



Cigna Healthcare National Preferred 6-Tier Prescription Drug List

Coverage as of July 1, 2024

For the State of California

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

View your drug list online: Cigna.com/druglist

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

View your coverage info online: [myCigna® App](#) or myCigna.com®

Last updated: 03/01/2024. This drug list is subject to change and all prior versions are no longer in effect.

Offered by: Cigna Health and Life Insurance Company, Connecticut General Life Insurance Company, or their affiliates.

975748 c CA NPF 6-Tier 03/24 © 2024 Cigna Healthcare.





What's Inside?	Page
Information about this drug list	3
· Frequently asked questions (FAQs)	3
· Words you may need to know	11
· About this drug list	13
· How to read this drug list	13
· How to find your medication	16
List of prescription medications	19
Exclusions and limitations for coverage	233
Index of medications	234

View your drug list online

This document was last updated on 03/01/2024.* Go online to see the most up-to-date list of medications your plan covers.

- **myCigna® App¹ or myCigna.com®.** Click on the Prescriptions tab and select Price a Medication from the dropdown menu. Then type in your medication name.
- **Cigna.com/druglist.** Select **National Preferred 6 Tier** from the dropdown menu. Then type in your medication name or view the full list.

Questions?

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

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

Last updated: 03/01/2024, for changes starting 07/01/2024

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 1st and July 1st.
- **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**

Information about this drug list

Frequently Asked Questions (FAQs) *(cont.)*

next to it, you may need approval depending on the amount you're filling. If it has **AGE** next to it, you may need approval depending on the covered age range for the medication.

Q. What types of medications typically need approval?

A. Medications that:

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

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
- Allergies
- Bladder problems
- Breathing problems
- Depression
- High blood pressure
- High cholesterol
- Osteoporosis
- Pain
- Skin conditions
- Sleep disorders

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 your medication meets coverage requirements. We'll send you and your doctor a letter with the decision and next steps. It can take 1-5 business days to hear from us. You can always check with your doctor's office to find out if a decision's been made. You can also log in to the **myCigna App** or **myCigna.com** to check the status of your approval.

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

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

Information about this drug list

Frequently Asked Questions (FAQs) *(cont.)*

approved and your plan can't deny coverage of the medication. Also, if you've already received approval from Cigna Healthcare for your plan to cover your medication, Cigna Healthcare can't limit or exclude coverage for that medication if your doctor continues to prescribe it to treat your condition (as long as the medication is appropriately prescribed and is safe and effective in treating your condition).

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

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

Cigna Healthcare will review information your doctor sends us to make sure your medication meets coverage requirements. We'll send you and your doctor a letter with the decision and next steps. It can take 1-5 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 your medication meets coverage requirements. We'll send you and your doctor a letter with the decision and next steps. It can take 1-5 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

Information about this drug list

Frequently Asked Questions (FAQs) *(cont.)*

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

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

Your Step Therapy rights under California State law:

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.

Information about this drug list

Frequently Asked Questions (FAQs) *(cont.)*

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

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

Q. What are preventive medications?

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

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

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

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

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

Information about this drug list

Frequently Asked Questions (FAQs) *(cont.)*

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

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

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

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

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

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

A. It depends on your plan. Some plans require you to fill maintenance medications through Express Scripts® Pharmacy and/or specialty medications through Accredo® 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 specialty 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 specialty-trained pharmacists and nurses

Information about this drug list

Frequently Asked Questions (FAQs) *(cont.)*

- 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 free 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.

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 pharmacy of your choice or to Express Scripts® Pharmacy.
- 2. Give you a paper prescription.** You can bring it to the in-network pharmacy of your choice or mail it to Express Scripts® Pharmacy.

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

Information about this drug list

Frequently Asked Questions (FAQs) *(cont.)*

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

1. **Check your Cigna Healthcare ID card.** It lists your cost-share for Tier 1, Tier 2, Tier 3, Tier 4, Tier 5 and Tier 6 medications.
2. **Log in to the myCigna App or myCigna.com to view your pharmacy coverage information.** You can also use the Price a Medication tool to find out how much your medication may cost you at the different pharmacies in your plan's network.
3. **Check your Summary of Benefits** coverage document.

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

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

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

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

- **For copay plans:** These medications will be covered at 100%, or no cost-share (\$0) to you.

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

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

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

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

Information about this drug list

Frequently Asked Questions (FAQs) *(cont.)*

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

Words you may need to know

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

Information about this drug list

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

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

Information about this drug list

About this drug list

This is a list of the most commonly prescribed medications covered on the Cigna Healthcare National Preferred 6-Tier Prescription Drug List as of July 1, 2024. Medications are listed alphabetically by their generic and brand names within their therapeutic category and class.

The drug list is updated often so it isn't a full list of the medications your plan covers. Also, your specific plan may not cover all of these medications. Log in to the **myCigna App** or **myCigna.com**, or check your plan materials, to see all of the medications your plan covers.

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	Preferred Generic Medications. Generics have the same strength and active ingredients as brand-name medications, but often cost much less. Preferred generic medications are covered at your plan's lowest cost-share.	\$
Tier 2	Non-Preferred Generic Medications. Non-preferred generic medications may cost more than preferred generics.	\$\$
Tier 3	Preferred Brand Medications. These medications typically have a lower-cost generic alternative available.	\$\$\$
Tier 4	Non-Preferred Brand Medications. These medications typically have a generic and/or preferred brand alternative.	\$\$\$\$
Tier 5	Preferred Specialty. These medications typically cost less than non-preferred specialty medications.	\$\$\$\$\$
Tier 6	Non-Preferred Specialty. These medications are covered at your plan's highest cost-share. Non-preferred specialty medications typically have a preferred alternative.	\$\$\$\$\$\$

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

Information about this drug list

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

Letters (acronyms) next to medication names

Certain medications may need approval from Cigna Healthcare before they can be covered.* This extra step helps make sure you're getting the right coverage for the right medication. In this drug list, medications that have extra coverage requirements or limits have **letters (acronyms)** 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 the medication meets coverage requirements.
QL	Quantity Limits – 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	Specialty Medications are used to treat complex medical conditions. They're typically injected or infused and may need special handling (like refrigeration). 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	No Cost-Share Preventive Medications – Health care reform under the Patient Protection and Affordable Care Act (PPACA) requires plans to cover certain preventive medications and products 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 help you read this drug list. This chart is just an example. It may not show how these medications are actually covered on the Cigna Healthcare National Preferred 6-Tier Prescription Drug List.

ANALGESICS (Pain Relief and Inflammatory Disease)			Therapeutic drug category and class describes the condition the medication is used to treat
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits	
ANALGESIC, NON-SALICYLATE AND BARBITURATE COMBINAT			Coverage requirements and limits lets you know if your plan has extra requirements before it will cover the medication
<i>butalbital/acetaminophen</i>	T1		
ANALGESIC, SALICYLATE, BARBITURATE, XANTHINE COMB.			Drug tier gives you an idea of how much you may pay for a medication
<i>butalb-aspirin-caffe 50-325-40</i>	T1	QL (6 tabs/day)	
<i>butalbital-asa-caffeine cap</i> (Fiorinal) FIORINAL (<i>butalbital-aspirin-caffeine</i>)	T1 T3	QL (6 caps/day) QL (6 caps/day)	
ANALGESIC, NON-SALICYLATE, BARBITURATE, XANTHINE COMB.			Prescription drug name is the name of the medication
<i>butalb/acetaminophen/caffeine</i>	T3		
<i>butalb/acetaminophen/caffeine</i> (Esgic)	T3	QL (6 caps/day)	
<i>butalb-acetamin-caff 50-300-40</i> (Fioricet)	T1	QL (6 caps/day)	
<i>butalb-acetamin-caff 50-325-40</i> (Esgic)	T1	QL (6 tabs/day)	
ESGIC 50-325-40 MG TABLET (<i>butalbital-acetaminophen-caffe</i>)	T3	QL (6 tabs/day)	
ESGIC CAPSULE (<i>zebutal</i>)	T3	QL (6 caps/day)	
FIORICET (<i>phrenilin forte</i>)	T1	QL (6 caps/day)	
ANALGESIC/ANTIPYRETICS, SALICYLATES			Medications are listed in alphabetical order within each column
<i>choline salicyl/mag salicylate</i>	T1	HD	
<i>diflunisal</i>	T1	HD	
ANTI-MIGRAINE PREPARATIONS			Brand name medications are in all CAPITAL letters
AIMOVIG AUTOINJECTOR	T2	PA	
AJOVY AUTOINJECTOR	T2	PA	
AJOVY SYRINGE	T2	PA	
<i>almotriptan malate</i>	T1	QL (12 tabs/30 days)	
CAFERGOT (<i>ergotamine-caffeine</i>)	T3	QL (40 tabs/28 days)	
<i>dihydroergotamine 1 mg/ml amp</i>	T1	QL (10 amps/30 days)	
<i>eletriptan hydrobromide</i>	T1	QL (6 tabs/30 days)	
EMGALITY PEN	T2	PA	
EMGALITY SYRINGE	T2	PA	
<i>ergotamine tartrate/caffeine</i>	T1		
<i>ergotamine tartrate/caffeine</i> (Cafergot)	T1	QL (40 tabs/28 days)	
			Generic medications are in lowercase italics

This chart is just a sample. It may not show how these medications are actually covered on the Cigna Healthcare National Preferred 6-Tier Prescription Drug List.

Information about this drug list

How to find your medication

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

Condition	Page	Condition	Page
Analgesics (Pain Relief and Inflammatory Disease)	19-24	Anti-Infectives/Miscellaneous (Infections)	52, 53
Analgesics (Urinary Tract Conditions)	24	Anti-Infectives/Miscellaneous (Miscellaneous)	53
Anesthetics (Miscellaneous)	25	Anti-Infectives/Miscellaneous (Skin Conditions)	53
Anesthetics (Pain Relief and Inflammatory Disease)	25	Anti-Inflammatory Tumor Necrosis Factor Inhibiting Agents (Pain Relief and Inflammatory Disease)	54, 55
Anesthetics (Urinary Tract Conditions)	25	Anti-Neoplastics (Cancer)	55-61
Anti-Allergy (Allergy and Nasal Sprays)	26	Anti-Neoplastics (Skin Conditions)	61
Anti-Arthritics (Pain Relief and Inflammatory Disease)	26-29	Anti-Obesity Drugs (Weight Management)	62
Anti-Asthmatics (Asthma/COPD/Respiratory)	29-32	Anti-Parasitics (Eye Conditions)	62
Antibiotics (Ear Medications)	32, 33	Anti-Parasitics (Infections)	63
Antibiotics (Eye Conditions)	33, 34	Anti-Parkinson's Drugs (Parkinson's Disease)	63, 64
Antibiotics (Infections)	34-40	Anti-Platelet Drugs (Blood Thinners/Anti-Clotting)	64, 65
Antibiotics (Skin Conditions)	40-42	Antivirals (AIDS/HIV)	65-68
Anti-Coagulants (Blood Thinners/Anti-Clotting)	42, 43	Antivirals (Eye Conditions)	68
Antidotes (Gastrointestinal/Heartburn)	43	Antivirals (Infections)	68, 69
Antidotes (Substance Abuse)	43, 44	Antivirals (Skin Conditions)	69, 70
Anti-Fungals (Eye Conditions)	44	Autonomic Drugs (Allergy/Nasal Sprays)	70
Anti-Fungals (Feminine Products)	44	Autonomic Drugs (Alzheimer's Disease)	70
Anti-Fungals (Infections)	44, 45	Autonomic Drugs (Attention Deficit Hyperactivity Disorder)	71
Anti-Fungals (Skin Conditions)	45, 46	Autonomic Drugs (Blood Pressure/Heart Medications)	71
Antihistamine and Decongestant Combination (Allergy/Nasal Sprays)	46, 47	Autonomic Drugs (Urinary Tract Conditions)	71
Antihistamines (Allergy/Nasal Sprays)	47	Biologicals (Allergy/Nasal Sprays)	72
Antihistamines (Eye Conditions)	47	Biologicals (Blood Pressure/Heart Medications)	72
Anti-Hyperglycemics (Diabetes)	48-51	Biologicals (Miscellaneous)	72
Anti-Infectives (Feminine Products)	51	Biologicals (Vaccines)	72-74
Anti-Infectives (Infections)	52	Blood (Blood Modifiers/Bleeding Disorders)	74, 75
Anti-Infectives/Miscellaneous (Feminine Products)	52	Blood (Blood Thinners/Anti-Clotting)	75

Information about this drug list

How to find your medication *(cont.)*

Condition	Page	Condition	Page
Cardiac Drugs (Blood Pressure/Heart Medications)	75-78	Hormones (Gastrointestinal/Heartburn)	120
Cardiovascular (Asthma/COPD/Respiratory)	78, 79	Hormones (Hormonal Agents)	120-124
Cardiovascular (Blood Pressure/Heart Medications)	79-83	Hormones (Infertility)	124, 125
Cardiovascular (Cholesterol Medications)	83-85	Hormones (Miscellaneous)	125
CNS Drugs (Alzheimer's Disease)	85	Hormones (Osteoporosis Products)	125
CNS Drugs (Miscellaneous)	86	Immunosuppressants (Pain Relief and Inflammatory Disease)	125, 126
CNS Drugs (Multiple Sclerosis)	86-88	Immunosuppressants (Skin Conditions)	126
CNS Drugs (Pain Relief and Inflammatory Disease)	88	Immunosuppressants (Transplant Medications)	126, 127
CNS Drugs (Seizure Disorders)	88-91	Miscellaneous Medical Supplies, Devices, Non-Drug (Diabetes)	127-148
CNS Drugs (Sleep Disorders/Sedatives)	91	Miscellaneous Medical Supplies, Devices, Non-Drug (Miscellaneous)	148-157
Colony Stimulating Factors (Blood Modifiers/Bleeding Disorders)	91	Muscle Relaxants (Pain Relief and Inflammatory Disease)	157, 158
Contraceptives (Contraception Products)	91, 92	Prenatal Vitamins (Nutritional/Dietary)	158-162
Cough/Cold Preparations (Allergy/Nasal Sprays)	92	Psychotherapeutic Drugs (Anxiety/Depression/Bipolar Disorder)	162-166
Cough/Cold Preparations (Cough/Cold Medications)	93, 94	Psychotherapeutic Drugs (Attention Deficit Hyperactivity Disorder)	166-168
Diagnostic (Diabetes)	94	Psychotherapeutic Drugs (Miscellaneous)	168
Diagnostic (Miscellaneous)	95-97	Psychotherapeutic Drugs (Schizophrenia/Anti-Psychotics)	168-170
Diuretics (Diuretics)	97, 98	Psychotherapeutic Drugs (Seizure Disorders)	170
EENT Preps (Allergy/Nasal Sprays)	98, 99	Psychotherapeutic Drugs (Sleep Disorders/Sedatives)	170
EENT Preps (Ear Medications)	99	Sedative/Hypnotics (Sleep Disorders/Sedatives)	171, 172
EENT Preps (Eye Conditions)	99-103	Skin Preps (Miscellaneous)	172
Elect/Caloric/H2O (Cholesterol Medications)	104	Skin Preps (Pain Relief and Inflammatory Disease)	172, 173
Elect/Caloric/H2O (Dental Products)	104	Skin Preps (Skin Conditions)	173-183
Elect/Caloric/H2O (Diabetes)	105, 106	Smoking Deterrents (Smoking Cessation)	183
Elect/Caloric/H2O (Miscellaneous)	106	Thyroid Prep (Hormonal Agents)	183, 184
Elect/Caloric/H2O (Nutritional/Dietary)	106-112	Unclassified Drug Products (AIDS/HIV)	184
Elect/Caloric/H2O (Urinary Tract Conditions)	112, 113	Unclassified Drug Products (Asthma/COPD/Respiratory)	184, 185
Gastrointestinal (Cholesterol Medications)	113		
Gastrointestinal (Gastrointestinal/Heartburn)	113-119		
Gastrointestinal (Pain Relief and Inflammatory Disease)	119		

Information about this drug list

How to find your medication *(cont.)*

Condition	Page	Condition	Page
Unclassified Drug Products (Blood Modifiers/Bleeding Disorders)	185	Unclassified Drug Products (Osteoporosis Products)	191, 192
Unclassified Drug Products (Blood Pressure/Heart Medications)	185	Unclassified Drug Products (Pain Relief and Inflammatory Disease)	192
Unclassified Drug Products (Cancer)	185	Unclassified Drug Products (Seizure Disorders)	192
Unclassified Drug Products (Dental Products)	185, 186	Unclassified Drug Products (Skin Conditions)	192, 193
Unclassified Drug Products (Erectile Dysfunction)	186	Unclassified Drug Products (Substance Abuse)	193
Unclassified Drug Products (Eye Conditions)	186	Unclassified Drug Products (Transplant Medications)	193
Unclassified Drug Products (Gastrointestinal/Heartburn)	187	Unclassified Drug Products (Urinary Tract Conditions)	193, 194
Unclassified Drug Products (Hormonal Agents)	187	Unclassified Drug Products (Weight Management)	194
Unclassified Drug Products (Miscellaneous)	187-191	Vitamins (Nutritional/Dietary)	194-232
Unclassified Drug Products (Nutritional/Dietary)	191	Vitamins (Vitamins)	232

List of Prescription Medications

ANALGESICS (Pain Relief and Inflammatory Disease)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ANALGESIC, NON-SALICYLATE AND BARBITURATE COMBINAT		
ALLZITAL	T4	PA
<i>butalbital/acetaminophen</i>	T2	
<i>butalbital/acetaminophen (Bupap)</i>	T2	
ANALGESIC, SALICYLATE, BARBITURATE, XANTHINE COMB.		
<i>butalbital/aspirin/caffeine</i>	T2	
ANALGESIC, NON-SALICYLATE, BARBITURATE, XANTHINE COMB		
<i>butalb/acetaminophen/caffeine (Esgic)</i>	T2	
<i>butalb/acetaminophen/caffeine (Fioricet)</i>	T2	
ESGIC (<i>butalb/acetaminophen/caffeine</i>)	T4	PA
FIORICET (<i>butalb/acetaminophen/caffeine</i>)	T4	PA
ANALGESIC/ANTIPYRETICS, SALICYLATES		
<i>choline salicyl/mag salicylate</i>	T2	HD
<i>diflunisal</i>	T2	HD
ANTIMIGRAINE PREPARATIONS		
AIMOVIG AUTOINJECTOR	T3	PA QL(1 auto-inj/30 days)
AJOVY 225 MG/1.5 ML AUTOINJECT	T3	PA QL(1 auto-inj/30 days)
AJOVY 225 MG/1.5 ML AUTOINJECT	T3	PA QL(3 auto-injs/90 days)
AJOVY SYRINGE	T3	PA QL(1 syringe/30 days)
<i>almotriptan malate 12.5 mg tab</i>	T2	QL(12 tabs/fill)
<i>almotriptan malate 6.25 mg tab</i>	T2	QL(6 tabs/fill)
AMERGE (<i>naratriptan hcl</i>)	T4	ST QL(9 tabs/fill)
CAFERGOT (<i>ergotamine tartrate/caffeine</i>)	T4	
CAMBIA	T4	ST QL(9 packs/fill)
<i>dihydroergotamine 1 mg/ml amp</i>	T2	
<i>dihydroergotamine 4 mg/ml spry (Migranal)</i>	T2	ST QL(8 mls/fill)
<i>eletriptan hydrobromide (Relpax)</i>	T2	QL(6 tabs/fill)
EMGALITY 120 MG/ML SYRINGE	T3	PA QL(1 syringe/30 days)
EMGALITY PEN	T3	PA QL(1 pen/30 days)
ERGOMAR	T4	
<i>ergotamine tartrate/caffeine</i>	T2	
<i>ergotamine tartrate/caffeine (Cafergot)</i>	T2	
FROVA (<i>frovatriptan succinate</i>)	T4	ST QL(9 tabs/fill)
<i>frovatriptan succinate (Frova)</i>	T2	QL(9 tabs/fill)
MIGRANAL (<i>dihydroergotamine mesylate</i>)	T4	ST QL(8 mls/fill)

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

T5 – Preferred Specialty
 T6 – Non-Preferred Specialty
 PA – Prior Authorization
 QL – Quantity Limit

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

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

List of Prescription Medications

ANALGESICS (Pain Relief And Inflammatory Disease) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ANTIMIGRAINE PREPARATIONS (cont.)		
<i>naratriptan hcl</i> (Amerge)	T2	QL(9 tabs/fill)
NURTEC ODT	T3	PA QL(16 tabs/fill)
QULIPTA	T3	PA QL(30 tabs/30 days)
REYVOW	T4	PA QL(8 tabs/fill)
<i>rizatriptan benzoate</i> (Maxalt)	T2	QL(18 tabs/fill)
<i>sumatriptan</i> (Imitrex)	T2	QL(6 units/fill)
<i>sumatriptan 4 mg/0.5 ml cart</i> (Imitrex)	T2	QL(1 ml/fill)
<i>sumatriptan 4 mg/0.5 ml inject</i> (Imitrex)	T2	QL(2 pens/fill)
<i>sumatriptan 6 mg/0.5 ml cart</i> (Imitrex)	T2	QL(1 ml/fill)
<i>sumatriptan 6 mg/0.5 ml inject</i> (Imitrex)	T2	QL(2 pens/fill)
<i>sumatriptan 6 mg/0.5 ml vial</i>	T2	QL(2 vials/fill)
<i>sumatriptan succ 100 mg tablet</i> (Imitrex)	T2	
<i>sumatriptan succ 25 mg tablet</i> (Imitrex)	T2	
<i>sumatriptan succ 50 mg tablet</i> (Imitrex)	T2	
<i>sumatriptan succ/naproxen sod</i> (Treximet)	T2	ST QL(9 tabs/fill)
TOSYMRA	T4	ST QL(6 units/fill)
TRUDHESA	T4	ST QL(4 mls/fill)
UBRELVY	T3	PA QL(10 tabs/fill)
ZEMBRACE SYMTOUCH	T4	ST QL(4 pens/fill)
<i>zolmitriptan</i> (Zomig Zmt)	T2	QL(6 tabs/fill)
<i>zolmitriptan 2.5 mg tablet</i> (Zomig)	T2	QL(6 tabs/fill)
<i>zolmitriptan 5 mg nasal spray</i> (Zomig)	T2	ST QL(6 units/fill)
<i>zolmitriptan 5 mg tablet</i> (Zomig)	T2	QL(6 tabs/fill)
ZOMIG 2.5 MG NASAL SPRAY	T3	ST QL(6 units/fill)
ZOMIG 5 MG NASAL SPRAY (<i>zolmitriptan</i>)	T4	ST QL(6 units/fill)
NASAL NSAIDS, COX NON-SELECTIVE, SYSTEMIC ANALGESIC		
SPRIX	T4	ST QL(5 units/fill)
NSAIDS, CYCLOOXYGENASE INHIBITOR - TYPE ANALGESICS		
<i>diclofenac pot 25mg tablet</i>	T2	ST HD
<i>diclofenac pot 50 mg tablet</i>	T2	HD
<i>diclofenac pot 50 mg powdr pkt</i>	T2	HD
<i>diclofenac potassium</i>	T2	ST HD
<i>diclofenac potassium 25 mg cap</i> (Zipsor)	T2	HD
<i>ketorolac 10 mg tablet</i>	T2	QL(20 tabs/fill)

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

T5 – Preferred Specialty
 T6 – Non-Preferred Specialty
 PA – Prior Authorization
 QL – Quantity Limit

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

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

List of Prescription Medications

ANALGESICS (Pain Relief And Inflammatory Disease) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
NSAIDS, CYCLOOXYGENASE INHIBITOR - TYPE ANALGESICS (cont.)		
<i>ketorolac 15 mg/ml carpject</i>	T2	HD
<i>ketorolac 15 mg/ml isecure syr</i>	T2	HD
<i>ketorolac 15 mg/ml syringe</i>	T2	HD
<i>ketorolac 15 mg/ml vial</i>	T2	HD
<i>ketorolac 30 mg/ml carpject</i>	T2	HD
<i>ketorolac 30 mg/ml isecure syr</i>	T2	HD
<i>ketorolac 30 mg/ml syringe</i>	T2	HD
<i>ketorolac 30 mg/ml vial</i>	T2	HD
<i>ketorolac 300 mg/10 ml vial</i>	T2	HD
<i>ketorolac 60 mg/2 ml carpject</i>	T2	HD
<i>ketorolac 60 mg/2 ml syringe</i>	T2	HD
<i>ketorolac 60 mg/2 ml vial</i>	T2	HD
<i>mefenamic acid</i>	T2	HD
OPIOID ANALGESIC AND NON-SALICYLATE ANALGESICS		
<i>acetaminophen with codeine</i>	T2	PA QL
<i>hydrocodone-acetamin 10-300 mg</i>	T2	PA QL
<i>hydrocodone-acetamin 10-325 mg</i>	T2	PA QL
<i>hydrocodone-acetamin 10-325/15</i>	T2	PA QL
HYDROCODONE-ACETAMIN 2.5-108/5	T4	PA QL
<i>hydrocodone-acetamin 2.5-108/5</i>	T2	PA QL
HYDROCODONE-ACETAMIN 5-217/10	T4	PA QL
<i>hydrocodone-acetamin 5-217/10</i>	T2	PA QL
<i>hydrocodone-acetamin 5-300 mg</i>	T2	PA QL
<i>hydrocodone-acetamin 5-325 mg</i>	T2	PA QL
<i>hydrocodone-acetamin 7.5-300</i>	T2	PA QL
<i>hydrocodone-acetamin 7.5-325</i>	T2	PA QL
<i>hydrocodone-acetamin 7.5-325/15</i>	T2	PA QL
HYDROCODONE-ACETAMIN 7.5-325/15	T4	PA QL
LORTAB	T4	PA QL
NALOCET	T4	PA QL
<i>oxycodone hcl/acetaminophen</i>	T2	PA QL
<i>oxycodone hcl/acetaminophen (Percocet)</i>	T2	PA QL
<i>prolate 10-300 mg tablet</i>	T2	PA QL
<i>prolate 5-300 mg tablet</i>	T2	PA QL

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

T5 – Preferred Specialty
 T6 – Non-Preferred Specialty
 PA – Prior Authorization
 QL – Quantity Limit

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

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

List of Prescription Medications

ANALGESICS (Pain Relief And Inflammatory Disease) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
OPIOID ANALGESIC AND NON-SALICYLATE ANALGESICS (cont.)		
<i>prolone 7.5-300 mg tablet</i>	T2	PA QL
<i>tramadol hcl/acetaminophen</i>	T2	PA QL(12 ds/60 days)
OPIOID ANALGESIC AND NSAID COMBINATION		
<i>hydrocodone/ibuprofen</i>	T2	PA QL
OPIOID ANALGESIC AND SALICYLATE ANALGESIC COMB		
<i>oxycodone hcl/aspirin</i>	T2	PA QL
OPIOID ANALGESIC, NON-SALICYLATE, XANTHINE COMB		
<i>acetaminophen/caff/dihydrocod</i>	T2	PA QL
TREZIX	T4	PA QL
OPIOID ANALGESICS		
ABSTRAL	T4	PA QL
ACTIQ (<i>fentanyl citrate</i>)	T4	PA QL
BELBUCA	T3	ST QL (60 films/fill)
<i>buprenorphine (Butrans)</i>	T2	ST
<i>buprenorphine 150 mcg film</i>	T2	ST QL (60 films/fill)
<i>buprenorphine 300 mcg film</i>	T2	ST QL (60 films/fill)
<i>buprenorphine 450 mcg film</i>	T2	ST QL (60 films/fill)
<i>buprenorphine 600 mcg film</i>	T2	ST QL (60 films/fill)
<i>buprenorphine 75 mcg film</i>	T2	ST QL (60 films/fill)
<i>buprenorphine 750 mcg film</i>	T2	ST QL (60 films/fill)
<i>buprenorphine 900 mcg film</i>	T2	ST QL (60 films/fill)
<i>butorphanol tartrate</i>	T2	PA QL(< 18 yo 12 ds/130 days)
<i>codeine sulfate</i>	T2	PA QL
DILAUDID (<i>hydromorphone hcl</i>)	T4	PA QL
<i>fentanyl</i>	T2	ST QL (15 patches/30 days)
<i>fentanyl cit otc 1,200 mcg (Actiq)</i>	T2	PA QL
<i>fentanyl cit otc 1,600 mcg (Actiq)</i>	T2	PA QL
<i>fentanyl citrate otc 200 mcg (Actiq)</i>	T2	PA QL
<i>fentanyl citrate otc 400 mcg (Actiq)</i>	T2	PA QL
<i>fentanyl citrate otc 600 mcg (Actiq)</i>	T2	PA QL
<i>fentanyl citrate otc 800 mcg (Actiq)</i>	T2	PA QL
<i>hydrocodone er 10 mg capsule (Zohydro Er)</i>	T2	ST QL (90 caps/30 days)
<i>hydrocodone er 100 mg tablet (Hysingla Er)</i>	T2	ST QL (60 tabs/30 days)

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

T5 – Preferred Specialty
T6 – Non-Preferred Specialty
PA – Prior Authorization
QL – Quantity Limit

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

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

List of Prescription Medications

ANALGESICS (Pain Relief And Inflammatory Disease) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
OPIOID ANALGESICS (cont.)		
<i>hydrocodone er 120 mg tablet</i> (Hysingla Er)	T2	ST QL (60 tabs/30 days)
<i>hydrocodone er 15 mg capsule</i> (Zohydro Er)	T2	ST QL (90 caps/30 days)
<i>hydrocodone er 20 mg capsule</i> (Zohydro Er)	T2	ST QL (90 caps/30 days)
<i>hydrocodone er 20 mg tablet</i> (Hysingla Er)	T2	ST QL (60 tabs/30 days)
<i>hydrocodone er 30 mg capsule</i> (Zohydro Er)	T2	ST QL (90 caps/30 days)
<i>hydrocodone er 30 mg tablet</i> (Hysingla Er)	T2	ST QL (60 tabs/30 days)
<i>hydrocodone er 40 mg capsule</i> (Zohydro Er)	T2	ST QL (90 caps/30 days)
<i>hydrocodone er 40 mg tablet</i> (Hysingla Er)	T2	ST QL (60 tabs/30 days)
<i>hydrocodone er 50 mg capsule</i> (Zohydro Er)	T2	ST QL (90 caps/30 days)
<i>hydrocodone er 60 mg tablet</i> (Hysingla Er)	T2	ST QL (60 tabs/30 days)
<i>hydrocodone er 80 mg tablet</i> (Hysingla Er)	T2	ST QL (60 tabs/30 days)
<i>hydromorphone hcl</i>	T2	PA QL
<i>hydromorphone hcl</i>	T2	ST QL (60 tabs/30 days)
<i>hydromorphone hcl</i> (Dilaudid)	T2	PA QL
HYSINGLA ER (<i>hydrocodone bitartrate</i>)	T3	ST QL (60 tabs/30 days)
KADIAN	T4	ST QL (90 caps/30 days)
KADIAN (<i>morphine sulfate</i>)	T4	ST QL (90 caps/30 days)
LAZANDA 100 MCG NASAL SPRAY	T4	PA QL (23 units/30 days)
LAZANDA 400 MCG NASAL SPRAY	T4	PA QL (23 units/30 days)
<i>levorphanol tartrate</i>	T2	PA QL
<i>meperidine hcl</i>	T2	
<i>methadone hcl</i>	T2	ST
<i>methadone hcl</i>	T1	ST
<i>morphine sulf er 100 mg tablet</i> (Ms Contin)	T2	ST QL (120 tabs/30 days)
<i>morphine sulf er 15 mg tablet</i> (Ms Contin)	T2	ST QL (120 tabs/30 days)
<i>morphine sulf er 200 mg tablet</i> (Ms Contin)	T2	ST QL (120 tabs/30 days)
<i>morphine sulf er 30 mg tablet</i> (Ms Contin)	T2	ST QL (120 tabs/30 days)
<i>morphine sulf er 60 mg tablet</i> (Ms Contin)	T2	ST QL (120 tabs/30 days)
<i>morphine sulfate er 10 mg cap</i> (Kadian)	T2	ST QL (90 caps/30 days)
<i>morphine sulfate er 100 mg cap</i> (Kadian)	T2	ST QL (90 caps/30 days)
<i>morphine sulfate er 120 mg cap</i>	T2	ST QL (60 caps/30 days)
<i>morphine sulfate er 20 mg cap</i>	T2	ST QL (90 caps/30 days)
<i>morphine sulfate er 30 mg cap</i>	T2	ST QL (60 caps/30 days)
<i>morphine sulfate er 30 mg cap</i>	T2	ST QL (90 caps/30 days)

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

T5 – Preferred Specialty
 T6 – Non-Preferred Specialty
 PA – Prior Authorization
 QL – Quantity Limit

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

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

List of Prescription Medications

ANALGESICS (Pain Relief And Inflammatory Disease) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
OPIOID ANALGESICS (cont.)		
<i>morphine sulfate er 45 mg, 60 mg, 75 mg, 90 mg cap</i>	T2	ST QL (60 caps/30 days)
<i>morphine sulfate er 50 mg cap (Kadian)</i>	T2	ST QL (90 caps/30 days)
<i>morphine sulfate er 60 mg cap (Kadian)</i>	T2	ST QL (90 caps/30 days)
<i>morphine sulfate er 80 mg cap (Kadian)</i>	T2	ST QL (90 caps/30 days)
MS CONTIN (<i>morphine sulfate</i>)	T4	ST QL (120 tabs/30 days)
<i>opium/belladonna alkaloids</i>	T2	PA QL
<i>oxycodone hcl</i>	T2	PA QL
<i>oxycodone hcl (Roxicodone)</i>	T2	PA QL
OXYCONTIN	T3	ST QL (90 tabs/30 days)
<i>oxymorphone hcl</i>	T2	PA QL
<i>oxymorphone hcl</i>	T2	ST QL
<i>pentazocine hcl/naloxone hcl</i>	T2	PA QL
ROXICODONE (<i>oxycodone hcl</i>)	T4	PA QL
<i>tramadol er 100 mg tablet</i>	T2	PA ST QL (30 tabs/fill)
<i>tramadol er 200 mg tablet</i>	T2	PA ST QL (30 tabs/fill)
<i>tramadol er 300 mg tablet</i>	T2	PA ST QL (30 tabs/fill)
<i>tramadol hcl 50 mg tablet</i>	T2	PA QL
<i>tramadol hcl er 100 mg tablet</i>	T2	PA ST QL (30 tabs/fill)
<i>tramadol hcl er 200 mg tablet</i>	T2	PA ST QL (30 tabs/fill)
<i>tramadol hcl er 300 mg tablet</i>	T2	PA ST QL (30 tabs/fill)
OPIOID AND SALICYLATE ANALGESICS, BARBIT, XANTHINE		
<i>codeine/butalbital/asa/caffein</i>	T2	PA QL
OPIOID, NON-SALICYL. ANALGESIC, BARBITURATE, XANTHINE		
<i>butalbit/acetamin/caff/codeine</i>	T2	PA QL
butalbit/acetamin/caff/codeine (Fioricet With Codeine)	T2	PA QL
FIORICET WITH CODEINE (<i>butalbit/acetamin/caff/codeine</i>)	T4	PA QL
SKELETAL MUSCLE RELAXANT, SALICYLAT, OPIOID ANALGESC		
<i>carisoprodol/aspirin/codeine</i>	T2	PA QL
ANALGESICS (Urinary Tract Conditions)		
URINARY TRACT ANALGESIC AGENTS		
ELMIRON	T3	
RIMSO-50	T4	

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

T5 – Preferred Specialty
 T6 – Non-Preferred Specialty
 PA – Prior Authorization
 QL – Quantity Limit

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

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

List of Prescription Medications

ANESTHETICS (Miscellaneous)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
GENERAL ANESTHETICS, INHALANT		
<i>desflurane</i>	T2	
<i>isoflurane</i>	T2	
<i>sevoflurane (Ultane)</i>	T2	
SUPRANE	T4	
ULTANE (<i>sevoflurane</i>)	T4	
ANESTHETICS (Pain Relief And Inflammatory Disease)		
LOCAL ANESTHETICS		
<i>lidocaine hcl</i>	T2	QL(60 mls/30 days)
<i>lidocaine hcl</i>	T2	
<i>lidocaine hcl 2% jel urojet ac</i>	T2	QL(60 mls/30 days)
<i>lidocaine hcl 2% jelly</i>	T2	QL(60 mls/30 days)
<i>lidocaine hcl 2% jelly uro-jet</i>	T2	QL(60 mls/30 days)
<i>lidocaine hcl 4% solution</i>	T2	
TOPICAL LOCAL ANESTHETICS		
CETACAINE ANESTHETIC	T4	
L.E.T. (LIDO-EPINEPH-TETRA)	T4	
<i>lidocaine 5% ointment</i>	T2	QL(50 gms/28 days)
<i>lidocaine 5% patch (Lidocan li)</i>	T2	PA
<i>lidocaine 5% patch (Lidoderm)</i>	T2	PA
<i>lidocaine (Lidocan li)</i>	T2	PA
<i>lidocaine hcl</i>	T2	
<i>lidocaine hcl 4% solution</i>	T2	
LIDOCAINE-EPINEPHRIN-TETRACAIN	T4	
<i>lidocaine-prilocaine cream</i>	T2	QL(30 gms/30 days)
<i>lidocaine-prilocaine cream</i>	T2	
LIDOCAN II (lidocaine)	T4	PA
SYNERA	T4	PA
ZTLIDO	T3	PA
ANESTHETICS (Urinary Tract Conditions)		
URINARY TRACT ANESTHETIC/ANALGESIC AGNT (AZO-DYE)		
<i>phenazopyridine hcl (Pyridium)</i>	T2	

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

T5 – Preferred Specialty
 T6 – Non-Preferred Specialty
 PA – Prior Authorization
 QL – Quantity Limit

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

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

List of Prescription Medications

ANTIALLERGY (Allergy/Nasal Sprays)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
MAST CELL STABILIZER		
<i>cromolyn 100 mg/5 ml oral conc (Gastrocrom)</i>	T2	
GASTROCROM (<i>cromolyn sodium</i>)	T4	
ANTIARTHRITICS (Pain Relief And Inflammatory Disease)		
ANALGESIC/ANTIPYRETICS, SALICYLATES		
DISALCID (<i>salsalate</i>)	T4	HD
<i>salsalate</i> (Disalcid)	T2	HD
ANTI-ARTHRITIC AND CHELATING AGENTS		
DEPEN (<i>penicillamine</i>)	T6	PA SP
<i>penicillamine</i> (Cuprimine)	T2	PA SP
<i>penicillamine</i> (Depen)	T2	PA SP
ANTI-ARTHRITIC, FOLATE ANTAGONIST AGENTS		
RASUVO	T3	ST
ANTI-INFLAMMATORY, PYRIMIDINE SYNTHESIS INHIBITOR		
ARAVA (<i>leflunomide</i>)	T4	QL(30 tabs/fill) HD
<i>leflunomide</i> (Arava)	T2	QL(30 tabs/fill) HD
ANTI-INFLAMMATORY, PHOSPHODIESTERASE-4(PDE4) INHIB.		
OTEZLA 28 DAY STARTER PACK	T5	PA QL(55 tabs/365 days) SP HD
OTEZLA 30 MG TABLET	T5	PA QL(60 tabs/30 days) SP HD
COLCHICINE		
<i>colchicine 0.6 mg tablet</i> (Colcrys)	T2	HD
GLOPERBA	T4	HD
MITIGARE (<i>colchicine</i>)	T3	ST HD
GOLD SALTS		
RIDAURA	T3	
HYPERURICEMIA TX - XANTHINE OXIDASE INHIBITORS		
<i>allopurinol 100 mg tablet</i> (Zyloprim)	T1	HD
<i>allopurinol 300 mg tablet</i> (Zyloprim)	T1	HD
<i>febuxostat</i> (Uloric)	T2	ST HD
ZYLOPRIM (<i>allopurinol</i>)	T4	HD
JANUS KINASE (JAK) INHIBITORS		
RINVOQ ER 15 MG TABLET	T5	PA QL(30 tabs/fill) SP HD
RINVOQ ER 30 MG TABLET	T5	PA QL(30 tabs/fill) SP HD
RINVOQ ER 45 MG TABLET	T5	PA QL(56 tabs/365 days) SP HD
XELJANZ 1 MG/ML SOLUTION	T5	PA QL(300 mls/fill) SP HD

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

T5 – Preferred Specialty
 T6 – Non-Preferred Specialty
 PA – Prior Authorization
 QL – Quantity Limit

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

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

List of Prescription Medications

ANTIARTHRITICS (Pain Relief And Inflammatory Disease) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
JANUS KINASE (JAK) INHIBITORS (cont.)		
XELJANZ 10 MG TABLET	T5	PA QL(60 tabs/fill) SP HD
XELJANZ 5 MG TABLET	T5	PA QL(60 tabs/fill) SP HD
XELJANZ XR	T5	PA QL(30 tabs/fill) SP HD
NSAID AND HISTAMINE H2 RECEPTOR ANTAGONIST COMB.		
DUEXIS (<i>ibuprofen/famotidine</i>)	T4	ST HD
<i>ibuprofen/famotidine</i> (Duexis)	T2	ST HD
NSAID AND TOPICAL IRRITANT COUNTER-IRRITANT COMB.		
COMFORT PAC-IBUPROFEN	T4	
COMFORT PAC-MELOXICAM	T4	
COMFORT PAC-NAPROXEN	T4	
NSAID,COX INHIBITOR-TYPE AND PROTON-PUMP INHIBITOR		
<i>naproxen/esomeprazole mag</i> (Vimovo)	T2	ST HD
NSAIDS(COX NON-SPEC.INHIB)AND PROSTAGLANDIN ANALOG		
ARTHROTEC 50 (<i>diclofenac sodium/misoprostol</i>)	T4	ST HD
ARTHROTEC 75 (<i>diclofenac sodium/misoprostol</i>)	T4	ST HD
<i>diclofenac sodium/misoprostol</i> (Arthrotec 50)	T2	HD
<i>diclofenac sodium/misoprostol</i> (Arthrotec 75)	T2	HD
NSAIDS, CYCLOOXYGENASE INHIBITOR - TYPE ANALGESICS		
ANAPROX DS (<i>naproxen sodium</i>)	T4	ST HD
DAYPRO (<i>oxaprozin</i>)	T4	ST HD
<i>diclofenac sod dr 25 mg tab</i>	T2	HD
<i>diclofenac sod dr 50 mg tab</i>	T2	HD
<i>diclofenac sod dr 75 mg tab</i>	T2	HD
<i>diclofenac sod ec 25 mg tab</i>	T2	HD
<i>diclofenac sod ec 50 mg tab</i>	T2	HD
<i>diclofenac sod ec 75 mg tab</i>	T2	HD
<i>diclofenac sodium</i>	T2	HD
EC-NAPROSYN (<i>naproxen</i>)	T4	ST HD
<i>etodolac</i>	T2	HD
<i>etodolac</i> (Lodine)	T2	HD
FELDENE (<i>piroxicam</i>)	T4	ST HD
<i>fenoprofen 400 mg capsule</i> (Nalfon)	T2	ST HD
<i>fenoprofen 600 mg tablet</i> (Nalfon)	T2	ST HD
FENORTHO 200 MG CAPSULE	T4	ST HD

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

T5 – Preferred Specialty
 T6 – Non-Preferred Specialty
 PA – Prior Authorization
 QL – Quantity Limit

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

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

List of Prescription Medications

ANTIARTHRITICS (Pain Relief And Inflammatory Disease) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
NSAIDS, CYCLOOXYGENASE INHIBITOR - TYPE ANALGESICS (cont.)		
<i>flurbiprofen</i>	T2	HD
<i>ibuprofen</i>	T1	HD
<i>ibuprofen</i>	T2	HD
<i>indomethacin</i>	T2	HD
<i>indomethacin 25 mg capsule</i>	T2	HD
<i>indomethacin 50 mg capsule</i>	T2	HD
<i>indomethacin 25 mg/5 ml susp</i>	T2	HD
<i>ketoprofen</i>	T2	ST HD
<i>ketoprofen 25 mg capsule</i>	T2	ST HD
<i>ketoprofen 50 mg capsule</i>	T2	HD
<i>ketoprofen 75 mg capsule</i>	T2	HD
<i>ketoprofen er 200 mg capsule</i>	T2	ST HD
LODINE (<i>etodolac</i>)	T4	ST HD
<i>meclofenamate sodium</i>	T2	HD
<i>meloxicam 5 mg capsule (Vivlodex)</i>	T2	ST QL (30 caps/fill) HD
<i>meloxicam 10 mg capsule (Vivlodex)</i>	T2	ST QL (30 caps/fill) HD
MOBIC (<i>meloxicam</i>)	T4	ST QL (30 tabs/fill) HD
<i>nabumetone (Relafen)</i>	T2	HD
NALFON 600 MG TABLET (<i>fenoprofen calcium</i>)	T4	ST HD
NAPRELAN	T4	ST HD
NAPRELAN (<i>naproxen sodium</i>)	T4	ST HD
NAPROSYN (<i>naproxen</i>)	T4	ST HD
<i>naproxen (Ec-Naprosyn)</i>	T2	HD
<i>naproxen 125 mg/5 ml suspen (Naprosyn)</i>	T2	ST HD
<i>naproxen 250 mg tablet</i>	T1	HD
<i>naproxen 375 mg tablet</i>	T1	HD
<i>naproxen 500 mg kit (Naprosyn)</i>	T1	HD
<i>naproxen 500 mg tablet (Naprosyn)</i>	T1	HD
<i>naproxen dr 375 mg tablet (Ec-Naprosyn)</i>	T2	ST HD
<i>naproxen dr 500 mg tablet (Ec-Naprosyn)</i>	T2	HD
<i>naproxen sod er 750 mg tablet</i>	T2	ST HD
<i>naproxen sodium</i>	T2	HD
<i>naproxen sodium (Anaprox Ds)</i>	T2	HD
<i>naproxen sodium (Naprelan)</i>	T2	ST HD

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

T5 – Preferred Specialty
 T6 – Non-Preferred Specialty
 PA – Prior Authorization
 QL – Quantity Limit

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

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

List of Prescription Medications

ANTIARTHRITICS (Pain Relief And Inflammatory Disease) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
NSAIDS, CYCLOOXYGENASE INHIBITOR - TYPE ANALGESICS (cont.)		
<i>oxaprozin 600 mg caplet</i> (Daypro)	T2	HD
<i>oxaprozin 600 mg tablet</i> (Daypro)	T2	HD
<i>piroxicam</i> (Feldene)	T2	HD
RELAFEN (<i>nabumetone</i>)	T4	ST HD
<i>sulindac</i>	T1	HD
<i>tolmetin sodium 200 mg tab</i>	T2	HD
<i>tolmetin sodium 400 mg, 600 mg cap</i>	T2	ST HD
NSAIDS, CYCLOOXYGENASE-2(COX-2) SELECTIVE INHIBITOR		
<i>celecoxib</i> (Celebrex)	T2	ST HD
URICOSURIC AGENTS		
<i>probenecid</i>	T2	HD
<i>probenecid/colchicine</i>	T2	HD
ANTIASTHMATICS (Asthma/COPD/Respiratory)		
5-LIPOXYGENASE INHIBITORS		
<i>zileuton</i>	T2	PA HD
ZYFLO	T4	PA HD
ANTICHOLINERGICS, ORALLY INHALED LONG ACTING		
LONHALA MAGNAIR REFILL	T4	QL(60 mls/fill) HD
LONHALA MAGNAIR STARTER	T4	QL(60 mls/fill) HD
SPIRIVA HANDIHALER 18 MCG CAP	T3	QL(30 caps/fill) HD
SPIRIVA HANDIHALER 18 MCG CAP	T3	QL(90 caps/fill) HD
SPIRIVA HANDIHALER 18 MCG CAP	T3	QL(5 caps/fill) HD
SPIRIVA RESPIMAT	T3	QL(1 inhaler/fill) HD
YUPELRI	T3	QL(30 vls/fill) HD
ANTICHOLINERGICS, ORALLY INHALED SHORT ACTING		
ATROVENT HFA	T4	QL(2 inhalers/fill) HD
<i>ipratropium br 0.02% soln</i>	T2	HD
BETA-ADRENERGIC AGENTS		
<i>albuterol sulf 2 mg/5 ml syrup</i>	T2	HD
<i>albuterol sulfate 2 mg, 4 mg tab</i>	T2	HD
<i>albuterol sulfate er 4 mg tab</i>	T2	HD
<i>albuterol sulfate er 8 mg tab</i>	T2	HD
<i>metaproterenol sulfate</i>	T2	HD
<i>terbutaline sulfate</i>	T2	HD

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

T5 – Preferred Specialty
T6 – Non-Preferred Specialty
PA – Prior Authorization
QL – Quantity Limit

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

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

List of Prescription Medications

ANTIASTHMATICS (Asthma/COPD/Respiratory) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
BETA-ADRENERGIC AGENTS, INHALED, SHORT ACTING		
<i>albuterol 2.5 mg/0.5 ml sol</i>	T2	
<i>albuterol 75 mg/15 ml soln</i>	T2	
<i>albuterol 100 mg/20 ml soln</i>	T2	
<i>albuterol 5 mg/ml solution</i>	T2	
<i>albuterol 15 mg/3 ml solution</i>	T2	
<i>albuterol hfa 90 mcg inhaler (Proair Hfa)</i>	T2	QL(2 inhalers/fill)
<i>albuterol hfa 90 mcg inhaler (Proventil Hfa)</i>	T2	QL(2 inhalers/fill)
<i>albuterol sul 0.63 mg/3 ml sol</i>	T2	
<i>albuterol sul 1.25 mg/3 ml sol</i>	T2	
<i>albuterol sul 2.5 mg/3 ml soln</i>	T2	
<i>levalbuterol hcl (Xopenex Concentrate)</i>	T2	
<i>levalbuterol hcl (Xopenex)</i>	T2	
XOPENEX (<i>levalbuterol hcl</i>)	T4	
XOPENEX CONCENTRATE (<i>levalbuterol hcl</i>)	T4	
BETA-ADRENERGIC AGENTS, INHALED, ULTRA-LONG ACTING		
STRIVERDI RESPIMAT	T3	QL(1 inhaler/30 days) HD
BETA-ADRENERGIC AGENTS, ORALLY INHALED, LONG ACTING		
<i>arformoterol tartrate (Brovana)</i>	T2	QL(120 mls/fill) HD
BROVANA (<i>arformoterol tartrate</i>)	T4	QL(120 mls/fill) HD
<i>formoterol fumarate (Perforomist)</i>	T2	QL(120 mls/fill) HD
BETA-ADRENERGIC AND ANTICHOLINERGIC COMBO, INHALED		
ANORO ELLIPTA	T3	QL(1 inhaler/fill) HD
COMBIVENT RESPIMAT	T3	HD
<i>ipratropium/albuterol sulfate</i>	T2	
SEEBRI NEOHALER 15.6MCG INHALER	T4	
STIOLTO RESPIMAT	T3	QL(1 inhaler/fill) HD
UTIBRON NEOHALER	T4	
BETA-ADRENERGIC AND GLUCOCORTICOID COMBO, INHALED		
ADVAIR DISKUS (<i>fluticasone propion/salmeterol</i>)	T4	PA QL(1 inhaler/fill) HD
ADVAIR HFA	T3	PA QL(1 inhaler/fill) HD
AIRDUO DIGIHALER	T4	PA QL(1 inhaler/fill) HD
AIRSUPRA	T3	HD
BREO ELLIPTA 100-25 MCG INH	T3	PA QL(60 blisters/fill) HD
BREO ELLIPTA 100-25 MCG INH	T3	PA QL(28 blisters/fill) HD

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

T5 – Preferred Specialty
T6 – Non-Preferred Specialty
PA – Prior Authorization
QL – Quantity Limit

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

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

List of Prescription Medications

ANTIASTHMATICS (Asthma/COPD/Respiratory) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
BETA-ADRENERGIC AND GLUCOCORTICOID COMBO, INHALED (cont.)		
BREO ELLIPTA 200-25 MCG INH	T3	PA QL(1 inhaler/fill) HD
BREO ELLIPTA 50-25 MCG INHALER	T3	PA QL(60 blisters/fill) HD
<i>breyza 80-4.mcg, 160-4.5 mcg inhaler</i>	T2	PA
<i>budesonide-formoterol 160-4.5, 80-4.5</i>	T2	PA QL (1 inhaler/30 days) HD
DULERA 100 MCG-5 MCG INHALER	T3	PA QL(1 inhaler/fill) HD
DULERA 200 MCG-5 MCG INHALER	T3	PA QL(1 inhaler/fill) HD
DULERA 50 MCG-5 MCG INHALER	T3	PA QL(13 gms/fill) HD
<i>fluticasone propion/salmeterol (Advair Diskus)</i>	T2	PA QL(1 inhaler/fill) HD
<i>fluticasone-salmeterol 100-50 (Advair Diskus)</i>	T2	PA QL(1 inhaler/fill) HD
<i>fluticasone-salmeterol 250-50 (Advair Diskus)</i>	T2	PA QL(1 inhaler/fill) HD
<i>fluticasone-salmeterol 500-50 (Advair Diskus)</i>	T2	PA QL(1 inhaler/fill) HD
SYMBICORT (<i>budesonide/formoterol fumarate</i>)	T4	PA QL(1 inhaler/30 days) HD
BETA-ADRENERGIC-ANTICHOLINERGIC-GLUCOCORT, INHALED		
BREZTRI AEROSPHERE	T3	QL(1 inhaler/fill)
TRELEGY ELLIPTA 100-62.5-25	T3	QL(60 blisters/fill)
TRELEGY ELLIPTA 100-62.5-25	T3	QL(28 blisters/fill)
TRELEGY ELLIPTA 200-62.5-25	T3	QL(60 blisters/fill)
TRELEGY ELLIPTA 200-62.5-25	T3	QL(28 blisters/fill)
GLUCOCORTICIDS, ORALLY INHALED		
ALVESCO 80 MCG INHALER	T4	QL(1 inhaler/fill) HD
ALVESCO 160 MCG INHALER	T4	QL(2 inhalers/fill) HD
ARNUIITY ELLIPTA 50 MCG INH	T3	QL(30 blisters/fill) HD
ARNUIITY ELLIPTA 100 MCG, 200 MCG INH	T3	QL(1 inhaler/fill) HD
ASMANEX	T3	QL(1 inhaler/fill) HD
ASMANEX HFA 50 MCG INHALER	T3	QL(13 gms/fill) HD
ASMANEX HFA 100 MCG, 200 MCG INHALER	T3	QL(1 inhaler/fill) HD
<i>budesonide 0.25 mg/2 ml susp (Pulmicort)</i>	T2	
<i>budesonide 0.5 mg/2 ml susp (Pulmicort)</i>	T2	
<i>budesonide 1 mg/2 ml inh susp (Pulmicort)</i>	T2	QL(60 mls/fill) HD
FLOVENT 50 MCG, 100 MCG DISKUS	T3	QL(1 inhaler/fill) HD
FLOVENT 250 MCG DISKUS	T3	QL(4 inhalers/fill) HD
FLOVENT HFA 44 MCG INHALER	T3	QL(11 gms/fill) HD
FLOVENT HFA 110 MCG INHALER	T3	QL(12 gms/fill) HD
FLOVENT HFA 220 MCG INHALER	T3	QL(24 gms/fill) HD

T1 – Preferred Generics

T2 – Non-Preferred Generics

T3 – Preferred Brands

T4 – Non-Preferred Brands

T5 – Preferred Specialty

T6 – Non-Preferred Specialty

PA – Prior Authorization

QL – Quantity Limit

ST – Step Therapy

AGE – Age Requirement

SP – Specialty Medication

HD – May require home delivery pharmacy

PPACA – No Cost-Share Preventive Medication

CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

ANTIASTHMATICS (Asthma/COPD/Respiratory) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
GLUCOCORTICIDS, ORALLY INHALED (cont.)		
QVAR REDHALER 40 MCG	T3	QL(11 gms/fill) HD
QVAR REDHALER 80 MCG	T3	QL(22 gms/fill) HD
INTERLEUKIN-5 (IL-5) ANTAGONISTS, MAB		
NUCALA 100 MG/ML AUTO-INJECTOR	T5	PA QL(1 auto-inj/28 days) SP HD
NUCALA 100 MG/ML SYRINGE	T5	PA QL(1 syringe/28 days) SP HD
NUCALA 40 MG/0.4 ML SYRINGE	T5	PA QL(1 syringe/28 days) SP HD
INTERLEUKIN-5(IL-5) RECEPTOR ALPHA ANTAGONIST, MAB		
FASENRA PEN	T5	PA QL(1 syringe/56 days) SP HD
LEUKOTRIENE RECEPTOR ANTAGONISTS		
ACCOLATE (<i>zafirlukast</i>)	T4	HD
<i>montelukast sodium</i> (Singulair)	T2	HD
<i>zafirlukast</i> (Accolate)	T2	HD
MAST CELL STABILIZERS, ORALLY INHALED		
<i>cromolyn 20 mg/2 ml neb soln</i>	T2	HD
MONOCLONAL ANTIBODIES TO IMMUNOGLOBULIN E (IGE)		
XOLAIR 150 MG/1.2 ML POWDER VL	T5	PA QL(6 vls/28 days) SP HD
XOLAIR 150 MG/ML SYRINGE	T5	PA QL(4 syringes/28 days) SP HD
XOLAIR 75 MG/0.5 ML SYRINGE	T5	PA QL(2 syringes/28 days) SP HD
XOLAIR 300 MG/2 ML SYRINGE	T5	PA SP HD
MUCOLYTICS		
<i>acetylcysteine</i>	T2	
PHOSPHODIESTERASE-4 (PDE4) INHIBITORS		
<i>roflumilast 250 mcg tablet</i> (Daliresp)	T2	PA QL(30 tabs/fill) HD
<i>roflumilast 500 mcg tablet</i> (Daliresp)	T2	PA HD
XANTHINES		
ELIXOPHYLLIN	T4	HD
THEO-24	T4	HD
<i>theophylline anhydrous</i>	T2	HD

ANTIBIOTICS (Ear Medications)

EAR PREPARATIONS, ANTIBIOTICS

<i>ciprofloxacin hcl</i>	T2	
CORTISPORIN-TC	T4	
<i>neomycin/polymyxin b/hydrocort</i>	T2	
<i>ofloxacin</i>	T2	

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

T5 – Preferred Specialty
T6 – Non-Preferred Specialty
PA – Prior Authorization
QL – Quantity Limit

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

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

List of Prescription Medications

ANTIBIOTICS (Ear Medications) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
EAR PREPARATIONS, ANTIBIOTICS (cont.)		
OTIPRIO	T4	QL(1 ml/fill)
OTIC PREPARATIONS, ANTI-INFLAMMATORY-ANTIBIOTICS		
CIPRODEX (<i>ciprofloxacin hcl/dexameth</i>)	T4	
<i>ciprofloxacin hcl/dexameth</i> (Ciprodex)	T2	
OTOVEL	T4	
ANTIBIOTICS (Eye Conditions)		
EYE ANTIBIOTIC AND GLUCOCORTICOID COMBINATIONS		
GATIFLOXACIN-DEXAMETHASONE	T4	
MAXITROL (<i>neomycin/polymyxin b/dexametha</i>)	T4	
<i>neomycin/bacit/p-myx/hydrocort</i>	T2	
<i>neomycin/polymyxin b/dexametha</i> (Maxitrol)	T2	
<i>neomycin/polymyxin b/hydrocort</i>	T2	
PRED-G	T4	
PREDNISOLONE ACET-GATIFLOXACIN	T4	
PREDNISOLONE ACET-MOXIFLOXACIN	T4	
PREDNISOLONE PHOS-GATIFLOXACIN	T4	
PREDNISOLONE PHOS-MOXIFLOXACIN	T4	
TOBRADEX	T4	
TOBRADEX (<i>tobramycin/dexamethasone</i>)	T4	
<i>tobramycin/dexamethasone</i> (Tobradex)	T2	
EYE ANTIBIOTIC, GLUCOCORTICOID AND NSAID COMB.		
PREDNISOLONE ACET-GATIFLO-BROM	T4	
PREDNISOLONE AC-MOXIFLOX-BROMF	T4	
PREDNISOLONE AC-MOXIFLOX-NEPAF	T4	
PREDNISOLONE PHOS-GATIFLO-BROM	T4	
PREDNISOLONE PHOS-MOXIFLO-BROM	T4	
EYE SULFONAMIDES		
BLEPH-10 (<i>sulfacetamide sodium</i>)	T4	
BLEPHAMIDE S.O.P.	T4	
<i>sulfacetamide sodium</i>	T2	
<i>sulfacetamide sodium</i> (Bleph-10)	T2	
<i>sulfacetamide/prednisolone sp</i>	T2	
OPHTHALMIC ANTIBIOTICS		
AZASITE	T3	

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

T5 – Preferred Specialty
T6 – Non-Preferred Specialty
PA – Prior Authorization
QL – Quantity Limit

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

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

List of Prescription Medications

ANTIBIOTICS (Eye Conditions) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
OPHTHALMIC ANTIBIOTICS (cont.)		
<i>bacitracin</i>	T2	
<i>bacitracin/polymyxin b sulfate</i>	T2	
CEFUROXIME SODIUM-0.9% NAACL	T4	PA
CILOXAN 0.3% EYE DROPS (<i>ciprofloxacin hcl</i>)	T4	
<i>ciprofloxacin hcl</i> (Ciloxan)	T2	
<i>erythromycin base</i>	T2	
<i>gatifloxacin</i> (Zymaxid)	T2	
<i>gentamicin 0.3% eye drop</i>	T2	
<i>gentamicin sulfate</i>	T2	
KLARITY-A(AZITHROMYCIN-CHONDR)	T4	
<i>levofloxacin</i>	T2	
<i>moxifloxacin</i> (Vigamox)	T2	
<i>moxifloxacin</i>	T2	
<i>neomycin/bacitracin/polymyxinb</i>	T2	
<i>neomycin/polymyxn b/gramicidin</i>	T2	
OCUFLOX (<i>ofloxacin</i>)	T4	
<i>ofloxacin</i> (Ocuflax)	T2	
<i>polymyxin b sulf/trimethoprim</i> (Polytrim)	T2	
POLYTRIM (<i>polymyxin b sulf/trimethoprim</i>)	T4	
<i>tobramycin 0.3% eye drop</i> (Tobrex)	T2	
TOBEX	T4	
TOBEX (<i>tobramycin</i>)	T4	
VIGAMOX (<i>moxifloxacin hcl</i>)	T4	
ZYMAXID (<i>gatifloxacin</i>)	T4	

ANTIBIOTICS (Infections)

2ND GEN. ANAEROBIC ANTIPROTOZOAL-ANTIBACTERIAL

SOLOSEC	T3	QL(1 pack/fill)
---------	----	-----------------

ABSORBABLE SULFONAMIDE ANTIBACTERIAL AGENTS

BACTRIM (<i>sulfamethoxazole/trimethoprim</i>)	T4	
BACTRIM DS (<i>sulfamethoxazole/trimethoprim</i>)	T4	
<i>sulfadiazine</i>	T2	
<i>sulfamethoxazole/trimethoprim</i>	T2	
<i>sulfamethoxazole/trimethoprim</i> (Bactrim Ds)	T1	
<i>sulfamethoxazole/trimethoprim</i> (Bactrim)	T1	

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

T5 – Preferred Specialty
 T6 – Non-Preferred Specialty
 PA – Prior Authorization
 QL – Quantity Limit

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

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

List of Prescription Medications

ANTIBIOTICS (Infections) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
AMINOGLYCOSIDE ANTIBIOTICS		
ARIKAYCE	T5	PA SP
BETHKIS (<i>tobramycin</i>)	T6	PA QL(224 mls/fill) SP HD
<i>gentamicin 20 mg/2 ml vial</i>	T2	PA
<i>gentamicin 80 mg/2 ml vial</i>	T2	PA
<i>gentamicin 800 mg/20 ml vial</i>	T2	PA
<i>gentamicin ped 20 mg/2 ml vial</i>	T2	PA
KITABIS PAK	T5	PA QL(280 mls/fill) SP HD
<i>neomycin sulfate</i>	T2	
TOBI PODHALER	T5	PA QL(224 caps/fill) SP HD
<i>tobramycin 300 mg/4 ml ampule (Bethkis)</i>	T2	PA QL(224 mls/fill) SP HD
<i>tobramycin 300 mg/5 ml ampule (Tobi)</i>	T2	PA QL(280 mls/fill) SP HD
TOBRAMYCIN PAK 300 MG/5 ML	T6	PA QL(280 mls/fill) SP HD
<i>tobramycin sulfate</i>	T2	PA
ANAEROBIC ANTIPROTOZOAL-ANTIBACTERIAL AGENTS		
FLAGYL (<i>metronidazole</i>)	T4	
<i>metronidazole (Flagyl)</i>	T2	
ANTIBIOTIC, ANTIBACTERIAL, MISC.		
<i>fosfomycin tromethamine</i>	T2	
HIPREX (<i>methenamine hippurate</i>)	T4	
<i>meth/meblue/sod phos/psal/hyos</i>	T2	
<i>methen/mblue/sal/sod phos/hyos</i>	T2	
<i>methenam/m.blue/salicyl/hyoscy (Uribel Tabs)</i>	T2	
<i>methenam/sod phos/mblue/hyoscy</i>	T2	
<i>methenamine hippurate (Hiprex)</i>	T2	
<i>methenamine mandelate</i>	T2	
PRIMSOL	T4	
<i>trimethoprim</i>	T2	
TRIMPEX	T4	
URELLE	T4	
URIBEL	T4	
URIBEL TABS (<i>methenam/m.blue/salicyl/hyoscy</i>)	T4	
ANTILEPROTICS		
<i>dapsone</i>	T2	
THALOMID 50 MG, 100 MG CAPSULE	T5	PA QL(30 caps/fill) SP HD

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

T5 – Preferred Specialty
 T6 – Non-Preferred Specialty
 PA – Prior Authorization
 QL – Quantity Limit

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

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

List of Prescription Medications

ANTIBIOTICS (Infections) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ANTILEPTOTICS (cont.)		
THALOMID 150 MG, 200 MG CAPSULE	T5	PA QL (60 caps/fill) SP HD
ANTI-MYCOBACTERIUM AGENTS		
<i>clindamycin hcl</i> (Cleocin Hcl)	T2	
<i>clindamycin palmitate hcl</i> (Cleocin Pediatric)	T2	
<i>ethambutol hcl</i>	T2	HD
<i>ethambutol hcl</i> (Myambutol)	T2	HD
<i>isoniazid</i>	T2	HD
MYAMBUTOL (<i>ethambutol hcl</i>)	T4	HD
MYCOBUTIN (<i>rifabutin</i>)	T4	HD
PASER	T4	HD
<i>pyrazinamide</i>	T2	HD
<i>rifabutin</i> (Mycobutin)	T2	HD
TRECTOR	T4	HD
ANTITUBERCULAR ANTIBIOTICS		
CYCLOSERINE	T4	
PRETOMANID	T4	PA
PRIFTIN	T3	
<i>rifampin</i>	T2	
SIRTURO	T5	PA SP
BETALACTAMS		
CAYSTON	T5	PA QL (84 mls/fill) SP HD
CEPHALOSPORIN ANTIBIOTICS - 1ST GENERATION		
<i>cefadroxil</i>	T2	
<i>cephalexin</i>	T2	
CEPHALOSPORIN ANTIBIOTICS - 2ND GENERATION		
<i>cefaclor</i>	T2	
<i>cefprozil</i>	T2	
<i>cefuroxime axetil</i>	T2	
CEPHALOSPORIN ANTIBIOTICS - 3RD GENERATION		
<i>cefdinir</i>	T2	
<i>cefditoren pivoxil</i>	T2	
<i>cefditoren pivoxil</i> (Spectracef)	T2	
<i>cefixime</i> (Suprax)	T2	
<i>cefepodoxime proxetil</i>	T2	

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

T5 – Preferred Specialty
 T6 – Non-Preferred Specialty
 PA – Prior Authorization
 QL – Quantity Limit

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

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

List of Prescription Medications

ANTIBIOTICS (Infections) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
CEPHALOSPORIN ANTIBIOTICS - 3RD GENERATION (cont.)		
<i>ceftriaxone sodium</i>	T2	PA
SPECTRACEF (<i>cefditoren pivoxil</i>)	T4	
SUPRAX (<i>cefixime</i>)	T4	
LINCOSAMIDE ANTIBIOTICS		
CLEOCIN HCL (<i>clindamycin hcl</i>)	T4	
CLEOCIN PEDIATRIC (<i>clindamycin palmitate hcl</i>)	T4	
MACROLIDE ANTIBIOTICS		
<i>azithromycin</i>	T2	
<i>azithromycin (Zithromax Tri-Pak)</i>	T2	
<i>azithromycin (Zithromax)</i>	T2	
<i>clarithromycin</i>	T2	
DIFICID 200 MG TABLET	T4	QL(20 tabs/fill)
DIFICID 40 MG/ML SUSPENSION	T4	QL(1 bottle/fill)
E.E.S. 200 (<i>erythromycin ethylsuccinate</i>)	T4	
ERYPED 200 (<i>erythromycin ethylsuccinate</i>)	T4	
ERYPED 400 (<i>erythromycin ethylsuccinate</i>)	T4	
<i>ery-tab dr 250 mg, 333 mg tablet</i>	T2	
ERY-TAB DR 500 MG TABLET (<i>erythromycin base</i>)	T4	
<i>erythromycin base</i>	T2	
<i>erythromycin base (Ery-Tab)</i>	T2	
<i>erythromycin ethylsuccinate</i>	T2	
<i>erythromycin ethylsuccinate (E.E.S. 200)</i>	T2	
<i>erythromycin ethylsuccinate (Eryped 200)</i>	T2	
<i>erythromycin ethylsuccinate (Eryped 400)</i>	T2	
<i>erythromycin stearate</i>	T2	
ZITHROMAX (<i>azithromycin</i>)	T4	
ZITHROMAX TRI-PAK (<i>azithromycin</i>)	T4	
NITROFURAN DERIVATIVES ANTIBACTERIAL AGENTS		
FURADANTIN (<i>nitrofurantoin</i>)	T4	
MACROBID (<i>nitrofurantoin monohyd/m-cryst</i>)	T4	
MACRODANTIN (<i>nitrofurantoin macrocrystal</i>)	T4	
<i>nitrofurantoin (Furadantin)</i>	T2	
<i>nitrofurantoin macrocrystal (Macrodantin)</i>	T2	
<i>nitrofurantoin monohyd/m-cryst (Macrobid)</i>	T2	

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

T5 – Preferred Specialty
 T6 – Non-Preferred Specialty
 PA – Prior Authorization
 QL – Quantity Limit

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

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

List of Prescription Medications

ANTIBIOTICS (Infections) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
OXAZOLIDINONE ANTIBIOTICS		
<i>linezolid</i> (Zyvox)	T2	PA
ZYVOX (<i>linezolid</i>)	T4	PA
PENICILLIN ANTIBIOTICS		
<i>amoxicillin</i>	T2	
<i>amoxicillin/potassium clav</i>	T2	
<i>amoxicillin/potassium clav</i> (Augmentin Xr)	T2	
<i>amoxicillin/potassium clav</i> (Augmentin)	T2	
<i>ampicillin trihydrate</i>	T2	
AUGMENTIN 125-31.25 MG/5 ML	T3	
AUGMENTIN 250-62.5 MG/5 ML (<i>amoxicillin/potassium clav</i>)	T4	
AUGMENTIN XR (<i>amoxicillin/potassium clav</i>)	T4	
<i>dicloxacillin sodium</i>	T2	
MOXATAG	T4	
<i>penicillin v potassium</i>	T2	
PLEUROMUTILIN DERIVATIVES		
XENLETA	T4	
QUINOLONE ANTIBIOTICS		
BAXDELA	T3	QL(28 tabs/fill)
CIPRO (<i>ciprofloxacin hcl</i>)	T4	
CIPRO (<i>ciprofloxacin</i>)	T4	
<i>ciprofloxacin</i> (Cipro)	T2	
<i>ciprofloxacin hcl</i>	T1	
<i>ciprofloxacin hcl</i> (Cipro)	T1	
FACTIVE	T4	
<i>levofloxacin</i>	T2	
<i>moxifloxacin hcl</i>	T2	
<i>ofloxacin</i>	T2	
RIFAMYCINS AND RELATED DERIVATIVE ANTIBIOTICS		
AEMCOLO	T4	QL(12 tabs/fill)
XIFAXAN 200 MG TABLET	T3	QL(9 tabs/fill)
XIFAXAN 550 MG TABLET	T3	QL(60 tabs/fill)
TETRACYCLINE ANTIBIOTICS		
ACTICLATE (<i>doxycycline hyclate</i>)	T4	ST
AVIDOXY DK	T4	ST

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

T5 – Preferred Specialty
T6 – Non-Preferred Specialty
PA – Prior Authorization
QL – Quantity Limit

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

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

List of Prescription Medications

ANTIBIOTICS (Infections) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
TETRACYCLINE ANTIBIOTICS (cont.)		
<i>demeclocycline hcl</i>	T2	
<i>doxycycline 25 mg/5 ml susp</i> (Vibramycin)	T2	
<i>doxycycline 50 mg tablet</i> (Targadox)	T2	ST
<i>doxycycline hyc dr 100 mg tab</i>	T2	ST
<i>doxycycline hyc dr 150 mg tab</i>	T2	ST
<i>doxycycline hyc dr 200 mg tab</i> (Doryx)	T2	ST
<i>doxycycline hyc dr 50 mg tab</i> (Doryx)	T2	ST
<i>doxycycline hyc dr 75 mg tab</i>	T2	ST
<i>doxycycline hyclate 100 mg cap</i> (Vibramycin)	T2	
<i>doxycycline hyclate 100 mg tab</i> (Lymepak)	T2	
<i>doxycycline hyclate 150 mg tab</i> (Acticlate)	T2	ST
<i>doxycycline hyclate 50 mg cap</i>	T2	
<i>doxycycline hyclate 75 mg tab</i> (Acticlate)	T2	ST
<i>doxycycline mono 100 mg cap</i> (Monodox)	T2	
<i>doxycycline mono 100 mg tablet</i>	T2	
<i>doxycycline mono 150 mg cap</i>	T2	ST
<i>doxycycline mono 150 mg tablet</i>	T2	
<i>doxycycline mono 50 mg cap</i> (Monodox)	T2	
<i>doxycycline mono 50 mg tablet</i>	T2	
<i>doxycycline mono 75 mg capsule</i> (Monodox)	T2	
<i>doxycycline mono 75 mg tablet</i>	T2	
<i>doxycycline monohydrate</i>	T2	
<i>doxycycline monohydrate</i> (Monodox)	T2	
LYMEPAK (<i>doxycycline hyclate</i>)	T4	
<i>minocycline hcl</i>	T2	
<i>minocycline hcl</i>	T2	ST
<i>minocycline hcl</i> (Solodyn)	T2	ST
MINOLIRA ER	T4	ST
MONODOX (<i>doxycycline monohydrate</i>)	T4	ST
<i>morgidox 100 mg capsule</i> (Vibramycin)	T2	
MORGIDOX 1X100 MG KIT	T4	ST
MORGIDOX 1X50 MG KIT	T4	ST
MORGIDOX 2X100 MG KIT	T4	ST
<i>morgidox 50 mg capsule</i>	T2	

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

T5 – Preferred Specialty
 T6 – Non-Preferred Specialty
 PA – Prior Authorization
 QL – Quantity Limit

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

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

List of Prescription Medications

ANTIBIOTICS (Infections) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
TETRACYCLINE ANTIBIOTICS (cont.)		
NUZYRA	T6	QL(30 tabs/30 days) SP
SEYSARA	T4	ST
SOLODYN (<i>minocycline hcl</i>)	T4	ST
TARGADOX (<i>doxycycline hyclate</i>)	T4	ST
<i>tetracycline 250 mg capsule</i>	T2	
<i>tetracycline 250 mg tablet</i>	T2	ST
<i>tetracycline 500 mg capsule</i>	T2	
<i>tetracycline 500 mg tablet</i>	T2	ST
XACIATO	T4	
VIBRAMYCIN	T4	ST
VIBRAMYCIN (<i>doxycycline hyclate</i>)	T4	ST
VIBRAMYCIN (<i>doxycycline monohydrate</i>)	T4	ST
VAGINAL ANTIBIOTICS		
CLEOCIN	T4	
CLEOCIN (clindamycin phosphate)	T4	
<i>clindamycin 2% vaginal cream (Cleocin)</i>	T2	
CLINDESSE	T4	
METROGEL-VAGINAL (<i>metronidazole</i>)	T4	
<i>metronidazole (Metrogel-Vaginal)</i>	T2	
NUVESSA	T4	
VANCOMYCIN ANTIBIOTICS AND DERIVATIVES		
VANCOCLIN HCL 125 MG CAPSULE (<i>vancomycin hcl</i>)	T4	PA QL(40 caps/fill)
VANCOCLIN HCL 250 MG CAPSULE (<i>vancomycin hcl</i>)	T4	PA QL(80 caps/fill)
<i>vancomycin 250 mg/5 ml soln</i>	T2	QL(450 mls/fill)
<i>vancomycin hcl 125 mg capsule (Vancocin Hcl)</i>	T2	
<i>vancomycin hcl 250 mg capsule (Vancocin Hcl)</i>	T2	
ANTIBIOTICS (Skin Conditions)		
TOPICAL ANTIBIOTIC AND ANTI-INFLAMMATORY STEROID		
CORTISPORIN	T4	
NEO-SYNALAR	T4	
TOPICAL ANTIBIOTICS		
AKTIPAK	T4	ST
AMZEEQ	T4	ST
BENZAMYCIN (<i>erythromycin/benzoyl peroxide</i>)	T4	ST

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

T5 – Preferred Specialty
 T6 – Non-Preferred Specialty
 PA – Prior Authorization
 QL – Quantity Limit

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

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

List of Prescription Medications

ANTIBIOTICS (Skin Conditions) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
TOPICAL ANTIBIOTICS (cont.)		
CENTANY	T4	ST QL (30 gms/fill)
CENTANY AT	T4	ST QL (1 kit/fill)
CLEOCIN T 1% LOTION (<i>clindamycin phosphate</i>)	T4	ST QL (120 mls/30 days)
CLEOCIN T 1% PLEDGETS (<i>clindamycin phosphate</i>)	T4	ST
<i>clindacin etz 1% pledget (Cleocin T)</i>	T2	
CLINDACIN ETZ KIT	T4	ST
CLINDACIN PAC	T4	ST
<i>clindamycin ph 1% gel</i>	T2	QL (120 gms/30 days)
<i>clindamycin ph 1% solution</i>	T2	QL (120 mls/30 days)
<i>clindamycin phos 1% pledget (Cleocin T)</i>	T2	
<i>clindamycin phosp 1% lotion (Cleocin T)</i>	T2	QL (120 mls/30 days)
<i>clindamycin phosphate (Cleocin T)</i>	T2	
<i>clindamycin phosphate 1% foam (Evoclin)</i>	T2	QL (100 gms/30 days)
<i>clindamycin phosphate 1% gel (Clindagel)</i>	T2	QL (150 mls/30 days)
<i>erythromycin base in ethanol</i>	T2	
<i>erythromycin/benzoyl peroxide (Benzamycin)</i>	T2	
EVOCLIN (<i>clindamycin phosphate</i>)	T4	ST QL (100 gms/30 days)
<i>gentamicin 0.1% cream</i>	T2	QL (60 gms/fill)
<i>gentamicin 0.1% ointment</i>	T2	QL (60 gms/fill)
<i>mupirocin 2% cream</i>	T2	ST QL (30 gms/fill)
<i>mupirocin 2% ointment</i>	T2	QL (1 treatment/30 days)
<i>mupirocin 2% ointment</i>	T2	QL (30 gms/fill)
XEPI	T4	ST QL (30 gms/fill)
TOPICAL SULFONAMIDES		
AVAR LS	T4	ST
AVAR-E	T4	ST
AVAR-E GREEN	T4	ST
AVAR-E LS	T4	ST
<i>mafenide acetate (Sulfamylon)</i>	T2	
PLEXION	T4	ST
ROSULA 10%-4.5% WASH	T4	ST
<i>rosula 10%-5% cloths</i>	T2	
SILVADENE (<i>silver sulfadiazine</i>)	T4	
<i>silver sulfadiazine (Silvadene)</i>	T2	

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

T5 – Preferred Specialty
T6 – Non-Preferred Specialty
PA – Prior Authorization
QL – Quantity Limit

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

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

List of Prescription Medications

ANTIBIOTICS (Skin Conditions) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
TOPICAL SULFONAMIDES (cont.)		
<i>sod sulface-sulf 9.8-4.8% clsr</i>	T2	
<i>sod sulface-sulfur 9-4.5% wash</i>	T2	
<i>sod sulfacet-sulfr 9.8-4.8%pad</i>	T2	
<i>sod sulfacet-sulfur 10-2% clsr</i>	T2	
<i>sod sulfacet-sulfur 10-4% pad (Sumaxin)</i>	T2	
<i>sod sulfacet-sulfur 10-5% clsr</i>	T2	
<i>sod sulfac-sulfur 9.8-4.8% crm</i>	T2	
<i>sod sulfac-sulfur 9.8-4.8% lot</i>	T2	
<i>sulfacetamide sodium/sulfur</i>	T2	
<i>sulfacetamide sodium/sulfur</i>	T2	ST
<i>sulfacetamide-sulfur 10-2% crm</i>	T2	
<i>sulfacetamide-sulfur 10-5% crm</i>	T2	
<i>sulfacetamide-sulfur 10-5% lot</i>	T2	
<i>sulfacetamide-sulfur 10-5% sus</i>	T2	
<i>sulfacetamide-sulfur 8-4% susp</i>	T2	
<i>sulfacetamide-sulfur 9-4% clsr</i>	T2	
SULFAMYLON 8.5% CREAM	T3	
SULFAMYLON POWDER PACKET (<i>mafenide acetate</i>)	T4	
SUMADAN	T4	ST
SUMADAN XLT	T4	ST
SUMAXIN	T4	ST
SUMAXIN (<i>sulfacetamide sodium/sulfur</i>)	T4	ST
SUMAXIN CP	T4	ST
SUMAXIN TS	T4	ST
ANTICOAGULANTS (Blood Thinners/Anti-Clotting)		
CITRATES AS ANTICOAGULANTS		
ACD SOLUTION A	T3	
ACD-A	T3	
ANTICOAGULANT SODIUM CITRATE	T4	
CITRATE PHOSPHATE DEXTROSE	T3	
CRRT TRISODIUM CITRATE	T4	
SODIUM CITRATE	T4	
TRISODIUM CITRATE CRRT	T4	

