD
mesalamine dr 1.2 gm tablet (Lialda)	T1	HD
PENTASA 500 MG CAPSULE (mesalamine)	T3	HD
sulfasalazine (Azulfidine)	T1	HD
FARNESOID X RECEPTOR (FXR) AGONIST, BILE AC ANALOG		
OCALIVA	T4	PA SP HD
FECAL MICROBIOTA TRANSPLANTATION (FMT)		
VOWST	T4	PA QL(12 caps/56 days) SP
GASTRIC ENZYMES		
SUCRAID	T4	PA SP
HISTAMINE H2-RECEPTOR INHIBITORS		
cimetidine	T1	HD
cimetidine hcl	T1	HD
famotidine	T1	HD
nizatidine	T1	HD
ranitidine 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

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List of Prescription Medications

GASTROINTESTINAL (Gastrointestinal/Heartburn) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
IBS AGENTS, MIXED OPIOID RECEPTOR AGONISTS/ANTAGONISTS		
VIBERZI	T2	HD
IBS-C/CIC AGENTS, GUANYLATE CYCLASE-C AGONIST		
LINZESS	T2	
TRULANCE	T2	
INTESTINAL MOTILITY STIMULANTS		
metoclopramide hcl	T1	
metoclopramide hcl (Reglan)	T1	
REGLAN (metoclopramide hcl)	T3	
IRRITABLE BOWEL SYNDROME AGENTS, 5-HT3 ANTAGONIST		
alosetron hcl	T4	SP HD
LAXATIVES AND CATHARTICS		
bisac/nacl/nahco3/kcl/peg 3350	T1	PPACA
lactulose	T1	
lactulose 10 gm/15 ml solution	T1	
lactulose 20 gm/30 ml solution	T1	
lubiprostone (Amitiza)	T1	
NULYTELY	T3	PPACA
peg3350/sod sul/nacl/kcl/asb/c	T1	PPACA
peg3350/sod sulf, bicarb, cl/kcl	T1	PPACA
PREPOPIK	T2	PPACA
sodium chloride/nahco3/kcl/peg	T1	PPACA
LOCAL ANORECTAL NITRATE PREPARATIONS		
nitroglycerin 0.4% ointment (Rectiv)	T1	
RECTIV	T3	
PANCREATIC ENZYMES		
PANCREAZE	T2	HD
VIOKACE	T3	HD
ZENPEP	T2	HD
POTASSIUM-COMPETITIVE ACID BLOCKERS (PCABS)		
VOQUEZNA	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

GASTROINTESTINAL (Gastrointestinal/Heartburn) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
PROTON-PUMP INHIBITORS		
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 60 MG CAPSULE (<i>dexlansoprazole</i>)	T2	QL(1 cap/day) HD
<i>dexlansoprazole dr 30 mg cap</i> (Dexilant)	T1	QL(2 caps/day)
<i>dexlansoprazole dr 60 mg cap</i> (Dexilant)	T1	QL(1 caps/day)
<i>esomeprazole dr 10 mg packet</i>	T1	QL (4 packets/day) HD
<i>esomeprazole dr 20 mg packet</i>	T1	QL (2 packs/day) HD
<i>esomeprazole dr 40 mg packet</i>	T1	QL (1 packet/day) HD
<i>esomeprazole mag dr 20 mg cap</i>	T1	QL (20ml/day) HD
<i>esomeprazole mag dr 40 mg cap</i>	T1	QL (1 cap/day) HD
ESOMEPRAZOLE STRONTIUM	T3	QL (1 cap/day) HD
<i>lansoprazole dr 15 mg capsule</i> (Prevacid)	T1	QL (2 caps/day) HD
<i>lansoprazole dr 30 mg capsule</i> (Prevacid)	T1	QL (30 caps/30 days) HD
<i>lansoprazole odt 15 mg tablet</i>	T1	QL (2 tabs/day) HD
<i>lansoprazole odt 30 mg tablet</i>	T1	QL (30 tabs/30 days) HD
NEXIUM DR 2.5 MG PACKET	T2	QL (480 packs/30 days) HD
NEXIUM DR 5 MG PACKET	T2	QL (240 packs/30 days) HD
NEXIUM I.V. (<i>esomeprazole sodium</i>)	T3	
<i>omeprazole dr 10 mg capsule</i>	T1	QL (120 caps/30 days) HD
<i>omeprazole dr 20 mg capsule</i>	T1	QL (2 caps/day) HD
<i>omeprazole dr 40 mg capsule</i>	T1	QL (1 cap/day) HD
<i>pantoprazole 40 mg suspension</i> (Protonix)	T1	QL (1 dose/day) HD
<i>pantoprazole sod dr 20 mg tab</i> (Protonix)	T1	QL (2 tabs/day) HD
<i>pantoprazole sod dr 40 mg tab</i> (Protonix)	T1	QL (1 tab/day) HD
PANTOPRAZOLE SODIUM-0.9% NACL	T3	HD
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	
<i>rabeprazole sodium</i> (Aciphenx)	T1	QL (30 tabs/30 days) HD

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

T4 – Specialty Medications

PA – Prior Authorization

QL – Quantity Limit

ST – Step Therapy

AGE – Age Requirement

SP – Specialty Medication

HD – May require home delivery pharmacy

PPACA – No Cost-Share Preventive Medication

CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

GASTROINTESTINAL (Gastrointestinal/Heartburn) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
RECTAL PREPARATIONS		
hydrocortisone acetate	T1	
SBS - GLUCAGON-LIKE PEPTIDE-2 (GLP-2) ANALOGS		
GATTEX	T4	PA SP HD
GASTROINTESTINAL (Pain Relief And Inflammatory Disease)		
HEMORRHOID PREP, ANTI-INFLAM STEROID-LOCAL ANESTHET		
ANA-LEX	T1	
ANALPRAM HC 1% CREAM	T3	
hydrocortisone/lidocaine/aloe	T1	
hydrocortisone/pramoxine (Analpram Hc)	T1	
lidocaine/hydrocortisone ac	T1	
LIDOCAINE-HYDROCORTISONE	T1	
PROCORT	T3	
PROCTOFOAM-HC	T2	
RECTAL/LOWER BOWEL PREP., GLUCOCORT. (NON-HEMORR)		
budesonide 2 mg rectal foam	T1	QL(2 kits/180 days)
CORTENEMA (hydrocortisone)	T3	
hydrocortisone (Cortenema)	T1	
HORMONES (Hormonal Agents)		
ANDROGEN/ESTROGEN PREPS FOR FEMALE SEXUAL DYSFUNC		
INTRAROSA	T3	
ANDROGENIC AGENTS		
ANADROL-50	T2	PA
ANDRODERM	T2	PA QL (1 patch/day)
ANDROGEL 1% (25 MG/2.5 G) PKT (testosterone)	T3	PA QL (150gm/30 days)
ANDROGEL 1% (50 MG/5 G) PKT (testosterone)	T3	PA QL (2 packs/day)
ANDROGEL 1.62% GEL PUMP (testosterone)	T3	PA QL (150gm/30 days)
ANDROGEL 1.62%(1.25G) GEL PCKT (testosterone)	T3	PA QL (2 packs/day)
ANDROGEL 1.62%(2.5G) GEL PCKT (testosterone)	T3	PA QL (150gm/30 days)
DEPO-TESTOSTERONE	T3	
DEPO-TESTOSTERONE (testosterone cypionate)	T3	
METHITEST	T1	
methyltestosterone	T1	

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

T4 – Specialty Medications

PA – Prior Authorization

QL – Quantity Limit

ST – Step Therapy

AGE – Age Requirement

SP – Specialty Medication

HD – May require home delivery pharmacy

PPACA – No Cost-Share Preventive Medication

CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

HORMONES (Hormonal Agents) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ANDROGENIC AGENTS (cont.)		
<i>oxandrolone</i>	T1	PA
<i>testosterone 1% (50 mg/5 g) pk (Testosterone)</i>	T1	PA QL (2 packs/day)
<i>testosterone 1% (25mg/2.5g) pk (Androgel)</i>	T1	PA QL (150gm/30 days)
<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)
<i>TESTOSTERONE 12.5 MG/1.25 GRAM</i>	T1	PA QL (150gm/30 days)
<i>testosterone 30 mg/1.5 ml pump</i>	T1	PA QL (180ml/30 days)
<i>testosterone 50 mg/5 gram gel</i>	T1	PA QL (2 tubes/day)
<i>TESTOSTERONE 50 MG/5 GRAM PKT</i>	T1	PA QL (2 packs/day)
<i>testosterone cypionate (Depo-testosterone)</i>	T1	
<i>testosterone enanthate</i>	T1	
ANTI-DIURETIC AND VASOPRESSOR HORMONES		
<i>desmopressin acetate (Ddavp)</i>	T1	HD
<i>NOCTIVA</i>	T3	PA
<i>STIMATE</i>	T4	SP
<i>VASOPRESSIN-0.9% NACL</i>	T3	
ESTROGEN AND PROGESTIN COMBINATIONS		
<i>BIJUVA</i>	T3	
ESTROGEN/ANDROGEN COMBINATIONS		
<i>estrogen, ester/me-testosterone (Estratest H.S.)</i>	T1	HD
ESTROGENIC AGENTS		
<i>ACTIVELLA (mimvey lo)</i>	T3	HD
<i>ACTIVELLA (mimvey)</i>	T3	HD
<i>ALORA</i>	T3	QL (16 patches/28 days) HD
<i>CLIMARA (estradiol (once weekly))</i>	T3	HD
<i>CLIMARA PRO</i>	T3	HD
<i>COMBIPATCH</i>	T3	HD
<i>DEPO-ESTRADIOL</i>	T3	HD
<i>DIVIGEL</i>	T2	HD
<i>ELESTRIN</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

HORMONES (Hormonal Agents) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ESTROGENIC AGENTS (cont.)		
estradiol (Climara)	T1	HD
estradiol (Vivelle-dot)	T1	QL (8 patches/21) 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
estradiol 0.05 mg patch (2/wk) (Minivelle)	T1	QL(16 patches/28 days) HD
estradiol 0.05 mg patch (2/wk) (Vivelle-Dot)	T1	QL(16 patches/28 days) HD
estradiol 0.06% 1.25g gel pump (Estrogel)	T1	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)	T3	HD
EVAMIST	T3	HD
FEMHRT (norethindron-ethinyl estradiol)	T3	HD
MENEST	T3	HD
MENOSTAR	T3	QL (8 patches/28 days) HD
MINIVELLE (yllana)	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 (yllana)	T3	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) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ESTROGEN-PROGESTIN WITH ANTI-MINERALOCORTICOID COMB		
ANGELIQ	T3	HD
ESTROGEN-SELECTIVE ESTROGEN RECEPTOR MOD (SERM) COMB		
DUAVEE	T2	
GLUCOCORTICOIDS		
budesonide	T1	PA QL (56 tabs/180 days)
budesonide (Entocort Ec)	T1	
cortisone acetate	T1	
deflazacort (Emflaza)	T4	PA SP HD
dexamethasone	T1	
dexamethasone sodium phosp/pf	T1	
EMFLAZA	T4	PA SP HD
ENTOCORT EC (budesonide ec)	T3	
hydrocortisone (Cortef)	T1	
LOCORT	T1	
MEDROL 16 MG TABLET (methylprednisolone)	T3	
MEDROL 2 MG TABLET	T2	
MEDROL 32 MG TABLET (methylprednisolone)	T3	
MEDROL 4 MG DOSEPAK (methylprednisolone)	T3	
MEDROL 4 MG TABLET (methylprednisolone)	T3	
MEDROL 8 MG TABLET (methylprednisolone)	T3	
methylprednisolone (Medrol)	T1	
MILLIPRED 10 MG/5 ML SOLUTION (prednisolone sodium phosphate)	T3	
millipred 5 mg tablet	T1	
ORAPRED ODT (prednisolone sodium phos odt)	T3	
prednisolone	T1	
prednisolone sodium phosphate	T1	
prednisolone sodium phosphate (Millipred)	T1	
prednisolone sodium phosphate (Orapred Odt)	T1	
prednisone	T1	
GROWTH HORMONE RELEASING HORMONE (GHRH) AND ANALOGS		
EGRIFTA	T4	PA SP HD
EGRIFTA SV	T4	PA SP HD

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

T4 – Specialty Medications

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List of Prescription Medications

HORMONES (Hormonal Agents) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
GROWTH HORMONES		
GENOTROPIN	T4	PA SP HD
NORDITROPIN FLEXPRO	T4	PA SP HD
OMNITROPE	T4	PA SP HD
SEROSTIM	T4	PA SP
SKYTROFA	T4	SP HD
SOGROYA	T4	PA SP
INSULIN-LIKE GROWTH FACTOR-I (IGF-I) HORMONES		
INCRELEX	T4	PA SP HD
LHRH (GNRH) AGONIST ANALOG AND PROGESTIN COMB		
LUPANETA PACK	T4	PA SP HD
LHRH (GNRH) AGONIST ANALOG PITUITARY SUPPRESSANTS		
LUPRON DEPOT	T4	PA SP HD
TRIPTODUR	T4	PA SP
SYNAREL	T4	PA SP HD
LHRH (GNRH) ANTAGONIST, ESTROGEN AND PROGESTIN COMB		
MYFEMBREE	T2	PA QL (24 month therapy)
ORIAHNN	T2	PA QL (2 capsules/day)
LHRH (GNRH) ANTAGONIST, PITUITARY SUPPRESSANT AGENTS		
CETROTIDE	T4	PA SP
ganirelix acet 250 mcg/0.5 ml (Ganirelix Acetate)	T4	PA SP
GANIRELIX ACET 250 MCG/0.5 ML (ganirelix acetate)	T4	PA SP
ORLISSA 150 MG TABLET	T2	PA QL (1 tab/day)
ORLISSA 200 MG TABLET	T2	PA QL (6 months therapy/lifetime)
LHRH (GNRH) AGNST PIT.SUP-CENTRAL PRECOCIOUS PUBERTY		
FENSOLVI	T4	PA SP
LUPRON DEPOT-PED	T4	PA SP HD
MINERALOCORTICOIDS		
fludrocortisone acetate	T1	HD
OXYTOCICS		
carboprost 250 mcg/ml ampul (Hemabate)	T1	
CARBOPROST 250 MCG/ML SYRINGE	T3	
CERVIDIL	T3	
methylergonovine maleate	T1	
PREPIDIL	T3	

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

T4 – Specialty Medications

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List of Prescription Medications

HORMONES (Hormonal Agents) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
OXYTOCICS (cont.)		
PROSTIN E2 VAGINAL SUPPOSITORY	T3	
PARATHYROID HORMONES		
YORVIPATH	T3	
PITUITARY SUPPRESSIVE AGENTS		
<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
PROGESTATIONAL AGENTS		
AYGESTIN (<i>norethindrone acetate</i>)	T3	HD
CRINONE 4% GEL	T3	PA HD
DEPO-PROVERA 400 MG/ML VIAL	T3	HD
<i>hydroxyprogesterone</i>	T1	HD
<i>medroxyprogesterone 10 mg tab (Provera)</i>	T1	HD
<i>medroxyprogesterone 2.5 mg tab (Provera)</i>	T1	HD
<i>medroxyprogesterone 5 mg tab (Provera)</i>	T1	HD
<i>norethindrone acetate (Aygestin)</i>	T1	HD
<i>progesterone, micronized (Prometrium)</i>	T1	HD
SOMATOSTATIC AGENTS		
LANREOTIDE	T4	PA SP HD
<i>lanreotide 120 mg/0.5 ml syng</i>	T4	PA SP HD
<i>octreotide acetate (Sandostatin)</i>	T4	PA SP HD
SANDOSTATIN (<i>octreotide acetate</i>)	T4	PA SP HD
SANDOSTATIN LAR DEPOT	T4	PA SP
SIGNIFOR	T4	PA SP
SIGNIFOR LAR	T4	PA SP
SOMATULINE DEPOT	T4	PA SP HD
VAGINAL ESTROGEN FOR SEXUAL DYSFUNCTION		
IMVEXXY 10 MCG MAINTENANCE PAK	T3	QL (16/28 days) HD
IMVEXXY 10 MCG STARTER PACK	T3	QL (36/28 days) HD
IMVEXXY 4 MCG MAINTENANCE PACK	T3	QL (16/28 days) HD
IMVEXXY 4 MCG STARTER PACK	T3	QL (36/28 days) HD

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

T4 – Specialty Medications

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List of Prescription Medications

HORMONES (Hormonal Agents)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
VAGINAL ESTROGEN PREPARATIONS (cont.)		
ESTRACE (estradiol)	T3	HD
estradiol	T1	QL (36 tabs/28 days) HD
estradiol 0.01% cream	T1	HD
estradiol 10 mcg vaginal insert	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

HORMONES (Infertility)

FERTILITY STIMULATING PREPARATIONS, NON-FSH		
clomiphene citrate	T1	
FOLLICLE-STIMULATING AND LUTEINIZING HORMONES		
MENOPUR	T4	PA SP
FOLLICLE-STIMULATING HORMONE (FSH)		
FOLLISTIM AQ	T4	PA SP
GONAL-F	T4	PA SP
GONAL-F RFF	T4	PA SP
GONAL-F RFF REDI-JECT	T4	PA SP

HUMAN CHORIONIC GONADOTROPIN (HCG)		
CHORIONIC GONAD 10,000 UNIT VL	T4	PA SP
CHORIONIC GONAD 12,000 UNIT VL	T4	SP
NOVAREL	T4	PA SP
PREGNYL	T4	PA SP

PREGNANCY FACILITATING/MAINTAINING AGENT, HORMONAL		
CRINONE 8% GEL	T2	
ENDOMETRIN	T3	
hydroxyprogesterone	T1	PA
MAKENA	T3	PA

HORMONES (Miscellaneous)

LEPTIN HORMONE ANALOGS		
MYALEPT	T4	PA SP HD

HORMONES (Osteoporosis Products)

BONE FORMATION STIMULATING AGTS - PTH REL PEPTIDES		
teriparatide 600 mcg/2.4ml pen	T4	PA QL(0.09 mls/day) SP HD
TERIPARATIDE 620 MCG/2.48 ML	T4	PA QL(0.09 mls/day) SP HD

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 (Osteoporosis Products) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
BONE RESORPTION INHIBITORS		
calcitonin, salmon, synthetic	T1	HD
RECLAST 5 MG/100 ML SOLUTION	T3	
MIACALCIN	T2	HD
zoledronic acid 4 mg vial	T1	
ZOLEDRONIC ACID 4MG/100ML	T3	
IMMUNOSUPPRESSANTS (Pain Relief And Inflammatory Disease)		
IL-23 RECEPTOR ANTAGONIST, MONOCLONAL ANTIBODY		
OMVOH 100 MG/ML SYRINGE	T4	PA QL SP HD
OMVOH 300 MG/15 ML VIAL	T4	PA SP HD
INTERLEUKIN-4(IL-4) RECEPTOR ALPHA ANTAGONIST, MAB		
DUPIXENT	T4	PA SP HD
INTERLEUKIN-6 (IL-6) RECEPTOR INHIBITORS		
ACTEMRA	T4	PA QL (4 syringes/28 days) SP HD
ACTEMRA ACTPEN	T4	PA QL (4 pens/28 days) SP HD
ENSPRYNG	T4	PA SP HD
KEVZARA 150 MG/1.14 ML PEN INJ	T4	PA QL (2 pens/28 days) SP HD
KEVZARA 150 MG/1.14 ML SYRINGE	T4	PA QL (2 syringes/28 days) SP HD
KEVZARA 200 MG/1.14 ML PEN INJ	T4	PA QL (2 pens/28 days) SP HD
KEVZARA 200 MG/1.14 ML SYRINGE	T4	PA QL (2 syringes/28 days) SP HD
TYENNE	T4	PA SP
TYENNE AUTOINJECTOR	T4	PA QL(3.6 ml/28 days) SP
MONOCLONAL ANTIBODY-HUMAN INTERLEUKIN 12/23 INHIB		
STELARA 45 MG/0.5 ML SYRINGE	T4	PA QL (1 syringe/84 days) SP HD
STELARA 45 MG/0.5 ML VIAL	T4	PA QL (1 vial/84 days) SP HD
STELARA 90 MG/ML SYRINGE	T4	PA QL (1 syringe/84 days) SP HD
USTEKINUMAB-TTWE	T4	PA QL(1 syringe/84 days) SP HD
YESINTEK	T4	PA QL(1 syringe/84 days) SP
IMMUNOSUPPRESSANTS (Skin Conditions)		
TOPICAL IMMUNOSUPPRESSIVE AGENTS		
ELIDEL (<i>pimecrolimus</i>)	T3	
NEMLUVIO	T4	PA SP
<i>pimecrolimus</i> (Elidel)	T1	
PROTOPIC (<i>tacrolimus</i>)	T3	
<i>tacrolimus</i> ointment (Protopic)	T1	

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

PA – Prior Authorization

QL – Quantity Limit

AGE – Age Requirement

SP – Specialty Medication

PPACA – No Cost-Share Preventive Medication

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List of Prescription Medications

