



Cigna Healthcare National Preferred 5-Tier Prescription Drug List

Coverage as of January 1, 2026

For the State of California

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

View your drug list online: **Cigna.com/druglist**

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

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

Last updated: 10/01/2025. This drug list is subject to change and all prior versions are no longer in effect.



What's Inside?	Page
Information about this drug list	3
• Frequently asked questions (FAQs)	3
• Words you may need to know	11
• About this drug list	13
• How to read this drug list	13
• How to find your medication	16
List of prescription medications	19
Exclusions and limitations for coverage	246
Index of medications	247

View your drug list online, 24/7

This document was last updated on 10/01/2025.* Go online to see the most up-to-date information about the medications your plan covers.

- **Cigna.com/druglist.** Choose **National Preferred 5 Tier** from the dropdown list. Then type in your medication name or view the full list.
- **myCigna App¹ or myCigna.com.** Log into your account and use the Price a Medication tool to see how your medication is covered.

Questions?

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

Information about this drug list

Frequently asked questions (FAQs)

Here are answers to questions you may have about your drug list and prescription medication coverage.

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

A. We review and update the drug list on a regular basis to make sure you have coverage for low-cost, safe and effective medications. We make changes for many reasons; for example, when a new medication comes out or is no longer available, or when a medication's price changes. 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 comes out.** This can happen at any time during the year.
- **Moving a medication to a higher cost tier and/or no longer covering a medication.** This typically happens twice a year on January 1 and July 1.
- **Adding extra coverage rules (requirements) to a medication.** This typically happens twice a year on January 1 and July 1.

When we make a change that affects your medication (for example, it'll cost more, won't be covered, and/or has an extra coverage requirement), we let you know before it happens. This way, you have time to talk with your doctor about your options. Only you and your doctor can decide what's best for your treatment.

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

A. To help lower your overall health care costs, your plan doesn't cover certain high-cost brand-name medications that have lower-cost alternatives that can treat the same condition. If your medication isn't covered and your doctor feels a different medication isn't right for you, your doctor's office can ask us to cover it through our review process.

There are also some medications and products that your plan won't cover for any reason because they're a "plan (or benefit) exclusion." This means the medication or product isn't on your drug list, and there's no option to ask us to cover it through our

review process. For example, your plan doesn't cover (or "excludes") medications that the U.S. Food and Drug Administration (FDA) hasn't approved.

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 make sure you're getting coverage for the right medication, at the right cost, in the right amount and for the right situation.

Q. How do I know if a medication needs approval?

A. Check your drug list or log in to the myCigna App or **myCigna.com** and use the Price a Medication tool. If the medication has:

- **PA** (Prior Authorization) or **ST** (Step Therapy) next to it, it needs approval before your plan will cover it.
- **QL** (Quantity Limit) next to it, you may need approval depending on how much you're filling at one time.
- **AGE** (Age Requirement) next to it, you may need approval depending on your age.

Information about this drug list

Frequently asked questions (FAQs) (cont.)

Q. What types of medications typically need approval?

A. Medications that:

- May not be safe when you take them with other medications.
- Have lower-cost alternatives that work just as well at treating the same condition.
- Should only be used for certain health conditions.
- Are often used in the wrong way or are abused (taken more often than you should).

Q. What types of medications typically have quantity limits?

A. Medications that are often:

- Taken in a greater amount or used for a longer time than they should be.
- Used in the wrong way or are abused (taken more often than you should).

Q. What medications are part of Step Therapy?

A. They're typically high-cost medications that treat 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. Not all medications are right for all ages. Some medications work best for people of a certain age or within a certain age range. As you get older, body changes can decrease the body's ability to break down or get rid of certain medications. This means that the medication may stay in your body longer. So, an older adult may need a lower dose of the medication or a different medication that's safer.

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

A. Ask your doctor's office to contact us 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 our provider portal at cignaforhcp.com.

We'll review the information your doctor sends us to make sure you meet the medication's coverage rules (requirements). We'll send you and your doctor a letter with our decision (approved/not approved) and next steps. It can take up to five (5) business days to hear from us. You can always check with your doctor's office to find out if we've made a decision. Or, you can log in to the myCigna App or [myCigna.com](https://mycigna.com) to see where your medication is in the review process or to read about the decision we made.

Many times, we don't get all of the information we need from the doctor's office to approve coverage. If we don't approve your medication, 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 us a request, in writing, that explains why we should cover the medication.

- **For non-urgent requests**, we'll 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**, we'll 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 we don't respond to a completed prior authorization exception request within 72 hours of receiving a non-urgent request and 24

Information about this drug list

Frequently asked questions (FAQs) (cont.)

hours of receiving a request based on exigent circumstances, the request will be considered approved and your plan can't deny coverage of the medication. Also, if you've already received approval for your plan to cover your medication, we 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, your doctor can ask us to consider approving coverage of your medication. Ask your doctor's office to contact us 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 our provider portal at **cignaforhcp.com**.

We'll review the information your doctor sends us to make sure you meet the medication's coverage rules (requirements). We'll send you and your doctor a letter with our decision (approved/not approved) and next steps. It can take up to five (5) business days to hear from us. You can always check with your doctor's office to find out if we've made a decision. Or, you can log in to the myCigna App or **myCigna.com** to see where your medication is in the review process or to read about the decision we made.

Many times, we don't get all of the information we need from the doctor's office to approve coverage. If we don't approve your medication, 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 us a request, in writing, that explains why we should cover the medication.

- **For non-urgent requests**, we'll 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**, we'll 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 our coverage rules (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 us to consider approving coverage of your current medication. Ask your doctor's office to contact us 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 our provider portal at **cignaforhcp.com**.

We'll review the information your doctor sends us to make sure you meet the medication's coverage rules (requirements). We'll send you and your doctor a letter with our decision (approved/not approved) and next steps. It can take up to five (5) business days to hear from us. You can always check with your doctor's office to find out if we've made a decision. Or, you can log in to the myCigna App or **myCigna.com** to see where your medication is in the review process or to read about the decision we made.

Many times, we don't get all of the information we need from the doctor's office to approve coverage. If we don't approve your medication, your doctor can send us more information to review, using the same process as before. We're happy to review the request

Information about this drug list

Frequently asked questions (FAQs) (cont.)

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 us a request, in writing, that explains why we should cover the medication.

- **For non-urgent requests**, we'll 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**, we'll 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 we don't respond to a completed prior authorization exception request within 72 hours of receiving a non-urgent request and 24 hours of receiving a request based on exigent circumstances, the request will be considered approved and your plan can't deny coverage of the medication.

Your Step Therapy rights under California State law:

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

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

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

A. When your pharmacist tries to fill your prescription, they'll see that the medication needs our approval before it can be covered. Because you didn't get approval ahead of time, your plan won't cover its cost. If that happens, ask your doctor to contact us to start the coverage review process.

You can still fill it (without using your plan/insurance), but you'll pay its full price at the pharmacy counter. And, if you do this, your costs 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 can ask us to cover it through our review process.

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). These include, but are not limited to, medications, medical supplies and/or devices covered under standard pharmacy benefits. It can take up to six months from the date the FDA approved them for us to make a decision.

If your doctor wants you to use a recently approved medication, your doctor's office can ask us to cover it through our review process.

Information about this drug list

Frequently asked questions (FAQs) *(cont.)*

Q. What are preventive medications?

A. Preventive medications can help keep you from getting certain long-term health conditions such as asthma, depression, diabetes, heart attack, high blood pressure, high cholesterol, osteoporosis (a disease that causes bones to become weak), prenatal nutrient deficiency (when a pregnant person doesn't get enough of the nutrients they need) and stroke. They improve your chances of staying well and living longer.

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

A. The Patient Protection and Affordable Care Act (PPACA), also known as health care reform, helps make health care and preventive care more affordable. PPACA requires health plans to cover the full cost of certain preventive medications and over-the-counter (OTC) products. This means you don't have to pay anything – not even a copay, coinsurance or deductible for these products.

To see a list of \$0 medications, go to **Cigna.com/PDL** and click on the dropdown next to "Drug Lists for Employer Plans." Under the Preventive Drug Lists section, click on the link for the PPACA No Cost-Share Preventive Drug List.

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

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

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

A. When you and your doctor are thinking about the right medication for your treatment, knowing how much it costs, what lower-cost options are available, and which pharmacies have 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. You should think about 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). Ask your doctor if one of these options may work for you.

Q. What's a generic medication?

A. A generic is the same as its brand-name version. It has the same active ingredient, strength and dosage form, treats the same condition(s), and works in the same way – and typically costs less.³ Generics are typically sold under their chemical or scientific name, instead of the 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 the brand-name medication.³

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

A. The generic and brand-name medication may³:

- Look different. For example, generics may have a different shape, size or color than their brand-name versions.
- Have a different flavor and/or different preservatives, come in different packaging and/or with different labeling and may expire at different times.

It's important to know that these differences don't affect how the generic works.

Information about this drug list

Frequently asked questions (FAQs) (cont.)

Q. What is a "biosimilar" medication?

A. A biosimilar is "highly similar" to its original biologic medication, which is also known as a reference product, that the FDA has already approved. Even though biosimilars aren't identical to the original medication, they're used to treat the same conditions, and provide the same clinical outcomes and treatment benefits. There are no clinical differences in how safe they are to use and how well they work. They also typically cost less.⁴

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 list.

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.⁵ 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.⁵

Fill maintenance medications through Express Scripts Pharmacy

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

- Easily order, manage, track and pay for your medications on your phone or online.
- Get standard shipping at no extra cost.⁶
- Fill up to a 90-day supply at one time.
- Talk with a pharmacist, 24/7.
- Sign up for automatic refills or refill reminders so you don't miss a dose.⁷
- Use a payment plan (if you need it).

Here are two easy ways to get started:

1. **Online.** Log in to the myCigna App or **myCigna.com** and click on the Prescriptions tab. Choose My Medications from the dropdown list. Then click the button next to your medication name to move your prescription(s) from your retail pharmacy to home delivery. Or,
2. **By phone.**
 - Call your doctor's office. Ask them to send a 90-day prescription (with refills) to Express Scripts home delivery. Or,
 - Call Express Scripts Pharmacy at **800.835.3784**. They'll contact your doctor's office to get your prescription. Have your ID card, doctor's contact information and medication name(s) ready when you call.

Fill specialty medications through Accredo Specialty Pharmacy

If you're using a specialty medication, Accredo's team can help you manage your rare and/or complex medical condition. They'll also fill and ship your specialty medication to you, so you don't have to stand in line at the pharmacy. To learn more, go to **Cigna.com/specialty**.

- Talk with specially-trained pharmacists and nurses, 24/7.

Information about this drug list

Frequently asked questions (FAQs) (cont.)

- Get fast shipping at no extra cost.⁶
- Sign up for refills and reminders. Some refills can be done by text.⁸
- Get help paying for your medication (if you need it).
- Manage and track your medications online.

To get started, call **877.826.7657**, Monday–Friday, 7:00 am–10:00 pm CST and Saturdays, 7:00 am–4:00 pm CST.

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 them 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; they have access to most specialty medications.⁵ Call Accredo at **877.826.7657**, Monday–Friday, 7:00 am–10:00 pm CST or Saturdays, 7:00 am–4:00 pm CST, for more information.

Q. How do I fill my prescription?

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

1. **Send it electronically** to the in-network retail pharmacy of your choice, Express Scripts home delivery or Accredo. Or

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

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

A. Managing a rare and/or complex medical condition isn't easy. Accredo's team of specialty-trained pharmacists and nurses can help. They'll also fill and ship your specialty medication to you, so you don't have to stand in line at the pharmacy.

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

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

A. Use the online tools and resources on the myCigna App or **myCigna.com**. You can find out how much your medication costs (and what lower-cost options may be available), 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 home delivery orders.

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

A. We put covered medications into tiers (or cost-share levels). Typically, the higher the tier, the higher the price you'll pay for the medication. 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, Tier 4 and Tier 5 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.

Information about this drug list

Frequently asked questions (FAQs) (cont.)

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. Log in to the myCigna App or **myCigna.com**, or check your plan materials, to learn more about how your plan covers your medication.

- Medications that you fill at the pharmacy and take yourself are typically covered under the pharmacy benefit.
- Medications that are injected or infused and are given to you at a doctor's office, hospital, an infusion center or at home are typically covered under the medical benefit.

Why this matters: Which benefit the medication's covered under may affect how much it costs, if it needs approval from Cigna Healthcare before your plan will cover it and/or if you have to fill it through a certain pharmacy to be covered. Check your medical summary of benefits coverage to learn more about how your plan covers your medication.

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

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

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

- **For plans with a combined deductible [including Health Reimbursements Accounts (HRAs) with a combined deductible]:** You'll pay your plan deductible first. After that, these medications will be covered at 100%, or no cost-share (\$0) to you.
- **For plans with a split deductible [including Health Reimbursements Accounts (HRAs) with a split deductible]:** These medications will be covered at 100%, or no cost-share (\$0) to you.

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

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

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

Information about this drug list

Frequently asked questions (FAQs) (cont.)

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

Words you may need to know

- **Brand name drug:** A drug that is marketed under a proprietary, trademark-protected name. A brand name drug is listed in this formulary in all CAPITAL letters.
- **Coinsurance:** A percentage of the cost of a covered health care benefit that you pay after you have paid the deductible, if a deductible applies to the health care benefit.
- **Copayment:** A fixed dollar amount that you pay for a covered health care benefit after you have paid the deductible, if a deductible applies to the health care benefit.
- **Deductible:** The amount you pay for covered health care benefits that are subject to the deductible before your health insurer begins to pay. If your health insurance policy has a deductible, it may have either one deductible or separate deductibles for medical benefits and prescription drug benefits. After you pay your deductible, you usually pay only a copayment or coinsurance for covered health care benefits. Your insurance company pays the rest.
- **Drug tier:** A group of prescription drugs that correspond to a specified cost sharing tier in your health insurance policy. The drug tier in which a prescription drug is placed determines your portion of the cost for the drug.
- **Exception request:** A request for coverage of a non-formulary drug. If you, your designee, or your prescribing health care provider submits a request for coverage of a non-formulary drug, your insurer must cover the non-formulary drug when it is medically necessary for you to take the drug.
- **Exigent circumstances:** When you are suffering from a medical condition that may seriously jeopardize your life, health, or ability to regain maximum function, or when you are undergoing a current course of treatment using a non-formulary drug.
- **Formulary or prescription drug list:** The list of drugs that is covered by your health insurance policy under the prescription drug benefit of the policy.
- **Generic drug:** A drug that is the same as its brand name drug equivalent in dosage, strength, effect, how it is taken, quality, safety, and intended use. A generic drug is listed in this formulary in italicized lowercase letters.
- **Medically Necessary:** Health care benefits needed to diagnose, treat, or prevent a medical condition or its symptoms and that meet accepted standards of medicine. Health insurance usually does not cover health care benefits that are not medically necessary.

Information about this drug list

Words you may need to know (cont.)

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

Information about this drug list

About this drug list

This is a list of the most commonly prescribed medications covered on the Cigna Healthcare National Preferred 5-Tier Prescription Drug List as of January 1, 2026. **The drug list is updated often**; so, not all of the medications your plan covers may be listed here. Also, your plan may not cover all of these medications. Log in to the myCigna App or **myCigna.com** to see which 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

We put covered medications into tiers (or cost-share levels). Typically, the higher the tier, the higher the price you'll pay for the medication.

Tier 1	Preferred Generics. These medications are covered at your plan's lowest cost-share. Generics work in the same way and provide the same clinical benefits as their brand-name versions – and typically cost much less. ³	\$
Tier 2	Non-Preferred Generics. These medications may cost more than preferred generics. ³	\$\$
Tier 3	Preferred Brands. These medications typically have one or more lower-cost generic that treats the same condition.	\$\$\$
Tier 4	Non-Preferred Brands. These medications typically have a generic and/or preferred brand alternative(s) that treats the same condition.	\$\$\$\$
Tier 5	Brand Specialty. These medications are covered at your plan's highest cost-share. Generic specialty medications are covered on a lower tier.	\$\$\$\$\$

* 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) in the Notes column

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

PA	Prior Authorization* – This medication needs approval from Cigna Healthcare before your plan will cover it. Your doctor's office will have to send us information to review to make sure you meet the medication's coverage rules (requirements).
QL	Quantity Limit* – Your plan will only cover so much of this medication at one time. If your doctor wants you to fill more than what's allowed, your doctor's office can ask us to cover more.
ST	Step Therapy* – This is a high-cost medication that has a lower-cost alternative(s) that treats the same condition. Your plan won't cover this medication until you try at least one preferred medication first (typically a generic or preferred brand) and can show that it didn't work for you. If your doctor feels a preferred medication isn't right for you, your doctor's office can ask us to cover the higher-cost 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 use the medication, your doctor's office can ask us to cover it.
SP	This is a specialty medication , which is used to treat a rare and/or complex medical condition. Some plans have extra coverage rules (requirements) for specialty medications. For example, some may only cover up to a 30-day supply and/or require you to fill it at a preferred specialty pharmacy to be covered.
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 you have to switch to home delivery.
PPACA	Health care reform under the Patient Protection and Affordable Care Act (PPACA) requires plans to cover the full cost of this preventive medication or product. This means you don't have to pay anything – not even a copay, coinsurance or deductible.
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.

* Not all plans have extra coverage rules (requirements) on medications. Log in to the myCigna App or myCigna.com, or check your plan materials, to see if yours does.

Information about this drug list

How to read this drug list (cont.)

Use the table below to understand how medications are covered on the Cigna Healthcare National Preferred 5-Tier Prescription Drug List.*

ANALGESICS (Pain Relief and Inflammatory Disease)			Therapeutic drug category and class describes the condition the medication is used to treat.
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits	Coverage requirements and limits lets you know if your plan has extra requirements before it will cover the medication.
ANALGESIC, NON-SALICYLATE AND BARBITURATE COMBINAT			
<i>butorbital/acetaminophen</i>	T1		
ANALGESIC, SALICYLATE, BARBITURATE, XANTHINE COMB.			
<i>butorbital-aspirin-caffe 50-325-40</i>	T1	QL (6 tabs/day)	
<i>butorbital-asa-caffeine cap</i> (Fiorinal)	T1	QL (6 caps/day)	
FIORINAL (<i>butorbital-aspirin-caffeine</i>)	T3	QL (6 caps/day)	
ANALGESIC, NON-SALICYLATE, BARBITURATE, XANTHINE COMB.			
<i>butorbital/acetaminophen/caffeine</i>	T3		
<i>butorbital/acetaminophen/caffeine</i> (Esgic)	T3	QL (6 caps/day)	
<i>butorbital-acetamin-caff 50-300-40</i> (Fioricet)	T1	QL (6 caps/day)	
<i>butorbital-acetamin-caff 50-325-40</i> (Esgic)	T1	QL (6 tabs/day)	
ESGIC 50-325-40 MG TABLET (<i>butorbital-acetaminophen-caffe</i>)	T3	QL (6 tabs/day)	
ESGIC CAPSULE (<i>zebutorbital</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)	

*This table is just an example. It may not show how these medications are currently covered on this drug list.

Information about this drug list

How to find your medication

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

Condition	Page	Condition	Page
Analgesics (Pain Relief and Inflammatory Disease)	19-24	Anti-Infectives/Miscellaneous (Infections)	52, 53
Analgesics (Urinary Tract Conditions)	24	Anti-Infectives/Miscellaneous (Miscellaneous)	53, 54
Anesthetics (Miscellaneous)	24, 25	Anti-Infectives/Miscellaneous (Skin Conditions)	54
Anesthetics (Pain Relief and Inflammatory Disease)	25	Anti-Inflammatory Tumor Necrosis Factor Inhibiting Agents (Pain Relief and Inflammatory Disease)	54
Anesthetics (Urinary Tract Conditions)	25	Anti-Neoplastics (Cancer)	54-62
Anti-Allergy (Allergy and Nasal Sprays)	26	Anti-Neoplastics (Skin Conditions)	62
Anti-Arthritics (Pain Relief and Inflammatory Disease)	26-29	Anti-Obesity Drugs (Weight Management)	62, 63
Anti-Asthmatics (Asthma/COPD/Respiratory)	29-32	Anti-Parasitics (Eye Conditions)	64
Antibiotics (Ear Medications)	33	Anti-Parasitics (Infections)	64
Antibiotics (Eye Conditions)	33, 34	Anti-Parkinson's Drugs (Parkinson's Disease)	64, 65
Antibiotics (Infections)	34-40	Anti-Platelet Drugs (Blood Thinners/Anti-Clotting)	65
Antibiotics (Skin Conditions)	41, 42	Antivirals (AIDS/HIV)	66-68
Anti-Coagulants (Blood Thinners/Anti-Clotting)	42-44	Antivirals (Eye Conditions)	68
Antidotes (Gastrointestinal/Heartburn)	44	Antivirals (Infections)	69, 70
Antidotes (Substance Abuse)	44	Antivirals (Skin Conditions)	70, 71
Anti-Fungals (Eye Conditions)	44	Autonomic Drugs (Allergy/Nasal Sprays)	71
Anti-Fungals (Feminine Products)	44	Autonomic Drugs (Alzheimer's Disease)	71
Anti-Fungals (Infections)	44, 45	Autonomic Drugs (Attention Deficit Hyperactivity Disorder)	72
Anti-Fungals (Skin Conditions)	46, 47	Autonomic Drugs (Blood Pressure/Heart Medications)	72
Antihistamine and Decongestant Combination (Allergy/Nasal Sprays)	47	Autonomic Drugs (Urinary Tract Conditions)	72, 73
Antihistamines (Allergy/Nasal Sprays)	47	Biologicals (Allergy/Nasal Sprays)	73
Antihistamines (Eye Conditions)	48	Biologicals (Blood Pressure/Heart Medications)	73
Anti-Hyperglycemics (Diabetes)	48-52	Biologicals (Miscellaneous)	73
Anti-Infectives (Feminine Products)	52	Biologicals (Vaccines)	73-76
Anti-Infectives/Miscellaneous (Feminine Products)	52	Blood (Blood Modifiers/Bleeding Disorders)	76-78
		Blood (Blood Thinners/Anti-Clotting)	78

Information about this drug list

How to find your medication (cont.)

Condition	Page	Condition	Page
Cardiac Drugs (Blood Pressure/Heart Medications)	78-80	Gastrointestinal (Pain Relief and Inflammatory Disease)	124
Cardiovascular (Asthma/COPD/Respiratory)	80, 81	Hormones (Gastrointestinal/Heartburn)	125
Cardiovascular (Blood Pressure/Heart Medications)	81-85	Hormones (Hormonal Agents)	125-129
Cardiovascular (Cholesterol Medications)	86, 87	Hormones (Infertility)	129, 130
CNS Drugs (Alzheimer's Disease)	88	Hormones (Miscellaneous)	130
CNS Drugs (Miscellaneous)	88, 89	Hormones (Osteoporosis Products)	130
CNS Drugs (Multiple Sclerosis)	89, 90	Immunosuppressants (Pain Relief and Inflammatory Disease)	130, 131
CNS Drugs (Pain Relief and Inflammatory Disease)	90	Immunosuppressants (Skin Conditions)	131
CNS Drugs (Seizure Disorders)	90-94	Immunosuppressants (Transplant Medications)	132
CNS Drugs (Sleep Disorders/Sedatives)	94	Miscellaneous Medical Supplies, Devices, Non-Drug (Diabetes)	133-154
Colony Stimulating Factors (Blood Modifiers/Bleeding Disorders)	94	Miscellaneous Medical Supplies, Devices, Non-Drug (Miscellaneous)	154-163
Colony Stimulating Factors (Cancer)	94	Muscle Relaxants (Pain Relief and Inflammatory Disease)	163, 164
Contraceptives (Contraception Products)	95, 96	Prenatal Vitamins (Nutritional/Dietary)	165-169
Cough/Cold Preparations (Allergy/Nasal Sprays)	96	Psychotherapeutic Drugs (Anxiety/Depression/Bipolar Disorder)	169-173
Cough/Cold Preparations (Cough/Cold Medications)	96, 97	Psychotherapeutic Drugs (Attention Deficit Hyperactivity Disorder)	173, 174
Diagnostic (Diabetes)	97, 98	Psychotherapeutic Drugs (Miscellaneous)	174
Diagnostic (Miscellaneous)	98-100	Psychotherapeutic Drugs (Schizophrenia/Anti-Psychotics)	175, 176
Diuretics (Diuretics)	100-102	Psychotherapeutic Drugs (Seizure Disorders)	177
EENT Preps (Allergy/Nasal Sprays)	102, 103	Psychotherapeutic Drugs (Sleep Disorders/Sedatives)	177
EENT Preps (Ear Medications)	103	Sedative/Hypnotics (Sleep Disorders/Sedatives)	177, 178
EENT Preps (Eye Conditions)	103-108	Skin Preps (Miscellaneous)	178-180
Elect/Caloric/H2O (Cholesterol Medications)	108	Skin Preps (Pain Relief and Inflammatory Disease)	180
Elect/Caloric/H2O (Dental Products)	108, 109	Skin Preps (Skin Conditions)	180-190
Elect/Caloric/H2O (Diabetes)	109, 110	Smoking Deterrents (Smoking Cessation)	190
Elect/Caloric/H2O (Miscellaneous)	110	Thyroid Prep (Hormonal Agents)	190, 191
Elect/Caloric/H2O (Nutritional/Dietary)	110-117	Unclassified Drug Products (AIDS/HIV)	191
Elect/Caloric/H2O (Urinary Tract Conditions)	117		
Gastrointestinal (Cholesterol Medications)	118		
Gastrointestinal (Gastrointestinal/Heartburn)	118-124		

Information about this drug list

How to find your medication (cont.)

Condition	Page	Condition	Page
Unclassified Drug Products (Asthma/COPD/Respiratory)	191, 192	Unclassified Drug Products (Osteoporosis Products)	199
Unclassified Drug Products (Blood Modifiers/Bleeding Disorders)	192	Unclassified Drug Products (Pain Relief and Inflammatory Disease)	200
Unclassified Drug Products (Blood Pressure/Heart Medications)	192	Unclassified Drug Products (Seizure Disorders)	200
Unclassified Drug Products (Cancer)	192	Unclassified Drug Products (Skin Conditions)	200
Unclassified Drug Products (Dental Products)	192, 193	Unclassified Drug Products (Substance Abuse)	200
Unclassified Drug Products (Erectile Dysfunction)	193, 194	Unclassified Drug Products (Transplant Medications)	201
Unclassified Drug Products (Eye Conditions)	194	Unclassified Drug Products (Urinary Tract Conditions)	201, 202
Unclassified Drug Products (Gastrointestinal/Heartburn)	194	Unclassified Drug Products (Weight Management)	202
Unclassified Drug Products (Hormonal Agents)	195	Vitamins (Nutritional/Dietary)	202-245
Unclassified Drug Products (Miscellaneous)	195-198	Vitamins (Vitamins)	245
Unclassified Drug Products (Nutritional/Dietary)	199		

List of Prescription Medications

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

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

T5 – Brand Specialty
PA – Prior Authorization
QL – Quantity Limit

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

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

List of Prescription Medications

ANALGESICS (Pain Relief And Inflammatory Disease) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ANTIMIGRAINE PREPARATIONS (cont.)		
MIGRANAL (<i>dihydroergotamine mesylate</i>)	T4	ST QL (8 mls/fill)
<i>naratriptan hcl</i> (Amerge)	T2	QL (9 tabs/fill)
NURTEC ODT	T3	PA QL (16 tabs/fill)
QULIPTA	T3	PA QL (30 tabs/30 days)
REYVOW	T4	PA QL (8 tabs/fill)
<i>rizatriptan benzoate</i> (Maxalt)	T2	QL (18 tabs/fill)
<i>sumatriptan</i>	T2	QL (6 units/30 days)
<i>sumatriptan 4 mg/0.5 ml inject</i> (Imitrex)	T2	QL (2 pens/fill)
<i>sumatriptan 6 mg/0.5 ml cart</i> (Imitrex)	T2	QL (1 ml/fill)
<i>sumatriptan 6 mg/0.5 ml inject</i> (Imitrex)	T2	QL (2 pens/fill)
<i>sumatriptan 6 mg/0.5 ml vial</i>	T2	QL (2 vials/fill)
TOSYMRA	T4	ST QL (6 units/fill)
UBRELVY	T3	PA QL (10 tabs/fill)
ZEMBRACE SYMTOUCH	T4	ST QL (4 pens/fill)
<i>zolmitriptan</i>	T2	QL (6 tabs/30 days)
<i>zolmitriptan 2.5 mg tablet</i> (Zomig)	T2	QL (6 tabs/fill)
<i>zolmitriptan 5 mg nasal spray</i> (Zomig)	T2	ST QL (6 units/fill)
<i>zolmitriptan 5 mg tablet</i> (Zomig)	T2	QL (6 tabs/fill)
ZOMIG 2.5 MG NASAL SPRAY	T3	ST QL (6 units/30 days)
ZOMIG 5 MG NASAL SPRAY (<i>zolmitriptan</i>)	T4	ST QL (6 units/fill)
ZOLMITRIPTAN 2.5 MG NASAL SPRAY	T4	ST QL (6 units/30 days)
NASAL NSAIDS, COX NON-SELECTIVE, SYSTEMIC ANALGESIC		
SPRIX	T4	ST QL (5 units/fill)
NSAIDS, CYCLOOXYGENASE INHIBITOR - TYPE ANALGESICS		
<i>diclofenac pot 25mg tablet</i>	T2	ST HD
<i>diclofenac pot 50 mg tablet</i>	T2	HD
<i>diclofenac pot 50 mg powdr pkt</i>	T2	HD
<i>diclofenac potassium</i>	T2	ST HD
<i>diclofenac potassium 25 mg cap</i> (Zipsor)	T2	ST HD
<i>ketorolac 15 mg/ml syr</i>	T2	
<i>ketorolac 10 mg tablet</i>	T2	QL (20 tabs/fill)
<i>ketorolac 15 mg/ml carpupject, syr, syringe</i>	T2	HD
<i>ketorolac 15 mg/ml vial</i>	T2	

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

T5 – Brand Specialty
PA – Prior Authorization
QL – Quantity Limit

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

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

List of Prescription Medications

ANALGESICS (Pain Relief And Inflammatory Disease) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
NSAIDS, CYCLOOXYGENASE INHIBITOR - TYPE ANALGESICS (cont.)		
<i>ketorolac 30 mg/ml syr</i>	T2	HD
<i>ketorolac 30 mg/ml syringe</i>	T2	
<i>ketorolac 30 mg/ml vial</i>	T2	
<i>ketorolac 300 mg/10 ml vial</i>	T2	
<i>ketorolac 60 mg/2 ml syringe</i>	T2	
<i>ketorolac 60 mg/2 ml vial</i>	T2	
<i>mefenamic acid</i>	T2	HD
OPIOID ANALGESIC AND NON-SALICYLATE ANALGESICS		
<i>acetaminophen with codeine</i>	T2	PA QL
<i>hydrocodone-acetamin 2.5-325</i>	T2	PA QL (12 ds/60 days)
<i>hydrocodone-acetamin 10-300 mg</i>	T2	PA QL
<i>hydrocodone-acetamin 10-325 mg</i>	T2	PA QL
<i>hydrocodone-acetamin 10-300/15 (Lortab)</i>	T2	PA QL (12 ds/60 days)
<i>hydrocodone-acetamin 10-325/15</i>	T2	PA QL
HYDROCODONE-ACETAMIN 2.5-108/5	T4	PA QL
HYDROCODONE-ACETAMIN 5-217/10	T4	PA QL
<i>hydrocodone-acetamin 5-300 mg</i>	T2	PA QL
<i>hydrocodone-acetamin 5-325 mg</i>	T2	PA QL
<i>hydrocodone-acetamin 7.5-300</i>	T2	PA QL
<i>hydrocodone-acetamin 7.5-325/15</i>	T2	PA QL
HYDROCODONE-ACETAMIN 7.5-325/15	T4	PA QL
LORTAB (<i>hydrocodone/acetaminophen</i>)	T4	PA QL (12 ds/60 days)
NALOCET	T4	PA QL
<i>oxycodone hcl/acetaminophen</i>	T2	PA QL
<i>tramadol hcl/acetaminophen</i>	T2	PA QL (12 ds/60 days)
OPIOID ANALGESIC AND NSAID COMBINATION		
<i>hydrocodone/ibuprofen</i>	T2	PA QL
OPIOID ANALGESIC, NON-SALICYLATE, XANTHINE COMB		
<i>acetaminophen/caff/dihydrocod</i>	T2	PA QL
TREZIX	T4	PA QL
OPIOID ANALGESICS		
ABSTRAL	T4	PA QL
ACTIQ (<i>fentanyl citrate</i>)	T4	PA QL

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

T5 – Brand Specialty
PA – Prior Authorization
QL – Quantity Limit

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

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

List of Prescription Medications

ANALGESICS (Pain Relief And Inflammatory Disease) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
OPIOID ANALGESICS (cont.)		
BELBUCA	T3	PA QL (60 films/30 days)
buprenorphine (Butrans)	T2	PA
butorphanol tartrate	T2	PA QL (12 ds/180 days)
codeine sulfate	T2	PA QL
DILAUDID (hydromorphone hcl)	T4	PA QL
fentanyl	T2	PA QL (15 patches/30 days)
fentanyl cit otfc 1,200 mcg	T2	PA QL (90 lozs/30 days)
fentanyl cit otfc 1,600 mcg (Actiq)	T2	PA QL
FENTANYL CIT 400 MCG BUCCAL TB	T4	PA QL (90 tabs/30 days)
FENTANYL CIT 600 MCG BUCCAL TB	T4	PA QL (90 tabs/30 days)
FENTANYL CIT 800 MCG BUCCAL TB	T4	PA QL (90 tabs/30 days)
fentanyl citrate otfc 200 mcg	T2	PA QL (90 lozs/30 days)
fentanyl citrate otfc 400 mcg	T2	PA QL (90 lozs/30 days)
fentanyl citrate otfc 800 mcg	T2	PA QL (90 lozs/30 days)
hydrocodone er 10 mg capsule	T2	PA QL (90 caps/30 days)
hydrocodone er 15 mg capsule	T2	PA QL (90 caps/30 days)
hydrocodone er 20 mg capsule	T2	PA QL (90 caps/30 days)
hydrocodone er 30 mg capsule	T2	PA QL (90 caps/30 days)
hydrocodone er 40 mg capsule	T2	PA QL (90 caps/30 days)
hydrocodone er 50 mg capsule	T2	PA QL (90 caps/30 days)
hydrocodone er 20 mg tablet (Hysingla Er)	T2	PA QL (60 tabs/30 days)
hydrocodone er 30 mg tablet (Hysingla Er)	T2	PA QL (60 tabs/30 days)
hydrocodone er 40 mg tablet (Hysingla Er)	T2	PA QL (60 tabs/30 days)
hydrocodone er 60 mg tablet (Hysingla Er)	T2	PA QL (60 tabs/30 days)
hydrocodone er 80 mg tablet (Hysingla Er)	T2	PA QL (60 tabs/30 days)
hydrocodone er 100 mg tablet (Hysingla Er)	T2	PA QL (60 tabs/30 days)
hydrocodone er 120 mg tablet	T2	PA QL (60 tabs/30 days)
hydromorphone hcl	T2	PA QL (60 tabs/30 days)
hydromorphone hcl (Dilaudid)	T2	PA QL
HYSINGLA ER (hydrocodone bitartrate)	T3	PA QL (60 tabs/30 days)
KADIAN	T4	ST QL (90 caps/30 days)
KADIAN (morphine sulfate)	T4	ST QL (90 caps/30 days)
LAZANDA 100 MCG NASAL SPRAY	T4	PA QL (23 units/30 days)

T1 – Preferred Generics

T2 – Non-Preferred Generics

T3 – Preferred Brands

T4 – Non-Preferred Brands

T5 – Brand Specialty

PA – Prior Authorization

QL – Quantity Limit

ST – Step Therapy

AGE – Age Requirement

SP – Specialty Medication

HD – May require home delivery pharmacy

PPACA – No Cost-Share Preventive Medication

CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

ANALGESICS (Pain Relief And Inflammatory Disease) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
OPIOID ANALGESICS (cont.)		
LAZANDA 400 MCG NASAL SPRAY	T4	PA QL (23 units/30 days)
methadone hcl	T1	
methadone hcl	T2	
morphine sulfate	T2	
morphine sulf er 15 mg tablet (Ms Contin)	T2	PA QL (120 tabs/30 days)
morphine sulf er 30 mg tablet (Ms Contin)	T2	PA QL (120 tabs/30 days)
morphine sulf er 60 mg tablet (Ms Contin)	T2	PA QL (120 tabs/30 days)
morphine sulf er 100 mg tablet (Ms Contin)	T2	PA QL (120 tabs/30 days)
morphine sulf er 200 mg tablet (Ms Contin)	T2	PA QL (120 tabs/30 days)
morphine sulfate er 10 mg cap (Kadian)	T2	ST QL (90 caps/30 days)
morphine sulfate er 50 mg cap (Kadian)	T2	ST QL (90 caps/30 days)
morphine sulfate er 60 mg cap (Kadian)	T2	ST QL (90 caps/30 days)
morphine sulfate er 80 mg cap (Kadian)	T2	ST QL (90 caps/30 days)
morphine sulfate er 100 mg cap (Kadian)	T2	ST QL (90 caps/30 days)
morphine sulfate er 10 mg cap	T2	PA QL (90 caps/30 days)
morphine sulfate er 20 mg cap	T2	PA QL (90 caps/30 days)
morphine sulfate er 30 mg cap	T2	PA QL (60 caps/30 days)
morphine sulfate er 30 mg cap	T2	PA QL (90 caps/30 days)
morphine sulfate er 45 mg cap	T2	PA QL (60 caps/30 days)
morphine sulfate er 50 mg cap	T2	PA QL (90 caps/30 days)
morphine sulfate er 60 mg cap	T2	PA QL (60 caps/30 days)
morphine sulfate er 60 mg cap	T2	PA QL (90 caps/30 days)
morphine sulfate er 75 mg cap	T2	PA QL (60 caps/30 days)
morphine sulfate er 80 mg cap	T2	PA QL (90 caps/30 days)
morphine sulfate er 90 mg cap	T2	PA QL (60 caps/30 days)
morphine sulfate er 100 mg cap	T2	PA QL (90 caps/30 days)
morphine sulfate er 120 mg cap	T2	PA QL (60 caps/30 days)
MS CONTIN (morphine sulfate)	T4	ST QL (120 tabs/30 days)
opium/belladonna alkaloids	T2	PA QL
oxycodone hcl (ir) 10 mg tab	T2	PA QL (12 ds/60 days)
oxycodone hcl (ir) 15 mg tab (Roxicodone)	T2	PA QL (12 ds/60 days)
oxycodone hcl (ir) 20 mg tab	T2	PA QL (12 ds/60 days)
oxycodone hcl (ir) 30 mg tab (Roxicodone)	T2	PA QL (12 ds/60 days)
oxycodone hcl (ir) 5 mg cap	T2	PA QL (12 ds/60 days)

T1 – Preferred Generics

T2 – Non-Preferred Generics

T3 – Preferred Brands

T4 – Non-Preferred Brands

T5 – Brand Specialty

PA – Prior Authorization

QL – Quantity Limit

ST – Step Therapy

AGE – Age Requirement

SP – Specialty Medication

HD – May require home delivery pharmacy

PPACA – No Cost-Share Preventive Medication

CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

ANALGESICS (Pain Relief And Inflammatory Disease) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
OPIOID ANALGESICS (cont.)		
<i>oxycodone hcl (ir) 5 mg tablet (Roxicodone)</i>	T2	PA QL (12 ds/60 days)
<i>oxycodone hcl 100 mg/5 ml conc</i>	T2	PA QL (12 ds/60 days)
<i>oxycodone hcl 5 mg/5 ml cup</i>	T2	PA QL (12 ds/60 days)
<i>oxycodone hcl 5 mg/5 ml soln</i>	T2	PA QL (12 ds/60 days)
OXYCONTIN	T4	PA QL (90 tabs/30 days)
<i>oxymorphone hcl</i>	T2	PA QL (90 tabs/30 days)
<i>pentazocine hcl/naloxone hcl</i>	T2	PA QL
ROXICODONE (<i>oxycodone hcl</i>)	T4	PA QL
SUBSYS	T4	PA QL (90 units/30 days)
<i>tramadol hcl 100 mg tablet</i>	T2	PA QL (12 ds/60 days)
<i>tramadol er 100 mg tablet</i>	T2	PA QL (30 tabs/30 days)
<i>tramadol er 200 mg tablet</i>	T2	PA QL (30 tabs/30 days)
<i>tramadol er 300 mg tablet</i>	T2	PA QL (30 tabs/30 days)
<i>tramadol hcl 50 mg tablet</i>	T2	PA QL (240 tabs/fill)
<i>tramadol hcl 50 mg tablet</i>	T2	PA QL
<i>tramadol hcl er 100 mg tablet</i>	T2	PA QL (30 tabs/30 days)
<i>tramadol hcl er 200 mg tablet</i>	T2	PA QL (30 tabs/30 days)
<i>tramadol hcl er 300 mg tablet</i>	T2	PA QL (30 tabs/30 days)
OPIOID AND SALICYLATE ANALGESICS, BARBIT, XANTHINE		
<i>codeine/butalbital/asa/cafein</i>	T2	PA QL
OPIOID, NON-SALICYL ANALGESIC, BARBITURATE, XANTHINE		
<i>butalbital/acetamin/caff/codeine</i>	T2	
<i>butalbital/acetamin/caff/codeine (Fioricet With Codeine)</i>	T2	PA QL
FIORICET WITH CODEINE (<i>butalbital/acetamin/caff/codeine</i>)	T4	PA QL
SKELETAL MUSCLE RELAXANT, SALICYLATE, OPIOID ANALGESIC		
<i>carisoprodol/aspirin/codeine</i>	T2	PA QL
ANALGESICS (Urinary Tract Conditions)		
URINARY TRACT ANALGESIC AGENTS		
ELMIRON	T3	
RIMSO-50	T4	
ANESTHETICS (Miscellaneous)		
GENERAL ANESTHETICS, INHALANT		
<i>desflurane</i>	T2	

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

T5 – Brand Specialty
PA – Prior Authorization
QL – Quantity Limit

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

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

List of Prescription Medications

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

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

T5 – Brand Specialty
PA – Prior Authorization
QL – Quantity Limit

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

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

List of Prescription Medications

ANTIALLERGY (Allergy/Nasal Sprays)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
MAST CELL STABILIZERS		
<i>cromolyn 100 mg/5 ml oral conc</i> (Gastrocrom)	T2	
GASTROCROM (<i>cromolyn sodium</i>)	T4	
ANTIARTHRITICS (Pain Relief And Inflammatory Disease)		
ANALGESIC/ANTIPYRETICS, SALICYLATES		
DISALCID (<i>salsalate</i>)	T4	HD
<i>salsalate</i> (Disalcid)	T2	HD
ANTI-ARTHRITIC AND CHELATING AGENTS		
DEPEN (<i>penicillamine</i>)	T5	PA SP
<i>penicillamine</i> (Cuprimine)	T2	PA SP
<i>penicillamine</i> (Depen)	T2	PA SP
ANTI-ARTHRITIC, FOLATE ANTAGONIST AGENTS		
RASUVO	T4	ST
ANTI-INFLAMMATORY, PYRIMIDINE SYNTHESIS INHIBITOR		
ARAVAL (<i>leflunomide</i>)	T4	QL (30 tabs/fill) HD
<i>leflunomide</i> (Arava)	T2	QL (30 tabs/fill) HD
ANTI-INFLAMMATORY, PHOSPHODIESTERASE-4(PDE4) INHIB.		
OTEZLA 10-20 MG STARTER 28 DAY	T5	PA QL (55 tabs/365 days) SP HD
OTEZLA 10-20-30MG START 28 DAY	T5	PA QL (55 tabs/365 days) SP HD
OTEZLA 20 MG TABLET	T5	PA QL (60 tabs/30 days) SP HD
OTEZLA 30 MG TABLET	T5	PA QL (60 tabs/30 days) SP HD
OTEZLA XR	T5	PA SP HD
COLCHICINE		
<i>colchicine 0.6 mg capsule</i> (Mitigare)	T2	ST
<i>colchicine 0.6 mg tablet</i> (Colcrys)	T2	HD
GLOPERBA	T4	HD
MITIGARE (<i>colchicine</i>)	T3	ST
GOLD SALTS		
RIDAURA	T3	
HYPERURICEMIA TX - XANTHINE OXIDASE INHIBITORS		
<i>allopurinol</i>	T1	HD
<i>allopurinol</i> (Zyloprim)	T1	HD
<i>febuxostat</i> (Uloric)	T2	ST HD
ZYLOPRIM (<i>allopurinol</i>)	T4	HD

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

T5 – Brand Specialty
PA – Prior Authorization
QL – Quantity Limit

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

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

List of Prescription Medications

ANTIARTHRITICS (Pain Relief And Inflammatory Disease) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
JANUS KINASE (JAK) INHIBITORS		
RINVOQ ER 15 MG TABLET	T5	PA QL (30 tabs/fill) SP HD
RINVOQ ER 30 MG TABLET	T5	PA QL (30 tabs/fill) SP HD
RINVOQ ER 45 MG TABLET	T5	PA QL (56 tabs/365 days) SP HD
RINVOQ LQ	T5	PA QL (360 mls/30 days) SP HD
XELJANZ 1 MG/ML SOLUTION	T5	PA QL (300 mls/fill) SP HD
XELJANZ 10 MG TABLET	T5	PA QL (60 tabs/fill) SP HD
XELJANZ 5 MG TABLET	T5	PA QL (60 tabs/fill) SP HD
XELJANZ XR	T5	PA QL (30 tabs/fill) SP HD
NSAID AND TOPICAL IRRITANT COUNTER-IRRITANT COMB.		
COMFORT PAC-IBUPROFEN	T4	
COMFORT PAC-MELOXICAM	T4	
COMFORT PAC-NAPROXEN	T4	
NSAIDS(COX NON-SPEC.INHIB)AND PROSTAGLANDIN ANALOG		
ARTHROTEC 50 (diclofenac sodium/misoprostol)	T4	ST HD
ARTHROTEC 75 (diclofenac sodium/misoprostol)	T4	ST HD
diclofenac sodium/misoprostol (Arthrotec 50)	T2	HD
diclofenac sodium/misoprostol (Arthrotec 75)	T2	HD
NSAIDS, CYCLOOXYGENASE INHIBITOR - TYPE ANALGESICS		
ANAPROX DS (naproxen sodium)	T4	ST HD
DAYPRO (oxaprozin)	T4	ST HD
diclofenac sod dr 25 mg, 50 mg, 75 mg tab	T2	HD
diclofenac sod ec 25 mg tab	T2	HD
diclofenac sod ec 50 mg tab	T2	HD
diclofenac sod ec 75 mg tab	T2	HD
diclofenac sodium	T2	HD
EC-NAPROSYN (naproxen)	T4	ST HD
ec-naproxen dr 375 mg tablet (Ec-Naprosyn)	T2	HD
ec-naproxen dr 500 mg tablet (Ec-Naprosyn)	T2	ST HD
etodolac	T2	HD
etodolac (Lodine)	T2	HD
FELDENE (piroxicam)	T4	ST HD
fenoprofen 400 mg capsule (Nalfon)	T2	ST HD
fenoprofen 600 mg tablet (Nalfon)	T2	ST HD

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

T5 – Brand Specialty
PA – Prior Authorization
QL – Quantity Limit

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

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

List of Prescription Medications

ANTIARTHRITICS (Pain Relief And Inflammatory Disease) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
NSAIDS, CYCLOOXYGENASE INHIBITOR - TYPE ANALGESICS (cont.)		
FENORTHO 200 MG CAPSULE	T4	ST HD
<i>flurbiprofen</i>	T2	HD
<i>ibuprofen</i>	T1	HD
<i>ibuprofen</i>	T2	HD
<i>indomethacin</i>	T2	HD
INDOMETHACIN 20 MG CAPSULE	T4	ST QL (90 caps/30 days) HD
<i>indomethacin 25 mg capsule</i>	T2	HD
<i>indomethacin 50 mg capsule</i>	T2	HD
<i>indomethacin 50 mg suppository (Indocin)</i>	T2	HD
<i>indomethacin 25 mg/5 ml susp (Indocin)</i>	T2	ST HD
<i>ketoprofen</i>	T2	ST HD
<i>ketoprofen 25 mg capsule</i>	T2	ST HD
<i>ketoprofen 50 mg capsule</i>	T2	HD
<i>ketoprofen 75 mg capsule</i>	T2	HD
<i>ketoprofen er 200 mg capsule</i>	T2	ST HD
LODINE (<i>etodolac</i>)	T4	ST HD
<i>meclofenamate sodium</i>	T2	HD
<i>meloxicam 10 mg capsule (Vivlodex)</i>	T2	ST QL (30 caps/fill) HD
<i>meloxicam 5 mg capsule (Vivlodex)</i>	T2	ST QL (30 caps/fill) HD
<i>meloxicam 7.5 mg tablet</i>	T1	QL (30 tabs/30 days) HD
<i>nabumetone (Relafen)</i>	T2	HD
NALFON 600 MG TABLET (<i>fenoprofen calcium</i>)	T4	ST HD
NAPRELAN	T4	ST HD
NAPRELAN (<i>naproxen sodium</i>)	T4	ST HD
NAPROSYN (<i>naproxen</i>)	T4	ST HD
<i>naproxen 125 mg/5 ml suspen (Naprosyn)</i>	T2	ST HD
<i>naproxen 250 mg tablet</i>	T1	HD
<i>naproxen 375 mg tablet</i>	T1	HD
<i>naproxen 500 mg kit (Naprosyn)</i>	T1	HD
<i>naproxen 500 mg tablet (Naprosyn)</i>	T1	HD
<i>naproxen dr 375 mg tablet (Ec-Naprosyn)</i>	T2	ST HD
<i>naproxen dr 500 mg tablet (Ec-Naprosyn)</i>	T2	ST HD
<i>naproxen sod er 750 mg tablet</i>	T2	ST HD
<i>naproxen sodium</i>	T2	HD

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

T5 – Brand Specialty
PA – Prior Authorization
QL – Quantity Limit

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

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

List of Prescription Medications

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

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
NSAIDS, CYCLOOXYGENASE INHIBITOR - TYPE ANALGESICS (cont.)		
<i>naproxen sodium</i> (Anaprox Ds)	T2	HD
<i>naproxen sodium</i> (Naprelan)	T2	ST HD
<i>oxaprozin 600 mg caplet, tablet</i> (Daypro)	T2	HD
<i>piroxicam</i>	T2	HD
<i>piroxicam</i> (Feldene)	T2	HD
RELAFEN (<i>nabumetone</i>)	T4	ST HD
<i>sulindac</i>	T1	HD
TIVORBEX	T4	ST QL (90 caps/30 days) HD
TOLECTIN 600 (<i>tolmetin sodium</i>)	T4	ST HD
<i>tolmetin sodium 200 mg tab</i>	T2	HD
<i>tolmetin sodium 400 mg cap</i>	T2	ST HD
<i>tolmetin sodium 600 mg tab</i> (Tolectin 600)	T2	ST HD

NSAIDS, CYCLOOXYGENASE-2 (COX-2) SELECTIVE INHIBITOR

<i>celecoxib</i> (Celebrex)	T2	ST HD
-----------------------------	----	-------

URICOSURIC AGENTS

<i>probenecid</i>	T2	HD
<i>probenecid/colchicine</i>	T2	HD

ANTIASTHMATICS (Asthma/COPD/Respiratory)

ANTICHOLINERGICS, ORALLY INHALED LONG ACTING

INCRUSE ELLIPTA	T3	QL (1 inhaler/30 days) HD
LONHALA MAGNAIR REFILL	T4	QL (60 mls/fill) HD
LONHALA MAGNAIR STARTER	T4	QL (60 mls/fill) HD
SPIRIVA HANDIHALER 18 MCG CAP (<i>tiotropium bromide</i>)	T4	QL (90 caps/30 days) HD
SPIRIVA RESPIMAT	T3	QL (1 inhaler/fill) HD
YUPELRI	T3	QL (30 vls/fill) HD

ANTICHOLINERGICS, ORALLY INHALED SHORT ACTING

ATROVENT HFA	T4	QL (2 inhalers/fill) HD
<i>ipratropium br 0.02% soln</i>	T2	HD

BETA-ADRENERGIC AGENTS

<i>albuterol 2 mg/5 ml syrup cup</i>	T2	HD
<i>albuterol 8 mg/20 ml syrup cup</i>	T2	HD
<i>albuterol sulf 2 mg/5 ml syrup</i>	T2	HD
<i>albuterol sulfate 2 mg tab</i>	T2	HD

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

T5 – Brand Specialty
PA – Prior Authorization
QL – Quantity Limit

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

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

List of Prescription Medications

ANTIASTHMATICS (Asthma/COPD/Respiratory) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
BETA-ADRENERGIC AGENTS (cont.)		
<i>albuterol sulfate 4 mg tab</i>	T2	HD
<i>albuterol sulfate er 4 mg tab</i>	T2	HD
<i>albuterol sulfate er 8 mg tab</i>	T2	HD
<i>metaproterenol sulfate</i>	T2	HD
<i>terbutaline sulfate</i>	T2	HD
BETA-ADRENERGIC AGENTS, INHALED, SHORT ACTING		
<i>albuterol 100 mg/20 ml soln</i>	T2	
<i>albuterol 2.5 mg/0.5 ml sol</i>	T2	
<i>albuterol 5 mg/ml solution</i>	T2	
<i>albuterol 15 mg/3 ml solution</i>	T2	
<i>albuterol 75 mg/15 ml soln</i>	T2	
<i>albuterol hfa 90 mcg inhaler</i>	T2	QL (2 inhalers/30 days)
<i>albuterol sul 0.63 mg/3 ml sol</i>	T2	
<i>albuterol sul 1.25 mg/3 ml sol</i>	T2	
<i>albuterol sul 2.5 mg/3 ml soln</i>	T2	
<i>levalbuterol hcl (Xopenex Concentrate)</i>	T2	
<i>levalbuterol hcl (Xopenex)</i>	T2	
XOPENEX (<i>levalbuterol hcl</i>)	T4	
XOPENEX CONCENTRATE (<i>levalbuterol hcl</i>)	T4	
BETA-ADRENERGIC AGENTS, INHALED, ULTRA-LONG ACTING		
STRIVERDI RESPIMAT	T3	QL (1 inhaler/30 days) HD
BETA-ADRENERGIC AGENTS, ORALLY INHALED, LONG ACTING		
<i>arformoterol tartrate (Brovana)</i>	T2	QL (120 mls/fill) HD
BROVANA (<i>arformoterol tartrate</i>)	T4	QL (120 mls/fill) HD
<i>formoterol fumarate (Perforomist)</i>	T1	
FORMOTEROL FUMARATE-NEBULIZER	T3	QL (120 mls/30 days) HD
BETA-ADRENERGIC AND ANTICHOLINERGIC COMBO, INHALED		
ANORO ELLIPTA	T3	QL (1 inhaler/fill) HD
COMBIVENT RESPIMAT	T3	QL (2 inhalers/30 days)
SEEBRI NEOHALER 15.6MCG INHALER	T4	
STIOLTO RESPIMAT	T3	QL (1 inhaler/fill) HD
UTIBRON NEOHALER	T4	
BETA-ADRENERGIC AND GLUCOCORTICOID COMBO, INHALED		
ADVAIR HFA	T3	PA QL (1 inhaler/fill) HD

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

T5 – Brand Specialty
PA – Prior Authorization
QL – Quantity Limit

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

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

List of Prescription Medications

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

T1 – Preferred Generics

T2 – Non-Preferred Generics

T3 – Preferred Brands

T4 – Non-Preferred Brands

T5 – Brand Specialty

PA – Prior Authorization

QL – Quantity Limit

ST – Step Therapy

AGE – Age Requirement

SP – Specialty Medication

HD – May require home delivery pharmacy

PPACA – No Cost-Share Preventive Medication

CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

ANTIASTHMATICS (Asthma/COPD/Respiratory) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
GLUCOCORTICOIDs, ORALLY INHALED (cont.)		
FLOVENT 100 MCG DISKUS	T3	QL (1 inhaler/fill) HD
FLOVENT 250 MCG DISKUS	T3	QL (4 inhalers/fill) HD
FLOVENT HFA 44 MCG INHALER	T3	QL (11 gms/fill) HD
FLOVENT HFA 110 MCG INHALER	T3	QL (12 gms/fill) HD
FLOVENT HFA 220 MCG INHALER	T3	QL (24 gms/fill) HD
QVAR REDHALER 40 MCG	T3	QL (11 gms/30 days)
QVAR REDHALER 80 MCG	T3	QL (22 gms/30 days)
INTERLEUKIN-5 (IL-5) ANTAGONISTS, MAB		
NUCALA 40 MG/0.4 ML SYRINGE	T5	PA QL (1 syringe/28 days) SP HD
NUCALA 100 MG/ML AUTO-INJECTOR	T5	PA QL (1 auto-inj/28 days) SP HD
NUCALA 100 MG/ML SYRINGE	T5	PA QL (1 syringe/28 days) SP HD
INTERLEUKIN-5(IL-5) RECEPTOR ALPHA ANTAGONIST, MAB		
FASENRA PEN	T5	PA QL (1 syringe/56 days) SP HD
LEUKOTRIENE RECEPTOR ANTAGONISTS		
ACCOLATE (<i>zafirlukast</i>)	T4	HD
<i>montelukast sodium</i> (Singulair)	T2	HD
<i>zafirlukast</i> (Accolate)	T2	HD
MAST CELL STABILIZERS, ORALLY INHALED		
<i>cromolyn 20 mg/2 ml neb soln</i>	T2	HD
MONOCLONAL ANTIBODIES TO IMMUNOGLOBULIN E (IGE)		
XOLAIR 75 MG/0.5 ML AUTOINJECT	T5	PA QL (2 auto-injs/28 days) SP HD
XOLAIR 300 MG/2 ML AUTOINJECT	T5	PA QL (2 auto-injs/28 days) SP HD
XOLAIR 150 MG/ML AUTOINJECTOR	T5	PA QL (2 auto-injs/28 days) SP HD
XOLAIR 150 MG/1.2 ML POWDER VL	T5	PA QL (6 vls/28 days) SP HD
XOLAIR 300 MG/2 ML SYRINGE	T5	PA QL (2 syringes/28 days) SP HD
MUCOLYTICS		
<i>acetylcysteine</i>	T2	
PHOSPHODIESTERASE (PDE) INHIBITORS		
<i>roflumilast 250 mcg tablet</i> (Daliresp)	T2	PA QL (30 tabs/30 days) HD
<i>roflumilast 500 mcg tablet</i> (Daliresp)	T2	PA HD
XANTHINES		
ELIXOPHYLLIN	T4	HD
THEO-24	T4	HD
<i>theophylline anhydrous</i>	T2	HD

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

T5 – Brand Specialty
PA – Prior Authorization
QL – Quantity Limit

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

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

List of Prescription Medications

ANTIBIOTICS (Ear Medications)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
EAR PREPARATIONS, ANTIBIOTICS		
<i>ciprofloxacin hcl</i>	T2	
CORTISPORIN-TC	T4	
<i>neomycin/polymyxin b/hydrocort</i>	T2	
<i>ofloxacin</i>	T2	
OTIPRIO	T4	QL (1 ml/fill)
OTIC PREPARATIONS, ANTI-INFLAMMATORY-ANTIBIOTICS		
<i>ciprofloxacin hcl/dexameth</i>	T2	
OTOVEL	T4	
ANTIBIOTICS (Eye Conditions)		
EYE ANTIBIOTIC AND GLUCOCORTICOID COMBINATIONS		
GATIFLOXACIN-DEXAMETHASONE	T4	
MAXITROL (<i>neomycin/polymyxin b/dexametha</i>)	T4	
<i>neomycin/bacit/p-myx/hydrocort</i>	T2	
<i>neomycin/polymyxin b/dexametha</i> (Maxitrol)	T2	
<i>neomycin/polymyxin b/hydrocort</i>	T2	
PRED-G	T4	
PREDNISOLONE ACET-MOXIFLOXACIN	T4	
PREDNISOLONE PHOS-GATIFLOXACIN	T4	
PREDNISOLONE PHOS-MOXIFLOXACIN	T4	
TOBRADEX	T4	
<i>tobramycin/dexamethasone</i>	T2	
EYE ANTIBIOTIC AND NSAID COMBINATIONS.		
MOXIFLOXACIN-BROMFENAC	T4	
EYE ANTIBIOTIC, GLUCOCORTICOID AND NSAID COMB.		
PREDNISOLONE ACET-GATIFLO-BROM	T4	
PREDNISOLONE AC-MOXIFLOX-BROMF	T4	
EYE ANTIBIOTIC, GLUCOCORTICOID AND NSAID COMB.		
PREDNISOLONE AC-MOXIFLOX-NEPAF	T4	
<i>pred ph-moxi-brom 1-0.5-0.075%</i>	T2	
PRED PH-MOXI-BROM 1-0.5-0.075%	T4	
PREDNISOLONE PH-MOXIFLOX-KETOR	T4	
PREDNISOLONE PHOS-GATIFLO-BROM	T4	

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

T5 – Brand Specialty
PA – Prior Authorization
QL – Quantity Limit

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

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

List of Prescription Medications

ANTIBIOTICS (Eye Conditions) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
EYE SULFONAMIDES		
BLEPH-10 (<i>sulfacetamide sodium</i>)	T4	
BLEPHAMIDE S.O.P.	T4	
<i>sulfacetamide sodium</i>	T2	
<i>sulfacetamide sodium</i> (Bleph-10)	T2	
<i>sulfacetamide/prednisolone sp</i>	T2	
OPHTHALMIC ANTIBIOTICS		
AZASITE	T3	
<i>bacitracin</i>	T2	
<i>bacitracin/polymyxin b sulfate</i>	T2	
CEFUROXIME SODIUM-0.9% NACL	T4	PA
CILOXAN 0.3% EYE DROPS (<i>ciprofloxacin hcl</i>)	T4	
<i>ciprofloxacin hcl</i> (Ciloxan)	T2	
<i>erythromycin base</i>	T2	
<i>gatifloxacin</i>	T2	
<i>gentamicin 0.3% eye drop</i>	T2	
<i>gentamicin sulfate</i>	T2	
KLARITY-A(AZITHROMYCIN-CHONDR)	T4	
<i>levofloxacin</i>	T2	
<i>moxifloxacin</i>	T2	
<i>moxifloxacin</i> (Vigamox)	T2	
<i>neomycin/bacitracin/polymyxinb</i>	T2	
<i>neomycin/polymyxn b/gramicidin</i>	T2	
OCUFLOX (<i>ofloxacin</i>)	T4	
<i>ofloxacin</i> (Ocuflox)	T2	
<i>polymyxin b sulf/trimethoprim</i> (Polytrim)	T2	
POLYTRIM (<i>polymyxin b sulf/trimethoprim</i>)	T4	
<i>tobramycin 0.3% eye drop</i> (Tobrex)	T2	
TOBEX	T4	
TOBEX (<i>tobramycin</i>)	T4	
VIGAMOX (<i>moxifloxacin hcl</i>)	T4	
ANTIBIOTICS (Infections)		
2ND GEN. ANAEROBIC ANTIPROTOZOAL-ANTIBACTERIAL		
SOLOSEC	T3	QL (1 pack/fill)

T1 – Preferred Generics

T2 – Non-Preferred Generics

T3 – Preferred Brands

T4 – Non-Preferred Brands

T5 – Brand Specialty

PA – Prior Authorization

QL – Quantity Limit

ST – Step Therapy

AGE – Age Requirement

SP – Specialty Medication

HD – May require home delivery pharmacy

PPACA – No Cost-Share Preventive Medication

CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

ANTIBIOTICS (Infections) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ABSORBABLE SULFONAMIDE ANTIBACTERIAL AGENTS		
BACTRIM (sulfamethoxazole/trimethoprim)	T4	
BACTRIM DS (sulfamethoxazole/trimethoprim)	T4	
sulfadiazine	T2	
sulfamethoxazole/trimethoprim	T2	
sulfamethoxazole/trimethoprim (Bactrim Ds)	T1	
sulfamethoxazole/trimethoprim (Bactrim)	T1	
AMINOGLYCOSIDE ANTIBIOTICS		
ARIKAYCE	T5	PA SP
BETHKIS (tobramycin)	T5	PA QL (224 mls/fill) SP HD
gentamicin 80 mg/2 ml vial	T2	PA
gentamicin 800 mg/20 ml vial	T2	PA
gentamicin ped 20 mg/2 ml vial	T2	PA
KITABIS PAK	T5	PA QL (280 mls/fill) SP HD
neomycin sulfate	T2	
TOBI PODHALER	T5	PA QL (224 caps/fill) SP HD
tobramycin 300 mg/4 ml ampule (Bethkis)	T2	PA QL (224 mls/fill) SP HD
tobramycin 300 mg/5 ml ampule (Tobi)	T2	PA QL (280 mls/fill) SP HD
TOBRAMYCIN PAK 300 MG/5 ML	T5	PA QL (280 mls/fill) SP HD
tobramycin sulfate	T2	PA
ANAEROBIC ANTIPROTOZOAL-ANTIBACTERIAL AGENTS		
FLAGYL (metronidazole)	T4	
metronidazole 250 mg, 500 mg tablet	T2	
metronidazole 375 mg capsule (Flagyl)	T2	
ANTIBIOTIC, ANTIBACTERIAL, MISC.		
fosfomycin tromethamine	T2	
meth/meblue/sod phos/psal/hyos	T2	
methen/mbblue/sal/sod phos/hyos	T2	
methenam/m.blue/salicyl/hyoscy (Uribel Tabs)	T2	
methenam/sod phos/mbblue/hyoscy	T2	
methenamine hippurate	T2	
methenamine mandelate	T2	
PRIMSOL	T4	
trimethoprim	T2	
TRIMPEX	T4	

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

T5 – Brand Specialty
PA – Prior Authorization
QL – Quantity Limit

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

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

List of Prescription Medications

ANTIBIOTICS (Infections) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ANTIBIOTIC, ANTIBACTERIAL, MISC. (cont.)		
URELLE	T4	
URIBEL	T4	
URIBEL TABS (<i>methenam/m.blue/salicyl/hyoscy</i>)	T4	
ANTILEPTICS		
dapsone 100 mg tablet	T2	
dapsone 25 mg tablet	T2	
THALOMID 100 MG CAPSULE	T5	PA QL (30 caps/fill) SP HD
THALOMID 200 MG CAPSULE	T5	PA QL (60 caps/fill) SP HD
THALOMID 50 MG CAPSULE	T5	PA QL (30 caps/fill) SP HD
ANTI-MYCOBACTERIUM AGENTS		
clindamycin hcl (Cleocin Hcl)	T2	
clindamycin palmitate hcl (Cleocin Pediatric)	T2	
ethambutol hcl	T2	HD
isoniazid	T2	HD
MYCOBUTIN (<i>rifabutin</i>)	T4	HD
PASER	T4	HD
pyrazinamide	T2	HD
rifabutin (Mycobutin)	T2	HD
TRECTOR	T4	HD
ANTITUBERCULAR ANTIBIOTICS		
cycloserine	T2	
PRETOMANID	T4	PA
PRIFTIN	T3	
rifampin	T2	
SIRTURO	T5	PA SP
BETALACTAMS		
CAYSTON	T5	PA QL (84 mls/fill) SP HD
CEPHALOSPORIN ANTIBIOTICS - 1ST GENERATION		
cefadroxil	T2	
cephalexin	T2	
CEPHALOSPORIN ANTIBIOTICS - 2ND GENERATION		
cefaclor	T2	
cefprozil	T2	
cefuroxime axetil	T2	

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

T5 – Brand Specialty
PA – Prior Authorization
QL – Quantity Limit

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

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

List of Prescription Medications

ANTIBIOTICS (Infections) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
CEPHALOSPORIN ANTIBIOTICS - 3RD GENERATION		
<i>cefdinir</i>	T2	
<i>cefditoren pivoxil</i> (Spectracef)	T2	
<i>cefepodoxime proxetil</i>	T2	
<i>ceftriaxone sodium</i>	T2	PA
SPECTRACEF (<i>cefditoren pivoxil</i>)	T4	
LINCOSAMIDE ANTIBIOTICS		
CLEOCIN HCL (<i>clindamycin hcl</i>)	T4	
CLEOCIN PEDIATRIC (<i>clindamycin palmitate hcl</i>)	T4	
MACROLIDE ANTIBIOTICS		
<i>azithromycin</i>	T2	
<i>azithromycin</i> (Zithromax Tri-Pak)	T2	
<i>azithromycin</i> (Zithromax)	T2	
<i>clarithromycin</i>	T2	
DIFICID 200 MG TABLET (<i>fidaxomicin</i>)	T4	QL (20 tabs/30 days)
DIFICID 40 MG/ML SUSPENSION	T4	QL (1 bottle/fill)
E.E.S. 200 (<i>erythromycin ethylsuccinate</i>)	T4	
ERYPED 200 (<i>erythromycin ethylsuccinate</i>)	T4	
ERYPED 400 (<i>erythromycin ethylsuccinate</i>)	T4	
<i>ery-tab dr 250 mg tablet</i>	T2	
<i>ery-tab dr 333 mg tablet</i>	T2	
ERY-TAB DR 500 MG TABLET (<i>erythromycin base</i>)	T4	
<i>erythromycin base</i>	T2	
<i>erythromycin base</i> (Ery-Tab)	T2	
<i>erythromycin ethylsuccinate</i>	T2	
<i>erythromycin ethylsuccinate</i> (E.E.S. 200)	T2	
<i>erythromycin ethylsuccinate</i> (Eryped 200)	T2	
<i>erythromycin ethylsuccinate</i> (Eryped 400)	T2	
<i>erythromycin stearate</i>	T2	
<i>fidaxomicin</i> (Difcid)	T2	QL (20 tabs/30 days)
ZITHROMAX (<i>azithromycin</i>)	T4	
ZITHROMAX TRI-PAK (<i>azithromycin</i>)	T4	
NITROFURAN DERIVATIVES ANTIBACTERIAL AGENTS		
FURADANTIN (<i>nitrofurantoin</i>)	T4	
MACROBID (<i>nitrofurantoin monohyd/m-cryst</i>)	T4	

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

T5 – Brand Specialty
PA – Prior Authorization
QL – Quantity Limit

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

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

List of Prescription Medications

ANTIBIOTICS (Infections) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
NITROFURAN DERIVATIVES ANTIBACTERIAL AGENTS (cont.)		
<i>nitrofurantoin mcr 100 mg cap</i>	T2	
<i>nitrofurantoin mcr 50 mg cap</i>	T2	
<i>nitrofurantoin (Furadantin)</i>	T2	
<i>nitrofurantoin mcr 25 mg cap</i>	T2	
<i>nitrofurantoin monohyd/m-cryst (Macrobid)</i>	T2	
OXAZOLIDINONE ANTIBIOTICS		
<i>linezolid (Zyvox)</i>	T2	PA
ZYVOX (<i>linezolid</i>)	T4	PA
PENICILLIN ANTIBIOTICS		
<i>amoxicillin/potassium clav</i>	T2	
<i>amoxicillin/potassium clav (Augmentin Xr)</i>	T2	
<i>amoxicillin/potassium clav (Augmentin)</i>	T2	
<i>ampicillin trihydrate</i>	T2	
AUGMENTIN 125-31.25 MG/5 ML	T3	
AUGMENTIN 250-62.5 MG/5 ML (<i>amoxicillin/potassium clav</i>)	T4	
AUGMENTIN XR (<i>amoxicillin/potassium clav</i>)	T4	
<i>dicloxacillin sodium</i>	T2	
MOXATAG	T4	
<i>penicillin v potassium</i>	T2	
PLEUROMUTILIN DERIVATIVES		
XENLETA	T4	
QUINOLONE ANTIBIOTICS		
BAXDELA	T3	QL (28 tabs/fill)
CIPRO (<i>ciprofloxacin hcl</i>)	T4	
CIPRO (<i>ciprofloxacin</i>)	T4	
<i>ciprofloxacin (Cipro)</i>	T2	
<i>ciprofloxacin hcl</i>	T1	
<i>ciprofloxacin hcl (Cipro)</i>	T1	
FACTIVE	T4	
<i>levofloxacin</i>	T2	
<i>moxifloxacin hcl</i>	T2	
<i>ofloxacin</i>	T2	
RIFAMYCINS AND RELATED DERIVATIVE ANTIBIOTICS		
AEMCOLO	T4	QL (12 tabs/fill)

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

T5 – Brand Specialty
PA – Prior Authorization
QL – Quantity Limit

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

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

List of Prescription Medications

ANTIBIOTICS (Infections) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
RIFAMYCINS AND RELATED DERIVATIVE ANTIBIOTICS (cont.)		
XIFAXAN 200 MG TABLET	T3	QL (9 tabs/fill)
XIFAXAN 550 MG TABLET	T3	QL (60 tabs/fill)
TETRACYCLINE ANTIBIOTICS		
ACTICLATE (<i>doxycycline hyclate</i>)	T4	ST
AVIDOXY DK	T4	ST
<i>demeclocycline hcl</i>	T2	
<i>doxycycline 25 mg/5 ml susp</i> (Vibramycin)	T2	
<i>doxycycline 50 mg tablet</i> (Targadox)	T2	ST
<i>doxycycline hyc dr 50 mg tab</i>	T2	ST
<i>doxycycline hyc dr 75 mg tab</i>	T2	ST
<i>doxycycline hyc dr 100 mg tab</i>	T2	ST
<i>doxycycline hyc dr 150 mg tab</i>	T2	ST
<i>doxycycline hyc dr 200 mg tab</i> (Doryx)	T2	ST
<i>doxycycline hyclate 50 mg cap</i>	T2	
<i>doxycycline hyclate 100 mg cap</i>	T2	
<i>doxycycline hyclate 75 mg tab</i> (Acticlate)	T2	ST
<i>doxycycline hyclate 100 mg tab</i> (Lymepak)	T2	
<i>doxycycline hyclate 150 mg tab</i> (Acticlate)	T2	ST
<i>doxycycline mono 50 mg cap</i>	T2	
<i>doxycycline mono 75 mg capsule</i>	T2	ST
<i>doxycycline mono 100 mg cap</i>	T2	
<i>doxycycline mono 150 mg cap</i>	T2	ST
<i>doxycycline mono 50 mg tablet</i>	T2	
<i>doxycycline mono 75 mg tablet</i>	T2	
<i>doxycycline mono 100 mg tablet</i>	T2	
<i>doxycycline mono 150 mg tablet</i>	T2	
<i>doxycycline monohydrate</i>	T2	
<i>doxycycline monohydrate</i> (Oracea)	T2	ST
LYMEPAK (<i>doxycycline hyclate</i>)	T4	
<i>minocycline 100 mg capsule</i>	T2	
<i>minocycline 50 mg capsule</i>	T2	
<i>minocycline 75 mg capsule</i>	T2	
<i>minocycline hcl 100 mg tablet</i>	T2	ST

T1 – Preferred Generics

T2 – Non-Preferred Generics

T3 – Preferred Brands

T4 – Non-Preferred Brands

T5 – Brand Specialty

PA – Prior Authorization

QL – Quantity Limit

ST – Step Therapy

AGE – Age Requirement

SP – Specialty Medication

HD – May require home delivery pharmacy

PPACA – No Cost-Share Preventive Medication

CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

ANTIBIOTICS (Infections) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
TETRACYCLINE ANTIBIOTICS (cont.)		
<i>minocycline hcl 50 mg tablet</i>	T2	ST
<i>minocycline hcl 75 mg tablet</i>	T2	ST
<i>minocycline hcl (Solodyn)</i>	T2	ST
MINOLIRA ER	T4	ST
<i>mondoxylene nl 100 mg capsule</i>	T2	
<i>mondoxylene nl 75 mg capsule</i>	T2	ST
MORGIDOX 1X100 MG KIT	T4	ST
MORGIDOX 1X50 MG KIT	T4	ST
MORGIDOX 2X100 MG KIT	T4	ST
<i>morgidox 50 mg capsule</i>	T2	
NUZYRA	T5	QL (30 tabs/30 days) SP
SEYSARA	T4	ST
SOLODYN (<i>minocycline hcl</i>)	T4	ST
TARGADOX (<i>doxycycline hyclate</i>)	T4	ST
<i>tetracycline 250 mg, 500 mg capsule</i>	T2	
<i>tetracycline 250 mg, 500 mg tablet</i>	T2	ST
XACIATO	T4	
VIBRAMYCIN	T4	ST
VIBRAMYCIN (<i>doxycycline monohydrate</i>)	T4	ST
VAGINAL ANTIBIOTICS		
CLEOCIN	T4	
CLEOCIN (clindamycin phosphate)	T4	
<i>clindamycin 2% vaginal cream (Cleocin)</i>	T2	
CLINDESSE	T4	
<i>metronidazole</i>	T2	
<i>metronidazole vaginal 0.75% gel</i>	T2	
NUVESSA	T4	
VANCOMYCIN ANTIBIOTICS AND DERIVATIVES		
VANCOCLIN HCL 125 MG CAPSULE (<i>vancomycin hcl</i>)	T4	PA QL (40 caps/fill)
VANCOCLIN HCL 250 MG CAPSULE (<i>vancomycin hcl</i>)	T4	PA QL (80 caps/fill)
<i>vancomycin 250 mg/5 ml soln</i>	T2	QL (450 mls/fill)

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

T5 – Brand Specialty
PA – Prior Authorization
QL – Quantity Limit

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

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

List of Prescription Medications

ANTIBIOTICS (Skin Conditions)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
TOPICAL ANTIBIOTIC AND ANTI-INFLAMMATORY STEROID		
NEO-SYNALAR	T4	
TOPICAL ANTIBIOTICS		
AKTIPAK	T4	ST
AMZEEQ	T4	ST
BENZAMYCIN (<i>erythromycin/benzoyl peroxide</i>)	T4	ST
CENTANY	T4	ST QL (30 gms/fill)
CENTANY AT	T4	ST QL (1 kit/fill)
CLEOCIN T 1% LOTION (<i>clindamycin phosphate</i>)	T4	ST QL (120 mls/30 days)
CLEOCIN T 1% PLEDGETS (<i>clindamycin phosphate</i>)	T4	ST
<i>clindacin etz 1% pledget</i> (Cleocin T)	T2	
CLINDACIN ETZ KIT	T4	ST
CLINDACIN PAC	T4	ST
<i>clindamycin ph 1% gel</i>	T2	QL (120 gms/30 days)
<i>clindamycin ph 1% solution</i>	T2	QL (120 mls/30 days)
<i>clindamycin phos 1% pledget</i> (Cleocin T)	T2	
<i>clindamycin phosp 1% lotion</i> (Cleocin T)	T2	QL (120 mls/30 days)
<i>clindamycin phosphate</i> (Cleocin T)	T2	
<i>clindamycin phosphate</i> (Evoclin)	T2	ST QL (100 gms/30 days)
<i>clindamycin phosphate 1% foam</i> (Evoclin)	T2	ST QL (100 gms/30 days)
<i>clindamycin phosphate 1% gel</i> (Clindagel)	T2	QL (150 mls/30 days)
<i>erythromycin base in ethanol</i>	T2	
<i>erythromycin/benzoyl peroxide</i> (Benzamycin)	T2	
EVOCLIN (<i>clindamycin phosphate</i>)	T4	ST QL (100 gms/30 days)
<i>gentamicin 0.1% cream</i>	T2	QL (60 gms/fill)
<i>gentamicin 0.1% ointment</i>	T2	QL (60 gms/fill)
<i>mupirocin 2% cream</i>	T2	ST QL (30 gms/fill)
<i>mupirocin 2% ointment</i>	T2	QL (1 treatment/30 days)
<i>mupirocin 2% ointment</i>	T2	QL (30 gms/fill)
XEPI	T4	ST QL (30 gms/fill)
TOPICAL SULFONAMIDES		
AVAR LS	T4	ST
AVAR-E	T4	ST
AVAR-E GREEN	T4	ST
AVAR-E LS	T4	ST

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

T5 – Brand Specialty
PA – Prior Authorization
QL – Quantity Limit

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

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

List of Prescription Medications

ANTIBIOTICS (Skin Conditions) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
TOPICAL SULFONAMIDES (cont.)		
<i>mafenide acetate</i> (Sulfamylon)	T2	
PLEXION	T4	ST
ROSULA 10%-4.5% WASH	T4	ST
<i>rosula 10%-5% cloths</i>	T2	
SILVADENE (<i>silver sulfadiazine</i>)	T4	
<i>silver sulfadiazine</i> (Silvadene)	T2	
<i>sod sulface-sulf 9.8-4.8% clsr</i>	T2	ST
<i>sod sulface-sulfur 9-4.5% wash</i>	T2	ST
<i>sod sulfacet-sulfr 9.8-4.8%pad</i>	T2	ST
<i>sod sulfacet-sulfur 10-2% clsr</i>	T2	ST
<i>sod sulfacet-sulfur 10-4% pad</i> (Sumaxin)	T2	
<i>sod sulfacet-sulfur 10-5% clsr</i>	T2	
<i>sod sulfac-sulfur 9.8-4.8% crm</i>	T2	ST
<i>sod sulfac-sulfur 9.8-4.8% lot</i>	T2	ST
<i>sss 10-5 cream</i>	T2	
<i>sss 10-5 foam</i>	T2	ST
<i>sulfacetamide sodium/sulfur</i>	T2	ST
<i>sulfacetamide-sulfur 10-2% crm</i>	T2	ST
<i>sulfacetamide-sulfur 10-5% crm</i>	T2	
<i>sulfacetamide-sulfur 10-5% lot</i>	T2	ST
<i>sulfacetamide-sulfur 10-5% sus</i>	T2	ST
<i>sulfacetamide-sulfur 8-4% susp</i>	T2	ST
<i>sulfacetamide-sulfur 9-4% clsr</i>	T2	ST
SULFAMYLON 8.5% CREAM	T3	
SULFAMYLON POWDER PACKET (<i>mafenide acetate</i>)	T4	
SUMADAN	T4	ST
SUMADAN XLT	T4	ST
SUMAXIN	T4	ST
SUMAXIN (<i>sulfacetamide sodium/sulfur</i>)	T4	ST
SUMAXIN CP	T4	ST
SUMAXIN TS	T4	ST

ANTICOAGULANTS (Blood Thinners/Anti-Clotting)

CITRATES AS ANTICOAGULANTS

ACD SOLUTION A	T3	
----------------	----	--

T1 – Preferred Generics

T2 – Non-Preferred Generics

T3 – Preferred Brands

T4 – Non-Preferred Brands

T5 – Brand Specialty

PA – Prior Authorization

QL – Quantity Limit

ST – Step Therapy

AGE – Age Requirement

SP – Specialty Medication

HD – May require home delivery pharmacy

PPACA – No Cost-Share Preventive Medication

CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

ANTICOAGULANTS (Blood Thinners/Anti-Clotting) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
CITRATES AS ANTICOAGULANTS (cont.)		
ACD-A	T3	
ANTICOAGULANT SODIUM CITRATE	T4	
CITRATE PHOSPHATE DEXTROSE	T3	
CRRT TRISODIUM CITRATE	T4	
sodium citrate 4% lock flush	T2	
SODIUM CITRATE 4% LOCK FLUSH, SOLN, SYRINGE	T4	
SODIUM CITRATE 4% VIAL	T4	
TRISODIUM CITRATE CRRT	T4	
DIRECT FACTOR XA INHIBITORS		
ELIQUIS 2.5 MG TABLET	T3	
ELIQUIS 5 MG TABLET	T3	
ELIQUIS DVT-PE TREAT START 5MG	T3	
rivaroxaban (Xarelto)	T2	
XARELTO (rivaroxaban)	T3	PA
XARELTO	T3	PA
HEPARIN AND RELATED PREPARATIONS		
ARIXTRA (fondaparinux sodium)	T5	SP
enoxaparin sodium (Lovenox)	T2	SP
ARIXTRA (fondaparinux sodium)	T5	SP
FRAGMIN	T5	SP
heparin 2,000 unit/2 ml vial	T2	
heparin 5,000 unit/ml carpject	T2	
heparin 10,000 unit/10 ml vial	T2	
heparin 30,000 unit/30 ml vial	T2	
heparin 40,000 unit/4 ml vial	T2	
heparin 50,000 unit/10 ml vial	T2	
heparin 50,000 unit/5 ml vial	T2	
heparin sod 1,000 unit/ml vial	T2	
heparin sod 5,000 unit/0.5 ml	T2	
HEPARIN SOD 5,000 UNIT/0.5 ML	T3	
HEPARIN SOD 5,000 UNIT/0.5 ML	T4	
heparin sod 5,000 unit/ml syrg	T2	
HEPARIN SOD 5,000 UNIT/ML SYRG	T4	
heparin sod 5,000 unit/ml vial	T2	

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

T5 – Brand Specialty
PA – Prior Authorization
QL – Quantity Limit

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

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

List of Prescription Medications

ANTICOAGULANTS (Blood Thinners/Anti-Clotting) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
HEPARIN AND RELATED PREPARATIONS (cont.)		
heparin sod 10,000 unit/ml v1	T2	
heparin sod 20,000 unit/ml v1	T2	
ANTIDOTES (Gastrointestinal/Heartburn)		
MU-OPIOID RECEPTOR ANTAGONISTS, PERIPHERALLY-ACTING		
MOVANTIK	T3	QL (30 tabs/fill)
RELISTOR 8 MG/0.4 ML SYRINGE	T3	ST
RELISTOR 12 MG/0.6 ML SYRINGE, VIAL	T3	ST
SYMPROIC	T3	
ANTIDOTES (Substance Abuse)		
OPIOID ANTAGONISTS		
EVZIO (naloxone)	T4	QL (1 ml/fill)
KLOXXADO	T3	QL (2 units/fill)
naloxone 0.4 mg/ml carpject, syringe, vial	T2	
naloxone 2 mg/2 ml syringe	T2	
naloxone 4 mg/10 ml vial	T2	
naloxone hcl 4 mg nasal spray (Narcan)	T2	QL (2 units/fill)
naltrexone hcl	T1	
NARCAN (naloxone hcl)	T4	QL (2 units/30 days)
RETOVY	T3	QL (2 units/30 days)
ANTIFUNGALS (Eye Conditions)		
OPHTHALMIC ANTIFUNGAL AGENTS		
NATACYN	T3	
ANTIFUNGALS (Feminine Products)		
VAGINAL ANTIFUNGALS		
GYNAZOLE 1	T4	
miconazole nitrate	T2	
terconazole	T2	
ANTIFUNGALS (Infections)		
ANTIFUNGAL AGENTS		
ANCOBON (flucytosine)	T4	PA
clotrimazole	T2	
CRESEMBA	T3	PA