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

T5 – Preferred Specialty
T6 – Non-Preferred Specialty
PA – Prior Authorization
QL – Quantity Limit

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

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

List of Prescription Medications

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

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
------------------------	-----------	----------------------------------

DIRECT FACTOR XA INHIBITORS

ELIQUIS	T3	PA
XARELTO	T3	PA

HEPARIN AND RELATED PREPARATIONS

ARIXTRA (<i>fondaparinux sodium</i>)	T6	SP
<i>enoxaparin sodium</i> (Lovenox)	T2	SP
<i>fondaparinux sodium</i> (Arixtra)	T2	SP
FRAGMIN	T5	SP
<i>heparin 10,000 unit/10 ml vial</i>	T2	
<i>heparin 2,000 unit/2 ml vial</i>	T2	
<i>heparin 30,000 unit/30 ml vial</i>	T2	
<i>heparin 40,000 unit/4 ml vial</i>	T2	
<i>heparin 5,000 unit/ml carpuct</i>	T2	
<i>heparin 50,000 unit/10 ml vial</i>	T2	
<i>heparin 50,000 unit/5 ml vial</i>	T2	
<i>heparin sod 1,000 unit/ml vial</i>	T2	
<i>heparin sod 10,000 unit/ml vl</i>	T2	
<i>heparin sod 20,000 unit/ml vl</i>	T2	
<i>heparin sod 5,000 unit/0.5 ml</i>	T2	
HEPARIN SOD 5,000 UNIT/0.5 ML	T3	
HEPARIN SOD 5,000 UNIT/0.5 ML	T4	
<i>heparin sod 5,000 unit/ml syrg</i>	T2	
HEPARIN SOD 5,000 UNIT/ML SYRG	T4	
<i>heparin sod 5,000 unit/ml vial</i>	T2	

THROMBIN INHIBITORS, SELECTIVE, DIRECT, REVERSIBLE

<i>dabigatran etexilate mesylate</i>	T2	HD
--------------------------------------	----	----

ANTIDOTES (Gastrointestinal/Heartburn)

MU-OPIOID RECEPTOR ANTAGONISTS, PERIPHERALLY-ACTING

MOVANTIK	T3	QL(30 tabs/fill)
RELISTOR	T3	ST
SYMPROIC	T3	

ANTIDOTES (Substance Abuse)

OPIOID ANTAGONISTS

EVZIO (<i>naloxone</i>)	T4	QL(1 ml/fill)
---------------------------	----	---------------

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

T5 – Preferred Specialty
 T6 – Non-Preferred Specialty
 PA – Prior Authorization
 QL – Quantity Limit

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

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

List of Prescription Medications

ANTIDOTES (Substance Abuse) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
OPIOID ANTAGONISTS (cont.)		
KLOXXADO	T3	QL(2 units/fill)
<i>naloxone 0.4 mg/ml carpject</i>	T2	
<i>naloxone 0.4 mg/ml vial</i>	T2	
<i>naloxone 2 mg/2 ml syringe</i>	T2	
<i>naloxone 4 mg/10 ml vial</i>	T2	
<i>naloxone hcl 4 mg nasal spray (Narcan)</i>	T2	QL(2 units/fill)
<i>naltrexone hcl</i>	T1	
NARCAN (<i>naloxone hcl</i>)	T4	QL(2 units/30 days)

ANTIFUNGALS (Eye Conditions)

OPHTHALMIC ANTIFUNGAL AGENTS

NATACYN	T3	
---------	----	--

ANTIFUNGALS (Feminine Products)

VAGINAL ANTIFUNGALS

GYNAZOLE 1	T4	
<i>miconazole nitrate</i>	T2	
<i>terconazole</i>	T2	

ANTIFUNGALS (Infections)

ANTIFUNGAL AGENTS

ANCOBON (<i>flucytosine</i>)	T4	PA
<i>clotrimazole</i>	T2	
CRESEMBA	T3	PA
DIFLUCAN 10 MG/ML SUSPENSION (<i>fluconazole</i>)	T4	
DIFLUCAN 100 MG TABLET (<i>fluconazole</i>)	T4	
DIFLUCAN 150 MG TABLET (<i>fluconazole</i>)	T4	QL(2 tabs/fill)
DIFLUCAN 200 MG TABLET (<i>fluconazole</i>)	T4	
DIFLUCAN 40 MG/ML SUSPENSION (<i>fluconazole</i>)	T4	
DIFLUCAN 50 MG TABLET (<i>fluconazole</i>)	T4	
<i>fluconazole 10 mg/ml susp (Diflucan)</i>	T2	
<i>fluconazole 100 mg tablet (Diflucan)</i>	T2	
<i>fluconazole 150 mg tablet (Diflucan)</i>	T2	QL(2 tabs/fill)
<i>fluconazole 200 mg tablet (Diflucan)</i>	T2	
<i>fluconazole 40 mg/ml susp (Diflucan)</i>	T2	
<i>fluconazole 50 mg tablet (Diflucan)</i>	T2	

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

T5 – Preferred Specialty
 T6 – Non-Preferred Specialty
 PA – Prior Authorization
 QL – Quantity Limit

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

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

List of Prescription Medications

ANTIFUNGALS (Infections) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ANTIFUNGAL AGENTS (cont.)		
<i>flucytosine (Ancobon)</i>	T2	
<i>itraconazole 10 mg/ml solution (Sporanox)</i>	T2	QL(2 bottles/fill)
<i>itraconazole 100 mg capsule (Sporanox)</i>	T2	QL(30 caps/fill)
<i>itraconazole 100 mg/10 ml cup (Sporanox)</i>	T2	QL(2 bottles/fill)
<i>ketoconazole 200 mg tablet</i>	T2	
NOXAFIL 300 MG POWDERMIX SUSP	T3	PA
NOXAFIL 40 MG/ML SUSPENSION	T3	PA SP
ORAVIG	T4	
POSACONAZOLE 200 MG/5 ML SUSP	T3	PA
<i>posaconazole dr 100 mg tablet (Noxafil)</i>	T2	PA
SPORANOX 10 MG/ML SOLUTION (<i>itraconazole</i>)	T4	QL(2 bottles/fill)
SPORANOX 100 MG CAPSULE (<i>itraconazole</i>)	T4	QL(30 caps/fill)
<i>terbinafine hcl</i>	T2	
VFEND (<i>voriconazole</i>)	T4	PA
VIVJOA	T4	PA QL(18 caps/fill)
<i>voriconazole (Vfend)</i>	T2	PA

ANTIFUNGAL ANTIBIOTICS

BREXAFEMME	T4	ST QL(4 tabs/fill)
<i>griseofulvin ultramicrosize</i>	T2	
<i>griseofulvin, microsize</i>	T2	
<i>nystatin 100,000 unit/ml susp</i>	T2	
<i>nystatin 500,000 unit oral tab</i>	T2	
<i>nystatin 500,000 unit/5 ml cup</i>	T2	

ANTIFUNGALS (Skin Conditions)

TOPICAL ANTIFUNGAL/ANTI-INFLAMMATORY, STEROID AGENT

<i>clotrimazole-betamethasone crm</i>	T2	QL(90 gms/28 days)
<i>clotrimazole-betamethasone lot</i>	T2	QL(60 mls/28 days)

TOPICAL ANTIFUNGALS

<i>ciclodan 0.77% cream (Loprox)</i>	T2	QL(90 gms/28 days)
CICLODAN 0.77% CREAM KIT	T4	
<i>ciclodan 8% solution</i>	T2	
<i>ciclopirox 0.77% cream (Loprox)</i>	T2	QL(90 gms/28 days)
<i>ciclopirox 0.77% gel</i>	T2	QL(100 gms/28 days)

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

T5 – Preferred Specialty
T6 – Non-Preferred Specialty
PA – Prior Authorization
QL – Quantity Limit

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

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

List of Prescription Medications

ANTIFUNGALS (Skin Conditions) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
TOPICAL ANTIFUNGALS (cont.)		
<i>ciclopirox 0.77% topical susp (Loprox)</i>	T2	QL(60 mls/28 days)
<i>ciclopirox 1% shampoo</i>	T2	QL(120 mls/28 days)
<i>ciclopirox 8% solution</i>	T2	
<i>econazole nitrate</i>	T2	QL(85 gms/28 days)
EXELDERM 1% CREAM	T4	QL(60 gms/28 days)
EXELDERM 1% SOLUTION	T4	QL(60 mls/28 days)
EXTINA (<i>ketoconazole</i>)	T4	ST QL(100 gms/28 days)
JUBLIA	T4	ST
<i>ketoconazole 2% cream</i>	T2	QL(60 gms/28 days)
<i>ketoconazole 2% foam (Extina)</i>	T2	ST QL(100 gms/28 days)
<i>ketoconazole 2% shampoo</i>	T2	QL(120 mls/28 days)
<i>ketodan 2% foam (Extina)</i>	T2	ST QL(100 gms/28 days)
<i>ketodan 2% foam kit</i>	T2	
LOPROX 0.77% CREAM (<i>ciclopirox olamine</i>)	T4	QL(90 gms/28 days)
LOPROX 0.77% CREAM KIT	T4	QL(544 gms/30 days)
LOPROX 0.77% SUSPENSION KIT	T4	QL(1 kit/30 days)
LOPROX 0.77% TOPICAL SUSP (<i>ciclopirox olamine</i>)	T4	QL(60 mls/28 days)
<i>naftifine hcl</i>	T2	QL(60 gms/28 days)
<i>naftifine hcl (Naftin)</i>	T2	QL(60 gms/28 days)
NAFTIN	T4	QL(60 gms/28 days)
NAFTIN (<i>naftifine hcl</i>)	T4	QL(60 gms/28 days)
<i>nystatin</i>	T2	QL(180 gms/fill)
<i>nystatin 100,000 unit/gm cream</i>	T2	QL(60 gms/28 days)
<i>nystatin 100,000 unit/gm oint</i>	T2	QL(60 gms/28 days)
<i>nystatin 100,000 unit/gm powd</i>	T2	QL(180 gms/fill)
<i>nystatin/triamcin</i>	T2	QL(60 gms/28 days)
<i>oxiconazole nitrate</i>	T2	QL(60 gms/28 days)
<i>tavorole</i>	T2	ST
ANTI-HISTAMINE AND DECONGESTANT COMBINATION (Allergy/Nasal Sprays)		
1ST GEN ANTI-HISTAMINE AND DECONGESTANT COMBINATION		
<i>phenylephrine hcl/prometh hcl</i>	T2	
<i>phenylephrine/chlor-tan</i>	T2	

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

T5 – Preferred Specialty
 T6 – Non-Preferred Specialty
 PA – Prior Authorization
 QL – Quantity Limit

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

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

List of Prescription Medications

ANTI-HISTAMINE AND DECONGESTANT COMBINATION (Allergy/Nasal Sprays) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
------------------------	-----------	----------------------------------

2ND GEN ANTIHISTAMINE AND DECONGESTANT COMBINATION

CLARINEX-D 12 HOUR	T4	
CLARINEX-D 24 HOUR	T4	

ANTI-HISTAMINES (Allergy/Nasal Sprays)

ANTI-HISTAMINES - 1ST GENERATION

<i>carbinoxamine 4 mg/5 ml liquid</i>	T2	
<i>carbinoxamine maleate 4 mg tab</i>	T2	
<i>carbinoxamine maleate 6 mg tab</i>	T2	ST
<i>clemastine fumarate</i>	T2	
<i>cyproheptadine 2 mg/5 ml soln</i>	T2	
<i>cyproheptadine 2 mg/5 ml syrup</i>	T2	
<i>cyproheptadine 4 mg tablet</i>	T2	
CYPROHEPTADINE 4 MG/10 ML SYRP	T4	
<i>dexchlorpheniramine maleate (Ryclora)</i>	T2	
<i>hydroxyzine hcl</i>	T2	
<i>hydroxyzine hcl</i>	T1	
<i>hydroxyzine pamoate</i>	T1	
<i>hydroxyzine pamoate (Vistaril)</i>	T1	
KARBINAL ER	T4	ST
<i>promethazine hcl</i>	T2	
RYCLORA (<i>dexchlorpheniramine maleate</i>)	T4	
RYVENT	T4	ST
VISTARIL (<i>hydroxyzine pamoate</i>)	T4	

ANTI-HISTAMINES - 2ND GENERATION

CLARINEX (<i>desloratadine</i>)	T4	QL(30 tabs/fill) HD
<i>desloratadine</i>	T2	QL(30 tabs/fill) HD
<i>desloratadine (Clarinx)</i>	T2	QL(30 tabs/fill) HD

ANTI-HISTAMINES (Eye Conditions)

EYE ANTIHISTAMINES

<i>azelastine hcl 0.05% drops</i>	T2	
BEPREVE	T2	
<i>epinastine hcl</i>	T2	
LASTACFT 0.25% EYE DROPS	T4	ST

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

T5 – Preferred Specialty
 T6 – Non-Preferred Specialty
 PA – Prior Authorization
 QL – Quantity Limit

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

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

List of Prescription Medications

ANTIHYPERGLYCEMICS (Diabetes)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ANTIHYPERGLY,DPP-4 ENZYME INHIB.-THIAZOLIDINEDIONE		
OSENI	T4	ST QL (30 tabs/fill) HD
ANTIHYPERGLY,INCRETIN MIMETIC(GLP-I RECEPT.AGONIST)		
ADLYXIN 10-20 MCG STARTER PACK	T4	PA QL (1 kit/28 days) HD
ADLYXIN 20 MCG MAINTENANCE PK	T4	PA QL (1 kit/28 days) HD
BYDUREON BCISE	T3	PA QL(4 auto-injs/fill) HD
BYDUREON PEN	T3	PA QL(4 pens/fill) HD
BYETTA	T3	PA QL(1 pen/fill) HD
OZEMPIC	T3	PA QL(1 pen/28 days
TRULICITY 1.5 MG/0.5 ML PEN	T3	PA QL(1 pen/fill) HD
TRULICITY 3 MG/0.5 ML PEN	T3	PA QL(2 pens/fill) HD
TRULICITY 4.5 MG/0.5 ML PEN	T3	PA QL(1 pen/fill) HD
VICTOZA 2-PAK	T3	PA QL(1 pen/fill) HD
VICTOZA 3-PAK	T3	PA QL(30 tabs/fill) HD
TRULICITY 0.75 MG/0.5 ML PEN	T3	PA QL(4 pens/fill) HD
ANTIHYPERGLY, INSULIN, LONG ACT-GLP-I RECEPT.AGONIST		
SOLIQUA 100-33	T3	QL(15 mls/fill) HD
ANTIHYPERGLYCEMIC - DOPAMINE RECEPTOR AGONISTS		
CYCLOSET	T4	HD
ANTIHYPERGLYCEMIC - INCRETIN MIMETICS COMBINATION		
MOUNJARO	T3	PA QL(4 pens/fill)
ANTIHYPERGLYCEMIC, ALPHA-GLUCOSIDASE INHIBITORS		
<i>acarbose (Precose)</i>	T2	HD
<i>miglitol</i>	T2	HD
PRECOSE (<i>acarbose</i>)	T4	HD
ANTIHYPERGLYCEMIC, AMYLIN ANALOG-TYPE		
SYMLINPEN 120	T3	PA QL(7 pens/fill) HD
SYMLINPEN 60	T3	PA QL(7 pens/fill) HD
ANTIHYPERGLYCEMIC, BIGUANIDE TYPE		
FORTAMET ER 1,000 MG TABLET (<i>metformin hcl</i>)	T4	PA QL(60 tabs/fill) HD
FORTAMET ER 500 MG TABLET (<i>metformin hcl</i>)	T4	PA QL(30 tabs/fill) HD
<i>metformin er 1,000 mg gastr-tb (Glumetza)</i>	T2	PA QL(60 tabs/fill) HD
<i>metformin er 1,000 mg osm-tab (Fortamet)</i>	T2	PA QL(60 tabs/fill) HD
<i>metformin er 500 mg gastr-tb (Glumetza)</i>	T2	PA QL(120 tabs/fill) HD
<i>metformin er 500 mg osmotic tb (Fortamet)</i>	T2	PA QL(30 tabs/fill) HD

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

T5 – Preferred Specialty
 T6 – Non-Preferred Specialty
 PA – Prior Authorization
 QL – Quantity Limit

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

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

List of Prescription Medications

ANTIHYPERGLYCEMICS (Diabetes) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ANTIHYPERGLYCEMIC, BIGUANIDE TYPE (cont.)		
<i>metformin hcl 1,000 mg tablet</i>	T1	HD
<i>metformin hcl 500 mg tablet</i>	T1	HD
<i>metformin hcl 500 mg/5 ml soln (Riomet)</i>	T2	ST HD
<i>metformin hcl 850 mg tablet</i>	T1	HD
<i>metformin hcl 850 mg/8.5ml cup (Riomet)</i>	T2	ST HD
<i>metformin hcl er 500 mg tablet</i>	T1	QL(120 tabs/fill) HD
<i>metformin hcl er 750 mg tablet</i>	T1	QL(60 tabs/fill) HD
RIOMET (<i>metformin hcl</i>)	T4	ST HD
RIOMET ER	T4	ST HD
ANTIHYPERGLYCEMIC, DPP-4 INHIBITORS		
JANUVIA	T3	ST QL(30 tabs/fill) HD
<i>saxagliptin (Onglyza)</i>	T2	ST QL(30 tabs/30 days) HD
ANTIHYPERGLYCEMIC, INSULIN-RELEASE STIMULANT TYPE		
AMARYL (<i>glimepiride</i>)	T4	HD
<i>glimepiride (Amaryl)</i>	T1	HD
<i>glipizide</i>	T1	HD
<i>glipizide (Glucotrol XL)</i>	T1	HD
GLUCOTROL XL (<i>glipizide</i>)	T4	HD
<i>glyburide</i>	T2	HD
<i>glyburide, micronized (Glynase)</i>	T2	HD
GLYNASE (<i>glyburide, micronized</i>)	T4	HD
<i>nateglinide</i>	T2	HD
PRANDIN (<i>repaglinide</i>)	T4	HD
<i>repaglinide</i>	T2	HD
<i>repaglinide (Prandin)</i>	T2	HD
ANTIHYPERGLYCEMIC, SGLT-2 AND DPP-4 INHIBITOR COMB		
GLYXAMBI	T3	ST QL(30 tabs/fill) HD
ANTIHYPERGLYCEMIC, THIAZOLIDINEDIONE AND BIGUANIDE		
ACTOPLUS MET (<i>pioglitazone hcl/metformin hcl</i>)	T4	ST HD
<i>pioglitazone hcl/metformin hcl</i>	T2	QL(90 tabs/fill) HD
<i>pioglitazone hcl/metformin hcl (Actoplus Met)</i>	T2	QL(90 tabs/fill) HD
ANTIHYPERGLYCEMIC, THIAZOLIDINEDIONE-SULFONYLUREA		
DUETACT (<i>pioglitazone-glimepiride</i>)	T4	ST QL(30 tabs/fill) HD
<i>pioglitazone hcl/glimepiride (Duetact)</i>	T2	QL(30 tabs/fill) HD

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

T5 – Preferred Specialty
 T6 – Non-Preferred Specialty
 PA – Prior Authorization
 QL – Quantity Limit

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

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

List of Prescription Medications

ANTIHYPERGLYCEMICS (Diabetes) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ANTIHYPERGLYCEMIC, DPP-4 INHIBITOR-BIGUANIDE COMBS.		
JANUMET	T3	ST QL (60 tabs/fill) HD
JANUMET XR 100-1,000 MG TABLET	T3	ST QL (30 tabs/fill) HD
JANUMET XR 50-1,000 MG TABLET	T3	ST QL (60 tabs/fill) HD
JANUMET XR 50-500 MG TABLET	T3	ST QL (60 tabs/fill) HD
<i>saxagliptin-metformin er 2.5-1000</i> (Kombiglyze Xr)	T2	ST QL (60 tabs/30 days) HD
<i>saxagliptin-metformin er 5-500</i> (Kombiglyze Xr)	T2	ST QL (30 tabs/30 days) HD
<i>saxagliptin-metformin er 5-1000</i> (Kombiglyze Xr)	T2	ST QL (30 tabs/30 days) HD
ANTIHYPERGLYCEMIC, INSULIN-RELEASE STIM.-BIGUANIDE		
<i>glipizide/metformin hcl</i>	T1	HD
<i>glyburide/metformin hcl</i>	T2	HD
ANTIHYPERGLYCEMIC, THIAZOLIDINEDIONE (PPARG AGONIST)		
<i>ACTOS (pioglitazone hcl)</i>	T4	ST QL (30 tabs/fill) HD
ANTIHYPERGLYCEMIC-GLUCOCORTICOID RECEPTOR BLOCKER		
<i>mifepristone 300 mg tablet</i>	T2	PA SP
ANTIHYPERGLYCEMIC-SGLT2 INHIBITOR-BIGUANIDE COMBS.		
SEGLUROMET	T3	ST QL (60 tabs/fill) HD
SYNJARDY	T3	ST QL (60 tabs/fill) HD
SYNJARDY XR 10-1,000 MG TABLET	T3	ST QL (30 tabs/fill) HD
SYNJARDY XR 12.5-1,000 MG TAB	T3	ST QL (60 tabs/fill) HD
SYNJARDY XR 25-1,000 MG TABLET	T3	ST QL (30 tabs/fill) HD
SYNJARDY XR 5-1,000 MG TABLET	T3	ST QL (60 tabs/fill) HD
XIGDUO XR 10 MG-1,000 MG TAB	T3	ST QL (30 tabs/fill) HD
XIGDUO XR 10 MG-500 MG TABLET	T3	ST QL (30 tabs/fill) HD
XIGDUO XR 2.5 MG-1,000 MG TAB	T3	ST QL (60 tabs/fill) HD
XIGDUO XR 5 MG-1,000 MG TABLET	T3	ST QL (60 tabs/fill) HD
XIGDUO XR 5 MG-500 MG TABLET	T3	ST QL (30 tabs/fill) HD
ANTIHYPERGLYCEMIC-SOD/GLUC COTRANSPORT2(SGLT2) INH		
FARXIGA	T3	ST QL (30 tabs/fill) HD
JARDIANCE	T3	ST QL (30 tabs/fill) HD
STEGLATRO	T3	ST QL (30 tabs/fill) HD
ANTIHYPERGLY-SGLT-2 INHIB, DPP-4 INHIB, BIGUANIDE CB		
TRIJARDY XR	T3	ST HD

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

T5 – Preferred Specialty
 T6 – Non-Preferred Specialty
 PA – Prior Authorization
 QL – Quantity Limit

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

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

List of Prescription Medications

ANTIHYPERGLYCEMICS (Diabetes) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
INSULINS		
BASAGLAR KWIKPEN U-100	T4	HD
HUMALOG	T3	HD
HUMALOG JUNIOR KWIKPEN	T3	HD
HUMALOG KWIKPEN U-100	T3	HD
HUMALOG KWIKPEN U-200	T3	HD
HUMALOG MIX 50-50	T3	HD
HUMALOG MIX 50-50 KWIKPEN	T3	HD
HUMALOG MIX 75-25	T3	HD
HUMALOG MIX 75-25 KWIKPEN	T3	HD
HUMULIN 70/30 KWIKPEN	T3	HD
HUMULIN 70-30	T3	HD
HUMULIN N	T3	HD
HUMULIN N KWIKPEN	T3	HD
HUMULIN R	T3	HD
HUMULIN R U-500	T3	HD
HUMULIN R U-500 KWIKPEN	T3	HD
INSULIN LISPRO 100 UNIT/ML VIAL	T3	HD
INSULIN LISPRO JUNIOR KWIKPEN	T3	HD
INSULIN LISPRO KWIKPEN U-100	T3	HD
INSULIN LISPRO PROTAMINE MIX	T3	HD
LYUMJEV	T3	HD
LYUMJEV KWIKPEN U-100	T3	HD
LYUMJEV KWIKPEN U-200	T3	HD
MYXREDLIN	T4	HD
SEMGLEE (YFGN)	T3	HD
SEMGLEE (YFGN) PEN	T3	HD
TOUJEO MAX SOLOSTAR	T3	HD
TOUJEO SOLOSTAR	T3	HD
TRESIBA	T3	HD
TRESIBA FLEXTOUCH U-100	T3	HD
TRESIBA FLEXTOUCH U-200	T3	HD

ANTIINFECTIVES (Feminine Products)

VAGINAL SULFONAMIDES

AVC	T4	
-----	----	--

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

T5 – Preferred Specialty
 T6 – Non-Preferred Specialty
 PA – Prior Authorization
 QL – Quantity Limit

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

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

List of Prescription Medications

ANTIINFECTIVES (Infections)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
PENICILLIN ANTIBIOTICS		
<i>amoxicillin</i>	T2	
ANTIINFECTIVES/MISCELLANEOUS (Feminine Products)		
VAGINAL ANTISEPTICS		
<i>acetic acid/oxyquinoline (Relagard)</i>	T2	
RELAGARD (<i>acetic acid/oxyquinoline</i>)	T4	
TRIMO-SAN	T3	
ANTIINFECTIVES/MISCELLANEOUS (Infections)		
2ND GEN. ANAEROBIC ANTIPROTOZOAL-ANTIBACTERIAL		
tinidazole 250 mg tablet	T2	QL(40 tabs/30 days)
<i>tinidazole 500 mg tablet</i>	T2	QL(20 tabs/30 days)
AMEBICIDES		
HUMATIN	T4	
<i>paromomycin sulfat</i> e	T2	
ANTHELMINTICS		
<i>albendazole (Albenza)</i>	T2	QL(120 tabs/30 days)
ALBENZA (<i>albendazole</i>)	T4	QL(120 tabs/30 days)
BILTRICIDE (<i>praziquantel</i>)	T4	
EMVERM	T3	QL(6 tabs/30 days)
<i>ivermectin 3 mg tablet (Stromectol)</i>	T2	PA QL(14 tabs/30 days)
<i>praziquantel (Biltricide)</i>	T2	
STROMECTOL (<i>ivermectin</i>)	T4	PA QL(14 tabs/30 days)
ANTIMALARIAL DRUGS		
ARAKODA	T4	QL(16 tabs/fill)
<i>atovaquone-proguanil 250-100 (Malarone)</i>	T2	QL(60 tabs/180 days)
<i>atovaquone-proguanil 62.5-25 (Malarone)</i>	T2	QL(180 tabs/180 days)
<i>chloroquine phosphate</i>	T2	
COARTEM	T3	QL(24 tabs/30 days)
DARAPRIM (<i>pyrimethamine</i>)	T6	PA SP
HYDROXYCHLOROQUINE 100 MG TAB	T4	
<i>hydroxychloroquine 200 mg tab (Plaquenil)</i>	T2	
HYDROXYCHLOROQUINE 300 MG TAB	T4	
HYDROXYCHLOROQUINE 400 MG TAB	T4	
<i>hydroxychloroquine sulfate (Sovuna)</i>	T2	
KRINTAFEL	T4	QL(2 tabs/30 days)

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

T5 – Preferred Specialty
 T6 – Non-Preferred Specialty
 PA – Prior Authorization
 QL – Quantity Limit

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

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

List of Prescription Medications

ANTIINFECTIVES/MISCELLANEOUS (Infections) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ANTIMALARIAL DRUGS (cont.)		
MALARONE 250-100 MG TABLET (<i>atovaquone/proguanil hcl</i>)	T4	QL(60 tabs/180 days)
MALARONE 62.5-25 MG PED TAB (<i>atovaquone/proguanil hcl</i>)	T4	QL(180 tabs/180 days)
<i>mefloquine hcl</i>	T2	QL(13 tabs/180 days)
PRIMAQUINE 26.3 MG TABLET	T3	QL(120 tabs/180 days)
<i>primaquine 26.3 mg tablet</i>	T2	QL(120 tabs/180 days)
<i>pyrimethamine 25 mg tablet</i> (Daraprim)	T2	PA
<i>pyrimethamine 25 mg tablet</i> (Daraprim)	T2	PA SP
QUALAQUIN (<i>quinine sulfate</i>)	T4	QL(42 caps/30 days)
<i>quinine sulfate</i> (Qualaquin)	T2	QL(42 caps/30 days)
SOVUNA	T4	
SOVUNA (hydroxychloroquine sulfate)	T4	
ANTIPROTOZOAL DRUGS, MISCELLANEOUS		
<i>atovaquone</i> (Mepron)	T2	
BENZNIDAZOLE	T3	QL(360 tabs/fill)
IMPAVIDO	T3	PA QL(84 caps/30 days)
MEPRON (<i>atovaquone</i>)	T4	
NEBUPENT (<i>pentamidine isethionate</i>)	T4	QL(1 v1/28 days)
<i>pentamidine isethionate</i> (Nebupent)	T2	QL(1 v1/28 days)
ANTIINFECTIVES/MISCELLANEOUS (Miscellaneous)		
ANTIBACTERIAL AGENTS,MISCELLANEOUS		
<i>glycine urologic solution</i>	T2	
ANTISEPTICS,GENERAL		
ALCOHOL SWABSTICK	T4	
CVS ISOPROPYL ALCOHOL 91% SPRY	T4	
GS ISOPROPYL ALCOHOL 70% SPRAY	T4	
ISOPROPYL ALCOHOL 70% SPRAY	T4	
MEDI-FIRST ISOPROPYL ALCOHOL	T4	
TOPICAL ANTISEPTIC DRYING AGENTS		
<i>formaldehyde</i>	T2	
ANTIINFECTIVES/MISCELLANEOUS (Skin Conditions)		
TOPICAL ANTIFUNGALS		
CICLODAN 8% KIT	T4	ST
<i>ciclopirox 8% treatment kit</i>	T2	

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

T5 – Preferred Specialty
T6 – Non-Preferred Specialty
PA – Prior Authorization
QL – Quantity Limit

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

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

List of Prescription Medications

ANTIINFLAM.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-ADAZ (CF)	T5	PA QL(2 syringes/28 days) SP HD
ADALIMUMAB-ADAZ (CF) PEN	T5	PA QL(2 pens/28 days) SP HD
ADALIMUMAB-ADBM(CF)	T5	PA QL(2 srnge kits/28 days) SP HD
ADALIMUMAB-ADBM(CF) PEN CROHNS	T5	PA QL(6 pens/365 days) SP HD
ADALIMUMAB-ADBM(CF) PEN PS-UV	T5	PA QL(4 pens/365 days) SP HD
ADALIMUMAB-ADBM(CF)PEN	T5	PA QL(2 kits/28 days) SP HD
CYLTEZO(CF)	T5	PA SP
ENBREL 25 MG KIT	T5	PA QL SP HD
ENBREL 25 MG/0.5 ML SYRINGE	T5	PA QL SP HD
ENBREL 25 MG/0.5 ML VIAL	T5	PA QL SP HD
ENBREL 50 MG/ML SYRINGE	T5	PA QL(2 srnge kits/28 days) SP HD
ENBREL MINI	T5	PA QL(2 kits/28 days) SP HD
ENBREL SURECLICK	T5	PA QL(6 pens/365 days) SP HD
HUMIRA	T5	PA QL(4 pens/365 days) SP HD
HUMIRA PEN	T5	PA QL(2 srnge kits/28 days) SP HD
HUMIRA PEN CROHN'S-UC-HS	T5	PA QL(2 srnge kits/365 days) SP HD
HUMIRA PEN PSOR-UVEITS-ADOL HS	T5	PA QL(3 srnge kits/365 days) SP HD
HUMIRA(CF) 10 MG/0.1 ML SYRING	T5	PA QL(2 srnge kits/28 days) SP HD
HUMIRA(CF) 20 MG/0.2 ML SYRING	T5	PA QL(2 srnge kits/28 days) SP HD
HUMIRA(CF) 40 MG/0.4 ML SYRING	T5	PA QL(2 srnge kits/28 days) SP HD
HUMIRA(CF) PEDI CROHN 80-40 MG	T5	PA QL(2 pens/28 days) SP HD
HUMIRA(CF) PEDI CROHN 80MG/0.8	T5	PA QL(3 kits/365 days) SP HD
HUMIRA(CF) PEN 40 MG/0.4 ML	T5	PA QL(4 pens/365 days) SP HD
HUMIRA(CF) PEN 80 MG/0.8 ML	T5	PA QL(3 kits/365 days) SP HD
HUMIRA(CF) PEN CROHN'S-UC-HS	T5	PA QL(1 pen/30 days) SP HD
HUMIRA(CF) PEN PEDIATRIC UC	T5	PA QL(1 syringe/30 days) SP HD
HUMIRA(CF) PEN PSOR-UV-ADOL HS	T5	PA SP HD
HYRIMOZ(CF)	T5	PA QL(2 syringes/28 days) SP HD
HYRIMOZ(CF) PEN	T5	PA QL(2 pens/28 days) SP HD
HYRIMOZ(CF) PEN CROHN-UC START	T5	PA QL(3 pens/365 days) SP HD
HYRIMOZ(CF) PEN PSORIASIS	T5	PA QL(3 pens/365 days) SP HD
HYRIMOZ(CF) PEDI CROHN 80 MG	T5	PA QL(3 syringes/365 days) SP HD
HYRIMOZ(CF) PEDI CROHN 80-40MG	T5	PA QL(2 syringes/365 days) SP HD
SIMPONI 100 MG/ML PEN INJECTOR	T5	PA QL(1 pen/30 days) SP HD

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

T5 – Preferred Specialty
T6 – Non-Preferred Specialty
PA – Prior Authorization
QL – Quantity Limit

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

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

List of Prescription Medications

ANTIINFLAM.TUMOR NECROSIS FACTOR INHIBITING AGENTS (Pain Relief And Inflammatory Disease) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ANTI-INFLAMMATORY TUMOR NECROSIS FACTOR INHIBITOR (cont.)		
SIMPONI 100 MG/ML SYRINGE	T5	PA QL(1 syringe/30 days) SP HD
SIMPONI ARIA	T6	PA SP HD

ANTINEOPLASTICS (Cancer)

ANP - SELECTIVE RETINOID X RECEPTOR AGONISTS (RXR)

<i>bexarotene</i> (Targretin)	T2	PA SP HD CSL
-------------------------------	----	--------------

ANTINEOPLAST, HISTONE DEACETYLASE (HDAC) INHIBITORS

FARYDAK	T4	PA QL(6 caps/fill) CSL
ZOLINZA	T5	PA QL(120 caps/fill) SP HD CSL

ANTINEOPLASTIC - ALKYLATING AGENTS

ALKERAN (<i>melfalan</i>)	T6	SP CSL
<i>cyclophosphamide 25 mg capsule</i>	T2	SP HD CSL
CYCLOPHOSPHAMIDE 25 MG TABLET	T6	SP HD CSL
<i>cyclophosphamide 50 mg capsule</i>	T2	SP HD CSL
CYCLOPHOSPHAMIDE 50 MG TABLET	T6	SP HD CSL
GLEOSTINE	T3	CSL
HYDREA (<i>hydroxyurea</i>)	T4	CSL
<i>hydroxyurea</i> (Hydrea)	T2	CSL
LEUKERAN	T3	CSL
<i>melfalan</i> (Alkeran)	T2	SP CSL
MYLERAN	T3	CSL
TEMODAR (<i>temozolomide</i>)	T6	PA SP HD CSL
<i>temozolomide</i>	T2	PA SP HD CSL
<i>temozolomide</i> (Temodar)	T2	PA SP HD CSL

ANTINEOPLASTIC - ANTIANDROGENIC AGENTS

<i>abiraterone acetate 250 mg tab</i> (Zytiga)	T2	PA QL(120 tabs/fill) SP HD CSL
<i>abiraterone acetate 500 mg tab</i> (Zytiga)	T2	PA QL(60 tabs/fill) SP HD CSL
<i>bicalutamide</i> (Casodex)	T2	CSL
CASODEX (<i>bicalutamide</i>)	T4	CSL
ERLEADA	T5	PA QL(30 tabs/fill) SP HD CSL
EULEXIN (<i>flutamide</i>)	T4	CSL
<i>flutamide</i> (Eulexin)	T2	CSL
NILANDRON (<i>nilutamide</i>)	T4	PA CSL
<i>nilutamide</i> (Nilandron)	T2	PA CSL
NUBEQA	T5	PA QL(120 tabs/fill) SP HD CSL

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

T5 – Preferred Specialty
T6 – Non-Preferred Specialty
PA – Prior Authorization
QL – Quantity Limit

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

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

List of Prescription Medications

ANTINEOPLASTICS (Cancer) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ANTINEOPLASTIC - ANTIANDROGENIC AGENTS (cont.)		
XTANDI 40 MG CAPSULE	T5	PA QL(120 tabs/caps/fill) SP HD CSL
XTANDI 40 MG TABLET	T5	PA QL(120 tabs/caps/fill) SP HD CSL
XTANDI 80 MG TABLET	T5	PA QL(60 tabs/fill) SP HD CSL
ANTINEOPLASTIC - ANTIMETABOLITES		
<i>capecitabine 150 mg tablet (Xeloda)</i>	T2	PA QL(56 tabs/fill) SP HD CSL
<i>capecitabine 500 mg tablet (Xeloda)</i>	T2	PA QL(140 tabs/fill) SP HD CSL
LONSURF	T5	PA SP HD CSL
<i>mercaptopurine</i>	T2	CSL
<i>methotrexate 2.5 mg tablet</i>	T2	CSL
<i>methotrexate 250 mg/10 ml vial</i>	T2	
<i>methotrexate 50 mg/2 ml vial</i>	T2	
<i>methotrexate sodium/pf</i>	T2	
PURIXAN	T5	SP CSL
TABLOID	T4	CSL
TREXALL	T4	CSL
XELODA 150 MG TABLET (<i>capecitabine</i>)	T6	PA QL(56 tabs/fill) SP HD CSL
XELODA 500 MG TABLET (<i>capecitabine</i>)	T6	PA QL(140 tabs/fill) SP HD CSL
ANTINEOPLASTIC - AROMATASE INHIBITORS		
<i>anastrozole (Arimidex)</i>	T2	HD PPACA CSL
AROMASIN (<i>exemestane</i>)	T4	HD CSL
<i>exemestane (Aromasin)</i>	T2	HD PPACA CSL
FEMARA (<i>letrozole</i>)	T4	HD CSL
<i>letrozole (Femara)</i>	T2	HD CSL
ANTINEOPLASTIC - BRAF KINASE INHIBITORS		
TAFINLAR	T5	PA QL(120 caps/fill) SP HD CSL
TAFINLAR 10 MG TABLET FOR SUSP	T5	PA QL (840ml/30 days) SP HD CSL
ZELBORAF	T5	PA QL(240 tabs/fill) SP HD CSL
ANTINEOPLASTIC - HEDGEHOG PATHWAY INHIBITOR		
DAURISMO 100 MG TABLET	T6	PA QL(30 tabs/fill) SP HD CSL
DAURISMO 25 MG TABLET	T6	PA QL(60 tabs/fill) SP HD CSL
ERIVEDGE	T5	PA QL(30 caps/fill) SP HD CSL
ODOMZO	T5	PA QL(30 caps/fill) SP HD CSL
ANTINEOPLASTIC - JANUS KINASE (JAK) INHIBITORS		
JAKAFI	T5	PA QL(60 tabs/fill) SP HD CSL

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

T5 – Preferred Specialty
 T6 – Non-Preferred Specialty
 PA – Prior Authorization
 QL – Quantity Limit

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

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

List of Prescription Medications

ANTINEOPLASTICS (Cancer) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ANTINEOPLASTIC - KRAS PROTEIN INHIBITOR		
LUMAKRAS	T6	PA SP HD CSL
ANTINEOPLASTIC - MEKI AND MEK2 KINASE INHIBITORS		
COTELLIC	T5	PA QL(63 tabs/fill) SP HD CSL
KOSELUGO	T6	PA SP CSL
MEKINIST 0.05 MG/ML SOLUTION	T5	PA QL (108ml/30 days) SP HD CSL
MEKINIST 0.5 MG TABLET	T5	PA QL(90 tabs/fill) SP HD CSL
MEKINIST 2 MG TABLET	T5	PA QL(30 tabs/fill) SP HD CSL
ANTINEOPLASTIC - MTOR KINASE INHIBITORS		
<i>everolimus 2 mg tab for susp (Afinitor Disperz)</i>	T2	PA QL(30 tabs/fill) SP CSL
<i>everolimus 2.5 mg tablet (Afinitor)</i>	T2	
<i>everolimus 3 mg tab for susp (Afinitor Disperz)</i>	T2	PA QL(30 tabs/fill) SP CSL
<i>everolimus 5 mg tab for susp (Afinitor Disperz)</i>	T2	PA QL(30 tabs/fill) SP CSL
<i>everolimus 5 mg tablet (Afinitor)</i>	T2	
<i>everolimus 7.5 mg tablet (Afinitor)</i>	T2	
ANTINEOPLASTIC - PROTEIN METHYLTRANSFERASE INHIBIT		
TAZVERIK	T6	PA SP CSL
ANTINEOPLASTIC - TOPOISOMERASE I INHIBITORS		
HYCAMTIN	T5	PA SP HD CSL
ANTINEOPLASTIC IMMUNOMODULATOR AGENTS		
<i>lenalidomide</i>	T2	PA QL(30 caps/fill) SP HD CSL
POMALYST	T5	PA SP HD CSL
REVLIMID	T5	PA QL(30 caps/fill) SP HD CSL
ANTINEOPLASTIC LHRH(GNRH) ANTAGONIST,PITUIT.SUPPRS		
ORGOVYX	T6	PA QL(30 tabs/fill) SP CSL
ANTINEOPLASTIC SYSTEMIC ENZYME INHIBITORS		
ALECENSA	T5	PA QL(240 caps/fill) SP HD CSL
ALUNBRIG 30 MG TABLET	T5	PA QL(60 tabs/fill) SP CSL
ALUNBRIG 90 MG , 180 MG TABLET	T5	PA QL(30 tabs/fill) SP CSL
ALUNBRIG 90 MG-180 MG TAB PACK	T5	PA QL(30 tabs/fill) SP CSL
AYVAKIT	T6	PA QL(30 tabs/fill) SP CSL
BALVERSA	T5	PA SP CSL
BOSULIF 50 MG CAPSULE	T5	
BOSULIF 100 MG CAPSULE	T5	PA QL(90 tabs/fill) SP HD CSL
BOSULIF 100 MG TABLET	T5	PA QL(90 tabs/fill) SP HD CSL

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

T5 – Preferred Specialty
 T6 – Non-Preferred Specialty
 PA – Prior Authorization
 QL – Quantity Limit

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

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

List of Prescription Medications

ANTINEOPLASTICS (Cancer) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ANTINEOPLASTIC SYSTEMIC ENZYME INHIBITORS (cont.)		
BOSULIF 400 MG, 500 MG TABLET	T5	PA QL(30 tabs/fill) SP HD CSL
BRUKINSA	T5	PA SP CSL
CABOMETYX	T5	
CALQUENCE	T5	PA QL(60 tabs/caps/fill) SP CSL
CAPRELSA 100 MG TABLET	T5	PA QL(60 tabs/fill) SP CSL
CAPRELSA 300 MG TABLET	T5	PA QL(30 tabs/fill) SP CSL
COMETRIQ 100 MG DAILY-DOSE PK	T5	PA QL(56 caps/fill) SP HD CSL
COMETRIQ 140 MG DAILY-DOSE PK	T5	PA QL(112 caps/fill) SP HD CSL
COMETRIQ 60 MG DAILY-DOSE PACK	T5	PA QL(84 caps/fill) SP HD CSL
COPIKTRA	T6	PA QL(56 caps/fill) SP CSL
<i>erlotinib hcl 100 mg tablet (Tarceva)</i>	T2	PA QL(30 tabs/fill) SP HD CSL
<i>erlotinib hcl 150 mg tablet (Tarceva)</i>	T2	PA QL(30 tabs/fill) SP HD CSL
<i>erlotinib hcl 25 mg tablet (Tarceva)</i>	T2	PA QL(60 tabs/fill) SP HD CSL
EXKIVITY	T5	PA QL(120 caps/fill) SP CSL
GAVRETO	T5	PA QL(120 caps/fill) SP HD CSL
GILOTRIF	T5	PA QL(30 tabs/fill) SP HD CSL
ICLUSIG	T5	PA QL(30 tabs/fill) SP CSL
IMBRUVICA 70 MG CAPSULE	T5	PA QL(30 caps/fill) SP CSL
IMBRUVICA 70 MG/ML SUSPENSION	T5	PA QL(3 bottles/fill) SP CSL
IMBRUVICA 140 MG CAPSULE	T5	PA QL(120 caps/fill) SP CSL
IMBRUVICA 140 MG, 280 MG, 420 MG TABLET	T5	PA QL(30 tabs/fill) SP CSL
IMBRUVICA 560 MG TABLET	T5	PA ST SP CSL
INLYTA 1 MG TABLET	T5	PA QL(180 tabs/fill) SP HD CSL
INLYTA 5 MG TABLET	T5	PA QL(120 tabs/fill) SP HD CSL
IRESSA (<i>gefitinib</i>)	T6	PA QL(30 tabs/30 days) SP HD CSL
IWILFIN	T5	PA SP CSL
KISQALI	T6	PA QL (1 pack/1 time) CSL SP HD
KISQALI FEMARA CO-PACK	T6	PA QL (1 pack/28 days) CSL SP HD
<i>lapatinib ditosylate (Tykerb)</i>	T2	PA QL(180 tabs/fill) SP HD CSL
LENVIMA 10 MG DAILY DOSE	T5	PA QL(30 caps/fill) SP HD CSL
LENVIMA 12 MG DAILY DOSE	T5	PA QL(90 caps/fill) SP HD CSL
LENVIMA 14 MG DAILY DOSE	T5	PA QL(60 caps/fill) SP HD CSL
LENVIMA 18 MG DAILY DOSE	T5	PA QL(90 caps/fill) SP HD CSL
LENVIMA 20 MG DAILY DOSE	T5	PA QL(60 caps/fill) SP HD CSL

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

T5 – Preferred Specialty
 T6 – Non-Preferred Specialty
 PA – Prior Authorization
 QL – Quantity Limit

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

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

List of Prescription Medications

ANTINEOPLASTICS (Cancer) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ANTINEOPLASTIC SYSTEMIC ENZYME INHIBITORS (cont.)		
LENVIMA 24 MG DAILY DOSE	T5	PA QL(90 caps/fill) SP HD CSL
LENVIMA 4 MG CAPSULE	T5	PA QL(30 caps/fill) SP HD CSL
LENVIMA 8 MG DAILY DOSE	T5	PA QL(60 caps/fill) SP HD CSL
LORBRENA 100 MG TABLET	T5	PA QL(30 tabs/fill) SP HD CSL
LORBRENA 25 MG TABLET	T5	PA QL(90 tabs/fill) SP HD CSL
LYNPARZA	T5	PA QL(120 tabs/fill) SP HD CSL
LYTGOBI	T5	PA SP CSL
NERLYNX	T5	PA SP HD CSL
NEXAVAR (<i>sorafenib tosylate</i>)	T6	PA QL(120 tabs/fill) SP HD CSL
NINLARO	T5	PA QL(3 caps/fill) SP HD CSL
OGSIVEO	T6	PA SP CSL
<i>pazopanib (Votrient)</i>	T2	PA QL(120 tabs/30 days) SP HD CSL
PEMAZYRE	T5	PA QL(28 tabs/fill) SP CSL
PIQRAY	T6	PA SP HD CSL
RETEVMO 40 MG CAPSULE	T5	PA QL(180 caps/fill) SP HD CSL
RETEVMO 80 MG CAPSULE	T5	PA QL(120 caps/fill) SP HD CSL
ROZLYTREK 100 MG CAPSULE	T5	PA QL(30 caps/fill) SP HD CSL
ROZLYTREK 200 MG CAPSULE	T5	PA QL(90 caps/fill) SP HD CSL
ROZLYTREK 50 MG PELLETT PACKET	T5	
RUBRACA	T5	PA QL(120 tabs/fill) SP CSL
RYDAPT	T5	PA QL(224 caps/fill) SP HD CSL
SCEMBLIX 20MG TABLET	T6	PA SP HD QL (600 tabs/30 days) CSL
SCEMBLIX 40MG TABLET	T6	PA SP HD QL (300 tabs/30 days) CSL
<i>sorafenib tosylate (Nexavar)</i>	T2	PA QL(120 tabs/fill) SP HD CSL
SPRYCEL 20 MG TABLET	T5	PA QL(90 tabs/fill) SP HD CSL
SPRYCEL 50 MG, 80 MG, 100 MG, 140 MG TABLET	T5	PA QL(30 tabs/fill) SP HD CSL
SPRYCEL 70 MG TABLET	T5	PA QL(60 tabs/fill) SP HD CSL
STIVARGA	T5	PA QL(84 tabs/fill) SP HD CSL
<i>sunitinib malate 12.5 mg cap (Sutent)</i>	T2	PA QL(90 caps/fill) SP HD CSL
<i>sunitinib malate 25 mg capsule (Sutent)</i>	T2	PA QL(30 caps/fill) SP HD CSL
<i>sunitinib malate 37.5 mg cap (Sutent)</i>	T2	PA QL(30 caps/fill) SP HD CSL
<i>sunitinib malate 50 mg capsule (Sutent)</i>	T2	PA QL(30 caps/fill) SP HD CSL
SUTENT 12.5 MG CAPSULE (<i>sunitinib malate</i>)	T6	PA QL(90 caps/fill) SP HD CSL
SUTENT 25 MG CAPSULE (<i>sunitinib malate</i>)	T6	PA QL(30 caps/fill) SP HD CSL

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

T5 – Preferred Specialty
 T6 – Non-Preferred Specialty
 PA – Prior Authorization
 QL – Quantity Limit

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

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

List of Prescription Medications

ANTINEOPLASTICS (Cancer) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ANTINEOPLASTIC SYSTEMIC ENZYME INHIBITORS (cont.)		
SUTENT 37.5 MG CAPSULE (<i>sunitinib malate</i>)	T6	PA QL(30 caps/fill) SP HD CSL
SUTENT 50 MG CAPSULE (<i>sunitinib malate</i>)	T6	PA QL(30 caps/fill) SP HD CSL
TABRECTA	T5	PA SP HD CSL
TAGRISSO	T5	PA QL(30 tabs/fill) SP HD CSL
TALZENNA	T5	PA QL(30 caps/fill) SP HD CSL
TARCEVA 25 MG TABLET (<i>erlotinib hcl</i>)	T6	PA QL(60 tabs/fill) SP HD CSL
TARCEVA 100 MG TABLET (<i>erlotinib hcl</i>)	T6	PA QL(30 tabs/fill) SP HD CSL
TARCEVA 150 MG TABLET (<i>erlotinib hcl</i>)	T6	PA QL(30 tabs/fill) SP HD CSL
TASIGNA 50 MG CAPSULE	T5	PA QL(120 caps/fill) SP HD CSL
TASIGNA 150 MG CAPSULE	T5	PA QL(112 caps/fill) SP HD CSL
TASIGNA 200 MG CAPSULE	T5	PA QL(112 caps/fill) SP HD CSL
TUKYSA 150 MG TABLET	T6	PA QL(120 tabs/fill) SP CSL
TUKYSA 50 MG TABLET	T6	PA QL(300 tabs/fill) SP CSL
TURALIO	T6	PA QL(120 caps/fill) SP CSL
TYKERB (<i>lapatinib ditosylate</i>)	T6	PA QL(180 tabs/fill) SP HD CSL
VERZENIO	T5	PA QL(60 tabs/fill) SP HD CSL
VITRAKVI 100 MG CAPSULE	T5	PA QL(60 caps/fill) SP HD CSL
VITRAKVI 20 MG/ML SOLUTION	T5	PA QL(300 mls/fill) SP HD CSL
VITRAKVI 25 MG CAPSULE	T5	PA QL(180 caps/fill) SP HD CSL
VIZIMPRO	T5	PA QL(30 tabs/fill) SP HD CSL
VONJO	T5	PA QL(120 caps/fill) SP CSL
VOTRIENT (<i>pazopanib hcl</i>)	T6	PA QL(120 tabs/30 days) SP HD CSL
XALKORI 200MG, 250 MG CAPSULE	T5	PA QL(60 caps/30 days) SP HD CSL
XALKORI 20MG, 50 MG, 150 MG PELLETT	T5	PA SP HD CSL
XOSPATA	T5	PA QL(90 tabs/fill) SP CSL
ZEJULA	T5	PA QL(90 caps/fill) SP CSL
ZYDELIG	T5	PA QL(60 tabs/fill) SP HD CSL
ZYKADIA	T5	PA QL(90 tabs/caps/fill) SP HD CSL
ANTINEOPLASTIC-B CELL LYMPHOMA-2(BCL-2) INHIBITORS		
VENCLEXTA 10 MG TABLET	T5	PA QL(56 tabs/fill) SP CSL
VENCLEXTA 10 MG TAB (10MG X 2)	T5	PA QL(56 tabs/fill) SP CSL
VENCLEXTA 50 MG TABLET	T5	PA QL(28 tabs/fill) SP CSL
VENCLEXTA 100 MG TABLET	T5	PA QL(180 tabs/fill) SP CSL
VENCLEXTA STARTING PACK	T5	PA QL(42 tabs/fill) SP CSL

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

T5 – Preferred Specialty
 T6 – Non-Preferred Specialty
 PA – Prior Authorization
 QL – Quantity Limit

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

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

List of Prescription Medications

ANTINEOPLASTICS (Cancer) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ANTINEOPLASTIC-HYPOXIA INDUCIBLE FACTOR (HIF) INH		
WELIREG	T6	PA SP CSL
ANTINEOPLASTIC-ISOCITRATE DEHYDROGENASE INHIBITORS		
IDHIFA	T5	PA QL(30 tabs/fill) SP HD CSL
TIBSOVO	T5	PA SP CSL
ANTINEOPLASTICS, MISCELLANEOUS		
<i>etoposide</i>	T2	SP HD CSL
LYSODREN	T3	CSL
MATULANE	T5	SP CSL
<i>tretinoin 10 mg capsule</i>	T2	CSL
IMMUNOMODULATORS		
ACTIMMUNE	T5	PA SP HD
SELECTIVE ESTROGEN RECEPTOR MODULATORS (SERMS)		
FARESTON (<i>toremifene citrate</i>)	T4	HD CSL
SOLTAMOX	T4	HD PPACA CSL
<i>tamoxifen citrate</i>	T2	HD PPACA CSL
<i>toremifene citrate (Fareston)</i>	T2	HD CSL
STEROID ANTINEOPLASTICS		
EMCYT	T5	SP HD CSL
<i>megestrol 20 mg , 40 mg tablet</i>	T2	CSL
ANTINEOPLASTICS (Skin Conditions)		
PHOTOACT, TOPICAL ANTINEOPLAST, PREMALIGNANT LESIONS		
LEVULAN	T6	SP
TOPICAL ANTINEOPLASTIC PREMALIGNANT LESION AGENTS		
bexarotene 1% gel (Targretin)	T2	PA SP HD
diclofenac sodium 3% gel	T2	PA QL(100 gms/28 days)
EFUDEX (<i>fluorouracil</i>)	T4	
FLUOROPLEX	T4	
<i>fluorouracil 2% topical soln</i>	T2	
<i>fluorouracil 5% cream (Efudex)</i>	T2	
<i>fluorouracil 5% topical soln</i>	T2	
PANRETIN	T6	PA SP HD
TARGRETIN 1% GEL (<i>bexarotene</i>)	T6	PA SP HD
TOLAK	T4	
VALCHLOR	T5	PA SP HD

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

T5 – Preferred Specialty
 T6 – Non-Preferred Specialty
 PA – Prior Authorization
 QL – Quantity Limit

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

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

List of Prescription Medications

ANTI-OBESITY DRUGS (Weight Management)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ANTI-OBESITY - ANOREXIC AGENTS		
ADIPEX-P (<i>phentermine hcl</i>)	T4	PA QL(30 tabs/30 days)
<i>benzphetamine hcl</i>	T2	PA QL(90 tabs/fill)
<i>diethylpropion hcl</i>	T2	PA QL(90 tabs/fill)
<i>diethylpropion hcl</i>	T2	PA QL(30 tabs/fill)
LOMAIRA	T4	PA QL(90 tabs/fill)
<i>phendimetrazine tartrate</i>	T2	PA QL(30 caps/fill)
<i>phendimetrazine tartrate</i>	T2	PA QL(180 tabs/fill)
<i>phentermine 15 mg capsule</i>	T2	PA QL(30 caps/fill)
<i>phentermine 30 mg capsule</i>	T2	PA QL(30 caps/fill)
<i>phentermine 37.5 mg capsule</i>	T2	PA QL(30 caps/30 days)
<i>phentermine 37.5 mg tablet (Adipex-P)</i>	T2	PA QL(30 tabs/fill)
QSYMIA	T4	PA QL(30 caps/fill)
ANTI-OBESITY - INCRETIN MIMETICS COMBINATION		
ZEPBOUND	T3	
ANTI-OBESITY - MELANOCORTIN 4 RECEPTOR AGONISTS		
IMCIVREE	T6	PA QL(6 mls/30 days) SP
ANTI-OBESITY GLUCAGON-LIKE PEPTIDE-1 RECEPTOR AGONIST		
SAXENDA	T4	PA QL(5 pens/fill)
WEGOVY 0.25 MG/0.5 ML PEN	T3	PA QL(8 pens/year)
WEGOVY 0.5 MG/0.5 ML PEN	T3	PA QL(8 pens/year)
WEGOVY 1 MG/0.5 ML PEN	T3	PA QL(8 pens/year)
WEGOVY 1.7 MG/0.75 ML PEN	T3	PA QL(8 pens/year)
WEGOVY 2.4 MG/0.75 ML PEN	T3	PA QL(4 pens/28 days)
ANTI-OBESITY SEROTONIN 2C RECEPTOR AGONISTS		
BELVIQ	T4	PA
BELVIQ XR	T4	PA
ANTI-OBESITY-OPIOID ANTAG-NOREPI, DOPAMINE RU INHIB		
CONTRACE	T4	PA QL(120 tabs/fill)
FAT ABSORPTION DECREASING AGENTS		
ORLISTAT	T4	PA QL(90 caps/fill)
XENICAL	T4	PA QL(90 caps/fill)
ANTIPARASITICS (Eye Conditions)		
OPHTHALMIC (EYE) ANTIPARASITICS		
XDEMZY	T5	QL(10 mgs/30 days) SP

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

T5 – Preferred Specialty
 T6 – Non-Preferred Specialty
 PA – Prior Authorization
 QL – Quantity Limit

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

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

List of Prescription Medications

ANTIPARASITICS (Infections)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ANTIPARASITICS		
ALINIA 100 MG/5 ML SUSPENSION	T3	QL(360 mls/30 days)
<i>nitazoxanide</i> (Alinia)	T2	QL(12 tabs/30 days)
TOPICAL ANTIPARASITICS		
<i>crotamiton</i>	T2	
ELIMITE (<i>permethrin</i>)	T4	
EURAX	T4	
<i>ivermectin 0.5% lotion</i> (Sklice)	T2	
<i>permethrin</i> (Elimite)	T2	
SKLICE (<i>ivermectin</i>)	T4	
<i>spinosad</i> (Natroba)	T2	
ULESFIA	T4	
ANTIPARKINSON DRUGS (Parkinson's Disease)		
ANTIPARKINSONISM DRUGS, ANTICHOLINERGIC		
<i>benztropine mesylate</i>	T1	HD
<i>trihexphenidyl hcl</i>	T2	HD
ANTIPARKINSONISM DRUGS, OTHER		
<i>amantadine hcl</i>	T2	HD
<i>apomorphine hcl</i>	T2	PA QL(30 mls/30 days) SP
AZILECT (<i>rasagiline mesylate</i>)	T4	ST HD
<i>bromocriptine mesylate</i> (Parlodel)	T2	HD
<i>carbidopa/levodopa</i>	T2	HD
<i>carbidopa/levodopa</i> (Sinemet 10-100)	T2	HD
<i>carbidopa/levodopa</i> (Sinemet 25-100)	T2	HD
<i>carbidopa/levodopa/entacapone</i> (Stalevo 100)	T2	HD
<i>carbidopa/levodopa/entacapone</i> (Stalevo 125)	T2	HD
<i>carbidopa/levodopa/entacapone</i> (Stalevo 150)	T2	HD
<i>carbidopa/levodopa/entacapone</i> (Stalevo 200)	T2	HD
<i>carbidopa/levodopa/entacapone</i> (Stalevo 50)	T2	HD
<i>carbidopa/levodopa/entacapone</i> (Stalevo 75)	T2	HD
COMTAN (<i>entacapone</i>)	T4	HD
DUOPA	T6	PA SP HD
<i>entacapone</i> (Comtan)	T2	HD
INBRIJA	T5	PA QL(300 caps/fill) SP HD
KYNMOBI	T3	PA QL(150 films/30 days) HD

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

T5 – Preferred Specialty
 T6 – Non-Preferred Specialty
 PA – Prior Authorization
 QL – Quantity Limit

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

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

List of Prescription Medications

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

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
------------------------	-----------	----------------------------------

ANTIPARKINSONISM DRUGS, OTHER (cont.)

MIRAPEX ER (<i>pramipexole di-hcl</i>)	T4	HD
NEUPRO	T4	HD
NOURIANZ	T6	PA QL(30 tabs/fill) SP HD
PARLODEL (<i>bromocriptine mesylate</i>)	T4	HD
<i>pramipexole di-hcl</i>	T2	HD
<i>pramipexole di-hcl</i> (Mirapex Er)	T2	HD
<i>rasagiline mesylate</i> (Azilect)	T2	HD
<i>ropinirole hcl</i>	T2	HD
RYTARY	T4	HD
<i>selegiline hcl</i>	T2	HD
SINEMET 10-100 (<i>carbidopa/levodopa</i>)	T4	HD
SINEMET 25-100 (<i>carbidopa/levodopa</i>)	T4	HD
STALEVO 100 (<i>carbidopa/levodopa/entacapone</i>)	T4	HD
STALEVO 125 (<i>carbidopa/levodopa/entacapone</i>)	T4	HD
STALEVO 150 (<i>carbidopa/levodopa/entacapone</i>)	T4	HD
STALEVO 200 (<i>carbidopa/levodopa/entacapone</i>)	T4	HD
STALEVO 50 (<i>carbidopa/levodopa/entacapone</i>)	T4	HD
STALEVO 75 (<i>carbidopa/levodopa/entacapone</i>)	T4	HD
TASMAR (<i>tolcapone</i>)	T4	PA HD
<i>tolcapone</i> (Tasmar)	T2	PA HD

DECARBOXYLASE INHIBITORS

<i>carbidopa</i> (Lodosyn)	T2	PA
LODOSYN (<i>carbidopa</i>)	T4	PA

ANTIPLATELET DRUGS (Blood Thinners/Anti-Clotting)

PLATELET AGGREGATION INHIBITORS

<i>aspirin/dipyridamole</i>	T2	HD
BRILINTA	T3	HD
<i>cilostazol</i>	T2	HD
<i>clopidogrel bisulfate</i>	T1	HD
<i>clopidogrel bisulfate</i> (Plavix)	T1	HD
<i>dipyridamole</i>	T2	HD
EFFIENT (<i>prasugrel hcl</i>)	T4	HD
<i>prasugrel hcl</i> (Effient)	T2	HD
ZONTIVITY	T4	PA HD

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

T5 – Preferred Specialty
 T6 – Non-Preferred Specialty
 PA – Prior Authorization
 QL – Quantity Limit

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

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

List of Prescription Medications

ANTIPLATELET DRUGS (Blood Thinners/Anti-Clotting) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
------------------------	-----------	----------------------------------

PLATELET REDUCING AGENTS

AGRYLIN (<i>anagrelide hcl</i>)	T4	
<i>anagrelide hcl</i>	T2	
<i>anagrelide hcl</i> (Agrylin)	T2	

ANTIVIRALS (AIDS/HIV)

ANTIRETROVIRAL-INTEGRASE INHIBITOR AND NNRTI COMB.

JULUCA	T5	SP
DOVATO	T5	SP
TRIUMEQ	T5	SP
TRIUMEQ PD	T5	SP

ANTIRETROVIRAL-NUCLEOSIDE, NUCLEOTIDE, PROTEASE INH.

SYMITUZA	T5	SP
----------	----	----

ANTIVIRALS, HIV-SPEC, NON-PEPTIDIC PROTEASE INHIB

APTIVUS	T5	SP
<i>darunavir</i> (Prezista)	T2	SP
PREZISTA	T5	PA SP
PREZISTA 600 MG TABLET (<i>darunavir</i>)	T6	SP
PREZISTA 800 MG TABLET (<i>darunavir</i>)	T6	SP

ANTIVIRALS, HIV-SPEC, NUCLEOSIDE-NUCLEOTIDE ANALOG

CIMDUO	T5	SP
DESCOVY	T5	SP
<i>emtricitabine-tenofv 100-150mg</i> (Truvada)	T2	SP
<i>emtricitabine-tenofv 133-200mg</i> (Truvada)	T2	SP
<i>emtricitabine-tenofv 167-250mg</i> (Truvada)	T2	SP
<i>emtricitabine-tenofv 200-300mg</i> (Truvada)	T2	SP PPACA
TEMIXYS	T5	SP

ANTIVIRALS, HIV-SPEC., NUCLEOSIDE ANALOG, RTI COMB

<i>abacavir sulfate/lamivudine</i> (Epzicom)	T2	SP
<i>abacavir/lamivudine/zidovudine</i> (Trizivir)	T2	SP
COMBIVIR (<i>lamivudine/zidovudine</i>)	T6	SP
EPZICOM (<i>abacavir sulfate/lamivudine</i>)	T6	SP
<i>lamivudine/zidovudine</i> (Combivir)	T2	SP
TRIZIVIR (<i>abacavir/lamivudine/zidovudine</i>)	T6	SP

ANTIVIRALS, HIV-SPECIFIC, CCR5 CO-RECEPTOR ANTAG.

<i>maraviroc</i> (Selzentry)	T2	SP
------------------------------	----	----

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

T5 – Preferred Specialty
 T6 – Non-Preferred Specialty
 PA – Prior Authorization
 QL – Quantity Limit

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

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

List of Prescription Medications

ANTIVIRALS (AIDS/HIV) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ANTIVIRALS, HIV-SPECIFIC, CCR5 CO-RECEPTOR ANTAG. (cont.)		
SELZENTRY 150 MG TABLET (<i>maraviroc</i>)	T6	SP
SELZENTRY 20 MG/ML ORAL SOLN	T5	SP
SELZENTRY 25 MG TABLET	T5	SP
SELZENTRY 300 MG TABLET (<i>maraviroc</i>)	T6	SP
SELZENTRY 75 MG TABLET	T5	SP
ANTIVIRALS, HIV-SPECIFIC, FUSION INHIBITORS		
FUZEON	T5	PA SP
ANTIVIRALS, HIV-SPECIFIC, NON-NUCLEOSIDE, RTI		
EDURANT	T5	SP
<i>efavirenz</i> (Sustiva)	T2	SP
<i>etravirine</i> (Intelence)	T2	SP
INTELENCE 100 MG TABLET (<i>etravirine</i>)	T6	SP
INTELENCE 200 MG TABLET (<i>etravirine</i>)	T6	SP
INTELENCE 25 MG TABLET	T5	SP
<i>nevirapine</i>	T2	SP
<i>nevirapine</i> (Viramune Xr)	T2	SP
SUNLENCA	T6	PA SP
SUSTIVA (<i>efavirenz</i>)	T6	SP
VIRAMUNE XR (<i>nevirapine</i>)	T6	SP
ANTIVIRALS, HIV-SPECIFIC, NUCLEOSIDE ANALOG, RTI		
<i>abacavir sulfate</i> (Ziagen)	T2	SP
<i>didanosine</i>	T2	SP
<i>emtricitabine</i> (Emtriva)	T2	SP
EMTRIVA 10 MG/ML SOLUTION	T5	SP
EMTRIVA 200 MG CAPSULE (<i>emtricitabine</i>)	T6	SP
EPIVIR (<i>lamivudine</i>)	T6	SP
<i>lamivudine</i> (EpiVir)	T2	SP
RETROVIR (<i>zidovudine</i>)	T6	SP
<i>stavudine</i>	T2	SP
<i>tenofovir disoproxil fumarate</i> (Viread)	T2	SP
VIREAD 150 MG TABLET	T5	SP
VIREAD 200 MG TABLET	T5	SP
VIREAD 250 MG TABLET	T5	SP
VIREAD 300 MG TABLET (<i>tenofovir disoproxil fumarate</i>)	T6	SP

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

T5 – Preferred Specialty
 T6 – Non-Preferred Specialty
 PA – Prior Authorization
 QL – Quantity Limit

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

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

List of Prescription Medications

ANTIVIRALS (AIDS/HIV) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ANTIVIRALS, HIV-SPECIFIC, NUCLEOSIDE ANALOG, RTI (cont.)		
VIREAD POWDER	T5	SP
ZIAGEN (<i>abacavir sulfate</i>)	T6	SP
<i>zidovudine</i>	T2	SP
<i>zidovudine</i> (Retrovir)	T2	SP
ANTIVIRALS, HIV-SPECIFIC, PROTEASE INHIBITOR COMB		
KALETRA (<i>lopinavir/ritonavir</i>)	T6	SP
<i>lopinavir/ritonavir</i> (Kaletra)	T2	SP
ANTIVIRALS, HIV-SPECIFIC, PROTEASE INHIBITORS		
<i>atazanavir sulfate</i> (Reyataz)	T2	SP
EVOTAZ	T6	SP
<i>fosamprenavir calcium</i> (Lexiva)	T2	SP
INVIRASE	T5	SP
LEXIVA 50 MG/ML SUSPENSION	T5	SP
LEXIVA 700 MG TABLET (<i>fosamprenavir calcium</i>)	T6	SP
NORVIR 100 MG POWDER PACKET	T5	SP
NORVIR 100 MG TABLET (<i>ritonavir</i>)	T6	SP
REYATAZ 150 MG CAPSULE (<i>atazanavir sulfate</i>)	T6	SP
REYATAZ 200 MG CAPSULE (<i>atazanavir sulfate</i>)	T6	SP
REYATAZ 300 MG CAPSULE (<i>atazanavir sulfate</i>)	T6	SP
REYATAZ 50 MG POWDER PACKET	T5	SP
<i>ritonavir</i> (Norvir)	T2	SP
VIRACEPT	T5	SP
ANTIVIRALS, HIV-I INTEGRASE STRAND TRANSFER INHIBTR		
APRETUDE	T5	PA SP PPACA
ISENTRESS	T5	SP
ISENTRESS HD	T5	SP
TIVICAY	T5	SP
TIVICAY PD	T5	SP
ARTV NUCLEOSIDE, NUCLEOTIDE, NON-NUCLEOSIDE RTI COMB		
<i>efavirenz/emtricit/tenofovr df</i> (Atripla)	T2	SP
<i>efavirenz/lamivu/tenofov disop</i> (Symfi Lo)	T2	SP
<i>efavirenz/lamivu/tenofov disop</i> (Symfi)	T2	SP
ODEFSEY	T5	SP
SYMFI (<i>efavirenz/lamivu/tenofov disop</i>)	T5	SP

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

T5 – Preferred Specialty
 T6 – Non-Preferred Specialty
 PA – Prior Authorization
 QL – Quantity Limit

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

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

List of Prescription Medications

ANTIVIRALS (AIDS/HIV) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ARTV NUCLEOSIDE, NUCLEOTIDE, NON-NUCLEOSIDE RTI COMB (cont.)		
SYMFI LO (<i>efavirenz/lamivu/tenofovir disop</i>)	T5	SP
ARV-NUCLEOSIDE, NUCLEOTIDE RTI, INTEGRASE INHIBITORS		
BIKTARVY	T5	SP
GENVOYA	T5	SP
ANTIVIRALS (Eye Conditions)		
EYE ANTIVIRALS		
<i>trifluridine</i>	T2	
ZIRGAN	T4	
ANTIVIRALS (Infections)		
ANTIVIRALS, GENERAL		
<i>acyclovir 200 mg capsule</i>	T2	
<i>acyclovir 200 mg/5 ml susp (Zovirax)</i>	T2	
<i>acyclovir 400 mg tablet</i>	T2	
<i>acyclovir 800 mg tablet</i>	T2	
<i>famciclovir 125 mg tablet</i>	T2	QL(21 tabs/fill)
<i>famciclovir 250 mg tablet</i>	T2	QL(60 tabs/fill)
<i>famciclovir 500 mg tablet</i>	T2	QL(21 tabs/fill)
FLUMADINE (<i>rimantadine hcl</i>)	T4	
LIVTENCITY	T6	PA QL(112 tabs/28 days) SP
<i>oseltamivir 6 mg/ml suspension (Tamiflu)</i>	T2	QL(180 mls/fill)
<i>oseltamivir phos 30 mg capsule (Tamiflu)</i>	T2	QL(20 caps/fill)
<i>oseltamivir phos 45 mg capsule (Tamiflu)</i>	T2	QL(10 caps/fill)
<i>oseltamivir phos 75 mg capsule (Tamiflu)</i>	T2	QL(10 caps/fill)
PREVYMIS	T5	QL(30 tabs/fill) SP HD
RELENZA	T4	QL(20 blisters/fill)
<i>rimantadine hcl (Flumadine)</i>	T2	
TAMIFLU 30 MG CAPSULE (<i>oseltamivir phosphate</i>)	T4	QL(20 caps/fill)
TAMIFLU 45 MG CAPSULE (<i>oseltamivir phosphate</i>)	T4	QL(10 caps/fill)
TAMIFLU 6 MG/ML SUSPENSION (<i>oseltamivir phosphate</i>)	T4	QL(180 mls/fill)
TAMIFLU 75 MG CAPSULE (<i>oseltamivir phosphate</i>)	T4	QL(10 caps/fill)
<i>valacyclovir hcl (Valtrex)</i>	T2	QL(30 tabs/fill)
VALCYTE (<i>valganciclovir hcl</i>)	T4	
<i>valganciclovir hcl (Valcyte)</i>	T2	

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

T5 – Preferred Specialty
 T6 – Non-Preferred Specialty
 PA – Prior Authorization
 QL – Quantity Limit

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

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

List of Prescription Medications

ANTIVIRALS (Infections) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ANTIVIRALS, GENERAL (cont.)		
XOFLUZA	T4	QL(1 tab/fill)
ZOVIRAX 200 MG/5 ML SUSP (<i>acyclovir</i>)	T4	
HEP C - NS5A, NS3/4A, NUCLEOTIDE NS5B INHIB COMBO		
VOSEVI	T5	PA QL(28 tabs/fill) SP HD
HEP C VIRUS-NS5B POLYMERASE AND NS5A INHIB. COMBO.		
EPCLUSA 150-37.5 MG PELLETT PKT	T5	PA QL(28 packs/fill) SP HD
EPCLUSA 200 MG-50 MG TABLET	T5	PA QL(28 tabs/fill) SP HD
EPCLUSA 200-50 MG PELLETT PACK	T5	PA QL(28 packs/fill) SP HD
EPCLUSA 400 MG-100 MG TABLET	T5	PA QL(28 tabs/fill) SP HD
HARVONI 33.75-150 MG PELLETT PK	T5	PA QL(28 packs/fill) SP HD
HARVONI 45-200 MG PELLETT PACKT	T5	PA QL(56 packs/fill) SP HD
HARVONI 45-200 MG TABLET	T5	PA QL(56 tabs/fill) SP HD
HARVONI 90-400 MG TABLET	T5	PA QL(>= 18 yo 28 tabs/fill) SP HD
HEPATITIS B TREATMENT AGENTS		
<i>adefovir dipivoxil</i>	T2	SP HD
BARACLUDE 0.05 MG/ML SOLUTION	T5	SP HD
<i>entecavir (Baraclude)</i>	T2	SP HD
EPIVIR HBV 100 MG TABLET (<i>lamivudine</i>)	T6	SP
EPIVIR HBV 25 MG/5 ML SOLN	T5	SP
<i>lamivudine (Epiriv Hbv)</i>	T2	SP
VELMIDY	T5	SP HD
PEGASYS 180 MCG/0.5 ML SYRINGE	T5	SP HD
PEGASYS 180 MCG/ML VIAL	T5	SP HD
<i>ribasphere 200 mg capsule</i>	T2	ST SP HD
<i>ribasphere 600 mg tablet</i>	T2	ST SP
HEPATITIS C TREATMENT AGENTS		
<i>ribavirin</i>	T2	ST SP HD
HEPATITIS C VIRUS- NS5A AND NS3/4A INHIBITOR COMB		
ZEPATIER	T5	PA QL(28 tabs/fill) SP HD
ANTIVIRALS (Skin Conditions)		
TOPICAL ANTIVIRALS		
<i>acyclovir 5% cream (Zovirax)</i>	T2	PA QL(5 gms/fill)
<i>acyclovir 5% ointment (Zovirax)</i>	T2	PA QL(30 gms/fill)
DENAVIR	T4	

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

T5 – Preferred Specialty
T6 – Non-Preferred Specialty
PA – Prior Authorization
QL – Quantity Limit

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

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

List of Prescription Medications

ANTIVIRALS (Skin Conditions) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
TOPICAL ANTIVIRALS (cont.)		
<i>penciclovir</i>	T2	
ZOVIRAX 5% CREAM (<i>acyclovir</i>)	T4	PA QL(5 gms/fill)

AUTONOMIC DRUGS (Allergy/Nasal Sprays)

ANAPHYLAXIS THERAPY AGENTS

AUVI-Q	T3	QL(2 auto-injs/30 days)
<i>epinephrine 0.15 mg auto-inject</i> (Epipen Jr 2-Pak)	T2	QL(2 auto-injs/fill)
<i>epinephrine 0.15 mg auto-inject</i> (Epipen Jr)	T2	QL(2 auto-injs/fill)
<i>epinephrine 0.3 mg auto-inject</i> (Epipen 2-Pak)	T2	QL(2 auto-injs/fill)
<i>epinephrine 0.3 mg auto-inject</i> (Epipen)	T2	QL(2 auto-injs/fill)
EPIPEN (<i>epinephrine</i>)	T3	PA QL(2 auto-injs/fill)
EPIPEN 2-PAK (<i>epinephrine</i>)	T3	PA QL(2 auto-injs/fill)
EPIPEN JR (<i>epinephrine</i>)	T3	PA QL(2 auto-injs/fill)
EPIPEN JR 2-PAK (<i>epinephrine</i>)	T3	PA QL(2 auto-injs/fill)
SYMJEPI	T3	QL(2 syringes/fill)

AUTONOMIC DRUGS (Alzheimer's Disease)

CHOLINESTERASE INHIBITORS

ADLARITY	T4	ST HD
ARICEPT (<i>donepezil hcl</i>)	T4	ST HD
<i>donepezil hcl</i>	T1	HD
<i>donepezil hcl 10 mg tablet</i> (Aricept)	T1	HD
<i>donepezil hcl 23 mg tablet</i> (Aricept)	T1	ST HD
<i>donepezil hcl 5 mg tablet</i> (Aricept)	T1	HD
EXELON (<i>rivastigmine</i>)	T4	ST HD
<i>galantamine hbr</i>	T2	HD
<i>galantamine hbr</i> (Razadyne Er)	T2	HD
<i>pyridostigmine 60 mg/5 ml soln</i> (Mestinon)	T2	HD
PYRIDOSTIGMINE BR 30 MG TABLET	T4	HD
<i>pyridostigmine br 60 mg tablet</i> (Mestinon)	T2	HD
<i>pyridostigmine bromide</i> (Mestinon)	T2	HD
RAZADYNE ER (<i>galantamine hbr</i>)	T4	ST HD
<i>rivastigmine</i> (Exelon)	T2	HD
<i>rivastigmine tartrate</i>	T2	HD

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

T5 – Preferred Specialty
 T6 – Non-Preferred Specialty
 PA – Prior Authorization
 QL – Quantity Limit

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

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

List of Prescription Medications

AUTONOMIC DRUGS (Attention Deficit Hyperactivity Disorder)⁸

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ADRENERGICS, AROMATIC, NON-CATECHOLAMINE		
ADZENYS XR-ODT	T4	ST
<i>amphetamine sulfate</i> (Evekeo)	T2	
DESOXYN (<i>methamphetamine hcl</i>)	T4	
DEXEDRINE (<i>dextroamphetamine sulfate</i>)	T4	ST
<i>dextroamphetamine sulfate</i>	T2	
<i>dextroamphetamine sulfate</i> (Dexedrine)	T2	
<i>dextroamphetamine sulfate</i> (Zenzedi)	T2	
<i>dextroamphetamine/amphetamine</i> (Adderall Xr)	T2	
<i>dextroamphetamine/amphetamine</i> (Adderall)	T2	
<i>dextroamphetamine/amphetamine</i> (Mydayis)	T2	
EVEKEO ODT	T4	
<i>methamphetamine hcl</i> (Desoxyn)	T2	
MYDAYIS (<i>dextroamphetamine/amphetamine</i>)	T4	ST
<i>zenzedi 10 mg tablet</i>	T2	
ZENZEDI 15 MG TABLET (<i>dextroamphetamine sulfate</i>)	T4	
ZENZEDI 2.5 MG, 7.5 MG TABLET	T4	
ZENZEDI 20 MG TABLET (<i>dextroamphetamine sulfate</i>)	T4	
ZENZEDI 30 MG TABLET (<i>dextroamphetamine sulfate</i>)	T4	
<i>zenzedi 5 mg tablet</i>	T2	

AUTONOMIC DRUGS (Blood Pressure/Heart Medications)

ADRENERGIC VASOPRESSOR AGENTS

<i>droxidopa</i> (Northera)	T2	PA SP HD
<i>midodrine hcl</i>	T2	
DIBENZYLIN (<i>phenoxybenzamine hcl</i>)	T4	PA HD
<i>phenoxybenzamine hcl</i> (Dibenzylin)	T2	PA HD

AUTONOMIC DRUGS (Urinary Tract Conditions)

PARASYMPATHETIC AGENTS

<i>bethanechol chloride</i>	T2	HD
<i>bethanechol chloride</i> (Urecholine)	T2	HD
<i>cevimeline hcl</i> (Evoxac)	T2	HD
EVOXAC (<i>cevimeline hcl</i>)	T4	HD
<i>pilocarpine hcl</i> (Salagen)	T2	HD
SALAGEN (<i>pilocarpine hcl</i>)	T4	HD
URECHOLINE (<i>bethanechol chloride</i>)	T4	HD

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

T5 – Preferred Specialty
T6 – Non-Preferred Specialty
PA – Prior Authorization
QL – Quantity Limit

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

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

List of Prescription Medications

BIOLOGICALS (Allergy/Nasal Sprays)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ALLERGENIC EXTRACTS, THERAPEUTIC		
GRASTEK	T3	PA
ODACTRA	T3	PA
ORALAIR	T3	PA
RAGWITEK	T3	PA

BIOLOGICALS (Blood Pressure/Heart Medications)

PLASMA KALLIKREIN INHIBITORS

TAKHZYRO	T4	PA SP HD
----------	----	----------

BIOLOGICALS (Miscellaneous)

PKU TREATMENT AGENTS - PHENYLALANINE AMMONIA LYASE

PALYNZIQ 10 MG/0.5 ML SYRINGE	T5	PA QL(30 syringes/fill) SP HD
PALYNZIQ 2.5 MG/0.5 ML SYRINGE	T5	PA QL(8 syringes/fill) SP HD
PALYNZIQ 20 MG/ML SYRINGE	T5	PA QL(60 syringes/fill) SP HD

BIOLOGICALS (Vaccines)

COVID-19 VACCINES

COMIRNATY	T3	PPACA
JANSSEN COVID-19 VACCINE (EUA)	T3	PPACA
MODERNA COVID VAC(EUA)	T3	PPACA
MODERNA COVID-19 BOOSTER (EUA)	T3	PPACA
NOVAVAX COVID-19 VACC,ADJ(EUA)	T3	PPACA
PFIZER COVID VAC(EUA)	T3	PPACA
PFIZER COVID-19 VACCINE (EUA)	T3	PPACA
SPIKEVAX COVID (18Y UP) VACC	T3	PPACA

ENTERIC VIRUS VACCINES

IPOL	T3	PPACA
ROTARIX	T4	HD PPACA
ROTATEQ	T3	PPACA

GRAM NEGATIVE COCCI VACCINES

BEXSERO	T3	PPACA
MENACTRA	T3	PPACA
MENQUADFI	T3	PPACA
MENVEO A-C-Y-W-135-DIP	T3	PPACA
PENBRAYA	T3	PPACA

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

T5 – Preferred Specialty
 T6 – Non-Preferred Specialty
 PA – Prior Authorization
 QL – Quantity Limit

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

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

List of Prescription Medications

BIOLOGICALS (Vaccines) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
GRAM NEGATIVE COCCI VACCINES (cont.)		
PNEUMOVAX 23	T3	PPACA
PREVNAR 13	T3	PPACA
PREVNAR 20	T3	PPACA
TRUMENBA	T3	PPACA
VAXNEUVANCE	T3	PPACA
INFLUENZA VIRUS VACCINES		
AFLURIA QUAD	T3	PPACA
FLUAD	T3	PPACA
FLUAD QUAD	T3	PPACA
FLUARIX QUAD	T3	PPACA
FLUBLOK QUAD	T3	PPACA
FLUCELVAX QUAD	T3	PPACA
FLULAVAL QUAD	T3	PPACA
FLUMIST QUAD	T3	PPACA
FLUZONE HIGH-DOSE	T3	PPACA
FLUZONE HIGH-DOSE QUAD	T3	PPACA
FLUZONE QUAD	T3	PPACA
FLUZONE QUAD PEDI	T3	PPACA
NEUROTOXIC VIRUS VACCINES		
DENGVAXIA	T3	PPACA
VACCINE/TOXOID PREPARATIONS, COMBINATIONS		
ACTHIB	T3	PPACA
ADACEL TDAP	T3	PPACA
BOOSTRIX TDAP	T3	PPACA
DAPTACEL DTAP	T3	PPACA
DIPHtheria-TETANUS TOXoids-PED	T3	PPACA
HIBERIX	T3	PPACA
INFANRIX DTAP	T3	PPACA
KINRIX	T3	PPACA
M-M-R II VACCINE	T3	PPACA
PEDVAXHIB	T3	PPACA
PENTACEL	T3	PPACA
PENTACEL ACTHIB COMPONENT	T3	PPACA
PRIORIX	T3	PPACA

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

T5 – Preferred Specialty
T6 – Non-Preferred Specialty
PA – Prior Authorization
QL – Quantity Limit

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

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

List of Prescription Medications

BIOLOGICALS (Vaccines) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
------------------------	-----------	----------------------------------

VACCINE/TOXOID PREPARATIONS, COMBINATIONS (cont.)

