



Cigna Healthcare Standard 3-Tier Prescription Drug List

Coverage as of July 1, 2024

For the State of California

Health Maintenance Organization (HMO), Network, Network Point of Service (POS)

View your drug list online: Cigna.com/druglist

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

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

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 This drug list is subject to change and all prior versions are no longer in effect.

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

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View your drug list online

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

- **myCigna® App¹ or myCigna.com®.** Click on the Prescriptions tab and select Price a Medication from the dropdown menu. Then type in your medication name.
- **Cigna.com/druglist.** Select **Standard 3 Tier** from the dropdown menu. Then type in your medication name or view the full list.

Questions?

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

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

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 1st and July 1st.
- **Adding extra coverage requirements to a medication.**

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

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

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

There are also certain medications and products that can't be covered by your plan for any reason because they're considered to be a "plan or benefit exclusion." This means the medication or product isn't on your plan's drug list, and there's no option to ask

Cigna Healthcare to consider approving it through the coverage review process. For example, your plan doesn't cover, or "excludes," medications that aren't approved by the U.S. Food and Drug Administration (FDA).

Q. How do you decide which medications to cover?

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

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

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

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

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

Information about this drug list

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

Q. What types of medications typically need approval?

A. Medications that:

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

Q. What types of medications typically have quantity limits?

A. Medications that are often:

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

Q. What types of medications require Step Therapy?

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

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

Q. Why does my medication have an age requirement?

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

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

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

Cigna Healthcare will review information your

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

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

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

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

A. If your doctor feels that your medication is necessary for your treatment and an alternative isn't

Information about this drug list

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

right for you, he or she can ask Cigna Healthcare to consider approving coverage of your medication. Ask your doctor's office to contact Cigna Healthcare to start the coverage review process. They know how the review process works and will take care of everything for you. In case the office asks, they can download a request form from the Cigna Healthcare provider portal at cignaforhcp.com.

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

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

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

Q. My medication was just taken off the drug list. My doctor still wants me to take it. What do I have to do to get it covered?

A. You don't need to do anything. If your doctor

continues to prescribe the medication, we'll continue to cover it. If your medication already requires prior authorization, your doctor just has to continue to request (and receive) approval from Cigna Healthcare for the medication to be covered.

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

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

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

Information about this drug list

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

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**.

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

Information about this drug list

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

asthma, depression, diabetes, heart attack, high blood pressure, high cholesterol, osteoporosis, prenatal nutrient deficiency and stroke.

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

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

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

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

Q. What's a cost-share?

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

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

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

Q. What's a generic medication?

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

Generics are typically sold under their chemical or scientific name, instead of the manufacturer's patented brand name.

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

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

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

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

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

Q. Can I fill my prescription at any pharmacy in my network?

A. It depends. Some plans only allow fills at certain in-network pharmacies or through home delivery. Log in to the myCigna App or myCigna.com, or check your plan materials, to learn more about the pharmacies in your plan's network.

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

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

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

A. To get the most from your plan coverage, you

Information about this drug list

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

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

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

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

Q. Can I fill my prescriptions by mail?

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

Express Scripts® Pharmacy for maintenance medications

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

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

Here are three easy ways to get started.

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

Accredo for specialty medications

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

- 24/7 access to specialty-trained pharmacists and nurses
- 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 medication every day to treat diabetes. My plan requires me to fill my medication through Express Scripts® Pharmacy. How do I get started?

A. Some plans allow one or more fills at a retail pharmacy before switching to home delivery. Check your plan materials to find out if your plan allows retail fills. Here are three easy ways to get started.

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

Information about this drug list

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

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

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

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

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

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

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

Q. How do I fill my prescription?

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

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

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

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

approved for coverage, and more.

Go to [Cigna.com/specialty](https://www.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 and Tier 3 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

Information about this drug list

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

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

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

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

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

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

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

- **Preventive care medications and products covered under the Patient Protection and Affordable Care Act (PPACA), also known as "health care reform:"**
 - **Contraceptives:** Covered at 100%, or no cost-share (\$0) to you. Certain prescription

contraceptives are available at their applicable cost-share.

- **Tobacco cessation products:** Up to two (2) 90-day courses of treatment per plan year are covered at 100%, or no cost-share (\$0) to you. Certain prescription tobacco cessation products are available at their applicable cost-share.
- **Certain vitamins:** Covered at 100%, or no cost-share (\$0) to you. All other prescription vitamins are available at their applicable cost-share and deductible (if applicable).
- **Certain over-the-counter (OTC) products:** If you have a prescription from your doctor, these are covered at 100%, or no cost-share (\$0) to you. All other OTC products are excluded from coverage.
- **Oral fertility medications:** Covered at their applicable tier cost-share. For some plans, injectable fertility medications are covered under the medical benefit.
- **Generic preventive care medications:** Covered at 100%, or no cost-share (\$0) to you before you meet your deductible. You'll pay your deductible and applicable cost-share to fill a preferred brand and/or non-preferred brand preventive care medication.
- **Diabetic supplies:** Covered at their applicable cost-share.
- **Growth Hormones:** Need approval from Cigna Healthcare before your plan will cover them (prior authorization). If you receive approval for coverage, you'll pay your applicable tier cost-share to fill the medication.
- **Vaccines:** Vaccines are now covered under the pharmacy benefit. Not all plans cover vaccines in the same way. Log in to the **myCigna App** or **myCigna.com**, or check your plan materials, to find out how your specific plan covers them.
- **Compounded medications:** If the medication is more than \$200, you'll need approval from Cigna Healthcare before your plan will cover them (prior authorization). coverage, you'll pay your applicable tier cost-share to fill the medication.

Information about this drug list

Words you may need to know

- **Brand name drug:** A drug that is marketed under a proprietary, trademark-protected name. The brand name drug shall be listed in all CAPITAL letters.
- **Coinsurance:** A percentage of the cost of a covered health care benefit that an enrollee pays after the enrollee has paid the deductible, if a deductible applies to the health care benefit, such as the prescription drug benefit.
- **Copayment:** A fixed dollar amount that an enrollee pays for a covered health care benefit after the enrollee has paid the deductible, if a deductible applies to the health care benefit, such as the prescription drug benefit.
- **Deductible:** The amount an enrollee pays for covered health care benefits before the enrollee's health plan begins payment for all or part of the cost of the health care benefit under the terms of the policy.
- **Drug tier:** A group of prescription drugs that corresponds to a specified cost sharing tier in the health plan's prescription drug coverage. The tier in which a prescription drug is placed determines the enrollee's portion of the cost for the drug.
- **Enrollee:** A person enrolled in a health plan who is entitled to receive services from the plan.
- **Exception request:** A request for coverage of a prescription drug. If an enrollee, his or her designee, or prescribing health care provider submits an exception request for coverage of a prescription drug, the health plan must cover the prescription drug when the drug is determined to be medically necessary to treat the enrollee's condition.
- **Exigent circumstances:** When an enrollee is suffering from a health condition that may seriously jeopardize the enrollee's life, health, or ability to regain maximum function, or when an enrollee is undergoing a current course of treatment using a nonformulary drug.
- **Formulary:** The complete list of drugs preferred for use and eligible for coverage under a health plan product, and includes all drugs covered under the outpatient prescription drug benefit.
- **Generic drug:** The same drug as its brand name equivalent in dosage, safety, strength, how it is taken, quality, performance, and intended use. A generic drug is listed in bold and italicized lowercase letters.
- **Non-formulary drug:** A prescription drug that is not listed on the health plan's formulary.
- **Out-of-pocket costs:** Copayments, coinsurance, and the applicable deductible, plus all costs for health care services that are not covered by the health plan.
- **Prescribing provider:** A health care provider authorized to write a prescription to treat a medical condition for a health plan enrollee.
- **Prescription:** An oral, written, or electronic order by a prescribing provider for a specific enrollee that contains the name of the prescription drug, the quantity of the prescribed drug, the date of issue, the name and contact information of the prescribing provider, the signature of the prescribing provider if the prescription is in writing, and if requested by the enrollee, the medical condition or purpose for which the drug is being prescribed.
- **Prescription drug:** A drug that is prescribed by the enrollee's prescribing provider and requires a prescription under applicable law.
- **Prior Authorization:** A health plan's requirement that the enrollee or the enrollee's prescribing provider obtain the health plan's authorization for a prescription drug before the health plan will cover the drug. The health plan shall grant a prior authorization when it is medically necessary for the enrollee to obtain the drug.
- **Step Therapy:** A process specifying the sequence in which different prescription drugs for a given medical condition and medically appropriate for a particular patient are prescribed. The health plan may require the enrollee to try one or more drugs to treat the enrollee's medical condition before the health plan will cover a particular drug for the condition pursuant to a step therapy request.

Information about this drug list

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

If the enrollee's prescribing provider submits a request for step therapy exception, the health plans shall make exceptions to step therapy when the criteria is met.

- **Subscriber:** The person who is responsible for payment to a plan or whose employment or other status, except for family dependency, is the basis for eligibility for membership in the plan.

About this drug list

This is a list of the most commonly prescribed medications covered on the Cigna Healthcare Standard 3-Tier Prescription Drug List as of July 1, 2024. Medications are listed alphabetically by their generic and brand names within their therapeutic category and class.

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

How to read this drug list

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

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

Tiers

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

| | | |
|--|---------------------------|--------|
| • Tier 1 – Typically Generics | (Lowest-cost medication) | \$ |
| • Tier 2 – Typically Preferred Brands | (Medium-cost medication) | \$\$ |
| • Tier 3 – Typically Non-Preferred Brands | (Highest-cost medication) | \$\$\$ |

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

Information about this drug list

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

Letters (acronyms) next to medication names

Certain medications may need approval from Cigna Healthcare before they can be covered.* This extra step helps make sure you're getting the right coverage for the right medication. In this drug list, medications that have extra coverage requirements or limits have **letters (acronyms)** in the Coverage Requirements and Limits column. Here's what they mean.

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

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

Information about this drug list

How to read this drug list (cont.)

Use the chart below to help you read this drug list. This chart is just an example. It may not show how these medications are actually covered on the Cigna Healthcare Standard 3-Tier Prescription Drug List.

| ANALGESICS (Pain Relief and Inflammatory Disease) | | |
|---|-----------|----------------------------------|
| Prescription Drug Name | Drug Tier | Coverage Requirements and Limits |
| ANALGESIC, NON-SALICYLATE AND BARBITURATE COMBINAT | | |
| <i>butalbital/acetaminophen</i> | T1 | |
| ANALGESIC, SALICYLATE, BARBITURATE, XANTHINE COMB. | | |
| <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) |
| ANALGESIC, NON-SALICYLATE, BARBITURATE, XANTHINE COMB. | | |
| <i>butalb/acetaminophen/caffeine</i> | T3 | |
| <i>butalb/acetaminophen/caffeine</i> (Esgic) | T3 | QL (6 caps/day) |
| <i>butalb-acetamin-caff 50-300-40</i> (Fioricet) | T1 | QL (6 caps/day) |
| <i>butalb-acetamin-caff 50-325-40</i> (Esgic) | T1 | QL (6 tabs/day) |
| ESGIC 50-325-40 MG TABLET (<i>butalbital-acetaminophen-caffe</i>) | T3 | QL (6 tabs/day) |
| ESGIC CAPSULE (<i>zebutal</i>) | T3 | QL (6 caps/day) |
| FIORICET (<i>phrenilin forte</i>) | T1 | QL (6 caps/day) |
| ANALGESIC/ANTIPYRETICS, SALICYLATES | | |
| <i>choline salicyl/mag salicylate</i> | T1 | HD |
| <i>diflunisal</i> | T1 | HD |
| ANTI-MIGRAINE PREPARATIONS | | |
| 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 Standard 3-Tier Prescription Drug List.

Information about this drug list

How to find your medication

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

| Condition | Page | Condition | Page |
|--|--------|--|--------|
| Analgesics (Pain Relief and Inflammatory Disease) | 18-22 | Anti-Infectives/Miscellaneous (Infections) | 44, 45 |
| Analgesics (Urinary Tract Conditions) | 22 | Anti-Infectives/Miscellaneous (Miscellaneous) | 45, 46 |
| Anesthetics (Miscellaneous) | 22 | Anti-Infectives/Miscellaneous (Skin Conditions) | 46 |
| Anesthetics (Pain Relief and Inflammatory Disease) | 23 | Anti-Inflammatory Tumor Necrosis Factor Inhibiting Agents (Pain Relief and Inflammatory Disease) | 46, 47 |
| Anesthetics (Urinary Tract Conditions) | 23 | Anti-Neoplastics (Cancer) | 47-52 |
| Anti-Allergy (Allergy and Nasal Sprays) | 23 | Anti-Neoplastics (Skin Conditions) | 52, 53 |
| Anti-Arthritics (Pain Relief and Inflammatory Disease) | 23-26 | Anti-Obesity Drugs (Weight Management) | 53 |
| Anti-Asthmatics (Asthma/COPD/Respiratory) | 26-28 | Anti-Parasitics (Infections) | 54 |
| Antibiotics (Allergy/Nasal Sprays) | 28 | Anti-Parkinson's Drugs (Parkinson's Disease) | 54-56 |
| Antibiotics (Ear Medications) | 29 | Anti-Platelet Drugs (Blood Thinners/Anti-Clotting) | 56 |
| Antibiotics (Eye Conditions) | 29, 30 | Antivirals (AIDS/HIV) | 56-59 |
| Antibiotics (Infections) | 30-35 | Antivirals (Eye Conditions) | 59 |
| Antibiotics (Skin Conditions) | 36 | Antivirals (Infections) | 59-61 |
| Anti-Coagulants (Blood Thinners/Anti-Clotting) | 36-38 | Antivirals (Skin Conditions) | 61 |
| Antidotes (Gastrointestinal/Heartburn) | 38 | Autonomic Drugs (Allergy/Nasal Sprays) | 61 |
| Antidotes (Substance Abuse) | 38 | Autonomic Drugs (Alzheimer's Disease) | 61 |
| Anti-Fungals (Eye Conditions) | 38 | Autonomic Drugs (Attention Deficit Hyperactivity Disorder) | 62 |
| Anti-Fungals (Feminine Products) | 38 | Autonomic Drugs (Blood Pressure/Heart Medications) | 62 |
| Anti-Fungals (Infections) | 38, 39 | Autonomic Drugs (Urinary Tract Conditions) | 63 |
| Anti-Fungals (Skin Conditions) | 39, 40 | Biologicals (Allergy/Nasal Sprays) | 63 |
| Antihistamine and Decongestant Combination (Allergy/Nasal Sprays) | 40 | Biologicals (Blood Pressure/Heart Medications) | 63 |
| Antihistamines (Eye Conditions) | 40 | Biologicals (Miscellaneous) | 63 |
| Anti-Hyperglycemics (Diabetes) | 41-44 | Biologicals (Vaccines) | 63-65 |
| Anti-Infectives (Feminine Products) | 44 | Blood (Blood Modifiers/Bleeding Disorders) | 65, 66 |
| Anti-Infectives (Infections) | 44 | Blood (Blood Thinners/Anti-Clotting) | 66 |
| Anti-Infectives/Miscellaneous (Feminine Products) | 44 | Cardiac Drugs (Blood Pressure/Heart Medications) | 66-69 |

Information about this drug list

How to find your medication *(cont.)*

| Condition | Page | Condition | Page |
|--|---------|---|----------|
| Cardiovascular (Asthma/COPD/Respiratory) | 69, 70 | Hormones (Infertility) | 108 |
| Cardiovascular (Blood Pressure/Heart Medications) | 70-76 | Hormones (Miscellaneous) | 108 |
| Cardiovascular (Cholesterol Medications) | 76-78 | Hormones (Osteoporosis Products) | 108 |
| CNS Drugs (Alzheimer's Disease) | 78, 79 | Immunosuppressants (Pain Relief and Inflammatory Disease) | 108, 109 |
| CNS Drugs (Miscellaneous) | 79 | Immunosuppressants (Skin Conditions) | 109 |
| CNS Drugs (Multiple Sclerosis) | 79, 80 | Immunosuppressants (Transplant Medications) | 109, 110 |
| CNS Drugs (Pain Relief and Inflammatory Disease) | 80 | Miscellaneous Medical Supplies, Devices, Non-Drug (Diabetes) | 110, 111 |
| CNS Drugs (Seizure Disorders) | 80-83 | Miscellaneous Medical Supplies, Devices, Non-Drug (Miscellaneous) | 111-118 |
| CNS Drugs (Sleep Disorders/Sedatives) | 83 | Muscle Relaxants (Pain Relief and Inflammatory Disease) | 118 |
| Colony Stimulating Factors (Blood Modifiers/Bleeding Disorders) | 83, 84 | Prenatal Vitamins (Nutritional/Dietary) | 119 |
| Contraceptives (Contraception Products) | 84-86 | Psychotherapeutic Drugs (Anxiety/Depression/Bipolar Disorder) | 119-123 |
| Cough/Cold Preparations (Allergy/Nasal Sprays) | 86 | Psychotherapeutic Drugs (Attention Deficit Hyperactivity Disorder) | 124, 125 |
| Cough/Cold Preparations (Cough/Cold Medications) | 86, 87 | Psychotherapeutic Drugs (Miscellaneous) | 125 |
| Diagnostic (Miscellaneous) | 87, 88 | Psychotherapeutic Drugs (Schizophrenia/Anti-Psychotics) | 126-128 |
| Diuretics (Diuretics) | 89, 90 | Psychotherapeutic Drugs (Sleep Disorders/Sedatives) | 128, 129 |
| EENT Preps (Allergy/Nasal Sprays) | 90 | Skin Preps (Miscellaneous) | 129 |
| EENT Preps (Ear Medications) | 90 | Skin Preps (Pain Relief and Inflammatory Disease) | 129 |
| EENT Preps (Eye Conditions) | 91-93 | Skin Preps (Skin Conditions) | 129-136 |
| Elect/Caloric/H ₂ O (Cholesterol Medications) | 93 | Smoking Deterrents (Smoking Cessation) | 136 |
| Elect/Caloric/H ₂ O (Dental Products) | 93, 94 | Thyroid Prep (Hormonal Agents) | 137, 138 |
| Elect/Caloric/H ₂ O (Diabetes) | 94 | Unclassified Drug Products (AIDS/HIV) | 138 |
| Elect/Caloric/H ₂ O (Miscellaneous) | 94 | Unclassified Drug Products (Asthma/COPD/Respiratory) | 137 |
| Elect/Caloric/H ₂ O (Nutritional/Dietary) | 95 | Unclassified Drug Products (Blood Modifiers/Bleeding Disorders) | 137 |
| Elect/Caloric/H ₂ O (Urinary Tract Conditions) | 96 | Unclassified Drug Products (Blood Pressure/Heart Medications) | 137, 138 |
| Gastrointestinal (Cholesterol Medications) | 96 | Unclassified Drug Products (Cancer) | 138 |
| Gastrointestinal (Gastrointestinal/Heartburn) | 96-102 | Unclassified Drug Products (Dental Products) | 138 |
| Gastrointestinal (Pain Relief and Inflammatory Disease) | 102 | | |
| Hormones (Hormonal Agents) | 102-107 | | |

Information about this drug list

How to find your medication *(cont.)*

| Condition | Page | Condition | Page |
|---|----------|---|----------|
| Unclassified Drug Products (Erectile Dysfunction) | 139, 140 | Unclassified Drug Products (Pain Relief and Inflammatory Disease) | 143 |
| Unclassified Drug Products (Gastrointestinal/Heartburn) | 140 | Unclassified Drug Products (Substance Abuse) | 144 |
| Unclassified Drug Products (Hormonal Agents) | 140 | Unclassified Drug Products (Transplant Medications) | 144 |
| Unclassified Drug Products (Miscellaneous) | 140-143 | Unclassified Drug Products (Urinary Tract Conditions) | 144, 145 |
| Unclassified Drug Products (Nutritional/Dietary) | 143 | Unclassified Drug Products (Weight Management) | 145 |
| Unclassified Drug Products (Osteoporosis Products) | 143 | Vitamins (Nutritional/Dietary) | 145, 146 |

List of Prescription Medications

| ANALGESICS (Pain Relief and Inflammatory Disease) | | |
|---|-----------|----------------------------------|
| Prescription Drug Name | Drug Tier | Coverage Requirements and Limits |
| ANALGESIC, NON-SALICYLATE AND BARBITURATE COMBINAT | | |
| <i>butalbital/acetaminophen</i> | T1 | |
| ANALGESIC, SALICYLATE, BARBITURATE, XANTHINE COMB. | | |
| <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) |
| ANALGESIC, NON-SALICYLATE, BARBITURATE, XANTHINE COMB. | | |
| <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) |
| ANALGESIC/ANTIPYRETICS, SALICYLATES | | |
| <i>choline salicyl/mag salicylate</i> | T1 | HD |
| <i>diflunisal</i> | T1 | HD |
| ANTI-MIGRAINE PREPARATIONS | | |
| 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) |
| <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> (Amerge) | T1 | QL (9 tabs/30 days) |
| NURTEC ODT | T2 | PA QL (16 tabs/30 days) |
| <i>rizatriptan ODT</i> (Maxalt Mlt) | T1 | QL(12 tabs/30 days) |
| <i>rizatriptan tablet</i> (Maxalt) | 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) |

T1 – Typically Generics

PA – Prior Authorization

AGE – Age Requirement

PPACA – No Cost-Share Preventive Medication

T2 – Typically Preferred Brands

QL – Quantity Limit

SP – Specialty Medication

CSL – Oral cancer medication subject to cost-share limits

T3 – Typically Non-Preferred Brands

ST – Step Therapy

HD – May require home delivery pharmacy

List of Prescription Medications

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

| Prescription Drug Name | Drug Tier | Coverage Requirements and Limits |
|---|-----------|----------------------------------|
| ANTI-MIGRAINE PREPARATIONS (cont.) | | |
| <i>sumatriptan 4 mg/0.5 ml inject</i> | T1 | QL (4ml/30 days) |
| <i>sumatriptan 6 mg/0.5 ml cart</i> | T1 | QL (4ml/30 days) |
| <i>sumatriptan 6 mg/0.5 ml inject</i> | T1 | QL (4ml/30 days) |
| <i>sumatriptan 6 mg/0.5 ml syrng</i> | T1 | QL (4ml/30 days) |
| <i>sumatriptan 6 mg/0.5 ml vial</i> | T1 | QL (5ml/30 days) |
| <i>sumatriptan succ 100 mg tablet</i> | T1 | QL (18 tabs/28 days) |
| <i>sumatriptan succ 25 mg tablet</i> | T1 | QL (18 tabs/28 days) |
| <i>sumatriptan succ 50 mg tablet</i> | T1 | QL (9 tabs/30 days) |
| <i>sumatriptan succ/naproxen sod</i> | T1 | QL (18 tabs/30 days) |
| TRUDHESA | T2 | PA QL (2 pkgs/30 days) |
| UBRELVY | T2 | PA QL (0.67 TABS/DAY) |
| ZAVZPRET | | |
| <i>zolmitriptan</i> | T1 | QL (12 tabs/30 days) |
| NSAIDS, CYCLOOXYGENASE INHIBITOR-TYPE ANALGESICS | | |
| <i>diclofenac potassium</i> | T1 | HD |
| <i>ketorolac 10 mg tablet</i> | T1 | QL (20 tabs/25 days) 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 carpject</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 |
| <i>ketorolac 30 mg/ml vial</i> | T1 | QL (20ml/30 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 |
| OPIOID ANALGESIC AND NON-SALICYLATE ANALGESICS | | |
| <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 |

T1 – Typically Generics

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T2 – Typically Preferred Brands

QL – Quantity Limit

SP – Specialty Medication

CSL – Oral cancer medication subject to cost-share limits

T3 – Typically Non-Preferred Brands

ST – Step Therapy

HD – May require home delivery pharmacy

List of Prescription Medications

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

| Prescription Drug Name | Drug Tier | Coverage Requirements and Limits |
|---|-----------|----------------------------------|
| OPIOID ANALGESIC AND NON-SALICYLATE ANALGESICS (cont.) | | |
| APADAZ | T3 | |
| BENZHYDROCODONE-ACETAMINOPHEN | T1 | |
| <i>hydrocodone/acetaminophen</i> | T1 | PA |
| <i>hydrocodone/acetaminophen</i> (Hydrocodone-acetaminophen) | T1 | PA |
| <i>hydrocodone/acetaminophen</i> (Norco) | 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</i> (Nalocet) | T1 | PA |
| <i>oxycodone hcl/acetaminophen</i> (Percocet) | T1 | PA |
| <i>oxycodone hcl/acetaminophen</i> (Primlev) | T1 | PA |
| PERCOCET (<i>oxycodone-acetaminophen</i>) | T3 | PA |
| PRIMLEV | T1 | PA |
| <i>tramadol hcl/acetaminophen</i> (Ultracet) | T1 | |
| ULTRACET (<i>tramadol hcl-acetaminophen</i>) | T3 | |
| OPIOID ANALGESIC AND NSAID COMBINATION | | |
| <i>hydrocodone/ibuprofen</i> | T1 | PA |
| <i>hydrocodone/ibuprofen</i> (Ibudone) | T1 | PA |
| IBUDONE | T1 | PA |
| <i>ibuprofen/oxycodone hcl</i> | T1 | PA |
| OPIOID ANALGESIC AND SALICYLATE ANALGESIC COMB | | |
| <i>oxycodone hcl/aspirin</i> | T1 | PA |
| OPIOID ANALGESIC AND NON-SALICYLATE XANTHINE COMB | | |
| 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 |
| OPIOID ANALGESICS | | |
| ACTIQ (<i>fentanyl citrate</i>) | T3 | PA |
| ARYMO ER | T3 | PA |
| BELBUCA | T2 | QL (2 films/day) |

T1 – Typically Generics

PA – Prior Authorization

AGE – Age Requirement

PPACA – No Cost-Share Preventive Medication

T2 – Typically Preferred Brands

QL – Quantity Limit

SP – Specialty Medication

CSL – Oral cancer medication subject to cost-share limits

T3 – Typically Non-Preferred Brands

ST – Step Therapy

HD – May require home delivery pharmacy

List of Prescription Medications

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

| Prescription Drug Name | Drug Tier | Coverage Requirements and Limits |
|---|-----------|----------------------------------|
| OPIOID ANALGESICS (cont.) | | |
| <i>buprenorphine</i> (Butrans) | T1 | QL (4 patches/28 days) |
| <i>butorphanol tartrate</i> | T1 | PA QL (6 bots/30 days) |
| BUTRANS (<i>buprenorphine</i>) | T3 | QL (4 patches/28 days) |
| <i>codeine sulfate</i> | T1 | PA |
| DILAUDID 2 MG TABLET (<i>hydromorphone hcl</i>) | T3 | PA |
| DILAUDID 4 MG TABLET (<i>hydromorphone hcl</i>) | T3 | PA |
| 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 CITRATE | T1 | PA |
| <i>fentanyl citrate</i> (Actiq) | T1 | PA |
| FENTORA | T3 | PA |
| <i>hydrocodone bitartrate</i> (Hysingla Er) | T1 | PA |
| <i>hydrocodone bitartrate</i> (Zohydro Er) | T1 | PA |
| <i>hydromorphone hcl</i> | T1 | PA |
| <i>hydromorphone hcl</i> (Dilaudid) | T1 | PA |
| HYSINGLA ER (<i>hydrocodone bitartrate er</i>) | T2 | PA |
| KADIAN (<i>morphine sulfate er</i>) | T3 | PA |
| LAZANDA | T3 | PA |
| <i>meperidine hcl</i> | T1 | PA |
| MORPHABOND ER | T2 | PA |
| <i>morphine sulfate</i> | T1 | PA |
| <i>morphine sulfate</i> (Kadian) | T1 | PA |
| <i>morphine sulfate</i> (Ms Contin) | T1 | PA |
| MS CONTIN (<i>morphine sulfate er</i>) | T3 | PA |
| NUCYNTA | T2 | PA |
| NUCYNTA ER | T3 | PA |
| <i>opium/belladonna alkaloids</i> | T1 | PA |
| OXAYDO | T3 | PA |
| <i>oxycodone hcl</i> | T1 | PA |
| OXYCODONE HCL ER | T1 | PA |

T1 – Typically Generics

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HD – May require home delivery pharmacy

List of Prescription Medications

| ANALGESICS (Pain Relief and Inflammatory Disease) (cont.) | | |
|---|-----------|----------------------------------|
| Prescription Drug Name | Drug Tier | Coverage Requirements and Limits |
| OPIOID ANALGESICS (cont.) | | |
| <i>oxymorphone hcl</i> | T1 | PA |
| <i>pentazocine hcl/naloxone hcl</i> | T1 | PA |
| ROXYBOND | T3 | PA |
| <i>tramadol er 100 mg tablet</i> | T1 | QL (1 tab/day) |
| <i>tramadol er 200 mg tablet</i> | T1 | QL (1 tab/day) |
| <i>tramadol er 300 mg tablet</i> | T1 | QL (1 tab/day) |
| <i>tramadol hcl 50 mg tablet (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 AND SALICYLATE ANALGESICS, BARBIT, XANTHINE | | |
| <i>codeine/butalbital/asa/caffeine (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, SALICYLAT, OPIOID ANALGES | | |
| <i>carisoprodol/aspirin/codeine</i> | T1 | PA |
| ANALGESICS (Urinary Tract Conditions) | | |
| URINARY TRACT ANALGESIC AGENTS | | |
| ELMIRON | T2 | |
| RIMSO-50 | T2 | |
| ANESTHETICS (Miscellaneous) | | |
| GENERAL ANESTHETICS, INHALANT | | |
| <i>desflurane (Suprane)</i> | T1 | |

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List of Prescription Medications

| ANESTHETICS (Pain Relief and Inflammatory Disease) | | |
|--|-----------|----------------------------------|
| Prescription Drug Name | Drug Tier | Coverage Requirements and Limits |
| GENERAL ANESTHETICS, INHALANT | | |
| <i>isoflurane</i> | T1 | |
| <i>isoflurane</i> | T3 | |
| <i>sevoflurane</i> (Ultane) | T1 | |
| ULTANE (<i>sevoflurane</i>) | T3 | |
| LOCAL ANESTHETICS | | |
| <i>lidocaine hcl</i> | T1 | |
| TOPICAL LOCAL ANESTHETICS | | |
| <i>lidocaine 5% ointment</i> | T1 | QL (145gm/30 days) |
| <i>lidocaine 5% patch</i> (Lidocan II) | T1 | |
| <i>lidocaine 5% patch</i> (Lidoderm) | T1 | |
| <i>lidocaine hcl</i> | T1 | |
| <i>lidocaine hcl</i> | T3 | |
| <i>lidocaine/prilocaine</i> | T1 | |
| LIDODERM (<i>lidocaine</i>) | T3 | |
| PAIN EASE MEDIUM STREAM SPRAY | T3 | |
| 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 |

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List of Prescription Medications

| ANTI-ARTHRITICS (Pain Relief and Inflammatory Disease) (cont.) | | |
|--|-----------|-----------------------------------|
| Prescription Drug Name | Drug Tier | Coverage Requirements and Limits |
| ANTI-ARTHRITIC AND CHELATING AGENTS (cont.) | | |
| <i>penicillamine</i> (Depen) | T1 | PA SP |
| ANTI-ARTHRITIC, FOLATE ANTAGONIST AGENTS | | |
| OTREXUP | T2 | PA |
| ANTI-INFLAM. INTERLEUKIN-1 RECEPTOR ANTAGONIST | | |
| KINERET | T3 | PA QL (28 syringes/28 days) SP |
| ANTI-INFLAMMATORY, PYRIMIDINE SYNTHESIS INHIBITOR | | |
| ARAVA (<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, SEL.COSTIM.MOD., T-CELL INHIBITOR | | |
| ORENCIA | T3 | PA QL (4 syringes/28 days) SP HD |
| ORENCIA CLICKJECT | T3 | PA QL (4 injectors/28 days) SP HD |
| COLCHICINE | | |
| COLCHICINE | T1 | HD |
| <i>colchicine</i> (Colcrys) | T1 | HD |
| <i>colchicine</i> (Mitigare) | T1 | HD |
| COLCRYS (<i>colchicine</i>) | T3 | HD |
| MITIGARE (<i>colchicine</i>) | T3 | HD |
| GOLD SALTS | | |
| RIDAURA | T2 | |
| HYPERURICEMIA TX - XANTHINE OXIDASE INHIBITORS | | |
| <i>allopurinol</i> (Zyloprim) | T1 | HD |
| <i>febuxostat 40 mg tablet</i> (Uloric) | T1 | QL (1 tab/day) HD |
| <i>febuxostat 80 mg tablet</i> (Uloric) | 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 |
| JANUS KINASE (JAK) INHIBITORS | | |
| <i>febuxostat 40 mg tablet</i> (Uloric) | T1 | QL (1 tab/day) HD |
| <i>febuxostat 80 mg tablet</i> (Uloric) | T1 | HD |
| LITFULO | T3 | PA QL(1 cap/day) SP HD |
| ULORIC 40 MG TABLET (<i>febuxostat</i>) | T3 | QL (1 tab/day) HD |
| ULORIC 80 MG TABLET (<i>febuxostat</i>) | T3 | HD |

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List of Prescription Medications

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

| Prescription Drug Name | Drug Tier | Coverage Requirements and Limits |
|---|-----------|----------------------------------|
| JANUS KINASE (JAK) INHIBITORS | | |
| ZYLOPRIM (<i>allopurinol</i>) | T3 | HD |
| XELJANZ 5 MG TABLET | T2 | PA QL (2 tabs/day) SP HD |
| XELJANZ XR | T2 | PA QL (1 tab/day) SP HD |
| NSAIDS (COX NON-SPEC.INHIB) AND PROSTAGLANDIN ANALOG | | |
| ARTHROTEC 50 (<i>diclofenac sodium-misoprostol</i>) | T3 | ST HD |
| ARTHROTEC 75 (<i>diclofenac sodium-misoprostol</i>) | T3 | ST HD |
| <i>diclofenac sodium/misoprostol</i> (Arthrotec 50) | T1 | HD |
| <i>diclofenac sodium/misoprostol</i> (Arthrotec 75) | T1 | HD |
| NSAIDS, CYCLOOXYGENASE INHIBITOR - TYPE ANALGESICS | | |
| ANAPROX DS (<i>naproxen sodium ds</i>) | T3 | ST HD |
| DAYPRO (<i>oxaprozin</i>) | T3 | ST HD |
| <i>diclofenac sod dr 25 mg tab</i> | T1 | HD |
| <i>diclofenac sod dr 50 mg tab</i> | T1 | HD |
| <i>diclofenac sod dr 75 mg tab</i> | T1 | HD |
| <i>diclofenac sod ec 25 mg tab</i> | T1 | HD |
| <i>diclofenac sod ec 50 mg tab</i> | T1 | HD |
| <i>diclofenac sod ec 75 mg tab</i> | T1 | HD |
| <i>diclofenac sodium</i> | T1 | HD |
| EC-NAPROSYN (<i>naproxen</i>) | T3 | ST HD |
| <i>etodolac</i> | T1 | HD |
| <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>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> (Mobic) | 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 tablet</i> | T1 | HD |

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List of Prescription Medications

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

| Prescription Drug Name | Drug Tier | Coverage Requirements and Limits |
|---|-----------|----------------------------------|
| NSAIDS, CYCLOOXYGENASE INHIBITOR - TYPE ANALGESICS (cont.) | | |
| <i>naproxen</i> (Ec-naprosyn) | T1 | HD |
| <i>naproxen</i> (Naprosyn) | T1 | HD |
| <i>naproxen DR</i> (Ec-Naprosyn) | T1 | HD |
| <i>naproxen sodium</i> (Anaprox Ds) | T1 | HD |
| <i>oxaprozin</i> (Daypro) | T1 | HD |
| OXAPROZIN 300 MG CAPSULE | T3 | HD |
| <i>piroxicam</i> (Feldene) | T1 | HD |
| QMIIZ ODT 15 MG TABLET | T3 | ST HD |
| QMIIZ ODT 7.5 MG TABLET | T3 | QL (1 tab/day) ST HD |
| <i>tolmetin sodium</i> | T1 | HD |
| NSAIDS, CYCLOOXYGENASE-2(COX-2) SELECTIVE INHIBITOR | | |
| <i>arformoterol tartrate</i> (Brovana) | T1 | QL(4 mls/day) HD |
| CELEBREX 100 MG CAPSULE (<i>celecoxib</i>) | T3 | QL (2 caps/day) ST HD |
| CELEBREX 200 MG CAPSULE (<i>celecoxib</i>) | T3 | QL (2 caps/day) ST HD |
| CELEBREX 400 MG CAPSULE (<i>celecoxib</i>) | T3 | QL (1 cap/day) ST HD |
| CELEBREX 50 MG CAPSULE (<i>celecoxib</i>) | T3 | QL (2 caps/day) ST HD |
| <i>celecoxib 100 mg capsule</i> (Celebrex) | T1 | QL (2 caps/day) HD |
| <i>celecoxib 200 mg capsule</i> (Celebrex) | T1 | QL (2 caps/day) HD |
| <i>celecoxib 400 mg capsule</i> (Celebrex) | T1 | QL (1 cap/day) HD |
| <i>celecoxib 50 mg capsule</i> (Celebrex) | T1 | QL (2 caps/day) HD |
| URICOSURIC AGENTS | | |
| <i>probenecid</i> | T1 | HD |
| <i>probenecid/colchicine</i> | T1 | HD |
| ANTI-ASTHMATICS (Asthma/COPD/Respiratory) | | |
| 5-LIPOXYGENASE INHIBITORS | | |
| <i>zileuton</i> | T1 | HD |
| ANTICHOLINERGICS, ORALLY INHALED LONG ACTING | | |
| INCRUSE ELLIPTA | T2 | HD |
| LONHALA MAGNAIR REFILL | T3 | PA HD |
| LONHALA MAGNAIR STARTER | T3 | PA HD |
| SPIRIVA RESPIMAT | T2 | HD |
| ANTICHOLINERGICS, ORALLY INHALED SHORT ACTING | | |
| ATROVENT HFA | T2 | HD |
| <i>ipratropium bromide</i> | T1 | HD |

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List of Prescription Medications

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

| Prescription Drug Name | Drug Tier | Coverage Requirements and Limits |
|---|-----------|----------------------------------|
| 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 (18gm/30 days) |
| ALBUTEROL SULFATE HFA | T1 | QL (18gm/30 days) |
| <i>levalbuterol hcl (Xopenex Concentrate)</i> | T1 | |
| <i>levalbuterol hcl (Xopenex)</i> | T1 | |
| XOPENEX (<i>levalbuterol hcl</i>) | T3 | |
| XOPENEX CONCENTRATE (<i>levalbuterol concentrate</i>) | T3 | |
| BETA-ADRENERGIC AGENTS, INHALED, ULTRA-LONG ACTING | | |
| ARCAPTA NEOHALER | T3 | HD |
| STRIVERDI RESPIMAT | T2 | QL(1 inhaler/30 days) HD |
| BETA-ADRENERGIC AGENTS, ORALLY INHALED, LONG ACTING | | |
| BROVANA | T3 | HD |
| BETA-ADRENERGIC AND ANTICHOLINERGIC COMBO, INHALED | | |
| ANORO ELLIPTA | T2 | HD |
| COMBIVENT RESPIMAT | T2 | HD |
| <i>ipratropium/albuterol sulfate</i> | T1 | HD |
| STIOLTO RESPIMAT INHAL SPRAY | T2 | HD |
| BETA-ADRENERGIC AGENTS AND GLUCOCORTICOID COMBO, INHALED | | |
| ADVAIR HFA | T2 | HD |
| AIRDUO DIGIHALER | T3 | ST HD |
| BREO ELLIPTA | T2 | HD |
| <i>budesonide/formoterol fumarate (Symbicort)</i> | T2 | QL HD |

