



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

Coverage as of July 1, 2024

For the State of California

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

Cigna.com/PDL
[800.Cigna24 \(800.244.6224\)](tel:800.244.6224)
[myCigna® AppmyCigna.com®](https://myCigna.com)

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 This drug list is subject to change and all prior versions are no longer in effect.

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View your drug list online

This document was last updated on 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/PDL.** Scroll down to the "California Employer Drug Lists" section. Under Cigna Legacy (Performance) Prescription Drug List, click on the pdf named **California Legacy (Performance) 4 Tier (all specialty medications covered on tier 4).**

Questions?

- **myCigna.com:** Click to Chat - Monday-Friday, 9:00 am-8:00 pm EST.
- **By phone:** Call the toll-free number on your Cigna 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. There are certain medications and products that can't be covered by your plan for any reason because they're considered to be a "plan or benefit exclusion." This means the medication or product isn't on your plan's drug list, and there's no option to ask Cigna Healthcare to consider approving it through the coverage review process. For example, your plan doesn't cover, or "excludes," medications that aren't approved by the U.S. Food and Drug Administration (FDA).

Q. How do you decide which medications to cover?

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

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

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

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

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

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

Q. What types of medications typically need approval?

A. Medications that:

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

Information about this drug list

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

Q. What types of medications typically have quantity limits?

A. Medications that are often:

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

Q. What types of medications require Step Therapy?

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

- ADD/ADHD
- 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 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.

Information about this drug list

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

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

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

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

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

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

form from the Cigna Healthcare provider portal at **cignaforhcp.com**.

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

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

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

Your Step Therapy rights under California State law:

1. A carrier may impose prior authorization requirements on prescription drug benefits.
2. When there is more than one drug that is appropriate for the treatment of a medical condition, a carrier may require step therapy.
 - a. In circumstances where an insured is changing

Information about this drug list

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

policies, the new policy shall not require a repeat of step therapy when that insured is already being treated for a medical condition by a prescription drug provided that the drug is appropriately prescribed and is considered safe and effective. A new policy can impose a prior authorization requirement for the continued coverage of a prescription drug prescribed pursuant to step therapy imposed by the former policy. A new policy must also allow a prescribing provider to prescribe another drug covered by the new policy that is medically appropriate for the insured.

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

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

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

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

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

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

A. Yes.

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

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

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

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

Q. What are preventive medications?

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

Information about this drug list

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

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

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

Q. What's a cost-share?

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

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

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

Q. What's a generic medication?

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

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

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

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

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

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

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

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

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

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

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

A. It depends on your plan. Some plans require you to fill maintenance medications through Express Scripts[®] 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.

Information about this drug list

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

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](https://www.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](https://www.cigna.com/specialty).

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

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

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

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

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

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

Information about this drug list

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

Q. How do I fill my prescription?

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

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

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

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

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

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

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

Information about this drug list

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

- **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).

Words you may need to know

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

Information about this drug list

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

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

Information about this drug list

About this drug list

This is a list of the most commonly prescribed medications covered on the Cigna Healthcare Legacy (Performance) 4-Tier Prescription Drug List as of January 1, 2024. Medications are listed alphabetically by their generic and brand names within their therapeutic category and class.

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

How to read this drug list

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

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

Tiers

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

• Tier 1 – Typically Generics	(Lowest-cost medication)	\$
• Tier 2 – Typically Preferred Brands	(Medium-cost medication)	\$\$
• Tier 3 – Typically Non-Preferred Brands	(Higher-cost medication)	\$\$\$
• Tier 4 – Specialty Medications	(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 Legacy (Performance) 4-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 Legacy (Performance) 4-Tier Prescription Drug List.

Information about this drug list

How to find your medication

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

Condition	Page	Condition	Page
Analgesics (Pain Relief and Inflammatory Disease)	18-25	Anti-Infectives (Infections)	62
Analgesics (Urinary Tract Conditions)	25	Anti-Infectives/Miscellaneous (Feminine Products)	63
Anesthetics (Miscellaneous)	25, 26	Anti-Infectives/Miscellaneous (Infections)	63, 64
Anesthetics (Pain Relief and Inflammatory Disease)	27-30	Anti-Infectives/Miscellaneous (Miscellaneous)	64
Anesthetics (Urinary Tract Conditions)	30	Anti-Infectives/Miscellaneous (Skin Conditions)	64
Anti-Allergy (Allergy and Nasal Sprays)	30, 31	Anti-Inflammatory Tumor Necrosis Factor Inhibiting Agents (Pain Relief and Inflammatory Disease)	64, 65
Anti-Arthritics (Pain Relief and Inflammatory Disease)	31-34	Anti-Neoplastics (Cancer)	66-78
Anti-Asthmatics (Asthma/COPD/Respiratory)	34-36	Anti-Neoplastics (Skin Conditions)	78
Antibiotics (Allergy/Nasal Sprays)	36	Anti-Parasitics (Infections)	78, 79
Antibiotics (Ear Medications)	36, 37	Anti-Parkinson's Drugs (Parkinson's Disease)	79-81
Antibiotics (Eye Conditions)	37, 38	Anti-Platelet Drugs (Blood Thinners/Anti-Clotting)	81
Antibiotics (Infections)	38-49	Antivirals (AIDS/HIV)	81-85
Antibiotics (Miscellaneous)	49	Antivirals (Eye Conditions)	85
Antibiotics (Skin Conditions)	50, 51	Antivirals (Infections)	85-87
Anti-Coagulants (Blood Thinners/Anti-Clotting)	51-53	Antivirals (Skin Conditions)	88
Antidotes (Gastrointestinal/Heartburn)	53	Autonomic Drugs (Allergy/Nasal Sprays)	88
Antidotes (Substance Abuse)	53, 54	Autonomic Drugs (Alzheimer's Disease)	88, 89
Anti-Fungals (Eye Conditions)	54	Autonomic Drugs (Attention Deficit Hyperactivity Disorder)	89, 90
Anti-Fungals (Feminine Products)	54	Autonomic Drugs (Blood Pressure/Heart Medications)	90
Anti-Fungals (Infections)	54, 55	Autonomic Drugs (Miscellaneous)	90-92
Anti-Fungals (Skin Conditions)	55, 56	Autonomic Drugs (Urinary Tract Conditions)	92
Antihistamine and Decongestant Combination (Allergy/Nasal Sprays)	56	Biologicals (Allergy/Nasal Sprays)	92
Antihistamines (Allergy/Nasal Sprays)	56, 57	Biologicals (Blood Pressure/Heart Medications)	92
Antihistamines (Eye Conditions)	57	Biologicals (Miscellaneous)	92
Anti-Hyperglycemics (Diabetes)	57-62	Biologicals (Vaccines)	93, 94
Anti-Infectives (Feminine Products)	62	Blood (Blood Modifiers/Bleeding Disorders)	94-96

Information about this drug list

How to find your medication *(cont.)*

Condition	Page	Condition	Page
Blood (Miscellaneous)	96	Gastrointestinal (Cholesterol Medications)	144
Cardiac Drugs (Blood Pressure/Heart Medications)	97-101	Gastrointestinal (Gastrointestinal/Heartburn)	144-153
Cardiovascular (Allergy/Nasal Sprays)	101	Gastrointestinal (Pain Relief and Inflammatory Disease)	153
Cardiovascular (Asthma/COPD/Respiratory)	102, 103	Hormones (Hormonal Agents)	154-162
Cardiovascular (Blood Pressure/Heart Medications)	103-109	Hormones (Infertility)	162
Cardiovascular (Cholesterol Medications)	110-113	Hormones (Miscellaneous)	162
Cardiovascular (Miscellaneous)	113	Hormones (Osteoporosis Products)	163
CNS Drugs (Alzheimer's Disease)	114	Immunosuppressants (Pain Relief and Inflammatory Disease)	163
CNS Drugs (Miscellaneous)	114, 115	Immunosuppressants (Transplant Medications)	164, 165
CNS Drugs (Multiple Sclerosis)	115, 116	Miscellaneous Medical Supplies, Devices, Non-Drug (Diabetes)	165-175
CNS Drugs (Pain Relief and Inflammatory Disease)	116	Miscellaneous Medical Supplies, Devices, Non-Drug (Miscellaneous)	176-180
CNS Drugs (Seizure Disorders)	116-121	Muscle Relaxants (Pain Relief and Inflammatory Disease)	180, 181
Colony Stimulating Factors (Blood Modifiers/Bleeding Disorders)	121, 122	Prenatal Vitamins (Nutritional/Dietary)	181, 182
Colony Stimulating Factors (Cancer)	122	Psychotherapeutic Drugs (Anxiety/Depression/Bipolar Disorder)	182-188
Contraceptives (Contraception Products)	122-124	Psychotherapeutic Drugs (Attention Deficit Hyperactivity Disorder)	188-190
Cough/Cold Preparations (Allergy/Nasal Sprays)	124	Psychotherapeutic Drugs (Miscellaneous)	190
Cough/Cold Preparations (Cough/Cold Medications)	125	Psychotherapeutic Drugs (Schizophrenia/Anti-Psychotics)	191-194
Diagnostic (Diabetes)	125	Psychotherapeutic Drugs (Sleep Disorders/Sedatives)	195, 196
Diagnostic (Miscellaneous)	126-129	Sedative/Hypnotics (Sleep Disorders/Sedatives)	196
Diuretics (Diuretics)	129-131	Skin Preps (Miscellaneous)	196, 197
EENT Preps (Allergy/Nasal Sprays)	131, 132	Skin Preps (Pain Relief and Inflammatory Disease)	197, 198
EENT Preps (Ear Medications)	132	Skin Preps (Skin Conditions)	198-208
EENT Preps (Eye Conditions)	132-137	Smoking Deterrents (Smoking Cessation)	208
Elect/Caloric/H ₂ O (Cholesterol Medications)	137	Thyroid Prep (Hormonal Agents)	208, 209
Elect/Caloric/H ₂ O (Dental Products)	137, 138	Unclassified Drug Products (Asthma/COPD/Respiratory)	209, 210
Elect/Caloric/H ₂ O (Diabetes)	138	Unclassified Drug Products (Blood Modifiers/Bleeding Disorders)	210
Elect/Caloric/H ₂ O (Miscellaneous)	138, 139		
Elect/Caloric/H ₂ O (Nutritional/Dietary)	140-143		
Elect/Caloric/H ₂ O (Urinary Tract Conditions)	143, 144		

Information about this drug list

How to find your medication *(cont.)*

Condition	Page	Condition	Page
Unclassified Drug Products (Blood Pressure/Heart Medications)	211	Unclassified Drug Products (Pain Relief and Inflammatory Disease)	220
Unclassified Drug Products (Cancer)	211, 212	Unclassified Drug Products (Seizure Disorders)	220
Unclassified Drug Products (Dental Products)	212	Unclassified Drug Products (Skin Conditions)	220
Unclassified Drug Products (Diabetes)	212	Unclassified Drug Products (Substance Abuse)	220, 221
Unclassified Drug Products (Erectile Dysfunction)	212	Unclassified Drug Products (Transplant Medications)	221
Unclassified Drug Products (Eye Conditions)	213	Unclassified Drug Products (Urinary Tract Conditions)	221, 222
Unclassified Drug Products (Gastrointestinal/Heartburn)	213	Unclassified Drug Products (Weight Management)	222
Unclassified Drug Products (Hormonal Agents)	213, 214	Vitamins (Nutritional/Dietary)	222-224
Unclassified Drug Products (Miscellaneous)	214-218	Vitamins (Vitamins)	224
Unclassified Drug Products (Multiple Sclerosis)	218		
Unclassified Drug Products (Nutritional/Dietary)	218, 219		
Unclassified Drug Products (Osteoporosis Products)	219		

List of Prescription Medications

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

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

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

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

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

List of Prescription Medications

ANALGESICS (Pain Relief And Inflammatory Disease)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ANALGESICS, NEURONAL-TYPE CALCIUM CHANNEL BLOCKERS		
<i>clonidine 1,000 mcg/10 ml vial (Duraclon)</i>	T1	
<i>clonidine 5,000 mcg/10 ml vial</i>	T1	
DURACLON (<i>clonidine hcl</i>)	T3	
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)
CAMBIA (<i>diclofenac potassium</i>)	T3	PA
D.H.E.45 (<i>dihydroergotamine mesylate</i>)	T3	PA QL (10 amps/30 days)
<i>diclofenac pot 50 mg powdr pkt (Cambia)</i>	T1	PA
<i>dihydroergotamine 1 mg/ml amp (D.h.e.45)</i>	T1	QL (10 amps/30 days)
<i>dihydroergotamine 4 mg/ml spry (Migranal)</i>	T1	QL (8/30 days)
<i>eletriptan hydrobromide (Relpax)</i>	T1	QL (6 tabs/30 days)
ELYXYB	T3	PA QL (9 bottles/30 days)
EMGALITY PEN	T2	PA
EMGALITY SYRINGE	T2	PA
ERGOMAR	T3	PA
<i>ergotamine tartrate/caffeine</i>	T1	
<i>ergotamine tartrate/caffeine (Cafergot)</i>	T1	QL (40 tabs/28 days)
<i>frovatriptan succinate (Frova)</i>	T1	QL (18 tabs/30 days)
IMITREX 100 MG TABLET (<i>sumatriptan succinate</i>)	T3	PA QL (9 tabs/30 days)
IMITREX 20 MG NASAL SPRAY (<i>sumatriptan</i>)	T3	PA QL (2 boxes/30 days)
IMITREX 25 MG TABLET (<i>sumatriptan succinate</i>)	T3	PA QL (9 tabs/30 days)
IMITREX 4 MG/0.5 ML CARTRIDGES (<i>sumatriptan succinate</i>)	T3	PA QL (4ml/30 days)
IMITREX 4 MG/0.5 ML PEN INJECT (<i>sumatriptan succinate</i>)	T3	PA QL (4ml/30 days)
IMITREX 5 MG NASAL SPRAY (<i>sumatriptan</i>)	T3	PA QL (2 boxes/30 days)
IMITREX 50 MG TABLET (<i>sumatriptan succinate</i>)	T3	PA QL (9 tabs/30 days)
IMITREX 6 MG/0.5 ML CARTRIDGES (<i>sumatriptan succinate</i>)	T3	PA QL (4ml/30 days)
IMITREX 6 MG/0.5 ML PEN INJECT (<i>sumatriptan succinate</i>)	T3	PA QL (4ml/30 days)
IMITREX 6 MG/0.5 ML VIAL (<i>sumatriptan succinate</i>)	T3	PA QL (5ml/30 days)

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

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

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

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

List of Prescription Medications

ANALGESICS (Pain Relief and Inflammatory Disease)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ANTI-MIGRAINE PREPARATIONS		
<i>isomethept/dichlphn/acetaminop</i>	T1	
<i>isomethepten/caf/acetaminophen</i>	T1	
MAXALT (<i>rizatriptan</i>)	T3	PA QL (12 tabs/30 days)
MAXALT MLT (<i>rizatriptan</i>)	T3	PA QL (12 tabs/30 days)
MIGRANAL (<i>dihydroergotamine mesylate</i>)	T3	PA QL (8/30 days)
<i>naratriptan hcl</i>	T1	QL (9 tabs/30 days)
NURTEC ODT	T2	PA QL (16 tabs/30 days)
ONZETRA XSAIL	T3	PA QL (1 box/30 days)
RELPAK (<i>eletriptan hbr</i>)	T3	PA QL (6 tabs/30 days)
REYVOW	T3	PA QL (8 tabs/30 days)
<i>rizatriptan (Maxalt Mlt)</i>	T1	QL (12 tabs/30 days)
<i>rizatriptan (Maxalt)</i>	T1	QL (12 tabs/30 days)
<i>rizatriptan</i>	T1	QL (12 tabs/30 days)
QULIPTA	T3	PA QL (1 set/day)
<i>sumatriptan (Imitrex)</i>	T1	QL (2 boxes/30 days)
<i>sumatriptan 4 mg/0.5 ml cart (Imitrex)</i>	T1	QL (4ml/30 days)
<i>sumatriptan 4 mg/0.5 ml inject (Imitrex)</i>	T1	QL (4ml/30 days)
<i>sumatriptan 6 mg/0.5 ml cart (Imitrex)</i>	T1	QL (4ml/30 days)
<i>sumatriptan 6 mg/0.5 ml inject (Imitrex)</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 (Imitrex)</i>	T1	QL (5ml/30 days)
<i>sumatriptan succ 100 mg tablet (Imitrex)</i>	T1	QL (9 tabs/30 days)
<i>sumatriptan succ 25 mg tablet (Imitrex)</i>	T1	QL (18 tabs/28 days)
<i>sumatriptan succ 50 mg tablet (Imitrex)</i>	T1	QL (9 tabs/30 days)
<i>sumatriptan succ/naproxen sod (Treximet)</i>	T1	QL (18 tabs/30 days)
SUMAVEL DOSEPRO	T3	QL (12 injectors/30 days)
TOSYMRA	T3	PA QL (2 boxes/30 days)
TREXIMET 10-60 MG TABLET	T3	PA QL (18 tabs/30 days)
TREXIMET 85-500 MG TABLET (<i>sumatriptan succ-naproxen sod</i>)	T3	PA QL (18 tabs/28 days)
TRUDHESA	T2	PA QL (2 pkgs/30 days)
UBRELVY	T2	PA QL (0.67 tabs/day)
VYEPTI	T3	PA SP
ZAVAPRET	T2	PA QL (6 units/30 days)
ZEMBRACE SYMTOUCH	T3	PA QL (16 injectors/30 days)
<i>zolmitriptan (Zomig Zmt)</i>	T1	QL (12 tabs/30 days)

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

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

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

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

List of Prescription Medications

ANALGESICS (Pain Relief and Inflammatory Disease)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ANTI-MIGRAINE PREPARATIONS		
ZOLMITRIPTAN 2.5 MG NASAL SPRAY	T3	PA QL (12 spray/22 days)
<i>zolmitriptan 2.5 mg tablet (Zomig)</i>	T1	QL (12 tabs/30 days)
ZOLMITRIPTAN 5 MG NASAL SPRAY	T3	PA QL (6 spray/22 days)
<i>zolmitriptan 5 mg tablet (Zomig)</i>	T1	QL (12 tabs/30 days)
ZOMIG 2.5 MG, 5MG NASAL SPRAY	T3	PA QL (2 boxes/30 days)
ZOMIG 2.5 MG TABLET (<i>zolmitriptan</i>)	T3	PA QL (12 tabs/30 days)
ZOMIG 5 MG TABLET (<i>zolmitriptan</i>)	T3	PA QL (12 tabs/30 days)
ZOMIG ZMT (<i>zolmitriptan odt</i>)	T3	PA QL (12 tabs/30 days)
NASAL NSAIDS, COX NON-SELECTIVE, SYSTEMIC ANALGESIC		
KETOROLAC 15.75 MG NASAL SPRAY	T3	QL (10 bots/30 days)
SPRIX	T3	PA QL (10 bots/30 days)
NSAIDS, CYCLOOXYGENASE INHIBITOR-TYPE ANALGESICS		
<i>diclofenac pot 25 mg tablet</i>	T1	PA HD
<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
ZIPSOR	T3	PA 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

T1 – Typically Generics
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T4 – Specialty Medications
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ST – Step Therapy
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List of Prescription Medications

ANALGESICS (Pain Relief and Inflammatory Disease)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
OPIOID ANALGESIC AND NON-SALICYLATE ANALGESICS		
<i>acetaminophen-cod #4 tablet</i>	T1	PA
APADAZ	T3	
BENZHYDROCODONE-ACETAMINOPHEN	T1	
CAPITAL W-CODEINE	T3	
<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
SEGLENTIS	T3	PA QL (4 tabs/day)
OPIOID ANALGESIC AND SALICYLATE ANALGESIC COMB		
<i>oxycodone hcl/aspirin</i>	T1	PA
OPIOID ANALGESIC, ANESTHETIC ADJUNCT AGENTS		
<i>alfentanil 1,000 mcg/2 ml amp</i> (Alfentanil Hcl)	T1	PA
<i>alfentanil 500 mcg/ml ampul</i> (Alfentanil Hcl)	T1	PA
ALFENTANIL 500 MCG/ML AMPULE (<i>alfentanil hcl</i>)	T3	PA
<i>fentanyl 1,000 mcg/20 ml vial</i>	T1	
<i>fentanyl 100 mcg/2 ml ampul</i>	T1	

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List of Prescription Medications

ANALGESICS (Pain Relief and Inflammatory Disease)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
OPIOID ANALGESIC, ANESTHETIC ADJUNCT AGENTS (cont.)		
<i>fentanyl 100 mcg/2 ml vial</i>	T1	
FENTANYL 25 MCG/0.5 ML SYRINGE	T2	
FENTANYL 2, 500 MCG/50 ML BAG	T1	
<i>fentanyl 2, 500 mcg/50 ml vial</i>	T1	
<i>fentanyl 250 mcg/5 ml ampul</i>	T1	
<i>fentanyl 250 mcg/5 ml vial</i>	T1	
FENTANYL 5,000 MCG/100 ML BAG	T1	
<i>fentanyl 50 mcg/ml vial</i>	T1	
<i>fentanyl 500 mcg/10 ml vial</i>	T1	
FENTANYL CITRATE-STERILE WATER	T1	
<i>remifentanyl hcl (Ultiva)</i>	T1	PA
<i>sufentanyl citrate</i>	T1	PA
ULTIVA (<i>remifentanyl hcl</i>)	T3	PA
OPIOID ANALGESIC AND NON-SALICYLATE XANTHINE COMB		
ACETAMIN-CAFF-DIHYDROCODEINE	T1	PA
<i>acetaminophen/caff/dihydrocod (Acetamin-caff-dihydrocodeine)</i>	T1	PA
<i>acetaminophen/caff/dihydrocod (Trezix)</i>	T1	PA
TREZIX	T3	PA
OPIOID ANALGESICS		
ACTIQ (<i>fentanyl citrate</i>)	T3	PA
ARYMO ER	T3	PA
BELBUCA	T2	QL (2 films/day)
<i>buprenorphine (Butrans)</i>	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 0.2 MG/ML SYRINGE	T3	PA
DILAUDID 0.5 MG/0.5 ML SYRINGE	T3	PA
DILAUDID 1 MG/ML SYRINGE	T3	PA
DILAUDID 2 MG TABLET (<i>hydromorphone hcl</i>)	T3	PA
DILAUDID 2 MG/ML SYRINGE	T3	PA
DILAUDID 4 MG TABLET (<i>hydromorphone hcl</i>)	T3	PA
DILAUDID 4 MG/ML SYRINGE	T3	PA
DILAUDID 5 MG/5 ML ORAL LIQUID (<i>hydromorphone hcl</i>)	T3	PA

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ANALGESICS (Pain Relief and Inflammatory Disease)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
OPIOID ANALGESICS		
DILAUDID 8 MG TABLET (<i>hydromorphone hcl</i>)	T3	PA
DURAGESIC (<i>fentanyl</i>)	T3	PA
FENTANYL/BUPIVACAINE/NS <i>fentanyl</i>	T3	
<i>fentanyl</i> (Duragesic)	T1	PA
FENTANYL CITRATE/NACL/ML-NS <i>fentanyl citrate</i> (Actiq)	T1	PA
FENTORA <i>hydrocodone bitartrate</i> (Hysingla Er)	T3	PA
<i>hydrocodone bitartrate</i> (Zohydro Er)	T1	PA
<i>hydromorphone hcl</i>	T1	PA
<i>hydromorphone hcl</i> (Dilaudid)	T1	PA
HYDROMORPHONE 0.25 MG/0.5 ML	T3	PA
HYSINGLA ER (<i>hydrocodone bitartrate er</i>)	T2	PA
KADIAN (<i>morphine sulfate er</i>)	T3	PA
LAZANDA <i>meperidine hcl</i>	T3	PA
<i>methadone hcl</i>	T1	PA
MITIGO	T1	PA
MORPHABOND ER <i>morphine sulfate</i>	T2	PA
<i>morphine sulfate</i> (Kadian)	T1	PA
<i>morphine sulfate</i> (Ms Contin)	T1	PA
MS CONTIN (<i>morphine sulfate er</i>)	T3	PA
<i>nalbuphine hcl</i>	T1	
NUCYNTA	T2	PA
NUCYNTA ER <i>opium/belladonna alkaloids</i>	T3	PA
<i>opium/belladonna alkaloids</i>	T1	PA
OXAYDO <i>oxycodone hcl</i>	T3	PA
<i>oxycodone hcl</i>	T1	PA
OXYCODONE HCL ER <i>oxymorphone hcl</i>	T1	PA
<i>oxymorphone hcl</i>	T1	PA
<i>pentazocine hcl/naloxone hcl</i>	T1	PA
QDOLO	T3	PA QL (80ml/day)
ROXICODONE (<i>oxycodone hcl</i>)	T3	PA

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List of Prescription Medications

ANALGESICS (Pain Relief and Inflammatory Disease)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
OPIOID ANALGESICS		
ROXYBOND	T3	PA
SUBSYS	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)
tramadol hcl (Ultram)	T1	QL (8 tabs/day)
TRAMADOL HCL 25 MG TABLET	T3	PA QL(>= 18 yo 4 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/caffein</i> (Fiorinal With Codeine #3)	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</i> (Fioricet With Codeine)	T1	PA
FIORICET WITH CODEINE (<i>butalb-acetaminoph-caff-codein</i>)	T3	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</i> (Suprane)	T1	
<i>isoflurane</i>	T1	

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List of Prescription Medications

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

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List of Prescription Medications

ANESTHETICS (Pain Relief And Inflammatory Disease)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
LOCAL ANESTHETICS (cont.)		
<i>bupivacaine hcl/epinephrine/pf</i> (Sensorcaine-mpf Epinephrine)	T1	
<i>bupivacaine hcl/pf</i> (Marcaine)	T1	
<i>bupivacaine hcl/pf</i> (Sensorcaine-mpf)	T1	
<i>bupivacaine hcl/pf</i> (Sensorcaine-mpf)	T3	
BUPIVACAINE HCL-0.9% NAACL	T1	
CARBOCAINE	T3	
CARBOCAINE (<i>polocaine</i>)	T3	
CARBOCAINE (<i>polocaine-mpf</i>)	T3	
<i>chloroprocaine hcl/pf</i> (Nesacaine-mpf)	T1	
CITANEST FORTE DENTAL	T3	
CITANEST PLAIN DENTAL	T3	
CLOROTEKAL	T3	
EXPAREL	T3	
LIDOCAINE 0.5MG INTRADERM SYST	T1	
<i>lidocaine 100 mg/10 ml (1%) syr</i>	T1	
LIDOCAINE 100 MG/5 ML (2%) SYR	T1	
LIDOCAINE 200 MG/10 ML (2%) SYR	T1	
LIDOCAINE 200 MG/20 ML (1%) SYR	T1	
LIDOCAINE 40 MG/2 ML (2%) SYRG	T1	
<i>lidocaine 50 mg/5 ml (1%) syrg</i>	T1	
LIDOCAINE 200 MG/10 ML(2%) SYR	T1	
<i>lidocaine hcl</i>	T1	
<i>lidocaine</i> (Lidocan II)	T1	PA
<i>lidocaine hcl 0.5% vial</i> (Xylocaine)	T1	
<i>lidocaine hcl 0.5% vial</i> (Xylocaine-mpf)	T1	
<i>lidocaine hcl 1% 20 mg/2 ml</i> (Xylocaine-mpf)	T1	
<i>lidocaine hcl 1% 20 mg/2 ml vl</i> (Xylocaine-mpf)	T1	
<i>lidocaine hcl 1% 300 mg/30 ml</i> (Xylocaine-mpf)	T1	
<i>lidocaine hcl 1% 50 mg/5 ml</i> (Xylocaine-mpf)	T1	
<i>lidocaine hcl 1% 50 mg/5 ml vl</i> (Xylocaine-mpf)	T1	
<i>lidocaine hcl 1% ampul</i> (Xylocaine-mpf)	T1	
<i>lidocaine hcl 1% 100 mg/10 ml</i> (Xylocaine-Mpf)	T1	

T1 – Typically Generics

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T4 – Specialty Medications

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AGE – Age Requirement

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List of Prescription Medications

ANESTHETICS (Pain Relief And Inflammatory Disease)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
LOCAL ANESTHETICS (cont.)		
<i>lidocaine hcl 1% vial (Xylocaine-mpf)</i>	T1	
<i>lidocaine hcl 1.5% ampul (Xylocaine-mpf)</i>	T1	
<i>lidocaine hcl 10 mg/ml syringe, 100 mg/10 ml syr</i>	T1	
<i>lidocaine hcl 2% 100 mg/5 ml (Xylocaine-mpf)</i>	T1	
<i>lidocaine hcl 2% 40 mg/2 ml (Xylocaine-mpf)</i>	T1	
<i>lidocaine hcl 2% 40 mg/2 ml vl (Xylocaine-mpf)</i>	T1	
<i>lidocaine hcl 2% ampul (Xylocaine-mpf)</i>	T1	
<i>lidocaine hcl 2% jel urojet ac</i>	T1	
<i>lidocaine hcl 2% jelly</i>	T1	
<i>lidocaine hcl 2% jelly uro-jet</i>	T1	
<i>lidocaine hcl 2% vial (Xylocaine)</i>	T1	
<i>lidocaine hcl 2% vial (Xylocaine-mpf)</i>	T1	
LIDOCAINE HCL 200 MG/10 ML SYR	T1	
LIDOCAINE HCL 30 MG/3 ML SYR	T1	
<i>lidocaine hcl 4% ampul, 4% solution</i>	T1	
<i>lidocaine hcl/dextrose 7.5%/pf</i>	T1	
<i>lidocaine hcl/epinephrine (Xylocaine With Epinephrine)</i>	T1	
<i>lidocaine hcl/epinephrine bit (Lidocaine-epinephrine)</i>	T3	
<i>lidocaine hcl/epinephrine/pf (Xylocaine With Epinephrine)</i>	T1	
<i>lidocaine hcl/epinephrine/pf (Xylocaine-mpf With Epinephrine)</i>	T1	
LIDOCAINE HCL-0.9% NAACL	T1	
LIDOCAINE-EPINEPHRINE	T1	
LIDOCAN II (<i>lidocaine</i>)	T1	
MARCAINE (<i>bupivacaine hcl</i>)	T3	
MARCAINE (<i>sensorcaine</i>)	T3	
MARCAINE (<i>sensorcaine-mpf</i>)	T3	
MARCAINE SPINAL	T3	
MARCAINE-EPINEPHRINE (<i>bupivacaine hcl-epinephrine</i>)	T3	
MARCAINE-EPINEPHRINE (<i>sensorcaine-epinephrine</i>)	T3	
<i>mepivacaine hcl (Carbocaine)</i>	T1	
<i>mepivacaine hcl/pf</i>	T1	
<i>mepivacaine hcl/pf</i>	T3	

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List of Prescription Medications

ANESTHETICS (Pain Relief And Inflammatory Disease)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
LOCAL ANESTHETICS (cont.)		
<i>mepivacaine hcl/pf</i> (Carbocaine)	T1	
NAROPIN	T3	
NESACAINE	T3	
NESACAINE-MPF (<i>chlorprocaine hcl</i>)	T3	
ORABLOC	T3	
POLOCAINE	T1	
<i>ropivacaine 0.2% 20 mg/10 ml</i> (Naropin)	T1	
<i>ropivacaine 0.2% 200 mg/100 ml</i> (Naropin)	T1	
<i>ropivacaine 0.2% 40 mg/20 ml</i> (Naropin)	T1	
<i>ropivacaine 0.2% 400 mg/200 ml</i> (Naropin)	T1	
ROPIVACAINE 0.2% SYRINGE	T1	
<i>ropivacaine 0.5% 100 mg/20 ml</i> (Naropin)	T1	
ROPIVACAINE 0.5% 1000 MG/200ML	T3	
<i>ropivacaine 0.5% 150 mg/30 ml</i> (Naropin)	T1	
ROPIVACAINE 0.5% 500 MG/100 ML	T3	
ROPIVACAINE 0.5% BAG	T1	
<i>ropivacaine 0.75% 150 mg/20 ml</i> (Naropin)	T1	
<i>ropivacaine 1% 100 mg/10 ml v1</i> (Naropin)	T1	
<i>ropivacaine 1% 200 mg/20 ml v1</i> (Naropin)	T1	
ROPIVACAINE 50 MG/10 ML SYRNG	T1	
ROPIVACAINE HCL 0.2% ON-Q PUMP	T1	
ROPIVACAINE HCL 0.5% SYRINGE	T1	
ROPIVACAINE HCL-0.9% NACL	T1	
ROPIVACAINE HCL-NACL	T1	
SENSORC MPF 0.75%-EPI 1:200000	T3	
SENSORCAINE 0.25% VIAL (<i>bupivacaine hcl</i>)	T3	
<i>sensorcaine 0.5% vial</i> (Marcaine)	T1	
SENSORCAINE WITH DEXTROSE	T1	
SENSORCAINE-MPF 0.25% AMPUL (<i>bupivacaine hcl</i>)	T3	
SENSORCAINE-MPF 0.25% VIAL (<i>bupivacaine hcl</i>)	T3	
SENSORCAINE-MPF 0.5% AMPUL (<i>bupivacaine hcl</i>)	T3	
<i>sensorcaine-mpf 0.5% vial</i> (Marcaine)	T1	

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

T1 – Typically Generics
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T4 – Specialty Medications
 PA – Prior Authorization
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ST – Step Therapy
 AGE – Age Requirement
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List of Prescription Medications

ANTI-ARTHRITICS (Pain Relief and Inflammatory Disease)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ANALGESIC/ANTIPYRETICS, SALICYLATES		
DISALCID (<i>salsalate</i>)	T3	HD
<i>salsalate</i> (Disalcid)	T1	HD
ANTI-ARTHRITIC AND CHELATING AGENTS		
CUPRIMINE (<i>penicillamine</i>)	T4	PA SP
DEPEN (<i>penicillamine</i>)	T4	PA SP
<i>penicillamine</i>	T4	PA SP
penicillamine (Depen)	T4	PA SP
ANTI-ARTHRITIC, FOLATE ANTAGONIST AGENTS		
OTREXUP	T2	PA
RASUVO	T3	PA
ANTI-INFLAM. INTERLEUKIN-1 RECEPTOR ANTAGONIST		
KINERET	T4	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	T4	PA QL (1 pack/180 days) SP HD
OTEZLA 30 MG TABLET	T4	PA QL (2 tabs/day) SP HD
ANTI-INFLAMMATORY/ANTIARTHRITICS AGENTS, MISC.		
DUROLANE	T4	PA SP HD
EUFLEXXA	T4	PA SP HD
GEL-ONE	T4	PA SP HD
GELSYN-3	T4	PA SP HD
GENVISC 850	T4	PA SP
HYALGAN	T4	PA SP HD
HYMOVIS	T4	PA SP HD
MONOVISC	T4	PA SP HD
ORTHOVISC	T4	PA SP HD
SODIUM HYALURONATE	T4	PA SP

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ANTI-ARTHRITICS (Pain Relief and Inflammatory Disease)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ANTI-INFLAMMATORY/ANTIARTHRITICS AGENTS, MISC.		
SUPARTZ FX	T4	PA SP HD
SYNOJOYNT	T4	PA SP
SYNVISC	T4	PA SP HD
SYNVISC-ONE	T4	PA SP HD
TRILURON	T4	PA SP HD
TRIVISC	T4	PA SP
VISCO-3	T4	PA SP HD
ANTI-INFLAMMATORY, SEL.COSTIM.MOD., T-CELL INHIBITOR		
ORENCIA	T4	PA QL (4 syringes/28 days) SP HD
ORENCIA CLICKJECT	T4	PA QL (4 injectors/28 days) SP HD
COLCHICINE		
<i>colchicine 0.6mg capsule</i>	T1	HD
<i>colchicine (Colcrys)</i>	T1	HD
COLCRYS (<i>colchicine</i>)	T3	HD
GLOPERBA	T3	PA QL (10ml/day) HD
MITIGARE (<i>colchicine</i>)	T3	HD
GOLD SALTS		
RIDAURA	T2	
HYPERURICEMIA TX - URATE-OXIDASE ENZYME-TYPE		
ELITEK	T4	SP
KRYSTEXXA	T4	PA SP
HYPERURICEMIA TX - XANTHINE OXIDASE INHIBITORS		
<i>allopurinol (Zyloprim)</i>	T1	HD
<i>febuxostat 40 mg tablet (Uloric)</i>	T1	QL (1 tab/day) HD
<i>febuxostat 80 mg tablet (Uloric)</i>	T1	HD
ULORIC 40 MG TABLET (<i>febuxostat</i>)	T3	QL (1 tab/day) HD
ULORIC 80 MG TABLET (<i>febuxostat</i>)	T3	HD
ZYLOPRIM (<i>allopurinol</i>)	T3	HD
JANUS KINASE (JAK) INHIBITORS		
CIBINQO	T4	PA QL (30 tabs/30 days) SP
LITFULO	T4	PA QL(1 cap/day) SP HD
OLUMIANT	T4	PA QL (1 tab/day) SP HD
RINVOQ	T4	PA QL (1 tab/day) SP HD
XELJANZ 1 MG/ML SOLUTION	T4	PA QL (480ML/22 Days) SP HD
XELJANZ 10 MG TABLET	T4	PA QL (2 tabs/day) SP HD
XELJANZ 5 MG TABLET	T4	PA QL (2 tabs/day) SP HD
XELJANZ XR	T4	PA QL (1 tab/day) SP HD

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List of Prescription Medications

ANTI-ARTHRITICS (Pain Relief and Inflammatory Disease)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
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NSAID ANALGESIC AND NON-SALICYLATE ANALGESIC COMB

COMBOGESIC IV	T3	PA HD
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NSAID AND HISTAMINE H2 RECEPTOR ANTAGONIST COMB.

DUEXIS	T3	PA HD
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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
COXANTO	T3	PA HD
DAYPRO (<i>oxaprozin</i>)	T3	ST HD
<i>diclofenac sod dr 25 mg tab</i>	T1	HD
<i>diclofenac sod dr 50 mg tab</i>	T1	HD
<i>diclofenac sod dr 75 mg tab</i>	T1	HD
<i>diclofenac sod ec 25 mg tab</i>	T1	HD
<i>diclofenac sod ec 50 mg tab</i>	T1	HD
<i>diclofenac sod ec 75 mg tab</i>	T1	HD
<i>diclofenac sodium</i>	T1	HD
EC-NAPROSYN (<i>naproxen</i>)	T3	ST HD
<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	PA 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
<i>naproxen</i> (Ec-naprosyn)	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		
<i>naproxen</i> (Naprosyn)	T1	HD
<i>naproxen sodium</i> (Anaprox Ds)	T1	HD
<i>oxaprozin 600 mg caplet</i> (Daypro)	T1	HD
<i>oxaprozin 600 mg tablet</i> (Daypro)	T1	HD
OXAPROZIN 300 MG CAPSULE	T3	PA 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>sulindac</i>	T1	HD
<i>tolmetin sodium</i>	T1	HD
NSAIDS, CYCLOOXYGENASE-2(COX-2) SELECTIVE INHIBITOR		
CELEBREX 100 MG CAPSULE (<i>celecoxib</i>)	T3	QL (2 caps/day) ST HD
CELEBREX 200 MG CAPSULE (<i>celecoxib</i>)	T3	QL (2 caps/day) ST HD
CELEBREX 400 MG CAPSULE (<i>celecoxib</i>)	T3	QL (1 cap/day) ST HD
CELEBREX 50 MG CAPSULE (<i>celecoxib</i>)	T3	QL (2 caps/day) ST HD
<i>celecoxib 100 mg capsule</i> (Celebrex)	T1	QL(2 CAPS/DAY) HD
<i>celecoxib 200 mg capsule</i> (Celebrex)	T1	QL (2 caps/day) HD
<i>celecoxib 400 mg capsule</i> (Celebrex)	T1	QL (1 cap/day) HD
<i>celecoxib 50 mg capsule</i> (Celebrex)	T1	QL (2 caps/day) HD
URICOSURIC AGENTS		
<i>probenecid</i>	T1	HD
<i>probenecid/colchicine</i>	T1	HD
ANTI-ASTHMATICS (Asthma/COPD/Respiratory)		
5-LIPOXYGENASE INHIBITORS		
<i>zileuton</i>	T1	HD
ANTICHOLINERGICS, ORALLY INHALED LONG ACTING		
INCRUSE ELLIPTA	T2	HD
SPIRIVA RESPIMAT	T2	HD
ANTICHOLINERGICS, ORALLY INHALED SHORT ACTING		
ATROVENT HFA	T2	HD
<i>ipratropium bromide</i>	T1	HD
BETA-ADRENERGIC AGENTS		
<i>albuterol sulf 2 mg/5 ml syrup</i>	T1	HD
<i>albuterol sulfate 2 mg tab</i>	T1	HD
<i>albuterol sulfate 4 mg tab</i>	T1	HD
<i>albuterol sulfate er 4 mg tab</i>	T1	HD
<i>albuterol sulfate er 8 mg tab</i>	T1	HD

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S1 – Step Therapy
AGE – Age Requirement
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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 (cont.)		
<i>metaproterenol sulfate</i>	T1	HD
<i>terbutaline sulfate</i>	T1	HD
BETA-ADRENERGIC AGENTS, INHALED, SHORT ACTING		
<i>albuterol 100 mg/20 ml soln</i>	T1	
<i>albuterol 2.5 mg/0.5 ml sol</i>	T1	
<i>albuterol 5 mg/ml solution</i>	T1	
<i>albuterol sul 0.63 mg/3 ml sol</i>	T1	
<i>albuterol sul 1.25 mg/3 ml sol</i>	T1	
<i>albuterol sul 2.5 mg/3 ml soln</i>	T1	
<i>albuterol sulfate (Albuterol Sulfate Hfa)</i>	T1	QL (18gm/30 days)
ALBUTEROL SULFATE HFA	T1	QL (18gm/30 days)
<i>levalbuterol hcl (Xopenex Concentrate)</i>	T1	
<i>levalbuterol hcl (Xopenex)</i>	T1	
XOPENEX (<i>levalbuterol hcl</i>)	T3	
XOPENEX CONCENTRATE (<i>levalbuterol concentrate</i>)	T3	
BETA-ADRENERGIC AGENTS, INHALED, ULTRA-LONG ACTING		
ARCAPTA NEOHALER	T3	HD
STRIVERDI RESPIMAT	T2	QL(1 inhaler/30 days) HD
BETA-ADRENERGIC AGENTS, ORALLY INHALED, LONG ACTING		
SEREVENT DISKUS	T3	ST QL(1 blister/30 days) HD
BETA-ADRENERGIC AND ANTICHOLINERGIC COMBO, INHALED		
ANORO ELLIPTA	T2	HD
BEVESPI AEROSPHERE	T3	PA QL(1 inhaler/30 days) HD
COMBIVENT RESPIMAT	T2	HD
<i>ipratropium/albuterol sulfate</i>	T1	HD
STIOLTO RESPIMAT INHAL SPRAY	T2	HD
BETA-ADRENERGIC AGENTS AND GLUCOCORTICOID COMBO, INHALED		
ADVAIR HFA	T2	HD
AIRDUO DIGIHALER	T3	ST HD
AIRSUPRA	T3	PA QL(1 GM/28 DAYS) HD
BREO ELLIPTA	T2	QL(1 inhaler/30 days) HD
<i>budesonide/formoterol fumarate (Symbicort)</i>	T1	QL HD
DULERA	T2	HD
<i>fluticasone propion/salmeterol</i>	T1	HD
<i>fluticasone-salmeterol 100-50 (Advair Diskus)</i>	T3	QL(1 inhaler/30 days) HD
<i>fluticasone-salmeterol 250-50 (Advair Diskus)</i>	T3	QL(1 inhaler/30 days) HD
<i>fluticasone-salmeterol 500-50 (Advair Diskus)</i>	T3	QL(1 inhaler/30 days) HD

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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 (cont.)		
FLUTICASONE-SALMETEROL 113-14	T1	QL(1 inhaler/30 days) HD
FLUTICASONE-SALMETEROL 232-14	T1	QL(1 inhaler/30 days) HD
FLUTICASONE-SALMETEROL 55-14	T1	QL(1 inhaler/30 days) HD
SYMBICORT	T3	ST QL(1 inhaler/30 days) HD
BETA-ADRENERGIC-ANTICHOLINERGIC-GLUCOCORT, INHALED		
BREZTRI AEROSPHERE	T2	
TRELEGY ELLIPTA	T2	
GLUCOCORTICIDS, ORALLY INHALED		
ALVESCO	T2	HD
<i>budesonide</i> (Pulmicort)	T1	HD
FLOVENT DISKUS	T3	PA QL(1 inhalers/30 days) HD
FLOVENT HFA	T2	PA QL(1 inhalers/30 days) HD
FLUTICASONE PROP DISKUS	T3	PA QL(1 inhaler/30 days) HD
PULMICORT (<i>budesonide</i>)	T3	HD
PULMICORT FLEXHALER	T3	PA HD
QVAR REDIHALER	T2	HD
INTERLEUKIN-5(IL-5) RECEPTOR ALPHA ANTAGONIST, MAB		
FASENRA PEN	T4	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	T4	PA SP HD
MONOCLONAL ANTIBODY - INTERLEUKIN-5 ANTAGONISTS		
NUCALA	T4	PA SP HD
MUCOLYTICS		
<i>acetylcysteine</i>	T1	
PHOSPHODIESTERASE-4 (PDE4) INHIBITORS		
DALIRESP 250 MCG TABLET	T3	QL (28 tabs/180 days) HD
DALIRESP 500 MCG TABLET	T3	QL (2 tabs/day) HD
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	
CIPRODEX (<i>ciprofloxacin-dexamethasone</i>)	T3	PA
<i>ciprofloxacin hcl/dexameth</i> (Ciprodex)	T1	
CIPROFLOXACIN HCL-FLUOCINOLONE	T3	
OTOVEL	T3	
ANTIBIOTICS (Eye Conditions)		
EYE ANTIBIOTIC AND GLUCOCORTICOID COMBINATIONS		
MAXITROL (<i>neomycin-polymyxin-dexameth</i>)	T3	PA
<i>neomycin/bacit/p-myx/hydrocort</i>	T1	
<i>neomycin/polymyxin b/dexametha</i> (Maxitrol)	T1	
<i>neomycin/polymyxin b/hydrocort</i>	T1	
TOBRADEX EYE DROPS (<i>tobramycin-dexamethasone</i>)	T3	PA
TOBRADEX EYE OINTMENT	T2	
TOBRADEX ST	T3	
<i>tobramycin/dexamethasone</i> (Tobradex)	T1	
ZYLET	T3	
EYE SULFONAMIDES		
BLEPH-10 (<i>sulfacetamide sodium</i>)	T3	
BLEPHAMIDE	T2	
<i>sulfacetamide sodium</i>	T1	
<i>sulfacetamide sodium</i> (Bleph-10)	T1	
<i>sulfacetamide/prednisolone sp</i>	T1	
OPHTHALMIC ANTIBIOTICS		
AZASITE	T2	
BACIGUENT (<i>bacitracin</i>)	T3	
<i>bacitracin</i> (Baciguent)	T1	
<i>bacitracin/polymyxin b sulfate</i>	T1	
BESIVANCE	T2	

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List of Prescription Medications

ANTIBIOTICS (Eye Conditions) (cont.)			
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits	
OPHTHALMIC ANTIBIOTICS (cont.)			
CILOXAN	T2		
<i>erythromycin base</i>	T1		
<i>gatifloxacin (Zymaxid)</i>	T1		
<i>gentamicin sulfate</i>	T1		
<i>levofloxacin</i>	T1		
MOXEZA (<i>moxifloxacin</i>)	T3		
<i>moxifloxacin hcl (Moxeza)</i>	T1		
<i>moxifloxacin hcl (Vigamox)</i>	T1		
<i>neomycin sulf/bacitracin/poly</i>	T1		
<i>neomycin/polymyxn b/gramicidin</i>	T1		
OCUFLOX (<i>ofloxacin</i>)	T3	PA	
<i>ofloxacin (Ocuflax)</i>	T1		
<i>polymyxin b sulf/trimethoprim</i>	T1		
<i>tobramycin 0.3% eye drop (Tobrex)</i>	T1		
TOBEX	T3	PA	
VIGAMOX (<i>moxifloxacin</i>)	T3	PA	
ZYMAXID (<i>gatifloxacin</i>)	T3	PA	
ANTIBIOTICS (Infections)			
2ND GEN. ANAEROBIC ANTIPROTOZOAL-ANTIBACTERIAL			
SOLOSEC	T2		
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 (Bactrim Ds)</i>	T1		
<i>sulfamethoxazole/trimethoprim (Bactrim)</i>	T1		
AMINOGLYCOSIDE ANTIBIOTICS			
<i>amikacin sulfate</i>	T1		
ARIKAYCE	T3	PA SP	
BETHKIS (<i>tobramycin</i>)	T4	PA QL (8ml/day) SP HD	
<i>gentamicin in nacl, iso-osm</i>	T1		
<i>gentamicin sulfate</i>	T1		
GENTAMICIN SULFATE IN NS	T1		
<i>gentamicin sulfate/pf</i>	T1		
T1 – Typically Generics	T4 – Specialty Medications	ST – Step Therapy	HD – May require home delivery pharmacy
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List of Prescription Medications

ANTIBIOTICS (Infections)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
AMINOGLYCOSIDE ANTIBIOTICS (cont.)		
KITABIS PAK	T4	PA QL (10ml/day) SP HD
<i>neomycin sulfate</i>	T1	
STREPTOMYCIN SULFATE	T1	
TOBI (<i>tobramycin</i>)	T4	PA QL (10ml/day) SP HD
TOBI PODHALER	T4	PA QL (8 caps/day) SP HD
<i>tobramycin 300 mg/4 ml ampule</i> (Bethkis)	T4	PA QL (28 Therapy/56 Days) SP HD
<i>tobramycin 300 mg/5 ml ampule</i> (Tobi)	T4	PA QL (10ml/day) SP HD
TOBRAMYCIN PAK 300 MG/5 ML	T4	PA QL (10ml/day) SP HD
<i>tobramycin sulfate</i>	T1	
<i>tobramycin/sodium chloride</i>	T1	
ZEMDRI	T3	
ANAEROBIC ANTIPROTOZOAL-ANTIBACTERIAL AGENTS		
FLAGYL (<i>metronidazole</i>)	T3	
LIKMEZ	T3	PA
<i>metronidazole</i> (Flagyl)	T1	
<i>metronidazole/sodium chloride</i>	T1	
<i>metronidazole/sodium chloride</i>	T3	
ANTIBIOTIC, ANTIBACTERIAL, MISC.		
<i>fosfomycin tromethamine</i> (Monurol)	T1	
HIPREX (<i>methenamine hippurate</i>)	T3	
<i>meth/meblue/sod phos/psal/hyos</i>	T1	
<i>meth/meblue/sod phos/psal/hyos</i>	T3	
<i>meth/meblue/sod phos/psal/hyos</i> (Uribel)	T1	
<i>methen/mbblue/sal/sod phos/hyos</i>	T1	
<i>methenam/m.blue/salicyl/hyoscy</i>	T1	
<i>methenam/sod phos/mblue/hyoscy</i>	T1	
<i>methenam/sod phos/mblue/hyoscy</i>	T3	
<i>methenamine hippurate</i> (Hiprex)	T1	
<i>methenamine mandelate</i>	T1	
MONUROL (<i>fosfomycin tromethamine</i>)	T3	
PRIMSOL	T3	
<i>trimethoprim</i>	T1	
URIBEL	T3	
UTA	T3	
ANTIBIOTICS, MISCELLANEOUS, OTHER		
<i>bacitracin</i>	T1	

T1 – Typically Generics
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T4 – Specialty Medications
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List of Prescription Medications

ANTIBIOTICS (Infections)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ANTILEPROTICS		
<i>dapsone 100 mg tablet</i>	T1	
<i>dapsone 25 mg tablet</i>	T1	
THALOMID	T4	PA SP HD
ANTI-MYCOBACTERIUM AGENTS		
<i>ethambutol hcl</i>	T1	HD
<i>ethambutol hcl (Myambutol)</i>	T1	HD
<i>isoniazid</i>	T1	HD
MYAMBUTOL (<i>ethambutol hcl</i>)	T3	HD
PASER	T2	HD
<i>pyrazinamide</i>	T1	HD
<i>rifabutin (Mycobutin)</i>	T1	HD
TRECTOR	T2	HD
ANTI-TUBERCULAR ANTIBIOTICS		
CAPASTAT SULFATE	T3	
CYCLOSERINE	T1	
<i>cycloserine</i>	T1	
PRETOMANID	T3	PA QL (1 tab/day)
PRIFTIN	T3	
RIFADIN (<i>rifampin</i>)	T3	
RIFAMATE	T2	
<i>rifampin</i>	T1	
<i>rifampin (Rifadin)</i>	T1	
RIFATER	T2	
SIRTURO	T4	SP
BETALACTAMS		
AZACTAM (<i>aztreonam</i>)	T3	
<i>aztreonam (Azactam)</i>	T1	
CAYSTON	T4	PA QL (3ml/day) SP HD
CARBAPENEM ANTIBIOTICS (THIENAMYCINS)		
<i>ertapenem sodium (Invanz)</i>	T1	
<i>imipenem/cilastatin sodium</i>	T1	
<i>imipenem/cilastatin sodium (Primaxin)</i>	T1	
INVANZ (<i>ertapenem</i>)	T3	
<i>meropenem (Merrem)</i>	T1	
MEROPENEM-0.9% NACL	T1	
MERREM (<i>meropenem</i>)	T3	