IMMUNOSUPPRESSANTS (Transplant Medications)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
IMMUNOSUPPRESSIVES		
ASTAGRAF XL	T4	SP HD
AZASAN	T4	SP HD
<i>azathioprine</i> (Imuran)	T4	SP HD
CELLCEPT (<i>mycophenolate mofetil</i>)	T4	SP HD
<i>cyclosporine</i> (Sandimmune)	T4	SP HD
<i>cyclosporine, modified</i> (Neoral)	T4	SP HD
ENVARSUS XR	T4	SP HD
<i>everolimus 0.25 mg tablet</i> (Zortress)	T4	SP HD
<i>everolimus 0.5 mg tablet</i> (Zortress)	T4	SP HD
<i>everolimus 0.75 mg tablet</i> (Zortress)	T4	SP HD
IMURAN (<i>azathioprine</i>)	T4	SP HD
LUPKYNIS	T4	PA QL(6 caps/day) SP
<i>mycophenolate mofetil</i> (Cellcept)	T4	SP HD
<i>mycophenolate sodium</i> (Myfortic)	T4	SP HD
PROGRAF (<i>tacrolimus</i>)	T4	SP HD
<i>sirolimus</i> (Rapamune)	T4	SP HD
<i>tacrolimus ointment</i>	T1	
<i>tacrolimus 0.5 mg capsule (ir)</i> (Prograf)	T4	SP HD
<i>tacrolimus 1 mg capsule (ir)</i> (Prograf)	T4	SP HD
<i>tacrolimus 5 mg capsule (ir)</i> (Prograf)	T4	SP HD
ZORTRESS (<i>everolimus</i>)	T4	SP HD
IMMUNOSUPP - MONOCLONAL AB INHIBITING T LYMPH FXN		
SIMULECT	T4	SP
MISCELLANEOUS MEDICAL SUPPLIES, DEVICES, NON-DRUG (Diabetes)		
DIABETIC SUPPLIES		
2TEK CONTROL SOLUTION	T1	
2TEK GLUCOSE-WRIST MONITOR KIT	T3	
ACCU-CHEK FASTCLIX LANCING DEV	T1	
ACCU-CHEK GUIDE CONTROL SOLN	T1	
ACCU-CHEK SMARTVIEW CONTRL SOL	T1	
ACCU-CHEK SOFTCLIX	T1	

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

T4 – Specialty Medications

PA – Prior Authorization

QL – Quantity Limit

ST – Step Therapy

AGE – Age Requirement

SP – Specialty Medication

HD – May require home delivery pharmacy

PPACA – No Cost-Share Preventive Medication

CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

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

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
DIABETIC SUPPLIES (cont.)		
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	
BLOOD GLUCOSE CONTROL	T1	
BLULINK DIABETIC TEST BUNDLE	T3	
BLULINK GLUCOSE MONITOR SYST	T3	
BREEZE 2	T1	
CAREONE	T1	
CARESENS	T1	
CARETOUCH CONTROL SOLUTION	T1	
CARETOUCH LANCING DEVICE	T1	
CEQUR SIMPLICITY	T2	
CHEMSTRIP BG DIARY	T1	
CHOSEN LANCING DEVICE	T1	
CLEVER CHOICE CONTROL SOLUTION	T1	
CONTOUR METER	T3	
CONTOUR PLUS BLUE	T3	

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

T4 – Specialty Medications

PA – Prior Authorization

QL – Quantity Limit

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List of Prescription Medications

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

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
DIABETIC SUPPLIES (cont.)		
CONTOUR NEXT CONTROL SOLUTION	T1	
CONTOUR SOLUTION	T1	
COOL CONTROL SOLUTION	T1	
DEXCOM G6 RECEIVER	T2	PA QL (1 syringe/365 days)
DEXCOM G6 SENSOR	T2	PA QL (3/30 days)
DEXCOM G6 TRANSMITTER	T2	PA QL (1 syringe/67 days)
DEXCOM G7 RECEIVER	T2	PA QL(1 unit/365 days)
DEXCOM G7 SENSOR	T2	PA QL(3 sensors/30 days)
DIATRUE	T1	
DROPLET GENTEL LANCING DEVICE	T1	
DROPLET LANCING DEVICE	T1	
EASY MINI EJECT LANCING DEVICE	T1	
EASY PLUS II CONTROL SOLN HIGH	T1	
EASY PLUS II CONTROL SOLN LOW	T1	
EASY STEP CONTROL SOLUTION	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 CONTROL SOLUTION	T1	
EASY TOUCH LANCING DEVICE	T1	
EASYTRAK CONTROL SOLN HIGH	T1	
EASYTRAK CONTROL SOLN LOW	T1	
EASYTRAK II CONTROL SOLUTION	T1	
EASYGLUCO PLUS CONTROL NORMAL	T1	
EASymax	T1	
EASymax NORMAL CONTROL SOLN	T1	
ELEMENT COMPACT CONTROL SOLN	T1	
ELEMENT CONTROL SOLUTION	T1	
EMBRACE EVO LEVEL 1 CTRL SOLN	T1	
EMBRACE GLUC CONTROL SOLN HIGH	T1	
EMBRACE GLUCOSE CONTROL SOLN	T1	
EMBRACE LANCING DEVICE	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 (Diabetes) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
DIABETIC SUPPLIES (cont.)		
EMBRACE PRO	T1	
EMBRACE TALK CONTROL SOLUTION	T1	
EMBRACE WAVE PLUS GLUCOSE MTR	T3	
ENLITE SERTER	T1	
EVENCARE G2 CONTROL SOLUTION	T1	
EVENCARE G3 CONTROL SOLUTION	T1	
EVOLUTION CONTROL SOLUTION	T1	
EZ-VAC	T1	
FORA CONTROL SOLUTION	T1	
FORA LANCING DEVICE	T1	
FORA TN'GO ADVANCE MULTIFN MTR	T3	
FORACARE GDH	T1	
FORTISCARE	T1	
FREESTYLE CONTROL SOLUTION	T1	
FREESTYLE LIBRE 2 PLUS SENSOR	T2	PA QL(2 units/30 days)
FREESTYLE LIBRE 2 READER	T2	PA QL (1 reader/day)
FREESTYLE LIBRE 2 SENSOR	T2	PA QL (2 sensors/21 days)
FREESTYLE LIBRE 3 PLUS SENSOR	T2	PA QL(2 units/28 days)
FREESTYLE LIBRE 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 TEST STRIP	T2	
GE100 CONTROL SOLUTION NORMAL	T1	
GE333 BLOOD GLUCOSE SYSTEM	T3	
GENTEEL VACUUM LANCING DEVICE	T1	
GLUCOCARD 01 CONTROL	T1	
GLUCOCARD EXPRESSION CNTRL SLN	T1	
GLUCOCARD SHINE CONTROL SOLN	T1	
GLUCOCOM AUTOLINK	T1	
GLUCOSE CONTROL	T1	
GOJJI GLUCOSE CONTROL SOLUTION	T1	
GOJJI LANCING DEVICE	T1	
GUARDIAN RT CHARGER	T1	
GUARDIAN RT STARTER KIT	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 (Diabetes) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
DIABETIC SUPPLIES (cont.)		
GUARDIAN RT SYSTEM	T1	
GUARDIAN TEST PLUG	T1	
GUARDIAN TRANSMITTER TAPE	T1	
HEALTHPRO GLUCOSE CONTROL SOLN	T1	
HEALTHY ACCENTS AUTOLET	T1	
HUMAPEN LUXURA HD	T1	
HYPOLANCE	T1	
IHEALTH CONTROL SOLN LEVEL 2	T1	
IHEALTH GLUCO PLUS METER	T3	
INCONTROL LANCING DEVICE	T1	
INFINITY CONTROL SOLUTION	T1	
INFINITY VOICE CONTROL SOLN	T1	
INPEN (FOR HUMALOG)	T1	
INPEN (FOR NOVOLOG OR FIASP)	T1	
INSUL-CAP	T1	
INSUL-EZE	T1	
LANCING DEVICE	T1	
LANCING SYSTEM	T1	
LANZO	T1	
LITE TOUCH	T1	
MAGNI-GUIDE MAGNIFIER	T1	
MEDISENSE	T1	
MEDISENSE GLUCOSE KETONE	T1	
MEDISENSE GLUCOSE KETONE CONTR	T1	
MEDTRONIC REMOTE CONTROL	T1	
MICRODOT HIGH-LOW CONTROL SOL	T1	
MICRODOT NORMAL CONTROL SOLUT	T1	
MICROLET 2	T1	
MINI LANCING DEVICE	T1	
MINIMED QUICK-SERTER	T1	
MOBILE LANCETS	T2	
MULTI-LANCET	T1	
MYGLUCOHEALTH CONTROL SOLUTION	T1	
NOVAMAX PLUS GLU-KET	T1	
NOVOPEN ECHO	T1	

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

T4 – Specialty Medications

PA – Prior Authorization

QL – Quantity Limit

ST – Step Therapy

AGE – Age Requirement

SP – Specialty Medication

HD – May require home delivery pharmacy

PPACA – No Cost-Share Preventive Medication

CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

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

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
DIABETIC SUPPLIES (cont.)		
OMNIPOD 5 G6-G7 INTRO KT(GEN5)	T2	QL
OMNIPOD 5 G6-G7 PODS (GEN 5)	T2	QL
OMNIPOD DASH 5 PACK POD	T2	PA QL (6 boxes/30 days)
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 ULTRASOFT 2 LANCET	T2	
ONETOUCH VERIO HIGH CNTRL SOLN	T1	
ONETOUCH VERIO MID CNTRL SOLN	T1	
OPTUMRX GLUCOSE CONTROL SOLN	T1	
OVAL TAPE	T1	
PIP GLUCOSE CONTROL SOLUTION	T1	
PRO COMFORT SAFETY LANCET	T2	
PRODIGY CONTROL SOLUTION	T1	
PRODIGY LANCING DEVICE	T1	
REFUAH PLUS GLUCOSE CONTROL	T1	
RELIAMED MINI LANCING DEVICE	T1	
REPLACEMENT PEDIATRIC MONITOR	T1	
RIGHTEST CONTROL SOLUTION	T1	
RIGHTEST GD500	T1	
SAFE-CLIP	T1	
SEN-SERTER	T1	
SIL-SERTER	T1	
SMARTDIABETES VANTAGE	T1	
SMARTTEST	T1	
SOLUS V2 CONTROL SOLUTION	T1	
SOLUS V2 LANCING DEVICE	T1	
SURE COMFORT LANCING PEN	T1	
SUREFLEX	T1	
SURE-PEN	T1	

T1 – Typically Generics

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T4 – Specialty Medications

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List of Prescription Medications

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

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
DIABETIC SUPPLIES (cont.)		
SURE-TEST EASYPLUS MINI SOLN	T1	
TELCARE CONTROL SOLUTION	T1	
TRUE METRIX	T1	
TRUECONTROL	T1	
TRUEDRAW	T1	
ULTI-LANCE	T1	
ULTRATRAK CONTROL SOLUTION	T1	
ULTRATRAK ULTIMATE CNTRL SOLN	T1	
UNISTIK 2	T1	
UNISTIK 3	T1	
UNISTIK 3 COMFORT	T1	
UNISTIK 3 NEONATAL	T1	
UNISTRIP	T1	
VERASENS CONTROL SOLUTION	T1	
V-GO 20	T2	
V-GO 30	T2	
V-GO 40	T2	
VIVAGUARD INO CONTROL SOLUTION	T1	
VIVAGUARD LANCING DEVICE	T1	
WAVESENSE CONTROL SOLUTION	T1	
DURABLE MEDICAL EQUIPMENT,MISC (GROUP I)		
CHOSEN LANCET	T1	
CHOSEN SAFETY LANCET	T1	
NEEDLES/NEEDLELESS DEVICES		
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	

T1 – Typically Generics

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

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
NEEDLES/NEEDLELESS DEVICES (cont.)		
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	
EASY COMFORT PEN 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	
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	

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

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

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
NEEDLES/NEEDLELESS DEVICES (cont.)		
LITE TOUCH	T1	
MAXICOMFORT II PEN NEEDLE	T1	
MAXICOMFORT SAFETY PEN NEEDLE	T1	
MICRODOT INSULIN PEN NEEDLE	T1	
MINI PEN NEEDLE	T1	
MINI ULTRA-THIN II	T1	
MONOJECT BLOOD COLLECTION	T1	
MONOJECT FILTER NEEDLE	T1	
NANO 2ND GEN PEN NEEDLE	T1	
NEEDLES	T1	
needles,safety huber,disposable	T1	
NOKOR ADMIX NEEDLE	T1	
NOKOR NEEDLE	T1	
NOVOFINE 32	T1	
NOVOFINE AUTOCOVER	T1	
NOVOFINE PLUS	T1	
NOVOTWIST	T1	
PEN NEEDLES	T1	
PENTIPS	T1	
PHASEAL PROTECTOR	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	
RELION PEN NEEDLES	T1	
SAFETY PEN NEEDLE	T1	
SAFETYGLIDE NEEDLE	T1	
SECURESAFE PEN NEEDLE	T1	
SHORT BEVEL NEEDLES	T1	

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

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
NEEDLES/NEEDLELESS DEVICES (cont.)		
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	
TERUMO SURGUARD2	T1	
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	
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 PLUS	T1	
UNIFINE PENTIPS PLUS MAXFLOW	T1	
UNIFINE SAFECONTROL	T1	

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

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
NEEDLES/NEEDLELESS DEVICES (cont.)		
UNIFINE ULTRA PEN NEEDLE	T1	
VERIFINE PEN NEEDLE	T1	
VERIFINE PLUS PEN NEEDLE	T1	
YALE NEEDLES	T1	
SYRINGES AND ACCESSORIES		
ADVOCATE SYRINGES	T1	
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	
EASY-TOUCH INSULIN SYRINGE	T1	
ECLIPSE SYRINGE	T1	
FREESTYLE PRECISION	T1	
HEALTHWISE INSULIN SYRINGE	T1	
INSULIN SYRINGE	T1	
INSULIN SYRINGE U-500	T1	
LITE TOUCH	T1	
LITETOUCH INSULIN SYRINGE	T1	
LUER-LOK SYRINGE	T1	
MAGELLAN INSULIN SAFETY SYRNG	T1	
MAGELLAN INSULIN SYRINGE	T1	
MAXI-COMFORT	T1	
MAXICOMFORT INSULIN SYRINGE	T1	
MINIMED RESERVOIR 1.8 ML	T1	

T1 – Typically Generics

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List of Prescription Medications

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

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
SYRINGES AND ACCESSORIES (cont.)		
MINIMED RESERVOIR 3 ML	T3	
MONOJECT	T1	
MONOJECT INSULIN SAFETY SYRNG	T1	
MONOJECT INSULIN SYRINGE	T1	
PARADIGM RESERVOIR 1.8 ML	T1	
PARADIGM RESERVOIR 3 ML	T3	
PRO COMFORT INSULIN SYRINGE	T1	
PRODIGY INSULIN SYRINGE	T1	
SAFESNAP INSULIN SYRINGE	T1	
SAFETYGLIDE INSULIN SYRINGE	T1	
SECURESAFE INSULIN SYRINGE	T1	
SURE COMFORT	T1	
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	
TRUE COMFORT PRO INS SYRINGE	T1	
TRUEPLUS INSULIN SYRINGE	T1	
ULTICARE INSULIN SYRINGE	T1	
ULTIGUARD SAFE 1ML 30G 12.7MM	T3	
ULTIGUARD SAFE0.3ML 30G 12.7MM	T3	
ULTIGUARD SAFE0.5ML 30G 12.7MM	T1	
ULTIGUARD SAFEPACK 1ML 31G 8MM	T3	
ULTIGUARD SAFEPK 0.3ML 31G 8MM	T3	
ULTIGUARD SAFEPK 0.5ML 31G 8MM	T1	
ULTILET INSULIN SYRINGE	T1	
ULTRA COMFORT	T1	
ULTRA FLO INSULIN SYRINGE	T1	

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

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
SYRINGES AND ACCESSORIES (cont.)		
ULTRACARE INSULIN SYRINGE	T1	
ULTRA-THIN II	T1	
VANISHPOINT	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)		
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 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	
BLULINK BG SYSTEM REFILL	T3	
BULLSEYE MINI SAFETY LANCETS	T1	
BUTTERFLY TOUCH LANCET	T1	
CAREONE	T1	
CARETOUCH TWIST LANCET	T1	
CLEVER CHEK LANCETS	T1	
COAGUCHEK	T1	
COLOR LANCETS	T1	
COMFORT EZ	T1	

T1 – Typically Generics

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List of Prescription Medications

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

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
DURABLE MEDICAL EQUIPMENT,MISC (GROUP I) (cont.)		
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	
EASY TWIST & 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 UNISTIK 2	T1	
GLUCOCOM LANCETS	T1	
GOJJI LANCETS	T1	
HEALTHY ACCENTS UNILET LANCET	T1	
INCONTROL SUPERTHIN 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	
MEDLANCE PLUS SPECIAL BLADE	T1	
MICRO THIN LANCETS	T1	
MICROLET	T1	

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

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
DURABLE MEDICAL EQUIPMENT,MISC (GROUP I) (cont.)		
MICROTAINER LANCETS	T1	
MOBILE LANCETS	T1	
MONOLET LANCETS	T1	
MONOLET THIN LANCETS	T1	
MYGLUCOHEALTH LANCETS	T1	
NOVA SAFETY LANCETS	T1	
NOVA SUREFLEX	T1	
ON CALL LANCET	T1	
ON CALL PLUS LANCET	T1	
ONETOUCH DELICA PLUS LANCET	T1	
ONETOUCH DELICA SAFETY LANCET	T1	
ONETOUCH LANCETS	T1	
ONETOUCH SURESOFT	T1	
ONETOUCH ULTRASOFT 2 LANCET	T1	
ON-THE-GO	T1	
PIP LANCET	T1	
PRESSURE ACTIVATED LANCETS	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	
SAFETY LANCETS	T1	
SAFETY SEAL LANCETS	T1	
SAFETY-LET	T1	
SINGLE-LET	T1	
SMART SENSE	T1	

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

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
DURABLE MEDICAL EQUIPMENT,MISC (GROUP I) (cont.)		
SMART SENSE LANCETS	T1	
SMARTEST LANCET	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 LANCETS	T1	
TWIST LANCETS	T1	
TWIST TOP LANCET	T1	
ULTILET BASIC	T1	
ULTILET CLASSIC	T1	
ULTILET LANCETS	T1	
ULTILET SAFETY	T1	
ULTRA THIN LANCETS	T1	
ULTRA THIN PLUS LANCETS	T1	
ULTRA-CARE LANCETS	T1	
ULTRALANCE	T1	
ULTRA-THIN II	T1	
ULTRATLC LANCETS	T1	
UNILET COMFORTOUCH	T1	
UNILET EXCELITE	T1	

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

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
DURABLE MEDICAL EQUIPMENT,MISC (GROUP I) (cont.)		
UNILET EXCELITE II	T1	
UNILET GP LANCET	T1	
UNILET LANCET	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	
UNISTIK TOUCH	T1	
UNIVERSAL 1	T1	
VERIFINE SAFETY LANCET MINI	T1	
VERIFINE UNIVERSAL LANCET	T1	
VIVAGUARD LANCET	T1	
NEEDLES/NEEDLELESS DEVICES		
NEEDLES	T1	
RESPIRATORY AIDS, DEVICES, EQUIPMENT		
ACE AEROSOL CLOUD ENHANCER	T2	QL (1 unit/year)
AEROCHAMBER MINI	T2	QL (1 unit/year)
AEROCHAMBER MV	T2	QL (1 unit/year)
AEROCHAMBER PLUS FLOW-VU	T2	QL (1 unit/year)
AEROCHAMBER WITH FLOWSIGNAL	T2	QL (1 unit/year)
AEROCHAMBER Z-STAT PLUS	T2	QL (1 unit/year)
AEROTRACH PLUS	T2	QL (1 unit/year)
AEROVENT PLUS	T2	QL (1 unit/year)
BREATHERITE	T2	QL (1 unit/year)
BREATHERITE SPACER-ADULT MASK	T2	QL (1 unit/year)
BREATHERITE SPACER-INFANT MASK	T2	QL (1 unit/year)
BREATHERITE SPACER-LARGE MASK	T2	QL (1 mask/365 days)
BREATHERITE SPACER-LG CHLD MSK	T2	QL (1 unit/year)
BREATHERITE SPACER-MEDIUM MASK	T2	QL (1 mask/365 days)
BREATHERITE SPACER-NEONATE MSK	T2	QL (1 unit/year)

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

T4 – Specialty Medications

PA – Prior Authorization

QL – Quantity Limit

ST – Step Therapy

AGE – Age Requirement

SP – Specialty Medication

HD – May require home delivery pharmacy

PPACA – No Cost-Share Preventive Medication

CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

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

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
RESPIRATORY AIDS, DEVICES, EQUIPMENT (cont.)		
BREATHERITE SPACER-SM CHLD MSK	T2	QL (1 unit/year)
BREATHERITE SPACER-SMALL MASK	T2	QL (1 mask/365 days)
BREATHRITE	T2	QL (1 unit/year)
CLEVER CHOICE HOLDING CHAMBER	T2	QL (1 unit/year)
COMPACT SPACE CHAMBER	T2	QL (1 unit/year)
EASIVENT	T2	QL (1 unit/year)
E-Z SPACER	T2	QL (1 unit/year)
FLEXICHAMBER	T2	QL (1 unit/year)
FLEXICHAMBER MASK	T2	QL (1 unit/year)
INSPIRACHAMBER	T2	QL (1 unit/year)
LITEAIRE	T2	QL (1 unit/year)
LITETOUCH	T2	QL (1 unit/year)
MICROCHAMBER	T2	QL (1 unit/year)
MICROSPACER	T2	QL (1 unit/year)
OPTICHAMBER	T2	QL (1 unit/year)
OPTICHAMBER DIAMOND	T2	QL (1 unit/year)
POCKET CHAMBER	T2	QL (1 unit/year)
PRIMEAIRE	T2	QL (1 unit/year)
PRO COMFORT SPACER WITH MASK	T2	QL (1 unit/year)
PROCARE SPACER WITH ADULT MASK	T2	QL (1 unit/year)
PROCARE SPACER WITH CHILD MASK	T2	QL (1 unit/year)
PROCHAMBER	T2	QL (1 unit/year)
RITEFLO	T2	QL (1 unit/year)
SILICONE MASK	T2	QL (1 unit/year)
SPACE CHAMBER MASK	T2	QL (1 unit/year)
VORTEX	T2	QL (1 unit/year)
VORTEX HOLDING CHAMBER-CHILD, TODDLER	T2	QL (1 unit/year)
VORTEX VHC FROG MASK	T2	QL (1 unit/year)
VORTEX VHC LADYBUG MASK	T2	QL (1 unit/year)
SYRINGES AND ACCESSORIES		
LITE TOUCH INSULIN SYR	T1	
SURE COMFORT SYRINGE	T1	
ULTRA-THIN II	T1	
TISSUE BULKING IMPLANTS		
BARRIGEL (hyaluronate sodium, stabilized)	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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ST – Step Therapy