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List of Prescription Medications

| ANTI-ASTHMATICS (Asthma/COPD/Respiratory) (cont.) | | |
|---|-----------|----------------------------------|
| Prescription Drug Name | Drug Tier | Coverage Requirements and Limits |
| BETA-ADRENERGIC AGENTS AND GLUCOCORTICOID COMBO, INHALED | | |
| DULERA | T2 | HD |
| <i>fluticasone propion/salmeterol</i> | T1 | QL (1 Inhaler/30 days) HD |
| BETA-ADRENERGIC-ANTICHOLINERGIC-GLUCOCORT, INHALED | | |
| BREZTRI AEROSPHERE | T2 | |
| TRELEGY ELLIPTA | T2 | |
| GLUCOCORTICIDS, ORALLY INHALED | | |
| ALVESCO | T2 | HD |
| ASMANEX HFA/TWISTHALER | T3 | QL(1 inhaler/30 days) HD |
| <i>budesonide</i> (Pulmicort) | T1 | HD |
| <i>deflazacort</i> (Emflaza) | T1 | PA SP HD |
| EMFLAZA (deflazacort) | T3 | PA SP HD |
| FLOVENT DISKUS | T2 | HD |
| FLUTICASONE PROP DISKUS | T3 | QL HD |
| PULMICORT (<i>budesonide</i>) | T3 | HD |
| QVAR REDHALER | T2 | HD |
| INTERLEUKIN-5(IL-5) RECEPTOR ALPHA ANTAGONIST, MAB | | |
| FASENRA PEN | T3 | PA SP HD |
| LEUKOTRIENE RECEPTOR ANTAGONISTS | | |
| 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 |
| MAST CELL STABILIZERS, ORALLY INHALED | | |
| <i>cromolyn 20 mg/2 ml neb soln</i> | T1 | QL (480ml/30 days) HD |
| MONOCLONAL ANTIBODIES TO IMMUNOGLOBULIN E (IGE) | | |
| XOLAIR | T3 | PA SP HD |
| MONOCLONAL ANTIBODY - INTERLEUKIN-5 ANTAGONISTS | | |
| NUCALA | T3 | PA SP HD |
| MUCOLYTICS | | |
| <i>acetylcysteine</i> | T1 | |
| PHOSPHODIESTERASE-4 (PDE4) INHIBITORS | | |
| DALIRESP 250 MCG TABLET | T3 | QL (28 tabs/180 days) HD |
| DALIRESP 500 MCG TABLET | T3 | QL (2 tabs/day) HD |
| XANTHINES | | |
| THEO-24 | T2 | HD |
| <i>theophylline anhydrous</i> | T1 | HD |

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List of Prescription Medications

| ANTIBIOTICS (Allergy/Nasal Sprays) | | |
|---|-----------|----------------------------------|
| Prescription Drug Name | Drug Tier | Coverage Requirements and Limits |
| NOSE PREPARATIONS ANTIBIOTICS | | |
| BACTROBAN NASAL | T2 | |
| ANTIBIOTICS (Ear Medications) | | |
| EAR PREPARATIONS, ANTIBIOTICS | | |
| <i>ciprofloxacin hcl</i> | T1 | |
| CORTISPORIN-TC | T3 | |
| <i>neomycin/polymyxin b/hydrocort</i> | T1 | |
| <i>ofloxacin</i> | T1 | |
| OTIC PREPARATIONS, ANTI-INFLAMMATORY-ANTIBIOTICS | | |
| CIPRO HC | T2 | |
| <i>ciprofloxacin hcl/dexameth</i> (Ciprodex) | T1 | |
| CIPROFLOXACIN HCL-FLUOCINOLONE | T3 | |
| OTOVEL | T3 | |
| ANTIBIOTICS (Eye Conditions) | | |
| EYE ANTIBIOTIC AND GLUCOCORTICOID COMBINATIONS | | |
| <i>neomycin/bacit/p-myx/hydrocort</i> | T1 | |
| <i>neomycin/polymyxin b/dexametha</i> (Maxitrol) | T1 | |
| <i>neomycin/polymyxin b/hydrocort</i> | T1 | |
| TOBRADEX ST | T2 | |
| <i>tobramycin/dexamethasone</i> (Tobradex) | T1 | |
| ZYLET | T3 | |
| EYE SULFONAMIDES | | |
| BLEPH-10 (<i>sulfacetamide sodium</i>) | T3 | |
| BLEPHAMIDE | T2 | |
| <i>sulfacetamide sodium</i> | T1 | |
| <i>sulfacetamide sodium</i> (Bleph-10) | T1 | |
| <i>sulfacetamide/prednisolone sp</i> | T1 | |
| OPHTHALMIC ANTIBIOTICS | | |
| AZASITE | T2 | |
| <i>bacitracin</i> (Baciguent) | T1 | |
| <i>bacitracin/polymyxin b sulfat</i> e | T1 | |
| BESIVANCE | T2 | |
| <i>ciprofloxacin hcl</i> (Ciloxan) | T1 | |
| <i>erythromycin base</i> | T1 | |
| <i>gatifloxacin</i> (Zymaxid) | T1 | |

T1 – Typically Generics

PA – Prior Authorization

AGE – Age Requirement

PPACA – No Cost-Share Preventive Medication

T2 – Typically Preferred Brands

QL – Quantity Limit

SP – Specialty Medication

CSL – Oral cancer medication subject to cost-share limits

T3 – Typically Non-Preferred Brands

ST – Step Therapy

HD – May require home delivery pharmacy

List of Prescription Medications

ANTIBIOTICS (Eye Conditions) (cont.)

| Prescription Drug Name | Drug Tier | Coverage Requirements and Limits |
|---------------------------------------|-----------|----------------------------------|
| OPHTHALMIC ANTIBIOTICS (cont.) | | |
| <i>gentamicin sulfate</i> | T1 | |
| <i>levofloxacin</i> | T1 | |
| MOXEZA (<i>moxifloxacin</i>) | T3 | |
| <i>moxifloxacin hcl</i> (Moxeza) | T1 | |
| <i>moxifloxacin hcl</i> (Vigamox) | T1 | |
| <i>neomycin sulf/bacitracin/poly</i> | T1 | |
| <i>neomycin/polymyxn b/gramicidin</i> | T1 | |
| <i>ofloxacin</i> (Ocuflox) | T1 | |
| <i>tobramycin 0.3% eye drop</i> | T1 | |
| TOBEX 0.3% EYE OINTMENT | T2 | |

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 | |
| <i>sulfamethoxazole/trimethoprim</i> | T3 | |
| <i>sulfamethoxazole/trimethoprim</i> (Bactrim Ds) | T1 | |
| <i>sulfamethoxazole/trimethoprim</i> (Bactrim) | T1 | |

AMINOGLYCOSIDE ANTIBIOTICS

| | | |
|---------------------------------------|----|---------------------------------------|
| ARIKAYCE | T3 | PA SP |
| <i>gentamicin sulfate</i> | T1 | |
| <i>gentamicin sulfate/pf</i> | T1 | |
| KITABIS PAK | T3 | PA QL (10ml/day) SP HD |
| <i>neomycin sulfate</i> | T1 | |
| TOBI PODHALER | T2 | PA QL (28 days therapy/56 days) SP HD |
| <i>tobramycin 1,200 mg/30 ml vial</i> | T1 | |
| <i>tobramycin 1.2 gm vial</i> | T1 | PA |
| <i>tobramycin 1.2 gram/30 ml vial</i> | T1 | |
| <i>tobramycin 10 mg/ml vial</i> | T1 | |
| <i>tobramycin 300 mg/4 ml ampule</i> | T1 | QL (8 ML/DAY) SP HD |
| <i>tobramycin 300 mg/5 ml ampule</i> | T1 | PA QL (10ml/day) SP HD |
| <i>tobramycin 40 mg/ml vial</i> | T1 | |
| <i>tobramycin 80 mg/2 ml vial</i> | T1 | |
| TOBRAMYCIN PAK 300 MG/5 ML | T3 | PA QL (10ml/day) SP HD |

T1 – Typically Generics

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T2 – Typically Preferred Brands

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CSL – Oral cancer medication subject to cost-share limits

T3 – Typically Non-Preferred Brands

ST – Step Therapy

HD – May require home delivery pharmacy

List of Prescription Medications

| ANTIBIOTICS (Infections) (cont.) | | |
|---|-----------|----------------------------------|
| Prescription Drug Name | Drug Tier | Coverage Requirements and Limits |
| ANAEROBIC ANTIPROTOZOAL-ANTIBACTERIAL AGENTS | | |
| FLAGYL (<i>metronidazole</i>) | T3 | PA |
| LIKMEZ | T3 | |
| <i>metronidazole</i> (Flagyl) | T1 | |
| ANTIBIOTIC, ANTIBACTERIAL, MISC. | | |
| <i>fosfomycin tromethamine</i> | T1 | |
| HIPREX (<i>methenamine hippurate</i>) | T3 | |
| <i>meth/meblue/sod phos/psal/hyos</i> | T1 | |
| <i>meth/meblue/sod phos/psal/hyos</i> | T2 | |
| <i>meth/meblue/sod phos/psal/hyos</i> (Uribel) | 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 | |
| PRIMSOL | T2 | |
| <i>trimethoprim</i> | T1 | |
| TRIMPEX | T2 | |
| URIBEL (<i>methenam/m.blue/salicyl/hyoscy</i>) | T3 | |
| UTA | T3 | |
| ANTILEPTOTICS | | |
| <i>dapsone</i> | T1 | PA SP HD |
| THALOMID | T2 | |
| ANTI-MYCOBACTERIUM AGENTS | | |
| <i>ethambutol hcl</i> | T1 | HD |
| <i>ethambutol hcl</i> (Myambutol) | T1 | HD |
| <i>isoniazid</i> | T1 | HD |
| MYAMBUTOL (<i>ethambutol hcl</i>) | T3 | HD |
| PASER | T2 | HD |
| <i>pyrazinamide</i> | T1 | HD |
| <i>rifabutin</i> | T1 | HD |
| TRECTOR | T2 | HD |
| ANTI-TUBERCULAR ANTIBIOTICS | | |
| CYCLOSERINE | T1 | |

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List of Prescription Medications

| ANTIBIOTICS (Infections) (cont.) | | |
|---|-----------|----------------------------------|
| Prescription Drug Name | Drug Tier | Coverage Requirements and Limits |
| ANTI-TUBERCULAR ANTIBIOTICS | | |
| PRETOMANID | T3 | PA QL (1 tab/day) |
| PRIFTIN | T3 | |
| RIFAMATE | T2 | |
| <i>rifampin</i> | T1 | |
| RIFATER | T2 | |
| SIRTURO | T3 | SP |
| BETALACTAMS | | |
| CAYSTON | T3 | PA QL (3ml/day) SP HD |
| CEPHALOSPORIN ANTIBIOTICS - 1ST GENERATION | | |
| <i>cefadroxil</i> | T1 | |
| <i>cephalexin</i> | T1 | |
| <i>cephalexin</i> (Keflex) | T1 | |
| DAXBIA | T3 | |
| KEFLEX (<i>cephalexin</i>) | T3 | |
| CEPHALOSPORIN ANTIBIOTICS - 2ND GENERATION | | |
| <i>cefaclor</i> | T1 | |
| <i>cefprozil</i> | T1 | |
| <i>cefuroxime axetil</i> | T1 | |
| CEPHALOSPORIN ANTIBIOTICS - 3RD GENERATION | | |
| <i>cefdinir</i> | T1 | |
| <i>cefditoren pivoxil</i> | T1 | |
| <i>cefixime</i> (Suprax) | T1 | |
| <i>cefpodoxime proxetil</i> | T1 | |
| <i>ceftriaxone sodium</i> | T1 | |
| SUPRAX | T3 | |
| SUPRAX (<i>cefixime</i>) | T3 | |
| LINCOSAMIDE ANTIBIOTICS | | |
| CLEOCIN HCL 150 MG CAPSULE (<i>clindamycin hcl</i>) | T3 | |
| CLEOCIN HCL 300 MG CAPSULE (<i>clindamycin hcl</i>) | T3 | |
| CLEOCIN HCL 75 MG CAPSULE (<i>clindamycin hcl</i>) | T2 | |
| CLEOCIN PEDIATRIC (<i>clindamycin (pediatric)</i>) | T3 | |
| <i>clindamycin hcl</i> (Cleocin Hcl) | T1 | |
| <i>clindamycin palmitate hcl</i> (Cleocin Pediatric) | T1 | |

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List of Prescription Medications

ANTIBIOTICS (Infections) (cont.)

| Prescription Drug Name | Drug Tier | Coverage Requirements and Limits |
|---|-----------|----------------------------------|
| MACROLIDE ANTIBIOTICS | | |
| <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 tablet (Zithromax Tri-pak)</i> | T1 | |
| <i>azithromycin 600 mg tablet</i> | T1 | |
| <i>clarithromycin</i> | T1 | |
| DIFICID 200 MG TABLET | T3 | QL (28 tabs/28 days) |
| DIFICID 40 MG/ML SUSPENSION | T3 | QL (5ML/Day) |
| ERYPED 200 (<i>erythromycin ethylsuccinate</i>) | T3 | |
| <i>ery-tab dr 250 mg tablet</i> | T3 | |
| <i>ery-tab dr 333 mg tablet</i> | T2 | |
| ERY-TAB DR 500 MG TABLET (<i>erythromycin</i>) | T3 | |
| <i>erythromycin base</i> | T1 | |
| <i>erythromycin base (Ery-tab)</i> | T1 | |
| <i>erythromycin ethylsuccinate</i> | T1 | |
| <i>erythromycin ethylsuccinate</i> | T2 | |
| <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 | |
| ZITHROMAX 250 MG Z-PAK TABLET (<i>azithromycin</i>) | T3 | |
| ZITHROMAX 500 MG TABLET (<i>azithromycin</i>) | T3 | |
| ZITHROMAX TRI-PAK (<i>azithromycin</i>) | T3 | |
| NITROFURAN DERIVATIVES ANTIBACTERIAL AGENTS | | |
| FURADANTIN (<i>nitrofurantoin</i>) | T3 | |
| MACROBID (<i>nitrofurantoin mono-macro</i>) | T3 | |
| MACRODANTIN (<i>nitrofurantoin</i>) | T3 | |
| <i>nitrofurantoin 25 mg/5 ml susp (Furadantin)</i> | T1 | |
| <i>nitrofurantoin 25 mg/5 ml susp (Furadantin)</i> | T1 | |

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CSL – Oral cancer medication subject to cost-share limits

T3 – Typically Non-Preferred Brands

ST – Step Therapy

HD – May require home delivery pharmacy

List of Prescription Medications

| ANTIBIOTICS (Infections) (cont.) | | |
|--|-----------|----------------------------------|
| Prescription Drug Name | Drug Tier | Coverage Requirements and Limits |
| NITROFURAN DERIVATIVES ANTIBACTERIAL AGENTS | | |
| <i>nitrofurantoin monohyd/m-cryst</i> (Macrobid) | T1 | |
| OXAZOLIDINONE ANTIBIOTICS | | |
| <i>linezolid</i> (Zyvox) | T1 | PA |
| SIVEXTRO | T3 | PA |
| ZYVOX (<i>linezolid</i>) | T3 | PA |
| PENICILLIN ANTIBIOTICS | | |
| <i>amoxicillin</i> | T1 | |
| <i>ampicillin trihydrate</i> | T1 | |
| <i>dicloxacillin sodium</i> | T1 | |
| MOXATAG | T3 | |
| <i>penicillin v potassium</i> | T1 | |
| PLEUROMUTILIN DERIVATIVES | | |
| XENLETA | T3 | PA QL (10 tabs/30 days) |
| QUINOLONE ANTIBIOTICS | | |
| AVELOX (<i>moxifloxacin hcl</i>) | T3 | |
| BAXDELA | T3 | PA |
| CIPRO 10% SUSPENSION (<i>ciprofloxacin</i>) | T2 | |
| CIPRO 250 MG TABLET (<i>ciprofloxacin hcl</i>) | T3 | |
| CIPRO 5% SUSPENSION (<i>ciprofloxacin</i>) | T2 | |
| CIPRO 500 MG TABLET (<i>ciprofloxacin hcl</i>) | T3 | |
| <i>ciprofloxacin</i> (Cipro) | T1 | |
| <i>ciprofloxacin hcl</i> | T1 | |
| <i>ciprofloxacin hcl</i> (Cipro) | T1 | |
| <i>ciprofloxacin/ciprofloxacin hcl</i> | T1 | |
| FACTIVE | T3 | |
| <i>levofloxacin</i> | T1 | |
| <i>moxifloxacin hcl</i> (Avelox) | T1 | |
| <i>ofloxacin</i> | T1 | |
| RIFAMYCINS AND RELATED DERIVATIVE ANTIBIOTICS | | |
| AEMCOLO | T3 | QL (12 tabs/3 days) |
| XIFAXAN 200 MG TABLET | T2 | |
| XIFAXAN 550 MG TABLET | T2 | QL (126 tabs/year) |
| TETRACYCLINE ANTIBIOTICS | | |
| <i>coremino er 135 mg tablet</i> | T1 | |
| <i>coremino er 45 mg tablet</i> | T1 | QL (1 tab/day) |

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CSL – Oral cancer medication subject to cost-share limits

T3 – Typically Non-Preferred Brands

ST – Step Therapy

HD – May require home delivery pharmacy

List of Prescription Medications

| ANTIBIOTICS (Infections) (cont.) | | |
|---|-----------|----------------------------------|
| Prescription Drug Name | Drug Tier | Coverage Requirements and Limits |
| TETRACYCLINE ANTIBIOTICS (cont.) | | |
| coremino er 90 mg tablet | T1 | QL (1 tab/day) |
| demeclocycline hcl | T1 | |
| doxycycline hyclate | T1 | |
| minocycline er 135 mg tablet | T1 | |
| minocycline er 45 mg tablet | T1 | |
| minocycline er 55 mg tablet | T1 | |
| minocycline er 65 mg tablet | T1 | |
| minocycline er 80 mg tablet | T1 | |
| minocycline er 90 mg tablet | T1 | |
| minocycline hcl | T1 | |
| NUZYRA | T3 | PA QL (30 tablets/28 days) SP |
| tetracycline hcl | T1 | |
| VIBRAMYCIN 50 MG/5 ML SYRUP | T2 | |
| VAGINAL ANTIBIOTICS | | |
| clindamycin phosphate (Cleocin) | T1 | |
| metronidazole (Metrogel-vaginal) | T1 | |
| VANCOMYCIN ANTIBIOTICS AND DERIVATIVES | | |
| vancomycin hcl | T1 | |
| vancomycin hcl (Firvanq) | T1 | |
| TOPICAL ANTIBIOTIC AND ANTI-INFLAMMATORY STEROID | | |
| CORTISPORIN | T3 | |
| NEO-SYNALAR | T3 | |
| TOPICAL ANTIBIOTICS | | |
| BENZAMYCIN (erythromycin-benzoyl peroxide) | T3 | |
| CENTANY | T3 | |
| CENTANY AT | T3 | |
| CLEOCIN T (clindamycin phosphate) | T3 | |
| CLINDACIN ETZ KIT | T3 | |
| CLINDACIN PAC | T3 | |
| clindamycin phosphate | T1 | |
| clindamycin phosphate (Cleocin T) | T1 | |
| clindamycin phosphate (Evoclin) | T1 | |
| erythromycin base in ethanol | T1 | |

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CSL – Oral cancer medication subject to cost-share limits

T3 – Typically Non-Preferred Brands

ST – Step Therapy

HD – May require home delivery pharmacy

List of Prescription Medications

| ANTIBIOTICS (Skin Conditions) | | |
|---|-----------|----------------------------------|
| Prescription Drug Name | Drug Tier | Coverage Requirements and Limits |
| TOPICAL ANTIBIOTICS (cont.) | | |
| <i>erythromycin base in ethanol</i> | T3 | |
| <i>erythromycin/benzoyl peroxide</i> (Benzamycin) | T1 | |
| EVOCLIN (<i>clindamycin phosphate</i>) | T3 | |
| <i>gentamicin sulfate</i> | T1 | |
| <i>mupirocin</i> (Centany) | T1 | |
| <i>mupirocin calcium</i> | T1 | |
| XEPI | T3 | |
| TOPICAL SULFONAMIDES | | |
| AVAR 9.5-5% CLEANSING PADS | T3 | |
| <i>avar cleanser</i> (Rosanil) | T1 | |
| AVAR LS | T3 | |
| AVAR-E | T1 | |
| <i>mafenide acetate</i> | T1 | |
| <i>mafenide acetate</i> (Sulfamylon) | 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 | T2 | |
| ANTI-COAGULANTS (Blood Thinners/Anti-Clotting) | | |
| ANTI-COAGULANTS, COUMARIN TYPE | | |
| <i>warfarin sodium</i> | T1 | HD |
| CITRATES AS ANTI-COAGULANTS | | |
| ACD SOLUTION A | T3 | |
| ACD-A | T3 | |
| ANTICOAG SODIUM CITRATE 4% SOL | T3 | |
| CITRATE PHOSPHATE DEXTROSE | T1 | |
| DIRECT FACTOR XA INHIBITORS | | |
| BEVYXXA | T3 | QL (42 caps/42 days) |

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T3 – Typically Non-Preferred Brands

ST – Step Therapy

HD – May require home delivery pharmacy

List of Prescription Medications

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

| Prescription Drug Name | Drug Tier | Coverage Requirements and Limits |
|--|-----------|----------------------------------|
| DIRECT FACTOR XA INHIBITORS (cont.) | | |
| 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 |
| HEPARIN AND RELATED PREPARATIONS | | |
| ARIXTRA (<i>fondaparinux sodium</i>) | T3 | QL (1 syringe/day) SP |
| <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 |
| <i>heparin 10,000 unit/10 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 50,000 unit/10 ml vial</i> | T1 | |
| <i>heparin 50,000 unit/5 ml vial</i> | T1 | |
| <i>heparin sod 1,000 unit/ml vial</i> | T1 | |
| <i>heparin sod 10,000 unit/ml vl</i> | T1 | |
| <i>heparin sod 2,000 unit/2ml vial</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 | T1 | |
| <i>heparin sod 5,000 unit/0.5 ml (Heparin Sodium)</i> | T1 | |
| <i>heparin sod 5,000 unit/ml syrg</i> | T3 | |
| <i>heparin sod 5,000 unit/ml vial</i> | 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 |

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List of Prescription Medications

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

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

HEPARIN AND RELATED PREPARATIONS (cont.)

| | | |
|---|----|------------------------|
| 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>) | T3 | 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

| | | |
|--------------------------------------|----|------------------------|
| <i>dabigatran etexilate mesylate</i> | T3 | QL (2 syringes/day) SP |
|--------------------------------------|----|------------------------|

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) |
| <i>naloxone 0.4 mg/ml carpuject</i> | T1 | |
| <i>naloxone 0.4 mg/ml vial</i> | T1 | |
| NALOXONE 2 MG AUTO-INJECTOR | T3 | QL (0.8ml/day) |
| <i>naloxone 2 mg/2 ml syringe</i> | T1 | |
| <i>naloxone 4 mg/10 ml vial</i> | T1 | |
| <i>naltrexone 50 mg tablet</i> | T1 | QL (180 tabs/30 days) |
| NARCAN | T2 | QL (2 units/30 days) |
| OPVEE | T3 | QL (2 units/30 days) |
| ZIMHI | T3 | QL (2 units/30 days) |

ANTI-FUNGALS (Eye Conditions)

OPHTHALMIC ANTI-FUNGAL AGENTS

| | | |
|---------|----|--|
| NATACYN | T2 | |
|---------|----|--|

ANTI-FUNGALS (Feminine Products)

VAGINAL ANTI-FUNGALS

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

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

PA – Prior Authorization

QL – Quantity Limit

ST – Step Therapy

AGE – Age Requirement

SP – Specialty Medication

HD – May require home delivery pharmacy

PPACA – No Cost-Share Preventive Medication

CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

| ANTI-FUNGALS (Infections) | | | | |
|---|--------------------------|---|---------------------------|---|
| Prescription Drug Name | Drug Tier | Coverage Requirements and Limits | | |
| ANTI-FUNGAL AGENTS | | | | |
| ANCOBON (<i>flucytosine</i>) | T3 | PA | | |
| <i>clotrimazole</i> | T1 | | | |
| CRESEMBA | T3 | | | |
| <i>fluconazole</i> | T1 | | | |
| <i>flucytosine</i> (Ancobon) | T1 | | | |
| <i>itraconazole</i> | T1 | | | |
| <i>ketoconazole</i> | T1 | | | |
| ORAVIG | T3 | | | |
| <i>posaconazole</i> (Noxafil) | T1 | | | |
| <i>terbinafine hcl</i> | T1 | | | |
| VFEND (<i>voriconazole</i>) | T3 | | | |
| <i>voriconazole</i> (Vfend) | T1 | | | |
| ANTI-FUNGAL ANTIBIOTICS | | | | |
| GRIS-PEG (<i>griseofulvin ultramicrosize</i>) | T3 | | | |
| <i>nystatin</i> | T1 | | | |
| ANTI-FUNGALS (Skin Conditions) | | | | |
| TOPICAL ANTI-FUNGAL/ANTI-INFLAMMATORY, STEROID AGENT | | | | |
| <i>clotrimazole/betamethasone dip</i> | T1 | | | |
| TOPICAL ANTI-FUNGALS | | | | |
| <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>econazole nitrate</i> | T1 | | | |
| ECOZA | T3 | | | |
| EXODERM | T1 | | | |
| <i>ketoconazole</i> | T1 | | | |
| <i>ketoconazole/skin cleanser 28</i> | T1 | | | |
| LOPROX | T3 | | | |
| LOPROX (<i>ciclopirox</i>) | T3 | | | |
| LULICONAZOLE | T1 | | | |
| <i>naftifine hcl</i> | T1 | | | |
| <i>naftifine hcl</i> (Naftin) | T1 | | | |
| T1 – Typically Generics | PA – Prior Authorization | | AGE – Age Requirement | PPACA – No Cost-Share Preventive Medication |
| T2 – Typically Preferred Brands | QL – Quantity Limit | | SP – Specialty Medication | CSL – Oral cancer medication subject to cost-share limits |
| T3 – Typically Non-Preferred Brands | ST – Step Therapy | HD – May require home delivery pharmacy | | |

List of Prescription Medications

ANTI-FUNGALS (Skin Conditions) (cont.)

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

TOPICAL ANTI-FUNGALS (cont.)

| | | |
|------------------------------------|----|--|
| NAFTIN (<i>naftifine hcl</i>) | T2 | |
| <i>nystatin</i> | T1 | |
| <i>nystatin/triamcinolone acet</i> | T1 | |

ANTIHISTAMINE AND DECONGESTANT COMBINATION (Allergy/Nasal Sprays)

1ST GEN ANTIHISTAMINE AND DECONGESTANT COMBINATION

| | | |
|--------------------------------------|----|--|
| <i>phenylephrine hcl/prometh hcl</i> | T1 | |
|--------------------------------------|----|--|

2ND GEN ANTIHISTAMINE AND DECONGESTANT COMBINATION

| | | |
|--------------------|----|--|
| CLARINEX-D 12 HOUR | T3 | |
|--------------------|----|--|

ANTIHISTAMINES - 1ST GENERATION

| | | |
|--|----|--|
| <i>carbinoxamine maleate</i> | T1 | |
| <i>clemastine fumarate</i> | T1 | |
| <i>cyproheptadine hcl</i> (Cyproheptadine Hcl) | T1 | |
| <i>hydroxyzine hcl</i> | T1 | |
| <i>hydroxyzine pamoate</i> | T1 | |
| <i>hydroxyzine pamoate</i> (Vistaril) | T1 | |
| <i>promethazine hcl</i> | T1 | |
| VISTARIL (<i>hydroxyzine pamoate</i>) | T3 | |

ANTIHISTAMINES - 2ND GENERATION

| | | |
|---|----|-------------------|
| <i>cetirizine hcl</i> | T1 | HD |
| CLARINEX (<i>desloratadine</i>) | T3 | HD |
| <i>desloratadine 2.5 mg odt</i> | T1 | QL (1 tab/day) HD |
| <i>desloratadine 5 mg odt</i> | T1 | HD |
| <i>desloratadine 5 mg tablet</i> (Clarinet) | T1 | HD |

ANTIHISTAMINES (Eye Conditions)

EYE ANTIHISTAMINES

| | | |
|--|----|--|
| <i>azelastine hcl 0.05% drops</i> | T1 | |
| <i>bepotastine besilate</i> (Bepreve) | | |
| <i>epinastine hcl</i> | T1 | |
| LASTACFT | T3 | |
| <i>olopatadine hcl 0.1% eye drops</i> | T1 | |
| <i>olopatadine hcl 0.2% eye drop</i> (Pataday) | T1 | |
| PATADAY (<i>olopatadine hcl</i>) | T3 | |
| PAZEO | T2 | |
| ZERVIAE | T2 | |

T1 – Typically Generics

PA – Prior Authorization

AGE – Age Requirement

PPACA – No Cost-Share Preventive Medication

T2 – Typically Preferred Brands

QL – Quantity Limit

SP – Specialty Medication

CSL – Oral cancer medication subject to cost-share limits

T3 – Typically Non-Preferred Brands

ST – Step Therapy

HD – May require home delivery pharmacy

List of Prescription Medications

| ANTI-HYPERGLYCEMICS (Diabetes) | | |
|--|-----------|----------------------------------|
| Prescription Drug Name | Drug Tier | Coverage Requirements and Limits |
| ANTIHYPENGLY, 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 |
| 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 (2ML/28 Days) ST HD |
| TRULICITY 4.5 MG/0.5 ML PEN | T2 | QL (2ML/28 Days) ST HD |
| ANTI-HYPENGLY, INSULIN, LONG ACT-GLP-1 RECEPTOR AGONIST | | |
| SOLIQUA 100-33 | T2 | HD |
| ANTI-HYPENGLYCEMIC-SODIUM/GLUCOCOTRANSPORT2(SGLT2) INHIBITORS | | |
| FARXIGA | T2 | QL (1 tab/day) ST HD |
| JARDIANCE | T2 | QL (1 tab/day) ST HD |
| ANTI-HYPENGLYCEMIC-DOPAMINE RECEPTOR AGONISTS | | |
| CYCLOSET | T3 | HD |
| ANTI-HYPENGLYCEMIC, ALPHA-GLUCOSIDASE INHIBITORS | | |
| <i>acarbose (Precose)</i> | T1 | HD |
| <i>GLYSET (miglitol)</i> | T3 | HD |
| <i>miglitol (Glyset)</i> | T1 | HD |
| <i>PRECOSE (acarbose)</i> | T3 | HD |
| ANTI-HYPENGLYCEMIC, AMYLIN ANALOG-TYPE | | |
| SYMLINPEN 120 | T2 | HD |
| SYMLINPEN 60 | T2 | HD |
| ANTI-HYPENGLYCEMIC, BIGUANIDE TYPE | | |
| <i>GLUCOPHAGE XR (metformin hcl er)</i> | T3 | HD |
| <i>metformin hcl</i> | T1 | HD |
| <i>metformin hcl (Glucophage Xr)</i> | T1 | HD |
| <i>metformin hcl (Riomet)</i> | T1 | HD |
| <i>RIOMET (metformin hcl)</i> | T3 | HD |

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T2 – Typically Preferred Brands

QL – Quantity Limit

SP – Specialty Medication

CSL – Oral cancer medication subject to cost-share limits

T3 – Typically Non-Preferred Brands

ST – Step Therapy

HD – May require home delivery pharmacy

List of Prescription Medications

| ANTI-HYPERGLYCEMICS (Diabetes) (cont.) | | |
|---|-----------|----------------------------------|
| Prescription Drug Name | Drug Tier | Coverage Requirements and Limits |
| ANTI-HYPERGLYCEMIC, BIGUANIDE TYPE (cont.) | | |
| RIOMET ER | T3 | HD |
| ANTI-HYPERGLYCEMIC, DPP-4 INHIBITORS | | |
| JANUVIA | T2 | QL (1 tab/day) ST HD |
| ANTI-HYPERGLYCEMIC, INSULIN-RELEASE STIMULANT TYPE | | |
| AMARYL (<i>glimepiride</i>) | T3 | HD |
| <i>chlorpropamide</i> | T1 | HD |
| <i>glimepiride</i> (Amaryl) | T1 | HD |
| <i>glipizide</i> (Glucotrol XL) | 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> (Prandin) | T1 | HD |
| STARLIX (<i>nateglinide</i>) | T3 | HD |
| <i>tolbutamide</i> | T1 | HD |
| ANTI-HYPERGLYCEMIC, SGLT-2 AND DPP-4 INHIBITOR COMB | | |
| GLYXAMBI | T2 | QL (1 tab/day) ST HD |
| ANTI-HYPERGLYCEMIC, THIAZOLIDINEDIONE AND BIGUANIDE | | |
| ACTOPLUS MET (<i>pioglitazone-metformin</i>) | T3 | HD |
| <i>pioglitazone hcl/metformin hcl</i> (Actoplus Met) | T1 | HD |
| ANTI-HYPERGLYCEMIC, THIAZOLIDINEDIONE-SULFONYLUREA | | |
| DUETACT (<i>pioglitazone-glimepiride</i>) | T3 | HD |
| <i>pioglitazone hcl/glimepiride</i> (Duetact) | T1 | HD |
| ANTI-HYPERGLYCEMIC, DPP-4 INHIBITOR-BIGUANIDE COMBS. | | |
| JANUMET | T2 | QL (2 tabs/day) ST HD |
| JANUMET XR 100-1,000 MG TABLET | T2 | QL (1 tab/day) ST HD |
| JANUMET XR 50-1,000 MG TABLET | T2 | QL (2 tabs/day) ST HD |
| JANUMET XR 50-500 MG TABLET | T2 | QL (1 tab/day) ST HD |
| ANTI-HYPERGLYCEMIC, INSULIN-RELEASE STIM.-BIGUANIDE | | |
| <i>glipizide/metformin hcl</i> | T1 | HD |

T1 – Typically Generics

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T2 – Typically Preferred Brands

QL – Quantity Limit

SP – Specialty Medication

CSL – Oral cancer medication subject to cost-share limits

T3 – Typically Non-Preferred Brands

ST – Step Therapy

HD – May require home delivery pharmacy

List of Prescription Medications

ANTI-HYPERGLYCEMICS (Diabetes) (cont.)

| Prescription Drug Name | Drug Tier | Coverage Requirements and Limits |
|--|-----------|----------------------------------|
| ANTI-HYPERGLYCEMIC, INSULIN-RELEASE STIM.-BIGUANIDE (cont.) | | |
| <i>glyburide/metformin hcl</i> | T1 | HD |
| <i>pioglitazone hcl (Actos)</i> | T1 | HD |
| <i>repaglinide/metformin hcl</i> | T1 | HD |
| ANTI-HYPERGLYCEMIC, THIAZOLIDINEDIONE (PPARG AGONIST) | | |
| ACTOS (<i>pioglitazone hcl</i>) | T3 | HD |
| AVANDIA | T3 | HD |
| <i>pioglitazone hcl (Actos)</i> | T1 | HD |
| ANTI-HYPERGLYCEMIC-GLUCOCORTICOID RECEPTOR BLOCKER | | |
| <i>mifepristone 300 mg tablet</i> | T1 | PA SP |
| ANTI-HYPERGLYCEMIC-SGLT2 INHIBITOR-BIGUANIDE COMBS. | | |
| INVOKAMET | T2 | QL (2 tabs/day) ST HD |
| SYNJARDY | T2 | QL (2 tabs/day) ST HD |
| SYNJARDY XR 10-1,000 MG TABLET | T2 | QL (2 tabs/day) ST HD |
| SYNJARDY XR 12.5-1,000 MG TAB | T2 | QL (2 tabs/day) ST HD |
| SYNJARDY XR 25-1,000 MG TABLET | T2 | QL (1 tab/day) ST HD |
| SYNJARDY XR 5-1,000 MG TABLET | T2 | QL (2 tabs/day) ST HD |
| XIGDUO XR 10 MG-1,000 MG TAB | T2 | QL (1 tab/day) ST HD |
| XIGDUO XR 10 MG-500 MG TABLET | T2 | QL (1 tab/day) ST HD |
| XIGDUO XR 2.5 MG-1,000 MG TAB | T2 | QL (2 tabs/day) ST HD |
| XIGDUO XR 5 MG-1,000 MG TABLET | T2 | QL (2 tabs/day) ST HD |
| XIGDUO XR 5 MG-500 MG TABLET | T2 | QL (1 tab/day) ST HD |
| ANTIHYPERGLY-SGLT-2 INHIB, DPP-4 INHIB, BIGUANIDE CB | | |
| TRIJARDY XR | T2 | QL (1 tab/day) ST HD |
| INSULINS | | |
| BASAGLAR KWIKPEN U-100 | T2 | QL (1.5ml/day) HD |
| HUMALOG 100 UNIT/ML CARTRIDGE | T2 | QL (1.5ml/day) HD |
| HUMALOG JUNIOR KWIKPEN | T2 | QL (1.5ml/day) HD |
| HUMALOG KWIKPEN U-100 | T2 | QL (1.5 ML/DAY) HD |
| HUMALOG KWIKPEN U-200 | T2 | QL (1 ML/DAY) HD |
| HUMALOG MIX 50-50 | 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 (1 ML/DAY) HD |

T1 – Typically Generics

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PPACA – No Cost-Share Preventive Medication

T2 – Typically Preferred Brands

QL – Quantity Limit

SP – Specialty Medication

CSL – Oral cancer medication subject to cost-share limits

T3 – Typically Non-Preferred Brands

ST – Step Therapy

HD – May require home delivery pharmacy

List of Prescription Medications

ANTI-HYPERGLYCEMICS (Diabetes) (cont.)

| Prescription Drug Name | Drug Tier | Coverage Requirements and Limits |
|---|-----------|----------------------------------|
| INSULINS (cont.) | | |
| HUMULIN R U-500 KWIKPEN | T2 | QL (1 ML/DAY) HD |
| INSULIN ASPART | T2 | QL (1.5ml/day) HD |
| INSULIN ASPART FLEXPEN | T2 | QL (1.5ml/day) HD |
| INSULIN ASPART PENFILL | T2 | QL (1.5ml/day) HD |
| INSULIN ASPART PROT-INSULN ASP | T2 | QL (2 ML/DAY) HD |
| INSULIN GLARGINE YFGN (SEMGLEE-YFGN), VIAL, PEN | T3 | QL (1.5ml/day) HD |
| INSULIN LISPRO (HUMALOG) (U-100 VIAL) | T3 | QL (1.5ml/day) HD |
| INSULIN LISPRO PROTAMINE MIX | T3 | QL (2 ml/day) HD |
| LYUMJEV | T2 | QL (1.5ML/DAY) HD |
| LYUMJEV KWIKPEN U-100 | T2 | QL (1.5ML/DAY) HD |
| LYUMJEV KWIKPEN U-200 | T2 | QL (1 ML/DAY) HD |
| SEMGLEE | T2 | PA QL(1.5 MLS/DAY) HD |
| TRESIBA | T2 | QL (1.5ml/day) HD |
| TRESIBA FLEXTOUCH U-100 | T2 | QL (1.5ml/day) HD |
| TRESIBA FLEXTOUCH U-200 | T2 | QL (0.9ml/day) HD |

ANTI-INFECTIVES (Feminine Products)

VAGINAL SULFONAMIDES

| | | |
|-----|----|--|
| AVC | T3 | |
|-----|----|--|

ANTI-INFECTIVES (Infections)

PENICILLIN ANTIBIOTICS

| | | |
|--------------------|----|--|
| <i>amoxicillin</i> | T1 | |
|--------------------|----|--|

ANTI-INFECTIVES/MISCELLANEOUS (Feminine Products)

VAGINAL ANTISEPTICS

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

ANTI-INFECTIVES/MISCELLANEOUS (Infections)

2ND GEN. ANAEROBIC ANTI-PROTOZOAL-ANTIBACTERIAL

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

AMEBICIDES

| | | |
|----------------------------|----|--|
| <i>paromomycin sulfate</i> | T1 | |
|----------------------------|----|--|

