



Cigna Healthcare National Preferred 6-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 This drug list is subject to change and all prior versions are no longer in effect.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	247
Index of medications	248

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 6 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.

. 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 | • High cholesterol |
| • Allergies | • Osteoporosis |
| • Bladder problems | • Pain |
| • Breathing problems | • Skin conditions |
| • Depression | • Sleep disorders |
| • High blood pressure | |

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

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 6-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	Preferred Specialty. These medications typically cost less than non-preferred specialty medications.	\$\$\$\$\$
Tier 6	Non-Preferred Specialty. These medications are covered at your plan's highest cost-share. They typically have a preferred alternative.	\$\$\$\$\$\$

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

Information about this drug list

How to read this drug list (cont.)

Letters (acronyms) 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 6-Tier Prescription Drug List.*

ANALGESICS (Pain Relief and Inflammatory Disease)			Therapeutic drug category and class describes the condition the medication is used to treat.
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits	
ANALGESIC, NON-SALICYLATE AND BARBITURATE COMBINAT			Coverage requirements and limits lets you know if your plan has extra requirements before it will cover the medication.
<i>butorbital/acetaminophen</i>	T1		
ANALGESIC, SALICYLATE, BARBITURATE, XANTHINE COMB.			Drug tier gives you an idea of how much you may pay for a medication.
<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)	Prescription drug name is the name of the medication.
<i>FIORINAL</i> (<i>butorbital-aspirin-caffeine</i>)	T3	QL (6 caps/day)	
ANALGESIC, NON-SALICYLATE, BARBITURATE, XANTHINE COMB.			Medications are listed in alphabetical order (A-Z) within each column.
<i>butorbital/acetaminophen/caffeine</i>	T3		
<i>butorbital/acetaminophen/caffeine</i> (Esgic)	T3	QL (6 caps/day)	Brand name medications are in all CAPITAL letters.
<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)	Generic medications are in lowercase italics.
<i>ESGIC 50-325-40 MG TABLET</i> (<i>butorbital-acetaminophen-caffe</i>)	T3	QL (6 tabs/day)	
<i>ESGIC CAPSULE</i> (<i>zebutorbital</i>)	T3	QL (6 caps/day)	
<i>FIORICET</i> (<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			
<i>AIMOVIG AUTOINJECTOR</i>	T2	PA	
<i>AJOVY AUTOINJECTOR</i>	T2	PA	
<i>AJOVY SYRINGE</i>	T2	PA	
<i>almotriptan malate</i>	T1	QL (12 tabs/30 days)	
<i>CAFERGOT</i> (<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)	
<i>EMGALITY PEN</i>	T2	PA	
<i>EMGALITY SYRINGE</i>	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
Anesthetics (Miscellaneous)	24, 25	Anti-Infectives/Miscellaneous (Skin Conditions)	53
Anesthetics (Pain Relief and Inflammatory Disease)	25	Anti-Inflammatory Tumor Necrosis Factor Inhibiting Agents (Pain Relief and Inflammatory Disease)	54
Anesthetics (Urinary Tract Conditions)	25	Anti-Neoplastics (Cancer)	54-61
Anti-Allergy (Allergy and Nasal Sprays)	25	Anti-Neoplastics (Skin Conditions)	61, 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)	63
Antibiotics (Ear Medications)	32	Anti-Parasitics (Infections)	63, 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)	40-42	Antivirals (AIDS/HIV)	65-68
Anti-Coagulants (Blood Thinners/Anti-Clotting)	42, 43	Antivirals (Eye Conditions)	68
Antidotes (Gastrointestinal/Heartburn)	43	Antivirals (Infections)	68-70
Antidotes (Substance Abuse)	44	Antivirals (Skin Conditions)	70
Anti-Fungals (Eye Conditions)	44	Autonomic Drugs (Allergy/Nasal Sprays)	70, 71
Anti-Fungals (Feminine Products)	44	Autonomic Drugs (Alzheimer's Disease)	71
Anti-Fungals (Infections)	44, 45	Autonomic Drugs (Attention Deficit Hyperactivity Disorder)	71, 72
Anti-Fungals (Skin Conditions)	45, 46	Autonomic Drugs (Blood Pressure/Heart Medications)	72
Antihistamine and Decongestant Combination (Allergy/Nasal Sprays)	46, 47	Autonomic Drugs (Urinary Tract Conditions)	72
Antihistamines (Allergy/Nasal Sprays)	47	Biologicals (Allergy/Nasal Sprays)	73
Antihistamines (Eye Conditions)	47	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, 77
		Blood (Blood Thinners/Anti-Clotting)	77

Information about this drug list

How to find your medication (cont.)

Condition	Page	Condition	Page
Cardiac Drugs (Blood Pressure/Heart Medications)	77-80	Gastrointestinal (Pain Relief and Inflammatory Disease)	125
Cardiovascular (Asthma/COPD/Respiratory)	80, 81	Hormones (Gastrointestinal/Heartburn)	125
Cardiovascular (Blood Pressure/Heart Medications)	81-86	Hormones (Hormonal Agents)	125-130
Cardiovascular (Cholesterol Medications)	86-88	Hormones (Infertility)	130, 131
CNS Drugs (Alzheimer's Disease)	88	Hormones (Miscellaneous)	131
CNS Drugs (Miscellaneous)	88, 89	Hormones (Osteoporosis Products)	131
CNS Drugs (Multiple Sclerosis)	89, 90	Immunosuppressants (Pain Relief and Inflammatory Disease)	131, 132
CNS Drugs (Pain Relief and Inflammatory Disease)	90, 91	Immunosuppressants (Skin Conditions)	132
CNS Drugs (Seizure Disorders)	91-94	Immunosuppressants (Transplant Medications)	132, 133
Colony Stimulating Factors (Blood Modifiers/Bleeding Disorders)	95	Miscellaneous Medical Supplies, Devices, Non-Drug (Diabetes)	134-155
Colony Stimulating Factors (Cancer)	95	Miscellaneous Medical Supplies, Devices, Non-Drug (Miscellaneous)	155-164
Contraceptives (Contraception Products)	95, 96	Muscle Relaxants (Pain Relief and Inflammatory Disease)	164-166
Cough/Cold Preparations (Allergy/Nasal Sprays)	96	Prenatal Vitamins (Nutritional/Dietary)	166-170
Cough/Cold Preparations (Cough/Cold Medications)	96-98	Psychotherapeutic Drugs (Anxiety/Depression/Bipolar Disorder)	170-174
Diagnostic (Diabetes)	98	Psychotherapeutic Drugs (Attention Deficit Hyperactivity Disorder)	174, 175
Diagnostic (Miscellaneous)	98-101	Psychotherapeutic Drugs (Miscellaneous)	175
Diuretics (Diuretics)	101, 102	Psychotherapeutic Drugs (Schizophrenia/Anti-Psychotics)	176, 177
EENT Preps (Allergy/Nasal Sprays)	102, 103	Psychotherapeutic Drugs (Seizure Disorders)	178
EENT Preps (Ear Medications)	103	Psychotherapeutic Drugs (Sleep Disorders/Sedatives)	178
EENT Preps (Eye Conditions)	103-108	Sedative/Hypnotics (Sleep Disorders/Sedatives)	178, 179
Elect/Caloric/H2O (Cholesterol Medications)	108	Skin Preps (Miscellaneous)	179-181
Elect/Caloric/H2O (Dental Products)	108, 109	Skin Preps (Pain Relief and Inflammatory Disease)	181
Elect/Caloric/H2O (Diabetes)	109-111	Skin Preps (Skin Conditions)	181-191
Elect/Caloric/H2O (Miscellaneous)	111	Smoking Deterrents (Smoking Cessation)	191
Elect/Caloric/H2O (Nutritional/Dietary)	111-118	Thyroid Prep (Hormonal Agents)	192
Elect/Caloric/H2O (Urinary Tract Conditions)	118		
Gastrointestinal (Cholesterol Medications)	118		
Gastrointestinal (Gastrointestinal/Heartburn)	119-125		

Information about this drug list

How to find your medication *(cont.)*

Condition	Page	Condition	Page
Unclassified Drug Products (AIDS/HIV)	192	Unclassified Drug Products (Nutritional/Dietary)	200
Unclassified Drug Products (Asthma/COPD/Respiratory)	192, 193	Unclassified Drug Products (Osteoporosis Products)	200
Unclassified Drug Products (Blood Modifiers/Bleeding Disorders)	193	Unclassified Drug Products (Pain Relief and Inflammatory Disease)	201
Unclassified Drug Products (Blood Pressure/Heart Medications)	193	Unclassified Drug Products (Seizure Disorders)	201
Unclassified Drug Products (Cancer)	193	Unclassified Drug Products (Skin Conditions)	201
Unclassified Drug Products (Dental Products)	194	Unclassified Drug Products (Substance Abuse)	201
Unclassified Drug Products (Erectile Dysfunction)	194, 195	Unclassified Drug Products (Transplant Medications)	202
Unclassified Drug Products (Eye Conditions)	195	Unclassified Drug Products (Urinary Tract Conditions)	202, 203
Unclassified Drug Products (Gastrointestinal/Heartburn)	195, 196	Unclassified Drug Products (Weight Management)	203
Unclassified Drug Products (Hormonal Agents)	196	Vitamins (Nutritional/Dietary)	203-246
Unclassified Drug Products (Miscellaneous)	196-199	Vitamins (Vitamins)	246

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 12.5 mg tab</i>	T2	ST QL (12 tabs/30 days)
<i>almotriptan malate 6.25 mg tab</i>	T2	ST QL (6 tabs/30 days)
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	ST QL (9 tabs/30 days)

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

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

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

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

List of Prescription Medications

ANALGESICS (Pain Relief And Inflammatory Disease) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
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)
ZOLMITRIPTAN 2.5MG NASAL SPRAY	T4	ST QL (6 units/30 days)
<i>zolmitriptan 5 mg nasal spray</i> (Zomig)	T2	ST QL (6 units/fill)
<i>zolmitriptan 2.5 mg tablet</i> (Zomig)	T2	QL (6 tabs/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)
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 10 mg tablet</i>	T2	QL (20 tabs/fill)
<i>ketorolac 15 mg/ml carpupject</i>	T2	HD
<i>ketorolac 15 mg/ml syr</i>	T2	HD
<i>ketorolac 15 mg/ml syringe</i>	T2	

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

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

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

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

List of Prescription Medications

ANALGESICS (Pain Relief And Inflammatory Disease) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
NSAIDS, CYCLOOXYGENASE INHIBITOR - TYPE ANALGESICS (cont.)		
<i>ketorolac 15 mg/ml vial</i>	T2	
<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 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
<i>hydrocodone-acetamin 2.5-325</i>	T2	PA QL (12 ds/60 days)
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
TREXIX	T4	PA QL
OPIOID ANALGESICS		
ABSTRAL	T4	PA QL

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

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

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

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

List of Prescription Medications

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

T1 – Preferred Generics

T2 – Non-Preferred Generics

T3 – Preferred Brands

T4 – Non-Preferred Brands

T5 – Preferred Specialty

T6 – Non-Preferred Specialty

PA – Prior Authorization

QL – Quantity Limit

ST – Step Therapy

AGE – Age Requirement

SP – Specialty Medication

HD – May require home delivery pharmacy

PPACA – No Cost-Share Preventive Medication

CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

ANALGESICS (Pain Relief And Inflammatory Disease) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
OPIOID ANALGESICS (cont.)		
LAZANDA 400 MCG NASAL SPRAY	T4	PA QL (23 units/30 days)
methadone hcl	T1	
methadone hcl	T2	
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)
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 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)
MS CONTIN (morphine sulfate)	T4	PA 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)
oxycodone hcl (ir) 5 mg tablet (Roxicodone)	T2	PA QL (12 ds/60 days)

T1 – Preferred Generics

T2 – Non-Preferred Generics

T3 – Preferred Brands

T4 – Non-Preferred Brands

T5 – Preferred Specialty

T6 – Non-Preferred Specialty

PA – Prior Authorization

QL – Quantity Limit

ST – Step Therapy

AGE – Age Requirement

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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 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 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
<i>tramadol hcl 100 mg tablet</i>	T2	PA QL (12 ds/60 days)
<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	PA QL
butalbital/acetamin/caff/codeine (Fioricet With Codeine)	T2	PA QL
FIORICET WITH CODEINE (<i>butalbital/acetamin/caff/codeine</i>)	T4	PA QL
SKELETAL MUSCLE RELAXANT, SALICYLAT, 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	
<i>isoflurane</i>	T2	
<i>sevoflurane (Ultane)</i>	T2	

T1 – Preferred Generics
T2 – Non-Preferred Generics
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T5 – Preferred Specialty
T6 – Non-Preferred Specialty
PA – Prior Authorization
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ST – Step Therapy
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List of Prescription Medications

ANESTHETICS (Miscellaneous) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
GENERAL ANESTHETICS, INHALANT (cont.)		
SUPRANE	T4	
ULTANE (sevoflurane)	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		
CETACAIN ANESTHETIC	T4	
DYCLOPRO	T4	
L.E.T. (LIDO-EPINEPH-TETRA)	T4	
<i>lidocaine 5% ointment</i>	T2	QL(50 gms/28 days)
<i>lidocaine 5% patch (Lidocan li)</i>	T2	PA
<i>lidocaine 5% patch (Lidoderm)</i>	T2	PA
<i>lidocaine (Lidocan li)</i>	T2	PA
<i>lidocaine hcl</i>	T2	
<i>lidocaine hcl 4% solution</i>	T2	
LIDOCAINE-EPINEPHRIN-TETRACAIN	T4	
<i>lidocaine-prilocaine cream</i>	T2	QL (30 gms/30 days) PPACA
<i>lidocaine-prilocaine cream</i>	T2	
<i>lidocaine/racepinep/tetracaine</i>	T2	
LIDOCAN II (<i>lidocaine</i>)	T4	PA
SYNERA	T4	PA
ZTLIDO	T3	PA
ANESTHETICS (Urinary Tract Conditions)		
URINARY TRACT ANESTHETIC/ANALGESIC AGNT (AZO-DYE)		
<i>phenazopyridine hcl (Pyridium)</i>	T2	
ANTIALLERGY (Allergy/Nasal Sprays)		
MAST CELL STABILIZER		
<i>cromolyn 100 mg/5 ml oral conc (Gastrocrom)</i>	T2	
GASTROCROM (<i>cromolyn sodium</i>)	T4	

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List of Prescription Medications

ANTIARTHRITICS (Pain Relief And Inflammatory Disease)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ANALGESIC/ANTIPYRETICS, SALICYLATES		
DISALCID (<i>salsalate</i>)	T4	HD
<i>salsalate</i> (Disalcid)	T2	HD
ANTI-ARTHRITIC AND CHELATING AGENTS		
DEPEN (penicillamine)	T6	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		
ARAVA (<i>leflunomide</i>)	T4	QL(30 tabs/fill) HD
<i>leflunomide</i> (Arava)	T2	QL(30 tabs/fill) HD
ANTI-INFLAMMATORY, PHOSPHODIESTERASE-4(PDE4) INHIB.		
OTEZLA 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 tablet</i> (Colcrys)	T2	HD
<i>colchicine 0.6 mg capsule</i> (Mitigare)	T2	ST
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
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

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T3 – Preferred Brands
T4 – Non-Preferred Brands

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List of Prescription Medications

ANTIARTHRITICS (Pain Relief And Inflammatory Disease) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
JANUS KINASE (JAK) INHIBITORS (cont.)		
XELJANZ 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 (<i>diclofenac sodium/misoprostol</i>)	T4	ST HD
ARTHROTEC 75 (<i>diclofenac sodium/misoprostol</i>)	T4	ST HD
<i>diclofenac sodium/misoprostol</i> (Arthrotec 50)	T2	HD
<i>diclofenac sodium/misoprostol</i> (Arthrotec 75)	T2	HD
NSAIDS, CYCLOOXYGENASE INHIBITOR - TYPE ANALGESICS		
ANAPROX DS (<i>naproxen sodium</i>)	T4	ST HD
DAYPRO (<i>oxaprozin</i>)	T4	ST HD
<i>diclofenac sod dr 25 mg, 50 mg, 75 mg tab</i>	T2	HD
<i>diclofenac sod ec 25 mg tab</i>	T2	HD
<i>diclofenac sod ec 50 mg tab</i>	T2	HD
<i>diclofenac sod ec 75 mg tab</i>	T2	HD
<i>diclofenac sodium</i>	T2	HD
EC-NAPROSYN (<i>naproxen</i>)	T4	ST HD
<i>ec-naproxen dr 375 mg tablet</i> (Ec-Naprosyn)	T2	HD
<i>ec-naproxen dr 500 mg tablet</i> (Ec-Naprosyn)	T2	ST HD
<i>etodolac</i>	T2	HD
<i>etodolac</i> (Lodine)	T2	HD
FELDENE (<i>piroxicam</i>)	T4	ST HD
<i>fenoprofen 400 mg capsule</i> (Nalfon)	T2	ST HD
<i>fenoprofen 600 mg tablet</i> (Nalfon)	T2	ST HD
FENORTHO 200 MG CAPSULE	T4	ST HD
<i>flurbiprofen</i>	T2	HD
<i>ibuprofen</i>	T1	HD
<i>ibuprofen</i>	T2	HD

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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>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, 75 mg capsule</i>	T2	HD
<i>ketoprofen er 200 mg capsule</i>	T2	ST HD
LODINE (<i>etodolac</i>)	T4	ST HD
<i>meclofenamate sodium</i>	T2	HD
<i>meloxicam 5 mg capsule (Vivlodex)</i>	T2	ST QL(30 caps/fill) HD
<i>meloxicam 10 mg capsule (Vivlodex)</i>	T2	ST QL(30 caps/fill) HD
<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, 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
<i>naproxen sodium (Anaprox Ds)</i>	T2	HD
<i>naproxen sodium (Naprelan)</i>	T2	ST HD
<i>oxaprozin 600 mg caplet (Daypro)</i>	T2	HD
<i>oxaprozin 600 mg tablet (Daypro)</i>	T2	HD
<i>piroxicam</i>	T2	HD
<i>piroxicam (Feldene)</i>	T2	HD

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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.)		
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 400 mg, 600 mg cap</i>	T2	ST HD
<i>tolmetin sodium 200 mg tab</i>	T2	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, 4 mg tab</i>	T2	HD
<i>albuterol sulfate er 4 mg, 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 2.5 mg/0.5 ml sol</i>	T2	
<i>albuterol 75 mg/15 ml soln</i>	T2	

T1 – Preferred Generics

T2 – Non-Preferred Generics

T3 – Preferred Brands

T4 – Non-Preferred Brands

T5 – Preferred Specialty

T6 – Non-Preferred Specialty

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List of Prescription Medications

ANTIASTHMATICS (Asthma/COPD/Respiratory) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
BETA-ADRENERGIC AGENTS, INHALED, SHORT ACTING (cont.)		
<i>albuterol 100 mg/20 ml soln</i>	T2	
<i>albuterol 5 mg/ml solution</i>	T2	
<i>albuterol 15 mg/3 ml solution</i>	T2	
<i>albuterol hfa 90 mcg inhaler</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>	T2	
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
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>breynd 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

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QL – Quantity Limit

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AGE – Age Requirement
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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.)		
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</i> (Advair Diskus)	T2	PA QL(1 inhaler/30 days)
<i>fluticasone-salmeterol 100-50</i> (Advair Diskus)	T2	PA QL(1 inhaler/fill) HD
<i>fluticasone-salmeterol 250-50</i> (Advair Diskus)	T2	PA QL(1 inhaler/fill) HD
<i>fluticasone-salmeterol 500-50</i> (Advair Diskus)	T2	PA QL(1 inhaler/fill) HD
SYMBICORT (<i>budesonide/formoterol fumarate</i>)	T4	PA QL(1 inhaler/30 days) HD
BETA-ADRENERGIC-ANTICHOLINERGIC-GLUCOCORT, INHALED		
BREZTRI AEROSPHERE	T3	QL(1 inhaler/fill)
TRELEGY ELLIPTA 100-62.5-25	T3	QL(60 blisters/fill)
TRELEGY ELLIPTA 100-62.5-25	T3	QL(28 blisters/fill)
TRELEGY ELLIPTA 200-62.5-25	T3	QL(60 blisters/fill)
TRELEGY ELLIPTA 200-62.5-25	T3	QL(28 blisters/fill)
GLUCOCORTICIDS, ORALLY INHALED		
ALVESCO 80 MCG INHALER	T4	QL(1 inhaler/fill) HD
ALVESCO 160 MCG INHALER	T4	QL(2 inhalers/fill) HD
ARNUIITY ELLIPTA 50 MCG INH	T4	QL (30 blisters/30 days)
ARNUIITY ELLIPTA 100 MCG, 200 MCG INH	T4	QL (1 inhaler/30 days)
ASMANEX	T3	QL(1 inhaler/fill) HD
ASMANEX HFA 50 MCG INHALER	T3	QL(13 gms/fill) HD
ASMANEX HFA 100 MCG, 200 MCG INHALER	T3	QL(1 inhaler/fill) HD
<i>budesonide 1 mg/2 ml inh susp</i> (Pulmicort)	T2	QL(60 mls/fill) HD
FLOVENT 50 MCG, 100 MCG DISKUS	T3	QL(1 inhaler/fill) HD
FLOVENT 250 MCG DISKUS	T3	QL(4 inhalers/fill) HD
FLOVENT HFA 44 MCG INHALER	T3	QL(11 gms/fill) HD
FLOVENT HFA 110 MCG INHALER	T3	QL(12 gms/fill) HD
FLOVENT HFA 220 MCG INHALER	T3	QL(24 gms/fill) HD
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 100 MG/ML AUTO-INJECTOR	T5	PA QL(1 auto-inj/28 days) SP HD
NUCALA 100 MG/ML SYRINGE	T5	PA QL(1 syringe/28 days) SP HD
NUCALA 40 MG/0.4 ML SYRINGE	T5	PA QL(1 syringe/28 days) SP HD

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ANTIASTHMATICS (Asthma/COPD/Respiratory) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
INTERLEUKIN-5(IL-5) RECEPTOR ALPHA ANTAGONIST, MAB		
FASENRA PEN	T5	PA QL(1 syringe/56 days) SP HD
LEUKOTRIENE RECEPTOR ANTAGONISTS		
ACCOLATE (zafirlukast)	T4	HD
montelukast sodium (Singulair)	T2	HD
zafirlukast (Accolate)	T2	HD
MAST CELL STABILIZERS, ORALLY INHALED		
cromolyn 20 mg/2 ml neb soln	T2	HD
MONOCLONAL ANTIBODIES TO IMMUNOGLOBULIN E (IGE)		
XOLAIR 300 MG/2 ML AUTOINJECT	T5	PA QL (2 auto-injs/28 days) SP HD
XOLAIR 75 MG/0.5 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		
acetylcysteine	T2	
PHOSPHODIESTERASE (PDE) INHIBITORS		
roflumilast 250 mcg tablet (Daliresp)	T2	PA QL (30 tabs/30 days) HD
roflumilast 500 mcg tablet (Daliresp)	T2	PA HD
XANTHINES		
ELIXOPHYLLIN	T4	HD
THEO-24	T4	HD
theophylline anhydrous	T2	HD
ANTIBIOTICS (Ear Medications)		
EAR PREPARATIONS, ANTIBIOTICS		
ciprofloxacin hcl	T2	
CORTISPORIN-TC	T4	
neomycin/polymyxin b/hydrocort	T2	
ofloxacin	T2	
OTIPRIO	T4	QL(1 ml/fill)
OTIC PREPARATIONS, ANTI-INFLAMMATORY-ANTIBIOTICS		
ciprofloxacin hcl/dexameth	T2	
OTOVEL	T4	

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List of Prescription Medications

ANTIBIOTICS (Eye Conditions)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
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.		
<i>pred ph-moxi-brom 1-0.5-0.075%</i>	T2	
PRED PH-MOXI-BROM 1-0.5-0.075%	T4	
PREDNISOLONE ACET-GATIFLO-BROM	T4	
PREDNISOLONE AC-MOXIFLOX-BROMF	T4	
PREDNISOLONE AC-MOXIFLOX-NEPAF	T4	
PREDNISOLONE PH-MOXIFLOX-KETOR	T4	
PREDNISOLONE PHOS-GATIFLO-BROM	T4	
EYE SULFONAMIDES		
BLEPH-10 (<i>sulfacetamide sodium</i>)	T4	
BLEPHAMIDE S.O.P.	T4	
<i>sulfacetamide sodium</i>	T2	
<i>sulfacetamide sodium</i> (Bleph-10)	T2	
<i>sulfacetamide/prednisolone sp</i>	T2	
OPHTHALMIC ANTIBIOTICS		
AZASITE	T3	
<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	

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List of Prescription Medications

ANTIBIOTICS (Eye Conditions) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
OPHTHALMIC ANTIBIOTICS (cont.)		
<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 (Vigamox)</i>	T2	
<i>moxifloxacin</i>	T2	
<i>neomycin/bacitracin/polymyxinb</i>	T2	
<i>neomycin/polymyxn b/gramicidin</i>	T2	
OCUFLOX (<i>ofloxacin</i>)	T4	
<i>ofloxacin (Ocuflox)</i>	T2	
<i>polymyxin b sulf/trimethoprim (Polytrim)</i>	T2	
POLYTRIM (<i>polymyxin b sulf/trimethoprim</i>)	T4	
<i>tobramycin 0.3% eye drop (Tobrex)</i>	T2	
TOBREX	T4	
TOBREX (<i>tobramycin</i>)	T4	
VIGAMOX (<i>moxifloxacin hcl</i>)	T4	
ANTIBIOTICS (Infections)		
2ND GEN. ANAEROBIC ANTIPROTOZOAL-ANTIBACTERIAL		
SOLOSEC	T3	QL(1 pack/fill)
ABSORBABLE SULFONAMIDE ANTIBACTERIAL AGENTS		
BACTRIM (<i>sulfamethoxazole/trimethoprim</i>)	T4	
BACTRIM DS (<i>sulfamethoxazole/trimethoprim</i>)	T4	
<i>sulfadiazine</i>	T2	
<i>sulfamethoxazole/trimethoprim</i>	T2	
<i>sulfamethoxazole/trimethoprim (Bactrim Ds)</i>	T1	
<i>sulfamethoxazole/trimethoprim (Bactrim)</i>	T1	
AMINOGLYCOSIDE ANTIBIOTICS		
ARIKAYCE	T5	PA SP
BETHKIS (<i>tobramycin</i>)	T6	PA QL(224 mls/fill) SP HD
<i>gentamicin 80 mg/2 ml vial</i>	T2	PA
<i>gentamicin 800 mg/20 ml vial</i>	T2	PA

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List of Prescription Medications

ANTIBIOTICS (Infections) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
AMINOGLYCOSIDE ANTIBIOTICS (cont.)		
<i>gentamicin ped 20 mg/2 ml vial</i>	T2	PA
KITABIS PAK	T5	PA QL(280 mls/fill) SP HD
<i>neomycin sulfate</i>	T2	
TOBI PODHALER	T5	PA QL(224 caps/fill) SP HD
<i>tobramycin 300 mg/4 ml ampule (Bethkis)</i>	T2	PA QL(224 mls/fill) SP HD
<i>tobramycin 300 mg/5 ml ampule (Tobi)</i>	T2	PA QL(280 mls/fill) SP HD
TOBRAMYCIN PAK 300 MG/5 ML	T6	PA QL(280 mls/fill) SP HD
<i>tobramycin sulfate</i>	T2	PA
ANAEROBIC ANTIPROTOZOAL-ANTIBACTERIAL AGENTS		
FLAGYL (<i>metronidazole</i>)	T4	
<i>metronidazole 375 mg capsule (Flagyl)</i>	T2	
<i>metronidazole 250 mg tablet</i>	T2	
<i>metronidazole 500 mg tablet</i>	T2	
ANTIBIOTIC, ANTIBACTERIAL, MISC.		
<i>fosfomycin tromethamine</i>	T2	
<i>meth/meblue/sod phos/psal/hyos</i>	T2	
<i>methen/mblue/sal/sod phos/hyos</i>	T2	
<i>methenam/m.blue/salicyl/hyoscy (Uribel Tabs)</i>	T2	
<i>methenam/sod phos/mblue/hyoscy</i>	T2	
<i>methenamine hippurate</i>	T2	
<i>methenamine mandelate</i>	T2	
PRIMSOL	T4	
<i>trimethoprim</i>	T2	
TRIMPEX	T4	
URELLE	T4	
URIBEL	T4	
URIBEL TABS (<i>methenam/m.blue/salicyl/hyoscy</i>)	T4	
ANTILEPTOTICS		
<i>dapsone 100 mg tablet</i>	T2	
<i>dapsone 25 mg tablet</i>	T2	
THALOMID 50 MG CAPSULE	T5	PA QL(30 caps/fill) SP HD
THALOMID 100 MG CAPSULE	T5	PA QL(30 caps/fill) SP HD
THALOMID 200 MG CAPSULE	T5	PA QL(60 caps/fill) SP HD

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List of Prescription Medications

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

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List of Prescription Medications

ANTIBIOTICS (Infections) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
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, 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	
<i>nitrofurantoin</i> (Furadantin)	T2	
<i>nitrofurantoin mcr 25 mg, 50 mg, 100 mg cap</i>	T2	
<i>nitrofurantoin monohyd/m-cryst</i> (Macrobid)	T2	
OXAZOLIDINONE ANTIBIOTICS		
<i>linezolid</i> (Zyvox)	T2	PA
ZYVOX (<i>linezolid</i>)	T4	PA
PENICILLIN ANTIBIOTICS		
<i>amoxicillin/potassium clav</i>	T2	
<i>amoxicillin/potassium clav</i> (Augmentin Xr)	T2	
<i>amoxicillin/potassium clav</i> (Augmentin)	T2	

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

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TETRACYCLINE ANTIBIOTICS (cont.)		
<i>doxycycline hyc dr 150 mg tab</i>	T2	ST
<i>doxycycline hyc dr 200 mg tab (Doryx)</i>	T2	ST
<i>doxycycline hyclate 50 mg cap</i>	T2	
<i>doxycycline hyclate 100 mg cap</i>	T2	
<i>doxycycline hyclate 75 mg tab (Acticlate)</i>	T2	ST
<i>doxycycline hyclate 100 mg tab (Lymepak)</i>	T2	
<i>doxycycline hyclate 150 mg tab (Acticlate)</i>	T2	ST
<i>doxycycline mono 50 mg cap (Monodox)</i>	T2	
<i>doxycycline mono 100 mg cap</i>	T2	
<i>doxycycline mono 150 mg cap</i>	T2	ST
<i>doxycycline mono 75 mg capsule</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 (Monodox)</i>	T2	
<i>doxycycline monohydrate (Oracea)</i>	T2	ST
<i>LYMEPAK (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
<i>minocycline hcl 50 mg tablet</i>	T2	ST
<i>minocycline hcl 75 mg tablet</i>	T2	ST
<i>minocycline hcl</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	

T1 – Preferred Generics

T2 – Non-Preferred Generics

T3 – Preferred Brands

T4 – Non-Preferred Brands

T5 – Preferred Specialty

T6 – Non-Preferred Specialty

PA – Prior Authorization

QL – Quantity Limit

ST – Step Therapy

AGE – Age Requirement

SP – Specialty Medication

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List of Prescription Medications

ANTIBIOTICS (Infections) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
TETRACYCLINE ANTIBIOTICS (cont.)		
NUZYRA	T6	QL(30 tabs/30 days) SP
SEYSARA	T4	ST
SOLODYN (<i>minocycline hcl</i>)	T4	ST
TARGADOX (<i>doxycycline hyclate</i>)	T4	ST
tetracycline 250 mg, 500 mg capsule	T2	
tetracycline 250 mg tablet	T2	ST
tetracycline 500 mg tablet	T2	ST
XACIATO	T4	
VIBRAMYCIN	T4	ST
VIBRAMYCIN (<i>doxycycline monohydrate</i>)	T4	ST
VAGINAL ANTIBIOTICS		
CLEOCIN	T4	
CLEOCIN (clindamycin phosphate)	T4	
clindamycin 2% vaginal cream (Cleocin)	T2	
CLINDESSE	T4	
metronidazole	T2	
metronidazole vaginal 0.75% gl	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)
vancomycin 250 mg/5 ml soln	T2	QL(450 mls/fill)
ANTIBIOTICS (Skin Conditions)		
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