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List of Prescription Medications

MUSCLE RELAXANTS (Pain Relief And Inflammatory Disease)

SKELETAL MUSCLE RELAXANTS

<i>baclofen</i>	T1	HD
<i>carisoprodol (Soma)</i>	T1	
<i>carisoprodol/aspirin</i>	T1	
<i>chlorzoxazone</i>	T1	
<i>cyclobenzaprine hcl</i>	T1	
<i>cyclobenzaprine hcl (Fexmid)</i>	T1	
<i>DANTRIUM (dantrolene sodium)</i>	T3	
<i>dantrolene sodium</i>	T1	
<i>dantrolene sodium (Dantrium)</i>	T1	
<i>FEXMID (cyclobenzaprine hcl)</i>	T3	
<i>FLEQSVFY (baclofen)</i>	T3	HD
<i>metaxalone</i>	T1	
<i>metaxalone (Skelaxin)</i>	T1	
<i>methocarbamol</i>	T1	
<i>orphenadrine citrate</i>	T1	
<i>OZOBAX DS</i>	T3	
<i>ROBAXIN-750 (methocarbamol)</i>	T3	
<i>SKELAXIN (metaxalone)</i>	T3	
<i>tizanidine hcl (Zanaflex)</i>	T1	
<i>ZANAFLEX (tizanidine hcl)</i>	T3	

PRE-NATAL VITAMINS (Nutritional/Dietary)

PREGNANT VITAMIN PREPARATIONS

<i>ATABEX EC</i>	T2	
<i>CITRANATAL 90 DHA</i>	T2	
<i>CITRANATAL ASSURE</i>	T2	
<i>CITRANATAL DHA</i>	T2	
<i>CITRANATAL HARMONY</i>	T2	
<i>CITRANATAL RX</i>	T2	
<i>OBSTETRIX EC</i>	T2	
<i>OBTREX DHA</i>	T2	
<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	

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

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

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
PRENATAL VITAMIN PREPARATIONS (cont.)		
pnv 80/iron fum/folic/dss/dha	T1	
pnv no.154/iron fum/folic acid	T1	
pnv/ferrous fum/docusate/folic	T1	
pnv/iron, carb/docusat/folic ac	T1	
prenatal 12/iron/folic/dss/om3 (Obtrex Dha)	T1	
PRENATAL 19	T1	
prenatal 34/iron/folic/dss/dha	T1	
prenatal vits15/iron/folic/dss	T1	
VITAFOL FE+	T2	

PSYCHOTHERAPEUTIC DRUGS (Anxiety/Depression/Bipolar Disorder)⁸

ALPHA-2 RECEPTOR ANTAGONIST ANTI-DEPRESSANTS		
mirtazapine	T1	HD
mirtazapine (Remeron)	T1	HD
ANTI-ANXIETY - BENZODIAZEPINES		
alprazolam	T1	
alprazolam (Xanax Xr)	T1	
alprazolam (Xanax)	T1	
chlordiazepoxide hcl	T1	
clorazepate dipotassium	T1	
clorazepate dipotassium (Tranxene T-tab)	T1	
diazepam 10 mg tablet (Valium)	T1	
diazepam 2 mg tablet (Valium)	T1	
diazepam 5 mg tablet (Valium)	T1	
diazepam 5 mg/5 ml solution	T1	
diazepam 5 mg/ml oral conc	T1	
lorazepam	T1	
oxazepam	T1	
TRANXENE T-TAB (clorazepate dipotassium)	T3	
XANAX XR (alprazolam xr)	T3	
ANTI-ANXIETY DRUGS		
buspirone hcl	T1	
meprobamate	T1	

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

T4 – Specialty Medications

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QL – Quantity Limit

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AGE – Age Requirement

SP – Specialty Medication

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List of Prescription Medications

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

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ANTIDEPRESSANT - POSTPARTUM DEPRESSION (PPD)		
ZURZUVAE 20 MG CAPSULE	T4	PA QL(28 caps/270 days) SP HD
ZURZUVAE 25 MG CAPSULE	T4	PA QL(28 caps/270 days) SP HD
BIPOLAR DISORDER DRUGS		
EQUETRO	T3	HD
<i>lithium carbonate</i> (Lithobid)	T1	HD
<i>lithium citrate</i>	T1	HD
MAOIS -NON-SELECTIVE, IRREVERSIBLE ANTI-DEPRESSANTS		
MARPLAN	T3	QL (12 tabs/day)
<i>phenelzine sulfate</i> (Nardil)	T1	
<i>tranylcypromine sulfate</i>	T1	
MONOAMINE OXIDASE (MAO) INHIBITOR ANTI-DEPRESSANTS		
EMSAM 12 MG/24 HOURS PATCH	T3	QL (1 patch/day)
EMSAM 6 MG/24 HOURS PATCH	T3	QL (2 patches/day)
EMSAM 9 MG/24 HOURS PATCH	T3	QL (1 patch/day)
NOREPINEPHRINE AND DOPAMINE REUPTAKE INHIB (NDRIs)		
<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>	T1	QL (3 tabs/day) HD
<i>bupropion hcl xl 300 mg tablet</i>	T1	QL (1 tab/day) HD
SELECTIVE SEROTONIN 5-HT2A INVERSE AGONISTS (SSIAs)		
NUPLAZID	T4	PA SP HD
SELECTIVE SEROTONIN REUPTAKE INHIBITOR (SSRIs)		
<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>	T1	QL (2 tabs/day) HD
<i>escitalopram 20 mg tablet</i>	T1	QL (1 tab/day) HD

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

T4 – Specialty Medications

PA – Prior Authorization

QL – Quantity Limit

ST – Step Therapy

AGE – Age Requirement

SP – Specialty Medication

HD – May require home delivery pharmacy

PPACA – No Cost-Share Preventive Medication

CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

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

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
SELECTIVE SEROTONIN REUPTAKE INHIBITOR (SSRIs) (cont.)		
escitalopram 5 mg tablet	T1	QL (4 tabs/day) HD
escitalopram oxalate 5 mg/5 ml	T1	QL (20ml/day) HD
fluoxetine hcl	T1	QL (4 caps/28 days) HD
fluoxetine 20 mg/5 ml soln cup	T1	QL(20 mls/day) HD
fluoxetine hcl 10 mg capsule (Prozac)	T1	QL (8 caps/day) HD
fluoxetine hcl 20 mg capsule (Prozac)	T1	QL (4 caps/day) HD
fluoxetine hcl 20 mg tablet	T1	HD
fluoxetine hcl 40 mg capsule (Prozac)	T1	QL (2 caps/day) HD
fluoxetine hcl 60 mg tablet	T1	QL (1 tab/day) HD
fluvoxamine er 100 mg capsule	T1	QL (3 caps/day) HD
fluvoxamine er 150 mg capsule	T1	QL (2 caps/day) HD
fluvoxamine maleate 100 mg tab	T1	QL (3 tabs/day) HD
fluvoxamine maleate 25 mg tab	T1	QL (12 tabs/day) HD
fluvoxamine maleate 50 mg tab	T1	QL (6 tabs/day) HD
paroxetine cr 12.5 mg tablet (Paxil Cr)	T1	QL (6 tabs/day) HD
paroxetine cr 25 mg tablet (Paxil Cr)	T1	QL (3 tabs/day) HD
paroxetine cr 37.5 mg tablet (Paxil Cr)	T1	QL (2 tabs/day) HD
paroxetine er 12.5 mg tablet (Paxil Cr)	T1	QL (1 tab/day) HD
paroxetine er 25 mg tablet (Paxil Cr)	T1	QL (3 tabs/day) HD
paroxetine er 37.5 mg tablet (Paxil Cr)	T1	QL (2 tabs/day) HD
paroxetine hcl 10 mg tablet (Paxil)	T1	QL (6 tabs/day) HD
paroxetine hcl 20 mg tablet (Paxil)	T1	QL (3 tabs/day) HD
paroxetine hcl 30 mg tablet (Zoloft)	T1	QL (2 tabs/day) HD
paroxetine hcl 40 mg tablet (Paxil)	T1	QL (1 tab/day) HD
SARAFEM (fluoxetine hcl)	T3	ST HD
sertraline 20 mg/ml oral conc (Zoloft)	T1	QL (10ml/day) HD
sertraline hcl 100 mg tablet (Zoloft)	T1	QL (2 tabs/day) HD
sertraline hcl 25 mg tablet (Zoloft)	T1	QL (8 tabs/day) HD
sertraline hcl 50 mg tablet (Zoloft)	T1	QL (4 tabs/day) HD
SEROTONIN-2 ANTAGONIST/REUPTAKE INHIBITORS (SARIs)		
nefazodone hcl	T1	HD
trazodone hcl	T1	HD
SEROTONIN-NOREPINEPHRINE REUPTAKE-INHIB (SNRIs)		
desvenlafaxine succnt er 100mg (Pristiq)	T1	QL (4 tabs/day) HD
desvenlafaxine succnt er 25 mg (Pristiq)	T1	QL (16 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)⁸ (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
SEROTONIN-NOREPINEPHRINE REUPTAKE-INHIB (SNRIs) (cont.)		
desvenlafaxine succnt er 50 mg (Pristiq)	T1	QL (1 tab/day) HD
duloxetine hcl dr 20 mg cap	T1	QL (6 caps/day) HD
duloxetine hcl dr 30 mg cap	T1	QL (4 caps/day) HD
duloxetine hcl dr 40 mg cap	T1	QL (3 caps/day) HD
duloxetine hcl dr 60 mg cap	T1	QL (2 caps/day) HD
FETZIMA 20-40 MG TITRATION PAK	T3	QL (28 caps/180 days) ST 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	QL (2 tabs/day) ST HD
PRISTIQ ER 25 MG TABLET (desvenlafaxine succinate er)	T3	QL (16 tabs/day) ST HD
PRISTIQ ER 50 MG TABLET (desvenlafaxine succinate er)	T3	QL (1 tab/day) ST 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
SSRI AND 5HTIA PARTIAL AGONIST ANTI-DEPRESSANTS		
VIIBRYD 10 MG TABLET	T3	QL (1 tab/day) ST HD
VIIBRYD 10-20 MG STARTER PACK	T3	ST HD
VIIBRYD 20 MG TABLET	T3	QL (1 tab/day) ST HD
VIIBRYD 40 MG TABLET	T3	ST HD
SSRI, SEROTONIN RECEPTOR MODULATOR ANTI-DEPRESSANTS		
TRINTELLIX 10 MG TABLET	T2	QL (1 tab/day) ST HD
TRINTELLIX 20 MG TABLET	T2	ST HD
TRINTELLIX 5 MG TABLET	T2	QL (1 tab/day) ST HD

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

T4 – Specialty Medications

PA – Prior Authorization

QL – Quantity Limit

ST – Step Therapy

AGE – Age Requirement

SP – Specialty Medication

HD – May require home delivery pharmacy

PPACA – No Cost-Share Preventive Medication

CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

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

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

PSYCHOTHERAPEUTIC DRUGS (Attention Deficit Hyperactivity Disorder)⁸

ADRENERGICS, AROMATIC, NON-CATECHOLAMINE		
MYDAYIS	T2	QL
VYVANSE 10 MG CAPSULE	T3	PA QL (1 cap/day)
VYVANSE 10 MG CHEWABLE TABLET	T3	PA QL (1 tab/day)
VYVANSE 20 MG CAPSULE	T3	PA QL (1 cap/day)
VYVANSE 20 MG CHEWABLE TABLET	T3	PA QL (1 tab/day)
VYVANSE 30 MG CAPSULE	T3	PA QL (1 cap/day)
VYVANSE 30 MG CHEWABLE TABLET	T3	PA QL (1 tab/day)
VYVANSE 40 MG CAPSULE	T3	PA QL (1 cap/day)
VYVANSE 40 MG CHEWABLE TABLET	T3	PA QL (1 tab/day)
VYVANSE 50 MG CAPSULE	T3	PA QL (1 cap/day)
VYVANSE 50 MG CHEWABLE TABLET	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

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List of Prescription Medications

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

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ADRENERGICS, AROMATIC, NON-CATECHOLAMINE (cont.)		
VYVANSE 60 MG CAPSULE	T3	PA QL (1 cap/day)
VYVANSE 60 MG CHEWABLE TABLET	T3	PA QL (1 tab/day)
VYVANSE 70 MG CAPSULE	T3	PA QL (1 cap/day)
TX FOR ADHD - SELECTIVE ALPHA-2 RECEPTOR AGONIST		
clonidine hcl (Kapvay)	T1	
guanfacine hcl (Intuniv)	T1	HD
TX FOR ATTENTION DEFICIT-HYPERACT (ADHD)/NARCOLEPSY		
DAYTRANA (methylphenidate)	T3	PA QL(1 PATCH/DAY)
DAYTRANA 10 MG/9 HR PATCH	T3	PA QL (1 patch/day)
DAYTRANA 15 MG/9 HR PATCH	T3	PA QL (1 per day)
DAYTRANA 20 MG/9 HOUR PATCH	T3	PA QL (1 patch/day)
DAYTRANA 30 MG/9 HOUR PATCH	T3	PA QL (1 patch/day)
dexamethylphenidate er (Focalin Xr)	T1	PA QL(1 cap/day)
dexamethylphenidate hcl	T1	PA QL (1 cap/day)
dexamethylphenidate hcl (Focalin)	T1	PA
FOCALIN (dexamethylphenidate hcl)	T3	PA ST
METHYLIN (methylphenidate hcl)	T3	PA
methylphenidate (Daytrana)	T1	PA QL(1 patch/day)
methylphenidate 10 mg/9hr ptch (Daytrana)	T1	PA QL(1 patch/day)
methylphenidate 15 mg/9hr ptch (Daytrana)	T1	PA QL(1 patch/day)
methylphenidate 20 mg/9hr ptch (Daytrana)	T1	PA QL(1 patch/day)
methylphenidate 30 mg/9hr ptch (Daytrana)	T1	PA QL(1 patch/day)
methylphenidate er 10 mg cap	T1	QL (1 per day)
methylphenidate er 10 mg tab	T1	PA QL (2 tabs/day)
methylphenidate er 15 mg cap	T1	QL (1 per day)
methylphenidate er 18 mg tab	T1	PA QL (1 tab/day)
methylphenidate er 18 mg tab (Relexxii)	T1	PA QL(1 tab/day)
methylphenidate er 20 mg cap	T1	QL (1 cap/day)
methylphenidate er 20 mg tab	T1	PA QL (3 tabs/day)
methylphenidate er 27 mg tab	T1	PA QL (1 tab/day)
methylphenidate er 30 mg cap	T1	QL (1 per day)
methylphenidate er 36 mg tab	T1	PA QL (2 tabs/day)
methylphenidate er 40 mg cap	T1	QL (1 per day)
methylphenidate er 50 mg cap	T1	QL (1 per day)
methylphenidate er 54 mg tab	T1	PA QL (1 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

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

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
TX FOR ATTENTION DEFICIT-HYPERACT (ADHD)/NARCOLEPSY (cont.)		
methylphenidate er 60 mg cap	T1	QL (1 per day)
methylphenidate hcl (Metadata CD)	T1	PA QL (1 cap/day)
methylphenidate hcl (Methylin)	T1	PA
methylphenidate hcl (Ritalin)	T1	PA
methylphenidate la 10 mg cap	T1	PA QL (1 cap/day)
methylphenidate la 20 mg cap	T1	PA QL (1 per day)
methylphenidate la 30 mg cap	T1	PA QL (1 per day)
methylphenidate la 40 mg cap	T1	PA QL (1 per day)
methylphenidate la 60 mg cap	T1	PA QL (1 cap/day)
QUILLICHEW ER	T3	PA QL (1 tab/day)
QUILLIVANT XR	T3	PA QL (12ml/day)
RITALIN (methylphenidate hcl)	T3	PA ST
TX FOR ATTENTION DEFICIT-HYPERACT.(ADHD), NRI-TYPE		
atomoxetine hcl 10 mg capsule (Strattera)	T1	HD
atomoxetine hcl 100 mg capsule (Strattera)	T1	HD
atomoxetine hcl 18 mg capsule (Strattera)	T1	HD
atomoxetine hcl 25 mg capsule (Strattera)	T1	HD
atomoxetine hcl 40 mg capsule (Strattera)	T1	QL (1 cap/day) HD
atomoxetine hcl 60 mg capsule (Strattera)	T1	HD
atomoxetine hcl 80 mg capsule (Strattera)	T1	HD
SUPARTZ FX 25MG/2.5ML SYR	T4	PA SP
PSYCHOTHERAPEUTIC DRUGS (Miscellaneous)		
HYPACTIVE SEXUAL DESIRE DISORDER (HSDD) TX AGENTS		
ADDYI	T3	PA QL (1 tab/day)
VYLEESI	T4	PA QL (8 injectors/30 days) SP
PSYCHOTHERAPEUTIC DRUGS (Schizophrenia/Anti-Psychotics)⁸		
ANTI-PSYCH, DOPAMINE ANTAG., DIPHENYLBUTYLPIPERIDINES		
pimozide	T1	
ANTI-PSYCHOTIC,ATYPICAL,DOPAMINE,SEROTONIN ANTAGNST		
ABILITY MAINTENA	T2	
asenapine maleate (Saphris)	T1	
CAPLYTA	T3	ST QL(1 tabs/caps/day)
clozapine	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)⁸ (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ANTI-PSYCHOTIC,ATYPICAL,DOPAMINE,SEROTONIN ANTAGNIST (cont.)		
clozapine (Clozapine Odt)	T1	
clozapine (Clozaril)	T1	
CLOZAPINE ODT	T1	
CLOZARIL (clozapine)	T3	ST
ERZOFRI	T3	QL
INVEGA ER 1.5 MG TABLET (<i>paliperidone er</i>)	T2	ST
INVEGA ER 3 MG TABLET (<i>paliperidone er</i>)	T2	QL (1 tab/day) ST
INVEGA ER 6 MG TABLET (<i>paliperidone er</i>)	T2	ST
INVEGA ER 9 MG TABLET (<i>paliperidone er</i>)	T2	ST
INVEGA SUSTENNA 117 MG/0.75 ML	T2	
INVEGA SUSTENNA 156 MG/ML SYRG	T2	
INVEGA SUSTENNA 234 MG/1.5 ML	T2	
INVEGA SUSTENNA 39 MG/0.25 ML	T2	
INVEGA SUSTENNA 78 MG/0.5 ML	T2	
<i>ilurasidone hcl 120 mg tablet (Latuda)</i>	T1	
<i>ilurasidone hcl 20 mg tablet (Latuda)</i>	T1	
<i>ilurasidone hcl 40 mg tablet (Latuda)</i>	T1	QL(1 tab/day)
<i>ilurasidone hcl 60 mg tablet (Latuda)</i>	T1	QL(1 tab/day)
<i>ilurasidone hcl 80 mg tablet (Latuda)</i>	T1	
<i>olanzapine</i>	T1	
<i>paliperidone er 1.5 mg tablet</i>	T1	
<i>paliperidone er 3 mg tablet (Invega)</i>	T1	QL (1 tab/day)
<i>paliperidone er 6 mg tablet (Invega)</i>	T1	
<i>paliperidone er 9 mg tablet (Invega)</i>	T1	
<i>quetiapine fumarate (Seroquel Xr)</i>	T1	
<i>quetiapine fumarate (Seroquel)</i>	T1	
<i>risperidone</i>	T1	
<i>risperidone microspheres</i>	T1	QL
<i>risperidone microspheres (Risperdal Consta)</i>	T1	QL(4 vials/28 days)
<i>risperidone (Risperdal)</i>	T1	
<i>SAPHRIS (asenapine maleate)</i>	T3	ST
<i>SECUADO</i>	T3	ST

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

T4 – Specialty Medications

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List of Prescription Medications

PSYCHOTHERAPEUTIC DRUGS (Schizophrenia/Anti-Psychotics)⁸ (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ANTI-PSYCHOTIC,ATYPICAL,DOPAMINE,SEROTONIN ANTAGNST (cont.)		
SEROQUEL (quetiapine fumarate)	T3	ST
SEROQUEL XR (quetiapine fumarate er)	T3	ST
ziprasidone hcl	T1	
ZYPREXA	T3	
ANTI-PSYCHOTIC-ATYPICAL, D3/D2 PARTIAL AG-5HT MIXED		
VRAYLAR 1.5 MG CAPSULE	T3	QL (1 cap/day) ST
VRAYLAR 3 MG CAPSULE	T3	QL (1 cap/day) ST
VRAYLAR 4.5 MG CAPSULE	T3	ST
VRAYLAR 6 MG CAPSULE	T3	ST
ANTIPSYCHOTICS, ATYP, D2 PARTIAL AGONIST/5HT MIXED		
ABILIFY ASIMTUFII	T3	
ariPIPRAZOLE	T1	
ariPIPRAZOLE 1 mg/ml solution	T1	
ariPIPRAZOLE 10 mg tablet	T1	
ariPIPRAZOLE 15 mg tablet	T1	
ariPIPRAZOLE 2 mg tablet	T1	
ariPIPRAZOLE 20 mg tablet	T1	
ariPIPRAZOLE 30 mg tablet	T1	
ariPIPRAZOLE 5 mg tablet	T1	QL (1 tab/day)
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
ANTI-PSYCHOTICS, DOPAMINE AND SEROTONIN ANTAGONISTS		
loxpiprazole succinate	T1	
ANTI-PSYCHOTICS, DOPAMINE ANTAGONISTS, THIOXANTHENES		
thiothixene	T1	
ANTI-PSYCHOTICS, DOPAMINE ANTAGONISTS, BUTYROPHENONES		
haloperidol	T1	
haloperidol lactate	T1	