T1 – Typically Generics

PA – Prior Authorization

AGE – Age Requirement

PPACA – No Cost-Share Preventive Medication

T2 – Typically Preferred Brands

QL – Quantity Limit

SP – Specialty Medication

CSL – Oral cancer medication subject to cost-share limits

T3 – Typically Non-Preferred Brands

ST – Step Therapy

HD – May require home delivery pharmacy

List of Prescription Medications

| ANTI-INFECTIVES/MISCELLANEOUS (Infections) (cont.) | | |
|--|-----------|----------------------------------|
| Prescription Drug Name | Drug Tier | Coverage Requirements and Limits |
| ANTHELMINTICS | | |
| <i>albendazole</i> (Albenza) | T1 | |
| ALBENZA (<i>albendazole</i>) | T3 | |
| BILTRICIDE (<i>praziquantel</i>) | T3 | |
| EMVERM | T1 | |
| <i>ivermectin</i> (Stromectol) | T1 | |
| <i>praziquantel</i> (Biltricide) | T1 | |
| STROMEKTOL (<i>ivermectin</i>) | T3 | PA |
| ANTI-MALARIAL DRUGS | | |
| <i>atovaquone/proguanil hcl</i> (Malarone) | T1 | |
| <i>chloroquine ph 250 mg tablet</i> | T1 | |
| <i>chloroquine ph 500 mg tablet</i> | T1 | QL (28 tabs/365 days) |
| COARTEM | T3 | PA QL (24 tabs/30 days) |
| DARAPRIM (<i>pyrimethamine</i>) | T3 | 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 | PA QL (30 tabs/365 days) |
| 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) | T1 | PA SP |
| QUALAQUIN (<i>quinine sulfate</i>) | T3 | PA |
| <i>quinine sulfate</i> (Qualaquin) | T1 | |
| SOVUNA 200 MG TABLET (<i>hydroxychloroquine sulfate</i>) | T3 | PA |
| ANTI-PROTOZOAL DRUGS, MISCELLANEOUS | | |
| <i>atovaquone</i> | T1 | |
| BENZNIDAZOLE | T3 | |
| IMPAVIDO | T3 | PA |
| LAMPIT | T3 | |
| NEBUPENT (<i>pentamidine isethionate</i>) | T3 | |
| <i>pentamidine isethionate</i> (Nebupent) | T1 | |

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T2 – Typically Preferred Brands

QL – Quantity Limit

SP – Specialty Medication

CSL – Oral cancer medication subject to cost-share limits

T3 – Typically Non-Preferred Brands

ST – Step Therapy

HD – May require home delivery pharmacy

List of Prescription Medications

| ANTI-INFECTIVES/MISCELLANEOUS (Miscellaneous) | | |
|--|-----------|--------------------------------------|
| Prescription Drug Name | Drug Tier | Coverage Requirements and Limits |
| ANTIBACTERIAL AGENTS, MISCELLANEOUS | | |
| <i>glycine urologic solution</i> | T3 | |
| ANTISEPTICS, GENERAL | | |
| ALCOHOL SWABSTICK | T3 | |
| TOPICAL ANTISEPTIC DRYING AGENTS | | |
| <i>formaldehyde</i> | T1 | |
| ANTI-INFECTIVES/MISCELLANEOUS (Skin Conditions) | | |
| TOPICAL ANTI-FUNGALS | | |
| CICLODAN 8% KIT | T3 | |
| <i>ciclopirox/urea/camph/men/euc</i> (Ciclodan) | T1 | |
| ANTI-INFLAM.TUMOR NECROSIS FACTOR INHIBITING AGENTS (Pain Relief And Inflammatory Disease) | | |
| ANTI-INFLAMMATORY TUMOR NECROSIS FACTOR INHIBITOR | | |
| ADALIMUMAB-ADAZ | T2 | PA QL 2 (doses/ 28 days) SP |
| ADALIMUMAB-ADB(M)(CF) | T2 | PA QL(2 pens/syringes/28 days) SP HD |
| AVSOLA | T2 | PA SP |
| CIMZIA 200 MG VIAL KIT | T3 | PA QL (1 kit/28 days) SP HD |
| CIMZIA 2X200 MG/ML SYRINGE KIT | T3 | PA QL (1 kit/28 days) SP HD |
| CIMZIA 2X200 MG/ML(X3) START KT | T3 | PA QL (1 kit/year) SP HD |
| CYLTEZO | T3 | PA QL (2 doses/ 28 days) SP |
| ENBREL 25 MG KIT | T3 | PA QL (8 vials/28 days) SP HD |
| ENBREL 25 MG/0.5 ML SYRINGE | T3 | PA QL (8 syringes/28 days) SP HD |
| ENBREL 25 MG/0.5 ML VIAL | T3 | PA QL (4 ML/28 Days) SP HD |
| ENBREL 50 MG/ML SYRINGE | T3 | PA QL (4 syringes/28 days) SP HD |
| ENBREL MINI | T3 | PA QL (4 cartridges/28 days) SP HD |
| ENBREL SURECLICK | T3 | PA QL (4 syringes/28 days) SP HD |
| HUMIRA | T3 | PA QL (2 syringes/28 days) SP HD |
| HUMIRA PEN | T3 | PA QL (2 pens/28 days) SP HD |
| HUMIRA PEN CROHN'S-UC-HS | T3 | PA QL (1 kit/year) SP HD |
| HUMIRA PEN PSOR-UVEITS-ADOL HS | T3 | PA QL (1 kit/year) SP HD |
| HUMIRA(CF) | T3 | PA QL (2 syringes/28 days) SP HD |
| HUMIRA(CF) PEDIATRIC CROHN'S | T3 | PA QL (1 kit/year) SP HD |
| HUMIRA(CF) PEN 40 MG/0.4 ML | T3 | PA QL (2 pens/28 days) SP HD |
| HUMIRA(CF) PEN 80 MG/0.8 ML | T3 | PA QL (1 kit/year) SP HD |
| HUMIRA(CF) PEN CROHN'S-UC-HS | T3 | PA QL (1 kit/year) SP HD |
| HUMIRA(CF) PEN PEDIATRIC UC | T3 | PA QL (4 KITS/365 DAYS) SP HD |

T1 – Typically Generics

PA – Prior Authorization

AGE – Age Requirement

PPACA – No Cost-Share Preventive Medication

T2 – Typically Preferred Brands

QL – Quantity Limit

SP – Specialty Medication

CSL – Oral cancer medication subject to cost-share limits

T3 – Typically Non-Preferred Brands

ST – Step Therapy

HD – May require home delivery pharmacy

List of Prescription Medications

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

| Prescription Drug Name | Drug Tier | Coverage Requirements and Limits |
|--|-----------|----------------------------------|
| ANTI-INFLAMMATORY TUMOR NECROSIS FACTOR INHIBITOR (cont.) | | |
| HUMIRA(CF) PEN PSOR-UV-ADOL HS | T3 | PA QL (1 kit/year) SP HD |
| INFLECTRA | T2 | PA SP HD |
| REMICADE | T3 | PA SP HD |
| SIMPONI 100 MG/ML PEN INJECTOR | T3 | PA QL (1 injector/28 days) SP HD |
| SIMPONI 100 MG/ML SYRINGE | T3 | PA QL (1 syringe/28 days) SP HD |
| SIMPONI 50 MG/0.5 ML PEN INJEC | T3 | PA QL (1 injector/28 days) SP HD |
| SIMPONI 50 MG/0.5 ML SYRINGE | T3 | PA QL (1 syringe/28 days) SP HD |
| SIMPONI ARIA | T3 | PA SP HD |
| ZYMFENTRA | T3 | PA QL SP HD |

ANTI-NEOPLASTICS (Cancer)

ANP - SELECTIVE RETINOID X RECEPTOR AGONISTS (RXR)

| | | |
|-------------------------------|----|----------|
| <i>bexarotene</i> (Targretin) | T1 | PA SP HD |
|-------------------------------|----|----------|

ANTI-NEOPLAST, HISTONE DEACETYLASE (HDAC) INHIBITORS

| | | |
|---------|----|----------|
| FARYDAK | T3 | PA SP HD |
| ZOLINZA | T2 | PA SP HD |

ANTI-NEOPLASTIC - ALKYLATING AGENTS

| | | |
|---------------------------------|----|----------|
| ALKERAN (<i>melphalan</i>) | T3 | SP |
| <i>cyclophosphamide</i> | T1 | SP HD |
| GLEOSTINE | T2 | |
| HYDREA (<i>hydroxyurea</i>) | T3 | |
| <i>hydroxyurea</i> (Hydrea) | T1 | |
| LEUKERAN | T2 | |
| <i>melphalan</i> (Alkeran) | T1 | SP |
| MYLERAN | T2 | |
| TEMODAR (<i>temozolomide</i>) | T3 | PA SP HD |
| <i>temozolomide</i> | T1 | PA SP HD |
| <i>temozolomide</i> (Temodar) | T1 | PA SP HD |

ANTI-NEOPLASTIC - ANTI-ANDROGENIC AGENTS

| | | |
|---------------------------------|----|----------------------------|
| <i>abiraterone acetate</i> | T1 | PA SP HD CSL |
| <i>bicalutamide</i> (Casodex) | T1 | |
| CASODEX (<i>bicalutamide</i>) | T3 | |
| ERLEADA 240 MG TABLET | T2 | PA QL(1 TAB/DAY) SP HD CSL |
| ERLEADA 60 MG TABLET | T2 | PA SP HD CSL |
| <i>flutamide</i> | T1 | |

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T3 – Typically Non-Preferred Brands

ST – Step Therapy

HD – May require home delivery pharmacy

List of Prescription Medications

| ANTI-NEOPLASTICS (Cancer) (cont.) | | |
|---|-----------|----------------------------------|
| Prescription Drug Name | Drug Tier | Coverage Requirements and Limits |
| ANTI-NEOPLASTIC - ANTI-ANDROGENIC AGENTS (cont.) | | |
| <i>nilutamide</i> | T1 | QL (4 tabs/day) |
| NUBEQA | T2 | PA SP HD |
| XTANDI | T2 | PA SP HD |
| ANTI-NEOPLASTIC - ANTI-METABOLITES | | |
| <i>capecitabine (Xeloda)</i> | T1 | PA SP HD |
| INQOVI | T3 | PA SP HD |
| JYLAMVO | T3 | CSL |
| LONSURF | T3 | PA SP HD |
| <i>mercaptopurine</i> | T1 | |
| <i>methotrexate sodium</i> | T1 | |
| <i>methotrexate sodium/pf</i> | T1 | |
| ONUREG | T3 | PA QL (14 tabs/28 Days) SP |
| PURIXAN | T3 | SP |
| TABLOID | T3 | |
| TREXALL | T2 | |
| XATMEP | T3 | |
| XELODA (<i>capecitabine</i>) | T3 | PA SP HD |
| ANTI-NEOPLASTIC - AROMATASE INHIBITORS | | |
| <i>anastrozole (Arimidex)</i> | T1 | HD PPACA |
| ARIMIDEX (<i>anastrozole</i>) | T3 | HD |
| AROMASIN (<i>exemestane</i>) | T3 | HD |
| <i>exemestane (Aromasin)</i> | T1 | HD PPACA |
| FEMARA (<i>letrozole</i>) | T3 | HD |
| <i>letrozole (Femara)</i> | T1 | HD |
| ANTI-NEOPLASTIC - BRAF KINASE INHIBITORS | | |
| BRAFTOVI | T3 | PA SP HD |
| TAFINLAR | T3 | PA SP HD |
| ZELBORAF | T3 | PA SP HD |
| ANTI-NEOPLASTIC - HEDGEHOG PATHWAY INHIBITOR | | |
| DAURISMO | T3 | PA SP HD |
| ERIVEDGE | T2 | PA SP HD |
| ODOMZO | T3 | PA SP HD |
| ANTI-NEOPLASTIC - JANUS KINASE (JAK) INHIBITORS | | |
| JAKAFI | T3 | PA SP HD |

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List of Prescription Medications

| ANTI-NEOPLASTICS (Cancer) (cont.) | | |
|--|-----------|----------------------------------|
| Prescription Drug Name | Drug Tier | Coverage Requirements and Limits |
| ANTI-NEOPLASTIC - KRAS PROTEIN INHIBITOR | | |
| LUMAKRAS 120 MG TABLET | T3 | PA SP QL (8 tabs per day) HD |
| LUMAKRAS 320 MG TABLET | T3 | PA SP QL (3 tabs per day) HD |
| ANTI-NEOPLASTIC - MEKI AND MEK2 KINASE INHIBITORS | | |
| COTELLIC | T3 | PA SP HD |
| KOSELUGO 10 MG CAPSULE | T3 | PA QL (10 capsules/day) SP |
| KOSELUGO 25 MG CAPSULE | T3 | PA QL (4 caps/day) SP |
| MEKTOVI | T3 | PA SP HD |
| ANTI-NEOPLASTIC - MTOR KINASE INHIBITORS | | |
| AFINITOR | T3 | PA SP HD |
| AFINITOR (<i>everolimus</i>) | T3 | PA SP HD |
| AFINITOR DISPERZ | T3 | PA SP |
| <i>everolimus 2.5 mg tablet</i> (Afinitor) | T1 | PA SP HD |
| <i>everolimus 5 mg tablet</i> (Afinitor) | T1 | PA QL(1 tab/day) SP HD |
| <i>everolimus 7.5 mg tablet</i> (Afinitor) | T1 | PA QL(1 tab/day) SP HD |
| <i>everolimus 10 mg tablet</i> (Afinitor) | T1 | PA QL(1 tab/day) SP HD |
| ANTI-NEOPLASTIC - PROTEIN METHYLTRANSFERASE INHIBIT | | |
| TAZVERIK | T3 | PA SP |
| ANTI-NEOPLASTIC - TOPOISOMERASE I INHIBITORS | | |
| HYCAMTIN | T3 | PA SP HD |
| ANTI-NEOPLASTIC COMB - KINASE AND AROMATASE INHIBIT | | |
| KISQALI 200 MG DAILY DOSE | T2 | PA QL (21 per 28 days) SP HD |
| KISQALI 400 MG DAILY DOSE | T2 | PA QL (42 per 28 days) SP HD |
| KISQALI 600 MG DAILY DOSE | T2 | PA QL (63 per 28 days) SP HD |
| KISQALI Femara Co-Pack- One pack | T2 | PA QL (63 per 28 days) SP HD |
| ANTI-NEOPLASTIC EGF RECEPTOR BLOCKER MCLON ANTIBODY | | |
| PHESGO | T3 | PA SP HD |
| ANTI-NEOPLASTIC IMMUNOMODULATOR AGENTS | | |
| lenalidomide | T1 | PA QL(1 TAB/DAY) SP HD CSL |
| POMALYST | T3 | PA SP HD |
| REVLIMID | T2 | PA QL(1 TAB/DAY) SP HD CSL |
| ANTI-NEOPLASTIC LHRH (GNRH) AGONIST, PITUITARY SUPPR. | | |
| <i>leuprolide acetate</i> | T1 | PA SP HD |
| LEUPROLIDE DEPOT | T3 | PA SP |
| LUPRON DEPOT | T2 | PA SP HD |

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List of Prescription Medications

| ANTI-NEOPLASTICS (Cancer) (cont.) | | |
|--|-----------|----------------------------------|
| Prescription Drug Name | Drug Tier | Coverage Requirements and Limits |
| ANTI-NEOPLASTIC LHRH (GNRH) AGONIST, PITUITARY SUPPR. (cont.) | | |
| ZOLADEX | T2 | PA SP HD |
| ANTI-NEOPLASTIC LHRH (GNRH) ANTAGONIST, PITUIT.SUPPRS | | |
| FIRMAGON | T3 | PA SP HD |
| ORGOVYX | T3 | PA SP |
| ANTI-NEOPLASTIC SYSTEMIC ENZYME INHIBITORS | | |
| ALECENSA | T2 | PA QL(8 tabs/day) SP HD CSL |
| AYVAKIT | T3 | PA QL (1 tab/day) SP |
| BALVERSA | T3 | PA SP |
| BOSULIF | T3 | PA QL(3 caps/day) SP HD |
| BRUKINSA | T2 | PA QL (4 caps/day) SP |
| CABOMETYX | T3 | PA SP HD |
| CALQUENCE | T3 | PA SP |
| CAPRELSA | T3 | PA SP |
| COMETRIQ | T3 | PA SP HD |
| COPIKTRA | T3 | PA SP |
| <i>erlotinib hcl</i> | T1 | PA SP HD |
| EXKIVITY | T3 | PA SP HD |
| FOTIVDA | T3 | PA QL (30 caps/30 days) SP HD |
| GAVRETO | T3 | PA QL (4 tabs/Day) SP HD |
| <i>gefitinib</i> | T1 | PA SP HD CSL |
| GILOTRIF | T3 | PA SP HD |
| GLEEVEC (<i>imatinib mesylate</i>) | T3 | PA SP HD |
| IBRANCE | T3 | PA QL(21 caps/28 days) SP HD |
| <i>imatinib mesylate 100 mg tab (Gleevec)</i> | T1 | QL (6 tabs/day) SP HD CSL |
| <i>imatinib mesylate 400 mg tab (Gleevec)</i> | T1 | QL (2 tabs/day) SP HD CSL |
| IMBRUVICA | T2 | PA SP |
| INLYTA | T3 | PA SP HD |
| INREBIC | T3 | PA SP HD |
| IRESSA | T3 | PA SP HD |
| IWILFIN | T3 | PA QL(8 TABS/DAY) SP CSL |
| KISQALI 200 MG DAILY DOSE | T2 | PA QL (21 per 28 days) SP HD |
| KISQALI 400 MG DAILY DOSE | T2 | PA QL (42 per 28 days) SP HD |
| KISQALI 600 MG DAILY DOSE | T2 | PA QL (63 per 28 days) SP HD |
| <i>lapatinib ditosylate (Tykerb)</i> | T1 | PA SP HD |

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List of Prescription Medications

ANTI-NEOPLASTICS (Cancer) (cont.)

| Prescription Drug Name | Drug Tier | Coverage Requirements and Limits |
|---|-----------|----------------------------------|
| ANTI-NEOPLASTIC SYSTEMIC ENZYME INHIBITORS (cont.) | | |
| LENVIMA | T2 | PA SP HD |
| LORBRENA | T3 | PA SP HD |
| LYNPARZA | T2 | PA SP HD |
| LYTGOBI 12 MG DAILY DOSE PACK | T3 | PA QL(3 TABS/DAY) SP CSL |
| LYTGOBI 16 MG DAILY DOSE PACK | T3 | PA QL(4 TABS/DAY) SP CSL |
| LYTGOBI 20 MG DAILY DOSE PACK | T3 | PA QL(5 TABS/DAY) SP CSL |
| NERLYNX | T3 | PA SP HD |
| NINLARO | T3 | PA SP HD |
| OGSIVEO | T3 | PA QL(6 TABS/DAY) SP CSL |
| OJJAARA | T3 | PA QL(1 TAB/DAY) SP CSL |
| <i>pazopanib (Votrient)</i> | T1 | PA QL (4 tabs/day) SP HD CSL |
| PEMAZYRE | T3 | PA QL (14 tabs/21 days) SP |
| PIQRAY | T3 | PA SP HD |
| QINLOCK | T3 | PA QL (3 tabs/day) SP |
| RETEVMO 40 MG CAPSULE | T3 | PA QL (6 caps/day) SP HD |
| RETEVMO 80 MG CAPSULE | T3 | PA QL (4 tabs/day) SP HD |
| ROZLYTREK | T3 | PA SP HD |
| RUBRACA | T2 | PA SP |
| RYDAPT | T3 | PA SP HD |
| SPRYCEL | T2 | PA SP HD |
| STIVARGA | T3 | PA SP HD |
| TABRECTA | T3 | PA QL (4 tabs/day) SP HD |
| TAGRISSO | T3 | PA SP HD |
| TALZENNA | T3 | PA SP HD |
| TASIGNA | T2 | PA SP HD |
| TEPMETKO | T3 | PA QL (2 tabs/day) SP |
| TRUQAP | T3 | PA QL(64 tabs/28 days) SP CSL |
| TUKYSA | T3 | PA SP |
| TURALIO | T2 | PA QL(4 CAPS/DAY) SP CSL |
| TYKERB (<i>lapatinib</i>) | T3 | PA SP HD |
| UKONIQ | T3 | PA QL (4 tabs/day) SP |
| VANFLYTA | T3 | PA QL(2 tabs/day) SP CSL |
| VERZENIO | T2 | PA QL SP HD |
| VITRAKVI | T3 | PA SP HD |
| VIZIMPRO | T3 | PA SP HD |

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List of Prescription Medications

| ANTI-NEOPLASTICS (Cancer) (cont.) | | |
|---|-----------|----------------------------------|
| Prescription Drug Name | Drug Tier | Coverage Requirements and Limits |
| ANTI-NEOPLASTIC SYSTEMIC ENZYME INHIBITORS (cont.) | | |
| XALKORI CAPSULES | T3 | PA QL(4 caps/day) SP HD CSL |
| XALKORI PELLETS | T3 | PA QL(4 pellets/day) SP HD CSL |
| XOSPATA | T3 | PA SP |
| ZEJULA | T2 | PA SP |
| ZYDELIG | T3 | PA SP HD |
| ANTI-NEOPLASTIC, ANTI-PROGRAMMED DEATH-1 (PD-1) MAB | | |
| OPDIVO | T3 | PA SP HD |
| ANTI-NEOPLASTIC-B CELL LYMPHOMA-2(BCL-2) INHIBITORS | | |
| VENCLEXTA | T3 | PA SP |
| ANTI-NEOPLASTIC-ENZYME INHIB, ANTIANDROGEN COMB. | | |
| AKEEGA | T3 | PA QL(2 tabs/day) SP CSL |
| ANTI-NEOPLASTIC-ISOCITRATE DEHYDROGENASE INHIBITOR | | |
| IDHIFA | T3 | PA SP HD |
| REZLIDHIA | T3 | PA QL(2 CAPS/DAY) SP CSL |
| TIBSOVO | T3 | PA SP |
| ANTI-NEOPLASTICS ANTIBODY/ANTIBODY-DRUG COMPLEXES | | |
| ENHERTU | T3 | PA SP HD |
| ANTI-NEOPLASTICS, MISCELLANEOUS | | |
| <i>etoposide</i> | T1 | SP HD |
| LYSODREN | T2 | |
| MATULANE | T2 | SP |
| <i>tretinoin 10 mg capsule</i> | T1 | PA |
| ANTI-NEOPLASTIC-SELECT INHIB OF NUCLEAR EXP (SINE) | | |
| XPOVIO | T3 | PA SP |
| CYTOTOXIC T-LYMPHOCYTE ANTIGEN (CTLA-4) RMC ANTIBODY | | |
| YERVOY | T3 | PA SP HD |
| IMMUNOMODULATORS | | |
| ACTIMMUNE | T3 | PA SP HD |
| SELECTIVE ESTROGEN RECEPTOR MODULATORS (SERMS) | | |
| FARESTON (<i>toremifene citrate</i>) | T3 | QL (2 tabs/day) HD |
| SOLTAMOX | T3 | HD |
| <i>tamoxifen citrate</i> | T1 | HD PPACA |
| <i>toremifene citrate</i> (Fareston) | T1 | QL (2 tabs/day) HD |
| STEROID ANTI-NEOPLASTICS | | |
| EMCYT | T2 | SP HD |
| <i>megestrol acetate</i> | T1 | |

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HD – May require home delivery pharmacy

List of Prescription Medications

| ANTI-NEOPLASTICS (Skin Conditions) | | |
|--|-----------|----------------------------------|
| Prescription Drug Name | Drug Tier | Coverage Requirements and Limits |
| PHOTOACT, TOPICAL ANTI-NEOPLAST, PREMALIGNANT LESIONS | | |
| LEVULAN | T3 | SP |
| TOPICAL ANTI-NEOPLASTIC PREMALIGNANT LESION AGENTS | | |
| EFUDEX (<i>fluorouracil</i>) | T3 | |
| FLUOROPLEX | T2 | |
| <i>fluorouracil</i> | T1 | |
| <i>fluorouracil</i> (Efudex) | T1 | |
| PANRETIN | T3 | SP HD |
| PICATO | T2 | |
| TOLAK | T3 | |
| VALCHLOR | T3 | SP HD |
| ANTI-OBESITY DRUGS (Weight Management) | | |
| ANTI-OBESITY - ANOREXIC AGENTS | | |
| ADIPEX-P (<i>phentermine hcl</i>) | T3 | PA |
| <i>benzphetamine hcl</i> | T1 | |
| <i>benzphetamine hcl</i> (Regimex) | T1 | |
| <i>diethylpropion hcl</i> | T1 | |
| LOMAIRA | T1 | |
| <i>phendimetrazine tartrate</i> | T1 | |
| <i>phentermine hcl</i> | T1 | |
| <i>phentermine hcl</i> (Adipex-p) | T1 | |
| QSYMIA | T3 | PA |
| REGIMEX (<i>benzphetamine hcl</i>) | T3 | |
| ANTI-OBESITY - INCRETIN MIMETICS COMBINATION | | |
| ZEPBOUND PEN | T2 | PA QL(2 mls/30 days) |
| ANTI-OBESITY - MELANOCORTIN 4 RECEPTOR AGONISTS | | |
| IMCIVREE | T3 | PA QL (9 ML/22 DAYS) SP |
| ANTI-OBESITY GLUCAGON-LIKE PEPTIDE-I RECEPTOR AGONIST | | |
| SAXENDA | T3 | PA |
| WEGOVY | T2 | PA QL (1 BOX/MONTH) |
| ANTI-OBESITY SEROTONIN 2C RECEPTOR AGONISTS | | |
| BELVIQ | T3 | PA |
| BELVIQ XR | T3 | PA |
| ANTI-OBESITY - OPIOID ANTAG-NOREPI, DOPAMINE RU INHIB | | |
| CONTRAVE | T3 | PA |

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List of Prescription Medications

| ANTI-PARASITICS (Infections) | | |
|--|-----------|----------------------------------|
| Prescription Drug Name | Drug Tier | Coverage Requirements and Limits |
| OPHTHALMIC (EYE) ANTIPARASITICS | | |
| XDEMVY | T2 | PA QL(4 bottles/30 days) SP |
| FAT ABSORPTION DECREASING AGENTS | | |
| XENICAL | T3 | PA |
| ANTI-PARASITICS | | |
| ALINIA | T3 | |
| ALINIA (<i>nitazoxanide</i>) | T3 | |
| <i>nitazoxanide</i> (Alinia) | T1 | |
| TOPICAL ANTI-PARASITICS | | |
| <i>crotamiton</i> (Eurax) | T1 | |
| ELIMITE (<i>permethrin</i>) | T3 | |
| EURAX 10% CREAM | T2 | |
| EURAX 10% LOTION | T3 | |
| <i>ivermectin</i> (Sklice) | T1 | PA |
| NATROBA (<i>spinosad</i>) | T3 | |
| <i>permethrin</i> (Elimite) | T1 | |
| TOPICAL ANTI-PARASITICS (cont.) | | |
| SKLICE (<i>ivermectin</i>) | T3 | |
| <i>spinosad</i> (Natroba) | T1 | |
| ULESFIA | T3 | |
| ANTI-PARKINSON DRUGS (Parkinson's Disease) | | |
| ANTI-PARKINSONISM DRUGS, ANTI-CHOLINERGIC | | |
| <i>benztropine mesylate</i> | T1 | HD |
| <i>trihexyphenidyl hcl</i> | T1 | HD |
| ANTI-PARKINSONISM DRUGS, OTHER | | |
| <i>amantadine hcl</i> | T1 | HD |
| APOKYN | T3 | 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 |

T1 – Typically Generics

PA – Prior Authorization

AGE – Age Requirement

PPACA – No Cost-Share Preventive Medication

T2 – Typically Preferred Brands

QL – Quantity Limit

SP – Specialty Medication

CSL – Oral cancer medication subject to cost-share limits

T3 – Typically Non-Preferred Brands

ST – Step Therapy

HD – May require home delivery pharmacy

List of Prescription Medications

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

| Prescription Drug Name | Drug Tier | Coverage Requirements and Limits |
|--|-----------|----------------------------------|
| ANTI-PARKINSONISM DRUGS, OTHER (cont.) | | |
| <i>carbidopa/levodopa/entacapone</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 | T3 | SP HD |
| <i>entacapone</i> (Comtan) | T1 | HD |
| INBRIJA | T3 | 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 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 | T3 | PA QL (1 tab/day) SP HD |
| OSMOLEX ER | T3 | QL (1 tab/day) HD |
| PARLODEL (<i>bromocriptine mesylate</i>) | T3 | HD |
| <i>pramipexole di-hcl</i> | T1 | HD |
| <i>pramipexole er 0.375 mg tablet</i> (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 |

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T2 – Typically Preferred Brands

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CSL – Oral cancer medication subject to cost-share limits

T3 – Typically Non-Preferred Brands

ST – Step Therapy

HD – May require home delivery pharmacy

List of Prescription Medications

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

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

ANTI-PARKINSONISM DRUGS, OTHER (cont.)

| | | |
|---|----|-------|
| STALEVO 100 (carbidopa-levodopa-entacapone) | T3 | HD |
| STALEVO 125 (carbidopa-levodopa-entacapone) | T3 | HD |
| STALEVO 150 (carbidopa-levodopa-entacapone) | T3 | HD |
| STALEVO 200 (carbidopa-levodopa-entacapone) | T3 | HD |
| STALEVO 50 (carbidopa-levodopa-entacapone) | T3 | HD |
| STALEVO 75 (carbidopa-levodopa-entacapone) | T3 | HD |
| TASMAR (tolcapone) | T3 | HD |
| tolcapone (Tasmar) | T1 | HD |
| XADAGO | T3 | ST HD |

DECARBOXYLASE INHIBITORS

| | | |
|-----------|----|--|
| carbidopa | T1 | |
|-----------|----|--|

ANTI-PLATELET DRUGS (Blood Thinners/Anti-Clotting)

PLATELET AGGREGATION INHIBITORS

| | | |
|--------------------------------|----|----|
| aspirin/dipyridamole | T1 | HD |
| BRILINTA | T2 | HD |
| cilostazol | T1 | HD |
| clopidogrel bisulfate | T1 | HD |
| clopidogrel bisulfate (Plavix) | T1 | HD |
| dipyridamole | T1 | HD |
| EFFIENT (prasugrel hcl) | T3 | HD |
| PLAVIX (clopidogrel) | T3 | HD |
| prasugrel hcl (Effient) | T1 | HD |
| ticlopidine hcl | T1 | HD |

PLATELET REDUCING AGENTS

| | | |
|--------------------------|----|--|
| AGRYLIN (anagrelide hcl) | T3 | |
| anagrelide hcl | T1 | |
| anagrelide hcl (Agrylin) | T1 | |

ANTIVIRALS (AIDS/HIV)

ANTI-RETROVIRAL - CAPSID INHIBITORS

| | | |
|-------------------------------|----|---------------------------|
| SUNLENCA 463.5 MG/1.5 ML VIAL | T3 | PA SP |
| SUNLENCA TABLET | T3 | PA QL(5 TABS/180 DAYS) SP |

T1 – Typically Generics

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T3 – Typically Non-Preferred Brands

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AGE – Age Requirement

SP – Specialty Medication

HD – 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 |
| ANTI-RETROVIRAL - INTEGRASE INHIBITOR AND NNRTI COMB. | | |
| CABENUVA | T3 | PA SP |
| JULUCA | T2 | SP |
| ANTI-RETROVIRAL - INTEGRASE INHIBITOR AND NRTI COMB. | | |
| DOVATO | T2 | SP |
| ANTI-RETROVIRAL - NRTIS AND INTEGRASE INHIBITORS COMB | | |
| TRIUMEQ | T2 | SP |
| ANTI-RETROVIRAL - NUCLEOSIDE, NUCLEOTIDE, PROTEASE INH. | | |
| SYMTUZA | T2 | SP |
| ANTIVIRALS - HIV-SPEC, NON-PEPTIDIC PROTEASE INHIB | | |
| APTIVUS | T2 | PA SP |
| <i>darunavir ethanolate</i> (Prezista) | T1 | PA SP |
| PREZCOBIX | T3 | PA SP |
| PREZISTA | T2 | SP |
| ANTIVIRALS - HIV-SPEC, NUCLEOSIDE-NUCLEOTIDE ANALOG | | |
| CIMDUO | T3 | PA SP |
| DESCOVY | T2 | PA SP PPACA |
| <i>emtricitabine-tenofv 100-150mg</i> | T1 | SP PPACA |
| <i>emtricitabine-tenofv 133-200mg</i> | T1 | SP PPACA |
| <i>emtricitabine-tenofv 167-250mg</i> | T1 | SP PPACA |
| <i>emtricitabine-tenofv 200-300mg</i> (Truvada) | T1 | SP PPACA |
| TEMIXYS | T3 | PA SP |
| ANTIVIRALS - HIV-SPEC, NUCLEOSIDE ANALOG, RTI COMB | | |
| <i>abacavir sulfate/lamivudine</i> | T1 | PA SP |
| <i>abacavir/lamivudine/zidovudine</i> | T1 | PA SP |
| <i>lamivudine/zidovudine</i> | T1 | SP |
| ANTIVIRALS - HIV-SPECIFIC, CCR5 CO-RECEPTOR ANTAG. | | |
| <i>maraviroc</i> (Selzentry) | T1 | PA SP |
| SELZENTRY | T2 | PA SP |
| ANTIVIRALS - HIV-SPECIFIC, CD4 ATTACHMENT INHIBITOR | | |
| RUKOBIA | T3 | PA QL (2 SYRINGE/DAY) SP |
| ANTIVIRALS - HIV-SPECIFIC, FUSION INHIBITORS | | |
| FUZEON | T3 | PA SP |
| ANTIVIRALS - HIV-SPECIFIC, NON-NUCLEOSIDE, RTI | | |
| EDURANT | T3 | PA SP |
| <i>efavirenz</i> | T1 | PA SP |
| INTELENCE | T3 | PA SP |

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T2 – Typically Preferred Brands

QL – Quantity Limit

SP – Specialty Medication

CSL – Oral cancer medication subject to cost-share limits

T3 – Typically Non-Preferred Brands

ST – Step Therapy

HD – May require home delivery pharmacy

List of Prescription Medications

| ANTIVIRALS (AIDS/HIV) (cont.) | | |
|---|------------------|---|
| Prescription Drug Name | Drug Tier | Coverage Requirements and Limits |
| ANTIVIRALS - HIV-SPECIFIC, NON-NUCLEOSIDE, RTI (cont.) | | |
| <i>nevirapine</i> | T1 | PA SP |
| PIFELTRO | T3 | PA SP |
| ANTIVIRALS - HIV-SPECIFIC, NUCLEOSIDE ANALOG, RTI | | |
| <i>abacavir sulfate</i> | T1 | PA SP |
| <i>emtricitabine (Emtriva)</i> | T1 | PA SP |
| EMTRIVA 10 MG/ML SOLUTION | T2 | PA SP |
| EMTRIVA 200 MG CAPSULE (<i>emtricitabine</i>) | T3 | PA SP |
| <i>lamivudine 10 mg/ml oral soln</i> | T1 | SP |
| <i>lamivudine 150 mg tablet</i> | T1 | SP |
| ANTIVIRALS - HIV-SPECIFIC, NUCLEOSIDE ANALOG, RTI | | |
| <i>lamivudine 300 mg tablet</i> | T1 | PA SP |
| <i>zidovudine</i> | T1 | SP |
| ANTIVIRALS - HIV-SPECIFIC, NUCLEOTIDE ANALOG, RTI | | |
| <i>tenofovir disoproxil fumarate</i> | T1 | PA SP |
| VIREAD | T2 | PA SP |
| ANTIVIRALS - HIV-SPECIFIC, PROTEASE INHIBITOR COMB | | |
| <i>lopinavir/ritonavir</i> | T1 | SP |
| ANTIVIRALS - HIV-SPECIFIC, PROTEASE INHIBITORS | | |
| <i>atazanavir sulfate</i> | T1 | PA SP |
| <i>efavirenz</i> | | |
| EVOTAZ | T3 | PA SP |
| <i>fosamprenavir calcium</i> | T1 | PA SP |
| INVIRASE | T2 | PA SP |
| LEXIVA | T2 | PA SP |
| REYATAZ | T2 | PA SP |
| <i>ritonavir</i> | T1 | SP |
| ANTIVIRALS - HIV-I INTEGRASE STRAND TRANSFER INHIBTR | | |
| APRETUDE | T3 | PA SP |
| ISENTRESS | T2 | SP |
| ISENTRESS HD | T2 | PA SP |
| TIVICAY | T2 | SP |
| TIVICAY PD | T2 | SP |

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List of Prescription Medications

ANTIVIRALS (AIDS/HIV) (cont.)

| Prescription Drug Name | Drug Tier | Coverage Requirements and Limits |
|---|-----------|----------------------------------|
| ARTV NUCLEOSIDE, NUCLEOTIDE, NON-NUCLEOSIDE RTI COMB | | |
| ATRIPLA (<i>efavirenz-emtricit-tenofovir disop</i>) | T3 | PA SP |
| COMPLERA | T3 | PA SP |
| DELSTRIGO | T3 | PA SP |
| <i>efavirenz/emtricit/tenofovir df</i> (Atripla) | T1 | PA SP |
| <i>efavirenz/lamivudine/tenofovir disop</i> (Symfi Lo) | T1 | SP |
| <i>efavirenz/lamivudine/tenofovir disop</i> (Symfi) | T1 | SP |
| ODEFSEY | T3 | PA SP |
| ARV-NUCLEOSIDE, NUCLEOTIDE RTI, INTEGRASE INHIBITORS | | |
| BIKTARVY | T2 | SP |
| GENVOYA | T2 | SP |
| STRIBILD | T3 | PA SP |

ANTIVIRALS (Eye Conditions)

EYE ANTIVIRALS

| | | |
|---------------------|----|--|
| <i>trifluridine</i> | T1 | |
| ZIRGAN | T3 | |

ANTIVIRALS (Infections)

ANTIVIRALS, GENERAL

| | | |
|---|----|-----------------------|
| <i>acyclovir</i> | T1 | |
| <i>famciclovir</i> | T1 | |
| FLUMADINE (<i>rimantadine hcl</i>) | T3 | |
| LIVTENCITY | T3 | PA QL (4 tabs/day) SP |
| <i>oseltamivir 6 mg/ml suspension</i> (Tamiflu) | T1 | QL (180ml/30 days) |
| <i>oseltamivir phos 30 mg capsule</i> (Tamiflu) | T1 | QL (20/30 days) |
| <i>oseltamivir phos 45 mg capsule</i> (Tamiflu) | T1 | QL (10 caps/30 days) |
| <i>oseltamivir phos 75 mg capsule</i> (Tamiflu) | T1 | QL (10/30 days) |
| PREVYMIS | T3 | SP HD |
| RELENZA | T3 | QL (20/30 days) |
| <i>ribavirin</i> (Virazole) | T1 | SP HD |
| <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) |

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CSL – Oral cancer medication subject to cost-share limits

T3 – Typically Non-Preferred Brands

ST – Step Therapy

HD – May require home delivery pharmacy

List of Prescription Medications

| ANTIVIRALS (Infections) (cont.) | | |
|---|------------------|---|
| Prescription Drug Name | Drug Tier | Coverage Requirements and Limits |
| ANTIVIRALS, GENERAL (cont.) | | |
| <i>valacyclovir hcl</i> (Valtrex) | T1 | |
| <i>valganciclovir hcl</i> | T1 | |
| VALTREX (<i>valacyclovir</i>) | T3 | |
| VIRAZOLE | T3 | SP HD |
| XOFLUZA | T3 | QL (2 tabs/30 days) |
| HEP C - NS5A, NS3/4A, NON-NUCLEO.NS5B INHIB COMB. | | |
| VIEKIRA PAK | T3 | PA SP HD |
| HEP C - NS5A, NS3/4A, NUCLEOTIDE NS5B INHIB COMBO | | |
| VOSEVI | T2 | PA SP HD |
| HEP C VIRUS, NUCLEOTIDE ANALOG NS5B POLYMERASE INH | | |
| SOVALDI 150 MG PELLETT PACKET | T2 | PA QL (1 tab/day) SP HD |
| SOVALDI 200 MG PELLETT PACKET | T2 | PA QL (1 tab/day) SP HD |
| SOVALDI 200 MG TABLET | T2 | PA QL (1 tab/day) SP HD |
| SOVALDI 400 MG TABLET | T2 | PA SP HD |
| HEP C VIRUS-NS5B POLYMERASE AND NS5A INHIB. COMBO. | | |
| EPCLUSA 200 MG-50 MG TABLET | T2 | PA QL (1 tab/Day) SP HD |
| EPCLUSA 400 MG-100 MG TABLET | T2 | PA SP HD |
| HARVONI 33.75-150 MG PELLETT PK | T2 | PA QL (1 tab/day) SP HD |
| HARVONI 45-200 MG PELLETT PACKT | T2 | PA QL (1 tab/day) SP HD |
| HARVONI 45-200 MG TABLET | T2 | PA QL (1 tab/day) SP HD |
| HARVONI 90-400 MG TABLET | T2 | PA SP HD |
| HEPATITIS B TREATMENT AGENTS | | |
| HEPSERA (adefovir dipivoxil) | T3 | SP HD |
| PEGASYS | T3 | PA SP HD |
| PEGINTRON | T3 | PA SP HD |
| <i>ribasphere 200 mg capsule</i> | T1 | SP HD |
| <i>ribasphere 200 mg tablet</i> | T1 | SP HD |
| <i>ribasphere 400 mg tablet</i> | T1 | SP |
| <i>ribasphere 600 mg tablet</i> | T1 | SP |
| <i>ribasphere ribapak 200-400 mg</i> | T1 | SP HD |
| <i>ribasphere ribapak 400-400 mg</i> | T1 | SP HD |
| <i>ribasphere ribapak 600-400 mg</i> | T1 | SP HD |
| <i>ribasphere ribapak 600-600 mg</i> | T1 | SP HD |
| <i>ribavirin</i> | T1 | SP HD |

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T3 – Typically Non-Preferred Brands

ST – Step Therapy

HD – May require home delivery pharmacy

List of Prescription Medications

ANTIVIRALS (Infections) (cont.)