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ANTIBIOTICS (Infections)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
CARBAPENEM ANTIBIOTICS (THIENAMYCINS)		
PRIMAXIN (<i>imipenem-cilastatin sodium</i>)	T3	
RECARBRIO	T3	
VABOMERE	T3	
CEPHALOSPORIN ANTIBIOTICS - 1ST GENERATION		
<i>cefadroxil</i>	T1	
<i>cefazolin sodium</i>	T1	
<i>cefazolin sodium/dextrose, iso</i>	T1	
<i>cefazolin 3 gm vial</i>	T1	
CEFAZOLIN SODIUM-0.9% NACL	T1	
CEFAZOLIN SODIUM-D5W	T1	
CEFAZOLIN SODIUM-DEXTROSE	T1	
CEFAZOLIN SODIUM-STERILE WATER	T1	
<i>cephalexin</i>	T1	
<i>cephalexin</i> (Keflex)	T1	
DAXBIA	T3	
KEFLEX (<i>cephalexin</i>)	T3	
CEPHALOSPORIN ANTIBIOTICS - 2ND GENERATION		
<i>cefaclor</i>	T1	
CEFOTAN	T3	
CEFOTETAN DEXTROSE	T1	
<i>cefotetan disodium</i>	T1	
<i>cefotetan disodium</i> (Cefotan)	T1	
<i>cefoxitin sodium</i>	T1	
<i>cefoxitin sodium/dextrose, iso</i>	T1	
<i>cefprozil</i>	T1	
<i>cefuroxime axetil</i>	T1	
<i>cefuroxime sodium</i> (Zinacef)	T1	
ZINACEF	T3	
ZINACEF (<i>cefuroxime sodium</i>)	T3	
CEPHALOSPORIN ANTIBIOTICS - 3RD GENERATION		
AVYCAZ	T3	
<i>cefdinir</i>	T1	
<i>cefditoren pivoxil</i>	T1	
<i>cefixime</i> (Suprax)	T1	
<i>cefotaxime sodium</i>	T1	

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
CEPHALOSPORIN ANTIBIOTICS - 3RD GENERATION (con't)		
<i>cefepodoxime proxetil</i>	T1	
<i>ceftazidime</i>	T1	
<i>ceftazidime (Fortaz)</i>	T1	
CEFTRIAXONE	T1	
<i>ceftriaxone in is-osm dextrose</i>	T1	
<i>ceftriaxone sodium</i>	T1	
CLAFORAN	T3	
FORTAZ	T3	
FORTAZ (<i>tazicef</i>)	T3	
FORTAZ IN ISO-OSMOTIC DEXTROSE	T3	
SUPRAX	T3	
SUPRAX (<i>cefixime</i>)	T3	
CEPHALOSPORIN ANTIBIOTICS - 4TH GENERATION		
CEFEPIME HCL	T1	
<i>cefepime hcl (Maxipime)</i>	T1	
<i>cefepime in iso-osm dextrose</i>	T1	
CEFEPIME-DEXTROSE	T1	
MAXIPIME	T3	
MAXIPIME (<i>cefepime hcl</i>)	T3	
CEPHALOSPORIN ANTIBIOTICS - SIDEROPHORE		
FETROJA	T3	
CEPHALOSPORINS - 5TH GENERATION		
TEFLARO	T3	
ZERBAXA	T3	
CHLORAMPHENICOL ANTIBIOTICS AND DERIVATIVES		
<i>chloramphenicol sod succinate</i>	T1	
GLYCYLCYCLINES		
<i>tigecycline (Tygacil)</i>	T1	
TYGACIL (<i>tigecycline</i>)	T3	
LINCOSAMIDE ANTIBIOTICS		
CLEOCIN HCL 150 MG CAPSULE (<i>clindamycin hcl</i>)	T3	

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
LINCOSAMIDE ANTIBIOTICS		
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	
CLEOCIN PHOS 150 MG/ML VIAL (<i>clindamycin phosphate</i>)	T3	
CLEOCIN PHOS 300 MG/2 ML VIAL (<i>clindamycin phosphate</i>)	T3	
<i>cleocin phos 300 mg/2ml addvan</i>	T1	
CLEOCIN PHOS 600 MG/4 ML VIAL (<i>clindamycin phosphate</i>)	T3	
CLEOCIN PHOS 600 MG/4ML ADDVAN (<i>clindamycin phosphate</i>)	T3	
CLEOCIN PHOS 9 G/60 ML VIAL (<i>clindamycin phosphate</i>)	T3	
CLEOCIN PHOS 900 MG/6 ML VIAL (<i>clindamycin phosphate</i>)	T3	
CLEOCIN PHOS 900 MG/6ML ADDVAN (<i>clindamycin phosphate</i>)	T3	
CLIN SINGLE USE	T3	
<i>clindamycin hcl</i> (Cleocin Hcl)	T1	
<i>clindamycin palmitate hcl</i> (Cleocin Pediatric)	T1	
<i>clindamycin phosphate</i>	T1	
<i>clindamycin phosphate</i> (Cleocin Phosphate)	T1	
<i>clindamycin phosphate/d5w</i>	T1	
CLINDAMYCIN-0.9% NACL	T1	
LINCOCIN	T3	
<i>lincomycin hcl</i> (Lincocin)	T1	
LIPOGLYCOPEPTIDE ANTIBIOTICS		
DALVANCE	T3	
ORBACTIV	T3	
VIBATIV	T3	
MACROLIDE ANTIBIOTICS		
<i>azithromycin 1 gm pwd packet</i> (Zithromax)	T1	
<i>azithromycin 100 mg/5 ml susp</i> (Zithromax)	T1	
<i>azithromycin 200 mg/5 ml susp</i> (Zithromax)	T1	
<i>azithromycin 200 mg/5 ml susp</i> (Zithromax)	T1	
<i>azithromycin 250 mg tablet</i> (Zithromax)	T1	
<i>azithromycin 500 mg add-van vl</i>	T1	
<i>azithromycin 500 mg tablet</i> (Zithromax Tri-pak)	T1	
<i>azithromycin 600 mg tablet</i>	T1	
<i>azithromycin i.v. 500 mg vial</i> (Zithromax)	T1	

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List of Prescription Medications

ANTIBIOTICS (Infections)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
MACROLIDE ANTIBIOTICS (con't.)		
<i>clarithromycin</i>	T1	
DIFICID 200 MG TABLET	T3	QL (28 tabs/28 days)
DIFICID 40 MG/ML SUSPENSION	T3	QL (5ML/Day)
E.E.S. 200 (<i>erythromycin ethylsuccinate</i>)	T3	PA
ERYPED 200 (<i>erythromycin ethylsuccinate</i>)	T3	
ERYPED 400 (<i>erythromycin ethylsuccinate</i>)	T3	PA
ERY-TAB (<i>erythromycin</i>)	T3	
ERYTHROCIN LACTOBIONATE	T3	
<i>erythromycin base</i>	T1	
<i>erythromycin base</i>	T3	
<i>erythromycin base</i> (Ery-tab)	T1	
<i>erythromycin ethylsuccinate</i>	T1	
<i>erythromycin ethylsuccinate</i>	T3	
<i>erythromycin ethylsuccinate</i> (Eryped 200)	T1	
<i>erythromycin ethylsuccinate</i> (Eryped 400)	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	QL (15 tabs/90 days)
ZITHROMAX 500 MG TABLET (<i>azithromycin</i>)	T3	QL (15 tabs/90 days)
ZITHROMAX I.V. 500 MG VIAL (<i>azithromycin</i>)	T3	
ZITHROMAX TRI-PAK (<i>azithromycin</i>)	T3	QL (15 tabs/90 days)
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</i> (Furadantin)	T1	
<i>nitrofurantoin 25 mg/5 ml susp</i> (Furadantin)	T1	
<i>nitrofurantoin mcr 100 mg cap</i> (Macrofantin)	T1	
<i>nitrofurantoin mcr 25 mg cap</i> (Macrofantin)	T1	
<i>nitrofurantoin mcr 50 mg cap</i> (Macrofantin)	T1	
<i>nitrofurantoin monohyd/m-cryst</i> (Macrobid)	T1	

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List of Prescription Medications

ANTIBIOTICS (Infections)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
OXAZOLIDINONE ANTIBIOTICS (con't.)		
<i>linezolid in 0.9% sodium chlor</i>	T1	
<i>linezolid in dextrose 5% (Zyvox)</i>	T1	
SIVEXTRO 200 MG TABLET	T3	PA
SIVEXTRO 200 MG VIAL	T3	
ZYVOX 100 MG/5 ML SUSPENSION (<i>linezolid</i>)	T3	PA
ZYVOX 200 MG/100 ML-D5W	T3	
ZYVOX 600 MG TABLET (<i>linezolid</i>)	T3	PA
ZYVOX 600 MG/300 ML-D5W	T3	
PENICILLIN ANTIBIOTICS		
<i>amoxicillin</i>	T1	
<i>amoxicillin/potassium clav</i>	T1	
<i>amoxicillin/potassium clav</i> (Augmentin Xr)	T1	
<i>amoxicillin/potassium clav</i> (Augmentin)	T1	
<i>ampicillin sodium</i>	T1	
<i>ampicillin sodium/sulbactam na</i>	T1	
<i>ampicillin sodium/sulbactam na</i> (Unasyn)	T1	
<i>ampicillin trihydrate</i>	T1	
AUGMENTIN	T3	PA
AUGMENTIN (<i>amoxicillin-clavulanate potass</i>)	T3	PA
AUGMENTIN XR (<i>amoxicillin-clavulanate pot er</i>)	T3	PA
BICILLIN C-R	T3	
BICILLIN L-A	T3	
<i>dicloxacillin sodium</i>	T1	
MOXATAG	T3	
<i>nafcillin in dextrose, iso-osm</i>	T1	
<i>nafcillin sodium</i>	T1	
<i>oxacillin in dextrose (iso-osm)</i>	T1	
<i>oxacillin sodium</i>	T1	
<i>penicillin g potassium</i>	T1	
<i>penicillin g sodium</i>	T1	
PENICILLIN GK-ISO-OSM DEXTROSE	T1	
<i>penicillin v potassium</i>	T1	
<i>piperacillin sodium/tazobactam</i>	T1	
<i>piperacillin sodium/tazobactam</i> (Piperacillin-tazobactam)	T1	
<i>piperacillin sodium/tazobactam</i> (Zosyn)	T1	

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ANTIBIOTICS (Infections)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
PENICILLIN ANTIBIOTICS (cont.)		
PIPERACILLIN-TAZOBACTAM	T1	
UNASYN (<i>ampicillin-sulbactam</i>)	T3	
ZOSYN	T3	
ZOSYN (<i>piperacillin-tazobactam</i>)	T3	
PLEUROMUTILIN DERIVATIVES		
XENLETA 150 MG/15 ML VIAL	T3	
XENLETA 600 MG TABLET	T3	PA QL (10 tabs/30 days)
POLYMYXIN ANTIBIOTICS AND DERIVATIVES		
<i>colistin (colistimethate na)</i> (Coly-mycin M Parenteral)	T1	
COLY-MYCIN M PARENTERAL (<i>colistimethate</i>)	T3	
<i>polymyxin b sulfate</i>	T1	
QUINOLONE ANTIBIOTICS		
AVELOX (<i>moxifloxacin hcl</i>)	T3	
AVELOX IV (<i>moxifloxacin</i>)	T2	
BAXDELA 300 MG VIAL	T3	
BAXDELA 450 MG TABLET	T3	PA
CIPRO 10% SUSPENSION (<i>ciprofloxacin</i>)	T2	
CIPRO 250 MG TABLET (<i>ciprofloxacin hcl</i>)	T3	
CIPRO 5% SUSPENSION (<i>ciprofloxacin</i>)	T2	
CIPRO 500 MG TABLET (<i>ciprofloxacin hcl</i>)	T3	
CIPRO I.V. (<i>ciprofloxacin-d5w</i>)	T3	
<i>ciprofloxacin</i> (Cipro)	T1	
<i>ciprofloxacin hcl</i>	T1	
<i>ciprofloxacin hcl</i> (Cipro)	T1	
<i>ciprofloxacin in 5 % dextrose</i>	T1	
<i>ciprofloxacin in 5 % dextrose</i> (Cipro I.v.)	T1	
<i>ciprofloxacin lactate</i>	T1	
<i>ciprofloxacin/ciprofloxacin hcl</i>	T1	
FACTIVE	T3	
<i>levofloxacin</i>	T1	
<i>levofloxacin in dextrose 5 %</i>	T1	
MOXIFLOXACIN	T1	
<i>moxifloxacin hcl</i> (Avelox)	T1	
<i>moxifloxacin-sod.chloride (iso)</i> (Avelox Iv)	T1	
<i>ofloxacin</i>	T1	
RIFAMYCINS AND RELATED DERIVATIVE ANTIBIOTICS		
AEMCOLO	T3	QL (12 tabs/3 days)

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ANTIBIOTICS (Infections)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
RIFAMYCINS AND RELATED DERIVATIVE ANTIBIOTICS		
XIFAXAN 200 MG TABLET	T2	
XIFAXAN 550 MG TABLET	T2	QL (42 tabs/14 days)
STREPTOGRAMIN ANTIBIOTICS		
SYNERCID	T3	
TETRACYCLINE ANTIBIOTICS		
ACTICLATE (<i>doxycycline hyclate</i>)	T3	ST
<i>coremino er 135 mg tablet</i>	T1	
<i>coremino er 45 mg tablet</i>	T1	QL (1 tab/day)
<i>coremino er 90 mg tablet</i>	T1	
<i>demeclocycline hcl</i>	T1	
DORYX	T3	PA
DORYX (<i>doxycycline hyclate</i>)	T3	PA
DORYX MPC	T3	PA
<i>doxycycline 50 mg tablet (Targadox)</i>	T1	PA
<i>doxycycline hyc dr 100 mg tab</i>	T1	PA
<i>doxycycline hyc dr 150 mg tab</i>	T1	PA
<i>doxycycline hyc dr 200 mg tab (Doryx)</i>	T1	PA
<i>doxycycline hyc dr 50 mg tab (Doryx)</i>	T1	PA
<i>doxycycline hyc dr 75 mg tab</i>	T1	PA
DOXYCYCLINE HYC DR 80 MG TAB	T3	PA
<i>doxycycline hyclate</i>	T1	
<i>doxycycline hyclate (Vibramycin)</i>	T1	
<i>doxycycline hyclate 100 mg cap (Vibramycin)</i>	T1	
<i>doxycycline hyclate 100 mg tab</i>	T1	
<i>doxycycline hyclate 100 mg vl</i>	T1	
<i>doxycycline hyclate 150 mg tab (Acticlate)</i>	T1	
<i>doxycycline hyclate 50 mg cap</i>	T1	
<i>doxycycline hyclate 75 mg tab (Acticlate)</i>	T1	
DOXYCYCLINE IR-DR	T1	PA
<i>doxycycline monohydrate</i>	T1	
<i>doxycycline monohydrate (Monodox)</i>	T1	
MINOCIN 100 MG VIAL	T3	
MINOCIN 75 MG PELLETTIZED CAP (<i>minocycline hcl</i>)	T3	PA
MINOCYCLINE ER	T3	ST
<i>minocycline er 105 mg tablet (Solodyn)</i>	T1	

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ANTIBIOTICS (Infections)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
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TETRACYCLINE ANTIBIOTICS (con't.)

<i>minocycline er 115 mg tablet</i> (Solodyn)	T1	
<i>minocycline er 135 mg tablet</i>	T1	
<i>minocycline er 45 mg tablet</i>	T1	QL (1 tab/day)
<i>minocycline er 55 mg tablet</i> (Solodyn)	T1	
<i>minocycline er 65 mg tablet</i> (Solodyn)	T1	
<i>minocycline er 80 mg tablet</i> (Solodyn)	T1	
<i>minocycline er 90 mg tablet</i>	T1	
<i>minocycline hcl</i> (Minocin)	T1	
MINOLIRA ER	T3	ST
MONODOX (<i>mondoxyne nl</i>)	T3	
MONODOX (<i>okebo</i>)	T3	
NUZYRA 100 MG VIAL	T4	PA SP
NUZYRA 150 MG TABLET	T4	PA QL (30 tablets/28 days) SP
ORACEA	T3	PA
SEYSARA	T3	PA
SOLODYN (<i>minocycline hcl er</i>)	T3	PA
SOLOXIDE	T1	PA
TARGADOX	T3	PA
<i>tetracycline hcl</i>	T1	
<i>tetracycline capsule</i>	T1	
<i>tetracycline tablet</i>	T3	PA
VIBRAMYCIN 50 MG/5 ML SYRUP	T3	
XERAHA	T3	
XIMINO	T3	ST

VAGINAL ANTIBIOTICS

CLEOCIN	T3	PA
CLEOCIN (<i>clindamycin phosphate</i>)	T3	PA
<i>clindamycin phosphate</i> (Cleocin)	T1	
CLINDESSE	T3	
METROGEL-VAGINAL (<i>vandazole</i>)	T3	PA
<i>metronidazole</i> (Metrogel-vaginal)	T1	
NUVESSA	T3	PA
XACIATO	T3	

VANCOMYCIN ANTIBIOTICS AND DERIVATIVES

FIRVANQ (<i>vancomycin hcl</i>)	T2	PA
VANCOGIN HCL (<i>vancomycin hcl</i>)	T3	PA

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

T4 – Specialty Medications

PA – Prior Authorization

QL – Quantity Limit

ST – Step Therapy

AGE – Age Requirement

SP – Specialty Medication

HD – May require home delivery pharmacy

PPACA – No Cost-Share Preventive Medication

CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

ANTIBIOTICS (Infections)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
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VANCOMYCIN ANTIBIOTICS AND DERIVATIVES (cont)

VANCOMYCIN 25 MG/ML SOLUTION	T3	PA
<i>vancomycin</i> 50 mg/ml solution	T1	
VANCOMYCIN	T1	
<i>vancomycin 1 gm add-van vial</i>	T1	
<i>vancomycin 1 gm vial</i>	T1	
VANCOMYCIN 1 GRAM/200 ML BAG	T3	
VANCOMYCIN 1.25 GM/250 ML BAG	T3	
VANCOMYCIN 1.5 GRAM/300 ML BAG	T3	
VANCOMYCIN 1.75 GM/350 ML BAG	T3	
VANCOMYCIN 2 GRAM/400 ML BAG	T3	
<i>vancomycin 250 mg/5 ml soln (Firvanq)</i>	T1	
<i>vancomycin 50 mg/5 ml soln (Firvanq)</i>	T1	
<i>vancomycin 500 mg add-van vial</i>	T1	
<i>vancomycin 500 mg vial</i>	T1	
VANCOMYCIN 500 MG/100 ML BAG	T3	
VANCOMYCIN 750 MG ADD-VAN VIAL	T1	
VANCOMYCIN 750 MG/150 ML BAG	T3	
VANCOMYCIN HCL 1.25 GRAM VIAL	T1	
VANCOMYCIN HCL 1.5 GRAM VIAL	T1	
<i>vancomycin hcl 10 gm vial</i>	T1	
<i>vancomycin hcl 125 mg capsule (Vancocin Hcl)</i>	T1	
VANCOMYCIN HCL 1G/200 ML BAG	T1	
<i>vancomycin hcl 250 mg capsule (Vancocin Hcl)</i>	T1	
VANCOMYCIN HCL 250 MG VIAL	T1	
<i>vancomycin hcl 5 gm vial</i>	T1	
<i>vancomycin hcl 750 mg vial</i>	T1	
VANCOMYCIN HCL-0.9% NAACL	T1	
VANCOMYCIN HCL-D5W	T1	

ANTIBIOTICS (Miscellaneous)

CYCLIC LIPOPEPTIDES

CUBICIN (<i>daptomycin</i>)	T3	
CUBICIN RF (<i>daptomycin</i>)	T3	
DAPTOMYCIN	T1	
<i>daptomycin</i> (Cubicin Rf)	T1	

T1 – Typically Generics
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 T3 – Typically Non-Preferred Brands

T4 – Specialty Medications
 PA – Prior Authorization
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List of Prescription Medications

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

T1 – Typically Generics
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List of Prescription Medications

ANTIBIOTICS (Skin Conditions)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
TOPICAL SULFONAMIDES		
<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 (<i>mafenide acetate</i>)	T3	
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% SYR	T1	
CITRATE PHOSPHATE DEXTROSE	T1	
TRICITRASOL	T3	
DIRECT FACTOR XA INHIBITORS		
BEVYXXA	T3	QL (42 caps/42 days)
ELIQUIS	T2	PA
SAVAYSA 15 MG TABLET	T3	PA QL (1 tab/day)
SAVAYSA 30 MG TABLET	T3	PA QL (1 tab/day)
SAVAYSA 60 MG TABLET	T3	PA
XARELTO	T2	PA
HEPARIN AND RELATED PREPARATIONS		
ARIXTRA (<i>fondaparinux sodium</i>)	T4	QL (1 syringe/day) SP
<i>enoxaparin 100 mg/ml syringe</i> (Lovenox)	T4	QL (2 syringes/day) SP
<i>enoxaparin 120 mg/0.8 ml syr</i> (Lovenox)	T4	QL (2 syringes/day) SP
<i>enoxaparin 150 mg/ml syringe</i> (Lovenox)	T4	QL (2 syringes/day) SP
<i>enoxaparin 30 mg/0.3 ml syr</i> (Lovenox)	T4	QL (2 syringes/day) SP
<i>enoxaparin 300 mg/3 ml vial</i> (Lovenox)	T4	QL (1 vial/day) SP
<i>enoxaparin 40 mg/0.4 ml syr</i> (Lovenox)	T4	QL (2 syringes/day) SP
<i>enoxaparin 60 mg/0.6 ml syr</i> (Lovenox)	T4	QL (2 syringes/day) SP
<i>enoxaparin 80 mg/0.8 ml syr</i> (Lovenox)	T4	QL (2 syringes/day) SP
<i>fondaparinux sodium</i> (Arixtra)	T4	QL (1 syringe/day) SP

T1 – Typically Generics
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T4 – Specialty Medications
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List of Prescription Medications

ANTI-COAGULANTS (Blood Thinners/Anti-Clotting)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
HEPARIN AND RELATED PREPARATIONS		
FRAGMIN	T4	QL (2ml/day) SP
<i>heparin 1,000 unit/500 ml-ns</i>	T1	
<i>HEPARIN 2,000 UNIT/1,000 ML-NS (heparin sodium,porcine/ns/pf)</i>	T3	
<i>heparin 2,000 unit/1,000 ml-ns (Heparin Sodium-0.9% Nacl)</i>	T1	
<i>HEPARIN 2,500 UNIT/500 ML-NS</i>	T1	
<i>HEPARIN 30,000 UNIT/1,000-NS</i>	T1	
<i>HEPARIN 5,000 UNIT/1,000 ML-NS</i>	T1	
<i>HEPARIN 5,000 UNIT/500 ML-NS</i>	T1	
<i>heparin 10,000 unit/10 ml vial</i>	T1	
<i>heparin 2,000 unit/2 ml vial</i>	T1	
<i>heparin 30,000 unit/30 ml vial</i>	T1	
<i>heparin 40,000 unit/4 ml vial</i>	T1	
<i>heparin 5,000 unit/ml carpuct</i>	T1	
<i>heparin 50,000 unit/10 ml vial</i>	T1	
<i>heparin 50,000 unit/5 ml vial</i>	T1	
<i>heparin sod 1,000 unit/ml vial</i>	T1	
<i>heparin sod 10,000 unit/ml vl</i>	T1	
<i>heparin sod 20,000 unit/ml vl</i>	T1	
<i>heparin sod 5,000 unit/0.5 ml</i>	T1	
<i>HEPARIN SOD 5,000 UNIT/0.5 ML</i>	T3	
<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	
<i>heparin sod, porcine/0.9 % nacl</i>	T1	
<i>heparin sod, pork in 0.45% nacl</i>	T1	
<i>heparin sodium, porcine</i>	T1	
<i>heparin sodium, porcine/d5w</i>	T1	
<i>heparin sodium, porcine/pf</i>	T1	
<i>HEPARIN SODIUM-0.45% NAACL</i>	T1	
<i>LOVENOX 100 MG/ML SYRINGE (enoxaparin sodium)</i>	T4	QL (2 syringes/day) SP
<i>LOVENOX 120 MG/0.8 ML SYRINGE (enoxaparin sodium)</i>	T4	QL (2 syringes/day) SP
<i>LOVENOX 150 MG/ML SYRINGE (enoxaparin sodium)</i>	T4	QL (2 syringes/day) SP
<i>LOVENOX 30 MG/0.3 ML SYRINGE (enoxaparin sodium)</i>	T4	QL (2 syringes/day) SP
<i>LOVENOX 300 MG/3 ML VIAL (enoxaparin sodium)</i>	T4	QL (1 vial/day) SP
<i>LOVENOX 40 MG/0.4 ML SYRINGE (enoxaparin sodium)</i>	T4	QL (2 syringes/day) SP

T1 – Typically Generics
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T4 – Specialty Medications
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List of Prescription Medications

ANTI-COAGULANTS (Blood Thinners/Anti-Clotting)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
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HEPARIN AND RELATED PREPARATIONS

LOVENOX 60 MG/0.6 ML SYRINGE (<i>enoxaparin sodium</i>)	T4	QL (2 syringes/day) SP
LOVENOX 80 MG/0.8 ML SYRINGE (<i>enoxaparin sodium</i>)	T4	QL (2 syringes/day) SP

THROMBIN INHIBITORS, SELECTIVE, DIRECT, REVERSIBLE

ARGATROBAN	T4	SP HD
ARGATROBAN-0.9% NACL	T4	SP HD
ARGATROBAN-SODIUM CHLORIDE	T4	SP HD
<i>dabigatran etexilate mesylate</i>	T1	PA HD
PRADAXA 110 MG CAPSULE	T3	PA HD
PRADAXA 150 MG CAPSULE	T3	PA HD
PRADAXA 75 MG CAPSULE	T3	PA HD

THROMBIN INHIBITORS, SEL, DIRECT, REVERS-HIRUDIN TYPE

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

ANTIDOTES (Gastrointestinal/Heartburn)

MU-OPIOID RECEPTOR ANTAGONISTS, PERIPHERALLY-ACTING

MOVANTIK	T3	PA
RELISTOR	T3	PA
SYMPROIC	T3	PA

ANTIDOTES (Substance Abuse)

OPIOID ANTAGONISTS

EVZIO	T3	PA QL (0.8ml/day)
KLOXXADO	T2	PA QL (2 sprays/30 days)
<i>naloxone 0.4 mg/ml carpuject</i>	T1	
<i>naloxone 0.4 mg/ml vial</i>	T1	
NALOXONE 2 MG AUTO-INJECTOR	T3	QL (0.8ml/day)
<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)

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

T4 – Specialty Medications
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List of Prescription Medications

ANTIDOTES (Substance Abuse)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
OPIOID ANTAGONISTS		
OPVEE	T3	QL (2 units/30 days)
ZIMHI	T3	QL (2 inj/month)
ANTI-FUNGALS (Eye Conditions)		
OPHTHALMIC ANTI-FUNGAL AGENTS		
NATACYN	T2	
ANTI-FUNGALS (Feminine Products)		
VAGINAL ANTI-FUNGALS		
GNAZOLE 1	T1	
<i>miconazole nitrate</i>	T1	
<i>terconazole</i>	T1	
ANTI-FUNGALS (Infections)		
ANTI-FUNGAL AGENTS		
ANCOBON (<i>flucytosine</i>)	T3	
<i>clotrimazole</i>	T1	
CRESEMBA CAPSULE	T3	PA
CRESEMBA 372 MG VIAL	T3	
DIFLUCAN (<i>fluconazole</i>)	T3	PA
<i>fluconazole</i> (Diflucan)	T1	
<i>fluconazole in dextrose, iso-os</i>	T1	
<i>fluconazole in nacl, iso-osm</i>	T1	
<i>flucytosine</i> (Ancobon)	T1	
<i>itraconazole</i> (Sporanox)	T1	
<i>ketoconazole</i>	T1	
NOXAFIL 300 MG/16.7 ML VIAL (<i>posaconazole</i>)	T3	PA
NOXAFIL 40 MG/ML SUSPENSION (<i>posaconazole</i>)	T3	PA
NOXAFIL DR 100 MG TABLET (<i>posaconazole</i>)	T3	PA
ORAVIG	T3	
<i>posaconazole</i> (Noxafil)	T1	
SPORANOX (<i>itraconazole</i>)	T3	PA
<i>terbinafine hcl</i>	T1	
TOLSURA	T3	
VFEND (<i>voriconazole</i>)	T3	PA
VFEND IV (<i>voriconazole</i>)	T3	
VIVJOA	T3	PA

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List of Prescription Medications

ANTI-FUNGALS (Infections)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ANTI-FUNGAL ANTIBIOTICS		
<i>voriconazole 200 mg tablet (Vfend)</i>	T1	PA
<i>voriconazole 200 mg vial (Vfend Iv)</i>	T1	
<i>voriconazole 40 mg/ml susp (Vfend)</i>	T1	PA
<i>voriconazole 50 mg tablet (Vfend)</i>	T1	PA
ABELCET	T3	
AMBISOME	T3	
<i>amphotericin b</i>	T1	
BREXAFEMME	T3	PA
CANCIDAS (<i>caspofungin acetate</i>)	T3	
<i>caspofungin acetate (Cancidas)</i>	T1	
ERAXIS	T3	
<i>griseofulvin ultramicrosize (Gris-peg)</i>	T1	
<i>griseofulvin, microsize</i>	T1	
GRIS-PEG (<i>griseofulvin ultramicrosize</i>)	T3	
<i>micafungin sodium (Mycamine)</i>	T1	
MYCAMINE (<i>micafungin</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 (Loprox)</i>	T1	
CICLODAN 0.77% CREAM KIT	T3	
<i>ciclodan 8% solution</i>	T1	
<i>ciclopirox</i>	T1	
<i>ciclopirox (Loprox)</i>	T1	
<i>ciclopirox olamine (Loprox)</i>	T1	
<i>econazole nitrate</i>	T1	
ECOZA	T3	
ERTACZO	T3	PA
EXELDERM	T3	PA
EXODERM	T1	
EXTINA (<i>ketodan</i>)	T3	PA
JUBLIA	T3	PA

T1 – Typically Generics
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List of Prescription Medications

ANTI-FUNGALS (Skin Conditions)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
TOPICAL ANTI-FUNGALS (con't.)		
KERYDIN	T3	PA
KERYDIN (<i>tavaborole</i>)	T3	PA
<i>ketoconazole</i>	T1	
<i>ketoconazole</i> (Extina)	T1	
<i>ketoconazole/skin cleanser 28</i>	T1	
LOPROX 0.77% CREAM (<i>ciclopirox</i>)	T3	PA
LOPROX 0.77% TOPICAL SUSP (<i>ciclopirox</i>)	T3	
LOPROX 1% SHAMPOO (<i>ciclopirox</i>)	T3	PA
LULICONAZOLE	T1	
LUZU	T3	PA
MICONAZOLE-ZINC OXIDE-PETROLTM	T1	PA
<i>naftifine hcl</i>	T1	
<i>naftifine hcl</i> (Naftin)	T1	
NAFTIN (<i>naftifine hcl</i>)	T2	
<i>nystatin</i>	T1	
<i>nystatin/triamcinolone acet</i>	T1	
<i>oxiconazole nitrate</i> (Oxistat)	T1	
OXISTAT 1% CREAM (<i>oxiconazole nitrate</i>)	T3	PA
OXISTAT 1% LOTION	T2	PA
SULCONAZOLE NITRATE	T3	PA
<i>tavaborole</i> (Kerydin)	T1	PA
VUSION	T3	PA
XOLEGEL	T3	PA

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

1ST GEN ANTIHISTAMINE AND DECONGESTANT COMBINATION

<i>phenylephrine hcl/prometh hcl</i>	T1	
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2ND GEN ANTIHISTAMINE AND DECONGESTANT COMBINATION

CLARINEX-D 12 HOUR	T3	
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ANTI-HISTAMINES (Allergy/Nasal Sprays)

ANTI-HISTAMINES - 1ST GENERATION

<i>carbinoxamine 4 mg/5 ml liquid</i>	T1	
<i>carbinoxamine maleate 4 mg tab</i>	T1	
<i>carbinoxamine maleate 6 mg tab</i> (Ryvent)	T1	PA
<i>clemastine fumarate</i>	T1	
<i>cyproheptadine hcl</i> (Cyproheptadine Hcl)	T1	
<i>dexchlorpheniramine maleate</i> (Ryclora)	T1	

T1 – Typically Generics
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List of Prescription Medications

ANTIHISTAMINES (Allergy/Nasal Sprays)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
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ANTIHISTAMINES - 1ST GENERATION

<i>diphenhydramine hcl</i>	T1	
<i>hydroxyzine hcl</i>	T1	
<i>hydroxyzine pamoate</i>	T1	
<i>hydroxyzine pamoate (Vistaril)</i>	T1	
KARBINAL ER	T3	PA
PHENERGAN (<i>promethazine hcl</i>)	T3	
<i>promethazine hcl</i>	T1	
<i>promethazine hcl (Phenergan)</i>	T1	
RYCLORA (<i>dexchlorpheniramine maleate</i>)	T3	
RYVENT	T3	PA
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 (Clarinx)</i>	T1	HD
QUZYTIR	T3	HD

ANTIHISTAMINES (Eye Conditions)

EYE ANTIHISTAMINES

<i>azelastine hcl 0.05% drops</i>	T1	
BEPREVE	T3	PA
<i>epinastine hcl</i>	T1	
LASTACFT	T3	
<i>olopatadine hcl 0.1% eye drops</i>	T1	
<i>olopatadine hcl 0.2% eye drop (Pataday)</i>	T1	
PATADAY (<i>olopatadine hcl</i>)	T3	
PATANOL 0.1%	T3	PA
PAZEO	T2	
ZERVIATE	T2	

ANTI-HYPERGLYCEMICS (Diabetes)

ANTIHYPERGLY, DPP-4 ENZYME INHIB.-THIAZOLIDINEDIONE

ALOGLIPTIN-PIOGLITAZONE	T1	PA QL (1 tab/day) HD
OSENI	T3	PA QL (1 tab/day) HD

T1 – Typically Generics
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List of Prescription Medications

ANTI-HYPERGLYCEMICS (Diabetes)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ANTIHYPERGLY, INCRETIN MIMETIC (GLP-I RECEPTOR AGONIST)		
BYDUREON	T2	QL (4 vials/28 days) ST HD
BYDUREON BCISE	T2	QL (4 pens/28 days) ST HD
BYDUREON PEN	T2	QL (4 pens/28 days) ST HD
BYETTA	T2	QL (1 pen/30 days) ST HD
OZEMPIC 0.25-0.5 MG DOSE PEN	T2	QL (2 pens/28 days) ST HD
OZEMPIC 1 MG DOSE PEN (1.5 ML)	T2	QL (2 pens/28 days) ST HD
OZEMPIC 1 MG DOSE PEN (3 ML)	T2	QL (3ML/21 Days) ST HD
REZVOGLAR KWIKPEN	T2	PA
RYBELSUS	T2	QL (1 tab/day) ST HD
TRULICITY 0.75 MG/0.5 ML PEN	T2	QL (4 pens/28 days) ST HD
TRULICITY 1.5 MG/0.5 ML PEN	T2	QL (4 pens/28 days) ST HD
TRULICITY 3 MG/0.5 ML PEN	T2	QL (2 ML/28 Days) ST HD
TRULICITY 4.5 MG/0.5 ML PEN	T2	QL (2 ML/28 Days) ST HD
VICTOZA 2-PAK	T3	QL (3 pens/30 days) ST HD
VICTOZA 3-PAK	T3	QL (3 pens/30 days) ST HD
ANTI-HYPERGLY, INSULIN, LONG ACT-GLP-I RECEPTOR AGONIST		
SOLIQUA 100-33	T2	HD
XULTOPHY 100-3.6	T3	PA HD
ANTI-HYPERGLYCEMIC-SODIUM/GLUCOCOTRANSPORT2(SGLT2) INHIBITORS		
FARXIGA	T2	QL (1 tab/day) ST HD
INVOKANA	T2	QL (1 tab/day) ST HD
JARDIANCE	T2	QL (1 tab/day) ST HD
STEGLATRO	T2	QL (1 tab/day) ST HD
ANTI-HYPERGLYCEMIC-DOPAMINE RECEPTOR AGONISTS		
CYCLOSET	T3	HD
ANTI-HYPERGLYCEMIC, 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-HYPERGLYCEMIC, AMYLIN ANALOG-TYPE		
SYMLINPEN 120	T2	HD
SYMLINPEN 60	T2	HD

T1 – Typically Generics
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T4 – Specialty Medications
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ST – Step Therapy
 AGE – Age Requirement
 SP – Specialty Medication

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

List of Prescription Medications

ANTI-HYPERGLYCEMICS (Diabetes)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ANTI-HYPERGLYCEMIC, BIGUANIDE TYPE		
FORTAMET (<i>metformin er osmotic</i>)	T3	PA HD
GLUCOPHAGE XR (<i>metformin hcl er</i>)	T3	HD
GLUMETZA (<i>metformin er gastric</i>)	T3	PA HD
<i>metformin hcl</i>	T1	HD
<i>metformin hcl</i> (Fortamet)	T1	PA HD
<i>metformin hcl</i> (Glucophage Xr)	T1	HD
<i>metformin hcl</i> (Glumetza)	T1	PA HD
<i>metformin hcl</i> (Riomet)	T1	HD
RIOMET (<i>metformin hcl</i>)	T3	HD
RIOMET ER	T3	HD
ANTI-HYPERGLYCEMIC, DPP-4 INHIBITORS		
ALOGLIPTIN	T1	PA QL (1 tab/day) HD
JANUVIA	T2	QL (1 tab/day) ST HD
NESINA	T3	PA QL (1 tab/day) HD
ONGLYZA	T3	PA QL (1 tab/day) HD
TRADJENTA	T3	PA QL (2 tabs/day) HD
ZITUVIO	T3	PA QL(1 tab/day) 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
<i>glipizide</i> (Glucotrol)	T1	HD
GLUCOTROL (<i>glipizide</i>)	T3	HD
GLUCOTROL XL (<i>glipizide xl</i>)	T3	HD
<i>glyburide, micronized</i> (Glynase)	T1	HD
GLYNASE (<i>glyburide micronized</i>)	T3	HD
<i>nateglinide</i> (Starlix)	T1	HD
<i>repaglinide</i>	T1	HD
STARLIX (<i>nateglinide</i>)	T3	HD
<i>tolbutamide</i>	T1	HD
ANTI-HYPERGLYCEMIC, SGLT-2 AND DPP-4 INHIBITOR COMB		
GLYXAMBI	T2	QL (1 tab/day) ST HD
QTERN	T3	QL (1 tab/day) ST HD
STEGLUJAN	T3	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

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List of Prescription Medications

ANTI-HYPERGLYCEMICS (Diabetes)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
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.		
ALOGLIPTIN-METFORMIN	T1	PA QL (2 tabs/day) HD
JANUMET	T2	QL (2 tabs/day) ST HD
JANUMET XR 100-1,000 MG TABLET	T2	QL (1 tab/day) ST HD
JANUMET XR 50-1,000 MG TABLET	T2	QL (2 tabs/day) ST HD
JANUMET XR 50-500 MG TABLET	T2	QL (1 tab/day) ST HD
JENTADUETO	T3	PA QL (4 tabs/day) HD
JENTADUETO XR 2.5 MG-1,000 MG	T3	PA QL (2 tabs/day) HD
JENTADUETO XR 5 MG-1,000 MG TB	T3	PA QL (1 tab/day) HD
KAZANO	T3	PA QL (2 tabs/day) HD
KOMBIGLYZE XR 2.5-1,000 MG TAB	T3	PA QL (2 tabs/day) HD
KOMBIGLYZE XR 5-1,000 MG TAB	T3	PA QL (1 tab/day) HD
KOMBIGLYZE XR 5-500 MG TABLET	T3	PA QL (1 tab/day) HD
ANTI-HYPERGLYCEMIC, INSULIN-RELEASE STIM.-BIGUANIDE		
<i>glipizide/metformin hcl</i>	T1	HD
<i>glyburide/metformin hcl</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</i> (Actos)	T1	HD
ANTI-HYPERGLYCEMIC-GLUCOCORTICOID RECEPTOR BLOCKER		
KORLYM	T3	PA SP
ANTI-HYPERGLYCEMIC-SGLT2 INHIBITOR-BIGUANIDE COMBS.		
DAPAGLIFLOZIN-METFO ER 10-1000	T3	PA QL(1 TAB/DAY) HD
DAPAGLIFLOZIN-METFOR ER 5-1000	T3	PA QL(2 TABS/DAY) HD
INVOKAMET	T2	QL (2 tabs/day) ST HD
INVOKAMET XR	T2	QL (2 tabs/day) ST HD
SEGLUROMET	T2	QL (2 tabs/day) ST HD
SYNJARDY	T2	QL (2 tabs/day) ST HD
SYNJARDY XR 10-1,000 MG TABLET	T2	QL (2 tabs/day) ST HD
SYNJARDY XR 12.5-1,000 MG TAB	T2	QL (2 tabs/day) ST HD

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List of Prescription Medications

ANTI-HYPERGLYCEMICS (Diabetes)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
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ANTI-HYPERGLYCEMIC-SGLT2 INHIBITOR-BIGUANIDE COMBS. (con't.)

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

ANTI-HYPERGLY-SGLT-2 INHIB, DPP-4 INHIB, BIGUANIDE CB

TRIJARDY XR	T2	QL (1 tab/day) ST HD
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ANTIHYPERGLYCEMIC-SOD/GLUC COTRANSPORT2(SGLT2) INH

BRENZAVVY	T3	PA QL(1 tabs/day) HD
DAPAGLIFLOZIN	T3	PA QL(1 tab/day) HD

INSULINS

ADMELOG	T3	QL (1.5ml/day) HD
ADMELOG SOLOSTAR	T3	QL (1.5ml/day) HD
AFREZZA 12 UNIT CARTRIDGE	T3	PA QL (12 cartridges/day) HD
AFREZZA 4 UNIT CARTRIDGE	T3	PA QL (36 cartridges/day) HD
AFREZZA 4 UNIT/8 UNIT/12 UNIT	T3	PA QL (6 cartridges/day) HD
AFREZZA 8 UNIT CARTRIDGE	T3	PA QL (18 cartridges/day) HD
AFREZZA 90-4 UNIT / 90-8 UNIT	T3	PA QL (12 cartridges/day) HD
AFREZZA 90-8 UNIT / 90-12 UNIT	T3	PA QL (6 cartridges/day) HD
APIDRA	T3	QL (1.5ml/day) HD
APIDRA SOLOSTAR	T3	QL (1.5ml/day) HD
BASAGLAR KWIKPEN U-100	T2	QL (1.5ml/day) HD
FIASP	T2	QL (1.5ml/day) HD
FIASP FLEXTOUCH	T2	QL (1.5ml/day) HD
FIASP PENFILL	T2	QL (1.5ml/day) HD
HUMALOG	T2	QL (1.5ml/day) HD
HUMALOG JUNIOR KWIKPEN	T2	QL (1.5ml/day) HD
HUMALOG KWIKPEN U-100	T2	QL (1.5ML/DAY) HD
HUMALOG KWIKPEN U-200	T2	QL (1ML/DAY) HD
HUMALOG MIX 50-50	T2	QL (2ml/day) HD
HUMALOG MIX 50-50 KWIKPEN	T2	QL (2ml/day) HD
HUMALOG MIX 75-25	T2	QL (2ml/day) HD
HUMALOG MIX 75-25 KWIKPEN	T2	QL (2ml/day) HD
HUMULIN R U-500	T2	QL (1ML/DAY) HD

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List of Prescription Medications

ANTI-HYPERGLYCEMICS (Diabetes)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
INSULINS		
HUMULIN R U-500 KWIKPEN	T2	QL (1ML/DAY) HD
INSULIN ASPART	T2	QL (1.5ml/day) HD
INSULIN ASPART FLEXPEN	T2	QL (1.5ml/day) HD
INSULIN ASPART PENFILL	T2	QL (1.5ml/day) HD
INSULIN ASPART PROT-INSULN ASP	T2	QL (2ml/day) HD
INSULIN GLARGINE MAX SOLOSTAR	T3	PA QL(0.6 mls/day) HD
INSULIN GLARGINE SOLOSTAR U100	T3	PA QL(1.5 mls/day) HD
INSULIN GLARGINE SOLOSTAR U300	T3	PA QL(0.6 mls/day) HD
INSULIN GLARGINE-YFGN	T3	QL (1.5ml/day) HD
INSULIN LISPRO	T2	QL (1.5ml/day) HD
INSULIN LISPRO PROTAMINE MIX	T2	QL (2ml/day) HD
LANTUS	T3	PA QL (1.5ml/day) HD
LANTUS SOLOSTAR	T3	PA QL (1.5ml/day) HD
LEVEMIR	T3	PA QL (1.5ml/day) HD
LEVEMIR FLEXTOUCH	T3	PA QL (1.5ml/day) HD
LYUMJEV	T2	QL (1.5ML/DAY) HD
LYUMJEV KWIKPEN U-100	T2	QL (1.5ML/DAY) HD
LYUMJEV KWIKPEN U-200	T2	QL (1ML/DAY) HD
NOVOLOG	T2	QL (1.5ml/day) HD
NOVOLOG FLEXPEN	T2	QL (1.5ml/day) HD
NOVOLOG MIX 70-30	T2	QL (2ml/day) HD
NOVOLOG MIX 70-30 FLEXPEN	T2	QL (2ml/day) HD
SEMGLEE	T3	PA QL (1.5ML/DAY) HD
SEMGLEE PEN	T3	PA QL (1.5ML/DAY) HD
TOUJEO MAX SOLOSTAR	T3	PA QL (0.6ml/day) HD
TOUJEO SOLOSTAR	T3	PA QL (0.6ml /day) HD
TRESIBA	T2	QL (1.5ml/day) HD
TRESIBA FLEXTOUCH U-100	T2	QL (1.5ml/day) HD
TRESIBA FLEXTOUCH U-200	T2	QL (0.9ml/day) HD

ANTI-INFECTIVES (Feminine Products)

VAGINAL SULFONAMIDES		
AVC	T3	

ANTI-INFECTIVES (Infections)

PENICILLIN ANTIBIOTICS		
<i>amoxicillin</i>	T1	
<i>amoxicillin/potassium clav</i> (Augmentin Es-600)	T1	

T1 – Typically Generics

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T3 – Typically Non-Preferred Brands

T4 – Specialty Medications

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CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

ANTI-INFECTIVES/MISCELLANEOUS (Feminine Products)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
PENICILLIN ANTIBIOTICS		
<i>ampicillin sodium</i>	T1	
AUGMENTIN ES-600 (<i>amoxicillin/potassium clav</i>)	T3	PA
<i>nafcillin sodium</i>	T1	
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	
ANTHELMINTICS		
<i>albendazole</i> (Albenza)	T1	
ALBENZA (<i>albendazole</i>)	T3	
BILTRICIDE (<i>praziquantel</i>)	T3	
EMVERM	T1	
<i>ivermectin</i> (Stromectol)	T1	PA
<i>praziquantel</i> (Biltricide)	T1	
STROMECTOL (<i>ivermectin</i>)	T3	PA
ANTI-MALARIAL DRUGS		
ARAKODA	T3	PA
<i>atovaquone/proguanil hcl</i> (Malarone)	T1	
<i>chloroquine ph 250 mg tablet</i>	T1	QL (56 Tabs/365 days)
<i>chloroquine ph 500 mg tablet</i>	T1	
COARTEM	T3	PA QL (24 tabs/30 days)
DARAPRIM (<i>pyrimethamine</i>)	T3	PA SP
<i>hydroxychloroquine sulfate</i> (Plaquenil)	T1	
<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

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List of Prescription Medications

ANTI-INFECTIVES/MISCELLANEOUS (Infections)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
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ANTI-MALARIAL DRUGS (cont.)