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

T4 – Specialty Medications

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List of Prescription Medications

PSYCHOTHERAPEUTIC DRUGS (Schizophrenia/Anti-Psychotics)⁸ (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ANTI-PSYCHOTICS, DOPAMINE ANTAGONIST, DIHYDROINDOLONES		
<i>molindone hcl</i>	T1	
ANTI-PSYCHOTICS, PHENOTHIAZINES		
<i>chlorpromazine hcl</i>	T1	
<i>fluphenazine hcl</i>	T1	
<i>perphenazine</i>	T1	
<i>thioridazine hcl</i>	T1	
<i>trifluoperazine hcl</i>	T1	
SSRI-ANTI-PSYCH, ATYPICAL, DOPAMINE, SEROTONIN ANTAG		
<i>olanzapine/fluoxetine hcl</i>	T1	
<i>olanzapine/fluoxetine hcl (Symbyax)</i>	T1	
PSYCHOTHERAPEUTIC DRUGS (Sleep Disorders/Sedatives)		
NARCOLEPSY AND SLEEP DISORDER THERAPY AGENTS		
<i>armodafinil</i>	T1	PA
<i>modafinil</i>	T1	PA
SUNOSI	T2	PA QL (1 tab/day)
SEDATIVE/HYPNOTICS (Sleep Disorders/Sedatives)		
ANTI-NARCOLEPSY, ANTI-CATAPLEXY, SEDATIVE-TYPE AGENT		
LUMRYZ	T4	PA QL (1 pack/day) SP HD
SODIUM OXYBATE 0.5 G/ML SOLN	T4	PA QL(18 mls/day) SP HD
XYWAV	T4	PA SP HD
BARBITURATES		
<i>phenobarbital</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 (Rozerem)</i>	T3	QL (1 tab/day)
<i>tasimelteon</i>	T4	PA SP
SEDATIVE-HYPNOTICS - BENZODIAZEPINES		
DORAL	T3	
<i>estazolam</i>	T1	
HALCION (<i>triazolam</i>)	T3	
<i>midazolam hcl</i>	T1	

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

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

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
SEDATIVE-HYPNOTICS - BENZODIAZEPINES (cont.)		
QUAZEPAM	T1	
<i>quazepam</i> (Quazepam)	T1	
<i>temazepam</i>	T1	
<i>triazolam</i>	T1	
<i>triazolam</i> (Halcion)	T1	
SEDATIVE-HYPNOTICS, NON-BARBITURATE		
DAYVIGO	T2	QL (1 tab/day) ST
<i>doxepin hcl 3 mg tablet</i> (Silenor)	T1	QL (1 tab/day)
<i>doxepin hcl 6 mg tablet</i> (Silenor)	T1	
<i>eszopiclone</i> (Lunesta)	T1	
<i>flurazepam hcl</i>	T1	
<i>zaleplon</i>	T1	
<i>zolpidem tart er 12.5 mg tab</i>	T1	
<i>zolpidem tart er 6.25 mg tab</i>	T1	QL (1 tab/day)
<i>zolpidem tartrate</i>	T1	
SKIN PREPS (Miscellaneous)		
IRRIGANTS		
<i>acetic acid</i>	T1	
<i>neomycin sulf/polymyxin b sulf</i>	T1	
PHYSIOLYTE	T3	
PHYSIOSOL	T3	
<i>ringer's solution</i>	T1	
<i>ringer's solution, lactated</i>	T1	
<i>sod, pot chlor/mag/sod, pot phosph</i>	T3	
<i>sodium chloride irrig solution</i>	T1	
SORBITOL	T1	
SORBITOL-MANNITOL	T1	
VASHE WOUND	T3	
VASHE WOUND THERAPY	T3	
<i>water for irrigation, sterile</i>	T1	
OXIDIZING AGENTS		
SORBITOL	T1	
ANTI-PSORIATICS AGENTS, SYSTEMIC		
<i>acitretin</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

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List of Prescription Medications

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

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ANTI-PSORIATICS AGENTS, SYSTEMIC (cont.)		
COSENTYX	T4	PA SP
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
SILIQ	T4	PA QL (2 inj/15 days) SP HD
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 SYRINGE	T4	PA QL (1 syringe/28 days) SP HD
TOPICAL ANTI-INFLAMMATORY, NSAIDS		
DICLAREAL	T3	HD
DICLOFENAC EPOLAMINE	T3	PA QL (2 patches/day) HD
<i>diclofenac sodium 1% gel</i> (Voltaren)	T1	QL (1000gm/30 days) HD
FLECTOR	T2	PA QL (2 patches/day) HD
LICART 1.3% PATCH	T2	PA QL (1 patch/day) HD
VOLTAREN (<i>diclofenac sodium</i>)	T3	PA QL (1000gm/30 days) HD
SKIN PREPS (Skin Conditions)		
ACNE AGENTS, SYSTEMIC		
ACCUTANE	T1	
AMNESTEEM	T1	
CLARAVIS	T1	
isotretinoin	T1	
MYORISAN	T1	
ZENATANE	T1	
ACNE AGENTS, TOPICAL		
<i>adapalene/benzoyl peroxide</i>	T1	
<i>clindamycin phos/benzoyl perox</i> (Onexton)	T1	
<i>clindamycin phos/benzoyl perox</i>	T1	
<i>clindamycin/tretinoin</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

SKIN PREPS (Skin Conditions) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ACNE AGENTS, TOPICAL (cont.)		
<i>dapsone</i>	T1	
KLARON (<i>sulfacetamide sodium</i>)	T3	
<i>sulfacetamide sodium</i> (Klaron)	T1	
ANTI-PERSPIRANTS		
DRYSOL	T2	
ANTI-PRURITICS, TOPICAL		
ALEVICYN PLUS	T3	
ANTI-PSORIATICS AGENTS		
<i>anthralin</i>	T1	
BIMZELX	T4	PA QL(10 mls/365 days) SP HD
BIMZELX AUTOINJECTOR	T4	PA QL(10 mls/365 days) SP HD
<i>calcipotriene</i>	T1	
<i>calcipotriene 0.005% cream</i> (Dovonex)	T1	
CALCIPOTRIENE 0.005% FOAM	T3	
<i>calcipotriene 0.005% ointment</i>	T1	
<i>calcipotriene 0.005% solution</i>	T1	
<i>calcitriol 3 mcg/g ointment</i> (Vectical)	T1	QL (800gm/30 days)
COSENTYX	T4	SP HD
DOVONEX (<i>calcipotriene</i>)	T3	
<i>tazarotene 0.05% cream</i>	T1	
ANTISEPTICS, GENERAL		
ALCOHOL SWAB	T1	
CURITY ALCOHOL PREPS	T1	
DROPSAFE PREP PADS	T1	
EASY COMFORT ALCOHOL PAD	T1	
INCONTROL ALCOHOL PADS	T1	
PRO COMFORT ALCOHOL PADS	T1	
PURE COMFORT ALCOHOL PAD	T1	
SINGLE USE SWAB	T1	
SURE COMFORT ALCOHOL	T1	
TRUE COMFORT ALCOHOL PADS	T1	
TRUE COMFORT PRO ALCOHOL PADS	T1	
ULTILET ALCOHOL SWAB	T1	
ALCOHOL PREP PADS		
alcohol antiseptic pads	T1	

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) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ALCOHOL PREP PADS (cont.)		
ALCOHOL SWABS	T1	
ALCOHOL WIPES	T1	
CARETOUCH ALCOHOL PREP PAD	T1	
EASY TOUCH ALCOHOL PREP PADS	T1	
GUAIACOL	T1	
SURE-PREP ALCOHOL PREP PADS	T1	
WEBCOL	T1	
ANTI-SEBORRHEIC AGENTS		
<i>tazarotene</i>	T1	
VECTICAL (<i>calcitriol</i>)	T3	QL (800gm/30 days)
OVACE PLUS	T3	
<i>selenium sulfide</i>	T1	
<i>sulfacetamide sodium</i>	T1	
TERSI FOAM	T3	
DIABETIC ULCER PREPARATIONS, TOPICAL		
REGRANEX	T3	PA QL (2 tubs/30 days)
EMOLLIENTS		
<i>emollient combination no.60</i> (Restizan)	T3	
HALUCORT	T3	
MIMYX (<i>prumyx</i>)	T3	
RESTIZAN	T1	
<i>vite ac/grape/hyaluronic acid</i> (Atopiclair)	T1	
XCLAIR	T3	
IMMUNOMODULATORS		
<i>imiquimod</i>	T1	
IRRITANTS/COUNTER-IRRITANTS		
<i>methyl salicylate</i>	T1	
QUTENZA	T3	
KERATOLYTICS		
BENZEOFAM	T3	
BENZEPRO	T1	
<i>benzoyl peroxide</i> (Enzoclear)	T1	
<i>benzoyl peroxide</i> (Pacnex)	T1	
ENZOCLEAR	T3	

T1 – Typically Generics

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T3 – Typically Non-Preferred Brands

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List of Prescription Medications

SKIN PREPS (Skin Conditions) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
KERATOLYTICS (cont.)		
HYDRO 35	T3	
HYDRO 40 (<i>umecta</i>)	T3	
INOVA	T3	
KERAFOAM	T3	
KERALYT 6% GEL (<i>salicylic acid</i>)	T3	
<i>keralyt 6% shampoo</i>	T1	
KERALYT SCALP	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	
<i>salicylic acid</i>	T1	
<i>salicylic acid (Keralyt Scalp)</i>	T1	
<i>salicylic acid/ceramide comb 1</i>	T1	
SALIMEZ FORTE	T1	
SALICATE	T3	
SALKERA	T3	
SVLAX DUO PLUS	T3	
<i>silver nitrate</i>	T1	
<i>silver nitrate applicator</i>	T1	
URAMAXIN	T3	
URAMAXIN (<i>urea</i>)	T3	
<i>urea (Hydro 35)</i>	T1	
<i>urea (Hydro 40)</i>	T3	
<i>urea (Uramaxin)</i>	T1	
<i>urea (Xurea)</i>	T1	
XUREA	T3	
PROTECTIVES		
PHARMABASE BARRIER	T1	
<i>polydimethylsiloxanes/silicon</i>	T1	
<i>protectives2/ceramide 1,3,6-ii</i>	T1	
RADIAPLEXRX	T3	
<i>zinc oxide</i>	T1	

T1 – Typically Generics

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T3 – Typically Non-Preferred Brands

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List of Prescription Medications

SKIN PREPS (Skin Conditions) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ROSACEA AGENTS, TOPICAL		
<i>azelaic acid</i>	T1	
<i>ivermectin</i>	T1	
<i>metronidazole</i>	T1	
SOOLANTRA (<i>ivermectin</i>)	T3	
TISSUE/WOUND ADHESIVES		
ARTISS	T3	
SURGISEAL STYLUS	T3	
SURGISEAL TEARDROP	T3	
SURGISEAL TWIST	T3	
TISSEEL VHSD	T3	
TOP. ANTI-INFLAM., PHOSPHODIESTERASE-4 (PDE4) INHIB		
EUCRISA	T2	
ZORYVE 0.15% CREAM	T2	PA QL(60 gms/30 days)
TOPICAL AGENTS, MISCELLANEOUS		
GORDON'S UREA	T3	
MEDIHONEY	T3	
L-MESITRAN SOFT	T3	
SAF-CLENS AF	T1	
<i>trichloroacetic acid</i>	T3	
TRICHLOROACETIC ACID	T1	
TOPICAL ANTIBIOTIC PLEUROMUTILIN DERIVATIVES		
ALTABAX	T3	
TOPICAL ANTI-INFLAMMATORY STEROIDAL		
ALA-SCALP (<i>scalacort</i>)	T3	ST
<i>alclometasone dipropionate</i>	T1	
<i>amcinonide 0.1% cream</i>	T1	
<i>amcinonide 0.1% lotion</i>	T1	
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

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T3 – Typically Non-Preferred Brands

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List of Prescription Medications

SKIN PREPS (Skin Conditions) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
TOPICAL ANTI-INFLAMMATORY STEROIDAL (cont.)		
clobetasol propionate	T1	
clobetasol propionate (Temovate)	T1	
clobetasol propionate/emolli	T1	
CLOCORTOLONE PIVALATE	T1	
CLODAN 0.05% KIT	T3	ST
clodan 0.05% shampoo	T1	
CLODERM	T3	ST
DERMA-SMOOTH-E-FS (fluocinolone acetonide)	T3	ST
DERMATOP (prednicarbate)	T3	ST
desonide (Desowen)	T1	
DESOWEN (desonide)	T3	ST
desoximetasone (Topicort)	T1	
DIPROLENE (betamethasone diprop augmented)	T3	ST
fluocinolone acetonide	T1	
fluocinolone acetonide (Derma-smoothe-fs)	T1	
fluocinolone acetonide (Synalar)	T1	
fluocinolone/shower cap (Derma-smoothe-fs)	T1	
fluocinonide	T1	
fluocinonide/emollient base	T1	
fluticasone prop 0.005% oint	T1	
fluticasone prop 0.05% cream	T1	
fluticasone prop 0.05% lotion	T1	
halobetasol prop 0.05% foam	T1	
halobetasol propionate (Ultravate)	T1	
hydrocortisone	T1	
hydrocortisone (Ala-scalp)	T1	
hydrocortisone butyrate	T1	
hydrocortisone valerate	T1	
LUXIQ (betamethasone valerate)	T3	ST
MOMETACURE	T3	
mometasone furoate 0.1% cream	T1	
mometasone furoate 0.1% oint	T1	
mometasone furoate 0.1% soln	T1	
NUCORT	T3	ST

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T3 – Typically Non-Preferred Brands

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SKIN PREPS (Skin Conditions) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
TOPICAL ANTI-INFLAMMATORY STEROIDAL (cont.)		
<i>prednicarbate</i> (Dermatop)	T1	
SCALACORT DK	T3	ST
SYNALAR	T3	ST
SYNALAR (<i>fluocinolone acetonide</i>)	T3	ST
SYNALARTS	T3	ST
TEMOVATE (<i>clobetasol propionate</i>)	T3	ST
TEXACORT	T3	ST
TOPICORT (<i>desoximetasone</i>)	T3	ST
ULTRAVATE (<i>halobetasol propionate</i>)	T3	ST
TOPICAL ANTI-INFLAMMATORY STEROID-LOCAL ANESTHETIC		
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	
TOPICAL ANTI-PARASITICS		
<i>malathion</i> (Ovide)	T1	
OVIDE (<i>malathion</i>)	T3	
TOPICAL PREPARATIONS, ANTIBACTERIALS		
<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	
IODOSORB	T3	
<i>silver nitrate</i>	T1	

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

T4 – Specialty Medications

PA – Prior Authorization

QL – Quantity Limit

ST – Step Therapy

AGE – Age Requirement

SP – Specialty Medication

HD – May require home delivery pharmacy

PPACA – No Cost-Share Preventive Medication

CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

SKIN PREPS (Skin Conditions) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
TOPICAL VIT D ANALOG/ANTI-INFLAMMATORY STEROID		
calcipotriene/betamethasone	T1	
TACLONEX 0.005%-0.064% SUSPENS (calcipotriene/betamethasone)	T3	
TOPICAL/MUCOUS MEMBR./SUBCUT. ENZYMES		
SANTYL	T2	QL (60gm/30 days)
VITAMIN A DERIVATIVES		
adapalene 0.1% cream	T1	PA
adapalene 0.3% gel pump	T1	PA
PLIXDA	T1	PA
tretinoin 0.01% gel	T1	
tretinoin 0.025% cream	T1	PA
tretinoin 0.025% gel	T1	
tretinoin 0.05% cream	T1	PA
tretinoin 0.05% gel	T1	PA
tretinoin 0.1% cream	T1	PA
SMOKING DETERRENTS (Smoking Cessation)⁸		
SMOKING DETERRENT AGENTS (GANGLIONIC STIM, OTHERS)		
NICOTROL	T2	PPACA
NICOTROL NS	T2	PPACA
SMOKING DETERENT-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
THYROID PREPS (Hormonal Agents)		
ANTI-THYROID PREPARATIONS		
methimazole (Tapazole)	T1	HD
propylthiouracil	T1	HD
TAPAZOLE (methimazole)	T3	HD
THYROID HORMONES		
ARMOUR THYROID	T3	HD
CYTOMEL (liothyronine sodium)	T3	HD
LEVOTHYROXINE	T3	HD
levothyroxine sodium (Synthroid)	T1	HD
levothyroxine sodium (Synthroid)	T3	HD

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

T4 – Specialty Medications

PA – Prior Authorization

QL – Quantity Limit

ST – Step Therapy

AGE – Age Requirement

SP – Specialty Medication

HD – May require home delivery pharmacy

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List of Prescription Medications

THYROID PREPS (Hormonal Agents) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
THYROID HORMONES (cont.)		
<i>liothyronine sodium (Cytomel)</i>	T1	HD
SYNTHROID (<i>unithroid</i>)	T3	HD
<i>thyroid, pork</i>	T1	HD
<i>thyroid, pork (Armour Thyroid)</i>	T1	HD
<i>thyroid, pork (Wp Thyroid)</i>	T1	HD
THYROLAR-1	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
WP THYROID	T1	HD
WP THYROID (<i>nature-throid</i>)	T1	HD
WP THYROID (<i>westhroid</i>)	T1	HD

UNCLASSIFIED DRUG PRODUCTS (AIDS/HIV)

CYTOCHROME P450 INHIBITORS		
TYBOST	T4	SP

UNCLASSIFIED DRUG PRODUCTS (Asthma/COPD/Respiratory)

CYSTIC FIBROSIS-CFTR POTENTIATOR-CORRECTOR COMBIN.		
ALYFTREK 10-50-125 MG TABLET	T3	PA QL(2 tabs/day) SP HD
ALYFTREK 4-20-50 MG TABLET	T3	PA QL(3 tabs/day) SP HD
BRONCHITOL 40 MG INHALE CAPSULE	T4	PA SP
ORKAMBI 100 MG-125 MG TABLET	T4	PA QL (4 tabs/day) SP HD
ORKAMBI 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

CYSTICFIB-TRANSMEMB CONDUCT.REG. (CFTR) POTENTIATOR		
KALYDECO 5.8 MG GRANULES PKT	T4	PA QL SP HD
KALYDECO 150 MG TABLET	T4	PA QL (2 tabs/day) SP HD
KALYDECO 25 MG GRANULES PACKET	T4	PA QL (2 packs/day) SP HD

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

T4 – Specialty Medications

PA – Prior Authorization

QL – Quantity Limit

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SP – Specialty Medication

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List of Prescription Medications

UNCLASSIFIED DRUG PRODUCTS (Asthma/COPD/Respiratory) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
CYSTICFIB-TRANSMEMB CONDUCT.REG. (CFTR) POTENTIATOR (cont.)		
KALYDECO 50 MG GRANULES PACKET	T4	PA QL (2 packs/day) SP HD
KALYDECO 75 MG GRANULES PACKET	T4	PA QL (2 packs/day) SP HD
LUNG SURFACTANTS		
CUROSURF	T3	
INFASURF	T3	
SURVANTA	T3	
MUCOLYTICS		
PULMOZYME	T4	PA SP HD
PULMONARY FIBROSIS - SYSTEMIC ENZYME INHIBITORS		
OFEV	T4	PA SP HD
SYSTEMIC ENZYME INHIBITORS		
JOENJA	T4	PA QL(2 tabs/day) SP
PROLASTIN C	T4	PA SP HD
VIJOICE 125mg, 50mg	T4	PA QL (30 tabs/30 days) SP
VIJOICE 250mg	T4	PA QL (2tabs/30 days) SP
ZEMAIRA	T4	PA SP
ZOKINVY	T4	PA QL (4 caps/day) SP
UNCLASSIFIED DRUG PRODUCTS (Blood Modifiers/Bleeding Disorders)		
SPLEEN TYROSINE KINASE INHIBITORS		
TAVALISSE	T4	PA SP
UNCLASSIFIED DRUG PRODUCTS (Blood Pressure/Heart Medications)		
BRADYKININ B2 RECEPTOR ANTAGONISTS		
icatibant acetate	T4	PA SP HD
CI ESTERASE INHIBITORS		
BERINERT	T4	PA SP HD
CINRYZE	T4	PA SP HD
HAEGARDA	T4	PA SP HD
RUCONEST	T4	PA SP HD
PLASMA KALLIKREIN INHIBITORS		
KALBITOR	T4	PA SP HD
ORLADEYO	T4	PA QL (1 caps/day) SP

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

T4 – Specialty Medications

PA – Prior Authorization

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List of Prescription Medications