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

HEPATITIS C VIRUS- NS5A AND NS3/4A INHIBITOR COMB

| | | |
|----------|----|----------|
| MAVYRET | T2 | PA SP HD |
| ZEPATIER | T3 | PA SP HD |

RNA POLYMERASE INHIBITOR

| | | |
|----------------|----|----------------------|
| LAGEVRIO (EUA) | T2 | QL (1 pack/120 days) |
| MOLNUPIRAVIR | T3 | QL (1 pkg/120 days) |

ANTIVIRALS (Skin Conditions)

TOPICAL GENITAL WART-HPV TREATMENT AGENTS

| | | |
|---------|----|--|
| VEREGEN | T3 | |
|---------|----|--|

AUTONOMIC DRUGS (Allergy/Nasal Sprays)

ANAPHYLAXIS THERAPY AGENTS

| | | |
|----------------------------------|----|----------------------|
| <i>epinephrine</i> | T1 | QL (2 packs/30 days) |
| <i>epinephrine</i> (Epinephrine) | T1 | QL (2 packs/30 days) |

AUTONOMIC DRUGS (Alzheimer's Disease)

CHOLINESTERASE INHIBITORS

| | | |
|---|----|---------------------------|
| ADLARITY | T1 | PA QL (4 patcher/28 days) |
| ARICEPT (<i>donepezil hcl</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>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)⁸

ADRENERGICS, AROMATIC, NON-CATECHOLAMINE

| | | |
|---|----|-------------------|
| ADDERALL (<i>dextroamphetamine-amphetamine</i>) | T3 | PA ST |
| ADZENYS ER | T3 | PA QL (15ml/day) |
| ADZENYS XR-ODT | T3 | PA QL (1 tab/day) |

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SP – Specialty Medication

CSL – Oral cancer medication subject to cost-share limits

T3 – Typically Non-Preferred Brands

ST – Step Therapy

HD – May require home delivery pharmacy

List of Prescription Medications

AUTONOMIC DRUGS (Attention Deficit Hyperactivity Disorder)⁸

| Prescription Drug Name | Drug Tier | Coverage Requirements and Limits |
|--|-----------|----------------------------------|
| ADRENERGICS, AROMATIC, NON-CATECHOLAMINE | | |
| AMPHETAMINE | T3 | PA QL (15ml/day) |
| <i>amphetamine sulfate (Evekeo)</i> | T1 | PA |
| <i>dextroamp-amphet er 10 mg cap</i> | T1 | PA QL (1 per day) |
| <i>dextroamp-amphet er 12.5mg cp (Mydayis)</i> | T1 | PA QL (1 per day) |
| <i>dextroamp-amphet er 15 mg cap</i> | T1 | PA QL (1 cap/day) |
| <i>dextroamp-amphet er 20 mg cap</i> | T1 | PA QL (1 cap/day) |
| <i>dextroamp-amphet er 25 mg cap</i> | T1 | PA QL (1 per day) |
| <i>dextroamp-amphet er 30 mg cap</i> | T1 | PA QL (1 cap/day) |
| <i>dextroamp-amphet er 37.5mg cp</i> | T1 | PA QL (1 cap/day) |
| <i>dextroamp-amphet er 5 mg cap</i> | T1 | PA QL (1 cap/day) |
| <i>dextroamp-amphet er 50 mg cap (Mydayis)</i> | T1 | PA QL (1 cap/day) |
| <i>dextroamphetamine er 10 mg cap</i> | T1 | PA QL (1 cap/day) |
| <i>dextroamphetamine er 15 mg cap</i> | T1 | PA QL (3/day) |
| <i>dextroamphetamine er 5 mg cap</i> | T1 | PA QL (1 cap/day) |
| <i>dextroamphetamine sulfate</i> | T1 | PA |
| <i>dextroamphetamine sulfate</i> | T3 | PA ST |
| DYANAVEL XR | T3 | PA QL (8ml/day) |
| EVEKEO (<i>amphetamine sulfate</i>) | T3 | PA ST |
| EVEKEO ODT | T3 | PA |
| <i>methamphetamine hcl</i> | T1 | PA |
| MYDAYIS (<i>dextroamphetamine/amphetamine</i>) | T3 | PA QL(1 cap/day) |
| XELSTRYM | T3 | PA QL(1 PATCH/DAY) |
| ZENZEDI | T3 | PA ST |

AUTONOMIC DRUGS (Blood Pressure/Heart Medications)

ADRENERGIC VASOPRESSOR AGENTS

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

ALPHA-ADRENERGIC BLOCKING AGENTS

| | | |
|--|----|----|
| <i>DIBENZYLIN (phenoxybenzamine hcl)</i> | T3 | HD |
| <i>phenoxybenzamine hcl (Dibenzylin)</i> | T1 | HD |

AUTONOMIC DRUGS (Urinary Tract Conditions)

PARASYMPATHETIC AGENTS

| | | |
|----------------------------------|----|----|
| <i>cevimeline hcl (Evoxac)</i> | T1 | HD |
| EVOXAC (<i>cevimeline hcl</i>) | T3 | HD |

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CSL – Oral cancer medication subject to cost-share limits

T3 – Typically Non-Preferred Brands

ST – Step Therapy

HD – May require home delivery pharmacy

List of Prescription Medications

| AUTONOMIC DRUGS (Urinary Tract Conditions) | | |
|---|-----------|----------------------------------|
| Prescription Drug Name | Drug Tier | Coverage Requirements and Limits |
| PARASYMPATHETIC AGENTS | | |
| <i>guanidine hcl</i> | T1 | HD |
| <i>pilocarpine hcl</i> (Salagen) | T1 | HD |
| SALAGEN (<i>pilocarpine hcl</i>) | T3 | HD |
| URECHOLINE (<i>bethanechol chloride</i>) | T3 | HD |
| BIOLOGICALS (Allergy/Nasal Sprays) | | |
| ALLERGENIC EXTRACTS, THERAPEUTIC | | |
| GRASTEK | 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 | T3 | PA SP HD |
| BIOLOGICALS (Miscellaneous) | | |
| PKU TREATMENT AGENTS - PHENYLALANINE AMMONIA LYASE | | |
| PALYNZIQ | T3 | PA SP HD |
| BIOLOGICALS (Vaccines) | | |
| COVID-19 VACCINES | | |
| COMIRNATY | T2 | PPACA |
| JANSSEN COVID-19 VACCINE (EUA) | T2 | PPACA |
| MODERNA COVID-19 VACCINE (EUA) | T2 | PPACA |
| NOVAVAX | T2 | PPACA |
| PFIZER COVID-19 VACCINE (EUA) | T2 | PPACA |
| ENTERIC VIRUS VACCINES | | |
| IPOL | T2 | PPACA |
| ROTARIX | T3 | PPACA |
| ROTATEQ | T3 | PPACA |
| GRAM NEGATIVE COCCI VACCINES | | |
| BEXSERO | T2 | PPACA |
| MENACTRA | T2 | PPACA |
| MENQUADFI | T2 | PPACA |
| MENVEO A-C-Y-W-135-DIP | T2 | PPACA |
| PENBRAYA | T2 | PPACA |
| TRUMENBA | T2 | PPACA |

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

PA – Prior Authorization

QL – Quantity Limit

ST – Step Therapy

AGE – Age Requirement

SP – Specialty Medication

HD – May require home delivery pharmacy

PPACA – No Cost-Share Preventive Medication

CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

| BIOLOGICALS (Vaccines) (cont.) | | |
|--|------------------|---|
| Prescription Drug Name | Drug Tier | Coverage Requirements and Limits |
| GRAM POSITIVE COCCI VACCINES | | |
| PNEUMOVAX 23 | T2 | PPACA |
| PREVNAR 13 | T2 | PPACA |
| INFLUENZA VIRUS VACCINES | | |
| FLUAD | T2 | PPACA |
| FLUAD QUAD | T2 | PPACA |
| FLUARIX QUAD | T2 | PPACA |
| FLUBLOK | T2 | PPACA |
| FLUBLOK QUAD | T2 | PPACA |
| FLUCELVAX QUAD | T2 | PPACA |
| FLULAVAL QUAD | T2 | PPACA |
| FLUMIST QUAD | T3 | PPACA |
| FLUVIRIN | T2 | PPACA |
| FLUZONE HIGH-DOSE | T2 | PPACA |
| FLUZONE HIGH-DOSE QUAD | T2 | PPACA |
| FLUZONE INTRADERM QUAD | T2 | PPACA |
| FLUZONE QUAD | T2 | PPACA |
| FLUZONE QUAD PEDI | T2 | PPACA |
| VACCINE/TOXOID PREPARATIONS, COMBINATIONS | | |
| ACTHIB | T2 | PPACA |
| ADACEL TDAP | T2 | PPACA |
| BOOSTRIX TDAP | T2 | PPACA |
| DAPTACEL DTAP | T2 | PPACA |
| DIPHTHERIA-TETANUS TOXOIDS-PED | T2 | PPACA |
| HIBERIX | T2 | PPACA |
| INFANRIX DTAP | T2 | PPACA |
| KINRIX | T2 | PPACA |
| M-M-R II VACCINE | T2 | PPACA |
| PEDVAXHIB | T2 | PPACA |
| PENTACEL | T2 | PPACA |
| PENTACEL ACTHIB COMPONENT | T2 | PPACA |
| PROQUAD | T2 | PPACA |
| QUADRACEL DTAP-IPV | T2 | PPACA |
| TDVAX | T2 | PPACA |
| TENIVAC | T2 | PPACA |

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List of Prescription Medications

| BIOLOGICALS (Vaccines) (cont.) | | |
|--|------------------|---|
| Prescription Drug Name | Drug Tier | Coverage Requirements and Limits |
| VACCINE/TOXOID PREPARATIONS, COMBINATIONS (cont.) | | |
| VAXELIS | T2 | PPACA |
| VIRAL/TUMORIGENIC VACCINES | | |
| ACAM2000 (NATIONAL STOCKPILE) | T3 | PPACA |
| ENGERIX-B ADULT | T2 | PPACA |
| ENGERIX-B PEDIATRIC-ADOLESCENT | T2 | PPACA |
| GARDASIL 9 | T2 | PPACA |
| HEPLISAV-B | T2 | PPACA |
| IXCHIQ | T3 | PPACA |
| JYNNEOS | T3 | PPACA |
| PEDIARIX | T2 | PPACA |
| RECOMBIVAX HB | T2 | PPACA |
| SHINGRIX | T2 | QL (2 doses/lifetime) PPACA |
| TWINRIX | T2 | PPACA |
| VARIVAX VACCINE | T2 | PPACA |
| ZOSTAVAX | T2 | PPACA |
| BLOOD (Blood Modifiers/Bleeding Disorders) | | |
| AGENTS TO TX THROMBOTIC THROMBOCYTOPENIC PURPURA | | |
| CABLIVI | T3 | PA SP |
| ANTI-FIBRINOLYTIC AGENTS | | |
| AMICAR (<i>aminocaproic acid</i>) | T3 | SP HD |
| <i>aminocaproic acid</i> (Amicar) | T1 | SP HD |
| LYSTEDA (<i>tranexamic acid</i>) | T3 | SP |
| <i>tranexamic acid</i> (Lysteda) | T1 | SP |
| ANTI-HEMOPHILIC FACTORS | | |
| ALTUVIIIO | T2 | PA SP HD |
| COMPLEMENT (C3) INHIBITORS | | |
| EMPAVELI | T2 | PA SP |
| FABHALTA | T2 | PA QL(2 caps/day) SP |
| HEMOPHILIA TREATMENT AGENTS, NON-FACTOR REPLACEMENT | | |
| HEMLIBRA | T3 | PA SP HD |
| SICKLE CELL ANEMIA AGENTS | | |
| DROXIA | T2 | |
| SIKLOS | T3 | PA |
| TOPICAL HEMOSTATICS | | |
| ASTRINGYN | T3 | |

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List of Prescription Medications

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

| Prescription Drug Name | Drug Tier | Coverage Requirements and Limits |
|---|-----------|----------------------------------|
| TOPICAL HEMOSTATICS (cont.) | | |
| 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 | |

BLOOD (Blood Thinners/Anti-Clotting)

HEMORRHEOLOGIC AGENTS

| | | |
|-----------------------|----|----|
| <i>pentoxifylline</i> | T1 | HD |
|-----------------------|----|----|

CARDIAC DRUGS (Blood Pressure/Heart Medications)

ANTI-ANGINAL, ANTI-ISCHEMIC AGENTS, NON-HEMODYNAMIC

| | | |
|----------------------------|----|--------------------|
| <i>ranolazine (Ranexa)</i> | T1 | QL (4 tabs/day) HD |
|----------------------------|----|--------------------|

ANTI-ARRHYTHMICS

| | | |
|---|----|--------------------|
| <i>amiodarone hcl</i> | T1 | HD |
| <i>disopyramide phosphate (Norpace)</i> | T1 | HD |
| <i>dofetilide 125 mcg capsule (Tikosyn)</i> | T1 | QL (8 caps/day) HD |
| <i>dofetilide 250 mcg capsule (Tikosyn)</i> | T1 | QL (4 caps/day) HD |
| <i>dofetilide 500 mcg capsule (Tikosyn)</i> | T1 | QL (2 caps/day) HD |
| <i>flecainide acetate</i> | T1 | HD |
| <i>mexiletine hcl</i> | T1 | HD |
| NORPACE (<i>disopyramide phosphate</i>) | T3 | PA HD |
| NORPACE CR | T3 | HD |
| <i>pacerone 100 mg tablet</i> | T3 | PA HD |

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List of Prescription Medications

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

| Prescription Drug Name | Drug Tier | Coverage Requirements and Limits |
|--|-----------|----------------------------------|
| ANTI-ARRHYTHMICS (cont.) | | |
| <i>pacерone 200 mg tablet</i> | T1 | HD |
| <i>pacерone 400 mg tablet</i> | T3 | PA HD |
| <i>propafenone hcl</i> | T1 | HD |
| <i>propafenone hcl (Rythmol Sr)</i> | T1 | HD |
| <i>quinidine sulfate</i> | T1 | HD |
| <i>RYTHMOL SR (propafenone hcl er)</i> | T3 | PA HD |
| <i>TIKOSYN 125 MCG CAPSULE (dofetilide)</i> | T3 | PA QL (8 caps/day) HD |
| <i>TIKOSYN 250 MCG CAPSULE (dofetilide)</i> | T3 | PA QL (4 caps/day) HD |
| <i>TIKOSYN 500 MCG CAPSULE (dofetilide)</i> | T3 | PA QL (2 caps/day) HD |
| CALCIUM CHANNEL BLOCKING AGENTS | | |
| <i>ADALAT CC (nifedipine er)</i> | T3 | HD |
| <i>amlodipine besylate (Norvasc)</i> | T1 | HD |
| <i>CALAN SR (verapamil er)</i> | T3 | HD |
| <i>CAMZYOS</i> | T3 | PA QL (30caps/30days) SP |
| <i>CARDIZEM LA 180 MG TABLET (matzim la)</i> | T3 | HD |
| <i>CARDIZEM LA 240 MG TABLET (matzim la)</i> | T3 | HD |
| <i>CARDIZEM LA 300 MG TABLET (matzim la)</i> | T3 | HD |
| <i>CARDIZEM LA 360 MG TABLET (matzim la)</i> | T3 | HD |
| <i>CARDIZEM LA 420 MG TABLET (matzim la)</i> | T3 | HD |
| <i>diltiazem hcl</i> | T1 | HD |
| <i>diltiazem hcl (Cardizem La)</i> | T1 | QL(1 TAB/DAY) HD |
| <i>diltiazem hcl (Tiazac)</i> | T1 | HD |
| <i>felodipine</i> | T1 | HD |
| <i>isradipine</i> | T1 | HD |
| <i>nicardipine hcl</i> | T1 | HD |
| <i>nifedipine</i> | T1 | HD |
| <i>nifedipine (Adalat Cc)</i> | T1 | HD |
| <i>nifedipine (Procardia XI)</i> | T1 | HD |
| <i>nifedipine (Procardia)</i> | T1 | HD |
| <i>nisoldipine er 17 mg tablet (Sular)</i> | T1 | HD |
| <i>nisoldipine er 20 mg tablet</i> | T1 | QL (1 tab/day) HD |

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CSL – Oral cancer medication subject to cost-share limits

T3 – Typically Non-Preferred Brands

ST – Step Therapy

HD – May require home delivery pharmacy

List of Prescription Medications

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

| Prescription Drug Name | Drug Tier | Coverage Requirements and Limits |
|--|-----------|----------------------------------|
| CALCIUM CHANNEL BLOCKING AGENTS (cont.) | | |
| <i>nisoldipine er 25.5 mg tablet</i> | T1 | HD |
| <i>nisoldipine er 30 mg tablet</i> | T1 | HD |
| <i>nisoldipine er 34 mg tablet (Sular)</i> | T1 | HD |
| <i>nisoldipine er 40 mg tablet</i> | T1 | HD |
| <i>nisoldipine er 8.5 mg tablet (Sular)</i> | 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 (Calan Sr)</i> | T1 | HD |
| <i>verapamil hcl (Verelan Pm)</i> | T1 | HD |
| <i>verapamil hcl (Verelan)</i> | 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 |
| DIGITALIS GLYCOSIDES | | |
| <i>digoxin</i> | T1 | HD |
| HEART RATE REDUCING, SA SELECTIVE I(F) CURRENT INH. | | |
| CORLANOR | T2 | PA HD |
| CORLANOR 5 MG/5 ML ORAL SOLN | | |
| SOLUBLE GUANYLATE CYCLASE (SGC) STIMULATOR | | |
| VERQUVO | T2 | PA QL HD |
| VASODILATORS, CORONARY | | |
| DILATRATE-SR | T3 | HD |
| <i>isosorbide dinitrate</i> | T1 | HD |
| MINITRAN | T1 | HD |
| NITRO-DUR 0.1 MG/HR PATCH | T3 | HD |
| NITRO-DUR 0.2 MG/HR PATCH | T3 | HD |
| NITRO-DUR 0.3 MG/HR PATCH | T2 | HD |
| NITRO-DUR 0.4 MG/HR PATCH | T3 | HD |

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List of Prescription Medications

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

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

VASODILATORS, CORONARY (cont.)

| | | |
|---------------------------------------|----|----|
| NITRO-DUR 0.6 MG/HR PATCH | T3 | HD |
| NITRO-DUR 0.8 MG/HR PATCH | T2 | HD |
| <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 |
| NITROLINGUAL (<i>nitroglycerin</i>) | T3 | HD |
| NITROMIST (<i>nitroglycerin</i>) | T3 | HD |
| NITROSTAT (<i>nitroglycerin</i>) | T3 | HD |

CARDIOVASCULAR (Asthma/COPD/Respiratory)

PULM ANTI-HTN, SOLUBLE GUANYLATE CYCLASE STIMULATOR

| | | |
|---------|----|----------|
| ADEMPAS | T3 | PA SP HD |
|---------|----|----------|

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

| | | |
|--|----|----------|
| <i>sildenafil 10 mg/ml oral susp</i> (Revatio) | T1 | PA SP HD |
| <i>sildenafil 20 mg tablet</i> (Revatio) | T1 | PA SP HD |
| <i>tadalafil</i> (Adcirca) | T1 | PA SP HD |
| <i>tadalafil 20 mg tablet</i> (Adcirca) | T1 | PA SP HD |

PULMONARY ANTI-HTN, ENDOTHELIN RECEPTOR ANTAGONIST

| | | |
|---|----|----------|
| <i>ambrisentan</i> (Letairis) | T1 | PA SP HD |
| <i>bosentan</i> (Tracleer) | T1 | PA SP HD |
| LETAIRIS (<i>ambrisentan</i>) | T3 | PA SP HD |
| OPSUMIT | T2 | PA SP HD |
| TRACLEER 125 MG TABLET (<i>bosentan</i>) | T3 | PA SP HD |
| TRACLEER 32 MG TABLET FOR SUSP | T2 | PA SP HD |
| TRACLEER 62.5 MG TABLET (<i>bosentan</i>) | T3 | PA SP HD |

PULMONARY ANTIHYPERTENSIVES, PROSTACYCLIN-TYPE

| | | |
|--------------------------------|----|--------------------------------|
| ORENITRAM ER | T3 | PA SP HD |
| ORENITRAM MONTH 1 TITRATION KT | T3 | PA QL(168 TABS/180 DAYS) SP HD |
| ORENITRAM MONTH 2 TITRATION KT | T3 | PA QL(336 TABS/180 DAYS) SP HD |
| ORENITRAM MONTH 3 TITRATION KT | T3 | PA QL(252 TABS/180 DAYS) SP HD |
| TYVASO | T3 | PA SP HD |
| TYVASO DPI | T3 | PA SP HD |

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List of Prescription Medications

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

| Prescription Drug Name | Drug Tier | Coverage Requirements and Limits |
|---|-----------|----------------------------------|
| PULMONARY ANTIHYPERTENSIVES, PROSTACYCLIN-TYPE (cont.) | | |
| TYVASO INSTITUTIONAL START KIT | T3 | PA SP HD |
| TYVASO REFILL KIT | T3 | PA SP HD |
| TYVASO STARTER KIT | T3 | PA SP HD |
| UPTRAVI | T2 | PA SP HD |
| VENTAVIS | T3 | PA SP HD |

CARDIOVASCULAR (Blood Pressure/Heart Medications)

ACE INHIBITOR-CALCIUM CHANNEL BLOCKER COMBINATION

| | | |
|--|----|----|
| <i>amlodipine besylate/benazepril</i> | T1 | HD |
| <i>amlodipine besylate/benazepril</i> (Lotrel) | T1 | HD |
| LOTREL (<i>amlodipine besylate-benazepril</i>) | T3 | HD |
| PRESTALIA 14 MG-10 MG TABLET | T3 | HD |

ACE INHIBITOR-CALCIUM CHANNEL BLOCKER COMBINATION (cont.)

| | | |
|--|----|-------------------|
| PRESTALIA 3.5 MG-2.5 MG TABLET | T3 | QL (1 tab/day) HD |
| PRESTALIA 7 MG-5 MG TABLET | T3 | QL (1 tab/day) HD |
| TARKA (<i>trandolapril-verapamil er</i>) | T3 | HD |
| <i>trandolapril/verapamil hcl</i> | T1 | HD |
| <i>trandolapril/verapamil hcl</i> (Tarka) | T1 | HD |

ACE INHIBITOR-THIAZIDE OR THIAZIDE-LIKE DIURETIC

| | | |
|--|----|--------------------|
| ACCURETIC (<i>quinapril-hydrochlorothiazide</i>) | T3 | ST HD |
| <i>benazepril/hydrochlorothiazide</i> (Lotensin Hct) | 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>enalapril/hydrochlorothiazide</i> (Vaseretic) | T1 | HD |
| <i>fosinopril/hydrochlorothiazide</i> | T1 | HD |
| <i>lisinopril/hydrochlorothiazide</i> (Zestoretic) | T1 | HD |
| LOTENSIN HCT (<i>benazepril-hydrochlorothiazide</i>) | T3 | ST HD |
| <i>quinapril/hydrochlorothiazide</i> (Accuretic) | T1 | HD |
| VASERETIC (<i>enalapril-hydrochlorothiazide</i>) | T3 | ST HD |
| ZESTORETIC (<i>lisinopril-hydrochlorothiazide</i>) | T3 | ST HD |

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List of Prescription Medications

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

| Prescription Drug Name | Drug Tier | Coverage Requirements and Limits |
|---|-----------|----------------------------------|
| ALPHA/BETA-ADRENERGIC BLOCKING AGENTS | | |
| <i>carvedilol</i> (Coreg) | T1 | HD |
| <i>carvedilol er 10 mg capsule</i> (Coreg Cr) | T1 | QL (1 cap/day) HD |
| <i>carvedilol er 40 mg capsule</i> (Coreg Cr) | T1 | QL (1 cap/day) HD |
| <i>carvedilol er 80 mg capsule</i> (Coreg Cr) | 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 |
| <i>labetalol hcl</i> | T1 | HD |
| ALPHA-ADRENERGIC BLOCKING AGENTS | | |
| CARDURA (<i>doxazosin mesylate</i>) | T3 | HD |
| CARDURA XL | T3 | HD |
| <i>doxazosin mesylate</i> (Cardura) | T1 | HD |
| MINIPRESS (<i>prazosin hcl</i>) | T3 | HD |
| <i>terazosin hcl</i> | T1 | HD |
| ANGIOTEN.RECEPTR ANTAG-CALCIUM CHANL BLKR-THIAZIDE | | |
| <i>amlodipine/valsartan/hcthiazid</i> (Exforge Hct) | T1 | HD |
| <i>olmesartan/amlodipin/hcthiazid</i> (Tribenzor) | T1 | HD |
| TRIBENZOR (<i>olmesartan-amlodipine-hctz</i>) | T3 | HD |
| ANGIOTENSIN RECEPT-NEPRILYSIN INHIBITOR COMB (ARNI) | | |
| ENTRESTO | T2 | HD |
| ANGIOTENSIN RECEPTOR ANTAG.-THIAZIDE DIURETIC COMB | | |
| ATACAND HCT (<i>candesartan-hydrochlorothiazid</i>) | T3 | ST HD |
| AVALIDE (<i>irbesartan-hydrochlorothiazide</i>) | T3 | ST HD |
| BENICAR HCT 20-12.5 MG TABLET (<i>olmesartan-hydrochlorothiazide</i>) | T3 | QL (1 tab/day) ST HD |
| BENICAR HCT 40-12.5 MG TABLET (<i>olmesartan-hydrochlorothiazide</i>) | T3 | ST HD |
| BENICAR HCT 40-25 MG TABLET (<i>olmesartan-hydrochlorothiazide</i>) | T3 | ST HD |
| <i>candesartan/hydrochlorothiazid</i> (Atacand Hct) | T1 | HD |
| DIOVAN HCT (<i>valsartan-hydrochlorothiazide</i>) | T3 | ST HD |
| HYZAAR (<i>losartan-hydrochlorothiazide</i>) | T3 | ST HD |

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PPACA – No Cost-Share Preventive Medication

T2 – Typically Preferred Brands

QL – Quantity Limit

SP – Specialty Medication

CSL – Oral cancer medication subject to cost-share limits

T3 – Typically Non-Preferred Brands

ST – Step Therapy

HD – May require home delivery pharmacy

List of Prescription Medications

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

| Prescription Drug Name | Drug Tier | Coverage Requirements and Limits |
|--|-----------|----------------------------------|
| ANGIOTENSIN RECEPTOR ANTAG.-THIAZIDE DIURETIC COMB (cont.) | | |
| <i>irbesartan/hydrochlorothiazide (Avalide)</i> | T1 | HD |
| <i>losartan/hydrochlorothiazide (Hyzaar)</i> | T1 | HD |
| MICARDIS HCT 40-12.5 MG TABLET (<i>telmisartan-hydrochlorothiazid</i>) | T3 | QL (1 tab/day) ST HD |
| MICARDIS HCT 80-12.5 MG TABLET (<i>telmisartan-hydrochlorothiazid</i>) | T3 | ST HD |
| MICARDIS HCT 80-25 MG TABLET (<i>telmisartan-hydrochlorothiazid</i>) | T3 | ST HD |
| <i>olmesartan-hctz 20-12.5 mg tab (Benicar Hct)</i> | T1 | QL (1 tab/day) HD |
| <i>olmesartan-hctz 40-12.5 mg tab (Benicar Hct)</i> | T1 | HD |
| <i>olmesartan-hctz 40-25 mg tab (Benicar Hct)</i> | T1 | HD |
| <i>telmisartan-hctz 40-12.5 mg tb (Micardis Hct)</i> | T1 | QL (1 tab/day) HD |
| <i>telmisartan-hctz 80-12.5 mg tb (Micardis Hct)</i> | T1 | HD |
| <i>telmisartan-hctz 80-25 mg tab (Micardis Hct)</i> | T1 | HD |
| <i>valsartan/hydrochlorothiazide (Diovan Hct)</i> | T1 | HD |
| ANGIOTENSIN RECEPTOR BLOCKR-CALCIUM CHANNEL BLOCKR | | |
| <i>amlodipine besylate/valsartan (Exforge)</i> | T1 | HD |
| <i>amlodipine-olmesartan 10-20 mg (Azor)</i> | T1 | HD |
| <i>amlodipine-olmesartan 10-40 mg (Azor)</i> | T1 | HD |
| <i>amlodipine-olmesartan 5-20 mg (Azor)</i> | T1 | QL (1 tab/day) HD |
| <i>amlodipine-olmesartan 5-40 mg (Azor)</i> | T1 | HD |
| AZOR 10-20 MG TABLET (<i>amlodipine-olmesartan</i>) | T3 | HD |
| AZOR 10-40 MG TABLET (<i>amlodipine-olmesartan</i>) | T3 | HD |
| AZOR 5-20 MG TABLET (<i>amlodipine-olmesartan</i>) | T3 | QL (1 tab/day) HD |
| AZOR 5-40 MG TABLET (<i>amlodipine-olmesartan</i>) | T3 | HD |
| EXFORGE (<i>amlodipine-valsartan</i>) | T3 | 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 |
| ANTI-HYPERTENSIVES, ACE INHIBITORS | | |
| ACCUPRIL (<i>quinapril hcl</i>) | T3 | ST HD |
| ALTACE (<i>ramipril</i>) | T3 | ST HD |
| <i>benazepril hcl</i> | T1 | HD |
| <i>benazepril hcl (Lotensin)</i> | T1 | HD |
| <i>captopril</i> | T1 | HD |

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T3 – Typically Non-Preferred Brands

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HD – May require home delivery pharmacy

List of Prescription Medications

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

| Prescription Drug Name | Drug Tier | Coverage Requirements and Limits |
|--|-----------|----------------------------------|
| ANTI-HYPERTENSIVES, ACE INHIBITORS (cont.) | | |
| <i>enalapril maleate</i> (Vasotec) | T1 | HD |
| EPANED | T3 | HD |
| <i>fosinopril sodium</i> | T1 | HD |
| <i>lisinopril</i> (Zestril) | T1 | HD |
| LOTENSIN (<i>benazepril hcl</i>) | T3 | ST HD |
| <i>moexipril hcl</i> | T1 | HD |
| <i>perindopril erbumine</i> | T1 | HD |
| PRINIVIL (<i>lisinopril</i>) | T3 | ST HD |
| <i>quinapril hcl</i> (Accupril) | T1 | HD |
| <i>ramipril</i> (Altace) | T1 | HD |
| <i>trandolapril</i> | T1 | HD |
| VASOTEC (<i>enalapril maleate</i>) | T3 | ST HD |
| ZESTRIL (<i>lisinopril</i>) | T3 | ST HD |
| ANTI-HYPERTENSIVES, ANGIOTENSIN RECEPTOR ANTAGONIST | | |
| ATACAND (<i>candesartan cilexetil</i>) | T3 | ST HD |
| AVAPRO (<i>irbesartan</i>) | T3 | ST HD |
| BENICAR 20 MG TABLET (<i>olmesartan medoxomil</i>) | T3 | QL (1 tab/day) ST HD |
| BENICAR 40 MG TABLET (<i>olmesartan medoxomil</i>) | T3 | ST HD |
| BENICAR 5 MG TABLET (<i>olmesartan medoxomil</i>) | T3 | ST HD |
| <i>candesartan cilexetil</i> (Atacand) | T1 | HD |
| COZAAR (<i>losartan potassium</i>) | T3 | ST HD |
| DIOVAN (<i>valsartan</i>) | T3 | ST HD |
| EDARBI 40 MG TABLET | T3 | QL (1 tab/day) ST HD |
| EDARBI 80 MG TABLET | T3 | ST HD |
| <i>eprosartan mesylate</i> | T1 | HD |
| <i>irbesartan</i> (Avapro) | T1 | HD |
| <i>losartan potassium</i> (Cozaar) | T1 | HD |
| MICARDIS 20 MG TABLET (<i>telmisartan</i>) | T3 | QL (1 tab/day) ST HD |
| MICARDIS 40 MG TABLET (<i>telmisartan</i>) | T3 | QL (1 tab/day) ST HD |
| MICARDIS 80 MG TABLET (<i>telmisartan</i>) | T3 | ST HD |
| <i>olmesartan medoxomil 20 mg tab</i> (Benicar) | T1 | QL (1 tab/day) HD |
| <i>olmesartan medoxomil 40 mg tab</i> (Benicar) | T1 | HD |
| <i>olmesartan medoxomil 5 mg tab</i> (Benicar) | T1 | HD |

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CSL – Oral cancer medication subject to cost-share limits

T3 – Typically Non-Preferred Brands

ST – Step Therapy

HD – May require home delivery pharmacy

List of Prescription Medications

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

| Prescription Drug Name | Drug Tier | Coverage Requirements and Limits |
|--|-----------|----------------------------------|
| ANTI-HYPERTENSIVES, ANGIOTENSIN RECEPTOR ANTAGONIST (cont.) | | |
| <i>telmisartan 20 mg tablet</i> (Micardis) | T1 | QL (1 tab/day) HD |
| <i>telmisartan 40 mg tablet</i> (Micardis) | T1 | QL (1 tab/day) HD |
| <i>telmisartan 80 mg tablet</i> (Micardis) | T1 | HD |
| <i>valsartan</i> (Diovan) | T1 | ST HD |
| ANTI-HYPERTENSIVES, GANGLIONIC BLOCKERS | | |
| VECAMYL | T1 | |
| ANTI-HYPERTENSIVES, MISCELLANEOUS | | |
| DEMSEER (<i>metyrosine</i>) | T3 | HD |
| <i>metyrosine</i> (Demser) | T1 | HD |
| ANTI-HYPERTENSIVES, SYMPATHOLYTIC | | |
| 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</i> (Catapres-tts 1) | T1 | HD |
| <i>clonidine</i> (Catapres-tts 2) | T1 | HD |
| <i>clonidine</i> (Catapres-tts 3) | T1 | HD |
| <i>clonidine hcl</i> (Catapres) | T1 | HD |
| <i>guanfacine hcl</i> | T1 | HD |
| <i>methyldopa</i> | T1 | HD |
| <i>methyldopa/hydrochlorothiazide</i> | T1 | HD |
| ANTI-HYPERTENSIVES, VASODILATORS | | |
| <i>hydralazine hcl</i> | T1 | HD |
| <i>minoxidil</i> | T1 | HD |
| BETA-ADRENERGIC BLOCKING AGENTS | | |
| <i>acebutolol hcl</i> | T1 | HD |
| <i>atenolol</i> (Tenormin) | T1 | HD |
| <i>betaxolol hcl</i> | T1 | HD |
| <i>bisoprolol fumarate</i> | T1 | HD |
| BYSTOLIC 10 MG TABLET | T2 | QL (1 tab/day) ST HD |
| BYSTOLIC 2.5 MG TABLET | T2 | QL (1 tab/day) ST HD |
| BYSTOLIC 20 MG TABLET | T2 | ST HD |
| BYSTOLIC 5 MG TABLET | T2 | QL (1 tab/day) ST HD |
| INDERAL LA (<i>propranolol hcl er</i>) | T3 | ST HD |

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List of Prescription Medications

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

| Prescription Drug Name | Drug Tier | Coverage Requirements and Limits |
|--|-----------|----------------------------------|
| BETA-ADRENERGIC BLOCKING AGENTS (cont.) | | |
| INDERAL XL | T3 | ST HD |
| INNOPRAN XL | T3 | ST HD |
| <i>metoprolol succinate</i> (Toprol XL) | T1 | HD |
| <i>metoprolol tartrate</i> | T1 | HD |
| <i>metoprolol tartrate</i> (Lopressor) | T1 | HD |
| <i>nadolol</i> (Corgard) | T1 | HD |
| <i>pindolol</i> | T1 | HD |
| <i>propranolol hcl</i> | T1 | HD |
| <i>propranolol hcl</i> (Inderal La) | T1 | HD |
| <i>sotalol hcl</i> | T1 | HD |
| <i>sotalol hcl</i> (Betapace Af) | T1 | HD |
| SOTYLIZE | T3 | HD |
| TENORMIN (<i>atenolol</i>) | T3 | ST HD |
| <i>timolol maleate</i> | T1 | HD |
| BETA-BLOCKERS AND THIAZIDE, THIAZIDE-LIKE DIURETICS | | |
| <i>atenolol/chlorthalidone</i> (Tenoretic 100) | T1 | HD |
| <i>atenolol/chlorthalidone</i> (Tenoretic 50) | T1 | HD |
| <i>bisoprolol/hydrochlorothiazide</i> (Ziac) | T1 | HD |
| METOPROLOL SUCCINATE ER-HCTZ | T1 | HD |
| <i>metoprolol/hydrochlorothiazide</i> | T1 | HD |
| <i>nadolol/bendroflumethiazide</i> | T1 | HD |
| <i>propranolol/hydrochlorothiazid</i> | T1 | HD |
| RENIN INHIBITOR, DIRECT | | |
| <i>aliskiren 150 mg tablet</i> (Tekturna) | T1 | QL (1 tab/day) HD |
| <i>aliskiren 300 mg tablet</i> (Tekturna) | T1 | HD |
| RENIN INHIBITOR, DIRECT AND THIAZIDE DIURETIC COMB | | |
| TEKTURNA HCT | T2 | QL (1 tab/day) HD |
| VASODILATORS, COMBINATION | | |
| BIDIL | T3 | QL (6 tabs/day) HD |
| <i>isosorbide-hydralazine 20-37.5</i> (Bidil) | T1 | QL (6 tabs/day) HD |

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List of Prescription Medications

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

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

VASODILATORS, PERIPHERAL

| | | |
|---------------------------|----|--|
| <i>ergoloid mesylates</i> | T1 | |
| <i>isoxsuprine hcl</i> | T1 | |

CARDIOVASCULAR (Cholesterol Medications)

ANTI-HYPERLIPID.HMG COA REDUCT INHIB-CHOLEST.AB.INHIB

| | | |
|--|----|-------|
| <i>ezetimibe/simvastatin (Vytorin)</i> | T1 | HD |
| ROSZET | T3 | PA HD |
| VYTORIN (<i>ezetimibe-simvastatin</i>) | T3 | ST HD |

ANTI-HYPERLIPID- HMG-COA RI-CALCIUM CHANNEL BLOCKER

| | | |
|--|----|-------------------|
| <i>amlodipine-atorvast 10-10 mg (Caduet)</i> | T1 | HD |
| <i>amlodipine-atorvast 10-20 mg (Caduet)</i> | T1 | HD |
| <i>amlodipine-atorvast 10-40 mg (Caduet)</i> | T1 | HD |
| <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 |

ANTI-HYPERLIPIDEMIC - APO B-100 SYNTHESIS INHIBITOR

| | | |
|---------|----|-------|
| KYNAMRO | T3 | PA SP |
|---------|----|-------|

ANTI-HYPERLIPIDEMIC - ATP CITRATE LYASE INHIBITOR

| | | |
|----------|----|-------------------|
| NEXLETOL | T2 | PA QL (1 tab/day) |
|----------|----|-------------------|

ANTI-HYPERLIPIDEMIC - PCSK9 INHIBITORS

| | | |
|--------------------|----|----|
| REPATHA PUSHTRONEX | T2 | PA |
|--------------------|----|----|

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T3 – Typically Non-Preferred Brands

ST – Step Therapy

HD – May require home delivery pharmacy

List of Prescription Medications

| CARDIOVASCULAR (Cholesterol Medications) (cont.) | | |
|---|-----------|----------------------------------|
| Prescription Drug Name | Drug Tier | Coverage Requirements and Limits |
| ANTI-HYPERLIPIDEMIC - PCSK9 INHIBITORS (cont.) | | |
| REPATHA SURECLICK | T2 | PA |
| REPATHA SYRINGE | T2 | PA |
| ANTI-HYPERLIPIDEMIC-ACLY AND CHOLEST ABSORP INHIB | | |
| NEXLIZET | T2 | PA QL (1 SYRINGE/DAY) |
| ANTI-HYPERLIPIDEMIC-HMGCOA REDUCTASE INHIB (Statins) | | |
| ALTOPREV 20 MG TABLET | T3 | QL (1 tab/day) ST HD |
| ALTOPREV 40 MG TABLET | T3 | ST HD |
| ALTOPREV 60 MG TABLET | T3 | ST HD |
| <i>atorvastatin 10 mg tablet</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>fluvastatin sodium (Lescol XI)</i> | T1 | HD PPACA |
| LIVALO (<i>pitavastatin calcium</i>) | T2 | ST QL(1 tab/day) HD |
| <i>lovastatin 10 mg tablet</i> | T1 | HD |
| <i>lovastatin 20 mg tablet</i> | T1 | HD PPACA |
| <i>lovastatin 40 mg tablet</i> | T1 | HD PPACA |
| <i>pitavastatin (Livalo) 1 mg tablet</i> | T1 | QL HD PPACA |
| <i>pitavastatin (Livalo) 2 mg tablet</i> | T1 | QL HD PPACA |
| <i>pitavastatin (Livalo) 4 mg tablet</i> | T1 | HD PPACA |
| <i>pravastatin sodium</i> | T1 | HD PPACA |
| <i>pravastatin sodium (Pravachol)</i> | T1 | HD PPACA |
| <i>rosuvastatin calcium 10 mg tab (Crestor)</i> | T1 | QL (1 tab/day) HD PPACA |
| <i>rosuvastatin calcium 20 mg tab (Crestor)</i> | T1 | QL (1 tab/day) HD |
| <i>rosuvastatin calcium 40 mg tab (Crestor)</i> | T1 | HD |
| <i>rosuvastatin calcium 5 mg tab (Crestor)</i> | T1 | QL (1 tab/day) HD PPACA |
| <i>simvastatin 10 mg tablet (Zocor)</i> | T1 | HD PPACA |
| <i>simvastatin 20 mg tablet (Zocor)</i> | T1 | HD PPACA |
| <i>simvastatin 40 mg tablet (Zocor)</i> | T1 | HD PPACA |
| <i>simvastatin 5 mg tablet</i> | T1 | HD |
| BILE SALT SEQUESTRANTS | | |
| <i>cholestyramine (with sugar) (Questran)</i> | T1 | HD |
| <i>cholestyramine/aspartame</i> | T1 | HD |
| <i>cholestyramine/aspartame (Questran Light)</i> | T1 | HD |

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ST – Step Therapy

HD – May require home delivery pharmacy

List of Prescription Medications

CARDIOVASCULAR (Cholesterol Medications) (cont.)