<i>primaquine phosphate</i> (Primaquine)	T1	
PRIMAQUINE (<i>primaquine phosphate</i>)	T1	
<i>pyrimethamine 25 mg tablet</i> (Daraprim)	T1	PA
<i>pyrimethamine 25 mg tablet</i> (Daraprim)	T4	PA SP
QUALAQUIN (<i>quinine sulfate</i>)	T3	PA
<i>quinine sulfate</i> (Qualaquin)	T1	
SOVUNA (<i>hydroxychloroquine sulfate</i>)	T3	PA

ANTI-PROTOZOAL DRUGS, MISCELLANEOUS

<i>atovaquone</i> (Mepron)	T1	
BENZNIDAZOLE	T3	
IMPAVIDO	T3	PA
LAMPIT	T3	
MEPRON	T3	PA
MEPRON (<i>atovaquone</i>)	T3	PA
NEBUPENT (<i>pentamidine isethionate</i>)	T3	
PENTAM 300 (<i>pentamidine isethionate</i>)	T3	
<i>pentamidine isethionate</i> (Nebupent)	T1	
<i>pentamidine isethionate</i> (Pentam 300)	T1	

ANTI-INFECTIVES/MISCELLANEOUS (Miscellaneous)

ANTIBACTERIAL AGENTS, MISCELLANEOUS

<i>glycine urologic solution</i>	T1	
<i>glycine urologic solution</i>	T3	

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

ABRILADA(CF)	T4	PA QL(2 pens/syringes/28 days) SP
ADALIMUMAB-AACF(CF) PEN	T3	PA
ADALIMUMAB-ADBM(CF)	T4	PA QL(2 pens/syringes/28 days) SP HD
ADALIMUMAB-ADBM(CF) PEN CROHNS	T4	PA QL(1 starter kit/365 days) SP HD
ADALIMUMAB-ADAZ	T4	PA QL (2 doses/ 28 days) SP
AMJEVITA(CF)	T4	PA QL(2 syringes/28 days) SP HD
AMJEVITA(CF) AUTOINJECTOR	T4	PA QL(2 auto-injs/28 days) SP HD
AVSOLA	T4	PA SP

T1 – Typically Generics

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T4 – Specialty Medications

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List of Prescription Medications

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

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ANTI-INFLAMMATORY TUMOR NECROSIS FACTOR INHIBITOR (cont.)		
CIMZIA 200 MG VIAL KIT	T4	PA QL (1 kit/28 days) SP HD
CIMZIA 2X200 MG/ML SYRINGE KIT	T4	PA QL (1 kit/28 days) SP HD
CIMZIA 2X200 MG/ML (X3) START KT	T4	PA QL (1 kit/year) SP HD
CYLTEZO	T4	PA QL (2 doses/ 28 days) SP
ENBREL 25 MG KIT	T4	PA QL (8 vials/28 days) SP HD
ENBREL 25 MG/0.5 ML SYRINGE	T4	PA QL (8 syringes/28 days) SP HD
ENBREL 25 MG/0.5 ML VIAL	T4	PA QL (4ml/28 days) SP HD
ENBREL 50 MG/ML SYRINGE	T4	PA QL (4 syringes/28 days) SP HD
ENBREL MINI	T4	PA QL (4 cartridges/28 days) SP HD
ENBREL SURECLICK	T4	PA QL (4 syringes/28 days) SP HD
HADLIMA	T4	PA QL (2 doses/ 28 days) SP HD
HADLIMA (CF-citrate free)	T4	PA QL (2 doses/ 28 days) SP HD
HULIO(CF)	T4	PA QL (2 pens/syringes/28 days) SP
HUMIRA	T4	PA QL (2 syringes/28 days) SP HD
HUMIRA PEN	T4	PA QL (2 pens/28 days) SP HD
HUMIRA PEN CROHN'S-UC-HS	T4	PA QL (1 kit/year) SP HD
HUMIRA PEN PSOR-UVEITS-ADOL HS	T4	PA QL (1 kit/year) SP HD
HUMIRA (CF)	T4	PA QL (2 syringes/28 days) SP HD
HUMIRA (CF) PEDIATRIC CROHN'S	T4	PA QL (1 kit/year) SP HD
HUMIRA (CF) PEN 40 MG/0.4 ML	T4	PA QL (2 pens/28 days) SP HD
HUMIRA (CF) PEN 80 MG/0.8 ML	T4	PA QL (1 kit/year) SP HD
HUMIRA (CF) PEN CROHN'S-UC-HS	T4	PA QL (1 kit/year) SP HD
HUMIRA (CF) PEN PEDIATRIC UC	T4	PA QL (4 KITS/365 DAYS) SP HD
HUMIRA (CF) PEN PSOR-UV-ADOL HS	T4	PA QL (1 kit/year) SP HD
HYRIMOZ	T4	PA QL (2 doses/ 28 days) SP
IDACIO (CF)	T4	PA QL (2 doses/ 28 days) SP
INFLECTRA	T4	PA SP HD
REMICADE	T4	PA SP HD
RENFLEXIS	T4	PA SP HD
SIMPONI 100 MG/ML PEN INJECTOR	T4	PA QL (1 injector/28 days) SP HD
SIMPONI 100 MG/ML SYRINGE	T4	PA QL (1 syringe/28 days) SP HD
SIMPONI 50 MG/0.5 ML PEN INJEC	T4	PA QL (1 injector/28 days) SP HD
SIMPONI 50 MG/0.5 ML SYRINGE	T4	PA QL (1 syringe/28 days) SP HD
SIMPONI ARIA	T4	PA SP HD
YUFLYMA	T4	PA QL (2 doses/ 28 days) SP
YUSIMRY (CF)	T4	PA QL (2 doses/ 28 days) SP

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List of Prescription Medications

ANTI-NEOPLASTICS (Cancer)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ANP - SELECTIVE RETINOID X RECEPTOR AGONISTS (RXR)		
<i>bexarotene</i> (Targretin)	T4	PA SP HD
TARGRETIN 75 MG CAPSULE (<i>bexarotene</i>)	T4	PA SP HD
ANTIBIOTIC ANTINEOPLASTICS		
<i>adriamycin 10 mg vial</i>	T4	PA SP
<i>adriamycin 10 mg/5 ml vial</i>	T4	PA SP
<i>adriamycin 20 mg/10 ml vial</i>	T4	PA SP
ADRIAMYCIN (<i>doxorubicin hcl</i>)	T4	PA SP
<i>bleomycin sulfate</i>	T4	PA SP
COSMEGEN	T4	PA SP
<i>dactinomycin</i> (Cosmegen)	T4	PA SP
<i>daunorubicin hcl</i>	T4	PA SP
DOXIL (<i>lipodox 50</i>)	T4	PA SP
<i>doxorubicin hcl</i>	T4	PA SP
<i>doxorubicin hcl</i> (Adriamycin)	T4	PA SP
<i>doxorubicin hcl peg-liposomal</i> (Doxil)	T4	PA SP
ELLECE	T4	PA SP
ELLECE (<i>epirubicin hcl</i>)	T4	PA SP
<i>epirubicin 200 mg/100 ml vial</i> (Elevance)	T4	PA SP
<i>epirubicin 50 mg/25 ml vial</i> (Elevance)	T4	PA SP
<i>epirubicin hcl 200 mg vial</i>	T4	SP
IDAMYCIN PFS (<i>idarubicin hcl</i>)	T4	PA SP
<i>idarubicin hcl</i> (Idamycin Pfs)	T4	PA SP
<i>mitomycin</i> (Mutamycin)	T4	PA SP
MUTAMYCIN (<i>mitomycin</i>)	T4	PA SP
<i>valrubicin</i> (Valstar)	T4	SP
VALSTAR (<i>valrubicin</i>)	T4	SP
ZANOSAR	T4	PA SP
ANTI-CD20 (B LYMPHOCYTE) MONOCLONAL ANTIBODY		
GAZYVA	T4	PA SP
RIABNI	T4	PA SP
RITUXAN	T4	PA SP
RITUXAN HYCELA	T4	PA SP
RUXIENCE	T4	PA SP
TRUXIMA	T4	PA SP

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

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ANTI-NEOPLASTICS (Cancer)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ANTI-NEOPLASTIC - ALKYLATING AGENTS (con't.)		
GLEOSTINE	T2	
GLIADEL	T4	SP
HYDREA (<i>hydroxyurea</i>)	T3	
<i>hydroxyurea</i> (Hydrea)	T1	
IFEX (<i>ifosfamide</i>)	T4	PA SP
<i>ifosfamide</i>	T4	PA SP
<i>ifosfamide</i> (Ifex)	T4	PA SP
LEUKERAN	T2	
<i>melphalan</i> (Alkeran)	T4	SP
<i>melphalan hcl</i> (Alkeran)	T4	PA SP
MYLERAN	T2	
<i>oxaliplatin</i>	T4	PA SP
PEPAXTO	T4	PA SP
TEMODAR 100 MG CAPSULE (<i>temozolomide</i>)	T4	PA SP HD
TEMODAR 100 MG VIAL	T4	PA SP
TEMODAR 140 MG CAPSULE (<i>temozolomide</i>)	T4	PA SP HD
TEMODAR 180 MG CAPSULE (<i>temozolomide</i>)	T4	PA SP HD
TEMODAR 20 MG CAPSULE (<i>temozolomide</i>)	T4	PA SP HD
<i>temozolomide</i>	T4	PA SP HD
<i>temozolomide</i> (Temodar)	T4	PA SP HD
TEPADINA	T4	PA SP
TEPADINA (<i>thiotepa</i>)	T4	PA SP
<i>thiotepa</i> (Tepadina)	T4	PA SP
TREANDA (<i>bendamustine hcl</i>)	T4	PA SP
YONDELIS	T4	PA SP
ZEPZELCA	T4	PA SP
ANTI-NEOPLASTIC - ANTI-ANDROGENIC AGENTS		
<i>abiraterone acetate</i> (Zytiga)	T4	PA SP HD
<i>bicalutamide</i> (Casodex)	T1	
CASODEX (<i>bicalutamide</i>)	T3	
ERLEADA 240 MG TABLET	T4	PA QL (1 tab/day) SP HD CSL
ERLEADA 60 MG TABLET	T4	PA SP HD CSL
<i>flutamide</i>	T1	
NILANDRON (<i>nilutamide</i>)	T3	PA QL (4 tabs/day)
<i>nilutamide</i> (Nilandron)	T1	QL (4 tabs/day)

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ANTI-NEOPLASTIC - ANTI-ANDROGENIC AGENTS (cont.)		
NUBEQA	T4	PA SP HD
XTANDI	T4	PA SP HD
YONSA	T4	PA SP HD
ZYTIGA (<i>abiraterone acetate</i>)	T4	PA SP HD
ANTINEOPLASTIC - ANTIBIOTIC AND ANTIMETABOLITE		
VYXEOS	T4	PA SP
ANTINEOPLASTIC - ANTI-CD38 MONOCLONAL ANTIBODY		
DARZALEX	T4	PA SP HD
DARZALEX FASPRO	T4	PA SP
SARCLISA	T4	PA SP
ANTI-NEOPLASTIC - ANTI-METABOLITES		
ALIMTA	T4	PA SP
ARRANON	T4	PA SP
<i>azacitidine (Vidaza)</i>	T4	PA SP
<i>capecitabine (Xeloda)</i>	T4	PA SP HD
<i>cladribine</i>	T4	PA SP
<i>clofarabine (Clolar)</i>	T4	PA SP
CLOLAR (<i>clofarabine</i>)	T4	PA SP
<i>cytarabine</i>	T4	PA SP
<i>cytarabine/pf</i>	T4	PA SP
DACOGEN (<i>decitabine</i>)	T4	PA SP
<i>decitabine (Dacogen)</i>	T4	PA SP
<i>floxuridine</i>	T4	PA SP
<i>fludarabine phosphate</i>	T4	PA SP
<i>fluorouracil</i>	T4	PA SP
<i>fluorouracil 1,000 mg/20 ml vial</i>	T4	PA SP
<i>fluorouracil 2,500 mg/50 ml vial</i>	T4	PA SP
<i>fluorouracil 2.5 gm/50 ml btl</i>	T4	PA SP
<i>fluorouracil 2.5 gm/50 ml vial</i>	T4	PA SP
<i>fluorouracil 5 gm/100 ml btl</i>	T4	PA SP
<i>fluorouracil 5 gm/100 ml vial</i>	T4	PA SP
<i>fluorouracil 5,000 mg/100 ml</i>	T4	PA SP
<i>fluorouracil 500 mg/10 ml vial</i>	T4	PA SP
FOLOTYN 20 MG/ML VIAL	T4	PA SP
FOLOTYN 40 MG/2 ML VIAL	T4	PA SP

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ANTI-NEOPLASTIC - ANTI-METABOLITES (cont.)		
<i>gemcitabine hcl</i>	T4	PA SP
INFUGEM	T4	PA SP HD
INQOVI	T4	PA SP HD
LONSURF	T4	PA SP HD
<i>mercaptopurine</i>	T1	
<i>methotrexate sodium</i>	T1	
<i>methotrexate sodium/pf</i>	T1	
NIPENT	T4	PA SP
ONUREG	T4	PA QL (14 tabs/28 days) SP
PEMRYDI RTU	T4	PA SP
PURIXAN	T4	SP
TABLOID	T3	
TREXALL	T2	
VIDAZA (<i>azacitidine</i>)	T4	PA SP
XATMEP	T3	
XELODA (<i>capecitabine</i>)	T4	PA SP HD
ZYNYZ	T4	PA SP
ANTINEOPLASTIC - ANTI-SLAMF7 MONOCLONAL ANTIBODY		
EMPLICITI	T4	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	T4	PA SP HD
TAFINLAR	T4	PA SP HD
ZELBORAF	T4	PA SP HD
ANTINEOPLASTIC - CD19 (B LYMPHOCYTE) MC ANTIBODY		
MONJUVI	T4	PA SP
ANTINEOPLASTIC - EPOTHILONES AND ANALOGS		
IXEMPRA	T4	PA SP
ANTI-NEOPLASTIC - HEDGEHOG PATHWAY INHIBITOR		
DAURISMO	T4	PA SP HD

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ANTI-NEOPLASTIC - HEDGEHOG PATHWAY INHIBITOR		
ERIVEDGE	T4	PA SP HD
ODOMZO	T4	PA SP HD
ANTI-NEOPLASTIC - JANUS KINASE (JAK) INHIBITORS		
JAKAFI	T4	PA SP HD
ANTI-NEOPLASTIC - KRAS PROTEIN INHIBITOR		
KRAZATI	T4	PA QL (6 tabs/day) SP CSL
LUMAKRAS 120 MG TABLET	T4	PA QL (8 tabs/day) SP HD CSL
LUMAKRAS 320 MG TABLET	T4	PA QL (3 tabs/day) SP HD CSL
ANTI-NEOPLASTIC - MEKI AND MEK2 KINASE INHIBITORS		
COTELLIC	T4	PA SP HD
KOSELUGO 10 MG CAPSULE	T4	PA QL (10 capsules/day) SP
KOSELUGO 25 MG CAPSULE	T4	PA QL (4 caps/day) SP
MEKINIST	T4	PA SP HD
MEKTOVI	T4	PA SP HD
ANTINEOPLASTIC - MICROTUBULE INHIBITORS		
HALAVEN	T4	PA SP
ANTI-NEOPLASTIC - MTOR KINASE INHIBITORS		
AFINITOR	T4	PA SP HD
AFINITOR (<i>everolimus</i>)	T4	PA SP HD
AFINITOR DISPERZ	T4	PA SP
<i>everolimus 2.5 mg tablet</i> (Afinitor)	T4	PA SP HD
<i>everolimus 5 mg tablet</i> (Afinitor)	T4	PA SP HD
<i>everolimus 7.5 mg tablet</i> (Afinitor)	T4	PA SP HD
<i>temsirolimus</i> (Torisel)	T4	PA SP
TORISEL (<i>temsirolimus</i>)	T4	PA SP
ANTI-NEOPLASTIC - PROTEIN METHYLTRANSFERASE INHIBIT		
TAZVERIK	T4	PA SP
ANTI-NEOPLASTIC - TOPOISOMERASE I INHIBITORS		
CAMPTOSAR 100 MG/5 ML VIAL (<i>irinotecan hcl</i>)	T4	PA SP
CAMPTOSAR 300 MG/15 ML VIAL	T4	PA SP
CAMPTOSAR 40 MG/2 ML VIAL (<i>irinotecan hcl</i>)	T4	PA SP
HYCAMTIN 0.25 MG CAPSULE	T4	PA SP HD CSL
HYCAMTIN 1 MG CAPSULE	T4	PA SP HD CSL
HYCAMTIN 4 MG VIAL (<i>topotecan hcl</i>)	T4	PA SP HD CSL

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ANTI-NEOPLASTIC - TOPOISOMERASE I INHIBITORS		
<i>irinotecan hcl</i>	T4	PA SP
<i>irinotecan hcl</i> (Camptosar)	T4	PA SP
ONIVYDE	T4	PA SP
<i>topotecan hcl</i>	T4	PA SP HD
<i>topotecan hcl</i> (Hycamtin)	T4	PA SP HD
ANTINEOPLASTIC - VEGF-A, B AND PLGF INHIBITORS		
ZALTRAP	T4	PA SP
ANTINEOPLASTIC - VEGFR ANTAGONIST		
CYRAMZA	T4	PA SP
ANTINEOPLASTIC - VINCA ALKALOIDS		
MARQIBO	T4	PA SP
NAVELBINE (<i>vinorelbine tartrate</i>)	T4	PA SP
<i>vinblastine sulfate</i>	T4	PA SP
<i>vincristine sulfate</i>	T4	PA SP
<i>vinorelbine tartrate</i> (Navelbine)	T4	PA SP
ANTINEOPLASTIC- CD22 ANTIBODY-CYTOTOXIC ANTIBIOTIC		
BESPONSA	T4	PA SP
ANTINEOPLASTIC- CD33 ANTIBODY-CYTOTOXIC ANTIBIOTIC		
MYLOTARG	T4	PA SP
ANTI-NEOPLASTIC COMB - KINASE AND AROMATASE INHIBIT		
KISQALI FEMARA CO-PACK	T4	PA QL(1 tab/28 days) SP HD CSL
ANTI-NEOPLASTIC EGF RECEPTOR BLOCKER MCLON ANTIBODY		
ERBITUX	T4	PA SP
HERCEPTIN	T4	PA SP
HERCEPTIN HYLECTA	T4	PA SP
HERZUMA	T4	PA SP
KANJINTI	T4	PA SP
MARGENZA	T4	PA SP
OGIVRI	T4	PA SP
ONTRUZANT	T4	PA SP
PERJETA	T4	PA SP
PHESGO	T4	PA SP HD
PORTRAZZA	T4	PA SP
TRAZIMERA	T4	PA SP
VECTIBIX	T4	PA SP

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ANTI-NEOPLASTICS (Cancer)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ANTI-NEOPLASTIC IMMUNOMODULATOR AGENTS		
<i>lenalidomide</i>	T4	PA QL(1 tab/day) SP HD CSL
POMALYST	T4	PA SP HD
REVLIMID	T4	PA QL(1 tab/day) SP HD CSL
ANTI-NEOPLASTIC LHRH (GNRH) AGONIST, PITUITARY SUPPR.		
ELIGARD	T4	SP HD
<i>leuprolide acetate</i>	T4	PA SP HD
LEUPROLIDE DEPOT	T4	PA SP
LUPRON DEPOT	T4	PA SP HD
TRELSTAR	T4	SP HD
ZOLADEX	T4	PA SP HD
ANTI-NEOPLASTIC LHRH (GNRH) ANTAGONIST, PITUIT.SUPPRS		
FIRMAGON	T4	PA SP HD
ORGOVYX	T4	PA SP
ANTI-NEOPLASTIC SYSTEMIC ENZYME INHIBITORS		
ALECENSA	T4	PA QL(8 tabs/day) SP HD CSL
ALIQOPA	T4	PA SP
ALUNBRIG	T4	PA SP HD
AUGTYRO	T4	PA QL(8 caps/day) SP HD CSL
AYVAKIT	T4	PA QL (1 tab/day) SP
BALVERSA	T4	PA SP
BORTEZOMIB	T4	PA SP
BOSULIF	T4	PA QL(3 caps/day) SP HD
BRUKINSA	T4	PA QL (4 caps/day) SP
CABOMETYX	T4	PA SP HD
CALQUENCE	T4	PA SP
CAPRELSA	T4	PA SP
COMETRIQ	T4	PA SP HD
COPIKTRA	T4	PA SP
<i>erlotinib hcl (Tarceva)</i>	T4	PA SP HD
EXKIVITY	T4	PA SP HD
FOTIVDA	T4	PA QL (30 caps/30 days) SP HD
FRUZAQLA 1 MG CAPSULE	T4	PA QL(84 caps/28 days) SP CSL
FRUZAQLA 5 MG CAPSULE	T4	PA QL(21 caps/28 days) SP CSL
GAVRETO	T4	PA QL (4 tabs/day) SP
<i>gefitinib</i>	T4	PA SP HD CSL
GILOTRIF	T4	PA SP HD

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ANTI-NEOPLASTICS (Cancer)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ANTI-NEOPLASTIC SYSTEMIC ENZYME INHIBITORS		
GLEEVEC (<i>imatinib mesylate</i>)	T4	PA SP HD
IBRANCE	T4	PA QL (21/30 days) SP HD
ICLUSIG	T4	PA SP
<i>imatinib mesylate</i> (Gleevec)	T4	PA SP HD
IMBRUVICA	T4	PA SP
INLYTA	T4	PA SP HD
INREBIC	T4	PA SP HD
IRESSA	T4	PA SP HD
OGSIVEO	T4	PA QL (6 TABS/DAY) SP CSL
OJJAARA	T4	PA QL (1 TAB/DAY) SP CSL
IWILFIN	T4	PA QL (8 tabs/day) SP CSL
KISQALI 200 MG	T4	PA QL (21 per 28 days) SP HD CSL
KISQALI 400 MG	T4	PA QL (42 per 28 days) SP HD CSL
KISQALI 800 MG	T4	PA QL (63 per 28 days) SP HD CSL
KISQALI FEMARA CO-PACK	T4	PA QL (1 pack per 28 days) SP HD CSL
KYPROLIS	T4	PA SP HD
<i>lapatinib ditosylate</i> (Tykerb)	T4	PA SP HD
LENVIMA	T4	PA SP HD CSL
LORBRENA	T4	PA SP HD
LYNPARZA	T4	PA SP HD
LYTGOBI 12 MG DOSE (3X 4MG TB)	T4	PA QL (3 tabs/day) SP CSL
LYTGOBI 16 MG DOSE PACK (4X 4MG TB)	T4	PA QL (4 tabs/day) SP CSL
LYTGOBI 20 MG DOSE PACK (5X 4MG TB)	T4	PA QL (5 tabs/day) SP CSL
NERLYNX	T4	PA SP HD
NEXAVAR	T4	PA QL (4 tabs/day) SP HD CSL
NINLARO	T4	PA SP HD
PEMAZYRE	T4	PA QL (14 tabs/21 days) SP
PIQRAY	T4	PA SP HD
<i>pazopanib hcl</i> (Votrient)	T4	PA QL (4 tabs/day) SP HD CSL
QINLOCK	T4	PA QL (3 tabs/day) SP
RETEVMO 40 MG CAPSULE	T4	PA QL (6 caps/day) SP HD
RETEVMO 80 MG CAPSULE	T4	PA QL (4 tabs/day) SP HD
ROZLYTREK	T4	PA SP HD
RUBRACA	T4	PA SP
RYDAPT	T4	PA SP HD
SCSEMBLIX	T4	PA QL (2 tablets/day) SP HD

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ANTI-NEOPLASTIC SYSTEMIC ENZYME INHIBITORS		
SPRYCEL	T4	PA SP HD
STIVARGA	T4	PA SP HD
SUTENT	T4	PA SP HD
TABRECTA	T4	PA QL (4 tabs/day) SP HD
TAGRISSO	T4	PA SP HD
TRUQAP	T4	PA QL(64 TABS/28 DAYS) SP CSL
TALZENNA	T4	PA SP HD
TARCEVA (<i>erlotinib hcl</i>)	T4	PA SP HD
TASIGNA	T4	PA SP HD
TEPMETKO	T4	PA SP QL (2 tabs/day)
TUKYSA	T4	PA SP
TURALIO 200 MG CAPSULE	T4	PA SP CSL
TURALIO 125 MG CAPSULE	T4	PA QL(4 caps/day) SP CSL
TYKERB (<i>lapatinib</i>)	T4	PA SP HD
UKONIQ	T4	PA QL (4 tabs/day) SP
VANFLYTA	T4	PA QL(2 tabs/day) SP CSL
VELCADE	T4	PA SP
VERZENIO	T4	PA QL (120mg/day) SP HD
VITRAKVI	T4	PA SP HD
VIZIMPRO	T4	PA SP HD
VOTRIENT (<i>pazopanib hcl</i>)	T4	PA QL(4 tabs/day) SP HD CSL
XALKORI	T4	PA SP HD
XOSPATA	T4	PA SP
ZEJULA	T4	PA SP
ZYDELIG	T4	PA SP HD
ZYKADIA	T4	PA SP HD
ANTI-NEOPLASTIC, ANTI-PROGRAMMED DEATH-I (PD-I) MAB		
KEYTRUDA	T4	PA SP
LIBTAYO	T4	PA SP
LOQTORZI	T4	PA SP
OPDIVO	T4	PA SP HD
ANTI-NEOPLASTIC-B CELL LYMPHOMA-2(BCL-2) INHIBITORS		
VENCLEXTA	T4	PA SP
VENCLEXTA STARTING PACK	T4	PA SP
ANTI-NEOPLASTIC-ENZYME INHIB, ANTIANDROGEN COMB.		
AKEEGA	T4	PA QL(2 TABS/DAY) SP CSL

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 PA – Prior Authorization
 QL – Quantity Limit

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List of Prescription Medications

ANTI-NEOPLASTICS (Cancer)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ANTINEOPLASTIC-CD22 DIRECT ANTIBODY/CYTOTOXIN CONJ		
LUMOXITI	T4	PA SP
ANTINEOPLASTIC-INTERLEUKIN-6 (IL-6) INHIB, ANTIBODY		
SYLVANT	T4	PA SP
ANTI-NEOPLASTIC-ISOCITRATE DEHYDROGENASE INHIBITOR		
IDHIFA	T4	PA SP HD
REZLIDHIA	T4	PA QL(2 caps/day) SP CSL
TIBSOVO	T4	PA SP
ANTI-NEOPLASTICS ANTIBODY/ANTIBODY-DRUG COMPLEXES		
ADCETRIS	T4	PA SP
BLNREP	T4	PA
BLINCYTO	T4	PA SP
ENHERTU	T4	PA SP HD
KADCYLA	T4	PA SP
LUNSUMIO	T4	PA SP
PADCEV	T4	PA SP
POLIVY	T4	PA SP HD
POTELIGEO	T4	PA SP
TRODELVY	T4	PA SP
UNITUXIN	T4	PA SP
ZEVALIN	T4	PA SP
ANTI-NEOPLASTICS, MISCELLANEOUS		
ABRAXANE	T4	PA SP
ARSENIC TRIOXIDE	T4	PA SP
<i>arsenic trioxide (Trisenox)</i>	T4	PA SP
ASPARLAS	T4	SP
BCG (TICE STRAIN)	T4	SP
<i>dacarbazine</i>	T4	PA SP
DOCEFREZ	T4	PA SP
<i>docetaxel 160 mg/16 ml vial</i>	T4	PA SP
<i>docetaxel 160 mg/8 ml vial</i>	T4	PA SP HD
<i>docetaxel 20 mg/2 ml vial</i>	T4	PA SP
<i>docetaxel 20 mg/ml vial</i>	T4	PA SP
<i>docetaxel 80 mg/4 ml vial (Taxotere)</i>	T4	PA SP
ERWINAZE	T4	PA SP
ETOPOPHOS	T4	PA SP
<i>etoposide</i>	T4	PA SP

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ANTI-NEOPLASTICS (Cancer)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ANTI-NEOPLASTICS, MISCELLANEOUS		
<i>etoposide 1,000 mg/50 ml vial</i>	T4	PA SP
<i>etoposide 100 mg/5 ml vial</i>	T4	PA SP
<i>etoposide 50 mg capsule</i>	T4	SP HD
<i>etoposide 500 mg/25 ml vial</i>	T4	PA SP
JEVTANA	T4	PA SP HD
LYSODREN	T3	
MATULANE	T4	SP
<i>mitoxantrone hcl</i>	T4	PA SP
ONCASPAR	T4	PA SP
<i>paclitaxel</i>	T4	PA SP
SYNRIBO	T4	PA SP
TAXOTERE (<i>docetaxel</i>)	T4	PA SP
TENIPOSIDE	T4	PA SP
<i>tretinoin 10 mg capsule</i>	T1	PA
TRISENOX (<i>arsenic trioxide</i>)	T4	PA SP
ANTI-NEOPLASTIC-SELECT INHIB OF NUCLEAR EXP (SINE)		
XPOVIO	T4	PA SP
ANTI-PROGRAMMED CELL DEATH-LIGA		
BAVENCIO	T4	PA SP
IMFINZI	T4	PA SP
TECENTRIQ	T4	PA SP HD
CYTOTOXIC T-LYMPHOCYTE ANTIGEN (CTLA-4) RMC ANTIBODY		
IMJUDO	T4	PA SP HD
YERVOY	T4	PA SP HD
IMMUNOMODULATORS		
ACTIMMUNE	T4	PA SP HD
ALFERON N	T4	PA SP HD
BESREMI	T4	PA QL (2 syringes/28 days) SP
PROLEUKIN	T4	PA SP
PHOTOACTIVATED, ANTINEOPLASTIC AGENTS (SYSTEMIC)		
PHOTOFRIN	T4	SP
UVADEX	T2	
RADIOACTIVE THERAPEUTIC AGENTS		
AZEDRA DOSIMETRIC	T4	PA SP
AZEDRA THERAPEUTIC	T4	PA SP
SELECTIVE ESTROGEN RECEPTOR MODULATORS (SERMS)		
FARESTON (<i>toremifene citrate</i>)	T3	QL (2 tabs/day) HD

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ANTI-NEOPLASTICS (Cancer)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
SELECTIVE ESTROGEN RECEPTOR MODULATORS (SERMS) (con't.)		
FASLODEX (<i>fulvestrant</i>)	T4	PA SP HD
<i>fulvestrant</i> (Faslodex)	T4	PA SP HD
SOLTAMOX	T2	HD
<i>tamoxifen citrate</i>	T1	HD PPACA
<i>toremifene citrate</i> (Fareston)	T1	QL (2 tabs/day) HD
STEROID ANTI-NEOPLASTICS		
EMCYT	T4	SP HD
<i>megestrol acetate</i>	T1	
ANTI-NEOPLASTICS (Skin Conditions)		
PHOTOACT, TOPICAL ANTI-NEOPLAST, PREMALIGNANT LESIONS		
LEVULAN	T4	SP
TOPICAL ANTI-NEOPLASTIC PREMALIGNANT LESION AGENTS		
CARAC	T3	PA
<i>diclofenac sodium 3% gel</i>	T1	PA
EFUDEX (<i>fluorouracil</i>)	T3	
FLUOROPLEX	T2	
FLUOROURACIL 0.5% CREAM	T1	
<i>fluorouracil 2% topical soln</i>	T1	
<i>fluorouracil 5% cream</i> (Efudex)	T1	
<i>fluorouracil 5% topical soln</i>	T1	
KLISYRI	T3	PA QL (5 packs/30 Days)
PANRETIN	T4	SP HD
PICATO	T2	
TARGRETIN 1% GEL	T4	PA SP HD
TOLAK	T3	
VALCHLOR	T4	SP HD
ANTI-PARASITICS (Infections)		
ANTI-PARASITICS		
ALINIA (<i>nitazoxanide</i>)	T3	
<i>nitazoxanide</i> (Alinia)	T1	
OPHTHALMIC (EYE) ANTIPARASITICS		
XDEMVY	T4	PA QL(4 bottles/30 days) SP
TOPICAL ANTI-PARASITICS		
<i>crotamiton</i> (Eurax)	T1	
ELIMITE (<i>permethrin</i>)	T3	

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List of Prescription Medications

ANTI-PARASITICS (Infections)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
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TOPICAL ANTI-PARASITICS

EURAX 10% CREAM	T2	
EURAX 10% LOTION	T3	
<i>ivermectin</i> (Sklice)	T1	
NATROBA (<i>spinosad</i>)	T3	
<i>permethrin</i> (Elimite)	T1	
SKLICE (<i>ivermectin</i>)	T3	
<i>spinosad</i> (Natroba)	T1	
ULESFIA	T3	

ANTI-PARKINSON DRUGS (Parkinson's Disease)

ANTI-PARKINSONISM DRUGS, ANTI-CHOLINERGIC

<i>benztropine mesylate</i>	T1	HD
<i>trihexyphenidyl hcl</i>	T1	HD

ANTI-PARKINSONISM DRUGS, OTHER

<i>amantadine hcl</i>	T1	HD
APOKYN	T4	PA SP HD
AZILECT 0.5 MG TABLET (<i>rasagiline mesylate</i>)	T3	QL (1 tab/day) HD
AZILECT 1 MG TABLET (<i>rasagiline mesylate</i>)	T3	HD
<i>bromocriptine mesylate</i> (Parlodel)	T1	HD
<i>carbidopa/levodopa</i>	T1	HD
<i>carbidopa/levodopa</i> (Sinemet 10-100)	T1	HD
<i>carbidopa/levodopa</i> (Sinemet 25-100)	T1	HD
<i>carbidopa/levodopa</i> (Sinemet 25-250)	T1	HD
<i>carbidopa/levodopa/entacapone</i> (Stalevo 100)	T1	HD
<i>carbidopa/levodopa/entacapone</i> (Stalevo 125)	T1	HD
<i>carbidopa/levodopa/entacapone</i> (Stalevo 150)	T1	HD
<i>carbidopa/levodopa/entacapone</i> (Stalevo 200)	T1	HD
<i>carbidopa/levodopa/entacapone</i> (Stalevo 50)	T1	HD
<i>carbidopa/levodopa/entacapone</i> (Stalevo 75)	T1	HD
COMTAN (<i>entacapone</i>)	T3	HD
DHIVY	T3	PA
DUOPA	T4	SP HD
<i>entacapone</i> (Comtan)	T1	HD
GOCOVRI	T3	HD
INBRIJA	T4	PA SP HD
KYNMOBI	T2	PA HD
MIRAPEX ER 0.375 MG TABLET (<i>pramipexole er</i>)	T3	QL (1 tab/day) HD

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ANTI-PARKINSON DRUGS (Parkinson's Disease)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ANTI-PARKINSONISM DRUGS, OTHER		
MIRAPEX ER 0.75 MG TABLET (<i>pramipexole er</i>)	T3	HD
MIRAPEX ER 1.5 MG TABLET (<i>pramipexole er</i>)	T3	QL (1 tab/day) HD
MIRAPEX ER 2.25 MG TABLET (<i>pramipexole er</i>)	T3	QL (1 tab/day) HD
MIRAPEX ER 3 MG TABLET (<i>pramipexole er</i>)	T3	HD
MIRAPEX ER 3.75 MG TABLET (<i>pramipexole er</i>)	T3	HD
MIRAPEX ER 4.5 MG TABLET (<i>pramipexole er</i>)	T3	HD
NEUPRO	T3	HD
NOURIANZ	T4	PA QL (1 tab/day) SP HD
ONGENTYS	T3	PA QL (1 CAPS/DAY) HD
OSMOLEX ER 258 MG TABLET	T3	QL (1 tab/day) HD
OSMOLEX ER	T3	QL (1 tab/day) HD
PARLODEL (<i>bromocriptine mesylate</i>)	T3	HD
<i>pramipexole di-hcl</i>	T1	HD
<i>pramipexole er 0.375 mg tablet</i> (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
<i>rasagiline mesylate 1 mg tab</i> (Azilect)	T1	HD
<i>ropinirole hcl</i>	T1	HD
RYTARY	T3	HD
<i>selegiline hcl</i>	T1	HD
SINEMET 10-100 (<i>carbidopa-levodopa</i>)	T3	HD
SINEMET 25-100 (<i>carbidopa-levodopa</i>)	T3	HD
SINEMET 25-250 (<i>carbidopa-levodopa</i>)	T3	HD
STALEVO 100 (<i>carbidopa-levodopa-entacapone</i>)	T3	HD
STALEVO 125 (<i>carbidopa-levodopa-entacapone</i>)	T3	HD
STALEVO 150 (<i>carbidopa-levodopa-entacapone</i>)	T3	HD
STALEVO 200 (<i>carbidopa-levodopa-entacapone</i>)	T3	HD
STALEVO 50 (<i>carbidopa-levodopa-entacapone</i>)	T3	HD
STALEVO 75 (<i>carbidopa-levodopa-entacapone</i>)	T3	HD
TASMAR (<i>tolcapone</i>)	T3	HD
<i>tolcapone</i> (Tasmar)	T1	HD

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ANTI-PARKINSON DRUGS (Parkinson's Disease)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ANTI-PARKINSONISM DRUGS, OTHER (con't.)		
XADAGO	T3	ST HD
ZELAPAR	T3	PA HD
DECARBOXYLASE INHIBITORS		
<i>carbidopa</i> (Lodosyn)	T1	
LODOSYN (<i>carbidopa</i>)	T3	PA
ANTI-PLATELET DRUGS (Blood Thinners/Anti-Clotting)		
PLATELET AGGREGATION INHIBITORS		
AGGRASTAT	T3	HD
<i>aspirin/dipyridamole</i>	T1	HD
ASPIRIN-OMEPRAZOLE	T3	PA HD
BRILINTA	T2	HD
<i>cilostazol</i>	T1	HD
<i>clopidogrel bisulfate</i>	T1	HD
<i>clopidogrel bisulfate</i> (Plavix)	T1	HD
<i>dipyridamole 25 mg tablet</i>	T1	HD
<i>dipyridamole 50 mg tablet</i>	T1	HD
<i>dipyridamole 75 mg tablet</i>	T1	HD
EFFIENT (<i>prasugrel hcl</i>)	T3	HD
EPTIFIBATIDE	T1	HD
<i>eptifibatide</i> (Integrilin)	T1	HD
INTEGRILIN (<i>eptifibatide</i>)	T3	HD
PLAVIX (<i>clopidogrel</i>)	T3	HD
<i>prasugrel hcl</i> (Effient)	T1	HD
<i>ticlopidine hcl</i>	T1	HD
YOSPRALA	T3	PA HD
ZONTIVITY	T3	HD
PLATELET REDUCING AGENTS		
AGRYLIN (<i>anagrelide hcl</i>)	T3	
<i>anagrelide hcl</i> (Agylin)	T1	
ANTIVIRALS (AIDS/HIV)		
ANTIRETROVIRAL - ANTI-CD4 DOMAIN 2 MONOCLONAL AB		
TROGARZO	T4	PA SP
ANTI-RETROVIRAL - CAPSID INHIBITORS		
SUNLENCA 463.5 MG/1.5 ML VIAL	T4	PA SP
SUNLENCA TABLET	T4	PA QL(5 tabs/180 days) SP

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ANTIVIRALS (AIDS/HIV)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ANTI-RETROVIRAL - INTEGRASE INHIBITOR AND NNRTI COMB.		
CABENUVA	T4	PA SP
JULUCA	T4	SP
ANTI-RETROVIRAL - INTEGRASE INHIBITOR AND NRTI COMB.		
DOVATO	T4	SP
ANTI-RETROVIRAL - NRTIS AND INTEGRASE INHIBITORS COMB		
TRIUMEQ	T4	SP
ANTI-RETROVIRAL - NUCLEOSIDE, NUCLEOTIDE, PROTEASE INH.		
SYMITUZA	T4	SP
ANTIVIRALS - HIV-SPEC, NON-PEPTIDIC PROTEASE INHIB		
APTIVUS	T3	PA SP
ANTIVIRALS - HIV-SPEC, NON-PEPTIDIC PROTEASE INHIB		
<i>darunavir (Prezista)</i>	T4	SP
PREZCOBIX	T4	PA SP
PREZISTA	T4	PA SP
ANTIVIRALS - HIV-SPEC, NUCLEOSIDE-NUCLEOTIDE ANALOG		
CIMDUO	T4	PA SP
DESCOVY	T4	PA SP PPACA
<i>emtricitabine-tenofv 100-150mg (Truvada)</i>	T4	SP
<i>emtricitabine-tenofv 133-200mg (Truvada)</i>	T4	SP
<i>emtricitabine-tenofv 167-250mg (Truvada)</i>	T4	SP
<i>emtricitabine-tenofv 200-300mg (Truvada)</i>	T4	SP PPACA
TEMIXYS	T4	PA SP
TRUVADA (<i>emtricitabine-tenofovir disop</i>)	T4	PA SP
ANTIVIRALS - HIV-SPEC, NUCLEOSIDE ANALOG, RTI COMB		
<i>abacavir sulfate/lamivudine (Epzicom)</i>	T4	PA SP
<i>abacavir/lamivudine/zidovudine (Trizivir)</i>	T4	PA SP
COMBIVIR (<i>lamivudine-zidovudine</i>)	T4	PA SP
EPZICOM (<i>abacavir-lamivudine</i>)	T4	PA SP
<i>lamivudine/zidovudine (Combivir)</i>	T4	SP
TRIZIVIR (<i>abacavir-lamivudine-zidovudine</i>)	T4	PA SP
ANTIVIRALS - HIV-SPECIFIC, CCR5 CO-RECEPTOR ANTAG.		
SELZENTRY 150 MG TABLET (<i>maraviroc</i>)	T4	PA SP
SELZENTRY 20 MG/ML ORAL SOLN	T4	PA SP
SELZENTRY 25 MG TABLET	T4	PA SP
SELZENTRY 300 MG TABLET (<i>maraviroc</i>)	T4	PA SP
SELZENTRY 75 MG TABLET	T4	PA SP

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List of Prescription Medications

ANTIVIRALS (AIDS/HIV)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ANTIVIRALS - HIV-SPECIFIC, CD4 ATTACHMENT INHIBITOR		
RUKOBIA	T4	PA QL (2 syringes/day) SP
ANTIVIRALS - HIV-SPECIFIC, FUSION INHIBITORS		
FUZEON	T4	PA SP
ANTIVIRALS - HIV-SPECIFIC, NON-NUCLEOSIDE, RTI		
EDURANT	T4	PA SP
<i>efavirenz</i>	T4	PA SP
INTELENCE	T4	PA SP
ANTIVIRALS - HIV-SPECIFIC, NUCLEOSIDE ANALOG, RTI		
<i>nevirapine</i>	T4	PA SP
<i>nevirapine</i> (Viramune Xr)	T4	PA SP
<i>nevirapine</i> (Viramune)	T4	PA SP
PIFELTRO	T4	PA SP
SUSTIVA (<i>efavirenz</i>)	T4	PA SP
VIRAMUNE (<i>nevirapine</i>)	T4	PA SP
VIRAMUNE XR (<i>nevirapine er</i>)	T4	PA SP
<i>abacavir sulfate</i> (Ziagen)	T4	PA SP
<i>didanosine</i> (Videx Ec)	T4	PA SP
<i>emtricitabine</i> (Emtriva)	T4	PA SP
EMTRIVA 10 MG/ML SOLUTION	T4	PA SP
EMTRIVA 200 MG CAPSULE (<i>emtricitabine</i>)	T4	PA SP
EPIVIR (<i>lamivudine</i>)	T4	PA SP
<i>lamivudine 10 mg/ml oral soln</i> (EpiVir)	T4	SP
<i>lamivudine 150 mg tablet</i> (EpiVir)	T4	SP
<i>lamivudine 300 mg tablet</i> (EpiVir)	T4	PA SP
RETROVIR	T4	PA SP
RETROVIR (<i>zidovudine</i>)	T4	PA SP
<i>stavudine</i>	T4	PA SP
VIDEX EC	T4	PA SP
VIDEX EC (<i>didanosine</i>)	T4	PA SP
ZIAGEN (<i>abacavir</i>)	T4	PA SP
<i>zidovudine</i>	T4	SP
<i>zidovudine</i> (Retrovir)	T4	SP
ANTIVIRALS, HIV-SPECIFIC, NUCLEOTIDE ANALOG, RTI		
<i>tenofovir disoproxil fumarate</i> (Viread)	T4	PA SP
VIREAD 150 MG TABLET	T4	PA SP
VIREAD 200 MG TABLET	T4	PA SP

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ANTIVIRALS (AIDS/HIV)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ANTIVIRALS, HIV-SPECIFIC, NUCLEOTIDE ANALOG, RTI		
VIREAD 250 MG TABLET	T4	PA SP
VIREAD 300 MG TABLET (<i>tenofovir disoproxil fumarate</i>)	T4	PA SP
VIREAD POWDER	T4	PA SP
ANTIVIRALS - HIV-SPECIFIC, PROTEASE INHIBITOR COMB		
KALETRA 100-25 MG TABLET	T4	SP
KALETRA 200-50 MG TABLET	T4	SP
KALETRA 80 MG-20 MG/ML SOLN (<i>lopinavir-ritonavir</i>)	T4	PA SP
<i>lopinavir/ritonavir</i> (Kaletra)	T4	SP
ANTIVIRALS - HIV-SPECIFIC, PROTEASE INHIBITORS		
<i>atazanavir sulfate</i> (Reyataz)	T4	PA SP
CRIXIVAN	T4	PA SP
EVOTAZ	T4	PA SP
<i>fosamprenavir calcium</i> (Lexiva)	T4	PA SP
INVIRASE	T3	PA
LEXIVA 50 MG/ML SUSPENSION	T4	PA SP
LEXIVA 700 MG TABLET (<i>fosamprenavir calcium</i>)	T4	PA SP
NORVIR 100 MG POWDER PACKET	T4	SP
NORVIR 100 MG TABLET (<i>ritonavir</i>)	T4	PA SP
REYATAZ 150 MG CAPSULE (<i>atazanavir sulfate</i>)	T4	PA SP
REYATAZ 200 MG CAPSULE (<i>atazanavir sulfate</i>)	T4	PA SP
REYATAZ 300 MG CAPSULE (<i>atazanavir sulfate</i>)	T4	PA SP
REYATAZ 50 MG POWDER PACKET	T4	PA SP
<i>ritonavir</i> (Norvir)	T4	SP
VIRACEPT	T4	PA SP
ANTIVIRALS - HIV-I INTEGRASE STRAND TRANSFER INHIBTR		
APRETUDE	T4	PA SA
ISENTRESS	T4	SP
ISENTRESS HD	T4	PA SP
TIVICAY	T4	SP
TIVICAY PD	T4	SP
ARTV NUCLEOSIDE, NUCLEOTIDE, NON-NUCLEOSIDE RTI COMB		
ATRIPLA (<i>efavirenz-emtricit-tenofovir disop</i>)	T4	PA SP
COMPLERA	T4	PA SP
DELSTRIGO	T4	PA SP
<i>efavirenz/emtricit/tenofovir df</i> (Atripla)	T4	PA SP
<i>efavirenz/lamivudine/tenofovir disop</i> (Symfi Lo)	T4	SP

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ANTIVIRALS (AIDS/HIV)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ARTV NUCLEOSIDE, NUCLEOTIDE, NON-NUCLEOSIDE RTI COMB		
<i>efavirenz/lamivu/tenofov disop (Symfi)</i>	T4	SP
ODEFSEY	T4	PA SP
SYMFI (<i>efavirenz-lamivu-tenofov disop</i>)	T4	SP
SYMFI LO (<i>efavirenz-lamivu-tenofov disop</i>)	T4	SP
ARV-NUCLEOSIDE, NUCLEOTIDE RTI, INTEGRASE INHIBITORS		
BIKTARVY	T4	SP
GENVOYA	T4	SP
STRIBILD	T4	PA SP
ANTIVIRALS (Eye Conditions)		
EYE ANTIVIRALS		
<i>trifluridine</i>	T1	
ZIRGAN	T3	
ANTIVIRALS (Infections)		
ANTIVIRAL MONOCLONAL ANTIBODIES		
SYNAGIS	T4	PA SP HD
ANTIVIRALS, GENERAL		
<i>acyclovir 200 mg capsule</i>	T1	
<i>acyclovir 200 mg/5 ml susp (Zovirax)</i>	T1	
<i>acyclovir 400 mg tablet</i>	T1	
<i>acyclovir 800 mg tablet</i>	T1	
<i>acyclovir sodium</i>	T1	
<i>cidofovir</i>	T4	SP
CYTOVENE (<i>ganciclovir sodium</i>)	T4	SP
<i>famciclovir</i>	T1	
FLUMADINE (<i>rimantadine hcl</i>)	T3	
<i>foscarnet sodium (Foscavir)</i>	T1	
FOSCAVIR	T3	
FOSCAVIR (<i>foscarnet sodium</i>)	T3	
GANCICLOVIR	T4	SP
<i>ganciclovir sodium</i>	T4	SP
<i>ganciclovir sodium (Cytovene)</i>	T4	SP
LIVTENCITY	T4	PA QL (4 tabs/day) SP
<i>oseltamivir 6 mg/ml suspension (Tamiflu)</i>	T1	QL (180ml/30 days)
<i>oseltamivir phos 30 mg capsule (Tamiflu)</i>	T1	QL (20 caps/30 days)
<i>oseltamivir phos 45 mg capsule (Tamiflu)</i>	T1	QL (10 caps/30 days)

T1 – Typically Generics
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T4 – Specialty Medications
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List of Prescription Medications

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

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List of Prescription Medications

ANTIVIRALS (Infections)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
HEP C VIRUS-NS5B POLYMERASE AND NS5A INHIB. COMBO.		
SOFOSBUVIR-VELPATASVIR	T4	PA QL(1 tab/day) SP HD
HEPATITIS B TREATMENT AGENTS		
<i>adefovir dipivoxil</i>	T4	SP HD
BARACLUDE 0.05 MG/ML SOLUTION	T4	SP HD
BARACLUDE 0.5 MG TABLET (<i>entecavir</i>)	T4	PA QL (1 tab/day) SP HD
BARACLUDE 1 MG TABLET (<i>entecavir</i>)	T4	PA SP HD
<i>entecavir 0.5 mg tablet</i> (Baraclude)	T4	QL (1 tab/day) SP HD
<i>entecavir 1 mg tablet</i> (Baraclude)	T4	SP HD
EPIVIR HBV 100 MG TABLET (<i>lamivudine hbv</i>)	T4	SP
EPIVIR HBV 25 MG/5 ML SOLN	T4	SP
<i>lamivudine</i> (Epiriv Hbv)	T4	SP
VEMLIDY	T4	SP HD
HEPATITIS C TREATMENT AGENTS		
PEGASYS	T4	PA SP HD
PEGINTRON	T4	PA SP HD
<i>ribasphere 200 mg capsule</i>	T4	SP HD
<i>ribasphere 200 mg tablet</i>	T4	SP HD
<i>ribasphere 400 mg tablet</i>	T4	SP
<i>ribasphere 600 mg tablet</i>	T4	SP
<i>ribasphere ribapak 200-400 mg</i>	T4	SP HD
<i>ribasphere ribapak 400-400 mg</i>	T4	SP HD
<i>ribasphere ribapak 600-400 mg</i>	T4	SP HD
<i>ribasphere ribapak 600-600 mg</i>	T4	SP HD
<i>ribavirin</i>	T4	SP HD
HEPATITIS C VIRUS- NS5A AND NS3/4A INHIBITOR COMB		
MAVYRET 100-40 MG TABLET	T4	PA QL(3 tabs/day) SP HD
MAVYRET 50-20 MG PELLETT PACKET	T4	PA QL(5 packs/day) SP HD
ZEPATIER	T4	PA SP HD
RNA POLYMERASE INHIBITOR		
LAGEVRIO (EUA)	T2	QL (1 pkg/120 days)
MOLNUPIRAVIR	T3	QL (1 pkg/120 days)

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List of Prescription Medications

ANTIVIRALS (Skin Conditions)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
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TOPICAL GENITAL WART-HPV TREATMENT AGENTS

VEREGEN	T3	PA
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AUTONOMIC DRUGS (Allergy/Nasal Sprays)

ANAPHYLAXIS THERAPY AGENTS

ADYPHREN	T1	
ADYPHREN AMP	T1	
AUVI-Q	T3	PA QL (2 packs/30 days)
EPINEPHRINE 0.15 MG AUTO-INJECT	T3	PA QL (2 packs/30 days)
<i>epinephrine 0.15 mg auto-inject</i> (Epipen Jr 2-pak)	T1	QL (2 packs/30 days)
EPINEPHRINE 0.3 MG AUTO-INJECT	T1	QL (2 packs/30 days)
<i>epinephrine 0.3 mg auto-inject</i> (Epipen 2-pak)	T1	QL (2 packs/30 days)
EPINEPHRINE PROFESSIONAL EMS	T3	
EPINEPHRINE PROFESSIONAL KIT	T3	
EPINEPHRINESNAP-EMS	T3	
EPINEPHRINESNAP-V	T3	
EPIPEN (<i>epinephrine</i>)	T3	PA QL (4 pens/22 days)
EPIPEN 2-PAK (<i>epinephrine</i>)	T3	PA QL (2 packs/30 days)
EPIPEN JR (<i>epinephrine</i>)	T3	PA QL (4 pens/22 days)
EPIPEN JR 2-PAK (<i>epinephrine</i>)	T3	PA QL (2 packs/30 days)
SYMJEPI	T3	PA QL (4 syringes/30 days)

AUTONOMIC DRUGS (Alzheimer's Disease)

CHOLINESTERASE INHIBITORS

ARICEPT (<i>donepezil hcl</i>)	T3	HD
BLOXIVERZ (<i>neostigmine methylsulfate</i>)	T3	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
MESTINON (<i>pyridostigmine bromide</i>)	T3	HD
NEOSTIGMINE METHYLSULFATE	T1	HD

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List of Prescription Medications

AUTONOMIC DRUGS (Alzheimer's Disease)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
CHOLINESTERASE INHIBITORS		
<i>neostigmine methylsulfate</i> (Bloxivert)	T1	HD
<i>neostigmine methylsulfate</i> (Neostigmine Methylsulfate)	T1	HD
NEOSTIGMINE-STERILE WATER	T1	HD
<i>physostigmine salicylate</i>	T1	HD
<i>pyridostigmine 60 mg/5 ml soln</i> (Mestinon)	T1	HD
PYRIDOSTIGMINE BR 30 MG TABLET	T3	PA QL (20 tabs/day) HD
<i>pyridostigmine br 60 mg tablet</i> (Mestinon)	T1	HD
<i>pyridostigmine bromide</i>	T3	HD
<i>pyridostigmine bromide</i> (Mestinon)	T1	HD
RAZADYNE ER 16 MG CAPSULE (<i>galantamine er</i>)	T3	HD
RAZADYNE ER 24 MG CAPSULE (<i>galantamine er</i>)	T3	HD
RAZADYNE ER 8 MG CAPSULE (<i>galantamine er</i>)	T3	QL (1 cap/day) HD
<i>rivastigmine</i> (Exelon)	T1	HD
<i>rivastigmine tartrate</i>	T1	HD

AUTONOMIC DRUGS (Attention Deficit Hyperactivity Disorder)⁸

ADRENERGICS, AROMATIC, NON-CATECHOLAMINE

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

T1 – Typically Generics

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T4 – Specialty Medications

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List of Prescription Medications

AUTONOMIC DRUGS (Attention Deficit Hyperactivity Disorder)⁸

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ADRENERGICS, AROMATIC, NON-CATECHOLAMINE		
<i>dextroamp-amphet er 20 mg cap</i> (Adderall Xr)	T1	PA QL (1 cap/day)
<i>dextroamp-amphet er 25 mg cap</i> (Adderall Xr)	T1	PA QL (1 per day)
<i>dextroamp-amphet er 30 mg cap</i> (Adderall Xr)	T1	PA QL (1 per day)
<i>dextroamp-amphet er 5 mg cap</i> (Adderall Xr)	T1	PA QL (1 cap/day)
<i>dextroamphetamine er 12.5 mg cap</i> (Mydayis)	T1	PA QL
<i>dextroamphetamine er 10 mg cap</i> (Dexedrine)	T1	PA QL (1 cap/day)
<i>dextroamphetamine er 15 mg cap</i> (Dexedrine)	T1	PA QL (3/day)
<i>dextroamphetamine er 5 mg cap</i> (Dexedrine)	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> (Desoxyn)	T1	PA
MYDAYIS (<i>dextroamphetamine/amphetamine</i>)	T3	PA QL (1 cap/day) ST
XELSTRYM	T3	PA QL (1 patch/day)
ZENZEDI	T3	PA ST

AUTONOMIC DRUGS (Blood Pressure/Heart Medications)

ADRENERGIC VASOPRESSOR AGENTS

<i>droxidopa</i> (Northera)	T3	SP HD
<i>midodrine hcl</i>	T1	
NORTHERA (<i>droxidopa</i>)	T3	PA SP HD

ALPHA-ADRENERGIC BLOCKING AGENTS

DIBENZYLIN (<i>phenoxybenzamine hcl</i>)	T3	HD
<i>phenoxybenzamine hcl</i> (Dibenzylin)	T1	HD
<i>phentolamine mesylate</i>	T1	HD

AUTONOMIC DRUGS (Miscellaneous)

ADRENERGIC AGENTS, CATECHOLAMINES

<i>dopamine hcl</i>	T1	
<i>dopamine hcl in dextrose 5 %</i>	T1	
<i>epinephrine</i>	T3	
<i>epinephrine 0.1 mg/ml syringe</i>	T1	
<i>epinephrine 1 mg/10 ml abbojct</i>	T1	

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T4 – Specialty Medications
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List of Prescription Medications

AUTONOMIC DRUGS (Miscellaneous)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
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ADRENERGIC AGENTS, CATECHOLAMINES

<i>epinephrine 1 mg/10 ml luerjet</i>	T1	
<i>epinephrine 1 mg/ml ampul</i>	T1	
<i>epinephrine 30 mg/30 ml vial</i>	T1	
<i>epinephrine hcl in 0.9 % nacl</i>	T1	
<i>epinephrine hcl in 0.9 % nacl (Epinephrine Hcl-0.9% Nacl)</i>	T1	
<i>epinephrine hcl in dextrose 5%</i>	T1	
<i>epinephrine hcl in dextrose 5% (Epinephrine Hcl-d5w)</i>	T1	
EPINEPHRINE HCL-0.9% NACL	T1	
EPINEPHRINE HCL-0.9% NACL (<i>epinephrine hcl-0.9% nacl</i>)	T1	
EPINEPHRINE HCL-D5W	T1	
EPINEPHRINE HCL-D5W (<i>epinephrine hcl-d5w</i>)	T1	
<i>isoproterenol hcl</i>	T1	
<i>isoproterenol hcl (Isuprel)</i>	T1	
ISUPREL	T3	
LEVOPHED (<i>norepinephrine bitartrate</i>)	T3	
LEVOPHED BITARTRATE (<i>norepinephrine bitartrate</i>)	T3	
<i>norepinephrine bit/0.9 % nacl</i>	T1	
NOREPINEPHRINE BITAR-0.9% NACL	T1	
<i>norepinephrine bitartrate (Levophed Bitartrate)</i>	T1	
<i>norepinephrine bitartrate (Levophed)</i>	T1	
<i>norepinephrine bitartrate/d5w</i>	T1	
NOREPINEPHRINE BITARTRATE-D5W	T1	

NEUROMUSCULAR BLOCKING AGENTS

<i>atracurium besylate</i>	T1	
BOTOX 100 UNIT VIAL	T4	PA SP
BOTOX 200 UNIT VIAL	T4	PA SP HD
<i>cisatracurium besylate (Nimbex)</i>	T1	
DAXXIFY	T4	PA SP
DYSPORE	T4	PA SP HD
MIVACRON	T3	
MYOBLOC	T4	PA SP
NIMBEX (<i>cisatracurium besylate</i>)	T3	
<i>pancuronium bromide</i>	T1	

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AUTONOMIC DRUGS (Miscellaneous)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
NEUROMUSCULAR BLOCKING AGENTS		
QUELICIN (<i>succinylcholine chloride</i>)	T3	
<i>rocuronium bromide</i>	T1	
<i>rocuronium bromide</i> (Rocuronium Bromide)	T1	
SUCCINYLCHOLINE CHLORIDE	T1	
<i>succinylcholine chloride</i> (Quelicin)	T1	
AUTONOMIC DRUGS (Urinary Tract Conditions)		
PARASYMPATHETIC AGENTS		
<i>bethanechol chloride</i>	T1	HD
<i>cevimeline hcl</i> (Evoxac)	T1	HD
EVOXAC (<i>cevimeline hcl</i>)	T3	HD
<i>guanidine hcl</i>	T1	HD
<i>pilocarpine hcl</i> (Salagen)	T1	HD
SALAGEN (<i>pilocarpine hcl</i>)	T3	HD
BIOLOGICALS (Allergy/Nasal Sprays)		
ALLERGENIC EXTRACTS, THERAPEUTIC		
GRASTEK	T3	PA QL (1 tab/day)
ODACTRA	T3	PA QL (1 tab/day)
ORALAIR	T3	PA QL (1 tab/day)
PALFORZIA	T4	PA SP
RAGWITEK	T3	PA QL (1 tab/day)
BIOLOGICALS (Blood Pressure/Heart Medications)		
PLASMA KALLIKREIN INHIBITORS		
TAKHZYRO	T4	PA SP HD
BIOLOGICALS (Miscellaneous)		
ANTISERA		
HYPERRHO S-D	T4	SP
MICRHOGAM ULTRA-FILTERED PLUS	T4	SP
RHOGAM ULTRA-FILTERED PLUS	T4	SP
RHOPHYLAC	T4	SP
WINRHO SDF	T4	SP HD
PKU TREATMENT AGENTS - PHENYLALANINE AMMONIA LYASE		
PALYNZIQ	T4	PA SP HD

