



# Cigna Healthcare Advantage 4-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/PDL](https://Cigna.com/PDL)

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 This drug list is subject to change and all prior versions are no longer in effect.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

927841 k CA Advantage 4-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	10
· About this drug list	12
· How to read this drug list	12
· How to find your medication	15
List of prescription medications	18
Exclusions and limitations for coverage	199
Index of medications	200

### 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® App<sup>1</sup> 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/PDL.** Scroll down to the "California Employer Drug Lists" section. Under Cigna Advantage Prescription Drug List, click on the pdf named **California Advantage 4 Tier (all specialty medications covered on tier 4).**

### 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 Healthcare<sup>SM</sup> ID card. We're here 24/7/365.

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

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 1<sup>st</sup> and July 1<sup>st</sup>.
- **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:"

- Prescription medications used to treat heartburn/stomach acid conditions (such as Nexium, Prilosec OTC and any generics) and allergies (such as Allegra, Clarinex, Xyzal and any generics). These are available over-the-counter without a prescription.
- Medications used to treat lifestyle conditions such as infertility, erectile dysfunction and smoking cessation.<sup>2</sup>
- 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

## Information about this drug list

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

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

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

A. Medications that:

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

#### 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](http://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 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

## Information about this drug list

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

limit or exclude coverage for that medication if your doctor continues to prescribe it to treat your condition (as long as the medication is appropriately prescribed and is safe and effective in treating your condition).

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

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

Cigna Healthcare will review information your doctor sends us to make sure 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](http://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

## Information about this drug list

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

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.

#### **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**.

## Information about this drug list

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

#### **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.<sup>3</sup>

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

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

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

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

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

**A.** A generic medication is the same as its brand-name version in safety, effectiveness, quality, strength and dosage, as well as in the way it's taken and used.<sup>4</sup>

Brand-name medications are protected by patents. Patents keep other manufacturers from selling generic versions of the brand-name medication. Once a patent ends, other companies can make and sell a generic version of the brand-name medication. Generics are typically sold under their chemical or scientific name, instead of the manufacturer's patented brand name.

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

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

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

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

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

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

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

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

**A.** To get the most from your plan coverage, you should use an in-network pharmacy. If your plan

## Information about this drug list

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

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.<sup>5</sup> Log in to the **myCigna App** or **myCigna.com**, or check your plan materials, to find out what your plan requires.

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

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

#### **Express Scripts® Pharmacy for maintenance medications**

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

- Easily order, manage, track and pay for your medications on your phone or online
- Standard shipping at no extra cost<sup>6</sup>
- Automatic refills or refill reminders
- Fill up to a 90-day supply at one time<sup>7</sup>
- Helpful pharmacists available 24/7
- Flexible payment options

#### **Here are three easy ways to get started.**

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

card, doctor's contact information and medication name(s) ready when you call.

#### **Accredo for specialty medications**

If you're taking a specialty medication to treat a complex medical condition, Accredo's team of specialty trained pharmacists and nurses can help. They'll fill and ship your specialty medication to your home (or location of your choice).<sup>8</sup> They'll also provide you with the personalized care and support you need to manage your therapy – at no extra cost.

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



## Information about this drug list

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

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

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

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

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

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

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

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

## Information about this drug list

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

- **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.
- **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.

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

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

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

## Information about this drug list

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

- **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 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.

## Information about this drug list

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

- **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.

### About this drug list

This is a list of the most commonly prescribed medications covered on the Cigna Healthcare Advantage 4-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.

**Prescription medications used to treat allergies (ex. Allegra, Clarinex, Xyzal and generics) and heartburn/stomach acid conditions (ex. Nexium, Prilosec and generics) aren't covered on this drug list.** These medications are considered plan (or benefit) exclusions. You can buy these medications at the pharmacy without a prescription.

### How to read this drug list

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

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

### Tiers

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

• <b>Tier 1 – Typically Generics</b>	(Lowest-cost medication)	<b>\$</b>
• <b>Tier 2 – Typically Preferred Brands</b>	(Medium-cost medication)	<b>\$\$</b>
• <b>Tier 3 – Typically Non-Preferred Brands</b>	(Higher-cost medication)	<b>\$\$\$</b>
• <b>Tier 4 – Specialty Medications</b>	(Highest-cost medication)	<b>\$\$\$\$</b>

\* 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.

<b>PA</b>	<b>Prior Authorization</b> – This medication needs approval from Cigna Healthcare before your plan will cover it. Your doctor's office will have to send us information to review to make sure the medication meets coverage requirements.
<b>QL</b>	<b>Quantity Limits</b> – Your plan will only cover a certain amount of this medication at one time. If your doctor wants you to fill more than what's allowed, your doctor's office can ask Cigna Healthcare to approve more.
<b>ST</b>	<b>Step Therapy</b> – Your plan doesn't cover this high-cost medication until you try at least one lower-cost option first (typically a generic or preferred brand) and it didn't work for you. If your doctor feels a different medication isn't right for you, your doctor's office can ask Cigna Healthcare to approve coverage of this medication.
<b>AGE</b>	<b>Age Requirement</b> – Your plan will only cover this medication if you're a certain age or within a certain age range. If you're not within the allowed age range and your doctor wants you to take this medication, your doctor's office can ask Cigna Healthcare to approve coverage.
<b>SP</b>	<b>Specialty Medications</b> 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.
<b>HD</b>	<b>Home Delivery Medications</b> – Some plans only cover certain maintenance medications if they're filled through home delivery with Express Scripts® Pharmacy. Depending on your plan, you may be able to get coverage for one, two or three fills at an in-network retail pharmacy before switching to home delivery.
<b>PPACA</b>	<b>No Cost-Share Preventive Medications</b> – 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.
<b>CSL</b>	<b>Oral Cancer Medications Subject to Cost-Share Limits</b> – State law in California limits the cost-share (or amount you pay out-of-pocket) for certain oral chemotherapy medications.

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

# Information about this drug list

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

Use the chart below to 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 Advantage 4-Tier Prescription Drug List.

<b>ANALGESICS (Pain Relief and Inflammatory Disease)</b>		
<b>Prescription Drug Name</b>	<b>Drug Tier</b>	<b>Coverage Requirements and Limits</b>
<b>ANALGESIC, NON-SALICYLATE AND BARBITURATE COMBINAT</b>		
<i>butalbital/acetaminophen</i>	T1	
<b>ANALGESIC, SALICYLATE, BARBITURATE, XANTHINE COMB.</b>		
<i>butalb-aspirin-caffe 50-325-40</i>	T1	QL (6 tabs/day)
<i>butalbital-asa-caffeine cap</i> (Fiorinal)	T1	QL (6 caps/day)
FIORINAL ( <i>butalbital-aspirin-caffeine</i> )	T3	QL (6 caps/day)
<b>ANALGESIC, NON-SALICYLATE, BARBITURATE, XANTHINE COMB.</b>		
<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)
<b>ANALGESIC/ANTIPYRETICS, SALICYLATES</b>		
<i>choline salicyl/mag salicylate</i>	T1	HD
<i>difenhydramine</i>	T1	HD
<b>ANTI-MIGRAINE PREPARATIONS</b>		
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)

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

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

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

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

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

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

Generic medications are in **lowercase italics**

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

## Information about this drug list

### How to find your medication

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

Condition	Page	Condition	Page
<b>Analgesics</b> (Pain Relief and Inflammatory Disease)	18-26	<b>Anti-Infectives</b> (Infections)	59
<b>Analgesics</b> (Urinary Tract Conditions)	26	<b>Anti-Infectives/Miscellaneous</b> (Feminine Products)	59
<b>Anesthetics</b> (Miscellaneous)	26, 27	<b>Anti-Infectives/Miscellaneous</b> (Infections)	59, 60
<b>Anesthetics</b> (Pain Relief and Inflammatory Disease)	27-31	<b>Anti-Infectives/Miscellaneous</b> (Miscellaneous)	61
<b>Anesthetics</b> (Urinary Tract Conditions)	31	<b>Anti-Infectives/Miscellaneous</b> (Skin Conditions)	61
<b>Anti-Allergy</b> (Allergy and Nasal Sprays)	31	<b>Anti-Inflammatory Tumor Necrosis Factor Inhibiting Agents</b> (Pain Relief and Inflammatory Disease)	61, 62
<b>Anti-Arthritics</b> (Pain Relief and Inflammatory Disease)	31-35	<b>Anti-Neoplastics</b> (Cancer)	62-74
<b>Anti-Asthmatics</b> (Asthma/COPD/Respiratory)	35-37	<b>Anti-Neoplastics</b> (Skin Conditions)	75
<b>Antibiotics</b> (Allergy/Nasal Sprays)	37	<b>Anti-Obesity Drugs</b> (Weight Management)	75
<b>Antibiotics</b> (Ear Medications)	37	<b>Anti-Parasitics</b> (Infections)	75
<b>Antibiotics</b> (Eye Conditions)	37, 38	<b>Anti-Parkinson's Drugs</b> (Parkinson's Disease)	76, 77
<b>Antibiotics</b> (Infections)	38-49	<b>Anti-Platelet Drugs</b> (Blood Thinners/Anti-Clotting)	77, 78
<b>Antibiotics</b> (Miscellaneous)	49	<b>Antivirals</b> (AIDS/HIV)	78-81
<b>Antibiotics</b> (Skin Conditions)	49, 50	<b>Antivirals</b> (Eye Conditions)	81
<b>Anti-Coagulants</b> (Blood Thinners/Anti-Clotting)	50-52	<b>Antivirals</b> (Infections)	81-83
<b>Antidotes</b> (Gastrointestinal/Heartburn)	52	<b>Antivirals</b> (Skin Conditions)	83
<b>Antidotes</b> (Substance Abuse)	52, 53	<b>Autonomic Drugs</b> (Allergy/Nasal Sprays)	83
<b>Anti-Fungals</b> (Eye Conditions)	53	<b>Autonomic Drugs</b> (Alzheimer's Disease)	84
<b>Anti-Fungals</b> (Feminine Products)	53	<b>Autonomic Drugs</b> (Attention Deficit Hyperactivity Disorder)	84, 85
<b>Anti-Fungals</b> (Infections)	53, 54	<b>Autonomic Drugs</b> (Blood Pressure/Heart Medications)	85
<b>Anti-Fungals</b> (Skin Conditions)	54, 55	<b>Autonomic Drugs</b> (Miscellaneous)	85-87
<b>Antihistamine and Decongestant Combination</b> (Allergy/Nasal Sprays)	55	<b>Autonomic Drugs</b> (Urinary Tract Conditions)	87
<b>Antihistamines</b> (Allergy/Nasal Sprays)	55, 56	<b>Biologicals</b> (Allergy/Nasal Sprays)	87
<b>Antihistamines</b> (Eye Conditions)	56	<b>Biologicals</b> (Blood Pressure/Heart Medications)	87
<b>Anti-Hyperglycemics</b> (Diabetes)	56-59	<b>Biologicals</b> (Miscellaneous)	87
<b>Anti-Infectives</b> (Feminine Products)	59	<b>Biologicals</b> (Vaccines)	87-90

## Information about this drug list

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

Condition	Page	Condition	Page
Blood (Blood Modifiers/Bleeding Disorders)	90-92	Elect/Caloric/H2O (Nutritional/Dietary)	129-133
Blood (Blood Thinners/Anti-Clotting)	92	Elect/Caloric/H2O (Urinary Tract Conditions)	133
Blood (Miscellaneous)	93	Gastrointestinal (Cholesterol Medications)	133
Cardiac Drugs (Blood Pressure/Heart Medications)	93-97	Gastrointestinal (Gastrointestinal/Heartburn)	134-141
Cardiovascular (Allergy/Nasal Sprays)	97	Gastrointestinal (Pain Relief and Inflammatory Disease)	141
Cardiovascular (Asthma/COPD/Respiratory)	97, 98	Gastrointestinal (Skin Conditions)	141
Cardiovascular (Blood Pressure/Heart Medications)	98-103	Hormones (Gastrointestinal/Heartburn)	141
Cardiovascular (Cholesterol Medications)	103-106	Hormones (Hormonal Agents)	141-148
Cardiovascular (Miscellaneous)	106	Hormones (Infertility)	148
CNS Drugs (Alzheimer's Disease)	106	Hormones (Miscellaneous)	149
CNS Drugs (Miscellaneous)	107, 108	Immunosuppressants (Miscellaneous)	149
CNS Drugs (Pain Relief and Inflammatory Disease)	108	Immunosuppressants (Pain Relief and Inflammatory Disease)	149
CNS Drugs (Seizure Disorders)	108-112	Immunosuppressants (Skin Conditions)	150
CNS Drugs (Sleep Disorders/Sedatives)	112	Immunosuppressants (Transplant Medications)	150, 151
Colony Stimulating Factors (Blood Modifiers/Bleeding Disorders)	112, 113	Miscellaneous Medical Supplies, Devices, Non-Drug (Diabetes)	151-162
Colony Stimulating Factors (Cancer)	113	Muscle Relaxants (Pain Relief and Inflammatory Disease)	162, 163
Contraceptives (Contraception Products)	113-115	Prenatal Vitamins (Nutritional/Dietary)	163, 164
Cough/Cold Preparations (Allergy/Nasal Sprays)	115	Psychotherapeutic Drugs (Anxiety/Depression/Bipolar Disorder)	164-168
Cough/Cold Preparations (Cough/Cold Medications)	115, 116	Psychotherapeutic Drugs (Attention Deficit Hyperactivity Disorder)	168-170
Diagnostic (Diabetes)	116	Psychotherapeutic Drugs (Schizophrenia/Anti-Psychotics)	170-174
Diagnostic (Miscellaneous)	116-120	Psychotherapeutic Drugs (Sleep Disorders/Sedatives)	174
Diuretics (Diuretics)	120-122	Sedative/Hypnotics (Sleep Disorders/Sedatives)	174, 175
EENT Preps (Allergy/Nasal Sprays)	122	Skin Preps (Miscellaneous)	176
EENT Preps (Ear Medications)	122	Skin Preps (Pain Relief and Inflammatory Disease)	176
EENT Preps (Eye Conditions)	122-126	Skin Preps (Skin Conditions)	177-183
Elect/Caloric/H2O (Cholesterol Medications)	126	Thyroid Prep (Hormonal Agents)	183, 184
Elect/Caloric/H2O (Dental Products)	127		
Elect/Caloric/H2O (Diabetes)	127		
Elect/Caloric/H2O (Miscellaneous)	127-129		



## Information about this drug list

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

Condition	Page
Unclassified Drug Products (AIDS/HIV)	184
Unclassified Drug Products (Asthma/COPD/Respiratory)	184, 185
Unclassified Drug Products (Blood Modifiers/Bleeding Disorders)	185, 186
Unclassified Drug Products (Cancer)	186, 187
Unclassified Drug Products (Dental Products)	187
Unclassified Drug Products (Eye Conditions)	187
Unclassified Drug Products (Gastrointestinal/Heartburn)	187, 188
Unclassified Drug Products (Miscellaneous)	188-192
Unclassified Drug Products (Multiple Sclerosis)	193
Unclassified Drug Products (Nutritional/Dietary)	193, 194
Unclassified Drug Products (Osteoporosis Products)	194

Condition	Page
Unclassified Drug Products (Pain Relief and Inflammatory Disease)	194
Unclassified Drug Products (Skin Conditions)	195
Unclassified Drug Products (Substance Abuse)	195
Unclassified Drug Products (Transplant Medications)	195
Unclassified Drug Products (Urinary Tract Conditions)	195, 196
Unclassified Drug Products (Weight Management)	196
Vaccines (Vaccines)	196
Vitamins (Nutritional/Dietary)	197, 198
Vitamins (Vitamins)	198

## List of Prescription Medications

ANALGESICS (Pain Relief and Inflammatory Disease)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>ANALGESIC, NON-SALICYLATE AND BARBITURATE COMBINAT</b>		
<i>butalbital/acetaminophen</i>	T1	
<b>ANALGESIC, SALICYLATE, BARBITURATE, XANTHINE COMB.</b>		
<i>butalb-aspirin-caffe 50-325-40</i>	T1	QL (6 tabs/day)
<i>butalbital-asa-caffeine cap</i> (Fiorinal)	T1	QL (6 caps/day)
FIORINAL ( <i>butalbital-aspirin-caffeine</i> )	T3	QL (6 caps/day)
<b>ANALGESIC, NON-SALICYLATE, BARBITURATE, XANTHINE COMB.</b>		
<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)
<b>ANALGESIC/ANTIPYRETICS, SALICYLATES</b>		
<i>choline salicyl/mag salicylate</i>	T1	HD
<i>diflunisal</i>	T1	HD
<b>ANALGESIC/ANTIPYRETICS, NON-SALICYLATES</b>		
ACETAMINOPHEN 1000MG/100ML BAG	T3	
<i>acetaminophen 1,000mg/100ml vl</i> (Ofirmev)	T1	
OFIRMEV ( <i>acetaminophen</i> )	T3	
<b>ANALGESICS, NEURONAL-TYPE CALCIUM CHANNEL BLOCKERS</b>		
PRIALT	T3	SP
<b>ANALGESICS, NON-OPIOID</b>		
<i>clonidine 1,000 mcg/10 ml vial</i> (Duraclon)	T1	
<i>clonidine 5,000 mcg/10 ml vial</i>	T1	
<b>ANTI-MIGRAINE PREPARATIONS</b>		
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)
DURACLON ( <i>clonidine hcl</i> )	T3	
<i>eletriptan hydrobromide</i>	T1	QL (6 tabs/30 days)
EMGALITY PEN	T2	PA
EMGALITY SYRINGE	T2	PA
<i>ergotamine tartrate/caffeine</i>	T1	

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

T4 – Specialty Medications  
 PA – Prior Authorization  
 QL – Quantity Limit

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

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

# List of Prescription Medications

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

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>ANTI-MIGRAINE PREPARATIONS (cont.)</b>		
<i>ergotamine tartrate/caffeine (Cafergot)</i>	T1	QL (40 tabs/28 days)
<i>frovatriptan succinate</i>	T1	QL (18 tabs/30 days)
<i>isomethept/dichlphn/acetaminop</i>	T1	
<i>isomethepten/caf/acetaminophen</i>	T1	
<i>naratriptan hcl</i>	T1	QL (9 tabs/30 days)
NURTEC ODT	T2	PA QL (16 tabs/30 days)
<i>rizatriptan benzoate</i>	T1	QL (12 tabs/30 days)
<i>rizatriptan benzoate (Maxalt Mlt)</i>	T1	QL(12 tabs/30 days)
<i>rizatriptan benzoate (Maxalt)</i>	T1	QL(12 tabs/30 days)
<i>rizatriptan</i>	T1	QL(12 tabs/30 days)
<i>sumatriptan</i>	T1	QL (2 boxes/30 days)
<i>sumatriptan 4 mg/0.5 ml cart</i>	T1	QL (4ml/30 days)
<i>sumatriptan 4 mg/0.5 ml inject</i>	T1	QL (4ml/30 days)
<i>sumatriptan 6 mg/0.5 ml cart</i>	T1	QL (4ml/30 days)
<i>sumatriptan 6 mg/0.5 ml inject</i>	T1	QL (4ml/30 days)
<i>sumatriptan 6 mg/0.5 ml syrng</i>	T1	QL (4ml/30 days)
<i>sumatriptan 6 mg/0.5 ml vial</i>	T1	QL (5ml/30 days)
<i>sumatriptan succ 100 mg tablet</i>	T1	QL (9 tabs/30 days)
<i>sumatriptan succ 25 mg tablet</i>	T1	QL (18 tabs/28 days)
<i>sumatriptan succ/naproxen sod</i>	T1	QL (18 tabs/30 days)
TRUDHESA	T2	PA QL (2 pkgs/30 days)
UBRELVY	T2	PA QL (0.67 tabs/day)
VYEPTI	T3	PA SP
ZAVZPRET	T2	PA QL (6 units/30 days)
<i>zolmitriptan</i>	T1	QL (12 tabs/30 days)
<b>NSAIDS, CYCLOOXYGENASE INHIBITOR-TYPE ANALGESICS</b>		
<i>diclofenac potassium</i>	T1	HD
<i>ketorolac 10 mg tablet</i>	T1	QL (20 tabs/25 days) HD
<i>ketorolac 15 mg/ml syringe</i>	T1	QL (40 ml/30 days) HD
<i>ketorolac 15 mg/ml vial</i>	T1	QL (40 ml/30 days) HD
<i>ketorolac 30 mg/ml carpuproject</i>	T1	HD
<i>ketorolac 30 mg/ml isecure syr</i>	T1	QL (20ml/30 days) HD
<i>ketorolac 30 mg/ml syringe</i>	T1	QL (20ml/30 days) HD

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

T4 – Specialty Medications  
 PA – Prior Authorization  
 QL – Quantity Limit

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

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

## List of Prescription Medications

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

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>NSAIDS, CYCLOOXYGENASE INHIBITOR-TYPE ANALGESICS (cont.)</b>		
<i>ketorolac 30 mg/ml vial</i>	T1	QL(4 ml/ days) HD
<i>ketorolac 300 mg/10 ml vial</i>	T1	HD
<i>ketorolac 60 mg/2 ml carpject</i>	T1	QL (20ml/30 days) HD
<i>ketorolac 60 mg/2 ml syringe</i>	T1	QL (20ml/30 days) HD
<i>ketorolac 60 mg/2 ml vial</i>	T1	QL (20ml/30 days) HD
<i>mefenamic acid</i>	T1	HD
<b>OPIOID ANALGESIC AND NON-SALICYLATE ANALGESICS</b>		
<i>acetamin-codein 300-30 mg/12.5</i>	T1	
<i>acetaminop-codeine 120-12 mg/5</i>	T1	
<i>acetaminophen-cod #2 tablet</i>	T1	PA
<i>acetaminophen-cod #3 tablet</i>	T1	PA
<i>acetaminophen-cod #4 tablet</i>	T1	PA
APADAZ	T3	
BENZHYDROCODONE-ACETAMINOPHEN	T1	
<i>hydrocodone/acetaminophen</i>	T1	PA
<i>hydrocodone/acetaminophen (Hydrocodone-acetaminophen)</i>	T1	PA
<i>hydrocodone/acetaminophen (Norco)</i>	T1	PA
HYDROCODONE-ACETAMINOPHEN	T1	PA
LORTAB	T1	PA
NALOCET	T1	PA
NORCO ( <i>lorcet hd</i> )	T3	PA
NORCO ( <i>lorcet plus</i> )	T3	PA
NORCO ( <i>lorcet</i> )	T3	PA
<i>oxycodone hcl/acetaminophen (Nalocet)</i>	T1	PA
<i>oxycodone hcl/acetaminophen (Percocet)</i>	T1	PA
<i>oxycodone hcl/acetaminophen (Primlev)</i>	T1	PA
PERCOCET ( <i>oxycodone-acetaminophen</i> )	T3	PA
PRIMLEV	T1	PA
<i>tramadol hcl/acetaminophen (Ultracet)</i>	T1	
ULTRACET ( <i>tramadol hcl-acetaminophen</i> )	T3	
<b>OPIOID ANALGESIC AND NSAID COMBINATION</b>		
<i>hydrocodone/ibuprofen</i>	T1	PA
<i>hydrocodone/ibuprofen (Ibudone)</i>	T1	PA
IBUDONE	T1	PA
<i>ibuprofen/oxycodone hcl</i>	T1	PA

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

T4 – Specialty Medications  
 PA – Prior Authorization  
 QL – Quantity Limit

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

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

# List of Prescription Medications

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

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>OPIOID ANALGESIC AND SALICYLATE ANALGESIC COMB</b>		
<i>oxycodone hcl/aspirin</i>	T1	PA
<b>OPIOID ANALGESIC, ANESTHETIC ADJUNCT AGENTS</b>		
<i>alfentanil 1, 000 mcg/2 ml amp</i> (Alfentanil Hcl)	T1	PA
<i>alfentanil 500 mcg/ml ampul</i> (Alfentanil Hcl)	T1	PA
ALFENTANIL 500 MCG/ML AMPULE ( <i>alfentanil hcl</i> )	T3	PA
<i>fentanyl 100 mcg/2 ml ampul</i>	T1	
<i>fentanyl 100 mcg/2 ml vial</i>	T1	
FENTANYL 2, 500 MCG/50 ML BAG	T1	
<i>fentanyl 2, 500 mcg/50 ml vial</i>	T1	
<i>fentanyl 250 mcg/5 ml ampul</i>	T1	
<i>fentanyl 250 mcg/5 ml vial</i>	T1	
FENTANYL 5, 000 MCG/100 ML BAG	T1	
<i>fentanyl 50 mcg/ml vial</i>	T1	
<i>fentanyl 500 mcg/10 ml vial</i>	T1	
FENTANYL CITRATE-STERILE WATER	T1	
<i>remifentanil hcl</i> (Ultiva)	T1	PA
<i>sufentanil citrate</i>	T1	PA
ULTIVA ( <i>remifentanil hcl</i> )	T3	PA
<b>OPIOID ANALGESIC AND NON-SALICYLATE XANTHINE COMB</b>		
ACETAMIN-CAFF-DIHYDROCODEINE	T1	PA
<i>acetaminophen/caff/dihydrocod</i> (Acetamin-caff-dihydrocodeine)	T1	PA
<i>acetaminophen/caff/dihydrocod</i> (Trezix)	T1	PA
TREZIX	T3	PA
<b>OPIOID ANALGESICS</b>		
ACTIQ ( <i>fentanyl citrate</i> )	T3	PA
ARYMO ER	T3	PA
BELBUCA 150 MCG FILM	T2	QL (2 films/day)
BELBUCA 300 MCG FILM	T2	QL (2 films/day)
BELBUCA 450 MCG FILM	T2	QL (2 films/day)
BELBUCA 600 MCG FILM	T2	QL (2 films/day)
BELBUCA 75 MCG FILM	T2	QL (2 films/day)
BELBUCA 750 MCG FILM	T2	QL (60 films/30 days)
BELBUCA 900 MCG FILM	T2	QL (2 films/day)

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

T4 – Specialty Medications  
 PA – Prior Authorization  
 QL – Quantity Limit

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

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

## List of Prescription Medications

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

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>OPIOID ANALGESICS (cont.)</b>		
<i>buprenorphine</i> (Butrans)	T1	QL (4 patches/28 days)
<i>buprenorphine hcl</i>	T1	
<i>butorphanol 1 mg/ml vial</i>	T1	
<i>butorphanol 10 mg/ml spray</i>	T1	PA QL (6 bots/30 days)
<i>butorphanol 2 mg/ml vial</i>	T1	
<i>butorphanol 4 mg/2 ml vial</i>	T1	
BUTRANS ( <i>buprenorphine</i> )	T3	QL (4 patches/28 days)
<i>codeine sulfate</i>	T1	PA
DEMEROL	T3	PA
DILAUDID 0.2 MG/ML SYRINGE	T3	PA
DILAUDID 0.5 MG/0.5 ML SYRINGE	T3	PA
DILAUDID 1 MG/ML SYRINGE	T3	PA
DILAUDID 2 MG TABLET ( <i>hydromorphone hcl</i> )	T3	PA
DILAUDID 2 MG/ML SYRINGE	T3	PA
DILAUDID 4 MG TABLET ( <i>hydromorphone hcl</i> )	T3	PA
DILAUDID 4 MG/ML SYRINGE	T3	
DILAUDID 5 MG/5 ML ORAL LIQUID ( <i>hydromorphone hcl</i> )	T3	PA
DILAUDID 8 MG TABLET ( <i>hydromorphone hcl</i> )	T3	PA
DURAGESIC ( <i>fentanyl</i> )	T3	PA
<i>fentanyl</i>	T1	PA
<i>fentanyl</i> (Duragesic)	T1	PA
FENTANYL 1,000 MCG/100 ML-NS	T3	
FENTANYL 1,000 MCG/100 ML-NS	T1	
FENTANYL 1,000 MCG/50-0.9% NAACL	T1	
<i>fentanyl 1,250 mcg/250-0.9% nacl</i>	T1	
<i>fentanyl 10 mcg/ml-0.9% nacl</i>	T1	
FENTANYL 100 MCG/2 ML CARPUJCT	T1	
<i>fentanyl 100 mcg/2 ml carpujct</i> (Fentanyl Citrate)	T1	

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

T4 – Specialty Medications  
 PA – Prior Authorization  
 QL – Quantity Limit

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

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

## List of Prescription Medications

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

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>OPIOID ANALGESICS (cont.)</b>		
<i>fentanyl 100 mcg/2 ml syringe</i>	T1	
FENTANYL 2 MCG-BUP 0.0625%-NS	T1	
FENTANYL 2 MCG-BUPIV 0.1%-NS	T1	
FENTANYL 2 MCG-BUPIV 0.125%-NS	T1	
FENTANYL 2 MCG-BUPIV 0.125%-NS	T3	
FENTANYL 2 MCG-BUPIVAC 0.1%-NS	T1	
FENTANYL 2,000MCG/100-0.9%NACL	T1	
FENTANYL 2,500MCG/250-0.9%NACL	T1	
FENTANYL 2,750 MCG/55 ML SYR	T1	
FENTANYL 2.5MG/250ML-0.9% NACL	T1	
FENTANYL 25 MCG/0.5 ML SYRINGE	T3	
FENTANYL 250 MCG/5 ML SYRINGE	T1	
FENTANYL 5,000MCG/250-0.9%NACL	T1	
FENTANYL 50 MCG/ML SYRINGE	T1	
FENTANYL 500 MCG/50ML-0.9%NACL	T1	
FENTANYL 550 MCG/55ML-0.9%NACL	T1	
FENTANYL CIT 100 MCG BUCCAL TB	T1	PA
FENTANYL CIT 200 MCG BUCCAL TB	T1	PA
FENTANYL CIT 400 MCG BUCCAL TB	T1	PA
FENTANYL CIT 600 MCG BUCCAL TB	T1	PA
FENTANYL CIT 800 MCG BUCCAL TB	T1	PA
<i>fentanyl cit ofc 1, 200 mcg (Actiq)</i>	T1	PA
<i>fentanyl cit ofc 1, 600 mcg (Actiq)</i>	T1	PA
<i>fentanyl citrate ofc 200 mcg (Actiq)</i>	T1	PA
<i>fentanyl citrate ofc 400 mcg (Actiq)</i>	T1	PA
<i>fentanyl citrate ofc 600 mcg (Actiq)</i>	T1	PA
<i>fentanyl citrate ofc 800 mcg (Actiq)</i>	T1	PA
FENTANYL-ROPIVACAINE-0.9% NACL	T1	
FENTORA	T3	PA
<i>hydrocodone bitartrate (Hysingla Er)</i>	T1	PA
<i>hydrocodone bitartrate (Zohydro Er)</i>	T1	PA
HYDROMORPHONE 0.25 MG/0.5 ML	T3	PA
HYDROMORPHONE 0.5 MG/ML-NS SYR	T1	PA
HYDROMORPHONE 1 MG/ML-NS SYRNG	T1	PA

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

T4 – Specialty Medications

PA – Prior Authorization

QL – Quantity Limit

ST – Step Therapy

AGE – Age Requirement

SP – Specialty Medication

HD – May require home delivery pharmacy

PPACA – No Cost-Share Preventive Medication

CSL – Oral cancer medication subject to cost-share limits

## List of Prescription Medications

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

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>OPIOID ANALGESICS (cont.)</b>		
HYDROMORPHONE 10 MG/50 ML-NS	T1	PA
<i>hydromorphone 10 mg/50 ml-ns</i> (Hydromorphone Hcl-0.9% Nacl)	T1	PA
HYDROMORPHONE 100 MG/100 ML-NS	T1	PA
HYDROMORPHONE 100 MG/50 ML-NS	T1	PA
<i>hydromorphone 15 mg/30 ml-ns</i>	T1	PA
HYDROMORPHONE 2 MG/10 ML-NS	T1	PA
HYDROMORPHONE 2 MG/ML-NS SYRNG	T1	PA
HYDROMORPHONE 20 MG/100 ML-NS	T1	PA
HYDROMORPHONE 200 MG/100 ML-NS	T1	PA
HYDROMORPHONE 25 MG/50 ML-NS	T1	PA
HYDROMORPHONE 30 MG/30 ML-NS	T1	PA
HYDROMORPHONE 5 MG/25 ML-NS	T1	PA
HYDROMORPHONE 50 MG/50 ML-NS	T1	PA
HYDROMORPHONE 55 MG/55 ML-NS	T1	PA
HYDROMORPHONE 6 MG/30 ML-NS	T1	PA
<i>hydromorphone hcl</i>	T1	PA
<i>hydromorphone hcl</i> (Dilaudid)	T1	PA
<i>hydromorphone hcl/pf</i>	T1	PA
HYDROMORPHONE HCL-WATER	T1	PA
HYDROMORPH-ROPIVA-0.9% NACL	T1	PA
HYSINGLA ER ( <i>hydrocodone bitartrate er</i> )	T2	PA
INFUMORPH	T3	PA
KADIAN ( <i>morphine sulfate er</i> )	T3	PA
LAZANDA	T3	PA
<i>meperidine hcl</i>	T1	PA
<i>meperidine hcl/pf</i>	T1	PA
<i>meperidine hcl/pf</i>	T3	PA
METHADONE HCL-0.9% NACL	T3	
MITIGO	T1	PA
MORPHABOND ER	T2	PA
<i>morphine 0.5 mg/ml-0.9% nacl</i>	T1	PA
MORPHINE 100 MG/100 ML-NS	T3	
<i>morphine 100mg/100ml-0.9% nacl</i>	T1	PA
MORPHINE 2 MG/2 ML-0.9% NACL	T1	PA

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

T4 – Specialty Medications

PA – Prior Authorization

QL – Quantity Limit

ST – Step Therapy

AGE – Age Requirement

SP – Specialty Medication

HD – May require home delivery pharmacy

PPACA – No Cost-Share Preventive Medication

CSL – Oral cancer medication subject to cost-share limits



## List of Prescription Medications

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

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>OPIOID ANALGESICS (cont.)</b>		
<i>morphine 2 mg/2 ml-0.9% nacl</i> (Morphine Sulfate-0.9% Nacl)	T1	PA
MORPHINE 2 MG/2 ML-0.9% NACL ( <i>morphine sulfate-nacl</i> )	T1	PA
MORPHINE 2 MG/ML-0.9% NACL SYR	T1	PA
MORPHINE 275 MG/55 ML-0.9%NACL	T1	PA
MORPHINE 4 MG/ML-0.9% NACL SYR	T1	PA
<i>morphine 5 mg/5 ml-0.9% nacl</i> (Morphine Sulfate-0.9% Nacl)	T1	PA
<i>morphine 50 mg/50 ml-0.9% nacl</i>	T1	PA
MORPHINE 50 MG/50 ML-0.9% NACL	T1	
MORPHINE 500MG/100ML-0.9% NACL	T1	PA
MORPHINE 55 MG/55 ML-0.9% NACL	T1	PA
<i>morphine sulfate</i>	T1	PA
<i>morphine sulfate</i> (Kadian)	T1	PA
<i>morphine sulfate</i> (Morphine Sulfate)	T1	PA
<i>morphine sulfate</i> (Ms Contin)	T1	PA
<i>morphine sulfate/0.9% nacl/pf</i> (Morphine Sulfate-0.9% Nacl)	T1	PA
<i>morphine sulf 1,000 mg/20 ml</i>	T1	PA
<i>morphine sulfate/pf</i>	T1	PA
<i>morphine sulfate/pf</i>	T3	PA
MS CONTIN ( <i>morphine sulfate er</i> )	T3	PA
<i>nalbuphine hcl</i>	T1	
NUCYNTA	T3	PA
NUCYNTA ER	T3	PA
OLINVYK	T3	PA
OPANA	T3	
<i>opium/belladonna alkaloids</i>	T1	PA
OXAYDO	T3	PA
<i>oxycodone hcl</i>	T1	PA
OXYCODONE HCL ER	T1	PA
<i>oxymorphone hcl</i>	T1	PA
<i>pentazocine hcl/naloxone hcl</i>	T1	PA
ROXYBOND	T3	PA
<i>tramadol hcl 50 mg tablet</i>	T1	QL (8 tabs/day)
<i>tramadol er 100 mg tablet</i>	T1	QL (1 tab/day)
<i>tramadol er 200 mg tablet</i>	T1	QL (1 tab/day)

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

T4 – Specialty Medications  
 PA – Prior Authorization  
 QL – Quantity Limit

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

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

## List of Prescription Medications

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

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>OPIOID ANALGESICS (cont.)</b>		
<i>tramadol er 300 mg tablet</i>	T1	QL (1 tab/day)
<i>tramadol hcl (Ultram)</i>	T1	QL (8 tabs/day)
TRAMADOL HCL ER 100 MG CAPSULE	T1	QL (1 cap/day)
<i>tramadol hcl er 100 mg tablet</i>	T1	QL (1 tab/day)
TRAMADOL HCL ER 150 MG CAPSULE	T1	QL (1 cap/day)
TRAMADOL HCL ER 200 MG CAPSULE	T1	QL (1 cap/day)
<i>tramadol hcl er 200 mg tablet</i>	T1	QL (1 tab/day)
TRAMADOL HCL ER 300 MG CAPSULE	T1	QL (1 cap/day)
<i>tramadol hcl er 300 mg tablet</i>	T1	QL (1 tab/day)
ULTRAM ( <i>tramadol hcl</i> )	T3	QL (8 tabs/day)
XTAMPZA ER	T2	PA
ZOHYDRO ER ( <i>hydrocodone bitartrate er</i> )	T3	PA

### OPIOID, SALICYLATE, ANALGESIC, BARBITUATE, XANTHINE

<i>codeine/butalbital/asa/caffein (Fiorinal With Codeine #3)</i>	T1	PA
FIORINAL WITH CODEINE #3 ( <i>butalbital compound-codeine</i> )	T3	PA

### OPIOID, NON-SALICYL, ANALGESIC, BARBITUATE, XANTHINE

<i>butalbit/acetamin/caff/codeine</i>	T1	PA
<i>butalbit/acetamin/caff/codeine (Fioricet With Codeine)</i>	T1	PA

### SKELETAL MUSCLE RELAXANT, SALICYLATE, OPIOID ANALGESIC

<i>carisoprodol/aspirin/codeine</i>	T1	PA
-------------------------------------	----	----

### ANALGESICS (Urinary Tract Conditions)

#### URINARY TRACT ANALGESIC AGENTS

ELMIRON	T3	
RIMSO-50	T3	

### ANESTHETICS (Miscellaneous)

#### GENERAL ANESTHETICS, INHALANT

<i>desflurane (Suprane)</i>	T1	
<i>isoflurane</i>	T1	

#### GENERAL ANESTHETICS, INJECTABLE

AMIDATE	T3	
AMIDATE ( <i>etomidate</i> )	T3	
BREVITAL SODIUM	T3	
DIPRIVAN ( <i>propofol</i> )	T3	
<i>etomidate (Amidate)</i>	T1	

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

T4 – Specialty Medications  
PA – Prior Authorization  
QL – Quantity Limit

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

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

## List of Prescription Medications

ANESTHETICS (Miscellaneous)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>GENERAL ANESTHETICS, INJECTABLE (cont.)</b>		
KETALAR	T3	
KETALAR ( <i>ketamine hcl</i> )	T3	
KETAMINE HCL	T1	
<i>ketamine hcl</i> (Ketalar)	T1	
<i>ketamine hcl in 0.9 % nacl</i>	T1	
<i>ketamine hcl in 0.9 % nacl</i> (Ketamine Hcl-0.9% Nacl)	T1	
KETAMINE HCL-0.9% NACL	T1	
KETAMINE HCL-0.9% NACL ( <i>ketamine hcl-0.9% nacl</i> )	T1	
METHOHEXITAL-STERILE WATER	T1	
PROPOFOL	T1	
<b>GENERAL ANESTHETICS, INJECTABLE-BENZODIAZEPINE TYPE</b>		
<i>midazolam hcl</i>	T1	
<i>midazolam hcl/pf</i>	T1	
MIDAZOLAM HCL-0.9% NACL	T1	
MIDAZOLAM HCL-D5W	T1	
MIDAZOLAM-0.9% NACL	T1	
<b>ANESTHETICS (Pain Relief and Inflammatory Disease)</b>		
<b>LOCAL ANESTHETICS</b>		
ARTICADENT DENTAL	T3	
BUFFERED LIDOCAINE	T1	
BUPIVACAINE HCL	T1	
<i>bupivacaine hcl</i> (Marcaine)	T1	
<i>bupivacaine hcl</i> (Sensorcaine)	T1	
<i>bupivacaine hcl in dextrose/pf</i> (Sensorcaine With Dextrose)	T1	
<i>bupivacaine hcl/epinephrine</i> (Marcaine-epinephrine)	T1	
<i>bupivacaine hcl/epinephrine/pf</i> (Sensorcaine-mpf Epinephrine)	T1	
<i>bupivacaine hcl/pf</i> (Marcaine)	T1	
<i>bupivacaine hcl/pf</i> (Sensorcaine-mpf)	T1	
<i>bupivacaine hcl/pf</i> (Sensorcaine-mpf)	T3	
BUPIVACAINE HCL-0.9% NACL	T1	
CARBOCAINE	T3	
CARBOCAINE ( <i>polocaine</i> )	T3	

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

T4 – Specialty Medications  
 PA – Prior Authorization  
 QL – Quantity Limit

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

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

## List of Prescription Medications

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

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>LOCAL ANESTHETICS (cont.)</b>		
CARBOCAINE ( <i>polocaine-mpf</i> )	T3	
<i>chlorprocaine hcl/pf</i> (Nesacaine-mpf)	T1	
CITANEST FORTE DENTAL	T3	
CITANEST PLAIN DENTAL	T3	
CLOROTEKAL	T3	
EXPAREL	T3	
LIDOCAINE 0.5MG INTRADERM SYST	T1	
<i>lidocaine 100 mg/10 ml (1%) syr</i>	T1	
LIDOCAINE 100 MG/5 ML (2%) SYR	T1	
LIDOCAINE 200 MG/10 ML (2%) SYR	T1	
LIDOCAINE 200 MG/20 ML (1%) SYR	T1	
LIDOCAINE 40 MG/2 ML (2%) SYRG	T1	
<i>lidocaine hcl</i>	T1	
<i>lidocaine hcl 0.5% vial</i> (Xylocaine)	T1	
<i>lidocaine hcl 0.5% vial</i> (Xylocaine-mpf)	T1	
<i>lidocaine hcl 1% 20 mg/2 ml</i> (Xylocaine-mpf)	T1	
<i>lidocaine hcl 1% 20 mg/2 ml vl</i> (Xylocaine-mpf)	T1	
<i>lidocaine hcl 1% 100 mg/10 ml</i> (Xylocaine-Mpf)		
<i>lidocaine hcl 1% 300 mg/30 ml</i> (Xylocaine-mpf)	T1	
<i>lidocaine hcl 1% 50 mg/5 ml</i> (Xylocaine-mpf)	T1	
<i>lidocaine hcl 1% 50 mg/5 ml vl</i> (Xylocaine-mpf)	T1	
<i>lidocaine hcl 1% vial</i> (Xylocaine)	T1	
<i>lidocaine hcl 1.5% ampul</i> (Xylocaine-mpf)	T1	
<i>lidocaine hcl 10 mg/ml syringe</i>	T1	
<i>lidocaine hcl 100 mg/10 ml syr</i>	T1	
<i>lidocaine hcl 2% 100 mg/5 ml</i> (Xylocaine-mpf)	T1	
<i>lidocaine hcl 2% 200 mg/10 ml</i> (Xylocaine-mpf)	T1	
<i>lidocaine hcl 2% 40 mg/2 ml</i> (Xylocaine-mpf)	T1	
<i>lidocaine hcl 2% 40 mg/2 ml vl</i> (Xylocaine-mpf)	T1	
<i>lidocaine hcl 2% jel urojet ac</i>	T1	
<i>lidocaine hcl 2% jelly</i>	T1	
<i>lidocaine hcl 2% jelly uro-jet</i>	T1	
<i>lidocaine hcl 2% vial</i> (Xylocaine)	T1	
<i>lidocaine hcl 2% vial</i> (Xylocaine-mpf)	T1	

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

T4 – Specialty Medications

PA – Prior Authorization

QL – Quantity Limit

ST – Step Therapy

AGE – Age Requirement

SP – Specialty Medication

HD – May require home delivery pharmacy

PPACA – No Cost-Share Preventive Medication

CSL – Oral cancer medication subject to cost-share limits

## List of Prescription Medications

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

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>LOCAL ANESTHETICS (cont.)</b>		
LIDOCAINE HCL 200 MG/10 ML SYR	T1	
LIDOCAINE HCL 30 MG/3 ML SYR	T1	
<i>lidocaine hcl 4% ampul</i>	T1	
<i>lidocaine hcl 4% solution</i>	T1	
<i>lidocaine hcl 4% 200 mg/5 ml</i>	T1	
<i>lidocaine hcl/dextrose 7.5%/pf</i>	T1	
<i>lidocaine hcl/epinephrine (Xylocaine With Epinephrine)</i>	T1	
<i>lidocaine hcl/epinephrine bit (Lidocaine-epinephrine)</i>	T3	
<i>lidocaine hcl/epinephrine/pf (Xylocaine With Epinephrine)</i>	T1	
<i>lidocaine hcl/epinephrine/pf (Xylocaine-mpf With Epinephrine)</i>	T1	
LIDOCAINE HCL-0.9% NAACL	T1	
MARCAINE ( <i>bupivacaine hcl</i> )	T3	
MARCAINE ( <i>sensorcaine</i> )	T3	
MARCAINE ( <i>sensorcaine-mpf</i> )	T3	
MARCAINE SPINAL	T3	
MARCAINE-EPINEPHRINE ( <i>bupivacaine hcl-epinephrine</i> )	T3	
MARCAINE-EPINEPHRINE ( <i>sensorcaine-epinephrine</i> )	T3	
<i>mepivacaine hcl (Carbocaine)</i>	T1	
<i>mepivacaine hcl/pf</i>	T1	
<i>mepivacaine hcl/pf</i>	T3	
<i>mepivacaine hcl/pf (Carbocaine)</i>	T1	
NAROPIN	T3	
NESACAINE	T3	
NESACAINE-MPF ( <i>chloroprocaine hcl</i> )	T3	
ORABLOC	T3	
POLOCAINE	T1	
<i>ropivacaine 0.2% 20 mg/10 ml (Naropin)</i>	T1	
<i>ropivacaine 0.2% 200 mg/100 ml (Naropin)</i>	T1	
<i>ropivacaine 0.2% 40 mg/20 ml (Naropin)</i>	T1	
<i>ropivacaine 0.2% 400 mg/200 ml (Naropin)</i>	T1	
ROPIVACAINE 0.2% SYRINGE	T1	
<i>ropivacaine 0.5% 100 mg/20 ml (Naropin)</i>	T1	
ROPIVACAINE 0.5% 1000 MG/200ML	T3	
<i>ropivacaine 0.5% 150 mg/30 ml (Naropin)</i>	T1	

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

T4 – Specialty Medications

PA – Prior Authorization

QL – Quantity Limit

ST – Step Therapy

AGE – Age Requirement

SP – Specialty Medication

HD – May require home delivery pharmacy

PPACA – No Cost-Share Preventive Medication

CSL – Oral cancer medication subject to cost-share limits

## List of Prescription Medications

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

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>LOCAL ANESTHETICS (cont.)</b>		
ROPIVACAINE 0.5% 500 MG/100 ML	T3	
ROPIVACAINE 0.5% BAG	T1	
<i>ropivacaine 0.75% 150 mg/20 ml (Naropin)</i>	T1	
<i>ropivacaine 1% 100 mg/10 ml v1 (Naropin)</i>	T1	
<i>ropivacaine 1% 200 mg/20 ml v1 (Naropin)</i>	T1	
ROPIVACAINE 50 MG/10 ML SYRNG	T1	
ROPIVACAINE HCL 0.2% ON-Q PUMP	T1	
ROPIVACAINE HCL 0.5% SYRINGE	T1	
ROPIVACAINE HCL-0.9% NAACL	T1	
ROPIVACAINE HCL-NAACL	T1	
SENSORC MPF 0.75%-EPI 1:200000	T3	
SENSORCAINE 0.25% VIAL ( <i>bupivacaine hcl</i> )	T3	
<i>sensorcaine 0.5% vial (Marcaine)</i>	T1	
SENSORCAINE WITH DEXTROSE	T1	
SENSORCAINE-MPF 0.25% AMPUL ( <i>bupivacaine hcl</i> )	T3	
SENSORCAINE-MPF 0.25% VIAL ( <i>bupivacaine hcl</i> )	T3	
SENSORCAINE-MPF 0.5% AMPUL ( <i>bupivacaine hcl</i> )	T3	
<i>sensorcaine-mpf 0.5% vial (Marcaine)</i>	T1	
SENSORCAINE-MPF 0.75% AMPUL ( <i>bupivacaine hcl</i> )	T1	
SENSORCAINE-MPF 0.75% VIAL ( <i>marcaine</i> )	T3	
SENSORC-MPF 0.25%-EPI 1:200000 ( <i>bupivacaine hcl-epinephrine</i> )	T1	
SENSORCN-MPF 0.5%-EPI 1:200000 ( <i>bupivacaine hcl-epinephrine</i> )	T3	
<i>tetracaine hcl/pf</i>	T1	
XYLOCAINE ( <i>lidocaine hcl</i> )	T3	
XYLOCAINE WITH EPINEPHRINE ( <i>lidocaine hcl-epinephrine</i> )	T3	
XYLOCAINE-MPF	T3	
XYLOCAINE-MPF ( <i>lidocaine hcl</i> )	T3	
XYLOCAINE-MPF WITH EPINEPHRINE	T3	
XYLOCAINE-MPF WITH EPINEPHRINE ( <i>lidocaine hcl-epinephrine</i> )	T3	
ZINGO	T3	
<b>TOPICAL LOCAL ANESTHETICS</b>		
<i>lidocaine 5% ointment</i>	T1	QL (145gm/30 days)
<i>lidocaine 5% patch (Lidoderm II)</i>	T1	
<i>lidocaine hcl (Lidoderm)</i>	T1	
<i>lidocaine hcl (Lidoderm)</i>	T3	

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

T4 – Specialty Medications  
PA – Prior Authorization  
QL – Quantity Limit

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

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

## List of Prescription Medications

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

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>TOPICAL LOCAL ANESTHETICS (cont.)</b>		
<i>lidocaine hcl 4% solution</i>	T1	
<i>lidocaine/prilocaine</i>	T1	
LIDODERM ( <i>lidocaine</i> )	T3	
PAIN EASE MEDIUM STREAM SPRAY	T3	
ZTLIDO	T2	

### ANESTHETICS (Urinary Tract Conditions)

#### URINARY TRACT ANESTHETIC/ANALGESIC AGNT (AZO-DYE)

<i>phenazopyridine hcl</i> (Pyridium)	T1	
PYRIDIUM ( <i>phenazopyridine hcl</i> )	T3	

### ANTI-ALLERGY (Allergy/Nasal Sprays)

#### MAST CELL STABILIZERS

<i>cromolyn 100 mg/5 ml oral conc</i> (Gastrocrom)	T1	
GASTROCROM ( <i>cromolyn sodium</i> )	T3	

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

#### ANALGESIC/ANTIPYRETICS, SALICYLATES

DISALCID ( <i>salsalate</i> )	T3	HD
<i>salsalate</i> (Disalcid)	T1	HD

#### ANTI-ARTHRITIC AND CHELATING AGENTS

DEPEN ( <i>penicillamine</i> )	T3	PA SP
<i>penicillamine</i>	T1	PA SP
<i>penicillamine</i> (Depen)	T1	PA SP

#### ANTI-ARTHRITIC, FOLATE ANTAGONIST AGENTS

OTREXUP	T2	PA
---------	----	----

#### ANTI-INFLAMMATORY, PYRIMIDINE SYNTHESIS INHIBITOR

ARAVAL ( <i>leflunomide</i> )	T3	HD
<i>leflunomide</i> (Arava)	T1	HD

#### ANTI-INFLAMMATORY, PHOSPHODIESTERASE-4(PDE4) INHIB.

OTEZLA 28 DAY STARTER PACK	T2	PA QL (1 pack/180 days) SP HD
OTEZLA 30 MG TABLET	T2	PA QL (2 tabs/day) SP HD

#### ANTI-INFLAMMATORY/ANTIARTHRITICS AGENTS, MISC.

DUROLANE	T3	PA SP HD
EUFLEXXA	T3	PA SP HD

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

T4 – Specialty Medications  
PA – Prior Authorization  
QL – Quantity Limit

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

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

## List of Prescription Medications

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

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>ANTI-INFLAMMATORY/ANTIARTHRITICS AGENTS, MISC. (cont.)</b>		
GEL-ONE 30MG/3ML SYR	T3	PA SP HD
GELSYN-3	T3	PA SP HD
GENVISC 850 25MG/2.5ML SYR	T3	PA SP
HYALGAN	T3	PA SP HD
HYMOVIS	T3	PA SP HD
MONOVISC	T3	PA SP HD
ORTHOVISC	T3	PA SP HD
SODIUM HYALURONATE	T3	PA SP
SUPARTZ FX 25MG/2.5ML SYR	T3	PA SP HD
SYNVISC	T3	PA SP HD
SYNVISC-ONE	T3	PA SP HD
SYNOJOYNT	T3	PA SP
TRILURON	T3	PA SP HD
TRIVISC 25MG/2.5ML SYR	T3	PA SP
VISCO-3	T3	PA SP HD
<b>ANTI-INFLAMMATORY, SEL.COSTIM.MOD., T-CELL INHIBITOR</b>		
ORENCIA 125 MG/ML SYRINGE	T3	PA QL (4 syringes/28 days) SP HD
ORENCIA 250 MG VIAL	T3	PA SP HD
ORENCIA 50 MG/0.4 ML SYRINGE	T3	PA QL (4 syringes/28 days) SP HD
ORENCIA 87.5 MG/0.7 ML SYRINGE	T3	PA QL (4 syringes/28 days) SP HD
ORENCIA CLICKJECT	T3	PA QL (4 injectors/28 days) SP HD
<b>COLCHICINE</b>		
COLCHICINE	T1	HD
<i>colchicine</i> (Colcrys)	T1	HD
<i>colchicine</i> (Mitigare)	T1	HD
COLCRYS (colchicine)	T3	HD
MITIGARE	T3	HD
MITIGARE (colchicine)	T2	HD
RIDAURA	T3	
<b>HYPERURICEMIA TX - URATE-OXIDASE ENZYME-TYPE</b>		
ELITEK	T2	SP
KRYSTEXXA	T3	PA SP
<b>HYPERURICEMIA TX - XANTHINE OXIDASE INHIBITORS</b>		
<i>allopurinol</i> (Zyloprim)	T1	HD

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

T4 – Specialty Medications  
PA – Prior Authorization  
QL – Quantity Limit

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

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



## List of Prescription Medications

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

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>HYPERURICEMIA TX - XANTHINE OXIDASE INHIBITORS (cont.)</b>		
<i>allopurinol sodium</i>	T1	HD
<i>allopurinol sodium</i>	T3	HD
<i>febuxostat 80 mg tablet (Uloric)</i>	T1	HD
ULORIC 40 MG TABLET ( <i>febuxostat</i> )	T3	QL (1 tab/day) HD
ULORIC 80 MG TABLET ( <i>febuxostat</i> )	T3	HD
ZYLOPRIM ( <i>allopurinol</i> )	T3	HD
<b>JANUS KINASE (JAK) INHIBITORS</b>		
LITFULO	T3	PA QL(1 cap/day) SP HD
OLUMIANT	T3	PA QL (1 tab/day) SP HD
RINVOQ	T2	PA QL (1 tab/day) SP HD
XELJANZ 1 MG/ML SOLUTION	T2	PA QL (480ml/22 days) SP HD
XELJANZ 10 MG TABLET	T2	PA QL (2 tabs/day) SP HD
XELJANZ 5 MG TABLET	T2	PA QL (2 tabs/day) SP HD
XELJANZ XR	T2	PA QL (1 tab/day) SP HD
<b>NSAID ANALGESIC AND NON-SALICYLATE ANALGESIC COMB</b>		
COMBOGESIC IV	T3	
<b>NSAIDS (COX NON-SPEC.INHIB) AND PROSTAGLANDIN ANALOG</b>		
ARTHROTEC 50 ( <i>diclofenac sodium-misoprostol</i> )	T3	ST HD
ARTHROTEC 75 ( <i>diclofenac sodium-misoprostol</i> )	T3	ST HD
<i>diclofenac sodium/misoprostol</i> (Arthrotec 50)	T1	HD
<i>diclofenac sodium/misoprostol</i> (Arthrotec 75)	T1	HD
<b>NSAIDS, CYCLOOXYGENASE INHIBITOR - TYPE ANALGESICS</b>		
ANAPROX DS ( <i>naproxen sodium ds</i> )	T3	ST HD
ANJESO	T3	HD
CALDOLOR	T3	HD
DAYPRO ( <i>oxaprozin</i> )	T3	ST HD
<i>diclofenac sod dr 25 mg tab</i>	T1	HD
<i>diclofenac sod dr 50 mg tab</i>	T1	HD
<i>diclofenac sod dr 75 mg tab</i>	T1	HD
<i>diclofenac sod ec 25 mg tab</i>	T1	HD
<i>diclofenac sod ec 50 mg tab</i>	T1	HD
<i>diclofenac sod ec 75 mg tab</i>	T1	HD
<i>diclofenac sodium</i>	T1	HD
EC-NAPROSYN ( <i>naproxen</i> )	T3	ST HD
<i>etodolac</i>	T1	HD

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

T4 – Specialty Medications  
 PA – Prior Authorization  
 QL – Quantity Limit

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

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

## List of Prescription Medications

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

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

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

T4 – Specialty Medications  
PA – Prior Authorization  
QL – Quantity Limit

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

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

## List of Prescription Medications

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

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>NSAIDS, CYCLOOXYGENASE-2(COX-2) SELECTIVE INHIBITOR (cont.)</b>		
CELEBREX 400 MG CAPSULE ( <i>celecoxib</i> )	T3	QL (1 cap/day) HD
CELEBREX 50 MG CAPSULE ( <i>celecoxib</i> )	T3	QL (2 caps/day) HD
<b>URICOSURIC AGENTS</b>		
<i>probenecid/colchicine</i>	T1	HD

### ANTIASTHMATICS (Asthma/COPD/Respiratory)

#### 5-LIPOXYGENASE INHIBITORS

<i>zileuton</i>	T1	HD
-----------------	----	----

#### ANTICHOLINERGICS, ORALLY INHALED LONG ACTING

INCRUSE ELLIPTA	T2	HD
LONHALA MAGNAIR REFILL	T3	PA HD
LONHALA MAGNAIR STARTER	T3	PA HD
SPIRIVA RESPIMAT	T2	HD

#### ANTICHOLINERGICS, ORALLY INHALED SHORT ACTING

ATROVENT HFA	T2	HD
<i>ipratropium bromide</i>	T1	HD

#### BETA-ADRENERGIC AGENTS

<i>albuterol sulf 2 mg/5 ml syrup</i>	T1	HD
<i>albuterol sulfate 2 mg tab</i>	T1	HD
<i>albuterol sulfate 4 mg tab</i>	T1	HD
<i>albuterol sulfate er 4 mg tab</i>	T1	HD
<i>albuterol sulfate er 8 mg tab</i>	T1	HD
<i>metaproterenol sulfate</i>	T1	HD
<i>terbutaline sulfate</i>	T1	HD

#### BETA-ADRENERGIC AGENTS, INHALED, SHORT ACTING

<i>albuterol 2.5 mg/0.5 ml sol</i>	T1	
<i>albuterol 5 mg/ml solution</i>	T1	
<i>albuterol 15 mg/3 ml solution</i>	T1	
<i>albuterol 75 mg/15 ml soln</i>	T1	
<i>albuterol sul 0.63 mg/3 ml sol</i>	T1	
<i>albuterol sul 1.25 mg/3 ml sol</i>	T1	
<i>albuterol sul 2.5 mg/3 ml soln</i>	T1	
<i>albuterol sulfate (Albuterol Sulfate Hfa)</i>	T1	QL (8.5gm/30 days)
ALBUTEROL SULFATE HFA	T1	QL (8.5gm/30 days)
arformoterol tartrate (Brovana)	T1	QL (4 ml/day) HD

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

T4 – Specialty Medications

PA – Prior Authorization

QL – Quantity Limit

ST – Step Therapy

AGE – Age Requirement

SP – Specialty Medication

HD – May require home delivery pharmacy

PPACA – No Cost-Share Preventive Medication

CSL – Oral cancer medication subject to cost-share limits

## List of Prescription Medications

ANTIASTHMATICS (Asthma/COPD/Respiratory) (cont.)			
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits	
<b>BETA-ADRENERGIC AGENTS, INHALED, SHORT ACTING</b>			
<i>levalbuterol hcl</i> (Xopenex / Xopenex Concentrate)	T1		
XOPENEX ( <i>levalbuterol hcl</i> )	T3		
XOPENEX CONCENTRATE ( <i>levalbuterol concentrate</i> )	T3		
<b>BETA-ADRENERGIC AND ANTICHOLINERGIC COMBO, INHALED</b>			
ANORO ELLIPTA	T2	HD	
COMBIVENT RESPIMAT	T2	HD	
<i>ipratropium/albuterol sulfate</i>	T1	HD	
DULERA	T2	HD	
<i>fluticasone propion/salmeterol</i>	T1	HD	
STIOLTO RESPIMAT INHAL SPRAY	T2	HD	
STRIVERDI RESPIMAT	T2	QL	
BREZTRI AEROSPHERE	T2		
TRELEGY ELLIPTA	T2		
<b>BETA-ADRENERGIC AND GLUCOCORTICOID COMBO, INHALED</b>			
AIRDUO DIGIHALER	T3	ST HD	
<i>budesonide/formoterol fumarate</i> (Symbicort)	T1	QL HD	
FLUTICASONE-SALMETEROL	T1	QL(1 inhaler/30 days) HD	
<i>fluticasone-salmeterol</i> (Advair Diskus)	T1	QL(1 inhaler/30 days) HD	
<b>GLUCOCORTICOID, ORALLY INHALED</b>			
ALVESCO	T2		
ASMANEX HFA	T2	QL (1 inhaler/30days)	
ASMANEX TWISTHALER	T2	QL (1 inhaler/30days)	
<i>budesonide</i> (Pulmicort)	T1	HD	
FLUTICASONE PROP	T3	QL HD	
PULMICORT ( <i>budesonide</i> )	T3	HD	
QVAR REDIHALER	T2	HD	
<b>INTERLEUKIN-5 (IL-5) RECEPTOR ALPHA ANTAGONIST, MAB</b>			
FASENRA	T2	PA SP HD	
FASENRA PEN	T2	PA SP HD	
<b>LEUKOTRIENE RECEPTOR ANTAGONISTS</b>			
ACCOLATE ( <i>zafirlukast</i> )	T3	HD	
<i>montelukast sodium</i> (Singulair)	T1	HD	
SINGULAIR ( <i>montelukast sodium</i> )	T3	HD	
<i>zafirlukast</i> (Accolate)	T1	HD	
<b>MAST CELL STABILIZERS, ORALLY INHALED</b>			
<i>cromolyn 20 mg/2 ml neb soln</i>	T1	QL (480ml/30 days) HD	

I1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

I4 – Specialty Medications

PA – Prior Authorization

QL – Quantity Limit

S1 – Step Therapy

AGE – Age Requirement

SP – Specialty Medication

HD – 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	
<b>MONOCLONAL ANTIBODIES TO IMMUNOGLOBULIN E (IGE)</b>			
XOLAIR	T2	PA SP HD	
<b>MONOCLONAL ANTIBODY - INTERLEUKIN-5 ANTAGONISTS</b>			
CINQAIR	T3	PA SP	
NUCALA	T2	PA SP HD	
<b>MUCOLYTICS</b>			
<i>acetylcysteine</i>	T1		
<b>PHOSPHODIESTERASE-4 (PDE4) INHIBITORS</b>			
DALIRESP 250 MCG TABLET	T3	QL (28 tabs/180 days) HD	
DALIRESP 500 MCG TABLET	T3	QL (2 tabs/day) HD	
<b>XANTHINES</b>			
<i>aminophylline</i>	T1	HD	
THEO-24	T3	HD	
<i>theophylline anhydrous</i>	T1	HD	
<i>theophylline in dextrose 5 %</i>	T1	HD	
<b>ANTIBIOTICS (Allergy/Nasal Sprays)</b>			
<b>NOSE PREPARATIONS ANTIBIOTICS</b>			
BACTROBAN NASAL	T3		
<b>ANTIBIOTICS (Ear Medications)</b>			
<b>EAR PREPARATIONS, ANTIBIOTICS</b>			
<i>ciprofloxacin hcl</i>	T1		
CORTISPORIN-TC	T3		
<i>neomycin/polymyxin b/hydrocort</i>	T1		
<i>ofloxacin</i>	T1		
<b>OTIC PREPARATIONS, ANTI-INFLAMMATORY-ANTIBIOTICS</b>			
CIPRO HC	T3		
<i>ciprofloxacin hcl/dexameth (Ciprodex)</i>	T1		
CIPROFLOXACIN HCL-FLUOCINOLONE	T3		
OTOVEL	T3		
<b>ANTIBIOTICS (Eye Conditions)</b>			
<b>EYE ANTIBIOTIC AND GLUCOCORTICOID COMBINATIONS</b>			
<i>neomycin/bacit/p-myx/hydrocort</i>	T1		
<i>neomycin/polymyxin b/dexametha (Maxitrol)</i>	T1		

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

T4 – Specialty Medications  
PA – Prior Authorization  
QL – Quantity Limit

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

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

## List of Prescription Medications

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

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>EYE ANTIBIOTIC AND GLUCOCORTICOID COMBINATIONS</b>		
<i>neomycin/polymyxin b/hydrocort</i>	T1	
<i>tobramycin/dexamethasone</i> (Tobradex)	T1	
TOBRADEX EYE OINTMENT	T2	
TOBRADEX ST	T3	
ZYLET	T3	
<b>EYE SULFONAMIDES</b>		
BLEPH-10 ( <i>sulfacetamide sodium</i> )	T3	
BLEPHAMIDE	T3	
<i>sulfacetamide sodium</i>	T1	
<i>sulfacetamide sodium</i> (Bleph-10)	T1	
<i>sulfacetamide/prednisolone sp</i>	T1	
<b>OPHTHALMIC ANTIBIOTICS</b>		
AZASITE 1% EYE DROPS	T3	
<i>bacitracin</i> (Baciguent)	T1	
<i>bacitracin/polymyxin b sulfate</i>	T1	
BESIVANCE 0.6% SUSP	T2	
<i>erythromycin base</i>	T1	
<i>gatifloxacin</i> (Zymaxid)	T1	
<i>gentamicin sulfate</i>	T1	
<i>levofloxacin</i>	T1	
MOXEZA ( <i>moxifloxacin</i> )	T3	
<i>moxifloxacin hcl</i> (Moxeza)	T1	
<i>moxifloxacin hcl</i> (Vigamox)	T1	
MOXIFLOXACIN HCL-BSS	T1	
MOXIFLOXACIN HCL-NACL	T1	
<i>neomycin sulf/bacitracin/poly</i>	T1	
<i>neomycin/polymyxin b/gramicidin</i>	T1	
<i>ofloxacin</i> (Ocuflox)	T1	
<i>tobramycin 0.3% eye drop</i>	T1	

### ANTIBIOTICS (Infections)

#### ABSORBABLE SULFONAMIDE ANTIBACTERIAL AGENTS

BACTRIM ( <i>sulfamethoxazole-trimethoprim</i> )	T3	
BACTRIM DS ( <i>sulfamethoxazole-trimethoprim</i> )	T3	
<i>sulfadiazine</i>	T1	
<i>sulfamethoxazole/trimethoprim</i>	T1	

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

T4 – Specialty Medications

PA – Prior Authorization

QL – Quantity Limit

ST – Step Therapy

AGE – Age Requirement

SP – Specialty Medication

HD – May require home delivery pharmacy

PPACA – No Cost-Share Preventive Medication

CSL – Oral cancer medication subject to cost-share limits

## List of Prescription Medications

ANTIBIOTICS (Infections) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>ABSORBABLE SULFONAMIDE ANTIBACTERIAL AGENTS</b>		
<i>sulfamethoxazole/trimethoprim</i>	T3	
<i>sulfamethoxazole/trimethoprim</i> (Bactrim Ds)	T1	
<i>sulfamethoxazole/trimethoprim</i> (Bactrim)	T1	
<b>AMINOGLYCOSIDE ANTIBIOTICS</b>		
<i>amikacin sulfate</i>	T1	
ARIKAYCE	T4	PA SP
<i>gentamicin in nacl, iso-osm</i>	T1	
<i>gentamicin sulfate</i>	T1	
GENTAMICIN SULFATE IN NS	T1	
<i>gentamicin sulfate/pf</i>	T1	
KITABIS PAK	T4	PA QL (10ml/day) SP HD
<i>neomycin sulfate</i>	T1	
STREPTOMYCIN SULFATE	T1	
TOBI PODHALER	T4	PA QL (8 caps/day) SP HD
<i>tobramycin 300 mg/4 ml ampule</i>	T4	PA QL (8ml/day) SP HD
<i>tobramycin 300 mg/5 ml ampule</i>	T4	PA QL (10ml/day) SP HD
TOBRAMYCIN PAK 300 MG/5 ML	T4	PA QL (10ml/day) SP HD
<b>AMINOGLYCOSIDE ANTIBIOTICS</b>		
<i>tobramycin sulfate</i>	T1	
<i>tobramycin/sodium chloride</i>	T1	
ZEMDRI	T3	
<b>ANAEROBIC ANTIPROTOZOAL-ANTIBACTERIAL AGENTS</b>		
FLAGYL ( <i>metronidazole</i> )	T3	
LIKMEZ	T3	PA
<i>metronidazole</i> (Flagyl)	T1	
<i>metronidazole/sodium chloride</i>	T1	
<i>metronidazole/sodium chloride</i>	T3	
<b>ANTIBIOTIC, ANTIBACTERIAL, MISC.</b>		
<i>fosfomycin tromethamine</i>	T1	
<i>fosfomycin tromethamine</i> (Monurol)	T1	
HIPREX ( <i>methenamine hippurate</i> )	T3	
<i>meth/m.blue/salicyl/hyoscy</i> (Uribel Tabs)	T1	
<i>meth/meblue/sod phos/psal/hyos</i>	T1	
<i>meth/meblue/sod phos/psal/hyos</i>	T3	
<i>meth/meblue/sod phos/psal/hyos</i> (Uribel)	T1	