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

BILE SALT SEQUESTRANTS (cont.)

| | | |
|--|----|----|
| <i>colesevelam hcl</i> (Welchol) | T1 | HD |
| COLESTID 1 GM TABLET (<i>colestipol hcl</i>) | T3 | HD |
| COLESTID FLAVORED GRANULES | T2 | HD |
| COLESTID GRANULES | T3 | HD |
| COLESTID GRANULES (<i>colestipol hcl</i>) | T3 | HD |
| COLESTID GRANULES PACKET (<i>colestipol hcl</i>) | T3 | HD |
| <i>colestipol hcl</i> (Colestid) | T1 | HD |
| QUESTRAN (<i>cholestyramine</i>) | T3 | HD |
| QUESTRAN LIGHT (<i>prevalite</i>) | T3 | HD |

LIPOTROPICS

| | | |
|--|----|-------|
| <i>ezetimibe</i> (Zetia) | T1 | HD |
| <i>fenofibrate</i> | T1 | HD |
| <i>fenofibrate nanocrystallized</i> (Tricor) | T1 | HD |
| <i>fenofibrate, micronized</i> | T1 | HD |
| <i>fenofibric acid</i> (choline) (Trilipix) | T1 | HD |
| <i>fenofibric acid</i> (Fibricor) | T1 | HD |
| FIBRICOR (<i>fenofibric acid</i>) | T3 | ST HD |
| <i>gemfibrozil</i> (Lopid) | T1 | HD |
| LIPOFEN | T3 | ST HD |
| LOPID (<i>gemfibrozil</i>) | T3 | HD |
| <i>niacin</i> (Niaspan) | T1 | HD |
| NIASPAN (<i>niacin er</i>) | T3 | HD |
| TRICOR (<i>fenofibrate</i>) | T3 | ST HD |
| TRIGLIDE | T3 | ST HD |
| TRILIPIX (<i>fenofibric acid</i>) | T3 | ST HD |
| ZETIA (<i>ezetimibe</i>) | T3 | HD |

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 |

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List of Prescription Medications

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

| Prescription Drug Name | Drug Tier | Coverage Requirements and Limits |
|---|-----------|----------------------------------|
| ALZHEIMER'S THERAPY, NMDA RECEPTOR ANTAGONISTS (cont.) | | |
| NAMENDA 10 MG TABLET (<i>memantine hcl</i>) | T3 | HD |
| NAMENDA 5 MG TABLET (<i>memantine hcl</i>) | T3 | HD |
| NAMENDA 5-10 MG TITRATION PK | T2 | HD |
| NAMENDA XR 14 MG CAPSULE (<i>memantine hcl er</i>) | T3 | QL (1 cap/day) HD |
| NAMENDA XR 21 MG CAPSULE (<i>memantine hcl er</i>) | T3 | HD |
| NAMENDA XR 28 MG CAPSULE (<i>memantine hcl er</i>) | T3 | HD |
| NAMENDA XR 7 MG CAPSULE (<i>memantine hcl er</i>) | T3 | QL (1 cap/day) HD |
| NAMENDA XR TITRATION PACK | T3 | QL (112/365 days) HD |
| ALZHEIMER'S THX, NMDA RECEPTOR ANTAG-CHOLINES INHIB | | |
| NAMZARIC 14 MG-10 MG CAPSULE | T3 | QL (2 caps/day) HD |
| NAMZARIC 21 MG-10 MG CAPSULE | T3 | QL (2 caps/day) HD |
| NAMZARIC 28 MG-10 MG CAPSULE | T3 | QL (2 caps/day) HD |
| NAMZARIC 7 MG-10 MG CAPSULE | T3 | QL (2 caps/day) HD |
| NAMZARIC TITRATION PACK | T3 | QL (112/365 days) HD |

CNS DRUGS (Miscellaneous)

AMYOTROPHIC LATERAL SCLEROSIS AGENTS

| | | |
|-----------------------------|----|-------------------------|
| RADICAVA ORS | T3 | PA QL (50ml/28 days) SP |
| RILUTEK (<i>riluzole</i>) | T3 | SP HD |
| <i>riluzole</i> (Rilutek) | T1 | SP HD |
| TIGLUTIK | T3 | PA SP |

DRUGS TO TREAT MOVEMENT DISORDERS

| | | |
|---------------------------------|----|-----------------------------|
| AUSTEDO | T3 | PA SP HD |
| AUSTEDO XR 12 MG TABLET | T3 | PA QL(1 TAB/DAY) SP HD |
| AUSTEDO XR 24 MG TABLET | T3 | PA QL(2 TABS/DAY) SP HD |
| AUSTEDO XR 6 MG TABLET | T3 | PA QL(3 TABS/DAY) SP HD |
| AUSTEDO XR TITRATION KIT(WK1-4) | T3 | PA QL(1 KIT/180 DAYS) SP HD |
| INGREZZA | T3 | PA SP |
| <i>tetrabenazine</i> | T1 | PA SP HD |

PSEUDOBULBAR AFFECT (PBA) AGENTS, NMDA ANTAGONISTS

| | | |
|----------|----|-----------------|
| NUEDEXTA | T3 | QL (4 caps/day) |
|----------|----|-----------------|

XANTHINES

| | | |
|-------------------------|----|----|
| <i>caffeine citrate</i> | T1 | HD |
|-------------------------|----|----|

CNS DRUGS (Multiple Sclerosis)

AGENTS TO TREAT MULTIPLE SCLEROSIS

| | | |
|--------|----|----------|
| AVONEX | T3 | PA SP HD |
|--------|----|----------|

T1 – Typically Generics

PA – Prior Authorization

AGE – Age Requirement

PPACA – No Cost-Share Preventive Medication

T2 – Typically Preferred Brands

QL – Quantity Limit

SP – Specialty Medication

CSL – Oral cancer medication subject to cost-share limits

T3 – Typically Non-Preferred Brands

ST – Step Therapy

HD – May require home delivery pharmacy

List of Prescription Medications

CNS DRUGS (Multiple Sclerosis) (cont.)

| Prescription Drug Name | Drug Tier | Coverage Requirements and Limits |
|---|-----------|----------------------------------|
| AGENTS TO TREAT MULTIPLE SCLEROSIS (cont.) | | |
| AVONEX PEN | T3 | PA SP HD |
| BAFIERTAM | T2 | PA SP HD |
| BETASERON | T3 | PA SP HD |
| <i>dimethyl fumarate</i> | T1 | PHD |
| GILENYA | T2 | PA SP HD |
| <i>glatiramer acetate</i> | T3 | HD |
| glatopa | T3 | HD |
| KESIMPTA PEN | T3 | PA SP HD |
| MAVENCLAD | T3 | PA SP HD |
| MAYZENT | T2 | PA SP HD |
| PLEGRIDY | T3 | PA SP HD |
| PLEGRIDY PEN | T3 | PA SP HD |
| PONVORY | T2 | PA SP HD |
| REBIF | T3 | PA SP HD |
| REBIF REBIDOSE | T3 | PA SP HD |
| <i>teriflunomide (Aubagio)</i> | T1 | SP HD |
| VUMERITY | T2 | PA SP HD |

AGTS TX NEUROMUSC TRANSMISSION DIS, POT-CHAN BLKR

| | | |
|----------------------|----|-----------------------|
| <i>dalfampridine</i> | T1 | PA SP HD |
| FIRDAPSE | T3 | PA QL (8 tabs/day) SP |
| RUZURGI | T3 | PA SP |

CNS DRUGS (Pain Relief And Inflammatory Disease)

CALCITONIN GENE-RELATED PEPTIDE (CGRP) INHIBITORS

| | | |
|------------------|----|----|
| EMGALITY SYRINGE | T2 | PA |
|------------------|----|----|

CNS DRUGS (Seizure Disorders)

ANTI-CONVULSANT - BENZODIAZEPINE TYPE

| | | |
|---|----|-------|
| <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 |
| <i>diazepam 20 mg rectal gel syst</i> | T1 | HD |
| KLONOPIN (<i>clonazepam</i>) | T3 | PA HD |

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ST – Step Therapy

HD – May require home delivery pharmacy

List of Prescription Medications

CNS DRUGS (Seizure Disorders) (cont.)

| Prescription Drug Name | Drug Tier | Coverage Requirements and Limits |
|--|-----------|----------------------------------|
| ANTI-CONVULSANT - BENZODIAZEPINE TYPE (cont.) | | |
| NAYZILAM | T2 | PA QL (5 kits/30 days) HD |
| ONFI (<i>clobazam</i>) | T3 | PA HD |
| VALTOCO | T3 | PA QL (5 boxes/30 Days) HD |
| ANTI-CONVULSANT - CANNABINOID TYPE | | |
| EPIDIOLEX | T3 | PA SP HD |
| ANTI-CONVULSANTS | | |
| APTIOM 200 MG TABLET | T3 | PA QL (1 tab/day) HD |
| APTIOM 400 MG TABLET | T3 | PA QL (1 tab/day) HD |
| APTIOM 600 MG TABLET | T3 | PA HD |
| APTIOM 800 MG TABLET | T3 | PA HD |
| BRIVIACT | T3 | PA HD |
| <i>carbamazepine</i> | T1 | HD |
| <i>carbamazepine</i> (Carbatrol) | T1 | HD |
| <i>carbamazepine</i> (Tegretol Xr) | T1 | HD |
| <i>carbamazepine</i> (Tegretol) | T1 | HD |
| CARBATROL (<i>carbamazepine er</i>) | T3 | PA HD |
| CELONTIN | T2 | HD |
| DIACOMIT | T3 | PA SP HD |
| 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 |

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List of Prescription Medications

CNS DRUGS (Seizure Disorders) (cont.)

| Prescription Drug Name | Drug Tier | Coverage Requirements and Limits |
|--|-----------|----------------------------------|
| ANTI-CONVULSANTS (cont.) | | |
| FINTEPLA | T3 | 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 (Neurontin)</i> | 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 |
| <i>lamotrigine</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 |
| PEGANONE | T2 | HD |
| PHENYTEK (<i>phenytoin sodium extended</i>) | T3 | PA HD |
| <i>phenytoin</i> | T1 | HD |
| <i>phenytoin (Dilantin)</i> | T1 | HD |
| <i>phenytoin (Dilantin-125)</i> | T1 | HD |
| <i>phenytoin sodium extended (Dilantin)</i> | T1 | HD |
| <i>phenytoin sodium extended (Phenytek)</i> | T1 | HD |
| <i>pregabalin</i> | T1 | HD |
| <i>pregabalin (Lyrica)</i> | T1 | HD |
| <i>primidone (Mysoline)</i> | T1 | HD |
| <i>rufinamide 200 mg tablet (Banzel)</i> | T1 | PA QL(16 TABS/DAY) HD |
| <i>rufinamide 400 mg tablet (Banzel)</i> | T1 | PA QL (80ML/DAY HD) |
| SPRITAM | T3 | PA HD |
| TEGRETOL (<i>carbamazepine</i>) | T3 | PA HD |

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ST – Step Therapy

HD – May require home delivery pharmacy

List of Prescription Medications

CNS DRUGS (Seizure Disorders) (cont.)

| Prescription Drug Name | Drug Tier | Coverage Requirements and Limits |
|--|-----------|----------------------------------|
| ANTI-CONVULSANTS (cont.) | | |
| 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</i> | T1 | HD |
| <i>topiramate er (Trokendi XR)</i> | T1 | QL(1 cap/day) HD |
| <i>valproic acid</i> | T1 | HD |
| <i>valproic acid</i> (as sodium salt) | T1 | HD |
| <i>vigabatrin</i> | T1 | SP HD |
| VIMPAT | 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 |
| ZEPOSIA | T2 | PA SP HD |
| <i>zonisamide</i> | T1 | HD |
| ZTALMY | T3 | PA QL (1800mg/day) SP |

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 | T2 | PA SP |
| EPOGEN | T2 | PA SP |
| MIRCERA | T3 | PA SP |
| PROCRIT | T2 | PA SP |

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CSL – Oral cancer medication subject to cost-share limits

T3 – Typically Non-Preferred Brands

ST – Step Therapy

HD – May require home delivery pharmacy

List of Prescription Medications

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

| Prescription Drug Name | Drug Tier | Coverage Requirements and Limits |
|---|-----------|----------------------------------|
| ERYTHROPOIESIS-STIMULATING AGENTS (cont.) | | |
| RETACRIT | T2 | PA SP |
| LEUKOCYTE (WBC) STIMULANTS | | |
| FULPHILA | T3 | PA SP |
| GRANIX | T3 | PA SP |
| LEUKINE | T2 | SP |
| NEULASTA | T3 | PA SP |
| NEULASTA ONPRO | T3 | PA SP HD |
| NEUPOGEN | T3 | PA SP |
| NIVESTYM | T2 | SP |
| NYVEPRIA | T3 | PA SP |
| STIMUFEND | T3 | PA SP |
| UDENYCA | T2 | PA SP |
| ZARXIO | T2 | SP HD |
| ZIEXTENZO | T3 | PA SP |
| THROMBOPOIETIN RECEPTOR AGONISTS | | |
| DOPTELET | T3 | PA SP HD |
| MULPLETA | T3 | PA SP HD |
| PROMACTA | T3 | PA SP HD |
| CONTRACEPTIVES (Contraception Products) | | |
| CONTRACEPTIVES, INTRAVAGINAL, SYSTEMIC | | |
| <i>etonogestrel</i> | T3 | |
| <i>etonogestrel/ethinyl estradiol (Nuvaring)</i> | T1 | PPACA |
| NUVARING (<i>etonogestrel-ethinyl estradiol</i>) | T3 | |
| CONTRACEPTIVES, IMPLANTABLE | | |
| NEXPLANON | T3 | SP PPACA |
| CONTRACEPTIVES, INJECTABLE | | |
| DEPO-PROVERA 150 MG/ML SYRINGE (<i>medroxyprogesterone acetate</i>) | T3 | |
| DEPO-PROVERA 150 MG/ML VIAL (<i>medroxyprogesterone acetate</i>) | T3 | |
| DEPO-SUBQ PROVERA 104 | T2 | |
| CONTRACEPTIVES, ORAL | | |
| BALCOLTRA | T3 | HD |
| BEYAZ (<i>rajani</i>) | T3 | HD |
| <i>desog-e.estradiol/e.estradiol (Mircette)</i> | T1 | HD PPACA |
| <i>desogestrel-ethinyl estradiol</i> | T1 | HD PPACA |

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ST – Step Therapy

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List of Prescription Medications

CONTRACEPTIVES (Contraception Products) (cont.)

| Prescription Drug Name | Drug Tier | Coverage Requirements and Limits |
|---|-----------|----------------------------------|
| CONTRACEPTIVES, ORAL (cont.) | | |
| <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 |
| <i>ethinyl estradiol/drospirenone</i> (Yaz) | T1 | HD PPACA |
| <i>ethynodiol d-ethinyl estradiol</i> | T1 | HD PPACA |
| <i>levonorgestrel/ethin.estradiol</i> | T1 | HD PPACA |
| <i>l-norgest/e.estradiol-e.estrad</i> (Loseasonique) | T1 | HD PPACA |
| <i>l-norgest/e.estradiol-e.estrad</i> (Quartette) | T1 | HD PPACA |
| <i>l-norgest/e.estradiol-e.estrad</i> (Seasonique) | 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 |
| NATAZIA | T3 | HD |
| NEXTSTELLIS | T3 | HD |
| <i>noreth-ethinyl estradiol/iron</i> | T1 | HD PPACA |
| <i>noreth-ethinyl estradiol/iron</i> (Generess Fe) | T1 | HD PPACA |
| <i>noreth-ethinyl estradiol/iron</i> (Generess Fe) | T3 | HD PPACA |
| <i>norethind-eth estrad 1-0.02 mg</i> (Loestrin) | T1 | HD PPACA |
| <i>norethindrone</i> (Ortho Micronor) | T1 | HD PPACA |
| <i>norethindrone ac-eth estradiol</i> (Loestrin) | T1 | HD PPACA |
| <i>norethindrone-e.estradiol-iron</i> (Estrostep Fe) | T1 | HD PPACA |
| <i>norethindrone-e.estradiol-iron</i> (Loestrin Fe) | T1 | HD PPACA |
| <i>norethindrone-e.estradiol-iron</i> (Microgestin 24 Fe) | T1 | HD PPACA |
| <i>norethindrone-e.estradiol-iron</i> (Minastrin 24 Fe) | T1 | HD PPACA |
| <i>norethindrone-e.estradiol-iron</i> (Taytulla) | T1 | HD PPACA |

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T3 – Typically Non-Preferred Brands

ST – Step Therapy

HD – May require home delivery pharmacy

List of Prescription Medications

| CONTRACEPTIVES (Contraception Products) (cont.) | | |
|---|-----------|----------------------------------|
| Prescription Drug Name | Drug Tier | Coverage Requirements and Limits |
| CONTRACEPTIVES, ORAL (cont.) | | |
| <i>norethindrone-ethin. estradiol</i> | T1 | HD PPACA |
| <i>norethin-ee 1.5-0.03 mg(21) tb</i> (Loestrin) | 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 |
| SLYND | T3 | HD |
| TAYTULLA (<i>norethin-eth estra-ferrous fum</i>) | T3 | HD |
| TYBLUME | T3 | HD |
| YASMIN 28 (<i>zumandimine</i>) | T3 | HD |
| YAZ (<i>vestura</i>) | T3 | HD |
| CONTRACEPTIVES, TRANSDERMAL | | |
| <i>norelgestromin/ethin.estradiol</i> | T1 | HD PPACA |
| TWIRLA | T3 | HD PPACA |
| DIAPHRAGMS/CERVICAL CAP | | |
| CAYA CONTOURED | T1 | PPACA |
| FEMCAP | T1 | PPACA |
| WIDE SEAL DIAPHRAGM | T1 | PPACA |
| INTRA-UTERINE DEVICES (IUDS) | | |
| KYLEENA | T3 | SP PPACA |
| LILETTA | T3 | SP PPACA |
| MIRENA | T3 | SP PPACA |
| PARAGARDT 380-A | T3 | SP PPACA |
| SKYLA | T3 | SP PPACA |
| COUGH/COLD PREPARATIONS (Allergy/Nasal Sprays) | | |
| 1ST GEN ANTIHIST-DECONGEST-ANTICHOLINERGIC COMB | | |
| RESPA A.R. | T3 | |
| COUGH/COLD PREPARATIONS (Cough/Cold Medications) | | |
| ANTI-TUSSIVES, NON-OPIOID | | |
| <i>benzonatate</i> | T1 | |
| <i>benzonatate</i> (Tessalon Perle) | T1 | |

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List of Prescription Medications

| COUGH/COLD PREPARATIONS (Cough/Cold Medications) (cont.) | | |
|--|-----------|----------------------------------|
| Prescription Drug Name | Drug Tier | Coverage Requirements and Limits |
| ANTI-TUSSIVES, NON-OPIOID (cont.) | | |
| TESSALON PERLE (<i>benzonatate</i>) | T3 | |
| NON-OPIOID ANTI-TUS-IST GEN.ANTIHISTAMINE-DECONGEST | | |
| <i>brompheniramine/pseudoephed/dm</i> (Bromfed Dm) | T1 | |
| NON-OPIOID ANTI-TUSSIVE-IST GEN ANTIHISTAMINE COMB. | | |
| <i>promethazine/dextromethorphan</i> | T1 | |
| OPIOID ANTI-TUSSIV-IST GEN. ANTIHISTAMINE-DECONGEST | | |
| <i>hydrocodone/cpm/pseudoephed</i> | T1 | PA |
| <i>promethazine/phenyleph/codeine</i> | T1 | PA QL (480ML/22 DAYS) |
| <i>promethazine/phenyleph/codeine</i> | T1 | PA QL (480ml/30 days) |
| OPIOID ANTI-TUSSIVE-IST GENERATION ANTIHISTAMINE | | |
| <i>hydrocodone/chlorphen p-stirex</i> | T1 | PA |
| <i>promethazine-codeine solution</i> | T1 | PA QL (480ML/22 Days) |
| <i>promethazine-codeine syrup</i> | T1 | PA QL (480ml/30 days) |
| TUXARIN ER | T3 | PA QL (2 tabs/day) |
| TUZISTRA XR | T3 | PA QL (960ml/30 days) |
| OPIOID ANTI-TUSSIVE-ANTI-CHOLINERGIC COMBINATIONS | | |
| HYCODAN (<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) |
| OPIOID ANTI-TUSSIVE-EXPECTORANT COMBINATION | | |
| HYDROCODONE-GUAIFENESIN | T1 | PA QL (960ml/30 days) |
| OBREDON | T3 | PA QL (960ml/30 days) |
| DIAGNOSTIC (Miscellaneous) | | |
| DIAGNOSTIC PREPARATIONS, MISCELLANEOUS | | |
| ADVANCED DNA MEDICATED COLLECT | T3 | |
| ARIDOL | T3 | |
| GLUCAGEN DIAGNOSTIC 1 MG VIAL | T2 | |
| <i>lidocaine hcl/glycerin</i> (Advanced Dna Medicated Collect) | T1 | |
| PROVOCHOLINE | T3 | |
| TC99M SULFUR COLLOID PREP | T1 | |

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List of Prescription Medications

| DIAGNOSTIC (Miscellaneous) (cont.) | | |
|---|------------------|---|
| Prescription Drug Name | Drug Tier | Coverage Requirements and Limits |
| EYE DIAGNOSTIC AGENTS | | |
| <i>fluorescein sodium</i> | T1 | |
| <i>ful-glo 1 mg oph strip</i> | T1 | |
| FUL-GLO EYE STRIPS | T3 | |
| <i>lissamine green</i> | T1 | |
| GASTROINTESTINAL RADIOPAQUE DIAGNOSTICS | | |
| ENTEROVU | T3 | |
| E-Z DISK | T3 | |
| E-Z-HD | T3 | |
| E-Z-PAQUE | T3 | |
| E-Z-PASTE | T3 | |
| GASTROMARK | T3 | |
| LIQUID E-Z PAQUE | T3 | |
| LIQUID POLIBAR PLUS | T3 | |
| NEULUMEX | T3 | |
| POLIBAR ACB | T3 | |
| READI-CAT 2 | T3 | |
| SITZMARKS | T3 | |
| TAGITOL V | T3 | |
| VARIBAR HONEY | T3 | |
| VARIBAR NECTAR | T3 | |
| VARIBAR PUDDING | T3 | |
| VARIBAR THIN HONEY | T3 | |
| VARIBAR THIN LIQUID | T3 | |
| METABOLIC FUNCTION DIAGNOSTICS | | |
| METOPIRONE | T2 | |
| RADIOPHARMACEUTICALS ELEMENTS | | |
| INDICLOR | T3 | |
| URINARY TRACT RADIOPAQUE DIAGNOSTICS | | |
| CYSTO-CONRAY II | T3 | |
| CYSTOGRAFIN | T3 | |
| CYSTOGRAFIN-DILUTE | T3 | |
| <i>diatrizoate meglumine, sodium</i> (Gastrografin) | T1 | |
| GASTROGRAFIN (<i>md-gastroview</i>) | T3 | |

T1 – Typically Generics

PA – Prior Authorization

AGE – Age Requirement

PPACA – No Cost-Share Preventive Medication

T2 – Typically Preferred Brands

QL – Quantity Limit

SP – Specialty Medication

CSL – Oral cancer medication subject to cost-share limits

T3 – Typically Non-Preferred Brands

ST – Step Therapy

HD – May require home delivery pharmacy

List of Prescription Medications

| DIURETICS (Diuretics) | | |
|---|-----------|----------------------------------|
| Prescription Drug Name | Drug Tier | Coverage Requirements and Limits |
| ARGININE VASOPRESSIN (AVP) RECEPTOR ANTAGONISTS | | |
| TOLVAPTAN 15 MG TABLET | T3 | SP |
| <i>tolvaptan 30 mg tablet (Samsca)</i> | T1 | SP |
| CARBONIC ANHYDRASE INHIBITORS | | |
| <i>acetazolamide</i> | T1 | HD |
| <i>methazolamide</i> | T1 | HD |
| LOOP DIURETICS | | |
| <i>bumetanide</i> | T1 | HD |
| FUROSCIX | T3 | QL(2 kits/30 days) HD |
| <i>furosemide</i> | T1 | HD |
| <i>furosemide (Lasix)</i> | T1 | HD |
| <i>toremide</i> | T1 | HD |
| POLYCYSTIC KIDNEY DISEASE AGENT, AVP RECEPTOR ANTAGONIST | | |
| JYNARQUE 15 MG TABLET | T3 | SP |
| JYNARQUE 15 MG-15 MG TABLET | T3 | PA SP |
| JYNARQUE 30 MG TABLET | T3 | SP |
| JYNARQUE 30 MG-15 MG TABLET | T3 | PA SP |
| JYNARQUE 45 MG-15 MG TABLET | T3 | PA SP |
| JYNARQUE 60 MG-30 MG TABLET | T3 | PA SP |
| JYNARQUE 90 MG-30 MG TABLET | T3 | PA SP |
| POTASSIUM SPARING DIURETICS | | |
| <i>amiloride hcl</i> | T1 | HD |
| CAROSPIR (<i>spironolactone</i>) | T2 | HD |
| <i>eplerenone (Inspra)</i> | T1 | HD |
| INSPRA (<i>eplerenone</i>) | T3 | HD |
| KERENDIA | T2 | PA QL (30 tabs/30 days) |
| <i>spironolactone (Aldactone)</i> | T1 | HD |
| <i>triamterene (Dyrenium)</i> | T1 | HD |
| POTASSIUM SPARING DIURETICS IN COMBINATION | | |
| 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 |

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HD – May require home delivery pharmacy

List of Prescription Medications

| DIURETICS (Diuretics) (cont.) | | |
|---|------------------|---|
| Prescription Drug Name | Drug Tier | Coverage Requirements and Limits |
| POTASSIUM SPARING DIURETICS IN COMBINATION (cont.) | | |
| <i>spironolact/hydrochlorothiazid</i> | T1 | HD |
| <i>triamterene/hydrochlorothiazid (Dyazide)</i> | T1 | HD |
| <i>triamterene/hydrochlorothiazid (Maxzide)</i> | T1 | HD |
| <i>triamterene/hydrochlorothiazid (Maxzide-25 Mg)</i> | T1 | HD |
| THIAZIDE AND RELATED DIURETICS | | |
| <i>chlorthalidone</i> | T1 | HD |
| DIURIL | T2 | HD |
| <i>hydrochlorothiazide</i> | T1 | HD |
| <i>indapamide</i> | T1 | HD |
| <i>metolazone</i> | T1 | HD |
| EENT PREPS (Allergy/Nasal Sprays) | | |
| NASAL ANTIHISTAMINE | | |
| <i>azelastine 0.1% (137 mcg) sry</i> | T1 | HD |
| <i>azelastine 0.15% nasal spray</i> | T1 | HD |
| <i>olopatadine 665 mcg nasal sry (Patanase)</i> | T1 | HD |
| PATANASE (<i>olopatadine hcl</i>) | T3 | HD |
| NASAL ANTIHISTAMINE AND ANTI-INFLAM. STEROID COMB. | | |
| <i>azelastine/fluticasone</i> | T1 | HD |
| NASAL ANTI-INFLAMMATORY STEROIDS | | |
| <i>flunisolide</i> | T1 | HD |
| <i>fluticasone prop 50 mcg spray</i> | T1 | HD |
| <i>mometasone furoate 50 mcg sry</i> | T1 | QL (4 bots/30 days) HD |
| NOSE PREPARATIONS, MISCELLANEOUS (RX) | | |
| <i>ipratropium bromide</i> | T1 | HD |
| NOSE PREPARATIONS, VASOCONSTRICTORS (RX) | | |
| ADRENALIN CHLORIDE | T3 | |
| <i>epinephrine hcl (Adrenalin Chloride)</i> | T1 | |
| EENT PREPS (Ear Medications) | | |
| EAR PREPARATIONS ANTI-INFLAMMATORY | | |
| DERMOTIC (<i>fluocinolone acetonide oil</i>) | T3 | |
| <i>fluocinolone acetonide oil (Dermotic)</i> | T1 | |
| EAR PREPARATIONS, MISC. ANTI-INFECTIVES | | |
| <i>acetic acid</i> | T1 | |
| <i>hydrocortisone/acetic acid</i> | T1 | |

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T3 – Typically Non-Preferred Brands

ST – Step Therapy

HD – May require home delivery pharmacy

List of Prescription Medications

| EENT PREPS (Eye Conditions) | | |
|---|-----------|----------------------------------|
| Prescription Drug Name | Drug Tier | Coverage Requirements and Limits |
| ARTIFICIAL TEARS | | |
| LACRISERT | T2 | |
| EYE ANTI-INFECTIVES (RX ONLY) | | |
| BETADINE | T2 | |
| EYE ANTI-INFLAMMATORY AGENTS | | |
| ACUVAIL | T3 | QL (8.3ML/14 DAYS) |
| ALREX | T3 | |
| <i>bromfenac sodium</i> | T1 | |
| BROMSITE (<i>bromfenac sodium</i>) | T2 | |
| <i>dexamethasone sodium phosphate</i> | T1 | |
| <i>diclofenac 0.1% eye drops</i> | T1 | |
| EYSUVIS | T2 | |
| FLAREX | T2 | |
| <i>fluorometholone (Fml)</i> | T1 | |
| <i>flurbiprofen sodium</i> | T1 | |
| ILEVRO | T3 | |
| INVELTYS | T2 | |
| <i>ketorolac 0.4% ophth solution (Acular Ls)</i> | T1 | |
| <i>ketorolac 0.5% ophth solution (Acular)</i> | T1 | |
| LOTEMAX 0.5% EYE OINT | T3 | |
| <i>loteprednol etabonate (Lotemax)</i> | T1 | |
| OMNIPRED (<i>prednisolone acetate</i>) | T3 | |
| <i>prednisolone acetate (Pred Forte)</i> | T1 | |
| <i>prednisolone sodium phosphate</i> | T1 | |
| PROLENSA | T3 | |
| EYE LOCAL ANESTHETICS | | |
| AKTEN | T3 | |
| ALCAINE (<i>proparacaine hcl</i>) | T3 | |
| ALTAFLUOR BENOX (<i>flurox</i>) | T3 | |
| <i>benoxinate hcl/fluorescein sod (Altafluor Benox)</i> | T1 | |
| <i>benoxinate hcl/fluorescein sod (Altafluor Benox)</i> | T3 | |
| <i>proparacaine hcl (Alcaine)</i> | T1 | |
| <i>proparacaine/fluorescein sod</i> | T1 | |
| <i>proparacaine/fluorescein sod</i> | T2 | |
| <i>tetracaine hcl</i> | T1 | |

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List of Prescription Medications

| EENT PREPS (Eye Conditions) (cont.) | | |
|--|-----------|----------------------------------|
| Prescription Drug Name | Drug Tier | Coverage Requirements and Limits |
| EYE LOCAL ANESTHETICS (cont.) | | |
| TETRAVISC | T2 | |
| TETRAVISC FORTE | T2 | |
| EYE MAST CELL STABILIZERS | | |
| <i>cromolyn 4% eye drops</i> | T1 | |
| EYE PREPARATIONS, MISCELLANEOUS (OTC) | | |
| GELFILM | T3 | |
| EYE VASOCONSTRICTORS | | |
| <i>phenylephrine hcl</i> | T1 | |
| MIOTICS AND OTHER INTRAOCULAR PRESSURE REDUCERS | | |
| <i>apraclonidine hcl (Iopidine)</i> | T1 | HD |
| <i>betaxolol hcl</i> | T1 | HD |
| BETOPTIC S | T2 | HD |
| <i>bimatoprost</i> | T1 | QL (10 gm/30 days) HD |
| <i>brimonidine tartrate</i> | T1 | HD |
| <i>brimonidine tartrate (Alphagan P)</i> | T1 | HD |
| <i>brinzolamide (Azopt)</i> | T1 | HD |
| <i>carteolol hcl</i> | T1 | HD |
| <i>dorzolamide hcl (Trusopt)</i> | T1 | HD |
| <i>dorzolamide hcl/timolol maleat (Cosopt)</i> | T1 | HD |
| <i>dorzolamide/timolol/pf (Cosopt Pf)</i> | T1 | HD |
| IOPIDINE 0.5% EYE DROPS (<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 |
| PHOSPHOLINE IODIDE | T2 | HD |
| <i>pilocarpine hcl (Isopto Carpine)</i> | T1 | HD |
| RHOPRESSA | T3 | HD |
| ROCKLATAN | T3 | HD |
| SIMBRINZA | T2 | HD |
| <i>timolol maleate (Istalol)</i> | T1 | HD |
| <i>timolol maleate (Timoptic)</i> | T1 | HD |
| <i>timolol maleate (Timoptic-xe)</i> | T1 | HD |
| <i>timolol maleate/pf (Timoptic Ocudose)</i> | T1 | HD |
| <i>travoprost</i> | T1 | HD |

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List of Prescription Medications

| EENT PREPS (Eye Conditions) (cont.) | | |
|--|------------------|---|
| Prescription Drug Name | Drug Tier | Coverage Requirements and Limits |
| MYDRIATICS | | |
| <i>atropine sulfate</i> | T1 | HD |
| <i>atropine sulfate</i> (Isopto Atropine) | T1 | HD |
| CYCLOGYL 0.5% EYE DROPS (<i>cyclopentolate hcl</i>) | T2 | HD |
| CYCLOGYL 1% EYE DROPS | T3 | HD |
| CYCLOGYL 1% EYE DROPS (<i>cyclopentolate hcl</i>) | T3 | HD |
| CYCLOGYL 2% EYE DROPS (<i>cyclopentolate hcl</i>) | T3 | HD |
| CYCLOMYDRIL | T2 | 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 |
| OPHTHALMIC ANTI-FIBROTIC AGENTS | | |
| MITOSOL | T3 | |
| OPHTHALMIC ANTI-INFLAMMATORY IMMUNOMODULATOR-TYPE | | |
| CEQUA | T3 | HD |
| RESTASIS | T2 | HD |
| RESTASIS MULTIDOSE | T2 | HD |
| VEVYE | T3 | QL HD |
| XIIDRA | T2 | HD |
| OPHTHALMIC CYSTINE DEPLETING AGENTS | | |
| CYSTADROPS | T3 | PA QL (20ML/21 DAYS) SP |
| CYSTARAN | T3 | PA QL (120ml/28 days) SP |
| OPHTHALMIC HUMAN NERVE GROWTH FACTOR (HNGF) | | |
| OXERVATE | T3 | PA SP HD |
| ELECT/CALORIC/H2O (Cholesterol Medications) | | |
| ORAL LIPID SUPPLEMENTS | | |
| DOJOLVI | T3 | PA SP HD |
| ELECT/CALORIC/H2O (Dental Products) | | |
| FLUORIDE PREPARATIONS | | |
| CLINPRO 5000 | T3 | |
| <i>fluoride (sodium)</i> (Prevident 5000 Ortho Defense) | T1 | |

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List of Prescription Medications

ELECT/CALORIC/H2O (Dental Products) (cont.)

| Prescription Drug Name | Drug Tier | Coverage Requirements and Limits |
|---|-----------|----------------------------------|
| FLUORIDE PREPARATIONS (cont.) | | |
| <i>fluoride</i> (sodium) (Prevident 5000 Plus) | T1 | |
| <i>fluoride</i> (sodium) (Prevident 5000) | T1 | |
| <i>fluoride</i> (sodium) (Prevident) | T1 | |
| FLUORIDEX | T1 | |
| FLUORIDEX SENSITIVITY RELIEF | T3 | |
| PREVIDENT 0.2% RINSE | T2 | |
| PREVIDENT 1.1% GEL (<i>sodium fluoride</i>) | T3 | |
| PREVIDENT 5000 | T3 | |
| PREVIDENT 5000 BOOSTER PLUS | 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 | |
| PREVIDENT DENTAL RINSE | T2 | |
| <i>sodium fluoride/potassium nit</i> (Prevident 5000 Sensitive) | T1 | |