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

T5 – Brand Specialty
PA – Prior Authorization
QL – Quantity Limit

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

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

List of Prescription Medications

ANTIFUNGALS (Infections) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ANTIFUNGAL AGENTS (cont.)		
DIFLUCAN 10 MG/ML SUSPENSION (<i>fluconazole</i>)	T4	
DIFLUCAN 40 MG/ML SUSPENSION (<i>fluconazole</i>)	T4	
DIFLUCAN 50 MG TABLET (<i>fluconazole</i>)	T4	
DIFLUCAN 100 MG TABLET (<i>fluconazole</i>)	T4	
DIFLUCAN 150 MG TABLET (<i>fluconazole</i>)	T4	QL (2 tabs/fill)
DIFLUCAN 200 MG TABLET (<i>fluconazole</i>)	T4	
<i>fluconazole 10 mg/ml susp</i>	T2	
<i>fluconazole 40 mg/ml susp</i> (Diflucan)	T2	
<i>fluconazole 50 mg tablet</i> (Diflucan)	T2	
<i>fluconazole 100 mg, 200 mg tablet</i>	T2	
<i>fluconazole 150 mg tablet</i> (Diflucan)	T2	QL (2 tabs/fill)
<i>flucytosine</i> (Ancobon)	T2	
<i>itraconazole 10 mg/ml solution</i>	T2	QL (2 bottles/30 days)
<i>itraconazole 100 mg capsule</i> (Sporanox)	T2	QL (30 caps/fill)
<i>itraconazole 100 mg/10 ml cup</i>	T2	QL (2 bottles/30 days)
<i>ketoconazole 200 mg tablet</i>	T2	
NOXAFIL 300 MG POWDERMIX SUSP	T3	PA
NOXAFIL 40 MG/ML SUSPENSION	T3	PA SP
ORAVIG	T4	
POSACONAZOLE 200 MG/5 ML SUSP	T3	PA
<i>posaconazole dr 100 mg tablet</i> (Noxafil)	T2	PA
SPORANOX (<i>itraconazole</i>)	T4	QL (30 caps/30 days)
<i>terbinafine hcl</i>	T2	
VFEND (<i>voriconazole</i>)	T4	PA
VIVJOA	T5	PA QL (18 caps/30 days) SP
<i>voriconazole</i> (Vfend)	T2	PA
ANTIFUNGAL ANTIBIOTICS		
BREXAFEMME	T4	ST QL (4 tabs/fill)
<i>griseofulvin ultramicrosize</i>	T2	
<i>griseofulvin, microsize</i>	T2	
<i>nystatin 100,000 unit/ml susp</i>	T2	
<i>nystatin 500,000 unit oral tab</i>	T2	
<i>nystatin 500,000 unit/5 ml cup</i>	T2	

T1 – Preferred Generics

T2 – Non-Preferred Generics

T3 – Preferred Brands

T4 – Non-Preferred Brands

T5 – Brand Specialty

PA – Prior Authorization

QL – Quantity Limit

ST – Step Therapy

AGE – Age Requirement

SP – Specialty Medication

HD – May require home delivery pharmacy

PPACA – No Cost-Share Preventive Medication

CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

ANTIFUNGALS (Skin Conditions)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
TOPICAL ANTIFUNGAL/ANTI-INFLAMMATORY, STEROID AGENT		
<i>clotrimazole-betamethasone crm</i>	T2	QL (90 gms/28 days)
<i>clotrimazole-betamethasone lot</i>	T2	QL (60 mls/28 days)
TOPICAL ANTIFUNGALS		
<i>ciclodan 0.77% cream (Loprox)</i>	T2	QL (90 gms/28 days)
CICLODAN 0.77% CREAM KIT	T4	
<i>ciclodan 8% solution</i>	T2	
<i>ciclopirox 0.77% cream (Loprox)</i>	T2	QL (90 gms/28 days)
<i>ciclopirox 0.77% gel</i>	T2	QL (100 gms/28 days)
<i>ciclopirox 0.77% topical susp (Loprox)</i>	T2	QL (60 mls/28 days)
<i>ciclopirox 1% shampoo</i>	T2	QL (120 mls/28 days)
<i>ciclopirox 8% solution</i>	T2	
<i>econazole nitrate 1% cream</i>	T2	QL (85 gms/28 days)
EXELDERM 1% CREAM	T4	QL (60 gms/28 days)
EXELDERM 1% SOLUTION	T4	QL (60 mls/28 days)
EXTINA (<i>ketoconazole</i>)	T4	ST QL (100 gms/28 days)
JUBLIA	T4	ST
<i>ketoconazole 2% cream</i>	T2	QL (60 gms/28 days)
<i>ketoconazole 2% foam (Extina)</i>	T2	ST QL (100 gms/28 days)
<i>ketodan 2% foam (Extina)</i>	T2	ST QL (100 gms/28 days)
<i>ketodan 2% foam kit</i>	T2	
LOPROX 0.77% CREAM (<i>ciclopirox olamine</i>)	T4	QL (90 gms/28 days)
LOPROX 0.77% CREAM KIT	T4	QL (544 gms/30 days)
LOPROX 0.77% SUSPENSION KIT	T4	QL (1 kit/30 days)
LOPROX 0.77% TOPICAL SUSP (<i>ciclopirox olamine</i>)	T4	QL (60 mls/28 days)
<i>naftifine hcl 1% cream</i>	T2	QL (90 gms/28 days)
<i>naftifine hcl 2% cream</i>	T2	QL (60 gms/28 days)
<i>naftifine hcl 2% gel (Naftin)</i>	T2	QL (60 gms/28 days)
NAFTIN	T4	QL (60 gms/28 days)
NAFTIN 1% GEL (<i>naftifine hcl</i>)	T4	QL (90 gms/28 days)
NAFTIN 2% GEL (<i>naftifine hcl</i>)	T4	QL (60 gms/28 days)
<i>nystatin</i>	T2	QL (180 gms/fill)
<i>nystatin 100,000 unit/gm cream</i>	T2	QL (60 gms/28 days)
<i>nystatin 100,000 unit/gm oint</i>	T2	QL (60 gms/28 days)

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

T5 – Brand Specialty
PA – Prior Authorization
QL – Quantity Limit

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

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

List of Prescription Medications

ANTIFUNGALS (Skin Conditions) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
TOPICAL ANTIFUNGALS (cont.)		
<i>nystatin/triamcin</i>	T2	QL (60 gms/28 days)
<i>oxiconazole nitrate</i>	T2	QL (60 gms/28 days)
<i>tavaborole</i>	T2	ST
ANTIHISTAMINE AND DECONGESTANT COMBINATION (Allergy/Nasal Sprays)		
1ST GEN ANTIHISTAMINE AND DECONGESTANT COMBINATION		
<i>phenylephrine hcl/prometh hcl</i>	T2	
2ND GEN ANTIHISTAMINE AND DECONGESTANT COMBINATION		
CLARINEX-D 12 HOUR	T4	
CLARINEX-D 24 HOUR	T4	
ANTIHISTAMINES (Allergy/Nasal Sprays)		
ANTIHISTAMINES - 1ST GENERATION		
<i>carbinoxamine 4 mg/5 ml liquid</i>	T2	
<i>carbinoxamine maleate</i>	T2	ST
<i>carbinoxamine maleate 4 mg tab</i>	T2	
<i>carbinoxamine maleate 6 mg tab</i>	T2	ST
<i>cyproheptadine 2 mg/5 ml soln, syrup</i>	T2	
<i>cyproheptadine 4 mg tablet</i>	T2	
CYPROHEPTADINE 4 MG/10 ML SYRP	T4	
<i>dexchlorpheniramine maleate (Ryclora)</i>	T2	
<i>hydroxyzine hcl</i>	T2	
<i>hydroxyzine hcl</i>	T1	
<i>hydroxyzine pamoate</i>	T1	
<i>hydroxyzine pamoate (Vistaril)</i>	T1	
<i>promethazine hcl</i>	T2	
RYCLORA (<i>dexchlorpheniramine maleate</i>)	T4	
RYVENT	T4	ST
VISTARIL (<i>hydroxyzine pamoate</i>)	T4	
ANTIHISTAMINES - 2ND GENERATION		
CLARINEX (<i>desloratadine</i>)	T4	QL (30 tabs/fill) HD
<i>desloratadine</i>	T2	QL (30 tabs/fill) HD
<i>desloratadine (Clarinx)</i>	T2	QL (30 tabs/fill) HD

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

T5 – Brand Specialty
PA – Prior Authorization
QL – Quantity Limit

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

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

List of Prescription Medications

ANTI-HISTAMINES (Eye Conditions)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
EYE ANTI-HISTAMINES		
<i>azelastine hcl 0.05% drops</i>	T2	
<i>bepotastine besilate</i> (Bepreve)	T2	ST
BEPREVE	T2	
<i>epinastine hcl</i>	T2	
LASTACFT 0.25% EYE DROPS	T4	ST
ANTI-HYPERGLYCEMICS (Diabetes)		
ANTI-HYPERGLY, DPP-4 ENZYME INHIB.-THIAZOLIDINEDIONE		
OSENI	T4	ST QL (30 tabs/fill) HD
ANTI-HYPERGLY, INCRETIN MIMETIC (GLP-1 RECEPT. AGONIST)		
ADLYXIN 10-20 MCG STARTER PACK	T4	PA QL (1 kit/28 days) HD
ADLYXIN 20 MCG MAINTENANCE PK	T4	PA QL (1 kit/28 days) HD
BYDUREON BCISE	T3	PA QL (4 auto-injs/28 days)
BYDUREON PEN	T3	PA QL (4 pens/fill) HD
BYETTA	T3	PA QL (1 pen/30 days)
<i>exenatide</i>	T2	PA QL (1 pen/30 days)
<i>liraglutide 2-pak 18 mg/3 ml</i> (Victoza 2-Pak)	T2	PA
<i>liraglutide 2-pak 18 mg/3 ml</i> (Victoza 2-Pak)	T2	PA
<i>liraglutide 2-pak 18 mg/3 ml</i> (Victoza 3-Pak)	T2	PA
<i>liraglutide 2-pak 18 mg/3 ml</i> (Victoza 3-Pak)	T2	PA QL (2 pens/30 days)
<i>liraglutide 3-pak 18 mg/3 ml</i> (Victoza 2-Pak)	T2	PA
<i>liraglutide 3-pak 18 mg/3 ml</i> (Victoza 2-Pak)	T2	PA QL (3 pens/30 days)
<i>liraglutide 3-pak 18 mg/3 ml</i> (Victoza 3-Pak)	T2	PA
<i>liraglutide 3-pak 18 mg/3 ml</i> (Victoza 3-Pak)	T2	PA QL (3 pens/30 days)
OZEMPIC	T3	PA QL (1 pen/28 days)
RYBELSUS	T3	PA QL (30 tabs/30 days)
TRULICITY 0.75 MG/0.5 ML PEN	T3	PA QL (4 pens/fill) HD
TRULICITY 1.5 MG/0.5 ML PEN	T3	PA QL (1 pen/fill) HD
TRULICITY 3 MG/0.5 ML PEN	T3	PA QL (2 pens/fill) HD
TRULICITY 4.5 MG/0.5 ML PEN	T3	PA QL (1 pen/fill) HD
VICTOZA 2-PAK	T3	PA QL (1 pen/fill) HD
VICTOZA 3-PAK	T3	PA QL (30 tabs/fill) HD
ANTI-HYPERGLY, INSULIN, LONG ACT-GLP-1 RECEPT. AGONIST		
SOLIQUA 100-33	T3	QL (15 mls/30 days)

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

T5 – Brand Specialty
PA – Prior Authorization
QL – Quantity Limit

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

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

List of Prescription Medications

ANTIHYPERGLYCEMICS (Diabetes) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ANTIHYPERGLYCEMIC - DOPAMINE RECEPTOR AGONISTS		
CYCLOSET	T4	HD
ANTIHYPERGLYCEMIC - INCRETIN MIMETICS COMBINATION		
MOUNJARO	T3	PA QL (4 pens/fill)
ANTIHYPERGLYCEMIC, ALPHA-GLUCOSIDASE INHIBITORS		
acarbose (Precose)	T2	HD
miglitol	T2	HD
PRECOSE (acarbose)	T4	HD
ANTIHYPERGLYCEMIC, AMYLIN ANALOG-TYPE		
SYMLINPEN 120	T3	PA QL (7 pens/fill) HD
SYMLINPEN 60	T3	PA QL (7 pens/30 days)
ANTIHYPERGLYCEMIC, BIGUANIDE TYPE		
metformin er 1,000 mg osm-tab	T2	PA QL (60 tabs/30 days) HD
metformin er 500 mg osmotic tb	T2	PA QL (30 tabs/30 days) HD
metformin er 1,000 mg gastr-tb (Glumetza)	T2	PA QL (60 tabs/fill) HD
metformin er 500 mg gastrc-tb (Glumetza)	T2	PA QL (120 tabs/fill) HD
metformin hcl 1,000 mg tablet	T1	HD
metformin hcl 500 mg tablet	T1	HD
metformin hcl 750 mg tablet	T1	ST HD
metformin hcl 500 mg/5 ml soln (Riomet)	T2	ST HD
metformin hcl 850 mg tablet	T1	HD
metformin hcl er 500 mg tablet	T1	QL (120 tabs/fill) HD
metformin hcl er 750 mg tablet	T1	QL (60 tabs/fill) HD
RIOMET (metformin hcl)	T4	ST HD
ANTIHYPERGLYCEMIC, DPP-4 INHIBITORS		
JANUVIA	T3	ST QL (30 tabs/fill) HD
saxagliptin (Onglyza)	T2	ST QL (30 tabs/30 days) HD
ANTIHYPERGLYCEMIC, INSULIN-RELEASE STIMULANT TYPE		
glimepiride 1 mg tablet	T1	HD
glyburide, micronized	T2	HD
glimepiride 2 mg tablet	T1	HD
glimepiride 4 mg tablet	T1	HD
glipizide	T1	HD
glipizide (Glucotrol XL)	T1	HD
GLUCOTROL XL (glipizide)	T4	HD

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

T5 – Brand Specialty
PA – Prior Authorization
QL – Quantity Limit

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

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

List of Prescription Medications

ANTIHYPERGLYCEMICS (Diabetes) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ANTIHYPERGLYCEMIC, INSULIN-RELEASE STIMULANT TYPE (cont.)		
<i>glyburide</i>	T2	HD
<i>glyburide, micronized</i>	T2	HD
<i>glyburide, micronized</i> (Glynase)	T2	HD
GLYNASE (<i>glyburide, micronized</i>)	T4	HD
<i>nateglinide</i>	T2	HD
PRANDIN (<i>repaglinide</i>)	T4	HD
<i>repaglinide</i>	T2	HD
<i>repaglinide</i> (Prandin)	T2	HD
ANTIHYPERGLYCEMIC, SGLT-2 AND DPP-4 INHIBITOR COMB		
GLYXAMBI	T3	ST QL (30 tabs/fill) HD
ANTIHYPERGLYCEMIC, THIAZOLIDINEDIONE AND BIGUANIDE		
ACTOPLUS MET (<i>pioglitazone hcl/metformin hcl</i>)	T4	QL (90 tabs/30 days) HD
<i>pioglitazone hcl/metformin hcl</i>	T2	QL (90 tabs/fill) HD
<i>pioglitazone hcl/metformin hcl</i> (Actoplus Met)	T2	QL (90 tabs/fill) HD
ANTIHYPERGLYCEMIC, THIAZOLIDINEDIONE-SULFONYLUREA		
DUETACT (<i>pioglitazone-glimepiride</i>)	T4	QL (30 tabs/30 days) HD
<i>pioglitazone hcl/glimepiride</i> (Duetact)	T2	QL (30 tabs/fill) HD
ANTIHYPERGLYCEMIC, DPP-4 INHIBITOR-BIGUANIDE COMBS.		
JANUMET	T3	ST QL (60 tabs/fill) HD
JANUMET XR 100-1,000 MG TABLET	T3	ST QL (30 tabs/fill) HD
JANUMET XR 50-1,000 MG TABLET	T3	ST QL (60 tabs/fill) HD
JANUMET XR 50-500 MG TABLET	T3	ST QL (60 tabs/fill) HD
<i>saxagliptin-metformin er 5-500</i> (Kombiglyze Xr)	T2	ST QL (30 tabs/30 days) HD
<i>saxagliptin-metformin er 5-1000</i> (Kombiglyze Xr)	T2	ST QL (30 tabs/30 days) HD
<i>saxagliptin-metformin er 2.5-1000</i> (Kombiglyze Xr)	T2	ST QL (60 tabs/30 days) HD
ANTIHYPERGLYCEMIC, INSULIN-RELEASE STIM.-BIGUANIDE		
<i>glipizide/metformin hcl</i>	T1	HD
<i>glyburide/metformin hcl</i>	T2	HD
ANTIHYPERGLYCEMIC, THIAZOLIDINEDIONE (PPARG AGONIST)		
ACTOS (<i>pioglitazone hcl</i>)	T4	QL (30 tabs/30 days) HD
ANTIHYPERGLYCEMIC-GLUCOCORTICOID RECEPTOR BLOCKER		
<i>mifepristone 300 mg tablet</i> (Korlym)	T2	PA SP
SYNJARDY	T3	ST QL (60 tabs/fill) HD

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

T5 – Brand Specialty
PA – Prior Authorization
QL – Quantity Limit

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

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

List of Prescription Medications

ANTIHYPERGLYCEMICS (Diabetes) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ANTIHYPERGLYCEMIC-SGLT2 INHIBITOR-BIGUANIDE COMBS.		
SYNJARDY XR 10-1,000 MG TABLET	T3	ST QL (30 tabs/fill) HD
SYNJARDY XR 12.5-1,000 MG TAB	T3	ST QL (60 tabs/fill) HD
SYNJARDY XR 25-1,000 MG TABLET	T3	ST QL (30 tabs/fill) HD
SYNJARDY XR 5-1,000 MG TABLET	T3	ST QL (60 tabs/fill) HD
XIGDUO XR 10 MG-1,000 MG TAB	T3	ST QL (30 tabs/fill) HD
XIGDUO XR 10 MG-500 MG TABLET	T3	ST QL (30 tabs/fill) HD
XIGDUO XR 2.5 MG-1,000 MG TAB	T3	ST QL (60 tabs/fill) HD
XIGDUO XR 5 MG-1,000 MG TABLET	T3	ST QL (60 tabs/fill) HD
XIGDUO XR 5 MG-500 MG TABLET	T3	ST QL (30 tabs/fill) HD
ANTIHYPERGLYCEMIC-SOD/GLUC COTRANSPORT2(SGLT2) INH		
FARXIGA	T3	ST QL (30 tabs/30 days)
JARDIANCE	T3	ST QL (30 tabs/fill) HD
ANTIHYPERGLY-SGLT-2 INHIB, DPP-4 INHIB, BIGUANIDE CB		
TRIJARDY XR	T3	ST HD
INSULINS		
HUMALOG 100 unit/ML CARTRIDGE	T3	HD
HUMALOG JUNIOR KWIKPEN	T3	HD
HUMALOG KWIKPEN U-100	T3	HD
HUMALOG KWIKPEN U-200	T3	HD
HUMALOG MIX 50-50 KWIKPEN	T3	HD
HUMALOG MIX 75-25	T3	HD
HUMALOG MIX 75-25 KWIKPEN	T3	HD
HUMULIN 70/30 KWIKPEN	T3	HD
HUMULIN 70-30	T3	HD
HUMULIN N	T3	HD
HUMULIN N KWIKPEN	T3	HD
HUMULIN R	T3	HD
HUMULIN R U-500	T3	HD
HUMULIN R U-500 KWIKPEN	T3	HD
INSULIN GLARGINE-YFGN	T3	HD
INSULIN LISPRO JUNIOR KWIKPEN	T3	HD
INSULIN LISPRO KWIKPEN U-100	T3	HD
INSULIN LISPRO PROTAMINE MIX	T3	HD
INSULIN LISPRO 100 UNIT/ML VIAL	T3	HD

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

T5 – Brand Specialty
PA – Prior Authorization
QL – Quantity Limit

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

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

List of Prescription Medications

ANTIHYPERGLYCEMICS (Diabetes) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
INSULINS (cont.)		
LANTUS	T3	HD
LANTUS SOLOSTAR	T3	HD
LYUMJEV	T3	HD
LYUMJEV KWIKPEN U-100, U-200	T3	HD
MYXREDLIN	T4	
SEMGLEE (YFGN)	T3	HD
SEMGLEE (YFGN) PEN	T3	HD
TOUJEO MAX SOLOSTAR	T3	HD
TOUJEO SOLOSTAR	T3	HD
TRESIBA	T3	HD
TRESIBA FLEXTOUCH U-100, U-200	T3	HD
ANTIINFECTIVES (Feminine Products)		
VAGINAL SULFONAMIDES		
AVC	T4	
ANTIINFECTIVES/MISCELLANEOUS (Feminine Products)		
VAGINAL ANTISEPTICS		
<i>acetic acid/oxyquinoline (Relagard)</i>	T2	
RELAGARD (<i>acetic acid/oxyquinoline</i>)	T4	
TRIMO-SAN	T3	
ANTIINFECTIVES/MISCELLANEOUS (Infections)		
2ND GEN. ANAEROBIC ANTIPROTOZOAL-ANTIBACTERIAL		
<i>tinidazole 250 mg tablet</i>	T2	QL (40 tabs/30 days)
<i>tinidazole 500 mg tablet</i>	T2	QL (20 tabs/30 days)
AMEBICIDES		
HUMATIN	T4	
ANTHELMINTICS		
<i>albendazole (Albenza)</i>	T2	QL (120 tabs/30 days)
ALBENZA (<i>albendazole</i>)	T4	QL (120 tabs/30 days)
BILTRICIDE (<i>praziquantel</i>)	T4	
EMVERM	T3	QL (6 tabs/30 days)
<i>ivermectin 6 mg tablet</i>	T2	PA QL (8 tabs/30 days)
<i>praziquantel (Biltricide)</i>	T2	
STROMECTOL (<i>ivermectin</i>)	T4	PA QL (14 tabs/30 days)

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

T5 – Brand Specialty
PA – Prior Authorization
QL – Quantity Limit

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

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

List of Prescription Medications

ANTIINFECTIVES/MISCELLANEOUS (Infections) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ANTIMALARIAL DRUGS		
ARAKODA	T4	QL (16 tabs/fill)
atovaquone-proguanil 250-100 (Malarone)	T2	QL (60 tabs/180 days)
atovaquone-proguanil 62.5-25 (Malarone)	T2	QL (180 tabs/180 days)
chloroquine phosphate	T2	
COARTEM	T3	QL (24 tabs/30 days)
DARAPRIM (pyrimethamine)	T5	PA SP
HYDROXYCHLOROQUINE 100 MG TAB	T4	
hydroxychloroquine 200 mg tab (Plaquenil)	T2	
HYDROXYCHLOROQUINE 300 MG TAB	T4	
HYDROXYCHLOROQUINE 400 MG TAB	T4	
KRINTAFEL	T4	QL (2 tabs/30 days)
MALARONE 250-100 MG TABLET (atovaquone/proguanil hcl)	T4	QL (60 tabs/180 days)
MALARONE 62.5-25 MG PED TAB (atovaquone/proguanil hcl)	T4	QL (180 tabs/180 days)
mefloquine hcl	T2	QL (13 tabs/180 days)
PRIMAQUINE 26.3 MG TABLET	T3	QL (120 tabs/180 days)
primaquine 26.3 mg tablet	T2	QL (120 tabs/180 days)
pyrimethamine 25 mg tablet (Daraprim)	T2	PA
pyrimethamine 25 mg tablet (Daraprim)	T2	PA SP
quinine sulfate	T2	QL (42 caps/30 days)
ANTIPROTOZOAL DRUGS, MISCELLANEOUS		
atovaquone (Mepron)	T2	
BENZNIDAZOLE	T3	QL (360 tabs/fill)
IMPAVIDO	T3	PA QL (84 caps/30 days)
MEPRON (atovaquone)	T4	
NEBUPENT (pentamidine isethionate)	T4	QL (1 v1/28 days)
pentamidine isethionate (Nebupent)	T2	QL (1 v1/28 days)
ANTIINFECTIVES/MISCELLANEOUS (Miscellaneous)		
ANTIBACTERIAL AGENTS,MISCELLANEOUS		
glycine urologic solution	T2	
ANTISEPTICS,GENERAL		
ALCOHOL SWABSTICK	T4	
CVS ISOPROPYL ALCOHOL 91% SPRY	T4	
GS ISOPROPYL ALCOHOL 70% SPRAY	T4	
ISOPROPYL ALCOHOL 70% SPRAY	T4	

T1 – Preferred Generics

T2 – Non-Preferred Generics

T3 – Preferred Brands

T4 – Non-Preferred Brands

T5 – Brand Specialty

PA – Prior Authorization

QL – Quantity Limit

ST – Step Therapy

AGE – Age Requirement

SP – Specialty Medication

HD – May require home delivery pharmacy

PPACA – No Cost-Share Preventive Medication

CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

ANTIINFECTIVES/MISCELLANEOUS (Miscellaneous) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ANTISEPTICS,GENERAL (cont.)		
MEDI-FIRST ISOPROPYL ALCOHOL	T4	
TOPICAL ANTISEPTIC DRYING AGENTS		
formaldehyde	T2	
ANTIINFECTIVES/MISCELLANEOUS (Skin Conditions)		
TOPICAL ANTIFUNGALS		
CICLODAN 8% KIT	T4	ST
ciclopirox 8% treatment kit	T2	
ANTIINFLAM.TUMOR NECROSIS FACTOR INHIBITING AGENTS (Pain Relief And Inflammatory Disease)		
ANTI-INFLAMMATORY TUMOR NECROSIS FACTOR INHIBITOR		
ADALIMUMAB-ADAZ(CF)	T5	PA QL (2 syringes/28 days) SP
ADALIMUMAB-ADAZ(CF) PEN	T5	PA QL (2 pens/28 days) SP
ADALIMUMAB-ADBM(CF)PEN	T5	PA QL (2 kits/28 days) SP HD
ADALIMUMAB-RYVK(CF)	T5	PA QL (2 srnge kits/28 days) SP HD
ADALIMUMAB-RYVK(CF) AI 40 MG	T5	PA QL (2 auto-injs/28 days) SP HD
CYLTEZO(CF)	T5	PA QL (2 srnge kits/28 days) SP HD
CYLTEZO(CF) PEN	T5	PA QL (2 kits/28 days) SP HD
CYLTEZO(CF) PEN CROHN'S-UC-HS	T5	PA QL (6 pens/365 days) SP HD
CYLTEZO(CF) PEN PSORIASIS-UV	T5	PA QL (4 pens/365 days) SP HD
ENBREL 25 MG KIT	T5	PA QL SP HD
ENBREL 25 MG/0.5 ML SYRINGE	T5	PA QL SP HD
ENBREL 25 MG/0.5 ML VIAL	T5	PA QL SP HD
ENBREL 50 MG/ML SYRINGE	T5	PA QL (2 srnge kits/28 days) SP HD
ENBREL MINI	T5	PA QL (2 kits/28 days) SP HD
ENBREL SURECLICK	T5	PA QL (6 pens/365 days) SP HD
SIMLANDI(CF) AUTOINJECTOR	T5	PA QL (2 auto-injs/28 days) SP HD
SIMLANDI(CF)	T5	PA QL (2 srnge kits/28 days) SP HD
SIMPONI 100 MG/ML PEN INJECTOR	T5	PA QL (1 pen/30 days) SP HD
SIMPONI 100 MG/ML SYRINGE	T5	PA QL (1 syringe/30 days) SP HD
SIMPONI ARIA	T5	PA SP HD
ANTINEOPLASTICS (Cancer)		
ANP - SELECTIVE RETINOID X RECEPTOR AGONISTS (RXR)		
bexarotene (Targretin)	T2	PA SP HD CSL

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

T5 – Brand Specialty
PA – Prior Authorization
QL – Quantity Limit

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

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

List of Prescription Medications

ANTINEOPLASTICS (Cancer) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ANTINEOPLAST, HISTONE DEACETYLASE (HDAC) INHIBITORS		
FARYDAK	T4	PA QL (6 caps/fill) CSL
ZOLINZA	T5	PA QL (120 caps/fill) SP HD CSL
ANTINEOPLASTIC - ALKYLATING AGENTS		
ALKERAN (<i>melphalan</i>)	T5	SP CSL
cyclophosphamide 25 mg, 50 mg capsule	T2	SP HD CSL
CYCLOPHOSPHAMIDE 50 MG TABLET	T5	SP HD CSL
GLEOSTINE	T3	CSL
HYDREA (<i>hydroxyurea</i>)	T4	CSL
<i>hydroxyurea</i> (Hydrea)	T2	CSL
LEUKERAN	T3	CSL
MYLERAN	T3	CSL
temozolomide	T2	PA SP HD CSL
ANTINEOPLASTIC - ANTIANDROGENIC AGENTS		
abiraterone acetate (Zytiga)	T2	PA QL (120 tabs/30 days) CSL
abiraterone acetate 250 mg tab (Zytiga)	T2	PA QL (120 tabs/fill) SP HD CSL
abiraterone acetate 500 mg tab (Zytiga)	T2	PA QL (60 tabs/fill) SP HD CSL
bicalutamide (Casodex)	T2	CSL
CASODEX (<i>bicalutamide</i>)	T4	CSL
ERLEADA	T5	PA QL (30 tabs/fill) SP HD CSL
EULEXIN (<i>flutamide</i>)	T4	CSL
<i>flutamide</i> (Eulexin)	T2	CSL
NILANDRON (<i>nilutamide</i>)	T4	PA CSL
<i>nilutamide</i> (Nilandron)	T2	PA CSL
NUBEQA	T5	PA QL (120 tabs/fill) SP HD CSL
XTANDI 40 MG CAPSULE	T5	PA QL (120 tabs/caps/fill) SP HD CSL
XTANDI 40 MG TABLET	T5	PA QL (120 tabs/caps/fill) SP HD CSL
XTANDI 80 MG TABLET	T5	PA QL (60 tabs/fill) SP HD CSL
YONSA	T5	PA QL (120 tabs/30 days) SP HD CSL
ANTINEOPLASTIC - ANTIMETABOLITES		
LONSURF	T5	PA SP HD CSL
mercaptopurine 20 mg/ml suspen (Purixan)	T2	ST SP CSL
mercaptopurine 50 mg tablet	T2	CSL
methotrexate 2.5 mg tablet	T2	CSL
methotrexate 250 mg/10 ml vial	T2	

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

T5 – Brand Specialty
PA – Prior Authorization
QL – Quantity Limit

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

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

List of Prescription Medications

ANTINEOPLASTICS (Cancer) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ANTINEOPLASTIC - ANTIMETABOLITES (cont.)		
<i>methotrexate 50 mg/2 ml vial</i>	T2	
<i>methotrexate sodium/pf</i>	T2	
PURIXAN (<i>mercaptopurine</i>)	T5	ST SP CSL
TABLOID	T4	CSL
TREXALL	T4	CSL
XELODA 150 MG TABLET (<i>capecitabine</i>)	T5	PA QL (56 tabs/fill) SP HD CSL
XELODA 500 MG TABLET (<i>capecitabine</i>)	T5	PA QL (140 tabs/fill) SP HD CSL
ANTINEOPLASTIC - AROMATASE INHIBITORS		
<i>anastrozole (Arimidex)</i>	T2	HD PPACA CSL
AROMASIN (<i>exemestane</i>)	T4	HD CSL
<i>exemestane (Aromasin)</i>	T2	HD PPACA CSL
FEMARA (<i>letrozole</i>)	T4	HD CSL
<i>letrozole (Femara)</i>	T2	HD CSL
ANTINEOPLASTIC - BRAF KINASE INHIBITORS		
BRAFTOVI	T5	PA QL (180 caps/30 days) SP HD CSL
OJEMDA	T5	PA SP CSL
TAFINLAR	T5	PA QL (120 caps/fill) SP HD CSL
TAFINLAR 10 MG TABLET FOR SUSP	T5	PA QL (840ml/30 days) SP HD CSL
ZELBORAF	T5	PA QL (240 tabs/fill) SP HD CSL
ANTINEOPLASTIC - HEDGEHOG PATHWAY INHIBITOR		
DAURISMO 25 MG TABLET	T5	PA QL (60 tabs/fill) SP HD CSL
DAURISMO 100 MG TABLET	T5	PA QL (30 tabs/fill) SP HD CSL
ERIVEDGE	T5	PA QL (30 caps/fill) SP HD CSL
ODOMZO	T5	PA QL (30 caps/fill) SP HD CSL
ANTINEOPLASTIC - JANUS KINASE (JAK) INHIBITORS		
JAKAFI	T5	PA QL (60 tabs/fill) SP HD CSL
ANTINEOPLASTIC COMB - KINASE AND AROMATASE INHIBIT		
KISQALI FEMARA 200 MG CO-PACK	T5	PA QL (49 tabs/30 days) SP CSL
KISQALI FEMARA 400 MG CO-PACK	T5	PA QL (70 tabs/30 days) SP CSL
KISQALI FEMARA 600 MG CO-PACK	T5	PA QL (91 tabs/30 days) SP CSL
ANTINEOPLASTIC - KRAS PROTEIN INHIBITOR		
LUMAKRAS	T5	PA SP HD CSL
ANTINEOPLASTIC - MEK KINASE INHIBITORS		
COTELLIC	T5	PA QL (63 tabs/30 days) SP HD CSL

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

T5 – Brand Specialty
PA – Prior Authorization
QL – Quantity Limit

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

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

List of Prescription Medications

ANTINEOPLASTICS (Cancer) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ANTINEOPLASTIC - MEK KINASE INHIBITORS (cont.)		
GOMEKLI	T5	PA SP CSL
KOSELUGO 10 MG CAPSULE	T5	PA SP CSL
KOSELUGO 25 MG CAPSULE	T5	PA SP CSL
MEKINIST 0.05 MG/ML SOLUTION	T5	PA QL (1080 mls/30 days) SP HD CSL
MEKINIST 0.5 MG TABLET	T5	PA QL (90 tabs/30 days) SP HD CSL
MEKINIST 2 MG TABLET	T5	PA QL (30 tabs/30 days) SP HD CSL
MEKTOVI	T5	PA QL (180 tabs/30 days) SP HD CSL
ANTINEOPLASTIC - MTOR KINASE INHIBITORS		
<i>everolimus</i> (Afinitor)	T2	PA QL (30 tabs/30 days) SP CSL
<i>everolimus 2 mg tab for susp</i> (Afinitor Disperz)	T2	PA QL (30 tabs/fill) SP CSL
<i>everolimus 3 mg tab for susp</i> (Afinitor Disperz)	T2	PA QL (30 tabs/fill) SP CSL
<i>everolimus 5 mg tab for susp</i> (Afinitor Disperz)	T2	PA QL (30 tabs/fill) SP CSL
ANTINEOPLASTIC - PROTEIN METHYLTRANSFERASE INHIBIT		
TAZVERIK	T5	PA SP CSL
ANTINEOPLASTIC - SYSTEMIC ENZYME INHIBITORS COMBS		
AVMAPKI-FAKZYNJA	T5	PA SP CSL
ANTINEOPLASTIC - TOPOISOMERASE I INHIBITORS		
HYCAMTIN	T5	PA SP HD CSL
ANTINEOPLASTIC IMMUNOMODULATOR AGENTS		
<i>lenalidomide</i>	T2	PA QL (30 caps/fill) SP HD CSL
POMALYST	T5	PA SP HD CSL
REVLIMID	T5	PA QL (30 caps/fill) SP HD CSL
ANTINEOPLASTIC LHRH(GNRH) ANTAGONIST,PITUIT.SUPPRS		
ORGOVYX	T5	PA QL (30 tabs/fill) SP CSL
ANTINEOPLASTIC SYSTEMIC ENZYME INHIBITORS		
ALECENSA	T5	PA QL (240 caps/fill) SP HD CSL
ALUNBRIG 90 MG, 180 MG TABLET	T5	PA QL (30 tabs/fill) SP CSL
ALUNBRIG 30 MG TABLET	T5	PA QL (60 tabs/fill) SP CSL
ALUNBRIG 90 MG-180 MG TAB PACK	T5	PA QL (30 tabs/fill) SP CSL
AUGTYRO	T5	PA SP CSL
AYVAKIT	T5	PA QL (30 tabs/fill) SP CSL
BALVERSA	T5	PA SP CSL
BOSULIF 50 MG CAPSULE	T5	PA QL (30 caps/fill) SP HD CSL
BOSULIF 100 MG CAPSULE	T5	PA QL (90 caps/fill) SP HD CSL

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

T5 – Brand Specialty
PA – Prior Authorization
QL – Quantity Limit

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

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

List of Prescription Medications

ANTINEOPLASTICS (Cancer) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ANTINEOPLASTIC SYSTEMIC ENZYME INHIBITORS (cont.)		
BOSULIF 100 MG TABLET	T5	PA QL (90 tabs/fill) SP HD CSL
BOSULIF 400 MG, 500 MG TABLET	T5	PA QL (30 tabs/fill) SP HD CSL
BRUKINSA	T5	PA SP CSL
CALQUENCE	T5	PA QL (60 tabs/caps/fill) SP CSL
CAPRELSA 100 MG TABLET	T5	PA QL (60 tabs/fill) SP CSL
CAPRELSA 300 MG TABLET	T5	PA QL (30 tabs/fill) SP CSL
COMETRIQ 100 MG DAILY-DOSE PK	T5	PA QL (56 caps/fill) SP HD CSL
COMETRIQ 140 MG DAILY-DOSE PK	T5	PA QL (112 caps/fill) SP HD CSL
COMETRIQ 60 MG DAILY-DOSE PACK	T5	PA QL (84 caps/fill) SP HD CSL
COPIKTRA	T5	PA QL (56 caps/fill) SP CSL
DANZITEN	T5	PA SP CSL
<i>dasatinib 100 mg tablet (Sprycel)</i>	T2	PA QL (30 tabs/30 days) SP CSL
<i>dasatinib 100 mg tablet (Sprycel)</i>	T2	PA QL (30 tabs/30 days) SP HD CSL
<i>dasatinib 140 mg tablet (Sprycel)</i>	T2	PA QL (30 tabs/30 days) SP CSL
<i>dasatinib 140 mg tablet (Sprycel)</i>	T2	PA QL (30 tabs/30 days) SP HD CSL
<i>dasatinib 20 mg tablet (Sprycel)</i>	T2	PA QL (90 tabs/30 days) SP CSL
<i>dasatinib 20 mg tablet (Sprycel)</i>	T2	PA QL (90 tabs/30 days) SP HD CSL
<i>dasatinib 50 mg tablet (Sprycel)</i>	T2	PA QL (30 tabs/30 days) SP CSL
<i>dasatinib 50 mg tablet (Sprycel)</i>	T2	PA QL (30 tabs/30 days) SP HD CSL
<i>dasatinib 70 mg tablet (Sprycel)</i>	T2	PA QL (60 tabs/30 days) SP CSL
<i>dasatinib 70 mg tablet (Sprycel)</i>	T2	PA QL (60 tabs/30 days) SP HD CSL
<i>dasatinib 80 mg tablet (Sprycel)</i>	T2	PA QL (30 tabs/30 days) SP CSL
<i>dasatinib 80 mg tablet (Sprycel)</i>	T2	PA QL (30 tabs/30 days) SP HD CSL
ENSACOVE	T5	PA SP CSL
<i>erlotinib hcl 25 mg tablet</i>	T2	PA QL (60 tabs/30 days) SP HD CSL
<i>erlotinib hcl 100 mg tablet</i>	T2	PA QL (30 tabs/30 days) SP HD CSL
<i>erlotinib hcl 150 mg tablet</i>	T2	PA QL (30 tabs/30 days) SP HD CSL
FRUZAQLA	T5	PA SP CSL
GAVRETO	T5	PA QL (120 caps/30 days) SP CSL
GILOTRIF	T5	PA QL (30 tabs/fill) SP HD CSL
IBRANCE	T5	PA QL (21 tabs/caps/30 days) SP HD CSL
IBTROZI	T5	PA SP CSL
ICLUSIG	T5	PA QL (30 tabs/fill) SP CSL
IMBRUVICA 70 MG CAPSULE	T5	PA QL (30 caps/fill) SP CSL

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

T5 – Brand Specialty
PA – Prior Authorization
QL – Quantity Limit

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

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

List of Prescription Medications

ANTINEOPLASTICS (Cancer) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ANTINEOPLASTIC SYSTEMIC ENZYME INHIBITORS (cont.)		
IMBRUVICA 70 MG/ML SUSPENSION	T5	PA QL (3 bottles/fill) SP CSL
IMBRUVICA 140 MG CAPSULE	T5	PA QL (120 caps/fill) SP CSL
IMBRUVICA 140 MG, 280 MG, 420 MG TABLET	T5	PA QL (30 tabs/fill) SP CSL
IMKELDI	T5	PA SP CSL
INLYTA 1 MG TABLET	T5	PA QL (180 tabs/fill) SP HD CSL
INLYTA 5 MG TABLET	T5	PA QL (120 tabs/fill) SP HD CSL
IRESSA (<i>gefitinib</i>)	T5	PA QL (30 tabs/30 days) SP HD CSL
IWILFIN	T5	PA SP CSL
KISQALI	T5	PA QL (1 pack/1 time) CSL SP HD
KISQALI FEMARA CO-PACK	T5	PA QL (1 pack/28 days) CSL SP HD
LAZCLUZE	T5	PA SP CSL
<i>lapatinib ditosylate</i> (Tykerb)	T2	PA QL (180 tabs/fill) SP HD CSL
LENVIMA 4 MG CAPSULE	T5	PA QL (30 caps/fill) SP HD CSL
LENVIMA 8 MG, 14 MG DAILY DOSE	T5	PA QL (60 caps/fill) SP HD CSL
LENVIMA 10 MG DAILY DOSE	T5	PA QL (30 caps/fill) SP HD CSL
LENVIMA 12 MG, 18 MG DAILY DOSE	T5	PA QL (90 caps/fill) SP HD CSL
LENVIMA 20 MG DAILY DOSE	T5	PA QL (60 caps/fill) SP HD CSL
LENVIMA 24 MG DAILY DOSE	T5	PA QL (90 caps/fill) SP HD CSL
LORBRENA 100 MG TABLET	T5	PA QL (30 tabs/fill) SP HD CSL
LORBRENA 25 MG TABLET	T5	PA QL (90 tabs/fill) SP HD CSL
LYNPARZA	T5	PA QL (120 tabs/fill) SP HD CSL
LYTGOBI	5	PA SP CSL
NERLYNX	T5	PA SP HD CSL
NEXAVAR (<i>sorafenib tosylate</i>)	T5	PA QL (120 tabs/fill) SP HD CSL
<i>nilotinib 150 mg capsule</i> (Tasigna)	T2	PA QL (112 caps/30 days) SP HD CSL
<i>nilotinib 200 mg capsule</i> (Tasigna)	T2	PA QL (112 caps/30 days) SP HD CSL
<i>nilotinib 50 mg capsule</i> (Tasigna)	T2	PA QL (120 caps/30 days) SP HD CSL
NINLARO	T5	PA QL (3 caps/fill) SP HD CSL
OGSIVEO	T5	PA SP CSL
<i>pazopanib hcl</i> (Votrient)	T2	PA QL (120 tabs/30 days) SP HD CSL
PEMAZYRE	T5	PA QL (28 tabs/fill) SP CSL
PIQRAY	T5	PA SP CSL
RETEVMO 40 MG CAPSULE	T5	PA QL (180 caps/fill) SP HD CSL
RETEVMO 80 MG CAPSULE	T5	PA QL (120 caps/fill) SP HD CSL

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

T5 – Brand Specialty
PA – Prior Authorization
QL – Quantity Limit

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

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

List of Prescription Medications

ANTINEOPLASTICS (Cancer) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ANTINEOPLASTIC SYSTEMIC ENZYME INHIBITORS (cont.)		
RETEVMO 40 MG TABLET	T5	PA QL (90 tabs/fill) SP HD CSL
RETEVMO 80 MG, 120 MG, 160 MG TABLET	T5	PA QL (60 tabs/fill) SP HD CSL
REVUFORJ	T5	PA SP CSL
ROMVIMZA	T5	PA QL (8 caps/fill) SP CSL
ROZLYTREK 100 MG CAPSULE	T5	PA QL (30 caps/fill) SP HD CSL
ROZLYTREK 200 MG CAPSULE	T5	PA QL (90 caps/fill) SP HD CSL
ROZLYTREK 50 MG PELLETT PACKET	T5	PA QL (42 packs/fill) SP HD CSL
RYDAPT	T5	PA QL (224 caps/fill) SP HD CSL
SCEMBLIX 20 MG TABLET	T5	PA QL (600 tabs/30 days) SP CSL
SCEMBLIX 40 MG TABLET	T5	PA QL (300 tabs/30 days) SP CSL
SCEMBLIX 100 MG TABLET	T5	PA QL (120 tabs/fill) SP CSL
sorafenib tosylate (Nexavar)	T2	PA QL (120 tabs/fill) SP HD CSL
STIVARGA	T5	PA QL (84 tabs/fill) SP HD CSL
sunitinib malate 12.5 mg cap (Sutent)	T2	PA QL (90 caps/fill) SP HD CSL
sunitinib malate 25 mg capsule (Sutent)	T2	PA QL (30 caps/fill) SP HD CSL
sunitinib malate 37.5 mg cap (Sutent)	T2	PA QL (30 caps/fill) SP HD CSL
sunitinib malate 50 mg capsule (Sutent)	T2	PA QL (30 caps/fill) SP HD CSL
SUTENT 12.5 MG CAPSULE (sunitinib malate)	T5	PA QL (90 caps/fill) SP HD CSL
SUTENT 25 MG CAPSULE (sunitinib malate)	T5	PA QL (30 caps/fill) SP HD CSL
SUTENT 37.5 MG CAPSULE (sunitinib malate)	T5	PA QL (30 caps/fill) SP HD CSL
SUTENT 50 MG CAPSULE (sunitinib malate)	T5	PA QL (30 caps/fill) SP HD CSL
TABRECTA	T5	PA SP HD CSL
TAGRISSO	T5	PA QL (30 tabs/fill) SP HD CSL
TALZENNA	T5	PA QL (30 caps/fill) SP HD CSL
TALZENNA 0.1 MG CAPSULE, SOFTGEL	T5	PA QL (30 caps/fill) SP HD CSL
TALZENNA 0.25 MG SOFTGEL	T5	PA QL (30 caps/30 days) SP HD CSL
TALZENNA 0.35 MG CAPSULE, SOFTGEL	T5	PA QL (30 caps/fill) SP HD CSL
TALZENNA 0.5 MG SOFTGEL	T5	PA QL (30 caps/30 days) SP HD CSL
TALZENNA 0.75 MG SOFTGEL	T5	PA QL (30 caps/30 days) SP HD CSL
TALZENNA 1 MG SOFTGEL	T5	PA QL (30 caps/30 days) SP HD CSL
TASIGNA 50 MG CAPSULE (nilotinib hcl)	T5	PA QL (120 caps/30 days) SP HD CSL
TASIGNA 150 MG CAPSULE (nilotinib hcl)	T5	PA QL (112 caps/30 days) SP HD CSL
TASIGNA 200 MG CAPSULE (nilotinib hcl)	T5	PA QL (112 caps/30 days) SP HD CSL
TRUQAP	T5	PA SP CSL

T1 – Preferred Generics

T2 – Non-Preferred Generics

T3 – Preferred Brands

T4 – Non-Preferred Brands

T5 – Brand Specialty

PA – Prior Authorization

QL – Quantity Limit

ST – Step Therapy

AGE – Age Requirement

SP – Specialty Medication

HD – May require home delivery pharmacy

PPACA – No Cost-Share Preventive Medication

CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

ANTINEOPLASTICS (Cancer) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ANTINEOPLASTIC SYSTEMIC ENZYME INHIBITORS (cont.)		
TUKYSA 150 MG TABLET	T5	PA QL (120 tabs/fill) SP CSL
TUKYSA 50 MG TABLET	T5	PA QL (300 tabs/fill) SP CSL
TURALIO	T5	PA QL (120 caps/fill) SP CSL
VERZENIO	T5	PA QL (60 tabs/fill) SP HD CSL
VITRAKVI 100 MG CAPSULE	T5	PA QL (60 caps/fill) SP HD CSL
VITRAKVI 20 MG/ML SOLUTION	T5	PA QL (300 mls/fill) SP HD CSL
VITRAKVI 25 MG CAPSULE	T5	PA QL (180 caps/fill) SP HD CSL
VIZIMPRO	T5	PA QL (30 tabs/fill) SP HD CSL
VONJO	T5	PA QL (120 caps/fill) SP CSL
VOTRIENT (<i>pazopanib hcl</i>)	T5	PA QL (120 tabs/30 days) SP HD CSL
XALKORI 200MG, 250MG CAPSULE	T5	PA QL (60 caps/30 days) SP HD CSL
XALKORI 20MG, 50MG, 150MG PELLETT	T5	PA QL (120 caps/fill) SP HD CSL
XOSPATA	T5	PA QL (90 tabs/fill) SP CSL
ZYDELIG	T5	PA QL (60 tabs/fill) SP HD CSL
ZYKADIA	T5	PA QL (90 tabs/caps/fill)SP HD CSL
ANTINEOPLASTIC-B CELL LYMPHOMA-2(BCL-2) INHIBITORS		
VENCLEXTA 10 MG TAB (10MG X 2)	T5	PA QL (56 tabs/fill) SP CSL
VENCLEXTA 10 MG TABLET	T5	PA QL (56 tabs/fill) SP CSL
VENCLEXTA 100 MG TABLET	T5	PA QL (180 tabs/fill) SP CSL
VENCLEXTA 50 MG TABLET	T5	PA QL (28 tabs/fill) SP CSL
VENCLEXTA STARTING PACK	T5	PA QL (42 tabs/fill) SP CSL
ANTINEOPLASTIC-HYPOXIA INDUCIBLE FACTOR (HIF) INH		
WELIREG	T5	PA SP CSL
ANTINEOPLASTIC-ISOCITRATE DEHYDROGENASE INHIBITORS		
IDHIFA	T5	PA QL (30 tabs/fill) SP HD CSL
TIBSzeppbouOVO	T5	PA SP CSL
VORANIGO	T5	PA SP CSL
ANTINEOPLASTICS, MISCELLANEOUS		
<i>etoposide</i>	T2	SP HD CSL
LYSODREN	T3	CSL
MATULANE	T5	SP CSL
<i>tretinoin 10 mg capsule</i>	T2	CSL
IMMUNOMODULATORS		
ACTIMMUNE	T5	PA SP HD

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

T5 – Brand Specialty
PA – Prior Authorization
QL – Quantity Limit

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

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

List of Prescription Medications

ANTINEOPLASTICS (Cancer) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
SELECTIVE ESTROGEN RECEPTOR MODULATORS (SERMS)		
FARESTON (<i>toremifene citrate</i>)	T4	HD CSL
SOLTAMOX	T4	HD PPACA CSL
<i>tamoxifen citrate</i>	T2	HD PPACA CSL
<i>toremifene citrate</i> (Fareston)	T2	HD CSL
STEROID ANTINEOPLASTICS		
<i>megestrol 20 mg, 40 mg tablet</i>	T2	CSL
ANTINEOPLASTICS (Skin Conditions)		
PHOTOACT, TOPICAL ANTINEOPLAST, PREMALIGNANT LESIONS		
LEVULAN	T5	SP
TOPICAL ANTINEOPLASTIC PREMALIGNANT LESION AGENTS		
<i>bexarotene 1% gel</i> (Targretin)	T2	PA SP HD
diclofenac sodium 3% gel	T2	PA QL (100 gms/28 days)
EFUDEX (<i>fluorouracil</i>)	T4	
FLUOROPLEX	T4	
<i>fluorouracil 2% topical soln</i>	T2	
<i>fluorouracil 5% cream</i> (Efudex)	T2	
<i>fluorouracil 5% topical soln</i>	T2	
PANRETIN	T5	PA SP HD
TARGRETIN 1% GEL (<i>bexarotene</i>)	T5	PA SP HD
VALCHLOR	T5	PA SP HD
ANTI-OBESITY DRUGS (Weight Management)		
ANTI-OBESITY - ANOREXIC AGENTS		
ADIPEX-P (<i>phentermine hcl</i>)	T4	PA QL (30 tabs/30 days)
<i>benzphetamine hcl</i>	T2	PA QL (90 tabs/fill)
<i>diethylpropion hcl</i>	T2	PA QL (90 tabs/fill)
<i>diethylpropion hcl</i>	T2	PA QL (30 tabs/fill)
LOMAIRA	T4	PA QL (90 tabs/fill)
<i>phendimetrazine tartrate</i>	T2	PA QL (30 caps/fill)
<i>phendimetrazine tartrate</i>	T2	PA QL (180 tabs/fill)
<i>phentermine 15 mg capsule</i>	T2	PA QL (30 caps/fill)
<i>phentermine 30 mg capsule</i>	T2	PA QL (30 caps/fill)
<i>phentermine 37.5 mg capsule</i>	T2	PA QL (30 caps/30 days)
<i>phentermine 8 mg tablet</i>	T2	PA QL (90 tabs/30 days)

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

T5 – Brand Specialty
PA – Prior Authorization
QL – Quantity Limit

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

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

List of Prescription Medications

ANTI-OBESITY DRUGS (Weight Management) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ANTI-OBESITY - ANOREXIC AGENTS		
<i>phentermine 37.5 mg tablet</i> (Adipex-P)	T2	PA QL (30 tabs/fill)
<i>phentermine/topiramate</i> (Qsymia)	T2	PA QL (30 caps/30 days)
QSYMIA (<i>phentermine/topiramate</i>)	T4	PA QL (30 caps/30 days)
ANTI-OBESITY - MELANOCORTIN 4 RECEPTOR AGONISTS		
IMCIVREE	T5	PA QL (6 mls/30 days) SP
ANTI-OBESITY GLUCAGON-LIKE PEPTIDE-1 RECEPTOR AGONIST		
<i>liraglutide 18 mg/3 ml pen</i> (Saxenda)	T2	PA QL (5 pens/30 days)
<i>liraglutide 5-pak 18 mg/3 ml</i> (Saxenda)	T2	PA QL (5 pens/30 days)
SAXENDA (<i>liraglutide</i>)	T4	PA QL (5 pens/30 days)
WEGOVY 0.25 MG/0.5 ML PEN	T3	PA QL (8 pens/year)
WEGOVY 0.5 MG/0.5 ML PEN	T3	PA QL (8 pens/year)
WEGOVY 1 MG/0.5 ML PEN	T3	PA QL (8 pens/year)
WEGOVY 1.7 MG/0.75 ML PEN	T3	PA QL (8 pens/year)
WEGOVY 2.4 MG/0.75 ML PEN	T3	PA QL (4 pens/28 days)
ANTI-OBESITY - INCRETIN MIMETICS COMBINATION		
ZEPBOUND 2.5 MG/0.5 ML PEN	T3	PA QL (2 mls/28 days)
ZEPBOUND 5 MG/0.5 ML PEN	T3	PA QL (2 mls/28 days)
ZEPBOUND 7.5 MG/0.5 ML PEN	T3	PA QL (2 mls/28 days)
ZEPBOUND 10 MG/0.5 ML PEN	T3	PA QL (2 mls/28 days)
ZEPBOUND 12.5 MG/0.5 ML PEN	T3	PA QL (2 mls/28 days)
ZEPBOUND 15 MG/0.5 ML PEN	T3	PA QL (2 mls/28 days)
ZEPBOUND 2.5 MG/0.5 ML VIAL	T4	PA QL (2 mls/28 days)
ZEPBOUND 5 MG/0.5 ML VIAL	T4	PA QL (2 mls/28 days)
ZEPBOUND 7.5 MG/0.5 ML VIAL	T4	PA QL (2 mls/28 days)
ZEPBOUND 10 MG/0.5 ML VIAL	T4	PA QL (2 mls/28 days)
ZEPBOUND 12.5 MG/0.5 ML VIAL	T4	PA QL (2 mls/28 days)
ZEPBOUND 15 MG/0.5 ML VIAL	T4	PA QL (2 mls/28 days)
ANTI-OBESITY SEROTONIN 2C RECEPTOR AGONISTS		
BELVIQ	T4	PA
BELVIQ XR	T4	PA
ANTI-OBESITY-OPIOID ANTAG-NOREPI, DOPAMINE RECEPTOR INHIB		
CONTRAVE	T4	PA QL (120 tabs/fill)
FAT ABSORPTION DECREASING AGENTS		
ORLISTAT	T4	PA QL (90 caps/fill)
XENICAL	T4	PA QL (90 caps/fill)

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

T5 – Brand Specialty
PA – Prior Authorization
QL – Quantity Limit

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

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

List of Prescription Medications

ANTIPARASITICS (Eye Conditions)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
OPHTHALMIC (EYE) ANTIPARASITICS		
XDEMVI	T5	QL (10 mgs/30 days) SP
ANTIPARASITICS (Infections)		
ANTIPARASITICS		
ALINIA 100 MG/5 ML SUSPENSION	T3	QL (360 mls/30 days)
TOPICAL ANTIPARASITICS		
<i>crotamiton</i>	T2	
ELIMITE (<i>permethrin</i>)	T4	
EURAX	T4	
<i>permethrin</i> (Elimite)	T2	
<i>spinosad</i> (Natroba)	T2	
ULESFIA	T4	
ANTIPARKINSON DRUGS (Parkinson's Disease)		
ANTIPARKINSONISM DRUGS,ANTICHOLINERGIC		
<i>benztropine mesylate</i>	T1	HD
<i>trihexyphenidyl hcl</i>	T2	HD
ANTIPARKINSONISM DRUGS, OTHER		
<i>amantadine hcl</i>	T2	HD
<i>apomorphine hcl</i>	T2	PA QL (30 mls/30 days) SP
AZILECT (<i>rasagiline mesylate</i>)	T4	ST HD
<i>bromocriptine mesylate</i>	T2	HD
<i>carbidopa/levodopa</i>	T2	HD
<i>carbidopa/levodopa</i> (Sinemet)	T2	HD
<i>carbidopa/levodopa/entacapone</i>	T2	HD
<i>carbidopa/levodopa/entacapone</i> (Stalevo 75)	T2	HD
<i>carbidopa/levodopa/entacapone</i> (Stalevo 100)	T2	HD
<i>carbidopa/levodopa/entacapone</i> (Stalevo 125)	T2	HD
<i>carbidopa/levodopa/entacapone</i>	T2	HD
CREXONT	T4	ST HD
DUOPA	T5	PA SP HD
<i>entacapone</i>	T2	HD
INBRIJA	T5	PA QL (300 caps/fill) SP HD
KYNMOBI	T3	PA QL (150 films/30 days) HD
NEUPRO	T4	HD

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

T5 – Brand Specialty
PA – Prior Authorization
QL – Quantity Limit

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

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

List of Prescription Medications

ANTIPARKINSON DRUGS (Parkinson's Disease) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ANTIPARKINSONISM DRUGS, OTHER		
NOURIANZ	T5	PA QL (30 tabs/fill) SP HD
ONGENTYS	T4	PA QL (30 caps/30 days) HD
<i>pramipexole di-hcl</i>	T2	HD
<i>rasagiline mesylate</i> (Azilect)	T2	HD
<i>ropinirole hcl</i>	T2	HD
RYTARY	T4	HD
<i>selegiline hcl</i>	T2	HD
SINEMET (<i>carbidopa/levodopa</i>)	T4	HD
STALEVO 75 (<i>carbidopa/levodopa/entacapone</i>)	T4	HD
STALEVO 100 (<i>carbidopa/levodopa/entacapone</i>)	T4	HD
TASMAR (<i>tolcapone</i>)	T4	PA HD
<i>tolcapone</i> (Tasmar)	T2	PA HD
DECARBOXYLASE INHIBITORS		
<i>carbidopa</i> (Lodosyn)	T2	PA
LODOSYN (<i>carbidopa</i>)	T4	PA
ANTIPLATELET DRUGS (Blood Thinners/Anti-Clotting)		
PLATELET AGGREGATION INHIBITORS		
<i>aspirin/dipyridamole</i>	T2	HD
ASPIRIN-OMEPRAZOLE	T4	PA HD
BRILINTA (<i>ticagrelor</i>)	T4	ST HD
<i>cilostazol</i>	T2	HD
<i>clopidogrel bisulfate</i>	T1	HD
<i>clopidogrel bisulfate</i> (Plavix)	T1	HD
<i>dipyridamole</i>	T2	HD
EFFIENT (<i>prasugrel hcl</i>)	T4	HD
<i>prasugrel hcl</i> (Effient)	T2	HD
<i>ticagrelor</i> (Brilinta)	T2	HD
ZONTIVITY	T4	PA HD
PLATELET REDUCING AGENTS		
AGRYLIN (<i>anagrelide hcl</i>)	T4	
<i>anagrelide hcl</i>	T2	
<i>anagrelide hcl</i> (Agyrin)	T2	

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

T5 – Brand Specialty
PA – Prior Authorization
QL – Quantity Limit

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

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

List of Prescription Medications

ANTIVIRALS (AIDS/HIV)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ANTIRETROVIRAL - CAPSID INHIBITORS		
YEZTUGO	T5	SP
ANTIRETROVIRAL-INTEGRASE INHIBITOR AND NNRTI COMB.		
JULUCA	T5	SP
DOVATO	T5	SP
TRIUMEQ	T5	SP
TRIUMEQ PD	T5	SP
ANTIRETROVIRAL-NUCLEOSIDE, NUCLEOTIDE, PROTEASE INH.		
SYMITUZA	T5	SP
ANTIVIRALS, HIV-SPEC, NON-PEPTIDIC PROTEASE INHIB		
APTIVUS	T5	SP
<i>darunavir</i> (Prezista)	T2	SP
PREZISTA 600MG, 800MG TABLET (<i>darunavir</i>)	T5	SP
ANTIVIRALS, HIV-SPEC, NUCLEOSIDE-NUCLEOTIDE ANALOG		
CIMDUO	T5	SP
DESCOVY	T5	SP
<i>emtricitabine-tenofv 100-150mg</i> (Truvada)	T2	SP
<i>emtricitabine-tenofv 133-200mg</i> (Truvada)	T2	SP
<i>emtricitabine-tenofv 167-250mg</i> (Truvada)	T2	SP
<i>emtricitabine-tenofv 200-300mg</i> (Truvada)	T2	SP PPACA
TEMIXYS	T5	SP
ANTIVIRALS, HIV-SPEC., NUCLEOSIDE ANALOG, RTI COMB		
<i>abacavir sulfate/lamivudine</i> (Epzicom)	T2	SP
COMBIVIR (<i>lamivudine/zidovudine</i>)	T5	SP
EPZICOM (<i>abacavir sulfate/lamivudine</i>)	T5	SP
<i>lamivudine/zidovudine</i> (Combivir)	T2	SP
ANTIVIRALS, HIV-SPECIFIC, CCR5 CO-RECEPTOR ANTAG.		
<i>maraviroc</i> (Selzentry)	T2	SP
SELZENTRY 150 MG TABLET (<i>maraviroc</i>)	T5	SP
SELZENTRY 20 MG/ML ORAL SOLN	T5	SP
SELZENTRY 300 MG TABLET (<i>maraviroc</i>)	T5	SP
ANTIVIRALS, HIV-SPECIFIC, FUSION INHIBITORS		
FUZEON	T5	PA SP
ANTIVIRALS, HIV-SPECIFIC, NON-NUCLEOSIDE, RTI		
EDURANT	T5	SP

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

T5 – Brand Specialty
PA – Prior Authorization
QL – Quantity Limit

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

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

List of Prescription Medications

ANTIVIRALS (AIDS/HIV) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ANTIVIRALS, HIV-SPECIFIC, NON-NUCLEOSIDE, RTI (cont.)		
EDURANT PED	T5	SP
<i>efavirenz</i> (Sustiva)	T2	SP
<i>etravirine</i> (Intelence)	T2	SP
INTELENCE 100 MG TABLET (<i>etravirine</i>)	T5	SP
INTELENCE 200 MG TABLET (<i>etravirine</i>)	T5	SP
INTELENCE 25 MG TABLET	T5	SP
<i>nevirapine</i>	T2	SP
PIFELTRO	T5	SP
SUNLENCA	T5	PA SP
SUSTIVA (<i>efavirenz</i>)	T5	SP
ANTIVIRALS, HIV-SPECIFIC, NUCLEOSIDE ANALOG, RTI		
<i>abacavir sulfate</i> (Ziagen)	T2	SP
<i>didanosine</i>	T2	SP
<i>emtricitabine</i> (Emtriva)	T2	SP
EMTRIVA 10 MG/ML SOLUTION	T5	SP
EMTRIVA 200 MG CAPSULE (<i>emtricitabine</i>)	T5	SP
EPIVIR (<i>lamivudine</i>)	T5	SP
<i>lamivudine</i> (EpiVir)	T2	SP
RETROVIR (<i>zidovudine</i>)	T5	SP
<i>stavudine</i>	T2	SP
ZIAGEN (<i>abacavir sulfate</i>)	T5	SP
<i>zidovudine</i>	T2	SP
<i>zidovudine</i> (Retrovir)	T2	SP
<i>tenofovir disoproxil fumarate</i> (Viread)	T2	SP
VIREAD 150 MG, 200 MG TABLET	T5	SP
VIREAD 250 MG TABLET	T5	SP
VIREAD 300 MG TABLET (<i>tenofovir disoproxil fumarate</i>)	T5	SP
VIREAD POWDER	T5	SP
ANTIVIRALS, HIV-SPECIFIC, PROTEASE INHIBITOR COMB		
<i>lopinavir/ritonavir</i>	T2	SP
KALETRA	T5	SP
<i>lopinavir/ritonavir</i> (Kaletra)	T2	SP
KALETRA (<i>lopinavir/ritonavir</i>)	T5	SP

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

T5 – Brand Specialty
PA – Prior Authorization
QL – Quantity Limit

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

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

List of Prescription Medications

ANTIVIRALS (AIDS/HIV) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ANTIVIRALS, HIV-SPECIFIC, PROTEASE INHIBITORS		
<i>abacavir sulfate</i>	T2	SP
<i>atazanavir sulfate</i> (Reyataz)	T2	SP
EVOTAZ	T5	SP
<i>fosamprenavir calcium</i>	T2	SP
NORVIR 100 MG POWDER PACKET	T5	SP
NORVIR 100 MG TABLET (<i>ritonavir</i>)	T5	SP
REYATAZ 150 MG CAPSULE (<i>atazanavir sulfate</i>)	T5	SP
REYATAZ 200 MG CAPSULE (<i>atazanavir sulfate</i>)	T5	SP
REYATAZ 300 MG CAPSULE (<i>atazanavir sulfate</i>)	T5	SP
REYATAZ 50 MG POWDER PACKET	T5	SP
<i>ritonavir</i> (Norvir)	T2	SP
VIRACEPT	T5	SP
ANTIVIRALS, HIV-1 INTEGRASE STRAND TRANSFER INHIBITORS		
APRETUDE	T5	SP PPACA
ISENTRESS	T5	SP
ISENTRESS HD	T5	SP
TIVICAY	T5	SP
TIVICAY PD	T5	SP
ARTV NUCLEOSIDE, NUCLEOTIDE, NON-NUCLEOSIDE RTI COMB		
DELSTRIGO	T5	SP
<i>efavirenz/emtricit/tenofovr df</i> (Complera)	T2	SP
<i>efavirenz/lamivu/tenofov disop</i> (Symfi Lo)	T2	SP
<i>efavirenz/lamivu/tenofov disop</i> (Symfi)	T2	SP
<i>emtricit/rilpivirine/tenof df</i>	T2	SP
ODEFSEY	T5	SP
SYMFI (<i>efavirenz/lamivu/tenofov disop</i>)	T5	SP
SYMFI LO (<i>efavirenz/lamivu/tenofov disop</i>)	T5	SP
ARV-NUCLEOSIDE, NUCLEOTIDE RTI, INTEGRASE INHIBITORS		
BIKTARVY	T5	SP
GENVOYA	T5	SP
ANTIVIRALS (Eye Conditions)		
EYE ANTIVIRALS		
<i>trifluridine</i>	T2	
ZIRGAN	T4	

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

T5 – Brand Specialty
PA – Prior Authorization
QL – Quantity Limit

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

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

List of Prescription Medications

ANTIVIRALS (Infections)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ANTIVIRAL - MAIN PROTEASE (MPRO) INHIBITOR		
PAXLOVID 150-100 MG (MODERATE)	T3	QL (20 tabs/180 days)
PAXLOVID 300/150-100MG(SEVERE)	T3	
ANTIVIRAL MONOCLONAL ANTIBODIES		
BEYFORTUS	T2	PPACA
ENFLONSIA	T3	PPACA
ANTIVIRALS, GENERAL		
<i>acyclovir 200 mg/5 ml susp cup</i>	T2	
<i>acyclovir 800 mg/20ml susp cup</i>	T2	
<i>acyclovir 200 mg capsule</i>	T2	
<i>acyclovir 200 mg/5 ml susp (Zovirax)</i>	T2	
<i>acyclovir 400 mg tablet</i>	T2	
<i>acyclovir 800 mg tablet</i>	T2	
<i>famciclovir 125 mg tablet</i>	T2	QL (21 tabs/fill)
<i>famciclovir 250 mg tablet</i>	T2	QL (60 tabs/fill)
<i>famciclovir 500 mg tablet</i>	T2	QL (21 tabs/fill)
FLUMADINE (<i>rimantadine hcl</i>)	T4	
LIVTENCITY	T5	PA QL (112 tabs/28 days) SP
<i>oseltamivir 6 mg/ml suspension (Tamiflu)</i>	T2	QL (180 mls/fill)
<i>oseltamivir phos 30 mg capsule (Tamiflu)</i>	T2	QL (20 caps/fill)
<i>oseltamivir phos 45 mg capsule (Tamiflu)</i>	T2	QL (10 caps/fill)
<i>oseltamivir phos 75 mg capsule (Tamiflu)</i>	T2	QL (10 caps/fill)
PREVYMIS 20 MG PELLETT PACKET	T5	SP
PREVYMIS 120 MG PELLETT PACKET	T5	SP
PREVYMIS 240 MG TABLET	T5	QL (30 tabs/28 days) SP HD
PREVYMIS 480 MG TABLET	T5	QL (30 tabs/28 days) SP HD
RELENZA	T4	QL (20 blisters/fill)
<i>rimantadine hcl (Flumadine)</i>	T2	
SITAVIG	T4	PA QL (2 tabs/30 days)
TAMIFLU 30 MG CAPSULE (<i>oseltamivir phosphate</i>)	T4	QL (20 caps/fill)
TAMIFLU 45 MG CAPSULE (<i>oseltamivir phosphate</i>)	T4	QL (10 caps/fill)
TAMIFLU 75 MG CAPSULE (<i>oseltamivir phosphate</i>)	T4	QL (10 caps/fill)
TAMIFLU 6 MG/ML SUSPENSION (<i>oseltamivir phosphate</i>)	T4	QL (180 mls/fill)
<i>valacyclovir hcl (Valtrex)</i>	T2	QL (30 tabs/fill)

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

T5 – Brand Specialty
PA – Prior Authorization
QL – Quantity Limit

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

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

List of Prescription Medications

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

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

T5 – Brand Specialty
PA – Prior Authorization
QL – Quantity Limit

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

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

List of Prescription Medications

ANTIVIRALS (Skin Conditions) (cont.)

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

AUTONOMIC DRUGS (Allergy/Nasal Sprays)

ANAPHYLAXIS THERAPY AGENTS		
AUVI-Q	T3	QL (2 auto-injs/30 days)
<i>epinephrine 0.15 mg auto-inject</i> (Epipen Jr 2-Pak)	T2	QL (2 auto-injs/fill)
<i>epinephrine 0.15 mg auto-inject</i> (Epipen Jr)	T2	QL (2 auto-injs/fill)
<i>epinephrine 0.3 mg auto-inject</i> (Epipen 2-Pak)	T2	QL (2 auto-injs/fill)
<i>epinephrine 0.3 mg auto-inject</i> (Epipen)	T2	QL (2 auto-injs/fill)
EPIPEN (<i>epinephrine</i>)	T3	PA QL (2 auto-injs/fill)
EPIPEN 2-PAK (<i>epinephrine</i>)	T3	PA QL (2 auto-injs/fill)
EPIPEN JR (<i>epinephrine</i>)	T3	PA QL (2 auto-injs/fill)
EPIPEN JR 2-PAK (<i>epinephrine</i>)	T3	PA QL (2 auto-injs/fill)
EPINEPHRINE 0.3 MG/0.3 ML SYR	T4	QL (2 syringes/30 days)
NEFFY	T3	QL (4 units/fill)

AUTONOMIC DRUGS (Alzheimer's Disease)

CHOLINESTERASE INHIBITORS		
ADLARITY	T4	ST HD
ARICEPT (<i>donepezil hcl</i>)	T4	ST HD
<i>donepezil hcl</i>	T1	HD
<i>donepezil hcl 10 mg tablet</i> (Aricept)	T1	HD
<i>donepezil hcl 23 mg tablet</i> (Aricept)	T1	ST HD
<i>donepezil hcl 5 mg tablet</i> (Aricept)	T1	HD
EXELON (<i>rivastigmine</i>)	T4	ST HD
<i>galantamine hbr</i>	T2	HD
<i>galantamine hbr</i> (Razadyne Er)	T2	HD
<i>pyridostigmine 60 mg/5 ml soln</i> (Mestinon)	T2	HD
PYRIDOSTIGMINE ER 105 MG TAB	T4	
<i>pyridostigmine er 180 mg tab</i> (Mestinon)	T2	HD
PYRIDOSTIGMINE BR 30 MG TABLET	T4	HD
<i>pyridostigmine br 60 mg tablet</i> (Mestinon)	T2	HD
RAZADYNE ER (<i>galantamine hbr</i>)	T4	ST HD
<i>rivastigmine</i> (Exelon)	T2	HD
<i>rivastigmine tartrate</i>	T2	HD

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

T5 – Brand Specialty
PA – Prior Authorization
QL – Quantity Limit

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

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

List of Prescription Medications

AUTONOMIC DRUGS (Attention Deficit Hyperactivity Disorder)⁹

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

AUTONOMIC DRUGS (Blood Pressure/Heart Medications)

ADRENERGIC VASOPRESSOR AGENTS		
<i>droxidopa</i> (Northera)	T2	PA SP HD
<i>midodrine hcl</i>	T2	
DIBENZYLINE (<i>phenoxybenzamine hcl</i>)	T4	PA HD
<i>phenoxybenzamine hcl</i> (Dibenzylamine)	T2	PA HD

AUTONOMIC DRUGS (Urinary Tract Conditions)

PARASYMPATHETIC AGENTS		
<i>bethanechol chloride</i>	T2	HD
<i>bethanechol chloride</i> (Urecholine)	T2	HD
<i>cevimeline hcl</i> (Evoxac)	T2	HD
EVOXAC (<i>cevimeline hcl</i>)	T4	HD
<i>pilocarpine hcl 5 mg tablet</i> (Salagen)	T2	HD
<i>pilocarpine hcl 7.5 mg tablet</i> (Salagen)	T2	HD

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

T5 – Brand Specialty
PA – Prior Authorization
QL – Quantity Limit

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

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

List of Prescription Medications

AUTONOMIC DRUGS (Urinary Tract Conditions) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
PARASYMPATHETIC AGENTS (cont.)		
SALAGEN (<i>pilocarpine hcl</i>)	T4	HD
URECHOLINE (<i>bethanechol chloride</i>)	T4	HD
BIOLOGICALS (Allergy/Nasal Sprays)		
ALLERGENIC EXTRACTS, THERAPEUTIC		
GRASTEK	T3	PA
ODACTRA	T3	PA
ORALAIR	T3	PA
RAGWITEK	T3	PA
BIOLOGICALS (Blood Pressure/Heart Medications)		
PLASMA KALLIKREIN INHIBITORS		
TAKHZYRO	T4	PA SP HD
BIOLOGICALS (Miscellaneous)		
PKU TREATMENT AGENTS - PHENYLALANINE AMMONIA LYASE		
PALYNZIQ 10 MG/0.5 ML SYRINGE	T5	PA QL (30 syringes/fill) SP HD
PALYNZIQ 2.5 MG/0.5 ML SYRINGE	T5	PA QL (8 syringes/fill) SP HD
PALYNZIQ 20 MG/ML SYRINGE	T5	PA QL (60 syringes/fill) SP HD
BIOLOGICALS (Vaccines)		
COVID-19 VACCINES		
COMIRNATY	T3	PPACA
JANSSEN COVID-19 VACCINE (EUA)	T3	PPACA
MNEXSPIKE	T3	PPACA
MODERNA COVID EUA	T3	PPACA
MODERNA COVID-19 BOOSTER (EUA)	T3	PPACA
NOVAVAX COVID (EUA)	T3	PPACA
NOVAVAX COVID-19 VACC,ADJ(EUA)	T3	PPACA
NUVAXOVID	T3	PPACA
PFIZER COVID EUA	T3	PPACA
PFIZER COVID-19 VACCINE (EUA)	T3	PPACA
SPIKEVAX	T3	PPACA
SPIKEVAX COVID (18Y UP) VACC	T3	PPACA
ENTERIC VIRUS VACCINES		
IPOL	T3	PPACA

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

T5 – Brand Specialty
PA – Prior Authorization
QL – Quantity Limit

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

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

List of Prescription Medications

BIOLOGICALS (Vaccines) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ENTERIC VIRUS VACCINES (cont.)		
ROTARIX	T4	HD PPACA
ROTATEQ	T3	PPACA
GRAM NEGATIVE COCCI VACCINES		
BEXSERO	T3	PPACA
MENACTRA	T3	
MENQUADFI	T3	PPACA
MENVEO A-C-Y-W-135-DIP	T3	PPACA
PENBRAYA	T3	PPACA
PENMENVY MEN A-B-C-W-Y	T3	PPACA
TRUMENBA	T3	PPACA
GRAM POSITIVE COCCI VACCINES		
CAPVAXIVE	T3	PPACA
PNEUMOVAX 23	T3	PPACA
PREVNAR 13	T3	
PREVNAR 20	T3	PPACA
VAXNEUVANCE	T3	PPACA
INFLUENZA VIRUS VACCINES		
AUDENZ (NATIONAL STOCKPILE)	T3	
AFLURIA	T3	PPACA
AFLURIA QUAD	T3	PPACA
AFLURIA TRIV	T3	PPACA
AFLURIA TRIVALENT	T3	PPACA
FLUAD	T3	PPACA
FLUAD QUAD	T3	PPACA
FLUAD TRIVALENT	T3	PPACA
FLUARIX	T3	PPACA
FLUARIX QUAD	T3	PPACA
FLUARIX TRIVALENT	T3	PPACA
FLUBLOK	T3	PPACA
FLUBLOK QUAD	T3	PPACA
FLUBLOK TRIVALENT	T3	PPACA
FLUCELVAX	T3	PPACA
FLUCELVAX QUAD	T3	PPACA
FLUCELVAX TRIVALENT	T3	PPACA

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

T5 – Brand Specialty
PA – Prior Authorization
QL – Quantity Limit

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

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

List of Prescription Medications

BIOLOGICALS (Vaccines) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
INFLUENZA VIRUS VACCINES (cont.)		
FLULAVAL	T3	PPACA
FLULAVAL QUAD	T3	PPACA
FLULAVAL TRIVALENT	T3	PPACA
FLUMIST	T3	PPACA
FLUMIST HOME	T3	PPACA
FLUMIST QUAD	T3	PPACA
FLUMIST TRIVALENT	T3	PPACA
FLUZONE	T3	PPACA
FLUZONE HIGH-DOSE	T3	PPACA
FLUZONE HIGH-DOSE QUAD	T3	PPACA
FLUZONE HIGH-DOSE TRIV	T3	PPACA
FLUZONE TRIVALENT	T3	PPACA
FLUZONE QUAD	T3	PPACA
FLUZONE QUAD PEDI	T3	PPACA
NEUROTOXIC VIRUS VACCINES		
DENGVAXIA	T3	PPACA
TOXIN-PRODUCING BACILLI VACCINES/TOXOIDS		
BCG VACCINE (TICE STRAIN)	T5	SP
VACCINE/TOXOID PREPARATIONS, COMBINATIONS		
ACTHIB	T3	PPACA
ADACEL TDAP	T3	PPACA
BOOSTRIX TDAP	T3	PPACA
DAPTACEL DTAP	T3	PPACA
DIPHTHERIA-TETANUS TOXOIDS-PED	T3	
HIBERIX	T3	PPACA
INFANRIX DTAP	T3	PPACA
KINRIX	T3	PPACA
M-M-R II VACCINE	T3	PPACA
PEDVAXHIB	T3	PPACA
PENTACEL	T3	PPACA
PENTACEL ACTHIB COMPONENT	T3	PPACA
PRIORIX	T3	PPACA
PROQUAD	T3	PPACA
QUADRACEL DTAP-IPV	T3	PPACA

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

T5 – Brand Specialty
PA – Prior Authorization
QL – Quantity Limit

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

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

List of Prescription Medications

BIOLOGICALS (Vaccines) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
VACCINE/TOXOID PREPARATIONS, COMBINATIONS (cont.)		
TDVAX	T3	PPACA
TENIVAC	T3	PPACA
VAXELIS	T3	PPACA
VIRAL/TUMORIGENIC VACCINES		
ABRYSVO	T3	PPACA
ACAM2000	T3	PPACA
AREXVY VIAL KIT	T3	PPACA
ENGRIX-B ADULT	T3	PPACA
ENGRIX-B PEDIATRIC-ADOLESCENT	T3	PPACA
ERVEBO (NATIONAL STOCKPILE)	T3	
GARDASIL 9	T3	PPACA
HAVRIX	T3	PPACA
HEPLISAV-B	T3	PPACA
JYNNEOS	T3	
MRESVIA	T3	PPACA
PEDIARIX	T3	PPACA
PREHEVBRIO	T3	PPACA
RECOMBIVAX HB	T3	PPACA
SHINGRIX	T3	PPACA
TWINRIX	T3	PPACA
VAQTA	T3	PPACA
VARIVAX VACCINE	T3	PPACA
BLOOD (Blood Modifiers/Bleeding Disorders)		
ANTIFIBRINOLYTIC AGENTS		
AMICAR (<i>aminocaproic acid</i>)	T4	SP HD
<i>aminocaproic acid</i> (Amicar)	T2	SP HD
LYSTEDA (<i>tranexamic acid</i>)	T5	SP
<i>tranexamic acid</i> (Lysteda)	T2	SP
COMPLEMENT INHIBITORS		
EMPAVELI	T5	PA SP
FABHALTA	T5	PA SP
TAVNEOS	T5	PA QL (180 caps/30 days) SP
VOYDEYA	T5	PA SP

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

T5 – Brand Specialty
PA – Prior Authorization
QL – Quantity Limit

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

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

List of Prescription Medications

BLOOD (Blood Modifiers/Bleeding Disorders) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
HEMOPHILIA TREATMENT AGENTS, NON-FACTOR REPLACEMENT		
ALHEMO PEN	T5	PA SP
HEMLIBRA	T5	PA SP HD
HYMPAVZI PEN	T5	PA SP
PYRUVATE KINASE ACTIVATORS		
PYRUKYND 20 MG TABLET	T5	PA QL (56 tabs/28 days) SP
PYRUKYND 20-5 MG TAPER PACK	T5	PA QL (14 tabs/365 days) SP
PYRUKYND 5 MG TABLET	T5	PA QL (56 tabs/28 days) SP
PYRUKYND 5 MG TAPER PACK	T5	PA QL (7 tabs/365 days) SP
PYRUKYND 50 MG TABLET	T5	PA QL (56 tabs/28 days) SP
PYRUKYND 50-20 MG TAPER PACK	T5	PA QL (14 tabs/365 days) SP
SICKLE CELL ANEMIA AGENTS		
DROXIA	T3	
ENDARI (<i>glutamine</i>)	T4	PA
<i>glutamine</i> (Endari)	T2	PA
OXBRYTA	T5	SP
TOPICAL HEMOSTATICS		
ASTRINGYN	T4	
AVITENE	T4	
ENDO-AVITENE	T4	
EVICEL	T4	
GEL-FLOW	T4	
GEL-FLOW NT	T4	
GELFOAM	T4	
GELFOAM (<i>gelatin sponge, absorb/porcine</i>)	T4	
GELFOAM COMPRESSED	T4	
GELFOAM JMI	T4	
MONSEL'S	T3	
RECOTHROM	T4	
SURGICEL	T4	
SURGIFOAM SPONGE SIZE 100	T4	
SURGIFOAM SPONGE SIZE 100C	T4	
<i>surgifoam sponge size 12-7</i> (Gelfoam)	T2	
SYRINGE AVITENE	T4	
THROMBI-GEL (<i>thrombin/cal/cmc/gel/dress,hem</i>)	T4	