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

T4 – Specialty Medications  
PA – Prior Authorization  
QL – Quantity Limit

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

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

## List of Prescription Medications

ANTIBIOTICS (Infections) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>ANTIBIOTIC, ANTIBACTERIAL, MISC (cont.).</b>		
<i>methen/mblue/sal/sod phos/hyos</i>	T1	
<i>methenam/m.blue/salicyl/hyoscy</i>	T1	
<i>methenam/sod phos/mblue/hyoscy</i>	T1	
<i>methenam/sod phos/mblue/hyoscy</i>	T3	
<i>methenamine hippurate</i> (Hiprex)	T1	
<i>methenamine mandelate</i>	T1	
MONUROL ( <i>fosfomycin tromethamine</i> )	T3	
PRIMSOL	T3	
<i>trimethoprim</i>	T1	
URIBEL	T3	
URIBEL TABS ( <i>methenam/m.blue/salicyl/hyoscy</i> )	T3	
UTA	T3	
<b>ANTIBIOTICS, MISCELLANEOUS, OTHER</b>		
<i>bacitracin</i>	T1	
<b>ANTILEPTICS</b>		
<i>dapsone</i>	T1	
THALOMID	T4	PA SP HD
<b>ANTI-MYCOBACTERIUM AGENTS</b>		
<i>ethambutol hcl</i>	T1	HD
<i>ethambutol hcl</i> (Myambutol)	T1	HD
<i>isoniazid</i>	T1	HD
<b>ANTI-MYCOBACTERIUM AGENTS</b>		
MYAMBUTOL ( <i>ethambutol hcl</i> )	T3	HD
PASER	T3	HD
<i>pyrazinamide</i>	T1	HD
<i>rifabutin</i>	T1	HD
TRECTOR	T3	HD
<b>ANTITUBERCULAR ANTIBIOTICS</b>		
CAPASTAT SULFATE	T3	
CYCLOSERINE	T1	
<i>cycloserine</i>	T1	
PRETOMANID	T3	PA QL (1 tab/day)
PRIFTIN	T3	
RIFADIN ( <i>rifampin</i> )	T3	

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

T4 – Specialty Medications  
PA – Prior Authorization  
QL – Quantity Limit

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

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



## List of Prescription Medications

ANTIBIOTICS (Infections) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>ANTITUBERCULAR ANTIBIOTICS (cont.)</b>		
RIFAMATE	T3	
<i>rifampin</i>	T1	
<i>rifampin</i> (Rifadin)	T1	
RIFATER	T3	
SIRTURO	T4	SP
<b>BETALACTAMS</b>		
AZACTAM ( <i>aztreonam</i> )	T3	
<i>aztreonam</i> (Azactam)	T1	
CAYSTON	T4	PA QL (3ml/day) SP HD
<b>CARBAPENEM ANTIBIOTICS (THIENAMYCINS)</b>		
<i>ertapenem sodium</i> (Invanz)	T1	
<i>imipenem/cilastatin sodium</i>	T1	
<i>imipenem/cilastatin sodium</i> (Primaxin)	T1	
INVANZ ( <i>ertapenem</i> )	T3	
<i>meropenem</i>	T1	
<i>meropenem</i> (Merrem)	T1	
MEROPENEM	T3	
MEROPENEM-0.9% NAACL	T1	
MERREM ( <i>meropenem</i> )	T3	
PRIMAXIN ( <i>imipenem-cilastatin sodium</i> )	T3	
RECARBRIO	T3	
VABOMERE	T3	
<b>CEPHALOSPORIN ANTIBIOTICS - 1ST GENERATION</b>		
<i>cefadroxil</i>	T1	
<i>cefazolin sodium</i>	T1	
CEFAZOLIN 2 GM VIAL	T3	
CEFAZOLIN 3 GM VIAL	T3	
<i>cefazolin sodium/dextrose, iso</i>	T1	
CEFAZOLIN SODIUM-0.9% NAACL	T1	
CEFAZOLIN SODIUM-D5W	T1	
CEFAZOLIN SODIUM-DEXTROSE	T1	
CEFAZOLIN SODIUM-STERILE WATER	T1	
<i>cephalexin</i>	T1	
<i>cephalexin</i> (Keflex)	T1	
DAXBIA	T3	

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

T4 – Specialty Medications  
PA – Prior Authorization  
QL – Quantity Limit

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

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

# List of Prescription Medications

ANTIBIOTICS (Infections) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>CEPHALOSPORIN ANTIBIOTICS - 1ST GENERATION (cont.)</b>		
KEFLEX ( <i>cephalexin</i> )	T3	
<b>CEPHALOSPORIN ANTIBIOTICS - 2ND GENERATION</b>		
<i>cefaclor</i>	T1	
CEFOTAN	T3	
CEFOTETAN DEXTROSE	T1	
<i>cefotetan disodium</i>	T1	
<i>cefotetan disodium</i> (Cefotan)	T1	
<i>cefoxitin sodium</i>	T1	
<i>cefoxitin sodium/dextrose, iso</i>	T1	
<i>cefprozil</i>	T1	
<i>cefuroxime axetil</i>	T1	
<i>cefuroxime sodium</i> (Zinacef)	T1	
ZINACEF	T3	
ZINACEF ( <i>cefuroxime sodium</i> )	T3	
<b>CEPHALOSPORIN ANTIBIOTICS - 3RD GENERATION</b>		
AVYCAZ	T3	
<i>cefditoren pivoxil</i>	T1	
<i>cefixime</i> (Suprax)	T1	
<i>cefpodoxime proxetil</i>	T1	
<i>ceftazidime</i>	T1	
<i>ceftazidime</i> (Fortaz)	T1	
CEFTRIAXONE	T1	
<i>ceftriaxone in iso-osm dextrose</i>	T1	
<i>ceftriaxone sodium</i>	T1	
CLAFORAN	T3	
FORTAZ	T3	
FORTAZ ( <i>tazicef</i> )	T3	
FORTAZ IN ISO-OSMOTIC DEXTROSE	T3	
ZERBAXA	T3	
<b>CEPHALOSPORIN ANTIBIOTICS - 4TH GENERATION</b>		
CEFEPIME HCL	T1	
<i>cefepime hcl</i> (Maxipime)	T1	
<i>cefepime in iso-osm dextrose</i>	T1	
CEFEPIME-DEXTROSE	T1	

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

T4 – Specialty Medications  
 PA – Prior Authorization  
 QL – Quantity Limit

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

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

# List of Prescription Medications

ANTIBIOTICS (Infections) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>CEPHALOSPORIN ANTIBIOTICS - 4TH GENERATION (cont.)</b>		
MAXIPIME	T3	
MAXIPIME ( <i>cefepime hcl</i> )	T3	
<b>CEPHALOSPORIN ANTIBIOTICS - SIDEROPHORE</b>		
FETROJA	T3	
<b>CEPHALOSPORINS - 5TH GENERATION</b>		
TEFLARO	T3	
<b>CHLORAMPHENICOL ANTIBIOTICS AND DERIVATIVES</b>		
<i>chloramphenicol sod succinate</i>	T1	
<b>GLYCYLCYCLINES</b>		
<i>tigecycline</i> (Tygacil)	T1	
TYGACIL ( <i>tigecycline</i> )	T3	
<b>LINCOSAMIDE ANTIBIOTICS</b>		
CLEOCIN HCL ( <i>clindamycin hcl</i> )	T3	
CLEOCIN PEDIATRIC ( <i>clindamycin (pediatric)</i> )	T3	
CLEOCIN PHOS 150 MG/ML VIAL ( <i>clindamycin phosphate</i> )	T3	
CLEOCIN PHOS 300 MG/2 ML VIAL ( <i>clindamycin phosphate</i> )	T3	
<i>cleocin phos 300 mg/2ml addvan</i>	T1	
CLEOCIN PHOS 600 MG/4 ML VIAL ( <i>clindamycin phosphate</i> )	T3	
<b>LINCOSAMIDE ANTIBIOTICS</b>		
CLEOCIN PHOS 600 MG/4ML ADDVAN ( <i>clindamycin phosphate</i> )	T3	
CLEOCIN PHOS 9 G/60 ML VIAL ( <i>clindamycin phosphate</i> )	T3	
CLEOCIN PHOS 900 MG/6 ML VIAL ( <i>clindamycin phosphate</i> )	T3	
CLEOCIN PHOS 900 MG/6ML ADDVAN ( <i>clindamycin phosphate</i> )	T3	
CLIN SINGLE USE	T3	
<i>clindamycin hcl</i> (Cleocin Hcl)	T1	
<i>clindamycin palmitate hcl</i> (Cleocin Pediatric)	T1	
<i>clindamycin phosphate</i>	T1	
<i>clindamycin phosphate</i> (Cleocin Phosphate)	T1	
<i>clindamycin phosphate/d5w</i>	T1	
CLINDAMYCIN-0.9% NACL	T1	
LINCOCIN	T3	
<i>lincomycin hcl</i> (Lincocin)	T1	

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

T4 – Specialty Medications  
 PA – Prior Authorization  
 QL – Quantity Limit

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

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

# List of Prescription Medications

ANTIBIOTICS (Infections) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>LIPOGLYCOPEPTIDE ANTIBIOTICS</b>		
DALVANCE	T3	
ORBACTIV	T3	
VIBATIV	T3	
<b>MACROLIDE ANTIBIOTICS</b>		
<i>azithromycin (Zithromax)</i>	T1	
<i>azithromycin 1 gm pwd packet (Zithromax)</i>	T1	
<i>azithromycin 100 mg/5 ml susp (Zithromax)</i>	T1	
<i>azithromycin 200 mg/5 ml susp (Zithromax)</i>	T1	
<i>azithromycin 200 mg/5 ml susp (Zithromax)</i>	T1	
<i>azithromycin 250 mg tablet (Zithromax)</i>	T1	
<i>azithromycin 500 mg add-van vl</i>	T1	
<i>azithromycin 500 mg tablet (Zithromax Tri-pak)</i>	T1	
<i>azithromycin 600 mg tablet</i>	T1	
<i>azithromycin i.v. 500 mg vial (Zithromax)</i>	T1	
<i>clarithromycin</i>	T1	
DIFICID 200 MG TABLET	T3	QL (28 tabs/28 days)
DIFICID 40 MG/ML SUSPENSION	T3	QL (5ml/day)
ERYPED 200 ( <i>erythromycin ethylsuccinate</i> )	T3	
ERY-TAB ( <i>erythromycin</i> )	T3	
ERYTHROCIN LACTOBIONATE	T3	
<i>erythromycin base</i>	T1	
<i>erythromycin base</i>	T3	
<i>erythromycin base (Ery-tab)</i>	T1	
<i>erythromycin ethylsuccinate</i>	T1	
<i>erythromycin ethylsuccinate</i>	T3	
<i>erythromycin ethylsuccinate (Eryped 200)</i>	T1	
<i>erythromycin stearate</i>	T1	
PCE	T3	
ZITHROMAX 1 GM POWDER PACKET ( <i>azithromycin</i> )	T3	
ZITHROMAX 100 MG/5 ML SUSP ( <i>azithromycin</i> )	T3	
ZITHROMAX 200 MG/5 ML SUSP ( <i>azithromycin</i> )	T3	
ZITHROMAX 200 MG/5 ML SUSP ( <i>azithromycin</i> )	T3	
ZITHROMAX 250 MG TABLET ( <i>azithromycin</i> )	T3	

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

T4 – Specialty Medications  
 PA – Prior Authorization  
 QL – Quantity Limit

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

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

# List of Prescription Medications

ANTIBIOTICS (Infections) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>MACROLIDE ANTIBIOTICS (cont.)</b>		
ZITHROMAX 250 MG Z-PAK TABLET ( <i>azithromycin</i> )	T3	
ZITHROMAX 500 MG TABLET ( <i>azithromycin</i> )	T3	
ZITHROMAX I.V. 500 MG VIAL ( <i>azithromycin</i> )	T3	
ZITHROMAX TRI-PAK ( <i>azithromycin</i> )	T3	
<b>NITROFURAN DERIVATIVES ANTIBACTERIAL AGENTS</b>		
FURADANTIN ( <i>nitrofurantoin</i> )	T3	
MACROBID ( <i>nitrofurantoin mono-macro</i> )	T3	
MACRODANTIN ( <i>nitrofurantoin</i> )	T3	
<i>nitrofurantoin</i> (Furadantin)	T1	
<i>nitrofurantoin macrocrystal</i> (Macrofantin)	T1	
<i>nitrofurantoin monohyd/m-cryst</i> (Macrobid)	T1	
<b>OXAZOLIDINONE ANTIBIOTICS</b>		
<i>linezolid</i> (Zyvox)	T1	PA
<i>linezolid in 0.9% sodium chlor</i>	T1	
<i>linezolid in dextrose 5%</i> (Zyvox)	T1	
SIVEXTRO 200 MG TABLET	T3	PA
SIVEXTRO 200 MG VIAL	T3	
ZYVOX 100 MG/5 ML SUSPENSION ( <i>linezolid</i> )	T3	PA
ZYVOX 200 MG/100 ML-D5W	T3	
ZYVOX 600 MG TABLET ( <i>linezolid</i> )	T3	PA
ZYVOX 600 MG/300 ML-D5W	T3	
<b>PENICILLIN ANTIBIOTICS</b>		
<i>amoxicillin</i>	T1	
<i>amoxicillin/potassium clav</i> (Augmentin Es-600)	T1	
<i>ampicillin sodium</i>	T1	
<i>ampicillin sodium/sulbactam na</i>	T1	
<i>ampicillin trihydrate</i>	T1	
BICILLIN C-R	T3	
BICILLIN L-A	T3	
<i>dicloxacillin sodium</i>	T1	
MOXATAG	T3	
<i>nafcillin in dextrose, iso-osm</i>	T1	
<i>nafcillin sodium</i>	T1	

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

T4 – Specialty Medications  
 PA – Prior Authorization  
 QL – Quantity Limit

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

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

# List of Prescription Medications

ANTIBIOTICS (Infections) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>PENICILLIN ANTIBIOTICS (cont.)</b>		
<i>oxacillin in dextrose (iso-osm)</i>	T1	
<i>oxacillin sodium</i>	T1	
<i>penicillin g potassium</i>	T1	
<i>penicillin g sodium</i>	T1	
PENICILLIN GK-ISO-OSM DEXTROSE	T1	
<i>penicillin v potassium</i>	T1	
<i>piperacillin sodium/tazobactam</i>	T1	
<i>piperacillin sodium/tazobactam</i> (Piperacillin-tazobactam)	T1	
<i>piperacillin sodium/tazobactam</i> (Zosyn)	T1	
PIPERACILLIN-TAZOBACTAM	T1	
UNASYN ( <i>ampicillin-sulbactam</i> )	T3	
ZOSYN	T3	
ZOSYN ( <i>piperacillin-tazobactam</i> )	T3	
<b>PLEUROMUTILIN DERIVATIVES</b>		
XENLETA 150 MG/15 ML VIAL	T3	
XENLETA 600 MG TABLET	T3	PA QL (10 tabs/30 days)
<b>POLYMYXIN ANTIBIOTICS AND DERIVATIVES</b>		
<i>colistin (colistimethate na)</i> (Coly-mycin M Parenteral)	T1	
COLY-MYCIN M PARENTERAL ( <i>colistimethate</i> )	T3	
<i>polymyxin b sulfate</i>	T1	
<b>QUINOLONE ANTIBIOTICS</b>		
AVELOX ( <i>moxifloxacin hcl</i> )	T3	
AVELOX IV ( <i>moxifloxacin</i> )	T3	
BAXDELA 300 MG VIAL	T3	
BAXDELA 450 MG TABLET	T3	PA
CIPRO ( <i>ciprofloxacin hcl</i> )	T3	
CIPRO ( <i>ciprofloxacin</i> )	T3	
CIPRO I.V. ( <i>ciprofloxacin-d5w</i> )	T3	
<i>ciprofloxacin</i> (Cipro)	T1	
<i>ciprofloxacin hcl</i>	T1	
<i>ciprofloxacin hcl</i> (Cipro)	T1	

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

T4 – Specialty Medications  
 PA – Prior Authorization  
 QL – Quantity Limit

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

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

# List of Prescription Medications

ANTIBIOTICS (Infections) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>QUINOLONE ANTIBIOTICS (cont.)</b>		
<i>ciprofloxacin in 5 % dextrose</i>	T1	
<i>ciprofloxacin in 5 % dextrose (Cipro I.v.)</i>	T1	
<i>ciprofloxacin lactate</i>	T1	
<i>ciprofloxacin/ciprofloxacin hcl</i>	T1	
FACTIVE	T3	
<i>levofloxacin</i>	T1	
<i>levofloxacin in dextrose 5 %</i>	T1	
MOXIFLOXACIN	T1	
<i>moxifloxacin hcl (Avelox)</i>	T1	
<i>moxifloxacin-sod.chloride (iso) (Avelox Iv)</i>	T1	
<i>ofloxacin</i>	T1	
<b>RIFAMYCINS AND RELATED DERIVATIVE ANTIBIOTICS</b>		
AEMCOLO	T3	QL (12 tabs/3 days)
XIFAXAN 200 MG TABLET	T2	
XIFAXAN 550 MG TABLET	T2	QL (42 tabs/14 days)
<b>STREPTOGRAMIN ANTIBIOTICS</b>		
SYNERCID	T3	
<b>TETRACYCLINE ANTIBIOTICS</b>		
<i>coremino er 135 mg tablet</i>	T1	
<i>coremino er 45 mg tablet</i>	T1	QL (1 tab/day)
<b>TETRACYCLINE ANTIBIOTICS</b>		
<i>coremino er 90 mg tablet</i>	T1	
<i>demeclocycline hcl (Targadox)</i>	T1	
<i>doxycycline hyclate</i>	T1	
<i>doxycycline monohydrate</i>	T1	
<i>doxycycline monohydrate (Vibramycin)</i>	T1	
MINOCIN	T3	
<i>minocycline er 115 mg tablet</i>	T1	
<i>minocycline er 45 mg tablet</i>	T1	QL (1 tab/day)
<i>minocycline er 55 mg tablet</i>	T1	
<i>minocycline er 65 mg tablet</i>	T1	
<i>minocycline er 80 mg tablet</i>	T1	
<i>minocycline er 90 mg tablet</i>	T1	

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

T4 – Specialty Medications  
 PA – Prior Authorization  
 QL – Quantity Limit

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

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

# List of Prescription Medications

## ANTIBIOTICS (Infections) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>TETRACYCLINE ANTIBIOTICS (cont.)</b>		
<i>minocycline hcl</i>	T1	
NUZYRA 100 MG VIAL	T3	SP
NUZYRA 150 MG TABLET	T3	QL (30 tablets/28 days) SP
<i>tetracycline hcl</i>	T1	
VIBRAMYCIN	T3	
XERAVA	T3	
<b>VAGINAL ANTIBIOTICS</b>		
<i>clindamycin phosphate</i> (Cleocin)	T1	
<i>metronidazole</i> (Metrogel-vaginal)	T1	
NUVESSA	T3	
<b>VANCOMYCIN ANTIBIOTICS AND DERIVATIVES</b>		
VANCOMYCIN	T1	
<i>vancomycin</i> 50 mg/ml solution	T1	
<i>vancomycin 1 gm add-van vial</i>	T1	
<i>vancomycin 1 gm vial</i>	T1	
VANCOMYCIN 1 GRAM/200 ML BAG	T3	
VANCOMYCIN 1.25 GM/250 ML BAG	T3	
VANCOMYCIN 1.5 GRAM/300 ML BAG	T3	
VANCOMYCIN 1.75 GM/350 ML BAG	T3	
VANCOMYCIN 2 GRAM/400 ML BAG	T3	
<i>vancomycin 250 mg/5 ml soln</i> (Firvanq)	T1	
<i>vancomycin 500 mg add-van vial</i>	T1	
<i>vancomycin 500 mg vial</i>	T1	
VANCOMYCIN 500 MG/100 ML BAG	T3	
VANCOMYCIN 750 MG ADD-VAN VIAL	T1	
VANCOMYCIN 750 MG/150 ML BAG	T3	
VANCOMYCIN HCL 1.25 GRAM VIAL	T1	
VANCOMYCIN HCL 1.5 GRAM VIAL	T1	
<i>vancomycin hcl 10 gm vial</i>	T1	
<i>vancomycin hcl 125 mg capsule</i>	T1	
VANCOMYCIN HCL 1G/200 ML BAG	T1	
<i>vancomycin hcl 250 mg capsule</i>	T1	

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

T4 – Specialty Medications

PA – Prior Authorization

QL – Quantity Limit

ST – Step Therapy

AGE – Age Requirement

SP – Specialty Medication

HD – May require home delivery pharmacy

PPACA – No Cost-Share Preventive Medication

CSL – Oral cancer medication subject to cost-share limits



## List of Prescription Medications

ANTIBIOTICS (Infections) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>VANCOMYCIN ANTIBIOTICS AND DERIVATIVES (cont.)</b>		
VANCOMYCIN HCL 250 MG VIAL	T1	
<i>vancomycin hcl 5 gm vial</i>	T1	
<i>vancomycin hcl 750 mg vial</i>	T1	
VANCOMYCIN HCL-0.9% NAACL	T1	
VANCOMYCIN HCL-D5W	T1	
<b>ANTIBIOTICS (Miscellaneous)</b>		
<b>CYCLIC LIPOPEPTIDES</b>		
CUBICIN ( <i>daptomycin</i> )	T3	
CUBICIN RF ( <i>daptomycin</i> )	T3	
DAPTOMYCIN	T1	
DAPTOMYCIN-0.9% NAACL	T1	
<b>ANTIBIOTICS (Skin Conditions)</b>		
<b>TOPICAL ANTIBIOTIC AND ANTI-INFLAMMATORY STEROID</b>		
CORTISPORIN	T3	
NEO-SYNALAR	T3	
<b>TOPICAL ANTIBIOTICS</b>		
BENZAMYCIN ( <i>erythromycin-benzoyl peroxide</i> )	T3	
CENTANY	T3	
CENTANY AT	T3	
CLEOCIN T ( <i>clindamycin phosphate</i> )	T3	
CLINDACIN ETZ KIT	T3	
CLINDACIN PAC	T3	
<i>clindamycin phosphate</i>	T1	
<i>clindamycin phosphate (Cleocin T)</i>	T1	
<i>clindamycin phosphate (Evoclin)</i>	T1	
<i>erythromycin base in ethanol</i>	T1	
<i>erythromycin base in ethanol</i>	T3	
<i>erythromycin/benzoyl peroxide (Benzamycin)</i>	T1	
EVOCLIN ( <i>clindamycin phosphate</i> )	T3	
<i>gentamicin sulfate</i>	T1	
<i>mupirocin (Centany)</i>	T1	
<i>mupirocin calcium</i>	T1	
XEPI	T3	

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

T4 – Specialty Medications  
 PA – Prior Authorization  
 QL – Quantity Limit

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

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

## List of Prescription Medications

ANTIBIOTICS (Skin Conditions) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>TOPICAL SULFONAMIDES</b>		
AVAR 9.5-5% CLEANSING PADS	T3	
<i>avar cleanser</i> (Rosanil)	T1	
AVAR LS	T3	
<i>mafenide acetate</i>	T1	
ROSANIL ( <i>sodium sulfacetamide-sulfur</i> )	T1	
SILVADENE ( <i>ssd</i> )	T3	
<i>silver sulfadiazine</i> (Silvadene)	T1	
<i>sulfacetamide sod/sulfur/urea</i>	T1	
<i>sulfacetamide sodium/sulfur</i>	T1	
<i>sulfacetamide sodium/sulfur</i> (Avar-e Green)	T1	
<i>sulfacetamide sodium/sulfur</i> (Rosanil)	T1	
<i>sulfacetamide/sulfur/cleansr23</i>	T1	
<i>sulfact sod/sulur/avob/otn/oct</i>	T1	
SULFAMYLON	T3	
<b>ANTICOAGULANTS (Blood Thinners/Anti-Clotting)</b>		
<b>ANTICOAGULANTS, COUMARIN TYPE</b>		
<i>warfarin sodium</i>	T1	HD
<b>CITRATES AS ANTICOAGULANTS</b>		
ACD SOLUTION A	T3	
ACD-A	T3	
ANTICOAG SODIUM CITRATE 4% SOL	T3	
CITRATE PHOSPHATE DEXTROSE	T1	
TRICITRASOL	T3	
<b>DIRECT FACTOR XA INHIBITORS</b>		
BEVYXXA	T3	QL (42 caps/42 days)
ELIQUIS	T2	PA
SAVAYSA 15 MG TABLET	T3	PA QL (1 tab/day)
SAVAYSA 30 MG TABLET	T3	PA QL (1 tab/day)
SAVAYSA 60 MG TABLET	T3	PA
XARELTO	T2	PA
<b>HEPARIN AND RELATED PREPARATIONS</b>		
ARIXTRA ( <i>fondaparinux sodium</i> )	T3	QL (1 syringe/day) SP

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

T4 – Specialty Medications  
 PA – Prior Authorization  
 QL – Quantity Limit

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

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

## List of Prescription Medications

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

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>HEPARIN AND RELATED PREPARATIONS (cont.)</b>		
<i>enoxaparin 100 mg/ml syringe (Lovenox)</i>	T1	QL (2 syringes/day) SP
<i>enoxaparin 120 mg/0.8 ml syr (Lovenox)</i>	T1	QL (2 syringes/day) SP
<i>enoxaparin 150 mg/ml syringe (Lovenox)</i>	T1	QL (2 syringes/day) SP
<i>enoxaparin 30 mg/0.3 ml syr (Lovenox)</i>	T1	QL (2 syringes/day) SP
<i>enoxaparin 300 mg/3 ml vial (Lovenox)</i>	T1	QL (1 vial/day) SP
<i>enoxaparin 40 mg/0.4 ml syr (Lovenox)</i>	T1	QL (2 syringes/day) SP
<i>enoxaparin 60 mg/0.6 ml syr (Lovenox)</i>	T1	QL (2 syringes/day) SP
<i>enoxaparin 80 mg/0.8 ml syr (Lovenox)</i>	T1	QL (2 syringes/day) SP
<i>fondaparinux sodium (Arixtra)</i>	T1	QL (1 syringe/day) SP
FRAGMIN	T3	QL (2ml/day) SP
<i>heparin 10, 000 unit/10 ml vial</i>	T1	
<i>heparin 2, 000 unit/2 ml vial</i>	T1	
<i>heparin 30, 000 unit/30 ml vial</i>	T1	
<i>heparin 40, 000 unit/4 ml vial</i>	T1	
<i>heparin 5, 000 unit/ml carpuct</i>	T1	
<i>heparin 50, 000 unit/10 ml vial</i>	T1	
<i>heparin 50, 000 unit/5 ml vial</i>	T1	
<i>heparin 1,000 unit/500 ml-ns</i>	T1	
HEPARIN 2,000 UNIT/1,000 ML-NS ( <i>heparin sodium,porcine/ns/pf</i> )	T3	
<i>heparin 2,000 unit/1,000 ml-ns (Heparin Sodium-0.9% Nacl)</i>	T1	
HEPARIN 2,500 UNIT/500 ML-NS	T1	
HEPARIN 30,000 UNIT/1,000-NS	T1	
HEPARIN 5,000 UNIT/1,000 ML-NS	T1	
HEPARIN 5,000 UNIT/500 ML-NS	T1	
<i>heparin sod 1, 000 unit/ml vial</i>	T1	
<i>heparin sod 10, 000 unit/ml vl</i>	T1	
<i>heparin sod 20, 000 unit/ml vl</i>	T1	
<i>heparin sod 5, 000 unit/0.5 ml</i>	T1	
HEPARIN SOD 5, 000 UNIT/0.5 ML	T3	
<i>heparin sod 5, 000 unit/0.5 ml (Heparin Sodium)</i>	T1	
<i>heparin sod 5, 000 unit/ml syrg</i>	T1	
<i>heparin sod 5, 000 unit/ml vial</i>	T1	
<i>heparin sod, porcine/0.9 % nacl</i>	T1	

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

T4 – Specialty Medications

PA – Prior Authorization

QL – Quantity Limit

ST – Step Therapy

AGE – Age Requirement

SP – Specialty Medication

HD – May require home delivery pharmacy

PPACA – No Cost-Share Preventive Medication

CSL – Oral cancer medication subject to cost-share limits

# List of Prescription Medications

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

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>HEPARIN AND RELATED PREPARATIONS (cont.)</b>		
<i>heparin sod, pork in 0.45% nacl</i>	T1	
<i>heparin sodium, porcine</i>	T1	
<i>heparin sodium, porcine/pf</i>	T1	
HEPARIN SODIUM-0.45% NACL	T1	
LOVENOX 100 MG/ML SYRINGE ( <i>enoxaparin sodium</i> )	T3	QL (2 syringes/day) SP
LOVENOX 120 MG/0.8 ML SYRINGE ( <i>enoxaparin sodium</i> )	T3	QL (2 syringes/day) SP
LOVENOX 150 MG/ML SYRINGE ( <i>enoxaparin sodium</i> )	T3	QL (2 syringes/day) SP
LOVENOX 30 MG/0.3 ML SYRINGE ( <i>enoxaparin sodium</i> )	T3	QL (2 syringes/day) SP
LOVENOX 300 MG/3 ML VIAL ( <i>enoxaparin sodium</i> )	T2	QL (1 vial/day) SP
LOVENOX 40 MG/0.4 ML SYRINGE ( <i>enoxaparin sodium</i> )	T3	QL (2 syringes/day) SP
LOVENOX 60 MG/0.6 ML SYRINGE ( <i>enoxaparin sodium</i> )	T3	QL (2 syringes/day) SP
LOVENOX 80 MG/0.8 ML SYRINGE ( <i>enoxaparin sodium</i> )	T3	QL (2 syringes/day) SP

## THROMBIN INHIBITORS, SELECTIVE, DIRECT, REVERSIBLE

ARGATROBAN	T1	SP HD
ARGATROBAN 250MG/2.5ML VIAL	T3	SP
ARGATROBAN-0.9% NACL	T1	SP HD
ARGATROBAN-SODIUM CHLORIDE	T1	HD
<i>dabigatran etexilate mesylate</i>	T1	PA HD
PRADAXA	T3	PA HD

## THROMBIN INHIBITORS, SEL, DIRECT, REVERS-HIRUDIN TYPE

ANGIOMAX ( <i>bivalirudin</i> )	T3	
BIVALIRUDIN 250 MG ADD-VANT VL	T1	
<i>bivalirudin 250 mg vial (Angiomax)</i>	T1	
BIVALIRUDIN RTU 250 MG/50 ML	T3	
BIVALIRUDIN-0.9% NACL	T1	

## ANTIDOTES (Gastrointestinal/Heartburn)

### MU-OPIOID RECEPTOR ANTAGONISTS, PERIPHERALLY-ACTING

MOVANTIK	T3	PA
RELISTOR	T3	PA
SYMPROIC	T3	PA

## ANTIDOTES (Substance Abuse)

### OPIOID ANTAGONISTS

KLOXXADO	T2	PA QL (2 sprays/30 days)
----------	----	--------------------------

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

T4 – Specialty Medications

PA – Prior Authorization

QL – Quantity Limit

ST – Step Therapy

AGE – Age Requirement

SP – Specialty Medication

HD – May require home delivery pharmacy

PPACA – No Cost-Share Preventive Medication

CSL – Oral cancer medication subject to cost-share limits

## List of Prescription Medications

### ANTIDOTES (Substance Abuse) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>OPIOID ANTAGONISTS (cont.)</b>		
<i>naloxone 0.4 mg/ml carpject</i>	T1	
<i>naloxone 0.4 mg/ml vial</i>	T1	
NALOXONE 2 MG AUTO-INJECTOR	T3	QL (0.8ml/day)
<i>naloxone 2 mg/2 ml syringe</i>	T1	
<i>naloxone 4 mg/10 ml vial</i>	T1	
<i>naltrexone hcl</i>	T1	QL (180 tabs/30 days)
NARCAN	T2	QL (2 units/30 days)
OPVEE	T2	QL (2 units/30 days)
ZIMHI	T3	QL (2 inj/month)

### ANTIFUNGALS (Eye Conditions)

#### OPHTHALMIC ANTIFUNGAL AGENTS

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

### ANTIFUNGALS (Feminine Products)

#### VAGINAL ANTIFUNGALS

GYNAZOLE 1	T1	
<i>miconazole nitrate</i>	T1	
<i>terconazole</i>	T1	

### ANTIFUNGALS (Infections)

#### ANTIFUNGAL AGENTS

ANCOBON ( <i>flucytosine</i> )	T3	
<i>clotrimazole</i>	T1	
CRESEMBA 74.5 MG CAPSULE	T3	PA
CRESEMBA 186 MG CAPSULE	T3	PA
CRESEMBA 372 MG VIAL	T3	
<i>fluconazole</i>	T1	
<i>fluconazole in dextrose, iso-os</i>	T1	
<i>flucytosine (Ancobon)</i>	T1	
<i>itraconazole</i>	T1	
<i>ketoconazole</i>	T1	
ORAVIG	T3	
<i>posaconazole (Noxafil)</i>	T1	
<i>terbinafine hcl</i>	T1	
VFEND ( <i>voriconazole</i> )	T3	PA

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

T4 – Specialty Medications  
 PA – Prior Authorization  
 QL – Quantity Limit

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

HD – 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
<b>ANTIFUNGAL AGENTS (cont.)</b>		
VFEND IV ( <i>voriconazole</i> )	T3	
VIVJOA	T3	PA
<i>voriconazole 200 mg tablet</i> (Vfend)	T1	PA
<i>voriconazole 200 mg vial</i> (Vfend IV)	T1	
<i>voriconazole 40 mg/ml susp</i> (Vfend)	T1	PA
<i>voriconazole 50 mg tablet</i> (Vfend)	T1	PA
<b>ANTIFUNGAL ANTIBIOTICS</b>		
ABELCET	T3	
AMBISOME	T3	
<i>amphotericin b</i>	T1	
CANCIDAS ( <i>caspofungin acetate</i> )	T3	
<i>caspofungin acetate</i> (Cancidas)	T1	
ERAXIS	T3	
<i>griseofulvin ultramicrosize</i> (Gris-peg)	T1	
<i>griseofulvin, microsize</i>	T1	
GRIS-PEG ( <i>griseofulvin ultramicrosize</i> )	T3	
<i>micafungin sodium</i> (Mycamine)	T1	
MYCAMINE ( <i>micafungin</i> )	T3	
<i>nystatin</i>	T1	
<b>ANTIFUNGALS (Skin Conditions)</b>		
<b>TOPICAL ANTIFUNGAL/ANTI-INFLAMMATORY, STEROID AGENT</b>		
<i>clotrimazole/betamethasone dip</i>	T1	
<b>TOPICAL ANTIFUNGALS</b>		
<i>ciclodan 0.77% cream</i>	T1	
CICLODAN 0.77% CREAM KIT	T3	
<i>ciclodan 8% solution</i>	T1	
<i>ciclopirox</i>	T1	
<i>ciclopirox olamine</i>	T1	
<i>ciclopirox olamine</i> (Loprox)	T1	
<i>econazole nitrate</i>	T1	
ECOZA	T3	
EXODERM	T1	

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

T4 – Specialty Medications  
 PA – Prior Authorization  
 QL – Quantity Limit

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

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

# List of Prescription Medications

ANTIFUNGALS (Skin Conditions) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>TOPICAL ANTIFUNGALS (cont.)</b>		
<i>ketoconazole</i>	T1	
<i>ketoconazole/skin cleanser 28</i>	T1	
LOPROX ( <i>ciclopirox</i> )	T3	
LULICONAZOLE	T1	
<i>naftifine hcl</i>	T1	
<i>naftifine hcl</i> (Naftin)	T1	
NAFTIN ( <i>naftifine hcl</i> )	T3	
<i>nystatin</i>	T1	
<i>nystatin/triamcinolone acet</i>	T1	
ANTI-HISTAMINE AND DECONGESTANT COMBINATION (Allergy/Nasal Sprays)		
<b>1ST GEN ANTI-HISTAMINE AND DECONGESTANT COMBINATION</b>		
<i>phenylephrine hcl/prometh hcl</i>	T1	
<b>2ND GEN ANTI-HISTAMINE AND DECONGESTANT COMBINATION</b>		
CLARINEX-D 12 HOUR	T3	
ANTI-HISTAMINES (Allergy/Nasal Sprays)		
<b>ANTI-HISTAMINES - 1ST GENERATION</b>		
<i>carbinoxamine maleate</i>	T1	
<i>clemastine fumarate</i>	T1	
<i>cyproheptadine hcl</i>	T1	
<i>cyproheptadine hcl</i> (Cyproheptadine Hcl)	T1	
<i>diphenhydramine hcl</i>	T1	
<i>hydroxyzine hcl</i>	T1	
<i>hydroxyzine pamoate</i>	T1	
<i>hydroxyzine pamoate</i> (Vistaril)	T1	
PHENERGAN ( <i>promethazine hcl</i> )	T3	
<i>promethazine hcl</i>	T1	
<i>promethazine hcl</i> (Phenergan)	T1	
VISTARIL ( <i>hydroxyzine pamoate</i> )	T3	
<b>ANTI-HISTAMINES - 2ND GENERATION</b>		
<i>cetirizine hcl</i>	T1	HD
<i>desloratadine 2.5 mg odt</i>	T1	QL (1 tab/day) HD
<i>desloratadine 5 mg odt</i>	T1	HD

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

T4 – Specialty Medications  
 PA – Prior Authorization  
 QL – Quantity Limit

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

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

# List of Prescription Medications

## ANTI-HISTAMINES (Allergy/Nasal Sprays) (cont.)

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

### ANTI-HISTAMINES - 2ND GENERATION (cont.)

<i>desloratadine 5 mg tablet</i>	T1	HD
<i>levocetirizine dihydrochloride</i>	T1	HD

## ANTI-HISTAMINES (Eye Conditions)

### EYE ANTI-HISTAMINES

<i>azelastine hcl 0.05% drops</i>	T1	
<i>bepotastine besilate</i>	T1	
<i>epinastine hcl</i>	T1	
<i>olopatadine hcl 0.1% eye drops</i>	T1	
<i>olopatadine hcl 0.2% eye drop</i>	T1	

## ANTI-HYPERGLYCEMICS (Diabetes)

### ANTI-HYPERGLY, INCRETIN MIMETIC (GLP-1 RECEPTOR AGONIST)

BYDUREON	T2	QL (4 vials/28 days) ST HD
BYDUREON BCISE	T2	QL (4 pens/28 days) ST HD
BYDUREON PEN	T2	QL (4 pens/28 days) ST HD
BYETTA	T2	QL (1 pen/30 days) ST HD
OZEMPIC 0.25-0.5 MG DOSE PEN	T2	QL (2 pens/28 days) ST HD
OZEMPIC 1 MG DOSE PEN (1.5 ML)	T2	QL (2 pens/28 days) ST HD
OZEMPIC 1 MG DOSE PEN (3 ML)	T2	QL (3ml/21 days) ST HD
REZVOGLAR KWIKPEN	T2	QL
RYBELSUS	T2	QL (1 tab/day) ST HD
TRULICITY 0.75 MG/0.5 ML PEN	T2	QL (4 pens/28 days) ST HD
TRULICITY 1.5 MG/0.5 ML PEN	T2	QL (4 pens/28 days) ST HD
TRULICITY 3 MG/0.5 ML PEN	T2	QL (2 ml/28 days) ST HD
TRULICITY 4.5 MG/0.5 ML PEN	T2	QL (2 ml/28 days) ST HD

### ANTI-HYPERGLY, INSULIN, LONG ACT-GLP-1 RECEPTOR AGONIST

SOLIQUA 100-33	T2	HD
----------------	----	----

### ANTI-HYPERGLYCEMIC-SOD/GLUC COTRANSPORT2 (SGLT2) INHIB

FARXIGA	T2	QL (1 tab/day) ST HD
JARDIANCE	T2	QL (1 tab/day) ST HD

### ANTI-HYPERGLYCEMIC - DOPAMINE RECEPTOR AGONISTS

CYCLOSET	T3	HD
----------	----	----

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

T4 – Specialty Medications  
 PA – Prior Authorization  
 QL – Quantity Limit

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

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



# List of Prescription Medications

## ANTIHYPERGLYCEMICS (Diabetes) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>ANTIHYPERGLYCEMIC, ALPHA-GLUCOSIDASE INHIBITORS</b>		
<i>acarbose</i> (Precose)	T1	HD
GLYSET ( <i>miglitol</i> )	T3	HD
<i>miglitol</i> (Glyset)	T1	HD
PRECOSE ( <i>acarbose</i> )	T3	HD
<b>ANTIHYPERGLYCEMIC, AMYLIN ANALOG-TYPE</b>		
SYMLINPEN 120	T2	HD
SYMLINPEN 60	T2	HD
<b>ANTIHYPERGLYCEMIC, BIGUANIDE TYPE</b>		
GLUCOPHAGE XR ( <i>metformin hcl er</i> )	T3	HD
<i>metformin hcl</i>	T1	HD
<i>metformin hcl</i> (Glucophage Xr)	T1	HD
<i>metformin hcl</i> (Riomet)	T1	HD
RIOMET ( <i>metformin hcl</i> )	T3	HD
RIOMET ER	T3	HD
<b>ANTIHYPERGLYCEMIC, DPP-4 INHIBITORS</b>		
JANUVIA	T2	QL (1 tab/day) ST HD
<b>ANTIHYPERGLYCEMIC, INSULIN-RELEASE STIMULANT TYPE</b>		
AMARYL ( <i>glimepiride</i> )	T3	HD
<i>chlorpropamide</i>	T1	HD
<i>glimepiride</i> (Amaryl)	T1	HD
<i>glipizide</i> (Glucotrol XI)	T1	HD
<i>glipizide</i> (Glucotrol)	T1	HD
GLIPIZIDE 2.5 MG TABLET	T3	HD
GLUCOTROL ( <i>glipizide</i> )	T3	HD
GLUCOTROL XL ( <i>glipizide xl</i> )	T3	HD
<i>glyburide</i>	T1	HD
<i>glyburide, micronized</i> (Glynase)	T1	HD
GLYNASE ( <i>glyburide micronized</i> )	T3	HD
<i>repaglinide</i>	T1	HD
STARLIX ( <i>nateglinide</i> )	T3	HD
<i>tolbutamide</i>	T1	HD
<b>ANTIHYPERGLYCEMIC, SGLT-2 AND DPP-4 INHIBITOR COMB</b>		
GLYXAMBI	T2	QL (1 tab/day) ST HD

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

T4 – Specialty Medications  
 PA – Prior Authorization  
 QL – Quantity Limit

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

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

## List of Prescription Medications

ANTIHYPERGLYCEMICS (Diabetes) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>ANTIHYPERGLYCEMIC, THIAZOLIDINEDIONE AND BIGUANIDE</b>		
ACTOPLUS MET ( <i>pioglitazone-metformin</i> )	T3	HD
<i>pioglitazone hcl/metformin hcl</i> (Actoplus Met)	T1	HD
<b>ANTIHYPERGLYCEMIC, THIAZOLIDINEDIONE-SULFONYLUREA</b>		
DUETACT ( <i>pioglitazone-glimepiride</i> )	T3	HD
<i>pioglitazone hcl/glimepiride</i> (Duetact)	T1	HD
<b>ANTIHYPERGLYCEMIC, DPP-4 INHIBITOR-BIGUANIDE COMBS.</b>		
JANUMET	T2	QL (2 tabs/day) ST HD
JANUMET XR 100-1,000 MG TABLET	T2	QL (1 tab/day) ST HD
JANUMET XR 50-1,000 MG TABLET	T2	QL (2 tabs/day) ST HD
JANUMET XR 50-500 MG TABLET	T2	QL (1 tab/day) ST HD
<b>ANTIHYPERGLYCEMIC, INSULIN-RELEASE STIM.-BIGUANIDE</b>		
<i>glipizide/metformin hcl</i>	T1	HD
<i>glyburide/metformin hcl</i>	T1	HD
<i>repaglinide/metformin hcl</i>	T1	HD
<b>ANTIHYPERGLYCEMIC, THIAZOLIDINEDIONE (PPARG AGONIST)</b>		
ACTOS ( <i>pioglitazone hcl</i> )	T3	HD
AVANDIA	T3	HD
<i>pioglitazone hcl</i> (Actos)	T1	HD
<b>ANTIHYPERGLYCEMIC-SGLT2 INHIBITOR-BIGUANIDE COMBS.</b>		
SYNJARDY	T2	QL (2 tabs/day) ST HD
SYNJARDY XR 10-1,000 MG TABLET	T2	QL (2 tabs/day) ST HD
SYNJARDY XR 12.5-1,000 MG TAB	T2	QL (2 tabs/day) ST HD
SYNJARDY XR 25-1,000 MG TABLET	T2	QL (1 tab/day) ST HD
SYNJARDY XR 5-1,000 MG TABLET	T2	QL (2 tabs/day) ST HD
XIGDUO XR 10 MG-1,000 MG TAB	T2	QL (1 tab/day) ST HD
XIGDUO XR 10 MG-500 MG TABLET	T2	QL (1 tab/day) ST HD
XIGDUO XR 2.5 MG-1,000 MG TAB	T2	QL (2 tabs/day) ST HD
XIGDUO XR 5 MG-1,000 MG TABLET	T2	QL (2 tabs/day) ST HD
XIGDUO XR 5 MG-500 MG TABLET	T2	QL (1 tab/day) ST HD
<b>ANTIHYPERGLY-SGLT-2 INHIB, DPP-4 INHIB, BIGUANIDE CB</b>		
TRIJARDY XR	T2	QL (1 tab/day) ST HD

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

T4 – Specialty Medications  
 PA – Prior Authorization  
 QL – Quantity Limit

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

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

## List of Prescription Medications

### ANTIHYPERGLYCEMICS (Diabetes) (cont.)

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

#### INSULINS

BASAGLAR KWIKPEN U-100	T2	QL (1.5ml/day) HD
FIASP PENFILL	T3	QL (1.5ml/day) HD
HUMALOG 100 UNIT/ML CARTRIDGE	T2	QL(1.5 mls/day) HD
HUMALOG KWIKPEN U-200	T2	QL (1ml/day )HD
HUMALOG MIX 50-50	T2	QL (2ml/day) HD
HUMALOG MIX 50-50 KWIKPEN	T2	QL (2ml/day) HD
HUMALOG MIX 75-25	T2	QL (2ml/day) HD
HUMALOG MIX 75-25 KWIKPEN	T2	QL (2ml/day) HD
HUMULIN R U-500	T2	QL (1ml/day )HD
HUMULIN R U-500 KWIKPEN	T2	QL (1ml/day )HD
LYUMJEV	T2	QL (1.5ml/day) HD
LYUMJEV KWIKPEN U-100	T2	QL (1.5ml/day) HD
LYUMJEV KWIKPEN U-200	T2	QL (1ml/day )HD
TRESIBA	T2	QL (1.5ml/day) HD
TRESIBA FLEXTOUCH U-100	T2	QL (1.5ml/day) HD
TRESIBA FLEXTOUCH U-200	T2	QL (0.9ml/day) HD

### ANTIINFECTIVES (Feminine Products)

#### VAGINAL SULFONAMIDES

AVC	T3	
-----	----	--

### ANTIINFECTIVES (INFECTIONS)

#### PENICILLIN ANTIBIOTICS

<i>amoxicillin</i>	T1	
<i>ampicillin sodium</i>	T1	
<i>nafcillin sodium</i>	T1	

### ANTIINFECTIVES/MISCELLANEOUS (Feminine Products)

#### VAGINAL ANTISEPTICS

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

### ANTIINFECTIVES/MISCELLANEOUS (Infections)

#### 2ND GEN. ANAEROBIC ANTIPROTOZOAL-ANTIBACTERIAL

TINDAMAX ( <i>tinidazole</i> )	T3	
<i>tinidazole</i> (Tindamax)	T1	

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

T4 – Specialty Medications  
 PA – Prior Authorization  
 QL – Quantity Limit

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

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

## List of Prescription Medications

### ANTIINFECTIVES/MISCELLANEOUS (Infections) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>AMEBICIDES</b>		
<i>paromomycin sulfate</i>	T1	
<b>ANTHELMINTICS</b>		
<i>albendazole</i> (Albenza)	T1	
ALBENZA ( <i>albendazole</i> )	T3	
BILTRICIDE ( <i>praziquantel</i> )	T3	
EMVERM	T1	
<i>ivermectin</i> (Stromectol)	T1	PA
<i>praziquantel</i> (Biltricide)	T1	
STROMECTOL ( <i>ivermectin</i> )	T3	PA
<b>ANTIMALARIAL DRUGS</b>		
<i>atovaquone/proguanil hcl</i> (Malarone)	T1	
<i>chloroquine ph 250 mg tablet</i>	T1	QL (56 Tabs/365 Days)
<i>chloroquine ph 500 mg tablet</i>	T1	
COARTEM	T3	PA QL (24 tabs/30 days)
DARAPRIM ( <i>pyrimethamine</i> )	T4	PA SP
<i>hydroxychloroquine sulfate</i> (Plaquenil)	T1	
<i>hydroxychloroquine sulfate</i> (Sovuna)	T1	
KRINTAFEL	T3	PA QL (2 tabs/30 days)
MALARONE ( <i>atovaquone-proguanil hcl</i> )	T3	PA
<i>mefloquine hcl</i>	T1	
PLAQUENIL ( <i>hydroxychloroquine sulfate</i> )	T3	
PRIMAQUINE ( <i>primaquine phosphate</i> )	T1	
<i>primaquine phosphate</i> (Primaquine)	T1	
<i>pyrimethamine 25 mg tablet</i> (Daraprim)	T1	PA
<i>pyrimethamine 25 mg tablet</i> (Daraprim)	T4	PA SP
QUALAQUIN ( <i>quinine sulfate</i> )	T3	PA
<i>quinine sulfate</i> (Qulaquin)	T1	
SOVUNA 200 MG TABLET ( <i>hydroxychloroquine sulfate</i> )	T3	PA
<b>ANTIPROTOZOAL DRUGS, MISCELLANEOUS</b>		
<i>atovaquone</i>	T1	
BENZNIDAZOLE	T3	
IMPAVIDO	T3	PA
LAMPIT	T3	
NEBUPENT ( <i>pentamidine isethionate</i> )	T3	
PENTAM 300 ( <i>pentamidine isethionate</i> )	T3	

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

T4 – Specialty Medications

PA – Prior Authorization

QL – Quantity Limit

ST – Step Therapy

AGE – Age Requirement

SP – Specialty Medication

HD – May require home delivery pharmacy

PPACA – No Cost-Share Preventive Medication

CSL – Oral cancer medication subject to cost-share limits

## List of Prescription Medications

ANTIINFECTIVES/MISCELLANEOUS (Miscellaneous)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>ANTIPROTOZOAL DRUGS, MISCELLANEOUS (con't.)</b>		
<i>pentamidine isethionate</i> (Nebupent)	T1	
<i>pentamidine isethionate</i> (Pentam 300)	T1	
<b>ANTIBACTERIAL AGENTS, MISCELLANEOUS</b>		
<i>glycine urologic solution</i>	T1	
<i>glycine urologic solution</i>	T3	
<b>TOPICAL ANTISEPTIC DRYING AGENTS</b>		
<i>formaldehyde</i>	T1	
ANTIINFECTIVES/MISCELLANEOUS (SKIN CONDITIONS)		
<b>TOPICAL ANTIFUNGALS</b>		
CICLODAN 8% KIT	T3	
<i>ciclopirox/urea/camph/men/euc</i> (Ciclodan)	T1	
ANTIINFLAM.TUMOR NECROSIS FACTOR INHIBITING AGENTS (Pain Relief And Inflammatory Disease)		
<b>ANTI-INFLAMMATORY TUMOR NECROSIS FACTOR INHIBITOR</b>		
ADALIMUMAB-ADAZ	T4	PA QL (2 doses/28 days) SP
ADALIMUMAB-ADB(M)CF) PEN CROHNS	T4	PA QL(1 starter kit/365 days) SP HD
ADALIMUMAB-ADB(M)CF)PEN	T4	PA QL(2 pens/syringes/28 days) SP HD
AMJEVITA(CF)	T4	PA QL(2 syringes/28 days) SP HD
AMJEVITA(CF) AUTOINJECTOR	T4	PA QL(2 auto-injs/28 days) SP HD
AVSOLA	T4	PA SP
CIMZIA 200 MG VIAL KIT	T4	PA QL (1 kit/28 days) SP HD
CIMZIA 2X200 MG/ML SYRINGE KIT	T4	PA QL (1 kit/28 days) SP HD
CIMZIA 2X200 MG/ML (X3) START KT	T4	PA QL (1 kit/year) SP HD
CYLTEZO(CF) PEN PSORIASIS-UV	T4	PA QL(1 starter kit/365 days) SP
ENBREL 25 MG KIT	T4	PA QL (8 vials/28 days) SP HD
ENBREL 25 MG/0.5 ML SYRINGE	T4	PA QL (8 syringes/28 days) SP HD
ENBREL 25 MG/0.5 ML VIAL	T4	PA QL (4ml/28 days) SP HD
ENBREL 50 MG/ML SYRINGE	T4	PA QL (4 syringes/28 days) SP HD
ENBREL MINI	T4	PA QL (4 cartridges/28 days) SP HD
ENBREL SURECLICK	T4	PA QL (4 syringes/28 days) SP HD
HADLIMA	T4	PA QL (2 doses/28 days) SP
HADLIMA (CF-citrate free)	T4	PA QL (2 doses/28 days) SP
HUMIRA	T4	PA QL (2 syringes/28 days) SP HD
HUMIRA PEN	T4	PA QL (2 pens/28 days) SP HD
HUMIRA PEN CROHN'S-UC-HS	T4	PA QL (1 kit/year) SP HD
HUMIRA PEN PSOR-UEVITS-ADOL HS	T4	PA QL (1 kit/year) SP HD

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

T4 – Specialty Medications  
PA – Prior Authorization  
QL – Quantity Limit

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

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

## List of Prescription Medications

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

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>ANTI-INFLAMMATORY TUMOR NECROSIS FACTOR INHIBITOR (cont.)</b>		
HUMIRA (CF)	T4	PA QL (2 syring/28 days) SP HD
HUMIRA (CF) PEDIATRIC CROHN'S	T4	PA QL (1 kit/year) SP HD
HUMIRA (CF) PEN 40 MG/0.4 ML	T4	PA QL (2 pens/28 days) SP HD
HUMIRA (CF) PEN 80 MG/0.8 ML	T4	PA QL (1 kit/year) SP HD
HUMIRA (CF) PEN CROHN'S-UC-HS	T4	PA QL (1 kit/year) SP HD
HUMIRA (CF) PEN PEDIATRIC UC	T4	PA QL (4 KITS/365 DAYS) SP HD
HUMIRA (CF) PEN PSOR-UV-ADOL HS	T4	PA QL (1 kit/year) SP HD
HYRIMOZ / HYRIMOZ PEN	T4	PA SP
HYRIMOZ(CF)	T4	PA QL (2 syringe/28 days) SP HD
HYRIMOZ(CF) PEN	T4	PA QL (2 pens/28 days) SP HD
IBRANCE	T4	PA QL SP
INFLECTRA	T4	PA SP HD
RENFLEXIS	T4	PA SP HD
SIMPONI 100 MG/ML PEN INJECTOR	T4	PA QL (1 injector/28 days) SP HD
SIMPONI 100 MG/ML SYRINGE	T4	PA QL (1 syringe/28 days) SP HD
SIMPONI ARIA	T4	PA SP HD

### ANTINEOPLASTICS (Cancer)

#### ANP - SELECTIVE RETINOID X RECEPTOR AGONISTS (RXR)

<i>bexarotene (Targretin)</i>	T4	PA SP HD
-------------------------------	----	----------

#### ANTIBIOTIC ANTINEOPLASTICS

<i>adriamycin 10 mg vial</i>	T4	PA SP
<i>adriamycin 10 mg/5 ml vial</i>	T4	PA SP
<i>adriamycin 20 mg/10 ml vial</i>	T4	PA SP
ADRIAMYCIN ( <i>doxorubicin hcl</i> )	T4	PA SP
<i>bleomycin sulfate</i>	T4	PA SP
COSMEGEN	T4	PA SP
<i>dactinomycin (Cosmegen)</i>	T4	PA SP
<i>daunorubicin hcl</i>	T4	PA SP
DOXIL ( <i>lipodox 50</i> )	T4	PA SP
<i>doxorubicin hcl</i>	T4	PA SP
<i>doxorubicin hcl (Adriamycin)</i>	T4	PA SP
<i>doxorubicin hcl peg-liposomal (Doxil)</i>	T4	PA SP
ELLENCÉ	T4	PA SP
ELLENCÉ ( <i>epirubicin hcl</i> )	T4	PA SP

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

T4 – Specialty Medications  
 PA – Prior Authorization  
 QL – Quantity Limit

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

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

## List of Prescription Medications

<b>ANTINEOPLASTICS (Cancer) (cont.)</b>			
<b>Prescription Drug Name</b>	<b>Drug Tier</b>	<b>Coverage Requirements and Limits</b>	
<b>ANTIBIOTIC ANTINEOPLASTICS (cont.)</b>			
<i>epirubicin 200 mg/100 ml vial</i> (Elevance)	T4	PA SP	
<i>epirubicin 50 mg/25 ml vial</i> (Elevance)	T4	PA SP	
<i>epirubicin hcl 200 mg vial</i>	T4	SP	
IDAMYCIN PFS ( <i>idarubicin hcl</i> )	T4	PA SP	
<i>idarubicin hcl</i> (Idamycin Pfs)	T4	PA SP	
<i>mitomycin</i> (Mutamycin)	T4	PA SP	
MUTAMYCIN ( <i>mitomycin</i> )	T4	PA SP	
<i>valrubicin</i> (Valstar)	T4	SP	
VALSTAR ( <i>valrubicin</i> )	T4	SP	
ZANOSAR	T4	PA SP	
<b>ANTINEOPLASTICS ANTIBODY/ANTIBODY-DRUG COMPLEXES</b>			
LUNSUMIO	T4	PA SP	
<b>ANTINEOPLASTIC, ANTI-PROGRAMMED DEATH-1 (PD-1) MAB</b>			
ZYNYZ	T4	PA SP	
<b>ANTI-CD20 (B LYMPHOCYTE) MONOCLONAL ANTIBODY</b>			
GAZYVA	T4	PA SP	
RIABNI	T4	PA SP	
RITUXAN	T4	PA SP	
RITUXAN HYCELA	T4	PA SP	
RUXIENCE	T4	PA SP	
TRUXIMA	T4	PA SP	
<b>ANTINEOPLAST HUM VEGF INHIBITOR RECOMB MC ANTIBODY</b>			
AVASTIN	T4	PA SP	
MVASI	T4	PA SP	
VEGZELMA	T4	PA SP	
ZIRABEV	T4	PA SP	
<b>ANTINEOPLAST, HISTONE DEACETYLASE (HDAC) INHIBITORS</b>			
BELEODAQ	T4	PA SP	
FARYDAK	T4	PA SP HD	
ISTODAX	T4	PA SP	
ROMIDEPSIN 10 MG KIT	T4	PA SP	
ROMIDEPSIN 27.5 MG/5.5 ML VIAL	T4	PA SP	
ZOLINZA	T4	PA SP HD	
<b>ANTINEOPLASTIC - ALKYLATING AGENTS</b>			
ALKERAN 2 MG TABLET ( <i>melphalan</i> )	T4	SP	

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

T4 – Specialty Medications  
PA – Prior Authorization  
QL – Quantity Limit

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

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

## List of Prescription Medications

ANTINEOPLASTICS (Cancer) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>ANTINEOPLASTIC - ALKYLATING AGENTS (cont.)</b>		
ALKERAN 50 MG VIAL ( <i>melphalan hcl</i> )	T4	PA SP
BELRAPZO	T4	PA SP HD
<i>bendamustine 100 mg vial</i>	T4	PA SP
<i>bendamustine 25 mg vial</i>	T4	PA SP
BENDEKA	T4	PA SP HD
BICNU ( <i>carmustine</i> )	T4	SP
<i>busulfan</i> (Busulfex)	T4	SP
<i>carboplatin</i>	T4	PA SP
<i>carmustine</i> (Bicnu)	T4	SP
CISPLATIN 50MG VIAL	T4	PA SP
<i>cisplatin vial</i>	T4	PA QL(2 pens/28 days) SP HD
<i>cyclophosphamide 1 gm vial</i>	T4	SP
CYCLOPHOSPHAMIDE 1 GM/5 ML VL	T4	SP
<i>cyclophosphamide 2 gm vial</i>	T4	SP
<i>cyclophosphamide 25 mg capsule</i>	T4	SP HD
<i>cyclophosphamide 50 mg capsule</i>	T4	SP HD
<i>cyclophosphamide 500 mg vial</i>	T4	SP
CYCLOPHOSPHAMIDE 500 MG/2.5 ML	T4	SP
EVOMELA	T4	PA SP
GLEOSTINE	T2	
GLIADEL	T4	SP
HYDREA ( <i>hydroxyurea</i> )	T3	
<i>hydroxyurea</i> (Hydrea)	T1	
IFEX ( <i>ifosfamide</i> )	T4	PA SP
<i>ifosfamide</i>	T4	PA SP
<i>ifosfamide</i> (Ifex)	T4	PA SP
LEUKERAN	T2	
<i>melphalan</i> (Alkeran)	T4	SP
<i>melphalan hcl</i> (Alkeran)	T4	PA SP
MYLERAN	T2	
<i>oxaliplatin</i>	T4	PA SP
PEPAXTO	T4	PA SP
TEMODAR 100 MG CAPSULE ( <i>temozolomide</i> )	T4	PA SP HD

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

T4 – Specialty Medications

PA – Prior Authorization

QL – Quantity Limit

ST – Step Therapy

AGE – Age Requirement

SP – Specialty Medication

HD – May require home delivery pharmacy

PPACA – No Cost-Share Preventive Medication

CSL – Oral cancer medication subject to cost-share limits



## List of Prescription Medications

ANTINEOPLASTICS (Cancer) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>ANTINEOPLASTIC - ALKYLATING AGENTS (cont.)</b>		
TEMODAR 100 MG VIAL	T4	PA SP
TEMODAR 140 MG CAPSULE ( <i>temozolomide</i> )	T4	PA SP HD
TEMODAR 180 MG CAPSULE ( <i>temozolomide</i> )	T4	PA SP HD
TEMODAR 20 MG CAPSULE ( <i>temozolomide</i> )	T4	PA SP HD
<i>temozolomide</i>	T4	PA SP HD CSL
<i>temozolomide</i> (Temodar)	T4	PA SP HD
TEPADINA	T4	PA SP
TEPADINA ( <i>thiotepa</i> )	T4	PA SP
<i>thiotepa</i> (Tepadina)	T4	PA SP
TREANDA	T4	PA SP
YONDELIS	T4	PA SP
ZEPZELCA	T4	PA SP
<b>ANTINEOPLASTIC - ANTIANDROGENIC AGENTS</b>		
<i>abiraterone 500 mg tablet</i>	T4	SP HD
<i>abiraterone acetate 250 mg tab</i>	T4	PA SP HD
<i>abiraterone acetate 500 mg tab (Zytiga)</i>	T4	SP HD CSL
<i>bicalutamide</i> (Casodex)	T1	
CASODEX ( <i>bicalutamide</i> )	T3	
ERLEADA 240 MG TABLET	T4	PA QL(1 tab/day) SP HD CSL
ERLEADA 60 MG TABLET	T4	PA SP HD CSL
<i>flutamide</i>	T1	
<i>nilutamide</i>	T1	QL (4 tabs/day)
NUBEQA	T4	PA SP HD
XTANDI	T4	PA SP HD
<b>ANTINEOPLASTIC - ANTIBIOTIC AND ANTIMETABOLITE</b>		
VYXEOS	T4	PA SP
<b>ANTINEOPLASTIC - ANTI-CD38 MONOCLONAL ANTIBODY</b>		
DARZALEX	T4	PA SP HD
DARZALEX FASPRO	T4	PA SP
SARCLISA	T4	PA SP
<b>ANTINEOPLASTIC - ANTIMETABOLITES</b>		
ALIMTA	T4	PA SP
ARRANON	T4	PA SP
<i>capecitabine</i> (Xeloda)	T4	PA SP HD

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

T4 – Specialty Medications  
PA – Prior Authorization  
QL – Quantity Limit

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

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

## List of Prescription Medications

### ANTINEOPLASTICS (Cancer) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>ANTINEOPLASTIC - ANTIMETABOLITES (cont.)</b>		
<i>cladribine</i>	T4	PA SP
<i>clofarabine</i> (Clolar)	T4	PA SP
CLOLAR ( <i>clofarabine</i> )	T4	PA SP
<i>cytarabine</i>	T4	PA SP
<i>cytarabine/pf</i>	T4	PA SP
DACOGEN ( <i>decitabine</i> )	T4	PA SP
<i>floxuridine</i>	T4	PA SP
<i>fludarabine phosphate</i>	T4	PA SP
<i>fluorouracil</i>	T4	PA SP
<i>fluorouracil 2.5 gm/50 ml btl</i>	T4	PA SP
<i>fluorouracil 2.5 gm/50 ml vial</i>	T4	PA SP
<i>fluorouracil 5 gm/100 ml btl</i>	T4	PA SP
<i>fluorouracil 5 gm/100 ml vial</i>	T4	PA SP
<i>fluorouracil 5,000 mg/100 ml</i>	T4	PA SP
<i>fluorouracil 500 mg/10 ml vial</i>	T4	PA SP
FOLOTYN 20 MG/ML VIAL	T4	PA SP
FOLOTYN 40 MG/2 ML VIAL	T4	PA SP
<i>gemcitabine hcl</i>	T4	PA SP
GEMCITABINE 1GM/10ML VIAL	T4	PA SP
GEMCITABINE 1.5GM/15ML VIAL	T4	PA SP
GEMCITABINE 2GM/20ML VIAL	T4	PA SP
GEMCITABINE 200MG/2ML VIAL	T4	PA SP
INFUGEM	T4	PA SP HD
INQOVI	T4	PA SP HD
JYLAMVO	T3	CSL
LONSURF	T4	PA SP HD
<i>mercaptopurine</i>	T1	
<i>methotrexate sodium</i>	T1	
<i>methotrexate sodium/pf</i>	T1	
NIPENT	T4	PA SP
ONUREG	T4	PA QL (14 Tabs/28 Days) SP
PEMRYDI RTU	T4	PA SP
PURIXAN	T4	SP

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

T4 – Specialty Medications  
 PA – Prior Authorization  
 QL – Quantity Limit

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

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

# List of Prescription Medications

<b>ANTINEOPLASTICS (Cancer) (cont.)</b>		
<b>Prescription Drug Name</b>	<b>Drug Tier</b>	<b>Coverage Requirements and Limits</b>
<b>ANTINEOPLASTIC - ANTIMETABOLITES (cont.)</b>		
TABLOID	T3	
TREXALL	T2	
VIDAZA ( <i>azacitidine</i> )	T4	PA SP
XATMEP	T3	
XELODA ( <i>capecitabine</i> )	T4	PA SP HD
<b>ANTINEOPLASTIC - ANTI-SLAMF7 MONOCLONAL ANTIBODY</b>		
EMPLICITI	T4	PA SP HD
<b>ANTINEOPLASTIC - AROMATASE INHIBITORS</b>		
<i>anastrozole</i> (Arimidex)	T1	HD PPACA
ARIMIDEX ( <i>anastrozole</i> )	T3	HD
AROMASIN ( <i>exemestane</i> )	T3	HD
BRAFTOVI	T4	PA SP HD
<i>exemestane</i> (Aromasin)	T1	HD PPACA
FEMARA ( <i>letrozole</i> )	T3	HD
<i>letrozole</i> (Femara)	T1	HD
TAFINLAR	T4	PA SP HD
ZELBORAF	T4	PA SP HD
<b>ANTI-NEOPLASTIC-ENZYME INHIB, ANTIANDROGEN COMB.</b>		
AKEEGA	T4	PA QL(2 TABS/DAY) SP CSL
<b>ANTINEOPLASTIC - CD19 (B LYMPHOCYTE) MC ANTIBODY</b>		
MONJUVI	T4	PA SP
<b>ANTINEOPLASTIC - EPOTHILONES AND ANALOGS</b>		
IXEMPRA	T4	PA SP
<b>ANTINEOPLASTIC - HEDGEHOG PATHWAY INHIBITOR</b>		
DAURISMO	T4	PA SP HD
ERIVEDGE	T4	PA SP HD
ODOMZO	T4	PA SP HD
<b>ANTINEOPLASTIC - IMMUNOTHERAPY, VIRUS-BASED AGENTS</b>		
IMLYGIC	T4	PA SP
<b>ANTINEOPLASTIC - JANUS KINASE (JAK) INHIBITORS</b>		
JAKAFI	T4	PA SP HD
<b>ANTINEOPLASTIC - KRAS PROTEIN INHIBITOR</b>		
LUMAKRAS 120 MG TABLET	T4	PA QL(8 tabs/day) SP HD CSL
LUMAKRAS 320 MG TABLET	T4	PA QL(3 tabs/day) SP HD CSL