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

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List of Prescription Medications

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

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

T5 – Preferred Specialty
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List of Prescription Medications

ANTIBIOTICS (Skin Conditions) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
TOPICAL SULFONAMIDES (cont.)		
<i>sod sulfacet-sulfur 10-2% clsr</i>	T2	ST
<i>sod sulfacet-sulfur 10-4% pad (Sumaxin)</i>	T2	
<i>sod sulfacet-sulfur 10-5% clsr</i>	T2	
<i>sod sulfac-sulfur 9.8-4.8% crm</i>	T2	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	
<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	
ACD-A	T3	
ANTICOAGULANT SODIUM CITRATE	T4	
CITRATE PHOSPHATE DEXTROSE	T3	
CRRT TRISODIUM CITRATE	T4	
<i>sodium citrate 4% lock flush</i>	T2	
SODIUM CITRATE 4% LOCK FLUSH	T4	
SODIUM CITRATE 4% SOLN	T4	
SODIUM CITRATE 4% SYRINGE	T4	

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

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List of Prescription Medications

ANTICOAGULANTS (Blood Thinners/Anti-Clotting) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
CITRATES AS ANTICOAGULANTS (cont.)		
SODIUM CITRATE 4% VIAL	T4	
TRISODIUM CITRATE CRRT	T4	
DIRECT FACTOR XA INHIBITORS		
ELIQUIS 2.5 MG, 5 MG TABLET	T3	
ELIQUIS DVT-PE TREAT START 5MG	T3	
<i>rivaroxaban (Xarelto)</i>	T2	
XARELTO	T3	PA
XARELTO (<i>rivaroxaban</i>)	T3	
HEPARIN AND RELATED PREPARATIONS		
ARIXTRA (<i>fondaparinux sodium</i>)	T6	SP
<i>enoxaparin sodium (Lovenox)</i>	T2	SP
<i>fondaparinux sodium (Arixtra)</i>	T2	SP
FRAGMIN	T5	SP
<i>heparin 5,000 unit/ml carpuijct</i>	T2	
<i>heparin 2,000 unit/2 ml vial</i>	T2	
<i>heparin 10,000 unit/10 ml vial</i>	T2	
<i>heparin 30,000 unit/30 ml vial</i>	T2	
<i>heparin 40,000 unit/4 ml vial</i>	T2	
<i>heparin 50,000 unit/10 ml vial</i>	T2	
<i>heparin 50,000 unit/5 ml vial</i>	T2	
<i>heparin sod 1,000 unit/ml vial</i>	T2	
<i>heparin sod 5,000 unit/0.5 ml</i>	T2	
HEPARIN SOD 5,000 UNIT/0.5 ML	T3	
HEPARIN SOD 5,000 UNIT/0.5 ML	T4	
HEPARIN SOD 5,000 UNIT/ML SYRG	T4	
<i>heparin sod 5,000 unit/ml syringe, vial</i>	T2	
<i>heparin sod 10,000 unit/ml vl</i>	T2	
<i>heparin sod 20,000 unit/ml vl</i>	T2	
ANTIDOTES (Gastrointestinal/Heartburn)		
MU-OPIOID RECEPTOR ANTAGONISTS, PERIPHERALLY-ACTING		
MOVANTIK	T3	QL(30 tabs/fill)
RELISTOR 12 MG/0.6 ML SYRINGE, VIAL	T3	ST
RELISTOR 8 MG/0.4 ML SYRINGE	T3	ST
SYMPROIC	T3	

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

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List of Prescription Medications

ANTIDOTES (Substance Abuse)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
OPIOID ANTAGONISTS		
EVZIO (<i>naloxone</i>)	T4	QL(1 ml/fill)
KLOXXADO	T3	QL(2 units/fill)
<i>naloxone 0.4 mg/ml carpject, syringe, vial</i>	T2	
<i>naloxone 2 mg/2 ml syringe</i>	T2	
<i>naloxone 4 mg/10 ml vial</i>	T2	
<i>naloxone hcl 4 mg nasal spray (Narcan)</i>	T2	QL(2 units/fill)
<i>naltrexone hcl</i>	T1	
NARCAN (<i>naloxone hcl</i>)	T4	QL(2 units/30 days)
REXTOVY	T3	QL (2 units/30 days)
ANTIFUNGALS (Eye Conditions)		
OPHTHALMIC ANTIFUNGAL AGENTS		
NATACYN	T3	
ANTIFUNGALS (Feminine Products)		
VAGINAL ANTIFUNGALS		
GYNAZOLE 1	T4	
<i>miconazole nitrate</i>	T2	
<i>terconazole</i>	T2	
ANTIFUNGALS (Infections)		
ANTIFUNGAL AGENTS		
ANCOBON (<i>flucytosine</i>)	T4	PA
<i>clotrimazole</i>	T2	
CRESEMBA	T3	PA
DIFLUCAN 10 MG/ML SUSPENSION (<i>fluconazole</i>)	T4	
DIFLUCAN 100 MG TABLET (<i>fluconazole</i>)	T4	
DIFLUCAN 150 MG TABLET (<i>fluconazole</i>)	T4	QL(2 tabs/fill)
DIFLUCAN 200 MG TABLET (<i>fluconazole</i>)	T4	
DIFLUCAN 40 MG/ML SUSPENSION (<i>fluconazole</i>)	T4	
DIFLUCAN 50 MG TABLET (<i>fluconazole</i>)	T4	
<i>fluconazole 10 mg/ml susp</i>	T2	
<i>fluconazole 40 mg/ml susp (Diflucan)</i>	T2	
<i>fluconazole 50 mg tablet (Diflucan)</i>	T2	
<i>fluconazole 100 mg tablet</i>	T2	
<i>fluconazole 150 mg tablet (Diflucan)</i>	T2	QL(2 tabs/fill)

T1 – Preferred Generics

T2 – Non-Preferred Generics

T3 – Preferred Brands

T4 – Non-Preferred Brands

T5 – Preferred Specialty

T6 – Non-Preferred Specialty

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List of Prescription Medications

ANTIFUNGALS (Infections) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ANTIFUNGAL AGENTS (cont.)		
<i>fluconazole 200 mg tablet</i>	T2	
<i>flucytosine (Ancobon)</i>	T2	
<i>itraconazole 10 mg/ml solution</i>	T2	QL (2 bottles/30 days)
<i>itraconazole 100 mg capsule (Sporanox)</i>	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 (Noxafil)</i>	T2	PA
SPORANOX (<i>itraconazole</i>)	T4	QL (30 caps/30 days)
<i>terbinafine hcl</i>	T2	
VFEND (<i>voriconazole</i>)	T4	PA
VIVJOA	T6	PA QL (18 caps/30 days) SP
<i>voriconazole (Vfend)</i>	T2	PA
ANTIFUNGAL ANTIBIOTICS		
BREXAFEMME	T4	ST QL (4 tabs/fill)
<i>griseofulvin ultramicrosize</i>	T2	
<i>griseofulvin, microsize</i>	T2	
<i>nystatin 100,000 unit/ml susp</i>	T2	
<i>nystatin 500,000 unit oral tab</i>	T2	
<i>nystatin 500,000 unit/5 ml cup</i>	T2	
ANTIFUNGALS (Skin Conditions)		
TOPICAL ANTIFUNGAL/ANTI-INFLAMMATORY, STEROID AGENT		
<i>clotrimazole-betamethasone crm</i>	T2	QL (90 gms/28 days)
<i>clotrimazole-betamethasone lot</i>	T2	QL (60 mls/28 days)
TOPICAL ANTIFUNGALS		
<i>ciclodan 0.77% cream (Loprox)</i>	T2	QL (90 gms/28 days)
CICLODAN 0.77% CREAM KIT	T4	
<i>ciclodan 8% solution</i>	T2	
<i>ciclopirox 0.77% cream (Loprox)</i>	T2	QL (90 gms/28 days)
<i>ciclopirox 0.77% gel</i>	T2	QL (100 gms/28 days)

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List of Prescription Medications

ANTIFUNGALS (Skin Conditions) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
TOPICAL ANTIFUNGALS (cont.)		
<i>ciclopirox 0.77% topical susp (Loprox)</i>	T2	QL(60 mls/28 days)
<i>ciclopirox 1% shampoo</i>	T2	QL(120 mls/28 days)
<i>ciclopirox 8% solution</i>	T2	
<i>econazole nitrate 1% cream</i>	T2	QL (85 gms/28 days)
EXELDERM 1% CREAM, SOLUTION	T4	QL(60 gms/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)
<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	

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

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List of Prescription Medications

ANTIHISTAMINE AND DECONGESTANT COMBINATION (Allergy/Nasal Sprays) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
2ND GEN ANTIHISTAMINE AND DECONGESTANT COMBINATION		
CLARINEX-D 12 HOUR	T4	
CLARINEX-D 24 HOUR	T4	
ANTIHISTAMINES (Allergy/Nasal Sprays)		
ANTIHISTAMINES - 1ST GENERATION		
carbinoxamine 4 mg/5 ml liquid	T2	
carbinoxamine maleate	T2	ST
carbinoxamine maleate 4 mg tab	T2	
carbinoxamine maleate 6 mg tab	T2	ST
cyproheptadine 2 mg/5 ml soln, syrup	T2	
cyproheptadine 4 mg tablet	T2	
CYPROHEPTADINE 4 MG/10 ML SYRP	T4	
dexchlorpheniramine maleate (Ryclora)	T2	
hydroxyzine hcl	T2	
hydroxyzine hcl	T1	
hydroxyzine pamoate	T1	
hydroxyzine pamoate (Vistaril)	T1	
promethazine hcl	T2	
RYCLORA (dexchlorpheniramine maleate)	T4	
RYVENT	T4	ST
VISTARIL (hydroxyzine pamoate)	T4	
ANTIHISTAMINES - 2ND GENERATION		
CLARINEX (desloratadine)	T4	QL(30 tabs/fill) HD
desloratadine	T2	QL(30 tabs/fill) HD
desloratadine (Clarinet)	T2	QL(30 tabs/fill) HD
ANTIHISTAMINES (Eye Conditions)		
EYE ANTIHISTAMINES		
azelastine hcl 0.05% drops	T2	
bepotastine besilate (Bepreve)	T2	ST
BEPREVE	T2	
epinastine hcl	T2	
LASTACFT 0.25% EYE DROPS	T4	ST

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T3 – Preferred Brands
T4 – Non-Preferred Brands

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List of Prescription Medications

ANTIHYPERGLYCEMICS (Diabetes)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ANTIHYPERGLY,DPP-4 ENZYME INHIB.-THIAZOLIDINEDIONE		
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)
OSENI	T4	ST QL (30 tabs/fill) HD
OZEMPIC	T3	PA QL (1 pen/28 days)
RYBELSUS	T3	PA QL (30 tabs/30 days)
TRULICITY	T3	PA QL (4 pens/28 days)
VICTOZA 2-PAK	T3	PA QL (1 pen/fill) HD
VICTOZA 3-PAK	T3	PA QL (30 tabs/fill) HD
ANTIHYPERGLY,INCRETIN MIMETIC(GLP-I RECEPT.AGONIST)		
<i>exenatide</i>	T2	PA QL (1 pen/30 days)
<i>liraglutide 2-pak 18 mg/3 ml (Victoza 2-Pak)</i>	T2	PA
<i>liraglutide 2-pak 18 mg/3 ml (Victoza 2-Pak)</i>	T2	PA QL (2 pens/30 days)
<i>liraglutide 2-pak 18 mg/3 ml (Victoza 3-Pak)</i>	T2	PA
<i>liraglutide 2-pak 18 mg/3 ml (Victoza 3-Pak)</i>	T2	PA QL (2 pens/30 days)
<i>liraglutide 3-pak 18 mg/3 ml (Victoza 2-Pak)</i>	T2	PA
<i>liraglutide 3-pak 18 mg/3 ml (Victoza 2-Pak)</i>	T2	PA QL (3 pens/30 days)
<i>liraglutide 3-pak 18 mg/3 ml (Victoza 3-Pak)</i>	T2	PA
<i>liraglutide 3-pak 18 mg/3 ml (Victoza 3-Pak)</i>	T2	PA QL (3 pens/30 days)
RYBELSUS	T3	PA QL (30 tabs/30 days)
ANTIHYPERGLY, INSULIN, LONG ACT-GLP-I RECEPT.AGONIST		
SOLIQUA 100-33	T3	QL (15 mls/30 days)
ANTIHYPERGLYCEMIC - DOPAMINE RECEPTOR AGONISTS		
CYCLOSET	T4	HD
ANTIHYPERGLYCEMIC - INCRETIN MIMETICS COMBINATION		
MOUNJARO	T3	PA QL (4 pens/fill)
ANTIHYPERGLYCEMIC, ALPHA-GLUCOSIDASE INHIBITORS		
<i>acarbose (Precose)</i>	T2	HD
<i>miglitol</i>	T2	HD
PRECOSE (<i>acarbose</i>)	T4	HD
ANTIHYPERGLYCEMIC, AMYLIN ANALOG-TYPE		
SYMLINPEN 60	T3	PA QL (7 pens/30 days)
SYMLINPEN 120	T3	PA QL (7 pens/fill) HD

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List of Prescription Medications

ANTIHYPERGLYCEMICS (Diabetes) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ANTIHYPERGLYCEMIC, BIGUANIDE TYPE		
<i>metformin er 1,000 mg gastr-tb</i> (Glumetza)	T2	PA QL(60 tabs/fill) HD
<i>metformin er 500 mg gastrc-tb</i> (Glumetza)	T2	PA QL(120 tabs/fill) HD
<i>metformin er 500 mg osmotic tb</i>	T2	PA QL (30 tabs/30 days) HD
<i>metformin er 1,000 mg osm-tab</i>	T2	PA QL (60 tabs/30 days) HD
<i>metformin hcl 500 mg tablet</i>	T1	HD
<i>metformin hcl 750 mg tablet</i>	T1	ST HD
<i>metformin hcl 1,000 mg tablet</i>	T1	HD
<i>metformin hcl 500 mg/5 ml soln</i> (Riomet)	T2	ST HD
<i>metformin hcl 850 mg tablet</i>	T1	HD
<i>metformin hcl er 500 mg tablet</i>	T1	QL(120 tabs/fill) HD
<i>metformin hcl er 750 mg tablet</i>	T1	QL(60 tabs/fill) HD
RIOMET (<i>metformin hcl</i>)	T4	ST HD
ANTIHYPERGLYCEMIC, DPP-4 INHIBITORS		
JANUVIA	T3	ST QL(30 tabs/fill) HD
<i>saxagliptin</i> (Onglyza)	T2	ST QL(30 tabs/30 days) HD
ANTIHYPERGLYCEMIC, INSULIN-RELEASE STIMULANT TYPE		
<i>glimepiride</i> (Amaryl)	T1	HD
<i>glimepiride 1 mg tablet</i>	T1	HD
<i>glimepiride 2 mg tablet</i>	T1	HD
<i>glimepiride 4 mg tablet</i>	T1	HD
<i>glipizide</i>	T1	HD
<i>glipizide</i> (Glucotrol XL)	T1	HD
GLUCOTROL XL (<i>glipizide</i>)	T4	HD
<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

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List of Prescription Medications

ANTIHYPERGLYCEMICS (Diabetes) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
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>saxagliptn-metform er 2.5-1000</i> (Kombiglyze Xr)	T2	ST QL(60 tabs/30 days) HD
<i>saxagliptin-metformin er 5-500</i> (Kombiglyze Xr)	T2	ST QL(30 tabs/30 days) HD
<i>saxagliptin-metformn er 5-1000</i> (Kombiglyze Xr)	T2	ST QL(30 tabs/30 days) HD
ANTIHYPERGLYCEMIC, INSULIN-RELEASE STIM.-BIGUANIDE		
<i>glipizide/metformin hcl</i>	T1	HD
<i>glyburide/metformin hcl</i>	T2	HD
ANTIHYPERGLYCEMIC, THIAZOLIDINEDIONE (PPARG AGONIST)		
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
ANTIHYPERGLYCEMIC-SGLT2 INHIBITOR-BIGUANIDE COMBS.		
SYNJARDY	T3	ST QL(60 tabs/fill) HD
SYNJARDY XR 10-1,000 MG TABLET	T3	ST QL(30 tabs/fill) HD
SYNJARDY XR 12.5-1,000 MG TAB	T3	ST QL(60 tabs/fill) HD
SYNJARDY XR 25-1,000 MG TABLET	T3	ST QL(30 tabs/fill) HD
SYNJARDY XR 5-1,000 MG TABLET	T3	ST QL(60 tabs/fill) HD
XIGDUO XR 10 MG-1,000 MG TAB	T3	ST QL(30 tabs/fill) HD
XIGDUO XR 10 MG-500 MG TABLET	T3	ST QL(30 tabs/fill) HD
XIGDUO XR 2.5 MG-1,000 MG TAB	T3	ST QL(60 tabs/fill) HD
XIGDUO XR 5 MG-1,000 MG TABLET	T3	ST QL(60 tabs/fill) HD
XIGDUO XR 5 MG-500 MG TABLET	T3	ST QL(30 tabs/fill) HD

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
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, 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 100 UNIT/ML VIAL	T3	HD
INSULIN LISPRO JUNIOR KWIKPEN	T3	HD
INSULIN LISPRO KWIKPEN U-100	T3	HD
INSULIN LISPRO PROTAMINE MIX	T3	HD
LANTUS	T3	HD
LANTUS SOLOSTAR	T3	HD
LYUMJEV	T3	HD
LYUMJEV KWIKPEN U-100	T3	HD
LYUMJEV KWIKPEN 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

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ANTIHYPERGLYCEMICS (Diabetes) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
INSULINS (cont.)		
TRESIBA FLEXTOUCH U-100	T3	HD
TRESIBA FLEXTOUCH U-200	T3	HD
ANTIINFECTIVES (Feminine Products)		
VAGINAL SULFONAMIDES		
AVC	T4	
ANTIINFECTIVES/MISCELLANEOUS (Feminine Products)		
VAGINAL ANTISEPTICS		
acetic acid/oxyquinoline (Relagard)	T2	
RELAGARD (acetic acid/oxyquinoline)	T4	
TRIMO-SAN	T3	
ANTIINFECTIVES/MISCELLANEOUS (Infections)		
2ND GEN. ANAEROBIC ANTIPROTOZOAL-ANTIBACTERIAL		
tinidazole 250 mg tablet	T2	QL(40 tabs/30 days)
tinidazole 500 mg tablet	T2	QL(20 tabs/30 days)
AMEBICIDES		
HUMATIN	T4	
ANTHELMINTICS		
albendazole (Albenza)	T2	QL(120 tabs/30 days)
ALBENZA (albendazole)	T4	QL(120 tabs/30 days)
BILTRICIDE (praziquantel)	T4	
EMVERM	T3	QL(6 tabs/30 days)
ivermectin 6 mg tablet	T2	PA QL (8 tabs/30 days)
praziquantel (Biltricide)	T2	
STROMEKTOL (ivermectin)	T4	PA QL(14 tabs/30 days)
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)	T6	PA SP
HYDROXYCHLOROQUINE 100 MG TAB	T4	

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ANTIINFECTIVES/MISCELLANEOUS (Infections) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ANTIMALARIAL DRUGS (cont.)		
<i>hydroxychloroquine 200 mg tab</i> (Plaquenil)	T2	
HYDROXYCHLOROQUINE 300 MG TAB	T4	
HYDROXYCHLOROQUINE 400 MG TAB	T4	
KRINTAFEL	T4	QL(2 tabs/30 days)
MALARONE 250-100 MG TABLET (<i>atovaquone/proguanil hcl</i>)	T4	QL(60 tabs/180 days)
MALARONE 62.5-25 MG PED TAB (<i>atovaquone/proguanil hcl</i>)	T4	QL(180 tabs/180 days)
<i>mefloquine hcl</i>	T2	QL(13 tabs/180 days)
PRIMAQUINE 26.3 MG TABLET	T3	QL(120 tabs/180 days)
<i>primaquine 26.3 mg tablet</i>	T2	QL(120 tabs/180 days)
<i>pyrimethamine 25 mg tablet</i> (Daraprim)	T2	PA
<i>pyrimethamine 25 mg tablet</i> (Daraprim)	T2	PA SP
<i>quinine sulfate</i>	T2	QL (42 caps/30 days)
ANTIPROTOZOAL DRUGS, MISCELLANEOUS		
<i>atovaquone</i> (Mepron)	T2	
BENZNIDAZOLE	T3	QL(360 tabs/fill)
IMPAVIDO	T3	PA QL(84 caps/30 days)
MEPRON (<i>atovaquone</i>)	T4	
NEBUPENT (<i>pentamidine isethionate</i>)	T4	QL(1 v1/28 days)
<i>pentamidine isethionate</i> (Nebupent)	T2	QL(1 v1/28 days)
ANTIINFECTIVES/MISCELLANEOUS (Miscellaneous)		
ANTIBACTERIAL AGENTS,MISCELLANEOUS		
<i>glycine urologic solution</i>	T2	
ANTISEPTICS,GENERAL		
ALCOHOL SWABSTICK	T4	
CVS ISOPROPYL ALCOHOL 91% SPRY	T4	
GS ISOPROPYL ALCOHOL 70% SPRAY	T4	
ISOPROPYL ALCOHOL 70% SPRAY	T4	
MEDI-FIRST ISOPROPYL ALCOHOL	T4	
TOPICAL ANTISEPTIC DRYING AGENTS		
<i>formaldehyde</i>	T2	
ANTIINFECTIVES/MISCELLANEOUS (Skin Conditions)		
TOPICAL ANTIFUNGALS		
CICLODAN 8% KIT	T4	ST
<i>ciclopirox 8% treatment kit</i>	T2	

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List of Prescription Medications

ANTIINFLAM.TUMOR NECROSIS FACTOR INHIBITING AGENTS (Pain Relief And Inflammatory Disease)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ANTI-INFLAMMATORY TUMOR NECROSIS FACTOR INHIBITOR		
ADALIMUMAB-ADAZ (CF)	T5	PA QL (2 syringes/28 days) SP
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)	T6	PA QL (2 srnge kits/28 days) SP HD
CYLTEZO(CF) PEN	T6	PA QL (2 kits/28 days) SP HD
CYLTEZO(CF) PEN CROHN'S-UC-HS	T6	PA QL (6 pens/365 days) SP HD
CYLTEZO(CF) PEN PSORIASIS-UV	T6	PA QL (4 pens/365 days) SP HD
SIMLANDI(CF)	T6	PA QL (2 srnge kits/28 days) SP
ENBREL 25 MG KIT	T5	PA QL SP HD
ENBREL 25 MG/0.5 ML SYRINGE	T5	PA QL SP HD
ENBREL 25 MG/0.5 ML VIAL	T5	PA QL SP HD
ENBREL 50 MG/ML SYRINGE	T5	PA QL (2 srnge kits/28 days) SP HD
ENBREL MINI	T5	PA QL (2 kits/28 days) SP HD
ENBREL SURECLICK	T5	PA QL (6 pens/365 days) SP HD
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	T6	PA SP HD
ANTINEOPLASTICS (Cancer)		
ANP - SELECTIVE RETINOID X RECEPTOR AGONISTS (RXR)		
bexarotene (Targretin)	T2	PA SP HD CSL
ANTINEOPLAST, HISTONE DEACETYLASE (HDAC) INHIBITORS		
FARYDAK	T4	PA QL (6 caps/fill) CSL
ZOLINZA	T5	PA QL (120 caps/fill) SP HD CSL
ANTINEOPLASTIC - ALKYLATING AGENTS		
ALKERAN (<i>melphalan</i>)	T6	SP CSL
cyclophosphamide 25 mg, 50 mg capsule	T2	SP HD CSL
CYCLOPHOSPHAMIDE 50 MG TABLET	T6	SP HD CSL
GLEOSTINE	T3	CSL
HYDREA (<i>hydroxyurea</i>)	T4	CSL
<i>hydroxyurea</i> (Hydrea)	T2	CSL
LEUKERAN	T3	CSL

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List of Prescription Medications

ANTINEOPLASTICS (Cancer) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ANTINEOPLASTIC - ALKYLATING AGENTS (cont.)		
MYLERAN	T3	CSL
<i>temozolomide</i>	T2	PA SP HD CSL
ANTINEOPLASTIC - ANTIANDROGENIC AGENTS		
<i>abiraterone acetate (Zytiga)</i>	T2	PA QL (120 tabs/30 days) CSL
<i>bicalutamide (Casodex)</i>	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 (Eulexin)</i>	T2	CSL
NILANDRON (<i>nilutamide</i>)	T4	PA CSL
<i>nilutamide (Nilandron)</i>	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
ANTINEOPLASTIC - ANTIMETABOLITES		
LONSURF	T5	PA SP HD CSL
<i>mercaptopurine 20 mg/ml suspen (Purixan)</i>	T2	ST SP CSL
<i>mercaptopurine 2.5 mg, 50 mg tablet</i>	T2	CSL
<i>methotrexate 250 mg/10 ml vial</i>	T2	
<i>methotrexate 50 mg/2 ml vial</i>	T2	
<i>methotrexate sodium/pf</i>	T2	
PURIXAN (<i>mercaptopurine</i>)	T5	ST SP CSL
TABLOID	T4	CSL
TREXALL	T4	CSL
XELODA 150 MG TABLET (<i>capecitabine</i>)	T6	PA QL(56 tabs/fill) SP HD CSL
XELODA 500 MG TABLET (<i>capecitabine</i>)	T6	PA QL(140 tabs/fill) SP HD CSL
YONSA	T5	PA QL (120 tabs/30 days) 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

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ANTINEOPLASTICS (Cancer) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
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 100 MG TABLET	T6	PA QL (30 tabs/fill) SP HD CSL
DAURISMO 25 MG TABLET	T6	PA QL (60 tabs/fill) SP HD CSL
ERIVEDGE	T5	PA QL (30 caps/fill) SP HD CSL
ODOMZO	T5	PA QL (30 caps/fill) SP HD CSL
ANTINEOPLASTIC - JANUS KINASE (JAK) INHIBITORS		
JAKAFI	T5	PA QL (60 tabs/fill) SP HD CSL
ANTINEOPLASTIC - KRAS PROTEIN INHIBITOR		
LUMAKRAS	T6	PA SP HD CSL
ANTINEOPLASTIC - MEK KINASE INHIBITORS		
COTELLIC	T5	PA QL (63 tabs/30 days) SP HD CSL
GOMEKLI	T5	PA SP CSL
KOSELUGO 10 MG CAPSULE	T6	PA SP CSL
KOSELUGO 25 MG CAPSULE	T6	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		
everolimus (Afinitor)	T2	PA QL (30 tabs/30 days) SP CSL
everolimus 2 mg tab for susp (Afinitor Disperz)	T2	PA QL (30 tabs/fill) SP CSL
everolimus 3 mg tab for susp (Afinitor Disperz)	T2	PA QL (30 tabs/fill) SP CSL
everolimus 5 mg tab for susp (Afinitor Disperz)	T2	PA QL (30 tabs/fill) SP CSL
ANTINEOPLASTIC - PROTEIN METHYLTRANSFERASE INHIBIT		
TAZVERIK	T6	PA SP CSL
ANTINEOPLASTIC - SYSTEMIC ENZYME INHIBITORS COMBS		
AVMAPKI-FAKZYNJA	T5	PA SP CSL
ANTINEOPLASTIC - TOPOISOMERASE I INHIBITORS		
HYCAMTIN	T5	PA SP HD CSL

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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 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 IMMUNOMODULATOR AGENTS		
<i>lenalidomide</i>	T2	PA QL(30 caps/fill) SP HD CSL
POMALYST	T5	PA SP HD CSL
REVLIMID	T5	PA QL(30 caps/fill) SP HD CSL
ANTINEOPLASTIC LHRH(GNRH) ANTAGONIST,PITUIT.SUPPRS		
ORGOVYX	T6	PA QL(30 tabs/fill) SP CSL
ANTINEOPLASTIC SYSTEMIC ENZYME INHIBITORS		
ALECENSA	T5	PA QL(240 caps/fill) SP HD CSL
ALUNBRIG 30 MG TABLET	T5	PA QL(60 tabs/fill) SP CSL
ALUNBRIG 90 MG , 180 MG TABLET	T5	PA QL(30 tabs/fill) SP CSL
ALUNBRIG 90 MG-180 MG TAB PACK	T5	PA QL(30 tabs/fill) SP CSL
AUGTYRO	T5	PA SP CSL
AYVAKIT	T6	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 tabs/fill) SP HD CSL
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	T6	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

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

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

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

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

List of Prescription Medications

ANTINEOPLASTICS (Cancer) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ANTINEOPLASTIC SYSTEMIC ENZYME INHIBITORS (cont.)		
<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 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
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>)	T6	PA QL (30 tabs/30 days) SP HD CSL
IWILFIN	T5	PA SP CSL
KISQALI	T6	PA QL (1 pack/1 time) CSL SP HD
KISQALI FEMARA CO-PACK	T6	PA QL (1 pack/28 days) CSL SP HD
LAZCLUZE	T6	PA SP CSL
<i>lapatinib ditosylate (Tykerb)</i>	T2	PA QL (180 tabs/fill) SP HD CSL
LENVIMA 10 MG DAILY DOSE	T5	PA QL (30 caps/fill) SP HD CSL
LENVIMA 12 MG DAILY DOSE	T5	PA QL (90 caps/fill) SP HD CSL
LENVIMA 14 MG DAILY DOSE	T5	PA QL (60 caps/fill) SP HD CSL
LENVIMA 18 MG DAILY DOSE	T5	PA QL (90 caps/fill) SP HD CSL

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List of Prescription Medications

ANTINEOPLASTICS (Cancer) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ANTINEOPLASTIC SYSTEMIC ENZYME INHIBITORS (cont.)		
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
LENVIMA 4 MG CAPSULE	T5	PA QL(30 caps/fill) SP HD CSL
LENVIMA 8 MG DAILY DOSE	T5	PA QL(60 caps/fill) SP HD CSL
LORBRENA 100 MG TABLET	T5	PA QL(30 tabs/fill) SP HD CSL
LORBRENA 25 MG TABLET	T5	PA QL(90 tabs/fill) SP HD CSL
LYNPARZA	T5	PA QL(120 tabs/fill) SP HD CSL
LYTGOBI	T5	PA SP CSL
NERLYNX	T5	PA SP HD CSL
NEXAVAR (<i>sorafenib tosylate</i>)	T6	PA QL(120 tabs/fill) SP HD CSL
<i>nilotinib 150 mg capsule (Tasigna)</i>	T2	PA QL (112 caps/30 days) SP HD CSL
<i>nilotinib 200 mg capsule (Tasigna)</i>	T2	PA QL (112 caps/30 days) SP HD CSL
<i>nilotinib 50 mg capsule (Tasigna)</i>	T2	PA QL (120 caps/30 days) SP HD CSL
NINLARO	T5	PA QL(3 caps/fill) SP HD CSL
OGSIVEO	T6	PA SP CSL
<i>pazopanib (Votrient)</i>	T2	PA QL(120 tabs/30 days) SP HD CSL
PEMAZYRE	T5	PA QL(28 tabs/fill) SP CSL
PIQRAY	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
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 PELLET PACKET	T5	PA QL(42 packs/fill) SP HD CSL
RETEVMO 40 MG TABLET	T6	PA QL (90 tabs/fill) SP HD CSL
RETEVMO 80 MG TABLET	T6	PA QL (60 tabs/fill) SP HD CSL
RETEVMO 120 MG TABLET	T6	PA QL (60 tabs/fill) SP HD CSL
RETEVMO 160 MG TABLET	T6	PA QL (60 tabs/fill) SP HD CSL
REVUFORJ	T5	PA SP CSL
ROMVIMZA	T6	PA QL (8 caps/fill) SP 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
<i>sorafenib tosylate (Nexavar)</i>	T2	PA QL(120 tabs/fill) SP HD CSL