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

T5 – Brand Specialty
PA – Prior Authorization
QL – Quantity Limit

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

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

List of Prescription Medications

BLOOD (Blood Modifiers/Bleeding Disorders) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
TOPICAL HEMOSTATICS (cont.)		
THROMBIN-JMI	T4	
THROMBI-PAD	T4	
ULTRAFOAM	T4	
VISTASEAL FIBRIN SEALANT	T4	
BLOOD (Blood Thinners/Anti-Clotting)		
HEMORRHEOLOGIC AGENTS		
<i>pentoxifylline</i>	T2	HD
CARDIAC DRUGS (Blood Pressure/Heart Medications)		
ANTIANGINAL, ANTI-ISCHEMIC AGENTS, NON-HEMODYNAMIC		
<i>ranolazine</i>	T2	HD
<i>ranolazine</i> (Ranexa)	T2	HD
RANEXA (<i>ranolazine</i>)	T4	ST HD
ANTIARRHYTHMICS		
<i>amiodarone hcl</i>	T2	HD
<i>disopyramide phosphate</i> (Norpace)	T2	HD
<i>dofetilide</i> (Tikosyn)	T2	HD
<i>flecainide acetate</i>	T2	HD
<i>mexiletine hcl</i>	T2	HD
MULTAQ	T3	HD
<i>propafenone hcl</i>	T2	HD
<i>quinidine gluconate</i>	T2	HD
<i>quinidine sulfate</i>	T2	HD
CALCIUM CHANNEL BLOCKER AND NSAID, COX-2 INHIBITOR		
CONSENSI	T4	
CALCIUM CHANNEL BLOCKING AGENTS		
<i>amlodipine besylate</i> (Norvasc)	T1	HD
CALAN SR (<i>verapamil hcl</i>)	T4	ST HD
CARDIZEM (<i>diltiazem hcl</i>)	T4	HD
CARDIZEM CD (<i>diltiazem hcl</i>)	T4	HD
CARDIZEM LA	T4	HD
CARDIZEM LA (<i>diltiazem hcl</i>)	T4	HD
<i>diltiazem hcl</i>	T2	HD
<i>diltiazem hcl</i>	T1	HD

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

T5 – Brand Specialty
PA – Prior Authorization
QL – Quantity Limit

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

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

List of Prescription Medications

CARDIAC DRUGS (Blood Pressure/Heart Medications) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
CALCIUM CHANNEL BLOCKING AGENTS (cont.)		
<i>diltiazem hcl</i> (Cardizem Cd)	T1	HD
<i>diltiazem hcl</i> (Cardizem La)	T2	HD
<i>diltiazem hcl</i> (Cardizem)	T1	HD
<i>diltiazem hcl</i> (Tiazac)	T1	HD
<i>felodipine</i>	T2	HD
<i>isradipine</i>	T2	
<i>nicardipine hcl</i>	T2	HD
<i>nifedipine</i>	T2	HD
<i>nifedipine</i> (Procardia XL)	T2	HD
<i>nifedipine</i> (Procardia)	T2	HD
<i>nimodipine 30 mg capsule</i>	T2	HD
<i>nimodipine 60 mg/20 ml soln</i>	T2	
<i>nisoldipine</i>	T2	HD
<i>nisoldipine</i> (Sular)	T2	HD
NYMALIZE	T4	
PROCARDIA (<i>nifedipine</i>)	T4	ST HD
PROCARDIA XL (<i>nifedipine</i>)	T4	ST HD
SULAR (<i>nisoldipine</i>)	T4	ST HD
TIAZAC (<i>diltiazem hcl</i>)	T4	HD
<i>verapamil hcl</i>	T1	HD
<i>verapamil hcl</i> (Calan Sr)	T1	HD
<i>verapamil hcl</i> (Verelan Pm)	T2	ST HD
<i>verapamil hcl</i> (Verelan)	T2	HD
VERELAN (<i>verapamil hcl</i>)	T4	ST HD
VERELAN PM (<i>verapamil hcl</i>)	T4	ST HD
CARDIAC MYOSIN INHIBITOR		
CAMZYOS	T5	PA QL (30 caps/fill) SP HD
DIGITALIS GLYCOSIDES		
<i>digoxin</i>	T2	HD
<i>digoxin</i> (Lanoxin)	T2	HD
LANOXIN	T4	HD
LANOXIN (<i>digoxin</i>)	T4	HD
HEART RATE REDUCING,SA SELECTIVE I(F) CURRENT INH.		
<i>ivabradine hcl</i> (Corlanor)	T2	PA HD

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

T5 – Brand Specialty
PA – Prior Authorization
QL – Quantity Limit

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

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

List of Prescription Medications

CARDIAC DRUGS (Blood Pressure/Heart Medications) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
SOLUBLE GUANYLATE CYCLASE (SGC) STIMULATOR		
VERQUVO	T3	QL (30 tabs/fill)
VASODILATORS, CORONARY		
GONITRO	T4	HD
ISORDIL (<i>isosorbide dinitrate</i>)	T4	HD
ISORDIL TITRADOSE (<i>isosorbide dinitrate</i>)	T4	HD
<i>isosorbide dinitrate</i>	T2	HD
<i>isosorbide dinitrate</i> (Isordil Titradose)	T2	HD
<i>isosorbide dinitrate</i> (Isordil)	T2	HD
<i>isosorbide mononitrate</i>	T1	HD
NITRO-DUR	T4	HD
<i>nitroglycerin</i>	T2	HD
<i>nitroglycerin 0.3 mg tablet sl</i> (Nitrostat)	T2	HD
<i>nitroglycerin 0.4 mg tablet sl</i> (Nitrostat)	T2	HD
<i>nitroglycerin 0.6 mg tablet sl</i> (Nitrostat)	T2	HD
<i>nitroglycerin 400 mcg spray</i> (Nitrolingual)	T2	HD
NITROLINGUAL (<i>nitroglycerin</i>)	T4	HD
NITROMIST (<i>nitroglycerin</i>)	T4	HD
NITROSTAT (<i>nitroglycerin</i>)	T4	HD
CARDIOVASCULAR (Asthma/COPD/Respiratory)		
PULM ANTI-HTN, SOLUBLE GUANYLATE CYCLASE STIMULATOR		
ADEMPAS	T5	PA QL (90 tabs/fill) SP HD
PULM.ANTI-HTN, SEL.C-GMP PHOSPHODIESTERASE T5 INHIB		
REVATIO 10 MG/ML ORAL SUSP (<i>sildenafil citrate</i>)	T5	PA QL (112 mls/fill) SP HD
REVATIO 20 MG TABLET (<i>sildenafil citrate</i>)	T5	PA QL (90 tabs/fill) SP HD
<i>sildenafil 20 mg tablet</i> (Revatio)	T2	PA QL (90 tabs/fill) SP HD
<i>tadalafil 20 mg tablet</i> (Adcirca)	T2	PA QL (60 tabs/fill) SP HD
PULMONARY ANTI-HTN, ENDOTHELIN RECEPTOR ANTAGONIST		
<i>ambrisentan</i> (Letairis)	T2	PA QL (30 tabs/fill) SP HD
<i>bosentan 32 mg tablet for susp</i> (Tracleer)	T2	PA QL (120 tabs/30 days) SP HD
<i>bosentan 62.5 mg tablet</i> (Tracleer)	T2	PA QL (60 tabs/30 days) SP HD
<i>bosentan 125 mg tablet</i> (Tracleer)	T2	PA QL (60 tabs/30 days) SP HD
OPSUMIT	T5	PA QL (30 tabs/fill) SP HD
TRACLEER 32 MG TABLET FOR SUSP (<i>bosentan</i>)	T5	PA QL (120 tabs/30 days) SP HD
TRACLEER 62.5 MG TABLET (<i>bosentan</i>)	T5	PA QL (60 tabs/fill) SP HD
TRACLEER 125 MG TABLET (<i>bosentan</i>)	T5	PA QL (60 tabs/fill) SP HD

T1 – Preferred Generics

T2 – Non-Preferred Generics

T3 – Preferred Brands

T4 – Non-Preferred Brands

T5 – Brand Specialty

PA – Prior Authorization

QL – Quantity Limit

ST – Step Therapy

AGE – Age Requirement

SP – Specialty Medication

HD – May require home delivery pharmacy

PPACA – No Cost-Share Preventive Medication

CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

CARDIOVASCULAR (Asthma/COPD/Respiratory) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
PULMONARY ANTIHYPER AGENT, ACTRIIA-FC		
WINREVAIR	T5	PA SP HD
WINREVAIR (2 PACK)	T5	PA SP HD
PULMONARY ANTIHYPERTENSIVES, PROSTACYCLIN-TYPE		
ORENITRAM TITRATION KT MONTH 1	T5	PA QL (168 tabs/28 days) SP
ORENITRAM TITRATION KT MONTH 2	T5	PA QL (336 tabs/28 days) SP
ORENITRAM TITRATION KT MONTH 3	T5	PA QL (252 tabs/28 days) SP
ORENITRAM ER	T5	PA QL (90 tabs/fill) SP HD
TYVASO	T5	PA SP HD
TYVASO DPI	T5	PA SP HD
TYVASO INSTITUTIONAL START KIT	T5	PA SP HD
TYVASO REFILL KIT	T5	PA SP HD
TYVASO STARTER KIT	T5	PA SP HD
UPTRAVI 200 MCG TABLET	T5	PA QL (60 tabs/fill) SP HD
UPTRAVI 400 MCG TABLET	T5	PA QL (60 tabs/fill) SP HD
UPTRAVI 600 MCG TABLET	T5	PA QL (60 tabs/fill) SP HD
UPTRAVI 800 MCG TABLET	T5	PA QL (60 tabs/fill) SP HD
UPTRAVI 1,000 MCG TABLET	T5	PA QL (60 tabs/fill) SP HD
UPTRAVI 1,200 MCG TABLET	T5	PA QL (60 tabs/fill) SP HD
UPTRAVI 1,400 MCG TABLET	T5	PA QL (60 tabs/fill) SP HD
UPTRAVI 1,600 MCG TABLET	T5	PA QL (60 tabs/fill) SP HD
VENTAVIS	T5	PA SP HD
YUTREPIA	T5	PA SP HD
PULMONARY HTN-ENDOTHELIN RECEPT ANTG-CGMP PDE5 INH		
OPSYNVI	T5	PA QL (30 tabs/fill) SP HD
CARDIOVASCULAR (Blood Pressure/Heart Medications)		
ACE INHIBITOR-CALCIUM CHANNEL BLOCKER COMBINATION		
<i>amlodipine besylate/benazepril</i>	T1	HD
<i>amlodipine besylate/benazepril (Lotrel)</i>	T1	HD
PRESTALIA	T4	ST HD
<i>trandolapril/verapamil hcl</i>	T2	HD
ACE INHIBITOR-THIAZIDE OR THIAZIDE-LIKE DIURETIC		
<i>ACCURETIC (quinapril/hydrochlorothiazide)</i>	T4	HD
<i>benazepril/hydrochlorothiazide</i>	T2	HD
<i>benazepril/hydrochlorothiazide (Lotensin Hct)</i>	T2	HD

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

T5 – Brand Specialty
PA – Prior Authorization
QL – Quantity Limit

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

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

List of Prescription Medications

CARDIOVASCULAR (Blood Pressure/Heart Medications) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ACE INHIBITOR-THIAZIDE OR THIAZIDE-LIKE DIURETIC (cont.)		
<i>captopril/hydrochlorothiazide</i>	T2	HD
<i>enalapril/hydrochlorothiazide</i>	T1	HD
<i>enalapril/hydrochlorothiazide</i> (Vaseretic)	T1	HD
<i>fosinopril/hydrochlorothiazide</i>	T2	HD
<i>lisinopril/hydrochlorothiazide</i> (Zestoretic)	T1	HD
LOTENSIN HCT (<i>benazepril/hydrochlorothiazide</i>)	T4	HD
<i>quinapril/hydrochlorothiazide</i> (Accuretic)	T1	HD
VASERETIC (<i>enalapril/hydrochlorothiazide</i>)	T4	HD
ZESTORETIC (<i>lisinopril/hydrochlorothiazide</i>)	T4	HD
ALPHA/BETA-ADRENERGIC BLOCKING AGENTS		
<i>carvedilol</i> (Coreg)	T1	HD
<i>carvedilol phosphate</i> (Coreg Cr)	T2	HD
COREG CR (<i>carvedilol phosphate</i>)	T4	ST HD
ALPHA-ADRENERGIC BLOCKING AGENTS		
CARDURA 1 MG TABLET (<i>doxazosin mesylate</i>)	T4	ST QL (30 tabs/fill) HD
CARDURA 2 MG TABLET (<i>doxazosin mesylate</i>)	T4	ST QL (30 tabs/fill) HD
CARDURA 4 MG TABLET (<i>doxazosin mesylate</i>)	T4	ST QL (30 tabs/fill) HD
CARDURA 8 MG TABLET (<i>doxazosin mesylate</i>)	T4	ST QL (60 tabs/fill) HD
CARDURA XL	T4	ST QL (30 tabs/fill) HD
<i>doxazosin mesylate 1 mg tab</i> (Cardura)	T1	QL (30 tabs/fill) HD
<i>doxazosin mesylate 2 mg tab</i> (Cardura)	T1	QL (30 tabs/fill) HD
<i>doxazosin mesylate 4 mg tab</i> (Cardura)	T1	QL (30 tabs/fill) HD
<i>doxazosin mesylate 8 mg tab</i> (Cardura)	T1	QL (60 tabs/fill) HD
MINIPRESS (<i>prazosin hcl</i>)	T4	HD
<i>prazosin hcl</i>	T2	HD
<i>prazosin hcl</i> (Minipress)	T2	HD
<i>terazosin 1 mg, 2 mg, 5 mg capsule</i>	T1	QL (30 caps/fill) HD
<i>terazosin 10 mg capsule</i>	T1	QL (60 caps/fill) HD
ANGIOTEN.RECEPTR ANTAG-CALCIUM CHANL BLKR-THIAZIDE		
<i>amlodipine/valsartan/hcthiazyd</i> (Exforge Hct)	T2	HD
<i>olmesartan/amlodipin/hcthiazyd</i> (Tribenzor)	T2	HD
ANGIOTENSIN RECEPT-NEPRILYSIN INHIBITOR COMB (ARNI)		
ENTRESTO (<i>sacubitril/valsartan</i>)	T4	QL (60 tabs/30 days)
ENTRESTO SPRINKLE	T3	QL (240 caps/fill) HD
<i>sacubitril/valsartan</i> (Entresto)	T2	QL (60 tabs/30 days) HD

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

T5 – Brand Specialty
PA – Prior Authorization
QL – Quantity Limit

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

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

List of Prescription Medications

CARDIOVASCULAR (Blood Pressure/Heart Medications) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ANGIOTENSIN RECEPTOR ANTAG.-THIAZIDE DIURETIC COMB		
<i>candesartan/hydrochlorothiazid (Atacand Hct)</i>	T2	HD
<i>irbesartan/hydrochlorothiazide (Avalide)</i>	T1	HD
<i>losartan/hydrochlorothiazide (Hyzaar)</i>	T1	HD
<i>olmesartan/hydrochlorothiazide (Benicar Hct)</i>	T1	HD
<i>telmisartan/hydrochlorothiazid (Micardis Hct)</i>	T2	HD
<i>valsartan/hydrochlorothiazide (Diovan Hct)</i>	T2	HD
ANGIOTENSIN RECEPTOR BLOCKR-CALCIUM CHANNEL BLOCKR		
<i>amlodipine bes/olmesartan med (Azor)</i>	T2	HD
<i>amlodipine besylate/valsartan (Exforge)</i>	T2	HD
<i>telmisartan/amlodipine</i>	T2	HD
ANTIHYPERTENSIVES, ACE INHIBITORS		
<i>ACCUPRIL (quinapril hcl)</i>	T4	HD
<i>ALTACE (ramipril)</i>	T4	HD
<i>benazepril hcl</i>	T1	HD
<i>benazepril hcl (Lotensin)</i>	T1	HD
<i>captopril</i>	T2	HD
<i>enalapril maleate (Epaned)</i>	T2	HD
<i>enalapril maleate (Vasotec)</i>	T1	HD
<i>fosinopril sodium</i>	T1	HD
<i>lisinopril (Zestril)</i>	T1	HD
<i>LOTENSIN (benazepril hcl)</i>	T4	HD
<i>moexipril hcl</i>	T2	HD
<i>perindopril erbumine</i>	T1	HD
<i>quinapril hcl (Accupril)</i>	T1	HD
<i>ramipril</i>	T1	HD
<i>ramipril (Altace)</i>	T1	HD
<i>trandolapril</i>	T1	HD
<i>VASOTEC (enalapril maleate)</i>	T4	HD
<i>ZESTRIL (lisinopril)</i>	T4	HD
ANTIHYPERTENSIVES, ANGIOTENSIN RECEPTOR ANTAGONIST		
<i>candesartan cilexetil (Atacand)</i>	T2	HD
<i>eprosartan mesylate</i>	T2	HD
<i>irbesartan</i>	T1	HD
<i>irbesartan (Avapro)</i>	T1	HD

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

T5 – Brand Specialty
PA – Prior Authorization
QL – Quantity Limit

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

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

List of Prescription Medications

CARDIOVASCULAR (Blood Pressure/Heart Medications) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ANTIHYPERTENSIVES, ANGIOTENSIN RECEPTOR ANTAGONIST (cont.)		
<i>losartan potassium</i> (Cozaar)	T1	HD
<i>olmesartan medoxomil</i> (Benicar)	T1	HD
<i>telmisartan</i>	T2	HD
<i>telmisartan</i> (Micardis)	T2	HD
<i>valsartan 20 mg/5 ml solution</i>	T2	HD
<i>valsartan 160 mg tablet</i> (Diovan)	T1	HD
<i>valsartan 320 mg tablet</i> (Diovan)	T1	HD
<i>valsartan 40 mg tablet</i> (Diovan)	T1	HD
<i>valsartan 80 mg tablet</i> (Diovan)	T1	HD
ANTIHYPERTENSIVES, GANGLIONIC BLOCKERS		
VECAMYL	T4	PA
ANTIHYPERTENSIVES, MISCELLANEOUS		
DEMSEER (<i>metirosine</i>)	T4	PA HD
<i>metirosine</i> (Demser)	T2	PA HD
ANTIHYPERTENSIVES, SYMPATHOLYTIC		
CATAPRES-TTS 1 (<i>clonidine</i>)	T4	QL (4 patches/28 days) HD
CATAPRES-TTS 2 (<i>clonidine</i>)	T4	QL (4 patches/28 days) HD
CATAPRES-TTS 3 (<i>clonidine</i>)	T4	QL (4 patches/28 days) HD
<i>clonidine</i> (Catapres-Tts 1)	T2	QL (4 patches/28 days) HD
<i>clonidine</i> (Catapres-Tts 2)	T2	QL (4 patches/28 days) HD
<i>clonidine</i> (Catapres-Tts 3)	T2	QL (4 patches/28 days) HD
<i>guanfacine hcl</i>	T2	HD
<i>methyldopa</i>	T2	HD
<i>methyldopa/hydrochlorothiazide</i>	T2	HD
ANTIHYPERTENSIVES, VASODILATORS		
<i>hydralazine hcl</i>	T2	HD
<i>minoxidil</i>	T2	HD
BETA-ADRENERGIC BLOCKING AGENTS		
<i>acebutolol hcl</i>	T2	HD
<i>atenolol</i> (Tenormin)	T1	HD
BETAPACE (<i>sotalol hcl</i>)	T4	ST HD
BETAPACE AF (<i>sotalol hcl</i>)	T4	ST HD
<i>betaxolol hcl</i>	T2	HD
<i>bisoprolol fumarate 5 mg, 10 mg tab</i>	T2	HD

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

T5 – Brand Specialty
PA – Prior Authorization
QL – Quantity Limit

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

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

List of Prescription Medications

CARDIOVASCULAR (Blood Pressure/Heart Medications) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
BETA-ADRENERGIC BLOCKING AGENTS (cont.)		
LOPRESSOR 50 MG TABLET (<i>metoprolol tartrate</i>)	T4	ST HD
LOPRESSOR 100 MG TABLET (<i>metoprolol tartrate</i>)	T4	ST HD
<i>metoprolol succinate</i> (Toprol XL)	T1	HD
<i>metoprolol tartrate</i>	T1	HD
<i>metoprolol tartrate</i> (Lopressor)	T1	HD
<i>nebivolol hcl</i> (Bystolic)	T2	HD
<i>pindolol</i>	T2	HD
<i>propranolol hcl</i>	T1	HD
<i>propranolol hcl</i> (Inderal La)	T1	HD
<i>sotalol hcl</i> (Betapace Af)	T2	HD
<i>sotalol hcl</i> (Betapace)	T2	HD
SOTYLIZE	T3	HD
TENORMIN (<i>atenolol</i>)	T4	ST HD
<i>timolol maleate</i> 5 mg, 10 mg, 20 mg tablet	T2	HD
BETA-BLOCKERS AND THIAZIDE, THIAZIDE-LIKE DIURETICS		
<i>atenolol/chlorthalidone</i> (Tenoretic 100)	T2	HD
<i>atenolol/chlorthalidone</i> (Tenoretic 50)	T2	HD
<i>bisoprolol/hydrochlorothiazide</i>	T1	HD
METOPROLOL SUCCINATE ER-HCTZ	T4	ST HD
<i>metoprolol/hydrochlorothiazide</i>	T2	HD
<i>propranolol/hydrochlorothiazid</i>	T2	HD
TENORETIC 100 (<i>atenolol/chlorthalidone</i>)	T4	ST HD
TENORETIC 50 (<i>atenolol/chlorthalidone</i>)	T4	ST HD
RENIN INHIBITOR, DIRECT		
<i>aliskiren hemifumarate</i> (Tekturna)	T2	HD
RENIN INHIBITOR, DIRECT AND THIAZIDE DIURETIC COMB		
TEKTURNA HCT	T3	HD
VASODILATORS, COMBINATION		
<i>isosorbide dinit/hydralazine</i> (Bidil)	T2	HD
VASODILATORS, PERIPHERAL		
<i>ergoloid mesylates</i>	T2	
<i>isoxsuprine hcl</i>	T2	

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

T5 – Brand Specialty
PA – Prior Authorization
QL – Quantity Limit

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

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

List of Prescription Medications

CARDIOVASCULAR (Cholesterol Medications)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ANTIHYPERLIP.HMG COA REDUCT INHIB-CHOLEST.AB.INHIB		
<i>ezetimibe-atorvastatin tabs</i>	T2	ST QL (30 tabs/30 days) HD
ANTIHYPERLIP.HMG COA REDUCT INHIB-CHOLEST.AB.INHIB		
<i>ezetimibe/simvastatin (Vytorin)</i>	T2	QL (30 tabs/fill) HD
ROSZET	T4	ST QL (30 tabs/fill) HD
ANTIHYPERLIPID- HMG-COA RI-CALCIUM CHANNEL BLOCKER		
<i>amlodipine/atorvastatin</i>	T2	QL (30 tabs/fill) HD
<i>amlodipine/atorvastatin (Caduet)</i>	T2	QL (30 tabs/fill) HD
CADUET (<i>amlodipine/atorvastatin</i>)	T4	ST QL (30 tabs/fill) HD
ANTIHYPERLIPIDEMIC - APOLIPOPROTEIN INHIBITOR		
TRYNGOLZA	T5	PA SP
ANTIHYPERLIPIDEMIC - ATP CITRATE LYASE INHIBITOR		
NEXLETOL	T3	PA
ANTIHYPERLIPIDEMIC - MTP INHIBITOR		
JUXTAPID	T5	PA SP HD
ANTIHYPERLIPIDEMIC - PCSK9 INHIBITORS		
REPATHA PUSHTRONEX	T3	PA
REPATHA SURECLICK	T3	PA
REPATHA SYRINGE	T3	PA
ANTIHYPERLIPIDEMIC-ACLY AND CHOLEST ABSORP INHIB		
NEXLIZET	T3	PA
ANTIHYPERLIPIDEMIC-HMGCOA REDUCTASE INHIB (STATINS)		
FLOLIPID	T4	ST QL (150 mls/fill) HD
<i>fluvastatin sodium (Lescol XL)</i>	T2	QL (30 tabs/fill) HD PPACA
<i>fluvastatin sodium 20 mg cap</i>	T2	QL (30 caps/fill) HD PPACA
<i>fluvastatin sodium 40 mg cap</i>	T2	QL (60 caps/fill) HD PPACA
LESCOL XL (<i>fluvastatin sodium</i>)	T4	ST QL (30 tabs/fill) HD
<i>lovastatin 10 mg tablet</i>	T2	QL (30 tabs/fill) HD PPACA
<i>lovastatin 20 mg, 40 mg tablet</i>	T2	QL (60 tabs/fill) HD PPACA
<i>pitavastatin calcium (Livalo)</i>	T2	QL (30 tabs/30 days) HD PPACA
<i>pravastatin sodium</i>	T2	QL (30 tabs/fill) HD PPACA
<i>simvastatin 5 mg tablet</i>	T1	QL (30 tabs/fill) HD PPACA
<i>simvastatin 10 mg tablet (Zocor)</i>	T1	QL (30 tabs/fill) HD PPACA
<i>simvastatin 20 mg tablet (Zocor)</i>	T1	QL (30 tabs/fill) HD PPACA
SIMVASTATIN 20 MG/5 ML SUSP	T4	ST QL (150 mls/fill) HD

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

T5 – Brand Specialty
PA – Prior Authorization
QL – Quantity Limit

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

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

List of Prescription Medications

CARDIOVASCULAR (Cholesterol Medications) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ANTIHYPERLIPIDEMIC-HMGCOA REDUCTASE INHIB (STATINS) (cont.)		
<i>simvastatin 40 mg tablet (Zocor)</i>	T1	QL (30 tabs/fill) HD PPACA
<i>simvastatin 80 mg tablet (Zocor)</i>	T1	QL (30 tabs/fill) HD
ZYPITAMAG	T4	ST QL (30 tabs/fill) HD
BILE SALT SEQUESTRANTS		
<i>cholestyramine</i>	T2	HD
<i>cholestyramine (Questran Light)</i>	T2	HD
<i>cholestyramine (with sugar) (Questran)</i>	T2	HD
<i>cholestyramine/aspartame</i>	T2	HD
<i>colesevelam hcl (Welchol)</i>	T2	HD
COLESTID	T4	ST HD
COLESTID (<i>colestipol hcl</i>)	T4	ST HD
<i>colestipol hcl</i>	T2	HD
<i>colestipol hcl (Colestid)</i>	T2	HD
QUESTRAN (<i>cholestyramine (with sugar)</i>)	T4	ST HD
QUESTRAN LIGHT (<i>cholestyramine</i>)	T4	ST HD
LIPOTROPICS		
<i>ezetimibe (Zetia)</i>	T2	HD
<i>fenofibrate 40 mg tablet (Fenoglide)</i>	T2	ST HD
<i>fenofibrate 43mg, 67mg, 134mg, 200mg capsule</i>	T2	HD
<i>fenofibrate 130 mg capsule</i>	T2	ST HD
<i>fenofibrate 48 mg tablet (Tricor)</i>	T2	HD
<i>fenofibrate 54mg, 160mg tablet</i>	T2	HD
<i>fenofibrate 120 mg tablet (Fenoglide)</i>	T2	ST HD
<i>fenofibrate 145 mg tablet (Tricor)</i>	T2	HD
<i>fenofibric acid</i>	T2	HD
<i>fenofibric acid (choline)</i>	T2	HD
<i>fenofibric acid (Fibricor)</i>	T2	HD
FENOGLIDE (<i>fenofibrate</i>)	T4	ST HD
FIBRICOR (<i>fenofibric acid</i>)	T4	ST HD
<i>gemfibrozil (Lopid)</i>	T1	HD
LOPID (<i>gemfibrozil</i>)	T4	HD
<i>niacin</i>	T2	HD
<i>niacin 500 mg tablet</i>	T2	HD
NIACOR	T4	HD

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

T5 – Brand Specialty
PA – Prior Authorization
QL – Quantity Limit

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

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

List of Prescription Medications

CNS DRUGS (Alzheimer's Disease)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ALZHEIMER'S THERAPY, NMDA RECEPTOR ANTAGONISTS		
<i>memantine hcl</i>	T2	HD
<i>memantine hcl 10 mg/5 ml cup</i>	T2	HD
<i>memantine hcl</i> (Namenda Xr)	T2	HD
<i>memantine hcl 2 mg/ml solution</i>	T2	HD
<i>memantine hcl 5 mg tablet</i>	T2	HD
<i>memantine hcl 10 mg tablet</i>	T2	HD
NAMENDA	T4	HD
NAMENDA XR TITRATION PACK	T4	HD
NAMZARIC	T3	ST HD
ALZHEIMER'S THX,NMDA RECEPTOR ANTAG-CHOLINES INHIB		
<i>memantine hcl/donepezil hcl</i> (Namzaric)	T2	HD
NAMZARIC (<i>memantine hcl/donepezil hcl</i>)	T3	ST HD
CNS DRUGS (Miscellaneous)		
AMYOTROPHIC LATERAL SCLEROSIS AGENTS		
RADICAVA ORS	T5	PA SP HD
RILUTEK (<i>riluzole</i>)	T5	PA SP HD
<i>riluzole</i> (Rilutek)	T2	PA SP HD
TEGLUTIK	T5	PA SP
TIGLUTIK	T5	PA SP
DRUGS TO TREAT MOVEMENT DISORDERS		
AUSTEDO 6 MG TABLET	T5	PA QL (60 tabs/30 days) SP HD
AUSTEDO 9MG, 12MG TABLET	T5	PA QL (120 tabs/30 days) SP HD
AUSTEDO XR 6 MG TABLET	T5	PA QL (210 tabs/30 days) SP HD
AUSTEDO XR 12 MG TABLET	T5	PA QL (90 tabs/30 days) SP HD
AUSTEDO XR 18 MG TABLET	T5	PA QL (30 tabs/fill) SP HD
AUSTEDO XR 24 MG TABLET	T5	PA QL (60 tabs/30 days) SP HD
AUSTEDO XR 30 MG TABLET	T5	PA QL (30 tabs/fill) SP HD
AUSTEDO XR 36 MG TABLET	T5	PA QL (30 tabs/fill) SP HD
AUSTEDO XR 42 MG TABLET	T5	PA QL (30 tabs/fill) SP HD
AUSTEDO XR 48 MG TABLET	T5	PA QL (30 tabs/fill) SP HD
AUSTEDO XR TITRATION KT(WK1-4)	T5	PA QL (28 tabs/fill) SP HD
HORIZANT	T4	ST
INGREZZA	T5	PA QL (30 caps/30 days) SP
INGREZZA INITIATION PK (TARDIV)	T5	PA QL (28 caps/30 days) SP

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

T5 – Brand Specialty
PA – Prior Authorization
QL – Quantity Limit

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

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

List of Prescription Medications

CNS DRUGS (Miscellaneous) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
DRUGS TO TREAT MOVEMENT DISORDERS (cont.)		
INGREZZA SPRINKLE	T5	PA QL (30 caps/fill) SP
tetrabenazine 12.5 mg tablet (Xenazine)	T2	
tetrabenazine 25 mg tablet (Xenazine)	T2	
ENDOTHELIN-ANGIOTENSIN RECEPTOR ANTAGONIST		
FILSPARI	T5	PA QL (30 tabs/30 days) SP
PSEUDOBULBAR AFFECT (PBA) AGENTS, NMDA ANTAGONISTS		
NUEDEXTA	T3	PA
XANTHINES		
caffeine citrate	T2	HD
CNS DRUGS (Multiple Sclerosis)		
AGENTS TO TREAT MULTIPLE SCLEROSIS		
AVONEX (4 PACK)	T5	PA QL (1 kit/28 days) SP HD
AVONEX PEN (4 PACK)	T5	PA QL (4 pens/28 days) SP HD
BAFIERTAM	T5	PA QL (120 caps/fill) SP HD
BETASERON	T5	PA QL (14 kits/30 days) SP HD
glatiramer 20 mg/ml syringe (Copaxone)	T2	PA QL (30 syringes/30 days) SP HD
glatiramer 40 mg/ml syringe (Copaxone)	T2	PA QL (12 syringes/30 days) SP HD
glatopa 20 mg/ml syringe (Copaxone)	T2	PA QL (30 syringes/30 days) SP HD
glatopa 40 mg/ml syringe (Copaxone)	T2	PA QL (12 syringes/30 days) SP HD
KESIMPTA PEN	T5	PA QL (1 pen/28 days) SP HD
MAVENCLAD 10 MG X 10 TABLET PK	T5	PA QL (10 tabs/fill) SP HD
MAVENCLAD 10 MG X 4 TABLET PK	T5	PA QL (4 tabs/fill) SP HD
MAVENCLAD 10 MG X 5 TABLET PK	T5	PA QL (5 tabs/fill) SP HD
MAVENCLAD 10 MG X 6 TABLET PK	T5	PA QL (6 tabs/fill) SP HD
MAVENCLAD 10 MG X 7 TABLET PK	T5	PA QL (7 tabs/fill) SP HD
MAVENCLAD 10 MG X 8 TABLET PK	T5	PA QL (8 tabs/fill) SP HD
MAVENCLAD 10 MG X 9 TABLET PK	T5	PA QL (9 tabs/fill) SP HD
MAYZENT 0.25 MG TABLET	T5	PA QL (30 tabs/fill) SP HD
MAYZENT 0.25MG START-1MG MAINT	T5	PA QL (7 tabs/fill) SP HD
MAYZENT 0.25MG START-2MG MAINT	T5	PA QL (12 tabs/fill) SP HD
MAYZENT 1 MG , 2 MG TABLET	T5	PA QL (30 tabs/fill) SP HD
PLEGRIDY 125 MCG/0.5 ML PEN	T5	PA QL (1 ml/28 days) SP HD
PLEGRIDY 125 MCG/0.5 ML SYRING	T5	PA QL (1 ml/28 days) SP HD
PLEGRIDY PEN INJ STARTER PACK	T5	PA QL (1 ml/365 days) SP HD

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

T5 – Brand Specialty
PA – Prior Authorization
QL – Quantity Limit

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

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

List of Prescription Medications

CNS DRUGS (Multiple Sclerosis) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
AGENTS TO TREAT MULTIPLE SCLEROSIS (cont.)		
PLEGRIDY SYRINGE STARTER PACK	T5	PA QL (1 ml/365 days) SP HD
REBIF 22 MCG/0.5 ML SYRINGE	T5	PA QL (6 mls/28 days) SP HD
REBIF 44 MCG/0.5 ML SYRINGE	T5	PA QL (6 mls/28 days) SP HD
REBIF REBIDOSE 22 MCG/0.5 ML	T5	PA QL (6 mls/28 days) SP HD
REBIF REBIDOSE 44 MCG/0.5 ML	T5	PA QL (6 mls/28 days) SP HD
REBIF REBIDOSE TITRATION PACK	T5	PA QL (4.2 mls/28 days) SP HD
REBIF TITRATION PACK	T5	PA QL (4.2 mls/28 days) SP HD
VUMERITY	T5	PA QL (120 caps/fill) SP HD
AGTS TX NEUROMUSC TRANSMISSION DIS, POT-CHAN BLKR		
FIRDAPSE	T5	PA SP
SPHINGOSINE I-PHOSPHATE (SIP) RECEPTOR MODULATOR		
ZEPOSIA 0.92 MG CAPSULE	T5	PA QL (30 caps/30 days) SP HD
ZEPOSIA STARTER KIT (28-DAY)	T5	PA QL (28 caps/30 days) SP HD
ZEPOSIA STARTER PACK (7-DAY)	T5	PA QL (7 caps/30 days) SP HD
CNS DRUGS (Pain Relief And Inflammatory Disease)		
CALCITONIN GENE-RELATED PEPTIDE (CGRP) INHIBITORS		
EMGALITY 100 MG/ML SYR(1 OF 3)	T3	PA QL (3 mls/30 days)
EMGALITY 300 MG (100 MG X3SYR)	T3	PA QL (3 mls/30 days)
POSTHERPETIC NEURALGIA AGENTS		
<i>gabapentin</i>	T2	ST
GRALISE	T4	ST
GRALISE (<i>gabapentin</i>)	T4	ST
SPHINGOSINE I-PHOSPHATE (SIP) RECEPTOR MODULATOR		
VELSIPITY	T5	PA QL (30 tabs/30 days) SP HD
ZEPOSIA 0.23-0.46 MG START PCK	T5	PA QL (7 caps/fill) SP HD
ZEPOSIA 0.23-0.46-0.92 MG KIT	T5	PA QL (1 kit/fill) SP HD
ZEPOSIA 0.92 MG CAPSULE	T5	PA QL (30 caps/fill) SP HD
ZEPOSIA STARTER KIT (28-DAY)	T5	
CNS DRUGS (Seizure Disorders)		
ANTICONSULSANT - BENZODIAZEPINE TYPE		
<i>clobazam</i> (Onfi)	T2	PA HD
<i>clonazepam</i>	T2	HD
<i>clonazepam</i> (Klonopin)	T1	HD

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

T5 – Brand Specialty
PA – Prior Authorization
QL – Quantity Limit

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

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

List of Prescription Medications

CNS DRUGS (Seizure Disorders) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ANTICONVULSANT - BENZODIAZEPINE TYPE (cont.)		
DIASTAT (<i>diazepam</i>)	T4	HD
<i>diazepam 10 mg rectal gel syrg</i>	T2	HD
<i>diazepam 10mg rectal gel (2pk)</i>	T2	HD
<i>diazepam 2.5mg rectal gel(2pk)</i> (Diatstat)	T2	HD
<i>diazepam 20 mg rectal gel syrg</i>	T2	HD
<i>diazepam 20mg rectal gel (2pk)</i>	T2	HD
NAYZILAM	T3	PA QL (2 units/fill) HD
SYMPAZAN	T4	PA HD
VALTOCO	T3	PA QL (2 units/fill) HD
ANTICONVULSANT - CANNABINOID TYPE		
EPIDIOLEX	T5	PA SP HD
ANTICONVULSANTS		
APTIOM (<i>eslicarbazepine acetate</i>)	T4	HD
BRIVIACT	T4	ST HD
<i>carbamazepine</i> (Carbatrol)	T2	HD
<i>carbamazepine</i> (Tegretol Xr)	T2	HD
<i>carbamazepine</i> (Tegretol)	T4	HD
<i>carbamazepine 100 mg tab chew</i>	T2	HD
<i>carbamazepine 100 mg/5 ml cup</i>	T2	HD
<i>carbamazepine 100 mg/5 ml susp</i> (Tegretol)	T2	HD
<i>carbamazepine 200 mg tablet</i> (Tegretol)	T2	HD
<i>carbamazepine 200 mg/10 ml cup</i>	T2	HD
CARBAMAZEPINE 200 MG TAB CHEW	T4	HD
CARBATROL (<i>carbamazepine</i>)	T3	HD
CELONTIN (<i>methsuximide</i>)	T4	HD
DEPAKOTE (<i>divalproex sodium</i>)	T4	ST HD
DEPAKOTE ER (<i>divalproex sodium</i>)	T4	ST HD
DEPAKOTE SPRINKLE (<i>divalproex sodium</i>)	T4	ST HD
DIACOMIT	T5	PA SP HD
DILANTIN 100 MG CAPSULE (<i>phenytoin sodium extended</i>)	T4	HD
DILANTIN 30 MG CAPSULE	T3	HD
DILANTIN 50 MG INFATAB (<i>phenytoin</i>)	T4	HD
DILANTIN-125 (<i>phenytoin</i>)	T4	HD
<i>divalproex sodium</i> (Depakote Er)	T2	HD

T1 – Preferred Generics

T2 – Non-Preferred Generics

T3 – Preferred Brands

T4 – Non-Preferred Brands

T5 – Brand Specialty

PA – Prior Authorization

QL – Quantity Limit

ST – Step Therapy

AGE – Age Requirement

SP – Specialty Medication

HD – May require home delivery pharmacy

PPACA – No Cost-Share Preventive Medication

CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

CNS DRUGS (Seizure Disorders) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ANTICONVULSANTS (cont.)		
<i>divalproex sodium</i> (Depakote Sprinkle)	T2	HD
<i>divalproex sodium</i> (Depakote)	T2	HD
ELEPSIA XR	T4	ST HD
<i>eslicarbazepine acetate</i> (Aptiom)	T2	HD
<i>ethosuximide</i> (Zarontin)	T2	HD
<i>felbamate</i> (Felbatol)	T2	HD
FELBATOL (<i>felbamate</i>)	T4	HD
FYCOMPA	T3	HD
FYCOMPA (<i>perampanel</i>)	T3	HD
<i>gabapentin</i>	T2	HD
<i>gabapentin</i> (Neurontin)	T1	HD
<i>gabapentin</i> (Neurontin)	T2	HD
<i>lacosamide</i> (Vimpat)	T2	HD
LAMICTAL XR (BLUE)	T4	ST HD
LAMICTAL XR (GREEN)	T4	ST HD
LAMICTAL XR (ORANGE)	T4	ST HD
<i>lamotrigine</i> (Lamictal (Blue))	T2	HD
<i>lamotrigine</i> (Lamictal (Green))	T2	HD
<i>lamotrigine</i> (Lamictal (Orange))	T2	HD
<i>lamotrigine</i> (Lamictal Odt (Blue))	T2	HD
<i>lamotrigine</i> (Lamictal Odt (Green))	T2	HD
<i>lamotrigine</i> (Lamictal Odt (Orange))	T2	HD
<i>lamotrigine</i> (Lamictal Odt)	T2	HD
<i>lamotrigine</i> (Lamictal Xr)	T2	HD
<i>lamotrigine</i> (Lamictal)	T1	HD
<i>lamotrigine</i> (Lamictal)	T2	HD
<i>levetiracetam</i> (Keppra Xr)	T2	HD
<i>levetiracetam</i> (Keppra)	T2	HD
<i>levetiracetam</i> 500 mg/5 ml cup	T2	HD
<i>levetiracetam</i> 1,000mg/10ml cup (Keppra)	T2	HD
<i>levetiracetam</i> 500 mg/5 ml soln	T2	HD
<i>levetiracetam</i> 100 mg/ml soln (Keppra)	T2	HD
LEVETIRACETAM 250 MG TAB SUSP	T4	ST HD
<i>levetiracetam</i> 250 mg tablet (Keppra)	T2	HD

T1 – Preferred Generics

T2 – Non-Preferred Generics

T3 – Preferred Brands

T4 – Non-Preferred Brands

T5 – Brand Specialty

PA – Prior Authorization

QL – Quantity Limit

ST – Step Therapy

AGE – Age Requirement

SP – Specialty Medication

HD – May require home delivery pharmacy

PPACA – No Cost-Share Preventive Medication

CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

CNS DRUGS (Seizure Disorders) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ANTICONVULSANTS (cont.)		
<i>levetiracetam 500 mg tablet (Keppra)</i>	T2	HD
<i>levetiracetam 750 mg tablet (Keppra)</i>	T2	HD
<i>levetiracetam 1,000 mg tablet (Keppra)</i>	T2	HD
MYSOLINE (<i>primidone</i>)	T4	HD
<i>oxcarbazepine (Oxtellar Xr)</i>	T2	HD
<i>oxcarbazepine (Trileptal)</i>	T2	HD
OXTELLAR XR (<i>oxcarbazepine</i>)	T4	ST HD
<i>perampanel (Fycompa)</i>	T2	HD
PHENYTEK (<i>phenytoin sodium extended</i>)	T4	HD
<i>phenytoin</i>	T2	HD
<i>phenytoin (Dilantin)</i>	T2	HD
<i>phenytoin (Dilantin-125)</i>	T2	HD
<i>phenytoin sodium extended (Dilantin)</i>	T2	HD
<i>phenytoin sodium extended (Phenytek)</i>	T2	HD
<i>pregabalin (Lyrica)</i>	T2	HD
QUDEXY XR (<i>topiramate</i>)	T4	ST HD
<i>rufinamide (Banzel)</i>	T2	PA HD
SPRITAM	T4	ST HD
TEGRETOL (<i>carbamazepine</i>)	T4	HD
TEGRETOL XR (<i>carbamazepine</i>)	T4	HD
<i>tiagabine hcl</i>	T2	HD
<i>topiramate (Qudexy Xr)</i>	T2	ST HD
<i>topiramate 25 mg/ml solution (Eprontia)</i>	T2	HD
<i>topiramate 50 mg sprinkle cap</i>	T2	HD
<i>topiramate 100 mg tablet (Topamax)</i>	T1	HD
<i>topiramate 15 mg sprinkle cap (Topamax)</i>	T2	HD
<i>topiramate 200 mg tablet (Topamax)</i>	T1	HD
<i>topiramate 25 mg sprinkle cap (Topamax)</i>	T2	HD
<i>topiramate 25 mg tablet (Topamax)</i>	T1	HD
<i>topiramate 50 mg tablet (Topamax)</i>	T1	HD
<i>topiramate er (Trokendi XR)</i>	T2	ST HD
TROKENDI XR	T4	ST HD
<i>valproic acid</i>	T2	HD
<i>valproic acid (as sodium salt)</i>	T2	HD

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

T5 – Brand Specialty
PA – Prior Authorization
QL – Quantity Limit

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

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

List of Prescription Medications

CNS DRUGS (Seizure Disorders) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ANTICONVULSANTS (cont.)		
<i>vigabatrin</i> (Sabril)	T2	PA QL (150 packs/30 days) SP HD
VIGADONE	T2	PA SP HD QL (150 pkts/30 days)
XCOPRI 25 MG, 50 MG TABLET	T4	QL (30 tabs/fill) HD
XCOPRI 50-100 MG TITRATION PAK	T4	QL (28 tabs/fill) HD
XCOPRI 100 MG TABLET	T4	QL (30 tabs/fill) HD
XCOPRI 12.5-25 MG TITRATION PK	T4	QL (28 tabs/fill) HD
XCOPRI 150 MG TABLET	T4	QL (30 tabs/fill) HD
XCOPRI 150-200 MG TITRATION PK	T4	QL (28 tabs/fill) HD
XCOPRI 200 MG TABLET	T4	QL (30 tabs/fill) HD
XCOPRI 250 MG DAILY DOSE PACK	T4	QL (56 tabs/fill) HD
XCOPRI 350 MG DAILY DOSE PACK	T4	QL (56 tabs/fill) HD
ZARONTIN (<i>ethosuximide</i>)	T4	HD
<i>zonisamide</i>	T2	HD
<i>zonisamide</i> (Zonegran)	T2	HD
CNS DRUGS (Sleep Disorders/Sedatives)		
NARCOLEPSY TX-H3-RECEPT.ANTAGONIST/INVERSE AGONIST		
WAKIX 4.45 MG TABLET	T5	PA QL (30 tabs/fill) SP HD
WAKIX 17.8 MG TABLET	T5	PA QL (60 tabs/fill) SP HD
COLONY STIMULATING FACTORS (Blood Modifiers/Bleeding Disorders)		
LEUKOCYTE (WBC) STIMULANTS		
FULPHILA	T5	PA QL (1.2 mls/30 days) SP
LEUKINE	T5	PA SP
NIVESTYM	T5	PA SP HD
THROMBOPOIETIN RECEPTOR AGONISTS		
DOPTELET	T5	PA QL (15 tabs/fill) SP HD
<i>eltrombopag olamine</i> (Promacta)	T2	PA SP HD
PROMACTA (<i>eltrombopag olamine</i>)	T5	PA SP HD
COLONY STIMULATING FACTORS (Cancer)		
CXCR4 CHEMOKINE RECEPTOR ANTAGONIST		
XOLREMDI	T5	PA SP CSL

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

T5 – Brand Specialty
PA – Prior Authorization
QL – Quantity Limit

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

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

List of Prescription Medications

CONTRACEPTIVES (Contraception Products)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
CONTRACEPTIVES, INTRAVAGINAL, SYSTEMIC		
ANNOVERA	T4	ST QL (1 ring/365 days) PPACA
etonogestrel/ethinyl estradiol (Nuvaring)	T2	PPACA
CONTRACEPTIVES, INJECTABLE		
DEPO-PROVERA (medroxyprogesterone acetate)	T4	QL (1 ml/90 days) PPACA
DEPO-SUBQ PROVERA 104	T4	QL (1 ml/90 days) PPACA
medroxyprogesterone 150 mg/ml (Depo-Provera)	T2	QL (1 ml/90 days) PPACA
CONTRACEPTIVES, ORAL		
BEYAZ (drospir/eth estra/levomefol ca)	T4	ST HD PPACA
desog-e.estradiol/e.estradiol	T2	HD PPACA
desog-e.estradiol/e.estradiol	T2	PPACA
desogestrel-ethinyl estradiol	T2	HD PPACA
drospir/eth estra/levomefol ca (Beyaz)	T2	HD PPACA
drospir/eth estra/levomefol ca (Safyral)	T2	HD PPACA
ELLA	T3	QL (1 tab/fill) HD PPACA
ethinyl estradiol/drospirenone (Yasmin 28)	T2	PPACA
ethinyl estradiol/drospirenone (Yaz)	T2	HD PPACA
ethynodiol d-ethinyl estradiol	T2	HD PPACA
levonorgestrel/ethin.estradiol	T2	HD PPACA
l-norgest/e.estradiol-e.estrad	T2	HD PPACA
noreth-ethinyl estradiol/iron	T2	HD PPACA
noreth-ethinyl estradiol/iron (Generess Fe)	T2	HD PPACA
norethind-eth estrad 1-0.02 mg (Loestrin)	T2	HD PPACA
norethindrone	T2	HD PPACA
norethindrone ac/eth estradiol (Loestrin)	T2	HD PPACA
norethindrone-e.estradiol-iron	T2	HD PPACA
norethindrone-e.estradiol-iron (Loestrin Fe)	T2	HD PPACA
norethindrone-e.estradiol-iron (Taytulla)	T2	HD PPACA
norethindrone-ethin. estradiol	T2	HD PPACA
norethin-ee 1.5-0.03 mg(21) tb (Loestrin)	T2	HD PPACA
norgestimate-ethinyl estradiol	T2	HD PPACA
NORGESTREL-ETHINYL ESTRADIOL	T2	HD PPACA
YAZ (ethinyl estradiol/drospirenone)	T4	ST HD PPACA
CONTRACEPTIVES, TRANSDERMAL		
norelgestromin/ethin.estradiol	T2	HD PPACA
norelgestromin/ethin.estradiol	T2	PPACA

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

T5 – Brand Specialty
PA – Prior Authorization
QL – Quantity Limit

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

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

List of Prescription Medications

CONTRACEPTIVES (Contraception Products) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
INTRA-UTERINE DEVICES (IUDS)		
KYLEENA	T5	SP PPACA
LILETTA	T5	SP PPACA
MIRENA	T5	SP PPACA
SKYLA	T5	SP PPACA
COUGH/COLD PREPARATIONS (Allergy/Nasal Sprays)		
IST GEN ANTIHIST-DECONGEST-ANTICHOLINERGIC COMB		
RESPA A.R. (<i>pseudoephed/chlor-mal/bell alk</i>)	T4	
COUGH/COLD PREPARATIONS (Cough/Cold Medications)		
ANTITUSSIVES, NON-OPIOID		
<i>benzonatate</i>	T2	
NON-OPIOID ANTITUS-IST GEN.ANTIHISTAMINE-DECONGEST		
BROMFED DM (<i>brompheniramine/pseudoephed/dm</i>)	T4	
<i>brompheniramine/pseudoephed/dm</i> (Bromfed Dm)	T2	
NON-OPIOID ANTITUSSIVE-IST GEN ANTIHISTAMINE COMB.		
<i>promethazine/dextromethorphan</i>	T2	
OPIOID ANTITUSSIV-IST GEN. ANTIHISTAMINE-DECONGEST		
CAPCOF	T4	
HISTEX-AC	T4	
MAXI-TUSS CD	T4	
POLY-TUSSIN AC	T4	
<i>promethazine/phenyleph/codeine</i>	T2	
ZODRYL DAC 25	T4	
ZODRYL DAC 30	T4	
ZODRYL DAC 35	T4	
ZODRYL DAC 40	T4	
ZODRYL DAC 50	T4	
OPIOID ANTITUSSIV-IST GEN. ANTIHISTAMINE-DECONGEST		
ZODRYL DAC 60	T4	
ZODRYL DAC 80	T4	
OPIOID ANTITUSSIVE-IST GENERATION ANTIHISTAMINE		
<i>hydrocodone/chlorphen p-stirex</i>	T2	
<i>promethazine hcl/codeine</i>	T2	
TUXARIN ER	T4	

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

T5 – Brand Specialty
PA – Prior Authorization
QL – Quantity Limit

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

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

List of Prescription Medications

COUGH/COLD PREPARATIONS (Cough/Cold Medications) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
OPIOID ANTITUSSIVE-1ST GENERATION ANTIHISTAMINE (cont.)		
TUZISTRA XR	T4	PA
ZODRYL AC 25	T4	
ZODRYL AC 30	T4	
ZODRYL AC 35	T4	
ZODRYL AC 40	T4	
ZODRYL AC 50	T4	
ZODRYL AC 60	T4	
ZODRYL AC 80	T4	
OPIOID ANTITUSSIVE-ANTICHOLINERGIC COMBINATIONS		
HYCODAN	T4	
HYCODAN (hydrocodone bit/homatrop me-br)	T4	
hydrocodone bit/homatrop me-br	T2	
hydrocodone bit/homatrop me-br (Hycodan)	T2	
OPIOID ANTITUSSIVE-DECONGESTANT-EXPECTORANT COMB		
CODITUSSIN DAC	T4	
ZODRYL DEC 25	T4	
ZODRYL DEC 30	T4	
ZODRYL DEC 35	T4	
ZODRYL DEC 40	T4	
ZODRYL DEC 50	T4	
ZODRYL DEC 60	T4	
ZODRYL DEC 80	T4	
OPIOID ANTITUSSIVE-EXPECTORANT COMBINATION		
codeine phosphate/guaifenesin	T2	
CODITUSSIN AC	T4	
GUAIFEN-CODEINE 100-10 MG/5 ML	T4	
guaifen-codeine 100-10 mg/5 ml	T2	
GUAIFEN-CODEINE 200-20 MG/10ML	T4	
MAR-COF CG	T4	
NINJACOF-XG	T4	
OBREDON	T4	PA
DIAGNOSTIC (Diabetes)		
BLOOD SUGAR DIAGNOSTICS		
FREESTYLE INSULINX	T3	

T1 – Preferred Generics

T2 – Non-Preferred Generics

T3 – Preferred Brands

T4 – Non-Preferred Brands

T5 – Brand Specialty

PA – Prior Authorization

QL – Quantity Limit

ST – Step Therapy

AGE – Age Requirement

SP – Specialty Medication

HD – May require home delivery pharmacy

PPACA – No Cost-Share Preventive Medication

CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

DIAGNOSTIC (Diabetes) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
FREESTYLE INSULINX TEST STRIPS	T3	
FREESTYLE LITE TEST STRIP	T3	
FREESTYLE TEST STRIPS	T3	
FREESTYLE PRECISION NEO	T3	
HUMANA TRUE METRIX TEST STRIP	T3	
PRECISION XTRA	T3	
RELION TRUE METRIX TEST STRIP	T3	
TRUE METRIX GLUCOSE TEST STRIP	T3	
TRUETRACK GLUCOSE TEST STRIPS	T3	
URINE GLUCOSE TEST AIDS		
DIASTIX REAGENT	T3	
DIAGNOSTIC (Miscellaneous)		
BLOOD TESTING PREPARATIONS		
FORA GTEL KETONE TEST STRIP	T4	
GOJJI BLOOD KETONE TEST STRIP	T4	
NOVAMAX PLUS	T3	
PRECISION XTRA	T3	
CARDIOVASCULAR DIAGNOSTICS-RADIOPAQUE		
OMNIPAQUE	T4	
DIAGNOSTIC PREPARATIONS, MISCELLANEOUS		
ARIDOL	T4	
METHACHOLINE CHLORIDE	T4	
PROVOCHOLINE	T4	
TC 99M SULFUR COLLOID PREP	T4	
TOXICOLOGY SALIVA COLLECTION	T4	
VUEBLU	T4	
EYE DIAGNOSTIC AGENTS		
<i>fluorescein sodium</i>	T2	
<i>ful-glo 1 mg oph strip</i>	T2	
FUL-GLO EYE STRIPS	T4	
FLUORESCENCE IMAGING AGENTS - MALIGNANT TISSUE		
GLEOLAN	T4	
GASTROINTESTINAL RADIOPAQUE DIAGNOSTICS		
<i>diatrizoate meglumine, sodium</i> (Gastrografin)	T2	

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

T5 – Brand Specialty
PA – Prior Authorization
QL – Quantity Limit

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

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

List of Prescription Medications

DIAGNOSTIC (Miscellaneous) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
GASTROINTESTINAL RADIOPAQUE DIAGNOSTICS (cont.)		
ENTERO VU	T4	
E-Z DISK	T4	
E-Z-HD	T4	
E-Z-PAQUE	T4	
E-Z-PASTE	T4	
GASTROGRAFIN (<i>diatrizoate meglumine, sodium</i>)	T4	
GASTROMARK	T4	
LIQUID E-Z PAQUE	T4	
LIQUID POLIBAR PLUS	T4	
NEULUMEX	T4	
POLIBAR ACB	T4	
READI-CAT 2	T4	
SITZMARKS	T4	
SITZMARKS FOR KIDS	T4	
TAGITOL	T4	
VANILLA SILQ	T4	
VARIBAR HONEY	T4	
VARIBAR NECTAR	T4	
VARIBAR PUDDING	T4	
VARIBAR THIN HONEY	T4	
VARIBAR THIN LIQUID	T4	
VOLUMEN	T4	
METABOLIC FUNCTION DIAGNOSTICS		
METOPIRON	T4	
RADIOACTIVE DIAGNOSTICS, GENERAL		
XENON XE-133	T4	
RADIOACTIVE METABOLIC FUNCTION DIAGNOSTICS		
SODIUM IODIDE I-123	T4	
RADIOPHARMACEUTICALS ELEMENTS		
INDICLOR	T4	
URINARY TRACT RADIOPAQUE DIAGNOSTICS		
CYSTO-CONRAY II	T4	
CYSTOGRAFIN	T4	
CYSTOGRAFIN-DILUTE	T4	

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

T5 – Brand Specialty
PA – Prior Authorization
QL – Quantity Limit

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

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

List of Prescription Medications

DIAGNOSTIC (Miscellaneous) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
URINARY TRACT RADIOPAQUE DIAGNOSTICS (cont.)		
KETONE CARE TEST STRIP	T3	
KETONE TEST STRIP	T3	
KETOSTIX REAGENT	T3	
TRUEPLUS KETONE TEST STRIP	T3	
URINE GLUCOSE/ACETONE TEST AIDS,STRIPS		
KETO-DIASTIX REAGENT	T3	
URINE MULTIPLE TEST AIDS		
CHEK-STIX	T3	
CHEMSTRIP	T3	
CHEMSTRIP 10 WITH SG	T3	
CHEMSTRIP 2 GP	T3	
CHEMSTRIP 50B	T3	
CHEMSTRIP 7	T3	
CHEMSTRIP 9	T3	
COMBISTIX REAGENT	T3	
HEMA-COMBISTIX	T3	
KETO-DIASTIX REAGENT	T3	
LABSTIX REAGENT	T3	
MULTISTIX	T3	
MULTISTIX 10 SG	T3	
MULTISTIX 5	T3	
MULTISTIX 7	T3	
MULTISTIX 8 SG	T3	
MULTISTIX 9	T3	
MULTISTIX 9 SG	T3	
URISTIX 4	T3	
URISTIX REAGENT	T3	
DIURETICS (Diuretics)		
ARGININE VASOPRESSIN (AVP) RECEPTOR ANTAGONISTS		
<i>tolvaptan 15 mg tablet (Samsca)</i>	T2	PA QL (30 tabs/fill) SP
<i>tolvaptan 30 mg tablet (Samsca)</i>	T2	PA QL (60 tabs/fill) SP
CARBONIC ANHYDRASE INHIBITORS		
<i>acetazolamide</i>	T2	HD
<i>methazolamide</i>	T2	HD

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

T5 – Brand Specialty
PA – Prior Authorization
QL – Quantity Limit

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

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

List of Prescription Medications

DIURETICS (Diuretics) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
LOOP DIURETICS		
<i>bumetanide</i>	T2	HD
EDECRIN (<i>ethacrynic acid</i>)	T4	ST
<i>ethacrynic acid</i> (Edecrin)	T2	
<i>furosemide</i>	T1	HD
<i>furosemide</i> (Lasix)	T1	HD
LASIX (<i>furosemide</i>)	T4	ST HD
<i>torsemide</i>	T2	HD
POLYCYSTIC KIDNEY DISEASE AGENT, AVP RECEP. ANTAG		
<i>tolvaptan 15 mg tablet</i> (Jynarque)	T2	PA SP HD
<i>tolvaptan 15 mg-15 mg tablet</i> (Jynarque)	T2	PA SP HD
<i>tolvaptan 30 mg tablet</i> (Jynarque)	T2	PA SP HD
<i>tolvaptan 30 mg-15 mg tablet</i> (Jynarque)	T2	PA SP HD
<i>tolvaptan 45 mg-15 mg tablet</i> (Jynarque)	T2	PA SP HD
<i>tolvaptan 60 mg-30 mg tablet</i> (Jynarque)	T2	PA SP HD
<i>tolvaptan 90 mg-30 mg tablet</i> (Jynarque)	T2	PA SP HD
JYNARQUE 15 MG TABLET (<i>tolvaptan</i>)	T5	PA SP HD
JYNARQUE 15 MG-15 MG TABLET (<i>tolvaptan</i>)	T5	PA SP HD
JYNARQUE 30 MG TABLET (<i>tolvaptan</i>)	T5	PA SP HD
JYNARQUE 30 MG-15 MG TABLET (<i>tolvaptan</i>)	T5	PA SP HD
JYNARQUE 45 MG-15 MG TABLET (<i>tolvaptan</i>)	T5	PA SP HD
JYNARQUE 60 MG-30 MG TABLET (<i>tolvaptan</i>)	T5	PA SP HD
JYNARQUE 90 MG-30 MG TABLET (<i>tolvaptan</i>)	T5	PA SP HD
POTASSIUM SPARING DIURETICS		
ALDACTONE (<i>spironolactone</i>)	T4	HD
<i>amiloride hcl</i>	T2	HD
DYRENIUM (<i>triamterene</i>)	T4	HD
<i>eplerenone</i> (Inspra)	T2	HD
INSPIRA (<i>eplerenone</i>)	T4	HD
KERENDIA 10 MG TABLET	T3	PA QL (30 tabs/30 days)
KERENDIA 20 MG TABLET	T3	PA QL (30 tabs/30 days)
KERENDIA 40 MG TABLET	T3	PA
<i>spironolactone 100 mg tablet</i> (Aldactone)	T1	HD
<i>spironolactone 25 mg tablet</i> (Aldactone)	T1	HD
<i>spironolactone 25 mg/5 ml susp</i> (Carospir)	T2	

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

T5 – Brand Specialty
PA – Prior Authorization
QL – Quantity Limit

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

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

List of Prescription Medications

DIURETICS (Diuretics) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
POTASSIUM SPARING DIURETICS (cont.)		
<i>spironolactone 50 mg tablet (Aldactone)</i>	T1	HD
<i>triamterene (Dyrenium)</i>	T2	HD
POTASSIUM SPARING DIURETICS IN COMBINATION		
<i>amiloride/hydrochlorothiazide</i>	T2	HD
DYAZIDE (<i>triamterene/hydrochlorothiazid</i>)	T4	HD
<i>spironolact/hydrochlorothiazid</i>	T2	HD
<i>triamterene/hydrochlorothiazid (Dyazide)</i>	T1	HD
THIAZIDE AND RELATED DIURETICS		
<i>chlorthalidone</i>	T2	HD
DIURIL	T4	HD
<i>hydrochlorothiazide</i>	T1	HD
<i>indapamide</i>	T1	HD
<i>metolazone</i>	T2	HD
EENT PREPS (Allergy/Nasal Sprays)		
NASAL ANTIHISTAMINE		
<i>azelastine 0.1% (137 mcg) spray</i>	T2	QL (60 mls/fill) HD
<i>azelastine 0.15% nasal spray</i>	T2	HD
<i>olopatadine hcl (Patanase)</i>	T2	QL (31 gms/fill) HD
PATANASE (<i>olopatadine hcl</i>)	T4	QL (31 gms/fill) HD
NASAL ANTIHISTAMINE AND ANTI-INFLAM. STEROID COMB.		
<i>azelastine/fluticasone (Dymista)</i>	T2	ST QL (23 gms/fill) HD
RYALTRIS	T4	ST QL (1 bottle/fill) HD
NASAL ANTI-INFLAMMATORY STEROIDS		
<i>flunisolide</i>	T2	ST QL (50 mls/fill) HD
<i>fluticasone prop 50 mcg spray</i>	T2	QL (16 gms/fill) HD
<i>mometasone furoate 50 mcg spray (Nasonex)</i>	T2	ST QL (17 gms/fill) HD
XHANCE	T3	ST QL (32 mls/30 days) HD
NOSE PREPARATIONS, MISCELLANEOUS (RX)		
COCAINE HCL	T4	
GOPRELTO	T4	
<i>ipratropium 0.03% spray</i>	T2	QL (30 mls/fill) HD
<i>ipratropium 0.06% spray</i>	T2	QL (30 mls/fill) HD
NUMBRINO	T4	

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

T5 – Brand Specialty
PA – Prior Authorization
QL – Quantity Limit

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

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

List of Prescription Medications

EENT PREPS (Allergy/Nasal Sprays) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
NOSE PREPARATIONS, VASOCONSTRICTORS (RX)		
ADRENALIN CHLORIDE	T4	
<i>epinephrine hcl</i>	T2	
EENT PREPS (Ear Medications)		
EAR PREPARATIONS ANTI-INFLAMMATORY		
DERMOTIC (<i>fluocinolone acetonide oil</i>)	T4	
<i>fluocinolone acetonide oil</i> (Dermotic)	T2	
EAR PREPARATIONS, MISC. ANTI-INFECTIVES		
<i>acetic acid</i>	T2	
CORTANE-B (<i>hydrocort/pramoxine/chloroxyl</i>)	T4	
<i>hydrocortisone/acetic acid</i>	T2	
EENT PREPS (Eye Conditions)		
AGENTS FOR CORNEAL COLLAGEN CROSS-LINKING		
PHOTREXA CROSS-LINKING	T4	
PHOTREXA VISCOUS	T4	
ARTIFICIAL TEARS		
KLARITY (CHONDROITIN)	T4	
LACRISERT	T4	PA QL (60 inserts/fill)
MIEBO	T3	PA QL (3 mls/fill)
EYE ANTI-INFECTIVES (RX ONLY)		
BETADINE	T4	
<i>povidone-iodine</i>	T2	
EYE ANTI-INFLAMMATORY AGENTS		
ACULAR (<i>ketorolac tromethamine</i>)	T4	ST
ACULAR LS (<i>ketorolac tromethamine</i>)	T4	ST
<i>bromfenac sodium</i>	T2	
<i>bromfenac sodium</i> (Bromsite)	T2	
<i>bromfenac sodium</i> (Prolensa)	T2	
<i>dexamethasone sodium phosphate</i>	T2	
DEXTENZA	T4	
<i>diclofenac 0.1% eye drops</i>	T2	
<i>difluprednate</i> (Durezol)	T2	
EYSUVIS	T3	PA QL (8.3 mls/30 days)
<i>fluorometholone</i> (Fml)	T2	

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

T5 – Brand Specialty
PA – Prior Authorization
QL – Quantity Limit

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

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

List of Prescription Medications

EENT PREPS (Eye Conditions) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
EYE ANTI-INFLAMMATORY AGENTS (cont.)		
<i>flurbiprofen sodium</i>	T2	
FML (<i>fluorometholone</i>)	T4	ST
ILEVRO	T4	
INVELTYS	T4	ST
<i>ketorolac 0.4% ophth solution</i> (Acular Ls)	T2	
<i>ketorolac 0.5% ophth solution</i> (Acular)	T2	
KLARITY-L (LOTEPREDNOL-CHONDR)	T4	
LOTEMAX 0.5% EYE DROPS (<i>loteprednol etabonate</i>)	T4	
LOTEMAX 0.5% EYE OINTMENT	T4	ST
LOTEMAX 0.5% OPHTHALMIC GEL (<i>loteprednol etabonate</i>)	T4	ST
LOTEMAX SM	T4	ST
<i>loteprednol etabonate</i> (Alrex)	T2	PA SP HD
<i>loteprednol etabonate</i> (Lotemax)	T2	PA SP HD
PRED FORTE (<i>prednisolone acetate</i>)	T4	
<i>prednisolone ac 1% eye drop</i> (Pred Forte)	T2	
PREDNISOLONE ACET 1% EYE DROP	T4	
<i>prednisolone sod ph/bromfenac</i>	T2	
<i>prednisolone sodium phosphate</i>	T2	
PREDNISOLONE-BROMFENAC	T4	
PREDNISOLONE-NEPAFENAC	T4	
PROLENSA	T4	
PROLENSA (<i>bromfenac sodium</i>)	T4	ST
EYE LOCAL ANESTHETICS		
AKTEN	T4	
ALCAINE (<i>proparacaine hcl</i>)	T4	
ALTAFLUOR BENOX (<i>benoxinate hcl/fluorescein sod</i>)	T4	
FLUORESCIN-BENOXINATE	T4	
<i>proparacaine hcl</i> (Alcaine)	T2	
<i>proparacaine/fluorescein sod</i>	T2	
<i>tetracaine 0.5% eye drop</i>	T2	
TETRACAINE 0.5% STERI-UNIT SOL	T4	
<i>tetracaine hcl</i>	T2	
TETRAVISC	T4	
TETRAVISC FORTE	T4	

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

T5 – Brand Specialty
PA – Prior Authorization
QL – Quantity Limit

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

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

List of Prescription Medications

EENT PREPS (Eye Conditions) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
EYE MAST CELL STABILIZERS		
ALOCRIIL	T4	ST
<i>cromolyn 4% eye drops</i>	T2	
EYE MYDRIATIC AND NSAID COMBINATIONS		
MYDRIATIC4(TROP-PROP-PE-KTRLC)	T4	
EYE PREPARATIONS, MISCELLANEOUS (OTC)		
GELFILM	T4	
EYE VASOCONSTRICTORS		
<i>phenylephrine hcl</i>	T2	
MIOTICS AND OTHER INTRAOCULAR PRESSURE REDUCERS		
ALPHAGAN P	T4	ST HD
ALPHAGAN P (<i>brimonidine tartrate</i>)	T4	ST HD
<i>apraclonidine hcl</i>	T2	HD
<i>betaxolol hcl</i>	T2	HD
BETOPTIC S	T4	HD
<i>bimatoprost</i>	T2	PA HD
BIMATOPROST-BRIMONIDINE-DORZOL	T4	HD
BIMATOPROST-DORZOLAMID-TIMOLOL	T4	HD
<i>brimonidine tartrate</i>	T2	HD
<i>brimonidine tartrate</i> (Alphagan P)	T2	HD
<i>brimonidine tartrate/timolol</i> (Combigan)	T2	HD
BRIMONIDINE 0.1%-DORZOLAM 2%	T4	
BRIMONIDINE 0.15%-DORZOLAM 2%	T4	HD
<i>brinzolamide</i> (Azopt)	T2	HD
<i>carteolol hcl</i>	T2	HD
COMBIGAN (<i>brimonidine tartrate/timolol</i>)	T4	ST HD
DORZOLAMIDE	T4	HD
<i>dorzolamide hcl</i>	T2	HD
<i>dorzolamide hcl/timolol maleat</i> (Cosopt)	T2	HD
<i>dorzolamide/timolol/pf</i> (Cosopt Pf)	T2	HD
IOPIDINE	T4	ST HD
ISOPTO CARPINE (<i>pilocarpine hcl</i>)	T4	HD
LATANOPROST 0.005% EYE DROP	T4	HD
<i>latanoprost 0.005% eye drops</i> (Xalatan)	T2	PA HD
<i>levobunolol hcl</i>	T2	HD

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

T5 – Brand Specialty
PA – Prior Authorization
QL – Quantity Limit

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

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

List of Prescription Medications

EENT PREPS (Eye Conditions) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
MIOTICS AND OTHER INTRAOCULAR PRESSURE REDUCERS (cont.)		
PHOSPHOLINE IODIDE	T5	SP HD
<i>pilocarpine 1% eye drops</i>	T2	HD
<i>pilocarpine 2% eye drops</i>	T2	HD
<i>pilocarpine 4% eye drops</i>	T2	HD
<i>pilocarpine hcl (Isopto Carpine)</i>	T2	HD
RHOPRESSA	T4	
ROCKLATAN	T4	PA
SIMBRINZA	T4	HD
<i>timolol (Betimol)</i>	T2	ST HD
TIMOLOL-BIMATOPROST	T4	HD
<i>timolol 0.25% gel-solution (Timoptic-Xe)</i>	T2	ST HD
<i>timolol 0.5% eye drop (Istalol)</i>	T2	ST HD
<i>timolol 0.5% gel-solution (Timoptic-Xe)</i>	T2	ST HD
<i>timolol 0.5% gfs gel-solution (Timoptic-Xe)</i>	T2	ST HD
<i>timolol maleate 0.25% eye drop</i>	T2	ST HD
<i>timolol maleate 0.25% eye drop (Timoptic)</i>	T1	HD
<i>timolol maleate 0.5% eye drop (Timoptic Ocudose)</i>	T2	ST HD
<i>timolol maleate 0.5% eye drops (Timoptic)</i>	T1	HD
TIMOLOL-BRIMONIDIN-DORZOLAMIDE	T4	HD
TIMOLOL-BRIMONI-DORZOL-BIMATOP	T4	HD
TIMOLOL-BRIMONI-DORZOL-LATANOP	T4	HD
TIMOLOL-DORZOLAMIDE	T4	HD
TIMOLOL-DORZOLAMIDE-BIMATOPRST	T4	HD
TIMOLOL-DORZOLAMIDE-LATANOPRST	T4	HD
TIMOLOL-LATANOPROST	T4	HD
TIMOPTIC (<i>timolol maleate</i>)	T4	ST HD
TIMOPTIC-XE (<i>timolol maleate</i>)	T4	ST HD
<i>travoprost (Travatan Z)</i>	T2	PA HD
MYDRIATICS		
<i>atropine 1% eye drop</i>	T2	PA SP HD
<i>atropine 1% eye ointment</i>	T2	HD
<i>atropine sulf 0.025% eye drop</i>	T2	HD
ATROPINE SULF 0.025% EYE DROP	T4	HD
ATROPINE SULFATE 0.05% EYE DRP	T4	HD

T1 – Preferred Generics

T2 – Non-Preferred Generics

T3 – Preferred Brands

T4 – Non-Preferred Brands

T5 – Brand Specialty

PA – Prior Authorization

QL – Quantity Limit

ST – Step Therapy

AGE – Age Requirement

SP – Specialty Medication

HD – May require home delivery pharmacy

PPACA – No Cost-Share Preventive Medication

CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

EENT PREPS (Eye Conditions) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
MYDRIATICS (cont.)		
ATROPINE SULFATE 0.01% EYE DRP	T4	HD
ATROPINE SULFATE-0.9% NACL	T4	HD
<i>atropine sulfate 0.01% eye drp</i>	T2	PA SP HD
CYCLOGYL	T4	HD
CYCLOGYL (<i>cyclopentolate hcl</i>)	T4	HD
CYCLOMYDRIL	T4	HD
<i>cyclopentolat/tropic/phenyleph</i>	T2	HD
<i>cyclopentolate hcl</i>	T2	HD
<i>cyclopentolate hcl (Cyclogyl)</i>	T2	HD
CYCLOPENTOLATE-TROPICAMIDE-PE	T4	HD
<i>homatropine hbr</i>	T2	HD
MYDCOMBI	T4	HD
MYDRIACYL (<i>tropicamide</i>)	T4	HD
PAREMYD	T4	HD
<i>tropicamide</i>	T2	HD
<i>tropicamide (Mydriacyl)</i>	T2	HD
<i>tropicamide 1%-phenylephr 2.5%</i>	T2	
TROPICAMIDE-CYCLOPENTOLATE-PE	T4	HD
TROPICAMIDE-CYCLOPENT-PE-KTRLC	T4	
TROPICAMIDE 1%-PHENYLEPHR 2.5%	T4	
TROPIC-CYCLOPENT-PE-KTRLC-PROP	T4	HD
OPHTH. VEGF-A RECEPTOR ANTAG. RCMB MC ANTIBODY		
LUCENTIS	T5	PA SP
OPHTHALMIC ANTIFIBROTIC AGENTS		
MITOMYCIN-WATER	T4	
MITOSOL	T4	
OPHTHALMIC ANTI-INFLAMMATORY IMMUNOMODULATOR-TYPE		
CEQUA	T4	PA QL (60 vls/30 days)
<i>cyclosporine 0.05% eye emuls (Restasis)</i>	T2	PA QL (60 vials/fill) HD
CYCLOSPORINE IN KLARITY	T4	HD
RESTASIS (<i>cyclosporine</i>)	T4	PA QL (60 vials/fill) HD
RESTASIS MULTIDOSE	T3	PA QL (6 mls/fill) HD
XIIDRA	T3	PA QL (60 vls/fill) HD
VEVYE	T4	PA QL (2 mls/fill) HD

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

T5 – Brand Specialty
PA – Prior Authorization
QL – Quantity Limit

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

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

List of Prescription Medications

EENT PREPS (Eye Conditions) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
OPHTHALMIC CYSTINE DEPLETING AGENTS		
CYSTARAN	T5	PA SP
OPHTHALMIC HUMAN NERVE GROWTH FACTOR (HNGF)		
OXERVATE	T5	PA SP HD
OPHTHALMIC PREPARATIONS, MISCELLANEOUS		
HEALON GV	T4	
OPHTHALMIC TRPM8 AGONISTS		
TRYPTYR	T4	PA
ELECT/CALORIC/H2O (Cholesterol Medications)		
ORAL LIPID SUPPLEMENTS		
DOJOLVI	T5	PA SP HD
ELECT/CALORIC/H2O (Dental Products)		
FLUORIDE PREPARATIONS		
CLINPRO 5000	T4	
FRAICHE 5000 PREVI	T4	
FLORIVA	T4	
fluoride (sodium)	T2	
fluoride (sodium) (Prevident 5000 Plus)	T2	
fluoride (sodium) (Prevident)	T2	
FLUORIDEX	T4	
FLUORIDEX SENSITIVITY RELIEF	T4	
JUSTRIGHT 5000	T4	
PREVIDENT	T4	
PREVIDENT (fluoride (sodium))	T4	
PREVIDENT KIDS	T4	
PREVIDENT 5000 DRY MOUTH	T4	
PREVIDENT 5000 ENAMEL PROTECT	T4	
PREVIDENT 5000 ORTHO DEFENSE	T4	
PREVIDENT 5000 PLUS (fluoride (sodium))	T4	
PREVIDENT 5000 SENSITIVE	T4	
sodium fluoride 0.2% rinse (Prevident)	T2	
sodium fluoride 1.1% cream (Prevident 5000 Plus)	T2	
sodium fluoride 1.1% gel (Prevident)	T2	
sodium fluoride 5000 ppm cream (Prevident 5000 Plus)	T2	

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

T5 – Brand Specialty
PA – Prior Authorization
QL – Quantity Limit

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

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

List of Prescription Medications

ELECT/CALORIC/H2O (Dental Products) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
FLUORIDE PREPARATIONS (cont.)		
sodium fluoride 5000 ppm paste	T2	
sodium fluoride/potassium nit	T2	
PEDIATRIC VITAMIN PREPARATIONS		
fluoride (sodium)	T2	PPACA
FLURA-DROPS	T4	
sodium fluoride 0.25 (0.55) mg	T2	PPACA
sodium fluoride 0.5 mg(1.1 mg)	T2	PPACA
sodium fluoride 0.5 mg/ml drop	T2	PPACA
sodium fluoride 1 mg (2.2 mg)	T2	PPACA
ELECT/CALORIC/H2O (Diabetes)		
AGENTS TO TREAT HYPOGLYCEMIA (HYPERGLYCEMICS)		
cvs glucose 4 gram tablet chew (Trueplus Glucose)	T2	
CVS GLUCOSE LIQUID SHOT	T4	
DEX4 GLUCOSE 15 GM GEL PACKET	T4	
dex4 glucose 4 gm tablet chew (Trueplus Glucose)	T2	
DEX4 GLUCOSE LIQUID	T4	
DEX4 GLUCOSE LIQUID BLAST	T4	
dex4 glucose tab pouch pack (Trueplus Glucose)	T2	
dex4 quick dissolve tab chew (Trueplus Glucose)	T2	
dextrose	T2	
dextrose (Glucose-15)	T2	
dextrose (Glucose-45)	T2	
dextrose/vitamin d3	T2	
diazoxide (Proglycem)	T2	
drug mart glucose 4 gm tab chw (Trueplus Glucose)	T2	
GLUCO SHOT	T4	
GLUCOSE 2 GRAM GUMMY	T4	
glucose 3.75 gram tablet chew (Trueplus Glucose)	T2	
glucose 4 gram tablet chew (Trueplus Glucose)	T2	
GLUCOSE LIQUID	T4	
GLUTOSE-15 (dextrose)	T3	
GLUTOSE-45 (dextrose)	T3	
gnp glucose 3.75 gram tab chew (Trueplus Glucose)	T2	

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

T5 – Brand Specialty
PA – Prior Authorization
QL – Quantity Limit

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

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

List of Prescription Medications

ELECT/CALORIC/H2O (Diabetes) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
AGENTS TO TREAT HYPOGLYCEMIA (HYPERGLYCEMICS) (cont.)		
<i>gnp glucose 4 gram tablet chew</i> (Trueplus Glucose)	T2	
<i>gnp quick dissolve glucose tab</i> (Trueplus Glucose)	T2	
<i>gs glucose 4 gram tablet chew</i> (Trueplus Glucose)	T2	
GVOKE	T3	QL (2 vials/fill)
GVOKE HYPOPEN 1-PACK, 2-PACK	T3	QL (2 auto-injs/fill)
GVOKE PFS 1-PACK SYRINGE	T3	QL (2 syringes/fill)
GVOKE PFS 2-PACK SYRINGE	T3	QL (2 syringes/fill)
INSTA-GLUCOSE	T4	
<i>kro glucose 4 gram tablet chew</i> (Trueplus Glucose)	T2	
<i>croger glucose 4 gram tab chew</i> (Trueplus Glucose)	T2	
<i>leader glucose 4 gm tab chew</i> (Trueplus Glucose)	T2	
<i>leader quick dissolve gluc tab</i> (Trueplus Glucose)	T2	
<i>longs glucose 4 gram tab chew</i> (Trueplus Glucose)	T2	
<i>meijer glucose 4 gram tab chew</i> (Trueplus Glucose)	T2	
<i>ms glucose 4 gram tablet chew</i> (Trueplus Glucose)	T2	
<i>ms quick dissolve glucose tab</i> (Trueplus Glucose)	T2	
<i>preferred plus glucose tab chw</i> (Trueplus Glucose)	T2	
PROGLYCEM (<i>diazoxide</i>)	T4	
<i>pub glucose 4 gram tablet chew</i> (Trueplus Glucose)	T2	
<i>ra glucose 4 gram tablet chew</i> (Trueplus Glucose)	T2	
<i>relion glucose 4 gram tab chew</i> (Trueplus Glucose)	T2	
<i>reli-on glucose 4 gram tab chw</i> (Trueplus Glucose)	T2	
RELION GLUCOSE LIQUID	T4	
<i>smart sense glucose 4 gram tab</i> (Trueplus Glucose)	T2	
TRUEPLUS GLUCOSE	T4	
TRUEPLUS GLUCOSE (<i>dextrose</i>)	T4	
<i>upup glucose 4 gram tab chew</i> (Trueplus Glucose)	T2	
ELECT/CALORIC/H2O (Miscellaneous)		
NUCLEIC ACID/NUCLEOTIDE SUPPLEMENTS		
XURIDEN	T5	PA SP
ELECT/CALORIC/H2O (Nutritional/Dietary)		
CARBOHYDRATES		
ENFAMIL	T3	
GLUTOL	T3	

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

T5 – Brand Specialty
PA – Prior Authorization
QL – Quantity Limit

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

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

List of Prescription Medications

ELECT/CALORIC/H2O (Nutritional/Dietary) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ELECTROLYTE DEPLETERS		
AURYXIA	T4	
calcium acetate 667 mg capsule, gelcap, tablet	T2	QL (360 caps/fill)
lanthanum carbonate (Fosrenol)	T2	QL (90 tabs/fill)
LOKELMA	T3	QL (30 packs/fill)
REVELA 0.8 GM POWDER PACKET (sevelamer carbonate)	T4	QL (180 packs/fill)
REVELA 2.4 GM POWDER PACKET (sevelamer carbonate)	T4	QL (90 packs/fill)
REVELA 800 MG TABLET (sevelamer carbonate)	T4	QL (270 tabs/fill)
sodium polystyrene sulfon/sorb	T2	
sodium polystyrene sulfonate	T2	
VELPHORO	T4	QL (120 tabs/30 days)
VELTASSA 1 GM POWDER PACKET	T3	
VELTASSA 16.8 GM POWDER PACKET	T3	QL (30 packs/30 days)
VELTASSA 25.2 GM POWDER PACKET	T3	QL (30 packs/30 days)
VELTASSA 8.4 GM POWDER PACKET	T3	QL (30 packs/30 days)
FLUORIDE PREPARATIONS		
CLINPRO 5000	T4	
fluoride (sodium)	T2	
fluoride (sodium) (Prevident 5000 Plus)	T2	
fluoride (sodium) (Prevident)	T2	
FLUORIDEX	T4	
JUSTRIGHT 5000	T4	
PREVIDENT	T4	
PREVIDENT KIDS	T4	
PREVIDENT (fluoride (sodium))	T4	
PREVIDENT 5000 DRY MOUTH	T4	
PREVIDENT 5000 ORTHO DEFENSE	T4	
PREVIDENT 5000 PLUS (fluoride (sodium))	T4	
sodium fluoride 0.2% rinse (Prevident)	T2	
sodium fluoride 1.1% cream (Prevident 5000 Plus)	T2	
sodium fluoride 1.1% gel (Prevident)	T2	
sodium fluoride 5000 ppm cream (Prevident 5000 Plus)	T2	
sodium fluoride 5000 ppm paste	T2	