UNCLASSIFIED DRUG PRODUCTS (Cancer)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
CHEMOTHERAPY RESCUE/ANTIDOTE AGENTS		
<i>leucovorin calcium</i>	T1	
MESNEX	T4	SP
VISTOGARD	T4	SP
UNCLASSIFIED DRUG PRODUCTS (Dental Products)		
DENTAL AIDS AND PREPARATIONS		
<i>chlorhexidine gluconate (Peridex)</i>	T1	
PERIDEX (<i>periogard</i>)	T1	
<i>triamcinolone acetonide</i>	T1	
PERIODONTAL COLLAGENASE INHIBITORS		
<i>doxycycline hyclate</i>	T1	
UNCLASSIFIED DRUG PRODUCTS (Erectile Dysfunction)		
DRUGS TO TREAT ERECTILE DYSFUNCTION (ED)		
CAVERJECT	T3	PA 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	PA QL (6 injectors/30 days)
IFE-BIMIX 30/1	T2	
IFE-PG20	T2	
LEVITRA (<i>vardenafil hc</i>)	T3	QL (10 tabs/30 days) ST
MUSE	T2	PA QL (6/30 days)
PAPAVERINE-ALPROSTADIL	T1	
PAPAVERINE-PHENTOLAMINE	T1	
PAPAVERINE-PHENTOLMN-ALPROSTDL	T1	
PHENTOLAMINE-ALPROSTADIL	T1	
<i>sildenafil 100 mg tablet (Viagra)</i>	T1	QL (10 tabs/30 days) HD
<i>sildenafil 25 mg tablet (Viagra)</i>	T1	QL (6 tabs/30 days) HD
<i>sildenafil 50 mg tablet (Viagra)</i>	T1	QL (6 tabs/30 days) HD
STENDRA (<i>avanafil</i>)	T3	QL (8 tabs/30 days) ST
<i>tadalafil 2.5 mg tablet</i>	T1	QL(1 Tab/day)
<i>tadalafil 5 mg tablet (Cialis)</i>	T1	QL (8 tabs/30 days)
<i>tadalafil 10 mg tablet (Cialis)</i>	T1	QL (10 tabs/30 days)
<i>tadalafil 20 mg tablet (Cialis)</i>	T1	PA QL (10 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

UNCLASSIFIED DRUG PRODUCTS (Erectile Dysfunction) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
DRUGS TO TREAT ERECTILE DYSFUNCTION (ED) (cont.)		
TRI-MIX (PAPVRN-PHNTLMN-PGE1)	T3	
vardenafil hcl (Levitra)	T1	QL (10 tabs/30 days)
VIAGRA (sildenafil citrate)	T3	QL (6 tabs/30 days) ST HD

UNCLASSIFIED DRUG PRODUCTS (Gastrointestinal/Heartburn)

CALCIMIMETIC, PARATHYROID CALCIUM ENHANCER		
cinacalcet hcl	T4	SP
ORAL MUCOSITIS/STOMATITIS AGENTS		
EBGLYSS	T2	PA SP
ORAMAGICRX	T3	
PPAR AGONIST		
IQIRVO	T2	
SALIVA STIMULANT AGENTS		
NUMOISYN	T3	
THYROID HORMONE RECEPTOR (THR) AGONIST		
REZDIFRA	T4	PA QL(1 tab/day) SP HD

UNCLASSIFIED DRUG PRODUCTS (Hormonal Agents)

BONE FORMATION STIM. AGENTS - PARATHYROID HORMONE		
teriparatide 600 mcg/2.4ml pen (Forteo)	T4	PA QL(0.09 mls/day) SP HD
GROWTH HORMONE RECEPTOR ANTAGONISTS		
SOMAVERT	T4	PA SP HD
HYPERPARATHYROID TX AGENTS - VITAMIN D ANALOG-TYPE		
doxercalciferol	T1	
PARICALCITOL 10MCG/2ML	T4	SP
PARICALCITOL 2MCG/ML VIAL	T4	SP
PARICALCITOL 5MCG/ML VIAL	T4	SP
RAYALDEE	T3	
ZEMPLAR (paricalcitol)	T4	SP HD
MENOPAUSAL SYMPT SUPP-SEL ESTROGEN RECEP MODULATOR		
OSPHENA	T3	HD

UNCLASSIFIED DRUG PRODUCTS (Miscellaneous)

ABORTIFACIENT-PROGESTERONE RECEPTOR ANTAGONISTS		
MIFEPREX	T3	
mifepristone (Mifeprex)	T1	
ACID AND ALKALI POISON ANTIDOTES		
METHYLENE BLUE 1%	T3	

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

T4 – Specialty Medications

PA – Prior Authorization

QL – Quantity Limit

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List of Prescription Medications

methylene blue 1%	T1		
UNCLASSIFIED DRUG PRODUCTS (Miscellaneous) (cont.)			
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits	
AGENTS TO TX PERIODIC PARALYSIS - CARBON ANHYD INH			
<i>dichlorphenamide</i> (Keveyis)	T4	PA SP	
AMMONIA INHIBITORS			
<i>CARBAGLU</i> (<i>carglumic acid</i>)	T4	SP HD	
<i>carglumic acid</i> (Carbaglu)	T4	SP HD	
AMYLOIDOSIS AGENTS-TRANSTHYRETIN (TTR) SUPPRESSION			
TEGSEDI	T4	PA SP HD	
ANTI-ALCOHOLIC PREPARATIONS			
<i>acamprosate calcium</i>	T1		
<i>ANTABUSE</i> (<i>disulfiram</i>)	T3		
<i>disulfiram</i> (Antabuse)	T1		
ANTIDOTES, MISCELLANEOUS			
CETYLEV	T3		
ANTI-FIBROTIC THERAPY - PYRIDONE ANALOGS			
<i>pirfenidone 267 mg capsule</i> (Esbriet)	T4	PA SP HD	
CATHETER LOCK SOLUTIONS			
DEFENCATH	T3		
CRYOPRESERVATIVE AGENTS			
<i>dimethyl sulfoxide</i>	T1		
DRUGS TO TREAT HEREDITARY TYROSINEMIA			
<i>nitisinone</i> (Orfadin)	T4	PA SP HD	
NITYR	T4	PA SP	
ORFADIN (<i>nitisinone</i>)	T4	PA SP	
GENERAL INHALATION AGENTS			
HYPER-SAL	T3		
<i>nebusal 3% vial</i>	T1		
NEBUSAL 6% VIAL	T3		
<i>sodium chloride for inhalation</i> (Hyper-sal)	T1		
GENETIC D/O TX - SMN PROTEIN DEFICIENCY TREATMENT			
EVRYSDI	T4	PA SP HD	
GLUCOSYL CERAMIDE SYNTHASE INHIBITOR			
CERDELGA	T4	PA SP HD	
<i>miglustat</i> (Zavesca)	T4	PA SP	
OPFOLDA	T4	PA QL(8 caps/30 days) SP HD	
INTERLEUKIN-13 (IL-13) INHIBITORS, MAB			
ADBRY	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

UNCLASSIFIED DRUG PRODUCTS (Miscellaneous) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
MENOPAUSAL SYMPTOMS SUPPRESSANT-NK3 RECEPTOR ANTAG		
VEOZAH	T3	QL(1 tab/day)
MENOPAUSAL SYMPTOMS SUPPRESSANT - SSRIs		
paroxetine mesylate	T1	QL(1 cap/day) HD
METABOLIC DX ENZYME REPLACEMENT, ALPHA-MANNOSIDOSIS		
LAMZEDE	T4	PA SP
METABOLIC DISEASE ENZYME REPLACE, HYPOPHOSPHATASIA		
STRENSIQ	T4	PA SP
METABOLIC DISEASE ENZYME REPLACEMENT, MOCD		
NULIBRY	T4	PA SP
METABOLIC DISEASE ENZYME REPLACEMENT, POMPE DISEASE		
ELFABRIO	T4	PA SP
POMBILITI	T4	PA SP HD
METALLIC POISON, AGENTS TO TREAT		
CHEMET	T3	
deferasirox (Exjade)	T4	SP HD
deferasirox (Jadenu Sprinkle)	T4	SP HD
deferasirox (Jadenu)	T4	SP HD
deferiprone (Ferriprox)	T4	PA SP
EXJADE (deferasirox)	T4	PA SP HD
FERRIPROX	T4	PA SP
GALZIN	T3	
RADIOGARDASE	T3	
trientine hcl	T4	PA SP HD
trientine hcl 250 mg capsule (Syprine)	T4	PA SP HD
TRIENTINE HCL 500 MG CAPSULE	T4	PA SP HD
NATRIURETIC PEPTIDES		
VOXZOGO	T4	PA SP HD
NICOTINIC RECEPT.PARTIAL AGONIST, ALPHA4BETA2 SPEC		
TYRVAYA	T2	QL(8.4 mls/30 days)
OINTMENT/CREAM BASES		
RADIAGEL	T1	
PHARMACOLOGICAL CHAPERONE-ALPHA-GALACTOSID.A STABZ		
GALAFOLD	T4	PA SP HD

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

T4 – Specialty Medications

PA – Prior Authorization

QL – Quantity Limit

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SP – Specialty Medication

HD – May require home delivery pharmacy

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
PKU TX AGENT-COFACTOR OF PHENYLALANINE HYDROXYLASE		
javygtor 100 mg tablet (Kuvan)	T4	PA SP HD
javygtor powder packet (Kuvan)	T4	PA SP
sapropterin dihydrochloride	T4	PA SP HD
PROTEIN STABILIZERS		
ATTRUBY	T3	
VYNDAMAX	T4	PA QL (1 cap/day) SP HD
VYndaQEL	T4	PA QL (4 caps/day) SP HD
SOLVENTS		
isopropyl alcohol	T1	
MURI-LUBE MINERAL OIL	T1	
THYMIC STROMAL LYMPHOPOIETIN (TSLP) INHIBITORS		
TEZSPIRE 210 MG/1.91 ML PEN	T3	PA QL(1 pen/28 days) SP HD
TEZSPIRE 210 MG/1.91 ML SYRING	T4	PA SP HD

UNCLASSIFIED DRUG PRODUCTS (Skin Conditions)

WOUND HEALING AGENTS, LOCAL	T4	PA SP
FILSUVEZ	T4	PA SP

UNCLASSIFIED DRUG PRODUCTS (Osteoporosis Products)

BONE RESORPTION INHIBITOR AND VITAMIN D COMBS.	T3	ST HD
BONE RESORPTION INHIBITORS		
ACTONEL (risedronate sodium)	T3	ST HD
alendronate sodium (FOSAMAX)	T1	HD
ATELVIA (risedronate sodium dr)	T3	ST HD
BINOSTO	T3	ST HD
BONIVA (ibandronate sodium)	T3	ST HD
EVISTA (raloxifene hcl)	T3	HD
FOSAMAX (alendronate sodium)	T3	ST HD
ibandronate sodium (Boniva)	T1	HD
raloxifene hcl (Evista)	T1	HD PPACA
risedronate sodium (Actonel) (Atelvia)	T1	HD
PROLIA	T4	PA SP
XGEVA	T4	PA SP

UNCLASSIFIED DRUG PRODUCTS (Pain Relief And Inflammatory Disease)

ANTI-INFLAM. INTERLEUKIN-1 RECEPTOR ANTAGONIST	T4	PA SP HD
ARCALYST		
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

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

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ANTI-INFLAMMATORY, INTERLEUKIN-1 BETA BLOCKERS		
ILARIS	T4	PA SP HD
FIBROMYALGIA AGENTS, SEROTONIN-NOREPINEPHRINE INHIBITORS		
SAVELLA	T2	HD
IMMUNOMODULATOR, B-LYMPHOCYTE STIM (BLYS)-SPEC INHIB		
BENLYSTA	T4	PA SP HD
UNCLASSIFIED DRUG PRODUCTS (Substance Abuse)		
OPIOID WITHDRAWAL THERAPY, ALPHA-2 ADRENERGIC AGONIST		
lofexidine hcl (Lucemyra)	T1	QL(192 tabs/30 days)
LUCEMYRA (lofexidine hcl)	T2	QL (168 tabs/14 days)
OPIOID WITHDRAWAL THERAPY AGENTS, OPIOID-TYPE		
BUNAVAIL	T3	
buprenorphine hcl	T1	
buprenorphine hcl/naloxone hcl	T1	
buprenorphine hcl/naloxone hcl (Suboxone)	T1	
SUBOXONE (buprenorphine-naloxone)	T3	
ZUBSOLV	T2	
UNCLASSIFIED DRUG PRODUCTS (Transplant Medications)		
RHO KINASE INHIBITOR		
REZUROCK	T4	PA SP HD
UNCLASSIFIED DRUG PRODUCTS (Urinary Tract Conditions)		
BENIGN PROSTATIC HYPERPLASIA/MICTURITION AGENTS		
alfuzosin hcl (Uroxatral)	T1	HD
dutasteride (Avodart)	T1	HD
finasteride (Proscar)	T1	HD
PROSCAR (finasteride)	T3	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

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

T4 – Specialty Medications

PA – Prior Authorization

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List of Prescription Medications

UNCLASSIFIED DRUG PRODUCTS (Urinary Tract Conditions) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
BPH 5-ALPHA-REDUCTASE INHIB-ALPHAI-ADRENOCEP ANTAG		
dutasteride/tamsulosin hcl	T1	HD
CYSTINE-DEPLETING AGENTS, NEPHROPATHIC CYSTINOSIS		
CYSTAGON	T4	SP
KIDNEY STONE AGENTS		
mirabegron er 25 mg tablet (Myrbetriq)	T1	QL(1 tab/day) HD
mirabegron er 50 mg tablet (Myrbetriq)	T1	HD
tiopronin	T4	SP
URINARY TRACT ANTI-SPASMODIC, M(3) SELECTIVE ANTAG.		
darifenacin er 15 mg tablet	T1	HD
darifenacin er 7.5 mg tablet	T1	QL (1 tab/day) HD
solifenacin 10 mg tablet	T1	HD
solifenacin 5 mg tablet	T1	QL (1 tab/day) HD
URINARY TRACT ANTI-SPASMODIC/ANTI-INCONTINENCE AGENT		
flavoxate hcl	T1	HD
oxybutynin 5 mg tablet	T1	HD
oxybutynin 5 mg/5 ml solution	T1	HD
oxybutynin 5 mg/5 ml syrup	T1	HD
oxybutynin chloride	T1	HD
tolterodine tart er 2 mg cap	T1	QL (1 cap/day) HD
tolterodine tart er 4 mg cap	T1	HD
tolterodine tartrate	T1	HD
trospium chloride	T1	HD
UNCLASSIFIED DRUG PRODUCTS (Weight Management)		
APPETITE STIM. FOR ANOREXIA, CACHEXIA, WASTING SYND.		
megestrol acetate	T1	
VITAMINS (Nutritional/Dietary)		
FOLIC ACID PREPARATIONS		
folic acid	T1	
MULTIVITAMIN PREPARATIONS		
CITRANATAL MEDLEY	T3	
FOLET ONE	T2	
mvn no.53/iron/folic/dss/dha	T1	
OBSTETRIX ONE	T1	
VITLIPID N ADULT	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

VITAMINS (Nutritional/Dietary) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
PEDIATRIC VITAMIN PREPARATIONS		
VITLIPID N INFANT	T3	
VITAMIN B PREPARATIONS		
POTABA	T2	HD
NIVA-FOL	T1	HD
VITAMIN B12 PREPARATIONS		
cyanocobalamin (vitamin b-12) (Nascobal)	T1	
VITAMIN D PREPARATIONS		
calcitriol 0.25 mcg capsule	T1	
calcitriol 0.5 mcg capsule	T1	
calcitriol 1 mcg/ml solution	T1	HD
calcitriol 1 mcg/ml vial	T1	
DRISDOL	T3	HD
ergocalciferol (vitamin d2)	T1	HD
ROCALTROL	T3	HD
VITAMIN K PREPARATIONS		
MEPHYTON	T3	
phytonadione 5mg tablet	T1	

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

T4 – Specialty Medications

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HD – May require home delivery pharmacy

PPACA – No Cost-Share Preventive Medication

CSL – Oral cancer medication subject to cost-share limits

Exclusions and limitations for coverage

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

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

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

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

Index of Medications

Symbols

1ST TIER.....	123, 129
2TEK	117
A	
abacavir.....	61
abacavir/lamivudine/zidovudine.....	61
abacavir sulfate/lamivudine.....	61
ABILITY ASIMTUFII.....	144
ABILITY MAINTENA.....	142
abiraterone.....	50
ABOUTTIME.....	123
ACAM2000.....	69
acamprosate.....	159
acarbose.....	44
ACCOLATE.....	29
ACCU-CHEK.....	117, 129
ACCUPRIL.....	78
ACCURETIC.....	76
ACCUTANE.....	147
ACCUTREND	118
ACD-A.....	39
ACD SOLUTION A.....	39
ACE AEROSOL.....	133
acebutolol.....	80
ACETAMIN-CAFF-DIHYDROCODEINE.....	20
acetamin-codein 300-30 mg/12.5.....	20
acetaminop-codeine 120-12 mg/5.....	20
acetaminophen/caff/dihydrocod.....	20
acetaminophen-cod.....	20
acetazolamide.....	95
acetic.....	97, 146
acetic acid/oxyquinoline.....	47
acetylcysteine	30
ACIPHEX	108
acitretin	146
ACTEMRA	116
ACTHIB	69
ACTIGALL	105
ACTI-LANCE	129
ACTIMMUNE	56
ACTIQ.....	21
ACTIVELLA.....	110
ACTONEL.....	161
ACTOPLUS MET.....	45
ACTOS.....	45
ACUVAIL.....	97
acyclovir.....	63
ADACEL TDAP.....	69

ADALAT CC	72
ADALIMUMAB.....	49
ADALIMUMAB-ADAZ.....	49
adapalene	147, 154
adapalene/benzoyl peroxide.....	147
ADBRY	159
ADDERALL.....	66
ADDYI	142
adefovir dipivoxil.....	64
ADEMPAS	74, 75
adenosine.....	72
ADIPEX-P.....	57
ADJUSTABLE.....	118
ADRENALIN	96
ADRIAMYCIN	50
ADUHELM	85
ADVAIR HFA.....	28
ADVANCED	93, 118, 129
ADVANCED DNA MEDICATED COLLECT	93
ADVOCATE.....	118, 123, 127, 129
ADZENYS	66
ADZYNMA	70
AEMCOLO	36
AEROCHAMBER.....	133
AEROTRACH	133
AEROVENT.....	133
AFINITOR	52
AFINITOR DISPERZ.....	52
AFLURIA	68
AGAMATRIX	118
AGGRASTAT	60
AGRYLIN	60
AIMOVIG	14, 18
AIRDUO DIGIHALER.....	28
AIRSUPRA	28
AJOVY	14, 18
AKEEGA	52
AK-FLUOR	94
AKTEN	98
AKYNZE	104
ALA-SCALP	151
albendazole	47
ALBENZA	47
albuterol.....	27, 28
ALBUTEROL	28
ALCAINE	98
alclometasone	151
ALCOHOL	148, 149

Index of Medications

ALDACTAZIDE.....	96	ANADROL-50	109
ALECENSA.....	53	anagrelide.....	60
alendronate.....	161	ANA-LEX.....	109
ALEVICYN PLUS.....	148	ANALPRAM.....	109, 153
alfuzosin.....	162	ANALPRAM HC	153
ALINIA.....	58	ANAPROX DS.....	25
aliskiren.....	81	anastrozole.....	52
ALKALINE.....	118	ANCOBON.....	41
ALKERAN.....	50	ANDRODERM.....	109
allopurinol.....	25	ANDROGEL.....	109
almotriptan malate.....	14, 18	ANGELIQ.....	112
ALOCRIL.....	98	ANNOVERA.....	90
ALOMIDE.....	98	ANORO ELLIPTA	28
ALORA.....	110	ANTABUSE.....	159
alosetron.....	107	anthralin.....	148
alprazolam.....	136	ANTICOAG SODIUM CITRATE.....	39
ALREX.....	97	ANZEMET.....	104
ALTABAX.....	151	APADAZ.....	20
ALTAFLUOR BENOX.....	98	APOKYN.....	58
ALTERNATE.....	118, 129	apractolinidine	98, 99
ALTUVILLO.....	70	aprepitant.....	104
ALVESCO.....	29	APRETUDE.....	62
amantadine.....	58	APRISO	106
AMARYL.....	44	APTIOM.....	87
ambrisentan.....	75	APTIVUS	61
amcinonide.....	151	AQUA.....	118, 151
AMICAR.....	70	AQUA GLYCOLIC HC	151
amiloride.....	95, 96	ARANESP.....	90
AMINO.....	102	ARAVA.....	24
aminocaproic acid.....	70	ARCALYST.....	161
aminophylline.....	30	ARCAPTA NEHALER.....	28
amiodarone.....	72	ARGATROBAN.....	40
amitriptyline	140	ARICEPT.....	65
amitriptyline/chlordiazepoxide.....	140	ARIDOL.....	93
AMJEVITA.....	49	ARIKAYCE.....	32
amlodipine.....	72, 73, 75, 76, 77, 78, 82	ARIMIDEX.....	52
amlodipine-atorvast.....	82	ariPIPRAZOLE	144
amlodipine besylate/benazepril	75, 76	ARIIXTRA.....	39
amlodipine besylate/valsartan	78	armodafnil	145
amlodipine-olmesartan.....	78	ARMOURTHYROID.....	154
amlodipine/valsartan/hcthiazid	77	AROMASIN.....	52
AMMONUL.....	103	ARTHROTEC.....	25
AMNESTEEM	147	ARTISS.....	151
amoxapine	140	ARYMO ER.....	21
amoxicillin.....	36, 47	asenapine	142, 143
amphetamine	66	ASMANEX HFA.....	29
AMPHETAMINE	66	ASMANEX TWISTHALER	29
ampicillin	36	aspirin/dipyridamole	60