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List of Prescription Medications

ANTINEOPLASTICS (Cancer) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ANTINEOPLASTIC SYSTEMIC ENZYME INHIBITORS (cont.)		
<i>sunitinib malate 12.5 mg cap (Sutent)</i>	T2	PA QL(90 caps/fill) SP HD CSL
<i>sunitinib malate 25 mg capsule (Sutent)</i>	T2	PA QL(30 caps/fill) SP HD CSL
<i>sunitinib malate 37.5 mg cap (Sutent)</i>	T2	PA QL(30 caps/fill) SP HD CSL
<i>sunitinib malate 50 mg capsule (Sutent)</i>	T2	PA QL(30 caps/fill) SP HD CSL
SUTENT 12.5 MG CAPSULE (<i>sunitinib malate</i>)	T6	PA QL(90 caps/fill) SP HD CSL
SUTENT 25 MG CAPSULE (<i>sunitinib malate</i>)	T6	PA QL(30 caps/fill) SP HD CSL
SUTENT 37.5 MG CAPSULE (<i>sunitinib malate</i>)	T6	PA QL(30 caps/fill) SP HD CSL
SUTENT 50 MG CAPSULE (<i>sunitinib malate</i>)	T6	PA QL(30 caps/fill) SP HD CSL
TABRECTA	T5	PA SP HD CSL
TAGRISSO	T5	PA QL(30 tabs/fill) SP HD CSL
TALZENNA	T5	PA QL(30 caps/fill) SP HD CSL
TALZENNA 0.1 MG CAPSULE, SOFTGEL	T5	PA QL (30 caps/fill) SP CSL
TALZENNA 0.25 MG CAPSULE, SOFTGEL	T5	PA QL (30 caps/30 days) SP CSL
TALZENNA 0.35 MG CAPSULE, SOFTGEL	T5	PA QL (30 caps/fill) SP CSL
TALZENNA 0.5 MG CAPSULE, SOFTGEL	T5	PA QL (30 caps/30 days) SP CSL
TALZENNA 0.75 MG CAPSULE, SOFTGEL	T5	PA QL (30 caps/30 days) SP CSL
TALZENNA 1 MG CAPSULE, SOFTGEL	T5	PA QL (30 caps/30 days) SP CSL
TASIGNA 150 MG CAPSULE (<i>nilotinib hcl</i>)	T6	PA QL (112 caps/30 days) SP HD CSL
TASIGNA 200 MG CAPSULE (<i>nilotinib hcl</i>)	T6	PA QL (112 caps/30 days) SP HD CSL
TASIGNA 50 MG CAPSULE (<i>nilotinib hcl</i>)	T6	PA QL (120 caps/30 days) SP HD CSL
TRUQAP	T5	PA SP CSL
TUKYSA 150 MG TABLET	T6	PA QL(120 tabs/fill) SP CSL
TUKYSA 50 MG TABLET	T6	PA QL(300 tabs/fill) SP CSL
TURALIO	T6	PA QL(120 caps/fill) SP CSL
VERZENIO	T5	PA QL(60 tabs/fill) SP HD CSL
VITRAKVI 100 MG CAPSULE	T5	PA QL(60 caps/fill) SP HD CSL
VITRAKVI 20 MG/ML SOLUTION	T5	PA QL(300 mls/fill) SP HD CSL
VITRAKVI 25 MG CAPSULE	T5	PA QL(180 caps/fill) SP HD CSL
VIZIMPRO	T5	PA QL(30 tabs/fill) SP HD CSL
VONJO	T5	PA QL(120 caps/fill) SP CSL
VOTRIENT (<i>pazopanib hcl</i>)	T6	PA QL(120 tabs/30 days) SP HD CSL
XALKORI 200MG, 250 MG CAPSULE	T5	PA QL(60 caps/30 days) SP HD CSL
XALKORI 20MG PELLET	T5	PA QL (120 caps/fill) SP HD CSL
XALKORI 50 MG PELLET	T5	PA QL (120 caps/fill) SP HD CSL

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List of Prescription Medications

ANTINEOPLASTICS (Cancer) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ANTINEOPLASTIC SYSTEMIC ENZYME INHIBITORS (cont.)		
XALKORI 150 MG PELLET	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 TABLET	T5	PA QL(56 tabs/fill) SP CSL
VENCLEXTA 10 MG TAB (10MG X 2)	T5	PA QL(56 tabs/fill) SP CSL
VENCLEXTA 50 MG TABLET	T5	PA QL(28 tabs/fill) SP CSL
VENCLEXTA 100 MG TABLET	T5	PA QL(180 tabs/fill) SP CSL
VENCLEXTA STARTING PACK	T5	PA QL(42 tabs/fill) SP CSL
ANTINEOPLASTIC-HYPOXIA INDUCIBLE FACTOR (HIF) INH		
WELIREG	T6	PA SP CSL
ANTINEOPLASTIC-ISOCITRATE DEHYDROGENASE INHIBITORS		
IDHIFA	T5	PA QL(30 tabs/fill) SP HD CSL
TIBSOVO	T5	PA SP CSL
VORANIGO	T6	PA SP CSL
ANTINEOPLASTICS, MISCELLANEOUS		
<i>etoposide</i>	T2	SP HD CSL
LYSODREN	T3	CSL
MATULANE	T5	SP CSL
<i>tretinoin 10 mg capsule</i>	T2	CSL
IMMUNOMODULATORS		
ACTIMMUNE	T5	PA SP HD
SELECTIVE ESTROGEN RECEPTOR MODULATORS (SERMS)		
FARESTON (<i>toremifene citrate</i>)	T4	HD CSL
SOLTAMOX	T4	HD PPACA CSL
<i>tamoxifen citrate</i>	T2	HD PPACA CSL
<i>toremifene citrate</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	T6	SP

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

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

ST – Step Therapy
AGE – Age Requirement
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PPACA – No Cost-Share Preventive Medication
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List of Prescription Medications

ANTINEOPLASTICS (Skin Conditions) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
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	T6	PA SP HD
TARGRETIN 1% GEL (<i>bexarotene</i>)	T6	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 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)
<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 - INCRETIN MIMETICS COMBINATION		
ZEPBOUND 2.5 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 PEN	T3	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 PEN	T3	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 PEN	T3	PA QL (2 mls/28 days)

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

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

ST – Step Therapy
AGE – Age Requirement
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List of Prescription Medications

ANTI-OBESITY DRUGS (Weight Management) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ANTI-OBESITY - INCRETIN MIMETICS COMBINATION (cont.)		
ZEPBOUND 10 MG/0.5 ML VIAL	T4	PA QL (2 mls/28 days)
ZEPBOUND 12.5 MG/0.5 ML PEN	T3	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 PEN	T3	PA QL (2 mls/28 days)
ZEPBOUND 15 MG/0.5 ML VIAL	T4	PA QL (2 mls/28 days)
ANTI-OBESITY - MELANOCORTIN 4 RECEPTOR AGONISTS		
IMCIVREE	T6	PA QL (6 mls/30 days) SP
ANTI-OBESITY GLUCAGON-LIKE PEPTIDE-I RECEPTOR AGONIST		
<i>liraglutide 18 mg/3 ml pen (Saxenda)</i>	T2	PA QL (5 pens/30 days)
<i>liraglutide 5-pak 18 mg/3 ml (Saxenda)</i>	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 SEROTONIN 2C RECEPTOR AGONISTS		
BELVIQ	T4	PA
BELVIQ XR	T4	PA
ANTI-OBESITY-OPIOID ANTAGONIST, DOPAMINE RECEPTOR INHIBITOR		
CONTRACE	T4	PA QL (120 tabs/fill)
FAT ABSORPTION DECREASING AGENTS		
ORLISTAT	T4	PA QL (90 caps/fill)
XENICAL	T4	PA QL (90 caps/fill)
ANTIPARASITICS (Eye Conditions)		
OPHTHALMIC (EYE) ANTIPARASITICS		
XDEMZY	T5	QL (10 mgs/30 days) SP
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	

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List of Prescription Medications

ANTIPARASITICS (Infections) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
TOPICAL ANTIPARASITICS (cont.)		
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/entacapone</i> (Stalevo 100)	T2	HD
<i>carbidopa/levodopa/entacapone</i> (Stalevo 125)	T2	HD
<i>carbidopa/levodopa/entacapone</i> (Stalevo 75)	T2	HD
CREXONT	T4	ST HD
DUOPA	T6	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
NOURIANZ	T6	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	ST HD
<i>selegiline hcl</i>	T2	HD
STALEVO 100 (<i>carbidopa/levodopa/entacapone</i>)	T4	HD
STALEVO 75 (<i>carbidopa/levodopa/entacapone</i>)	T4	HD
TASMAR (<i>tolcapone</i>)	T4	PA HD
<i>tolcapone</i> (Tasmar)	T2	PA HD

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

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

ST – Step Therapy
AGE – Age Requirement
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PPACA – No Cost-Share Preventive Medication
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List of Prescription Medications

ANTIPARKINSON DRUGS (Parkinson's Disease) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
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> (Agrylin)	T2	
ANTIVIRALS (AIDS/HIV)		
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.		
SYM TUZA	T5	SP
ANTIVIRALS, HIV-SPEC, NON-PEPTIDIC PROTEASE INHIB		
APTIVUS	T5	SP
<i>darunavir</i> (Prezista)	T2	SP
PREZISTA	T5	PA SP

T1 – Preferred Generics
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T3 – Preferred Brands
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List of Prescription Medications

ANTIVIRALS (AIDS/HIV) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ANTIVIRALS, HIV-SPEC, NON-PEPTIDIC PROTEASE INHIB (cont.)		
PREZISTA 600 MG TABLET (<i>darunavir</i>)	T6	SP
PREZISTA 800 MG TABLET (<i>darunavir</i>)	T6	SP
ANTIVIRALS, HIV-SPEC, NUCLEOSIDE-NUCLEOTIDE ANALOG		
CIMDUO	T5	SP
DESCOVY	T5	SP
<i>emtricitabine-tenofv 100-150mg (Truvada)</i>	T2	SP
<i>emtricitabine-tenofv 133-200mg (Truvada)</i>	T2	SP
<i>emtricitabine-tenofv 167-250mg (Truvada)</i>	T2	SP
<i>emtricitabine-tenofv 200-300mg (Truvada)</i>	T2	SP PPACA
TEMIXYS	T5	SP
ANTIVIRALS, HIV-SPEC., NUCLEOSIDE ANALOG, RTI COMB		
<i>abacavir sulfate/lamivudine (Epzicom)</i>	T2	SP
COMBIVIR (<i>lamivudine/zidovudine</i>)	T6	SP
EPZICOM (<i>abacavir sulfate/lamivudine</i>)	T6	SP
<i>lamivudine/zidovudine (Combivir)</i>	T2	SP
ANTIVIRALS, HIV-SPECIFIC, CCR5 CO-RECEPTOR ANTAG.		
<i>maraviroc (Selzentry)</i>	T2	SP
SELZENTRY 150 MG TABLET (<i>maraviroc</i>)	T6	SP
SELZENTRY 20 MG/ML ORAL SOLN	T5	SP
SELZENTRY 300 MG TABLET (<i>maraviroc</i>)	T6	SP
ANTIVIRALS, HIV-SPECIFIC, FUSION INHIBITORS		
FUZEON	T5	PA SP
ANTIVIRALS, HIV-SPECIFIC, NON-NUCLEOSIDE, RTI		
EDURANT	T5	SP
EDURANT PED	T6	SP
<i>efavirenz (Sustiva)</i>	T2	SP
<i>etravirine (Intelence)</i>	T2	SP
INTELENCE 100 MG TABLET (<i>etravirine</i>)	T6	SP
INTELENCE 200 MG TABLET (<i>etravirine</i>)	T6	SP
INTELENCE 25 MG TABLET	T5	SP
<i>nevirapine</i>	T2	SP
PIFELTRO	T5	SP
SUNLENCA	T6	PA SP
SUSTIVA (<i>efavirenz</i>)	T6	SP

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List of Prescription Medications

ANTIVIRALS (AIDS/HIV) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ANTIVIRALS, HIV-SPECIFIC, NUCLEOSIDE ANALOG, RTI		
<i>abacavir sulfate</i> (Ziagen)	T2	SP
<i>didanosine</i>	T2	SP
<i>emtricitabine</i> (Emtriva)	T2	SP
EMTRIVA 10 MG/ML SOLUTION	T5	SP
EMTRIVA 200 MG CAPSULE (<i>emtricitabine</i>)	T6	SP
EPIVIR (<i>lamivudine</i>)	T6	SP
<i>lamivudine</i> (EpiVir)	T2	SP
RETROVIR (<i>zidovudine</i>)	T6	SP
<i>stavudine</i>	T2	SP
<i>tenofovir disoproxil fumarate</i> (Viread)	T2	SP
VIREAD 150 MG TABLET	T5	SP
VIREAD 200 MG TABLET	T5	SP
VIREAD 250 MG TABLET	T5	SP
VIREAD 300 MG TABLET (<i>tenofovir disoproxil fumarate</i>)	T6	SP
VIREAD POWDER	T5	SP
ZIAGEN (<i>abacavir sulfate</i>)	T6	SP
<i>zidovudine</i>	T2	SP
<i>zidovudine</i> (Retrovir)	T2	SP
ANTIVIRALS, HIV-SPECIFIC, PROTEASE INHIBITOR COMB		
<i>lopinavir/ritonavir</i>	T2	SP
<i>lopinavir/ritonavir</i> (Kaletra)	T2	SP
KALETRA	T6	SP
KALETRA (<i>lopinavir/ritonavir</i>)	T6	SP
ANTIVIRALS, HIV-SPECIFIC, PROTEASE INHIBITORS		
<i>abacavir sulfate</i>	T2	SP
<i>atazanavir sulfate</i> (Reyataz)	T2	SP
EVOTAZ	T6	SP
<i>fosamprenavir calcium</i>	T2	SP
NORVIR 100 MG POWDER PACKET	T5	SP
NORVIR 100 MG TABLET (<i>ritonavir</i>)	T6	SP
REYATAZ 150 MG CAPSULE (<i>atazanavir sulfate</i>)	T6	SP
REYATAZ 200 MG CAPSULE (<i>atazanavir sulfate</i>)	T6	SP
REYATAZ 300 MG CAPSULE (<i>atazanavir sulfate</i>)	T6	SP

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List of Prescription Medications

ANTIVIRALS (AIDS/HIV) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ANTIVIRALS, HIV-SPECIFIC, PROTEASE INHIBITORS (cont.)		
REYATAZ 50 MG POWDER PACKET	T5	SP
<i>ritonavir</i> (Norvir)	T2	SP
VIRACEPT	T5	SP
ANTIVIRALS, HIV-I INTEGRASE STRAND TRANSFER INHIBTR		
APRETUDE	T5	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>	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> (Complera)	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	
ANTIVIRALS (Infections)		
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	T3	PPACA
ENFLONSLIA	T3	PPACA

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T3 – Preferred Brands
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List of Prescription Medications

ANTIVIRALS (Infections) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
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	T6	PA QL(112 tabs/28 days) SP
<i>oseltamivir 6 mg/ml suspension (Tamiflu)</i>	T2	QL(180 mls/fill)
<i>oseltamivir phos 30 mg capsule (Tamiflu)</i>	T2	QL(20 caps/fill)
<i>oseltamivir phos 45 mg capsule (Tamiflu)</i>	T2	QL(10 caps/fill)
<i>oseltamivir phos 75 mg capsule (Tamiflu)</i>	T2	QL(10 caps/fill)
PREVYMIS 120 MG PELLET PACKET	T5	SP
PREVYMIS 20 MG PELLET 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 6 MG/ML SUSPENSION (<i>oseltamivir phosphate</i>)	T4	QL(180 mls/fill)
TAMIFLU 75 MG CAPSULE (<i>oseltamivir phosphate</i>)	T4	QL(10 caps/fill)
<i>valacyclovir hcl (Valtrex)</i>	T2	QL(30 tabs/fill)
VALCYTE (<i>valganciclovir hcl</i>)	T4	
<i>valganciclovir hcl (Valcyte)</i>	T2	
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

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

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

ST – Step Therapy
AGE – Age Requirement
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List of Prescription Medications

ANTIVIRALS (Infections) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
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	
<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)

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

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

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List of Prescription Medications

AUTONOMIC DRUGS (Allergy/Nasal Sprays) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ANAPHYLAXIS THERAPY AGENTS (cont.)		
<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)
EPINEPHRINE 0.3 MG/0.3 ML SYR	T4	QL (2 syringes/30 days)
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)
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 BR 30 MG TABLET	T4	HD
<i>pyridostigmine br 60 mg tablet</i> (Mestinon)	T2	HD
PYRIDOSTIGMINE ER 105 MG TABLET	T4	
<i>pyridostigmine er 180 mg tab</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

AUTONOMIC DRUGS (Attention Deficit Hyperactivity Disorder)⁹

ADRENERGICS, AROMATIC, NON-CATECHOLAMINE		
ADZENYS XR-ODT	T4	ST
<i>amphetamine sulfate</i> (Evekeo)	T2	
DESOXYN (<i>methamphetamine hcl</i>)	T4	

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

T5 – Preferred Specialty
T6 – Non-Preferred Specialty
PA – Prior Authorization
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List of Prescription Medications

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

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ADRENERGICS, AROMATIC, NON-CATECHOLAMINE (cont.)		
DEXEDRINE (<i>dextroamphetamine sulfate</i>)	T4	ST
<i>dextroamphetamine sulfate</i>	T2	
<i>dextroamphetamine sulfate</i> (Dexedrine)	T2	
<i>dextroamphetamine sulfate</i> (Zenzedi)	T2	
<i>dextroamphetamine/amphetamine</i> (Adderall Xr)	T2	
<i>dextroamphetamine/amphetamine</i> (Adderall)	T2	
<i>dextroamphetamine/amphetamine</i> (Mydayis)	T2	
EVEKEO ODT	T4	
<i>methamphetamine hcl</i> (Desoxyn)	T2	
MYDAYIS (<i>dextroamphetamine/amphetamine</i>)	T4	ST
ZENZEDI 2.5 MG TABLET	T4	
<i>zenzedi 5 mg tablet</i>	T2	
ZENZEDI 7.5 MG TABLET (<i>dextroamphetamine sulfate</i>)	T4	
<i>zenzedi 10 mg tablet</i>	T2	
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
SALAGEN (<i>pilocarpine hcl</i>)	T4	HD
URECHOLINE (<i>bethanechol chloride</i>)	T4	HD

T1 – Preferred Generics

T2 – Non-Preferred Generics

T3 – Preferred Brands

T4 – Non-Preferred Brands

T5 – Preferred Specialty

T6 – Non-Preferred Specialty

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BIOLOGICALS (Allergy/Nasal Sprays)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ALLERGENIC EXTRACTS, THERAPEUTIC		
GRASTEK	T3	PA
ODACTRA	T3	PA
ORALAIR	T3	PA
RAGWITEK	T3	PA
BIOLOGICALS (Blood Pressure/Heart Medications)		
PLASMA KALLIKREIN INHIBITORS		
TAKHZYRO	T4	PA SP HD
BIOLOGICALS (Miscellaneous)		
PKU TREATMENT AGENTS - PHENYLALANINE AMMONIA LYASE		
PALYNZIQ 10 MG/0.5 ML SYRINGE	T5	PA QL (30 syringes/fill) SP HD
PALYNZIQ 2.5 MG/0.5 ML SYRINGE	T5	PA QL (8 syringes/fill) SP HD
PALYNZIQ 20 MG/ML SYRINGE	T5	PA QL (60 syringes/fill) SP HD
BIOLOGICALS (Vaccines)		
COVID-19 VACCINES		
COMIRNATY	T3	PPACA
JANSSEN COVID-19 VACCINE (EUA)	T3	PPACA
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 VACC	T3	PPACA
ENTERIC VIRUS VACCINES		
IPOL	T3	PPACA
ROTARIX	T4	HD PPACA
ROTATEQ	T3	PPACA

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

T5 – Preferred Specialty
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List of Prescription Medications

BIOLOGICALS (Vaccines) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
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		
AFLURIA	T3	PPACA
AFLURIA QUAD	T3	PPACA
AFLURIA TRIV	T3	PPACA
AFLURIA TRIVALENT	T3	PPACA
AUDENZ (NATIONAL STOCKPILE)	T3	
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
FLULAVAL	T3	PPACA
FLULAVAL QUAD	T3	PPACA
FLULAVAL TRIVALENT	T3	PPACA

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QL – Quantity Limit

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List of Prescription Medications

BIOLOGICALS (Vaccines) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
INFLUENZA VIRUS VACCINES (cont.)		
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 QUAD	T3	PPACA
FLUZONE QUAD PEDI	T3	PPACA
FLUZONE TRIVALENT	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
TDVAX	T3	PPACA
TENIVAC	T3	PPACA
VAXELIS	T3	PPACA

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List of Prescription Medications

BIOLOGICALS (Vaccines) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
VIRAL/TUMORIGENIC VACCINES		
ABRYVO	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
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>)	T6	SP
<i>tranexamic acid</i> (Lysteda)	T2	SP
COMPLEMENT INHIBITORS		
EMPAVELI	T5	PA SP
FABHALTA	T5	PA SP
TAVNEOS	T6	PA QL (180 caps/30 days) SP
VOYDEYA	T5	PA SP
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	T6	PA QL (56 tabs/28 days) SP

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List of Prescription Medications

BLOOD (Blood Modifiers/Bleeding Disorders) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
PYRUVATE KINASE ACTIVATORS (cont.)		
PYRUKYND 20-5 MG TAPER PACK	T6	PA QL(14 tabs/365 days) SP
PYRUKYND 5 MG , 50 MG TABLET	T6	PA QL(56 tabs/28 days) SP
PYRUKYND 5 MG TAPER PACK	T6	PA QL(7 tabs/365 days) SP
PYRUKYND 50-20 MG TAPER PACK	T6	PA QL(14 tabs/365 days) SP
SICKLE CELL ANEMIA AGENTS		
<i>glutamine</i> (Endari)	T2	PA
DROXIA	T3	
ENDARI (<i>glutamine</i>)	T4	PA
OXBRYTA	T6	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, 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	
THROMBIN-JMI	T4	
THROMBI-PAD	T4	
ULTRAFOAM	T4	
VISTASEAL FIBRIN SEALANT	T4	
BLOOD (Blood Thinners/Anti-Clotting)		
HEMORRHEOLOGIC AGENTS		
<i>pentoxifylline</i>	T2	HD

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List of Prescription Medications

CARDIAC DRUGS (Blood Pressure/Heart Medications)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
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
<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

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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>nimodipine 30 mg capsule</i>	T2	HD
<i>nimodipine 60 mg/20 ml soln</i>	T2	
<i>nisoldipine</i>	T2	HD
<i>nisoldipine (Sular)</i>	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 (Calan Sr)</i>	T1	HD
<i>verapamil hcl (Verelan Pm)</i>	T2	ST HD
<i>verapamil hcl (Verelan)</i>	T2	HD
VERELAN (<i>verapamil hcl</i>)	T4	ST HD
VERELAN PM (<i>verapamil hcl</i>)	T4	ST HD
CARDIAC MYOSIN INHIBITOR		
CAMZYOS	T5	PA QL(30 caps/fill) SP HD
DIGITALIS GLYCOSIDES		
<i>digoxin</i>	T2	HD
<i>digoxin (Lanoxin)</i>	T2	HD
LANOXIN	T4	HD
LANOXIN (<i>digoxin</i>)	T4	HD
HEART RATE REDUCING,SA SELECTIVE I(F) CURRENT INH.		
<i>ivabradine hcl (Corlanor)</i>	T2	PA HD
SOLUBLE GUANYLATE CYCLASE (SGC) STIMULATOR		
VERQUVO	T3	QL(30 tabs/fill)
VASODILATORS, CORONARY		
GONITRO	T4	HD
ISORDIL (<i>isosorbide dinitrate</i>)	T4	HD
ISORDIL TITRADOSE (<i>isosorbide dinitrate</i>)	T4	HD
<i>isosorbide dinitrate</i>	T2	HD
<i>isosorbide dinitrate (Isordil Titradose)</i>	T2	HD
<i>isosorbide dinitrate (Isordil)</i>	T2	HD
<i>isosorbide mononitrate</i>	T1	HD

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List of Prescription Medications

CARDIAC DRUGS (Blood Pressure/Heart Medications) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
VASODILATORS, CORONARY (cont.)		
NITRO-DUR	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>)	T6	PA QL(112 mls/fill) SP HD
REVATIO 20 MG TABLET (<i>sildenafil citrate</i>)	T6	PA QL(90 tabs/fill) SP HD
<i>sildenafil 20 mg tablet</i> (Revatio)	T2	PA QL(90 tabs/fill) SP HD
<i>tadalafil 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 125 mg tablet</i> (Tracleer)	T2	PA QL (60 tabs/30 days) 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
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>)	T6	PA QL(60 tabs/fill) SP HD
TRACLEER 125 MG TABLET (<i>bosentan</i>)	T6	PA QL(60 tabs/fill) SP HD
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	T6	PA QL (168 tabs/28 days) SP
ORENITRAM TITRATION KT MONTH 2	T6	PA QL (336 tabs/28 days) SP
ORENITRAM TITRATION KT MONTH 3	T6	PA QL (252 tabs/28 days) SP
ORENITRAM ER	T6	PA QL(90 tabs/fill) SP HD

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List of Prescription Medications

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

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
PULMONARY ANTIHYPERTENSIVES, PROSTACYCLIN-TYPE (cont.)		
TYVASO	T5	PA SP HD
TYVASO DPI	T5	PA SP HD
TYVASO INSTITUTIONAL START KIT	T5	PA SP HD
TYVASO REFILL KIT	T5	PA SP HD
TYVASO STARTER KIT	T5	PA SP HD
UPTRAVI 1,000 MCG TABLET	T5	PA QL(60 tabs/fill) SP HD
UPTRAVI 1,200 MCG TABLET	T5	PA QL(60 tabs/fill) SP HD
UPTRAVI 1,400 MCG TABLET	T5	PA QL(60 tabs/fill) SP HD
UPTRAVI 1,600 MCG TABLET	T5	PA QL(60 tabs/fill) SP HD
UPTRAVI 200 MCG TABLET	T5	PA QL(60 tabs/fill) SP HD
UPTRAVI 400 MCG TABLET	T5	PA QL(60 tabs/fill) SP HD
UPTRAVI 600 MCG TABLET	T5	PA QL(60 tabs/fill) SP HD
UPTRAVI 800 MCG TABLET	T5	PA QL(60 tabs/fill) SP HD
VENTAVIS	T6	PA SP HD
YUTREPIA	T5	PA SP HD

PULMONARY HTN-ENDOTHELIN RECEPT ANTG-CGMP PDE5 INH

OPSYNVI	T5	PA QL (30 tabs/fill) SP HD
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CARDIOVASCULAR (Blood Pressure/Heart Medications)

ACE INHIBITOR-CALCIUM CHANNEL BLOCKER COMBINATION

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

ACE INHIBITOR-THIAZIDE OR THIAZIDE-LIKE DIURETIC

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

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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.)		
VASERETIC (<i>enalapril/hydrochlorothiazide</i>)	T4	HD
ZESTORETIC (<i>lisinopril/hydrochlorothiazide</i>)	T4	HD
ALPHA/BETA-ADRENERGIC BLOCKING AGENTS		
carvedilol (Coreg)	T1	HD
carvedilol phosphate (Coreg Cr)	T2	HD
COREG CR (<i>carvedilol phosphate</i>)	T4	ST HD
labetalol hcl 100 mg tablet	T2	HD
labetalol hcl 200 mg tablet	T2	HD
labetalol hcl 300 mg tablet	T2	HD
ALPHA-ADRENERGIC BLOCKING AGENTS		
CARDURA 1 MG TABLET (<i>doxazosin mesylate</i>)	T4	ST QL (30 tabs/fill) HD
CARDURA 2 MG TABLET (<i>doxazosin mesylate</i>)	T4	ST QL (30 tabs/fill) HD
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
doxazosin mesylate 1 mg tab (Cardura)	T1	QL (30 tabs/fill) HD
doxazosin mesylate 2 mg tab (Cardura)	T1	QL (30 tabs/fill) HD
doxazosin mesylate 4 mg tab (Cardura)	T1	QL (30 tabs/fill) HD
doxazosin mesylate 8 mg tab (Cardura)	T1	QL (60 tabs/fill) HD
MINIPRESS (<i>prazosin hcl</i>)	T4	HD
prazosin hcl	T2	HD
prazosin hcl (Minipress)	T2	HD
terazosin 1 mg capsule	T1	QL (30 caps/fill) HD
terazosin 10 mg capsule	T1	QL (60 caps/fill) HD
terazosin 2 mg capsule	T1	QL (30 caps/fill) HD
terazosin 5 mg capsule	T1	QL (30 caps/fill) HD
ANGIOTEN.RECEPTR ANTAG-CALCIUM CHANL BLKR-THIAZIDE		
amlodipine/valsartan/hcthiazid (Exforge Hct)	T2	HD
olmesartan/amlodipin/hcthiazid (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
sacubitril/valsartan (Entresto)	T2	QL (60 tabs/30 days) HD

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

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

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

List of Prescription Medications

CARDIOVASCULAR (Blood Pressure/Heart Medications) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ANTIHYPERTENSIVES, ANGIOTENSIN RECEPTOR ANTAGONIST (cont.)		
<i>losartan potassium (Cozaar)</i>	T1	HD
<i>olmesartan medoxomil (Benicar)</i>	T1	HD
<i>telmisartan</i>	T2	HD
<i>telmisartan (Micardis)</i>	T2	HD
<i>valsartan 20 mg/5 ml solution</i>	T2	HD
<i>valsartan 160 mg tablet (Diovan)</i>	T1	HD
<i>valsartan 320 mg tablet (Diovan)</i>	T1	HD
<i>valsartan 40 mg tablet (Diovan)</i>	T1	HD
<i>valsartan 80 mg tablet (Diovan)</i>	T1	HD
ANTIHYPERTENSIVES, GANGLIONIC BLOCKERS		
VECAMYL	T4	PA
ANTIHYPERTENSIVES, MISCELLANEOUS		
DEMSER (<i>metirosine</i>)	T4	PA HD
<i>metirosine (Demser)</i>	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 (Catapres-Tts 1)</i>	T2	QL(4 patches/28 days) HD
<i>clonidine (Catapres-Tts 2)</i>	T2	QL(4 patches/28 days) HD
<i>clonidine (Catapres-Tts 3)</i>	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 (Tenormin)</i>	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 10 mg tab</i>	T2	HD

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List of Prescription Medications

CARDIOVASCULAR (Blood Pressure/Heart Medications) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
BETA-ADRENERGIC BLOCKING AGENTS (cont.)		
<i>bisoprolol fumarate 5 mg tab</i>	T2	HD
HEMANGEOL	T3	PA
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 10 mg tablet</i>	T2	HD
<i>timolol maleate 20 mg tablet</i>	T2	HD
<i>timolol maleate 5 mg tablet</i>	T2	HD
BETA-BLOCKERS AND THIAZIDE, THIAZIDE-LIKE DIURETICS		
atenolol/chlorthalidone (Tenoretic 100)	T2	HD
atenolol/chlorthalidone (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		
TEKTRUNA HCT	T3	HD
VASODILATORS, COMBINATION		
<i>isosorbide dinit/hydralazine</i> (Bidil)	T2	HD

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List of Prescription Medications