PROQUAD	T3	PPACA
QUADRACEL DTAP-IPV	T3	PPACA
TDVAX	T3	PPACA
TENIVAC	T3	PPACA
VAXELIS	T3	PPACA

VIRAL/TUMORIGENIC VACCINES

ACAM2000	T3	PPACA
AREXVY VIAL KIT	T3	PPACA
ENGERIX-B ADULT	T3	PPACA
ENGERIX-B PEDIATRIC-ADOLESCENT	T3	PPACA
GARDASIL 9	T3	PPACA
HEPLISAV-B	T3	PPACA
JYNNEOS	T3	
PREHEVBRIO	T3	PPACA
RECOMBIVAX HB	T3	PPACA
SHINGRIX	T3	PPACA
TWINRIX	T3	PPACA
VARIVAX VACCINE	T3	PPACA

BLOOD (Blood Modifiers/Bleeding Disorders)

ANTIFIBRINOLYTIC AGENTS

AMICAR (<i>aminocaproic acid</i>)	T4	SP HD
<i>aminocaproic acid</i> (Amicar)	T2	SP HD
LYSTEDA (<i>tranexamic acid</i>)	T6	SP
<i>tranexamic acid</i> (Lysteda)	T2	SP

COMPLEMENT INHIBITORS

EMPAVELI	T5	PA SP
FABHALTA	T5	PA SP

HEMOPHILIA TREATMENT AGENTS, NON-FACTOR REPLACEMENT

HEMLIBRA	T5	PA SP HD
----------	----	----------

PYRUVATE KINASE ACTIVATORS

PYRUKYND 20 MG TABLET	T6	PA QL(56 tabs/28 days) SP
PYRUKYND 20-5 MG TAPER PACK	T6	PA QL(14 tabs/365 days) SP
PYRUKYND 5 MG TABLET	T6	PA QL(56 tabs/28 days) SP
PYRUKYND 5 MG TAPER PACK	T6	PA QL(7 tabs/365 days) SP

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

T5 – Preferred Specialty
T6 – Non-Preferred Specialty
PA – Prior Authorization
QL – Quantity Limit

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

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

List of Prescription Medications

BLOOD (Blood Modifiers/Bleeding Disorders) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
PYRUVATE KINASE ACTIVATORS (cont.)		
PYRUKYND 50 MG TABLET	T6	PA QL(56 tabs/28 days) SP
PYRUKYND 50-20 MG TAPER PACK	T6	PA QL(14 tabs/365 days) SP
SICKLE CELL ANEMIA AGENTS		
DROXIA	T3	
ENDARI	T4	PA
TOPICAL HEMOSTATICS		
ASTRINGYN	T4	
AVITENE	T4	
ENDO-AVITENE	T4	
EVICEL	T4	
GEL-FLOW	T4	
GEL-FLOW NT	T4	
GELFOAM	T4	
GELFOAM (<i>gelatin sponge, absorb/porcine</i>)	T4	
GELFOAM COMPRESSED	T4	
GELFOAM JMI	T4	
MONSEL'S	T3	
RECOTHROM	T4	
SURGICEL	T4	
SURGIFOAM SPONGE SIZE 100, 100C	T4	
<i>surgifoam sponge size 12-7 (Gelfoam)</i>	T2	
SYRINGE AVITENE	T4	
TACHOSIL	T4	
THROMBI-GEL (<i>thrombin/cal/cmc/gel/dress,hem</i>)	T4	
THROMBIN-JMI	T4	
THROMBI-PAD	T4	
ULTRAFOAM	T4	
BLOOD (Blood Thinners/Anti-Clotting)		
HEMORRHOLOGIC AGENTS		
<i>pentoxifylline</i>	T2	HD
CARDIAC DRUGS (Blood Pressure/Heart Medications)		
ANTIANGINAL, ANTI-ISCHEMIC AGENTS, NON-HEMODYNAMIC		
<i>ranolazine (Ranexa)</i>	T2	HD

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

T5 – Preferred Specialty
T6 – Non-Preferred Specialty
PA – Prior Authorization
QL – Quantity Limit

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

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

List of Prescription Medications

CARDIAC DRUGS (Blood Pressure/Heart Medications) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ANTIARRHYTHMICS		
<i>amiodarone hcl</i>	T2	HD
<i>disopyramide phosphate</i> (Norpace)	T2	HD
<i>dofetilide</i> (Tikosyn)	T2	HD
<i>flecainide acetate</i>	T2	HD
<i>mexiletine hcl</i>	T2	HD
MULTAQ	T4	HD
<i>propafenone hcl</i>	T2	HD
<i>propafenone hcl</i> (Rythmol Sr)	T2	HD
<i>quinidine gluconate</i>	T2	HD
<i>quinidine sulfate</i>	T2	HD
RYTHMOL SR (<i>propafenone hcl</i>)	T4	HD
CALCIUM CHANNEL BLOCKER AND NSAID, COX-2 INHIBITOR		
CONSENSI	T4	
CALCIUM CHANNEL BLOCKING AGENTS		
<i>amlodipine besylate</i> (Norvasc)	T1	HD
CALAN SR (<i>verapamil hcl</i>)	T4	ST HD
CARDIZEM (<i>diltiazem hcl</i>)	T4	HD
CARDIZEM CD (<i>diltiazem hcl</i>)	T4	HD
CARDIZEM LA	T4	HD
CARDIZEM LA (<i>diltiazem hcl</i>)	T4	HD
<i>diltiazem hcl</i>	T2	HD
<i>diltiazem hcl</i>	T1	HD
<i>diltiazem hcl</i> (Cardizem Cd)	T1	HD
<i>diltiazem hcl</i> (Cardizem La)	T2	HD
<i>diltiazem hcl</i> (Cardizem)	T1	HD
<i>diltiazem hcl</i> (Tiazac)	T1	HD
<i>felodipine</i>	T2	HD
<i>isradipine</i>	T2	HD
<i>nicardipine hcl</i>	T2	HD
<i>nifedipine</i>	T2	HD
<i>nifedipine</i> (Procardia XI)	T2	HD
<i>nifedipine</i> (Procardia)	T2	HD
<i>nimodipine</i>	T2	HD
<i>nisoldipine</i>	T2	HD

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

T5 – Preferred Specialty
 T6 – Non-Preferred Specialty
 PA – Prior Authorization
 QL – Quantity Limit

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

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

List of Prescription Medications

CARDIAC DRUGS (Blood Pressure/Heart Medications) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
CALCIUM CHANNEL BLOCKING AGENTS (cont.)		
<i>nisoldipine (Sular)</i>	T2	HD
NYMALIZE	T4	HD
PROCARDIA (<i>nifedipine</i>)	T4	ST HD
PROCARDIA XL (<i>nifedipine</i>)	T4	ST HD
SULAR (<i>nisoldipine</i>)	T4	ST HD
TIAZAC (<i>diltiazem hcl</i>)	T4	HD
<i>verapamil hcl</i>	T1	HD
<i>verapamil hcl (Calan Sr)</i>	T1	HD
<i>verapamil hcl (Verelan Pm)</i>	T2	HD
<i>verapamil hcl (Verelan)</i>	T2	HD
VERELAN (<i>verapamil hcl</i>)	T4	ST HD
VERELAN PM (<i>verapamil hcl</i>)	T4	ST HD
CARDIAC MYOSIN INHIBITOR		
CAMZYOS	T5	PA QL(30 caps/fill) SP HD
DIGITALIS GLYCOSIDES		
<i>digoxin</i>	T2	HD
<i>digoxin (Lanoxin)</i>	T2	HD
LANOXIN	T4	HD
LANOXIN (<i>digoxin</i>)	T4	HD
SOLUBLE GUANYLATE CYCLASE (SGC) STIMULATOR		
VERQUVO	T3	QL(30 tabs/fill)
VASODILATORS, CORONARY		
GONITRO	T4	HD
ISORDIL (<i>isosorbide dinitrate</i>)	T4	HD
ISORDIL TITRADOSE (<i>isosorbide dinitrate</i>)	T4	HD
<i>isosorbide dinitrate</i>	T2	HD
<i>isosorbide dinitrate (Isordil Titradose)</i>	T2	HD
<i>isosorbide dinitrate (Isordil)</i>	T2	HD
<i>isosorbide mononitrate</i>	T1	HD
MINITRAN	T4	HD
NITRO-DUR	T4	HD
<i>nitroglycerin</i>	T2	HD
<i>nitroglycerin 0.3 mg tablet sl (Nitrostat)</i>	T2	HD
<i>nitroglycerin 0.4 mg tablet sl (Nitrostat)</i>	T2	HD

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

T5 – Preferred Specialty
 T6 – Non-Preferred Specialty
 PA – Prior Authorization
 QL – Quantity Limit

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

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

List of Prescription Medications

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

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
VASODILATORS, CORONARY (cont.)		
<i>nitroglycerin 0.6 mg tablet sl</i> (Nitrostat)	T2	HD
<i>nitroglycerin 400 mcg spray</i> (Nitrolingual)	T2	HD
NITROLINGUAL (<i>nitroglycerin</i>)	T4	HD
NITROMIST (<i>nitroglycerin</i>)	T4	HD
NITROSTAT (<i>nitroglycerin</i>)	T4	HD

CARDIOVASCULAR (Asthma/COPD/Respiratory)

PULM ANTI-HTN, SOLUBLE GUANYLATE CYCLASE STIMULATOR

ADEMPAS	T5	PA QL(90 tabs/fill) SP HD
---------	----	---------------------------

PULM.ANTI-HTN, SEL.C-GMP PHOSPHODIESTERASE T5 INHIB

REVATIO 10 MG/ML ORAL SUSP (<i>sildenafil citrate</i>)	T6	PA QL(112 mls/fill) SP HD
REVATIO 20 MG TABLET (<i>sildenafil citrate</i>)	T6	PA QL(90 tabs/fill) SP HD
<i>sildenafil 20 mg tablet</i> (Revatio)	T2	PA QL(90 tabs/fill) SP HD
<i>tadalafil</i> (Adcirca)	T2	
<i>tadalafil 20 mg tablet</i> (Adcirca)	T2	PA QL(60 tabs/fill) SP HD

PULMONARY ANTI-HTN, ENDOTHELIN RECEPTOR ANTAGONIST

<i>ambrisentan</i> (Letairis)	T2	PA QL(30 tabs/fill) SP HD
<i>bosentan</i> (Tracleer)	T2	PA QL(60 tabs/fill) SP HD
OPSUMIT	T5	PA QL(30 tabs/fill) SP HD
TRACLEER 125 MG TABLET (<i>bosentan</i>)	T6	PA QL(60 tabs/fill) SP HD
TRACLEER 32 MG TABLET FOR SUSP	T5	PA QL(120 tabs/fill) SP HD
TRACLEER 62.5 MG TABLET (<i>bosentan</i>)	T6	PA QL(60 tabs/fill) SP HD

PULMONARY ANTIHYPERTENSIVES, PROSTACYCLIN-TYPE

ORENITRAM TITRATION KT MONTH 1	T6	PA QL (168 tabs/28 days) SP
ORENITRAM TITRATION KT MONTH 2	T6	PA QL (336 tabs/28 days) SP
ORENITRAM TITRATION KT MONTH 3	T6	PA QL (252 tabs/28 days) SP
ORENITRAM ER	T6	PA QL(90 tabs/fill) SP HD
TYVASO	T5	PA SP HD
TYVASO DPI	T5	PA SP HD
TYVASO INSTITUTIONAL START KIT	T5	PA SP HD
TYVASO REFILL KIT	T5	PA SP HD
TYVASO STARTER KIT	T5	PA SP HD
UPTRAVI 1,000 MCG TABLET	T5	PA QL(60 tabs/fill) SP HD
UPTRAVI 1,200 MCG TABLET	T5	PA QL(60 tabs/fill) SP HD
UPTRAVI 1,400 MCG TABLET	T5	PA QL(60 tabs/fill) SP HD

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

T5 – Preferred Specialty
T6 – Non-Preferred Specialty
PA – Prior Authorization
QL – Quantity Limit

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

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

List of Prescription Medications

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

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
PULMONARY ANTIHYPERTENSIVES, PROSTACYCLIN-TYPE (cont.)		
UPTRAVI 1,600 MCG TABLET	T5	PA QL(60 tabs/fill) SP HD
UPTRAVI 200 MCG TABLET	T5	PA QL(60 tabs/fill) SP HD
UPTRAVI 200-800 TITRATION PACK	T5	PA QL(1 dose pk/fill) SP HD
UPTRAVI 400 MCG TABLET	T5	PA QL(60 tabs/fill) SP HD
UPTRAVI 600 MCG TABLET	T5	PA QL(60 tabs/fill) SP HD
UPTRAVI 800 MCG TABLET	T5	PA QL(60 tabs/fill) SP HD
VENTAVIS	T6	PA SP HD

CARDIOVASCULAR (Blood Pressure/Heart Medications)

ACE INHIBITOR-CALCIUM CHANNEL BLOCKER COMBINATION

<i>amlodipine besylate/benazepril</i>	T1	HD
<i>amlodipine besylate/benazepril (Lotrel)</i>	T1	HD
PRESTALIA	T4	ST HD
<i>trandolapril/verapamil hcl</i>	T2	HD

ACE INHIBITOR-THIAZIDE OR THIAZIDE-LIKE DIURETIC

<i>ACCURETIC (quinapril/hydrochlorothiazide)</i>	T4	HD
<i>benazepril/hydrochlorothiazide</i>	T2	HD
<i>benazepril/hydrochlorothiazide (Lotensin Hct)</i>	T2	HD
<i>captopril/hydrochlorothiazide</i>	T2	HD
<i>enalapril/hydrochlorothiazide</i>	T1	HD
<i>enalapril/hydrochlorothiazide (Vaseretic)</i>	T1	HD
<i>fosinopril/hydrochlorothiazide</i>	T2	HD
<i>lisinopril/hydrochlorothiazide (Zestoretic)</i>	T1	HD
LOTENSIN HCT (<i>benazepril/hydrochlorothiazide</i>)	T4	HD
<i>quinapril/hydrochlorothiazide (Accuretic)</i>	T1	HD
<i>VASERETIC (enalapril/hydrochlorothiazide)</i>	T4	HD
<i>ZESTORETIC (lisinopril/hydrochlorothiazide)</i>	T4	HD

ALPHA/BETA-ADRENERGIC BLOCKING AGENTS

<i>carvedilol (Coreg)</i>	T1	HD
<i>carvedilol phosphate (Coreg Cr)</i>	T2	HD
COREG CR (<i>carvedilol phosphate</i>)	T4	ST HD
<i>labetalol hcl</i>	T2	HD

ALPHA-ADRENERGIC BLOCKING AGENTS

CARDURA 1 MG TABLET (<i>doxazosin mesylate</i>)	T4	ST QL(30 tabs/fill) HD
CARDURA 2 MG TABLET (<i>doxazosin mesylate</i>)	T4	ST QL(30 tabs/fill) HD

T1 – Preferred Generics

T2 – Non-Preferred Generics

T3 – Preferred Brands

T4 – Non-Preferred Brands

T5 – Preferred Specialty

T6 – Non-Preferred Specialty

PA – Prior Authorization

QL – Quantity Limit

ST – Step Therapy

AGE – Age Requirement

SP – Specialty Medication

HD – May require home delivery pharmacy

PPACA – No Cost-Share Preventive Medication

CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

CARDIOVASCULAR (Blood Pressure/Heart Medications) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ALPHA-ADRENERGIC BLOCKING AGENTS (cont.)		
CARDURA 4 MG TABLET (<i>doxazosin mesylate</i>)	T4	ST QL (30 tabs/fill) HD
CARDURA 8 MG TABLET (<i>doxazosin mesylate</i>)	T4	ST QL (60 tabs/fill) HD
CARDURA XL <i>doxazosin mesylate 1 mg tab</i> (Cardura)	T4	ST QL (30 tabs/fill) HD
<i>doxazosin mesylate 2 mg tab</i> (Cardura)	T1	QL (30 tabs/fill) HD
<i>doxazosin mesylate 4 mg tab</i> (Cardura)	T1	QL (30 tabs/fill) HD
<i>doxazosin mesylate 8 mg tab</i> (Cardura)	T1	QL (60 tabs/fill) HD
MINIPRESS (<i>prazosin hcl</i>)	T4	HD
<i>prazosin hcl</i> (Minipress)	T2	HD
<i>terazosin 1 mg capsule</i>	T1	QL (30 caps/fill) HD
<i>terazosin 10 mg capsule</i>	T1	QL (60 caps/fill) HD
<i>terazosin 2 mg capsule</i>	T1	QL (30 caps/fill) HD
<i>terazosin 5 mg capsule</i>	T1	QL (30 caps/fill) HD
ANGIOTEN.RECEPTR ANTAG-CALCIUM CHANL BLKR-THIAZIDE		
<i>amlodipine/valsartan/hcthiazid</i> (Exforge Hct)	T2	HD
<i>olmesartan/amlodipin/hcthiazid</i> (Tribenzor)	T2	HD
ANGIOTENSIN RECEPT-NEPRILYSIN INHIBITOR COMB (ARNI)		
ENTRESTO	T3	QL (60 tabs/fill) HD
ANGIOTENSIN RECEPTOR ANTAG.-THIAZIDE DIURETIC COMB		
<i>candesartan/hydrochlorothiazid</i> (Atacand Hct)	T2	HD
<i>irbesartan/hydrochlorothiazide</i> (Avalide)	T1	HD
<i>losartan/hydrochlorothiazide</i> (Hyzaar)	T1	HD
<i>olmesartan/hydrochlorothiazide</i> (Benicar Hct)	T1	HD
<i>telmisartan/hydrochlorothiazid</i> (Micardis Hct)	T2	HD
<i>valsartan/hydrochlorothiazide</i> (Diovan Hct)	T2	HD
ANGIOTENSIN RECEPTOR BLOCKR-CALCIUM CHANNEL BLOCKR		
<i>amlodipine bes/olmesartan med</i> (Azor)	T2	HD
<i>amlodipine besylate/valsartan</i> (Exforge)	T2	HD
<i>telmisartan/amlodipine</i>	T2	HD
ANTIHYPERTENSIVES, ACE INHIBITORS		
ACCUPRIL (<i>quinapril hcl</i>)	T4	HD
ALTACE (<i>ramipril</i>)	T4	HD
<i>benazepril hcl</i>	T1	HD
<i>benazepril hcl</i> (Lotensin)	T1	HD

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

T5 – Preferred Specialty
T6 – Non-Preferred Specialty
PA – Prior Authorization
QL – Quantity Limit

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

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

List of Prescription Medications

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

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ANTIHYPERTENSIVES, ACE INHIBITORS (cont.)		
<i>captopril</i>	T2	HD
<i>enalapril maleate</i> (Epaned)	T2	HD
<i>enalapril maleate</i> (Vasotec)	T1	HD
<i>fosinopril sodium</i>	T1	HD
<i>lisinopril</i> (Zestril)	T1	HD
LOTENSIN (<i>benazepril hcl</i>)	T4	HD
<i>moexipril hcl</i>	T2	HD
<i>perindopril erbumine</i>	T1	HD
<i>quinapril hcl</i> (Accupril)	T1	HD
<i>ramipril</i> (Altace)	T1	HD
<i>trandolapril</i>	T1	HD
VASOTEC (<i>enalapril maleate</i>)	T4	HD
ZESTRIL (<i>lisinopril</i>)	T4	HD
ANTIHYPERTENSIVES, ANGIOTENSIN RECEPTOR ANTAGONIST		
<i>candesartan cilexetil</i> (Atacand)	T2	HD
<i>eprosartan mesylate</i>	T2	HD
<i>irbesartan</i> (Avapro)	T1	HD
<i>losartan potassium</i> (Cozaar)	T1	HD
<i>olmesartan medoxomil</i> (Benicar)	T1	HD
<i>telmisartan</i> (Micardis)	T2	HD
<i>valsartan 160 mg tablet</i> (Diovan)	T1	HD
<i>valsartan 320 mg tablet</i> (Diovan)	T1	HD
<i>valsartan 40 mg tablet</i> (Diovan)	T1	HD
<i>valsartan 80 mg tablet</i> (Diovan)	T1	HD
ANTIHYPERTENSIVES, GANGLIONIC BLOCKERS		
VECAMYL	T4	PA
ANTIHYPERTENSIVES, MISCELLANEOUS		
DEMSEK (<i>metirosine</i>)	T4	PA HD
<i>metirosine</i> (Demser)	T2	PA HD
ANTIHYPERTENSIVES, SYMPATHOLYTIC		
CATAPRES (<i>clonidine hcl</i>)	T4	HD
CATAPRES-TTS 1 (<i>clonidine</i>)	T4	QL(4 patches/28 days) HD
CATAPRES-TTS 2 (<i>clonidine</i>)	T4	QL(4 patches/28 days) HD
CATAPRES-TTS 3 (<i>clonidine</i>)	T4	QL(4 patches/28 days) HD

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

T5 – Preferred Specialty
T6 – Non-Preferred Specialty
PA – Prior Authorization
QL – Quantity Limit

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

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

List of Prescription Medications

CARDIOVASCULAR (Blood Pressure/Heart Medications) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ANTIHYPERTENSIVES, SYMPATHOLYTIC (cont.)		
<i>clonidine</i> (Catapres-Tts 1)	T2	QL(4 patches/28 days) HD
<i>clonidine</i> (Catapres-Tts 2)	T2	QL(4 patches/28 days) HD
<i>clonidine</i> (Catapres-Tts 3)	T2	QL(4 patches/28 days) HD
<i>clonidine hcl</i> (Catapres)	T1	HD
<i>guanfacine hcl</i>	T2	HD
<i>methyldopa</i>	T2	HD
<i>methyldopa/hydrochlorothiazide</i>	T2	HD
ANTIHYPERTENSIVES, VASODILATORS		
<i>hydralazine hcl</i>	T2	HD
<i>minoxidil</i>	T2	HD
BETA-ADRENERGIC BLOCKING AGENTS		
<i>acebutolol hcl</i>	T2	HD
<i>atenolol</i> (Tenormin)	T1	HD
BETAPACE (<i>sotalol hcl</i>)	T4	ST HD
BETAPACE AF (<i>sotalol hcl</i>)	T4	ST HD
<i>betaxolol hcl</i>	T2	HD
<i>bisoprolol fumarate</i>	T2	HD
CORGARD (<i>nadolol</i>)	T4	ST HD
LOPRESSOR (<i>metoprolol tartrate</i>)	T4	ST HD
<i>metoprolol succinate</i> (Toprol XL)	T1	HD
<i>metoprolol tartrate</i>	T1	HD
<i>metoprolol tartrate</i> (Lopressor)	T1	HD
<i>nadolol</i> (Corgard)	T2	HD
<i>nebivolol hcl</i> (Bystolic)	T2	HD
<i>pindolol</i>	T2	HD
<i>propranolol hcl</i>	T1	HD
<i>propranolol hcl</i> (Inderal La)	T1	HD
<i>sotalol hcl</i> (Betapace Af)	T2	HD
<i>sotalol hcl</i> (Betapace)	T2	HD
SOTYLIZE	T3	HD
TENORMIN (<i>atenolol</i>)	T4	ST HD
<i>timolol maleate</i>	T2	HD
BETA-BLOCKERS AND THIAZIDE, THIAZIDE-LIKE DIURETICS		
<i>atenolol/chlorthalidone</i> (Tenoretic 100)	T2	HD

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

T5 – Preferred Specialty
T6 – Non-Preferred Specialty
PA – Prior Authorization
QL – Quantity Limit

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

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

List of Prescription Medications

CARDIOVASCULAR (Blood Pressure/Heart Medications) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
BETA-BLOCKERS AND THIAZIDE, THIAZIDE-LIKE DIURETICS (cont.)		
atenolol/chlorthalidone (Tenoretic 50)	T2	HD
bisoprolol/hydrochlorothiazide (Ziac)	T1	HD
METOPROLOL SUCCINATE ER-HCTZ	T4	ST HD
metoprolol/hydrochlorothiazide	T2	HD
propranolol/hydrochlorothiazid	T2	HD
TENORETIC 100 (atenolol/chlorthalidone)	T4	ST HD
TENORETIC 50 (atenolol/chlorthalidone)	T4	ST HD
ZIAC (bisoprolol/hydrochlorothiazide)	T4	ST HD
RENIN INHIBITOR, DIRECT		
aliskiren hemifumarate (Tekturna)	T2	HD
RENIN INHIBITOR, DIRECT AND THIAZIDE DIURETIC COMB		
TEKTRUNA HCT	T3	HD
VASODILATORS, COMBINATION		
isosorbide dinit/hydralazine (Bidil)	T2	
VASODILATORS, PERIPHERAL		
ergoloid mesylates	T2	
isoxsuprine hcl	T2	
CARDIOVASCULAR (Cholesterol Medications)		
ANTIHYPERLIP.HMG COA REDUCT INHIB-CHOLEST.AB.INHIB		
ezetimibe-atorvastatin tabs	T2	ST QL (30 tabs/30 days) HD
ezetimibe/simvastatin (Vytorin)	T2	QL(30 tabs/fill) HD
ROSZET	T4	ST QL(30 tabs/fill) HD
ANTIHYPERLIPID- HMG-COA RI-CALCIUM CHANNEL BLOCKER		
amlodipine/atorvastatin	T2	QL(30 tabs/fill) HD
amlodipine/atorvastatin (Caduet)	T2	QL(30 tabs/fill) HD
CADUET (amlodipine/atorvastatin)	T4	ST QL(30 tabs/fill) HD
ANTIHYPERLIPIDEMIC - ATP CITRATE LYASE INHIBITOR		
NEXLETOL	T3	PA
ANTIHYPERLIPIDEMIC - MTP INHIBITOR		
JUXTAPID	T5	PA SP HD
ANTIHYPERLIPIDEMIC - PCSK9 INHIBITORS		
REPATHA PUSHTRONEX	T3	PA
REPATHA SURECLICK	T3	PA
REPATHA SYRINGE	T3	PA

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

T5 – Preferred Specialty
 T6 – Non-Preferred Specialty
 PA – Prior Authorization
 QL – Quantity Limit

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

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

List of Prescription Medications

CARDIOVASCULAR (Cholesterol Medications) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ANTIHYPERLIPIDEMIC-ACLY AND CHOLESTEROL ABSORPTION INHIBITORS		
NEXLIZET	T3	PA
ANTIHYPERLIPIDEMIC-HMGCOA REDUCTASE INHIBITORS (STATINS)		
<i>atorvastatin 10 mg tablet (Lipitor)</i>	T1	
<i>atorvastatin 20 mg tablet (Lipitor)</i>	T1	
<i>atorvastatin 40 mg tablet (Lipitor)</i>	T1	
<i>atorvastatin 80 mg tablet (Lipitor)</i>	T1	
FLOLIPID	T4	ST QL (150 mls/fill) HD
<i>fluvastatin sodium (Lescol XL)</i>	T2	QL (30 tabs/fill) HD PPACA
<i>fluvastatin sodium 20 mg cap</i>	T2	QL (30 caps/fill) HD PPACA
<i>fluvastatin sodium 40 mg cap</i>	T2	QL (60 caps/fill) HD PPACA
LESCOL XL (<i>fluvastatin sodium</i>)	T4	ST QL (30 tabs/fill) HD
LIVALO (<i>pitavastatin calcium</i>)	T4	ST QL (30 tabs/30 days) HD
<i>lovastatin 10 mg tablet</i>	T2	QL (30 tabs/fill) HD PPACA
<i>lovastatin 20 mg tablet</i>	T2	QL (60 tabs/fill) HD PPACA
<i>lovastatin 40 mg tablet</i>	T2	QL (60 tabs/fill) HD PPACA
<i>pitavastatin (Livalo)</i>	T2	QL (30 tabs/30 days) HD PPACA
<i>pravastatin sodium</i>	T2	QL (30 tabs/fill) HD PPACA
<i>simvastatin 5 mg tablet</i>	T1	QL (30 tabs/fill) HD PPACA
<i>simvastatin 10 mg tablet (Zocor)</i>	T1	QL (30 tabs/fill) HD PPACA
<i>simvastatin 20 mg tablet (Zocor)</i>	T1	QL (30 tabs/fill) HD PPACA
SIMVASTATIN 20 MG/5 ML SUSP	T4	ST QL (150 mls/fill) HD
<i>simvastatin 40 mg tablet (Zocor)</i>	T1	QL (30 tabs/fill) HD PPACA
<i>simvastatin 80 mg tablet (Zocor)</i>	T1	QL (30 tabs/fill) HD
ZYPITAMAG	T4	ST QL (30 tabs/fill) HD
BILE SALT SEQUESTRANTS		
<i>cholestyramine (with sugar) (Questran)</i>	T2	HD
<i>cholestyramine/aspartame</i>	T2	HD
<i>cholestyramine/aspartame (Questran Light)</i>	T2	HD
<i>colesevelam hcl (Welchol)</i>	T2	HD
COLESTID	T4	ST HD
COLESTID (<i>colestipol hcl</i>)	T4	ST HD
<i>colestipol hcl (Colestid)</i>	T2	HD
QUESTRAN (<i>cholestyramine (with sugar)</i>)	T4	ST HD
QUESTRAN LIGHT (<i>cholestyramine/aspartame</i>)	T4	ST HD

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

T5 – Preferred Specialty
 T6 – Non-Preferred Specialty
 PA – Prior Authorization
 QL – Quantity Limit

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

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

List of Prescription Medications

CARDIOVASCULAR (Cholesterol Medications) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
LIPOTROPICS		
<i>ezetimibe</i> (Zetia)	T2	HD
<i>fenofibrate 120 mg tablet</i> (Fenoglide)	T2	ST HD
<i>fenofibrate 130 mg capsule</i>	T2	HD
<i>fenofibrate 134 mg capsule</i>	T2	HD
<i>fenofibrate 145 mg tablet</i> (Tricor)	T2	HD
<i>fenofibrate 160 mg tablet</i>	T2	HD
<i>fenofibrate 200 mg capsule</i>	T2	HD
<i>fenofibrate 40 mg tablet</i> (Fenoglide)	T2	ST HD
<i>fenofibrate 43 mg capsule</i>	T2	HD
<i>fenofibrate 48 mg tablet</i> (Tricor)	T2	HD
<i>fenofibrate 54 mg tablet</i>	T2	HD
<i>fenofibrate 67 mg capsule</i>	T2	HD
<i>fenofibric acid (choline)</i> (Trilipix)	T2	HD
<i>fenofibric acid</i> (Fibricor)	T2	HD
FENOGLIDE (<i>fenofibrate</i>)	T4	ST HD
FIBRICOR (<i>fenofibric acid</i>)	T4	ST HD
<i>gemfibrozil</i> (Lopid)	T1	HD
LOPID (<i>gemfibrozil</i>)	T4	HD
<i>niacin</i>	T2	HD
<i>niacin 500 mg tablet</i>	T2	HD
NIACOR	T4	HD
TRILIPIX (<i>fenofibric acid (choline)</i>)	T4	ST HD

CNS DRUGS (Alzheimer's Disease)

ALZHEIMER'S THERAPY, NMDA RECEPTOR ANTAGONISTS		
MEMANTINE 5-10 MG TITRATION PK	T4	HD
<i>memantine hcl</i> (Namenda Xr)	T2	HD
<i>memantine hcl 10 mg tablet</i> (Namenda)	T2	HD
<i>memantine hcl 2 mg/ml solution</i>	T2	HD
<i>memantine hcl 5 mg tablet</i> (Namenda)	T2	HD
NAMENDA 10 MG TABLET (<i>memantine hcl</i>)	T4	ST HD
NAMENDA 5 MG TABLET (<i>memantine hcl</i>)	T4	ST HD
NAMENDA 5-10 MG TITRATION PK	T4	HD
NAMENDA XR TITRATION PACK	T4	HD
NAMZARIC	T3	ST HD

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

T5 – Preferred Specialty
 T6 – Non-Preferred Specialty
 PA – Prior Authorization
 QL – Quantity Limit

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

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

List of Prescription Medications

CNS DRUGS (Miscellaneous)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
AMYOTROPHIC LATERAL SCLEROSIS AGENTS		
EXSERVAN	T6	PA SP
RADICAVA ORS	T5	PA SP HD
RILUTEK (<i>riluzole</i>)	T6	PA SP HD
<i>riluzole</i> (Rilutek)	T2	PA SP HD
TEGLUTIK	T6	PA SP
TIGLUTIK	T6	PA SP
DRUGS TO TREAT MOVEMENT DISORDERS		
AUSTEDO 6 MG TABLET	T5	PA QL(60 tabs/fill) SP HD
AUSTEDO 9 MG TABLET	T5	PA QL(120 tabs/fill) SP HD
AUSTEDO 12 MG TABLET	T5	PA QL(120 tabs/fill) SP HD
AUSTEDO XR 12 MG TABLET	T5	PA QL (90 tabs/30 days) SP HD
AUSTEDO XR 24 MG TABLET	T5	PA QL (60 tabs/30 days) SP HD
AUSTEDO XR 6 MG TABLET	T5	PA QL (210 tabs/30 days) SP HD
AUSTEDO XR TITRATION KT(WK1-4)	T5	PA QL(42 tabs/30 days) SP HD
HORIZANT	T4	ST
INGREZZA	T6	PA QL(30 caps/fill) SP
INGREZZA INITIATION PACK	T6	PA QL(28 caps/fill) SP
<i>tetrabenazine 12.5 mg tablet</i> (Xenazine)	T2	PA QL(120 tabs/fill) SP HD
<i>tetrabenazine 25 mg tablet</i> (Xenazine)	T2	PA QL(60 tabs/fill) SP HD
PSEUDOBULBAR AFFECT (PBA) AGENTS, NMDA ANTAGONISTS		
NUEDEXTA	T3	PA
XANTHINES		
<i>caffeine citrate</i>	T2	HD
CNS DRUGS (Multiple Sclerosis)		
AGENTS TO TREAT MULTIPLE SCLEROSIS		
AVONEX	T5	PA QL(1 kit/28 days) SP HD
AVONEX PEN	T5	PA QL(4 pens/28 days) SP HD
BAFIERTAM	T5	PA QL(120 caps/fill) SP HD
BETASERON	T5	PA QL(14 kits/30 days) SP HD
COPAXONE 20 MG/ML SYRINGE (<i>glatiramer acetate</i>)	T6	PA QL(30 syringes/30 days) SP HD
COPAXONE 40 MG/ML SYRINGE (<i>glatiramer acetate</i>)	T6	PA QL(12 syringes/30 days) SP HD
<i>dimethyl fumarate</i> (Tecfidera)	T2	PA QL(60 caps/fill) SP HD
<i>fingolimod hcl</i> (Gilenya)	T2	
<i>glatiramer 20 mg/ml syringe</i> (Copaxone)	T2	PA QL(30 syringes/30 days) SP HD

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

T5 – Preferred Specialty
 T6 – Non-Preferred Specialty
 PA – Prior Authorization
 QL – Quantity Limit

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

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

List of Prescription Medications

CNS DRUGS (Multiple Sclerosis) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
AGENTS TO TREAT MULTIPLE SCLEROSIS (cont.)		
<i>glatiramer 40 mg/ml syringe (Copaxone)</i>	T2	PA QL(12 syringes/30 days) SP HD
<i>glatopa 20 mg/ml syringe (Copaxone)</i>	T2	PA QL(30 syringes/30 days) SP HD
<i>glatopa 40 mg/ml syringe (Copaxone)</i>	T2	PA QL(12 syringes/30 days) SP HD
KESIMPTA PEN	T5	PA QL(1 pen/28 days SP HD
MAVENCLAD 10 MG X 10 TABLET PK	T6	PA QL(10 tabs/fill) SP HD
MAVENCLAD 10 MG X 4 TABLET PK	T6	PA QL(4 tabs/fill) SP HD
MAVENCLAD 10 MG X 5 TABLET PK	T6	PA QL(5 tabs/fill) SP HD
MAVENCLAD 10 MG X 6 TABLET PK	T6	PA QL(6 tabs/fill) SP HD
MAVENCLAD 10 MG X 7 TABLET PK	T6	PA QL(7 tabs/fill) SP HD
MAVENCLAD 10 MG X 8 TABLET PK	T6	PA QL(8 tabs/fill) SP HD
MAVENCLAD 10 MG X 9 TABLET PK	T6	PA QL(9 tabs/fill) SP HD
MAYZENT 0.25 MG TABLET	T5	PA QL(30 tabs/fill) SP HD
MAYZENT 0.25MG START-1MG MAINT	T5	PA QL(7 tabs/fill) SP HD
MAYZENT 0.25MG START-2MG MAINT	T5	PA QL(12 tabs/fill) SP HD
MAYZENT 1 MG, 2 MG TABLET	T5	PA QL(30 tabs/fill) SP HD
PLEGRIDY 125 MCG/0.5 ML PEN	T5	PA QL(1 ml/28 days SP HD
PLEGRIDY 125 MCG/0.5 ML SYRINGE	T5	PA QL(1 ml/28 days SP HD
PLEGRIDY PEN INJ STARTER PACK	T5	PA QL(1 ml/365 days SP HD
PLEGRIDY SYRINGE STARTER PACK	T5	PA QL(1 ml/365 days SP HD
PONVORY 14-DAY STARTER PACK	T5	PA QL(14 tabs/365 days) SP HD
PONVORY 20 MG TABLET	T5	PA QL(30 tabs/30 days) SP HD
REBIF 22 MCG/0.5 ML SYRINGE	T5	PA QL(6 mls/28 days) SP HD
REBIF 44 MCG/0.5 ML SYRINGE	T5	PA QL(6 mls/28 days) SP HD
REBIF REBIDOSE 22 MCG/0.5 ML	T5	PA QL(6 mls/28 days) SP HD
REBIF REBIDOSE 44 MCG/0.5 ML	T5	PA QL(6 mls/28 days) SP HD
REBIF REBIDOSE TITRATION PACK	T5	PA QL(4.2 mls/28 days) SP HD
REBIF TITRATION PACK	T5	PA QL(4.2 mls/28 days) SP HD
VUMERITY	T5	PA QL(120 caps/fill) SP HD
AGTS TX NEUROMUSC TRANSMISSION DIS, POT-CHAN BLKR		
<i>dalfampridine (Ampyra)</i>	T2	PA QL(60 tabs/fill) SP HD
FIRDAPSE	T5	PA SP
RUZURGI	T3	PA
SPHINGOSINE I-PHOSPHATE (SIP) RECEPTOR MODULATOR		
ZEPOSIA 0.23-0.46 MG START PCK	T5	PA QL(7 caps/fill) SP HD
ZEPOSIA 0.23-0.46-0.92 MG KIT	T5	PA QL(1 kit/fill) SP HD

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

T5 – Preferred Specialty
T6 – Non-Preferred Specialty
PA – Prior Authorization
QL – Quantity Limit

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

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

List of Prescription Medications

CNS DRUGS (Multiple Sclerosis) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
SPHINGOSINE I-PHOSPHATE (SIP) RECEPTOR MODULATOR (cont.)		
ZEPOSIA 0.92 MG CAPSULE	T5	PA QL(30 caps/fill) SP HD
ZEPOSIA STARTER KIT (28-DAY)	T5	

CNS DRUGS (Pain Relief And Inflammatory Disease)

CALCITONIN GENE-RELATED PEPTIDE (CGRP) INHIBITORS

EMGALITY 100 MG/ML SYR(1 OF 3)	T3	PA QL(3 mls/30 days)
EMGALITY 300 MG (100 MG X3SYR)	T3	PA QL(3 mls/30 days)

POSTHERPETIC NEURALGIA AGENTS

<i>gabapentin</i> (Gralise)	T2	ST
GRALISE	T4	ST
GRALISE (<i>gabapentin</i>)	T4	ST

CNS DRUGS (Seizure Disorders)

ANTICONSULSANT - BENZODIAZEPINE TYPE

<i>clobazam</i> (Onfi)	T2	PA HD
<i>clonazepam</i>	T2	HD
<i>clonazepam</i> (Klonopin)	T1	HD
DIASTAT (<i>diazepam</i>)	T4	HD
DIASTAT ACUDIAL (<i>diazepam</i>)	T4	HD
<i>diazepam 10 mg rectal gel syst</i> (Diastat Acudial)	T2	HD
<i>diazepam 2.5 mg rectal gel sys</i> (Diastat)	T2	HD
<i>diazepam 20 mg rectal gel syst</i>	T2	HD
NAYZILAM	T3	PA QL(2 units/fill) HD
SYMPAZAN	T4	PA HD
VALTOCO	T4	PA QL(2 units/fill) HD

ANTICONSULSANT - CANNABINOID TYPE

EPIDIOLEX	T5	PA SP HD
-----------	----	----------

ANTICONSULSANTS

APTIOM	T4	HD
BRIVIACT	T4	ST HD
<i>carbamazepine</i>	T2	HD
<i>carbamazepine</i>	T2	HD
<i>carbamazepine</i> (Carbatrol)	T2	HD
<i>carbamazepine</i> (Tegretol Xr)	T2	HD
<i>carbamazepine</i> (Tegretol)	T4	HD

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

T5 – Preferred Specialty
T6 – Non-Preferred Specialty
PA – Prior Authorization
QL – Quantity Limit

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

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

List of Prescription Medications

CNS DRUGS (Seizure Disorders) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ANTICONVULSANTS (cont.)		
CARBATROL (<i>carbamazepine</i>)	T3	HD
CELONTIN (<i>methsuximide</i>)	T4	HD
DEPAKOTE (<i>divalproex sodium</i>)	T4	ST HD
DEPAKOTE ER (<i>divalproex sodium</i>)	T4	ST HD
DEPAKOTE SPRINKLE (<i>divalproex sodium</i>)	T4	ST HD
DIACOMIT	T5	PA SP HD
DILANTIN 100 MG CAPSULE (<i>phenytoin sodium extended</i>)	T4	HD
DILANTIN 30 MG CAPSULE	T3	HD
DILANTIN 50 MG INFATAB (<i>phenytoin</i>)	T4	HD
DILANTIN-125 (<i>phenytoin</i>)	T4	HD
<i>divalproex sodium</i> (Depakote Er)	T2	HD
<i>divalproex sodium</i> (Depakote Sprinkle)	T2	HD
<i>divalproex sodium</i> (Depakote)	T2	HD
ELEPSIA XR	T4	ST HD
<i>ethosuximide</i> (Zarontin)	T2	HD
<i>felbamate</i> (Felbatol)	T2	HD
FELBATOL (<i>felbamate</i>)	T4	HD
FYCOMPA	T3	HD
<i>gabapentin</i>	T2	HD
<i>gabapentin</i> (Neurontin)	T1	HD
<i>gabapentin</i> (Neurontin)	T2	HD
GABITRIL (<i>tiagabine hcl</i>)	T4	HD
<i>lacosamide</i> (Vimpat)	T2	HD
LAMICTAL XR (BLUE)	T4	ST HD
LAMICTAL XR (GREEN)	T4	ST HD
LAMICTAL XR (ORANGE)	T4	ST HD
<i>lamotrigine</i> (Lamictal (Blue))	T2	HD
<i>lamotrigine</i> (Lamictal (Green))	T2	HD
<i>lamotrigine</i> (Lamictal (Orange))	T2	HD
<i>lamotrigine</i> (Lamictal Odt (Blue))	T2	HD
<i>lamotrigine</i> (Lamictal Odt (Green))	T2	HD
<i>lamotrigine</i> (Lamictal Odt (Orange))	T2	HD
<i>lamotrigine</i> (Lamictal Odt)	T2	HD
<i>lamotrigine</i> (Lamictal Xr)	T2	HD

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

T5 – Preferred Specialty
 T6 – Non-Preferred Specialty
 PA – Prior Authorization
 QL – Quantity Limit

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

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

List of Prescription Medications

CNS DRUGS (Seizure Disorders) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ANTICONVULSANTS (cont.)		
<i>lamotrigine</i> (Lamictal)	T1	HD
<i>lamotrigine</i> (Lamictal)	T2	HD
<i>levetiracetam</i>	T2	HD
<i>levetiracetam</i> (Keppra Xr)	T2	HD
<i>levetiracetam</i> (Keppra)	T2	HD
MYSOLINE (<i>primidone</i>)	T4	HD
<i>oxcarbazepine</i> (Trileptal)	T2	HD
OXTELLAR XR	T4	ST HD
PHENYTEK (<i>phenytoin sodium extended</i>)	T4	HD
<i>phenytoin</i>	T2	HD
<i>phenytoin</i> (Dilantin)	T2	HD
<i>phenytoin</i> (Dilantin-125)	T2	HD
<i>phenytoin sodium extended</i> (Dilantin)	T2	HD
<i>phenytoin sodium extended</i> (Phenytek)	T2	HD
<i>pregabalin</i> (Lyrica)	T2	HD
QUDEXY XR (<i>topiramate</i>)	T4	ST HD
<i>rufinamide</i> (Banzel)	T2	PA HD
SPRITAM	T4	ST HD
TEGRETOL (<i>carbamazepine</i>)	T4	HD
TEGRETOL XR (<i>carbamazepine</i>)	T4	HD
<i>tiagabine hcl</i> (Gabitril)	T2	HD
<i>topiramate</i> (Qudexy Xr)	T2	ST HD
<i>topiramate</i> (Topamax)	T1	HD
<i>topiramate</i> (Topamax)	T2	HD
<i>topiramate er</i> (Trokendi XR)	T2	ST HD
TROKENDI XR	T4	ST HD
<i>valproic acid</i>	T2	HD
<i>valproic acid</i> (as sodium salt)	T2	HD
<i>vigabatrin</i> (Sabril)	T2	PA QL(150 packs/30 days) SP HD
<i>vigabatrin 500 mg tablet</i> (Sabril)	T2	
VIGADRONE	T2	PA SP HD QL (150 pkts/30 days)
XCOPRI 100 MG TABLET	T4	QL(30 tabs/fill) HD
XCOPRI 12.5-25 MG TITRATION PK	T4	QL(28 tabs/fill) HD
XCOPRI 150 MG TABLET	T4	QL(30 tabs/fill) HD

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

T5 – Preferred Specialty
 T6 – Non-Preferred Specialty
 PA – Prior Authorization
 QL – Quantity Limit

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

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

List of Prescription Medications

CNS DRUGS (Seizure Disorders) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ANTICONVULSANTS (cont.)		
XCOPRI 150-200 MG TITRATION PK	T4	QL(28 tabs/fill) HD
XCOPRI 200 MG TABLET	T4	QL(30 tabs/fill) HD
XCOPRI 250 MG DAILY DOSE PACK	T4	QL(56 tabs/fill) HD
XCOPRI 350 MG DAILY DOSE PACK	T4	QL(56 tabs/fill) HD
XCOPRI 50 MG TABLET	T4	QL(30 tabs/fill) HD
XCOPRI 50-100 MG TITRATION PAK	T4	QL(28 tabs/fill) HD
ZARONTIN (<i>ethosuximide</i>)	T4	HD
<i>zonisamide</i>	T2	HD
<i>zonisamide</i> (Zonegran)	T2	HD
NARCOLEPSY TX-H3-RECEPT.ANTAGONIST/INVERSE AGONIST		
WAKIX 17.8 MG TABLET	T6	PA QL(60 tabs/fill) SP HD
WAKIX 4.45 MG TABLET	T6	PA QL(30 tabs/fill) SP HD
COLONY STIMULATING FACTORS (Blood Modifiers/Bleeding Disorders)		
LEUKOCYTE (WBC) STIMULANTS		
FULPHILA	T5	PA QL(1.2 mls/30 days) SP
ZIEXTENZO	T5	PA QL(1.2 mls/30 days) SP
THROMBOPOIETIN RECEPTOR AGONISTS		
DOPTELET	T5	PA QL(15 tabs/fill) SP HD
PROMACTA	T5	PA SP HD
CONTRACEPTIVES (Contraception Products)		
CONTRACEPTIVES, INTRAVAGINAL, SYSTEMIC		
ANNOVERA	T4	ST QL(1 ring/365 days) PPACA
<i>etonogestrel/ethinyl estradiol</i> (Nuvaring)	T2	PPACA
CONTRACEPTIVES, INJECTABLE		
DEPO-PROVERA (<i>medroxyprogesterone acetate</i>)	T4	QL(1 ml/90 days) PPACA
DEPO-SUBQ PROVERA 104	T4	QL(1 ml/90 days) PPACA
<i>medroxyprogesterone 150 mg/ml</i> (Depo-Provera)	T2	QL(1 ml/90 days) PPACA
CONTRACEPTIVES, ORAL		
BEYAZ (<i>drosipir/eth estra/levomefol ca</i>)	T4	ST HD PPACA
<i>desog-e.estradiol/e.estradiol</i> (Mircette)	T2	HD PPACA
<i>desogestrel-ethinyl estradiol</i>	T2	HD PPACA
<i>drosipir/eth estra/levomefol ca</i> (Beyaz)	T2	HD PPACA
<i>drosipir/eth estra/levomefol ca</i> (Safyral)	T2	HD PPACA

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

T5 – Preferred Specialty
T6 – Non-Preferred Specialty
PA – Prior Authorization
QL – Quantity Limit

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

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

List of Prescription Medications

CONTRACEPTIVES (Contraception Products) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
CONTRACEPTIVES, ORAL (cont.)		
ELLA	T3	QL(1 tab/fill) HD PPACA
<i>ethinyl estradiol/drospirenone (Yasmin 28)</i>	T2	HD PPACA
<i>ethinyl estradiol/drospirenone (Yaz)</i>	T2	HD PPACA
<i>ethynodiol d-ethinyl estradiol</i>	T2	HD PPACA
<i>levonorgestrel/ethin.estradiol</i>	T2	HD PPACA
<i>l-norgest/e.estradiol-e.estradiol (Loseasonique)</i>	T2	HD PPACA
<i>l-norgest/e.estradiol-e.estradiol (Quartette)</i>	T2	HD PPACA
<i>l-norgest/e.estradiol-e.estradiol (Seasonique)</i>	T2	HD PPACA
<i>noreth-ethinyl estradiol/iron</i>	T2	HD PPACA
<i>noreth-ethinyl estradiol/iron (Generess Fe)</i>	T2	HD PPACA
<i>norethind-eth estrad 1-0.02 mg (Loestrin)</i>	T2	HD PPACA
<i>norethindrone</i>	T2	HD PPACA
<i>norethindrone ac-eth estradiol (Loestrin)</i>	T2	HD PPACA
<i>norethindrone-e.estradiol-iron</i>	T2	HD PPACA
<i>norethindrone-e.estradiol-iron (Loestrin Fe)</i>	T2	HD PPACA
<i>norethindrone-e.estradiol-iron (Minastrin 24 Fe)</i>	T2	HD PPACA
<i>norethindrone-e.estradiol-iron (Taytulla)</i>	T2	HD PPACA
<i>norethindrone-ethin. estradiol</i>	T2	HD PPACA
<i>norethin-ee 1.5-0.03 mg(21) tb (Loestrin)</i>	T2	HD PPACA
<i>norgestimate-ethinyl estradiol</i>	T2	HD PPACA
NORGESTREL-ETHINYL ESTRADIOL	T2	HD PPACA
YAZ (ethinyl estradiol/drospirenone)	T4	ST HD PPACA
CONTRACEPTIVES, TRANSDERMAL		
<i>norelgestromin/ethin.estradiol</i>	T2	HD PPACA
INTRA-UTERINE DEVICES (IUDS)		
KYLEENA	T5	SP PPACA
LILETTA	T6	SP PPACA
MIRENA	T5	SP PPACA
SKYLA	T5	SP PPACA
COUGH/COLD PREPARATIONS (Allergy/Nasal Sprays)		
1ST GEN ANTIHIST-DECONGEST-ANTICHOLINERGIC COMB		
RESPA A.R. (<i>pseudoephed/chlor-mal/bell alk</i>)	T4	

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

T5 – Preferred Specialty
 T6 – Non-Preferred Specialty
 PA – Prior Authorization
 QL – Quantity Limit

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

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

List of Prescription Medications

COUGH/COLD PREPARATIONS (Cough/Cold Medications)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ANTITUSSIVES, NON-OPIOID		
<i>benzonatate</i>	T2	
DECONGESTANT-EXPECTORANT COMBINATIONS		
<i>guaifenesin/phenylephrine hcl</i>	T2	
NON-OPIOID ANTITUS-IST GEN.ANTIHISTAMINE-DECONGEST		
BROMFED DM (<i>brompheniramine/pseudoephed/dm</i>)	T4	
<i>brompheniramine/pseudoephed/dm</i> (Bromfed Dm)	T2	
NON-OPIOID ANTITUSSIVE-IST GEN ANTIHISTAMINE COMB.		
<i>promethazine/dextromethorphan</i>	T2	
OPIOID ANTITUSSIV-IST GEN. ANTIHISTAMINE-DECONGEST		
CAPCOF	T4	
HISTEX-AC	T4	
MAXI-TUSS CD	T4	
POLY-TUSSIN AC	T4	
<i>promethazine/phenyleph/codeine</i>	T2	
ZODRYL DAC 25	T4	
ZODRYL DAC 30	T4	
ZODRYL DAC 35	T4	
ZODRYL DAC 40	T4	
ZODRYL DAC 50	T4	
ZODRYL DAC 60	T4	
ZODRYL DAC 80	T4	
OPIOID ANTITUSSIVE-IST GENERATION ANTIHISTAMINE		
<i>hydrocodone/chlorphen p-stirex</i>	T2	
<i>promethazine hcl/codeine</i>	T2	
TUSSICAPS	T4	PA
TUXARIN ER	T4	
TUZISTRA XR	T4	PA
ZODRYL AC 25	T4	
ZODRYL AC 30	T4	
ZODRYL AC 35	T4	
ZODRYL AC 40	T4	
ZODRYL AC 50	T4	
ZODRYL AC 60	T4	
ZODRYL AC 80	T4	

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

T5 – Preferred Specialty
 T6 – Non-Preferred Specialty
 PA – Prior Authorization
 QL – Quantity Limit

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

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

List of Prescription Medications

COUGH/COLD PREPARATIONS (Cough/Cold Medications) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
OPIOID ANTITUSSIVE-ANTICHOLINERGIC COMBINATIONS		
HYCODAN	T4	
HYCODAN (<i>hydrocodone bit/homatrop me-br</i>)	T4	
<i>hydrocodone bit/homatrop me-br</i>	T2	
<i>hydrocodone bit/homatrop me-br</i> (Hycodan)	T2	
OPIOID ANTITUSSIVE-DECONGESTANT-EXPECTORANT COMB		
CODITUSSIN DAC	T4	
<i>pseudoephed/codeine/guaifien</i>	T2	
ZODRYL DEC 25	T4	
ZODRYL DEC 30	T4	
ZODRYL DEC 35	T4	
ZODRYL DEC 40	T4	
ZODRYL DEC 50	T4	
ZODRYL DEC 60	T4	
ZODRYL DEC 80	T4	
OPIOID ANTITUSSIVE-EXPECTORANT COMBINATION		
<i>codeine phosphate/guaifenesin</i>	T2	
CODITUSSIN AC	T4	
GUAIFEN-CODEINE 100-10 MG/5 ML	T4	
<i>guaifien-codeine 100-10 mg/5 ml</i>	T2	
GUAIFEN-CODEINE 200-20 MG/10ML	T4	
MAR-COF CG	T4	
NINJACOF-XG	T4	
OBREDON	T4	PA
DIAGNOSTIC (Diabetes)		
BLOOD SUGAR DIAGNOSTICS		
FREESTYLE INSULINX	T3	
FREESTYLE INSULINX TEST STRIPS	T3	
FREESTYLE LITE TEST STRIP	T3	
FREESTYLE TEST STRIPS	T3	
ONETOUCH ULTRA TEST STRIP	T3	
ONETOUCH VERIO TEST STRIP	T3	
PRECISION XTRA	T3	
URINE GLUCOSE TEST AIDS		
DIASTIX REAGENT	T3	

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

T5 – Preferred Specialty
T6 – Non-Preferred Specialty
PA – Prior Authorization
QL – Quantity Limit

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

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

List of Prescription Medications

DIAGNOSTIC (Miscellaneous)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
BLOOD TESTING PREPARATIONS		
FORA GTEL KETONE TEST STRIP	T4	
GOJJI BLOOD KETONE TEST STRIP	T4	
NOVAMAX PLUS	T3	
PRECISION XTRA	T3	
CARDIOVASCULAR DIAGNOSTICS-RADIOPAQUE		
OMNIPAQUE	T4	
DIAGNOSTIC PREPARATIONS, MISCELLANEOUS		
ARIDOL	T4	
GLUCAGEN DIAGNOSTIC 1 MG VIAL	T3	
METHACHOLINE CHLORIDE	T4	
PROVOCHOLINE	T4	
TC 99M SULFUR COLLOID PREP	T4	
TOXICOLOGY SALIVA COLLECTION	T4	
EYE DIAGNOSTIC AGENTS		
<i>fluorescein sodium</i>	T2	
<i>ful-glo 1 mg oph strip</i>	T2	
FUL-GLO EYE STRIPS	T4	
FLUORESCENCE IMAGING AGENTS - MALIGNANT TISSUE		
GLEOLAN	T4	
GASTROINTESTINAL RADIOPAQUE DIAGNOSTICS		
<i>diatrizoate meglumine, sodium (Gastrografin)</i>	T2	
ENTERO VU	T4	
E-Z DISK	T4	
E-Z-HD	T4	
E-Z-PAQUE	T4	
E-Z-PASTE	T4	
GASTROGRAFIN (<i>diatrizoate meglumine, sodium</i>)	T4	
GASTROMARK	T4	
LIQUID E-Z PAQUE	T4	
LIQUID POLIBAR PLUS	T4	
NEULUMEX	T4	
POLIBAR ACB	T4	
READI-CAT 2	T4	
SITZMARKS	T4	

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

T5 – Preferred Specialty
 T6 – Non-Preferred Specialty
 PA – Prior Authorization
 QL – Quantity Limit

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

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

List of Prescription Medications

DIAGNOSTIC (Miscellaneous) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
GASTROINTESTINAL RADIOPAQUE DIAGNOSTICS (cont.)		
TAGITOL	T4	
VANILLA SILQ	T4	
VARIBAR HONEY	T4	
VARIBAR NECTAR	T4	
VARIBAR PUDDING	T4	
VARIBAR THIN HONEY	T4	
VARIBAR THIN LIQUID	T4	
VOLUMEN	T4	
METABOLIC FUNCTION DIAGNOSTICS		
METOPIRON	T4	
RADIOACTIVE DIAGNOSTICS, GENERAL		
XENON XE-133	T4	
RADIOPHARMACEUTICALS ELEMENTS		
INDICLOR	T4	
URINARY TRACT RADIOPAQUE DIAGNOSTICS		
CYSTO-CONRAY II	T4	
CYSTOGRAFIN	T4	
CYSTOGRAFIN-DILUTE	T4	
URINARY TRACT RADIOPAQUE DIAGNOSTICS		
KETONE CARE TEST STRIP	T3	
KETONE TEST STRIP	T3	
KETOSTIX REAGENT	T3	
TRUEPLUS KETONE TEST STRIP	T3	
URINE GLUCOSE/ACETONE TEST AIDS,STRIPS		
KETO-DIASTIX REAGENT	T3	
URINE MULTIPLE TEST AIDS		
CHEK-STIX	T3	
CHEMSTRIP	T3	
CHEMSTRIP 10 WITH SG	T3	
CHEMSTRIP 2 GP	T3	
CHEMSTRIP 50B	T3	
CHEMSTRIP 7	T3	
CHEMSTRIP 9	T3	
COMBISTIX REAGENT	T3	

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

T5 – Preferred Specialty
 T6 – Non-Preferred Specialty
 PA – Prior Authorization
 QL – Quantity Limit

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

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

List of Prescription Medications

DIAGNOSTIC (Miscellaneous) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
URINE MULTIPLE TEST AIDS (cont.)		
HEMA-COMBISTIX	T3	
KETO-DIASTIX REAGENT	T3	
LABSTIX REAGENT	T3	
MULTISTIX	T3	
MULTISTIX 10 SG	T3	
MULTISTIX 5	T3	
MULTISTIX 7	T3	
MULTISTIX 8 SG	T3	
MULTISTIX 9	T3	
MULTISTIX 9 SG	T3	
URISTIX 4	T3	
URISTIX REAGENT	T3	

DIURETICS (Diuretics)

ARGININE VASOPRESSIN (AVP) RECEPTOR ANTAGONISTS

<i>tolvaptan 15 mg tablet (Samsca)</i>	T2	PA QL(30 tabs/fill) SP
<i>tolvaptan 30 mg tablet (Samsca)</i>	T2	PA QL(60 tabs/fill) SP

CARBONIC ANHYDRASE INHIBITORS

<i>acetazolamide</i>	T2	HD
<i>methazolamide</i>	T2	HD

LOOP DIURETICS

<i>bumetanide</i>	T2	HD
EDECIN (<i>ethacrynic acid</i>)	T4	ST HD
<i>ethacrynic acid</i> (Edecrin)	T2	HD
<i>furosemide</i>	T1	HD
<i>furosemide</i> (Lasix)	T1	HD
LASIX (<i>furosemide</i>)	T4	ST HD
<i>torseamide</i>	T2	HD

POLYCYSTIC KIDNEY DISEASE AGENT, AVP RECEPTOR ANTAGONIST

JYNARQUE 15 MG TABLET	T6	PA QL(120 tabs/fill) SP
JYNARQUE 15 MG-15 MG TABLET	T6	PA QL(56 tabs/fill) SP
JYNARQUE 30 MG TABLET	T6	PA QL(120 tabs/fill) SP
JYNARQUE 30 MG-15 MG TABLET	T6	PA QL(56 tabs/fill) SP
JYNARQUE 45 MG-15 MG TABLET	T6	PA QL(56 tabs/fill) SP
JYNARQUE 60 MG-30 MG TABLET	T6	PA QL(56 tabs/fill) SP

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

T5 – Preferred Specialty
T6 – Non-Preferred Specialty
PA – Prior Authorization
QL – Quantity Limit

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

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

List of Prescription Medications

DIURETICS (Diuretics) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
POLYCYSTIC KIDNEY DISEASE AGENT, AVP RECEPTOR ANTAGONIST (cont.)		
JYNARQUE 90 MG-30 MG TABLET	T6	PA QL(56 tabs/fill) SP
POTASSIUM SPARING DIURETICS		
ALDACTONE (<i>spironolactone</i>)	T4	HD
<i>amiloride hcl</i>	T2	HD
DYRENIUM (<i>triamterene</i>)	T4	HD
<i>eplerenone</i> (Inspra)	T2	HD
INSPRA (<i>eplerenone</i>)	T4	HD
KERENDIA	T3	PA QL(30 tabs/fill) HD
<i>spironolactone</i> (Carospir)	T2	HD
<i>spironolactone</i> (Aldactone)	T1	HD
<i>triamterene</i> (Dyrenium)	T2	HD
POTASSIUM SPARING DIURETICS IN COMBINATION		
ALDACTAZIDE	T4	HD
<i>amiloride/hydrochlorothiazide</i>	T2	HD
DYAZIDE (<i>triamterene/hydrochlorothiazid</i>)	T4	HD
MAXZIDE (<i>triamterene/hydrochlorothiazid</i>)	T4	HD
MAXZIDE-25 MG (<i>triamterene/hydrochlorothiazid</i>)	T4	HD
<i>spironolact/hydrochlorothiazid</i>	T2	HD
<i>triamterene/hydrochlorothiazid</i> (Dyazide)	T1	HD
<i>triamterene/hydrochlorothiazid</i> (Maxzide)	T1	HD
<i>triamterene/hydrochlorothiazid</i> (Maxzide-25 Mg)	T1	HD
THIAZIDE AND RELATED DIURETICS		
<i>chlorthalidone</i>	T2	HD
DIURIL	T4	HD
<i>hydrochlorothiazide</i>	T1	HD
<i>indapamide</i>	T1	HD
<i>metolazone</i>	T2	HD
EENT PREPS (Allergy/Nasal Sprays)		
NASAL ANTIHISTAMINE		
<i>azelastine 0.1% (137 mcg) spray</i>	T2	QL(60 mls/fill) HD
<i>azelastine 0.15% nasal spray</i>	T2	HD
<i>olopatadine hcl</i> (Patanase)	T2	QL(31 gms/fill) HD
PATANASE (<i>olopatadine hcl</i>)	T4	QL(31 gms/fill) HD

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

T5 – Preferred Specialty
 T6 – Non-Preferred Specialty
 PA – Prior Authorization
 QL – Quantity Limit

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

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

List of Prescription Medications

EENT PREPS (Allergy/Nasal Sprays) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
NASAL ANTIHISTAMINE AND ANTI-INFLAM. STEROID COMB.		
<i>azelastine/fluticasone (Dymista)</i>	T2	ST QL (23 gms/fill) HD
DYMISTA (<i>azelastine/fluticasone</i>)	T4	ST QL (23 gms/fill) HD
RYALTRIS	T4	ST QL (1 bottle/fill) HD
NASAL ANTI-INFLAMMATORY STEROIDS		
<i>flunisolide</i>	T2	ST QL (50 mls/fill) HD
<i>fluticasone prop 50 mcg spray</i>	T2	QL (16 gms/fill) HD
<i>mometasone furoate 50 mcg spry (Nasonex)</i>	T2	ST QL (17 gms/fill) HD
XHANCE	T4	ST QL (32 mls/fill) HD
NOSE PREPARATIONS, MISCELLANEOUS (RX)		
COCAINE HCL	T4	HD
GOPRELTO	T4	HD
<i>ipratropium 0.03% spray</i>	T2	QL (30 mls/fill) HD
<i>ipratropium 0.06% spray</i>	T2	QL (30 mls/fill) HD
NUMBRINO	T4	HD
NOSE PREPARATIONS, VASOCONSTRICTORS (RX)		
ADRENALIN CHLORIDE	T4	
<i>epinephrine hcl</i>	T2	
EENT PREPS (Ear Medications)		
EAR PREPARATIONS ANTI-INFLAMMATORY		
DERMOTIC (<i>fluocinolone acetonide oil</i>)	T4	
<i>fluocinolone acetonide oil (Dermotic)</i>	T2	
EAR PREPARATIONS, MISC. ANTI-INFECTIVES		
<i>acetic acid</i>	T2	
CORTANE-B (<i>hydrocort/pramoxine/chloroxyl</i>)	T4	
<i>hydrocortisone/acetic acid</i>	T2	
EENT PREPS (Eye Conditions)		
AGENTS FOR CORNEAL COLLAGEN CROSS-LINKING		
PHOTREXA CROSS-LINKING	T4	
PHOTREXA VISCOUS	T4	
ARTIFICIAL TEARS		
KLARITY (CHONDROITIN)	T4	
LACRISERT	T4	PA QL (60 inserts/fill)
MIEBO	T3	

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

T5 – Preferred Specialty
T6 – Non-Preferred Specialty
PA – Prior Authorization
QL – Quantity Limit

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

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

List of Prescription Medications

EENT PREPS (Eye Conditions) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
EYE ANTI-INFECTIVES (RX ONLY)		
BETADINE	T4	
EYE ANTI-INFLAMMATORY AGENTS		
ACULAR (<i>ketorolac tromethamine</i>)	T4	ST
ACULAR LS (<i>ketorolac tromethamine</i>)	T4	ST
<i>bromfenac sodium</i>	T2	
<i>bromfenac sodium</i> (Bromsite)	T2	
<i>bromfenac sodium</i> (Prolensa)	T2	
<i>dexamethasone sodium phosphate</i>	T2	
DEXTENZA	T4	
<i>diclofenac 0.1% eye drops</i>	T2	
<i>difluprednate</i> (Durezol)	T2	
EYSUVIS	T4	PA QL(8.3 mls/fill)
<i>fluorometholone</i> (Fml)	T2	
<i>flurbiprofen sodium</i>	T2	
FML (<i>fluorometholone</i>)	T4	ST
ILEVRO	T4	
INVELTYS	T4	ST
<i>ketorolac 0.4% ophth solution</i> (Acular Ls)	T2	
<i>ketorolac 0.5% ophth solution</i> (Acular)	T2	
KLARITY-B(BETAMETHASONE-CHOND)	T4	
KLARITY-L (<i>LOTEPREDNOL-CHONDR</i>)	T4	
LOTEMAX 0.5% EYE DROPS (<i>loteprednol etabonate</i>)	T4	
LOTEMAX 0.5% EYE OINTMENT	T4	ST
LOTEMAX 0.5% OPHTHALMIC GEL (<i>loteprednol etabonate</i>)	T4	ST
LOTEMAX SM	T4	ST
<i>loteprednol etabonate</i> (Alrex)	T2	ST
<i>loteprednol etabonate</i> (Lotemax)	T2	
PRED FORTE (<i>prednisolone acetate</i>)	T4	
<i>prednisolone ac 1% eye drop</i> (Pred Forte)	T2	
PREDNISOLONE ACET 1% EYE DROP	T4	
<i>prednisolone sodium phosphate</i>	T2	
PREDNISOLONE-BROMFENAC	T4	
PREDNISOLONE-NEPAFENAC	T4	
PROLENSA (<i>bromfenac sodium</i>)	T4	

T1 – Preferred Generics

T2 – Non-Preferred Generics

T3 – Preferred Brands

T4 – Non-Preferred Brands

T5 – Preferred Specialty

T6 – Non-Preferred Specialty

PA – Prior Authorization

QL – Quantity Limit

ST – Step Therapy

AGE – Age Requirement

SP – Specialty Medication

HD – May require home delivery pharmacy

PPACA – No Cost-Share Preventive Medication

CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

EENT PREPS (Eye Conditions) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
EYE LOCAL ANESTHETICS		
AKTEN	T4	
ALCAINE (<i>proparacaine hcl</i>)	T4	
ALTAFLUOR BENOX (<i>benoxinate hcl/fluorescein sod</i>)	T4	
FLUORESCIN-BENOXINATE	T4	
<i>proparacaine hcl</i> (Alcaine)	T2	
<i>proparacaine/fluorescein sod</i>	T2	
<i>tetracaine 0.5% eye drop</i>	T2	
TETRACAINE 0.5% STERI-UNIT SOL	T4	
<i>tetracaine hcl</i>	T2	
TETRAVISC	T4	
TETRAVISC FORTE	T4	
EYE MAST CELL STABILIZERS		
cromolyn 4% eye drops	T2	
EYE MYDRIATIC AND NSAID COMBINATIONS		
MYDRIATIC4(TROP-PROP-PE-KTRLC)	T4	
EYE PREPARATIONS, MISCELLANEOUS (OTC)		
GELFILM	T4	
EYE VASOCONSTRICTORS		
<i>phenylephrine hcl</i>	T2	
MIOTICS AND OTHER INTRAOCULAR PRESSURE REDUCERS		
ALPHAGAN P	T4	ST HD
ALPHAGAN P (<i>brimonidine tartrate</i>)	T4	ST HD
<i>apraclonidine hcl</i>	T2	HD
betaxolol hcl	T2	HD
BETOPTIC S	T4	HD
<i>bimatoprost</i>	T2	PA HD
<i>brimonidine tartrate</i>	T2	HD
<i>brimonidine tartrate</i> (Alphagan P)	T2	HD
<i>brimonidine tartrate/timolol</i> (Combigan)	T2	HD
BRIMONIDINE-DORZOLAMIDE	T4	HD
<i>brinzolamide</i> (Azopt)	T2	HD
<i>carteolol hcl</i>	T2	HD
COMBIGAN (<i>brimonidine tartrate/timolol</i>)	T4	ST HD
DORZOLAMIDE	T4	HD

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

T5 – Preferred Specialty
T6 – Non-Preferred Specialty
PA – Prior Authorization
QL – Quantity Limit

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

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

List of Prescription Medications

EENT PREPS (Eye Conditions) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
MIOTICS AND OTHER INTRAOCULAR PRESSURE REDUCERS (cont.)		
<i>dorzolamide hcl</i> (Trusopt)	T2	HD
<i>dorzolamide hcl/timolol maleate</i> (Cosopt)	T2	HD
<i>dorzolamide/timolol/pf</i> (Cosopt Pf)	T2	HD
IOPIDINE	T4	ST HD
ISOPTO CARPINE (<i>pilocarpine hcl</i>)	T4	HD
LATANOPROST 0.005% EYE DROP	T4	HD
<i>latanoprost 0.005% eye drops</i> (Xalatan)	T2	PA HD
<i>levobunolol hcl</i>	T2	HD
LUMIGAN	T4	PA HD
PHOSPHOLINE IODIDE	T5	SP HD
<i>pilocarpine hcl</i>	T2	HD
<i>pilocarpine hcl</i> (Isopto Carpine)	T2	HD
SIMBRINZA	T4	HD
<i>timolol maleate</i> (Istalol)	T2	HD
<i>timolol maleate</i> (Timoptic)	T1	HD
<i>timolol maleate</i> (Timoptic-Xe)	T2	HD
<i>timolol maleate/pf</i>	T2	HD
<i>timolol maleate/pf</i> (Timoptic Ocudose)	T2	HD
TIMOLOL-BRIMONIDIN-DORZOLAMIDE	T4	HD
TIMOLOL-BRIMONI-DORZOL-LATANOP	T4	HD
TIMOLOL-DORZOLAMIDE	T4	HD
TIMOLOL-DORZOLAMIDE-LATANOPRST	T4	HD
TIMOLOL-LATANOPROST	T4	HD
TIMOPTIC (<i>timolol maleate</i>)	T4	ST HD
TIMOPTIC-XE (<i>timolol maleate</i>)	T4	ST HD
<i>travoprost</i> (Travatan Z)	T2	PA HD
TRUSOPT (<i>dorzolamide hcl</i>)	T4	ST HD
VYZULTA	T4	PA HD
MYDRIATICS		
<i>atropine 1% eye drops</i>	T2	HD
<i>atropine 1% eye ointment</i>	T2	HD
ATROPINE SULFATE 0.01% EYE DRP	T4	HD
ATROPINE SULFATE-0.9% NAACL	T4	HD
CYCLOGYL	T4	HD

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

T5 – Preferred Specialty
T6 – Non-Preferred Specialty
PA – Prior Authorization
QL – Quantity Limit

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

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

List of Prescription Medications

EENT PREPS (Eye Conditions) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
MYDRIATICS (cont.)		
CYCLOGYL (<i>cyclopentolate hcl</i>)	T4	HD
CYCLOMYDRIL	T4	HD
<i>cyclopentolat/tropic/phenyleph</i>	T2	HD
<i>cyclopentolate hcl (Cyclogyl)</i>	T2	HD
CYCLOPENTOLATE-TROPICAMIDE-PE	T4	HD
<i>homatropine hbr</i>	T2	HD
MYDRIACYL (<i>tropicamide</i>)	T4	HD
PAREMYD	T4	HD
<i>tropicamide</i>	T2	HD
<i>tropicamide (Mydriacyl)</i>	T2	HD
TROPICAMIDE-CYCLOPENTOLATE-PE	T4	HD
TROPICAMIDE-CYCLOPENT-PE-KTRLC	T4	HD
TROPICAMIDE-PHENYLEPHRINE	T4	HD
TROPIC-CYCLOPENT-PE-KTRLC-PROP	T4	HD
OPHTH. VEGF-A RECEPTOR ANTAG. RCMB MC ANTIBODY		
LUCENTIS	T6	PA SP
OPHTHALMIC ANTIFIBROTIC AGENTS		
MITOMYCIN	T4	
MITOSOL	T4	
OPHTHALMIC ANTI-INFLAMMATORY IMMUNOMODULATOR-TYPE		
CEQUA	T4	PA QL(60 vls/30 days) HD
<i>cyclosporine 0.05% eye emuls (Restasis)</i>	T2	PA QL(60 vials/fill) HD
CYCLOSPORINE IN KLARITY	T4	HD
RESTASIS (<i>cyclosporine</i>)	T4	PA QL(60 vials/fill) HD
RESTASIS MULTIDOSE	T3	PA QL(6 mls/fill) HD
XIIDRA	T3	PA QL(60 vls/fill) HD
VEVYE	T4	PA HD
OPHTHALMIC CYSTINE DEPLETING AGENTS		
CYSTARAN	T5	PA SP
OPHTHALMIC HUMAN NERVE GROWTH FACTOR (HNGF)		
OXERVATE	T5	PA SP HD
OPHTHALMIC PREPARATIONS, MISCELLANEOUS		
HEALON GV	T4	

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

T5 – Preferred Specialty
 T6 – Non-Preferred Specialty
 PA – Prior Authorization
 QL – Quantity Limit

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

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

List of Prescription Medications

ELECT/CALORIC/H2O (Cholesterol Medications)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
------------------------	-----------	----------------------------------

ORAL LIPID SUPPLEMENTS

DOJOLVI	T6	PA SP HD
---------	----	----------

ELECT/CALORIC/H2O (Dental Products)