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

T4 – Specialty Medications  
 PA – Prior Authorization  
 QL – Quantity Limit

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

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

## List of Prescription Medications

ANTINEOPLASTICS (Cancer) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>ANTINEOPLASTIC - MEKI AND MEK2 KINASE INHIBITORS</b>		
COTELLIC	T4	PA SP HD
KOSELUGO 10 MG CAPSULE	T4	PA QL (10 capsules/day) SP
KOSELUGO 25 MG CAPSULE	T4	PA QL (4 caps/day) SP
MEKINIST	T4	PA SP HD
MEKTOVI	T4	PA SP HD
<b>ANTINEOPLASTIC - MICROTUBULE INHIBITORS</b>		
HALAVEN	T4	PA SP
AFINITOR	T4	PA SP HD
AFINITOR ( <i>everolimus</i> )	T4	PA SP HD
AFINITOR DISPERZ	T4	PA SP
<i>everolimus 2.5 mg tablet</i> (Afinitor)	T4	PA SP HD
<i>everolimus 5 mg tablet</i> (Afinitor)	T4	PA SP HD
<i>everolimus 7.5 mg tablet</i> (Afinitor)	T4	PA SP HD
<i>temsirolimus</i> (Torisel)	T4	PA SP
TORISEL ( <i>temsirolimus</i> )	T4	PA SP
<b>ANTINEOPLASTIC - MTOR KINASE INHIBITORS</b>		
<i>everolimus 10 mg tablet</i> (Afinitor)	T4	PA QL(1 tab/day) SP HD CSL
<i>everolimus 7.5 mg tablet</i> (Afinitor)	T4	PA QL(1 tab/day) SP HD CSL
<b>ANTINEOPLASTIC - PROTEIN METHYLTRANSFERASE INHIBIT</b>		
TAZVERIK	T4	PA SP
<b>ANTINEOPLASTIC - TOPOISOMERASE I INHIBITORS</b>		
CAMPTOSAR	T4	PA SP
CAMPTOSAR ( <i>irinotecan hcl</i> )	T4	PA SP
HYCAMTIN 0.25 MG CAPSULE	T4	PA SP HD
HYCAMTIN 1 MG CAPSULE	T4	PA SP HD
HYCAMTIN 4 MG VIAL ( <i>topotecan hcl</i> )	T4	PA SP HD
<i>irinotecan hcl</i>	T4	PA SP
<i>irinotecan hcl</i> (Camptosar)	T4	PA SP
ONIVYDE	T4	PA SP
<i>topotecan hcl</i>	T4	PA SP HD
<i>topotecan hcl</i> (Hycamtin)	T4	PA SP HD
<b>ANTINEOPLASTIC - VEGF-A, B AND PLGF INHIBITORS</b>		
ZALTRAP	T4	PA SP
<b>ANTINEOPLASTIC - VEGFR ANTAGONIST</b>		
CYRAMZA	T4	PA SP

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

T4 – Specialty Medications  
 PA – Prior Authorization  
 QL – Quantity Limit

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

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

# List of Prescription Medications

## ANTINEOPLASTICS (Cancer) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>ANTINEOPLASTIC - VINCA ALKALOIDS</b>		
MARQIBO	T4	PA SP
NAVELBINE ( <i>vinorelbine tartrate</i> )	T4	PA SP
<i>vinblastine sulfate</i>	T4	PA SP
<i>vincristine sulfate</i>	T4	PA SP
<i>vinorelbine tartrate</i> (Navelbine)	T4	PA SP
<b>ANTINEOPLASTIC- CD22 ANTIBODY-CYTOTOXIC ANTIBIOTIC</b>		
BESPONSА	T4	PA SP
MYLOTARG	T4	PA SP
<b>ANTINEOPLASTIC COMB - KINASE AND AROMATASE INHIBIT</b>		
KISQALI FEMARA CO-PACK	T4	PA QL (1 pack/28 days) SP HD CSL
<b>ANTINEOPLASTIC EGF RECEPTOR BLOCKER MCLON ANTIBODY</b>		
ERBITUX	T4	PA SP
HERCEPTIN	T4	PA SP
HERCEPTIN HYLECTA	T4	PA SP
HERZUMA	T4	PA SP
KANJINTI	T4	PA SP
MARGENZA	T4	PA SP
OGIVRI	T4	PA SP
ONTRUZANT	T4	PA SP
PERJETA	T4	PA SP
PHESGO	T4	PA SP HD
PORTRAZZA	T4	PA SP
TRAZIMERA	T4	PA SP
VECTIBIX	T4	PA SP
<b>ANTINEOPLASTIC IMMUNOMODULATOR AGENTS</b>		
<i>lenalidomide</i>	T4	PA QL(1 cap/day) SP HD CSL
POMALYST	T4	PA SP HD
REVLIMID	T4	PA QL(1 tab/day) SP HD CSL
<b>ANTINEOPLASTIC LHRH (GNRH) AGONIST, PITUITARY SUPPR.</b>		
ELIGARD	T4	SP HD
<i>leuprolide acetate</i>	T4	PA SP HD
LEUPROLIDE DEPOT	T4	PA SP HD
LUPRON DEPOT	T4	PA SP HD

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

T4 – Specialty Medications  
PA – Prior Authorization  
QL – Quantity Limit

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

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

## List of Prescription Medications

ANTINEOPLASTICS (Cancer) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>ANTINEOPLASTIC LHRH (GNRH) AGONIST, PITUITARY SUPPR. (cont.)</b>		
TRELSTAR	T4	SP HD
ZOLADEX	T4	PA SP HD
FIRMAGON	T4	PA SP HD
ORGOVYX	T4	PA SP
<b>ANTINEOPLASTIC SYSTEMIC ENZYME INHIBITORS</b>		
ALECENSA	T4	PA QL(8 tabs/day) SP HD CSL
ALIQOPA	T4	PA SP
AYVAKIT	T4	PA QL (1 tab/day) SP
BALVERSA	T4	PA SP
BORTEZOMIB	T4	PA SP
BORTEZOMIB 3.5MG IV VIAL	T4	PA SP
BOSULIF	T4	PA SP HD
BRUKINSA	T4	PA QL (4 caps/day) SP
CABOMETYX	T4	PA SP HD
CALQUENCE	T4	PA SP
CAPRELSA	T4	PA SP
COMETRIQ	T4	PA SP HD
COPIKTRA	T4	PA SP
<i>erlotinib hcl</i>	T4	PA SP HD
EXKIVITY	T4	PA SP HD
FOTIVDA	T4	PA QL (30 caps/30 days) SP HD
GAVRETO	T4	PA QL (4 Tabs/Day) SP
<i>gefitinib</i>	T4	PA SP HD CSL
GILOTRIF	T4	PA SP HD
GLEEVEC ( <i>imatinib mesylate</i> )	T4	PA SP HD
IBRANCE	T4	PA QL(21 caps/28 days) SP HD CSL
<i>imatinib mesylate 100 mg tab (Gleevec)</i>	T4	QL(6 tabs/day) SP HD CSL
<i>imatinib mesylate 400 mg tab (Gleevec)</i>	T4	QL(2 tabs/day) SP HD CSL
IMBRUVICA	T4	PA SP
INLYTA	T4	PA SP HD
INREBIC	T4	PA SP HD
IRESSA	T4	PA SP HD
IWILFIN	T4	PA QL(8 tabs/day) SP CSL
KISQALI 600MG	T4	PA QL (63/28days) SP HD CSL

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

T4 – Specialty Medications  
 PA – Prior Authorization  
 QL – Quantity Limit

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

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

## List of Prescription Medications

### ANTINEOPLASTICS (Cancer) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>ANTINEOPLASTIC SYSTEMIC ENZYME INHIBITORS (cont.)</b>		
KISQALI 400MG	T4	PA QL (42/28days) SP HD CSL
KISQALI 200MG	T4	PA QL (21/28days) SP HD CSL
KYPROLIS	T4	PA SP HD
<i>lapatinib ditosylate</i> (Tykerb)	T4	PA SP HD
LENVIMA	T4	PA SP HD
LORBRENA	T4	PA SP HD
LYNPARZA	T4	PA SP HD
LYTGOBI 12 MG DAILY DOSE (3X 4MG TB)	T4	PA QL(3 tabs/day) SP CSL
LYTGOBI 16 MG DAILY DOSE (4X 4MG TB)	T4	PA QL(4 tabs/day) SP CSL
LYTGOBI 20 MG DAILY DOSE (5X 4MG TB)	T4	PA QL(5 tabs/day) SP CSL
NERLYNX	T4	PA SP HD
NEXAVAR	T4	PA SP HD
NINLARO	T4	PA SP HD
OGSIVEO	T4	PA QL(6 tabs/day) SP CSL
OJJAARA	T4	PA QL(1 tab/day) SP CSL
<i>pazopanib</i> (Votrient)	T4	PA QL(4 tabs/day) SP HD CSL
PEMAZYRE	T4	PA QL (14 tabs/21 days) SP
PIQRAY	T4	PA SP HD
QINLOCK	T4	PA QL (3 tabs/day) SP
RETEVMO 40 MG CAPSULE	T4	PA QL (6 caps/day) SP HD
RETEVMO 80 MG CAPSULE	T4	PA QL (4 tabs/day) SP HD
ROZLYTREK	T4	PA SP HD
RUBRACA	T4	PA SP
RYDAPT	T4	PA SP HD
SPRYCEL	T4	PA SP HD
STIVARGA	T4	PA SP HD
TABRECTA	T4	PA QL (4 tabs/day) SP HD
TAGRISSO	T4	PA SP HD
TALZENNA	T4	PA SP HD
TASIGNA	T4	PA SP HD
TEPMETKO	T4	PA QL (2 tabs/day) SP
TRUQAP	T4	PA QL(64 tabs/28 days) SP CSL
TUKYSA	T4	PA SP
TURALIO 125 MG CAPSULE	T4	PA QL(4 caps/day) SP CSL
TURALIO 200 MG CAPSULE	T4	PA SP CSL

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

T4 – Specialty Medications  
 PA – Prior Authorization  
 QL – Quantity Limit

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

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

## List of Prescription Medications

### ANTINEOPLASTICS (Cancer) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>ANTINEOPLASTIC SYSTEMIC ENZYME INHIBITORS (cont.)</b>		
TYKERB ( <i>lapatinib</i> )	T4	PA SP HD
UKONIQ	T4	PA QL (4 tabs/day) SP
VELCADE	T4	PA SP
VERZENIO	T4	PA QL (120mg/day) SP HD
VITRAKVI	T4	PA SP HD
VIZIMPRO	T4	PA SP HD
XALKORI	T4	PA SP HD
XALKORI 150 MG PELLETT	T4	PA QL (4 pellets/day) SP HD CSL
XALKORI 20 MG PELLETT	T4	PA QL (4 pellets/day) SP HD CSL
XALKORI 200 MG CAPSULE	T4	PA QL (4 caps/day) SP HD CSL
XALKORI 250 MG CAPSULE	T4	PA QL (4 caps/day) SP HD CSL
XALKORI 50 MG PELLETT	T4	PA QL (4 pellets/day) SP HD CSL
XOSPATA	T4	PA SP
ZEJULA	T4	PA SP
ZYDELIG	T4	PA SP HD
<b>ANTINEOPLASTIC, ANTI-PROGRAMMED DEATH-1 (PD-1) MAB</b>		
KEYTRUDA	T4	PA SP
LIBTAYO	T4	PA SP
LOQTORZI	T4	PA SP
OPDIVO	T4	PA SP HD
ZYNYZ	T4	PA SP
<b>ANTINEOPLASTIC-B CELL LYMPHOMA-2 (BCL-2) INHIBITORS</b>		
VENCLEXTA	T4	PA SP
VENCLEXTA STARTING PACK	T4	PA SP
<b>ANTINEOPLASTIC-CD22 DIRECT ANTIBODY/CYTOTOXIN CONJ</b>		
LUMOXITI	T4	PA SP
<b>ANTINEOPLASTIC-INTERLEUKIN-6 (IL-6) INHIB, ANTIBODY</b>		
SYLVANT	T4	PA SP
<b>ANTINEOPLASTIC-ISOCITRATE DEHYDROGENASE INHIBITORS</b>		
REZLIDHIA	T4	PA QL(2 caps/day) SP CSL
IDHIFA	T4	PA SP HD
TIBSOVO	T4	PA SP
<b>ANTINEOPLASTIC-ISOCITRATE DEHYDROGENASE INHIBITORS</b>		
ADCETRIS	T4	PA SP
BLENREP	T4	PA

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

T4 – Specialty Medications  
PA – Prior Authorization  
QL – Quantity Limit

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

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



## List of Prescription Medications

ANTINEOPLASTICS (Cancer) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>ANTINEOPLASTIC-ISOCITRATE DEHYDROGENASE INHIBITORS (cont.)</b>		
BLINCYTO	T4	PA SP
ENHERTU	T4	PA SP HD
KADCYLA	T4	PA SP
PADCEV	T4	PA SP
POLIVY	T4	PA SP HD
POTELIGEO	T4	PA SP
TRODELVY	T4	PA SP
UNITUXIN	T4	PA SP
ZEVALIN	T4	PA SP
<b>ANTINEOPLASTICS, MISCELLANEOUS</b>		
ABRAXANE	T4	PA SP
ARSENIC TRIOXIDE	T4	PA SP
<i>arsenic trioxide (Trisenox)</i>	T4	PA SP
ASPARLAS	T4	SP
BCG (TICE STRAIN)	T4	SP
<i>dacarbazine</i>	T4	PA SP
DOCEFREZ	T4	PA SP
<i>docetaxel 160 mg/16 ml vial</i>	T4	PA SP
<i>docetaxel 160 mg/8 ml vial</i>	T4	PA SP HD
<i>docetaxel 20 mg/2 ml vial</i>	T4	PA SP
<i>docetaxel 20 mg/ml vial</i>	T4	PA SP
<i>docetaxel 80 mg/4 ml vial (Taxotere)</i>	T4	PA SP
<i>docetaxel 80 mg/8 ml vial</i>	T4	PA SP
ERWINAZE	T4	PA SP
ETOPOPHOS	T4	PA SP
<i>etoposide</i>	T4	PA SP
<i>etoposide 1,000 mg/50 ml vial</i>	T4	PA SP
<i>etoposide 100 mg/5 ml vial</i>	T4	PA SP
<i>etoposide 50 mg capsule</i>	T4	SP HD
<i>etoposide 500 mg/25 ml vial</i>	T4	PA SP
JEVTANA	T4	PA SP HD
LYSODREN	T4	
MATULANE	T4	SP
<i>mitoxantrone hcl</i>	T4	PA SP
ONCASPAR	T4	PA SP

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

T4 – Specialty Medications  
PA – Prior Authorization  
QL – Quantity Limit

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

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

## List of Prescription Medications

<b>ANTINEOPLASTICS (Cancer) (cont.)</b>		
<b>Prescription Drug Name</b>	<b>Drug Tier</b>	<b>Coverage Requirements and Limits</b>
<b>ANTINEOPLASTICS, MISCELLANEOUS (cont.)</b>		
<i>paclitaxel</i>	T4	PA SP
SYNRIBO	T4	PA SP
TAXOTERE ( <i>docetaxel</i> )	T4	PA SP
TENIPOSIDE 50MG/5ML AMPULE	T4	PA SP
<i>tretinoin 10 mg capsule</i>	T4	PA
TRISENOX ( <i>arsenic trioxide</i> )	T4	PA SP
<b>ANTINEOPLASTIC-SELECT INHIB OF NUCLEAR EXP (SINE)</b>		
XPOVIO	T4	PA SP
<b>ANTI-PROGRAMMED CELL DEATH-LIGAND 1 (PD-L1) MAB</b>		
BAVENCIO	T4	PA SP
IMFINZI	T4	PA SP
TECENTRIQ	T4	PA SP HD
<b>CYTOTOXIC T-LYMPHOCYTE ANTIGEN (CTLA-4) RMC ANTIBODY</b>		
IMJUDO	T4	PA SP HD
YERVOY	T4	PA SP HD
<b>IMMUNOMODULATORS</b>		
ACTIMMUNE	T4	PA SP HD
ALFERON N	T4	PA SP HD
PROLEUKIN	T4	PA SP
<b>PHOTOACTIVATED, ANTINEOPLASTIC AGENTS (SYSTEMIC)</b>		
PHOTOFRIN	T4	SP
UVADEX	T2	
<b>RADIOACTIVE THERAPEUTIC AGENTS</b>		
AZEDRA DOSIMETRIC	T4	PA SP
AZEDRA THERAPEUTIC	T4	PA SP
<b>SELECTIVE ESTROGEN RECEPTOR MODULATORS (SERMS)</b>		
FARESTON ( <i>toremifene citrate</i> )	T3	QL (2 tabs/day) HD
FASLODEX ( <i>fulvestrant</i> )	T4	PA SP HD
<i>fulvestrant (Faslodex)</i>	T4	PA SP HD
SOLTAMOX	T2	HD
<i>tamoxifen citrate</i>	T1	HD PPACA
<i>toremifene citrate (Fareston)</i>	T1	QL (2 tabs/day) HD
<b>STEROID ANTINEOPLASTICS</b>		
EMCYT	T4	SP HD
<i>megestrol acetate</i>	T1	

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

T4 – Specialty Medications  
PA – Prior Authorization  
QL – Quantity Limit

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

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

## List of Prescription Medications

ANTINEOPLASTICS (Skin Conditions)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>PHOTOACT, TOPICAL ANTINEOPLAST, PREMALIGNANT LESIONS</b>		
LEVULAN	T4	SP
<b>TOPICAL ANTINEOPLASTIC PREMALIGNANT LESION AGENTS</b>		
EFUDEX ( <i>fluorouracil</i> )	T3	
FLUOROPLEX	T2	
FLUOROURACIL 0.5% CREAM	T1	
<i>fluorouracil 2% topical soln</i>	T1	
<i>fluorouracil 5% cream (Efudex)</i>	T1	
<i>fluorouracil 5% topical soln</i>	T1	
PANRETIN	T4	SP HD
PICATO	T3	
TOLAK	T3	
VALCHLOR	T4	SP HD
ANTI-OBESITY DRUGS (Weight Management)		
<b>ANTI-OBESITY GLUCAGON-LIKE PEPTIDE-1 RECEPTOR AGONIST</b>		
WEGOVY	T2	PA QL (1 box/ month)
ANTIPARASITICS (Infections)		
<b>ANTIPARASITICS</b>		
ALINIA	T3	
ALINIA ( <i>nitazoxanide</i> )	T3	
<i>nitazoxanide (Alinia)</i>	T1	
<b>OPHTHALMIC (EYE) ANTIPARASITICS</b>		
XDEMY	T4	PA QL(4 bottles/30 days) SP
<b>TOPICAL ANTIPARASITICS</b>		
<i>crotamiton (Eurax)</i>	T1	
ELIMITE ( <i>permethrin</i> )	T3	
EURAX	T3	
<i>ivermectin (Sklice)</i>	T1	
<b>TOPICAL ANTIPARASITICS</b>		
NATROBA ( <i>spinosad</i> )	T3	
<i>permethrin (Elimite)</i>	T1	
SKLICE ( <i>ivermectin</i> )	T3	
<i>spinosad (Natroba)</i>	T1	
ULESFIA	T3	

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

T4 – Specialty Medications  
PA – Prior Authorization  
QL – Quantity Limit

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

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

# List of Prescription Medications

ANTIPARKINSON DRUGS (Parkinson's Disease)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>ANTIPARKINSONISM DRUGS, ANTICHOLINERGIC</b>		
<i>benztropine mesylate</i>	T1	HD
<i>trihexyphenidyl hcl</i>	T1	HD
<b>ANTIPARKINSONISM DRUGS, OTHER</b>		
<i>amantadine hcl</i>	T1	HD
APOKYN	T4	PA SP HD
AZILECT 0.5 MG TABLET ( <i>rasagiline mesylate</i> )	T3	QL (1 tab/day) HD
AZILECT 1 MG TABLET ( <i>rasagiline mesylate</i> )	T3	HD
<i>bromocriptine mesylate</i> (Parlodel)	T1	HD
<i>carbidopa/levodopa</i>	T1	HD
<i>carbidopa/levodopa</i> (Sinemet 10-100)	T1	HD
<i>carbidopa/levodopa</i> (Sinemet 25-100)	T1	HD
<i>carbidopa/levodopa</i> (Sinemet 25-250)	T1	HD
<i>carbidopa/levodopa/entacapone</i> (Stalevo 100)	T1	HD
<i>carbidopa/levodopa/entacapone</i> (Stalevo 125)	T1	HD
<i>carbidopa/levodopa/entacapone</i> (Stalevo 150)	T1	HD
<i>carbidopa/levodopa/entacapone</i> (Stalevo 200)	T1	HD
<i>carbidopa/levodopa/entacapone</i> (Stalevo 50)	T1	HD
<i>carbidopa/levodopa/entacapone</i> (Stalevo 75)	T1	HD
COMTAN ( <i>entacapone</i> )	T3	HD
DUOPA	T4	SP HD
<i>entacapone</i> (Comtan)	T1	HD
INBRIJA	T4	PA SP HD
KYNMOBI	T2	PA HD
MIRAPEX ER 0.375 MG TABLET ( <i>pramipexole er</i> )	T3	QL (1 tab/day) HD
MIRAPEX ER 0.75 MG TABLET ( <i>pramipexole er</i> )	T3	HD
MIRAPEX ER 1.5 MG TABLET ( <i>pramipexole er</i> )	T3	QL (1 tab/day) HD
MIRAPEX ER 2.25 MG TABLET ( <i>pramipexole er</i> )	T3	QL (1 tab/day) HD
MIRAPEX ER 3 MG TABLET ( <i>pramipexole er</i> )	T3	HD
MIRAPEX ER 3.75 MG TABLET ( <i>pramipexole er</i> )	T3	HD
MIRAPEX ER 4.5 MG TABLET ( <i>pramipexole er</i> )	T3	HD
NEUPRO	T3	HD
NOURIANZ	T4	PA QL (1 tab/day) SP HD
OSMOLEX ER	T3	QL(1 tab/day) HD

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

T4 – Specialty Medications  
 PA – Prior Authorization  
 QL – Quantity Limit

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

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

# List of Prescription Medications

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

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>ANTIPARKINSONISM DRUGS, OTHER (cont.)</b>		
OSMOLEX ER 258 MG TABLET	T3	QL (1 tab/day) HD
PARLODEL ( <i>bromocriptine mesylate</i> )	T3	HD
<i>pramipexole di-hcl</i>	T1	HD
<i>pramipexole er 0.375 mg tablet</i> (Mirapex Er)	T1	QL (1 tab/day) HD
<i>pramipexole er 0.75 mg tablet</i> (Mirapex Er)	T1	HD
<i>pramipexole er 1.5 mg tablet</i> (Mirapex Er)	T1	QL (1 tab/day) HD
<i>pramipexole er 2.25 mg tablet</i> (Mirapex Er)	T1	QL (1 tab/day) HD
<i>pramipexole er 3 mg tablet</i> (Mirapex Er)	T1	HD
<i>pramipexole er 3.75 mg tablet</i> (Mirapex Er)	T1	HD
<i>pramipexole er 4.5 mg tablet</i> (Mirapex Er)	T1	HD
<i>rasagiline mesylate 0.5 mg tab</i> (Azilect)	T1	QL (1 tab/day) HD
RYTARY	T3	HD
<i>selegiline hcl</i>	T1	HD
SINEMET 10-100 ( <i>carbidopa-levodopa</i> )	T3	HD
SINEMET 25-100 ( <i>carbidopa-levodopa</i> )	T3	HD
SINEMET 25-250 ( <i>carbidopa-levodopa</i> )	T3	HD
STALEVO 100 ( <i>carbidopa-levodopa-entacapone</i> )	T3	HD
STALEVO 125 ( <i>carbidopa-levodopa-entacapone</i> )	T3	HD
STALEVO 150 ( <i>carbidopa-levodopa-entacapone</i> )	T3	HD
STALEVO 200 ( <i>carbidopa-levodopa-entacapone</i> )	T3	HD
STALEVO 50 ( <i>carbidopa-levodopa-entacapone</i> )	T3	HD
STALEVO 75 ( <i>carbidopa-levodopa-entacapone</i> )	T3	HD
TASMAR ( <i>tolcapone</i> )	T3	HD
<i>tolcapone</i> (Tasmar)	T1	HD
XADAGO	T3	ST HD

## DECARBOXYLASE INHIBITORS

<i>carbidopa</i>	T1	
------------------	----	--

## ANTIPLATELET DRUGS (Blood Thinners/Anti-Clotting)

### PLATELET AGGREGATION INHIBITORS

AGGRASTAT	T3	HD
<i>aspirin/dipyridamole</i>	T1	HD

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

T4 – Specialty Medications  
 PA – Prior Authorization  
 QL – Quantity Limit

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

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

## List of Prescription Medications

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

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>PLATELET AGGREGATION INHIBITORS (cont.)</b>		
BRILINTA	T2	HD
<i>cilostazol</i>	T1	HD
<i>clopidogrel bisulfate</i>	T1	HD
<i>clopidogrel bisulfate</i> (Plavix)	T1	HD
<i>dipyridamole 25 mg tablet</i>	T1	HD
<i>dipyridamole 50 mg tablet</i>	T1	HD
<i>dipyridamole 75 mg tablet</i>	T1	HD
EFFIENT ( <i>prasugrel hcl</i> )	T3	HD
EPTIFIBATIDE	T1	HD
<i>eptifibatide</i> (Integrilin)	T1	HD
INTEGRILIN ( <i>eptifibatide</i> )	T3	HD
PLAVIX ( <i>clopidogrel</i> )	T3	HD
<i>prasugrel hcl</i> (Effient)	T1	HD
<i>ticlopidine hcl</i>	T1	HD
<i>tirofiban-0.9% sodium chloride</i>	T1	HD
<b>PLATELET REDUCING AGENTS</b>		
AGRYLIN ( <i>anagrelide hcl</i> )	T3	
<i>anagrelide hcl</i>	T1	
<i>anagrelide hcl</i> (Agyrin)	T1	
<b>ANTIVIRALS (AIDS/HIV)</b>		
<b>ANTIRETROVIRAL - ANTI-CD4 DOMAIN 2 MONOCLONAL AB</b>		
TROGARZO	T4	PA SP
<b>ANTIRETROVIRAL - CAPSID INHIBITORS</b>		
SUNLENCA 4- 300 MG TABLET	T4	PA QL(5 tabs/180 days) SP
SUNLENCA 5- 300 MG TABLET	T4	PA QL(5 tabs/180 days) SP
SUNLENCA 463.5 MG/1.5 ML VIAL	T4	PA SP
<b>ANTIRETROVIRAL-INTEGRASE INHIBITOR AND NNRTI COMB.</b>		
CABENUVA	T4	PA SP
JULUCA	T4	SP
<b>ANTIRETROVIRAL-INTEGRASE INHIBITOR AND NRTI COMB.</b>		
DOVATO	T4	SP

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

T4 – Specialty Medications  
 PA – Prior Authorization  
 QL – Quantity Limit

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

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

## List of Prescription Medications

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

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>ANTIRETROVIRAL-NRTIS AND INTEGRASE INHIBITORS COMB</b>		
TRIUMEQ	T4	SP
<b>ANTIRETROVIRAL-NUCLEOSIDE, NUCLEOTIDE, PROTEASE INH.</b>		
SYM TUZA	T4	SP
<b>ANTIVIRALS, HIV-SPEC, NON-PEPTIDIC PROTEASE INHIB</b>		
APTIVUS	T4	PA SP
<i>darunavir ethanolate (Prezista)</i>	T4	SP
PREZCOBIX	T4	PA SP
PREZISTA	T4	SP
<b>ANTIVIRALS, HIV-SPEC, NUCLEOSIDE-NUCLEOTIDE ANALOG</b>		
CIMDUO	T4	PA SP
DESCOVY	T4	PA SP PPACA
<i>emtricitabine-tenofv 100-150mg</i>	T4	SP
<i>emtricitabine-tenofv 133-200mg</i>	T4	SP
<i>emtricitabine-tenofv 167-250mg</i>	T4	SP
<i>emtricitabine-tenofv 200-300mg</i>	T4	SP PPACA
TEMIXYS	T4	PA SP
<b>ANTIVIRALS, HIV-SPEC., NUCLEOSIDE ANALOG, RTI COMB</b>		
<i>abacavir sulfate/lamivudine</i>	T4	PA SP
<i>abacavir/lamivudine/zidovudine</i>	T4	PA SP
<i>lamivudine/zidovudine</i>	T4	SP
<b>ANTIVIRALS, HIV-SPECIFIC, CCR5 CO-RECEPTOR ANTAG.</b>		
<i>maraviroc (Selzentry)</i>	T4	PA SP
SELZENTRY	T4	PA SP
<b>ANTIVIRALS, HIV-SPECIFIC, CD4 ATTACHMENT INHIBITOR</b>		
RUKOBIA	T4	PA QL (2 syringe/day) SP
<b>ANTIVIRALS, HIV-SPECIFIC, FUSION INHIBITORS</b>		
FUZEON	T4	PA SP
<b>ANTIVIRALS, HIV-SPECIFIC, NON-NUCLEOSIDE, RTI</b>		
EDURANT	T4	PA SP
<i>efavirenz</i>	T4	PA SP
<i>nevirapine</i>	T4	PA SP
PIFELTRO	T4	PA SP
<b>ANTIVIRALS, HIV-SPECIFIC, NUCLEOSIDE ANALOG, RTI</b>		
<i>abacavir sulfate</i>	T4	PA SP
<i>emtricitabine (Emtriva)</i>	T4	PA SP
EMTRIVA 10 MG/ML SOLUTION	T4	PA SP

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

T4 – Specialty Medications  
 PA – Prior Authorization  
 QL – Quantity Limit

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

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

## List of Prescription Medications

<b>ANTIVIRALS (AIDS/HIV) (cont.)</b>		
<b>Prescription Drug Name</b>	<b>Drug Tier</b>	<b>Coverage Requirements and Limits</b>
<b>ANTIVIRALS, HIV-SPECIFIC, NUCLEOSIDE ANALOG, RTI (cont.)</b>		
<i>lamivudine 10 mg/ml oral soln</i>	T4	SP
<i>lamivudine 150 mg tablet</i>	T4	SP
<i>lamivudine 300 mg tablet</i>	T4	PA SP
RETROVIR	T4	PA SP
<i>zidovudine</i>	T4	SP
<i>tenofovir disoproxil fumarate</i>	T4	PA SP
VIREAD	T4	PA SP
<b>ANTIVIRALS, HIV-SPECIFIC, PROTEASE INHIBITOR COMB</b>		
<i>lopinavir/ritonavir</i>	T1	
<b>ANTIVIRALS, HIV-SPECIFIC, PROTEASE INHIBITORS</b>		
<i>atazanavir sulfate</i>	T4	PA SP
EVOTAZ	T4	PA SP
<i>fosamprenavir calcium</i>	T4	PA SP
INVIRASE	T2	PA
LEXIVA	T4	PA SP
REYATAZ	T4	PA SP
<i>ritonavir</i>	T1	SP
<b>ANTIVIRALS, HIV-I INTEGRASE STRAND TRANSFER INHIBTR</b>		
APRETUDE	T4	PA SP
ISENTRESS	T4	SP
ISENTRESS HD	T4	PA SP
TIVICAY	T4	SP
TIVICAY PD	T4	SP
<b>ARTV NUCLEOSIDE, NUCLEOTIDE, NON-NUCLEOSIDE RTI COMB</b>		
COMPLERA	T4	PA SP
DELSTRIGO	T4	PA SP
<i>efavirenz/emtricit/tenofovr df (Atripla)</i>	T4	PA SP
<i>efavirenz</i>	T4	PA SP
<i>efavirenz/lamivu/tenofov disop (Symfi Lo)</i>	T4	SP
<i>efavirenz/lamivu/tenofov disop (Symfi)</i>	T4	SP
ODEFSEY	T4	PA SP
<b>ARV-NUCLEOSIDE, NUCLEOTIDE RTI, INTEGRASE INHIBITORS</b>		
BIKTARVY	T4	SP

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

T4 – Specialty Medications  
 PA – Prior Authorization  
 QL – Quantity Limit

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

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



# List of Prescription Medications

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

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

### ARV-NUCLEOSIDE, NUCLEOTIDE RTI, INTEGRASE INHIBITORS (cont.)

GENVOYA	T4	SP
STRIBILD	T4	PA SP

## ANTIVIRALS (Eye Conditions)

### EYE ANTIVIRALS

trifluridine	T1	
ZIRGAN	T3	

## ANTIVIRALS (Infections)

### ANTIVIRAL MONOCLONAL ANTIBODIES

SYNAGIS	T4	PA SP HD
---------	----	----------

### ANTIVIRALS, GENERAL

acyclovir	T1	
acyclovir sodium	T1	
cidofovir	T4	SP
CYTOVENE (ganciclovir sodium)	T4	SP
famciclovir	T1	
FLUMADINE (rimantadine hcl)	T3	
foscarnet sodium (Foscavir)	T1	
FOSCAVIR	T3	
FOSCAVIR (foscarnet sodium)	T3	
GANCICLOVIR 500MG/250ML BAG	T4	SP
ganciclovir sodium	T4	SP
ganciclovir sodium (Cytovene)	T4	SP
LIVTENCITY	T3	PA QL (4 tabs/day) SP
oseltamivir 6 mg/ml suspension (Tamiflu)	T1	QL (180ml/30 days)
oseltamivir phos 30 mg capsule (Tamiflu)	T1	QL (20 caps/30 days)
oseltamivir phos 45 mg capsule (Tamiflu)	T1	QL (10 caps/30 days)
oseltamivir phos 75 mg capsule (Tamiflu)	T1	QL (10 caps/30 days)
PREVMIS 240 MG TABLET	T4	SP HD
PREVMIS 240 MG/12 ML VIAL	T4	SP
PREVMIS 480 MG TABLET	T4	SP HD
PREVMIS 480 MG/24 ML VIAL	T4	SP
RAPIVAB	T3	
RELENZA	T3	QL (20/30 days)

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

T4 – Specialty Medications  
 PA – Prior Authorization  
 QL – Quantity Limit

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

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

# List of Prescription Medications

ANTIVIRALS (Infections) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>ANTIVIRALS, GENERAL (cont.)</b>		
<i>rimantadine hcl</i> (Flumadine)	T1	
TAMIFLU 30 MG CAPSULE ( <i>oseltamivir phosphate</i> )	T3	QL (20/30 days)
TAMIFLU 45 MG CAPSULE ( <i>oseltamivir phosphate</i> )	T3	QL (10/30 days)
TAMIFLU 6 MG/ML SUSPENSION ( <i>oseltamivir phosphate</i> )	T3	QL (180ml/30 days)
TAMIFLU 75 MG CAPSULE ( <i>oseltamivir phosphate</i> )	T3	QL (10/30 days)
<i>valganciclovir hcl</i>	T1	
VALTREX ( <i>valacyclovir</i> )	T3	
XOFLUZA	T3	QL (2 tabs/30 days)
<b>ANTIVIRAL - RNA POLYMERASE INHIBITOR</b>		
LAGEVRIO (EUA)	T3	QL (1 pack/120 days)
<b>HEP C - NS5A, NS3/4A, NUCLEOTIDE NS5B INHIB COMBO</b>		
VOSEVI	T4	PA SP HD
<b>HEP C VIRUS, NUCLEOTIDE ANALOG NS5B POLYMERASE INH</b>		
SOVALDI 150 MG PELLETT PACKET	T4	PA QL (1 tab/day) SP HD
SOVALDI 200 MG PELLETT PACKET	T4	PA QL (1 tab/day) SP HD
SOVALDI 200 MG TABLET	T4	PA QL (1 tab/day) SP HD
SOVALDI 400 MG TABLET	T4	PA SP HD
<b>HEP C VIRUS-NS5B POLYMERASE AND NS5A INHIB. COMBO.</b>		
EPCLUSA 200 MG-50 MG TABLET	T4	PA QL (1 tab/Day) SP HD
EPCLUSA 400 MG-100 MG TABLET	T4	PA SP HD
HARVONI 33.75-150 MG PELLETT PK	T4	PA QL (1 tab/day) SP HD
HARVONI 45-200 MG PELLETT PACKT	T4	PA QL (1 tab/day) SP HD
HARVONI 45-200 MG TABLET	T4	PA QL (1 tab/day) SP HD
HARVONI 90-400 MG TABLET	T4	PA SP HD
<b>HEPATITIS B TREATMENT AGENTS</b>		
<i>adefovir dipivoxil</i> (Hepsera)	T4	SP HD
BARACLUDE	T4	SP HD
<i>entecavir 0.5 mg tablet</i>	T4	QL (1 tab/day) SP HD
<i>entecavir 1 mg tablet</i>	T4	SP HD
EPIVIR HBV 100 MG TABLET ( <i>lamivudine hbv</i> )	T4	SP
EPIVIR HBV 25 MG/5 ML SOLN	T4	SP
<i>lamivudine</i> (EpiVIR Hbv)	T4	SP

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

T4 – Specialty Medications  
 PA – Prior Authorization  
 QL – Quantity Limit

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

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

## List of Prescription Medications

ANTIVIRALS (Infections) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>HEPATITIS B TREATMENT AGENTS (cont.)</b>		
VEMLIDY	T4	SP HD
PEGASYS	T4	PA SP HD
PEGINTRON	T4	PA SP HD
<i>ribasphere 200 mg capsule</i>	T4	SP HD
<i>ribasphere 200 mg tablet</i>	T4	SP HD
<i>ribasphere 400 mg tablet</i>	T4	SP
<i>ribasphere 600 mg tablet</i>	T4	SP
<i>ribasphere ribapak 200-400 mg</i>	T4	SP HD
RIBASPHERE RIBAPAK 400-400 mg	T4	SP HD
RIBASPHERE RIBAPAK 600-400 mg	T4	SP HD
RIBASPHERE RIBAPAK 600-600 mg	T4	SP HD
<i>ribavirin</i>	T4	SP HD
<b>HEPATITIS C VIRUS- NS5A AND NS3/4A INHIBITOR COMB</b>		
ZEPATIER	T4	PA SP HD
<b>RNA POLYMERASE INHIBITOR</b>		
LAGEVRIO 200 MG CAP (EUA)	T2	QL(1 pack/120 days)
MOLNUPIRAVIR	T3	QL (1 pkg/120 days)
ANTIVIRALS (Skin Conditions)		
<b>TOPICAL GENITAL WART-HPV TREATMENT AGENTS</b>		
VEREGEN	T3	
AUTONOMIC DRUGS (Allergy/Nasal Sprays)		
<b>ANAPHYLAXIS THERAPY AGENTS</b>		
ADYPHREN	T1	
ADYPHREN AMP	T1	
<i>epinephrine 0.15 mg auto-inject</i>	T1	QL (2 packs/30 days)
EPINEPHRINE 0.3 MG AUTO-INJECT	T1	QL (2 packs/30 days)
<i>epinephrine 0.3 mg auto-inject (Epinephrine)</i>	T1	QL (2 packs/30 days)
EPINEPHRINE PROFESSIONAL EMS	T3	
EPINEPHRINE PROFESSIONAL KIT	T3	
EPINEPHRINESNAP-EMS	T3	
EPINEPHRINESNAP-V	T3	

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

T4 – Specialty Medications  
 PA – Prior Authorization  
 QL – Quantity Limit

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

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

# List of Prescription Medications

## AUTONOMIC DRUGS (Alzheimer's Disease)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>CHOLINESTERASE INHIBITORS</b>		
ARICEPT ( <i>donepezil hcl</i> )	T3	HD
BLOXIVERZ ( <i>neostigmine methylsulfate</i> )	T3	HD
<i>donepezil hcl</i>	T1	HD
<i>donepezil hcl</i> (Aricept)	T1	HD
EXELON ( <i>rivastigmine</i> )	T3	HD
<i>galantamine er 16 mg capsule</i> (Razadyne Er)	T1	HD
<i>galantamine er 24 mg capsule</i> (Razadyne Er)	T1	HD
<i>galantamine er 8 mg capsule</i> (Razadyne Er)	T1	QL (1 cap/day) HD
<i>galantamine hbr</i>	T1	HD
<i>neostigmine methylsulfate</i> (Bloxiverz)	T1	HD
<i>neostigmine methylsulfate</i> (Bloxiverz)	T1	HD
<i>neostigmine methylsulfate</i> (Neostigmine Methylsulfate)	T1	HD
NEOSTIGMINE-STERILE WATER	T1	HD
<i>physostigmine salicylate</i>	T1	HD
<i>pyridostigmine bromide</i>	T3	HD
<i>pyridostigmine bromide</i> (Mestinon)	T1	HD
RAZADYNE ER 16 MG CAPSULE ( <i>galantamine er</i> )	T3	HD
RAZADYNE ER 24 MG CAPSULE ( <i>galantamine er</i> )	T3	HD
RAZADYNE ER 8 MG CAPSULE ( <i>galantamine er</i> )	T3	QL (1 cap/day) HD
<i>rivastigmine</i> (Exelon)	T1	HD
<i>rivastigmine tartrate</i>	T1	HD

## AUTONOMIC DRUGS (Attention Deficit Hyperactivity Disorder)<sup>1</sup>

### ADRENERGICS, AROMATIC, NON-CATECHOLAMINE

ADDERALL ( <i>dextroamphetamine-amphetamine</i> )	T3	PA ST
<i>amphetamine sulfate</i> (Evekeo)	T1	PA
<i>dextroamp/amphet</i> (Adderall Xr) (Mydayis)	T1	PA QL (1 cap/day)
<i>dextroamp-amphet er 10 mg cap</i> (Adderall Xr)	T1	PA QL (1 cap/day)
<i>dextroamp-amphet er 15 mg cap</i> (Adderall Xr)	T1	PA QL (1 cap/day)
<i>dextroamp-amphet er 20 mg cap</i> (Adderall Xr)	T1	PA QL (1 cap/day)
<i>dextroamp-amphet er 25 mg cap</i> (Adderall Xr)	T1	PA QL (1 per day)
<i>dextroamp-amphet er 30 mg cap</i> (Adderall Xr)	T1	PA QL (1 per day)
<i>dextroamp-amphet er 5 mg cap</i> (Adderall Xr)	T1	PA QL (1 cap/day)

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

T4 – Specialty Medications  
 PA – Prior Authorization  
 QL – Quantity Limit

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

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

# List of Prescription Medications

## AUTONOMIC DRUGS (Attention Deficit Hyperactivity Disorder)<sup>1</sup> (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>ADRENERGICS, AROMATIC, NON-CATECHOLAMINE (cont.)</b>		
<i>dextroamphetamine er 10 mg cap</i>	T1	PA QL (1 cap/day)
<i>dextroamphetamine er 15 mg cap</i>	T1	PA QL (3/day)
<i>dextroamphetamine er 5 mg cap</i>	T1	PA QL (1 cap/day)
<i>dextroamphetamine sulfate</i>	T1	PA
<i>dextroamphetamine sulfate</i>	T3	PA ST
<i>dextroamph-amphet er cp (Mydayis)</i>	T1	QL
<i>EVEKEO (amphetamine sulfate)</i>	T3	PA ST
<i>methamphetamine hcl</i>	T1	PA
XELSTRYM	T3	PA QL(1 patch/day)
ZENZEDI	T3	PA ST

## AUTONOMIC DRUGS (Blood Pressure/Heart Medications)

### ADRENERGIC VASOPRESSOR AGENTS

<i>droxidopa (Northera)</i>	T4	SP HD
<i>midodrine hcl</i>	T1	

### ALPHA-ADRENERGIC BLOCKING AGENTS

<i>DIBENZYLINE (phenoxybenzamine hcl)</i>	T3	HD
<i>phenoxybenzamine hcl (Dibenzyline)</i>	T1	HD
<i>phentolamine mesylate</i>	T1	HD

## AUTONOMIC DRUGS (Miscellaneous)

### ADRENERGIC AGENTS, CATECHOLAMINES

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

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

T4 – Specialty Medications  
PA – Prior Authorization  
QL – Quantity Limit

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

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

## List of Prescription Medications

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

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

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

T4 – Specialty Medications

PA – Prior Authorization

QL – Quantity Limit

ST – Step Therapy

AGE – Age Requirement

SP – Specialty Medication

HD – May require home delivery pharmacy

PPACA – No Cost-Share Preventive Medication

CSL – Oral cancer medication subject to cost-share limits

## List of Prescription Medications

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

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

#### NEUROMUSCULAR BLOCKING AGENTS (cont.)

VECURONIUM BROMIDE-WATER	T1	
XEOMIN	T4	PA SP HD

### AUTONOMIC DRUGS (Urinary Tract Conditions)

#### PARASYMPATHETIC AGENTS

<i>bethanechol chloride</i>	T1	HD
<i>cevimeline hcl</i> (Evoxac)	T1	HD
EVOXAC ( <i>cevimeline hcl</i> )	T3	HD
<i>guanidine hcl</i>	T1	HD
<i>pilocarpine hcl</i> (Salagen)	T1	HD
SALAGEN ( <i>pilocarpine hcl</i> )	T3	HD

### BIOLOGICALS (Allergy/Nasal Sprays)

#### ALLERGENIC EXTRACTS, THERAPEUTIC

GRASTEK	T3	PA QL (1 tab/day)
ODACTRA	T3	PA QL (1 tab/day)
ORALAIR	T3	PA QL (1 tab/day)
RAGWITEK	T3	PA QL (1 tab/day)

### BIOLOGICALS (Blood Pressure/Heart Medications)

#### PLASMA KALLIKREIN INHIBITORS

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

### BIOLOGICALS (Miscellaneous)

#### ANTISERA

HYPERRHO S-D	T4	SP
MICRHOGAM ULTRA-FILTERED PLUS	T4	SP
RHOGAM ULTRA-FILTERED PLUS	T4	SP
RHOPHYLAC	T4	SP
WINRHO SDF	T4	SP HD

#### PKU TREATMENT AGENTS - PHENYLALANINE AMMONIA LYASE

PALYNZIQ	T4	PA SP HD
----------	----	----------

### BIOLOGICALS (Vaccines)

#### COVID-19 VACCINES

COMIRNATY 2023-2024	T3	PPACA
MODERNA COVID EUA	T3	PPACA
PFIZER COVIDEUA	T3	PPACA
SPIKEVAX 2023-2024	T3	PPACA

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

T4 – Specialty Medications  
PA – Prior Authorization  
QL – Quantity Limit

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

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

## List of Prescription Medications

BIOLOGICALS (Vaccines) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>ENTERIC VIRUS VACCINES</b>		
IPOL	T3	PPACA
ROTARIX	T3	PPACA
ROTATEQ	T3	PPACA
<b>GRAM NEGATIVE COCCI VACCINES</b>		
BEXSERO	T3	PPACA
MENACTRA	T3	PPACA
MENQUADFI	T3	PPACA
MENVEO A-C-Y-W-135-DIP	T3	PPACA
PENBRAYA	T3	PPACA
TRUMENBA	T3	PPACA
<b>GRAM POSITIVE COCCI VACCINES</b>		
PNEUMOVAX 23	T3	PPACA
PREVNAR 13	T3	PPACA
<b>INFLUENZA VIRUS VACCINES</b>		
AFLURIA 2017-2018	T3	PPACA
AFLURIA 2018-2019	T3	PPACA
AFLURIA QUAD 2017-2018	T3	PPACA
AFLURIA QUAD 2018-2019	T3	PPACA
AFLURIA QUAD 2019-20 (3YR UP)	T3	PPACA
AFLURIA QUAD 2019-20 (6-35MO)	T3	PPACA
AFLURIA QUAD 2019-2020	T3	PPACA
AFLURIA QUAD 2020-2021	T3	PPACA
AFLURIA QUAD 2020-21 (3YR UP)	T3	PPACA
AFLURIA QUAD 2020-21 (6-35MO)	T3	PPACA
EZ FLU 2018-2019 (FLUCELVAX)	T3	PPACA
FLUAD 2017-2018	T3	PPACA
FLUAD 2018-2019	T3	PPACA
FLUAD 2019-2020	T3	PPACA
FLUAD 2020-2021	T3	PPACA
FLUAD QUAD 2020-2021	T3	PPACA
FLUARIX QUAD 2017-2018	T3	PPACA
FLUARIX QUAD 2018-2019	T3	PPACA
FLUARIX QUAD 2019-2020	T3	PPACA
FLUARIX QUAD 2020-2021	T3	PPACA

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

T4 – Specialty Medications  
 PA – Prior Authorization  
 QL – Quantity Limit

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

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



## List of Prescription Medications

BIOLOGICALS (Vaccines) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>INFLUENZA VIRUS VACCINES (cont.)</b>		
FLUBLOK QUAD 2020-2021	T3	PPACA
FLUCELVAX QUAD 2017-2018	T3	PPACA
FLUCELVAX QUAD 2018-2019	T3	PPACA
FLUCELVAX QUAD 2019-2020	T3	PPACA
FLUCELVAX QUAD 2020-2021	T3	PPACA
FLULAVAL QUAD 2017-2018	T3	PPACA
FLULAVAL QUAD 2018-2019	T3	PPACA
FLULAVAL QUAD 2019-2020	T3	PPACA
FLULAVAL QUAD 2020-2021	T3	PPACA
FLUMIST QUAD 2017-2018	T3	PPACA
FLUMIST QUAD 2018-2019	T3	PPACA
FLUMIST QUAD 2019-2020	T3	PPACA
FLUMIST QUAD 2020-2021	T3	PPACA
FLUVIRIN 2017-2018	T3	PPACA
FLUZONE HIGH-DOSE 2017-2018	T3	PPACA
FLUZONE HIGH-DOSE 2018-2019	T3	PPACA
FLUZONE HIGH-DOSE 2019-2020	T3	PPACA
FLUZONE HIGH-DOSE QUAD 2020-21	T3	PPACA
FLUZONE INTRADERM QUAD 2017-18	T3	PPACA
FLUZONE QUAD 2017-2018	T3	PPACA
FLUZONE QUAD 2018-2019	T3	PPACA
FLUZONE QUAD 2019-2020	T3	PPACA
FLUZONE QUAD 2020-2021	T3	PPACA
FLUZONE QUAD PEDI 2017-2018	T3	PPACA
FLUZONE QUAD PEDI 2018-2019	T3	PPACA
FLUZONE QUAD PEDI 2019-2020	T3	PPACA
<b>VACCINE/TOXOID PREPARATIONS, COMBINATIONS</b>		
ACTHIB	T3	PPACA
ADACEL TDAP	T3	PPACA
BOOSTRIX TDAP	T3	PPACA
DAPTACEL DTAP	T3	PPACA

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

T4 – Specialty Medications  
 PA – Prior Authorization  
 QL – Quantity Limit

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

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

## List of Prescription Medications

### BIOLOGICALS (Vaccines) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>VACCINE/TOXOID PREPARATIONS, COMBINATIONS (cont.)</b>		
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
PROQUAD	T3	PPACA
QUADRACEL DTAP-IPV	T3	PPACA
TDVAX	T3	PPACA
TENIVAC	T3	PPACA
VAXELIS	T3	PPACA

### VIRAL/TUMORIGENIC VACCINES

ACAM2000	T3	PPACA
ENGERIX-B ADULT	T3	PPACA
ENGERIX-B PEDIATRIC-ADOLESCENT	T3	PPACA
GARDASIL 9	T3	PPACA
HEPLISAV-B	T3	PPACA
IXCHIQ	T3	PPACA
JYNNEOS	T3	PPACA
PEDIARIX	T3	PPACA
RECOMBIVAX HB	T3	PPACA
SHINGRIX	T3	PPACA
TWINRIX	T3	PPACA
VARIVAX VACCINE	T3	PPACA
ZOSTAVAX	T3	PPACA

### BLOOD (Blood Modifiers/Bleeding Disorders)

#### AGENTS TO TX THROMBOTIC THROMBOCYTOPENIC PURPURA

ADZYNMA	T4	PA SP
CABLIVI	T4	PA SP

#### ANTIFIBRINOLYTIC AGENTS

AMICAR ( <i>aminocaproic acid</i> )	T4	SP HD
<i>aminocaproic acid</i>	T4	SP HD

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

T4 – Specialty Medications  
 PA – Prior Authorization  
 QL – Quantity Limit

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

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

# List of Prescription Medications

<b>BLOOD (Blood Modifiers/Bleeding Disorders) (cont.)</b>		
<b>Prescription Drug Name</b>	<b>Drug Tier</b>	<b>Coverage Requirements and Limits</b>
<b>ANTIFIBRINOLYTIC AGENTS (cont.)</b>		
<i>aminocaproic acid</i> (Amicar)	T4	SP HD
CYKLOKAPRON ( <i>tranexamic acid</i> )	T4	SP
FIBRYGA	T4	PA SP
LYSTEDA ( <i>tranexamic acid</i> )	T4	SP
RIASTAP	T4	PA SP
<i>tranexamic acid</i> (Cyklokapron)	T4	SP
<i>tranexamic acid</i> (Lysteda)	T4	SP
<i>tranexamic acid in nacl,iso-os</i>	T4	SP
TRANEXAMIC ACID-NACL	T4	SP
TRANEXAMIC 1,000 MG/100ML-NACL	T4	SP
<b>ANTIHEMOPHILIC FACTORS</b>		
ALTUVILLO	T4	PA SP HD
<b>COMPLEMENT (C3) INHIBITORS</b>		
EMPAVELI	T4	PA SP
FABHALTA	T4	PA QL(2 caps/day) SP
<b>BLOOD FACTORS, MISCELLANEOUS</b>		
VONVENDI	T4	SP HD
<b>COAGULANTS</b>		
<i>protamine sulfate</i>	T1	
<b>FACTOR IX COMPLEX (PCC) PREPARATIONS</b>		
KCENTRA	T4	SP
<b>FACTOR X PREPARATIONS</b>		
COAGADEX	T4	PA SP
CORIFACT	T4	PA SP
TRETTEN	T4	PA SP
<b>HEMOPHILIA TREATMENT AGENTS, NON-FACTOR REPLACEMENT</b>		
HEMLIBRA	T4	PA SP HD
<b>HUMAN MONOCLONAL ANTIBODY COMPLEMENT (C5) INHIBITOR</b>		
SOLIRIS	T4	PA SP
ULTOMIRIS	T4	PA SP HD
<b>PROTEIN C PREPARATIONS</b>		
CEPROTIN	T4	PA SP
<b>SICKLE CELL ANEMIA AGENTS</b>		
ADAKVEO	T4	PA SP
DROXIA	T2	

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

T4 – Specialty Medications  
PA – Prior Authorization  
QL – Quantity Limit

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

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

## List of Prescription Medications

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

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>TOPICAL HEMOSTATICS</b>		
OXBRYTA 300MG TAB	T4	PA QL (5 tabs/day) SP
SIKLOS	T3	PA
ASTRINGYN	T3	
AVITENE	T3	
ENDO-AVITENE	T3	
EVICEL	T3	
<i>gelatin sponge, absorb/porcine (Gelfoam)</i>	T1	
GELFOAM	T3	
GELFOAM ( <i>surgifoam</i> )	T3	
GELFOAM COMPRESSED	T3	
MONSEL'S	T3	
RAPLIXA	T3	
RECOTHROM	T3	
SURGIFOAM	T1	
SYRINGE AVITENE	T3	
TACHOSIL	T3	
THROMBI-GEL	T3	
THROMBIN-JMI	T3	
THROMBI-PAD	T3	
ULTRAFOAM	T3	
<b>BLOOD (Blood Thinners/Anti-Clotting)</b>		
<b>ANTICOAGULANT REVERSAL AGENT FOR FACTOR XA INHIB.</b>		
ANDEXXA	T4	SP
<b>ANTICOAGULANT REVERSAL AGENT, DIRECT THROMBIN INHIB</b>		
PRAXBIND	T4	SP
<b>HEMORRHOLOGIC AGENTS</b>		
<i>pentoxifylline</i>	T1	HD
<b>THROMBOLYTIC - NUCLEOTIDE TYPE</b>		
DEFITELIO	T4	PA SP
<b>THROMBOLYTIC ENZYMES</b>		
ACTIVASE	T3	
CATHFLO ACTIVASE	T3	
RETAVASE	T3	
TNKASE	T3	

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

T4 – Specialty Medications  
 PA – Prior Authorization  
 QL – Quantity Limit

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

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

# List of Prescription Medications

BLOOD (Miscellaneous)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>CELL/GENE THERAPY AGENTS - HEMATOPOIETIC</b>		
OMISIRGE	T3	
<b>CARDIAC DRUGS (Blood Pressure/Heart Medications)</b>		
<b>ANTIANGINAL, ANTI-ISCHEMIC AGENTS, NON-HEMODYNAMIC</b>		
RANEXA ( <i>ranolazine er</i> )	T3	QL (4 tabs/day) HD
<i>ranolazine</i> (Ranexa)	T1	QL (4 tabs/day) HD
<b>ANTIARRHYTHMICS</b>		
<i>adenosine 12 mg/4 ml syringe</i>	T1	HD
<i>adenosine 12 mg/4 ml vial</i>	T1	HD
<i>adenosine 6 mg/2 ml syringe</i>	T1	HD
<i>adenosine 6 mg/2 ml vial</i>	T1	HD
<i>amiodarone hcl</i>	T1	HD
AMIODARONE HCL-D5W	T1	HD
<i>bretylum tosylate</i>	T1	HD
CORVERT ( <i>ibutilide fumarate</i> )	T3	PA HD
<i>disopyramide phosphate</i> (Norpace)	T1	HD
<i>dofetilide 125 mcg capsule</i> (Tikosyn)	T1	QL (8 caps/day) HD
<i>dofetilide 250 mcg capsule</i> (Tikosyn)	T1	QL (4 caps/day) HD
<i>dofetilide 500 mcg capsule</i> (Tikosyn)	T1	QL (2 caps/day) HD
<i>flecainide acetate</i>	T1	HD
<i>ibutilide fumarate</i> (Corvert)	T1	HD
<i>lidocaine hcl 1% abboject</i>	T1	HD
<i>lidocaine hcl 1% syringe</i>	T1	HD
<i>lidocaine hcl 2% abboject</i>	T1	HD
<i>lidocaine hcl 2% luer-jet</i>	T1	HD
<i>lidocaine hcl 2% syringe</i>	T1	HD
<i>lidocaine hcl 2% vial</i>	T1	HD
<i>lidocaine hcl/dextrose 5 %/pf</i>	T1	HD
<i>mexiletine hcl</i>	T1	HD
NEXTERONE	T3	HD
NORPACE ( <i>disopyramide phosphate</i> )	T3	PA HD
NORPACE CR	T3	HD
<i>pacerone 100 mg tablet</i>	T3	PA HD
<i>pacerone 200 mg tablet</i>	T1	HD

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

T4 – Specialty Medications  
 PA – Prior Authorization  
 QL – Quantity Limit

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

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

# List of Prescription Medications

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

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>ANTIARRHYTHMICS (cont.)</b>		
<i>pacerone 400 mg tablet</i>	T3	PA HD
<i>procainamide hcl</i>	T1	HD
<i>propafenone hcl</i>	T1	HD
<i>propafenone hcl (Rythmol Sr)</i>	T1	HD
<i>quinidine gluconate</i>	T1	HD
RYTHMOL SR ( <i>propafenone hcl er</i> )	T3	PA HD
TIKOSYN 125 MCG CAPSULE ( <i>dofetilide</i> )	T3	PA QL (8 caps/day) HD
TIKOSYN 250 MCG CAPSULE ( <i>dofetilide</i> )	T3	PA QL (4 caps/day) HD
TIKOSYN 500 MCG CAPSULE ( <i>dofetilide</i> )	T3	PA QL (2 caps/day) HD
XYLOCAINE IV	T3	HD
<b>CALCIUM CHANNEL BLOCKING AGENTS</b>		
ADALAT CC ( <i>nifedipine er</i> )	T3	HD
<i>amlodipine besylate (Norvasc)</i>	T1	HD
CALAN SR ( <i>verapamil er</i> )	T3	HD
CAMZYOS	T4	PA QL (30 caps/30 days) SP
CARDENE I.V.	T3	HD
CARDENE I.V. ( <i>nicardipine hcl</i> )	T3	HD
CARDIZEM LA 120 MG TABLET ( <i>diltiazem hcl</i> )	T3	QL (1 tab/day) HD
CARDIZEM LA 180 MG TABLET ( <i>matzim la</i> )	T3	HD
CARDIZEM LA 240 MG TABLET ( <i>matzim la</i> )	T3	HD
CARDIZEM LA 300 MG TABLET ( <i>matzim la</i> )	T3	HD
CARDIZEM LA 360 MG TABLET ( <i>matzim la</i> )	T3	HD
CARDIZEM LA 420 MG TABLET ( <i>matzim la</i> )	T3	HD
CLEVIPREX	T3	HD
<i>diltiazem 24h er(la) 120 mg tb (Cardizem La)</i>	T1	QL(1 tab/day) HD
<i>diltiazem 24h er(la) 180 mg tb (Cardizem La)</i>	T1	HD
<i>diltiazem 24h er(la) 240 mg tb (Cardizem La)</i>	T1	HD
<i>diltiazem 24h er(la) 300 mg tb (Cardizem La)</i>	T1	HD
<i>diltiazem 24h er(la) 360 mg tb (Cardizem La)</i>	T1	HD
<i>diltiazem 24h er(la) 420 mg tb (Cardizem La)</i>	T1	HD
<i>diltiazem hcl</i>	T1	HD
<i>diltiazem hcl (Cardizem La)</i>	T1	HD

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

T4 – Specialty Medications  
 PA – Prior Authorization  
 QL – Quantity Limit

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

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

## List of Prescription Medications

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

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>CALCIUM CHANNEL BLOCKING AGENTS (cont.)</b>		
<i>diltiazem hcl</i> (Tiazac)	T1	HD
DILTIAZEM HCL-0.7% NACL	T3	HD
DILTIAZEM HCL-0.9% NACL	T1	HD
<i>felodipine</i>	T1	HD
<i>isradipine</i>	T1	HD
NICARDIPIN 20MG/200ML-0.9%NACL	T3	HD
NICARDIPIN 40MG/200ML-0.9%NACL	T3	HD
NICARDIPINE 1 MG/10 ML-NS SYRG	T1	HD
<i>nicardipine hcl</i>	T1	HD
<i>nicardipine hcl</i> (Cardene I.v.)	T1	HD
NICARDIPINE HCL-D5W	T1	HD
<i>nifedipine</i>	T1	HD
<i>nifedipine</i> (Adalat Cc)	T1	HD
<i>nifedipine</i> (Procardia XI)	T1	HD
<i>nifedipine</i> (Procardia)	T1	HD
<i>nisoldipine er 17 mg tablet</i> (Sular)	T1	HD
<i>nisoldipine er 20 mg tablet</i>	T1	QL (1 tab/day) HD
<i>nisoldipine er 25.5 mg tablet</i>	T1	HD
<i>nisoldipine er 30 mg tablet</i>	T1	HD
<i>nisoldipine er 34 mg tablet</i> (Sular)	T1	HD
<i>nisoldipine er 40 mg tablet</i>	T1	HD
<i>nisoldipine er 8.5 mg tablet</i> (Sular)	T1	HD
NORLIQVA ORAL SOLN	T2	PA QL(10 mls/day) HD
NORVASC ( <i>amlodipine besylate</i> )	T3	HD
NYMALIZE	T3	HD
PROCARDIA ( <i>nifedipine</i> )	T3	HD
SULAR ( <i>nisoldipine</i> )	T3	HD
TIAZAC ( <i>tiadylt er</i> )	T3	HD
<i>verapamil hcl</i>	T1	HD
<i>verapamil hcl</i> (Calan Sr)	T1	HD
<i>verapamil hcl</i> (Verelan Pm)	T1	HD

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

T4 – Specialty Medications  
PA – Prior Authorization  
QL – Quantity Limit

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

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

## List of Prescription Medications

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

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>CALCIUM CHANNEL BLOCKING AGENTS (cont.)</b>		
<i>verapamil hcl</i> (Verelan)	T1	HD
VERELAN ( <i>verapamil hcl</i> )	T3	HD
VERELAN ( <i>verapamil sr</i> )	T3	HD
VERELAN PM ( <i>verapamil er pm</i> )	T3	HD
<b>CARDIOPLEGIC SOLUTIONS</b>		
CARDIOPLEGIA DEL NIDO FORMULA	T3	
CARDIOPLEGIA HIGH POTASSIUM	T3	
CARDIOPLEGIA IND 8:1 NON-ENRCH	T3	
CARDIOPLEGIA INDUCTION 4:1	T3	
CARDIOPLEGIA INDUCTION 8:1	T3	
CARDIOPLEGIA MAINTENANCE 4:1	T3	
CARDIOPLEGIA MAINTENANCE 8:1	T3	
CARDIOPLEGIA REPERFUSATE 4:1	T3	
<i>cardioplegic solution no.1</i> (Plegisol)	T1	
PLEGISOL	T3	
<b>DIGITALIS GLYCOSIDES</b>		
<i>digoxin</i>	T1	HD
<i>digoxin</i> (Lanoxin)	T1	HD
LANOXIN	T3	HD
LANOXIN ( <i>digoxin</i> )	T3	HD
LANOXIN PEDIATRIC	T3	HD
<b>HEART RATE REDUCING, SA SELECTIVE I (F) CURRENT INH.</b>		
CORLANOR 5 MG TABLET	T2	PA HD
CORLANOR 5 MG/5 ML ORAL SOLN	T4	PA SP HD
CORLANOR 7.5 MG TABLET	T2	PA HD
<b>INOTROPIC DRUGS</b>		
<i>dobutamine hcl</i>	T1	
<i>dobutamine hcl in dextrose 5 %</i>	T1	
<i>milrinone lactate</i>	T1	
<i>milrinone lactate/d5w</i>	T1	
<b>VASODILATORS, CORONARY</b>		
DILATRATE-SR	T3	HD
<i>isosorbide dinitrate</i>	T1	HD
MINITRAN	T1	HD
NITRO-DUR	T3	HD

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

T4 – Specialty Medications  
PA – Prior Authorization  
QL – Quantity Limit

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

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



## List of Prescription Medications

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

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>VASODILATORS, CORONARY (cont.)</b>		
<i>nitroglycerin</i> (Nitro-dur)	T1	HD
<i>nitroglycerin</i> (Nitrolingual)	T1	HD
<i>nitroglycerin</i> (Nitromist)	T1	HD
<i>nitroglycerin</i> (Nitrostat)	T1	HD
<i>nitroglycerin 50 mg/10 ml vial</i>	T1	HD
<i>nitroglycerin in 5 % dextrose</i>	T1	HD
NITROLINGUAL ( <i>nitroglycerin</i> )	T3	HD
NITROMIST ( <i>nitroglycerin</i> )	T3	HD
NITROSTAT ( <i>nitroglycerin</i> )	T3	HD
<b>SOLUBLE GUANYLATE CYCLASE (SGC) STIMULATOR</b>		
VERQUVO	T2	PA QL(1 tab/day)

### CARDIOVASCULAR (Allergy/Nasal Sprays)

#### SYMPATHOMIMETIC AGENTS

AKOVAZ	T3	
BIORPHEN	T3	
EPHEDRINE SULFATE	T1	
<i>ephedrine sulfate</i> (Akovaz)	T1	
EPHEDRINE SULFATE-0.9% NACL	T1	
EPHEDRINE SULFATE-NACL	T1	
IMMPHENTIV	T3	
<i>phenylephrine hcl</i> (Vazculep)	T1	
<i>phenylephrine hcl in 0.9% nacl</i> (Phenylephrine Hcl-0.9% Nacl)	T1	
<i>phenylephrine hcl/dextrose 5 %</i>	T1	
PHENYLEPHRINE HCL-0.9% NACL	T1	
PHENYLEPHRINE HCL-0.9% NACL ( <i>phenylephrine hcl-0.9% nacl</i> )	T1	
PHENYLEPHRINE HCL-D5W	T1	
REZIPRES		
VAZCULEP ( <i>phenylephrine hcl</i> )	T3	

### CARDIOVASCULAR (Asthma/COPD/Respiratory)

#### PULM ANTI-HTN, SOLUBLE GUANYLATE CYCLASE STIMULATOR

ADEMPAS	T4	PA SP HD
<b>PULM.ANTI-HTN, SEL.C-GMP PHOSPHODIESTERASE T5 INHIB</b>		
REVATIO 10 MG/12.5 ML VIAL	T4	PA SP HD
<i>sildenafil citrate</i> (Revatio)	T4	PA SP HD