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List of Prescription Medications

BIOLOGICALS (Vaccines)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
COVID-19 VACCINES		
COMIRANTY	T3	PPACA
JANSSEN COVID-19 VACCINE (EUA)	T3	PPACA
MODERNA COVID-19 VACCINE (EUA)	T3	PPACA
NOVAVAX COVID (EUA)	T3	PPACA
PFIZER COVID-19 VACCINE (EUA)	T3	PPACA
SPIKEVAX	T3	PPACA
ENTERIC VIRUS VACCINES		
IPOL	T3	PPACA
ROTARIX	T3	PPACA
ROTATEQ	T3	PPACA
GRAM NEGATIVE COCCI VACCINES		
BEXSERO	T3	PPACA
MENACTRA	T3	PPACA
MENQUADFI	T3	PPACA
MENVEO A-C-Y-W-135-DIP	T3	PPACA
PENBRAYA	T3	PPACA
TRUMENBA	T3	PPACA
GRAM POSITIVE COCCI VACCINES		
PNEUMOVAX 23	T3	PPACA
PREVNAR 13	T3	PPACA
INFLUENZA VIRUS VACCINES		
AFLURIA QUAD	T3	PPACA
FLUAD QUAD	T3	PPACA
FLUARIX	T3	PPACA
FLUARIX QUAD	T3	PPACA
FLUBLOK QUAD	T3	PPACA
FLUCELVAX QUAD	T3	PPACA
FLULAVAL	T3	PPACA
FLULAVAL QUAD	T3	PPACA
FLUMIST	T3	PPACA
FLUMIST QUAD	T3	PPACA
FLUZONE HIGH-DOSE QUAD	T3	PPACA
FLUZONE QUAD	T3	PPACA
VACCINE/TOXOID PREPARATIONS, COMBINATIONS		
ACTHIB	T3	PPACA
ADACEL TDAP	T3	PPACA

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List of Prescription Medications

BIOLOGICALS (Vaccines)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
VACCINE/TOXOID PREPARATIONS, COMBINATIONS (con't)		
BOOSTRIX TDAP	T3	PPACA
DAPTACEL DTAP	T3	PPACA
DIPHtheria-TETANUS TOXOIDS-PED	T3	PPACA
HIBERIX	T3	PPACA
INFANRIX DTAP	T3	PPACA
KINRIX	T3	PPACA
M-M-R II VACCINE	T3	PPACA
PEDVAXHIB	T3	PPACA
PENTACEL	T3	PPACA
PENTACEL ACTHIB COMPONENT	T3	PPACA
PROQUAD	T3	PPACA
QUADRACEL DTAP-IPV	T3	PPACA
TDVAX	T3	PPACA
TENIVAC	T3	PPACA
VAXELIS	T3	PPACA
VIRAL/TUMORIGENIC VACCINES		
ACAM2000	T3	
ENGERIX-B ADULT	T3	PPACA
ENGERIX-B PEDIATRIC-ADOLESCENT	T3	PPACA
GARDASIL 9	T3	PPACA
HEPLISAV-B	T3	PPACA
IXCHIQ	T3	PPACA
JYNNEOS	T3	
PEDIARIX	T3	PPACA
RECOMBIVAX HB	T3	PPACA
SHINGRIX	T3	QL (2 doses/lifetime) PPACA
TWINRIX	T3	PPACA
VARIVAX VACCINE	T3	PPACA
ZOSTAVAX	T3	PPACA
BLOOD (Blood Modifiers/Bleeding Disorders)		
AGENTS TO TX THROMBOTIC THROMBOCYTOPENIC PURPURA		
ADZYNMA	T4	PA SP
CABLIVI	T4	PA SP
ANTI-FIBRINOLYTIC AGENTS		
AMICAR (<i>aminocaproic acid</i>)	T4	SP HD
<i>aminocaproic acid</i>	T4	SP HD

T1 – Typically Generics
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List of Prescription Medications

BLOOD (Blood Modifiers/Bleeding Disorders)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ANTI-FIBRINOLYTIC AGENTS (cont.)		
<i>aminocaproic acid</i> (Amicar)	T4	SP HD
CYKLOKAPRON (<i>tranexamic acid</i>)	T4	SP
FIBRYGA	T4	PA SP
LYSTEDA (<i>tranexamic acid</i>)	T4	SP
RIASTAP	T4	PA SP
<i>tranexamic acid</i> (Cyklokapron)	T4	SP
<i>tranexamic acid</i> (Lysteda)	T4	SP
<i>tranexamic 1,000 mg/100ml-nacl</i>	T4	SP
TRANEXAMIC 1,000 MG/100ML-NACL	T4	SP
ANTI-HEMOPHILIC FACTORS		
ALTUVIIIO	T4	PA SP HD
COMPLEMENT (C3) INHIBITORS		
EMPAVELI	T4	PA SP
FABHALTA	T4	PA QL (2 caps/day) SP
COAGULANTS		
<i>protamine sulfate</i>	T1	
COMPLEMENT(C5) INHIBITOR		
TAVNEOS	T4	PA QL (6 caps/day) SP HD
FACTOR IX COMPLEX (PCC) PREPARATIONS		
KCENTRA	T4	SP
FACTOR X PREPARATIONS		
COAGADEX	T4	PA SP
FACTOR XIII PREPARATIONS		
CORIFACT	T4	PA SP
TRETEN	T4	PA SP
HEMOPHILIA TREATMENT AGENTS, NON-FACTOR REPLACEMENT		
HEMLIBRA	T4	PA SP HD
HUMAN MONOCLONAL ANTIBODY COMPLEMENT (C5) INHIBITOR		
SOLIRIS	T4	PA SP
ULTOMIRIS	T4	PA SP HD
PROTEIN C PREPARATIONS		
CEPROTIN	T4	PA SP
SICKLE CELL ANEMIA AGENTS		
ADAKVEO	T4	PA SP
DROXIA	T2	
OXBRYTA	T4	PA QL (5 tabs/day) SP HD

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

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List of Prescription Medications

CARDIAC DRUGS (Blood Pressure/Heart Medications)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ANTI-ANGINAL, ANTI-ISCHEMIC AGENTS, NON-HEMODYNAMIC		
RANEXA (<i>ranolazine er</i>)	T3	PA QL (4 tabs/day) HD
<i>ranolazine</i> (Ranexa)	T1	QL (4 tabs/day) HD
ANTI-ARRHYTHMICS		
<i>adenosine 12 mg/4 ml syringe</i>	T1	HD
<i>adenosine 12 mg/4 ml vial</i>	T1	HD
<i>adenosine 6 mg/2 ml syringe</i>	T1	HD
<i>adenosine 6 mg/2 ml vial</i>	T1	HD
<i>amiodarone hcl</i>	T1	HD
AMIODARONE HCL-D5W	T1	HD
<i>bretylum tosylate</i>	T1	HD
CORVERT (<i>ibutilide fumarate</i>)	T3	PA HD
<i>disopyramide phosphate</i> (Norpace)	T1	HD
<i>dofetilide 125 mcg capsule</i> (Tikosyn)	T1	QL (8 caps/day) HD
<i>dofetilide 250 mcg capsule</i> (Tikosyn)	T1	QL (4 caps/day) HD
<i>dofetilide 500 mcg capsule</i> (Tikosyn)	T1	QL (2 caps/day) HD
<i>flecainide acetate</i>	T1	HD
<i>ibutilide fumarate</i> (Corvert)	T1	HD
<i>lidocaine hcl 1% abboject</i>	T1	HD
<i>lidocaine hcl 1% syringe</i>	T1	HD
<i>lidocaine hcl 2% abboject</i>	T1	HD
<i>lidocaine hcl 2% luer-jet</i>	T1	HD
<i>lidocaine hcl 2% syringe</i>	T1	HD
<i>lidocaine hcl 2% vial</i>	T1	HD
<i>lidocaine hcl/dextrose 5 %/pf</i>	T1	HD
<i>mexiletine hcl</i>	T1	HD
MULTAQ	T3	HD
NEXTERONE	T3	HD
NORPACE (<i>disopyramide phosphate</i>)	T3	PA HD
NORPACE CR	T3	HD
<i>pacerone 100 mg tablet</i>	T3	PA HD
<i>pacerone 200 mg tablet</i>	T1	HD
<i>pacerone 400 mg tablet</i>	T3	PA HD
<i>procainamide hcl</i>	T1	HD
<i>propafenone hcl</i>	T1	HD
<i>propafenone hcl</i> (Rythmol Sr)	T1	HD

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List of Prescription Medications

CARDIAC DRUGS (Blood Pressure/Heart Medications)

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

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List of Prescription Medications

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

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List of Prescription Medications

CARDIAC DRUGS (Blood Pressure/Heart Medications)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
CALCIUM CHANNEL BLOCKING AGENTS		
<i>verapamil hcl</i> (Verelan Pm)	T1	HD
<i>verapamil hcl</i> (Verelan)	T1	HD
VERELAN (<i>verapamil hcl</i>)	T3	HD
VERELAN (<i>verapamil sr</i>)	T3	HD
VERELAN PM (<i>verapamil er pm</i>)	T3	HD
CARDIOPLEGIC SOLUTIONS		
CARDIOPLEGIA DEL NIDO FORMULA	T3	
CARDIOPLEGIA HIGH POTASSIUM	T3	
CARDIOPLEGIA IND 8:1 NON-ENRCH	T3	
CARDIOPLEGIA INDUCTION 4:1	T3	
CARDIOPLEGIA INDUCTION 8:1	T3	
CARDIOPLEGIA MAINTENANCE 4:1	T3	
CARDIOPLEGIA MAINTENANCE 8:1	T3	
CARDIOPLEGIA REPERFUSATE 4:1	T3	
<i>cardioplegic solution no. 1</i> (Plegisol)	T1	
PLEGISOL	T3	
DIGITALIS GLYCOSIDES		
<i>digoxin</i>	T1	HD
<i>digoxin</i> (Lanoxin)	T1	HD
LANOXIN 125 MCG TABLET (<i>digoxin</i>)	T3	PA HD
LANOXIN 187.5 MCG TABLET	T3	PA HD
LANOXIN 250 MCG TABLET (<i>digoxin</i>)	T3	PA HD
LANOXIN 500 MCG/2 ML AMPULE (<i>digoxin</i>)	T3	HD
LANOXIN 500 MCG/2 ML VIAL	T3	HD
LANOXIN 62.5 MCG TABLET	T3	PA HD
LANOXIN PEDIATRIC	T3	HD
HEART RATE REDUCING, SA SELECTIVE I(F) CURRENT INH.		
CORLANOR TABLET	T2	PA HD
CORLANOR SOLUTION	T3	PA SP HD
INOTROPIC DRUGS		
<i>dobutamine hcl</i>	T1	
<i>dobutamine hcl in dextrose 5 %</i>	T1	
<i>milrinone lactate</i>	T1	
<i>milrinone lactate/d5w</i>	T1	
VASODILATORS, CORONARY		
DILATRATE-SR	T3	HD

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CARDIAC DRUGS (Blood Pressure/Heart Medications)

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

CARDIOVASCULAR (Allergy/Nasal Sprays)

SYMPATHOMIMETIC AGENTS

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

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List of Prescription Medications

CARDIOVASCULAR (Asthma/COPD/Respiratory)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
PULM ANTI-HTN, SOLUBLE GUANYLATE CYCLASE STIMULATOR		
ADEMPAS	T4	PA SP HD
VERQUVO	T2	PA QL (1 tab/day)
PULM.ANTI-HTN, SEL.C-GMP PHOSPHODIESTERASE T5 INHIB		
ADCIRCA (<i>tadalafil</i>)	T4	PA SP HD
LIQREV	T4	PA SP HD
REVATIO	T4	PA SP HD
REVATIO (<i>sildenafil citrate</i>)	T4	PA SP HD
TADLIQ	T4	PA SP HD
<i>sildenafil 10 mg/12.5 ml vial</i> (Revatio)	T4	PA SP HD
<i>sildenafil 10 mg/ml oral susp</i> (Revatio)	T4	PA SP HD
<i>sildenafil 20 mg tablet</i> (Revatio)	T4	PA SP HD
<i>tadalafil</i> (Adcirca)	T4	PA SP HD
<i>tadalafil 20 mg tablet</i> (Adcirca)	T4	PA SP HD
PULMONARY ANTI-HTN, ENDOTHELIN RECEPTOR ANTAGONIST		
<i>ambrisentan</i> (Letairis)	T4	PA SP HD
<i>bosentan</i> (Tracleer)	T4	PA SP HD
LETAIRIS (<i>ambrisentan</i>)	T4	PA SP HD
OPSUMIT	T4	PA SP HD
TRACLEER 125 MG TABLET (<i>bosentan</i>)	T4	PA SP HD
TRACLEER 32 MG TABLET FOR SUSP	T4	PA SP HD
TRACLEER 62.5 MG TABLET (<i>bosentan</i>)	T4	PA SP HD
PULMONARY ANTIHYPERTENSIVES, PROSTACYCLIN-TYPE		
<i>epoprostenol sodium</i>	T4	PA SP HD
<i>epoprostenol sodium 0.5 mg vI</i>	T4	PA SP HD
<i>epoprostenol sodium 0.5 mg vI</i> (Flolan)	T4	PA SP
<i>epoprostenol sodium 1.5 mg vI</i>	T4	PA SP HD
<i>epoprostenol sodium 1.5 mg vI</i> (Flolan)	T4	PA SP
FLOLAN	T4	PA SP
ORENITRAM MONTH 1 TITRATION KT	T4	PA QL(168 tabs/180 days) SP HD
ORENITRAM MONTH 2 TITRATION KT	T4	PA QL(336 tabs/180 days) SP HD
ORENITRAM MONTH 3 TITRATION KT	T4	PA QL(252 tabs/180 days) SP HD
ORENITRAM ER	T4	PA SP HD
REMODULIN (<i>treprostinil</i>)	T4	PA SP HD
<i>treprostinil sodium</i> (Remodulin)	T4	PA SP HD

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CARDIOVASCULAR (Asthma/COPD/Respiratory)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
PULMONARY ANTIHYPERTENSIVES, PROSTACYCLIN-TYPE		
TYVASO	T4	PA SP HD
TYVASO INSTITUTIONAL START KIT	T4	PA SP HD
TYVASO REFILL KIT	T4	PA SP HD
TYVASO STARTER KIT	T4	PA SP HD
UPTRAVI	T4	PA SP HD
VELETRI VIAL	T4	PA SP
VENTAVIS	T4	PA SP HD

CARDIOVASCULAR (Blood Pressure/Heart Medications)

ACE INHIBITOR-CALCIUM CHANNEL BLOCKER COMBINATION

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 (Tarka)</i>	T1	HD

ACE INHIBITOR-THIAZIDE OR THIAZIDE-LIKE DIURETIC

ACCURETIC (<i>quinapril-hydrochlorothiazide</i>)	T3	ST HD
<i>benazepril/hydrochlorothiazide</i>	T1	HD
<i>benazepril/hydrochlorothiazide (Lotensin Hct)</i>	T1	HD
<i>captopril-hctz 25-15 mg tablet</i>	T1	QL (3 tabs/day) HD
<i>captopril-hctz 25-25 mg tablet</i>	T1	QL (2 tabs/day) HD
<i>captopril-hctz 50-15 mg tablet</i>	T1	QL (3 tabs/day) HD
<i>captopril-hctz 50-25 mg tablet</i>	T1	QL (2 tabs/day) HD
<i>enalapril/hydrochlorothiazide</i>	T1	HD
<i>enalapril/hydrochlorothiazide (Vaseretic)</i>	T1	HD
<i>fosinopril/hydrochlorothiazide</i>	T1	HD
<i>lisinopril/hydrochlorothiazide (Zestoretic)</i>	T1	HD
LOTENSIN HCT (<i>benazepril-hydrochlorothiazide</i>)	T3	ST HD
<i>quinapril/hydrochlorothiazide (Accuretic)</i>	T1	HD
VASERETIC (<i>enalapril-hydrochlorothiazide</i>)	T3	ST HD
ZESTORETIC (<i>lisinopril-hydrochlorothiazide</i>)	T3	ST HD

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

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

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

HD – May require home delivery pharmacy
 PPACA – No Cost-Share Preventive Medication
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List of Prescription Medications

CARDIOVASCULAR (Blood Pressure/Heart Medications)		
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 20 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
LABETALOL HCL 10 MG/2 ML SYRNG	T3	HD
<i>labetalol hcl 100 mg tablet</i>	T1	HD
<i>labetalol hcl 100 mg/20 ml vl</i>	T1	HD
<i>labetalol hcl 20 mg/4 ml crpjt</i>	T1	HD
<i>labetalol hcl 20 mg/4 ml syrng</i>	T1	HD
<i>labetalol hcl 20 mg/4 ml vial</i>	T1	HD
<i>labetalol hcl 200 mg tablet</i>	T1	HD
<i>labetalol hcl 200 mg/40 ml vl</i>	T1	HD
<i>labetalol hcl 300 mg tablet</i>	T1	HD
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>prazosin hcl</i> (Minipress)	T1	HD
<i>terazosin hcl</i>	T1	HD
ANGIOTEN.RECEPTR ANTAG-CALCIUM CHANL BLKR-THIAZIDE		
<i>amlodipine/valsartan/hcthiazyd</i> (Exforge Hct)	T1	HD
EXFORGE HCT (<i>amlodipine-valsartan-hctz</i>)	T3	PA HD
<i>olmesartan/amlodipin/hcthiazyd</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

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List of Prescription Medications

CARDIOVASCULAR (Blood Pressure/Heart Medications)

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

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List of Prescription Medications

CARDIOVASCULAR (Blood Pressure/Heart Medications)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ANTI-HYPERTENSIVES, ACE INHIBITORS		
ALTACE (<i>ramipril</i>)	T3	ST HD
<i>benazepril hcl</i>	T1	HD
ANGIOTENSIN RECEPTOR BLOCKR-CALCIUM CHANNEL BLOCKR		
<i>benazepril hcl</i> (Lotensin)	T1	HD
<i>captopril</i>	T1	HD
<i>enalapril maleate</i> (Vasotec)	T1	HD
<i>enalaprilat dihydrate</i>	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
QBRELIS	T3	PA 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

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List of Prescription Medications

CARDIOVASCULAR (Blood Pressure/Heart Medications)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ANTI-HYPERTENSIVES, ANGIOTENSIN RECEPTOR ANTAGONIST		
MICARDIS 80 MG TABLET (<i>telmisartan</i>)	T3	ST HD
<i>olmesartan medoxomil 20 mg tab</i> (Benicar)	T1	QL (1 tab/day) HD
<i>olmesartan medoxomil 40 mg tab</i> (Benicar)	T1	HD
<i>olmesartan medoxomil 5 mg tab</i> (Benicar)	T1	HD
<i>telmisartan 20 mg tablet</i> (Micardis)	T1	QL (1 tab/day) HD
<i>telmisartan 40 mg tablet</i> (Micardis)	T1	QL (1 tab/day) HD
<i>telmisartan 80 mg tablet</i> (Micardis)	T1	HD
<i>valsartan</i> (Diovan)	T1	HD
VALSARTAN 20 MG/5 ML SOLUTION	T3	ST HD
ANTIHYPERTENSIVES, GANGLIONIC BLOCKERS		
VECAMYL	T1	
ANTI-HYPERTENSIVES, MISCELLANEOUS		
DEMSEER (<i>metyrosine</i>)	T3	HD
<i>metyrosine</i> (Demser)	T1	HD
NITROPRESS	T3	HD
<i>nitroprusside sodium</i> (Nitropress)	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 0.1 mg tablet</i> (Catapres)	T1	HD
<i>clonidine hcl 0.2 mg tablet</i> (Catapres)	T1	HD
<i>clonidine hcl 0.3 mg tablet</i> (Catapres)	T1	HD
<i>guanfacine hcl</i>	T1	HD
<i>methyldopa</i>	T1	HD
<i>methyldopa/hydrochlorothiazide</i>	T1	HD
<i>methyldopate hcl</i>	T1	HD
ANTI-HYPERTENSIVES, VASODILATORS		
CORLOPAM	T3	HD
<i>hydralazine hcl</i>	T1	HD
<i>minoxidil</i>	T1	HD

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List of Prescription Medications

CARDIOVASCULAR (Blood Pressure/Heart Medications)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
BETA-ADRENERGIC BLOCKING AGENTS		
<i>acebutolol hcl</i>	T1	HD
<i>atenolol</i> (Tenormin)	T1	HD
BETAPACE (<i>sotalol af</i>)	T3	PA HD
BETAPACE (<i>sotalol</i>)	T3	PA HD
BETAPACE AF (<i>sotalol af</i>)	T3	PA HD
<i>betaxolol hcl</i>	T1	HD
<i>bisoprolol fumarate</i>	T1	HD
BREVIBLOC	T3	HD
BYSTOLIC 10 MG TABLET	T3	PA QL (1 tab/day) HD
BYSTOLIC 2.5 MG TABLET	T3	PA QL (1 tab/day) HD
BYSTOLIC 20 MG TABLET	T3	PA HD
BYSTOLIC 5 MG TABLET	T2	QL (1 tab/day) ST HD
CORGARD (<i>nadolol</i>)	T3	PA HD
<i>esmolol hcl</i>	T1	HD
<i>esmolol hcl</i> (Brevibloc)	T1	HD
ESMOLOL HCL-WATER	T1	HD
<i>esmolol in sodium chloride, iso</i> (Brevibloc)	T1	HD
HEMANGEOL	T3	PA HD
INDERAL LA (<i>propranolol hcl er</i>)	T3	PA HD
INDERAL XL	T3	PA HD
INNOPRAN XL	T3	ST HD
KAPSPARGO SPRINKLE	T3	PA HD
LOPRESSOR (<i>metoprolol tartrate</i>)	T3	PA HD
<i>metoprolol succinate</i> (Toprol XL)	T1	HD
<i>metoprolol tartrate</i>	T1	HD
<i>metoprolol tartrate</i> (Lopressor)	T1	HD
<i>nadolol</i>	T1	HD
<i>pindolol</i>	T1	HD
<i>propranolol hcl</i>	T1	HD
<i>propranolol hcl</i> (Inderal La)	T1	HD
SOTALOL HCL	T1	HD
<i>sotalol hcl</i> (Betapace Af)	T1	HD
<i>sotalol hcl</i> (Betapace)	T1	HD
SOTYLIZE	T3	HD
TENORMIN (<i>atenolol</i>)	T3	PA HD

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CARDIOVASCULAR (Blood Pressure/Heart Medications)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
BETA-ADRENERGIC BLOCKING AGENTS		
<i>timolol maleate</i>	T1	HD
TOPROL XL (<i>metoprolol succinate</i>)	T3	PA 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
DUTOPROL	T3	PA HD
<i>metoprolol/hydrochlorothiazide</i>	T1	HD
<i>nadolol/bendroflumethiazide</i>	T1	HD
<i>propranolol/hydrochlorothiazid</i>	T1	HD
TENORETIC 100 (<i>atenolol-chlorthalidone</i>)	T3	PA HD
TENORETIC 50 (<i>atenolol-chlorthalidone</i>)	T3	PA HD
ZIAC (<i>bisoprolol-hydrochlorothiazide</i>)	T3	PA HD
MUSCARINIC RECEPTOR ANTAGONISTS (ANTICHOLINERGIC)		
ATROPEN	T3	
PATENT DUCTUS ARTERIOSUS TREAT. AGENTS, NSAID-TYPE		
<i>ibuprofen lysine/pf</i> (Neoprofen)	T1	
<i>indomethacin 1 mg vial</i>	T1	
NEOPROFEN (<i>ibuprofen lysine</i>)	T3	
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
TEKTURNA 150 MG TABLET (<i>aliskiren</i>)	T3	PA QL (1 tab/day) HD
TEKTURNA 300 MG TABLET (<i>aliskiren</i>)	T3	PA HD
RENIN INHIBITOR, DIRECT AND THIAZIDE DIURETIC COMB		
TEKTURNA HCT	T2	HD
VASODILATORS, COMBINATION		
BIDIL	T3	QL (6 tabs/day) HD
<i>isosorbide-hydralazine 20-37.5</i> (Bidil)	T1	QL (6 tabs/day) HD
VASODILATORS, PERIPHERAL		
<i>ergoloid mesylates</i>	T1	
<i>isoxsuprine hcl</i>	T1	
<i>papaverine hcl</i>	T1	

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List of Prescription Medications

CARDIOVASCULAR (Cholesterol Medications)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ANTI-HYPERLIPIDEMIC - 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
ANTIHYPERTENSIVE - ANGIOPOIETIN-LIKE 3 INHIBITOR		
EVKEEZA	T4	PA SP
ANTI-HYPERLIPIDEMIC - APO B-100 SYNTHESIS INHIBITOR		
KYNAMRO	T4	PA SP
ANTI-HYPERLIPIDEMIC - ATP CITRATE LYASE INHIBITOR		
NEXLETOL	T2	PA QL (1 tab/day)
ANTI-HYPERLIPIDEMIC - MTP INHIBITOR		
JUXTAPID	T4	PA SP HD
ANTI-HYPERLIPIDEMIC - PCSK9 INHIBITORS		
PRALUENT PEN	T3	PA
REPATHA PUSHTRONEX	T2	PA
REPATHA SURECLICK	T2	PA
REPATHA SYRINGE	T2	PA

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List of Prescription Medications

CARDIOVASCULAR (Cholesterol Medications)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
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 (Lipitor)</i>	T1	HD PPACA
<i>atorvastatin 20 mg tablet (Lipitor)</i>	T1	HD PPACA
<i>atorvastatin 40 mg tablet (Lipitor)</i>	T1	HD
<i>atorvastatin 80 mg tablet (Lipitor)</i>	T1	HD
CRESTOR 10 MG TABLET (<i>rosuvastatin calcium</i>)	T3	QL (1 tab/day) ST HD
CRESTOR 20 MG TABLET (<i>rosuvastatin calcium</i>)	T3	QL (1 tab/day) ST HD
CRESTOR 40 MG TABLET (<i>rosuvastatin calcium</i>)	T3	ST HD
CRESTOR 5 MG TABLET (<i>rosuvastatin calcium</i>)	T3	QL (1 tab/day) ST HD
EZALLOR SPRINKLE 10 MG CAPSULE	T3	QL (1 tab/day) ST HD
EZALLOR SPRINKLE 20 MG CAPSULE	T3	QL (1 tab/day) ST HD
EZALLOR SPRINKLE 40 MG CAPSULE	T3	ST HD
EZALLOR SPRINKLE 5 MG CAPSULE	T3	QL (1 tab/day) ST HD
FLOLIPID	T3	ST HD
<i>fluvastatin sodium</i>	T1	HD PPACA
<i>fluvastatin sodium (Lescol XL)</i>	T1	HD PPACA
LESCOL XL (<i>fluvastatin er</i>)	T3	PA HD
LIPITOR (<i>atorvastatin calcium</i>)	T3	PA HD
LIVALO 1 MG TABLET	T2	QL (1 tab/day) ST HD
LIVALO 2 MG TABLET	T2	QL (1 tab/day) ST HD
LIVALO 4 MG TABLET	T2	PA HD
<i>lovastatin 10 mg tablet</i>	T1	HD
<i>lovastatin 20 mg tablet</i>	T1	HD PPACA
<i>lovastatin 40 mg tablet</i>	T1	HD PPACA
<i>pitavastatin tablet</i>	T1	QL (1 tab/day) HD PPACA
PRAVACHOL (<i>pravastatin sodium</i>)	T3	PA HD
<i>pravastatin sodium</i>	T1	HD PPACA
<i>pravastatin sodium (Pravachol)</i>	T1	HD PPACA
<i>rosuvastatin calcium 10 mg tab (Crestor)</i>	T1	QL (1 tab/day) HD PPACA
<i>rosuvastatin calcium 20 mg tab (Crestor)</i>	T1	QL (1 tab/day) HD
<i>rosuvastatin calcium 40 mg tab (Crestor)</i>	T1	HD
<i>rosuvastatin calcium 5 mg tab (Crestor)</i>	T1	QL (1 tab/day) HD PPACA

T1 – Typically Generics
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T4 – Specialty Medications
 PA – Prior Authorization
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ST – Step Therapy
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 CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

CARDIOVASCULAR (Cholesterol Medications)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ANTI-HYPERLIPIDEMIC-HMGCOA REDUCTASE INHIB (Statins) (con't.)		
<i>simvastatin 10 mg tablet (Zocor)</i>	T1	HD PPACA
<i>simvastatin 20 mg tablet (Zocor)</i>	T1	HD PPACA
SIMVASTATIN 20 MG/5 ML SUSP	T3	ST HD
<i>simvastatin 40 mg tablet (Zocor)</i>	T1	HD PPACA
<i>simvastatin 5 mg tablet</i>	T1	HD
ZOCOR	T3	PA HD
ZYPITAMAG	T3	ST HD
BILE SALT SEQUESTRANTS		
<i>cholestyramine (with sugar) (Questran)</i>	T1	HD
<i>cholestyramine/aspartame</i>	T1	HD
<i>cholestyramine/aspartame (Questran Light)</i>	T1	HD
<i>colesevelam hcl (Welchol)</i>	T1	HD
COLESTID	T3	HD
COLESTID (<i>colestipol hcl</i>)	T3	HD
<i>colestipol hcl (Colestid)</i>	T1	HD
QUESTRAN (<i>cholestyramine</i>)	T3	HD
QUESTRAN LIGHT (<i>prevalite</i>)	T3	HD
WELCHOL (<i>colesevelam hcl</i>)	T3	PA HD
LIPOTROPICS		
ANTARA	T3	PA HD
<i>ezetimibe (Zetia)</i>	T1	HD
<i>fenofibrate 120 mg tablet (Fenoglide)</i>	T1	HD
<i>fenofibrate 130 mg capsule</i>	T1	HD
<i>fenofibrate 134 mg capsule</i>	T1	HD
<i>fenofibrate 145 mg tablet (Tricor)</i>	T1	HD
FENOFIBRATE 150 MG CAPSULE	T1	HD
<i>fenofibrate 160 mg tablet</i>	T1	HD
FENOFIBRATE 160 MG TABLET	T3	PA HD
<i>fenofibrate 200 mg capsule</i>	T1	HD
<i>fenofibrate 40 mg tablet (Fenoglide)</i>	T1	HD
<i>fenofibrate 43 mg capsule</i>	T1	HD
<i>fenofibrate 48 mg tablet (Tricor)</i>	T1	HD
FENOFIBRATE 50 MG CAPSULE	T1	HD
<i>fenofibrate 54 mg tablet</i>	T1	HD
<i>fenofibrate 67 mg capsule</i>	T1	HD

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List of Prescription Medications

CARDIOVASCULAR (Cholesterol Medications)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
LIPOTROPICS (con't.)		
<i>fenofibric acid (choline)</i> (Trilipix)	T1	HD
<i>fenofibric acid</i> (Fibricor)	T1	HD
FENOGLIDE (<i>fenofibrate</i>)	T3	PA HD
FIBRICOR (<i>fenofibric acid</i>)	T3	ST HD
<i>gemfibrozil</i> (Lopid)	T1	HD
LIPOFEN	T3	ST HD
LOPID (<i>gemfibrozil</i>)	T3	HD
<i>niacin</i> (Niacor)	T1	HD
<i>niacin</i> (Niaspan)	T1	HD
NIACOR	T1	HD
NIASPAN (<i>niacin er</i>)	T3	HD
TRICOR (<i>fenofibrate</i>)	T3	ST HD
TRIGLIDE	T3	ST HD
TRILIPIX (<i>fenofibric acid</i>)	T3	ST HD
ZETIA (<i>ezetimibe</i>)	T3	HD

CARDIOVASCULAR (Miscellaneous)

VENOSCLEROSING AGENTS

ASCLERA	T4	PA SP
ETHAMOLIN	T3	
<i>sodium tetradecyl sulfate</i> (Sotradecol)	T1	
SOTRADECOL	T3	
SOTRADECOL (<i>sodium tetradecyl sulfate</i>)	T3	
<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 21 mg capsule</i> (Namenda Xr)	T1	HD
<i>memantine hcl er 28 mg capsule</i> (Namenda Xr)	T1	HD
<i>memantine hcl er 7 mg capsule</i> (Namenda Xr)	T1	QL (1 cap/day) HD
NAMENDA 10 MG TABLET (<i>memantine hcl</i>)	T3	HD
NAMENDA 5 MG TABLET (<i>memantine hcl</i>)	T3	HD
NAMENDA 5-10 MG TITRATION PK	T2	HD
NAMENDA XR 14 MG CAPSULE (<i>memantine hcl er</i>)	T3	QL (1 cap/day) HD
NAMENDA XR 21 MG CAPSULE (<i>memantine hcl er</i>)	T3	HD
NAMENDA XR 28 MG CAPSULE (<i>memantine hcl er</i>)	T3	HD
NAMENDA XR 7 MG CAPSULE (<i>memantine hcl er</i>)	T3	QL (1 cap/day) HD

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List of Prescription Medications

CNS DRUGS (Alzheimer's Disease)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ALZHEIMER'S THERAPY, NMDA RECEPTOR ANTAGONISTS		
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)		
ALCOHOL, SYSTEMIC USE		
ALCOHOL, DEHYDRATED	T1	
AMYOTROPHIC LATERAL SCLEROSIS AGENTS		
EXSERVAN	T3	PA
RADICAVA	T4	PA SP
RADICAVA ORS	T4	PA QL (50ml/28 days) SP
RELYVRIO	T4	PA QL (2 packs/day) SP HD
RILUTEK (<i>riluzole</i>)	T4	PA SP HD
<i>riluzole</i> (Rilutek)	T4	SP HD
TIGLUTIK	T4	PA SP
QALSODY	T3	
CENTRAL NERVOUS SYSTEM STIMULANTS		
DOPRAM	T3	
<i>doxapram hcl</i> (Dopram)	T1	
DRUGS TO TREAT MOVEMENT DISORDERS		
AUSTEDO XR 6 MG TABLET	T4	PA QL (90 tabs/30 days) SP HD
AUSTEDO XR 12 MG TABLET	T4	PA QL (30 tabs/30 days) SP HD
AUSTEDO XR 24 MG TABLET	T4	PA QL (60 tabs/30 days) SP HD
AUSTEDO XR TITRATION KIT (WK1-4)	T4	PA QL (1 kit/180 days) SP HD
HORIZANT	T3	PA
INGREZZA	T4	PA SP
INGREZZA INITIATION PACK	T4	PA QL (28 caps/year) SP
<i>tetrabenazine</i> (Xenazine)	T4	PA SP HD
XENAZINE (<i>tetrabenazine</i>)	T4	PA SP HD
PSEUDOBULBAR AFFECT (PBA) AGENTS, NMDA ANTAGONISTS		
NUDEXTA	T3	QL (4 caps/day)
XANTHINES		
CAFICIT (<i>caffeine citrate</i>)	T3	HD

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List of Prescription Medications

CNS DRUGS (Miscellaneous)

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

CNS DRUGS (Multiple Sclerosis)

AGENTS TO TREAT MULTIPLE SCLEROSIS

AUBAGIO (<i>teriflunomide</i>)	T4	PA SP HD
AVONEX	T4	PA SP HD
AVONEX PEN	T4	PA SP HD
BAFIERTAM	T4	PA SP HD
BETASERON	T4	PA SP HD
BRIUMVI	T4	PA SP
COPAXONE (<i>glatopa</i>)	T4	PA SP HD
<i>dimethyl fumarate (Tecfidera)</i>	T4	HD
EXTAVIA	T4	PA SP HD
GILENYA	T4	PA SP HD
GILENYA 0.25 MG CAPSULE	T4	PA QL(1 cap/day) SP
GILENYA 0.5 MG CAPSULE (<i>fingolimod hcl</i>)	T4	PA SP HD
<i>glatiramer</i>	T4	HD
<i>glatopa</i>	T4	HD
<i>glatiramer acetate (Copaxone)</i>	T4	PA SP HD
KESIMPTA PEN	T4	PA SP HD
LEMRADA	T4	PA SP HD
MAVENCLAD	T4	PA SP HD
MAYZENT	T4	PA SP HD
OCREVUS	T4	PA SP HD
PLEGRIDY	T4	PA SP HD
PLEGRIDY PEN	T4	PA SP HD
PONVORY	T4	PA SP HD
REBIF	T4	PA SP HD
REBIF REBIDOSE	T4	PA SP HD
TASCENSO ODT	T4	PA QL(1 tab/day) SP HD
TECFIDERA (<i>dimethyl fumarate</i>)	T4	PA SP HD
<i>teriflunomide (Aubagio)</i>	T4	SP HD
VUMERITY	T4	PA SP HD

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List of Prescription Medications

CNS DRUGS (Multiple Sclerosis)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
AGTS TX NEUROMUSC TRANSMISSION DIS, POT-CHAN BLKR		
AMPYRA (<i>dalfampridine er</i>)	T4	PA SP HD
<i>dalfampridine</i> (Ampyra)	T4	PA SP HD
FIRDAPSE	T4	PA QL (8 tabs/day) SP
RUZURGI	T4	PA SP
AMPYRA (<i>dalfampridine er</i>)	T4	PA SP HD
<i>dalfampridine</i> (Ampyra)	T4	PA SP HD
FIRDAPSE	T4	PA QL (8 tabs/day) SP
RUZURGI	T4	PA SP
CNS DRUGS (Pain Relief And Inflammatory Disease)		
CALCITONIN GENE-RELATED PEPTIDE (CGRP) INHIBITORS		
EMGALITY SYRINGE	T2	PA
GLYPROMATE (GPE) ANALOGS		
DAYBUE	T4	PA QL (120ml/day) SP
POSTHERPETIC NEURALGIA AGENTS		
GRALISE	T3	PA
AGENTS TO TREAT MULTIPLE SCLEROSIS (cont.)		
VELSIPITY	T4	PA QL(30 tabs/30 days) SP HD
ZEPOSIA	T4	PA SP HD
CNS DRUGS (Seizure Disorders)		
ANTI-CONVULSANT - BENZODIAZEPINE TYPE		
<i>clobazam</i> (Onfi)	T1	HD
<i>clonazepam</i>	T1	HD
<i>clonazepam</i> (Klonopin)	T1	HD
DIASTAT (<i>diazepam</i>)	T3	PA HD
DIASTAT ACUDIAL (<i>diazepam</i>)	T3	PA HD
<i>diazepam 10 mg rectal gel syst</i>	T1	HD
<i>diazepam 2.5 mg rectal gel sys</i> (Diastat)	T1	HD
<i>diazepam 20 mg rectal gel syst</i> (Diastat Acudial)	T1	HD
<i>diazepam 20 mg rectal gel syst</i> (Diastat Acudial)	T1	HD
KLONOPIN (<i>clonazepam</i>)	T3	PA HD
NAYZILAM	T2	PA QL (5 kits/30 days) HD

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List of Prescription Medications

CNS DRUGS (Seizure Disorders)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ANTI-CONVULSANT - BENZODIAZEPINE TYPE		
ONFI (<i>clobazam</i>)	T3	PA HD
SYMPAZAN	T3	PA HD
VALTOCO	T3	PA QL (5 boxes/30 days) HD
ANTI-CONVULSANT - CANNABINOID TYPE		
EPIDIOLEX	T4	PA SP HD
ANTI-CONVULSANTS		
APTIOM 200 MG TABLET	T3	PA QL (1 tab/day) HD
APTIOM 400 MG TABLET	T3	PA QL (1 tab/day) HD
APTIOM 600 MG TABLET	T3	PA HD
APTIOM 800 MG TABLET	T3	PA HD
BANZEL 200 MG TABLET	T3	PA QL (16 tabs/day) HD
BANZEL 40 MG/ML SUSPENSION (<i>rufinamide</i>)	T3	PA QL (80ml/day) HD
BANZEL 400 MG TABLET	T3	PA QL (8 tabs/day) HD
BRIVIACT 10 MG TABLET	T3	PA HD
BRIVIACT 10 MG/ML ORAL SOLN	T3	PA HD
BRIVIACT 100 MG TABLET	T3	PA HD
BRIVIACT 25 MG TABLET	T3	PA HD
BRIVIACT 50 MG TABLET	T3	PA HD
BRIVIACT 50 MG/5 ML VIAL	T3	HD
BRIVIACT 75 MG TABLET	T3	PA HD
<i>carbamazepine</i>	T1	HD
<i>carbamazepine</i> (Carbatrol)	T1	HD
<i>carbamazepine</i> (Tegretol Xr)	T1	HD
<i>carbamazepine</i> (Tegretol)	T1	HD
CARBATROL (<i>carbamazepine er</i>)	T3	PA HD
CELONTIN	T2	HD
CEREBYX (<i>fosphenytoin sodium</i>)	T3	HD
DEPAKOTE (<i>divalproex sodium</i>)	T3	PA HD
DEPAKOTE ER (<i>divalproex sodium er</i>)	T3	PA HD
DEPAKOTE SPRINKLE (<i>divalproex sodium</i>)	T3	PA HD

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List of Prescription Medications

CNS DRUGS (Seizure Disorders)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ANTI-CONVULSANTS		
DIACOMIT	T4	PA SP HD
DILANTIN	T3	PA HD
DILANTIN (<i>phenytoin sodium extended</i>)	T3	PA HD
DILANTIN (<i>phenytoin</i>)	T3	PA HD
DILANTIN-125 (<i>phenytoin</i>)	T3	PA HD
<i>divalproex sodium</i> (Depakote Er)	T1	HD
<i>divalproex sodium</i> (Depakote Sprinkle)	T1	HD
<i>divalproex sodium</i> (Depakote)	T1	HD
ELEPSIA XR	T3	PA
EPRONTIA	T3	PA
<i>ethosuximide</i> (Zarontin)	T1	HD
<i>felbamate</i> (Felbatol)	T1	HD
FELBATOL (<i>felbamate</i>)	T3	PA HD
FINTEPLA	T4	PA SP HD
<i>fosphephenytoin sodium</i> (Cerebyx)	T1	HD
FYCOMPA 0.5 MG/ML ORAL SUSP	T2	PA HD
FYCOMPA 10 MG TABLET	T2	PA HD
FYCOMPA 12 MG TABLET	T2	PA HD
FYCOMPA 2 MG TABLET	T2	PA HD
FYCOMPA 4 MG TABLET	T2	PA QL (1 tab/day) HD
FYCOMPA 6 MG TABLET	T2	PA QL (1 tab/day) HD
FYCOMPA 8 MG TABLET	T2	PA HD
<i>gabapentin</i>	T1	HD
<i>gabapentin</i> (Neurontin)	T1	HD
GABITRIL 12 MG TABLET (<i>tiagabine hcl</i>)	T3	PA QL (8 tabs/day) HD
GABITRIL 16 MG TABLET (<i>tiagabine hcl</i>)	T3	PA QL (6 tabs/day) HD
GABITRIL 2 MG TABLET (<i>tiagabine hcl</i>)	T3	PA HD
GABITRIL 4 MG TABLET (<i>tiagabine hcl</i>)	T3	PA HD
KEPPRA 1,000 MG TABLET (<i>roweepira</i>)	T3	PA HD
KEPPRA 100 MG/ML ORAL SOLN (<i>levetiracetam</i>)	T3	PA HD
KEPPRA 250 MG TABLET (<i>levetiracetam</i>)	T3	PA HD
KEPPRA 500 MG TABLET (<i>roweepira</i>)	T3	PA HD
KEPPRA 500 MG/5 ML VIAL (<i>levetiracetam</i>)	T3	HD
KEPPRA 750 MG TABLET (<i>roweepira</i>)	T3	PA HD
KEPPRA XR (<i>levetiracetam er</i>)	T3	PA HD
LAMICTAL (BLUE) (<i>subvenite (blue)</i>)	T3	PA HD

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T4 – Specialty Medications

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QL – Quantity Limit

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AGE – Age Requirement

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List of Prescription Medications

CNS DRUGS (Seizure Disorders)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ANTI-CONVULSANTS		
LAMICTAL (GREEN) (<i>subvenite (green)</i>)	T3	PA HD
LAMICTAL (<i>lamotrigine</i>)	T3	PA HD
LAMICTAL (ORANGE) (<i>subvenite (orange)</i>)	T3	PA HD
LAMICTAL (<i>subvenite</i>)	T3	PA HD
LAMICTAL ODT (BLUE) (<i>lamotrigine odt (blue)</i>)	T3	PA HD
LAMICTAL ODT (GREEN) (<i>lamotrigine odt (green)</i>)	T3	PA HD
LAMICTAL ODT (<i>lamotrigine odt</i>)	T3	PA HD
LAMICTAL ODT (ORANGE) (<i>lamotrigine odt (orange)</i>)	T3	PA HD
LAMICTAL XR (BLUE)	T3	PA HD
LAMICTAL XR (GREEN)	T3	PA HD
LAMICTAL XR (<i>lamotrigine er</i>)	T3	PA HD
LAMICTAL XR (ORANGE)	T3	PA HD
<i>lamotrigine</i> (Lamictal (blue))	T1	HD
<i>lamotrigine</i> (Lamictal (green))	T1	HD
<i>lamotrigine</i> (Lamictal (orange))	T1	HD
<i>lamotrigine</i> (Lamictal Odt (blue))	T1	HD
<i>lamotrigine</i> (Lamictal Odt (green))	T1	HD
<i>lamotrigine</i> (Lamictal Odt (orange))	T1	HD
<i>lamotrigine</i> (Lamictal Odt)	T1	HD
<i>lamotrigine</i> (Lamictal Xr)	T1	HD
<i>lamotrigine</i> (Lamictal)	T1	HD
<i>levetiracetam</i>	T1	HD
<i>levetiracetam</i> (Keppra Xr)	T1	HD
<i>levetiracetam</i> (Keppra)	T1	HD
<i>levetiracetam in nacl (iso-os)</i>	T1	HD
LYRICA (<i>pregabalin</i>)	T3	PA HD
MOTPOLY XR 100 MG CAPSULE	T3	PA QL(1 cap/day) HD
MOTPOLY XR 150 MG CAPSULE	T3	PA QL(2 caps/day) HD
MOTPOLY XR 200 MG CAPSULE	T3	PA QL(2 caps/day) HD
MYSOLINE (<i>primidone</i>)	T3	PA HD
NEURONTIN (<i>gabapentin</i>)	T3	PA HD
<i>oxcarbazepine</i> (Trileptal)	T1	HD
OXTELLAR XR	T3	PA HD
PEGANONE	T2	HD
PHENYTEK (<i>phenytoin sodium extended</i>)	T3	PA HD

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List of Prescription Medications

CNS DRUGS (Seizure Disorders)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ANTI-CONVULSANTS		
<i>phenytoin</i>	T1	HD
<i>phenytoin</i> (Dilantin)	T1	HD
<i>phenytoin</i> (Dilantin-125)	T1	HD
<i>phenytoin sodium</i>	T1	HD
<i>phenytoin sodium extended</i> (Dilantin)	T1	HD
<i>phenytoin sodium extended</i> (Phenytek)	T1	HD
<i>pregabalin</i> (Lyrica)	T1	HD
PRIMIDONE 125 MG TABLET	T3	PA HD
<i>primidone 250 mg tablet</i> (Mysoline)	T1	HD
<i>primidone 50 mg tablet</i> (Mysoline)	T1	HD
QUDEXY XR (<i>topiramate er</i>)	T3	PA HD
<i>rufinamide</i> (Banzel)	T1	PA QL (80ml/day) HD
SABRIL (<i>vigabatrin</i>)	T3	PA SP HD
SABRIL (<i>vigadrone</i>)	T3	PA SP HD
SPRITAM	T3	PA HD
TEGRETOL (<i>carbamazepine</i>)	T3	PA HD
TEGRETOL (<i>epitol</i>)	T3	PA HD
TEGRETOL XR (<i>carbamazepine er</i>)	T3	PA HD
<i>tiagabine hcl 12 mg tablet</i> (Gabitril)	T1	QL (8 tabs/day) HD
<i>tiagabine hcl 16 mg tablet</i> (Gabitril)	T1	QL (6 tabs/day) HD
<i>tiagabine hcl 2 mg tablet</i> (Gabitril)	T1	HD
<i>tiagabine hcl 4 mg tablet</i> (Gabitril)	T1	HD
TOPAMAX (<i>topiramate</i>)	T3	PA HD
<i>topiramate</i> (Qudexy Xr)	T1	HD
<i>topiramate</i> (Topamax)	T1	HD
<i>topiramate er 50 mg capsule</i> (Trokendi Xr)	T1	HD
<i>topiramate er 25 mg capsule</i> (Trokendi Xr)	T1	QL(1 cap/day) HD
<i>topiramate er 100 mg capsule</i> (Trokendi Xr)	T1	QL(1 cap/day) HD
<i>topiramate er 200 mg capsule</i> (Trokendi Xr)	T1	HD
TRILEPTAL (<i>oxcarbazepine</i>)	T3	PA HD
TROKENDI XR 50 MG CAPSULE (<i>topiramate</i>)	T3	PA HD
TROKENDI XR 25 MG CAPSULE (<i>topiramate</i>)	T3	PA QL(1 cap/day) HD
TROKENDI XR 100 MG CAPSULE (<i>topiramate</i>)	T3	PA QL(1 cap/day) HD
TROKENDI XR 200 MG CAPSULE (<i>topiramate</i>)	T3	PA HD
<i>valproic acid</i>	T1	HD

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T4 – Specialty Medications
 PA – Prior Authorization
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List of Prescription Medications

CNS DRUGS (Seizure Disorders)

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

<i>valproic acid (as sodium salt)</i>	T1	HD
<i>vigabatrin (Sabril)</i>	T3	SP HD
VIMPAT 10 MG/ML SOLUTION	T2	PA HD
VIMPAT 100 MG TABLET	T2	PA HD
VIMPAT 150 MG TABLET	T2	PA HD
VIMPAT 200 MG TABLET	T2	PA HD
VIMPAT 200 MG/20 ML VIAL	T3	HD
VIMPAT 50 MG TABLET	T2	PA HD
XCOPRI 100 MG TABLET	T3	PA QL (1 tab/day) HD
XCOPRI 12.5-25 MG TITRATION PK	T3	PA QL (1 pack/28 day) HD
XCOPRI 150 MG TABLET	T3	PA QL (1 tab/day) HD
XCOPRI 150-200 MG TITRATION PK	T3	PA QL (1 pack/28 Days) HD
XCOPRI 200 MG TABLET	T3	PA QL (2 tabs/day) HD
XCOPRI 250 MG DAILY DOSE PACK	T3	PA QL (1 pack/28 day) HD
XCOPRI 350 MG DAILY DOSE PACK	T3	PA QL (1 pack/28 day) HD
XCOPRI 50 MG TABLET	T3	PA QL (1 tab/day) HD
XCOPRI 50-100 MG TITRATION PAK	T3	PA QL (1 pack/28 day) HD
ZARONTIN (<i>ethosuximide</i>)	T3	PA HD
ZONEGRAN (<i>zonisamide</i>)	T3	PA HD
ZONISADE	T3	PA QL (6 mls/30 days)
<i>zonisamide</i>	T1	HD
<i>zonisamide (Zonegran)</i>	T1	HD

COLONY STIMULATING FACTORS (Blood Modifiers/Bleeding Disorders)

ERYTHROPOIESIS-STIMULATING AGENTS

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

LEUKOCYTE (WBC) STIMULANTS

FULPHILA	T4	PA SP
GRANIX	T4	PA SP
LEUKINE	T4	SP
NEULASTA	T4	PA SP
NEULASTA ONPRO	T4	PA SP HD

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List of Prescription Medications

COLONY STIMULATING FACTORS (Blood Modifiers/Bleeding Disorders)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
LEUKOCYTE (WBC) STIMULANTS		
NEUPOGEN	T4	PA SP
NIVESTYM	T4	SP
NYVEPRIA	T4	PA SP
STIMUFEND	T4	PA SP
UDENYCA	T4	PA SP
ZARXIO	T4	SP HD
ZIEXTENZO	T4	PA SP
THROMBOPOIETIN RECEPTOR AGONISTS		
DOPTELET	T4	PA SP HD
MULPLETA	T4	PA SP HD
NPLATE	T4	PA SP
PROMACTA	T4	PA SP HD
COLONY STIMULATING FACTORS (Cancer)		
CXCR4 CHEMOKINE RECEPTOR ANTAGONIST		
APHEXDA	T4	PA SP
MOZOBIL	T4	PA SP
CONTRACEPTIVES (Contraception Products)		
CONTRACEPTIVES, INTRAVAGINAL, SYSTEMIC		
ANNOVERA	T3	
<i>etonogestrel/ethinyl estradiol (Nuvaring)</i>	T1	PPACA
NUVARING (<i>etonogestrel-ethinyl estradiol</i>)	T3	
CONTRACEPTIVES, IMPLANTABLE		
NEXPLANON	T4	SP PPACA
CONTRACEPTIVES, INJECTABLE		
DEPO-PROVERA 150 MG/ML SYRINGE (<i>medroxyprogesterone acetate</i>)	T3	
DEPO-PROVERA 150 MG/ML VIAL (<i>medroxyprogesterone acetate</i>)	T3	
DEPO-SUBQ PROVERA 104	T3	
<i>medroxyprogesterone 150 mg/ml (Depo-provera)</i>	T1	PPACA
CONTRACEPTIVES, INTRAVAGINAL		
PHEXXI	T3	PA PPACA
CONTRACEPTIVES, ORAL		
BALCOLTRA (<i>levonorgest/eth.estradiol/iron</i>)	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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List of Prescription Medications

CONTRACEPTIVES (Contraception Products)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
CONTRACEPTIVES, ORAL		
<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>levonorgest/eth.estradiol/iron</i> (Balcoltra)	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>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
<i>norethindrone-ethin. estradiol</i>	T1	HD PPACA
<i>norethin-ee 1.5-0.03 mg (21) tb</i> (Loestrin)	T1	HD PPACA