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

T5 – Brand Specialty
PA – Prior Authorization
QL – Quantity Limit

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

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

List of Prescription Medications

ELECT/CALORIC/H2O (Nutritional/Dietary) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
IODINE CONTAINING AGENTS		
<i>potassium iodide</i>	T2	
<i>potassium iodide/iodine</i>	T2	
SSKI	T4	
IRON REPLACEMENT		
ABATRON	T4	
ABATRON AF	T4	
ACCRUFER	T4	
ACTIVE FE	T4	
APETIGEN-PLUS	T3	
BENTIVITE BX	T4	
CHROMAGEN	T4	
CITRANATAL BLOOM	T4	
CORVITE 150	T4	
CORVITE FE	T4	
<i>cvs iron 27 mg tablet (Fergon)</i>	T2	
<i>cvs iron 65 mg tablet</i>	T2	
CVS SLOW RELEASE IRON 45 MG TB	T4	
<i>cvs slow release iron 45 mg tb</i>	T2	
<i>cvs slow release iron tablet</i>	T2	
<i>eql iron 65 mg tablet</i>	T2	
<i>eql slow release iron 45 mg tab</i>	T2	
<i>eql slow release iron 50 mg tb</i>	T2	
FEOSOL 45 MG CAPLET (<i>iron,carbonyl</i>)	T3	
<i>feosol 65 mg tablet</i>	T2	
FEOSOL BIFERA 28 MG CAPLET	T3	
FERAHEME (<i>ferumoxytol</i>)	T4	PA
FERGON 27 MG TABLET	T4	
FERGON 27 MG TABLET (<i>ferrous gluconate</i>)	T3	
FERGON TABLET	T4	
FER-IN-SOL (<i>ferrous sulfate</i>)	T3	
FERIVA 21-7	T4	
FERIVA FA	T4	
FERRACTIV IRON	T4	
FERRALET 90	T4	

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

T5 – Brand Specialty
PA – Prior Authorization
QL – Quantity Limit

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

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

List of Prescription Medications

ELECT/CALORIC/H2O (Nutritional/Dietary) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
IRON REPLACEMENT (cont.)		
FERRETTS IPS 18 MG CAP	T4	
FERRETTS IPS 40 MG/15 ML LIQ	T3	
FERRIMIN 150	T3	
FERRLECIT (<i>sodium ferric gluconat/sucrose</i>)	T4	PA
FERRO-SEQUELS	T4	
<i>ferrous fum/vit c/b12-if/folic</i>	T2	PPACA
<i>ferrous fumarate</i>	T2	
<i>ferrous fumarate</i> (Hemocyte)	T2	
FERROUS FUMARATE 29 MG TAB	T4	
<i>ferrous fumarate 324 mg tablet</i>	T2	
<i>ferrous fumarate/folic acid</i> (Hemocyte-F)	T2	
<i>ferrous gluconate</i>	T2	
<i>ferrous gluconate</i> (Fergon)	T2	
<i>ferrous sulf 15 mg iron/ml drp</i> (Fer-In-Sol)	T2	
<i>ferrous sulf 220 mg/5 ml elix, liq</i>	T2	
<i>ferrous sulf 300 mg/5 ml cup</i>	T2	
FERROUS SULF 325 MG/5 ML CUP	T4	
<i>ferrous sulf 300 mg/6.8ml soln</i>	T2	
<i>ferrous sulf 44 mg iron/5ml lq</i>	T2	
<i>ferrous sulf ec 324 mg, 325 mg tablet</i>	T2	
<i>ferrous sulfate 325 mg tablet</i>	T2	
<i>ferrous sulfate</i>	T2	
<i>ferrous sulfate</i> (Fer-In-Sol)	T2	
<i>ferrous sulfate/vit c/folic ac</i>	T2	PPACA
<i>ferumoxytol</i> (Feraheme)	T2	PA
<i>ft iron 65 mg tablet</i>	T2	
FT IRON 45 MG TABLET	T4	
FUSION	T4	
FUSION PLUS	T4	
GENTLE IRON	T4	
<i>gnp iron 45 mg, 65 mg tablet</i>	T2	
HEMATEX	T4	
HEMATEX (<i>iron polysaccharide complex</i>)	T4	
HEMATOGEN	T4	

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

T5 – Brand Specialty
PA – Prior Authorization
QL – Quantity Limit

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

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

List of Prescription Medications

ELECT/CALORIC/H2O (Nutritional/Dietary) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
IRON REPLACEMENT (cont.)		
HEMATRON-AF	T4	
HEMAX	T4	
HEMOCYTE PLUS (<i>iron fum/folic acid/mv,min 15</i>)	T4	
HEMOCYTE-F (<i>ferrous fumarate/folic acid</i>)	T4	
<i>hm iron 65 mg tablet</i>	T2	
<i>hm slow release iron tablet</i>	T2	
I.L.X. B-12	T3	
ICAR	T3	
ICAR-C (<i>iron,carbonyl/ascorbic acid</i>)	T3	
ICAR-C PLUS (<i>iron,carb/vit c/vit b12/folic</i>)	T4	
INFED	T3	PA
INJECTAFER	T4	PA
INTEGRA	T3	
INTEGRA F (<i>iron fum,ps/folic acid/vitc/b3</i>)	T4	
INTEGRA PLUS (<i>iron fum,ps/folic/bcomp,c no.9</i>)	T4	
<i>iron 27 mg, 28 mg, 45 mg, 65 mg tablet</i>	T2	
<i>iron 27 mg tablet (Fergon)</i>	T2	
<i>iron aspgly,ps/c/b12/fa/ca/suc</i>	T2	
<i>iron aspgly,ps/c/succinic acid</i>	T2	
<i>iron aspgly,c/b12/fa/ca-th/suc</i>	T2	
<i>iron bg,ps/vitc/b12/fa/calcium</i>	T2	
IRON BISGLYCINATE	T4	
<i>iron,carb/vit c/vit b12/folic (Icar-C Plus)</i>	T2	
<i>iron,carbonyl</i>	T2	
<i>iron,carbonyl (Feosol)</i>	T2	
<i>iron,carbonyl/ascorbic acid (Icar-C)</i>	T2	
<i>iron fum,ag/c/b12/folic/ca/suc</i>	T2	
<i>iron fum,ps/folic acid/vitc/b3 (Integra F)</i>	T2	
<i>iron fum,ps/folic/bcomp,c no.9 (Integra Plus)</i>	T2	
<i>iron fum/folic acid/mv,min 15 (Hemocyte Plus)</i>	T2	
<i>iron fumarate/vit c/vit b12/fa</i>	T2	
<i>iron polysaccharide complex</i>	T2	
<i>iron polysaccharide complex (Nu-Iron 150)</i>	T2	
<i>iron ps complex/b12/folic acid</i>	T2	

T1 – Preferred Generics

T2 – Non-Preferred Generics

T3 – Preferred Brands

T4 – Non-Preferred Brands

T5 – Brand Specialty

PA – Prior Authorization

QL – Quantity Limit

ST – Step Therapy

AGE – Age Requirement

SP – Specialty Medication

HD – May require home delivery pharmacy

PPACA – No Cost-Share Preventive Medication

CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

ELECT/CALORIC/H2O (Nutritional/Dietary) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
IRON REPLACEMENT (cont.)		
<i>iron/c/b12/calcium/stomach conc</i>	T2	
<i>iron/c/folic acid/mv cmb11/calc</i>	T2	
<i>iron/folic acid/vit bcomp,c/min</i>	T2	
<i>iron/folic acid/b12/c/docusate</i>	T2	
<i>iron/folic acid/c/b6/b12/zinc</i>	T2	
<i>iron/vit c/fructooligosaccharide</i>	T2	
<i>iron sucrose complex</i>	T2	PA
<i>iron-vitamin c 100-250 mg tab (Icar-C)</i>	T2	PA SP HD
IRON-VITAMIN C 65-125 MG TAB	T3	PA SP HD
IRONUP	T4	
IRO-PLEX	T4	
IROSPAN	T4	
LIQUID IRON	T4	
LYDIA PINKHAM HERBAL	T4	
MAXFE	T4	
MONOFERRIC	T4	PA
NEONATAL FE	T4	
NIFEREX	T4	
NOVAFERRUM ALL GOOD	T4	PA SP HD
NOVAFERRUM WOW	T4	PA SP HD
NOVAFERRUM YAY IRON	T4	
NOVAFERRUM YUMMY PEDIATRIC	T3	PA SP HD
NUFERA	T4	
NU-IRON 150 (<i>iron polysaccharide complex</i>)	T3	
PARVLEX	T4	
PERFECT IRON	T4	
PRO FE	T3	
PROFERRIN	T3	
PROFERRIN-FORTE	T4	
PROTECT IRON	T4	
<i>ra high potency iron 27 mg tab</i>	T2	
RA HIGH POTENCY IRON 27 MG TAB	T4	
<i>ra iron 65 mg tablet</i>	T2	
RA SLOW RELEASE IRON 45 MG TAB	T3	

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

T5 – Brand Specialty
PA – Prior Authorization
QL – Quantity Limit

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

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

List of Prescription Medications

ELECT/CALORIC/H2O (Nutritional/Dietary) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
IRON REPLACEMENT (cont.)		
SIDEROL	T4	
SLOW FE	T3	
<i>slow release iron 160 mg tab</i>	T2	
SLOW RELEASE IRON 45 MG TAB	T3	
SLOW RELEASE IRON 45 MG TABLET	T3	
<i>slow release iron 45 mg tablet</i>	T2	
SLOW RELEASE IRON 45 MG TABLET	T4	
SLOW RELEASE IRON TABLET	T3	
<i>sm iron 160 mg tablet sa</i>	T2	
<i>sm iron 65 mg, 325 mg tablet</i>	T2	
SM SLOW RELEASE IRON 45 MG TAB	T3	
<i>sodium ferric gluconat/sucrose (Ferrlecit)</i>	T2	PA
<i>sv iron 65 mg tablet</i>	T2	
SV SLOW RELEASE IRON 45 MG TAB	T3	
TANDEM DUAL ACTION	T3	
TL-HEM 150	T4	
TRIFERIC	T4	
<i>true ferrous sulf ec 324 mg tb</i>	T2	
TULIVITE	T4	
VENOFER	T3	PA
VIRT-FEFA PLUS CAPSULE	T4	
<i>virt-fefa plus capsule (Integra Plus)</i>	T2	
VITABEX IRON	T4	
VITAFOL	T4	
VITRON-C	T3	
PEDIATRIC VITAMIN PREPARATIONS		
<i>fluoride (sodium)</i>	T2	PPACA
FLURA-DROPS	T4	
<i>sodium fluoride 0.25 (0.55) mg</i>	T2	PPACA
<i>sodium fluoride 0.5 mg(1.1 mg)</i>	T2	PPACA
<i>sodium fluoride 0.5 mg/ml drop</i>	T2	PPACA
<i>sodium fluoride 1 mg (2.2 mg)</i>	T2	PPACA
POTASSIUM REPLACEMENT		
EFFER-K 10 MEQ TABLET EFF	T4	

T1 – Preferred Generics

T2 – Non-Preferred Generics

T3 – Preferred Brands

T4 – Non-Preferred Brands

T5 – Brand Specialty

PA – Prior Authorization

QL – Quantity Limit

ST – Step Therapy

AGE – Age Requirement

SP – Specialty Medication

HD – May require home delivery pharmacy

PPACA – No Cost-Share Preventive Medication

CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

ELECT/CALORIC/H2O (Nutritional/Dietary) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
POTASSIUM REPLACEMENT (cont.)		
EFFER-K 20 MEQ TABLET EFF	T4	
<i>effe-r-k 25 meq tablet eff</i>	T2	
<i>potassium bicarbonate/cit ac</i>	T2	
<i>potassium chloride</i>	T1	
<i>potassium chloride</i>	T2	
<i>potassium cl 10% (20 meq/15ml)</i>	T2	
<i>potassium cl 20 meq packet</i>	T2	
<i>potassium cl 20% (40 meq/15ml)</i>	T2	
<i>potassium cl er 10 meq capsule</i>	T1	
<i>potassium cl er 10 meq tablet</i>	T1	
<i>potassium cl er 15 meq tablet</i>	T1	
<i>potassium cl er 20 meq tablet</i>	T1	
<i>potassium cl er 8 meq capsule</i>	T1	
<i>potassium cl er 8 meq tablet</i>	T1	
<i>potassium cl10%(20meq/15ml)cup</i>	T2	
<i>potassium cl10%(40meq/30ml)cup</i>	T2	
<i>potassium cl20%(40meq/15ml)cup</i>	T2	
POTASSIUM CL ER 15 MEQ TABLET	T4	
PROTEIN REPLACEMENT		
AQNEURSA	T5	PA SP
ELECT/CALORIC/H2O (Urinary Tract Conditions)		
DIALYSIS SOLUTIONS		
PRISMASOL	T4	
URINARY PH MODIFIERS		
<i>citric acid/sodium citrate</i>	T2	HD
K-PHOS NO.2	T4	HD
K-PHOS ORIGINAL	T3	HD
ORACIT	T4	HD
<i>potassium citrate</i>	T2	HD
<i>potassium citrate (Urocit-K)</i>	T2	HD
RENACIDIN	T3	HD
UROCIT-K (<i>potassium citrate</i>)	T4	HD
UROQID-ACID NO.2	T4	HD

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

T5 – Brand Specialty
PA – Prior Authorization
QL – Quantity Limit

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

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

List of Prescription Medications

GASTROINTESTINAL (Cholesterol Medications)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
LIPOTROPICS		
<i>icosapent ethyl</i> (Vascepa)	T2	PA HD
<i>omega-3 acid ethyl esters</i> (Lovaza)	T2	PA HD
VASCEPA (<i>icosapent ethyl</i>)	T3	PA HD
GASTROINTESTINAL (Gastrointestinal/Heartburn)		
AMMONIA INHIBITORS		
BUPHENYL (<i>sodium phenylbutyrate</i>)	T5	PA SP HD
<i>lactulose</i>	T2	HD
<i>lactulose 10 gm/15 ml solution</i>	T2	HD
LITHOSTAT	T4	HD
OLPRUVA DOSE KIT, DOSE ENVELOPE	T5	SP PA HD
RAVICTI	T5	PA SP HD
<i>sodium phenylbutyrate</i> (Buphenyl)	T2	PA SP HD
PHEBURANE	T5	PA SP
ANTICHOLINERGICS, QUATERNARY AMMONIUM		
<i>chlordiazepoxide/clidinium br</i> (Librax)	T2	
GLYCAT	T4	
<i>glycopyrrolate</i>	T2	
<i>glycopyrrolate</i> (Cuvposa)	T2	
<i>glycopyrrolate</i> (Robinul Forte)	T2	
<i>glycopyrrolate</i> (Robinul)	T2	
ROBINUL (<i>glycopyrrolate</i>)	T4	
ROBINUL FORTE (<i>glycopyrrolate</i>)	T4	
ANTICHOLINERGICS/ANTISPASMODICS		
<i>dicyclomine 10 mg capsule</i>	T2	
<i>dicyclomine 10 mg/5 ml soln</i>	T2	
<i>dicyclomine 20 mg tablet</i>	T2	
ANTIDIARRHEAL - TRYPTOPHAN HYDROXYLASE INHIBITOR		
XERMELO	T5	PA QL (90 tabs/fill) SP
ANTIDIARRHEALS		
<i>diphenoxylate hcl/atropine</i>	T2	
<i>diphenoxylate hcl/atropine</i> (Lomotil)	T2	
LOMOTIL (<i>diphenoxylate hcl/atropine</i>)	T4	
MOTOFEN	T4	
<i>opium tincture</i>	T2	
<i>paregoric</i>	T2	

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

T5 – Brand Specialty
PA – Prior Authorization
QL – Quantity Limit

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

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

List of Prescription Medications

GASTROINTESTINAL (Gastrointestinal/Heartburn) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ANTIEMETIC, CANNABINOID-TYPE		
<i>dronabinol</i> (Marinol)	T2	PA
MARINOL (<i>dronabinol</i>)	T4	PA
SYNDROS	T4	PA
ANTIEMETIC/ANTIVERTIGO AGENTS		
<i>aprepitant</i> 125 mg capsule	T2	QL (1 cap/fill)
<i>aprepitant</i> 125-80-80 mg pack (Emend)	T2	QL (3 caps/fill)
<i>aprepitant</i> 40 mg capsule (Emend)	T2	QL (1 cap/fill)
<i>aprepitant</i> 80 mg capsule (Emend)	T2	QL (2 caps/fill)
COMPAZINE (<i>prochlorperazine maleate</i>)	T4	
COMPAZINE (<i>prochlorperazine</i>)	T4	
DICLEGIS (<i>doxylamine succinate/vit b6</i>)	T4	QL (120 tabs/fill)
<i>fosaprepitant</i> dimeglumine (Emend)	T2	
<i>granisetron hcl</i> 0.1 mg/ml vial	T2	
<i>granisetron hcl</i> 1 mg tablet	T2	QL (6 tabs/fill)
<i>granisetron hcl</i> 1 mg/ml vial	T2	
<i>granisetron hcl</i> 4 mg/4 ml vial	T2	
<i>meclizine</i> 50 mg tablet	T2	
<i>ondansetron</i> 4 mg/2 ml	T2	
<i>ondansetron</i> 40 mg/20 ml vial	T2	
<i>ondansetron hcl</i> 4 mg tablet	T2	QL (9 tabs/fill)
<i>ondansetron hcl</i> 4 mg/2 ml syr	T2	
<i>ondansetron hcl</i> 4 mg/2 ml vial	T2	
<i>ondansetron hcl</i> 8 mg tablet	T2	QL (9 tabs/fill)
<i>ondansetron odt</i> 4 mg, 8 mg tablet	T2	QL (9 tabs/30 days)
<i>prochlorperazine</i> (Compazine)	T2	
<i>prochlorperazine maleate</i> (Compazine)	T2	
<i>promethazine hcl</i>	T2	
SANCUSO	T4	QL (1 patch/fill)
<i>scopolamine</i> (Transderm-Scop)	T2	
<i>trimethobenzamide hcl</i>	T2	
VARUBI	T3	QL (2 tabs/fill)

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

T5 – Brand Specialty
PA – Prior Authorization
QL – Quantity Limit

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

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

List of Prescription Medications

GASTROINTESTINAL (Gastrointestinal/Heartburn) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ANTI-ULCER PREPARATIONS		
CYTOTEC (<i>misoprostol</i>)	T4	HD
<i>misoprostol</i> (Cytotec)	T2	HD
<i>sucralfate</i> (Carafate)	T2	HD
ANTI-ULCER-H.PYLORI AGENTS		
<i>lansoprazole/amoxicilin/clarith</i>	T2	QL (112 units/fill)
OMECLAMOX-PAK	T4	QL (80 units/fill)
TALICIA	T3	QL (168 caps/fill)
VOQUEZNA DUAL PAK	T4	
VOQUEZNA TRIPLE PAK	T4	
BELLADONNA ALKALOIDS		
DONNATAL	T4	HD
DONNATAL (<i>phenobarb/hyoscy/atropine/scop</i>)	T4	HD
<i>hyoscyamine sulfate</i>	T2	HD
<i>hyoscyamine sulfate</i> (Levid)	T2	HD
<i>hyoscyamine sulfate</i> (Levsin)	T2	HD
<i>hyoscyamine sulfate</i> (Levsin-SI)	T2	HD
<i>hyoscyamine sulfate</i> (Nulev)	T2	HD
LEVBIID (<i>hyoscyamine sulfate</i>)	T4	HD
LEVSIN (<i>hyoscyamine sulfate</i>)	T4	HD
LEVSIN-SL (<i>hyoscyamine sulfate</i>)	T4	HD
<i>methscopolamine bromide</i>	T2	HD
NULEV (<i>hyoscyamine sulfate</i>)	T4	HD
<i>phenobarb/hyoscy/atropine/scop</i>	T2	HD
<i>phenobarb/hyoscy/atropine/scop</i> (Donnatal)	T2	HD
<i>phenobarb/hyoscy/atropine/scop</i> (Phenobarbital-Belladonna)	T2	HD
PHENOBARBITAL-BELLADONNA (<i>phenobarb/hyoscy/atropine/scop</i>)	T4	HD
SYMAX DUOTAB	T4	HD
BILE SALTS		
CHENODAL	T5	PA SP HD
CHOLBAM 50 MG CAPSULE	T5	PA QL (120 caps/fill) SP HD
CHOLBAM 250 MG CAPSULE	T5	PA SP HD
CTEXLI	T5	PA SP
URSO FORTE (<i>ursodiol</i>)	T4	HD
<i>ursodiol</i>	T2	HD
<i>ursodiol</i> (Urso Forte)	T2	HD

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

T5 – Brand Specialty
PA – Prior Authorization
QL – Quantity Limit

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

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

List of Prescription Medications

GASTROINTESTINAL (Gastrointestinal/Heartburn) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
CHRONIC INFLAM. COLON DX, 5-A-SALICYLAT, RECTAL TX		
<i>mesalamine 1,000 mg supp</i> (Canasa)	T2	
<i>mesalamine 4 gm/60 ml enema</i> (Sfrowasa)	T2	
<i>mesalamine 4 gm/60 ml kit</i> (Rowasa)	T2	
ROWASA (<i>mesalamine w/cleansing wipes</i>)	T4	
SFROWASA (<i>mesalamine</i>)	T4	
DRUG TX-CHRONIC INFLAM. COLON DX, 5-AMINOSALICYLAT		
APRISO (<i>mesalamine</i>)	T4	HD
ASACOL HD (<i>mesalamine</i>)	T4	HD
AZULFIDINE (<i>sulfasalazine</i>)	T4	HD
<i>balsalazide disodium</i> (Colazal)	T2	HD
COLAZAL (<i>balsalazide disodium</i>)	T4	HD
<i>mesalamine</i> (Apriso)	T2	HD
<i>mesalamine</i>	T2	HD
<i>mesalamine</i> (Pentasa)	T2	HD
<i>mesalamine 800 mg dr tablet</i> (Asacol Hd)	T2	HD
<i>mesalamine dr 1.2 gm tablet</i> (Lialda)	T2	HD
PENTASA 250 MG CAPSULE	T3	HD
PENTASA 500 MG CAPSULE (<i>mesalamine</i>)	T4	HD
<i>sulfasalazine</i> (Azulfidine)	T2	HD
FARNESOID X RECEPTOR (FXR) AGONIST, BILE AC ANALOG		
OICALIVA	T5	PA QL (30 tabs/fill) SP HD
FECAL MICROBIOTA TRANSPLANTATION (FMT)		
VOWST CAPSULE	T5	PA SP
GASTRIC ENZYMES		
SUCRAID	T5	PA SP
HEMORRHOID PREP,ANTI-INFLAM STEROID-LOCAL ANESTHET		
ANALPRAM HC 1% CREAM	T4	
ANALPRAM HC 2.5%-1% CREAM (<i>hydrocortisone/pramoxine</i>)	T4	ST
ANALPRAM HC 2.5%-1% CRM SINGLE (<i>hydrocortisone/pramoxine</i>)	T4	ST
<i>hydrocort-pramoxine 1%-1% crm</i>	T2	
<i>hydrocort-pramoxine 2.5-1% crm</i> (Analpram Hc)	T2	ST
PROCORT	T4	

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

T5 – Brand Specialty
PA – Prior Authorization
QL – Quantity Limit

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

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

List of Prescription Medications

GASTROINTESTINAL (Gastrointestinal/Heartburn) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
HISTAMINE H2-RECEPTOR INHIBITORS		
<i>cimetidine</i>	T2	HD
<i>famotidine</i>	T2	HD
<i>famotidine</i> (Pepcid)	T1	HD
<i>nizatidine</i>	T2	HD
PEPCID (<i>famotidine</i>)	T4	HD
<i>ranitidine hcl</i>	T2	HD
IBS AGENTS, MIXED OPIOID RECEPTOR AGONISTS/ANTAGONISTS		
VIBERZI	T3	HD
IBS-C/CIC AGENTS, GUANYLATE CYCLASE-C AGONIST		
LINZESS	T3	QL (30 caps/fill)
TRULANCE	T3	
ILEAL BILE ACID TRANSPORTER (IBAT) INHIBITOR		
BYLVAY 1,200 MCG CAPSULE	T5	PA QL (60 caps/fill) SP HD
BYLVAY 200 MCG PELLET	T5	PA QL (120 pellets/fill) SP HD
BYLVAY 400 MCG CAPSULE	T5	PA QL (150 caps/fill) SP HD
BYLVAY 600 MCG PELLET	T5	PA QL (30 pellets/fill) SP HD
LIVMARLI	T5	PA SP
INTESTINAL MOTILITY STIMULANTS		
<i>metoclopramide hcl</i>	T1	
<i>metoclopramide hcl</i> (Reglan)	T1	
<i>prucalopride succinate</i> (Motegrity)	T2	QL (30 tabs/30 days)
REGLAN (<i>metoclopramide hcl</i>)	T4	
IRRITABLE BOWEL SYNDROME AGENTS, 5-HT₃ ANTAGONIST		
<i>alosetron hcl</i> (Lotronex)	T2	SP HD
IRRITABLE BOWEL SYND. AGENT, 5-HT₄ PARTIAL AGONIST		
ZELNORM	T4	
LAXATIVES AND CATHARTICS		
<i>bisac/nahco3/kcl/peg 3350</i>	T2	PPACA
GIALAX	T4	PPACA
GOLYTELY (<i>peg3350/sod sulf, bicarb, cl/kcl</i>)	T4	
KRISTALOSE	T4	
<i>lactulose</i>	T2	
<i>lactulose 10 gm packet</i>	T2	
<i>lactulose 10 gm/15 ml solution</i>	T2	

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

T5 – Brand Specialty
PA – Prior Authorization
QL – Quantity Limit

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

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

List of Prescription Medications

GASTROINTESTINAL (Gastrointestinal/Heartburn) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
LAXATIVES AND CATHARTICS (cont.)		
<i>lactulose 20 gm/30 ml solution</i>	T2	
<i>lubiprostone</i>	T2	QL (60 caps/30 days)
NULYTELY WITH FLAVOR PACKS (<i>sodium chloride/nahco3/kcl/peg</i>)	T4	
OSMOPREP	T4	PPACA
<i>peg3350/sod sul/nacl/kcl/asb/c</i> (Moviprep)	T2	PPACA
<i>peg3350/sod sulf,bicarb,cl/kcl</i>	T2	PPACA
<i>peg3350/sod sulf,bicarb,cl/kcl</i> (Golytely)	T2	PPACA
<i>sodium chloride/nahco3/kcl/peg</i> (Nulytely With Flavor Packs)	T2	PPACA
<i>sodium, potassium,mag sulfates</i> (Suprep)	T2	PPACA
LOCAL ANORECTAL NITRATE PREPARATIONS		
<i>nitroglycerin 0.4% ointment</i> (Rectiv)	T2	
RECTIV (<i>nitroglycerin</i>)	T3	
MU-OPIOID RECEPTOR ANTAGONISTS,PERIPHERALLY-ACTING		
<i>alvimopan</i>	T2	
ENTEREG	T4	
PANCREATIC ENZYMES		
CREON	T3	HD
PANCREAZE	T3	HD
VIOKACE	T3	HD
ZENPEP	T3	HD
POTASSIUM-COMPETITIVE ACID BLOCKERS (PCABS)		
VOQUEZNA	T4	ST
PROTON-PUMP INHIBITORS		
<i>dexlansoprazole dr 60 mg cap</i>	T2	ST HD
<i>esomeprazole dr 2.5 mg packet</i> (Nexium)	T2	ST QL (30 packs/30 days) HD
<i>esomeprazole dr 5 mg packet</i> (Nexium)	T2	ST QL (30 packs/30 days) HD
<i>esomeprazole dr 10 mg packet</i> (Nexium)	T2	ST QL (30 packs/fill) HD
<i>esomeprazole dr 40 mg packet</i> (Nexium)	T2	ST HD
<i>esomeprazole dr 40 mg cap</i> (Nexium)	T2	HD
ESOMEPRAZOLE DR 49.3 MG CAP (Nexium)	T4	ST HD
<i>lansoprazole dr 30 mg capsule</i> (Prevacid)	T1	HD
<i>lansoprazole odt 15 mg tablet</i> (Prevacid)	T2	ST QL (30 tabs/fill) HD
<i>lansoprazole odt 30 mg tablet</i> (Prevacid)	T2	ST HD
<i>omeprazole dr 10 mg capsule</i>	T1	QL (30 caps/fill) HD

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

T5 – Brand Specialty
PA – Prior Authorization
QL – Quantity Limit

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

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

List of Prescription Medications

GASTROINTESTINAL (Gastrointestinal/Heartburn) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
PROTON-PUMP INHIBITORS (cont.)		
<i>omeprazole dr 40 mg capsule</i>	T1	HD
<i>omeprazole/sodium bicarbonate (Zegerid)</i>	T2	PA HD
<i>omeprazole-bicarb 20-1,680 pkt (Zegerid)</i>	T2	PA QL (30 packs/fill) HD
<i>omeprazole-bicarb 40-1,100 cap (Zegerid)</i>	T2	PA HD
<i>omeprazole-bicarb 40-1,680 pkt (Zegerid)</i>	T2	PA HD
<i>pantoprazole 40 mg suspension (Protonix)</i>	T2	ST HD
<i>pantoprazole sod dr 40 mg tab (Protonix)</i>	T1	HD
<i>rabeprazole sod dr 20 mg tab (Aciphex)</i>	T2	HD
RECTAL PREPARATIONS		
<i>hydrocortisone acetate (Anusol-Hc)</i>	T2	
<i>hydrocortisone acetate (Proctocort)</i>	T2	
PROCTOCORT (<i>hydrocortisone acetate</i>)	T4	ST
SBS - GLUCAGON-LIKE PEPTIDE-2 (GLP-2) ANALOGS		
GATTEX	T5	PA SP HD
GASTROINTESTINAL (Pain Relief And Inflammatory Disease)		
HEMORRHOID PREP, ANTI-INFLAM STEROID-LOCAL ANESTHET		
ANA-LEX	T4	
ANALPRAM HC 1% CREAM	T4	
ANALPRAM HC 2.5%-1% CREAM (<i>hydrocortisone/pramoxine</i>)	T4	ST
ANALPRAM HC 2.5%-1% CRM SINGLE (<i>hydrocortisone/pramoxine</i>)	T4	ST
<i>hydrocort-pramoxine 1%-1% crm</i>	T2	
<i>hydrocort-pramoxine 2.5%-1% cm (Analpram Hc)</i>	T2	ST
<i>hydrocort-pramoxine 2.5-1% crm (Analpram Hc)</i>	T2	ST
<i>lidocaine-hc 2-2% cream kit</i>	T2	
<i>lidocaine-hc 3-1% cream kit</i>	T2	
<i>lidocaine-hc 3-0.5% cream</i>	T2	
<i>lidocaine-hc 3-0.5% cream kit</i>	T2	
<i>lidocaine-hc 2.8-0.55% gel</i>	T2	
<i>lidocaine-hc 3-2.5% gel kit</i>	T2	
PROCORT	T4	

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

T5 – Brand Specialty
PA – Prior Authorization
QL – Quantity Limit

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

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

List of Prescription Medications

HORMONES (Gastrointestinal/Heartburn)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
RECTAL/LOWER BOWEL PREP.,GLUCOCORT. (NON-HEMORR)		
CORTENEMA (<i>hydrocortisone</i>)	T4	
<i>hydrocortisone</i> (Cortenema)	T2	
UCERIS (<i>budesonide</i>)	T3	
HORMONES (Hormonal Agents)		
ADRENOCORTICOTROPHIC HORMONES		
ACTHAR SELFJECT	T5	PA SP HD
ANDROGENIC AGENTS		
DEPO-TESTOSTERONE	T4	PA
DEPO-TESTOSTERONE (<i>testosterone cypionate</i>)	T4	PA
JATENZO 158 MG, 198 MG CAPSULE	T4	PA QL (120 caps/30 days)
METHITEST	T3	
<i>methyltestosterone</i>	T2	
<i>oxandrolone</i>	T2	
<i>testosterone</i> 1% (25mg/2.5g) pk (AndroGel)	T2	PA QL (75 gms/fill)
<i>testosterone</i> 1% (50 mg/5 g) pk (AndroGel)	T2	PA QL (300 gms/fill)
<i>testosterone</i> 1.62% (2.5 g) pkt	T2	QL (60 packs/30 days)
<i>testosterone</i> 1.62% gel pump (AndroGel)	T2	PA QL (150 gms/fill)
<i>testosterone</i> 1.62%(1.25 g) pkt	T2	QL (30 packs/30 days)
<i>testosterone</i> 10 mg gel pump	T2	QL (120 gms/30 days)
TESTOSTERONE 12.5 MG/1.25 GRAM	T4	PA QL (300 gms/fill)
<i>testosterone</i> 12.5 mg/1.25 gram	T2	PA QL (300 gms/fill)
<i>testosterone</i> 30 mg/1.5 ml pump	T2	PA QL (180 mls/fill)
<i>testosterone</i> 50 mg/5 gram gel (Testim)	T2	PA QL (60 tubes/fill)
<i>testosterone</i> 50 mg/5 gram gel (Vogelxo)	T2	PA QL (60 tubes/fill)
TESTOSTERONE 50 MG/5 GRAM PKT	T4	PA QL (300 gms/fill)
<i>testosterone cypionate</i>	T2	PA
<i>testosterone cypionate</i> (Depo-Testosterone)	T2	PA
<i>testosterone enanthate</i>	T2	PA
VOGELXO 12.5 MG/1.25 GRAM PUMP	T4	PA QL (300 gms/fill)
VOGELXO 50 MG/5 GRAM GEL (<i>testosterone</i>)	T4	PA QL (60 tubes/fill)
VOGELXO 50 MG/5 GRAM GEL PACKT	T4	PA QL (60 packs/fill)
XYOSTED	T3	PA QL (2 mls/28 days)

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

T5 – Brand Specialty
PA – Prior Authorization
QL – Quantity Limit

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

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

List of Prescription Medications

HORMONES (Hormonal Agents) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ANTIDIURETIC AND VASOPRESSOR HORMONES		
DDAVP (<i>desmopressin (nonrefrigerated)</i>)	T4	
DDAVP 0.1 MG TABLET (<i>desmopressin acetate</i>)	T4	HD
DDAVP 0.2 MG TABLET (<i>desmopressin acetate</i>)	T4	HD
<i>desmopressin 0.01% solution</i>	T2	HD
DESMOPRESSIN 1.5 MG/ML SPRAY	T3	HD
<i>desmopressin 10 mcg/0.1 ml spr</i>	T2	HD
<i>desmopressin acetate 0.1 mg tb (Ddavp)</i>	T2	HD
<i>desmopressin acetate 0.2 mg tb (Ddavp)</i>	T2	HD
NOCTIVA	T4	
ESTROGEN/ANDROGEN COMBINATIONS		
<i>estrogen,ester/me-testosterone</i>	T2	HD
<i>estrogen,ester/me-testosterone</i>	T2	HD
<i>estrogen,ester/me-testosterone (Estratest H.S.)</i>	T2	HD
ESTRATEST H.S. (<i>estrogen,ester/me-testosterone</i>)	T4	HD
ESTROGENIC AGENTS		
ACTIVELLA (<i>estradiol/norethindrone acet</i>)	T4	HD
CLIMARA (<i>estradiol</i>)	T4	QL (4 patches/28 days) HD
COMBIPATCH	T3	
DELESTROGEN	T4	HD
DELESTROGEN (<i>estradiol valerate</i>)	T4	HD
DEPO-ESTRADIOL	T3	HD
ESTRACE 0.5 MG TABLET (<i>estradiol</i>)	T4	HD
ESTRACE 1 MG TABLET (<i>estradiol</i>)	T4	HD
ESTRACE 2 MG TABLET (<i>estradiol</i>)	T4	HD
<i>estradiol (Climara)</i>	T2	QL (4 patches/28 days) HD
<i>estradiol 0.1% (0.25mg) gel pk (Divigel)</i>	T2	QL (30 packs/fill) HD
<i>estradiol 0.1% (0.75mg) gel pk (Divigel)</i>	T2	QL (30 packs/fill) HD
<i>estradiol 0.1% (1 mg) gel pkt (Divigel)</i>	T2	QL (30 packs/fill) HD
<i>estradiol 0.1% (1.25mg) gel pk</i>	T2	QL (30 packs/fill) HD
<i>estradiol 0.06% 1.25g gel pump (EstroGel)</i>	T2	QL (50 gms/30 days) HD
<i>estradiol 0.5 mg tablet (Estrace)</i>	T2	HD
<i>estradiol 1 mg tablet (Estrace)</i>	T2	HD
<i>estradiol 2 mg tablet (Estrace)</i>	T2	HD
<i>estradiol valerate (Delestrogen)</i>	T2	HD

T1 – Preferred Generics

T2 – Non-Preferred Generics

T3 – Preferred Brands

T4 – Non-Preferred Brands

T5 – Brand Specialty

PA – Prior Authorization

QL – Quantity Limit

ST – Step Therapy

AGE – Age Requirement

SP – Specialty Medication

HD – May require home delivery pharmacy

PPACA – No Cost-Share Preventive Medication

CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

HORMONES (Hormonal Agents) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ESTROGENIC AGENTS (cont.)		
<i>estradiol/norethindrone acet</i>	T2	HD
<i>estradiol/norethindrone acet</i> (Activella)	T2	HD
EVAMIST	T4	QL (17 mls/30 days) HD
MENOSTAR	T4	QL (4 patches/28 days) HD
<i>norethind-eth estrad 0.5-2.5</i>	T2	HD
<i>norethindrone ac/eth estradiol</i>	T2	HD
<i>norethin-eth estrad 1 mg-5 mcg</i>	T2	HD
ESTROGEN-PROGESTIN WITH ANTIMINERALOCORTICOID COMB		
ANGELIQ	T4	HD
ESTROGEN-SELECTIVE ESTROGEN RECEPTOR MOD (SERM) COMB		
DUAVEE	T3	
GLUCOCORTICOIDS		
<i>budesonide</i>	T2	
<i>budesonide</i> (Uceris)	T2	
CORTEF (<i>hydrocortisone</i>)	T4	
<i>cortisone acetate</i>	T2	
<i>deflazacort</i> (Emflaza)	T2	PA SP
<i>dexamethasone</i>	T2	PA
<i>dexamethasone</i>	T2	
<i>dexamethasone 0.5 mg, 0.75 mg, 1 mg, 1.5 mg tablet</i>	T1	
<i>dexamethasone 0.5 mg/5 ml elx, liq</i>	T1	
<i>dexamethasone 10 day 1.5 mg tb</i>	T2	PA
<i>dexamethasone 13 day 1.5 mg tb</i>	T2	PA
<i>dexamethasone 2 mg, 4 mg, 6 mg tablet</i>	T1	
<i>dexamethasone 6 day 1.5 mg tab</i>	T2	PA
DEXONTO	T4	
<i>hydrocortisone</i> (Cortef)	T2	
MEDROL	T4	
MEDROL (<i>methylprednisolone</i>)	T4	
<i>methylprednisolone</i>	T2	
<i>methylprednisolone</i> (Medrol)	T2	
ORAPRED ODT (<i>prednisolone sodium phosphate</i>)	T4	
<i>prednisolone</i>	T2	
<i>prednisolone sodium phosphate</i>	T2	

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

T5 – Brand Specialty
PA – Prior Authorization
QL – Quantity Limit

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

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

List of Prescription Medications

HORMONES (Hormonal Agents) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
GLUCOCORTICOIDS (cont.)		
<i>prednisolone sodium phosphate (Orapred Odt)</i>	T2	
<i>prednisone</i>	T2	
<i>prednisone</i>	T1	
RAYOS	T4	PA
TAPERDEX	T4	PA
TARPEYO	T5	PA QL (28 caps/30 days) SP
UCERIS 9 MG ER TABLET (<i>budesonide</i>)	T4	
ZCORT	T4	PA
GROWTH HORMONE RELEASING HORMONE (GHRH) AND ANALOGS		
EGRIFTA SV	T5	PA SP HD
EGRIFTA WR	T5	PA SP HD
GROWTH HORMONES		
GENOTROPIN	T5	PA SP HD
OMNITROPE	5	PA SP
SEROSTIM	T5	PA SP HD
ZORBTIVE	T5	PA SP HD
INSULIN-LIKE GROWTH FACTOR-I (IGF-I) HORMONES		
INCRELEX	T5	PA SP
LHRH (GNRH) AGONIST ANALOG PITUITARY SUPPRESSANTS		
SYNAREL	T5	PA SP HD
LHRH (GNRH) ANTAGONIST, ESTROGEN AND PROGESTIN COMB		
MYFEMBREE	T3	PA
ORIAHNN	T3	PA
LHRH (GNRH) ANTAGONIST, PITUITARY SUPPRESSANT AGENTS		
<i>cetorelix acetate</i>	T2	SP
CETROTIDE	T5	SP
GANIRELIX ACET 250 MCG/0.5 ML (<i>ganirelix acetate</i>)	T5	ST SP
<i>ganirelix acet 250 mcg/0.5 ml (Ganirelix Acetate)</i>	T2	ST SP
<i>ganirelix acetate (Ganirelix Acetate)</i>	T2	SP
ORILISSA 150 MG TABLET	T3	PA QL (30 tabs/fill)
ORILISSA 200 MG TABLET	T3	PA QL (60 tabs/fill)
MINERALOCORTICOIDS		
<i>fludrocortisone acetate</i>	T1	HD

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

T5 – Brand Specialty
PA – Prior Authorization
QL – Quantity Limit

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

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

List of Prescription Medications

HORMONES (Hormonal Agents) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
OXYTOCICS		
CERVIDIL	T4	
<i>methylgonovine maleate</i>	T2	QL (240 tabs/30 days)
PREPIDIL	T4	
PARATHYROID HORMONES		
NATPARA	T5	PA SP HD
YORVIPATH	T5	PA SP
PITUITARY SUPPRESSIVE AGENTS		
<i>cabergoline</i>	T2	QL (8 tabs/28 days) HD
CRENESSITY	T5	PA SP
<i>danazol</i>	T2	HD
PROGESTATIONAL AGENTS		
<i>medroxyprogesterone 10 mg tab (Provera)</i>	T2	HD
<i>medroxyprogesterone 2.5 mg tab (Provera)</i>	T2	HD
<i>medroxyprogesterone 5 mg tab (Provera)</i>	T2	HD
<i>norethindrone acetate</i>	T2	HD
<i>progesterone 100 mg capsule (Prometrium)</i>	T2	HD
<i>progesterone 200 mg capsule (Prometrium)</i>	T2	HD
PROMETRIUM (<i>progesterone, micronized</i>)	T4	HD
PROVERA (<i>medroxyprogesterone acetate</i>)	T4	HD
SOMATOSTATIC AGENTS		
MYCAPSSA	T5	PA QL (56 caps/28 days) SP
VAGINAL ESTROGEN PREPARATIONS		
<i>estradiol (Vagifem)</i>	T2	
<i>estradiol 0.01% cream (Estrace)</i>	T2	HD
<i>estradiol 10 mcg vaginal insrt (Vagifem)</i>	T2	HD
PREMARIN VAGINAL CREAM-APPL	T3	HD
HORMONES (Infertility)		
FERTILITY STIMULATING PREPARATIONS, NON-FSH		
<i>clomiphene citrate</i>	T2	
FOLLICLE-STIMULATING AND LUTEINIZING HORMONES		
MENOPUR	T5	SP
FOLLICLE-STIMULATING HORMONE (FSH)		
FOLLISTIM AQ	T5	ST SP
GONAL-F	T5	ST SP

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

T5 – Brand Specialty
PA – Prior Authorization
QL – Quantity Limit

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

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

List of Prescription Medications

HORMONES (Infertility) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
FOLLICLE-STIMULATING HORMONE (FSH) (cont.)		
GONAL-F RFF REDI-JECT	T5	ST SP
HUMAN CHORIONIC GONADOTROPIN (HCG)		
CHORIONIC GONAD 10,000 UNIT VL	T5	ST QL (3 vials/30 days) SP
CHORIONIC GONAD 6, 000 UNIT, 50,000 UNIT VL	T5	ST SP
NOVAREL	T5	ST QL (6 vls/30 days) SP
OVIDREL	T5	SP
PREGNYL	T5	QL (3 vials/30 days) SP
PREGNANCY FACILITATING/MAINTAINING AGENT, HORMONAL		
CRINONE	T3	
ENDOMETRIN	T3	
progesterone 100 mg vag insert	T2	
HORMONES (Miscellaneous)		
LEPTIN HORMONE ANALOGS		
MYALEPT	T5	PA SP HD
HORMONES (Osteoporosis Products)		
BONE FORMATION STIMULATING AGTS - PTH REL PEPTIDES		
TYMLOS	T5	PA QL (1 pen/fill) SP HD
BONE RESORPTION INHIBITORS		
calcitonin,salmon,synthetic	T2	HD
calcitonin,salmon,synthetic (Miacalcin)	T2	HD
MIACALCIN (calcitonin,salmon,synthetic)	T4	HD
IMMUNOSUPPRESSANTS (Pain Relief And Inflammatory Disease)		
HUMAN INTERLEUKIN 12/23 (IL-12/13) INHIBITORS, MAB		
IMULDOSA 45 MG/0.5 ML SYRINGE	T5	PA QL (1 syringe/84 days) SP
IMULDOSA 90 MG/ML SYRINGE	T5	PA QL (1 syringe/56 days) SP
SELARSDI 45 MG/0.5 ML SYRINGE	T5	PA QL (1 syringe/84 days) SP
SELARSDI 90 MG/ML SYRINGE	T5	PA QL (1 syringe/56 days) SP
STELARA	T5	PA QL SP HD
USTEKINUMAB-TTWE 45MG/0.5ML SY	T5	PA SP HD
USTEKINUMAB-TTWE 90 MG/ML SYR	T5	PA SP HD
YESINTEK 45 MG/0.5 ML SYRINGE	T5	PA SP HD
YESINTEK 45 MG/0.5 ML VIAL	T5	PA SP HD
YESINTEK 90 MG/ML SYRINGE	T5	PA SP HD

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

T5 – Brand Specialty
PA – Prior Authorization
QL – Quantity Limit

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

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

List of Prescription Medications

IMMUNOSUPPRESSANTS (Pain Relief And Inflammatory Disease) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
IL-23 RECEPTOR ANTAGONIST, MONOCLONAL ANTIBODY		
OMVOH 100 MG/ML PEN	T5	PA QL (2 mls/28 days) SP HD
OMVOH 100 MG/ML SYRINGE	T5	PA QL (2 mls/28 days) SP HD
OMVOH 200 MG DOSE - 2 PENS	T5	PA QL (2 mls/28 days) SP HD
OMVOH 200 MG DOSE - 2 SYRINGES	T5	PA QL (2 mls/28 days) SP HD
OMVOH 300 MG DOSE - 2 PENS	T5	PA QL (3 mls/28 days) SP HD
OMVOH 300 MG DOSE - 2 SYRINGES	T5	PA QL (3 mls/28 days) SP HD
SKYRIZI ON-BODY	T5	PA QL (1 cartridge/56 days) SP HD
TREMFYA 100 MG/ML PEN	T5	PA SP HD
TREMFYA 200 MG/2 ML PEN	T5	PA SP HD
TREMFYA ONE-PRESS	T5	PA SP HD
TREMFYA PEN INDUCTION (2 PEN)	T5	PA QL (1200 mgs/365 days) SP HD
TREMFYA 100 MG/ML SYRINGE	T5	PA QL (1 syringe/56 days) SP HD
TREMFYA 200 MG/2 ML SYRINGE	T5	PA QL (200 mgs/28 days) SP HD
INTERLEUKIN-4(IL-4) RECEPTOR ALPHA ANTAGONIST, MAB		
DUPIXENT 100 MG/0.67 ML SYRING	T5	PA QL (2 syringes/28 days) SP HD
DUPIXENT 200 MG/1.14 ML PEN	T5	PA QL (400 mgs/28 days) SP HD
DUPIXENT 200 MG/1.14 ML SYRING	T5	PA QL (400 mgs/28 days) SP HD
DUPIXENT 300 MG/2 ML PEN	T5	PA QL (600 mgs/28 days) SP HD
DUPIXENT 300 MG/2 ML SYRINGE	T5	PA QL (600 mgs/28 days) SP HD
INTERLEUKIN-6 (IL-6) RECEPTOR INHIBITORS		
ACTEMRA	T5	PA QL (3.6 mls/28 days) SP HD
ACTEMRA ACTPEN	T5	PA QL (2 pens/28 days) SP HD
ENSPRYNG	T5	PA SP HD
TYENNE	T5	PA QL (3.6 mls/28 days) SP
TYENNE AUTOINJECTOR	T5	PA QL (2 pens/28 days) SP
IMMUNOSUPPRESSANTS (Skin Conditions)		
INTERLEUKIN-3I(IL-3I)RECEPTOR ALPHA ANTAGONIST,MAB		
NEMLUVIO	T5	PA QL (2 pens/28 days) SP HD
TOPICAL IMMUNOSUPPRESSIVE AGENTS		
HYFTOR	T5	PA SP
<i>pimecrolimus (Elidel)</i>	T2	ST QL (120 gms/30 days)
<i>tacrolimus 0.03% ointment</i>	T2	ST QL (120 gms/30 days)
<i>tacrolimus 0.1% ointment</i>	T2	ST QL (120 gms/30 days)

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

T5 – Brand Specialty
PA – Prior Authorization
QL – Quantity Limit

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

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

List of Prescription Medications

IMMUNOSUPPRESSANTS (Transplant Medications)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
IMMUNOSUPPRESSIVES		
ASTAGRAF XL	T5	PA SP HD
AZASAN (azathioprine)	T5	SP HD
azathioprine (Azasan)	T2	SP HD
azathioprine (Imuran)	T2	SP HD
CELLCEPT (mycophenolate mofetil)	T5	SP HD
cyclosporine 100 mg capsule (Sandimmune)	T2	SP HD
cyclosporine 25 mg capsule (Sandimmune)	T2	SP HD
cyclosporine, modified	T2	SP HD
cyclosporine, modified (Neoral)	T2	SP HD
everolimus 0.25 mg tablet (Zortress)	T2	SP HD
everolimus 0.5 mg tablet (Zortress)	T2	SP HD
everolimus 0.75 mg tablet (Zortress)	T2	SP HD
everolimus 1 mg tablet (Zortress)	T2	SP HD
IMURAN (azathioprine)	T5	SP HD
LUPKYNIS	T5	PA QL (180 caps/30 days) SP
mycophenolate mofetil (Cellcept)	T2	SP HD
mycophenolate sodium (Myfortic)	T2	SP HD
MYFORTIC (mycophenolate sodium)	T5	SP HD
MYHIBBIN	T5	SP
NEORAL (cyclosporine, modified)	T5	SP HD
PROGRAF 0.2 MG GRANULE PACKET	T5	SP HD
PROGRAF 0.5 MG CAPSULE (tacrolimus)	T5	SP HD
PROGRAF 1 MG CAPSULE (tacrolimus)	T5	SP HD
PROGRAF 1 MG GRANULE PACKET	T5	SP HD
PROGRAF 5 MG CAPSULE (tacrolimus)	T5	SP HD
RAPAMUNE (sirolimus)	T5	SP HD
SANDIMMUNE 100 MG CAPSULE (cyclosporine)	T5	SP HD
SANDIMMUNE 100 MG/ML SOLN	T5	SP HD
SANDIMMUNE 25 MG CAPSULE (cyclosporine)	T5	SP HD
sirolimus	T2	SP HD
sirolimus (Rapamune)	T2	SP HD
tacrolimus 0.5 mg capsule (ir) (Prograf)	T2	SP HD
tacrolimus 1 mg capsule (ir) (Prograf)	T2	SP HD
tacrolimus 5 mg capsule (ir) (Prograf)	T2	SP HD
ZORTRESS (everolimus)	T5	SP HD

T1 – Preferred Generics

T2 – Non-Preferred Generics

T3 – Preferred Brands

T4 – Non-Preferred Brands

T5 – Brand Specialty

PA – Prior Authorization

QL – Quantity Limit

ST – Step Therapy

AGE – Age Requirement

SP – Specialty Medication

HD – May require home delivery pharmacy

PPACA – No Cost-Share Preventive Medication

CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

MISCELLANEOUS MEDICAL SUPPLIES, DEVICES, NON-DRUG (Diabetes)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
DIABETIC SUPPLIES		
2TEK	T4	
ACCU-CHEK	T4	
ACCU-CHEK COMPACT PLUS CONTROL	T4	
ACCU-CHEK FASTCLIX LANCING DEV	T3	
ACCU-CHEK GUIDE CONTROL SOLN	T4	
ACCU-CHEK SMARTVIEW CONTRL SOL	T4	
ACCU-CHEK SOFTCLIX	T3	
ACCUTREND GLUCOSE CONTROL	T4	
ADJUSTABLE LANCING DEVICE	T3	
ADVANCED LANCING DEVICE	T3	
ADVOCATE CONTROL SOLUTION	T4	
ADVOCATE LANCING DEVICE	T3	
ADVOCATE RAPID-SAFE LANCING DV	T3	
ADVOCATE REDI-CODE+ CTRL SOLN	T4	
AGAMATRIX CONTROL	T4	
AGAMATRIX CONTROL SOLUTION	T4	
ALKALINE BATTERIES	T4	
ALTERNATE SITE LANCING DEVICE	T3	
AQUA LANCE LANCING DEVICE	T3	
ASSURE 4 CONTROL SOLUTION	T4	
ASSURE DOSE	T4	
ASSURE PRISM	T4	
AT HOME A1C	T4	
AUTOJECT 2	T3	
AUTO-LANCET MINI	T3	
AUTOLET IMPRESSION	T3	
AUTOLET LANCING DEVICE	T3	
AUTOLET LITE	T3	
AUTOLET PLUS	T3	
AUTOPEN	T3	
AUTOSOFT 30	T3	
AUTOSOFT 90	T3	
AUTOSOFT 30 INFUSION SET PACK	T4	
AUTOSOFT XC INFUSION SET PACK	T4	

T1 – Preferred Generics

T2 – Non-Preferred Generics

T3 – Preferred Brands

T4 – Non-Preferred Brands

T5 – Brand Specialty

PA – Prior Authorization

QL – Quantity Limit

ST – Step Therapy

AGE – Age Requirement

SP – Specialty Medication

HD – May require home delivery pharmacy

PPACA – No Cost-Share Preventive Medication

CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

MISCELLANEOUS MEDICAL SUPPLIES, DEVICES, NON-DRUG (Diabetes) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
DIABETIC SUPPLIES (cont.)		
AUTOSOFT XC	T3	
BLOOD GLUCOSE CONTROL	T4	
BLOOD-GLUCOSE CONTROL	T4	
BREEZE 2	T4	
CAREONE	T3	
CARESENS	T4	
CARESENS S CONTROL SOLUTION	T4	
CARETOUCH CONTROL SOLUTION	T4	
CARETOUCH LANCING DEVICE	T3	
CEQUR SIMPLICITY	T3	
CEQUR SIMPLICITY INSERTER	T3	
CHEMSTRIP BG DIARY	T4	
CHOSEN LANCING DEVICE	T3	
CLEVER CHOICE CONTROL SOLUTION	T4	
CONTOUR	T4	
CONTOUR NEXT CONTROL SOLUTION	T4	
CONTROL SOLUTION	T4	
COOL CONTROL SOLUTION	T4	
DEXCOM G6 RECEIVER	T3	PA QL (1 unit/365 days)
DEXCOM G6 SENSOR	T3	PA QL (3 kits/30 days)
DEXCOM G6 TRANSMITTER	T3	PA QL (1 kit/90 days)
DEXCOM G7 RECEIVER	T3	PA QL (1 unit/365 days)
DEXCOM G7 SENSOR	T3	PA QL (3 units/30 days)
DIATRUE	T4	
DROPLET GENTEEL LANCING DEVICE	T3	
DROPLET LANCING DEVICE	T3	
EASY MINI EJECT LANCING DEVICE	T3	
EASY PLUS II CONTROL SOLN HIGH	T4	
EASY PLUS II CONTROL SOLN LOW	T4	
EASY STEP CONTROL SOLUTION	T4	
EASY TALK CONTROL SOLN LOW	T4	
EASY TALK HIGH CONTROL SOLN	T4	
EASY TALK PLUS II HIGH CONTROL	T4	
EASY TALK PLUS II LOW CTRL SLN	T4	

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

T5 – Brand Specialty
PA – Prior Authorization
QL – Quantity Limit

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

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

List of Prescription Medications

MISCELLANEOUS MEDICAL SUPPLIES, DEVICES, NON-DRUG (Diabetes) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
DIABETIC SUPPLIES (cont.)		
EASY TOUCH BLULINK CTRL SOLN	T4	
EASY TOUCH CONTROL SOLUTION	T4	
EASY TOUCH LANCING DEVICE	T3	
EASY TRAK CONTROL SOLN HIGH	T4	
EASY TRAK CONTROL SOLN LOW	T4	
EASY TRAK II CONTROL SOLUTION	T4	
EASYGLUCO PLUS CONTROL NORMAL	T4	
EASYMAX 15 LEVEL 2 SOLUTION	T4	
EASYMAX NORMAL CONTROL SOLN	T4	
ELEMENT COMPACT CONTROL SOLN	T4	
ELEMENT CONTROL SOLUTION	T4	
EMBRACE EVO LEVEL 1 CTRL SOLN	T4	
EMBRACE GLUC CONTROL SOLN HIGH	T4	
EMBRACE GLUCOSE CONTROL SOLN	T4	
EMBRACE LANCING DEVICE	T3	
EMBRACE PRO	T4	
EMBRACE TALK CONTROL SOLUTION	T4	
ENLITE SERTER	T4	
EVENCARE G2 CONTROL SOLUTION	T4	
EVENCARE G3 CONTROL SOLUTION	T4	
EVOLUTION CONTROL SOLUTION	T4	
FORA CONTROL SOLUTION	T4	
FORA GTEL MULTIFUNCTN MONITOR	T4	
FORA KETONE CONTROL SOLUTION	T4	
FORA LANCING DEVICE	T3	
FORA TN'G ADVANCE PRO MONITOR	T4	
FORA TN'GO ADV MOBILE MULT MTR	T4	
FORA TN'GO ADVANCE MULTIFN MTR	T4	
FORACARE GDH	T4	
FORTISCARE	T4	
FREESTYLE CONTROL SOLUTION	T3	
FREESTYLE LIBRE 2 PLUS SENSOR	T3	PA QL (2 units/30 days)
FREESTYLE LIBRE 2 READER	T3	PA QL (1 unit/365 days)
FREESTYLE LIBRE 2 SENSOR	T3	PA QL (2 sensors/28 days)

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

T5 – Brand Specialty
PA – Prior Authorization
QL – Quantity Limit

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

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

List of Prescription Medications

MISCELLANEOUS MEDICAL SUPPLIES, DEVICES, NON-DRUG (Diabetes) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
DIABETIC SUPPLIES (cont.)		
FREESTYLE LIBRE 3 PLUS SENSOR	T3	PA QL (2 units/30 days)
FREESTYLE LIBRE 3 READER	T3	PA QL (1 unit/365 days)
FREESTYLE LIBRE 3 SENSOR	T3	PA QL (2 units/28 days)
FREESTYLE LIBRE 10 DAY READER	T3	PA
FREESTYLE LIBRE 10 DAY SENSOR	T3	PA
FREESTYLE LIBRE 14 DAY READER	T3	PA
FREESTYLE LIBRE 14 DAY SENSOR	T3	PA QL (2 kits/30 days)
FREESTYLE NAVIGATOR SENSOR KIT	T3	
GE100 CONTROL SOLUTION NORMAL	T4	
GENTEEL VACUUM LANCING DEVICE	T4	
GLUCOCARD 01 CONTROL	T4	
GLUCOCARD EXPRESSION CNTRL SLN	T4	
GLUCOCARD SHINE CONTROL SOLN	T4	
GLUCOCOM AUTOLINK	T4	
GLUCOCOM CONTROL SOLUTION	T4	
GLUCOSE CONTROL	T4	
GLUCOSE CONTROL SOLUTION	T4	
GOJJI GLUCOSE CONTROL SOLUTION	T4	
GOJJI KETONE CONTROL SOLUTION	T4	
GOJJI LANCING DEVICE	T3	
GOJJI MULTI-FUNCTIONAL METER	T4	PA QL (1 transmitter/273 days)
GUARDIAN 4 GLUCOSE SENSOR	T4	PA QL (5 sensors/30 days)
GUARDIAN 4 TRANSMITTER	T4	PA QL (1 transmitter/273 days)
GUARDIAN LINK 3 TRANSMITTER	T4	
GUARDIAN RT CHARGER	T4	
GUARDIAN RT STARTER KIT	T4	
GUARDIAN TEST PLUG	T4	
GUARDIAN TRANSMITTER TAPE	T4	
HEALTHPRO GLUCOSE CONTROL SOLN	T4	
HEALTHY ACCENTS AUTOLET	T3	
HYPOLANCE	T3	
IHEALTH CONTROL SOLN LEVEL 2	T4	
ILET INFUSION KIT-INSET	T3	
ILET INFUSION-CONTACT DETACH	T3	

T1 – Preferred Generics

T2 – Non-Preferred Generics

T3 – Preferred Brands

T4 – Non-Preferred Brands

T5 – Brand Specialty

PA – Prior Authorization

QL – Quantity Limit

ST – Step Therapy

AGE – Age Requirement

SP – Specialty Medication

HD – May require home delivery pharmacy

PPACA – No Cost-Share Preventive Medication

CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

MISCELLANEOUS MEDICAL SUPPLIES, DEVICES, NON-DRUG (Diabetes) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
DIABETIC SUPPLIES (cont.)		
ILET STARTER KIT-INSET	T3	
INCONTROL LANCING DEVICE	T3	
INFINITY CONTROL SOLUTION	T4	
INFINITY VOICE CONTROL SOLN	T4	
INPEN (FOR HUMALOG)	T4	
INPEN (FOR NOVOLOG OR FIASP)	T4	
INSUL-CAP	T4	
INSUL-EZE	T3	
LANCING DEVICE	T3	
LANCING SYSTEM	T3	
LANZO	T3	
LITE TOUCH LANCING PEN	T3	
MEDISENSE	T3	
MEDISENSE GLUCOSE KETONE	T3	
MEDISENSE GLUCOSE KETONE CONTR	T3	
MEDTRONIC EXT INFUSION SET	T3	
MEDTRONIC REMOTE CONTROL	T4	
MICRODOT HIGH-LOW CONTROL SOL	T4	
MICRODOT NORMAL CONTROL SOLUT	T3	
MICROLET 2	T3	
MICROLET NEXT LANCING DEVICE	T3	
MINI LANCING DEVICE	T2	
MINIMED MIO ADVANCE	T3	
MINIMED QUICK SET	T3	
MINIMED QUICK-SERTER	T4	
MINIMED QUICK-SERTER	T3	
MINIMED SILHOUETTE	T3	
MINIMED SURE T	T3	
MODD1 PATIENT WELCOME KIT	T4	
MODD1 SUPPLY KIT	T4	
MULTI-LANCET	T3	
MYGLUCOHEALTH CONTROL SOLUTION	T4	
NOVA MAX PLUS GLUC-KETON METER	T4	
NOVAMAX PLUS GLU-KET	T4	

T1 – Preferred Generics

T2 – Non-Preferred Generics

T3 – Preferred Brands

T4 – Non-Preferred Brands

T5 – Brand Specialty

PA – Prior Authorization

QL – Quantity Limit

ST – Step Therapy

AGE – Age Requirement

SP – Specialty Medication

HD – May require home delivery pharmacy

PPACA – No Cost-Share Preventive Medication

CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

MISCELLANEOUS MEDICAL SUPPLIES, DEVICES, NON-DRUG (Diabetes) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
DIABETIC SUPPLIES (cont.)		
NOVOPEN 3	T3	
NOVOPEN ECHO	T4	
OMNIPOD CLASSIC PDM KIT(GEN 3)	T3	
OMNIPOD 5 G6-G7 INTRO KT(GEN5)	T3	QL (1 kit/720 days)
OMNIPOD 5 G6-G7 PODS (GEN 5)	T3	QL (15 crtgs/30 days)
OMNIPOD 5 (G6/LIBRE 2 PLUS)	T3	QL (15 crtgs/30 days)
OMNIPOD 5 DEXG7G6 INTRO(GEN 5)	T3	QL (1 kit/720 days)
OMNIPOD 5 DEXG7G6 PODS (GEN 5)	T3	QL (15 crtgs/30 days)
OMNIPOD 5 DEXG7G6 PODS (GEN 5)	T3	QL (15 pods/28 days)
OMNIPOD 5 INTRO(G6/LIBRE2PLUS)	T3	QL (1 kit/720 days)
OMNIPOD CLASSIC PODS (GEN 3)	T3	
OMNIPOD DASH INTRO KIT (GEN 4)	T3	QL (1 kit/720 days)
OMNIPOD DASH PODS (GEN 4)	T3	QL (15 pods/28 days)
OMNIPOD GO PODS	T3	QL (10 crtgs/30 days)
ON CALL EXPRESS CONTROL SOLN	T4	
ON CALL LANCING DEVICE	T3	
ON CALL PLUS CONTROL	T4	
ON CALL PLUS LANCING DEVICE	T3	
ON CALL VIVID CONTROL	T4	
ONETOUCH DELICA	T3	
ONETOUCH DELICA PLUS LANC DEV	T3	
ONETOUCH ULTRA CONTROL SOLN	T4	
ONETOUCH VERIO HIGH CNTRL SOLN	T4	
ONETOUCH VERIO MID CNTRL SOLN	T4	
OPTUMRX GLUCOSE CONTROL SOLN	T4	
OVAL TAPE	T4	
PIP GLUCOSE CONTROL SOLUTION	T4	
PRECISION XTRA KETONE-GLUCOSE	T3	
PRODIGY CONTROL SOLUTION	T4	
PRODIGY LANCING DEVICE	T3	
QUICK RELEASE SOFT TEFLON	T3	
REFUAH PLUS GLUCOSE CONTROL	T4	
RELIAMED MINI LANCING DEVICE	T3	
REPLACEMENT PEDIATRIC MONITOR	T4	

T1 – Preferred Generics

T2 – Non-Preferred Generics

T3 – Preferred Brands

T4 – Non-Preferred Brands

T5 – Brand Specialty

PA – Prior Authorization

QL – Quantity Limit

ST – Step Therapy

AGE – Age Requirement

SP – Specialty Medication

HD – May require home delivery pharmacy

PPACA – No Cost-Share Preventive Medication

CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

MISCELLANEOUS MEDICAL SUPPLIES, DEVICES, NON-DRUG (Diabetes) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
DIABETIC SUPPLIES (cont.)		
RIGHTEST CONTROL SOLUTION	T4	
RIGHTEST GD500	T3	
SAFE-CLIP	T3	
SEN-SERTER	T4	
SIL-SERTER	T3	
SMARTDIABETES VANTAGE	T3	
SMARTEST	T4	
SOF-SERTER	T3	
SOF-SET	T3	
SOF-SET MICRO	T3	
SOLUS V2 CONTROL SOLUTION	T4	
SOLUS V2 LANCING DEVICE	T3	
SURE COMFORT LANCING PEN	T3	
SUREFLEX	T3	
SURE-PEN	T3	
SURE-TEST EASYPLUS MINI SOLN	T4	
T:FLEX	T3	
T:SLIM X2	T3	
TANDEM MOBI AUTOSOFT 30	T3	PA SP HD
TANDEM MOBI AUTOSOFT XC	T3	PA SP HD
TANDEM MOBI AUTOSOFT 30 SUPPLY	T3	
TANDEM MOBI AUTOSOFT XC SUPPLY	T3	
TANDEM MOBI CARTRIDGE	T3	
TANDEM MOBI TRUSTEEL SUPPLY	T3	
TANDEM T:SLIM ASFT 30	T3	
TANDEM T:SLIM ASFT XC	T3	
TANDEM T:SLIM TRUSTL	T3	
TELCARE CONTROL SOLUTION	T4	
TRUE METRIX	T3	
TRUECONTROL	T3	
TRUEDRAW	T3	
TRUSTEEL INFUSION SET	T3	
TRUSTEEL INFUSION SET PACK	T4	
TWIST REFILL KT(CSST-NDL-SYR)	T3	

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

T5 – Brand Specialty
PA – Prior Authorization
QL – Quantity Limit

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

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

List of Prescription Medications

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

T1 – Preferred Generics

T2 – Non-Preferred Generics

T3 – Preferred Brands

T4 – Non-Preferred Brands

T5 – Brand Specialty

PA – Prior Authorization

QL – Quantity Limit

ST – Step Therapy

AGE – Age Requirement

SP – Specialty Medication

HD – May require home delivery pharmacy

PPACA – No Cost-Share Preventive Medication

CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

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

T1 – Preferred Generics

T2 – Non-Preferred Generics

T3 – Preferred Brands

T4 – Non-Preferred Brands

T5 – Brand Specialty

PA – Prior Authorization

QL – Quantity Limit

ST – Step Therapy

AGE – Age Requirement

SP – Specialty Medication

HD – May require home delivery pharmacy

PPACA – No Cost-Share Preventive Medication

CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

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

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

T5 – Brand Specialty
PA – Prior Authorization
QL – Quantity Limit

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

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

List of Prescription Medications

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

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

T5 – Brand Specialty
PA – Prior Authorization
QL – Quantity Limit

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

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

List of Prescription Medications

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

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

T5 – Brand Specialty
PA – Prior Authorization
QL – Quantity Limit

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

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

List of Prescription Medications

MISCELLANEOUS MEDICAL SUPPLIES, DEVICES, NON-DRUG (Diabetes) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
DURABLE MEDICAL EQUIPMENT,MISC(GROUP I) (cont.)		
ULTRATLC LANCETS	T3	
UNILET COMFORTOUCH	T3	
UNILET EXCELITE	T3	
UNILET EXCELITE II	T3	
UNILET GP LANCET	T3	
UNILET LANCET	T3	
UNILET LANCETS	T3	
UNISTIK 2 COMFORT	T3	
UNISTIK 2 EXTRA	T3	
UNISTIK 2 NORMAL	T3	
UNISTIK 3	T3	
UNISTIK 3 COMFORT	T3	
UNISTIK 3 DUAL	T3	
UNISTIK 3 EXTRA	T3	
UNISTIK 3 NORMAL	T3	
UNISTIK COMFORT	T3	
UNISTIK CZT	T3	
UNISTIK EXTRA	T3	
UNISTIK NORMAL	T3	
UNISTIK PRO	T3	
UNISTIK SAFETY	T3	
UNISTIK TOUCH	T3	
UNIVERSAL 1	T3	
VERIFINE SAFETY LANCET MINI	T3	
VERIFINE UNIVERSAL LANCET	T3	
VIVAGUARD LANCET	T3	
VIVAGUARD SAFETY LANCET	T3	
NEEDLES/NEEDLELESS DEVICES		
AUTOSHIELD DUO PEN NEEDLE	T3	
BD ECLIPSE NEEDLE 18G 40MM	T4	
BD ECLIPSE NEEDLE 21GX1"	T3	
BD ECLIPSE NEEDLE 22GX1"	T3	
BD ECLIPSE NEEDLE 23GX1"	T4	
BD ECLIPSE NEEDLE 25G 16MM	T4	

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

T5 – Brand Specialty
PA – Prior Authorization
QL – Quantity Limit

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

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

List of Prescription Medications

MISCELLANEOUS MEDICAL SUPPLIES, DEVICES, NON-DRUG (Diabetes) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
NEEDLES/NEEDLELESS DEVICES (cont.)		
BD ECLIPSE NEEDLE 25G 25MM	T4	
BD ECLIPSE NEEDLE 25GX1"	T3	
BD ECLIPSE NEEDLE 25GX1.5"	T3	
BD ECLIPSE NEEDLES 21GX1.5"	T3	
BD SAFETYGLIDE NEEDLE	T3	
BD SAFETYGLIDE NEEDLE 18GX1.5"	T3	
BD SAFETYGLIDE NEEDLE 21GX1"	T3	
BD SAFETYGLIDE NEEDLE 21GX1.5"	T3	
BD SAFETYGLIDE NEEDLE 22GX1.5"	T3	
BD SAFETYGLIDE NEEDLE 23G 40MM	T4	
BD SAFETYGLIDE NEEDLE 25GX1"	T3	
BD SAFETYGLIDE NEEDLE 27GX5/8"	T3	
BLUNT NEEDLE	T3	
CAREPOINT PRECISION NEEDLE	T4	
CARETOUCH HYPODERMIC NEEDLE	T4	
CHEMO TRANSFER PIN	T3	
DROPSAFE SICURA SAFETY NEEDLE	T4	
EASY TOUCH FLIPLOCK NEEDLE	T4	
EASY TOUCH FLIPLOCK NEEDLES	T4	
EASY TOUCH HYPODERMIC NEEDLE	T4	
EASYPOINT NEEDLE	T4	
EXEL HUBER NEEDLE	T3	
EXEL HYPODERMIC NEEDLE	T3	
EXEL MTI DRAWING NEEDLE	T3	
FILTER ASPIRATOR NEEDLE	T3	
FILTER NEEDLE	T3	
FLOW-EZE	T3	
HURRICANE LUER-LOCK	T3	
HYPODERMIC NEEDLE	T3	
INTEGRA NEEDLE	T3	
INTEGRA PRECISIONGLIDE NEEDLE	T4	
LIFESHIELD BLUNT CANNULA	T3	
MINI TRANSFER PIN	T3	
MONOJECT BLOOD COLLECTION	T3	

T1 – Preferred Generics

T2 – Non-Preferred Generics

T3 – Preferred Brands

T4 – Non-Preferred Brands

T5 – Brand Specialty

PA – Prior Authorization

QL – Quantity Limit

ST – Step Therapy

AGE – Age Requirement

SP – Specialty Medication

HD – May require home delivery pharmacy

PPACA – No Cost-Share Preventive Medication

CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

MISCELLANEOUS MEDICAL SUPPLIES, DEVICES, NON-DRUG (Diabetes) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
NEEDLES/NEEDLELESS DEVICES (cont.)		
MONOJECT FILTER NEEDLE	T4	
NANO 2ND GEN PEN NEEDLE	T3	
NANO PEN NEEDLE	T3	
NEEDLES	T3	
<i>needles,safety huber,disposabl</i>	T2	
NOKOR ADMIX NEEDLE	T3	
NOKOR NEEDLE	T3	
PEN NEEDLE 30G X 8MM	T4	
PERFECT POINT SAFETY NEEDLE	T4	
PHASEAL PROTECTOR	T4	
POLY HUB NEEDLE	T3	
PRECISIONGLIDE	T3	
PRECISIONGLIDE NEEDLE	T3	
QUINCE SPINAL NEEDLE	T3	
RAYA SURE PEN NEEDLE 29G 12MM	T4	
RAYA SURE PEN NEEDLE 31G 5MM	T4	
RAYA SURE PEN NEEDLE 31G 6MM	T4	
REGULAR BEVEL NEEDLES	T3	
SHORT BEVEL NEEDLES	T3	
SPECIALTY USE NEEDLES	T3	
TERUMO SURGUARD2	T3	
THIN WALL NEEDLES	T3	
TRANSFER NEEDLE	T3	
TRANSFER PIN	T3	
ULTRA-FINE MICRO PEN NEEDLE	T3	
ULTRA-FINE MINI PEN NEEDLE	T3	
ULTRA-FINE NANO PEN NEEDLE	T3	
ULTRA-FINE PEN NEEDLE	T3	
ULTRA-FINE ORIGINAL PEN NEEDLE	T3	
ULTRA-FINE SHORT PEN NEEDLE	T3	
YALE NEEDLES	T3	
SYRINGES AND ACCESSORIES		
ALLERGIST TRAY	T4	
ALLERGIST TRAY SYR-DETACH NDL	T3	

T1 – Preferred Generics

T2 – Non-Preferred Generics

T3 – Preferred Brands

T4 – Non-Preferred Brands

T5 – Brand Specialty

PA – Prior Authorization

QL – Quantity Limit

ST – Step Therapy

AGE – Age Requirement

SP – Specialty Medication

HD – May require home delivery pharmacy

PPACA – No Cost-Share Preventive Medication

CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

MISCELLANEOUS MEDICAL SUPPLIES, DEVICES, NON-DRUG (Diabetes) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
SYRINGES AND ACCESSORIES (cont.)		
ALLERGIST TRAY SYR-PERM NEEDLE	T3	
ALLERGY SYRINGE 1 ML 27GX1/2"	T4	
ALLERGY SYRINGE 1 ML 27GX3/8"	T4	
BD ALLERGY SYRINGE-NEEDLE 1 ML	T3	
BD ECLIPSE LUER-LOK SYR 1 ML	T3	
BD ECLIPSE LUER-LOK SYR 3 ML	T3	
BD ECLIPSE SYR 3 ML 22GX1-1/2"	T4	
BD INS SYR 0.3 ML 8MMX31G(1/2)	T3	
BD INS SYR UF 0.3ML 12.7MMX30G	T3	
BD INS SYR UF 0.5ML 12.7MMX30G	T3	
BD INS SYRN UF 1 ML 12.7MMX30G	T3	
BD INS SYRNG 0.3 ML 29GX12.7MM	T3	
BD INS SYRNG 0.5 ML 29GX12.7MM	T3	
BD INS SYRNG UF 0.3 ML 8MMX31G	T3	
BD INS SYRNG UF 0.5 ML 8MMX31G	T3	
BD INSULIN SYR 0.5 ML 28GX1/2"	T3	
BD INSULIN SYR 1 ML 27GX12.7MM	T3	
BD INSULIN SYR 1 ML 27GX5/8"	T3	
BD INSULIN SYR 1 ML 28GX1/2"	T3	
BD INSULIN SYR 1 ML 29GX1/2"	T3	
BD INSULIN SYR 1 ML 29GX12.7MM	T3	
BD INSULIN SYR UF 1 ML 8MMX31G	T3	
BD SAFETYGLIDE 3 ML SYRINGE	T3	
BD SAFETYGLIDE SYR 22GX1.5"	T3	
BD SAFETYGLIDE SYR 3 ML 25GX1"	T4	
BD SAFETYGLIDE SYRINGE 27GX5/8	T3	
BD SAFETYGLIDE TB 1 ML SYR	T3	
BD SAFETYGLIDE TB 1ML 27G 10MM	T4	
BD SAFETYGLIDE TUBERCULIN SYR	T3	
BD SYRINGE-SAFETY GLIDE	T3	
BD UF INS SYR 1 ML 30GX1/2"	T3	
BULK SYRINGE	T3	
CANNULA	T3	
CAREPOINT LUER LOCK SYRINGE	T4	

T1 – Preferred Generics

T2 – Non-Preferred Generics

T3 – Preferred Brands

T4 – Non-Preferred Brands

T5 – Brand Specialty

PA – Prior Authorization

QL – Quantity Limit

ST – Step Therapy

AGE – Age Requirement

SP – Specialty Medication

HD – May require home delivery pharmacy

PPACA – No Cost-Share Preventive Medication

CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

MISCELLANEOUS MEDICAL SUPPLIES, DEVICES, NON-DRUG (Diabetes) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
SYRINGES AND ACCESSORIES (cont.)		
CAREPOINT LUER LOCK SYRING-NDL	T3	
CAREPOINT LUER SLIP SYRINGE	T4	
CAREPOINT LUER SLIP SYRING-NDL	T4	
CARETOUCH LUER LOCK	T3	
CARETOUCH LUER LOCK SYRINGE	T4	
CARETOUCH LUER SLIP SYRINGE	T4	
CAREPOINT PRECISION LUER LOCK	T4	
CAREPOINT PRECISION SAFETY	T3	
CAREPOINT SAFETY LUER LOCK SYR	T3	
CORNWALL SYRINGE TIP CONNECTOR	T3	
DAVOL IRRIGATION SYRINGE	T3	
DOVER BULB SYRINGE	T4	
EASY GLIDE CATHETER TIP SYRING	T4	
EASY GLIDE LUER LOCK SYRINGE	T4	
EASY GLIDE LUER SLIP TB SYRING	T4	
EASY TOUCH FLIPLK 10ML 20GX1.5	T4	
EASY TOUCH FLIPLK 10ML 21GX1.5	T4	
EASY TOUCH FLIPLK 10ML 22GX1.5	T4	
EASY TOUCH FLIPLK 5 ML 20GX1.5	T4	
EASY TOUCH FLIPLK 5 ML 21GX1.5	T4	
EASY TOUCH FLIPLK 5 ML 22GX1.5	T4	
EASY TOUCH FLIPLOCK	T4	
EASY TOUCH FLIPLOCK 1 ML 25GX1	T3	
EASY TOUCH FLIPLOCK 10ML 21GX1	T4	
EASY TOUCH FLIPLOCK 3 ML 18GX1	T4	
EASY TOUCH FLIPLOCK 3 ML 20GX1	T4	
EASY TOUCH FLIPLOCK 3 ML 21GX1	T4	
EASY TOUCH FLIPLOCK 5 ML 18GX1	T4	
EASY TOUCH FLIPLOCK 5 ML 21GX1	T4	
EASY TOUCH FLIPLOCK SYRINGE	T4	
EASY TOUCH FLIPLOK 10 ML 20GX1	T4	
EASY TOUCH FLIPLOK 10 ML 25GX1	T4	
EASY TOUCH FLIPLOK 1ML 26GX3/8	T3	
EASY TOUCH FLIPLOK 1ML 27GX0.5	T3	

T1 – Preferred Generics

T2 – Non-Preferred Generics

T3 – Preferred Brands

T4 – Non-Preferred Brands

T5 – Brand Specialty

PA – Prior Authorization

QL – Quantity Limit

ST – Step Therapy

AGE – Age Requirement

SP – Specialty Medication

HD – May require home delivery pharmacy

PPACA – No Cost-Share Preventive Medication

CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

MISCELLANEOUS MEDICAL SUPPLIES, DEVICES, NON-DRUG (Diabetes) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
SYRINGES AND ACCESSORIES (cont.)		
EASY TOUCH FLIPLOK 3ML 18GX1.5	T4	
EASY TOUCH FLIPLOK 3ML 20GX1.5	T4	
EASY TOUCH FLIPLOK 3ML 21GX1.5	T4	
EASY TOUCH FLURINGE	T3	
EASY TOUCH FLURINGE FLIPLOCK	T3	
EASY TOUCH FLURINGE FLU TRAY	T4	
EASY TOUCH FLURINGE SHEATHLOCK	T3	
EASY TOUCH LUER LOCK INSULIN	T4	
EASY TOUCH LUER LOCK SYRINGE	T4	
EASY TOUCH SHEATHLOCK SYRG-NDL	T4	
EASY TOUCH SHEATHLOCK SYRINGE	T4	
EASY TOUCH SYR 1 ML 25GX5/8"	T3	
EASY TOUCH SYR 3 ML 22GX1-1/2"	T3	
EASY TOUCH SYR 3 ML 25GX5/8"	T3	
EASY TOUCH SYR ALLERGY TRAY	T4	
EASY TOUCH SYRINGE 1 ML 25GX1"	T3	
EASY TOUCH SYRINGE 3 ML 20GX1"	T3	
EASY TOUCH SYRINGE 3 ML 21GX1"	T3	
EASY TOUCH SYRINGE 3 ML 22GX1"	T3	
EASY TOUCH SYRINGE 3 ML 23GX1"	T3	
EASY TOUCH SYRINGE 3 ML 25GX1"	T3	
EASY TOUCH TUBERCULIN FLIPLOCK	T3	
EASY TOUCH TUBERCULIN SHEATHLK	T3	
EASY TOUCH UNI-SLIP	T4	
ECLIPSE SYRINGE	T3	
ECLIPSE SYRINGE-NEEDLE	T3	
ENFIT CAP	T4	
ENFIT MULTIFIL SYRINGE	T4	
ENFIT POP ON CAP	T4	
ENFIT SCREW-ON CAP	T4	
ENFIT SYRINGE	T4	
ENFIT SYRINGE STERILE	T4	
ENFIT THUMB CONTROL RING SYRIN	T4	
EXEL SYRINGE	T3	

T1 – Preferred Generics

T2 – Non-Preferred Generics

T3 – Preferred Brands

T4 – Non-Preferred Brands

T5 – Brand Specialty

PA – Prior Authorization

QL – Quantity Limit

ST – Step Therapy

AGE – Age Requirement

SP – Specialty Medication

HD – May require home delivery pharmacy

PPACA – No Cost-Share Preventive Medication

CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

MISCELLANEOUS MEDICAL SUPPLIES, DEVICES, NON-DRUG (Diabetes) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
SYRINGES AND ACCESSORIES (cont.)		
EXEL TB WITH NEEDLE	T3	
EXEL TUBERCULIN SYRINGE	T3	
EXTENDED RESERVOIR	T4	
FILTER, MILLEX-OR SYRINGE	T4	
FINGER GRIP EXTENDER	T4	
INJECT-EASE	T3	
INSULIN SYR 0.5 ML 28G 12.7MM	T3	
INSULIN SYR 0.5 ML 28G 12.7MM	T4	
INSULIN SYRINGE 1 ML 27G 16MM	T3	
INSULIN SYRINGE 1ML 28G 12.7MM	T3	
INTEGRA SYRINGE	T3	
INTERLINK SYRINGE	T3	
INTERLINK SYRINGE W-CANNULA	T4	
KENDALL DISINFECTANT CAP	T4	
LEVER LOCK CANNULA	T4	
LIFESHIELD BLUNT CANNULA	T3	
LUER LOCK SYRINGE	T3	
LUER LOCK SYRINGE-NEEDLE	T4	PA SP HD
LUER-LOK SYRINGE	T3	
LUER-LOK SYRINGE-NEEDLE	T3	
LUER-LOK TIP SYRINGE	T3	
LUER SLIP TIP SYRINGE TRAY	T4	
LUER TIP CAP TRAY	T4	
LUERSLIP SYRINGE	T3	
MAD NASAL ATOMIZER-SYRG-ADAPTR	T4	
MAGELLAN SAFETY SYRINGE	T3	
MAGELLAN TB SAFETY SYRINGE	T3	
MAGELLAN TUBERCULIN SYRINGE	T3	
MINIMED RESERVOIR 1.8 ML	T4	
MINIMED RESERVOIR 3 ML	T3	
MONOJECT 3 ML SYRINGE 25GX1"	T3	
MONOJECT 6CC SAFETY SYRINGE	T3	
MONOJECT ALLERGY TRAY-NEEDLE	T3	
MONOJECT CONTROL SYRINGE	T3	