CARDIOVASCULAR (Blood Pressure/Heart Medications) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
VASODILATORS, PERIPHERAL		
<i>ergoloid mesylates</i>	T2	
<i>isoxsuprine hcl</i>	T2	
CARDIOVASCULAR (Cholesterol Medications)		
ANTHYPERLIP.HMG COA REDUCT INHIB-CHOLEST.AB.INHIB		
<i>ezetimibe-atorvastatin tabs</i>	T2	ST QL (30 tabs/30 days) HD
<i>ezetimibe/simvastatin (Vytorin)</i>	T2	QL(30 tabs/fill) HD
ROSZET	T4	ST QL (30 tabs/fill) HD
ANTHYPERLIPID- 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
ANTHYPERLIPIDEMIC - APOLIPOPROTEIN INHIBITOR		
TRYNGOLZA	T6	PA SP
ANTHYPERLIPIDEMIC - ATP CITRATE LYASE INHIBITOR		
NEXLETOL	T3	PA
ANTHYPERLIPIDEMIC - MTP INHIBITOR		
JUXTAPID	T5	PA SP HD
ANTHYPERLIPIDEMIC - PCSK9 INHIBITORS		
REPATHA PUSHTRONEX	T3	PA
REPATHA SURECLICK	T3	PA
REPATHA SYRINGE	T3	PA
ANTHYPERLIPIDEMIC-ACLY AND CHOLEST ABSORP INHIB		
NEXLIZET	T3	PA
ANTHYPERLIPIDEMIC-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 tablet</i>	T2	QL(60 tabs/fill) HD PPACA
<i>lovastatin 40 mg tablet</i>	T2	QL(60 tabs/fill) HD PPACA
<i>pitavastatin (Livalo)</i>	T2	QL(30 tabs/30 days) HD PPACA
<i>pravastatin sodium</i>	T2	QL(30 tabs/fill) HD PPACA

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

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

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

HD – May require home delivery pharmacy
PPACA – No Cost-Share Preventive Medication
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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 5 mg tablet</i>	T1	QL(30 tabs/fill) HD PPACA
<i>simvastatin 10 mg tablet (Zocor)</i>	T1	QL(30 tabs/fill) HD PPACA
<i>simvastatin 20 mg tablet (Zocor)</i>	T1	QL(30 tabs/fill) HD PPACA
SIMVASTATIN 20 MG/5 ML SUSP	T4	ST QL(150 mls/fill) HD
<i>simvastatin 40 mg tablet (Zocor)</i>	T1	QL(30 tabs/fill) HD PPACA
<i>simvastatin 80 mg tablet (Zocor)</i>	T1	QL(30 tabs/fill) HD
ZYPITAMAG	T4	ST QL(30 tabs/fill) HD
BILE SALT SEQUESTRANTS		
<i>cholestyramine</i>	T2	HD
<i>cholestyramine (with sugar) (Questran)</i>	T2	HD
<i>cholestyramine/aspartame</i>	T2	HD
<i>cholestyramine (Questran Light)</i>	T2	HD
<i>colesevelam hcl (Welchol)</i>	T2	HD
COLESTID	T4	ST HD
COLESTID (<i>colestipol hcl</i>)	T4	ST HD
<i>colestipol hcl</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 120 mg tablet (Fenoglide)</i>	T2	ST HD
<i>fenofibrate 130 mg capsule</i>	T2	ST HD
<i>fenofibrate 134 mg capsule</i>	T2	HD
<i>fenofibrate 145 mg tablet (Tricor)</i>	T2	HD
<i>fenofibrate 160 mg tablet</i>	T2	HD
<i>fenofibrate 200 mg capsule</i>	T2	HD
<i>fenofibrate 40 mg tablet (Fenoglide)</i>	T2	ST HD
<i>fenofibrate 43 mg capsule</i>	T2	HD
<i>fenofibrate 48 mg tablet (Tricor)</i>	T2	HD
<i>fenofibrate 54 mg tablet</i>	T2	HD
<i>fenofibrate 67 mg capsule</i>	T2	HD
<i>fenofibric acid</i>	T2	HD
<i>fenofibric acid (choline)</i>	T2	HD

T1 – Preferred Generics

T2 – Non-Preferred Generics

T3 – Preferred Brands

T4 – Non-Preferred Brands

T5 – Preferred Specialty

T6 – Non-Preferred Specialty

PA – Prior Authorization

QL – Quantity Limit

ST – Step Therapy

AGE – Age Requirement

SP – Specialty Medication

HD – May require home delivery pharmacy

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List of Prescription Medications

CARDIOVASCULAR (Cholesterol Medications) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
LIPOTROPICS (cont.)		
<i>fenofibric acid</i> (Fibricor)	T2	HD
FENOGLIDE (<i>fenofibrate</i>)	T4	ST HD
FIBRICOR (<i>fenofibric acid</i>)	T4	ST HD
<i>gemfibrozil</i> (Lopid)	T1	HD
LOPID (<i>gemfibrozil</i>)	T4	HD
<i>niacin</i>	T2	HD
<i>niacin 500 mg tablet</i>	T2	HD
NIACOR	T4	HD
CARDIOVASCULAR (Miscellaneous)		
ENDOTHELIN-ANGIOTENSIN RECEPTOR ANTAGONIST		
FILSPARI	T5	PA QL (30 tabs/30 days) SP
CNS DRUGS (Alzheimer's Disease)		
ALZHEIMER'S THERAPY, NMDA RECEPTOR ANTAGONISTS		
MEMANTINE 5-10 MG TITRATION PK	T4	HD
<i>memantine hcl 10 mg/5 ml cup</i>	T2	HD
<i>memantine hcl</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	ST 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>)	T6	PA SP HD
<i>riluzole</i> (Rilutek)	T2	PA SP HD
TEGLUTIK	T6	PA SP
TIGLUTIK	T6	PA SP

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

T5 – Preferred Specialty
T6 – Non-Preferred Specialty
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QL – Quantity Limit

ST – Step Therapy
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List of Prescription Medications

CNS DRUGS (Miscellaneous) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
DRUGS TO TREAT MOVEMENT DISORDERS		
AUSTEDO 6 MG TABLET	T6	PA QL (60 tabs/30 days) SP HD
AUSTEDO 9 MG TABLET	T6	PA QL (120 tabs/30 days) SP HD
AUSTEDO 12 MG TABLET	T6	PA QL (120 tabs/30 days) SP HD
AUSTEDO XR 6 MG TABLET	T6	PA QL (210 tabs/30 days) SP HD
AUSTEDO XR 12 MG TABLET	T6	PA QL (90 tabs/30 days) SP HD
AUSTEDO XR 18 MG TABLET	T6	PA QL (30 tabs/fill) SP HD
AUSTEDO XR 24 MG TABLET	T6	PA QL (60 tabs/30 days) SP HD
AUSTEDO XR 30 MG TABLET	T6	PA QL (30 tabs/fill) SP HD
AUSTEDO XR 36 MG TABLET	T6	PA QL (30 tabs/fill) SP HD
AUSTEDO XR 42 MG TABLET	T6	PA QL (30 tabs/fill) SP HD
AUSTEDO XR 48 MG TABLET	T6	PA QL (30 tabs/fill) SP HD
AUSTEDO XR TITRATION KT(WK1–4)	T6	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
INGREZZA SPRINKLE	T5	PA QL (30 caps/fill) SP
tetrabenazine 12.5 mg tablet (Xenazine)	T2	
tetrabenazine 25 mg tablet (Xenazine)	T2	
PSEUDOBULBAR AFFECT (PBA) AGENTS, NMDA ANTAGONISTS		
NUDEXTA	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	T6	PA QL(10 tabs/fill) SP HD

T1 – Preferred Generics

T2 – Non-Preferred Generics

T3 – Preferred Brands

T4 – Non-Preferred Brands

T5 – Preferred Specialty

T6 – Non-Preferred Specialty

PA – Prior Authorization

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AGE – Age Requirement

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List of Prescription Medications

CNS DRUGS (Multiple Sclerosis) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
AGENTS TO TREAT MULTIPLE SCLEROSIS (cont.)		
MAVENCLAD 10 MG X 4 TABLET PK	T6	PA QL(4 tabs/fill) SP HD
MAVENCLAD 10 MG X 5 TABLET PK	T6	PA QL(5 tabs/fill) SP HD
MAVENCLAD 10 MG X 6 TABLET PK	T6	PA QL(6 tabs/fill) SP HD
MAVENCLAD 10 MG X 7 TABLET PK	T6	PA QL(7 tabs/fill) SP HD
MAVENCLAD 10 MG X 8 TABLET PK	T6	PA QL(8 tabs/fill) SP HD
MAVENCLAD 10 MG X 9 TABLET PK	T6	PA QL(9 tabs/fill) SP HD
MAYZENT 0.25 MG TABLET	T5	PA QL(30 tabs/fill) SP HD
MAYZENT 0.25MG START-1MG MAINT	T5	PA QL(7 tabs/fill) SP HD
MAYZENT 0.25MG START-2MG MAINT	T5	PA QL(12 tabs/fill) SP HD
MAYZENT 1 MG, 2 MG TABLET	T5	PA QL(30 tabs/fill) SP HD
PLEGRIDY 125 MCG/0.5 ML PEN	T5	PA QL(1 ml/28 days SP HD
PLEGRIDY 125 MCG/0.5 ML SYRINGE	T5	PA QL(1 ml/28 days SP HD
PLEGRIDY PEN INJ STARTER PACK	T5	PA QL(1 ml/365 days SP HD
PLEGRIDY SYRINGE STARTER PACK	T5	PA QL(1 ml/365 days SP HD
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

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

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

ST – Step Therapy
AGE – Age Requirement
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List of Prescription Medications

CNS DRUGS (Pain Relief And Inflammatory Disease) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
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POSTHERPETIC NEURALGIA AGENTS (cont.)

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
DIASAT (<i>diazepam</i>)	T4	HD
<i>diazepam</i> 10 mg rectal gel syrg	T2	HD
<i>diazepam</i> 10mg rectal gel (2pk)	T2	HD
<i>diazepam</i> 2.5mg rectal gel(2pk) (Diasat)	T2	HD
<i>diazepam</i> 20 mg rectal gel syrg	T2	HD
<i>diazepam</i> 20mg rectal gel (2pk)	T2	HD
NAYZILAM	T3	PA QL(2 units/fill) HD
SYMPAZAN	T4	PA HD
VALTOCO	T3	PA QL (2 units/30 days) HD

ANTICONSULSANT - CANNABINOID TYPE

EPIDIOLEX	T5	PA SP HD
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ANTICONSULSANTS

APTOM (<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</i> 100 mg tab chew	T2	HD
<i>carbamazepine</i> 100 mg/5 ml cup	T2	HD
<i>carbamazepine</i> 100 mg/5 ml susp (Tegretol)	T2	HD
<i>carbamazepine</i> 200 mg tablet (Tegretol)	T2	HD

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

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

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

HD – May require home delivery pharmacy
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List of Prescription Medications

CNS DRUGS (Seizure Disorders) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ANTICONVULSANTS (cont.)		
<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
<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

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List of Prescription Medications

CNS DRUGS (Seizure Disorders) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ANTICONVULSANTS (cont.)		
<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> 100 mg/ml soln (Keppra)	T2	HD
<i>levetiracetam</i> 500 mg/5 ml soln	T2	HD
LEVETIRACETAM 250 MG TAB SUSP	T4	ST HD
<i>levetiracetam</i> 250 mg tablet (Keppra)	T2	HD
<i>levetiracetam</i> 500 mg tablet (Keppra)	T2	HD
<i>levetiracetam</i> 750 mg tablet (Keppra)	T2	HD
<i>levetiracetam</i> 1,000 mg tablet (Keppra)	T2	HD
<i>topiramate</i> 100 mg tablet (Topamax)	T1	HD
MYSOLINE (<i>primidone</i>)	T4	HD
<i>oxcarbazepine</i> (Oxtellar Xr)	T2	HD
<i>oxcarbazepine</i> (Trileptal)	T2	HD
OXTELLAR XR (<i>oxcarbazepine</i>)	T4	ST HD
<i>perampanel</i> (Fycompa)	T2	HD
PHENYTEK (<i>phenytoin sodium extended</i>)	T4	HD
<i>phenytoin</i>	T2	HD
<i>phenytoin</i> (Dilantin)	T2	HD
<i>phenytoin</i> (Dilantin-125)	T2	HD
<i>phenytoin sodium extended</i> (Dilantin)	T2	HD
<i>phenytoin sodium extended</i> (Phenytek)	T2	HD
<i>pregabalin</i> (Lyrica)	T2	HD
QUDEXY XR (<i>topiramate</i>)	T4	ST HD
<i>rufinamide</i> (Banzel)	T2	PA HD
SPRITAM	T4	ST HD
TEGRETOL (<i>carbamazepine</i>)	T4	HD
TEGRETOL XR (<i>carbamazepine</i>)	T4	HD

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List of Prescription Medications

CNS DRUGS (Seizure Disorders) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ANTICONVULSANTS (cont.)		
<i>tiagabine hcl</i>	T2	HD
<i>topiramate</i> (Qudexy Xr)	T2	ST HD
<i>topiramate</i> (Topamax)	T1	HD
<i>topiramate</i> (Topamax)	T2	HD
<i>topiramate 15 mg sprinkle cap</i> (Topamax)	T2	HD
<i>topiramate 25 mg sprinkle cap</i> (Topamax)	T2	HD
<i>topiramate 50 mg sprinkle cap</i>	T2	HD
<i>topiramate 25 mg/ml solution</i> (Eprontia)	T2	HD
<i>topiramate 25 mg tablet</i> (Topamax)	T1	HD
<i>topiramate 50 mg tablet</i> (Topamax)	T1	HD
<i>topiramate 200 mg tablet</i> (Topamax)	T1	HD
<i>topiramate er</i> (Trokendi XR)	T2	ST HD
TROKENDI XR	T4	ST HD
<i>valproic acid</i>	T2	HD
<i>valproic acid</i> (as sodium salt)	T2	HD
<i>vigabatrin</i> (Sabril)	T2	PA QL(150 packs/30 days) SP HD
VIGADRONE	T2	PA SP HD QL (150 pkts/30 days)
XCOPRI 25 MG TABLET	T4	QL (30 tabs/fill) HD
XCOPRI 100 MG TABLET	T4	QL(30 tabs/fill) HD
XCOPRI 150 MG TABLET	T4	QL(30 tabs/fill) HD
XCOPRI 12.5–25 MG TITRATION PK	T4	QL(28 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
XCOPRI 50 MG TABLET	T4	QL(30 tabs/fill) HD
XCOPRI 50–100 MG TITRATION PAK	T4	QL(28 tabs/fill) HD
ZARONTIN (<i>ethosuximide</i>)	T4	HD
<i>zonisamide</i>	T2	HD
<i>zonisamide</i> (Zonegran)	T2	HD
NARCOLEPSY TX-H3-RECEPT.ANTAGONIST/INVERSE AGONIST		
WAKIX 17.8 MG TABLET	T6	PA QL(60 tabs/fill) SP HD
WAKIX 4.45 MG TABLET	T6	PA QL(30 tabs/fill) SP HD

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List of Prescription Medications

COLONY STIMULATING FACTORS (Blood Modifiers/Bleeding Disorders)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
LEUKOCYTE (WBC) STIMULANTS		
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>)	T6	PA SP HD
COLONY STIMULATING FACTORS (Cancer)		
CXCR4 CHEMOKINE RECEPTOR ANTAGONIST		
XOLREMDI	T6	PA SP CSL
CONTRACEPTIVES (Contraception Products)		
CONTRACEPTIVES, INTRAVAGINAL, SYSTEMIC		
ANNOVERA	T4	ST QL(1 ring/365 days) PPACA
<i>etonogestrel/ethinyl estradiol</i> (Nuvaring)	T2	PPACA
CONTRACEPTIVES, INJECTABLE		
DEPO-PROVERA (<i>medroxyprogesterone acetate</i>)	T4	QL(1 ml/90 days) PPACA
DEPO-SUBQ PROVERA 104	T4	QL(1 ml/90 days) PPACA
<i>medroxyprogesterone 150 mg/ml</i> (Depo-Provera)	T2	QL(1 ml/90 days) PPACA
CONTRACEPTIVES, ORAL		
BEYAZ (<i>drospir/eth estra/levomefol ca</i>)	T4	ST HD PPACA
<i>desog-e.estradiol/e.estradiol</i>	T2	HD PPACA
<i>desog-e.estradiol/e.estradiol</i>	T2	PPACA
<i>desogestrel-ethinyl estradiol</i>	T2	HD PPACA
<i>drospir/eth estra/levomefol ca</i> (Beyaz)	T2	HD PPACA
<i>drospir/eth estra/levomefol ca</i> (Safyral)	T2	HD PPACA
ELLA	T3	QL(1 tab/fill) HD PPACA
<i>ethinyl estradiol/drospirenone</i> (Yasmin 28)	T2	PPACA
<i>ethinyl estradiol/drospirenone</i> (Yaz)	T2	HD PPACA
<i>ethynodiol d-ethinyl estradiol</i>	T2	HD PPACA
<i>levonorgestrel/ethin.estradiol</i>	T2	HD PPACA
<i>l-norgest/e.estradiol-e.estradiol</i>	T2	HD PPACA
<i>noreth-ethinyl estradiol/iron</i>	T2	HD PPACA
<i>noreth-ethinyl estradiol/iron</i> (Generess Fe)	T2	HD PPACA

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List of Prescription Medications

CONTRACEPTIVES (Contraception Products) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
CONTRACEPTIVES, ORAL		
<i>norethind-eth estrad 1-0.02 mg (Loestrin)</i>	T2	HD PPACA
<i>norethindrone</i>	T2	HD PPACA
<i>norethindrone ac/eth estradiol (Loestrin)</i>	T2	HD PPACA
<i>norethindrone-e.estradiol-iron</i>	T2	HD PPACA
<i>norethindrone-e.estradiol-iron (Loestrin Fe)</i>	T2	HD PPACA
<i>norethindrone-e.estradiol-iron (Taytulla)</i>	T2	HD PPACA
<i>norethindrone-ethin. estradiol</i>	T2	HD PPACA
<i>norethin-ee 1.5-0.03 mg(21) tb (Loestrin)</i>	T2	HD PPACA
<i>norgestimate-ethinyl estradiol</i>	T2	HD PPACA
NORGESTREL-ETHINYL ESTRADIOL	T2	HD PPACA
YAZ (<i>ethinyl estradiol/drospirenone</i>)	T4	ST HD PPACA
CONTRACEPTIVES, TRANSDERMAL		
<i>norelgestromin/ethin.estradiol</i>	T2	PPACA
INTRA-UTERINE DEVICES (IUDS)		
KYLEENA	T5	SP PPACA
LILETTA	T6	SP PPACA
MIRENA	T5	SP PPACA
SKYLA	T5	SP PPACA
COUGH/COLD PREPARATIONS (Allergy/Nasal Sprays)		
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 (Bromfed Dm)</i>	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	

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List of Prescription Medications

COUGH/COLD PREPARATIONS (Cough/Cold Medications) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
OPIOID ANTITUSSIV-IST GEN. ANTIHISTAMINE-DECONGEST (cont.)		
POLY-TUSSIN AC	T4	
<i>promethazine/phenyleph/codeine</i>	T2	
ZODRYL DAC 25	T4	
ZODRYL DAC 30	T4	
ZODRYL DAC 35	T4	
ZODRYL DAC 40	T4	
ZODRYL DAC 50	T4	
ZODRYL DAC 60	T4	
ZODRYL DAC 80	T4	
OPIOID ANTITUSSIVE-IST GENERATION ANTIHISTAMINE		
<i>hydrocodone/chlorphen p-stirex</i>	T2	
<i>promethazine hcl/codeine</i>	T2	
TUXARIN ER	T4	
TUZISTRA XR	T4	PA
ZODRYL AC 25	T4	
ZODRYL AC 30	T4	
ZODRYL AC 35	T4	
ZODRYL AC 40	T4	
ZODRYL AC 50	T4	
ZODRYL AC 60	T4	
ZODRYL AC 80	T4	
OPIOID ANTITUSSIVE-ANTICHOLINERGIC COMBINATIONS		
HYCODAN	T4	
HYCODAN (<i>hydrocodone bit/homatrop me-br</i>)	T4	
<i>hydrocodone bit/homatrop me-br</i>	T2	
<i>hydrocodone bit/homatrop me-br</i> (Hycodan)	T2	
OPIOID ANTITUSSIVE-DECONGESTANT-EXPECTORANT COMB		
CODITUSSIN DAC	T4	
ZODRYL DEC 25	T4	
ZODRYL DEC 30	T4	
ZODRYL DEC 35	T4	
ZODRYL DEC 40	T4	
ZODRYL DEC 50	T4	

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List of Prescription Medications

COUGH/COLD PREPARATIONS (Cough/Cold Medications) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
OPIOID ANTITUSSIVE-DECONGESTANT-EXPECTORANT COMB (cont.)		
ZODRYL DEC 60	T4	
ZODRYL DEC 80	T4	
OPIOID ANTITUSSIVE-EXPECTORANT COMBINATION		
<i>codeine phosphate/guaifenesin</i>	T2	
CODITUSSIN AC	T4	
GUAIFEN-CODEINE 100-10 MG/5 ML	T4	
<i>guaifen-codeine 100-10 mg/5 ml</i>	T2	
GUAIFEN-CODEINE 200-20 MG/10ML	T4	
MAR-COF CG	T4	
NINJACOF-XG	T4	
OBREDON	T4	PA
DIAGNOSTIC (Diabetes)		
BLOOD SUGAR DIAGNOSTICS		
FREESTYLE INSULINX	T3	
FREESTYLE INSULINX TEST STRIPS	T3	
FREESTYLE PRECISION NEO	T3	
FREESTYLE LITE TEST STRIP	T3	
FREESTYLE TEST STRIPS	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	

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List of Prescription Medications

DIAGNOSTIC (Miscellaneous) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
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 ophth 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	
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	

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DIAGNOSTIC (Miscellaneous) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
GASTROINTESTINAL RADIOPAQUE DIAGNOSTICS (cont.)		
VARIBARTHIN HONEY	T4	
VARIBARTHIN 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	
URINARY TRACT RADIOPAQUE DIAGNOSTICS		
KETONE CARE TEST STRIP	T3	
KETONE TEST STRIP	T3	
KETOSTIX REAGENT	T3	
TRUEPLUS KETONE TEST STRIP	T3	
URINE GLUCOSE/ACETONE TEST AIDS,STRIPS		
KETO-DIASTIX REAGENT	T3	
URINE MULTIPLE TEST AIDS		
CHEK-STIX	T3	
CHEMSTRIP	T3	
CHEMSTRIP 10 WITH SG	T3	
CHEMSTRIP 2 GP	T3	
CHEMSTRIP 50B	T3	
CHEMSTRIP 7	T3	
CHEMSTRIP 9	T3	
COMBISTIX REAGENT	T3	
HEMA-COMBISTIX	T3	
KETO-DIASTIX REAGENT	T3	
LABSTIX REAGENT	T3	

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DIAGNOSTIC (Miscellaneous) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
URINE MULTIPLE TEST AIDS (cont.)		
MULTISTIX	T3	
MULTISTIX 10 SG	T3	
MULTISTIX 5	T3	
MULTISTIX 7	T3	
MULTISTIX 8 SG	T3	
MULTISTIX 9	T3	
MULTISTIX 9 SG	T3	
URISTIX 4	T3	
URISTIX REAGENT	T3	
DIURETICS (Diuretics)		
ARGININE VASOPRESSIN (AVP) RECEPTOR ANTAGONISTS		
<i>tolvaptan 15 mg tablet (Samsca)</i>	T2	PA QL(30 tabs/fill) SP
<i>tolvaptan 30 mg tablet (Samsca)</i>	T2	PA QL(60 tabs/fill) SP
CARBONIC ANHYDRASE INHIBITORS		
<i>acetazolamide</i>	T2	HD
<i>methazolamide</i>	T2	HD
LOOP DIURETICS		
<i>bumetanide</i>	T2	HD
EDECIN (<i>ethacrynic acid</i>)	T4	ST
<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 RECEPTOR ANTAGONIST		
JYNARQUE 15 MG TABLET (<i>tolvaptan</i>)	T6	PA SP HD
JYNARQUE 15 MG-15 MG TABLET (<i>tolvaptan</i>)	T6	PA SP HD
JYNARQUE 30 MG TABLET (<i>tolvaptan</i>)	T6	PA SP HD
JYNARQUE 30 MG-15 MG TABLET (<i>tolvaptan</i>)	T6	PA SP HD
JYNARQUE 45 MG-15 MG TABLET (<i>tolvaptan</i>)	T6	PA SP HD
JYNARQUE 60 MG-30 MG TABLET (<i>tolvaptan</i>)	T6	PA SP HD
JYNARQUE 90 MG-30 MG TABLET (<i>tolvaptan</i>)	T6	PA SP HD
<i>tolvaptan 15 mg tablet</i> (Jynarque)	T2	PA SP HD
<i>tolvaptan 15 mg-15 mg tablet</i> (Jynarque)	T2	PA SP HD

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PPACA – No Cost-Share Preventive Medication
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List of Prescription Medications

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

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

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

ST – Step Therapy
AGE – Age Requirement
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List of Prescription Medications

EENT PREPS (Allergy/Nasal Sprays) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
NASAL ANTIHISTAMINE (cont.)		
<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	
NOSE PREPARATIONS, VASOCONSTRICTORS (RX)		
ADRENALIN CHLORIDE	T4	
<i>epinephrine hcl</i>	T2	
EENT PREPS (Ear Medications)		
EAR PREPARATIONS ANTI-INFLAMMATORY		
DERMOTIC (<i>fluocinolone acetonide oil</i>)	T4	
<i>fluocinolone acetonide oil (Dermotic)</i>	T2	
EAR PREPARATIONS, MISC. ANTI-INFECTIVES		
<i>acetic acid</i>	T2	
CORTANE-B (<i>hydrocort/pramoxine/chloroxyl</i>)	T4	
<i>hydrocortisone/acetic acid</i>	T2	
EENT PREPS (Eye Conditions)		
AGENTS FOR CORNEAL COLLAGEN CROSS-LINKING		
PHOTREXA CROSS-LINKING	T4	
PHOTREXA VISCOUS	T4	

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

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List of Prescription Medications

EENT PREPS (Eye Conditions) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
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	
<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	

T1 – Preferred Generics

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List of Prescription Medications

EENT PREPS (Eye Conditions) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
EYE ANTI-INFLAMMATORY AGENTS (cont.)		
<i>prednisolone sod ph/bromfenac</i>	T2	
<i>prednisolone sodium phosphate</i>	T2	
PREDNISOLONE-BROMFENAC	T4	
PREDNISOLONE-NEPAFENAC	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	
EYE MAST CELL STABILIZERS		
ALOCRIAL	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
betaxolol hcl	T2	HD
BETOPTIC S	T4	HD
<i>bimatoprost</i>	T2	PA HD
BIMATOPROST-BRIMONIDINE-DORZOL	T4	HD

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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.)		
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 maleate</i> (Cosopt)	T2	HD
<i>dorzolamide/timolol/pf</i> (Cosopt Pf)	T2	HD
IOPIDINE	T4	ST HD
ISOPTO CARPINE (<i>pilocarpine hcl</i>)	T4	HD
LATANOPROST 0.005% EYE DROP	T4	HD
<i>latanoprost 0.005% eye drops</i> (Xalatan)	T2	PA HD
<i>levobunolol hcl</i>	T2	HD
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</i> (Isopto Carpine)	T2	HD
RHOPRESSA	T4	
ROCKLATAN	T4	PA
SIMBRINZA	T4	HD
<i>timolol</i> (Betimol)	T2	HD
TIMOLOL-BIMATOPROST	T4	HD
<i>timolol 0.25% gel-solution</i> (Timoptic-Xe)	T2	ST HD
<i>timolol 0.5% eye drop</i> (Istalol)	T2	ST HD
<i>timolol 0.5% gel-solution</i> (Timoptic-Xe)	T2	ST HD
<i>timolol 0.5% gfs gel-solution</i> (Timoptic-Xe)	T2	ST HD
<i>timolol maleate 0.25% eye drop</i>	T2	ST HD
<i>timolol maleate 0.25% eye drop</i> (Timoptic)	T1	HD

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List of Prescription Medications

EENT PREPS (Eye Conditions) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
MIOTICS AND OTHER INTRAOCULAR PRESSURE REDUCERS (cont.)		
<i>timolol maleate 0.5% eye drop</i> (Timoptic Ocudose)	T2	ST HD
<i>timolol maleate 0.5% eye drops</i> (Timoptic)	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</i> (Travatan Z)	T2	PA HD
MYDRIATICS		
<i>atropine 1% eye drop</i>	T2	PA SP HD
<i>atropine 1% eye ointment</i>	T2	HD
ATROPINE SULF 0.025% EYE DROP	T4	HD
<i>atropine sulf 0.025% eye drop</i>	T2	HD
<i>atropine sulfate 0.01% eye drp</i>	T2	PA SP HD
ATROPINE SULFATE 0.05% EYE DRP	T4	HD
ATROPINE SULFATE 0.01% EYE DRP	T4	HD
ATROPINE SULFATE-0.9% NACL	T4	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</i> (Cyclogyl)	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
TROPIC-CYCLOPENT-PE-KTRLC-PROP	T4	HD
<i>tropicamide</i>	T2	HD

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List of Prescription Medications

EENT PREPS (Eye Conditions) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
MYDRIATICS (cont.)		
<i>tropicamide</i> (Mydracyl)	T2	HD
TROPICAMIDE-CYCLOPENTOLATE-PE	T4	HD
TROPICAMIDE-CYCLOPENT-PE-KTRLC	T4	
<i>tropicamide 1%-phenylephr 2.5%</i>	T2	
TROPICAMIDE 1%-PHENYLEPHR 2.5%	T4	
OPHTH. VEGF-A RECEPTOR ANTAG. RCMB MC ANTIBODY		
LUCENTIS	T6	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</i> (Restasis)	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
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	T6	PA SP HD
ELECT/CALORIC/H2O (Dental Products)		
FLUORIDE PREPARATIONS		
CLINPRO 5000	T4	
FLORIVA	T4	

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

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List of Prescription Medications

ELECT/CALORIC/H2O (Dental Products) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
FLUORIDE PREPARATIONS (cont.)		
<i>fluoride (sodium)</i>	T2	
<i>fluoride (sodium)</i> (Prevident 5000 Plus)	T2	
<i>fluoride (sodium)</i> (Prevident)	T2	
FLUORIDEX	T4	
FLUORIDEX SENSITIVITY RELIEF	T4	
FRAICHE 5000 PREVI	T4	
JUSTRIGHT 5000	T4	
PREVIDENT	T4	
PREVIDENT (<i>fluoride (sodium)</i>)	T4	
PREVIDENT 5000 DRY MOUTH	T4	
PREVIDENT 5000 ENAMEL PROTECT	T4	
PREVIDENT 5000 ORTHO DEFENSE	T4	
PREVIDENT 5000 PLUS (<i>fluoride (sodium)</i>)	T4	
PREVIDENT 5000 SENSITIVE	T4	
PREVIDENT KIDS	T4	
<i>sodium fluoride 0.2% rinse</i> (Prevident)	T2	
<i>sodium fluoride 1.1% cream</i> (Prevident 5000 Plus)	T2	
<i>sodium fluoride 1.1% gel</i> (Prevident)	T2	
<i>sodium fluoride 5000 ppm cream</i> (Prevident 5000 Plus)	T2	
<i>sodium fluoride 5000 ppm paste</i>	T2	
<i>sodium fluoride/potassium nit</i>	T2	
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
ELECT/CALORIC/H2O (Diabetes)		
AGENTS TO TREAT HYPOGLYCEMIA (HYPERGLYCEMICS)		
<i>cvs glucose 4 gram tablet chew (Trueplus Glucose)</i>	T2	
CVS GLUCOSE LIQUID SHOT	T4	
DEX4 GLUCOSE 15 GM GEL PACKET	T4	
<i>dex4 glucose 4 gm tablet chew (Trueplus Glucose)</i>	T2	

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

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List of Prescription Medications