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CONTRACEPTIVES (Contraception Products)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
CONTRACEPTIVES, ORAL		
<i>norgestimate-ethinyl estradiol</i>	T1	HD PPACA
<i>norgestrel-ethinyl estradiol</i>	T1	HD PPACA
ORTHO MICRONOR (<i>tulana</i>)	T3	HD
QUARTETTE (<i>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	T3	PPACA
FEMCAP	T3	PPACA
WIDE SEAL DIAPHRAGM	T3	PPACA
INTRA-UTERINE DEVICES (IUDS)		
KYLEENA	T4	SP PPACA
LILETTA	T4	SP PPACA
MIRENA	T4	SP PPACA
PARAGARD T 380-A	T4	SP PPACA
SKYLA	T4	SP PPACA
1ST GEN ANTIHIST-DECONGEST-ANTICHOLINERGIC COMB		
RESPA A.R.	T3	
COUGH/COLD PREPARATIONS (Cough/Cold Medications)		
ANTI-TUSSIVES, NON-OPIOID		
<i>benzonatate 100 mg capsule</i> (Tessalon Perle)	T1	
<i>benzonatate 150 mg capsule</i>	T1	PA
<i>benzonatate 200 mg capsule</i>	T1	
<i>benzonatate perle 100 mg cap</i> (Tessalon Perle)	T1	
TESSALON PERLE (<i>benzonatate</i>)	T3	
NON-OPIOID ANTI-TUS-1ST GEN.ANTIHISTAMINE-DECONGEST		
BROMFED DM (<i>brompheniramine-pseudoephed-dm</i>)	T3	PA

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List of Prescription Medications

COUGH/COLD PREPARATIONS (Allergy/Nasal Sprays)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
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)
TUSSICAPS	T2	PA
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 (Diabetes)

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

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List of Prescription Medications

DIAGNOSTIC (Miscellaneous)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ULTRAK TEST STRIP		
ADREVIEW	T3	
BILIARY DIAGNOSTICS		
CHOLETEC	T3	
TC99M MEBROFENIN PREP	T1	
BILIARY DIAGNOSTICS, RADIOPAQUE		
<i>indocyanine green</i>	T1	
SINOGRAFIN	T3	
CARDIOVASCULAR DIAGNOSTICS - RADIOACTIVE		
AMMONIA N-13	T3	
MYOVUE	T3	
TC99M PYROPHOSPHATE PREP	T1	
TC99M SESTAMIBI PREP	T1	
THALLOUS CHLORIDE TL-201	T1	
CARDIOVASCULAR DIAGNOSTICS, NON-RADIOPAQUE AGENTS		
<i>adenosine 60 mg/20 ml vial</i>	T1	
<i>adenosine 90 mg/30 ml vial</i>	T1	
DEFINITY	T3	
<i>dipyridamole 5 mg/ml vial</i>	T1	
LEXISCAN	T3	
OPTISON	T3	
<i>regadenoson</i>	T1	
CARDIOVASCULAR DIAGNOSTICS-RADIOPAQUE		
ISOVUE-200	T3	
ISOVUE-250	T3	
ISOVUE-300	T3	
ISOVUE-370	T3	
ISOVUE-M 200	T3	
ISOVUE-M 300	T3	
NEUROLITE	T3	
OMNIPAQUE	T3	
OPTIRAY 240, 300, 320, 350	T3	
ULTRAVIST	T3	
VISIPAQUE	T3	

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DIAGNOSTIC (Miscellaneous)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
CEREBRAL SPINAL RADIOACTIVE DIAGNOSTICS		
CERETEC	T3	
INDIUM IN-111 DTPA	T3	
CEREBRAL SPINAL RADIOPAQUE DIAGNOSTICS		
DOTAREM	T3	
<i>gadoterate meglumine (Dotarem)</i>	T1	
MAGNEVIST	T3	
MULTIHANCE	T3	
MULTIHANCE MULTIPACK	T3	
OMNISCAN	T3	
OMNISCAN PREFILL PLUS	T3	
OPTIMARK	T3	
PROHANCE	T3	
PROHANCE MULTIPACK	T3	
DIAGNOSTIC PREPARATIONS, MISCELLANEOUS		
ADVANCED DNA MEDICATED COLLECT	T3	
ARIDOL	T3	
DMSA	T3	
DRAXIMAGE DTPA	T3	
GADAVIST	T3	
GLUCAGEN DIAGNOSTIC 1 MG VIAL	T3	
GLUCAGON HCL	T1	
<i>isosulfan blue (Lymphazurin)</i>	T1	
<i>lidocaine hcl/glycerin (Advanced Dna Medicated Collect)</i>	T1	
LIPIODOL	T3	
LUMASON	T3	
LYMPHAZURIN	T3	
NETSPOT	T3	
PROVOCHOLINE	T3	
TC99M MEDRONATE PREP	T1	
TC99M SULFUR COLLOID PREP	T1	
DIAGNOSTIC RADIOPHARM - AMYLOID/TAU IMAGING		
AMYVID	T3	
VIZAMYL	T3	PA
DIAGNOSTIC RADIOPHARM - DOPAMINE TRANSPORTER (DAT)		
DATSCAN	T3	

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DIAGNOSTIC (Miscellaneous)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
EYE DIAGNOSTIC AGENTS		
AK-FLUOR	T3	
AK-FLUOR (<i>fluorescite</i>)	T3	
<i>fluorescein sodium</i>	T1	
<i>fluorescein sodium</i> (Ak-fluor)	T3	
DIAGNOSTIC PREPARATIONS, MISCELLANEOUS		
<i>ful-glo 1 mg opth strip</i>	T1	
FUL-GLO EYE STRIPS	T3	
<i>lissamine green</i>	T1	
FLUORESCENCE CYSTOSCOPY/OPTICAL IMAGING AGENTS		
CYSVIEW	T3	
GASTROINTESTINAL RADIOPAQUE DIAGNOSTICS		
ENTERO VU	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	
HEPATIC DIAGNOSTICS		
EOVIST	T3	
HISTAMINE PREPARATIONS		
HISTATROL INTRADERMAL	T3	
HISTATROL PERCUTANEOUS	T3	

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DIAGNOSTIC (Miscellaneous)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
METABOLIC FUNCTION DIAGNOSTICS		
CHIRHOSTIM	T3	
METOPIRONE	T3	
R-GENE 10	T3	
NEOPLASM MONOCLONAL DIAGNOSTIC AGENTS		
PROTASCINT	T3	
RADIOACTIVE DIAGNOSTICS, GENERAL		
OCTREOSCAN	T3	
RADIOACTIVE DX RADIOLABEL OF AUTOLOGOUS LEUKOCYTES		
INDIUM IN-111 OXYQUINOLINE	T1	
RADIOACTIVE DX RADIOLABEL OF SYNTHETIC AMINO ACIDS		
AXUMIN	T3	
RADIOACTIVE METABOLIC FUNCTION DIAGNOSTICS		
FLUDEOXYGLUCOSE F-18	T3	
RADIOPHARMACEUTICALS ELEMENTS		
GA 68 DOTATOC	T3	
INDICLOR	T3	
RENAL FUNCTION DIAGNOSTICS AGENTS		
<i>indigotindisulfonate sodium</i>	T3	
URINARY TRACT RADIOPAQUE DIAGNOSTICS		
CONRAY	T3	
CONRAY-30	T3	
CONRAY-43	T3	
CYSTO-CONRAY II	T3	
CYSTOGRAFIN	T3	
CYSTOGRAFIN-DILUTE	T3	
<i>diatrizoate meglumine, sodium</i>	T3	
<i>diatrizoate meglumine, sodium (Gastrografin)</i>	T1	
GASTROGRAFIN (<i>md-gastroview</i>)	T3	
DIURETICS (Diuretics)		
ARGININE VASOPRESSIN (AVP) RECEPTOR ANTAGONISTS		
SAMSCA	T4	PA QL SP
SAMSCA (<i>tolvaptan</i>)	T4	SP
TOLVAPTAN 15 MG TABLET	T4	SP
<i>tolvaptan 30 mg tablet (Samsca)</i>	T4	SP
VAPRISOL-5% DEXTROSE	T3	

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DIURETICS (Diuretics)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
CARBONIC ANHYDRASE INHIBITORS		
<i>acetazolamide</i>	T1	HD
<i>acetazolamide sodium</i>	T1	HD
<i>methazolamide</i>	T1	HD
LOOP DIURETICS		
<i>bumetanide</i>	T1	HD
EDECIN (<i>ethacrynic acid</i>)	T3	PA HD
<i>ethacrynate sodium</i> (Sodium Edecrin)	T1	HD
<i>furosemide</i>	T1	HD
<i>furosemide</i> (Lasix)	T1	HD
FUROSEMIDE-0.9% NACL	T1	HD
FUROSCIX	T3	PA QL(2 kits/30 days) HD
LASIX (<i>furosemide</i>)	T3	PA HD
SODIUM EDECIN (<i>ethacrynate sodium</i>)	T3	HD
<i>torseamide</i>	T1	HD
OSMOTIC DIURETICS		
<i>mannitol</i>	T1	
<i>mannitol</i> (Osmitol)	T1	
OSMITROL 10% IV SOLUTION (<i>mannitol</i>)	T3	
<i>osmitrol 15% iv solution</i>	T3	
<i>osmitrol 20% iv solution</i>	T2	
OSMITROL 10% (50 GM/500 ML) (<i>mannitol</i>)	T3	
POLYCYSTIC KIDNEY DISEASE AGENT, AVP RECEPTOR ANTAGONIST		
JYNARQUE 15 MG TABLET	T4	SP
JYNARQUE 15 MG-15 MG TABLET	T4	PA SP
JYNARQUE 30 MG TABLET	T4	SP
JYNARQUE 30 MG-15 MG TABLET	T4	PA SP
JYNARQUE 45 MG-15 MG TABLET	T4	PA SP
JYNARQUE 60 MG-30 MG TABLET	T4	PA SP
JYNARQUE 90 MG-30 MG TABLET	T4	PA SP
POTASSIUM SPARING DIURETICS		
ALDACTONE (<i>spironolactone</i>)	T3	PA HD
<i>amiloride hcl</i>	T1	HD
CAROSPIR	T2	PA HD
DYRENIUM (<i>triamterene</i>)	T3	PA HD
<i>eplerenone</i> (Inspra)	T1	HD
<i>spironolactone</i>	T1	HD

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DIURETICS (Diuretics)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
POTASSIUM SPARING DIURETICS IN COMBINATION		
INSPRA (<i>eplerenone</i>)	T3	HD
<i>spironolactone</i> (Aldactone)	T1	HD
<i>triamterene</i> (Dyrenium)	T1	HD
ALDACTAZIDE	T3	HD
ALDACTAZIDE (<i>spironolactone-hctz</i>)	T3	HD
<i>amiloride/hydrochlorothiazide</i>	T1	HD
DYAZIDE (<i>triamterene-hydrochlorothiazid</i>)	T3	HD
MAXZIDE (<i>triamterene-hydrochlorothiazid</i>)	T3	HD
MAXZIDE-25 MG (<i>triamterene-hydrochlorothiazid</i>)	T3	HD
<i>spironolact/hydrochlorothiazid</i> (Aldactazide)	T1	HD
<i>triamterene/hydrochlorothiazid</i> (Dyazide)	T1	HD
<i>triamterene/hydrochlorothiazid</i> (Maxzide)	T1	HD
<i>triamterene/hydrochlorothiazid</i> (Maxzide-25 Mg)	T1	HD
THIAZIDE AND RELATED DIURETICS		
<i>chlorothiazide sodium</i> (Sodium Diuril)	T1	HD
<i>chlorthalidone</i>	T1	HD
DIURIL	T2	HD
<i>hydrochlorothiazide</i>	T1	HD
<i>indapamide</i>	T1	HD
<i>metolazone</i>	T1	HD
SODIUM DIURIL (<i>chlorothiazide sodium</i>)	T2	HD
THALITONE	T3	PA HD
EENT PREPS (Allergy/Nasal Sprays)		
NASAL ANTIHISTAMINE		
<i>azelastine 0.1% (137 mcg) spray</i>	T1	HD
<i>azelastine 0.15% nasal spray</i>	T1	HD
<i>olopatadine 665 mcg nasal spray</i> (Patanase)	T1	HD
PATANASE (<i>olopatadine hcl</i>)	T3	HD
NASAL ANTIHISTAMINE AND ANTI-INFLAM. STEROID COMB.		
<i>azelastine/fluticasone</i> (Dymista)	T1	HD
DYMISTA (<i>azelastine-fluticasone</i>)	T3	ST HD
RYALTRIS	T3	PA QL (1 gm/30 days)
NASAL ANTI-INFLAMMATORY STEROIDS		
BECONASE AQ	T3	ST HD
<i>flunisolide</i>	T1	HD

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List of Prescription Medications

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

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
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NASAL ANTI-INFLAMMATORY STEROIDS (con't.)

<i>fluticasone prop 50 mcg spray</i>	T1	HD
<i>mometasone furoate 50 mcg spray</i> (Nasonex)	T1	QL (4 bots/30 days) HD
NASONEX (<i>mometasone furoate</i>)	T3	QL (4 bots/30 days) ST HD
OMNARIS	T3	ST HD
QNASL	T3	ST HD
QNASL CHILDREN	T3	HD
SINUVA	T3	PA SP HD
XHANCE	T3	ST HD
ZETONNA	T3	ST HD

NOSE PREPARATIONS, MISCELLANEOUS (RX)

<i>ipratropium bromide</i>	T1	HD
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NOSE PREPARATIONS, VASOCONSTRICTORS (RX)

ADRENALIN CHLORIDE	T3	
<i>epinephrine hcl</i> (Adrenalin Chloride)	T1	

EENT PREPS (Ear Medications)

EAR PREPARATIONS ANTI-INFLAMMATORY

DERMOTIC (<i>fluocinolone acetonide oil</i>)	T3	
<i>fluocinolone acetonide oil</i> (Dermotic)	T1	

EAR PREPARATIONS, MISC. ANTI-INFECTIVES

<i>acetic acid</i>	T1	
<i>hydrocortisone/acetic acid</i>	T1	

EENT PREPS (Eye Conditions)

ARTIFICIAL TEARS

LACRISERT	T3	
MIEBO	T3	PA QL(4 bottles/22 days)

EYE ANTI-INFECTIVES (RX ONLY)

BETADINE	T2	
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EYE ANTI-INFLAMMATORY AGENTS

ACULAR (<i>ketorolac tromethamine</i>)	T3	PA
ACULAR LS (<i>ketorolac tromethamine</i>)	T3	PA
ACUVAIL	T3	
ALREX (<i>loteprednol etabonate</i>)	T3	
<i>bromfenac sodium</i> (Bromsite)	T1	
BROMSITE (<i>bromfenac sodium</i>)	T2	
<i>diclofenac 0.1% eye drops</i>	T1	
DUREZOL	T3	PA

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

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EYE LOCAL ANESTHETICS		
<i>proparacaine hcl</i> (Alcaine)	T1	
<i>proparacaine/fluorescein sod</i>	T1	
<i>proparacaine/fluorescein sod</i>	T3	
<i>tetracaine hcl</i>	T1	
TETRAVISC	T2	
TETRAVISC FORTE	T2	
EYE MAST CELL STABILIZERS		
ALOCRIL	T3	PA
ALOMIDE	T3	PA
<i>cromolyn 4% eye drops</i>	T1	
EYE MYDRIATIC AND NSAID COMBINATIONS		
OMIDRIA	T3	
EYE PREPARATIONS, MISCELLANEOUS (OTC)		
GELFILM	T3	
EYE VASOCONSTRICTORS		
<i>phenylephrine hcl</i>	T1	
UPNEEQ	T3	PA
MIOTICS AND OTHER INTRAOCULAR PRESSURE REDUCERS		
<i>apraclonidine hcl</i> (Iopidine)	T1	HD
ALPHAGAN P (brimonidine tartrate)	T3	PA HD
AZOPT (<i>brinzolamide</i>)	T3	PA HD
<i>betaxolol hcl</i>	T1	HD
BETIMOL	T3	PA HD
BETOPTIC S	T2	HD
<i>bimatoprost</i>	T1	QL (10 gm/30 days) HD
<i>brimonidine tartrate</i>	T1	HD
<i>brimonidine tartrate</i> (Alphagan P)	T1	HD
<i>brinzolamide</i> (Azopt)	T1	HD
<i>carbachol</i>	T3	HD
<i>carteolol hcl</i>	T1	HD
COMBIGAN	T3	PA HD
COSOPT (<i>dorzolamide-timolol</i>)	T3	PA HD
COSOPT PF (<i>dorzolamide-timolol</i>)	T3	PA HD
<i>dorzolamide hcl</i> (Trusopt)	T1	HD

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EENT PREPS (Eye Conditions)		
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MIOTICS AND OTHER INTRAOCULAR PRESSURE REDUCERS		
<i>dorzolamide hcl/timolol maleate</i> (Cosopt)	T1	HD
<i>dorzolamide/timolol/pf</i> (Cosopt Pf)	T1	HD
DURYSTA	T4	PA SP HD
IOPIDINE 1% EYE DROPS	T3	PA HD
ISOPTO CARPINE (<i>pilocarpine hcl</i>)	T3	HD
ISTALOL (<i>timolol maleate</i>)	T3	PA HD
IYUZEH	T3	PA QL(30 vials/30 days) HD
<i>latanoprost</i> (Xalatan)	T1	HD
<i>levobunolol hcl</i>	T1	HD
LUMIGAN	T3	PA HD
MIOCHOL-E	T3	HD
PHOSPHOLINE IODIDE	T2	HD
<i>pilocarpine hcl</i> (Isopto Carpine)	T1	HD
RHOPRESSA	T3	HD
ROCKLATAN	T3	HD
SIMBRINZA	T2	HD
<i>timolol maleate</i> (Istalol)	T1	HD
<i>timolol maleate</i> (Timoptic)	T1	HD
<i>timolol maleate</i> (Timoptic-xe)	T1	HD
<i>timolol maleate/pf</i> (Timoptic Ocudose)	T1	HD
TIMOPTIC (<i>timolol maleate</i>)	T3	PA HD
TIMOPTIC OCUDOSE	T3	PA HD
TIMOPTIC OCUDOSE (<i>timolol maleate</i>)	T3	PA HD
TIMOPTIC-XE (<i>timolol maleate</i>)	T3	PA HD
TRAVATAN Z (<i>travoprost</i>)	T3	PA HD
<i>travoprost</i> (Travatan Z)	T1	HD
TRUSOPT (<i>dorzolamide hcl</i>)	T3	PA HD
VUITY	T3	PA
VYZULTA	T3	PA HD
XALATAN (<i>latanoprost</i>)	T3	PA HD
XELPROS	T3	PA HD
ZIOPTAN 0.0015% EYE DROPS (<i>tafluprost/pf</i>)	T3	PA QL (60 droppers/30 days) HD
MYDRIATICS		
<i>atropine 1% eye drops</i>	T1	HD
<i>atropine 1% eye ointment</i>	T1	HD
ATROPINE SULFATE-0.9% NAACL	T1	HD

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List of Prescription Medications

EENT PREPS (Eye Conditions)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
MYDRIATICS		
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
MIOTICS AND OTHER INTRAOCULAR PRESSURE REDUCERS		
<i>cyclopentolate hcl</i> (Cyclogyl)	T1	HD
<i>homatropine hbr</i>	T1	HD
ISOPTO ATROPINE (<i>atropine sulfate</i>)	T3	HD
MYDRIACYL (<i>tropicamide</i>)	T3	HD
PAREMYD	T3	HD
<i>tropicamide</i>	T1	HD
<i>tropicamide</i> (Mydriacyl)	T1	HD
TROPICAMIDE-CYCLOPENTOLATE-PE	T3	HD
OPHTH VASC. ENDOTHELIAL GROWTH FACTOR ANTAGONISTS		
EYLEA	T4	PA SP
OPHTH. VEGF-A RECEPTOR ANTAG. RCMB MC ANTIBODY		
BEOVU	T4	PA SP
LUCENTIS	T4	PA SP
OPHTHALMIC ANTI-FIBROTIC AGENTS		
MITOSOL	T3	
OPHTHALMIC ANTI-INFLAMMATORY IMMUNOMODULATOR-TYPE		
CEQUA	T3	HD
RESTASIS	T2	HD
RESTASIS MULTIDOSE	T2	HD
VERKAZIA	T3	PA QL (1 box/month)
VEVYE	T3	PA HD
XIIDRA	T2	HD
OPHTHALMIC COMPLEMENT INHIBITORS		
SYFOVRE	T4	PA SP HD
OPHTHALMIC CYSTINE DEPLETING AGENTS		
CYSTADROPS	T4	PA QL (20ml/21 days) SP
CYSTARAN	T4	PA QL (120ml/28 days) SP
OPHTHALMIC HUMAN NERVE GROWTH FACTOR (HNGF)		
OXERVATE	T4	PA SP HD

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List of Prescription Medications

EENT PREPS (Eye Conditions)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
OPHTHALMIC PREPARATIONS, MISCELLANEOUS		
AMVISC	T4	SP
AMVISC PLUS	T4	SP
DISCOVISC	T3	
DUOVISC	T3	
HEALON (<i>biolon</i>)	T4	SP
HEALONS	T3	
<i>hyaluronate sodium</i> (Provisc)	T4	SP
PROVISC	T4	SP
TOTALVISC	T4	SP
VISCOAT	T3	
OPHTHALMIC SURGICAL AIDS		
CELLUGEL	T3	
<i>hypromellose</i> (Cellugel)	T1	
MEMBRANEBLUE	T3	
VISIONBLUE	T3	
ELECT/CALORIC/H2O (Cholesterol Medications)		
ORAL LIPID SUPPLEMENTS		
DOJOLVI	T4	PA SP HD
ELECT/CALORIC/H2O (Dental Products)		
FLUORIDE PREPARATIONS		
CLINPRO 5000	T3	
<i>fluoride (sodium)</i> (Prevident 5000 Ortho Defense)	T1	
<i>fluoride (sodium)</i> (Prevident 5000 Plus)	T1	
<i>fluoride (sodium)</i> (Prevident 5000)	T1	
<i>fluoride (sodium)</i> (Prevident)	T1	
FLUORIDEX	T1	
FLUORIDEX SENSITIVITY RELIEF	T3	
PREVIDENT 0.2% RINSE	T3	
PREVIDENT 1.1% GEL (<i>sodium fluoride</i>)	T3	
PREVIDENT 5000	T2	
PREVIDENT 5000 BOOSTER PLUS	T2	
PREVIDENT 5000 ENAMEL PROTECT	T2	

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List of Prescription Medications

ELECT/CALORIC/H2O (Dental Products)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
FLUORIDE PREPARATIONS		
PREVIDENT 5000 ORTHO DEFENSE	T2	
PREVIDENT 5000 PLUS (<i>sodium fluoride 5000 plus</i>)	T3	
PREVIDENT 5000 SENSITIVE	T2	
PREVIDENT DENTAL RINSE	T3	
<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 HYPOPEN 1-PACK	T3	QL (2 packs/22 days)
GVOKE HYPOPEN 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)

BICARBONATE PRODUCING/CONTAINING AGENTS

<i>sodium acetate</i>	T1	
<i>sodium bicarbonate</i>	T1	
<i>sodium bicarbonate in d5w</i>	T1	

DRUGS USED TO TREAT ACIDOSIS

THAM	T3	
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IV SOLUTIONS: DEXTROSE AND LACTATED RINGERS

<i>dextrose 5%-lactated ringers</i>	T1	
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IV SOLUTIONS: DEXTROSE-SALINE

<i>dextrose 10 % and 0.2 % nacl</i>	T1	
<i>dextrose 10 % and 0.45 % nacl</i>	T1	
<i>dextrose 2.5 % and 0.45 % nacl</i>	T1	
<i>dextrose 5 % and 0.3 % nacl</i>	T1	
<i>dextrose 5 % and 0.9 % nacl</i>	T1	
<i>dextrose 5 %-0.2 % sod chlorid</i>	T1	
<i>dextrose 5 %-0.45 % sod chlord</i>	T1	

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List of Prescription Medications

ELECT/CALORIC/H2O (Miscellaneous)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
IV SOLUTIONS: DEXTROSE-WATER		
<i>dextrose 10 % in water</i>	T1	
<i>dextrose 20 % in water</i>	T1	
<i>dextrose 25 % in water</i>	T1	
<i>dextrose 30 % in water</i>	T1	
<i>dextrose 40 % in water</i>	T1	
<i>dextrose 5 % in water</i>	T1	
<i>dextrose 5 % in water (Glucose In Water)</i>	T1	
<i>dextrose 50 % in water</i>	T1	
<i>dextrose 70 % in water</i>	T1	
GLUCOSE IN WATER (<i>dextrose in water</i>)	T1	
NUCLEIC ACID/NUCLEOTIDE SUPPLEMENTS		
XURIDEN	T4	PA SP
PARENTERAL AMINO ACID SOLUTIONS AND COMBINATIONS		
AA 3%-D10W-CALCIUM-HEPARIN	T3	
AMINOSYN	T3	
AMINOSYN II	T3	
AMINOSYN II WITH ELECTROLYTES	T3	
AMINOSYN M	T3	
AMINOSYN WITH ELECTROLYTES	T3	
AMINOSYN-PF	T3	
AMINOSYN-RF	T3	
CLINIMIX	T3	
CLINIMIX E	T3	
CLINISOL	T3	
HEPATAMINE	T3	
KABIVEN	T3	
<i>parenteral amino acid 10% no.4</i>	T3	
<i>parenteral amino acid 10% no.6</i>	T3	
<i>parenteral amino acid 10% no.7</i>	T3	
PERIKABIVEN	T3	
PLENAMINE	T3	
PROCALAMINE	T3	
PROSOL	T3	
TROPHAMINE	T3	

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List of Prescription Medications

ELECT/CALORIC/H2O (Nutritional/Dietary)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
CALCIUM REPLACEMENT		
<i>calcium chloride</i>	T1	
CALCIUM GLU 2,000MG/100ML-NACL	T3	
CALCIUM GLUC 1,000MG/50ML-NACL	T1	
<i>calcium gluconate</i>	T1	
<i>calcium gluconate in 0.9% nacl (Calcium Gluconate-0.9% Nacl)</i>	T1	
CALCIUM GLUCONATE-0.9% NACL	T1	
CALCIUM GLUCONATE-0.9% NACL (<i>calcium gluconate-0.9% nacl</i>)	T1	
CALCIUM GLUCONATE-D5W	T1	
ELECTROLYTE DEPLETERS		
AURYXIA	T3	QL (12 tabs/day)
<i>calcium acetate</i>	T1	
FOSRENOL 1,000 MG POWDER PACK	T2	PA
FOSRENOL 1,000 MG TABLET CHEW (<i>lanthanum carbonate</i>)	T3	PA
FOSRENOL 500 MG TABLET CHEW (<i>lanthanum carbonate</i>)	T3	PA
FOSRENOL 750 MG POWDER PACKET	T2	PA
FOSRENOL 750 MG TABLET CHEW (<i>lanthanum carbonate</i>)	T3	PA
<i>lanthanum carbonate (Fosrenol)</i>	T1	
LOKELMA	T2	
PHOSLYRA	T3	
RENAGEL (<i>sevelamer hcl</i>)	T3	PA
REVELA (<i>sevelamer carbonate</i>)	T3	PA
<i>sevelamer carbonate (Renvela)</i>	T1	
<i>sevelamer hcl</i>	T1	
<i>sevelamer hcl (Renagel)</i>	T1	
<i>sodium polystyrene sulfon/sorb</i>	T1	
<i>sodium polystyrene sulfonate</i>	T1	
<i>sps 15 gm/60 ml suspension</i>	T1	
<i>sps 30 gm/120 ml enema susp</i>	T3	
VELPHORO	T2	
VELTASSA	T2	
XPHOZAH	T3	PA
ELECTROLYTE MAINTENANCE		
<i>electrolyte-48 solution/d5w</i>	T1	
IONOSOL B WITH DEXTROSE 5%	T3	
IONOSOL MB-DEXTROSE 5%	T3	
ISOLYTE P WITH DEXTROSE	T3	

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ELECT/CALORIC/H2O (Nutritional/Dietary)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ELECTROLYTE MAINTENANCE		
ISOLYTE S	T3	
NORMOSOL-M AND DEXTROSE	T3	
NORMOSOL-R	T3	
NORMOSOL-R AND DEXTROSE	T3	
NORMOSOL-R PH 7.4	T3	
PLASMA-LYTE 148	T3	
PLASMA-LYTE A PH 7.4	T3	
<i>ringer's solution</i>	T1	
<i>ringer's solution, lactated</i>	T1	
TPN ELECTROLYTES	T3	
TPN ELECTROLYTES II	T3	
IODINE CONTAINING AGENTS		
IODOPEN	T3	
<i>potassium iodide/iodine</i>	T1	
SSKI	T1	
IRON REPLACEMENT		
HEMOCYTE PLUS (<i>mv-mins no.73/iron fum/folic</i>)	T3	
<i>mv-mins no.73/iron fum/folic</i> (Hemocyte Plus)	T1	
MAGNESIUM SALTS REPLACEMENT		
<i>magnesium chloride</i>	T1	
<i>magnesium sulfate</i>	T1	
<i>magnesium sulfate in water</i>	T1	
MAGNESIUM SULFATE-0.9% NACL	T1	
MAGNESIUM SULFATE-D5W	T1	
MAGNESIUM-LACTATED RINGERS	T1	
MINERAL REPLACEMENT, MISCELLANEOUS		
ADDAMEL N	T3	
<i>chromic chloride</i>	T1	
<i>cupric chloride</i>	T1	
<i>manganese chloride</i>	T1	
<i>manganese sulfate</i>	T1	
MULTITRACE-4 CONC VIAL	T1	
<i>multitrace-4 vial</i>	T3	
MULTITRACE-5	T1	
PEDITRACE	T3	
SELENIOS ACID	T1	
TRALEMENT	T3	

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List of Prescription Medications

ELECT/CALORIC/H2O (Nutritional/Dietary)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
PHOSPHATE REPLACEMENT		
GLYCOPHOS	T3	
<i>potassium phos, m-basic-d-basic</i>	T1	
POTASSIUM PHOSPHATE-0.9% NACL	T1	
POTASSIUM PHOSPHATES	T3	
<i>sod phosphate, monobasic-dibas</i>	T1	
SODIUM PHOSPHATE-0.9% NACL	T1	
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	
POKONZA	T3	
<i>potassium acetate</i>	T1	
<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	
<i>potassium chloride in 0.9%nacl</i>	T1	
<i>potassium chloride in d5w</i>	T1	
<i>potassium chloride in lr-d5</i>	T1	
<i>potassium chloride in water</i>	T1	
<i>potassium chloride/d5-0.2%nacl</i>	T1	
<i>potassium chloride/d5-0.3%nacl</i>	T1	
<i>potassium chloride/d5-0.45nacl</i>	T1	
<i>potassium chloride/d5-0.9%nacl</i>	T1	
<i>potassium chloride-0.45% nacl</i>	T1	
POTASSIUM CHLORIDE-0.9% NACL	T1	
<i>potassium cl/lido/0.9 % nacl (Potassium Cl-lidocaine-ns)</i>	T1	
POTASSIUM CL-LIDOCAINE-NS (<i>potassium cl-lidocaine-ns</i>)	T1	

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ELECT/CALORIC/H2O (Nutritional/Dietary)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
SODIUM/SALINE PREPARATIONS		
0.9 % sodium chloride	T1	
KENDALL 0.9% NACL WITH CAP	T1	
sodium chloride	T1	
sodium chloride 0.45 %	T1	
sodium chloride 0.9 % (flush)	T1	
sodium chloride 3 %	T1	
sodium chloride 5 %	T1	
SWABFLUSH	T3	
ZINC REPLACEMENT		
zinc chloride	T1	
zinc sulfate 10 mg/10 ml vial	T1	
zinc sulfate 25 mg/5 ml vial	T1	
ZINC SULFATE 30 MG/10 ML VIAL	T3	
ELECT/CALORIC/H2O (Urinary Tract Conditions)		
DIALYSIS SOLUTIONS		
DELFLX WITH 1.5% DEXTROSE	T3	
DELFLX-2.5% DEXTROSE	T3	
DIANEAL PD-2W-1.5% DEXTROSE	T3	
DIANEAL PD-2W-2.5% DEXTROSE	T2	
DIANEAL PD-2W-4.25% DEXTROSE	T3	
DIANEAL WITH 1.5% DEXTROSE	T3	
DIANEAL WITH 2.5% DEXTROSE	T3	
DIANEAL WITH 4.25% DEXTROSE	T3	
EXTRANEAL ICODextrin DIALYSIS	T3	
perit. dialysis no.6-1.5 % dex (Dianeal With 1.5% Dextrose)	T3	
periton.dialysis 7-2.5 % dextr (Dianeal With 2.5% Dextrose)	T3	
periton.dialysis 8-4.25 % dext (Dianeal With 4.25% Dextrose)	T3	
PHOXILLUM	T3	
PRISMASOL	T3	
URINARY PH MODIFIERS		
K-PHOS NO.2	T2	HD
K-PHOS ORIGINAL	T2	HD
ORACIT	T3	HD
potassium citrate (Urocit-k)	T1	HD
potassium citrate/citric acid	T1	HD
RENACIDIN	T3	HD

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ELECT/CALORIC/H2O (Urinary Tract Conditions)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
URINARY PH MODIFIERS		
UROCID-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
LOVAZA (<i>triklo</i>)	T3	PA HD
<i>omega-3 acid ethyl esters</i> (Lovaza)	T1	HD
VASCEPA	T2	PA HD
GASTROINTESTINAL (Gastrointestinal/Heartburn)		
AMMONIA INHIBITORS		
AMMONUL (<i>sodium phenylacet-sod benzoate</i>)	T3	HD
BUPHENYL (<i>sodium phenylbutyrate</i>)	T4	SP HD
<i>lactulose</i>	T1	HD
<i>lactulose 10 gm/15 ml solution</i>	T1	
LITHOSTAT	T2	HD
PHEBURANE	T4	PA QL (8 bottles/30 days) SP HD
RAVICTI	T4	PA SP HD
<i>sodium benzoate/sod phenylacet</i> (Ammonul)	T1	HD
<i>sodium phenylbutyrate</i> (Buphenyl)	T4	SP HD
ANTI-CHOLINERGICS, QUATERNARY AMMONIUM		
<i>chlordiazepoxide/clidinium br</i> (Librax)	T1	
CUVPOSA	T3	
DARTISLA	T3	PA
GLYCATE	T3	
<i>glycopyrrolate</i>	T1	
<i>glycopyrrolate</i> (Glycate)	T1	
<i>glycopyrrolate</i> (Robinul Forte)	T1	
<i>glycopyrrolate</i> (Robinul)	T1	
GLYCOPYRROLATE-WATER	T1	
LIBRAX (<i>chlordiazepoxide-clidinium</i>)	T3	PA
<i>propantheline bromide</i>	T1	
ROBINUL (<i>glycopyrrolate</i>)	T3	
ROBINUL FORTE (<i>glycopyrrolate</i>)	T3	

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ANTI-CHOLINERGICS/ANTI-SPASMODICS		
BENTYL	T3	
<i>dicyclomine hcl</i>	T1	
<i>dicyclomine hcl (Bentyl)</i>	T1	
ANTI-DIARRHEAL - G.I. CHLORIDE CHANNEL INHIBITORS		
MYTESI	T3	
ANTI-DIARRHEAL - TRYPTOPHAN HYDROXYLASE INHIBITOR		
XERMELO	T4	PA SP
ANTI-DIARRHEALS		
<i>diphenoxylate hcl/atropine</i>	T1	
<i>diphenoxylate hcl/atropine (Lomotil)</i>	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 (Marinol)</i>	T1	
MARINOL (<i>dronabinol</i>)	T3	PA
SYNDROS	T3	PA
ANTI-EMETIC/ANTI-VERTIGO AGENTS		
AKYNZEO 235-0.25 MG VIAL	T3	PA
AKYNZEO 235-0.25 MG/20 ML VIAL	T3	PA
AKYNZEO 300-0.5 MG CAPSULE	T3	PA QL (4 caps/28 days)
ALOXI (<i>palonosetron hcl</i>)	T3	PA
ANZEMET	T4	PA QL (5 tabs/30 days) SP
<i>aprepitant 125 mg capsule</i>	T1	QL (4 caps/28 days)
<i>aprepitant 125-80-80 mg pack (Emend)</i>	T1	QL (12 caps/28 days)
<i>aprepitant 40 mg capsule</i>	T1	QL (1 cap/28 days)
<i>aprepitant 80 mg capsule (Emend)</i>	T1	QL (8 caps/28 days)
BARHEMSYS	T3	
BONJESTA	T3	
CINVANTI	T3	PA
COMPAZINE (<i>prochlorperazine maleate</i>)	T3	
COMPAZINE (<i>prochlorperazine</i>)	T3	
DICLEGIS (<i>doxylamine succ-pyridoxine hcl</i>)	T3	

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ANTI-EMETIC/ANTI-VERTIGO AGENTS		
<i>dimenhydrinate</i>	T1	
<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)
<i>fosaprepitant dimeglumine</i> (Emend)	T1	PA
<i>granisetron hcl</i>	T1	
<i>granisetron hcl/pf</i>	T1	
<i>ondansetron</i>	T1	
<i>ondansetron hcl</i>	T1	
<i>ondansetron hcl</i> (Zofran)	T1	
<i>ondansetron hcl/pf</i>	T1	
ONDANSETRON HCL-0.9% NACL	T1	
ONDANSETRON HCL-D5W	T1	
<i>palonosetron hcl</i>	T1	PA
<i>palonosetron hcl</i> (Aloxi)	T1	PA
<i>prochlorperazine</i> (Compazine)	T1	
<i>prochlorperazine edisylate</i>	T1	
<i>prochlorperazine maleate</i> (Compazine)	T1	
<i>promethazine hcl</i>	T1	
<i>promethazine hcl</i>	T3	
SANCUSO	T3	PA QL (4 patches/30 days)
<i>scopolamine</i> (Transderm-scop)	T1	
SUSTOL	T3	PA
TIGAN	T3	
TIGAN (<i>trimethobenzamide hcl</i>)	T3	
TRANSDERM-SCOP (<i>scopolamine</i>)	T3	
<i>trimethobenzamide hcl</i> (Tigan)	T1	
VARUBI	T3	PA QL (4 tabs/28 days)
ZOFRAN 2 MG/ML VIAL (<i>ondansetron hcl</i>)	T3	
ZOFRAN 4 MG TABLET (<i>ondansetron hcl</i>)	T3	PA
ZOFRAN 8 MG TABLET (<i>ondansetron hcl</i>)	T3	PA
ZUPLENZ	T3	PA QL (24 films/30 days)

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List of Prescription Medications

GASTROINTESTINAL (Gastrointestinal/Heartburn)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
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ANTI-ULCER PREPARATIONS

CARAFATE (<i>sucralfate</i>)	T3	HD
CYTOTEC (<i>misoprostol</i>)	T3	HD
<i>misoprostol</i> (Cytotec)	T1	HD
<i>sucralfate</i> (Carafate)	T1	HD

ANTI-ULCER-H.PYLORI AGENTS

<i>bismuth/metronid/tetracycline</i> (Pylera)	T1	
HELIDAC	T3	PA
<i>lansoprazole/amoxiciln/clarith</i>	T1	
OMECLAMOX-PAK	T3	PA
PYLERA (<i>bismuth/metronid/tetracycline</i>)	T3	PA
TALICIA	T3	PA
VOQUEZNA DUAL, TRIPLE PAK	T3	PA

BELLADONNA ALKALOIDS

<i>atropine 0.4 mg/ml vial</i>	T1	HD
ATROPINE 0.4 MG/ML VIAL	T3	HD
<i>atropine 0.25 mg/5 ml syringe</i>	T1	HD
<i>atropine 0.5 mg/5 ml abboject</i>	T1	HD
<i>atropine 1 mg/10 ml abboject</i>	T1	HD
<i>atropine 1 mg/10 ml syringe</i>	T1	HD
ATROPINE 1 MG/2.5 ML SYRINGE	T1	HD
ATROPINE 1 MG/2.5 ML SYRINGE	T3	HD
<i>atropine 1 mg/ml vial</i>	T1	HD
ATROPINE 1 MG/ML VIAL	T3	HD
ATROPINE 2 MG/5 ML SYRINGE	T3	HD
ATROPINE SULFATE 0.25 MG/5 ML SYRINGE	T3	HD
<i>atropine 8 mg/20 ml vial</i>	T1	HD
DONNATAL	T3	HD
DONNATAL (<i>phenohydro</i>)	T3	HD
<i>hyoscyamine 0.125 mg odt</i> (Nulev)	T1	HD
<i>hyoscyamine 0.125 mg tab sl</i> (Levsin-sl)	T1	HD
<i>hyoscyamine 0.125 mg/5 ml elix</i>	T1	HD
<i>hyoscyamine 0.125 mg/ml drop</i>	T1	HD
<i>hyoscyamine sulf 0.125 mg tab</i> (Levsin)	T1	HD
<i>hyoscyamine sulfate</i>	T1	HD
<i>hyoscyamine sulfate</i> (Levbid)	T1	HD
<i>hyoscyamine sulfate</i> (Levsin)	T1	HD

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GASTROINTESTINAL (Gastrointestinal/Heartburn)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
BELLADONNA ALKALOIDS		
<i>hyoscyamine sulfate</i> (Levsin-sl)	T1	HD
<i>hyoscyamine sulfate</i> (Nulev)	T1	HD
<i>hyoscyamine sulfate</i> (Nulev)	T3	HD
HYOSCYAMINE SULFATE 0.5 MG/ML	T3	HD
LEVIBID (<i>symax-sr</i>)	T3	HD
LEVSIN	T3	HD
LEVSIN (<i>oscimin</i>)	T3	HD
LEVSIN-SL (<i>symax-sl</i>)	T3	HD
<i>methscopolamine bromide</i>	T1	HD
NULEV (<i>symax</i>)	T1	HD
<i>phenobarb/hyoscy/atropine/scop</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	T4	SP HD
CHOLBAM	T4	PA SP HD
RELTONE	T3	PA HD
URSO (<i>ursodiol</i>)	T3	HD
URSO FORTE (<i>ursodiol</i>)	T3	HD
<i>ursodiol</i> (Actigall)	T1	HD
<i>ursodiol</i> (Urso Forte)	T1	HD
<i>ursodiol</i> (Urso)	T1	HD
CHOLERETICS		
KINEVAC	T3	
CHRONIC INFLAM. COLON DX, 5-A-SALICYLAT, RECTAL TX		
CANASA (<i>mesalamine</i>)	T3	PA
<i>mesalamine 1,000 mg supp</i> (Canasa)	T1	
<i>mesalamine 4 gm/60 ml enema</i> (Sfrowasa)	T1	
<i>mesalamine 4 gm/60 ml kit</i> (Rowasa)	T1	
ROWASA (<i>mesalamine</i>)	T3	PA
SFROWASA (<i>mesalamine</i>)	T3	

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GASTROINTESTINAL (Gastrointestinal/Heartburn)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
DRUG TX-CHRONIC INFLAM. COLON DX, 5-AMINOSALICYLAT		
APRISO (<i>mesalamine er</i>)	T3	ST HD
ASACOL HD (<i>mesalamine</i>)	T3	ST HD
AZULFIDINE (<i>sulfasalazine dr</i>)	T3	PA HD
AZULFIDINE (<i>sulfasalazine</i>)	T3	PA HD
<i>balsalazide disodium</i> (Colazal)	T1	HD
COLAZAL (<i>balsalazide disodium</i>)	T3	ST HD
DELZICOL (<i>mesalamine dr</i>)	T3	ST HD
DIPENTUM	T3	ST HD
LIALDA (<i>mesalamine</i>)	T3	ST HD
<i>mesalamine</i> (Apriso)	T1	HD
<i>mesalamine</i> (Delzicol)	T1	HD
<i>mesalamine 800 mg dr tablet</i> (Asacol Hd)	T1	HD
<i>mesalamine dr 1.2 gm tablet</i> (Lialda)	T1	HD
PENTASA	T3	ST HD
<i>sulfasalazine</i> (Azulfidine)	T1	HD
FARNESOID X RECEPTOR (FXR) AGONIST, BILE AC ANALOG		
OCALIVA	T3	PA SP HD
FECAL MICROBIOTA TRANSPLANTATION (FMT)		
VOWST CAPSULE	T3	PA QL (12 caps/8 weeks) SP HD
GASTRIC ENZYMES		
SUCRAID	T4	PA SP
<i>cimetidine</i>	T1	HD
<i>cimetidine hcl</i>	T1	HD
<i>famotidine</i>	T1	HD
<i>famotidine</i> (Pepcid)	T1	HD
<i>famotidine in nacl, iso-osm/pf</i>	T1	HD
<i>famotidine/pf</i>	T1	HD
FAMOTIDINE-0.9% NACL	T1	HD
<i>nizatidine</i>	T1	HD
PEPCID (<i>famotidine</i>)	T1	PA HD
<i>ranitidine hcl</i>	T1	HD
<i>ranitidine hcl</i> (Zantac)	T1	HD
ZANTAC (<i>ranitidine hcl</i>)	T3	HD
IBS AGENTS, MIXED OPIOID RECEPTOR AGONISTS/ANTAGONISTS		
VIBERZI	T2	HD

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
IBS-C/CIC AGENTS, GUANYLATE CYCLASE-C AGONIST		
LINZESS	T2	
TRULANCE	T2	
ILEAL BILE ACID TRANSPORTER (IBAT) INHIBITOR		
BYLVAY	T4	PA SP HD
LIVMARLI	T4	PA SP HD
INTEGRIN RECEPTOR ANTAGONIST, MONOCLONAL ANTIBODY		
ENTYVIO	T4	PA QL(2 pens/30 days) SP HD
INTESTINAL MOTILITY STIMULANTS		
GIMOTI	T4	PA SP
<i>metoclopramide hcl</i>	T1	
<i>metoclopramide hcl (Reglan)</i>	T1	
MOTEGRITY	T3	PA
REGLAN (<i>metoclopramide hcl</i>)	T3	
IRRITABLE BOWEL SYNDROME AGENTS, 5-HT3 ANTAGONIST		
<i>alosetron hcl (Lotronex)</i>	T4	SP HD
LOTROXEX (<i>alosetron hcl</i>)	T4	PA SP HD
ZELNORM	T3	PA
IV FAT EMULSIONS		
CLINOLIPID	T3	
<i>fat emulsions (Nutrilipid)</i>	T3	
INTRALIPID	T3	
NUTRILIPID (<i>intralipid</i>)	T3	
OMEGAVEN	T3	
SMOFLIPID	T3	
LAXATIVES AND CATHARTICS		
AMITIZA (<i>lubiprostone</i>)	T3	PA
<i>bisac/nac1/na3co3/kcl/peg 3350</i>	T1	PPACA
CLENPIQ	T2	PPACA
COLYTE WITH FLAVOR PACKETS (<i>peg 3350-electrolyte</i>)	T3	PPACA
COLYTE WITH FLAVOR PACKETS (<i>peg 3350-electrolyte</i>)	T3	PA PPACA
GOLYTELY	T3	PA PPACA
GOLYTELY (<i>peg-3350 and electrolytes</i>)	T3	PA PPACA
KRISTALOSE	T3	
<i>lactulose</i>	T1	
<i>lactulose 10 gm packet (Kristalose)</i>	T1	
<i>lactulose 10 gm/15 ml solution</i>	T1	
<i>lactulose 20 gm/30 ml solution</i>	T1	

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CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

GASTROINTESTINAL (Gastrointestinal/Heartburn)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
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LAXATIVES AND CATHARTICS (cont.)