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

T5 – Brand Specialty
PA – Prior Authorization
QL – Quantity Limit

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

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

List of Prescription Medications

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

T1 – Preferred Generics

T2 – Non-Preferred Generics

T3 – Preferred Brands

T4 – Non-Preferred Brands

T5 – Brand Specialty

PA – Prior Authorization

QL – Quantity Limit

ST – Step Therapy

AGE – Age Requirement

SP – Specialty Medication

HD – May require home delivery pharmacy

PPACA – No Cost-Share Preventive Medication

CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

MISCELLANEOUS MEDICAL SUPPLIES, DEVICES, NON-DRUG (Diabetes) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
SYRINGES AND ACCESSORIES (cont.)		
SLIP-TIP SYRINGE	T4	
SUPOR	T4	
SYRINGE	T3	
SYRINGE BULK	T3	
SYRINGE CATHETER TIP	T3	
SYRINGE CATHETER TIP NON-STER	T3	
SYRINGE FILTER, MILLEX-GP	T4	
SYRINGE FILTER, MILLEX-GS	T4	
SYRINGE LUER LOCK	T3	PA SP HD
SYRINGE LUER-LOK	T3	
SYRINGE LUER-LOK NON-STERILE	T3	
SYRINGE LUER-LOK STERILE	T3	
SYRINGE SLIP TIP	T3	
SYRINGE SLIP TIP NON-STERILE	T3	
SYRINGE TIP CAP	T3	
SYRINGE WITH NEEDLE DISP	T3	
SYRINGE WITHOUT NEEDLE	T3	
SYRINGE-LUER TIP CAP	T3	
SYRINGE WITH NEEDLE	T3	
SYRINGE-PRECISIONGLIDE NEEDLE	T3	
TB SYRINGE	T3	
TERUMO ALLERGY SYRINGE	T3	
TERUMO HYPODERMIC NEEDLE-SYRIN	T3	
TERUMO SURGUARD2	T3	
TERUMO SYRINGE	T3	
TOOMEY SYRINGE	T3	
TUBERCULIN SLIP-TIP SYRINGE	T4	
TUBERCULIN SYRINGE	T3	
TUBERCULIN SYRINGE-NEEDLE	T3	
TWINPAK DUAL CANNULA	T3	
ULTICARE LDS SYR 1 ML 22G 1.5"	T4	
ULTICARE LDS SYR 3 ML 22GX1.5"	T3	
ULTICARE SAFETY SYRINGE	T4	
ULTICARE SYRINGE	T4	

T1 – Preferred Generics

T2 – Non-Preferred Generics

T3 – Preferred Brands

T4 – Non-Preferred Brands

T5 – Brand Specialty

PA – Prior Authorization

QL – Quantity Limit

ST – Step Therapy

AGE – Age Requirement

SP – Specialty Medication

HD – May require home delivery pharmacy

PPACA – No Cost-Share Preventive Medication

CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

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

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
SYRINGES AND ACCESSORIES (cont.)		
ULTICARE TB SAFETY 1 ML 25GX1"	T3	
ULTICARE TB SAFETY 1ML 25GX5/8	T3	
ULTICARE TB SAFETY SYRINGE	T3	
ULTIGUARD SAFE 1ML 30G 12.7MM	T4	
ULTIGUARD SAFEPACK 1ML 31G 8MM	T4	
ULTRA-FINE INSULIN SYRINGE	T3	
UNIVERSAL SYRINGE TIP ADAPTOR	T4	
VANISHPOINT 1 ML TB SYR 25X5/8	T3	
VANISHPOINT 1 ML TB SYR 27X1/2	T3	
VANISHPOINT 20GX1" 3 ML SYRING	T3	
VANISHPOINT 21GX1" 5 ML SYRING	T3	
VANISHPOINT 21GX1.5" 3 ML SYR	T3	
VANISHPOINT 22GX1" 3 ML SYR	T3	
VANISHPOINT 22GX1-1/2" 5 ML SY	T3	
VANISHPOINT 23GX1" 3 ML SYRING	T3	
VANISHPOINT 23GX1-1/2 3 ML SYR	T3	
VANISHPOINT 25GX1" 3 ML SYRING	T3	
VANISHPOINT 25GX5/8" 3 ML SYR	T3	
VANISHPOINT 3 ML 21GX1" SYRING	T3	
VANISHPOINT 3 ML 22GX1.5" SYRG	T3	
VANISHPOINT SYRINGE	T4	
VANISHPOINT SYRINGE 1 ML 25X1"	T3	
VEO INSULIN SYRINGE	T3	

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

BANDAGES AND RELATED SUPPLIES		
ARGLAES FILM	T4	
CONFORMANT 2	T4	
DERMAVIEW	T3	
DERMAVIEW II	T3	
IV 3000	T3	
IV3000 FRAME DELIVERY	T4	
KENDALL	T3	
NEXCARE TEGADERM 2.375"X2.75"	T4	

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

T5 – Brand Specialty
PA – Prior Authorization
QL – Quantity Limit

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

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

List of Prescription Medications

MISCELLANEOUS MEDICAL SUPPLIES, DEVICES, NON-DRUG (Miscellaneous) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
BANDAGES AND RELATED SUPPLIES (cont.)		
NEXCARE TEGADERM DRESSING	T3	
OPSITE	T4	
OPSITE IV 3000	T3	
POLYSKIN II	T3	
SURESITE MATRIX	T3	
SURESITE WINDOW	T3	
TEGADERM 1.75X1.75" DRSSNG	T4	
TEGADERM 2"X2.75" DRESSING	T3	
TEGADERM 2.375"X2.75" DRESSING	T3	
TEGADERM 2.375"X4" DRESSING	T3	
TEGADERM 2.375X2.75" DRSSNG	T3	
TEGADERM 3.5" X 4" DRESSING	T3	
TEGADERM 3.5"X 10" DRESSING	T4	
TEGADERM 3.5"X 6" DRESSING	T4	
TEGADERM 3.5"X13.75" DRESS	T4	
TEGADERM 3.5"X4.125" DRESS	T3	
TEGADERM 3.5"X8" DRESSING	T4	
TEGADERM 4" X 10" DRESSING	T3	
TEGADERM 4" X 4-3/4" DRESSING	T3	
TEGADERM 4"X4.75" DRESSING	T3	
TEGADERM 6" X 8" DRESSING	T3	
TEGADERM 8" X 12" DRESSING	T3	
TEGADERM ABSORBENT	T4	
TEGADERM HP 4" X 4.5 " DRSSN	T3	
TEGADERM HP 4.5"X4.75" DRSS	T3	
TEGADERM HP DRESSING	T3	
TEGADERM HP DRESSING	T4	
TEGADERM I.V.	T4	
TEGADERM I.V. 2.5"X2.75" DRSSN	T4	
TEGADERM I.V. 4"X4.75" DRSSN	T3	
TRANSPARENT DRESSING	T4	
TRANSPARENT FILM DRESSING	T4	
TRANSPARENT I.V. SITE DRESSING	T3	
TRANSPARENT MEPITEL FILM DRESS	T4	

T1 – Preferred Generics

T2 – Non-Preferred Generics

T3 – Preferred Brands

T4 – Non-Preferred Brands

T5 – Brand Specialty

PA – Prior Authorization

QL – Quantity Limit

ST – Step Therapy

AGE – Age Requirement

SP – Specialty Medication

HD – May require home delivery pharmacy

PPACA – No Cost-Share Preventive Medication

CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

MISCELLANEOUS MEDICAL SUPPLIES, DEVICES, NON-DRUG (Miscellaneous) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
BANDAGES AND RELATED SUPPLIES (cont.)		
TRANSPARENT THIN FILM DRESSING	T3	
WINDOW BANDAGES	T4	
DURABLE MEDICAL EQUIPMENT,MISC(GROUP I)		
1ST TIER UNILET COMFORTOUCH	T3	
2-IN-1 LANCET DEVICE	T3	
ACCU-CHEK FASTCLIX LANCET DRUM	T3	
ACCU-CHEK SAFE-T-PRO	T3	
ACCU-CHEK SAFE-T-PRO PLUS	T3	
ACCU-CHEK SOFTCLIX	T3	
<i>acti-lance lite 28g lancets</i>	T2	
<i>acti-lance special 17g lancets</i>	T2	
ACTI-LANCE UNIVERS 23G LANCETS	T3	
<i>acti-lance univers 23g lancets</i>	T2	
ADVANCED TRAVEL LANCETS	T3	
ADVOCATE LANCET	T3	
ADVOCATE LANCETS	T3	
ADVOCATE SAFETY LANCET	T3	
AGAMATRIX ULTRA-THIN LANCET	T3	PA SP HD
ALTERNATE SITE LANCETS	T3	
ASSURE HAEMOLANCE PLUS	T3	
ASSURE LANCE	T3	
ASSURE LANCE PLUS	T3	
BD MICROTAINER LANCETS	T3	
BLOOD LANCETS	T3	
BULLSEYE MINI SAFETY LANCETS	T3	
BUTTERFLY TOUCH LANCET	T3	
CAREONE	T3	
CARESENS LANCET	T3	
CARETOUCH SAFETY LANCETS	T3	
CARETOUCH TWIST LANCET	T3	
CLEVER CHEK LANCETS	T3	
CHOSEN LANCET	T3	
CHOSEN SAFETY LANCET	T3	
COAGUCHEK	T3	

T1 – Preferred Generics

T2 – Non-Preferred Generics

T3 – Preferred Brands

T4 – Non-Preferred Brands

T5 – Brand Specialty

PA – Prior Authorization

QL – Quantity Limit

ST – Step Therapy

AGE – Age Requirement

SP – Specialty Medication

HD – May require home delivery pharmacy

PPACA – No Cost-Share Preventive Medication

CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

MISCELLANEOUS MEDICAL SUPPLIES, DEVICES, NON-DRUG (Miscellaneous) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
DURABLE MEDICAL EQUIPMENT,MISC(GROUP I) (cont.)		
COLOR LANCETS	T3	
COMFORT EZ	T3	
COMFORT LANCETS	T3	
DROPLET LANCETS	T3	
DROPSAFE ACTI-LANCE	T3	
EASY COMFORT LANCETS	T3	
EASY TOUCH BUTTON 30G LANCETS	T3	
EASY TOUCH PULL-TOP 26G LANCET	T3	
EASY TOUCH PULL-TOP 28G LANCET	T3	
EASY TOUCH PULL-TOP 30G LANCET	T3	
EASY TOUCH PULL-TOP 32G LANCET	T3	
EASY TOUCH SAFETY 21G LANCETS	T3	
EASY TOUCH SAFETY 23G LANCETS	T3	
EASY TOUCH SAFETY 26G LANCETS	T3	
EASY TOUCH SAFETY 28G LANCETS	T3	
EASY TOUCH SAFETY 30G LANCETS	T3	
EASY TOUCH SAFETY 32G LANCETS	T3	
EASY TOUCH TWIST 26G LANCETS	T3	
EASY TOUCH TWIST 28G LANCETS	T3	
EASY TOUCH TWIST 30G LANCETS	T3	
EASY TOUCH TWIST 32G LANCETS	T3	
EASY TOUCH TWIST 33G LANCETS	T3	
EASY TWIST CAP LANCETS	T3	
EMBRACE 30G LANCETS	T3	
EMBRACE SAFETY LANCET	T3	
EZ SMART LANCETS	T3	
EZ-LETS	T3	
FIFTY50 SAFETY SEAL LANCETS	T3	
FINGERSTIX	T3	
FORA LANCETS	T3	
FORACARE LANCETS	T3	
FREESTYLE LANCETS	T3	
FREESTYLE UNISTIK 2	T3	
GLUCOCOM	T3	

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

T5 – Brand Specialty
PA – Prior Authorization
QL – Quantity Limit

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

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

List of Prescription Medications

MISCELLANEOUS MEDICAL SUPPLIES, DEVICES, NON-DRUG (Miscellaneous) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
DURABLE MEDICAL EQUIPMENT,MISC(GROUP I) (cont.)		
GLUCOCOM LANCETS	T3	
GOJJI LANCETS	T3	
HEALTHY ACCENTS UNILET LANCET	T3	
INCONTROL SUPER THIN LANCETS	T3	
INCONTROL ULTRA THIN LANCETS	T3	
INJECT EASE LANCETS	T3	
INVACARE LANCETS	T3	
<i>lancets</i>	T2	
LANCETS	T3	
LITE TOUCH 28G LANCETS	T3	
LITE TOUCH 30G LANCETS	T3	
LITE TOUCH 33G LANCETS	T3	
MEDISENSE THIN LANCETS	T3	
MEDLANCE PLUS 21G LANCETS	T3	
<i>medlance plus 21g lancets</i>	T2	
MEDLANCE PLUS 30G LANCETS	T3	
<i>medlance plus 30g lancets</i>	T2	
MEDLANCE PLUS EXTRA 21G LANCET	T3	
MEDLANCE PLUS LITE 25G LANCETS	T3	
<i>medlance plus lite 25g lancets</i>	T2	
MEDLANCE PLUS SPECIAL BLADE	T3	
MICRO THIN LANCET	T3	
MICRO THIN LANCETS	T3	
MICROLET	T3	
MICROTAINER LANCETS	T3	
MONOLET LANCETS	T3	
MONOLET THIN LANCETS	T3	
MYGLUCOHEALTH LANCETS	T3	
NOVA SAFETY LANCETS	T3	
NOVA SUREFLEX	T3	
ON CALL LANCET	T3	
ON CALL PLUS LANCET	T3	
ONETOUCH DELICA	T3	
ONETOUCH DELICA PLUS LANCET	T3	

T1 – Preferred Generics

T2 – Non-Preferred Generics

T3 – Preferred Brands

T4 – Non-Preferred Brands

T5 – Brand Specialty

PA – Prior Authorization

QL – Quantity Limit

ST – Step Therapy

AGE – Age Requirement

SP – Specialty Medication

HD – May require home delivery pharmacy

PPACA – No Cost-Share Preventive Medication

CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

MISCELLANEOUS MEDICAL SUPPLIES, DEVICES, NON-DRUG (Miscellaneous) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
DURABLE MEDICAL EQUIPMENT,MISC(GROUP I) (cont.)		
ONETOUCH DELICA SAFETY LANCET	T3	
ONETOUCH LANCETS	T3	
ONETOUCH SURESOFT	T3	
ON-THE-GO	T3	
PERFECT POINT SAFETY LANCETS	T3	
PIP LANCET	T3	
PRESSURE ACTIVATED LANCETS	T3	
PRO COMFORT LANCET	T3	
PRO COMFORT LANCETS	T3	
PRODIGY LANCETS	T3	
PRODIGY TWIST TOP LANCET	T3	
PURE COMFORT LANCETS	T3	
PURE COMFORT SAFETY LANCETS	T3	
PUSH BUTTON SAFETY LANCETS	T3	
READYLANCER SAFETY LANCETS	T3	
RELIAMED	T3	
RELIAMED SAFETY SEAL LANCETS	T3	
RIGHTTEST GL300 LANCETS	T3	
SAFETY LANCETS	T3	
SAFETY SEAL LANCETS	T3	
SAFETY-LET	T3	
SINGLE-LET	T3	
SMART SENSE	T3	
SMART SENSE LANCETS	T3	
SMARTTEST LANCET	T3	
SOLUS V2	T3	
SOLUS V2 LANCETS	T3	
STERILANCE TL	T3	
STERILE LANCETS	T3	
SUPER THIN LANCETS	T3	
SURE COMFORT LANCETS	T3	
SURE-LANCE	T3	
SURE-TOUCH	T3	
TECHLITE LANCETS	T3	

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

T5 – Brand Specialty
PA – Prior Authorization
QL – Quantity Limit

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

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

List of Prescription Medications

MISCELLANEOUS MEDICAL SUPPLIES, DEVICES, NON-DRUG (Miscellaneous) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
DURABLE MEDICAL EQUIPMENT,MISC(GROUP I) (cont.)		
TELCARE ULTRA THIN 30G LANCETS	T3	
THIN LANCETS	T3	
TOPCARE UNIVERSAL1 LANCET	T3	
TOPCARE UNIVERSAL1 THIN LANCET	T3	
TRUE COMFORT LANCET	T3	
TRUEPLUS LANCET	T3	
TRUEPLUS LANCETS	T3	
TWIST LANCETS	T3	
TWIST TOP LANCET	T3	
ULTILET BASIC	T3	
ULTILET CLASSIC	T3	
ULTILET LANCETS	T3	
ULTILET SAFETY	T3	
ULTRA THIN LANCET	T3	
ULTRA THIN LANCETS	T3	
ULTRA THIN PLUS LANCETS	T3	
ULTRA-CARE LANCETS	T3	
ULTRALANCE	T3	
ULTRA-THIN II 28G LANCETS	T3	
ULTRA-THIN II 30G LANCETS	T3	
ULTRATLC LANCETS	T3	
UNILET COMFORTOUCH	T3	
UNILET EXCELITE	T3	
UNILET EXCELITE II	T3	
UNILET GP LANCET	T3	
UNILET LANCETS	T3	
UNISTIK 2 COMFORT	T3	
UNISTIK 2 EXTRA	T3	
UNISTIK 2 NORMAL	T3	
UNISTIK 3	T3	
UNISTIK 3 COMFORT	T3	
UNISTIK 3 DUAL	T3	
UNISTIK 3 EXTRA	T3	
UNISTIK COMFORT	T3	

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

T5 – Brand Specialty
PA – Prior Authorization
QL – Quantity Limit

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

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

List of Prescription Medications

MISCELLANEOUS MEDICAL SUPPLIES, DEVICES, NON-DRUG (Miscellaneous) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
DURABLE MEDICAL EQUIPMENT,MISC(GROUP I) (cont.)		
UNISTIK CZT	T3	
UNISTIK EXTRA	T3	
UNISTIK NORMAL	T3	
UNISTIK PRO	T3	
UNISTIK SAFETY	T3	
UNISTIK TOUCH	T3	
UNIVERSAL 1	T3	
VIVAGUARD LANCET	T3	
VIVAGUARD SAFETY LANCET	T3	
MEDICAL SUPPLIES,MISCELLANEOUS		
ALCOH-GLOVE	T4	
ALCOH-WIPE	T4	
PARENTERAL ADMINISTRATION SETS		
1.5 VOLT BATTERIES #357	T3	
ACCU-CHEK	T4	
ACCU-CHEK RAPID D 10-100	T4	
ACCU-CHEK RAPID D 10-50	T4	
ACCU-CHEK RAPID D 10-70	T3	
ACCU-CHEK RAPID D 6-100	T4	
ACCU-CHEK RAPID D 6-50	T3	
ACCU-CHEK RAPID D 6-70	T4	
ACCU-CHEK RAPID D 8-100	T4	
ACCU-CHEK RAPID D 8-50	T3	
ACCU-CHEK RAPID D 8-70	T3	
ACCU-CHEK SPIRIT	T3	
ACCU-CHEK TENDER	T3	
ACCU-CHEK ULTRAFLEX	T3	
IVENIX PRIMARY ADMINISTRAT SET	T4	
IV ADMINISTRATION SET	T3	
NERIA	T4	
PARADIGM INFUSION	T3	
POLYFIN QR	T3	
PSV SET	T4	

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

T5 – Brand Specialty
PA – Prior Authorization
QL – Quantity Limit

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

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

List of Prescription Medications

MISCELLANEOUS MEDICAL SUPPLIES, DEVICES, NON-DRUG (Miscellaneous) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
PARENTERAL ADMINISTRATION SETS (cont.)		
Q-SYTE	T3	
SILHOUETTE	T3	
SURE-T	T3	
RESPIRATORY AIDS, DEVICES, EQUIPMENT		
ACE AEROSOL CLOUD ENHANCER	T3	
AEROCHAMBER MECHANICAL VENT	T3	
AEROCHAMBER MINI	T3	
AEROCHAMBER MV	T3	
AEROCHAMBER PLUS FLOW-VU	T3	
AEROCHAMBER Z-STAT PLUS	T3	
AEROCHAMBER2GO	T3	PA SP HD
AEROTRACH PLUS	T3	
AEROVENT PLUS	T3	
BREATHERITE	T3	
BREATHERITE SPACER-ADULT MASK	T3	
BREATHERITE SPACER-INFANT MASK	T3	
BREATHERITE SPACER-LG CHLD MSK	T3	
BREATHERITE SPACER-NEONATE MSK	T3	
BREATHERITE SPACER-SM CHLD MSK	T3	
BREATHRITE	T3	
CLEVER CHOICE HOLDING CHAMBER	T3	
COMFORTSEAL	T3	
COMPACT SPACE CHAMBER	T3	
EASIVENT	T3	
FLEXICHAMBER	T3	
FLEXICHAMBER MASK	T3	
INSPIRACHAMBER	T3	
LITEAIRE	T3	
LITETOUCH	T3	
MICROCHAMBER	T3	
MICROSPACER	T3	
MOUTHPIECE	T3	
ONE WAY MOUTHPIECE	T3	
OPTICHAMBER	T3	

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

T5 – Brand Specialty
PA – Prior Authorization
QL – Quantity Limit

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

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

List of Prescription Medications

MISCELLANEOUS MEDICAL SUPPLIES, DEVICES, NON-DRUG (Miscellaneous) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
RESPIRATORY AIDS,DEVICES,EQUIPMENT (cont.)		
OPTICHAMBER DIAMOND	T3	
PANDA MASK	T3	
PEDIATRIC MASK	T3	
PEDIATRIC PANDA MASK	T3	
POCKET CHAMBER	T3	
PRIMEAIRE	T3	
PRO COMFORT SPACER-ADULT MASK	T3	
PRO COMFORT SPACER-CHILD MASK	T4	
PRO COMFORT SPACER-INFANT MASK	T4	
PROCARE SPACER WITH ADULT MASK	T3	
PROCARE SPACER WITH CHILD MASK	T3	
PROCHAMBER	T3	
PURECOMFORT PEAK FLOW MOUTH PCE	T3	
PURE COMFORT SPACER WITH MASK	T4	
RITEFLO	T3	
SIDESTREAM PEDIATRIC	T3	
SILICONE MASK	T3	
SPACE CHAMBER	T3	
SPACE CHAMBER-LARGE MASK	T3	
SPACE CHAMBER-MEDIUM MASK	T3	
SPACE CHAMBER-SMALL MASK	T3	
VORTEX	T3	
VORTEX VHC FROG MASK	T3	
VORTEX VHC LADYBUG MASK	T3	
VORTEX VHC PEDIATRIC MASK	T3	
MUSCLE RELAXANTS (Pain Relief And Inflammatory Disease)		
SKELETAL MUSCLE RELAX.-TOP. IRRITANT COUNTER-IRRIT		
COMFORT PAC-CYCLOBENZAPRINE	T4	
COMFORT PAC-TIZANIDINE	T4	
SKELETAL MUSCLE RELAXANTS		
<i>baclofen 5 mg tablet</i>	T2	HD
<i>baclofen 10 mg tablet</i>	T2	HD
<i>baclofen 15 mg tablet</i>	T2	HD

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

T5 – Brand Specialty
PA – Prior Authorization
QL – Quantity Limit

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

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

List of Prescription Medications

MUSCLE RELAXANTS (Pain Relief And Inflammatory Disease) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
SKELETAL MUSCLE RELAXANTS (cont.)		
<i>baclofen 20 mg tablet</i>	T2	HD
<i>baclofen 10 mg/5 ml solution</i>	T2	PA HD
<i>baclofen 25 mg/5 ml suspension (Fleqsuvy)</i>	T2	HD
<i>baclofen 5 mg/5 ml solution</i>	T2	PA HD
<i>carisoprodol (Soma)</i>	T2	
<i>carisoprodol/aspirin</i>	T2	
<i>chlorzoxazone</i>	T2	
<i>chlorzoxazone (Lorzone)</i>	T2	
<i>cyclobenzaprine hcl</i>	T2	
<i>cyclobenzaprine hcl (Amrix)</i>	T2	PA
<i>cyclobenzaprine hcl (Fexmid)</i>	T2	
<i>DANTRIUM (dantrolene sodium)</i>	T4	
<i>dantrolene sodium</i>	T2	
<i>dantrolene sodium (Dantrium)</i>	T2	
<i>FEXMID (cyclobenzaprine hcl)</i>	T4	PA
<i>LORZONE (chlorzoxazone)</i>	T4	PA
<i>metaxalone 400 mg tablet</i>	T2	
<i>metaxalone 800 mg tablet</i>	T2	
<i>methocarbamol</i>	T2	
<i>methocarbamol 500 mg tablet</i>	T2	
<i>methocarbamol 750 mg tablet</i>	T2	
<i>methocarbamol 1,000 mg tablet</i>	T2	
<i>NORGESIC (orphenadrine/aspirin/caffeine)</i>	T4	
<i>NORGESIC FORTE (orphenadrine/aspirin/caffeine)</i>	T4	
<i>orphenadrine citrate</i>	T2	
<i>orphenadrine/aspirin/caffeine (Norgesic Forte)</i>	T2	
<i>orphenadrine/aspirin/caffeine (Norgesic)</i>	T2	
<i>SOMA (carisoprodol)</i>	T4	
<i>tizanidine hcl</i>	T2	
<i>tizanidine hcl (Zanaflex)</i>	T2	
<i>ZANAFLEX 2 MG CAPSULE (tizanidine hcl)</i>	T4	
<i>ZANAFLEX 4 MG CAPSULE (tizanidine hcl)</i>	T4	
<i>ZANAFLEX 4 MG TABLET (tizanidine hcl)</i>	T4	
<i>ZANAFLEX 6 MG CAPSULE (tizanidine hcl)</i>	T4	

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

T5 – Brand Specialty
PA – Prior Authorization
QL – Quantity Limit

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

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

List of Prescription Medications

PRE-NATAL VITAMINS (Nutritional/Dietary)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
PRENATAL VITAMIN PREPARATIONS		
BAL-CARE DHA ESSENTIAL	T4	
CADEAU DHA	T4	
CITRANATAL 90 DHA	T4	
CITRANATAL ASSURE	T4	
CITRANATAL DHA	T4	
CITRANATAL HARMONY	T4	
CITRANATAL RX	T4	
<i>cvs prenatal multi-dha softgel</i>	T2	PPACA
<i>cvs prenatal multivit-dha sfgl</i>	T2	PPACA
<i>cvs prenatal vitamins tablet</i>	T2	PPACA
DUET DHA BALANCED	T4	
EXPECTA PRENATAL	T3	
<i>ft prenatal tablet</i>	T2	PPACA
<i>gnp prenatal tablet</i>	T2	PPACA
GS PRENATAL VITAMINS TABLET	T4	
HM ONE DAILY PRENATAL COMBO PK	T3	
<i>hm prenatal tablet</i>	T2	PPACA
KOSHER PRENATAL PLUS IRON	T4	
KPN	T3	
MARNATAL-F	T4	
MASONATAL PRENATAL	T4	
MINI PRENATAL	T4	
MTERYTI	T4	
MTERYTI FOLIC 5	T4	
NATACHEW	T4	
NEONATAL COMPLETE	T4	
NEONATAL PLUS	T4	
NEONATAL-DHA	T4	
NESTABS	T4	
NESTABS ABC	T4	
NESTABS DHA	T4	
OB COMPLETE ONE	T4	
OB COMPLETE PETITE	T4	
OB COMPLETE PREMIER	T4	

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

T5 – Brand Specialty
PA – Prior Authorization
QL – Quantity Limit

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

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

List of Prescription Medications

PRE-NATAL VITAMINS (Nutritional/Dietary) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
PRENATAL VITAMIN PREPARATIONS (cont.)		
OB COMPLETE WITH DHA	T4	
OBSTETRIX EC	T4	
OBTREX DHA	T4	
ONE A DAY WOMEN'S PRENATAL DHA	T4	
ONE-A-DAY PRENATAL-1	T4	
<i>pnv 11/iron fum/folic acid/om3</i>	T2	
<i>pnv19/iron bg,s,p/folic ac/om3</i>	T2	
<i>pnv 119/iron fum/folic acid</i>	T2	
<i>pnv 154/iron fum/folic acid</i>	T2	
<i>pnv 66/iron/folic/docusate/dha</i>	T2	
<i>pnv 69/iron/folic/docusate/dha</i>	T2	
<i>pnv 80/iron fum/folic/dss/dha</i>	T2	
<i>pnv 81/iron ps,edta/folic/omeg3</i>	T2	PA SP HD
<i>pnv no.52/iron/fa/omega-3/dha</i>	T2	PA SP HD
<i>pnv no.118/iron fumarate/fa</i>	T2	
<i>pnv,calcium 72/iron,carb/folic</i>	T2	
<i>pnv,calcium 72/iron/folic acid</i>	T2	
<i>pnv/iron,carb/docusat/folic ac</i>	T2	
PRENATA	T4	
<i>prenatal 105/iron/folic ac/dha</i>	T2	
<i>prenatal 12/iron/folic/dss/om3</i>	T2	
PRENATAL 19 CHEWABLE TABLET	T4	
<i>prenatal 19 chewable tablet</i>	T2	
PRENATAL 19 TABLET	T4	
<i>prenatal 19 tablet</i>	T2	
<i>prenatal 21/iron fu/folic acid</i>	T2	PPACA
<i>prenatal 53/iron/folic ac/omg3</i>	T2	
<i>prenatal 54/iron/folic ac/omg3</i>	T2	
<i>prenatal 93/iron/folate 9/dha</i>	T2	
<i>prenatal caplet</i>	T2	PPACA
PRENATAL FORMULA	T3	
PRENATAL FORMULA-DHA (<i>prenatal vit 116/iron/fa/dha</i>)	T4	PA SP HD
PRENATAL GUMMIES	T4	
PRENATAL MULTI	T4	

T1 – Preferred Generics

T2 – Non-Preferred Generics

T3 – Preferred Brands

T4 – Non-Preferred Brands

T5 – Brand Specialty

PA – Prior Authorization

QL – Quantity Limit

ST – Step Therapy

AGE – Age Requirement

SP – Specialty Medication

HD – May require home delivery pharmacy

PPACA – No Cost-Share Preventive Medication

CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

PRE-NATAL VITAMINS (Nutritional/Dietary) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
PRENATAL VITAMIN PREPARATIONS (cont.)		
<i>prenatal multi-dha softgel</i>	T2	PPACA
PRENATAL MULTI-DHA SOFTGEL	T3	
PRENATAL MULTI-DHA SOFTGEL	T4	
<i>prenatal multivitamin tablet</i>	T2	PPACA
PRENATAL MULTIVITAMIN TABLET	T4	
PRENATAL MULTIVITAMIN-DHA SFG	T3	
PRENATAL PLUS VITAMIN-MINERAL	T4	
PRENATAL PLUS-DHA	T4	
<i>prenatal tablet</i>	T2	PPACA
PRENATAL TABLET	T4	
<i>prenatal vit 14/iron fum/folic</i>	T2	
<i>prenatal vit 55/iron/folic/om3</i>	T2	
<i>prenatal vit 91/iron/folic/dha</i>	T2	
<i>prenatal vit no.126/iron/folic</i>	T2	PPACA
<i>prenatal vit no.129/iron/folic</i>	T2	PPACA
<i>prenatal vit,cal 73/iron/folic</i>	T2	
<i>prenatal vit,cal 76/iron/folic</i>	T2	PA SP HD
<i>prenatal vit,cal 78/iron/folic</i>	T2	PA SP HD
<i>prenatal no.42/folic acid (Vitamedmd Redichew Rx)</i>	T2	PA SP HD
<i>prenatal vit 27,calc/iron/fa</i>	T2	PA SP HD
<i>prenatal,calc 40/iron/folate 1</i>	T2	PA SP HD
<i>prenatal vit/iron fum/folic ac</i>	T2	
PRENATAL VITAMIN + DHA	T3	
<i>prenatal vitamin tablet</i>	T2	PPACA
PRENATAL VITAMIN TABLET (<i>prenatal vit no.124/iron/folic</i>)	T4	
<i>prenatal vitamins tablet</i>	T2	PPACA
<i>prenatal vits 86/iron/folic ac</i>	T2	PA SP HD
<i>prenatal vits calc.36/iron/fa</i>	T2	PPACA
<i>prenatal 71/iron/folic ac/dha</i>	T2	
PRENATE ENHANCE	T4	
PRENATE RESTORE	T4	
PRIMACARE	T4	
PROVIDA OB	T4	
<i>ra one daily prenatal dha pack</i>	T2	PPACA

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

T5 – Brand Specialty
PA – Prior Authorization
QL – Quantity Limit

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

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

List of Prescription Medications

PRE-NATAL VITAMINS (Nutritional/Dietary) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
PRENATAL VITAMIN PREPARATIONS (cont.)		
<i>ra prenatal tablet</i>	T2	PPACA
SELECT-OB	T4	
SELECT-OB (<i>prenatal vit 128/iron/folic ac</i>)	T4	
SELECT-OB + DHA	T4	
SIMILAC PRENATAL	T4	
<i>sm prenatal vitamins tablet</i>	T2	PPACA
STUART ONE (<i>pnv no.63/iron,carb/folic/dha</i>)	T4	
<i>sv prenatal tablet</i>	T2	PPACA
SV PRENATAL VITAMINS TABLET	T4	
THERANATAL	T4	
THERANATAL COMPLETE	T4	
THERANATAL ONE	T4	
THERANATAL PLUS	T4	
THRIVITE RX	T4	
TRICARE	T4	
TRICARE PRENATAL DHA ONE	T4	
TRISTART DHA	T4	
ULTRA PRENATAL PLUS DHA	T4	
VITAFOL FE PLUS	T4	
VITAFOL NANO	T4	
VITAFOL ULTRA	T4	
VITAFOL-OB	T4	
VITAFOL-OB+DHA	T4	
VITAFOL-ONE	T4	
VITAMEDMD ONE RX	T4	
VITAMEDMD REDICHEW RX (<i>prenatal no.42/folic acid</i>)	T4	PA SP HD
VITAPEARL	T4	
VITATRUE	T4	
WOMEN'S PRENATAL PLUS DHA	T3	
PRENATAL VITAMINS WITH LOW OR NO IRON		
CITRANATAL B-CALM	T4	PA SP HD
CVS PRENATAL GUMMIES	T4	
DUET DHA 400	T4	PA SP HD

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

T5 – Brand Specialty
PA – Prior Authorization
QL – Quantity Limit

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

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

List of Prescription Medications

PRE-NATAL VITAMINS (Nutritional/Dietary) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
PRENATAL VITAMINS WITH LOW OR NO IRON (cont.)		
P21 PRENATAL WITH CHOLINE	T4	
PRENATAL GUMMIES	T4	
PRENATE DHA	T4	PA SP HD
PRENATE ELITE	T4	PA SP HD
PRENATE MINI	T4	PA SP HD
PRENATE PIXIE	T4	PA SP HD
PRENATE STAR	T4	PA SP HD
R-NATAL OB	T4	PA SP HD
THERANATAL OVAVITE	T4	PA SP HD
TRINAZ	T4	
VITAFOL GUMMIES	T4	PA SP HD
PSYCHOTHERAPEUTIC DRUGS (Anxiety/Depression/Bipolar Disorder)⁹		
ALPHA-2 RECEPTOR ANTAGONIST ANTIDEPRESSANTS		
<i>mirtazapine</i>	T1	HD
<i>mirtazapine</i> (Remeron)	T2	HD
REMERON (<i>mirtazapine</i>)	T4	HD
ANTI-ANXIETY - BENZODIAZEPINES		
<i>alprazolam</i>	T2	
<i>alprazolam</i> (Xanax Xr)	T1	
<i>alprazolam</i> (Xanax)	T1	
ATIVAN (<i>lorazepam</i>)	T4	
<i>chlordiazepoxide hcl</i>	T2	
<i>clorazepate dipotassium</i>	T2	
<i>diazepam 10 mg tablet</i> (Valium)	T2	
<i>diazepam 2 mg tablet</i> (Valium)	T2	
<i>diazepam 25 mg/5 ml oral conc</i>	T2	
<i>diazepam 5 mg tablet</i> (Valium)	T2	
<i>diazepam 5 mg/5 ml oral soln</i>	T2	
<i>diazepam 5 mg/5 ml solution</i>	T2	
<i>diazepam 5 mg/ml oral conc</i>	T2	
<i>lorazepam</i>	T2	
<i>lorazepam</i> (Ativan)	T1	
<i>oxazepam</i>	T2	

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

T5 – Brand Specialty
PA – Prior Authorization
QL – Quantity Limit

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

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

List of Prescription Medications

PSYCHOTHERAPEUTIC DRUGS (Anxiety/Depression/Bipolar Disorder) ⁹ (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ANTI-ANXIETY DRUGS		
<i>buspirone hcl</i>	T1	HD
<i>meprobamate</i>	T2	
ANTIDEPRESSANT - POSTPARTUM DEPRESSION (PPD)		
ZURZUVAE 20 MG CAPSULE	T5	QL (28 caps/365 days) SP HD
ZURZUVAE 25 MG CAPSULE	T5	QL (28 caps/365 days) SP HD
ZURZUVAE 30 MG CAPSULE	T5	QL (14 caps/365 days) SP HD
BIPOLAR DISORDER DRUGS		
EQUETRO	T4	HD
<i>lithium carbonate</i>	T1	HD
<i>lithium carbonate</i> (Lithobid)	T1	HD
LITHOBID (<i>lithium carbonate</i>)	T4	HD
MAOIS -NON-SELECTIVE, IRREVERSIBLE ANTIDEPRESSANTS		
MARPLAN	T4	
NARDIL (<i>phenelzine sulfate</i>)	T4	
PARNATE (<i>tranylcypromine sulfate</i>)	T4	
<i>phenelzine sulfate</i> (Nardil)	T2	
<i>tranylcypromine sulfate</i> (Parnate)	T2	
MONOAMINE OXIDASE (MAO) INHIBITOR ANTIDEPRESSANTS		
EMSAM	T4	
NDMA RECEPTOR ANTAGONIST AND NDRI COMB		
AUVELITY	T4	ST QL (60 tabs/30 days)
NOREPINEPHRINE AND DOPAMINE REUPTAKE INHIB (NDRIS)		
<i>bupropion hcl</i>	T1	HD
SELECTIVE SEROTONIN 5-HT_{2A} INVERSE AGONISTS (SSIA)		
NUPLAZID 10 MG TABLET	T5	PA QL (30 tabs/fill) SP HD
NUPLAZID 34 MG CAPSULE	T5	PA QL (30 caps/fill) SP HD
SELECTIVE SEROTONIN REUPTAKE INHIBITOR (SSRIS)		
<i>citalopram hbr 10 mg/5 ml soln</i>	T2	HD
<i>citalopram hbr 20 mg/10 ml cup</i>	T2	PA SP HD
<i>escitalopram 10 mg/10 ml cup</i>	T1	PA SP HD
<i>escitalopram oxalate 5 mg/5 ml</i>	T1	ST HD
<i>fluoxetine 20 mg/5 ml solution cup</i>	T2	HD
<i>fluoxetine hcl</i>	T2	ST QL (4 caps/fill) HD
<i>fluoxetine hcl 10 mg tablet</i>	T2	ST QL (30 tabs/fill) HD

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

T5 – Brand Specialty
PA – Prior Authorization
QL – Quantity Limit

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

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

List of Prescription Medications

PSYCHOTHERAPEUTIC DRUGS (Anxiety/Depression/Bipolar Disorder) ⁹ (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
SELECTIVE SEROTONIN REUPTAKE INHIBITOR (SSRIS) (cont.)		
<i>fluoxetine hcl 20 mg capsule (Prozac)</i>	T1	HD
<i>fluoxetine hcl 20 mg, 60 mg tablet</i>	T2	ST HD
<i>fluvoxamine maleate</i>	T2	ST QL (60 caps/fill) HD
<i>fluvoxamine maleate 100 mg tab</i>	T2	QL (90 tabs/fill) HD
<i>fluvoxamine maleate 25 mg tab</i>	T2	QL (30 tabs/fill) HD
<i>fluvoxamine maleate 50 mg tab</i>	T2	QL (60 tabs/fill) HD
<i>paroxetine hcl (Paxil Cr)</i>	T2	ST QL (60 tabs/fill) HD
<i>paroxetine hcl 10 mg tablet (Paxil)</i>	T1	QL (30 tabs/fill) HD
<i>paroxetine hcl 10 mg/5 ml susp (Paxil)</i>	T2	ST HD
<i>paroxetine hcl 20 mg tablet (Paxil)</i>	T1	QL (60 tabs/fill) HD
<i>paroxetine hcl 30 mg tablet (Paxil)</i>	T1	QL (60 tabs/fill) HD
<i>paroxetine hcl 40 mg tablet (Paxil)</i>	T1	QL (30 tabs/fill) HD
PAXIL 10 MG TABLET (<i>paroxetine hcl</i>)	T4	ST QL (30 tabs/fill) HD
PAXIL 10 MG/5 ML SUSPENSION (<i>paroxetine hcl</i>)	T4	ST HD
PAXIL 20 MG TABLET (<i>paroxetine hcl</i>)	T4	ST QL (60 tabs/fill) HD
PAXIL 30 MG TABLET (<i>paroxetine hcl</i>)	T4	ST QL (60 tabs/fill) HD
PAXIL 40 MG TABLET (<i>paroxetine hcl</i>)	T4	ST QL (30 tabs/fill) HD
PAXIL CR (<i>paroxetine hcl</i>)	T4	ST QL (60 tabs/fill) HD
<i>sertraline 150 mg capsule</i>	T2	QL (30 caps/30 days) HD
<i>sertraline 150 mg capsule</i>	T2	ST QL (30 caps/30 days) HD
<i>sertraline 200 mg capsule</i>	T2	QL (30 caps/30 days) HD
<i>sertraline 200 mg capsule</i>	T2	ST QL (30 caps/30 days) HD
<i>sertraline 20 mg/ml oral conc (Zoloft)</i>	T2	HD
<i>sertraline hcl 25 mg tablet (Zoloft)</i>	T1	QL (45 tabs/fill) HD
SEROTONIN-2 ANTAGONIST/REUPTAKE INHIBITORS (SARIS)		
<i>nefazodone hcl</i>	T2	HD
<i>trazodone hcl</i>	T1	HD
SEROTONIN-NOREPINEPHRINE REUPTAKE-INHIB (SNRIS)		
DESVENLAFAXINE ER	T4	ST QL (30 tabs/fill) HD
<i>duloxetine hcl dr 20 mg cap (Cymbalta)</i>	T1	QL (60 caps/fill) HD
<i>duloxetine hcl dr 30 mg cap (Cymbalta)</i>	T1	QL (30 caps/fill) HD
<i>duloxetine hcl dr 40 mg cap</i>	T1	ST QL (30 caps/fill) HD
<i>duloxetine hcl dr 60 mg cap (Cymbalta)</i>	T1	QL (60 caps/fill) HD
FETZIMA 20-40 MG TITRATION PAK	T3	ST QL (28 caps/30 days)

T1 – Preferred Generics

T2 – Non-Preferred Generics

T3 – Preferred Brands

T4 – Non-Preferred Brands

T5 – Brand Specialty

PA – Prior Authorization

QL – Quantity Limit

ST – Step Therapy

AGE – Age Requirement

SP – Specialty Medication

HD – May require home delivery pharmacy

PPACA – No Cost-Share Preventive Medication

CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

PSYCHOTHERAPEUTIC DRUGS (Anxiety/Depression/Bipolar Disorder) ⁹ (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
SEROTONIN-NOREPINEPHRINE REUPTAKE-INHIB (SNRIS) (cont.)		
FETZIMA ER 120 MG CAPSULE	T3	ST QL (30 caps/30 days)
FETZIMA ER 20 MG CAPSULE	T3	ST QL (30 caps/30 days)
FETZIMA ER 40 MG CAPSULE	T3	ST QL (30 caps/30 days)
FETZIMA ER 80 MG CAPSULE	T3	ST QL (30 caps/30 days)
venlafaxine hcl	T1	QL (90 tabs/fill) HD
venlafaxine hcl er 150 mg tab	T2	ST QL (30 tabs/fill) HD
venlafaxine hcl er 225 mg tab	T2	ST QL (30 tabs/fill) HD
venlafaxine hcl er 37.5 mg tab	T2	ST QL (30 tabs/fill) HD
venlafaxine hcl er 75 mg tab	T2	ST QL (30 tabs/fill) HD
SSRI, SEROTONIN RECEPTOR MODULATOR ANTIDEPRESSANTS		
TRINTELLIX	T4	ST QL (30 tabs/30 days)
TRINTELLIX 10 MG TABLET	T4	ST QL (30 tabs/fill) HD
TRICYCLIC ANTIDEPRESSANT-BENZODIAZEPINE COMBINATNS		
amitriptyline/chlordiazepoxide	T2	HD
perphenazine/amitriptyline hcl	T2	HD
TRICYCLIC ANTIDEPRESSANTS, REL.NON-SEL.REUPT-INHIB		
amitriptyline hcl	T1	HD
amoxapine	T2	HD
ANAFRANIL (clomipramine hcl)	T4	HD
clomipramine hcl (Anafranil)	T2	HD
desipramine hcl	T2	HD
doxepin 10 mg capsule	T2	HD
doxepin 10 mg/ml oral conc	T2	HD
doxepin 25 mg capsule	T2	HD
doxepin 50 mg capsule	T2	HD
doxepin 75 mg capsule	T2	HD
doxepin 100 mg capsule	T2	HD
doxepin 150 mg capsule	T2	HD
imipramine hcl (Tofranil)	T1	HD
imipramine pamoate	T2	HD
maprotiline hcl	T2	HD
nortriptyline hcl	T2	HD
nortriptyline hcl (Pamelor)	T1	HD
PAMELOR (nortriptyline hcl)	T4	HD

T1 – Preferred Generics

T2 – Non-Preferred Generics

T3 – Preferred Brands

T4 – Non-Preferred Brands

T5 – Brand Specialty

PA – Prior Authorization

QL – Quantity Limit

ST – Step Therapy

AGE – Age Requirement

SP – Specialty Medication

HD – May require home delivery pharmacy

PPACA – No Cost-Share Preventive Medication

CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

PSYCHOTHERAPEUTIC DRUGS (Anxiety/Depression/Bipolar Disorder) ⁹ (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
TRICYCLIC ANTIDEPRESSANTS, REL.NON-SEL.REUPT-INHIB (cont.)		
<i>protriptyline hcl</i>	T2	HD
SURMONTIL (<i>trimipramine maleate</i>)	T4	HD
TOFRANIL (<i>imipramine hcl</i>)	T4	HD
<i>trimipramine maleate</i> (Surmontil)	T2	HD
PSYCHOTHERAPEUTIC DRUGS (Attention Deficit Hyperactivity Disorder)⁹		
ADRENERGICS, AROMATIC, NON-CATECHOLAMINE		
<i>lisdexamfetamine 10 mg capsule</i> (Vyvanse)	T2	
<i>lisdexamfetamine 10 mg tb chew</i> (Vyvanse)	T2	ST
<i>lisdexamfetamine 20 mg capsule</i> (Vyvanse)	T2	
<i>lisdexamfetamine 20 mg tb chew</i> (Vyvanse)	T2	ST
<i>lisdexamfetamine 30 mg capsule</i> (Vyvanse)	T2	
<i>lisdexamfetamine 30 mg tb chew</i> (Vyvanse)	T2	ST
<i>lisdexamfetamine 40 mg capsule</i> (Vyvanse)	T2	
<i>lisdexamfetamine 40 mg tb chew</i> (Vyvanse)	T2	ST
<i>lisdexamfetamine 50 mg capsule</i> (Vyvanse)	T2	
<i>lisdexamfetamine 50 mg tb chew</i> (Vyvanse)	T2	ST
<i>lisdexamfetamine 60 mg capsule</i> (Vyvanse)	T2	
<i>lisdexamfetamine 60 mg tb chew</i> (Vyvanse)	T2	ST
<i>lisdexamfetamine 70 mg capsule</i> (Vyvanse)	T2	
VYVANSE (<i>lisdexamfetamine dimesylate</i>)	T4	ST
TX FOR ADHD - SELECTIVE ALPHA-2 RECEPTOR AGONIST		
<i>clonidine hcl er 0.1 mg tablet</i> (Kapvay)	T2	
<i>guanfacine hcl</i> (Intuniv)	T2	HD
KAPVAY (<i>clonidine hcl</i>)	T4	ST
TX FOR ATTENTION DEFICIT-HYPERACT (ADHD)/NARCOLEPSY		
APTENSIO XR (<i>methylphenidate hcl</i>)	T4	ST
AZSTARYS	T3	ST
COTEMPLA XR-ODT	T4	ST
DAYTRANA (<i>methylphenidate</i>)	T4	ST
<i>dexmethylphenidate hcl</i> (Focalin Xr)	T2	
<i>dexmethylphenidate hcl</i> (Focalin)	T1	
JORNAY PM	T4	ST
METADATE CD (<i>methylphenidate hcl</i>)	T4	ST
METHYLIN (<i>methylphenidate hcl</i>)	T4	

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

T5 – Brand Specialty
PA – Prior Authorization
QL – Quantity Limit

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

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

List of Prescription Medications

PSYCHOTHERAPEUTIC DRUGS (Attention Deficit Hyperactivity Disorder)⁹ (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
TX FOR ATTENTION DEFICIT-HYPERACT (ADHD)/NARCOLEPSY (cont.)		
<i>methylphenidate</i>	T2	ST
<i>methylphenidate er 10 mg cap</i> (Aptensio Xr)	T2	ST
<i>methylphenidate er 10 mg, 20 mg tab</i>	T2	
<i>methylphenidate er 15 mg cap</i> (Aptensio Xr)	T2	ST
<i>methylphenidate er 18 mg tab</i> (Concerta)	T2	
<i>methylphenidate er 18 mg tab</i> (Relexxii)	T2	
<i>methylphenidate er 20 mg cap</i> (Aptensio Xr)	T2	ST
<i>methylphenidate er 27 mg tab</i> (Concerta)	T2	
<i>methylphenidate er 27 mg tab</i> (Relexxii)	T2	
<i>methylphenidate er 30 mg cap</i> (Aptensio Xr)	T2	ST
<i>methylphenidate er 36 mg tab</i> (Concerta)	T2	
<i>methylphenidate er 36 mg tab</i> (Relexxii)	T2	
<i>methylphenidate er 40 mg cap</i> (Aptensio Xr)	T2	ST
<i>methylphenidate er 50 mg cap</i> (Aptensio Xr)	T2	ST
<i>methylphenidate er 54 mg tab</i> (Concerta)	T2	
<i>methylphenidate er 54 mg tab</i> (Relexxii)	T2	
<i>methylphenidate er 60 mg cap</i> (Aptensio Xr)	T2	ST
METHYLPHENIDATE ER 72 MG TAB	T4	ST
<i>methylphenidate er 72 mg tab</i>	T2	
<i>methylphenidate hcl</i>	T2	
<i>methylphenidate hcl</i> (Metadate Cd)	T2	
<i>methylphenidate hcl</i> (Methylin)	T2	
<i>methylphenidate hcl</i> (Ritalin La)	T2	
<i>methylphenidate hcl</i> (Ritalin)	T2	
QELBREE	T4	ST
QELBREE ER	T4	ST
RELEXXII ER 72 MG TABLET	T4	ST
<i>atomoxetine hcl</i> (Strattera)	T2	HD

PSYCHOTHERAPEUTIC DRUGS (Miscellaneous)

HYPOACTIVE SEXUAL DESIRE DISORDER (HSDD) TX AGENTS

ADDYI	T4	PA
VYLEESI	T5	PA QL (8 auto-injs/fill) SP

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

T5 – Brand Specialty
PA – Prior Authorization
QL – Quantity Limit

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

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

List of Prescription Medications

PSYCHOTHERAPEUTIC DRUGS (Schizophrenia/Anti-Psychotics) ⁹		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ANTIPSYCH, DOPAMINE ANTAG., DIPHENYLBUTYLPIPERIDINES		
<i>pimozide</i>	T2	
ANTIPSYCHOTIC, ATYPICAL, DOPAMINE, SEROTONIN ANTAGNST		
<i>asenapine maleate</i> (Saphris)	T2	QL (60 tabs/fill)
CAPLYTA	T4	QL (30 caps/fill)
<i>clozapine</i>	T2	
<i>clozapine</i> (Clozaril)	T2	
CLOZARIL (<i>clozapine</i>)	T4	
GEODON (<i>ziprasidone hcl</i>)	T4	QL (60 caps/fill)
INVEGA ER 3 MG TABLET (<i>paliperidone</i>)	T4	QL (30 tabs/fill)
INVEGA ER 6 MG TABLET (<i>paliperidone</i>)	T4	QL (60 tabs/fill)
INVEGA ER 9 MG TABLET (<i>paliperidone</i>)	T4	QL (30 tabs/fill)
LYBALVI	T4	QL (30 tabs/30 days)
<i>olanzapine</i>	T2	PA SP HD
<i>olanzapine</i> (Zyprexa Zydis)	T2	QL (30 tabs/fill)
<i>quetiapine er 200 mg tablet</i> (Seroquel Xr)	T2	QL (30 tabs/fill)
<i>quetiapine er 300 mg tablet</i> (Seroquel Xr)	T2	QL (60 tabs/fill)
<i>quetiapine er 400 mg tablet</i> (Seroquel Xr)	T2	QL (60 tabs/fill)
<i>quetiapine er 50 mg tablet</i> (Seroquel Xr)	T2	QL (60 tabs/fill)
<i>quetiapine fumarate 200 mg tab</i> (Seroquel)	T1	QL (90 tabs/fill)
<i>quetiapine fumarate 300 mg tab</i> (Seroquel)	T1	QL (60 tabs/fill)
RISPERDAL 0.5 MG TABLET (<i>risperidone</i>)	T4	QL (60 tabs/fill)
RISPERDAL 1 MG TABLET (<i>risperidone</i>)	T4	QL (60 tabs/fill)
RISPERDAL 1 MG/ML SOLUTION (<i>risperidone</i>)	T4	
RISPERDAL 2 MG TABLET (<i>risperidone</i>)	T4	QL (60 tabs/fill)
RISPERDAL 3 MG TABLET (<i>risperidone</i>)	T4	QL (60 tabs/fill)
RISPERDAL 4 MG TABLET (<i>risperidone</i>)	T4	QL (60 tabs/fill)
<i>risperidone</i>	T2	QL (60 tabs/fill)
<i>risperidone 0.5 mg tablet</i> (Risperdal)	T1	QL (60 tabs/fill)
<i>risperidone 1 mg tablet</i> (Risperdal)	T1	QL (60 tabs/fill)
<i>risperidone 1 mg/ml solution</i> (Risperdal)	T2	
<i>risperidone 2 mg tablet</i> (Risperdal)	T1	QL (60 tabs/fill)
<i>risperidone 3 mg tablet</i> (Risperdal)	T1	QL (60 tabs/fill)
<i>risperidone 4 mg tablet</i> (Risperdal)	T1	QL (60 tabs/fill)
SECUADO	T4	QL (30 patches/fill)

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

T5 – Brand Specialty
PA – Prior Authorization
QL – Quantity Limit

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

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

List of Prescription Medications

PSYCHOTHERAPEUTIC DRUGS (Schizophrenia/Anti-Psychotics) ⁹		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ANTIPSYCHOTIC, ATYPICAL, DOPAMINE, SEROTONIN ANTAGNST (cont.)		
VERSACLOZ	T4	
ziprasidone hcl (Geodon)	T2	QL (60 caps/fill)
ZYPREXA (olanzapine)	T4	QL (30 tabs/fill)
ZYPREXA ZYDIS (olanzapine)	T4	QL (30 tabs/fill)
ANTIPSYCHOTIC-ATYPICAL, D3/D2 PARTIAL AG-5HT MIXED		
VRAYLAR	T4	QL (30 caps/fill)
ANTIPSYCHOTICS, ATYP, D2 PARTIAL AGONIST/5HT MIXED		
ABILIFY ASIMTUFI	T4	
ABILIFY MYCITE	T4	QL (30 tabs/fill)
aripiprazole	T2	QL (60 tabs/fill)
aripiprazole 1 mg/ml solution	T2	
aripiprazole 2 mg tablet (Abilify)	T1	QL (30 tabs/fill)
aripiprazole 10 mg tablet (Abilify)	T1	QL (30 tabs/fill)
aripiprazole 20 mg tablet (Abilify)	T1	QL (30 tabs/fill)
aripiprazole 30 mg tablet (Abilify)	T1	QL (30 tabs/fill)
REXULTI	T4	QL (30 tabs/fill)
ANTIPSYCHOTICS, DOPAMINE AND SEROTONIN ANTAGONISTS		
loxapine succinate	T2	
ANTIPSYCHOTICS, DOPAMINE ANTAGONISTS, THIOXANTHENES		
thiothixene	T2	
ANTIPSYCHOTICS, DOPAMINE ANTAGONISTS, BUTYROPHENONES		
haloperidol	T1	
haloperidol lactate	T2	
ANTIPSYCHOTICS, DOPAMINE ANTAGONST, DIHYDROINDOLONES		
molindone hcl	T2	
ANTIPSYCHOTICS, PHENOTHIAZINES		
chlorpromazine hcl	T2	
fluphenazine hcl	T2	
perphenazine	T2	
thioridazine hcl	T2	
trifluoperazine hcl	T2	
SSRI-ANTIPSYCH, ATYPICAL, DOPAMINE, SEROTONIN ANTAG		
olanzapine/fluoxetine hcl	T2	

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

T5 – Brand Specialty
PA – Prior Authorization
QL – Quantity Limit

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

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

List of Prescription Medications

PSYCHOTHERAPEUTIC DRUGS (Seizure Disorders)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
NEUROACTIVE STEROID GABA-A RECEPTOR MODULATOR		
ZTALMY	T5	PA SP
PSYCHOTHERAPEUTIC DRUGS (Sleep Disorders/Sedatives)		
NARCOLEPSY AND SLEEP DISORDER THERAPY AGENTS		
armodafinil (Nuvigil)	T2	PA QL (30 tabs/fill)
modafinil 100 mg tablet (Provigil)	T2	PA QL (30 tabs/fill)
SUNOSI	T3	PA QL (30 tabs/fill)
SEDATIVE/HYPNOTICS (Sleep Disorders/Sedatives)		
ANTI-NARCOLEPSY, ANTI-CATAPLEXY, SEDATIVE-TYPE AGENT		
LUMRYZ STARTER PACK	T5	PA SP HD
LUMRYZ ER	T5	PA QL (30 packets/30 days) SP HD
SODIUM OXYBATE	T5	PA QL (540ml/30 days) SP HD
XYREM	T5	PA QL (540 mls/fill) SP HD
XYWAV	T5	PA QL (540 mls/fill) SP HD
BARBITURATES		
phenobarbital	T2	
HYPNOTICS, MELATONIN MT1/MT2 RECEPTOR AGONISTS		
HETLIOZ	T5	PA QL (30 caps/fill) SP HD
HETLIOZ LQ	T5	PA QL (158 mls/fill) SP HD
ramelteon (Rozerem)	T2	QL (30 tabs/fill)
SEDATIVE-HYPNOTICS - BENZODIAZEPINES		
estazolam	T2	QL (15 tabs/fill)
flurazepam hcl	T2	QL (15 caps/fill)
HALCION (triazolam)	T4	QL (15 tabs/fill)
midazolam hcl	T2	
RESTORIL (temazepam)	T4	QL (15 caps/fill)
temazepam (Restoril)	T2	QL (15 caps/fill)
triazolam	T2	QL (15 tabs/fill)
triazolam (Halcion)	T2	QL (15 tabs/fill)
SEDATIVE-HYPNOTICS, NON-BARBITURATE		
BELSOMRA	T4	ST QL (30 tabs/fill)
DAYVIGO	T4	ST QL (30 tabs/fill)
doxepin hcl 3 mg tablet (Silenor)	T2	ST QL (30 tabs/fill)
doxepin hcl 6 mg tablet (Silenor)	T2	ST QL (30 tabs/fill)

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

T5 – Brand Specialty
PA – Prior Authorization
QL – Quantity Limit

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

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

List of Prescription Medications

SEDATIVE/HYPNOTICS (Sleep Disorders/Sedatives) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
SEDATIVE-HYPNOTICS, NON-BARBITURATE (cont.)		
EDLUAR	T4	ST QL (30 tabs/fill)
<i>eszopiclone (Lunesta)</i>	T2	QL (30 tabs/fill)
IGALMI	T4	
MKO (MIDAZOLAM-KETAMINE-ONDAN)	T4	
QUVIVIQ	T4	ST QL (30 tabs/fill)
SILENOR (<i>doxepin hcl</i>)	T4	ST QL (30 tabs/fill)
<i>zaleplon 10 mg capsule</i>	T2	QL (60 caps/fill)
<i>zaleplon 5 mg capsule</i>	T2	QL (30 caps/fill)
<i>zolpidem tartrate</i>	T2	QL (30 tabs/fill)
<i>zolpidem tartrate (Ambien Cr)</i>	T2	QL (30 tabs/fill)
<i>zolpidem tartrate (Ambien)</i>	T2	QL (30 tabs/fill)
ZOLPIMIST	T4	ST QL (1 canister/30 days)
SKIN PREPS (Miscellaneous)		
ANTISEPTICS, GENERAL		
ADVOCATE ALCOHOL 70% PREP PADS	T3	
ALCOHOL 70% PREP PADS	T3	
<i>alcohol 70% swabs</i>	T2	
ALCOHOL 70% SWABS	T3	
ALCOHOL 70% WIPES	T3	
<i>alcohol antiseptic pads</i>	T2	
<i>alcohol prep pads</i>	T2	
<i>alcohol swab</i>	T2	
<i>alcohol swabs</i>	T2	
CARETOUCH ALCOHOL PREP PAD	T3	
CURITY ALCOHOL PREPS	T3	
CVS ALCOHOL 70% PREP PADS	T3	
<i>cvs isopropyl alcohol 70% wipe</i>	T2	
DROPSAFE PREP PADS	T3	
EASY COMFORT ALCOHOL PAD	T3	
EASY TOUCH ALCOHOL PREP PADS	T3	
<i>fifty50 alcohol prep pads</i>	T2	
GNP ALCOHOL SWAB	T3	
GS ALCOHOL 70% SWABS	T3	

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

T5 – Brand Specialty
PA – Prior Authorization
QL – Quantity Limit

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

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

List of Prescription Medications

SKIN PREPS (Miscellaneous) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ANTISEPTICS, GENERAL (cont.)		
HM ALCOHOL 70% PREP PADS	T3	
INCONTROL ALCOHOL PADS	T3	
<i>pharm choice alcohol prep pads</i>	T2	
PHARM CHOICE ALCOHOL PREP PADS	T3	
PRO COMFORT ALCOHOL PADS	T3	
PURE COMFORT ALCOHOL PAD	T3	
<i>ra alcohol swabs</i>	T2	
RA ISOPROPYL ALCOHOL 70% WIPES	T3	
RELION ALCOHOL 70% SWABS	T3	
SAPS ALCOHOL 70% PREP PADS	T3	
SINGLE USE SWAB	T3	
SURE COMFORT ALCOHOL	T3	
SURE-PREP ALCOHOL PREP PADS	T3	
SWI ALCOHOL 70% PREP PADS	T3	
TRUE COMFORT ALCOHOL PADS	T3	
TRUE COMFORT PRO ALCOHOL PADS	T3	
ULTILET ALCOHOL SWAB	T3	
WEBCOL	T3	
IRRIGANTS		
<i>acetic acid</i>	T2	
<i>neomycin sulf/polymyxin b sulf</i>	T2	
PHYSIOLYTE (<i>physiological irrig soln no. 1</i>)	T4	
PHYSIOSOL (<i>physiological irrig soln no. 1</i>)	T4	
<i>ringer's solution</i>	T2	
<i>ringer's solution, lactated</i>	T2	
<i>sod, pot chlor/mag/sod, pot phos</i>	T2	
<i>sodium chloride 0.9% irrig</i>	T2	
<i>sodium chloride 0.9% irrig.</i>	T2	
<i>sodium chloride 0.9% prcss sol</i>	T2	
SODIUM CHLORIDE 0.9% IRRIG.	T4	
<i>sodium chloride irrig solution</i>	T2	
SORBITOL	T4	
SORBITOL-MANNITOL	T4	
<i>water for irrigation, sterile</i>	T2	

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

T5 – Brand Specialty
PA – Prior Authorization
QL – Quantity Limit

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

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

List of Prescription Medications

SKIN PREPS (Miscellaneous) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
OXIDIZING AGENTS		
<i>hydrogen peroxide</i>	T2	
PRESERVATIVES		
<i>formaldehyde</i>	T2	
SKIN PREPS (Pain Relief And Inflammatory Disease)		
ANTIPSORIATIC AGENTS, SYSTEMIC		
<i>acitretin</i>	T2	
<i>methoxsalen</i>	T2	
SKYRIZI	T5	PA QL (150mg/84 days) SP HD
SKYRIZI (2 SYRINGES) KIT	T5	PA QL (150mg/84 days) SP HD
SKYRIZI PEN	T5	PA QL (150mg/84 days) SP HD
SOTYKTU	T5	PA QL (30 tabs/30 days) SP HD
SPEVIGO	T5	PA SP HD
TALTZ AUTOINJECTOR	T5	PA QL (1 ml/28 days) SP HD
TALTZ AUTOINJECTOR (2 PACK)	T5	PA QL (1 ml/28 days) SP HD
TALTZ AUTOINJECTOR (3 PACK)	T5	PA QL (1 ml/28 days) SP HD
TALTZ 20 MG/0.25 ML SYRINGE	T5	PA QL (1 syringe/28 days) SP HD
TALTZ 40 MG/0.5 ML SYRINGE	T5	PA QL (1 syringe/28 days) SP HD
TALTZ 80 MG/ML SYRINGE	T5	PA QL (1 ml/28 days) SP HD
TOPICAL ANTI-INFLAMMATORY, NSAIDS		
<i>diclofenac sodium 1% gel</i>	T2	QL (500 gms/28 days) HD
FLECTOR	T3	ST QL (60 patches/fill) HD
LICART	T3	ST QL (30 patches/fill) HD
SKIN PREPS (Skin Conditions)		
ACNE AGENTS, SYSTEMIC		
ABSORICA (isotretinoin)	T4	ST
<i>isotretinoin</i> (Absorica)	T2	
ACZONE (<i>dapsone</i>)	T4	ST
<i>adapalene/benzoyl peroxide</i>	T2	
<i>adapalene/benzoyl peroxide</i> (Epiduo Forte)	T2	
AZELEX	T4	ST
<i>clindamycin phos/benzoyl perox</i>	T2	
<i>clindamycin phos/benzoyl perox</i> (Acanya)	T2	
<i>clindamycin/tretinoin</i> (Ziana)	T2	PA

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

T5 – Brand Specialty
PA – Prior Authorization
QL – Quantity Limit

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

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

List of Prescription Medications

SKIN PREPS (Skin Conditions) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ACNE AGENTS, SYSTEMIC (cont.)		
<i>dapsone</i> (Aczone)	T2	
EPIDUO FORTE	T4	ST
EPIDUO FORTE (<i>adapalene/benzoyl peroxide</i>)	T4	ST
KLARON (<i>sulfacetamide sodium</i>)	T4	ST
NEUAC 1.2-5% KIT	T4	ST
<i>neuac gel</i>	T2	
ONEXTON	T3	ST
<i>sulfacetamide sodium</i> (Klaron)	T2	
ACNE AGENTS, TOPICAL		
<i>clindamycin/tretinoin</i> (Veltin)	T2	
<i>dapsone 5% gel</i> (Aczone)	T2	PA SP HD
<i>dapsone 7.5% gel pump</i> (Aczone)	T2	PA SP HD
ONEXTON (<i>clindamycin phos/benzoyl perox</i>)	T4	ST
ANTIPRURITICS, TOPICAL		
ZONALON	T4	ST QL (90 gms/30 days)
ZONALON (<i>doxepin hcl</i>)	T4	ST QL (90 gms/30 days)
ANTIPSORIATICS AGENTS		
<i>calcipotriene 0.005% cream</i> (Dovonex)	T2	QL (120 gms/30 days)
<i>calcipotriene 0.005% ointment, solution</i>	T2	QL (120 gms/30 days)
<i>calcitriol 3 mcg/g ointment</i> (Vectical)	T2	
DOVONEX (<i>calcipotriene</i>)	T4	ST QL (120 gms/30 days)
DUOBRII	T4	ST QL (200 gms/30 days)
<i>tazarotene 0.05% gel</i> (Tazorac)	T2	PA
<i>tazarotene 0.05% cream</i> (Tazorac)	T2	PA
<i>tazarotene 0.1% cream</i> (Tazorac)	T2	PA
<i>tazarotene 0.1% gel</i> (Tazorac)	T2	PA
TWYNEO	T4	PA ST
VECTICAL (<i>calcitriol</i>)	T4	
VTAMA	T3	PA QL (60 gms/28 days)
ZIANA (<i>clindamycin/tretinoin</i>)	T4	PA ST
ZORYVE 0.3% CREAM	T4	PA QL (60 gms/30 days)
ANTISEBORRHEIC AGENTS		
ESKATA	T4	
OVACE (<i>sulfacetamide sodium</i>)	T4	

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

T5 – Brand Specialty
PA – Prior Authorization
QL – Quantity Limit

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

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

List of Prescription Medications

SKIN PREPS (Skin Conditions) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ANTISEBORRHEIC AGENTS (cont.)		
OVACE PLUS	T4	
OVACE PLUS WASH	T4	
PLEXION NS	T4	
<i>selenium sulfide</i>	T2	
<i>sod sulfacetam 10% clnsng gel</i>	T2	
<i>sod sulfacetamide 10% shampoo</i>	T2	
<i>sod sulfacetamide 9.8% shampoo</i>	T2	
SODIUM SULFACETAMIDE 10% WASH	T4	
<i>sodium sulfacetamide 10% wash (Ovace)</i>	T2	
ANTISEPTICS, GENERAL		
ADVOCATE ALCOHOL 70% PREP PADS	T3	
ALCOHOL 70% PREP PADS	T3	
<i>alcohol 70% swabs</i>	T2	
ALCOHOL 70% WIPES	T3	
<i>alcohol antiseptic pads</i>	T2	
<i>alcohol prep pads</i>	T2	
<i>alcohol swabs</i>	T2	
CARETOUCH ALCOHOL PREP PAD	T3	
CURITY ALCOHOL PREPS	T3	
CVS ALCOHOL 70% PREP PADS	T3	
<i>cvs isopropyl alcohol 70% wipe</i>	T2	
DROPSAFE PREP PADS	T3	
EASY COMFORT ALCOHOL PAD	T3	
EASY TOUCH ALCOHOL PREP PADS	T3	
<i>fifty50 alcohol prep pads</i>	T2	
GS ALCOHOL 70% SWABS	T3	
HM ALCOHOL 70% PREP PADS	T3	
INCONTROL ALCOHOL PADS	T3	
PHARM CHOICE ALCOHOL PREP PADS	T3	
<i>pharm choice alcohol prep pads</i>	T2	
PRO COMFORT ALCOHOL PADS	T3	
PURE COMFORT ALCOHOL PAD	T3	
<i>ra alcohol swabs</i>	T2	
RA ISOPROPYL ALCOHOL 70% WIPES	T3	

T1 – Preferred Generics

T2 – Non-Preferred Generics

T3 – Preferred Brands

T4 – Non-Preferred Brands

T5 – Brand Specialty

PA – Prior Authorization

QL – Quantity Limit

ST – Step Therapy

AGE – Age Requirement

SP – Specialty Medication

HD – May require home delivery pharmacy

PPACA – No Cost-Share Preventive Medication

CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

SKIN PREPS (Skin Conditions) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ANTISEPTICS, GENERAL (cont.)		
RELION ALCOHOL 70% SWABS	T3	
SAPS ALCOHOL 70% PREP PADS	T3	
SINGLE USE SWAB	T3	
<i>sm alcohol prep pads</i>	T2	
SURE COMFORT ALCOHOL	T3	
SURE-PREP ALCOHOL PREP PADS	T3	
TRUE COMFORT ALCOHOL PADS	T3	
TRUE COMFORT PRO ALCOHOL PADS	T3	
ULTILET ALCOHOL SWAB	T3	
<i>v-r alcohol prep pads</i>	T2	
WEBCOL	T3	
ANTISEPTICS, MISCELLANEOUS		
GUAIACOL	T3	
IMMUNOMODULATORS		
<i>imiquimod</i>	T2	
<i>imiquimod (Zyclara)</i>	T2	
IRRITANTS/COUNTER-IRRITANTS		
CANTHARIDIN-ACETONE	T4	
<i>methyl salicylate</i>	T2	
YCANTH	T5	SP
JANUS KINASE (JAK) INHIBITORS		
CIBINQO	T5	PA QL (30 tabs/30 days) SP
KERATOLYTIC-GLUCOCORTICOID COMBINATIONS		
VANOXIDE-HC	T4	ST
KERATOLYTICS		
<i>benzepro 6% foaming cloths</i>	T2	
BENZEPRO 7% CREAMY WASH (<i>benzoyl peroxide microspheres</i>)	T4	ST
<i>benzoyl peroxide</i>	T2	
<i>benzoyl peroxide (Pacnex)</i>	T2	
ENZOCLEAR	T4	ST
INOVA	T4	ST
INOVA 4-1	T4	ST
INOVA 8-2	T4	ST
PACNEX (<i>benzoyl peroxide</i>)	T4	ST

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

T5 – Brand Specialty
PA – Prior Authorization
QL – Quantity Limit

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

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

List of Prescription Medications

SKIN PREPS (Skin Conditions) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
KERATOLYTICS (cont.)		
<i>podofilox 0.5% gel</i> (Condylox)	T2	ST QL (7 gms/30 days)
<i>podofilox 0.5% topical soln</i>	T2	
PR BENZOYL PEROXIDE (<i>benzoyl peroxide microspheres</i>)	T4	ST
PROTECTIVES		
PHARMABASE BARRIER (<i>zinc oxide</i>)	T4	
<i>zinc oxide 20% ointment</i>	T2	
ZINC OXIDE PASTE	T3	
ROSACEA AGENTS, TOPICAL		
<i>azelaic acid</i> (Finacea)	T2	
EPSOLAY	T4	ST
FINACEA 15% FOAM	T3	ST
FINACEA 15% GEL (<i>azelaic acid</i>)	T4	ST
<i>ivermectin 1% cream</i> (Soolantra)	T2	QL (45 gms/30 days)
METROCREAM (<i>metronidazole</i>)	T4	ST
METROGEL (<i>metronidazole</i>)	T4	ST
<i>metronidazole 0.75% cream</i> (Metrocream)	T2	
<i>metronidazole top 1% gel pump</i>	T2	
<i>metronidazole topical 0.75% gl</i>	T2	
<i>metronidazole topical 1% gel</i> (Metrogel)	T2	
<i>metronidazole 0.75% lotion</i>	T2	
MIRVASO	T3	PA
RHOFADE	T4	PA
<i>rosadan 0.75% cream</i> (Metrocream)	T2	
ROSADAN 0.75% CREAM KIT	T4	ST
<i>rosadan 0.75% gel</i>	T2	
ROSADAN 0.75% GEL KIT	T4	ST
SOOLANTRA (<i>ivermectin</i>)	T4	ST QL (60 gms/30 days)
TISSUE/WOUND ADHESIVES		
ARTISS	T4	
SURGISEAL STYLUS	T4	
SURGISEAL TEARDROP	T4	
SURGISEAL TWIST	T4	
TISSEEL VHSD	T4	

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

T5 – Brand Specialty
PA – Prior Authorization
QL – Quantity Limit

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

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

List of Prescription Medications

SKIN PREPS (Skin Conditions) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
TOP. ANTI-INFLAM., PHOSPHODIESTERASE-4 (PDE4) INHIB		
EUCRISA	T3	ST QL (120 gms/30 days)
ZORYVE 0.15% CREAM	T3	ST QL (60 gms/30 days)
ZORYVE 0.3% FOAM	T4	ST QL (60 gms/30 days)
TOPICAL ACNE AGENT,RETINOIC ACID RECEPTOR AGONIST		
AKLIEF	T4	PA ST
ARAZLO	T4	PA
TOPICAL AGENTS, MISCELLANEOUS		
L-MESITRAN SOFT	T4	
MEDIHONEY	T4	
<i>trichloroacetic acid</i>	T2	
TRICHLOROACETIC ACID 100% (<i>trichloroacetic acid</i>)	T4	
TRICHLOROACETIC ACID 20% (<i>trichloroacetic acid</i>)	T3	
TRICHLOROACETIC ACID 25%	T4	
TRICHLOROACETIC ACID 30%	T3	
TRICHLOROACETIC ACID 35%	T3	
TRICHLOROACETIC ACID 40%	T3	
TRICHLOROACETIC ACID 50%	T3	
TRICHLOROACETIC ACID 75%	T4	
TRICHLOROACETIC ACID 80%	T3	
TRICHLOROACETIC ACID 85%	T3	
TRICHLOROACETIC ACID 90%	T3	
TOPICAL ANTIBIOTIC PLEUROMUTILIN DERIVATIVES		
ALTABAX	T4	ST QL (30 gms/fill)
TOPICAL ANTI-INFLAMMATORY STEROIDAL		
ALA-SCALP (<i>hydrocortisone</i>)	T4	ST
<i>alclometasone dipropionate</i>	T2	
<i>amcinonide</i>	T2	ST
<i>betamethasone dipropionate</i>	T2	
<i>betamethasone va 0.1% cream</i>	T2	
<i>betamethasone va 0.1% lotion</i>	T2	
<i>betamethasone valer 0.1% ointm</i>	T2	
<i>betamethasone valer 0.12% foam</i>	T2	ST
<i>betamethasone/propylene glyc</i>	T2	
<i>betamethasone/propylene glyc (Diprolene)</i>	T2	

T1 – Preferred Generics

T2 – Non-Preferred Generics

T3 – Preferred Brands

T4 – Non-Preferred Brands

T5 – Brand Specialty

PA – Prior Authorization

QL – Quantity Limit

ST – Step Therapy

AGE – Age Requirement

SP – Specialty Medication

HD – May require home delivery pharmacy

PPACA – No Cost-Share Preventive Medication

CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

SKIN PREPS (Skin Conditions) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
TOPICAL ANTI-INFLAMMATORY STEROIDAL (cont.)		
BRYHALI	T4	ST
CAPEX SHAMPOO	T4	ST
<i>clobetasol 0.05% cream</i>	T2	QL (120 gms/30 days)
<i>clobetasol 0.05% gel</i>	T2	QL (120 gms/30 days)
<i>clobetasol 0.05% ointment (Temovate)</i>	T2	QL (120 gms/30 days)
<i>clobetasol 0.05% shampoo (Clobex)</i>	T2	ST QL (236 mls/30 days)
<i>clobetasol 0.05% solution</i>	T2	QL (100 mls/30 days)
<i>clobetasol 0.05% topical lotn</i>	T2	ST QL (118 mls/30 days)
<i>clobetasol emollient 0.05% crm</i>	T2	QL (120 gms/30 days)
<i>clobetasol emollnt 0.05% foam</i>	T2	ST QL (100 gms/30 days)
<i>clobetasol prop 0.05% foam (Olux)</i>	T2	ST QL (100 gms/30 days)
<i>clobetasol prop 0.05% spray (Clobex)</i>	T2	ST QL (125 mls/30 days)
<i>clobetasol propionate/emoll</i>	T2	ST QL (100 gms/30 days)
CLOBEX 0.05% SHAMPOO (<i>clobetasol propionate</i>)	T4	ST QL (236 mls/30 days)
CLOBEX 0.05% SPRAY (<i>clobetasol propionate</i>)	T4	ST QL (125 mls/30 days)
CLODAN 0.05% KIT	T4	ST QL (2 kits/28 days)
<i>clodan 0.05% shampoo (Clobex)</i>	T2	ST QL (236 mls/30 days)
CLODERM	T4	ST
CLODERM (<i>clocortolone pivalate</i>)	T4	ST
CORDRAN 0.025% CREAM	T4	ST QL (120 gms/30 days)
CORDRAN 0.05% CREAM (<i>flurandrenolide</i>)	T4	ST QL (120 gms/30 days)
CORDRAN 0.05% LOTION (<i>flurandrenolide</i>)	T4	ST QL (120 mls/30 days)
CORDRAN 0.05% OINTMENT (<i>flurandrenolide</i>)	T4	ST QL (120 gms/30 days)
CORDRAN 4 MCG/SQ CM TAPE LARGE	T4	ST
DERMA-SMOOTHIE-FS (<i>fluocinolone acetonide</i>)	T4	ST
DERMA-SMOOTHIE-FS (<i>fluocinolone/shower cap</i>)	T4	ST
DERMASORB HC	T4	ST
DERMASORB TA	T4	ST
DERMATOP (<i>prednicarbate</i>)	T4	ST
DESONATE (<i>desonide</i>)	T4	ST
<i>desonide (Desonate)</i>	T2	ST
<i>desonide 0.05% cream (Tridesilon)</i>	T2	
<i>desonide 0.05% gel (Desonate)</i>	T2	ST
<i>desonide 0.05% lotion</i>	T2	ST

T1 – Preferred Generics

T2 – Non-Preferred Generics

T3 – Preferred Brands

T4 – Non-Preferred Brands

T5 – Brand Specialty

PA – Prior Authorization

QL – Quantity Limit

ST – Step Therapy

AGE – Age Requirement

SP – Specialty Medication

HD – May require home delivery pharmacy

PPACA – No Cost-Share Preventive Medication

CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

SKIN PREPS (Skin Conditions) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
TOPICAL ANTI-INFLAMMATORY STEROIDAL (cont.)		
<i>desonide 0.05% ointment</i>	T2	
<i>desoximetasone (Topicort)</i>	T2	ST
<i>DIPROLENE (betamethasone/propylene glyc)</i>	T4	ST
<i>fluocinolone acetonide</i>	T2	
<i>fluocinolone acetonide (Derma-Smoothie-Fs)</i>	T2	
<i>fluocinolone acetonide (Synalar)</i>	T2	
<i>fluocinolone/shower cap (Derma-Smoothie-Fs)</i>	T2	
<i>fluocinonide 0.05% cream</i>	T2	QL (120 gms/30 days)
<i>fluocinonide 0.05% gel</i>	T2	QL (120 gms/30 days)
<i>fluocinonide 0.05% ointment</i>	T2	QL (120 gms/30 days)
<i>fluocinonide 0.05% solution</i>	T2	QL (120 gms/30 days)
<i>fluocinonide 0.1% cream (Vanos)</i>	T2	ST QL (120 gms/30 days)
<i>fluocinonide/emollient base</i>	T2	QL (120 gms/30 days)
<i>fluticasone prop 0.005% oint</i>	T2	
<i>fluticasone prop 0.05% cream</i>	T2	
<i>fluticasone prop 0.05% lotion</i>	T2	ST
<i>fluticasone propionate</i>	T2	ST
<i>halobetasol propionate</i>	T2	ST
<i>halobetasol prop 0.05% cream (Ultravate)</i>	T2	
<i>halobetasol prop 0.05% ointmnt (Ultravate)</i>	T2	
<i>halobetasol prop 0.05% cream</i>	T2	
<i>halobetasol prop 0.05% foam</i>	T2	ST
<i>halobetasol prop 0.05% ointmnt</i>	T2	
HALOG	T4	ST
<i>HALOG (halcinonide)</i>	T4	ST
<i>hydrocort buty 0.1% lipo cream (Locoid Lipocream)</i>	T2	QL (120 gms/30 days)
<i>hydrocort/min oil/petrolat,wht</i>	T2	
<i>hydrocortisone</i>	T2	
<i>hydrocortisone acetate</i>	T2	
<i>hydrocortisone (Ala-Scalp)</i>	T2	
<i>hydrocortisone (Anusol-Hc)</i>	T2	
<i>hydrocortisone buty 0.1% cream</i>	T2	QL (120 gms/30 days)
<i>hydrocortisone butyr 0.1% lotn</i>	T2	PA SP HD
<i>hydrocortisone butyr 0.1% oint</i>	T2	ST QL (10gm/28 days)

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

T5 – Brand Specialty
PA – Prior Authorization
QL – Quantity Limit

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

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

List of Prescription Medications

SKIN PREPS (Skin Conditions) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
TOPICAL ANTI-INFLAMMATORY STEROIDAL (cont.)		
<i>hydrocortisone butyr 0.1% soln</i>	T2	ST QL (120 mls/30 days)
<i>hydrocortisone valerate</i>	T2	
IMPEKLO	T4	ST QL (136 gms/28 days)
KENALOG 0.147 MG/GRAM SPRAY (<i>triamcinolone acetonide</i>)	T4	ST QL (100 gms/30 days)
KENALOG 0.147 MG/GRAM SPRAY (<i>triamcinolone acetonide</i>)	T4	ST QL (126 gms/30 days)
<i>mometasone furoate 0.1% cream, oint, soln</i>	T2	
NUCORT	T4	ST
OLUX (<i>clobetasol propionate</i>)	T4	ST QL (100 gms/30 days)
PANDEL	T4	ST
<i>prednicarbate</i>	T2	
<i>prednicarbate</i> (Dermatop)	T2	
SCALACORT DK	T4	ST
SYNALAR	T4	ST
SYNALAR (<i>fluocinolone acetonide</i>)	T4	ST
SYNALARTS	T4	ST
TEMOVATE (<i>clobetasol propionate</i>)	T4	ST QL (120 gms/30 days)
TEXACORT	T4	ST
TOPICORT 0.05% CREAM (<i>desoximetasone</i>)	T4	ST
TOPICORT 0.05% GEL (<i>desoximetasone</i>)	T4	ST
TOPICORT 0.05% OINTMENT (<i>desoximetasone</i>)	T4	ST
TOPICORT 0.25% CREAM (<i>desoximetasone</i>)	T4	ST
TOPICORT 0.25% OINTMENT (<i>desoximetasone</i>)	T4	ST
<i>triamcinolone 0.025% cream, lotion, oint</i>	T2	
<i>triamcinolone 0.05% ointment</i>	T2	ST
<i>triamcinolone 0.1% cream, lotion, ointment</i>	T2	
<i>triamcinolone 0.147 mg/g spray</i> (Kenalog)	T2	ST QL (126 gms/30 days)
<i>triamcinolone 0.147 mg/g spray</i> (Kenalog)	T2	ST QL (100 gms/30 days)
<i>triamcinolone 0.5% cream, ointment</i>	T2	
<i>triamcinolone acetonide</i>	T2	ST
<i>triderm 0.1% cream</i>	T2	
<i>triderm 0.5% cream</i>	T2	ST
TRIDESILON (<i>desonide</i>)	T4	ST
ULTRAVATE X	T4	ST