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

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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>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	
ELECTROLYTE DEPLETERS		
AURYXIA	T4	
<i>calcium acetate 667 mg capsule, gelcap, tablet</i>	T2	QL(360 caps/fill)
<i>lanthanum carbonate</i> (Fosrenol)	T2	QL(90 tabs/fill)
LOKELMA	T3	QL(30 packs/fill)
REVELA 0.8 GM POWDER PACKET (<i>sevelamer carbonate</i>)	T4	QL(180 packs/fill)
REVELA 2.4 GM POWDER PACKET (<i>sevelamer carbonate</i>)	T4	QL(90 packs/fill)
REVELA 800 MG TABLET (<i>sevelamer carbonate</i>)	T4	QL(270 tabs/fill)
<i>sodium polystyrene sulfon/sorb</i>	T2	
<i>sodium polystyrene sulfonate</i>	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)

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List of Prescription Medications

ELECT/CALORIC/H2O (Nutritional/Dietary) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ELECTROLYTE DEPLETERS (cont.)		
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 (fluoride (sodium))	T4	
PREVIDENT KIDS	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	
IODINE CONTAINING AGENTS		
potassium iodide	T2	
potassium iodide/iodine	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	

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ELECT/CALORIC/H2O (Nutritional/Dietary) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
IRON REPLACEMENT (cont.)		
<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>eqi iron 65 mg tablet</i>	T2	
<i>eqi slow release iron 45 mg tab</i>	T2	
<i>eqi 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	
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	
FERROUS FUMARATE 29 MG TAB	T4	
<i>ferrous fumarate 324 mg tab</i>	T2	
<i>ferrous fumarate/folic acid (Hemocyte-F)</i>	T2	
<i>ferrous gluconate</i>	T2	
<i>ferrous gluconate (Fergon)</i>	T2	
<i>ferrous sulf 300 mg/5 ml cup</i>	T2	
FERROUS SULF 300 MG/5 ML CUP	T4	

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
IRON REPLACEMENT (cont.)		
<i>ferrous sulf 15 mg iron/ml drp (Fer-In-Sol)</i>	T2	
<i>ferrous sulf 220 mg/5 ml elix</i>	T2	
<i>ferrous sulf 220 mg/5 ml liq</i>	T2	
<i>ferrous sulf 44 mg iron/5ml lq</i>	T2	
<i>ferrous sulf 300 mg/6.8ml soln</i>	T2	
<i>ferrous sulf ec 324 mg tablet</i>	T2	
<i>ferrous sulf ec 325 mg tablet</i>	T2	
<i>ferrous sulfate 325 mg tablet</i>	T2	
<i>true ferrous sulf ec 324 mg tb</i>	T2	
<i>ferrous sulfate</i>	T2	
<i>ferrous sulfate (Fer-In-Sol)</i>	T2	
<i>ferrous sulfate/vit c/folic ac</i>	T2	PPACA
<i>ferumoxylol (Feraheme)</i>	T2	PA
FT IRON 45 MG TABLET	T4	
<i>ft iron 65 mg tablet</i>	T2	
FUSION	T4	
FUSION PLUS	T4	
GENTLE IRON	T4	
<i>gnp iron 45 mg tablet</i>	T2	
<i>gnp iron 65 mg tablet</i>	T2	
HEMATEX	T4	
HEMATEX (<i>iron polysaccharide complex</i>)	T4	
HEMATOGEN	T4	
HEMATRON-AF	T4	
HEMAX	T4	
HEMOCYTE 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

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ELECT/CALORIC/H2O (Nutritional/Dietary) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
IRON REPLACEMENT (cont.)		
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 na.9</i>)	T4	
<i>iron 27 mg tablet</i>	T2	
<i>iron 27 mg tablet (Fergon)</i>	T2	
<i>iron 28 mg tablet</i>	T2	
<i>iron 45 mg tablet</i>	T2	
<i>iron 65 mg tablet</i>	T2	
<i>iron aspgly,ps/c/b12/fa/ca/suc</i>	T2	
<i>iron aspgly,ps/c/succinic acid</i>	T2	
<i>iron aspgly,c/b12/fa/ca-th/suc</i>	T2	
<i>iron bg,ps/vitc/b12/fa/calcium</i>	T2	
IRON BISGLYCINATE	T4	
<i>iron 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 na.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	
<i>iron,carb/vit c/vit b12/folic (Icar-C Plus)</i>	T2	
<i>iron,carbonyl</i>	T2	
<i>iron,carbonyl (Feosol)</i>	T2	
<i>iron,carbonyl/ascorbic acid (Icar-C)</i>	T2	
<i>iron/c/b12/calciu/stomach conc</i>	T2	
<i>iron/c/folic acd/mv cmb11/calc</i>	T2	
<i>iron/folic ac/vit bcomp,c/min</i>	T2	
<i>iron/folic acid/b12/c/docusate</i>	T2	
<i>iron/folic acid/c/b6/b12/zinc</i>	T2	
<i>iron sucrose complex</i>	T2	PA
<i>iron/vit c/fructooligosacchard</i>	T2	
<i>iron-vitamin c 100-250 mg tab (Icar-C)</i>	T2	PA SP HD

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ELECT/CALORIC/H2O (Nutritional/Dietary) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
IRON REPLACEMENT (cont.)		
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	
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	

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ELECT/CALORIC/H2O (Nutritional/Dietary) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
IRON REPLACEMENT (cont.)		
<i>sm iron 65 mg tablet</i>	T2	
<i>sm iron 160 mg tablet sa</i>	T2	
<i>sm iron 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	
TULIVITE	T4	
VENOFER	T3	PA
VIRT-FEFA PLUS CAPSULE	T4	
<i>virt-fefa plus capsule (Integra Plus)</i>	T2	
VITABEX IRON	T4	
VITAFOL	T4	
VITRON-C	T3	
PEDIATRIC VITAMIN PREPARATIONS		
<i>fluoride (sodium)</i>	T2	PPACA
FLURA-DROPS	T4	
<i>sodium fluoride 0.25 (0.55) mg</i>	T2	PPACA
<i>sodium fluoride 0.5 mg(1.1 mg)</i>	T2	PPACA
<i>sodium fluoride 0.5 mg/ml drop</i>	T2	PPACA
<i>sodium fluoride 1 mg (2.2 mg)</i>	T2	PPACA
POTASSIUM REPLACEMENT		
EFFER-K 10 MEQ TABLET EFF	T4	
EFFER-K 20 MEQ TABLET EFF	T4	
<i>effe-r-k 25 meq tablet eff</i>	T2	
<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% (40 meq/15ml)</i>	T2	
<i>potassium cl 20 meq packet</i>	T2	

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ELECT/CALORIC/H2O (Nutritional/Dietary) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
POTASSIUM REPLACEMENT (cont.)		
<i>potassium chloride 8 meq capsule</i>	T1	
<i>potassium chloride 10 meq capsule</i>	T1	
<i>potassium chloride 10%(20meq/15ml)cup</i>	T2	
<i>potassium chloride 10%(40meq/30ml)cup</i>	T2	
<i>potassium chloride 20%(40meq/15ml)cup</i>	T2	
<i>potassium chloride 8 meq tablet</i>	T1	
<i>potassium chloride 10 meq tablet</i>	T1	
<i>potassium chloride 15 meq tablet</i>	T1	
POTASSIUM CLER 15 MEQ TABLET	T4	
<i>potassium chloride 20 meq tablet</i>	T1	
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
GASTROINTESTINAL (Cholesterol Medications)		
LIPOTROPICS		
<i>icosapent ethyl (Vascepa)</i>	T2	PA HD
<i>omega-3 acid ethyl esters (Lovaza)</i>	T2	PA HD
VASCEPA (<i>icosapent ethyl</i>)	T3	PA HD

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List of Prescription Medications

GASTROINTESTINAL (Gastrointestinal/Heartburn)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
AMMONIA INHIBITORS		
BUPHENYL (<i>sodium phenylbutyrate</i>)	T6	PA SP HD
<i>lactulose</i>	T2	HD
<i>lactulose 10 gm/15 ml solution</i>	T2	HD
LITHOSTAT	T4	HD
OLPRUVA DOSE KIT, DOSE ENVELOPE	T6	SP PA HD
RAVICTI	T5	PA SP HD
<i>sodium phenylbutyrate</i> (Buphenyl)	T2	PA SP HD
PHEBURANE	T5	PA SP
ANTICHOLINERGICS, QUATERNARY AMMONIUM		
<i>chlordiazepoxide/clidinium br</i> (Librax)	T2	
GLYCATE	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	
ANTIEMETIC, CANNABINOID-TYPE		
<i>dronabinol</i> (Marinol)	T2	PA
MARINOL (<i>dronabinol</i>)	T4	PA
SYNDROS	T4	PA

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GASTROINTESTINAL (Gastrointestinal/Heartburn) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ANTIEMETIC/ANTIVERTIGO AGENTS		
<i>aprepitant 125 mg capsule</i>	T2	QL(1 cap/fill)
<i>aprepitant 125-80-80 mg pack (Emend)</i>	T2	QL(3 caps/fill)
<i>aprepitant 40 mg capsule (Emend)</i>	T2	QL(1 cap/fill)
<i>aprepitant 80 mg capsule (Emend)</i>	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 dimeglumine (Emend)</i>	T2	
<i>granisetron hcl 0.1 mg/ml vial</i>	T2	
<i>granisetron hcl 1 mg tablet</i>	T2	QL(6 tabs/fill)
<i>granisetron hcl 1 mg/ml vial</i>	T2	
<i>granisetron hcl 4 mg/4 ml vial</i>	T2	
<i>meclizine 50 mg tablet</i>	T2	
<i>ondansetron 4 mg/2 ml</i>	T2	
<i>ondansetron 40 mg/20 ml vial</i>	T2	
<i>ondansetron hcl 4 mg, 8 mg tablet</i>	T2	QL(9 tabs/fill)
<i>ondansetron hcl 4 mg/2 ml syr, vial</i>	T2	
<i>ondansetron odt 4 mg tablet</i>	T2	QL (9 tabs/30 days)
<i>ondansetron odt 8 mg tablet</i>	T2	QL(9 tabs/30 days)
<i>prochlorperazine (Compazine)</i>	T2	
<i>prochlorperazine maleate (Compazine)</i>	T2	
<i>promethazine hcl</i>	T2	
SANCUSO	T4	QL(1 patch/fill)
<i>scopolamine (Transderm-Scop)</i>	T2	
<i>trimethobenzamide hcl</i>	T2	
VARUBI	T3	QL(2 tabs/fill)
ANTI-ULCER PREPARATIONS		
CYTOTEC (<i>misoprostol</i>)	T4	HD
<i>misoprostol (Cytotec)</i>	T2	HD
<i>sucralfate (Carafate)</i>	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)

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ANTI-ULCER-H.PYLORI AGENTS (cont.)		
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 (Levbid)</i>	T2	HD
<i>hyoscyamine sulfate (Levsin)</i>	T2	HD
<i>hyoscyamine sulfate (Levsin-Sl)</i>	T2	HD
<i>hyoscyamine sulfate (Nulev)</i>	T2	HD
LEVIBID (<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 (Donnatal)</i>	T2	HD
<i>phenobarb/hyoscy/atropine/scop (Phenobarbital-Belladonna)</i>	T2	HD
PHENOBARBITAL-BELLADONNA (<i>phenobarb/hyoscy/atropine/scop</i>)	T4	HD
SYMAX DUOTAB	T4	HD
BILE SALTS		
CHENODAL	T5	PA SP HD
CHOLBAM 250 MG CAPSULE	T5	PA SP HD
CHOLBAM 50 MG CAPSULE	T5	PA QL (120 caps/fill) SP HD
CTEXLI	T5	PA SP HD
URSO FORTE (<i>ursodiol</i>)	T4	HD
<i>ursodiol</i>	T2	HD
<i>ursodiol (Urso Forte)</i>	T2	HD
CHRONIC INFLAM. COLON DX, 5-A-SALICYLAT, RECTAL TX		
<i>mesalamine 1,000 mg supp (Canasa)</i>	T2	
<i>mesalamine 4 gm/60 ml enema (Sfrowasa)</i>	T2	
<i>mesalamine 4 gm/60 ml kit (Rowasa)</i>	T2	
ROWASA (<i>mesalamine w/cleansing wipes</i>)	T4	
SFROWASA (<i>mesalamine</i>)	T4	

T1 – Preferred Generics

T2 – Non-Preferred Generics

T3 – Preferred Brands

T4 – Non-Preferred Brands

T5 – Preferred Specialty

T6 – Non-Preferred Specialty

PA – Prior Authorization

QL – Quantity Limit

ST – Step Therapy

AGE – Age Requirement

SP – Specialty Medication

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List of Prescription Medications

GASTROINTESTINAL (Gastrointestinal/Heartburn) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
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		
OCALIVA	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	
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

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List of Prescription Medications

GASTROINTESTINAL (Gastrointestinal/Heartburn) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
IBS AGENTS, MIXED OPIOID RECEPTOR AGONISTS/ANTAGONISTS		
VIBERZI	T3	HD
IBS-C/CIC AGENTS, GUANYLATE CYCLASE-C AGONIST		
LINZESS	T3	QL(30 caps/fill)
TRULANCE	T3	
ILEAL BILE ACID TRANSPORTER (IBAT) INHIBITOR		
BYLVAY 1,200 MCG CAPSULE	T6	PA QL(60 caps/fill) SP HD
BYLVAY 200 MCG PELLET	T6	PA QL(120 pellets/fill) SP HD
BYLVAY 400 MCG CAPSULE	T6	PA QL(150 caps/fill) SP HD
BYLVAY 600 MCG PELLET	T6	PA QL(30 pellets/fill) SP HD
LIVMARLI	T6	PA SP
INTESTINAL MOTILITY STIMULANTS		
<i>metoclopramide hcl</i>	T1	
<i>metoclopramide hcl (Reglan)</i>	T1	
<i>prucalopride succinate (Motegrity)</i>	T2	QL (30 tabs/30 days)
REGLAN (<i>metoclopramide hcl</i>)	T4	
IRRITABLE BOWEL SYNDROME AGENTS, 5-HT₃ ANTAGONIST		
<i>alosetron hcl (Lotronex)</i>	T2	SP HD
IRRITABLE BOWEL SYND. AGENT, 5-HT₄ PARTIAL AGONIST		
ZELNORM	T4	
LAXATIVES AND CATHARTICS		
<i>bisac/nac/na/co3/kcl/peg 3350</i>	T2	PPACA
GIALAX	T4	PPACA
GOLYTELY (<i>peg3350/sod sulf,bicarb,cl/kcl</i>)	T4	
KRISTALOSE	T4	
<i>lactulose</i>	T2	
<i>lactulose 10 gm packet</i>	T2	
<i>lactulose 10 gm/15 ml solution</i>	T2	
<i>lactulose 20 gm/30 ml solution</i>	T2	
<i>lubiprostone</i>	T2	QL (60 caps/30 days)
NULYTELY WITH FLAVOR PACKS (<i>sodium chloride/na/co3/kcl/peg</i>)	T4	
OSMOPREP	T4	PPACA
<i>peg3350/sod sul/nacl/kcl/asb/c (Moviprep)</i>	T2	PPACA
<i>peg3350/sod sulf,bicarb,cl/kcl</i>	T2	PPACA
<i>peg3350/sod sulf,bicarb,cl/kcl (Golytely)</i>	T2	PPACA

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List of Prescription Medications

GASTROINTESTINAL (Gastrointestinal/Heartburn) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
LAXATIVES AND CATHARTICS (cont.)		
sodium chloride/na ₂ hco ₃ /kcl/peg (Nulytely With Flavor Packs)	T2	PPACA
sodium, potassium, mag sulfates (Suprep)	T2	PPACA
LOCAL ANORECTAL NITRATE PREPARATIONS		
nitroglycerin 0.4% ointment (Rectiv)	T2	
RECTIV (nitroglycerin)	T3	
MU-OPIOID RECEPTOR ANTAGONISTS, PERIPHERALLY-ACTING		
alvimopan	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		
dexlansoprazole dr 60 mg cap	T2	ST HD
esomeprazole dr 2.5 mg packet (Nexium)	T2	ST QL (30 packs/30 days) HD
esomeprazole dr 5 mg packet (Nexium)	T2	ST QL (30 packs/30 days) HD
esomeprazole dr 10 mg packet (Nexium)	T2	ST QL (30 packs/fill) HD
esomeprazole dr 40 mg packet (Nexium)	T2	ST HD
esomeprazole dr 40 mg cap (Nexium)	T2	HD
ESOMEPRAZOLE DR 49.3 MG CAP (Nexium)	T4	ST HD
lansoprazole dr 30 mg capsule (Prevacid)	T1	HD
lansoprazole odt 15 mg tablet (Prevacid)	T2	ST QL (30 tabs/fill) HD
lansoprazole odt 30 mg tablet (Prevacid)	T2	ST HD
omeprazole dr 10 mg, 20 mg capsule	T1	QL (30 caps/fill) HD
omeprazole dr 40 mg capsule	T1	HD
omeprazole/sodium bicarbonate (Zegerid)	T2	PA HD
omeprazole-bicarb 20-1,680 pkt (Zegerid)	T2	ST QL (30 packs/30 days) HD
omeprazole-bicarb 40-1,100 cap (Zegerid)	T2	ST HD
omeprazole-bicarb 40-1,680 pkt (Zegerid)	T2	ST HD
pantoprazole 40 mg suspension (Protonix)	T2	ST HD

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
PROTON-PUMP INHIBITORS (cont.)		
<i>pantoprazole sod dr 40 mg tab (Protonix)</i>	T1	HD
<i>rabeprazole sod dr 20 mg tab (Aciphex)</i>	T2	HD
RECTAL PREPARATIONS		
<i>hydrocortisone acetate (Anusol-Hc)</i>	T2	
<i>hydrocortisone acetate (Proctocort)</i>	T2	
PROCTOCORT (<i>hydrocortisone acetate</i>)	T4	ST
SBS - GLUCAGON-LIKE PEPTIDE-2 (GLP-2) ANALOGS		
GATTEX	T6	PA SP HD
GASTROINTESTINAL (Pain Relief And Inflammatory Disease)		
HEMORRHOID PREP, ANTI-INFLAM STEROID-LOCAL ANESTHET		
ANA-LEX	T4	
ANALPRAM HC 1% CREAM	T4	
ANALPRAM HC 2.5%-1% CREAM (<i>hydrocortisone/pramoxine</i>)	T4	ST
ANALPRAM HC 2.5%-1% CRM SINGLE (<i>hydrocortisone/pramoxine</i>)	T4	ST
<i>hydrocort-pramoxine 1%-1% crm</i>	T2	
<i>hydrocort-pramoxine 2.5%-1% cm (Analpram Hc)</i>	T2	ST
<i>hydrocort-pramoxine 2.5-1% crm (Analpram Hc)</i>	T2	ST
<i>lidocaine-hc 2.8-0.55% gel</i>	T2	
<i>lidocaine-hc 2-2% cream kit</i>	T2	
<i>lidocaine-hc 3-0.5% cream</i>	T2	
<i>lidocaine-hc 3-0.5% cream kit</i>	T2	
<i>lidocaine-hc 3-1% cream kit</i>	T2	
<i>lidocaine-hc 3-2.5% gel kit</i>	T2	
PROCORT	T4	
HORMONES (Gastrointestinal/Heartburn)		
RECTAL/LOWER BOWEL PREP.,GLUCOCORT. (NON-HEMORR)		
CORTENEMA (<i>hydrocortisone</i>)	T4	
<i>hydrocortisone (Cortenema)</i>	T2	
UCERIS (<i>budesonide</i>)	T4	
HORMONES (Hormonal Agents)		
ADRENOCORTICOTROPHIC HORMONES		
ACTHAR SELFJECT	T6	PA SP HD

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List of Prescription Medications

HORMONES (Hormonal Agents) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
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 1% (25mg/2.5g) pk (AndroGel)</i>	T2	PA QL(75 gms/fill)
<i>testosterone 1% (50 mg/5 g) pk (AndroGel)</i>	T2	PA QL(300 gms/fill)
<i>testosterone 1.62% (2.5 g) pkt</i>	T2	QL (60 packs/30 days)
<i>testosterone 1.62% gel pump (AndroGel)</i>	T2	PA QL(150 gms/fill)
<i>testosterone 1.62%(1.25 g) pkt</i>	T2	QL (30 packs/30 days)
<i>testosterone 10 mg gel pump</i>	T2	QL (120 gms/30 days)
TESTOSTERONE 12.5 MG/1.25 GRAM	T4	PA QL(300 gms/fill)
<i>testosterone 12.5 mg/1.25 gram</i>	T2	PA QL(300 gms/fill)
<i>testosterone 30 mg/1.5 ml pump</i>	T2	PA QL(180 mls/fill)
<i>testosterone 50 mg/5 gram gel (Testim)</i>	T2	PA QL(60 tubes/fill)
<i>testosterone 50 mg/5 gram gel (Vogelxo)</i>	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 (Depo-Testosterone)</i>	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	QL(2 mls/28 days)
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	
<i>desmopressin 10 mcg/0.1 ml spr</i>	T2	HD
<i>desmopressin acetate 0.1 mg tb (Ddavp)</i>	T2	HD

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List of Prescription Medications

HORMONES (Hormonal Agents) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ANTIDIURETIC AND VASOPRESSOR HORMONES (cont.)		
<i>desmopressin acetate 0.2 mg tb (Ddavp)</i>	T2	HD
NOCTIVA	T4	QL (4 gms/30 days)
ESTROGEN/ANDROGEN COMBINATIONS		
ESTRATEST H.S. (<i>estrogen, ester/me-testosterone</i>)	T4	HD
<i>estrogen, ester/me-testosterone</i>	T2	HD
<i>estrogen, ester/me-testosterone</i>	T2	HD
<i>estrogen, ester/me-testosterone</i> (Estratest H.S.)	T2	HD
ESTROGENIC AGENTS		
ACTIVELLA (<i>estradiol/norethindrone acet</i>)	T4	HD
CLIMARA (<i>estradiol</i>)	T4	QL(4 patches/28 days) HD
COMBIPATCH	T3	
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</i> (Climara)	T2	QL(4 patches/28 days) HD
<i>estradiol 0.1% (0.25mg) gel pk</i> (Divigel)	T2	QL(30 packs/fill) HD
<i>estradiol 0.1% (0.75mg) gel pk</i> (Divigel)	T2	QL(30 packs/fill) HD
<i>estradiol 0.1% (1 mg) gel pkt</i> (Divigel)	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</i> (EstroGel)	T2	QL (50 gms/30 days) HD
<i>estradiol 0.5 mg tablet</i> (Estrace)	T2	HD
<i>estradiol 1 mg tablet</i> (Estrace)	T2	HD
<i>estradiol 2 mg tablet</i> (Estrace)	T2	HD
<i>estradiol valerate</i> (Delestrogen)	T2	HD
<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

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List of Prescription Medications

HORMONES (Hormonal Agents) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ESTROGEN-PROGESTIN WITH ANTIMINERALOCORTICOID COMB		
ANGELIQ	T4	HD
ESTROGEN-SELECTIVE ESTROGEN RECEPTOR MOD (SERM) COMB		
DUAVEE	T3	
GLUCOCORTICOIDS		
<i>budesonide</i>	T2	
<i>budesonide (Uceris)</i>	T2	
CORTEF (<i>hydrocortisone</i>)	T4	
<i>cortisone acetate</i>	T2	
<i>deflazacort (Emflaza)</i>	T2	PA SP
<i>dexamethasone</i>	T2	PA
<i>dexamethasone</i>	T2	
<i>dexamethasone 0.5 mg, 0.75 mg tablet</i>	T1	
<i>dexamethasone 0.5 mg/5 ml elx</i>	T1	
<i>dexamethasone 0.5 mg/5 ml liq</i>	T2	
<i>dexamethasone 1 mg, 1.5 mg tablet</i>	T1	
<i>dexamethasone 10 day 1.5 mg tb</i>	T2	PA
<i>dexamethasone 13 day 1.5 mg tb</i>	T2	PA
<i>dexamethasone 2 mg, 4 mg, 6 mg tablet</i>	T1	
<i>dexamethasone 6 day 1.5 mg tab</i>	T2	PA
DEXONTO	T4	
<i>hydrocortisone (Cortef)</i>	T2	
MEDROL	T4	
MEDROL (<i>methylprednisolone</i>)	T4	
<i>methylprednisolone</i>	T2	
<i>methylprednisolone (Medrol)</i>	T2	
ORAPRED ODT (<i>prednisolone sodium phosphate</i>)	T4	
<i>prednisolone</i>	T2	
<i>prednisolone sodium phosphate</i>	T2	
<i>prednisolone sodium phosphate (Orapred Odt)</i>	T2	
<i>prednisone</i>	T2	
<i>prednisone</i>	T1	
RAYOS	T4	PA
TAPERDEX	T4	PA
TARPEYO	T6	PA QL (28 caps/30 days) SP

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HORMONES (Hormonal Agents) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
GLUCOCORTICOIDS (cont.)		
UCERIS (<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	T5	PA SP
SEROSTIM	T5	PA SP HD
ZORBTIVE	T6	PA SP HD
INSULIN-LIKE GROWTH FACTOR-I (IGF-I) HORMONES		
INCRELEX	T5	PA SP
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>cetrotex acetate</i>	T2	SP
CETROTIDE	T5	SP
GANIRELIX ACET 250 MCG/0.5 ML (<i>ganirelix acetate</i>)	T6	ST SP
<i>ganirelix acet 250 mcg/0.5 ml</i> (Ganirelix Acetate)	T2	ST SP
<i>ganirelix acetate</i> (Ganirelix Acetate)	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
OXYTOCICS		
CERVIDIL	T4	
<i>methylgonovine maleate</i>	T2	QL (240 tabs/30 days)
PREPIDIL	T4	
PARATHYROID HORMONES		
NATPARA	T5	PA SP HD
YORVIPATH	T6	PA SP

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
PITUITARY SUPPRESSIVE AGENTS		
<i>cabergoline</i>	T2	QL(8 tabs/28 days) HD
CRENESSITY	T6	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	T6	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	T6	ST SP
GONAL-F	T5	ST SP
GONAL-F RFF REDI-JECT	T5	ST SP
HUMAN CHORIONIC GONADOTROPIN (HCG)		
CHORIONIC GONAD 10,000 UNIT VL	T6	ST QL (3 vials/30 days) SP
CHORIONIC GONAD 50,000 UNIT VL	T6	ST SP
CHORIONIC GONAD 6,000 UNIT VL	T6	ST SP
NOVAREL	T6	ST QL (6 vls/30 days) SP

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List of Prescription Medications

HORMONES (Infertility) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
HUMAN CHORIONIC GONADOTROPIN (HCG) (cont.)		
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
IL-23 RECEPTOR ANTAGONIST, MONOCLONAL ANTIBODY		
OMVOH 100 MG/ML PEN	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 300 MG DOSE - 2 PENS	T5	PA QL (3 mls/28 days) SP HD
OMVOH 100 MG/ML SYRINGE	T5	PA QL (2 mls/28 days) SP HD

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List of Prescription Medications

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

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
IL-23 RECEPTOR ANTAGONIST, MONOCLONAL ANTIBODY (cont.)		
OMVOH 200 MG DOSE - 2 SYRINGES	T5	PA QL (2 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 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
TREMFYA PEN INDUCTION (2 PEN)	T5	PA QL (1200 mgs/365 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	T6	PA QL (3.6 mls/28 days) SP HD
ACTEMRA ACTPEN	T6	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
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TOPICAL IMMUNOSUPPRESSIVE AGENTS

HYFTOR	T6	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)

IMMUNOSUPPRESSANTS (Transplant Medications)

IMMUNOSUPPRESSIVES

ASTAGRAF XL	T6	PA SP HD
AZASAN (<i>azathioprine</i>)	T6	SP HD

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IMMUNOSUPPRESSANTS (Transplant Medications) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
IMMUNOSUPPRESSIVES (cont.)		
<i>azathioprine</i> (Azasan)	T2	SP HD
<i>azathioprine</i> (Imuran)	T2	SP HD
CELLCEPT (<i>mycophenolate mofetil</i>)	T6	SP HD
<i>cyclosporine 100 mg capsule</i> (Sandimmune)	T2	SP HD
<i>cyclosporine 25 mg capsule</i> (Sandimmune)	T2	SP HD
<i>cyclosporine, modified</i>	T2	SP HD
<i>cyclosporine, modified</i> (Neoral)	T2	SP HD
<i>everolimus 0.25 mg tablet</i> (Zortress)	T2	SP HD
<i>everolimus 0.5 mg tablet</i> (Zortress)	T2	SP HD
<i>everolimus 0.75 mg tablet</i> (Zortress)	T2	SP HD
<i>everolimus 1 mg tablet</i> (Zortress)	T2	SP HD
IMURAN (<i>azathioprine</i>)	T6	SP HD
LUPKYNIS	T6	PA QL (180 caps/30 days) SP
<i>mycophenolate mofetil</i> (Cellcept)	T2	SP HD
<i>mycophenolate sodium</i> (Myfortic)	T2	SP HD
MYFORTIC (<i>mycophenolate sodium</i>)	T6	SP HD
MYHIBBIN	T5	SP
NEORAL (<i>cyclosporine, modified</i>)	T6	SP HD
PROGRAF 0.2 MG GRANULE PACKET	T5	SP HD
PROGRAF 0.5 MG CAPSULE (<i>tacrolimus</i>)	T6	SP HD
PROGRAF 1 MG CAPSULE (<i>tacrolimus</i>)	T6	SP HD
PROGRAF 1 MG GRANULE PACKET	T5	SP HD
PROGRAF 5 MG CAPSULE (<i>tacrolimus</i>)	T6	SP HD
RAPAMUNE (<i>sirolimus</i>)	T6	SP HD
SANDIMMUNE 100 MG CAPSULE (<i>cyclosporine</i>)	T6	SP HD
SANDIMMUNE 100 MG/ML SOLN	T5	SP HD
SANDIMMUNE 25 MG CAPSULE (<i>cyclosporine</i>)	T6	SP HD
<i>sirolimus</i>	T2	SP HD
<i>sirolimus</i> (Rapamune)	T2	SP HD
<i>tacrolimus 0.5 mg capsule (ir)</i> (Prograf)	T2	SP HD
<i>tacrolimus 1 mg capsule (ir)</i> (Prograf)	T2	SP HD
<i>tacrolimus 5 mg capsule (ir)</i> (Prograf)	T2	SP HD
ZORTRESS (<i>everolimus</i>)	T6	SP HD

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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	PA QL (2 units/30 days)
AUTOLET PLUS	T3	
AUTOPEN	T3	
AUTOSOFT 30	T3	
AUTOSOFT 90	T3	
AUTOSOFT 30 INFUSION SET PACK	T4	
AUTOSOFT XC INFUSION SET PACK	T4	

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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	

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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)

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MISCELLANEOUS MEDICAL SUPPLIES, DEVICES, NON-DRUG (Diabetes) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
DIABETIC SUPPLIES (cont.)		
FREESTYLE LIBRE 3 SENSOR	T3	PA QL (2 units/28 days)
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 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-CONTACT DETACH	T3	
ILET INFUSION KIT-INSET	T3	

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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	

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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 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 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 CLASSIC PDM KIT(GEN 3)	T3	
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	