<i>lactulose 10 gm/15 ml solution</i>	T1	
<i>lactulose 20 gm/30 ml solution</i>	T1	
<i>lubiprostone</i>	T1	
LUBIPROSTONE	T3	PA
MOVIPREP (<i>peg3350-sod sul-nacl-kcl-asb-c</i>)	T3	PA PPACA
NULYTELY	T3	PA PPACA
OSMOPREP	T3	PA PPACA
<i>peg3350/sod sul/nacl/kcl/asb/c (Moviprep)</i>	T1	PPACA
<i>peg3350/sod sulf, bicarb, cl/kcl (Colyte With Flavor Packets)</i>	T1	PPACA
<i>peg3350/sod sulf, bicarb, cl/kcl (Golytely)</i>	T1	PPACA
PLENVU	T3	PA PPACA
PREPOPIK	T2	PPACA
<i>sodium chloride/na₂hco₃/kcl/peg</i>	T1	PPACA
SUFLAVE	T2	
SUPREP	T3	PA PPACA
SUTAB	T2	PPACA

LOCAL ANORECTAL NITRATE PREPARATIONS

<i>nitroglycerin 0.4% ointment</i>	T1	
RECTIV	T3	

PANCREATIC ENZYMES

CREON	T3	PA HD
PANCREAZE	T2	HD
PERTZYE	T3	PA HD
VIOKACE	T3	HD
ZENPEP	T3	PA HD

POTASSIUM-COMPETITIVE ACID BLOCKERS (PCABS)

VOQUEZNA	T3	PA QL(1 tab/day)
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PROTON-PUMP INHIBITORS

<i>ACIPHEX (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
DEXILANT DR 30 MG CAPSULE (<i>dexlansoprazole</i>)	T2	QL (2 caps/day) HD
DEXILANT DR 60 MG CAPSULE	T3	PA QL (30 caps/30 days) HD
<i>dexlansoprazole dr 30 mg cap (Dexilant)</i>	T1	QL(2 CAPS/DAY) HD
<i>esomeprazole dr 10 mg packet (Nexium)</i>	T1	QL (4 packets/day) HD
<i>esomeprazole dr 20 mg packet (Nexium)</i>	T1	QL (2 packs/day) HD
<i>esomeprazole dr 40 mg packet (Nexium)</i>	T1	QL (1 packet/day) HD

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

T4 – Specialty Medications
 PA – Prior Authorization
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ST – Step Therapy
 AGE – Age Requirement
 SP – Specialty Medication

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List of Prescription Medications

GASTROINTESTINAL (Gastrointestinal/Heartburn)

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

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List of Prescription Medications

GASTROINTESTINAL (Gastrointestinal/Heartburn)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
PROTON-PUMP INHIBITORS (cont.)		
PROTONIX 40 MG SUSPENSION (<i>pantoprazole sodium</i>)	T3	QL (30 packs/30 days) ST HD
PROTONIX DR 20 MG TABLET (<i>pantoprazole sodium</i>)	T3	QL (60 tabs/30 days) ST HD
PROTONIX DR 40 MG TABLET (<i>pantoprazole sodium</i>)	T3	QL (30 tabs/30 days) ST HD
PROTONIX IV (<i>pantoprazole sodium</i>)	T3	HD
RABEPRAZOLE DR 10 MG SPRNKL CP <i>rabeprazole sod dr 20 mg tab</i> (Aciphex)	T3 T1	QL (2 caps/day) HD QL (1 tab/day) HD
ZEGERID 20 MG CAPSULE (<i>omeprazole-sodium bicarbonate</i>)	T3	PA QL (60 caps/30 days) HD
ZEGERID 20 MG PACKET (<i>omeprazole-sodium bicarbonate</i>)	T3	PA QL (60 packs/30 days) HD
ZEGERID 40 MG CAPSULE (<i>omeprazole-sodium bicarbonate</i>)	T3	PA QL (30 caps/30 days) HD
ZEGERID 40 MG PACKET (<i>omeprazole-sodium bicarbonate</i>)	T3	PA QL (30 packs/30 days) HD
RECTAL PREPARATIONS		
ANUSOL-HC 25 MG SUPPOSITORY (<i>hydrocortisone acetate</i>) <i>hydrocortisone acetate</i> <i>hydrocortisone acetate</i> (Anusol-hc)	T3 T1 T1	PA
SBS - GLUCAGON-LIKE PEPTIDE-2 (GLP-2) ANALOGS		
GATTEX	T4	PA SP HD
GASTROINTESTINAL (Pain Relief And Inflammatory Disease)		
HEMORRHOID PREP, ANTI-INFLAM STEROID-LOCAL ANESTHET		
ANA-LEX	T1	
ANALPRAM HC	T3	PA
ANALPRAM HC (<i>hydrocortisone-pramoxine</i>) <i>hydrocortisone/lidocaine/aloe</i> <i>hydrocortisone/pramoxine</i> (Analpram Hc) <i>lidocaine/hydrocortisone ac</i>	T3 T1 T1 T1	
LIDOCAINE-HYDROCORTISONE	T1	
PROCORT	T3	
PROCTOFOAM-HC	T2	
KERATINOCYTE GROWTH FACTOR (KGF)		
KEPIVANCE	T4	SP
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	
CORTIFOAM <i>hydrocortisone</i> (Cortenema)	T3 T1	PA
TARPEYO	T4	PA QL (4 caps/day) SP
UCERIS 2 MG RECTAL FOAM	T4	PA QL (2 kits/180 days)

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List of Prescription Medications

HORMONES (Hormonal Agents)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ADRENAL STEROID INHIBITORS		
ISTURISA	T4	PA QL (2 TABS/DAY) SP
RECORLEV	T4	PA QL (8 tabs/day) SP
ADRENOCORTICOTROPHIC HORMONES		
ACTHAR	T4	PA SP HD
ACTHREL	T4	SP
CORTROSYN (<i>cosyntropin</i>)	T3	
<i>cosyntropin</i> (Cortrosyn)	T1	
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)
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	
AVEED	T4	PA SP
DEPO-TESTOSTERONE (<i>testosterone cypionate</i>)	T3	
FORTESTA (<i>testosterone</i>)	T3	PA QL (120 gm/30 days)
JATENZO 158, 198 MG CAPSULE	T3	PA QL (4 caps/day)
JATENZO 237 MG CAPSULE	T3	PA QL (2 caps/day)
KYZATREX	T3	PA QL (60 tabs/30 days)
METHITEST	T1	
<i>methyltestosterone</i> (Testred)	T1	
TLANDO	T3	PA QL (4/day)
NATESTO	T3	PA QL (3 bots/30 days)
<i>oxandrolone</i>	T1	PA
TESTIM (<i>testosterone</i>)	T3	PA QL (2 tubes/day)
TESTOPEL	T3	PA
<i>testosterone 1% (25mg/2.5g) pk</i> (Androgel)	T1	PA QL (150gm/30 days)
<i>testosterone 1% (50 mg/5 g) pk</i> (Vogelxo)	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)

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List of Prescription Medications

HORMONES (Hormonal Agents)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
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ANDROGENIC AGENTS

<i>testosterone 10 mg gel pump (Fortesta)</i>	T1	PA QL (120 gm/30 days)
TESTOSTERONE 12.5 MG/1.25 GRAM	T1	PA QL (150gm/30 days)
<i>testosterone 12.5 mg/1.25 gram (Vogelxo)</i>	T1	PA QL (150gm/30 days)
<i>testosterone 30 mg/1.5 ml pump</i>	T1	PA QL (180ml/30 days)
<i>testosterone 50 mg/5 gram gel (Vogelxo)</i>	T1	PA QL (2 tubes/day)
TESTOSTERONE 50 MG/5 GRAM PKT	T1	PA QL (2 packs/day)
TESTRED (<i>methyltestosterone</i>)	T3	
VOGELXO 12.5 MG/1.25 GRAM PUMP	T3	PA QL (150gm/30 days)
VOGELXO 50 MG/5 GRAM GEL (<i>testosterone</i>)	T3	PA QL (2 tubes/day)
VOGELXO 50 MG/5 GRAM GEL PACKET	T3	PA QL (2 packs/day)
XYOSTED	T3	PA QL (4 injectors/28 days)

ANTI-DIURETIC AND VASOPRESSOR HORMONES

DDAVP 0.01% NASAL SPRAY (<i>desmopressin acetate</i>)	T3	PA
DDAVP 0.1 MG TABLET (<i>desmopressin acetate</i>)	T3	PA HD
DDAVP 0.2 MG TABLET (<i>desmopressin acetate</i>)	T3	PA HD
DDAVP 10 MCG/0.1 ML SOLUTION	T3	PA
DDAVP 4 MCG/ML AMPUL (<i>desmopressin acetate</i>)	T4	PA SP
DDAVP 4 MCG/ML VIAL (<i>desmopressin acetate</i>)	T4	PA SP
<i>desmopressin 0.01% solution (Ddavp)</i>	T1	HD
<i>desmopressin 0.01% spray (Ddavp)</i>	T1	HD
<i>desmopressin 10 mcg/0.1 ml spr (Ddavp)</i>	T1	HD
<i>desmopressin 40 mcg/10 ml vial (Ddavp)</i>	T4	SP
<i>desmopressin ac 4 mcg/ml ampul (Ddavp)</i>	T4	SP
<i>desmopressin ac 4 mcg/ml vial (Ddavp)</i>	T4	SP
<i>desmopressin acetate 0.1 mg tb (Ddavp)</i>	T1	HD
<i>desmopressin acetate 0.2 mg tb (Ddavp)</i>	T1	HD
NOCDURNA	T3	PA
NOCTIVA	T3	PA
STIMATE	T4	SP
<i>vasopressin in 0.9% nacl</i>	T1	
VASOPRESSIN-0.9% NACL	T1	
VASOPRESSIN-D5W	T1	
VASOSTRICT	T3	

ESTROGEN AND PROGESTIN COMBINATIONS

BIJUVA	T3	
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ESTROGEN/ANDROGEN COMBINATIONS

<i>estrogen, ester/me-testosterone</i>	T1	HD
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List of Prescription Medications

HORMONES (Hormonal Agents)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ESTROGENIC AGENTS		
ACTIVELLA (<i>mimvey lo</i>)	T3	HD
ACTIVELLA (<i>mimvey</i>)	T3	HD
ALORA	T3	QL (16 patches/28 days) HD
CLIMARA (<i>estradiol (once weekly)</i>)	T3	HD
CLIMARA PRO	T3	HD
COMBIPATCH	T3	HD
DELESTROGEN (<i>estradiol valerate</i>)	T3	PA HD
DEPO-ESTRADIOL	T3	HD
DIVIGEL	T2	HD
ELESTRIN	T3	HD
ESTRACE (<i>estradiol</i>)	T3	HD
<i>estradiol</i> (Climara)	T1	HD
<i>estradiol</i> (Vivelle-dot)	T1	QL (8 patches/21 days) HD
<i>estradiol</i> (Vivelle-dot)	T1	QL (16 patches/28 days) HD
<i>estradiol 0.025 mg patch(2/wk)</i> (Minivelle)	T1	QL (16 patches/28 days) HD
<i>estradiol 0.025 mg patch(2/wk)</i> (Vivelle-Dot)	T1	QL (16 patches/28 days) HD
<i>estradiol 0.0375mg patch(2/wk)</i> (Minivelle)	T1	QL (16 patches/28 days) HD
<i>estradiol 0.0375mg patch(2/wk)</i> (Vivelle-Dot)	T1	QL (16 patches/28 days) HD
<i>estradiol 0.05 mg patch (2/wk)</i> (Minivelle)	T1	QL (16 patches/28 days) HD
<i>estradiol 0.05 mg patch (2/wk)</i> (Vivelle-Dot)	T1	QL (16 patches/28 days) HD
<i>estradiol 0.075 mg patch(2/wk)</i> (Minivelle)	T1	QL (16 patches/28 days) HD
<i>estradiol 0.075 mg patch(2/wk)</i> (Vivelle-Dot)	T1	QL (16 patches/28 days) HD
<i>estradiol 0.1 mg patch (2/wk)</i> (Minivelle)	T1	QL (16 patches/28 days) HD
<i>estradiol 0.1 mg patch (2/wk)</i> (Vivelle-Dot)	T1	QL (16 patches/28 days) HD
<i>estradiol 0.5 mg tablet</i> (Estrace)	T1	HD
<i>estradiol 1 mg tablet</i> (Estrace)	T1	HD
<i>estradiol 2 mg tablet</i> (Estrace)	T1	HD
<i>estradiol valerate</i> (Delestrogen)	T1	HD
<i>estradiol/norethindrone acet</i> (Activella)	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

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List of Prescription Medications

HORMONES (Hormonal Agents)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ESTROGENIC AGENTS (cont.)		
<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>lyllana</i>)	T3	QL (16 patches/28 days) HD
ESTROGEN-PROGESTIN WITH ANTI-MINERALOCORTICOID COMB		
ANGELIQ	T3	HD
ESTROGEN-SELECTIVE ESTROGEN RECEPTOR MOD (SERM) COMB		
DUAVEE	T2	
GLUCOCORTICOIDS		
ALKINDI SPRINKLE	T3	PA
BETA 1	T3	
<i>betamethasone acetate, sod phos (Celestone)</i>	T1	
BSP 0820	T3	
<i>budesonide (Entocort Ec)</i>	T1	
<i>budesonide (Uceris)</i>	T1	PA QL (56 tabs/180 days)
CELESTONE (<i>betamethasone sod phos-acetate</i>)	T2	
CORTEF (<i>hydrocortisone</i>)	T3	
<i>cortisone acetate</i>	T1	
<i>deflazacort (Emflaza)</i>	T4	PA SP HD
DEPO-MEDROL	T3	
<i>dexamethasone (Dxevo)</i>	T1	
<i>dexamethasone (Taperdex)</i>	T1	PA
<i>dexamethasone 0.5 mg tablet</i>	T1	
<i>dexamethasone 0.5 mg/5 ml elx</i>	T1	
<i>dexamethasone 0.5 mg/5 ml liq</i>	T1	
<i>dexamethasone 0.75 mg tablet</i>	T1	
<i>dexamethasone 1 mg tablet</i>	T1	
<i>dexamethasone 1.5 mg tablet</i>	T1	
<i>dexamethasone 10 day 1.5 mg tb</i>	T1	PA
DEXAMETHASONE 10 MG/ML SYRING	T3	
<i>dexamethasone 10 mg/ml vial</i>	T1	
<i>dexamethasone 100 mg/10 ml vl</i>	T1	

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List of Prescription Medications

HORMONES (Hormonal Agents)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
GLUCOCORTICOIDS (cont.)		
dexamethasone 120 mg/30 ml vial	T1	
dexamethasone 13 day 1.5 mg tb	T1	PA
dexamethasone 2 mg tablet	T1	
dexamethasone 20 mg/5 ml vial	T1	
dexamethasone 4 mg tablet	T1	
dexamethasone 4 mg/ml syringe	T1	
dexamethasone 4 mg/ml vial	T1	
dexamethasone 6 day 1.5 mg tab (Taperdex)	T1	PA
dexamethasone 6 mg tablet	T1	
dexamethasone in 0.9% sod chl	T1	
DXEVO	T3	
EMFLAZA	T4	PA SP HD
ENTOCORT EC (budesonide ec)	T3	
HEMADY	T3	
hydrocortisone (Cortef)	T1	
hydrocortisone sod succinate (Solu-cortef)	T1	
KENALOG-10	T3	
KENALOG-40 (triamcinolone acetonide)	T3	
KENALOG-80	T3	
LOCORT	T1	
MEDROL 16 MG TABLET (methylprednisolone)	T3	
MEDROL 2 MG TABLET	T2	
MEDROL 32 MG TABLET (methylprednisolone)	T3	
MEDROL 4 MG DOSEPAK (methylprednisolone)	T3	
MEDROL 4 MG TABLET (methylprednisolone)	T3	
MEDROL 8 MG TABLET (methylprednisolone)	T3	
MEDROLOAN II SUIK	T3	
methylprednisolone (Medrol)	T1	
methylprednisolone acetate (Depo-medrol)	T1	
methylprednisolone sod succ	T1	
methylprednisolone sod succ (Solu-medrol)	T1	
MILLIPRED 10 MG/5 ML SOLUTION (prednisolone sodium phosphate)	T3	
millipred 5 mg tablet	T1	
NGENLA	T4	PA SP
ORAPRED ODT (prednisolone sodium phos odt)	T3	
P-CARE D80G	T1	
P-CARE K80	T1	

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HORMONES (Hormonal Agents)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
GLUCOCORTICOIDS (cont.)		
POD-CARE 100C	T1	
<i>prednisolone</i>	T1	
<i>prednisolone sodium phosphate</i>	T1	
<i>prednisolone sodium phosphate</i> (Millipred)	T1	
<i>prednisolone sodium phosphate</i> (Orapred Odt)	T1	
<i>prednisone</i>	T1	
PRO-C-DURE 5	T3	
PRO-C-DURE 6	T3	
RAYOS	T3	PA
READYSHARP BETAMETHASONE	T1	
SOLU-CORTEF	T3	
SOLU-MEDROL	T3	
TAPERDEX	T1	PA
<i>triamcinolone acetonide</i> (Kenalog-40)	T1	
UCERIS 9 MG ERTABLET (<i>budesonide er</i>)	T3	PA QL (1 tab/day)
ZCORT	T3	PA
ZILRETTA	T3	PA
ZONACORT	T3	
GROWTH HORMONE RELEASING HORMONE (GHRH) AND ANALOGS		
EGRIFTA	T4	PA SP HD
EGRIFTA SV	T4	PA SP HD
GROWTH HORMONES		
GENOTROPIN	T4	PA SP HD
HUMATROPE	T4	PA SP HD
NGENLA	T4	PA SP
NORDITROPIN FLEXPRO	T4	PA SP HD
NUTROPIN AQ NUSPIN	T4	PA SP HD
OMNITROPE	T4	PA SP HD
SAIZEN	T4	PA SP HD
SAIZEN-SAIZENPREP	T4	PA HD
SEROSTIM	T4	PA SP HD
SKYTROFA	T4	PA SP HD
SOGROYA	T4	PA SP
ZOMACTON	T4	PA SP HD

T1 – Typically Generics
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List of Prescription Medications

HORMONES (Hormonal Agents)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
INSULIN-LIKE GROWTH FACTOR-I (IGF-I) HORMONES		
INCRELEX	T4	PA SP HD
LHRH (GNRH) AGONIST ANALOG AND PROGESTIN COMB		
LUPANETA PACK	T4	PA SP HD
LHRH (GNRH) AGONIST ANALOG PITUITARY SUPPRESSANTS		
LUPRON DEPOT	T4	PA SP HD
SYNAREL	T4	PA SP HD
LHRH (GNRH) ANTAGONIST, ESTROGEN AND PROGESTIN COMB		
MYFEMBREE	T2	PA QL (24 month therapy)
ORIAHNN	T2	PA QL (2 caps/day)
LHRH (GNRH) ANTAGONIST, PITUITARY SUPPRESSANT AGENTS		
CETROTIDE	T4	PA SP
<i>ganirelix acet 250 mcg/0.5 ml</i> (Ganirelix Acetate)	T4	PA SP
GANIRELIX ACET 250 MCG/0.5 ML (<i>ganirelix acetate</i>)	T4	PA SP
ORILISSA 150 MG TABLET	T2	PA QL (24 months of treatment/lifetime)
ORILISSA 200 MG TABLET	T2	PA QL (2 tabs/day)
LHRH (GNRH) AGNST PIT.SUP-CENTRAL PRECOCIOUS PUBERTY		
FENSOLVI	T4	PA SP
LUPRON DEPOT-PED	T4	PA SP HD
SUPPRELIN LA	T4	PA SP HD
TRIPTODUR	T4	PA SP
MINERALOCORTICIDS		
<i>fludrocortisone acetate</i>	T1	HD
OXYTOCICS		
CARBOPROST TROMETHAMINE	T3	
CERVIDIL	T3	
HEMABATE	T3	
<i>methylergonovine maleate</i>	T1	
<i>oxytocin</i> (Pitocin)	T1	
OXYTOCIN-D5-LACTATED RINGERS	T1	
OXYTOCIN-D5W	T1	
OXYTOCIN-LACTATED RINGERS	T1	
PITOCIN (<i>oxytocin</i>)	T3	
PREPIDIL	T3	
PROSTIN E2 VAGINAL SUPPOSITORY	T3	
PITUITARY SUPPRESSIVE AGENTS		
<i>cabergoline</i>	T1	QL (16 tabs/28 days) HD
<i>danazol</i>	T1	HD

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HORMONES (Hormonal Agents)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
PROGESTATIONAL AGENTS		
AYGESTIN (<i>norethindrone acetate</i>)	T3	HD
CRINONE 4% GEL	T3	PA HD
DEPO-PROVERA 400 MG/ML VIAL	T2	HD
<i>hydroxyprogesterone 1.25 g/5ml</i>	T1	HD
<i>medroxyprogesterone 10 mg tab (Provera)</i>	T1	HD
<i>medroxyprogesterone 2.5 mg tab (Provera)</i>	T1	HD
<i>medroxyprogesterone 5 mg tab (Provera)</i>	T1	HD
<i>norethindrone acetate (Aygestin)</i>	T1	HD
<i>progesterone 100 mg capsule (Prometrium)</i>	T1	HD
<i>progesterone 200 mg capsule (Prometrium)</i>	T1	HD
<i>progesterone 500 mg/10 ml vial</i>	T4	SP HD
PROMETRIUM (<i>progesterone</i>)	T3	PA HD
PROVERA (<i>medroxyprogesterone acetate</i>)	T3	HD
RENIN-ANGIOTENSIN-ALDOSTERONE SYS. (RAAS) HORMONES		
GIAPREZA	T3	SP
SOMATOSTATIC AGENTS		
BYNFEZIA	T3	PA SP
MYCAPSSA	T4	PA QL (4 caps/day) SP
<i>octreotide acetate</i>	T4	PA SP HD
<i>octreotide acetate (Sandostatin)</i>	T4	PA SP HD
SANDOSTATIN 0.05 MG/ML AMPUL (<i>octreotide acetate</i>)	T4	PA SP HD
SANDOSTATIN 0.1 MG/ML AMPUL (<i>octreotide acetate</i>)	T4	PA SP HD
SANDOSTATIN 0.5 MG/ML AMPUL (<i>octreotide acetate</i>)	T4	PA SP HD
SANDOSTATIN LAR DEPOT	T4	PA SP
SIGNIFOR	T4	PA SP
SIGNIFOR LAR	T4	PA SP
SOMATULINE DEPOT	T4	PA SP HD
VAGINAL ESTROGEN FOR SEXUAL DYSFUNCTION		
IMVEXXY 10 MCG MAINTENANCE PAK	T3	QL (16/28 days) HD
IMVEXXY 10 MCG STARTER PACK	T3	QL (36/28 days) HD
IMVEXXY 4 MCG MAINTENANCE PACK	T3	QL (16/28 days) HD
IMVEXXY 4 MCG STARTER PACK	T3	QL (36/28 days) HD
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

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List of Prescription Medications

HORMONES (Hormonal Agents)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
VAGINAL ESTROGEN PREPARATIONS		
<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
HORMONES (Infertility)		
FERTILITY STIMULATING PREPARATIONS, NON-FSH		
<i>clomiphene citrate</i>	T1	
FOLLICLE-STIMULATING AND LUTEINIZING HORMONES		
MENOPUR	T4	PA SP
FOLLICLE-STIMULATING HORMONE (FSH)		
FOLLISTIM AQ	T4	PA SP
GONAL-F	T4	PA SP
GONAL-F RFF	T4	PA SP
GONAL-F RFF REDI-JECT	T4	PA SP
HUMAN CHORIONIC GONADOTROPIN (HCG)		
CHORIONIC GONAD 10,000 UNIT VL	T4	PA SP
CHORIONIC GONAD 12,000 UNIT VL	T4	SP
CHORIONIC GONAD 6,000 UNIT VL	T4	SP
NOVAREL 10,000 UNITS VIAL	T4	PA SP
NOVAREL 5,000 UNIT VIAL	T4	PA SP
OVIDREL	T4	PA SP
PREGNYL	T4	PA SP
FACILITATING/MAINTAINING AGENT, HORMONAL		
CRINONE 8% GEL	T2	
ENDOMETRIN	T2	
PREGNANCY FACILITATING/MAINTAINING AGENT, HORMONAL		
<i>hydroxyprogest 1, 250 mg/5 ml</i>	T1	PA
<i>hydroxyprogest 250 mg/ml vial</i>	T1	PA
MAKENA	T3	PA
MAKENA (<i>hydroxyprogesterone caproate</i>)	T4	PA SP
HORMONES (Miscellaneous)		
LEPTIN HORMONE ANALOGS		
MYALEPT	T4	PA SP HD

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List of Prescription Medications

HORMONES (Osteoporosis Products)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
BONE FORMATION STIMULATING AGTS - PTH REL PEPTIDES		
TYMLOS	T4	PA QL (1 pen/30 days) SP HD
BONE RESORPTION INHIBITORS		
JESDUVROQ 1 MG, 2 MG, 4 MG TABLET	T3	PA QL(1 tab/day)
JESDUVROQ 6 MG TABLET	T3	PA QL(2 tabs/day)
JESDUVROQ 8 MG TABLET	T3	PA QL(3 tabs/day)
MIACALCIN	T3	HD
HYPOXIA INDUCIBLE FACTOR PROLYL HYDROXYLASE INH.		
<i>calcitonin, salmon, synthetic</i>	T1	HD
MIACALCIN	T3	HD
IMMUNOSUPPRESSANTS (Miscellaneous)		
IMMUNOSUPPRESSANT-INTERFERON GAMMA INHIBITOR, MAB		
GAMIFANT	T4	PA SP
IMMUNOSUPPRESSANTS (Pain Relief And Inflammatory Disease)		
ANTI-CDI9 (B LYMPHOCYTE) MONOCLONAL ANTIBODY		
UPLIZNA	T3	PA SP
IL-23 RECEPTOR ANTAGONIST, MONOCLONAL ANTIBODY T4		
OMVOH	T4	SP HD
OMVOH PEN	T4	PA QL(2 pens/28 days) SP HD
INTERLEUKIN-4(IL-4) RECEPTOR ALPHA ANTAGONIST, MAB		
DUPIXENT PEN	T4	PA SP HD
DUPIXENT SYRINGE	T4	PA SP HD
INTERLEUKIN-6 (IL-6) RECEPTOR INHIBITORS		
ACTEMRA 162 MG/0.9 ML SYRINGE	T4	PA QL (4 syringes/28 days) SP HD
ACTEMRA 200 MG/10 ML VIAL	T4	PA SP HD
ACTEMRA 400 MG/20 ML VIAL	T4	PA SP HD
INTERLEUKIN-6 (IL-6) RECEPTOR INHIBITORS		
ACTEMRA 80 MG/4 ML VIAL	T4	PA SP HD
ACTEMRA ACTPEN	T4	PA QL (4 pens/28 days) SP HD
ENSPRYNG	T4	PA SP HD
KEVZARA 150 MG/1.14 ML PEN INJ	T4	PA QL (2 pens/28 days) SP HD
KEVZARA 150 MG/1.14 ML SYRINGE	T4	PA QL (2 syringes/28 days) SP HD
KEVZARA 200 MG/1.14 ML PEN INJ	T4	PA QL (2 pens/28 days) SP HD
KEVZARA 200 MG/1.14 ML SYRINGE	T4	PA QL (2 syringes/28 days) SP HD
MONOCLONAL ANTIBODY-HUMAN INTERLEUKIN I2/23 INHIB		
STELARA 130 MG/26 ML VIAL	T4	PA SP HD

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List of Prescription Medications

IMMUNOSUPPRESSANTS (Transplant Medications)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
MONOCLONAL ANTIBODY-HUMAN INTERLEUKIN 12/23 INHIB		
STELARA 45 MG/0.5 ML SYRINGE	T4	PA QL (1 syringe/84 days) SP HD
STELARA 45 MG/0.5 ML VIAL	T4	PA QL (1 vial/84 days) SP HD
STELARA 90 MG/ML SYRINGE	T4	PA QL (1 syringe/84 days) SP HD
TOPICAL IMMUNOSUPPRESSIVE AGENTS		
ELIDEL (<i>pimecrolimus</i>)	T3	
<i>pimecrolimus</i> (Elidel)	T1	
PROTOPIC (<i>tacrolimus</i>)	T3	
<i>tacrolimus 0.03% ointment</i> (Protopic)	T1	
<i>tacrolimus 0.1% ointment</i> (Protopic)	T1	
IMMUNOSUPP - MONOCLONAL AB INHIBITING T LYMPH FXN		
SIMULECT	T4	SP
IMMUNOSUPPRESSIVES		
ASTAGRAF XL	T4	SP HD
AZASAN	T4	SP HD
<i>azathioprine</i> (Imuran)	T4	PA SP HD
<i>azathioprine sodium</i>	T4	PA
CELLCEPT 200 MG/ML ORAL SUSP (<i>mycophenolate mofetil</i>)	T4	SP HD
CELLCEPT 250 MG CAPSULE (<i>mycophenolate mofetil</i>)	T4	SP HD
CELLCEPT 500 MG TABLET (<i>mycophenolate mofetil</i>)	T4	SP HD
CELLCEPT 500 MG VIAL (<i>mycophenolate mofetil</i>)	T4	SP
<i>cyclosporine 100 mg capsule</i> (Sandimmune)	T4	SP HD
<i>cyclosporine 25 mg capsule</i> (Sandimmune)	T4	SP HD
<i>cyclosporine 250 mg/5 ml ampul</i> (Sandimmune)	T4	SP
<i>cyclosporine, modified</i>	T4	SP HD
<i>cyclosporine, modified</i> (Neoral)	T4	SP HD
ENVARUS XR	T4	SP HD
<i>everolimus 0.25 mg tablet</i> (Zortress)	T4	SP HD
<i>everolimus 0.5 mg tablet</i> (Zortress)	T4	SP HD
<i>everolimus 0.75 mg tablet</i> (Zortress)	T4	SP HD
IMURAN (<i>azathioprine</i>)	T4	SP HD
LUPKYNIS	T4	PA SP QL (6 caps/day)
<i>mycophenolate 200 mg/ml susp</i> (Cellcept)	T4	SP HD
<i>mycophenolate 250 mg capsule</i> (Cellcept)	T4	SP HD
<i>mycophenolate 500 mg tablet</i> (Cellcept)	T4	SP HD
<i>mycophenolate 500 mg vial</i> (Cellcept)	T4	SP
<i>mycophenolate sodium</i> (Myfortic)	T4	SP HD

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List of Prescription Medications

IMMUNOSUPPRESSANTS (Transplant Medications)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
IMMUNOSUPPRESSIVES (cont.)		
MYFORTIC (<i>mycophenolic acid</i>)	T4	SP HD
NEORAL (<i>engraf</i>)	T4	PA SP HD
NULOJIX	T4	SP
PROGRAF 0.2 MG GRANULE PACKET	T4	SP HD
PROGRAF 0.5 MG CAPSULE (<i>tacrolimus</i>)	T4	SP HD
PROGRAF 1 MG CAPSULE (<i>tacrolimus</i>)	T4	SP HD
PROGRAF 1 MG GRANULE PACKET	T4	SP HD
PROGRAF 5 MG CAPSULE (<i>tacrolimus</i>)	T4	SP HD
PROGRAF 5 MG/ML AMPULE	T4	SP
RAPAMUNE (<i>sirolimus</i>)	T4	SP HD
SANDIMMUNE 100 MG CAPSULE (<i>cyclosporine</i>)	T4	PA SP HD
SANDIMMUNE 100 MG/ML SOLN	T4	SP HD
SANDIMMUNE 25 MG CAPSULE (<i>cyclosporine</i>)	T4	PA SP HD
SANDIMMUNE 50 MG/ML AMPUL (<i>cyclosporine</i>)	T4	PA SP
<i>sirolimus</i> (Rapamune)	T4	SP HD
<i>tacrolimus 0.5 mg capsule (ir)</i> (Prograf)	T4	SP HD
<i>tacrolimus 1 mg capsule (ir)</i> (Prograf)	T4	SP HD
<i>tacrolimus 5 mg capsule (ir)</i> (Prograf)	T4	SP HD
ZORTRESS	T4	SP HD
ZORTRESS (<i>everolimus</i>)	T4	SP HD

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

BLOOD SUGAR DIAGNOSTICS

BLU LINK GLUCOSE TEST STRIP	T1	
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DIABETIC SUPPLIES

2TEK CONTROL SOLUTION	T1	
2TEK GLUCOSE-WRIST MONITOR KIT	T3	
ACCU-CHEK	T1	
ACCU-CHEK FASTCLIX LANCING DEV	T1	
ACCU-CHEK GUIDE CONTROL SOLN	T1	
ACCU-CHEK SMARTVIEW CONTRL SOL	T1	
ACCU-CHEK SOFTCLIX	T1	
ACCUTREND GLUCOSE CONTROL	T1	
ADJUSTABLE LANCING DEVICE	T1	
ADVANCED LANCING DEVICE	T1	
ADVOCATE CONTROL SOLUTION	T1	
ADVOCATE LANCING DEVICE	T1	

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

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
DIABETIC SUPPLIES (cont.)		
ADVOCATE RAPID-SAFE LANCING DV	T1	
ADVOCATE REDI-CODE+ CTRL SOLN	T1	
AGAMATRIX CONTROL	T1	
ALKALINE BATTERIES	T1	
ALTERNATE SITE LANCING DEVICE	T1	
AQUA LANCE LANCING DEVICE	T1	
ASSURE 4 CONTROL SOLUTION	T1	
ASSURE DOSE	T1	
ASSURE PRISM	T1	
AT HOME A1C	T1	
AUTOJECT 2	T1	
AUTO-LANCET MINI	T1	
AUTOLET IMPRESSION	T1	
AUTOLET LANCING DEVICE	T1	
AUTOLET PLUS	T1	
AUTOPEN	T1	
BLOOD-GLUCOSE CONTROL	T1	
BLU LINK DIABETIC TEST BUNDLE	T3	
BLU LINK GLUCOSE MONITOR SYST	T3	
BREEZE 2	T1	
CAREONE	T1	
CARESENS	T3	
CARETOUCH CONTROL SOLUTION	T1	
CARETOUCH LANCING DEVICE	T1	
CEQR SIMPLICITY	T2	
CEQR SIMPLICITY INSERTER	T2	
CLEVER CHOICE CONTROL SOLUTION	T1	
CONTOUR	T1	
CONTOUR METER	T1	
CONTOUR NEXT CONTROL SOLUTION	T1	
CONTOUR SOLUTION	T1	
CONTROL SOLUTION	T1	
COOL CONTROL SOLUTION	T1	
DEXCOM	T3	
DEXCOM G4	T3	
DEXCOM G5	T3	

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

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
DIABETIC SUPPLIES (cont.)		
DEXCOM G5-G4 SENSOR	T3	
DEXCOM G6 RECEIVER	T2	PA QL (1 syringe/365 days)
DEXCOM G6 SENSOR	T2	PA QL (3/30 days)
DEXCOM G6 TRANSMITTER	T2	PA QL (1 syringe/67 days)
DEXCOM G7 SENSOR	T2	PA QL(3 sensors/30 days)
DEXCOM G7 RECEIVER	T2	PA QL(1 unit/365 days)
DIATRUE	T1	
DROPLET GENTEEL LANCING DEVICE	T1	
DROPLET LANCING DEVICE	T1	
EASY MINI EJECT LANCING DEVICE	T1	
EASY PLUS II BLOOD GLUCOSE SYS	T1	
EASY PLUS II CONTROL SOLN HIGH	T1	
EASY PLUS II CONTROL SOLN LOW	T1	
EASY STEP CONTROL SOLUTION	T1	
EASY TALK BLOOD GLUCOSE METER	T1	
EASY TALK CONTROL SOLN LOW	T1	
EASY TALK HIGH CONTROL SOLN	T1	
EASY TALK PLUS II HIGH CONTROL	T1	
EASY TALK PLUS II LOW CTRL SLN	T1	
EASY TOUCH BLU LINK CTRL SOLN	T1	
EASY TOUCH CONTROL SOLUTION	T1	
EASY TOUCH LANCING DEVICE	T1	
EASY TRAK BLOOD GLUCOSE METER	T1	
EASY TRAK CONTROL SOLN HIGH	T1	
EASY TRAK CONTROL SOLN LOW	T1	
EASY TRAK II CONTROL SOLUTION	T1	
EASYGLUCO PLUS CONTROL NORMAL	T1	
EASYMAX 15 LEVEL 2 SOLUTION	T1	
EASYMAX NORMAL CONTROL SOLN	T1	
ELEMENT COMPACT CONTROL SOLN	T1	
ELEMENT CONTROL SOLUTION	T1	
EMBRACE EVO BLOOD GLUCOSE KIT	T1	
EMBRACE EVO BLOOD GLUCOSE MTR	T1	
EMBRACE EVO LEVEL 1 CTRL SOLN	T1	
EMBRACE GLUC CONTROL SOLN HIGH	T1	
EMBRACE GLUCOSE CONTROL SOLN	T1	
EMBRACE LANCING DEVICE	T1	

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

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
DIABETIC SUPPLIES (cont.)		
EMBRACE PRO	T1	
EMBRACE TALK CONTROL SOLUTION	T1	
EMBRACE WAVE PLUS GLUCOSE MTR	T1	
ENLITE	T1	
ENLITE GLUCOSE SENSOR	T1	
ENLITE SERTER	T1	
EVENCARE G2 BLOOD GLUCOSE SYS	T1	
EVENCARE G2 CONTROL SOLUTION	T1	
EVENCARE G3 BLOOD GLUCOSE SYS	T1	
EVENCARE G3 CONTROL SOLUTION	T1	
EVERSENSE SENSOR-HOLDER	T3	
EVERSENSE SMART TRANSMITTER	T3	
EVOLUTION CONTROL SOLUTION	T1	
EZ-VAC	T1	
FORA CONTROL SOLUTION	T1	
FORA LANCING DEVICE	T1	
FORACARE GDH	T1	
FORA TN'GO ADVANCE MULTIFN MTR	T3	
FORTISCARE	T1	
FREESTYLE CONTROL SOLUTION	T1	
FREESTYLE LIBRE 10 DAY READER	T2	PA QL (1 reader/day)
FREESTYLE LIBRE 10 DAY SENSOR	T2	PA QL (3/30 days)
FREESTYLE LIBRE 14 DAY READER	T2	PA QL (1 reader/day)
FREESTYLE LIBRE 14 DAY SENSOR	T2	PA QL (2/28 days)
FREESTYLE LIBRE 2 READER	T2	PA QL (1 reader/day)
FREESTYLE LIBRE 2 SENSOR	T2	PA QL (2 sensors/21 days)
FREESTYLE LIBRE 3 READER	T2	PA QL(1 unit/720 days)
FREESTYLE NAVIGATOR	T3	
GE100 CONTROL SOLUTION NORMAL	T1	
GE333 BLOOD GLUCOSE TEST STRIP	T3	
GE333 BLOOD GLUCOSE SYSTEM	T3	
GENTEEL VACUUM LANCING DEVICE	T1	
GLUCOCARD 01 CONTROL	T1	
GLUCOCARD EXPRESSION CNTRL SLN	T1	
GLUCOCARD EXPRESSION METER	T1	
GLUCOCARD EXPRESSION METER KIT	T1	
GLUCOCARD SHINE CONTROL SOLN	T1	

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

T4 – Specialty Medications

PA – Prior Authorization

QL – Quantity Limit

ST – Step Therapy

AGE – Age Requirement

SP – Specialty Medication

HD – May require home delivery pharmacy

PPACA – No Cost-Share Preventive Medication

CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

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

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
DIABETIC SUPPLIES		
GLUCOCARD SHINE METER	T1	
GLUCOCARD SHINE METER KIT	T1	
GLUCOCOM AUTOLINK	T1	
GLUCOCOM CONTROL SOLUTION	T1	
GLUCOSE CONTROL	T1	
GLUCOSE CONTROL SOLUTION	T1	
GOJJI GLUCOSE CONTROL SOLUTION	T1	
GOJJI LANCING DEVICE	T1	
GUARDIAN CONNECT TRANSMITTER	T3	
GUARDIAN LINK 3	T3	
GUARDIAN REAL-TIME	T3	
GUARDIAN RT CHARGER	T1	
GUARDIAN RT STARTER KIT	T3	
GUARDIAN RT SYSTEM	T1	
GUARDIAN SENSOR 3	T3	
GUARDIAN TEST PLUG	T1	
HUMAPEN LUXURA HD	T3	
INPEN (FOR HUMALOG)	T1	
INPEN (FOR NOVOLOG OR FIASP)	T1	
LITE TOUCH LANCING PEN	T1	
MOBILE LANCETS	T2	
MINILINK REAL-TIME TRANSMITTER	T2	
MINIMED 630G GUARDIAN START KT	T3	
NOVA MAX GLUCOSE CONTROL SOLN	T3	
NOVOPEN ECHO	T3	
ON CALL EXPRESS CONTROL SOLN	T1	
ON CALL LANCING DEVICE	T1	
ON CALL PLUS CONTROL	T1	
ON CALL PLUS LANCING DEVICE	T1	
ON CALL VIVID CONTROL	T1	
ONETOUCH DELICA PLUS LANC DEV	T1	
ONETOUCH ULTRA CONTROL SOLN	T1	
ONETOUCH VERIO HIGH CNTRL SOLN	T1	
ONETOUCH VERIO MID CNTRL SOLN	T1	
OMNIPOD DASH 5 PACK POD	T2	PA QL (6 boxes/30 days)
OMNIPOD 5 G6-G7 INTRO KT(GEN5)	T2	QL

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

T4 – Specialty Medications

PA – Prior Authorization

QL – Quantity Limit

ST – Step Therapy

AGE – Age Requirement

SP – Specialty Medication

HD – May require home delivery pharmacy

PPACA – No Cost-Share Preventive Medication

CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

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

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
DIABETIC SUPPLIES		
OMNIPOD 5 G6-G7 PODS (GEN 5)	T2	QL
ONETOUCH ULTRASOFT 2 LANCET	T2	
OPTUMRX BLOOD GLUCOSE METER	T3	
OPTUMRX BLOOD GLUCOSE SYSTEM	T3	
OPTUMRX GLUCOSE CONTROL SOLN	T1	
OVAL TAPE	T1	
PARADIGM REMOTE CONTROL	T1	
PARADIGM REAL-TIME	T2	
PIP GLUCOSE CONTROL SOLUTION	T1	
PRODIGY CONTROL SOLUTION	T1	
PRODIGY LANCING DEVICE	T1	
REFUAH PLUS GLUCOSE CONTROL	T1	
RELIAMED MINI LANCING DEVICE	T1	
REPLACEMENT PEDIATRIC MONITOR	T3	
RIGHTEST CONTROL SOLUTION	T1	
RIGHTEST GD500	T1	
SAFE-CLIP	T1	
SEN-SERTER	T2	
SIL-SERTER	T1	
SMARTDIABETES VANTAGE	T1	
SMARTEST	T1	
SOF-SENSOR	T2	
SOLUS V2 CONTROL SOLUTION	T1	
SOLUS V2 LANCING DEVICE	T1	
SURE COMFORT LANCING PEN	T1	
SUREFLEX	T1	
SURE-PEN	T1	
SURE-TEST EASYPLUS MINI METER	T1	
SURE-TEST EASYPLUS MINI SOLN	T1	
TELCARE CONTROL SOLUTION	T1	
TRUE METRIX	T1	
TRUECONTROL	T1	
TRUEDRAW	T1	
ULTI-LANCE	T1	
ULTRATRAK BLOOD GLUCOSE METER	T1	
ULTRATRAK CONTROL SOL NORMAL	T1	

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

T4 – Specialty Medications

PA – Prior Authorization

QL – Quantity Limit

ST – Step Therapy

AGE – Age Requirement

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HD – May require home delivery pharmacy

PPACA – No Cost-Share Preventive Medication

CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

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

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
DIABETIC SUPPLIES		
ULTRATRAK CONTROL SOLUTION	T1	
ULTRATRAK ULTIMATE CNTRL SOLN	T1	
ULTRATRAK ULTIMATE GLUCOSE MTR	T3	
UNISTIK 2	T1	
UNISTIK 2 NORMAL	T1	
UNISTIK 3	T1	
UNISTIK 3 COMFORT	T1	
UNISTIK 3 NEONATAL	T1	
UNISTRIP	T1	
V-GO 20	T2	
V-GO 30	T2	
V-GO 40	T2	
VERASENS CONTROL SOLUTION	T1	
VIVAGUARD INO CONTROL SOLUTION	T1	
VIVAGUARD LANCING DEVICE	T1	
WAVESENSE CONTROL SOLUTION	T1	
DURABLE MEDICAL EQUIPMENT,MISC(GROUP I)		
ADVOCATE SAFETY LANCET	T1	
CARESENS LANCET	T1	
CARETOUCH SAFETY LANCETS	T1	
LITE TOUCH LANCETS	T1	
ULTRA-THIN II 28G LANCETS	T1	
NEEDLES/NEEDLELESS DEVICES		
1ST TIER UNIFINE PENTIPS	T1	
1ST TIER UNIFINE PENTIPS PLUS	T1	
ABOUTTIME PEN NEEDLE	T1	
ADVOCATE PEN NEEDLE	T1	
ADVOCATE PEN NEEDLES	T1	
AQINJECT PEN NEEDLE	T1	
ASSURE ID PEN NEEDLE	T1	
AUTOSHIELD DUO PEN NEEDLE	T1	
BLUNT NEEDLE	T1	
CAREFINE PEN NEEDLE	T1	
CARETOUCH HYPODERMIC NEEDLE	T1	
CARETOUCH PEN NEEDLE	T1	
CLICKFINE	T1	
COMFORT EZ PEN NEEDLE	T1	

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

T4 – Specialty Medications

PA – Prior Authorization

QL – Quantity Limit

ST – Step Therapy

AGE – Age Requirement

SP – Specialty Medication

HD – May require home delivery pharmacy

PPACA – No Cost-Share Preventive Medication

CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

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

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
NEEDLES/NEEDLELESS DEVICES		
COMFORT EZ PRO SAFETY PEN NDL	T1	
COMFORT TOUCH PEN NEEDLE	T1	
DROPLET MICRON PEN NEEDLE	T1	
DROPLET PEN NEEDLE	T1	
DROPSAFE PEN NEEDLE	T1	
EASY COMFORT PEN NEEDLES	T1	
EASY GLIDE PEN NEEDLE	T1	
EASY TOUCH FLIPLOCK NEEDLE	T1	
EASY TOUCH FLIPLOCK NEEDLES	T1	
EASY TOUCH HYPODERMIC NEEDLE	T1	
EASY TOUCH PEN NEEDLE	T1	
EASY TOUCH SAFETY PEN NEEDLE	T1	
EASYPPOINT NEEDLE	T1	
ECLIPSE NEEDLE	T1	
EMBRACE PEN NEEDLE	T1	
EXEL HUBER NEEDLE	T1	
EXEL HYPODERMIC NEEDLE	T1	
FILTER ASPIRATOR NEEDLE	T1	
FILTER NEEDLE	T1	
FLOW-EZE	T1	
HEALTHWISE PEN NEEDLE	T1	
HEALTHY ACCENTS UNIFINE PENTIP	T1	
HYPODERMIC NEEDLE	T1	
INCONTROL PEN NEEDLE	T1	
INSULIN PEN NEEDLE	T1	
INSUPEN	T1	
INSUPEN PEN NEEDLE	T1	
INTEGRA NEEDLE	T1	
INTEGRA PRECISIONGLIDE NEEDLE	T1	
LIFESHIELD BLUNT CANNULA	T1	
LITE TOUCH	T1	
MAXICOMFORT II PEN NEEDLE	T1	
MAXICOMFORT SAFETY PEN NEEDLE	T1	
MICRODOT INSULIN PEN NEEDLE	T1	
MINI PEN NEEDLE	T1	
MINI ULTRA-THIN II	T1	
MONOJECT FILTER NEEDLE	T1	

T1 – Typically Generics

T4 – Specialty Medications

ST – Step Therapy

HD – May require home delivery pharmacy

T2 – Typically Preferred Brands

PA – Prior Authorization

AGE – Age Requirement

PPACA – No Cost-Share Preventive Medication

T3 – Typically Non-Preferred Brands

QL – Quantity Limit

SP – Specialty Medication

CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

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

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
NEEDLES/NEEDLELESS DEVICES		
NANO 2ND GEN PEN NEEDLE	T1	
NEEDLE	T1	
<i>needles,safety huber,disposabl</i>	T1	
NOKOR ADMIX NEEDLE	T1	
NOKOR NEEDLE	T1	
NOVOFINE 32	T1	
NOVOFINE AUTOCOVER	T1	
NOVOFINE PLUS	T1	
NOVOTWIST	T1	
PEN NEEDLE	T1	
PENTIPS	T1	
PIP PEN NEEDLE	T1	
POLY HUB NEEDLE	T1	
PRECISIONGLIDE	T1	
PREVENT DROPSAFE PEN NEEDLE	T1	
PRO COMFORT PEN NEEDLE	T1	
PURE COMFORT PEN NEEDLE	T1	
PURE COMFORT SAFETY PEN NEEDLE	T1	
RAYA SURE PEN NEEDLE	T1	
REGULAR BEVEL NEEDLES	T1	
RELION PEN NEEDLES	T1	
SAFETY PEN NEEDLE	T1	
SAFETYGLIDE NEEDLE	T1	
SECURESAFE PEN NEEDLE	T1	
SHORT BEVEL NEEDLES	T1	
SKY SAFETY PEN NEEDLE	T1	
SPECIALTY USE NEEDLES	T1	
SURE COMFORT	T1	
SURE COMFORT PEN NEEDLE	T1	
SURE COMFORT SAFETY PEN NEEDLE	T1	
SURE-FINE PEN NEEDLES	T1	
TECHLITE PEN NEEDLE	T1	
TERUMO SURGUARD2	T1	
THIN WALL NEEDLES	T1	
TOPCARE CLICKFINE	T1	
TRANSFER NEEDLE	T1	

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

T4 – Specialty Medications

PA – Prior Authorization

QL – Quantity Limit

ST – Step Therapy

AGE – Age Requirement

SP – Specialty Medication

HD – May require home delivery pharmacy

PPACA – No Cost-Share Preventive Medication

CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

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

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
NEEDLES/NEEDLELESS DEVICES		
TRUE COMFORT PEN NEEDLE	T1	
TRUE COMFORT PRO PEN NEEDLE	T1	
TRUE COMFORT SAFETY PEN NEEDLE	T1	
TRUEPLUS PEN NEEDLE	T1	
ULTICARE PEN NEEDLE	T1	
ULTICARE SAFETY PEN NEEDLE	T1	
ULTIGUARD SAFEPACK-PEN NEEDLE	T1	
ULTILET PEN NEEDLE	T1	
ULTRA FLO PEN NEEDLE	T1	
ULTRA THIN	T1	
ULTRACARE PEN NEEDLE	T1	
ULTRA-FINE MICRO PEN NEEDLE	T1	
ULTRA-FINE MINI PEN NEEDLE	T1	
ULTRA-FINE NANO PEN NEEDLE	T1	
ULTRA-FINE ORIGINAL PEN NEEDLE	T1	
ULTRA-FINE SHORT PEN NEEDLE	T1	
ULTRA-THIN II	T1	
UNIFINE PEN NEEDLE	T1	
UNIFINE PENTIPS	T1	
UNIFINE PENTIPS MAXFLOW	T1	
UNIFINE PENTIPS PLUS	T1	
UNIFINE PENTIPS PLUS MAXFLOW	T1	
UNIFINE SAFECONTROL	T1	
UNIFINE ULTRA PEN NEEDLE	T1	
VERIFINE PEN NEEDLE	T1	
VERIFINE PLUS PEN NEEDLE	T1	
YALE NEEDLE	T1	
SYRINGES AND ACCESSORIES		
ASSURE ID INSULIN SAFETY	T1	
CARETOUCH INSULIN SYRINGE	T1	
COMFORT EZ INSULIN SYRINGE	T1	
DROPLET INSULIN SYRINGE	T1	
DROPSAFE INSULIN SYRINGE	T1	
EASY COMFORT INSULIN SYRINGE	T1	
EASY GLIDE INSULIN SYRINGE	T1	
EASY TOUCH	T1	

T1 – Typically Generics

T4 – Specialty Medications

ST – Step Therapy

HD – May require home delivery pharmacy

T2 – Typically Preferred Brands

PA – Prior Authorization

AGE – Age Requirement

PPACA – No Cost-Share Preventive Medication

T3 – Typically Non-Preferred Brands

QL – Quantity Limit

SP – Specialty Medication

CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

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

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
SYRINGES AND ACCESSORIES		
EASY TOUCH FLIPLOCK INSULIN	T1	
EASY TOUCH INSULIN SAFETY	T1	
EASY TOUCH INSULIN SYRINGE	T1	
EASY TOUCH LUER LOCK INSULIN	T1	
EASY TOUCH SHEATHLOCK INSULIN	T1	
EASY TOUCH UNI-SLIP	T1	
EASY-TOUCH INSULIN SYRINGE	T1	
ECLIPSE SYRINGE	T1	
FREESTYLE PRECISION	T1	
HEALTHWISE INSULIN SYRINGE	T1	
INSULIN SYRINGE	T2	
INSULIN SYRINGE U-500	T1	
LITETOUCH INSULIN SYRINGE	T1	
LUER-LOK SYRINGE	T1	
MAGELLAN INSULIN SAFETY SYRNG	T1	
MAGELLAN INSULIN SYRINGE	T1	
MINIMED RESERVOIR	T1	
MONOJECT INSULIN SYRINGE	T1	
PARADIGM	T3	
SECURESAFE INSULIN SYRINGE	T2	
SURE COMFORT INSULIN SYRINGE	T1	
SURE-JECT INSULIN SYRINGE	T1	
<i>syringe and needle,insulin,1ml</i>	T1	
<i>syringe-needle,insulin,0.5 ml</i>	T1	
<i>syring-needl,disp,insul,0.3 ml</i>	T1	
TECHLITE INSULIN SYRINGE	T1	
TERUMO INSULIN SYRINGE	T1	
THINPRO INSULIN SYRINGE	T1	
TOPCARE ULTRA COMFORT	T1	
TRUE COMFORT INSULIN SYRINGE	T1	
TRUEPLUS INSULIN SYRINGE	T1	
ULTICARE INSULIN SYRINGE	T1	
ULTIGUARD SAFE 1ML 30G 12.7MM	T1	
ULTIGUARD SAFE0.3ML 30G 12.7MM	T1	
ULTIGUARD SAFE0.5ML 30G 12.7MM	T1	
ULTIGUARD SAFEPACK 1ML 31G 8MM	T1	
ULTIGUARD SAFEPK 0.3ML 31G 8MM	T1	

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

T4 – Specialty Medications

PA – Prior Authorization

QL – Quantity Limit

ST – Step Therapy

AGE – Age Requirement

SP – Specialty Medication

HD – May require home delivery pharmacy

PPACA – No Cost-Share Preventive Medication

CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

MISCELLANEOUS MEDICAL SUPPLIES, DEVICES, NON-DRUG (Miscellaneous)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
SYRINGES AND ACCESSORIES		
ULTIGUARD SAFEPK 0.5ML 31G 8MM	T1	
ULTILET INSULIN SYRINGE	T1	
ULTRA COMFORT	T1	
ULTRA FLO INSULIN SYRINGE	T1	
ULTRACARE INSULIN SYRINGE	T1	
ULTRA-THIN II	T1	
VANISHPOINT INSULIN SYRINGE	T1	
VEO INSULIN SYRINGE	T1	
VERIFINE INSULIN SYRINGE	T1	
DURABLE MEDICAL EQUIPMENT,MISC(GROUP I)		
1ST TIER UNILET COMFORTOUCH	T1	
2-IN-1 LANCET DEVICE	T1	
ACCU-CHEK FASTCLIX LANCET DRUM	T1	
ACCU-CHEK SAFE-T-PRO	T1	
ACCU-CHEK SAFE-T-PRO PLUS	T1	
ACCU-CHEK SOFTCLIX	T1	
ACTI-LANCE	T1	
ADVANCED TRAVEL LANCETS	T1	
ADVOCATE LANCET	T1	
ADVOCATE LANCETS	T1	
ALTERNATE SITE LANCETS	T1	
ASSURE HAEMOLANCE PLUS	T1	
ASSURE LANCE	T1	
ASSURE LANCE PLUS	T1	
BD MICROTAINER LANCETS	T1	
BD ULTRA-FINE	T1	
BD ULTRA-FINE II	T1	
BLOOD LANCETS	T1	
BULLSEYE MINI SAFETY LANCETS	T1	
BUTTERFLY TOUCH LANCET	T1	
CAREONE	T1	
CARESENS LANCET	T1	
CARETOUCH TWIST LANCET	T1	
CLEVER CHEK LANCETS	T1	
COAGUCHEK	T1	
COLOR LANCETS	T1	

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

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

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

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

List of Prescription Medications

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

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
DURABLE MEDICAL EQUIPMENT,MISC(GROUP I)		
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	
EMBRACE 30G LANCETS	T1	
EMBRACE SAFETY LANCET	T1	
EZ SMART LANCETS	T1	
EZ-LETS	T1	
FIFTY50 SAFETY SEAL LANCETS	T1	
FINE 30 UNIVERSAL LANCETS	T1	
FINGERSTIX	T1	
FORA LANCETS	T1	
FORACARE LANCETS	T1	
FREESTYLE LANCETS	T1	
FREESTYLE UNISTIK 2	T1	
GLUCOCOM	T1	
GLUCOCOM LANCETS	T1	
GOJJI LANCETS	T1	
HEALTHY ACCENTS UNILET LANCET	T1	
INCONTROL SUPER THIN LANCETS	T1	
INCONTROL ULTRA THIN LANCETS	T1	
INJECT EASE LANCETS	T1	
INVACARE LANCETS	T1	
<i>lancets</i>	T1	
LANCETS	T1	
LANCETS THIN	T1	
LANCETS ULTRA THIN	T1	
LITE TOUCH	T1	
MEDISENSE THIN LANCETS	T1	
MEDLANCE PLUS	T1	
MEDLANCE PLUS SPECIAL BLADE	T1	
MICRO THIN LANCET	T1	

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

T4 – Specialty Medications

PA – Prior Authorization

QL – Quantity Limit

ST – Step Therapy

AGE – Age Requirement

SP – Specialty Medication

HD – May require home delivery pharmacy

PPACA – No Cost-Share Preventive Medication

CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

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

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
DURABLE MEDICAL EQUIPMENT,MISC(GROUP I)		
MICRO THIN LANCETS	T1	
MICROLET	T1	
MICROTAINER LANCETS	T1	
MOBILE LANCETS	T1	
MONOLET LANCETS	T1	
MONOLET THIN LANCETS	T1	
MYGLUCOHEALTH LANCETS	T1	
NOVA SAFETY LANCETS	T1	
NOVA SUREFLEX	T1	
ON CALL LANCET	T1	
ON CALL PLUS LANCET	T1	
ONETOUCH DELICA PLUS LANCET	T1	
ONETOUCH DELICA SAFETY LANCET	T1	
ONETOUCH LANCETS	T1	
ONETOUCH SURESOFT	T1	
ONETOUCH ULTRASOFT 2 LANCET	T1	
ON-THE-GO	T1	
PIP LANCET	T1	
PRESSURE ACTIVATED LANCETS	T1	
PRO COMFORT 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	

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

T4 – Specialty Medications

PA – Prior Authorization

QL – Quantity Limit

ST – Step Therapy

AGE – Age Requirement

SP – Specialty Medication

HD – May require home delivery pharmacy

PPACA – No Cost-Share Preventive Medication

CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

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

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
DURABLE MEDICAL EQUIPMENT,MISC(GROUP I)		
SMART SENSE	T1	
SMART SENSE LANCETS	T1	
SMARTEST LANCET	T1	
SOFT TOUCH	T1	
SOLUS V2 28G LANCETS	T1	
SOLUS V2 LANCETS	T1	
STERILANCE TL	T1	
STERILE LANCETS	T1	
SUPER THIN LANCETS	T1	
SURE COMFORT LANCETS	T1	
SURE-LANCE	T1	
SURE-TOUCH	T1	
TECHLITE LANCETS	T1	
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	
TWIST TOP LANCET	T1	
ULTILET BASIC	T1	
ULTILET CLASSIC	T1	
ULTILET LANCETS	T1	
ULTILET SAFETY	T1	
ULTRA THIN LANCET	T1	
ULTRA THIN LANCETS	T1	
ULTRA THIN PLUS	T1	
ULTRA THIN PLUS LANCETS	T1	
ULTRA-CARE LANCETS	T1	
ULTRALANCE	T1	
ULTRA-THIN II	T1	
ULTRATLC LANCETS	T1	
UNILET COMFORTOUCH	T1	
UNILET EXCELITE	T1	

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

T4 – Specialty Medications

PA – Prior Authorization

QL – Quantity Limit

ST – Step Therapy

AGE – Age Requirement

SP – Specialty Medication

HD – May require home delivery pharmacy

PPACA – No Cost-Share Preventive Medication

CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

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

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
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DURABLE MEDICAL EQUIPMENT, MISC (GROUP I)

UNILET EXCELITE II	T1	
UNILET GP LANCET	T1	
UNILET LANCET	T1	
UNILET LANCETS	T1	
UNISTIK 3	T1	
UNISTIK 3 EXTRA	T1	
UNISTIK 3 NORMAL	T1	
UNISTIK COMFORT	T1	
UNISTIK CZT	T1	
UNISTIK EXTRA	T1	
UNISTIK NORMAL	T1	
UNISTIK PRO	T1	
UNISTIK SAFETY	T1	
UNISTIK TOUCH	T1	
UNIVERSAL 1	T1	
VERIFINE SAFETY LANCET MINI	T1	
VERIFINE UNIVERSAL LANCET	T1	
VIVAGUARD LANCET	T1	