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

T4 – Specialty Medications  
PA – Prior Authorization  
QL – Quantity Limit

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

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

## List of Prescription Medications

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

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

#### PULM.ANTI-HTN, SEL.C-GMP PHOSPHODIESTERASE T5 INHIB (cont.)

<i>tadalafil</i> (Adcirca)	T4	PA SP HD
----------------------------	----	----------

#### PULMONARY ANTI-HTN, ENDOTHELIN RECEPTOR ANTAGONIST

<i>ambrisentan</i> (Letairis)	T4	PA SP HD
-------------------------------	----	----------

<i>bosentan</i> (Tracleer)	T4	PA SP HD
----------------------------	----	----------

LETAIRIS ( <i>ambrisentan</i> )	T4	PA SP HD
---------------------------------	----	----------

OPSUMIT	T4	PA SP HD
---------	----	----------

TRACLEER 125 MG TABLET ( <i>bosentan</i> )	T4	PA SP HD
--	----	----------

TRACLEER 32 MG TABLET FOR SUSP	T4	PA SP HD
--------------------------------	----	----------

TRACLEER 62.5 MG TABLET ( <i>bosentan</i> )	T4	PA SP HD
---	----	----------

#### PULMONARY ANTIHYPERTENSIVES, PROSTACYCLIN-TYPE

<i>epoprostenol sodium</i>	T4	PA SP HD
----------------------------	----	----------

<i>epoprostenol sodium 0.5 mg v1</i>	T4	PA SP HD
--------------------------------------	----	----------

<i>epoprostenol sodium 0.5 mg v1</i> (Flolan)	T4	PA SP
---	----	-------

<i>epoprostenol sodium 1.5 mg v1</i>	T4	PA SP HD
--------------------------------------	----	----------

<i>epoprostenol sodium 1.5 mg v1</i> (Flolan)	T4	PA SP
---	----	-------

FLOLAN	T4	PA SP
--------	----	-------

ORENITRAM ER	T4	PA SP HD
--------------	----	----------

ORENITRAM MONTH 1 TITRATION KT	T4	PA QL(168 tabs/180 days) SP HD
--------------------------------	----	--------------------------------

ORENITRAM MONTH 2 TITRATION KT	T4	PA QL(336 tabs/180 days) SP HD
--------------------------------	----	--------------------------------

ORENITRAM MONTH 3 TITRATION KT	T4	PA QL(252 tabs/180 days) SP HD
--------------------------------	----	--------------------------------

REMODULIN ( <i>treprostinil</i> )	T4	PA SP HD
-----------------------------------	----	----------

<i>treprostinil sodium</i> (Remodulin)	T4	PA SP HD
--	----	----------

TYVASO	T4	PA SP HD
--------	----	----------

TYVASO INSTITUTIONAL START KIT	T4	PA SP HD
--------------------------------	----	----------

TYVASO REFILL KIT	T4	PA SP HD
-------------------	----	----------

TYVASO STARTER KIT	T4	PA SP HD
--------------------	----	----------

UPTRAVI	T4	PA SP HD
---------	----	----------

VENTAVIS	T4	PA SP HD
----------	----	----------

VELETRI VIAL	T4	PA SP
--------------	----	-------

### CARDIOVASCULAR (Blood Pressure/Heart Medications)

#### ACE INHIBITOR-CALCIUM CHANNEL BLOCKER COMBINATION

<i>amlodipine besylate/benazepril</i>	T1	HD
---------------------------------------	----	----

PRESTALIA 14 MG-10 MG TABLET	T3	HD
------------------------------	----	----

PRESTALIA 3.5 MG-2.5 MG TABLET	T3	QL (1 tab/day) HD
--------------------------------	----	-------------------

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

T4 – Specialty Medications

PA – Prior Authorization

QL – Quantity Limit

ST – Step Therapy

AGE – Age Requirement

SP – Specialty Medication

HD – May require home delivery pharmacy

PPACA – No Cost-Share Preventive Medication

CSL – Oral cancer medication subject to cost-share limits

# List of Prescription Medications

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

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>ACE INHIBITOR-THIAZIDE OR THIAZIDE-LIKE DIURETIC</b>		
PRESTALIA 7 MG-5 MG TABLET	T3	QL (1 tab/day) HD
<i>trandolapril/verapamil hcl</i>	T1	HD
<i>captopril-hctz 25-15 mg tablet</i>	T1	QL (3 tabs/day) HD
<i>captopril-hctz 25-25 mg tablet</i>	T1	QL (2 tabs/day) HD
<i>captopril-hctz 50-15 mg tablet</i>	T1	QL (3 tabs/day) HD
<i>captopril-hctz 50-25 mg tablet</i>	T1	QL (2 tabs/day) HD
<i>enalapril/hydrochlorothiazide</i>	T1	HD
<i>fosinopril/hydrochlorothiazide</i>	T1	HD
<i>lisinopril/hydrochlorothiazide</i>	T1	HD
<i>quinapril/hydrochlorothiazide</i>	T1	HD
<b>ALPHA/BETA-ADRENERGIC BLOCKING AGENTS</b>		
<i>carvedilol (Coreg)</i>	T1	HD
<i>carvedilol er 10 mg capsule (Coreg Cr)</i>	T1	QL (1 cap/day) HD
<i>carvedilol er 20 mg capsule (Coreg Cr)</i>	T1	QL (1 cap/day) HD
<i>carvedilol er 40 mg capsule (Coreg Cr)</i>	T1	QL (1 cap/day) HD
<i>carvedilol er 80 mg capsule (Coreg Cr)</i>	T1	HD
COREG ( <i>carvedilol</i> )	T3	ST HD
COREG CR 10 MG CAPSULE ( <i>carvedilol er</i> )	T3	QL (1 cap/day) ST HD
COREG CR 20 MG CAPSULE ( <i>carvedilol er</i> )	T3	QL (1 cap/day) ST HD
COREG CR 40 MG CAPSULE ( <i>carvedilol er</i> )	T3	QL (1 cap/day) ST HD
COREG CR 80 MG CAPSULE ( <i>carvedilol er</i> )	T3	ST HD
LABELALOL HCL 10 MG/2 ML SYRNG	T3	HD
<i>labetalol hcl 100 mg tablet</i>	T1	HD
<i>labetalol hcl 100 mg/20 ml vl</i>	T1	HD
<i>labetalol hcl 20 mg/4 ml crpjt</i>	T1	HD
<i>labetalol hcl 20 mg/4 ml syrng</i>	T1	HD
<i>labetalol hcl 20 mg/4 ml vial</i>	T1	HD
CARDURA ( <i>doxazosin mesylate</i> )	T3	HD
CARDURA XL	T3	HD
<i>labetalol hcl 200 mg tablet</i>	T1	HD
<i>labetalol hcl 200 mg/40 ml vl</i>	T1	HD
<i>labetalol hcl 300 mg tablet</i>	T1	HD
<i>doxazosin mesylate (Cardura)</i>	T1	HD
MINIPRESS ( <i>prazosin hcl</i> )	T3	HD

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

T4 – Specialty Medications  
 PA – Prior Authorization  
 QL – Quantity Limit

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

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

# List of Prescription Medications

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

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>ALPHA/BETA-ADRENERGIC BLOCKING AGENTS (cont.)</b>		
<i>terazosin hcl</i>	T1	HD
<b>ANGIOTEN.RECEPTR ANTAG-CALCIUM CHANL BLKR-THIAZIDE</b>		
<i>amlodipine/valsartan/hcthiazyd</i>	T1	HD
<i>olmesartan/amlodipin/hcthiazyd</i>	T1	HD
<b>ANGIOTENSIN RECEPT-NEPRILYSIN INHIBITOR COMB (ARNI)</b>		
ENTRESTO	T2	HD
<b>ANGIOTENSIN RECEPTOR ANTAG.-THIAZIDE DIURETIC COMB</b>		
<i>candesartan/hydrochlorothiazid</i>	T1	HD
<i>irbesartan/hydrochlorothiazide</i>	T1	HD
<i>losartan/hydrochlorothiazide</i>	T1	HD
<i>olmesartan-hctz 20-12.5 mg tab</i>	T1	QL (1 tab/day) HD
<i>olmesartan-hctz 40-12.5 mg tab</i>	T1	HD
<i>olmesartan-hctz 40-25 mg tab</i>	T1	HD
<i>telmisartan-hctz 40-12.5 mg tb</i>	T1	QL (1 tab/day) HD
<i>telmisartan-hctz 80-12.5 mg tb</i>	T1	HD
<i>telmisartan-hctz 80-25 mg tab</i>	T1	HD
<i>valsartan/hydrochlorothiazide (Diovan Hct)</i>	T1	HD
<b>ANGIOTENSIN RECEPTOR BLOCKR-CALCIUM CHANNEL BLOCKR</b>		
<i>amlodipine besylate/valsartan</i>	T1	HD
<i>amlodipine-olmesartan 10-20 mg</i>	T1	HD
<i>amlodipine-olmesartan 10-40 mg</i>	T1	HD
<i>amlodipine-olmesartan 5-20 mg</i>	T1	QL (1 tab/day) HD
<i>amlodipine-olmesartan 5-40 mg</i>	T1	HD
<i>telmisartan-amlodipine 40-10</i>	T1	HD
<i>telmisartan-amlodipine 40-5 mg</i>	T1	QL (1 tab/day) HD
<i>telmisartan-amlodipine 80-10</i>	T1	HD
<i>telmisartan-amlodipine 80-5 mg</i>	T1	HD
<b>ANTIHYPERTENSIVES, ACE INHIBITORS</b>		
<i>benazepril hcl</i>	T1	HD
<i>captopril</i>	T1	HD
<i>enalapril maleate (Vasotec)</i>	T1	HD
<i>enalaprilat dihydrate</i>	T1	HD
EPANED	T3	HD

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

T4 – Specialty Medications  
 PA – Prior Authorization  
 QL – Quantity Limit

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

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

# List of Prescription Medications

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

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>ANTIHYPERTENSIVES, ACE INHIBITORS (cont.)</b>		
<i>fosinopril sodium</i>	T1	HD
<i>lisinopril (Zestril)</i>	T1	HD
<i>moexipril hcl</i>	T1	HD
<i>perindopril erbumine</i>	T1	HD
<i>quinapril hcl</i>	T1	HD
<i>ramipril</i>	T1	HD
<i>trandolapril</i>	T1	HD
<b>ANTIHYPERTENSIVES, ANGIOTENSIN RECEPTOR ANTAGONIST</b>		
<i>candesartan cilexetil</i>	T1	HD
<i>eprosartan mesylate</i>	T1	HD
<i>irbesartan</i>	T1	HD
<i>losartan potassium</i>	T1	HD
<i>olmesartan medoxomil 20 mg tab</i>	T1	QL (1 tab/day) HD
<i>olmesartan medoxomil 40 mg tab</i>	T1	HD
<i>olmesartan medoxomil 5 mg tab</i>	T1	HD
<i>telmisartan 20 mg tablet</i>	T1	QL (1 tab/day) HD
<i>telmisartan 40 mg tablet</i>	T1	QL (1 tab/day) HD
<i>telmisartan 80 mg tablet</i>	T1	HD
<i>valsartan</i>	T1	HD
<b>ANTIHYPERTENSIVES, GANGLIONIC BLOCKERS</b>		
VECAMYL	T1	
<b>ANTIHYPERTENSIVES, MISCELLANEOUS</b>		
DEMSEK ( <i>metirosine</i> )	T3	HD
<i>metirosine (Demser)</i>	T1	HD
NITROPRESS	T3	HD
<i>nitroprusside sodium (Nitropress)</i>	T1	HD
<b>ANTIHYPERTENSIVES, SYMPATHOLYTIC</b>		
CATAPRES ( <i>clonidine hcl</i> )	T3	HD
CATAPRES-TTS 1 ( <i>clonidine</i> )	T3	HD
CATAPRES-TTS 2 ( <i>clonidine</i> )	T3	HD
CATAPRES-TTS 3 ( <i>clonidine</i> )	T3	HD
<i>clonidine (Catapres-tts 1)</i>	T1	HD
<i>clonidine (Catapres-tts 2)</i>	T1	HD
<i>clonidine (Catapres-tts 3)</i>	T1	HD

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

T4 – Specialty Medications  
PA – Prior Authorization  
QL – Quantity Limit

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

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

## List of Prescription Medications

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

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>ANTIHYPERTENSIVES, SYMPATHOLYTIC (cont.)</b>		
<i>clonidine hcl 0.1 mg tablet (Catapres)</i>	T1	HD
<i>clonidine hcl 0.2 mg tablet (Catapres)</i>	T1	HD
<i>clonidine hcl 0.3 mg tablet (Catapres)</i>	T1	HD
<i>guanfacine hcl</i>	T1	HD
<i>methyldopa</i>	T1	HD
<i>methyldopa/hydrochlorothiazide</i>	T1	HD
<i>methyldopate hcl</i>	T1	HD
<b>ANTIHYPERTENSIVES, VASODILATORS</b>		
CORLOPAM	T3	HD
<i>hydralazine hcl</i>	T1	HD
<i>minoxidil</i>	T1	HD
<b>BETA-ADRENERGIC BLOCKING AGENTS</b>		
<i>acebutolol hcl</i>	T1	HD
<i>atenolol (Tenormin)</i>	T1	HD
<i>betaxolol hcl</i>	T1	HD
<i>bisoprolol fumarate</i>	T1	HD
BREVIBLOC	T3	HD
<i>esmolol hcl</i>	T1	HD
<i>esmolol hcl (Brevibloc)</i>	T1	HD
ESMOLOL HCL-WATER	T1	HD
<i>esmolol in sodium chloride, iso (Brevibloc)</i>	T1	HD
INNOPRAN XL	T3	ST HD
<i>metoprolol succinate (Toprol XL)</i>	T1	HD
<i>metoprolol tartrate</i>	T1	HD
<i>metoprolol tartrate (Lopressor)</i>	T1	HD
<i>nadolol</i>	T1	HD
<i>nadolol (Corgard)</i>	T1	HD
<i>pindolol</i>	T1	HD
<i>propranolol hcl</i>	T1	HD
<i>propranolol hcl (Inderal La)</i>	T1	HD
<i>sotalol hcl</i>	T1	HD
<i>sotalol hcl (Betapace Af)</i>	T1	HD

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

T4 – Specialty Medications  
PA – Prior Authorization  
QL – Quantity Limit

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

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

# List of Prescription Medications

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

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>BETA-ADRENERGIC BLOCKING AGENTS (cont.)</b>		
SOTYLIZE SOLN	T3	HD
<i>timolol maleate</i>	T1	HD
<b>BETA-BLOCKERS AND THIAZIDE, THIAZIDE-LIKE DIURETICS</b>		
<i>atenolol/chlorthalidone</i> (Tenoretic 100)	T1	HD
<i>atenolol/chlorthalidone</i> (Tenoretic 50)	T1	HD
<i>bisoprolol/hydrochlorothiazide</i> (Ziac)	T1	HD
<i>metoprolol/hydrochlorothiazide</i>	T1	HD
<i>nadolol/bendroflumethiazide</i>	T1	HD
<i>propranolol/hydrochlorothiazid</i>	T1	HD
<b>MUSCARINIC RECEPTOR ANTAGONISTS (ANTICHOLINERGIC)</b>		
ATROPEN	T3	
<b>PATENT DUCTUS ARTERIOSUS TREAT. AGENTS, NSAID-TYPE</b>		
<i>ibuprofen lysine/pf</i> (Neoprofen)	T1	
<i>indomethacin 1 mg vial</i>	T1	
NEOPROFEN ( <i>ibuprofen lysine</i> )	T3	
<b>RENIN INHIBITOR, DIRECT</b>		
<i>aliskiren 150 mg tablet</i>	T1	QL (1 tab/day) HD
<i>aliskiren 300 mg tablet</i>	T1	HD
<b>VASODILATORS, COMBINATION</b>		
BIDIL	T3	QL (6 tabs/day) HD
<i>isosorbide-hydralazine 20-37.5</i> (Bidil)	T1	QL(6 tabs/day) HD
<b>VASODILATORS, MISCELLANEOUS</b>		
<i>alprostadil</i>	T1	
PROSTIN VR PEDIATRIC	T3	
<b>VASODILATORS, PERIPHERAL</b>		
<i>ergoloid mesylates</i>	T1	
<i>isoxsuprine hcl</i>	T1	
<i>papaverine hcl</i>	T1	

## CARDIOVASCULAR (Cholesterol Medications)

### ANTIHYPERLIP.HMG COA REDUCT INHIB-CHOLEST.AB.INHIB

<i>ezetimibe/simvastatin</i>	T1	HD
ROSZET	T3	HD

### ANTIHYPERLIPID- HMG-COA RI-CALCIUM CHANNEL BLOCKER

<i>amlodipine-atorvast 10-40 mg</i> (Caduet)	T1	HD
--	----	----

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

T4 – Specialty Medications  
 PA – Prior Authorization  
 QL – Quantity Limit

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

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

# List of Prescription Medications

## CARDIOVASCULAR (Cholesterol Medications) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>ANTIHYPERLIPID- HMG-COA RI-CALCIUM CHANNEL BLOCKER (cont.)</b>		
<i>amlodipine-atorvast 10-80 mg (Caduet)</i>	T1	HD
<i>amlodipine-atorvast 2.5-10 mg</i>	T1	HD
<i>amlodipine-atorvast 2.5-20 mg</i>	T1	QL (1 tab/day) HD
<i>amlodipine-atorvast 2.5-40 mg</i>	T1	QL (1 tab/day) HD
<i>amlodipine-atorvast 5-10 mg (Caduet)</i>	T1	HD
<i>amlodipine-atorvast 5-20 mg (Caduet)</i>	T1	QL (1 tab/day) HD
<i>amlodipine-atorvast 5-40 mg (Caduet)</i>	T1	QL (1 tab/day) HD
<i>amlodipine-atorvast 5-80 mg (Caduet)</i>	T1	HD
CADUET 10 MG-10 MG TABLET ( <i>amlodipine-atorvastatin</i> )	T3	HD
CADUET 10 MG-20 MG TABLET ( <i>amlodipine-atorvastatin</i> )	T3	HD
CADUET 10 MG-40 MG TABLET ( <i>amlodipine-atorvastatin</i> )	T3	HD
CADUET 10 MG-80 MG TABLET ( <i>amlodipine-atorvastatin</i> )	T3	HD
CADUET 5 MG-10 MG TABLET ( <i>amlodipine-atorvastatin</i> )	T3	HD
CADUET 5 MG-20 MG TABLET ( <i>amlodipine-atorvastatin</i> )	T3	QL (1 tab/day) HD
CADUET 5 MG-40 MG TABLET ( <i>amlodipine-atorvastatin</i> )	T3	QL (1 tab/day) HD
CADUET 5 MG-80 MG TABLET ( <i>amlodipine-atorvastatin</i> )	T3	HD
<b>ANTIHYPERLIPIDEMIC - ANGIOPOIETIN-LIKE 3 INHIBITOR</b>		
EVKEEZA	T4	PA SP
<b>ANTIHYPERLIPIDEMIC - APO B-100 SYNTHESIS INHIBITOR</b>		
KYNAMRO	T4	PA SP
<b>ANTIHYPERLIPIDEMIC - PCSK9 INHIBITORS</b>		
REPATHA PUSHTRONEX	T2	PA
REPATHA SURECLICK	T2	PA
REPATHA SYRINGE	T2	PA
<b>ANTIHYPERLIPIDEMIC-HMGCOA REDUCTASE INHIB (STATINS)</b>		
<i>atorvastatin 10 mg tablet</i>	T1	HD PPACA
<i>atorvastatin 20 mg tablet</i>	T1	HD PPACA
<i>atorvastatin 40 mg tablet</i>	T1	HD
<i>atorvastatin 80 mg tablet</i>	T1	HD
<i>fluvastatin sodium</i>	T1	HD PPACA
<i>lovastatin 10 mg tablet</i>	T1	HD
<i>lovastatin 20 mg tablet</i>	T1	HD PPACA
<i>lovastatin 40 mg tablet</i>	T1	HD PPACA
<i>pitavastatin 1 mg tablet (Livalo)</i>	T1	QL (1 tab/day) HD PPACA
<i>pitavastatin 2 mg tablet (Livalo)</i>	T1	QL (1 tab/day) HD PPACA

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

T4 – Specialty Medications

PA – Prior Authorization

QL – Quantity Limit

ST – Step Therapy

AGE – Age Requirement

SP – Specialty Medication

HD – May require home delivery pharmacy

PPACA – No Cost-Share Preventive Medication

CSL – Oral cancer medication subject to cost-share limits



# List of Prescription Medications

CARDIOVASCULAR (Cholesterol Medications) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>ANTIHYPERLIPIDEMIC-HMGCOA REDUCTASE INHIB (STATINS) (cont.)</b>		
<i>pitavastatin 4 mg tablet (Livalo)</i>	T1	HD PPACA
<i>pravastatin sodium</i>	T1	HD PPACA
<i>rosuvastatin calcium 10 mg tab</i>	T1	QL (1 tab/day) HD PPACA
<i>rosuvastatin calcium 20 mg tab (Crestor)</i>	T1	QL (1 tab/day) HD
<i>rosuvastatin calcium 40 mg tab (Crestor)</i>	T1	HD
<i>rosuvastatin calcium 5 mg tab</i>	T1	QL (1 tab/day) HD PPACA
<i>simvastatin 10 mg tablet</i>	T1	HD PPACA
<i>simvastatin 20 mg tablet</i>	T1	HD PPACA
<i>simvastatin 40 mg tablet</i>	T1	HD PPACA
<i>simvastatin 5 mg tablet</i>	T1	HD
<b>BILE SALT SEQUESTRANTS</b>		
<i>cholestyramine (with sugar) (Questran)</i>	T1	HD
<i>cholestyramine/aspartame</i>	T1	HD
<i>cholestyramine/aspartame (Questran Light)</i>	T1	HD
<i>colesevelam hcl (Welchol)</i>	T1	HD
COLESTID	T3	HD
COLESTID ( <i>colestipol hcl</i> )	T3	HD
<i>colestipol hcl (Colestid)</i>	T1	HD
QUESTRAN ( <i>cholestyramine</i> )	T3	HD
QUESTRAN LIGHT ( <i>prevalite</i> )	T3	HD
<b>LIPOTROPICS</b>		
<i>ezetimibe (Zetia)</i>	T1	HD
<i>fenofibrate</i>	T1	HD
<i>fenofibrate nanocrystallized (Tricor)</i>	T1	HD
<i>fenofibrate, micronized</i>	T1	HD
<i>fenofibrate 120 mg tablet (Fenoglide)</i>	T1	HD
<i>fenofibrate 40 mg tablet (Fenoglide)</i>	T1	HD
<i>fenofibric acid (choline) (Trilipix)</i>	T1	HD
<i>fenofibric acid (Fibricor)</i>	T1	HD
FIBRICOR ( <i>fenofibric acid</i> )	T3	ST HD
<i>gemfibrozil (Lopid)</i>	T1	HD
LIPOFEN	T3	ST HD
LOPID ( <i>gemfibrozil</i> )	T3	HD

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

T4 – Specialty Medications  
 PA – Prior Authorization  
 QL – Quantity Limit

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

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

## List of Prescription Medications

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

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>LIPOTROPICS (cont.)</b>		
<i>niacin</i> (Niaspan)	T1	HD
NIASPAN ( <i>niacin er</i> )	T3	HD
TRICOR ( <i>fenofibrate</i> )	T3	ST HD
TRIGLIDE	T3	ST HD
TRILIPIX ( <i>fenofibric acid</i> )	T3	ST HD
ZETIA ( <i>ezetimibe</i> )	T3	HD

### CARDIOVASCULAR (Miscellaneous)

#### VENOSCLEROSING AGENTS

ASCLERA	T4	PA SP
ETHAMOLIN	T3	
<i>sodium tetradecyl sulfate</i> (Sotradecol)	T1	
SOTRADECOL	T3	
SOTRADECOL ( <i>sodium tetradecyl sulfate</i> )	T3	

### CNS DRUGS (Alzheimer's Disease)

#### ALZHEIMER'S THERAPY, NMDA RECEPTOR ANTAGONISTS

<i>memantine hcl</i>	T1	HD
<i>memantine hcl</i> (Namenda)	T1	HD
<i>memantine hcl er 14 mg capsule</i> (Namenda Xr)	T1	QL (1 cap/day) HD
<i>memantine hcl er 28 mg capsule</i> (Namenda Xr)	T1	HD
NAMENDA	T3	HD
NAMENDA ( <i>memantine hcl</i> )	T3	HD
NAMENDA XR 14 MG CAPSULE ( <i>memantine hcl er</i> )	T3	QL (1 cap/day) HD
NAMENDA XR 21 MG CAPSULE ( <i>memantine hcl er</i> )	T3	HD
NAMENDA XR 28 MG CAPSULE ( <i>memantine hcl er</i> )	T3	HD
NAMENDA XR 7 MG CAPSULE ( <i>memantine hcl er</i> )	T3	QL (1 cap/day) HD
NAMENDA XR TITRATION PACK	T3	QL (112/365 days) HD
NAMZARIC 14 MG-10 MG CAPSULE	T3	QL (2 caps/day) HD
NAMZARIC 21 MG-10 MG CAPSULE	T3	QL (2 caps/day) HD
NAMZARIC 28 MG-10 MG CAPSULE	T3	QL (2 caps/day) HD
NAMZARIC 7 MG-10 MG CAPSULE	T3	QL (2 caps/day) HD
NAMZARIC TITRATION PACK	T3	QL (112/365 days) HD

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

T4 – Specialty Medications  
 PA – Prior Authorization  
 QL – Quantity Limit

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

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

# List of Prescription Medications

CNS DRUGS (Miscellaneous)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>ALCOHOL, SYSTEMIC USE</b>		
ALCOHOL, DEHYDRATED	T1	
<i>ethyl alcohol</i>	T1	
<b>AMYOTROPHIC LATERAL SCLEROSIS AGENTS</b>		
QALSODY	T3	
RADICAVA ORS	T4	PA SP QL (50ml/28days)
RADICAVA	T4	PA SP
RILUTEK ( <i>riluzole</i> )	T4	SP HD
<i>riluzole</i> (Rilutek)	T4	SP HD
TIGLUTIK	T4	PA SP
<b>CENTRAL NERVOUS SYSTEM STIMULANTS</b>		
DOPRAM	T3	
<i>doxapram hcl</i> (Dopram)	T1	
<b>DRUGS TO TREAT MOVEMENT DISORDERS</b>		
AUSTEDO	T4	PA SP HD
AUSTEDO XR 6 MG TABLET	T4	PA QL (90 tabs/30 days) SP HD
AUSTEDO XR 12 MG TABLET	T4	PA QL (30 tabs/30 days) SP HD
AUSTEDO XR 24 MG TABLET	T4	PA QL (60 tabs/30 days) SP HD
AUSTEDO XR TITRATION KIT(WK1-4)	T4	PA QL (1 kit/180 days) SP HD
INGREZZA	T4	PA SP
INGREZZA INITIATION PACK	T4	PA QL (28 caps/year) SP
<i>tetrabenazine</i>	T4	PA SP HD
<b>PSEUDOBLBAR AFFECT (PBA) AGENTS, NMDA ANTAGONISTS</b>		
NUDEXTA	T3	QL (4 caps/day)
<b>XANTHINES</b>		
CAFCIT ( <i>caffeine citrate</i> )	T3	HD
CAFFEINE AND SODIUM BENZOATE	T1	HD
<i>caffeine citrate</i>	T1	HD
<i>caffeine citrate</i> (Cafcit)	T1	HD
<i>caffeine/sodium benzoate</i> (Caffeine And Sodium Benzoate)	T1	HD
<b>AGENTS TO TREAT MULTIPLE SCLEROSIS</b>		
AVONEX	T4	PA SP HD
AVONEX PEN	T4	PA SP HD
BAFIERTAM	T2	PA SP HD
BETASERON	T4	PA SP HD

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

T4 – Specialty Medications  
 PA – Prior Authorization  
 QL – Quantity Limit

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

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

# List of Prescription Medications

CNS DRUGS (Miscellaneous) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>AGENTS TO TREAT MULTIPLE SCLEROSIS (cont.)</b>		
BRIUMVI	T4	PA SP
<i>dimethyl fumarate</i>	T1	HD
<i>glatopa</i>	T1	HD
<i>glatiramer</i>	T1	HD
<i>glatiramer acetate</i>	T4	PA SP HD
KESIMPTA PEN	T4	PA SP HD
LEMTRADA	T4	PA SP HD
MAVENCLAD	T4	PA SP HD
MAYZENT	T4	PA SP HD
OCREVUS	T4	PA SP HD
PLEGRIDY	T4	PA SP HD
PLEGRIDY PEN	T4	PA SP HD
PONVORY	T4	PA SP HD
REBIF	T4	PA SP HD
REBIF REBIDOSE	T4	PA SP HD
<i>teriflunomide (Aubagio)</i>	T4	SP HD
VUMERITY	T4	PA SP HD
<b>AGTS TX NEUROMUSC TRANSMISSION DIS, POT-CHAN BLKR</b>		
<i>dalfampridine</i>	T4	PA SP HD
FIRDAPSE	T4	PA QL (8 tabs/day) SP
RUZURGI	T4	PA SP
<b>CNS DRUGS (Pain Relief And Inflammatory Disease)</b>		
<b>CALCITONIN GENE-RELATED PEPTIDE (CGRP) INHIBITORS</b>		
EMGALITY SYRINGE	T2	PA
<b>CNS DRUGS (Seizure Disorders)</b>		
<b>ANTICONVULSANT - BENZODIAZEPINE TYPE</b>		
<i>clobazam (Onfi)</i>	T1	HD
<i>clonazepam</i>	T1	HD
<i>clonazepam (Klonopin)</i>	T1	HD
DIASTAT ( <i>diazepam</i> )	T3	PA HD
DIASTAT ACUDIAL ( <i>diazepam</i> )	T3	PA HD
<i>diazepam 10 mg rectal gel syst (Diastat Acudial)</i>	T1	HD
<i>diazepam 2.5 mg rectal gel sys (Diastat)</i>	T1	HD

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

T4 – Specialty Medications  
 PA – Prior Authorization  
 QL – Quantity Limit

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

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

## List of Prescription Medications

CNS DRUGS (Seizure Disorders) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>ANTICONVULSANT - BENZODIAZEPINE TYPE (cont.)</b>		
<i>diazepam 20 mg rectal gel syst</i>	T1	HD
KLONOPIN ( <i>clonazepam</i> )	T3	PA HD
NAYZILAM	T2	PA QL (5 kits/30 days) HD
ONFI ( <i>clobazam</i> )	T3	PA HD
VALTOCO	T3	PA QL (5 boxes/30 Days) HD
<b>ANTICONVULSANT - CANNABINOID TYPE</b>		
EPIDIOLEX	T4	PA SP HD
<b>ANTICONVULSANTS</b>		
APTIOM 200 MG TABLET	T3	PA QL (1 tab/day) HD
APTIOM 400 MG TABLET	T3	PA QL (1 tab/day) HD
APTIOM 600 MG TABLET	T3	PA HD
APTIOM 800 MG TABLET	T3	PA HD
BRIVIACT 10 MG TABLET	T3	PA HD
BRIVIACT 10 MG/ML ORAL SOLN	T3	PA HD
BRIVIACT 100 MG TABLET	T3	PA HD
BRIVIACT 25 MG TABLET	T3	PA HD
BRIVIACT 50 MG TABLET	T3	PA HD
BRIVIACT 50 MG/5 ML VIAL	T3	HD
BRIVIACT 75 MG TABLET	T3	PA HD
<i>carbamazepine</i>	T1	HD
<i>carbamazepine (Carbatrol)</i>	T1	HD
<i>carbamazepine (Tegretol Xr)</i>	T1	HD
<i>carbamazepine (Tegretol)</i>	T1	HD
CARBATROL ( <i>carbamazepine er</i> )	T3	PA HD
CELONTIN	T2	HD
CEREBYX ( <i>fosphenytoin sodium</i> )	T3	HD
DIACOMIT	T4	PA SP HD

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

T4 – Specialty Medications  
 PA – Prior Authorization  
 QL – Quantity Limit

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

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

# List of Prescription Medications

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

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>ANTICONVULSANTS (cont.)</b>		
DILANTIN 100 MG CAPSULE ( <i>phenytoin sodium extended</i> )	T3	PA HD
DILANTIN 30 MG CAPSULE	T2	PA HD
DILANTIN 50 MG INFATAB ( <i>phenytoin</i> )	T3	PA HD
DILANTIN-125 ( <i>phenytoin</i> )	T3	PA HD
<i>divalproex sodium</i> (Depakote Er)	T1	HD
<i>divalproex sodium</i> (Depakote Sprinkle)	T1	HD
<i>divalproex sodium</i> (Depakote)	T1	HD
<i>ethosuximide</i> (Zarontin)	T1	HD
<i>felbamate</i>	T1	HD
FINTEPLA	T4	PA SP HD
FYCOMPA 0.5 MG/ML ORAL SUSP	T2	PA HD
FYCOMPA 10 MG TABLET	T2	PA HD
FYCOMPA 12 MG TABLET	T2	PA HD
FYCOMPA 2 MG TABLET	T2	PA HD
FYCOMPA 4 MG TABLET	T2	PA QL (1 tab/day) HD
FYCOMPA 6 MG TABLET	T2	PA QL (1 tab/day) HD
FYCOMPA 8 MG TABLET	T2	PA HD
<i>gabapentin</i> (Gralise)	T1	HD
<i>gabapentin</i> (Neurontin)	T1	HD
GABITRIL 12 MG TABLET ( <i>tiagabine hcl</i> )	T3	PA QL (8 tabs/day) HD
GABITRIL 16 MG TABLET ( <i>tiagabine hcl</i> )	T3	PA QL (6 tabs/day) HD
GABITRIL 2 MG TABLET ( <i>tiagabine hcl</i> )	T3	PA HD
GABITRIL 4 MG TABLET ( <i>tiagabine hcl</i> )	T3	PA HD
KEPPRA ( <i>levetiracetam</i> )	T3	HD
<i>lacosamide</i> (Vimpat)	T1	HD
<i>lamotrigine</i>	T1	HD
<i>levetiracetam</i> (Keppra)	T1	HD
<i>levetiracetam in nacl (iso-os)</i>	T1	HD
LYRICA ( <i>pregabalin</i> )	T3	PA HD
NEURONTIN ( <i>gabapentin</i> )	T3	PA HD
<i>oxcarbazepine</i>	T1	HD
OXTELLAR XR	T3	PA HD

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

T4 – Specialty Medications  
 PA – Prior Authorization  
 QL – Quantity Limit

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

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

# List of Prescription Medications

CNS DRUGS (Seizure Disorders) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>ANTICONVULSANTS (cont.)</b>		
PEGANONE	T2	HD
PHENYTEK ( <i>phenytoin sodium extended</i> )	T3	PA HD
<i>phenytoin</i>	T1	HD
<i>phenytoin</i> (Dilantin)	T1	HD
<i>phenytoin</i> (Dilantin-125)	T1	HD
<i>phenytoin sodium</i>	T1	HD
<i>phenytoin sodium extended</i> (Dilantin)	T1	HD
<i>phenytoin sodium extended</i> (Phenytek)	T1	HD
<i>pregabalin</i>	T1	HD
<i>pregabalin</i> (Lyrica)	T1	HD
<i>primidone</i>	T1	HD
<i>primidone 250 mg tablet</i> (Mysoline)	T1	HD
<i>primidone 50 mg tablet</i> (Mysoline)	T1	HD
<i>rufinamide 200 mg tablet</i> (Banzel)	T1	PA QL (16 tabs/day) HD
<i>rufinamide 400 mg tablet</i> (Banzel)	T1	PA QL (8 tabs/day) HD
SPRITAM	T3	PA HD
TEGRETOL ( <i>carbamazepine</i> )	T3	PA HD
TEGRETOL ( <i>epitol</i> )	T3	PA HD
TEGRETOL XR ( <i>carbamazepine er</i> )	T3	PA HD
<i>tiagabine hcl 12 mg tablet</i> (Gabitril)	T1	QL (8 tabs/day) HD
<i>tiagabine hcl 16 mg tablet</i> (Gabitril)	T1	QL (6 tabs/day) HD
<i>tiagabine hcl 2 mg tablet</i> (Gabitril)	T1	HD
<i>tiagabine hcl 4 mg tablet</i> (Gabitril)	T1	HD
<i>topiramate er 200 mg capsule</i> (Trokendi Xr)	T1	HD
<i>topiramate er 100 mg capsule</i> (Trokendi Xr)	T1	QL(1 cap/day) HD
<i>topiramate er 25 mg capsule</i> (Trokendi Xr)	T1	QL(1 cap/day) HD
<i>topiramate er 50 mg capsule</i> (Trokendi Xr)	T1	HD
<i>topiramate</i>	T1	HD
<i>valproic acid</i>	T1	HD
<i>valproic acid (as sodium salt)</i>	T1	HD
<i>vigabatrin</i>	T4	SP HD
VIMPAT 10 MG/ML SOLUTION	T2	PA HD
VIMPAT 100 MG TABLET	T2	PA HD
VIMPAT 150 MG TABLET	T2	PA HD

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

T4 – Specialty Medications  
 PA – Prior Authorization  
 QL – Quantity Limit

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

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

## List of Prescription Medications

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

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>ANTICONVULSANTS (cont.)</b>		
VIMPAT 200 MG TABLET	T2	PA HD
VIMPAT 200 MG/20 ML VIAL	T3	HD
VIMPAT 50 MG TABLET	T2	PA HD
XCOPRI 100 MG TABLET	T3	PA QL (1 tab/day) HD
XCOPRI 12.5-25 MG TITRATION PK	T3	PA QL (1/28 days) HD
XCOPRI 150 MG TABLET	T3	PA QL (1/day) HD
XCOPRI 150-200 MG TITRATION PK	T3	PA QL (1/28 days) HD
XCOPRI 200 MG TABLET	T3	PA QL (2/day) HD
XCOPRI 250 MG DAILY DOSE PACK	T3	PA QL (1/28 days) HD
XCOPRI 350 MG DAILY DOSE PACK	T3	PA QL (1/28 days) HD
XCOPRI 50 MG TABLET	T3	PA QL (1/day) HD
XCOPRI 50-100 MG TITRATION PAK	T3	PA QL (1/28 days) HD
ZARONTIN ( <i>ethosuximide</i> )	T3	PA HD
<i>zonisamide</i>	T1	HD

### CNS DRUGS (Sleep Disorders/Sedatives)

#### NARCOLEPSY TX-H3-RECEPT.ANTAGONIST/INVERSE AGONIST

WAKIX	T3	PA QL (2 tabs/day) SP HD
-------	----	--------------------------

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

#### ERYTHROPOIESIS-STIMULATING AGENTS

ARANESP	T4	PA SP
EPOGEN	T4	PA SP
MIRCERA	T4	PA SP
PROCRIT	T4	PA SP
RETACRIT	T4	PA SP

#### LEUKOCYTE (WBC) STIMULANTS

FULPHILA	T4	PA SP
GRANIX	T4	PA SP
LEUKINE	T4	SP
NEULASTA	T4	PA SP
NEULASTA ONPRO	T4	PA SP HD
NEUPOGEN	T4	PA SP
NIVESTYM	T4	SP
NYVEPRIA	T4	PA SP

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

T4 – Specialty Medications  
 PA – Prior Authorization  
 QL – Quantity Limit

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

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



## List of Prescription Medications

COLONY STIMULATING FACTORS (Blood Modifiers/Bleeding Disorders) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>LEUKOCYTE (WBC) STIMULANTS (cont.)</b>		
STIMUFEND	T4	PA SP
UDENYCA	T4	PA SP
ZARXIO	T4	SP HD
ZIEXTENZO	T4	PA SP
<b>THROMBOPOIETIN RECEPTOR AGONISTS</b>		
DOPTELET	T4	PA SP HD
MULPLETA	T4	PA SP HD
NPLATE	T4	PA SP
PROMACTA	T4	PA SP HD
<b>COLONY STIMULATING FACTORS (Cancer)</b>		
<b>CXCR4 CHEMOKINE RECEPTOR ANTAGONIST</b>		
MOZOBIL	T4	PA SP
<b>CONTRACEPTIVES (Contraception Products)</b>		
<b>CONTRACEPTIVES, INTRAVAGINAL, SYSTEMIC</b>		
ANNOVERA	T3	
<i>etonogestrel/ethinyl estradiol</i> (Nuvaring)	T1	PPACA
NUVARING ( <i>etonogestrel-ethinyl estradiol</i> )	T3	
<b>CONTRACEPTIVES, IMPLANTABLE</b>		
NEXPLANON	T4	SP PPACA
<b>CONTRACEPTIVES, INJECTABLE</b>		
DEPO-PROVERA 150 MG/ML SYRINGE ( <i>medroxyprogesterone acetate</i> )	T3	
DEPO-PROVERA 150 MG/ML VIAL ( <i>medroxyprogesterone acetate</i> )	T3	
DEPO-SUBQ PROVERA 104	T3	
<b>CONTRACEPTIVES, ORAL</b>		
BEYAZ ( <i>rajani</i> )	T3	HD
<i>desog-e.estradiol/e.estradiol</i> (Mircette)	T1	HD PPACA
<i>desogestrel-ethinyl estradiol</i>	T1	HD PPACA
<i>drospir/eth estra/levomefol ca</i> (Beyaz)	T1	HD PPACA
<i>drospir/eth estra/levomefol ca</i> (Safyral)	T1	HD PPACA
ELLA	T3	HD PPACA
ESTROSTEP FE ( <i>tri-legest fe</i> )	T3	HD
<i>ethinyl estradiol/drospirenone</i> (Yasmin 28)	T1	HD PPACA

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

T4 – Specialty Medications  
 PA – Prior Authorization  
 QL – Quantity Limit

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

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

# List of Prescription Medications

## CONTRACEPTIVES (Contraception Products) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>CONTRACEPTIVES, ORAL (cont.)</b>		
<i>ethinyl estradiol/drospirenone (Yaz)</i>	T1	HD PPACA
<i>ethynodiol d-ethinyl estradiol</i>	T1	HD PPACA
<i>levonorgest/eth.estradiol/iron (Balcoltra)</i>	T1	HD PPACA
<i>l-norgest/e.estradiol-e.estrad (Loseasonique)</i>	T1	HD PPACA
<i>l-norgest/e.estradiol-e.estrad (Quartette)</i>	T1	HD PPACA
<i>l-norgest/e.estradiol-e.estrad (Seasonique)</i>	T1	HD PPACA
LO LOESTRIN FE	T2	HD
LOESTRIN ( <i>norethindron-ethinyl estradiol</i> )	T3	HD
LOESTRIN FE ( <i>norethindrone-eth estradiol-fe</i> )	T3	HD
LOESTRIN FE ( <i>tarina fe 1-20 eq</i> )	T3	HD
LOSEASONIQUE ( <i>lojaimiess</i> )	T3	HD
MICROGESTIN 24 FE ( <i>tarina 24 fe</i> )	T3	HD
MINASTRIN 24 FE ( <i>norethin-eth estra-ferrous fum</i> )	T3	HD
MIRCETTE ( <i>volnea</i> )	T3	HD
<i>noreth-ethinyl estradiol/iron</i>	T1	HD PPACA
<i>noreth-ethinyl estradiol/iron (Generess Fe)</i>	T1	HD PPACA
<i>noreth-ethinyl estradiol/iron (Generess Fe)</i>	T3	HD PPACA
<i>norethind-eth estrad 1-0.02 mg (Loestrin)</i>	T1	HD PPACA
<i>norethindrone (Ortho Micronor)</i>	T1	HD PPACA
<i>norethindrone ac-eth estradiol (Loestrin)</i>	T1	HD PPACA
<i>norethindrone-e.estradiol-iron</i>	T1	HD PPACA
<i>norethindrone-e.estradiol-iron (Estrostep Fe)</i>	T1	HD PPACA
<i>norethindrone-e.estradiol-iron (Loestrin Fe)</i>	T1	HD PPACA
<i>norethindrone-e.estradiol-iron (Microgestin 24 Fe)</i>	T1	HD PPACA
<i>norethindrone-e.estradiol-iron (Minastrin 24 Fe)</i>	T1	HD PPACA
<i>norethindrone-ethin. estradiol</i>	T1	HD PPACA
<i>norethin-ee 1.5-0.03 mg (21) tb (Loestrin)</i>	T1	HD PPACA
<i>norgestrel-ethinyl estradiol</i>	T1	HD PPACA
ORTHO MICRONOR ( <i>tulana</i> )	T3	HD
QUARTETTE ( <i>rivelsa</i> )	T3	HD
SAFYRAL ( <i>tydemy</i> )	T3	HD
SEASONIQUE ( <i>simpesse</i> )	T3	HD

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

T4 – Specialty Medications

PA – Prior Authorization

QL – Quantity Limit

ST – Step Therapy

AGE – Age Requirement

SP – Specialty Medication

HD – May require home delivery pharmacy

PPACA – No Cost-Share Preventive Medication

CSL – Oral cancer medication subject to cost-share limits

## List of Prescription Medications

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

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>CONTRACEPTIVES, ORAL (cont.)</b>		
TYBLUME	T3	HD
YASMIN 28 (zumandimine)	T3	HD
YAZ (vestura)	T3	HD
<b>CONTRACEPTIVES, TRANSDERMAL</b>		
norelgestromin/ethin.estradiol	T1	HD PPACA
<b>DIAPHRAGMS/CERVICAL CAP</b>		
CAYA CONTOURED	T3	PPACA
FEMCAP	T3	PPACA
WIDE SEAL DIAPHRAGM	T3	PPACA
<b>INTRA-UTERINE DEVICES (IUDS)</b>		
KYLEENA	T4	SP PPACA
LILETTA	T4	SP PPACA
MIRENA	T4	SP PPACA
PARAGARD T 380-A	T4	SP PPACA
SKYLA	T4	SP PPACA

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

<b>1ST GEN ANTIHIST-DECONGEST-ANTICHOLINERGIC COMB</b>		
RESPA A.R.	T3	

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

<b>ANTITUSSIVES, NON-OPIOID</b>		
benzonatate	T1	
benzonatate (Tessalon Perle)	T1	
TESSALON PERLE (benzonatate)	T3	
<b>NON-OPIOID ANTITUS-1ST GEN.ANTIHISTAMINE-DECONGEST</b>		
brompheniramine/pseudoephed/dm (Bromfed Dm)	T1	
<b>NON-OPIOID ANTITUSSIVE-1ST GEN ANTIHISTAMINE COMB.</b>		
promethazine/dextromethorphan	T1	
<b>OPIOID ANTITUSSIV-1ST GEN. ANTIHISTAMINE-DECONGEST</b>		
hydrocodone/cpm/pseudoephed	T1	PA
promethazine/phenyleph/codeine	T1	PA QL (480ml/22 days)
promethazine/phenyleph/codeine	T1	PA QL (480ml/30 days)
<b>OPIOID ANTITUSSIVE-1ST GENERATION ANTIHISTAMINE</b>		
hydrocodone/chlorphen p-stirex	T1	PA
promethazine-codeine solution	T1	PA QL (480ml/22 days)
promethazine-codeine syrup	T1	PA QL (480ml/30 days)

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

T4 – Specialty Medications  
 PA – Prior Authorization  
 QL – Quantity Limit

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

HD – 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
<b>OPIOID ANTITUSSIVE-1ST GENERATION ANTIHISTAMINE (cont.)</b>		
TUXARIN ER	T3	PA QL (2 tabs/day)
TUZISTRA XR	T3	PA QL (960ml/30 days)
<b>OPIOID ANTITUSSIVE-ANTICHOLINERGIC COMBINATIONS</b>		
HYCODAN ( <i>hydromet</i> )	T3	PA QL (480ml/22 days)
<i>hydrocodone bit/homatrop me-br</i> (Hycodan)	T1	PA QL (480ml/22 days)
<i>hydrocodone-homatropine 5-1.5</i>	T1	PA QL (180 tabs/30 days)
<i>hydrocodone-homatropine soln</i> (Hycodan)	T1	PA QL (480ml/30 days)
HYDROCODONE-HOMATROPINE SYRUP	T1	PA QL (480ml/30 days)
<b>OPIOID ANTITUSSIVE-EXPECTORANT COMBINATION</b>		
HYDROCODONE-GUAIFENESIN	T1	PA QL (960ml/30 days)
OBREDON	T3	PA QL (960ml/30 days)

### DIAGNOSTIC (Diabetes)

#### BLOOD SUGAR DIAGNOSTICS

ONETOUCH ULTRA TEST STRIP	T2	
ONETOUCH VERIO TEST STRIP	T2	

### DIAGNOSTIC (Miscellaneous)

#### ADRENAL RADIOACTIVE DIAGNOSTICS

ADREVIEW	T3	
----------	----	--

#### BILIARY DIAGNOSTICS

CHOLETEC	T3	
TC99M MEBROFENIN PREP	T1	

#### BILIARY DIAGNOSTICS, RADIOPAQUE

<i>indocyanine green</i>	T1	
SINOGRAFIN	T3	

#### CARDIOVASCULAR DIAGNOSTICS - RADIOACTIVE

AMMONIA N-13	T3	
MYOVIEW	T3	
TC99M PYROPHOSPHATE PREP	T1	
TC99M SESTAMIBI PREP	T1	
THALLOUS CHLORIDE TL-201	T1	

#### CARDIOVASCULAR DIAGNOSTICS, NON-RADIOPAQUE AGENTS

<i>adenosine 60 mg/20 ml vial</i>	T1	
<i>adenosine 90 mg/30 ml vial</i>	T1	
DEFINITY	T3	

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

T4 – Specialty Medications  
PA – Prior Authorization  
QL – Quantity Limit

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

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

# List of Prescription Medications

DIAGNOSTIC (Miscellaneous) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>CARDIOVASCULAR DIAGNOSTICS, NON-RADIOPAQUE AGENTS (cont.)</b>		
<i>dipyridamole 5 mg/ml vial</i>	T1	
LEXISCAN	T3	
OPTISON	T3	
<i>regadenoson 0.4 mg/5 ml syring</i>	T1	
<b>CARDIOVASCULAR DIAGNOSTICS-RADIOPAQUE</b>		
ISOVUE-200	T3	
ISOVUE-250	T3	
ISOVUE-300	T3	
<b>CARDIOVASCULAR DIAGNOSTICS-RADIOPAQUE</b>		
ISOVUE-370	T3	
ISOVUE-M 200	T3	
ISOVUE-M 300	T3	
OMNIPAQUE	T3	
OPTIRAY 240	T3	
OPTIRAY 300	T3	
OPTIRAY 320	T3	
OPTIRAY 350	T3	
ULTRAVIST	T3	
VISIPAQUE	T3	
<b>CEREBRAL SPINAL RADIOACTIVE DIAGNOSTICS</b>		
CERETEC	T3	
INDIUM IN-111 DTPA	T3	
DOTAREM	T3	
<i>gadoterate meglumine (Dotarem)</i>	T1	
MAGNEVIST	T3	
MULTIHANCE	T3	
MULTIHANCE MULTIPACK	T3	
OMNISCAN	T3	
OMNISCAN PREFILL PLUS	T3	
OPTIMARK	T3	
PROHANCE	T3	
PROHANCE MULTIPACK	T3	
<b>DIAGNOSTIC PREPARATIONS, MISCELLANEOUS</b>		
ADVANCED DNA MEDICATED COLLECT	T3	

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

T4 – Specialty Medications  
 PA – Prior Authorization  
 QL – Quantity Limit

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

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

## List of Prescription Medications

DIAGNOSTIC (Miscellaneous) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>DIAGNOSTIC PREPARATIONS, MISCELLANEOUS (cont.)</b>		
ARIDOL	T3	
DMSA	T3	
DRAXIMAGE DTPA	T3	
GADAVIST	T3	
<i>gadobutrol</i>	T1	
GLUCAGEN	T3	
GLUCAGON HCL	T1	
<i>isosulfan blue</i> (Lymphazurin)	T1	
<i>lidocaine hcl/glycerin</i> (Advanced Dna Medicated Collect)	T1	
LIPIODOL	T3	
LUMASON	T3	
LYMPHAZURIN	T3	
NETSPOT	T3	
PROVOCHOLINE	T3	
TC99M MEDRONATE PREP	T1	
TC99M SULFUR COLLOID PREP	T1	
<b>DIAGNOSTIC RADIOPHARM - AMYLOID/TAU IMAGING</b>		
AMYVID	T3	
VIZAMYL	T3	PA
<b>DIAGNOSTIC RADIOPHARM - DOPAMINE TRANSPORTER (DAT)</b>		
DATSCAN	T3	
<b>EYE DIAGNOSTIC AGENTS</b>		
AK-FLUOR	T3	
AK-FLUOR ( <i>fluorescite</i> )	T3	
<i>fluorescein sodium</i>	T1	
<i>fluorescein sodium</i> (Ak-fluor)	T1	
<i>ful-glo 1 mg oph strip</i>	T1	
FUL-GLO EYE STRIPS	T3	
<i>lissamine green</i>	T1	
<b>FLUORESCENCE CYSTOSCOPY/OPTICAL IMAGING AGENTS</b>		
CYSVIEW	T3	
<b>GASTROINTESTINAL RADIOPAQUE DIAGNOSTICS</b>		
ENTEROVU	T3	
E-Z DISK	T3	

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

T4 – Specialty Medications  
PA – Prior Authorization  
QL – Quantity Limit

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

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

## List of Prescription Medications

<b>DIAGNOSTIC (Miscellaneous) (cont.)</b>		
<b>Prescription Drug Name</b>	<b>Drug Tier</b>	<b>Coverage Requirements and Limits</b>
<b>GASTROINTESTINAL RADIOPAQUE DIAGNOSTICS (cont.)</b>		
E-Z-HD	T3	
E-Z-PAQUE	T3	
E-Z-PASTE	T3	
GASTROMARK	T3	
LIQUID E-Z PAQUE	T3	
LIQUID POLIBAR PLUS	T3	
NEULUMEX	T3	
POLIBAR ACB	T3	
READI-CAT 2	T3	
SITZMARKS	T3	
TAGITOL V	T3	
VARIBAR HONEY	T3	
VARIBAR NECTAR	T3	
VARIBAR PUDDING	T3	
VARIBAR THIN HONEY	T3	
VARIBAR THIN LIQUID	T3	
<b>HEPATIC DIAGNOSTICS</b>		
EOVIST	T3	
<b>HISTAMINE PREPARATIONS</b>		
HISTATROL INTRADERMAL	T3	
HISTATROL PERCUTANEOUS	T3	
<b>METABOLIC FUNCTION DIAGNOSTICS</b>		
CHIRHOSTIM	T3	
METOPIRONE	T3	
R-GENE 10	T3	
<b>NEOPLASM MONOCLONAL DIAGNOSTIC AGENTS</b>		
PROTASCINT	T3	
<b>RADIOACTIVE DIAGNOSTICS, GENERAL</b>		
OCTREOSCAN	T3	
<b>RADIOACTIVE DX RADIOLABEL OF AUTOLOGOUS LEUKOCYTES</b>		
INDIUM IN-111 OXYQUINOLINE	T1	
<b>RADIOACTIVE DX RADIOLABEL OF SYNTHETIC AMINO ACIDS</b>		
AXUMIN	T3	

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

T4 – Specialty Medications  
 PA – Prior Authorization  
 QL – Quantity Limit

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

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

## List of Prescription Medications

DIAGNOSTIC (Miscellaneous) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>RADIOACTIVE METABOLIC FUNCTION DIAGNOSTICS</b>		
FLUDEOXYGLUCOSE F-18	T3	
<b>RADIOPHARMACEUTICALS ELEMENTS</b>		
GA 68 DOTATOC	T3	
INDICLOR	T3	
<b>RENAL FUNCTION DIAGNOSTICS AGENTS</b>		
<i>indigotindisulfonate sodium</i>	T3	
<b>URINARY TRACT RADIOPAQUE DIAGNOSTICS</b>		
CONRAY	T3	
CONRAY-30	T3	
<b>URINARY TRACT RADIOPAQUE DIAGNOSTICS</b>		
CONRAY-43	T3	
CYSTO-CONRAY II	T3	
CYSTOGRAFIN	T3	
CYSTOGRAFIN-DILUTE	T3	
<i>diatrizoate meglumine, sodium</i>	T3	
<i>diatrizoate meglumine, sodium (Gastrografin)</i>	T1	
GASTROGRAFIN ( <i>md-gastroview</i> )	T3	
DIURETICS (Diuretics)		
<b>ARGININE VASOPRESSIN (AVP) RECEPTOR ANTAGONISTS</b>		
TOLVAPTAN 15 MG TABLET	T4	SP
<i>tolvaptan 30 mg tablet (Samsca)</i>	T4	SP
VAPRISOL-5% DEXTROSE	T3	
<b>CARBONIC ANHYDRASE INHIBITORS</b>		
<i>acetazolamide</i>	T1	HD
<i>acetazolamide sodium</i>	T1	HD
<i>methazolamide</i>	T1	HD
<b>LOOP DIURETICS</b>		
<i>bumetanide</i>	T1	HD
FUROSCIX	T3	QL(2 kits/30 days) HD
<i>furosemide</i>	T1	HD
<i>furosemide (Lasix)</i>	T1	HD
FUROSEMIDE-0.9% NACL	T1	HD
SODIUM EDECIN ( <i>ethacrynate sodium</i> )	T3	HD
<i>toremide</i>	T1	HD

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

T4 – Specialty Medications  
 PA – Prior Authorization  
 QL – Quantity Limit

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

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



## List of Prescription Medications

DIURETICS (Diuretics) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>OSMOTIC DIURETICS</b>		
<i>mannitol</i>	T3	
<i>mannitol</i> (Osmitrol)	T1	
OSMITROL ( <i>mannitol</i> )	T3	
<b>POLYCYSTIC KIDNEY DISEASE AGENT, AVP RECEP. ANTAG</b>		
JYNARQUE 15 MG TABLET	T4	SP
JYNARQUE 15 MG-15 MG TABLET	T3	PA SP
<b>POLYCYSTIC KIDNEY DISEASE AGENT, AVP RECEP. ANTAG</b>		
JYNARQUE 30 MG TABLET	T4	SP
JYNARQUE 30 MG-15 MG TABLET	T4	PA SP
JYNARQUE 45 MG-15 MG TABLET	T4	PA SP
JYNARQUE 60 MG-30 MG TABLET	T4	PA SP
JYNARQUE 90 MG-30 MG TABLET	T4	PA SP
<b>POTASSIUM SPARING DIURETICS</b>		
<i>amiloride hcl</i>	T1	HD
CAROSPIR SUSP	T2	PA HD
CAROSPIR ( <i>spironolactone</i> )	T1	HD
<i>eplerenone</i> (Inspra)	T1	HD
INSPRA ( <i>eplerenone</i> )	T3	HD
KERENDIA	T2	PA QL (30 tabs/30 days) HD
<i>spironolactone</i>	T1	HD
<i>spironolactone</i> (Aldactone) (Carospir)	T1	HD
<i>triamterene</i> (Dyrenium)	T1	HD
<b>POTASSIUM SPARING DIURETICS IN COMBINATION</b>		
ALDACTAZIDE	T3	HD
ALDACTAZIDE ( <i>spironolactone-hctz</i> )	T3	HD
<i>amiloride/hydrochlorothiazide</i>	T1	HD
DYAZIDE ( <i>triamterene-hydrochlorothiazid</i> )	T3	HD
MAXZIDE ( <i>triamterene-hydrochlorothiazid</i> )	T3	HD
MAXZIDE-25 MG ( <i>triamterene-hydrochlorothiazid</i> )	T3	HD
<i>spironolact/hydrochlorothiazid</i> (Aldactazide)	T1	HD
<i>triamterene/hydrochlorothiazid</i> (Dyazide)	T1	HD
<i>triamterene/hydrochlorothiazid</i> (Maxzide)	T1	HD
<i>triamterene/hydrochlorothiazid</i> (Maxzide-25 Mg)	T1	HD

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

T4 – Specialty Medications  
 PA – Prior Authorization  
 QL – Quantity Limit

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

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

## List of Prescription Medications

DIURETICS (Diuretics) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>THIAZIDE AND RELATED DIURETICS</b>		
<i>chlorothiazide sodium</i> (Sodium Diuril)	T1	HD
<i>chlorthalidone</i>	T1	HD
DIURIL	T3	HD
<i>hydrochlorothiazide</i>	T1	HD
<i>indapamide</i>	T1	HD
<i>metolazone</i>	T1	HD
SODIUM DIURIL ( <i>chlorothiazide sodium</i> )	T3	HD
<b>EENT PREPS (Allergy/Nasal Sprays)</b>		
<b>NASAL ANTIHISTAMINE</b>		
<i>azelastine 0.1% (137 mcg) spry</i>	T1	HD
<i>azelastine 0.15% nasal spray</i>	T1	HD
<i>olopatadine 665 mcg nasal spry</i> (Patanase)	T1	HD
PATANASE ( <i>olopatadine hcl</i> )	T3	HD
<b>NASAL ANTIHISTAMINE AND ANTI-INFLAM. STEROID COMB.</b>		
<i>azelastine/fluticasone</i>	T1	HD
<b>NASAL ANTI-INFLAMMATORY STEROIDS</b>		
<i>flunisolide</i>	T1	HD
<i>fluticasone prop 50 mcg spray</i>	T1	HD
<i>mometasone furoate 50 mcg spry</i>	T1	QL (4 bots/30 days) HD
<b>NOSE PREPARATIONS, MISCELLANEOUS (RX)</b>		
<i>ipratropium bromide</i>	T1	HD
<b>NOSE PREPARATIONS, VASOCONSTRICTORS (RX)</b>		
ADRENALIN CHLORIDE	T3	
<i>epinephrine hcl</i> (Adrenalin Chloride)	T1	
<b>EENT PREPS (Ear Medications)</b>		
<b>EAR PREPARATIONS ANTI-INFLAMMATORY</b>		
DERMOTIC ( <i>fluocinolone acetonide oil</i> )	T3	
<i>fluocinolone acetonide oil</i> (Dermotic)	T1	
<b>EAR PREPARATIONS, MISC. ANTI-INFECTIVES</b>		
<i>hydrocortisone/acetic acid</i>	T1	
<b>EENT PREPS (Eye Conditions)</b>		
<b>ARTIFICIAL TEARS</b>		
LACRISERT	T3	

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

T4 – Specialty Medications  
 PA – Prior Authorization  
 QL – Quantity Limit

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

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

## List of Prescription Medications

EENT PREPS (Eye Conditions) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>EYE ANTI-INFECTIVES (RX ONLY)</b>		
BETADINE	T3	
<b>EYE ANTI-INFLAMMATORY AGENTS</b>		
ACUVAIL	T3	
ALREX	T3	
<i>bromfenac sodium</i> (Bromsite)	T1	
<b>EYE ANTI-INFLAMMATORY AGENTS (con't.)</b>		
BROMSITE .( <i>bromfenac sodium</i> )	T2	
<i>dexamethasone 0.1% eye drop</i>	T1	
<i>diclofenac 0.1% eye drops</i>	T1	
EYSUVIS	T2	QL (8.3ml/14 days)
FLAREX 0.1% EYE DROPS	T2	
<i>fluorometholone</i> (Fml)	T1	
<i>flurbiprofen sodium</i>	T1	
ILEVRO	T3	
ILLUVIEN	T4	SP
INVELTYS 1% EYE DROP	T2	
<i>ketorolac 0.4% ophth solution</i> (Acular Ls)	T1	
<i>ketorolac 0.5% ophth solution</i> (Acular)	T1	
LOTEMAX 0.5% EYE OINTMENT	T2	
LOTEMAX ( <i>loteprednol etabonate</i> )	T3	
LOTEMAX SM 0.38% OPHTH GEL	T2	
<i>loteprednol etabonate</i> (Lotemax)	T1	
OMNIPRED ( <i>prednisolone acetate</i> )	T3	
OZURDEX	T4	SP
<i>prednisolone acetate</i> (Pred Forte)	T1	
<i>prednisolone sodium phosphate</i>	T1	
PROLENSA	T3	
TRIESENCE	T3	
<b>EYE IRRIGATIONS</b>		
<i>balanced salt irrig soln no.2</i>	T1	
<i>balanced salt irrig soln no.2</i>	T3	
BSS PLUS	T3	

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

T4 – Specialty Medications  
 PA – Prior Authorization  
 QL – Quantity Limit

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

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

## List of Prescription Medications

EENT PREPS (Eye Conditions) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>EYE LOCAL ANESTHETICS</b>		
AKTEN	T3	
ALCAINE ( <i>proparacaine hcl</i> )	T3	
ALTAFLUOR BENOX ( <i>flurox</i> )	T3	
<i>benoxinate hcl/fluorescein sod</i> (Altaflur Benox)	T1	
<i>benoxinate hcl/fluorescein sod</i> (Altaflur Benox)	T3	
<i>proparacaine hcl</i> (Alcaine)	T1	
<i>proparacaine/fluorescein sod</i>	T1	
<i>proparacaine/fluorescein sod</i>	T3	
<i>tetracaine hcl</i>	T1	
TETRAVISC	T3	
TETRAVISC FORTE	T3	
<b>EYE MAST CELL STABILIZERS</b>		
<i>cromolyn 4% eye drops</i>	T1	
<b>EYE MYDRIATIC AND NSAID COMBINATIONS</b>		
OMIDRIA	T3	
<b>EYE PREPARATIONS, MISCELLANEOUS (OTC)</b>		
GELFILM	T3	
<b>EYE VASOCONSTRICTORS</b>		
<i>phenylephrine hcl</i>	T1	
<b>MIOTICS AND OTHER INTRAOCULAR PRESSURE REDUCERS</b>		
<i>apraclonidine hcl</i> (Iopidine)	T1	HD
AZOPT ( <i>brinzolamide</i> )	T3	HD
<i>betaxolol hcl</i>	T1	HD
BETOPTIC S 0.25% DROPS	T2	HD
<i>bimatoprost</i>	T1	QL (10 gm/30 days) HD
<i>brimonidine tartrate</i>	T1	HD
<i>brimonidine tartrate</i> (Alphagan P)	T1	HD
<i>brimonidine tartrate/timolol</i> (Combigan)	T1	HD
<i>brinzolamide</i> (Azopt)	T1	HD
<i>carbachol</i>	T3	HD
<i>carteolol hcl</i>	T1	HD
COMBIGAN	T2	HD
<i>dorzolamide hcl</i> (Trusopt)	T1	HD

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

T4 – Specialty Medications  
PA – Prior Authorization  
QL – Quantity Limit

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

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

## List of Prescription Medications

EENT PREPS (Eye Conditions) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>MIOTICS AND OTHER INTRAOCULAR PRESSURE REDUCERS (cont.)</b>		
<i>dorzolamide hcl/timolol maleat</i> (Cosopt)	T1	HD
<i>dorzolamide/timolol/pf</i> (Cosopt Pf)	T1	HD
DURYSTA	T4	PA SP HD
IOPIDINE	T3	HD
IOPIDINE ( <i>apraclonidine hcl</i> )	T3	HD
ISOPTO CARPINE ( <i>pilocarpine hcl</i> )	T3	HD
<i>latanoprost</i>	T1	HD
<i>levobunolol hcl</i>	T1	HD
MIOCHOL-E	T3	HD
PHOSPHOLINE IODIDE	T3	HD
<i>pilocarpine hcl</i> (Isopto Carpine)	T1	HD
RHOPRESSA	T3	HD
ROCKLATAN	T3	HD
SIMBRINZA	T2	HD
<i>timolol maleate</i> (Istalol)	T1	HD
<i>timolol maleate</i> (Timoptic)	T1	HD
<i>timolol maleate</i> (Timoptic-xe)	T1	HD
<i>timolol maleate/pf</i> (Timoptic Ocudose)	T1	HD
<i>travoprost</i>	T1	HD
<b>MYDRIATICS</b>		
<i>atropine 1% eye drops</i> (Isopto Atropine)	T1	HD
<i>atropine 1% eye ointment</i>	T1	HD
ATROPINE SULFATE-0.9% NAACL	T3	HD
CYCLOGYL	T3	HD
CYCLOGYL ( <i>cyclopentolate hcl</i> )	T3	HD
CYCLOMYDRIL	T3	HD
<i>cyclopentolate hcl</i> (Cyclogyl)	T1	HD
<i>homatropine hbr</i>	T1	HD
MYDRIACYL ( <i>tropicamide</i> )	T3	HD
PAREMYD	T3	HD
<i>tropicamide</i>	T1	HD
<i>tropicamide</i> (Mydriacyl)	T1	HD

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

T4 – Specialty Medications  
PA – Prior Authorization  
QL – Quantity Limit

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

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

## List of Prescription Medications

EENT PREPS (Eye Conditions) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>OPHTH VASC. ENDOTHELIAL GROWTH FACTOR ANTAGONISTS</b>		
EYLEA	T4	PA SP
<b>OPHTH. VEGF-A RECEPTOR ANTAG. RCMB MC ANTIBODY</b>		
BEOVU	T4	PA SP
LUCENTIS	T4	PA SP
<b>OPHTHALMIC ANTIFIBROTIC AGENTS</b>		
MITOSOL	T3	
<b>OPHTHALMIC ANTI-INFLAMMATORY IMMUNOMODULATOR-TYPE</b>		
CEQUA	T3	HD
RESTASIS	T2	HD
VEVYE		
XIIDRA	T2	HD
<b>OPHTHALMIC COMPLEMENT INHIBITORS</b>		
SYFOVRE	T4	PA SP HD
<b>OPHTHALMIC CYSTINE DEPLETING AGENTS</b>		
CYSTADROPS	T4	PA QL (20ml/21 days) SP
CYSTARAN	T4	PA QL (120ml/28 days) SP
<b>OPHTHALMIC HUMAN NERVE GROWTH FACTOR (HNGF)</b>		
OXERVATE	T4	PA SP HD
<b>OPHTHALMIC PREPARATIONS, MISCELLANEOUS</b>		
AMVISC	T4	SP
AMVISC PLUS	T4	SP
DISCOVISC	T3	
DUOVISC	T3	
HEALON ( <i>biolon</i> )	T4	SP
HEALON5	T3	
<i>hyaluronate sodium</i> (Provisc)	T4	SP
PROVISC 10MG/ML DISP SYR	T4	SP
TOTALVISC	T4	SP
VISCOAT	T3	
<b>OPHTHALMIC SURGICAL AIDS</b>		
CELLUGEL	T3	
<i>hypromellose</i> (Cellugel)	T1	
MEMBRANEBLUE	T3	
VISIONBLUE	T3	