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

T5 – Brand Specialty
PA – Prior Authorization
QL – Quantity Limit

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

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

List of Prescription Medications

SKIN PREPS (Skin Conditions) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
TOPICAL ANTI-INFLAMMATORY STEROID-LOCAL ANESTHETIC		
ANALPRAM HC 2.5%-1% LOTION	T4	ST
EPIFOAM	T4	ST
hydrocort-pramoxine 2.5-1% cm	T2	ST
lidocaine/hydrocortisone ac	T2	
lidocaine-hc 3-0.5% cream	T2	
PRAMOSONE	T4	ST
TOPICAL ANTIPARASITICS		
lindane	T2	
malathion (Ovide)	T2	
OVIDE (malathion)	T4	
TOPICAL JANUS KINASE (JAK) INHIBITORS		
OPZELURA	T4	PA QL (240 gms/28 days)
TOPICAL PREPARATIONS, ANTIBACTERIALS		
iodine/potassium iodide	T2	
iodine/sodium iodide	T2	
IODOFLEX	T4	
IODOSORB	T4	
NORMLGEL AG	T4	
TOPICAL VIT D ANALOG/ANTI-INFLAMMATORY STEROID		
calcipotriene/betamethasone (Taclonex)	T2	ST QL (60 gms/30 days)
calcipotriene/betamethasone (Taclonex)	T2	QL (60 gms/30 days)
ENSTILAR	T3	ST QL (60 gms/30 days)
WYNZORA	T4	ST QL (60 gms/30 days)
TOPICAL/MUCOUS MEMBR./SUBCUT. ENZYMES		
SANTYL	T3	QL (180 gms/fill)
VITAMIN A DERIVATIVES		
adapalene 0.1% cream (Differin)	T2	
ADAPALENE 0.1% LOTION	T4	ST
adapalene 0.1% solution	T2	
adapalene 0.1% swab	T2	ST
adapalene 0.3% gel	T2	
adapalene 0.3% gel pump (Differin)	T2	
ALTRENO	T4	PA
avita 0.025% cream (Retin-A)	T2	PA

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

T5 – Brand Specialty
PA – Prior Authorization
QL – Quantity Limit

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

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

List of Prescription Medications

SKIN PREPS (Skin Conditions) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
VITAMIN A DERIVATIVES (cont.)		
AVITA 0.025% GEL	T4	PA
DIFFERIN	T4	ST
DIFFERIN (<i>adapalene</i>)	T4	ST
RETIN-A (<i>tretinoin</i>)	T4	PA
RETIN-A MICRO PUMP 0.06% GEL	T4	PA
RETIN-A MICRO PUMP 0.08% GEL	T4	PA
<i>tretinoin 0.01% gel</i> (Retin-A)	T2	PA
<i>tretinoin 0.025% cream</i> (Retin-A)	T2	PA
<i>tretinoin 0.025% gel</i> (Retin-A)	T2	PA
<i>tretinoin 0.05% cream</i> (Retin-A)	T2	PA
<i>tretinoin 0.05% gel</i> (Atralin)	T2	PA
<i>tretinoin 0.1% cream</i> (Retin-A)	T2	PA
<i>tretinoin microspheres</i> (Retin-A Micro Pump)	T2	PA
<i>tretinoin microspheres</i> (Retin-A Micro)	T2	PA
SMOKING DETERRENTS (Smoking Cessation)		
SMOKING DETERRENT AGENTS (GANGLIONIC STIM, OTHERS)		
NICOTROL	T4	QL (180 ds/365 days) PPACA
NICOTROL NS	T4	QL (180 ds/365 days) PPACA
SMOKING DETERRENT-NICOTINIC RECEPT.PARTIAL AGONIST		
APO-VARENICLINE 0.5 MG TABLET	T3	QL (180 ds/365 days) PPACA
APO-VARENICLINE 1 MG TABLET	T3	QL (180 ds/365 days) PPACA
CHANTIX	T4	QL (180 ds/365 days) PPACA
<i>varenicline starting month box</i>	T2	
SMOKING DETERRENTS, OTHER		
<i>bupropion hcl sr 150 mg tablet</i>	T2	QL (180 ds/365 days) PPACA
THYROID PREPS (Hormonal Agents)		
ANTITHYROID PREPARATIONS		
<i>methimazole</i>	T1	HD
<i>propylthiouracil</i>	T2	HD
THYROID HORMONES		
<i>adthyza 15 mg tablet</i>	T2	HD
<i>adthyza 30 mg, 60 mg tablet</i>	T2	HD
<i>adthyza 90 mg tablet</i>	T2	HD

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

T5 – Brand Specialty
PA – Prior Authorization
QL – Quantity Limit

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

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

List of Prescription Medications

THYROID PREPS (Hormonal Agents) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
THYROID HORMONES (cont.)		
<i>adthyza 120 mg tablet</i>	T2	HD
ARMOUR THYROID	T3	HD
ERMEZA	T4	ST HD
<i>levothyroxine sodium (Synthroid)</i>	T1	HD
<i>liothyronine sodium (Cytomel)</i>	T2	HD
<i>thyroid, pork</i>	T2	HD
UNCLASSIFIED DRUG PRODUCTS (AIDS/HIV)		
CYTOCHROME P450 INHIBITORS		
TYBOST	T5	SP
UNCLASSIFIED DRUG PRODUCTS (Asthma/COPD/Respiratory)		
CYSTIC FIBROSIS - INHALED OSMOTIC AGENTS		
BRONCHITOL	T5	PA SP HD
CYSTIC FIBROSIS-CFTR POTENTIATOR-CORRECTOR COMBIN.		
ALYFTREK 10-50-125 MG TABLET	T5	PA QL (56 tabs/fill) SP HD
ALYFTREK 4-20-50 MG TABLET	T5	PA QL (84 tabs/fill) SP HD
ORKAMBI 75-94 MG GRANULE PKT	T5	PA QL (56 packs/fill) SP HD
ORKAMBI 100-125 MG GRANULE PKT	T5	PA QL (56 packs/fill) SP HD
ORKAMBI 150-188 MG GRANULE PKT	T5	PA QL (56 packs/fill) SP HD
ORKAMBI 100 MG-125 MG TABLET	T5	PA QL (112 tabs/fill) SP HD
ORKAMBI 200 MG-125 MG TABLET	T5	PA QL (112 tabs/fill) SP HD
SYMDEKO	T5	PA QL (56 tabs/fill) SP HD
TRIKAFTA	T5	PA QL (84 tabs/fill) SP HD
TRIKAFTA GRANULE PKT	T5	PA QL (84 pkts/fill) SP HD
CYSTIC FIB-TRANSMEMB CONDUCT.REG.(CFTR) POTENTIATOR		
KALYDECO 5.8 MG GRANULES PKT	T5	PA QL (56 packs/fill) SP HD
KALYDECO GRANULES PACKET	T5	PA QL (56 packs/fill) SP HD
KALYDECO 150 MG TABLET	T5	PA QL (56 tabs/fill) SP HD
DIPEPTIDYL PEPTIDASE I (DPPI) INHIBITOR		
BRINSUPRI	T5	PA SP
LUNG SURFACTANTS		
CUROSURF	T4	
INFASURF	T4	
SURVANTA	T4	

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

T5 – Brand Specialty
PA – Prior Authorization
QL – Quantity Limit

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

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

List of Prescription Medications

UNCLASSIFIED DRUG PRODUCTS (Asthma/COPD/Respiratory) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
MUCOLYTICS		
PULMOZYME	T5	PA SP HD
PULMONARY FIBROSIS - SYSTEMIC ENZYME INHIBITORS		
OFEV	T5	PA QL (60 caps/fill) SP HD
SYSTEMIC ENZYME INHIBITORS		
JOENJA 70 MG TABLET	T5	PA QL (60 tabs/30 days) SP
VIJOICE 50 MG GRANULE PACKET	T5	PA QL (28 packs/28 days) SP
VIJOICE 250 MG DAILY DOSE PACK	T5	PA QL (56 tabs/28 days) SP
VIJOICE 50 MG, 125 MG TABLET	T5	PA QL (28 tabs/28 days) SP
ZOKINVY	T5	PA QL (120 caps/fill) SP
THYMIC STROMAL LYMPHOPOIETIN (TSLP) INHIBITORS		
TEZSPIRE 210 MG/1.91 ML PEN	T5	PA QL (1 pen/28 days) SP HD
TEZSPIRE 210 MG/1.91 ML SYRING	T5	PA QL (1 syg/28 days) SP HD
UNCLASSIFIED DRUG PRODUCTS (Blood Modifiers/Bleeding Disorders)		
SPLEEN/BRUTON'S TYROSINE KINASE INHIBITORS		
TAVALISSE	T5	PA QL (60 tabs/30 days) SP
UNCLASSIFIED DRUG PRODUCTS (Blood Pressure/Heart Medications)		
BRADYKININ B2 RECEPTOR ANTAGONISTS		
<i>icatibant acetate (Firazyr)</i>	T2	PA SP HD
<i>icatibant acetate (Firazyr)</i>	T2	PA SP
PLASMA KALLIKREIN INHIBITORS		
ORLADEYO	T5	PA QL (28 caps/28 days) SP
TAKHZYRO 300MG/2ML	T5	PA QL (2units/28 days) SP HD
UNCLASSIFIED DRUG PRODUCTS (Cancer)		
CHEMOTHERAPY RESCUE/ANTIDOTE AGENTS		
<i>leucovorin calcium</i>	T2	CSL
<i>mesna (Mesnex)</i>	T2	SP CSL
MESNEX (<i>mesna</i>)	T5	SP CSL
VISTOGARD	T5	PA QL (20 packs/fill) SP CSL
UNCLASSIFIED DRUG PRODUCTS (Dental Products)		
DENTAL AIDS AND PREPARATIONS		
<i>chlorhexidine gluconate (Peridex)</i>	T1	
PERIDEX (<i>chlorhexidine gluconate</i>)	T4	

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

T5 – Brand Specialty
PA – Prior Authorization
QL – Quantity Limit

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

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

List of Prescription Medications

UNCLASSIFIED DRUG PRODUCTS (Dental Products) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
DENTAL AIDS AND PREPARATIONS (cont.)		
<i>triamcinolone 0.1% paste</i>	T2	
<i>triamcinolone acetonide</i>	T2	
PERIODONTAL COLLAGENASE INHIBITORS		
<i>doxycycline hyclate 20 mg tab</i>	T2	
UNCLASSIFIED DRUG PRODUCTS (Erectile Dysfunction)		
DRUGS TO TREAT ERECTILE DYSFUNCTION (ED)		
<i>avanafil (Stendra)</i>	T2	PA QL (8 tabs/30 days)
CAVERJECT 20 MCG VIAL	T2	PA QL (12 vials/fill)
CAVERJECT 40 MCG VIAL	T2	PA QL (12 vials/fill)
CAVERJECT IMPULSE 10 MCG KIT	T2	PA QL (12 kits/fill)
CAVERJECT IMPULSE 10 MCG SYRNG	T2	PA QL (12 syringes/fill)
CAVERJECT IMPULSE 20 MCG KIT	T2	PA QL (12 kits/fill)
CAVERJECT IMPULSE 20 MCG SYRNG	T2	PA QL (12 syringes/fill)
CIALIS (<i>tadalafil</i>)	T4	PA QL (8 tabs/30 days) HD
EDEX 10 MCG CARTRIDGE 2-PK KIT	T3	PA QL (6 kits/fill)
EDEX 10 MCG CARTRIDGE 6-PK KIT	T3	PA QL (2 kits/fill)
EDEX 20 MCG CARTRIDGE 2-PK KIT	T3	PA QL (6 kits/fill)
EDEX 20 MCG CARTRIDGE 6-PK KIT	T3	PA QL (2 kits/fill)
EDEX 40 MCG CARTRIDGE 2-PK KIT	T3	PA QL (6 kits/fill)
EDEX 40 MCG CARTRIDGE 6-PK KIT	T3	PA QL (2 kits/fill)
IFE-BIMIX 30/1	T3	
LEVITRA (<i>varafenafil hcl</i>)	T3	PA QL (8 tabs/fill)
MUSE	T2	PA QL (12 supps/fill)
PAPAVERINE-PHENTOLAMINE	T3	
PAPAVERINE-PHENTOLMN-ALPROSTD	T3	
STENDRA (<i>avanafil</i>)	T4	PA QL (8 tabs/30 days)
<i>tadalafil 2.5 mg tablet</i>	T2	PA QL (30 tabs/30 days) HD
<i>tadalafil 5 mg tablet (Cialis)</i>	T2	PA QL (8 tabs/30 days) HD
<i>tadalafil 10 mg tablet (Cialis)</i>	T2	PA QL (8 tabs/30 days) HD
<i>tadalafil 20 mg tablet (Cialis)</i>	T2	PA QL (8 tabs/30 days) HD
<i>sildenafil 25 mg tablet (Viagra)</i>	T2	PA QL (8 tabs/30 days) HD
<i>sildenafil 50 mg tablet (Viagra)</i>	T2	PA QL (8 tabs/30 days) HD
<i>sildenafil 100 mg tablet (Viagra)</i>	T2	PA QL (8 tabs/30 days) HD

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

T5 – Brand Specialty
PA – Prior Authorization
QL – Quantity Limit

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

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

List of Prescription Medications

UNCLASSIFIED DRUG PRODUCTS (Erectile Dysfunction) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
DRUGS TO TREAT ERECTILE DYSFUNCTION (ED) (cont.)		
TRI-MIX (PAPVRN-PHNTLMN-PGE1)	T3	
<i>varденаfil hcl</i>	T2	PA QL (8 tabs/fill)
<i>varденаfil hcl</i> (Levitra)	T2	PA QL (8 tabs/fill)
UNCLASSIFIED DRUG PRODUCTS (Eye Conditions)		
NICOTINIC RECEPT.PARTIAL AGONIST, ALPHA4BETA2 SPEC		
TYRVAYA	T4	PA
UNCLASSIFIED DRUG PRODUCTS (Gastrointestinal/Heartburn)		
AGENTS FOR STOMATOLOGICAL USE		
PROTHELIAL	T4	
COMPOUNDING KIT		
FIRST-MOUTHWASH BLM	T4	
ORAL MUCOSITIS/STOMATITIS AGENTS		
GELCLAIR	T4	
GELX	T4	
ORAMAGICRX	T4	
ORAL MUCOSITIS/STOMATITIS ANTI-INFLAMMATORY AGENT		
EPISIL	T4	
PPAR AGONIST		
IQIRVO	T5	PA SP HD
LIVDELZI	T5	PA SP
SALIVA STIMULANT AGENTS		
NUMOISYN	T4	
SALIVA SUBSTITUTE AGENTS		
AQUORAL	T4	
BOCASAL	T4	
CAPHOSOL	T4	
MUCOSITISRX	T4	
NEUTRASAL	T4	
NUMOISYN	T4	
SALIVAMAX	T4	
THYROID HORMONE RECEPTOR (THR) AGONIST		
REZDIFFRA	T5	PA QL (30 tabs/30 days) SP HD

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

T5 – Brand Specialty
PA – Prior Authorization
QL – Quantity Limit

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

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

List of Prescription Medications

UNCLASSIFIED DRUG PRODUCTS (Hormonal Agents)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
GROWTH HORMONE RECEPTOR ANTAGONISTS		
SOMAVERT	T5	PA SP HD
HYPERPARATHYROID TX AGENTS - VITAMIN D ANALOG-TYPE		
<i>doxercalciferol</i>	T2	ST
<i>paricalcitol</i>	T2	ST SP HD
<i>paricalcitol</i> (Zemplar)	T2	ST SP HD
RAYALDEE	T4	ST
ZEMPLAR (<i>paricalcitol</i>)	T5	ST SP HD
UNCLASSIFIED DRUG PRODUCTS (Miscellaneous)		
ABORTIFACIENT-PROGESTERONE RECEPTOR ANTAGONISTS		
MIFEPREX	T4	
<i>mifepristone 200 mg tablet</i>	T2	
AGENTS TO TX PERIODIC PARALYSIS - CARBON ANHYD INH		
<i>dichlorphenamide</i> (Keveyis)	T2	PA SP
AMMONIA INHIBITORS		
CARBAGLU (<i>carglumic acid</i>)	T5	PA SP HD
<i>carglumic acid</i> (Carbaglu)	T2	PA SP HD
ANTI-ALCOHOLIC PREPARATIONS		
<i>acamprosate calcium</i>	T2	
<i>disulfiram</i>	T2	
CI ESTERASE INHIBITORS		
HAEGARDA 2,000UNIT VIAL	T5	PA QL (24 vls/28 days) SP HD
HAEGARDA 3,000UNIT VIAL	T5	PA QL (16 vls/28 days) SP HD
CALCIMIMETIC,PARATHYROID CALCIUM ENHANCER		
<i>cinacalcet hcl</i> (Sensipar)	T2	PA SP
COLORING AGENTS AND DYES		
<i>methylene blue</i>	T2	
COMPOUNDING KIT		
FIRST-MOUTHWASH BLM	T4	
CRYOPRESERVATIVE AGENTS		
<i>dimethyl sulfoxide</i>	T2	
DRUGS TO TX GAUCHER DX-TYPE I, SUBSTRATE REDUCING		
CERDELGA	T5	PA QL (56 caps/28 days) SP HD
ENVIRONMENT ALLERGENS AND IRRITANTS, OTHER		
T.R.U.E. TEST	T4	

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

T5 – Brand Specialty
PA – Prior Authorization
QL – Quantity Limit

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

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

List of Prescription Medications

UNCLASSIFIED DRUG PRODUCTS (Miscellaneous) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
GENERAL INHALATION AGENTS		
HYPER-SAL	T4	
nebusal 3% vial	T2	
NEBUSAL 6% VIAL	T4	
sodium chloride for inhalation	T2	
sodium chloride 0.9% inhal vI	T2	
sodium chloride 10% vial	T2	
sodium chloride 3% vial	T2	
sodium chloride 7% vial	T2	
GENETIC D/O TX - SMN PROTEIN DEFICIENCY TREATMENT		
EVRYSDI	T5	PA SP HD
GLUCOSYLCERAMIDE SYNTHASE (GCS) INHIBITOR		
miglustat (Zavesca)	T2	PA QL (90 caps/30 days) SP
OPFOLDA	T5	PA QL (8 caps/fill) SP HD
HOMEOPATHIC DRUGS		
VERTIGOHEEL	T4	
HYDROXYPHENYL-PYRUVATE DIOXYGENASE(HPPD) INHIBITOR		
nitisinone (Orfadin)	T2	PA SP HD
NITYR	T5	PA SP
ORFADIN	T5	PA SP
ORFADIN (nitisinone)	T5	PA SP
MENOPAUSAL SYMPTOMS SUPPRESSANT-NK RECEPTOR ANTAG		
VEOZAH	T4	
MENOPAUSAL SYMPTOMS SUPPRESSANT - SSRIS		
paroxetine mesylate (Brisdelle)	T2	ST QL (30 caps/fill) HD
METABOLIC DISEASE ENZYME REPLACE, HYPOPHOSPHATASIA		
STRENSIQ	T5	PA SP
METALLIC POISON, AGENTS TO TREAT		
CHEMET	T3	PA
deferasirox (Exjade)	T2	PA SP HD
deferasirox (Jadenu Sprinkle)	T2	PA SP HD
deferasirox (Jadenu)	T2	PA SP HD
deferiprone (Ferroprox (3 Times A Day))	T2	PA SP HD
FERRIPROX (2 TIMES A DAY)	T5	PA SP

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

T5 – Brand Specialty
PA – Prior Authorization
QL – Quantity Limit

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

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

List of Prescription Medications

UNCLASSIFIED DRUG PRODUCTS (Miscellaneous) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
METALLIC POISON, AGENTS TO TREAT (cont.)		
FERRIPROX (3 TIMES A DAY) (<i>deferiprone</i>)	T5	PA SP
FERRIPROX 100 MG/ML SOLUTION	T5	PA SP
FERRIPROX 500 MG TABLET (<i>deferiprone</i>)	T5	PA SP
GALZIN	T5	SP
RADIOGARDASE	T4	
SYPRINE (<i>trientine hcl</i>)	T5	PA SP HD
NATRIURETIC PEPTIDES		
VOXZOGO	T5	PA SP HD
NEONATAL FC RECEPTOR (FCRN) INHIBITORS		
VYVGART HYTRULO	T5	PA SP HD
NUCLEAR FACTOR ERYTHROID 2-REL. FACTOR 2 ACTIVATOR		
SKYCLARYS	T5	PA SP
PHARMACOLOGICAL CHAPERONE-ALPHA-GALACTOSID.A STABZ		
GALAFOLD	T5	PA QL (15 caps/fill) SP HD
PKU TX AGENT-COFACTOR OF PHENYLALANINE HYDROXYLASE		
<i>sapropterin dihydrochloride</i> (Kuvan)	T2	PA SP
<i>sapropterin dihydrochloride</i> (Kuvan)	T2	PA SP HD
PROTEIN STABILIZERS		
ATTRUBY	T5	PA SP
VYNDAMAX	T5	PA SP HD
VYNDAQEL	T5	PA SP HD
RETINOIC ACID RECEPTOR (RAR) AGONISTS		
SOHONOS 1 MG CAPSULE	T5	PA QL (112 caps/fill) SP
SOHONOS 1.5 MG CAPSULE	T5	PA QL (112 caps/fill) SP
SOHONOS 10 MG CAPSULE	T5	PA QL (56 caps/fill) SP
SOHONOS 2.5 MG CAPSULE	T5	PA QL (140 caps/fill) SP
SOHONOS 5 MG CAPSULE	T5	PA QL (84 caps/fill) SP
SOLVENTS		
CVS ISOPROPYL ALCOHOL 91%	T4	
<i>cvs isopropyl alcohol 91%</i>	T2	
CVS ISOPROPYL RUB ALCOHOL 70%	T4	
<i>cvs isopropyl rub alcohol 70%</i>	T2	
<i>eq1 isopropyl alcohol 91%</i>	T2	
<i>eq1 isopropyl rub alcohol 70%</i>	T2	

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

T5 – Brand Specialty
PA – Prior Authorization
QL – Quantity Limit

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

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

List of Prescription Medications

UNCLASSIFIED DRUG PRODUCTS (Miscellaneous) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
SOLVENTS (cont.)		
FT ISOPROPYL ALCOHOL 91%	T4	
FT ISOPROPYL RUB ALCOHOL 70%	T4	
GNP ISOPROPYL ALCOHOL 70%	T4	
<i>gnp isopropyl alcohol 99%</i>	T2	
GS ISOPROPYL ALCOHOL 91%	T4	
<i>hm isopropyl alcohol 70%</i>	T2	
<i>hm isopropyl alcohol 91%</i>	T2	
INSTACLEAN	T3	
ISOPROPANOL	T3	
<i>isopropyl 70% alcohol</i>	T2	
<i>isopropyl alcohol</i>	T2	
ISOPROPYL ALCOHOL 70%	T4	
<i>isopropyl alcohol 70%</i>	T2	
<i>isopropyl alcohol 91%</i>	T2	
<i>isopropyl alcohol 99%</i>	T2	
<i>isopropyl rubbing alcohol 70%</i>	T2	
ISOPROPYL RUBBING ALCOHOL 70%	T4	
ISOPROPYL RUBBING ALCOHOL 91%	T4	
<i>kro isopropyl alcohol 91%</i>	T2	
MURI-LUBE MINERAL OIL	T3	
<i>polyethylene glycol</i>	T2	
<i>ra isopropyl alcohol 70%</i>	T2	
<i>ra isopropyl alcohol 91%</i>	T2	
<i>sm isopropyl alcohol 70%</i>	T2	
<i>swan isopropyl alcohol 70%</i>	T2	
SUSPENDING AGENTS		
GELFILM	T4	
HYDROXYPROPYLCELLULOSE	T3	
HYPROMELLOSE	T3	
TREATMENT OF HYPERPHAGIA IN PRADER-WILLI SYNDROME		
VYKAT XR	T5	PA SP

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

T5 – Brand Specialty
PA – Prior Authorization
QL – Quantity Limit

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

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

List of Prescription Medications

UNCLASSIFIED DRUG PRODUCTS (Nutritional/Dietary)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
METABOLIC DEFICIENCY AGENTS		
<i>betaine</i> (Cystadane)	T2	PA SP
CARNITOR (<i>levocarnitine (with sugar)</i>)	T4	
CARNITOR (<i>levocarnitine</i>)	T4	
CARNITOR SF (<i>levocarnitine</i>)	T4	
<i>levocarnitine</i> (Carnitor Sf)	T2	
<i>levocarnitine</i> (Carnitor)	T2	
<i>levocarnitine (with sugar)</i> (Carnitor)	T2	
UNCLASSIFIED DRUG PRODUCTS (Osteoporosis Products)		
BONE FORMATION STIM. AGENTS - PARATHYROID HORMONE		
BONSITY (<i>teriparatide</i>)	T5	PA QL (1 pens/28 days) SP
<i>teriparatide</i> (Bonsity)	T2	PA QL (1 pens/28 days) SP HD
<i>teriparatide</i> (Forteo)	T2	PA QL (1 pens/28 days) SP HD
BONE RESORPTION INHIBITOR AND VITAMIN D COMBS.		
FOSAMAX PLUS D	T4	ST QL (4 tabs/28 days) HD
BONE RESORPTION INHIBITORS		
ACTONEL 150 MG TABLET (<i>risedronate sodium</i>)	T4	ST QL (1 TAB/30 DAYS) HD
ACTONEL 35 MG TABLET (<i>risedronate sodium</i>)	T4	ST QL (4 tabs/28 days) HD
<i>alendronate sod</i> 70 mg/75 ml	T2	QL (300 mls/28 days) HD
<i>alendronate sodium</i> 10 mg tab	T1	QL (30 tabs/fill) HD
<i>alendronate sodium</i> 35 mg tab	T1	QL (4 tabs/28 days) HD
<i>alendronate sodium</i> 40 mg tab	T1	HD
<i>alendronate sodium</i> 5 mg tablet	T1	QL (30 tabs/fill) HD
<i>alendronate sodium</i> 70 mg tab (Fosamax)	T1	QL (4 tabs/28 days) HD
ATELVIA (<i>risedronate sodium</i>)	T4	ST QL (4 tabs/28 days) HD
BINOSTO	T4	ST QL (4 tabs/28 days) HD
EVISTA (<i>raloxifene hcl</i>)	T4	HD
FOSAMAX (<i>alendronate sodium</i>)	T4	ST QL (4 tabs/28 days) HD
<i>ibandronate sodium</i>	T2	QL (1 tab/30 days) HD
<i>raloxifene hcl</i> (Evista)	T2	HD PPACA
<i>risedronate sodium</i> (Atelvia)	T2	QL (4 tabs/28 days) HD
<i>risedronate sodium</i> 150 mg tab (Actonel)	T2	QL (1 tab/30 days) HD
<i>risedronate sodium</i> 30 mg tab	T2	QL (30 tabs/fill) HD
<i>risedronate sodium</i> 35 mg tab (Actonel)	T2	QL (4 tabs/28 days) HD
<i>risedronate sodium</i> 5 mg tablet	T2	QL (30 tabs/fill) HD

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

T5 – Brand Specialty
PA – Prior Authorization
QL – Quantity Limit

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

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

List of Prescription Medications

UNCLASSIFIED DRUG PRODUCTS (Pain Relief And Inflammatory Disease)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ANTI-INFLAM. INTERLEUKIN-1 RECEPTOR ANTAGONIST		
ARCALYST	T5	PA QL (4 vls/28 days) SP HD
FIBROMYALGIA AGENTS, SEROTONIN-NOREPINEPH RU INHIB		
SAVELLA 100 MG TABLET	T3	ST QL (60 tabs/30 days)
SAVELLA 12.5 MG TABLET	T3	ST QL (60 tabs/30 days)
SAVELLA 25 MG TABLET	T3	ST QL (60 tabs/30 days)
SAVELLA 50 MG TABLET	T3	ST QL (60 tabs/30 days)
SAVELLA TITRATION PACK	T3	ST QL (55 tabs/30 days)
IMMUNOMODULATOR, B-LYMPHOCYTE STIM (BLYS)-SPEC INHIB		
BENLYSTA	T5	PA QL (4 mls/28 days) SP HD
UNCLASSIFIED DRUG PRODUCTS (Seizure Disorders)		
NEUROPATHIC AGENTS		
<i>pregabalin</i> (Lyrica Cr)	T2	PA HD
UNCLASSIFIED DRUG PRODUCTS (Skin Conditions)		
INTERLEUKIN-13 (IL-13) INHIBITORS, MAB		
ADBRY	T5	PA QL (4 syringes/28 days) SP HD
ADBRY AUTOINJECTOR	T5	PA QL (2 auto-injs/28 days) SP HD
EBGLYSS PEN	T5	PA QL (4 mls/28 days) SP
EBGLYSS SYRINGE	T5	PA SP
JANUS KINASE (JAK) INHIBITORS		
LEQSELVI	T5	PA SP HD
LITFULO	T5	PA QL (28 caps/28 days) SP HD
WOUND HEALING AGENTS, LOCAL		
FILSUEVZ	T5	PA SP
UNCLASSIFIED DRUG PRODUCTS (Substance Abuse)		
OPIOID WITHDRAWAL THER, ALPHA-2 ADRENERGIC AGONIST		
<i>lofexidine hcl</i> (Lucemyra)	T2	PA QL (224 tabs/30 days)
OPIOID WITHDRAWAL THERAPY AGENTS, OPIOID-TYPE		
<i>buprenorphine hcl</i>	T2	
<i>buprenorphine hcl/naloxone hcl</i>	T2	
<i>buprenorphine hcl/naloxone hcl</i> (Suboxone)	T2	
ZUBSOLV	T3	

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

T5 – Brand Specialty
PA – Prior Authorization
QL – Quantity Limit

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

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

List of Prescription Medications

UNCLASSIFIED DRUG PRODUCTS (Transplant Medications)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
RHO KINASE INHIBITOR		
REZUROCK	T5	PA QL (30 tabs/fill) SP
UNCLASSIFIED DRUG PRODUCTS (Urinary Tract Conditions)		
BENIGN PROSTATIC HYPERTROPHY/MICTURITION AGENTS		
<i>alfuzosin hcl</i> (Uroxatral)	T2	HD
<i>dutasteride</i> (Avodart)	T2	ST HD
<i>finasteride</i> (Proscar)	T2	HD
FLOMAX (<i>tamsulosin hcl</i>)	T4	ST HD
PROSCAR (<i>finasteride</i>)	T4	ST HD
<i>silodosin</i> (Rapaflo)	T2	HD
<i>tamsulosin hcl</i> (Flomax)	T1	HD
BPH 5-ALPHA-REDUCTASE INHIB-ALPHA1-ADRENOCEP ANTAG		
<i>dutasteride/tamsulosin hcl</i> (Jalyn)	T2	ST HD
JALYN (<i>dutasteride/tamsulosin hcl</i>)	T4	ST HD
CYSTINE-DEPLETING AGENTS, NEPHROPATHIC CYSTINOSIS		
CYSTAGON	T5	SP
ENDOTHELIN RECEPTOR ANTAGONISTS		
VANRAFIA	T5	PA SP
KIDNEY STONE AGENTS		
<i>tiopronin dr 100 mg tablet</i> (Thiola Ec)	T2	PA SP
<i>tiopronin dr 100 mg tablet</i> (Thiola Ec)	T2	PA SP HD
<i>tiopronin dr 300 mg tablet</i> (Thiola Ec)	T2	PA SP
<i>tiopronin dr 300 mg tablet</i> (Thiola Ec)	T2	PA SP HD
<i>tiopronin</i> (Thiola Ec)	T2	PA SP
THIOLA EC (<i>tiopronin</i>)	T5	PA SP
OVERACTIVE BLADDER AGENTS, BETA-3 ADRENERGIC RECEPTOR		
GEMTESA	T4	HD
<i>mirabegron</i> (Myrbetriq)	T2	HD
MYRBETRIQ	T3	HD
MYRBETRIQ (<i>mirabegron</i>)	T3	HD
URINARY TRACT ANTISPASMODIC, M(3) SELECTIVE ANTAG.		
<i>darifenacin hydrobromide</i>	T2	HD
<i>solifenacin succinate</i> (Vesicare)	T2	HD
URINARY TRACT ANTISPASMODIC/ANTIINCONTINENCE AGENT		
<i>fesoterodine fumarate</i> (Toviaz)	T2	HD

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

T5 – Brand Specialty
PA – Prior Authorization
QL – Quantity Limit

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

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

List of Prescription Medications

UNCLASSIFIED DRUG PRODUCTS (Urinary Tract Conditions) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
URINARY TRACT ANTISPASMODIC/ANTIINCONTINENCE AGENT (cont.)		
<i>flavoxate hcl</i>	T2	HD
<i>oxybutynin 5 mg/5 ml soln cup</i>	T2	HD
<i>oxybutynin chloride</i>	T2	HD
OXYTROL	T4	ST QL (8 patches/28 days) HD
<i>tolterodine tartrate (Detrol La)</i>	T2	HD
<i>tolterodine tartrate (Detrol)</i>	T2	HD
<i>tropium chloride</i>	T2	HD
UNCLASSIFIED DRUG PRODUCTS (Weight Management)		
APPETITE STIM. FOR ANOREXIA, CACHEXIA, WASTING SYND.		
<i>megestrol 625 mg/5 ml susp</i>	T2	
<i>megestrol acet 40 mg/ml susp</i>	T2	
VITAMINS (Nutritional/Dietary)		
ANTIOXIDANT MULTIVITAMIN COMBINATIONS		
50 PLUS ADULT EYE HEALTH	T4	
<i>a/c/e/zinc ox/cupric ox/lutein</i>	T2	
ADULT 50 PLUS EYE HEALTH	T4	
ANTIOXIDANT FORMULA	T4	
BIOTECT PLUS SOFTGEL	T4	
EQ VISION FORMULA TABLET	T3	
<i>eq1 eye health plus lutein tab</i>	T2	
EYE HEALTH AND LUTEIN	T4	
EYE HEALTH WITH LUTEIN	T4	
EYE HEALTH PLUS LUTEIN TABLET	T4	
EYE MULTIVITAMIN	T3	
EYE MULTIVITAMIN WITH LUTEIN	T4	
EYEPROTECT	T4	
<i>gnp healthy eyes tablet</i>	T2	
HEALTHY EYES TABLET	T3	
<i>healthy eyes tablet</i>	T2	
I-CAPS	T3	
ICAPS AREDS FORMULA DR TABLET	T4	
ICAPS AREDS2	T4	
LIPOTRIAD	T4	
LIPOTRIAD VISIONARY	T4	

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

T5 – Brand Specialty
PA – Prior Authorization
QL – Quantity Limit

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

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

List of Prescription Medications

VITAMINS (Nutritional/Dietary) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ANTIOXIDANT MULTIVITAMIN COMBINATIONS (cont.)		
LUTEIN PLUS WITH ZEAXANTHIN	T4	
MACULAR BENEFITS	T4	
MACULAR HEALTH FORMULA	T4	
MACUVEX	T4	
MACUZIN	T4	
OCULAR VITAMINS	T4	
OCUVEL	T4	
OCUVITE ADULT 50 PLUS	T3	
OCUVITE WITH LUTEIN	T3	
PRESERVISION AREDS	T3	
PRESERVISION AREDS 2 CO Q-10	T4	
PRESERVISION LUTEIN	T3	
VITEYES AREDS 2 PLUS MULTIVIT	T4	
VISION FORMULA TABLET	T4	
VISION FORMULA WITH LUTEIN	T4	
VISION OPTIMIZER	T4	
VISTA ADVANCED AREDS2	T4	
<i>vit a/vit c/vit e/zinc/copper</i>	T2	
<i>vits a,c,e/lutein/minerals</i>	T2	
BIOFLAVONOIDS		
<i>bioflav,lemon/vit bcomp,c</i>	T2	
<i>bioflav,lemon/vit bcomp,c</i> (Lipo-Flavonoid Plus)	T2	
CITRUS BIOFLAVONOIDS	T4	
EAR HEALTH PLUS CAPLET	T4	
<i>ear health plus caplet</i> (Lipo-Flavonoid Plus)	T2	
FLAVOVIT	T4	
FLOGEN	T4	
INNER EAR PLUS	T4	
LIPO FLAVONOID	T4	
LIPO-FLAVONOID PLUS (<i>bioflav,lemon/vit bcomp,c</i>)	T3	
QUERCETIN	T4	
<i>rutin</i>	T2	
VASCULERA	T4	
VASOFLEX D1	T4	
VENALIV	T4	

T1 – Preferred Generics

T2 – Non-Preferred Generics

T3 – Preferred Brands

T4 – Non-Preferred Brands

T5 – Brand Specialty

PA – Prior Authorization

QL – Quantity Limit

ST – Step Therapy

AGE – Age Requirement

SP – Specialty Medication

HD – May require home delivery pharmacy

PPACA – No Cost-Share Preventive Medication

CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

VITAMINS (Nutritional/Dietary) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
FOLIC ACID PREPARATIONS		
COBALEFOL	T4	
<i>cvs folic acid 800 mcg tablet</i>	T2	PPACA
DENOVO	T4	
DEPLIN-ALGAL OIL (<i>levomefolate/algal oil</i>)	T4	
DEPLIN FC	T4	
ENLYTE	T4	
FA-8	T4	
FOLETRA	T4	
<i>folic acid 0.4 mg, 0.8 mg tablet</i>	T2	PPACA
<i>folic acid 1 mg tablet</i>	T2	
<i>folic acid 1,000 mcg tablet</i>	T2	
FOLIC ACID 5 MG, 20 MG CAPSULE	T4	
<i>folic acid 400 mcg, 800 mcg tablet</i>	T2	PPACA
<i>folic acid 5 mg/ml vial</i>	T2	
<i>folic acid 50 mg/10 ml vial</i>	T2	
FOLIC ACID 800 MCG CAPSULE	T4	
<i>folic acid/b6/ca phos/ginger</i>	T2	
FOLIKA-V	T4	
FOLITE	T4	
<i>ft folic acid 400 mcg, 800 mcg tablet</i>	T2	PPACA
GENICIN VITA-Q	T4	
<i>gnp folic acid 400 mcg tablet</i>	T2	PPACA
<i>hm folic acid 400 mcg tablet</i>	T2	PPACA
HYLAZINC	T4	
<i>levomefolate calcium</i>	T2	
<i>levomefolate/algal oil (Deplin-Algal Oil)</i>	T2	
METHYLFOLATE	T4	
MI-VITE RX	T4	
<i>purevita folic acid 400 mcg tb</i>	T2	PPACA
PUREVITA FOLIC ACID 400MCG/2ML	T4	
<i>ra folic acid 0.4 mg tablet</i>	T2	PPACA
<i>ra folic acid 800 mcg tablet</i>	T2	PPACA
<i>sm folic acid 0.4 mg tablet</i>	T2	PPACA
<i>sm folic acid 400 mcg tablet</i>	T2	PPACA

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

T5 – Brand Specialty
PA – Prior Authorization
QL – Quantity Limit

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

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

List of Prescription Medications

VITAMINS (Nutritional/Dietary) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
FOLIC ACID PREPARATIONS (cont.)		
<i>sv folic acid 800 mcg tablet</i>	T2	PPACA
<i>true folic acid 1600mcg dfe tb</i>	T2	
<i>true folic acid 667 mcg dfe tb</i>	T2	PPACA
XAQUIL XR	T4	
GERIATRIC VITAMIN PREPARATIONS		
<i>a thru z advanced formula tab</i> (Vision Plus Lutein)	T2	
<i>a thru z select tablet</i> (Vision Plus Lutein)	T2	
CENTRUM SILVER CHEWABLE TABLET	T3	
<i>eldertonic elixir</i>	T2	
ELDERTONIC LIQUID	T4	
GERITOL COMPLETE	T3	
GERITOL TONIC	T3	
<i>multivit with iron,minerals</i>	T2	
<i>multivit with minerals/lutein</i> (Vision Plus Lutein)	T2	
REQ49+	T4	
SPECTRAVITE ADULT 50+	T4	
VISION PLUS LUTEIN (<i>multivit with minerals/lutein</i>)	T3	
MULTIVITAMIN PREPARATIONS		
<i>a thru z advanced formula tab</i>	T2	
A THRU Z MEN'S ULTIMATE TABLET	T3	
A THRU Z SELECT MEN 50+ TABLET	T4	
<i>a thru z select multivit tab</i>	T2	
<i>a thru z select multivit tab</i> (Centrum Silver)	T2	
<i>a thru z select multivit tab</i> (Certavite Senior)	T2	
<i>a thru z select tablet</i> (Centrum Silver)	T2	
<i>a thru z select tablet</i> (Certavite Senior)	T2	
<i>a thru z select women's tablet</i>	T2	
<i>a/c/e/zinc/sod selenate/copper</i>	T2	
ABC COMPLETE ADULT	T3	
ABC COMPLETE MEN'S	T3	
ABC COMPLETE SENIOR WOMEN'S	T4	
ACTIVNUTRIENTS	T4	
ACTIVNUTRIENTS PERFORMANCE	T4	
ADEK GUMMIES PLUS ZINC	T4	

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

T5 – Brand Specialty
PA – Prior Authorization
QL – Quantity Limit

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

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

List of Prescription Medications

VITAMINS (Nutritional/Dietary) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
MULTIVITAMIN PREPARATIONS (cont.)		
ADULT MULTI	T4	
ADULT MULTI GUMMIES	T4	
ADULT MULTIVITAMIN GUMMIES	T4	
ADULT ONE DAILY GUMMIES	T4	
ADULTS' DAILY FORMULA	T4	
ADULTS MULTIVITAMIN	T4	
ADVANCED MULTI EA	T4	
AFLORA	T4	
ALIVE ADULT ULTRA POTENCY	T4	
ALIVE COMPLETE PREMIUM PRENATL	T4	
ALIVE DAILY ENERGY	T4	
ALIVE DAILY SUPPORT PRENATAL	T4	
ALIVE HAIR, SKIN AND NAILS	T4	
ALIVE MAX POTENCY	T4	
ALIVE MAX6 POTENCY	T4	
ALIVE WOMEN'S 50 PLUS COMPLETE	T4	
ALIVE WOMEN'S MULTIVITAMIN	T4	
ALIVE MEN'S 50 PLUS GUMMY	T4	
ALIVE MEN'S 50 PLUS ULTRA	T4	
ALIVE MEN'S ENERGY	T4	
ALIVE MEN'S GUMMY	T4	
ALIVE MEN'S ULTRA POTENCY	T4	
ALIVE PREMIUM ADULT	T4	
ALIVE PREMIUM PRENATAL	T4	
ALIVE WOMEN'S 50 PLUS	T4	
ALIVE WOMEN'S 50 PLUS ULTRA	T4	
ALIVE WOMEN'S ENERGY	T4	
ALIVE WOMEN'S GUMMY VITAMIN	T4	
ALIVE WOMEN'S ULTRA POTENCY	T4	
ALPHA BETIC MULTIVITAMIN	T4	
ALTRIXA	T4	
<i>amino acids/mv,tx,iron,mineral</i>	T2	
AMLADEX	T4	
ANIMI-3	T4	

T1 – Preferred Generics

T2 – Non-Preferred Generics

T3 – Preferred Brands

T4 – Non-Preferred Brands

T5 – Brand Specialty

PA – Prior Authorization

QL – Quantity Limit

ST – Step Therapy

AGE – Age Requirement

SP – Specialty Medication

HD – May require home delivery pharmacy

PPACA – No Cost-Share Preventive Medication

CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

VITAMINS (Nutritional/Dietary) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
MULTIVITAMIN PREPARATIONS (cont.)		
BACMIN	T4	
BARIATRIC MULTIVITAMINS	T4	
<i>b-complex with vitamin c</i>	T2	
<i>b-complex with vitamin c (Support-500)</i>	T2	
<i>b-complex w-vitamin c caplet</i>	T2	
BEROCCA	T4	
<i>beta-carotene(a)-vits c,e/mins</i>	T2	
BIO-35	T4	
<i>biotect plus liquid</i>	T2	
BLADDER 2.2	T3	
BODY, HAIR, SKIN AND NAILS	T4	
CENTRAL-VITE	T4	
CENTRAL-VITE WOMEN'S MATURE (<i>multivit-min/iron/folic/lutein</i>)	T4	
CENTRAVITES ADULTS	T4	
CENTRUM	T3	
CENTRUM ADULT 50 FRESH-FRUITY	T4	
CENTRUM ADULT 50 PLUS	T4	
CENTRUM CHEWABLES ADULTS TAB	T3	
CENTRUM CHEWABLES ADULTS TAB	T4	
CENTRUM COMPLETE	T3	
CENTRUM FLAVOR BURST ADULT	T4	
CENTRUM MEN 50 PLUS	T4	
CENTRUM MEN MULTIGUMMY	T4	
CENTRUM MEN'S TABLET	T3	
CENTRUM MENOPAUSE MULTIVITAMIN	T4	
CENTRUM MULTIGUMMIES	T4	
CENTRUM MULTI MENTAL FOCUS	T4	
CENTRUM MULTI PLUS BEAUTY	T4	
CENTRUM MULTI PLUS OMEGA-3	T4	
CENTRUM POSTNATAL	T4	
CENTRUM PRENATAL	T4	
CENTRUM SILVER MEN	T4	
CENTRUM SILVER TABLET (<i>multivit-min/fa/lycopen/lutein</i>)	T4	
CENTRUM SILVER ULTRA MEN'S (<i>multivit-min/fa/lycopen/lutein</i>)	T3	

T1 – Preferred Generics

T2 – Non-Preferred Generics

T3 – Preferred Brands

T4 – Non-Preferred Brands

T5 – Brand Specialty

PA – Prior Authorization

QL – Quantity Limit

ST – Step Therapy

AGE – Age Requirement

SP – Specialty Medication

HD – May require home delivery pharmacy

PPACA – No Cost-Share Preventive Medication

CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

VITAMINS (Nutritional/Dietary) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
MULTIVITAMIN PREPARATIONS (cont.)		
CENTRUM SILVER WOMEN (<i>multivit-min/iron/folic/lutein</i>)	T4	
CENTRUM SPECIALIST ENERGY	T4	
CENTRUM SPECIALIST HEART	T3	
CENTRUM ULTRA MEN'S	T3	
CENTRUM WOMEN 50 PLUS	T4	
CENTRUM WOMEN IMMUNE MINIS	T4	
CENTRUM WOMEN MULTIGUMMY	T4	
<i>centrum women tablet</i> (Certavite-Antioxidant)	T2	
<i>centrum women tablet</i> (Tab-A-Vite Multivit With Iron)	T2	
<i>certavite-antioxidant tablet</i> (Certavite-Antioxidant)	T2	
CERTAVITE-ANTIOXIDANT TABLET (<i>multivitamin/iron/folic acid</i>)	T4	
<i>certavite-antioxidant tablet</i> (Tab-A-Vite Multivit With Iron)	T2	
COMPLETE MEN	T3	
COMPLETE MEN 50 PLUS	T4	
COMPLETE MULTIVITAMIN-MINERAL	T4	
COMPLETIA DIABETIC MULTIVIT	T4	
CONCEPT DHA (<i>mvn-min75/iron/iron ps/om3/dha</i>)	T4	
CONCEPT OB (<i>mvn-min 74/iron fum/iron/fa</i>)	T4	
CORVITE	T4	
CULTURELLE PROBIOTIC-MULTIVIT	T4	
<i>cvs b-complex-vit c caplet</i>	T2	
<i>cvs adult multivitamin gummy</i>	T2	
<i>cvs hair, skin and nails cplt</i>	T2	
<i>cvs one daily essential tablet</i> (Daily-Vite)	T2	
DAILY GUMMIES	T4	
DAILY MULTIPLE	T3	
DAILY MULTIVITAMIN	T4	
<i>daily-vite tablet</i> (Daily-Vite)	T2	
DAILY-VITE TABLET (<i>multivitamin with folic acid</i>)	T4	
DAVIMET WITH IRON	T4	
DAYAVITE	T4	
DECUBI VITE	T4	
DEKAS BARIATRIC	T4	
DEKAS ESSENTIAL	T4	

T1 – Preferred Generics

T2 – Non-Preferred Generics

T3 – Preferred Brands

T4 – Non-Preferred Brands

T5 – Brand Specialty

PA – Prior Authorization

QL – Quantity Limit

ST – Step Therapy

AGE – Age Requirement

SP – Specialty Medication

HD – May require home delivery pharmacy

PPACA – No Cost-Share Preventive Medication

CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

VITAMINS (Nutritional/Dietary) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
MULTIVITAMIN PREPARATIONS (cont.)		
DEKAS PLUS	T4	
DERMACINRX FOLIFLEX	T4	
DERMACINRX FOLITIN-Z	T4	
DERMACINRX MULTITAM	T4	
DERMACINRX RIBOTIN-E	T4	
DERMACINRX VENEXA	T4	
DERMACINRX VENEXA FE	T4	
DERMACINRX VENTRIXYL	T4	
DERMACINRX VENTRIXYL FE	T4	
DERMACINRX VITRAMYN	T4	
DERMACINRX VITRANOL	T4	
DERMACINRX VITRANOL FE	T4	
DERMACINRX VITREXATE	T4	
DERMACINRX VITREXATE FE	T4	
DERMACINRX ZINTREXYL-C	T4	
DIABETES HEALTH FORMULA	T4	
DIABETES HEALTH PACK	T4	
DIABETIC VITAMIN	T4	
DIALYVITE 800 WITH IRON	T4	
DIATROL	T4	
ELON MATRIX 5000 COMPLETE	T4	
ENBRACE HR	T4	
ENDUR-VM IRON-FREE	T4	
ENDUR-VM WITH IRON	T4	
EQ ONE DAILY MEN'S TABLET	T3	
EQ ONE DAILY WOMEN'S HEALTH TB	T4	
EQ ONE DAILY WOMEN'S TABLET	T3	
ESSENTIAL MAN	T4	
ESSENTIAL MAN 50+	T4	
ESSENTIAL WOMAN 50+	T4	
ESTROVEN MENOPAUSE	T4	
<i>fa/mv,ca,iron,min/lycopene/lut</i>	T2	
FATIGUE RELIEF COMPLEX (<i>bcomp,c/st,jhn wrt/s.ginsg/pgn</i>)	T4	
FINAZOL	T4	

T1 – Preferred Generics

T2 – Non-Preferred Generics

T3 – Preferred Brands

T4 – Non-Preferred Brands

T5 – Brand Specialty

PA – Prior Authorization

QL – Quantity Limit

ST – Step Therapy

AGE – Age Requirement

SP – Specialty Medication

HD – May require home delivery pharmacy

PPACA – No Cost-Share Preventive Medication

CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

VITAMINS (Nutritional/Dietary) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
MULTIVITAMIN PREPARATIONS (cont.)		
FLORRAXYL	T4	
FOLACHEW	T4	
FOLAGENT DHA	T4	
FOLAMAX	T4	
FOLAMED DHA	T4	
FOLAPRIME	T4	
FOLAWISE	T4	
<i>folic acid/multivit,iron,miner</i>	T2	
<i>folic acid/mv,iron,min/lutein</i>	T2	
FOLIC ACID-VIT B-6-VIT B-12	T4	
<i>folic/mvi ther-min/lycop/lut</i>	T2	
FOLIKA-CI	T4	
FOLIKA-MG	T4	
FORTAVIT	T4	
FREEDAVITE	T4	
FT HAIR, SKIN AND NAILS TABLET	T4	
<i>ft b complex plus vit c tablet</i>	T2	
<i>ft century men tablet</i>	T2	
<i>ft one daily men's tablet</i>	T2	
<i>ft one daily women's tablet</i>	T2	
<i>ft century women tablet (Certavite-Antioxidant)</i>	T2	
<i>ft century women tablet (Tab-A-Vite Multivit With Iron)</i>	T2	
GENADEK STEP 1	T4	
GENADEK STEP 2	T4	
GERBER GS PRENATAL NOURISH PLS	T4	
GNP B-COMPLEX PLUS VIT C TAB	T4	
GNP CENTURY ADULT FORMULA TAB	T4	
<i>gnp century adult formula tab (Certavite-Antioxidant)</i>	T2	
<i>gnp century adult formula tab (Tab-A-Vite Multivit With Iron)</i>	T2	
GNP CENTURY MEN TABLET	T4	
GNP CENTURY WOMEN TABLET	T4	
GNP ONE DAILY MAXIMUM TABLET	T4	
<i>gnp one daily tablet</i>	T2	
HAIR, SKIN AND NAILS CAPLET	T4	

T1 – Preferred Generics

T2 – Non-Preferred Generics

T3 – Preferred Brands

T4 – Non-Preferred Brands

T5 – Brand Specialty

PA – Prior Authorization

QL – Quantity Limit

ST – Step Therapy

AGE – Age Requirement

SP – Specialty Medication

HD – May require home delivery pharmacy

PPACA – No Cost-Share Preventive Medication

CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

VITAMINS (Nutritional/Dietary) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
MULTIVITAMIN PREPARATIONS (cont.)		
HAIR, SKIN AND NAILS SOFTGEL	T4	
HAIR, SKIN AND NAILS TABLET (<i>multivitamin/folic acid/biotin</i>)	T4	
HEARTBURN ACID REFLUX	T4	
<i>high potency multivitamin tab</i>	T2	
HIGH POTENCY MULTIVITAMIN TAB	T4	
<i>high potency multivitamin tab</i> (Certavite-Antioxidant)	T2	
<i>high potency multivitamin tab</i> (Tab-A-Vite Multivit With Iron)	T2	
HM HAIR, SKIN AND NAILS TABLET	T4	
HM MEN'S ONE DAILY TABLET	T3	
ICAPS MV	T3	
ICAPS TABLET	T3	
IMMUNERX	T4	
INFUVITE ADULT	T4	
K-PAX IMMUNE SUPPORT	T3	
<i>lecithin/pyridoxine/kelp</i>	T2	
<i>lmeofolate/b3/copp/znsel/chrom</i>	T2	
MAXIMIN	T4	
MEBOLIC	T4	
MEN 50 PLUS ADVANCED ONE DAILY	T4	
MEN 50 PLUS MULTIVITAMIN	T4	
MEN'S 50 PLUS DAILY FORMULA	T4	
MEN'S 50 PLUS MULTIVITAMIN	T4	
MEN'S DAILY FORMULA	T4	
MEN'S DAILY GUMMIES	T4	
MEN'S DAILY MULTIVITAMIN	T3	
MEN'S DAILY PACK	T4	
MEN'S ONE DAILY	T3	
MEN'S MULTIVITAMIN	T4	
MICRONEX	T4	
MONOCAPS	T4	
MULTI FOR HER 50 PLUS	T4	
MULTI FOR HER SOFTGEL	T4	
<i>multi for her tablet</i>	T2	
MULTI PRO	T4	

T1 – Preferred Generics

T2 – Non-Preferred Generics

T3 – Preferred Brands

T4 – Non-Preferred Brands

T5 – Brand Specialty

PA – Prior Authorization

QL – Quantity Limit

ST – Step Therapy

AGE – Age Requirement

SP – Specialty Medication

HD – May require home delivery pharmacy

PPACA – No Cost-Share Preventive Medication

CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

VITAMINS (Nutritional/Dietary) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
MULTIVITAMIN PREPARATIONS (cont.)		
MULTIA DAILY MULTIVITAMIN	T4	
MULTI-DAY PLUS MINERALS	T4	
MULTILEX TABLET	T4	
<i>multilex tablet</i>	T2	
MULTILEX T-M	T4	
<i>multivit 47/iron/folate 1/dha</i>	T2	
<i>multivit no.18/iron no.1/folic (Tandem Plus)</i>	T2	
<i>multivit no.51/iron/folic acid</i>	T2	
<i>multivit with calcium,iron,min</i>	T2	
<i>multivit,calc,mins/iron/folic</i>	T2	
<i>multivit,iron,minerals/lutein</i>	T2	
<i>multivit,stress formula/zinc (Stress Formula With Zinc)</i>	T2	
<i>multivit/iron/folic acid</i>	T2	
<i>multivit/iron/folic acid/hb179</i>	T2	
<i>multivitamin</i>	T2	
MULTI-VITAMIN	T4	
<i>multivitamin combination no.56</i>	T2	
MULTIVITAMIN GUMMIES	T4	
MULTIVITAMIN LIQUID	T4	
MULTIVITAMIN-MULTIMINERAL	T4	
<i>multivitamin tablet</i>	T2	
<i>multivitamin with folic acid (Daily-Vite)</i>	T2	
<i>multivitamin with iron</i>	T2	
MULTIVITAMIN WITH MINERALS	T4	
<i>multivitamin with minerals</i>	T2	
<i>multivitamin,stress formula</i>	T2	
<i>multivitamin,ther and minerals</i>	T2	
<i>multivitamin,therapeutic</i>	T2	
<i>multivitamin,therapeutic (Oncovite)</i>	T2	
<i>multivitamin/ferrous gluconate</i>	T2	
<i>multivitamin/iron/folic acid (Certavite-Antioxidant)</i>	T2	
<i>multivitamin/iron/folic acid (Tab-A-Vite Multivit With Iron)</i>	T2	
MULTI-VITE	T4	

T1 – Preferred Generics

T2 – Non-Preferred Generics

T3 – Preferred Brands

T4 – Non-Preferred Brands

T5 – Brand Specialty

PA – Prior Authorization

QL – Quantity Limit

ST – Step Therapy

AGE – Age Requirement

SP – Specialty Medication

HD – May require home delivery pharmacy

PPACA – No Cost-Share Preventive Medication

CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

VITAMINS (Nutritional/Dietary) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
MULTIVITAMIN PREPARATIONS (cont.)		
<i>multivit-min/fa/lycopen/lutein</i>	T2	
<i>multivit-min/fa/lycopen/lutein</i> (Centrum Silver)	T2	
<i>multivit-min/ferrous gluconate</i>	T2	
<i>multivit-min/folic acid/biotin</i>	T2	
<i>multivit-min/iron fum/folic ac</i>	T2	
<i>multivit-min/iron/folic acid</i>	T2	
<i>multivit-min/iron/folic/lutein</i> (Central-Vite Women'S Mature)	T2	
<i>multivit-min/iron/folic/lutein</i> (Centrum Silver Women)	T2	
<i>multivit-min69/iron/folic acid</i>	T2	
<i>multivit-minerals/fa/lycopene</i>	T2	
<i>multivit-minerals/folic acid</i>	T2	
<i>multivit-minerals/folic acid</i> (One-A-Day)	T2	
<i>multivit-minerals/folic/ginkgo</i>	T2	
<i>multivit-mins no.7/folic acid</i>	T2	
<i>multivit-mins/iron/folic/lycop</i>	T2	
<i>mv,cal,min/iron/folic acid/lut</i>	T2	
<i>mv,iron,min/ginkgo/pan.ginseng</i>	T2	
<i>mv-min 59/iron/folic/docusate</i>	T2	
<i>mv-min/iron/folic ac/vit k/lut</i>	T2	
<i>mv-mins 71/iron/folic no.1/dha</i>	T2	
<i>mv-mins/folic/lycopene/ginkgo</i>	T2	
<i>mv-mn/folic acid/lutein/hrb178</i>	T2	
<i>mvn no.53/iron/folic/dss/dha</i>	T2	
<i>mvn-min 74/iron fum/iron/fa</i> (Concept Ob)	T2	
<i>mvn-min75/iron/iron ps/om3/dha</i> (Concept Dha)	T2	
<i>mv-mn/folic ac/calcium/vit k1</i>	T2	
MVW MODULATR FORM MINI MULTIVT	T4	
NEEVODHA	T4	
NEOVITE	T4	
NESTABS ONE	T4	
NICOMIDE	T4	
NIVA-PLUS (<i>multivit-min 60/iron fum/folic</i>)	T4	
NUTRALYN	T4	

T1 – Preferred Generics

T2 – Non-Preferred Generics

T3 – Preferred Brands

T4 – Non-Preferred Brands

T5 – Brand Specialty

PA – Prior Authorization

QL – Quantity Limit

ST – Step Therapy

AGE – Age Requirement

SP – Specialty Medication

HD – May require home delivery pharmacy

PPACA – No Cost-Share Preventive Medication

CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

VITAMINS (Nutritional/Dietary) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
MULTIVITAMIN PREPARATIONS (cont.)		
NUTRIVIT	T3	
OB COMPLETE	T4	
OBSTETRIX ONE	T4	
OCUVITE EYE PLUS MULTI	T4	
<i>om-3/dha/epa/b12/fa/b6/phytost</i>	T2	
OMNIVEX	T4	
ONCOVITE (<i>multivitamin, therapeutic</i>)	T3	
ONE DAILY ESSENTIALS	T4	
ONE DAILY ESSENTIAL TABLET	T4	
<i>one daily essential tablet</i>	T2	
<i>one daily essential tablet (Daily-Vite)</i>	T2	
ONE DAILY HEALTHY WEIGHT	T4	
<i>one daily maximum tablet</i>	T2	
ONE DAILY MEN'S 50 PLUS	T4	
ONE DAILY MEN'S 50 PLUS D3	T4	
ONE DAILY MEN'S HEALTH	T4	
ONE DAILY MEN'S MULTIVITAMIN	T4	
<i>one daily multivit-mineral tab</i>	T2	
ONE DAILY MULTIVIT-MINERAL TAB	T4	
<i>one daily multivitamin tab</i>	T2	
ONE DAILY MULTIVITAMIN TABLET	T4	
<i>one daily multivitamin tablet (Daily-Vite)</i>	T2	
<i>one daily tablet</i>	T2	
ONE DAILY WOMEN 50 PLUS TAB	T4	
ONE DAILY WOMEN'S 50 PLUS ADV	T4	
ONE DAILY WOMEN'S 50+	T3	
ONE DAILY WOMEN'S FORMULA	T4	
<i>one daily women's health tab</i>	T2	
ONE DAILY WOMEN'S MULTIVITAMIN	T4	
ONE-A-DAY (<i>multivit-minerals/folic acid</i>)	T4	
ONE-A-DAY ENERGY	T4	
ONE-A-DAY MEN VITACRAVES	T4	
ONE-A-DAY MENOPAUSE FORMULA	T4	
ONE-A-DAY MEN'S	T3	

T1 – Preferred Generics

T2 – Non-Preferred Generics

T3 – Preferred Brands

T4 – Non-Preferred Brands

T5 – Brand Specialty

PA – Prior Authorization

QL – Quantity Limit

ST – Step Therapy

AGE – Age Requirement

SP – Specialty Medication

HD – May require home delivery pharmacy

PPACA – No Cost-Share Preventive Medication

CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

VITAMINS (Nutritional/Dietary) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
MULTIVITAMIN PREPARATIONS (cont.)		
ONE-A-DAY MEN'S 50 PLUS	T3	
ONE-A-DAY MEN'S 50 PLUS (<i>mv-mins/folic/lycopene/ginkgo</i>)	T3	
ONE-A-DAY MEN'S COMPLETE	T4	
ONE-A-DAY PROACTIVE 65 PLUS	T4	
ONE-A-DAY TRIPLE IMMUNE SUPPRT	T4	
ONE-A-DAY WOMEN'S 50 PLUS TAB	T4	
<i>one-a-day women's 50 plus tab</i> (One-A-Day)	T2	
ONE-A-DAY VITACRAVES	T4	
ONE-A-DAY VITACRAVES IMMUNITY	T4	
ONE-A-DAY VITACRAVES OMEGA-3	T4	
ONE-A-DAY VITACRAVES SOUR	T4	
ONE-A-DAY WEIGHTSMART	T3	
ONE-A-DAY WOMEN VITACRAVES	T4	
ONE-A-DAY WOMEN'S COMPLETE	T3	
ONE-A-DAY WOMEN'S HEALTHY SKIN	T4	
ONE-A-DAY WOMEN'S PETITES	T4	
ONE-A-DAY WOMEN'S TABLET	T3	
ONE-A-DAY WOMEN'S TABLET	T4	
ONE-DAILY MULTI	T4	
ONE-DAILY MULTI-VITAMIN-IRON	T4	
ONE-DAILY MULTIVITAMIN-MINERAL	T4	
ONEVITE	T4	
OPTIFAST	T4	
OPTISOURCE	T4	
OPURITY MULTIVITAMIN	T4	
POLY VITAMIN-IRON	T4	
PRENATAL GUMMIES	T4	
PRENATE AM	T4	
PRENATE CHEWABLE	T4	
PRENATE ESSENTIAL	T4	
PREV-RX	T4	
PROCERV HP	T4	
PROFOLA	T4	
PRORENAL QD	T3	

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

T5 – Brand Specialty
PA – Prior Authorization
QL – Quantity Limit

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

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

List of Prescription Medications

VITAMINS (Nutritional/Dietary) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
MULTIVITAMIN PREPARATIONS (cont.)		
PROTECT CARDIO AF	T4	
PROTECT IRON	T4	
PROTECT PLUS SO	T4	
PUREFE OB PLUS	T4	
PUREFE PLUS	T4	
QUINTABS	T4	
QUINTABS-M	T4	
<i>ra one daily essential tablet (One-A-Day)</i>	T2	
<i>ra one daily maximum tablet</i>	T2	
<i>ra one daily women's tablet</i>	T2	
REMEDIENT	T4	
<i>sm b complex with vit c tablet</i>	T2	
<i>sm super b complex-c caplet</i>	T2	
SOLO	T4	
SPECTRAVITE MEN 50 PLUS	T4	
SPECTRAVITE ULTRA MEN 50+	T4	
SPECTRAVITE ULTRA MEN'S	T4	
STRESS B-COMPLEX	T4	
<i>stress formula tablet</i>	T2	
STRESS FORMULA WITH ZINC TAB (<i>multivit, stress formula/zinc</i>)	T4	
<i>stress formula with zinc tab (Stress Formula With Zinc)</i>	T2	
<i>stress-c with zinc tablet (Stress Formula With Zinc)</i>	T2	
STROVITE FORTE (<i>multivit, iron, min 5/folic acid</i>)	T4	
STROVITE ONE	T4	
SUPER GINSENG MULTIVITAMIN	T4	
SUPER MULTIPLE-LOW IRON	T4	
SUPERIOR MEN'S MULTI	T4	
SUPPORT-500 (<i>b-complex with vitamin c</i>)	T4	
SV HAIR, SKIN AND NAILS CAPLET	T4	
TAB-A-VITE MULTIVIT WITH IRON	T4	
TAB-A-VITE MULTIVIT WITH IRON (<i>multivitamin/iron/folic acid</i>)	T4	
TANDEM PLUS (<i>multivit no.18/iron no.1/folic</i>)	T4	
THERAGRAN-M PREMIER 50 PLUS	T4	
<i>thera-m caplet</i>	T2	

T1 – Preferred Generics

T2 – Non-Preferred Generics

T3 – Preferred Brands

T4 – Non-Preferred Brands

T5 – Brand Specialty

PA – Prior Authorization

QL – Quantity Limit

ST – Step Therapy

AGE – Age Requirement

SP – Specialty Medication

HD – May require home delivery pharmacy

PPACA – No Cost-Share Preventive Medication

CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

VITAMINS (Nutritional/Dietary) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
MULTIVITAMIN PREPARATIONS (cont.)		
<i>thera-m tablet</i>	T2	
THERA-M CAPLET	T4	
THERAMILL FORTE	T4	
THERANATAL LACTATION SUPPORT	T4	
THEREMS-H	T3	
TOBAKIENT	T4	
TRIVIA COMPLETE	T4	
TRUE MULTIVITAMIN	T4	
TRUEPLUS MULTIVITAMIN (<i>multivit-min/folic acid/vit k1</i>)	T4	
<i>thera-m tablet</i>	T2	
UDAMIN SP	T4	
ULTRA FREEDA	T4	
VITABEX PLUS	T4	
VITACORE	T4	
VITAFUSION PRENATAL	T4	
VITAJoy ADULT MULTI	T4	
<i>vitamin b complex-vit c cap (Support-500)</i>	T2	
<i>vitamin b complex-vit c caplet</i>	T2	
<i>vitamin b complex-vitamin c tb</i>	T2	
VITAMIN D3-ALOE	T4	
VITAMINS A-D-E	T4	
VITREXYL	T4	
VITREXYL PLUS IRON	T4	
VITRUM 50 PLUS SENIOR	T3	
WOMEN'S 50 PLUS ADVANCED	T4	
WOMEN'S 50 PLUS DAILY FORMULA	T4	
<i>women's daily formula caplet</i>	T2	
WOMEN'S DAILY FORMULA CAPLET	T3	
WOMEN'S DAILY FORMULA TABLET	T4	
WOMENS DAILY GUMMIES	T4	
WOMEN'S DAILY PACK	T4	
WOMEN'S MULTIVITAMIN	T4	
WOMEN'S MULTIVITAMIN W-BIOTIN	T4	
XYZBAC	T4	

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

T5 – Brand Specialty
PA – Prior Authorization
QL – Quantity Limit

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

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

List of Prescription Medications

VITAMINS (Nutritional/Dietary) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
MULTIVITAMIN PREPARATIONS (cont.)		
ZYVANA	T4	
ZYVIT	T4	
NIACIN PREPARATIONS		
<i>cvs niacin 400 mg capsule</i>	T2	
ENDUR-AMIDE	T4	
ENDUR-THINE	T4	
<i>ft niacin 400 mg capsule</i>	T2	
<i>gnp niacin 250 mg tablet</i>	T2	
<i>gnp niacin 400 mg capsule</i>	T2	
<i>hm niacin tr 250 mg tablet (Slo-Niacin)</i>	T2	
<i>niacin</i>	T2	
<i>niacin (inositol niacinate)</i>	T2	
<i>niacin (Slo-Niacin)</i>	T2	
NIACIN 100 MG CAPSULE	T4	
NIACINAMIDE 500 MG CAPSULE	T4	
<i>niacin 500 mg capsule</i>	T2	
<i>niacin 500 mg capsule sa</i>	T2	
NIACIN 500 MG SOFTGEL	T3	
<i>niacin 50 mg, 100 mg, 250 mg, 500 mg tablet</i>	T2	
<i>niacin 750 mg tablet sa (Slo-Niacin)</i>	T2	
NIACIN ER 1,000 MG TABLET	T3	
<i>niacin er 250 mg tablet (Slo-Niacin)</i>	T2	
<i>niacin er 500 mg caplet, capsule, tablet</i>	T2	
<i>niacin flush free 500 mg cap</i>	T2	
NIACIN FLUSH FREE 750 MG CAP	T3	
<i>niacin sa 250 mg capsule</i>	T2	
<i>niacin tr 250 mg capsule</i>	T2	
<i>niacin tr 250 mg tablet (Slo-Niacin)</i>	T2	
<i>niacin tr 500 mg caplet, tablet</i>	T2	
<i>niacinamide 500 mg tablet</i>	T2	
NIACINAMIDE ER 500 MG TABLET	T4	
NO FLUSH NIACIN	T4	
PUREVITA VITAMIN B3	T4	
<i>ra niacin 100 mg, 500 mg tablet</i>	T2	

T1 – Preferred Generics

T2 – Non-Preferred Generics

T3 – Preferred Brands

T4 – Non-Preferred Brands

T5 – Brand Specialty

PA – Prior Authorization

QL – Quantity Limit

ST – Step Therapy

AGE – Age Requirement

SP – Specialty Medication

HD – May require home delivery pharmacy

PPACA – No Cost-Share Preventive Medication

CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

VITAMINS (Nutritional/Dietary) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
NIACIN PREPARATIONS (cont.)		
RA NIACIN 500 MG TABLET	T4	
SLO-NIACIN 250 MG TABLET (<i>niacin</i>)	T3	
<i>slo-niacin 500 mg tablet</i>	T2	
SLO-NIACIN 750 MG TABLET (<i>niacin</i>)	T3	
<i>sv niacin flush free 500 mg</i>	T2	
<i>true vitamin b3 50 mg, 500 mg tablet</i>	T2	
TRUE VITAMIN B3 250 MG TABLET	T4	
PANTHENOL PREPARATIONS		
CALCIUM PANTOTHENATE	T4	
PANTETHINE	T4	
PANTOTHENIC ACID	T4	
PUREVITA VITAMIN B5	T4	
PEDIATRIC VITAMIN PREPARATIONS		
ABDEK MULTIVITAMIN	T4	
ALIVE KIDS MULTIVITAMIN	T4	
ANIMAL SHAPES COMPLETE	T4	
CENTRUM KIDS	T4	
CHILD CHEWABLE VITAMN COMPLETE	T4	
CHILD COMPLETE CHEWABLE VITAMN	T4	
CHILD COMPLETE MULTIVITAMIN	T4	
CHILD MULTIVITAMIN PLUS IRON	T4	
CHILDREN MULTIVITAMIN	T4	
<i>children multivitamin chew tab</i>	T2	
CHILDREN MULTIVITAMIN GUMMIES	T4	
CHILDREN MULTIVITAMIN GUMMIES (<i>pediatric multivitamin no.120</i>)	T4	
CHILDREN'S CHEW MULTIVIT-IRON (<i>pedi multivit no.91/iron fum</i>)	T4	
<i>childrens chew vitamin tab</i> (Flintstones With Extra C)	T2	
<i>childrens chew vitamin tab</i> (Flintstones)	T2	
CHILDREN'S CHEWABLE	T4	
CHILDREN'S MULTI-VIT GUMMIES	T4	
CHILDREN'S MULTIVITAMIN GUMMY	T4	
CHILD'S CHEWABLE VITAMIN TAB	T4	
CHILD'S OMEGA-3 DHA MULTIVITAM	T4	
CULTURELLE KIDS PROBIOTIC-MV	T4	

T1 – Preferred Generics

T2 – Non-Preferred Generics

T3 – Preferred Brands

T4 – Non-Preferred Brands

T5 – Brand Specialty

PA – Prior Authorization

QL – Quantity Limit

ST – Step Therapy

AGE – Age Requirement

SP – Specialty Medication

HD – May require home delivery pharmacy

PPACA – No Cost-Share Preventive Medication

CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

VITAMINS (Nutritional/Dietary) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
PEDIATRIC VITAMIN PREPARATIONS (cont.)		
CULTURELLE KIDS PRO-MV-LUTEIN	T4	
DAVIMET WITH FLUORIDE	T4	
DEKAS PLUS	T2	
EMERGEN-C KIDZ DAILY IMMUNE	T4	
EMERGEN-C KIDZ IMMUNE PLUS	T4	
EMERGEN-C KIDZ	T4	
EQ CHILD MULTIVITAMIN GUMMIES	T4	
FLINTSTONES COMPLETE GUMMIES	T3	
FLINTSTONES COMPLETE TABLET <i>(multivit with iron,minerals)</i>	T4	
FLINTSTONES EXTRA C GUMMIES	T3	
FLINTSTONES EXTRA C TAB CHEW <i>(multivitamin)</i>	T4	
FLINTSTONES GUMMIES	T3	
FLINTSTONES GUMMIES CHEW TAB	T3	
FLINTSTONES IMMUNITY SUPPORT	T4	
FLINTSTONES MULTIVIT CHEW TAB <i>(pedi multivit no.25/folic acid)</i>	T4	
FLINTSTONES MULTI-VIT GUMMIES	T4	
FLINTSTONES PLUS CALCIUM	T3	
FLINTSTONES SOUR-GUM CHEW TAB	T3	
FLINTSTONES TAB CHEW	T4	
FLINTSTONES TABLET CHEWABLE <i>(multivitamin)</i>	T3	
FLINTSTONES WITH IRON	T4	
FLORAFOL PEDIATRIC	T4	
FLORAFOL FE PEDIATRIC	T4	
FLORIVA	T3	
FLORIVA PLUS	T4	
GENADEK	T4	
GERBER GROW MIGHTY	T4	
GERBER LIL BRAINIES	T4	
GUMMIES CHILDREN MULTIVITAMIN	T4	
GUMMY	T4	
GUMMY DINOS	T4	
INFANT-TODDLER MULTIVITAMIN	T4	
INFANT-TODDLER MULTIVIT-IRON	T4	
<i>infant-toddler multivit-iron</i>	T2	

T1 – Preferred Generics

T2 – Non-Preferred Generics

T3 – Preferred Brands

T4 – Non-Preferred Brands

T5 – Brand Specialty

PA – Prior Authorization

QL – Quantity Limit

ST – Step Therapy

AGE – Age Requirement

SP – Specialty Medication

HD – May require home delivery pharmacy

PPACA – No Cost-Share Preventive Medication

CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

VITAMINS (Nutritional/Dietary) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
PEDIATRIC VITAMIN PREPARATIONS (cont.)		
INFANT-TODDLER TRI-VITAMIN	T4	
INFUVITE PEDIATRIC	T3	
JUST 4 KIDZ MULTIVIT-PROBIOTIC	T4	
KIDS COD LIVER OIL +D	T4	
KIDS MULTIVITAMIN-MINERALS	T3	
<i>little animals child tb chw (Flintstones With Extra C)</i>	T2	
<i>little animals child tb chw (Flintstones)</i>	T2	
LITTLE ANIMALS CHILD TB CHW	T4	
LITTLE ANIMALS PLUS IRON	T4	
LIVITA FOR CHILDREN	T4	
<i>multivit with iron,minerals</i>	T2	
<i>multivit with iron,minerals (Flintstones Complete)</i>	T2	
<i>multivit with iron,minerals (Scooby-Doo)</i>	T2	
<i>multivitamin (Flintstones With Extra C)</i>	T2	
<i>multivitamin (Flintstones)</i>	T2	
<i>multivitamin with iron</i>	T2	
MULTI-VIT-FLOR	T4	
MULTIVIT-FLUOR 0.25 MG TAB CHW	T4	
<i>multivit-fluor 0.25 mg tab chw</i>	T2	PPACA
<i>multivit-fluor 0.25 mg/ml drop</i>	T2	PPACA
<i>multivit-fluor 0.5 mg tab chew</i>	T2	PPACA
MULTIVIT-FLUOR 0.5 MG TAB CHEW	T4	
<i>multivit-fluor 0.5 mg/ml drop</i>	T2	PPACA
<i>multivit-fluoride 1 mg tab chw</i>	T2	PPACA
MULTIVIT-FLUORIDE 1 MG TAB CHW	T4	
MVW COMPLETE FORMLTN PEDIATRIC	T4	
MVW COMPLETE FORMULATION D3000	T4	
MVW COMPLETE FORMULATION D5000	T4	
MVW COMPLETE FORMULTN MULTIVIT	T4	
MVW MODULATR FORMLTN PEDIATRIC	T4	
NANO VM 1-3	T3	
NANO VM 4-8	T3	
NANOVN 9-18	T4	
NANOVN T-F	T4	

T1 – Preferred Generics

T2 – Non-Preferred Generics

T3 – Preferred Brands

T4 – Non-Preferred Brands

T5 – Brand Specialty

PA – Prior Authorization

QL – Quantity Limit

ST – Step Therapy

AGE – Age Requirement

SP – Specialty Medication

HD – May require home delivery pharmacy

PPACA – No Cost-Share Preventive Medication

CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

VITAMINS (Nutritional/Dietary) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
PEDIATRIC VITAMIN PREPARATIONS (cont.)		
NOVAFERRUM YUM PEDIATR MV-IRON	T4	
NOVAMV MMM PEDIATRIC MULTIVIT	T4	
ONE-A-DAY KID'S	T4	
ONE-A-DAY TEEN HER VITACRAVES	T4	
ONE-A-DAY TEEN HIM VITACRAVES	T4	
<i>ped mvit a,c,d3 no.21/fluoride</i>	T2	PPACA
<i>pedi multivit 158/iron/vit k1</i>	T2	
<i>pedi multivit 45/fluoride/iron</i>	T2	
<i>pedi multivit no.12 w-fluoride</i>	T2	PPACA
<i>pedi multivit no.17 w-fluoride</i>	T2	PPACA
<i>pedi multivit no.23/folic acid</i>	T2	
<i>pedi multivit no.25/folic acid (Flintstones)</i>	T2	
<i>pedia poly-vite iron 5mg/0.5ml</i>	T2	
PEDIA POLY-VITE WITH IRON DROP	T4	
PEDIA TRI-VITE	T4	
<i>pediatric multivit no.36/iron</i>	T2	
<i>pediatric multivitamin no.17, 111, 112</i>	T2	
PEDIATRIC POLY-VITAMIN	T4	
PEDIATRIC POLY-VITAMIN-IRON	T4	
PEDIATRIC POLY-VITE	T4	
PEDIATRIC POLY-VITE WITH IRON	T4	
PEDIATRIC TRI-VITAMIN	T4	
PEDIATRIC TRI-VITE	T4	
POLY-VI-FLOR	T4	
POLY-VI-FLOR WITH IRON	T4	
<i>poly-vi-sol 0.5 ml oral syringe</i>	T2	
POLY-VI-SOL 1 ML ENFIT SYRINGE	T4	
POLY-VI-SOL 250MCG-50MG/ML DRP	T4	
POLY-VI-SOL WITH IRON	T4	
POLY-VITA	T4	
POLY-VITA WITH IRON	T4	
QUFLORA	T4	
QUFLORA FE	T4	
SCOOPY-DOO ONE A DAY GUMMIES	T4	

T1 – Preferred Generics

T2 – Non-Preferred Generics

T3 – Preferred Brands

T4 – Non-Preferred Brands

T5 – Brand Specialty

PA – Prior Authorization

QL – Quantity Limit

ST – Step Therapy

AGE – Age Requirement

SP – Specialty Medication

HD – May require home delivery pharmacy

PPACA – No Cost-Share Preventive Medication

CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

VITAMINS (Nutritional/Dietary) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
PEDIATRIC VITAMIN PREPARATIONS (cont.)		
SCOOBY-DOO ONE A DAY TABLET (<i>multivit with iron,minerals</i>)	T3	
SOLUVITA MULTIVITAMIN FLUORIDE	T4	
SOLUVITA MULTIVITAMIN FLUORIDE (<i>pedi multivit no.82 w-fluoride</i>)	T4	
TRI-VI-FLOR	T4	
TRI-VI-SOL	T4	
<i>tri-vit-fluor 0.25 mg/ml drop</i>	T2	PPACA
<i>tri-vit-fluor 0.5 mg/ml drop</i>	T2	PPACA
TRI-VIT-FLUOR 0.25 MG/ML DROP	T4	
TROPICAL LIQUID NUTRITION (<i>pediatric multivitamin no.118</i>)	T4	
<i>vit a palmitate/vit c/vit d3</i>	T2	
ZOO FRIENDS	T4	
ZOO FRIENDS COMPLETE	T4	
VITAMIN A AND D PREPARATIONS		
<i>cod liver oil softgel</i>	T2	
<i>gnp norwegian cod liver oil</i>	T2	
SV COD LIVER OIL SOFTGEL	T4	
VITAMIN A PREPARATIONS		
A-25	T4	
AQUASOL A	T3	
<i>beta-carotene</i>	T2	
<i>cvs vitamin a 2,400 mcg sftgl</i>	T2	
FT VITAMIN A 3,000 MCG SOFTGEL	T4	
GNP VITAMIN A 3,000 MCG SOFTGL	T4	
NORWEGIAN COD LIVER OIL SFGL	T4	
PREVENT	T3	
PUREVITA VITAMIN A	T4	
<i>ra vitamin a 10,000 unit sftgl</i>	T2	
VITAMIN A BETA CAROTENE	T4	
<i>vitamin a 10,000 unit capsule</i>	T2	
<i>vitamin a 10,000 unit softgel</i>	T2	
VITAMIN A 10,000 UNIT SOFTGEL	T4	
<i>vitamin a 3,000 mcg softgel</i>	T2	
<i>vitamin a 8,000 unit capsule</i>	T2	
VITAMIN A PALMITATE	T4	

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

T5 – Brand Specialty
PA – Prior Authorization
QL – Quantity Limit

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

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

List of Prescription Medications

VITAMINS (Nutritional/Dietary) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
VITAMIN A PREPARATIONS (cont.)		
<i>vitamin a/vit c/zinc/propolis</i>	T2	
VITAMINS A D	T4	
VITAMIN B PREPARATIONS		
5-MTHF PLUS B12	T4	HD
<i>acetylcyst/methylb12/levomefol (Cerefolin Brain Wellness)</i>	T2	HD
ALBA-LYBE	T3	HD
APETEX (<i>vitamin b complex/lysine</i>)	T3	HD
APETIGEN (<i>vitamin b complex/lysine</i>)	T3	HD
ARKALIOX	T4	HD
B ACTIV	T4	HD
<i>b comp no3/folic/c/biotin/zinc</i>	T2	HD
<i>b comp/ferrous gluc/lysine/znax</i>	T2	HD
<i>b complex 11/folic/c/biot/zinc</i>	T2	HD
<i>b complex c no.10/folic acid</i>	T2	HD
<i>b complex capsule</i>	T2	HD
<i>b complex tablet</i>	T2	HD
<i>b complex, c no.20/folic acid (Virt-Caps)</i>	T2	HD
B COMPLEX WITH B-12	T4	HD
B COMPLEX WITH VITAMIN C	T4	HD
B COMPLEX-FOLIC ACID (<i>cyanocobalamin/folic ac/vit b6</i>)	T4	HD
<i>b12/levomefolate calcium/b-6</i>	T2	HD
B-50 COMPLEX	T4	HD
<i>b-100 complex tr caplet</i>	T2	HD
B-100 COMPLEX CAPSULE	T4	HD
<i>balanced b-100 complex tab sa</i>	T2	HD
B-COMPLEX 100	T4	HD
<i>b-complex 100 injection</i>	T2	HD
<i>b-complex injection vial</i>	T2	HD
<i>b-complex plus vitamin c cplt (Vita-Bee With C)</i>	T2	HD PPACA
<i>b-complex tablet (Vitamin B Complex-Electrolytes)</i>	T2	HD PPACA
B-COMPLEX FAST DISSOLVE TABLET	T4	HD
B-COMPLEX WITH B-12	T4	HD
<i>b-complex with b12 tablet</i>	T2	HD
<i>b-complex with vit c caplet (Vita-Bee With C)</i>	T2	HD PPACA