ELECT/CALORIC/H2O (Diabetes)

AGENTS TO TREAT HYPOGLYCEMIA (HYPERGLYCEMICS)

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

ELECT/CALORIC/H2O (Miscellaneous)

NUCLEIC ACID/NUCLEOTIDE SUPPLEMENTS

| | | |
|---------|----|-------|
| XURIDEN | T3 | PA SP |
|---------|----|-------|

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List of Prescription Medications

| ELECT/CALORIC/H2O (Nutritional/Dietary) | | |
|--|-----------|----------------------------------|
| Prescription Drug Name | Drug Tier | Coverage Requirements and Limits |
| ELECTROLYTE DEPLETERS | | |
| AURYXIA | T3 | QL (12 tabs/day) |
| <i>calcium acetate</i> | T1 | |
| <i>lanthanum carbonate (Fosrenol)</i> | T1 | |
| LOKELMA | T2 | |
| PHOSLYRA | T3 | |
| <i>sevelamer carbonate (Renvela)</i> | T1 | |
| <i>sevelamer hcl</i> | T1 | |
| <i>sevelamer hcl (Renagel)</i> | T1 | |
| <i>sodium polystyrene sulfon/sorb</i> | T1 | |
| <i>sodium polystyrene sulfonate</i> | T1 | |
| <i>sps 15 gm/60 ml suspension</i> | T1 | |
| <i>sps 30 gm/120 ml enema susp</i> | T3 | |
| VELPHORO | T2 | |
| VELTASSA | T2 | |
| IODINE CONTAINING AGENTS | | |
| <i>potassium iodide/iodine</i> | T1 | |
| SSKI | T1 | |
| IRON REPLACEMENT | | |
| CITRANATAL BLOOM | T3 | |
| mv-mins no.73/iron fum/folic (Hemocyte Plus) | | |
| POTASSIUM REPLACEMENT | | |
| EFFER-K 10 MEQ TABLET EFF | T3 | |
| EFFER-K 20 MEQ TABLET EFF | T3 | |
| <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 | |
| K-TAB ER (<i>potassium chloride</i>) | T3 | |
| <i>potassium bicarbonate/cit ac</i> | T1 | |
| <i>potassium chloride</i> | T1 | |
| <i>potassium chloride</i> | T2 | |
| <i>potassium chloride</i> | T3 | |
| <i>potassium chloride (K-tab Er)</i> | T1 | |

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List of Prescription Medications

| ELECT/CALORIC/H2O (Urinary Tract Conditions) | | |
|---|-----------|----------------------------------|
| Prescription Drug Name | Drug Tier | Coverage Requirements and Limits |
| DIALYSIS SOLUTIONS | | |
| PRISMASOL | T3 | |
| URINARY PH MODIFIERS | | |
| K-PHOS NO.2 | T2 | HD |
| K-PHOS ORIGINAL | T2 | HD |
| ORACIT | T3 | HD |
| <i>potassium citrate</i> (Urocit-k) | T1 | HD |
| <i>potassium citrate/citric acid</i> | T1 | HD |
| RENACIDIN | T3 | HD |
| UROCI-K (<i>potassium citrate er</i>) | T3 | HD |
| UROQID-ACID NO.2 | T2 | HD |
| GASTROINTESTINAL (Cholesterol Medications) | | |
| LIPOTROPICS | | |
| <i>icosapent ethyl</i> (Vascepa) | T1 | HD |
| <i>omega-3 acid ethyl esters</i> (Lovaza) | T1 | HD |
| VASCEPA | T2 | PA HD |
| GASTROINTESTINAL (Gastrointestinal/Heartburn) | | |
| AMMONIA INHIBITORS | | |
| <i>lactulose</i> | T1 | HD |
| <i>lactulose 10 gm/15 ml solution</i> | T1 | HD |
| LITHOSTAT | T2 | HD |
| OLPRUVA | T3 | PA SP HD |
| RAVICTI | T3 | PA SP HD |
| <i>sodium phenylbutyrate</i> (Buphenyl) | T1 | SP HD |
| ANTI-CHOLINERGICS, QUATERNARY AMMONIUM | | |
| <i>chlordiazepoxide/clidinium br</i> | T1 | |
| CUVPOSA | T3 | |
| GLYCATE | T3 | |
| <i>glycopyrrolate</i> (Glycate) | T1 | |
| <i>glycopyrrolate</i> (Robinul Forte) | T1 | |
| <i>glycopyrrolate</i> (Robinul) | T1 | |
| <i>propantheline bromide</i> | T1 | |

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List of Prescription Medications

| GASTROINTESTINAL (Gastrointestinal/Heartburn) (cont.) | | |
|--|------------------|---|
| Prescription Drug Name | Drug Tier | Coverage Requirements and Limits |
| ANTI-CHOLINERGICS, QUATERNARY AMMONIUM (cont.) | | |
| ROBINUL (<i>glycopyrrolate</i>) | T3 | |
| ROBINUL FORTE (<i>glycopyrrolate</i>) | T3 | |
| ANTI-CHOLINERGICS/ANTI-SPASMODICS | | |
| <i>dicyclomine hcl</i> | T1 | |
| ANTI-DIARRHEAL - G.I. CHLORIDE CHANNEL INHIBITORS | | |
| MYTESI | T3 | |
| ANTI-DIARRHEAL - TRYPTOPHAN HYDROXYLASE INHIBITOR | | |
| XERMELO | T3 | PA SP |
| ANTI-DIARRHEALS | | |
| <i>diphenoxylate hcl/atropine</i> | T1 | |
| <i>diphenoxylate hcl/atropine</i> (Lomotil) | T1 | |
| LOMOTIL (<i>diphenoxylate-atropine</i>) | T3 | |
| <i>loperamide hcl</i> | T1 | |
| MOTOFEN | T3 | |
| <i>opium tincture</i> | T1 | PA |
| <i>paregoric</i> | T1 | |
| ANTI-EMETIC, CANNABINOID-TYPE | | |
| <i>dronabinol</i> | T1 | |
| ANTI-EMETIC/ANTI-VERTIGO AGENTS | | |
| AKYNZEO | T3 | PA QL (4 caps/28 days) |
| ANZEMET | T3 | PA QL (5 tabs/30 days) SP |
| <i>aprepitant 125 mg capsule</i> | T1 | QL (4 caps/28 days) |
| <i>aprepitant 125-80-80 mg pack</i> (Emend) | T1 | QL (12 caps/28 days) |
| <i>aprepitant 40 mg capsule</i> | T1 | QL (1 cap/28 days) |
| <i>aprepitant 80 mg capsule</i> (Emend) | T1 | QL (8 caps/28 days) |
| BONJESTA | T3 | |
| COMPAZINE (<i>prochlorperazine maleate</i>) | T3 | |
| COMPAZINE (<i>prochlorperazine</i>) | T3 | |
| DICLEGIS (<i>doxylamine succ-pyridoxine hcl</i>) | T3 | |
| <i>doxylamine succinate/vit b6</i> (Diclegis) | 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) |

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T2 – Typically Preferred Brands

QL – Quantity Limit

SP – Specialty Medication

CSL – Oral cancer medication subject to cost-share limits

T3 – Typically Non-Preferred Brands

ST – Step Therapy

HD – May require home delivery pharmacy

List of Prescription Medications

GASTROINTESTINAL (Gastrointestinal/Heartburn) (cont.)

| Prescription Drug Name | Drug Tier | Coverage Requirements and Limits |
|--|-----------|----------------------------------|
| ANTI-EMETIC/ANTI-VERTIGO AGENTS (cont.) | | |
| <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 | |
| <i>prochlorperazine (Compazine)</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 | |
| TIGAN (<i>trimethobenzamide hcl</i>) | T3 | |
| TRANSDERM-SCOP (<i>scopolamine</i>) | T3 | |
| <i>trimethobenzamide hcl (Tigan)</i> | T1 | |
| VARUBI | T3 | PA QL (4 tabs/28 days) |
| ANTI-ULCER PREPARATIONS | | |
| CARAFATE (<i>sucralfate</i>) | T3 | HD |
| CYTOTEC (<i>misoprostol</i>) | T3 | HD |
| <i>misoprostol (Cytotec)</i> | T1 | HD |
| <i>sucralfate (Carafate)</i> | T1 | HD |
| ANTI-ULCER-H.PYLORI AGENTS | | |
| <i>bismuth/metronid/tetracycline (Pylera)</i> | T1 | |
| <i>lansoprazole/amoxicilin/clarith</i> | T1 | |
| BELLADONNA ALKALOIDS | | |
| DONNATAL | T3 | HD |
| DONNATAL (<i>phenohydro</i>) | T3 | 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 |

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List of Prescription Medications

GASTROINTESTINAL (Gastrointestinal/Heartburn) (cont.)

| Prescription Drug Name | Drug Tier | Coverage Requirements and Limits |
|--|-----------|----------------------------------|
| BELLADONNA ALKALOIDS (cont.) | | |
| LEVBIID (<i>symax-sr</i>) | T3 | HD |
| LEVSIN (<i>oscimin</i>) | T3 | HD |
| LEVSIN-SL (<i>symax-sl</i>) | T3 | HD |
| <i>methscopolamine bromide</i> | T1 | HD |
| NULEV (<i>symax</i>) | T1 | HD |
| <i>phenobarb/hyoscy/atropine/scop</i> (Donnatal) | T1 | HD |
| <i>phenobarb/hyoscy/atropine/scop</i> (Phenobarbital-belladonna) | T1 | HD |
| <i>phenobarbital-belladonna elixr</i> (Donnatal) | T1 | HD |
| <i>phenobarbital-belladonna elixr</i> (Phenobarbital-belladonna) | T1 | HD |
| PHENOBARBITAL-BELLADONNA ELIXR (<i>phenohytr</i>) | T3 | HD |
| SYMAX DUOTAB | T2 | HD |
| BILE SALTS | | |
| ACTIGALL (<i>ursodiol</i>) | T3 | HD |
| CHENODAL | T3 | SP HD |
| CHOLBAM | T3 | 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 |
| CHRONIC INFLAM. COLON DX, 5-A-SALICYLAT, RECTAL TX | | |
| <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 | |
| DRUG TX-CHRONIC INFLAM. COLON DX, 5-AMINOSALICYLAT | | |
| APRISO (<i>mesalamine er</i>) | T3 | HD |
| AZULFIDINE (<i>sulfasalazine dr</i>) | T3 | HD |
| <i>balsalazide disodium</i> | T1 | HD |
| <i>mesalamine</i> | T1 | HD |
| <i>mesalamine</i> (Apriso) | T1 | HD |
| <i>mesalamine 800 mg dr tablet</i> | T1 | HD |
| <i>mesalamine dr 1.2 gm tablet</i> (Lialda) | T1 | HD |

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List of Prescription Medications

GASTROINTESTINAL (Gastrointestinal/Heartburn) (cont.)

| Prescription Drug Name | Drug Tier | Coverage Requirements and Limits |
|--|-----------|----------------------------------|
| LAXATIVES AND CATHARTICS (cont.) | | |
| <i>peg3350/sod sulf, bicarb, cl/kcl</i> | T1 | PPACA |
| PREPOIK | T2 | PPACA |
| <i>sodium chloride/na₂hco₃/kcl/peg</i> | T1 | PPACA |
| SUFLAVE | T2 | PPACA |
| SUTAB | T2 | PPACA |
| LOCAL ANORECTAL NITRATE PREPARATIONS | | |
| <i>nitroglycerin 0.4% ointment</i> | T1 | |
| RECTIV | T3 | |
| PANCREATIC ENZYMES | | |
| PANCREAZE | T2 | HD |
| VIOKACE | T3 | HD |
| POTASSIUM-COMPETITIVE ACID BLOCKERS (PCABS) | | |
| VOQUEZNA | T3 | PA QL(1 tab/day) |
| PROTON-PUMP INHIBITORS | | |
| ACIPHEX (<i>rabeprazole sodium</i>) | T3 | QL (30 tabs/30 days) ST HD |
| ACIPHEX SPRINKLE DR 10 MG CAP | T3 | QL (60 caps/30 days) HD |
| ACIPHEX SPRINKLE DR 5 MG CAP | T3 | QL (120 caps/30 days) HD |
| <i>dexlansoprazole dr 30 mg cap (Dexilant)</i> | T1 | QL(2 caps/day) HD |
| <i>esomeprazole dr 10 mg packet</i> | T1 | QL (4 packets/day) HD |
| <i>esomeprazole dr 20 mg packet</i> | T1 | QL (2 packs/day) HD |
| <i>esomeprazole dr 40 mg packet</i> | T1 | QL (1 packet/day) HD |
| <i>esomeprazole mag dr 20 mg cap</i> | T1 | QL (20ml/day) HD |
| <i>esomeprazole mag dr 40 mg cap</i> | T1 | QL (1 cap/day) HD |
| ESOMEPRAZOLE STRONTIUM | T3 | QL (1 cap/day) HD |
| <i>lansoprazole dr 15 mg capsule (Prevacid)</i> | T1 | QL (2 caps/day) HD |
| <i>lansoprazole dr 30 mg capsule (Prevacid)</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>omeprazole dr 10 mg capsule</i> | T1 | QL (120 caps/30 days) HD |
| <i>omeprazole dr 20 mg capsule</i> | T1 | HD |
| <i>omeprazole dr 40 mg capsule</i> | T1 | QL (1 cap/day) HD |
| <i>pantoprazole 40 mg suspension (Protonix)</i> | T1 | QL (1 dose/day) HD |

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T3 – Typically Non-Preferred Brands

ST – Step Therapy

HD – May require home delivery pharmacy

List of Prescription Medications

| GASTROINTESTINAL (Gastrointestinal/Heartburn) (cont.) | | | |
|--|--------------------------|---|---|
| Prescription Drug Name | Drug Tier | Coverage Requirements and Limits | |
| PROTON-PUMP INHIBITORS (cont.) | | | |
| <i>pantoprazole sod dr 20 mg tab</i> (Protonix) | T1 | QL (2 tabs/day) HD | |
| <i>pantoprazole sod dr 40 mg tab</i> (Protonix) | T1 | QL (1 tab/day) HD | |
| PREVACID DR 15 MG CAPSULE (<i>lansoprazole</i>) | T3 | QL (60 caps/30 days) ST HD | |
| PREVACID DR 30 MG CAPSULE (<i>lansoprazole</i>) | T3 | QL (30 caps/30 days) ST HD | |
| PRILOSEC DR 10 MG SUSPENSION | T3 | QL (120 packs/30 days) HD | |
| PRILOSEC DR 2.5 MG SUSPENSION | T3 | QL (480 packs/30 days) HD | |
| PROTONIX 40 MG SUSPENSION (<i>pantoprazole sodium</i>) | T3 | QL (30 packs/30 days) ST HD | |
| PROTONIX DR 20 MG TABLET (<i>pantoprazole sodium</i>) | T3 | QL (60 tabs/30 days) ST HD | |
| PROTONIX DR 40 MG TABLET (<i>pantoprazole sodium</i>) | T3 | QL (30 tabs/30 days) ST HD | |
| <i>rabeprazole sodium</i> (Aciphex) | T1 | QL (30 tabs/30 days) HD | |
| RECTAL PREPARATIONS | | | |
| <i>hydrocortisone ac 25 mg supp</i> | T1 | | |
| SBS - GLUCAGON-LIKE PEPTIDE-2 (GLP-2) ANALOGS | | | |
| GATTEX | T3 | 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</i> (Analpram Hc) | T1 | | |
| <i>lidocaine/hydrocortisone ac</i> | T1 | | |
| LIDOCAINE-HYDROCORTISONE | T1 | | |
| PROCORT | T3 | | |
| PROCTOFOAM-HC | T2 | | |
| RECTAL/LOWER BOWEL PREP., GLUCOCORT. (NON-HEMORR) | | | |
| <i>budesonide 2 mg rectal foam</i> | T1 | QL(2 KITS/180 DAYS) | |
| CORTENEMA (<i>hydrocortisone</i>) | T3 | | |
| <i>hydrocortisone</i> (Cortenema) | T1 | | |
| HORMONES (Hormonal Agents) | | | |
| ANDROGEN/ESTROGEN PREPS FOR FEMALE SEXUAL DYSFUNC | | | |
| INTRAROSA | T3 | | |
| ANDROGENIC AGENTS | | | |
| ANADROL-50 | T2 | PA | |
| ANDRODERM | T2 | PA QL (1 patch/day) | |
| ANDROGEL 1% (25 MG/2.5 G) PKT (<i>testosterone</i>) | T3 | PA QL (150gm/30 days) | |
| T1 – Typically Generics | PA – Prior Authorization | AGE – Age Requirement | PPACA – No Cost-Share Preventive Medication |
| T2 – Typically Preferred Brands | QL – Quantity Limit | SP – Specialty Medication | CSL – Oral cancer medication subject to cost-share limits |
| T3 – Typically Non-Preferred Brands | ST – Step Therapy | HD – May require home delivery pharmacy | |

List of Prescription Medications

| HORMONES (Hormonal Agents) (cont.) | | |
|--|------------------|---|
| Prescription Drug Name | Drug Tier | Coverage Requirements and Limits |
| ANDROGENIC AGENTS (cont.) | | |
| ANDROGEL 1% (50 MG/5 G) PKT (<i>testosterone</i>) | T3 | PA QL (2 packs/day) |
| ANDROGEL 1.62% GEL PUMP (<i>testosterone</i>) | T3 | PA QL (150gm/30 days) |
| ANDROGEL 1.62%(1.25G) GEL PCKT (<i>testosterone</i>) | T3 | PA QL (2 packs/day) |
| ANDROGEL 1.62%(2.5G) GEL PCKT (<i>testosterone</i>) | T3 | PA QL (150gm/30 days) |
| ANDROID (<i>methyltestosterone</i>) | T3 | |
| DEPO-TESTOSTERONE | T3 | |
| DEPO-TESTOSTERONE (<i>testosterone cypionate</i>) | T3 | |
| METHITEST | T1 | |
| <i>methyltestosterone</i> (Testred) | T1 | |
| <i>oxandrolone</i> | T1 | 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 | |
| XYOSTED | T3 | PA QL(2 ML/28 DAYS) |
| ANTI-DIURETIC AND VASOPRESSOR HORMONES | | |
| <i>desmopressin</i> (nonrefrigerated) | T1 | |
| <i>desmopressin acetate</i> | T1 | |
| NOCTIVA | T3 | PA |
| STIMATE | T2 | SP |
| ESTROGEN AND PROGESTIN COMBINATIONS | | |
| BIJUVA | T3 | |
| ESTROGEN/ANDROGEN COMBINATIONS | | |
| <i>estrogen, ester/me-testosterone</i> | T1 | HD |
| ESTROGENIC AGENTS | | |
| ACTIVELLA (<i>mimvey lo</i>) | T3 | HD |

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List of Prescription Medications

HORMONES (Hormonal Agents) (cont.)

| Prescription Drug Name | Drug Tier | Coverage Requirements and Limits |
|--|-----------|----------------------------------|
| ESTROGENIC AGENTS (cont.) | | |
| 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 | T2 | HD |
| ELESTRIN | T3 | HD |
| ESTRACE (<i>estradiol</i>) | T3 | HD |
| <i>estradiol (Climara)</i> | T1 | HD |
| <i>estradiol 0.5 mg tablet (Estrace)</i> | T1 | HD |
| <i>estradiol 1 mg tablet (Estrace)</i> | T1 | HD |
| <i>estradiol 2 mg tablet (Estrace)</i> | T1 | HD |
| <i>estradiol valerate</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 |
| <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 |

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List of Prescription Medications

| HORMONES (Hormonal Agents) (cont.) | | |
|--|------------------|---|
| Prescription Drug Name | Drug Tier | Coverage Requirements and Limits |
| ESTROGEN-PROGESTIN WITH ANTI-MINERALOCORTICOID COMB | | |
| ANGELIQ | T3 | HD |
| ESTROGEN-SELECTIVE ESTROGEN RECEPTOR MOD (SERM) COMB | | |
| DUAVEE | T2 | |
| GLUCOCORTICOIDS | | |
| <i>budesonide</i> | T1 | PA QL (56 tabs/180 days) |
| <i>budesonide</i> (Entocort Ec) | T1 | |
| CORTEF (<i>hydrocortisone</i>) | T3 | |
| <i>cortisone acetate</i> | T1 | |
| <i>dexamethasone</i> | T1 | |
| EMFLAZA | T3 | PA SP HD |
| ENTOCORT EC (<i>budesonide ec</i>) | T3 | |
| <i>hydrocortisone</i> (Cortef) | T1 | |
| LOCORT | T1 | |
| MEDROL 16 MG TABLET (<i>methylprednisolone</i>) | T3 | |
| MEDROL 2 MG TABLET | T2 | |
| MEDROL 32 MG TABLET (<i>methylprednisolone</i>) | T3 | |
| MEDROL 4 MG DOSEPAK (<i>methylprednisolone</i>) | T3 | |
| MEDROL 4 MG TABLET (<i>methylprednisolone</i>) | T3 | |
| MEDROL 8 MG TABLET (<i>methylprednisolone</i>) | T3 | |
| <i>methylprednisolone</i> (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 | |
| <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 | |
| GROWTH HORMONE RELEASING HORMONE (GHRH) AND ANALOGS | | |
| EGRIFTA | T3 | PA SP HD |
| EGRIFTA SV | T3 | PA SP HD |
| GROWTH HORMONES | | |
| GENOTROPIN | T3 | PA SP HD |
| NGENLA | T2 | PA SP |
| NORDITROPIN FLEXPRO | T3 | PA SP HD |

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List of Prescription Medications

| HORMONES (Hormonal Agents) (cont.) | | |
|---|------------------|---|
| Prescription Drug Name | Drug Tier | Coverage Requirements and Limits |
| GROWTH HORMONES (cont.) | | |
| OMNITROPE | T2 | PA SP HD |
| SEROSTIM | T3 | PA SP |
| SKYTROFA | T3 | PA SP |
| SOGROYA | T3 | PA SP |
| INSULIN-LIKE GROWTH FACTOR-I (IGF-I) HORMONES | | |
| INCRELEX | T3 | PA SP HD |
| LHRH (GNRH) AGONIST ANALOG AND PROGESTIN COMB | | |
| LUPANETA PACK | T3 | PA SP HD |
| LHRH (GNRH) AGONIST ANALOG PITUITARY SUPPRESSANTS | | |
| LUPRON DEPOT | T2 | PA SP HD |
| LHRH (GNRH) ANTAGONIST, ESTROGEN AND PROGESTIN COMB | | |
| MYFEMBREE | T2 | PA QL (24 MONTH THERAPY) |
| ORIAHNN | T2 | PA QL (2 CAPSULES/DAY) |
| LHRH (GNRH) ANTAGONIST, PITUITARY SUPPRESSANT AGENTS | | |
| CETROTIDE | T2 | PA SP |
| <i>ganirelix acet 250 mcg/0.5 ml (Ganirelix Acetate)</i> | T1 | PA SP |
| GANIRELIX ACET 250 MCG/0.5 ML (<i>ganirelix acetate</i>) | T2 | PA SP |
| ORLISSA 150 MG TABLET | T2 | PA QL (1 tab/day) |
| ORLISSA 200 MG TABLET | T2 | PA QL (6 months therapy/lifetime) |
| LHRH (GNRH) AGNST PIT.SUP-CENTRAL PRECOCIOUS PUBERTY | | |
| FENSOLVI | T3 | PA SP |
| LUPRON DEPOT-PED | T2 | PA SP HD |
| MINERALOCORTICIDS | | |
| <i>fludrocortisone acetate</i> | T1 | HD |
| OXYTOCICS | | |
| CERVIDIL | T3 | |
| <i>methylergonovine maleate</i> | T1 | |
| PREPIDIL | T3 | |
| PROSTIN E2 VAGINAL SUPPOSITORY | T3 | |
| PITUITARY SUPPRESSIVE AGENTS | | |
| <i>cabergoline</i> | T1 | QL (16 tabs/28 days) HD |
| <i>danazol</i> | T1 | HD |
| PROGESTATIONAL AGENTS | | |
| AYGESTIN (<i>norethindrone acetate</i>) | T3 | HD |

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List of Prescription Medications

| HORMONES (Hormonal Agents) (cont.) | | |
|---|------------------|---|
| Prescription Drug Name | Drug Tier | Coverage Requirements and Limits |
| PROGESTATIONAL AGENTS (cont.) | | |
| CRINONE 4% GEL | T3 | PA HD |
| DEPO-PROVERA 400 MG/ML VIAL | T3 | HD |
| <i>medroxyprogesterone 10 mg tab (Provera)</i> | T1 | HD |
| <i>medroxyprogesterone 2.5 mg tab (Provera)</i> | T1 | HD |
| <i>medroxyprogesterone 5 mg tab (Provera)</i> | T1 | HD |
| <i>norethindrone acetate (Aygestin)</i> | T1 | HD |
| <i>progesterone, micronized (Prometrium)</i> | T1 | HD |
| PROVERA (<i>medroxyprogesterone acetate</i>) | T3 | HD |
| SOMATOSTATIC AGENTS | | |
| BYNFEZIA | T3 | PA SP |
| <i>octreotide acetate</i> | T1 | PA SP HD |
| <i>octreotide acetate (Sandostatin)</i> | T1 | PA SP HD |
| SANDOSTATIN (<i>octreotide acetate</i>) | T3 | PA SP HD |
| SANDOSTATIN LAR DEPOT | T2 | PA SP |
| SIGNIFOR | T3 | PA SP |
| SIGNIFOR LAR | T3 | PA SP |
| SOMATULINE DEPOT | T2 | PA SP HD |
| VAGINAL ESTROGEN FOR SEXUAL DYSFUNCTION | | |
| IMVEXXY 10 MCG MAINTENANCE PAK | T3 | QL (16/28 days) HD |
| IMVEXXY 10 MCG STARTER PACK | T3 | QL (36/28 days) HD |
| IMVEXXY 4 MCG MAINTENANCE PAK | T3 | QL (16/28 days) HD |
| IMVEXXY 4 MCG STARTER PACK | T3 | QL (36/28 days) HD |
| VAGINAL ESTROGEN PREPARATIONS | | |
| ESTRACE (<i>estradiol</i>) | T3 | HD |
| <i>estradiol (Vagifem)</i> | T1 | QL (36 tabs/28 days) HD |
| <i>estradiol 0.01% cream (Estrace)</i> | T1 | HD |
| <i>estradiol 10 mcg vaginal insrt (Vagifem)</i> | T1 | QL (36 tabs/28 days) HD |
| ESTRING | T2 | QL (2 rings/90 days) HD |
| FEMRING | T3 | HD |
| PREMARIN | T2 | HD |
| VAGIFEM (<i>yuvafem</i>) | T3 | QL (36 tabs/28 days) HD |

T1 – Typically Generics

PA – Prior Authorization

AGE – Age Requirement

PPACA – No Cost-Share Preventive Medication

T2 – Typically Preferred Brands

QL – Quantity Limit

SP – Specialty Medication

CSL – Oral cancer medication subject to cost-share limits

T3 – Typically Non-Preferred Brands

ST – Step Therapy

HD – May require home delivery pharmacy

List of Prescription Medications

| HORMONES (Infertility) | | |
|--|------------------|---|
| Prescription Drug Name | Drug Tier | Coverage Requirements and Limits |
| FERTILITY STIMULATING PREPARATIONS, NON-FSH | | |
| <i>clomiphene citrate</i> | T1 | |
| FOLLICLE-STIMULATING AND LUTEINIZING HORMONES | | |
| MENOPUR | T2 | PA SP |
| FOLLICLE-STIMULATING HORMONE (FSH) | | |
| FOLLISTIM AQ | T3 | PA SP |
| GONAL-F | T2 | PA SP |
| GONAL-F RFF | T2 | PA SP |
| GONAL-F RFF REDI-JECT | T2 | PA SP |
| HUMAN CHORIONIC GONADOTROPIN (HCG) | | |
| CHORIONIC GONAD 10,000 UNIT VL | T3 | PA SP |
| CHORIONIC GONAD 12,000 UNIT VL | T1 | SP |
| CHORIONIC GONAD 6,000 UNIT VL | T1 | SP |
| NOVAREL | T2 | PA SP |
| OVIDREL | T2 | PA SP |
| PREGNYL | T2 | PA SP |
| PREGNANCY FACILITATING/MAINTAINING AGENT, HORMONAL | | |
| CRINONE 8% GEL | T3 | PA |
| ENDOMETRIN | T2 | |
| HORMONES (Miscellaneous) | | |
| LEPTIN HORMONE ANALOGS | | |
| MYALEPT | T3 | PA SP HD |
| HORMONES (Osteoporosis Products) | | |
| BONE FORMATION STIM. AGENTS - PARATHYROID HORMONE | | |
| teriparatide 600 mcg/2.4ml pen | T1 | PA QL(0.09 mls/day) SP HD |
| TERIPARATIDE 620 MCG/2.48 ML | T3 | PA QL(0.09 mls/day) SP HD |
| BONE RESORPTION INHIBITORS | | |
| <i>ibandronate sodium</i> | T1 | HD |
| <i>calcitonin, salmon, synthetic</i> | T1 | HD |
| MIACALCIN | T2 | HD |
| IMMUNOSUPPRESSANTS (Pain Relief And Inflammatory Disease) | | |
| INTERLEUKIN-4(IL-4) RECEPTOR ALPHA ANTAGONIST, MAB | | |
| DUPIXENT PEN | T3 | PA SP HD |
| DUPIXENT SYRINGE | T3 | PA SP HD |

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List of Prescription Medications

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

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

IL-23 RECEPTOR ANTAGONIST, MONOCLONAL ANTIBODY

| | | |
|-----------|----|-----------------------------|
| OMVOH PEN | T2 | PA QL(2 pens/28 days) SP HD |
|-----------|----|-----------------------------|

INTERLEUKIN-6 (IL-6) RECEPTOR INHIBITORS (cont.)

| | | |
|--------------------------------|----|----------------------------------|
| ACTEMRA | T3 | PA QL (4 syringes/28 days) SP HD |
| ACTEMRA ACTPEN | T3 | PA QL (4 pens/28 days) SP HD |
| ENSPRYNG | T3 | PA SP HD |
| KEVZARA 150 MG/1.14 ML PEN INJ | T3 | PA QL (2 pens/28 days) SP HD |
| KEVZARA 150 MG/1.14 ML SYRINGE | T3 | PA QL (2 syringes/28 days) SP HD |
| KEVZARA 200 MG/1.14 ML PEN INJ | T3 | PA QL (2 pens/28 days) SP HD |
| KEVZARA 200 MG/1.14 ML SYRINGE | T3 | PA QL (2 syringes/28 days) SP HD |

MONOCLONAL ANTIBODY-HUMAN INTERLEUKIN I2/23 INHIB

| | | |
|------------------------------|----|---------------------------------|
| STELARA 45 MG/0.5 ML SYRINGE | T3 | PA QL (1 syringe/84 days) SP HD |
| STELARA 45 MG/0.5 ML VIAL | T3 | PA QL (1 vial/84 days) SP HD |
| STELARA 90 MG/ML SYRINGE | T3 | PA QL (1 syringe/84 days) SP HD |

IMMUNOSUPPRESSANTS (Skin Conditions)

TOPICAL IMMUNOSUPPRESSIVE AGENTS

| | | |
|---|----|--|
| ELIDEL (<i>pimecrolimus</i>) | T3 | |
| <i>pimecrolimus</i> (Elidel) | T1 | |
| PROTOPIC (<i>tacrolimus</i>) | T3 | |
| <i>tacrolimus</i> 0.03% ointment (Protopic) | T1 | |
| <i>tacrolimus</i> 0.1% ointment (Protopic) | T1 | |

IMMUNOSUPPRESSANTS (Transplant Medications)

IMMUNOSUPPRESSIVES

| | | |
|---|----|-------|
| ASTAGRAF XL | T3 | SP HD |
| AZASAN | T2 | SP HD |
| <i>azathioprine</i> (Imuran) | T1 | SP HD |
| CELLCEPT (<i>mycophenolate mofetil</i>) | T3 | SP HD |
| <i>cyclosporine</i> (Sandimmune) | T1 | SP HD |
| <i>cyclosporine, modified</i> | T1 | SP HD |
| <i>cyclosporine, modified</i> (Neoral) | T1 | SP HD |
| ENVARUSUS XR | T3 | SP HD |
| <i>everolimus</i> 0.25 mg tablet (Zortress) | T1 | SP HD |
| <i>everolimus</i> 0.5 mg tablet (Zortress) | T1 | SP HD |
| <i>everolimus</i> 0.75 mg tablet (Zortress) | T1 | SP HD |
| IMURAN (<i>azathioprine</i>) | T3 | SP HD |

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List of Prescription Medications

IMMUNOSUPPRESSANTS (Transplant Medications) (cont.)

| Prescription Drug Name | Drug Tier | Coverage Requirements and Limits |
|---|-----------|----------------------------------|
| IMMUNOSUPPRESSIVES (cont.) | | |
| LUPKYNIS | T3 | PA QL(6 caps/day) SP |
| <i>mycophenolate mofetil</i> (Cellcept) | T1 | SP HD |
| MYFORTIC (<i>mycophenolic acid</i>) | T3 | SP HD |
| NEORAL (<i>gengraf</i>) | T3 | SP HD |
| PROGRAF | T3 | SP HD |
| PROGRAF (<i>tacrolimus</i>) | T3 | SP HD |
| RAPAMUNE (<i>sirolimus</i>) | T3 | SP HD |
| <i>sirolimus</i> (Rapamune) | T1 | SP HD |
| <i>tacrolimus 0.5 mg capsule</i> (ir) (Prograf) | T1 | SP HD |
| <i>tacrolimus 1 mg capsule</i> (ir) (Prograf) | T1 | SP HD |
| <i>tacrolimus 5 mg capsule</i> (ir) (Prograf) | T1 | SP HD |
| ZORTRESS | T3 | SP HD |
| ZORTRESS (<i>everolimus</i>) | T3 | SP HD |

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

DIABETIC SUPPLIES

| | | |
|--------------------------------|----|----------------------------|
| CARESENS | T1 | |
| CARETOUCH CONTROL SOLUTION | T1 | |
| CEQR SIMPLICITY | T2 | |
| CEQR SIMPLICITY INSERTER | T2 | |
| DEXCOM G6 RECEIVER | T2 | PA QL (1 syringe/365 days) |
| DEXCOM G6 SENSOR | T2 | PA QL (3/30 days) |
| DEXCOM G6 TRANSMITTER | T2 | PA QL (1 syringe/67 days) |
| DEXCOM G7 RECEIVER | T2 | PA QL(1 unit/365 days) |
| DEXCOM G7 SENSOR | T2 | PA QL(3 sensors/30 days) |
| EASY TOUCH BLU LINK CTRL SOLN | T1 | |
| EASY TRAK II CONTROL SOLUTION | T1 | |
| ENLITE SERTER | 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) |
| FORA TN'GO ADVANCE MULTIFN MTR | T3 | |

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HD – May require home delivery pharmacy

List of Prescription Medications

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

| Prescription Drug Name | Drug Tier | Coverage Requirements and Limits |
|----------------------------------|-----------|----------------------------------|
| DIABETIC SUPPLIES (cont.) | | |
| GLUCOCOM AUTOLINK | T1 | |
| GUARDIAN RT CHARGER | T1 | |
| GUARDIAN RT STARTER KIT | T1 | |
| GUARDIAN RT SYSTEM | T1 | |
| GUARDIAN TEST PLUG | T1 | |
| HUMAPEN LUXURA HD | T1 | |
| INPEN (FOR HUMALOG) | T1 | |
| INPEN (FOR NOVOLOG OR FIASP) | T1 | |
| LITE TOUCH LANCING PEN | T1 | |
| NOVOPEN ECHO | T1 | |
| OMNIPOD 5 G6-G7 INTRO KT(GEN5) | T2 | QL |
| OMNIPOD 5 G6-G7 PODS (GEN 5) | T2 | QL |
| OMNIPOD CLASSIC (GEN 3 & 4) kit | T2 | PA QL (1 kit/365 days) |
| OMNIPOD CLASSIC (GEN 3 & 4) pods | T2 | PA QL (30 pods/30 days) |
| OMNIPOD DASH 5 PACK POD | T2 | PA QL (6 boxes/30 days) |
| ONETOUCH DELICA PLUS LANC DEV | T1 | |
| ONETOUCH ULTRA CONTROL SOLN | T1 | |
| ONETOUCH VERIO HIGH CNTRL SOLN | T1 | |
| ONETOUCH VERIO MID CNTRL SOLN | T1 | |
| REPLACEMENT PEDIATRIC MONITOR | T1 | |
| SEN-SERTER | T1 | |
| V-GO 20, 30, 40 | T2 | |
| SYRINGES AND ACCESSORIES | | |
| ASSURE ID INSULIN SAFETY | T1 | |
| EASY COMFORT INSULIN SYRINGE | T1 | |
| INSULIN SYRINGE | T1 | |
| INSULIN SYRINGE U-500 | T1 | |
| MAGELLAN INSULIN SAFETY SYRNG | T1 | |
| MAGELLAN INSULIN SYRINGE | T1 | |
| MINIMED RESERVOIR | T1 | |
| MONOJECT | T1 | |
| MONOJECT INSULIN SYRINGE | T1 | |
| PARADIGM | T1 | |
| SECURESAFE INSULIN SYRINGE | T1 | |
| UNIFINE SAFECONTROL | T3 | |
| VERIFINE PEN NEEDLE | T1 | |

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List of Prescription Medications

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

DURABLE MEDICAL EQUIPMENT, MISC (GROUP I)

| | | |
|--------------------------------|----|--|
| 2-IN-1 LANCET DEVICE | T1 | |
| ACCU-CHEK FASTCLIX LANCET DRUM | T1 | |
| ACCU-CHEK SAFE-T-PRO | T1 | |

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

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

DURABLE MEDICAL EQUIPMENT, MISC (GROUP I)

| | | |
|--------------------------------|----|--|
| ACCU-CHEK SAFE-T-PRO PLUS | T1 | |
| ACCU-CHEK SOFTCLIX | T1 | |
| ACTI-LANCE | T1 | |
| ADVANCED TRAVEL LANCETS | T1 | |
| ADVOCATE LANCET | T1 | |
| ADVOCATE LANCETS | T1 | |
| ALTERNATE SITE LANCETS | T1 | |
| ASSURE HAEMOLANCE PLUS | T1 | |
| ASSURE LANCE | T1 | |
| ASSURE LANCE PLUS | T1 | |
| BD MICROTAINER LANCETS | T1 | |
| BD ULTRA-FINE | T1 | |
| BD ULTRA-FINE II | T1 | |
| BLOOD LANCETS | T1 | |
| BULLSEYE MINI SAFETY LANCETS | T1 | |
| BUTTERFLY TOUCH LANCET | T1 | |
| CAREONE | T1 | |
| CARESENS LANCET | T1 | |
| CARETOUCH TWIST LANCET | T1 | |
| CLEVER CHEK LANCETS | T1 | |
| COAGUCHEK | T1 | |
| COLOR LANCETS | T1 | |
| COMFORT EZ | T1 | |
| COMFORT LANCETS | T1 | |
| COMFORT TOUCH PLUS SAFETY LANC | T1 | |
| COMFORT TOUCH ULT THIN LANCET | T1 | |
| DROPLET LANCETS | T1 | |
| EASY COMFORT LANCETS | T1 | |
| EASY TOUCH | T1 | |
| EASY TWIST & CAP LANCETS | T1 | |

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List of Prescription Medications