FLUORIDE PREPARATIONS

CLINPRO 5000	T4	
FLORIVA	T4	
fluoride (sodium)	T2	PPACA
fluoride (sodium)	T2	
fluoride (sodium) (Prevident 5000 Plus)	T2	
fluoride (sodium) (Prevident)	T2	
FLUORIDEX	T4	
FLUORIDEX SENSITIVITY RELIEF	T4	
JUSTRIGHT 5000	T4	
PREVIDENT	T4	
PREVIDENT (fluoride (sodium))	T4	
PREVIDENT 5000 DRY MOUTH	T4	
PREVIDENT 5000 ENAMEL PROTECT	T4	
PREVIDENT 5000 ORTHO DEFENSE	T4	
PREVIDENT 5000 PLUS (fluoride (sodium))	T4	
PREVIDENT 5000 SENSITIVE	T4	
sodium fluoride 0.2% rinse (Prevident)	T2	
sodium fluoride 1.1% cream (Prevident 5000 Plus)	T2	
sodium fluoride 1.1% gel (Prevident)	T2	
sodium fluoride 5000 ppm cream (Prevident 5000 Plus)	T2	
sodium fluoride 5000 ppm paste	T2	
sodium fluoride/potassium nit	T2	

PEDIATRIC VITAMIN PREPARATIONS

fluoride (sodium)	T2	PPACA
FLURA-DROPS	T4	
sodium fluoride 0.25 (0.55) mg	T2	PPACA
sodium fluoride 0.5 mg(1.1 mg)	T2	PPACA
sodium fluoride 0.5 mg/ml drop	T2	PPACA
sodium fluoride 1 mg (2.2 mg)	T2	PPACA

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

T5 – Preferred Specialty
 T6 – Non-Preferred Specialty
 PA – Prior Authorization
 QL – Quantity Limit

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

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

List of Prescription Medications

ELECT/CALORIC/H2O (Diabetes)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
AGENTS TO TREAT HYPOGLYCEMIA (HYPERGLYCEMICS)		
BAQSIMI	T3	
<i>cvs glucose 4 gram tablet chew (Trueplus Glucose)</i>	T2	
CVS GLUCOSE LIQUID SHOT	T4	
DEX4 GLUCOSE 15 GM GEL PACKET	T4	
<i>dex4 glucose 4 gm tablet chew (Trueplus Glucose)</i>	T2	
<i>dex4 glucose 40% gel (Glucose-15)</i>	T2	
<i>dex4 glucose 40% gel (Glucose-45)</i>	T2	
DEX4 GLUCOSE LIQUID	T4	
DEX4 GLUCOSE LIQUID BLAST	T4	
<i>dex4 glucose tab pouch pack (Trueplus Glucose)</i>	T2	
<i>dex4 quick dissolve tab chew (Trueplus Glucose)</i>	T2	
<i>dextrose</i>	T2	
<i>dextrose (Glucose-15)</i>	T2	
<i>dextrose (Glucose-45)</i>	T2	
<i>dextrose/vitamin d3</i>	T2	
<i>diazoxide (Proglycem)</i>	T2	
<i>drug mart glucose 4 gm tab chw (Trueplus Glucose)</i>	T2	
<i>glucagon 1 mg emergency kit</i>	T2	QL(2 vials/fill)
GLUCO SHOT	T4	
GLUCOSE 2 GRAM GUMMY	T4	
<i>glucose 3.75 gram tablet chew (Trueplus Glucose)</i>	T2	
<i>glucose 4 gram tablet chew (Trueplus Glucose)</i>	T2	
GLUCOSE LIQUID	T4	
GLUTOSE-15 (<i>dextrose</i>)	T3	
GLUTOSE-45 (<i>dextrose</i>)	T3	
<i>gnp glucose 3.75 gram tab chew (Trueplus Glucose)</i>	T2	
<i>gnp glucose 4 gram tablet chew (Trueplus Glucose)</i>	T2	
<i>gnp quick dissolve glucose tab (Trueplus Glucose)</i>	T2	
<i>gs glucose 4 gram tablet chew (Trueplus Glucose)</i>	T2	
GVOKE	T3	QL(2 vials/fill)
GVOKE HYPOPEN 1-PACK	T3	QL(2 auto-injs/fill)
GVOKE HYPOPEN 2-PACK	T3	QL(2 auto-injs/fill)
GVOKE PFS 1-PACK SYRINGE	T3	QL(2 syringes/fill)
GVOKE PFS 2-PACK SYRINGE	T3	QL(2 syringes/fill)

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

T5 – Preferred Specialty
 T6 – Non-Preferred Specialty
 PA – Prior Authorization
 QL – Quantity Limit

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

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

List of Prescription Medications

ELECT/CALORIC/H2O (Diabetes) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
AGENTS TO TREAT HYPOGLYCEMIA (HYPERGLYCEMICS) (cont.)		
INSTA-GLUCOSE GEL	T4	
<i>insta-glucose gel</i>	T2	
<i>kro glucose 4 gram tablet chew</i> (Trueplus Glucose)	T2	
<i>croger glucose 4 gram tab chew</i> (Trueplus Glucose)	T2	
<i>leader glucose 4 gm tab chew</i> (Trueplus Glucose)	T2	
<i>leader quick dissolve gluc tab</i> (Trueplus Glucose)	T2	
<i>longs glucose 4 gram tab chew</i> (Trueplus Glucose)	T2	
<i>meijer glucose 4 gram tab chew</i> (Trueplus Glucose)	T2	
<i>ms glucose 4 gram tablet chew</i> (Trueplus Glucose)	T2	
<i>ms quick dissolve glucose tab</i> (Trueplus Glucose)	T2	
<i>preferred plus glucose tab chw</i> (Trueplus Glucose)	T2	
PROGLYCEM (<i>diazoxide</i>)	T4	
<i>pub glucose 4 gram tablet chew</i> (Trueplus Glucose)	T2	
<i>ra glucose 4 gram tablet chew</i> (Trueplus Glucose)	T2	
<i>relion glucose 4 gram tab chew</i> (Trueplus Glucose)	T2	
<i>reli-on glucose 4 gram tab chw</i> (Trueplus Glucose)	T2	
RELION GLUCOSE LIQUID	T4	
<i>sm glucose 4 gram tab chew</i> (Trueplus Glucose)	T2	
<i>smart sense glucose 4 gram tab</i> (Trueplus Glucose)	T2	
TRUEPLUS GLUCOSE	T4	
TRUEPLUS GLUCOSE (<i>dextrose</i>)	T4	
<i>upup glucose 4 gram tab chew</i> (Trueplus Glucose)	T2	
ELECT/CALORIC/H2O (Miscellaneous)		
NUCLEIC ACID/NUCLEOTIDE SUPPLEMENTS		
XURIDEN	T5	PA SP
ELECT/CALORIC/H2O (Nutritional/Dietary)		
CARBOHYDRATES		
ENFAMIL	T3	
GLUTOL	T3	
ELECTROLYTE DEPLETERS		
AURYXIA	T4	
<i>calcium acetate 667 mg capsule</i>	T2	QL(360 caps/fill)
<i>calcium acetate 667 mg gelcap</i>	T2	QL(360 caps/fill)

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

T5 – Preferred Specialty
 T6 – Non-Preferred Specialty
 PA – Prior Authorization
 QL – Quantity Limit

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

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

List of Prescription Medications

ELECT/CALORIC/H2O (Nutritional/Dietary) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ELECTROLYTE DEPLETERS (cont.)		
calcium acetate 667 mg tablet	T2	QL(360 tabs/fill)
lanthanum carbonate (Fosrenol)	T2	QL(90 tabs/fill)
LOKELMA	T3	QL(30 packs/fill)
PHOSLYRA	T3	
REVELA 0.8 GM POWDER PACKET (<i>sevelamer carbonate</i>)	T4	QL(180 packs/fill)
REVELA 2.4 GM POWDER PACKET (<i>sevelamer carbonate</i>)	T4	QL(90 packs/fill)
REVELA 800 MG TABLET (<i>sevelamer carbonate</i>)	T4	QL(270 tabs/fill)
<i>sevelamer hcl 400 mg, 800 mg tablet</i>	T2	
<i>sodium polystyrene sulfon/sorb</i>	T2	
<i>sodium polystyrene sulfonate</i>	T2	
VELPHORO	T3	QL(120 tabs/fill)
VELTASSA	T3	QL(30 packs/fill)
FLUORIDE PREPARATIONS		
CLINPRO 5000	T4	
<i>fluoride (sodium)</i>	T2	PPACA
<i>fluoride (sodium)</i>	T2	
<i>fluoride (sodium) (Prevident 5000 Plus)</i>	T2	
<i>fluoride (sodium) (Prevident)</i>	T2	
FLUORIDEX	T4	
JUSTRIGHT 5000	T4	
PREVIDENT	T4	
PREVIDENT (<i>fluoride (sodium)</i>)	T4	
PREVIDENT 5000 DRY MOUTH	T4	
PREVIDENT 5000 ORTHO DEFENSE	T4	
PREVIDENT 5000 PLUS (<i>fluoride (sodium)</i>)	T4	
<i>sodium fluoride 0.2% rinse (Prevident)</i>	T2	
<i>sodium fluoride 1.1% cream (Prevident 5000 Plus)</i>	T2	
<i>sodium fluoride 1.1% gel (Prevident)</i>	T2	
<i>sodium fluoride 5000 ppm cream (Prevident 5000 Plus)</i>	T2	
<i>sodium fluoride 5000 ppm paste</i>	T2	
IODINE CONTAINING AGENTS		
<i>potassium iodide</i>	T2	
<i>potassium iodide/iodine</i>	T2	
SSKI	T4	

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

T5 – Preferred Specialty
T6 – Non-Preferred Specialty
PA – Prior Authorization
QL – Quantity Limit

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

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

List of Prescription Medications

ELECT/CALORIC/H2O (Nutritional/Dietary) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
IRON REPLACEMENT		
ABATRON	T4	
ABATRON AF	T4	
ACCRUFER	T4	
ACTIVE FE	T4	
APETIGEN-PLUS	T3	
BENTIVITE BX	T4	
CHROMAGEN	T4	
CITRANATAL BLOOM	T4	
CORVITE 150	T4	
CORVITE FE	T4	
<i>cvs iron 27 mg tablet (Fergon)</i>	T2	
<i>cvs iron 65 mg tablet</i>	T2	
CVS SLOW RELEASE IRON 45 MG TB	T4	
<i>cvs slow release iron 45 mg tb</i>	T2	
<i>cvs slow release iron tablet</i>	T2	
<i>eql slow release iron 45 mg tab</i>	T2	
<i>eql slow release iron 50 mg tb</i>	T2	
FEOSOL 45 MG CAPLET (<i>iron, carbonyl</i>)	T3	
<i>feosol 65 mg tablet</i>	T2	
FEOSOL BIFERA 28 MG CAPLET	T3	
FERAHEME (<i>ferumoxytol</i>)	T4	PA
FERGON 27 MG TABLET	T4	
FERGON 27 MG TABLET (<i>ferrous gluconate</i>)	T3	
FERGON TABLET	T4	
FER-IN-SOL (<i>ferrous sulfate</i>)	T3	
FERIVA 21-7	T4	
FERIVA FA	T4	
FERRACTIV IRON	T4	
FERRALET 90	T4	
FERRETTIS IPS 18 MG CAP	T4	
FERRETTIS IPS 40 MG/15 ML LIQ	T3	
FERRIMIN 150	T3	
FERRLECIT (<i>sodium ferric gluconat/sucrose</i>)	T4	PA
FERRO-SEQUELS	T4	

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

T5 – Preferred Specialty
T6 – Non-Preferred Specialty
PA – Prior Authorization
QL – Quantity Limit

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

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

List of Prescription Medications

ELECT/CALORIC/H2O (Nutritional/Dietary) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
IRON REPLACEMENT (cont.)		
<i>ferrous fum/vit c/b12-if/folic</i>	T2	PPACA
<i>ferrous fumarate</i>	T2	
<i>ferrous fumarate</i> (Hemocyte)	T2	
FERROUS FUMARATE 29 MG TAB	T4	
<i>ferrous fumarate 324 mg tab</i> (Hemocyte)	T2	
<i>ferrous fumarate/folic acid</i> (Hemocyte-F)	T2	
<i>ferrous gluconate</i>	T2	
<i>ferrous gluconate</i> (Fergon)	T2	
<i>ferrous sulfate</i>	T2	
<i>ferrous sulfate</i> (Fer-In-Sol)	T2	
<i>ferrous sulfate/vit c/folic ac</i>	T2	PPACA
<i>ferumoxytol</i> (Feraheme)	T2	PA
FUSION	T4	
FUSION PLUS	T4	
FUSION SPRINKLES	T4	
GENTLE IRON	T4	
<i>gnp iron 45 mg tablet</i>	T2	
<i>gnp iron 65 mg tablet</i>	T2	
HEMATEX	T4	
HEMATEX (<i>iron polysaccharide complex</i>)	T4	
HEMATOGEN	T4	
HEMATRON-AF	T4	
HEMAX	T4	
HEMOCYTE (<i>ferrous fumarate</i>)	T3	
HEMOCYTE PLUS (<i>iron fum/folic acid/mv,min 15</i>)	T4	
HEMOCYTE-F (<i>ferrous fumarate/folic acid</i>)	T4	
<i>hm iron 65 mg tablet</i>	T2	
<i>hm slow release iron tablet</i>	T2	
I.L.X. B-12	T3	
ICAR	T3	
ICAR-C (<i>iron,carbonyl/ascorbic acid</i>)	T3	
ICAR-C PLUS (<i>iron,carb/vit c/vit b12/folic</i>)	T4	
INFED	T3	PA
INJECTAFER	T4	PA

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

T5 – Preferred Specialty
T6 – Non-Preferred Specialty
PA – Prior Authorization
QL – Quantity Limit

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

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

List of Prescription Medications

ELECT/CALORIC/H2O (Nutritional/Dietary) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
IRON REPLACEMENT (cont.)		
INTEGRA	T3	
INTEGRA F (<i>iron fum,ps/folic acid/vitc/b3</i>)	T4	
INTEGRA PLUS (<i>iron fum,ps/folic/bcomp,c no.9</i>)	T4	
IRON 18 MG TABLET	T4	
<i>iron 27 mg tablet</i>	T2	
<i>iron 27 mg tablet (Fergon)</i>	T2	
<i>iron 28 mg, 45 mg, 65 mg tablet</i>	T2	
<i>iron aspgly,ps/c/b12/fa/ca/suc</i>	T2	
<i>iron aspgly,ps/c/succinic acid</i>	T2	
<i>iron aspgly,c/b12/fa/ca-th/suc</i>	T2	
<i>iron bg,ps/vitc/b12/fa/calcium</i>	T2	
IRON BISGLYCINATE	T4	
<i>iron fm,ps no.1/folic/mv no.18 (Tandem Plus)</i>	T2	
<i>iron fum,ag/c/b12/folic/ca/suc</i>	T2	
<i>iron fum,ps/folic acid/vitc/b3 (Integra F)</i>	T2	
<i>iron fum,ps/folic/bcomp,c no.9 (Integra Plus)</i>	T2	
<i>iron fum/folic acid/mv,min 15 (Hemocyt Plus)</i>	T2	
<i>iron fumarate/vit c/vit b12/fa</i>	T2	
<i>iron polysac/iron heme/fa/b12</i>	T2	
<i>iron polysaccharide complex</i>	T2	
<i>iron polysaccharide complex (Nu-Iron 150)</i>	T2	
<i>iron ps complex/b12/folic acid</i>	T2	
<i>iron,carb/vit c/vit b12/folic (Icar-C Plus)</i>	T2	
<i>iron,carbonyl</i>	T2	
<i>iron,carbonyl (Feosol)</i>	T2	
<i>iron,carbonyl/ascorbic acid (Icar-C)</i>	T2	
<i>iron/c/b12/calcium/stomach conc</i>	T2	
<i>iron/c/folic acid/mv cmb11/calc</i>	T2	
<i>iron/folic ac/vit bcomp,c/min</i>	T2	
<i>iron/folic acid/b12/c/docusate</i>	T2	
<i>iron/folic acid/c/b6/b12/zinc</i>	T2	
<i>iron/vit c/fructooligosacchard</i>	T2	
IRONUP	T4	
IRO-PLEX	T4	

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

T5 – Preferred Specialty
 T6 – Non-Preferred Specialty
 PA – Prior Authorization
 QL – Quantity Limit

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

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

List of Prescription Medications

ELECT/CALORIC/H2O (Nutritional/Dietary) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
IRON REPLACEMENT (cont.)		
IROSPAN	T4	
LYDIA PINKHAM HERBAL	T4	
MAXFE	T4	
MONOFERRIC	T4	PA
NEONATAL FE	T4	
NIFEREX	T4	
NOVAFERRUM 125 MG/5 ML LIQUID	T4	
NOVAFERRUM 15 MG/ML DROPS	T3	
NOVAFERRUM 50	T4	
NUFERA	T4	
NU-IRON 150 (<i>iron polysaccharide complex</i>)	T3	
PARVLEX	T4	
PERFECT IRON	T4	
PRO FE	T3	
PROFERRIN	T3	
PROFERRIN-FORTE	T4	
PROTECT IRON	T4	
<i>ra high potency iron 27 mg tab</i>	T2	
RA HIGH POTENCY IRON 27 MG TAB	T4	
<i>ra iron 65 mg tablet</i>	T2	
RA SLOW RELEASE IRON 45 MG TAB	T3	
SIDEROL	T4	
SLOW FE	T3	
<i>slow release iron 160 mg tab</i>	T2	
SLOW RELEASE IRON 45 MG TAB	T3	
SLOW RELEASE IRON 45 MG TABLET	T3	
<i>slow release iron 45 mg tablet</i>	T2	
SLOW RELEASE IRON 45 MG TABLET	T4	
<i>slow release iron tablet</i>	T2	
SLOW RELEASE IRON TABLET	T3	
<i>sm iron 160 mg tablet sa</i>	T2	
<i>sm iron 65 mg, 325 mg tablet</i>	T2	
SM SLOW RELEASE IRON 45 MG TAB	T3	
<i>sodium ferric gluconat/sucrose (Ferrlecit)</i>	T2	PA

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

T5 – Preferred Specialty
 T6 – Non-Preferred Specialty
 PA – Prior Authorization
 QL – Quantity Limit

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

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

List of Prescription Medications

ELECT/CALORIC/H2O (Nutritional/Dietary) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
IRON REPLACEMENT (cont.)		
<i>sv iron 65 mg tablet</i>	T2	
SV SLOW RELEASE IRON 45 MG TAB	T3	
TANDEM DUAL ACTION	T3	
TANDEM PLUS (<i>iron fm,ps no.1/folic/mv no.18</i>)	T4	
TL-HEM 150	T4	
TRIFERIC	T4	
TULIVITE	T4	
VENOFER	T3	PA
VIRT-FEFA PLUS CAPSULE	T4	
<i>virt-fefa plus capsule (Integra Plus)</i>	T2	
VITABEX IRON	T4	
VITAFOL	T4	
VITRON-C	T3	
PEDIATRIC VITAMIN PREPARATIONS		
<i>fluoride (sodium)</i>	T2	PPACA
FLURA-DROPS	T4	
<i>sodium fluoride 0.25 (0.55) mg</i>	T2	PPACA
<i>sodium fluoride 0.5 mg(1.1 mg)</i>	T2	PPACA
<i>sodium fluoride 0.5 mg/ml drop</i>	T2	PPACA
<i>sodium fluoride 1 mg (2.2 mg)</i>	T2	PPACA
POTASSIUM REPLACEMENT		
EFFER-K 10 MEQ TABLET EFF	T4	
EFFER-K 20 MEQ TABLET EFF	T4	
<i>effe-r-k 25 meq tablet eff</i>	T2	
K-TAB ER 20 MEQ TABLET (<i>potassium chloride</i>)W	T4	
<i>k-tab er 8 meq tablet</i>	T1	
<i>potassium bicarbonate/cit ac</i>	T2	
<i>potassium chloride</i>	T1	
<i>potassium chloride</i>	T2	
<i>potassium chloride (K-Tab Er)</i>	T1	
ELECT/CALORIC/H2O (Urinary Tract Conditions)		
DIALYSIS SOLUTIONS		
PRISMASOL	T4	

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

T5 – Preferred Specialty
 T6 – Non-Preferred Specialty
 PA – Prior Authorization
 QL – Quantity Limit

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

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

List of Prescription Medications

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

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
URINARY PH MODIFIERS		
<i>citric acid/sodium citrate</i>	T2	HD
K-PHOS NO.2	T4	HD
K-PHOS ORIGINAL	T3	HD
ORACIT	T4	HD
<i>potassium citrate (Urocit-K)</i>	T2	HD
RENACIDIN	T3	HD
UROCIT-K (<i>potassium citrate</i>)	T4	HD
UROQID-ACID NO.2	T4	HD

GASTROINTESTINAL (Cholesterol Medications)

LIPOTROPICS

<i>icosapent ethyl (Vascepa)</i>	T2	PA HD
<i>omega-3 acid ethyl esters (Lovaza)</i>	T2	PA HD
VASCEPA (<i>icosapent ethyl</i>)	T3	PA HD

GASTROINTESTINAL (Gastrointestinal/Heartburn)

AMMONIA INHIBITORS

BUPHENYL (<i>sodium phenylbutyrate</i>)	T6	PA SP HD
<i>lactulose</i>	T2	HD
<i>lactulose 10 gm/15 ml solution</i>	T2	HD
LITHOSTAT	T4	HD
OLPRUVA DOSE KIT, DOSE ENVELOPE	T6	SP PA HD
RAVICTI	T5	PA SP HD
<i>sodium phenylbutyrate (Buphenyl)</i>	T2	PA SP HD
PHEBURANE	T5	PA SP

ANTICHOLINERGICS, QUATERNARY AMMONIUM

<i>chlordiazepoxide/clidinium br (Librax)</i>	T2	
GLYCATÉ	T4	
<i>glycopyrrolate</i>	T2	
<i>glycopyrrolate (Cuvposa)</i>	T2	
<i>glycopyrrolate (Robinul Forte)</i>	T2	
<i>glycopyrrolate (Robinul)</i>	T2	
ROBINUL (<i>glycopyrrolate</i>)	T4	
ROBINUL FORTE (<i>glycopyrrolate</i>)	T4	

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

T5 – Preferred Specialty
 T6 – Non-Preferred Specialty
 PA – Prior Authorization
 QL – Quantity Limit

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

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

List of Prescription Medications

GASTROINTESTINAL (Gastrointestinal/Heartburn) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ANTICHOLINERGICS/ANTISPASMODICS		
<i>dicyclomine hcl</i>	T2	
ANTIDIARRHEAL - TRYPTOPHAN HYDROXYLASE INHIBITOR		
XERMELO	T5	PA QL(90 tabs/fill) SP
ANTIDIARRHEALS		
<i>diphenoxylate hcl/atropine</i>	T2	
<i>diphenoxylate hcl/atropine</i> (Lomotil)	T2	
LOMOTIL (<i>diphenoxylate hcl/atropine</i>)	T4	
MOTOFEN	T4	
<i>opium tincture</i>	T2	
<i>paregoric</i>	T2	
ANTIEMETIC, CANNABINOID-TYPE		
<i>dronabinol</i> (Marinol)	T2	PA
MARINOL (<i>dronabinol</i>)	T4	PA
SYNDROS	T4	PA
ANTIEMETIC/ANTIVERTIGO AGENTS		
<i>aprepitant 125 mg capsule</i>	T2	QL(1 cap/fill)
<i>aprepitant 125-80-80 mg pack</i> (Emend)	T2	QL(3 caps/fill)
<i>aprepitant 40 mg capsule</i> (Emend)	T2	QL(1 cap/fill)
<i>aprepitant 80 mg capsule</i> (Emend)	T2	QL(2 caps/fill)
COMPAZINE (<i>prochlorperazine maleate</i>)	T4	
COMPAZINE (<i>prochlorperazine</i>)	T4	
DICLEGIS (<i>doxylamine succinate/vit b6</i>)	T4	QL(120 tabs/fill)
EMEND 150 MG VIAL (<i>fosaprepitant dimeglumine</i>)	T4	
<i>fosaprepitant dimeglumine</i> (Emend)	T2	
<i>granisetron hcl 0.1 mg/ml vial</i>	T2	
<i>granisetron hcl 1 mg tablet</i>	T2	QL(6 tabs/fill)
<i>granisetron hcl 1 mg/ml vial</i>	T2	
<i>granisetron hcl 4 mg/4 ml vial</i>	T2	
<i>ondansetron</i>	T2	QL(9 tabs/fill)
<i>ondansetron 4 mg/2 ml isecure</i>	T2	
<i>ondansetron 40 mg/20 ml vial</i>	T2	
<i>ondansetron hcl 4 mg, 8 mg tablet</i>	T2	QL(9 tabs/fill)
<i>ondansetron hcl 4 mg/2 ml syr</i>	T2	
<i>ondansetron hcl 4 mg/2 ml vial</i>	T2	

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

T5 – Preferred Specialty
 T6 – Non-Preferred Specialty
 PA – Prior Authorization
 QL – Quantity Limit

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

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

List of Prescription Medications

GASTROINTESTINAL (Gastrointestinal/Heartburn) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ANTIEMETIC/ANTIVERTIGO AGENTS (cont.)		
<i>prochlorperazine</i> (Compazine)	T2	
<i>prochlorperazine maleate</i> (Compazine)	T2	
<i>promethazine hcl</i>	T2	
SANCUSO	T4	QL(1 patch/fill)
<i>scopolamine</i> (Transderm-Scop)	T2	
TIGAN (<i>trimethobenzamide hcl</i>)	T4	
<i>trimethobenzamide hcl</i> (Tigan)	T2	
VARUBI	T3	QL(2 tabs/fill)
ZUPLENZ	T4	QL(10 films/fill)
ANTI-ULCER PREPARATIONS		
CYTOTEC (<i>misoprostol</i>)	T4	HD
<i>misoprostol</i> (Cytotec)	T2	HD
<i>sucralfate</i> (Carafate)	T2	HD
ANTI-ULCER-H.PYLORI AGENTS		
<i>lansoprazole/amoxicilin/clarith</i>	T2	QL(112 units/fill)
OMECLAMOX-PAK	T4	QL(80 units/fill)
TALICIA	T3	QL(168 caps/fill)
BELLADONNA ALKALOIDS		
DONNATAL	T4	HD
DONNATAL (<i>phenobarb/hyoscy/atropine/scop</i>)	T4	HD
<i>hyoscyamine sulfate</i>	T2	HD
<i>hyoscyamine sulfate</i> (Levbid)	T2	HD
<i>hyoscyamine sulfate</i> (Levsin)	T2	HD
<i>hyoscyamine sulfate</i> (Levsin-SI)	T2	HD
<i>hyoscyamine sulfate</i> (Nulev)	T2	HD
LEVBID (<i>hyoscyamine sulfate</i>)	T4	HD
LEVSIN (<i>hyoscyamine sulfate</i>)	T4	HD
LEVSIN-SL (<i>hyoscyamine sulfate</i>)	T4	HD
<i>methscopolamine bromide</i>	T2	HD
NULEV (<i>hyoscyamine sulfate</i>)	T4	HD
<i>phenobarb/hyoscy/atropine/scop</i>	T2	HD
<i>phenobarb/hyoscy/atropine/scop</i> (Donnatal)	T2	HD
<i>phenobarb/hyoscy/atropine/scop</i> (Phenobarbital-Belladonna)	T2	HD
<i>phenobarbital-belladonna elixr</i>	T2	HD

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

T5 – Preferred Specialty
 T6 – Non-Preferred Specialty
 PA – Prior Authorization
 QL – Quantity Limit

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

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

List of Prescription Medications

GASTROINTESTINAL (Gastrointestinal/Heartburn) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
BELLADONNA ALKALOIDS (cont.)		
<i>phenobarbital-belladonna elixir</i> (Donnatal)	T2	HD
PHENOBARBITAL-BELLADONNA ELIXIR (<i>phenobarb/hyoscy/atropine/scop</i>)	T4	HD
<i>phenobarbital-belladonna elixir</i> (Phenobarbital-Belladonna)	T2	HD
SYMAX DUOTAB	T4	HD
BILE SALTS		
CHENODAL	T5	PA SP HD
CHOLBAM 250 MG CAPSULE	T5	PA SP HD
CHOLBAM 50 MG CAPSULE	T5	PA QL(120 caps/fill) SP HD
URSO (<i>ursodiol</i>)	T4	HD
URSO FORTE (<i>ursodiol</i>)	T4	HD
<i>ursodiol</i>	T2	HD
<i>ursodiol</i> (Urso Forte)	T2	HD
<i>ursodiol</i> (Urso)	T2	HD
CHRONIC INFLAM. COLON DX, 5-A-SALICYLAT, RECTAL TX		
<i>mesalamine 1,000 mg supp</i> (Canasa)	T2	
<i>mesalamine 4 gm/60 ml enema</i> (Sfrowasa)	T2	
<i>mesalamine 4 gm/60 ml kit</i> (Rowasa)	T2	
ROWASA (<i>mesalamine w/cleansing wipes</i>)	T4	
SFROWASA (<i>mesalamine</i>)	T4	
DRUG TX-CHRONIC INFLAM. COLON DX, 5-AMINOSALICYLAT		
APRISO (<i>mesalamine</i>)	T4	HD
ASACOL HD (<i>mesalamine</i>)	T4	HD
AZULFIDINE (<i>sulfasalazine</i>)	T4	HD
<i>balsalazide disodium</i> (Colazal)	T2	HD
COLAZAL (<i>balsalazide disodium</i>)	T4	HD
<i>mesalamine</i> (Apriso)	T2	HD
<i>mesalamine</i> (Delzicol)	T2	HD
<i>mesalamine</i> (Pentasa)	T2	HD
<i>mesalamine 800 mg dr tablet</i> (Asacol Hd)	T2	HD
<i>mesalamine dr 1.2 gm tablet</i> (Lialda)	T2	HD
PENTASA 250 MG CAPSULE	T3	HD
PENTASA 500 MG CAPSULE (<i>mesalamine</i>)	T4	HD
<i>sulfasalazine</i> (Azulfidine)	T2	HD

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

T5 – Preferred Specialty
 T6 – Non-Preferred Specialty
 PA – Prior Authorization
 QL – Quantity Limit

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

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

List of Prescription Medications

GASTROINTESTINAL (Gastrointestinal/Heartburn) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
FARNESOID X RECEPTOR (FXR) AGONIST, BILE AC ANALOG		
OCALIVA	T5	PA QL(30 tabs/fill) SP HD
FECAL MICROBIOTA TRANSPLANTATION (FMT)		
VOWST CAPSULE	T5	PA SP
GASTRIC ENZYMES		
SUCRAID	T5	PA SP
HISTAMINE H2-RECEPTOR INHIBITORS		
<i>cimetidine</i>	T2	HD
<i>cimetidine hcl</i>	T2	HD
<i>famotidine</i>	T2	HD
<i>famotidine (Pepcid)</i>	T1	HD
<i>nizatidine</i>	T2	HD
PEPCID (<i>famotidine</i>)	T4	HD
<i>ranitidine hcl</i>	T2	HD
IBS AGENTS, MIXED OPIOID RECEPTOR AGONISTS/ANTAGONISTS		
VIBERZI	T3	HD
IBS-C/CIC AGENTS, GUANYLATE CYCLASE-C AGONIST		
LINZESS	T3	QL(30 caps/fill)
TRULANCE	T3	
ILEAL BILE ACID TRANSPORTER (IBAT) INHIBITOR		
BYLVAY 1,200 MCG CAPSULE	T6	PA QL(60 caps/fill) SP HD
BYLVAY 200 MCG PELLETT	T6	PA QL(120 pellets/fill) SP HD
BYLVAY 400 MCG CAPSULE	T6	PA QL(150 caps/fill) SP HD
BYLVAY 600 MCG PELLETT	T6	PA QL(30 pellets/fill) SP HD
LIVMARLI	T6	PA SP
INTESTINAL MOTILITY STIMULANTS		
<i>metoclopramide hcl</i>	T1	
<i>metoclopramide hcl (Reglan)</i>	T1	
REGLAN (<i>metoclopramide hcl</i>)	T4	
IRRITABLE BOWEL SYNDROME AGENTS, 5-HT3 ANTAGONIST		
<i>alosetron hcl (Lotronex)</i>	T2	SP HD
LAXATIVES AND CATHARTICS		
<i>bisac/nac/na/co3/kcl/peg 3350</i>	T2	PPACA
GIALAX	T4	PPACA
GOLYTELY (<i>peg3350/sod sulf,bicarb,cl/kcl</i>)	T4	

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

T5 – Preferred Specialty
T6 – Non-Preferred Specialty
PA – Prior Authorization
QL – Quantity Limit

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

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

List of Prescription Medications

GASTROINTESTINAL (Gastrointestinal/Heartburn) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
LAXATIVES AND CATHARTICS (cont.)		
KRISTALOSE	T4	
<i>lactulose</i>	T2	
<i>lactulose 10 gm packet</i>	T2	
<i>lactulose 10 gm/15 ml solution</i>	T2	
<i>lactulose 20 gm/30 ml solution</i>	T2	
<i>lubiprostone</i>	T2	QL (60 caps/30 days)
NULYTELY	T4	
NULYTELY WITH FLAVOR PACKS (<i>sodium chloride/nahco3/kcl/peg</i>)	T4	
<i>peg3350/sod sul/nacl/kcl/asb/c (Moviprep)</i>	T2	PPACA
<i>peg3350/sod sulf,bicarb,cl/kcl</i>	T2	PPACA
<i>peg3350/sod sulf,bicarb,cl/kcl (Golytely)</i>	T2	PPACA
<i>sodium chloride/nahco3/kcl/peg (Nulytely With Flavor Packs)</i>	T2	PPACA
<i>sodium, potassium,mag sulfates (Suprep)</i>	T2	PPACA
LOCAL ANORECTAL NITRATE PREPARATIONS		
<i>nitroglycerin 0.4% ointment</i>	T2	
RECTIV	T3	
MU-OPIOID RECEPTOR ANTAGONISTS,PERIPHERALLY-ACTING		
<i>alvimopan</i>	T2	
ENTEREG	T4	
PANCREATIC ENZYMES		
CREON	T3	HD
PANCREAZE	T3	HD
VIOKACE	T3	HD
ZENPEP	T3	HD
POTASSIUM-COMPETITIVE ACID BLOCKERS (PCABS)		
VOQUEZNA	T4	St
PROTON-PUMP INHIBITORS		
<i>dexlansoprazole dr 60 mg cap</i>	T2	ST HD
<i>esomeprazole dr 10 mg packet (Nexium)</i>	T2	ST QL (30 packs/fill) HD
<i>esomeprazole dr 40 mg packet (Nexium)</i>	T2	ST HD
<i>esomeprazole dr 40 mg cap (Nexium)</i>	T2	HD
<i>ESOMEPRAZOLE DR 49.3 MG CAP (Nexium)</i>	T4	ST HD
<i>lansoprazole dr 30 mg capsule (Prevacid)</i>	T1	HD

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

T5 – Preferred Specialty
 T6 – Non-Preferred Specialty
 PA – Prior Authorization
 QL – Quantity Limit

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

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

List of Prescription Medications

GASTROINTESTINAL (Gastrointestinal/Heartburn) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
PROTON-PUMP INHIBITORS (cont.)		
<i>lansoprazole odt 15 mg tablet (Prevacid)</i>	T2	ST QL(30 tabs/fill) HD
<i>lansoprazole odt 30 mg tablet (Prevacid)</i>	T2	ST HD
<i>omeprazole dr 10 mg 20 mg capsule</i>	T1	QL(30 caps/fill) HD
<i>omeprazole dr 40 mg capsule</i>	T1	HD
<i>omeprazole/sodium bicarbonate (Zegerid)</i>	T2	PA HD
<i>omeprazole-bicarb 20-1,680 pkt (Zegerid)</i>	T2	PA QL(30 packs/fill) HD
<i>omeprazole-bicarb 40-1,100 cap (Zegerid)</i>	T2	PA HD
<i>omeprazole-bicarb 40-1,680 pkt (Zegerid)</i>	T2	PA HD
<i>pantoprazole 40 mg suspension (Protonix)</i>	T2	ST HD
<i>pantoprazole sod dr 40 mg tab (Protonix)</i>	T1	HD
<i>rabeprazole sod dr 20 mg tab (Aciphex)</i>	T2	HD
RECTAL PREPARATIONS		
<i>hydrocortisone acetate (Anusol-Hc)</i>	T2	
<i>hydrocortisone acetate (Proctocort)</i>	T2	
PROCTOCORT (<i>hydrocortisone acetate</i>)	T4	ST
SBS - GLUCAGON-LIKE PEPTIDE-2 (GLP-2) ANALOGS		
GATTEX	T6	PA SP HD
GASTROINTESTINAL (Pain Relief And Inflammatory Disease)		
HEMORRHOID PREP, ANTI-INFLAM STEROID-LOCAL ANESTHET		
ANA-LEX	T4	
ANALPRAM HC 1% CREAM	T4	
ANALPRAM HC 2.5%-1% CREAM (<i>hydrocortisone/pramoxine</i>)	T4	ST
ANALPRAM HC 2.5%-1% CRM SINGLE (<i>hydrocortisone/pramoxine</i>)	T4	ST
<i>hydrocort-pramoxine 1%-1% crm</i>	T2	
<i>hydrocort-pramoxine 2.5%-1% cm (Analpram Hc)</i>	T2	ST
<i>hydrocort-pramoxine 2.5-1% crm (Analpram Hc)</i>	T2	ST
<i>lidocaine-hc 2.8-0.55% gel</i>	T2	
<i>lidocaine-hc 2-2% cream kit</i>	T2	
<i>lidocaine-hc 3-0.5% cream</i>	T2	
<i>lidocaine-hc 3-0.5% cream kit</i>	T2	
<i>lidocaine-hc 3-1% cream kit</i>	T2	
<i>lidocaine-hc 3-2.5% gel kit</i>	T2	
LIDOCAINE-HYDROCORT 3-2.5% GEL	T4	
PROCORT	T4	

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

T5 – Preferred Specialty
T6 – Non-Preferred Specialty
PA – Prior Authorization
QL – Quantity Limit

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

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

List of Prescription Medications

HORMONES (Gastrointestinal/Heartburn)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
RECTAL/LOWER BOWEL PREP.,GLUCOCORT. (NON-HEMORR)		
CORTENEMA (<i>hydrocortisone</i>)	T4	
<i>hydrocortisone</i> (Cortenema)	T2	
UCERIS 2 MG RECTAL FOAM	T3	

HORMONES (Hormonal Agents)

ANDROGENIC AGENTS

ANDRODERM	T3	PA QL(30 patches/fill)
ANDROID (<i>methyltestosterone</i>)	T4	PA
DEPO-TESTOSTERONE	T4	PA
DEPO-TESTOSTERONE (<i>testosterone cypionate</i>)	T4	PA
FORTESTA (<i>testosterone</i>)	T4	PA QL(120 gms/fill)
JATENZO 158 MG, 198 MG CAPSULE	T4	PA QL(120 caps/30 days)
METHITEST	T3	
<i>methyltestosterone</i> (Android)	T2	
<i>methyltestosterone</i> (Testred)	T2	
<i>oxandrolone</i>	T2	
<i>testosterone 1% (25mg/2.5g) pk</i> (Androgel)	T2	PA QL(75 gms/fill)
<i>testosterone 1% (50 mg/5 g) pk</i> (Androgel)	T2	PA QL(300 gms/fill)
<i>testosterone 1.62% (2.5 g) pkt</i> (Androgel)	T2	PA QL(60 packs/fill)
<i>testosterone 1.62% gel pump</i> (Androgel)	T2	PA QL(150 gms/fill)
<i>testosterone 1.62%(1.25 g) pkt</i> (Androgel)	T2	PA QL(30 packs/fill)
<i>testosterone 10 mg gel pump</i> (Fortesta)	T2	PA QL(120 gms/fill)
TESTOSTERONE 12.5 MG/1.25 GRAM	T4	PA QL(300 gms/fill)
<i>testosterone 12.5 mg/1.25 gram</i>	T2	PA QL(300 gms/fill)
<i>testosterone 30 mg/1.5 ml pump</i>	T2	PA QL(180 mls/fill)
<i>testosterone 50 mg/5 gram gel</i> (Testim)	T2	PA QL(60 tubes/fill)
<i>testosterone 50 mg/5 gram gel</i> (Vogelxo)	T2	PA QL(60 tubes/fill)
TESTOSTERONE 50 MG/5 GRAM PKT	T4	PA QL(300 gms/fill)
<i>testosterone cypionate</i>	T2	PA
<i>testosterone cypionate</i> (Depo-Testosterone)	T2	PA
<i>testosterone enanthate</i>	T2	PA
TESTRED (<i>methyltestosterone</i>)	T4	PA
VOGELXO 12.5 MG/1.25 GRAM PUMP	T4	PA QL(300 gms/fill)
VOGELXO 50 MG/5 GRAM GEL (<i>testosterone</i>)	T4	PA QL(60 tubes/fill)

T1 – Preferred Generics

T2 – Non-Preferred Generics

T3 – Preferred Brands

T4 – Non-Preferred Brands

T5 – Preferred Specialty

T6 – Non-Preferred Specialty

PA – Prior Authorization

QL – Quantity Limit

ST – Step Therapy

AGE – Age Requirement

SP – Specialty Medication

HD – May require home delivery pharmacy

PPACA – No Cost-Share Preventive Medication

CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

HORMONES (Hormonal Agents) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ANDROGENIC AGENTS (cont.)		
VOGELXO 50 MG/5 GRAM GEL PACKT	T4	PA QL(60 packs/fill)
XYOSTED	T3	QL(2 mls/28 days)
ANTIDIURETIC AND VASOPRESSOR HORMONES		
DDAVP (<i>desmopressin (nonrefrigerated)</i>)	T4	
DDAVP (<i>desmopressin acetate</i>)	T4	
<i>desmopressin 0.01% solution</i>	T2	
DESMOPRESSIN 1.5 MG/ML SPRAY	T3	
<i>desmopressin 10 mcg/0.1 ml spr</i>	T2	
<i>desmopressin acetate 0.1 mg tb (Ddavp)</i>	T2	
<i>desmopressin acetate 0.2 mg tb (Ddavp)</i>	T2	
NOC DURNA	T4	PA QL(30 tabs/fill)
ESTROGEN/ANDROGEN COMBINATIONS		
<i>estrogen, ester/me-testosterone</i>	T2	HD
ESTROGENIC AGENTS		
ACTIVELLA (<i>estradiol/norethindrone acet</i>)	T4	HD
CLIMARA (<i>estradiol</i>)	T4	QL(4 patches/28 days) HD
COMBIPATCH	T3	HD
DELESTROGEN	T4	HD
DELESTROGEN (<i>estradiol valerate</i>)	T4	HD
DEPO-ESTRADIOL	T3	HD
ESTRACE 0.5 MG TABLET (<i>estradiol</i>)	T4	HD
ESTRACE 1 MG TABLET (<i>estradiol</i>)	T4	HD
ESTRACE 2 MG TABLET (<i>estradiol</i>)	T4	HD
<i>estradiol (Climara)</i>	T2	QL(4 patches/28 days) HD
<i>estradiol 0.1% (0.25mg) gel pk (Divigel)</i>	T2	QL(30 packs/fill) HD
<i>estradiol 0.1% (0.75mg) gel pk (Divigel)</i>	T2	QL(30 packs/fill) HD
<i>estradiol 0.1% (1 mg) gel pkt (Divigel)</i>	T2	QL(30 packs/fill) HD
<i>estradiol 0.1% (1.25mg) gel pk</i>	T2	QL(30 packs/fill) HD
<i>estradiol 0.5 mg tablet (Estrace)</i>	T2	HD
<i>estradiol 1 mg tablet (Estrace)</i>	T2	HD
<i>estradiol 2 mg tablet (Estrace)</i>	T2	HD
<i>estradiol valerate (Delestrogen)</i>	T2	HD
<i>estradiol/norethindrone acet</i>	T2	HD
<i>estradiol/norethindrone acet (Activella)</i>	T2	HD

T1 – Preferred Generics

T2 – Non-Preferred Generics

T3 – Preferred Brands

T4 – Non-Preferred Brands

T5 – Preferred Specialty

T6 – Non-Preferred Specialty

PA – Prior Authorization

QL – Quantity Limit

ST – Step Therapy

AGE – Age Requirement

SP – Specialty Medication

HD – May require home delivery pharmacy

PPACA – No Cost-Share Preventive Medication

CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

HORMONES (Hormonal Agents) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ESTROGENIC AGENTS (cont.)		
MENOSTAR	T4	QL(4 patches/28 days) HD
<i>norethind-eth estrad 0.5-2.5</i>	T2	HD
<i>norethindrone ac-eth estradiol</i>	T2	HD
<i>norethin-eth estrad 1 mg-5 mcg</i>	T2	HD
PREFEST	T4	HD
ESTROGEN-PROGESTIN WITH ANTIMINERALOCORTICOID COMB		
ANGELIQ	T4	HD
ESTROGEN-SELECTIVE ESTROGEN RECEPTOR MOD (SERM) COMB		
DUAVEE	T3	
GLUCOCORTICOIDS		
<i>budesonide</i>	T2	
<i>budesonide (Uceris)</i>	T2	
CORTEF (<i>hydrocortisone</i>)	T4	
<i>cortisone acetate</i>	T2	
<i>deflazacort (Emflaza)</i>	T2	PA SP HD
<i>dexamethasone</i>	T2	PA
<i>dexamethasone</i>	T2	
<i>dexamethasone 0.5 mg, 0.75 mg tablet</i>	T1	
<i>dexamethasone 0.5 mg/5 ml elx</i>	T1	
<i>dexamethasone 0.5 mg/5 ml liq</i>	T2	
<i>dexamethasone 1 mg, 1.5 mg tablet</i>	T1	
<i>dexamethasone 10 day 1.5 mg tb</i>	T2	PA
<i>dexamethasone 13 day 1.5 mg tb</i>	T2	PA
<i>dexamethasone 2 mg, 4 mg, 6 mg tablet</i>	T1	
<i>dexamethasone 6 day 1.5 mg tab</i>	T2	PA
DEXONTO	T4	
DXEVO	T4	PA
<i>hydrocortisone (Cortef)</i>	T2	
MEDROL	T4	
MEDROL (<i>methylprednisolone</i>)	T4	
<i>methylprednisolone</i>	T2	
<i>methylprednisolone (Medrol)</i>	T2	
ORAPRED ODT (<i>prednisolone sodium phosphate</i>)	T4	
<i>prednisolone</i>	T2	

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

T5 – Preferred Specialty
 T6 – Non-Preferred Specialty
 PA – Prior Authorization
 QL – Quantity Limit

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

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

List of Prescription Medications

HORMONES (Hormonal Agents) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
GLUCOCORTICOIDS		
<i>prednisolone sodium phosphate</i>	T2	
<i>prednisolone sodium phosphate (Orapred Odt)</i>	T2	
<i>prednisone</i>	T2	
<i>prednisone</i>	T1	
RAYOS	T4	PA
TAPERDEX	T4	PA
TARPEYO	T6	PA QL(28 caps/30 days) SP
UCERIS 9 MG ER TABLET (<i>budesonide</i>)	T4	
ZCORT	T4	PA
GROWTH HORMONE RELEASING HORMONE (GHRH) AND ANALOGS		
EGRIFTA SV	T5	PA SP HD
GROWTH HORMONES		
GENOTROPIN	T5	PA SP HD
OMNITROPE	T5	PA SP
SEROSTIM	T5	PA SP HD
ZORBTIVE	T6	PA SP HD
INSULIN-LIKE GROWTH FACTOR-I (IGF-I) HORMONES		
INCRELEX	T5	PA SP HD
LHRH (GNRH) AGONIST ANALOG PITUITARY SUPPRESSANTS		
SYNAREL	T5	PA SP HD
LHRH (GNRH) ANTAGONIST, ESTROGEN AND PROGESTIN COMB		
MYFEMBREE	T3	PA
ORIAHNN	T3	PA
LHRH (GNRH) ANTAGONIST, PITUITARY SUPPRESSANT AGENTS		
<i>cetorelix acetate</i>	T2	SP
CETROTIDE	T5	SP
GANIRELIX ACET 250 MCG/0.5 ML (<i>ganirelix acetate</i>)	T6	ST SP
<i>ganirelix acet 250 mcg/0.5 ml (Ganirelix Acetate)</i>	T2	ST SP
<i>ganirelix acetate (Ganirelix Acetate)</i>	T2	SP
ORILISSA 150 MG TABLET	T3	PA QL(30 tabs/fill)
ORILISSA 200 MG TABLET	T3	PA QL(60 tabs/fill)
MINERALOCORTICOIDS		
<i>fludrocortisone acetate</i>	T1	HD

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

T5 – Preferred Specialty
T6 – Non-Preferred Specialty
PA – Prior Authorization
QL – Quantity Limit

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

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

List of Prescription Medications

HORMONES (Hormonal Agents) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
OXYTOCICS		
CERVIDIL	T4	
<i>methylgonovine maleate</i>	T2	PA QL(240 tabs/fill)
PREPIDIL	T4	
PROSTIN E2 VAGINAL SUPPOSITORY	T4	
PARATHYROID HORMONES		
NATPARA	T5	PA SP HD
PITUITARY SUPPRESSIVE AGENTS		
<i>cabergoline</i>	T2	QL(8 tabs/28 days) HD
<i>danazol</i>	T2	HD
PROGESTATIONAL AGENTS		
AYGESTIN (<i>norethindrone acetate</i>)	T4	HD
<i>medroxyprogesterone 10 mg tab (Provera)</i>	T2	HD
<i>medroxyprogesterone 2.5 mg tab (Provera)</i>	T2	HD
<i>medroxyprogesterone 5 mg tab (Provera)</i>	T2	HD
<i>norethindrone acetate (Aygestin)</i>	T2	HD
<i>progesterone, micronized (Prometrium)</i>	T2	HD
PROMETRIUM (<i>progesterone, micronized</i>)	T4	HD
PROVERA (<i>medroxyprogesterone acetate</i>)	T4	HD
SOMATOSTATIC AGENTS		
MYCAPSSA	T6	PA QL (56 caps/28 days) SP
VAGINAL ESTROGEN PREPARATIONS		
<i>estradiol (Vagifem)</i>	T2	HD
<i>estradiol 0.01% cream (Estrace)</i>	T2	HD
<i>estradiol 10 mcg vaginal insrt (Vagifem)</i>	T2	HD
PREMARIN VAGINAL CREAM-APPL	T3	HD
HORMONES (Infertility)		
FERTILITY STIMULATING PREPARATIONS, NON-FSH		
<i>clomiphene citrate</i>	T2	
FOLLICLE-STIMULATING AND LUTEINIZING HORMONES		
MENOPUR	T5	SP
FOLLICLE-STIMULATING HORMONE (FSH)		
FOLLISTIM AQ	T6	ST SP
GONAL-F	T5	ST SP
GONAL-F RFF	T5	ST SP

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

T5 – Preferred Specialty
 T6 – Non-Preferred Specialty
 PA – Prior Authorization
 QL – Quantity Limit

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

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

List of Prescription Medications

HORMONES (Infertility) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
------------------------	-----------	----------------------------------

FOLLICLE-STIMULATING HORMONE (FSH) (cont.)

GONAL-F RFF REDI-JECT	T5	ST SP
-----------------------	----	-------

HUMAN CHORIONIC GONADOTROPIN (HCG)

CHORIONIC GONAD 10,000 UNIT VL	T6	ST QL(3 vials/30 days) SP
--------------------------------	----	---------------------------

CHORIONIC GONAD 12,000 UNIT VL	T6	ST SP
--------------------------------	----	-------

CHORIONIC GONAD 50,000 UNIT VL	T6	ST SP
--------------------------------	----	-------

CHORIONIC GONAD 6,000 UNIT VL	T6	ST SP
-------------------------------	----	-------

NOVAREL	T5	QL(6 vls/30 days) SP
---------	----	----------------------

OVIDREL	T5	SP
---------	----	----

PREGNYL	T6	ST QL(3 vials/fill) SP
---------	----	------------------------

PREGNANCY FACILITATING/MAINTAINING AGENT, HORMONAL

CRINONE	T3	
---------	----	--

ENDOMETRIN	T4	
------------	----	--

HORMONES (Miscellaneous)

LEPTIN HORMONE ANALOGS

MYALEPT	T5	PA SP HD
---------	----	----------

HORMONES (Osteoporosis Products)

BONE FORMATION STIMULATING AGTS - PTH REL PEPTIDES

TYMLOS	T5	PA QL(1 pen/fill) SP HD
--------	----	-------------------------

BONE RESORPTION INHIBITORS

<i>calcitonin, salmon, synthetic</i>	T2	HD
--------------------------------------	----	----

<i>calcitonin, salmon, synthetic (Miacalcin)</i>	T2	HD
--	----	----

MIACALCIN (<i>calcitonin, salmon, synthetic</i>)	T4	HD
--	----	----

IMMUNOSUPPRESSANTS (Pain Relief And Inflammatory Disease)

HUMAN INTERLEUKIN 12/23 (IL-12/13) INHIBITORS, MAB

STELARA	T5	PA QL SP HD
---------	----	-------------

IL-23 RECEPTOR ANTAGONIST, MONOCLONAL ANTIBODY

OMVOH PEN	T5	
-----------	----	--

SKYRIZI ON-BODY	T5	PA QL(1 cartridge/56 days) SP HD
-----------------	----	----------------------------------

INTERLEUKIN-4(IL-4) RECEPTOR ALPHA ANTAGONIST, MAB

DUPIXENT 100 MG/0.67 ML SYRING	T5	PA QL(2 syringes/28 days) SP HD
--------------------------------	----	---------------------------------

DUPIXENT 200 MG/1.14 ML PEN	T5	PA QL(400 mgs/28 days) SP HD
-----------------------------	----	------------------------------

DUPIXENT 200 MG/1.14 ML SYRING	T5	PA QL(400 mgs/28 days) SP HD
--------------------------------	----	------------------------------

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

T5 – Preferred Specialty
T6 – Non-Preferred Specialty
PA – Prior Authorization
QL – Quantity Limit

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

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

List of Prescription Medications

IMMUNOSUPPRESSANTS (Pain Relief And Inflammatory Disease) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
INTERLEUKIN-4(IL-4) RECEPTOR ALPHA ANTAGONIST, MAB (cont.)		
DUPIXENT 300 MG/2 ML PEN	T5	PA QL(600 mgs/28 days) SP HD
DUPIXENT 300 MG/2 ML SYRINGE	T5	PA QL(600 mgs/28 days) SP HD

INTERLEUKIN-6 (IL-6) RECEPTOR INHIBITORS

ACTEMRA	T5	PA QL(3.6 mls/28 days) SP HD
ACTEMRA ACTPEN	T5	PA QL(2 pens/28 days) SP HD
ENSPRYNG	T5	PA SP HD

IMMUNOSUPPRESSANTS (Skin Conditions)

TOPICAL IMMUNOSUPPRESSIVE AGENTS

HYFTOR	T6	PA SP
<i>pimecrolimus (Elidel)</i>	T2	ST QL(120 gms/30 days)
PROTOPIC (<i>tacrolimus</i>)	T4	ST QL(120 gms/30 days)
<i>tacrolimus 0.03% ointment (Protopic)</i>	T2	ST QL(120 gms/30 days)

IMMUNOSUPPRESSANTS (Transplant Medications)

IMMUNOSUPPRESSIVES

ASTAGRAF XL	T6	PA SP HD
AZASAN (<i>azathioprine</i>)	T6	SP HD
<i>azathioprine (Azasan)</i>	T2	SP HD
<i>azathioprine (Imuran)</i>	T2	SP HD
CELLCEPT (<i>mycophenolate mofetil</i>)	T6	SP HD
<i>cyclosporine 100 mg capsule (Sandimmune)</i>	T2	SP HD
<i>cyclosporine 25 mg capsule (Sandimmune)</i>	T2	SP HD
<i>cyclosporine, modified</i>	T2	SP HD
<i>cyclosporine, modified (Neoral)</i>	T2	SP HD
<i>everolimus 0.25 mg tablet (Zortress)</i>	T2	SP HD
<i>everolimus 0.5 mg tablet (Zortress)</i>	T2	SP HD
<i>everolimus 0.75 mg tablet (Zortress)</i>	T2	SP HD
<i>everolimus 1 mg tablet (Zortress)</i>	T2	SP HD
IMURAN (<i>azathioprine</i>)	T6	SP HD
LUPKYNIS	T6	PA QL (180 caps/30 days) SP
<i>mycophenolate mofetil (Cellcept)</i>	T2	SP HD
<i>mycophenolate sodium (Myfortic)</i>	T2	SP HD
MYFORTIC (<i>mycophenolate sodium</i>)	T6	SP HD

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

T5 – Preferred Specialty
T6 – Non-Preferred Specialty
PA – Prior Authorization
QL – Quantity Limit

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

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

List of Prescription Medications

IMMUNOSUPPRESSANTS (Transplant Medications) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
IMMUNOSUPPRESSIVES (cont.)		
NEORAL (<i>cyclosporine, modified</i>)	T6	SP HD
PROGRAF 0.2 MG GRANULE PACKET	T5	SP HD
PROGRAF 0.5 MG CAPSULE (<i>tacrolimus</i>)	T6	SP HD
PROGRAF 1 MG CAPSULE (<i>tacrolimus</i>)	T6	SP HD
PROGRAF 1 MG GRANULE PACKET	T5	SP HD
PROGRAF 5 MG CAPSULE (<i>tacrolimus</i>)	T6	SP HD
RAPAMUNE (<i>sirolimus</i>)	T6	SP HD
SANDIMMUNE 100 MG CAPSULE (<i>cyclosporine</i>)	T6	SP HD
SANDIMMUNE 100 MG/ML SOLN	T5	SP HD
SANDIMMUNE 25 MG CAPSULE (<i>cyclosporine</i>)	T6	SP HD
<i>sirolimus</i> (Rapamune)	T2	SP HD
<i>tacrolimus 0.5 mg capsule (ir)</i> (Prograf)	T2	SP HD
<i>tacrolimus 1 mg capsule (ir)</i> (Prograf)	T2	SP HD
<i>tacrolimus 5 mg capsule (ir)</i> (Prograf)	T2	SP HD
ZORTRESS (<i>everolimus</i>)	T6	SP HD
MISCELLANEOUS MEDICAL SUPPLIES, DEVICES, NON-DRUG (Diabetes)		
DIABETIC SUPPLIES		
2TEK	T4	
ACCU-CHEK AVIVA SOLUTION	T4	
ACCU-CHEK COMPACT PLUS CONTROL	T4	
ACCU-CHEK FASTCLIX LANCING DEV	T3	
ACCU-CHEK GUIDE CONTROL SOLN	T4	
ACCU-CHEK MULTICLIX LANCET KIT	T3	
ACCU-CHEK SMARTVIEW CONTRL SOL	T4	
ACCU-CHEK SOFTCLIX	T3	
ACCU-TREND GLUCOSE CONTROL	T4	
ADJUSTABLE LANCING DEVICE	T3	
ADVANCED LANCING DEVICE	T3	
ADVOCATE CONTROL SOLUTION	T4	
ADVOCATE LANCING DEVICE	T3	
ADVOCATE RAPID-SAFE LANCING DV	T3	
ADVOCATE REDI-CODE+ CTRL SOLN	T4	
AGAMATRIX CONTROL	T4	

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

T5 – Preferred Specialty
T6 – Non-Preferred Specialty
PA – Prior Authorization
QL – Quantity Limit

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

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

List of Prescription Medications

MISCELLANEOUS MEDICAL SUPPLIES, DEVICES, NON-DRUG (Diabetes) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
DIABETIC SUPPLIES (cont.)		
ALKALINE BATTERIES	T4	
ALTERNATE SITE LANCING DEVICE	T3	
AQUA LANCE LANCING DEVICE	T3	
ASSURE 4 CONTROL SOLUTION	T4	
ASSURE DOSE	T4	
ASSURE PRISM	T4	
AT HOME A1C	T4	
AUTOJECT 2	T3	
AUTO-LANCET MINI	T3	
AUTOLET IMPRESSION	T3	
AUTOLET LANCING DEVICE	T3	
AUTOLET PLUS	T3	
AUTOPEN	T3	
AUTOSOFT 30	T3	
AUTOSOFT 90	T3	
AUTOSOFT XC	T3	
BLOOD GLUCOSE CONTROL	T4	
BLOOD-GLUCOSE CONTROL	T4	
BREEZE 2	T4	
CAREONE	T3	
CARESENS	T4	
CARETOUCH CONTROL SOLUTION	T4	
CARETOUCH LANCING DEVICE	T3	
CEQR SIMPLICITY	T3	
CEQR SIMPLICITY INSERTER	T3	
CHEMSTRIP BG DIARY	T4	
CLEVER CHOICE CONTROL SOLUTION	T4	
COMFORT	T3	
COMFORT SHORT	T3	
CONTACT DETACH INFUSION SET	T3	
CONTOUR	T4	
CONTOUR NEXT CONTROL SOLUTION	T4	
CONTROL SOLUTION	T4	
COOL CONTROL SOLUTION	T4	

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

T5 – Preferred Specialty
T6 – Non-Preferred Specialty
PA – Prior Authorization
QL – Quantity Limit

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

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

List of Prescription Medications

MISCELLANEOUS MEDICAL SUPPLIES, DEVICES, NON-DRUG (Diabetes) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
DIABETIC SUPPLIES (cont.)		
DEXCOM G6 RECEIVER	T3	
DEXCOM G6 SENSOR	T3	PA QL(3 kits/30 days)
DEXCOM G6 TRANSMITTER	T3	PA QL(1 kit/90 days)
DEXCOM G7 RECEIVER	T3	
DEXCOM G7 SENSOR	T3	PA QL(3 units/30 days)
DIATRUE	T4	
DROPLET GENTEEL LANCING DEVICE	T3	
DROPLET LANCING DEVICE	T3	
EASY MINI EJECT LANCING DEVICE	T3	
EASY PLUS II CONTROL SOLN HIGH	T4	
EASY PLUS II CONTROL SOLN LOW	T4	
EASY STEP CONTROL SOLUTION	T4	
EASY TALK CONTROL SOLN LOW	T4	
EASY TALK HIGH CONTROL SOLN	T4	
EASY TALK PLUS II HIGH CONTROL	T4	
EASY TALK PLUS II LOW CTRL SLN	T4	
EASY TOUCH BLU LINK CTRL SOLN	T4	
EASY TOUCH CONTROL SOLUTION	T4	
EASY TOUCH LANCING DEVICE	T3	
EASY TRAK CONTROL SOLN HIGH	T4	
EASY TRAK CONTROL SOLN LOW	T4	
EASY TRAK II CONTROL SOLUTION	T4	
EASYGLUCO PLUS CONTROL NORMAL	T4	
EASYMAX 15 LEVEL 2 SOLUTION	T4	
EASYMAX NORMAL CONTROL SOLN	T4	
ELEMENT COMPACT CONTROL SOLN	T4	
ELEMENT CONTROL SOLUTION	T4	
EMBRACE EVO LEVEL 1 CTRL SOLN	T4	
EMBRACE GLUC CONTROL SOLN HIGH	T4	
EMBRACE GLUCOSE CONTROL SOLN	T4	
EMBRACE LANCING DEVICE	T3	
EMBRACE PRO	T4	
EMBRACE TALK CONTROL SOLUTION	T4	
ENLITE SERTER	T4	

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

T5 – Preferred Specialty
T6 – Non-Preferred Specialty
PA – Prior Authorization
QL – Quantity Limit

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

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

List of Prescription Medications

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

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
DIABETIC SUPPLIES (cont.)		
EVENCARE G2 CONTROL SOLUTION	T4	
EVENCARE G3 CONTROL SOLUTION	T4	
EVOLUTION CONTROL SOLUTION	T4	
FORA CONTROL SOLUTION	T4	
FORA GTEL MULTIFUNCTN MONITOR	T4	
FORA KETONE CONTROL SOLUTION	T4	
FORA LANCING DEVICE	T3	
FORA TN'G ADVANCE PRO MONITOR	T4	
FORA TN'GO ADVANCE MULTIFN MTR	T4	
FORACARE GDH	T4	
FORTISCARE	T4	
FREESTYLE CONTROL SOLUTION	T3	
FREESTYLE LIBRE 10 DAY READER	T3	PA
FREESTYLE LIBRE 10 DAY SENSOR	T3	PA
FREESTYLE LIBRE 14 DAY READER	T3	PA
FREESTYLE LIBRE 14 DAY SENSOR	T3	PA QL(2 kits/30 days)
FREESTYLE LIBRE 2 READER	T3	PA
FREESTYLE LIBRE 2 SENSOR	T3	PA QL(2 sensors/28 days)
FREESTYLE LIBRE 3 SENSOR	T3	PA QL(2 units/28 days)
FREESTYLE NAVIGATOR SENSOR KIT	T3	
GE100 CONTROL SOLUTION NORMAL	T4	
GENTEEL VACUUM LANCING DEVICE	T4	
GLUCOCARD 01 CONTROL	T4	
GLUCOCARD EXPRESSION CNTRL SLN	T4	
GLUCOCARD SHINE CONTROL SOLN	T4	
GLUCOCOM AUTOLINK	T4	
GLUCOCOM CONTROL SOLUTION	T4	
GLUCOSE CONTROL	T4	
GLUCOSE CONTROL SOLUTION	T4	
GOJJI GLUCOSE CONTROL SOLUTION	T4	
GOJJI KETONE CONTROL SOLUTION	T4	
GOJJI LANCING DEVICE	T3	
GOJJI MULTI-FUNCTIONAL METER	T4	PA QL (1 transmitter/273 days)
GUARDIAN 4 GLUCOSE SENSOR	T4	PA QL (5 sensors/30 days)

T1 – Preferred Generics

T2 – Non-Preferred Generics

T3 – Preferred Brands

T4 – Non-Preferred Brands

T5 – Preferred Specialty

T6 – Non-Preferred Specialty

PA – Prior Authorization

QL – Quantity Limit

ST – Step Therapy

AGE – Age Requirement

SP – Specialty Medication

HD – May require home delivery pharmacy

PPACA – No Cost-Share Preventive Medication

CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

MISCELLANEOUS MEDICAL SUPPLIES, DEVICES, NON-DRUG (Diabetes) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
DIABETIC SUPPLIES (cont.)		
GUARDIAN 4 TRANSMITTER	T4	PA QL (1 transmitter/273 days)
GUARDIAN LINK 3 TRANSMITTER	T4	
GUARDIAN RT CHARGER	T4	
GUARDIAN RT STARTER KIT	T4	
GUARDIAN RT SYSTEM	T4	
GUARDIAN TEST PLUG	T4	
GUARDIAN TRANSMITTER TAPE	T4	
HEALTHPRO GLUCOSE CONTROL SOLN	T4	
HEALTHY ACCENTS AUTOLET	T3	
HYPOLANCE	T3	
ILET INFUSION KIT-INSET	T3	
ILET INFUSION-CONTACT DETACH	T3	
INCONTROL LANCING DEVICE	T3	
INFINITY CONTROL SOLUTION	T4	
INFINITY VOICE CONTROL SOLN	T4	
INPEN (FOR HUMALOG)	T4	
INPEN (FOR NOVOLOG OR FIASP)	T4	
INSUL-CAP	T4	
INSUL-EZE	T3	
LANCING DEVICE	T3	
LANCING SYSTEM	T3	
LANZO	T3	
LITE TOUCH LANCING PEN	T3	
MEDISENSE	T3	
MEDISENSE GLUCOSE KETONE	T3	
MEDISENSE GLUCOSE KETONE CONTR	T3	
MEDTRONIC EXT INFUSION SET	T3	
MEDTRONIC REMOTE CONTROL	T4	
MICRODOT HIGH-LOW CONTROL SOL	T4	
MICRODOT NORMAL CONTROL SOLUT	T3	
MICROLET 2	T3	
MICROLET NEXT LANCING DEVICE	T3	
MINI LANCING DEVICE	T2	
MINIMED	T3	

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

T5 – Preferred Specialty
 T6 – Non-Preferred Specialty
 PA – Prior Authorization
 QL – Quantity Limit

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

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

List of Prescription Medications

MISCELLANEOUS MEDICAL SUPPLIES, DEVICES, NON-DRUG (Diabetes) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
DIABETIC SUPPLIES (cont.)		
MINIMED MIO	T3	
MINIMED MIO ADVANCE	T3	
MINIMED QUICK SET	T3	
MINIMED QUICK-SERTER	T4	
MINIMED QUICK-SERTER	T3	
MINIMED SILHOUETTE	T3	
MINIMED SURE T	T3	
MULTI-LANCET	T3	
MYGLUCOHEALTH CONTROL SOLUTION	T4	
NOVA MAX PLUS GLUC-KETON METER	T4	
NOVAMAX PLUS GLU-KET	T4	
NOVOPEN 3	T3	
NOVOPEN ECHO	T4	
OMNIPOD 5 G6 INTRO KIT (GEN 5)	T3	QL(1 kit/720 days)
OMNIPOD 5 G6 PODS (GEN 5)	T3	QL(15 pods/28 days)
OMNIPOD CLASSIC PODS (GEN 3)	T3	QL(15 pods/28 days)
OMNIPOD DASH INTRO KIT (GEN 4)	T3	QL(1 kit/720 days)
OMNIPOD DASH PODS (GEN 4)	T3	QL(15 pods/28 days)
OMNIPOD GO PODS	T3	QL(10 crtgs/30 days)
ON CALL EXPRESS CONTROL SOLN	T4	
ON CALL LANCING DEVICE	T3	
ON CALL PLUS CONTROL	T4	
ON CALL PLUS LANCING DEVICE	T3	
ON CALL VIVID CONTROL	T4	
ONETOUCH DELICA	T3	
ONETOUCH DELICA PLUS LANC DEV	T3	
ONETOUCH ULTRA CONTROL SOLN	T3	
ONETOUCH VERIO HIGH CNTRL SOLN	T3	
ONETOUCH VERIO MID CNTRL SOLN	T3	
OPTUMRX GLUCOSE CONTROL SOLN	T4	
OVAL TAPE	T4	
PARADIGM REMOTE CONTROL	T4	
PIP GLUCOSE CONTROL SOLUTION	T4	

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

T5 – Preferred Specialty
T6 – Non-Preferred Specialty
PA – Prior Authorization
QL – Quantity Limit

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

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

List of Prescription Medications

MISCELLANEOUS MEDICAL SUPPLIES, DEVICES, NON-DRUG (Diabetes) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
DIABETIC SUPPLIES (cont.)		
PRECISION XTRA KETONE-GLUCOSE	T3	
PRODIGY CONTROL SOLUTION	T4	
PRODIGY LANCING DEVICE	T3	
QUICK RELEASE SOFT TEFLON	T3	
REFUAH PLUS GLUCOSE CONTROL	T4	
RELIAMED MINI LANCING DEVICE	T3	
REPLACEMENT PEDIATRIC MONITOR	T4	
RIGHTEST CONTROL SOLUTION	T4	
RIGHTEST GD500	T3	
SAFE-CLIP	T3	
SEN-SERTER	T4	
SILHOUETTE	T3	
SIL-SERTER	T3	
SMARTDIABETES VANTAGE	T3	
SMARTEST	T4	
SOF-SERTER	T3	
SOF-SET	T3	
SOF-SET MICRO	T3	
SOLUS V2 CONTROL SOLUTION	T4	
SOLUS V2 LANCING DEVICE	T3	
SURE COMFORT LANCING PEN	T3	
SUREFLEX	T3	
SURE-PEN	T3	
SURE-TEST EASYPLUS MINI SOLN	T4	
T:30 INFUSION SET	T3	
T:90	T3	
T:FLEX	T3	
T:SLIM	T3	
T:SLIM G4	T3	
T:SLIM X2	T3	
TELCARE CONTROL SOLUTION	T4	
TRUE METRIX	T4	
TRUECONTROL	T4	
TRUEDRAW	T3	

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

T5 – Preferred Specialty
T6 – Non-Preferred Specialty
PA – Prior Authorization
QL – Quantity Limit

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

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

List of Prescription Medications

MISCELLANEOUS MEDICAL SUPPLIES, DEVICES, NON-DRUG (Diabetes) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
DIABETIC SUPPLIES (cont.)		
TRUSTEEL INFUSION SET	T3	
ULTI-LANCE	T3	
ULTRATRAK CONTROL SOL NORMAL	T4	
ULTRATRAK CONTROL SOLUTION	T4	
ULTRATRAK ULTIMATE CNTRL SOLN	T4	
UNISTIK 2	T3	
UNISTRIP	T4	
VARISOFT INFUSION SET	T3	
V-GO 20	T3	
V-GO 30	T3	
V-GO 40	T3	
VIVAGUARD INO CONTROL SOLUTION	T4	
VIVAGUARD LANCING DEVICE	T3	
WAVESENSE CONTROL SOLUTION	T4	
DURABLE MEDICAL EQUIPMENT,MISC(GROUP I)		
1ST TIER UNILET COMFORTOUCH	T3	
2-IN-1 LANCET DEVICE	T3	
ACCU-CHEK FASTCLIX LANCET DRUM	T3	
ACCU-CHEK SAFE-T-PRO	T3	
ACCU-CHEK SAFE-T-PRO PLUS	T3	
ACCU-CHEK SOFTCLIX	T3	
<i>acti-lance lite 28g lancets</i>	T2	
<i>acti-lance special 17g lancets</i>	T2	
<i>acti-lance univers 23g lancets</i>	T2	
ACTI-LANCE UNIVERS 23G LANCETS	T3	
ADVANCED TRAVEL LANCETS	T3	
ADVOCATE LANCET	T3	
ADVOCATE LANCETS	T3	
ADVOCATE SAFETY LANCET	T3	
ALTERNATE SITE LANCETS	T3	
ASSURE HAEMOLANCE PLUS	T3	
ASSURE LANCE	T3	
ASSURE LANCE PLUS	T3	
BD MICROTAINER LANCETS	T3	

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

T5 – Preferred Specialty
 T6 – Non-Preferred Specialty
 PA – Prior Authorization
 QL – Quantity Limit

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

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

List of Prescription Medications

MISCELLANEOUS MEDICAL SUPPLIES, DEVICES, NON-DRUG (Diabetes) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
DURABLE MEDICAL EQUIPMENT,MISC(GROUP I) (cont.)		
BLOOD LANCETS	T3	
BULLSEYE MINI SAFETY LANCETS	T3	
BUTTERFLY TOUCH LANCET	T3	
CAREONE	T3	
CARESENS LANCET	T3	
CARETOUCH SAFETY LANCETS	T3	
CARETOUCH TWIST LANCET	T3	
CLEVER CHEK LANCETS	T3	
COAGUCHEK	T3	
COLOR LANCETS	T3	
COMFORT EZ	T3	
COMFORT LANCETS	T3	
COMFORT TOUCH PLUS SAFETY LANC	T3	
COMFORT TOUCH ULT THIN LANCET	T3	
DROPLET LANCETS	T3	
EASY COMFORT LANCETS	T3	
EASY TOUCH PULL-TOP 26G LANCET	T3	
EASY TOUCH PULL-TOP 28G LANCET	T3	
EASY TOUCH PULL-TOP 30G LANCET	T3	
EASY TOUCH PULL-TOP 32G LANCET	T3	
EASY TOUCH SAFETY 21G LANCETS	T3	
EASY TOUCH SAFETY 23G LANCETS	T3	
EASY TOUCH SAFETY 26G LANCETS	T3	
EASY TOUCH SAFETY 28G LANCETS	T3	
EASY TOUCH SAFETY 30G LANCETS	T3	
EASY TOUCH SAFETY 32G LANCETS	T3	
EASY TOUCH TWIST 26G LANCETS	T3	
EASY TOUCH TWIST 28G LANCETS	T3	
EASY TOUCH TWIST 30G LANCETS	T3	
EASY TOUCH TWIST 32G LANCETS	T3	
EASY TOUCH TWIST 33G LANCETS	T3	
EASY TWIST & CAP LANCETS	T3	
EMBRACE 30G LANCETS	T3	
EMBRACE SAFETY LANCET	T3	

T1 – Preferred Generics

T2 – Non-Preferred Generics

T3 – Preferred Brands

T4 – Non-Preferred Brands

T5 – Preferred Specialty

T6 – Non-Preferred Specialty

PA – Prior Authorization

QL – Quantity Limit

ST – Step Therapy

AGE – Age Requirement

SP – Specialty Medication

HD – May require home delivery pharmacy

PPACA – No Cost-Share Preventive Medication

CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

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

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
DURABLE MEDICAL EQUIPMENT,MISC(GROUP I) (cont.)		
EZ SMART LANCETS	T3	
EZ-LETS	T3	
FIFTY50 SAFETY SEAL LANCETS	T3	
FINE 30 UNIVERSAL LANCETS	T3	
FINGERSTIX	T3	
FORA LANCETS	T3	
FORACARE LANCETS	T3	
FREESTYLE LANCETS	T3	
FREESTYLE UNISTIK 2	T3	
GLUCOCOM	T3	
GLUCOCOM LANCETS	T3	
GOJJI LANCETS	T3	
HEALTHY ACCENTS UNILET LANCET	T3	
INCONTROL SUPER THIN LANCETS	T3	
INCONTROL ULTRA THIN LANCETS	T3	
INJECT EASE LANCETS	T3	
INVACARE LANCETS	T3	
<i>lancets</i>	T2	
LANCETS	T3	
LANCETS THIN	T3	
LANCETS ULTRA THIN	T3	
LITE TOUCH 28G LANCETS	T3	
LITE TOUCH 30G LANCETS	T3	
LITE TOUCH 33G LANCETS	T3	
MEDISENSE THIN LANCETS	T3	
<i>medlance plus 21g lancets</i>	T2	
MEDLANCE PLUS 21G LANCETS	T3	
<i>medlance plus 30g lancets</i>	T2	
MEDLANCE PLUS 30G LANCETS	T3	
MEDLANCE PLUS EXTRA 21G LANCET	T3	
<i>medlance plus lite 25g lancets</i>	T2	
MEDLANCE PLUS LITE 25G LANCETS	T3	
MICRO THIN LANCET	T3	
MICRO THIN LANCETS	T3	

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

T5 – Preferred Specialty
 T6 – Non-Preferred Specialty
 PA – Prior Authorization
 QL – Quantity Limit

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

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

List of Prescription Medications

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

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
DURABLE MEDICAL EQUIPMENT,MISC(GROUP I) (cont.)		
MICROLET	T3	
MOBILE LANCETS	T3	
MONOLET LANCETS	T3	
MONOLET THIN LANCETS	T3	
MYGLUCOHEALTH LANCETS	T3	
NOVA SAFETY LANCETS	T3	
NOVA SUREFLEX	T3	
ON CALL LANCET	T3	
ON CALL PLUS LANCET	T3	
ONETOUCH DELICA PLUS LANCET	T3	
ONETOUCH DELICA SAFETY LANCET	T3	
ONETOUCH LANCETS	T3	
ONETOUCH SURESOFT	T3	
ONETOUCH ULTRASOFT 2 LANCET	T3	
ON-THE-GO	T3	
PIP LANCET	T3	
PRESSURE ACTIVATED LANCETS	T3	
PRO COMFORT LANCET	T3	
PRO COMFORT LANCETS	T3	
PRO COMFORT SAFETY LANCET	T3	
PRODIGY LANCETS	T3	
PRODIGY TWIST TOP LANCET	T3	
PURE COMFORT LANCETS	T3	
PURE COMFORT SAFETY LANCETS	T3	
PUSH BUTTON SAFETY LANCETS	T3	
READYLANC SAFETY LANCETS	T3	
RELIAMED	T3	
RELIAMED SAFETY SEAL LANCETS	T3	
RELION THIN	T3	
RIGHTEST GL300 LANCETS	T3	
SAFETY LANCETS	T3	
SAFETY SEAL LANCETS	T3	
SAFETY-LET	T3	
SINGLE-LET	T3	

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

T5 – Preferred Specialty
T6 – Non-Preferred Specialty
PA – Prior Authorization
QL – Quantity Limit

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

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

List of Prescription Medications

MISCELLANEOUS MEDICAL SUPPLIES, DEVICES, NON-DRUG (Diabetes) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
DURABLE MEDICAL EQUIPMENT,MISC(GROUP I) (cont.)		
SMART SENSE	T3	
SMART SENSE LANCETS	T3	
SMARTEST LANCET	T3	
SOFT TOUCH	T3	
SOLUS V2	T3	
SOLUS V2 LANCETS	T3	
STERILANCETL	T3	
STERILE LANCETS	T3	
SUPER THIN LANCETS	T3	
SURE COMFORT LANCETS	T3	
SURE-LANCE	T3	
SURE-TOUCH	T3	
TECHLITE LANCETS	T3	
TELCARE ULTRA THIN 30G LANCETS	T3	
THIN LANCETS	T3	
TOPCARE UNIVERSAL1 LANCET	T3	
TOPCARE UNIVERSAL1 THIN LANCET	T3	
TRUE COMFORT LANCET	T3	
TRUE COMFORT SAFETY LANCET	T3	
TRUEPLUS LANCET	T3	
TRUEPLUS LANCETS	T3	
TWIST LANCETS	T3	
TWIST TOP LANCET	T3	
ULTILET BASIC	T3	
ULTILET CLASSIC	T3	
ULTILET LANCETS	T3	
ULTILET SAFETY	T3	
ULTRA THIN LANCET	T3	
ULTRA THIN LANCETS	T3	
ULTRA THIN PLUS	T3	
ULTRA THIN PLUS LANCETS	T3	
ULTRA-CARE LANCETS	T3	
ULTRALANCE	T3	
ULTRA-THIN II 28G LANCETS	T3	

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

T5 – Preferred Specialty
T6 – Non-Preferred Specialty
PA – Prior Authorization
QL – Quantity Limit

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

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

List of Prescription Medications

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

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
------------------------	-----------	----------------------------------

DURABLE MEDICAL EQUIPMENT,MISC(GROUP I) (cont.)