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

ST – Step Therapy
AGE – Age Requirement
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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	
UNISTRIIP	T4	
VARISOFT INFUSION SET	T3	
V-GO 20	T3	
V-GO 30	T3	
V-GO 40	T3	
VIVAGUARD INO CONTROL SOLUTION	T4	
VIVAGUARD LANCING DEVICE	T3	
WAVESENSE CONTROL SOLUTION	T4	
DURABLE MEDICAL EQUIPMENT,MISC(GROUP I)		
1ST TIER UNILET COMFORTOUCH	T3	
2-IN-1 LANCET DEVICE	T3	
ACCU-CHEK FASTCLIX LANCET DRUM	T3	
ACCU-CHEK SAFE-T-PRO	T3	
ACCU-CHEK SAFE-T-PRO PLUS	T3	
ACCU-CHEK SOFTCLIX	T3	
<i>acti-lance lite 28g lancets</i>	T2	
<i>acti-lance special 17g lancets</i>	T2	
<i>acti-lance univers 23g lancets</i>	T2	
ACTI-LANCE UNIVERS 23G LANCETS	T3	
ADVANCED TRAVEL LANCETS	T3	
ADVOCATE LANCET	T3	
ADVOCATE LANCETS	T3	
ADVOCATE SAFETY LANCET	T3	
AGAMATRIX ULTRA-THIN LANCET	T3	PA SP HD
ALTERNATE SITE LANCETS	T3	
ASSURE HAEMOLANCE PLUS	T3	
ASSURE LANCE	T3	

T1 – Preferred Generics

T2 – Non-Preferred Generics

T3 – Preferred Brands

T4 – Non-Preferred Brands

T5 – Preferred Specialty

T6 – Non-Preferred Specialty

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MISCELLANEOUS MEDICAL SUPPLIES, DEVICES, NON-DRUG (Diabetes) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
DURABLE MEDICAL EQUIPMENT,MISC(GROUP I) (cont.)		
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	
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	

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

T5 – Preferred Specialty
T6 – Non-Preferred Specialty
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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 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	
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	

T1 – Preferred Generics

T2 – Non-Preferred Generics

T3 – Preferred Brands

T4 – Non-Preferred Brands

T5 – Preferred Specialty

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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 LANCET	T3	
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	

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

T5 – Preferred Specialty
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MISCELLANEOUS MEDICAL SUPPLIES, DEVICES, NON-DRUG (Diabetes) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
DURABLE MEDICAL EQUIPMENT,MISC(GROUP I) (cont.)		
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	
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 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
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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 – Preferred Specialty
T6 – Non-Preferred Specialty
PA – Prior Authorization
QL – Quantity Limit

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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 – Preferred Specialty

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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 ORIGINAL PEN NEEDLE	T3	
ULTRA-FINE 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

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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 SAFETYGLIDE TB 1 ML SYR	T3	
BD SAFETYGLIDE TB 1ML 27G 10MM	T4	
BD SAFETYGLIDE TUBERCULIN SYR	T3	
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 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
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T3 – Preferred Brands
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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	
CAREPOINT PRECISION LUER LOCK	T4	
CAREPOINT PRECISION SAFETY	T4	
CAREPOINT SAFETY LUER LOCK SYR	T3	
CARETOUCH LUER LOCK	T3	
CARETOUCH LUER LOCK SYRINGE	T4	
CARETOUCH LUER SLIP SYRINGE	T4	
CORNWALL SYRINGE TIP CONNECTOR	T3	
DAVOL IRRIGATION SYRINGE	T3	
DOVER BULB SYRINGE	T4	
EASY GLIDE CATHETER TIP SYRING	T4	
EASY GLIDE LUER LOCK SYRINGE	T4	
EASY GLIDE LUER SLIP TB SYRING	T4	
EASY TOUCH FLIPLK 10ML 20GX1.5	T4	
EASY TOUCH FLIPLK 10ML 21GX1.5	T4	
EASY TOUCH FLIPLK 10ML 22GX1.5	T4	
EASY TOUCH FLIPLK 5 ML 20GX1.5	T4	
EASY TOUCH FLIPLK 5 ML 21GX1.5	T4	
EASY TOUCH FLIPLK 5 ML 22GX1.5	T4	
EASY TOUCH 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

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T4 – Non-Preferred Brands

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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 – Preferred Specialty

T6 – Non-Preferred Specialty

PA – Prior Authorization

QL – Quantity Limit

ST – Step Therapy

AGE – Age Requirement

SP – Specialty Medication

HD – May require home delivery pharmacy

PPACA – No Cost-Share Preventive Medication

CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

MISCELLANEOUS MEDICAL SUPPLIES, DEVICES, NON-DRUG (Diabetes) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
SYRINGES AND ACCESSORIES (cont.)		
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	
INSULIN SYRINGE U-500	T3	
INTEGRA SYRINGE	T3	
INTERLINK SYRINGE	T3	
INTERLINK SYRINGE W-CANNULA	T4	
KENDALL DISINFECTANT CAP	T4	
LEVER LOCK CANNULA	T4	
LIFESHIELD BLUNT CANNULA	T3	
LUER LOCK SYRINGE	T3	
LUER LOCK SYRINGE-NEEDLE	T4	PA SP HD
LUER SLIP TIP SYRINGE TRAY	T4	
LUER TIP CAP TRAY	T4	
LUER-LOK SYRINGE	T3	
LUER-LOK SYRINGE-NEEDLE	T3	
LUER-LOK TIP SYRINGE	T3	
LUERSLIP SYRINGE	T3	
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	

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

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

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MISCELLANEOUS MEDICAL SUPPLIES, DEVICES, NON-DRUG (Diabetes) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
SYRINGES AND ACCESSORIES (cont.)		
MONOJECT CONTROL SYRINGE	T3	
MONOJECT ENFIT SYRINGE	T4	
MONOJECT ENFIT SYRINGE CAP	T4	
MONOJECT LUER LOCK TB SYRINGE	T3	
MONOJECT MAGELLAN	T3	
MONOJECT PHARMACY TRAY	T3	
MONOJECT SAFETY SYR TIP CAP	T4	
MONOJECT SAFETY SYRINGE	T3	
MONOJECT SMARTIP CANNULA	T4	
MONOJECT SYRINGE	T3	
MONOJECT SYRINGE 140 ML	T4	
MONOJECT SYRINGE 35 ML	T3	
MONOJECT SYRINGE PHARMACY TRAY	T3	
MONOJECT TB	T3	
MONOJECT TB SYRINGE	T3	
MONOJECT TB 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	

T1 – Preferred Generics

T2 – Non-Preferred Generics

T3 – Preferred Brands

T4 – Non-Preferred Brands

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MISCELLANEOUS MEDICAL SUPPLIES, DEVICES, NON-DRUG (Diabetes) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
SYRINGES AND ACCESSORIES (cont.)		
SAFETYGLIDE INSULIN SYRINGE	T3	
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	T3	
TUBERCULIN SYRINGE	T3	
TUBERCULIN SYRINGE-NEEDLE	T3	
TWINPAK DUAL CANNULA	T3	
ULTICARE LDS SYR 1 ML 22G 1.5"	T4	
ULTICARE LDS SYR 3 ML 22GX1.5"	T3	

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

T5 – Preferred Specialty
T6 – Non-Preferred Specialty
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MISCELLANEOUS MEDICAL SUPPLIES, DEVICES, NON-DRUG (Diabetes) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
SYRINGES AND ACCESSORIES (cont.)		
ULTICARE SAFETY SYRINGE	T4	
ULTICARE SYRINGE	T4	
ULTICARE TB SAFETY 1 ML 25GX1"	T3	
ULTICARE TB SAFETY 1ML 25GX5/8	T3	
ULTICARE TB SAFETY SYRINGE	T3	
ULTIGUARD SAFE 1ML 30G 12.7MM	T4	
ULTIGUARD SAFEPACK 1ML 31G 8MM	T4	
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	

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

T5 – Preferred Specialty
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MISCELLANEOUS MEDICAL SUPPLIES, DEVICES, NON-DRUG (Miscellaneous) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
BANDAGES AND RELATED SUPPLIES (cont.)		
KENDALL	T3	
NEXCARE TEGADERM 2.375"X2.75"	T4	
NEXCARE TEGADERM DRESSING	T3	
OPSITE	T4	
OPSITE IV 3000	T3	
POLYSKIN II	T3	
SURESITE MATRIX	T3	
SURESITE WINDOW	T3	
TEGADERM 1.75X1.75" DRSSNG	T4	
TEGADERM 2"X2.75" DRESSING	T3	
TEGADERM 2.375"X2.75" DRESSING	T3	
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	

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

T5 – Preferred Specialty
T6 – Non-Preferred Specialty
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MISCELLANEOUS MEDICAL SUPPLIES, DEVICES, NON-DRUG (Miscellaneous) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
BANDAGES AND RELATED SUPPLIES (cont.)		
TRANSPARENT I.V. SITE DRESSING	T3	
TRANSPARENT MEPITEL FILM DRESS	T4	
TRANSPARENT THIN FILM DRESSING	T3	
WINDOW BANDAGES	T4	
DURABLE MEDICAL EQUIPMENT,MISC (GROUP I)		
1ST TIER UNILET COMFORTOUCH	T3	
2-IN-1 LANCET DEVICE	T3	
ACCU-CHEK FASTCLIX LANCET DRUM	T3	
ACCU-CHEK SAFE-T-PRO	T3	
ACCU-CHEK SAFE-T-PRO PLUS	T3	
ACCU-CHEK SOFTCLIX	T3	
<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 TWIST LANCET	T3	
CHOSEN LANCET	T3	
CHOSEN SAFETY LANCET	T3	
CLEVER CHEK LANCETS	T3	

T1 – Preferred Generics

T2 – Non-Preferred Generics

T3 – Preferred Brands

T4 – Non-Preferred Brands

T5 – Preferred Specialty

T6 – Non-Preferred Specialty

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List of Prescription Medications

MISCELLANEOUS MEDICAL SUPPLIES, DEVICES, NON-DRUG (Miscellaneous) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
DURABLE MEDICAL EQUIPMENT,MISC (GROUP I) (cont.)		
COAGUCHEK	T3	
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	

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T3 – Preferred Brands
T4 – Non-Preferred Brands

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
DURABLE MEDICAL EQUIPMENT,MISC (GROUP I) (cont.)		
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	
MEDLANCE PLUS 21G LANCETS	T3	
<i>medlance plus 21g lancets</i>	T2	
<i>medlance plus 30g lancets</i>	T2	
MEDLANCE PLUS 30G LANCETS	T3	
MEDLANCE PLUS EXTRA 21G LANCET	T3	
<i>medlance plus lite 25g lancets</i>	T2	
MEDLANCE PLUS LITE 25G LANCETS	T3	
MEDLANCE PLUS SPECIAL BLADE	T3	
MICRO THIN LANCET	T3	
MICRO THIN LANCETS	T3	
MICROLET	T3	
MICROTAINER LANCETS	T3	
MONOLET LANCETS	T3	
MONOLET THIN LANCETS	T3	
MYGLUCOHEALTH LANCETS	T3	
NOVA SAFETY LANCETS	T3	
NOVA SUREFLEX	T3	
ON CALL LANCET	T3	
ON CALL PLUS LANCET	T3	

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

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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	T3	
ONETOUCH DELICA PLUS LANCET	T3	
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	
READYLANC 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	
SOFT TOUCH	T3	
SOLUS V2	T3	
SOLUS V2 LANCETS	T3	
STERILANCE TL	T3	
STERILE LANCETS	T3	
SUPER THIN LANCETS	T3	

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T3 – Preferred Brands
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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
DURABLE MEDICAL EQUIPMENT,MISC (GROUP I) (cont.)		
SURE COMFORT LANCETS	T3	
SURE-LANCE	T3	
SURE-TOUCH	T3	
TECHLITE LANCETS	T3	
TELCARE ULTRA THIN 30G LANCETS	T3	
THIN LANCETS	T3	
TOPCARE UNIVERSAL1 LANCET	T3	
TOPCARE UNIVERSAL1 THIN LANCET	T3	
TRUE COMFORT LANCET	T3	
TRUEPLUS LANCET	T3	
TRUEPLUS LANCETS	T3	
TWIST LANCETS	T3	
TWIST TOP LANCET	T3	
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, 30G LANCETS	T3	
ULTRATLC LANCETS	T3	
UNILET COMFORTOUCH	T3	
UNILET EXCELITE	T3	
UNILET EXCELITE II	T3	
UNILET GP LANCET	T3	
UNILET LANCET	T3	
UNILET LANCETS	T3	
UNISTIK 2 COMFORT	T3	
UNISTIK 2 EXTRA	T3	
UNISTIK 2 NORMAL	T3	
UNISTIK 3	T3	

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List of Prescription Medications

MISCELLANEOUS MEDICAL SUPPLIES, DEVICES, NON-DRUG (Miscellaneous) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
DURABLE MEDICAL EQUIPMENT,MISC (GROUP I) (cont.)		
UNISTIK 3 COMFORT	T3	
UNISTIK 3 DUAL	T3	
UNISTIK 3 EXTRA	T3	
UNISTIK COMFORT	T3	
UNISTIK CZT	T3	
UNISTIK EXTRA	T3	
UNISTIK NORMAL	T3	
UNISTIK PRO	T3	
UNISTIK SAFETY	T3	
UNISTIK TOUCH	T3	
UNIVERSAL 1	T3	
VIVAGUARD LANCET	T3	
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	
IV ADMINISTRATION SET	T3	
IVENIX PRIMARY ADMINISTRAT SET	T4	

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

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

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

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List of Prescription Medications

MISCELLANEOUS MEDICAL SUPPLIES, DEVICES, NON-DRUG (Miscellaneous) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
PARENTERAL ADMINISTRATION SETS (cont.)		
NERIA	T4	
PARADIGM INFUSION	T3	
POLYFIN QR	T3	
PSV SET	T4	
Q-SYTE	T3	
SILHOUETTE	T3	
SURE-T	T3	
RESPIRATORY AIDS,DEVICES,EQUIPMENT		
ACE AEROSOL CLOUD ENHANCER	T3	
AEROCHAMBER 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	

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MISCELLANEOUS MEDICAL SUPPLIES, DEVICES, NON-DRUG (Miscellaneous) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
RESPIRATORY AIDS, DEVICES, EQUIPMENT (cont.)		
MICROSPACER	T3	
MOUTHPIECE	T3	
ONE WAY MOUTHPIECE	T3	
OPTICHAMBER	T3	
OPTICHAMBER DIAMOND	T3	
PANDA MASK	T3	
PEDIATRIC MASK	T3	
PEDIATRIC PANDA MASK	T3	
POCKET CHAMBER	T3	
PRIMEAIRE	T3	
PRO COMFORT SPACER-ADULT MASK	T3	
PRO COMFORT SPACER-CHILD MASK	T4	
PRO COMFORT SPACER-INFANT MASK	T4	
PROCARE SPACER WITH ADULT MASK	T3	
PROCARE SPACER WITH CHILD MASK	T3	
PROCHAMBER	T3	
PURECOMFORT PEAK FLOW MOUTHPIECE	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	

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T2 – Non-Preferred Generics

T3 – Preferred Brands

T4 – Non-Preferred Brands

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List of Prescription Medications

MUSCLE RELAXANTS (Pain Relief And Inflammatory Disease) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
SKELETAL MUSCLE RELAXANTS		
<i>baclofen 5 mg/5 ml solution</i>	T2	PA HD
<i>baclofen 10 mg/5 ml solution</i>	T2	PA HD
<i>baclofen 25 mg/5 ml suspension</i>	T2	HD
<i>baclofen 5 mg tablet</i>	T2	HD
<i>baclofen 10 mg tablet</i>	T2	HD
<i>baclofen 15 mg tablet</i>	T2	HD
<i>baclofen 20 mg tablet</i>	T2	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	

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MUSCLE RELAXANTS (Pain Relief And Inflammatory Disease) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
SKELETAL MUSCLE RELAXANTS (cont.)		
ZANAFLEX 4 MG CAPSULE (<i>tizanidine hcl</i>)	T4	
ZANAFLEX 4 MG TABLET (<i>tizanidine hcl</i>)	T4	
ZANAFLEX 6 MG CAPSULE (<i>tizanidine hcl</i>)	T4	
PRE-NATAL VITAMINS (Nutritional/Dietary)		
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	

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PRE-NATAL VITAMINS (Nutritional/Dietary) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
PRENATAL VITAMIN PREPARATIONS (cont.)		
NESTABS	T4	
NESTABS ABC	T4	
NESTABS DHA	T4	
OB COMPLETE ONE	T4	
OB COMPLETE PETITE	T4	
OB COMPLETE PREMIER	T4	
OB COMPLETE WITH DHA	T4	
OBSTETRIX EC	T4	
OBTREX DHA	T4	
ONE A DAY WOMEN'S PRENATAL DHA	T4	
ONE-A-DAY PRENATAL-1	T4	
<i>pnv 11/iron fum/folic acid/om3</i>	T2	
<i>pnv 119/iron fum/folic acid</i>	T2	
<i>pnv 66/iron/folic/docusate/dha</i>	T2	
<i>pnv 69/iron/folic/docusate/dha</i>	T2	
<i>pnv 80/iron fum/folic/dss/dha</i>	T2	
<i>pnv no.118/iron fumarate/fa</i>	T2	
<i>pnv no.154/iron fum/folic acid</i>	T2	
<i>pnv,calcium 72/iron,carb/folic</i>	T2	
<i>pnv,calcium 72/iron/folic acid</i>	T2	
<i>pnv/iron,carb/docusat/folic ac</i>	T2	
<i>pnv19/iron bg,s.p/folic ac/om3</i>	T2	
<i>pnv no.52/iron/fa/omega-3/dha</i>	T2	PA SP HD
<i>pnv81/iron ps,edta/folic/omeg3</i>	T2	PA SP HD
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	

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PRE-NATAL VITAMINS (Nutritional/Dietary) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
PRENATAL VITAMIN PREPARATIONS (cont.)		
<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	
<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 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 vit,cal 76/iron/folic</i>	T2	PA SP HD
<i>prenatal vit,cal 78/iron/folic</i>	T2	PA SP HD
<i>prenatal vits 86/iron/folic ac</i>	T2	PA SP HD
<i>prenatal,calc 40/iron/folate 1</i>	T2	PA SP HD
<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/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 calc.36/iron/fa</i>	T2	PPACA

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PRE-NATAL VITAMINS (Nutritional/Dietary) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
PRENATAL VITAMIN PREPARATIONS (cont.)		
<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
<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	

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PRE-NATAL VITAMINS (Nutritional/Dietary) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
PRENATAL VITAMIN PREPARATIONS (cont.)		
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
P2I 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 (Remeron)</i>	T2	HD
REMERON (<i>mirtazapine</i>)	T4	HD
ANTI-ANXIETY - BENZODIAZEPINES		
<i>alprazolam</i>	T2	
<i>alprazolam (Xanax Xr)</i>	T1	
<i>alprazolam (Xanax)</i>	T1	
ATIVAN (<i>lorazepam</i>)	T4	
<i>chlordiazepoxide hcl</i>	T2	
<i>clorazepate dipotassium</i>	T2	
<i>diazepam 5 mg/ml oral conc</i>	T2	
<i>diazepam 25 mg/5 ml oral conc</i>	T2	
<i>diazepam 5 mg/5 ml oral soln, solution</i>	T2	
<i>diazepam 2 mg tablet (Valium)</i>	T2	
<i>diazepam 5 mg tablet (Valium)</i>	T2	

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PSYCHOTHERAPEUTIC DRUGS (Anxiety/Depression/Bipolar Disorder) ⁹ (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ANTI-ANXIETY - BENZODIAZEPINES (cont.)		
<i>diazepam 10 mg tablet (Valium)</i>	T2	
<i>lorazepam</i>	T2	
<i>lorazepam (Ativan)</i>	T1	
<i>oxazepam</i>	T2	
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 (Lithobid)</i>	T1	HD
LITHOBID (<i>lithium carbonate</i>)	T4	HD
MAOIS -NON-SELECTIVE, IRREVERSIBLE ANTIDEPRESSANTS		
MARPLAN	T4	
NARDIL (<i>phenelzine sulfate</i>)	T4	
PARNATE (<i>tranylcypromine sulfate</i>)	T4	
<i>phenelzine sulfate (Nardil)</i>	T2	
<i>tranylcypromine sulfate (Parnate)</i>	T2	
MONOAMINE OXIDASE (MAO) INHIBITOR ANTIDEPRESSANTS		
EMSAM	T4	
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	T6	PA QL(30 tabs/fill) SP HD
NUPLAZID 34 MG CAPSULE	T6	PA QL(30 caps/fill) SP HD
SELECTIVE SEROTONIN REUPTAKE INHIBITOR (SSRIS)		
<i>citalopram hbr 20 mg/10 ml cup</i>	T2	PA SP HD
<i>citalopram hbr 10 mg/5 ml soln</i>	T2	HD

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PSYCHOTHERAPEUTIC DRUGS (Anxiety/Depression/Bipolar Disorder) ⁹ (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
SELECTIVE SEROTONIN REUPTAKE INHIBITOR (SSRIS) (cont.)		
<i>escitalopram oxalate 5 mg/5 ml</i>	T1	ST HD
<i>escitalopram 10 mg/10 ml cup</i>	T1	PA SP 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
<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
<i>PAXIL 10 MG TABLET (paroxetine hcl)</i>	T4	ST QL (30 tabs/fill) HD
<i>PAXIL 10 MG/5 ML SUSPENSION (paroxetine hcl)</i>	T4	ST HD
<i>PAXIL 20 MG TABLET (paroxetine hcl)</i>	T4	ST QL (60 tabs/fill) HD
<i>PAXIL 30 MG TABLET (paroxetine hcl)</i>	T4	ST QL (60 tabs/fill) HD
<i>PAXIL 40 MG TABLET (paroxetine hcl)</i>	T4	ST QL (30 tabs/fill) HD
<i>PAXIL CR (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)		
<i>DESVENLAFAXINE ER</i>	T4	ST QL (30 tabs/fill) HD

T1 – Preferred Generics

T2 – Non-Preferred Generics

T3 – Preferred Brands

T4 – Non-Preferred Brands

T5 – Preferred Specialty

T6 – Non-Preferred Specialty

PA – Prior Authorization

QL – Quantity Limit

ST – Step Therapy

AGE – Age Requirement

SP – Specialty Medication

HD – May require home delivery pharmacy

PPACA – No Cost-Share Preventive Medication

CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

PSYCHOTHERAPEUTIC DRUGS (Anxiety/Depression/Bipolar Disorder) ⁹ (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
SEROTONIN-NOREPINEPHRINE REUPTAKE-INHIB (SNRIS) (cont.)		
<i>duloxetine hcl dr 20 mg cap</i> (Cymbalta)	T1	QL(60 caps/fill) HD
<i>duloxetine hcl dr 30 mg cap</i> (Cymbalta)	T1	QL(30 caps/fill) HD
<i>duloxetine hcl dr 40 mg cap</i>	T1	ST QL(30 caps/fill) HD
<i>duloxetine hcl dr 60 mg cap</i> (Cymbalta)	T1	QL(60 caps/fill) HD
FETZIMA 20-40 MG TITRATION PAK	T3	ST QL (28 caps/30 days)
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)
<i>venlafaxine hcl</i>	T1	QL(90 tabs/fill) HD
<i>venlafaxine hcl er 150 mg tab</i>	T2	ST QL(30 tabs/fill) HD
<i>venlafaxine hcl er 225 mg tab</i>	T2	ST QL(30 tabs/fill) HD
<i>venlafaxine hcl er 37.5 mg tab</i>	T2	ST QL(30 tabs/fill) HD
<i>venlafaxine hcl er 75 mg tab</i>	T2	ST QL(30 tabs/fill) HD
SSRI, SEROTONIN RECEPTOR MODULATOR ANTIDEPRESSANTS		
TRINTELLIX	T4	ST QL (30 tabs/30 days)
TRICYCLIC ANTIDEPRESSANT-BENZODIAZEPINE COMBINATNS		
<i>amitriptyline/chlordiazepoxide</i>	T2	HD
<i>perphenazine/amitriptyline hcl</i>	T2	HD
TRICYCLIC ANTIDEPRESSANTS, REL.NON-SEL.REUPT-INHIB		
<i>amitriptyline hcl</i>	T1	HD
<i>amoxapine</i>	T2	HD
ANAFRANIL (clomipramine hcl)	T4	HD
<i>clomipramine hcl</i> (Anafranil)	T2	HD
<i>desipramine hcl</i>	T2	HD
<i>doxepin 10 mg, 25 mg, 50 mg capsule</i>	T2	HD
<i>doxepin 10 mg/ml oral conc</i>	T2	HD
<i>doxepin 75 mg, 100 mg, 150 mg capsule</i>	T2	HD
<i>imipramine hcl</i> (Tofranil)	T1	HD
<i>imipramine pamoate</i>	T2	HD
<i>maprotiline hcl</i>	T2	HD
<i>nortriptyline hcl</i>	T2	HD
<i>nortriptyline hcl</i> (Pamelor)	T1	HD
PAMELOR (<i>nortriptyline hcl</i>)	T4	HD

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

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

T1 – Preferred Generics
T2 – Non-Preferred Generics
T3 – Preferred Brands
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QL – Quantity Limit

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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, 72 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 hcl</i>	T2	
<i>methylphenidate hcl</i> (Metadate Cd)	T2	
<i>methylphenidate hcl</i> (Methylin)	T2	
<i>methylphenidate hcl</i> (Ritalin La)	T2	
<i>methylphenidate hcl</i> (Ritalin)	T2	
QELBREE ER	T4	ST
RELEXXII ER 72 MG TABLET	T4	ST

TX FOR ATTENTION DEFICIT-HYPERACT.(ADHD), NRI-TYPE

<i>atomoxetine hcl</i> (Strattera)	T2	HD
QELBREE	T4	ST

PSYCHOTHERAPEUTIC DRUGS (Miscellaneous)

HYPOACTIVE SEXUAL DESIRE DISORDER (HSDD) TX AGENTS

ADDYI	T4	PA
VYLEESI	T6	PA QL(8 auto-injs/fill) SP

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T2 – Non-Preferred Generics
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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)

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

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

ST – Step Therapy
AGE – Age Requirement
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List of Prescription Medications

PSYCHOTHERAPEUTIC DRUGS (Schizophrenia/Anti-Psychotics) ⁹ (cont.)		
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/30 days)
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

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PA – Prior Authorization
QL – Quantity Limit

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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	
LUMRYZ ER	T6	PA QL (30 packets/30 days) SP HD
SODIUM OXYBATE	T5	PA QL (540ml/30 days) SP HD
XYREM	T5	PA QL(540 mls/fill) SP HD
XYWAV	T5	PA QL(540 mls/fill) SP HD
BARBITURATES		
phenobarbital	T2	
HYPNOTICS, MELATONIN MT1/MT2 RECEPTOR AGONISTS		
HETLIOZ	T6	PA QL(30 caps/fill) SP HD
HETLIOZ LQ	T6	PA QL(158 mls/fill) SP HD
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	
MIDAZOLAM HCL 10 MG/5 ML SYRUP	T4	
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)

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

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List of Prescription Medications

SEDATIVE/HYPNOTICS (Sleep Disorders/Sedatives) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
SEDATIVE-HYPNOTICS, NON-BARBITURATE (cont.)		
<i>doxepin hcl 6 mg tablet (Silenor)</i>	T2	ST QL (30 tabs/fill)
EDLUAR	T4	ST QL (30 tabs/fill)
<i>eszopiclone (Lunesta)</i>	T2	QL (30 tabs/fill)
IGALMI	T4	
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 5 mg capsule</i>	T2	QL (30 caps/fill)
<i>zaleplon 10 mg capsule</i>	T2	QL (60 caps/fill)
<i>zolpidem tartrate</i>	T2	QL (30 tabs/fill)
<i>zolpidem tartrate (Ambien Cr)</i>	T2	QL (30 tabs/fill)
<i>zolpidem tartrate (Ambien)</i>	T2	QL (30 tabs/fill)
ZOLPIMIST	T4	ST QL (1 canister/30 days)

SKIN PREPS (Miscellaneous) (cont.)