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

T4 – Specialty Medications  
PA – Prior Authorization  
QL – Quantity Limit

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

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

## List of Prescription Medications

ELECT/CALORIC/H2O (Cholesterol Medications)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>ORAL LIPID SUPPLEMENTS</b>		
DOJOLVI	T4	PA SP HD
ELECT/CALORIC/H2O (Dental Products)		
<b>FLUORIDE PREPARATIONS</b>		
CLINPRO 5000	T3	
<i>fluoride (sodium)</i> (Prevident 5000 Ortho Defense)	T1	
<i>fluoride (sodium)</i> (Prevident 5000 Plus)	T1	
<i>fluoride (sodium)</i> (Prevident 5000)	T1	
<i>fluoride (sodium)</i> (Prevident)	T1	
FLUORIDEX	T1	
FLUORIDEX SENSITIVITY RELIEF	T3	
PREVIDENT	T3	
PREVIDENT ( <i>sodium fluoride</i> )	T3	
PREVIDENT 5000	T3	
PREVIDENT 5000 ENAMEL PROTECT	T3	
PREVIDENT 5000 ORTHO DEFENSE	T3	
PREVIDENT 5000 PLUS ( <i>sodium fluoride 5000 plus</i> )	T3	
PREVIDENT 5000 SENSITIVE	T3	
<i>sodium fluoride/potassium nit</i> (Prevident 5000 Sensitive)	T1	
ELECT/CALORIC/H2O (Diabetes)		
<b>AGENTS TO TREAT HYPOGLYCEMIA (HYPERGLYCEMICS)</b>		
BAQSIMI	T2	QL (2/30 days)
<i>diazoxide</i> (Proglycem)	T1	
<i>glucagon 1 mg emergency kit</i>	T1	QL (2 pens/30 days)
GLUCAGON 1 MG EMERGENCY KIT	T3	QL (2 pens/30 days)
PROGLYCEM ( <i>diazoxide</i> )	T3	
ZEGALOGUE	T2	QL (2 units/23 days)
ELECT/CALORIC/H2O (Miscellaneous)		
<b>BICARBONATE PRODUCING/CONTAINING AGENTS</b>		
<i>sodium acetate</i>	T1	
<i>sodium bicarbonate</i>	T1	
<i>sodium bicarbonate in d5w</i>	T1	
<b>DRUGS USED TO TREAT ACIDOSIS</b>		
THAM	T3	

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

T4 – Specialty Medications  
 PA – Prior Authorization  
 QL – Quantity Limit

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

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

## List of Prescription Medications

### ELECT/CALORIC/H2O (Miscellaneous) (cont.)

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

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

T4 – Specialty Medications  
 PA – Prior Authorization  
 QL – Quantity Limit

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

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



## List of Prescription Medications

### ELECT/CALORIC/H2O (Miscellaneous) (cont.)

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

#### PARENTERAL AMINO ACID SOLUTIONS AND COMBINATIONS (cont.)

KABIVEN	T3	
<i>parenteral amino acid 10% no.4</i>	T3	
<i>parenteral amino acid 10% no.6</i>	T3	
<i>parenteral amino acid 10% no.7</i>	T3	
PERIKABIVEN	T3	
PLENAMINE	T3	
PROCALAMINE	T3	
PROSOL	T3	
TROPHAMINE	T3	

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

#### CALCIUM REPLACEMENT

<i>calcium chloride</i>	T1	
<i>calcium gluc 1,000mg/50ml-nacl</i>	T1	
<i>calcium glu 2,000mg/100ml-nacl</i>	T1	
<i>calcium gluconate</i>	T1	
<i>calcium gluconate in 0.9% nacl (Calcium Gluconate-0.9% Nacl)</i>	T1	
CALCIUM GLUCONATE-0.9% NACL	T1	
CALCIUM GLUCONATE-0.9% NACL ( <i>calcium gluconate-0.9% nacl</i> )	T1	
CALCIUM GLUCONATE-D5W	T1	

#### ELECTROLYTE MAINTENANCE

AURYXIA	T3	QL (12 tabs/day)
<i>calcium acetate</i>	T1	
<i>electrolyte-48 solution/d5w</i>	T1	
FOSRENOL 1,000 MG POWDER PACK	T2	
FOSRENOL 1,000 MG TABLET CHEW ( <i>lanthanum carbonate</i> )	T3	
FOSRENOL 500 MG TABLET CHEW ( <i>lanthanum carbonate</i> )	T3	
FOSRENOL 750 MG POWDER PACKET	T2	
FOSRENOL 750 MG TABLET CHEW ( <i>lanthanum carbonate</i> )	T3	
IONOSOL B WITH DEXTROSE 5%	T3	
IONOSOL MB-DEXTROSE 5%	T3	
ISOLYTE P WITH DEXTROSE	T3	
ISOLYTE S	T3	
<i>lanthanum carbonate (Fosrenol)</i>	T1	

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

T4 – Specialty Medications  
 PA – Prior Authorization  
 QL – Quantity Limit

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

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

## List of Prescription Medications

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

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>ELECTROLYTE MAINTENANCE (cont.)</b>		
LOKELMA	T2	
NORMOSOL-M AND DEXTROSE	T3	
NORMOSOL-R	T3	
NORMOSOL-R AND DEXTROSE	T3	
NORMOSOL-R PH 7.4	T3	
PLASMA-LYTE 148	T3	
PLASMA-LYTE A PH 7.4	T3	
<i>ringer's solution</i>	T1	
<i>ringer's solution, lactated</i>	T1	
<i>sevelamer carbonate (Renvela)</i>	T1	
<i>sevelamer hcl</i>	T1	
<i>sevelamer hcl (Renagel)</i>	T1	
<i>sodium polystyrene sulfon/sorb</i>	T1	
<i>sodium polystyrene sulfonate</i>	T1	
<i>sps 15 gm/60 ml suspension</i>	T1	
<i>sps 30 gm/120 ml enema susp</i>	T3	
TPN ELECTROLYTES	T3	
TPN ELECTROLYTES II	T3	
VELPHORO	T2	
VELTASSA	T2	
<b>IODINE CONTAINING AGENTS</b>		
IODOPEN	T3	
<i>potassium iodide/iodine</i>	T1	
SSKI	T1	
<b>IRON REPLACEMENT</b>		
CITRANATAL BLOOM	T3	
FERAHEME	T3	PA
FERRLECIT ( <i>sod ferric gluconate complex</i> )	T3	
INFED	T3	
INJECTAFER	T3	PA
<i>iron dextran complex (Infed)</i>	T3	
MONOFERRIC	T3	PA
<i>mv-mins no.73/iron fum/folic (Hemocyte Plus)</i>	T1	

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

T4 – Specialty Medications  
PA – Prior Authorization  
QL – Quantity Limit

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

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

## List of Prescription Medications

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

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>IRON REPLACEMENT (cont.)</b>		
<i>sodium ferric gluconat/sucrose (Ferlecit)</i>	T1	
TRIFERIC	T3	
VENOFER	T3	
<b>MAGNESIUM SALTS REPLACEMENT</b>		
<i>magnesium chloride</i>	T1	
<i>magnesium sulfate</i>	T1	
<i>magnesium sulfate in water</i>	T1	
MAGNESIUM SULFATE-0.9% NA CL	T1	
MAGNESIUM SULFATE-D5W	T1	
MAGNESIUM-LACTATED RINGERS	T1	
<b>MINERAL REPLACEMENT, MISCELLANEOUS</b>		
ADDAMEL N	T3	
<i>chromic chloride</i>	T1	
<i>cupric chloride</i>	T1	
<i>manganese chloride</i>	T1	
<i>manganese sulfate</i>	T1	
MULTITRACE-4 CONC VIAL	T1	
<i>multitrace-4 vial</i>	T3	
MULTITRACE-4 VIAL	T1	
MULTITRACE-5	T1	
PEDITRACE	T3	
SELENIOS ACID	T1	
TRALEMENT	T3	
<b>PHOSPHATE REPLACEMENT</b>		
GLYCOPHOS	T3	
<i>potassium phos, m-basic-d-basic</i>	T1	
POTASSIUM PHOSPHATE-0.9% NA CL	T1	
POTASSIUM PHOSPHATES	T3	
<i>potassium phos,m-basic-d-basic</i>	T1	
<i>potassium cl er 15 meq tablet</i>	T1	
<i>sod phosphate, monobasic-dibas</i>	T1	
SODIUM PHOSPHATE-0.9% NA CL	T1	
<b>POTASSIUM REPLACEMENT</b>		
EFFER-K 10 MEQ TABLET EFF	T3	
EFFER-K 20 MEQ TABLET EFF	T3	

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

T4 – Specialty Medications

PA – Prior Authorization

QL – Quantity Limit

ST – Step Therapy

AGE – Age Requirement

SP – Specialty Medication

HD – May require home delivery pharmacy

PPACA – No Cost-Share Preventive Medication

CSL – Oral cancer medication subject to cost-share limits

## List of Prescription Medications

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

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>POTASSIUM REPLACEMENT (cont.)</b>		
<i>effe-r-k 25 meq tablet eff</i>	T1	
<i>klor-con 10 meq tablet (K-tab Er)</i>	T1	
<i>klor-con 10 meq tablet (K-tab Er)</i>	T3	
<i>klor-con 8 meq tablet</i>	T1	
<i>klor-con 8 meq tablet</i>	T3	
<i>potassium acetate</i>	T1	
<i>potassium bicarbonate/cit ac</i>	T1	
<i>potassium chloride</i>	T1	
<i>potassium chloride</i>	T3	
<i>potassium chloride (K-tab Er)</i>	T1	
<i>potassium chloride in 0.9%nacl</i>	T1	
<i>potassium chloride in d5w</i>	T1	
<i>potassium chloride in Ir-d5</i>	T1	
<i>potassium chloride in water</i>	T1	
<i>potassium chloride/d5-0.2%nacl</i>	T1	
<i>potassium chloride/d5-0.3%nacl</i>	T1	
<i>potassium chloride/d5-0.45nacl</i>	T1	
<i>potassium chloride/d5-0.9%nacl</i>	T1	
<i>potassium chloride-0.45% nacl</i>	T1	
POTASSIUM CHLORIDE-0.9% NAACL	T1	
<i>potassium cl/lido/0.9 % nacl (Potassium Cl-lidocaine-ns)</i>	T1	
POTASSIUM CL-LIDOCAINE-NS ( <i>potassium cl-lidocaine-ns</i> )	T1	
<b>SODIUM/SALINE PREPARATIONS</b>		
<i>0.9 % sodium chloride</i>	T1	
KENDALL 0.9% NAACL WITH CAP	T1	
<i>sodium chloride 0.45 %</i>	T1	
<i>sodium chloride 0.9 % (flush)</i>	T1	
<i>sodium chloride 3 %</i>	T1	
<i>sodium chloride 5 %</i>	T1	
SWABFLUSH	T3	

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

T4 – Specialty Medications  
 PA – Prior Authorization  
 QL – Quantity Limit

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

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

## List of Prescription Medications

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

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

#### ZINC REPLACEMENT

<i>zinc chloride</i>	T1	
<i>zinc sulfate</i>	T1	

### ELECT/CALORIC/H2O (Urinary Tract Conditions)

#### DIALYSIS SOLUTIONS

DELFLX WITH 1.5% DEXTROSE	T3	
DELFLX-2.5% DEXTROSE	T3	
DIANEAL PD-2 W-1.5% DEXTROSE	T3	
DIANEAL PD-2 W-2.5% DEXTROSE	T2	
DIANEAL PD-2 W-4.25% DEXTROSE	T3	
DIANEAL WITH 1.5% DEXTROSE	T3	
DIANEAL WITH 2.5% DEXTROSE	T3	
DIANEAL WITH 4.25% DEXTROSE	T3	
EXTRANEAL ICODEXTRIN DIALYSIS	T3	
<i>perit. dialysis no.6-1.5 % dex</i> (Dianeal With 1.5% Dextrose)	T3	
<i>periton.dialysis 7-2.5 % dextr</i> (Dianeal With 2.5% Dextrose)	T3	
<i>periton.dialysis 8-4.25 % dext</i> (Dianeal With 4.25% Dextrose)	T3	
PHOXILLUM	T3	
PRISMASOL	T3	

#### URINARY PH MODIFIERS

K-PHOS NO.2	T3	HD
K-PHOS ORIGINAL	T3	HD
ORACIT	T3	HD

#### URINARY PH MODIFIERS

<i>potassium citrate</i> (Urocit-k)	T1	HD
<i>potassium citrate/citric acid</i>	T1	HD
RENACIDIN	T3	HD
UROCI-K ( <i>potassium citrate er</i> )	T3	HD
UROQID-ACID NO.2	T3	HD

### GASTROINTESTINAL (Cholesterol Medications)

#### LIPOTROPICS

<i>icosapent ethyl</i> (Vascepa)	T1	HD
LOVAZA ( <i>triklo</i> )	T3	HD
<i>omega-3 acid ethyl esters</i> (Lovaza)	T1	HD
VASCEPA	T2	PA HD

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

T4 – Specialty Medications  
PA – Prior Authorization  
QL – Quantity Limit

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

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

## List of Prescription Medications

GASTROINTESTINAL (Gastrointestinal/Heartburn)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>AMMONIA INHIBITORS</b>		
AMMONUL ( <i>sodium phenylacet-sod benzoate</i> )	T3	HD
<i>lactulose</i>	T1	HD
<i>lactulose 10 gm/15 ml solution</i>	T1	
LITHOSTAT	T3	HD
OLPRUVA	T3	PA SP HD
PHEBURANE	T2	PA QL(8 Bottles/30 Days) SP HD
<i>sodium benzoate/sod phenylacet (Ammonul)</i>	T1	HD
<i>sodium phenylbutyrate (Buphenyl)</i>	T4	SP HD
<b>ANTICHOLINERGICS, QUATERNARY AMMONIUM</b>		
<i>chlordiazepoxide/clidinium br</i>	T1	
CUVPOSA	T3	
GLYCATÉ	T3	
<i>glycopyrrolate</i>	T1	
GLYCOPYRROLATE 1 MG/5 ML SYRNG	T1	
<i>glycopyrrolate 1 mg/5 ml vial</i>	T1	
<i>glycopyrrolate (Glycate)</i>	T1	
<i>glycopyrrolate (Robinul Forte)</i>	T1	
<i>glycopyrrolate (Robinul)</i>	T1	
GLYCOPYRROLATE-WATER	T1	
<i>propantheline bromide</i>	T1	
ROBINUL ( <i>glycopyrrolate</i> )	T3	
ROBINUL FORTE ( <i>glycopyrrolate</i> )	T3	
<b>ANTICHOLINERGICS/ANTISPASMODICS</b>		
BENTYL	T3	
<i>dicyclomine hcl</i>	T1	
<i>dicyclomine hcl (Bentyl)</i>	T1	
<b>ANTIDIARRHEAL - G.I. CHLORIDE CHANNEL INHIBITORS</b>		
MYTESI	T3	
<b>ANTIDIARRHEAL - TRYPTOPHAN HYDROXYLASE INHIBITOR</b>		
XERMELO	T4	PA SP
<b>ANTIDIARRHEALS</b>		
<i>diphenoxylate hcl/atropine</i>	T1	
<i>diphenoxylate hcl/atropine (Lomotil)</i>	T1	
LOMOTIL ( <i>diphenoxylate-atropine</i> )	T3	
<i>loperamide hcl</i>	T1	

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

T4 – Specialty Medications  
 PA – Prior Authorization  
 QL – Quantity Limit

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

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

## List of Prescription Medications

### GASTROINTESTINAL (Gastrointestinal/Heartburn) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>ANTIDIARRHEALS (cont.)</b>		
MOTOFEN	T3	
<i>opium tincture</i>	T1	PA
<i>paregoric</i>	T1	
<b>ANTIEMETIC, CANNABINOID-TYPE</b>		
<i>dronabinol</i>	T1	
<b>ANTIEMETIC/ANTIVERTIGO AGENTS</b>		
AKYNZEO 235-0.25 MG VIAL	T3	PA
AKYNZEO 235-0.25 MG/20 ML VIAL	T3	PA
AKYNZEO 300-0.5 MG CAPSULE	T3	PA QL (4 caps/28 days)
ALOXI ( <i>palonosetron hcl</i> )	T3	PA
ANZEMET	T4	PA QL (5 tabs/30 days) SP
<i>aprepitant 125 mg capsule</i>	T1	QL (4 caps/28 days)
<i>aprepitant 125-80-80 mg pack (Emend)</i>	T1	QL (12 caps/28 days)
<i>aprepitant 40 mg capsule</i>	T1	QL (1 cap/28 days)
<i>aprepitant 80 mg capsule (Emend)</i>	T1	QL (8 caps/28 days)
BARHEMSYS	T3	
BONJESTA	T3	
CINVANTI	T3	PA
COMPAZINE ( <i>prochlorperazine maleate</i> )	T3	
COMPAZINE ( <i>prochlorperazine</i> )	T3	
DICLEGIS ( <i>doxylamine succ-pyridoxine hcl</i> )	T3	
<i>dimenhydrinate</i>	T1	
<i>doxylamine succinate/vit b6 (Diclegis)</i>	T1	
EMEND 125 MG POWDER PACKET	T3	PA QL (12 caps/28 days)
EMEND 150 MG VIAL ( <i>fosaprepitant dimeglumine</i> )	T3	PA
EMEND 80 MG CAPSULE ( <i>aprepitant</i> )	T3	PA QL (8 caps/28 days)
EMEND TRIPACK ( <i>aprepitant</i> )	T3	PA QL (12 caps/28 days)
<i>granisetron hcl</i>	T1	
<i>granisetron hcl/pf</i>	T1	
<i>ondansetron</i>	T1	
<i>ondansetron hcl</i>	T1	
<i>ondansetron hcl/pf</i>	T1	
ONDANSETRON HCL-0.9% NAACL	T1	

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

T4 – Specialty Medications  
PA – Prior Authorization  
QL – Quantity Limit

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

HD – 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
<b>ANTIEMETIC/ANTIVERTIGO AGENTS (cont.)</b>		
ONDANSETRON HCL-D5W	T1	
<i>palonosetron hcl</i>	T1	PA
<i>palonosetron hcl (Aloxi)</i>	T1	PA
<i>prochlorperazine (Compazine)</i>	T1	
<i>prochlorperazine edisylate</i>	T1	
<i>prochlorperazine maleate (Compazine)</i>	T1	
<i>promethazine hcl</i>	T1	
<i>promethazine hcl</i>	T3	
SANCUSO	T3	PA QL (4 patches/30 days)
<i>scopolamine (Transderm-scop)</i>	T1	
SUSTOL	T3	PA
TIGAN	T3	
<i>TIGAN (trimethobenzamide hcl)</i>	T3	
TRANSDERM-SCOP ( <i>scopolamine</i> )	T3	
<i>trimethobenzamide hcl (Tigan)</i>	T1	
VARUBI	T3	PA QL (4 tabs/28 days)
<b>ANTI-ULCER PREPARATIONS</b>		
CARAFATE ( <i>sucralfate</i> )	T3	HD
CYTOTEC ( <i>misoprostol</i> )	T3	HD
<i>misoprostol (Cytotec)</i>	T1	HD
<i>sucralfate (Carafate)</i>	T1	HD
<b>ANTI-ULCER-H.PYLORI AGENTS</b>		
<i>bismuth/metronid/tetracycline (Pylera)</i>	T1	
<i>lansoprazole/amoxiciln/clarith</i>	T1	
<b>BELLADONNA ALKALOIDS</b>		
ATROPINE 0.25 MG/5 ML SYRINGE	T1	HD
<i>atropine 0.4 mg/ml vial</i>	T1	HD
ATROPINE 0.4 MG/ML VIAL	T3	HD
ATROPINE SULFATE-0.9% NAACL	T3	HD
<i>atropine 0.5 mg/5 ml abboject</i>	T1	HD
<i>atropine 1 mg/10 ml abboject</i>	T1	HD
<i>atropine 1 mg/10 ml syringe</i>	T1	HD
ATROPINE 1 MG/2.5 ML SYRINGE	T3	HD

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

T4 – Specialty Medications  
 PA – Prior Authorization  
 QL – Quantity Limit

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

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



## List of Prescription Medications

GASTROINTESTINAL (Gastrointestinal/Heartburn) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>BELLADONNA ALKALOIDS (cont.)</b>		
<i>atropine 1 mg/ml vial</i>	T1	HD
ATROPINE 1 MG/ML VIAL	T3	HD
ATROPINE 2 MG/5 ML SYRINGE	T3	HD
<i>atropine 8 mg/20 ml vial</i>	T1	HD
DONNATAL	T3	HD
DONNATAL ( <i>phenohydro</i> )	T3	HD
<i>hyoscyamine 0.125 mg odt (Nulev)</i>	T1	HD
<i>hyoscyamine 0.125 mg tab sl (Levsin-sl)</i>	T1	HD
<i>hyoscyamine 0.125 mg/5 ml elix</i>	T1	HD
<i>hyoscyamine 0.125 mg/ml drop</i>	T1	HD
<i>hyoscyamine sulf 0.125 mg tab (Levsin)</i>	T1	HD
<i>hyoscyamine sulfate</i>	T1	HD
<i>hyoscyamine sulfate (Levbid)</i>	T1	HD
<i>hyoscyamine sulfate (Levsin)</i>	T1	HD
<i>hyoscyamine sulfate (Levsin-sl)</i>	T1	HD
<i>hyoscyamine sulfate (Nulev)</i>	T1	HD
<i>hyoscyamine sulfate (Nulev)</i>	T3	HD
HYOSCYAMINE SULFATE 0.5 MG/ML	T3	HD
LEVBID ( <i>symax-sr</i> )	T3	HD
LEVSIN	T3	HD
LEVSIN ( <i>oscimin</i> )	T3	HD
LEVSIN-SL ( <i>symax-sl</i> )	T3	HD
<i>methscopolamine bromide</i>	T1	HD
NULEV ( <i>symax</i> )	T1	HD
<i>phenobarb/hyoscy/atropine/scop (Donnatal)</i>	T1	HD
<i>phenobarb/hyoscy/atropine/scop (Phenobarbital-belladonna)</i>	T1	HD
<i>phenobarbital-belladonna elixr (Donnatal)</i>	T1	HD
<i>phenobarbital-belladonna elixr (Phenobarbital-belladonna)</i>	T1	HD
PHENOBARBITAL-BELLADONNA ELIXR ( <i>phenohydro</i> )	T3	HD
SYMAX DUOTAB	T3	HD
<b>BILE SALTS</b>		
ACTIGALL ( <i>ursodiol</i> )	T3	HD
CHENODAL	T4	SP HD

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

T4 – Specialty Medications  
 PA – Prior Authorization  
 QL – Quantity Limit

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

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

# List of Prescription Medications

<b>GASTROINTESTINAL (Gastrointestinal/Heartburn) (cont.)</b>		
<b>Prescription Drug Name</b>	<b>Drug Tier</b>	<b>Coverage Requirements and Limits</b>
<b>BILE SALTS (cont.)</b>		
CHOLBAM	T4	PA SP HD
URSO ( <i>ursodiol</i> )	T3	HD
URSO FORTE ( <i>ursodiol</i> )	T3	HD
<i>ursodiol</i> (Actigall)	T1	HD
<i>ursodiol</i> (Urso Forte)	T1	HD
<i>ursodiol</i> (Urso)	T1	HD
<b>CHOLERETICS</b>		
KINEVAC	T3	
<b>CHRONIC INFLAM. COLON DX, 5-A-SALICYLAT, RECTAL TX</b>		
<i>mesalamine 1,000 mg supp</i> (Canasa)	T1	
<i>mesalamine 4 gm/60 ml enema</i> (Sfrowasa)	T1	
<i>mesalamine 4 gm/60 ml kit</i>	T1	
SFROWASA ( <i>mesalamine</i> )	T3	
<b>DRUG TX-CHRONIC INFLAM. COLON DX, 5-AMINOSALICYLAT</b>		
APRISO ( <i>mesalamine er</i> )	T3	HD
<i>balsalazide disodium</i> (Colaza)	T1	HD
LIALDA ( <i>mesalamine</i> )	T3	HD
<i>mesalamine</i>	T1	HD
<i>mesalamine</i> (Apriso)	T1	HD
<i>mesalamine 800 mg dr tablet</i>	T1	HD
<b>DRUG TX-CHRONIC INFLAM. COLON DX, 5-AMINOSALICYLAT</b>		
<i>mesalamine dr 1.2 gm tablet</i> (Lialda)	T1	HD
<i>sulfasalazine</i> (Azulfidine)	T1	HD
<b>FARNESOID X RECEPTOR (FXR) AGONIST, BILE AC ANALOG</b>		
OCALIVA	T4	PA SP HD
<b>FECAL MICROBIOTA TRANSPLANTATION (FMT)</b>		
VOWST	T4	PA QL(12 CAPS/56 DAYS) SP
<b>GASTRIC ENZYMES</b>		
SUCRAID	T4	PA SP
<b>HISTAMINE H2-RECEPTOR INHIBITORS</b>		
<i>cimetidine hcl</i>	T1	HD
<i>famotidine</i>	T1	HD
<i>ranitidine hcl</i>	T1	HD
<b>IBS AGENTS, MIXED OPIOID RECEPTOR AGONISTS/ANTAGONISTS</b>		
VIBERZI	T2	HD

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

T4 – Specialty Medications  
PA – Prior Authorization  
QL – Quantity Limit

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

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

## List of Prescription Medications

<b>GASTROINTESTINAL (Gastrointestinal/Heartburn) (cont.)</b>		
<b>Prescription Drug Name</b>	<b>Drug Tier</b>	<b>Coverage Requirements and Limits</b>
<b>IBS-C/CIC AGENTS, GUANYLATE CYCLASE-C AGONIST</b>		
LINZESS	T2	
TRULANCE	T2	
<b>INTEGRIN RECEPTOR ANTAGONIST, MONOCLONAL ANTIBODY</b>		
ENTYVIO	T4	PA SP HD
ENTYVIO PEN	T4	PA QL(2 pens/30 days) SP HD
<b>INTESTINAL MOTILITY STIMULANTS</b>		
<i>metoclopramide hcl</i>	T1	
<i>metoclopramide hcl</i> (Reglan)	T1	
REGLAN ( <i>metoclopramide hcl</i> )	T3	
<b>IRRITABLE BOWEL SYNDROME AGENTS, 5-HT<sub>3</sub> ANTAGONIST</b>		
<i>alosetron hcl</i>	T4	SP HD
<b>IV FAT EMULSIONS</b>		
CLINOLIPID	T3	
<i>fat emulsions</i> (Nutrilipid)	T3	
INTRALIPID	T3	
NUTRILIPID ( <i>intralipid</i> )	T3	
OMEGAVEN	T3	
SMOFLIPID	T3	
<b>LAXATIVES AND CATHARTICS</b>		
<i>bisac/nac/nahco3/kcl/peg 3350</i>	T1	PPACA
CLENPIQ	T2	PPACA
<i>lactulose</i>	T1	
<i>lactulose 10 gm/15 ml solution</i>	T1	
<i>lactulose 20 gm/30 ml solution</i>	T1	
<i>lubiprostone</i> (Amitiza)	T1	
NULYTELY	T3	PPACA
<i>peg3350/sod sul/nac/kcl/asb/c</i>	T1	PPACA
<i>peg3350/sod sulf, bicarb, cl/kcl</i>	T1	PPACA
PREPOPIK	T2	PPACA
<i>sodium chloride/nahco3/kcl/peg</i>	T2	PPACA
SUFLAVE	T2	PPACA
SUPREP	T2	PPACA
SUTAB	T2	PPACA

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

T4 – Specialty Medications  
PA – Prior Authorization  
QL – Quantity Limit

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

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

# List of Prescription Medications

## GASTROINTESTINAL (Gastrointestinal/Heartburn) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>LOCAL ANORECTAL NITRATE PREPARATIONS</b>		
<i>nitroglycerin 0.4% ointment</i>	T1	
RECTIV	T3	
<b>PANCREATIC ENZYMES</b>		
PANCREAZE	T2	HD
VIOKACE	T3	HD
<b>POTASSIUM-COMPETITIVE ACID BLOCKERS (PCABS)</b>		
VOQUEZNA	T3	PA QL(1 tab/day)
<b>PROTON-PUMP INHIBITORS</b>		
<i>dexlansoprazole dr 30 mg cap</i>	T1	QL (2 caps/day) HD
<i>dexlansoprazole dr 60 mg cap</i>	T1	QL(1 cap/day) HD
<i>esomeprazole dr 10 mg packet</i>	T1	QL (4 packets/day) HD
<i>esomeprazole dr 20 mg packet (Nexium)</i>	T1	QL (2 packs/day) HD
<i>esomeprazole dr 40 mg packet (Nexium)</i>	T1	QL (1 packet/day) HD
<i>esomeprazole mag dr 20 mg cap</i>	T1	QL (2 caps/day) HD
<i>esomeprazole mag dr 40 mg cap</i>	T1	QL (1 cap/day) HD
<i>pantoprazole sodium 40 mg vial</i>	T1	HD
<i>lansoprazole dr 15 mg capsule</i>	T1	QL (2 caps/day) HD
<i>lansoprazole dr 30 mg capsule</i>	T1	QL (30 caps/30 days) HD
<i>lansoprazole odt 15 mg tablet</i>	T1	QL (2 tabs/day) HD
<i>lansoprazole odt 30 mg tablet</i>	T1	QL (30 tabs/30 days) HD
NEXIUM DR 2.5 MG PACKET	T2	QL (480 packs/30 days) HD
NEXIUM DR 5 MG PACKET	T2	QL (240 packs/30 days) HD
<i>omeppi 20 mg-1, 100 mg capsule</i>	T1	PA QL (60 caps/30 days) HD
<i>omeppi 40 mg-1, 100 mg capsule</i>	T1	PA QL (30 caps/30 days) HD
<i>omeprazole dr 10 mg capsule</i>	T1	QL (4 caps/day) HD
<i>omeprazole dr 20 mg capsule</i>	T1	QL (60 caps/30 days) HD
<i>omeprazole dr 40 mg capsule</i>	T1	QL (30 caps/30 days) HD
<i>omeprazole-bicarb 20-1, 100 cap</i>	T1	PA QL (60 caps/30 days) HD
<i>omeprazole-bicarb 20-1, 680 pkt</i>	T1	PA QL (60 packs/30 days) HD
<i>omeprazole-bicarb 40-1, 100 cap</i>	T1	PA QL (30 caps/30 days) HD
<i>omeprazole-bicarb 40-1, 680 pkt</i>	T1	PA QL (30 packs/30 days) HD
<i>pantoprazole 40 mg suspension</i>	T1	QL (1 dose/day) HD
<i>pantoprazole sod dr 20 mg tab</i>	T1	QL (2 tabs/day) HD
<i>pantoprazole sod dr 40 mg tab</i>	T1	QL (30 tabs/30 days) HD

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

T4 – Specialty Medications  
 PA – Prior Authorization  
 QL – Quantity Limit

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

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

## List of Prescription Medications

### GASTROINTESTINAL (Gastrointestinal/Heartburn) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>PROTON-PUMP INHIBITORS (cont.)</b>		
<i>pantoprazole sodium 40 mg vial</i>	T1	HD
<i>rabeprazole sodium</i>	T1	QL (1 tab/day) HD
<b>SBS - GLUCAGON-LIKE PEPTIDE-2 (GLP-2) ANALOGS</b>		
GATTEX	T4	PA SP HD

### GASTROINTESTINAL (Pain Relief And Inflammatory Disease)

#### HEMORRHOID PREP, ANTI-INFLAM STEROID-LOCAL ANESTHET

ANA-LEX	T1	
<i>hydrocortisone/lidocaine/aloe</i>	T1	
<i>hydrocortisone/pramoxine (Analpram Hc)</i>	T1	
<i>lidocaine/hydrocortisone ac</i>	T1	
LIDOCAINE-HYDROCORTISONE	T1	
PROCORT	T3	
PROCTOFOAM-HC	T3	

### GASTROINTESTINAL (Skin Conditions)

#### KERATINOCYTE GROWTH FACTOR (KGF)

KEPIVANCE	T4	SP
-----------	----	----

### HORMONES (Gastrointestinal/Heartburn)

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

<i>budesonide 2 mg rectal foam</i>	T1	
CORTENEMA ( <i>hydrocortisone</i> )	T3	
<i>hydrocortisone (Cortenema)</i>	T1	

### HORMONES (Hormonal Agents)

#### ADRENOCORTICOTROPHIC HORMONES

ACTHAR	T4	PA SP HD
ACTHREL	T4	SP
<i>cosyntropin</i>	T1	

#### ANDROGEN/ESTROGEN PREPS FOR FEMALE SEXUAL DYSFUNC

INTRAROSA	T3	
-----------	----	--

#### ANDROGENIC AGENTS

ANADROL-50	T3	PA
ANDRODERM	T3	PA QL (1 patch/day)
ANDROGEL 1% (25 MG/2.5 G) PKT ( <i>testosterone</i> )	T3	PA QL (150gm/30 days)
ANDROGEL 1% (50 MG/5 G) PKT ( <i>testosterone</i> )	T3	PA QL (2 packs/day)

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

T4 – Specialty Medications  
PA – Prior Authorization  
QL – Quantity Limit

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

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

## List of Prescription Medications

HORMONES (Hormonal Agents) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>ANDROGENIC AGENTS (cont.)</b>		
ANDROGEL 1.62% GEL PUMP ( <i>testosterone</i> )	T3	PA QL (150gm/30 days)
ANDROGEL 1.62% (1.25G) GEL PCKT ( <i>testosterone</i> )	T3	PA QL (2 packs/day)
ANDROID ( <i>methyltestosterone</i> )	T3	
AVEED	T4	PA SP
DEPO-TESTOSTERONE	T3	
DEPO-TESTOSTERONE ( <i>testosterone cypionate</i> )	T3	
METHITEST	T1	
<i>methyltestosterone</i> (Testred)	T1	
<i>oxandrolone</i>	T1	PA
TESTOPEL	T3	PA
<i>testosterone 1% (25mg/2.5g) pk</i> (Androgel)	T1	PA QL (150gm/30 days)
<i>testosterone 1% (50 mg/5 g) pk</i> (Testosterone)	T1	PA QL (2 packs/day)
<i>testosterone 1.62% (2.5 g) pkt</i> (Androgel)	T1	PA QL (150gm/30 days)
<i>testosterone 1.62% gel pump</i> (Androgel)	T1	PA QL (150gm/30 days)
<i>testosterone 1.62% (1.25 g) pkt</i> (Androgel)	T1	PA QL (2 packs/day)
<i>testosterone 10 mg gel pump</i>	T1	PA QL (120 gm/30 days)
TESTOSTERONE 12.5 MG/1.25 GRAM	T1	PA QL (150gm/30 days)
<i>testosterone 12.5 mg/1.25 gram</i> (Testosterone)	T1	PA QL (150gm/30 days)
<i>testosterone 30 mg/1.5 ml pump</i>	T1	PA QL (180ml/30 days)
<i>testosterone 50 mg/5 gram gel</i>	T1	PA QL (2 tubes/day)
TESTOSTERONE 50 MG/5 GRAM PKT	T1	PA QL (2 packs/day)
TESTRED ( <i>methyltestosterone</i> )	T3	
<b>ANTIDIURETIC AND VASOPRESSOR HORMONES</b>		
<i>desmopressin 0.01% solution</i>	T1	HD
<i>desmopressin 0.01% spray</i>	T1	HD
<i>desmopressin 10 mcg/0.1 ml spr</i>	T1	HD
<i>desmopressin 40 mcg/10 ml vial</i>	T4	SP
<i>desmopressin ac 4 mcg/ml ampul</i>	T4	SP
<i>desmopressin ac 4 mcg/ml vial</i>	T4	SP
<i>desmopressin acetate 0.1 mg tb</i>	T1	
<i>desmopressin acetate 0.2 mg tb</i>	T1	
NOCTIVA	T3	PA

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

T4 – Specialty Medications  
 PA – Prior Authorization  
 QL – Quantity Limit

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

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

## List of Prescription Medications

HORMONES (Hormonal Agents) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>ANTIDIURETIC AND VASOPRESSOR HORMONES (cont.)</b>		
STIMATE	T4	SP
<i>vasopressin</i>	T1	
VASOPRESSIN-0.9% NACL	T1	
VASOPRESSIN-D5W	T1	
VASOSTRICT	T3	
<b>ESTROGEN AND PROGESTIN COMBINATIONS</b>		
BIJUVA	T3	
<b>ESTROGEN/ANDROGEN COMBINATIONS</b>		
<i>estrogen, ester/me-testosterone</i>	T1	HD
<b>ESTROGENIC AGENTS</b>		
ACTIVELLA ( <i>mimvey lo</i> )	T3	HD
ACTIVELLA ( <i>mimvey</i> )	T3	HD
ALORA	T3	QL (16 patches/28 days) HD
CLIMARA ( <i>estradiol (once weekly)</i> )	T3	HD
CLIMARA PRO	T3	HD
COMBIPATCH	T3	HD
DEPO-ESTRADIOL	T3	HD
DIVIGEL	T3	HD
ELESTRIN	T3	HD
ESTRACE ( <i>estradiol</i> )	T3	HD
<i>estradiol (Climara)</i>	T1	HD
<i>estradiol 0.1% (0.5mg) gel pkt (Divigel)</i>	T1	HD
<i>estradiol patch (Minivelle)</i>	T1	QL (16 patches/28 days) HD
<i>estradiol patch (Vivelle-Dot)</i>	T1	QL (16 patches/28 days) HD
<i>estradiol tablet (Estrace)</i>	T1	HD
<i>estradiol valerate (Delestrogen)</i>	T1	HD
<i>estradiol/norethindrone acet (Activella)</i>	T1	HD
ESTROGEL	T3	HD
EVAMIST	T3	HD
FEMHRT ( <i>norethindron-ethinyl estradiol</i> )	T3	HD
MENEST	T3	HD
MENOSTAR	T3	QL (8 patches/28 days) HD
MINIVELLE ( <i>Jyllana</i> )	T3	QL (16 patches/28 days) HD

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

T4 – Specialty Medications  
PA – Prior Authorization  
QL – Quantity Limit

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

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

## List of Prescription Medications

<b>HORMONES (Hormonal Agents) (cont.)</b>		
<b>Prescription Drug Name</b>	<b>Drug Tier</b>	<b>Coverage Requirements and Limits</b>
<b>ESTROGENIC AGENTS (cont.)</b>		
<i>norethind-eth estrad 0.5-2.5 (Femhrt)</i>	T1	HD
<i>norethindrone ac-eth estradiol</i>	T1	HD
<i>norethindrone ac-eth estradiol (Femhrt)</i>	T1	HD
<i>norethin-eth estrad 1 mg-5 mcg</i>	T1	HD
PREFEST	T3	HD
PREMARIN	T2	HD
PREMPHASE	T2	HD
PREMPRO	T2	HD
VIVELLE-DOT ( <i>Jyllana</i> )	T3	QL (16 patches/28 days) HD
<b>ESTROGEN-PROGESTIN WITH ANTIMINERALOCORTICOID COMB</b>		
ANGELIQ	T3	HD
<b>ESTROGEN-SELECTIVE ESTROGEN RECEPTOR MOD (SERM) COMB</b>		
DUAVEE	T2	
<b>GLUCOCORTICOIDS</b>		
BETA 1	T3	
<i>betamethasone acetate, sod phos (Celestone)</i>	T1	
BSP 0820	T3	
<i>budesonide</i>	T1	PA QL (56 tabs/180 days)
<i>budesonide (Entocort Ec)</i>	T1	
CELESTONE ( <i>betamethasone sod phos-acetate</i> )	T3	
CORTEF ( <i>hydrocortisone</i> )	T3	
<i>cortisone acetate</i>	T1	
<i>deflazacort (Emflaza)</i>	T4	PA SP HD
DEPO-MEDROL	T3	
<i>dexamethasone</i>	T1	
<i>dexamethasone sodium phosp/pf</i>	T1	
<i>dexamethasone tablet</i>	T1	
DEXAMETHASONE 10 MG/ML SYRING	T3	
<i>dexamethasone 10 mg/ml vial</i>	T1	
<i>dexamethasone 100 mg/10 ml vial</i>	T1	
<i>dexamethasone 120 mg/30 ml vial</i>	T1	
<i>dexamethasone 20 mg/5 ml vial</i>	T1	
<i>dexamethasone 4 mg/ml syringe</i>	T1	
<i>dexamethasone 4 mg/ml vial</i>	T1	
<i>dexamethasone in 0.9% sod chl</i>	T1	

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

T4 – Specialty Medications  
 PA – Prior Authorization  
 QL – Quantity Limit

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

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



# List of Prescription Medications

HORMONES (Hormonal Agents) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>GLUCOCORTICOIDS (cont.)</b>		
EMFLAZA	T4	PA SP HD
ENTOCORT EC ( <i>budesonide ec</i> )	T3	
<i>hydrocortisone</i> (Cortef)	T1	
<i>hydrocortisone sod succinate</i> (Solu-cortef)	T1	
KENALOG-10	T3	
KENALOG-40 ( <i>triamcinolone acetonide</i> )	T3	
KENALOG-80	T3	
LOCORT	T1	
MEDROL	T3	
MEDROL ( <i>methylprednisolone</i> )	T3	
MEDROLOAN II SUIK	T3	
<i>methylprednisolone</i> (Medrol)	T1	
<i>methylprednisolone acetate</i> (Depo-medrol)	T1	
<i>methylprednisolone sod succ</i>	T1	
<i>methylprednisolone sod succ</i> (Solu-medrol)	T1	
MILLIPRED 10 MG/5 ML SOLUTION ( <i>prednisolone sodium phosphate</i> )	T3	
<i>millipred 5 mg tablet</i>	T1	
ORAPRED ODT ( <i>prednisolone sodium phos odt</i> )	T3	
P-CARE D80G	T1	
P-CARE K80	T1	
POD-CARE 100C	T1	
<i>prednisolone</i>	T1	
<i>prednisolone sodium phosphate</i>	T1	
<i>prednisolone sodium phosphate</i> (Millipred)	T1	
<i>prednisolone sodium phosphate</i> (Orapred Odt)	T1	
<i>prednisone</i>	T1	
PRO-C-DURE 5	T3	
PRO-C-DURE 6	T3	
READYSHARP BETAMETHASONE	T1	
SOLU-CORTEF	T3	
SOLU-MEDROL	T3	
ZILRETTA	T3	PA
<b>GROWTH HORMONES</b>		
GENOTROPIN	T4	PA SP HD

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

T4 – Specialty Medications  
PA – Prior Authorization  
QL – Quantity Limit

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

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

## List of Prescription Medications

<b>HORMONES (Hormonal Agents) (cont.)</b>			
<b>Prescription Drug Name</b>	<b>Drug Tier</b>	<b>Coverage Requirements and Limits</b>	
<b>GROWTH HORMONES (cont.)</b>			
NGENLA	T4	PA SP	
NORDITROPIN FLEXPPO	T4	PA SP HD	
OMNITROPE	T4	PA SP HD	
SEROSTIM	T4	PA SP	
SKYTROFA	T4	PA SP	
SOGROYA	T4	PA SP	
ZORBTIVE	T4	PA SP HD	
<b>LHRH (GNRH) AGONIST ANALOG AND PROGESTIN COMB</b>			
LUPANETA PACK	T4	PA SP HD	
<b>LHRH (GNRH) AGONIST ANALOG PITUITARY SUPPRESSANTS</b>			
LUPRON DEPOT	T4	PA SP HD	
<b>LHRH (GNRH) ANTAGONIST, ESTROGEN AND PROGESTIN COMB</b>			
MYFEMBREE	T2	PA QL (24 month therapy)	
ORIAHNN	T2	PA QL (2 capsules/day)	
<b>LHRH (GNRH) ANTAGONIST, PITUITARY SUPPRESSANT AGENTS</b>			
CETROTIDE	T4	PA SP	
<i>ganirelix acet 250 mcg/0.5 ml (Ganirelix Acetate)</i>	T4	PA SP	
GANIRELIX ACET 250 MCG/0.5 ML ( <i>ganirelix acetate</i> )	T4	PA SP	
ORLISSA 150 MG TABLET	T2	PA QL (24 months of treatment/lifetime)	
ORLISSA 200 MG TABLET	T2	PA QL (2 tabs/day)	
<b>LHRH (GNRH) AGNST PIT.SUP-CENTRAL PRECOCIOUS PUBERTY</b>			
FENSOLVI	T4	PA SP	
LUPRON DEPOT-PED	T4	PA SP HD	
SUPPRELIN LA	T4	PA SP HD	
TRIPTODUR	T4	PA SP	
<b>MINERALOCORTICIDS</b>			
<i>fludrocortisone acetate</i>	T1	HD	
<b>OXYTOCICS</b>			
CARBOPROST	T3		
<i>carboprost tromethamine</i>	T1		
CERVIDIL	T3		
HEMABATE	T3		
<i>methylergonovine maleate</i>	T1		
<i>oxytocin (Pitocin)</i>	T1		
OXYTOCIN-D5-LACTATED RINGERS	T1		
OXYTOCIN-D5W	T1		

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

T4 – Specialty Medications  
PA – Prior Authorization  
QL – Quantity Limit

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

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

## List of Prescription Medications

<b>HORMONES (Hormonal Agents) (cont.)</b>		
<b>Prescription Drug Name</b>	<b>Drug Tier</b>	<b>Coverage Requirements and Limits</b>
<b>OXYTOCICS (cont.)</b>		
OXYTOCIN-LACTATED RINGERS	T1	
PITOCIN ( <i>oxytocin</i> )	T3	
PREPIDIL	T3	
PROSTIN E2 VAGINAL SUPPOSITORY	T3	
<b>PITUITARY SUPPRESSIVE AGENTS</b>		
<i>cabergoline</i>	T1	QL (16 tabs/28 days) HD
<i>danazol</i>	T1	HD
<b>PROGESTATIONAL AGENTS</b>		
AYGESTIN ( <i>norethindrone acetate</i> )	T3	HD
CRINONE 4% GEL	T3	PA HD
DEPO-PROVERA 400 MG/ML VIAL	T2	HD
<i>hydroxyprogesterone 1.25 g/5ml</i>	T1	HD
<i>medroxyprogesterone 10 mg tab (Provera)</i>	T1	HD
<i>medroxyprogesterone 2.5 mg tab (Provera)</i>	T1	HD
<i>medroxyprogesterone 5 mg tab (Provera)</i>	T1	HD
<i>norethindrone acetate (Aygestin)</i>	T1	HD
<i>progesterone 100 mg capsule (Prometrium)</i>	T1	HD
<i>progesterone 200 mg capsule (Prometrium)</i>	T1	HD
<i>progesterone 500 mg/10 ml vial</i>	T4	SP HD
PROVERA ( <i>medroxyprogesterone acetate</i> )	T3	HD
<b>RENIN-ANGIOTENSIN-ALDOSTERONE SYS. (RAAS) HORMONES</b>		
GIAPREZA	T4	SP
<b>SOMATOSTATIC AGENTS</b>		
BYNFEZIA	T4	PA SP
<i>octreotide acetate</i>	T4	PA SP HD
<i>octreotide acetate (Sandostatin)</i>	T4	PA SP HD
SANDOSTATIN 0.05 MG/ML AMPUL ( <i>octreotide acetate</i> )	T4	PA SP HD
SANDOSTATIN 0.1 MG/ML AMPUL ( <i>octreotide acetate</i> )	T4	PA SP HD
SANDOSTATIN 0.5 MG/ML AMPUL ( <i>octreotide acetate</i> )	T4	PA SP HD
SANDOSTATIN LAR DEPOT	T4	PA SP
SIGNIFOR	T4	PA SP
SIGNIFOR LAR	T4	PA SP
SOMATULINE DEPOT	T4	PA SP HD
<b>VAGINAL ESTROGEN FOR SEXUAL DYSFUNCTION</b>		
IMVEXXY 10 MCG MAINTENANCE PAK	T3	QL (16/28 days) HD

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

T4 – Specialty Medications  
PA – Prior Authorization  
QL – Quantity Limit

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

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

## List of Prescription Medications

<b>HORMONES (Hormonal Agents) (cont.)</b>		
<b>Prescription Drug Name</b>	<b>Drug Tier</b>	<b>Coverage Requirements and Limits</b>
<b>VAGINAL ESTROGEN FOR SEXUAL DYSFUNCTION</b>		
OXYTOCIN-LACTATED RINGERS	T1	
IMVEXXY 4 MCG MAINTENANCE PACK	T3	QL (16/28 days) HD
IMVEXXY 4 MCG STARTER PACK	T3	QL (36/28 days) HD
<b>VAGINAL ESTROGEN PREPARATIONS</b>		
ESTRACE ( <i>estradiol</i> )	T3	HD
<i>estradiol</i> (Vagifem)	T1	QL (36 tabs/28 days) HD
<i>estradiol 0.01% cream</i> (Estrace)	T1	HD
<i>estradiol 10 mcg vaginal insrt</i> (Vagifem)	T1	QL (36 tabs/28 days) HD
ESTRING	T3	QL (2 rings/90 days) HD
FEMRING	T3	HD
PREMARIN	T2	HD
VAGIFEM ( <i>yuvafem</i> )	T3	QL (36 tabs/28 days) HD
<b>HORMONES (Infertility)</b>		
<b>FERTILITY STIMULATING PREPARATIONS, NON-FSH</b>		
<i>clomiphene citrate</i>	T1	
<b>FOLLICLE-STIMULATING AND LUTEINIZING HORMONES</b>		
MENOPUR	T4	PA SP
<b>FOLLICLE-STIMULATING HORMONE (FSH)</b>		
FOLLISTIM AQ	T4	PA SP
GONAL-F	T4	PA SP
GONAL-F RFF	T4	PA SP
GONAL-F RFF REDI-JECT	T4	PA SP
<b>HUMAN CHORIONIC GONADOTROPIN (HCG)</b>		
CHORIONIC GONAD 12,000 UNIT VL	T4	SP
CHORIONIC GONAD 6,000 UNIT VL	T4	SP
CHORIONIC GONADOTROPIN	T4	PA SP
NOVAREL	T4	PA SP
OVIDREL	T4	PA SP
PREGNYL	T4	PA SP
<b>PREGNANCY FACILITATING/MAINTAINING AGENT, HORMONAL</b>		
CRINONE 8% GEL	T2	PA
ENDOMETRIN	T2	
<b>PREGNANCY MAINTAINING AGENT, HORMONAL</b>		
<i>hydroxyprogesterone 250 mg/ml vial</i> (Makena)	T1	PA

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

T4 – Specialty Medications  
PA – Prior Authorization  
QL – Quantity Limit

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

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

# List of Prescription Medications

<b>HORMONES (Miscellaneous)</b>		
<b>Prescription Drug Name</b>	<b>Drug Tier</b>	<b>Coverage Requirements and Limits</b>
<b>PREGNANCY MAINTAINING AGENT, HORMONAL (con't.)</b>		
MAKENA	T3	PA
MAKENA ( <i>hydroxyprogesterone caproate</i> )	T3	PA
<b>LEPTIN HORMONE ANALOGS</b>		
MYALEPT	T4	PA SP HD
<b>BONE RESORPTION INHIBITORS</b>		
<i>calcitonin, salmon, synthetic</i>	T1	HD
MIACALCIN	T3	HD
<b>IMMUNOSUPPRESSANTS (Miscellaneous)</b>		
<b>IMMUNOSUPPRESSANT-INTERFERON GAMMA INHIBITOR, MAB</b>		
GAMIFANT	T4	PA SP
<b>IMMUNOSUPPRESSANTS (Pain Relief And Inflammatory Disease)</b>		
<b>ANTI-CD19 (B LYMPHOCYTE) MONOCLONAL ANTIBODY</b>		
UPLIZNA	T4	PA SP
<b>IL-23 RECEPTOR ANTAGONIST, MONOCLONAL ANTIBODY</b>		
OMVOH	T4	SP HD
OMVOH PEN	T4	PA QL(2 pens/28 days) SP HD
<b>INTERLEUKIN-4 (IL-4) RECEPTOR ALPHA ANTAGONIST, MAB</b>		
DUPIXENT PEN	T4	PA SP HD
DUPIXENT SYRINGE	T4	PA SP HD
<b>INTERLEUKIN-6 (IL-6) RECEPTOR INHIBITORS</b>		
ACTEMRA 162 MG/0.9 ML SYRINGE	T4	PA QL (4 syringes/28 days) SP HD
ACTEMRA 200 MG/10 ML VIAL	T4	PA SP HD
ACTEMRA 400 MG/20 ML VIAL	T4	PA SP HD
ACTEMRA 80 MG/4 ML VIAL	T4	PA SP HD
ACTEMRA ACTPEN	T4	PA QL (4 pens/28 days) SP HD
ENSPRYNG	T4	PA SP HD
KEVZARA 150 MG/1.14 ML PEN INJ	T4	PA QL (2 pens/28 days) SP HD
KEVZARA 150 MG/1.14 ML SYRINGE	T4	PA QL (2 syringes/28 days) SP HD
KEVZARA 200 MG/1.14 ML PEN INJ	T4	PA QL (2 pens/28 days) SP HD
KEVZARA 200 MG/1.14 ML SYRINGE	T4	PA QL (2 syringes/28 days) SP HD
<b>MONOCLONAL ANTIBODY-HUMAN INTERLEUKIN 12/23 INHIB</b>		
STELARA 130 MG/26 ML VIAL	T4	PA SP HD
STELARA 45 MG/0.5 ML SYRINGE	T4	PA QL (1 syringe/84 days) SP HD

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

T4 – Specialty Medications  
 PA – Prior Authorization  
 QL – Quantity Limit

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

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

## List of Prescription Medications

### IMMUNOSUPPRESSANTS (Skin Conditions)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>MONOCLONAL ANTIBODY-HUMAN INTERLEUKIN I2/23 INHIB (cont.)</b>		
STELARA 45 MG/0.5 ML VIAL	T4	PA QL (1 vial/84 days) SP HD
STELARA 90 MG/ML SYRINGE	T4	PA QL (1 syringe/84 days) SP HD
<b>TOPICAL IMMUNOSUPPRESSIVE AGENTS</b>		
ELIDEL ( <i>pimecrolimus</i> )	T3	
<i>pimecrolimus</i> (Elidel)	T1	
PROTOPIC ( <i>tacrolimus</i> )	T3	
<i>tacrolimus 0.03% ointment</i> (Protopic)	T1	
<i>tacrolimus 0.1% ointment</i> (Protopic)	T1	

### IMMUNOSUPPRESSANTS (Transplant Medications)

#### IMMUNOSUPP - MONOCLONAL AB INHIBITING T LYMPH FXN

SIMULECT	T4	SP
----------	----	----

#### IMMUNOSUPPRESSIVES

ASTAGRAF XL	T4	SP HD
AZASAN	T4	SP HD
<i>azathioprine</i> (Imuran)	T4	SP HD
<i>azathioprine sodium</i>	T1	
CELLCEPT 200 MG/ML ORAL SUSP ( <i>mycophenolate mofetil</i> )	T4	SP HD
CELLCEPT 250 MG CAPSULE ( <i>mycophenolate mofetil</i> )	T4	SP HD
CELLCEPT 500 MG TABLET ( <i>mycophenolate mofetil</i> )	T4	SP HD
CELLCEPT 500 MG VIAL ( <i>mycophenolate mofetil</i> )	T4	SP
<i>cyclosporine 100 mg capsule</i> (Sandimmune)	T4	SP HD
<i>cyclosporine 25 mg capsule</i> (Sandimmune)	T4	SP HD
<i>cyclosporine 250 mg/5 ml ampul</i> (Sandimmune)	T4	SP
<i>cyclosporine, modified</i>	T4	SP HD
<i>cyclosporine, modified</i> (Neoral)	T4	SP HD
ENVARUSUS XR	T4	SP HD
<i>everolimus 0.25 mg tablet</i> (Zortress)	T4	SP HD
<i>everolimus 0.5 mg tablet</i> (Zortress)	T4	SP HD
<i>everolimus 0.75 mg tablet</i> (Zortress)	T4	SP HD
IMURAN ( <i>azathioprine</i> )	T4	SP HD
LUPKYNIS	T4	PA QL(6 caps/day) SP
<i>mycophenolate 200 mg/ml susp</i> (Cellcept)	T1	SP HD
<i>mycophenolate 250 mg capsule</i> (Cellcept)	T1	SP HD
<i>mycophenolate 500 mg tablet</i> (Cellcept)	T4	SP HD

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

T4 – Specialty Medications  
PA – Prior Authorization  
QL – Quantity Limit

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

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

## List of Prescription Medications

### IMMUNOSUPPRESSANTS (Transplant Medications) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>IMMUNOSUPPRESSIVES (cont.)</b>		
<i>mycophenolate 500 mg vial</i> (Cellcept)	T4	SP
MYFORTIC ( <i>mycophenolic acid</i> )	T4	SP HD
NULOJIX	T4	SP
PROGRAF 0.2 MG GRANULE PACKET	T4	SP HD
PROGRAF 0.5 MG CAPSULE ( <i>tacrolimus</i> )	T4	SP HD
PROGRAF 1 MG CAPSULE ( <i>tacrolimus</i> )	T4	SP HD
PROGRAF 1 MG GRANULE PACKET	T4	SP HD
PROGRAF 5 MG CAPSULE ( <i>tacrolimus</i> )	T4	SP HD
PROGRAF 5 MG/ML AMPULE	T4	SP
RAPAMUNE ( <i>sirolimus</i> )	T4	SP HD
<i>sirolimus</i> (Rapamune)	T4	SP HD
<i>tacrolimus 0.5 mg capsule (ir)</i> (Prograf)	T4	SP HD
<i>tacrolimus 1 mg capsule (ir)</i> (Prograf)	T4	SP HD
<i>tacrolimus 5 mg capsule (ir)</i> (Prograf)	T4	SP HD
ZORTRESS	T4	SP HD
ZORTRESS ( <i>everolimus</i> )	T4	SP HD

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

#### DIABETIC SUPPLIES

2TEK CONTROL SOLUTION	T1	
2TEK GLUCOSE-WRIST MONITOR KIT	T1	
ACCU-CHEK	T1	
ACCUTREND GLUCOSE CONTROL	T1	
ADJUSTABLE LANCING DEVICE	T1	
ADVANCED LANCING DEVICE	T1	
ADVOCATE CONTROL SOLUTION	T1	
ADVOCATE LANCING DEVICE	T1	
ADVOCATE RAPID-SAFE LANCING DV	T1	
ADVOCATE REDI-CODE+ CTRL SOLN	T1	
AGAMATRIX CONTROL	T1	
ALKALINE BATTERIES	T1	
ALTERNATE SITE LANCING DEVICE	T1	
AQUA LANCE LANCING DEVICE	T1	
ASSURE	T1	
AT HOME A1C	T1	
AUTOJECT 2	T1	

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

T4 – Specialty Medications

PA – Prior Authorization

QL – Quantity Limit

ST – Step Therapy

AGE – Age Requirement

SP – Specialty Medication

HD – May require home delivery pharmacy

PPACA – No Cost-Share Preventive Medication

CSL – Oral cancer medication subject to cost-share limits

## List of Prescription Medications

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

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>DIABETIC SUPPLIES (cont.)</b>		
AUTO-LANCET MINI	T1	
AUTOLET	T1	
AUTOPEN	T1	
BLOOD GLUCOSE CONTROL	T1	
BLU LINK DIABETIC TEST BUNDLE	T3	
BLU LINK GLUCOSE MONITOR SYST	T3	
BREEZE 2	T1	
CAREONE	T1	
CARESENS	T1	
CARESENS N FELIZ GLUCOSE METER	T3	
CARETOUCH	T1	
CEQR SIMPLICITY	T2	
CEQR SIMPLICITY INSERTER	T2	
CHEMSTRIP BG DIARY	T1	
CLEVER CHOICE CONTROL SOLUTION	T1	
CONTOUR SOLUTION/METER/NEXT CONTROL SOLUTION	T1	
CONTROL SOLUTION	T1	
COOL CONTROL SOLUTION	T1	
DEXCOM G7 RECEIVER	T2	PA QL(1 unit/365 days)
DEXCOM G7 SENSOR	T2	PA QL(3 sensors/30 days)
DEXCOM	T3	
DEXCOM G4	T3	
DEXCOM G5	T3	
DEXCOM G5-G4 SENSOR	T3	
DEXCOM G6 RECEIVER	T2	PA QL (1 syringe/365 days)
DEXCOM G6 SENSOR	T2	PA QL (3/30 days)
DEXCOM G6 TRANSMITTER	T2	PA QL (1 syringe/67 days)
DIATRUE	T1	
DROPLET GENTEEL LANCING DEVICE	T1	
DROPLET LANCING DEVICE	T1	
EASY MINI EJECT LANCING DEVICE	T1	
EASY PLUS II CONTROL SOLN HIGH/ LOW	T1	
EASY STEP CONTROL SOLUTION	T1	
EASY TALK CONTROL SOLN LOW / HIGH CONTROL SOLN	T1	
EASY TALK PLUS II HIGH CONTROL/ LOW CTRL SLN	T1	

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

T4 – Specialty Medications

PA – Prior Authorization

QL – Quantity Limit

ST – Step Therapy

AGE – Age Requirement

SP – Specialty Medication

HD – May require home delivery pharmacy

PPACA – No Cost-Share Preventive Medication

CSL – Oral cancer medication subject to cost-share limits



## List of Prescription Medications

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

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>DIABETIC SUPPLIES (cont.)</b>		
EASY TOUCH	T1	
EASY TRAK	T1	
EASYGLUCO PLUS CONTROL NORMAL	T1	
EASYMAX	T1	
ELEMENT	T1	
EMBRACE	T1	
ENLITE	T3	
ENLITE GLUCOSE SENSOR	T3	
ENLITE SERTER	T3	
EVENCARE SOLUTION	T1	
EVERSENSE SENSOR-HOLDER	T3	
EVERSENSE SMART TRANSMITTER	T3	
EVOLUTION CONTROL SOLUTION	T1	
EZ-VAC	T1	
FORA CONTROL SOLUTION/ LANCING DEVICE	T1	
FORACARE GDH	T1	
FORTISCARE	T1	
FREESTYLE CONTROL SOLUTION	T1	
FREESTYLE LIBRE 10 DAY READER	T2	PA QL (1 reader/day)
FREESTYLE LIBRE 10 DAY SENSOR	T2	PA QL (3/30 days)
FREESTYLE LIBRE 14 DAY READER	T2	PA QL (1 reader/day)
FREESTYLE LIBRE 14 DAY SENSOR	T2	PA QL (2/28 days)
FREESTYLE LIBRE 2 READER	T2	PA QL (1 reader/day)
FREESTYLE LIBRE 2 SENSOR	T2	PA QL (2 sensors/21 days)
FREESTYLE LIBRE 3 READER	T2	PA QL(1 unit/720 days)
FREESTYLE NAVIGATOR	T3	
GE100 CONTROL SOLUTION NORMAL	T1	
GE333 BLOOD GLUCOSE SYSTEM	T3	
GENTEEL VACUUM LANCING DEVICE	T1	
GLUCOCARD	T1	
GLUCOCOM	T1	
GLUCOSE	T1	
GOJJI GLUCOSE CONTROL SOLUTION/ LANCING DEVICE	T1	
GUARDIAN CONNECT TRANSMITTER	T3	
GUARDIAN	T3	

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

T4 – Specialty Medications

PA – Prior Authorization

QL – Quantity Limit

ST – Step Therapy

AGE – Age Requirement

SP – Specialty Medication

HD – May require home delivery pharmacy

PPACA – No Cost-Share Preventive Medication

CSL – Oral cancer medication subject to cost-share limits

## List of Prescription Medications

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

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>DIABETIC SUPPLIES (cont.)</b>		
GUARDIAN RT CHARGER	T1	
GUARDIAN RT STARTER KIT	T3	
GUARDIAN RT SYSTEM	T1	
GUARDIAN SENSOR 3	T3	
GUARDIAN TEST PLUG	T1	
GUARDIAN TRANSMITTER TAPE	T1	
HEALTHPRO GLUCOSE CONTROL SOLN	T1	
HEALTHY ACCENTS AUTOLET	T1	
HUMAPEN LUXURA HD	T3	
HYPOLANCE	T1	
INCONTROL LANCING DEVICE	T1	
INFINITY CONTROL SOLUTION / VOICE CONTROL SOLN	T1	
INPEN (FOR HUMALOG) / (FOR NOVOLOG OR FIASP)	T1	
INSUL-CAP	T1	
INSUL-EZE	T1	
LANCING DEVICE/ SYSTEM	T1	
LANZO	T1	
LITE TOUCH	T1	
MAGNI-GUIDE MAGNIFIER	T1	
MEDISENSE	T1	
MEDTRONIC REMOTE CONTROL	T1	
MICRODOT HIGH-LOW CONTROL SOL / NORMAL CONTROL SOLUT	T1	
MICROLET 2/ NEXT LANCING DEVICE	T1	
MINI LANCING DEVICE	T1	
MINILINK REAL-TIME TRANSMITTER	T2	
MINIMED QUICK-SERTER	T1	
MINIMED 630G GUARDIAN START KT	T3	
MOBILE LANCETS	T2	
MYGLUCOHEALTH CONTROL SOLUTION	T1	
MOBILE	T1	
NOVA MAX GLUCOSE CONTROL SOLN/ PLUS GLU-KET	T1	
NOVOPEN ECHO	T1	
OMNIPOD CLASSIC (GEN 3 & 4) KIT	T2	QL (1 kit/365 days)
OMNIPOD CLASSIC (GEN 3 & 4) PODS	T2	QL (30 pods/30 days)
OMNIPOD 5 (GEN 5) KIT	T2	QL (1 kit/365 days)

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

T4 – Specialty Medications

PA – Prior Authorization

QL – Quantity Limit

ST – Step Therapy

AGE – Age Requirement

SP – Specialty Medication

HD – May require home delivery pharmacy

PPACA – No Cost-Share Preventive Medication

CSL – Oral cancer medication subject to cost-share limits

## List of Prescription Medications

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

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>DIABETIC SUPPLIES (cont.)</b>		
OMNIPOD 5 (GEN 5) PODS	T2	QL (30 pods/30 days)
OMNIPOD 5 G6-G7 INTRO KT(GEN5)	T2	QL
OMNIPOD 5 G6-G7 PODS (GEN 5)	T2	QL
OMNIPOD DASH 5 PACK POD	T2	QL (6 boxes/30 days)
ON CALL	T1	
ONETOUCH DELICA PLUS LANC DEV	T1	
ONETOUCH ULTRA CONTROL SOLN	T1	
ONETOUCH ULTRASOFT 2 LANCET	T2	
ONETOUCH VERIO	T1	
OPTUMRX GLUCOSE CONTROL SOLN	T1	
OVAL TAPE	T1	
PARADIGM REAL-TIME	T2	
PARADIGM REMOTE CONTROL	T1	
PIP GLUCOSE CONTROL SOLUTION	T1	
PRO COMFORT SAFETY LANCET	T2	
PRODIGY CONTROL SOLUTION / LANCING DEVICE	T1	
REFUAH PLUS GLUCOSE CONTROL	T1	
RELIAMED MINI LANCING DEVICE	T1	
REPLACEMENT PEDIATRIC MONITOR	T3	
RIGHTEST CONTROL SOLUTION/ GD500	T1	
SAFE-CLIP	T1	
SIL-SERTER	T1	
SEN-SERTER	T2	
SMARTDIABETES VANTAGE	T1	
SMARTEST	T1	
SOF-SENSOR	T2	
SOLUS V2 CONTROL SOLUTION / LANCING DEVICE	T1	
SURE COMFORT LANCING PEN	T1	
SUREFLEX	T1	
SURE-PEN	T1	
SURE-TEST EASYPLUS MINI SOLN	T1	
TELCARE CONTROL SOLUTION	T1	
TRUE METRIX	T1	
TRUECONTROL	T1	
TRUEDRAW	T1	