ULTRA-THIN II 30G LANCETS	T3	
ULTRATLC LANCETS	T3	
UNILET COMFORTOUCH	T3	
UNILET EXCELITE	T3	
UNILET EXCELITE II	T3	
UNILET GP LANCET	T3	
UNILET LANCET	T3	
UNILET LANCETS	T3	
UNISTIK 2 COMFORT	T3	
UNISTIK 2 EXTRA	T3	
UNISTIK 2 NORMAL	T3	
UNISTIK 3	T3	
UNISTIK 3 COMFORT	T3	
UNISTIK 3 DUAL	T3	
UNISTIK 3 EXTRA	T3	
UNISTIK 3 NORMAL	T3	
UNISTIK COMFORT	T3	
UNISTIK CZT	T3	
UNISTIK EXTRA	T3	
UNISTIK NORMAL	T3	
UNISTIK PRO	T3	
UNISTIK SAFETY	T3	
UNISTIK TOUCH	T3	
UNIVERSAL 1	T3	
VERIFINE SAFETY LANCET MINI	T3	
VERIFINE UNIVERSAL LANCET	T3	
VIVAGUARD LANCET	T3	

NEEDLES/NEEDLELESS DEVICES

AUTOSHIELD DUO PEN NEEDLE	T3	
BD ECLIPSE NEEDLE 18G 40MM	T4	
BD ECLIPSE NEEDLE 21GX1"	T3	
BD ECLIPSE NEEDLE 22GX1"	T3	
BD ECLIPSE NEEDLE 23GX1"	T4	
BD ECLIPSE NEEDLE 25G 16MM	T4	

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

T5 – Preferred Specialty
T6 – Non-Preferred Specialty
PA – Prior Authorization
QL – Quantity Limit

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

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

List of Prescription Medications

MISCELLANEOUS MEDICAL SUPPLIES, DEVICES, NON-DRUG (Diabetes) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
NEEDLES/NEEDLELESS DEVICES (cont.)		
BD ECLIPSE NEEDLE 25G 25MM	T4	
BD ECLIPSE NEEDLE 25GX1"	T3	
BD ECLIPSE NEEDLE 25GX1.5"	T3	
BD ECLIPSE NEEDLE 25GX5/8"	T4	
BD ECLIPSE NEEDLE 27GX1/2"	T4	
BD ECLIPSE NEEDLES 21GX1.5"	T3	
BD NEEDLES 21GX1"	T3	
BD NEEDLES 21GX1.5"	T3	
BD NEEDLES 22GX1"	T3	
BD NEEDLES 25GX0.875"	T3	
BLUNT NEEDLE	T3	
CAREPOINT PRECISION NEEDLE	T4	
CARETOUCH HYPODERMIC NEEDLE	T4	
CHEMO TRANSFER PIN	T3	
EASY TOUCH FLIPLOCK NEEDLE	T4	
EASY TOUCH FLIPLOCK NEEDLES	T4	
EASY TOUCH HYPODERMIC NEEDLE	T4	
EASYPPOINT NEEDLE	T4	
EXEL HUBER NEEDLE	T3	
EXEL HYPODERMIC NEEDLE	T3	
EXEL MTI DRAWING NEEDLE	T3	
FILTER ASPIRATOR NEEDLE	T3	
FILTER NEEDLE	T3	
FLOW-EZE	T3	
HURRICAINA LUER-LOCK	T3	
HYPODERMIC NEEDLE	T3	
INTEGRA NEEDLE	T3	
INTEGRA PRECISIONGLIDE NEEDLE	T4	
LIFESHIELD BLUNT CANNULA	T3	
MINI TRANSFER PIN	T3	
MONOJECT BLOOD COLLECTION	T3	
MONOJECT FILTER NEEDLE	T4	
NANO 2ND GEN PEN NEEDLE	T3	
NEEDLE	T3	

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

T5 – Preferred Specialty
T6 – Non-Preferred Specialty
PA – Prior Authorization
QL – Quantity Limit

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

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

List of Prescription Medications

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

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
NEEDLES/NEEDLELESS DEVICES (cont.)		
needles,safety huber,disposabl	T2	
NOKOR ADMIX NEEDLE	T3	
NOKOR NEEDLE	T3	
PEN NEEDLE 30G X 8MM	T4	
PHASEAL PROTECTOR	T4	
POLY HUB NEEDLE	T3	
PRECISIONGLIDE	T3	
QUINCE SPINAL NEEDLE	T3	
RAYA SURE PEN NEEDLE 29G 12MM	T4	
RAYA SURE PEN NEEDLE 31G 5MM	T4	
RAYA SURE PEN NEEDLE 31G 6MM	T4	
REGULAR BEVEL NEEDLES	T3	
SAFETYGLIDE NEEDLE	T3	
SHORT BEVEL NEEDLES	T3	
SPECIALTY USE NEEDLES	T3	
TERUMO SURGUARD2	T3	
THIN WALL NEEDLES	T3	
TRANSFER NEEDLE	T3	
TRANSFER PIN	T3	
ULTRA-FINE MICRO PEN NEEDLE	T3	
ULTRA-FINE MINI PEN NEEDLE	T3	
ULTRA-FINE NANO PEN NEEDLE	T3	
ULTRA-FINE ORIGINAL PEN NEEDLE	T3	
ULTRA-FINE SHORT PEN NEEDLE	T3	
YALE NEEDLE	T3	
YALE NEEDLES	T3	
SYRINGES AND ACCESSORIES		
ALLERGIST TRAY	T4	
ALLERGIST TRAY SYR-DETACH NDL	T3	
ALLERGIST TRAY SYR-PERM NEEDLE	T3	
ALLERGY SYRINGE 1 ML 27GX1/2"	T4	
ALLERGY SYRINGE 1 ML 27GX3/8"	T4	
BD ALLERGY SYRINGE-NEEDLE 1 ML	T3	
BD ECLIPSE LUER-LOK SYR 1 ML	T3	

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

T5 – Preferred Specialty
T6 – Non-Preferred Specialty
PA – Prior Authorization
QL – Quantity Limit

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

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

List of Prescription Medications

MISCELLANEOUS MEDICAL SUPPLIES, DEVICES, NON-DRUG (Diabetes) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
SYRINGES AND ACCESSORIES (cont.)		
BD ECLIPSE LUER-LOK SYR 3 ML	T3	
BD ECLIPSE SYR 3 ML 22GX1-1/2"	T4	
BD INS SYR 0.3 ML 8MMX31G(1/2)	T3	
BD INS SYR UF 0.3ML 12.7MMX30G	T3	
BD INS SYR UF 0.5ML 12.7MMX30G	T3	
BD INS SYRN UF 1 ML 12.7MMX30G	T3	
BD INS SYRNG 0.3 ML 29GX12.7MM	T3	
BD INS SYRNG 0.5 ML 29GX12.7MM	T3	
BD INS SYRNG UF 0.3 ML 8MMX31G	T3	
BD INS SYRNG UF 0.5 ML 8MMX31G	T3	
BD INSULIN SYR 0.5 ML 28GX1/2"	T3	
BD INSULIN SYR 0.5 ML 29GX1/2"	T3	
BD INSULIN SYR 1 ML 25GX1"	T3	
BD INSULIN SYR 1 ML 25GX5/8"	T3	
BD INSULIN SYR 1 ML 26GX1/2"	T3	
BD INSULIN SYR 1 ML 27GX12.7MM	T3	
BD INSULIN SYR 1 ML 27GX5/8"	T3	
BD INSULIN SYR 1 ML 28GX1/2"	T3	
BD INSULIN SYR 1 ML 29GX1/2"	T3	
BD INSULIN SYR 1 ML 29GX12.7MM	T3	
BD INSULIN SYR UF 1 ML 8MMX31G	T3	
BD INSULIN SYRINGE 1 ML	T3	
BD SAFETYGLIDE 3 ML SYRINGE	T3	
BD SAFETYGLIDE SYR 22GX1.5"	T3	
BD SAFETYGLIDE SYR 3 ML 25GX1"	T4	
BD SAFETYGLIDE SYRINGE 27GX5/8	T3	
BD SYRINGE-SAFETY GLIDE	T3	
BD UF INS SYR 1 ML 30GX1/2"	T3	
BULK SYRINGE	T3	
CANNULA	T3	
CAREPOINT LL SYR 3 ML 20GX1.5"	T3	
CAREPOINT LL SYR 3 ML 21GX1"	T3	
CAREPOINT LL SYR 3 ML 21GX1.5"	T3	
CAREPOINT LL SYR 3 ML 22G 38MM	T3	

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

T5 – Preferred Specialty
T6 – Non-Preferred Specialty
PA – Prior Authorization
QL – Quantity Limit

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

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

List of Prescription Medications

MISCELLANEOUS MEDICAL SUPPLIES, DEVICES, NON-DRUG (Diabetes) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
SYRINGES AND ACCESSORIES (cont.)		
CAREPOINT LL SYR 3 ML 22GX1"	T3	
CAREPOINT LL SYR 3 ML 23GX1"	T3	
CAREPOINT LL SYR 3 ML 23GX1.5"	T3	
CAREPOINT LL SYR 3 ML 25G X 1"	T3	
CAREPOINT LL SYR 3 ML 25GX5/8"	T3	
CAREPOINT LUER LOCK SYR 3 ML	T4	
CAREPOINT LUER SLIP SYRINGE	T4	
CAREPOINT LUER SLIP SYRING-NDL	T4	
CARETOUCH LUER LOCK	T3	
CARETOUCH LUER LOCK SYRINGE	T4	
CARETOUCH LUER SLIP SYRINGE	T4	
CORNWALL SYRINGE TIP CONNECTOR	T3	
DAVOL IRRIGATION SYRINGE	T3	
DOVER BULB SYRINGE	T4	
EASY GLIDE CATHETER TIP SYRING	T4	
EASY GLIDE LUER LOCK SYRINGE	T4	
EASY GLIDE LUER SLIP TB SYRING	T4	
EASY TOUCH FLIPLK 10ML 20GX1.5	T4	
EASY TOUCH FLIPLK 10ML 21GX1.5	T4	
EASY TOUCH FLIPLK 10ML 22GX1.5	T4	
EASY TOUCH FLIPLK 5 ML 20GX1.5	T4	
EASY TOUCH FLIPLK 5 ML 21GX1.5	T4	
EASY TOUCH FLIPLK 5 ML 22GX1.5	T4	
EASY TOUCH FLIPLK	T4	
EASY TOUCH FLIPLK 1 ML 25GX1	T3	
EASY TOUCH FLIPLK 10ML 21GX1	T4	
EASY TOUCH FLIPLK 3 ML 18GX1	T4	
EASY TOUCH FLIPLK 3 ML 20GX1	T4	
EASY TOUCH FLIPLK 3 ML 21GX1	T4	
EASY TOUCH FLIPLK 5 ML 18GX1	T4	
EASY TOUCH FLIPLK 5 ML 21GX1	T4	
EASY TOUCH FLIPLK SYRINGE	T4	
EASY TOUCH FLIPLK 10 ML 20GX1	T4	
EASY TOUCH FLIPLK 10 ML 25GX1	T4	

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

T5 – Preferred Specialty
 T6 – Non-Preferred Specialty
 PA – Prior Authorization
 QL – Quantity Limit

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

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

List of Prescription Medications

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

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
SYRINGES AND ACCESSORIES (cont.)		
EASY TOUCH FLIPILOK 1ML 26GX3/8	T3	
EASY TOUCH FLIPILOK 1ML 27GX0.5	T3	
EASY TOUCH FLIPILOK 3ML 18GX1.5	T4	
EASY TOUCH FLIPILOK 3ML 20GX1.5	T4	
EASY TOUCH FLIPILOK 3ML 21GX1.5	T4	
EASY TOUCH FLURINGE	T3	
EASY TOUCH FLURINGE FLIPILOCK	T3	
EASY TOUCH FLURINGE FLU TRAY	T4	
EASY TOUCH FLURINGE SHEATHLOCK	T3	
EASY TOUCH LUER LOCK INSULIN	T4	
EASY TOUCH LUER LOCK SYRINGE	T4	
EASY TOUCH SHEATHLOCK SYRG-NDL	T4	
EASY TOUCH SHEATHLOCK SYRINGE	T4	
EASY TOUCH SYR 1 ML 25GX5/8"	T3	
EASY TOUCH SYR 3 ML 22GX1-1/2"	T3	
EASY TOUCH SYR 3 ML 25GX5/8"	T3	
EASY TOUCH SYR ALLERGY TRAY	T4	
EASY TOUCH SYRINGE 1 ML 25GX1"	T3	
EASY TOUCH SYRINGE 3 ML 20GX1"	T3	
EASY TOUCH SYRINGE 3 ML 21GX1"	T3	
EASY TOUCH SYRINGE 3 ML 22GX1"	T3	
EASY TOUCH SYRINGE 3 ML 23GX1"	T3	
EASY TOUCH SYRINGE 3 ML 25GX1"	T3	
EASY TOUCH TUBERCULIN FLIPILOCK	T3	
EASY TOUCH TUBERCULIN SHEATHLK	T3	
EASY TOUCH UNI-SLIP	T4	
ECLIPSE SYRINGE	T3	
ECLIPSE SYRINGE-NEEDLE	T3	
EXEL SYRINGE	T3	
EXEL TB WITH NEEDLE	T3	
EXEL TUBERCULIN SYRINGE	T3	
EXTENDED RESERVOIR	T4	
FILTER, MILLEX-OR SYRINGE	T4	
FINGER GRIP EXTENDER	T4	

T1 – Preferred Generics

T2 – Non-Preferred Generics

T3 – Preferred Brands

T4 – Non-Preferred Brands

T5 – Preferred Specialty

T6 – Non-Preferred Specialty

PA – Prior Authorization

QL – Quantity Limit

ST – Step Therapy

AGE – Age Requirement

SP – Specialty Medication

HD – May require home delivery pharmacy

PPACA – No Cost-Share Preventive Medication

CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

MISCELLANEOUS MEDICAL SUPPLIES, DEVICES, NON-DRUG (Diabetes) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
SYRINGES AND ACCESSORIES (cont.)		
INJECT-EASE	T3	
INSULIN CARTRIDGE	T3	
INSULIN SYRINGE U-500	T3	
INTEGRA SYRINGE	T3	
INTERLINK SYRINGE	T3	
INTERLINK SYRINGE W-CANNULA	T4	
KENDALL DISINFECTANT CAP	T4	
LEVER LOCK CANNULA	T4	
LIFESHIELD BLUNT CANNULA	T3	
LUER LOCK SYRINGE	T3	
LUER SLIP TIP SYRINGE TRAY	T4	
LUER TIP CAP TRAY	T4	
LUER-LOK SYRINGE	T3	
LUER-LOK SYRINGE-NEEDLE	T3	
LUER-LOK TIP SYRINGE	T3	
LUERSLIP SYRINGE	T3	
MAGELLAN SAFETY SYRINGE	T3	
MAGELLAN TB SAFETY SYRINGE	T3	
MAGELLAN TUBERCULIN SYRINGE	T3	
MINIMED RESERVOIR 1.8 ML	T4	
MINIMED RESERVOIR 3 ML	T3	
MONOJECT 3 ML SYRINGE 25GX1"	T3	
MONOJECT 6CC SAFETY SYRINGE	T3	
MONOJECT ALLERGY TRAY-NEEDLE	T3	
MONOJECT CONTROL SYRINGE	T3	
MONOJECT ENFIT SYRINGE	T4	
MONOJECT ENFIT SYRINGE CAP	T4	
MONOJECT LUER LOCK TB SYRINGE	T3	
MONOJECT MAGELLAN	T3	
MONOJECT PHARMACY TRAY	T3	
MONOJECT SAFETY SYR TIP CAP	T4	
MONOJECT SAFETY SYRINGE	T3	
MONOJECT SMARTIP CANNULA	T4	
MONOJECT SYRINGE	T3	

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

T5 – Preferred Specialty
T6 – Non-Preferred Specialty
PA – Prior Authorization
QL – Quantity Limit

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

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

List of Prescription Medications

MISCELLANEOUS MEDICAL SUPPLIES, DEVICES, NON-DRUG (Diabetes) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
SYRINGES AND ACCESSORIES (cont.)		
MONOJECT SYRINGE 140 ML	T4	
MONOJECT SYRINGE 35 ML	T3	
MONOJECT SYRINGE PHARMACY TRAY	T3	
MONOJECT TB	T3	
MONOJECT TB SYRINGE	T3	
MONOJECT TUBERCULIN SAFETY SYR	T3	
MONOJECT TUBERCULIN SYRINGE	T3	
NORM-JECT SYRINGE	T4	
NORM-JECT TUBERKULIN SYRINGE	T4	
PARADIGM	T3	
PISTON ENFIT SYRINGE	T4	
PRECISIONGLIDE	T3	
PRODIGY COUNT-A-DOSE	T3	
SAFESNAP ALLERGY SYRINGE	T4	
SAFESNAP SYRINGE 10 ML	T3	
SAFESNAP SYRINGE 10 ML	T4	
SAFESNAP SYRINGE 3 ML	T3	
SAFESNAP SYRINGE 5 ML	T3	
SAFESNAP SYRINGE 5 ML	T4	
SAFESNAP TUBERCULIN SYRINGE	T4	
SAFETY SYRINGE WITH SHIELD	T3	
SAFETY SYRINGE-NEEDLE	T4	
SAFETYGLIDE ALLERGY	T3	
SAFETYGLIDE ALLERGY SYRINGE	T4	
SAFETYGLIDE INSULIN SYRINGE	T3	
SAFETYGLIDE TB SYRINGE	T3	
SAFETY-LOK SAFETY SYRINGE	T3	
SAFETY-LOK SAFETY SYRINGES	T3	
SAFETY-LOK SYRINGES	T3	
SLIP-TIP SYRINGE	T4	
SUPOR	T4	
SYRINGE	T3	
SYRINGE BULK	T3	
SYRINGE CATHETER TIP	T3	

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

T5 – Preferred Specialty
 T6 – Non-Preferred Specialty
 PA – Prior Authorization
 QL – Quantity Limit

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

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

List of Prescription Medications

MISCELLANEOUS MEDICAL SUPPLIES, DEVICES, NON-DRUG (Diabetes) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
SYRINGES AND ACCESSORIES (cont.)		
SYRINGE CATHETER TIP NON-STER	T3	
SYRINGE FILTER, MILLEX-GP	T4	
SYRINGE FILTER, MILLEX-GS	T4	
SYRINGE LUER-LOK	T3	
SYRINGE LUER-LOK NON-STERILE	T3	
SYRINGE LUER-LOK STERILE	T3	
SYRINGE SLIP TIP NON-STERILE	T3	
SYRINGE STORAGE BIN	T4	
SYRINGE TIP CAP	T3	
SYRINGE WITH NEEDLE DISP	T3	
SYRINGE WITHOUT NEEDLE	T3	
SYRINGE-LUER TIP CAP	T3	
SYRINGE-NEEDLE	T3	
SYRINGE-PRECISIONGLIDE NEEDLE	T3	
TB SYRINGE	T3	
TERUMO ALLERGY SYRINGE	T3	
TERUMO HYPODERMIC NEEDLE-SYRIN	T3	
TERUMO SURGUARD2	T3	
TERUMO SYRINGE	T3	
TOOMEY SYRINGE	T3	
TUBERCULIN SYRINGE	T3	
TUBERCULIN SYRINGE-NEEDLE	T3	
TWINPAK DUAL CANNULA	T3	
ULTICARE LDS SYR 1 ML 22G 1.5"	T4	
ULTICARE LDS SYR 3 ML 22GX1.5"	T3	
ULTICARE SAFETY SYRINGE	T4	
ULTICARE SYRINGE	T4	
ULTICARE TB SAFETY 1 ML 25GX1"	T3	
ULTICARE TB SAFETY 1ML 25GX5/8	T3	
ULTICARE TB SAFETY SYRINGE	T3	
ULTIGUARD SAFE 1ML 30G 12.7MM	T4	
ULTIGUARD SAFEPACK 1ML 31G 8MM	T4	
UNIVERSAL SYRINGE TIP ADAPTOR	T4	
VANISHPOINT 1 ML TB SYR 25X5/8	T3	

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

T5 – Preferred Specialty
T6 – Non-Preferred Specialty
PA – Prior Authorization
QL – Quantity Limit

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

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

List of Prescription Medications

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

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
SYRINGES AND ACCESSORIES (cont.)		
VANISHPOINT 1 ML TB SYR 27X1/2	T3	
VANISHPOINT 20GX1" 3 ML SYRING	T3	
VANISHPOINT 21GX1" 5 ML SYRING	T3	
VANISHPOINT 21GX1.5" 3 ML SYR	T3	
VANISHPOINT 22GX1" 3 ML SYR	T3	
VANISHPOINT 22GX1-1/2" 5 ML SY	T3	
VANISHPOINT 23GX1" 3 ML SYRING	T3	
VANISHPOINT 23GX1-1/2 3 ML SYR	T3	
VANISHPOINT 25GX1" 3 ML SYRING	T3	
VANISHPOINT 25GX5/8" 3 ML SYR	T3	
VANISHPOINT 3 ML 21GX1" SYRING	T3	
VANISHPOINT 3 ML 22GX1.5" SYRG	T3	
VANISHPOINT SYRINGE	T4	
VANISHPOINT SYRINGE 1 ML 25X1"	T3	
VEO INSULIN SYRINGE	T3	

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

BANDAGES AND RELATED SUPPLIES

ARGLAES FILM	T4	
CONFORMANT 2	T4	
DERMAVIEW	T3	
DERMAVIEW II	T3	
IV 3000	T3	
IV3000 FRAME DELIVERY	T4	
KENDALL	T3	
NEXCARE TEGADERM 2.375"X2.75"	T4	
NEXCARE TEGADERM DRESSING	T3	
OPSITE	T4	
OPSITE IV 3000	T3	
POLYSKIN II	T3	
SURESITE MATRIX	T3	
SURESITE WINDOW	T3	
TEGADERM 1.75X1.75" DRSSNG	T4	
TEGADERM 2"X2.75" DRESSING	T3	
TEGADERM 2.375"X2.75" DRESSING	T3	

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

T5 – Preferred Specialty
 T6 – Non-Preferred Specialty
 PA – Prior Authorization
 QL – Quantity Limit

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

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

List of Prescription Medications

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

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
BANDAGES AND RELATED SUPPLIES (cont.)		
TEGADERM 2.375"X4" DRESSING	T3	
TEGADERM 2.375X2.75" DRSSNG	T3	
TEGADERM 3.5" X 4" DRESSING	T3	
TEGADERM 3.5"X 10" DRESSING	T4	
TEGADERM 3.5"X 6" DRESSING	T4	
TEGADERM 3.5"X13.75" DRESS	T4	
TEGADERM 3.5"X4.125" DRESS	T3	
TEGADERM 3.5"X8" DRESSING	T4	
TEGADERM 4" X 10" DRESSING	T3	
TEGADERM 4" X 4-3/4" DRESSING	T3	
TEGADERM 4"X4.75" DRESSING	T3	
TEGADERM 6" X 8" DRESSING	T3	
TEGADERM 8" X 12" DRESSING	T3	
TEGADERM ABSORBENT	T4	
TEGADERM HP 4" X 4.5 " DRSSN	T3	
TEGADERM HP 4.5"X4.75" DRSS	T3	
TEGADERM HP DRESSING	T3	
TEGADERM HP DRESSING	T4	
TEGADERM I.V.	T4	
TEGADERM I.V. 2.5"X2.75" DRSSN	T4	
TEGADERM I.V. 4"X4.75" DRSSN	T3	
TRANSPARENT DRESSING	T4	
TRANSPARENT FILM DRESSING	T4	
TRANSPARENT I.V. SITE DRESSING	T3	
TRANSPARENT MEPITEL FILM DRESS	T4	
TRANSPARENT THIN FILM DRESSING	T3	
WINDOW BANDAGES	T4	
DURABLE MEDICAL EQUIPMENT,MISC(GROUP I)		
1ST TIER UNILET COMFORTOUCH	T3	
2-IN-1 LANCET DEVICE	T3	
ACCU-CHEK FASTCLIX LANCET DRUM	T3	
ACCU-CHEK SAFE-T-PRO	T3	
ACCU-CHEK SAFE-T-PRO PLUS	T3	
ACCU-CHEK SOFTCLIX	T3	

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

T5 – Preferred Specialty
 T6 – Non-Preferred Specialty
 PA – Prior Authorization
 QL – Quantity Limit

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

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

List of Prescription Medications

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

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
DURABLE MEDICAL EQUIPMENT,MISC(GROUP I) (cont.)		
<i>acti-lance lite 28g lancets</i>	T2	
<i>acti-lance special 17g lancets</i>	T2	
ACTI-LANCE UNIVERS 23G LANCETS	T3	
<i>acti-lance univers 23g lancets</i>	T2	
ADVANCED TRAVEL LANCETS	T3	
ADVOCATE LANCET	T3	
ADVOCATE LANCETS	T3	
ADVOCATE SAFETY LANCET	T3	
ALTERNATE SITE LANCETS	T3	
ASSURE HAEMOLANCE PLUS	T3	
ASSURE LANCE	T3	
ASSURE LANCE PLUS	T3	
BD MICROTAINER LANCETS	T3	
BLOOD LANCETS	T3	
BULLSEYE MINI SAFETY LANCETS	T3	
BUTTERFLY TOUCH LANCET	T3	
CAREONE	T3	
CARESENS LANCET	T3	
CARETOUCH TWIST LANCET	T3	
CLEVER CHEK LANCETS	T3	
COAGUCHEK	T3	
COLOR LANCETS	T3	
COMFORT EZ	T3	
COMFORT LANCETS	T3	
DROPLET LANCETS	T3	
EASY COMFORT LANCETS	T3	
EASY TOUCH BUTTON 30G LANCETS	T3	
EASY TOUCH PULL-TOP 26G LANCET	T3	
EASY TOUCH PULL-TOP 28G LANCET	T3	
EASY TOUCH PULL-TOP 30G LANCET	T3	
EASY TOUCH PULL-TOP 32G LANCET	T3	
EASY TOUCH SAFETY 21G LANCETS	T3	
EASY TOUCH SAFETY 23G LANCETS	T3	
EASY TOUCH SAFETY 26G LANCETS	T3	

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

T5 – Preferred Specialty
 T6 – Non-Preferred Specialty
 PA – Prior Authorization
 QL – Quantity Limit

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

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

List of Prescription Medications

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

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
DURABLE MEDICAL EQUIPMENT,MISC(GROUP I) (cont.)		
EASY TOUCH SAFETY 28G LANCETS	T3	
EASY TOUCH SAFETY 30G LANCETS	T3	
EASY TOUCH SAFETY 32G LANCETS	T3	
EASY TOUCH TWIST 26G LANCETS	T3	
EASY TOUCH TWIST 28G LANCETS	T3	
EASY TOUCH TWIST 30G LANCETS	T3	
EASY TOUCH TWIST 32G LANCETS	T3	
EASY TOUCH TWIST 33G LANCETS	T3	
EASY TWIST CAP LANCETS	T3	
EMBRACE 30G LANCETS	T3	
EMBRACE SAFETY LANCET	T3	
EZ SMART LANCETS	T3	
EZ-LETS	T3	
FIFTY50 SAFETY SEAL LANCETS	T3	
FINE 30 UNIVERSAL LANCETS	T3	
FINGERSTIX	T3	
FORA LANCETS	T3	
FORACARE LANCETS	T3	
FREESTYLE LANCETS	T3	
FREESTYLE UNISTIK 2	T3	
GLUCOCOM	T3	
GLUCOCOM LANCETS	T3	
GOJJI LANCETS	T3	
HEALTHY ACCENTS UNILET LANCET	T3	
INCONTROL SUPER THIN LANCETS	T3	
INCONTROL ULTRA THIN LANCETS	T3	
INJECT EASE LANCETS	T3	
INVACARE LANCETS	T3	
<i>lancets</i>	T2	
LANCETS	T3	
LANCETS THIN	T3	
LANCETS ULTRA THIN	T3	
LITE TOUCH 28G LANCETS	T3	
LITE TOUCH 30G LANCETS	T3	

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

T5 – Preferred Specialty
T6 – Non-Preferred Specialty
PA – Prior Authorization
QL – Quantity Limit

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

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

List of Prescription Medications

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

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
DURABLE MEDICAL EQUIPMENT,MISC(GROUP I) (cont.)		
LITE TOUCH 33G LANCETS	T3	
MEDISENSE THIN LANCETS	T3	
MEDLANCE PLUS 21G LANCETS	T3	
<i>medlance plus 21g lancets</i>	T2	
<i>medlance plus 30g lancets</i>	T2	
MEDLANCE PLUS 30G LANCETS	T3	
MEDLANCE PLUS EXTRA 21G LANCET	T3	
<i>medlance plus lite 25g lancets</i>	T2	
MEDLANCE PLUS LITE 25G LANCETS	T3	
MEDLANCE PLUS SPECIAL BLADE	T3	
MICRO THIN LANCET	T3	
MICRO THIN LANCETS	T3	
MICROLET	T3	
MICROTAINER LANCETS	T3	
MONOLET LANCETS	T3	
MONOLET THIN LANCETS	T3	
MYGLUCOHEALTH LANCETS	T3	
NOVA SAFETY LANCETS	T3	
NOVA SUREFLEX	T3	
ON CALL LANCET	T3	
ON CALL PLUS LANCET	T3	
ONETOUCH DELICA	T3	
ONETOUCH DELICA PLUS LANCET	T3	
ONETOUCH DELICA SAFETY LANCET	T3	
ONETOUCH LANCETS	T3	
ONETOUCH SURESOFT	T3	
ON-THE-GO	T3	
PIP LANCET	T3	
PRESSURE ACTIVATED LANCETS	T3	
PRO COMFORT LANCET	T3	
PRO COMFORT LANCETS	T3	
PRODIGY LANCETS	T3	
PRODIGY TWIST TOP LANCET	T3	

T1 – Preferred Generics

T2 – Non-Preferred Generics

T3 – Preferred Brands

T4 – Non-Preferred Brands

T5 – Preferred Specialty

T6 – Non-Preferred Specialty

PA – Prior Authorization

QL – Quantity Limit

ST – Step Therapy

AGE – Age Requirement

SP – Specialty Medication

HD – May require home delivery pharmacy

PPACA – No Cost-Share Preventive Medication

CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

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

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
DURABLE MEDICAL EQUIPMENT,MISC(GROUP I) (cont.)		
PURE COMFORT LANCETS	T3	
PURE COMFORT SAFETY LANCETS	T3	
PUSH BUTTON SAFETY LANCETS	T3	
READYLANCE SAFETY LANCETS	T3	
RELIAMED	T3	
RELIAMED SAFETY SEAL LANCETS	T3	
RELION THIN	T3	
RIGHTEST GL300 LANCETS	T3	
SAFETY LANCETS	T3	
SAFETY SEAL LANCETS	T3	
SAFETY-LET	T3	
SINGLE-LET	T3	
SMART SENSE	T3	
SMART SENSE LANCETS	T3	
SMARTEST LANCET	T3	
SOFT TOUCH	T3	
SOLUS V2	T3	
SOLUS V2 LANCETS	T3	
STERILANCE TL	T3	
STERILE LANCETS	T3	
SUPER THIN LANCETS	T3	
SURE COMFORT LANCETS	T3	
SURE-LANCE	T3	
SURE-TOUCH	T3	
TECHLITE LANCETS	T3	
TELCARE ULTRA THIN 30G LANCETS	T3	
THIN LANCETS	T3	
TOPCARE UNIVERSAL1 LANCET	T3	
TOPCARE UNIVERSAL1 THIN LANCET	T3	
TRUE COMFORT LANCET	T3	
TRUEPLUS LANCET	T3	
TRUEPLUS LANCETS	T3	
TWIST LANCETS	T3	
TWIST TOP LANCET	T3	

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

T5 – Preferred Specialty
T6 – Non-Preferred Specialty
PA – Prior Authorization
QL – Quantity Limit

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

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

List of Prescription Medications

MISCELLANEOUS MEDICAL SUPPLIES, DEVICES, NON-DRUG (Miscellaneous) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
DURABLE MEDICAL EQUIPMENT,MISC(GROUP I) (cont.)		
ULTILET BASIC	T3	
ULTILET CLASSIC	T3	
ULTILET LANCETS	T3	
ULTILET SAFETY	T3	
ULTRA THIN LANCET	T3	
ULTRA THIN LANCETS	T3	
ULTRA THIN PLUS	T3	
ULTRA THIN PLUS LANCETS	T3	
ULTRA-CARE LANCETS	T3	
ULTRALANCE	T3	
ULTRA-THIN II 28G, 30G LANCETS	T3	
ULTRATLC LANCETS	T3	
UNILET COMFORTOUCH	T3	
UNILET EXCELITE	T3	
UNILET EXCELITE II	T3	
UNILET GP LANCET	T3	
UNILET LANCET	T3	
UNILET LANCETS	T3	
UNISTIK 2 COMFORT	T3	
UNISTIK 2 EXTRA	T3	
UNISTIK 2 NORMAL	T3	
UNISTIK 3	T3	
UNISTIK 3 COMFORT	T3	
UNISTIK 3 DUAL	T3	
UNISTIK 3 EXTRA	T3	
UNISTIK COMFORT	T3	
UNISTIK CZT	T3	
UNISTIK EXTRA	T3	
UNISTIK NORMAL	T3	
UNISTIK PRO	T3	
UNISTIK SAFETY	T3	
UNISTIK TOUCH	T3	
UNIVERSAL 1	T3	
VIVAGUARD LANCET	T3	

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

T5 – Preferred Specialty
T6 – Non-Preferred Specialty
PA – Prior Authorization
QL – Quantity Limit

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

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

List of Prescription Medications

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

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
MEDICAL SUPPLIES, MISCELLANEOUS		
ALCOH-GLOVE	T4	
ALCOH-WIPE	T4	
PARENTERAL ADMINISTRATION SETS		
1.5 VOLT BATTERIES #357	T3	
ACCU-CHEK LINKASSIST	T4	
ACCU-CHEK RAPID D 10-100	T4	
ACCU-CHEK RAPID D 10-50	T4	
ACCU-CHEK RAPID D 10-70	T3	
ACCU-CHEK RAPID D 6-100	T4	
ACCU-CHEK RAPID D 6-50	T3	
ACCU-CHEK RAPID D 6-70	T4	
ACCU-CHEK RAPID D 8-100	T4	
ACCU-CHEK RAPID D 8-50	T3	
ACCU-CHEK RAPID D 8-70	T3	
ACCU-CHEK SPIRIT	T3	
ACCU-CHEK TENDER	T3	
ACCU-CHEK ULTRAFLEX	T3	
DELTEC COZMO CLEO INFUSION SET	T3	
INSET 30 TUBING	T3	
IV ADMINISTRATION SET	T3	
NERIA	T4	
PARADIGM INFUSION	T3	
PARADIGM SILHOUETTE	T3	
POLYFIN QR	T3	
PSV SET	T4	
Q-SYTE	T3	
SILHOUETTE	T3	
SURE-T	T3	
RESPIRATORY AIDS, DEVICES, EQUIPMENT		
ACE AEROSOL CLOUD ENHANCER	T3	
AEROCHAMBER MINI	T3	
AEROCHAMBER MV	T3	
AEROCHAMBER PLUS FLOW-VU	T3	
AEROCHAMBER Z-STAT PLUS	T3	

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

T5 – Preferred Specialty
T6 – Non-Preferred Specialty
PA – Prior Authorization
QL – Quantity Limit

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

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

List of Prescription Medications

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

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
RESPIRATORY AIDS, DEVICES, EQUIPMENT (cont.)		
AEROTRACH PLUS	T3	
AEROVENT PLUS	T3	
BREATHERITE	T3	
BREATHERITE SPACER-ADULT MASK	T3	
BREATHERITE SPACER-INFANT MASK	T3	
BREATHERITE SPACER-LG CHLD MSK	T3	
BREATHERITE SPACER-NEONATE MSK	T3	
BREATHERITE SPACER-SM CHLD MSK	T3	
BREATHRITE	T3	
CLEVER CHOICE HOLDING CHAMBER	T3	
COMFORTSEAL	T3	
COMPACT SPACE CHAMBER	T3	
EASIVENT	T3	
FLEXICHAMBER	T3	
FLEXICHAMBER MASK	T3	
INSPIRACHAMBER	T3	
LITEAIRE	T3	
LITETOUCH	T3	
MICROCHAMBER	T3	
MICROSPACER	T3	
MOUTHPIECE	T3	
ONE WAY MOUTHPIECE	T3	
OPTICHAMBER	T3	
OPTICHAMBER DIAMOND	T3	
PANDA MASK	T3	
PEDIATRIC MASK	T3	
PEDIATRIC PANDA MASK	T3	
POCKET CHAMBER	T3	
PRIMEAIRE	T3	
PRO COMFORT SPACER-ADULT MASK	T3	
PRO COMFORT SPACER-CHILD MASK	T4	
PRO COMFORT SPACER-INFANT MASK	T4	
PROCARE SPACER WITH ADULT MASK	T3	
PROCARE SPACER WITH CHILD MASK	T3	
PROCHAMBER	T3	

T1 – Preferred Generics

T2 – Non-Preferred Generics

T3 – Preferred Brands

T4 – Non-Preferred Brands

T5 – Preferred Specialty

T6 – Non-Preferred Specialty

PA – Prior Authorization

QL – Quantity Limit

ST – Step Therapy

AGE – Age Requirement

SP – Specialty Medication

HD – May require home delivery pharmacy

PPACA – No Cost-Share Preventive Medication

CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

MISCELLANEOUS MEDICAL SUPPLIES, DEVICES, NON-DRUG (Miscellaneous) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
RESPIRATORY AIDS, DEVICES, EQUIPMENT (cont.)		
PURE COMFORT SPACER WITH MASK	T4	
RITEFLO	T3	
SIDESTREAM PEDIATRIC	T3	
SILICONE MASK	T3	
SPACE CHAMBER	T3	
SPACE CHAMBER-LARGE MASK	T3	
SPACE CHAMBER-MEDIUM MASK	T3	
SPACE CHAMBER-SMALL MASK	T3	
VORTEX	T3	
VORTEX VHC FROG MASK	T3	
VORTEX VHC LADYBUG MASK	T3	
MUSCLE RELAXANTS (Pain Relief And Inflammatory Disease)		
SKELETAL MUSCLE RELAX.-TOP. IRRITANT COUNTER-IRRIT		
COMFORT PAC-CYCLOBENZAPRINE	T4	
COMFORT PAC-TIZANIDINE	T4	
SKELETAL MUSCLE RELAXANTS		
<i>baclofen 10 mg tablet</i>	T2	
<i>baclofen 20 mg tablet</i>	T2	
<i>baclofen 5 mg tablet</i>	T2	
<i>baclofen 25 mg/5 ml suspension</i>	T2	
<i>carisoprodol (Soma)</i>	T2	
<i>carisoprodol/aspirin</i>	T2	
<i>chlorzoxazone</i>	T2	
<i>chlorzoxazone (Lorzone)</i>	T2	
<i>cyclobenzaprine hcl</i>	T2	
<i>cyclobenzaprine hcl (Amrix)</i>	T2	PA
<i>cyclobenzaprine hcl (Fexmid)</i>	T2	
<i>DANTRIUM (dantrolene sodium)</i>	T4	
<i>dantrolene sodium</i>	T2	
<i>dantrolene sodium (Dantrium)</i>	T2	
<i>FEXMID (cyclobenzaprine hcl)</i>	T4	PA
<i>LORZONE (chlorzoxazone)</i>	T4	PA
<i>metaxalone</i>	T2	

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

T5 – Preferred Specialty
 T6 – Non-Preferred Specialty
 PA – Prior Authorization
 QL – Quantity Limit

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

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

List of Prescription Medications

MUSCLE RELAXANTS (Pain Relief And Inflammatory Disease) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
SKELETAL MUSCLE RELAXANTS (cont.)		
<i>methocarbamol 500 mg tablet</i>	T2	
<i>methocarbamol 750 mg tablet</i>	T2	
NORGESIC (<i>orphenadrine/aspirin/caffeine</i>)	T4	
NORGESIC FORTE (<i>orphenadrine/aspirin/caffeine</i>)	T4	
<i>orphenadrine citrate</i>	T2	
<i>orphenadrine/aspirin/caffeine (Norgesic Forte)</i>	T2	
<i>orphenadrine/aspirin/caffeine (Norgesic)</i>	T2	
SOMA (<i>carisoprodol</i>)	T4	
<i>tizanidine hcl</i>	T2	
<i>tizanidine hcl (Zanaflex)</i>	T2	
ZANAFLEX (<i>tizanidine hcl</i>)	T4	
PRE-NATAL VITAMINS (Nutritional/Dietary)		
PRENATAL VITAMIN PREPARATIONS		
BAL-CARE DHA ESSENTIAL	T4	
BRAINSTRONG PRENATAL	T4	
CADEAU DHA	T4	
CITRANATAL 90 DHA	T4	
CITRANATAL ASSURE	T4	
CITRANATAL B-CALM	T4	
CITRANATAL DHA	T4	
CITRANATAL HARMONY	T4	
CITRANATAL RX	T4	
CVS PRENATAL GUMMY VITAMINS	T4	
<i>cvs prenatal multi-dha softgel</i>	T2	PPACA
<i>cvs prenatal vitamins tablet</i>	T2	PPACA
DUET DHA 400	T4	
DUET DHA BALANCED	T4	
EXPECTA PRENATAL	T3	
<i>gnp prenatal vitamins tablet</i>	T2	PPACA
GS PRENATAL VITAMINS TABLET	T4	
HM ONE DAILY PRENATAL COMBO PK	T3	
<i>hm prenatal tablet</i>	T2	PPACA
KOSHER PRENATAL PLUS IRON	T4	

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

T5 – Preferred Specialty
 T6 – Non-Preferred Specialty
 PA – Prior Authorization
 QL – Quantity Limit

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

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

List of Prescription Medications

PRE-NATAL VITAMINS (Nutritional/Dietary) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
PRENATAL VITAMIN PREPARATIONS (cont.)		
KPN PRENATAL TABLET	T3	
<i>kpn tablet</i>	T2	PPACA
MARNATAL-F	T4	
MINI PRENATAL	T4	
MTERYTI	T4	
MTERYTI FOLIC 5	T4	
NATACHEW	T4	
NEONATAL COMPLETE	T4	
NEONATAL PLUS	T4	
NEONATAL-DHA	T4	
NESTABS	T4	
NESTABS ABC	T4	
NESTABS DHA	T4	
OB COMPLETE ONE	T4	
OB COMPLETE PETITE	T4	
OB COMPLETE PREMIER	T4	
OB COMPLETE WITH DHA	T4	
OBSTETRIX EC	T4	
OBTREX DHA	T4	
ONE A DAY WOMEN'S PRENATAL DHA	T4	
ONE-A-DAY PRENATAL-1	T4	
<i>pnv 11/iron fum/folic acid/om3</i>	T2	
<i>pnv 119/iron fum/folic acid</i>	T2	
<i>pnv 66/iron/folic/docusate/dha</i>	T2	
<i>pnv 69/iron/folic/docusate/dha</i>	T2	
<i>pnv 80/iron fum/folic/dss/dha</i>	T2	
<i>pnv cmb 52/iron/fa/omega-3/dha</i>	T2	
<i>pnv no.118/iron fumarate/fa</i>	T2	
<i>pnv,calcium 72/iron,carb/folic</i>	T2	
<i>pnv,calcium 72/iron/folic acid</i>	T2	
<i>pnv/iron,carb/docusat/folic ac</i>	T2	
<i>pnv19/iron bg,s,p/folic ac/om3</i>	T2	
<i>pnv81/iron edta,ps/folic/omeg3</i>	T2	
PRENATA	T4	

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

T5 – Preferred Specialty
T6 – Non-Preferred Specialty
PA – Prior Authorization
QL – Quantity Limit

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

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

List of Prescription Medications

PRE-NATAL VITAMINS (Nutritional/Dietary) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
PRENATAL VITAMIN PREPARATIONS (cont.)		
<i>prenatal 105/iron/folic ac/dha</i>	T2	
<i>prenatal 12/iron/folic/dss/om3</i>	T2	
PRENATAL 19 CHEWABLE TABLET	T4	
<i>prenatal 19 chewable tablet</i>	T2	
PRENATAL 19 TABLET	T4	
<i>prenatal 19 tablet</i>	T2	
<i>prenatal 21/iron fu/folic acid</i>	T2	PPACA
<i>prenatal 53/iron/folic ac/omg3</i>	T2	
<i>prenatal 54/iron/folic ac/omg3</i>	T2	
<i>prenatal 93/iron/folate 9/dha</i>	T2	
<i>prenatal caplet</i>	T2	PPACA
<i>prenatal comb no.42/folic acid (Vitamedmd Redichew Rx)</i>	T2	
PRENATAL FORMULA	T3	
PRENATAL FORMULA-DHA (<i>prenatal vit116/iron/folic/dha</i>)	T4	
PRENATAL GUMMIES	T4	
PRENATAL MULTI	T4	
<i>prenatal multi-dha softgel</i>	T2	PPACA
PRENATAL MULTI-DHA SOFTGEL	T3	
PRENATAL MULTI-DHA SOFTGEL	T4	
<i>prenatal multivitamin tablet</i>	T2	PPACA
PRENATAL MULTIVITAMIN TABLET	T4	
PRENATAL MULTIVITAMIN-DHA	T3	
PRENATAL PLUS VITAMIN-MINERAL	T4	
PRENATAL PLUS-DHA	T4	
<i>prenatal tablet</i>	T2	PPACA
PRENATAL TABLET	T4	
<i>prenatal vit 14/iron fum/folic</i>	T2	
<i>prenatal vit 55/iron/folic/om3</i>	T2	
<i>prenatal vit 91/iron/folic/dha</i>	T2	
<i>prenatal vit no.126/iron/folic</i>	T2	PPACA
<i>prenatal vit no.129/iron/folic</i>	T2	PPACA
<i>prenatal vit,cal 73/iron/folic</i>	T2	
<i>prenatal vit,calc76/iron/folic</i>	T2	
<i>prenatal vit,calc78/iron/folic</i>	T2	

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

T5 – Preferred Specialty
 T6 – Non-Preferred Specialty
 PA – Prior Authorization
 QL – Quantity Limit

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

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

List of Prescription Medications

PRE-NATAL VITAMINS (Nutritional/Dietary) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
PRENATAL VITAMIN PREPARATIONS (cont.)		
<i>prenatal vit/iron fum/folic ac</i>	T2	
<i>prenatal vit27,calcium/iron/fa</i>	T2	
<i>prenatal vit86/iron/folic acid</i>	T2	
PRENATAL VITAMIN + DHA	T3	
<i>prenatal vitamin tablet</i>	T2	PPACA
PRENATAL VITAMIN TABLET (<i>prenatal vit no.124/iron/folic</i>)	T4	
<i>prenatal vitamins tablet</i>	T2	PPACA
<i>prenatal vits calc.36/iron/fa</i>	T2	PPACA
<i>prenatal,calc.40/iron/folate 1</i>	T2	
<i>prenatal71/iron/folic acid/dha</i>	T2	
PRENATE DHA	T4	
PRENATE ELITE	T4	
PRENATE ENHANCE	T4	
PRENATE MINI	T4	
PRENATE PIXIE	T4	
PRENATE RESTORE	T4	
PRENATE STAR	T4	
PRIMACARE	T4	
PROVIDA OB	T4	
<i>qc prenatal tablet</i>	T2	PPACA
<i>ra one daily prenatal dha pack</i>	T2	PPACA
<i>ra prenatal tablet</i>	T2	PPACA
R-NATAL OB	T4	
SELECT-OB	T4	
SELECT-OB (<i>prenatal vit128/iron/folic acd</i>)	T4	
SELECT-OB + DHA	T4	
SIMILAC PRENATAL	T4	
<i>sm prenatal vitamins tablet</i>	T2	PPACA
STUART ONE (<i>pnv no.63/iron,carb/folic/dha</i>)	T4	
<i>sv prenatal tablet</i>	T2	PPACA
SV PRENATAL VITAMINS TABLET	T4	
THERANATAL	T4	
THERANATAL COMPLETE	T4	
THERANATAL ONE	T4	

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

T5 – Preferred Specialty
T6 – Non-Preferred Specialty
PA – Prior Authorization
QL – Quantity Limit

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

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

List of Prescription Medications

PRE-NATAL VITAMINS (Nutritional/Dietary) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
PRENATAL VITAMIN PREPARATIONS (cont.)		
THERANATAL OVAVITE	T4	
THERANATAL PLUS	T4	
THRIVITE RX	T4	
TRICARE	T4	
TRICARE PRENATAL DHA ONE	T4	
TRISTART DHA	T4	
ULTRA PRENATAL PLUS DHA	T4	
VITAFOL FE PLUS	T4	
VITAFOL GUMMIES	T4	
VITAFOL NANO	T4	
VITAFOL ULTRA	T4	
VITAFOL-OB	T4	
VITAFOL-OB+DHA	T4	
VITAFOL-ONE	T4	
VITAMEDMD ONE RX	T4	
VITAMEDMD REDICHEW RX (<i>prenatal comb no.42/folic acid</i>)	T4	
VITAPEARL	T4	
VITATRUE	T4	
VP-PNV-DHA	T4	
WOMEN'S PRENATAL PLUS DHA	T3	
PRENATAL VITAMINS WITH LOW OR NO IRON		
CVS PRENATAL GUMMIES	T4	
PRENATAL GUMMIES	T4	
TRINAZ	T4	
PSYCHOTHERAPEUTIC DRUGS (Anxiety/Depression/Bipolar Disorder)⁸		
ALPHA-2 RECEPTOR ANTAGONIST ANTIDEPRESSANTS		
<i>mirtazapine</i>	T1	HD
<i>mirtazapine (Remeron)</i>	T1	HD
REMERON (<i>mirtazapine</i>)	T4	HD
ANTI-ANXIETY - BENZODIAZEPINES		
<i>alprazolam</i>	T2	
<i>alprazolam (Xanax Xr)</i>	T1	
<i>alprazolam (Xanax)</i>	T1	
ATIVAN (<i>lorazepam</i>)	T4	

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

T5 – Preferred Specialty
T6 – Non-Preferred Specialty
PA – Prior Authorization
QL – Quantity Limit

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

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

List of Prescription Medications

PSYCHOTHERAPEUTIC DRUGS (Anxiety/Depression/Bipolar Disorder) ⁸ (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ANTI-ANXIETY - BENZODIAZEPINES (cont.)		
<i>chlordiazepoxide hcl</i>	T2	
<i>clorazepate dipotassium</i>	T2	
<i>diazepam 10 mg tablet (Valium)</i>	T2	
<i>diazepam 2 mg tablet (Valium)</i>	T2	
<i>diazepam 25 mg/5 ml oral conc</i>	T2	
<i>diazepam 5 mg tablet (Valium)</i>	T2	
<i>diazepam 5 mg/5 ml oral soln</i>	T2	
<i>diazepam 5 mg/5 ml solution</i>	T2	
<i>diazepam 5 mg/ml oral conc</i>	T2	
<i>lorazepam</i>	T2	
<i>lorazepam (Ativan)</i>	T1	
<i>oxazepam</i>	T2	
ANTI-ANXIETY DRUGS		
<i>buspirone hcl</i>	T1	
<i>meprobamate</i>	T2	
ANTIDEPRESSANT - POSTPARTUM DEPRESSION (PPD)		
ZURZUVAE	T5	
BIPOLAR DISORDER DRUGS		
EQUETRO	T4	HD
<i>lithium carbonate</i>	T1	HD
<i>lithium carbonate (Lithobid)</i>	T1	HD
LITHOBID (<i>lithium carbonate</i>)	T4	HD
MAOIS -NON-SELECTIVE, IRREVERSIBLE ANTIDEPRESSANTS		
MARPLAN	T4	
NARDIL (<i>phenelzine sulfate</i>)	T4	
PARNATE (<i>tranylcypromine sulfate</i>)	T4	
<i>phenelzine sulfate (Nardil)</i>	T2	
<i>tranylcypromine sulfate (Parnate)</i>	T2	
MONOAMINE OXIDASE (MAO) INHIBITOR ANTIDEPRESSANTS		
EMSAM	T4	
NOREPINEPHRINE AND DOPAMINE REUPTAKE INHIB (NDRIS)		
<i>bupropion hcl</i>	T1	HD
<i>bupropion hcl xl 150 mg tablet (Wellbutrin XI)</i>	T2	
<i>bupropion hcl xl 300 mg tablet (Wellbutrin XI)</i>	T2	

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

T5 – Preferred Specialty
 T6 – Non-Preferred Specialty
 PA – Prior Authorization
 QL – Quantity Limit

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

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

List of Prescription Medications

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

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
SELECTIVE SEROTONIN 5-HT2A INVERSE AGONISTS (SSIA)		
NUPLAZID 10 MG TABLET	T6	PA QL(30 tabs/fill) SP HD
NUPLAZID 34 MG CAPSULE	T6	PA QL(30 caps/fill) SP HD
SELECTIVE SEROTONIN REUPTAKE INHIBITOR (SSRIS)		
<i>citalopram hbr 10 mg/5 ml soln</i>	T2	HD
<i>escitalopram 10 mg tablet (Lexapro)</i>	T1	
<i>escitalopram 20 mg tablet (Lexapro)</i>	T1	
<i>escitalopram 5 mg tablet (Lexapro)</i>	T1	
<i>escitalopram oxalate 5 mg/5 ml</i>	T1	ST HD
<i>fluoxetine 20 mg/5 ml solution</i>	T2	HD
<i>fluoxetine hcl</i>	T2	ST QL(4 caps/fill) HD
<i>fluoxetine hcl 10 mg tablet</i>	T2	ST QL(30 tabs/fill) HD
<i>fluoxetine hcl 20 mg capsule (Prozac)</i>	T1	HD
<i>fluoxetine hcl 20 mg, 60 mg tablet</i>	T2	ST HD
<i>fluvoxamine maleate</i>	T2	ST QL(60 caps/fill) HD
<i>fluvoxamine maleate 100 mg tab</i>	T2	QL(90 tabs/fill) HD
<i>fluvoxamine maleate 25 mg tab</i>	T2	QL(30 tabs/fill) HD
<i>fluvoxamine maleate 50 mg tab</i>	T2	QL(60 tabs/fill) HD
<i>paroxetine hcl (Paxil Cr)</i>	T2	ST QL(60 tabs/fill) HD
<i>paroxetine hcl 10 mg tablet (Paxil)</i>	T1	QL(30 tabs/fill) HD
<i>paroxetine hcl 10 mg/5 ml susp (Paxil)</i>	T2	ST HD
<i>paroxetine hcl 20 mg tablet (Paxil)</i>	T1	QL(60 tabs/fill) HD
<i>paroxetine hcl 30 mg tablet (Paxil)</i>	T1	QL(60 tabs/fill) HD
<i>paroxetine hcl 40 mg tablet (Paxil)</i>	T1	QL(30 tabs/fill) HD
PAXIL 10 MG TABLET (<i>paroxetine hcl</i>)	T4	ST QL(30 tabs/fill) HD
PAXIL 10 MG/5 ML SUSPENSION (<i>paroxetine hcl</i>)	T4	ST HD
PAXIL 20 MG TABLET (<i>paroxetine hcl</i>)	T4	ST QL(60 tabs/fill) HD
PAXIL 30 MG TABLET (<i>paroxetine hcl</i>)	T4	ST QL(60 tabs/fill) HD
PAXIL 40 MG TABLET (<i>paroxetine hcl</i>)	T4	ST QL(30 tabs/fill) HD
PAXIL CR (<i>paroxetine hcl</i>)	T4	ST QL(60 tabs/fill) HD
<i>sertraline 20 mg/ml oral conc (Zoloft)</i>	T2	HD
<i>sertraline hcl 25 mg tablet (Zoloft)</i>	T1	QL(45 tabs/fill) HD
SEROTONIN-2 ANTAGONIST/REUPTAKE INHIBITORS (SARIS)		
<i>nefazodone hcl</i>	T2	HD
<i>trazodone hcl</i>	T1	HD

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

T5 – Preferred Specialty
 T6 – Non-Preferred Specialty
 PA – Prior Authorization
 QL – Quantity Limit

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

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

List of Prescription Medications

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

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
SEROTONIN-NOREPINEPHRINE REUPTAKE-INHIB (SNRIS)		
DESVENLAFAXINE ER	T4	ST QL (30 tabs/fill) HD
<i>duloxetine hcl dr 20 mg cap</i> (Cymbalta)	T1	QL(60 caps/fill) HD
<i>duloxetine hcl dr 30 mg cap</i> (Cymbalta)	T1	QL(30 caps/fill) HD
<i>duloxetine hcl dr 40 mg cap</i>	T1	ST QL (30 caps/fill) HD
<i>duloxetine hcl dr 60 mg cap</i> (Cymbalta)	T1	QL(60 caps/fill) HD
FETZIMA 20-40 MG TITRATION PAK	T3	ST QL (28 caps/fill) HD
FETZIMA ER 120 MG CAPSULE	T3	ST QL (30 caps/fill) HD
FETZIMA ER 20 MG CAPSULE	T3	ST QL (30 caps/fill) HD
FETZIMA ER 40 MG CAPSULE	T3	ST QL (30 caps/fill) HD
FETZIMA ER 80 MG CAPSULE	T3	ST QL (30 caps/fill) HD
<i>venlafaxine hcl</i>	T1	QL(90 tabs/fill) HD
<i>venlafaxine hcl er 150 mg tab</i>	T2	ST QL (30 tabs/fill) HD
<i>venlafaxine hcl er 225 mg tab</i>	T2	ST QL (30 tabs/fill) HD
<i>venlafaxine hcl er 37.5 mg tab</i>	T2	ST QL (30 tabs/fill) HD
<i>venlafaxine hcl er 75 mg tab</i>	T2	ST QL (30 tabs/fill) HD
<i>venlafaxine hcl er 150 mg cap</i> (Effexor Xr)	T1	
<i>venlafaxine hcl er 37.5 mg cap</i> (Effexor Xr)	T1	
<i>venlafaxine hcl er 75 mg cap</i> (Effexor Xr)	T1	
SSRI, SEROTONIN RECEPTOR MODULATOR ANTIDEPRESSANTS		
TRINTELLIX 10 MG TABLET	T4	ST QL (30 tabs/fill) HD
TRICYCLIC ANTIDEPRESSANT-BENZODIAZEPINE COMBINATNS		
<i>amitriptyline/chlordiazepoxide</i>	T2	HD
<i>perphenazine/amitriptyline hcl</i>	T2	HD
TRICYCLIC ANTIDEPRESSANTS, REL.NON-SEL.REUPT-INHIB		
<i>amitriptyline hcl</i>	T1	HD
<i>amoxapine</i>	T2	HD
<i>ANAFRANIL</i> (clomipramine hcl)	T4	HD
<i>clomipramine hcl</i> (Anafranil)	T2	HD
<i>desipramine hcl</i>	T2	HD
<i>desipramine hcl</i> (Norpramin)	T2	HD
<i>doxepin 10 mg, 25 mg, 50 mg capsule</i>	T2	HD
<i>doxepin 10 mg/ml oral conc</i>	T2	HD
<i>doxepin 100 mg capsule</i>	T2	HD
<i>doxepin 150 mg capsule</i>	T2	HD

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

T5 – Preferred Specialty
T6 – Non-Preferred Specialty
PA – Prior Authorization
QL – Quantity Limit

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

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

List of Prescription Medications

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

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
TRICYCLIC ANTIDEPRESSANTS, REL.NON-SEL.REUPT-INHIB (cont.)		
<i>doxepin 75 mg capsule</i>	T2	HD
<i>imipramine hcl (Tofranil)</i>	T1	HD
<i>imipramine pamoate</i>	T2	HD
<i>maprotiline hcl</i>	T2	HD
NORPRAMIN (<i>desipramine hcl</i>)	T4	HD
<i>nortriptyline hcl</i>	T2	HD
<i>nortriptyline hcl (Pamelor)</i>	T1	HD
PAMELOR (<i>nortriptyline hcl</i>)	T4	HD
<i>protriptyline hcl</i>	T2	HD
SURMONTIL (<i>trimipramine maleate</i>)	T4	HD
TOFRANIL (<i>imipramine hcl</i>)	T4	HD
<i>trimipramine maleate (Surmontil)</i>	T2	HD

PSYCHOTHERAPEUTIC DRUGS (Attention Deficit Hyperactivity Disorder)⁸

ADRENERGICS, AROMATIC, NON-CATECHOLAMINE

<i>lisdexamfetamine 10 mg capsule (Vyvanse)</i>	T2	
<i>lisdexamfetamine 10 mg tb chew</i>	T2	ST
<i>lisdexamfetamine 20 mg capsule (Vyvanse)</i>	T2	
<i>lisdexamfetamine 20 mg tb chew</i>	T2	ST
<i>lisdexamfetamine 30 mg capsule (Vyvanse)</i>	T2	
<i>lisdexamfetamine 30 mg tb chew</i>	T2	ST
<i>lisdexamfetamine 40 mg capsule (Vyvanse)</i>	T2	
<i>lisdexamfetamine 40 mg tb chew</i>	T2	ST
<i>lisdexamfetamine 50 mg capsule (Vyvanse)</i>	T2	
<i>lisdexamfetamine 50 mg tb chew</i>	T2	ST
<i>lisdexamfetamine 60 mg capsule (Vyvanse)</i>	T2	
<i>lisdexamfetamine 60 mg tb chew</i>	T2	ST
<i>lisdexamfetamine 70 mg capsule (Vyvanse)</i>	T2	
VYVANSE	T3	ST

TX FOR ADHD - SELECTIVE ALPHA-2 RECEPTOR AGONIST

<i>clonidine hcl er 0.1 mg tablet (Kapvay)</i>	T2	
<i>guanfacine hcl (Intuniv)</i>	T2	
KAPVAY (<i>clonidine hcl</i>)	T4	ST

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

T5 – Preferred Specialty
T6 – Non-Preferred Specialty
PA – Prior Authorization
QL – Quantity Limit

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

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

List of Prescription Medications

PSYCHOTHERAPEUTIC DRUGS (Attention Deficit Hyperactivity Disorder) ⁸ (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
TX FOR ATTENTION DEFICIT-HYPERACT (ADHD)/NARCOLEPSY		
APTENSIO XR (<i>methylphenidate hcl</i>)	T4	ST
AZSTARYS	T4	ST
COTEMPLA XR-ODT	T4	ST
DAYTRANA (<i>methylphenidate</i>)	T4	ST
<i>dexmethylphenidate hcl</i> (Focalin Xr)	T2	
<i>dexmethylphenidate hcl</i> (Focalin)	T1	
JORNAY PM	T4	ST
METHYLIN (<i>methylphenidate hcl</i>)	T4	
<i>methylphenidate</i>	T2	ST
<i>methylphenidate er 10 mg cap</i> (Aptensio Xr)	T2	ST
<i>methylphenidate er 10 mg tab</i>	T2	
<i>methylphenidate er 15 mg cap</i> (Aptensio Xr)	T2	ST
<i>methylphenidate er 18 mg tab</i> (Concerta)	T2	
<i>methylphenidate er 18 mg tab</i> (Relexxii)	T2	
<i>methylphenidate er 20 mg cap</i> (Aptensio Xr)	T2	ST
<i>methylphenidate er 20 mg tab</i>	T2	
<i>methylphenidate er 27 mg tab</i> (Concerta)	T2	
<i>methylphenidate er 27 mg tab</i> (Relexxii)	T2	
<i>methylphenidate er 30 mg cap</i> (Aptensio Xr)	T2	ST
<i>methylphenidate er 36 mg tab</i> (Concerta)	T2	
<i>methylphenidate er 36 mg tab</i> (Relexxii)	T2	
<i>methylphenidate er 40 mg cap</i> (Aptensio Xr)	T2	ST
<i>methylphenidate er 50 mg cap</i> (Aptensio Xr)	T2	ST
<i>methylphenidate er 54 mg tab</i> (Concerta)	T2	
<i>methylphenidate er 54 mg tab</i> (Relexxii)	T2	
<i>methylphenidate er 60 mg cap</i> (Aptensio Xr)	T2	ST
METHYLPHENIDATE ER 72 MG TAB	T4	ST
<i>methylphenidate hcl</i>	T2	
<i>methylphenidate hcl</i> (Metadate Cd)	T2	
<i>methylphenidate hcl</i> (Methylin)	T2	
<i>methylphenidate hcl</i> (Ritalin La)	T2	
<i>methylphenidate hcl</i> (Ritalin)	T2	
QELBREE ER	T4	ST
RELEXXII ER 72 MG TABLET	T4	ST

T1 – Preferred Generics

T2 – Non-Preferred Generics

T3 – Preferred Brands

T4 – Non-Preferred Brands

T5 – Preferred Specialty

T6 – Non-Preferred Specialty

PA – Prior Authorization

QL – Quantity Limit

ST – Step Therapy

AGE – Age Requirement

SP – Specialty Medication

HD – May require home delivery pharmacy

PPACA – No Cost-Share Preventive Medication

CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

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

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
------------------------	-----------	----------------------------------

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

<i>atomoxetine hcl</i> (Strattera)	T2	HD
------------------------------------	----	----

PSYCHOTHERAPEUTIC DRUGS (Miscellaneous)

HYPOACTIVE SEXUAL DESIRE DISORDER (HSDD) TX AGENTS

ADDYI	T4	PA
VYLEESI	T6	PA QL(8 auto-injs/fill) SP

PSYCHOTHERAPEUTIC DRUGS (Schizophrenia/Anti-Psychotics)⁸

ANTIPSYCH, DOPAMINE ANTAG., DIPHENYLBUTYLPIPERIDINES

<i>pimozide</i>	T2	
-----------------	----	--

ANTIPSYCHOTIC, ATYPICAL, DOPAMINE, SEROTONIN ANTAGNST

<i>asenapine maleate</i> (Saphris)	T2	QL(60 tabs/fill)
CAPLYTA	T4	QL(30 caps/fill)
<i>clozapine</i>	T2	
<i>clozapine</i> (Clozaril)	T2	
CLOZARIL (<i>clozapine</i>)	T4	
FANAPT 1 MG TABLET	T4	QL(60 tabs/fill)
FANAPT 10 MG TABLET	T4	QL(60 tabs/fill)
FANAPT 12 MG TABLET	T4	QL(60 tabs/fill)
FANAPT 2 MG TABLET	T4	QL(60 tabs/fill)
FANAPT 4 MG TABLET	T4	QL(60 tabs/fill)
FANAPT 6 MG TABLET	T4	QL(60 tabs/fill)
FANAPT 8 MG TABLET	T4	QL(60 tabs/fill)
FANAPT TITRATION PACK	T4	QL(8 tabs/fill)
GEODON (<i>ziprasidone hcl</i>)	T4	QL(60 caps/fill)
INVEGA ER 3 MG TABLET (<i>paliperidone</i>)	T4	QL(30 tabs/fill)
INVEGA ER 6 MG TABLET (<i>paliperidone</i>)	T4	QL(60 tabs/fill)
INVEGA ER 9 MG TABLET (<i>paliperidone</i>)	T4	QL(30 tabs/fill)
<i>olanzapine</i> (Zyprexa Zydis)	T2	QL(30 tabs/fill)
<i>quetiapine er 200 mg tablet</i> (Seroquel Xr)	T2	QL(30 tabs/fill)
<i>quetiapine er 300 mg tablet</i> (Seroquel Xr)	T2	QL(60 tabs/fill)
<i>quetiapine er 400 mg tablet</i> (Seroquel Xr)	T2	QL(60 tabs/fill)
<i>quetiapine er 50 mg tablet</i> (Seroquel Xr)	T2	QL(60 tabs/fill)
<i>quetiapine fumarate 100 mg tab</i> (Seroquel)	T1	
<i>quetiapine fumarate 200 mg tab</i> (Seroquel)	T1	QL(90 tabs/fill)

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

T5 – Preferred Specialty
 T6 – Non-Preferred Specialty
 PA – Prior Authorization
 QL – Quantity Limit

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

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

List of Prescription Medications

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

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ANTIPSYCHOTIC, ATYPICAL, DOPAMINE, SEROTONIN ANTAGNIST (cont.)		
<i>quetiapine fumarate 25 mg tab (Seroquel)</i>	T1	
<i>quetiapine fumarate 300 mg tab (Seroquel)</i>	T1	QL(60 tabs/fill)
<i>quetiapine fumarate 400 mg tab (Seroquel)</i>	T1	
<i>quetiapine fumarate 50 mg tab (Seroquel)</i>	T1	
RISPERDAL 0.5 MG TABLET (<i>risperidone</i>)	T4	QL(60 tabs/fill)
RISPERDAL 1 MG TABLET (<i>risperidone</i>)	T4	QL(60 tabs/fill)
RISPERDAL 1 MG/ML SOLUTION (<i>risperidone</i>)	T4	
RISPERDAL 2 MG TABLET (<i>risperidone</i>)	T4	QL(60 tabs/fill)
RISPERDAL 3 MG TABLET (<i>risperidone</i>)	T4	QL(60 tabs/fill)
RISPERDAL 4 MG TABLET (<i>risperidone</i>)	T4	QL(60 tabs/fill)
<i>risperidone</i>	T2	QL(60 tabs/fill)
<i>risperidone 0.5 mg tablet (Risperdal)</i>	T1	QL(60 tabs/fill)
<i>risperidone 1 mg tablet (Risperdal)</i>	T1	QL(60 tabs/fill)
<i>risperidone 1 mg/ml solution (Risperdal)</i>	T2	
<i>risperidone 2 mg tablet (Risperdal)</i>	T1	QL(60 tabs/fill)
<i>risperidone 3 mg tablet (Risperdal)</i>	T1	QL(60 tabs/fill)
<i>risperidone 4 mg tablet (Risperdal)</i>	T1	QL(60 tabs/fill)
SECUADO	T4	QL(30 patches/fill)
VERSACLOZ	T4	
<i>ziprasidone hcl (Geodon)</i>	T2	QL(60 caps/fill)
ZYPREXA (<i>olanzapine</i>)	T4	QL(30 tabs/fill)
ZYPREXA ZYDIS (<i>olanzapine</i>)	T4	QL(30 tabs/fill)
ANTIPSYCHOTIC-ATYPICAL, D3/D2 PARTIAL AG-5HT MIXED		
VRAYLAR 1.5 MG CAPSULE	T4	QL(30 caps/fill)
VRAYLAR 1.5 MG-3 MG PACK	T4	QL(7 caps/fill)
VRAYLAR 3 MG CAPSULE	T4	QL(30 caps/fill)
VRAYLAR 4.5 MG CAPSULE	T4	QL(30 caps/fill)
VRAYLAR 6 MG CAPSULE	T4	QL(30 caps/fill)
ANTIPSYCHOTICS, ATYP, D2 PARTIAL AGONIST/5HT MIXED		
ABILIFY ASIMTUFI	T4	
ABILIFY MYCITE	T4	QL(30 tabs/fill)
<i>aripiprazole</i>	T2	QL(60 tabs/fill)
<i>aripiprazole 1 mg/ml solution</i>	T2	
<i>aripiprazole 2 mg tablet (Abilify)</i>	T1	QL(30 tabs/fill)

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

T5 – Preferred Specialty
T6 – Non-Preferred Specialty
PA – Prior Authorization
QL – Quantity Limit

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

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

List of Prescription Medications

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

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
------------------------	-----------	----------------------------------

ANTIPSYCHOTICS, ATYP, D2 PARTIAL AGONIST/5HT MIXED (cont.)