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	

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List of Prescription Medications

SKIN PREPS (Miscellaneous) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ANTISEPTICS, GENERAL (cont.)		
GS ALCOHOL 70% SWABS	T3	
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	
SODIUM CHLORIDE 0.9% IRRIG.	T4	
<i>sodium chloride irrig solution</i>	T2	
<i>sodium chloride 0.9% prcss sol</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 – Preferred Specialty

T6 – Non-Preferred Specialty

PA – Prior Authorization

QL – Quantity Limit

ST – Step Therapy

AGE – Age Requirement

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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(150 mg/84 days) SP HD
SKYRIZI (2 SYRINGES) KIT	T5	PA QL(150 mg/84 days) SP HD
SKYRIZI PEN	T5	PA QL(150 mg/84 days) SP HD
SOTYKTU	T5	PA QL (30 tabs/30 days) SP HD
SPEVIGO	T6	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
isotretinoin (Absorica)	T2	
ACNE AGENTS, TOPICAL		
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	

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List of Prescription Medications

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

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List of Prescription Medications

SKIN PREPS (Skin Conditions) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ANTISEBORRHEIC AGENTS (cont.)		
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	
RELION ALCOHOL 70% SWABS	T3	

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SKIN PREPS (Skin Conditions) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ANTISEPTICS, GENERAL (cont.)		
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	T6	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
<i>podofilox 0.5% gel (Condylox)</i>	T2	ST QL (7 gms/30 days)

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

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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	

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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)
<i>clocortolone pivalate 0.1% crm</i>	T2	
CLODAN 0.05% KIT	T4	ST QL(2 kits/28 days)
<i>clodan 0.05% shampoo (Clobex)</i>	T2	ST QL(236 mls/30 days)
CLODERM	T4	ST
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

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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% lotion</i>	T2	ST
<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-Smoothe-Fs)</i>	T2	
<i>fluocinolone acetonide (Synalar)</i>	T2	
<i>fluocinolone/shower cap (Derma-Smoothe-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>halcinonide 0.1% solution</i>	T2	
<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	
<i>halobetasol propionate</i>	T2	ST
HALOG	T4	ST
HALOG (halcinonide)	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 (Ala-Scalp)</i>	T2	
<i>hydrocortisone (Anusol-Hc)</i>	T2	
<i>hydrocortisone acetate</i>	T2	
<i>hydrocortisone buty 0.1% cream</i>	T2	QL(120 gms/30 days)

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SKIN PREPS (Skin Conditions) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
TOPICAL ANTI-INFLAMMATORY STEROIDAL (cont.)		
<i>hydrocortisone butyr 0.1% lotn</i>	T2	PA SP HD
<i>hydrocortisone butyr 0.1% oint</i>	T2	ST QL (10gm/28 days)
<i>hydrocortisone butyr 0.1% soln</i>	T2	ST QL (120 mls/30 days)
<i>hydrocortisone valerate</i>	T2	
IMPEKLO	T4	ST QL (136 gms/28 days)
KENALOG 0.147 MG/GRAM SPRAY (<i>triamcinolone acetonide</i>)	T4	ST QL (100 gms/30 days)
KENALOG 0.147 MG/GRAM SPRAY (<i>triamcinolone acetonide</i>)	T4	ST QL (126 gms/30 days)
<i>mometasone furoate 0.1% cream</i>	T2	
<i>mometasone furoate 0.1% oint</i>	T2	
<i>mometasone furoate 0.1% soln</i>	T2	
NUCORT	T4	ST
OLUX (<i>clobetasol propionate</i>)	T4	ST QL (100 gms/30 days)
PANDEL	T4	ST
<i>prednicarbate</i>	T2	
<i>prednicarbate (Dermatop)</i>	T2	
SCALACORT DK	T4	ST
SYNALAR	T4	ST
SYNALAR (<i>fluocinolone acetonide</i>)	T4	ST
SYNALARTS	T4	ST
TEMOVATE (<i>clobetasol propionate</i>)	T4	ST QL (120 gms/30 days)
TEXACORT	T4	ST
TOPICORT 0.05% CREAM (<i>desoximetasone</i>)	T4	ST
TOPICORT 0.05% GEL (<i>desoximetasone</i>)	T4	ST
TOPICORT 0.05% OINTMENT (<i>desoximetasone</i>)	T4	ST
TOPICORT 0.25% CREAM (<i>desoximetasone</i>)	T4	ST
TOPICORT 0.25% OINTMENT (<i>desoximetasone</i>)	T4	ST
<i>triamcinolone 0.025% cream</i>	T2	
<i>triamcinolone 0.025% lotion</i>	T2	
<i>triamcinolone 0.025% oint</i>	T2	
<i>triamcinolone 0.05% ointment</i>	T2	ST
<i>triamcinolone 0.1% cream, lotion, ointment</i>	T2	
<i>triamcinolone 0.147 mg/g spray (Kenalog)</i>	T2	ST QL (126 gms/30 days)
<i>triamcinolone 0.147 mg/g spray (Kenalog)</i>	T2	ST QL (100 gms/30 days)
<i>triamcinolone 0.5% cream</i>	T2	

T1 – Preferred Generics

T2 – Non-Preferred Generics

T3 – Preferred Brands

T4 – Non-Preferred Brands

T5 – Preferred Specialty

T6 – Non-Preferred Specialty

PA – Prior Authorization

QL – Quantity Limit

ST – Step Therapy

AGE – Age Requirement

SP – Specialty Medication

HD – May require home delivery pharmacy

PPACA – No Cost-Share Preventive Medication

CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

SKIN PREPS (Skin Conditions) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
TOPICAL ANTI-INFLAMMATORY STEROIDAL (cont.)		
<i>triamcinolone 0.5% ointment</i>	T2	
<i>triamcinolone acetonide</i>	T2	ST
<i>triderm 0.1% cream</i>	T2	
<i>triderm 0.5% cream</i>	T2	ST
TRIDESILON (<i>desonide</i>)	T4	ST
ULTRAVATE X	T4	ST
TOPICAL ANTI-INFLAMMATORY STEROID-LOCAL ANESTHETIC		
ANALPRAM HC 2.5%-1% LOTION	T4	ST
EPIFOAM	T4	ST
<i>hydrocort-pramoxine 2.5-1% crm</i>	T2	ST
<i>lidocaine/hydrocortisone ac</i>	T2	
<i>lidocaine-hc 3-0.5% cream</i>	T2	
PRAMOSONE	T4	ST
TOPICAL ANTIPARASITICS		
<i>lindane</i>	T2	
<i>malathion (Ovide)</i>	T2	
OVIDE (<i>malathion</i>)	T4	
TOPICAL JANUS KINASE (JAK) INHIBITORS		
OPZELURA	T4	PA QL (240 gms/28 days)
TOPICAL PREPARATIONS, ANTIBACTERIALS		
<i>iodine/potassium iodide</i>	T2	
<i>iodine/sodium iodide</i>	T2	
IODOFLEX	T4	
IODOSORB	T4	
NORMLGEL AG	T4	
TOPICAL VIT D ANALOG/ANTI-INFLAMMATORY STEROID		
<i>calcipotriene/betamethasone (Taclonex)</i>	T2	ST QL (60 gms/30 days)
<i>calcipotriene/betamethasone (Taclonex)</i>	T2	QL (60 gms/30 days)
ENSTILAR	T3	ST QL (60 gms/30 days)
WYNZORA	T4	ST QL (60 gms/30 days)
TOPICAL/MUCOUS MEMBR./SUBCUT. ENZYMES		
SANTYL	T3	QL (180 gms/fill)
VITAMIN A DERIVATIVES		
<i>adapalene 0.1% cream (Differin)</i>	T2	

T1 – Preferred Generics
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T4 – Non-Preferred Brands

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List of Prescription Medications

SKIN PREPS (Skin Conditions) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
VITAMIN A DERIVATIVES (cont.)		
ADAPALENE 0.1% LOTION	T4	ST
<i>adapalene 0.1% solution</i>	T2	
<i>adapalene 0.1% swab</i>	T2	ST
<i>adapalene 0.3% gel</i>	T2	
<i>adapalene 0.3% gel pump (Differin)</i>	T2	
ALTRENO	T4	PA
<i>avita 0.025% cream (Retin-A)</i>	T2	PA
AVITA 0.025% GEL	T4	PA
DIFFERIN	T4	ST
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 (Retin-A)</i>	T2	PA
<i>tretinoin 0.025% cream (Retin-A)</i>	T2	PA
<i>tretinoin 0.025% gel (Retin-A)</i>	T2	PA
<i>tretinoin 0.05% cream (Retin-A)</i>	T2	PA
<i>tretinoin 0.05% gel (Atralin)</i>	T2	PA
<i>tretinoin 0.1% cream (Retin-A)</i>	T2	PA
<i>tretinoin microspheres (Retin-A Micro Pump)</i>	T2	PA
<i>tretinoin microspheres (Retin-A Micro)</i>	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

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

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List of Prescription Medications

THYROID PREPS (Hormonal Agents)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ANTITHYROID PREPARATIONS		
<i>methimazole</i>	T1	HD
<i>propylthiouracil</i>	T2	HD
THYROID HORMONES		
<i>adthyza 120 mg tablet</i>	T2	HD
<i>adthyza 15 mg tablet</i>	T2	HD
<i>adthyza 30 mg tablet</i>	T2	HD
<i>adthyza 60 mg tablet</i>	T2	HD
<i>adthyza 90 mg tablet</i>	T2	HD
ARMOUR THYROID	T3	HD
ERMEZA	T4	ST HD
<i>levothyroxine sodium (Synthroid)</i>	T1	HD
<i>liothyronine sodium (Cytomel)</i>	T2	HD
<i>thyroid,pork</i>	T2	HD
UNCLASSIFIED DRUG PRODUCTS (AIDS/HIV)		
CYTOCHROME P450 INHIBITORS		
TYBOST	T6	SP
UNCLASSIFIED DRUG PRODUCTS (Asthma/COPD/Respiratory)		
CYSTIC FIBROSIS - INHALED OSMOTIC AGENTS		
BRONCHITOL	T6	PA SP HD
CYSTIC FIBROSIS-CFTR POTENTIATOR-CORRECTOR COMBIN.		
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 100 MG-125 MG TABLET	T5	PA QL(112 tabs/fill) SP HD
ORKAMBI 100-125 MG GRANULE PKT	T5	PA QL(56 packs/fill) SP HD
ORKAMBI 150-188 MG GRANULE PKT	T5	PA QL(56 packs/fill) SP HD
ORKAMBI 200 MG-125 MG TABLET	T5	PA QL(112 tabs/fill) SP HD
ORKAMBI 75-94 MG GRANULE PKT	T5	PA QL(56 packs/fill) SP HD
SYMDEKO	T5	PA QL(56 tabs/fill) SP HD
TRIKAFTA	T5	PA QL(84 tabs/fill) SP HD
TRIKAFTA GRANULE PKT	T5	PA QL(84 pkts/fill) SP HD
CYSTIC FIB-TRANSMEMB CONDUCT.REG.(CFTR) POTENTIATOR		
KALYDECO 150 MG TABLET	T5	PA QL(56 tabs/fill) SP HD
KALYDECO GRANULES PACKET	T5	PA QL(56 packs/fill) SP HD
KALYDECO 5.8 MG GRANULES PKT	T5	PA QL(56 packs/fill) SP HD

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List of Prescription Medications

UNCLASSIFIED DRUG PRODUCTS (Asthma/COPD/Respiratory) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
DIPEPTIDYL PEPTIDASE I (DPPI) INHIBITOR		
BRINSUPRI	T6	PA SP
LUNG SURFACTANTS		
CUROSURF	T4	
INFASURF	T4	
SURVANTA	T4	
MUCOLYTICS		
PULMOZYME	T5	PA SP HD
PULMONARY FIBROSIS - SYSTEMIC ENZYME INHIBITORS		
OFEV	T5	PA QL (60 caps/fill) SP HD
SYSTEMIC ENZYME INHIBITORS		
VIJOICE 250 MG DAILY DOSE PACK	T5	PA QL (56 tabs/28 days) SP
VIJOICE 50 MG GRANULE PACKET	T5	PA QL (28 packs/28 days) SP
JOENJA 70 MG TABLET	T6	PA QL (60 tabs/30 days) SP
VIJOICE 50 MG, 125 MG TABLET	T5	PA QL (28 tabs/28 days) SP
ZOKINVY	T6	PA QL (120 caps/fill) SP
SYSTEMIC ENZYME INHIBITORS		
TEZSPIRE 210 MG/1.91 ML PEN	T5	PA QL (1 pen/28 days SP HD
TEZSPIRE 210 MG/1.91 ML SYRING	T5	PA QL (1 syg/28 days) SP HD
UNCLASSIFIED DRUG PRODUCTS (Blood Modifiers/Bleeding Disorders)		
SPLEEN/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</i> (Firazyr)	T2	PA SP HD
<i>icatibant acetate</i> (Firazyr)	T2	PA SP
PLASMA KALLIKREIN INHIBITORS		
ORLADEYO	T6	PA QL (28 caps/28 days) SP
TAKHZYRO 300MG/2ML	T5	PA QL (2 units/28 days) SP HD
UNCLASSIFIED DRUG PRODUCTS (Cancer)		
CHEMOTHERAPY RESCUE/ANTIDOTE AGENTS		
<i>leucovorin calcium</i>	T2	CSL
<i>mesna</i> (MESNEX)	T2	SP CSL
MESNEX (<i>mesna</i>)	T5	SP CSL
VISTOGARD	T5	PA QL (20 packs/fill) SP CSL

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T2 – Non-Preferred Generics
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List of Prescription Medications

UNCLASSIFIED DRUG PRODUCTS (Dental Products)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
DENTAL AIDS AND PREPARATIONS		
<i>chlorhexidine gluconate</i> (Peridex)	T1	
PERIDEX (<i>chlorhexidine gluconate</i>)	T4	
<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</i> (Stendra)	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)
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>sildenafil 25 mg tablet</i> (Viagra)	T2	PA QL (8 tabs/30 days) HD
<i>sildenafil 50 mg tablet</i> (Viagra)	T2	PA QL (8 tabs/30 days) HD
<i>sildenafil 100 mg tablet</i> (Viagra)	T2	PA QL (8 tabs/30 days) HD
<i>tadalafil 10 mg tablet</i> (Cialis)	T2	PA QL (8 tabs/30 days) HD
<i>tadalafil 2.5 mg tablet</i>	T2	PA QL (30 tabs/30 days) HD

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

T5 – Preferred Specialty
T6 – Non-Preferred Specialty
PA – Prior Authorization
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List of Prescription Medications

UNCLASSIFIED DRUG PRODUCTS (Erectile Dysfunction) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
DRUGS TO TREAT ERECTILE DYSFUNCTION (ED) (cont.)		
<i>tadalafil 5 mg tablet</i> (Cialis)	T2	PA QL (8 tabs/30 days) HD
<i>tadalafil 20 mg tablet</i> (Cialis)	T2	PA QL (8 tabs/30 days) HD
TRI-MIX (PAPVRN-PHNTLMN-PGE1)	T3	
<i> sildenafil hcl</i>	T2	PA QL (8 tabs/fill)
<i> sildenafil 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	

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List of Prescription Medications

UNCLASSIFIED DRUG PRODUCTS (Gastrointestinal/Heartburn) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
THYROID HORMONE RECEPTOR (THR) AGONIST		
REZDIFFRA	T5	PA QL (30 tabs/30 days) SP HD
UNCLASSIFIED DRUG PRODUCTS (Hormonal Agents)		
GROWTH HORMONE RECEPTOR ANTAGONISTS		
SOMAVERT	T5	PA SP HD
HYPERPARATHYROID TX AGENTS - VITAMIN D ANALOG-TYPE		
<i>doxercalciferol</i>	T2	ST
<i>paricalcitol</i>	T2	ST SP HD
<i>paricalcitol</i> (Zemplar)	T2	ST SP HD
RAYALDEE	T4	ST
ZEMPLAR (<i>paricalcitol</i>)	T6	ST SP HD
UNCLASSIFIED DRUG PRODUCTS (Miscellaneous)		
ABORTIFACIENT-PROGESTERONE RECEPTOR ANTAGONISTS		
MIFEPREX	T4	
<i>mifepristone 200 mg tablet</i>	T2	
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	

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List of Prescription Medications

UNCLASSIFIED DRUG PRODUCTS (Miscellaneous) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
DRUGS TO TX GAUCHER DX-TYPE I, SUBSTRATE REDUCING		
CERDELGA	T5	PA QL (56 caps/28 days) SP HD
ENVIRONMENT ALLERGENS AND IRRITANTS, OTHER		
T.R.U.E. TEST	T4	
GENERAL INHALATION AGENTS		
HYPER-SAL	T4	
nebusal 3% vial	T2	
NEBUSAL 6% VIAL	T4	
sodium chloride for inhalation	T2	
sodium chloride 0.9% inhal v	T2	
sodium chloride 10% vial	T2	
sodium chloride 3%, 7% vial	T2	
GENETIC D/O TX - SMN PROTEIN DEFICIENCY TREATMENT		
EVRYSDI	T6	PA SP HD
GLUCOSYLCERAMIDE SYNTHASE (GCS) INHIBITOR		
miglustat (Zavesca)	T2	PA QL(90 caps/30 days) SP
OPFOLDA	T6	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	T6	PA SP
ORFADIN (nitisinone)	T6	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

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UNCLASSIFIED DRUG PRODUCTS (Miscellaneous) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
METALLIC POISON, AGENTS TO TREAT (cont.)		
<i>deferiprone</i> (Ferriprox (3 Times A Day))	T2	PA SP HD
FERRIPROX (2 TIMES A DAY)	T5	PA SP
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>)	T6	PA SP
GALZIN	T6	SP
RADIOGARDASE	T4	
SYPRINE (<i>trientine hcl</i>)	T6	PA SP HD
NATRIURETIC PEPTIDES		
VOXZOGO	T6	PA SP HD
NEONATAL FC RECEPTOR (FCRN) INHIBITORS		
VYVGART HYTRULO	T6	PA SP HD
NUCLEAR FACTOR ERYTHROID 2-REL. FACTOR 2 ACTIVATOR		
SKYCLARYS	T6	PA SP
PHARMACOLOGICAL CHAPERONE-ALPHA-GALACTOSID.A STABZ		
GALAFOLD	T6	PA QL(15 caps/fill) SP HD
PKU TX AGENT-COFACTOR OF PHENYLALANINE HYDROXYLASE		
<i>sapropterin dihydrochloride</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	T6	PA QL(112 caps/fill) SP
SOHONOS 1.5 MG CAPSULE	T6	PA QL(112 caps/fill) SP
SOHONOS 10 MG CAPSULE	T6	PA QL(56 caps/fill) SP
SOHONOS 2.5 MG CAPSULE	T6	PA QL(140 caps/fill) SP
SOHONOS 5 MG CAPSULE	T6	PA QL(84 caps/fill) SP
SOLVENTS		
CVS ISOPROPYL ALCOHOL 91%	T4	
<i>cvs isopropyl alcohol 91%</i>	T2	
CVS ISOPROPYL RUB ALCOHOL 70%	T4	
<i>cvs isopropyl rub alcohol 70%</i>	T2	

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List of Prescription Medications

UNCLASSIFIED DRUG PRODUCTS (Miscellaneous) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
SOLVENTS (cont.)		
<i>eqi isopropyl alcohol 91%</i>	T2	
<i>eqi isopropyl rub alcohol 70%</i>	T2	
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	
<i>isopropyl alcohol 70%</i>	T2	
ISOPROPYL ALCOHOL 70%	T4	
<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	T6	PA SP

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

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

ST – Step Therapy
AGE – Age Requirement
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List of Prescription Medications

UNCLASSIFIED DRUG PRODUCTS (Nutritional/Dietary)

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

<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>)	T6	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
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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

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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	T6	PA QL (4 vls/28 days) SP HD
FIBROMYALGIA AGENTS, SEROTONIN-NOREPINEPH RU INHIB		
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 100 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	T6	PA SP HD
LITFULO	T6	PA QL (28 caps/28 days) SP HD
WOUND HEALING AGENTS, LOCAL		
FILSUEZ	T6	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	

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List of Prescription Medications

UNCLASSIFIED DRUG PRODUCTS (Transplant Medications)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
RHO KINASE INHIBITOR		
REZUROCK	T6	PA QL(30 tabs/fill) SP
UNCLASSIFIED DRUG PRODUCTS (Urinary Tract Conditions)		
BENIGN PROSTATIC HYPERTROPHY/MICTURITION AGENTS		
<i>alfuzosin hcl</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		
THIOLA EC (<i>tiopronin</i>)	T6	PA SP
<i>tiopronin 100 mg tablet</i> (Thiola)	T2	PA SP
<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
OVERACTIVE BLADDER AGENTS, BETA-3 ADRENERGIC RECEPTOR		
GEMTESA	T4	HD
MYRBETRIQ	T3	HD
<i>mirabegron</i> (Myrbetriq)	T2	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

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UNCLASSIFIED DRUG PRODUCTS (Urinary Tract Conditions) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
URINARY TRACT ANTISPASMODIC/ANTIINCONTINENCE AGENT		
<i>fesoterodine fumarate (Toviaz)</i>	T2	HD
<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	
PRESERVISION AREDS 2 CO Q-10	T4	
EQ VISION FORMULA TABLET	T3	
<i>eq 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	

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ANTIOXIDANT MULTIVITAMIN COMBINATIONS (cont.)		
ICAPS AREDS2	T4	
LIPOTRIAD	T4	
LIPOTRIAD VISIONARY	T4	
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 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 (Lipo-Flavonoid Plus)</i>	T2	
CITRUS BIOFLAVONOIDS	T4	
EAR HEALTH PLUS CAPLET	T4	
<i>ear health plus caplet (Lipo-Flavonoid Plus)</i>	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	

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VITAMINS (Nutritional/Dietary) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
BIOFLAVONOIDS (cont.)		
VASCULERA	T4	
VASOFLEX D1	T4	
VENALIV	T4	
FOLIC ACID PREPARATIONS		
COBALEFOL	T4	
<i>cvs folic acid 800 mcg tablet</i>	T2	PPACA
DENOVO	T4	
DEPLIN-ALGAL OIL (<i>levomefolate/algae 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 20 MG CAPSULE	T4	
<i>folic acid 400 mcg, 800 mcg tablet</i>	T2	PPACA
FOLIC ACID 5 MG CAPSULE	T4	
<i>folic acid 5 mg/ml vial</i>	T2	
<i>folic acid 50 mg/10 ml vial</i>	T2	
FOLIC ACID 800 MCG CAPSULE	T4	
<i>folic acid/b6/ca phos/ginger</i>	T2	
FOLIKA-V	T4	
FOLITE	T4	
<i>ft folic acid 400 mcg tablet</i>	T2	PPACA
<i>ft folic acid 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/algae oil (Deplin-Algae Oil)</i>	T2	
METHYLFOLATE	T4	
MI-VITE RX	T4	

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List of Prescription Medications

VITAMINS (Nutritional/Dietary) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
FOLIC ACID PREPARATIONS (cont.)		
PUREVITA FOLIC ACID	T4	
<i>ra folic acid 0.4 mg tablet</i>	T2	PPACA
<i>ra folic acid 800 mcg tablet</i>	T2	PPACA
<i>sm folic acid 0.4 mg tablet</i>	T2	PPACA
<i>sm folic acid 400 mcg tablet</i>	T2	PPACA
<i>sv folic acid 800 mcg tablet</i>	T2	PPACA
<i>true folic acid 1600mcg dfe tb</i>	T2	
<i>true folic acid 667 mcg dfe tb</i>	T2	PPACA
XAQUIL XR	T4	
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	

T1 – Preferred Generics

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VITAMINS (Nutritional/Dietary) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
MULTIVITAMIN PREPARATIONS (cont.)		
ABC COMPLETE MEN'S	T3	
ABC COMPLETE SENIOR WOMEN'S	T4	
ACTIVNUTRIENTS	T4	
ACTIVNUTRIENTS PERFORMANCE	T4	
ADEK GUMMIES PLUS ZINC	T4	
ADULT MULTI GUMMIES	T4	
ADULT MULTIVITAMIN GUMMIES	T4	
ADULT ONE DAILY GUMMIES	T4	
ADULTS' DAILY FORMULA	T4	
ADULTS MULTI	T4	
ADULTS MULTIVITAMIN	T4	
ADVANCED MULTI EA	T4	
AFLOA	T4	
ALIVE ADULT ULTRA POTENCY	T4	
ALIVE COMPLETE PREMIUM PRENATL	T4	
ALIVE HAIR, SKIN AND NAILS	T4	
ALIVE DAILY SUPPORT PRENATAL	T4	
ALIVE MAX POTENCY	T4	
ALIVE MAX6 POTENCY	T4	
ALIVE MEN'S 50 PLUS GUMMY	T4	
ALIVE MEN'S 50 PLUS ULTRA	T4	
ALIVE MEN'S ULTRA POTENCY	T4	
ALIVE PREMIUM ADULT	T4	
ALIVE MEN'S ENERGY	T4	
ALIVE MEN'S GUMMY	T4	
ALIVE PREMIUM PRENATAL	T4	
ALIVE WOMEN'S 50 PLUS	T4	
ALIVE WOMEN'S 50 PLUS COMPLETE	T4	
ALIVE WOMEN'S 50 PLUS ULTRA	T4	
ALIVE WOMEN'S ENERGY	T4	
ALIVE WOMEN'S GUMMY VITAMIN	T4	
ALIVE WOMEN'S MULTIVITAMIN	T4	
ALIVE WOMEN'S ULTRA POTENCY	T4	
ALPHA BETIC MULTIVITAMIN	T4	

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VITAMINS (Nutritional/Dietary) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
MULTIVITAMIN PREPARATIONS (cont.)		
ALTRIXA	T4	
<i>amino acids/mv,tx,iron,mineral</i>	T2	
AMLADEX	T4	
ANIMI-3	T4	
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 PLUS	T4	
CENTRUM ADULT 50 FRESH-FRUITY	T4	
CENTRUM CHEWABLES ADULTS TAB	T3	
CENTRUM CHEWABLES ADULTS TAB	T4	
CENTRUM COMPLETE	T3	
CENTRUM FLAVOR BURST ADULT	T4	
CENTRUM MEN 50 PLUS	T4	
CENTRUM MEN MULTIGUMMY	T4	
CENTRUM MEN'S TABLET	T3	
CENTRUM MENOPAUSE MULTIVITAMIN	T4	
CENTRUM MULTI MENTAL FOCUS	T4	
CENTRUM MULTI PLUS BEAUTY	T4	
CENTRUM MULTI PLUS OMEGA-3	T4	
CENTRUM MULTIGUMMIES	T4	
CENTRUM POSTNATAL	T4	

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AGE – Age Requirement

SP – Specialty Medication

HD – May require home delivery pharmacy

PPACA – No Cost-Share Preventive Medication

CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

VITAMINS (Nutritional/Dietary) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
MULTIVITAMIN PREPARATIONS (cont.)		
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	
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 (Certavite-Antioxidant)</i>	T2	
<i>centrum women tablet (Tab-A-Vite Multivit With Iron)</i>	T2	
<i>certavite-antioxidant tablet (Certavite-Antioxidant)</i>	T2	
CERTAVITE-ANTIOXIDANT TABLET (<i>multivitamin/iron/folic acid</i>)	T4	
<i>certavite-antioxidant tablet (Tab-A-Vite Multivit With Iron)</i>	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 adult multivitamin gummy</i>	T2	
<i>cvs b-complex-vit c caplet</i>	T2	
<i>cvs hair, skin and nails cplt</i>	T2	
<i>cvs one daily essential tablet (Daily-Vite)</i>	T2	
DAILY GUMMIES	T4	
DAILY MULTIVITAMIN	T4	
DAILY MULTIPLE	T3	
<i>daily-vite tablet (Daily-Vite)</i>	T2	
DAILY-VITE TABLET (<i>multivitamin with folic acid</i>)	T4	
DAVIMET WITH IRON	T4	

T1 – Preferred Generics

T2 – Non-Preferred Generics

T3 – Preferred Brands

T4 – Non-Preferred Brands

T5 – Preferred Specialty

T6 – Non-Preferred Specialty

PA – Prior Authorization

QL – Quantity Limit

ST – Step Therapy

AGE – Age Requirement

SP – Specialty Medication

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List of Prescription Medications

VITAMINS (Nutritional/Dietary) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
MULTIVITAMIN PREPARATIONS (cont.)		
DAYAVITE	T4	
DECUBI VITE	T4	
DEKAS BARIATRIC	T4	
DEKAS ESSENTIAL	T4	
DEKAS PLUS	T4	
DERMACINRX FOLIFLEX	T4	
DERMACINRX FOLITIN-Z	T4	
DERMACINRX MULTITAM	T4	
DERMACINRX RIBOTIN-E	T4	
DERMACINRX VENEXA	T4	
DERMACINRX VENEXA FE	T4	
DERMACINRX VENTRIXYL	T4	
DERMACINRX VENTRIXYL FE	T4	
DERMACINRX VITRAMYN	T4	
DERMACINRX VITRANOL	T4	
DERMACINRX VITRANOL FE	T4	
DERMACINRX VITREXATE	T4	
DERMACINRX VITREXATE FE	T4	
DERMACINRX ZINTREXYL-C	T4	
DIABETES HEALTH FORMULA	T4	
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	

T1 – Preferred Generics

T2 – Non-Preferred Generics

T3 – Preferred Brands

T4 – Non-Preferred Brands

T5 – Preferred Specialty

T6 – Non-Preferred Specialty

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List of Prescription Medications

VITAMINS (Nutritional/Dietary) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
MULTIVITAMIN PREPARATIONS (cont.)		
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	
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 century women tablet (Certavite-Antioxidant)</i>	T2	
<i>ft century women tablet (Tab-A-Vite Multivit With Iron)</i>	T2	
<i>ft one daily men's tablet</i>	T2	
<i>ft one daily women's tablet</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	

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

T5 – Preferred Specialty
T6 – Non-Preferred Specialty
PA – Prior Authorization
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List of Prescription Medications

VITAMINS (Nutritional/Dietary) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
MULTIVITAMIN PREPARATIONS (cont.)		
GNP CENTURY WOMEN TABLET	T4	
GNP ONE DAILY MAXIMUM TABLET	T4	
<i>gnp one daily tablet</i>	T2	
HAIR, SKIN AND NAILS CAPLET	T4	
HAIR, SKIN AND NAILS SOFTGEL	T4	
HAIR, SKIN AND NAILS TABLET (<i>multivitamin/folic acid/biotin</i>)	T4	
HEARTBURN ACID REFLUX	T4	
<i>high potency multivitamin tab</i>	T2	
HIGH POTENCY MULTIVITAMIN TAB	T4	
<i>high potency multivitamin tab</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>lme folate/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 MULTIVITAMIN	T4	
MEN'S ONE DAILY	T3	
MICRONEX	T4	

T1 – Preferred Generics

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T3 – Preferred Brands

T4 – Non-Preferred Brands

T5 – Preferred Specialty

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List of Prescription Medications

VITAMINS (Nutritional/Dietary) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
MULTIVITAMIN PREPARATIONS (cont.)		
MONOCAPS	T4	
MULTI FOR HER 50 PLUS	T4	
MULTI FOR HER SOFTGEL	T4	
<i>multi for her tablet</i>	T2	
MULTI PRO	T4	
MULTI-DAY PLUS MINERALS	T4	
MULTIA DAILY MULTIVITAMIN	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.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/hb179</i>	T2	
<i>multivit-minerals/folic acid</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	

T1 – Preferred Generics

T2 – Non-Preferred Generics

T3 – Preferred Brands

T4 – Non-Preferred Brands

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VITAMINS (Nutritional/Dietary) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
MULTIVITAMIN PREPARATIONS (cont.)		
<i>multivitamin/iron/folic acid</i> (Certavite-Antioxidant)	T2	
<i>multivitamin/iron/folic acid</i> (Tab-A-Vite Multivit With Iron)	T2	
MULTI-VITE	T4	
<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/folic acid</i>	T2	
<i>multivit-min/iron fum/folic ac</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> (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>multivit no.18/iron no.1/folic</i> (Tandem Plus)	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 ac/calcium/vit k1</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	
MVW MODULATR FORM MINI MULTIVT	T4	
NEEVODHA	T4	
NEOVITE	T4	
NESTABS ONE	T4	
NICOMIDE	T4	

T1 – Preferred Generics

T2 – Non-Preferred Generics

T3 – Preferred Brands

T4 – Non-Preferred Brands

T5 – Preferred Specialty

T6 – Non-Preferred Specialty

PA – Prior Authorization

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List of Prescription Medications

VITAMINS (Nutritional/Dietary) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
MULTIVITAMIN PREPARATIONS (cont.)		
NIVA-PLUS (<i>multivit-min 60/iron fum/folic</i>)	T4	
NUTRALYN	T4	
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	

T1 – Preferred Generics

T2 – Non-Preferred Generics

T3 – Preferred Brands

T4 – Non-Preferred Brands

T5 – Preferred Specialty

T6 – Non-Preferred Specialty

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List of Prescription Medications

VITAMINS (Nutritional/Dietary) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
MULTIVITAMIN PREPARATIONS (cont.)		
ONE-A-DAY MENOPAUSE FORMULA	T4	
ONE-A-DAY MEN'S	T3	
ONE-A-DAY MEN'S 50 PLUS	T3	
ONE-A-DAY MEN'S 50 PLUS (<i>mv-mins/folic/lycopene/ginkgo</i>)	T3	
ONE-A-DAY MEN'S COMPLETE	T4	
ONE-A-DAY PROACTIVE 65 PLUS	T4	
ONE-A-DAY TRIPLE IMMUNE SUPPRT	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 50 PLUS TAB	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	

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

T5 – Preferred Specialty
T6 – Non-Preferred Specialty
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List of Prescription Medications

VITAMINS (Nutritional/Dietary) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
MULTIVITAMIN PREPARATIONS (cont.)		
PROCERV HP	T4	
PROFOLA	T4	
PRORENAL QD	T3	
PROTECT CARDIO AF	T4	
PROTECT IRON	T4	
PROTECT PLUS SO	T4	
PUREFE OB PLUS	T4	
PUREFE PLUS	T4	
QUINTABS	T4	
QUINTABS-M	T4	
<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	
REMEDIANT	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	

T1 – Preferred Generics

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T3 – Preferred Brands

T4 – Non-Preferred Brands

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List of Prescription Medications

VITAMINS (Nutritional/Dietary) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
MULTIVITAMIN PREPARATIONS (cont.)		
TAB-A-VITE MULTIVIT WITH IRON (<i>multivitamin/iron/folic acid</i>)	T4	
TANDEM PLUS (multivit no.18/iron no.1/folic)	T4	
THERAGRAN-M PREMIER 50 PLUS	T4	
<i>thera-m caplet</i>	T2	
THERA-M CAPLET	T4	
THERAMILL FORTE	T4	
THERANATAL LACTATION SUPPORT	T4	
THEREMS-H	T3	
TOBAKIENT	T4	
TRIVIA COMPLETE	T4	
TRUE MULTIVITAMIN	T4	
TRUEPLUS MULTIVITAMIN (<i>multivit-min/folic acid/vit k1</i>)	T4	
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</i> (Support-500)	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	

T1 – Preferred Generics

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T3 – Preferred Brands

T4 – Non-Preferred Brands

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VITAMINS (Nutritional/Dietary) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
MULTIVITAMIN PREPARATIONS (cont.)		
WOMEN'S MULTIVITAMIN W-BIOTIN	T4	
XYZBAC	T4	
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	
<i>niacin 100 mg tablet</i>	T2	
<i>niacin 250 mg tablet</i>	T2	
<i>niacin 50 mg tablet</i>	T2	
<i>niacin 500 mg capsule</i>	T2	
<i>niacin 500 mg capsule sa</i>	T2	
NIACIN 500 MG SOFTGEL	T3	
<i>niacin 500 mg tablet</i>	T2	
<i>niacin 750 mg tablet sa (Slo-Niacin)</i>	T2	
NIACIN ER 1,000 MG TABLET	T3	
<i>niacin er 250 mg tablet (Slo-Niacin)</i>	T2	
<i>niacin er 500 mg caplet</i>	T2	
<i>niacin er 500 mg capsule</i>	T2	
<i>niacin er 500 mg tablet</i>	T2	
<i>niacin flush free 500 mg cap</i>	T2	
NIACIN FLUSH FREE 750 MG CAP	T3	
<i>niacin sa 250 mg capsule</i>	T2	
<i>niacin tr 250 mg capsule</i>	T2	
<i>niacin tr 250 mg tablet (Slo-Niacin)</i>	T2	