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

T5 – Brand Specialty
PA – Prior Authorization
QL – Quantity Limit

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

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

List of Prescription Medications

VITAMINS (Nutritional/Dietary) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
VITAMIN B PREPARATIONS (cont.)		
<i>b-complex with vit c tablet</i> (Vita-Bee With C)	T2	HD PPACA
B-COMPLEX-VITAMIN C TR TABLET	T3	HD
BIOTIN 1,000 MCG GUMMIES	T4	HD
<i>biotin 1,000 mcg tablet</i>	T2	HD
BIOTIN 10 MG TABLET	T3	HD
BIOTIN 10,000 MCG SOFTGEL	T4	HD
BIOTIN 10,000 MCG TABLET	T3	HD
<i>biotin 2,500 mcg softgel</i> (Hard Nails)	T2	HD
<i>biotin 300 mcg tablet</i>	T2	HD
BIOTIN 5 MG TABLET	T4	HD
<i>biotin 5,000 mcg capsule</i> (Meribin)	T2	HD
BIOTIN 5,000 MCG FAST DISSOLVE	T4	HD
BIOTIN 5,000 MCG QUICK DISSOLV	T4	HD
<i>biotin 5,000 mcg softgel</i> (Meribin)	T2	HD
BIOTIN 5,000 MCG TABLET	T4	HD
<i>biotin 800 mcg tablet</i>	T2	HD
BIOTIN FORTE 3 MG TABLET	T4	HD
BIOTIN FORTE 5 MG TABLET	T3	HD
B-STRESS	T4	HD
CARDIOTEK-RX	T4	HD
CEREFOLIN (<i>vit b12/levomefolate/vit b6/b2</i>)	T4	HD
CEREFOLIN BRAIN WELLNESS (<i>acetylcyst/methylb12/levomefol</i>)	T4	HD
CEREFOLIN NAC	T4	HD
COMPLEX B-100 ER CAPLET	T4	HD
<i>complex b-100 tablet sa</i>	T2	HD
COMPLEX B-50	T4	HD
COMPLETE LIVER CLEANSE	T4	HD
CVS BIOTIN 5,000 MCG TABLET	T4	HD
CVS BALANCED B-100 TR CAPLET	T4	HD
<i>cvs biotin 1,000 mcg tablet</i>	T2	HD
CVS BIOTIN 10,000 MCG SOFTGEL	T4	HD
<i>cvs super b-complex-vit c cplt</i> (Vita-Bee With C)	T2	HD PPACA
<i>cyanocobalamin/folic ac/vit b6</i>	T2	HD

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

T5 – Brand Specialty
PA – Prior Authorization
QL – Quantity Limit

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

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

List of Prescription Medications

VITAMINS (Nutritional/Dietary) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
VITAMIN B PREPARATIONS (cont.)		
<i>cyanocobalamin/folic ac/vit b6</i>	T2	HD PPACA
<i>cyanocobalamin/folic ac/vit b6 (Niva-Fol)</i>	T2	HD
CYTO B7	T4	HD
DIALYVITE 3000	T4	HD
DIALYVITE 5000	T4	HD
DIALYVITE 800 CHEWABLE WAFER	T4	HD
DIALYVITE 800 PLUS D	T4	HD
<i>dialyvite 800 tablet</i>	T2	HD PPACA
DIALYVITE 800 WITH ZINC	T4	HD
DIALYVITE 800-ULTRA D	T3	HD
DIALYVITE SUPREME D	T4	HD
ELFOLATE PLUS	T4	HD
ENDUR-B COMPLEX	T4	HD
<i>eq b complex 50 tablet</i>	T2	HD
FOLA-B COMPLEX	T4	HD
FOLIC ACID-B6-B12	T4	HD
<i>folic acid/b complex c no.17</i>	T2	HD
<i>folic acid/vit b complex and c</i>	T2	HD PPACA
<i>folic acid/vit b complex and c</i>	T2	HD
<i>folic acid/vit b complex and c (Vita-Bee With C)</i>	T2	HD PPACA
<i>folic acid/vit bcomp,c/cu/zinc</i>	T2	HD
FOLICORE B COMPLEX	T4	HD
FOLIKA-BC	T4	HD
FOLIKA-NC	T4	HD
FOLIKA-T	T4	HD
FOLINIC-PLUS	T4	HD
FOLTX	T4	HD
FOLVITA COMPLEX	T4	HD
<i>ft b-100 complex er tablet</i>	T2	HD
FT BIOTIN 2,500 MCG GUMMY	T4	HD
FT BIOTIN 10,000 MCG TABLET	T3	HD
GENICIN VITA-S	T4	HD
<i>gnp b-100 complex tablet</i>	T2	HD
GNP BIOTIN 10,000 MCG TABLET	T3	HD

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

T5 – Brand Specialty
PA – Prior Authorization
QL – Quantity Limit

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

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

List of Prescription Medications

VITAMINS (Nutritional/Dietary) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
VITAMIN B PREPARATIONS (cont.)		
GNP BIOTIN 2,500 MCG GUMMY	T4	HD
<i>gnp biotin 5,000 mcg capsule</i> (Meribin)	T2	HD
HAIR-SKIN-NAILS	T4	HD
HARD NAILS (<i>biotin</i>)	T4	HD
HM BIOTIN 10,000 MCG TABLET	T4	HD
<i>hm biotin 5,000 mcg capsule</i> (Meribin)	T2	HD
HOMOCYSTEINE FORMULA	T4	HD
HYLAVITE (<i>folic acid/vit b complex and c</i>)	T4	HD
KIDS BRAIN BUILDER	T4	HD
<i>levomefolate/b6/b12/algae oil</i>	T2	HD
LEVOMEFOLATE-NAC-MECOBAL-ALGAL	T4	HD
LEVOMEFOL-PYRIDOXAL-MEC-ALGAL	T4	HD
<i>l-mefol/a-cyst/meb12/algae oil</i>	T2	HD
L-METHYLFOL-ALGAL-NAC-ME-CBL	T4	HD
L-METHYLFOL-ALGAL-P5P-ME-CBL	T4	HD
LORID	T4	HD
LORMATE	T4	HD
<i>mecobal/levomefolat ca/b6 phos</i>	T2	HD
MEDTYCHOLL-B COMPLEX W-LIVER	T4	HD
MEGA BIOTIN	T4	HD
MERIBIN (<i>biotin</i>)	T3	HD
METANX	T4	HD
METANX FC	T4	HD
METANX RR	T4	HD
METANXPRO NERVE HEALTH	T4	HD
METHAVER	T4	HD
METHYL PROTECT	T4	HD
MINCORA	T4	HD
MULTIVITAMIN-ZINC-STRESS	T4	HD
NEPHRON FA	T4	HD
NEPHRO-VITE	T3	HD
NIVA-FOL (<i>cyanocobalamin/folic ac/vit b6</i>)	T4	HD
NUFOLA	T4	HD
PODIAPN	T4	HD

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

T5 – Brand Specialty
PA – Prior Authorization
QL – Quantity Limit

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

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

List of Prescription Medications

VITAMINS (Nutritional/Dietary) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
VITAMIN B PREPARATIONS (cont.)		
PRORENAL	T3	HD
PUREVITA SUPER B-COMPLEX	T4	HD
QUIN B STRONG	T4	HD
<i>ra balanced b-100 tablet (Vitamin B Complex-Electrolytes)</i>	T2	HD PPACA
<i>ra b-complex-vitamin b-12 tab</i>	T2	HD
<i>ra biotin 2,500 mcg capsule (Hard Nails)</i>	T2	HD
RELCARE	T4	HD
RENAL MULTIVITAMIN	T4	HD
RENAL VITAMIN	T4	HD
RENAL-VITE	T4	HD
RENAPLEX	T4	HD
RENAPLEX-D	T4	HD
RIBOZEL	T4	HD
<i>sm biotin 5,000 mcg capsule (Meribin)</i>	T2	HD
<i>sm stress formula+zinc tablet</i>	T2	HD
<i>super b complex-vit c caplet (Vita-Bee With C)</i>	T2	HD PPACA
<i>super quints b-50 tablet (Vitamin B Complex-Electrolytes)</i>	T2	HD PPACA
<i>super quints b-50 tablets</i>	T2	HD
SV BIOTIN 1,000 MCG SOFTGEL	T4	HD
<i>sv biotin 5,000 mcg softgel (Meribin)</i>	T2	HD
TRONVITE	T4	HD
ULTRA B-100 COMPLEX TABLET	T4	HD
<i>ultra b-100 complex tablet</i>	T2	HD
VIRT-CAPS (b complex, c no.20/folic acid)	T4	HD
<i>vit b comp c 19/folic acid/d3</i>	T2	HD PPACA
<i>vit b comp no.3/folic/c/biotin</i>	T2	HD
<i>vit b comp/c/fa/iron sulf/vite</i>	T2	HD PPACA
<i>vit b comp/c/folic/iron/vit e</i>	T2	HD PPACA
<i>vit b comp/folic/choline/inosi</i>	T2	HD PPACA
<i>vit b 12/levomefolate/vit b6/b2 (Cerefolin)</i>	T2	HD
VITA-BEE WITH C (<i>folic acid/vit b complex and c</i>)	T4	HD
VITAL-D RX	T4	HD
VITAJoy BIOTIN	T4	HD

T1 – Preferred Generics

T2 – Non-Preferred Generics

T3 – Preferred Brands

T4 – Non-Preferred Brands

T5 – Brand Specialty

PA – Prior Authorization

QL – Quantity Limit

ST – Step Therapy

AGE – Age Requirement

SP – Specialty Medication

HD – May require home delivery pharmacy

PPACA – No Cost-Share Preventive Medication

CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

VITAMINS (Nutritional/Dietary) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
VITAMIN B PREPARATIONS (cont.)		
<i>vitamin b complex</i>	T2	HD
<i>vitamin b complex capsule, softgel</i>	T2	HD
<i>vitamin b complex/folic acid</i> (Vitamin B Complex-Electrolytes)	T2	HD PPACA
<i>vitamin b complex tablet</i> (Vitamin B Complex-Electrolytes)	T2	HD PPACA
<i>vitamin b complex tablet</i>	T2	HD
VITAMIN B COMPLEX-ELECTROLYTES (<i>vitamin b complex/folic acid</i>)	T4	HD
<i>vitamin b complex/lysine</i> (Apetex)	T2	HD
<i>vitamin b complex/lysine</i> (Apetigen)	T2	HD
<i>vitamin b complex-vitamin c tb</i> (Vita-Bee With C)	T2	HD PPACA
<i>vitamin b-complex c caplet</i>	T2	HD PPACA
VITA-RESPA	T4	HD
VITASURE	T4	HD
XVITE	T4	HD
ZELDANA	T4	HD
VITAMIN B1 PREPARATIONS		
<i>cvs vitamin b-1 100 mg tablet</i>	T2	
CYTO B-1	T4	
<i>ft vitamin b-1 100 mg tablet</i>	T2	
<i>gnp vitamin b-1 100 mg tablet</i>	T2	
<i>ra vitamin b-1 100 mg tablet</i>	T2	
PUREVITA VITAMIN B1	T4	
THIAMINE HCL-0.9% NACL	T4	
<i>thiamine 100 mg tablet</i>	T2	
<i>thiamine 200 mg/2 ml vial</i>	T2	
<i>thiamine 250 mg tablet</i>	T2	
THIAMINE 500 MG TABLET	T4	
<i>thiamine hcl</i>	T2	
TRUE VITAMIN B-1 250 MG TABLET	T4	
TRUE VITAMIN B-1 50 MG TABLET	T4	
<i>true vitamin b-1 100 mg tablet</i>	T2	
VITAMIN B-1 100 MG CAPSULE	T4	
<i>vitamin b-1 100 mg tablet</i>	T2	
<i>vitamin b-1 250 mg tablet</i>	T2	
<i>vitamin b-1 50 mg tablet</i>	T2	

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

T5 – Brand Specialty
PA – Prior Authorization
QL – Quantity Limit

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

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

List of Prescription Medications

VITAMINS (Nutritional/Dietary) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
VITAMIN B12 PREPARATIONS		
ABANEU-SL	T4	
APATATE	T3	
B-12 1,000 MCG FAST DISSOLVE	T4	
B-12 1,000 MCG LOZENGE	T4	
B-12 1,000 MCG QUICK DISSOLVE	T4	
<i>b-12 1,000 mcg tablet</i>	T2	
B-12 1,000 MCG/15 ML LIQUID	T3	
<i>b-12 1,000 mcg/15 ml liquid</i>	T2	
<i>b-12 2,500 mcg microlozenge</i>	T2	
<i>b-12 2,500 mcg tablet sl</i>	T2	
B-12 3,000 MCG TABLET SL	T4	
<i>b-12 3,000 mcg/ml subling liq</i>	T2	
B-12 5,000 MCG FAST DISSOLVE	T4	
B-12 5,000 MCG MICROLOZENGE	T3	
B-12 5,000 MCG ODT	T4	
B-12 5,000 MCG QUICK DISSOLVE	T4	
B-12 5,000 MCG SUBLINGUAL TAB	T4	
B-12 5,000 MCG/ML SUBLING LIQ	T4	
B-12 500 MCG QUICK DISSOLVE TB	T4	
<i>b-12 500 mcg tablet</i>	T2	
B12 ACTIVE	T4	
B-12 DUAL SPECTRUM	T4	
<i>b-12 er 1,000 mcg tab</i>	T2	
B-12 WITH FOLIC ACID	T4	
<i>cvs b-12 1,000 mcg tablet</i>	T2	
CVS B-12 5,000 MCG MICROLOZENG	T4	
CVS VIT B12 2,500 MCG SOFT CHW	T4	
<i>cvs vitamin b12 5,000 mcg chew</i>	T2	
CVS VITAMIN B12 5,000 MCG TAB	T4	
CVS VIT B-12 500 MCG LOZENGE	T3	
<i>cvs vit b-12 500 mcg lozenge</i>	T2	
<i>cvs vit b-12 tr 1,000 mcg tab</i>	T2	
<i>cvs vit b-12 tr 2,000 mcg tab</i>	T2	
CVS VITAMIN B-12 500 MCG GUMMY	T4	

T1 – Preferred Generics

T2 – Non-Preferred Generics

T3 – Preferred Brands

T4 – Non-Preferred Brands

T5 – Brand Specialty

PA – Prior Authorization

QL – Quantity Limit

ST – Step Therapy

AGE – Age Requirement

SP – Specialty Medication

HD – May require home delivery pharmacy

PPACA – No Cost-Share Preventive Medication

CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

VITAMINS (Nutritional/Dietary) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
VITAMIN B12 PREPARATIONS (cont.)		
<i>cvs vitamin b-12 500 mcg tab</i>	T2	
<i>cyanocobalamin (vitamin b-12) (Nascobal)</i>	T2	ST QL (4 units/30 days)
<i>eql vitamin b-12 500 mcg tab</i>	T2	
<i>fn vitamin b-12 1,000 mcg tab</i>	T2	
FOLTRATE	T4	
<i>ft vit b-12 2,500 mcg tab sl</i>	T2	
<i>ft vitamin b-12 500 mcg tablet</i>	T2	
<i>ft vitamin b12 er 1,000 mcg tb</i>	T2	
FT VITAMIN B-12 1500 MCG GUMMY	T4	
FT VITAMIN B-12 5,000 MCG TAB	T3	
<i>gnp b12 2,500 mcg tablet sl</i>	T2	
<i>gnp vit b-12 er 1,000 mcg tab</i>	T2	
<i>gnp vitamin b-12 500 mcg tab</i>	T2	
GNP VITAMIN B-12 1500MCG GUMMY	T4	
GNP VITAMIN B-12 5,000 MCG TAB	T4	
<i>hm vit b-12 tr 1,000 mcg tab</i>	T2	
<i>hm vitamin b-12 500 mcg tablet</i>	T2	
<i>hydroxocobalamin</i>	T2	
INTRINSI B12-FOLATE	T4	
METHYL B-12	T4	
METHYLCOBALAMIN	T4	
METHYLCOBALAMIN 5,000 MCG TAB	T4	
MTX SUPPORT	T4	
NASCOBAL (<i>cyanocobalamin (vitamin b-12)</i>)	T3	ST QL (4 units/30 days)
NEURIN-SL	T4	
OPURITY	T4	
PAXLYTE	T4	
PUREVITA VITAMIN B12	T4	
<i>ra vit b12 1,000 mcg tab sa</i>	T2	
RA VIT B-12 1,000 MCG/ML LIQ	T4	
<i>ra vitamin b-12 100 mcg tablet</i>	T2	
<i>ra vitamin b12 er 2,000 mcg tb</i>	T2	
RAPID B-12 ENERGY	T4	
<i>sm vitamin b12 1,000 mcg tab</i>	T2	

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

T5 – Brand Specialty
PA – Prior Authorization
QL – Quantity Limit

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

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

List of Prescription Medications

VITAMINS (Nutritional/Dietary) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
VITAMIN B12 PREPARATIONS (cont.)		
<i>sm vitamin b-12 100 mcg tablet</i>	T2	
<i>sm vitamin b-12 500 mcg tablet</i>	T2	
<i>sv b-12 2,500 mcg microlozenge</i>	T2	
SV B-12 5,000 MCG MICROLOZENGE	T3	
SV VIT B-12 500 MCG LOZENGE	T3	
<i>sv vitamin b-12 500 mcg tablet</i>	T2	
<i>sv vitamin b12 tr 1,000 mcg tb</i>	T2	
<i>true vitamin b-12 1000 mcg tab</i>	T2	
<i>true vitamin b-12 500 mcg tab</i>	T2	
VIT B-12 500 MCG SUBLING TAB	T4	
VITAMIN B-12 1,000 MCG SOFTGEL	T4	
<i>vitamin b-12 1,000 mcg tab sl</i>	T2	
<i>vitamin b-12 1,000 mcg tablet</i>	T2	
<i>vitamin b-12 100 mcg tablet</i>	T2	
<i>vitamin b-12 2,000 mcg tab sa</i>	T2	
VITAMIN B-12 2,000 MCG TABLET	T4	
<i>vitamin b-12 2,500 mcg tab sl</i>	T2	
VITAMIN B12 2,500 MCG TABLET	T4	
VITAMIN B-12 250 MCG LOZENGE	T4	
<i>vitamin b-12 250 mcg tablet</i>	T2	
VITAMIN B-12 3,000 MCG SL LOZ	T4	
VITAMIN B-12 3,000 MCG SOFTGEL	T4	
VITAMIN B-12 3,000 MCG TAB SL	T4	
VITAMIN B-12 5,000 MCG ODT	T4	
VITAMIN B-12 5,000 MCG SOFTGEL	T4	
VITAMIN B-12 5,000 MCG TAB SL	T3	
<i>vitamin b-12 5,000 mcg tab sl</i>	T2	
VITAMIN B-12 5,000 MCG TAB SL	T4	
VITAMIN B-12 5,000 MCG TABLET	T4	
VITAMIN B-12 50 MCG LOZENGE	T4	
<i>vitamin b12 50 mcg tablet</i>	T2	
<i>vitamin b-12 50 mcg tablet</i>	T2	
VITAMIN B-12 500 MCG LOZENGE	T3	
<i>vitamin b12 500 mcg tablet</i>	T2	

T1 – Preferred Generics

T2 – Non-Preferred Generics

T3 – Preferred Brands

T4 – Non-Preferred Brands

T5 – Brand Specialty

PA – Prior Authorization

QL – Quantity Limit

ST – Step Therapy

AGE – Age Requirement

SP – Specialty Medication

HD – May require home delivery pharmacy

PPACA – No Cost-Share Preventive Medication

CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

VITAMINS (Nutritional/Dietary) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
VITAMIN B12 PREPARATIONS (cont.)		
<i>vitamin b-12 500 mcg tablet</i>	T2	
<i>vitamin b-12 er 1,000 mcg tab</i>	T2	
<i>vitamin b-12 tr 1,000 mcg tab</i>	T2	
<i>vitamin b-12 tr 2,000 mcg tab</i>	T2	
VITAMIN B12-FOLIC ACID	T4	
VITAMIN B2 PREPARATIONS		
CYTO B-2	T4	
PUREVITA VITAMIN B2	T4	
<i>riboflavin (vitamin b2)</i>	T2	
RIBOFLAVIN 100 MG CAPSULE	T4	
<i>riboflavin 100 mg tablet</i>	T2	
RIBOFLAVIN 400 MG TABLET	T4	
<i>riboflavin 50 mg tablet</i>	T2	
VITAMIN B6 PREPARATIONS		
<i>cvs vitamin b-6 100 mg tablet</i>	T2	
<i>eql vitamin b-6 100 mg tablet</i>	T2	
<i>ft vitamin b-6 100 mg tablet</i>	T2	
<i>gnp vitamin b-6 100 mg tablet</i>	T2	
PUREVITA VITAMIN B6	T4	
<i>pyridoxine 100 mg/ml vial</i>	T2	
<i>pyridoxine 25 mg, 250 mg tablet</i>	T2	
PYRIDOXINE 50 MG TABLET (<i>pyridoxine hcl (vitamin b6)</i>)	T3	
<i>pyridoxine 50 mg tablet (Pyridoxine Hcl)</i>	T2	
PYRIDOXINE 500 MG TABLET (<i>pyridoxine hcl (vitamin b6)</i>)	T4	
<i>pyridoxine hcl (vitamin b6)</i>	T2	
<i>pyridoxine hcl (vitamin b6) (Pyridoxine Hcl)</i>	T2	
<i>ra vitamin b-6 100 mg tablet</i>	T2	
<i>ra vitamin b-6 50 mg tablet</i>	T2	
<i>sm vitamin b-6 100 mg tablet</i>	T2	
<i>sv vitamin b-6 100 mg tablet</i>	T2	
<i>true vitamin b-6 100 mg tablet</i>	T2	
<i>true vitamin b-6 25 mg tablet</i>	T2	
<i>true vitamin b-6 50 mg tablet</i>	T2	
TRUE VITAMIN B-6 10 MG TABLET	T4	

T1 – Preferred Generics

T2 – Non-Preferred Generics

T3 – Preferred Brands

T4 – Non-Preferred Brands

T5 – Brand Specialty

PA – Prior Authorization

QL – Quantity Limit

ST – Step Therapy

AGE – Age Requirement

SP – Specialty Medication

HD – May require home delivery pharmacy

PPACA – No Cost-Share Preventive Medication

CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

VITAMINS (Nutritional/Dietary) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
VITAMIN B6 PREPARATIONS (cont.)		
VB6 P5P	T4	
vitamin b-6 100 mg tablet	T2	
vitamin b-6 25 mg tablet	T2	
vitamin b-6 250 mg tablet	T2	
vitamin b-6 50 mg tablet	T2	
VITAMIN C PREPARATIONS		
ASCOR	T4	
ascorbate calcium	T2	
ascorbic acid	T2	
ascorbic acid 500 mg/5 ml cup	T2	
ascorbic acid 500 mg tablet	T2	
ascorbic acid 500 mg/ml vial	T2	
ASCORBIC ACID GRANULES	T3	
ascorbic acid/ascorbate sodium	T2	
BIO C 1:1	T4	
c-1,000 mg tablet sa	T2	
cod liver oil tab chewable	T2	
cvs vit c-rose hip 1,000 mg tb	T2	
cvs vit c-rose hip 500 mg chew	T2	
cvs vit c-rose hip 500 mg cplt	T2	
cvs vit c-rose hips 500 mg tab	T2	
cvs vitamin c 1,000 mg caplet	T2	
CVS VITAMIN C 1,000 MG POWDER	T4	
cvs vitamin c 250 mg tablet	T2	
cvs vitamin c 500 mg caplet, tablet	T2	
CYTO C	T4	
EASY-C IMMUNE HEALTH	T4	
EMERGEN-C	T4	
EMERGEN-C APPLE CIDER VINEGAR	T4	
EMERGEN-C ASHWAGANDHA	T4	
EMERGEN-C TURMERIC GINGER	T4	
EMERGEN-C ELDERBERRY	T4	
EMERGEN-C ENERGY PLUS	T4	
EMERGEN-C IMMUNE PLUS	T4	

T1 – Preferred Generics

T2 – Non-Preferred Generics

T3 – Preferred Brands

T4 – Non-Preferred Brands

T5 – Brand Specialty

PA – Prior Authorization

QL – Quantity Limit

ST – Step Therapy

AGE – Age Requirement

SP – Specialty Medication

HD – May require home delivery pharmacy

PPACA – No Cost-Share Preventive Medication

CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

VITAMINS (Nutritional/Dietary) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
VITAMIN C PREPARATIONS (cont.)		
EMERGEN-C MSM LITE	T4	
<i>eqi vitamin c 1,000 mg tablet</i>	T2	
ESSENCE C	T4	
ESTER-C 1,000 MG TABLET	T4	
ESTER-C 500 MG TABLET	T3	
FLEVOXIN	T4	
FRUIT C-100 TABLET CHEWABLE	T4	
<i>fruit c-100 tablet chewable</i>	T2	
FRUIT C-200	T4	
<i>ft vit c-rose hip 1,000 mg tab</i>	T2	
<i>ft vit c-rose hips 500 mg tab</i>	T2	
FT VITAMIN C 500 MG CHEW TAB	T3	
<i>ft vitamin c 1,000 mg tablet</i>	T2	
<i>gnp vit c-rose hips 500 mg tab</i>	T2	
GNP VITAMIN C 125 MG GUMMY	T4	
<i>gnp vitamin c 1,000 mg tablet</i>	T2	
<i>gnp vitamin c 250 mg tablet</i>	T2	
<i>gnp vitamin c 500 mg tab chew</i>	T2	
<i>gnp vitamin c 500 mg tablet</i>	T2	
<i>gnp vitamin c er 500 mg tablet</i>	T2	
<i>hm vit c-rose hip 1,000 mg tab</i>	T2	
<i>hm vit c-rose hips 500 mg cplt</i>	T2	
<i>hm vitamin c 500 mg tab chew</i>	T2	
LIQUID-C	T4	
PAN-C 500	T4	
PERIDIN-C	T3	
PUREVITA VITAMIN C	T4	
<i>ra vit c-rose hips 500 mg tab</i>	T2	
<i>ra vitamin c 1,000 mg tab sa</i>	T2	
<i>ra vitamin c 1,000 mg tablet</i>	T2	
<i>ra vitamin c 250 mg tablet</i>	T2	
<i>ra vitamin c 500 mg chew tab</i>	T2	
<i>ra vitamin c 500 mg tab chew</i>	T2	

T1 – Preferred Generics

T2 – Non-Preferred Generics

T3 – Preferred Brands

T4 – Non-Preferred Brands

T5 – Brand Specialty

PA – Prior Authorization

QL – Quantity Limit

ST – Step Therapy

AGE – Age Requirement

SP – Specialty Medication

HD – May require home delivery pharmacy

PPACA – No Cost-Share Preventive Medication

CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

VITAMINS (Nutritional/Dietary) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
VITAMIN C PREPARATIONS (cont.)		
<i>ra vitamin c 500 mg tablet</i>	T2	
RA VITAMIN C 53 MG DROP	T4	
<i>ra vitamin c tr 500 mg caplet</i>	T2	
SAMBUCUS ELDERBERRY-VITAMIN C	T4	
<i>sm vit c-rose hips 500 mg tab</i>	T2	
<i>sm vitamin c 1,000 mg tablet</i>	T2	
<i>sm vitamin c 250 mg tablet</i>	T2	
<i>sm vitamin c 500 mg chew tab</i>	T2	
<i>sm vitamin c 500 mg tab chew</i>	T2	
<i>sm vitamin c 500 mg tablet</i>	T2	
<i>sm vitamin c with rose hips</i>	T2	
SPAN C	T4	
<i>sv vit c-rose hips 1,000 mg tb</i>	T2	
<i>sv vit c-rose hips 500 mg tab</i>	T2	
<i>sv vitamin c 500 mg tab chew</i>	T2	
<i>sv vitamin c tr 1,000 mg tab</i>	T2	
<i>true vitamin c 1,000 mg tablet</i>	T2	
<i>true vitamin c 250 mg tablet</i>	T2	
<i>true vitamin c 500 mg tablet</i>	T2	
<i>vit c-rose hip 1,000 mg caplet</i>	T2	
<i>vit c-rose hips 500 mg capsule</i>	T2	
VIT C-ROSE HIPS 500 MG CAPSULE	T4	
<i>vit c-rose hips 1,000 mg cplt</i>	T2	
<i>vit c-rose hips 1,000 mg tab</i>	T2	
VIT C-ROSE HIPS 500 MG CHEW TB	T4	
<i>vit c-rose hips 500 mg tablet</i>	T2	
<i>vit c-rose hips tr 1,000 mg</i>	T2	
<i>vit c-rose hips tr 500 mg cplt</i>	T2	
<i>vit c-rose hips tr 500 mg tab</i>	T2	
VITAJoy DAILY C	T4	
<i>vitamin c 1,000 mg caplet</i>	T2	
<i>vitamin c 100 mg, 1,000 mg tablet</i>	T2	
<i>vitamin c 1,500 mg tablet sa</i>	T2	
VITAMIN C 125 MG GUMMIES	T4	

T1 – Preferred Generics

T2 – Non-Preferred Generics

T3 – Preferred Brands

T4 – Non-Preferred Brands

T5 – Brand Specialty

PA – Prior Authorization

QL – Quantity Limit

ST – Step Therapy

AGE – Age Requirement

SP – Specialty Medication

HD – May require home delivery pharmacy

PPACA – No Cost-Share Preventive Medication

CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

VITAMINS (Nutritional/Dietary) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
VITAMIN C PREPARATIONS (cont.)		
<i>vitamin c 250 mg tablet</i>	T2	
VITAMIN C 250 MG TABLET CHEW	T4	
<i>vitamin c 250 mg tablet chew</i>	T2	
<i>vitamin c 500 mg capsule sa</i>	T2	
<i>vitamin c 500 mg chew tablet</i>	T2	
VITAMIN C 500 MG POWDER PACKET	T4	
VITAMIN C 500 MG SOFTGEL	T4	
<i>vitamin c 500 mg tablet</i>	T2	
<i>vitamin c 500 mg tablet chew</i>	T2	
VITAMIN C 500 MG WAFER	T4	
VITAMIN C 500 MG/15 ML LIQUID	T4	
<i>vitamin c 500 mg/5 ml liquid</i>	T2	
<i>vitamin c drops</i>	T2	
VITAMIN C FIZZY DRINK	T4	
VITAMIN C POWDER	T4	
<i>vitamin c powder</i>	T2	
<i>vitamin c tr 1,000 mg tablet</i>	T2	
<i>vitamin c tr 500 mg caplet</i>	T2	
<i>vitamin c tr 500 mg tablet</i>	T2	
<i>vitamin c-500 mg tablet</i>	T2	
<i>vitamin c-500 mg tr capsule</i>	T2	
VITAMIN C-BIOFLAVINOIDS-RH	T4	
<i>vitamin c-rose hip 1,000 mg tb</i>	T2	
<i>v-r vitamin c 1,000 mg tablet</i>	T2	
<i>v-r vitamin c 250 mg tab chew</i>	T2	
<i>v-r vitamin c 500 mg tab chew</i>	T2	
<i>well vitamin c 1,000 mg tablet</i>	T2	
<i>well vitamin c 500 mg tablet</i>	T2	
XCELLENT C	T4	
ZINC PLUS	T4	
ZINC-VITAMIN C	T4	
VITAMIN D PREPARATIONS		
BABY DDROPS	T4	HD
BABY VITAMIN D3	T4	HD

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

T5 – Brand Specialty
PA – Prior Authorization
QL – Quantity Limit

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

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

List of Prescription Medications

VITAMINS (Nutritional/Dietary) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
VITAMIN D PREPARATIONS (cont.)		
BABY'S SUPER DAILY D3	T4	HD
BIO-D-MULSION	T4	HD
BIO-D-MULSION FORTE	T4	HD
<i>calcitriol 0.25 mcg capsule</i>	T2	
<i>calcitriol 0.5 mcg capsule</i>	T2	
<i>calcitriol 1 mcg/ml ampul</i>	T2	
<i>calcitriol 1 mcg/ml solution (Rocaltrol)</i>	T2	
CHOLECAL DF	T4	HD
<i>cholecalciferol (vitamin d3)</i>	T2	HD
<i>cod liver oil</i>	T2	HD
<i>cod liver oil capsule</i>	T2	HD
<i>cvs vit d3 1,000 unit gummies</i>	T2	HD
<i>cvs vitamin d3 25 mcg gummies</i>	T2	HD
<i>cvs vitamin d3 400 unit sftgl</i>	T2	HD
<i>cvs vitamin d3 1,000 unit sftgl</i>	T2	HD
<i>cvs vitamin d3 2,000 unit sftgl</i>	T2	HD
<i>cvs vitamin d3 5,000 unit sftgl</i>	T2	HD
<i>cvs vit d3 250 mcg softgel</i>	T2	HD
<i>cvs vitamin d3 10 mcg softgel</i>	T2	HD
<i>cvs vitamin d3 25 mcg softgel</i>	T2	HD
<i>cvs vitamin d3 50 mcg softgel</i>	T2	HD
<i>cvs vitamin d3 125 mcg softgel</i>	T2	HD
CVS VITAMIN D3 250 MCG SOFTGEL	T4	HD
CYFOLEX	T4	HD
D3 LIQUID	T4	HD
D3 PLUS K2 DOTS	T4	HD
D3-50	T3	HD
DDROPS	T4	HD
<i>decara 10,000 unit softgel</i>	T2	HD
DECARA 25,000 UNIT VEGICAP	T3	HD
<i>decara 50,000 unit softgel</i>	T2	HD
DECARA K	T4	HD
DERMACINRX DOTREMIN	T4	HD
DERMACINRX FOLDITAM	T4	HD

T1 – Preferred Generics

T2 – Non-Preferred Generics

T3 – Preferred Brands

T4 – Non-Preferred Brands

T5 – Brand Specialty

PA – Prior Authorization

QL – Quantity Limit

ST – Step Therapy

AGE – Age Requirement

SP – Specialty Medication

HD – May require home delivery pharmacy

PPACA – No Cost-Share Preventive Medication

CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

VITAMINS (Nutritional/Dietary) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
VITAMIN D PREPARATIONS (cont.)		
DERMACINRX FOLIXAPURE	T4	HD
DERMACINRX FOLIXATE	T4	HD
DERMACINRX FOLTAMIN	T4	HD
DERMACINRX FOLTREXYL	T4	HD
DERMACINRX PUREFOLIX	T4	HD
DIALYVITE VITAMIN D3 MAX	T4	HD
DOSOKAP	T4	HD
<i>eqi vitamin d3 2,000 unit sfgl</i>	T2	HD
<i>eqi vitamin d3 400 unit sftgl</i>	T2	HD
ERGOCAL	T4	HD
<i>ergocalciferol (vitamin d2)</i>	T2	HD
FOLIC D3	T4	HD
FOLIKA-D	T4	HD
FOLVITE-D	T4	HD
<i>ft biotin 5,000 mcg capsule (Meribin)</i>	T2	HD
<i>ft vitamin d3 25 mcg softgel, tablet</i>	T2	HD
<i>ft vitamin d3 50 mcg softgel, tablet</i>	T2	HD
<i>ft vitamin d3 125 mcg softgel, tablet</i>	T2	HD
FT VITAMIN D3 250 MCG SOFTGEL, TABLET	T4	HD
GENICIN VITA-D	T4	HD
<i>gnp vit d3 10mcg(400 unit) chw</i>	T2	HD
<i>gnp vitamin d3 50 mcg softgel</i>	T2	HD
GNP VITAMIN D3 250 MCG SOFTGEL	T4	HD
<i>gnp vitamin d3 1,000 unit tab</i>	T2	HD
<i>gnp vitamin d3 10 mcg tablet</i>	T2	HD
<i>gnp vitamin d3 125 mcg softgel</i>	T2	HD
GNP VITAMIN D3 250 MCG TABLET	T4	HD
<i>gnp vitamin d3 2,000 unit tab</i>	T2	HD
<i>gnp vitamin d3 25 mcg tablet</i>	T2	HD
<i>gnp vitamin d3 25mcg(1000 unt)</i>	T2	HD
<i>gnp vitamin d3 5,000 unit tab</i>	T2	HD
<i>hm vitamin d3 1,000 unit tab</i>	T2	HD
<i>hm vitamin d3 2,000 unit sftgl</i>	T2	HD
HM VITAMIN D3 4,000 UNIT SFTGL	T4	HD

T1 – Preferred Generics

T2 – Non-Preferred Generics

T3 – Preferred Brands

T4 – Non-Preferred Brands

T5 – Brand Specialty

PA – Prior Authorization

QL – Quantity Limit

ST – Step Therapy

AGE – Age Requirement

SP – Specialty Medication

HD – May require home delivery pharmacy

PPACA – No Cost-Share Preventive Medication

CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

VITAMINS (Nutritional/Dietary) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
VITAMIN D PREPARATIONS (cont.)		
IS-D-10,000	T4	HD
K2 PLUS D3	T4	HD
K2-D3 10,000	T4	HD
K2-D3 5000	T4	HD
K2-D3 MAX	T4	HD
MAXIMUM D3	T3	HD
NOXIFOL-D3	T4	HD
OPTIMAL D3 M	T4	HD
ORTHO DF	T4	HD
OSTACHOL	T4	HD
<i>purevita vitamin d3 25 mcg tab</i>	T2	HD
PUREVITA VITAMIN D3 10 MCG/2ML	T4	HD
<i>ra cod liver oil</i>	T2	HD
<i>ra cod liver oil softgel</i>	T2	HD
<i>ra vitamin d3 1,000 unit tab</i>	T2	HD
<i>ra vitamin d3 2,000 unit sftgl</i>	T2	HD
<i>ra vitamin d3 2,000 unit sftgl</i>	T2	HD
<i>ra vitamin d3 5,000 unit sftgl</i>	T2	HD
REPLESTA NX	T3	HD
REVESTA	T4	HD
ROCALTROL (<i>calcitriol</i>)	T4	ST
ROXIFOL-D	T4	HD
<i>sm vitamin d3 1,000 unit tab</i>	T2	HD
<i>sm vitamin d3 2,000 unit sftgl</i>	T2	HD
<i>sm vitamin d3 50 mcg softgel</i>	T2	HD
SUPER DAILY D3	T4	HD
<i>sv vitamin d3 1,000 unit gummy</i>	T2	HD
<i>sv vitamin d3 1,000 unit sftgl</i>	T2	HD
<i>sv vitamin d3 2,000 unit sftgl</i>	T2	HD
<i>sv vitamin d3 25mcg(1000 unit)</i>	T2	HD
<i>sv vitamin d3 400 unit softgel</i>	T2	HD
<i>sv vitamin d3 5,000 unit sftgl</i>	T2	HD
<i>thera-d 2000 tablet</i>	T2	HD
THERA-D 4000 TABLET	T4	HD

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

T5 – Brand Specialty
PA – Prior Authorization
QL – Quantity Limit

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

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

List of Prescription Medications

VITAMINS (Nutritional/Dietary) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
VITAMIN D PREPARATIONS (cont.)		
<i>thera-d rapid repletion tablet</i>	T2	HD
<i>thera-d sport 2,000 unit tab</i>	T2	HD
<i>true vitamin d3 1,250 mcg tab</i>	T2	HD
<i>true vitamin d3 10 mcg capsule</i>	T2	HD
<i>true vitamin d3 10 mcg tablet</i>	T2	HD
<i>true vitamin d3 125 mcg cap</i>	T2	HD
<i>true vitamin d3 125 mcg tablet</i>	T2	HD
<i>true vitamin d3 25 mcg capsule</i>	T2	HD
<i>true vitamin d3 25 mcg tablet</i>	T2	HD
<i>true vitamin d3 50 mcg capsule</i>	T2	HD
<i>true vitamin d3 50 mcg tablet</i>	T2	HD
TRUE VITAMIN D3 1,250 MCG CAP	T4	HD
TRUE VITAMIN D3 250 MCG CAP, TABLET	T4	HD
<i>vit d3 125 mcg (5000 unit) tab</i>	T2	HD
VIT D3 5,000 UNIT FAST DISSOLV	T4	HD
<i>vitamin d2 1.25mg(50,000 unit)</i>	T2	HD
VITAMIN D2 2,000 UNIT TABLET	T3	HD
<i>vitamin d2 400 unit tablet</i>	T2	HD
VITAMIN D2 50 MCG (2,000 UNIT)	T4	HD
VITAMIN D2-VITAMIN K1	T4	HD
VITAMIN D3-VITAMIN K2	T4	HD
VITAMIN D3 50 MCG DISSOLVE TAB	T4	HD
<i>vitamin d3 1,000 unit gummies</i>	T2	HD
<i>vitamin d3 1,000 unit gummy</i>	T2	HD
<i>vitamin d3 1,000 unit softgel</i>	T2	HD
VITAMIN D3 62.5 MCG SOFTGEL	T4	HD
VITAMIN D3 1,000 UNIT SPRAY	T4	HD
<i>vitamin d3 1,000 unit tab chew</i>	T2	HD
<i>vitamin d3 1,000 unit tablet</i>	T2	HD
VITAMIN D3 1,000 UNIT/10 ML LQ	T4	HD
<i>vitamin d3 1,250 mcg capsule</i>	T2	HD
<i>vitamin d3 1.25 mg softgel</i>	T2	HD
<i>vitamin d3 10 mcg tablet</i>	T2	HD
<i>vitamin d3 10 mcg(400 unit)/ml</i>	T2	HD

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

T5 – Brand Specialty
PA – Prior Authorization
QL – Quantity Limit

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

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

List of Prescription Medications

VITAMINS (Nutritional/Dietary) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
VITAMIN D PREPARATIONS (cont.)		
VITAMIN D3 10,000 UNIT TABLET	T4	HD
<i>vitamin d3 10 mcg/ml drop</i>	T2	HD
<i>vitamin d3 10 mcg/ml liquid</i>	T2	HD
VITAMIN D3 10,000 UNIT CAPSULE	T4	HD
<i>vitamin d3 10,000 unit softgel</i>	T2	HD
<i>vitamin d3 125 mcg (5000 unit)</i>	T2	HD
<i>vitamin d3 125 mcg capsule</i>	T2	HD
<i>vitamin d3 125 mcg softgel</i>	T2	HD
<i>vitamin d3 125 mcg tablet</i>	T2	HD
VITAMIN D3 125 MCG/0.5 ML DROP	T4	HD
<i>vitamin d3 2,000 unit softgel</i>	T2	HD
VITAMIN D3 2,000 UNIT TAB CHEW	T4	HD
<i>vitamin d3 2,000 unit tablet</i>	T2	HD
<i>vitamin d3 25 mcg (1,000 unit)</i>	T2	HD
<i>vitamin d3 25 mcg gummy</i>	T2	HD
<i>vitamin d3 25 mcg softgel</i>	T2	HD
<i>vitamin d3 25 mcg tablet</i>	T2	HD
VITAMIN D3 250 MCG TABLET	T4	HD
VITAMIN D3 3,000 UNIT TABLET	T4	HD
<i>vitamin d3 400 unit softgel</i>	T2	HD
<i>vitamin d3 400 unit tab chew</i>	T2	HD
<i>vitamin d3 400 unit tablet</i>	T2	HD
VITAMIN D3 400 UNIT/5 ML LIQ	T4	HD
<i>vitamin d3 400 unit/ml liquid</i>	T2	HD
<i>vitamin d3 5,000 unit capsule</i>	T2	HD
VITAMIN D3 50,000 UNIT CAPSULE	T4	HD
<i>vitamin d3 5,000 unit softgel</i>	T2	HD
<i>vitamin d3 5,000 unit tablet</i>	T2	HD
<i>vitamin d3 5,000 unit/ml drops</i>	T2	HD
<i>vitamin d3 50 mcg (2,000 unit)</i>	T2	HD
<i>vitamin d3 50 mcg capsule</i>	T2	HD
<i>vitamin d3 50 mcg softgel</i>	T2	HD
<i>vitamin d3 50 mcg tablet</i>	T2	HD
<i>vitamin d3 50,000 unit capsule</i>	T2	HD

T1 – Preferred Generics

T2 – Non-Preferred Generics

T3 – Preferred Brands

T4 – Non-Preferred Brands

T5 – Brand Specialty

PA – Prior Authorization

QL – Quantity Limit

ST – Step Therapy

AGE – Age Requirement

SP – Specialty Medication

HD – May require home delivery pharmacy

PPACA – No Cost-Share Preventive Medication

CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

VITAMINS (Nutritional/Dietary) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
VITAMIN D PREPARATIONS (cont.)		
VITAMIN D3 10 MCG/ML ENFIT SYR	T4	HD
<i>v-r cod liver oil capsule</i>	T2	HD
<i>well vitamin d3 125 mcg softgl</i>	T2	HD
<i>well vitamin d3 25 mcg softgel</i>	T2	HD
<i>well vitamin d3 50 mcg softgel</i>	T2	HD
VITAMIN E PREPARATIONS		
AQUA-E	T3	
AQUA-E CONCENTRATE	T4	
<i>cvs vitamin e 180 mg softgel</i>	T2	
<i>cvs vitamin e 200 unit softgel</i>	T2	
CVS VITAMIN E 450 MG SOFTGEL	T4	
<i>cvs vitamin e 90 mg softgel</i>	T2	
<i>eql vitamin e 1,000 unit sftgl</i>	T2	
<i>eql vitamin e 180 mg softgel</i>	T2	
<i>ft vitamin e 180 mg softgel</i>	T2	
<i>gnp vitamin e 180 mg softgel</i>	T2	
<i>gnp vitamin e 400 unit softgel</i>	T2	
GNP VITAMIN E 450 MG SOFTGEL	T4	
<i>gnp vitamin e 90 mg softgel</i>	T2	
<i>hm vitamin e 180 mg softgel</i>	T2	
<i>hm vitamin e 200 unit softgel</i>	T2	
<i>hm vitamin e 400 unit softgel</i>	T2	
MIXED TOCOTRIENOLS	T4	
PUREVITA VITAMIN E	T4	
<i>ra vitamin e 268 mg softgel</i>	T2	
<i>sv vitamin e 180 mg softgel</i>	T2	
<i>sv vitamin e 400 unit softgel</i>	T2	
<i>sv vitamin e 450 mg softgel</i>	T2	
<i>sv vitamin e 670 mg softgel</i>	T2	
<i>true vitamin e 180 mg capsule</i>	T2	
<i>true vitamin e 90 mg capsule</i>	T2	
TRUE VITAMIN E 450 MG CAPSULE	T4	
<i>vitamin e (dl,tocopheryl acet)</i>	T2	
<i>vitamin e 1,000 unit softgel</i>	T2	

T1 – Preferred Generics

T2 – Non-Preferred Generics

T3 – Preferred Brands

T4 – Non-Preferred Brands

T5 – Brand Specialty

PA – Prior Authorization

QL – Quantity Limit

ST – Step Therapy

AGE – Age Requirement

SP – Specialty Medication

HD – May require home delivery pharmacy

PPACA – No Cost-Share Preventive Medication

CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

VITAMINS (Nutritional/Dietary) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
VITAMIN E PREPARATIONS (cont.)		
VITAMIN E 1,000 UNIT SOFTGEL	T4	
<i>vitamin e 100 unit softgel</i>	T2	
VITAMIN E 100 UNIT TABLET	T4	
<i>vitamin e 15 unit/0.3 ml drop</i>	T2	
<i>vitamin e 180 mg softgel</i>	T2	
<i>vitamin e 180mg(400 unit) sfgl</i>	T2	
<i>vitamin e 200 unit capsule</i>	T2	
<i>vitamin e 200 unit softgel</i>	T2	
<i>vitamin e 400 unit capsule</i>	T2	
<i>vitamin e 400 unit softgel</i>	T2	
<i>vitamin e 45 mg softgel</i>	T2	
VITAMIN E 450 MG SOFTGEL	T4	
<i>vitamin e 450 mg softgel</i>	T2	
<i>vitamin e 600 unit capsule</i>	T2	
<i>vitamin e 90 mg softgel</i>	T2	
VITAMIN E NATURAL OIL DROPS	T3	
VITAMIN E OIL	T4	
VITAMIN E OIL DROPS	T3	
VITAMIN E OIL DROPS	T4	
VITAMIN E-OIL	T3	
WHEAT GERM OIL	T3	
XCELLENT E	T4	
VITAMIN K PREPARATIONS		
FNP VITAMIN K2 40 MCG TABLET	T4	
<i>ft vitamin k2 100 mcg capsule</i>	T2	
<i>gnp vitamin k2 100 mcg capsule</i>	T2	
K1-1000	T4	
K2 LIQUID	T4	
K2-45	T4	
MEPHYTON (<i>phytonadione (vit k1)</i>)	T4	QL (10 tabs/fill)
<i>phytonadione (vit k1)</i>	T2	
PHYTONADIONE 1 MG/0.5 ML SYR	T3	
PHYTONADIONE 1 MG/0.5 ML VIAL	T3	
<i>phytonadione 10 mg/ml ampul</i>	T2	

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

T5 – Brand Specialty
PA – Prior Authorization
QL – Quantity Limit

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

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

List of Prescription Medications

VITAMINS (Nutritional/Dietary) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
VITAMIN K PREPARATIONS (cont.)		
<i>phytonadione 1 mg/0.5 ml syr</i>	T2	
<i>phytonadione 10 mg/ml vial</i>	T2	
VITAMIN K	T3	
VITAMIN K-1	T3	
VITAMIN K2 (MENAQUINONE-4)	T4	
VITAMIN K2 100 MCG SOFTGEL	T4	
VITAMINS (Vitamins)		
MULTIVITAMIN PREPARATIONS		
ALIVE MEN'S MAX3 POTENCY	T4	
BOOSTNOW IMMUNE SUPPORT	T4	
CENTRUM ADULTS 50 PLUS MINIS	T4	
CENTRUM MEN 50 PLUS MINIS	T4	
DAVIMET-M	T4	
DERMACINRX MULTIVITAMIN	T4	
LIVITA FOR ADULT	T4	
MULTITOL-M	T4	
NANOVN ADULT	T4	
SUPERIOR WOMEN'S MULTI	T4	
PEDIATRIC VITAMIN PREPARATIONS		
<i>ft children's multi gummy</i>	T2	
GNP CHILDREN'S MULTI GUMMY	T4	
<i>multivit-fluor 0.5 mg tab chew</i>	T2	PPACA

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

T5 – Brand Specialty
PA – Prior Authorization
QL – Quantity Limit

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

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

Exclusions and limitations for coverage

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

Plans generally do not provide coverage for the following under the pharmacy benefit, except as required by state or federal law, or by the terms of your specific plan:¹⁰

- 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,¹¹ sexual dysfunction, cosmetic purposes, weight loss, smoking cessation,¹¹ or athletic enhancement.
 - Prescription vitamins (other than prenatal vitamins) or dietary supplements unless state or federal law requires coverage of such products.
 - Immunization agents, biological products for allergy immunization, biological sera, blood, blood plasma and other blood products or fractions and medications used for travel prophylaxis.
 - Replacement of prescription medications and related supplies due to loss or theft.
 - Medications which are to be taken by or administered to a covered person while they are a patient in a licensed hospital, skilled nursing facility, rest home or similar institution which operates on its premises or allows to be operated on its premises a facility for dispensing pharmaceuticals.
 - Prescriptions more than one year from the date of issue.
 - Coverage for prescription medication products for the amount dispensed (days' supply) which is more than the applicable supply limit, or is less than any applicable supply minimum set forth in The Schedule, or which is more than the quantity limit(s) or dosage limit(s) set by the P&T Committee.
 - More than one prescription order or refill for a given prescription supply period for the same prescription medication product prescribed by one or more doctors and dispensed by one or more pharmacies.
 - Prescription medication products dispensed outside the jurisdiction of the United States, except as required for emergency or urgent care treatment.
- In addition to the plan's standard pharmacy exclusions, certain new FDA-approved medication products (including, but not limited to, medications, medical supplies or devices that are covered under standard pharmacy benefit plans) may not be covered for the first six months of market availability unless approved by Cigna Healthcare as medically necessary.

Index of Medications

Symbols

1.5 VOLT BATTERIES	161
IST TIER	140, 156
IST TIER UNILET COMFORTOUCH	156
2-IN-1	140, 156
2-IN-1 LANCET DEVICE	156
2TEK	133
5-MTHF	224
50 PLUS ADULT EYE	202

A

A-25	223
abacavir	66, 67, 68
abacavir sulfate/lamivudine	66
ABANEU-SL	230
ABATRON	112
ABC	165, 205
ABC COMPLETE	205
ABDEK	219
ABILIFY	176
abiraterone	55
ABRYSVO	76
ABSORICA	180
ABSTRAL	21
ACAM2000	76
acamprosate	195
acarbose	49
ACCOLATE	32
ACCRUFER	112
ACCU-CHEK	133, 140, 156, 161
ACCUPRIL	83
ACCURETIC	81
ACCU-TREND	133
ACD-A	43
ACD SOLUTION A	42
ACE	81, 82, 83
ACE AEROSOL	162
acebutolol	84
acetaminophen/caff/dihydrocod	21
acetaminophen with codeine	21
acetazolamide	100
acetic acid	52, 103, 179
acetic acid/oxyquinoline	52
acetylcyst	224
acetylcysteine	32
a/c/e/zinc ox/cupric ox/lutein	202
a/c/e/zinc/sod selenate/copper	205
acitretin	180
ACTEMRA	131

ACTHAR	125
ACTHIB	75
ACTICLATE	39
acti-lance	140, 156
ACTI-LANCE	140, 156
acti-lance lite	156
acti-lance univers	156
ACTI-LANCE UNIVERS	156
ACTIMMUNE	61
ACTIQ	21
ACTIVE FE	112
ACTIVELLA	126
ACTIVNUTRIENTS	205
ACTONEL	199
ACTOPLUS MET	50
ACTOS	50
ACULAR	103
acyclovir	69, 70, 71
ACZONE	180
ADACEL TDAP	75
ADALIMUMAB	54
ADALIMUMAB-ADAZ	54
ADALIMUMAB-ADBM	54
ADALIMUMAB-RYVK	54
adapalene	180, 181, 189, 190
ADAPALENE	189
adapalene/benzoyl peroxide	180, 181
ADBRY	200
ADDYI	174
adefovir	70
ADEK GUMMIES	205
ADEMPAS	80
ADIPEX-P	62
ADJUSTABLE LANCING DEVICE	133
ADLARITY	71
ADLYXIN	48
ADRENALIN CHLORIDE	103
adthyza	190, 191
ADULT 50 PLUS EYE HEALTH	202
ADULT MULTI	206
ADULT ONE DAILY	206
ADULTS' DAILY FORMULA	206
ADULTS MULTIVITAMIN	206
ADVAIR HFA	30
ADVANCED	133, 140, 156, 203, 206, 211, 217
ADVANCED LANCING DEVICE	133
ADVANCED MULTI EA	206

Index of Medications

ADVANCED TRAVEL LANCETS.....	156	ALIVE PREMIUM	206
ADVOCATE.....	133, 140, 156, 178, 182	ALIVE WOMEN'S	206
ADVOCATE CONTROL SOLUTION.....	133	ALKALINE BATTERIES.....	133
ADVOCATE LANCET.....	156	ALKERAN.....	55
ADVOCATE LANCETS	156	ALLERGIST TRAY.....	147, 148
ADVOCATE LANCING DEVICE.....	133	ALLERGY SYRINGE	148, 152, 153
ADVOCATE RAPID-SAFE LANCING DV.....	133	allopurinol.....	26
ADVOCATE REDI-CODE+ CTRL SOLN.....	133	almotriptan.....	19
ADZENYS	72	almotriptan malate	15
AEMCOLO.....	38	ALOCRI.....	105
AEROCHAMBER.....	162	alosetron.....	122
AEROCHAMBER2GO	162	ALPHA	32, 49, 82, 131, 169, 173, 197, 201, 206
AEROTRACH	162	ALPHAGAN P.....	105
AEROVENT	162	alprazolam.....	169
AFLORA.....	206	ALTABAX.....	185
AFLURIA.....	74	ALTACE	83
AFLURIA QUAD	74	ALTAFLUOR BENOX.....	104
AGAMATRIX	133, 140, 156	ALTERNATE.....	133, 140, 156
AGAMATRIX CONTROL	133	ALTERNATE SITE LANCETS	156
AGRYLIN	65	ALTERNATE SITE LANCING DEVICE.....	133
AIMOVIG.....	15	ALTRENO.....	189
AIMOVIG AUTOINJECTOR.....	19	ALTRIXA	206
AIRSUPRA	31	ALUNBRIG.....	57
AJOVY	15, 19	ALVESCO.....	31
AKLIEF	185	alvimopan	123
AKTEN.....	104	ALYFTREK.....	191
AKTIPAK	41	amantadine.....	64
ALA-SCALP.....	185	ambrisentan.....	80
ALBA-LYBE	224	amcinonide	185
albendazole.....	52	AMERGE.....	19
ALBENZA	52	AMICAR	76
albuterol	29, 30	amiloride.....	101, 102
ALCAINE.....	104	amino acids/my,tx,iron,mineral	206
alclometasone	185	aminocaproic	76
ALCOH-GLOVE	161	amiodarone	78
alcohol	178, 179, 182, 183, 197, 198	amitriptyline.....	172
ALCOHOL.....	53, 54, 178, 179, 182, 183, 197, 198	amitriptyline/chlordiazepoxide	172
ALCOH-WIPE.....	161	AMLADEX	206
ALDACTONE	101	amlodipine	78, 81, 82, 83, 86
ALECENSA.....	57	amoxapine	172
alendronate.....	199	amoxicillin	38
alfuzosin	201	amphetamine	72
ALHEMO	77	ampicillin	38
ALINIA	64	AMZEEQ.....	41
aliskiren hemifumarate.....	85	ANAFRANIL.....	172
ALIVE	206, 219, 245	anagrelide	65
ALIVE DAILY	206	ANA-LEX.....	124

Index of Medications

ANALPRAM.....	121, 124, 189	ARTISS.....	184
ANAPROX DS.....	27	ASACOL.....	121
anastrozole.....	56	ASCOR.....	234
ANCOBON.....	44	ascorbate.....	234
ANGELIQ.....	127	ascorbic.....	114, 234
ANIMAL SHAPES COMPLETE.....	219	ASCORBIC ACID.....	234
ANIMI-3.....	206	asenapine.....	175
ANNOVERA.....	95	ASMANEX.....	31
ANORO ELLIPTA.....	30	ASPIRIN.....	65
ANTICOAGULANT SODIUM CITRATE.....	43	aspirin/dipyridamole.....	65
ANTIOXIDANT FORMULA.....	202	ASSURE.....	133, 140, 156, 165
APATATE.....	230	ASSURE 4 CONTROL SOLUTION.....	133
APETEX.....	224	ASSURE DOSE.....	133
APETIGEN.....	112, 224	ASSURE HAEMOLANCE PLUS.....	156
APETIGEN-PLUS.....	112	ASSURE LANCE.....	156
apomorphine.....	64	ASSURE PRISM.....	133
APO-VARENICLINE.....	190	ASTAGRAF.....	132
apraclonidine.....	105	ASTRINGYN.....	77
aprepitant.....	119	atazanavir.....	68
APRETUDE.....	68	ATELVIA.....	199
APRISO.....	121	atenolol.....	84, 85
APTENSIO.....	173	AT HOME AIC.....	133
APTIOM.....	91	a thru z.....	205
APTIVUS.....	66	A THRU Z MEN'S ULTIMATE.....	205
AQUA-E.....	243	A THRU Z SELECT.....	205
AQUA LANCE LANCING DEVICE.....	133	ATIVAN.....	169
AQUASOL A.....	223	atomoxetine.....	174
AQUORAL.....	194	atorvastatin.....	86
ARAKODA.....	53	atovaquone.....	53
ARAVA.....	26	atovaquone-proguanil.....	53
ARAZLO.....	185	atropine.....	106, 107, 118, 120
ARCALYST.....	200	ATROPINE.....	106, 107
AREXVY.....	76	ATROVENT HFA.....	29
arformoterol.....	30	ATTRUBY.....	197
ARGLAES FILM.....	154	AUDENZ.....	74
ARICEPT.....	71	AUGMENTIN.....	38
ARIDOL.....	98	AUGTYRO.....	57
ARIKAYCE.....	35	AURYXIA.....	111
aripiprazole.....	176	AUSTEDO.....	88
ARIXTRA.....	43	AUTOJECT.....	133
ARKALIOX.....	224	AUTO-LANCET.....	133
armodafinil.....	177	AUTOLET.....	133, 136
ARMOUR THYROID.....	191	AUTOPEN.....	133
ARNUITY ELLIPTA.....	31	AUTOSHIELD.....	145
AROMASIN.....	56	AUTOSOFT.....	133, 134
ARTHROTEC 50.....	27	AUVELITY.....	170
ARTHROTEC 75.....	27	AUVI-Q.....	71

Index of Medications

avanafil.....	193	BARIATRIC MULTIVITAMINS.....	207
AVAR-E.....	41	BAXDELA.....	38
AVAR LS.....	41	BCG.....	75
AVC.....	52	b comp.....	224, 228
AVIDOXY.....	39	b complex.....	216, 217, 224, 226, 227, 228, 229
avita.....	189	b-complex.....	207, 208, 216, 224, 225, 228, 229
AVITA.....	190	B COMPLEX.....	224, 226, 227
AVITENE.....	77	B-COMPLEX.....	216, 224, 225
AVMAPKI.....	57	B-COMPLEX-VITAMIN C.....	225
AVONEX.....	89	B-COMPLEX WITH B-12.....	224
AYVAKIT.....	57	BD.....	141, 145, 146, 148, 156
AZASAN.....	132	BD ECLIPSE.....	145, 146, 148
AZASITE.....	34	BELBUCA.....	22
azathioprine.....	132	BELSOMRA.....	177
azelaic acid.....	184	BELVIQ.....	63
azelastine.....	48, 102	benazepril.....	81, 82, 83
AZELEX.....	180	benazepril/hydrochlorothiazide.....	81, 82
AZILECT.....	64	BENLYSTA.....	200
azithromycin.....	37	BENTIVITE BX.....	112
AZSTARYS.....	173	BENZAMYCIN.....	41
AZULFIDINE.....	121	benzepro.....	183
B		BENZEPRO.....	183
BI.....	229	BENZNIDAZOLE.....	53
b-12.....	228, 230, 231, 232, 233	benzonatate.....	96
bi2.....	113, 114, 115, 214, 224, 225, 227, 228, 231, 232	benzoyl peroxide.....	41, 180, 181, 183, 184
B-12.....	114, 210, 224, 230, 231, 232	benzphetamine.....	62
BI2.....	224, 230, 231, 233	benztropine.....	64
BI2 ACTIVE.....	230	bepotastine.....	48
b-12 er.....	230, 231	BEPREVE.....	48
bi2/levomefolate calcium/b-6.....	224	BEROCCA.....	207
B-50 COMPLEX.....	224	beta-carotene.....	207, 223
BABY DDROPS.....	237	BETADINE.....	103
BABY'S SUPER DAILY D3.....	238	betaine.....	199
BABY VITAMIN D3.....	237	betamethasone.....	46, 185, 187, 189
bacitracin.....	34	BETAPACE.....	84
baclofen.....	163, 164	BETASERON.....	89
BACLOFEN.....	164	betaxolol.....	84, 105
BACMIN.....	207	bethanechol.....	72, 73
B ACTIV.....	224	BETHKIS.....	35
BACTRIM.....	35	BETOPTIC S.....	105
BAFIERTAM.....	89	bexarotene.....	54, 62
BALANCED B-100.....	225	BEXSERO.....	74
balanced b-100 complex tab sa.....	224	BEYAZ.....	95
BAL-CARE DHA.....	165	BEYFORTUS.....	69
balsalazide.....	121	bicalutamide.....	55
BALVERSA.....	57	BIKTARVY.....	68
BARACLUDE.....	70	BILTRICIDE.....	52

Index of Medications

bimatoprost	105	BROVANA.....	30
BIMATOPROST.....	105, 106	BRUKINSA.....	58
BINOSTO	199	BRYHALI.....	186
BIO-35	207	B-STRESS	225
BIO C	234	budesonide	31, 127, 128
BIO-D-MULSION	238	BULK SYRINGE	148
bioflav,lemon/vit bcomp,c	203	BULLSEYE	141, 156
biotect.....	207	BULLSEYE MINI SAFETY LANCETS	156
BIOTECT.....	202	bumetanide.....	101
biotin.....	211, 213, 224, 225, 227, 228	BUPHENYL	118
BIOTIN.....	217, 225, 227, 228	buprenorphine	22, 200
bisac/nacl/nahco3/kcl/peg 3350	122	bupropion	170, 190
bisoprolol.....	84, 85	buspirone	170
BLADDER 2.2	207	butalb-acetamin-caff 50-300-40.....	15
BLEPH-IO	34	butalb-acetamin-caff 50-325-40	15
BLEPHAMIDE S.O.P.....	34	butalb/acetaminophen/caffeine	15, 19
BLOOD.....	76, 77, 78, 97, 98, 134, 141, 146, 156	butalb-aspirin-caffe 50-325-40	15
BLOOD GLUCOSE CONTROL.....	134	butalbit/acetamin/caff/codeine	24
BLOOD-GLUCOSE CONTROL.....	134	butalbital/acetaminophen.....	15, 19
BLOOD LANCETS	156	butalbital-asa-caffeine cap (Fiorinal).....	15
BLUNT	146, 151	butalbital/aspirin/caffeine	19
BOCASAL	194	butorphanol.....	22
BODY, HAIR, SKIN AND NAILS.....	207	BUTTERFLY	141, 156
BONSITY.....	199	BUTTERFLY TOUCH LANCET	156
BOOSTNOW	245	BYDUREON BCISE.....	48
BOOSTRIX TDAP	75	BYDUREON PEN.....	48
bosentan.....	80	BYETTA	48
BOSULIF	57, 58	BYLVAY	122
BRAFTOVI.....	56	C	
BREATHERITE.....	162	c-1,000	234
BREATHRITE.....	162	cabergoline	129
BREEZE 2	134	CADEAU DHA	165
BREO ELLIPTA	31	CADUET	86
BREXAFEMME.....	45	CAFERGOT	15
breynd.....	31	caffeine.....	19, 89, 164
BREZTRI AEROSPHERE	31	CALAN	78
BRILINTA	65	calcipotriene.....	181, 189
brimonidine	105	calcitonin,salmon,synthetic	130
BRIMONIDINE.....	105	calcitriol.....	181, 238, 240
BRINSUPRI	191	calcium acetate.....	111
brinzolamide.....	105	CALCIUM PANTOTHENATE.....	219
BRIVIACT	91	CALQUENCE	58
BROMFED DM	96	CAMBIA	19
bromfenac.....	103	CAMZYOS.....	79
bromocriptine.....	64	candesartan cilexetil	83
brompheniramine/pseudoephed/dm	96	candesartan/hydrochlorothiazid.....	83
BRONCHITOL.....	191	CANNULA	146, 148, 151, 152, 153

Index of Medications

CANTHARIDIN-ACETONE	183	CENTRAL-VITE	207
CAPCOF	96	CENTRAVITES	207
capecitabine	56	centrum	208
CAPEX	186	CENTRUM	205, 207, 208, 219, 245
CAPHOSOL	194	CENTRUM KIDS	219
CAPLYTA	175	CENTRUM SILVER	205, 207, 208
CAPRELSA	58	cephalexin	36
captopril	82, 83	CEQUA	107
captopril/hydrochlorothiazide	82	CEQUR SIMPLICITY	134
CAPVAXIVE	74	CERDELGA	195
CARBAGLU	195	CEREFOLIN	225
carbamazepine	91, 93	certavite	208
CARBAMAZEPINE	91	CERTAVITE	208
CARBATROL	91	CERVIDIL	129
carbidopa	64, 65	CETACAINE ANESTHETIC	25
carbidopa/levodopa	64, 65	cetrorelix	128
carbinoxamine	47	CETROTIDE	128
CARDIOTEK-RX	225	cevimeline	72
CARDIZEM	78	CHANTIX	190
CARDURA	82	CHEK-STIX	100
CAREONE	134, 141, 156	CHEMET	196
CAREPOINT	146, 148, 149	CHEMO TRANSFER PIN	146
CARESENS	134, 141, 156	CHEMSTRIP	100, 134
CARETOUCH	134, 141, 146, 149, 156, 178, 182	CHENODAL	120
carglumic	195	CHILD CHEWABLE VITAMN	219
carisoprodol	24, 164	CHILD COMPLETE	219
carisoprodol/aspirin/codeine	24	CHILD MULTIVITAMIN PLUS IRON	219
CARNITOR	199	children multivitamin	219
carteolol	105	CHILDREN MULTIVITAMIN	219, 220
carvedilol	82	CHILDREN'S	219
CASODEX	55	CHILDREN'S CHEWABLE	219
CATAPRES	84	CHILDREN'S CHEW MULTIVIT-IRON	219
CAVERJECT	193	childrens chew vitamin	219
CAYSTON	36	CHILDREN'S MULTI-VIT	219
cefaclor	36	CHILDREN'S MULTIVITAMIN GUMMY	219
cefadroxil	36	CHILD'S CHEWABLE	219
cefdinir	37	CHILD'S OMEGA-3	219
cefditoren pivoxil	37	chlordiazepoxide	118, 169
cefpodoxime proxetil	37	chlordiazepoxide/clidinium br	118
cefprozil	36	chlorhexidine	192
ceftriaxone	37	chloroquine	53
cefuroxime axetil	36	chlorpromazine	176
CEFUROXIME SODIUM-0.9% NACL	34	chlorthalidone	85, 102
celecoxib	29	chlorzoxazone	164
CELLCEPT	132	CHOLBAM	120
CELONTIN	91	cholecalciferol	238
CENTANY	41	CHOLECAL DF	238

Index of Medications

cholestyramine	87	clomipramine	172
choline salicyl/mag salicylate	15, 19	clonazepam	90
CHORIONIC	130	clonidine	84, 173
CHORIONIC GONAD	130	clopidogrel	65
CHOSEN	134, 141, 156	clorazepate	169
CHROMAGEN	112	clotrimazole	44, 46
CIALIS	193	clozapine	175
CIBINQO	183	CLOZARIL	175
ciclodan	46	COAGUCHEK	141, 156
CICLODAN	46, 54	COARTEM	53
ciclopirox	46	COBALEFOL	204
ciclopirox 8% treatment kit	54	COCAINE	102
cilostazol	65	codeine	21, 22, 24, 96, 97
CILOXAN	34	CODITUSSIN AC	97
CIMDUO	66	CODITUSSIN DAC	97
cimetidine	122	cod liver oil	223, 234, 238, 240, 243
cinacalcet	195	COLAZAL	121
CIPRO	38	colchicine	26, 29
ciprofloxacin	33, 34, 38	COLCHICINE	26
citalopram	170	colesevelam	87
CITRANATAL	112, 165, 168	COLESTID	87
CITRANATAL BLOOM	112	colestipol	87
CITRATE PHOSPHATE DEXTROSE	43	COLOR	141, 157
citric	117	COLOR LANCETS	157
CITRUS BIOFLAVONOIDS	203	COMBIGAN	105
CLARINEX	47	COMBIPATCH	126
CLARINEX-D	47	COMBISTIX REAGENT	100
clarithromycin	37	COMBIVENT RESPIMAT	30
CLEOCIN	37, 40, 41	COMBIVIR	66
CLEVER	134, 141, 156, 162	COMETRIQ	58
CLEVER CHEK LANCETS	156	COMFORT	27, 139, 141, 143, 144, 145, 157, 159, 160, 163, 182, 183
CLEVER CHOICE	162	COMFORT PAC-IBUPROFEN	27
CLEVER CHOICE CONTROL SOLUTION	134	COMFORT PAC-MELOXICAM	27
CLIMARA	126	COMFORT PAC-NAPROXEN	27
clindacin	41	COMFORTSEAL	162
CLINDACIN	41	COMIRNATY	73
clindamycin	36, 37, 40, 41, 180, 181	COMPACT SPACE CHAMBER	162
CLINDESSE	40	COMPAZINE	119
CLINPRO 5000	108, 111	COMPLETE165, 166, 168, 205, 207, 208, 209, 214, 215, 219, 220, 221, 223, 225	
clobazam	90	COMPLETIA	208
clobetasol	186, 188	COMPLEX B-50	225
CLOBEX	186	complex b-100	225
clocortolone	186	COMPLEX B-100	225
clodan	186	CONCEPT	208
CLODAN	186	CONFORMANT 2	154
CLODERM	186	CONSENSI	78
clomiphene	129		

Index of Medications

CONTOUR.....	134	cvs vitamin d3.....	238
CONTRACE.....	63	cvs vitamin e.....	243
CONTROL SOLUTION	133, 134, 135, 136, 137, 138, 139, 140	cvs vit c	234
COOL CONTROL SOLUTION	134	cvs vit d3.....	238
COPIKTRA.....	58	cyanocobalamin	224, 225, 226, 227, 231
CORDRAN.....	186	cyclobenzaprine	164
COREG.....	82	CYCLOGYL.....	107
CORNWALL SYRINGE TIP CONNECTOR.....	149	CYCLOMYDRIL.....	107
CORTANE-B.....	103	cyclopentolate.....	107
CORTEF.....	127	CYCLOPENTOLATE-TROPICAMIDE-PE.....	107
CORTENEMA.....	125	cyclopentolat/tropic/phenyleph	107
cortisone.....	127	cyclophosphamide.....	55
CORTISPORIN.....	33	CYCLOPHOSPHAMIDE	55
CORVITE.....	112, 208	cycloserine	36
CORVITE 150.....	112	CYCLOSET.....	49
CORVITE FE.....	112	cyclosporine.....	107, 132
COTELLIC	56	CYCLOSPORINE.....	107
COTEMPLA	173	CYFOLEX	238
CREON.....	123	CYLTEZO	54
CRESEMBA	44	cyproheptadine.....	47
CREXONT	64	CYPROHEPTADINE	47
CRINONE.....	130	CYSTAGON	201
cromolyn	26, 32, 105	CYSTARAN	108
crotamiton.....	64	CYSTO-CONRAY II	99
CRRT TRISODIUM CITRATE.....	43	CYSTOGRAFIN.....	99
CTEXLI	120	CYSTOGRAFIN-DILUTE.....	99
CULTURELLE.....	208, 219, 220	CYTO B-1.....	229
CULTURELLE KIDS	219, 220	CYTO B-2.....	233
CURITY	178, 182	CYTO B7	226
CURITY ALCOHOL PREPS	182	CYTO C.....	234
CUROSURF	191	CYTOTEC.....	120
cvs.109, 112, 165, 178, 182, 197, 204, 208, 218, 223, 225, 229, 230, 231, 233, 234, 238, 243		D	
CVS	53, 109, 112, 168, 178, 182, 197, 225, 230, 234, 238, 243	D3.....	176, 214, 217, 237, 238, 239, 240, 241, 242
CVS ALCOHOL 70% PREP PADS	182	DAILY	58, 59, 94, 165, 192, 206, 208, 209, 211, 212, 214, 215, 217, 236, 238, 240
cvs glucose.....	109	daily-vite.....	208
CVS GLUCOSE LIQUID	109	danazol.....	129
cvs isopropyl alcohol 70% wipe.....	182	DANTRIUM	164
CVS ISOPROPYL ALCOHOL 91% SPRY	53	dantrolene.....	164
cvs prenatal	165	DANZITEN	58
CVS PRENATAL	168	dapsone.....	36, 180, 181
cvs slow release iron.....	112	DAPTACEL DTAP	75
CVS SLOW RELEASE IRON.....	112	DARAPRIM.....	53
CVS VITAMIN.....	230, 234, 243	darifenacin	201
cvs vitamin a	223	darunavir.....	66
cvs vitamin b-12.....	231	dasatinib.....	58
cvs vitamin c	234	DAURISMO.....	56

Index of Medications

DAVIMET.....	208, 220, 245	desonide.....	186, 187, 188
DAVIMET-M.....	245	desoximetasone.....	187, 188
DAVOL IRRIGATION SYRINGE.....	149	DESOXYN.....	72
DAYAVITE.....	208	DESVENLAFAXINE.....	171
DAYPRO.....	27	dex4 glucose.....	109
DAYTRANA.....	173	DEX4 GLUCOSE.....	109
DAYVIGO.....	177	dex4 quick dissolve tab chew.....	109
DDAVP.....	126	dexamethasone.....	33, 103, 127
DDROPS.....	237, 238	dexchlorpheniramine.....	47
decara.....	238	DEXCOM.....	134
DECARA.....	238	DEXCOM G6.....	134
DECUBI.....	208	DEXEDRINE.....	72
deferasirox.....	196	dexlansoprazole.....	123
deferiprone.....	196, 197	dexmethylphenidate.....	173
deflazacort.....	127	DEXONTO.....	127
DEKAS.....	208, 209, 220	DEXENZA.....	103
DEKAS PLUS.....	209, 220	dextroamphetamine.....	72
DELESTROGEN.....	126	dextrose.....	109, 110
DELSTRIGO.....	68	DIABETES HEALTH.....	209
demeclocycline.....	39	DIABETIC VITAMIN.....	209
DEMSEER.....	84	DIACOMIT.....	91
DENAVIR.....	70	dialyvite.....	226
DENG VAXIA.....	75	DIALYVITE.....	209, 226, 239
DENOVO.....	204	DIASTAT.....	91
DEPAKOTE.....	91	DIASTIX REAGENT.....	98, 100
DEPEN.....	26	diatrizoate meglumine.....	98, 99
DEPLIN.....	204	DIATROL.....	209
DEPLIN-ALGAL OIL.....	204	DIATRUE.....	134
DEPO-ESTRADIOL.....	126	diazepam.....	91, 169
DEPO-PROVERA.....	95	diazoxide.....	109, 110
DEPO-SUBQ PROVERA.....	95	DIBENZYLINE.....	72
DEPO-TESTOSTERONE.....	125	dichlorphenamide.....	195
DERMACINRX.....	209, 238, 239, 245	DICLEGIS.....	119
DERMA-SMOOTH-ES.....	186	diclofenac.....	20, 27, 62, 103, 180
DERMASORB.....	186	dicloxacillin.....	38
DERMATOP.....	186	dicyclomine.....	118
DERMAVIEW.....	154	didanosine.....	67
DERMOTIC.....	103	diethylpropion.....	62
DESCOVY.....	66	DIFFERIN.....	190
desflurane.....	24	DIFICID.....	37
desipramine.....	172	DIFLUCAN.....	45
desloratadine.....	47	diflunisal.....	15, 19
desmopressin.....	126	difluprednate.....	103
DESMOPRESSIN.....	126	digoxin.....	79
desog-e.estradiol/e.estradiol.....	95	dihydroergotamine.....	15, 19, 20
desogestrel-ethinyl estradiol.....	95	DILANTIN.....	91
DESONATE.....	186	DILAUDID.....	22

Index of Medications

diltiazem.....	78, 79	dutasteride.....	201
dimethyl.....	195	DYAZIDE.....	102
diphenoxylate hcl/atropine.....	118	DYCLOPRO.....	25
DIPHThERIA-TETANUS TOXOIDS-PED.....	75	DYRENIUM.....	101
DIPROLENE.....	187	E	
dipyridamole.....	65	EAR HEALTH PLUS.....	203
DISALCID.....	26	ear health plus caplet.....	203
disopyramide.....	78	EASIVENT.....	162
disulfiram.....	195	EASY.....	134, 135, 141, 142, 146, 149, 150, 157, 178, 182, 234
DIURIL.....	102	EASY-C.....	234
divalproex.....	91, 92	EASY COMFORT ALCOHOL PAD.....	182
dofetilide.....	78	EASY COMFORT LANCETS.....	157
DOJOLVI.....	108	EASY GLIDE CATHETER.....	149
donepezil.....	71	EASY GLIDE LUER.....	149
DONNATAL.....	120	EASYGLUCO PLUS.....	135
DOPTLET.....	94	EASYMAX I5.....	135
dorzolamide.....	105	EASYMAX NORMAL.....	135
DORZOLAMIDE.....	105, 106	EASY MINI EJECT.....	134
DOSOKAP.....	239	EASY PLUS II.....	134
DOVATO.....	66	EASYPOINT.....	146
DOVER BULB SYRINGE.....	149	EASY STEP.....	134
DOVONEX.....	181	EASY TALK.....	134
doxazosin.....	82	EASY TOUCH.....	135, 146, 149, 150, 157, 182
doxepin.....	172, 177, 178, 181	EASY TOUCH FLIPLOCK.....	146, 149
doxercalciferol.....	195	EASY TRAK.....	135
doxycycline.....	39, 40, 193	EASY TWIST CAP LANCETS.....	157
doxylamine succinate/vit b6.....	119	EBGLYSS.....	200
dronabinol.....	119	ECLIPSE SYRINGE.....	150
DROPLET.....	134, 141, 157	EC-NAPROSYN.....	27
DROPLET GENTEEL LANCING DEVICE.....	134	ec-naproxen.....	27
DROPLET LANCETS.....	157	econazole.....	46
DROPLET LANCING DEVICE.....	134	EDECRIIN.....	101
DROPSAFE.....	141, 146, 157, 178, 182	EDEX.....	193
DROPSAFE PREP PADS.....	182	EDLUAR.....	178
drospir/eth estra/levomefol.....	95	EDURANT.....	66, 67
DROXIA.....	77	E.E.S. 200.....	37
droxidopa.....	72	efavirenz.....	67, 68
drug mart glucose.....	109	effer-k.....	117
DUAVEE.....	127	EFFER-K.....	116, 117
DUET.....	165, 168	EFFIENT.....	65
DUETACT.....	50	EFUDEX.....	62
DUET DHA.....	165	EGRIFTA.....	128
DULERA.....	31	eldertonic.....	205
duloxetine.....	171	ELDERTONIC LIQUID.....	205
DUOBRII.....	181	ELEMENT COMPACT.....	135
DUOPA.....	64	ELEMENT CONTROL.....	135
DUPIXENT.....	131	ELEPSIA.....	92

Index of Medications

eletriptan hydrobromide	15, 19	entacapone	64, 65
ELFOLATE.....	226	entecavir.....	70
ELIMITE	64	ENTEREG	123
ELIQUIS	43	ENTERO VU	99
ELIXOPHYLLIN.....	32	ENTRESTO.....	82
ELLA	95	ENZOCLEAR	183
ELMIRON.....	24	EPCLUSA.....	70
ELON	209	EPIDIOLEX.....	91
eltrombopag	94	EPIDUO FORTE	181
EMBRACE	135, 142, 157	EPIFOAM	189
EMBRACE EVO LEVEL I.....	135	epinastine	48
EMBRACE GLUC CONTROL SOLN.....	135	epinephrine.....	71, 103
EMBRACE LANCING DEVICE.....	135	EPINEPHRINE.....	71
EMBRACE PRO.....	135	EPIPEN.....	71
EMBRACE TALK CONTROL	135	EPISIL.....	194
EMERGEN.....	220, 234, 235	EPIVIR.....	67
EMERGEN-C.....	220, 234, 235	eplerenone	101
EMERGEN-C KIDZ.....	220	eprosartan	83
EMGALITY.....	15, 19, 90	EPSOLAY	184
EMGALITY PEN	19	EPZICOM.....	66
EMPAVELI	76	EQ.....	202, 209, 220
EMSAM	170	EQ CHILD	220
emtricitabine.....	68	eql.....	112, 197, 202, 226, 231, 233, 235, 239, 243
emtricitabine	66, 67	eql slow release iron.....	112
emtricitabine-tenofv	66	eql vitamin.....	231, 235, 239, 243
EMTRIVA	67	EQUETRO	170
EMVERM.....	52	EQ VISION	202
enalapril.....	82, 83	ERGOCAL	239
enalapril/hydrochlorothiazide.....	82	ergocalciferol	239
ENBRACE	209	ergoloid.....	85
ENBREL.....	54	ERGOMAR.....	19
ENDARI.....	77	ergotamine tartrate/caffeine	15, 19
ENDO-AVITENE.....	77	ERIVEDGE.....	56
ENDOMETRIN.....	130	ERLEADA	55
ENDUR-AMIDE.....	218	erlotinib	58
ENDUR-THINE	218	ERMEZA	191
ENDUR-VM	209	ERVEBO.....	76
ENFAMIL.....	110	ERYPED	37
ENFIT	150, 152, 222, 243	ERY-TAB.....	37
ENFLONSIA.....	69	ery-tab dr	37
ENGERIX-B	76	erythromycin.....	34, 37, 41
ENLITE SERTER.....	135	escitalopram.....	170
ENLYTE	204	ESGIC	15, 19
enoxaparin	43	ESKATA	181
ENSACOVE	58	eslicarbazepine.....	91, 92
ENSPRYNG	131	esomeprazole	123
ENSTILAR.....	189	ESOMEPRAZOLE.....	123