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

| Prescription Drug Name | Drug Tier | Coverage Requirements and Limits |
|--|-----------|----------------------------------|
| DURABLE MEDICAL EQUIPMENT, MISC (GROUP I) | | |
| EMBRACE 30G LANCETS | T1 | |
| EMBRACE SAFETY LANCET | T1 | |
| EZ SMART LANCETS | T1 | |
| EZ-LETS | T1 | |
| FIFTY50 SAFETY SEAL LANCETS | T1 | |
| FINE 30 UNIVERSAL LANCETS | T1 | |
| FINGERSTIX | T1 | |
| FORA LANCETS | T1 | |
| FORACARE LANCETS | T1 | |
| FREESTYLE LANCETS | T1 | |
| FREESTYLE UNISTIK 2 | T1 | |
| GLUCOCOM | T1 | |
| GLUCOCOM LANCETS | T1 | |
| GOJJI LANCETS | T1 | |
| HEALTHY ACCENTS UNILET LANCET | T1 | |
| INCONTROL SUPER THIN LANCETS | T1 | |
| INCONTROL ULTRA THIN LANCETS | T1 | |
| INJECT EASE LANCETS | T1 | |
| INVACARE LANCETS | T1 | |
| lancets | T1 | |
| LANCETS | T1 | |
| LANCETS THIN | T1 | |
| LANCETS ULTRA THIN | T1 | |
| LITE TOUCH | T1 | |
| MEDISENSE THIN LANCETS | T1 | |
| MEDLANCE PLUS | T1 | |
| MICRO THIN LANCET | T1 | |
| MICRO THIN LANCETS | T1 | |
| MICROLET | T1 | |
| MOBILE LANCETS | T1 | |
| MONOLET LANCETS | T1 | |
| MONOLET THIN LANCETS | T1 | |
| MYGLUCOHEALTH LANCETS | T1 | |
| NOVA SAFETY LANCETS | T1 | |
| NOVA SUREFLEX | T1 | |
| ON CALL LANCET | T1 | |

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List of Prescription Medications

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

| Prescription Drug Name | Drug Tier | Coverage Requirements and Limits |
|--|-----------|----------------------------------|
| DURABLE MEDICAL EQUIPMENT, MISC (GROUP I) | | |
| ON CALL PLUS LANCET | T1 | |
| ONETOUCH DELICA PLUS LANCET | T1 | |
| ONETOUCH DELICA SAFETY LANCET | T1 | |
| ONETOUCH LANCETS | T1 | |
| ONETOUCH SURESOFT | T1 | |
| ONETOUCH ULTRASOFT 2 LANCET | T1 | |
| ON-THE-GO | T1 | |
| PIP LANCET | T1 | |
| PRESSURE ACTIVATED LANCETS | T1 | |
| PRO COMFORT LANCET | T1 | |
| PRO COMFORT LANCETS | T1 | |
| PRO COMFORT SAFETY LANCET | T1 | |
| PRODIGY LANCETS | T1 | |
| PRODIGY TWIST TOP LANCET | T1 | |
| PURE COMFORT LANCETS | T1 | |
| PURE COMFORT SAFETY LANCETS | T1 | |
| PUSH BUTTON SAFETY LANCETS | T1 | |
| READYLANCE SAFETY LANCETS | T1 | |
| RELIAMED | T1 | |
| RELIAMED SAFETY SEAL LANCETS | T1 | |
| RELION THIN | T1 | |
| RIGHTEST GL300 LANCETS | T1 | |
| SAFETY LANCETS | T1 | |
| SAFETY SEAL LANCETS | T1 | |
| SAFETY-LET | T1 | |
| SINGLE-LET | T1 | |
| SMART SENSE | T1 | |
| SMART SENSE LANCETS | T1 | |
| SMARTTEST LANCET | T1 | |
| SOFT TOUCH | T1 | |
| SOLUS V2 | T1 | |
| SOLUS V2 LANCETS | T1 | |
| STERILANCE TL | T1 | |
| STERILE LANCETS | T1 | |
| SUPER THIN LANCETS | T1 | |
| SURE COMFORT LANCETS | T1 | |

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List of Prescription Medications

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

| Prescription Drug Name | Drug Tier | Coverage Requirements and Limits |
|--|-----------|----------------------------------|
| DURABLE MEDICAL EQUIPMENT, MISC (GROUP I) | | |
| SURE-LANCE | T1 | |
| SURE-TOUCH | T1 | |
| TECHLITE LANCETS | T1 | |
| TELCARE ULTRA THIN 30G LANCETS | T1 | |
| THIN LANCETS | T1 | |
| TOPCARE UNIVERSAL1 LANCET | T1 | |
| TOPCARE UNIVERSAL1 THIN LANCET | T1 | |
| TRUE COMFORT LANCET | T1 | |
| TRUE COMFORT SAFETY LANCET | T1 | |
| TRUEPLUS LANCET | T1 | |
| TRUEPLUS LANCETS | T1 | |
| TWIST LANCETS | T1 | |
| ULTILET BASIC | T1 | |
| ULTILET CLASSIC | T1 | |
| ULTILET LANCETS | T1 | |
| ULTILET SAFETY | T1 | |
| ULTRA THIN LANCET | T1 | |
| ULTRA THIN PLUS | T1 | |
| ULTRA THIN PLUS LANCETS | T1 | |
| ULTRA-CARE LANCETS | T1 | |
| ULTRALANCE | T1 | |
| ULTRA-THIN II LANCETS | T1 | |
| ULTRATLC LANCETS | T1 | |
| UNILET COMFORTOUCH | T1 | |
| UNILET EXCELITE | T1 | |
| UNILET EXCELITE II | T1 | |
| UNILET GP LANCET | T1 | |
| UNILET LANCETS | T1 | |
| UNISTIK 2 COMFORT | T1 | |
| UNISTIK 2 EXTRA | T1 | |
| UNISTIK 2 NORMAL | T1 | |
| UNISTIK 3 | T1 | |
| UNISTIK 3 COMFORT | T1 | |
| UNISTIK 3 DUAL | T1 | |
| UNISTIK 3 EXTRA | T1 | |

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List of Prescription Medications

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

| Prescription Drug Name | Drug Tier | Coverage Requirements and Limits |
|--|-----------|----------------------------------|
| DURABLE MEDICAL EQUIPMENT, MISC (GROUP I) | | |
| UNISTIK 3 NORMAL | T1 | |
| UNISTIK COMFORT | T1 | |
| UNISTIK CZT | T1 | |
| UNISTIK EXTRA | T1 | |
| UNISTIK NORMAL | T1 | |
| UNISTIK PRO | T1 | |
| UNISTIK SAFETY | T1 | |
| UNISTIK TOUCH | T1 | |
| UNIVERSAL 1 | T1 | |
| VERIFINE SAFETY LANCET MINI | T1 | |
| VERIFINE UNIVERSAL LANCET | T1 | |
| VIVAGUARD LANCET | T1 | |
| NEEDLES/NEEDLELESS DEVICES | | |
| BD NEEDLES | T1 | |
| CAREPOINT PRECISION NEEDLE | T1 | |
| RESPIRATORY AIDS, DEVICES, EQUIPMENT | | |
| ACE AEROSOL CLOUD ENHANCER | T2 | QL (1 unit/year) |
| AEROCHAMBER MINI | T2 | QL (1 unit/year) |
| AEROCHAMBER MV | T2 | QL (1 unit/year) |
| AEROCHAMBER PLUS FLOW-VU | T2 | QL (1 unit/year) |
| AEROCHAMBER WITH FLOWSIGNAL | T2 | QL (1 unit/year) |
| AEROCHAMBER Z-STAT PLUS | T2 | QL (1 unit/year) |
| AEROTRACH PLUS | T2 | QL (1 unit/year) |
| AEROVENT PLUS | T2 | QL (1 unit/year) |
| BREATHERITE | T2 | QL (1 unit/year) |
| BREATHERITE SPACER-ADULT MASK | T2 | QL (1 unit/year) |
| BREATHERITE SPACER-INFANT MASK | T2 | QL (1 unit/year) |
| BREATHERITE SPACER-LARGE MASK | T2 | QL (1 mask/365 days) |
| BREATHERITE SPACER-LG CHLD MSK | T2 | QL (1 unit/year) |
| BREATHERITE SPACER-MEDIUM MASK | T2 | QL (1 mask/365 days) |
| BREATHERITE SPACER-NEONATE MSK | T2 | QL (1 unit/year) |
| BREATHERITE SPACER-SM CHLD MSK | T2 | QL (1 unit/year) |

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List of Prescription Medications

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

| Prescription Drug Name | Drug Tier | Coverage Requirements and Limits |
|---|-----------|----------------------------------|
| RESPIRATORY AIDS, DEVICES, EQUIPMENT | | |
| BREATHRITE SPACER-SMALL MASK | T2 | QL (1 mask/365 days) |
| BREATHRITE | T2 | QL (1 unit/year) |
| CLEVER CHOICE HOLDING CHAMBER | T2 | QL (1 unit/year) |
| COMFORTSEAL | T2 | QL (1 unit/year) |
| COMPACT SPACE CHAMBER | T2 | QL (1 unit/year) |
| EASIVENT | T2 | QL (1 unit/year) |
| E-Z SPACER | T2 | QL (1 unit/year) |
| FLEXICHAMBER MASK | T2 | QL (1 unit/year) |
| INSPIRACHAMBER | T2 | QL (1 unit/year) |
| LITEAIRE | T2 | QL (1 unit/year) |
| LITETOUCH | T2 | QL (1 unit/year) |
| MICROCHAMBER | T2 | QL (1 unit/year) |
| MICROSPACER | T2 | QL (1 unit/year) |
| OPTICHAMBER | T2 | QL (1 unit/year) |
| OPTICHAMBER DIAMOND | T2 | QL (1 unit/year) |
| POCKET CHAMBER | T2 | QL (1 unit/year) |
| PRIMEAIRE | T2 | QL (1 unit/year) |
| PRO COMFORT SPACER WITH MASK | T2 | QL (1 unit/year) |
| PROCARE SPACER WITH ADULT MASK | T2 | QL (1 unit/year) |
| PROCARE SPACER WITH CHILD MASK | T2 | QL (1 unit/year) |
| PROCHAMBER | T2 | QL (1 unit/year) |
| RITEFLO | T2 | QL (1 unit/year) |
| SILICONE MASK | T2 | QL (1 unit/year) |
| SPACE CHAMBER | T2 | QL (1 unit/year) |
| SPACE CHAMBER-LARGE MASK | T2 | QL (1 unit/year) |
| SPACE CHAMBER-MEDIUM MASK | T2 | QL (1 unit/year) |
| SPACE CHAMBER-SMALL MASK | T2 | QL (1 unit/year) |
| VORTEX | T2 | QL (1 unit/year) |
| VORTEX HOLDING CHAMBER-CHILD | T2 | QL (1 unit/year) |
| VORTEX HOLDING CHAMBER-TODDLER | T2 | QL (1 unit/year) |
| VORTEX VHC FROG MASK | T2 | QL (1 unit/year) |
| VORTEX VHC LADYBUG MASK | T2 | QL (1 unit/year) |
| SYRINGES AND ACCESSORIES | | |
| LITE TOUCH INSULIN 0.5 ML SYR | T1 | |
| LITE TOUCH INSULIN 1 ML SYR | T1 | |

T1 – Typically Generics

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PPACA – No Cost-Share Preventive Medication

T2 – Typically Preferred Brands

QL – Quantity Limit

SP – Specialty Medication

CSL – Oral cancer medication subject to cost-share limits

T3 – Typically Non-Preferred Brands

ST – Step Therapy

HD – May require home delivery pharmacy

List of Prescription Medications

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

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

SYRINGES AND ACCESSORIES (cont.)

| | | |
|--------------------------------|----|--|
| LITE TOUCH INSULIN SYR 0.3 ML | T1 | |
| LITE TOUCH INSULIN SYR 0.5 ML | T1 | |
| LITE TOUCH INSULIN SYR 1 ML | T1 | |
| SURE COMFORT 0.3 ML SYRINGE | T1 | |
| SURE COMFORT 0.5 ML SYRINGE | T1 | |
| SURE COMFORT 1 ML SYRINGE | T1 | |
| SURE COMFORT 3/10 ML SYRINGE | T1 | |
| ULTRA-THIN II 1 ML 31GX5/16" | T1 | |
| ULTRA-THIN II INS 0.3 ML 30G | T1 | |
| ULTRA-THIN II INS 0.3 ML 31G | T1 | |
| ULTRA-THIN II INS 0.5 ML 29G | T1 | |
| ULTRA-THIN II INS 0.5 ML 30G | T1 | |
| ULTRA-THIN II INS 0.5 ML 31G | T1 | |
| ULTRA-THIN II INS SYR 1 ML 29G | T1 | |
| ULTRA-THIN II INS SYR 1 ML 30G | T1 | |

MUSCLE RELAXANTS (Pain Relief And Inflammatory Disease)

SKELETAL MUSCLE RELAXANTS

| | | |
|---------------------------------------|----|----|
| <i>baclofen</i> | T1 | HD |
| <i>carisoprodol/aspirin</i> | T1 | |
| <i>chlorzoxazone</i> | T1 | |
| <i>cyclobenzaprine hcl</i> | T1 | |
| <i>cyclobenzaprine hcl (Fexmid)</i> | T1 | |
| 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 |
| <i>metaxalone</i> | T1 | |
| <i>metaxalone (Skelaxin)</i> | T1 | |
| <i>methocarbamol</i> | T1 | |
| <i>methocarbamol (Robaxin-750)</i> | T1 | |
| <i>orphenadrine citrate</i> | T1 | |
| ROBAXIN-750 (<i>methocarbamol</i>) | T3 | |
| SKELAXIN (<i>metaxalone</i>) | T3 | |

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List of Prescription Medications

PRE-NATAL VITAMINS (Nutritional/Dietary)

| Prescription Drug Name | Drug Tier | Coverage Requirements and Limits |
|--|-----------|----------------------------------|
| PRENATAL VITAMIN PREPARATIONS | | |
| SOMA (<i>carisoprodol</i>) | T3 | |
| SOMA (<i>vanadom</i>) | T3 | |
| <i>tizanidine hcl</i> | T1 | |
| <i>tizanidine hcl</i> (Zanaflex) | T1 | |
| ZANAFLEX (<i>tizanidine hcl</i>) | T3 | |
| ATABEX EC | T2 | |
| CITRANATAL 90 DHA | T2 | |
| CITRANATAL ASSURE | T2 | |
| CITRANATAL DHA | T2 | |
| CITRANATAL HARMONY | T2 | |
| CITRANATAL RX | T2 | |
| OBSTETRIX EC | T2 | |
| OBTRET DHA | T2 | |
| <i>pnv 22/iron, gluc/folic/dss/dha</i> | T1 | |
| <i>pnv 66/iron/folic/docusate/dha</i> | T1 | |
| <i>pnv 69/iron/folic/docusate/dha</i> | T1 | |
| <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</i> (Obtrex Dha) | T1 | |
| PRENATAL 19 | T1 | |
| <i>prenatal 34/iron/folic/dss/dha</i> | T1 | |
| <i>prenatal vits 15/iron/folic/dss</i> | T1 | |
| VITAFOL FE+ | T2 | |

PSYCHOTHERAPEUTIC DRUGS (Anxiety/Depression/Bipolar Disorder)⁸

| | | |
|---|----|----|
| ALPHA-2 RECEPTOR ANTAGONIST ANTI-DEPRESSANTS | | |
| <i>mirtazapine</i> | T1 | HD |
| <i>mirtazapine</i> (Remeron) | T1 | HD |
| ANTI-ANXIETY - BENZODIAZEPINES | | |
| <i>alprazolam</i> | T1 | |
| <i>alprazolam</i> (Xanax Xr) | T1 | |
| <i>alprazolam</i> (Xanax) | T1 | |
| <i>chlordiazepoxide hcl</i> | T1 | |
| <i>clorazepate dipotassium</i> | T1 | |

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T3 – Typically Non-Preferred Brands

ST – Step Therapy

HD – May require home delivery pharmacy

List of Prescription Medications

PSYCHOTHERAPEUTIC DRUGS (Anxiety/Depression/Bipolar Disorder)⁸

| Prescription Drug Name | Drug Tier | Coverage Requirements and Limits |
|--|-----------|----------------------------------|
| ANTI-ANXIETY - BENZODIAZEPINES (cont.) | | |
| <i>clorazepate dipotassium (Tranxene T-tab)</i> | T1 | |
| <i>diazepam 20 mg rectal gel syst diazepam 20 mg rectal gel syst 10 mg tablet (Valium)</i> | T1 | |
| <i>diazepam 2 mg tablet (Valium)</i> | T1 | |
| <i>diazepam 5 mg tablet (Valium)</i> | T1 | |
| <i>diazepam 5 mg/5 ml solution</i> | T1 | |
| <i>diazepam 5 mg/ml oral conc</i> | T1 | |
| <i>lorazepam</i> | T1 | |
| <i>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 | |
| ANTI-ANXIETY DRUGS | | |
| <i>buspirone hcl</i> | T1 | |
| <i>meprobamate</i> | T1 | |
| ANTIDEPRESSANT - NMDA RECEPTOR ANTAGONIST | | |
| SPRAVATO | T3 | PA SP |
| ANTIDEPRESSANT - POSTPARTUM DEPRESSION (PPD) | | |
| ZURZUVAE 20 MG CAPSULE | T3 | PA QL(28 caps/270 days) SP HD |
| ZURZUVAE 25 MG CAPSULE | T3 | PA QL(28 caps/270 days) SP HD |
| ZURZUVAE 30 MG CAPSULE | T3 | PA QL(14 caps/270 days) SP HD |
| BIPOLAR DISORDER DRUGS | | |
| EQUETRO | T3 | HD |
| <i>lithium carbonate</i> | T1 | HD |
| <i>lithium carbonate (Lithobid)</i> | T1 | HD |
| <i>lithium citrate</i> | T1 | HD |
| MAOIS -NON-SELECTIVE, IRREVERSIBLE ANTI-DEPRESSANTS | | |
| MARPLAN | T3 | QL (12 tabs/day) |
| <i>phenelzine sulfate (Nardil)</i> | T1 | |
| <i>tranylcypromine sulfate</i> | T1 | |
| MONOAMINE OXIDASE (MAO) INHIBITOR ANTI-DEPRESSANTS | | |
| EMSAM 12 MG/24 HOURS PATCH | T3 | QL (1 patch/day) |
| EMSAM 6 MG/24 HOURS PATCH | T3 | QL (2 patches/day) |
| EMSAM 9 MG/24 HOURS PATCH | T3 | QL (1 patch/day) |
| NOREPINEPHRINE AND DOPAMINE REUPTAKE INHIB (NDRIs) | | |
| <i>bupropion hcl 100 mg tablet</i> | T1 | QL (4 tabs/day) HD |

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CSL – Oral cancer medication subject to cost-share limits

T3 – Typically Non-Preferred Brands

ST – Step Therapy

HD – May require home delivery pharmacy

List of Prescription Medications

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

| Prescription Drug Name | Drug Tier | Coverage Requirements and Limits |
|---|-----------|----------------------------------|
| NOREPINEPHRINE AND DOPAMINE REUPTAKE INHIB (NDRIs) (cont.) | | |
| <i>bupropion hcl 75 mg tablet</i> | T1 | QL (6 tabs/day) HD |
| <i>bupropion hcl sr 100 mg tablet</i> (Wellbutrin Sr) | T1 | QL (4 tabs/day) HD |
| <i>bupropion hcl sr 150 mg tablet</i> (Wellbutrin Sr) | T1 | QL (2 tabs/day) HD |
| <i>bupropion hcl sr 200 mg tablet</i> (Wellbutrin Sr) | T1 | QL (2 tabs/day) HD |
| <i>bupropion hcl xl 150 mg tablet</i> | T1 | QL (3 tabs/day) HD |
| <i>bupropion hcl xl 300 mg tablet</i> | T1 | QL (1 tab/day) HD |
| BUPROPION HCL XL 450 MG TABLET | T1 | QL (1 tab/day) HD |
| SELECTIVE SEROTONIN 5-HT2A INVERSE AGONISTS (SSiAs) | | |
| NUPLAZID | T3 | PA SP HD |
| SELECTIVE SEROTONIN REUPTAKE INHIBITOR (SSRIs) | | |
| <i>citalopram hbr 10 mg tablet</i> (Celexa) | T1 | QL (6 tabs/day) HD |
| <i>citalopram hbr 10 mg/5 ml soln</i> | T1 | QL (30ml/day) HD |
| <i>citalopram hbr 20 mg tablet</i> (Celexa) | T1 | QL (3 tabs/day) HD |
| <i>citalopram hbr 20 mg/10 ml sol</i> | T1 | QL (30ml/day) HD |
| <i>citalopram hbr 40 mg tablet</i> (Celexa) | T1 | QL (1 tab/day) HD |
| <i>escitalopram 10 mg tablet</i> | T1 | QL (2 tabs/day) HD |
| <i>escitalopram 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 (6 tabs/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 |

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SP – Specialty Medication

CSL – Oral cancer medication subject to cost-share limits

T3 – Typically Non-Preferred Brands

ST – Step Therapy

HD – May require home delivery pharmacy

List of Prescription Medications

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

| Prescription Drug Name | Drug Tier | Coverage Requirements and Limits |
|--|-----------|----------------------------------|
| SELECTIVE SEROTONIN REUPTAKE INHIBITOR (SSRIs) (cont.) | | |
| <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 |
| <i>paroxetine hcl 10 mg tablet</i> (Paxil) | T1 | QL (6 tabs/day) HD |
| <i>paroxetine hcl 20 mg tablet</i> (Paxil) | T1 | QL (3 tabs/day) HD |
| <i>paroxetine hcl 30 mg tablet</i> (Paxil) | T1 | QL (2 tabs/day) HD |
| <i>paroxetine hcl 40 mg tablet</i> (Paxil) | T1 | QL (1 tab/day) HD |
| SARAFEM (<i>fluoxetine hcl</i>) | T3 | ST HD |
| <i>sertraline 20 mg/ml oral conc</i> (Zoloft) | T1 | QL (10ml/day) HD |
| <i>sertraline hcl 100 mg tablet</i> (Zoloft) | T1 | QL (2 tabs/day) HD |
| <i>sertraline hcl 25 mg tablet</i> (Zoloft) | T1 | QL (8 tabs/day) HD |
| <i>sertraline hcl 50 mg tablet</i> (Zoloft) | T1 | QL (4 tabs/day) HD |
| SEROTONIN-2 ANTAGONIST/REUPTAKE INHIBITORS (SARIs) | | |
| <i>nefazodone hcl</i> | T1 | HD |
| <i>trazodone hcl</i> | T1 | HD |
| SEROTONIN-NOREPINEPHRINE REUPTAKE-INHIB (SNRIs) | | |
| <i>desvenlafaxine succnt er 100mg</i> (Pristiq) | T1 | QL (4 tabs/day) HD |
| <i>desvenlafaxine succnt er 25 mg</i> (Pristiq) | T1 | QL (16 tabs/day) HD |
| <i>desvenlafaxine succnt er 50 mg</i> (Pristiq) | 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 |
| PRISTIQ ER 50 MG TABLET (<i>desvenlafaxine succinate er</i>) | T3 | QL (1 tab/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</i> (Effexor Xr) | T1 | QL (2 caps/day) HD |
| <i>venlafaxine hcl er 150 mg tab</i> | T1 | QL (2 tabs/day) HD |

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List of Prescription Medications

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

| Prescription Drug Name | Drug Tier | Coverage Requirements and Limits |
|--|-----------|----------------------------------|
| SEROTONIN-NOREPINEPHRINE REUPTAKE-INHIB (SNRIs) (cont.) | | |
| <i>venlafaxine hcl er 225 mg tab</i> | T1 | QL (1 tab/day) HD |
| <i>venlafaxine hcl er 37.5 mg cap (Effexor Xr)</i> | 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 (Effexor Xr)</i> | T1 | QL (4 caps/day) HD |
| <i>venlafaxine hcl er 75 mg tab</i> | T1 | QL (4 tabs/day) HD |
| VIIBRYD 10 MG TABLET | T3 | QL (1 tab/day) ST HD |
| VIIBRYD 10-20 MG STARTER PACK | T3 | ST HD |
| VIIBRYD 20 MG TABLET | T3 | QL (1 tab/day) ST HD |
| VIIBRYD 40 MG TABLET | T3 | ST HD |
| <i>vilazodone hcl tablet (Viibryd)</i> | T1 | QL(1 tab/day) HD |
| SSRI, SEROTONIN RECEPTOR MODULATOR ANTI-DEPRESSANTS | | |
| TRINTELLIX 10 MG TABLET | T2 | QL (1 tab/day) ST HD |
| TRINTELLIX 20 MG TABLET | T2 | ST HD |
| TRINTELLIX 5 MG TABLET | T2 | QL (1 tab/day) ST HD |
| TRICYCLIC ANTI-DEPRESSANT-BENZODIAZEPINE COMBINATNS | | |
| <i>amitriptyline/chlordiazepoxide</i> | T1 | HD |
| TRICYCLIC ANTI-DEPRESSANT-PHENOTHIAZINE COMBINATNS | | |
| <i>perphenazine/amitriptyline hcl</i> | T1 | HD |
| TRICYCLIC ANTI-DEPRESSANTS, REL.NON-SEL.REUPT-INHIB | | |
| <i>amitriptyline hcl</i> | T1 | HD |
| <i>amoxapine</i> | T1 | HD |
| <i>clomipramine hcl</i> | T1 | HD |
| <i>desipramine hcl (Norpramin)</i> | T1 | HD |
| <i>doxepin 10 mg capsule</i> | T1 | HD |
| <i>doxepin 10 mg/ml oral conc</i> | T1 | HD |
| <i>doxepin 100 mg capsule</i> | T1 | HD |
| <i>doxepin 150 mg capsule</i> | T1 | HD |
| <i>doxepin 25 mg capsule</i> | T1 | HD |
| <i>doxepin 50 mg capsule</i> | T1 | HD |
| <i>doxepin 75 mg 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 |

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List of Prescription Medications

PSYCHOTHERAPEUTIC DRUGS (Attention Deficit Hyperactivity Disorder)⁸

| Prescription Drug Name | Drug Tier | Coverage Requirements and Limits | |
|--|--------------------------|---|---|
| ADRENERGICS, AROMATIC, NON-CATECHOLAMINE | | | |
| <i>trimipramine maleate</i> | T1 | HD | |
| <i>lisdexamfetamine 10 mg capsule (Vyvanse)</i> | T1 | PA QL (1 CAP/DAY) | |
| MYDAYIS | T2 | QL | |
| VYVANSE 10 MG CAPSULE | T3 | PA QL (1 cap/day) | |
| VYVANSE 10 MG CHEWABLE TABLET | T3 | PA QL (1 tab/day) | |
| VYVANSE 20 MG CAPSULE | T3 | PA QL (1 cap/day) | |
| VYVANSE 20 MG CHEWABLE TABLET | T3 | PA QL (1 tab/day) | |
| VYVANSE 30 MG CAPSULE | T3 | PA QL (1 cap/day) | |
| VYVANSE 30 MG CHEWABLE TABLET | T3 | PA QL (1 tab/day) | |
| VYVANSE 40 MG CAPSULE | T3 | PA QL (1 cap/day) | |
| VYVANSE 40 MG CHEWABLE TABLET | T3 | PA QL (1 tab/day) | |
| VYVANSE 50 MG CAPSULE | T3 | PA QL (1 cap/day) | |
| VYVANSE 50 MG CHEWABLE TABLET | T3 | PA QL (1 tab/day) | |
| VYVANSE 60 MG CAPSULE | T3 | PA QL (1 cap/day) | |
| VYVANSE 60 MG CHEWABLE TABLET | T3 | PA QL (1 tab/day) | |
| VYVANSE 70 MG CAPSULE | T3 | PA QL (1 cap/day) | |
| TX FOR ADHD - SELECTIVE ALPHA-2 RECEPTOR AGONIST | | | |
| <i>clonidine hcl (Kapvay)</i> | T1 | | |
| <i>guanfacine hcl (Intuniv)</i> | T1 | HD | |
| TX FOR ATTENTION DEFICIT-HYPERACT (ADHD)/NARCOLEPSY | | | |
| 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 hcl</i> | T1 | PA QL (1 cap/day) | |
| <i>dexmethylphenidate hcl (Focalin)</i> | T1 | PA | |
| FOCALIN (<i>dexmethylphenidate hcl</i>) | T3 | PA ST | |
| METADATE CD (<i>methylphenidate hcl</i>) | | | |
| METHYLIN (<i>methylphenidate hcl</i>) | T3 | PA | |
| <i>methylphenidate er 10 mg cap</i> | T1 | QL (1 per day) | |
| <i>methylphenidate er 10 mg tab</i> | T1 | PA QL (2 tabs/day) | |
| <i>methylphenidate er 15 mg cap</i> | T1 | QL (1 per day) | |
| <i>methylphenidate er 18 mg tab</i> | T1 | PA QL (1 tab/day) | |
| <i>methylphenidate er 20 mg cap</i> | T1 | QL (1 cap/day) | |
| <i>methylphenidate er 20 mg tab</i> | T1 | PA QL (3 tabs/day) | |
| T1 – Typically Generics | PA – Prior Authorization | AGE – Age Requirement | PPACA – No Cost-Share Preventive Medication |
| T2 – Typically Preferred Brands | QL – Quantity Limit | SP – Specialty Medication | CSL – Oral cancer medication subject to cost-share limits |
| T3 – Typically Non-Preferred Brands | ST – Step Therapy | HD – May require home delivery pharmacy | |

List of Prescription Medications

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

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

TX FOR ATTENTION DEFICIT-HYPERACT (ADHD)/NARCOLEPSY (cont.)

| | | |
|--|----|--------------------|
| <i>methylphenidate er 27 mg tab</i> | T1 | PA QL (1 per day) |
| <i>methylphenidate er 30 mg cap</i> | T1 | QL (1 per day) |
| <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 ptch</i> | T1 | PA QL(1 patch/day) |
| <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 per 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 per day) |
| <i>methylphenidate la 60 mg cap</i> | T1 | PA QL (1 cap/day) |
| QUILLICHEW ER | T3 | PA QL (1 tab/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 |

PSYCHOTHERAPEUTIC DRUGS (Miscellaneous)

HYPOACTIVE SEXUAL DESIRE DISORDER (HSDD) TX AGENTS

| | | |
|---------|----|--------------------------------|
| ADDYI | T3 | PA QL (1 tab/day) |
| VYLEESI | T3 | PA QL (8 injectors/30 days) SP |

ANTI-PSYCH, DOPAMINE ANTAG., DIPHENYLBUTYLPIPERIDINES

| | | |
|-----------------|----|--|
| <i>pimozide</i> | T1 | |
|-----------------|----|--|

T1 – Typically Generics

PA – Prior Authorization

AGE – Age Requirement

PPACA – No Cost-Share Preventive Medication

T2 – Typically Preferred Brands

QL – Quantity Limit

SP – Specialty Medication

CSL – Oral cancer medication subject to cost-share limits

T3 – Typically Non-Preferred Brands

ST – Step Therapy

HD – May require home delivery pharmacy

List of Prescription Medications

| PSYCHOTHERAPEUTIC DRUGS (Schizophrenia/Anti-Psychotics) ⁸ (cont.) | | |
|--|-----------|----------------------------------|
| Prescription Drug Name | Drug Tier | Coverage Requirements and Limits |
| ANTI-PSYCHOTIC, ATYPICAL, DOPAMINE, SEROTONIN ANTAGNIST (cont.) | | |
| <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 (clozapine) | 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 |
| 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 |
| LATUDA 120 MG TABLET | T2 | |
| LATUDA 20 MG TABLET | T2 | |
| LATUDA 40 MG TABLET | T2 | QL (1 tab/day) |
| LATUDA 60 MG TABLET | T2 | QL (1 tab/day) |
| LATUDA 80 MG TABLET | T2 | |
| <i>lurasidone hcl tablet</i> | T1 | QL(1 tab/day) |
| <i>olanzapine</i> (Zyprexa) | T1 | |
| <i>paliperidone er 1.5 mg tablet</i> | T1 | |
| <i>paliperidone er 3 mg tablet</i> (Invega) | T1 | QL (1 tab/day) |
| <i>paliperidone er 9 mg tablet</i> (Invega) | T1 | |
| <i>quetiapine fumarate</i> (Seroquel Xr) | T1 | |
| <i>quetiapine fumarate</i> (Seroquel) | T1 | |
| <i>risperidone</i> | T1 | |
| <i>risperidone</i> (Risperdal) | T1 | |

T1 – Typically Generics

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AGE – Age Requirement

PPACA – No Cost-Share Preventive Medication

T2 – Typically Preferred Brands

QL – Quantity Limit

SP – Specialty Medication

CSL – Oral cancer medication subject to cost-share limits

T3 – Typically Non-Preferred Brands

ST – Step Therapy

HD – May require home delivery pharmacy

List of Prescription Medications

| PSYCHOTHERAPEUTIC DRUGS (Schizophrenia/Anti-Psychotics) ⁸ (cont.) | | |
|--|-----------|----------------------------------|
| Prescription Drug Name | Drug Tier | Coverage Requirements and Limits |
| ANTI-PSYCHOTIC, ATYPICAL, DOPAMINE, SEROTONIN ANTAGONIST (cont.) | | |
| 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 | |
| ANTI-PSYCHOTIC-ATYPICAL, D3/D2 PARTIAL AG-5HT MIXED | | |
| 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 |
| ANTIPSYCHOTICS, ATYP, D2 PARTIAL AGONIST/5HT MIXED | | |
| <i>aripiprazole</i> | T1 | |
| <i>aripiprazole 1 mg/ml solution</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) |
| REXULTI 0.25 MG TABLET | T3 | QL (1 tab/day) ST |
| REXULTI 0.5 MG TABLET | T3 | QL (1 tab/day) ST |
| REXULTI 1 MG TABLET | T3 | QL (1 tab/day) ST |
| REXULTI 2 MG TABLET | T3 | QL (1 tab/day) ST |
| REXULTI 3 MG TABLET | T3 | ST |
| REXULTI 4 MG TABLET | T3 | ST |
| ANTI-PSYCHOTICS, DOPAMINE AND SEROTONIN ANTAGONISTS | | |
| <i>loxapine succinate</i> | T1 | |
| ANTI-PSYCHOTICS, DOPAMINE ANTAGONISTS, BUTYROPHENONES | | |
| <i>haloperidol</i> | T1 | |
| <i>haloperidol lactate</i> | T1 | |
| ANTI-PSYCHOTICS, DOPAMINE ANTAGONIST, DIHYDROINDOLONES | | |
| <i>molindone hcl</i> | T1 | |

T1 – Typically Generics

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T2 – Typically Preferred Brands

QL – Quantity Limit

SP – Specialty Medication

CSL – Oral cancer medication subject to cost-share limits

T3 – Typically Non-Preferred Brands

ST – Step Therapy

HD – May require home delivery pharmacy

List of Prescription Medications

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

| Prescription Drug Name | Drug Tier | Coverage Requirements and Limits |
|---|-----------|----------------------------------|
| ANTI-PSYCHOTICS, PHENOTHIAZINES | | |
| <i>chlorpromazine hcl</i> | T1 | |
| <i>fluphenazine hcl</i> | T1 | |
| <i>perphenazine</i> | T1 | |
| <i>thioridazine hcl</i> | T1 | |
| <i>trifluoperazine hcl</i> | T1 | |
| SSRI-ANTI-PSYCH, ATYPICAL, DOPAMINE, SEROTONIN ANTAG | | |
| <i>olanzapine/fluoxetine hcl</i> | T1 | |
| <i>olanzapine/fluoxetine hcl (Symbyax)</i> | T1 | |
| PSYCHOTHERAPEUTIC DRUGS (Sleep Disorders/Sedatives) | | |
| NARCOLEPSY AND SLEEP DISORDER THERAPY AGENTS | | |
| <i>armodafinil</i> | T1 | PA |
| <i>modafinil (Provigil)</i> | T1 | PA |
| SUNOSI | T2 | PA QL (1 tab/day) |
| ANTI-NARCOLEPSY, ANTI-CATAPLEXY, SEDATIVE-TYPE AGENT | | |
| LUMRYZ | T3 | PA QL (30 pkts/30 days) SP |
| XYWAV | T3 | PA SP HD |
| BARBITURATES | | |
| <i>phenobarbital</i> | T1 | |
| <i>secobarbital sodium</i> | T3 | PA |
| HYPNOTICS, MELATONIN MT1/MT2 RECEPTOR AGONISTS | | |
| HETLIOZ | T3 | PA SP HD |
| HETLIOZ LQ | T3 | PA SP HD |
| <i>ramelteon (Rozerem)</i> | T1 | QL (1 tab/day) |
| <i>tasimelteon</i> | T1 | PA SP HD |
| SEDATIVE-HYPNOTICS - BENZODIAZEPINES | | |
| DORAL | T3 | |
| <i>estazolam</i> | T1 | |
| <i>flurazepam hcl</i> | T1 | |
| HALCION (<i>triazolam</i>) | T3 | |
| <i>midazolam hcl</i> | T1 | |
| QUAZEPAM | T1 | |
| <i>quazepam (Quazepam)</i> | T1 | |
| <i>temazepam</i> | T1 | |

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T3 – Typically Non-Preferred Brands

ST – Step Therapy

HD – May require home delivery pharmacy

List of Prescription Medications

PSYCHOTHERAPEUTIC DRUGS (Sleep Disorders/Sedatives) (cont.)

| Prescription Drug Name | Drug Tier | Coverage Requirements and Limits |
|---|-----------|----------------------------------|
| SEDATIVE-HYPNOTICS - BENZODIAZEPINES (cont.) | | |
| <i>triazolam</i> | T1 | |
| <i>triazolam (Halcion)</i> | T1 | |
| SEDATIVE-HYPNOTICS, NON-BARBITURATE | | |
| DAYVIGO | T2 | QL (1 tab/day) ST |
| <i>doxepin hcl 3 mg tablet (Silenor)</i> | T1 | QL (1 tab/day) |
| <i>doxepin hcl 6 mg tablet (Silenor)</i> | T1 | |
| <i>eszopiclone (Lunesta)</i> | T1 | |
| SILENOR 6 MG TABLET (<i>doxepin hcl</i>) | T3 | ST |
| <i>zaleplon</i> | T1 | |
| <i>zolpidem tart er 12.5 mg tab</i> | T1 | |
| <i>zolpidem tart er 6.25 mg tab</i> | T1 | QL (1 tab/day) |
| <i>zolpidem tartrate</i> | T1 | |
| ANTI-NARCOLEPSY, ANTI-CATAPLEXY, SEDATIVE-TYPE AGENT | | |
| SODIUM OXYBATE 0.5 G/ML SOLN | T3 | PA QL(18 mls/day) SP HD |
| SKIN PREPS (Miscellaneous) | | |
| IRRIGANTS | | |
| <i>acetic acid</i> | T1 | |
| <i>neomycin sulf/polymyxin b sulf</i> | T1 | |
| PHYSIOLYTE | T3 | |
| PHYSIOSOL | T3 | |
| <i>ringer's solution</i> | T1 | |
| <i>ringer's solution, lactated</i> | T1 | |
| <i>sod, pot chlor/mag/sod, pot phos</i> | T3 | |
| <i>sodium chloride irrig solution</i> | T1 | |
| SORBITOL | T1 | |
| SORBITOL-MANNITOL | T1 | |
| VASHE WOUND | T3 | |
| VASHE WOUND THERAPY | T3 | |
| <i>water for irrigation, sterile</i> | T1 | |
| OXIDIZING AGENTS | | |
| <i>hydrogen peroxide</i> | T1 | |

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HD – May require home delivery pharmacy