TISSUE BULKING IMPLANTS

BARRIGEL (<i>hyaluronate sodium, stabilized</i>)	T4	PA SP HD
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MUSCLE RELAXANTS (Pain Relief And Inflammatory Disease)

SKELETAL MUSCLE RELAXANTS

AMRIX ER 15 MG CAPSULE (<i>cyclobenzaprine hcl er</i>)	T3	PA QL (1 cap/day)
AMRIX ER 30 MG CAPSULE (<i>cyclobenzaprine hcl er</i>)	T3	PA
<i>baclofen</i>	T1	HD
BACLOFEN 25 MG/5 ML SUSPENSION	T3	PA HD
BACLOFEN 10 MG/5 ML SOLUTION	T3	PA HD
<i>baclofen (Gablofen)</i>	T1	
<i>carisoprodol (Soma)</i>	T1	
<i>carisoprodol/aspirin</i>	T1	
<i>chlorzoxazone 250 mg tablet</i>	T1	PA
<i>chlorzoxazone 375 mg tablet (Lorzone)</i>	T1	PA
<i>chlorzoxazone 500 mg tablet</i>	T1	
<i>chlorzoxazone 750 mg tablet (Lorzone)</i>	T1	PA
<i>cyclobenzaprine er 15 mg cap (Amrix)</i>	T1	PA QL (1 cap/day)
<i>cyclobenzaprine er 30 mg cap (Amrix)</i>	T1	PA
<i>cyclobenzaprine hcl</i>	T1	

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

T4 – Specialty Medications

PA – Prior Authorization

QL – Quantity Limit

ST – Step Therapy

AGE – Age Requirement

SP – Specialty Medication

HD – May require home delivery pharmacy

PPACA – No Cost-Share Preventive Medication

CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

MUSCLE RELAXANTS (Pain Relief And Inflammatory Disease)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
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SKELETAL MUSCLE RELAXANTS

<i>cyclobenzaprine hcl</i> (Fexmid)	T1	
DANTRIUM	T3	
DANTRIUM (<i>dantrolene sodium</i>)	T3	
<i>dantrolene sodium</i>	T1	
<i>dantrolene sodium</i> (Dantrium)	T1	
FEXMID (<i>cyclobenzaprine hcl</i>)	T3	
FLEQSUVY (<i>baclofen</i>)	T3	PA HD
GABLOFEN	T3	
GABLOFEN (<i>baclofen</i>)	T3	
LIORESAL INTRATHECAL	T3	
LORZONE (<i>chlorzoxazone</i>)	T3	PA
LYVISPAH	T3	PA
<i>metaxalone</i>	T1	
<i>metaxalone</i> (Skelaxin)	T1	
<i>methocarbamol</i>	T1	
<i>methocarbamol</i> (Robaxin)	T1	
<i>methocarbamol</i> (Robaxin-750)	T1	
NORGESIC FORTE	T3	
<i>orphenadrine citrate</i>	T1	
<i>orphenadrine/aspirin/caffeine</i> (Norgesic Forte)	T1	
OZOBAX	T3	PA HD
OZOBAX DS	T3	PA HD
ROBAXIN	T3	
ROBAXIN-750 (<i>methocarbamol</i>)	T3	
RYANODEX	T3	
SKELAXIN (<i>metaxalone</i>)	T3	
SOMA (<i>carisoprodol</i>)	T3	
SOMA (<i>vanadom</i>)	T3	
<i>tizanidine hcl</i>	T1	PA
<i>tizanidine hcl</i> (Zanaflex)	T1	PA
ZANAFLEX (<i>tizanidine hcl</i>)	T3	

PRE-NATAL VITAMINS (Nutritional/Dietary)

PRENATAL VITAMIN PREPARATIONS

ATABEX EC	T3	
CITRANATAL 90 DHA	T2	
CITRANATAL ASSURE	T2	

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

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

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

HD – May require home delivery pharmacy
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 CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

PRE-NATAL VITAMINS (Nutritional/Dietary)

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

PSYCHOTHERAPEUTIC DRUGS (Anxiety/Depression/Bipolar Disorder)⁸

ALPHA-2 RECEPTOR ANTAGONIST ANTI-DEPRESSANTS

<i>mirtazapine</i>	T1	HD
<i>mirtazapine (Remeron)</i>	T1	HD
QELBREE	T3	PA QL
REMERON (<i>mirtazapine</i>)	T3	PA HD

ANTI-ANXIETY - BENZODIAZEPINES

ATIVAN (<i>lorazepam</i>)	T3	PA
<i>chlordiazepoxide hcl</i>	T1	
<i>clorazepate dipotassium</i>	T1	
<i>clorazepate dipotassium (Tranxene T-tab)</i>	T1	
<i>diazepam 10 mg tablet (Valium)</i>	T1	
<i>diazepam 10 mg/2 ml carpuject</i>	T1	
<i>diazepam 10 mg/2 ml syringe</i>	T1	
<i>diazepam 2 mg tablet (Valium)</i>	T1	
<i>diazepam 5 mg tablet (Valium)</i>	T1	
<i>diazepam 5 mg/5 ml solution</i>	T1	
<i>diazepam 5 mg/ml oral conc</i>	T1	
<i>diazepam 50 mg/10 ml vial</i>	T1	
<i>lorazepam</i>	T1	

T1 – Typically Generics
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T4 – Specialty Medications
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List of Prescription Medications

PSYCHOTHERAPEUTIC DRUGS (Anxiety/Depression/Bipolar Disorder) ⁸		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ANTI-ANXIETY - BENZODIAZEPINES		
<i>lorazepam</i> (Ativan)	T1	
LOREEV XR	T3	PA QL (30 tabs/30 days) SP
<i>oxazepam</i>	T1	
TRANXENE T-TAB (<i>clorazepate dipotassium</i>)	T3	PA
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	HD
<i>meprobamate</i>	T1	
ANTIDEPRESSANT - NMDA RECEPTOR ANTAGONIST		
SPRAVATO	T4	PA SP
ANTIDEPRESSANT - POSTPARTUM DEPRESSION (PPD)		
ZURZUVAE 20 MG CAPSULE	T4	PA QL(28 caps/270 days) SP HD
ZURZUVAE 25 MG CAPSULE	T4	PA QL(28 caps/270 day) SP HD
ZURZUVAE 30 MG CAPSULE	T4	PA QL(14 caps/270 day) SP HD
BIPOLAR DISORDER DRUGS		
EQUETRO	T3	HD
<i>lithium carbonate</i> (Lithobid)	T1	HD
<i>lithium citrate</i>	T1	HD
LITHOBID (<i>lithium carbonate er</i>)	T3	PA HD
MAOIS -NON-SELECTIVE, IRREVERSIBLE ANTI-DEPRESSANTS		
MARPLAN	T3	QL (12 tabs/day)
NARDIL (<i>phenelzine sulfate</i>)	T3	PA
PARNATE (<i>tranylcypromine sulfate</i>)	T3	PA
<i>phenelzine sulfate</i> (Nardil)	T1	
<i>tranylcypromine sulfate</i> (Parnate)	T1	
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)
NDMA RECEPTOR ANTAGONIST AND NDRI COMB		
AUVELITY	T3	PA QL (60 tabs/30days)
NOREPINEPHRINE AND DOPAMINE REUPTAKE INHIB (NDRIs)		
APLENZIN ER 174 MG TABLET	T3	PA QL (3 tabs/day) HD
APLENZIN ER 348 MG TABLET	T3	PA QL (1 tab/day) HD
APLENZIN ER 522 MG TABLET	T3	PA QL (1 tab/day) HD

T1 – Typically Generics
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 T3 – Typically Non-Preferred Brands

T4 – Specialty Medications
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ST – Step Therapy
 AGE – Age Requirement
 SP – Specialty Medication

HD – May require home delivery pharmacy
 PPACA – No Cost-Share Preventive Medication
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List of Prescription Medications

PSYCHOTHERAPEUTIC DRUGS (Anxiety/Depression/Bipolar Disorder) ⁸			
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits	
NOREPINEPHRINE AND DOPAMINE REUPTAKE INHIB (NDRIs)			
<i>bupropion hcl 100 mg tablet</i>	T1	QL (4 tabs/day) HD	
<i>bupropion hcl 75 mg tablet</i>	T1	QL (6 tabs/day) HD	
<i>bupropion hcl sr 100 mg tablet (Wellbutrin Sr)</i>	T1	QL (4 tabs/day) HD	
<i>bupropion hcl sr 150 mg tablet (Wellbutrin Sr)</i>	T1	QL (2 tabs/day) HD	
<i>bupropion hcl sr 200 mg tablet (Wellbutrin Sr)</i>	T1	QL (2 tabs/day) HD	
<i>bupropion hcl xl 150 mg tablet (Wellbutrin XL)</i>	T1	QL (3 tabs/day) HD	
<i>bupropion hcl xl 300 mg tablet (Wellbutrin XL)</i>	T1	QL (1 tab/day) HD	
BUPROPION HCL XL 450 MG TABLET	T1	QL (1 tab/day) HD	
FORFIVO XL	T3	QL (1 tab/day) ST HD	
WELLBUTRIN SR 100 MG TABLET (<i>bupropion hcl sr</i>)	T3	PA QL (4 tabs/day) HD	
WELLBUTRIN SR 150 MG TABLET (<i>bupropion hcl sr</i>)	T3	PA QL (2 tabs/day) HD	
WELLBUTRIN SR 200 MG TABLET (<i>bupropion hcl sr</i>)	T3	PA QL (2 tabs/day) HD	
WELLBUTRIN XL 150 MG TABLET (<i>bupropion xl</i>)	T3	PA QL (3 tabs/day) HD	
WELLBUTRIN XL 300 MG TABLET (<i>bupropion xl</i>)	T3	PA QL (1 tab/day) HD	
SELECTIVE SEROTONIN 5-HT_{2A} INVERSE AGONISTS (SSiAs)			
NUPLAZID	T4	PA SP HD	
SELECTIVE SEROTONIN REUPTAKE INHIBITOR (SSRIs)			
CELEXA 10 MG TABLET (<i>citalopram hbr</i>)	T3	PA QL (6 tabs/day) HD	
CELEXA 20 MG TABLET (<i>citalopram hbr</i>)	T3	PA QL (3 tabs/day) HD	
CELEXA 40 MG TABLET (<i>citalopram hbr</i>)	T3	PA QL (1 tab/day) HD	
<i>citalopram hbr 10 mg tablet (Celexa)</i>	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 (Celexa)</i>	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 (Celexa)</i>	T1	QL (1 tab/day) HD	
<i>escitalopram 10 mg tablet (Lexapro)</i>	T1	QL (2 tabs/day) HD	
<i>escitalopram 20 mg tablet (Lexapro)</i>	T1	QL (1 tab/day) HD	
<i>escitalopram 5 mg tablet (Lexapro)</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 10 mg capsule (Prozac)</i>	T1	QL (8 caps/day) HD	
<i>fluoxetine hcl 10 mg tablet (Sarafem)</i>	T1	HD	
<i>fluoxetine hcl 20 mg capsule (Prozac)</i>	T1	QL (4 caps/day) HD	
<i>fluoxetine hcl 20 mg tablet</i>	T1	HD	
<i>fluoxetine hcl 40 mg capsule (Prozac)</i>	T1	QL (2 caps/day) HD	
<i>fluoxetine hcl 60 mg tablet</i>	T1	QL (1 tab/day) HD	
T1 – Typically Generics	T4 – Specialty Medications	ST – Step Therapy	HD – May require home delivery pharmacy
T2 – Typically Preferred Brands	PA – Prior Authorization	AGE – Age Requirement	PPACA – No Cost-Share Preventive Medication
T3 – Typically Non-Preferred Brands	QL – Quantity Limit	SP – Specialty Medication	CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

PSYCHOTHERAPEUTIC DRUGS (Anxiety/Depression/Bipolar Disorder)⁸

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
SELECTIVE SEROTONIN REUPTAKE INHIBITOR (SSRIs)		
<i>fluvoxamine er 100 mg capsule</i>	T1	QL (3 caps/day) HD
<i>fluvoxamine er 150 mg capsule</i>	T1	QL (2 caps/day) HD
<i>fluvoxamine maleate 100 mg tab</i>	T1	QL (3 tabs/day) HD
<i>fluvoxamine maleate 25 mg tab</i>	T1	QL (12 tabs/day) HD
<i>fluvoxamine maleate 50 mg tab</i>	T1	QL (6 tabs/day) HD
LEXAPRO 10 MG TABLET (<i>escitalopram oxalate</i>)	T3	PA QL (2 tabs/day) HD
LEXAPRO 20 MG TABLET (<i>escitalopram oxalate</i>)	T3	PA QL (1 tab/day) HD
LEXAPRO 5 MG TABLET (<i>escitalopram oxalate</i>)	T3	PA QL (4 tabs/day) HD
<i>paroxetine cr 12.5 mg tablet (Paxil Cr)</i>	T1	QL (1 tab/day) HD
<i>paroxetine cr 25 mg tablet (Paxil Cr)</i>	T1	QL (3 tabs/day) HD
<i>paroxetine cr 37.5 mg tablet (Paxil Cr)</i>	T1	QL (2 tabs/day) HD
<i>paroxetine er 12.5 mg tablet (Paxil Cr)</i>	T1	QL (1 tab/day) HD
<i>paroxetine er 25 mg tablet (Paxil Cr)</i>	T1	QL (3 tabs/day) HD
<i>paroxetine er 37.5 mg tablet (Paxil Cr)</i>	T1	QL (2 tabs/day) HD
<i>paroxetine hcl 10 mg tablet (Paxil)</i>	T1	QL (6 tabs/day) HD
<i>paroxetine hcl 20 mg tablet (Paxil)</i>	T1	QL (3 tabs/day) HD
<i>paroxetine hcl 30 mg tablet (Paxil)</i>	T1	QL (2 tabs/day) HD
<i>paroxetine hcl 40 mg tablet (Paxil)</i>	T1	QL (1 tab/day) HD
PAXIL 10 MG TABLET (<i>paroxetine hcl</i>)	T3	PA QL (6 tabs/day) HD
PAXIL 10 MG/5 ML SUSPENSION	T3	PA QL (30ml/day) HD
PAXIL 20 MG TABLET (<i>paroxetine hcl</i>)	T3	PA QL (3 tabs/day) HD
PAXIL 30 MG TABLET (<i>paroxetine hcl</i>)	T3	PA QL (2 tabs/day) HD
PAXIL 40 MG TABLET (<i>paroxetine hcl</i>)	T3	PA QL (1 tab/day) HD
PAXIL CR 12.5 MG TABLET (<i>paroxetine er</i>)	T3	PA QL (1 tab/day) HD
PAXIL CR 25 MG TABLET (<i>paroxetine er</i>)	T3	PA QL (3 tabs/day) ST HD
PAXIL CR 37.5 MG TABLET (<i>paroxetine er</i>)	T3	PA QL (2 tabs/day) ST HD
PEXEVA 10 MG TABLET	T3	PA QL (6 tabs/day) HD
PEXEVA 20 MG TABLET	T3	PA QL (3 tabs/day) HD
PEXEVA 30 MG TABLET	T3	PA QL (2 tabs/day) HD
PEXEVA 40 MG TABLET	T3	PA QL (1 tab/day) HD
PROZAC 10 MG PULVULE (<i>fluoxetine hcl</i>)	T3	PA QL (8 caps/day) HD
PROZAC 20 MG PULVULE (<i>fluoxetine hcl</i>)	T3	PA QL (4 caps/day) HD
PROZAC 40 MG PULVULE (<i>fluoxetine hcl</i>)	T3	PA QL (2 caps/day) HD
SARAFEM (<i>fluoxetine hcl</i>)	T3	ST HD
<i>sertraline 20 mg/ml oral conc (Zoloft)</i>	T1	QL (10ml/day) HD
<i>sertraline hcl 100 mg tablet (Zoloft)</i>	T1	QL (2 tabs/day) HD

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

T4 – Specialty Medications

PA – Prior Authorization

QL – Quantity Limit

ST – Step Therapy

AGE – Age Requirement

SP – Specialty Medication

HD – May require home delivery pharmacy

PPACA – No Cost-Share Preventive Medication

CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

PSYCHOTHERAPEUTIC DRUGS (Anxiety/Depression/Bipolar Disorder)⁸

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
SELECTIVE SEROTONIN REUPTAKE INHIBITOR (SSRIs)		
<i>sertraline hcl 25 mg tablet (Zoloft)</i>	T1	QL (8 tabs/day) HD
<i>sertraline hcl 50 mg tablet (Zoloft)</i>	T1	QL (4 tabs/day) HD
ZOLOFT 100 MG TABLET (<i>sertraline hcl</i>)	T3	PA QL (2 tabs/day) HD
ZOLOFT 20 MG/ML ORAL CONC (<i>sertraline hcl</i>)	T3	PA QL (10ml/day) HD
ZOLOFT 25 MG TABLET (<i>sertraline hcl</i>)	T3	PA QL (8 tabs/day) HD
ZOLOFT 50 MG TABLET (<i>sertraline hcl</i>)	T3	PA 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)		
CYMBALTA 20 MG CAPSULE (<i>duloxetine hcl</i>)	T3	PA QL (6 caps/day) HD
CYMBALTA 30 MG CAPSULE (<i>duloxetine hcl</i>)	T3	PA QL (4 caps/day) HD
CYMBALTA 60 MG CAPSULE (<i>duloxetine hcl</i>)	T3	PA QL (2 caps/day) HD
DESVENLAFAXINE ER 100 MG TAB	T3	PA QL (4 tabs/day) HD
DESVENLAFAXINE ER 50 MG TAB	T3	PA QL (8 tabs/day) HD
<i>desvenlafaxine succnt er 100mg (Pristiq)</i>	T1	QL (4 tabs/day) HD
<i>desvenlafaxine succnt er 25 mg (Pristiq)</i>	T1	QL (16 tabs/day) HD
<i>desvenlafaxine succnt er 50 mg (Pristiq)</i>	T1	QL (1 tab/day) HD
DRIZALMA SPRINKLE DR 20 MG CAP	T3	QL (1 cap/day) ST HD
DRIZALMA SPRINKLE DR 30 MG CAP	T3	QL (1 cap/day) ST HD
DRIZALMA SPRINKLE DR 40 MG CAP	T3	QL (1 cap/day) ST HD
DRIZALMA SPRINKLE DR 60 MG CAP	T3	QL (2 caps/day) ST HD
<i>duloxetine hcl dr 20 mg cap (Cymbalta)</i>	T1	QL (6 caps/day) HD
<i>duloxetine hcl dr 30 mg cap (Cymbalta)</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 (Cymbalta)</i>	T1	QL (2 caps/day) HD
EFFEXOR XR 150 MG CAPSULE (<i>venlafaxine hcl er</i>)	T3	PA QL (2 caps/day) HD
EFFEXOR XR 37.5 MG CAPSULE (<i>venlafaxine hcl er</i>)	T3	PA QL (8 caps/day) HD
EFFEXOR XR 75 MG CAPSULE (<i>venlafaxine hcl er</i>)	T3	PA QL (4 caps/day) HD
FETZIMA 20-40 MG TITRATION PAK	T3	QL (28 caps/180 days) ST HD
FETZIMA ER 120 MG CAPSULE	T3	QL (1 cap/day) ST HD
FETZIMA ER 20 MG CAPSULE	T3	QL (6 caps/day) ST HD
FETZIMA ER 40 MG CAPSULE	T3	QL (3 caps/day) ST HD
FETZIMA ER 80 MG CAPSULE	T3	QL (1 cap/day) ST HD
PRISTIQ ER 100 MG TABLET (<i>desvenlafaxine succinate er</i>)	T3	PA QL (4 tabs/day) HD
PRISTIQ ER 25 MG TABLET (<i>desvenlafaxine succinate er</i>)	T3	PA QL (16 tabs/day) HD

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

T4 – Specialty Medications

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QL – Quantity Limit

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List of Prescription Medications

PSYCHOTHERAPEUTIC DRUGS (Anxiety/Depression/Bipolar Disorder) ⁸		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
SEROTONIN-NOREPINEPHRINE REUPTAKE-INHIB (SNRIs)		
PRISTIQ ER 50 MG TABLET (<i>desvenlafaxine succinate er</i>)	T3	PA QL (1 tab/day) HD
<i>venlafaxine hcl 100 mg tablet</i>	T1	QL (3 tabs/day) HD
<i>venlafaxine hcl 25 mg tablet</i>	T1	QL (15 tabs/day) HD
<i>venlafaxine hcl 37.5 mg tablet</i>	T1	QL (10 tabs/day) HD
<i>venlafaxine hcl 50 mg tablet</i>	T1	QL (7 tabs/day) HD
<i>venlafaxine hcl 75 mg tablet</i>	T1	QL (5 tabs/day) HD
<i>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
<i>venlafaxine hcl er 225 mg tab</i>	T1	QL (1 tab/day) HD
<i>venlafaxine hcl er 37.5 mg cap</i> (Effexor Xr)	T1	QL (8 caps/day) HD
<i>venlafaxine hcl er 37.5 mg tab</i>	T1	QL (8 tabs/day) HD
<i>venlafaxine hcl er 75 mg cap</i> (Effexor Xr)	T1	QL (4 caps/day) HD
<i>venlafaxine hcl er 75 mg tab</i>	T1	QL (4 tabs/day) HD
SSRI AND 5HT1A PARTIAL AGONIST ANTI-DEPRESSANTS		
VIIBRYD 10 MG TABLET	T3	PA QL (1 tab/day) HD
VIIBRYD 20 MG TABLET	T3	PA QL (1 tab/day) HD
VIIBRYD 40 MG TABLET	T3	PA HD
SSRI, SEROTONIN RECEPTOR MODULATOR ANTI-DEPRESSANTS		
TRINTELLIX 10 MG TABLET	T3	QL (1 tab/day) ST HD
TRINTELLIX 20 MG TABLET	T3	HD
TRINTELLIX 5 MG TABLET	T3	QL (1 tab/day) ST HD
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
ANAFRANIL (<i>clomipramine hcl</i>)	T3	PA HD
<i>clomipramine hcl</i> (Anafranil)	T1	HD
<i>desipramine hcl</i>	T1	HD
<i>desipramine hcl</i> (Norpramin)	T1	HD
<i>doxepin 10 mg capsule</i>	T1	HD
<i>doxepin 10 mg/ml oral conc</i>	T1	HD
<i>doxepin 100 mg capsule</i>	T1	HD

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

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

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

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

List of Prescription Medications

PSYCHOTHERAPEUTIC DRUGS (Anxiety/Depression/Bipolar Disorder)⁸

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
TRICYCLIC ANTI-DEPRESSANTS, REL.NON-SEL.REUPT-INHIB		
PRISTIQ ER 50 MG TABLET (<i>desvenlafaxine succinate er</i>)	T3	PA QL (1 tab/day) HD
<i>venlafaxine hcl 100 mg tablet</i>	T1	QL (3 tabs/day) HD
<i>venlafaxine hcl 25 mg tablet</i>	T1	QL (15 tabs/day) HD
<i>venlafaxine hcl 37.5 mg tablet</i>	T1	QL (10 tabs/day) HD
<i>venlafaxine hcl 50 mg tablet</i>	T1	QL (7 tabs/day) HD
<i>venlafaxine hcl 75 mg tablet</i>	T1	QL (5 tabs/day) HD
<i>imipramine pamoate</i>	T1	HD
<i>maprotiline hcl</i>	T1	HD
NORPRAMIN (<i>desipramine hcl</i>)	T3	PA HD
<i>nortriptyline hcl</i>	T1	HD
<i>nortriptyline hcl</i> (Pamelor)	T1	HD
PAMELOR (<i>nortriptyline hcl</i>)	T3	PA HD
<i>protriptyline hcl</i>	T1	HD
<i>trimipramine maleate</i>	T1	HD

PSYCHOTHERAPEUTIC DRUGS (Attention Deficit Hyperactivity Disorder)⁸

ADRENERGICS, AROMATIC, NON-CATECHOLAMINE

<i>lisdexamfetamine 10 mg capsule</i> (Vyvanse)	T1	PA QL(1 cap/day)
<i>lisdexamfetamine 20 mg capsule</i> (Vyvanse)	T1	PA QL(1 cap/day)
<i>lisdexamfetamine 30 mg capsule</i> (Vyvanse)	T1	PA QL(1 cap/day)
<i>lisdexamfetamine 40 mg capsule</i> (Vyvanse)	T1	PA QL(1 cap/day)
<i>lisdexamfetamine 50 mg capsule</i> (Vyvanse)	T1	PA QL(1 cap/day)
<i>lisdexamfetamine 60 mg capsule</i> (Vyvanse)	T1	PA QL(1 cap/day)
<i>lisdexamfetamine 70 mg capsule</i> (Vyvanse)	T1	PA QL(1 cap/day)
VYVANSE 10 MG CAPSULE (<i>lisdexamfetamine dimesylate</i>)	T3	PA QL (1 cap/day)
VYVANSE 10 MG CHEWABLE TABLET	T3	PA QL (1 tab/day)
VYVANSE 20 MG CAPSULE (<i>lisdexamfetamine dimesylate</i>)	T3	PA QL (1 per day)
VYVANSE 20 MG CHEWABLE TABLET	T3	PA QL (1 tab/day)
VYVANSE 30 MG CAPSULE (<i>lisdexamfetamine dimesylate</i>)	T3	PA QL (1 per day)
VYVANSE 30 MG CHEWABLE TABLET	T3	PA QL (1 tab/day)
VYVANSE 40 MG CAPSULE (<i>lisdexamfetamine dimesylate</i>)	T3	PA QL (1 cap/day)
VYVANSE 40 MG CHEWABLE TABLET	T3	PA QL (1 tab/day)
VYVANSE 50 MG CAPSULE (<i>lisdexamfetamine dimesylate</i>)	T3	PA QL (1 cap/day)
VYVANSE 50 MG CHEWABLE TABLET	T3	PA QL (1 tab/day)
VYVANSE 60 MG CAPSULE (<i>lisdexamfetamine dimesylate</i>)	T3	PA QL (1 cap/day)
VYVANSE 60 MG CHEWABLE TABLET	T3	PA QL (1 tab/day)
VYVANSE 70 MG CAPSULE (<i>lisdexamfetamine dimesylate</i>)	T3	PA QL (1 cap/day)

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

T4 – Specialty Medications
 PA – Prior Authorization
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ST – Step Therapy
 AGE – Age Requirement
 SP – Specialty Medication

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

List of Prescription Medications

PSYCHOTHERAPEUTIC DRUGS (Attention Deficit Hyperactivity Disorder)⁸

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
TX FOR ADHD - SELECTIVE ALPHA-2 RECEPTOR AGONIST		
<i>clonidine hcl</i> (Kapvay)	T1	
<i>guanfacine hcl</i> (Intuniv)	T1	HD
INTUNIV (<i>guanfacine hcl er</i>)	T3	PA HD
KAPVAY (<i>clonidine hcl er</i>)	T3	PA
TX FOR ATTENTION DEFICIT-HYPERACT (ADHD)/NARCOLEPSY		
ADHANSIA XR	T3	PA QL (1 cap/day) ST
APTENSIO XR (<i>methylphenidate er</i>)	T3	PA QL (1 cap/day) ST
CONCERTA (<i>methylphenidate er</i>)	T3	PA QL (1 tab/day) ST
COTEMPLA XR-ODT 17.3 MG TABLET	T3	PA QL (1 tab/day)
COTEMPLA XR-ODT 25.9 MG TABLET	T3	PA QL (2 tabs/day)
COTEMPLA XR-ODT 8.6 MG TABLET	T3	PA QL (1 tab/day)
DAYTRANA 10 MG/9 HR PATCH (<i>methylphenidate</i>)	T3	PA QL (1 patch/day)
DAYTRANA 15 MG/9 HR PATCH (<i>methylphenidate</i>)	T3	PA QL (1 per day)
DAYTRANA 20 MG/9 HOUR PATCH (<i>methylphenidate</i>)	T3	PA QL (1 patch/day)
DAYTRANA 30 MG/9 HOUR PATCH (<i>methylphenidate</i>)	T3	PA QL (1 patch/day)
<i>dexmethylphenidate er 10 mg cp</i> (Focalin Xr)	T1	PA QL (1 cap/day)
<i>dexmethylphenidate er 15 mg cp</i> (Focalin Xr)	T1	PA QL (1 per day)
<i>dexmethylphenidate er 20 mg cp</i> (Focalin Xr)	T1	PA QL (1 cap/day)
<i>dexmethylphenidate er 25 mg cp</i> (Focalin Xr)	T1	PA QL (1 cap/day)
<i>dexmethylphenidate er 30 mg cp</i> (Focalin Xr)	T1	PA QL (1 cap/day)
<i>dexmethylphenidate er 35 mg cp</i> (Focalin Xr)	T1	PA QL (1 cap/day)
<i>dexmethylphenidate er 40 mg cp</i> (Focalin Xr)	T1	PA QL (1 cap/day)
<i>dexmethylphenidate er 5 mg cap</i> (Focalin Xr)	T1	PA QL (1 cap/day)
<i>dexmethylphenidate hcl</i> (Focalin)	T1	PA
FOCALIN (<i>dexmethylphenidate hcl</i>)	T3	PA ST
FOCALIN XR (<i>dexmethylphenidate hcl er</i>)	T3	PA QL (1 cap/day) ST
JORNAY PM	T3	PA QL (1 cap/day) ST
METADATE CD (<i>methylphenidate hcl</i>)	T3	PA QL
METHYLIN (<i>methylphenidate hcl</i>)	T3	PA
<i>methylphenidate er 10 mg cap</i> (Aptensio Xr)	T1	PA QL (1 per day)
<i>methylphenidate er 10 mg tab</i>	T1	PA QL (2/day)
<i>methylphenidate er 15 mg cap</i> (Aptensio Xr)	T1	PA QL (1 per day)
<i>methylphenidate er 18 mg tab</i> (Concerta)	T1	PA QL (1 per day)
<i>methylphenidate er 20 mg cap</i> (Aptensio Xr)	T1	PA QL (1 per day)
<i>methylphenidate er 20 mg tab</i>	T1	PA QL (3/day)
<i>methylphenidate er 27 mg tab</i> (Concerta)	T1	PA QL (1 tab/day)

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

T4 – Specialty Medications

PA – Prior Authorization

QL – Quantity Limit

ST – Step Therapy

AGE – Age Requirement

SP – Specialty Medication

HD – May require home delivery pharmacy

PPACA – No Cost-Share Preventive Medication

CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

PSYCHOTHERAPEUTIC DRUGS (Attention Deficit Hyperactivity Disorder)⁸

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
TX FOR ATTENTION DEFICIT-HYPERACT (ADHD)/NARCOLEPSY		
<i>methylphenidate er 30 mg cap</i> (Aptensio Xr)	T1	PA QL (1 per day)
<i>methylphenidate er 36 mg tab</i> (Concerta)	T1	PA QL (1 per day)
<i>methylphenidate er 40 mg cap</i> (Aptensio Xr)	T1	PA QL (1 per day)
<i>methylphenidate er 50 mg cap</i> (Aptensio Xr)	T1	PA QL (1 per day)
<i>methylphenidate er 54 mg tab</i> (Concerta)	T1	PA QL (1 tab/day)
<i>methylphenidate er 60 mg cap</i> (Aptensio Xr)	T1	PA QL (1 per day)
METHYLPHENIDATE ER 72 MG TAB	T1	PA QL (1 tab/day)
<i>methylphenidate hcl</i> (Metadate CD)	T1	PA QL (1 cap/day)
<i>methylphenidate hcl</i> (Methylin)	T1	PA
<i>methylphenidate hcl</i> (Ritalin La)	T1	PA QL (1 cap/day)
<i>methylphenidate hcl</i> (Ritalin)	T1	PA
<i>methylphenidate la 10 mg cap</i> (Ritalin La)	T1	PA QL (1 cap/day)
<i>methylphenidate la 20 mg cap</i> (Ritalin La)	T1	PA QL (1 cap/day)
<i>methylphenidate la 30 mg cap</i> (Ritalin La)	T1	PA QL (1 per day)
<i>methylphenidate la 40 mg cap</i> (Ritalin La)	T1	PA QL (1 cap/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)
RELEXXII	T3	PA QL (1 tab/day)
RITALIN (<i>methylphenidate hcl</i>)	T3	PA ST
RITALIN LA (<i>methylphenidate la</i>)	T3	PA QL (1 cap/day) ST
TX FOR ATTENTION DEFICIT-HYPERACT.(ADHD), NRI-TYPE		
<i>atomoxetine hcl 10 mg capsule</i> (Strattera)	T1	HD
<i>atomoxetine hcl 100 mg capsule</i> (Strattera)	T1	HD
<i>atomoxetine hcl 18 mg capsule</i> (Strattera)	T1	HD
<i>atomoxetine hcl 25 mg capsule</i> (Strattera)	T1	HD
<i>atomoxetine hcl 40 mg capsule</i> (Strattera)	T1	QL (1 cap/day) HD
<i>atomoxetine hcl 60 mg capsule</i> (Strattera)	T1	HD
<i>atomoxetine hcl 80 mg capsule</i> (Strattera)	T1	HD
STRATTERA 10 MG CAPSULE (<i>atomoxetine hcl</i>)	T3	PA HD
STRATTERA 100 MG CAPSULE (<i>atomoxetine hcl</i>)	T3	PA HD
STRATTERA 18 MG CAPSULE (<i>atomoxetine hcl</i>)	T3	PA HD
STRATTERA 25 MG CAPSULE (<i>atomoxetine hcl</i>)	T3	PA HD
STRATTERA 40 MG CAPSULE (<i>atomoxetine hcl</i>)	T3	PA QL (1 cap/day) HD
STRATTERA 60 MG CAPSULE (<i>atomoxetine hcl</i>)	T3	PA HD
STRATTERA 80 MG CAPSULE (<i>atomoxetine hcl</i>)	T3	PA HD

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

T4 – Specialty Medications

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QL – Quantity Limit

ST – Step Therapy

AGE – Age Requirement

SP – Specialty Medication

HD – May require home delivery pharmacy

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CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

PSYCHOTHERAPEUTIC DRUGS (Miscellaneous)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
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HYPOACTIVE SEXUAL DESIRE DISORDER (HSDD) TX AGENTS

ADDYI	T3	QL (1 tab/day)
VYLEESI	T4	PA QL (8 injectors/30 days) SP

PSYCHOTHERAPEUTIC DRUGS (Schizophrenia/Anti-Psychotics)⁸

ANTI-PSYCH, DOPAMINE ANTAG., DIPHENYLBUTYLPIPERIDINES

<i>pimozide</i>	T1	
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ANTI-PSYCHOTIC, ATYPICAL, DOPAMINE, SEROTONIN ANTAGONIST

<i>asenapine maleate</i> (Saphris)	T1	
CAPLYTA	T3	QL (1 caps/day) ST
<i>clozapine</i>	T1	
<i>clozapine</i> (Clozapine Odt)	T1	
<i>clozapine</i> (Clozaril)	T1	
<i>clozapine</i> (Fazacllo)	T1	
CLOZAPINE ODT	T1	
CLOZARIL (<i>clozapine</i>)	T3	PA
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
FAZACLO (<i>clozapine odt</i>)	T3	PA
GEODON 20 MG CAPSULE (<i>ziprasidone hcl</i>)	T3	PA
GEODON 20 MG/ML VIAL	T3	
GEODON 40 MG CAPSULE (<i>ziprasidone hcl</i>)	T3	PA
GEODON 60 MG CAPSULE (<i>ziprasidone hcl</i>)	T3	PA
GEODON 80 MG CAPSULE (<i>ziprasidone hcl</i>)	T3	PA
INVEGA ER 1.5 MG TABLET (<i>paliperidone er</i>)	T3	ST
INVEGA ER 3 MG TABLET (<i>paliperidone er</i>)	T3	QL (1 tab/day) ST
INVEGA ER 6 MG TABLET (<i>paliperidone er</i>)	T3	ST
INVEGA ER 9 MG TABLET (<i>paliperidone er</i>)	T3	ST
INVEGA SUSTENNA 117 MG/0.75 ML	T3	QL (2 syringes/28 days)
INVEGA SUSTENNA 156 MG/ML SYRG	T3	QL (1 syringe/28 days)
INVEGA SUSTENNA 234 MG/1.5 ML	T3	QL (1 syringe/28 days)
INVEGA SUSTENNA 39 MG/0.25 ML	T3	QL (2 syringes/28 days)

T1 – Typically Generics
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T4 – Specialty Medications
 PA – Prior Authorization
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ST – Step Therapy
 AGE – Age Requirement
 SP – Specialty Medication

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

List of Prescription Medications

PSYCHOTHERAPEUTIC DRUGS (Schizophrenia/Anti-Psychotics)⁸

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ANTI-PSYCHOTIC, ATYPICAL, DOPAMINE, SEROTONIN ANTAGNIST		
INVEGA SUSTENNA 78 MG/0.5 ML	T3	QL (2 syring/28 days)
INVEGA TRINZA	T3	QL (2 injectors/90 days)
LATUDA 120 MG TABLET (<i>lurasidone hcl</i>)	T3	PA
LATUDA 20 MG TABLET (<i>lurasidone hcl</i>)	T3	PA
LATUDA 40 MG TABLET (<i>lurasidone hcl</i>)	T3	PA QL (1 tab/day)
LATUDA 40 MG TABLET (<i>lurasidone hcl</i>)	T3	PA QL (1 tab/day)
LATUDA 60 MG TABLET (<i>lurasidone hcl</i>)	T3	PA QL (1 tab/day)
LATUDA 80 MG TABLET (<i>lurasidone hcl</i>)	T3	
<i>lurasidone hcl 80 mg tablet</i> (Latuda)	T1	
<i>lurasidone hcl 60 mg tablet</i> (Latuda)	T1	QL(1 tab/day)
<i>lurasidone hcl 40 mg tablet</i> (Latuda)	T1	QL(1 tab/day)
<i>lurasidone hcl 20 mg tablet</i> (Latuda)	T1	
<i>lurasidone hcl 120 mg tablet</i> (Latuda)	T1	
<i>olanzapine</i> (Zyprexa Zydis)	T1	
<i>olanzapine</i> (Zyprexa)	T1	
<i>paliperidone er 1.5 mg tablet</i> (Invega)	T1	
<i>paliperidone er 3 mg tablet</i> (Invega)	T1	QL (1 tab/day)
<i>paliperidone er 6 mg tablet</i> (Invega)	T1	
<i>paliperidone er 9 mg tablet</i> (Invega)	T1	
PERSERIS	T3	QL (1 kit/28 days)
<i>quetiapine fumarate</i> (Seroquel Xr)	T1	
<i>quetiapine fumarate</i> (Seroquel)	T1	
RISPERDAL (<i>risperidone</i>)	T3	PA
RISPERDAL CONSTA	T3	PA QL(4 vials/28 days)
<i>risperidone</i>	T1	
<i>risperidone</i> (Risperdal)	T1	
<i>risperidone microspheres</i>	T1	QL
SAPHRIS (<i>asenapine maleate</i>)	T3	ST
SECUADO	T3	ST
SEROQUEL (<i>quetiapine fumarate</i>)	T3	ST
SEROQUEL XR (<i>quetiapine fumarate er</i>)	T3	ST
VERSACLOZ	T3	PA
<i>ziprasidone hcl</i> (Geodon)	T1	
<i>ziprasidone mesylate</i> (Geodon)	T1	
ZYPREXA 10 MG TABLET (<i>olanzapine</i>)	T3	PA
ZYPREXA 10 MG VIAL (<i>olanzapine</i>)	T3	
ZYPREXA 15 MG TABLET (<i>olanzapine</i>)	T3	PA

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

T4 – Specialty Medications

PA – Prior Authorization

QL – Quantity Limit

ST – Step Therapy

AGE – Age Requirement

SP – Specialty Medication

HD – May require home delivery pharmacy

PPACA – No Cost-Share Preventive Medication

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List of Prescription Medications

PSYCHOTHERAPEUTIC DRUGS (Schizophrenia/Anti-Psychotics)⁸

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ANTI-PSYCHOTIC, ATYPICAL, DOPAMINE, SEROTONIN ANTAGONIST		
ZYPREXA 2.5 MG TABLET (<i>olanzapine</i>)	T3	PA
ZYPREXA 20 MG TABLET (<i>olanzapine</i>)	T3	PA
ZYPREXA 5 MG TABLET (<i>olanzapine</i>)	T3	PA
ZYPREXA 7.5 MG TABLET (<i>olanzapine</i>)	T3	PA
ZYPREXA RELPREVV 210 MG VIAL	T3	QL (4 vials/28 days)
ZYPREXA RELPREVV 210 MG VL KIT	T3	QL (4 vials/28 days)
ZYPREXA RELPREVV 300 MG VIAL	T3	QL (4 vials/28 days)
ZYPREXA RELPREVV 300 MG VL KIT	T3	QL (4 vials/28 days)
ZYPREXA RELPREVV 405 MG VIAL	T3	QL (2 vials/28 days)
ZYPREXA RELPREVV 405 MG VL KIT	T3	QL (2 vials/28 days)
ZYPREXA ZYDIS (<i>olanzapine odt</i>)	T3	PA
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		
ABILIFY 10 MG TABLET (<i>aripiprazole</i>)	T3	ST
ABILIFY 15 MG TABLET (<i>aripiprazole</i>)	T3	ST
ABILIFY 2 MG TABLET (<i>aripiprazole</i>)	T3	ST
ABILIFY 20 MG TABLET (<i>aripiprazole</i>)	T3	ST
ABILIFY 30 MG TABLET (<i>aripiprazole</i>)	T3	ST
ABILIFY 5 MG TABLET (<i>aripiprazole</i>)	T3	QL (1 tab/day) ST
ABILIFY ASIMTUFI	T3	
ABILIFY MAINTENA ER 300 MG SYR	T2	QL (2 injectors/30 days)
ABILIFY MAINTENA ER 300 MG VL	T2	QL (2 injectors/30 days)
ABILIFY MAINTENA ER 400 MG SYR	T2	QL (2 injectors/30 days)
ABILIFY MAINTENA ER 400 MG VL	T2	
ABILIFY MYCITE	T3	PA
<i>aripiprazole</i>	T1	
<i>aripiprazole 1 mg/ml solution</i>	T1	
<i>aripiprazole 10 mg tablet (Abilify)</i>	T1	
<i>aripiprazole 15 mg tablet (Abilify)</i>	T1	
<i>aripiprazole 2 mg tablet (Abilify)</i>	T1	
<i>aripiprazole 20 mg tablet (Abilify)</i>	T1	
<i>aripiprazole 30 mg tablet (Abilify)</i>	T1	

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

T4 – Specialty Medications

PA – Prior Authorization

QL – Quantity Limit

ST – Step Therapy

AGE – Age Requirement

SP – Specialty Medication

HD – May require home delivery pharmacy

PPACA – No Cost-Share Preventive Medication

CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

PSYCHOTHERAPEUTIC DRUGS (Schizophrenia/Anti-Psychotics)⁸

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ANTIPSYCHOTICS, ATYP, D2 PARTIAL AGONIST/5HT MIXED		
<i>aripiprazole 5 mg tablet</i> (Abilify)	T1	QL (1 tab/day)
ARISTADA ER 1064 MG/3.9 ML SYR	T3	
ARISTADA ER 441 MG/1.6 ML SYRN	T3	QL (2 syring/30 days)
ARISTADA ER 662 MG/2.4 ML SYRN	T3	QL (2 syring/30 days)
ARISTADA ER 882 MG/3.2 ML SYRN	T3	QL (2 syring/30 days)
ARISTADA INITIO	T3	
REXULTI 0.25 MG TABLET	T3	QL (1 tab/day) ST
REXULTI 0.5 MG TABLET	T3	QL (1 tab/day) ST
REXULTI 1 MG TABLET	T3	QL (1 tab/day) ST
REXULTI 2 MG TABLET	T3	QL (1 tab/day) ST
REXULTI 3 MG TABLET	T3	ST
REXULTI 4 MG TABLET	T3	ST
ANTI-PSYCHOTICS, DOPAMINE AND SEROTONIN ANTAGONISTS		
<i>loxapine succinate</i>	T1	
ANTI-PSYCHOTICS, DOPAMINE ANTAGONISTS, THIOXANTHENES		
<i>thiothixene</i>	T1	
<i>droperidol</i>	T1	
HALDOL (<i>haloperidol lactate</i>)	T3	
HALDOL DECANOATE 100 (<i>haloperidol decanoate 100</i>)	T3	
HALDOL DECANOATE 50 (<i>haloperidol decanoate</i>)	T3	
<i>haloperidol</i>	T1	
<i>haloperidol decanoate</i>	T1	
<i>haloperidol decanoate</i> (Haldol Decanoate 100)	T1	
<i>haloperidol decanoate</i> (Haldol Decanoate 50)	T1	
<i>haloperidol lactate</i>	T1	
<i>haloperidol lactate</i> (Haldol)	T1	
ANTI-PSYCHOTICS, DOPAMINE ANTAGONST, DIHYDROINDOLONES		
<i>molindone hcl</i>	T1	
ANTI-PSYCHOTICS, PHENOTHIAZINES		
<i>chlorpromazine hcl</i>	T1	
<i>fluphenazine decanoate</i>	T1	
<i>fluphenazine hcl</i>	T1	
<i>perphenazine</i>	T1	
<i>thioridazine hcl</i>	T1	
<i>trifluoperazine hcl</i>	T1	
SSRI-ANTI-PSYCH, ATYPICAL, DOPAMINE, SEROTONIN ANTAG		
<i>olanzapine/fluoxetine hcl</i>	T1	

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

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

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

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

List of Prescription Medications

PSYCHOTHERAPEUTIC DRUGS (Sleep Disorders/Sedatives)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
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NARCOLEPSY AND SLEEP DISORDER THERAPY AGENTS

<i>olanzapine/fluoxetine hcl</i> (Symbyax)	T1	
SYMBYAX (<i>olanzapine-fluoxetine hcl</i>)	T3	PA
<i>armodafinil</i> (Nuvigil)	T1	PA
<i>modafinil</i> (Provigil)	T1	PA
NUVIGIL (<i>armodafinil</i>)	T3	PA
PROVIGIL (<i>modafinil</i>)	T3	PA
SUNOSI	T2	PA QL (1 tab/day)

ANTI-NARCOLEPSY, ANTI-CATAPLEXY, SEDATIVE-TYPE AGENT

SODIUM OXYBATE	T4	PA QL (18 mls/day) SP HD
LUMRYZ	T4	PA QL (30 pkts/30 days) SP
XYREM	T4	PA SP HD
XYWAV	T4	PA SP HD

BARBITURATES

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

HYPNOTICS, MELATONIN MT1/MT2 RECEPTOR AGONISTS

HETLIOZ	T4	PA SP HD
HETLIOZ LQ	T4	PA SP HD
<i>ramelteon</i> (Rozerem)	T1	QL (1 tab/day)
ROZEREM (<i>ramelteon</i>)	T3	PA QL (1 tab/day)
<i>tasimelteon</i>	T4	PA SP

SEDATIVE-HYPNOTICS - BENZODIAZEPINES

ATIVAN (<i>lorazepam</i>)	T3	PA
DORAL	T3	
<i>estazolam</i>	T1	
HALCION (<i>triazolam</i>)	T3	
<i>lorazepam</i>	T1	
<i>lorazepam</i> (Ativan)	T1	
LORAZEPAM-0.9% NACL	T1	
LORAZEPAM-D5W	T1	
QUAZEPAM	T1	
<i>quazepam</i> (Quazepam)	T1	
RESTORIL (<i>temazepam</i>)	T3	PA
<i>temazepam</i> (Restoril)	T1	

T1 – Typically Generics
 T2 – Typically Preferred Brands
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T4 – Specialty Medications
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List of Prescription Medications

PSYCHOTHERAPEUTIC DRUGS (Sleep Disorders/Sedatives)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
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SEDATIVE-HYPNOTICS, NON-BARBITURATE

<i>triazolam</i>	T1	
<i>triazolam</i> (Halcion)	T1	
AMBIEN (<i>zolpidem tartrate</i>)	T3	PA
AMBIEN CR 12.5 MG TABLET (<i>zolpidem tartrate er</i>)	T3	PA
AMBIEN CR 6.25 MG TABLET (<i>zolpidem tartrate er</i>)	T3	PA QL (1 tab/day)
BELSOMRA	T3	PA
DAYVIGO	T2	QL (1 tab/day) ST
DEXMEDETOMIDINE HCL	T1	
<i>dexmedetomidine hcl</i> (Precedex)	T1	
<i>dexmedetomidine in 0.9 % nacl</i> (Precedex)	T1	
<i>doxepin hcl 3 mg tablet</i> (Silenor)	T1	QL (1 tab/day)
<i>doxepin hcl 6 mg tablet</i> (Silenor)	T1	
EDLUAR 10 MG SL TABLET	T3	PA
EDLUAR 5 MG SL TABLET	T3	PA QL (1 tab/day)
<i>eszopiclone</i> (Lunesta)	T1	
LUNESTA (<i>eszopiclone</i>)	T3	PA
PRECEDEX	T3	
QUVIVIQ	T3	PA QL (1 tab/day)
SILENOR 3 MG TABLET (<i>doxepin hcl</i>)	T3	PA QL (1 tab/day)
SILENOR 6 MG TABLET (<i>doxepin hcl</i>)	T3	PA
<i>zaleplon</i>	T1	
<i>zolpidem tart er 12.5 mg tab</i> (Ambien Cr)	T1	
<i>zolpidem tart er 6.25 mg tab</i> (Ambien Cr)	T1	QL (1 tab/day)
<i>zolpidem tartrate</i>	T1	
<i>zolpidem tartrate</i> (Ambien)	T1	
ZOLPIMIST	T3	PA

SEDATIVE/HYPNOTICS (Sleep Disorders/Sedatives)

HYPNOTICS, MELATONIN MT1/MT2 RECEPTOR AGONISTS

<i>ramelteon</i> (Rozerem)	T1	QL(1 tab/day)
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SEDATIVE-HYPNOTICS - BENZODIAZEPINES

<i>flurazepam hcl</i>	T1	
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SKIN PREPS (Miscellaneous)

IRRIGANTS

<i>acetic acid</i>	T1	
<i>neomycin sulf/polymyxin b sulf</i>	T1	
PHYSIOLYTE	T3	

T1 – Typically Generics

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T4 – Specialty Medications

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List of Prescription Medications

SKIN PREPS (Miscellaneous)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
IRRIGANTS		
PHYSIOSOL	T3	
<i>ringer's solution</i>	T1	
<i>ringer's solution, lactated</i>	T1	
<i>sod, pot chlor/mag/sod, pot phos</i>	T3	
<i>sodium chloride irrig solution</i>	T1	
SORBITOL	T1	
SORBITOL-MANNITOL	T1	
<i>water for irrigation, sterile</i>	T1	
OXIDIZING AGENTS		
<i>hydrogen peroxide</i>	T1	
SKIN PREPS (Pain Relief And Inflammatory Disease)		
ANTI-PSORIATIC AGENTS, SYSTEMIC		
<i>acitretin</i>	T1	
<i>acitretin (Soriatane)</i>	T1	
BIMZELX	T4	PA QL (10 mls/365 days) SP HD
COSENTYX (2 SYRINGES)	T4	PA QL (2 syringes/28 days) SP HD
COSENTYX PEN	T4	PA QL (1 pen/28 days) SP HD
COSENTYX PEN (2 PENS)	T4	PA QL (2 pens/28 days) SP HD
COSENTYX SYRINGE	T4	PA QL (1 syringe/28 days) SP HD
ILUMYA	T4	PA QL (1 syringe/84 days) SP HD
<i>methoxsalen (Oxsoralen-ultra)</i>	T1	
<i>OXSORALEN-ULTRA (methoxsalen)</i>	T3	
SKYRIZI (2 SYRINGES) KIT	T4	PA QL (1 kit/84 days) SP HD
SORIATANE (<i>acitretin</i>)	T3	PA
SOTYKTU	T4	PA QL (1 TAB/DAY) SP HD
TALTZ AUTOINJECTOR	T4	PA QL (1 injector/28 days) SP HD
TALTZ AUTOINJECTOR (2 PACK)	T4	PA QL (1 injector/28 days) SP HD
TALTZ AUTOINJECTOR (3 PACK)	T4	PA QL (1 injector/28 days) SP HD
TALTZ SYRINGE	T4	PA QL (1 syringe/28 days) SP HD
TREMFYA 100 MG/ML INJECTOR	T4	PA QL (1 injector/56 days) SP HD
TREMFYA 100 MG/ML SYRINGE	T4	PA QL (1 syringe/56 days) SP HD
TOPICAL ANTI-INFLAMMATORY, NSAIDS		
DICLAREAL	T3	HD
<i>diclofenac 1.5% topical soln</i>	T1	PA HD
DICLOFENAC EPOLAMINE	T3	PA QL (2 patches/day) HD
<i>diclofenac sodium 1% gel (Voltaren)</i>	T1	QL (1000gm/30 days) HD

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List of Prescription Medications

SKIN PREPS (Pain Relief And Inflammatory Disease)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
TOPICAL ANTI-INFLAMMATORY, NSAIDS		
FLECTOR	T2	PA QL (2 patches/day) HD
LICART	T2	PA QL (1 patch/day) HD
PENNSAID	T3	PA HD
VOLTAREN (<i>diclofenac sodium</i>)	T3	PA QL (1000gm/30 days) HD
SKIN PREPS (Skin Conditions)		
ACNE AGENTS, SYSTEMIC		
ABSORICA	T3	
ABSORICA LD	T3	ST
ACCUTANE	T1	
AMNESTEEM	T1	
CABTREO	T3	PA
CLARAVIS	T1	
isotretinoin	T1	
MYORISAN	T1	
ZENATANE	T1	
ACNE AGENTS, TOPICAL		
ACANYA (<i>clindamycin phos-benzoyl perox</i>)	T3	
ACZONE 5% GEL (<i>dapsone</i>)	T3	
ACZONE 7.5% GEL PUMP	T2	
<i>adapalene/benzoyl peroxide</i>	T1	
AZELEX	T2	
BENZACLIN (<i>clindamycin-benzoyl peroxide</i>)	T3	PA
<i>clindamyc-bnz perox 1.2-3.75%</i> (Onexton)	T1	PA
<i>clindamycin phos/benzoyl perox</i>	T1	
<i>clindamycin phos/benzoyl perox</i> (Acanya)	T1	
<i>clindamycin phos/benzoyl perox</i> (Benzaclin)	T1	
<i>clindamycin/tretinoin</i> (Veltin)	T1	
<i>clindamycin/tretinoin</i> (Ziana)	T1	
<i>dapsone 5% gel</i> (Aczone)	T1	
DAPSONE 7.5% GEL PUMP	T3	PA
<i>dapsone 7.5% gel pump</i> (Dapsone)	T1	
KLARON (<i>sulfacetamide sodium</i>)	T3	
NEUAC 1.2-5% KIT	T3	
<i>neuac gel</i>	T1	
ONEXTON	T3	
<i>sulfacetamide sodium</i> (Klaron)	T1	