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

T4 – Specialty Medications

PA – Prior Authorization

QL – Quantity Limit

ST – Step Therapy

AGE – Age Requirement

SP – Specialty Medication

HD – May require home delivery pharmacy

PPACA – No Cost-Share Preventive Medication

CSL – Oral cancer medication subject to cost-share limits

## List of Prescription Medications

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

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>DIABETIC SUPPLIES (cont.)</b>		
ULTI-LANCE	T1	
ULTRATRAK	T1	
UNISTIK	T1	
UNISTRIP	T1	
VERASENS CONTROL SOLUTION	T1	
V-GO 20	T2	
V-GO 30	T2	
V-GO 40	T2	
VIVAGUARD	T1	
WAVESENSE CONTROL SOLUTION	T1	
<b>NEEDLES/NEEDLELESS DEVICES</b>		
1ST TIER UNIFINE PENTIPS / PLUS	T1	
ABOUTIME PEN NEEDLE	T1	
ADVOCATE PEN NEEDLES	T1	
AQINJECT PEN NEEDLE	T1	
ASSURE ID PEN NEEDLE	T1	
AUTOSHIELD DUO PEN NEEDLE	T1	
BD NEEDLES		
BLUNT NEEDLE	T1	
CAREFINE PEN NEEDLE	T1	
CARETOUCH HYPODERMIC NEEDLE / PEN NEEDLE	T1	
CAREPOINT PRECISION NEEDLE	T1	
CLICKFINE	T1	
COMFORT EZ PEN NEEDLE / EZ PRO SAFETY PEN NDL	T1	
COMFORT TOUCH PEN NEEDLE	T1	
DROPLET MICRON PEN NEEDLE / PEN NEEDLE	T1	
DROPSAFE PEN NEEDLE	T1	
EASY COMFORT PEN NEEDLES	T1	
EASY GLIDE PEN NEEDLE	T1	
EASY TOUCH	T1	
EASYPPOINT NEEDLE	T1	
ECLIPSE NEEDLE	T1	
EMBRACE PEN NEEDLE	T1	
EXEL HUBER NEEDLE/ HYPODERMIC NEEDLE	T1	
FILTER NEEDLE / ASPIRATOR NEEDLE	T1	

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

T4 – Specialty Medications

PA – Prior Authorization

QL – Quantity Limit

ST – Step Therapy

AGE – Age Requirement

SP – Specialty Medication

HD – May require home delivery pharmacy

PPACA – No Cost-Share Preventive Medication

CSL – Oral cancer medication subject to cost-share limits

## List of Prescription Medications

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

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>NEEDLES/NEEDLELESS DEVICES (cont.)</b>		
FLOW-EZE	T1	
HEALTHWISE PEN NEEDLE	T1	
HEALTHY ACCENTS UNIFINE PENTIP	T1	
HYPODERMIC NEEDLE	T1	
INCONTROL PEN NEEDLE	T1	
INSULIN PEN NEEDLE	T1	
INSUPEN	T1	
INTEGRA	T1	
LIFESHIELD BLUNT CANNULA	T1	
LITE TOUCH	T1	
MAXICOMFORT	T1	
MICRODOT INSULIN PEN NEEDLE	T1	
MINI PEN NEEDLE/ MINI ULTRA-THIN II	T1	
MONOJECT BLOOD COLLECTION / FILTER NEEDLE	T1	
NANO 2ND GEN PEN NEEDLE	T1	
NEEDLES	T1	
<i>needles,safety huber,disposabl</i>	T1	
NOKOR	T1	
NOVOFINE	T1	
NOVOTWIST	T1	
PEN NEEDLES	T1	
PHASEAL PROTECTOR	T2	
PENTIPS	T1	
PIP PEN NEEDLE	T1	
POLY HUB NEEDLE	T1	
PRECISIONGLIDE	T1	
PREVENT DROPSAFE PEN NEEDLE	T1	
PRO COMFORT PEN NEEDLE	T1	
PURE COMFORT PEN NEEDLE / SAFETY PEN NEEDLE	T1	
RAYA SURE PEN NEEDLE	T1	
REGULAR BEVEL NEEDLES	T1	
RELION PEN NEEDLES	T1	
SAFETY PEN NEEDLE	T1	
SAFETYGLIDE NEEDLE	T1	
SECURESAFE PEN NEEDLE	T1	

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

T4 – Specialty Medications

PA – Prior Authorization

QL – Quantity Limit

ST – Step Therapy

AGE – Age Requirement

SP – Specialty Medication

HD – May require home delivery pharmacy

PPACA – No Cost-Share Preventive Medication

CSL – Oral cancer medication subject to cost-share limits

# List of Prescription Medications

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

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>NEEDLES/NEEDLELESS DEVICES (cont.)</b>		
SHORT BEVEL NEEDLES	T1	
SKY SAFETY PEN NEEDLE	T1	
SPECIALTY USE NEEDLES	T1	
SURE COMFORT	T1	
SURE-FINE PEN NEEDLES	T1	
TECHLITE PEN NEEDLE	T1	
TERUMO SURGUARD2	T1	
THIN WALL NEEDLES	T1	
TOPCARE CLICKFINE	T1	
TRANSFER NEEDLE	T1	
TRUE COMFORT	T1	
TRUEPLUS PEN NEEDLE	T1	
ULTICARE PEN NEEDLE / SAFETY PEN NEEDLE	T1	
ULTIGUARD SAFEPACK-PEN NEEDLE	T1	
ULTILET PEN NEEDLE	T1	
ULTRA FLO PEN NEEDLE	T1	
ULTRA THIN / ULTRA-THIN II	T1	
ULTRACARE PEN NEEDLE	T1	
ULTRA-FINE	T1	
UNIFINE	T1	
VERIFINE	T1	
YALE NEEDLES	T1	
<b>SYRINGES AND ACCESSORIES</b>		
ADVOCATE SYRINGES	T1	
ASSURE ID INSULIN SAFETY	T1	
CARETOUCH INSULIN SYRINGE	T1	
COMFORT EZ INSULIN SYRINGE	T1	
DROPLET INSULIN SYRINGE	T1	
DROPSAFE INSULIN SYRINGE	T1	
EASY COMFORT INSULIN SYRINGE	T1	
EASY GLIDE INSULIN SYRINGE	T1	
EASY TOUCH	T1	
ECLIPSE SYRINGE	T1	
FREESTYLE PRECISION	T1	
HEALTHWISE INSULIN SYRINGE	T1	
INSULIN SYRINGE	T1	

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

14 – Specialty Medications

PA – Prior Authorization

QL – Quantity Limit

S1 – Step Therapy

AGE – Age Requirement

SP – Specialty Medication

HD – 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
<b>SYRINGES AND ACCESSORIES (cont.)</b>		
INSULIN SYRINGE U-500	T1	
LITE TOUCH	T1	
LITETOUCH INSULIN SYRINGE	T1	
LUER-LOK SYRINGE	T1	
MAGELLAN INSULIN SAFETY SYRNG	T1	
MAGELLAN INSULIN SYRINGE	T1	
MAXI-COMFORT	T1	
MAXICOMFORT INSULIN SYRINGE	T1	
MINIMED RESERVOIR	T1	
MONOJECT	T1	
MONOJECT INSULIN SYRINGE	T1	
PARADIGM	T1	
PRO COMFORT INSULIN SYRINGE	T1	
PRODIGY INSULIN SYRINGE	T1	
SAFESNAP INSULIN SYRINGE	T1	
SAFETYGLIDE	T1	
SECURESAFE INSULIN SYRINGE	T1	
SURE COMFORT	T1	
SURE-JECT INSULIN SYRINGE	T1	
<i>syringe and needle, insulin, 1ml</i>	T1	
<i>syring-needl, disp, insul</i>	T1	
TECHLITE INSULIN SYRINGE	T1	
TERUMO INSULIN SYRINGE	T1	
THINPRO INSULIN SYRINGE	T1	
TOPCARE ULTRA COMFORT	T1	
TRUE COMFORT INSULIN SYRINGE / PRO INS SYRINGE	T1	
TRUEPLUS INSULIN SYRINGE	T1	
ULTICARE	T1	
ULTICARE INSULIN SYRINGE	T1	
ULTIGUARD SAFE	T1	
ULTILET INSULIN SYRINGE	T1	
ULTRA COMFORT / FLO INSULIN SYRINGE	T1	
ULTRACARE INSULIN SYRINGE	T1	
ULTRA-THIN II	T1	
VANISHPOINT	T1	

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

T4 – Specialty Medications

PA – Prior Authorization

QL – Quantity Limit

ST – Step Therapy

AGE – Age Requirement

SP – Specialty Medication

HD – May require home delivery pharmacy

PPACA – No Cost-Share Preventive Medication

CSL – Oral cancer medication subject to cost-share limits

## List of Prescription Medications

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

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>SYRINGES AND ACCESSORIES (cont.)</b>		
VEO INSULIN SYRINGE	T1	
VERIFINE INSULIN SYRINGE	T1	
<b>DURABLE MEDICAL EQUIPMENT,MISC(GROUP I)</b>		
1ST TIER UNILET COMFORTOUCH	T1	
2-IN-1 LANCET DEVICE	T1	
ACCU-CHEK	T1	
<b>DURABLE MEDICAL EQUIPMENT,MISC(GROUP I) (cont.)</b>		
ACTI-LANCE	T1	
ADVANCED TRAVEL LANCETS	T1	
ADVOCATE LANCETS	T1	
ALTERNATE SITE LANCETS	T1	
ASSURE HAEMOLANCE PLUS	T1	
ASSURE LANCE	T1	
ASSURE LANCE PLUS	T1	
BD MICROTAINER LANCETS	T1	
BD ULTRA-FINE	T1	
BD ULTRA-FINE II	T1	
BLOOD LANCETS	T1	
BULLSEYE MINI SAFETY LANCETS	T1	
BUTTERFLY TOUCH LANCET	T1	
CAREONE	T1	
CARETOUCH TWIST LANCET	T1	
CLEVER CHEK LANCETS	T1	
COAGUCHEK	T1	
COLOR LANCETS	T1	
COMFORT EZ	T1	
COMFORT LANCETS	T1	
COMFORT TOUCH PLUS SAFETY LANC / ULT THIN LANCET	T1	
DROPLET LANCETS	T1	
EASY COMFORT LANCETS	T1	
EASY TOUCH	T1	
EASY TWIST & CAP LANCETS	T1	
EMBRACE 30G LANCETS / SAFETY LANCET	T1	
EZ SMART LANCETS	T1	
EZ-LETS	T1	

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

T4 – Specialty Medications  
 PA – Prior Authorization  
 QL – Quantity Limit

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

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



## List of Prescription Medications

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

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>DURABLE MEDICAL EQUIPMENT, MISC (GROUP I) (cont.)</b>		
FIFTY50 SAFETY SEAL LANCETS	T1	
FINE 30 UNIVERSAL LANCETS	T1	
FINGERSTIX	T1	
FORA LANCETS	T1	
FORACARE LANCETS	T1	
FREESTYLE LANCETS / UNISTIK 2	T1	
GLUCOCOM	T1	
GOJJI LANCETS	T1	
HEALTHY ACCENTS UNILET LANCET	T1	
INCONTROL SUPER THIN LANCETS / ULTRA THIN LANCETS	T1	
INJECT EASE LANCETS	T1	
INVACARE LANCETS	T1	
<i>lancets</i>	T1	
LANCETS	T1	
LITE TOUCH	T1	
MEDISENSE THIN LANCETS	T1	
MEDLANCE PLUS	T1	
MICRO THIN LANCETS	T1	
MICROLET	T1	
MICROTAINER LANCETS	T1	
MOBILE LANCETS	T1	
MONOLET LANCETS / THIN LANCETS	T1	
MYGLUCOHEALTH LANCETS	T1	
NOVA SAFETY LANCETS	T1	
NOVA SUREFLEX	T1	
ON CALL LANCET / PLUS LANCET	T1	
ONETOUCH	T1	
ON-THE-GO	T1	
PIP LANCET	T1	
PRESSURE ACTIVATED LANCETS	T1	
PRO COMFORT LANCETS / SAFETY LANCET	T1	
PRODIGY LANCETS / TWIST TOP LANCET	T1	
PURE COMFORT LANCETS / SAFETY LANCETS	T1	
PUSH BUTTON SAFETY LANCETS	T1	
READYLANCER SAFETY LANCETS	T1	

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

T4 – Specialty Medications

PA – Prior Authorization

QL – Quantity Limit

ST – Step Therapy

AGE – Age Requirement

SP – Specialty Medication

HD – May require home delivery pharmacy

PPACA – No Cost-Share Preventive Medication

CSL – Oral cancer medication subject to cost-share limits

## List of Prescription Medications

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

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>DURABLE MEDICAL EQUIPMENT,MISC(GROUP I) (cont.)</b>		
RELIAMED	T1	
RELIAMED SAFETY SEAL LANCETS	T1	
RELION THIN	T1	
RIGHTEST GL300 LANCETS	T1	
SAFETY LANCETS / SEAL LANCETS	T1	
SAFETY-LET	T1	
SINGLE-LET	T1	
SMART SENSE/ SENSE LANCETS	T1	
SMARTEST LANCET	T1	
SOFT TOUCH	T1	
SOLUS V2 LANCETS / 28G LANCETS	T1	
STERILANCE TL	T1	
STERILE LANCETS	T1	
SUPER THIN LANCETS	T1	
SURE COMFORT LANCETS	T1	
SURE-LANCE	T1	
SURE-TOUCH	T1	
TECHLITE LANCETS	T1	
TELCARE ULTRA THIN 30G LANCETS	T1	
THIN LANCETS	T1	
TOPCARE UNIVERSAL1 THIN LANCET / UNIVERSAL1 LANCET	T1	
TRUE COMFORT LANCET / SAFETY LANCET	T1	
TRUEPLUS LANCETS	T1	
TWIST LANCETS / TOP LANCET	T1	
ULTILET	T1	
ULTRA THIN	T1	
ULTRA-CARE LANCETS	T1	
ULTRALANCE	T1	
ULTRA-THIN II	T1	
ULTRATLC LANCETS	T1	
UNILET	T1	
UNISTIK	T1	
UNIVERSAL 1	T1	
VERIFINE SAFETY LANCET MINI / UNIVERSAL LANCET	T1	
VIVAGUARD LANCET	T1	

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

T4 – Specialty Medications

PA – Prior Authorization

QL – Quantity Limit

ST – Step Therapy

AGE – Age Requirement

SP – Specialty Medication

HD – May require home delivery pharmacy

PPACA – No Cost-Share Preventive Medication

CSL – Oral cancer medication subject to cost-share limits

## List of Prescription Medications

### MISCELLANEOUS MEDICAL SUPPLIES, DEVICES, NON-DRUG (Diagnostic Test Devices, Supplies, And Services Miscellaneous)

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

#### TISSUE BULKING IMPLANTS

BARRIGEL (hyaluronate sodium, stabilized)	T4	PA SP HD
---	----	----------

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

#### SKELETAL MUSCLE RELAXANTS

<i>baclofen 5 mg tablet</i>	T1	HD
<i>carisoprodol/aspirin</i>	T1	
<i>chlorzoxazone</i>	T1	
<i>cyclobenzaprine hcl</i>	T1	
<i>cyclobenzaprine hcl (Fexmid)</i>	T1	
DANTRIUM	T3	
DANTRIUM ( <i>dantrolene sodium</i> )	T3	
<i>dantrolene sodium</i>	T1	
<i>dantrolene sodium (Dantrium)</i>	T1	
FEXMID ( <i>cyclobenzaprine hcl</i> )	T3	
FLEQSUVY ( <i>baclofen</i> )	T3	HD
GABLOFEN	T3	
GABLOFEN ( <i>baclofen</i> )	T3	
LIORESAL INTRATHECAL	T3	
<i>metaxalone</i>	T1	
<i>metaxalone (Skelaxin)</i>	T1	
<i>methocarbamol (Robaxin)</i>	T1	
<i>methocarbamol (Robaxin-750)</i>	T1	
<i>orphenadrine citrate</i>	T1	
OZOBAX DS	T3	
ROBAXIN	T3	
ROBAXIN-750 ( <i>methocarbamol</i> )	T3	
RYANODEX	T3	
SKELAXIN ( <i>metaxalone</i> )	T3	
SOMA ( <i>carisoprodol</i> )	T3	
SOMA ( <i>vanadom</i> )	T3	
<i>tizanidine hcl (Zanaflex)</i>	T1	
ZANAFLEX ( <i>tizanidine hcl</i> )	T3	

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

#### PRENATAL VITAMIN PREPARATIONS

ATABEX EC	T3	
-----------	----	--

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

T4 – Specialty Medications

PA – Prior Authorization

QL – Quantity Limit

ST – Step Therapy

AGE – Age Requirement

SP – Specialty Medication

HD – May require home delivery pharmacy

PPACA – No Cost-Share Preventive Medication

CSL – Oral cancer medication subject to cost-share limits

## List of Prescription Medications

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

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>PRENATAL VITAMIN PREPARATIONS (cont.)</b>		
CITRANATAL 90 DHA	T3	
CITRANATAL ASSURE	T3	
CITRANATAL DHA	T3	
CITRANATAL HARMONY	T3	
CITRANATAL RX	T3	
OBSTETRIX EC	T3	
OBTREX DHA	T3	
<i>pnv 22/iron, gluc/folic/dss/dha</i>	T1	
<i>pnv 66/iron/folic/docusate/dha</i>	T1	
<i>pnv 69/iron/folic/docusate/dha</i>	T1	
<i>pnv 80/iron fum/folic/dss/dha</i>	T1	
<i>pnv/ferrous fum/docusate/folic</i>	T1	
<i>pnv/iron, carb/docusat/folic ac</i>	T1	
<i>prenatal 12/iron/folic/dss/om3 (Obtrex Dha)</i>	T1	
PRENATAL 19	T1	
<i>prenatal 34/iron/folic/dss/dha</i>	T1	
<i>prenatal vits15/iron/folic/dss</i>	T1	
VITAFOL FE+	T3	

### PSYCHOTHERAPEUTIC DRUGS (Anxiety/Depression/Bipolar Disorder)<sup>11</sup>

#### ALPHA-2 RECEPTOR ANTAGONIST ANTIDEPRESSANTS

<i>mirtazapine</i>	T1	HD
<i>mirtazapine (Remeron)</i>	T1	HD

#### ANTI-ANXIETY - BENZODIAZEPINES

<i>alprazolam</i>	T1	
<i>alprazolam (Xanax Xr)</i>	T1	
<i>alprazolam (Xanax)</i>	T1	
<i>chlordiazepoxide hcl</i>	T1	
<i>clorazepate dipotassium</i>	T1	
<i>clorazepate dipotassium (Tranxene T-tab)</i>	T1	
<i>diazepam 10 mg tablet (Valium)</i>	T1	
<i>diazepam 10 mg/2 ml carpject</i>	T1	
<i>diazepam 10 mg/2 ml syringe</i>	T1	
<i>diazepam 2 mg tablet (Valium)</i>	T1	
<i>diazepam 5 mg tablet (Valium)</i>	T1	

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

T4 – Specialty Medications  
 PA – Prior Authorization  
 QL – Quantity Limit

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

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

## List of Prescription Medications

### PSYCHOTHERAPEUTIC DRUGS (Anxiety/Depression/Bipolar Disorder)<sup>1</sup> (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>ANTI-ANXIETY - BENZODIAZEPINES (cont.)</b>		
<i>diazepam 5 mg/5 ml solution</i>	T1	
<i>diazepam 5 mg/ml oral conc</i>	T1	
<i>diazepam 50 mg/10 ml vial</i>	T1	
<i>lorazepam</i>	T1	
<i>oxazepam</i>	T1	
TRANXENET-TAB ( <i>clorazepate dipotassium</i> )	T3	
VALIUM ( <i>diazepam</i> )	T3	
XANAX ( <i>alprazolam</i> )	T3	
XANAX XR ( <i>alprazolam xr</i> )	T3	
<b>ANTI-ANXIETY DRUGS</b>		
<i>buspirone hcl</i>	T1	HD
<i>meprobamate</i>	T1	
<b>ANTIDEPRESSANT - NMDA RECEPTOR ANTAGONIST</b>		
SPRAVATO	T4	PA SP
<b>ANTIDEPRESSANT - POSTPARTUM DEPRESSION (PPD)</b>		
ZURZUVAE 20 MG CAPSULE	T4	PA QL(28 caps/270 days) SP HD
ZURZUVAE 25 MG CAPSULE	T4	PA QL(28 caps/270 day) SP HD
ZURZUVAE 30 MG CAPSULE	T4	PA QL(14 caps/270 day) SP HD
<b>BIPOLAR DISORDER DRUGS</b>		
EQUETRO	T3	HD
<i>lithium carbonate</i>	T1	HD
<i>lithium carbonate (Lithobid)</i>	T1	HD
<i>lithium citrate</i>	T1	HD
<b>MAOIS -NON-SELECTIVE, IRREVERSIBLE ANTIDEPRESSANTS</b>		
MARPLAN	T3	QL (12 tabs/day)
<i>phenelzine sulfate (Nardil)</i>	T1	
<i>tranylcypromine sulfate</i>	T1	
<b>MONOAMINE OXIDASE (MAO) INHIBITOR ANTIDEPRESSANTS</b>		
EMSAM 12 MG/24 HOURS PATCH	T3	QL (1 patch/day)
EMSAM 6 MG/24 HOURS PATCH	T3	QL (2 patches/day)
EMSAM 9 MG/24 HOURS PATCH	T3	QL (1 patch/day)
<b>NOREPINEPHRINE AND DOPAMINE REUPTAKE INHIB (NDRIS)</b>		
<i>bupropion hcl 100 mg tablet</i>	T1	QL (4 tabs/day) HD
<i>bupropion hcl 75 mg tablet</i>	T1	QL (6 tabs/day) HD
<i>bupropion hcl sr 100 mg tablet (Wellbutrin Sr)</i>	T1	QL (4 tabs/day) HD

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

T4 – Specialty Medications

PA – Prior Authorization

QL – Quantity Limit

ST – Step Therapy

AGE – Age Requirement

SP – Specialty Medication

HD – May require home delivery pharmacy

PPACA – No Cost-Share Preventive Medication

CSL – Oral cancer medication subject to cost-share limits

## List of Prescription Medications

### PSYCHOTHERAPEUTIC DRUGS (Anxiety/Depression/Bipolar Disorder)<sup>1</sup> (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>NOREPINEPHRINE AND DOPAMINE REUPTAKE INHIB (NDRIS) (con't.)</b>		
<i>bupropion hcl sr 150 mg tablet</i> (Wellbutrin Sr)	T1	QL (2 tabs/day) HD
<i>bupropion hcl sr 200 mg tablet</i> (Wellbutrin Sr)	T1	QL (2 tabs/day) HD
<i>bupropion hcl xl 150 mg tablet</i>	T1	QL (3 tabs/day) HD
<i>bupropion hcl xl 300 mg tablet</i>	T1	QL (1 tab/day) HD
<b>SELECTIVE SEROTONIN 5-HT<sub>2A</sub> INVERSE AGONISTS (SSIA)</b>		
NUPLAZID	T4	PA SP HD
<b>SELECTIVE SEROTONIN REUPTAKE INHIBITOR (SSRIS)</b>		
<i>citalopram hbr 10 mg tablet</i> (Celexa)	T1	QL (6 tabs/day) HD
<i>citalopram hbr 10 mg/5 ml soln</i>	T1	QL (30ml/day) HD
<i>citalopram hbr 20 mg tablet</i> (Celexa)	T1	QL (3 tabs/day) HD
<i>citalopram hbr 20 mg/10 ml sol</i>	T1	QL (30ml/day) HD
<i>citalopram hbr 40 mg tablet</i> (Celexa)	T1	QL (1 tab/day) HD
<i>escitalopram 10 mg tablet</i>	T1	QL (2 tabs/day) HD
<i>escitalopram 5 mg tablet</i>	T1	QL (4 tabs/day) HD
<i>escitalopram oxalate 5 mg/5 ml</i>	T1	QL (20ml/day) HD
<i>fluoxetine 20 mg/5 ml solution</i>	T1	QL (20ml/day) HD
<i>fluoxetine hcl</i>	T1	QL (4 caps/28 days) HD
<i>fluoxetine hcl 10 mg capsule</i> (Prozac)	T1	QL (8 caps/day) HD
<i>fluoxetine hcl 10 mg tablet</i> (Sarafem)	T1	HD
<i>fluoxetine hcl 20 mg capsule</i> (Prozac)	T1	QL (4 caps/day) HD
<i>fluoxetine hcl 20 mg tablet</i>	T1	HD
<i>fluoxetine hcl 40 mg capsule</i> (Prozac)	T1	QL (2 caps/day) HD
<i>fluoxetine hcl 60 mg tablet</i>	T1	QL (1 tab/day) HD
<i>fluvoxamine er 100 mg capsule</i>	T1	QL (3 caps/day) HD
<i>fluvoxamine er 150 mg capsule</i>	T1	QL (2 caps/day) HD
<i>fluvoxamine maleate 100 mg tab</i>	T1	QL (3 tabs/day) HD
<i>fluvoxamine maleate 25 mg tab</i>	T1	QL (12 tabs/day) HD
<i>fluvoxamine maleate 50 mg tab</i>	T1	QL (6 tabs/day) HD
<i>paroxetine cr 12.5 mg tablet</i> (Paxil Cr)	T1	QL (1 tab/day) HD
<i>paroxetine cr 25 mg tablet</i> (Paxil Cr)	T1	QL (3 tabs/day) HD
<i>paroxetine cr 37.5 mg tablet</i> (Paxil Cr)	T1	QL (2 tabs/day) HD
<i>paroxetine er 12.5 mg tablet</i> (Paxil Cr)	T1	QL (1 tab/day) HD
<i>paroxetine er 25 mg tablet</i> (Paxil Cr)	T1	QL (3 tabs/day) HD
<i>paroxetine er 37.5 mg tablet</i> (Paxil Cr)	T1	QL (2 tabs/day) HD

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

T4 – Specialty Medications

PA – Prior Authorization

QL – Quantity Limit

ST – Step Therapy

AGE – Age Requirement

SP – Specialty Medication

HD – May require home delivery pharmacy

PPACA – No Cost-Share Preventive Medication

CSL – Oral cancer medication subject to cost-share limits

# List of Prescription Medications

## PSYCHOTHERAPEUTIC DRUGS (Anxiety/Depression/Bipolar Disorder)<sup>1</sup> (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>SELECTIVE SEROTONIN REUPTAKE INHIBITOR (SSRIS) (cont.)</b>		
<i>paroxetine hcl 10 mg tablet (Paxil)</i>	T1	QL (6 tabs/day) HD
<i>paroxetine hcl 20 mg tablet (Paxil)</i>	T1	QL (3 tabs/day) HD
<i>paroxetine hcl 30 mg tablet (Paxil)</i>	T1	QL (2 tabs/day) HD
<i>paroxetine hcl 40 mg tablet (Paxil)</i>	T1	QL (1 tab/day) HD
PAXIL CR 12.5 MG TABLET ( <i>paroxetine er</i> )	T3	QL (1 tab/day) ST HD
PAXIL CR 25 MG TABLET ( <i>paroxetine er</i> )	T3	QL (3 tabs/day) ST HD
SARAFEM ( <i>fluoxetine hcl</i> )	T3	ST HD
<i>sertraline 20 mg/ml oral conc (Zoloft)</i>	T1	QL (10ml/day) HD
<i>sertraline hcl 100 mg tablet (Zoloft)</i>	T1	QL (2 tabs/day) HD
<i>sertraline hcl 25 mg tablet (Zoloft)</i>	T1	QL (8 tabs/day) HD
<i>sertraline hcl 50 mg tablet (Zoloft)</i>	T1	QL (4 tabs/day) HD
<b>SEROTONIN-2 ANTAGONIST/REUPTAKE INHIBITORS (SARIS)</b>		
<i>nefazodone hcl</i>	T1	HD
<i>trazodone hcl</i>	T1	HD
<b>SEROTONIN-NOREPINEPHRINE REUPTAKE-INHIB (SNRIS)</b>		
<i>desvenlafaxine succnt er 100mg</i>	T1	QL (4 tabs/day) HD
<i>desvenlafaxine succnt er 25 mg</i>	T1	QL (16 tabs/day) HD
<i>desvenlafaxine succnt er 50 mg</i>	T1	QL (1 tab/day) HD
<i>duloxetine hcl dr 20 mg cap</i>	T1	QL (6 caps/day) HD
<i>duloxetine hcl dr 30 mg cap</i>	T1	QL (4 caps/day) HD
<i>duloxetine hcl dr 40 mg cap</i>	T1	QL (3 caps/day) HD
<i>duloxetine hcl dr 60 mg cap</i>	T1	QL (2 caps/day) HD
FETZIMA 20-40 MG TITRATION PAK	T3	QL (28 caps/180 days) ST HD
FETZIMA ER 120 MG CAPSULE	T3	QL (1 cap/day) ST HD
FETZIMA ER 20 MG CAPSULE	T3	QL (6 caps/day) ST HD
FETZIMA ER 40 MG CAPSULE	T3	QL (3 caps/day) ST HD
FETZIMA ER 80 MG CAPSULE	T3	QL (1 cap/day) ST HD
<i>venlafaxine hcl 100 mg tablet</i>	T1	QL (3 tabs/day) HD
<i>venlafaxine hcl 25 mg tablet</i>	T1	QL (15 tabs/day) HD
<i>venlafaxine hcl 37.5 mg tablet</i>	T1	QL (10 tabs/day) HD
<i>venlafaxine hcl 50 mg tablet</i>	T1	QL (7 tabs/day) HD
<i>venlafaxine hcl 75 mg tablet</i>	T1	QL (5 tabs/day) HD
<i>venlafaxine hcl er 150 mg cap (Effexor Xr)</i>	T1	QL (2 caps/day) HD
<i>venlafaxine hcl er 150 mg tab</i>	T1	QL (2 tabs/day) HD
<i>venlafaxine hcl er 225 mg tab</i>	T1	QL (1 tab/day) HD

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

T4 – Specialty Medications

PA – Prior Authorization

QL – Quantity Limit

ST – Step Therapy

AGE – Age Requirement

SP – Specialty Medication

HD – May require home delivery pharmacy

PPACA – No Cost-Share Preventive Medication

CSL – Oral cancer medication subject to cost-share limits

## List of Prescription Medications

### PSYCHOTHERAPEUTIC DRUGS (Anxiety/Depression/Bipolar Disorder)<sup>11</sup> (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>SEROTONIN-NOREPINEPHRINE REUPTAKE-INHIB (SNRIS)</b>		
<i>venlafaxine hcl er 37.5 mg cap</i> (Effexor Xr)	T1	QL (8 caps/day) HD
<i>venlafaxine hcl er 37.5 mg tab</i>	T1	QL (8 tabs/day) HD
<i>venlafaxine hcl er 75 mg cap</i> (Effexor Xr)	T1	QL (4 caps/day) HD
<i>venlafaxine hcl er 75 mg tab</i>	T1	QL (4 tabs/day) HD
<b>SSRI AND 5HT1A PARTIAL AGONIST ANTIDEPRESSANTS</b>		
VIIIBRYD 10–20 MG STARTER PACK	T3	ST HD
<i>vilazodone hcl 10 mg tablet</i> (Viibryd)	T1	QL (1 tab/day) ST HD
<i>vilazodone hcl 20 mg tablet</i> (Viibryd)	T1	QL (1 tab/day) ST HD
<i>vilazodone hcl 40 mg tablet</i> (Viibryd)	T1	HD
<b>SSRI, SEROTONIN RECEPTOR MODULATOR ANTIDEPRESSANTS</b>		
TRINTELLIX 10 MG TABLET	T2	QL (1 tab/day) ST HD
TRINTELLIX 20 MG TABLET	T2	ST HD
TRINTELLIX 5 MG TABLET	T2	QL (1 tab/day) ST HD
<b>TRICYCLIC ANTIDEPRESSANT-BENZODIAZEPINE COMBINATNS</b>		
<i>amitriptyline/chlordiazepoxide</i>	T1	HD
<b>TRICYCLIC ANTIDEPRESSANT-PHENOTHIAZINE COMBINATNS</b>		
<i>perphenazine/amitriptyline hcl</i>	T1	HD
<b>TRICYCLIC ANTIDEPRESSANTS, REL.NON-SEL.REUPT-INHIB</b>		
<i>amitriptyline hcl</i>	T1	HD
<i>amoxapine</i>	T1	HD
<i>clomipramine hcl</i>	T1	HD
<i>desipramine hcl</i>	T1	HD
<i>desipramine hcl</i> (Norpramin)	T1	HD
<i>doxepin 10 mg capsule</i>	T1	HD
<i>doxepin 10 mg/ml oral conc</i>	T1	HD
<i>doxepin capsule</i>	T1	HD
<i>imipramine hcl</i>	T1	HD
<i>imipramine pamoate</i>	T1	HD
<i>maprotiline hcl</i>	T1	HD
<i>nortriptyline hcl</i>	T1	HD
<i>protriptyline hcl</i>	T1	HD
<i>trimipramine maleate</i>	T1	HD

### PSYCHOTHERAPEUTIC DRUGS (Attention Deficit Hyperactivity Disorder)<sup>11</sup>

#### ADRENERGICS, AROMATIC, NON-CATECHOLAMINE

<i>lisdexamfetamine</i> (Vyvanse)	T1	PA QL (1 cap/day)
-----------------------------------	----	-------------------

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

T4 – Specialty Medications

PA – Prior Authorization

QL – Quantity Limit

ST – Step Therapy

AGE – Age Requirement

SP – Specialty Medication

HD – May require home delivery pharmacy

PPACA – No Cost-Share Preventive Medication

CSL – Oral cancer medication subject to cost-share limits



# List of Prescription Medications

## PSYCHOTHERAPEUTIC DRUGS (Attention Deficit Hyperactivity Disorder)<sup>1</sup>

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>TX FOR ADHD - SELECTIVE ALPHA-2 RECEPTOR AGONIST</b>		
<i>clonidine hcl</i> (Kapvay)	T1	
<i>guanfacine hcl</i> (Intuniv)	T1	HD
INTUNIV ( <i>guanfacine hcl er</i> )	T3	
<b>TX FOR ATTENTION DEFICIT-HYPERACT (ADHD) /NARCOLEPSY</b>		
DAYTRANA 10 MG/9 HR PATCH	T3	PA QL (1 patch/day)
DAYTRANA 15 MG/9 HR PATCH	T3	PA QL (1 per day)
DAYTRANA 20 MG/9 HOUR PATCH	T3	PA QL (1 patch/day)
DAYTRANA 30 MG/9 HOUR PATCH	T3	PA QL (1 patch/day)
<i>dexmethylphenidate er 10 mg cp</i>	T1	PA QL (1 cap/day)
<i>dexmethylphenidate er 15 mg cp</i>	T1	PA QL (1 per day)
<i>dexmethylphenidate er 20 mg cp</i>	T1	PA QL (1 cap/day)
<i>dexmethylphenidate er 25 mg cp</i>	T1	PA QL (1 cap/day)
<i>dexmethylphenidate er 30 mg cp</i>	T1	PA QL (1 cap/day)
<i>dexmethylphenidate er 35 mg cp</i>	T1	PA QL (1 cap/day)
<i>dexmethylphenidate er 40 mg cp</i>	T1	PA QL (1 cap/day)
<i>dexmethylphenidate er 5 mg cap</i>	T1	PA QL (1 cap/day)
<i>dexmethylphenidate hcl</i> (Focalin)	T1	PA
FOCALIN ( <i>dexmethylphenidate hcl</i> )	T3	PA ST
METADATE CD ( <i>methylphenidate hcl</i> )	T3	PA QL
METHYLIN ( <i>methylphenidate hcl</i> )	T3	PA
<i>methylphenidate</i> (Daytrana)	T1	PA QL (1 patch/day)
<i>methylphenidate er 18, 27, 54mg cap</i>	T1	PA QL (1 tab/day)
<i>methylphenidate er 36mg cap</i>	T1	PA QL (2 tab/day)
<i>methylphenidate er 10 mg cap</i>	T1	QL (1 per day)
<i>methylphenidate er 10 mg tab</i>	T1	PA QL (2/day)
<i>methylphenidate 10 mg/9hr ptch</i> (Daytrana)	T1	PA QL (1 patch/day)
<i>methylphenidate er 15 mg cap</i>	T1	QL (1 per day)
<i>methylphenidate 15 mg/9hr ptch</i> (Daytrana)	T1	PA QL (1 patch/day)
<i>methylphenidate er 18 mg tab</i>	T1	PA QL (1 per day)
<i>methylphenidate er 20 mg cap</i>	T1	QL (1 per day)
<i>methylphenidate er 20 mg tab</i>	T1	PA QL (3/day)
<i>methylphenidate 20 mg/9hr ptch</i> (Daytrana)	T1	PA QL (1 patch/day)
<i>methylphenidate er 27 mg tab</i>	T1	PA QL (1 tab/day)
<i>methylphenidate er 30 mg cap</i>	T1	QL (1 per day)
<i>methylphenidate 30 mg/9hr ptch</i> (Daytrana)	T1	PA QL (1 patch/day)

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

T4 – Specialty Medications

PA – Prior Authorization

QL – Quantity Limit

ST – Step Therapy

AGE – Age Requirement

SP – Specialty Medication

HD – May require home delivery pharmacy

PPACA – No Cost-Share Preventive Medication

CSL – Oral cancer medication subject to cost-share limits

## List of Prescription Medications

### PSYCHOTHERAPEUTIC DRUGS (Attention Deficit Hyperactivity Disorder)<sup>1)</sup> (cont.)

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

#### TX FOR ATTENTION DEFICIT-HYPERACT (ADHD) /NARCOLEPSY (cont.)

<i>methylphenidate er 36 mg tab</i>	T1	PA QL (1 per day)
<i>methylphenidate er 40 mg cap</i>	T1	QL (1 per day)
<i>methylphenidate er 50 mg cap</i>	T1	QL (1 per day)
<i>methylphenidate er 54 mg tab</i>	T1	PA QL (1 tab/day)
<i>methylphenidate er 60 mg cap</i>	T1	QL (1 per day)
<i>methylphenidate hcl</i>	T1	PA
<i>methylphenidate hcl (Metadate CD)</i>	T1	PA QL (1 cap/day)
<i>methylphenidate hcl (Methylin)</i>	T1	PA
<i>methylphenidate hcl (Ritalin)</i>	T1	PA
<i>methylphenidate la 10 mg cap</i>	T1	PA QL (1 cap/day)
<i>methylphenidate la 20 mg cap</i>	T1	PA QL (1 cap/day)
<i>methylphenidate la 30 mg cap</i>	T1	PA QL (1 per day)
<i>methylphenidate la 40 mg cap</i>	T1	PA QL (1 cap/day)
<i>methylphenidate la 60 mg cap</i>	T1	PA QL (1 cap/day)
QUILLIVANT XR	T3	PA QL (12ml/day)
RITALIN ( <i>methylphenidate hcl</i> )	T3	PA ST

#### TX FOR ATTENTION DEFICIT-HYPERACT. (ADHD) , NRI-TYPE

<i>atomoxetine hcl 10 mg capsule (Strattera)</i>	T1	HD
<i>atomoxetine hcl 100 mg capsule (Strattera)</i>	T1	HD
<i>atomoxetine hcl 18 mg capsule (Strattera)</i>	T1	HD
<i>atomoxetine hcl 25 mg capsule (Strattera)</i>	T1	HD
<i>atomoxetine hcl 40 mg capsule (Strattera)</i>	T1	QL (1 cap/day) HD
<i>atomoxetine hcl 60 mg capsule (Strattera)</i>	T1	HD
<i>atomoxetine hcl 80 mg capsule (Strattera)</i>	T1	HD
STRATTERA 10 MG CAPSULE ( <i>atomoxetine hcl</i> )	T3	HD
STRATTERA 100 MG CAPSULE ( <i>atomoxetine hcl</i> )	T3	HD
STRATTERA 18 MG CAPSULE ( <i>atomoxetine hcl</i> )	T3	HD
STRATTERA 25 MG CAPSULE ( <i>atomoxetine hcl</i> )	T3	HD
STRATTERA 40 MG CAPSULE ( <i>atomoxetine hcl</i> )	T3	QL (1 cap/day) HD
STRATTERA 60 MG CAPSULE ( <i>atomoxetine hcl</i> )	T3	HD
STRATTERA 80 MG CAPSULE ( <i>atomoxetine hcl</i> )	T3	HD

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

T4 – Specialty Medications  
 PA – Prior Authorization  
 QL – Quantity Limit

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

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

# List of Prescription Medications

PSYCHOTHERAPEUTIC DRUGS (Schizophrenia/Anti-Psychotics) <sup>11</sup> (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>ANTIPSYCH, DOPAMINE ANTAG., DIPHENYLBUTYLPIPERIDINES</b>		
<i>pimozide</i>	T1	
<b>ANTIPSYCHOTIC, ATYPICAL, DOPAMINE, SEROTONIN ANTAGNST</b>		
<i>asenapine maleate</i> (Saphris)	T1	
CAPLYTA	T3	ST QL(1 tabs/caps/day)
<i>clozapine</i>	T1	
<i>clozapine</i> (Clozapine Odt)	T1	
<i>clozapine</i> (Clozaril)	T1	
CLOZAPINE ODT	T1	
CLOZARIL ( <i>clozapine</i> )	T3	ST
FANAPT 1 MG TABLET	T3	QL (4 tabs/day) ST
FANAPT 10 MG TABLET	T3	QL (4 tabs/day) ST
FANAPT 12 MG TABLET	T3	ST
FANAPT 2 MG TABLET	T3	QL (4 tabs/day) ST
FANAPT 4 MG TABLET	T3	QL (4 tabs/day) ST
FANAPT 6 MG TABLET	T3	QL (4 tabs/day) ST
FANAPT 8 MG TABLET	T3	QL (4 tabs/day) ST
FANAPT TITRATION PACK	T3	QL (4 packs/year) ST
GEODON	T3	
INVEGA ER 1.5 MG TABLET ( <i>paliperidone er</i> )	T3	ST
INVEGA ER 3 MG TABLET ( <i>paliperidone er</i> )	T3	QL (1 tab/day) ST
INVEGA ER 6 MG TABLET ( <i>paliperidone er</i> )	T3	ST
INVEGA ER 9 MG TABLET ( <i>paliperidone er</i> )	T3	ST
INVEGA SUSTENNA 117 MG/0.75 ML	T3	QL (2 syring/28 days)
INVEGA SUSTENNA 156 MG/ML SYRG	T3	QL (1 syringe/28 days)
INVEGA SUSTENNA 234 MG/1.5 ML	T3	QL (1 syringe/28 days)
INVEGA SUSTENNA 39 MG/0.25 ML	T3	QL (2 syring/28 days)
INVEGA SUSTENNA 78 MG/0.5 ML	T3	QL (2 syring/28 days)
INVEGA TRINZA	T3	QL (2 injectors/90 days)
<i>lurasidone hcl 120 mg tablet</i> (Latuda)	T1	
<i>lurasidone hcl 20 mg tablet</i> (Latuda)	T1	
<i>lurasidone hcl 40 mg tablet</i> (Latuda)	T1	QL(1 tab/day)
<i>lurasidone hcl 60 mg tablet</i> (Latuda)	T1	QL(1 tab/day)
<i>lurasidone hcl 80 mg tablet</i> (Latuda)	T1	

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

T4 – Specialty Medications  
 PA – Prior Authorization  
 QL – Quantity Limit

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

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

# List of Prescription Medications

PSYCHOTHERAPEUTIC DRUGS (Schizophrenia/Anti-Psychotics) <sup>II</sup> (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>ANTIPSYCHOTIC, ATYPICAL, DOPAMINE, SEROTONIN ANTAGNIST (cont.)</b>		
<i>olanzapine</i>	T1	
<i>olanzapine (Zyprexa)</i>	T1	
<i>paliperidone er 1.5 mg tablet (Invega)</i>	T1	
<i>paliperidone er 3 mg tablet (Invega)</i>	T1	QL (1 tab/day)
<i>paliperidone er 9 mg tablet (Invega)</i>	T1	
PERSERIS	T3	QL (1 kit/28 days)
<i>quetiapine fumarate (Seroquel Xr)</i>	T1	
<i>quetiapine fumarate 400 mg tab (Seroquel)</i>	T1	
<i>risperidone</i>	T1	QL
<i>risperidone (Risperdal)</i>	T1	
SAPHRIS ( <i>asenapine maleate</i> )	T3	ST
SECUADO	T3	ST
SEROQUEL ( <i>quetiapine fumarate</i> )	T3	ST
SEROQUEL XR ( <i>quetiapine fumarate er</i> )	T3	ST
<i>ziprasidone hcl</i>	T1	
<i>ziprasidone mesylate (Geodon)</i>	T1	
ZYPREXA ( <i>olanzapine</i> )	T2	
ZYPREXA RELPREVV 210 MG VIAL	T3	QL (4 vials/28 days)
ZYPREXA RELPREVV 210 MG VL KIT	T3	QL (4 vials/28 days)
ZYPREXA RELPREVV 300 MG VIAL	T3	QL (4 vials/28 days)
ZYPREXA RELPREVV 300 MG VL KIT	T3	QL (4 vials/28 days)
ZYPREXA RELPREVV 405 MG VIAL	T3	QL (2 vials/28 days)
ZYPREXA RELPREVV 405 MG VL KIT	T3	QL (2 vials/28 days)
<b>ANTIPSYCHOTIC-ATYPICAL, D3/D2 PARTIAL AG-5HT MIXED</b>		
VRAYLAR 1.5 MG CAPSULE	T3	QL (1 cap/day) ST
VRAYLAR 1.5 MG-3 MG PACK	T3	ST
VRAYLAR 3 MG CAPSULE	T3	QL (1 cap/day) ST
VRAYLAR 4.5 MG CAPSULE	T3	ST
VRAYLAR 6 MG CAPSULE	T3	ST
<b>ANTIPSYCHOTICS, ATYP, D2 PARTIAL AGONIST/5HT MIXED</b>		
ABILIFY ASIMTUFII	T3	

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

T4 – Specialty Medications  
 PA – Prior Authorization  
 QL – Quantity Limit

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

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

# List of Prescription Medications

## PSYCHOTHERAPEUTIC DRUGS (Schizophrenia/Anti-Psychotics)<sup>II</sup> (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>ANTIPSYCHOTICS, ATYP, D2 PARTIAL AGONIST/5HT MIXED (cont.)</b>		
ABILIFY MAINTENA ER 300 MG SYR	T2	QL (2 injectors/30 days)
ABILIFY MAINTENA ER 300 MG VL	T2	QL (2 injectors/30 days)
ABILIFY MAINTENA ER 400 MG SYR	T2	QL (2 injectors/30 days)
ABILIFY MAINTENA ER 400 MG VL	T2	
<i>aripiprazole</i>	T1	
<i>aripiprazole 10 mg tablet</i>	T1	
<i>aripiprazole 15 mg tablet</i>	T1	
<i>aripiprazole 2 mg tablet</i>	T1	
<i>aripiprazole 20 mg tablet</i>	T1	
<i>aripiprazole 30 mg tablet</i>	T1	
<i>aripiprazole 5 mg tablet</i>	T1	QL (1 tab/day)
ARISTADA ER 1064 MG/3.9 ML SYR	T3	
ARISTADA ER 441 MG/1.6 ML SYRN	T3	QL (2 syring/30 days)
ARISTADA ER 662 MG/2.4 ML SYRN	T3	QL (2 syring/30 days)
ARISTADA ER 882 MG/3.2 ML SYRN	T3	QL (2 syring/30 days)
ARISTADA INITIO	T3	
REXULTI 0.25 MG TABLET	T3	QL (1 tab/day) ST
REXULTI 0.5 MG TABLET	T3	QL (1 tab/day) ST
REXULTI 1 MG TABLET	T3	QL (1 tab/day) ST
REXULTI 2 MG TABLET	T3	QL (1 tab/day) ST
REXULTI 3 MG TABLET	T3	ST
REXULTI 4 MG TABLET	T3	ST
<b>ANTIPSYCHOTICS, DOPAMINE AND SEROTONIN ANTAGONISTS</b>		
<i>loxapine succinate</i>	T1	
<b>ANTIPSYCHOTICS, DOPAMINE ANTAGONISTS, BUTYROPHENONES</b>		
<i>droperidol</i>	T1	
HALDOL ( <i>haloperidol lactate</i> )	T3	
HALDOL DECANOATE 100 ( <i>haloperidol decanoate 100</i> )	T3	
HALDOL DECANOATE 50 ( <i>haloperidol decanoate</i> )	T3	
<i>haloperidol</i>	T1	
<i>haloperidol decanoate</i>	T1	
<i>haloperidol decanoate (Haldol Decanoate 100)</i>	T1	

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

T4 – Specialty Medications  
 PA – Prior Authorization  
 QL – Quantity Limit

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

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

## List of Prescription Medications

PSYCHOTHERAPEUTIC DRUGS (Schizophrenia/Anti-Psychotics) <sup>1</sup> (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>ANTIPSYCHOTICS, DOPAMINE ANTAGONISTS, BUTYROPHENONES (cont.)</b>		
<i>haloperidol decanoate</i> (Haldol Decanoate 50)	T1	
<i>haloperidol lactate</i>	T1	
<i>haloperidol lactate</i> (Haldol)	T1	
<b>ANTIPSYCHOTICS, DOPAMINE ANTAGONIST, DIHYDROINDOLONES</b>		
<i>molindone hcl</i>	T1	
<b>ANTIPSYCHOTICS, PHENOTHIAZINES</b>		
<i>chlorpromazine hcl</i>	T1	
<i>fluphenazine decanoate</i>	T1	
<i>fluphenazine hcl</i>	T1	
<i>perphenazine</i>	T1	
<i>thioridazine hcl</i>	T1	
<i>trifluoperazine hcl</i>	T1	
<b>SSRI-ANTIPSYCH, ATYPICAL, DOPAMINE, SEROTONIN ANTAG</b>		
<i>olanzapine/fluoxetine hcl</i>	T1	
<i>olanzapine/fluoxetine hcl</i> (Symbyax)	T1	
PSYCHOTHERAPEUTIC DRUGS (Sleep Disorders/Sedatives)		
<b>NARCOLEPSY AND SLEEP DISORDER THERAPY AGENTS</b>		
<i>armodafinil</i>	T1	PA
<i>modafinil</i> (Provigil)	T1	PA
SUNOSI	T2	PA QL (1 tab/day)
SEDATIVE/HYPNOTICS (Sleep Disorders/Sedatives)		
<b>ANTI-NARCOLEPSY, ANTI-CATAPLEXY, SEDATIVE-TYPE AGENT</b>		
LUMRYZ	T4	PA QL (1 pack/day) SP HD
SODIUM OXYBATE	T4	PA QL(18 mls/day) SP HD
<b>BARBITURATES</b>		
AMYTAL SODIUM	T3	
NEMBUTAL SODIUM ( <i>pentobarbital sodium</i> )	T3	PA
<i>pentobarbital sodium</i> (Nembutal Sodium)	T1	PA
<i>phenobarbital</i>	T1	
<i>phenobarbital sodium</i>	T1	
<i>secobarbital sodium</i>	T3	PA

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

T4 – Specialty Medications  
PA – Prior Authorization  
QL – Quantity Limit

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

HD – 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
<b>SEDATIVE-HYPNOTICS, NON-BARBITURATE (cont.)</b>		
HETLIOZ	T4	PA SP HD
HETLIOZ LQ	T4	PA SP HD
<i>ramelteon</i> (Rozerem)	T1	QL (1 tab/day)
<i>tasimelteon</i>	T4	PA SP
<b>SEDATIVE-HYPNOTICS - BENZODIAZEPINES</b>		
DORAL	T3	
<i>estazolam</i>	T1	
<i>flurazepam hcl</i>	T1	
HALCION ( <i>triazolam</i> )	T3	
<i>lorazepam</i>	T1	
LORAZEPAM-0.9% NACL	T1	
LORAZEPAM-D5W	T1	
QUAZEPAM	T1	
<i>quazepam</i> (Quazepam)	T1	
<i>temazepam</i>	T1	
<i>triazolam</i>	T1	
<i>triazolam</i> (Halcion)	T1	
<b>SEDATIVE-HYPNOTICS, NON-BARBITURATE</b>		
DAYVIGO	T2	QL (1 tab/day) ST
DEXMEDETOMIDINE HCL	T1	
<i>dexmedetomidine hcl</i> (Precedex)	T1	
<i>dexmedetomidine in 0.9 % nacl</i>	T1	
<i>doxepin hcl 3 mg tablet</i> (Silenor)	T1	QL (1 tab/day)
<i>doxepin hcl 6 mg tablet</i> (Silenor)	T1	
<i>eszopiclone</i> (Lunesta)	T1	
PRECEDEX	T3	
<i>zaleplon</i>	T1	
<i>zolpidem tartrate 10 mg tablet</i> (Ambien)	T1	
<i>zolpidem tartrate 5 mg tablet</i> (Ambien)	T1	
<i>zolpidem tart er 12.5 mg tab</i>	T1	
<i>zolpidem tart er 6.25 mg tab</i>	T1	QL (1 tab/day)
<i>zolpidem tartrate</i>	T1	

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

T4 – Specialty Medications  
PA – Prior Authorization  
QL – Quantity Limit

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

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

## List of Prescription Medications

SKIN PREPS (Miscellaneous)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>IRRIGANTS</b>		
<i>acetic acid</i>	T1	
<i>neomycin sulf/polymyxin b sulf</i>	T1	
PHYSIOLYTE	T3	
PHYSIOSOL	T3	
<i>ringer's solution</i>	T1	
<i>ringer's solution, lactated</i>	T1	
<i>sod, pot chlor/mag/sod, pot phos</i>	T3	
<i>sodium chloride irrig solution</i>	T1	
SORBITOL	T1	
SORBITOL-MANNITOL	T1	
<i>water for irrigation, sterile</i>	T1	
<b>OXIDIZING AGENTS</b>		
<i>hydrogen peroxide</i>	T1	
SKIN PREPS (Pain Relief And Inflammatory Disease)		
<b>ANTIPSORIATIC AGENTS, SYSTEMIC</b>		
<i>acitretin</i>	T1	
BIMZELX	T4	PA QL(10 mls/365 days) SP HD
BIMZELX AUTOINJECTOR	T4	PA QL(10 mls/365 days) SP HD
COSENTYX	T4	PA SP HD
ILLUMYA	T4	PA QL (1 syringe/84 days) SP HD
<i>methoxsalen (Oxsoralen-ultra)</i>	T1	
OXSORALEN-ULTRA ( <i>methoxsalen</i> )	T3	
SKYRIZI (2 SYRINGES) KIT	T4	PA QL (1 kit/84 days) SP HD
SILIQ	T4	PA QL (2 inj/15 days) SP HD
SOTYKTU	T4	PA QL (1 tab/day) SP HD
TALTZ AUTOINJECTOR	T4	PA QL (1 injector/28 days) SP HD
TALTZ AUTOINJECTOR (2 PACK)	T4	PA QL (1 injector/28 days) SP HD
TALTZ AUTOINJECTOR (3 PACK)	T4	PA QL (1 injector/28 days) SP HD
TALTZ SYRINGE	T4	PA QL (1 syringe/28 days) SP HD
TREMFYA 100 MG/ML INJECTOR	T4	PA QL (1 injector/56 days) SP HD
TREMFYA 100 MG/ML SYRINGE	T4	PA QL (1 syringe/56 days) SP HD
<b>TOPICAL ANTI-INFLAMMATORY, NSAIDS</b>		
DICLAREAL	T3	HD
<i>diclofenac sodium 1% gel</i>	T1	QL (1000gm/30 days) HD

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

T4 – Specialty Medications  
 PA – Prior Authorization  
 QL – Quantity Limit

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

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



## List of Prescription Medications

SKIN PREPS (Skin Conditions)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>ACNE AGENTS, SYSTEMIC</b>		
ABSORICA (isotretinoin)		
ACUTANE	T1	
AMNESTEEM	T1	
CLARAVIS	T1	
isotretinoin (Absorica)	T1	
MYORISAN	T1	
ZENATANE	T1	
<b>ACNE AGENTS, TOPICAL</b>		
ABSORICA ( <i>isotretinoin</i> )	T3	
ACZONE 7.5% GEL PUMP ( <i>dapsone</i> )		
<i>adapalene/benzoyl peroxide</i>	T1	
<i>clindamycin-benzoyl perox 1-5%</i>	T1	
<i>clindamycin-bnz perox 1-5% pmp</i>		
<i>clindamycin/tretinoin</i>	T1	
<i>dapsone (Aczone)</i>	T1	
KLARON ( <i>sulfacetamide sodium</i> )	T3	
<i>sulfacetamide sodium (Klaron)</i>	T1	
<b>ANTIPERSPIRANTS</b>		
DRYSOL	T3	
<b>ANTIPSORIATICS AGENTS</b>		
<i>anthralin</i>	T1	
<i>calcipotriene</i>	T1	
<i>calcipotriene 0.005% cream</i>	T1	
CALCIPOTRIENE 0.005% FOAM	T3	
<i>calcipotriene 0.005% ointment</i>	T1	
<i>calcipotriene 0.005% solution</i>	T1	
<i>calcitriol 3 mcg/g ointment</i>	T1	QL (800gm/30 days)
<i>tazarotene (Tazorac)</i>	T1	
OVACE PLUS	T3	
PROMISEB	T2	
<i>selenium sulfide</i>	T1	
<i>sulfacetamide sodium</i>	T1	
TERSI FOAM	T3	

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

T4 – Specialty Medications  
 PA – Prior Authorization  
 QL – Quantity Limit

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

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

## List of Prescription Medications

SKIN PREPS (Skin Conditions) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>ANTISEPTICS, GENERAL (cont.)</b>		
<i>alcohol antiseptic pads</i>	T1	
ALCOHOL PREP PADS / SWABS/WIPES	T1	
CARETOUCH ALCOHOL PREP PAD	T1	
CURITY ALCOHOL PREPS	T1	
DROPSAFE PREP PADS	T1	
EASY COMFORT ALCOHOL PAD	T1	
EASY TOUCH ALCOHOL PREP PADS	T1	
INCONTROL ALCOHOL PADS	T1	
PRO COMFORT ALCOHOL PADS	T1	
PURE COMFORT ALCOHOL PAD	T1	
SINGLE USE SWAB	T1	
SURE COMFORT ALCOHOL	T1	
SURE-PREP ALCOHOL PREP PADS	T1	
TRUE COMFORT ALCOHOL PADS / PRO ALCOHOL PADS	T1	
ULTILET ALCOHOL SWAB	T1	
WEBCOL	T1	
<b>ANTISEPTICS, MISCELLANEOUS</b>		
GUAIACOL	T3	
<b>DIABETIC ULCER PREPARATIONS, TOPICAL</b>		
REGRANEX	T3	PA QL (2 tubs/30 days)
<b>EMOLLIENTS</b>		
<i>ammonium lactate</i>	T1	
ATOPICLAIR	T3	
BIAFINE ( <i>sonafine</i> )	T3	
<i>emollient combination no.10 (Biafine)</i>	T1	
<i>emollient combination no.35 (Mimyx)</i>	T1	
<i>emollient combination no.44</i>	T1	
HALUCORT	T3	
MIMYX ( <i>prumyx</i> )	T3	
RESTIZAN	T1	
<i>vite ac/grape/hyaluronic acid (Atopiclair)</i>	T1	
XCLAIR	T3	
<b>IMMUNOMODULATORS</b>		
<i>imiquimod</i>	T1	

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

T4 – Specialty Medications  
 PA – Prior Authorization  
 QL – Quantity Limit

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

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

## List of Prescription Medications

SKIN PREPS (Skin Conditions) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>IRRITANTS/COUNTER-IRRITANTS</b>		
<i>methyl salicylate</i>	T1	
QUTENZA	T3	
<b>JANUS KINASE (JAK) INHIBITORS</b>		
CIBINQO	T2	PA QL (30 tabs/30 days) SP
<b>KERATOLYTICS</b>		
BENZEFOAM	T3	
BENZEPRO	T1	
<i>benzoyl peroxide</i>	T1	
<i>benzoyl peroxide</i> (Enzoclear)	T1	
<i>benzoyl peroxide</i> (Pacnex)	T1	
ENZOCLEAR	T3	
HYDRO 35	T3	
HYDRO 40 ( <i>umecta</i> )	T3	
INOVA	T3	
KERAFOAM	T3	
KERALYT 6% GEL ( <i>salicylic acid</i> )	T3	
<i>keralyt 6% shampoo</i>	T1	
KERALYT SCALP	T3	
KERALYT SCALP ( <i>salicylic acid</i> )	T3	
PACNEX ( <i>benzoyl peroxide</i> )	T3	
PODOCON-25	T1	
<i>podoofilox</i>	T1	
PR BENZOYL PEROXIDE	T1	
SALICATE	T3	
<i>salicylic acid</i>	T1	
<i>salicylic acid</i> (Keralyt Scalp)	T1	
<i>salicylic acid/ceramide comb 1</i>	T1	
SALIMEZ FORTE	T1	
SALKERA	T3	
SALVAX DUO PLUS	T3	
<i>silver nitrate</i>	T1	
<i>silver nitrate applicator</i>	T1	
URAMAXIN	T3	
URAMAXIN ( <i>urea</i> )	T3	

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

T4 – Specialty Medications  
 PA – Prior Authorization  
 QL – Quantity Limit

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

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

## List of Prescription Medications

SKIN PREPS (Skin Conditions) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>KERATOLYTICS (cont.)</b>		
<i>urea</i>	T1	
<i>urea</i> (Hydro 35)	T1	
<i>urea</i> (Hydro 40)	T3	
<i>urea</i> (Uramaxin)	T1	
<i>urea</i> (Xurea)	T1	
XUREA	T3	
<b>PROTECTIVES</b>		
BIONECT	T3	
PHARMABASE BARRIER	T1	
<i>polydimethylsiloxanes/silicon</i>	T1	
<i>protectives2/ceramide 1, 3, 6-ii</i>	T1	
RADIAPLEXRX	T3	
<i>zinc oxide</i>	T1	
<b>ROSACEA AGENTS, TOPICAL</b>		
<i>azelaic acid</i>	T1	
<i>ivermectin</i>	T1	
<i>metronidazole</i>	T1	
<b>TISSUE/WOUND ADHESIVES</b>		
ARTISS	T3	
SURGISEAL STYLUS	T3	
SURGISEAL TEARDROP	T3	
SURGISEAL TWIST	T3	
TISSEEL VHSD	T3	
<b>TOP. ANTI-INFLAM., PHOSPHODIESTERASE-4 (PDE4) INHIB</b>		
EUCRISA	T2	
<b>TOPICAL AGENTS, MISCELLANEOUS</b>		
GORDON'S UREA	T3	
HYFTOR	T4	PA SP
L-MESITRAN SOFT	T3	
MEDIHONEY	T3	
SAF-CLENS AF	T3	
<i>trichloroacetic acid</i>	T3	
TRICHLOROACETIC ACID	T1	

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

T4 – Specialty Medications  
PA – Prior Authorization  
QL – Quantity Limit

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

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

# List of Prescription Medications

SKIN PREPS (Skin Conditions) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>TOPICAL ANTIBIOTIC PLEUROMUTILIN DERIVATIVES</b>		
ALTABAX	T3	
<b>TOPICAL ANTI-INFLAMMATORY STEROIDAL</b>		
ALA-SCALP ( <i>scalacort</i> )	T3	ST
ACIOXIA	T3	
<i>alclometasone dipropionate</i>	T1	
<i>amcinonide 0.1% cream/ lotion</i>	T1	
AQUA GLYCOLIC HC	T3	
<i>betamethasone dipropionate</i>	T1	
<i>betamethasone valerate</i>	T1	
<i>betamethasone valerate (Luxiq)</i>	T1	
<i>betamethasone/propylene glyc</i>	T1	
<i>betamethasone/propylene glyc (Diprolene)</i>	T1	
BRYHALI	T3	ST
CAPEX SHAMPOO	T3	ST
<i>clobetasol propionate</i>	T1	
<i>clobetasol propionate (Temovate)</i>	T1	
<i>clobetasol propionate/emoll</i>	T1	
CLOCORTOLONE PIVALATE	T1	
CLODAN 0.05% KIT	T3	ST
<i>clodan 0.05% shampoo</i>	T1	
CLODERM	T3	ST
DERMA-SMOOTHIE-FS ( <i>fluocinolone acetonide</i> )	T3	ST
DERMATOP ( <i>prednicarbate</i> )	T3	ST
<i>desonide</i>	T1	
<i>desonide (Desowen)</i>	T1	
DESOWEN ( <i>desonide</i> )	T3	ST
<i>desoximetasone (Topicort)</i>	T1	
DIPROLENE ( <i>betamethasone diprop augmented</i> )	T3	ST
<i>fluocinolone acetonide</i>	T1	
<i>fluocinolone acetonide (Derma-smoothe-fs)</i>	T1	
<i>fluocinolone acetonide (Synalar)</i>	T1	
<i>fluocinolone/shower cap (Derma-smoothe-fs)</i>	T1	
<i>fluocinonide</i>	T1	

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

T4 – Specialty Medications  
 PA – Prior Authorization  
 QL – Quantity Limit

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

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

## List of Prescription Medications

SKIN PREPS (Skin Conditions) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>TOPICAL ANTI-INFLAMMATORY STEROIDAL (cont.)</b>		
<i>fluocinonide/emollient base</i>	T1	
<i>fluticasone prop 0.005% oint</i>	T1	
<i>fluticasone prop 0.05% cream</i>	T1	
<i>fluticasone prop 0.05% lotion</i>	T1	
<i>fluticasone propionate</i>	T1	
<i>halobetasol propionate (Ultravate)</i>	T1	
<i>halobetasol prop 0.05% cream</i>	T1	
<i>halobetasol prop 0.05% foam</i>	T1	
<i>halobetasol prop 0.05% ointmnt</i>	T1	
<i>hydrocortisone</i>	T1	
<i>hydrocortisone (Ala-scalp)</i>	T1	
<i>hydrocortisone butyrate</i>	T1	
<i>hydrocortisone valerate</i>	T1	
LUXIQ ( <i>betamethasone valerate</i> )	T3	ST
MOMETACURE	T3	
<i>mometasone furoate 0.1% cream</i>	T1	
<i>mometasone furoate 0.1% oint</i>	T1	
<i>mometasone furoate 0.1% soln</i>	T1	
NUCORT	T3	ST
<i>prednicarbate (Dermatop)</i>	T1	
SCALACORT DK	T3	ST
SYNALAR ( <i>fluocinolone acetonide</i> )	T3	ST
SYNALARTS	T3	ST
TACLONEX 0.005%-0.064% SUSPENS ( <i>calcipotriene/betamethasone</i> )	T3	
TEMOVATE ( <i>clobetasol propionate</i> )	T3	ST
TEXACORT	T3	ST
TOPICORT ( <i>desoximetasone</i> )	T3	ST
ULTRAVATE ( <i>halobetasol propionate</i> )	T3	ST
<b>TOPICAL ANTI-INFLAMMATORY STEROID-LOCAL ANESTHETIC</b>		
ANALPRAM HC	T3	
EPIFOAM	T2	
<i>hydrocortisone/pramoxine (Pramosone)</i>	T1	
<i>lidocaine/hydrocortisone ac</i>	T1	
MEZPAROX-HC	T1	
PRAMOSONE	T3	

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

T4 – Specialty Medications

PA – Prior Authorization

QL – Quantity Limit

ST – Step Therapy

AGE – Age Requirement

SP – Specialty Medication

HD – May require home delivery pharmacy

PPACA – No Cost-Share Preventive Medication

CSL – Oral cancer medication subject to cost-share limits

## List of Prescription Medications

SKIN PREPS (Skin Conditions) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>TOPICAL ANTIPARASITICS</b>		
<i>lindane</i>	T1	
<i>malathion</i> (Ovide)	T1	
OVIDE ( <i>malathion</i> )	T3	
<b>TOPICAL PREPARATIONS, ANTIBACTERIALS</b>		
<i>dermazene cream</i>	T1	
DERMAZENE CREAM PACKET	T3	
<i>hydrocortisone/iodoquinol</i>	T1	
<i>hydrocortisone/iodoquinol/aloe</i>	T1	
<i>iodine/potassium iodide</i>	T1	
<i>iodine/sodium iodide</i>	T1	
IODOFLEX	T3	
IODOSORB	T3	
<i>silver nitrate</i>	T1	
<b>TOPICAL VIT D ANALOG/ANTI-INFLAMMATORY STEROID</b>		
<i>calcipotriene/betamethasone</i>	T1	
<b>TOPICAL/MUCOUS MEMBR./SUBCUT. ENZYMES</b>		
AMPHADASE	T3	
SANTYL	T3	QL (60gm/30 days)
VITRASE	T3	
<b>VITAMIN A DERIVATIVES</b>		
<i>adapalene</i> (Plixda)	T1	PA
PLIXDA	T1	PA
<i>tretinoin 0.01% gel</i>	T1	
<i>tretinoin 0.025% cream</i>	T1	PA
<i>tretinoin 0.025% gel</i>	T1	
<i>tretinoin 0.05% cream</i>	T1	PA
<i>tretinoin 0.05% gel</i>	T1	PA
<i>tretinoin 0.1% cream</i>	T1	PA
<i>tretinoin microspheres</i>	T1	PA
<b>THYROID PREPS (Hormonal Agents)</b>		
<b>ANTITHYROID PREPARATIONS</b>		
<i>methimazole</i> (Tapazole)	T1	HD
<i>propylthiouracil</i>	T1	HD
TAPAZOLE ( <i>methimazole</i> )	T3	HD