List of Prescription Medications

SKIN PREPS (Pain Relief And Inflammatory Disease)

| Prescription Drug Name | Drug Tier | Coverage Requirements and Limits |
|--|-----------|----------------------------------|
| ANTI-PSORIATIC AGENTS, SYSTEMIC | | |
| <i>acitretin</i> | T1 | |
| BIMZELX | T3 | PA QL (10 mls/365 days) SP HD |
| COSENTYX | T3 | PA QL SP |
| ILUMYA | T3 | PA QL (1 syringe/84 days) SP HD |
| SILIQ | T3 | PA QL (2 syringes/15 days) SP |
| <i>methoxsalen (Oxsoralen-ultra)</i> | T1 | |
| OXSORALEN-ULTRA (<i>methoxsalen</i>) | T3 | |
| SKYRIZI (2 SYRINGES) KIT | T3 | PA QL (1 kit/84 days) SP HD |
| SOTYKTU | T3 | PA QL (1 tab/day) SP |
| TALTZ AUTOINJECTOR | T3 | PA QL (1 injector/28 days) SP HD |
| TALTZ AUTOINJECTOR (2 PACK) | T3 | PA QL (1 injector/28 days) SP HD |
| TALTZ AUTOINJECTOR (3 PACK) | T3 | PA QL (1 injector/28 days) SP HD |
| TALTZ SYRINGE | T3 | PA QL (1 syringe/28 days) SP HD |
| TREMFYA 100 MG/ML INJECTOR | T3 | PA QL (1 injector/56 days) SP HD |
| TREMFYA 100 MG/ML SYRINGE | T3 | PA QL (1 syringe/56 days) SP HD |
| TOPICAL ANTI-INFLAMMATORY, NSAIDS | | |
| DICLAREAL | T3 | HD |
| <i>diclofenac sodium 1% gel (Voltaren)</i> | T1 | QL (1000gm/30 days) HD |
| LICART | T2 | PA QL (1 patch/day) HD |

SKIN PREPS (Skin Conditions)

| | | |
|---|----|--|
| ACNE AGENTS, SYSTEMIC | | |
| ABSORICA (<i>isotretinoin</i>) | T3 | |
| ACCUTANE | T1 | |
| AMNESTEEM | T1 | |
| CLARAVIS | T1 | |
| clindamycin/tretinoin (Veltin) | T3 | |
| <i>isotretinoin (Absorica)</i> | T1 | |
| MYORISAN | T1 | |
| ZENATANE | T1 | |
| ACNE AGENTS, TOPICAL | | |
| ACZONE 7.5% GEL PUMP (<i>dapsone</i>) | | |
| <i>adapalene/benzoyl peroxide</i> | T1 | |
| <i>clindamycin phos/benzoyl perox</i> | T1 | |
| <i>clindamycin/tretinoin</i> | T1 | |

T1 – Typically Generics

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T2 – Typically Preferred Brands

QL – Quantity Limit

SP – Specialty Medication

CSL – Oral cancer medication subject to cost-share limits

T3 – Typically Non-Preferred Brands

ST – Step Therapy

HD – May require home delivery pharmacy

List of Prescription Medications

| SKIN PREPS (Skin Conditions) (cont.) | | | |
|---|-----------|----------------------------------|--|
| Prescription Drug Name | Drug Tier | Coverage Requirements and Limits | |
| ACNE AGENTS, TOPICAL | | | |
| <i>dapsone</i> (Aczone) | T1 | | |
| KLARON (<i>sulfacetamide sodium</i>) | T3 | | |
| <i>sulfacetamide sodium</i> (Klaron) | T1 | | |
| ANTI-PERSPIRANTS | | | |
| DRYSOL | T2 | | |
| ANTI-PRURITICS, TOPICAL | | | |
| ALEVICYN PLUS | T3 | | |
| ANTI-PSORIATICS AGENTS | | | |
| <i>anthralin</i> | T1 | | |
| DOVONEX (<i>calcipotriene</i>) | T3 | | |
| <i>tazarotene 0.05% gel</i> (Tazorac) | | | |
| ANTI-SEBORRHEIC AGENTS | | | |
| <i>tazarotene</i> | T1 | | |
| VECTICAL (<i>calcitriol</i>) | T3 | QL (800gm/30 days) | |
| OVACE PLUS | T3 | | |
| <i>selenium sulfide</i> | T1 | | |
| <i>sulfacetamide sodium</i> | T1 | | |
| TERSI FOAM | T3 | | |
| ANTISEPTICS, MISCELLANEOUS | | | |
| GUAIACOL | T1 | | |
| DIABETIC ULCER PREPARATIONS, TOPICAL | | | |
| REGRANEX | T3 | PA QL (2 tubs/30 days) | |
| EMOLLIENTS | | | |
| ATOPICLAIR | T3 | | |
| <i>emollient combination no.35</i> (Mimyx) | T1 | | |
| <i>emollient combination no.60</i> (Restizan) | T1 | | |
| <i>emollient combination no.60</i> (Restizan) | T3 | | |
| HALUCORT | T3 | | |
| MIMYX (<i>prumyx</i>) | T3 | | |
| RESTIZAN | T1 | | |
| <i>vite ac/grape/hyaluronic acid</i> (Atopiclair) | T1 | | |
| XCLAIR | T3 | | |
| IMMUNOMODULATORS | | | |
| <i>imiquimod</i> | T1 | | |
| IRRITANTS/COUNTER-IRRITANTS | | | |
| <i>methyl salicylate</i> | T1 | | |

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HD – May require home delivery pharmacy

List of Prescription Medications

| SKIN PREPS (Skin Conditions) (cont.) | | |
|--|-----------|----------------------------------|
| Prescription Drug Name | Drug Tier | Coverage Requirements and Limits |
| IRRITANTS/COUNTER-IRRITANTS | | |
| QUTENZA | T3 | |
| KERATOLYTICS | | |
| BENZEFOAM | T3 | |
| BENZEPRO | T1 | |
| <i>benzoyl peroxide</i> | T1 | |
| <i>benzoyl peroxide (Enzoclear)</i> | T1 | |
| <i>benzoyl peroxide (Pacnex)</i> | 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>podofilox</i> | T1 | |
| PR BENZOYL PEROXIDE | T1 | |
| <i>salicylic acid</i> | T1 | |
| <i>salicylic acid</i> | T3 | |
| <i>salicylic acid (Keralyt Scalp)</i> | 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 | |
| <i>urea</i> | T1 | |
| <i>urea (Hydro 35)</i> | T1 | |
| <i>urea (Hydro 40)</i> | T3 | |
| <i>urea (Uramaxin)</i> | T1 | |

T1 – Typically Generics

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T3 – Typically Non-Preferred Brands

ST – Step Therapy

HD – May require home delivery pharmacy

List of Prescription Medications

| SKIN PREPS (Skin Conditions) (cont.) | | |
|--|-----------|----------------------------------|
| Prescription Drug Name | Drug Tier | Coverage Requirements and Limits |
| KERATOLYTICS | | |
| <i>urea</i> (Xurea) | T1 | |
| XUREA | T3 | |
| PROTECTIVES | | |
| RADIAPLEXRX | T3 | |
| <i>zinc oxide</i> | T1 | |
| ROSACEA AGENTS, TOPICAL | | |
| <i>azelaic acid</i> | T1 | |
| <i>ivermectin</i> | T1 | |
| <i>metronidazole</i> | T1 | |
| TISSUE/WOUND ADHESIVES | | |
| ARTISS | T3 | |
| SURGISEAL STYLUS | T3 | |
| SURGISEAL TEARDROP | T3 | |
| SURGISEAL TWIST | T3 | |
| TISSEEL VHSD | T3 | |
| TOP. ANTI-INFLAM., PHOSPHODIESTERASE-4 (PDE4) INHIB | | |
| EUCRISA | T2 | |
| TOPICAL AGENTS, MISCELLANEOUS | | |
| GORDON'S UREA | T3 | |
| L-MESITRAN SOFT | T3 | |
| MEDIHONEY | T3 | |
| SAF-CLENS AF | T1 | |
| <i>trichloroacetic acid</i> | T3 | |
| TRICHLOROACETIC ACID | T1 | |
| TOPICAL ANTIBIOTIC PLEUROMUTILIN DERIVATIVES | | |
| ALTABAX | T3 | |
| TOPICAL ANTICHOLINERGIC HYPERHIDROSIS TX AGENTS | | |
| QBREXZA | T3 | PA |
| TOPICAL ANTI-INFLAMMATORY STEROIDAL | | |
| ALA-SCALP (<i>scalacort</i>) | T3 | ST |
| <i>alclometasone dipropionate</i> | T1 | |
| <i>amcinonide</i> | T1 | |
| AQUA GLYCOLIC HC | T3 | |
| <i>betamethasone valerate</i> | T1 | |

T1 – Typically Generics

PA – Prior Authorization

AGE – Age Requirement

PPACA – No Cost-Share Preventive Medication

T2 – Typically Preferred Brands

QL – Quantity Limit

SP – Specialty Medication

CSL – Oral cancer medication subject to cost-share limits

T3 – Typically Non-Preferred Brands

ST – Step Therapy

HD – May require home delivery pharmacy

List of Prescription Medications

SKIN PREPS (Skin Conditions) (cont.)

| Prescription Drug Name | Drug Tier | Coverage Requirements and Limits |
|---|-----------|----------------------------------|
| TOPICAL ANTI-INFLAMMATORY STEROIDAL (cont.) | | |
| <i>betamethasone valerate</i> (Luxiq) | T1 | |
| <i>betamethasone/propylene glyc</i> | T1 | |
| <i>betamethasone/propylene glyc</i> (Diprolene) | T1 | |
| BRYHALI | T3 | ST |
| CAPEX SHAMPOO | T3 | ST |
| <i>clobetasol propionate</i> | T1 | |
| <i>clobetasol propionate</i> (Temovate) | 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 |
| DESONATE (<i>desonide</i>) | T3 | ST |
| <i>desonide</i> | T1 | |
| <i>desonide</i> (Desowen) | T1 | |
| DESOWEN (<i>desonide</i>) | T3 | ST |
| <i>desoximetasone</i> (Topicort) | T1 | |
| DIPROLENE (<i>betamethasone diprop augmented</i>) | T3 | ST |
| <i>fluocinolone acetonide</i> | T1 | |
| <i>fluocinolone acetonide</i> (Derma-smoothe-fs) | T1 | |
| <i>fluocinolone acetonide</i> (Synalar) | T1 | |
| <i>fluocinolone/shower cap</i> (Derma-smoothe-fs) | T1 | |
| <i>fluocinonide</i> | T1 | |
| <i>fluocinonide/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 prop 0.05% foam</i> | T1 | |
| <i>halobetasol prop 0.05% cream</i> | T1 | |
| <i>halobetasol prop 0.05% ointmnt</i> | T1 | |

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T3 – Typically Non-Preferred Brands

ST – Step Therapy

HD – May require home delivery pharmacy

List of Prescription Medications

| SKIN PREPS (Skin Conditions) (cont.) | | |
|---|-----------|----------------------------------|
| Prescription Drug Name | Drug Tier | Coverage Requirements and Limits |
| TOPICAL ANTI-INFLAMMATORY STEROIDAL (cont.) | | |
| <i>hydrocortisone</i> | T1 | |
| <i>hydrocortisone</i> (Ala-scalp) | T1 | |
| <i>hydrocortisone butyrate</i> | T1 | |
| <i>hydrocortisone valerate</i> | T1 | |
| 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</i> (Dermatop) | T1 | |
| SCALACORT DK | T3 | ST |
| SYNALAR | T3 | ST |
| SYNALAR (<i>fluocinolone acetonide</i>) | T3 | ST |
| SYNALARTS | T3 | ST |
| TEMOVATE (<i>clobetasol propionate</i>) | T3 | ST |
| TEXACORT | T3 | ST |
| TOPICORT (<i>desoximetasone</i>) | T3 | ST |
| TOPICAL ANTI-INFLAMMATORY STEROID-LOCAL ANESTHETIC | | |
| ANALPRAM HC | T3 | |
| EPIFOAM | T3 | |
| <i>hydrocortisone/pramoxine</i> (Pramosone) | T1 | |
| <i>lidocaine/hydrocortisone ac</i> | T1 | |
| MEZPAROX-HC | T1 | |
| PRAMOSONE 1% LOTION | T2 | |
| PRAMOSONE 1%-1% CREAM | T2 | |
| PRAMOSONE 1%-1% OINTMENT | T2 | |
| PRAMOSONE 2.5%-1% CREAM | T3 | |
| PRAMOSONE 2.5%-1% LOTION | T3 | |
| PRAMOSONE 2.5%-1% OINTMENT | T2 | |
| TOPICAL ANTI-PARASITICS | | |
| <i>lindane</i> | T1 | |
| <i>malathion</i> (Ovide) | T1 | |
| OVIDE (<i>malathion</i>) | T3 | |

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HD – May require home delivery pharmacy

List of Prescription Medications

| SKIN PREPS (Skin Conditions) (cont.) | | |
|---|-----------|----------------------------------|
| Prescription Drug Name | Drug Tier | Coverage Requirements and Limits |
| TOPICAL PREPARATIONS, ANTIBACTERIALS | | |
| <i>dermazene cream</i> | T1 | |
| DERMAZENE CREAM PACKET | T3 | |
| <i>hydrocortisone/iodoquinol</i> | T1 | |
| <i>hydrocortisone/iodoquinol/aloe</i> | T1 | |
| <i>iodine/potassium iodide</i> | T1 | |
| <i>iodine/sodium iodide</i> | T1 | |
| IODOFLEX | T3 | |
| IODOSORB | T3 | |
| <i>silver nitrate</i> | T1 | |
| TOPICAL VIT D ANALOG/ANTI-INFLAMMATORY STEROID | | |
| <i>calcipotriene/betamethasone</i> | T1 | |
| TOPICAL/MUCOUS MEMBR./SUBCUT. ENZYMES | | |
| SANTYL | T2 | QL (60gm/30 days) |
| VITAMIN A DERIVATIVES | | |
| <i>adapalene</i> | T1 | PA |
| <i>adapalene (Plixda)</i> | 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 |
| TOPICAL VIT D ANALOG/ANTI-INFLAMMATORY STEROID | | |
| TACLONEX 0.005%-0.064% SUSPENS (<i>calcipotriene/betamethasone</i>) | T3 | |
| SMOKING DETERRENENTS (Smoking Cessation) | | |
| SMOKING DETERRENT AGENTS (GANGLIONIC STIM, OTHERS) | | |
| NICOTROL | T2 | PPACA |
| NICOTROL NS | T2 | PPACA |
| SMOKING DETERRENT-NICOTINIC RECEPT.PARTIAL AGONIST | | |
| CHANTIX | T2 | |
| <i>varenicline</i> | T1 | PPACA |
| SMOKING DETERRENENTS, OTHER | | |
| <i>bupropion hcl sr 150 mg tablet</i> | T1 | PPACA |

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CSL – Oral cancer medication subject to cost-share limits

T3 – Typically Non-Preferred Brands

ST – Step Therapy

HD – May require home delivery pharmacy

List of Prescription Medications

| THYROID PREPS (Hormonal Agents) | | | |
|---|--------------------------|---|---|
| Prescription Drug Name | Drug Tier | Coverage Requirements and Limits | |
| ANTI-THYROID PREPARATIONS | | | |
| <i>methimazole</i> (Tapazole) | T1 | HD | |
| <i>propylthiouracil</i> | T1 | HD | |
| TAPAZOLE (<i>methimazole</i>) | T3 | HD | |
| THYROID HORMONES | | | |
| ARMOURTHYROID | T3 | HD | |
| CYTOMEL (<i>liothyronine sodium</i>) | T3 | HD | |
| LEVOTHYROXINE | T3 | HD | |
| <i>levothyroxine sodium</i> (Synthroid) | T1 | HD | |
| <i>levothyroxine sodium</i> (Synthroid) | T3 | HD | |
| <i>liothyronine sodium</i> (Cytomel) | 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 | T2 | HD | |
| THYROLAR-1/2 | T2 | HD | |
| THYROLAR-1/4 | T2 | HD | |
| THYROLAR-2 | T2 | HD | |
| THYROLAR-3 | T2 | HD | |
| TIROSINT | T3 | HD | |
| TIROSINT-SOL | T3 | HD | |
| WP THYROID | T1 | HD | |
| WP THYROID (<i>nature-throid</i>) | T1 | HD | |
| WP THYROID (<i>westhroid</i>) | T1 | HD | |
| CYTOCHROME P450 INHIBITORS | | | |
| TYBOST | T3 | SP | |
| UNCLASSIFIED DRUG PRODUCTS (Asthma/COPD/Respiratory) | | | |
| CYSTIC FIBROSIS-CFTR POTENTIATOR-CORRECTOR COMBIN. | | | |
| BRONCHITOL 40 MG INHALE CAP | T3 | PA SP HD | |
| ORKAMBI 100 MG-125 MG TABLET | T3 | PA QL (4 tabs/day) SP HD | |
| ORKAMBI 100-125 MG GRANULE PKT | T3 | PA QL (2 packs/day) SP HD | |
| ORKAMBI 150-188 MG GRANULE PKT | T3 | PA QL (2 packs/day) SP HD | |
| ORKAMBI 200 MG-125 MG TABLET | T3 | PA QL (4 tabs/day) SP HD | |
| SYMDEKO | T3 | PA QL (2 tabs/day) SP HD | |
| TRIKAFTA | T3 | PA QL (3 tabs/day) SP HD | |
| T1 – Typically Generics | PA – Prior Authorization | AGE – Age Requirement | PPACA – No Cost-Share Preventive Medication |
| T2 – Typically Preferred Brands | QL – Quantity Limit | SP – Specialty Medication | CSL – Oral cancer medication subject to cost-share limits |
| T3 – Typically Non-Preferred Brands | ST – Step Therapy | HD – May require home delivery pharmacy | |

List of Prescription Medications

| UNCLASSIFIED DRUG PRODUCTS (Asthma/COPD/Respiratory) | | |
|---|-----------|----------------------------------|
| Prescription Drug Name | Drug Tier | Coverage Requirements and Limits |
| CYSTIC FIB-TRANSMEMB CONDUCT.REG.(CFTR) POTENTIATOR | | |
| KALYDECO 150 MG TABLET | T3 | PA QL (2 tabs/day) SP HD |
| KALYDECO 25 MG GRANULES PACKET | T3 | PA QL (2 packs/day) SP HD |
| KALYDECO 50 MG GRANULES PACKET | T3 | PA QL (2 packs/day) SP HD |
| KALYDECO 75 MG GRANULES PACKET | T3 | PA QL (2 packs/day) SP HD |
| LUNG SURFACTANTS | | |
| CUROSURF | T3 | |
| INFASURF | T3 | |
| SURVANTA | T3 | |
| MUCOLYTICS | | |
| PULMOZYME | T2 | PA SP HD |
| PULMONARY FIBROSIS - SYSTEMIC ENZYME INHIBITORS | | |
| OFEV | T2 | PA SP HD |
| SYSTEMIC ENZYME INHIBITORS | | |
| JOENJA | T3 | PA QL (2 tabs/day) SP |
| VIJOICE 125mg,50mg | T3 | PA QL (30tabs/30days) SP |
| VIJOICE 250mg | T3 | PA QL (2 tabs/30 days) SP |
| ZOKINVY | T3 | PA QL (4 CAPS/DAY) SP |
| UNCLASSIFIED DRUG PRODUCTS (Blood Modifiers/Bleeding Disorders) | | |
| SPLEEN TYROSINE KINASE INHIBITORS | | |
| TAVALISSE | T3 | PA SP |
| UNCLASSIFIED DRUG PRODUCTS (Blood Pressure/Heart Medications) | | |
| BRADYKININ B2 RECEPTOR ANTAGONISTS | | |
| <i>icatibant acetate</i> | T3 | PA SP HD |
| CI ESTERASE INHIBITORS | | |
| BERINERT | T3 | PA SP HD |
| CINRYZE | T3 | PA SP HD |
| HAEGARDA | T3 | PA SP HD |
| RUCONEST | T3 | PA SP HD |
| PLASMA KALLIKREIN INHIBITORS | | |
| KALBITOR | T3 | PA SP HD |
| ORLADEYO | T3 | PA QL (1 CAPS/DAY) SP |

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

PA – Prior Authorization

QL – Quantity Limit

ST – Step Therapy

AGE – Age Requirement

SP – Specialty Medication

HD – 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)

| Prescription Drug Name | Drug Tier | Coverage Requirements and Limits |
|--|-----------|----------------------------------|
| CHEMOTHERAPY RESCUE/ANTIDOTE AGENTS | | |
| <i>leucovorin calcium</i> | T1 | |
| MESNEX | T3 | SP |
| VISTOGARD | T3 | SP |

UNCLASSIFIED DRUG PRODUCTS (Dental Products)

DENTAL AIDS AND PREPARATIONS

| | | |
|--|----|--|
| <i>chlorhexidine gluconate</i> (Peridex) | T1 | |
| PERIDEX (<i>periogard</i>) | T1 | |
| <i>triamcinolone acetonide</i> | T1 | |

PERIODONTAL COLLAGENASE INHIBITORS

| | | |
|----------------------------|----|--|
| <i>doxycycline hyclate</i> | T1 | |
|----------------------------|----|--|

UNCLASSIFIED DRUG PRODUCTS (Erectile Dysfunction)

DRUGS TO TREAT ERECTILE DYSFUNCTION (ED)

| | | |
|--|----|-----------------------------|
| CAVERJECT | T3 | PA QL (6 injectors/30 days) |
| CIALIS 10 MG TABLET (<i>tadalafil</i>) | T3 | QL (6 tabs/30 days) ST HD |
| CIALIS 20 MG TABLET (<i>tadalafil</i>) | T3 | QL (6 tabs/30 days) ST HD |
| CIALIS 5 MG TABLET (<i>tadalafil</i>) | T3 | QL (8 tabs/30 days) ST HD |
| EDEX | T3 | PA QL (6 injectors/30 days) |
| IFE-BIMIX 30/1 | T2 | |
| IFE-PG20 | T2 | |
| LEVITRA (<i>varденаfil hcl</i>) | T3 | QL (10 tabs/30 days) ST |
| MUSE | T2 | PA QL (6/30 days) |
| PAPAVERINE-PHENTOLMN-ALPROSTDIL | T1 | |
| PHENTOLAMINE-ALPROSTADIL | T1 | |
| <i>sildenafil 100 mg tablet</i> (Viagra) | T1 | QL (10 tabs/30 days) HD |
| <i>sildenafil 25 mg tablet</i> (Viagra) | T1 | QL (6 tabs/30 days) HD |
| <i>sildenafil 50 mg tablet</i> (Viagra) | T1 | QL (6 tabs/30 days) HD |
| STENDRA | T3 | QL (8 tabs/30 days) ST |
| <i>tadalafil 10 mg tablet</i> (Cialis) | T1 | QL (10 tabs/30 days) HD |
| <i>tadalafil 20 mg tablet</i> (Cialis) | T1 | PA QL (10 tabs/30 days) HD |
| <i>tadalafil 5 mg tablet</i> (Cialis) | T1 | QL (8 tabs/30 days) HD |

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QL – Quantity Limit

SP – Specialty Medication

CSL – Oral cancer medication subject to cost-share limits

T3 – Typically Non-Preferred Brands

ST – Step Therapy

HD – May require home delivery pharmacy

List of Prescription Medications

UNCLASSIFIED DRUG PRODUCTS (Erectile Dysfunction) (cont.)

| Prescription Drug Name | Drug Tier | Coverage Requirements and Limits |
|---|-----------|----------------------------------|
| DRUGS TO TREAT ERECTILE DYSFUNCTION (ED) (cont.) | | |
| <i>vardenafil hcl</i> | T1 | QL (10 tabs/30 days) |
| <i>vardenafil hcl</i> (Levitra) | T1 | QL (10 tabs/30 days) |
| VIAGRA (<i>sildenafil citrate</i>) | T3 | QL (8 tabs/30 days) ST HD |

UNCLASSIFIED DRUG PRODUCTS (Gastrointestinal/Heartburn)

ORAL MUCOSITIS/STOMATITIS AGENTS

| | | |
|------------|----|--|
| ORAMAGICRX | T3 | |
|------------|----|--|

SALIVA STIMULANT AGENTS

| | | |
|----------|----|--|
| NUMOISYN | T3 | |
|----------|----|--|

UNCLASSIFIED DRUG PRODUCTS (Hormonal Agents)

BONE FORMATION STIM. AGENTS - PARATHYROID HORMONE

| | | |
|--|----|---------------------------|
| <i>teriparatide 600 mcg/2.4ml pen</i> (Forteo) | T1 | PA QL(0.09 mls/day) SP HD |
|--|----|---------------------------|

GROWTH HORMONE RECEPTOR ANTAGONISTS

| | | |
|----------|----|----------|
| SOMAVERT | T3 | PA SP HD |
|----------|----|----------|

HYPERPARATHYROID TX AGENTS - VITAMIN D ANALOG-TYPE

| | | |
|---------------------------------|----|-------|
| <i>doxercalciferol</i> | T1 | |
| <i>paricalcitol</i> | T1 | SP HD |
| <i>paricalcitol</i> (Zemplar) | T1 | SP HD |
| RAYALDEE | T3 | |
| ZEMPLAR (<i>paricalcitol</i>) | T3 | SP HD |

MENOPAUSAL SYMPT SUPP-SEL ESTROGEN RECEP MODULATOR

| | | |
|---------|----|------------------------|
| OSPHENA | T3 | QL(30 tabs/30 days) HD |
|---------|----|------------------------|

UNCLASSIFIED DRUG PRODUCTS (Miscellaneous)

ABORTIFACIENT-PROGESTERONE RECEPTOR ANTAGONISTS

| | | |
|--------------------------------|----|--|
| MIFEPREX | T3 | |
| <i>mifepristone</i> (Mifeprex) | T1 | |

AGENTS TO TX PERIODIC PARALYSIS - CARBON ANHYD INH

| | | |
|-----------------------------------|----|-------|
| <i>dichlorphenamide</i> (Keveyis) | T1 | PA SP |
|-----------------------------------|----|-------|

AMMONIA INHIBITORS

| | | |
|-----------|----|--------------------------------|
| CARBAGLU | T3 | SP HD |
| PHEBURANE | T2 | PA QL(8 Bottles/30 Days) SP HD |

AMYLOIDOSIS AGENTS-TRANSTHYRETIN (TTR) SUPPRESSION

| | | |
|---------|----|----------|
| TEGSEDI | T3 | PA SP HD |
|---------|----|----------|

ANTI-ALCOHOLIC PREPARATIONS

| | | |
|----------------------------|----|--|
| <i>acamprosate calcium</i> | T1 | |
|----------------------------|----|--|

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List of Prescription Medications

| UNCLASSIFIED DRUG PRODUCTS (Miscellaneous) | | |
|---|-----------|----------------------------------|
| Prescription Drug Name | Drug Tier | Coverage Requirements and Limits |
| ANTI-ALCOHOLIC PREPARATIONS | | |
| ANTABUSE (<i>disulfiram</i>) | T3 | |
| <i>disulfiram</i> (Antabuse) | T1 | |
| ANTIDOTES, MISCELLANEOUS | | |
| CETYLEV | T3 | |
| ANTI-FIBROTIC THERAPY - PYRIDONE ANALOGS | | |
| <i>pirfenidone 267 mg capsule</i> (Esbriet) | T1 | PA SP HD |
| <i>pirfenidone 801 mg tablet</i> (Esbriet) | T1 | PA SP HD |
| CRYOPRESERVATIVE AGENTS | | |
| <i>dimethyl sulfoxide</i> | T1 | |
| DRUGS TO TREAT HEREDITARY TYROSINEMIA | | |
| <i>nitisinone</i> (Orfadin) | T1 | PA SP HD |
| NITYR | T2 | PA SP |
| ORFADIN | T3 | PA SP |
| ORFADIN (<i>nitisinone</i>) | T3 | PA SP |
| GENERAL INHALATION AGENTS | | |
| HYPER-SAL | T3 | |
| <i>nebusal 3% vial</i> | T1 | |
| NEBUSAL 6% VIAL | T3 | |
| <i>sodium chloride for inhalation</i> | T1 | |
| <i>sodium chloride for inhalation</i> (Hyper-sal) | T1 | |
| GENETIC D/O TX - SMN PROTEIN DEFICIENCY TREATMENT | | |
| EVRYSDI | T3 | PA SP HD |
| GLUCOSYLCERAMIDE SYNTHASE (GCS) INHIBITOR | | |
| CERDELGA | T2 | PA SP HD |
| <i>miglustat</i> (Zavesca) | T1 | PA SP HD |
| OPFOLDA | T3 | PA QL(8 caps/30 days) SP HD |
| INTERLEUKIN-13 (IL-13) INHIBITORS, MAB | | |
| ADBRY | T3 | PA SP HD |
| MENOPAUSAL SYMPTOMS SUPPRESSANT-RECEPTOR ANTAG | | |
| VEOZAH | T3 | QL(1 tab/day) |
| MENOPAUSAL SYMPTOMS SUPPRESSANT - SSRIs | | |
| <i>paroxetine mesylate</i> | T1 | QL (1 cap/day) HD |
| METABOLIC DISEASE ENZYME REPLACE, HYPOPHOSPHATASIA | | |
| STRENSIQ | T3 | PA SP |

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List of Prescription Medications

| UNCLASSIFIED DRUG PRODUCTS (Miscellaneous) (cont.) | | |
|---|-----------|----------------------------------|
| Prescription Drug Name | Drug Tier | Coverage Requirements and Limits |
| METABOLIC DISEASE ENZYME REPLACEMENT, MOCD | | |
| NULIBRY | T3 | PA SP |
| METALLIC POISON, AGENTS TO TREAT | | |
| CHEMET | T3 | |
| <i>deferasirox</i> (Exjade) | T1 | SP HD |
| <i>deferasirox</i> (Jadenu Sprinkle) | T1 | SP HD |
| <i>deferasirox</i> (Jadenu) | T1 | SP HD |
| <i>deferiprone</i> (Ferriprox) | T1 | PA SP |
| EXJADE (<i>deferasirox</i>) | T3 | PA SP HD |
| FERRIPROX | T3 | PA SP |
| FERRIPROX (2 TIMES A DAY) | T3 | PA SP |
| GALZIN | T3 | |
| JADENU (<i>deferasirox</i>) | T3 | PA SP HD |
| JADENU SPRINKLE (<i>deferasirox</i>) | T3 | PA SP HD |
| RADIOGARDASE | T3 | |
| <i>trientine hcl</i> | T1 | PA SP HD |
| TRIENTINE HCL | T3 | PA SP HD |
| NATRIURETIC PEPTIDES | | |
| VOXZOGO | T3 | PA SP HD |
| OINTMENT/CREAM BASES | | |
| RADIAGEL | T1 | |
| PHARMACOLOGICAL CHAPERONE-ALPHA-GALACTOSID.A STABZ | | |
| GALAFOLD | T3 | PA SP HD |
| PKU TX AGENT-COFACTOR OF PHENYLALANINE HYDROXYLASE | | |
| <i>javygtor powder pkt</i> | T1 | PA SP |
| <i>javygtor tablet</i> | T1 | PA SP HD |
| PROTEIN STABILIZERS | | |
| VYNDAMAX | T3 | PA QL (1 cap/day) SP HD |
| VYNDAQEL | T3 | PA QL (4 caps/day) SP HD |
| RETINOIC ACID RECEPTOR (RAR) AGONISTS | | |
| SOHONOS | T3 | PA SP |
| SOLVENTS | | |
| FT ISOPROPYL ALCOHOL 91% | T1 | |
| FT ISOPROPYL RUB ALCOHOL 70% | T3 | |
| <i>isopropyl alcohol</i> | T1 | |
| MURI-LUBE MINERAL OIL | T1 | |

T1 – Typically Generics

PA – Prior Authorization

AGE – Age Requirement

PPACA – No Cost-Share Preventive Medication

T2 – Typically Preferred Brands

QL – Quantity Limit

SP – Specialty Medication

CSL – Oral cancer medication subject to cost-share limits

T3 – Typically Non-Preferred Brands

ST – Step Therapy

HD – May require home delivery pharmacy

List of Prescription Medications

| UNCLASSIFIED DRUG PRODUCTS (Miscellaneous) (cont.) | | |
|--|-----------|----------------------------------|
| Prescription Drug Name | Drug Tier | Coverage Requirements and Limits |
| THYMIC STROMAL LYMPHOPOIETIN (TSLP) INHIBITORS | | |
| TEZSPIRE 210 MG/1.91 ML PEN | T3 | PA QL(1 PEN/28 DAYS) SP HD |
| TEZSPIRE 210 MG/1.91 ML SYRING | T3 | PA SP HD |
| UNCLASSIFIED DRUG PRODUCTS (Nutritional/Dietary) | | |
| METABOLIC DEFICIENCY AGENTS | | |
| CYSTADANE | T2 | SP |
| <i>levocarnitine</i> (Carnitor Sf) | T1 | |
| <i>levocarnitine</i> (Carnitor) | T1 | |
| <i>levocarnitine</i> (with sugar) (Carnitor) | T1 | |
| UNCLASSIFIED DRUG PRODUCTS (Osteoporosis Products) | | |
| BONE RESORPTION INHIBITOR AND VITAMIN D COMBS. | | |
| FOSAMAX PLUS D | T3 | ST HD |
| BONE RESORPTION INHIBITORS | | |
| ACTONEL (<i>risedronate sodium</i>) | T3 | ST HD |
| <i>alendronate sodium</i> (Fosamax) | T1 | HD |
| ADELVIA (<i>risedronate sodium dr</i>) | T3 | ST HD |
| BINOSTO | T3 | ST HD |
| BONIVA (<i>ibandronate sodium</i>) | T3 | ST HD |
| EVISTA (<i>raloxifene hcl</i>) | T3 | HD |
| FOSAMAX (<i>alendronate sodium</i>) | T3 | ST HD |
| <i>ibandronate sodium</i> (Boniva) | T1 | HD |
| <i>raloxifene hcl</i> (Evista) | T1 | HD PPACA |
| <i>risedronate sodium</i> | T1 | HD |
| <i>risedronate sodium</i> (Actonel) | T1 | HD |
| <i>risedronate sodium</i> (Atelvia) | T1 | HD |
| UNCLASSIFIED DRUG PRODUCTS (Pain Relief And Inflammatory Disease) | | |
| ANTI-INFLAM. INTERLEUKIN-I RECEPTOR ANTAGONIST | | |
| ARCALYST | T3 | PA SP HD |
| ANTI-INFLAMMATORY, INTERLEUKIN-I BETA BLOCKERS | | |
| ILARIS | T3 | PA SP HD |
| FIBROMYALGIA AGENTS, SEROTONIN-NOREPINEPH RU INHIB | | |
| SAVELLA | T2 | HD |
| IMMUNOMODULATOR, B-LYMPHOCYTE STIM (BLYS)-SPEC INHIB | | |
| BENLYSTA | T3 | PA SP HD |

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T3 – Typically Non-Preferred Brands

ST – Step Therapy

HD – May require home delivery pharmacy

List of Prescription Medications

| UNCLASSIFIED DRUG PRODUCTS (Substance Abuse) | | |
|--|-----------|----------------------------------|
| Prescription Drug Name | Drug Tier | Coverage Requirements and Limits |
| OPIOID WITHDRAWAL THER, ALPHA-2 ADRENERGIC AGONIST | | |
| LUCEMYRA | T2 | QL (168 tabs/14 days) |
| OPIOID WITHDRAWAL THERAPY AGENTS, OPIOID-TYPE | | |
| BUNAVAIL | T3 | |
| <i>buprenorphine hcl</i> | T1 | |
| <i>buprenorphine hcl/naloxone hcl</i> | T1 | |
| <i>buprenorphine hcl/naloxone hcl</i> (Suboxone) | T1 | |
| SUBOXONE (<i>buprenorphine-naloxone</i>) | T3 | |
| ZUBSOLV | T2 | |
| UNCLASSIFIED DRUG PRODUCTS (Transplant Medications) | | |
| RHO KINASE INHIBITOR | | |
| REZUROCK | T3 | PA SP HD |
| UNCLASSIFIED DRUG PRODUCTS (Urinary Tract Conditions) | | |
| BENIGN PROSTATIC HYPERTROPHY/MICTURITION AGENTS | | |
| <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 |
| 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 |
| BPH 5-ALPHA-REDUCTASE INHIB-ALPHA1-ADRENOCEP ANTAG | | |
| <i>dutasteride/tamsulosin hcl</i> (Jalyn) | T1 | HD |
| CYSTINE-DEPLETING AGENTS, NEPHROPATHIC CYSTINOSIS | | |
| CYSTAGON | T2 | SP |
| KIDNEY STONE AGENTS | | |
| <i>tiopronin</i> | T1 | SP |
| URINARY TRACT ANTI-SPASMODIC, M(3) SELECTIVE ANTAG. | | |
| <i>darifenacin er 15 mg tablet</i> | T1 | HD |
| <i>darifenacin er 7.5 mg tablet</i> | T1 | QL (1 tab/day) HD |

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List of Prescription Medications

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

| Prescription Drug Name | Drug Tier | Coverage Requirements and Limits |
|---|-----------|----------------------------------|
| URINARY TRACT ANTI-SPASMODIC, M(3) SELECTIVE ANTAG. | | |
| <i>solifenacin 10 mg tablet</i> | T1 | HD |
| <i>solifenacin 5 mg tablet</i> | T1 | QL (1 tab/day) HD |
| URINARY TRACT ANTI-SPASMODIC/ANTI-INCONTINENCE AGENT | | |
| <i>flavoxate hcl</i> | T1 | HD |
| <i>oxybutynin</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 |
| URINARY TRACT ANTI-SPASMODIC/ANTI-INCONTINENCE AGENT (cont.) | | |
| <i>tolterodine tartrate</i> | T1 | HD |
| <i>tropium chloride</i> | T1 | HD |

UNCLASSIFIED DRUG PRODUCTS (Weight Management)

APPETITE STIM. FOR ANOREXIA, CACHEXIA, WASTING SYND.

| | | |
|--------------------------|----|--|
| <i>megestrol acetate</i> | T1 | |
|--------------------------|----|--|

VITAMINS (Nutritional/Dietary)

FOLIC ACID PREPARATIONS

| | | |
|---------------------------------------|----|--|
| <i>folic acid</i> | T1 | |
| <i>true folic acid 1600mcg dfe tb</i> | T1 | |

MULTIVITAMIN PREPARATIONS

| | | |
|-------------------------------------|----|--|
| CITRANATAL MEDLEY | T3 | |
| CONCEPT DHA CAPSULE | T3 | |
| FOLET ONE | T2 | |
| <i>mvn no.53/iron/folic/dss/dha</i> | T1 | |
| OBSTETRIX ONE | T1 | |

VITAMIN B PREPARATIONS

| | | |
|--------|----|----|
| POTABA | T2 | HD |
|--------|----|----|

VITAMIN B12 PREPARATIONS

| | | |
|--------------------------------------|----|--|
| <i>cyanocobalamin (vitamin b-12)</i> | T1 | |
|--------------------------------------|----|--|

VITAMIN D PREPARATIONS

| | | |
|---|----|----|
| <i>calcitriol 0.25 mcg capsule (Rocaltrol)</i> | T1 | HD |
| <i>calcitriol 0.5 mcg capsule (Rocaltrol)</i> | T1 | HD |
| <i>calcitriol 1 mcg/ml solution (Rocaltrol)</i> | T1 | HD |
| DRISDOL (vitamin d2) | T3 | HD |
| <i>ergocalciferol (vitamin d2) (Drisdol)</i> | T1 | HD |

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List of Prescription Medications

| VITAMINS (Nutritional/Dietary) | | |
|----------------------------------|-----------|----------------------------------|
| Prescription Drug Name | Drug Tier | Coverage Requirements and Limits |
| VITAMIN D PREPARATIONS | | |
| ROCALTROL (<i>calcitriol</i>) | T3 | HD |
| VITAMIN K PREPARATIONS | | |
| MEPHYTON (<i>phytonadione</i>) | T3 | |

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Exclusions and limitations for coverage

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

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

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

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

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

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



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

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

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

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DISCRIMINATION IS AGAINST THE LAW

Medical coverage

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

Cigna:

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

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

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

Cigna
Nondiscrimination Complaint Coordinator
PO Box 188016
Chattanooga, TN 37422

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

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



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Proficiency of Language Assistance Services

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

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

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

Vietnamese – XIN 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).