Index of Medications

ASSURE	118, 123, 127, 129, 135	BAFIERTAM	86
ASTAGRAF XL	117	BALCOLTRA	91
ASTRINGYN	71	balsalazide	106
ATABEX EC	135	BALVERSA	53
ATACAND	77, 79	BAQSIMI	100
atazanavir	62	BARACLUDE	64
ATELVIA	161	BARRIGEL	134
atenolol	80, 81	BASAGLAR KWIKPEN	46
AT HOME A1C	118	BAXDELA	36
atomoxetine	142	BCG	69
atorvastatin	82, 83	BD	129
atovaquone	48	BELBUCA	21
atovaquone/proguanil	48	BELVIQ	57
atropine	99, 103, 105	BELVIQ XR	57
ATROPINE	99	benazepril	75, 76, 78, 79
ATROVENT HFA	27	benazepril/hydrochlorothiazide	76
ATTRUBY	161	bendamustine	50
AURYXIA	101	BENDAMUSTINE	50
AUSTEDO	85	BENICAR	77, 79
AUTOJECT	118	BENLYSTA	162
AUTO-LANCET	118	benoxinate hcl/fluorescein	98
AUTOLET	118, 121	BENZAMYCIN	37
AUTOSHIELD	123	BENZEFOAM	149
AVALIDE	77	BENZEPRO	149
AVANDIA	45	BENZHYDROCODONE-ACETAMINOPHEN	20
AVAR	38	BENZNIDAZOLE	48
AVC	47	benzonatate	93
AVELOX	36	benzoyl peroxide	37, 38, 147, 149, 150
AVITENE	71	benzphetamine	57
AVONEX	86	benztropine	58
AVSOLA	49	BEPREVE	43
AYGESTIN	114	BERINERT	156
AYVAKIT	53	BESIVANCE	31
AZASAN	117	BETADINE	97
azathioprine	117	betamethasone	42, 151, 152, 154
azelaic acid	151	betamethasone/propylene glyc	151
azelastine	43, 96	BETASERON	86
AZILECT	58	betaxolol	80, 98
azithromycin	35	bethanechol	67
AZMIRO	109	BETIMOL	98
AZOR	78	BETOPTICS	98
B		BEVESPI AEROSPHERE	28
BACIGUENT	31	BEVYXXA	39
bacitracin	31	bexarotene	50
bacitracin/polymyxin b sulfate	31	BEXZERO	68
baclofen	135	BEYAZ	91
BACTRIM	32	bicalutamide	50
BACTRIM DS	32	BIDIL	81

Index of Medications

BIJUVA.....	110
BIKTARVY	63
BILTRICIDE	47
bimatoprost.....	98
BIMZELX.....	148
BINOSTO.....	161
bisac/nacl/nahco3/kcl/peg.....	107
bisoprolol.....	80, 81
BLEPH-10.....	31
BLEPHAMIDE.....	31
BLOOD	70, 71, 118, 120, 125, 129
BLOOD GLUCOSE	118, 120
BLOXIVERZ.....	65
BLU	118, 119
BLULINK.....	118, 119, 129
BLUNT.....	123, 124
BONIVA.....	161
BONJESTA.....	104
BOOSTRIXTDAP.....	69
BORTEZOMIB.....	53
BORUZU.....	53
bosentan	75
BOSULIF.....	53
BREATHERITE.....	133, 134
BREATHRITE.....	134
BREEZE	118
BREO ELLIPTA.....	28
bretylium.....	72
BREVIBLOC	80
BREZTRI AEROSPHERE	29
BRILINTA.....	60
brimonidine	98
brinzolamide	98
BRIUMVI.....	86
BRIVIACT	87
bromfenac.....	97
bromocriptine	58
brompheniramine/pseudoephed/dm	93
BROMSITE	97
BRONCHITOL	155
BRUKINSA	53
BRYHALI	151
budesonide	29, 109, 112
budesonide/formoterol	28
BULLSEYE.....	129
bumetanide	95
BUNAVAIL.....	162
BUPRENEX.....	21
buprenorphine	21, 162
bupropion	137, 154
buspirone	136
butalb-acetamin-caff 50-300-40.....	14, 18
butalb-acetamin-caff 50-325-40.....	14, 18
butalb/acetaminophen/caffeine.....	14, 18
butalb-aspirin-caff 50-325-40.....	14, 18
butalbit/acetamin/caff/codeine	22
butalbital/acetaminophen	14, 18
butalbital-asa-caffeine cap (Fiorinal)	14, 18
butorphanol tartrate.....	21
BUTTRANS.....	21
BUTTERFLY	129
BYDUREON	43
BYETTA	43
BYSTOLIC	80
C	
CABENUVA	60
cabergoline	114
CABLIVI.....	70
CABOMETYX	53
CADUET	82
CAFERGOT	14, 18
caffeine.....	86
CALAN SR	72
calcipotriene	148, 154
CALCIPOTRIENE	148
calcitriol	148, 149, 164
calcium acetate	101
calcium gluc.....	101
CALDOLOR	25
CALQUENCE	53
CAMZYOS	72
candesartan cilexetil	79
candesartan/hydrochlorothiazid	77
capecitabine	51
CAPEX	151
CAPLYTA	142
CAPRELSA	53
captopril	76, 78
captopril-hctz	76
CAPVAXIVE	68
CARBAGLU	159
carbamazepine	87, 89
CARBAMAZEPINE	87
CARBATROL	87
carbidopa	58, 59, 60
carbidopa/levodopa	58, 59

Index of Medications

carbinoxamine.....	42	CHEMSTRIP	118
CARDENE.....	72	CHENODAL	106
CARDURA.....	77	chlordiazepoxide.....	103, 136, 140
CARDURA XL.....	77	chlordiazepoxide/clidinium br.....	103
CAREFINE.....	123	chlorhexidine gluconate.....	157
CAREONE.....	118, 129	chloroquine.....	48
CARESENS.....	118	chlorpromazine.....	145
CARETOUCH	118, 123, 124, 127, 129, 149	chlorpropamide.....	44
carglumic.....	159	chlorthalidone	81, 96
carisoprodol.....	23, 135	chlorzoxazone.....	135
carisoprodol/aspirin.....	23	CHOLBAM	106
carisoprodol/aspirin/codeine.....	23	cholestyramine.....	.83, 84
CAROSPIR.....	95	choline salicyl/mag salicylate14, 18
CAROSPIR SUSP.....	96	CHORIONIC GONAD.....	115
carteolol.....	98	CHOSEN	118, 123
carvedilol.....	76	CIALIS	157
carvedilol er.....	76	CIBINQO	25
CASODEX.....	50	ciclodan.....	42
CATAPRES.....	80	CICLODAN.....	.42, 48
CAVERJECT	157	ciclopirox.....	.42, 48
CAYA CONTOURED.....	92	cilostazol.....	60
CAYSTON	33	CILOXAN	31
cefaclor.....	34	CIMDUO	61
cefadroxil.....	34	cimetidine	106
CEFAZOLIN.....	34	CIMZIA.....	.49
cefdinir.....	34	cinacalcet	158
cefepime.....	34	CINRYZE	156
cefixime.....	34	CIPRO.....	.36
cefpodoxime proxetil	34	ciprofloxacin30, 36
cefprozil.....	34	ciprofloxacin hcl.....	.30
ceftriaxone	34	CIPROFLOXACIN HCL-FLUOCINOLONE30
cefuroxime.....	34	cisplatin	50
CELEBREX.....	27	CISPLATIN	50
celecoxib	27	citalopram	137
CELLCEPT	117	CITRANATAL102, 135
CELONTIN	87	CITRANATAL BLOOM102
CENTANY	37	CITRANATAL MEDLEY163
cephalexin.....	34	CITRATE PHOSPHATE DEXTROSE39
CEQUA.....	100	CLARAVIS147
CEQR.....	118	CLARINEX42, 43
CERDELGA	159	clarithromycin35
CERVIDIL.....	113	clemastine42
ceritirizine.....	43	CLEOCIN34, 35, 38
CETROTIDE	113	CLEVER.....	.118, 129, 134
CETYLEV	159	CLEVER CHOICE HOLDING CHAMBER134
cevimeline.....	67	CLEVIPREX.....	.73
CHANTIX.....	154	CLICKFINE124, 126
CHEMET.....	160	CLIMARA110

Index of Medications

CLINDACIN.....	38	CORLANOR.....	74
CLINDACIN ETZ.....	38	CORTENEMA.....	109
clindamycin.....	34, 35, 37, 38, 147	cortisone	112
CLINDAMYCIN	35	CORTISPORIN.....	37
clindamycin palmitate.....	35	CORVERT.....	72
clobazam.....	87	COSENTYX.....	147, 148
clobetasol.....	152, 153	CRESEMBA.....	41
clobetasol propionate/emolli.....	152	CRINONE.....	114, 115
CLOCORTOLONE.....	152	cromolyn.....	24, 29, 98
clodan	152	crotamiton	58
CLODAN.....	152	CURITY	148
CLODERM	152	CUROSURF.....	156
clofarabine	51	CUVPOSA	103
clomiphene	115	cyanocobalamin	164
clomipramine.....	140	cyclobenzaprine.....	135
clonazepam.....	87	CYCLOGYL.....	99
clonidine	80, 141	CYCLOMYDRIL.....	99
clopidogrel	60	cyclopentolate.....	99
clorazepate dipotassium.....	136	cyclophosphamide	50
clotrimazole	41, 42	CYCLOPHOSPHAMIDE.....	50
clozapine	142, 143	CYCLOSERINE.....	33
CLOZAPINE ODT.....	143	CYCLOSET	44
CLOZARIL.....	143	cyclosporine	117
COAGUCHEK.....	129	CYLTEZO	49
COARTEM	48	CYSTADROPS	100
codeine/butalbital/asa/caffein	22	CYSTAGON.....	163
codeine sulfate.....	21	CYSTARAN	100
colchicine	25, 27, 171, 184	CYSTO-CONRAY II.....	94
COLCRYS.....	25	CYSTOGRAFIN.....	94
colesevelam	83	CYTOMEL.....	154
COLESTID.....	84	CYTOTEC	105
colestipol.....	84	D	
COLOR.....	129	DACOGEN	51
COMBIPATCH	110	dalfampridine	86
COMBIVENT RESPIMAT	28	DALIRESP.....	30
COMETRIQ	53	danazol.....	114
COMFORT	122, 123, 124, 125, 126, 127, 128, 129, 130, 131, 132, 133, 134, 148	DANTRIUM	135
COMIRNATY.....	68	dantrolene.....	135
COMPACT SPACE CHAMBER.....	134	dapsone	33, 148
COMPazine.....	104	DAPTACEL DTAP	69
COMPLERA.....	62	darifenacin er	163
CONTOUR.....	118, 119	darunavir	61
CONTRAVE.....	57	dasatinib53, 54
COOL.....	119	DAURISMO	52
COPIKTRA	53	DAXBIA	34
COREG.....	76	DAXXIFY	67
COREG CR	76	DAYPRO	25
coremino er.....	37	DAYTRANA	141

Index of Medications

DAYVIGO	146
DEFENCATH	159
deferasirox.....	160
deferiprone.....	160
deflazacort.....	112
DELSTRIGO	62
demeclacycline.....	37
DEM SER.....	80
DEPEN.....	24
DEPO-ESTRADIOL	110
DEPO-PROVERA	91, 114
DEPO-SUBQ PROVERA.....	91
DEPO-TESTOSTERONE.....	109
DERMA-SMOOTH-E-FS	152
DERMATOP	152
dermazene	153
DERMAZENE.....	153
DERMOTIC	96
DESCOVY	61
desflurane	23
desipramine	140
desloratadine	43
desmopressin.....	110
desog-e.estriadiol/e.estriadiol	91
desogestrel-ethinyl estradiol	91
desonide.....	152
DESOWEN.....	152
desoximetasone	152, 153
desvenlafaxine succnt er.....	138, 139
dexamethasone	31, 97, 112
DEXCOM	119
DEXILANT	108
dexlansoprazole	108
dexmethylphenidate	141, 172
dextroamp	66
dextroamp-amphet er.....	66
dextroamphetamine	66
dextroamphetamine er.....	66
DIACOMIT	87
diatrizoate	94
DIATRUE	119
diazepam	87, 136
diazoxide	101
DIBENZYLINE.....	67
dichlorphenamide	159
DICLAREAL	147
diclofenac	97, 147
DICLOFENAC EPOLAMINE	147
diclofenac potassium.....	19
diclofenac sod dr.....	26
diclofenac sod ec	26
diclofenac sodium.....	25, 26, 147
diclofenac sodium/misoprostol	25
dicloxacillin	36
dicyclomine hcl.....	103
diethylpropion	57
DIFCID	35
diflunisal	14, 18
digoxin	74
dihydroergotamine	14, 18
DILANTIN.....	88
DILATRATE-SR	74
diltiazem	73
dimethyl	86, 159
DIOVAN.....	77, 79
diphenoxylate hcl/atropine	103
DIPHTHERIA-TETANUS TOXOIDS-PED	69
DIPROLENE	152
dipyridamole	60
DISALCID	24
disopyramide	72
disulfiram	159
DIURIL.....	96
divalproex	88
DIVIGEL	110
docetaxel	56
dofetilide	72
DOJOLVI	100
donepezil	65
DONNATAL	105
DOPTELET	90
DORAL	145
dorzolamide	98, 99
DOVATO	60
DOVONEX	148
doxazosin	77
doxepin	140, 146
doxercalciferol	158
doxycycline	37, 157
doxylamine succinate/vit b6	104
DRISDOL	164
dronabinol	104
DROPLET	119, 124, 127, 130
DROPSAFE	124, 125, 127, 148
drospir/eth estra/levomefol ca.....	91
DROXIA	71

Index of Medications

droxidopa	67	emollient combination no.60	149
DRYSOL	148	Empaveli	70
DUAVEE	112	EMSAM	137
DUETACT	45	emtricitabine	61
DULERA	28	emtricitabine-tenofov	61
duloxetine	139	EMTRIVA	62
DUOPA	59	EMVERM	47
DUPIXENT	116	enalapril	76, 78, 79
DURAGESIC	21	enalaprilat	78
duasteride	162, 163	enalapril/hydrochlorothiazide	76
duasteride/tamsulosin	163	ENBREL	49
DYANAVEL XR	66	ENDO-AVITENE	71
DYAZIDE	96	ENDOMETRIN	115
E		ENGERIX	70
EASIVENT	134	ENGERIX-B	70
EASY	119, 124, 127, 130, 148, 149	ENHERTU	56
EASYGLUCO	119	ENLITE	120
EASYMAX	119	enoxaparin	39, 40
EASYPOINT	124	ENSPRYNG	116
EBGLYSS	158	entacapone58, 59
ECLIPSE	124, 127	entecavir	64
EC-NAPROSYN	26	ENTERO VU	94
econazole	42	ENTOCORT EC	112
ECOZA	42	ENTRESTO	77
edaravone	85	ENVARSUS XR	117
EDARBI	79	ENZOCLEAR	149
EDEX	157	EPCLUSIA	64
EDURANT	61	EPIDIOLEX	87
efavirenz	61, 62	EPIFOAM	153
effer-k	102	epinastine	43
EFFER-K	102	epinephrine65, 67, 96
EFFIENT	60	EPIVIR	64
EFUDEX	57	eplerenone	95
EGRIFTA	112	EPOGEN	90
ELEMENT	119	eprosartan	79
ELESTRIN	110	eptifibatide	60
eletriptan hydrobromide	14, 18	EQUETRO	137
ELFABRIO	160	ergocalciferol	164
ELIDEL	116	ergoloid	81
ELIMITE	58	ergotamine tartrate/caffeine14, 18
ELIQUIS	39	eribulin	52
ELLA	91	ERIVEDGE	52
ELMIRON	23	ERLEADA	51
EMBRACE	119, 120, 124, 130	erlotinib	54
EMCYT	56	ERVEBO	70
EMEND	104	ERYPED	35
EMFLAZA	112	ery-tab dr	35
EMGALITY	14, 18, 86	ERY-TAB DR	35

Index of Medications

erythromycin.....	31	EZ.....	69, 120, 124, 127, 129, 130
erythromycin base.....	35, 38	E-Z DISK.....	94
erythromycin ethylsuccinate.....	35	ezetimibe.....	.81, 82, 84
erythromycin stearate.....	35	ezetimibe/simvastatin.....	.81
ERZOFRI.....	143	EZ FLU.....	69
escitalopram	137, 138	E-Z-HD	94
ESGIC.....	14, 18	E-Z-PAQUE.....	94
esmolol	81	E-Z-PASTE.....	94
esomeprazole dr.....	108	E-Z SPACER.....	134
esomeprazole mag dr.....	108	EZ-VAC.....	120
ESOMEPRAZOLE STRONTIUM.....	108	F	
estazolam.....	145	FABHALTA.....	70
ESTRACE.....	114	FACTIVE.....	36
estradiol	90, 91, 92, 110, 111, 114, 115	famciclovir.....	63
ESTRING.....	115	famotidine.....	106
ESTROGEL.....	111	FARESTON.....	56
estrogen, ester/me-testosterone	110	FARXIGA.....	44
ESTROSTEP FE.....	91	FARYDAK.....	50
eszopiclone	146	febuxostat	25
ethacrynat.....	95	felbamate.....	88
ethambutol	33	FELDENE.....	26
ethinyl estradiol/drospirenone.....	91	felodipine.....	73
ethosuximide	88, 89	FEMARA.....	.52, 53
etodolac	26	FEMCAP.....	92
etonogestrel/ethinyl estradiol.....	90	FEMHRT.....	111
EUCRISA.....	151	FEMRING.....	115
EURAX.....	58	fenofibrate.....	84
EVAMIST.....	111	fenofibric.....	84
EVEKEO.....	.66	fenoprofen calcium.....	26
EVENCARE.....	120	FENSOLVI.....	113
everolimus.....	52, 117	fentanyl.....	21
EVICEL	71	FENTANYL.....	21
EVISTA.....	161	FENTORA.....	21
EOCLIN.....	38	FERAHEME.....	102
EVOLUTION.....	120	FERRIPROX.....	160
EVOTAZ.....	62	FETZIMA.....	139
EVOXAC.....	67	FETZIMA ER.....	139
EVRYSDI.....	159	FEXMID.....	135
EXEL.....	124	FIBRICOR.....	84
EXELON.....	.65	FIFTY50.....	130
exemestane.....	52	FILSUVEZ.....	161
EXFORGE	77, 78	FILTER	124, 125
EXFORGE HCT.....	.77	finasteride	162
EXJADE.....	160	FINE	126, 129, 130
EXKIVITY.....	.54	FINGERSTIX.....	130
EXODERM.....	.42	FINTEPLA.....	.88
EXTENCILLINE.....	.36	FIORICET.....	.14, 18, 22
EYSUVIS97	FIORINAL.....	.14, 18

Index of Medications

Fiorinal With Codeine #3.....	22	FOLET ONE.....	163
FIORINAL WITH CODEINE #3.....	22	folic acid.....	163
FIRDAPSE.....	86	FOLLISTIM AQ.....	115
FIRMAGON.....	53	fondaparinux.....	39
FLAGYL.....	32	FORA.....	120, 130
FLAREX.....	97	FORACARE.....	120, 130
flavoxate.....	163	formaldehyde.....	48
flecainide.....	72	FORTISCARE.....	120
FLECTOR.....	147	FOSAMAX.....	161
FLEQSUVY.....	135	fosamprenavir calcium.....	62
FLEXICHAMBER.....	134	fosaprepitant.....	104
FLOVENT.....	29	fosfomycin tromethamine.....	33
FLOW-EZE.....	124	fosinopril.....	76, 78
FLUAD.....	69	fosinopril/hydrochlorothiazide.....	76
FLUARIX QUAD.....	69	fosphenytoin.....	87, 88
FLUBLOK.....	69	Fotivda.....	54
FLUCELVAX QUAD.....	69	FRAGMIN.....	39
fluconazole.....	41	FRAICHE.....	100
flucytosine.....	41	FREESTYLE.....	120, 127, 130
fludrocortisone.....	113	FREESTYLE LIBRE.....	120
FLULALVAL QUAD.....	69	frovatriptan succinate.....	18
FLUMADINE.....	63	ful-glo.....	94
FLUMIST QUAD.....	69	FUL-GLO.....	94
flunisolide.....	96	FULPHILA.....	90
fluocinolone acetonide.....	96, 152, 153	FURADANTIN.....	35
fluocinolone/shower cap.....	152	FUROSCIX.....	95
fluocinonide.....	152	furosemide.....	95
fluorescein.....	94, 98	FUZEON.....	61
fluoride.....	100	FYCOMPA.....	88
fluorometholone.....	97	G	
FLUOROPLEX.....	57	gabapentin.....	87, 88
fluorouracil.....	57	GALAFOLD.....	160
fluoxetine.....	138, 145	galantamine.....	65
fluphenazine.....	145	galantamine er.....	65
flurbiprofen.....	26, 97	GALZIN.....	160
flutamide.....	51	GANCICLOVIR.....	63
fluticasone.....	28, 96, 152	ganirelix acet.....	113
FLUTICASONE.....	29	GANIRELIX ACET.....	113
fluticasone propion/salmeterol.....	28	GARDASIL 9.....	70
fluticasone-salmeterol	28, 29	GASTROCROM.....	24
FLUTICASONE-SALMETEROL.....	29	GASTROGRAFIN.....	94
fluvastatin.....	83	GASTROMARK.....	94
FLUVIRIN.....	69	gatifloxacin.....	31, 32
fluvoxamine.....	138	GATTEX.....	109
FLUZONE HIGH-DOSE.....	69	GAVRETO.....	54
FLUZONE QUAD.....	69	GE100.....	120
FML.....	97	GE333.....	120
FOCALIN.....	141	gefitinib.....	54