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

T4 – Specialty Medications  
PA – Prior Authorization  
QL – Quantity Limit

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

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

## List of Prescription Medications

THYROID PREPS (Hormonal Agents)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>THYROID FUNCTION DIAGNOSTIC AGENTS</b>		
THYROGEN	T4	SP
<b>THYROID HORMONES</b>		
ARMOUR THYROID	T3	HD
CYTOMEL ( <i>liothyronine sodium</i> )	T3	HD
LEVOTHYROXINE	T3	PA HD
<i>levothyroxine sodium</i>	T1	HD
<i>levothyroxine sodium</i> (Synthroid)	T1	HD
<i>liothyronine sodium</i> (Cytomel)	T1	HD
<i>liothyronine sodium</i> (Triostat)	T1	HD
SYNTHROID ( <i>unithroid</i> )	T3	HD
<i>thyroid, pork</i>	T1	HD
<i>thyroid, pork</i> (Armour Thyroid)	T1	HD
<i>thyroid, pork</i> (Wp Thyroid)	T1	HD
THYROLAR-1	T3	HD
THYROLAR-1/2	T3	HD
THYROLAR-1/4	T3	HD
THYROLAR-2	T3	HD
THYROLAR-3	T3	HD
TIROSINT	T3	PA HD
TIROSINT-SOL	T3	PA HD
TRIOSTAT ( <i>liothyronine sodium</i> )	T3	HD
WP THYROID	T1	HD
WP THYROID ( <i>nature-throid</i> )	T1	HD
WP THYROID ( <i>westhroid</i> )	T1	HD
<b>UNCLASSIFIED DRUG PRODUCTS (AIDS/HIV)</b>		
<b>CYTOCHROME P450 INHIBITORS</b>		
TYBOST	T4	SP
<b>UNCLASSIFIED DRUG PRODUCTS (Asthma/COPD/Respiratory)</b>		
<b>CYSTIC FIBROSIS-CFTR POTENTIATOR-CORRECTOR COMBIN.</b>		
BRONCHITOL 40 MG INHALE CAP	T4	PA SP
ORKAMBI 100 MG-125 MG TABLET	T4	PA QL (4 tabs/day) SP HD
ORKAMBI 100-125 MG GRANULE PKT	T4	PA QL (2 packs/day) SP HD
ORKAMBI 150-188 MG GRANULE PKT	T4	PA QL (2 packs/day) SP HD

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

T4 – Specialty Medications  
 PA – Prior Authorization  
 QL – Quantity Limit

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

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



## List of Prescription Medications

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

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>CYSTIC FIBROSIS-CFTR POTENTIATOR-CORRECTOR COMBIN. (cont.)</b>		
ORKAMBI 200 MG-125 MG TABLET	T4	PA QL (4 tabs/day) SP HD
SYMDEKO	T4	PA QL (2 tabs/day) SP HD
TRIKAFTA 100-50-75 MG/150 MG	T4	PA QL(3 tabs/day) SP HD
TRIKAFTA 100-50-75 MG/75MG PKT	T4	PA QL(3 tabs/day) HD
TRIKAFTA 50-25-37.5 MG/75 MG	T4	PA QL(3 tabs/day) SP HD
TRIKAFTA 80-40-60MG/59.5MG PKT	T3	PA QL(3 tabs/day) HD
<b>CYSTIC FIB-TRANSMEMB CONDUCT.REG. (CFTR) POTENTIATOR</b>		
KALYDECO 150 MG TABLET	T4	PA QL (2 tabs/day) SP HD
KALYDECO 5.8 MG GRANULES PACKET	T4	PA QL (2 tabs/day) SP
KALYDECO 25 MG GRANULES PACKET	T4	PA QL (2 packs/day) SP HD
KALYDECO 50 MG GRANULES PACKET	T4	PA QL (2 packs/day) SP HD
KALYDECO 75 MG GRANULES PACKET	T4	PA QL (2 packs/day) SP HD
<b>LUNG SURFACTANTS</b>		
CUROSURF	T3	
INFASURF	T3	
SURVANTA	T3	
<b>MUCOLYTICS</b>		
PULMOZYME	T4	PA SP HD
<b>PULMONARY FIBROSIS - SYSTEMIC ENZYME INHIBITORS</b>		
OFEV	T4	PA SP HD
<b>SYSTEMIC ENZYME INHIBITORS</b>		
ARALAST NP	T4	PA SP
GLASSIA	T4	PA QL(2 tabs/day) SP
JOENJA	T4	PA QL SP
PROLASTIN C	T4	PA SP
VIJOICE 125mg, 50mg	T4	PA QL (30 tabs/30 days) SP
VIJOICE 250mg dose pack	T4	PA QL (2 tabs/30 days) SP
ZEMAIRA	T4	PA SP HD
ZOKINVY	T4	PA QL (4 caps/day) SP
<b>UNCLASSIFIED DRUG PRODUCTS (Blood Modifiers/Bleeding Disorders)</b>		
<b>ANTIPORPHYRIA FACTORS</b>		
PANHEMATIN	T4	SP

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

T4 – Specialty Medications  
PA – Prior Authorization  
QL – Quantity Limit

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

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

## List of Prescription Medications

### UNCLASSIFIED DRUG PRODUCTS (Blood Modifiers/Bleeding Disorders) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>ERYTHROID MATURATION AGENTS</b>		
REBLOZYL	T4	PA SP
<b>SPLEEN TYROSINE KINASE INHIBITORS</b>		
TAVALISSE	T4	PA SP
<b>BRADYKININ B2 RECEPTOR ANTAGONISTS</b>		
<i>icatibant acetate</i>	T4	PA SP HD
<b>CI ESTERASE INHIBITORS</b>		
BERINERT	T4	PA SP HD
CINRYZE	T4	PA SP HD
HAEGARDA	T4	PA SP HD
RUCONEST	T4	PA SP HD
<b>PLASMA KALLIKREIN INHIBITORS</b>		
KALBITOR	T4	PA SP HD
ORLADEYO	T4	PA QL (1 caps/day) SP

### UNCLASSIFIED DRUG PRODUCTS (Cancer)

#### CHEMOTHERAPY RESCUE/ANTIDOTE AGENTS

<i>amifostine crystalline</i> (Ethyol)	T4	SP
<i>dexrazoxane hcl</i> (Zinecard)	T4	SP
ETHYOL ( <i>amifostine</i> )	T4	SP

#### CHEMOTHERAPY RESCUE/ANTIDOTE AGENTS

KHAPZORY	T3	PA
<i>leucovorin calcium</i>	T1	
<i>mesna</i> (Mesnex)	T4	SP
MESNEX	T4	SP
MESNEX ( <i>mesna</i> )	T4	SP
VISTOGARD	T4	SP
VORAXAZE	T4	PA SP
ZINECARD ( <i>dexrazoxane</i> )	T4	SP

#### INTRAPLEURAL SCLEROSING AGENTS, ANTINEOPLAST. ADJ.

SCLEROSOL	T3	
STERILE TALC	T1	
STERITALC	T3	

#### RADIOACTIVE THERAPEUTIC AGENTS

LUTATHERA	T4	PA SP
-----------	----	-------

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

T4 – Specialty Medications  
PA – Prior Authorization  
QL – Quantity Limit

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

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

## List of Prescription Medications

UNCLASSIFIED DRUG PRODUCTS (Cancer) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>RADIOACTIVE THERAPEUTIC AGENTS (cont.)</b>		
METASTRON	T3	PA
QUADRAMET	T3	PA
<i>strontium-89 chloride (Metastron)</i>	T1	PA
XOFIGO	T3	PA
<b>TISSUE PROTECTIVE TX OF CHEMOTHERAPY EXTRAVASATION</b>		
TOTECT	T3	
<b>UNCLASSIFIED DRUG PRODUCTS (Dental Products)</b>		
<b>DENTAL AIDS AND PREPARATIONS</b>		
<i>chlorhexidine gluconate (Peridex)</i>	T1	
PERIDEX ( <i>perigard</i> )	T1	
<i>triamcinolone acetonide</i>	T1	
<b>PERIODONTAL COLLAGENASE INHIBITORS</b>		
<i>doxycycline hyclate</i>	T1	
<b>UNCLASSIFIED DRUG PRODUCTS (Eye Conditions)</b>		
<b>INSULIN-LIKE GROWTH FACTOR RECEPTOR (IGF-R) INHIB</b>		
TEPEZZA	T4	PA SP HD
<b>OCULAR PHOTOACTIVATED VESSEL-OCCLUDING AGENTS</b>		
VISUDYNE	T4	SP
<b>UNCLASSIFIED DRUG PRODUCTS (Gastrointestinal/Heartburn)</b>		
<b>CALCIMIMETIC, PARATHYROID CALCIUM ENHANCER</b>		
<i>cinacalcet hcl</i>	T4	SP
PARSABIV	T4	PA SP
<b>ORAL MUCOSITIS/STOMATITIS AGENTS</b>		
ORAMAGICRX	T3	
<b>SALIVA STIMULANT AGENTS</b>		
NUMOISYN	T3	
<i>teriparatide 600 mcg/2.4ml pen</i>	T4	PA QL (0.09 mls/day) SP HD
TERIPARATIDE 620 MCG/2.48 ML	T4	PA QL (0.09 mls/day) SP HD
<b>GROWTH HORMONE RECEPTOR ANTAGONISTS</b>		
SOMAVERT	T4	PA SP HD
<b>HYPERPARATHYROID TX AGENTS - VITAMIN D ANALOG-TYPE</b>		
<i>doxercalciferol</i>	T1	

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

T4 – Specialty Medications  
 PA – Prior Authorization  
 QL – Quantity Limit

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

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

## List of Prescription Medications

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

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

T4 – Specialty Medications  
 PA – Prior Authorization  
 QL – Quantity Limit

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

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

## List of Prescription Medications

UNCLASSIFIED DRUG PRODUCTS (Miscellaneous) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>ANTI-ALCOHOLIC PREPARATIONS</b>		
<i>acamprosate calcium</i>	T1	
ANTABUSE ( <i>disulfiram</i> )	T3	
<i>disulfiram</i> (Antabuse)	T1	
VIVITROL	T4	SP HD
<b>ANTIDOTES, MISCELLANEOUS</b>		
ACETADOTE ( <i>acetylcysteine</i> )	T3	
<i>acetylcysteine</i> (Acetadote)	T1	
CETYLEV	T3	
CYANOKIT	T3	
DIGIFAB	T3	
<i>fomepizole</i>	T1	
SODIUM NITRITE	T1	
<b>ANTIFIBROTIC THERAPY - PYRIDONE ANALOGS</b>		
<i>pirfenidone 267 mg capsule</i> (Esbriet)	T4	PA SP HD
<i>pirfenidone 801 mg capsule</i> (Esbriet)	T4	PA SP HD
<b>BENZODIAZEPINE ANTAGONISTS</b>		
<i>flumazenil</i>	T1	
<b>CATHETER LOCK SOLUTIONS</b>		
DEFENCATH	T3	
<b>CHOLINESTERASE REACTIVAT.-MUSCARINIC ANTG.ANTIDOTE</b>		
DUODOTE	T3	
PRALIDOXIME CHLORIDE	T1	
PROTOPAM CHLORIDE	T3	
<b>COMPLEMENT INHIBITORS</b>		
VEOPOZ	T4	SP
<b>CRYOPRESERVATIVE AGENTS</b>		
<i>dimethyl sulfoxide</i>	T3	
<b>DILUENT SOLUTIONS</b>		
<i>diluent for epoprostenol (glyc)</i>	T1	
DILUENT FOR REMODULIN	T3	
<i>diluent for treprostinil (gly)</i> (Diluent For Remodulin)	T1	
ELLIOTTS B	T3	
PH 12 DILUENT FOR FLOLAN	T3	
<b>DRUGS TO TREAT ACUTE HEPATIC PORPHYRIA (AHP)</b>		
GIVLAARI	T4	PA SP HD

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

T4 – Specialty Medications  
 PA – Prior Authorization  
 QL – Quantity Limit

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

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

## List of Prescription Medications

UNCLASSIFIED DRUG PRODUCTS (Miscellaneous) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>DRUGS TO TREAT HEREDITARY TYROSINEMIA</b>		
<i>nitisinone</i> (Orfadin)	T4	PA SP HD
NITYR	T4	PA SP
ORFADIN	T4	PA SP
ORFADIN ( <i>nitisinone</i> )	T4	PA SP
<b>DRUGS TO TX GAUCHER DX-TYPE I, SUBSTRATE REDUCING</b>		
CERDELGA	T4	PA SP HD
<i>miglustat</i> (Zavesca)	T4	PA SP HD
ZAVESCA ( <i>miglustat</i> )	T4	PA SP HD
<b>GENERAL INHALATION AGENTS</b>		
HYPER-SAL	T3	
<i>nebusal 3% vial</i>	T1	
NEBUSAL 6% VIAL	T3	
<i>sodium chloride for inhalation</i> (Hyper-sal)	T1	
<b>GENETIC D/O TX - SMN PROTEIN DEFICIENCY TREATMENT</b>		
EVRYSDI	T4	PA SP HD
SPINRAZA	T4	PA SP HD
<b>GENETIC D/O TX-EXON SKIPPING ANTISENSE OLIGONUCLEO</b>		
AMONDYS-45	T4	PA SP
EXONDYS-51	T4	PA SP
VILTEPSO	T4	PA SP
VYONDYS-53	T4	PA SP
<b>GLUCOSYLCERAMIDE SYNTHASE (GCS) INHIBITOR</b>		
<i>miglustat</i> (Zavesca)	T4	PA SP
OPFOLDA	T4	PA QL(8 CAPS/30 DAYS) SP HD
<b>LEAD POISONING, AGENTS TO TREAT (CHELATING-TYPE)</b>		
CALCIUM DISODIUM VERSENATE	T1	PA
<b>MENOPAUSAL SYMPTOMS SUPPRESSANT - SSRIS</b>		
<i>paroxetine mesylate</i>	T1	QL (1 cap/day) HD
<b>METABOLIC DX ENZYME REPLACEMENT,ALPHA-MANNO SIDOSIS</b>		
LAMZEDE	T4	PA SP
<b>METABOLIC DISEASE ENZYME REPLACE, HYPOPHOSPHATASIA</b>		
STRENSIQ	T4	PA SP
BRINEURA	T4	PA SP
<b>METABOLIC DISEASE ENZYME REPLACEMENT, FABRY'S DX</b>		
ELFABRIO	T4	PA SP
FABRAZYME	T4	PA SP HD

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

T4 – Specialty Medications  
PA – Prior Authorization  
QL – Quantity Limit

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

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

## List of Prescription Medications

UNCLASSIFIED DRUG PRODUCTS (Miscellaneous) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>METABOLIC DISEASE ENZYME REPLACEMENT, GAUCHER'S DX</b>		
CEREZYME	T4	PA SP HD
ELELYSO	T4	PA SP
VPRIV	T4	PA SP HD
<b>METABOLIC DISEASE ENZYME REPLACEMENT, MOCD</b>		
NULIBRY	T4	PA SP
<b>METABOLIC DISEASE ENZYME REPLACEMENT, POMPE DISEASE</b>		
POMBILITI	T4	PA SP HD
<b>METABOLIC DX ENZYME REPLACE, MUCOPOLYSACCHARIDOSIS</b>		
ALDURAZYME	T4	PA SP HD
ELAPRASE	T4	PA SP
MEPSEVII	T4	PA SP
NAGLAZYME	T4	PA SP
VIMIZIM	T4	PA SP
<b>METABOLIC DX ENZYME REPLACEMENT, LYSO.ACID LIP.DEF.</b>		
KANUMA	T4	PA SP
<b>METABOLIC DX ENZYME REPLACEMENT, SEV.COMB.IMMUNE DEF.</b>		
ADAGEN	T4	PA SP
REVCovi	T4	PA SP
<b>METALLIC POISON, AGENTS TO TREAT</b>		
BAL IN OIL	T3	PA
CHEMET	T3	
<i>deferasirox</i> (Exjade)	T4	SP HD
<i>deferasirox</i> (Jadenu Sprinkle)	T4	SP HD
<i>deferasirox</i> (Jadenu)	T4	SP HD
<i>deferiprone</i> (Ferriprox)	T4	PA SP
<i>deferoxamine mesylate</i>	T4	
<i>deferoxamine mesylate</i> (Desferal Mesylate)	T4	
DESFERAL MESYLATE ( <i>deferoxamine mesylate</i> )	T4	
EXJADE ( <i>deferasirox</i> )	T4	PA SP HD
FERRIPROX	T4	PA SP
FERRIPROX (2 TIMES A DAY)	T4	PA SP
GALZIN	T3	
JADENU ( <i>deferasirox</i> )	T4	PA SP HD

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

T4 – Specialty Medications  
PA – Prior Authorization  
QL – Quantity Limit

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

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

# List of Prescription Medications

UNCLASSIFIED DRUG PRODUCTS (Miscellaneous) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>METALLIC POISON, AGENTS TO TREAT (cont.)</b>		
JADENU SPRINKLE ( <i>deferasirox</i> )	T4	PA SP HD
NITHIODOTE	T3	
PENTETATE CALCIUM TRISODIUM	T1	
PENTETATE ZINC TRISODIUM	T1	
RADIOGARDASE	T3	
<i>sodium thiosulf (poison treat)</i>	T1	
<i>trientine hcl 250 mg capsule (Syprine)</i>	T4	PA SP HD
TRIENTINE HCL 500 MG CAPSULE	T4	PA SP HD
<b>MISCELLANEOUS AGENTS</b>		
NEXAVIR	T4	SP
<b>NATRIURETIC PEPTIDES</b>		
VOXZOGO	T4	PA SP HD
<b>OINTMENT/CREAM BASES</b>		
RADIAGEL	T3	
<b>PHARMACOLOGICAL CHAPERONE-ALPHA-GALACTOSID.A STABZ</b>		
GALAFOLD	T4	PA SP HD
<b>PKU TX AGENT-COFACTOR OF PHENYLALANINE HYDROXYLASE</b>		
<i>javygtor 100 mg powder packet (Kuvan)</i>	T4	PA SP
<i>javygtor 100 mg tablet (Kuvan)</i>	T4	PA SP HD
<i>javygtor 500 mg powder packet (Kuvan)</i>	T4	PA SP
<b>PROTEIN STABILIZERS</b>		
VYNDAMAX	T4	PA QL (1 cap/day) SP HD
VYNDAQEL	T4	PA QL (4 caps/day) SP HD
<b>RADIOPHARMACEUTICALS ELEMENTS</b>		
TECHNELITE TC-99M GENERATOR	T3	
<b>RETINOIC ACID RECEPTOR (RAR) AGONISTS</b>		
SOHONOS	T4	PA SP
<b>SODIUM/SALINE PREPARATIONS</b>		
<i>bacteriostatic sodium chloride</i>	T1	
<b>SOLVENTS</b>		
ISOPROPYL ALCOHOL	T3	
MURI-LUBE MINERAL OIL	T3	
<b>SUSPENDING AGENTS</b>		
GELFILM	T3	
HYDROXYPROPYLCELLULOSE	T3	

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

T4 – Specialty Medications  
 PA – Prior Authorization  
 QL – Quantity Limit

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

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



# List of Prescription Medications

UNCLASSIFIED DRUG PRODUCTS (Multiple Sclerosis)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>SUSPENDING AGENTS (cont.)</b>		
HYPROMELLOSE	T3	
<b>LEUKOCYTE ADHESION INHIB, ALPHA4-MEDIAT IGG4K MC AB</b>		
TYSABRI	T4	PA SP HD
UNCLASSIFIED DRUG PRODUCTS (Nutritional/Dietary)		
<b>METABOLIC DEFICIENCY AGENTS</b>		
CYSTADANE	T4	SP
<i>levocarnitine</i> (Carnitor Sf)	T1	
<i>levocarnitine</i> (Carnitor)	T1	
<i>levocarnitine (with sugar)</i> (Carnitor)	T1	
<b>BONE FORMATION AGENTS - SCLEROSTIN INHIBITOR, MONO</b>		
EVENITY	T4	PA QL (2 syringes/month) SP
EVENITY (2 SYRINGES)	T4	PA QL (2 syringes/month) SP
<b>BONE RESORPTION INHIBITOR AND VITAMIN D COMBS.</b>		
FOSAMAX PLUS D	T3	ST HD
<b>BONE RESORPTION INHIBITORS</b>		
ACTONEL ( <i>risedronate sodium</i> )	T3	ST HD
<i>alendronate sodium</i>	T1	HD
<i>alendronate sodium</i> (FOSAMAX)	T1	HD
ATELVIA ( <i>risedronate sodium dr</i> )	T3	ST HD
BINOSTO	T3	ST HD
BONIVA 150 MG TABLET ( <i>ibandronate sodium</i> )	T3	ST HD
BONIVA 3 MG/3 ML SYRINGE ( <i>ibandronate sodium</i> )	T4	SP HD
EVISTA ( <i>raloxifene hcl</i> )	T3	HD
FOSAMAX ( <i>alendronate sodium</i> )	T3	ST HD
<i>ibandronate 3 mg/3 ml syringe</i> (Boniva)	T4	SP HD
<i>ibandronate 3 mg/3 ml vial</i>	T4	SP HD
<i>ibandronate sodium 150 mg tab</i> (Boniva)	T1	HD
<i>pamidronate disodium</i>	T4	SP HD
PROLIA	T4	PA SP HD
<i>raloxifene hcl</i> (Evista)	T1	HD PPACA
RECLAST ( <i>zoledronic acid</i> )	T4	SP HD
<i>risedronate sodium</i>	T1	HD
<i>risedronate sodium</i> (Actonel)	T1	HD
<i>risedronate sodium</i> (Atelvia)	T1	HD

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

T4 – Specialty Medications  
PA – Prior Authorization  
QL – Quantity Limit

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

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

## List of Prescription Medications

### UNCLASSIFIED DRUG PRODUCTS (Nutritional/Dietary) (cont.)

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

#### BONE RESORPTION INHIBITORS (cont.)

XGEVA	T4	PA SP HD
ZOLEDRONIC ACID 4MG/100ML	T4	SP HD
<i>zoledronic acid/mannitol-water</i>	T4	SP HD
<i>zoledronic acid/mannitol-water</i> (Reclast)	T4	SP HD

### UNCLASSIFIED DRUG PRODUCTS (Osteoporosis Products)

#### THYMIC STROMAL LYMPHOPOIETIN (TSLP) INHIBITORS

TEZSPIRE 210 MG/1.91 ML PEN	T4	PA QL(1 pen/28 days) SP HD
TEZSPIRE 210 MG/1.91 ML SYRING	T4	PA SP HD

#### TOPICAL/MUCOUS MEMBR./SUBCUT. ENZYMES

HYLENEX	T4	SP HD
---------	----	-------

#### WATER

<i>water for inj., bacteriostatic</i>	T1	
<i>water for injection, sterile</i>	T1	
<i>water/me-paraben/propylparaben</i>	T1	

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

#### ANTI-INFLAM. INTERLEUKIN-1 RECEPTOR ANTAGONIST

ARCALYST	T4	PA SP HD
----------	----	----------

#### ANTI-INFLAMMATORY, INTERLEUKIN-1 BETA BLOCKERS

ILARIS	T4	PA SP HD
--------	----	----------

#### FIBROMYALGIA AGENTS, SEROTONIN-NOREPINEPH RU INHIB

SAVELLA	T3	HD
---------	----	----

#### IMMUNOMODULATOR, B-LYMPHOCYTE STIM (BLYS) -SPEC INHIB

BENLYSTA 120 MG VIAL	T4	PA SP
BENLYSTA 200 MG/ML AUTOINJECT	T4	PA SP HD
BENLYSTA 200 MG/ML SYRINGE	T4	PA SP HD
BENLYSTA 400 MG VIAL	T4	PA SP

#### JOINT CONTRACTURE THERAPY, COLLAGENASE ENZYME

XIAFLEX	T4	PA SP
---------	----	-------

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

T4 – Specialty Medications  
PA – Prior Authorization  
QL – Quantity Limit

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

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

## List of Prescription Medications

UNCLASSIFIED DRUG PRODUCTS (Skin Conditions)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>INTERLEUKIN-13 (IL-13) INHIBITORS, MAB</b>		
ADBRY	T4	PA SP
<b>WOUND HEALING AGENTS, LOCAL</b>		
<i>balsam peru/castor oil</i> (Venelex)	T1	
BALSAM PERU-CASTOR OIL	T1	
DERMULCERA	T1	
VENELEX	T3	
UNCLASSIFIED DRUG PRODUCTS (Substance Abuse)		
<b>OPIOID WITHDRAWAL THER, ALPHA-2 ADRENERGIC AGONIST</b>		
LUCEMYRA	T2	QL (168 tabs/14 days)
<b>OPIOID WITHDRAWAL THERAPY AGENTS, OPIOID-TYPE</b>		
BUNAVAIL	T3	
<i>buprenorphine 2 mg tablet sl</i>	T1	
<i>buprenorphine 8 mg tablet sl</i>	T1	
<i>buprenorphine hcl</i>	T1	
<i>buprenorphine hcl/naloxone hcl</i>	T1	
<i>buprenorphine hcl/naloxone hcl</i> (Suboxone)	T1	
PROBUPHINE	T3	
SUBLOCADE	T4	SP
SUBOXONE ( <i>buprenorphine-naloxone</i> )	T3	
ZUBSOLV	T2	
UNCLASSIFIED DRUG PRODUCTS (Transplant Medications)		
<b>ORGAN TRANSPLANTATION PRESERVATION SOLUTIONS</b>		
VIASPAN BELZER-UW	T3	
<b>RHO KINASE INHIBITOR</b>		
REZUROCK	T4	PA SP HD
UNCLASSIFIED DRUG PRODUCTS (Urinary Tract Conditions)		
<b>BENIGN PROSTATIC HYPERTROPHY/MICTURITION AGENTS</b>		
<i>alfuzosin hcl</i> (Uroxatral)	T1	HD
<i>dutasteride</i> (Avodart)	T1	HD
<i>finasteride</i> (Proscar)	T1	HD
FLOMAX ( <i>tamsulosin hcl</i> )	T3	HD
PROSCAR ( <i>finasteride</i> )	T3	HD

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

T4 – Specialty Medications  
PA – Prior Authorization  
QL – Quantity Limit

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

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

## List of Prescription Medications

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

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>BENIGN PROSTATIC HYPERTROPHY/MICTURITION AGENTS (cont.)</b>		
RAPAFLO 4 MG CAPSULE ( <i>silodosin</i> )	T3	QL (1 cap/day) HD
RAPAFLO 8 MG CAPSULE ( <i>silodosin</i> )	T3	HD
<i>silodosin 4 mg capsule</i> (Rapaflo)	T1	QL (1 cap/day) HD
<i>silodosin 8 mg capsule</i> (Rapaflo)	T1	HD
<i>tamsulosin hcl</i> (Flomax)	T1	HD
UROXATRAL ( <i>alfuzosin hcl er</i> )	T3	HD
<b>BPH 5-ALPHA-REDUCTASE INHIB-ALPHA1-ADRENOCEP ANTAG</b>		
<i>dutasteride/tamsulosin hcl</i> (Jalyn)	T1	HD
<b>CYSTINE-DEPLETING AGENTS, NEPHROPATHIC CYSTINOSIS</b>		
CYSTAGON	T2	SP
<b>KIDNEY STONE AGENTS</b>		
<i>tiopronin</i>	T1	SP
<b>URINARY TRACT ANTISPASMODIC, M (3) SELECTIVE ANTAG.</b>		
<i>darifenacin er 15 mg tablet</i>	T1	HD
<i>darifenacin er 7.5 mg tablet</i>	T1	QL (1 tab/day) HD
<i>solifenacin 10 mg tablet</i>	T1	HD
<i>solifenacin 5 mg tablet</i>	T1	QL (1 tab/day) HD
<b>URINARY TRACT ANTISPASMODIC/ANTIINCONTINENCE AGENT</b>		
<i>flavoxate hcl</i>	T1	HD
<i>oxybutynin 5 mg/5 ml solution</i>	T1	HD
<i>oxybutynin 5 mg/5 ml syrup</i>	T1	HD
<i>oxybutynin chloride</i>	T1	HD
<i>tolterodine tart er 2 mg cap</i>	T1	QL (1 cap/day) HD
<i>tolterodine tart er 4 mg cap</i>	T1	HD
<i>tolterodine tartrate</i>	T1	HD
<i>trospium chloride</i>	T1	HD

### UNCLASSIFIED DRUG PRODUCTS (Weight Management)

#### APPETITE STIM. FOR ANOREXIA, CACHEXIA, WASTING SYND.

<i>megestrol acetate</i>	T1	
--------------------------	----	--

### VACCINES (Vaccines)

#### COVID-19 VACCINES

JANSSEN COVID-19 VACCINE (EUA)	T3	PPACA
MODERNA COVID-19 VACCINE (EUA)	T3	PPACA
PFIZER COVID-19 VACCINE (EUA)	T3	PPACA

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

T4 – Specialty Medications  
PA – Prior Authorization  
QL – Quantity Limit

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

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

## List of Prescription Medications

VITAMINS (Nutritional/Dietary)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>FOLIC ACID PREPARATIONS</b>		
<i>folic acid</i>	T1	
<b>MULTIVITAMIN PREPARATIONS</b>		
CITRANATAL MEDLEY	T3	
FOLET ONE	T3	
INFUVITE ADULT	T3	
<i>multivit infusn, adult 1, vit k</i>	T3	
<i>mvn no.53/iron/folic/dss/dha</i>	T1	
OBSTETRIX ONE	T1	
<b>PEDIATRIC VITAMIN PREPARATIONS</b>		
INFUVITE PEDIATRIC	T3	
M.V.I. PEDIATRIC	T3	
VITALIPID N INFANT	T3	
VITLIPIID N INFANT	T3	
<b>VITAMIN A PREPARATIONS</b>		
AQUASOL A	T3	
<b>VITAMIN B PREPARATIONS</b>		
<i>vitamins b1, b2, b3, b5, and b6</i>	T1	HD
<b>VITAMIN B1 PREPARATIONS</b>		
<i>thiamine hcl</i>	T1	
<b>VITAMIN B12 PREPARATIONS</b>		
B-12 COMPLIANCE	T1	
<i>cyanocobalamin (vitamin b-12) (Nascobal)</i>	T1	
<i>hydroxocobalamin</i>	T1	
PHYSICIANS EZ USE B-12	T3	
<b>VITAMIN B6 PREPARATIONS</b>		
<i>pyridoxine hcl (vitamin b6)</i>	T1	
<b>VITAMIN C PREPARATIONS</b>		
ASCOR	T3	
<i>ascorbic acid</i>	T1	
<b>VITAMIN D PREPARATIONS</b>		
<i>calcitriol 0.25 mcg capsule (Rocaltrol)</i>	T1	HD
<i>calcitriol 1 mcg/ml vial</i>	T1	HD

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

T4 – Specialty Medications  
 PA – Prior Authorization  
 QL – Quantity Limit

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

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

## List of Prescription Medications

VITAMINS (Nutritional/Dietary) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>VITAMIN D PREPARATIONS (cont.)</b>		
<i>calcitriol 0.5 mcg capsule</i> (Rocaltrol)	T1	HD
<i>calcitriol 1 mcg/ml ampul</i>	T1	HD
<i>calcitriol 1 mcg/ml solution</i> (Rocaltrol)	T1	HD
DRISDOL ( <i>vitamin d2</i> )	T3	HD
<i>ergocalciferol (vitamin d2)</i> (Drisdol)	T1	HD
ROCALTROL ( <i>calcitriol</i> )	T3	HD
<b>VITAMIN K PREPARATIONS</b>		
MEPHYTON ( <i>phytonadione</i> )	T3	
PHYTONADIONE	T1	
<i>phytonadione (vit k1)</i>	T1	
<i>phytonadione (vit k1)</i> (Mephyton)	T1	
<b>VITAMINS (Vitamins)</b>		
<b>MULTIVITAMIN PREPARATIONS</b>		
VITLIPID N ADULT	T3	

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

T4 – Specialty Medications  
 PA – Prior Authorization  
 QL – Quantity Limit

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

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

## Exclusions and limitations for coverage

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

Plans generally do not provide coverage for the following under the pharmacy benefit, except as required by state or federal law, or by the terms of your specific plan:<sup>10</sup>

- Over-the-counter (OTC) medicines (those that do not require a prescription) except insulin unless state or federal law requires coverage of such medicines.
  - Prescription medications or supplies for which there is a prescription or OTC therapeutic equivalent or therapeutic alternative.
  - Doctor-administered injectable medications covered under the Plan's medical benefit, unless otherwise covered under the Plan's prescription drug list or approved by Cigna Healthcare.
  - Implantable contraceptive devices covered under the Plan's medical benefit.
  - Medications that are not medically necessary.
  - Experimental or investigational medications, including U.S. Food and Drug Administration (FDA)-approved medications used for purposes other than those approved by the FDA unless the medication is recognized for the treatment of the particular indication.
  - Medications that are not approved by the FDA.
  - Prescription and non-prescription devices, supplies, and appliances other than those supplies specifically listed as covered.
  - Medications used for fertility,<sup>11</sup> sexual dysfunction, cosmetic purposes, weight loss, smoking cessation,<sup>12</sup> or athletic enhancement.
  - Prescription vitamins (other than prenatal vitamins) or dietary supplements unless state or federal law requires coverage of such products.
  - Immunization agents, biological products for allergy immunization, biological sera, blood, blood plasma and other blood products or fractions and medications used for travel prophylaxis.
  - Replacement of prescription medications and related supplies due to loss or theft.
  - Medications which are to be taken by or administered to a covered person while they are a patient in a licensed hospital, skilled nursing facility, rest home or similar institution which operates on its premises or allows to be operated on its premises a facility for dispensing pharmaceuticals.
  - Prescriptions more than one year from the date of issue.
  - Coverage for prescription medication products for the amount dispensed (days' supply) which is more than the applicable supply limit, or is less than any applicable supply minimum set forth in The Schedule, or which is more than the quantity limit(s) or dosage limit(s) set by the P&T Committee.
  - More than one prescription order or refill for a given prescription supply period for the same prescription medication product prescribed by one or more doctors and dispensed by one or more pharmacies.
  - Prescription medication products dispensed outside the jurisdiction of the United States, except as required for emergency or urgent care treatment.
- In addition to the plan's standard pharmacy exclusions, certain new FDA-approved medication products (including, but not limited to, medications, medical supplies or devices that are covered under standard pharmacy benefit plans) may not be covered for the first six months of market availability unless approved by Cigna Healthcare as medically necessary.

# Index of Medications

## Symbols

1ST TIER.....	156
1ST TIER UNILET COMFORTOUCH.....	160
2-IN-1 LANCET DEVICE.....	160
2TEK.....	151

## A

AA 3%.....	128
abacavir.....	79
abacavir/lamivudine/zidovudine.....	79
abacavir sulfate/lamivudine.....	79
ABELCET.....	54
ABILIFY ASIMTUFII.....	172
ABILIFY MAINTENA ER.....	173
abiraterone.....	65
ABOUTTIME.....	156
ABRAXANE.....	73
ABSORICA.....	177
ACAM2000.....	90
acamprosate calcium.....	189
acarbose.....	57
ACCOLATE.....	36
ACCU.....	151
ACCU-CHEK.....	151, 160
ACCUTANE.....	177
ACCUTREND.....	151
ACD-A.....	50
ACD SOLUTION A.....	50
acebutolol.....	102
ACETADOTE.....	189
ACETAMIN-CAFF-DIHYDROCODEINE.....	21
acetamin-codein.....	20
acetaminop-codeine.....	20
acetaminophen.....	18, 19, 20, 21
ACETAMINOPHEN.....	18, 20
acetazolamide.....	120
acetic acid.....	59, 122, 176
acetic acid/oxyquinoline.....	59
acetylcysteine.....	37, 189
ACIOXIA.....	181
acitretin.....	176
ACTEMRA.....	149
ACTHAR.....	141
ACTHIB.....	89, 90
ACTHREL.....	141
ACTIGALL.....	137
ACTI-LANCE.....	160
ACTIMMUNE.....	74
ACTIQ.....	21

ACTIVASE.....	92
ACTIVELLA.....	143
ACTONEL.....	193
ACTOPLUS MET.....	58
ACTOS.....	58
ACUVAIL.....	123
acyclovir.....	81
ACZONE.....	177
ADACEL TDAP.....	89
ADAGEN.....	191
ADAKVEO.....	91
ADALAT CC.....	94
ADALIMUMAB.....	61
ADALIMUMAB-ADAZ.....	61
adapalene.....	177, 183
adapalene/benzoyl peroxide.....	177
ADBRY.....	195
ADCETRIS.....	72
ADDAMEL N.....	131
ADDERALL.....	84
adefovir dipivoxil.....	82
ADEMPAS.....	97
adenosine.....	93, 116
ADJUSTABLE.....	151
ADRENALIN CHLORIDE.....	122
ADREVIEW.....	116
adriamycin.....	62
ADRIAMYCIN.....	62
ADVANCED.....	117, 151
ADVANCED DNA MEDICATED COLLECT.....	117
ADVANCED TRAVEL LANCETS.....	160
ADVOCATE.....	151, 156, 158, 160
ADYPHREN.....	83
ADZYNMA.....	90
AEMCOLO.....	47
AFINITOR.....	68
AFLURIA.....	88
AFLURIA QUAD.....	88
AGAMATRIX.....	151
AGGRASTAT.....	77
AGRYLIN.....	78
AIMOVIG.....	14, 18
AIRDUO DIGIHALER.....	36
AJOVY.....	14, 18
AKEEGA.....	67
AK-FLUOR.....	118
AKOVAZ.....	97
AKTEN.....	124



## Index of Medications

AKYNZEO.....	135	amifostine crystalline.....	186
ALA-SCALP.....	181	amikacin.....	39
albendazole.....	60	amiloride.....	121
ALBENZA.....	60	aminocaproic acid.....	90, 91
albuterol.....	35, 36	aminophylline.....	37
albuterol sulf.....	35	AMINOSYN.....	128
albuterol sulfate.....	35, 36	amiodarone.....	93
ALBUTEROL SULFATE HFA.....	35	AMIODARONE HCL-D5W.....	93
ALCAINE.....	124	amitriptyline.....	168
alclometasone.....	181	amitriptyline/chlordiazepoxide.....	168
alcohol.....	107, 178	AMJEVITA.....	61
ALCOHOL.....	107, 178	amlodipine.....	94, 95, 98, 100, 103, 104
ALCOHOL, DEHYDRATED.....	107	amlodipine-atorvast.....	103, 104
ALDACTAZIDE.....	121	amlodipine besylate/benazepril.....	98
ALDURAZYME.....	191	amlodipine besylate/valsartan.....	100
ALECENSA.....	70	amlodipine-olmesartan.....	100
alendronate.....	193	amlodipine/valsartan/hcthiazyd.....	100
alfentanil.....	21	AMMONIA N-13.....	116
ALFENTANIL.....	21	ammonium lactate.....	178
ALFERON N.....	74	AMMONUL.....	134
alfuzosin.....	195, 196	AMNESTEEM.....	177
ALIMTA.....	65	AMONDYS-45.....	190
ALINIA.....	75	amoxapine.....	168
ALIQOPA.....	70	amoxicillin.....	45, 59
aliskiren.....	103	AMPHADASE.....	183
ALKALINE.....	151	amphetamine.....	84, 85
ALKERAN.....	63, 64	amphotericin b.....	54
allopurinol.....	32, 33	ampicillin.....	45, 46, 59
almotriptan.....	18	AMVISC.....	126
almotriptan malate.....	14	AMYTAL.....	174
ALORA.....	143	AMYVID.....	118
alosetron.....	139	ANADROL-50.....	141
ALOXI.....	135	anagrelide.....	78
alprazolam.....	164, 165	ANA-LEX.....	141
alprostadil.....	103	ANALPRAM HC.....	182
ALREX.....	123	ANAPROX DS.....	33
ALTABAX.....	181	anastrozole.....	67
ALTAFLUOR BENOX.....	124	ANCOBON.....	53
ALTERNATE.....	151, 160	ANDEXXA.....	92
ALTUVIIO.....	36	ANDRODERM.....	141
ALTUVILLO.....	91	ANDROGEL.....	141, 142
amantadine.....	76	ANDROID.....	142
AMARYL.....	57	ANGELIQ.....	144
AMBISOME.....	54	ANGIOMAX.....	52
ambrisentan.....	98	ANJESO.....	33
amcinonide.....	181	ANNOVERA.....	113
AMICAR.....	90	ANORO ELLIPTA.....	36
AMIDATE.....	26	ANTABUSE.....	189

## Index of Medications

anthralin.....	177	ASSURE .....	151, 156, 158, 160, 164
ANTICOAG SODIUM CITRATE.....	50	ASSURE ID INSULIN SAFETY .....	158
ANZEMET .....	135	ASTAGRAF XL .....	150
APADAZ .....	20	ASTRINGYN .....	92
APOKYN .....	76	ATABEX EC .....	163
apraclonidine .....	124, 125	atazanavir.....	80
aprepitant.....	135	ATELVIA .....	193
APRETUDE.....	80	atenolol .....	102, 103
APRISO .....	138	AT HOME A1C.....	151
APTIOM .....	109	atomoxetine .....	170
APTIVUS .....	79	ATOPICLAIR .....	178
AQINJECT.....	156	atorvastatin .....	104
AQUA.....	151, 181	atovaquone .....	60
AQUA GLYCOLIC HC.....	181	atovaquone/proguanil.....	60
AQUASOL A .....	197	atracurium.....	86
ARALAST NP .....	185	ATROPEN .....	103
ARANESP.....	112	atropine.....	125, 134, 136, 137
ARAVA .....	31	ATROPINE .....	125, 136, 137
ARCALYST.....	194	ATROPINE SULFATE .....	125, 136
arformoterol.....	35	ATROVENT HFA.....	35
ARGATROBAN.....	52	AURYXIA.....	129
ARICEPT.....	84	AUSTEDO.....	107
ARIDOL .....	118	AUTOJECT .....	151
ARIKAYCE.....	39	AUTO-LANCET MINI .....	152
ARIMIDEX.....	67	AUTOLET.....	152
aripiprazole .....	173	AUTOPEN.....	152
ARISTADA ER.....	173	AUTOSHIELD.....	156
ARISTADA INITIO .....	173	AVANDIA .....	58
ARIXTRA.....	50	AVAR 9.5.....	50
armodafinil .....	174	avar cleanser .....	50
ARMOUR THYROID.....	184	AVAR LS.....	50
AROMASIN .....	67	AVASTIN .....	63
ARRANON.....	65	AVC.....	59
arsenic trioxide.....	73, 74	AVEED.....	142
ARSENIC TRIOXIDE.....	73	AVELOX.....	46
ARTHROTEC 50.....	33	AVITENE.....	92
ARTHROTEC 75.....	33	AVONEX.....	107
ARTICADENT DENTAL.....	27	AVONEX PEN .....	107
ARTISS .....	180	AVSOLA .....	61
ARYMO ER.....	21	AVYCAZ .....	42
ASCLERA .....	106	AXUMIN .....	119
ASCOR .....	197	AYGESTIN.....	147
ascorbic acid.....	197	AYVAKIT .....	70
asenapine.....	171, 172	azacitidine .....	67
ASMANEX HFA .....	36	AZACTAM .....	41
ASMANEX TWISTHALER.....	36	AZASAN.....	150
ASPARLAS .....	73	AZASITE.....	38
aspirin/dipyridamole .....	77	azathioprine .....	150

## Index of Medications

AZEDRA DOSIMETRIC.....	74	benzoyl peroxide.....	49, 177, 179
AZEDRA THERAPEUTIC.....	74	benztropine mesylate.....	76
azelaic acid.....	180	BEOVU.....	126
azelastine.....	56, 122	BERINERT.....	186
AZILECT.....	76	BESIVANCE.....	38
azithromycin.....	44, 45	BESPONSA.....	69
AZOPT.....	124	BETA 1.....	144
aztreonam.....	41	BETADINE.....	123
<b>B</b>		betamethasone.....	54, 144, 181, 182, 183
B-12 COMPLIANCE.....	197	betamethasone acetate, sod phos.....	144
bacitracin.....	38, 40	BETASERON.....	107
baclofen.....	163	betaxolol.....	102, 124
bacteriostatic.....	192, 194	bethanechol.....	87
BACTRIM.....	38	BETOPTIC S.....	124
BACTROBAN NASAL.....	37	BEVYXXA.....	50
BAFIERTAM.....	107	bexarotene.....	62
balanced salt irrig soln no.2.....	123	BEXSERO.....	88
BAL IN OIL.....	191	BEYAZ.....	113
balsalazide.....	138	BIAFINE.....	178
balsam peru/castor oil.....	195	bicalutamide.....	65
BALSAM PERU-CASTOR OIL.....	195	BICILLIN C-R.....	45
BALVERSA.....	70	BICILLIN L-A.....	45
BAQSIMI.....	127	BICNU.....	64
BARACLUDE.....	82	BIDIL.....	103
BARHEMSYS.....	135	BIJUVA.....	143
BARRIGEL.....	163	BIKTARVY.....	80
BASAGLAR KWIKPEN.....	59	BILTRICIDE.....	60
BAVENCIO.....	74	bimatoprost.....	124
BAXDELA.....	46	BIMZELX.....	176
BCG.....	73	BINOSTO.....	193
BD.....	156, 160	BIONECT.....	180
BD MICROTAINER LANCETS.....	160	BIORPHEN.....	97
BD ULTRA-FINE.....	160	bisac/nacl/nahco3/kcl/peg 3350.....	139
BELBUCA.....	21	bismuth.....	136
BELEODAQ.....	63	bisoprolol.....	102, 103
BELRAPZO.....	64	bivalirudin.....	52
benazepril.....	98, 100	BIVALIRUDIN.....	52
bendamustine.....	64	BLENREP.....	72
BENDEKA.....	64	bleomycin.....	62
BENLYSTA.....	194	BLEPH-10.....	38
benoxinate hcl/fluorescein sod.....	124	BLEPHAMIDE.....	38
BENTYL.....	134	BLINCYTO.....	73
BENZAMYCIN.....	49	BLOOD.....	90, 91, 92, 93, 116, 152, 153, 157, 160
BENZEFOAM.....	179	BLOOD GLUCOSE.....	152, 153
BENZEPRO.....	179	BLOXIVERZ.....	84
BENZHYDROCODONE-ACETAMINOPHEN.....	20	BLU.....	152
BENZNIDAZOLE.....	60	BLUNT NEEDLE.....	156
benzonatate.....	115	BONIVA.....	193

## Index of Medications

BONJESTA.....	135	butalbital-asa-caffeine cap (Fiorinal).....	14
BOOSTRIX TDAP.....	89	butorphanol.....	22
BORTEZOMIB.....	70	BUTRANS.....	22
bosentan.....	98	BUTTERFLY.....	160
BOSULIF.....	70	BYDUREON.....	56
BOTOX.....	86	BYETTA.....	56
BRAFTOVI.....	67	BYNFEZIA.....	147
BREEZE.....	152	<b>C</b>	
bretylium tosylate.....	93	CABENUVA.....	78
BREVIBLOC.....	102	cabergoline.....	147
BREVITAL.....	26	CABLIVI.....	90
BREZTRI AEROSPHERE.....	36	CABOMETYX.....	70
BRILINTA.....	78	CADUET.....	104
brimonidine.....	124	CAFECIT.....	107
brimonidine tartrate.....	124	CAFERGOT.....	14, 18
BRINEURA.....	190	CAFFEINE AND SODIUM BENZOATE.....	107
brinzolamide.....	124	caffeine citrate.....	107
BRIUMVI.....	108	caffeine/sodium benzoate.....	107
BRIVIACT.....	109	CALAN SR.....	94
bromfenac sodium.....	123	calcipotriene.....	177, 183
bromocriptine mesylate.....	76, 77	CALCIPOTRIENE.....	177
brompheniramine/pseudoephed/dm.....	115	calcitonin, salmon, synthetic.....	149
BROMSITE.....	123	calcitriol.....	177, 197, 198
BRONCHITOL.....	184	calcium.....	34, 49, 80, 105, 129, 186, 189
BRUKINSA.....	70	CALCIUM.....	94, 95, 96, 98, 100, 103, 104, 129, 187, 190, 192
BRYHALI.....	181	calcium acetate.....	129
BSP 0820.....	144	calcium chloride.....	129
BSS PLUS.....	123	CALCIUM DISODIUM VERSENATE.....	190
budesonide.....	36, 141, 144, 145	calcium gluconate.....	129
BUFFERED LIDOCAINE.....	27	CALDOLOR.....	33
BULLSEYE.....	160	CALQUENCE.....	70
bumetanide.....	120	CAMPTOSAR.....	68
BUNAVAIL.....	195	CAMZYOS.....	94
bupivacaine.....	27, 29, 30	CANCIDAS.....	54
BUPIVACAINE HCL.....	27	candesartan cilexetil.....	101
buprenorphine.....	22, 195	candesartan/hydrochlorothiazid.....	100
bupropion.....	165, 166	CAPASTAT SULFATE.....	40
bupirone.....	165	capecitabine.....	65, 67
busulfan.....	64	CAPEX.....	181
butalb-acetamin-caff.....	18	CAPLYTA.....	171
butalb-acetamin-caff 50-300-40.....	14	CAPRELSA.....	70
butalb-acetamin-caff 50-325-40.....	14	captopril.....	99, 100
butalb/acetaminophen/caffeine.....	14, 18	captopril-hctz 25-15 mg tablet.....	99
butalb-aspirin-caffe.....	18	captopril-hctz 25-25 mg tablet.....	99
butalb-aspirin-caffe 50-325-40.....	14	captopril-hctz 50-15 mg tablet.....	99
butalbit/acetamin/caff/codeine.....	26	captopril-hctz 50-25 mg tablet.....	99
butalbital/acetaminophen.....	14, 18	CARAFATE.....	136
butalbital-asa-caffeine cap.....	18	carbachol.....	124
		CARBAGLU.....	188

## Index of Medications

carbamazepine .....	109, 111	CEFOTETAN DEXTROSE.....	42
CARBATROL.....	109	cefoxitin sodium .....	42
carbidopa .....	76, 77	cefoxitin sodium/dextrose, iso .....	42
carbidopa/levodopa .....	76	cefpodoxime .....	42
carbinoxamine.....	55	cefprozil.....	42
CARBOCAINE.....	27, 28	ceftazidime .....	42
carboplatin.....	64	ceftriaxone .....	42
carboprost.....	146	CEFTRIAXONE .....	42
CARBOPROST .....	146	ceftriaxone in is-osm dextrose .....	42
CARDENE I.V.....	94	cefuroxime .....	42
CARDIOPLEGIA DEL NIDO FORMULA.....	96	CELEBREX .....	34
CARDIOPLEGIA HIGH POTASSIUM .....	96	celecoxib .....	34, 35
CARDIOPLEGIA IND.....	96	CELESTONE.....	144
CARDIOPLEGIA INDUCTION .....	96	CELLCEPT.....	150
CARDIOPLEGIA MAINTENANCE .....	96	CELLUGEL.....	126
CARDIOPLEGIA REPERFUSATE .....	96	CELONTIN .....	109
cardioplegic solution no.1 .....	96	CENTANY.....	49
CARDIZEM LA.....	94	cephalexin.....	41, 42
CARDURA .....	99	CEPROTIN .....	91
CAREFINE.....	156	CEQUA.....	126
CAREONE.....	152, 160	CEQR SIMPLICITY.....	152
CAREPOINT.....	156	CERDELGA .....	190
CARESENS .....	152	CEREBYX.....	109
CARETOUCH .....	152, 156, 158, 160, 178	CERETEC .....	117
carisoprodol .....	26, 163	CEREZYME.....	191
carisoprodol/aspirin/codeine .....	26	CERVIDIL.....	146
carmustine.....	64	cetirizine.....	55
CAROSPIR.....	121	CETROTIDE.....	146
carteolol.....	124	CETYLEV .....	189
carvedilol.....	99	cevimeline.....	87
CASODEX.....	65	CHEMET.....	191
caspofungin .....	54	CHEMSTRIP .....	152
CATAPRES .....	101	CHENODAL .....	137
CATHFLO ACTIVASE.....	92	CHIRHOSTIM .....	119
CAYA CONTOURED .....	115	chloramphenicol sod succinate.....	43
CAYSTON .....	41	chlordiazepoxide.....	134, 164, 168
cefaclor.....	42	chlordiazepoxide/clidinium br .....	134
cefadroxil.....	41	chlorhexidine gluconate .....	187
cefazolin .....	41	chlorprocaine .....	28, 29
CEFAZOLIN.....	41	chloroquine ph.....	60
CEFAZOLIN SODIUM.....	41	chlorothiazide sodium .....	122
cefditoren .....	42	chlorpromazine.....	174
cefepime .....	42, 43	chlorpropamide .....	57
CEFEPIME-DEXTROSE .....	42	chlorthalidone .....	103, 122
CEFEPIME HCL.....	42	chlorzoxazone .....	163
cefixime.....	42	CHOLBAM .....	138
CEFOTAN.....	42	cholestyramine.....	105
cefotetan.....	42	CHOLETEC.....	116

## Index of Medications

choline salicyl/mag salicylate .....	14, 18	CLEVIPREX.....	94
CHORIONIC.....	148	CLICKFINE.....	156
CHORIONIC GONAD.....	148	CLIMARA.....	143
chromic chloride.....	131	CLINDACIN ETZ KIT.....	49
CIBINQO.....	179	CLINDACIN PAC.....	49
ciclodan.....	54	clindamycin.....	43, 48, 49, 177, 206
CICLODAN.....	54, 61	CLINDAMYCIN-0.9% NACL.....	43
ciclopirox.....	54, 55, 61	CLINIMIX.....	128
cidofovir.....	81	CLINISOL.....	128
cilostazol.....	78	CLINOLIPID.....	139
CIMDUO.....	79	CLINPRO 5000.....	127
cimetidine.....	138	CLIN SINGLE USE.....	43
CIMZIA.....	61	clobazam.....	108, 109
cinacalcet.....	187	clobetasol.....	181, 182
CINQAIR.....	37	CLOCORTOLONE PIVALATE.....	181
CINRYZE.....	186	clodan.....	181
CINVANTI.....	135	CLODAN.....	181
CIPRO.....	37, 46	CLODERM.....	181
ciprofloxacin.....	37, 46, 47	clofarabine.....	66
CIPROFLOXACIN HCL-FLUOCINOLONE.....	37	CLOLAR.....	66
CIPRO HC.....	37	clomiphene.....	148
cisatracurium.....	86	clomipramine.....	168
cisplatin.....	64	clonazepam.....	108, 109
CISPLATIN.....	64	clonidine.....	18, 101, 102, 169
citalopram.....	166	clopidogrel.....	78
CITANEST FORTE DENTAL.....	28	clorazepate dipotassium.....	164, 165
CITANEST PLAIN DENTAL.....	28	CLOROTEKAL.....	28
CITRANATAL 90 DHA.....	164	clotrimazole.....	53, 54
CITRANATAL ASSURE.....	164	clozapine.....	171
CITRANATAL BLOOM.....	130	CLOZAPINE ODT.....	171
CITRANATAL DHA.....	164	COAGADEX.....	91
CITRANATAL HARMONY.....	164	COAGUCHEK.....	160
CITRANATAL MEDLEY.....	197	COARTEM.....	60
CITRANATAL RX.....	164	codeine.....	20, 22, 26, 115
CITRATE PHOSPHATE DEXTROSE.....	50	colchicine.....	32, 35
cladribine.....	66	COLCHICINE.....	32
CLAFORAN.....	42	COLCRYS.....	32
CLARAVIS.....	177	colesevelam.....	105
CLARINEX-D.....	55	COLESTID.....	105
clarithromycin.....	44	colestipol.....	105
clemastine.....	55	colistin.....	46
CLENPIQ.....	139	COLOR LANCETS.....	160
CLEOCIN.....	43, 49	COLY-MYCIN M PARENTERAL.....	46
CLEOCIN HCL.....	43	COMBIGAN.....	124
CLEOCIN PEDIATRIC.....	43	COMBIPATCH.....	143
cleocin phos.....	43	COMBIVENT RESPIMAT.....	36
CLEOCIN PHOS.....	43	COMETRIQ.....	70
CLEVER CHEK.....	160	COMFORT.....	155, 156, 157, 158, 159, 160
CLEVER CHOICE.....	152		

## Index of Medications

COMFORT EZ .....	156	CYLTEZO .....	61
COMIRNATY.....	87	cyproheptadine.....	55
COMPAZINE.....	135	CYRAMZA.....	68
COMPLERA.....	80	CYSTADANE.....	193
COMTAN.....	76	CYSTADROPS.....	126
CONRAY.....	120	CYSTAGON.....	196
CONRAY-43.....	120	CYSTARAN.....	126
CONTOUR.....	152	CYSTO-CONRAY II.....	120
CONTROL SOLUTION .....	151, 152	CYSTOGRAFIN.....	120
COOL CONTROL.....	152	CYSVIEW.....	118
COPIKTRA.....	70	cytarabine.....	66
COREG.....	99	CYTOMEL.....	184
coremino er.....	47	CYTOTEC.....	136
CORIFACT.....	91	CYTOVENE.....	81
CORLANOR.....	96	<b>D</b>	
CORLOPAM.....	102	dabigatran.....	52
CORTEF.....	144, 145	dacarbazine.....	73
CORTENEMA.....	141	DACOGEN.....	66
cortisone acetate.....	144	dactinomycin.....	62
CORTISPORIN.....	37, 49	dalfampridine.....	108
CORTISPORIN-TC.....	37	DALIRESP.....	37
CORVERT.....	93	DALVANCE.....	44
COSENTYX.....	176	danazol.....	147
COSMEGEN.....	62	DANTRIUM.....	163
cosyntropin.....	141	dantrolene.....	163
COTELLIC.....	68	dapsone.....	40, 177
CRESEMBA.....	53	DAPTACEL DTAP.....	89
CRINONE.....	147, 148	daptomycin.....	49
cromolyn.....	31, 36, 124	DAPTOMYCIN.....	49
crotamiton.....	75	DARAPRIM.....	60
CUBICIN.....	49	darifenacin er.....	196
cupric chloride.....	131	darunavir.....	79
CURITY.....	178	DARZALEX.....	65
CUROSURF.....	185	DATSCAN.....	118
CUVPOSA.....	134	daunorubicin.....	62
cyanocobalamin.....	197	DAURISMO.....	67
CYANOKIT.....	189	DAXBIA.....	41
cyclobenzaprine.....	163	DAXXIFY.....	86
CYCLOGYL.....	125	DAYPRO.....	33
CYCLOMYDRIL.....	125	DAYTRANA.....	169
cyclopentolate.....	125	DAYVIGO.....	175
cyclophosphamide.....	64	decitabine.....	66
CYCLOPHOSPHAMIDE.....	64	DEFENCATH.....	189
cycloserine.....	40	deferasirox.....	191, 192
CYCLOSERINE.....	40	deferiprone.....	191
CYCLOSET.....	56	deferoxamine.....	191
cyclosporine.....	150	DEFINITY.....	116
CYKLOKAPRON.....	91	DEFITELIO.....	92

## Index of Medications

deflazacort .....	144	dextrose.....	27, 29, 37, 41, 42, 45, 46, 47, 53, 85, 93, 96, 97, 128
DELFLEX .....	133	DIACOMIT .....	109
DELSTRIGO .....	80	DIANEAL.....	133
demeclocycline.....	47	DIASTAT .....	108
DEMEROL .....	22	diatrizoate meglumine, sodium .....	120
DEMSER.....	101	DIATRUE .....	152
DEPEN.....	31	diazepam .....	108, 109, 164, 165
DEPO-ESTRADIOL .....	143	diazoxide.....	127
DEPO-MEDROL .....	144	DIBENZYLIN.....	85
DEPO-PROVERA .....	113, 147	dichlorphenamide .....	188
DEPO-SUBQ PROVERA 104.....	113	DICLAREAL .....	176
DEPO-TESTOSTERONE.....	142	DICLEGIS.....	135
DERMA-SMOOTHIE-FS .....	181	diclofenac.....	19, 33, 123, 176
DERMATOP .....	181	dicloxacillin .....	45
dermazene .....	183	dicyclomine.....	134
DERMAZENE.....	183	DIFICID.....	44
DERMOTIC .....	122	diflunisal .....	14, 18
DERMULCERA.....	195	DIGIFAB .....	189
DESCOVY .....	79	digoxin .....	96
DESFERAL MESYLATE .....	191	dihydroergotamine.....	14, 18
desflurane .....	26	DILANTIN.....	110
desipramine .....	168	DILATRATE-SR .....	96
desloratadine .....	55, 56	DILAUDID .....	22
desmopressin.....	142	diltiazem .....	94, 95
desog-e.estradiol/e.estradiol .....	113	DILTIAZEM HCL .....	95
desogestrel-ethinyl estradiol .....	113	diluent for epoprostenol .....	189
desonide.....	181	DILUENT FOR REMODULIN.....	189
DESOWEN.....	181	diluent for treprostinil.....	189
desoximetasone.....	181, 182	dimenhydrinate .....	135
desvenlafaxine succnt er.....	167	dimethyl fumarate.....	108
dexamethasone .....	38, 123, 144	dimethyl sulfoxide .....	189
DEXAMETHASONE .....	144	diphenhydramine .....	55
DEXCOM .....	152	diphenoxylate hcl/atropine.....	134
DEXCOM G4.....	152	DIPHThERIA-TETANUS TOXOIDS-PED.....	90
DEXCOM G5.....	152	DIPRIVAN.....	26
DEXCOM G5-G4 .....	152	DIPROLENE .....	181
DEXCOM G6.....	152	dipyridamole.....	77, 78, 117
dexlansoprazole.....	140	DISALCID .....	31
dexmedetomidine .....	175	DISCOVISC .....	126
dexmedetomidine hcl.....	175	disulfram.....	189
DEXMEDETOMIDINE HCL .....	175	DIURIL.....	122
dexmethylphenidate .....	169	divalproex.....	110
dexmethylphenidate er .....	169	DIVIGEL .....	143
dexrazoxane .....	186	DMSA .....	118
dextroamp-amphet er.....	84	dobutamine .....	96
dextroamph .....	85	DOCEFREZ.....	73
dextroamphetamine.....	84, 85	docetaxel.....	73, 74
dextroamphetamine er.....	85	dofetilide.....	93, 94



## Index of Medications

DOJOLVI.....	127	EASYMAX.....	153
donepezil.....	84	EASY MINI EJECT.....	152
DONNATAL.....	137	EASY PLUS II.....	152
dopamine hcl.....	85	EASYPOINT.....	156
dopamine hcl in dextrose.....	85	EASY STEP.....	152
DOPRAM.....	107	EASY TALK.....	152
DOPTelet.....	113	EASY TOUCH.....	153, 156, 158
DORAL.....	175	EASY TRAK.....	153
dorzolamide.....	124, 125	ECLIPSE.....	156, 158
DOTAREM.....	117	ECLIPSE NEEDLE.....	156
DOVATO.....	78	EC-NAPROSYN.....	33
doxapram.....	107	econazole.....	54
doxazosin.....	99	ECOZA.....	54
doxepin.....	168, 175	EDURANT.....	79
doxercalciferol.....	187	efavirenz.....	79, 80
DOXIL.....	62	effer-k.....	132
doxorubicin.....	62	EFFER-K.....	131
doxycycline.....	47, 187	EFFIENT.....	78
doxylamine succinate/vit b6.....	135	EFUDEX.....	75
DRAXIMAGE DTPA.....	118	ELAPRASE.....	191
DRISDOL.....	198	electrolyte-48 solution/d5w.....	129
dronabinol.....	135	ELELYSO.....	191
droperidol.....	173	ELEMENT.....	153
DROPLET.....	152, 156, 158, 160	ELESTRIN.....	143
DROPSAFE.....	156, 157, 158, 178	eletriptan.....	18
drosipir/eth estra/levomefol ca.....	113	eletriptan hydrobromide.....	14
DROXIA.....	91	ELFABRIO.....	190
droxidopa.....	85	ELIDEL.....	150
DRYSOL.....	177	ELIGARD.....	69
DUAVEE.....	144	ELIMITE.....	75
DUETACT.....	58	ELIQUIS.....	50
DULERA.....	36	ELITEK.....	32
duloxetine.....	167	ELLA.....	113
DUODOTE.....	189	ELLENCE.....	62
DUOPA.....	76	ELLIOTTS B.....	189
DUOVISC.....	126	ELMIRON.....	26
DUPIXENT.....	149	EMBRACE.....	153, 156, 160
DURACLON.....	18	EMCYT.....	74
DURAGESIC.....	22	EMEND.....	135
DUROLANE.....	31	EMFLAZA.....	145
DURYSTA.....	125	EMGALITY.....	14, 18, 108
dutasteride.....	195, 196	emollient combination.....	178
DYAZIDE.....	121	Empaveli.....	91
DYSPORT.....	86	EMPLICITI.....	67
<b>E</b>		EMSAM.....	165
EASY.....	152, 153, 156, 158, 160, 178	emtricitabine.....	79
EASY COMFORT.....	156, 158	emtricitabine-tenofv.....	79
EASY GLIDE.....	156, 158	EMTRIVA.....	79
EASYGLUCO.....	153		

## Index of Medications

EMVERM .....	60	ergotamine tartrate/caffeine.....	14, 18, 19
enalapril .....	99, 100	ERIVEDGE .....	67
enalaprilat.....	100	ERLEADA .....	65
enalapril/hydrochlorothiazide.....	99	erlotinib.....	70
ENBREL.....	61	ertapenem .....	41
ENDO-AVITENE.....	92	ERWINAZE.....	73
ENDOMETRIN .....	148	ERYPED.....	44
ENGERIX-B ADULT.....	90	ERY-TAB.....	44
ENGERIX-B PEDIATRIC-ADOLESCENT .....	90	ERYTHROCIN LACTOBIONATE.....	44
ENHERTU .....	73	erythromycin.....	38, 44, 49
ENLITE .....	153	erythromycin base.....	38, 44, 49
ENLITE GLUCOSE SENSOR .....	153	erythromycin/benzoyl peroxide .....	49
ENLITE SERTER.....	153	escitalopram .....	166
enoxaparin .....	51, 52	ESGIC .....	14
ENSPRYNG.....	149	esmolol .....	102
entacapone .....	76, 77	ESMOLOL HCL-WATER .....	102
entecavir.....	82	esomeprazole.....	140
ENTERO VU .....	118	esomeprazole dr .....	140
ENTOCORT EC .....	145	esomeprazole mag dr.....	140
ENTRESTO.....	100	estazolam.....	175
ENTYVIO.....	139, 210	ESTRACE .....	143, 148
ENVARUSUS XR.....	150	estradiol .....	113, 114, 115, 143, 144, 148
ENZOCLEAR.....	179	ESTRING.....	148
EOVIST.....	119	ESTROGEL.....	143
EPANED .....	100	estrogen, ester/me-testosterone .....	143
EPCLUSA.....	82	ESTROSTEP FE .....	113
ephedrine.....	97	eszopiclone .....	175
EPHEDRINE.....	97	ethacrynate sodium.....	120
EPIDIOLEX .....	109	ethambutol .....	40
EPIFOAM .....	182	ETHAMOLIN .....	106
epinastine .....	56	ethinyl estradiol/drospirenone.....	113, 114
epinephrine.....	27, 29, 30, 83, 85, 86, 122	ethosuximide .....	110, 112
EPINEPHRINE.....	29, 30, 83, 86	ethyl alcohol .....	107
EPINEPHRINESNAP-EMS.....	83	ethynodiol d-ethinyl estradiol .....	114
EPINEPHRINESNAP-V.....	83	ETHYOL.....	186
epirubicin .....	62, 63	etodolac .....	33, 34
EPIVIR HBV.....	82	etomidate.....	26
eplerenone.....	121	etonogestrel/ethinyl estradiol.....	113
EPOGEN .....	112	ETOPOPHOS.....	73
epoprostenol.....	98, 189	etoposide .....	73
eprosartan.....	101	EUCRISA .....	180
eptifibatide.....	78	EUFLEXXA .....	31
EPTIFIBATIDE.....	78	EURAX.....	75
EQUETRO .....	165	EVAMIST.....	143
ERAXIS.....	54	EVEKEO.....	85
ERBITUX.....	69	EVENCARE.....	153
ergocalciferol.....	198	EVENITY .....	193
ergoloid.....	103	everolimus.....	68, 150, 151

## Index of Medications

EVERSENSE.....	153	FEMARA.....	67, 69
EVICEL.....	92	FEMCAP.....	115
EVISTA.....	193	FEMHRT.....	143
EVKEEZA.....	104	FEMRING.....	148
EVOCLIN.....	49	fenofibrate.....	105, 106
EVOLUTION CONTROL.....	153	fenofibric.....	105, 106
EVOMELA.....	64	fenoprofen calcium.....	34
EVOTAZ.....	80	FENSOLVI.....	146
EVOXAC.....	87	fentanyl.....	21, 22, 23
EVRYSDI.....	190	FENTANYL.....	21, 22, 23, 211
EXEL.....	156	FENTORA.....	23
EXELON.....	84	FERAHEME.....	130
exemestane.....	67	FERRIPROX.....	191
EXJADE.....	191	FERRLECIT.....	130
EXKIVITY.....	70	FETROJA.....	43
EXODERM.....	54	FETZIMA.....	167
EXONDYS-51.....	190	FEXMID.....	163
EXPAREL.....	28	FIASP PENFILL.....	59
EXTRANEAL ICODEXTRIN DIALYSIS.....	133	FIBRICOR.....	105
EYLEA.....	126	FIBRYGA.....	91
EYSUVIS.....	123	FIFTY50.....	161
E-Z DISK.....	118	FILTER NEEDLE.....	156
ezetimibe.....	103, 105, 106	finasteride.....	195
ezetimibe/simvastatin.....	103	FINE 30.....	161
EZ FLU.....	88	FINGERSTIX.....	161
E-Z-HD.....	119	FINTEPLA.....	110
EZ-LETS.....	160	FIORICET.....	14
E-Z-PAQUE.....	119	FIORINAL.....	14, 18, 26
E-Z-PASTE.....	119	FIORINAL WITH CODEINE #3.....	26
EZ SMART.....	160	FIRDAPSE.....	108
EZ-VAC.....	153	FIRMAGON.....	70
<b>F</b>		FLAGYL.....	39
FABHALTA.....	91	FLAREX.....	123
FABRAZYME.....	190	flavoxate.....	196
FACTIVE.....	47	flecainide.....	93
famciclovir.....	81	FLEQSUVY.....	163
famotidine.....	138	FLOLAN.....	98, 189
FANAPT.....	171	FLOMAX.....	195
FARESTON.....	74	FLOW.....	157
FARXIGA.....	56	floxuridine.....	66
FARYDAK.....	63	FLUAD.....	88
FASENRA.....	36	FLUAD QUAD.....	88
FASLODEX.....	74	FLUARIX QUAD.....	88
fat emulsions.....	139	FLUBLOK.....	89
febuxostat.....	33	FLUCELVAX QUAD.....	89
felbamate.....	110	fluconazole.....	53
FELDENE.....	34	flucytosine.....	53
felodipine.....	95	fludarabine.....	66