<i>aripiprazole 10 mg tablet (Abilify)</i>	T1	QL(30 tabs/fill)
<i>aripiprazole 15 mg tablet (Abilify)</i>	T1	
<i>aripiprazole 20 mg tablet (Abilify)</i>	T1	QL(30 tabs/fill)
<i>aripiprazole 30 mg tablet (Abilify)</i>	T1	QL(30 tabs/fill)
REXULTI	T4	QL(30 tabs/fill)

ANTIPSYCHOTICS, DOPAMINE AND SEROTONIN ANTAGONISTS

<i>loxapine succinate</i>	T2	
---------------------------	----	--

ANTIPSYCHOTICS, DOPAMINE ANTAGONISTS, THIOXANTHENES

<i>thiothixene</i>	T2	
--------------------	----	--

ANTIPSYCHOTICS, DOPAMINE ANTAGONISTS, BUTYROPHENONES

<i>haloperidol</i>	T1	
<i>haloperidol lactate</i>	T2	

ANTIPSYCHOTICS, DOPAMINE ANTAGONIST, DIHYDROINDOLONES

<i>molindone hcl</i>	T2	
----------------------	----	--

ANTIPSYCHOTICS, PHENOTHIAZINES

<i>chlorpromazine hcl</i>	T2	
<i>fluphenazine hcl</i>	T2	
<i>perphenazine</i>	T2	
<i>thioridazine hcl</i>	T2	
<i>trifluoperazine hcl</i>	T2	

SSRI-ANTIPSYCH, ATYPICAL, DOPAMINE, SEROTONIN ANTAG

<i>olanzapine/fluoxetine hcl</i>	T2	
<i>olanzapine/fluoxetine hcl (Symbyax)</i>	T2	
SYMBYAX (<i>olanzapine/fluoxetine hcl</i>)	T4	

PSYCHOTHERAPEUTIC DRUGS (Seizure Disorders)

NEUROACTIVE STEROID GABA-A RECEPTOR MODULATOR

ZTALMY	T5	PA SP
--------	----	-------

PSYCHOTHERAPEUTIC DRUGS (Sleep Disorders/Sedatives)

NARCOLEPSY AND SLEEP DISORDER THERAPY AGENTS

<i>armodafinil (Nuvigil)</i>	T2	PA QL(30 tabs/fill)
<i>modafinil 100 mg tablet (Provigil)</i>	T2	PA QL(30 tabs/fill)
SUNOSI	T3	PA QL(30 tabs/fill)

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

T5 – Preferred Specialty
T6 – Non-Preferred Specialty
PA – Prior Authorization
QL – Quantity Limit

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

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

List of Prescription Medications

SEDATIVE/HYPNOTICS (Sleep Disorders/Sedatives)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ANTI-NARCOLEPSY, ANTI-CATAPLEXY, SEDATIVE-TYPE AGENT		
LUMRYZ ER	T6	PA QL (30 packets/30 days) SP HD
SODIUM OXYBATE	T5	PA QL (540ml/30 days) SP HD
XYREM	T5	PA QL(540 mls/fill) SP HD
XYWAV	T5	PA QL(540 mls/fill) SP HD
BARBITURATES		
<i>phenobarbital</i>	T2	
<i>secobarbital sodium</i>	T2	QL(30 caps/fill)
HYPNOTICS, MELATONIN MT1/MT2 RECEPTOR AGONISTS		
HETLIOZ	T6	PA QL(30 caps/fill) SP HD
HETLIOZ LQ	T6	PA QL(158 mls/fill) SP HD
<i>ramelteon (Rozerem)</i>	T2	QL(30 tabs/fill)
SEDATIVE-HYPNOTICS - BENZODIAZEPINES		
estazolam	T2	
<i>flurazepam hcl</i>	T2	
HALCION (<i>triazolam</i>)	T4	
<i>midazolam hcl 2 mg/ml syrup</i>	T2	
MIDAZOLAM HCL 5 MG/2.5 ML SYRP	T4	
MIDAZOLAM HCL 10 MG/5 ML SYRUP	T4	
RESTORIL (<i>temazepam</i>)	T4	
<i>temazepam (Restoril)</i>	T2	
<i>triazolam</i>	T2	
<i>triazolam (Halcion)</i>	T2	
SEDATIVE-HYPNOTICS, NON-BARBITURATE		
BELSOMRA	T4	ST QL (30 tabs/fill)
DAYVIGO	T4	ST
<i>doxepin hcl 3 mg tablet (Silenor)</i>	T2	ST QL(30 tabs/fill)
<i>doxepin hcl 6 mg tablet (Silenor)</i>	T2	ST QL (30 tabs/fill)
EDLUAR	T4	ST QL(30 tabs/fill)
<i>eszopiclone (Lunesta)</i>	T2	QL(30 tabs/fill)
IGALMI	T4	
KETAMINE HCL	T4	
MKO (MIDAZOLAM-KETAMINE-ONDAN)	T4	
QUVIVIQ	T4	ST
SILENOR (<i>doxepin hcl</i>)	T4	ST QL (30 tabs/fill)

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

T5 – Preferred Specialty
 T6 – Non-Preferred Specialty
 PA – Prior Authorization
 QL – Quantity Limit

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

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

List of Prescription Medications

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

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
SEDATIVE-HYPNOTICS, NON-BARBITURATE (cont.)		
<i>zaleplon 5 mg capsule</i>	T2	QL(30 caps/fill)
<i>zaleplon 10 mg capsule</i>	T2	QL(60 caps/fill)
<i>zolpidem tartrate</i>	T2	QL(30 tabs/fill)
<i>zolpidem tartrate (Ambien Cr)</i>	T2	QL(30 tabs/fill)
<i>zolpidem tartrate (Ambien)</i>	T2	QL(30 tabs/fill)

SKIN PREPS (Miscellaneous)

IRRIGANTS

<i>acetic acid</i>	T2	
<i>neomycin sulf/polymyxin b sulf</i>	T2	
PHYSIOLYTE (<i>physiological irrig soln no.1</i>)	T4	
PHYSIOSOL (<i>physiological irrig soln no.1</i>)	T4	
<i>ringer's solution</i>	T2	
<i>ringer's solution,lactated</i>	T2	
<i>sod,pot chlor/mag/sod,pot phos</i>	T2	
<i>sodium chloride irrig solution</i>	T2	
SORBITOL	T4	
SORBITOL-MANNITOL	T4	
water for irrigation,sterile	T2	

OXIDIZING AGENTS

<i>hydrogen peroxide</i>	T2	
--------------------------	----	--

PRESERVATIVES

<i>formaldehyde</i>	T2	
---------------------	----	--

SKIN PREPS (Pain Relief And Inflammatory Disease)

ANTIPSORIATIC AGENTS, SYSTEMIC

<i>acitretin</i>	T2	
<i>methoxsalen</i>	T2	
SKYRIZI	T5	PA QL(150 mg/84 days) SP HD
SKYRIZI (2 SYRINGES) KIT	T5	PA QL(150 mg/84 days) SP HD
SKYRIZI PEN	T5	PA QL(150 mg/84 days) SP HD
TALTZ AUTOINJECTOR	T5	PA QL(1 ml/28 days) SP HD
TALTZ AUTOINJECTOR (2 PACK)	T5	PA QL(1 ml/28 days) SP HD
TALTZ AUTOINJECTOR (3 PACK)	T5	PA QL(1 ml/28 days) SP HD
TALTZ SYRINGE	T5	PA QL(1 ml/28 days) SP HD

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

T5 – Preferred Specialty
 T6 – Non-Preferred Specialty
 PA – Prior Authorization
 QL – Quantity Limit

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

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

List of Prescription Medications

SKIN PREPS (Pain Relief And Inflammatory Disease) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ANTIPSORIATIC AGENTS, SYSTEMIC (cont.)		
TREMFYA	T5	PA QL SP HD
TOPICAL ANTI-INFLAMMATORY, NSAIDS		
<i>diclofenac 2% solution pump (Pennsaid)</i>	T2	
<i>diclofenac sodium 1% gel</i>	T2	ST QL (500 gms/28 days) HD
FLECTOR	T3	ST QL (60 patches/fill) HD
LICART	T3	ST QL (30 patches/fill) HD
SKIN PREPS (Skin Conditions)		
ACNE AGENTS, SYSTEMIC		
ABSORICA (isotretinoin)	T4	ST
isotretinoin (Absorica)	T2	
ACNE AGENTS, TOPICAL		
ACZONE (<i>dapsone</i>)	T4	ST
<i>adapalene/benzoyl peroxide</i>	T2	
<i>adapalene/benzoyl peroxide (Epiduo Forte)</i>	T2	
AZELEX	T4	ST
<i>clindamycin phos/benzoyl perox</i>	T2	
<i>clindamycin phos/benzoyl perox (Acanya)</i>	T2	
<i>clindamycin/tretinoin (Veltin)</i>	T2	
<i>clindamycin/tretinoin (Ziana)</i>	T2	PA
<i>dapsone (Aczone)</i>	T2	
EPIDUO FORTE	T4	ST
EPIDUO FORTE (<i>adapalene/benzoyl peroxide</i>)	T4	ST
KLARON (<i>sulfacetamide sodium</i>)	T4	ST
NEUAC 1.2-5% KIT	T4	ST
<i>neuac gel</i>	T2	
ONEXTON (<i>clindamycin phos/benzoyl perox</i>)	T4	ST
<i>sulfacetamide sodium (Klaron)</i>	T2	
ANTIPRURITICS, TOPICAL		
<i>doxepin 5% cream (Zonalon)</i>	T2	ST QL (90 gms/30 days)
<i>doxepin hcl (Zonalon)</i>	T2	ST QL (90 gms/30 days)
ZONALON	T4	ST QL (90 gms/30 days)
ZONALON (<i>doxepin hcl</i>)	T4	ST QL (90 gms/30 days)
ANTIPSORIATICS AGENTS		
<i>calcipotriene 0.005% cream (Dovonex)</i>	T2	QL (120 gms/30 days)

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

T5 – Preferred Specialty
 T6 – Non-Preferred Specialty
 PA – Prior Authorization
 QL – Quantity Limit

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

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

List of Prescription Medications

SKIN PREPS (Skin Conditions) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ANTIPSORIATICS AGENTS (cont.)		
<i>calcipotriene 0.005% ointment</i>	T2	QL(120 gms/30 days)
<i>calcipotriene 0.005% solution</i>	T2	QL(120 mls/30 days)
<i>calcitriol 3 mcg/g ointment (Vectical)</i>	T2	
DOVONEX (<i>calcipotriene</i>)	T4	ST QL(120 gms/30 days)
DUOBRII	T4	ST QL(200 gms/30 days)
<i>tazarotene 0.05% gel (Tazorac)</i>	T2	PA
<i>tazarotene 0.1% cream (Tazorac)</i>	T2	PA
<i>tazarotene 0.1% gel (Tazorac)</i>	T2	PA
TWYNEO	T4	PA ST
VTAMA	T4	PA ST QL (1 tube/28 days)
VECTICAL (<i>calcitriol</i>)	T4	
ZIANA (<i>clindamycin/tretinoin</i>)	T4	PA ST
ZORYVE	T4	PA ST QL(60 gms/28 days)
ANTISEBORRHEIC AGENTS		
ESKATA	T4	
OVACE (<i>sulfacetamide sodium</i>)	T4	
OVACE PLUS	T4	
OVACE PLUS WASH	T4	
PLEXION NS	T4	
<i>selenium sulfide</i>	T2	
SELRX	T4	
<i>sod sulfacetam 10% clnsng gel</i>	T2	
<i>sod sulfacetamide 10% shampoo</i>	T2	
<i>sod sulfacetamide 9.8% shampoo</i>	T2	
SODIUM SULFACETAMIDE 10% WASH	T4	
<i>sodium sulfacetamide 10% wash (Ovace)</i>	T2	
TERSI FOAM	T4	
ANTISEPTICS,GENERAL		
ADVOCATE ALCOHOL 70% PREP PADS	T3	
ALCOHOL 70% PREP PADS	T3	
<i>alcohol 70% swabs</i>	T2	
ALCOHOL 70% WIPES	T3	
<i>alcohol antiseptic pads</i>	T2	
<i>alcohol prep pads</i>	T2	

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

T5 – Preferred Specialty
T6 – Non-Preferred Specialty
PA – Prior Authorization
QL – Quantity Limit

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

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

List of Prescription Medications

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

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

T5 – Preferred Specialty
T6 – Non-Preferred Specialty
PA – Prior Authorization
QL – Quantity Limit

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

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

List of Prescription Medications

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

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

T5 – Preferred Specialty
 T6 – Non-Preferred Specialty
 PA – Prior Authorization
 QL – Quantity Limit

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

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

List of Prescription Medications

SKIN PREPS (Skin Conditions) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ROSACEA AGENTS, TOPICAL (cont.)		
<i>metronidazole</i>	T2	
<i>metronidazole</i> (Metrocream)	T2	
<i>metronidazole</i> (Metrogel)	T2	
MIRVASO	T3	PA
RHOFADE	T4	PA
<i>rosadan 0.75% cream</i> (Metrocream)	T2	
ROSADAN 0.75% CREAM KIT	T4	ST
<i>rosadan 0.75% gel</i>	T2	
ROSADAN 0.75% GEL KIT	T4	ST
SOOLANTRA (<i>ivermectin</i>)	T4	ST QL (60 gms/30 days)
TISSUE/WOUND ADHESIVES		
ARTISS	T4	
SURGISEAL STYLUS	T4	
SURGISEAL TEARDROP	T4	
SURGISEAL TWIST	T4	
TISSEEL VHSD	T4	
TOP. ANTI-INFLAM., PHOSPHODIESTERASE-4 (PDE4) INHIB		
EUCRISA	T3	ST QL (120 gms/30 days)
ZORYVE	T4	
TOPICAL ACNE AGENT,RETINOIC ACID RECEPTOR AGONIST		
AKLIEF	T4	PA ST
ARAZLO	T4	PA
TOPICAL AGENTS, MISCELLANEOUS		
MEDIHONEY	T4	
<i>trichloroacetic acid</i>	T2	
TRICHLOROACETIC ACID 100% (<i>trichloroacetic acid</i>)	T4	
TRICHLOROACETIC ACID 20% (<i>trichloroacetic acid</i>)	T3	
TRICHLOROACETIC ACID 25%	T4	
TRICHLOROACETIC ACID 30%	T3	
TRICHLOROACETIC ACID 35%	T3	
TRICHLOROACETIC ACID 40%	T3	
TRICHLOROACETIC ACID 50%	T3	
TRICHLOROACETIC ACID 75%	T4	
TRICHLOROACETIC ACID 80%	T3	

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

T5 – Preferred Specialty
T6 – Non-Preferred Specialty
PA – Prior Authorization
QL – Quantity Limit

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

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

List of Prescription Medications

SKIN PREPS (Skin Conditions) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
TOPICAL AGENTS, MISCELLANEOUS (cont.)		
TRICHLOROACETIC ACID 85%	T3	
TRICHLOROACETIC ACID 90%	T3	
TOPICAL ANTIBIOTIC PLEUROMUTILIN DERIVATIVES		
ALTABAX	T4	ST QL (30 gms/fill)
TOPICAL ANTI-INFLAMMATORY STEROIDAL		
ALA-SCALP (<i>hydrocortisone</i>)	T4	ST
<i>alclometasone dipropionate</i>	T2	
<i>amcinonide</i>	T2	ST
<i>betamethasone dipropionate</i>	T2	
<i>betamethasone va 0.1% cream</i>	T2	
<i>betamethasone va 0.1% lotion</i>	T2	
<i>betamethasone valer 0.1% ointm</i>	T2	
<i>betamethasone valer 0.12% foam</i>	T2	ST
<i>betamethasone/propylene glyc</i>	T2	
betamethasone/propylene glyc (Diprolene)	T2	
BRYHALI	T4	ST
CAPEX SHAMPOO	T4	ST
<i>clobetasol 0.05% cream (Temovate)</i>	T2	QL(120 gms/30 days)
<i>clobetasol 0.05% gel</i>	T2	QL(120 gms/30 days)
<i>clobetasol 0.05% ointment (Temovate)</i>	T2	QL(120 gms/30 days)
<i>clobetasol 0.05% shampoo (Clobex)</i>	T2	ST QL(236 mls/30 days)
<i>clobetasol 0.05% solution</i>	T2	QL(100 mls/30 days)
<i>clobetasol 0.05% topical lotn</i>	T2	ST QL(118 mls/30 days)
<i>clobetasol emollient 0.05% crm</i>	T2	QL(120 gms/30 days)
<i>clobetasol emollnt 0.05% foam</i>	T2	ST QL(100 gms/30 days)
<i>clobetasol prop 0.05% foam (Olux)</i>	T2	ST QL(100 gms/30 days)
<i>clobetasol prop 0.05% spray (Clobex)</i>	T2	ST QL(125 mls/30 days)
<i>clobetasol propionate/emoll</i>	T2	ST QL(100 gms/30 days)
CLOBEX 0.05% SHAMPOO (<i>clobetasol propionate</i>)	T4	ST QL(236 mls/30 days)
CLOBEX 0.05% SPRAY (<i>clobetasol propionate</i>)	T4	ST QL(125 mls/30 days)
<i>clocortolone pivalate 0.1% crm</i>	T2	
CLODAN 0.05% KIT	T4	ST QL(2 kits/28 days)
<i>clodan 0.05% shampoo (Clobex)</i>	T2	ST QL(236 mls/30 days)
CLODERM	T4	ST

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

T5 – Preferred Specialty
 T6 – Non-Preferred Specialty
 PA – Prior Authorization
 QL – Quantity Limit

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

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

List of Prescription Medications

SKIN PREPS (Skin Conditions) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
TOPICAL ANTI-INFLAMMATORY STEROIDAL (cont.)		
CLODERM (<i>clocortolone pivalate</i>)	T4	ST
CORDRAN 0.025% CREAM	T4	ST QL(120 gms/30 days)
CORDRAN 0.05% CREAM (<i>flurandrenolide</i>)	T4	ST QL(120 gms/30 days)
CORDRAN 0.05% LOTION (<i>flurandrenolide</i>)	T4	ST QL(120 mls/30 days)
CORDRAN 0.05% OINTMENT (<i>flurandrenolide</i>)	T4	ST QL(120 gms/30 days)
CORDRAN 4 MCG/SQ CM TAPE LARGE	T4	ST
CUTIVATE (<i>fluticasone propionate</i>)	T4	ST
DERMA-SMOOTHIE-FS (<i>fluocinolone acetonide</i>)	T4	ST
DERMA-SMOOTHIE-FS (<i>fluocinolone/shower cap</i>)	T4	ST
DERMASORB HC	T4	ST
DERMASORB TA	T4	ST
DERMATOP (<i>prednicarbate</i>)	T4	ST
DESONATE (<i>desonide</i>)	T4	ST
<i>desonide</i> (Desonate)	T2	ST
<i>desonide 0.05% cream</i> (Tridesilon)	T2	
<i>desonide 0.05% gel</i> (Desonate)	T2	ST
<i>desonide 0.05% lotion</i>	T2	ST
<i>desonide 0.05% ointment</i>	T2	
<i>desoximetasone</i> (Topicort)	T2	ST
<i>diflorasone diacet/emollient</i>	T2	ST
<i>diflorasone diacetate</i>	T2	ST QL(120 gms/30 days)
DIPROLENE (<i>betamethasone/propylene glyc</i>)	T4	ST
<i>fluocinolone acetonide</i>	T2	
<i>fluocinolone acetonide</i> (Derma-Smoothie-Fs)	T2	
<i>fluocinolone acetonide</i> (Synalar)	T2	
<i>fluocinolone/shower cap</i> (Derma-Smoothie-Fs)	T2	
<i>fluocinonide 0.05% cream</i>	T2	QL(120 gms/30 days)
<i>fluocinonide 0.05% gel</i>	T2	QL(120 gms/30 days)
<i>fluocinonide 0.05% ointment</i>	T2	QL(120 gms/30 days)
<i>fluocinonide 0.05% solution</i>	T2	QL(120 gms/30 days)
<i>fluocinonide 0.1% cream</i> (Vanos)	T2	ST QL(120 gms/30 days)
<i>fluocinonide/emollient base</i>	T2	QL(120 gms/30 days)
<i>flurandrenolide 0.05% cream</i> (Cordran)	T2	ST QL(120 gms/30 days)
<i>flurandrenolide 0.05% lotion</i> (Cordran)	T2	ST QL(120 mls/30 days)

T1 – Preferred Generics

T2 – Non-Preferred Generics

T3 – Preferred Brands

T4 – Non-Preferred Brands

T5 – Preferred Specialty

T6 – Non-Preferred Specialty

PA – Prior Authorization

QL – Quantity Limit

ST – Step Therapy

AGE – Age Requirement

SP – Specialty Medication

HD – May require home delivery pharmacy

PPACA – No Cost-Share Preventive Medication

CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

SKIN PREPS (Skin Conditions) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
TOPICAL ANTI-INFLAMMATORY STEROIDAL (cont.)		
<i>flurandrenolide 0.05% ointment (Cordran)</i>	T2	ST QL(120 gms/30 days)
<i>fluticasone prop 0.005% oint</i>	T2	
<i>fluticasone prop 0.05% cream (Cutivate)</i>	T2	
<i>fluticasone prop 0.05% lotion (Cutivate)</i>	T2	ST
<i>fluticasone propionate (Cutivate)</i>	T2	ST
<i>halcinonide (Halog)</i>	T2	ST
<i>halobetasol prop 0.05% cream (Ultravate)</i>	T2	
<i>halobetasol prop 0.05% ointmnt (Ultravate)</i>	T2	
<i>halobetasol prop 0.05% cream</i>	T2	
<i>halobetasol prop 0.05% foam</i>	T2	ST
<i>halobetasol prop 0.05% ointmnt</i>	T2	
HALOG	T4	ST
HALOG (<i>halcinonide</i>)	T4	ST
<i>hydrocort buty 0.1% lipid crm (Locoid Lipocream)</i>	T2	QL(120 gms/30 days)
<i>hydrocort buty 0.1% lipo cream (Locoid Lipocream)</i>	T2	QL(120 gms/30 days)
<i>hydrocort/min oil/petrolat,wht</i>	T2	
<i>hydrocortisone</i>	T2	
<i>hydrocortisone (Ala-Scalp)</i>	T2	
<i>hydrocortisone (Anusol-Hc)</i>	T2	
<i>hydrocortisone buty 0.1% cream</i>	T2	QL(120 gms/30 days)
<i>hydrocortisone butyr 0.1% lotn (Locoid)</i>	T2	ST QL(118 mls/30 days)
<i>hydrocortisone butyr 0.1% oint</i>	T2	ST QL (10gm/28 days)
<i>hydrocortisone butyr 0.1% soln</i>	T2	ST QL(120 mls/30 days)
<i>hydrocortisone valerate</i>	T2	
IMPEKLO	T4	ST QL(136 gms/28 days)
KENALOG 0.147 MG/GRAM SPRAY (<i>triamcinolone acetonide</i>)	T4	ST QL(100 gms/30 days)
KENALOG 0.147 MG/GRAM SPRAY (<i>triamcinolone acetonide</i>)	T4	ST QL(126 gms/30 days)
<i>mometasone furoate 0.1% cream</i>	T2	
<i>mometasone furoate 0.1% oint</i>	T2	
<i>mometasone furoate 0.1% soln</i>	T2	
<i>nolix 0.05% cream (Cordran)</i>	T2	ST QL(120 gms/30 days)
<i>nolix 0.05% lotion (Cordran)</i>	T2	ST QL(120 mls/30 days)
NUCORT	T4	ST
OLUX (<i>clobetasol propionate</i>)	T4	ST QL(100 gms/30 days)

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

T5 – Preferred Specialty
 T6 – Non-Preferred Specialty
 PA – Prior Authorization
 QL – Quantity Limit

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

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

List of Prescription Medications

SKIN PREPS (Skin Conditions) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
TOPICAL ANTI-INFLAMMATORY STEROIDAL (cont.)		
PANDEL	T4	ST
<i>prednicarbate</i>	T2	
<i>prednicarbate (Dermatop)</i>	T2	
SCALACORT DK	T4	ST
SYNALAR	T4	ST
SYNALAR (<i>fluocinolone acetonide</i>)	T4	ST
SYNALARTS	T4	ST
TEMOVATE (<i>clobetasol propionate</i>)	T4	ST QL (120 gms/30 days)
TEXACORT	T4	ST
TOPICORT 0.05% CREAM (<i>desoximetasone</i>)	T4	ST
TOPICORT 0.05% GEL (<i>desoximetasone</i>)	T4	ST
TOPICORT 0.05% OINTMENT (<i>desoximetasone</i>)	T4	ST
TOPICORT 0.25% CREAM (<i>desoximetasone</i>)	T4	ST
TOPICORT 0.25% OINTMENT (<i>desoximetasone</i>)	T4	ST
<i>triamcinolone 0.025% cream</i>	T2	
<i>triamcinolone 0.025% lotion</i>	T2	
<i>triamcinolone 0.025% oint</i>	T2	
<i>triamcinolone 0.05% ointment</i>	T2	ST
<i>triamcinolone 0.1% cream</i>	T2	
<i>triamcinolone 0.1% lotion</i>	T2	
<i>triamcinolone 0.1% ointment</i>	T2	
<i>triamcinolone 0.147 mg/g spray (Kenalog)</i>	T2	ST QL (126 gms/30 days)
<i>triamcinolone 0.147 mg/g spray (Kenalog)</i>	T2	ST QL (100 gms/30 days)
<i>triamcinolone 0.5% cream</i>	T2	
<i>triamcinolone 0.5% ointment</i>	T2	
<i>triamcinolone acetonide</i>	T2	ST
<i>triderm 0.1% cream</i>	T2	
<i>triderm 0.5% cream</i>	T2	ST
TRIDESILON (<i>desonide</i>)	T4	ST
ULTRAVATE X	T4	ST
TOPICAL ANTI-INFLAMMATORY STEROID-LOCAL ANESTHETIC		
ANALPRAM HC 2.5%-1% LOTION (<i>hydrocortisone/pramoxine</i>)	T4	ST
EPIFOAM	T4	ST
<i>hydrocort-pramoxine 2.5-1% crm</i>	T2	ST

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

T5 – Preferred Specialty
 T6 – Non-Preferred Specialty
 PA – Prior Authorization
 QL – Quantity Limit

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

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

List of Prescription Medications

SKIN PREPS (Skin Conditions) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
TOPICAL ANTI-INFLAMMATORY STEROID-LOCAL ANESTHETIC (cont.)		
<i>lidocaine/hydrocortisone ac</i>	T2	
<i>lidocaine-hc 3-0.5% cream</i>	T2	
PRAMOSONE	T4	ST
TOPICAL ANTIPARASITICS		
<i>lindane</i>	T2	
<i>malathion (Ovide)</i>	T2	
OVIDE (<i>malathion</i>)	T4	
TOPICAL JANUS KINASE (JAK) INHIBITORS		
OPZELURA	T4	PA QL(240 gms/28 days)
TOPICAL PREPARATIONS, ANTIBACTERIALS		
<i>iodine/potassium iodide</i>	T2	
<i>iodine/sodium iodide</i>	T2	
IODOFLEX	T4	
IODOSORB	T4	
TOPICAL VIT D ANALOG/ANTI-INFLAMMATORY STEROID		
<i>calcipotriene/betamethasone (Taclonex)</i>	T2	ST QL (60 gms/30 days)
<i>calcipotriene/betamethasone (Taclonex)</i>	T2	QL(60 gms/30 days)
ENSTILAR	T3	ST QL(60 gms/30 days)
TACLONEX 0.005%-0.064% SUSPENS (<i>calcipotriene/betamethasone</i>)	T4	QL(60 gms/30 days)
TACLONEX OINTMENT (<i>calcipotriene/betamethasone</i>)	T4	ST QL (60 gms/30 days)
WYNZORA	T4	ST QL(60 gms/30 days)
TOPICAL/MUCOUS MEMBR./SUBCUT. ENZYMES		
SANTYL	T3	QL(180 gms/fill)
VITAMIN A DERIVATIVES		
<i>adapalene 0.1% cream (Differin)</i>	T2	
ADAPALENE 0.1% LOTION	T4	ST
<i>adapalene 0.1% solution</i>	T2	
<i>adapalene 0.1% swab</i>	T2	ST
<i>adapalene 0.3% gel</i>	T2	
<i>adapalene 0.3% gel pump (Differin)</i>	T2	
ALTRENO	T4	PA
<i>avita 0.025% cream (Retin-A)</i>	T2	PA
AVITA 0.025% GEL	T4	PA
DIFFERIN	T4	ST

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

T5 – Preferred Specialty
 T6 – Non-Preferred Specialty
 PA – Prior Authorization
 QL – Quantity Limit

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

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

List of Prescription Medications

SKIN PREPS (Skin Conditions) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
VITAMIN A DERIVATIVES (cont.)		
DIFFERIN (<i>adapalene</i>)	T4	ST
RETIN-A (<i>tretinoin</i>)	T4	PA
RETIN-A MICRO PUMP 0.06% GEL	T4	PA
RETIN-A MICRO PUMP 0.08% GEL	T4	PA
<i>tretinoin 0.01% gel</i> (Retin-A)	T2	PA
<i>tretinoin 0.025% cream</i> (Retin-A)	T2	PA
<i>tretinoin 0.025% gel</i> (Retin-A)	T2	PA
<i>tretinoin 0.05% cream</i> (Retin-A)	T2	PA
<i>tretinoin 0.05% gel</i> (Atralin)	T2	PA
<i>tretinoin 0.1% cream</i> (Retin-A)	T2	PA
<i>tretinoin microspheres</i> (Retin-A Micro Pump)	T2	PA
<i>tretinoin microspheres</i> (Retin-A Micro)	T2	PA
TRETIN-X	T4	PA

SMOKING DETERRENTS (Smoking Cessation)

SMOKING DETERRENT AGENTS (GANGLIONIC STIM, OTHERS)

NICOTROL	T4	QL(180 ds/365 days) PPACA
NICOTROL NS	T4	QL(180 ds/365 days) PPACA

SMOKING DETERRENT-NICOTINIC RECEPT.PARTIAL AGONIST

APO-VARENICLINE 0.5 MG TABLET	T3	QL(180 ds/365 days) PPACA
APO-VARENICLINE 1 MG TABLET	T3	QL(180 ds/365 days) PPACA
CHANTIX	T4	QL(180 ds/365 days) PPACA
<i>varenicline starting month box</i>	T2	

SMOKING DETERRENTS, OTHER

<i>bupropion hcl sr 150 mg tablet</i>	T2	QL(180 ds/365 days) PPACA
---------------------------------------	----	---------------------------

THYROID PREPS (Hormonal Agents)

ANTITHYROID PREPARATIONS

<i>methimazole</i> (Tapazole)	T1	HD
<i>propylthiouracil</i>	T2	HD
TAPAZOLE (<i>methimazole</i>)	T4	HD

THYROID HORMONES

<i>adthyza 120 mg tablet</i>	T2	HD
<i>adthyza 15 mg tablet</i>	T2	HD
<i>adthyza 30 mg tablet</i>	T2	HD

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

T5 – Preferred Specialty
T6 – Non-Preferred Specialty
PA – Prior Authorization
QL – Quantity Limit

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

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

List of Prescription Medications

THYROID PREPS (Hormonal Agents) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
THYROID HORMONES (cont.)		
<i>adthyza 60 mg tablet</i>	T2	HD
<i>adthyza 90 mg tablet</i>	T2	HD
ARMOUR THYROID	T3	HD
ERMEZA	T4	ST HD
<i>levothyroxine sodium (Synthroid)</i>	T1	HD
<i>liothyronine sodium (Cytomel)</i>	T2	HD
<i>thyroid,pork</i>	T2	HD
UNCLASSIFIED DRUG PRODUCTS (AIDS/HIV)		
CYTOCHROME P450 INHIBITORS		
TYBOST	T6	SP
UNCLASSIFIED DRUG PRODUCTS (Asthma/COPD/Respiratory)		
CYSTIC FIBROSIS - INHALED OSMOTIC AGENTS		
BRONCHITOL	T6	PA SP HD
CYSTIC FIBROSIS-CFTR POTENTIATOR-CORRECTOR COMBIN.		
ORKAMBI 100 MG-125 MG TABLET	T5	PA QL(112 tabs/fill) SP HD
ORKAMBI 100-125 MG GRANULE PKT	T5	PA QL(56 packs/fill) SP HD
ORKAMBI 150-188 MG GRANULE PKT	T5	PA QL(56 packs/fill) SP HD
ORKAMBI 200 MG-125 MG TABLET	T5	PA QL(112 tabs/fill) SP HD
ORKAMBI 75-94 MG GRANULE PKT	T5	PA QL(56 packs/fill) SP HD
SYMDEKO	T5	PA QL(56 tabs/fill) SP HD
TRIKAFTA	T5	PA QL(84 tabs/fill) SP HD
TRIKAFTA GRANULE PKT	T5	PA QL(84 pkts/fill) SP HD
CYSTIC FIB-TRANSMEMB CONDUCT.REG.(CFTR) POTENTIATOR		
KALYDECO 150 MG TABLET	T5	PA QL(56 tabs/fill) SP HD
KALYDECO GRANULES PACKET	T5	PA QL(56 packs/fill) SP HD
KALYDECO 5.8 MG GRANULES PKT	T5	PA QL(56 packs/fill) SP HD
LUNG SURFACTANTS		
CUROSURF	T4	
INFASURF	T4	
SURFAXIN	T4	
SURVANTA	T4	
MUCOLYTICS		
PULMOZYME	T5	PA SP HD

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

T5 – Preferred Specialty
T6 – Non-Preferred Specialty
PA – Prior Authorization
QL – Quantity Limit

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

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

List of Prescription Medications

UNCLASSIFIED DRUG PRODUCTS (Asthma/COPD/Respiratory) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
------------------------	-----------	----------------------------------

PULMONARY FIBROSIS - SYSTEMIC ENZYME INHIBITORS

OFEV	T5	PA QL(60 caps/fill) SP HD
------	----	---------------------------

SYSTEMIC ENZYME INHIBITORS

JOENJA 70 MG TABLET	T6	PA QL (60 tabs/30 days) SP
VIJOICE 125 MG TABLET	T5	PA QL(28 tabs/28 days) SP
VIJOICE 250 MG DAILY DOSE PACK	T5	PA QL(56 tabs/28 days) SP
VIJOICE 50 MG TABLET	T5	PA QL(28 tabs/28 days) SP
ZOKINVY	T6	PA QL(120 caps/fill) SP

SYSTEMIC ENZYME INHIBITORS

TEZSPIRE 210 MG/1.91 ML PEN	T5	PA QL (1 pen/28 days) SP HD
TEZSPIRE 210 MG/1.91 ML SYRING	T5	PA QL (1 syg/28 days) SP HD

UNCLASSIFIED DRUG PRODUCTS (Blood Modifiers/Bleeding Disorders)

SPLEEN TYROSINE KINASE INHIBITORS

TAVALISSE	T5	PA QL(60 tabs/fill) SP
-----------	----	------------------------

UNCLASSIFIED DRUG PRODUCTS (Blood Pressure/Heart Medications)

BRADYKININ B2 RECEPTOR ANTAGONISTS

<i>icatibant acetate (Firazyr)</i>	T2	PA SP HD
<i>icatibant acetate (Firazyr)</i>	T2	PA SP

PLASMA KALLIKREIN INHIBITORS

ORLADEYO	T6	PA QL (28 caps/28 days) SP
TAKHZYRO 300MG/2ML	T5	PA QL (2 units/28 days) SP HD

UNCLASSIFIED DRUG PRODUCTS (Cancer)

CHEMOTHERAPY RESCUE/ANTIDOTE AGENTS

<i>leucovorin calcium</i>	T2	CSL
MESNEX	T5	SP CSL
VISTOGARD	T5	PA QL(20 packs/fill) SP CSL

RADIOACTIVE THERAPEUTIC AGENTS

SODIUM IODIDE I-123	T4	CSL
---------------------	----	-----

UNCLASSIFIED DRUG PRODUCTS (Dental Products)

DENTAL AIDS AND PREPARATIONS

<i>chlorhexidine gluconate (Peridex)</i>	T1	
PERIDEX (<i>chlorhexidine gluconate</i>)	T4	
<i>triamcinolone 0.1% paste</i>	T2	
<i>triamcinolone acetonide</i>	T2	

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

T5 – Preferred Specialty
T6 – Non-Preferred Specialty
PA – Prior Authorization
QL – Quantity Limit

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

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

List of Prescription Medications

UNCLASSIFIED DRUG PRODUCTS (Dental Products) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
------------------------	-----------	----------------------------------

PERIODONTAL COLLAGENASE INHIBITORS

<i>doxycycline hyclate 20 mg tab</i>	T2	
--------------------------------------	----	--

UNCLASSIFIED DRUG PRODUCTS (Erectile Dysfunction)

DRUGS TO TREAT ERECTILE DYSFUNCTION (ED)

CAVERJECT 20 MCG VIAL	T2	PA QL(12 vials/fill)
CAVERJECT 40 MCG VIAL	T2	PA QL(12 vials/fill)
CAVERJECT IMPULSE 10 MCG KIT	T2	PA QL(12 kits/fill)
CAVERJECT IMPULSE 10 MCG SYRNG	T2	PA QL(12 syringes/fill)
CAVERJECT IMPULSE 20 MCG KIT	T2	PA QL(12 kits/fill)
CAVERJECT IMPULSE 20 MCG SYRNG	T2	PA QL(12 syringes/fill)
CIALIS (<i>tadalafil</i>)	T4	PA QL(8 tabs/30 days)
EDEX 10 MCG CARTRIDGE 2-PK KIT	T3	PA QL(6 kits/fill)
EDEX 10 MCG CARTRIDGE 6-PK KIT	T3	PA QL(2 kits/fill)
EDEX 20 MCG CARTRIDGE 2-PK KIT	T3	PA QL(6 kits/fill)
EDEX 20 MCG CARTRIDGE 6-PK KIT	T3	PA QL(2 kits/fill)
EDEX 40 MCG CARTRIDGE 2-PK KIT	T3	PA QL(6 kits/fill)
EDEX 40 MCG CARTRIDGE 6-PK KIT	T3	PA QL(2 kits/fill)
IFE-BIMIX 30/1	T3	
LEVITRA (<i>ildenafil hcl</i>)	T3	PA QL(8 tabs/fill)
MUSE	T2	PA QL(12 supps/fill)
PAPAVERINE-PHENTOLAMINE	T3	
PAPAVERINE-PHENTOLMN-ALPROSTD	T3	
STENDRA	T3	PA QL(8 tabs/fill)
<i>tadalafil 10 mg tablet (Cialis)</i>	T2	
<i>tadalafil 2.5 mg tablet</i>	T2	PA QL(30 tabs/30 days)
<i>tadalafil 20 mg tablet (Cialis)</i>	T2	
<i>tadalafil 5 mg tablet (Cialis)</i>	T2	
TRI-MIX (PAPVRN-PHNTLMN-PGE1)	T3	
<i>ildenafil hcl</i>	T2	PA QL(8 tabs/fill)
<i>ildenafil hcl (Levitra)</i>	T2	PA QL(8 tabs/fill)
VIAGRA (<i>sildenafil citrate</i>)	T4	PA QL(8 tabs/fill)

UNCLASSIFIED DRUG PRODUCTS (Eye Conditions)

NICOTINIC RECEPT.PARTIAL AGONIST, ALPHA4BETA2 SPEC

TYRVAYA	T4	PA
---------	----	----

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

T5 – Preferred Specialty
T6 – Non-Preferred Specialty
PA – Prior Authorization
QL – Quantity Limit

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

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

List of Prescription Medications

UNCLASSIFIED DRUG PRODUCTS (Gastrointestinal/Heartburn)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
AGENTS FOR STOMATOLOGICAL USE		
PROTHELIAL	T4	
SILATRIX	T4	
COMPOUNDING KIT		
FIRST-MOUTHWASH BLM	T4	
ORAL MUCOSITIS/STOMATITIS AGENTS		
GELCLAIR	T4	
GELX	T4	
ORAMAGICRX	T4	
ORAL MUCOSITIS/STOMATITIS ANTI-INFLAMMATORY AGENT		
EPISIL	T4	
SALIVA STIMULANT AGENTS		
NUMOISYN	T4	
SALIVA SUBSTITUTE AGENTS		
AQUORAL	T4	
BOCASAL	T4	
CAPHOSOL	T4	
MUCOSITISRX	T4	
NEUTRASAL	T4	
NUMOISYN	T4	
SALIVAMAX	T4	
UNCLASSIFIED DRUG PRODUCTS (Hormonal Agents)		
GROWTH HORMONE RECEPTOR ANTAGONISTS		
SOMAVERT	T5	PA SP HD
HYPERPARATHYROID TX AGENTS - VITAMIN D ANALOG-TYPE		
<i>doxercalciferol</i>	T2	ST
<i>paricalcitol</i>	T2	ST SP HD
<i>paricalcitol (Zemplar)</i>	T2	ST SP HD
RAYALDEE	T4	ST
ZEMPLAR (<i>paricalcitol</i>)	T6	ST SP HD
UNCLASSIFIED DRUG PRODUCTS (Miscellaneous)		
ABORTIFACIENT-PROGESTERONE RECEPTOR ANTAGONISTS		
MIFEPREX	T4	
<i>mifepristone 200 mg tablet</i>	T2	

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

T5 – Preferred Specialty
T6 – Non-Preferred Specialty
PA – Prior Authorization
QL – Quantity Limit

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

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

List of Prescription Medications

UNCLASSIFIED DRUG PRODUCTS (Miscellaneous) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
AMMONIA INHIBITORS		
CARBAGLU	T5	PA SP HD
<i>carglumic acid</i>	T2	PA SP HD
AMYLOIDOSIS AGENTS-TRANSTHYRETIN (TTR) SUPPRESSION		
TEGSEDI	T5	PA QL (4 syr/28 days) SP HD
ANTI-ALCOHOLIC PREPARATIONS		
<i>acamprosate calcium</i>	T2	
<i>disulfiram</i>	T2	
ANTIFIBROTIC THERAPY - PYRIDONE ANALOGS		
<i>pirfenidone 267 mg tablet (Esbriet)</i>	T2	
<i>pirfenidone 801 mg tablet (Esbriet)</i>	T2	
CI ESTERASE INHIBITORS		
HAEGARDA 2,000UNIT VIAL	T6	PA QL (24 vials/28 days) SP HD
HAEGARDA 3,000UNIT VIAL	T6	PA QL (16 vials/28 days) SP HD
CALCIMIMETIC,PARATHYROID CALCIUM ENHANCER		
<i>cinacalcet hcl (Sensipar)</i>	T2	PA SP
COMPOUNDING KIT		
FIRST-MOUTHWASH BLM	T4	
CRYOPRESERVATIVE AGENTS		
<i>dimethyl sulfoxide</i>	T2	
DRUGS TO TREAT HEREDITARY TYROSINEMIA		
<i>nitisinone (Orfadin)</i>	T2	PA SP HD
NITYR	T5	PA SP
ORFADIN	T6	PA SP
ORFADIN (<i>nitisinone</i>)	T6	PA SP
DRUGS TO TX GAUCHER DX-TYPE I, SUBSTRATE REDUCING		
CERDELGA	T5	PA QL (56 caps/28 days) SP HD
ENVIRONMENT ALLERGENS AND IRRITANTS, OTHER		
T.R.U.E. TEST	T4	
GENERAL INHALATION AGENTS		
HYPHER-SAL	T4	
<i>nebusal 3% vial</i>	T2	
NEBUSAL 6% VIAL	T4	
<i>sodium chloride for inhalation</i>	T2	
GENETIC D/O TX - SMN PROTEIN DEFICIENCY TREATMENT		
EVRYSDI	T6	PA QL(240 mls/fil) SP HD

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

T5 – Preferred Specialty
T6 – Non-Preferred Specialty
PA – Prior Authorization
QL – Quantity Limit

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

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

List of Prescription Medications

UNCLASSIFIED DRUG PRODUCTS (Miscellaneous) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
GLUCOSYLCERAMIDE SYNTHASE (GCS) INHIBITOR		
<i>miglustat (Zavesca)</i>	T2	PA QL(90 caps/30 days) SP
OPFOLDA	T6	PA QL(8 caps/fill) SP HD
HOMEOPATHIC DRUGS		
VERTIGOHEEL	T4	
MENOPAUSAL SYMPTOMS SUPPRESSANT-NK3 RECEPTOR ANTAG		
VEOZAH	T4	
MENOPAUSAL SYMPTOMS SUPPRESSANT - SSRIS		
<i>paroxetine mesylate (Brisdelle)</i>	T2	ST QL(30 caps/fill) HD
METABOLIC DISEASE ENZYME REPLACE, HYPOPHOSPHATASIA		
STRENSIQ	T5	PA SP
METALLIC POISON, AGENTS TO TREAT		
CHEMET	T3	PA
<i>deferasirox (Exjade)</i>	T2	PA SP HD
<i>deferasirox (Jadenu Sprinkle)</i>	T2	PA SP HD
<i>deferasirox (Jadenu)</i>	T2	PA SP HD
<i>deferiprone (Ferriprox (3 Times A Day))</i>	T2	PA SP HD
<i>deferiprone (Ferriprox)</i>	T2	PA SP HD
FERRIPROX (2 TIMES A DAY)	T5	PA SP
FERRIPROX (3 TIMES A DAY) (<i>deferiprone</i>)	T5	PA SP
FERRIPROX 1,000 MG TABLET (<i>deferiprone</i>)	T5	PA SP
FERRIPROX 100 MG/ML SOLUTION	T5	PA SP
FERRIPROX 500 MG TABLET (<i>deferiprone</i>)	T6	PA SP
GALZIN	T4	
RADIOGARDASE	T4	
SYPRINE (<i>trientine hcl</i>)	T6	PA SP HD
<i>trientine hcl (Syprine)</i>	T2	PA SP HD
NATRIURETIC PEPTIDES		
VOXZOGO	T6	PA SP HD
PHARMACOLOGICAL CHAPERONE-ALPHA-GALACTOSID.A STABZ		
GALAFOLD	T6	PA QL(15 caps/fill) SP HD
PKU TX AGENT-COFACTOR OF PHENYLALANINE HYDROXYLASE		
<i>sapropterin dihydrochloride (Kuvan)</i>	T2	PA SP
<i>sapropterin dihydrochloride (Kuvan)</i>	T2	PA SP HD

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

T5 – Preferred Specialty
T6 – Non-Preferred Specialty
PA – Prior Authorization
QL – Quantity Limit

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

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

List of Prescription Medications

UNCLASSIFIED DRUG PRODUCTS (Miscellaneous) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
PROTEIN STABILIZERS		
VYNDAMAX	T5	PA SP HD
VYNDAQEL	T5	PA SP HD
RETINOIC ACID RECEPTOR (RAR) AGONISTS		
SOHONOS 1 MG CAPSULE	T6	PA QL(112 caps/fill) SP
SOHONOS 1.5 MG CAPSULE	T6	PA QL(112 caps/fill) SP
SOHONOS 10 MG CAPSULE	T6	PA QL(56 caps/fill) SP
SOHONOS 2.5 MG CAPSULE	T6	PA QL(140 caps/fill) SP
SOHONOS 5 MG CAPSULE	T6	PA QL(84 caps/fill) SP
SOLVENTS		
CVS ISOPROPYL ALCOHOL 91%	T4	
<i>cvs isopropyl alcohol 91%</i>	T2	
CVS ISOPROPYL RUB ALCOHOL 70%	T4	
<i>cvs isopropyl rub alcohol 70%</i>	T2	
<i>eql isopropyl alcohol 91%</i>	T2	
<i>eql isopropyl rub alcohol 70%</i>	T2	
FT ISOPROPYL ALCOHOL 91%	T4	
FT ISOPROPYL RUB ALCOHOL 70%	T4	
<i>gnp isopropyl alcohol 99%</i>	T2	
<i>hm isopropyl alcohol 70%</i>	T2	
<i>hm isopropyl alcohol 91%</i>	T2	
INSTACLEAN	T3	
ISOPROPANOL	T3	
<i>isopropyl 70% alcohol</i>	T2	
<i>isopropyl alcohol</i>	T2	
<i>isopropyl alcohol 70%</i>	T2	
<i>isopropyl alcohol 91%</i>	T2	
<i>isopropyl alcohol 99%</i>	T2	
<i>isopropyl rubbing alcohol 70%</i>	T2	
ISOPROPYL RUBBING ALCOHOL 70%	T4	
ISOPROPYL RUBBING ALCOHOL 91%	T4	
<i>kro isopropyl alcohol 91%</i>	T2	
MURI-LUBE MINERAL OIL	T3	
<i>polyethylene glycol</i>	T2	
<i>qc isopropyl alcohol 91%</i>	T2	

T1 – Preferred Generics

T2 – Non-Preferred Generics

T3 – Preferred Brands

T4 – Non-Preferred Brands

T5 – Preferred Specialty

T6 – Non-Preferred Specialty

PA – Prior Authorization

QL – Quantity Limit

ST – Step Therapy

AGE – Age Requirement

SP – Specialty Medication

HD – May require home delivery pharmacy

PPACA – No Cost-Share Preventive Medication

CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

UNCLASSIFIED DRUG PRODUCTS (Miscellaneous) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
SOLVENTS (cont.)		
<i>qc isopropyl rubbing alcohol</i>	T2	
<i>ra isopropyl alcohol 70%</i>	T2	
<i>ra isopropyl alcohol 91%</i>	T2	
<i>sm isopropyl alcohol 70%</i>	T2	
SM ISOPROPYL ALCOHOL 91%	T4	
<i>sm isopropyl alcohol 91%</i>	T2	
<i>sm isopropyl alcohol 99%</i>	T2	
<i>swan isopropyl alcohol 70%</i>	T2	
SUSPENDING AGENTS		
GELFILM	T4	
HYDROXYPROPYLCELLULOSE	T3	
HYPROMELLOSE	T3	

UNCLASSIFIED DRUG PRODUCTS (Nutritional/Dietary)

METABOLIC DEFICIENCY AGENTS

<i>betaine (Cystadane)</i>	T2	PA SP HD
CARNITOR (<i>levocarnitine (with sugar)</i>)	T4	
CARNITOR (<i>levocarnitine</i>)	T4	
CARNITOR SF (<i>levocarnitine</i>)	T4	
<i>levocarnitine (Carnitor Sf)</i>	T2	
<i>levocarnitine (Carnitor)</i>	T2	
<i>levocarnitine (with sugar) (Carnitor)</i>	T2	

UNCLASSIFIED DRUG PRODUCTS (Osteoporosis Products)

BONE FORMATION STIM. AGENTS - PARATHYROID HORMONE

FORTEO (<i>teriparatide</i>)	T5	PA QL(1 pens/28 days) SP HD
<i>teriparatide 600 mcg/2.4ml pen (Forteo)</i>	T2	PA QL(1 pen/28 days) SP HD
TERIPARATIDE 620 MCG/2.48 ML	T6	PA QL(1 pen/28 days) SP HD

BONE RESORPTION INHIBITOR AND VITAMIN D COMBS.

FOSAMAX PLUS D	T4	ST QL(4 tabs/28 days) HD
----------------	----	--------------------------

BONE RESORPTION INHIBITORS

ACTONEL 150 MG TABLET (<i>risedronate sodium</i>)	T4	ST QL(1 tab/30 days) HD
ACTONEL 35 MG TABLET (<i>risedronate sodium</i>)	T4	ST QL(4 tabs/28 days) HD
<i>alendronate sod 70 mg/75 ml</i>	T2	QL(300 mls/28 days) HD
<i>alendronate sodium 10 mg tab</i>	T1	QL(30 tabs/fill) HD

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

T5 – Preferred Specialty
 T6 – Non-Preferred Specialty
 PA – Prior Authorization
 QL – Quantity Limit

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

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

List of Prescription Medications

UNCLASSIFIED DRUG PRODUCTS (Osteoporosis Products) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
BONE RESORPTION INHIBITORS (cont.)		
<i>alendronate sodium 35 mg tab</i>	T1	QL(4 tabs/28 days) HD
<i>alendronate sodium 40 mg tab</i>	T1	HD
<i>alendronate sodium 5 mg tablet</i>	T1	QL(30 tabs/fill) HD
<i>alendronate sodium 70 mg tab (Fosamax)</i>	T1	QL(4 tabs/28 days) HD
ATELVIA (<i>risedronate sodium</i>)	T4	ST QL(4 tabs/28 days) HD
BINOSTO	T4	ST QL(4 tabs/28 days) HD
EVISTA (<i>raloxifene hcl</i>)	T4	HD
FOSAMAX (<i>alendronate sodium</i>)	T4	ST QL(4 tabs/28 days) HD
<i>ibandronate sodium</i>	T2	QL(1 tab/30 days) HD
<i>raloxifene hcl (Evista)</i>	T2	HD PPACA
<i>risedronate sodium (Atelvia)</i>	T2	QL(4 tabs/28 days) HD
<i>risedronate sodium 150 mg tab (Actonel)</i>	T2	QL(1 tab/30 days) HD
<i>risedronate sodium 30 mg tab</i>	T2	QL(30 tabs/fill) HD
<i>risedronate sodium 35 mg tab (Actonel)</i>	T2	QL(4 tabs/28 days) HD
<i>risedronate sodium 5 mg tablet</i>	T2	QL(30 tabs/fill) HD

UNCLASSIFIED DRUG PRODUCTS (Pain Relief And Inflammatory Disease)

ANTI-INFLAM. INTERLEUKIN-I RECEPTOR ANTAGONIST

ARCALYST	T6	PA QL(4 vls/28 days) SP HD
----------	----	----------------------------

FIBROMYALGIA AGENTS, SEROTONIN-NOREPINEPH RU INHIB

SAVELLA 100 MG TABLET	T3	ST QL(60 tabs/fill) HD
SAVELLA 12.5 MG TABLET	T3	ST QL(60 tabs/fill) HD
SAVELLA 25 MG TABLET	T3	ST QL(60 tabs/fill) HD
SAVELLA 50 MG TABLET	T3	ST QL(60 tabs/fill) HD
SAVELLA TITRATION PACK	T3	ST QL(55 tabs/fill) HD

IMMUNOMODULATOR, B-LYMPHOCYTE STIM (BLYS)-SPEC INHIB

BENLYSTA	T5	PA QL(4 mls/28 days) SP HD
----------	----	----------------------------

UNCLASSIFIED DRUG PRODUCTS (Seizure Disorders)

NEUROPATHIC AGENTS

<i>pregabalin (Lyrica Cr)</i>	T2	PA HD
-------------------------------	----	-------

UNCLASSIFIED DRUG PRODUCTS (Skin Conditions)

INTERLEUKIN-I3 (IL-I3) INHIBITORS, MAB

ADBRY	T5	PA QL(4 syringes/28 days) SP HD
-------	----	---------------------------------

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

T5 – Preferred Specialty
T6 – Non-Preferred Specialty
PA – Prior Authorization
QL – Quantity Limit

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

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

List of Prescription Medications

UNCLASSIFIED DRUG PRODUCTS (Skin Conditions) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
------------------------	-----------	----------------------------------

JANUS KINASE (JAK) INHIBITORS

LITFULO	T6	PA QL(28 caps/28 days) SP HD
---------	----	------------------------------

WOUND HEALING AGENTS, LOCAL

FILSUVEZ	T6	SP
----------	----	----

UNCLASSIFIED DRUG PRODUCTS (Substance Abuse)

OPIOID WITHDRAWAL THERAPY AGENTS, OPIOID-TYPE

<i>buprenorphine 2 mg, 8 mg tablet sl</i>	T2	
<i>buprenorphine hcl/naloxone hcl</i>	T2	
<i>buprenorphine hcl/naloxone hcl (Suboxone)</i>	T2	
ZUBSOLV	T3	

UNCLASSIFIED DRUG PRODUCTS (Transplant Medications)

RHO KINASE INHIBITOR

REZUROCK	T6	PA QL(30 tabs/fill) SP
----------	----	------------------------

UNCLASSIFIED DRUG PRODUCTS (Urinary Tract Conditions)

BENIGN PROSTATIC HYPERTROPHY/MICTURITION AGENTS

<i>alfuzosin hcl (Uroxatral)</i>	T2	HD
<i>dutasteride (Avodart)</i>	T2	ST HD
<i>finasteride (Proscar)</i>	T2	HD
FLOMAX (<i>tamsulosin hcl</i>)	T4	ST HD
PROSCAR (<i>finasteride</i>)	T4	ST HD
<i>silodosin (Rapaflo)</i>	T2	HD
<i>tamsulosin hcl (Flomax)</i>	T1	HD

BPH 5-ALPHA-REDUCTASE INHIB-ALPHA1-ADRENOCEP ANTAG

<i>dutasteride/tamsulosin hcl (Jalyn)</i>	T2	ST HD
---	----	-------

BPH 5-ALPHA-REDUCTASE INHIB-ALPHA1-ADRENOCEP ANTAG

JALYN (<i>dutasteride/tamsulosin hcl</i>)	T4	ST HD
---	----	-------

CYSTINE-DEPLETING AGENTS, NEPHROPATHIC CYSTINOSIS

CYSTAGON	T5	SP
----------	----	----

KIDNEY STONE AGENTS

THIOLA EC	T6	PA SP
<i>tiopronin</i>	T2	PA SP
<i>tiopronin (Thiola)</i>	T2	PA SP

OVERACTIVE BLADDER AGENTS, BETA-3 ADRENERGIC RECEP

GEMTESA	T4	HD
MYRBETRIQ	T3	HD

T1 – Preferred Generics

T2 – Non-Preferred Generics

T3 – Preferred Brands

T4 – Non-Preferred Brands

T5 – Preferred Specialty

T6 – Non-Preferred Specialty

PA – Prior Authorization

QL – Quantity Limit

ST – Step Therapy

AGE – Age Requirement

SP – Specialty Medication

HD – May require home delivery pharmacy

PPACA – No Cost-Share Preventive Medication

CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

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

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
------------------------	-----------	----------------------------------

URINARY TRACT ANTISPASMODIC, M(3) SELECTIVE ANTAG.

<i>darifenacin hydrobromide</i>	T2	HD
<i>solifenacin succinate (Vesicare)</i>	T2	HD

URINARY TRACT ANTISPASMODIC/ANTIINCONTINENCE AGENT

<i>fesoterodine fumarate (Toviaz)</i>	T2	HD
<i>flavoxate hcl</i>	T2	HD
GELNIQUE	T3	QL(30 packs/fill) HD
<i>oxybutynin chloride</i>	T2	HD
OXYTROL	T4	ST QL(8 patches/28 days) HD
<i>tolterodine tartrate (Detrol La)</i>	T2	HD
<i>tolterodine tartrate (Detrol)</i>	T2	HD
<i>tropium chloride</i>	T2	HD

UNCLASSIFIED DRUG PRODUCTS (Weight Management)

APPETITE STIM. FOR ANOREXIA, CACHEXIA, WASTING SYND.

<i>megestrol 625 mg/5 ml susp</i>	T2	
<i>megestrol acet 40 mg/ml susp</i>	T2	
<i>megestrol acet 400 mg/10 ml</i>	T2	

VITAMINS (Nutritional/Dietary)

ANTIOXIDANT MULTIVITAMIN COMBINATIONS

50 PLUS ADULT EYE HEALTH	T4	
<i>a/c/e/zinc ox/cupric ox/lutein</i>	T2	
ADULT 50 PLUS EYE HEALTH	T4	
ANTIOXIDANT FORMULA	T4	
EQ VISION FORMULA TABLET	T3	
<i>eq eye health plus lutein tab</i>	T2	
EYE HEALTH AND LUTEIN	T4	
EYE HEALTH PLUS LUTEIN TABLET	T4	
EYE MULTIVITAMIN	T3	
EYE MULTIVITAMIN WITH LUTEIN	T4	
EYEPROTECT	T4	
<i>gnp healthy eyes tablet</i>	T2	
HEALTHY EYES TABLET	T3	
<i>healthy eyes tablet</i>	T2	
I-CAPS	T3	

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

T5 – Preferred Specialty
T6 – Non-Preferred Specialty
PA – Prior Authorization
QL – Quantity Limit

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

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

List of Prescription Medications

VITAMINS (Nutritional/Dietary) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ANTIOXIDANT MULTIVITAMIN COMBINATIONS (cont.)		
ICAPS AREDS FORMULA DR TABLET	T4	
ICAPS AREDS2	T4	
LIPOTRIAD	T4	
LIPOTRIAD VISIONARY	T4	
MACULAR BENEFITS	T4	
MACULAR HEALTH FORMULA	T4	
MACUVEX	T4	
MACUZIN	T4	
MULTI-BETIC	T3	
OCULAR VITAMINS	T4	
OCUVEL	T4	
OCUVITE ADULT 50 PLUS	T3	
OCUVITE WITH LUTEIN	T3	
PRESERVISION AREDS	T3	
PRESERVISION LUTEIN	T3	
VISION FORMULA TABLET	T4	
VISION FORMULA WITH LUTEIN	T4	
VISION OPTIMIZER	T4	
VISTA ADVANCED AREDS2	T4	
<i>vit a/vit c/vit e/zinc/copper</i>	T2	
<i>vits a,c,e/lutein/minerals</i>	T2	
BIOFLAVONOIDS		
<i>bioflav,lemon/vit bcomp,c</i>	T2	
<i>bioflav,lemon/vit bcomp,c (Lipo-Flavonoid Plus)</i>	T2	
CITRUS BIOFLAVONOIDS	T4	
EAR HEALTH PLUS CAPLET	T4	
<i>ear health plus caplet (Lipo-Flavonoid Plus)</i>	T2	
FLOGEN	T4	
INNER EAR PLUS	T4	
LIPO FLAVONOID	T4	
LIPO-FLAVONOID PLUS (<i>bioflav,lemon/vit bcomp,c</i>)	T3	
QUERCETIN	T4	
<i>rutin</i>	T2	
VASCULERA	T4	

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

T5 – Preferred Specialty
 T6 – Non-Preferred Specialty
 PA – Prior Authorization
 QL – Quantity Limit

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

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

List of Prescription Medications

VITAMINS (Nutritional/Dietary) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
BIOFLAVONOIDS (cont.)		
VASOFLEX D1	T4	
VENALIV	T4	
FOLIC ACID PREPARATIONS		
<i>cvs folic acid 800 mcg tablet</i>	T2	PPACA
DENOVO	T4	
DEPLIN-ALGAL OIL (<i>levomefolate/algae oil</i>)	T4	
ENLYTE	T4	
FA-8	T4	
<i>folic acid 0.4 mg, 0.8 mg tablet</i>	T2	PPACA
<i>folic acid 1 mg tablet</i>	T2	
<i>folic acid 1,000 mcg tablet</i>	T2	
FOLIC ACID 20 MG CAPSULE	T4	
<i>folic acid 400 mcg, 800 mcg tablet</i>	T2	PPACA
FOLIC ACID 5 MG CAPSULE	T4	
<i>folic acid 5 mg/ml vial</i>	T2	
<i>folic acid 50 mg/10 ml vial</i>	T2	
FOLIC ACID 800 MCG CAPSULE	T4	
<i>folic acid/b6/ca phos/ginger</i>	T2	
FOLIKA-V	T4	
FOLITE	T4	
GENICIN VITA-Q	T4	
<i>gnp folic acid 400 mcg tablet</i>	T2	PPACA
<i>hm folic acid 400 mcg tablet</i>	T2	PPACA
HYLAZINC	T4	
<i>levomefolate calcium</i>	T2	
<i>levomefolate/algae oil (Deplin-Algae Oil)</i>	T2	
METHYLFOLATE	T4	
<i>ra folic acid 0.4 mg tablet</i>	T2	PPACA
<i>ra folic acid 800 mcg tablet</i>	T2	PPACA
<i>sm folic acid 0.4 mg tablet</i>	T2	PPACA
<i>sm folic acid 400 mcg tablet</i>	T2	PPACA
<i>sv folic acid 800 mcg tablet</i>	T2	PPACA
<i>true folic acid 1600mcg dfe tb</i>	T2	
<i>true folic acid 667 mcg dfe tb</i>	T2	PPACA
XAQUIL XR	T4	

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

T5 – Preferred Specialty
 T6 – Non-Preferred Specialty
 PA – Prior Authorization
 QL – Quantity Limit

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

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

List of Prescription Medications

VITAMINS (Nutritional/Dietary) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
GERIATRIC VITAMIN PREPARATIONS		
<i>a thru z advanced formula tab</i> (Vision Plus Lutein)	T2	
<i>a thru z select tablet</i> (Vision Plus Lutein)	T2	
CENTRUM SILVER CHEWABLE TABLET	T3	
<i>eldertonic elixir</i>	T2	
ELDERTONIC LIQUID	T4	
GERITOL COMPLETE	T3	
GERITOL TONIC	T3	
<i>multivit with iron,minerals</i>	T2	
<i>multivit with minerals/lutein</i> (Vision Plus Lutein)	T2	
REQ49+	T4	
SPECTRAVITE ADULT 50+	T4	
VISION PLUS LUTEIN (<i>multivit with minerals/lutein</i>)	T3	
MULTIVITAMIN PREPARATIONS		
<i>a thru z advanced formula tab</i>	T2	
A THRU Z MEN'S ULTIMATE TABLET	T3	
A THRU Z SELECT MEN 50+ TABLET	T4	
<i>a thru z select multivit tab</i>	T2	
<i>a thru z select multivit tab</i> (Centrum Silver)	T2	
<i>a thru z select multivit tab</i> (Certavite Senior)	T2	
<i>a thru z select tablet</i> (Centrum Silver)	T2	
<i>a thru z select tablet</i> (Certavite Senior)	T2	
<i>a thru z select women's tablet</i>	T2	
<i>a/c/e/zinc/sod selenate/copper</i>	T2	
ABC COMPLETE SENIOR WOMEN'S	T4	
ACTIVNUTRIENTS	T4	
ADEK GUMMIES PLUS ZINC	T4	
ADULT MULTI GUMMIES	T4	
ADULT MULTIVITAMIN GUMMIES	T4	
ADULT ONE DAILY GUMMIES	T4	
ADULTS' DAILY FORMULA	T4	
ADULTS MULTIVITAMIN	T4	
ADVANCED MULTI EA	T4	
ALIVE DAILY SUPPORT PRENATAL	T4	
ALIVE MAX POTENCY	T4	

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

T5 – Preferred Specialty
T6 – Non-Preferred Specialty
PA – Prior Authorization
QL – Quantity Limit

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

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

List of Prescription Medications

VITAMINS (Nutritional/Dietary) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
MULTIVITAMIN PREPARATIONS (cont.)		
ALIVE MEN'S 50 PLUS GUMMY	T4	
ALIVE MEN'S ENERGY	T4	
ALIVE MEN'S GUMMY	T4	
ALIVE PREMIUM PRENATAL	T4	
ALIVE WOMEN'S 50 PLUS	T4	
ALIVE WOMEN'S 50 PLUS ULTRA	T4	
ALIVE WOMEN'S ENERGY	T4	
ALIVE WOMEN'S GUMMY VITAMIN	T4	
ALIVE WOMEN'S ULTRA POTENCY	T4	
<i>amino acids/mv,tx,iron,mineral</i>	T2	
AMLADEX	T4	
ANIMI-3	T4	
AQUADEKS	T3	
BACMIN	T4	
BARIATRIC MULTIVITAMINS	T4	
<i>b-complex plus vitamin c cplt</i>	T2	
<i>b-complex with vitamin c</i>	T2	
<i>b-complex with vitamin c (Support-500)</i>	T2	
<i>b-complex w-vitamin c caplet</i>	T2	
BEROCCA	T4	
<i>beta-carotene(a)-vits c,e/mins</i>	T2	
BIO-35	T4	
BLADDER 2.2	T3	
BODY, HAIR, SKIN AND NAILS	T4	
CENTRAL-VITE	T4	
CENTRAL-VITE WOMEN'S MATURE (<i>multivit-min/iron/folic/lutein</i>)	T4	
CENTRAVITES ADULTS	T4	
CENTRUM	T3	
CENTRUM ADULT 50 PLUS	T4	
CENTRUM ADULT 50 FRESH-FRUITY	T4	
CENTRUM CHEWABLES ADULTS TAB	T3	
CENTRUM CHEWABLES ADULTS TAB	T4	
CENTRUM COMPLETE	T3	
CENTRUM FLAVOR BURST ADULT	T4	

T1 – Preferred Generics

T2 – Non-Preferred Generics

T3 – Preferred Brands

T4 – Non-Preferred Brands

T5 – Preferred Specialty

T6 – Non-Preferred Specialty

PA – Prior Authorization

QL – Quantity Limit

ST – Step Therapy

AGE – Age Requirement

SP – Specialty Medication

HD – May require home delivery pharmacy

PPACA – No Cost-Share Preventive Medication

CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

VITAMINS (Nutritional/Dietary) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
MULTIVITAMIN PREPARATIONS (cont.)		
CENTRUM MEN	T3	
CENTRUM MULTIGUMMIES	T4	
CENTRUM SILVER MEN	T4	
CENTRUM SILVER TABLET (<i>multivit-min/fa/lycopen/lutein</i>)	T4	
CENTRUM SILVER ULTRA MEN'S (<i>multivit-min/fa/lycopen/lutein</i>)	T3	
CENTRUM SILVER WOMEN (<i>multivit-min/iron/folic/lutein</i>)	T4	
CENTRUM SPECIALIST ENERGY	T4	
CENTRUM SPECIALIST HEART	T3	
CENTRUM ULTRA MEN'S	T3	
CENTURY MEN'S	T4	
<i>certavite senior tablet</i> (Centrum Silver)	T2	
<i>certavite senior tablet</i> (Certavite Senior)	T2	
CERTAVITE SENIOR TABLET (<i>multivit-min/fa/lycopen/lutein</i>)	T4	
<i>certavite-antioxidant tablet</i> (Certavite-Antioxidant)	T2	
CERTAVITE-ANTIOXIDANT TABLET (<i>multivitamin/iron/folic acid</i>)	T4	
<i>certavite-antioxidant tablet</i> (Tab-A-Vite Multivit With Iron)	T2	
COMPLETE MEN	T3	
COMPLETE MEN 50 PLUS	T4	
COMPLETE MULTIVITAMIN-MINERAL	T4	
CONCEPT DHA (<i>mvn-min75/iron/iron ps/om3/dha</i>)	T4	
CONCEPT OB (<i>mvn-min 74/iron fum/iron/fa</i>)	T4	
CORVITE	T4	
CULTURELLE PROBIOTIC-MULTIVIT	T4	
<i>cvs b-complex-vit c caplet</i>	T2	
CVS DAILY MULTIPLE TABLET	T3	
<i>cvs daily multiple tablet</i> (One-A-Day)	T2	
<i>cvs hair, skin and nails cplt</i>	T2	
<i>cvs one daily essential tablet</i> (Daily-Vite)	T2	
DAILY GUMMIES	T4	
DAILY MULTIVITAMIN	T4	
<i>daily-vite tablet</i> (Daily-Vite)	T2	
DAILY-VITE TABLET (<i>multivitamin with folic acid</i>)	T4	
DAYAVITE	T4	
DECUBI VITE	T4	

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

T5 – Preferred Specialty
 T6 – Non-Preferred Specialty
 PA – Prior Authorization
 QL – Quantity Limit

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

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

List of Prescription Medications

VITAMINS (Nutritional/Dietary) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
MULTIVITAMIN PREPARATIONS (cont.)		
DEKAS BARIATRIC	T4	
DEKAS ESSENTIAL	T4	
DEKAS PLUS	T4	
DERMACINRX FOLIFLEX	T4	
DERMACINRX FOLITIN-Z	T4	
DERMACINRX MULTITAM	T4	
DERMACINRX RIBOTIN-E	T4	
DERMACINRX VENEXA	T4	
DERMACINRX VENEXA FE	T4	
DERMACINRX VENTRIXYL	T4	
DERMACINRX VENTRIXYL FE	T4	
DERMACINRX VITRAMYN	T4	
DERMACINRX VITRANOL	T4	
DERMACINRX VITRANOL FE	T4	
DERMACINRX VITREXATE	T4	
DERMACINRX VITREXATE FE	T4	
DERMACINRX ZINTREXYL-C	T4	
DIABETES HEALTH FORMULA	T4	
DIABETIC VITAMIN	T4	
DIALYVITE 800 WITH IRON	T4	
ELON MATRIX 5000 COMPLETE	T4	
ENBRACE HR	T4	
ENDUR-VM IRON-FREE	T4	
ENDUR-VM WITH IRON	T4	
EQ ONE DAILY WOMEN'S HEALTH TB	T4	
EQ ONE DAILY WOMEN'S TABLET	T3	
<i>eq1 one daily men's tablet</i>	T2	
ESSENTIAL MAN	T4	
ESSENTIAL MAN 50+	T4	
ESSENTIAL WOMAN 50+	T4	
ESTROVEN MENOPAUSE	T4	
<i>fa/mv,ca,iron,min/lycopene/lut</i>	T2	
FATIGUE RELIEF COMPLEX (<i>bcomp,c/st,jhn wrt/s.ginsg/pgn</i>)	T4	
FOLAGENT DHA	T4	

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

T5 – Preferred Specialty
 T6 – Non-Preferred Specialty
 PA – Prior Authorization
 QL – Quantity Limit

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

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

List of Prescription Medications

VITAMINS (Nutritional/Dietary) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
MULTIVITAMIN PREPARATIONS (cont.)		
FOLAMAX	T4	
FOLAMED DHA	T4	
<i>folic acid/multivit,iron,miner</i>	T2	
<i>folic acid/mv,iron,min/lutein</i>	T2	
FOLIC ACID-VIT B-6-VIT B-12	T4	
<i>folic/mvi ther-min/lycop/lut</i>	T2	
FOLIKA-CI	T4	
FOLIKA-MG	T4	
FORTAVIT	T4	
FREEDAVITE	T4	
GENADEK STEP 1	T4	
GENADEK STEP 2	T4	
GERBER GS PRENATAL NOURISH PLS	T4	
GNP B-COMPLEX PLUS VIT C TAB	T4	
<i>gnp one daily tablet</i>	T2	
HAIR FORMULA	T4	
HAIR, SKIN AND NAILS CAPLET	T4	
HAIR, SKIN AND NAILS SOFTGEL	T4	
HAIR, SKIN AND NAILS TABLET (<i>multivitamin/folic acid/biotin</i>)	T4	
HEARTBURN ACID REFLUX	T4	
<i>high potency multivitamin tab</i>	T2	
HIGH POTENCY MULTIVITAMIN TAB	T4	
<i>high potency multivitamin tab (Certavite-Antioxidant)</i>	T2	
<i>high potency multivitamin tab (Tab-A-Vite Multivit With Iron)</i>	T2	
HM HAIR, SKIN AND NAILS TABLET	T4	
HM MEN'S ONE DAILY TABLET	T3	
ICAPS MV	T3	
ICAPS TABLET	T3	
IMMUNERX	T4	
INFUVITE ADULT	T4	
K-PAX IMMUNE SUPPORT	T3	
<i>lecithin/pyridoxine/kelp</i>	T2	
<i>lmeolate/b3/copp/zn/sel/chrom</i>	T2	
MAXIMIN	T4	

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

T5 – Preferred Specialty
 T6 – Non-Preferred Specialty
 PA – Prior Authorization
 QL – Quantity Limit

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

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

List of Prescription Medications

VITAMINS (Nutritional/Dietary) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
MULTIVITAMIN PREPARATIONS (cont.)		
MEBOLIC	T4	
MEN 50 PLUS ADVANCED ONE DAILY	T4	
MEN 50 PLUS MULTIVITAMIN	T4	
MEN'S 50 PLUS DAILY FORMULA	T4	
MEN'S 50 PLUS MULTIVITAMIN	T4	
MEN'S DAILY FORMULA	T4	
MEN'S DAILY GUMMIES	T4	
MEN'S DAILY PACK	T4	
MEN'S MULTIVITAMIN	T4	
MONOCAPS	T4	
MULTI FOR HER 50 PLUS	T4	
MULTI FOR HER SOFTGEL	T4	
<i>multi for her tablet</i>	T2	
MULTI PRO	T4	
MULTI-DAY PLUS MINERALS	T4	
MULTILEX TABLET	T4	
<i>multilex tablet</i>	T2	
MULTILEX T-M	T4	
<i>multivit 47/iron/folate 1/dha</i>	T2	
<i>multivit infusn,adult 1,vit k</i>	T2	
<i>multivit no.51/iron/folic acid</i>	T2	
<i>multivit with calcium,iron,min</i>	T2	
<i>multivit with iron,minerals</i>	T2	
<i>multivit,calc,mins/iron/folic</i>	T2	
<i>multivit,iron,minerals/lutein</i>	T2	
<i>multivit,stress formula/zinc</i> (Stress Formula With Zinc)	T2	
<i>multivit/iron/folic acid/hb179</i>	T2	
<i>multivitamin</i>	T2	
MULTI-VITAMIN	T4	
<i>multivitamin combination no.55</i>	T2	
<i>multivitamin combination no.56</i>	T2	
MULTIVITAMIN GUMMIES	T4	
MULTIVITAMIN LIQUID	T4	
<i>multivitamin tablet</i>	T2	

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

T5 – Preferred Specialty
T6 – Non-Preferred Specialty
PA – Prior Authorization
QL – Quantity Limit

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

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

List of Prescription Medications

VITAMINS (Nutritional/Dietary) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
MULTIVITAMIN PREPARATIONS (cont.)		
<i>multivitamin with folic acid (Daily-Vite)</i>	T2	
<i>multivitamin with iron</i>	T2	
MULTIVITAMIN WITH MINERALS	T4	
<i>multivitamin with minerals</i>	T2	
<i>multivitamin, stress formula</i>	T2	
<i>multivitamin, ther and minerals</i>	T2	
<i>multivitamin, therapeutic</i>	T2	
<i>multivitamin, therapeutic (Oncovite)</i>	T2	
<i>multivitamin/ferrous gluconate</i>	T2	
<i>multivitamin/iron/folic acid (Certavite-Antioxidant)</i>	T2	
<i>multivitamin/iron/folic acid (Tab-A-Vite Multivit With Iron)</i>	T2	
MULTI-VITE	T4	
<i>multivit-min/fa/lycopen/lutein</i>	T2	
<i>multivit-min/fa/lycopen/lutein (Centrum Silver)</i>	T2	
<i>multivit-min/fa/lycopen/lutein (Certavite Senior)</i>	T2	
<i>multivit-min/ferrous gluconate</i>	T2	
<i>multivit-min/folic acid/biotin</i>	T2	
<i>multivit-min/iron/folic acid</i>	T2	
<i>multivit-min/iron fum/folic ac</i>	T2	
<i>multivit-min/iron/folic/lutein (Central-Vite Women'S Mature)</i>	T2	
<i>multivit-min/iron/folic/lutein (Centrum Silver Women)</i>	T2	
<i>multivit-min69/iron/folic acid</i>	T2	
<i>multivit-minerals/fa/lycopene</i>	T2	
<i>multivit-minerals/folic acid (One-A-Day)</i>	T2	
<i>multivit-minerals/folic/ginkgo</i>	T2	
<i>multivit-mins no.7/folic acid</i>	T2	
<i>multivit-mins/iron/folic/lycop</i>	T2	
<i>mv, min 59/iron/folic/docusate</i>	T2	
<i>mv, cal, min/iron/folic acid/lut</i>	T2	
<i>mv, iron, min/ginkgo/pan.ginseng</i>	T2	
<i>mv-min/iron/folic ac/vit k/lut</i>	T2	
<i>mv-mins 71/iron/folic no.1/dha</i>	T2	
<i>mv-mins/folic/lycopene/ginkgo</i>	T2	
<i>mv-mn/folic acid/lutein/hrb178</i>	T2	

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

T5 – Preferred Specialty
 T6 – Non-Preferred Specialty
 PA – Prior Authorization
 QL – Quantity Limit

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

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

List of Prescription Medications

VITAMINS (Nutritional/Dietary) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
MULTIVITAMIN PREPARATIONS (cont.)		
<i>mvn no.53/iron/folic/dss/dha</i>	T2	
<i>mvn-min 74/iron fum/iron/fa</i> (Concept Ob)	T2	
<i>mvn-min75/iron/iron ps/om3/dha</i> (Concept Dha)	T2	
MVW MODULATR FORM MINI MULTIVT	T4	
NEEVODHA	T4	
NEOVITE	T4	
NESTABS ONE	T4	
NICOMIDE	T4	
NIVA-PLUS (<i>multivit-mins60/iron fum/folic</i>)	T4	
NUTRIVIT	T3	
OB COMPLETE	T4	
OBSTETRIX ONE	T4	
O-CAL FA	T4	
OCUVITE EYE PLUS MULTI	T4	
<i>om-3/dha/epa/b12/fa/b6/phytost</i>	T2	
OMNIVEX	T4	
ONCOVITE (<i>multivitamin,therapeutic</i>)	T3	
ONE DAILY ESSENTIAL TABLET	T4	
<i>one daily essential tablet</i>	T2	
<i>one daily essential tablet</i> (Daily-Vite)	T2	
ONE DAILY HEALTHY WEIGHT	T4	
ONE DAILY MEN'S	T3	
ONE DAILY MEN'S 50 PLUS	T4	
ONE DAILY MEN'S 50 PLUS D3	T4	
ONE DAILY MEN'S HEALTH	T4	
ONE DAILY MEN'S MULTIVITAMIN	T4	
<i>one daily multivit-mineral tab</i>	T2	
ONE DAILY MULTIVIT-MINERAL TAB	T4	
<i>one daily multivitamin tab</i>	T2	
ONE DAILY MULTIVITAMIN TABLET	T4	
<i>one daily multivitamin tablet</i> (Daily-Vite)	T2	
<i>one daily tablet</i>	T2	
ONE DAILY WOMEN 50 PLUS TAB	T4	
ONE DAILY WOMEN'S 50 PLUS ADV	T4	

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

T5 – Preferred Specialty
T6 – Non-Preferred Specialty
PA – Prior Authorization
QL – Quantity Limit

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

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

List of Prescription Medications

VITAMINS (Nutritional/Dietary) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
MULTIVITAMIN PREPARATIONS (cont.)		
ONE DAILY WOMEN'S 50+	T3	
ONE DAILY WOMEN'S FORMULA	T4	
<i>one daily women's health tab</i>	T2	
ONE DAILY WOMEN'S MULTIVITAMIN	T4	
ONE-A-DAY (<i>multivit-minerals/folic acid</i>)	T4	
ONE-A-DAY ENERGY	T4	
ONE-A-DAY MEN VITACRAVES	T4	
ONE-A-DAY MENOPAUSE FORMULA	T4	
ONE-A-DAY MEN'S	T3	
ONE-A-DAY MEN'S 50 PLUS	T3	
ONE-A-DAY MEN'S 50 PLUS (<i>mv-mins/folic/lycopene/ginkgo</i>)	T3	
ONE-A-DAY MEN'S COMPLETE	T4	
ONE-A-DAY PROACTIVE 65 PLUS	T4	
ONE-A-DAY VITACRAVES	T4	
ONE-A-DAY VITACRAVES IMMUNITY	T4	
ONE-A-DAY VITACRAVES OMEGA-3	T4	
ONE-A-DAY VITACRAVES SOUR	T4	
ONE-A-DAY WEIGHTSMART	T3	
ONE-A-DAY WOMEN VITACRAVES	T4	
ONE-A-DAY WOMEN'S 50 PLUS	T4	
ONE-A-DAY WOMEN'S COMPLETE	T3	
ONE-A-DAY WOMEN'S HEALTHY SKIN	T4	
ONE-A-DAY WOMEN'S PETITES	T4	
ONE-A-DAY WOMEN'S TABLET	T3	
ONE-A-DAY WOMEN'S TABLET	T4	
ONE-DAILY MULTI	T4	
ONE-DAILY MULTI-VIT POWDER PKT	T4	
<i>one-daily multi-vitamin tab</i>	T2	
ONE-DAILY MULTI-VITAMIN-IRON	T4	
ONE-DAILY MULTIVITAMIN-MINERAL	T4	
ONEVITE	T4	
OPTIFAST	T4	
OPTISOURCE	T4	
OPURITY MULTIVITAMIN	T4	

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

T5 – Preferred Specialty
 T6 – Non-Preferred Specialty
 PA – Prior Authorization
 QL – Quantity Limit

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

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

List of Prescription Medications

VITAMINS (Nutritional/Dietary) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
MULTIVITAMIN PREPARATIONS (cont.)		
POLY VITAMIN-IRON	T4	
PRENATE AM	T4	
PRENATE CHEWABLE	T4	
PRENATE ESSENTIAL	T4	
PROCERV HP	T4	
PROFOLA	T4	
PRORENAL QD	T3	
PROTECT CARDIO AF	T4	
PROTECT IRON	T4	
PROTECT PLUS SO	T4	
PUREFE OB PLUS	T4	
PUREFE PLUS	T4	
QUINTABS	T4	
QUINTABS-M	T4	
RA MEN'S ONE DAILY TABLET	T3	
<i>ra one daily essential tablet (One-A-Day)</i>	T2	
<i>ra one daily women's tablet</i>	T2	
REMEDIENT	T4	
<i>sm b complex with vit c tablet</i>	T2	
<i>sm super b complex-c caplet</i>	T2	
SOLO	T4	
SPECTRAVITE MEN 50 PLUS	T4	
SPECTRAVITE ULTRA MEN 50+	T4	
SPECTRAVITE ULTRA MEN'S	T4	
STRESS B-COMPLEX	T4	
<i>stress formula tablet</i>	T2	
STRESS FORMULA WITH ZINC TAB (<i>multivit, stress formula/zinc</i>)	T4	
<i>stress formula with zinc tab (Stress Formula With Zinc)</i>	T2	
<i>stress-c with zinc tablet (Stress Formula With Zinc)</i>	T2	
STROVITE FORTE (<i>multivit, iron, min 5/folic acid</i>)	T4	
STROVITE ONE	T4	
SUPER GINSENG MULTIVITAMIN	T4	
SUPER MULTIPLE-LOW IRON	T4	
SUPPORT-500 (<i>b-complex with vitamin c</i>)	T4	

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

T5 – Preferred Specialty
 T6 – Non-Preferred Specialty
 PA – Prior Authorization
 QL – Quantity Limit

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

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

List of Prescription Medications

VITAMINS (Nutritional/Dietary) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
MULTIVITAMIN PREPARATIONS (cont.)		
SV HAIR, SKIN AND NAILS CAPLET	T4	
TAB-A-VITE MULTIVIT WITH IRON	T4	
<i>tab-a-vite multivit with iron</i>	T2	
TAB-A-VITE MULTIVIT WITH IRON (<i>multivitamin/iron/folic acid</i>)	T4	
THERAGRAN-M PREMIER 50 PLUS	T4	
<i>thera-m caplet</i>	T2	
THERA-M CAPLET	T4	
THERAMILL FORTE	T4	
THERANATAL LACTATION SUPPORT	T4	
THEREMS-H	T3	
TOBAKIENT	T4	
TRUE MULTIVITAMIN	T4	
TRUEPLUS MULTIVITAMIN (<i>multivit-min/folic acid/vit k1</i>)	T4	
UDAMIN SP	T4	
ULTRA FREEDA	T4	
VITABEX PLUS	T4	
VITAJoy ADULT MULTI	T4	
<i>vitamin b complex-vit c cap (Support-500)</i>	T2	
<i>vitamin b complex-vit c caplet</i>	T2	
<i>vitamin b complex-vitamin c tb</i>	T2	
VITAMIN D3-ALOE	T4	
<i>vitamins a and d</i>	T2	
VITAMINS A-D-E	T4	
VITREXYL	T4	
VITREXYL PLUS IRON	T4	
VITRUM 50 PLUS SENIOR	T3	
WELLESSE MULTI VITAMIN PLUS	T4	
WOMEN 50 PLUS MULTIVIT ADVANCE	T4	
WOMEN'S 50 PLUS ADVANCED	T4	
WOMEN'S 50 PLUS DAILY FORMULA	T4	
<i>women's daily formula caplet</i>	T2	
WOMEN'S DAILY FORMULA CAPLET	T3	
WOMEN'S DAILY FORMULA TABLET	T4	
WOMENS DAILY GUMMIES	T4	

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

T5 – Preferred Specialty
T6 – Non-Preferred Specialty
PA – Prior Authorization
QL – Quantity Limit

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

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

List of Prescription Medications

VITAMINS (Nutritional/Dietary) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
MULTIVITAMIN PREPARATIONS (cont.)		
WOMEN'S DAILY PACK	T4	
WOMEN'S MULTIVITAMIN	T4	
WOMEN'S MULTIVITAMIN W-BIOTIN	T4	
XYZBAC	T4	
ZYVANA	T4	
ZYVIT	T4	
NIACIN PREPARATIONS		
<i>cvs niacin 400 mg capsule</i>	T2	
<i>cvs niacin flush free 500 mg</i>	T2	
ENDUR-AMIDE	T4	
ENDUR-THINE	T4	
<i>gnp niacin 250 mg tablet</i>	T2	
<i>gnp niacin 400 mg capsule</i>	T2	
<i>hm niacin tr 250 mg tablet (Slo-Niacin)</i>	T2	
<i>niacin</i>	T2	
<i>niacin (inositol niacinate)</i>	T2	
<i>niacin (Slo-Niacin)</i>	T2	
<i>niacin 100 mg tablet</i>	T2	
<i>niacin 250 mg tablet</i>	T2	
<i>niacin 50 mg tablet</i>	T2	
<i>niacin 500 mg capsule</i>	T2	
<i>niacin 500 mg capsule sa</i>	T2	
NIACIN 500 MG SOFTGEL	T3	
<i>niacin 500 mg tablet</i>	T2	
<i>niacin 750 mg tablet sa (Slo-Niacin)</i>	T2	
NIACIN ER 1,000 MG TABLET	T3	
<i>niacin er 250 mg tablet (Slo-Niacin)</i>	T2	
<i>niacin er 500 mg caplet</i>	T2	
<i>niacin er 500 mg capsule</i>	T2	
<i>niacin er 500 mg tablet</i>	T2	
<i>niacin flush free 500 mg cap</i>	T2	
NIACIN FLUSH FREE 750 MG CAP	T3	
<i>niacin sa 250 mg capsule</i>	T2	
<i>niacin tr 250 mg capsule</i>	T2	

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

T5 – Preferred Specialty
 T6 – Non-Preferred Specialty
 PA – Prior Authorization
 QL – Quantity Limit

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

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

List of Prescription Medications

VITAMINS (Nutritional/Dietary) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
NIACIN PREPARATIONS (cont.)		
<i>niacin tr 250 mg tablet (Slo-Niacin)</i>	T2	
<i>niacin tr 500 mg caplet, tablet</i>	T2	
<i>niacinamide 500 mg tablet</i>	T2	
NIACINAMIDE ER 500 MG TABLET	T4	
NO FLUSH NIACIN	T4	
<i>ra niacin 100 mg, 500 mg tablet</i>	T2	
RA NIACIN 500 MG TABLET	T4	
SLO-NIACIN 250 MG TABLET (<i>niacin</i>)	T3	
<i>slo-niacin 500 mg tablet</i>	T2	
SLO-NIACIN 750 MG TABLET (<i>niacin</i>)	T3	
<i>sv niacin flush free 500 mg</i>	T2	
PANTHENOL PREPARATIONS		
CALCIUM PANTOTHENATE	T4	
PANTETHINE	T4	
PEDIATRIC VITAMIN PREPARATIONS		
ABDEK MULTIVITAMIN	T4	
ANIMAL SHAPES COMPLETE	T4	
AQUADEKS	T3	
CENTRUM KIDS	T4	
CHILD CHEWABLE VITAMN COMPLETE	T4	
CHILD COMPLETE CHEWABLE VITAMN	T4	
CHILD COMPLETE MULTIVITAMIN	T4	
CHILD MULTIVITAMIN PLUS IRON	T4	
CHILDREN MULTIVITAMIN	T4	
<i>children multivitamin chew tab</i>	T2	
CHILDREN MULTIVITAMIN GUMMIES	T4	
CHILDREN MULTIVITAMIN GUMMIES (<i>pediatric multivitamin no.120</i>)	T4	
CHILDREN'S CHEW MULTIVIT-IRON (<i>pedi multivit no.91/iron fum</i>)	T4	
<i>childrens chew vitamin tab (Flintstones With Extra C)</i>	T2	
<i>childrens chew vitamin tab (Flintstones)</i>	T2	
CHILDREN'S CHEWABLE	T4	
CHILDREN'S MULTI-VIT GUMMIES	T4	
CHILDREN'S MULTIVITAMIN GUMMY	T4	
CHILD'S CHEWABLE VITAMIN TAB	T4	