Index of Medications

gelatin sponge, absorb/porcine	71	GVOKE	101
GELFILM	98	GYNAZOLE 1	41
GELFOAM	71	H	
GEL-ONE	24	HAEGARDA	156
gemcitabine	51	HALAVEN	52
GEMCITABINE	51	HALCION	145
gemfibrozil	84	halobetasol	152, 153
GENERESS FE	91	haloperidol	144
GENOTROPIN	113	HALUCORT	149
gentamicin	32, 38	HARVONI	64
gentamicin sulfate	31	HEALTHPRO	121
GENTEEL	119, 120	HEALTHWISE	124, 127
GENVISC	24	HEALTHY	121, 124, 130
GENVOYA	63	HEMLIBRA	71
GILENYA	86	HEMOCYTE PLUS	102
GILOTrif	54	heparin	39, 40
glatiramer	86	HEPARIN	40
glatopa	86	HEPLISAV	70
GLEEVEC	54	HEPLISAV-B	70
GLEOSTINE	50	HETLIOZ	145
glimepiride	44, 45	HIBERIX	69
glipizide	44, 45	homatropine	93, 99
GLUCAGEN	101	HUMALOG	46
glucagon	101	HUMAPEN	121
GLUCOCARD	120	HUMIRA	49
GLUCOCOM	120, 130	HUMULIN	46, 176
GLUCOPHAGE XR	44	HUMULIN R	46
GLUCOSE	101, 117, 118, 119, 120, 121, 122	HYCAMTIN	53
GLUCOTROL	44	HYCODAN	93
glyburide	45	hydralazine	80
GLYCATE	103	HYDREA	50
glycine	48	HYDRO 35	150
glycopyrrolate	103	HYDRO 40	150
GLYNASE	45	hydrochlorothiazide	76, 77, 78, 80, 81, 96
GLYSET	44	hydrocodone/acetaminophen	20
GLYXAMBI	45	HYDROCODONE-ACETAMINOPHEN	20
GOJJI	120, 130	hydrocodone bitartrate	21, 22
GONAL-F	115	hydrocodone bit/homatrop me-br	93
GORDON'S UREA	151	hydrocodone/chlorphen p-stirex	93
granisetron	104	hydrocodone/cpm/pseudoephed	93
GRANIX	90	HYDROCODONE-GUAIFENESIN	93
GRASTEK	67	hydrocodone-homatropine	93
griseofulvin	41	HYDROCODONE-HOMATROPINE	93
GRIS-PEG	41	hydrocodone/ibuprofen	20
GUAIACOL	149	hydrocortisone	97, 109, 112, 152, 153
guanfacine	80, 141	hydrocortisone/acetic acid	97
guanidine	67	HYDROMORPHONE	21
GUARDIAN	120, 121	hydromorphone hcl	21

Index of Medications

hydroxychloroquine.....	48	INGREZZA.....	85
hydroxyprogesterone.....	115	INJECTAFER	102
hydroxyprogesterone.....	114	INLYTA	54
hydroxyurea	50	INNOPRAN XL.....	81
hydroxyzine.....	42, 43	INOVA	150
hyoscyamine.....	105	INPEN	121
HYPER-SAL	159	INQOVI.....	51
HYPODERMIC.....	123, 124	INREBIC.....	54
HYPOLANCE.....	121	INSPIRACHAMBER.....	134
HYSINGLA ER.....	21	INSPRA	95
HYZAAR.....	77	INSUL-CAP	121
I		INSUL-EZE	121
ibandronate.....	161	INSULIN.....	44, 45, 46, 113, 124, 125, 127, 128, 129
IBRANCE.....	54	INSULIN ASPART	46
IBUDONE	20	INSULIN LISPRO	46
ibuprofen.....	20, 26	INSUPEN.....	124
ibuprofen/oxycodone hcl	20	INTEGRA.....	124
ibutilide.....	72	INTRAROSA	109
icatibant	156	INTRON A	56
icosapent.....	103	INVEGA	143
IDHIFA.....	56	INVEGA ER.....	143
IFE.....	157	INVELTYS	97
IHEALTH.....	121	iodine/potassium iodide	153
ILARIS.....	162	iodine/sodium iodide	153
ILEVRO.....	97	IODOFLEX	153
ILUMYA.....	147	IODOSORB	153
imatinib.....	54	IOPIDINE	99
IMBRUVICA	54	IPOL.....	68
IMCIVREE.....	57	ipratropium/albuterol sulfate	28
IMDELLTRA	56	ipratropium bromide	27, 96
imipenem.....	34	irbesartan.....	77, 79
imipramine	140	irbesartan/hydrochlorothiazide	77
imiquimod	149	IRESSA	54
IMMPHENТИV	74	ISENTRESS	62
IMPAVIDO.....	48	isoflurane	23
IMURAN	117	isomethcpt/dichlphn/acetaminop	18
IMVEXXY	114	isomethhept/caf/acetaminophen.....	18
INBRIJA.....	59	isoniazid	33
INCONTROL	121, 124, 130, 148	isopropyl alcohol	161
INCRELEX.....	113	ISOPTO CARPINE	99
INCRUSE ELLIPTA	27	isosorbide	74, 81
indapamide.....	96	isotretinoin	147
INDICLOR	94	isoxyprine	81
indomethacin.....	26	isradipine	73
INFANRIX DTAP.....	69	itraconazole	41
INFASURF	156	ivabradine hcl	74
INFINITY	121	ivermectin	47, 58, 151
INFLECTRA.....	49	IWILFIN	54

Index of Medications

IXCHIQ	70	LAGEVRIO	62
J		lamivudine	61, 62, 64
JAKAFI	52	lamivudine/zidovudine	61
JANSSEN COVID-19 VACCINE	68	lamotrigine	88
JANUMET	45	LAMPIT	48
JANUMET XR	45	LAMZEDÉ	160
JANUVIA	44	LANCING	117, 118, 119, 120, 121, 122, 123
JARDIANCE	44	lanreotide	114
javygtor	161	LANREOTIDE	114
JOENJA	156	lansoprazole/amoxiciln/clarith	105
JULUCA	60	lansoprazole dr	108
JUXTAPID	82	lansoprazole odt	108
JYLYAMVO	51	lanthanum	101
JYNARQUE	95	LANZO	121
JYNNEOS	70	lapatinib	54, 55
K		LASTACRAFT	43
KADIAN	21	latanoprost	99
KALBITOR	156	LAZANDA	21
KALYDECO	155, 156	LEDIPASVIR-SOFOSBUVIR	64
KEFLEX	34	leflunomide	24
KEPPRA	88	lenalidomide	53
KERAFOAM	150	LETOCILIN	36
keralyt	150	LENVIMA	54
KERALYT	150	L.E.T.	23
KERENDIA	95	LETAIRIS	75
KESIMPTA	86	letrozole	52
ketoconazole	41, 42	leucovorin	157
ketoprofen	26	LEUKERAN	50
ketorolac	19, 97	LEUKINE	90
KEVZARA	116	leuprolide	53
KINERET	24	levalbuterol hcl	28
KINRIX	69	LEVIBID	105
KISQALI	53, 54	LEVEMIR	46
KITABIS PAK	32	levetiracetam	88
KLARON	148	LEVITRA	157
KLONOPIN	87	levobunolol	99
klor-con	102	levofloxacin	31, 36
Kloxxado	40	levonorgestrel/ethin.estradiol	91
KOSELUGO	52	levothyroxine	154
K-PHOS	102	LEVOHYROXINE	154
KRINTAFEL	48	LEVSIN	105
KYLEENA	92	LEVULAN	56
KYNAMRO	82	LEXIVA	62
KYNMOBI	59	LIBERVANT	87
L		LICART	147
LABETALOL	77	lidocaine	23, 93, 109, 153
LACRISERT	97	lidocaine 5% ointment	23
lactulose	103, 107	lidocaine hcl	23

Index of Medications

LIDOCaine-HYDROCORTISONE	109	lubiprostone	107
LIFESHIELD	124	LUCEMYRA	162
LIKMEZ	32	LUER	127
LILETTA	92	LULICONAZOLE	42
linezolid	36	LUMAKRAS	52
LINZEss	107	LUMRYZ	145
lothyronine	154, 155	LUPANETA	113
LIPOFEN	84	LUPKYNIS	117
LIQUID E-Z PAQUE	94	LUPRON DEPOT	113
LIQUID POLIBAR PLUS	94	Iurasidone	143
lisdexamfetamine	66	LUXIQ	152
lisinopril	76, 78, 79	LYNPARZA	54
lisinopril/hydrochlorothiazide	76	LYRICA	88
lissamine green	94	LYSTEDA	70
LITEAIRE	134	LYTGOGI	54
LITE TOUCH	121, 125, 127, 130, 134	LYUMJEV	46
LITETOUCH	127, 134	M	
LITFULO	25	MACROBID	35
lithium	137	MACRODANTIN	35
LITHOSTAT	103	mafénide	38
LIVALO	83	MAGELLAN	127
LIVTENCY	63	MAGNI-GUIDE	121
L-MESITRAN	151	MAKENA	115
LOCORT	112	MALARONE	48
LODINE	26	malathion	153
LOESTRIN	91	maprotiline	140
lofexidine	162	MARCAINE	23
LOKELMA	101	MARPLAN	137
LOMAIRA	57	MATULANE	56
LONGHALA MAGNAIR	27	MAVENCLAD	86
loperamide	103	MAXI	127
LOPID	84	MAXICOMFORT	125, 127
lopinavir/ritonavir	62	MAXIDEX	97
LOPROX	42	MAYZENT	86
LOQTORZI	51, 55	meclofenamate sodium	26
lorazepam	136	MEDIHONEY	151
LORBRENA	54	MEDISENSE	121, 130
LORTAB	20	MEDROL	112
losartan/hydrochlorothiazide	77	medroxyprogesterone	91, 114
losartan potassium	79	mefenamic acid	19
LOTEMAX	97	mefloquine	48
LOTENSIN	76, 79	megestrol	56, 163
LOTENSIN HCT	76	MEKINIST	52
loteprednol	97	meloxicam	26
LOTREL	76	melphalan	50
lovastatin	83	memantine	84, 85
LOVAZA	103	MENACTRA	68
LOVENOX	40	MENEST	111
loxapine	144	MENOPUR	115

Index of Medications

MENOSTAR.....	111	MICRODOT.....	121, 125
MENQUADFI.....	68	MICROGESTIN 24 FE.....	91
MENVEO A-C-Y-W-135-DIP.....	68	MICROLET.....	121, 130
meperidine hcl.....	21	MICROSPACER.....	134
MEPHYTON.....	164	midazolam.....	145
meprobamate.....	136	midodrine.....	67
mercaptopurine.....	51	MIEBO.....	97
meropenem.....	34	MIFEPREX.....	158
mesalamine.....	106	mifepristone.....	44, 158
MESNEX.....	157	miglitol.....	44
metaxalone.....	135	millipred.....	112
metformin.....	44, 45	MILLIPRED.....	112
methadone hcl.....	21	MIMYX.....	149
methamphetamine.....	66	MINI.....	49, 118, 119, 121, 122, 123, 125, 126, 129, 133
methazolamide.....	95	MINIMED.....	121, 127, 128
methenamine hippurate.....	33	MINIPRESS.....	77
methenamine mandelate.....	33	MINITRAN.....	74
methimazole.....	154	MINIVELLE.....	111
METHITEST.....	109	minocycline.....	37
methocarbamol.....	135	minocycline er.....	37
methotrexate.....	51	minoxidil.....	80
methoxsalen.....	147	mirabegron.....	163
methscopolamine.....	105	MIRCERA.....	90
methyldopa.....	80	MIRCETTE.....	91
methylldopate.....	80	MIRENA.....	92
methylene.....	158	mirtazapine.....	136
METHYLENE.....	158	misoprostol.....	25, 105
methylergonovine.....	113	MITIGARE.....	25, 180
METHYLIN.....	141	MITOSOL.....	99
methylphenidate.....	141, 142	M-M-R II VACCINE.....	69
methylphenidate er.....	141, 142	MOBIC.....	26
methylprednisolone.....	112	MOBILE.....	121, 131
methyl salicylate.....	149	modafinil.....	145
methyltestosterone.....	109	MODERNA COVID-19 VACCINE.....	68
metoclopramide.....	107	moexipril.....	79
metolazone.....	96	molindone.....	145
METOPIRONE.....	94	MOLNUPIRAVIR.....	65
metoprolol.....	81	MOMETACURE.....	152
metoprolol/hydrochlorothiazide.....	81	mometasone.....	96, 152
metronidazole.....	32, 37, 151	MONOFERRIC.....	102
metyrosine.....	80	MONOJECT.....	125, 128
mexiletine.....	72	MONSEL'S.....	71
MEZPAROX-HC.....	153	montelukast sodium.....	29
MIACALCIN.....	116	MONUROL.....	33
MICAFUNGIN.....	41	MORPHABOND ER.....	21
MICARDIS.....	77, 78, 79	morphine sulfate.....	21, 22
miconazole.....	41	MOTOFEN.....	103
MICROCHAMBER.....	134	MOVANTIK.....	40

Index of Medications

MOXATAG.....	36	NEBUSAL.....	159
MOXEZA.....	31	needles.....	125
moxifloxacin.....	36	NEEDLES.....	123, 124, 125, 126, 127, 133
moxifloxacin hcl.....	31	nefazodone.....	138
MRESVIA.....	70	neomycin	30, 31, 32, 146
MS CONTIN.....	22	neomycin/bacit/p-myx/hydrocort.....	30
MULPLETA.....	90	neomycin/polymyxin b/dexametha.....	30
MULTAQ.....	72	neomycin/polymyxin b/hydrocort.....	31
MULTI-LANCET.....	121	neomycin/polymyxn b/gramicidin.....	31
mupirocin.....	38	neomycin sulf/bacitracin/poly	31
mupirocin calcium.....	38	neostigmine.....	65
MURI-LUBE.....	161	NEO-SYNALAR.....	37
MUSE.....	157	NERLYNX.....	54
mvn no.53/iron/folic/dss/dha	163	NEULASTA.....	90
MYALEPT.....	115	NEULUMEX.....	94
MYAMBUTOL.....	33	NEUPOGEN.....	90
mycophenolate.....	117	NEUPRO.....	59
MYDAYIS.....	66, 140	NEURONTIN.....	88
MYDRIACYL.....	99	nevirapine	61
Myfembree.....	113	NEXIUM.....	108
MYGLUCOHEALTH.....	121, 131	NEXIUM DR.....	108
MYLERAN.....	50	NEXLETOL.....	82
MYOBLOC.....	67	NEXLIZET.....	82
MYORISAN.....	147	NEXPLANON.....	91
MYTESI.....	103	NEXTERONE.....	72
N		Nextstells.....	91
nabumetone	26	niacin.....	84
nadolol	81	NIASPAN.....	84
naftifine.....	42	nicardipin	73
NAFTIN.....	42	nicardipine	73
NALFON.....	26	NICOTROL.....	154
NALOCET	20	nifedipine	72, 73
naloxone.....	22, 40, 162	nilutamide	51
NALOXONE	40	nimodipine	73
naltrexone	40	NINLARO	54
NAMENDA.....	85	nisoldipine er	73
NAMZARIC	85	nitazoxanide	58
NANO	125, 126	nitisinone	159
NAPROSYN.....	26	NITRO-DUR.....	74
naproxen	19, 25, 26	nitrofurantoin	35, 36
naratriptan hcl	18	nitroglycerin	74
NARCAN	41	NITROLINGUAL.....	74
NATACYN	41	NITROMIST	74
NATAZIA	91	nitroprusside	80
nateglinide	45	NITROSTAT	74
NAYZILAM	87	NITYR.....	159
NEBUPENT.....	48	NIVA-FOL.....	164
nebusal.....	159	NIVESTYM	90

Index of Medications

nizatidine	106	ODEFSEY	62
NOCTIVA	110	ODOMZO	52
NOKOR	125	OFEV	156
NORCO	20	ofloxacin	31, 36
NORDITROPIN FLEXPRO	113	OGIVRI	53
norelgestromin/ethin.estradiol	92	OGSIVEO	54
NOREPINEPHRINE	137, 138, 139	OJEMDA	52
noreth-ethinyl estradiol/iron	91	OJJAARA	54
norethind-eth estrad	91, 111	olanzapine	143, 145
norethindrone	91, 92, 111, 114	olmesartan/amlodipin/hctiazid	77
norgestrel-ethinyl estradiol	92	olmesartan-hctz	78
NORLIQVA	73	olmesartan medoxomil	79
NORPACE	72	olopatadine	43, 96
NORPACE CR	72	OLPRUVA	103
nortriptyline	140	OLUMIANT	25
NORVASC	73	omega-3 acid ethyl esters	103
NORVIR	62	omeprazole dr	108
NOURIANZ	59	OMISIRGE	71
NOVAMAX	121	OMNIPOD	122
NOVAREL	115	OMNIPRED	97
NOVAVAX	68	OMNITROPE	113
NOVOFINE	125	ON CALL	122, 131
NOVOPEN	121	ondansetron	104
NOVOTWIST	125	ONETOUCH	122, 131
NUBEQA	51	ONFI	87
NUCORT	152	ON-THE-GO	131
NUCYNTA	22	ONUREG	51
NUCYNTA ER	22	OPDIVO	55
NUEDEXTA	86	OPFOLDA	159
NULEV	105	opium	22, 104
NULIBRY	160	opium/belladonna alkaloids	22
NULYTLY	107	OPSUMIT	75
NUMOISYN	158	OPSYNVI	75
NUPLAZID	137	OPTICHAMBER	134
NURTEC ODT	18	OPTUMRX	122
NUVARING	90	OPVEE	41
NUZYRA	37	ORACIT	102
NYMALIZE	73	ORALAIR	68
nystatin	41, 42	ORAMAGICRX	158
NYVEPRIA	90	ORAPRED ODT	112
O		ORAVIG	41
OBREDON	93	ORENCIA	24
OBSTETRIX EC	135	ORENITRAM	75
OBSTETRIX ONE	163	ORENITRAM ER	75
OBTREX	135	ORFADIN	159
OCALIVA	106	ORGOVYX	53
OCREVUS	86	ORIAHNN	113
octreotide	114	ORILISSA	113
OCUFLOX	31	ORKAMBI	155
ODACTRA	67		

Index of Medications

ORLADEYO.....	156	paroxetine	138, 160
orphenadrine	135	paroxetine cr	138
ORTHO MICRONOR.....	92	paroxetine er	138
oseltamivir	63	PASER	33
osmitrol.....	95	PATADAY.....	43
OSMITROL.....	95	PATANASE.....	96
OSMOLEX ER.....	59	PAVBLU.....	99
OSPHENA.....	158	PAXLOVID	65
OTEZLA.....	24	PAZEO.....	43
OTOVEL.....	30	pazopanib	54
OTREXUP.....	24	PCE	35
OVACE PLUS	149	PEDIARIX	70
OVAL.....	122	PEDVAXHIB	69
OVIDE.....	153	peg3350/sod sulf, bicarb, cl/kcl	107
oxandrolone.....	110	peg3350/sod sul/nacl/kcl/asb/c	107
oxaprozin.....	25, 26	PEGANONE	88
OXAPROZIN.....	26	PEGASYS	64
OXAYDO.....	22	PEGINTRON	64
oxazepam.....	136	PEMAZYRE	54
oxcarbazepine	88	PEMRYDI	51
OXERVATE.....	100	PENBRAYA	68
OXSORALEN-ULTRA.....	147	penicillamine	24
OXTELLAR XR.....	88	penicillin v potassium	36
oxybutynin.....	163	PEN NEEDLES	123, 124, 125, 126
oxycodone hcl	20, 22	PENTACEL	69
oxycodone hcl/acetaminophen	20	pentamidine	48
OXYCODONE HCL ER	22	pentazocine hcl/naloxone hcl	22
oxymorphone hcl.....	22	PENTIPS	123, 125, 126
OZEMPIC	43	pentoxifylline	71
OZOBAX DS	135	PERCOSET	20
P		PERIDEX	157
pacerone.....	72	perindopril	79
PACNEX.....	150	permethrin	58
PAIN EASE MEDIUM STREAM SPRAY.....	23	perphenazine	140, 145
paliperidone er.....	143	perphenazine/amitriptyline	140
palonosetron	104	PFIZER COVID-19 VACCINE.....	68
PALYNZIQ.....	68	PHARMABASE BARRIER	150
PANCREAZE	107	PHASEAL	125
PANRETIN	57	PHEBURANE	103
pantoprazole	108	phenazopyridine hcl	24
PANTOPRAZOLE.....	108	phendimetrazine	57
PAPAVERINE-ALPROSTADIL	157	phenelzine	137
PAPAVERINE-PHENTOLAMINE	157	phenobarb/hyosc/atropine/scop	105
PAPAVERINE-PHENTOLMN-ALPROSTDL.....	157	phenobarital	105, 145
PARADIGM	128	phenobarbital-belladonna	105
PARAGARD	92	PHENOBARBITAL-BELLADONNA	105
paregoric	104	phenoxybenzamine	67
PAREMYD	99	phentermine	57
paricalcitol.....	158	PHENTOLAMINE-ALPROSTADIL.....	157
paramomycin.....	47	phenylephrine	42, 98