## Index of Medications

FLUDEOXYGLUCOSE F-18.....	120	FOSAMAX PLUS D.....	193
fludrocortisone.....	146	fosamprenavir calcium.....	80
FLULAVAL.....	89	fosaprepitant dimeglumine.....	135
FLUMADINE.....	81	foscarnet.....	81
flumazenil.....	189	FOSCAVIR.....	81
FLUMIST QUAD.....	89	fosfomycin tromethamine.....	39, 40
flunisolide.....	122	fosinopril.....	99, 101
fluocinolone acetonide.....	122, 181, 182	fosinopril/hydrochlorothiazide.....	99
fluocinolone/shower cap.....	181	fosphenytoin.....	109
fluocinonide.....	181, 182	FOSRENOL.....	129
fluorescein sodium.....	118	Fotivda.....	70
fluoride.....	127	FRAGMIN.....	51
FLUORIDEX.....	127	FREESTYLE.....	153, 158, 161
fluorometholone.....	123	FREESTYLE LIBRE.....	153
FLUOROPLEX.....	75	FREESTYLE NAVIGATOR.....	153
fluorouracil.....	66, 75	frovatriptan.....	19
FLUOROURACIL.....	75	ful-glo 1 mg oph strip.....	118
fluoxetine.....	166, 167, 174	FUL-GLO EYE STRIPS.....	118
fluphenazine.....	174	FULPHILA.....	112
flurazepam.....	175	fulvestrant.....	74
flurbiprofen.....	34, 123	FURADANTIN.....	45
flutamide.....	65	FUROSCIX.....	120
fluticasone.....	36, 122, 182	furosemide.....	120
FLUTICASONE.....	36	FUROSEMIDE.....	120
fluticasone prop.....	122, 182	FUZEON.....	79
FLUTICASONE PROP.....	36	FYCOMPA.....	110
fluticasone propion/salmeterol.....	36	<b>G</b>	
fluvastatin.....	104	GA 68 DOTATOC.....	120
FLUVIRIN.....	89	gabapentin.....	110
fluvoxamine.....	166	GABITRIL.....	110
fluvoxamine er.....	166	GABLOFEN.....	163
FLUZONE HIGH-DOSE.....	89	GADAVIST.....	118
FLUZONE INTRADERM QUAD.....	89	gadobutrol.....	118
FLUZONE QUAD.....	89	gadoterate meglumine.....	117
FOCALIN.....	169	GALAFOLD.....	192
FOLET ONE.....	197	galantamine.....	84
folic acid.....	197	galantamine er.....	84
FOLLISTIM AQ.....	148	GALZIN.....	191
FOLOTYN.....	66	GAMIFANT.....	149
fomepizole.....	189	ganciclovir.....	81
fondaparinux.....	50, 51	ganirelix acet.....	146
FORA.....	153, 161	GANIRELIX ACET.....	146
FORACARE.....	153, 161	GARDASIL 9.....	90
FORA CONTROL.....	153	GASTROCROM.....	31
formaldehyde.....	61	GASTROGRAFIN.....	120
FORTAZ.....	42	GASTROMARK.....	119
FORTISCARE.....	153	gatifloxacin.....	38
FOSAMAX.....	193	GATTEX.....	141

## Index of Medications

GAVRETO.....	70	glycopyrrolate.....	134
GAZYVA.....	63	GLYCOPYRROLATE-WATER.....	134
GE100.....	153	GLYNASE.....	57
GE333.....	153	GLYSET.....	57
gefitinib.....	70	GLYXAMBI.....	57
gelatin sponge, absorb/porcine.....	92	GOJJI.....	153, 161
GELFILM.....	124, 192	GONAL-F.....	148
GELFOAM.....	92	GONAL-F RFF.....	148
GEL-ONE.....	32	GONAL-F RFF REDI-JECT.....	148
GELSYN-3.....	32	GORDON'S UREA.....	180
gemcitabine.....	66	granisetron.....	135
GEMCITABINE.....	66	GRANIX.....	112
gemfibrozil.....	105	GRASTEK.....	87
GENOTROPIN.....	145	griseofulvin.....	54
gentamicin.....	38, 39, 49	GRIS-PEG.....	54
GENTAMICIN SULFATE IN NS.....	39	GUAIACOL.....	178
GENTEEL.....	152, 153	guanfacine.....	102, 169
GENVISC 850.....	32	guanidine.....	87
GENVOYA.....	81	GUARDIAN.....	153, 154
GEODON.....	171	GYNAZOLE 1.....	53
GIAPREZA.....	147	<b>H</b>	
GILOTRIF.....	70	HADLIMA.....	61
GIVLAARI.....	189	HAEGARDA.....	186
GLASSIA.....	185	HALAVEN.....	68
glatiramer.....	108	HALCION.....	175
glatiramer acetate.....	108	HALDOL.....	173
glatopa.....	108	halobetasol.....	182
GLEEVEC.....	70	haloperidol.....	173, 174
GLEOSTINE.....	64	HALUCORT.....	178
GLIADEL.....	64	HARVONI.....	82
glimepiride.....	57, 58	HEALON.....	126
glipizide.....	57, 58	HEALONS.....	126
GLIPIZIDE.....	57	HEALTHPRO.....	154
GLUCAGEN.....	118	HEALTHWISE.....	157, 158
glucagon.....	127	HEALTHY ACCENTS.....	154, 157, 161
GLUCAGON.....	75, 118, 127, 141	HEMABATE.....	146
GLUCAGON HCL.....	118	HEMLIBRA.....	91
GLUCOCARD.....	153	heparin.....	51, 52
GLUCOCOM.....	153, 161	HEPARIN.....	50, 51, 52
GLUCOCOM AUTOLINK.....	153	HEPARIN SOD.....	51
GLUCOPHAGE XR.....	57	HEPARIN SODIUM.....	52
GLUCOSE.....	128, 151, 152, 153	HEPATAMINE.....	128
GLUCOSE IN WATER.....	128	HEPLISAV-B.....	90
GLUCOTROL.....	57	HERCEPTIN.....	69
glyburide.....	57, 58	HERZUMA.....	69
GLYCATE.....	134	HETLIOZ.....	175
glycine urologic solution.....	61	HIBERIX.....	90
GLYCOPHOS.....	131	HIPREX.....	39

## Index of Medications

HISTATROL.....	119	HYSINGLA ER.....	24
homatropine.....	116, 125	I	
HUMALOG.....	59, 154	ibandronate.....	193
HUMAPEN LUXURA HD.....	154	IBRANCE.....	62, 70
HUMIRA.....	61, 62	IBUDONE.....	20
HUMULIN R U-500.....	59	ibuprofen.....	20, 34, 103
HYALGAN.....	32	ibuprofen/oxycodone.....	20
hyaluronate.....	126	ibutilide.....	93
HYCAMTIN.....	68	icatibant acetate.....	186
HYCODAN.....	116	icosapent.....	133
hydralazine.....	102	IDAMYCIN PFS.....	63
HYDREA.....	64	idarubicin.....	63
HYDRO 35.....	179	IDHIFA.....	72
HYDRO 40.....	179	IFEX.....	64
hydrochlorothiazide.....	99, 100, 102, 103, 121, 122	ifosfamide.....	64
hydrocodone.....	20, 23, 24, 26, 115, 116	ILARIS.....	194
hydrocodone/acetaminophen.....	20	ILEVRO.....	123
HYDROCODONE-ACETAMINOPHEN.....	20	ILUMYA.....	176
HYDROCODONE-GUAIFENESIN.....	116	ILUVIEN.....	123
HYDROCODONE-HOMATROPINE.....	116	imatinib.....	70
hydrocodone/ibuprofen.....	20	imatinib mesylate.....	70
hydrocortisone.....	122, 141, 144, 145, 182, 183	IMBRUVICA.....	70
hydrocortisone/acetic acid.....	122	IMFINZI.....	74
hydrocortisone/lidocaine/aloe.....	141	imipenem/cilastatin sodium.....	41
hydrocortisone/pramoxine (Analpram Hc).....	141	imipramine.....	168
hydrogen peroxide.....	176	imiquimod.....	178
hydromorphone.....	22, 24	IMJUDO.....	74
HYDROMORPHONE.....	23, 24	IMLYGIC.....	67
HYDROMORPH-ROPIVA.....	24	IMMPHENTIV.....	97
hydroxocobalamin.....	197	IMPAVIDO.....	60
hydroxychloroquine.....	60	IMURAN.....	150
hydroxyprogesterone.....	147, 149	IMVEXXY.....	147, 148
HYDROXYPROPYLCELLULOSE.....	192	INBRIJA.....	76
hydroxyurea.....	64	INCONTROL.....	154, 157, 161, 178
hydroxyzine.....	55	INCONTROL LANCING.....	154
HYFTOR.....	180	INCRUSE ELLIPTA.....	35
HYLENEX.....	194	indapamide.....	122
HYMOVIS.....	32	INDICLOR.....	120
hyoscyamine.....	137	indigotindisulfonate sodium.....	120
HYOSCYAMINE SULFATE.....	137	INDIUM IN-111 DTPA.....	117
HYPERRHO S-D.....	87	INDIUM IN-111 OXYQUINOLINE.....	119
HYPEN-SAL.....	190	indocyanine green.....	116
HYPODERMIC NEEDLE.....	157	indomethacin.....	34, 103
HYPOLANCE.....	154	INFANRIX DTAP.....	90
hypromellose.....	126	INFASURF.....	185
HYPROMELLOSE.....	193	INFED.....	130
HYRIMOZ.....	62	INFINITY.....	154
		INFLECTRA.....	62

## Index of Medications

INFUGEM.....	66	ISENTRESS HD.....	80
INFUMORPH.....	24	isoflurane.....	26
INFUVITE ADULT.....	197	ISOLYTE P WITH DEXTROSE.....	129
INFUVITE PEDIATRIC.....	197	ISOLYTE S.....	129
INGREZZA.....	107	isomethept/dichlphn/acetaminop.....	19
INJECTAFER.....	130	isomethepten/caf/acetaminophen.....	19
INJECT EASE.....	161	isoniazid.....	40
INLYTA.....	70	isoproterenol.....	86
INNOPRAN XL.....	102	ISOPTO CARPINE.....	125
INOVA.....	179	isosorbide.....	96, 103, 215
INPEN.....	154	isosulfan blue.....	118
INQOVI.....	66	isotretinoin.....	177
INREBIC.....	70	ISOVUE-200.....	117
INSPRA.....	121	ISOVUE-250.....	117
INSUL-CAP.....	154	ISOVUE-300.....	117
INSUL-EZE.....	154	ISOVUE-370.....	117
INSULIN.....	56, 57, 58, 157, 158, 159, 187	ISOVUE-M 200.....	117
INSULIN SYRINGE.....	158, 159	ISOVUE-M 300.....	117
INSUPEN.....	157	isoxsuprine.....	103
INTEGRA.....	157	isradipine.....	95
INTEGRILIN.....	78	ISTODAX.....	63
INTRALIPID.....	139	ISUPREL.....	86
INTRAROSA.....	141	itraconazole.....	53
INTUNIV.....	169	ivermectin.....	60, 75, 180
INVACARE.....	161	IWILFIN.....	70
INVANZ.....	41	IXCHIQ.....	90
INVEGA ER.....	171	IXEMPRA.....	67
INVEGA SUSTENNA.....	171	<b>J</b>	
INVEGA TRINZA.....	171	JADENU.....	191, 192
INVELTYS.....	123	JAKAFI.....	67
INVIRASE.....	80	JANSSEN COVID-19 VACCINE.....	196
iodine/potassium iodide.....	183	JANUMET.....	58
iodine/sodium iodide.....	183	JANUVIA.....	57
IODOFLEX.....	183	JARDIANCE.....	56
IODOPEN.....	130	javygtor.....	192
IODOSORB.....	183	J EVTANA.....	73
IONOSOL B WITH DEXTROSE.....	129	JOENJA.....	185
IONOSOL MB-DEXTROSE.....	129	JULUCA.....	78
IOPIDINE.....	125	JYLAMVO.....	66
IPOL.....	88	JYNARQUE.....	121
ipratropium/albuterol sulfate.....	36	JYNNEOS.....	90
ipratropium bromide.....	35, 122	<b>K</b>	
irbesartan.....	100, 101	KABIVEN.....	129
irbesartan/hydrochlorothiazide.....	100	KADCYLA.....	73
IRESSA.....	70	KADIAN.....	24
irinotecan.....	68	KALBITOR.....	186
iron dextran complex.....	130	KALYDECO.....	185
ISENTRESS.....	80	KANJINTI.....	69

## Index of Medications

KANUMA.....	191	lamivudine.....	79, 80, 82
KCENTRA.....	91	lamivudine/zidovudine.....	79
KEFLEX.....	42	lamotrigine.....	110
KENALOG-10.....	145	LAMPIT.....	60
KENALOG-40.....	145	LAMZEDE.....	190
KENALOG-80.....	145	lancets.....	161
KENDALL.....	132	LANCETS.....	154, 160, 161
KEPIVANCE.....	141	LANCING.....	151, 152, 153, 154
KEPPRA.....	110	LANOXIN.....	96
KERAFOAM.....	179	lansoprazole/amoxiciln/clarith.....	136
keralyt.....	179	lansoprazole dr.....	140
KERALYT.....	179	lansoprazole odt.....	140
KERENDIA.....	121	lanthanum.....	129
KESIMPTA PEN.....	108	LANZO.....	154
KETALAR.....	27	lapatinib ditosylate.....	71
ketamine.....	27	latanoprost.....	125
KETAMINE.....	27	LAZANDA.....	24
ketoconazole.....	53, 55	leflunomide.....	31
ketoprofen.....	34	LEMTRADA.....	108
ketorolac.....	19, 20, 123	lenalidomide.....	69
KEVZARA.....	149	LENVIMA.....	71
KEYTRUDA.....	72	LETAIRIS.....	98
KHAPZORY.....	186	letrozole.....	67
KINEVAC.....	138	leucovorin calcium.....	186
KINRIX.....	90	LEUKERAN.....	64
KISQALI.....	69, 70, 71	LEUKINE.....	112
KISQALI FEMARA CO-PACK.....	69	leuprolide.....	69
KITABIS PAK.....	39	LEUPROLIDE DEPOT.....	69
KLARON.....	177	levabuterol.....	36
KLONOPIN.....	109	LEVBID.....	137
klor-con.....	132	levetiracetam.....	110
Kloxxado.....	52	levobunolol.....	125
KOSELUGO.....	68	levocarnitine.....	193
K-PHOS NO.2.....	133	levocetirizine.....	56
K-PHOS ORIGINAL.....	133	levofloxacin.....	38, 47
KRINTAFEL.....	60	LEVOPHED.....	86
KRYSTEXXA.....	32	levothyroxine.....	184
KYLEENA.....	115	LEVOTHYROXINE.....	184
KYNAMRO.....	104	LEVSIN.....	137
KYNMOBI.....	76	LEVULAN.....	75
KYPROLIS.....	71	LEXISCAN.....	117
<b>L</b>		LEXIVA.....	80
labetalol.....	99	LIALDA.....	138
LABETALOL.....	99	LIBTAYO.....	72
lacosamide.....	110	lidocaine.....	28, 29, 30, 31, 93, 118, 132, 141, 182, 214, 216
LACRISERT.....	122	LIDOCAINE.....	27, 28, 29, 132, 141
lactulose.....	134, 139	LIDODERM.....	31
LAGEVRIO.....	82, 83	LIFESHIELD.....	157



## Index of Medications

LIKMEZ.....	39	lovastatin.....	104
LILETTA.....	115	LOVAZA.....	133
LINCOCIN.....	43	LOVENOX.....	52
lincomycin.....	43	loxapine.....	173
lindane.....	183	lubiprostone.....	139
linezolid.....	45	LUCEMYRA.....	195
LINZESS.....	139	LUCENTIS.....	126
LIORESAL INTRATHECAL.....	163	LUER-LOK.....	159
liothyronine.....	184	LULICONAZOLE.....	55
LIPIODOL.....	118	LUMAKRAS.....	67
LIPOFEN.....	105	LUMASON.....	118
LIQUID E-Z PAQUE.....	119	LUMOXITI.....	72
LIQUID POLIBAR PLUS.....	119	LUMRYZ.....	174
lisdexamfetamine.....	168	LUNSUMIO.....	63
lisinopril.....	99, 101	LUPANETA PACK.....	146
lisinopril/hydrochlorothiazide.....	99	LUPKYNIS.....	150
lissamine green.....	118	LUPRON DEPOT.....	69, 146
LITE TOUCH.....	154, 157, 159, 161	lurasidone.....	171
LITETOUCH.....	159	LUTATHERA.....	186
LITFULO.....	33	LUXIQ.....	182
lithium.....	165	LYMPHAZURIN.....	118
LITHOSTAT.....	134	LYNPARZA.....	71
LIVTENCITY.....	81	LYRICA.....	110
L-MESITRAN.....	180	LYSODREN.....	73
l-norgest/e.estradiol-e.estrad.....	114	LYSTEDA.....	91
LOCORT.....	145	LYTGOBI.....	71
LODINE.....	34	LYUMJEV.....	59
LOESTRIN.....	114	<b>M</b>	
LOKELMA.....	130	MACROBID.....	45
LO LOESTRIN FE.....	114	MACRODANTIN.....	45
LOMOTIL.....	134	mafenide acetate.....	50
LONHALA MAGNAIR REFILL.....	35	MAGELLAN.....	159
LONHALA MAGNAIR STARTER.....	35	magnesium chloride.....	131
LONSURF.....	66	MAGNESIUM-LACTATED RINGERS.....	131
loperamide.....	134	magnesium sulfate.....	131
LOPID.....	105	MAGNESIUM SULFATE.....	131
lopinavir/ritonavir.....	80	magnesium sulfate in water.....	131
LOPROX.....	55	MAGNEVIST.....	117
LOQTORZI.....	72	MAGNI-GUIDE.....	154
lorazepam.....	165, 175	MAKENA.....	149
LORAZEPAM.....	175	MALARONE.....	60
LORBRENA.....	71	malathion.....	183
LORTAB.....	20	manganese.....	131
losartan/hydrochlorothiazide.....	100	manganese chloride.....	131
losartan potassium.....	101	mannitol.....	121, 194
LOSEASONIQUE.....	114	maprotiline.....	168
LOTEMAX.....	123	maraviroc.....	79
loteprednol.....	123	MARCAINE.....	29

## Index of Medications

MARGENZA .....	69	metaxalone .....	163
MARPLAN .....	165	metformin .....	57, 58
MARQIBO .....	69	METHADONE HCL .....	24
MATULANE .....	73	methamphetamine .....	85
MAVENCLAD .....	108	methazolamide .....	120
MAXI-COMFORT .....	159	methenamine .....	39, 40
MAXICOMFORT .....	157, 159	methenam/m.blue/salicyl/hyoscy .....	40
MAXIPIME .....	43	methenam/sod phos/mblue/hyoscy .....	40
MAXZIDE .....	121	methen/mblue/sal/sod phos/hyos .....	40
MAYZENT .....	108	methimazole .....	183
meclofenamate sodium .....	34	METHITEST .....	142
MEDIHONEY .....	180	meth/meblue/sod phos/psal/hyos .....	39
MEDISENSE .....	154, 161	methocarbamol .....	163
MEDLANCE .....	161	METHOHEXITAL .....	27
MEDROL .....	144, 145	methotrexate .....	66
MEDROLOAN II SUIK .....	145	methoxsalen .....	176
medroxyprogesterone .....	113, 147	methscopolamine .....	137
MEDTRONIC .....	154	methyl dopa .....	102
mefenamic .....	20	methyl dopate .....	102
mefloquine .....	60	methylene blue .....	188
megestrol .....	74, 196	methylergonovine .....	146
MEKINIST .....	68	METHYLIN .....	169
MEKTOVI .....	68	methylphenidate .....	169, 170
meloxicam .....	34	methylphenidate er .....	169, 170
melphalan .....	63, 64	methylprednisolone .....	145
memantine .....	106	methyl salicylate .....	179
MEMBRANEBLUE .....	126	methyltestosterone .....	142
MENACTRA .....	88	metoclopramide .....	139
MENEST .....	143	metolazone .....	122
MENOPUR .....	148	METOPIRONE .....	119
MENOSTAR .....	143	metoprolol .....	102, 103
MENQUADFI .....	88	metronid .....	136
MENVEO A-C-Y-W-135-DIP .....	88	metronidazole .....	39, 48, 180
mepерidine .....	24	metyrosine .....	101
MEPHYTON .....	198	mexiletine .....	93
mepivacaine .....	29	MEZPAROX-HC .....	182
meprobamate .....	165	MIACALCIN .....	149
MEPSEVII .....	191	micafungin .....	54
mercaptopurine .....	66	miconazole .....	53
meropenem .....	41	MICRHOGAM .....	87
MEROPENEM-0.9% NACL .....	41	MICRODOT .....	154, 157
MERREM .....	41	MICROGESTIN 24 FE .....	114
mesalamine .....	138	MICROLET .....	154, 161
mesna .....	186	MICROTAINER .....	160, 161
MESNEX .....	186	MICRO THIN .....	161
METADATE .....	169	midazolam .....	27
metaproterenol sulfate .....	35	MIDAZOLAM .....	27
METASTRON .....	187	MIDAZOLAM HCL .....	27

## Index of Medications

midodrine .....	85	mometasone furoate .....	122, 182
MIFEPREX .....	188	MONJUVI .....	67
mifepristone.....	188	MONOFERRIC .....	130
miglitol.....	57	MONOJECT .....	157, 159
miglustat.....	190	MONOJECT BLOOD COLLECTION .....	157
millipred.....	145	MONOLET .....	161
MILLIPRED.....	145	MONOVISC .....	32
milrinone lactate.....	96	MONSEL'S.....	92
milrinone lactate/d5w.....	96	montelukast sodium.....	36
MIMYX .....	178	MONUROL .....	40
MINASTRIN 24 FE.....	114	MORPHABOND ER.....	24
MINI.....	61, 152, 154, 155, 157	morphine .....	24, 25
MINI LANCING.....	154	MORPHINE .....	24, 25
MINILINK REAL-TIME TRANSMITTER .....	154	MOTOFEN .....	135
MINIMED.....	154, 159	MOVANTIK.....	52
MINIMED 630G GUARDIAN START KT .....	154	MOXATAG .....	45
MINIMED RESERVOIR.....	159	MOXEZA.....	38
MINIPRESS .....	99	moxifloxacin.....	38, 46, 47
MINITRAN .....	96	MOXIFLOXACIN .....	38, 47
MINIVELLE.....	143	MOXIFLOXACIN HCL-BSS .....	38
MINOCIN .....	47	MOXIFLOXACIN HCL-NACL.....	38
minocycline.....	47, 48	MOZOBIL .....	113
minocycline er.....	47	MS CONTIN.....	25
minoxidil .....	102	MULPLETA.....	113
MIOCHOL-E .....	125	MULTIHANCE.....	117
MIRAPEX ER.....	76	multitrace.....	131
MIRCERA .....	112	MULTITRACE.....	131
MIRCETTE .....	114	multivit infusn, adult 1, vit k .....	197
MIRENA .....	115	mupirocin.....	49
mirtazapine.....	164	MURI-LUBE MINERAL OIL.....	192
misoprostol .....	33, 136	MUTAMYCIN.....	63
MITIGARE .....	32	MVASI.....	63
MITIGO .....	24	M.V.I. PEDIATRIC.....	197
mitomycin.....	63	mv-mins no.73 .....	130
MITOSOL.....	126	mvn no.53/iron/folic/dss/dha .....	197
mitoxantrone .....	73	MYALEPT .....	149
MIVACRON .....	86	MYAMBUTOL.....	40
M-M-R II VACCINE.....	90	MYCAMINE.....	54
MOBIC .....	34	mycophenolate .....	150, 151
MOBILE.....	154, 161	MYDRIACYL.....	125
MOBILE LANCETS.....	154	Myfembree.....	146
modafinil.....	174	MYFORTIC .....	151
MODERNA .....	87, 196	MYGLUCOHEALTH .....	154, 161
MODERNA COVID-19 VACCINE .....	196	MYLERAN .....	64
moexipril.....	101	MYLOTARG .....	69
molindone.....	174	MYOBLOC .....	86
MOLNUPIRAVIR.....	83	MYORISAN .....	177
MOMETACURE.....	182	MYOVIEW.....	116
		MYTESI.....	134

## Index of Medications

### N

nabumetone .....	34	NEULUMEX .....	119
nadolol .....	102, 103	NEUPOGEN .....	112
nafcillin .....	45, 59	NEUPRO .....	76
nafcillin in dextrose, iso-osm .....	45	NEURONTIN .....	110
naftifine .....	55	nevirapine .....	79
NAFTIN .....	55	NEXAVAR .....	71
NAGLAZYME .....	191	NEXAVIR .....	192
nalbuphine .....	25	NEXIUM DR .....	140
NALFON .....	34	NEXPLANON .....	113
NALOCET .....	20	NEXTERONE .....	93
naloxone .....	25, 53, 195	NGENLA .....	146
NALOXONE .....	53	niacin .....	106
naltrexone .....	53	NIASPAN .....	106
NAMENDA .....	106	NICARDIPIN .....	95
NAMZARIC .....	106	nicardipine .....	94, 95
NANO .....	157	NICARDIPINE .....	95
NAPROSYN TABLET .....	34	nifedipine .....	94, 95
naproxen .....	19, 33, 34	nilutamide .....	65
naratriptan .....	19	NIMBEX .....	86
NARCAN .....	53	NINLARO .....	71
NAROPIN .....	29	NIPENT .....	66
NATACYN .....	53	nisoldipine er .....	95
nateglinide .....	57	nitazoxanide .....	75
NATROBA .....	75	NITHIODOTE .....	192
NAVELBINE .....	69	nitisinone .....	190
NAYZILAM .....	109	NITRO-DUR .....	96
NEBUPENT .....	60	nitrofurantoin .....	45
nebusal .....	190	nitroglycerin .....	97, 140, 220
NEBUSAL .....	190	NITROLINGUAL .....	97
NEEDLE .....	156, 157	NITROMIST .....	97
needles .....	157	NITROPRESS .....	101
nefazodone .....	167	nitroprusside .....	101
NEMBUTAL .....	174	NITROSTAT .....	97
neomycin .....	37, 38, 39, 176	NITYR .....	190
neomycin/bacit/p-myx/hydrocort .....	37	NIVESTYM .....	112
neomycin/polymyxin b/dexametha .....	37	NOCTIVA .....	142
neomycin/polymyxin b/hydrocort .....	37, 38	NOKOR .....	157
neomycin/polymyxn b/gramicidin .....	38	NORCO .....	20
neomycin sulf/bacitracin/poly .....	38	NORDITROPIN FLEXPPO .....	146
NEOPROFEN .....	103	norelgestromin/ethin.estradiol .....	115
neostigmine methylsulfate .....	84	norepinephrine .....	86
NEOSTIGMINE-STERILE WATER .....	84	NOREPINEPHRINE BITAR .....	86
NEO-SYNALAR .....	49	NOREPINEPHRINE BITARTRATE .....	86
NERLYNX .....	71	noreth-ethinyl estradiol/iron .....	114
NESACAINE .....	29	norethind-eth estrad .....	114, 144
NETSPOT .....	118	norethindrone .....	114, 143, 144, 147
NEULASTA .....	112	norethin-ee .....	114
		norethin-eth estrad .....	144

## Index of Medications

norgestrel-ethinyl estradiol.....	114	OFIRMEV.....	18
NORLIQVA ORAL SOLN.....	95	ofloxacin.....	37, 38, 47
NORMOSOL-M AND DEXTROSE.....	130	OGIVRI.....	69
NORMOSOL-R.....	130	OGSIVEO.....	71
NORPACE.....	93	OJJAARA.....	71
nortriptyline.....	168	olanzapine.....	172, 174
NORVASC.....	95	OLINVYK.....	25
NOURIANZ.....	76	olmesartan/amlodipin/hcthiazyd.....	100
NOVA.....	154, 161	olmesartan-hctz.....	100
NOVA MAX.....	154	olmesartan medoxomil.....	101
NOVAREL.....	148	olopatadine.....	56, 122
NOVOFINE.....	157	OLPRUVA.....	134
NOVOPEN ECHO.....	154	OLUMIANT.....	33
NOVOTWIST.....	157	omega-3 acid ethyl esters.....	133
NPLATE.....	113	OMEGAVEN.....	139
NUBEQA.....	65	omeppi.....	140
NUCALA.....	37	omeprazole-bicarb.....	140
NUCORT.....	182	omeprazole dr.....	140
NUCYNTA.....	25	OMIDRIA.....	124
NUDEXTA.....	107	OMISIRGE.....	93
NULEV.....	137	OMNIPAQUE.....	117
NULIBRY.....	191	OMNIPOD.....	154, 155, 221
NULOJIX.....	151	OMNIPOD 5 (GEN 5) KIT.....	154
NULYTELY.....	139	OMNIPOD 5 (GEN 5) PODS.....	155
NUMOISYN.....	187	OMNIPOD CLASSIC (GEN 3 & 4) KIT.....	154
NUPLAZID.....	166	OMNIPOD CLASSIC (GEN 3 & 4) PODS.....	154
NURTEC ODT.....	19	OMNIPOD DASH.....	155
NUTRILIPID.....	139	OMNIPRED.....	123
NUVARING.....	113	OMNISCAN.....	117
NUVESSA.....	48	OMNITROPE.....	146
NUZYRA.....	48	OMVOH.....	149, 221
NYMALIZE.....	95	ON CALL.....	155, 161
nystatin.....	54, 55	ONCASPAR.....	73
nystatin/triamcinolone acet.....	55	ondansetron.....	135
NYVEPRIA.....	112	ONDANSETRON.....	135, 136
<b>O</b>		ONETOUCH.....	116, 155, 161
OBREDON.....	116	ONFI.....	109
OBSTETRIX EC.....	164	ONIVYDE.....	68
OBSTETRIX ONE.....	197	ONPATTRO.....	188
OBTREX DHA.....	164	ON-THE-GO.....	161
OCALIVA.....	138	ONTRUZANT.....	69
OCREVUS.....	108	ONUREG.....	66
OCTREOSCAN.....	119	OPANA.....	25
octreotide.....	147	OPDIVO.....	72
ODACTRA.....	87	OPFOLDA.....	190
ODEFSEY.....	80	opium.....	25, 135
ODOMZO.....	67	OPSUMIT.....	98
OFEV.....	185	OPTIMARK.....	117

## Index of Medications

OPTIRAY 240	117	oxcarbazepine	110
OPTIRAY 300	117	OXERVATE	126
OPTIRAY 320	117	OXSORALEN-ULTRA	176
OPTIRAY 350	117	OXTELLAR XR	110
OPTISON	117	oxybutynin	196
OPTUMRX	155	oxycodone	20, 21, 25
OPVEE	53	oxycodone hcl/acetaminophen	20
ORABLOC	29	OXYCODONE HCL ER	25
ORACIT	133	oxymorphone	25
ORALAIR	87	oxytocin	146, 147
ORAMAGICRX	187	OXYTOCIN-D5-LACTATED RINGERS	146
ORAPRED ODT	145	OXYTOCIN-D5W	146
ORAVIG	53	OXYTOCIN-LACTATED RINGERS	147, 148
ORBACTIV	44	OZEMPIC	56
ORENCIA	32	OZURDEX	123
ORENITRAM	98	<b>P</b>	
ORENITRAM ER	98	pacerone	93, 94
ORFADIN	190	paclitaxel	74
ORIAHNN	146	PACNEX	179
ORILISSA	146	PADCEV	73
ORKAMBI	184, 185	PAIN EASE MEDIUM STREAM SPRAY	31
ORLADEYO	186	paliperidone er	171, 172
orphenadrine	163	palonosetron	135, 136
ORTHO MICRONOR	114	PALYNZIQ	87
ORTHOVISC	32	pamidronate	193
oseltamivir	81, 82	PANCREAZE	140
oseltamivir phos	81	pancuronium	86
OSMITROL	121	PANHEMATIN	185
OSMOLEX	76, 77	PANRETIN	75
OSMOLEX ER	77	pantoprazole	140, 141
OSPHENA	188	papaverine	103
OTEZLA	31	PARADIGM	155, 159
OTEZLA 28 DAY STARTER PACK	31	PARADIGM REAL-TIME	155
OTOVEL	37	PARAGARD T 380-A	115
OTREXUP	31	paregoric	135
OVACE PLUS	177	PAREMYD	125
OVAL TAPE	155	parenteral amino acid	129
OVIDE	183	paricalcitol	188
OVIDREL	148	PARICALCITOL	188
oxacillin	46	PARLODEL	77
oxacillin in dextrose	46	paromomycin	60
oxaliplatin	64	paroxetine	166, 167, 190
oxandrolone	142	paroxetine cr	166
oxaprozin	33, 34	paroxetine er	166, 167
OXAPROZIN	34	PARSABIV	187
OXAYDO	25	PASER	40
oxazepam	165	PATANASE	122
OXBRYTA	92	PAXIL	167
		pazopanib	71

## Index of Medications

P-CARE D80G .....	145	phenazopyridine .....	31
P-CARE K80 .....	145	phenelzine .....	165
PCE .....	44	PHENERGAN .....	55
PEDIARIX .....	90	phenobarb/hyoscy/atropine/scop .....	137
PEDITRACE .....	131	phenobarbital .....	137, 174
PEDVAXHIB .....	90	phenobarbital-belladonna elixr .....	137
peg3350/sod sulf, bicarb, cl/kcl .....	139	PHENOBARBITAL-BELLADONNA ELIXR .....	137
peg3350/sod sul/nacl/kcl/asb/c .....	139	phenoxybenzamine .....	85
PEGANONE .....	111	phentolamine .....	85
PEGASYS .....	83	phenylephrine .....	55, 97, 124
PEGINTRON .....	83	PHENYLEPHRINE HCL .....	97
PEMAZYRE .....	71	phenylephrine hcl/prometh hcl .....	55
PEMRYDI .....	66	PHENYTEK .....	111
PENBRAYA .....	88	phenytoin .....	110, 111
penicillamine .....	31	PHESGO .....	69
PENICILLIN GK-ISO-OSM DEXTROSE .....	46	PHOSPHOLINE IODIDE .....	125
penicillin g potassium .....	46	PHOTOFRIN .....	74
penicillin g sodium .....	46	PHOXILLUM .....	133
penicillin v potassium .....	46	PHYSICIANS EZ USE B-12 .....	197
PEN NEEDLES .....	156, 157	PHYSIOLYTE .....	176
PENTACEL .....	90	PHYSIOSOL .....	176
PENTAM 300 .....	60	physostigmine salicylate .....	84
pentamidine .....	60, 61	phytonadione .....	198
pentazocine hcl/naloxone hcl .....	25	PHYTONADIONE .....	198
PENTETATE CALCIUM TRISODIUM .....	192	PICATO .....	75
PENTETATE ZINC TRISODIUM .....	192	PIFELTRO .....	79
PENTIPS .....	156, 157	pilocarpine .....	87, 125
pentobarbital .....	174	pimecrolimus .....	150
pentoxifylline .....	92	pimozide .....	171
PEPAXTO .....	64	pindolol .....	102
PERCOCET .....	20	pioglitazone hcl .....	58
PERIDEX .....	187	pioglitazone hcl/glimepiride .....	58
PERIKABIVEN .....	129	pioglitazone hcl/metformin hcl .....	58
perindopril erbumine .....	101	PIP .....	155, 157, 161
perit. dialysis no.6 .....	133	piperacillin sodium/tazobactam .....	46
periton.dialysis 7 .....	133	PIPERACILLIN-TAZOBACTAM .....	46
periton.dialysis 8 .....	133	PIQRAY .....	71
PERJETA .....	69	pirfenidone .....	189
permethrin .....	75	piroxicam .....	34
perphenazine .....	168, 174	pitavastatin .....	104, 105
perphenazine/amitriptyline .....	168	PITOCIN .....	147
PERSERIS .....	172	PLAQUENIL .....	60
PFIZER .....	87, 196	PLASMA-LYTE .....	130
PFIZER COVID-19 VACCINE .....	196	PLASMA-LYTE 148 .....	130
PH 12 DILUENT FOR FLOLAN .....	189	PLAVIX .....	78
PHARMABASE BARRIER .....	180	PLEGISOL .....	96
PHASEAL PROTECTOR .....	157	PLEGRIDY .....	108
PHEBURANE .....	134	PLENAMINE .....	129

## Index of Medications

PLIXDA .....	183	prednicarbate.....	181, 182
PNEUMOVAX 23.....	88	prednisolone.....	38, 123, 145
pnv 22/iron, gluc/folic/dss/dha.....	164	prednisone.....	145
pnv 66/iron/folic/docusate/dha.....	164	PREFEST.....	144
pnv 69/iron/folic/docusate/dha.....	164	pregabalin.....	110, 111
pnv 80/iron fum/folic/dss/dha.....	164	PREGNYL.....	148
pnv/ferrous fum/docusate/folic.....	164	PREMARIN.....	144, 148
pnv/iron, carb/docusat/folic ac.....	164	PREMPHASE.....	144
POD-CARE 100C.....	145	PREMPRO.....	144
PODOCON-25.....	179	prenatal 12/iron/folic/dss/om3.....	164
podofilox.....	179	PRENATAL 19.....	164
POLIBAR ACB.....	119	prenatal 34/iron/folic/dss/dha.....	164
POLIVY.....	73	prenatal vits15/iron/folic/dss.....	164
POLOCAINE.....	29	PREPIDIL.....	147
POLY.....	157	PREPOPIK.....	139
polydimethylsiloxanes/silicon.....	180	PRESSURE.....	124, 125, 161
polymyxin b sulfate.....	38, 46	PRESTALIA.....	98, 99
POMALYST.....	69	PRETOMANID.....	40
Ponvory.....	108	PREVENT.....	157
PORTRAZZA.....	69	PREVIDENT.....	127
posaconazole.....	53	PREVNAR 13.....	88
potassium.....	19, 45, 46, 101, 127, 130, 131, 132, 133, 183	PREVYMIS.....	81
POTASSIUM.....	96, 121, 131, 132	PREZCOBIX.....	79
potassium acetate.....	132	PREZISTA.....	79
potassium bicarbonate/cit ac.....	132	PRIALT.....	18
potassium chloride.....	132	PRIFTIN.....	40
potassium chloride in d5w.....	132	primaquine.....	60
potassium chloride in water.....	132	PRIMAQUINE.....	60
potassium citrate.....	133	PRIMAXIN.....	41
potassium iodide/iodine.....	130	primidone.....	111
potassium phos, m-basic-d-basic.....	131	PRIMLEV.....	20
POTASSIUM PHOSPHATE.....	131	PRIMSOL.....	40
POTASSIUM PHOSPHATES.....	131	PRISMASOL.....	133
POTELIGEO.....	73	probenecid.....	35
PRADAXA.....	52	PROBUPHINE.....	195
PRALIDOXIME CHLORIDE.....	189	procainamide.....	94
pramipexole.....	76, 77	PROCALAMINE.....	129
pramipexole er.....	76, 77	PROCARDIA.....	95
PRAMOSONE.....	182	PRO-C-DURE 5.....	145
prasugrel.....	78	PRO-C-DURE 6.....	145
pravastatin.....	105	prochlorperazine.....	135, 136
PRAXBIND.....	92	PRO COMFORT.....	155, 157, 159, 161, 178
praziquantel.....	60	PROCORT.....	141
prazosin.....	99	PROCRIT.....	112
PR BENZOYL PEROXIDE.....	179	PROCTOFOAM-HC.....	141
PRECEDEX.....	175	PRODIGY.....	155, 159, 161
PRECISIONGLIDE.....	157	progesterone.....	147
PRECOSE.....	57	PROGLYCEM.....	127



## Index of Medications

PROGRAF.....	151	quazepam.....	175
PROHANCE.....	117	QUAZEPAM.....	175
PROLASTIN C.....	185	QUELICIN.....	86
PROLENSA.....	123	QUESTRAN.....	105
PROLEUKIN.....	74	quetiapine.....	172
PROLIA.....	193	QUILLIVANT XR.....	170
PROMACTA.....	113	quinapril.....	99, 101
promethazine.....	55, 115, 136	quinapril/hydrochlorothiazide.....	99
PROMISEB.....	177	quinidine.....	94
propafenone.....	94	quinine.....	60
propranolol.....	102, 103	QUTENZA.....	179
propylthiouracil.....	183	QVAR REDHALER.....	36
PROQUAD.....	90	<b>R</b>	
PROSCAR.....	195	rabeprazole.....	141
PROSOL.....	129	RADIAGEL.....	192
PROSTASCINT.....	119	RADIAPLEXRX.....	180
PROSTIN E2.....	147	RADICAVA.....	107
PROSTIN VR PEDIATRIC.....	103	RADICAVA ORS.....	107
protamine.....	91	RADIOGARDASE.....	192
protectives2/ceramide 1, 3, 6-ii.....	180	RAGWITEK.....	87
PROTOPAM CHLORIDE.....	189	raloxifene.....	193
PROTOPIC.....	150	ramelteon.....	175
protriptyline.....	168	ramipril.....	101
PROVAYBLUE.....	188	RANEXA.....	93
PROVERA.....	113, 147	ranitidine.....	138
PROVISC.....	126	ranolazine.....	93
PROVOCHOLINE.....	118	RAPAFLO.....	196
PULMICORT.....	36	RAPAMUNE.....	151
PULMOZYME.....	185	RAPIVAB.....	81
PURE COMFORT.....	157, 161, 178	RAPLIXA.....	92
PURIXAN.....	66	rasagiline mesylate.....	76, 77
PUSH BUTTON.....	161	RAYA.....	157
pyrazinamide.....	40	RAYALDEE.....	188
PYRIDIUM.....	31	RAZADYNE ER.....	84
pyridostigmine bromide.....	84	READI-CAT 2.....	119
pyridoxine.....	135, 197	READYLANCE.....	161
pyrimethamine.....	60	READYSHARP BETAMETHASONE.....	145
<b>Q</b>		REBIF.....	108
QALSODY.....	107	REBLOZYL.....	186
QINLOCK.....	71	RECARBRIO.....	41
QMIIZ ODT.....	34	RECLAST.....	193
QUADRACEL DTAP-IPV.....	90	RECOMBIVAX HB.....	90
QUADRAMET.....	187	RECOTHROM.....	92
QUALAQUIN.....	60	RECTIV.....	140
QUARTETTE.....	114	REFUAH.....	155
		regadenoson.....	117
		REGLAN.....	139
		REGRANEX.....	178
		REGULAR.....	157

## Index of Medications

RELAGARD.....	59	RIMSO-50.....	26
RELENZA.....	81	ringer's solution .....	130, 176
RELIAMED .....	155, 162	RINVOQ.....	33
RELION.....	157, 162	RIOMET.....	57
RELISTOR.....	52	risedronate .....	193
remifentanil.....	21	risperidone .....	172
REMODULIN .....	98, 189	RITALIN.....	170
RENACIDIN .....	133	ritonavir.....	80
RENFLEXIS.....	62	RITUXAN.....	63
repaglinide.....	57, 58	RITUXAN HYCELA.....	63
REPATHA PUSHTRONEX .....	104	rivastigmine .....	84
REPATHA SURECLICK.....	104	rizatriptan.....	19
REPATHA SYRINGE .....	104	ROBAXIN .....	163
REPLACEMENT PEDIATRIC MONITOR.....	155	ROBINUL.....	134
RESPA A.R.....	115	ROCALTROL .....	198
RESTASIS .....	126	ROCKLATAN.....	125
RESTIZAN .....	178	rocuronium.....	86
RETACRIT .....	112	ROMIDEPSIN .....	63
RETAVASE .....	92	ropivacaine.....	29, 30
RETEVMO .....	71	ROPIVACAINE .....	23, 29, 30
RETROVIR .....	80	ROSANIL.....	50
REVATIO.....	97	rosuvastatin calcium.....	105
REVCOVI .....	191	ROSZET .....	103
REVLIMID .....	69	ROTARIX.....	88
REXULTI .....	173	ROTATEQ.....	88
REYATAZ .....	80	ROXYBOND.....	25
REZIPRES.....	97	ROZLYTREK .....	71
REZLIDHIA.....	72	RUBRACA .....	71
REZUROCK.....	195	RUCONEST.....	186
REZVOGLAR KWIKPEN.....	56	rufinamide .....	111
R-GENE 10.....	119	RUKOBIA.....	79
RHOGAM.....	87	RUXIENCE .....	63
RHOPHYLAC.....	87	RUZURGI.....	108
RHOPRESSA.....	125	RYANODEX.....	163
RIABNI .....	63	RYBELSUS.....	56
RIASTAP.....	91	RYDAPT .....	71
ribasphere .....	83	RYTARY.....	77
ribasphere ribapak.....	83	RYTHMOL SR.....	94
ribavirin .....	83	<b>S</b>	
RIDAURA .....	32	SAF-CLENS AF.....	180
rifabutin.....	40	SAFE-CLIP .....	155
RIFADIN .....	40	SAFESNAP .....	159
RIFAMATE.....	41	SAFETY.....	155, 156, 157, 158, 159, 160, 161, 162
rifampin.....	40, 41	SAFETYGLIDE.....	157, 159
RIFATER.....	41	SAFYRAL .....	114
RIGHTEST.....	155, 162	SALAGEN .....	87
RILUTEK .....	107	SALICATE.....	179
riluzole.....	107	salicylic acid.....	179
rimantadine .....	81, 82	SALIMEZ FORTE.....	179

## Index of Medications

SALKERA .....	179	SINGLE.....	43, 162
salsalate .....	31	SINGLE USE SWAB .....	178
SALVAX DUO PLUS .....	179	SINGULAIR .....	36
SANCUSO .....	136	SINOGRAFIN .....	116
SANDOSTATIN .....	147	sirolimus.....	151
SANTYL .....	183	SIRTURO .....	41
SAPHRIS .....	172	SITZMARKS .....	119
SARAFEM .....	167	SIVEXTRO .....	45
SARCLISA .....	65	SKELAXIN .....	163
SAVAYSA.....	50	SKLICE .....	75
SAVELLA.....	194	SKY .....	158
SCALACORT DK.....	182	SKYLA.....	115
SCLEROSOL.....	186	SKYRIZI.....	176
scopolamine.....	136	SKYTROFA .....	146
SEASONIQUE .....	114	SMART.....	153, 160, 162
secobarbital.....	174	SMARTDIABETES.....	155
SECUADO.....	172	SMARTEST .....	155, 162
SECURESAFE.....	157, 159	SMOFLIPID .....	139
selegiline.....	77	sodium acetate .....	127
SELENIOS ACID .....	131	sodium benzoate/sod phenylacet.....	134
selenium sulfide .....	177	sodium bicarbonate.....	127
SELZENTRY .....	79	sodium bicarbonate in d5w .....	127
SEN-SERTER .....	155	sodium chloride.....	39, 102, 132, 176, 190, 192
sensorcaine .....	29, 30	sodium chloride/nahco3/kcl/peg .....	139
SENSORCAINE .....	30	SODIUM CITRATE.....	50
SENSORC MPF .....	30	SODIUM DIURIL.....	122
SENSORC-MPF .....	30	SODIUM EDECRIN.....	120
SENSORCN-MPF.....	30	sodium ferric gluconat/sucrose.....	131
SEROQUEL .....	172	sodium fluoride/potassium nit .....	127
SEROSTIM.....	146	SODIUM HYALURONATE.....	32
sertraline .....	167	SODIUM NITRITE .....	189
sevelamer.....	130	SODIUM OXYBATE.....	174
SFROWASA.....	138	sodium phenylbutyrate .....	134
SHINGRIX.....	90	SODIUM PHOSPHATE.....	131
SHORT .....	35, 36, 158	sodium polystyrene sulfonate .....	130
SIGNIFOR.....	147	sodium polystyrene sulfon/sorb .....	130
SIKLOS .....	92	sodium tetradecyl.....	106
sildenafil.....	97	sodium thiosulf.....	192
SILIQ.....	176	sod phosphate, monobasic-dibas.....	131
silodosin .....	196	sod, pot chlor/mag/sod, pot phos .....	176
SIL-SERTER .....	155	SOF-SENSOR .....	155
SILVADENE.....	50	SOFT .....	162
silver nitrate .....	179, 183	SOGROYA .....	146
silver sulfadiazine.....	50	SOHONOS.....	192
SIMBRINZA.....	125	solifenacin.....	196
SIMPONI .....	62	SOLIQUA.....	56
SIMULECT.....	150	SOLIRIS.....	91
simvastatin.....	103, 105	SOLTAMOX.....	74
SINEMET .....	77	SOLU-CORTEF .....	145

## Index of Medications

SOLU-MEDROL.....	145	succinylcholine chloride.....	86
SOLUS.....	155, 162	SUCCINYLCHOLINE CHLORIDE.....	86
SOMA.....	163	SUCRAID.....	138
SOMATULINE DEPOT.....	147	sucralfate.....	136
SOMAVERT.....	187	sufentanil.....	21
SORBITOL.....	176	SUFLAVE.....	139
sotalol.....	102	SULAR.....	95
SOTRADECOL.....	106	sulfacetamide/prednisolone sp.....	38
SOTYKTU.....	176	sulfacetamide sodium.....	38, 50, 177
SOTYLIZE.....	103	sulfacetamide sod/sulfur/urea.....	50
SOVALDI.....	82	sulfacetamide/sulfur/cleansr23.....	50
SOVUNA.....	60	sulfact sod/sulur/avob/otn/oct.....	50
SPECIALTY.....	158	sulfadiazine.....	38, 50
SPIKEVAX.....	87	sulfamethoxazole.....	38, 39
spinosad.....	75	sulfamethoxazole/trimethoprim.....	39
SPINRAZA.....	190	SULFAMYLON.....	50
SPIRIVA RESPIMAT.....	35	sulfasalazine.....	138
spironolact/hydrochlorothiazid.....	121	sumatriptan.....	19
spironolactone.....	121	SUNLENCA.....	78
SPRAVATO.....	165	SUNOSI.....	174
SPRITAM.....	111	SUPARTZ.....	32
SPRYCEL.....	71	SUPER.....	161, 162
sps.....	130	SUPPRELIN LA.....	146
SSKI.....	130	SUPREP.....	139
STALEVO 50.....	77	SURE.....	155, 157, 158, 159, 162
STALEVO 75.....	77	SURE COMFORT.....	155, 158, 159, 162, 178
STALEVO 100.....	77	SURE-FINE PEN NEEDLES.....	158
STALEVO 125.....	77	SURE-JECT.....	159
STALEVO 150.....	77	SURE-PREP.....	178
STALEVO 200.....	77	SURGIFOAM.....	92
STARLIX.....	57	SURGISEAL STYLUS.....	180
STELARA.....	149, 150	SURGISEAL TEARDROP.....	180
STERILANCE.....	162	SURGISEAL TWIST.....	180
STERILE.....	21, 27, 41, 84, 162, 186	SURVANTA.....	185
STERILE TALC.....	186	SUSTOL.....	136
STERITALC.....	186	SUTAB.....	139
STIMATE.....	143	SWABFLUSH.....	132
STIMUFEND.....	113	SYFOVRE.....	126
STIOLTO RESPIMAT INHAL SPRAY.....	36	SYLVANT.....	72
STIVARGA.....	71	SYMAX DUOTAB.....	137
STRATTERA.....	170	SYMDEKO.....	185
STRENSIQ.....	190	SYMLINPEN 60.....	57
STREPTOMYCIN.....	39	SYMLINPEN 120.....	57
STRIBILD.....	81	SYMPROIC.....	52
STRIVERDI RESPIMAT.....	36	SYMTUZA.....	79
STROMECTOL.....	60	SYNAGIS.....	81
strontium-89 chloride.....	187	SYNALAR.....	49, 182
SUBLOCADE.....	195	SYNERCID.....	47
SUBOXONE.....	195	SYNJARDY.....	58

## Index of Medications

SYNOJOYNT.....	32	TEMODAR.....	64, 65
SYNRIBO.....	74	TEMOVATE.....	182
SYNTHROID.....	184	temozolomide.....	64, 65
SYNVISC.....	32	temsirolimus.....	68
syringe 19, 20, 23, 28, 50, 51, 53, 62, 85, 93, 136, 144, 149, 150, 152, 159, 164, 171, 176, 193		TENIPOSIDE.....	74
SYRINGE AVITENE.....	92	TENIVAC.....	90
syring-needl.....	159	tenofovir.....	80
<b>T</b>		TEPADINA.....	65
TABLOID.....	67	TEPEZZA.....	187
TABRECTA.....	71	TEPMETKO.....	71
TACHOSIL.....	92	terazosin.....	100
tacrolimus.....	150, 151	terbinafine.....	53
tadalafil.....	98	terbutaline sulfate.....	35
TAFINLAR.....	67	terconazole.....	53
TAGITOL.....	119	teriflunomide.....	108
TAGRISSE.....	71	teriparatide.....	187
TAKHZYRO.....	87	TERIPARATIDE.....	187
TALTZ.....	176	TERSI FOAM.....	177
TALZENNA.....	71	TERUMO.....	158, 159
TAMIFLU.....	82	TERUMO SURGUARD2.....	158
tamoxifen citrate.....	74	TESSALON PERLE.....	115
tamsulosin.....	195, 196	TESTOPEL.....	142
TAPAZOLE.....	183	testosterone.....	141, 142, 143
TASIGNA.....	71	TESTOSTERONE.....	142
tasimelteon.....	175	TESTRED.....	142
TASMAR.....	77	tetrabenazine.....	107
TAVALISSE.....	186	tetracaine.....	30, 124
TAXOTERE.....	74	tetracaine hcl/pf.....	30
tazarotene.....	177	tetracycline.....	48, 136
TAZVERIK.....	68	TETRAVISC.....	124
TC99M MEBROFENIN PREP.....	116	TEXACORT.....	182
TC99M MEDRONATE PREP.....	118	TEZSPIRE.....	194
TC99M PYROPHOSPHATE PREP.....	116	THALLOUS CHLORIDE TL-201.....	116
TC99M SESTAMIBI PREP.....	116	THALOMID.....	40
TC99M SULFUR COLLOID PREP.....	118	THAM.....	127
TDVAX.....	90	THEO-24.....	37
TECENTRIQ.....	74	theophylline.....	37
TECHLITE.....	158, 159, 162	theophylline in dextrose.....	37
TECHNELITE TC-99M GENERATOR.....	192	thiamine.....	197
TEFLARO.....	43	THIN LANCETS.....	161, 162
TEGRETOL.....	111	THINPRO.....	159
TEGSEDI.....	188	THIN WALL NEEDLES.....	158
TELCARE.....	155, 162	thioridazine.....	174
telmisartan.....	100, 101	thiotepa.....	65
telmisartan-amlodipine.....	100	THROMBI-GEL.....	92
telmisartan-hctz.....	100	THROMBIN-JMI.....	92
temazepam.....	175	THROMBI-PAD.....	92
TEMIXYS.....	79	THYROGEN.....	184
		thyroid, pork.....	184

## Index of Medications

THYROLAR-1.....	184	TRALEMENT.....	131
THYROLAR-1/2.....	184	tramadol.....	20, 25, 26
THYROLAR-1/4.....	184	TRAMADOL HCL ER.....	26
THYROLAR-2.....	184	trandolapril.....	99, 101
THYROLAR-3.....	184	trandolapril/verapamil.....	99
tiagabine.....	110, 111	TRANEXAMIC.....	91
TIAZAC.....	95	tranexamic acid.....	91
TIBSOVO.....	72	TRANSDERM-SCOP.....	136
ticlopidine.....	78	TRANSFER.....	80, 158
TIGAN.....	136	TRANXENET-TAB.....	165
tigecycline.....	43	tranylcypromine.....	165
TIGLUTIK.....	107	travoprost.....	125
TIKOSYN.....	94	TRAZIMERA.....	69
timolol.....	103, 125	trazodone.....	167
TINDAMAX.....	59	TREANDA.....	65
tinidazole.....	59	TRECTOR.....	40
tiopronin.....	196	TRELEGY ELLIPTA.....	36
tirofiban.....	78	TRELSTAR.....	70
TIROSINT.....	184	TREMFYA.....	176
TISSEEL VHSD.....	180	treprostinil.....	98, 189
TIVICAY.....	80	TRESIBA.....	59
TIVICAY PD.....	80	tretinoin.....	74, 177, 183
tizanidine.....	163	TRETTEN.....	91
TNKASE.....	92	TREXALL.....	67
TOBI PODHALER.....	39	TREZIX.....	21
TOBRADEX.....	38	triamcinolone.....	145, 187
tobramycin.....	38, 39	triamterene.....	121
tobramycin/dexamethasone.....	38	triazolam.....	175
TOBRAMYCIN PAK.....	39	trichloroacetic acid.....	180
TOLAK.....	75	TRICHLOROACETIC ACID.....	180
tolbutamide.....	57	TRICITRASOL.....	50
tolcapone.....	77	TRICOR.....	106
tolmetin sodium.....	34	trientine.....	192
tolterodine tart er.....	196	TRIENTINE.....	192
tolterodine tartrate.....	196	TRIESENCE.....	123
tolvaptan.....	120	TRIFERIC.....	131
TOLVAPTAN.....	120	trifluoperazine.....	174
TOPCARE.....	158, 159, 162	trifluridine.....	81
TOPICORT.....	182	TRIGLIDE.....	106
topiramate.....	111	trihexyphenidyl.....	76
topotecan.....	68	TRIJARDY XR.....	58
toremifene citrate.....	74	TRIKAFTA.....	185
TORISEL.....	68	TRILIPIX.....	106
toremide.....	120	TRILURON.....	32
TOTALVISC.....	126	trimethobenzamide.....	136
TOTECT.....	187	trimethoprim.....	38, 39, 40
TPN ELECTROLYTES.....	130	trimipramine.....	168
TRACLEER.....	98	TRIMO-SAN.....	59

## Index of Medications

TRINTELLIX.....	168	ULTRACARE.....	158, 159
TRIOSTAT.....	184	ULTRACET.....	20
TRIPTODUR.....	146	ULTRA COMFORT.....	159
TRISENOX.....	74	ULTRA-FINE.....	158
TRIUMEQ.....	79	ULTRA FLO.....	158
TRIVISC.....	32	ULTRAFOAM.....	92
TRODELVY.....	73	ULTRALANCE.....	162
TROGARZO.....	78	ULTRAM.....	26
TROPHAMINE.....	129	ULTRA THIN.....	158, 161, 162
tropicamide.....	125	ULTRA-THIN.....	157, 158, 159, 162
tropium.....	196	ULTRA-THIN II.....	157, 158, 159
TRUDHESA.....	19	ULTRATLC.....	162
TRUE COMFORT.....	158, 159, 162, 178	ULTRATRAK.....	156
TRUECONTROL.....	155	ULTRAVATE.....	182
TRUEDRAW.....	155	ULTRAVIST.....	117
TRUE METRIX.....	155	UNASYN.....	46
TRUEPLUS.....	158, 159, 162	UNIFINE.....	156, 157, 158
TRULANCE.....	139	UNILET.....	160, 161, 162
TRULICITY.....	56	UNISTIK.....	156, 161, 162
TRUMENBA.....	88	UNISTRIP.....	156
TRUQAP.....	71	UNITUXIN.....	73
TRUXIMA.....	63	UNIVERSAL.....	161, 162
TUKYSA.....	71	UPLIZNA.....	149
TURALIO.....	71	UPTRAVI.....	98
TUXARIN ER.....	116	URAMAXIN.....	179
TUZISTRA XR.....	116	urea.....	50, 61, 179, 180
TWINRIX.....	90	URIBEL.....	40
TWIST LANCETS.....	162	UROCIT-K.....	133
TYBLUME.....	115	UROQID-ACID NO.2.....	133
TYBOST.....	184	UROXATRAL.....	196
TYGACIL.....	43	URSO.....	138
TYKERB.....	72	ursodiol.....	137, 138
TYSABRI.....	193	UTA.....	40
TYVASO.....	98	UVADEX.....	74
<b>U</b>		<b>V</b>	
UBRELVY.....	19	VABOMERE.....	41
UDENYCA.....	113	VAGIFEM.....	148
UKONIQ.....	72	valacyclovir.....	82
ULESFIA.....	75	VALCHLOR.....	75
ULORIC.....	33	valganciclovir.....	82
ULTICARE.....	158, 159	VALIUM.....	165
ULTIGUARD.....	158	valproic acid.....	111
ULTIGUARD SAFE.....	159	valrubicin.....	63
ULTI-LANCE.....	156	valsartan.....	100, 101
ULTILET.....	158, 159, 162, 178	valsartan/hydrochlorothiazide.....	100
ULTIVA.....	21	VALSTAR.....	63
ULTOMIRIS.....	91	VALTOCO.....	109
ULTRA.....	162	VALTRESX.....	82
ULTRA-CARE.....	162	vancomycin.....	48, 49

## Index of Medications

VANCOMYCIN.....	48, 49	VIOICE.....	185
VANISHPOINT.....	159	vilazodone.....	168
VAPRISOL.....	120	VILTEPSO.....	190
VARIBAR.....	119	VIMIZIM.....	191
VARIVAX VACCINE.....	90	VIMPAT.....	111, 112
VARUBI.....	136	vinblastine.....	69
VASCEPA.....	133	vincristine.....	69
vasopressin.....	143	vinorelbine.....	69
VASOPRESSIN.....	120, 143	VIOKACE.....	140
VASOPRESSIN-D5W.....	143	VIREAD.....	80
VASOSTRICT.....	143	VISCO-3.....	32
VAXELIS.....	90	VISCOAT.....	126
VAZCULEP.....	97	VISIONBLUE.....	126
VECAMYL.....	101	VISIPAQUE.....	117
VECTIBIX.....	69	VISTARIL.....	55
vecuronium.....	86	VISTOGARD.....	186
VECURONIUM BROMIDE-WATER.....	87	VISUDYNE.....	187
VEGZELMA.....	63	VITAFOL FE+.....	164
VELCADE.....	72	VITALIPID.....	197
VELETRI.....	98	vitamins b1, b2, b3, b5, and b6.....	197
VELPHORO.....	130	vite ac/grape/hyaluronic acid.....	178
VELTASSA.....	130	VITLIPID.....	197
VEMLIDY.....	83	VITRAKVI.....	72
VENCLEXTA.....	72	VITRASE.....	183
VENELEX.....	195	VIVAGUARD.....	156, 162
venlafaxine.....	167, 168	VIVELLE-DOT.....	144
VENOFER.....	131	VIVITROL.....	189
VENTAVIS.....	98	VIVJOA.....	54
VEO.....	160	VIZAMYL.....	118
VEOPOZ.....	189	VIZIMPRO.....	72
verapamil.....	94, 95, 96, 99	VONVENDI.....	91
VERASENS.....	156	VOQUEZNA.....	140
VEREGEN.....	83	VORAXAZE.....	186
VERELAN.....	96	voriconazole.....	53, 54
VERIFINE.....	158, 160, 162	VOSEVI.....	82
VERQUVO.....	97	VOWST.....	138
VERZENIO.....	72	VOXZOGO.....	192
VEVYE.....	126	VPRIV.....	191
VFEND.....	53, 54	VRAYLAR.....	172
V-GO 20.....	156	VUMERITY.....	108
V-GO 30.....	156	VYEPTI.....	19
V-GO 40.....	156	VYNDAMAX.....	192
VIASPAN BELZER-UW.....	195	VYNDAQEL.....	192
VIBATIV.....	44	VYONDYS-53.....	190
VIBERZI.....	138	VYXEOS.....	65
VIBRAMYCIN.....	48	<b>W</b>	
VIDAZA.....	67	WAKIX.....	112
vigabatrin.....	111	warfarin.....	50
VIIBRYD.....	168	water for inj, bacteriostatic.....	194



## Index of Medications

water for injection, sterile.....	194	zafirlukast.....	36
water for irrigation, sterile.....	176	zaleplon.....	175
water/me-paraben/propylparaben.....	194	ZALTRAP.....	68
WAVESENSE.....	156	ZANAFLEX.....	163
WEBCOL.....	178	ZANOSAR.....	63
Wegovy.....	75	ZARONTIN.....	112
WIDE SEAL DIAPHRAGM.....	115	ZARXIO.....	113
WINRHO SDF.....	87	ZAVESCA.....	190, 233
WP THYROID.....	184	ZAVZPRET.....	19
<b>X</b>		Zegalogue.....	127
XADAGO.....	77	ZEJULA.....	72
XALKORI.....	72	ZELBORAF.....	67
XANAX.....	165	ZEMAIRA.....	185
XARELTO.....	50	ZEMDRI.....	39
XATMEP.....	67	ZEMPLAR.....	188
XCLAIR.....	178	ZENATANE.....	177
XCOPRI.....	112	ZENZEDI.....	85
XDEMVY.....	75	ZEPATIER.....	83
XELJANZ.....	33	ZEPZELCA.....	65
XELODA.....	67	ZERBAXA.....	42
XELSTRYM.....	85	ZETIA.....	106
XENLETA.....	46	ZEVALIN.....	73
XEOMIN.....	87	zidovudine.....	79, 80
XEPI.....	49	ZIEXTENZO.....	113
XERAVA.....	48	zileuton.....	35
XERMELO.....	134	ZILRETTA.....	145
XGEVA.....	194	ZIMHI.....	53
XIAFLEX.....	194	ZINACEF.....	42
XIFAXAN.....	47	zinc chloride.....	133
XIGDUO XR.....	58	zinc oxide.....	180
XIIDRA.....	126	zinc sulfate.....	133
XOFIGO.....	187	ZINECARD.....	186
XOFLUZA.....	82	ZINGO.....	30
XOLAIR.....	37	ziprasidone.....	172
XOPENEX.....	36	ZIRABEV.....	63
XOSPATA.....	72	ZIRGAN.....	81
XPOVIO.....	74	ZITHROMAX.....	44, 45
XTAMPZA ER.....	26	ZOHYDRO ER.....	26
XTANDI.....	65	ZOKINVY.....	185
XUREA.....	180	ZOLADEX.....	70
XURIDEN.....	128	zoledronic acid.....	193, 194
XYLOCAINE.....	30, 94	ZOLINZA.....	63
<b>Y</b>		zolmitriptan.....	19
YALE NEEDLES.....	158	zolpidem.....	175
YASMIN 28.....	115	zolpidem tart er.....	175
YAZ.....	115	zonisamide.....	112
YERVOY.....	74	ZORBTIVE.....	146
YONDELIS.....	65	ZORTRESS.....	151
<b>Z</b>		ZOSTAVAX.....	90

## Index of Medications

ZOSYN .....	46
ZTLIDO.....	31
ZUBSOLV.....	195
ZURZUVAE.....	165
ZYDELIG.....	72
ZYLET .....	38
ZYLOPRIM .....	33
ZYNYZ .....	63
ZYPREXA.....	172
ZYVOX.....	45

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. Smoking cessation medications are not typically covered under the plan, except as required by law or by the terms of your specific plan. Costs and complete details of the plan's prescription drug coverage, including a full list of exclusions and limitations, 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.
3. Prices shown on myCigna are not guaranteed and coverage is subject to your plan terms and conditions. Visit myCigna for more information.
4. 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).
5. 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.
6. Standard shipping costs are included as part of your prescription plan.
7. 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.
8. As allowable by law. For medications administered by a health care provider, Accredo will ship the medication directly to your doctor's office.
9. **For insured plans that must follow Delaware's state insurance laws:** Brand-name antidepressants, smoking cessation, attention deficit hyperactivity disorder (ADHD) and anti-psychotic medications that don't have a generic equivalent available will be covered as Tier 2 (preferred brand). This is true even if the medication is listed as Tier 3 (non-preferred brand) on your plan's drug list. To find out how your specific plans covers these medications, log in to the myCigna App or myCigna.com, or call Customer Service using the number on your ID card.
10. 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.
11. **For plans that must follow state insurance laws, such as Delaware:** Your plan may provide coverage for infertility medications and smoking cessation medications even if this drug list states that your plan may not cover them. To find out if your specific plan covers these medications, log in to the myCigna App or myCigna.com, or check your plan materials.

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

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

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

# DISCRIMINATION IS AGAINST THE LAW

## Medical coverage

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

Cigna:

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

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

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

Cigna  
Nondiscrimination Complaint Coordinator  
PO Box 188016  
Chattanooga, TN 37422

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

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



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).