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

T5 – Preferred Specialty
 T6 – Non-Preferred Specialty
 PA – Prior Authorization
 QL – Quantity Limit

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

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

List of Prescription Medications

VITAMINS (Nutritional/Dietary) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
PEDIATRIC VITAMIN PREPARATIONS (cont.)		
CHILD'S OMEGA-3 DHA MULTIVITAM	T4	
CULTURELLE KIDS PROBIOTIC-MV	T4	
CULTURELLE KIDS PRO-MV-LUTEIN	T4	
CVS CHILD GUMMY DINOS GUMMIES	T4	
<i>cvs gummy dinos vitamin</i>	T4	
DEKAS PLUS	T2	
EMERGEN-C KIDZ	T4	
EQ CHILD MULTIVITAMIN GUMMIES	T4	
FLINTSTONES COMPLETE GUMMIES	T3	
FLINTSTONES COMPLETE TABLET (<i>multivit with iron,minerals</i>)	T4	
FLINTSTONES EXTRA C GUMMIES	T3	
FLINTSTONES EXTRA C TAB CHEW (<i>multivitamin</i>)	T4	
FLINTSTONES GUMMIES	T3	
FLINTSTONES GUMMIES CHEW TAB	T3	
FLINTSTONES IMMUNITY SUPPORT	T4	
FLINTSTONES MULTIVIT CHEW TAB (<i>pedi multivit no.25/folic acid</i>)	T4	
FLINTSTONES MULTI-VIT GUMMIES	T4	
FLINTSTONES PLUS CALCIUM	T3	
FLINTSTONES SOUR-GUM CHEW TAB	T3	
FLINTSTONES TAB CHEW	T4	
FLINTSTONES TABLET CHEWABLE (multivitamin)	T3	
FLINTSTONES WITH IRON	T4	
FLORIVA	T3	
FLORIVA PLUS	T4	
GENADEK	T4	
GERBER GROW MIGHTY	T4	
GERBER LIL BRAINIES	T4	
GUMMIES CHILDREN MULTIVITAMIN	T4	
GUMMY	T4	
INFANT-TODDLER MULTIVITAMIN	T4	
INFANT-TODDLER MULTIVIT-IRON	T4	
<i>infant-toddler multivit-iron</i>	T2	
INFANT-TODDLER TRI-VITAMIN	T4	
INFUVITE PEDIATRIC	T3	

T1 – Preferred Generics

T2 – Non-Preferred Generics

T3 – Preferred Brands

T4 – Non-Preferred Brands

T5 – Preferred Specialty

T6 – Non-Preferred Specialty

PA – Prior Authorization

QL – Quantity Limit

ST – Step Therapy

AGE – Age Requirement

SP – Specialty Medication

HD – May require home delivery pharmacy

PPACA – No Cost-Share Preventive Medication

CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

VITAMINS (Nutritional/Dietary) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
PEDIATRIC VITAMIN PREPARATIONS (cont.)		
JUST 4 KIDZ MULTIVIT-PROBIOTIC	T4	
KIDS COD LIVER OIL +D	T4	
KIDS MULTIVITAMIN-MINERALS	T3	
LITTLE ANIMALS PLUS IRON	T4	
LIVITA FOR CHILDREN	T4	
M.V.I. PEDIATRIC	T3	
<i>multivit with iron,minerals</i>	T2	
<i>multivit with iron,minerals (Flintstones Complete)</i>	T2	
<i>multivit with iron,minerals (Scooby-Doo)</i>	T2	
<i>multivitamin (Flintstones With Extra C)</i>	T2	
<i>multivitamin (Flintstones)</i>	T2	
<i>multivitamin with iron</i>	T2	
MULTI-VIT-FLOR	T4	
MULTIVIT-FLUOR 0.25 MG TAB CHW	T4	
<i>multivit-fluor 0.25 mg, 0.5 mg tab chw</i>	T2	PPACA
<i>multivit-fluor 0.25 mg/ml drop</i>	T2	PPACA
MULTIVIT-FLUOR 0.5 MG TAB CHEW	T4	
<i>multivit-fluor 0.5 mg/ml drop</i>	T2	PPACA
<i>multivit-fluoride 1 mg tab chw</i>	T2	PPACA
MULTIVIT-FLUORIDE 1 MG TAB CHW	T4	
MVW COMPLETE FORMLTN PEDIATRIC	T4	
MVW COMPLETE FORMULATION D3000	T4	
MVW COMPLETE FORMULATION D5000	T4	
MVW COMPLETE FORMULTN MULTIVIT	T4	
MVW MODULATR FORMLTN PEDIATRIC	T4	
NANOVM 1-3	T3	
NANOVM 4-8	T3	
NANOVM 9-18	T4	
NANOVM T-F	T4	
NOVAFERRUM PEDIATRIC MV-IRON	T4	
NOVAMV	T4	
ONE-A-DAY KID'S	T4	
ONE-A-DAY TEEN HER VITACRAVES	T4	
ONE-A-DAY TEEN HIM VITACRAVES	T4	

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

T5 – Preferred Specialty
T6 – Non-Preferred Specialty
PA – Prior Authorization
QL – Quantity Limit

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

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

List of Prescription Medications

VITAMINS (Nutritional/Dietary) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
PEDIATRIC VITAMIN PREPARATIONS (cont.)		
<i>ped mvit a,c,d3 no.21/fluoride</i>	T2	PPACA
<i>pedi multivit 158/iron/vit k1</i>	T2	
<i>pedi multivit 45/fluoride/iron</i>	T2	
<i>pedi multivit no.12 w-fluoride</i>	T2	PPACA
<i>pedi multivit no.159/iron sulf</i>	T2	
<i>pedi multivit no.23/folic acid</i>	T2	
<i>pedi multivit no.25/folic acid (Flintstones)</i>	T2	
PEDIA POLY-VITE	T4	
<i>pedia poly-vite iron 5mg/0.5ml</i>	T2	
PEDIA POLY-VITE WITH IRON DROP	T4	
PEDIA TRI-VITE	T4	
<i>pediatric multivit no.36/iron</i>	T2	
<i>pediatric multivitamin no.17</i>	T2	
PEDIATRIC POLY-VITAMIN	T4	
PEDIATRIC POLY-VITAMIN-IRON	T4	
PEDIATRIC POLY-VITE	T4	
PEDIATRIC POLY-VITE WITH IRON	T4	
PEDIATRIC TRI-VITAMIN	T4	
PEDIATRIC TRI-VITE	T4	
POLY-VI-FLOR	T4	
POLY-VI-FLOR WITH IRON	T4	
<i>poly-vi-sol 0.5 ml oral syring</i>	T2	
<i>POLY-VI-SOL 1 ML ENFIT SYRINGE</i>	T4	
<i>POLY-VI-SOL 250MCG-50MG/ML DRP</i>	T4	
<i>POLY-VI-SOL WITH IRON</i>	T4	
POLY-VITA	T4	
<i>POLY-VITA WITH IRON</i>	T4	
QUFLORA	T4	
QUFLORA FE	T4	
SCOOBY-DOO ONE A DAY GUMMIES	T4	
SCOOBY-DOO ONE A DAY TABLET (<i>multivit with iron,minerals</i>)	T3	
TRI-VI-FLOR	T4	
TRI-VI-SOL	T4	
TROPICAL LIQUID NUTRITION (<i>pediatric multivitamin no.118</i>)	T4	

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

T5 – Preferred Specialty
T6 – Non-Preferred Specialty
PA – Prior Authorization
QL – Quantity Limit

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

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

List of Prescription Medications

VITAMINS (Nutritional/Dietary) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
PEDIATRIC VITAMIN PREPARATIONS (cont.)		
<i>vit a palmitate/vit c/vit d3</i>	T2	
ZOO FRIENDS	T4	
ZOO FRIENDS COMPLETE	T4	
VITAMIN A AND D PREPARATIONS		
cod liver oil softgel	T2	
gnp norwegian cod liver oil	T2	
SV COD LIVER OIL SOFTGEL	T4	
VITAMIN A PREPARATIONS		
A-25	T4	
AQUASOL A	T3	
<i>beta-carotene</i>	T2	
<i>cvs vitamin a 2,400 mcg sftgl</i>	T2	
<i>gnp vitamin a 10,000 unit sftgl</i>	T2	
NORWEGIAN COD LIVER OIL SFGL	T4	
PREVENT	T3	
<i>ra vitamin a 10,000 unit sftgl</i>	T2	
VITAMIN A BETA CAROTENE	T4	
<i>vitamin a 10,000 unit capsule</i>	T2	
<i>vitamin a 10,000 unit softgel</i>	T2	
VITAMIN A 10,000 UNIT SOFTGEL	T4	
<i>vitamin a 3,000 mcg softgel</i>	T2	
<i>vitamin a 8,000 unit capsule</i>	T2	
<i>vitamin a 8,000 unit softgel</i>	T2	
VITAMIN A PALMITATE	T4	
<i>vitamin a/vit c/zinc/propolis</i>	T2	
VITAMINS A D	T4	
VITAMIN B PREPARATIONS		
5-MTHF PLUS B12	T4	HD
<i>acetylcyst/methylb12/levomefol</i>	T2	HD
ALBA-LYBE	T3	HD
APETEX (<i>vitamin b complex/lysine</i>)	T3	HD
APETIGEN (<i>vitamin b complex/lysine</i>)	T3	HD
ARKALIOX	T4	HD
B ACTIV	T4	HD
<i>b comp no3/folic/c/biotin/zinc</i>	T2	HD

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

T5 – Preferred Specialty
T6 – Non-Preferred Specialty
PA – Prior Authorization
QL – Quantity Limit

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

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

List of Prescription Medications

VITAMINS (Nutritional/Dietary) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
VITAMIN B PREPARATIONS (cont.)		
<i>b comp/ferrous gluc/lysin/znox</i>	T2	HD
<i>b complex 11/folic/c/biot/zinc</i>	T2	HD
<i>b complex c no.10/folic acid</i>	T2	HD
<i>b complex capsule</i>	T2	HD
<i>b complex tablet</i>	T2	HD
<i>b complex w-c no.20/folic acid (Nirt-Caps)</i>	T2	HD
B COMPLEX WITH B-12	T4	HD
B COMPLEX WITH VITAMIN C	T4	HD
B COMPLEX-FOLIC ACID (<i>cyanocobalamin/folic ac/vit b6</i>)	T4	HD
<i>b12/levomefolate calcium/b-6</i>	T2	HD
B-50 COMPLEX	T4	HD
<i>balanced b-100 complex tab sa</i>	T2	HD
B-COMPLEX FAST DISSOLVE TABLET	T4	HD
<i>b-complex 100 injection</i>	T2	HD
<i>b-complex injection vial</i>	T2	HD
<i>b-complex plus vitamin c cplt (Vita-Bee With C)</i>	T2	HD PPACA
<i>b-complex tablet</i>	T2	HD PPACA
B-COMPLEX WITH B-12	T4	HD
<i>b-complex with b12 tablet</i>	T2	HD
<i>b-complex with vit c caplet (Vita-Bee With C)</i>	T2	HD PPACA
<i>b-complex with vit c tablet (Vita-Bee With C)</i>	T2	HD PPACA
B-COMPLEX-VITAMIN C TR TABLET	T3	HD
BIOTIN 1,000 MCG GUMMIES	T4	HD
<i>biotin 1,000 mcg tablet</i>	T2	HD
BIOTIN 10 MG TABLET	T3	HD
BIOTIN 10,000 MCG SOFTGEL	T4	HD
BIOTIN 10,000 MCG TABLET	T3	HD
<i>biotin 2,500 mcg softgel (Hard Nails)</i>	T2	HD
<i>biotin 300 mcg tablet</i>	T2	HD
BIOTIN 5 MG TABLET	T4	HD
<i>biotin 5,000 mcg capsule (Meribin)</i>	T2	HD
BIOTIN 5,000 MCG FAST DISSOLVE	T4	HD
BIOTIN 5,000 MCG QUICK DISSOLV	T4	HD
<i>biotin 5,000 mcg softgel (Meribin)</i>	T2	HD

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

T5 – Preferred Specialty
T6 – Non-Preferred Specialty
PA – Prior Authorization
QL – Quantity Limit

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

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

List of Prescription Medications

VITAMINS (Nutritional/Dietary) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
VITAMIN B PREPARATIONS (cont.)		
BIOTIN 5,000 MCG TABLET	T4	HD
<i>biotin 800 mcg tablet</i>	T2	HD
BIOTIN FORTE 3 MG TABLET	T4	HD
BIOTIN FORTE 5 MG TABLET	T3	HD
BREWER'S YEAST	T4	HD
B-STRESS	T4	HD
CARDIOTEK-RX	T4	HD
CEREFOLIN (<i>vit b12/levomefolate/vit b6/b2</i>)	T4	HD
CEREFOLIN NAC	T4	HD
COMPLEX B-100 ER CAPLET	T4	HD
<i>complex b-100 tablet sa</i>	T2	HD
COMPLEX B-50	T4	HD
CVS BALANCED B-100 TR CAPLET	T4	HD
<i>cvs biotin 1,000 mcg tablet</i>	T2	HD
CVS BIOTIN 10,000 MCG SOFTGEL	T4	HD
<i>cvs super b-complex-vit c cplt (Vita-Bee With C)</i>	T2	HD PPACA
<i>cyanocobalamin/folic ac/vit b6</i>	T2	HD
<i>cyanocobalamin/folic ac/vit b6</i>	T2	HD PPACA
<i>cyanocobalamin/folic ac/vit b6 (Niva-Fol)</i>	T2	HD
CYTO B7	T4	HD
DIALYVITE 3000	T4	HD
DIALYVITE 5000	T4	HD
DIALYVITE 800 CHEWABLE WAFER	T4	HD
DIALYVITE 800 PLUS D	T4	HD
<i>dialyvite 800 tablet</i>	T2	HD PPACA
DIALYVITE 800 WITH ZINC	T4	HD
DIALYVITE 800-ULTRA D	T3	HD
DIALYVITE SUPREME D	T4	HD
ELFOLATE PLUS	T4	HD
ENDUR-B COMPLEX	T4	HD
<i>eql b complex 50 tablet</i>	T2	HD
<i>folic acid/b complex c no.17</i>	T2	HD
<i>folic acid/vit b complex and c</i>	T2	HD PPACA
<i>folic acid/vit b complex and c</i>	T2	HD
<i>folic acid/vit b complex and c (Hylavite)</i>	T2	HD

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

T5 – Preferred Specialty
 T6 – Non-Preferred Specialty
 PA – Prior Authorization
 QL – Quantity Limit

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

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

List of Prescription Medications

VITAMINS (Nutritional/Dietary) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
VITAMIN B PREPARATIONS (cont.)		
<i>folic acid/vit b complex and c</i> (Vita-Bee With C)	T2	HD PPACA
<i>folic acid/vit bcomp,c/cu/zinc</i>	T2	HD
FOLIKA-BC	T4	HD
FOLIKA-NC	T4	HD
FOLIKA-T	T4	HD
FOLINIC-PLUS	T4	HD
FOLTX	T4	HD
GENICIN VITA-S	T4	HD
<i>gnp biotin 5,000 mcg capsule</i> (Meribin)	T2	HD
HAIR-SKIN-NAILS	T4	HD
HARD NAILS (<i>biotin</i>)	T4	HD
HM BIOTIN 10,000 MCG TABLET	T4	HD
<i>hm biotin 5,000 mcg capsule</i> (Meribin)	T2	HD
HOMOCYSTEINE FORMULA	T4	HD
HYLAVITE (<i>folic acid/vit b complex and c</i>)	T4	HD
<i>levomefolate/b6/b12/algae oil</i>	T2	HD
LEVOMEFOLATE-NAC-MECOBAL-ALGAL	T4	HD
LEVOMEFOL-PYRIDOXAL-MEC-ALGAL	T4	HD
<i>l-mefol/a-cyst/meb12/algae oil</i>	T2	HD
L-METHYLFOL-ALGAL-NAC-ME-CBL	T4	HD
L-METHYLFOL-ALGAL-P5P-ME-CBL	T4	HD
LORID	T4	HD
LORMATE	T4	HD
<i>mecobal/levomefolat ca/b6 phos</i>	T2	HD
MEDTYCHOLL-B COMPLEX W-LIVER	T4	HD
MEGA BIOTIN	T4	HD
MERIBIN (<i>biotin</i>)	T3	HD
METANX	T4	HD
METHAVER	T4	HD
METHYL PROTECT	T4	HD
MULTIVITAMIN-ZINC-STRESS	T4	HD
NEPHRON FA	T4	HD
NEPHRO-VITE	T3	HD
NIVA-FOL (<i>cyanocobalamin/folic ac/vit b6</i>)	T4	HD

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

T5 – Preferred Specialty
T6 – Non-Preferred Specialty
PA – Prior Authorization
QL – Quantity Limit

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

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

List of Prescription Medications

VITAMINS (Nutritional/Dietary) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
VITAMIN B PREPARATIONS (cont.)		
NUFOLA	T4	HD
PODIAPN	T4	HD
POTABA	T4	HD
PRORENAL	T3	HD
QUIN B STRONG	T4	HD
<i>ra balanced b-100 tablet</i>	T2	HD PPACA
<i>ra b-complex-vitamin b-12 tab</i>	T2	HD
<i>ra biotin 2,500 mcg capsule (Hard Nails)</i>	T2	HD
RENAL VITAMIN	T4	HD
RENAL-VITE	T4	HD
RENAPLEX	T4	HD
RENAPLEX-D	T4	HD
RIBOZEL	T4	HD
<i>sm biotin 5,000 mcg capsule (Meribin)</i>	T2	HD
SM BIOTIN 5,000 MCG TABLET	T4	HD
<i>sm stress formula+zinc tablet</i>	T2	HD
<i>super b-50 complex capsule</i>	T2	HD
<i>super b-50 complex capsule</i>	T2	HD PPACA
<i>super b complex-vit c caplet (Vita-Bee With C)</i>	T2	HD PPACA
<i>super quints b-50 tablet</i>	T2	HD PPACA
<i>super quints b-50 tablets</i>	T2	HD
SV BIOTIN 1,000 MCG SOFTGEL	T4	HD
<i>sv biotin 5,000 mcg softgel (Meribin)</i>	T2	HD
TRONVITE	T4	HD
ULTRA B-100 COMPLEX TABLET	T4	HD
<i>ultra b-100 complex tablet</i>	T2	HD
VB7 MAX	T4	HD
VIRT-CAPS (<i>b complex w-c no.20/folic acid</i>)	T4	HD
<i>vit b comp c 19/folic acid/d3</i>	T2	HD PPACA
<i>vit b comp no.3/folic/c/biotin</i>	T2	HD
<i>vit b comp/c/fa/iron sulf/vite</i>	T2	HD PPACA
<i>vit b comp/c/folic/iron/vit e</i>	T2	HD PPACA
<i>vit b complex 100 combo no.2</i>	T2	HD
<i>vit b 12/levomefolate/vit b6/b2 (Cerefolin)</i>	T2	HD

T1 – Preferred Generics

T2 – Non-Preferred Generics

T3 – Preferred Brands

T4 – Non-Preferred Brands

T5 – Preferred Specialty

T6 – Non-Preferred Specialty

PA – Prior Authorization

QL – Quantity Limit

ST – Step Therapy

AGE – Age Requirement

SP – Specialty Medication

HD – May require home delivery pharmacy

PPACA – No Cost-Share Preventive Medication

CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

VITAMINS (Nutritional/Dietary) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
VITAMIN B PREPARATIONS (cont.)		
VITA-BEE WITH C (<i>folic acid/vit b complex and c</i>)	T4	HD
VITAJoy BIOTIN	T4	HD
VITAL-D RX	T4	HD
<i>vitamin b complex</i>	T2	HD
<i>vitamin b complex capsule</i>	T2	HD
<i>vitamin b complex softgel</i>	T2	HD
<i>vitamin b complex tablet</i>	T2	HD PPACA
<i>vitamin b complex tablet</i>	T2	HD
<i>vitamin b complex/folic acid</i>	T2	HD PPACA
<i>vitamin b complex/lysine (Apetex)</i>	T2	HD
<i>vitamin b complex/lysine (Apetigen)</i>	T2	HD
<i>vitamin b complex-vitamin c tb (Vita-Bee With C)</i>	T2	HD PPACA
<i>vitamin b-complex c caplet</i>	T2	HD PPACA
VITA-RESPA	T4	HD
VITASURE	T4	HD
WEST-VITE WITH FOLIC ACID	T4	HD
XVITE	T4	HD
ZELDANA	T4	HD
VITAMIN B1 PREPARATIONS		
CYTO B-1	T4	
<i>thiamine 100 mg tablet</i>	T2	
<i>thiamine 200 mg/2 ml vial</i>	T2	
<i>thiamine 250 mg tablet</i>	T2	
THIAMINE 500 MG TABLET	T4	
<i>thiamine hcl</i>	T2	
<i>thiamine mononitrate (vit b1)</i>	T2	
VITAMIN B1	T4	
VITAMIN B12 PREPARATIONS		
ABANEU-SL	T4	
APATATE	T3	
B-12 1,000 MCG FAST DISSOLVE	T4	
B-12 1,000 MCG LOZENGE	T4	
B-12 1,000 MCG QUICK DISSOLVE	T4	
<i>b-12 1,000 mcg tablet</i>	T2	

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

T5 – Preferred Specialty
T6 – Non-Preferred Specialty
PA – Prior Authorization
QL – Quantity Limit

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

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

List of Prescription Medications

VITAMINS (Nutritional/Dietary) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
VITAMIN B12 PREPARATIONS (cont.)		
B-12 1,000 MCG/15 ML LIQUID	T3	
<i>b-12 1,000 mcg/15 ml liquid</i>	T2	
<i>b-12 2,500 mcg microlozenge</i>	T2	
<i>b12 2,500 mcg tablet sl</i>	T2	
<i>b-12 2,500 mcg tablet sl</i>	T2	
B-12 3,000 MCG TABLET SL	T4	
<i>b-12 3,000 mcg/ml subling liq</i>	T2	
B-12 5,000 MCG FAST DISSOLVE	T4	
B12 5,000 MCG MICROLOZENGE	T4	
B-12 5,000 MCG MICROLOZENGE	T3	
B-12 5,000 MCG ODT	T4	
B-12 5,000 MCG QUICK DISSOLVE	T4	
B-12 5,000 MCG SUBLINGUAL TAB	T4	
B-12 5,000 MCG/ML SUBLING LIQ	T4	
B-12 500 MCG QUICK DISSOLVE TB	T4	
<i>b-12 500 mcg tablet</i>	T2	
B12 ACTIVE	T4	
B-12 DUAL SPECTRUM	T4	
<i>b-12 er 1,000 mcg tab</i>	T2	
B-12 WITH FOLIC ACID	T4	
<i>cvs b-12 1,000 mcg tablet</i>	T2	
CVS B-12 5,000 MCG MICROLOZENG	T4	
CVS B-12 5,000 MCG MICROLOZENG	T3	
CVS VIT B-12 500 MCG LOZENGE	T3	
<i>cvs vit b-12 500 mcg lozenge</i>	T2	
<i>cvs vit b-12 tr 1,000 mcg tab</i>	T2	
<i>cvs vit b-12 tr 2,000 mcg tab</i>	T2	
CVS VIT B12 2,500 MCG SOFT CHW	T4	
CVS VITAMIN B12 5,000 MCG TAB	T4	
CVS VITAMIN B-12 500 MCG GUMMY	T4	
<i>cvs vitamin b-12 500 mcg tab</i>	T2	
<i>cyanocobalamin (vitamin b-12) (Nascobal)</i>	T2	ST QL(4 units/30 days)
<i>eql vitamin b-12 500 mcg tab</i>	T2	
<i>fn vitamin b-12 1,000 mcg tab</i>	T2	

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

T5 – Preferred Specialty
 T6 – Non-Preferred Specialty
 PA – Prior Authorization
 QL – Quantity Limit

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

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

List of Prescription Medications

VITAMINS (Nutritional/Dietary) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
VITAMIN B12 PREPARATIONS (cont.)		
FOLTRATE	T4	
<i>gnp b12 2,500 mcg tablet sl</i>	T2	
<i>gnp vit b-12 er 1,000 mcg tab</i>	T2	
<i>gnp vitamin b-12 500 mcg tab</i>	T2	
<i>hm vit b-12 tr 1,000 mcg tab</i>	T2	
<i>hm vitamin b-12 500 mcg tablet</i>	T2	
<i>hydroxocobalamin</i>	T2	
INTRINSI B12-FOLATE	T4	
METHYL B-12	T4	
METHYLCOBALAMIN	T4	
METHYLCOBALAMIN 5,000 MCG TAB	T4	
MTX SUPPORT	T4	
NASCOBAL (<i>cyanocobalamin (vitamin b-12)</i>)	T3	ST QL(4 units/30 days)
NEURIN-SL	T4	
OPURITY	T4	
<i>ra vit b12 1,000 mcg tab sa</i>	T2	
RA VIT B-12 1,000 MCG/ML LIQ	T4	
<i>ra vitamin b-12 100 mcg tablet</i>	T2	
<i>ra vitamin b12 er 2,000 mcg tb</i>	T2	
RAPID B-12 ENERGY	T4	
<i>sm vitamin b12 1,000 mcg tab</i>	T2	
<i>sm vitamin b-12 100 mcg tablet</i>	T2	
<i>sm vitamin b-12 500 mcg tablet</i>	T2	
<i>sv b-12 2,500 mcg microlozenge</i>	T2	
SV B-12 5,000 MCG MICROLOZENGE	T3	
SV VIT B-12 500 MCG LOZENGE	T3	
<i>sv vitamin b-12 500 mcg tablet</i>	T2	
<i>sv vitamin b12 tr 1,000 mcg tb</i>	T2	
<i>true vitamin b-12 1000 mcg tab</i>	T2	
<i>true vitamin b-12 500 mcg tab</i>	T2	
VIT B-12 500 MCG SUBLING TAB	T4	
VITAMIN B12 2,500 MCG TABLET	T4	
VITAMIN B-12 1,000 MCG SOFTGEL	T4	
<i>vitamin b-12 1,000 mcg tab sl</i>	T2	

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

T5 – Preferred Specialty
T6 – Non-Preferred Specialty
PA – Prior Authorization
QL – Quantity Limit

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

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

List of Prescription Medications

VITAMINS (Nutritional/Dietary) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
VITAMIN B12 PREPARATIONS (cont.)		
<i>vitamin b-12 1,000 mcg tablet</i>	T2	
<i>vitamin b-12 100 mcg tablet</i>	T2	
<i>vitamin b-12 2,000 mcg tab sa</i>	T2	
VITAMIN B-12 2,000 MCG TABLET	T4	
<i>vitamin b-12 2,500 mcg tab sl</i>	T2	
VITAMIN B-12 250 MCG LOZENGE	T4	
<i>vitamin b-12 250 mcg tablet</i>	T2	
VITAMIN B-12 3,000 MCG SL LOZ	T4	
VITAMIN B-12 3,000 MCG SOFTGEL	T4	
VITAMIN B-12 3,000 MCG TAB SL	T4	
VITAMIN B-12 5,000 MCG ODT	T4	
VITAMIN B-12 5,000 MCG SOFTGEL	T4	
VITAMIN B-12 5,000 MCG TAB SL	T3	
<i>vitamin b-12 5,000 mcg tab sl</i>	T2	
VITAMIN B-12 5,000 MCG TAB SL	T4	
VITAMIN B-12 5,000 MCG TABLET	T4	
VITAMIN B-12 50 MCG LOZENGE	T4	
<i>vitamin b12 50 mcg tablet</i>	T2	
<i>vitamin b-12 50 mcg tablet</i>	T2	
VITAMIN B-12 500 MCG LOZENGE	T3	
<i>vitamin b12 500 mcg tablet</i>	T2	
<i>vitamin b-12 500 mcg tablet</i>	T2	
<i>vitamin b-12 tr 1,000 mcg tab</i>	T2	
<i>vitamin b-12 tr 2,000 mcg tab</i>	T2	
VITAMIN B12-FOLIC ACID	T4	
VITAMIN B2 PREPARATIONS		
CYTO B-2	T4	
<i>riboflavin (vitamin b2)</i>	T2	
<i>riboflavin 100 mg tablet</i>	T2	
RIBOFLAVIN 400 MG TABLET	T4	
<i>riboflavin 50 mg tablet</i>	T2	
VITAMIN B6 PREPARATIONS		
CHROMIUM PICOLINATE KLB6	T4	
<i>cvs vitamin b-6 100 mg tablet</i>	T2	

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

T5 – Preferred Specialty
T6 – Non-Preferred Specialty
PA – Prior Authorization
QL – Quantity Limit

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

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

List of Prescription Medications

VITAMINS (Nutritional/Dietary) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
VITAMIN B6 PREPARATIONS (cont.)		
<i>eql vitamin b-6 100 mg tablet</i>	T2	
<i>gnp vitamin b-6 100 mg tablet</i>	T2	
<i>pyridoxine 100 mg/ml vial</i>	T2	
<i>pyridoxine 25 mg, 250 mg tablet</i>	T2	
PYRIDOXINE 50 MG TABLET (<i>pyridoxine hcl (vitamin b6)</i>)	T3	
<i>pyridoxine 50 mg tablet (Pyridoxine Hcl)</i>	T2	
PYRIDOXINE 500 MG TABLET (<i>pyridoxine hcl (vitamin b6)</i>)	T4	
<i>pyridoxine hcl (vitamin b6)</i>	T2	
<i>pyridoxine hcl (vitamin b6) (Pyridoxine Hcl)</i>	T2	
<i>ra vitamin b-6 100 mg tablet</i>	T2	
<i>ra vitamin b-6 50 mg tablet</i>	T2	
<i>sm vitamin b-6 100 mg tablet</i>	T2	
<i>sv vitamin b-6 100 mg tablet</i>	T2	
TRUE VITAMIN B-6 10 MG TABLET	T4	
<i>true vitamin b-6 25 mg, 50 mg, 100 mg tablet</i>	T2	
<i>vitamin b-6 25 mg, 50 mg, 100 mg, 250 mg tablet</i>	T2	
VB6 P5P	T4	
VITAMIN C PREPARATIONS		
ASCOR	T4	
<i>ascorbate calcium</i>	T2	
<i>ascorbic acid</i>	T2	
<i>ascorbic acid 500 mg tablet</i>	T2	
<i>ascorbic acid 500 mg/ml vial</i>	T2	
ASCORBIC ACID GRANULES	T3	
<i>ascorbic acid/ascorbate sodium</i>	T2	
BIO C 1:1	T4	
<i>c-1,000 mg tablet sa</i>	T2	
<i>cod liver oil tab chewable</i>	T2	
<i>cvs vit c-rose hip 1,000 mg tb</i>	T2	
<i>cvs vit c-rose hip 500 mg chew</i>	T2	
<i>cvs vit c-rose hips 500 mg tab</i>	T2	
<i>cvs vitamin c 500 mg, 1,000 mg caplet</i>	T2	
CVS VITAMIN C 1,000 MG POWDER	T4	
<i>cvs vitamin c 250 mg, 500 mg tablet</i>	T2	

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

T5 – Preferred Specialty
 T6 – Non-Preferred Specialty
 PA – Prior Authorization
 QL – Quantity Limit

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

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

List of Prescription Medications

VITAMINS (Nutritional/Dietary) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
VITAMIN C PREPARATIONS (cont.)		
CYTO C	T4	
EMERGEN-C	T4	
EMERGEN-C IMMUNE PLUS	T4	
EMERGEN-C MSM LITE	T4	
<i>eql vitamin c 1,000 mg tablet</i>	T2	
ESSENCE C	T4	
ESTER-C 1,000 MG TABLET	T4	
ESTER-C 500 MG TABLET	T3	
FLEVOXIN	T4	
FRUIT C-100 TABLET CHEWABLE	T4	
<i>fruit c-100 tablet chewable</i>	T2	
FRUIT C-200	T4	
<i>gnp vit c-rose hips 500 mg tab</i>	T2	
<i>gnp vitamin c 250 mg, 500 mg, 1,000 mg tablet</i>	T2	
<i>gnp vitamin c 500 mg tab chew</i>	T2	
<i>gnp vitamin c er 500 mg tablet</i>	T2	
<i>hm vit c-rose hip 1,000 mg tab</i>	T2	
<i>hm vit c-rose hips 500 mg cplt</i>	T2	
<i>hm vitamin c 500 mg tab chew</i>	T2	
LIQUID C	T4	
PAN-C 500	T4	
PERIDIN-C	T3	
<i>ra vit c-rose hips 500 mg tab</i>	T2	
<i>ra vitamin c 1,000 mg tab sa</i>	T2	
<i>ra vitamin c 1,000 mg tablet</i>	T2	
<i>ra vitamin c 250 mg tablet</i>	T2	
<i>ra vitamin c 500 mg chew tab</i>	T2	
<i>ra vitamin c 500 mg tab chew</i>	T2	
<i>ra vitamin c 500 mg tablet</i>	T2	
RA VITAMIN C 53 MG DROP	T4	
<i>ra vitamin c tr 500 mg caplet</i>	T2	
<i>sm vit c-rose hips 500 mg tab</i>	T2	
<i>sm vitamin c 1,000 mg tablet</i>	T2	
<i>sm vitamin c 250 mg tablet</i>	T2	

T1 – Preferred Generics

T2 – Non-Preferred Generics

T3 – Preferred Brands

T4 – Non-Preferred Brands

T5 – Preferred Specialty

T6 – Non-Preferred Specialty

PA – Prior Authorization

QL – Quantity Limit

ST – Step Therapy

AGE – Age Requirement

SP – Specialty Medication

HD – May require home delivery pharmacy

PPACA – No Cost-Share Preventive Medication

CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

VITAMINS (Nutritional/Dietary) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
VITAMIN C PREPARATIONS (cont.)		
<i>sm vitamin c 500 mg chew tab</i>	T2	
<i>sm vitamin c 500 mg tab chew</i>	T2	
<i>sm vitamin c 500 mg tablet</i>	T2	
<i>sm vitamin c with rose hips</i>	T2	
SPAN C	T4	
<i>sv vit c-rose hip 1,000 mg tab</i>	T2	
<i>sv vit c-rose hips 1,000 mg tb</i>	T2	
<i>sv vit c-rose hips 500 mg tab</i>	T2	
<i>sv vitamin c 500 mg tab chew</i>	T2	
<i>sv vitamin c tr 1,000 mg tab</i>	T2	
<i>true vitamin c 250 mg tablet</i>	T2	
<i>true vitamin c 500 mg tablet</i>	T2	
<i>true vitamin c 1,000 mg tablet</i>	T2	
<i>vit c-rose hip 1,000 mg caplet</i>	T2	
<i>vit c-rose hips 1,000 mg cplt</i>	T2	
<i>vit c-rose hips 1,000 mg tab</i>	T2	
VIT C-ROSE HIPS 500 MG CHEW TB	T4	
<i>vit c-rose hips 500 mg tablet</i>	T2	
<i>vit c-rose hips tr 1,000 mg</i>	T2	
<i>vit c-rose hips tr 500 mg cplt</i>	T2	
<i>vit c-rose hips tr 500 mg tab</i>	T2	
VITAJEY DAILY C	T4	
<i>vitamin c 1,000 mg caplet</i>	T2	
<i>vitamin c 1,000 mg tablet</i>	T2	
<i>vitamin c 1,500 mg tablet sa</i>	T2	
<i>vitamin c 100 mg tablet</i>	T2	
VITAMIN C 125 MG GUMMIES	T4	
<i>vitamin c 250 mg tablet</i>	T2	
VITAMIN C 250 MG TABLET CHEW	T4	
<i>vitamin c 250 mg tablet chew</i>	T2	
<i>vitamin c 500 mg capsule sa</i>	T2	
<i>vitamin c 500 mg chew tablet</i>	T2	
VITAMIN C 500 MG POWDER PACKET	T4	
VITAMIN C 500 MG SOFTGEL	T4	

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

T5 – Preferred Specialty
T6 – Non-Preferred Specialty
PA – Prior Authorization
QL – Quantity Limit

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

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

List of Prescription Medications

VITAMINS (Nutritional/Dietary) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
VITAMIN C PREPARATIONS (cont.)		
<i>vitamin c 500 mg tablet</i>	T2	
<i>vitamin c 500 mg tablet chew</i>	T2	
VITAMIN C 500 MG WAFER	T4	
VITAMIN C 500 MG/15 ML LIQUID	T4	
<i>vitamin c 500 mg/5 ml liquid</i>	T2	
<i>vitamin c drops</i>	T2	
<i>vitamin c er 500 mg capsule</i>	T2	
VITAMIN C FIZZY DRINK	T4	
VITAMIN C POWDER	T4	
<i>vitamin c powder</i>	T2	
<i>vitamin c tr 1,000 mg tablet</i>	T2	
<i>vitamin c tr 500 mg caplet</i>	T2	
<i>vitamin c tr 500 mg tablet</i>	T2	
<i>vitamin c-500 mg tablet</i>	T2	
<i>vitamin c-500 mg tr capsule</i>	T2	
VITAMIN C-BIOFLAVINOIDS-RH	T4	
<i>vitamin c-rose hip 1,000 mg tb</i>	T2	
<i>v-r vitamin c 1,000 mg tablet</i>	T2	
<i>v-r vitamin c 250 mg tab chew</i>	T2	
<i>v-r vitamin c 500 mg tab chew</i>	T2	
XCELLENT C	T4	
ZINC PLUS	T4	
ZINC-VITAMIN C	T4	
VITAMIN D PREPARATIONS		
AQUA-D CONCENTRATE	T4	HD
BABY DDROPS	T4	HD
BABY VITAMIN D3	T4	HD
BABY'S SUPER DAILY D3	T4	HD
BIO-D-MULSION	T4	HD
BIO-D-MULSION FORTE	T4	HD
<i>calcitriol 0.25 mcg capsule (Rocaltrol)</i>	T2	HD
<i>calcitriol 0.5 mcg capsule (Rocaltrol)</i>	T2	HD
<i>calcitriol 1 mcg/ml ampul</i>	T2	HD
<i>calcitriol 1 mcg/ml solution (Rocaltrol)</i>	T2	HD

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

T5 – Preferred Specialty
T6 – Non-Preferred Specialty
PA – Prior Authorization
QL – Quantity Limit

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

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

List of Prescription Medications

VITAMINS (Nutritional/Dietary) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
VITAMIN D PREPARATIONS (cont.)		
CHOLECAL DF	T4	HD
<i>cholecalciferol (vitamin d3)</i>	T2	HD
<i>cod liver oil</i>	T2	HD
<i>cod liver oil capsule</i>	T2	HD
<i>cod liver oil softgel</i>	T2	HD
<i>cvs vit d3 1,000 unit gummies</i>	T2	HD
<i>cvs vit d3 250 mcg softgel</i>	T2	HD
<i>cvs vitamin d3 1,000 unit sfgl</i>	T2	HD
<i>cvs vitamin d3 10 mcg, 25 mcg, 50 mcg, 125 mcg softgel</i>	T2	HD
<i>cvs vitamin d3 2,000 unit sfgl</i>	T2	HD
<i>cvs vitamin d3 25 mcg gummies</i>	T2	HD
<i>cvs vitamin d3 400 unit sftgl</i>	T2	HD
<i>cvs vitamin d3 5,000 unit sfgl</i>	T2	HD
CVS VITAMIN D3 250 MCG SOFTGEL	T4	HD
CYFOLEX	T4	HD
D3 LIQUID	T4	HD
D3 PLUS K2 DOTS	T4	HD
D3-50	T3	HD
DDROPS	T4	HD
<i>decara 10,000 unit softgel</i>	T2	HD
DECARA 25,000 UNIT VEGICAP	T3	HD
<i>decara 50,000 unit softgel</i>	T2	HD
DECARA K	T4	HD
DERMACINRX DOTREMIN	T4	HD
DERMACINRX FOLDITAM	T4	HD
DERMACINRX FOLIXAPURE	T4	HD
DERMACINRX FOLTAMIN	T4	HD
DERMACINRX FOLTREXYL	T4	HD
DERMACINRX PUREFOLIX	T4	HD
DIALYVITE VITAMIN D3 MAX	T4	HD
DOSOKAP	T4	HD
DOSOQUIN	T4	HD
DRISDOL (<i>ergocalciferol (vitamin d2)</i>)	T4	HD
<i>eql vitamin d3 2,000 unit sfgl</i>	T2	HD

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

T5 – Preferred Specialty
T6 – Non-Preferred Specialty
PA – Prior Authorization
QL – Quantity Limit

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

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

List of Prescription Medications

VITAMINS (Nutritional/Dietary) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
VITAMIN D PREPARATIONS (cont.)		
<i>eql vitamin d3 400 unit sftgl</i>	T2	HD
ERGOCAL	T4	HD
<i>ergocalciferol (vitamin d2)</i>	T2	HD
FOLIC D3	T4	HD
FOLIKA-D	T4	HD
FOLIXAPURE	T4	HD
FOLVITE-D	T4	HD
<i>ft vitamin d3 25 mcg softgel</i>	T2	HD
<i>ft vitamin d3 50 mcg softgel</i>	T2	HD
GENICIN VITA-D	T4	HD
<i>gnp vit d3 10mcg(400 unit) chw</i>	T2	HD
<i>gnp vitamin d3 1,000 unit tab</i>	T2	HD
<i>gnp vitamin d3 10 mcg, 25 mcg tablet</i>	T2	HD
<i>gnp vitamin d3 2,000 unit tab</i>	T2	HD
<i>gnp vitamin d3 25mcg(1000 unt)</i>	T2	HD
<i>gnp vitamin d3 5,000 unit tab</i>	T2	HD
<i>hm vitamin d3 1,000 unit tab</i>	T2	HD
<i>hm vitamin d3 2,000 unit sftgl</i>	T2	HD
HM VITAMIN D3 4,000 UNIT SFTGL	T4	HD
IS-D-10,000	T4	HD
K2 PLUS D3	T4	HD
K2-D3 10,000	T4	HD
K2-D3 5000	T4	HD
MAXIMUM D3	T3	HD
NOXIFOL-D3	T4	HD
OPTIMAL D3 M	T4	HD
ORTHO DF	T4	HD
OSTACHOL	T4	HD
<i>qc cod liver oil</i>	T2	HD
<i>ra cod liver oil</i>	T2	HD
<i>ra cod liver oil softgel</i>	T2	HD
<i>ra vitamin d3 1,000 unit tab</i>	T2	HD

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

T5 – Preferred Specialty
 T6 – Non-Preferred Specialty
 PA – Prior Authorization
 QL – Quantity Limit

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

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

List of Prescription Medications

VITAMINS (Nutritional/Dietary) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
VITAMIN D PREPARATIONS (cont.)		
<i>ra vitamin d3 2,000 unit sftgl</i>	T2	HD
<i>ra vitamin d3 2,000 unit sftgl</i>	T2	HD
<i>ra vitamin d3 5,000 unit sftgl</i>	T2	HD
REPLESTA NX	T3	HD
REVESTA	T4	HD
ROCALTROL (<i>calcitriol</i>)	T4	ST HD
ROXIFOL-D	T4	HD
<i>sm vitamin d3 1,000 unit tab</i>	T2	HD
<i>sm vitamin d3 2,000 unit sftgl</i>	T2	HD
<i>sm vitamin d3 25 mcg tablet</i>	T2	HD
<i>sm vitamin d3 50 mcg softgel</i>	T2	HD
SUPER DAILY D3	T4	HD
<i>sv vitamin d3 1,000 unit gummy</i>	T2	HD
<i>sv vitamin d3 1,000 unit sftgl</i>	T2	HD
<i>sv vitamin d3 2,000 unit sftgl</i>	T2	HD
<i>sv vitamin d3 25mcg(1000 unit)</i>	T2	HD
<i>sv vitamin d3 400 unit softgel</i>	T2	HD
<i>sv vitamin d3 5,000 unit sftgl</i>	T2	HD
<i>thera-d 2000 tablet</i>	T2	HD
THERA-D 4000 TABLET	T4	HD
<i>thera-d rapid repletion tablet</i>	T2	HD
<i>thera-d sport 2,000 unit tab</i>	T2	HD
<i>true vitamin d3 1,250 mcg tab</i>	T2	HD
<i>true vitamin d3 10 mcg capsule</i>	T2	HD
<i>true vitamin d3 10 mcg tablet</i>	T2	HD
<i>true vitamin d3 125 mcg cap</i>	T2	HD
<i>true vitamin d3 125 mcg tablet</i>	T2	HD
<i>true vitamin d3 25 mcg capsule</i>	T2	HD
<i>true vitamin d3 25 mcg tablet</i>	T2	HD
TRUE VITAMIN D3 1,250 MCG CAP	T2	HD
TRUE VITAMIN D3 250 MCG CAP	T2	HD
TRUE VITAMIN D3 250 MCG TABLET	T2	HD
<i>vit d3 125 mcg (5000 unit) tab</i>	T2	HD
VIT D3 5,000 UNIT FAST DISSOLV	T4	HD

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

T5 – Preferred Specialty
 T6 – Non-Preferred Specialty
 PA – Prior Authorization
 QL – Quantity Limit

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

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

List of Prescription Medications

VITAMINS (Nutritional/Dietary) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
VITAMIN D PREPARATIONS (cont.)		
<i>vitamin d2 1.25mg(50,000 unit) (Drisdol)</i>	T2	HD
VITAMIN D2 2,000 UNIT TABLET	T3	HD
<i>vitamin d2 400 unit tablet</i>	T2	HD
VITAMIN D2 50 MCG (2,000 UNIT)	T4	HD
<i>vitamin d3 1,000 unit gummies</i>	T2	HD
<i>vitamin d3 1,000 unit gummy</i>	T2	HD
<i>vitamin d3 1,000 unit softgel</i>	T2	HD
VITAMIN D3 1,000 UNIT SPRAY	T4	HD
<i>vitamin d3 1,000 unit tab chew</i>	T2	HD
<i>vitamin d3 1,000 unit tablet</i>	T2	HD
VITAMIN D3 1,000 UNIT/10 ML LQ	T4	HD
<i>vitamin d3 1,250 mcg capsule</i>	T2	HD
<i>vitamin d3 1.25 mg softgel</i>	T2	HD
<i>vitamin d3 10 mcg tablet</i>	T2	HD
<i>vitamin d3 10 mcg(400 unit)/ml</i>	T2	HD
<i>vitamin d3 10 mcg/ml drop</i>	T2	HD
<i>vitamin d3 10 mcg/ml liquid</i>	T2	HD
VITAMIN D3 10,000 UNIT CAPSULE	T4	HD
<i>vitamin d3 10,000 unit softgel</i>	T2	HD
VITAMIN D3 10,000 UNIT TABLET	T4	HD
<i>vitamin d3 125 mcg (5000 unit)</i>	T2	HD
<i>vitamin d3 125 mcg capsule</i>	T2	HD
<i>vitamin d3 125 mcg softgel</i>	T2	HD
<i>vitamin d3 125 mcg tablet</i>	T2	HD
VITAMIN D3 125 MCG/0.5 ML DROP	T4	HD
<i>vitamin d3 2,000 unit softgel</i>	T2	HD
VITAMIN D3 2,000 UNIT TAB CHEW	T4	HD
<i>vitamin d3 2,000 unit tablet</i>	T2	HD
<i>vitamin d3 25 mcg (1,000 unit)</i>	T2	HD
<i>vitamin d3 25 mcg gummy</i>	T2	HD
<i>vitamin d3 25 mcg softgel</i>	T2	HD
<i>vitamin d3 25 mcg tablet</i>	T2	HD
VITAMIN D3 250 MCG TABLET	T4	HD
VITAMIN D3 3,000 UNIT TABLET	T4	HD

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

T5 – Preferred Specialty
 T6 – Non-Preferred Specialty
 PA – Prior Authorization
 QL – Quantity Limit

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

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

List of Prescription Medications

VITAMINS (Nutritional/Dietary) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
VITAMIN D PREPARATIONS (cont.)		
<i>vitamin d3 400 unit softgel</i>	T2	HD
<i>vitamin d3 400 unit tab chew</i>	T2	HD
<i>vitamin d3 400 unit tablet</i>	T2	HD
VITAMIN D3 400 UNIT/5 ML LIQ	T4	HD
<i>vitamin d3 400 unit/ml liquid</i>	T2	HD
<i>vitamin d3 5,000 unit capsule</i>	T2	HD
<i>vitamin d3 5,000 unit softgel</i>	T2	HD
<i>vitamin d3 5,000 unit tablet</i>	T2	HD
<i>vitamin d3 5,000 unit/ml drops</i>	T2	HD
<i>vitamin d3 50 mcg (2,000 unit)</i>	T2	HD
<i>vitamin d3 50 mcg capsule</i>	T2	HD
VITAMIN D3 50 MCG DISSOLVE TAB	T4	HD
<i>vitamin d3 50 mcg softgel</i>	T2	HD
<i>vitamin d3 50 mcg tablet</i>	T2	HD
VITAMIN D3 62.5 MCG SOFTGEL	T4	HD
<i>vitamin d3 50,000 unit capsule</i>	T2	HD
<i>vitamin d3/folic acid</i>	T2	HD
<i>v-r cod liver oil capsule</i>	T2	HD
VITAMIN E PREPARATIONS		
AQUA-E	T3	
AQUA-E CONCENTRATE	T4	
<i>cvs vitamin e 180 mg softgel</i>	T2	
<i>cvs vitamin e 200 unit softgel</i>	T2	
<i>cvs vitamin e 268 mg softgel</i>	T2	
CVS VITAMIN E 450 MG SOFTGEL	T4	
<i>cvs vitamin e 90 mg softgel</i>	T2	
<i>eql vitamin e 1,000 unit sftgl</i>	T2	
<i>eql vitamin e 180 mg softgel</i>	T2	
<i>gnp vitamin e 180 mg softgel</i>	T2	
<i>gnp vitamin e 400 unit softgel</i>	T2	
GNP VITAMIN E 450 MG SOFTGEL	T4	
<i>gnp vitamin e 90 mg softgel</i>	T2	
<i>hm vitamin e 180 mg softgel</i>	T2	
<i>hm vitamin e 200 unit softgel</i>	T2	

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

T5 – Preferred Specialty
 T6 – Non-Preferred Specialty
 PA – Prior Authorization
 QL – Quantity Limit

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

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

List of Prescription Medications

VITAMINS (Nutritional/Dietary) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
VITAMIN E PREPARATIONS (cont.)		
<i>hm vitamin e 400 unit softgel</i>	T2	
MIXED TOCOTRIENOLS	T4	
<i>ra vitamin e 268 mg softgel</i>	T2	
SOLUVITA-E	T4	
<i>sv vitamin e 180 mg softgel</i>	T2	
<i>sv vitamin e 400 unit softgel</i>	T2	
<i>sv vitamin e 450 mg softgel</i>	T2	
<i>sv vitamin e 670 mg softgel</i>	T2	
<i>true vitamin e 180 mg capsule</i>	T2	
<i>true vitamin e 90 mg capsule</i>	T2	
TRUE VITAMIN E 450 MG CAPSULE	T4	
<i>vitamin e (dl,tocopheryl acet)</i>	T2	
<i>vitamin e 1,000 unit capsule</i>	T2	
<i>vitamin e 1,000 unit softgel</i>	T2	
VITAMIN E 1,000 UNIT SOFTGEL	T4	
<i>vitamin e 100 unit softgel</i>	T2	
VITAMIN E 100 UNIT TABLET	T4	
VITAMIN E 15 UNIT/0.3 ML DROP	T4	
<i>vitamin e 15 unit/0.3 ml drop</i>	T2	
<i>vitamin e 180 mg softgel</i>	T2	
<i>vitamin e 180mg(400 unit) sfgl</i>	T2	
<i>vitamin e 200 unit capsule</i>	T2	
<i>vitamin e 200 unit softgel</i>	T2	
<i>vitamin e 268 mg softgel</i>	T2	
<i>vitamin e 400 unit capsule</i>	T2	
<i>vitamin e 400 unit softgel</i>	T2	
<i>vitamin e 45 mg softgel</i>	T2	
VITAMIN E 450 MG SOFTGEL	T4	
<i>vitamin e 450 mg softgel</i>	T2	
<i>vitamin e 600 unit capsule</i>	T2	
<i>vitamin e 90 mg capsule</i>	T2	
<i>vitamin e 90 mg softgel</i>	T2	
VITAMIN E NATURAL OIL DROPS	T3	
VITAMIN E OIL	T4	

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

T5 – Preferred Specialty
 T6 – Non-Preferred Specialty
 PA – Prior Authorization
 QL – Quantity Limit

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

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

List of Prescription Medications

VITAMINS (Nutritional/Dietary) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
VITAMIN E PREPARATIONS (cont.)		
VITAMIN E OIL DROPS	T3	
VITAMIN E OIL DROPS	T4	
VITAMIN E-OIL	T3	
WHEAT GERM OIL	T3	
XCELLENT E	T4	
VITAMIN K PREPARATIONS		
AQUA-K CONCENTRATE	T4	
K1-1000	T4	
K2 LIQUID	T4	
K2-45	T4	
MEPHYTON (<i>phytonadione (vit k1)</i>)	T4	QL(10 tabs/fill)
phytonadione (<i>vit k1</i>)	T2	
PHYTONADIONE 1 MG/0.5 ML SYR	T3	
PHYTONADIONE 1 MG/0.5 ML VIAL	T3	
<i>phytonadione 10 mg/ml ampul</i>	T2	
<i>phytonadione 10 mg/ml vial</i>	T2	
VITAMIN K	T3	
VITAMIN K-1	T3	
VITAMIN K2	T4	
VITAMIN K2 (MENAQUINONE-4)	T4	
VITAMINS (Vitamins)		
MULTIVITAMIN PREPARATIONS		
CENTRUM ADULTS 50 PLUS MINIS	T4	
CENTRUM MEN 50 PLUS MINIS	T4	
DAVIMET-M	T4	
PEDIATRIC VITAMIN PREPARATIONS		
CHILDREN'S MULTI	T4	

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

T5 – Preferred Specialty
T6 – Non-Preferred Specialty
PA – Prior Authorization
QL – Quantity Limit

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

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

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

I.5 VOLT BATTERIES	155
IST TIER.....	134, 149
IST TIER UNILET COMFORTOUCH.....	149
2-IN-1	134, 149
2-IN-1 LANCET DEVICE	149
2TEK.....	127
5-MTHF.....	213
50 PLUS ADULT EYE.....	194

A

A-25	213
abacavir	65, 66, 67
abacavir/lamivudine/zidovudine	65
abacavir sulfate/lamivudine	65
ABANEU-SL.....	218
ABATRON.....	108
ABC COMPLETE	197
ABDEK.....	209
ABILIFY.....	169
abiraterone.....	55
ABSORICA	173
ABSTRAL	22
acamprosate.....	188
acarbose	48
ACCOLATE	32
ACCRUFER.....	108
ACCU-CHEK.....	127, 134, 149, 155
ACCUPRIL.....	80
ACCURETIC.....	79
ACCU-TREND.....	127
ACD-A	42
ACD SOLUTION A	42
ACE.....	79, 80, 81
ACE AEROSOL.....	155
acebutolol.....	82
acetaminophen/caff/dihydrocod.....	22
acetaminophen with codeine.....	21
acetazolamide.....	97
acetic acid	52, 99, 172
acetic acid/oxyquinoline	52
acetylcysteine	32
acetylcyst/methylb12/levomefol	213
a/c/e/zinc ox/cupric ox/lutein.....	194
a/c/e/zinc/sod selenate/copper	197
acitretin	172
ACTEMRA.....	126
ACTHIB.....	73

ACTICLATE	38
acti-lance	134, 150
ACTI-LANCE	134, 150
acti-lance lite.....	150
acti-lance univers.....	150
ACTI-LANCE UNIVERS	150
ACTIMMUNE.....	61
ACTIQ	22
ACTIVE FE	108
ACTIVELLA.....	121
ACTIVNUTRIENTS.....	197
ACTONEL	191
ACTOPLUS MET	49
ACTOS	50
ACULAR.....	100
acyclovir	68, 69, 70
ACZONE.....	173
ADACEL TDAP	73
ADALIMUMAB-ADAZ	54
ADALIMUMAB-ADBIM	54
adapalene.....	173, 182, 183
ADAPALENE	182
adapalene/benzoyl peroxide.....	173
ADBRY.....	192
ADDYI	168
adefovir	69
ADEK GUMMIES	197
ADEMPAS	78
ADIPEX-P.....	62
ADJUSTABLE LANCING DEVICE	127
ADLARITY.....	70
ADLYXIN.....	48
ADRENALIN CHLORIDE	99
adthyza	183, 184
ADULT 50 PLUS EYE HEALTH.....	194
ADULT MULTI.....	197
ADULT ONE DAILY.....	197
ADULTS' DAILY FORMULA.....	197
ADULTS MULTIVITAMIN	197
ADVAIR DISKUS.....	30
ADVAIR HFA.....	30
ADVANCED	127, 134, 150, 195, 197, 202, 207
ADVANCED LANCING DEVICE.....	127
ADVANCED MULTI EA.....	197
ADVANCED TRAVEL LANCETS.....	150
ADVOCATE.....	127, 134, 150, 174

Index of Medications

ADVOCATE CONTROL SOLUTION.....	127	ALLERGY SYRINGE	141, 146, 147
ADVOCATE LANCET	150	allopurinol.....	26
ADVOCATE LANCETS	150	ALLZITAL	19
ADVOCATE LANCING DEVICE.....	127	almotriptan.....	19
ADVOCATE RAPID-SAFE LANCING DV	127	almotriptan malate	15
ADVOCATE REDI-CODE+ CTRL SOLN.....	127	alosetron.....	117
ADZENYS	71	ALPHAGAN P.....	101
AEMCOLO.....	38	alprazolam.....	162
AEROCHAMBER.....	155	ALTABAX.....	178
AEROTRACH	156	ALTACE	80
AEROVENT	156	ALTAFLUOR BENOX.....	101
AFLURIA QUAD	73	ALTERNATE.....	128, 134, 150
AGAMATRIX CONTROL	127	ALTERNATE SITE LANCETS	150
AGRYLIN	65	ALTERNATE SITE LANCING DEVICE.....	128
AIMOVIG	15	ALTRENO.....	182
AIMOVIG AUTOINJECTOR.....	19	ALUNBRIG.....	57
AIRDUO DIGIHALER	30	ALVESCO.....	31
AIRSUPRA	30	alvimopan	118
AJOVY	15, 19	amantadine.....	63
AKLIEF	177	AMARYL	49
AKTEN.....	101	ambrisentan.....	78
AKTIPAK	40	amcinonide.....	178
ALA-SCALP.....	178	AMERGE.....	19
ALBA-LYBE.....	213	AMICAR	74
albendazole.....	52	amiloride.....	98
ALBENZA	52	amino acids/mv,tx,iron,mineral	198
albuterol	29, 30	aminocaproic	74
ALCAINE.....	101	amiodarone	76
alclometasone	178	amitriptyline	165
ALCOH-GLOVE	155	amitriptyline/chlordiazepoxide.....	165
alcohol	174, 175, 190, 191	AMLADEx	198
ALCOHOL.....	53, 174, 175, 190, 191	amlodipine	76, 79, 80, 83
ALCOH-WIPE.....	155	amoxapine	165
ALDACTAZIDE	98	amoxicillin	38, 52
ALDACTONE	98	amphetamine	71
ALECENSA.....	57	ampicillin	38
alendronate	191, 192	AMZEEQ.....	40
alfuzosin	193	ANAFRANIL.....	165
ALINIA	63	anagrelide	65
aliskiren hemifumarate.....	83	ANA-LEX.....	119
ALIVE	197, 198	ANALPRAM.....	119, 181
ALIVE DAILY	197	ANAPROX DS.....	27
ALIVE PREMIUM	198	anastrozole	56
ALIVE WOMEN'S	198	ANCOBON	44
ALKALINE BATTERIES.....	128	ANDRODERM	120
ALKERAN.....	55	ANDROID.....	120
ALLERGIST TRAY.....	141	ANGELIQ.....	122

Index of Medications

ANIMAL SHAPES COMPLETE.....	209	ASCOR.....	222
ANIMI-3.....	198	ascorbate.....	222
ANNOVERA.....	91	ascorbic.....	109, 110, 222
ANORO ELLIPTA.....	30	ASCORBIC ACID.....	222
ANTICOAGULANT SODIUM CITRATE.....	42	asenapine.....	168
ANTIOXIDANT FORMULA.....	194	ASMANEX.....	31
APATATE.....	218	aspirin/dipyridamole.....	64
APETEX.....	213	ASSURE.....	128, 134, 150, 158
APETIGEN.....	108, 213	ASSURE 4 CONTROL SOLUTION.....	128
APETIGEN-PLUS.....	108	ASSURE DOSE.....	128
apomorphine.....	63	ASSURE HAEMOLANCE PLUS.....	150
APO-VARENICLINE.....	183	ASSURE LANCE.....	150
apraclonidine.....	101	ASSURE PRISM.....	128
aprepitant.....	114	ASTAGRAF.....	126
APRETUDE.....	67	ASTRINGYN.....	75
APRISO.....	116	atazanavir.....	67
APTENSIO.....	167	ATELVIA.....	192
APTIOM.....	88	atenolol.....	82, 83
APTIVUS.....	65	AT HOME AIC.....	128
AQUA-D.....	225	a thru z.....	197
AQUADEKS.....	198, 209	A THRU Z MEN'S ULTIMATE.....	197
AQUA-E.....	230	A THRU Z SELECT.....	197
AQUA-K.....	232	ATIVAN.....	162
AQUA LANCE LANCING DEVICE.....	128	atomoxetine.....	168
AQUASOL A.....	213	atorvastatin.....	83, 84
AQUORAL.....	187	atovaquone.....	52, 53
ARAKODA.....	52	atovaquone-proguanil.....	52
ARAVA.....	26	atropine.....	102, 114, 115, 116
ARAZLO.....	177	ATROPINE.....	102
ARCALYST.....	192	ATROVENT HFA.....	29
AREXVY.....	74	AUGMENTIN.....	38
arformoterol.....	30	AURYXIA.....	106
ARGLAES FILM.....	148	AUSTEDO.....	86
ARICEPT.....	70	AUTOJECT.....	128
ARIDOL.....	95	AUTO-LANCET.....	128
ARIKAYCE.....	35	AUTOLET.....	128
aripiprazole.....	169, 170	AUTOPEN.....	128
ARIXTRA.....	43	AUTOSHIELD DUO.....	139
ARKALIOX.....	213	AUTOSOFT.....	128
armodafinil.....	170	AUVI-Q.....	70
ARMOUR THYROID.....	184	AVAR-E.....	41
ARNUIITY ELLIPTA.....	31	AVAR LS.....	41
AROMASIN.....	56	AVC.....	51
ARTHROTEC 50.....	27	AVIDOXY.....	38
ARTHROTEC 75.....	27	avita.....	182
ARTISS.....	177	AVITA.....	182
ASACOL.....	116	AVITENE.....	75

Index of Medications

AVONEX	86	B-COMPLEX-VITAMIN C	214
AYGESTIN	124	B-COMPLEX WITH B-12	214
AYVAKIT	57	BD.....	134, 139, 140, 141, 142, 150
AZASAN.....	126	BD ECLIPSE.....	139, 140, 141, 142
AZASITE.....	33	BELBUCA.....	22
azathioprine.....	126	BELSOMRA	171
azelaic acid	176	BELVIQ.....	62
azelastine.....	47, 98, 99	benazepril.....	79, 80, 81
AZELEX	173	benazepril/hydrochlorothiazide.....	79
AZILECT.....	63	BENLYSTA.....	192
azithromycin.....	37	BENTIVITE BX	108
AZSTARYS.....	167	BENZAMYCIN.....	40
AZULFIDINE	116	benzebro	176
B		BENZEPRO.....	176
b-12.....	217, 218, 219, 220, 221	BENZNIDAZOLE.....	53
bi2.....	109, 110, 204, 214, 215, 216, 217, 219, 220, 221	benzonatate.....	93
B-12.....	109, 201, 214, 218, 219, 220, 221	benzoyl peroxide.....	40, 41, 173, 176
BI2.....	213, 218, 219, 220, 221	benzphetamine.....	62
BI2 ACTIVE.....	219	benztropine	63
b-12 er.....	219, 220	BEPREVE	47
bi2/levomefolate calcium/b-6.....	214	BEROCCA.....	198
B-50 COMPLEX	214	beta-carotene	198, 213
BABY DDROPS.....	225	BETADINE	100
BABY'S SUPER DAILY D3	225	betaine	191
BABY VITAMIN D3	225	betamethasone	45, 178, 179, 182
bacitracin.....	34	BETAPACE.....	82
baclofen.....	157	BETASERON.....	86
BACLOFEN	157	betaxolol.....	82, 101
BACMIN.....	198	bethanechol	71
B ACTIV	213	BETHKIS.....	35
BACTRIM.....	34	BETOPTIC S	101
BAFIERTAM.....	86	bexarotene.....	55, 61
BALANCED B-100	215	BEXSERO.....	72
balanced b-100 complex tab sa	214	BEYAZ	91
BAL-CARE DHA	158	bicalutamide.....	55
balsalazide.....	116	BIKTARVY	68
BALVERSA.....	57	BILTRICIDE.....	52
BAQSIMI.....	105	bimatoprost	101
BARACLUDE.....	69	BINOSTO	192
BARIATRIC MULTIVITAMINS.....	198	BIO-35	198
BASAGLAR KWIKPEN.....	51	BIO C	222
BAXDELA.....	38	BIO-D-MULSION	225
b comp	213, 214, 217	bioflav,lemon/vit bcomp,c	195
b complex.....	206, 207, 213, 214, 215, 216, 217, 218	biotin.....	201, 203, 213, 214, 215, 216, 217
b-complex	198, 199, 206, 214, 215, 217, 218	BIOTIN.....	208, 214, 215, 216, 217
B COMPLEX	214, 215, 216	bisac/nacl/nahco3/kcl/peg 3350.....	117
B-COMPLEX	201, 206, 214	bisoprolol.....	82, 83

Index of Medications

BLADDER 2.2	198	butalb-acetamin-caff 50-325-40	15
BLEPH-IO	33	butalb/acetaminophen/caffeine	15, 19
BLEPHAMIDE S.O.P.....	33	butalb-aspirin-caffe 50-325-40	15
BLOOD.....	74, 75, 94, 95, 128, 135, 140, 150	butalbit/acetamin/caff/codeine.....	24
BLOOD GLUCOSE CONTROL.....	128	butalbital/acetaminophen.....	15, 19
BLOOD-GLUCOSE CONTROL.....	128	butalbital-asa-caffeine cap (Fiorinal).....	15
BLOOD LANCETS	150	butalbital/aspirin/caffeine.....	19
BLUNT.....	140, 145	butorphanol.....	22
BOCASAL	187	BUTTERFLY	135, 150
BODY, HAIR, SKIN AND NAILS.....	198	BUTTERFLY TOUCH LANCET	150
BOOSTRIX TDAP	73	BYDUREON BCISE.....	48
bosentan.....	78	BYDUREON PEN.....	48
BOSULIF	57, 58	BYETTA	48
BRAINSTRONG	158	BYLVAY	117
BREATHERITE.....	156	C	
BREATHRITE.....	156	c-1,000	222
BREEZE 2	128	cabergoline	124
BREO	30, 31	CABOMETYX.....	58
BREO ELLIPTA	30, 31	CADEAU DHA	158
BREWER'S YEAST	215	CADUET	83
BREXAFEMME.....	45	CAFERGOT	15, 19
brey-na.....	31	caffeine	19, 86, 158
BREZTRI AEROSPHERE.....	31	CALAN	76
BRILINTA.....	64	calcipotriene.....	173, 174, 182
brimonidine	101	calcitonin,salmon,synthetic	125
BRIMONIDINE-DORZOLAMIDE	101	calcitriol.....	174, 225, 228
brinzolamide.....	101	calcium acetate.....	106, 107
BRIVIACT	88	CALCIUM PANTOTHENATE.....	209
BROMFED DM	93	CALQUENCE	58
bromfenac.....	100	CAMBIA	19
bromocriptine	63, 64	CAMZYOS.....	77
brompheniramine/pseudoephed/dm	93	candesartan cilexetil.....	81
BRONCHITOL.....	184	candesartan/hydrochlorothiazid.....	80
BROVANA.....	30	CANNULA	140, 142, 145, 147
BRUKINSA.....	58	CANTHARIDIN-ACETONE	176
BRYHALI.....	178	CAPCOF	93
B-STRESS	215	capecitabine.....	56
budesonide	31, 122, 123	CAPEX.....	178
BULK SYRINGE.....	142	CAPHOSOL.....	187
BULLSEYE	135, 150	CAPLYTA.....	168
BULLSEYE MINI SAFETY LANCETS.....	150	CAPRELSA	58
bumetanide.....	97	captopril	79, 81
BUPHENYL.....	113	captopril/hydrochlorothiazide.....	79
buprenorphine	22, 193	CARBAGLU.....	188
bupropion.....	163, 183	carbamazepine.....	88, 89, 90
bupirone	163	CARBATROL.....	89
butalb-acetamin-caff 50-300-40.....	15	carbidopa.....	63, 64

Index of Medications

carbidopa/levodopa	63, 64	CETACAINE ANESTHETIC.....	25
carbinoxamine	47	cetorelix.....	123
CARDIOTEK-RX	215	CETROTIDE	123
CARDIZEM.....	76	cevimeline.....	71
CARDURA.....	79, 80	CHANTIX.....	183
CAREONE.....	128, 135, 150	CHEK-STIX	96
CAREPOINT.....	140, 142, 143	CHEMET	189
CARESENS.....	128, 135, 150	CHEMO TRANSFER PIN	140
CARETOUCH.....	128, 135, 140, 143, 150, 175	CHEMSTRIP.....	96, 128
carglumic	188	CHENODAL	116
carisoprodol.....	24, 157, 158	CHILD CHEWABLE VITAMN	209
carisoprodol/aspirin/codeine.....	24	CHILD COMPLETE	209
CARNITOR.....	191	CHILD MULTIVITAMIN PLUS IRON.....	209
carteolol.....	101	children multivitamin.....	209
carvedilol.....	79	CHILDREN MULTIVITAMIN	209, 210
CASODEX.....	55	CHILDREN'S.....	209, 232
CATAPRES.....	81	CHILDREN'S CHEWABLE	209
CAVERJECT	186	CHILDREN'S CHEW MULTIVIT-IRON	209
CAYSTON.....	36	childrens chew vitamin	209
cefaclor.....	36	CHILDREN'S MULTI-VIT	209
cefadroxil.....	36	CHILDREN'S MULTIVITAMIN GUMMY	209
cefdinir	36	CHILD'S CHEWABLE.....	209
cefditoren pivoxil	36, 37	CHILD'S OMEGA-3.....	210
cefixime.....	36, 37	chlordiazepoxide.....	113, 163
cefpodoxime proxetil.....	36	chlordiazepoxide/clidinium br	113
cefprozil.....	36	chlorhexidine	185
ceftriaxone	37	chloroquine	52
cefuroxime axetil.....	36	chlorpromazine.....	170
CEFUROXIME SODIUM-0.9% NACL.....	34	chlorthalidone	82, 83, 98
celecoxib	29	chlorzoxazone.....	157
CELLCEPT	126	CHOLBAM.....	116
CELONTIN.....	89	cholecalciferol.....	226
CENTANY.....	41	CHOLECAL DF	226
CENTRAL-VITE.....	198	cholestyramine	84
CENTRAVITES.....	198	choline salicyl/mag salicylate.....	15, 19
CENTRUM.....	197, 198, 199, 209, 232	CHORIONIC	125
CENTRUM KIDS	209	CHORIONIC GONAD.....	125
CENTRUM SILVER.....	197, 199	CHROMAGEN.....	108
CENTURY	199	CHROMIUM PICOLINATE.....	221
cephalexin.....	36	CIALIS	186
CEQUA	103	CIBINQO.....	176
CEQR SIMPLICITY	128	ciclodan.....	45
CERDELGA.....	188	CICLODAN.....	45, 53
CEREFOLIN	215	ciclopirox.....	45, 46
certavite	199	ciclopirox 8% treatment kit.....	53
CERTAVITE.....	199	cilostazol	64
CERVIDIL.....	124	CILOXAN	34

Index of Medications

CIMDUO.....	65	codeine.....	21, 22, 24, 93, 94
cimetidine.....	117	CODITUSSIN AC.....	94
cinacalcet.....	188	CODITUSSIN DAC.....	94
CIPRO.....	38	cod liver oil.....	213, 222, 226, 227, 230
CIPRODEX.....	33	COLAZAL.....	116
ciprofloxacin.....	32, 33, 34, 38	colchicine.....	26, 29
citalopram.....	164	COLCHICINE.....	26
CITRANATAL.....	108, 158	colesevelam.....	84
CITRANATAL BLOOM.....	108	COLESTID.....	84
CITRATE PHOSPHATE DEXTROSE.....	42	colestipol.....	84
citric.....	113	COLOR.....	135, 150
CITRUS BIOFLAVONOIDS.....	195	COLOR LANCETS.....	150
CLARINEX.....	47	COMBIGAN.....	101
CLARINEX-D.....	47	COMBIPATCH.....	121
clarithromycin.....	37	COMBISTIX REAGENT.....	96
clemastine.....	47	COMBIVENT RESPIMAT.....	30
CLEO.....	155	COMBIVIR.....	65
CLEOCIN.....	37, 40, 41	COMETRIQ.....	58
CLEVER.....	128, 135, 150, 156	COMFORT	27, 128, 133, 135, 137, 138, 139, 150, 152, 153, 154, 156, 157, 175
CLEVER CHEK LANCETS.....	150	COMFORT PAC-IBUPROFEN.....	27
CLEVER CHOICE.....	156	COMFORT PAC-MELOXICAM.....	27
CLEVER CHOICE CONTROL SOLUTION.....	128	COMFORT PAC-NAPROXEN.....	27
CLIMARA.....	121	COMFORTSEAL.....	156
clindacin.....	41	COMIRNATY.....	72
CLINDACIN.....	41	COMPACT SPACE CHAMBER.....	156
clindamycin.....	36, 37, 40, 41, 173, 174	COMPAZINE.....	114
CLINDESSE.....	40	COMPLEX B-50.....	215
CLINPRO 5000.....	104, 107	complex b-100.....	215
clobazam.....	88	COMPLEX B-100.....	215
clobetasol.....	178, 180, 181	COMTAN.....	63
CLOBEX.....	178	CONCEPT.....	199
clocortolone.....	178, 179	CONFORMANT 2.....	148
clodan.....	178	CONSENSI.....	76
CLODAN.....	178	CONTACT DETACH INFUSION SET.....	128
CLODERM.....	178, 179	CONTOUR.....	128
clomiphene.....	124	CONTRAVE.....	62
clomipramine.....	165	CONTROL SOLUTION.....	127, 128, 129, 130, 132, 133, 134
clonazepam.....	88	COOL CONTROL SOLUTION.....	128
clonidine.....	81, 82, 166	COPAXONE.....	86
clopidogrel.....	64	COPIKTRA.....	58
clorazepate.....	163	CORDRAN.....	179
clotrimazole.....	44, 45	COREG.....	79
clozapine.....	168	CORGARD.....	82
CLOZARIL.....	168	CORNWALL SYRINGE TIP CONNECTOR.....	143
COAGUCHEK.....	135, 150	CORTANE-B.....	99
COARTEM.....	52	CORTEF.....	122
COCAINE.....	99		

Index of Medications

CORTENEMA.....	120	CYCLOPENTOLATE-TROPICAMIDE-PE.....	103
cortisone.....	122	cyclopentolat/tropic/phenyleph.....	103
CORTISPORIN.....	32, 40	cyclophosphamide.....	55
CORVITE.....	108, 199	CYCLOPHOSPHAMIDE.....	55
CORVITE 150.....	108	CYCLOSERINE.....	36
CORVITE FE.....	108	CYCLOSET.....	48
COTELLIC.....	57	cyclosporine.....	103, 126, 127
COTEMPLA.....	167	CYCLOSPORINE.....	103
CREON.....	118	CYFOLEX.....	226
CRESEMBA.....	44	CYLTEZO.....	54
CRINONE.....	125	cyproheptadine.....	47
cromolyn.....	26, 32, 101	CYPROHEPTADINE.....	47
crotamiton.....	63	CYSTAGON.....	193
CRRT TRISODIUM CITRATE.....	42	CYSTARAN.....	103
CULTURELLE.....	199, 210	CYSTO-CONRAY II.....	96
CULTURELLE KIDS.....	210	CYSTOGRAFIN.....	96
CURITY ALCOHOL PREPS.....	175	CYSTOGRAFIN-DILUTE.....	96
CUROSURF.....	184	CYTO B-1.....	218
CUTIVATE.....	179	CYTO B-2.....	221
cvs.....	105, 108, 158, 175, 190, 196, 199, 208, 210, 213, 215, 219, 221, 222, 226, 230	CYTO B7.....	215
CVS ...	53, 105, 108, 158, 162, 175, 190, 199, 210, 215, 219, 222, 226, 230	CYTO C.....	223
CVS ALCOHOL 70% PREP PADS.....	175	CYTOTEC.....	115
CVS CHILD GUMMY.....	210	D	
cvs glucose.....	105	D3.....	169, 204, 207, 225, 226, 227, 228, 229, 230
CVS GLUCOSE LIQUID.....	105	dabigatran.....	43
cvs iron.....	108	daily-vite.....	199
cvs isopropyl alcohol 70% wipe.....	175	dalfampridine.....	87
CVS ISOPROPYL ALCOHOL 91% SPRY.....	53	danazol.....	124
cvs prenatal.....	158	DANTRIUM.....	157
CVS PRENATAL.....	158, 162	dantrolene.....	157
cvs slow release iron.....	108	dapsone.....	35, 173
CVS SLOW RELEASE IRON.....	108	DAPTACEL DTAP.....	73
CVS VITAMIN.....	219, 222, 230	DARAPRIM.....	52
cvs vitamin a.....	213	darifenacin.....	194
cvs vitamin b-12.....	219	DAURISMO.....	56
cvs vitamin c.....	222	DAVIMET-M.....	232
cvs vitamin d3.....	226	DAVOL IRRIGATION SYRINGE.....	143
cvs vitamin e.....	230	DAYAVITE.....	199
cvs vit c.....	222	DAYPRO.....	27
cvs vit d3.....	226	DAYTRANA.....	167
cyanocobalamin.....	214, 215, 216, 219	DAYVIGO.....	171
cyclobenzaprine.....	157	DDAVP.....	121
CYCLOGYL.....	102, 103	DDROPS.....	225, 226
CYCLOMYDRIL.....	103	decara.....	226
cyclopentolate.....	103	DECARA.....	226
		DECUBI.....	199
		deferasirox.....	189

Index of Medications

deferiprone	189	DEXONTO.....	122
deflazacort.....	122	DEXTENZA	100
DEKAS	200, 210	dextroamphetamine	71
DEKAS PLUS.....	200, 210	dextrose	105, 106
DELESTROGEN	121	DIABETES HEALTH	200
DELTEC COZMO CLEO	155	DIABETIC VITAMIN	200
demeclocycline.....	39	DIACOMIT	89
DEMSEER.....	81	dialyvite.....	215
DENAVIR.....	69	DIALYVITE	200, 215, 226
DENG VAXIA.....	73	DIASTAT	88
DENOVO.....	196	DIASTIX REAGENT	94, 96, 97
DEPAKOTE	89	diatrizoate meglumine.....	95
DEPEN	26	DIATRUE.....	129
DEPLIN-ALGAL OIL.....	196	diazepam.....	88, 163
DEPO-ESTRADIOL.....	121	diazoxide	105, 106
DEPO-PROVERA	91	DIBENZYLIN.....	71
DEPO-SUBQ PROVERA.....	91	DICLEGIS	114
DEPO-TESTOSTERONE.....	120	diclofenac.....	20, 27, 61, 100, 173
DERMACINRX	200, 226	dicloxacillin.....	38
DERMA-SMOOTHIE-FS.....	179	dicyclomine.....	114
DERMASORB.....	179	didanosine	66
DERMATOP	179	diethylpropion	62
DERMAVIEW	148	DIFFERIN	182, 183
DERMOTIC	99	DIFICID	37
DESCOVY	65	diflorasone	179
desflurane.....	25	DIFLUCAN.....	44
desipramine	165, 166	diflunisal	15, 19
desloratadine	47	difluprednate	100
desmopressin	121	digoxin.....	77
DESMOPRESSIN.....	121	dihydroergotamine	15, 19
desog-e.estradiol/e.estradiol.....	91	DILANTIN.....	89
desogestrel-ethinyl estradiol	91	DILAUDID.....	22
DESONATE.....	179	diltiazem.....	76
desonide	179, 181	dimethyl.....	86, 188
desoximetasone.....	179, 181	dimethyl fumarate	86
DESOXYN.....	71	diphenoxylate hcl/atropine.....	114
DESVENLAFAXINE.....	165	DIPHThERIA-TETANUS TOXOIDS-PED	73
dex4 glucose.....	105	DIPROLENE.....	179
DEX4 GLUCOSE.....	105	dipyridamole	64
dex4 quick dissolve tab chew	105	DISALCID	26
dexamethasone	33, 100, 122	disopyramide.....	76
dexchlorpheniramine	47	disulfiram	188
DEXCOM.....	129	DIURIL.....	98
DEXCOM G6	129	divalproex	89
DEXEDRINE.....	71	dofetilide.....	76
dexlansoprazole.....	118	DOJOLVI	104
dexmethylphenidate.....	167	donepezil.....	70