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SKIN PREPS (Skin Conditions)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ACNE AGENTS, TOPICAL		
VELTIN	T3	PA
ZIANA (<i>clindamycin phos-tretinoin</i>)	T3	PA
ANTI-PERSPIRANTS		
DRYSOL	T3	
ANTI-PRURITICS, TOPICAL		
<i>doxepin 5% cream</i> (Zonalon)	T1	PA QL (90gm/30 days)
<i>doxepin hcl</i> (Zonalon)	T3	PA QL (90gm/30 days)
ZONALON	T3	PA QL (90gm/30 days)
ZONALON (<i>prudoxin</i>)	T3	PA QL (90gm/30 days)
ANTI-PSORIATICS AGENTS		
<i>anthralin</i>	T1	
<i>calcipotriene 0.005% cream</i> (Dovonex)	T1	
CALCIPOTRIENE 0.005% FOAM	T3	PA
<i>calcipotriene 0.005% ointment</i>	T1	
<i>calcipotriene 0.005% solution</i>	T1	
<i>calcitriol 3 mcg/g ointment</i> (Vectical)	T1	QL (800gm/30 days)
DOVONEX (<i>calcipotriene</i>)	T3	
DUOBRII	T3	
SORILUX	T3	PA
<i>tazarotene 0.1% cream</i> (Tazorac)	T1	
TAZORAC 0.05% CREAM	T2	
TAZORAC 0.05% GEL	T2	
ZORYVE 0.3%	T3	PA QL(1 gm/30 days)
TAZORAC 0.1% CREAM (<i>tazarotene</i>)	T3	
TAZORAC 0.1% GEL	T2	
VECTICAL (<i>calcitriol</i>)	T3	QL (800gm/30 days)
ANTI-SEBORRHEIC AGENTS		
OVACE PLUS	T3	
PROMISEB	T2	
<i>selenium sulfide</i>	T1	
<i>sulfacetamide sodium</i>	T1	
TERSI FOAM	T3	
ANTISEPTICS, GENERAL		
<i>alcohol antiseptic pads</i>	T1	
ALCOHOL PREP PADS	T1	
ALCOHOL SWAB	T1	
ALCOHOL WIPES	T1	

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SKIN PREPS (Skin Conditions)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ANTISEPTICS, GENERAL		
CARETOUCH ALCOHOL PREP PAD	T1	
CURITY ALCOHOL PREPS	T1	
DROPSAFE PREP PADS	T1	
EASY COMFORT ALCOHOL PAD	T1	
EASY TOUCH ALCOHOL PREP PADS	T1	
INCONTROL ALCOHOL PADS	T1	
PRO COMFORT ALCOHOL PADS	T1	
PURE COMFORT ALCOHOL PAD	T1	
SINGLE USE SWAB	T1	
SURE COMFORT ALCOHOL	T1	
SURE-PREP ALCOHOL PREP PADS	T1	
TRUE COMFORT ALCOHOL PADS	T1	
TRUE COMFORT PRO ALCOHOL PADS	T1	
ULTILET ALCOHOL SWAB	T1	
WEBCOL	T1	
ANTISEPTICS, MISCELLANEOUS		
GUAIACOL	T3	
DIABETIC ULCER PREPARATIONS, TOPICAL		
REGRANEX	T3	PA QL (2 tubs/30 days)
EMOLLIENTS		
<i>ammonium lactate</i>	T1	
ATOPICLAIR	T3	
BIAFINE (<i>sonafine</i>)	T3	
<i>emollient combination no.10</i> (Biafine)	T1	
<i>emollient combination no.35</i> (Mimyx)	T1	
<i>emollient combination no.44</i>	T1	
<i>emollient combination no.60</i> (Restizan)	T3	
HALUCORT	T3	
MIMYX (<i>prumyx</i>)	T3	
RESTIZAN	T1	
<i>vite ac/grape/hyaluronic acid</i> (Atopiclair)	T1	
XCLAIR	T3	
IMMUNOMODULATORS		
ALDARA (<i>imiquimod</i>)	T3	PA
<i>imiquimod 3.75% cream</i> (Zyclara)	T1	PA QL (112 PACKETS/67 DAYS)
IMIQUIMOD 3.75% CREAM PUMP	T1	PA

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SKIN PREPS (Skin Conditions)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
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IMMUNOMODULATORS

<i>imiquimod 5% cream packet (Aldara)</i>	T1	
ZYCLARA 2.5% CREAM PUMP	T3	PA QL (4 bots/30 days)
ZYCLARA 3.75% CREAM (<i>imiquimod</i>)	T3	PA QL (112 packs/30 days)
ZYCLARA 3.75% CREAM PUMP	T3	PA

IRRITANTS/COUNTER-IRRITANTS

<i>methyl salicylate</i>	T1	
QUTENZA	T3	

KERATOLYTICS

BENSAL HP	T1	PA
BENZEFOAM	T3	
BENZEPRO	T1	
<i>benzoyl peroxide</i>	T1	
<i>benzoyl peroxide (Enzoclear)</i>	T1	
<i>benzoyl peroxide (Pacnex)</i>	T1	
CONDYLOX	T3	PA
ENZOCLEAR	T3	
HYDRO 35	T3	
HYDRO 40 (<i>umecta</i>)	T3	
INOVA	T3	
KERAFOAM	T3	
KERALYT 6% GEL (<i>salicylic acid</i>)	T3	
<i>keralyt 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	
SALICATE	T3	
<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	

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SKIN PREPS (Skin Conditions)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
KERATOLYTICS		
<i>silver nitrate applicator</i>	T1	
URAMAXIN	T3	
URAMAXIN (<i>urea</i>)	T3	
<i>urea</i>	T1	
<i>urea</i> (Hydro 35)	T1	
<i>urea</i> (Hydro 40)	T3	
<i>urea</i> (Uramaxin)	T1	
<i>urea</i> (Xurea)	T1	
XUREA	T3	
PROTECTIVES		
BIONECT	T3	
PHARMABASE BARRIER	T1	
<i>polydimethylsiloxanes/silicon</i>	T1	
<i>protectives2/ceramide 1, 3, 6-ii</i>	T1	
RADIAPLEXRX	T3	
<i>zinc oxide</i>	T1	
ROSACEA AGENTS, TOPICAL		
<i>azelaic acid</i> (Finacea)	T1	
FINACEA	T3	PA
FINACEA (<i>azelaic acid</i>)	T3	PA
<i>ivermectin</i> (Soolantra)	T1	
METROCREAM (<i>rosadan</i>)	T3	PA
METROGEL (<i>metronidazole</i>)	T3	PA
<i>metronidazole</i>	T1	
<i>metronidazole</i> (Metrocream)	T1	
<i>metronidazole</i> (Metrogel)	T1	
NORITATE	T3	PA
SOOLANTRA (<i>ivermectin</i>)	T3	PA
TISSUE/WOUND ADHESIVES		
ARTISS	T3	
SURGISEAL STYLUS	T3	
SURGISEAL TEARDROP	T3	
SURGISEAL TWIST	T3	
TISSEEL VHSD	T3	

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SKIN PREPS (Skin Conditions)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
TOP. ANTI-INFLAM., PHOSPHODIESTERASE-4 (PDE4) INHIB		
EUCRISA	T2	
TOPICAL AGENTS, MISCELLANEOUS		
GORDON'S UREA	T3	
HYFTOR	T4	PA SP
L-MESITRAN SOFT	T3	
MEDIHONEY	T3	
SAF-CLENS AF	T3	
<i>trichloroacetic acid</i>	T3	
TRICHLOROACETIC ACID	T1	
TOPICAL ANTIANDROGENIC AGENTS		
WINLEVI	T3	PA
TOPICAL ANTIBIOTIC PLEUROMUTILIN DERIVATIVES		
ALTABAX	T3	
TOPICAL ANTICHOLINERGIC HYPERHIDROSIS TX AGENTS		
QBREXZA	T3	
TOPICAL ANTI-INFLAMMATORY STEROIDAL		
ALA-SCALP (<i>scalacort</i>)	T3	ST
<i>alclometasone dipropionate</i>	T1	
<i>amcinonide 0.1% cream, ointment, lotion</i>	T1	PA
ANUSOL-HC 2.5% CREAM (<i>proctozone-hc</i>)	T1	PA
AQUA GLYCOLIC HC	T3	
<i>betamethasone dipropionate</i>	T1	
<i>betamethasone valerate</i>	T1	
<i>betamethasone valerate (Luxiq)</i>	T1	
<i>betamethasone/propylene glyc</i>	T1	
<i>betamethasone/propylene glyc (Diprolene)</i>	T1	
BRYHALI	T3	ST
CAPEX SHAMPOO	T3	ST
<i>clobetasol propionate</i>	T1	
<i>clobetasol propionate (Clobex)</i>	T1	
<i>clobetasol propionate (Olux)</i>	T1	
<i>clobetasol propionate (Temovate)</i>	T1	
<i>clobetasol propionate/emoll</i>	T1	
<i>clobetasol propionate/emoll (Olux-e)</i>	T1	
CLOBEX (<i>clobetasol propionate</i>)	T3	PA
CLOBEX (<i>clodan</i>)	T3	PA
CLOCORTOLONE PIVALATE	T1	

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SKIN PREPS (Skin Conditions)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
TOPICAL ANTI-INFLAMMATORY STEROIDAL		
CLODAN 0.05% KIT	T3	ST
<i>clodan 0.05% shampoo</i> (Clobex)	T1	
CLODERM	T3	ST
CORDRAN	T3	PA
CORDRAN (<i>flurandrenolide</i>)	T3	PA
CORDRAN (<i>nolix</i>)	T3	PA
CUTIVATE 0.05% CREAM (<i>fluticasone propionate</i>)	T3	ST
CUTIVATE 0.05% LOTION (<i>fluticasone propionate</i>)	T3	PA
DERMA-SMOOTHIE-FS (<i>fluocinolone acetonide</i>)	T3	ST
DERMATOP (<i>prednicarbate</i>)	T3	ST
<i>desonide</i>	T1	
<i>desonide</i> (Desowen)	T1	
<i>desonide</i> (Tridesilon)	T1	
DESOWEN (<i>desonide</i>)	T3	ST
<i>desoximetasone</i> (Topicort)	T1	
<i>diflorasone diacetate</i>	T1	PA
<i>diflorasone diacetate</i> (Psorcon)	T1	PA
<i>diflorasone diacetate/emoll</i>	T1	PA
DIPROLENE (<i>betamethasone diprop augmented</i>)	T3	ST
<i>fluocinolone acetonide</i>	T1	
<i>fluocinolone acetonide</i> (Derma-smoothe-fs)	T1	
<i>fluocinolone acetonide</i> (Synalar)	T1	
<i>fluocinolone/shower cap</i> (Derma-smoothe-fs)	T1	
<i>fluocinonide</i>	T1	
<i>fluocinonide</i> (Vanos)	T1	
<i>fluocinonide/emollient base</i>	T1	
<i>flurandrenolide</i> (Cordran)	T1	PA
<i>fluticasone prop 0.005% oint</i>	T1	
<i>fluticasone prop 0.05% cream</i> (Cutivate)	T1	
<i>fluticasone prop 0.05% lotion</i> (Cutivate)	T1	
<i>fluticasone propionate</i> (Cutivate)	T1	
<i>halcinonide</i> (Halog)	T1	PA
HALOBETASOL PROPIONATE	T1	
<i>halobetasol prop 0.05% foam</i>	T1	
<i>halobetasol propionate</i> (Ultravate)	T1	
HALOG 0.1% CREAM (<i>halcinonide</i>)	T3	PA

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List of Prescription Medications

SKIN PREPS (Skin Conditions)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
TOPICAL ANTI-INFLAMMATORY STEROIDAL		
HALOG 0.1% OINTMENT	T3	PA
HALOG 0.1% SOLUTION	T3	ST
<i>hydrocort buty 0.1% lipid crm (Locoid Lipocream)</i>	T1	PA
<i>hydrocort buty 0.1% lipo cream (Locoid Lipocream)</i>	T1	PA
<i>hydrocortisone</i>	T1	
<i>hydrocortisone (Ala-scalp)</i>	T1	
<i>hydrocortisone (Anusol-hc)</i>	T1	
<i>hydrocortisone buty 0.1% cream</i>	T1	
<i>hydrocortisone butyr 0.1% lotn (Locoid)</i>	T1	PA
<i>hydrocortisone butyr 0.1% oint (Locoid)</i>	T1	
<i>hydrocortisone butyr 0.1% soln</i>	T1	
<i>hydrocortisone valerate</i>	T1	
IMPEKLO	T3	PA
IMPOYZ	T3	PA
KENALOG (<i>triamcinolone acetonide</i>)	T3	PA
LEXETTE	T3	ST
LOCOID 0.1% LOTION (<i>hydrocortisone butyrate</i>)	T3	PA
LOCOID 0.1% OINTMENT (<i>hydrocortisone butyrate</i>)	T3	
LOCOID LIPOCREAM	T3	PA
LOCOID LIPOCREAM (<i>hydrocortisone butyrate</i>)	T3	PA
LUXIQ (<i>betamethasone valerate</i>)	T3	ST
MOMETACURE	T3	
<i>mometasone furoate 0.1% cream</i>	T1	
<i>mometasone furoate 0.1% oint</i>	T1	
<i>mometasone furoate 0.1% soln</i>	T1	
NUCORT	T3	ST
OLUX (<i>clobetasol propionate</i>)	T3	PA
OLUX-E (<i>tovet emollient</i>)	T3	PA
PANDEL	T3	PA
<i>prednicarbate (Dermatop)</i>	T1	
PSORCON (<i>diflorasone diacetate</i>)	T3	PA
SCALACORT DK	T3	ST
SERNIVO	T3	PA
SYNALAR	T3	ST
SYNALAR (<i>fluocinolone acetonide</i>)	T3	ST
SYNALARTS	T3	ST

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SKIN PREPS (Skin Conditions)		
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TOPICAL ANTI-INFLAMMATORY STEROIDAL		
TEMOVATE (<i>clobetasol propionate</i>)	T3	ST
TEXACORT	T3	ST
TOPICORT (<i>desoximetasone</i>)	T3	ST
<i>triamcinolone acetonide</i>	T1	
<i>triamcinolone acetonide</i>	T1	PA
<i>triamcinolone acetonide</i> (Kenalog)	T1	
TRIDESILON (<i>desonide</i>)	T3	PA
ULTRAVATE	T3	ST
VANOS (<i>fluocinonide</i>)	T3	PA
VERDESO	T3	PA
TOPICAL ANTI-INFLAMMATORY STEROID-LOCAL ANESTHETIC		
ANALPRAM HC	T3	
EPIFOAM	T3	
<i>hydrocortisone/pramoxine</i> (Pramosone)	T1	
<i>lidocaine/hydrocortisone ac</i>	T1	
MEZPAROX-HC	T1	
PRAMOSONE 1% LOTION	T2	
PRAMOSONE 1%-1% CREAM	T2	
PRAMOSONE 1%-1% OINTMENT	T2	
PRAMOSONE 2.5%-1% CREAM	T3	
PRAMOSONE 2.5%-1% LOTION	T3	
PRAMOSONE 2.5%-1% OINTMENT	T2	
TOPICAL ANTI-PARASITICS		
<i>malathion</i> (Ovide)	T1	
OVIDE (<i>malathion</i>)	T3	
TOPICAL PREPARATIONS, ANTIBACTERIALS		
<i>dermazene cream</i>	T1	
DERMAZENE CREAM PACKET	T3	
<i>hydrocortisone/iodoquinol</i>	T1	
<i>hydrocortisone/iodoquinol/aloe</i>	T1	
<i>iodine/potassium iodide</i>	T1	
<i>iodine/sodium iodide</i>	T1	
IODOFLEX	T3	
IODOSORB	T3	
<i>silver nitrate</i>	T1	

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
TOPICAL VIT D ANALOG/ANTI-INFLAMMATORY STEROID		
<i>calcipotriene/betamethasone</i> (Taclonex)	T1	
ENSTILAR	T3	PA
TACLONEX 0.005%-0.064% SUSPENS (<i>calcipotriene-betamethasone dp</i>)	T3	PA
TACLONEX OINTMENT (<i>calcipotriene-betamethasone</i>)	T3	PA
WYNZORA	T3	PA
TOPICAL/MUCOUS MEMBR./SUBCUT. ENZYMES		
AMPHADASE	T3	
SANTYL	T2	QL (60gm/30 days)
VITRASE	T3	
VITAMIN A DERIVATIVES		
<i>adapalene</i>	T1	PA
<i>adapalene</i> (Differin)	T1	PA
<i>adapalene</i> (Plixda)	T1	PA
AKLIEF	T3	
ALTRENO	T3	PA
ATRALIN (<i>tretinoin</i>)	T3	PA
<i>avita 0.025% cream</i> (Retin-a)	T3	PA
AVITA 0.025% GEL	T3	
DIFFERIN	T3	PA
DIFFERIN (<i>adapalene</i>)	T3	PA
PLIXDA	T1	PA
RETIN-A 0.01% GEL (<i>tretinoin</i>)	T3	
RETIN-A 0.025% CREAM (<i>tretinoin</i>)	T3	PA
RETIN-A 0.025% GEL (<i>tretinoin</i>)	T3	
RETIN-A 0.05% CREAM (<i>tretinoin</i>)	T3	PA
RETIN-A 0.1% CREAM (<i>tretinoin</i>)	T3	PA
RETIN-A MICRO (<i>tretinoin microsphere</i>)	T3	PA
RETIN-A MICRO PUMP	T3	PA
RETIN-A MICRO PUMP (<i>tretinoin microsphere</i>)	T3	PA
<i>tretinoin 0.01% gel</i> (Retin-a)	T1	
<i>tretinoin 0.025% cream</i> (Retin-a)	T1	PA
<i>tretinoin 0.025% gel</i> (Retin-a)	T1	
<i>tretinoin 0.05% cream</i> (Retin-a)	T1	PA
<i>tretinoin 0.05% gel</i> (Atralin)	T1	PA

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VITAMIN A DERIVATIVES		
<i>tretinoin 0.1% cream (Retin-a)</i>	T1	PA
<i>tretinoin microspheres (Retin-a Micro Pump)</i>	T1	PA
<i>tretinoin microspheres (Retin-a Micro)</i>	T1	PA
TRETIN-X	T3	PA
VITAMIN A DERIVATIVES, TOPICAL ACNE AGENTS		
ARAZLO	T2	
FABIOR	T3	
TAZAROTENE 0.1% FOAM	T3	
SMOKING DETERRENTS (Smoking Cessation) ⁸		
SMOKING DETERRENT AGENTS (GANGLIONIC STIM, OTHERS)		
NICOTROL	T2	PPACA
NICOTROL NS	T2	PPACA
SMOKING DETERRENT-NICOTINIC RECEPT.PARTIAL AGONIST		
CHANTIX	T2	
<i>varenicline 1 mg cont month bx</i>	T1	PPACA
SMOKING DETERRENTS, OTHER		
<i>bupropion hcl sr 150 mg tablet</i>	T1	PPACA
THYROID PREPS (Hormonal Agents)		
ANTI-THYROID PREPARATIONS		
<i>methimazole (Tapazole)</i>	T1	HD
<i>propylthiouracil</i>	T1	HD
TAPAZOLE (<i>methimazole</i>)	T3	HD
THYROID FUNCTION DIAGNOSTIC AGENTS		
THYROGEN	T4	SP
THYROID HORMONES		
ADTHYZA	T3	PA HD
ARMOUR THYROID	T3	HD
CYTOMEL (<i>liothyronine sodium</i>)	T3	HD
ERMEZA	T3	PA HD
LEVOTHYROXINE 100 MCG CAPSULE	T3	HD
LEVOTHYROXINE 112 MCG CAPSULE	T3	HD
LEVOTHYROXINE 125 MCG CAPSULE	T3	HD
LEVOTHYROXINE 13 MCG CAPSULE	T3	HD
LEVOTHYROXINE 137 MCG CAPSULE	T3	HD

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THYROID PREPS (Hormonal Agents)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
THYROID HORMONES		
LEVOTHYROXINE 150 MCG CAPSULE	T3	HD
LEVOTHYROXINE 175 MCG CAPSULE	T3	HD
LEVOTHYROXINE 200 MCG CAPSULE	T3	HD
LEVOTHYROXINE 25 MCG CAPSULE	T3	HD
LEVOTHYROXINE 50 MCG CAPSULE	T3	HD
LEVOTHYROXINE 75 MCG CAPSULE	T3	HD
LEVOTHYROXINE 88 MCG CAPSULE	T3	HD
<i>levothyroxine sodium</i>	T1	HD
<i>levothyroxine sodium (Synthroid)</i>	T1	HD
<i>levothyroxine sodium (Synthroid)</i>	T3	HD
<i>liothyronine sodium (Cytomel)</i>	T1	HD
<i>liothyronine sodium (Triostat)</i>	T1	HD
SYNTHROID (<i>unithroid</i>)	T3	HD
THYQUIDITY	T3	PA HD
<i>thyroid, pork</i>	T1	HD
<i>thyroid, pork (Armour Thyroid)</i>	T1	HD
<i>thyroid, pork (Wp Thyroid)</i>	T1	HD
THYROLAR-1	T2	HD
THYROLAR-1/2	T2	HD
THYROLAR-1/4	T2	HD
THYROLAR-2	T2	HD
THYROLAR-3	T2	HD
TIROSINT	T3	HD
TIROSINT-SOL	T3	HD
TRIOSTAT (<i>liothyronine sodium</i>)	T3	HD
WP THYROID	T1	HD
WP THYROID (<i>nature-throid</i>)	T1	HD
WP THYROID (<i>westhroid</i>)	T1	HD

CYTOCHROME P450 INHIBITORS

TYBOST	T4	SP
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UNCLASSIFIED DRUG PRODUCTS (Asthma/COPD/Respiratory)

CYSTIC FIBROSIS-CFTR POTENTIATOR-CORRECTOR COMBIN.

BRONCHITOL	T4	PA SP
ORKAMBI 100 MG-125 MG TABLET	T4	PA QL (4 tabs/day) SP HD
ORKAMBI 100-125 MG GRANULE PKT	T4	PA QL (2 packs/day) SP HD
ORKAMBI 150-188 MG GRANULE PKT	T4	PA QL (2 packs/day) SP HD

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UNCLASSIFIED DRUG PRODUCTS (Asthma/COPD/Respiratory)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
CYSTIC FIBROSIS-CFTR POTENTIATOR-CORRECTOR COMBIN .		
ORKAMBI 200 MG-125 MG TABLET	T4	PA QL (4 tabs/day) SP HD
SYMDEKO	T4	PA QL (2 tabs/day) SP HD
TRIKAFTA 100-50-75 MG/150 MG	T4	PA QL (3 tabs/day) SP HD
TRIKAFTA 100-50-75 MG/75MG PKT	T4	PA QL (3 tabs/day) HD
TRIKAFTA 50-25-37.5 MG/75 MG	T4	PA QL (3 tabs/day) SP HD
TRIKAFTA 80-40-60MG/59.5MG PKT	T4	PA QL (3 tabs/day) HD
CYSTIC FIB-TRANSMEMB CONDUCT.REG.(CFTR) POTENTIATOR		
KALYDECO 150 MG TABLET	T4	PA QL (2 tabs/day) SP HD
KALYDECO 25 MG GRANULES PACKET	T4	PA QL (2 packs/day) SP HD
KALYDECO 5.8 MG GRANULES PACKET	T4	PA QL (2 packs/day) SP HD
KALYDECO 50 MG GRANULES PACKET	T4	PA QL (2 packs/day) SP HD
KALYDECO 75 MG GRANULES PACKET	T4	PA QL (2 packs/day) SP HD
LUNG SURFACTANTS		
CUROSURF	T3	
INFASURF	T3	
SURVANTA	T3	
MUCOLYTICS		
PULMOZYME	T4	PA SP HD
PULMONARY FIBROSIS - SYSTEMIC ENZYME INHIBITORS		
OFEV	T4	PA SP HD
SYSTEMIC ENZYME INHIBITORS		
ARALAST NP	T4	PA SP
GLASSIA	T4	PA SP
PROLASTIN C	T4	PA SP
JOENJA	T4	PA QL (2 tabs/day) SP
VIJOICE 125mg, 50mg	T4	PA QL (30 tabs/30 days) SP
VIJOICE 250mg dose pack	T4	PA QL (2 tabs/30 days) SP
ZEMAIRA	T4	PA SP
ZOKINVY	T4	PA QL (4 CAPS/DAY) SP
UNCLASSIFIED DRUG PRODUCTS (Blood Modifiers/Bleeding Disorders)		
ANTI-INFLAMMATORY - ANTIMITOTICS		
LODOCO	T3	PA
ANTIPORPHYRIA FACTORS		
PANHEMATIN	T4	SP
ERYTHROID MATURATION AGENTS		
REBLOZYL	T4	PA SP

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List of Prescription Medications

UNCLASSIFIED DRUG PRODUCTS (Blood Pressure/Heart Medications)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
SPLEEN TYROSINE KINASE INHIBITORS		
TAVALISSE	T4	PA SP
BRADYKININ B2 RECEPTOR ANTAGONISTS		
FIRAZYR (<i>icatibant</i>)	T4	PA SP HD
<i>icatibant acetate</i> (Firazyr)	T4	PA SP HD
CI ESTERASE INHIBITORS		
BERINERT	T4	PA SP HD
CINRYZE	T4	PA SP HD
HAEGARDA	T4	PA SP HD
RUCONEST	T4	PA SP HD
PLASMA KALLIKREIN INHIBITORS		
KALBITOR	T4	PA SP HD
ORLADEYO	T4	PA QL (1 caps/day) SP

UNCLASSIFIED DRUG PRODUCTS (Cancer)

CHEMOTHERAPY RESCUE/ANTIDOTE AGENTS		
<i>amifostine crystalline</i> (Ethyol)	T4	SP
<i>dexrazoxane hcl</i> (Zinecard)	T4	SP
ETHYOL (<i>amifostine</i>)	T4	SP
KHAPZORY	T3	PA
<i>leucovorin calcium</i>	T1	
<i>levoleucovorin calcium</i>	T1	PA
<i>mesna</i> (Mesnex)	T4	SP
MESNEX	T4	SP
MESNEX (<i>mesna</i>)	T4	SP
VISTOGARD	T4	SP
VORAXAZE	T4	PA SP
ZINECARD (<i>dexrazoxane</i>)	T4	SP
INTRAPLEURAL SCLEROSING AGENTS, ANTINEOPLAST. ADJ.		
SCLEROSOL	T3	
STERILE TALC	T1	
STERITALC	T3	
RADIOACTIVE THERAPEUTIC AGENTS		
LUTATHERA	T4	PA SP
METASTRON	T3	PA
QUADRAMET	T3	PA
<i>strontium-89 chloride</i> (Metastron)	T1	PA
XOFIGO	T3	PA

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UNCLASSIFIED DRUG PRODUCTS (Cancer) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
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TISSUE PROTECTIVE TX OF CHEMOTHERAPY EXTRAVASATION

TOTECT	T3	
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UNCLASSIFIED DRUG PRODUCTS (Dental Products)

DENTAL AIDS AND PREPARATIONS

<i>chlorhexidine gluconate</i> (Peridex)	T1	
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PERIDEX (<i>perio-gard</i>)	T1	
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<i>triamcinolone acetonide</i>	T1	
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PERIODONTAL COLLAGENASE INHIBITORS

<i>doxycycline hyclate 20 mg tab</i>	T1	
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UNCLASSIFIED DRUG PRODUCTS (Diabetes)

ANTIHYPERGLYCEMIC-SOD/GLUC COTRANSPORT2(SGLT2) INH

INPEFA	T3	PA QL(1 tab/day) HD
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UNCLASSIFIED DRUG PRODUCTS (Erectile Dysfunction)

DRUGS TO TREAT ERECTILE DYSFUNCTION (ED)

CAVERJECT	T3	QL (6 injectors/30 days)
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CIALIS 10 MG TABLET (<i>tadalafil</i>)	T3	QL (6 tabs/30 days) ST HD
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CIALIS 20 MG TABLET (<i>tadalafil</i>)	T3	QL (6 tabs/30 days) ST HD
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CIALIS 5 MG TABLET (<i>tadalafil</i>)	T3	QL (8 tabs/30 days) ST HD
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EDEX	T3	QL (6 injectors/30 days)
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LEVITRA (<i>ardenafil hcl</i>)	T3	QL (10 tabs/30 days) ST
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MUSE	T2	QL (6/30 days)
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<i>sildenafil 100 mg tablet</i> (Viagra)	T1	QL (6 tabs/30 days) HD
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<i>sildenafil 25 mg tablet</i> (Viagra)	T1	QL (10 tabs/30 days) HD
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<i>sildenafil 50 mg tablet</i> (Viagra)	T1	QL (6 tabs/30 days) HD
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STENDRA	T3	QL (8 tabs/30 days) ST
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<i>tadalafil 10 mg tablet</i> (Cialis)	T1	QL (10 tabs/30 days) HD
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<i>tadalafil 20 mg tablet</i> (Cialis)	T1	PA QL (10 tabs/30 days) HD
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<i>tadalafil 5 mg tablet</i> (Cialis)	T1	QL (1 tab/day) HD
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<i>ardenafil hcl</i>	T1	QL (10 tabs/30 days)
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<i>ardenafil hcl</i> (Levitra)	T1	QL (10 tabs/30 days)
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VIAGRA (<i>sildenafil citrate</i>)	T3	QL (6 tabs/30 days) ST HD
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UNCLASSIFIED DRUG PRODUCTS (Eye Conditions)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
INSULIN-LIKE GROWTH FACTOR RECEPTOR (IGF-R) INHIB		
TEPEZZA	T4	PA SP HD
OCULAR PHOTOACTIVATED VESSEL-OCCLUDING AGENTS		
VISUDYNE	T4	SP
UNCLASSIFIED DRUG PRODUCTS (Gastrointestinal/Heartburn)		
CALCIMIMETIC, PARATHYROID CALCIUM ENHANCER		
<i>cinacalcet hcl</i> (Sensipar)	T4	SP
PARSABIV	T4	PA SP
SENSIPAR (<i>cinacalcet hcl</i>)	T4	PA SP
ORAL MUCOSITIS/STOMATITIS AGENTS		
ORAMAGICRX	T3	
SALIVA STIMULANT AGENTS		
NUMOISYN	T2	
UNCLASSIFIED DRUG PRODUCTS (Hormonal Agents)		
BONE FORMATION STIM. AGENTS - PARATHYROID HORMONE		
FORTEO	T4	PA QL (3ml/21 days) SP HD
<i>teriparatide</i> 600 mcg/2.4ml pen (Forteo)	T4	PA QL (1 pen/28 days) SP HD
GROWTH HORMONE RECEPTOR ANTAGONISTS		
SOMAVERT	T4	PA SP HD
HYPERPARATHYROID TX AGENTS - VITAMIN D ANALOG-TYPE		
<i>doxercalciferol</i>	T1	
<i>doxercalciferol</i> (Hectorol)	T1	
HECTOROL	T3	
HECTOROL (<i>doxercalciferol</i>)	T3	
<i>paricalcitol</i> 1 mcg capsule (Zemplar)	T4	SP HD
PARICALCITOL 10 MCG/2 ML VIAL	T4	SP
<i>paricalcitol</i> 10 mcg/2 ml vial (Zemplar)	T4	SP
<i>paricalcitol</i> 2 mcg capsule (Zemplar)	T4	SP HD
PARICALCITOL 2 MCG/ML VIAL	T4	SP
<i>paricalcitol</i> 2 mcg/ml vial (Zemplar)	T4	SP
<i>paricalcitol</i> 4 mcg capsule	T4	SP HD
PARICALCITOL 5 MCG/ML VIAL	T4	SP
<i>paricalcitol</i> 5 mcg/ml vial (Zemplar)	T4	SP
RAYALDEE	T3	
ZEMPLAR 1 MCG CAPSULE (<i>paricalcitol</i>)	T4	SP HD

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UNCLASSIFIED DRUG PRODUCTS (Hormonal Agents) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
HYPERPARATHYROID TX AGENTS - VITAMIN D ANALOG-TYPE (cont.)		
ZEMPLAR 10 MCG/2 ML VIAL (<i>paricalcitol</i>)	T4	SP
HYPERPARATHYROID TX AGENTS - VITAMIN D ANALOG-TYPE		
ZEMPLAR 2 MCG CAPSULE (<i>paricalcitol</i>)	T4	SP HD
ZEMPLAR 2 MCG/ML VIAL (<i>paricalcitol</i>)	T4	SP
ZEMPLAR 5 MCG/ML VIAL (<i>paricalcitol</i>)	T4	SP
MENOPAUSAL SYMPT SUPP-SEL ESTROGEN RECEPT MODULATOR		
OSPHENA	T3	HD
UNCLASSIFIED DRUG PRODUCTS (Miscellaneous)		
ABORTIFACIENT-PROGESTERONE RECEPTOR ANTAGONISTS		
MIFEPREX	T3	
<i>mifepristone</i> (Mifeprex)	T1	
ACID AND ALKALI POISON ANTIDOTES		
<i>methylene blue</i> (antidotes)	T1	
PROVAYBLUE	T3	
AGENTS TO TX PERIODIC PARALYSIS - CARBON ANHYD INH		
<i>dichlorphenamide</i> (Keveyis)	T4	PA SP
KEVEYIS (<i>dichlorphenamide</i>)	T4	PA SP
AMMONIA INHIBITORS		
CARBAGLU	T4	SP HD
PHEBURANE	T4	PA QL (8 bottles/30days) SP
AMYLOIDOSIS AGENTS-TRANSTHYRETIN (TTR) SUPPRESSION		
ONPATTRO	T4	PA SP
TEGSEDI	T4	PA SP HD
ANTI-ALCOHOLIC PREPARATIONS		
<i>acamprosate calcium</i>	T1	
ANTABUSE (<i>disulfiram</i>)	T3	
<i>disulfiram</i> (Antabuse)	T1	
VIVITROL	T4	SP HD
ANTIDOTES, MISCELLANEOUS		
ACETADOTE (<i>acetylcysteine</i>)	T3	
<i>acetylcysteine</i> (Acetadote)	T1	
CETYLEV	T3	
CYANOKIT	T3	
DIGIFAB	T3	
<i>fomepizole</i>	T1	
SODIUM NITRITE	T1	

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List of Prescription Medications

UNCLASSIFIED DRUG PRODUCTS (Miscellaneous)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ANTI-FIBROTIC THERAPY - PYRIDONE ANALOGS		
<i>pirfenidone 267 mg capsule (Esbriet)</i>	T4	PA SP HD
BENZODIAZEPINE ANTAGONISTS		
<i>flumazenil</i>	T1	
CATHETER LOCK SOLUTIONS		
DEFENCATH	T3	
CHOLINESTERASE REACTIVAT.-MUSCARINIC ANTG.ANTIDOTE		
DUODOTE	T3	
CHOLINESTERASE REACTIVATING, ORGANOPHOS. ANTIDOTES		
PRALIDOXIME CHLORIDE	T1	
PROTOPAM CHLORIDE	T3	
COMPLEMENT INHIBITORS		
VEOPOZ	T4	SP
CRYOPRESERVATIVE AGENTS		
<i>dimethyl sulfoxide</i>	T3	
DILUENT SOLUTIONS		
<i>diluent for epoprostenol (glyc)</i>	T1	
DILUENT FOR REMODULIN	T3	
<i>diluent for treprostinil (gly)</i> (Diluent For Remodulin)	T1	
ELLIOTTS B	T3	
PH 12 DILUENT FOR FLOLAN	T3	
DRUGS TO TREAT ACUTE HEPATIC PORPHYRIA (AHP)		
GIVLAARI	T4	PA SP HD
DRUGS TO TREAT HEREDITARY TYROSINEMIA		
<i>nitisinone (Orfadin)</i>	T4	PA SP HD
NITYR	T4	PA SP
ORFADIN	T4	PA SP
ORFADIN (<i>nitisinone</i>)	T4	PA SP
GENERAL INHALATION AGENTS		
HYPER-SAL	T3	
<i>nebusal 3% vial</i>	T1	
NEBUSAL 6% VIAL	T3	
<i>sodium chloride for inhalation</i>	T1	
<i>sodium chloride for inhalation (Hyper-sal)</i>	T1	
GENETIC D/O TX - SMN PROTEIN DEFICIENCY TREATMENT		
EVRYSDI	T4	PA SP HD

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GENETIC D/O TX - SMN PROTEIN DEFICIENCY TREATMENT (cont.)		
SPINRAZA	T3	PA SP HD
AMONDYS-45	T3	PA SP
EXONDYS-51	T3	PA SP
VILTEPSO	T3	PA SP
VYONDYS-53	T3	PA SP
GLUCOSYLCERAMIDE SYNTHASE (GCS) INHIBITOR		
CERDELGA	T4	PA SP HD
<i>miglustat (Zavesca)</i>	T4	PA SP HD
OPFOLDA	T4	PA QL (8 caps/30 days) SP HD
ZAVESCA (<i>miglustat</i>)	T4	PA SP HD
KIDNEY STONE AGENTS		
<i>tiopronin</i>	T4	SP
LEAD POISONING, AGENTS TO TREAT (CHELATING-TYPE)		
CALCIUM DISODIUM VERSENATE	T1	PA
MENOPAUSAL SYMPTOMS SUPPRESSANT - SSRIs		
<i>paroxetine mesylate</i>	T1	QL (1 cap/day) HD
VEOZAH	T3	QL(1 tab/day)
METABOLIC DISEASE ENZYME REPLACE, HYPOPHOSPHATASIA		
STRENSIQ	T4	PA SP
METABOLIC DISEASE ENZYME REPLACEMENT, BATTEN DISEA		
BRINEURA	T3	PA SP
METABOLIC DISEASE ENZYME REPLACEMENT, FABRY'S DX		
FABRAZYME	T4	PA SP HD
METABOLIC DISEASE ENZYME REPLACEMENT, GAUCHER'S DX		
CEREZYME	T4	PA SP HD
ELELYSO	T4	PA SP
VPRIV	T4	PA SP HD
METABOLIC DISEASE ENZYME REPLACEMENT, MOCD		
NULIBRY	T4	PA SP
METABOLIC DISEASE ENZYME REPLACEMENT, POMPE DISEASE		
LUMIZYME	T4	PA SP
POMBILITI	T4	PA SP HD
METABOLIC DX ENZYME REPLACEMENT,ALPHA-MANNOSEDOSIS		
LAMZEDE	T4	PA SP
METABOLIC DX ENZYME REPLACE, MUCOPOLYSACCHARIDOSIS		
ALDURAZYME	T4	PA SP HD
ELAPRASE	T4	PA SP

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METABOLIC DX ENZYME REPLACE, MUCOPOLYSACCHARIDOSIS (con't.)		
MEPSEVII	T4	PA SP
NAGLAZYME	T4	PA SP
VIMIZIM	T4	PA SP
METABOLIC DX ENZYME REPLACEMENT, LYSO.ACID LIP.DEF.		
KANUMA	T4	PA SP
METABOLIC DX ENZYME REPLACEMT, SEV.COMB.IMMUNE DEF.		
ADAGEN	T4	PA SP
REVCOVI	T4	PA SP
METALLIC POISON, AGENTS TO TREAT		
BAL IN OIL	T3	PA
CHEMET	T3	
CUVRIOR	T4	PA SP
<i>deferasirox (Exjade)</i>	T4	SP HD
<i>deferasirox (Jadenu Sprinkle)</i>	T4	SP HD
<i>deferasirox (Jadenu)</i>	T4	SP HD
<i>deferiprone (Ferriprox)</i>	T4	PA SP HD
<i>deferoxamine mesylate</i>	T1	
<i>deferoxamine mesylate (Desferal Mesylate)</i>	T1	
DESFERAL MESYLATE (<i>deferoxamine mesylate</i>)	T3	
EXJADE (<i>deferasirox</i>)	T4	PA SP HD
FERRIPROX	T4	PA SP
FERRIPROX (2 TIMES A DAY)	T4	PA SP
GALZIN	T3	
JADENU (<i>deferasirox</i>)	T4	PA SP HD
JADENU SPRINKLE (<i>deferasirox</i>)	T4	PA SP HD
NITHIODOLE	T3	
PENTETATE CALCIUM TRISODIUM	T1	
ZINC TRISODIUM	T1	
RADIOGARDASE	T3	
<i>sodium thiosulf (poison treat)</i>	T1	
SYPRINE (<i>trientine hcl</i>)	T4	PA SP HD
<i>trientine hcl (Syprine)</i>	T4	PA SP HD
TRIENTINE HCL 500 MG CAPSULE	T4	PA SP HD
MISCELLANEOUS AGENTS		
NEXAVIR	T4	SP
NATRIURETIC PEPTIDES		
VOXZOGO	T4	PA SP HD

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
NICOTINIC RECEPT.PARTIAL AGONIST, ALPHA4BETA2 SPEC		
TYRVAYA	T3	PA QL (2/month) HD
NUCLEAR FACTOR ERYTHROID 2-REL. FACTOR 2 ACTIVATOR		
SKYCLARYS	T4	PA QL(3 caps/day) SP
OINTMENT/CREAM BASES		
RADIAGEL	T3	
PHARMACOLOGICAL CHAPERONE-ALPHA-GALACTOSID.A STABZ		
GALAFOLD	T4	PA SP HD
PKU TX AGENT-COFACTOR OF PHENYLALANINE HYDROXYLASE		
<i>javygtor 100 mg powder packet (Kuvan)</i>	T1	
<i>javygtor 100 mg tablet (Kuvan)</i>	T1	
<i>javygtor 500 mg powder packet (Kuvan)</i>	T1	
<i>KUVAN (sapropterin dihydrochloride)</i>	T4	PA SP HD
<i>sapropterin dihydrochloride (Kuvan)</i>	T4	PA SP HD
PROTEIN STABILIZERS		
VYNDAMAX	T4	PA QL (1 cap/day) SP HD
VYNDAQEL	T4	PA QL (4 caps/day) SP HD
RADIOPHARMACEUTICALS ELEMENTS		
TECHNELITE.TC-99M GENERATOR	T3	
RETINOIC ACID RECEPTOR (RAR) AGONISTS		
SOHONOS	T4	PA SP
SODIUM/SALINE PREPARATIONS		
<i>bacteriostatic sodium chloride</i>	T1	
SOLVENTS		
<i>isopropyl alcohol</i>	T3	
MURI-LUBE MINERAL OIL	T3	
TOPICAL/MUCOUS MEMBR./SUBCUT. ENZYMES		
HYLENEX	T4	SP HD
WATER		
<i>water for inj., bacteriostatic</i>	T1	
<i>water for injection, sterile</i>	T1	
<i>water/me-paraben/propylparaben</i>	T1	
UNCLASSIFIED DRUG PRODUCTS (Multiple Sclerosis)		
LEUKOCYTE ADHESION INHIB, ALPHA4-MEDIAT IGG4K MC AB		
TYSABRI	T4	PA SP HD

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List of Prescription Medications

UNCLASSIFIED DRUG PRODUCTS (Nutritional/Dietary)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
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METABOLIC DEFICIENCY AGENTS

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

UNCLASSIFIED DRUG PRODUCTS (Osteoporosis Products)

BONE FORMATION AGENTS - SCLEROSTIN INHIBITOR, MONO

EVENITY	T4	PA QL (2 syringes/month) SP
EVENITY (2 SYRINGES)	T4	PA QL (2 syringes/month) SP

BONE RESORPTION INHIBITOR AND VITAMIN D COMBS.

FOSAMAX PLUS D	T3	ST HD
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BONE RESORPTION INHIBITORS

ACTONEL (<i>risedronate sodium</i>)	T3	ST HD
<i>alendronate sodium</i>	T1	HD
<i>alendronate sodium</i> (Fosamax)	T1	HD
ATELVIA (<i>risedronate sodium dr</i>)	T3	ST HD
BINOSTO	T3	ST HD
BONIVA 150 MG TABLET (<i>ibandronate sodium</i>)	T3	ST HD
BONIVA 3 MG/3 ML SYRINGE (<i>ibandronate sodium</i>)	T3	SP HD
EVISTA (<i>raloxifene hcl</i>)	T3	HD
FOSAMAX (<i>alendronate sodium</i>)	T3	ST HD
<i>ibandronate 3 mg/3 ml syringe</i> (Boniva)	T4	SP HD
<i>ibandronate 3 mg/3 ml vial</i>	T4	SP HD
<i>ibandronate sodium 150 mg tab</i> (Boniva)	T1	HD
<i>pamidronate disodium</i>	T4	SP HD
PROLIA	T4	PA SP HD
<i>raloxifene hcl</i> (Evista)	T1	HD PPACA
RECLAST (<i>zoledronic acid</i>)	T4	SP HD
<i>risedronate sodium</i>	T1	HD
<i>risedronate sodium</i> (Actonel)	T1	HD

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UNCLASSIFIED DRUG PRODUCTS (Osteoporosis Products)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
BONE RESORPTION INHIBITORS		
<i>risedronate sodium</i> (Atelvia)	T1	HD
XGEVA	T4	PA SP HD
<i>zoledronic acid</i>	T4	SP HD
<i>zoledronic acid/mannitol-water</i>	T4	SP HD
<i>zoledronic acid/mannitol-water</i> (Reclast)	T4	SP HD
UNCLASSIFIED DRUG PRODUCTS (Pain Relief And Inflammatory Disease)		
ANTI-INFLAM. INTERLEUKIN-1 RECEPTOR ANTAGONIST		
ARCALYST	T4	PA SP HD
ANTI-INFLAMMATORY, INTERLEUKIN-1 BETA BLOCKERS		
ILARIS	T4	PA SP HD
FIBROMYALGIA AGENTS, SEROTONIN-NOREPINEPHRU INHIB		
SAVELLA	T2	HD
IMMUNOMODULATOR, B-LYMPHOCYTE STIM (BLYS)-SPEC INHIB		
BENLYSTA 120 MG VIAL	T4	PA SP
BENLYSTA 200 MG/ML AUTOINJECT	T4	PA SP HD
BENLYSTA 200 MG/ML SYRINGE	T4	PA SP HD
BENLYSTA 400 MG VIAL	T4	PA SP
JOINT CONTRACTURE THERAPY, COLLAGENASE ENZYME		
XIAFLEX	T4	PA SP
UNCLASSIFIED DRUG PRODUCTS (Seizure Disorders)		
NEUROPATHIC AGENTS		
LYRICA CR	T3	HD
UNCLASSIFIED DRUG PRODUCTS (Skin Conditions)		
INTERLEUKIN-13 (IL-13) INHIBITORS, MAB		
ADBRY	T4	PA SP HD
WOUND HEALING AGENTS, LOCAL		
<i>balsam peru/castor oil</i> (Venelex)	T1	
BALSAM PERU-CASTOR OIL	T1	
DERMULCERA	T1	
VENELEX	T3	
UNCLASSIFIED DRUG PRODUCTS (Substance Abuse)		
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	

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UNCLASSIFIED DRUG PRODUCTS (Substance Abuse) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
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OPIOID WITHDRAWAL THERAPY AGENTS, OPIOID-TYPE (cont.)

<i>buprenorphine hcl/naloxone hcl</i> (Suboxone)	T1	
PROBUPHINE	T3	
SUBLOCADE	T4	SP
SUBOXONE (<i>buprenorphine-naloxone</i>)	T3	
ZUBSOLV	T2	

UNCLASSIFIED DRUG PRODUCTS (Transplant Medications)

RHO KINASE INHIBITOR

REZUROCK	T4	PA SP HD
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UNCLASSIFIED DRUG PRODUCTS (Urinary Tract Conditions)

BENIGN PROSTATIC HYPERTROPHY/MICTURITION AGENTS

<i>alfuzosin hcl</i> (Uroxatral)	T1	HD
AVODART (<i>dutasteride</i>)	T3	PA 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 AGENT-5-ALPHA-REDUCTASE INH AND PDE5 INH COMB

ENTADFI	T3	PA QL(1 CAP/DAY)
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BPH 5-ALPHA-REDUCTASE INHIB-ALPHA1-ADRENOCEP ANTAG

<i>dutasteride/tamsulosin hcl</i> (Jalyn)	T1	HD
JALYN (<i>dutasteride-tamsulosin</i>)	T3	PA HD

CYSTINE-DEPLETING AGENTS, NEPHROPATHIC CYSTINOSIS

CYSTAGON	T4	SP
PROCYSBI	T4	PA SP HD

OVERACTIVE BLADDER AGENTS, BETA-3 ADRENERGIC RECEPTOR

GEMTESA	T3	QL (1 tab/day) ST HD
MYRBETRIQ ER 25 MG TABLET	T3	QL (1 tab/day) ST HD
MYRBETRIQ ER 50 MG TABLET	T3	ST HD

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UNCLASSIFIED DRUG PRODUCTS (Urinary Tract Conditions)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
URINARY TRACT ANTI-SPASMODIC, M(3) SELECTIVE ANTAG.		
<i>darifenacin er 15 mg tablet</i>	T1	HD
<i>darifenacin er 7.5 mg tablet (Enablex)</i>	T1	QL (1 tab/day) HD
ENABLEX (<i>darifenacin er</i>)	T3	QL (1 tab/day) ST HD
<i>solifenacin 10 mg tablet (Vesicare)</i>	T1	HD
<i>solifenacin 5 mg tablet (Vesicare)</i>	T1	QL (1 tab/day) HD
VESICARE 10 MG TABLET (<i>solifenacin succinate</i>)	T3	ST HD
VESICARE 5 MG TABLET (<i>solifenacin succinate</i>)	T3	QL (1 tab/day) ST HD
VESICARE LS	T3	ST HD
URINARY TRACT ANTI-SPASMODIC/ANTI-INCONTINENCE AGENT		
DETROL (<i>tolterodine tartrate</i>)	T3	ST HD
DETROL LA 2 MG CAPSULE (<i>tolterodine tartrate er</i>)	T3	QL (1 cap/day) ST HD
DETROL LA 4 MG CAPSULE (<i>tolterodine tartrate er</i>)	T3	ST HD
DITROPAN XL (<i>oxybutynin chloride er</i>)	T3	ST HD
<i>flavoxate hcl</i>	T1	HD
GELNIQUE	T3	ST HD
OXYBUTYNIN 2.5 MG TABLET	T3	PA HD
<i>oxybutynin 5 mg tablet</i>	T1	HD
<i>oxybutynin 5 mg/5 ml solution</i>	T1	HD
<i>oxybutynin 5 mg/5 ml syrup</i>	T1	HD
<i>oxybutynin chloride</i>	T1	HD
<i>oxybutynin chloride (Ditropan XL)</i>	T1	HD
OXYTROL	T3	ST HD
<i>tolterodine tart er 2 mg cap (Detrol La)</i>	T1	QL (1 cap/day) HD
<i>tolterodine tart er 4 mg cap (Detrol La)</i>	T1	HD
<i>tolterodine tartrate (Detrol)</i>	T1	HD
TOVIAZ ER 4 MG TABLET	T2	QL (1 tab/day) HD
TOVIAZ ER 8 MG TABLET	T2	HD
<i>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	

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VITAMINS (Nutritional/Dietary)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
MULTIVITAMIN PREPARATIONS		
CITRANATAL MEDLEY	T3	
FOLET ONE	T2	
INFUVITE ADULT	T3	
<i>multivit infusn, adult 1, vit k</i>	T3	
<i>mvn no.53/iron/folic/dss/dha</i>	T1	
OBSTETRIX ONE	T1	
PEDIATRIC VITAMIN PREPARATIONS		
INFUVITE PEDIATRIC	T3	
M.V.I. PEDIATRIC	T3	
VITALIPID N INFANT	T3	
VITLIPID N INFANT	T3	
VITAMIN A PREPARATIONS		
AQUASOL A	T3	
VITAMIN B PREPARATIONS		
<i>vitamins b1, b2, b3, b5, and b6</i>	T1	HD
VITAMIN B1 PREPARATIONS		
<i>thiamine hcl</i>	T1	
VITAMIN B12 PREPARATIONS		
B-12 COMPLIANCE	T1	
<i>cyanocobalamin (vitamin b-12)</i>	T1	PA
<i>hydroxocobalamin</i>	T1	
NASCOBAL	T3	PA
PHYSICIANS EZ USE B-12	T3	
VITAMIN C PREPARATIONS		
ASCOR	T3	
<i>ascorbic acid</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 ampul</i>	T1	HD
<i>calcitriol 1 mcg/ml vial</i>	T1	HD
<i>calcitriol 1 mcg/ml solution (Rocaltrol)</i>	T1	HD
DRISDOL (<i>vitamin d2</i>)	T3	HD
<i>ergocalciferol (vitamin d2) (Drisdol)</i>	T1	HD
ROCALTROL (<i>calcitriol</i>)	T3	HD

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

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

List of Prescription Medications

VITAMINS (Nutritional/Dietary)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
VITAMIN D PREPARATIONS (cont.)		
MEPHYTON (<i>phytonadione</i>)	T3	
PHYTONADIONE	T1	
<i>phytonadione (vit k1)</i>	T1	
VITAMIN K PREPARATIONS		
<i>phytonadione (vit k1)</i> (Mephyton)	T1	
VITAMINS (Vitamins)		
MULTIVITAMIN PREPARATIONS		
VITLIPID N ADULT	T3	

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

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

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

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

Exclusions and limitations for coverage

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

Plans generally do not provide coverage for the following under the pharmacy benefit, except as required by state or federal law, or by the terms of your specific plan: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 plans covers these medications, log in to the myCigna App or myCigna.com, or call Customer Service using the number on your ID card.
9. Costs and complete details of the plan's prescription drug coverage are set forth in the plan documents. If there are any differences between the information provided here and the plan documents, the information in the plan documents takes complete precedence.
10. **For plans that must follow state insurance laws, such as Delaware:** Your plan may provide coverage for infertility medications and smoking cessation medications even if this drug list states that your plan may not cover them. To find out if your specific plan covers these medications, log in to the myCigna App or myCigna.com, or check your plan materials.

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

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

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

DISCRIMINATION IS AGAINST THE LAW

Medical coverage

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

Cigna:

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

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

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