Index of Medications

ESSENCE C.....	235	EYEPROTECT	202
ESSENTIAL	165, 208, 209, 214, 215	EYSUVIS	103
estazolam.....	177	EZ	141, 142, 157
ESTER-C.....	235	E-Z DISK.....	99
ESTRACE	126	ezetimibe	86, 87
estradiol.....	95, 126, 127, 129	ezetimibe/simvastatin.....	86
ESTRATEST	126	E-Z-HD.....	99
estrogen.....	126	EZ-LETS	157
estrogen,ester/me-testosterone.....	126	E-Z-PAQUE	99
ESTROVEN	209	E-Z-PASTE.....	99
eszopiclone.....	178	EZ SMART LANCETS.....	157
ethacrynic	101	F	
ethambutol.....	36	FA-8.....	204
ethinyl estradiol/drospirenone.....	95	FABHALTA.....	76
ethosuximide.....	92, 94	FACTIVE	38
ethynodiol d-ethinyl estradiol.....	95	famciclovir	69
etodolac.....	27, 28	famotidine	122
etonogestrel/ethinyl estradiol	95	fa/mv,ca,iron,min/lycopene/lut	209
etoposide	61	FARESTON.....	62
etravirine	67	FARXIGA	51
EUCRISA	185	FARYDAK.....	55
EULEXIN	55	FASENRA	32
EURAX.....	64	FATIGUE RELIEF COMPLEX	209
EVAMIST	127	febuxostat.....	26
EVEKEO.....	72	felbamate.....	92
EVENCARE.....	135	FELBATOL.....	92
everolimus	57, 132	FELDENE.....	27
EVICEL.....	77	felodipine.....	79
EVISTA.....	199	FEMARA.....	56
EVOCLIN	41	fenofibrate.....	87
EVOLUTION.....	135	fenofibric.....	87
EVOTAZ.....	68	FENOGLIDE.....	87
EVOXAC	72	fenoprofen.....	27, 28
EVRYSDI.....	196	FENORTHO.....	28
EVZIO	44	fentanyl.....	21, 22
EXEL.....	146, 150, 151	FENTANYL.....	22
EXELDERM.....	46	feosol	112
EXEL HUBER	146	FEOSOL	112
EXELON.....	71	FERAHEME.....	112
exemestane	56	FERGON.....	112
exenatide	48	FER-IN-SOL	112
EXPECTA PRENATAL.....	165	FERIVA 21-7	112
EXTENDED RESERVOIR.....	151	FERIVA FA.....	112
EXTINA.....	46	FERRACTIV IRON.....	112
EYE HEALTH AND LUTEIN.....	202	FERRALET	112
EYE HEALTH PLUS LUTEIN TABLET	202	FERRETTS IPS	113
EYE MULTIVITAMIN	202	FERRIMIN.....	113

Index of Medications

FERRIPROX.....	196, 197	FLOVENT.....	31, 32
FERRLECIT.....	113	FLOW-EZE.....	146
FERRO-SEQUELS.....	113	FLUAD.....	74
ferrous.....	112, 113, 114, 116, 212, 213, 224	FLUAD QUAD.....	74
FERROUS.....	113	FLUARIX.....	74
ferrous fumarate.....	113, 114	FLUARIX QUAD.....	74
FERROUS FUMARATE.....	113	FLUBLOK.....	74
ferrous fum/vit c/b12-if/folic.....	113	FLUBLOK QUAD.....	74
ferrous gluconate.....	112, 113, 212, 213	FLUCELVAX.....	74
ferrous sulfate.....	112, 113	FLUCELVAX QUAD.....	74
ferumoxytol.....	112, 113	fluconazole.....	45
fesoterodine.....	201	flucytosine.....	44, 45
FETZIMA.....	171, 172	fludrocortisone.....	128
FEXMID.....	164	FLULAVAL.....	75
FIBRICOR.....	87	FLULAVAL QUAD.....	75
fidaxomicin.....	37	FLUMADINE.....	69
fifty50.....	178, 182	FLUMIST.....	75
FIFTY50.....	142, 157	FLUMIST QUAD.....	75
fifty50 alcohol prep pads.....	182	flunisolide.....	102
FIFTY50 SAFETY SEAL LANCETS.....	157	fluocinolone.....	103, 186, 187, 188
FILSPARI.....	89	fluocinonide.....	187
FILSUEVZ.....	200	fluorescein.....	98, 104
FILTER.....	146, 147, 151, 153	FLUORESCEIN-BENOXINATE.....	104
FILTER ASPIRATOR.....	146	fluoride.....	108, 109, 111, 116, 221, 222
FINACEA.....	184	FLUORIDEX.....	108, 111
finasteride.....	201	fluorometholone.....	103, 104
FINAZOL.....	209	FLUOROPLEX.....	62
FINE.....	147	fluorouracil.....	62
FINGER GRIP.....	151	fluoxetine.....	170, 171, 176
FINGERSTIX.....	142, 157	fluphenazine.....	176
FIORICET.....	15, 19, 24	FLURA-DROPS.....	109, 116
FIORINAL.....	15	flurandrenolide.....	186
FIRDAPSE.....	90	flurazepam.....	177
FIRST-MOUTHWASH BLM.....	194, 195	flurbiprofen.....	28, 104
FLAVOVIT.....	203	flutamide.....	55
flavoxate.....	202	fluticasone.....	31, 102, 187
flecainide.....	78	fluticasone propion/salmeterol.....	31
FLECTOR.....	180	fluticasone-salmeterol.....	31
FLEVOXIN.....	235	fluticasone-salmeterol 100-50.....	31
FLEXICHAMBER.....	162	fluvastatin.....	86
FLINTSTONES.....	220	fluvoxamine.....	171
FLOGEN.....	203	FLUZONE.....	75
FLOLIPID.....	86	FLUZONE HIGH-DOSE.....	75
FLOMAX.....	201	FLUZONE HIGH-DOSE QUAD.....	75
FLORAFOL.....	220	FLUZONE QUAD.....	75
FLORIVA.....	108, 220	FML.....	104
FLORRAXYL.....	210	FNP.....	244

Index of Medications

fn vitamin	231	FRAICHE.....	108
FOLA.....	226	FREEDAVITE.....	210
FOLACHEW	210	FREESTYLE.....	97, 98, 135, 136, 142, 157
FOLAGENT.....	210	FREESTYLE INSULINX	97, 98
FOLAMAX.....	210	FREESTYLE LITE.....	98
FOLAMED.....	210	FROVA	19
FOLAPRIME	210	frovatriptan succinate.....	19
FOLAWISE	210	FRUIT C.....	235
FOLETRA.....	204	fruit c-100	235
FOLIC.....	165, 204, 205, 210, 224, 226, 230, 233, 239	FRUIT C-100	235
folic acid.....	113, 114, 115, 166, 167, 204, 205, 208, 210, 211, 212, 213, 214, 216, 217, 220, 222, 224, 226, 227, 228	FRUZAQLA.....	58
folic/mvi ther-min/lycop/lut.....	210	ft.. 113, 165, 204, 210, 218, 229, 231, 233, 235, 239, 243, 244, 245	
FOLICORE	226	FT	113, 198, 210, 226, 231, 235, 239
FOLIKA.....	204, 210, 226, 239	ful-glo	98
FOLIKA-BC.....	226	FUL-GLO	98
FOLIKA-D	239	FULPHILA.....	94
FOLIKA-NC	226	FURADANTIN	37
FOLIKA-T	226	furosemide.....	101
FOLIKA-V	204	FUSION.....	66, 113
FOLINIC-PLUS	226	FUZEON.....	66
FOLITE.....	204	FYCOMPA	92
FOLIXAPURE.....	239	G	
FOLLISTIM AQ.....	129	gabapentin	90, 92
FOLTRATE	231	GALAFOLD	197
FOLTX	226	galantamine.....	71
FOLVITA.....	226	GALZIN.....	197
FOLVITE-D	239	ganirelix.....	128
fondaparinux.....	43	GANIRELIX	128
FORA.....	98, 135, 142, 157	GARDASIL 9	76
FORACARE	135, 142, 157	GASTROCROM.....	26
FORACARE LANCETS.....	157	GASTROGRAFIN	99
FORA GTEL	98, 135	GASTROMARK	99
FORA LANCETS	157	gatifloxacin.....	34
formaldehyde.....	54, 180	GATIFLOXACIN-DEXAMETHASONE	33
formoterol	30	GATTEX	124
FORMOTEROL.....	30	GAVRETO	58
FORTAVIT	210	GE100.....	136
FORTISCARE	135	GELCLAIR.....	194
FOSAMAX	199	GELFILM.....	105, 198
FOSAMAX PLUS D	199	GEL-FLOW	77
fosamprenavir	68	GELFOAM.....	77
fosaprepitant.....	119	GELX.....	194
fosfomycin tromethamine	35	gemfibrozil	87
fosinopril	82, 83	GEMTESA	201
fosinopril/hydrochlorothiazide	82	GENADEK	210, 220
FRAGMIN.....	43	GENICIN	204, 226, 239
		GENICIN VITA-Q	204

Index of Medications

GENICIN VITA-S.....	226	GOLYTELY	122
GENOTROPIN.....	128	GOMEKLI	57
gentamicin	34, 35, 41	GONAL-F.....	129, 130
GENTEEL	134, 136	GONITRO	80
GENTLE IRON.....	113	GOPRELTO	102
GENVOYA.....	68	GRALISE.....	90
GEODON.....	175	granisetron.....	119
GERBER	210, 220	GRASTEK	73
GERBER GROW MIGHTY.....	220	griseofulvin	45
GERBER LIL BRAINIES.....	220	gs	110
GERITOL	205	GS.....	53, 153, 165, 178, 182, 198, 210
GIALAX	122	GS PRENATAL	165, 210
GILOTTRIF	58	GUAIACOL.....	183
glatiramer	89	guaifen-codeine	97
glatopa.....	89	GUAIFEN-CODEINE.....	97
GLEOLAN.....	98	guanfacine.....	84, 173
GLEOSTINE.....	55	GUARDIAN.....	136
glimepiride.....	49, 50	GUMMIES CHILDREN MULTIVITAMIN	220
glipizide	49, 50	GUMMY.....	109, 206, 219, 220, 230, 231
GLOPERBA	26	GVOKE.....	110
GLUCAGEN	98	GYNAZOLE	44
GLUCAGON.....	63, 124	H	
GLUCO	109	HAEGARDA.....	195
GLUCOCARD.....	136	HAIR, SKIN AND NAILS.....	207, 210, 211, 216
GLUCOCOM.....	136, 142, 157, 158	HAIR-SKIN-NAILS.....	227
glucose.....	109, 110	halcinonide	187
GLUCOSE.....	109	HALCION.....	177
GLUCOSE CONTROL	133, 134, 135, 136, 138	halobetasol	187
GLUCOSE LIQUID.....	109, 110	HALOG.....	187
GLUCOTROL	49	haloperidol.....	176
glutamine.....	77	HARD NAILS.....	227
GLUTOL	110	HARVONI.....	70
GLUTOSE-I5	109	HAVRIX.....	76
GLUTOSE-45	109	HEALON GV.....	108
glyburide	49, 50	HEALTHPRO GLUCOSE CONTROL SOLN.....	136
GLYCATÉ.....	118	HEALTHY.....	136, 142, 158, 202, 214, 215
glycine urologic solution.....	53	HEALTHY ACCENTS AUTOLET	136
glycopyrrolate	118	HEALTHY ACCENTS UNILET LANCET	158
GLYNASE.....	50	healthy eyes tablet.....	202
GLYXAMBI	50	HEALTHY EYES TABLET	202
gnp109, 110, 113, 165, 198, 202, 204, 210, 218, 223, 226, 227, 229, 231, 233, 235, 239, 243, 244		HEARTBURN ACID REFLUX.....	211
GNP	178, 198, 210, 223, 226, 227, 231, 235, 239, 243, 245	HEMA-COMBISTIX.....	100
gnp glucose	109, 110	HEMATÉX	113
GNP VITAMIN E	243	HEMATOGEN.....	113
GOJJI	98, 136, 142, 158	HEMATRON-AF	114
		HEMAX	114

Index of Medications

HEMLIBRA	77	hydroxocobalamin	231
HEMOCYTE	114	hydroxychloroquine	53
heparin	43, 44	HYDROXYCHLOROQUINE	53
HEPARIN	43, 44	HYDROXYPROPYLCELLULOSE	198
HEPLISAV-B	76	hydroxyurea	55
HETLIOZ	177	hydroxyzine	47
HIBERIX	75	HYFTOR	131
high potency multivitamin tab	211	HYLAVITE	227
HIGH POTENCY MULTIVITAMIN TAB	211	HYLAZINC	204
HISTEX-AC	96	HYMPAVZI	77
hm	114, 165, 198, 204, 218, 227, 231, 235, 239, 243	hyoscyamine	120
HM	165, 179, 182, 211, 227, 239	HYPER-SAL	196
HM ALCOHOL 70% PREP PADS	182	HYPODERMIC NEEDLE	146, 153
HM BIOTIN	227	HYPOLANCE	136
HM HAIR, SKIN AND NAILS TABLET	211	HYPROMELLOSE	198
hm iron	114	HYSINGLA	22
HM MEN'S ONE DAILY TABLET	211	I	
HM ONE DAILY PRENATAL	165	ibandronate	199
hm prenatal	165	IBRANCE	58
hm slow release iron	114	IBTROZI	58
hm vit	231, 235	ibuprofen	21, 28
hm vitamin	231, 235, 239, 243	I-CAPS	202
HM VITAMIN	239	ICAPS	202, 211
homatropine	107	ICAPS AREDS2	202
HOMOCYSTEINE	227	ICAR	114
HORIZANT	88	icatibant	192
HORMONES	125, 126, 127, 128, 129, 130, 190, 191	ICLUSIG	58
HUMALOG	51	icosapent	118
HUMANA	98	IDHIFA	61
HUMATIN	52	IFE-BIMIX	193
HUMULIN	51	IGALMI	178
HURRICAIN LUER-LOCK	146	IHEALTH	136
HYCAMTIN	57	ILET	136, 137
HYCODAN	97	ILEVRO	104
hydralazine	84, 85	I.L.X. B-12	114
HYDREA	55	IMBRUVICA	58, 59
hydrochlorothiazide	81, 82, 83, 84, 85, 102	IMCIVREE	63
hydrocodone	21, 22, 96, 97	imipramine	172, 173
hydrocodone-acetamin	21	imiquimod	183
HYDROCODONE-ACETAMIN	21	IMKELDI	59
hydrocodone/ibuprofen	21	IMMUNERX	211
hydrocort	33, 103, 121, 124, 187, 189	IMPAVIDO	53
hydrocortisone	103, 124, 125, 127, 185, 187, 188, 189	IMPEKLO	188
hydrocortisone/acetic acid	103	IMULDOSA	130
hydrocort-pramoxine	124, 189	IMURAN	132
hydrogen peroxide	180	INBRIJA	64
hydromorphone	22	INCONTROL	137, 142, 158, 179, 182

Index of Medications

INCONTROL LANCING DEVICE	137	IQIRVO.....	194
INCRELEX	128	irbesartan.....	83
INCRUSE.....	29	irbesartan/hydrochlorothiazide.....	83
indapamide.....	102	IRESSA.....	59
INDICLOR	99	iron95, 112, 113, 114, 115, 116, 166, 167, 168, 205, 206, 207, 208, 209, 210, 212, 213, 216, 219, 220, 221, 222, 223, 228	
indomethacin	28	IRON 112, 113, 114, 115, 116, 117, 165, 168, 169, 209, 215, 216, 217, 219, 220, 221, 222	
INFANRIX DTAP	75	iron bg.....	114, 166
INFANT-TODDLER MULTIVITAMIN	220	IRON BISGLYCINATE.....	114
infant-toddler multivit-iron.....	220	iron/c.....	115
INFANT-TODDLER MULTIVIT-IRON	220	iron,carbonyl.....	112, 114
INFANT-TODDLER TRI-VITAMIN.....	221	iron/folic.....	115, 166, 167, 207, 208, 212, 213, 216
INFASURF	191	iron fum.....	114, 115, 166, 167, 208, 213, 219
INFED.....	114	iron fumarate	114, 166
INFINITY	137	iron polysaccharide	113, 114, 115
INFUSION SET	137, 139, 140	IRONUP.....	115
INFUVITE	211, 221	IRO-PLEX.....	115
INGREZZA.....	88, 89	IROSPAN.....	115
INJECT.....	142, 151, 158	IS-D.....	240
INJECTAFER.....	114	ISENTRESS.....	68
INJECT EASE.....	158	isoflurane.....	25
INJECT-EASE	151	isoniazid	36
INLYTA	59	ISOPROPANOL	198
INNER EAR PLUS.....	203	isopropyl	182, 197, 198
INOVA	183	ISOPROPYL.....	53, 54, 179, 182, 197, 198
INPEN.....	137	isopropyl alcohol.....	182, 197, 198
INSPIRACHAMBER.....	162	ISOPROPYL ALCOHOL	182, 197
INSPIRA.....	101	ISOPROPYL ALCOHOL 70% SPRAY	53
INSTACLEAN	198	isopropyl rubbing alcohol.....	198
INSTA-GLUCOSE.....	110	ISOPROPYL RUBBING ALCOHOL.....	198
INSUL-CAP.....	137	ISOPTO CARPINE.....	105
INSUL-EZE.....	137	ISORDIL	80
INSULIN	48, 49, 50, 51, 128, 148, 150, 151, 152, 154	isosorbide.....	80, 85
INSULIN LISPRO	51	isotretinoin.....	180
INTEGRA	114, 146, 151	isoxsuprine	85
INTELENCE	67	isradipine.....	79
INTERLINK.....	151	itraconazole	45
INTRINSI	231	IV 3000	154, 155
INVACARE	142, 158	IV3000	154
INVEGA	175	ivabradine.....	79
INVELTYS.....	104	IV ADMINISTRATION SET	161
iodine/potassium iodide	189	IVENIX.....	161
iodine/sodium iodide	189	ivermectin.....	52, 184
IODOFLEX	189	IWILFIN.....	59
IODOSORB.....	189	J	
IOPIDINE.....	105	JAKAFI	56
IPOL.....	73		
ipratropium	29, 102		

Index of Medications

JALYN.....	201
JANSSEN COVID-19 VACCINE.....	73
JANUMET.....	50
JANUVIA.....	49
JARDIANCE.....	51
JOENJA 70 MG TABLET.....	192
JORNAY.....	173
JOURNAVX.....	19
JUBLIA.....	46
JULUCA.....	66
JUST 4 KIDZ MULTIVIT-PROBIOTIC.....	221
JUSTRIGHT 5000.....	108, 111
JUXTAPID.....	86
JYNARQUE.....	101
JYNNEOS.....	76
K	
KI-1000.....	244
K2.....	238, 240, 244, 245
KADIAN.....	22
KALETRA.....	67
KALYDECO.....	191
KAPVAY.....	173
KENALOG.....	188
KENDALL.....	151, 154
KENDALL DISINFECTANT CAP.....	151
Keppra.....	92, 93
KERENDIA.....	101
KESIMPTA.....	89
KETAMINE.....	178
ketoconazole.....	45, 46
ketodan.....	46
KETO-DIASTIX REAGENT.....	100
KETONE CARE TEST STRIP.....	100
KETONE TEST STRIP.....	98, 100
ketoprofen.....	28
ketorolac.....	20, 21, 103, 104
KETOSTIX REAGENT.....	100
KIDS.....	99, 108, 111, 219, 220, 221, 227
KIDS COD LIVER OIL.....	221
KIDS MULTIVITAMIN.....	221
KINRIX.....	75
KISQALI.....	56, 59
KITABIS PAK.....	35
KLARITY.....	34, 103, 104, 107
KLARITY-A(AZITHROMYCIN-CHONDR).....	34
KLARON.....	181
KLOXXADO.....	44

KOSELUGO.....	57
KOSHER PRENATAL.....	165
K-PAX.....	211
K-PHOS.....	117
KPN PRENATAL.....	165
KRINTAFEL.....	53
KRISTALOSE.....	122
kroger glucose.....	110
kro glucose.....	110
kro isopropyl alcohol 91%.....	198
KYLEENA.....	96
KYNMOBI.....	64
L	
LABSTIX REAGENT.....	100
lacosamide.....	92
LACRISERT.....	103
lactulose.....	118, 122, 123
LAMICTAL.....	92
lamivudine.....	66, 67, 70
lamivudine/zidovudine.....	66
lamotrigine.....	92
lancets.....	140, 142, 156, 158
LANCETS.....	140, 141, 142, 143, 144, 145, 156, 157, 158, 159, 160
LANCING DEVICE.....	133, 134, 135, 136, 137, 138, 139, 140
LANCING SYSTEM.....	137
LANOXIN.....	79
lansoprazole.....	120, 123
lansoprazole/amoxicilin/clarith.....	120
lanthanum carbonate.....	111
LANTUS.....	52
LANZO.....	137
lapatinib ditosylate.....	59
LASIX.....	101
LASTACRAFT.....	48
latanoprost.....	105
LATANOPROST.....	105, 106
LAZANDA.....	22, 23
LAZCLUZE.....	59
leader glucose.....	110
leader quick dissolve gluc.....	110
lecithin/pyridoxine/kelp.....	211
leflunomide.....	26
lenalidomide.....	57
LENVIMA.....	59
LEQSELVI.....	200
LESCOL.....	86
L.E.T.....	25
letrozole.....	56

Index of Medications

leucovorin.....	192	little.....	221
LEUKERAN.....	55	LITTLE.....	221
LEUKINE.....	94	LITTLE ANIMALS.....	221
levalbuterol.....	30	LIVDELZI.....	194
LEVBIID.....	120	LIVITA.....	221, 245
LEVER LOCK CANNULA.....	151	LIVMARLI.....	122
levetiracetam.....	92, 93	LIVTENCITY.....	69
LEVETIRACETAM.....	92	l-mefol/a-cyst/mebl2/algal oil.....	227
LEVITRA.....	193	l-mefolate/b3/copp/zs/sel/chrom.....	211
levobunolol.....	105	L-MESITRAN.....	185
levocarnitine.....	199	L-METHYLFOL.....	227
levofloxacin.....	34, 38	l-norgest/e.estradiol-e.estrad.....	95
LEVOMEFOL.....	227	LODINE.....	28
levomefolate.....	204, 224, 225, 227, 228	LODOSYN.....	65
LEVOMEFOLATE.....	227	lofexidine.....	200
levonorgestrel/ethin.estradiol.....	95	LOKELMA.....	111
levothyroxine.....	191	LOMAIRA.....	62
LEVSIN.....	120	LOMOTIL.....	118
LEVULAN.....	62	longs glucose.....	110
LICART.....	180	LONHALA MAGNAIR.....	29
lidocaine.....	25, 124, 189	LONSURF.....	55
LIDOCAINE.....	124	LOPID.....	87
LIDOCAINE-HYDROCORT.....	124	lopinavir/ritonavir.....	67
LIDOCAN.....	25	LOPRESSOR.....	85
LIFESHIELD BLUNT CANNULA.....	146, 151	LOPROX.....	46
LILETTA.....	96	lorazepam.....	169
lindane.....	189	LORBRENA.....	59
linezolid.....	38	LORID.....	227
LINZESS.....	122	LORMATE.....	227
liothyronine.....	191	LORTAB.....	21
LIPO.....	203	LORZONE.....	164
LIPO-FLAVONOID PLUS.....	203	losartan/hydrochlorothiazide.....	83
LIPOTRIAD.....	202, 203	losartan potassium.....	84
LIQUID.....	99, 109, 110, 115, 205, 212, 223, 230, 237, 238, 244	LOTEMAX.....	104
LIQUID E-Z PAQUE.....	99	LOTENSIN.....	82, 83
LIQUID POLIBAR PLUS.....	99	LOTENSIN HCT.....	82
liraglutide.....	48, 63	loteprednol.....	104
lisinopril.....	82, 83	loteprednol etabonate.....	104
lisinopril/hydrochlorothiazide.....	82	lovastatin.....	86
LITE.....	98, 137, 142, 158, 235	loxapine.....	176
LITEAIRE.....	162	lubiprostone.....	123
LITE TOUCH.....	137, 158	LUCENTIS.....	107
LITETOUCH.....	162	LUER LOCK.....	149, 150, 151, 152
LITFULO.....	200	LUER-LOK.....	148, 151, 153
lithium.....	170	LUERSLIP.....	151
LITHOBID.....	170	LUER SLIP TIP.....	151
LITHOSTAT.....	118	LUER TIP CAP.....	151, 153

Index of Medications

LUMAKRAS.....	56	MEDLANCE PLUS.....	158
LUMRYZ.....	177	MEDROL.....	127
LUPKYNIS.....	132	medroxyprogesterone.....	95, 129
LUTEIN.....	202, 203, 205, 220	MEDTRONIC.....	137
LYBALVI.....	175	MEDTYCHOLL-B.....	227
LYDIA PINKHAM HERBAL.....	115	mefenamic.....	21
LYMEPAK.....	39	mefloquine.....	53
LYNPARZA.....	59	MEGA BIOTIN.....	227
LYSODREN.....	61	megestrol.....	62, 202
LYSTEDA.....	76	meijer glucose.....	110
LYTGOBI.....	59	MEKINIST.....	57
LYUMJEV.....	52	MEKTOVI.....	57
M		meloxicam.....	28
MACROBID.....	37	melphalan.....	55
MACULAR BENEFITS.....	203	memantine.....	88
MACUVEX.....	203	MEN 50.....	205, 208, 211, 216
MACUZIN.....	203	MENACTRA.....	74
MAD.....	151	MENOPUR.....	129
mafenide.....	42	MENOSTAR.....	127
MAGELLAN.....	151, 152	MENQUADFI.....	74
MALARONE.....	53	MEN'S.....	205, 206, 207, 208, 211, 214, 215, 216
malathion.....	189	MEN'S 50 PLUS.....	211, 214, 215
maprotiline.....	172	MEN'S DAILY.....	211
maraviroc.....	66	MEN'S MULTIVITAMIN.....	211, 214
MAR-COF CG.....	97	MENVEO.....	74
MARINOL.....	119	MEPHYTON.....	244
MARNATAL-F.....	165	meprobamate.....	170
MARPLAN.....	170	MEPRON.....	53
MASONATAL.....	165	mercaptopurine.....	55
MATULANE.....	61	MERIBIN.....	227
MAVENCLAD.....	89	mesalamine.....	121
MAXFE.....	115	mesna.....	192
MAXIMIN.....	211	MESNEX.....	192
MAXIMUM D3.....	240	METANX.....	227
MAXITROL.....	33	METANXPRO.....	227
MAXI-TUSS CD.....	96	metaproterenol.....	30
MAYZENT.....	89	metaxalone.....	164
MEBOLIC.....	211	metformin.....	49, 50
meclizine.....	119	METHACHOLINE.....	98
meclofenamate.....	28	methadone.....	23
mecobal/levomefolat ca/b6 phos.....	227	methamphetamine.....	72
MEDI-FIRST ISOPROPYL ALCOHOL.....	54	METHAVER.....	227
MEDIHONEY.....	185	methazolamide.....	100
MEDISENSE.....	137, 142, 158	methenamine hippurate.....	35
medlance.....	142, 158	methenamine mandelate.....	35
MEDLANCE.....	142, 158	methenam/m.blue/salicyl/hyoscy.....	35
medlance plus.....	158	methenam/sod phos/mblue/hyoscy.....	35

Index of Medications

methen/mbblue/sal/sod phos/hyos.....	35	MIFEPREX.....	195
methimazole.....	190	mifepristone.....	50, 195
METHITEST.....	125	miglitol.....	49
meth/meblue/sod phos/psal/hyos.....	35	miglustat.....	196
methocarbamol.....	164	MIGRANAL.....	20
methotrexate.....	55, 56	MINCORA.....	227
methoxsalen.....	180	MINI LANCING DEVICE.....	137, 138
methscopolamine.....	120	MINIMED.....	137, 151
METHYL B-12.....	231	MINIMED RESERVOIR.....	151
METHYLCOBALAMIN.....	231	MINI PRENATAL.....	165
methyldopa.....	84	MINIPRESS.....	82
methylene.....	195	minocycline.....	39, 40
methylergonovine.....	129	MINOLIRA.....	40
METHYLFOLATE.....	204	minoxidil.....	84
METHYLIN.....	173	MIRENA.....	96
methylphenidate.....	173, 174	mirtazapine.....	169
METHYLPHENIDATE.....	174	MIRVASO.....	184
methylprednisolone.....	127	misoprostol.....	27, 120
METHYL PROTECT.....	227	MITIGARE.....	26
methyl salicylate.....	183	MITOMYCIN.....	107
methyltestosterone.....	125	MITOSOL.....	107
metoclopramide.....	122	MI-VITE.....	204
metolazone.....	102	MIXED TOCOTRIENOLS.....	243
METOPIRONE.....	99	MKO.....	178
metoprolol.....	85	M-M-R II VACCINE.....	75
METOPROLOL SUCCINATE ER-HCTZ.....	85	MNEXSPIKE.....	73
METROCREAM.....	184	MOBILE.....	143
METROGEL.....	184	modafinil.....	177
metronidazole.....	35, 40, 184	MODDI.....	137
metyrosine.....	84	MODERNA COVID.....	73
mexiletine.....	78	MODERNA COVID-19 BOOSTER.....	73
MIACALCIN.....	130	moexipril.....	83
miconazole.....	44	molindone.....	176
MICRO.....	139, 142, 143, 147, 158, 190	mometasone.....	102, 188
MICROCHAMBER.....	162	mondoxyne.....	40
MICRODOT.....	137	MONOCAPS.....	211
MICROLET.....	137, 143, 158	MONOFERRIC.....	115
MICRONEX.....	211	MONOJECT.....	146, 147, 151, 152
MICROSPACER.....	162	MONOLET.....	143, 158
MICROTAINER.....	156, 158	MONSEL'S.....	77
MICRO THIN LANCET.....	158	montelukast.....	32
MICRO THIN LANCETS.....	158	morgidox.....	40
midazolam.....	177	MORGIDOX.....	40
MIDAZOLAM.....	178	morphine.....	22, 23
midodrine.....	72	MOTOFEN.....	118
MIEBO.....	103	MOUNJARO.....	49

Index of Medications

MOUTHPIECE	162	MYFEMBREE	128
MOVANTIK	44	MYFORTIC	132
MOXATAG	38	MYGLUCOHEALTH	137, 143, 158
moxifloxacin	34, 38	MYHIBBIN	132
MOXIFLOXACIN	33	MYLERAN	55
MRESVIA	76	MYRBETRIQ	201
MS CONTIN	23	MYSOLINE	93
ms glucose	110	MYXREDLIN	52
ms quick dissolve glucose	110	N	
MTERYTI	165	nabumetone	28, 29
MTX	231	naftifine	46
MUCOSITISRX	194	NAFTIN	46
MULTAQ	78	NALFON	28
MULTIA	212	NALOCET	21
MULTI-DAY PLUS MINERALS	212	naloxone	24, 44, 200
multi for her	211	naltrexone	44
MULTI FOR HER	211	NAMENDA	88
MULTI-LANCET	137	NAMZARIC	88
multilex	212	NANO	147, 168, 221
MULTILEX	212	NANOVM	221, 245
MULTI PRO	211	NAPRELAN	28
MULTISTIX	100	NAPROSYN	27, 28
MULTITOL-M	245	naproxen	27, 28, 29
multivit.. 165, 205, 207, 208, 210, 212, 213, 214, 216, 217, 219, 220, 221, 222, 223, 245		naratriptan	19, 20
multivitamin .. 167, 208, 211, 212, 214, 216, 219, 220, 221, 222, 223		NARCAN	44
MULTIVITAMINI 167, 202, 203, 205, 206, 207, 208, 209, 210, 211, 212, 213, 214, 215, 216, 217, 218, 219, 220, 221, 227		NARDIL	170
MULTI-VITE	212	NASCOBAL	231
MULTI-VIT-FLOR	221	NATACHEW	165
MULTIVIT-FLUOR	221	NATACYN	44
multivit-min/fa/lycopen/lutein	207, 213	nateglinide	50
mupirocin	41	NATPARA	129
MURI-LUBE	198	NAYZILAM	91
MUSE	193	nebivolol	85
mv	114, 115, 206, 209, 210, 213, 215	NEBUPENT	53
mvn	208, 213	nebusal	196
MVW	213, 221	NEBUSAL	196
MVW COMPLETE	221	NEEDLE	145, 146, 147, 148, 150, 151, 152, 153
MYALEPT	130	needles,safety huber,disposabl	147
MYCAPSSA	129	NEEVODHA	213
MYCOBUTIN	36	nefazodone	171
mycophenolate	132	NEFFY	71
MYDAYIS	72	NEMLUVIO	131
MYDCOMBI	107	neomycin	33, 34, 35, 179
MYDRIACYL	107	neomycin/bacit/p-myx/hydrocort	33
MYDRIATIC4	105	neomycin/bacitracin/polymyxinb	34
		neomycin/polymyxin b/dexametha	33
		neomycin/polymyxin b/hydrocort	33

Index of Medications

neomycin/polymyxn b/gramicidin	34	NITYR.....	196
neomycin sulfate	35	NIVA-FOL	227
NEONATAL	115, 165	NIVA-PLUS	213
NEONATAL FE	115	NIVESTYM	94
NEORAL	132	nizatidine	122
NEO-SYNALAR	41	NOCTIVA	126
NEOVITE	213	NO FLUSH NIACIN.....	218
NEPHRON FA	227	NOKOR	147
NEPHRO-VITE	227	norelgestromin/ethin.estradiol.....	95
NERIA	161	noreth-ethinyl estradiol/iron.....	95
NERLYNX.....	59	norethind-eth estrad	95, 127
NESTABS	165, 213	norethindrone.....	95, 126, 127, 129
NEUAC	181	norethin-ee.....	95
neuac gel.....	181	norethin-eth estrad	127
NEULUMEX	99	NORGESIC	164
NEUPRO	64	norgestimate-ethinyl estradiol.....	95
NEURIN-SL	231	norgestrel-ethinyl estradiol.....	95
NEUTRASAL	194	NORM-JECT	152
nevirapine	67	NORMLGEL.....	189
NEXAVAR	59	nortriptyline.....	172
NEXCARE TEGADERM.....	154, 155	NORVIR	68
NEXLETOL	86	NORWEGIAN COD LIVER OIL	223
NEXLIZET	86	NOURIANZ.....	65
niacin.....	87, 218, 219	NOVA	137, 143, 158
NIACIN	218, 219	NOVAFERRUM	115, 222
niacinamide	218	NOVAMAX PLUS.....	98, 137
NIACINAMIDE.....	218	NOVAMV	222
NIACOR	87	NOVAREL	130
nicardipine	79	NOVAVAX COVID-19 VACC,ADJ	73
NICOMIDE.....	213	NOVOPEN 3.....	138
NICOTROL	190	NOVOPEN ECHO.....	138
nifedipine.....	79	NOXAFIL.....	45
NIFEREX.....	115	NOXIFOL-D3.....	240
NILANDRON.....	55	NUBEQA	55
nilotinib	59	NUCALA	32
nilutamide.....	55	NUCORT.....	188
nimodipine	79	NUEDEXTA.....	89
NINJACOF-XG	97	NUFERA.....	115
NINLARO	59	NUFOLA	227
nisoldipine	79	NU-IRON.....	115
nitisinone.....	196	NULEV	120
NITRO-DUR.....	80	NULYTELY.....	123
nitrofurantoin	37, 38	NUMBRINO.....	102
nitroglycerin	80, 123	NUMOISYN	194
NITROLINGUAL	80	NUPLAZID	170
NITROMIST	80	NURTEC ODT	20
NITROSTAT	80	NUTRALYN.....	213

Index of Medications

NUTRIVIT	214	ONE-A-DAY.....	166, 214, 215, 222
NUVAXOVID.....	73	one daily	167, 208, 214, 216
NUVESSA.....	40	ONE DAILY	165, 206, 209, 211, 214
NUZYRA.....	40	ONE-DAILY	215
NYMALIZE.....	79	ONETOUCH.....	138, 143, 158, 159
nystatin	45, 46, 47	ONETOUCH DELICA	138, 158, 159
O		ONETOUCH ULTRA	138
OB COMPLETE.....	165, 166, 214	ONETOUCH VERIO.....	138
OBREDON.....	97	ONEVITE.....	215
OBSTETRIX EC.....	166	ONE WAY MOUTHPIECE	162
OBSTETRIX ONE.....	214	ONEXTON.....	181
OBTREX DHA.....	166	ONGENTYS.....	65
OCALIVA.....	121	ON-THE-GO.....	143, 159
OCUFLOX.....	34	OPFOLDA	196
OCULAR VITAMINS.....	203	opium/belladonna	23
OCUVEL	203	opium tincture.....	118
OCUVITE	203, 214	OPSITE.....	155
ODACTRA.....	73	OPSUMIT	80
ODEFSEY	68	OPSYNVI.....	81
ODOMZO	56	OPTICHAMBER.....	162, 163
OFEV	192	OPTIFAST.....	215
ofloxacin.....	33, 34, 38	OPTIMAL D3 M	240
OGSIVEO	59	OPTISOURCE.....	215
OJEMDA	56	OPTUMRX	138
olanzapine	175, 176	OPURITY	215, 231
olmesartan/amlodipin/hcthiazid.....	82	OPZELURA.....	189
olmesartan/hydrochlorothiazide	83	ORACIT.....	117
olmesartan medoxomil.....	84	ORALAIR	73
olopatadine	102	ORAMAGICRX	194
OLPRUVA	118	ORAPRED ODT.....	127
OLUX.....	188	ORAVIG.....	45
om-3	214	ORENITRAM.....	81
OMECLAMOX-PAK.....	120	ORFADIN.....	196
omega-3 acid.....	118	ORGOVYX	57
omeprazole	123, 124	ORIAHNN	128
OMNIPAQUE	98	ORILISSA	128
OMNIPOD	138	ORKAMBI	191
OMNITROPE	128	ORLADEYO	192
OMNIVEX.....	214	ORLISTAT	63
OMVOH.....	131	orphenadrine.....	164
ON CALL	138, 143, 158	ORTHO DF	240
ONCOVITE.....	214	oseltamivir.....	69
ondansetron.....	119	OSENI	48
one	167, 208, 214, 216	OSMOPREP	123
ONE.162, 165, 166, 168, 206, 209, 211, 213, 214, 215, 216, 222, 223		OSTACHOL.....	240
one-a-day.....	215	OTEZLA.....	26
ONE A DAY.....	166, 222, 223	OTIPRIO.....	33

Index of Medications

OTOVEL	33	PAXLYTE.....	231
OVACE	181, 182	pazopanib	59
OVAL TAPE	138	PEDIA POLY-VITE	222
OVIDE.....	189	pedia poly-vite iron	222
OVIDREL	130	PEDIARIX	76
oxandrolone.....	125	PEDIATRIC MASK	163
oxaprozin	27, 29	PEDIATRIC MONITOR.....	138
oxazepam.....	169	pediatric multivit	222
OXBRYTA	77	pediatric multivitamin.....	219, 222, 223
oxcarbazepine.....	93	PEDIATRIC PANDA MASK	163
OXERVATE	108	PEDIATRIC POLY-VITAMIN.....	222
oxiconazole.....	47	PEDIATRIC POLY-VITE.....	222
OXTELLAR	93	PEDIATRIC TRI-VITAMIN	222
oxybutynin	202	PEDIATRIC TRI-VITE.....	222
oxycodone	21, 23, 24	PEDIA TRI-VITE.....	222
oxycodone hcl/acetaminophen.....	21	pedi multivit.....	219, 220, 222
OXYCONTIN.....	24	ped mvit	222
oxymorphone	24	PEDVAXHIB	75
OXYTROL	202	peg3350/sod sulf,bicarb,cl/kcl	122, 123
OZEMPIC.....	48	peg3350/sod sul/nacl/kcl/asb/c.....	123
P		PEGASYS.....	70
P2I	169	PEMAZYRE	59
PACNEX	183	PENBRAYA	74
paliperidone.....	175	penciclovir.....	71
PALYNZIQ.....	73	penicillamine	26
PAMELOR.....	172	penicillin.....	38
PAN-C	235	PENMENVY	74
PANCREAZE	123	PENTACEL	75
PANDA.....	163	pentamidine.....	53
PANDEL	188	PENTASA.....	121
PANRETIN	62	pentazocine	24
PANTETHINE.....	219	pentoxifylline.....	78
pantoprazole	124	PEPCID	122
PANTOTHENIC	219	perampanel	92, 93
PAPAVERINE-PHENTOLAMINE.....	193	PERFECT	115, 143, 147, 159
PAPAVERINE-PHENTOLMN-ALPROSTD	193	PERFECT IRON	115
PARADIGM.....	152, 161	PERIDEX.....	192
paregoric.....	118	PERIDIN-C.....	235
PAREMYD	107	perindopril erbumine	83
paricalcitol.....	195	permethrin.....	64
PARNATE.....	170	perphenazine.....	176
paroxetine.....	171, 196	perphenazine/amitriptyline hcl.....	172
PARVLEX.....	115	PFIZER COVID	73
PASER	36	pharm.....	179, 182
PATANASE	102	PHARM	179, 182
PAXIL	171	PHARMABASE BARRIER.....	184
PAXLOVID	69	pharm choice alcohol prep pads	182

Index of Medications

PHARM CHOICE ALCOHOL PREP PADS.....	182	POLY-TUSSIN AC.....	96
PHASEAL.....	147	POLY-VI-FLOR.....	222
PHEBURANE.....	118	poly-vi-sol.....	222
phenazopyridine.....	25	POLY-VI-SOL.....	222
phendimetrazine.....	62	POLY-VITA.....	222
phenelzine.....	170	POLY VITAMIN-IRON.....	215
phenobarb/hyoscy/atropine/scop.....	120	POLY-VITE.....	222
phenobarbital.....	177	POMALYST.....	57
PHENOBARBITAL-BELLADONNA ELIXR.....	120	POSACONAZOLE.....	45
phenoxybenzamine.....	72	posaconazole dr.....	45
phentermine.....	62, 63	potassium.....	20, 38, 84, 109, 112, 117, 123, 189
phenylephrine.....	47, 105	POTASSIUM.....	101, 102, 116, 117, 123
PHENYTEK.....	93	potassium bicarbonate/cit ac.....	117
phenytoin.....	91, 93	potassium chloride.....	117
PHOSPHOLINE IODIDE.....	106	potassium citrate.....	117
PHOTREXA.....	103	potassium iodide.....	112, 189
PHYSIOLYTE.....	179	potassium iodide/iodine.....	112
PHYSIOSOL.....	179	povidone.....	103
phytonadione.....	244, 245	pramipexole.....	65
PHYTONADIONE.....	244	PRAMOSONE.....	189
PIFELTRO.....	67	PRANDIN.....	50
pilocarpine.....	72, 73, 105, 106	prasugrel.....	65
pimecrolimus.....	131	pravastatin.....	86
pimozide.....	175	praziquantel.....	52
pindolol.....	85	prazosin.....	82
pioglitazone.....	50	PR BENZOYL PEROXIDE.....	184
PIP.....	138, 143, 159	PRECISIONGLIDE.....	146, 147, 152, 153
PIP GLUCOSE CONTROL SOLUTION.....	138	PRECISION XTRA.....	98, 138
PIP LANCET.....	159	PRECOSE.....	49
PIQRAY.....	59	pred.....	33
piroxicam.....	27, 29	PRED.....	33, 104
PISTON ENFIT.....	152	PRED FORTE.....	104
pitavastatin.....	86	PRED-G.....	33
PLEGRIDY.....	89, 90	prednicarbate.....	186, 188
PLEXION.....	42, 182	prednisolone.....	34, 104, 127, 128
PNEUMOVAX 23.....	74	PREDNISOLONE.....	33, 104
pnv.....	166, 168	PREDNISOLONE ACET-GATIFLO-BROM.....	33
POCKET CHAMBER.....	163	PREDNISOLONE ACET-MOXIFLOXACIN.....	33
PODIAPN.....	227	PREDNISOLONE AC-MOXIFLOX-BROMF.....	33
podofilox.....	184	PREDNISOLONE AC-MOXIFLOX-NEPAF.....	33
POLIBAR ACB.....	99	PREDNISOLONE PHOS-GATIFLO-BROM.....	33
polyethylene.....	198	PREDNISOLONE PHOS-GATIFLOXACIN.....	33
POLYFIN.....	161	PREDNISOLONE PHOS-MOXIFLOXACIN.....	33
POLY HUB.....	147	prednisone.....	128
polymyxin b sulf/trimethoprim.....	34	preferred plus glucose.....	110
POLYSKIN II.....	155	pregabalin.....	93, 200
POLYTRIM.....	34	PREGNYL.....	130

Index of Medications

PREHEVBRIO.....	76	PROLENSA.....	104
PREMARIN.....	129	PROMACTA.....	94
PRENATA.....	166	promethazine.....	47, 96, 119
prenatal.....	165, 166, 167, 168, 246	PROMETRIUM.....	129
PRENATAL.....	165, 166, 167, 168, 169, 206, 210, 215, 217	propafenone.....	78
prenatal71.....	167	proparacaine.....	104
PRENATE.....	167, 169, 215	propranolol.....	85
PREPIDIL.....	129	propylthiouracil.....	190
PRESERVISION.....	203	PROQUAD.....	75
PRESSURE.....	105, 106, 143, 159	PRORENAL.....	215, 228
PRESSURE ACTIVATED LANCETS.....	159	PROSCAR.....	201
PRESTALIA.....	81	PROTECT.....	108, 115, 216, 227
PRETOMANID.....	36	PROTECT IRON.....	115, 216
PREV.....	215	PROTHELIAL.....	194
PREVENT.....	223	protiptyline.....	173
PREVIDENT.....	108, 111	PROVERA.....	95, 129
PREVNAR 13.....	74	PROVIDA OB.....	167
PREVNAR 20.....	74	PROVOCHOLINE.....	98
PREVYMIS.....	69	prucalopride.....	122
PREZISTA.....	66	PSV SET.....	161
PRIFTIN.....	36	pub glucose.....	110
PRIMACARE.....	167	PULMOZYME.....	192
primaquine.....	53	PURE.....	143, 159, 163, 179, 182
PRIMAQUINE.....	53	PURE COMFORT.....	159, 163, 182
PRIMEAIRE.....	163	PURECOMFORT.....	163
primidone.....	93	PUREFE.....	216
PRIMSOL.....	35	purevita.....	204, 240
PRIORIX.....	75	PUREVITA 204, 218, 219, 223, 228, 229, 231, 233, 235, 240, 243	
PRISMASOL.....	117	PURIXAN.....	56
PRO ..115, 135, 140, 143, 145, 156, 159, 161, 163, 179, 182, 183, 211, 220		PUSH.....	143, 159
probenecid.....	29	PUSH BUTTON.....	159
PROCARDIA.....	79	pyrazinamide.....	36
PROCARE SPACER.....	163	pyridostigmine.....	71
PROCERV HP.....	215	PYRIDOSTIGMINE.....	71
PROCHAMBER.....	163	pyridoxine.....	211, 233
prochlorperazine.....	119	PYRIDOXINE.....	233
PRO COMFORT.....	143, 159, 163, 182	pyrimethamine.....	53
PROCORT.....	121, 124	PYRUKYND.....	77
PROCTOCORT.....	124	Q	
PRODIGY.....	138, 143, 152, 159	QELBREE.....	174
PRODIGY COUNT-A-DOSE.....	152	QSYMIA.....	63
PRO FE.....	115	Q-SYTE.....	162
PROFERRIN.....	115	QUADRACEL DTAP-IPV.....	75
PROFOLA.....	215	QUDEXY.....	93
progesterone.....	129, 130	QUERCETIN.....	203
PROGLYCEM.....	110	QUESTRAN.....	87
PROGRAF.....	132	quetiapine.....	175

Index of Medications

QUFLORA.....	222	RAZADYNE.....	71
QUICK RELEASE SOFT TEFLON.....	138	READI-CAT 2.....	99
quinapril.....	81, 82, 83	READYLANCE.....	143, 159
quinapril/hydrochlorothiazide.....	81, 82	REBIF.....	90
QUIN B STRONG.....	228	RECOMBIVAX HB.....	76
QUINCE SPINAL.....	147	RECOTHROM.....	77
quinidine.....	78	RECTIV.....	123
quinine.....	53	REFUAH.....	138
QUINTABS.....	216	REGLAN.....	122
QULIPTA.....	20	REGULAR BEVEL.....	147
QUVIVIQ.....	178	RELAFEN.....	29
QVAR REDHALER.....	32	RELAGARD.....	52
R		RELCARE.....	228
ra alcohol swabs.....	182	RELENZA.....	69
ra balanced.....	228	RELEXXII.....	174
rabeprazole.....	124	RELIAMED.....	138, 143, 159
RADICAVA ORS.....	88	RELION.....	98, 110, 179, 183
RADIOGARDASE.....	197	reli-on glucose.....	110
ra glucose.....	110	relion glucose.....	110
RAGWITEK.....	73	RELION GLUCOSE.....	110
ra high potency iron.....	115	RELISTOR.....	44
RA HIGH POTENCY IRON.....	115	REMEDIENT.....	216
ra isopropyl alcohol 70%.....	198	REMERON.....	169
RA ISOPROPYL ALCOHOL 70% WIPES.....	182	RENACIDIN.....	117
ra isopropyl alcohol 91%.....	198	RENAL VITAMIN.....	228
raloxifene.....	199	RENAL-VITE.....	228
ramelteon.....	177	RENAPLEX.....	228
ramipril.....	83	RENVELA.....	111
RANEXA.....	78	repaglinide.....	50
RA NIACIN.....	219	REPATHA.....	86
ranitidine.....	122	REPLACEMENT.....	77, 112, 113, 114, 115, 116, 117
ranolazine.....	78	REPLACEMENT PEDIATRIC MONITOR.....	138
ra one daily prenatal dha pack.....	167	REPLESTA.....	240
RAPAMUNE.....	132	REQ49+.....	205
RAPID B-12 ENERGY.....	231	RESPA A.R.....	96
ra prenatal tablet.....	168	RESTASIS.....	107
rasagiline.....	64, 65	RESTORIL.....	177
RASUVO.....	26	RETEVMO.....	59, 60
RAVICTI.....	118	RETIN-A.....	190
ra vit.....	231, 235	RETROVIR.....	67
RA VIT.....	231	REVATIO.....	80
ra vitamin.....	223, 231, 235, 236, 240, 243	REVESTA.....	240
ra vitamin a.....	223	REVLIMID.....	57
RA VITAMIN C.....	236	REVUFORJ.....	60
RAYALDEE.....	195	REXTOVY.....	44
RAYA SURE.....	147	REXULTI.....	176
RAYOS.....	128	REYATAZ.....	68

Index of Medications

REYVOW.....	20	ROZLYTREK.....	60
REZDIFFRA.....	194	rufinamide.....	93
REZUROCK.....	201	rutin.....	203
RHOFADE.....	184	RYALTRIS.....	102
RHOPRESSA.....	106	RYBELSUS.....	48
ribasphere.....	70	RYCLORA.....	47
ribavirin.....	70	RYDAPT.....	60
riboflavin.....	233	RYTARY.....	65
RIBOFLAVIN.....	233	RYVENT.....	47
RIBOZEL.....	228	S	
RIDAURA.....	26	sacubitril.....	82
rifabutin.....	36	SAFE-CLIP.....	139
rifampin.....	36	SAFESNAP.....	152
RIGHTEST.....	139, 143, 159	SAFETY141, 142, 143, 144, 145, 148, 151, 152, 153, 154, 156, 157, 158, 159, 160, 161	
RILUTEK.....	88	SAFETYGLIDE.....	148, 152
riluzole.....	88	SAFETY LANCETS.....	156, 158, 159
rimantadine.....	69	SAFETY-LET.....	159
RIMSO-50.....	24	SAFETY SEAL LANCETS.....	157, 159
ringer's solution.....	179	SAFETY SYRINGE.....	151, 152, 153, 154
RINVOQ.....	27	SALAGEN.....	73
RIOMET.....	49	SALIVAMAX.....	194
risedronate.....	199	salsalate.....	26
RISPERDAL.....	175	SAMBUCUS.....	236
risperidone.....	175	SANCUSO.....	119
RITEFLO.....	163	SANDIMMUNE.....	132
ritonavir.....	67, 68	SANTYL.....	189
rivaroxaban.....	43	sapropterin.....	197
rivastigmine.....	71	SAPS.....	179, 183
rizatriptan.....	20	SAPS ALCOHOL 70% PREP PADS.....	183
R-NATAL.....	169	SAVELLA.....	200
ROBINUL.....	118	saxagliptin.....	49
ROCALTROL.....	240	saxagliptin-metformin.....	50
ROCKLATAN.....	106	saxagliptin-metformn.....	50
roflumilast.....	32	saxagliptn-metform.....	50
ROMVIMZA.....	60	SAXENDA.....	63
ropinirole.....	65	SCALACORT.....	188
rosadan.....	184	SCSEMBLIX.....	60
ROSADAN.....	184	SCOOBY-DOO ONE A DAY.....	222, 223
rosula.....	42	scopolamine.....	119
ROSULA.....	42	SECUADO.....	175
ROSZET.....	86	SEEBRI.....	30
ROTARIX.....	74	SELARSDI.....	130
ROTATEQ.....	74	SELECT-OB.....	168
ROWASA.....	121	selegiline.....	65
ROXICODONE.....	24	selenium.....	182
ROXIFOL.....	240		

Index of Medications

SELZENTRY	66	SMARTDIABETES VANTAGE	139
SEMGLEE	52	SMARTEST	139, 144, 159
SEN-SERTER	139	smart sense	110
SEROSTIM	128	SMART SENSE	159
sertraline	171	sm iron	116
sevelamer	111	sm isopropyl alcohol 70%	198
sevoflurane	25	sm prenatal vitamins tablet	168
SEYSARA	40	SM SLOW RELEASE IRON 45 MG TAB	116
SFROWASA	121	sm vitamin	231, 232, 236, 240
SHINGRIX	76	sodium	26, 27, 28, 29, 32, 34, 37, 38, 42, 43, 56, 62, 83, 86, 91, 92, 93, 98, 99, 103, 104, 108, 109, 111, 113, 116, 117, 118, 123, 124, 127, 128, 132, 164, 179, 180, 181, 182, 189, 191, 196, 199, 234
SHORT BEVEL	147	SODIUM	34, 43, 99, 177, 179, 182
SIDEROL	116	sodium chloride	123, 179, 196
SIDESTREAM	163	sodium chloride/nahco3/kcl/peg	123
sildenafil	80, 193	SODIUM CITRATE	43
SILENOR	178	sodium ferric gluconat/sucrose	113, 116
SILHOUETTE	137, 162	sodium fluoride	108, 109, 111, 116
SILICONE MASK	163	SODIUM OXYBATE	177
silodosin	201	sodium phenylbutyrate	118
SIL-SERTER	139	sodium polystyrene sulfonate	111
SILVADENE	42	sodium polystyrene sulfon/sorb	111
silver sulfadiazine	42	sodium, potassium, mag sulfates	123
SIMBRINZA	106	sodium sulfacetamide	182
SIMILAC PRENATAL	168	SODIUM SULFACETAMIDE 10% WASH	182
SIMLANDI	54	sod, pot chlor/mag/sod, pot phos	179
SIMPONI	54	sod sulfate-sulf	42
simvastatin	86, 87	sod sulfate-sulfur	42
SIMVASTATIN	86	sod sulfacetam 10% clnsng gel	182
SINEMET	65	sod sulfacetamide 9.8% shampoo	182
SINGLE	121, 124, 144, 159, 179, 183	sod sulfacetamide 10% shampoo	182
SINGLE-LET	144, 159	sod sulfacet-sulfr	42
SINGLE USE SWAB	183	sod sulfacet-sulfur	42
sirolimus	132	sod sulfac-sulfur	42
SIRTURO	36	SOF-SERTER	139
SITAVIG	69	SOF-SET	139
SITZMARKS	99	SOFT	138
SKYCLARYS	197	SOHONOS	197
SKYLA	96	solifenacin	201
SKYRIZI	131, 180	SOLIQUEA	48
SLIP-TIP	153	SOLO	216
slo-niacin	219	SOLODYN	40
SLO-NIACIN	219	SOLOSEC	34
SLOW FE	116	SOLTAMOX	62
slow release iron	112, 114, 116	SOLUS	139, 144, 159
SLOW RELEASE IRON	112, 115, 116	SOLUS V2	139, 159
sm	116, 168, 183, 198, 204, 216, 228, 231, 232, 233, 236, 240	SOLUVITA	223
sm alcohol prep pads	183		
SMART	142, 144, 157, 159		

Index of Medications

SOMA	164	SULAR	79
SOMAVERT	195	sulfacetamide	34, 42, 181, 182
SOOLANTRA	184	sulfadiazine	35, 42
sorafenib tosylate	59, 60	sulfamethoxazole/trimethoprim	35
SORBITOL	179	SULFAMYLON	42
sotalol	84, 85	sulfasalazine	121
SOTYKTU	180	sulindac	29
SOTYLIZE	85	SUMADAN	42
SPACE CHAMBER	162, 163	sumatriptan	20
SPAN C	236	SUMAXIN	42
SPECIALTY USE NEEDLES	147	sunitinib malate	60
SPECTRACEF	37	SUNLENCA	67
SPECTRAVITE	205, 216	SUNOSI	177
SPEVIGO	180	super	216, 225, 228
SPIKEVAX COVID	73	SUPER	142, 144, 158, 159, 216, 238, 240
spinosad	64	super b complex-vit c	228
SPIRIVA HANDIHALER	29	SUPER DAILY D3	238, 240
SPIRIVA RESPIMAT	29	SUPER GINSENG	216
spironolact/hydrochlorothiazid	102	SUPERIOR	216, 245
spironolactone	101, 102	super quintis	228
SPORANOX	45	SUPER THIN LANCETS	158, 159
SPRITAM	93	SUPOR	153
SPRIX	20	SUPPORT-500	216
SSKI	112	SUPRANE	25
sss	42	SURE	137, 139, 144, 147, 159, 162, 179, 183
STALEVO	65	SURE COMFORT	139, 159, 183
stavudine	67	SUREFLEX	139, 158
STELARA	130	SURE-LANCE	159
STENDRA	193	SURE-PEN	139
STERILANCE	144, 159	SURE-PREP ALCOHOL PREP PADS	183
STERILANCE TL	159	SURESITE	155
STERILE	144, 153, 159	SURE-T	162
STERILE LANCETS	159	SURE-TEST EASYPLUS	139
STIOLTO RESPIMAT	30	SURE-TOUCH	159
STIVARGA	60	SURGICEL	77
STRENSIQ	196	surgifoam	77
STRESS B-COMPLEX	216	SURGIFOAM	77
stress-c	216	SURGISEAL	184
stress formula	212, 216, 228	SURMONTIL	173
STRESS FORMULA	216	SURVANTA	191
STRIVERDI	30	SUSTIVA	67
STROMECTOL	52	SUTENT	60
STROVITE	216	sv	116, 168, 205, 219, 228, 232, 233, 236, 240, 243
STUART ONE	168	sv b-12	232
SUBSYS	24	sv biotin	228
SUCRAID	121	SV BIOTIN	228
sucrafate	120	SV COD LIVER OIL	223

Index of Medications

sv folic acid	205	TAKHZYRO.....	73, 192
SV HAIR, SKIN AND NAILS	216	TALICIA	120
sv niacin.....	219	TALTZ	180
sv prenatal tablet	168	TALZENNA.....	60
SV PRENATAL VITAMINS TABLET	168	TAMIFLU	69
SV SLOW RELEASE IRON 45 MG TAB	116	tamoxifen	62
sv vitamin.....	232, 236, 240, 243	tamsulosin	201
sv vitamin b-12.....	232	TANDEM.....	116, 139, 216
sv vitamin c	236	TANDEM DUAL ACTION.....	116
SV VIT B	232	TAPERDEX.....	128
sv vit c.....	236	TARGADOX	40
swan	198	TARGRETIN	62
SWI	179	TARPEYO.....	128
SYMAX DUOTAB.....	120	TASIGNA	60
SYMBICORT	31	TASMAR	65
SYMDEKO	191	tavaborole.....	47
SYMFI.....	68	TAVALISSE	192
SYMLINPEN.....	49	TAVNEOS.....	76
SYMPAZAN	91	tazarotene	181
SYMPROIC.....	44	TAZVERIK	57
SYMTUZA.....	66	TB SYRINGE	152, 153
SYNALAR.....	41, 188	TC 99M.....	98
SYNAREL.....	128	TDVAX	76
SYNDROS.....	119	TECHLITE.....	144, 159
SYNERA	25	TEGADERM.....	154, 155
SYNJARDY.....	50, 51	TEGLUTIK	88
SYPRINE.....	197	TEGRETOL	93
SYRINGE15, 19, 32, 44, 54, 70, 73, 77, 86, 90, 110, 130, 131, 148, 149, 150, 151, 152, 153, 154, 180, 200, 222		TEKTURNA HCT	85
SYRINGE AVITENE	77	TELCARE.....	139, 144, 160
SYRINGE BULK.....	153	TELCARE CONTROL SOLUTION.....	139
SYRINGE CATHETER	153	TELCARE ULTRA THIN	160
SYRINGE FILTER.....	153	telmisartan.....	83, 84
SYRINGE SLIP TIP	153	telmisartan/amlodipine	83
SYRINGE TIP CAP	153	telmisartan/hydrochlorothiazid	83
SYRINGE WITH NEEDLE DISP.....	153	temazepam	177
SYRINGE WITHOUT NEEDLE	153	TEMIXYS.....	66
T		TEMOVATE.....	188
TAB-A-VITE	216	temozolomide.....	55
TABLOID	56	TENIVAC.....	76
TABRECTA.....	60	tenofovir.....	67
tacrolimus.....	131, 132	TENORETIC.....	85
tadalafil.....	80, 193	TENORMIN	85
TAFINLAR	56	terazosin	82
TAGITOL.....	99	terbinafine	45
TAGRISSO	60	terbutaline	30
		terconazole	44

Index of Medications

teriparatide	199	TIMOLOL-DORZOLAMIDE.....	106
TERUMO.....	147, 153	TIMOLOL-LATANOPROST	106
TERUMO SURGUARD2.....	147, 153	TIMOPTIC	106
TERUMO SYRINGE.....	153	tinidazole.....	52
testosterone.....	125, 126	tiopronin.....	201
TESTOSTERONE.....	125	TISSEEL VHSD	184
tetrabenazine.....	89	TIVICAY	68
tetracaine.....	104	TIVORBEX	29
TETRACAINE	104	tizanidine	164
tetracycline.....	40	TL-HEM 150	116
TETRAVISC.....	104	TOBAKIENT.....	217
TEXACORT	188	TOBI PODHALER.....	35
TEZSPIRE.....	192	TOBRADEX.....	33
T:FLEX	139	tobramycin.....	33, 34, 35
THALOMID	36	tobramycin/dexamethasone	33
THEO-24	32	TOBRAMYCIN PAK.....	35
theophylline anhydrous	32	TOBREX	34
thera-d	240, 241	TOFRANIL	173
THERA-D.....	240	tolcapone.....	65
THERAGRAN	216	TOLECTIN	29
thera-m.....	216, 217	tolmetin.....	29
THERA-M	217	tolterodine	202
THERAMILL FORTE	217	tolvaptan.....	100, 101
THERANATAL.....	168, 169, 217	TOOMEY SYRINGE.....	153
THEREMS-H.....	217	Topamax	93
thiamine.....	229	TOPCARE.....	144, 160
THIAMINE.....	229	TOPICORT	188
THIN	99, 141, 142, 143, 144, 147, 156, 158, 159, 160	topiramate.....	93
THIN LANCETS.....	158, 159, 160	toremifene.....	62
THIN WALL NEEDLES.....	147	torseamide.....	101
THIOLA	201	TOSYMRA	20
thioridazine	176	TOUJEO	52
thiothixene	176	TOXICOLOGY SALIVA COLLECTION.....	98
THRIVITE.....	168	TRACLEER	80
THROMBI-GEL	77	tramadol	21, 24
THROMBIN-JMI.....	78	trandolapril	81, 83
THROMBI-PAD	78	trandolapril/verapamil.....	81
thyroid,pork.....	191	tranexamic	76
tiagabine	93	TRANSFER.....	68, 146, 147
TIAZAC	79	TRANSPARENT	155, 156
TIBSOVO	61	tranylcypromine.....	170
ticagrelor	65	travoprost.....	106
TIGLUTIK.....	88	trazodone	171
timolol	85, 105, 106	TRECTOR	36
TIMOLOL	105, 106	TRELEGY ELLIPTA.....	31
TIMOLOL-BRIMONIDIN-DORZOLAMIDE.....	106	TREMFYA.....	131
TIMOLOL-BRIMONI-DORZOL-LATANOP	106	TRESIBA.....	52

Index of Medications

tretinoin.....	61, 180, 181, 190	TRUECONTROL	139
TREXALL.....	56	TRUEDRAW	139
TREZIX.....	21	TRUE METRIX.....	139
triamcinolone	188, 193	TRUEPLUS.....	100, 110, 144, 160, 217
triamterene	101, 102	TRUEPLUS GLUCOSE.....	110
triamterene/hydrochlorothiazid	102	TRUEPLUS KETONE TEST STRIP.....	100
triazolam.....	177	T.R.U.E. TEST.....	195
TRICARE	168	TRUETRACK.....	98
trichloroacetic acid.....	185	TRULANCE.....	122
TRICHLOROACETIC ACID	185	TRULICITY	48
triderm.....	188	TRUMENBA.....	74
TRIDESILON.....	188	TRUQAP	60
trientine.....	197	TRUSTEEL INFUSION SET.....	139
TRIFERIC.....	116	TRYNGOLZA.....	86
trifluoperazine.....	176	TRYPTYR.....	108
trifluridine.....	68	T:SLIM	139
trihexyphenidyl.....	64	TUBERCULIN SYRINGE	151, 152, 153
TRIJARDY.....	51	TUKYSA	61
TRIKAFTA.....	191	TULIVITE.....	116
trimethobenzamide	119	TURALIO.....	61
trimethoprim.....	34, 35	TUXARIN	96
trimipramine.....	173	TUZISTRA	97
TRI-MIX.....	194	TWIIST	139, 140
TRIMO-SAN.....	52	TWINPAK DUAL CANNULA.....	153
TRIMPEX.....	35	TWINRIX.....	76
TRINAZ	169	TWIST	141, 142, 143, 144, 156, 157, 159, 160, 184
TRINTELLIX.....	172	TWYNEO	181
TRISODIUM CITRATE CRRT.....	43	TYBOST	191
TRISTART	168	TYENNE	131
TRIUMEQ.....	66	TYMLOS	130
TRIVIA	217	TYRVAYA	194
TRI-VI-FLOR	223	TYVASO	81
TRI-VI-SOL.....	223	U	
tri-vit-fluor	223	UBRELVY	20
TRI-VIT-FLUOR.....	223	UCERIS	125, 128
TROKENDI	93	UDAMIN SP	217
TRONVITE	228	ULESFIA	64
TROPICAL LIQUID.....	223	ULTANE.....	25
tropicamide.....	107	ULTICARE LDS SYR.....	153
TROPICAMIDE-CYCLOPENTOLATE-PE	107	ULTICARE SAFETY SYRINGE.....	153
TROPICAMIDE-CYCLOPENT-PE-KTRLC	107	ULTICARE SYRINGE.....	153
TROPICAMIDE-PHENYLEPHRINE	107	ULTICARE TB SAFETY	154
TROPIC-CYCLOPENT-PE-KTRLC-PROP	107	ULTIGUARD SAFE.....	154
tropium	202	ULTIGUARD SAFEPACK	154
true	116, 205, 219, 229, 232, 233, 236, 241, 243	ULTI-LANCE	140
TRUE.....	98, 139, 144, 160, 179, 183, 217, 219, 229, 233, 241, 243	ULTILET	144, 160, 179, 183
TRUE COMFORT	160, 183	ULTRA30, 138, 140, 142, 144, 147, 154, 156, 158, 160, 168, 206, 207,	

Index of Medications

208, 216, 217, 226, 228	
ultra b-100	228
ULTRA B-100 COMPLEX	228
ULTRA-CARE	160
ULTRA-FINE MICRO	147
ULTRA-FINE MINI	147
ULTRA-FINE NANO	147
ULTRA-FINE ORIGINAL	147
ULTRA-FINE SHORT	147
ULTRAFOAM	78
ULTRA FREEDA	217
ULTRALANCE	144, 160
ULTRA THIN	158, 160
ULTRA-THIN II	160
ULTRA THIN PLUS	160
ULTRATLC	145, 160
ULTRATRAK CONTROL	140
ULTRATRAK ULTIMATE	140
ULTRAVATE X	188
UNILET	140, 142, 145, 156, 158, 160
UNISTIK	140, 142, 145, 157, 160, 161
UNISTRIP	140
UNIVERSAL	145, 154, 161
UNIVERSAL I	161
UNIVERSAL SYRINGE	154
UPTRAVI	81
upup	110
URECHOLINE	73
URELLE	36
URIBEL	36
URISTIX	100
UROCIT-K	117
UROQID-ACID	117
URSO	120
ursodiol	120
USTEKINUMAB	130
UTIBRON NEOHALER	30
V	
valacyclovir	69
VALCHLOR	62
VALCYTE	70
valganciclovir	70
valproic	93
valsartan	82, 83, 84
valsartan/hydrochlorothiazide	83
VALTOCO	91
VANCOCIN	40
vancomycin	40
VANILLA SILQ	99
VANISHPOINT	154
VANOXIDE-HC	183
VANRAFIA	201
VAQTA	76
vardenafil	193, 194
varenicline	190
VARIBAR	99
VARISOFT	140
VARIVAX VACCINE	76
VARUBI	119
VASCEPA	118
VASCULERA	203
VASERETIC	82
VASOFLEX	203
VASOTEC	83
VAXELIS	76
VAXNEUVANCE	74
VB6 P5P	234
VECAMEYL	84
VECTICAL	181
VELPHORO	111
VELSIPITY	90
VELTASSA	111
VEMLIDY	70
VENALIV	203
VENCLEXTA	61
venlafaxine	172
VENOFER	116
VENTAVIS	81
VEO INSULIN SYRINGE	154
VEOZAH	196
verapamil	78, 79, 81
VERELAN	79
VERIFINE	145
VERQUVO	80
VERSACLOZ	176
VERTIGOHEEL	196
VERZENIO	61
VEVYE	107
VFEND	45
V-GO	140
VIBERZI	122
VIBRAMYCIN	40

Index of Medications

VICTOZA	48	VITAMIN E	243, 244
vigabatrin	94	VITAMIN K	245
VIGADRONE	94	VITAMIN K2	245
VIGAMOX	34	VITAMINS A D	224
VIJOICE	192	VITAMINS A-D-E	217
VIOKACE	123	VITAPEARL	168
VIRACEPT	68	VITA-RESPA	229
VIREAD	67	VITASURE	229
VIRT-CAPS	228	VITATRUE	168
virt-fea plus	116	vit a/vit c/vit e/zinc/copper	203
VIRT-FEFA PLUS	116	vit b	226, 227, 228, 230, 231
VISION FORMULA	202, 203	VIT B-12	210, 230, 231, 232
VISION PLUS	205	vit b12/levomefolate/vit b6/b2	225, 228
VISTA ADVANCED AREDS2	203	vit c-rose hip	234, 235, 236
VISTARIL	47	vit c-rose hips	234, 235, 236
VISTASEAL	78	VIT C-ROSE HIPS	236
VISTOGARD	192	vit d3	223, 238, 239, 241
vit. 113, 114, 115, 119, 167, 203, 208, 210, 213, 216, 217, 222, 223, 224, 225, 226, 227, 228, 230, 231, 234, 235, 236, 238, 239, 241, 244		VIT D3 5,000 UNIT FAST DISSOLV	241
vit a	203, 223	VITEYES	203
VITA-BEE	228	VITRAKVI	61
VITABEX	116, 217	VITREXYL	217
VITACORE	217	VITRON-C	116
VITAFOL	116, 168, 169	VITRUM 50	217
VITAFUSION	217	vits a,c,e/lutein/minerals	203
VITAJOY	217, 228, 236	VIVAGUARD	140, 145, 161
VITAL-D	228	VIVJOA	45
VITAMEDMD	168	VIZIMPRO	61
vitamin a	223, 224	VOGELXO	125
VITAMIN A189, 190, 223, 225, 226, 227, 228, 229, 231, 232, 233, 234, 235, 236, 237, 238, 239, 240, 241, 242, 243, 244, 245		VOLUMEN	99
vitamin b-1	229	VONJO	61
vitamin b-12	228, 231, 232, 233	VOQUEZNA	120, 123
vitamin b12	231, 232	VORANIGO	61
VITAMIN B-12	230, 232	voriconazole	45
VITAMIN B12	230, 233	VORTEX	163
vitamin b complex	217, 224, 229	VOSEVI	70
vitamin b-complex	229	VOTRIENT	61
vitamin c	207, 216, 217, 224, 229, 234, 235, 236, 237	VOWST	121
VITAMIN C	224, 225, 234, 236, 237	VOXZOGO	197
vitamin d2	239, 241	VOYDEYA	76
VITAMIN D2	241	v-r alcohol prep pads	183
VITAMIN D2-VITAMIN K1	241	VRAYLAR	176
vitamin d3	109, 238, 239, 240, 241, 242	VRAYLAR 1.5 MG CAPSULE	176
VITAMIN D3	217, 237, 239, 241, 242	v-r cod liver oil capsule	243
VITAMIN D3-ALOE	217	v-r vitamin c	237
vitamin e	243, 244	VTAMA	181
		VUEBLU	98
		VUMERITY	90

Index of Medications

VYKAT	198	XTANDI.....	55
VYLEESI.....	174	XURIDEN.....	110
VYNDAMAX	197	XVITE.....	229
VYNDAQEL.....	197	XYOSTED	125
VYVGART	197	XYREM	177
W		XYWAV.....	177
WAKIX	94	XYZBAC.....	217
water	179	Y	
WEBCOL	179, 183	YALE.....	147
WEGOVI.....	63	YAZ.....	95
WELIREG	61	YCANTH	183
well	237, 243	YESINTEK.....	130
WHEAT GERM	244	YEZTUGO.....	66
WINDOW BANDAGES.....	156	YONSA.....	55
WINREVAIR.....	81	YORVIPATH	129
WOMEN'S 50.....	206, 214, 217	YUPELRI.....	29
women's daily	217	YUTREPIA	81
WOMEN'S DAILY	217	Z	
WOMENS DAILY GUMMIES	217	zafirlukast.....	32
WOMEN'S MULTIVITAMIN	214, 217	zaleplon.....	178
WOMEN'S PRENATAL PLUS DHA.....	168	ZANAFLEX.....	164
WYNZORA.....	189	ZARONTIN	94
X		ZCORT	128
XACIATO.....	40	ZELBORAF.....	56
XALKORI.....	61	ZELDANA	229
XAQUIL.....	205	ZELNORM.....	122
XARELTO	43	ZEMBRACE SYMTOUCH.....	20
XCELLENT	237, 244	ZEMPLAR	195
XCELLENT C.....	237	ZENPEP	123
XCOPRI.....	94	zenzedi.....	72
XDEMVI.....	64	ZENZEDI.....	72
XELJANZ.....	27	ZEPATIER	70
XELODA	56	ZEPBOUND.....	63
XENICAL	63	ZEPOSIA	90
XENLETA.....	38	ZESTORETIC.....	82
XENON XE-133.....	99	ZESTRIL	83
XEPI	41	ZIAGEN.....	67
XERMELO	118	ZIANA	181
XHANCE.....	102	zidovudine	66, 67
XIFAXAN	39	zinc oxide	184
XIGDUO.....	51	ZINC OXIDE PASTE	184
XIIDRA	107	ZINC PLUS.....	237
XOFLUZA	70	ziprasidone.....	175, 176
XOLAIR.....	32	ZIRGAN.....	68
XOLREMDI	94	ZITHROMAX.....	37
XOPENEX.....	30	ZODRYL AC	97
XOSPATA.....	61	ZODRYL DAC	96

Index of Medications

ZODRYL DEC.....	97
ZOKINVY	192
ZOLINZA	55
zolmitriptan	20
ZOLMITRIPTAN.....	20
zolpidem.....	178
ZOLPIMIST.....	178
ZOMIG.....	20
ZONALON	181
zonisamide.....	94
ZONTIVITY.....	65
ZOO FRIENDS.....	223
ZORBTIVE.....	128
ZORTRESS.....	132
ZORYVE	181, 185
ZOVIRAX	70, 71
ZTALMY.....	177
ZTLIDO.....	25
ZUBSOLV.....	200
ZURZUVAE.....	170
ZYDELIG.....	61
ZYKADIA.....	61
ZYLOPRIM	26
ZYPITAMAG	87
ZYPREXA.....	176
ZYVANA.....	218
ZYVIT.....	218
ZYVOX.....	38

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 Drug Facts." Content current as of 11/01/21. [fda.gov/drugs/generic-drugs/generic-drug-facts](https://www.fda.gov/drugs/generic-drugs/generic-drug-facts).
4. U.S. Food and Drug Administration (FDA) website, "Biosimilar Basics for Patients." Last updated 08/01/24. [fda.gov/drugs/biosimilars/biosimilars-basics-patients](https://www.fda.gov/drugs/biosimilars/biosimilars-basics-patients).
5. **Not all plans offer Express Scripts Pharmacy and Accredo as covered pharmacy options.** Log in to the myCigna App or myCigna.com, or check your plan materials, to learn more about the pharmacies in your plan's network. Cigna Healthcare, Evernorth Health Services, Express Scripts and Accredo are all part of The Cigna Group. This means we have 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 (as your plan allows).
6. Your plan pays the cost for standard shipping.
7. Express Scripts Pharmacy can automatically refill certain medications. Log in to the myCigna App or myCigna.com, or call 800.835.3784, to sign up. You can sign up to get emails and/or texts from Express Scripts Pharmacy. To get text messages, you'll have to sign up for the Express Scripts texting service. You can do this online or when you call 800.835.3784 to refill your prescription. Once you sign up, just reply to their welcome text to get started. Standard text messaging rates apply.
8. You can only refill certain specialty medications by text. To get text messages, you'll have to sign up for Accredo's texting service. You can do this when you call Accredo to refill your prescription. Once you sign up, just reply to their welcome text to get started. Standard text messaging rates apply.
9. **For insured plans that must follow Delaware's state insurance laws:** Brand-name antidepressants, smoking cessation, attention deficit hyperactivity disorder (ADHD) and anti-psychotic medications that don't have a generic equivalent available will be covered as Tier 2 (preferred brand). This is true even if the medication is listed as Tier 3 (non-preferred brand) on your plan's drug list. To find out how your specific plans covers these medications, log in to the myCigna App or myCigna.com, or call the number on your ID card.
10. Costs and complete details of the plan's prescription drug coverage are set forth in the plan documents. If there are any differences between the information provided here and the plan documents, the information in the plan documents takes complete precedence.
11. **For plans that must follow state insurance laws, such as Delaware:** Your plan may provide coverage for infertility medications and smoking cessation medications even if this drug list states that your plan may not cover them. To find out if your specific plan covers these medications, log in to the myCigna App or myCigna.com, or check your plan materials.

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

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

Discrimination is against the law

Cigna Healthcare® complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, sex, ancestry, religion, marital status, gender, sexual orientation, gender identity or sexual stereotypes.

Cigna Healthcare does not exclude people or treat them less favorably differently because of race, color, national origin, age, disability, sex, ancestry, religion, marital status, gender, sexual orientation, gender identity or sexual stereotypes.

Cigna Healthcare:

- Provides people with disabilities reasonable modifications and free appropriate auxiliary aids 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 assistance services to people whose primary language is not English in a timely manner, such as:
 - Qualified interpreters
 - Information written in other languages



If you need reasonable modifications, appropriate auxiliary aids and services or language assistance services, contact the Civil Rights Coordinator.

If you believe that Cigna Healthcare has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, sex, ancestry, religion, marital status, gender, sexual orientation, gender identity or sexual stereotypes, you can file a grievance with the Civil Rights Coordinator

P.O. Box 188016, Chattanooga, TN 37422,
877.822.6561 (TTY: Dial 711)

ACAGrievance@CignaHealthcare.com

You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, the Civil Rights Coordinator is available to help you.

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
<https://www.hhs.gov/civil-rights/filing-a-complaint/complaint-process/index.html>

Cigna Healthcare products and services are provided exclusively by or through operating subsidiaries of The Cigna Group, including Cigna Health and Life Insurance Company, Connecticut General Life Insurance Company, Evernorth Behavioral Health, Inc., Evernorth Care Solutions, Inc. and HMO or service company subsidiaries of Cigna Health Corporation, including Cigna HealthCare of Arizona, Inc. Cigna HealthCare of California, Inc. Cigna HealthCare of Colorado, Inc. Cigna HealthCare of Connecticut, Inc. Cigna HealthCare of Florida, Inc. Cigna HealthCare of Georgia, Inc. Cigna HealthCare of Illinois, Inc., Cigna HealthCare of Indiana, Inc., Cigna HealthCare of St. Louis, Inc., Cigna HealthCare of North Carolina, Inc., Cigna HealthCare of New Jersey, Inc., Cigna HealthCare of South Carolina, Inc., Cigna HealthCare of Tennessee, Inc., and Cigna HealthCare of Texas, Inc. ATTENTION: If you speak languages other than English, language assistance service, free of charge are available to you. For current Cigna Healthcare customers, call the number on the back of your ID card. Otherwise, call 1.800.244.6224 (TTY: Dial 711). ATENCIÓN: Si usted habla un idioma que no sea inglés, tiene a su disposición servicios gratuitos de asistencia lingüística. Si es un cliente actual de Cigna

Proficiency of Language Assistance Services

English – ATTENTION: If you speak English, free language assistance services are available to you. Appropriate auxiliary aids and services to provide information in accessible formats are also available free of charge. Call 1-800-244-6224 (TTY: Dial 711) or speak to your provider.

Spanish – ATENCIÓN: Si habla español, los servicios de asistencia lingüística gratuitos están disponibles para usted. También están disponibles de forma gratuita ayudas y servicios auxiliares adecuados para proporcionar información en formatos accesibles. Llame al 1-800-244-6224 (TTY: Marque 711) o hable con su proveedor.

Chinese – 注意: 如果您讲中文, 我们提供免费的语言援助服务。适当的辅助设备和服务也可以免费提供, 以提供无障碍格式的信息。请拨打 1-800-244-6224 (TTY: 拨打 711) 或与您的服务提供者联系。

Vietnamese – XIN LƯU Ý: Nếu bạn nói tiếng Việt, dịch vụ hỗ trợ ngôn ngữ miễn phí có sẵn cho bạn. Các thiết bị và dịch vụ hỗ trợ phù hợp để cung cấp thông tin ở định dạng có thể tiếp cận cũng có sẵn miễn phí. Gọi số 1-800-244-6224 (TTY: Gọi 711) hoặc nói chuyện với nhà cung cấp của bạn).

Korean – 주의: 한국어를 사용하시는 경우, 무료 언어 지원 서비스가 제공됩니다. 접근 가능한 형식으로 정보를 제공하기 위한 적절한 보조 기기 및 서비스도 무료로 제공됩니다. 1-800-244-6224 (TTY: 711 로 전화) 로 전화하시거나 제공자에게 문의하십시오.

Tagalog – PAUNAWA: Kung ikaw ay nagsasalita ng Tagalog, ang mga libreng serbisyo ng tulong sa wika ay magagamit para sa iyo. Ang mga angkop na pantulong na kagamitan at serbisyo upang magbigay ng impormasyon sa mga naa-access na format ay magagamit din ng libre. Tumawag sa 1-800-244-6224 (TTY: Tumawag sa 711) o makipag-usap sa iyong tagapagbigay.

Russian – ВНИМАНИЕ: Если вы говорите на русском, доступны бесплатные услуги языковой помощи. Также бесплатно предоставляются соответствующие вспомогательные средства и услуги для предоставления информации в доступных форматах. Позвоните по телефону 1-800-244-6224 (TTY: Наберите 711) или обратитесь к вашему провайдеру.

Arabic - تنبيه: إذا كنت تتحدث العربية، تتوفر لك خدمات المساعدة اللغوية المجانية. كما تتوفر أيضًا مساعدات قابلة للوصول إليها، وذلك مجانًا. اتصل بالرقم 1-800-244-6224 (TTY: اطلب 711) أو تحدث إلى مقدم الخدمة الخاص بك (اطلب 711).

French Creole – ATANSYON: Si ou pale Kreyòl Ayisyen, sèvis asistans lang gratis yo disponib pou ou. Ekipman ak sèvis adisyonèl ki apwopriye pou bay enfòmasyon nan fòm ki aksesib yo disponib tou gratis. Rele 1-800-244-6224 (TTY: Rele 711) oswa pale ak founisè ou a.

French – ATTENTION : Si vous parlez français, des services d'assistance linguistique gratuits sont disponibles pour vous. Des aides et des services auxiliaires appropriés pour fournir des informations dans des formats accessibles sont également disponibles gratuitement. Appelez le 1-800-244-6224 (TTY : composez le 711) ou parlez à votre fournisseur.

Portuguese – ATENÇÃO: Se você fala português, serviços gratuitos de assistência linguística estão disponíveis para você. Auxílios e serviços apropriados para fornecer informações em formatos acessíveis também estão disponíveis gratuitamente. Ligue para 1-800-244-6224 (TTY: disque 711) ou fale com seu prestador de serviços.

Polish – UWAGA: Jeśli mówisz po polsku, dostępne są bezpłatne usługi pomocy językowej. Odpowiednie pomoce i usługi wspierające w celu dostarczenia informacji w dostępnych formatach są również dostępne bezpłatnie. Zadzwoń pod numer 1-800-244-6224 (TTY: wybierz 711) lub skontaktuj się ze swoim dostawcą usług.

Japanese – 注意: 日本語を話す場合は、無料の言語支援サービスが利用できます。アクセス可能な形式で情報を提供するための適切な補助機器やサービスも無料で利用できます。1-800-244-6224 (TTY: 711 にダイヤル) に電話するか、提供者に話してください。

Italian – ATTENZIONE: Se parli italiano, sono disponibili per te servizi gratuiti di assistenza linguistica. Sono disponibili gratuitamente anche ausili e servizi appropriati per fornire informazioni in formati accessibili. Chiama il numero 1-800-244-6224 (TTY: comporre il 711) o parla con il tuo fornitore.

German – Achtung: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlose Sprachassistentendienste zur Verfügung. Geeignete Hilfsmittel und Dienste, um Informationen in barrierefreien Formaten bereitzustellen, sind ebenfalls kostenlos verfügbar. Rufen Sie 1-800-244-6224 an (TTY: Wählen Sie 711) oder sprechen Sie mit Ihrem Anbieter.

Persian (Farsi) - همچنین، وسایل و خدمات کمکی مناسب برای در دسترس است. خدمات رایگان کمک زبان برای شما صحبت می‌کنید، توجه: اگر به فارسی تماس بگیرید یا با (شماره 711 را بگیرید: TTY) ارائه اطلاعات در قالبهای قابل دسترس به صورت رایگان در دسترس هستند. با شماره 1-800-244-6224 ارائه‌دهنده خود صحبت کنید