Index of Medications

DONNATAL.....	115	EASY GLIDE LUER.....	143
DOPTLET.....	91	EASYGLUCO PLUS.....	129
dorzolamide.....	102	EASYMAX I5.....	129
DORZOLAMIDE.....	101, 102	EASYMAX NORMAL.....	129
DOSOKAP.....	226	EASY MINI EJECT.....	129
DOSOQUIN.....	226	EASY PLUS II.....	129
DOVATO.....	65	EASYPOINT.....	140
DOVER BULB SYRINGE.....	143	EASY STEP.....	129
DOVONEX.....	174	EASY TALK.....	129
doxazosin.....	79, 80	EASY TOUCH.....	129, 140, 143, 144, 150, 151, 175
doxepin.....	165, 166, 171, 173	EASY TOUCH FLIPLOCK.....	140, 143
doxercalciferol.....	187	EASY TRAK.....	129
doxycycline.....	38, 39, 40, 186	EASY TWIST CAP LANCETS.....	151
doxylamine succinate/vit b6.....	114	ECLIPSE SYRINGE.....	144
DRISDOL.....	226	EC-NAPROSYN.....	27
dronabinol.....	114	econazole.....	46
DROPLET.....	129, 135, 150	EDECIN.....	97
DROPLET GENTEEL LANCING DEVICE.....	129	EDEX.....	186
DROPLET LANCETS.....	150	EDLUAR.....	171
DROPLET LANCING DEVICE.....	129	EDURANT.....	66
DROPSAFE PREP PADS.....	175	E.E.S. 200.....	37
drospir/eth estra/levomefol.....	91	efavirenz.....	66, 67, 68
DROXIA.....	75	effer-k.....	112
droxidopa.....	71	EFFER-K.....	112
drug mart glucose.....	105	EFFIENT.....	64
DUAVEE.....	122	EFUDEX.....	61
DUETACT.....	49	EGRIFTA.....	123
DUET DHA.....	158	eldertonic.....	197
DUEXIS.....	27	ELDERTONIC LIQUID.....	197
DULERA.....	31	ELEMENT COMPACT.....	129
duloxetine.....	165	ELEMENT CONTROL.....	129
DUOBRII.....	174	ELEPSIA.....	89
DUOPA.....	63	eletriptan hydrobromide.....	15, 19
DUPIXENT.....	125, 126	ELFOLATE.....	215
dutasteride.....	193	ELIMITE.....	63
DXEVO.....	122	ELIQUIS.....	43
DYAZIDE.....	98	ELIXOPHYLLIN.....	32
DYMISTA.....	99	ELLA.....	92
DYRENIUM.....	98	ELMIRON.....	24
E		ELON.....	200
EAR HEALTH PLUS.....	195	EMBRACE.....	129, 135, 151
ear health plus caplet.....	195	EMBRACE EVO LEVEL I.....	129
EASIVENT.....	156	EMBRACE GLUC CONTROL SOLN.....	129
EASY.....	129, 135, 140, 143, 144, 150, 151, 175	EMBRACE LANCING DEVICE.....	129
EASY COMFORT ALCOHOL PAD.....	175	EMBRACE PRO.....	129
EASY COMFORT LANCETS.....	150	EMBRACE TALK CONTROL.....	129
EASY GLIDE CATHETER.....	143	EMCYT.....	61

Index of Medications

EMEND.....	114	EQ.....	194, 200, 210
EMERGEN-C.....	210, 223	EQ CHILD.....	210
EMERGEN-C KIDZ.....	210	eql.....	108, 190, 194, 200, 215, 219, 222, 223, 226, 227, 230
EMGALITY.....	15, 19, 88	eql slow release iron.....	108
EMGALITY PEN.....	19	eql vitamin.....	219, 223, 226, 227, 230
EMPAVELI.....	74	EQUETRO.....	163
EMSAM.....	163	EQ VISION.....	194
emtricitabine.....	65, 66	ERGOCAL.....	227
emtricitabine-tenofv.....	65	ergocalciferol.....	226, 227
EMTRIVA.....	66	ergoloid.....	83
EMVERM.....	52	ERGOMAR.....	19
enalapril.....	79, 81	ergotamine tartrate/caffeine.....	15, 19
enalapril/hydrochlorothiazide.....	79	ERIVEDGE.....	56
ENBRACE.....	200	ERLEADA.....	55
ENBREL.....	54	erlotinib.....	58, 60
ENDARI.....	75	ERMEZA.....	184
ENDO-AVITENE.....	75	ERYPED.....	37
ENDOMETRIN.....	125	ERY-TAB.....	37
ENDUR-AMIDE.....	208	ery-tab dr.....	37
ENDUR-THINE.....	208	erythromycin.....	34, 37, 40, 41
ENDUR-VM.....	200	escitalopram.....	164
ENFAMIL.....	106	ESGIC.....	15, 19
ENGERIX-B.....	74	ESKATA.....	174
ENLITE SERTER.....	129	esomeprazole.....	27, 118
ENLYTE.....	196	ESOMEPRAZOLE.....	118
enoxaparin.....	43	ESSENCE C.....	223
ENSPRYNG.....	126	ESSENTIAL.....	158, 200, 204, 206
ENSTILAR.....	182	estazolam.....	171
entacapone.....	63, 64	ESTER-C.....	223
entecavir.....	69	ESTRACE.....	121
ENTEREG.....	118	estradiol.....	91, 92, 121, 122, 124
ENTERO VU.....	95	estrogen,ester/me-testosterone.....	121
ENTRESTO.....	80	ESTROVEN.....	200
ENZOCLEAR.....	176	eszopiclone.....	171
EPCLUSA.....	69	ethacrynic.....	97
EPIDIOLEX.....	88	ethambutol.....	36
EPIDUO FORTE.....	173	ethinyl estradiol/drospirenone.....	92
EPIFOAM.....	181	ethosuximide.....	89, 91
epinastine.....	47	ethynodiol d-ethinyl estradiol.....	92
epinephrine.....	70, 99	etodolac.....	27, 28
EPIPEN.....	70	etonogestrel/ethinyl estradiol.....	91
EPISIL.....	187	etoposide.....	61
EPIVIR.....	66, 69	etravirine.....	66
eplerenone.....	98	EUCRISA.....	177
eprosartan.....	81	EULEXIN.....	55
EPSOLAY.....	176	EURAX.....	63
EPZICOM.....	65	EVEKEO.....	71

Index of Medications

EVENCARE.....	130	febuxostat.....	26
everolimus.....	57, 126, 127	felbamate.....	89
EVICEL.....	75	FELBATOL.....	89
EVISTA.....	192	FELDENE.....	27
EVOCLIN.....	41	felodipine.....	76
EVOLUTION.....	130	FEMARA.....	56
EVOTAZ.....	67	fenofibrate.....	85
EVOXAC.....	71	fenofibric.....	85
EVRYSDI.....	188	FENOGLIDE.....	85
EVZIO.....	43	fenoprofen.....	27, 28
EXEL.....	140, 144	FENORTHO.....	27
EXELDERM.....	46	fentanyl.....	22
EXEL HUBER.....	140	feosol.....	108
EXELON.....	70	FEOSOL.....	108
exemestane.....	56	FERAHEME.....	108
EXKIVITY.....	58	FERGON.....	108
EXPECTA PRENATAL.....	158	FER-IN-SOL.....	108
EXSERVAN.....	86	FERIVA 2I-7.....	108
EXTENDED RESERVOIR.....	144	FERIVA FA.....	108
EXTINA.....	46	FERRACTIV IRON.....	108
EYE HEALTH AND LUTEIN.....	194	FERRALET.....	108
EYE HEALTH PLUS LUTEIN TABLET.....	194	FERRETTS IPS.....	108
EYE MULTIVITAMIN.....	194	FERRIMIN.....	108
EYEPROTECT.....	194	FERRIPROX.....	189
EYSUVIS.....	100	FERRLECIT.....	108
EZ.....	135, 136, 150, 151	FERRO-SEQUELS.....	108
E-Z DISK.....	95	ferrous fumarate.....	109
ezetimibe.....	83, 85	FERROUS FUMARATE.....	109
ezetimibe/simvastatin.....	83	ferrous fum/vit c/b12-if/folic.....	109
E-Z-HD.....	95	ferrous gluconate.....	108, 109, 203
EZ-LETS.....	151	ferrous sulfate.....	108, 109
E-Z-PAQUE.....	95	ferumoxytol.....	108, 109
E-Z-PASTE.....	95	fesoterodine.....	194
EZ SMART LANCETS.....	151	FETZIMA.....	165
F		FEXMID.....	157
FA-8.....	196	FIBRICOR.....	85
FABHALTA.....	74	FIFTY50.....	136, 151
FACTIVE.....	38	fifty50 alcohol prep pads.....	175
famciclovir.....	68	FIFTY50 SAFETY SEAL LANCETS.....	151
famotidine.....	27, 117	FILSUVEZ.....	193
fa/mv,ca,iron,min/lycopene/lut.....	200	FILTER.....	140, 144, 147
FANAPT.....	168	FILTER ASPIRATOR.....	140
FARESTON.....	61	FINACEA.....	176
FARXIGA.....	50	finasteride.....	193
FARYDAK.....	55	FINE.....	136, 141, 151
FASENRA.....	32	FINE 30 UNIVERSAL LANCETS.....	151
FATIGUE RELIEF COMPLEX.....	200	FINGER GRIP.....	144

Index of Medications

FINGERSTIX	136, 151	fluticasone	30, 31, 99, 179, 180
fingolimod	86	fluticasone propion/salmeterol	30, 31
FIORICET	15, 19, 24	fluticasone-salmeterol	31
FIORINAL	15	fluticasone-salmeterol 100-50	31
FIRDAPSE	87	fluvastatin	84
FIRST-MOUTHWASH BLM	187, 188	fluvoxamine	164
FLAGYL	35	FLUZONE HIGH-DOSE	73
flavoxate	194	FLUZONE HIGH-DOSE QUAD	73
flecainide	76	FLUZONE QUAD	73
FLECTOR	173	FML	100
FLEVOXIN	223	fn vitamin	219
FLEXICHAMBER	156	FOLAGENT	200
FLINTSTONES	210	FOLAMAX	201
FLOGEN	195	FOLAMED	201
FLOLIPID	84	FOLIC	159, 196, 201, 214, 218, 219, 221, 227
FLOMAX	193	folic acid 109, 110, 159, 160, 161, 162, 196, 199, 201, 202, 203, 205, 206, 207, 210, 212, 214, 215, 216, 217, 218, 230	
FLORIVA	104, 210	folic/mvi ther-min/lycop/lut	201
FLOVENT	31	FOLIKA	196, 201, 216, 227
FLOW-EZE	140	FOLIKA-BC	216
FLUAD	73	FOLIKA-D	227
FLUAD QUAD	73	FOLIKA-NC	216
FLUARIX QUAD	73	FOLIKA-T	216
FLUBLOK QUAD	73	FOLIKA-V	196
FLUCELVAX QUAD	73	FOLINIC-PLUS	216
fluconazole	44	FOLITE	196
flucytosine	44, 45	FOLIXAPURE	226, 227
fludrocortisone	123	FOLLISTIM AQ	124
FLULAVAL QUAD	73	FOLTRATE	220
FLUMADINE	68	FOLTX	216
FLUMIST QUAD	73	FOLVITE-D	227
flunisolide	99	fondaparinux	43
fluocinolone	99, 179, 181	FORA	95, 130, 136, 151
fluocinonide	179	FORACARE	130, 136, 151
fluorescein	95, 101	FORACARE LANCETS	151
FLUORESCEIN-BENOXINATE	101	FORA GTEL	95, 130
fluoride	104, 107, 112, 211, 212	FORA LANCETS	151
FLUORIDEX	104, 107	formaldehyde	53, 172
fluorometholone	100	formoterol	30
FLUOROPLEX	61	FORTAMET	48
fluorouracil	61	FORTAVIT	201
fluoxetine	164, 170	FORTEO	191
fluphenazine	170	FORTESTA	120
FLURA-DROPS	104, 112	FORTISCARE	130
flurandrenolide	179, 180	FOSAMAX	191, 192
flurazepam	171	FOSAMAX PLUS D	191
flurbiprofen	28, 100	fosamprenavir	67
flutamide	55		

Index of Medications

fosaprepitant	114	gemfibrozil	85
fosfomycin tromethamine	35	GEMTESA	193
fosinopril	79, 81	GENADEK	201, 210
fosinopril/hydrochlorothiazide	79	GENICIN	196, 216, 227
FRAGMIN	43	GENICIN VITA-Q	196
FREEDAVITE	201	GENICIN VITA-S	216
FREESTYLE	94, 130, 136, 151	GENOTROPIN	123
FREESTYLE INSULINX	94	gentamicin	34, 35, 41
FREESTYLE LITE	94	GENTEEL	129, 130
FROVA	19	GENTLE IRON	109
frovatriptan succinate	19	GENVOYA	68
FRUIT C	223	GEODON	168
fruit c-100	223	GERBER	201, 210
FRUIT C-100	223	GERBER GROW MIGHTY	210
ft	227	GERBER LIL BRAINIES	210
FT	190	GERITOL	197
ful-glo	95	GIALAX	117
FUL-GLO	95	GILOTRIF	58
FULPHILA	91	glatiramer	86, 87
FURADANTIN	37	glatopa	87
furosemide	97	GLEOLAN	95
FUSION	66, 109	GLEOSTINE	55
FUZEON	66	glimepiride	49
FYCOMPA	89	glipizide	49, 50
G		GLOPERBA	26
gabapentin	88, 89	GLUCAGEN	95
GABITRIL	89	glucagon	105
GALAFOLD	189	GLUCAGON	62, 119
galantamine	70	GLUCO	105
GALZIN	189	GLUCOCARD	130
ganirelix	123	GLUCOCOM	130, 136, 151
GANIRELIX	123	glucose	105, 106
GARDASIL 9	74	GLUCOSE	105
GASTROCROM	26	GLUCOSE CONTROL	127, 128, 129, 130, 132, 133
GASTROGRAFIN	95	GLUCOSE LIQUID	105, 106
GASTROMARK	95	GLUCOTROL	49
gatifloxacin	34	GLUTOL	106
GATIFLOXACIN-DEXAMETHASONE	33	GLUTOSE-15	105
GATTEX	119	GLUTOSE-45	105
GAVRETO	58	glyburide	49, 50
GE100	130	GLYCATE	113
GELCLAIR	187	glycine urologic solution	53
GELFILM	101, 191	glycopyrrolate	113
GEL-FLOW	75	GLYNASE	49
GELFOAM	75	GLYXAMBI	49
GELNIQUE	194	gnp	105, 109, 158, 190, 194, 196, 201, 208, 213, 216, 220, 222, 223, 227, 230
GELX	187		

Index of Medications

GNP B-COMPLEX PLUS VIT C TAB.....	201	HEMATRON-AF	109
gnp glucose.....	105	HEMAX	109
GNP VITAMIN E	230	HEMLIBRA	74
GOJJI	95, 130, 136, 151	HEMOCYTE	109
GOLYTELY	117	heparin.....	43
GONAL-F	124, 125	HEPARIN	43
GONITRO	77	HEPLISAV-B	74
GOPRELTO	99	HETLIOZ	171
GRALISE.....	88	HIBERIX	73
granisetron.....	114	high potency multivitamin tab.....	201
GRASTEK	72	HIGH POTENCY MULTIVITAMIN TAB	201
griseofulvin.....	45	HIPREX	35
gs	105	HISTEX-AC	93
GS	53, 147, 158, 201	hm.....	109, 158, 190, 196, 208, 216, 220, 223, 227, 230, 231
GS PRENATAL	158, 201	HM ALCOHOL 70% PREP PADS.....	175
GUAIACOL.....	175	HM BIOTIN.....	216
guaifen-codeine	94	HM HAIR, SKIN AND NAILS TABLET	201
GUAIFEN-CODEINE	94	hm iron	109
guaifenesin/phenylephrine	93	HM MEN'S ONE DAILY TABLET	201
guanfacine.....	82, 166	HM ONE DAILY PRENATAL	158
GUARDIAN	130, 131	hm prenatal.....	158
GUMMIES CHILDREN MULTIVITAMIN	210	hm slow release iron	109
GUMMY	158, 198, 209, 210, 219	hm vit	220, 223
GVOKE.....	105	hm vitamin.....	220, 223, 227, 230, 231
GYNAZOLE	44	HM VITAMIN	227
H		homatropine.....	103
HAIR FORMULA	201	HOMOCYSTEINE.....	216
HAIR, SKIN AND NAILS	198, 201, 207	HORIZANT	86
HAIR-SKIN-NAILS.....	216	HORMONES.....	120, 121, 122, 123, 124, 125, 183, 184
halcinonide.....	180	HUMALOG	51
HALCION.....	171	HUMATIN	52
halobetasol	180	HUMIRA.....	54
HALOG.....	180	HUMULIN.....	51
haloperidol.....	170	HURRICAIN LUER-LOCK	140
HARD NAILS	216	HYCANTIN.....	57
HARVONI.....	69	HYCODAN	94
HEALON GV.....	103	hydralazine.....	82, 83
HEALTHPRO GLUCOSE CONTROL SOLN	131	HYDREA.....	55
HEALTHY.....	131, 136, 151, 194, 204, 205	hydrochlorothiazide	79, 80, 82, 83, 98
HEALTHY ACCENTS AUTOLET	131	hydrocodone.....	21, 22, 23, 93, 94
HEALTHY ACCENTS UNILET LANCET	151	hydrocodone-acetamin.....	21
healthy eyes tablet.....	194	HYDROCODONE-ACETAMIN	21
HEALTHY EYES TABLET	194	hydrocodone/ibuprofen.....	22
HEARTBURN ACID REFLUX.....	201	hydrocort.....	32, 33, 99, 119, 180, 181
HEMA-COMBISTIX.....	97	hydrocortisone	99, 119, 120, 122, 178, 180, 181, 182
HEMATEX	109	hydrocortisone/acetic acid	99
HEMATOGEN.....	109	hydrocort-pramoxine	119, 181

Index of Medications

hydrogen peroxide.....	172	indapamide.....	98
hydromorphone.....	22, 23	INDICLOR.....	96
hydroxocobalamin.....	220	indomethacin.....	28
hydroxychloroquine.....	52	INFANRIX DTAP.....	73
HYDROXYCHLOROQUINE.....	52	INFANT-TODDLER MULTIVITAMIN.....	210
HYDROXYPROPYLCELLULOSE.....	191	infant-toddler multivit-iron.....	210
hydroxyurea.....	55	INFANT-TODDLER MULTIVIT-IRON.....	210
hydroxyzine.....	47	INFANT-TODDLER TRI-VITAMIN.....	210
HYFTOR.....	126	INFASURF.....	184
HYLAVITE.....	216	INFED.....	109
HYLAZINC.....	196	INFINITY.....	131
hyoscyamine.....	115	INFUSION SET.....	128, 131, 133, 134, 155
HYPER-SAL.....	188	INFUVITE.....	201, 210
HYPODERMIC NEEDLE.....	140, 147	INGREZZA.....	86
HYPOLANCE.....	131	INJECT.....	136, 145, 151
HYPROMELLOSE.....	191	INJECTAFER.....	109
HYRIMOZ.....	54	INJECT EASE.....	151
HYSINGLA.....	23	INJECT-EASE.....	145
I		INLYTA.....	58
ibandronate.....	192	INNER EAR PLUS.....	195
ibuprofen.....	22, 27, 28	INOVA.....	176
ibuprofen/famotidine.....	27	INPEN.....	131
I-CAPS.....	194	INSET.....	155
ICAPS.....	195, 201	INSET 30.....	155
ICAPS AREDS2.....	195	INSET 30 TUBING.....	155
ICAR.....	109	INSPIRACHAMBER.....	156
icatibant.....	185	INSPIRA.....	98
ICLUSIG.....	58	INSTACLEAN.....	190
icosapent.....	113	INSTA-GLUCOSE.....	106
IDHIFA.....	61	insta-glucose gel.....	106
IFE-BIMIX.....	186	INSUL-CAP.....	131
IGALMI.....	171	INSUL-EZE.....	131
ILET.....	131	INSULIN.....	48, 49, 50, 51, 123, 142, 144, 145, 146, 148
ILEVRO.....	100	INSULIN CARTRIDGE.....	145
I.L.X. B-12.....	109	INSULIN LISPRO.....	51
IMBRUVICA.....	58	INSULIN SYRINGE U-500.....	145
IMCIVREE.....	62	INTEGRA.....	110, 140, 145
imipramine.....	166	INTELENCE.....	66
imiquimod.....	176	INTERLINK.....	145
IMMUNERX.....	201	INTRINSI.....	220
IMPAVIDO.....	53	INVACARE.....	136, 151
IMPEKLO.....	180	INVEGA.....	168
IMURAN.....	126	INVELTYS.....	100
INBRIJA.....	63	INVIRASE.....	67
INCONTROL.....	131, 136, 151, 175	iodine/potassium iodide.....	182
INCONTROL LANCING DEVICE.....	131	iodine/sodium iodide.....	182
INCRELEX.....	123	IODOFLEX.....	182

Index of Medications

IODOSORB.....	182	JALYN.....	193
IOPIDINE.....	102	JANSSEN COVID-19 VACCINE.....	72
IPOL.....	72	JANUMET.....	50
ipratropium.....	29, 30, 99	JANUVIA.....	49
irbesartan.....	80, 81	JARDIANCE.....	50
irbesartan/hydrochlorothiazide.....	80	JATENZO.....	120
IRESSA.....	58	JOENJA 70 MG TABLET.....	185
IRON108, 109, 110, III, 112, 158, 162, 200, 205, 206, 207, 209, 210, 211, 212		JORNAY.....	167
iron bg.....	110, 159	JUBLIA.....	46
IRON BISGLYCINATE.....	110	JULUCA.....	65
iron/c.....	110	JUST 4 KIDZ MULTIVIT-PROBIOTIC.....	211
iron,carbonyl.....	108, 109, 110	JUSTRIGHT 5000.....	104, 107
iron fm.....	110, 112	JUXTAPID.....	83
iron/folic.....	110, 159, 160, 161, 198, 199, 202, 203, 204, 207	JYNARQUE.....	97, 98
iron fum.....	109, 110, 159, 160, 161, 199, 203, 204, 209	K	
iron fumarate.....	110, 159	KI-1000.....	232
iron polysac.....	110	K2.....	226, 227, 232
iron polysaccharide.....	109, 110, 111	KADIAN.....	23
IRONUP.....	110	KALETRA.....	67
IRO-PLEX.....	110	KALYDECO.....	184
IROSPAN.....	111	KAPVAY.....	166
IS-D.....	227	KARBINAL.....	47
ISENTRESS.....	67	KENALOG.....	180
isoflurane.....	25	KENDALL.....	145, 148
isoniazid.....	36	KENDALL DISINFECTANT CAP.....	145
ISOPROPANOL.....	190	KERENDIA.....	98
isopropyl.....	175, 190, 191	KESIMPTA.....	87
isopropyl alcohol.....	175, 190, 191	KETAMINE.....	171
ISOPROPYL ALCOHOL.....	175, 190, 191	ketoconazole.....	45, 46
ISOPROPYL ALCOHOL 70% SPRAY.....	53	ketodan.....	46
isopropyl rubbing alcohol.....	190, 191	KETO-DIASTIX REAGENT.....	96, 97
ISOPROPYL RUBBING ALCOHOL.....	190	KETONE CARE TEST STRIP.....	96
ISOPTO CARPINE.....	102	KETONE TEST STRIP.....	95, 96
ISORDIL.....	77	ketoprofen.....	28
isosorbide.....	77, 83	ketorolac.....	20, 21, 100
isotretinoin.....	173	KETOSTIX REAGENT.....	96
isoxsuprine.....	83	KIDS COD LIVER OIL.....	211
isradipine.....	76	KIDS MULTIVITAMIN.....	211
itraconazole.....	45	KINRIX.....	73
IV 3000.....	148	KISQALI.....	58
IV3000.....	148	KITABIS PAK.....	35
IV ADMINISTRATION SET.....	155	KLARITY.....	34, 99, 100, 103
ivermectin.....	52, 63, 176, 177	KLARITY-A(AZITHROMYCIN-CHONDR).....	34
IWILFIN.....	58	KLARON.....	173
J		KLOXXADO.....	44
JAKAFI.....	56	KOSELUGO.....	57
		KOSHER PRENATAL.....	158

Index of Medications

K-PAX.....	201	L.E.T.....	25
K-PHOS.....	113	letrozole.....	56
KPN PRENATAL.....	159	leucovorin.....	185
kpn tablet.....	159	LEUKERAN.....	55
KRINTAFEL.....	52	levabuterol.....	30
KRISTALOSE.....	118	LEVBID.....	115
croger glucose.....	106	LEVER LOCK CANNULA.....	145
kro glucose.....	106	levetiracetam.....	90
kro isopropyl alcohol 91%.....	190	LEVITRA.....	186
k-tab.....	112	levobunolol.....	102
K-TAB.....	112	levocarnitine.....	191
KYLEENA.....	92	levofloxacin.....	34, 38
KYNMOBI.....	63	LEVOMEFOL.....	216
L		levomefolate.....	196, 214, 215, 216, 217
labetalol.....	79	LEVOMEFOLATE.....	216
LABSTIX REAGENT.....	97	levonorgestrel/ethin.estradiol.....	92
lacosamide.....	89	levorphanol.....	23
LACRISERT.....	99	levothyroxine.....	184
lactulose.....	113, 118	LEVSIN.....	115
LAMICTAL.....	89	LEVULAN.....	61
lamivudine.....	65, 66, 69	LEXIVA.....	67
lamivudine/zidovudine.....	65	LICART.....	173
lamotrigine.....	89, 90	lidocaine.....	25, 119, 182
lancets.....	134, 136, 150, 151, 152	LIDOCAINE-EPINEPHRIN-TETRACAIN.....	25
LANCETS.....	134, 135, 136, 137, 138, 139, 150, 151, 152, 153, 154	LIDOCAINE-HYDROCORT.....	119
LANCETS THIN.....	151	LIDOCAN.....	25
LANCETS ULTRA THIN.....	151	LIFESHIELD BLUNT CANNULA.....	140, 145
LANCING DEVICE.....	127, 128, 129, 130, 131, 132, 133, 134	LILETTA.....	92
LANCING SYSTEM.....	131	lindane.....	182
LANOXIN.....	77	linezolid.....	38
lansoprazole.....	115, 118, 119	LINZESS.....	117
lansoprazole/amoxicilin/clarith.....	115	liothyronine.....	184
lanthanum carbonate.....	107	LIPO.....	195
LANZO.....	131	LIPO-FLAVONOID PLUS.....	195
lapatinib ditosylate.....	58, 60	LIPOTRIAD.....	195
LASIX.....	97	LIQUID C.....	223
LASTACAFT.....	47	LIQUID E-Z PAQUE.....	95
latanoprost.....	102	LIQUID POLIBAR PLUS.....	95
LATANOPROST.....	102	lisdexamfetamine.....	166
LAZANDA.....	23	lisinopril.....	79, 81
leader glucose.....	106	lisinopril/hydrochlorothiazide.....	79
leader quick dissolve gluc.....	106	LITE.....	94, 131, 136, 151, 152, 223
lecithin/pyridoxine/kelp.....	201	LITEAIRE.....	156
leflunomide.....	26	LITE TOUCH.....	131, 151, 152
lenalidomide.....	57	LITETOUCH.....	156
LENVIMA.....	58, 59	LITFULO.....	193
LESCOL.....	84	lithium.....	163

Index of Medications

LITHOBID.....	163	LUPKYNIS	126
LITHOSTAT	113	LYDIA PINKHAM HERBAL	III
LITTLE ANIMALS	211	LYMEPAK.....	39
LIVALO.....	84	LYNPARZA.....	59
LIVITA.....	211	LYSODREN	61
LIVMARLI	117	LYSTEDA	74
LIVTENCITY.....	68	LYTGOBI	59
l-mefol/a-cyst/mebl2/algal oil	216	LYUMJEV	51
l-mefolate/b3/copp/znsel/chrom	201	M	
L-METHYLFOL	216	MACROBID	37
l-norgest/e.estradiol-e.estrad	92	MACRODANTIN.....	37
LODINE.....	28	MACULAR BENEFITS	195
LODOSYN	64	MACUVEX.....	195
LOKELMA	107	MACUZIN	195
LOMAIRA	62	mafenide.....	41, 42
LOMOTIL.....	114	MAGELLAN.....	145
longs glucose.....	106	MALARONE	53
LONHALA MAGNAIR	29	malathion	182
LONSURF.....	56	maprotiline.....	166
LOPID	85	maraviroc.....	65, 66
lopinavir/ritonavir.....	67	MAR-COF CG.....	94
LOPRESSOR	82	MARINOL.....	114
LOPROX	46	MARNATAL-F	159
lorazepam.....	162, 163	MARPLAN.....	163
LORBRENA	59	MATULANE.....	61
LORID.....	216	MAVENCLAD.....	87
LORMATE.....	216	MAXFE.....	III
LORTAB.....	21	MAXIMIN.....	201
LORZONE.....	157	MAXIMUM D3	227
losartan/hydrochlorothiazide.....	80	MAXITROL.....	33
losartan potassium.....	81	MAXI-TUSS CD.....	93
LOTEMAX	100	MAXZIDE	98
LOTENSIN.....	79, 81	MAYZENT	87
LOTENSIN HCT	79	MEBOLIC.....	202
loteprednol etabonate.....	100	meclofenamate	28
lovastatin.....	84	mecobal/levomefolat ca/b6 phos.....	216
loxapine	170	MEDI-FIRST ISOPROPYL ALCOHOL.....	53
lubiprostone.....	118	MEDIHONEY	177
LUCENTIS	103	MEDISENSE.....	131, 136, 152
LUER LOCK.....	143, 144, 145	medlance	136, 152
LUER-LOK	141, 142, 145, 147	MEDLANCE	136, 152
LUERSLIP	145	medlance plus.....	152
LUER SLIP TIP.....	145	MEDLANCE PLUS	152
LUER TIP CAP.....	145, 147	MEDROL	122
LUMAKRAS.....	57	medroxyprogesterone	91, 124
LUMIGAN	102	MEDTRONIC.....	131
LUMRYZ	171	MEDTYCHOLL-B.....	216

Index of Medications

mefenamic.....	21	methscopolamine.....	115
mefloquine.....	53	METHYL B-12.....	220
MEGA BIOTIN.....	216	METHYLCOBALAMIN.....	220
megestrol.....	61, 194	methyldopa.....	82
meijer glucose.....	106	methylergonovine.....	124
MEKINIST.....	57	METHYLFOLATE.....	196
meloxicam.....	28	METHYLIN.....	167
melphalan.....	55	methylphenidate.....	167
memantine.....	85	METHYLPHENIDATE.....	167
MEMANTINE.....	85	methylprednisolone.....	122
MEN 50.....	197, 199, 202, 206	METHYL PROTECT.....	216
MENACTRA.....	72	methyl salicylate.....	176
MENOPUR.....	124	methyltestosterone.....	120
MENOSTAR.....	122	metoclopramide.....	117
MENQUADFI.....	72	metolazone.....	98
MEN'S 50 PLUS.....	202, 204, 205	METOPIRONE.....	96
MEN'S DAILY.....	202	metoprolol.....	82, 83
MEN'S MULTIVITAMIN.....	202, 204	METOPROLOL SUCCINATE ER-HCTZ.....	83
MENVEO.....	72	METROCREAM.....	176
mepерidine.....	23	METROGEL.....	40, 176
MEPHYTON.....	232	METROGEL-VAGINAL.....	40
meprobamate.....	163	metronidazole.....	35, 40, 176, 177
MEPRON.....	53	metyrosine.....	81
mercaptopurine.....	56	mexiletine.....	76
MERIBIN.....	216	MIACALCIN.....	125
mesalamine.....	116	miconazole.....	44
MESNEX.....	185	MICRO.....	133, 136, 141, 152, 183
METANX.....	216	MICROCHAMBER.....	156
metaproterenol.....	29	MICRODOT.....	131
metaxalone.....	157	MICROLET.....	131, 137, 152
metformin.....	48, 49, 50	MICROSPACER.....	156
METHACHOLINE.....	95	MICROTAINER.....	150, 152
methadone.....	23	MICRO THIN LANCET.....	152
methamphetamine.....	71	MICRO THIN LANCETS.....	152
METHAVER.....	216	midazolam.....	171
methazolamide.....	97	MIDAZOLAM.....	171
methenamine hippurate.....	35	midodrine.....	71
methenamine mandelate.....	35	MIEBO.....	99
methenam/m.blue/salicyl/hyoscy.....	35	MIFEPREX.....	187
methenam/sod phos/mblue/hyoscy.....	35	mifepristone.....	50, 187
methen/mblue/sal/sod phos/hyos.....	35	miglitol.....	48
methimazole.....	183	miglustat.....	189
METHITEST.....	120	MIGRANAL.....	19
meth/meblue/sod phos/psal/hyos.....	35	MINI LANCING DEVICE.....	131, 133
methocarbamol.....	158	MINIMED.....	131, 132, 145
methotrexate.....	56	MINIMED RESERVOIR.....	145
methoxsalen.....	172	MINI PRENATAL.....	159

Index of Medications

MINIPRESS.....	80	MULTAQ.....	76
MINITRAN.....	77	MULTI-BETIC.....	195
minocycline.....	39, 40	MULTI-DAY PLUS MINERALS.....	202
MINOLIRA.....	39	multi for her.....	202
minoxidil.....	82	MULTI FOR HER.....	202
MIRAPEX.....	64	MULTI-LANCET.....	132
MIRENA.....	92	multilex.....	202
mirtazapine.....	162	MULTILEX.....	202
MIRVASO.....	177	MULTI PRO.....	202
misoprostol.....	27, 115	MULTISTIX.....	97
MITIGARE.....	26	MULTIVITAMIN ..160, 194, 195, 197, 198, 199, 200, 201, 202, 203, 204, 205, 206, 207, 208, 209, 210, 211, 216, 232	
MITOMYCIN.....	103	MULTI-VITE.....	203
MITOSOL.....	103	MULTI-VIT-FLOR.....	211
MIXED TOCOTRIENOLS.....	231	MULTIVIT-FLUOR.....	211
MKO.....	171	MULTIVIT-FLUORIDE.....	211
M-M-R II VACCINE.....	73	multivit-min/fa/lycopen/lutein.....	199, 203
MOBIC.....	28	multivit-min/iron/folic acid.....	203
MOBILE.....	137	mupirocin.....	41
modafinil.....	170	MURI-LUBE.....	190
MODERNA COVID.....	72	MUSE.....	186
MODERNA COVID-19 BOOSTER.....	72	mv.....	109, 110, 112, 198, 200, 201, 203, 205
moexipril.....	81	M.V.I. PEDIATRIC.....	211
molindone.....	170	mvn.....	199, 204
mometasone.....	99, 180	MVW.....	204, 211
MONOCAPS.....	202	MVW COMPLETE.....	211
MONODOX.....	39	MYALEPT.....	125
MONOFERRIC.....	111	MYAMBUTOL.....	36
MONOJECT.....	140, 145, 146	MYCAPSSA.....	124
MONOLET.....	137, 152	MYCOBUTIN.....	36
MONSEL'S.....	75	mycophenolate.....	126
montelukast.....	32	MYDAYIS.....	71
morgidox.....	39	MYDRIACYL.....	103
MORGIDOX.....	39	MYDRIATIC4.....	101
morphine.....	23, 24	MYFEMBREE.....	123
MOTOFEN.....	114	MYFORTIC.....	126
MOUNJARO.....	48	MYGLUCOHEALTH.....	132, 137, 152
MOUTHPIECE.....	156	MYLERAN.....	55
MOVANTIK.....	43	MYRBETRIQ.....	193
MOXATAG.....	38	MYSOLINE.....	90
moxifloxacin.....	34, 38	MYXREDLIN.....	51
MOXIFLOXACIN.....	33	N	
MS CONTIN.....	24	nabumetone.....	28, 29
ms glucose.....	106	nadolol.....	82
ms quick dissolve glucose.....	106	naftifine.....	46
MTERYTI.....	159	NAFTIN.....	46
MTX.....	220	NALFON.....	28
MUCOSITISRX.....	187		

Index of Medications

NALOCET	21	neuac gel.....	173
naloxone.....	24, 43, 44, 193	NEULUMEX	95
naltrexone.....	44	NEUPRO	64
NAMENDA	85	NEURIN-SL	220
NAMZARIC	85	NEUTRASAL	187
NANO.....	140, 141, 162, 211	nevirapine.....	66
NANO 2ND GEN.....	140	NEXAVAR	59
NANOVM.....	211	NEXCARE TEGADERM	148
NAPRELAN.....	28	NEXLETOL	83
NAPROSYN	27, 28	NEXLIZET.....	84
naproxen.....	20, 27, 28	niacin.....	85, 208, 209
naproxen/esomeprazole mag.....	27	NIACIN	208, 209
naratriptan.....	19, 20	niacinamide.....	209
NARCAN	44	NIACINAMIDE.....	209
NARDIL	163	NIACOR.....	85
NASCOBAL	220	nicardipine.....	76
NATACHEW	159	NICOMIDE.....	204
NATACYN.....	44	NICOTROL	183
nateglinide.....	49	nifedipine.....	76, 77
NATPARA	124	NIFEREX.....	111
NAYZILAM.....	88	NILANDRON.....	55
nebivolol.....	82	nilutamide.....	55
NEBUPENT	53	nimodipine	76
nebusal.....	188	NINJACOF-XG	94
NEBUSAL.....	188	NINLARO	59
NEEDLE.....	139, 140, 141, 144, 145, 146, 147	nisoldipine.....	76, 77
needles,safety huber,disposabl.....	141	nitazoxanide	63
NEEVODHA	204	nitisinone.....	188
nefazodone	164	NITRO-DUR.....	77
neomycin.....	32, 33, 34, 35, 172	nitrofurantoin.....	37
neomycin/bacit/p-myx/hydrocort.....	33	nitroglycerin.....	77, 78, 118
neomycin/bacitracin/polymyxinb.....	34	NITROLINGUAL	78
neomycin/polymyxin b/dexametha.....	33	NITROMIST	78
neomycin/polymyxin b/hydrocort	32, 33	NITROSTAT	78
neomycin/polymyxn b/gramicidin	34	NITYR.....	188
neomycin sulfate.....	35	NIVA-FOL.....	216
NEONATAL	111, 159	NIVA-PLUS	204
NEONATAL FE.....	111	nizatidine.....	117
NEORAL.....	127	NOCDURNA	121
NEO-SYNALAR.....	40	NO FLUSH NIACIN.....	209
NEOVITE.....	204	NOKOR	141
NEPHRON FA	216	nolix.....	180
NEPHRO-VITE.....	216	norelgestromin/ethin.estradiol.....	92
NERIA	155	noreth-ethinyl estradiol/iron.....	92
NERLYNX.....	59	norethind-eth estrad.....	92, 122
NESTABS	159, 204	norethindrone.....	92, 121, 122, 124
NEUAC	173	norethin-ee.....	92

Index of Medications

norethin-eth estrad	122	OCULAR VITAMINS	195
NORGESIC	158	OCUVEL	195
norgestimate-ethinyl estradiol	92	OCUVITE	195, 204
norgestrel-ethinyl estradiol	92	ODACTRA	72
NORM-JECT	146	ODEFSEY	67
NORPRAMIN	166	ODOMZO	56
nortriptyline	166	OFEV	185
NORVIR	67	ofloxacin	32, 34, 38
NORWEGIAN COD LIVER OIL	213	OGSIVEO	59
NOURIANZ	64	olanzapine	168, 169, 170
NOVA	132, 137, 152	olmesartan/amlodipin/hcthiazid	80
NOVAFERRUM	III, 211	olmesartan/hydrochlorothiazide	80
NOVAMAX PLUS	95, 132	olmesartan medoxomil	81
NOVAMV	211	olopatadine	98
NOVAREL	125	OLPRUVA	113
NOVAVAX COVID-19 VACC,ADJ	72	OLUX	180
NOVOPEN 3	132	om-3	204
NOVOPEN ECHO	132	OMECLAMOX-PAK	115
NOXAFIL	45	omega-3 acid	113
NOXIFOL-D3	227	omeprazole	119
NUBEQA	55	OMNIPAQUE	95
NUCALA	32	OMNIPOD	132
NUCORT	180	OMNITROPE	123
NUEDEXTA	86	OMNIVEX	204
NUFERA	III	OMVOH	125
NUFOLA	217	ON CALL	132, 137, 152
NU-IRON	III	ONCOVITE	204
NULEV	115	ondansetron	114
NULYTELY	118	one	5, 6, 7, 8, 9, 12, 14, 161, 199, 200, 201, 204, 205, 206, 233
NUMBRINO	99	ONE	156, 158, 159, 161, 162, 197, 200, 201, 202, 204, 205, 206, 211, 212
NUMOISYN	187	ONE A DAY	159, 212
NUPLAZID	164	ONE-A-DAY	159, 205, 211
NURTEC ODT	20	one daily	161, 199, 200, 201, 204, 205, 206
NUTRIVIT	204	one-daily	205
NUVESSA	40	ONE DAILY	158, 197, 200, 201, 202, 204, 205, 206
NUZYRA	40	ONE-DAILY	205
NYMALIZE	77	ONETOUCH	94, 132, 137, 152
nystatin	45, 46	ONETOUCH DELICA	132, 152
O		ONETOUCH ULTRA	94, 132
OB COMPLETE	159, 204	ONETOUCH VERIO	94, 132
OBREDON	94	ONEVITE	205
OBSTETRIX EC	159	ONE WAY MOUTHPIECE	156
OBSTETRIX ONE	204	ONEXTON	173
OBTREX DHA	159	ON-THE-GO	137, 152
O-CAL FA	204	OPFOLDA	189
OCALIVA	117	opium/belladonna	24
OCUFLOX	34		

Index of Medications

opium tincture.....	114	OXYTROL.....	194
OPSITE.....	148	OZEMPIC.....	48
OPSUMIT.....	78	P	
OPTICHAMBER.....	156	PACNEX.....	176
OPTIFAST.....	205	paliperidone.....	168
OPTIMAL D3 M.....	227	PALYNZIQ.....	72
OPTISOURCE.....	205	PAMELOR.....	166
OPTUMRX.....	132	PAN-C.....	223
OPURITY.....	205, 220	PANCREAZE.....	118
OPZELURA.....	182	PANDA.....	156
ORACIT.....	113	PANDEL.....	181
ORALAIR.....	72	PANRETIN.....	61
ORAMAGICRX.....	187	PANTETHINE.....	209
ORAPRED ODT.....	122	pantoprazole.....	119
ORAVIG.....	45	PAPAVERINE-PHENTOLAMINE.....	186
ORENITRAM.....	78	PAPAVERINE-PHENTOLMN-ALPROSTD L.....	186
ORFADIN.....	188	PARADIGM.....	132, 146, 155
ORGOVYX.....	57	paregoric.....	114
ORIAHNN.....	123	PAREMYD.....	103
ORILISSA.....	123	paricalcitol.....	187
ORKAMBI.....	184	PARLODEL.....	64
ORLADEYO.....	185	PARNATE.....	163
ORLISTAT.....	62	paromomycin.....	52
orphenadrine.....	158	paroxetine.....	164, 189
ORTHO DF.....	227	PARVLEX.....	111
oseltamivir.....	68	PASER.....	36
OSENI.....	48	PATANASE.....	98
OSTACHOL.....	227	PAXIL.....	164
OTEZLA.....	26	pazopanib.....	59
OTIPRIO.....	33	PEDIA POLY-VITE.....	212
OTOVEL.....	33	pedia poly-vite iron.....	212
OVACE.....	174	PEDIATRIC MASK.....	156
OVAL TAPE.....	132	PEDIATRIC MONITOR.....	133
OVIDE.....	182	pediatric multivit.....	212
OVIDREL.....	125	pediatric multivitamin.....	209, 212
oxandrolone.....	120	PEDIATRIC PANDA MASK.....	156
oxaprozin.....	27, 29	PEDIATRIC POLY-VITAMIN.....	212
oxazepam.....	163	PEDIATRIC POLY-VITE.....	212
oxcarbazepine.....	90	PEDIATRIC TRI-VITAMIN.....	212
OXERVATE.....	103	PEDIATRIC TRI-VITE.....	212
oxiconazole.....	46	PEDIA TRI-VITE.....	212
OXTELLAR.....	90	pedi multivit.....	209, 210, 212
oxybutynin.....	194	ped mvit.....	212
oxycodone.....	21, 22, 24	PEDVAXHIB.....	73
oxycodone hcl/acetaminophen.....	21	peg3350/sod sulf,bicarb,cl/kcl.....	117, 118
OXYCONTIN.....	24	peg3350/sod sul/nacl/kcl/asb/c.....	118
oxymorphone.....	24	PEGASYS.....	69

Index of Medications

PEMAZYRE	59	pioglitazone	49, 50
PENBRAYA	72	PIP	132, 137, 152
penciclovir	70	PIP GLUCOSE CONTROL SOLUTION	132
penicillamine	26	PIP LANCET	152
penicillin	38	PIQRAY	59
PENTACEL	73	pirfenidone	188
pentamidine	53	piroxicam	27, 29
PENTASA	116	PISTON ENFIT	146
pentazocine	24	pitavastatin	84
pentoxifylline	75	PLEGRIDY	87
PEPCID	117	PLEXION	41, 174
PERFECT IRON	111	PNEUMOVAX 23	73
PERIDEX	185	pnv	159, 161
PERIDIN-C	223	pnv81	159
perindopril erbumine	81	POCKET CHAMBER	156
permethrin	63	PODIAPN	217
perphenazine	170	podofilox	176
perphenazine/amitriptyline hcl	165	POLIBAR ACB	95
PFIZER COVID	72	polyethylene	190
PHARMABASE BARRIER	176	POLY HUB	141
pharm choice alcohol prep pads	175	polymyxin b sulf/trimethoprim	34
PHARM CHOICE ALCOHOL PREP PADS	175	POLYSKIN II	148
PHASEAL	141	POLYTRIM	34
PHEBURANE	113	POLY-TUSSIN AC	93
phenazopyridine	25	POLY-VI-FLOR	212
phendimetrazine	62	poly-vi-sol	212
phenelzine	163	POLY-VI-SOL	212
phenobarb/hyoscy/atropine/scop	115, 116	POLY-VITA	212
phenobarbital	115, 116, 171	POLY VITAMIN-IRON	206
phenobarbital-belladonna elixr	115, 116	POLY-VITE	212
PHENOBARBITAL-BELLADONNA ELIXR	116	POMALYST	57
phenoxybenzamine	71	PONVORY	87
phentermine	62	POSACONAZOLE	45
phenylephrine	46, 93, 101	posaconazole dr	45
PHENYTEK	90	POTABA	217
phenytoin	89, 90	potassium bicarbonate/cit ac	112
PHOSLYRA	107	potassium chloride	112
PHOSPHOLINE IODIDE	102	potassium citrate	113
PHOTREXA	99	potassium iodide	107, 182
PHYSIOLYTE	172	potassium iodide/iodine	107
PHYSIOSOL	172	pramipexole	64
phytonadione	232	PRAMOSONE	182
PHYTONADIONE	232	PRANDIN	49
pilocarpine	71, 102	prasugrel	64
pimecrolimus	126	pravastatin	84
pimozide	168	praziquantel	52
pindolol	82	prazosin	80

Index of Medications

PR BENZOYL PEROXIDE.....	176	primidone	90
PRECISIONGLIDE.....	140, 141, 146, 147	PRIMSOL	35
PRECISION XTRA	94, 95, 133	PRIORIX	73
PRECOSE	48	PRISMASOL.....	112
PRED FORTE.....	100	probenecid.....	29
PRED-G.....	33	PROCARDIA	77
prednicarbate	179, 181	PROCARE SPACER.....	156
prednisolone.....	33, 100, 122, 123	PROCERV HP.....	206
PREDNISOLONE.....	33, 100	PROCHAMBER.....	156
PREDNISOLONE ACET-GATIFLO-BROM.....	33	prochlorperazine.....	114, 115
PREDNISOLONE ACET-GATIFLOXACIN	33	PRO COMFORT	137, 152, 156, 175
PREDNISOLONE ACET-MOXIFLOXACIN.....	33	PROCORT	119
PREDNISOLONE AC-MOXIFLOX-BROMF	33	PROCTOCORT	119
PREDNISOLONE AC-MOXIFLOX-NEPAF.....	33	PRODIGY	133, 137, 146, 152
PREDNISOLONE PHOS-GATIFLO-BROM.....	33	PRODIGY COUNT-A-DOSE.....	146
PREDNISOLONE PHOS-GATIFLOXACIN.....	33	PRO FE.....	III
PREDNISOLONE PHOS-MOXIFLO-BROM.....	33	PROFERRIN.....	III
PREDNISOLONE PHOS-MOXIFLOXACIN	33	PROFOLA.....	206
prednisone.....	123	progesterone	124
preferred plus glucose	106	PROGLYCEM.....	106
PREFEST	122	PROGRAF.....	127
pregabalin.....	90, 192	prolate	21, 22
PREGNYL.....	125	PROLENSA.....	100
PREHEVBRIO.....	74	PROMACTA	91
PREMARIN.....	124	promethazine.....	47, 93, 115
PRENATA	159	PROMETRIUM.....	124
prenatal.....	158, 160, 161, 162	propafenone.....	76
PRENATAL	158, 159, 160, 161, 162, 197, 198, 201	proparacaine.....	101
prenatal71.....	161	propranolol.....	82, 83
PRENATE	161, 206	propylthiouracil.....	183
PREPIDIL	124	PROQUAD	74
PRESERVISION	195	PRORENAL.....	206, 217
PRESSURE	101, 102, 137, 152	PROSCAR.....	193
PRESSURE ACTIVATED LANCETS.....	152	PROSTIN E2.....	124
PRESTALIA.....	79	PROTECT	104, III, 206, 216
PRETOMANID	36	PROTECT IRON	III, 206
PREVENT.....	213	PROTHELIAL	187
PREVIDENT	104, 107	PROTOPIC	126
PREVNAR 13.....	73	protriptyline.....	166
PREVNAR 20.....	73	PROVERA.....	91, 124
PREVYMIS.....	68	PROVIDA OB.....	161
PREZISTA.....	65	PROVOCHOLINE.....	95
PRIFTIN	36	pseudoephed/codeine/guaiifen	94
PRIMACARE.....	161	PSV SET	155
primaquine	53	pub glucose.....	106
PRIMAQUINE	53	PULMOZYME.....	184
PRIMEAIRE	156	PURE	137, 153, 157, 175

Index of Medications

PURE COMFORT	153, 157, 175	ra high potency iron	III
PUREFE	206	RA HIGH POTENCY IRON	III
PURIXAN	56	ra iron	III
PUSH	137, 153	ra isopropyl alcohol 70%	191
PUSH BUTTON	153	RA ISOPROPYL ALCOHOL 70% WIPES	175
pyrazinamide	36	ra isopropyl alcohol 91%	191
pyridostigmine	70	raloxifene	192
PYRIDOSTIGMINE	70	ramelteon	171
pyridoxine	201, 222	RA MEN'S	206
PYRIDOXINE	222	ramipril	80, 81
pyrimethamine	52, 53	RA NIACIN	209
PYRUKYND	74, 75	ranitidine	117
Q		ranolazine	75
qc	161, 175, 190, 191, 227	ra one daily prenatal dha pack	161
qc alcohol 70% swabs	175	RAPAMUNE	127
qc prenatal tablet	161	RAPID B-12 ENERGY	220
QELBREE	167	ra prenatal tablet	161
QSYMIA	62	rasagiline	63, 64
Q-SYTE	155	RASUVO	26
QUADRACEL DTAP-IPV	74	RAVICTI	113
QUALAQUIN	53	ra vit	220, 223
QUDEXY	90	RA VIT	220
QUERCETIN	195	ra vitamin	213, 220, 223, 227, 228, 231
QUESTRAN	84	ra vitamin a	213
quetiapine	168, 169	RA VITAMIN C	223
QUFLORA	212	RAYALDEE	187
QUICK RELEASE SOFT TEFLON	133	RAYA SURE	141
quinapril	79, 80, 81	RAYOS	123
quinapril/hydrochlorothiazide	79	RAZADYNE	70
QUIN B STRONG	217	READI-CAT 2	95
QUINCE SPINAL	141	READYLANCE	137, 153
quinidine	76	REBIF	87
quinine	53	RECOMBIVAX HB	74
QUINTABS	206	RECOTHROM	75
QULIPTA	20	RECTIV	118
QUVIVIQ	171	REFUAH	133
QVAR REDHALER	32	REGLAN	117
R		REGRANEX	175
ra	106, III, 161, 175, 191, 196, 206, 209, 213, 217, 220, 223, 227, 228, 231	REGULAR BEVEL	141
ra alcohol swabs	175	RELAFEN	29
ra balanced	217	RELAGARD	52
rabeprazole	119	RELENZA	68
RADICAVA ORS	86	RELEXXII	167
RADIOGARDASE	189	RELIAMED	133, 137, 153
ra glucose	106	RELION	106, 137, 153, 175
RAGWITEK	72	reli-on glucose	106
		relion glucose	106

Index of Medications

RELION GLUCOSE	106	risperidone	169
RELISTOR.....	43	RITEFLO	157
REMEDIENT.....	206	ritonavir.....	67
REMERON.....	162	rivastigmine.....	70
RENACIDIN.....	113	rizatriptan	20
RENAL VITAMIN.....	217	R-NATAL.....	161
RENAL-VITE.....	217	ROBINUL.....	113
RENAPLEX.....	217	ROCALTROL	228
REVELA.....	107	roflumilast.....	32
repaglinide	49	ropinirole	64
REPATHA	83	rosadan.....	177
REPLACEMENT	74, 108, 109, 110, 111, 112	ROSADAN.....	177
REPLACEMENT PEDIATRIC MONITOR	133	rosula.....	41
REPLESTA	228	ROSULA	41
REQ49+	197	ROSZET	83
RESPA A.R.....	92	ROTARIX.....	72
RESTASIS.....	103	ROTATEQ	72
RESTORIL.....	171	ROWASA.....	116
RETEVMO	59	ROXICODONE.....	24
RETIN-A.....	183	ROXIFOL.....	228
RETROVIR.....	66	ROZLYTREK	59
REVATIO	78	RUBRACA	59
REVESTA	228	rufinamide.....	90
REVLIMID	57	rutin.....	195
REXULTI	170	RUZURGI	87
REYATAZ.....	67	RYALTRIS	99
REYVOW.....	20	RYCLORA.....	47
REZUROCK	193	RYDAPT.....	59
RHOFADE	177	RYTARY	64
ribasphere	69	RYTHMOL	76
ribavirin	69	RYVENT	47
riboflavin.....	221	S	
RIBOFLAVIN.....	221	SAFE-CLIP.....	133
RIBOZEL.....	217	SAFESNAP.....	146
RIDAURA.....	26	SAFETY...135, 136, 137, 138, 139, 142, 145, 146, 147, 150, 151, 152, 153, 154	
rifabutin.....	36	SAFETYGLIDE.....	141, 142, 146
rifampin	36	SAFETY LANCETS	150, 152, 153
RIGHTEST.....	133, 137, 153	SAFETY-LET.....	153
RILUTEK.....	86	SAFETY-LOK.....	146
riluzole.....	86	SAFETY SEAL LANCETS.....	151, 153
rimantadine.....	68	SAFETY SYRINGE	145, 146, 147
RIMSO-50.....	24	SALAGEN	71
ringer's solution.....	172	SALIVAMAX	187
RINVOQ	26	salsalate.....	26
RIOMET	49	SANCUSO	115
risedronate.....	191, 192	SANDIMMUNE.....	127
RISPERDAL	169		

Index of Medications

SANTYL.....	182	SINGLE.....	119, 137, 153, 175
sapropterin.....	189	SINGLE-LET.....	153
SAPS ALCOHOL 70% PREP PADS.....	175	SINGLE USE SWAB.....	175
SAVELLA.....	192	sirolimus.....	127
saxagliptin.....	49, 50	SIRTURO.....	36
saxagliptn.....	50	SITZMARKS.....	95
SAXENDA.....	62	SKLICE.....	63
SCALACORT.....	181	SKYLA.....	92
SCEMBLIX.....	59	SKYRIZI.....	125, 172
SCOOBY-DOO ONE A DAY.....	212	SLIP-TIP.....	146
scopolamine.....	115	slo-niacin.....	209
secobarbital.....	171	SLO-NIACIN.....	209
SECUADO.....	169	SLOW FE.....	III
SEEBRI.....	30	slow release iron.....	108, 109, III
SEGLUROMET.....	50	SLOW RELEASE IRON.....	108, III, 112
SELECT-OB.....	161	sm.....	106, III, 161, 175, 191, 196, 206, 217, 220, 223, 224, 228
selegiline.....	64	SM ALCOHOL 70% PREP PADS.....	175
selenium.....	174	sm alcohol prep pads.....	175
SELRX.....	174	SMART.....	136, 138, 151, 153
SELZENTRY.....	66	SMARTDIABETES VANTAGE.....	133
SEMGLEE.....	51	SMARTEST.....	133, 138, 153
SEN-SERTER.....	133	smart sense.....	106
SEROSTIM.....	123	SMART SENSE.....	153
sertraline.....	164	SM BIOTIN.....	217
sevelamer.....	107	sm iron.....	III
sevoflurane.....	25	sm isopropyl alcohol 70%.....	191
SEYSARA.....	40	sm isopropyl alcohol 91%.....	191
SFROWASA.....	116	SM ISOPROPYL ALCOHOL 91%.....	191
SHINGRIX.....	74	sm prenatal vitamins tablet.....	161
SHORT BEVEL.....	141	SM SLOW RELEASE IRON 45 MG TAB.....	III
SIDEROL.....	III	sm vitamin.....	220, 223, 224, 228
SIDESTREAM.....	157	sodium chloride.....	118, 172, 188
SILATRIX.....	187	sodium chloride/nahco ₃ /kcl/peg.....	118
sildenafil.....	78, 186	SODIUM CITRATE.....	42
SILENOR.....	171	sodium ferric gluconat/sucrose.....	108, III
SILHOUETTE.....	132, 133, 155	sodium fluoride.....	104, 107, 112
SILICONE MASK.....	157	SODIUM IODIDE I-123.....	185
silodosin.....	193	SODIUM OXYBATE.....	171
SIL-SERTER.....	133	sodium phenylbutyrate.....	113
SILVADENE.....	41	sodium polystyrene sulfonate.....	107
silver sulfadiazine.....	41	sodium polystyrene sulfon/sorb.....	107
SIMBRINZA.....	102	sodium, potassium, mag sulfates.....	118
SIMILAC PRENATAL.....	161	sodium sulfacetamide.....	174
SIMPONI.....	54, 55	SODIUM SULFACETAMIDE 10% WASH.....	174
simvastatin.....	83, 84	sod,pot chlor/mag/sod,pot phos.....	172
SIMVASTATIN.....	84	sod sulface-sulf.....	42
SINEMET.....	64	sod sulface-sulfur.....	42

Index of Medications

sod sulfacetam 10% clnsng gel	174	STELARA.....	125
sod sulfacetamide 9.8% shampoo.....	174	STENDRA	186
sod sulfacetamide 10% shampoo.....	174	STERILANCE.....	138, 153
sod sulfacet-sulfr.....	42	STERILANCE TL	153
sod sulfacet-sulfur	42	STERILE.....	138, 147, 153
sod sulfac-sulfur.....	42	STERILE LANCETS	153
SOF-SERTER.....	133	STIOLTO RESPIMAT	30
SOF-SET	133	STIVARGA	59
SOFT.....	133, 138, 153	STRENSIQ	189
SOFT TOUCH	153	STRESS B-COMPLEX.....	206
SOHONOS.....	190	stress-c	206
solifenacin	194	stress formula.....	202, 203, 206, 217
SOLQUA	48	STRESS FORMULA	206
SOLO	206	STRIVERDI.....	30
SOLODYN	40	STROMECTOL.....	52
SOLOSEC	34	STROVITE	206
SOLTAMOX.....	61	STUART ONE	161
SOLUS.....	133, 138, 153	SUCRAID	117
SOLUS V2.....	133, 153	sucralfate	115
SOLUVITA-E.....	231	SULAR.....	77
SOMA	158	sulfacetamide.....	33, 42, 173, 174
SOMAVERT	187	sulfadiazine	34, 41
SOOLANTRA.....	177	sulfamethoxazole/trimethoprim.....	34
sorafenib tosylate.....	59	SULFAMYLON.....	42
SORBITOL	172	sulfasalazine	116
sotalol.....	82	sulindac	29
SOTYLIZE	82	SUMADAN.....	42
SOVUNA.....	53	sumatriptan.....	20
SPACE CHAMBER	156, 157	SUMAXIN	42
SPAN C.....	224	sunitinib malate.....	59, 60
SPECIALTY USE NEEDLES	141	SUNLENCA	66
SPECTRACEF.....	37	SUNOSI.....	170
SPECTRAVITE.....	197, 206	super	206, 215, 217
SPIKEVAX COVID	72	SUPER.....	136, 138, 151, 153, 206, 225, 228
spinosad.....	63	super b complex-vit c.....	217
SPIRIVA HANDHALER	29	SUPER DAILY D3.....	225, 228
SPIRIVA RESPIMAT	29	SUPER GINSENG.....	206
spironolact/hydrochlorothiazid	98	super quintis	217
spironolactone	98	SUPER THIN LANCETS	151, 153
SPORANOX	45	SUPOR	146
SPRITAM.....	90	SUPPORT-500.....	206
SPRIX.....	20	SUPRANE	25
SPRYCEL.....	59	SUPRAX	37
SSKI	107	SURE.....	132, 133, 138, 141, 153, 155, 175
STALEVO	64	SURE COMFORT	133, 153, 175
stavudine.....	66	SUREFLEX.....	133, 152
STEGLATRO	50	SURE-LANCE	153

Index of Medications

SURE-PEN.....	133	SYRINGE... 19, 32, 54, 55, 69, 72, 75, 83, 86, 87, 105, 126, 141, 142, 143, 144, 145, 146, 147, 148, 172, 212	
SURE-PREP ALCOHOL PREP PADS.....	175	SYRINGE AVITENE.....	75
SURESITE.....	148	SYRINGE BULK.....	146
SURE-T.....	155	SYRINGE CATHETER.....	146, 147
SURE-TEST EASYPLUS.....	133	SYRINGE FILTER.....	147
SURE-TOUCH.....	153	SYRINGE SLIP TIP.....	147
SURFAXIN.....	184	SYRINGE STORAGE BIN.....	147
SURGICEL.....	75	SYRINGE TIP CAP.....	147
surgifoam.....	75	SYRINGE WITH NEEDLE DISP.....	147
SURGIFOAM.....	75	SYRINGE WITHOUT NEEDLE.....	147
SURGISEAL.....	177	T	
SURMONTIL.....	166	T:30.....	133
SURVANTA.....	184	T:90.....	133
SUSTIVA.....	66	tab-a-vite.....	207
SUTENT.....	59, 60	TAB-A-VITE.....	207
sv b-12.....	220	TABLOID.....	56
sv biotin.....	217	TABRECTA.....	60
SV BIOTIN.....	217	TACHOSIL.....	75
SV COD LIVER OIL.....	213	TACLONEX.....	182
sv folic acid.....	196	tacrolimus.....	126, 127
SV HAIR, SKIN AND NAILS.....	207	tadalafil.....	78, 186
sv iron.....	112	TAFINLAR.....	56
sv niacin.....	209	TAGITOL.....	96
sv prenatal tablet.....	161	TAGRISSO.....	60
SV PRENATAL VITAMINS TABLET.....	161	TAKHZYRO.....	72, 185
SV SLOW RELEASE IRON 45 MG TAB.....	112	TALICIA.....	115
sv vitamin.....	220, 224, 228, 231	TALTZ.....	172
sv vitamin b-12.....	220	TALZENNA.....	60
sv vitamin c.....	224	TAMIFLU.....	68
SV VIT B.....	220	tamoxifen.....	61
sv vit c.....	224	tamsulosin.....	193
SYMAX DUOTAB.....	116	TANDEM DUAL ACTION.....	112
SYMBICORT.....	31	TANDEM PLUS.....	112
SYMBYAX.....	170	TAPAZOLE.....	183
SYMDEKO.....	184	TAPERDEX.....	123
SYMFI.....	67, 68	TARCEVA.....	60
SYMJEPI.....	70	TARGADOX.....	40
SYMLINPEN.....	48	TARGRETIN.....	61
SYMPAZAN.....	88	TARPEYO.....	123
SYMPROIC.....	43	TASIGNA.....	60
SYMTUZA.....	65	TASMAR.....	64
SYNALAR.....	40, 181	tavaborole.....	46
SYNAREL.....	123	TAVALISSE.....	185
SYNDROS.....	114	tazarotene.....	174
SYNERA.....	25	TAZVERIK.....	57
SYNJARDY.....	50	TB SYRINGE.....	145, 146, 147
SYPRINE.....	189		

Index of Medications

TC 99M.....	95	THERA-D	228
TDVAX.....	74	THERAGRAN	207
TECHLITE.....	138, 153	thera-m.....	207
TEGADERM.....	148, 149	THERA-M.....	207
TEGLUTIK	86	THERAMILL FORTE	207
TEGRETOL	90	THERANATAL.....	161, 162, 207
TEGSEDI	188	THEREMS-H.....	207
TEKTRUNA HCT	83	thiamine.....	218
TELCARE.....	133, 138, 153	THIAMINE.....	218
TELCARE CONTROL SOLUTION.....	133	THIN.....	96, 135, 136, 137, 138, 139, 141, 149, 151, 152, 153, 154
TELCARE ULTRA THIN	153	THIN LANCETS.....	151, 152, 153, 154
telmisartan.....	80, 81	THIN WALL NEEDLES.....	141
telmisartan/amlodipine	80	THIOLA EC	193
telmisartan/hydrochlorothiazid	80	thioridazine	170
temazepam	171	thiothixene	170
TEMIXYS.....	65	THRIVITE.....	162
TEMODAR.....	55	THROMBI-GEL.....	75
TEMOVATE.....	181	THROMBIN.....	43
temozolomide.....	55	THROMBIN-JMI.....	75
TENIVAC.....	74	THROMBI-PAD	75
tenofovir.....	66	thyroid,pork.....	184
TENORETIC.....	83	tiagabine	89, 90
TENORMIN	82	TIAZAC	77
terazosin	80	TIBSOVO	61
terbinafine	45	TIGAN.....	115
terbutaline	29	TIGLUTIK.....	86
terconazole	44	timolol.....	82, 101, 102
teriparatide	191	TIMOLOL-BRIMONIDIN-DORZOLAMIDE.....	102
TERIPARATIDE.....	191	TIMOLOL-BRIMONI-DORZOL-LATANOP	102
TERSİ FOAM.....	174	TIMOLOL-DORZOLAMIDE.....	102
TERUMO.....	141, 147	TIMOLOL-LATANOPROST	102
TERUMO SURGUARD2.....	141, 147	TIMOPTIC.....	102
TERUMO SYRINGE.....	147	tinidazole	52
testosterone.....	120, 121	tiopronin.....	193
TESTOSTERONE.....	120	TISSEEL VHSD	177
TESTRED	120	TIVICAY	67
tetrabenazine.....	86	tizanidine	158
tetracaine.....	101	TL-HEM 150	112
TETRACAINE	101	TOBAKIENT.....	207
tetracycline.....	40	TOBI PODHALER.....	35
TETRAVISC.....	101	TOBRADEX.....	33
TEXACORT	181	tobramycin.....	33, 34, 35
T:FLEX	133	tobramycin/dexamethasone	33
THALOMID	35, 36	TOBRAMYCIN PAK.....	35
THEO-24	32	TOBEX.....	34
theophylline anhydrous.....	32	TOFRANIL	166
thera-d.....	228	TOLAK	61

Index of Medications

tolcapone.....	64	TRILIPIX	85
tolmetin.....	29	trimethobenzamide	115
tolterodine	194	trimethoprim.....	34, 35
tolvaptan.....	97	trimipramine.....	166
TOOMEY SYRINGE.....	147	TRI-MIX.....	186
TOPCARE.....	138, 153	TRIMO-SAN.....	52
TOPICORT.....	181	TRIMPEX.....	35
topiramate.....	90	TRINAZ.....	162
toremifene.....	61	TRINTELLIX.....	165
toremide.....	97	TRISODIUM CITRATE CRRT.....	42
TOSYMRA.....	20	TRISTART.....	162
TOUJEO.....	51	TRIUMEQ.....	65
TOXICOLOGY SALIVA COLLECTION.....	95	TRI-VI-FLOR.....	212
TRACLEER.....	78	TRI-VI-SOL.....	212
tramadol.....	22, 24	TRIZIVIR.....	65
trandolapril.....	79, 81	TROKENDI.....	90
trandolapril/verapamil.....	79	TRONVITE.....	217
tranexamic.....	74	TROPICAL LIQUID.....	212
TRANSFER.....	67, 140, 141	tropicamide.....	103
TRANSPARENT.....	149	TROPICAMIDE-CYCLOPENTOLATE-PE.....	103
tranylcypropane.....	163	TROPICAMIDE-CYCLOPENT-PE-KTRLC.....	103
travoprost.....	102	TROPICAMIDE-PHENYLEPHRINE.....	103
trazodone.....	164	TROPIC-CYCLOPENT-PE-KTRLC-PROP.....	103
TRECTOR.....	36	tropium.....	194
TRELEGY ELLIPTA.....	31	TRUDHESA.....	20
TREMFYA.....	173	true.....	196, 220, 222, 224, 228, 231
TRESIBA.....	51	TRUE.....	133, 138, 153, 175, 207, 222, 228, 231
tretinoin.....	61, 173, 174, 183	TRUE COMFORT.....	153, 175
TRETIN-X.....	183	TRUECONTROL.....	133
TREXALL.....	56	TRUEDRAW.....	133
TREZIX.....	22	TRUE METRIX.....	133
triamcinolone.....	180, 181, 185	TRUEPLUS.....	96, 106, 138, 153, 207
triamterene.....	98	TRUEPLUS GLUCOSE.....	106
triamterene/hydrochlorothiazid.....	98	TRUEPLUS KETONE TEST STRIP.....	96
triazolam.....	171	T.R.U.E. TEST.....	188
TRICARE.....	162	TRULANCE.....	117
trichloroacetic acid.....	177	TRULICITY.....	48
TRICHLOROACETIC ACID.....	177, 178	TRUMENBA.....	73
triderm.....	181	TRUSOPT.....	102
TRIDESILON.....	181	TRUSTEEL INFUSION SET.....	134
trientine.....	189	T:SLIM.....	133
TRIFERIC.....	112	TUBERCULIN SYRINGE.....	144, 145, 146, 147
trifluoperazine.....	170	TUKYSA.....	60
trifluridine.....	68	TULIVITE.....	112
trihexyphenidyl.....	63	TURALIO.....	60
TRIJARDY.....	50	TUSSICAPS.....	93
TRIKAFTA.....	184	TUXARIN.....	93

Index of Medications

TUZISTRA	93	UNISTRIP	134
TWINPAK DUAL CANNULA	147	UNIVERSAL	136, 139, 147, 151, 154
TWINRIX	74	UNIVERSAL I	154
TWIST	135, 137, 138, 150, 151, 152, 153, 177	UNIVERSAL SYRINGE	147
TWYNEO	174	UPTRAVI	78, 79
TYBOST	184	upup	106
TYKERB	60	URECHOLINE	71
TYMLOS	125	URELLE	35
TYRVAYA	186	URIBEL	35
TYVASO	78	URISTIX	97
U		UROCIT-K	113
UBRELVY	20	UROQID-ACID	113
UCERIS	120, 123	URSO	116
UDAMIN SP	207	ursodiol	116
ULESFIA	63	UTIBRON NEOHALER	30
ULTANE	25	V	
ULTICARE LDS SYR	147	valacyclovir	68
ULTICARE SAFETY SYRINGE	147	VALCHLOR	61
ULTICARE SYRINGE	147	VALCYTE	68
ULTICARE TB SAFETY	147	valganciclovir	68
ULTIGUARD SAFE	147	valproic	90
ULTIGUARD SAFEPACK	147	valsartan	80, 81
ULTI-LANCE	134	valsartan/hydrochlorothiazide	80
ULTILET	138, 154, 175	VALTOCO	88
ULTRA ...94, 132, 136, 138, 139, 141, 151, 153, 154, 162, 198, 199, 206, 207, 215, 217		VANCOGIN	40
ultra b-100	217	vancomycin	40
ULTRA B-100 COMPLEX	217	VANILLA SILQ	96
ULTRA-CARE	154	VANISHPOINT	147, 148
ULTRA-FINE MICRO	141	VANOXIDE-HC	176
ULTRA-FINE MINI	141	vardenafil	186
ULTRA-FINE NANO	141	varenicline	183
ULTRA-FINE ORIGINAL	141	VARIBAR	96
ULTRA-FINE SHORT	141	VARISOFT	134
ULTRAFOAM	75	VARIVAX VACCINE	74
ULTRA FREEDA	207	VARUBI	115
ULTRALANCE	138, 154	VASCEPA	113
ULTRA PRENATAL PLUS DHA	162	VASCULERA	195
ULTRA THIN	151, 153, 154	VASERETIC	79
ULTRA-THIN II	154	VASOFLEX	196
ULTRA THIN PLUS	154	VASOTEC	81
ULTRATLC	139, 154	VAXELIS	74
ULTRATRAK CONTROL	134	VAXNEUVANCE	73
ULTRATRAK ULTIMATE	134	VB6 P5P	222
ULTRAVATE X	181	VB7 MAX	217
UNILET	134, 136, 139, 149, 151, 154	VECAMYL	81
UNISTIK	134, 136, 139, 151, 154	VECTICAL	174
		VELPHORO	107

Index of Medications

VELTASSA.....	107	VITAMIN A182, 213, 214, 215, 216, 217, 218, 219, 220, 221, 222, 223, 224, 225, 226, 227, 228, 229, 230, 231, 232
VEMLIDY.....	69	vitamin b-12.....
VENALIV.....	196	vitamin b12.....
VENCLEXTA.....	60	VITAMIN B-12.....
venlafaxine.....	165	VITAMIN B12.....
VENOFER.....	112	vitamin b complex.....
VENTAVIS.....	79	vitamin b-complex.....
VEO INSULIN SYRINGE.....	148	vitamin c.....
VEOZAH.....	189	VITAMIN C.....
verapamil.....	76, 77, 79	vitamin d2.....
VERELAN.....	77	VITAMIN D2.....
VERIFINE.....	139	vitamin d3.....
VERQUVO.....	77	VITAMIN D3.....
VERSACLOZ.....	169	VITAMIN D3-ALOE.....
VERTIGOHEEL.....	189	vitamin e.....
VERZENIO.....	60	VITAMIN E.....
VEVYE.....	103	VITAMIN K.....
VFEND.....	45	VITAMIN K2.....
V-GO.....	134	vitamins a and d.....
VIAGRA.....	186	VITAMINS A D.....
VIBERZI.....	117	VITAMINS A-D-E.....
VIBRAMYCIN.....	40	VITAPEARL.....
VICTOZA.....	48	VITA-RESPA.....
vigabatrin.....	90	VITASURE.....
VIGADRONE.....	90	VITATRUE.....
VIGAMOX.....	34	vit a/vit c/vit e/zinc/copper.....
VIJOICE.....	185	vit b.....
VIOKACE.....	118	VIT B-12.....
VIRACEPT.....	67	vit b12/levomefolate/vit b6/b2.....
VIRAMUNE.....	66	vit c-rose hip.....
VIREAD.....	66, 67	vit c-rose hips.....
VIRT-CAPS.....	217	VIT C-ROSE HIPS.....
virt-fefa plus.....	112	vit d3.....
VIRT-FEFA PLUS.....	112	VIT D3 5,000 UNIT FAST DISSOLV.....
VISION FORMULA.....	194, 195	VITRAKVI.....
VISION PLUS.....	197	VITREXYL.....
VISTA ADVANCED AREDS2.....	195	VITRON-C.....
VISTARIL.....	47	VITRUM 50.....
VISTOGARD.....	185	vits a,c,e/lutein/minerals.....
vit a.....	195, 213	VIVAGUARD.....
VITA-BEE.....	218	VIVJOA.....
VITABEX.....	112, 207	VIZIMPRO.....
VITAFOL.....	112, 162	VOGELXO.....
VITAJOY.....	207, 218, 224	VOLUMEN.....
VITAL-D.....	218	VONJO.....
VITAMEDMD.....	162	VOQUEZNA.....
vitamin a.....	213	

Index of Medications

voriconazole.....	45	XELJANZ.....	26, 27
VORTEX.....	157	XELODA.....	56
VOSEVI.....	69	XENICAL.....	62
VOTRIENT.....	60	XENLETA.....	38
VOWST.....	117	XENON XE-I33.....	96
VOXZOGO.....	189	XEPI.....	41
VP-PNV-DHA.....	162	XERMELO.....	114
v-r alcohol prep pads.....	175	XHANCE.....	99
VRAYLAR.....	169	XIFAXAN.....	38
VRAYLAR 1.5 MG CAPSULE.....	169	XIGDUO.....	50
v-r cod liver oil capsule.....	230	XIIDRA.....	103
v-r vitamin c.....	225	XOFLUZA.....	69
VTAMA.....	174	XOLAIR.....	32
VUMERITY.....	87	XOPENEX.....	30
VYLEESI.....	168	XOSPATA.....	60
VYNDAMAX.....	190	XTANDI.....	56
VYNDAQEL.....	190	XURIDEN.....	106
VYVANSE.....	166	XVITE.....	218
VYZULTA.....	102	XYOSTED.....	121
W		XYREM.....	171
WAKIX.....	91	XYWAV.....	171
water.....	172	XYZBAC.....	208
WAVESENSE.....	134	Y	
WEBCOL.....	175	YALE.....	141
WEGOVI.....	62	YAZ.....	92
WELIREG.....	61	YUPELRI.....	29
WELLESSE.....	207	Z	
WEST-VITE.....	218	zafirlukast.....	32
WHEAT GERM.....	232	zaleplon.....	172
WINDOW BANDAGES.....	149	ZANAFLEX.....	158
WOMEN 50 PLUS MULTIVIT ADVANCE.....	207	ZARONTIN.....	91
WOMEN'S 50.....	198, 204, 205, 207	ZCORT.....	123
women's daily.....	207	ZEJULA.....	60
WOMEN'S DAILY.....	207, 208	ZELBORAF.....	56
WOMENS DAILY GUMMIES.....	207	ZELDANA.....	218
WOMEN'S MULTIVITAMIN.....	205, 208	ZEMBRACE SYMTOUCH.....	20
WOMEN'S PRENATAL PLUS DHA.....	162	ZEMPLAR.....	187
WYNZORA.....	182	ZENPEP.....	118
X		zenzedi.....	71
XACIATO.....	40	ZENZEDI.....	71
XALKORI.....	60	ZEPATIER.....	69
XAQUIL.....	196	ZEPBOUND.....	62
XARELTO.....	43	ZEPOSIA.....	87, 88
XCELLENT.....	225, 232	ZESTORETIC.....	79
XCELLENT C.....	225	ZESTRIL.....	81
XCOPRI.....	90, 91	ZIAC.....	83
XDEMVY.....	62	ZIAGEN.....	67

Index of Medications

ZIANA	174	ZOO FRIENDS.....	213
zidovudine	65, 66, 67	ZORBTIVE.....	123
ZIEXTENZO.....	91	ZORTRESS	127
zileuton	29	ZORYVE	174, 177
zinc oxide	176	ZOVIRAX	69, 70
ZINC OXIDE PASTE	176	ZTALMY.....	170
ZINC PLUS.....	225	ZTLIDO.....	25
ziprasidone.....	168, 169	ZUBSOLV	193
ZIRGAN.....	68	ZUPLENZ	115
ZITHROMAX.....	37	ZURZUVAE.....	163
ZODRYL AC	93	ZYDELIG.....	60
ZODRYL DAC	93	ZYFLO.....	29
ZODRYL DEC.....	94	ZYKADIA	60
ZOKINVY	185	ZYLOPRIM	26
ZOLINZA	55	ZYMAXID	34
zolmitriptan	20	ZYPITAMAG	84
zolpidem.....	172	ZYPREXA.....	169
ZOMIG.....	20	ZYVANA.....	208
ZONALON	173	ZYVIT.....	208
zonisamide.....	91	ZYVOX.....	38
ZONTIVITY.....	64		

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](https://www.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. Standard shipping costs are included as part of your prescription plan.
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 plan covers these medications, log in to the myCigna App or myCigna.com, or call Customer Service using the number on your ID card.
9. Costs and complete details of the plan's prescription drug coverage are set forth in the plan documents. If there are any differences between the information provided here and the plan documents, the information in the plan documents takes complete precedence.
10. **For plans that must follow state insurance laws, such as Delaware:** Your plan may provide coverage for infertility medications and smoking cessation medications even if this drug list states that your plan may not cover them. To find out if your specific plan covers these medications, log in to the myCigna App or myCigna.com, or check your plan materials.

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

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

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

DISCRIMINATION IS AGAINST THE LAW

Medical coverage

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

Cigna:

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

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

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

Cigna
Nondiscrimination Complaint Coordinator
PO Box 188016
Chattanooga, TN 37422

If you need assistance filing a written grievance, please call the number on the back of your ID card or send an email to ACAGrievance@Cigna.com. 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>.



All Cigna products and services are provided exclusively by or through operating subsidiaries of Cigna Corporation, including Cigna Health and Life Insurance Company, Connecticut General Life Insurance Company, Evernorth Care Solutions, Inc., Evernorth Behavioral Health, Inc., Cigna Health Management, Inc., and HMO or service company subsidiaries of Cigna Health Corporation and Cigna Dental Health, Inc. The Cigna name, logos, and other Cigna marks are owned by Cigna Intellectual Property, Inc. ATTENTION: If you speak languages other than English, language assistance services, free of charge are available to you. For current Cigna customers, call the number on the back of your ID card. Otherwise, call 1.800.244.6224 (TTY: Dial 711). ATENCIÓN: Si usted habla un idioma que no sea inglés, tiene a su disposición servicios gratuitos de asistencia lingüística. Si es un cliente actual de Cigna, llame al número que figura en el reverso de su tarjeta de identificación. Si no lo es, llame al 1.800.244.6224 (los usuarios de TTY deben llamar al 711).

Proficiency of Language Assistance Services

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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