Index of Medications

phenylephrine hcl/prometh.....	42	potassium citrate/citric acid	102
PHENYTEK.....	88	potassium iodide/iodine	101
phenytoin.....	88	pramipexole	59
PHESGO.....	53	pramipexole er	59
PHOSLYRA.....	101	PRAMOSONE.....	153
PHOSPHOLINE IODIDE.....	99	prasugrel	60
PHYSIOLYTE.....	146	pravastatin	83
PHYSISOL.....	146	praziquantel	47
physostigmine	65	prazosin	77
phytonadione	164	PR BENZOYL PEROXIDE	150
PIASKY.....	70	PRECISIONGLIDE	124, 125
PICATO	57	PRECOSE	44
PIFELTRO.....	61	PRED MILD	97
pilocarpine	67, 99	prednicarbate	152, 153
pimecrolimus	116	prednisolone	31, 97, 112
pimozide	142	prednisone	112
pindolol	81	pregabalin	88, 89
pioglitazone	45	PREGNYL	115
PIP	122, 125, 131	PREMARIN	111, 115
PIQRAY	54	PREMPHASE	111
pirfenidone	159	PREMPRO	111
piroxicam.....	26	prenatal 12/iron/folic/dss/om3	136
pitavastatin	83	PRENATAL 19.....	136
PLAQUENIL.....	48	prenatal 34/iron/folic/dss/dha	136
PLAVIX.....	60	prenatal vits15/iron/folic/dss.....	136
PLEGRIDY	86	PREPIDIL	113
PLIXDA	154	PREPOPIK	107
PNEUMOVAX 23.....	68	PRESTALIA	76
pnv	136	PRETOMANID	33
pnv 22/iron, gluc/folic/dss/dha.....	135	PREVACID DR	108
pnv 66/iron/folic/docusate/dha	135	PREVENT	125
pnv 69/iron/folic/docusate/dha	135	PREVIDENT	100
pnv 80/iron fum/folic/dss/dha	136	PREVNAR 13.....	68
pnv/ferrous fum/docusate/folic	136	PREVYMIS	63
pnv/iron, carb/docusat/folic ac	136	PREZCOBIX	61
POCKET CHAMBER	134	PREZISTA	61
PODOCON-25	150	PRIFTIN	33
podoflox	150	PRILOSEC DR	108
POLIBAR ACB	94	primaquine	48
polydimethylsiloxanes/silicon	150	PRIMAQUINE	48
POLY HUB	125	Primaxin	34
POMALYST	53	PRIMAXIN	34
POMBILITI	160	PRIMEAIRE	134
Ponvory	86	primidone	89
POTABA	164	PRIMLEY	20
potassium	19	PRIMSOL	33
POTASSIUM	95, 96, 102, 107	PRINVIL	79
potassium bicarbonate/cit ac	102	PRISMASOL	102
potassium chloride	102	PRISTIQ ER	139
potassium citrate	102	probenecid	27

Index of Medications

probenecid/colchicine27	QUARTETTE92
PROCARDIA73	quazepam146
PROCARE SPACER WITH ADULT MASK134	QUAZEPAM146
PROCARE SPACER WITH CHILD MASK134	QUESTRAN84
PROCHAMBER134	quetiapine143, 144
prochlorperazine104	QUILLICHEW ER142
PRO COMFORT122, 125, 128, 131, 134, 148	QUILLIVANT XR142
PRO COMFORT SPACER WITH MASK134	quinapril76, 78, 79
PROCORT109	quinapril/hydrochlorothiazide76
PROCRIT90	quinidine72
PROCTOFOAM-HC109	quinine48
PRODIGY122, 128, 131	QUTENZA149
PROGLYCEM101	QVAR29
PROGRAF117	R	
PROLASTIN156	rabeprazole108
PROLENSA98	RADIAGEL160
PROLIA161	RADIAPLEXRX150
PROMACTA90	RADICAVA ORS85
promethazine43, 93, 104	RADIOGARDASE160
propafenone72	RAGWITEK68
propantheline103	raloxifene161
proparacaine98	ramelteon145
propranolol81	ramipril79
propylthiouracil154	ranitidine106
PROQUAD69	ranolazine71
PROSCAR162	RAPAFL0162
PROSTIN E2114	RAPLIXA71
protectives2/ceramide 1,3,6-ii150	rasagiline mesylate58, 59
PROTONIX108	RAYA125
PROTOPIC116	RAYALDEE158
protriptyline140	RAZADYNE ER65
PROVERA91, 114	READI-CAT 294
PROVISC100	READYLANCE131
PROVOCHOLINE94	REBIF86
PULMICORT29	RECARBRI034
PULMOZYME156	RECLAST116
PURE125, 131, 148	RECOMBIVAX HB70
PURIXAN51	RECOTHROM71
PUSH131	RECTIV107
pyrazinamide33	REFUAH122
PYRIDIUM24	regadenoson93
pyridostigmine65	REGIMEX57
pyrimethamine48	REGLAN107
Q		REGRANEX149
QALSODY85	REGULAR125
QINLOCK54	RELAGARD47
QMIIZ ODT26	RELENZA63
QSYMIA57	RELIAMED122, 131
QUALAQUN48	RELION125

Index of Medications

RELISTOR	40	ROSANIL	38
REMICADE	49	rosuvastatin	83
RENACIDIN	102	Roszet	82
repaglinide	45	ROTARIX	68
REPATHA	82	ROTATEQ	68
REPLACEMENT	71, 101, 102, 122, 160	ROXYBOND	22
RESPA A.R.	92	ROZLYTREK	55
RESTASIS	100	RUBRACA	55
RESTIZAN	149	RUCONEST	156
RETACRIT	90	rufinamide	89
RETEVMO	54	RUKOBIA	61
REVATIO	75	RUZURGI	86
REVLIMID	53	RYBELSUS	43
REXULTI	144	RYDAPT	55
REYATAZ	62	RYTARY	59
REZDIFRA	158	RYTELO	55
REZIPRES	74	RYTHMOL SR	72
REZLIDHIA	56	S	
REZUROCK	162	SAF-CLENS AF	151
RHOPRESSA	99	SAFE	118, 122, 128, 129
ribasphere	64	SAFETY	122, 124, 125, 126, 127, 128, 129, 130, 131, 132, 133
RIBASPHERE	65	SAFETYGLIDE	125, 128
ribavirin	63, 65	SAFYRAL	92
RIDAURA	25	SALAGEN	67
rifabutin	33	SALICATE	150
RIFAMATE	33	salicylic acid	150
rifampin	33	SALIMEZ FORTE	150
RIFATER	33	SALKERA	150
RIGHTEST	122, 131	salsalate	24
RILUTEK	85	SALVAX DUO PLUS	150
riluzole	85	SANCUSO	104
rimantadine	63	SANDOSTATIN	114
RIMSO-50	23	SANTYL	154
ringer's solution	146	SAPHRIS	143
RINVOQ	25	sapropterin	161
RIOMET	44	SARAFEM	138
RIOMET ER	44	SAVAYSA	39
risedronate	161	SAVELLA	162
risperidone	143	SAXENDA	57
RITALIN	142	SCALACORT DK	153
RITEFLO	134	SCEMBLIX	55
ritonavir	62	scopolamine	104
rivastigmine	65	secobarbital	145
rizatriptan	19	SECUADO	143
ROBAXIN-750	135	SECURESAFE	125, 128
ROBINUL	103	selegiline	59
ROCALTROL	164	selenium	149
ROCKLATAN	99	SELZENTRY	61
roflumilast	30	SEMGLEE	47
ropinirole	59	SEN-SERTER	122

Index of Medications

SEREVENT DISKUS.....	28	SODIUM OXYBATE.....	145
SEROQUEL.....	144	sodium phenylbutyrate	103
SEROQUEL XR.....	144	sodium polystyrene	101
SEROSTIM.....	113	sodium polystyrene sulfon/sorb	101
sertraline.....	138	sod, pot chlor/mag/sod, pot phos	146
sevelamer.....	101	SOGROYA.....	113
sevoflurane.....	23	solifenacin.....	163
SFROWASA.....	106	SOLIQUA.....	44
SHINGRIX.....	70	SOLOSEC.....	32
SHORT.....	27, 28, 125, 126	SOLTAMOX.....	56
SIGNIFOR.....	114	SOLUS.....	122, 132
SIKLOS.....	71	SOMATULINE DEPOT.....	114
sildenafil.....	75, 157, 158	SOMAVERT.....	158
SILICONE MASK.....	134	SOOLANTRA.....	151
SILIQ.....	147	SORBITOL.....	146
silodosin.....	162	sotalol.....	81
SIL-SERTER.....	122	SOTYKTU.....	147
SILVADENE.....	38	SOTYLIZE.....	81
silver nitrate	150, 153	SOVALDI.....	64
silver sulfadiazine.....	38	SPACE CHAMBER.....	134
SIMBRINZA.....	99	SPEVIGO.....	147
SIMLANDI.....	49	spinosad.....	58
SIMPONI.....	49, 50	SPIRIVA RESPIMAT.....	27
SIMULECT.....	117	spironolact/hydrochlorothiazid	96
simvastatin.....	81, 82, 83	spironolactone	95, 96
SINEMET.....	59	SPRAVATO.....	137
SINGLE.....	131, 148	SPRITAM.....	89
SINGULAIR	29	SPRYCEL.....	55
sirolimus.....	117	sps	101
SIRTURO	33	SSKI	101
SITZMARKS	94	STALEVO.....	59
SIVEXTRO	36	STARLIX.....	45
SKELAXIN	135	STELARA.....	116
SKLICE	58	STENDRA.....	157
SKYLA.....	92	STERILANCE.....	132
SKYRIZI.....	147	STERILE.....	132
SKY SAFETY.....	126	STIMATE.....	110
SKYTROFA	113	STIMUFEND.....	90
SLYND.....	92	STIOLTO RESPIMAT.....	28
SMART.....	130, 131, 132	STIVARGA.....	55
SMARTDIABETES.....	122	STRENSIQ.....	160
SMARTEST.....	122, 132	STRIBILD.....	63
sodium chloride for inhalation.....	159	STRIVERDI RESPIMAT.....	28
sodium chloride irrig solution	146	STROMECTOL	47
sodium chloride/nahco3/kcl/peg	107	SUBOXONE	162
SODIUM CITRATE.....	39	SUCRAID	106
SODIUM DIURIL.....	96	sucralfate	105
SODIUM EDECRIN.....	95	SULAR	73
sodium fluoride/potassium nit	100	sulfacetamide	31

Index of Medications

sulfacetamide sodium	38, 148, 149	TALTZ	147
sulfacetamide sod/sulfur/urea	38	TALZENNA	55
sulfacetamide/sulfur/cleansr23	38	TAMIFLU	63
sulfact sod/sulur/avob/otn/oct	38	tamoxifen	56
sulfadiazine	32, 38	tamsulosin	162, 163
sulfamethoxazole(trimethoprim)	32	TAPAZOLE	154
SULFAMYRON	38	TARKA	76
sulfasalazine	106	TASIGNA	55
sulindac	26	tasimelteon	145
sumatriptan	19	TASMAR	59
SUNLENCA	60	TAVALISSE	156
SUNOSI	145	TAVNEOS	70
SUPARTZ	24, 142	TAYTULLA	92
SUPER	130, 132	tazarotene	148, 149
SUPRANE	23	TAZVERIK	53
SUPRAX	34	TC99M SULFUR COLLOID PREP	94
SURE	122, 123, 125, 126, 128, 132, 134, 148, 149	TDVAX	69
SUREFLEX	122, 131	TECHLITE	126, 128, 132
SURE-PEN	122	TEGRETOL	89
SURE-TEST	123	TEGSEDI	159
SURGIFOAM	71	TEKTURNAR	81
SURGISEAL	151	TEL CARE	123, 132
SURVANTA	156	telmisartan	77, 78, 79
SUTENT	55	telmisartan-amlodipine	78
SYMAX	105	temazepam	146
SYMBICORT	29	TEMIXYS	61
SYMDEKO	155	TEMODAR	50
SYMLINPEN	44	TEMOVATE	153
SYMPROIC	40	temozolomide	50
SYMTUZA	61	TENIVAC	69
SYNALAR	37, 153	tenofovir disoproxil fumarate	62
SYNAREL	113	TEPMETKO	55
SYNERA	23	terazosin	77
SYNJARDY	45, 46	terbinafine	41
SYNJARDY XR	45, 46	terconazole	41
SYNTHROID	155	teriflunomide	86
SYRINGE AVITENE	71	teriparatide	115, 158
syring-needl,disp,insul	128	TERIPARATIDE	115
T		TERSI FOAM	149
TABLOID	51	TERUMO	126, 128
TABRECTA	55	TESSALON PERLE	93
TACHOSIL	71	testosterone	109, 110
TACLONEX	154	TESTOSTERONE	109, 110
tacrolimus	116, 117	tetabenazine	85
tadalafil	75, 157	tetracaine	98
TAFINLAR	52	tetracycline	37
TAGITOL	94	tetradecyl	84
TAGRISSO	55	TETRAVISC	98
TAHZYRO	68	TEVIMBRA	55

Index of Medications

TEXACORT.....	153
TEZSPIRE.....	161
THALOMID.....	33
THEO-24.....	30
theophylline.....	30
THIN.....	94, 125, 126, 129, 130, 131, 132
THIN WALL.....	126
thioridazine.....	145
thiothixene.....	144
THROMBIN-JMI.....	71
THROMBI-PAD.....	71
thyroid, pork.....	155
THYROLAR.....	155
tiagabine.....	89
TIAZAC.....	73
TIBSOVO.....	56
ticlopidine.....	60
TIGAN.....	104
TIGLUTIK.....	85
TIKOSYN.....	72
timolol.....	81, 98, 99
TINDAMAX.....	47
tinidazole.....	47
tiopronin.....	163
tirofiban-0.9% sodium chloride	60
TIROSINT.....	155
TISSEEL VHSD.....	151
TIVICAY.....	62
tizanidine.....	135
TOBI PODHALER.....	32
TOBRADEX.....	31
TOBRADEX EYE DROPS.....	31
tobramycin.....	31, 32
TOBRAMYCIN.....	32
tobramycin/dexamethasone.....	31
TOBREX.....	31
TOLAK.....	57
tolbutamide.....	45
tolcapone.....	59, 60
tolmetin sodium.....	26
tolterodine.....	163
tolterodine tart er.....	163
tolvaptan.....	95
TOLVAPTAN.....	95
TOPCARE.....	126, 128, 132
TOPICORT.....	153
topiramate	89
toremifene.....	56
torsemide.....	95
TOTALVISC.....	100
TRACLEER.....	75
TRAMADOL.....	22
tramadol er.....	22
tramadol hcl.....	20, 22
TRAMADOL HCL.....	22
tramadol hcl/acetaminophen	20
trandolapril	76, 79
trandolapril/verapamil	76
tranexamic	70
TRANEXAMIC	70
tranexamic acid.....	70
TRANSDERM-SCOP.....	104
TRANSFER.....	62, 126
TRANXENE.....	136
tranylcypromine	137
travoprost.....	99
trazodone.....	138
TREANDA.....	51
TRECATOR.....	33
TRELEGY ELLIPTA.....	29
TRESIBA.....	47
tretinoin.....	56, 147, 154
TREXALL.....	51
TREZIX	21
triamcinolone.....	157
triamterene	95, 96
triazolam.....	145, 146
TRIBENZOR.....	77
trichloroacetic acid.....	151
TRICHLOROACETIC ACID.....	151
TRICOR.....	84
trientine.....	160
TRIENTINE.....	160
trifluoperazine.....	145
trifluridine	63
TRIGLIDE.....	84
trihexyphenidyl.....	58
TRIJARDY XR	46
TRIKAFTA.....	155
TRILIPIX.....	84
trimethobenzamide.....	104, 105
trimethoprim	31, 32, 33
trimipramine.....	140
TRI-MIX.....	158
TRIMO-SAN.....	47
TRINTELLIX.....	139
TRIPTODUR.....	113
TRIUMEQ	61

Index of Medications

TRIVISC.....	24	UPTRAVI.....	75
tropicamide.....	99	URAMAXIN.....	150
trospium.....	163	urea	38, 48, 150
TRUE.....	123, 126, 128, 132, 148	URECHOLINE.....	67
TRUECONTROL.....	123	URIBEL.....	33
TRUEDRAW.....	123	UROCIT-K.....	102
TRUE METRIX.....	123	UROQID-ACID.....	102
TRUEPLUS.....	126, 128, 132	UROXATRAL.....	162
TRULANCE.....	107	URSO	106
TRULICITY.....	43	ursodiol	105, 106
TRUMENBA.....	68	UTA.....	33
TRUQAP.....	55	V	
TRUSOPT.....	99	VABOMERE.....	34
TUKYSA.....	55	VAGIFEM.....	115
TURALIO.....	55	valacyclovir	63
TUXARIN ER.....	93	VALCHLOR.....	57
TUZISTRA XR.....	93	valganciclovir	63
TWINRIX.....	70	valproic	89
TWIRLA.....	92	valsartan	77, 78, 79
TWIST.....	129, 130, 131, 132, 151	VALSARTAN.....	79
TYBLUME.....	92	VALTOCO.....	87
TYBOST.....	155	VALTREX.....	63
TYENNE.....	116	vancomycin.....	37
TYKERB.....	55	VANCOMYCIN.....	37
TYRVAYA.....	160	VANFLYTA.....	55
TYVASO.....	75	vardenafil	157, 158
U		VARIBAR.....	94
UBRELVY.....	19	VARIVAX VACCINE.....	70
UDENYCA.....	90	VARUBI.....	105
UKONIQ.....	55	VASCEPA.....	103
ULESFIA.....	58	VASERETIC.....	76
ULORIC.....	25	VASHEWOUND	146
ULTANE.....	23	VASOPRESSIN.....	95, 110
ULTI.....	123	VASOTEC.....	79
ULTICARE.....	126, 128	VAXELIS.....	69
ULTIGUARD.....	126, 128	VECAMYL.....	80
ULTILET.....	126, 128, 132, 148	VECTICAL.....	149
ULTRA.....	28, 122, 125, 126, 127, 128, 129, 130, 132, 147	VEGZELMA.....	50
ULTRACET.....	20	VELETRI.....	75
ULTRAFOAM.....	71	VELPHORO.....	101
ULTRALANCE.....	132	VELTASSA.....	101
ULTRAM.....	22	VEMLIDY.....	64
ULTRA-THIN.....	125, 126, 129, 132, 134	VENCLEXTA.....	56
ULTRATLC.....	132	venlafaxine	139
ULTRATRAK.....	123	VENTAVIS.....	75
ULTRAVATE.....	153	VEOPPOZ.....	70
UNIFINE.....	123, 124, 126, 127	VEOZAH.....	160
UNILET.....	129, 130, 132, 133	verapamil	72, 73, 74, 76
UNISTIK.....	123, 130, 133	VERASENS.....	123

Index of Medications

VEREGEN	65
VERELAN	74
VERELAN PM	74
VERIFINE	127, 129, 133
VERQUVO	74
VERZENIO	55
VEVYE	100
VFEND	41
V-GO	123
VIAGRA	158
VIBERZI	107
VIBRAMYCIN	37
VIDAZA	51
vigabatrin	89
VIGAMOX	31
VIBRYD	139
VIVOICE	156
VIMPAT	89
VIOKACE	107
VIRAZOLE	63
VIREAD	62
VISCO	24
VISTARIL	43
VISTOGARD	157
VITAFOL FE	136
VITALIPID	164
vite ac/grape/hyaluronic acid	149
VITRAKVI	55
VIVAGUARD	123, 133
VIVELLE-DOT	111
VIVIMUSTA	50
VIVJOA	41
VIZIMPRO	55
VOLTAREN	147
VOQUEZNA	107
voriconazole	41
VORTEX	134
VOSEVI	63
VOWST	106
VOXZOGO	160
VOYDEYA	71
VRAYLAR	144
VUMERTY	86
VYLESI	142
VYLOY	56
YNDAMAX	161
YNDAQEL	161
YTORIN	82
YVANSE	66, 67, 140, 141
W	
WAKIX	90
warfarin	38
water for irrigation, sterile	146
WAVENSE	123
Wegovy	57
WIDE SEAL DIAPHRAGM	92
WINREVAIR	75
WP THYROID	155
X	
XACIATO	47
XADAGO	60
XALKORI	55
XANAX	136
XARELTO	39
XATMEP	51
XCLAIR	149
XCOPRI	89
XDEMVY	58
XELJANZ	25
XELODA	51
XELTRYM	67
XENICAL	57
XENLETA	36
XEPI	38
XERMELO	103
XGEVA	161
XIFAXAN	36
XIGDUO XR	46
XiIDRA	100
XOFLUZA	63
XOLAIR	30
XOLREMDI	90
XOPENEX	28
XOSPATA	55
XPOVIO	56
XTAMPZA ER	22
XTANDI	51
XUREA	150
XURIDEN	101
XYLOCAINE	72
XYWAV	145
Y	
YALE	127
YASMIN 28	92
YAZ	92
YEROVY	56
Z	
zafirlukast	29

Index of Medications

zaleplon.....	146
ZANAFLEX.....	135
ZARONTIN89
ZARXIO	90
ZAVZPRET.....	19
Zeglogue	101
ZEJULA55
ZELBORAF	52
ZEMAIRA.....	156
ZEMPLAR.....	158
ZENATANE	147
ZENPEP	107
ZENZEDI.....	.67
ZEPATIER.....	.65
ZEPOSIA.....	.87
ZERBAXA.....	.34
ZERVIADE43
ZESTORETIC76
ZETIA84
zidovudine	61, 62
ZIEXTENZO.....	.90
ZIIHERA51
zileuton27
ZIMHI.....	.41
zinc oxide	150
ziprasidone.....	144
ZIRGAN.....	.63
ZITHROMAX35
ZOHYDRO ER.....	.22
ZOKINVY	156
ZOLADEX53
zoledronic.....	.116
ZOLEDRONIC ACID.....	.116
ZOLINZA50
zolmitriptan19
zolpidem146
zolpidem tart er146
zonisamide.....	.89
ZONTIVITY60
ZORTRESS117
ZOSTAVAX.....	.70
ZTLIDO23
ZUBSOLV.....	.162
ZURZUVAE.....	.137
ZYDELIG.....	.55
ZYLET31
ZYLOPRIM25
ZYNYZ51
ZYVOX36

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

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



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

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

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

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

Discrimination is against the law.

Medical coverage

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

Cigna Healthcare:

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

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

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

Cigna Healthcare

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

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

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

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



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

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