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List of Prescription Medications

VITAMINS (Nutritional/Dietary) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
NIACIN PREPARATIONS (cont.)		
<i>niacin tr 500 mg caplet, tablet</i>	T2	
NIACINAMIDE 500 MG CAPSULE	T4	
<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	
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 tablet</i>	T2	
<i>true vitamin b3 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	

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
PEDIATRIC VITAMIN PREPARATIONS (cont.)		
<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	
CULTURELLE KIDS PRO-MV-LUTEIN	T4	
DAVIMET WITH FLUORIDE	T4	
DEKAS PLUS	T2	
EMERGEN-C KIDZ	T4	
EMERGEN-C KIDZ DAILY IMMUNE	T4	
EMERGEN-C KIDZ IMMUNE PLUS	T4	
EQ CHILD MULTIVITAMIN GUMMIES	T4	
FLINTSTONES COMPLETE GUMMIES	T3	
FLINTSTONES COMPLETE TABLET (<i>multivit with iron,minerals</i>)	T4	
FLINTSTONES EXTRA C GUMMIES	T3	
FLINTSTONES EXTRA C TAB CHEW (<i>multivitamin</i>)	T4	
FLINTSTONES GUMMIES	T3	
FLINTSTONES GUMMIES CHEW TAB	T3	
FLINTSTONES IMMUNITY SUPPORT	T4	
FLINTSTONES MULTIVIT CHEW TAB (<i>pedi multivit no.25/folic acid</i>)	T4	
FLINTSTONES MULTI-VIT GUMMIES	T4	
FLINTSTONES PLUS CALCIUM	T3	
FLINTSTONES SOUR-GUM CHEW TAB	T3	
FLINTSTONES TAB CHEW	T4	
FLINTSTONES TABLET CHEWABLE (multivitamin)	T3	
FLINTSTONES WITH IRON	T4	
FLORAFOL PEDIATRIC	T4	
FLORAFOL FE PEDIATRIC	T4	
FLORIVA	T3	
FLORIVA PLUS	T4	
GENADEK	T4	

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PEDIATRIC VITAMIN PREPARATIONS (cont.)		
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	
infant-toddler multivit-iron	T2	
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	
M.V.I. PEDIATRIC	T3	
<i>multivit with iron,minerals</i>	T2	
<i>multivit with iron,minerals (Flintstones Complete)</i>	T2	
<i>multivit with iron,minerals (Scooby-Doo)</i>	T2	
<i>multivitamin (Flintstones With Extra C)</i>	T2	
<i>multivitamin (Flintstones)</i>	T2	
<i>multivitamin with iron</i>	T2	
MULTI-VIT-FLOR	T4	
MULTIVIT-FLUOR 0.25 MG TAB CHW	T4	
<i>multivit-fluor 0.25 mg, 0.5 mg tab chw</i>	T2	PPACA
<i>multivit-fluor 0.25 mg/ml drop</i>	T2	PPACA
MULTIVIT-FLUOR 0.5 MG TAB CHEW	T4	
<i>multivit-fluor 0.5 mg/ml drop</i>	T2	PPACA
<i>multivit-fluoride 1 mg tab chw</i>	T2	PPACA
MULTIVIT-FLUORIDE 1 MG TAB CHW	T4	
MVW COMPLETE FORMLTN PEDIATRIC	T4	

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
PEDIATRIC VITAMIN PREPARATIONS (cont.)		
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	
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</i>	T2	
<i>pediatric multivitamin no.111</i>	T2	
<i>pediatric multivitamin no.212</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	

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VITAMINS (Nutritional/Dietary) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
PEDIATRIC VITAMIN PREPARATIONS (cont.)		
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	
SCOOPY-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
TRI-VIT-FLUOR 0.25 MG/ML DROP	T4	
<i>tri-vit-fluor 0.5 mg/ml drop</i>	T2	PPACA
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		
cod liver oil softgel	T2	
gnp norwegian cod liver oil	T2	
SV COD LIVER OIL SOFTGEL	T4	
VITAMIN A PREPARATIONS		
A-25	T4	
AQUASOL A	T3	
<i>beta-carotene</i>	T2	
<i>cvs vitamin a 2,400 mcg sftgl</i>	T2	
FT VITAMIN A 3,000 MCG SOFTGEL	T4	
GNP VITAMIN A 10,000 UNIT SFGL	T4	
NORWEGIAN COD LIVER OIL SFGL	T4	

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VITAMINS (Nutritional/Dietary) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
VITAMIN A PREPARATIONS (cont.)		
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	
<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/lysin/znox</i>	T2	HD
<i>b complex 11/folic/c/biot/zinc</i>	T2	HD
<i>b complex c no.10/folic acid</i>	T2	HD
<i>b complex capsule</i>	T2	HD
<i>b complex tablet</i>	T2	HD
<i>b complex, 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>balanced b-100 complex tab sa</i>	T2	HD
<i>b-100 complex tr caplet</i>	T2	HD

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List of Prescription Medications

VITAMINS (Nutritional/Dietary) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
VITAMIN B PREPARATIONS (cont.)		
<i>b-complex tablet (Vitamin B Complex-Electrolytes)</i>	T2	HD PPACA
B-100 COMPLEX CAPSULE	T4	HD
B-COMPLEX FAST DISSOLVE TABLET	T4	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
B-COMPLEX WITH B-12	T4	HD
<i>b-complex with b12 tablet</i>	T2	HD
<i>b-complex with vit c caplet (Vita-Bee With C)</i>	T2	HD PPACA
<i>b-complex with vit c tablet (Vita-Bee With C)</i>	T2	HD PPACA
B-COMPLEX-VITAMIN C TR TABLET	T3	HD
BIOTIN 1,000 MCG GUMMIES	T4	HD
<i>biotin 1,000 mcg tablet</i>	T2	HD
BIOTIN 10 MG TABLET	T3	HD
BIOTIN 10,000 MCG SOFTGEL	T4	HD
BIOTIN 10,000 MCG TABLET	T3	HD
<i>biotin 2,500 mcg softgel (Hard Nails)</i>	T2	HD
<i>biotin 300 mcg tablet</i>	T2	HD
BIOTIN 5 MG TABLET	T4	HD
<i>biotin 5,000 mcg capsule (Meribin)</i>	T2	HD
BIOTIN 5,000 MCG FAST DISSOLVE	T4	HD
BIOTIN 5,000 MCG QUICK DISSOLV	T4	HD
<i>biotin 5,000 mcg softgel (Meribin)</i>	T2	HD
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

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
VITAMIN B PREPARATIONS (cont.)		
COMPLETE LIVER CLEANSE	T4	HD
COMPLEX B-100 ER CAPLET	T4	HD
<i>complex b-100 tablet sa</i>	T2	HD
COMPLEX B-50	T4	HD
CVS BALANCED B-100 TR CAPLET	T4	HD
<i>cvs biotin 1,000 mcg tablet</i>	T2	HD
CVS BIOTIN 5,000 MCG TABLET	T4	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
<i>cyanocobalamin/folic ac/vit b6</i>	T2	HD PPACA
<i>cyanocobalamin/folic ac/vit b6</i> (Niva-Fol)	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>eqi 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</i> (Vita-Bee With C)	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

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
VITAMIN B PREPARATIONS (cont.)		
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
<i>ft biotin 5,000 mcg capsule (Meribin)</i>	T2	HD
FT BIOTIN 10,000 MCG TABLET	T3	HD
FT BIOTIN 2,500 MCG GUMMY	T4	HD
GENICIN VITA-S	T4	HD
<i>gnp b-100 complex tablet</i>	T2	HD
GNP BIOTIN 10,000 MCG TABLET	T3	HD
GNP BIOTIN 2,500 MCG GUMMY	T4	HD
<i>gnp biotin 5,000 mcg capsule (Meribin)</i>	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 (Meribin)</i>	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/algal oil</i>	T2	HD
LEVOMEFOLATE-NAC-MECOBAL-ALGAL	T4	HD
LEVOMEFOL-PYRIDOXAL-MEC-ALGAL	T4	HD
<i>l-mefol/a-cyst/meb12/algal 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

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HD – May require home delivery pharmacy
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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.)		
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
PRORENAL	T3	HD
PUREVITA SUPER B-COMPLEX	T4	HD
QUIN B STRONG	T4	HD
<i>ra balanced b-100 tablet</i> (Vitamin B Complex-Electrolytes)	T2	HD PPACA
<i>ra b-complex-vitamin b-12 tab</i>	T2	HD
<i>ra biotin 2,500 mcg capsule</i> (Hard Nails)	T2	HD
RELCARE	T4	HD
RENAL VITAMIN	T4	HD
RENAL MULTIVITAMIN	T4	HD
RENAL-VITE	T4	HD
RENAPLEX	T4	HD
RENAPLEX-D	T4	HD
RIBOZEL	T4	HD
<i>sm biotin 5,000 mcg capsule</i> (Meribin)	T2	HD
<i>sm stress formula+zinc tablet</i>	T2	HD
<i>super b complex-vit c caplet</i> (Vita-Bee With C)	T2	HD PPACA
<i>super quints b-50 tablet</i> (Vitamin B Complex-Electrolytes)	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</i> (Meribin)	T2	HD
TRONVITE	T4	HD
ULTRA B-100 COMPLEX TABLET	T4	HD
<i>ultra b-100 complex tablet</i>	T2	HD

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

T5 – Preferred Specialty
T6 – Non-Preferred Specialty
PA – Prior Authorization
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List of Prescription Medications

VITAMINS (Nutritional/Dietary) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
VITAMIN B PREPARATIONS (cont.)		
VIRT-CAPS (<i>b complex, c no.20/folic acid</i>)	T4	HD
<i>vit b comp c 19/folic acid/d3</i>	T2	HD PPACA
<i>vit b comp no.3/folic/c/biotin</i>	T2	HD
<i>vit b comp/c/fa/iron sulf/vite</i>	T2	HD PPACA
<i>vit b comp/c/folic/iron/vit e</i>	T2	HD PPACA
<i>vit b 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
VITAJoy BIOTIN	T4	HD
VITAL-D RX	T4	HD
<i>vitamin b complex</i>	T2	HD
<i>vitamin b complex capsule</i>	T2	HD
<i>vitamin b complex softgel</i>	T2	HD
<i>vitamin b complex tablet</i>	T2	HD
<i>vitamin b complex tablet (Vitamin B Complex-Electrolytes)</i>	T2	HD PPACA
<i>vitamin b complex/folic acid (Vitamin B Complex-Electrolytes)</i>	T2	HD PPACA
VITAMIN B COMPLEX-ELECTROLYTES (<i>vitamin b complex/folic acid</i>)	T4	HD
<i>vitamin b complex/lysine (Apetex)</i>	T2	HD
<i>vitamin b complex/lysine (Apetigen)</i>	T2	HD
<i>vitamin b complex-vitamin c tb (Vita-Bee With C)</i>	T2	HD PPACA
<i>vitamin b-complex c caplet</i>	T2	HD PPACA
VITA-RESPA	T4	HD
VITASURE	T4	HD
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	
PUREVITA VITAMIN B1	T4	
<i>ra vitamin b-1 100 mg tablet</i>	T2	
<i>thiamine hcl</i>	T2	
THIAMINE HCL-0.9% NACL	T4	

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T4 – Non-Preferred Brands

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List of Prescription Medications

VITAMINS (Nutritional/Dietary) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
VITAMIN B1 PREPARATIONS (cont.)		
<i>thiamine 100 mg tablet</i>	T2	
<i>thiamine 250 mg tablet</i>	T2	
THIAMINE 500 MG TABLET	T4	
<i>thiamine 200 mg/2 ml vial</i>	T2	
<i>true vitamin b-1 100 mg tablet</i>	T2	
TRUE VITAMIN B-1 250 MG TABLET	T4	
TRUE VITAMIN B-1 50 MG TABLET	T4	
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	
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>b12 2,500 mcg tablet sl</i>	T2	
<i>b-12 2,500 mcg tablet sl</i>	T2	
B-12 3,000 MCG TABLET SL	T4	
<i>b-12 3,000 mcg/ml subling liq</i>	T2	
B-12 5,000 MCG FAST DISSOLVE	T4	
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	

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VITAMINS (Nutritional/Dietary) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
VITAMIN B12 PREPARATIONS (cont.)		
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	T3	
CVS VIT B-12 500 MCG LOZENGE	T3	
<i>cvs vit b-12 500 mcg lozenge</i>	T2	
<i>cvs vit b-12 tr 1,000 mcg tab</i>	T2	
<i>cvs vit b-12 tr 2,000 mcg tab</i>	T2	
<i>cvs vitamin b12 5,000 mcg chew</i>	T2	
CVS VIT B12 2,500 MCG SOFT CHW	T4	
CVS VITAMIN B12 5,000 MCG TAB	T4	
CVS VITAMIN B-12 500 MCG GUMMY	T4	
<i>cvs vitamin b-12 500 mcg tab</i>	T2	
<i>cyanocobalamin (vitamin b-12) (Nascobal)</i>	T2	ST QL(4 units/30 days)
<i>eql vitamin b-12 500 mcg tab</i>	T2	
<i>fn vitamin b-12 1,000 mcg tab</i>	T2	
FOLTRATE	T4	
FT VITAMIN B-12 1500 MCG GUMMY	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 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 1500 MCG 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	

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VITAMINS (Nutritional/Dietary) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
VITAMIN B12 PREPARATIONS (cont.)		
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	
<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 B-12 250 MCG LOZENGE	T4	
<i>vitamin b-12 250 mcg tablet</i>	T2	
VITAMIN B12 2,500 MCG TABLET	T4	
VITAMIN B-12 3,000 MCG SL LOZ	T4	

T1 – Preferred Generics

T2 – Non-Preferred Generics

T3 – Preferred Brands

T4 – Non-Preferred Brands

T5 – Preferred Specialty

T6 – Non-Preferred Specialty

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List of Prescription Medications

VITAMINS (Nutritional/Dietary) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
VITAMIN B12 PREPARATIONS (cont.)		
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	
VITAMIN B-12 500 MCG LOZENGE	T3	
<i>vitamin b12 500 mcg tablet</i>	T2	
<i>vitamin b-12 500 mcg tablet</i>	T2	
<i>vitamin b-12 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>ft vitamin b-6 100 mg tablet</i>	T2	
<i>eqi 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	

T1 – Preferred Generics

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T3 – Preferred Brands

T4 – Non-Preferred Brands

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T6 – Non-Preferred Specialty

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List of Prescription Medications

VITAMINS (Nutritional/Dietary) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
VITAMIN B6 PREPARATIONS (cont.)		
<i>pyridoxine 50 mg tablet</i> (Pyridoxine Hcl)	T2	
PYRIDOXINE 500 MG TABLET (<i>pyridoxine hcl (vitamin b6)</i>)	T4	
<i>pyridoxine hcl (vitamin b6)</i>	T2	
<i>pyridoxine hcl (vitamin b6)</i> (Pyridoxine Hcl)	T2	
<i>ra vitamin b-6 100 mg tablet</i>	T2	
<i>ra vitamin b-6 50 mg tablet</i>	T2	
<i>sm vitamin b-6 100 mg tablet</i>	T2	
<i>sv vitamin b-6 100 mg tablet</i>	T2	
TRUE VITAMIN B-6 10 MG TABLET	T4	
<i>true vitamin b-6 25 mg, 50 mg, 100 mg tablet</i>	T2	
<i>vitamin b-6 25 mg, 50 mg, 100 mg, 250 mg tablet</i>	T2	
VB6 P5P	T4	
VITAMIN C PREPARATIONS		
ASCOR	T4	
<i>ascorbate calcium</i>	T2	
<i>ascorbic acid</i>	T2	
<i>ascorbic acid 500 mg tablet</i>	T2	
<i>ascorbic acid 500 mg/5 ml cup</i>	T2	
<i>ascorbic acid 500 mg/ml vial</i>	T2	
ASCORBIC ACID GRANULES	T3	
<i>ascorbic acid/ascorbate sodium</i>	T2	
BIO C 1:1	T4	
<i>c-1,000 mg tablet sa</i>	T2	
<i>cod liver oil tab chewable</i>	T2	
<i>cvs vit c-rose hip 1,000 mg tb</i>	T2	
<i>cvs vit c-rose hip 500 mg chew</i>	T2	
<i>cvs vit c-rose hip 500 mg cplt</i>	T2	
<i>cvs vit c-rose hips 500 mg tab</i>	T2	
<i>cvs vitamin c 500 mg, 1,000 mg caplet</i>	T2	
CVS VITAMIN C 1,000 MG POWDER	T4	
<i>cvs vitamin c 250 mg, 500 mg tablet</i>	T2	
CYTO C	T4	
EASY-C IMMUNE HEALTH	T4	
EMERGEN-C	T4	

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VITAMINS (Nutritional/Dietary) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
VITAMIN C PREPARATIONS (cont.)		
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	
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	
<i>ft vitamin c 1,000 mg tablet</i>	T2	
FT VITAMIN C 500 MG CHEW TAB	T3	
GNP VITAMIN C 125 MG GUMMY	T4	
<i>gnp vit c-rose hips 500 mg tab</i>	T2	
<i>gnp vitamin c 250 mg, 500 mg, 1,000 mg tablet</i>	T2	
<i>gnp vitamin c 500 mg tab chew</i>	T2	
<i>gnp vitamin c er 500 mg tablet</i>	T2	
<i>hm vit c-rose hip 1,000 mg tab</i>	T2	
<i>hm vit c-rose hips 500 mg cplt</i>	T2	
<i>hm vitamin c 500 mg tab chew</i>	T2	
LIQUID-C	T4	
PAN-C 500	T4	
PERIDIN-C	T3	
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	

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VITAMINS (Nutritional/Dietary) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
VITAMIN C PREPARATIONS (cont.)		
<i>ra vitamin c 250 mg tablet</i>	T2	
<i>ra vitamin c 500 mg chew tab</i>	T2	
<i>ra vitamin c 500 mg tab chew</i>	T2	
<i>ra vitamin c 500 mg tablet</i>	T2	
RA VITAMIN C 53 MG DROP	T4	
<i>ra vitamin c tr 500 mg caplet</i>	T2	
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 hip 1,000 mg tab</i>	T2	
<i>sv vit c-rose hips 1,000 mg tb</i>	T2	
<i>sv vit c-rose hips 500 mg tab</i>	T2	
<i>sv vitamin c 500 mg tab chew</i>	T2	
<i>sv vitamin c tr 1,000 mg tab</i>	T2	
<i>true vitamin c 250 mg tablet</i>	T2	
<i>true vitamin c 500 mg tablet</i>	T2	
<i>true vitamin c 1,000 mg tablet</i>	T2	
<i>vit c-rose hip 1,000 mg caplet</i>	T2	
<i>vit c-rose hips 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	

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T3 – Preferred Brands

T4 – Non-Preferred Brands

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VITAMINS (Nutritional/Dietary) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
VITAMIN C PREPARATIONS (cont.)		
<i>vitamin c 1,000 mg caplet</i>	T2	
<i>vitamin c 1,000 mg tablet</i>	T2	
<i>vitamin c 1,500 mg tablet sa</i>	T2	
<i>vitamin c 100 mg tablet</i>	T2	
VITAMIN C 125 MG GUMMIES	T4	
<i>vitamin c 250 mg tablet</i>	T2	
VITAMIN C 250 MG TABLET CHEW	T4	
<i>vitamin c 250 mg tablet chew</i>	T2	
<i>vitamin c 500 mg capsule sa</i>	T2	
<i>vitamin c 500 mg chew tablet</i>	T2	
VITAMIN C 500 MG POWDER PACKET	T4	
VITAMIN C 500 MG SOFTGEL	T4	
<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	

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

T5 – Preferred Specialty
T6 – Non-Preferred Specialty
PA – Prior Authorization
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ST – Step Therapy
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List of Prescription Medications

VITAMINS (Nutritional/Dietary) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
VITAMIN C PREPARATIONS (cont.)		
ZINC PLUS	T4	
ZINC-VITAMIN C	T4	
VITAMIN D PREPARATIONS		
BABY DDROPS	T4	HD
BABY VITAMIN D3	T4	HD
BABY'S SUPER DAILY D3	T4	HD
BIO-D-MULSION	T4	HD
BIO-D-MULSION FORTE	T4	HD
<i>calcitriol 0.25 mcg capsule</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 vit d3 250 mcg softgel</i>	T2	HD
<i>cvs vitamin d3 1,000 unit sfgl</i>	T2	HD
<i>cvs vitamin d3 10 mcg, 25 mcg, 50 mcg, 125 mcg softgel</i>	T2	HD
<i>cvs vitamin d3 2,000 unit sfgl</i>	T2	HD
<i>cvs vitamin d3 25 mcg gummies</i>	T2	HD
<i>cvs vitamin d3 400 unit sftgl</i>	T2	HD
<i>cvs vitamin d3 5,000 unit sfgl</i>	T2	HD
CVS VITAMIN D3 250 MCG SOFTGEL	T4	HD
CYFOLEX	T4	HD
D3 LIQUID	T4	HD
D3 PLUS K2 DOTS	T4	HD
D3-50	T3	HD
DDROPS	T4	HD
<i>decara 10,000 unit softgel</i>	T2	HD
DECARA 25,000 UNIT VEGICAP	T3	HD
<i>decara 50,000 unit softgel</i>	T2	HD
DECARA K	T4	HD

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VITAMINS (Nutritional/Dietary) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
VITAMIN D PREPARATIONS (cont.)		
DERMACINRX DOTREMIN	T4	HD
DERMACINRX FOLDITAM	T4	HD
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>eq/ vitamin d3 2,000 unit sfgl</i>	T2	HD
<i>eq/ 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 vitamin d3 25 mcg softgel</i>	T2	HD
<i>ft vitamin d3 50 mcg softgel</i>	T2	HD
<i>ft vitamin d3 125 mcg softgel</i>	T2	HD
<i>ft vitamin d3 125 mcg tablet</i>	T2	HD
<i>ft vitamin d3 25 mcg tablet</i>	T2	HD
FT VITAMIN D3 250 MCG SOFTGEL	T4	HD
FT VITAMIN D3 250 MCG TABLET	T4	HD
<i>ft vitamin d3 50 mcg tablet</i>	T2	HD
GENICIN VITA-D	T4	HD
<i>gnp vit d3 10mcg(400 unit) chw</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 1,000 unit tab</i>	T2	HD
<i>gnp vitamin d3 10 mcg, 25 mcg tablet</i>	T2	HD
<i>gnp vitamin d3 2,000 unit tab</i>	T2	HD
<i>gnp vitamin d3 25mcg(1000 unt)</i>	T2	HD
<i>gnp vitamin d3 50 mcg softgel</i>	T2	HD
GNP VITAMIN D3 250 MCG SOFTGEL	T4	HD

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List of Prescription Medications

VITAMINS (Nutritional/Dietary) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
VITAMIN D PREPARATIONS (cont.)		
<i>gnp vitamin d3 5,000 unit tab</i>	T2	HD
<i>hm vitamin d3 1,000 unit tab</i>	T2	HD
<i>hm vitamin d3 2,000 unit sftgl</i>	T2	HD
HM VITAMIN D3 4,000 UNIT SFTGL	T4	HD
IS-D-10,000	T4	HD
K2 PLUS D3	T4	HD
K2-D3 MAX	T4	HD
K2-D3 10,000	T4	HD
K2-D3 5000	T4	HD
MAXIMUM D3	T3	HD
NOXIFOL-D3	T4	HD
OPTIMAL D3 M	T4	HD
ORTHO DF	T4	HD
OSTACHOL	T4	HD
<i>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 sfgl</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 25 mcg tablet</i>	T2	HD
<i>sm vitamin d3 50 mcg softgel</i>	T2	HD
SUPER DAILY D3	T4	HD
<i>sv vitamin d3 1,000 unit gummy</i>	T2	HD
<i>sv vitamin d3 1,000 unit sftgl</i>	T2	HD
<i>sv vitamin d3 2,000 unit sftgl</i>	T2	HD

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List of Prescription Medications

VITAMINS (Nutritional/Dietary) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
VITAMIN D PREPARATIONS (cont.)		
<i>sv vitamin d3 25mcg(1000 unit)</i>	T2	HD
<i>sv vitamin d3 400 unit softgel</i>	T2	HD
<i>sv vitamin d3 5,000 unit sftgl</i>	T2	HD
<i>thera-d 2000 tablet</i>	T2	HD
THERA-D 4000 TABLET	T4	HD
<i>thera-d rapid repletion tablet</i>	T2	HD
<i>thera-d sport 2,000 unit tab</i>	T2	HD
<i>true vitamin d3 1,250 mcg tab</i>	T2	HD
<i>true vitamin d3 10 mcg capsule</i>	T2	HD
<i>true vitamin d3 10 mcg tablet</i>	T2	HD
<i>true vitamin d3 125 mcg cap</i>	T2	HD
<i>true vitamin d3 125 mcg tablet</i>	T2	HD
<i>true vitamin d3 25 mcg capsule</i>	T2	HD
<i>true vitamin d3 25 mcg tablet</i>	T2	HD
<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	T2	HD
TRUE VITAMIN D3 250 MCG CAP	T2	HD
TRUE VITAMIN D3 250 MCG TABLET	T2	HD
<i>vit d3 125 mcg (5000 unit) tab</i>	T2	HD
VIT D3 5,000 UNIT FAST DISSOLV	T4	HD
<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 50,000 UNIT CAPSULE	T4	HD
<i>vitamin d3 1,000 unit gummies</i>	T2	HD
<i>vitamin d3 1,000 unit gummy</i>	T2	HD
<i>vitamin d3 1,000 unit softgel</i>	T2	HD
VITAMIN D3 1,000 UNIT SPRAY	T4	HD
<i>vitamin d3 1,000 unit tab chew</i>	T2	HD
<i>vitamin d3 1,000 unit tablet</i>	T2	HD

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List of Prescription Medications

VITAMINS (Nutritional/Dietary) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
VITAMIN D PREPARATIONS (cont.)		
VITAMIN D3 1,000 UNIT/10 ML LIQ	T4	HD
<i>vitamin d3 1,250 mcg capsule</i>	T2	HD
<i>vitamin d3 1.25 mg softgel</i>	T2	HD
<i>vitamin d3 10 mcg tablet</i>	T2	HD
<i>vitamin d3 10 mcg(400 unit)/ml</i>	T2	HD
<i>vitamin d3 10 mcg/ml drop</i>	T2	HD
<i>vitamin d3 10 mcg/ml liquid</i>	T2	HD
VITAMIN D3 10,000 UNIT CAPSULE	T4	HD
<i>vitamin d3 10,000 unit softgel</i>	T2	HD
VITAMIN D3 10,000 UNIT TABLET	T4	HD
<i>vitamin d3 125 mcg (5000 unit)</i>	T2	HD
<i>vitamin d3 125 mcg capsule</i>	T2	HD
<i>vitamin d3 125 mcg softgel</i>	T2	HD
<i>vitamin d3 125 mcg tablet</i>	T2	HD
VITAMIN D3 125 MCG/0.5 ML DROP	T4	HD
<i>vitamin d3 2,000 unit softgel</i>	T2	HD
VITAMIN D3 2,000 UNIT TAB CHEW	T4	HD
<i>vitamin d3 2,000 unit tablet</i>	T2	HD
<i>vitamin d3 25 mcg (1,000 unit)</i>	T2	HD
<i>vitamin d3 25 mcg gummy</i>	T2	HD
<i>vitamin d3 25 mcg softgel</i>	T2	HD
<i>vitamin d3 25 mcg tablet</i>	T2	HD
VITAMIN D3 250 MCG TABLET	T4	HD
VITAMIN D3 3,000 UNIT TABLET	T4	HD
<i>vitamin d3 400 unit softgel</i>	T2	HD
<i>vitamin d3 400 unit tab chew</i>	T2	HD
<i>vitamin d3 400 unit tablet</i>	T2	HD
VITAMIN D3 400 UNIT/5 ML LIQ	T4	HD
<i>vitamin d3 400 unit/ml liquid</i>	T2	HD
<i>vitamin d3 5,000 unit capsule</i>	T2	HD
<i>vitamin d3 5,000 unit softgel</i>	T2	HD
<i>vitamin d3 5,000 unit tablet</i>	T2	HD
<i>vitamin d3 5,000 unit/ml drops</i>	T2	HD
<i>vitamin d3 50 mcg (2,000 unit)</i>	T2	HD

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List of Prescription Medications

VITAMINS (Nutritional/Dietary) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
VITAMIN D PREPARATIONS (cont.)		
<i>vitamin d3 50 mcg capsule</i>	T2	HD
VITAMIN D3 50 MCG DISSOLVE TAB	T4	HD
<i>vitamin d3 50 mcg softgel</i>	T2	HD
<i>vitamin d3 50 mcg tablet</i>	T2	HD
VITAMIN D3 62.5 MCG SOFTGEL	T4	HD
<i>vitamin d3 50,000 unit capsule</i>	T2	HD
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>eqi vitamin e 1,000 unit sftgl</i>	T2	
<i>eqi 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	

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VITAMINS (Nutritional/Dietary) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
VITAMIN E PREPARATIONS (cont.)		
<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	
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	

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VITAMINS (Nutritional/Dietary) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
VITAMIN K PREPARATIONS (cont.)		
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	
<i>phytonadione 1 mg/0.5 ml syr</i>	T2	
PHYTONADIONE 1 MG/0.5 ML VIAL	T3	
<i>phytonadione 10 mg/ml ampul</i>	T2	
<i>phytonadione 10 mg/ml vial</i>	T2	
VITAMIN K	T3	
VITAMIN K-1	T3	
VITAMIN K2	T4	
VITAMIN K2 (MENAQUINONE-4)	T4	
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

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Exclusions and limitations for coverage

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

Plans generally do not provide coverage for the following under the pharmacy benefit, except as required by state or federal law, or by the terms of your specific plan: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	162
1ST TIER.....	141, 157
1ST TIER UNILET COMFORTOUCH.....	157
2-IN-1	141, 157
2-IN-1 LANCET DEVICE	157
2TEK.....	134
5-MTHF.....	225
50 PLUS ADULT EYE.....	203
(Tolectin 600).....	29

A

A-25	224
abacavir	66, 67
abacavir sulfate/lamivudine	66
ABANEU-SL.....	231
ABATRON.....	112
ABC.....	167, 206, 207
ABC COMPLETE	207
ABDEK.....	220
ABILIFY.....	177
abiraterone.....	55
ABRYSVO.....	76
ABSORICA.....	181
ABSTRAL	21
ACAM2000	76
acamprosate.....	196
acarbose	48
ACCOLATE	32
ACCRUFER	112
ACCU-CHEK	134, 141, 157, 162
ACCUPRIL.....	83
ACCURETIC.....	81
ACCUTREND.....	134
ACD-A	42
ACD SOLUTION A	42
ACE.....	81, 82, 83
ACE AEROSOL.....	163
acebutolol.....	84
acetaminophen/caff/dihydrocod.....	21
acetaminophen with codeine.....	21
acetazolamide.....	101
acetic acid	52, 103, 180
acetic acid/oxyquinoline	52
acetylcysteine	32
acetylcyst/methylb12/levomefol	225
a/c/e/zinc ox/cupric ox/lutein.....	203
a/c/e/zinc/sod selenate/copper	206

acitretin.....	181
ACTEMRA.....	132
ACTHAR	125
ACTHIB	75
ACTICLATE	38
acti-lance	141, 157
ACTI-LANCE	141, 157
acti-lance lite.....	157
acti-lance univers.....	157
ACTI-LANCE UNIVERS	157
ACTIMMUNE.....	61
ACTIQ	22
ACTIVE FE	112
ACTIVELLA.....	127
ACTIVNUTRIENTS.....	207
ACTONEL	200
ACTOPLUS MET	50
ACTOS	50
ACULAR	104
acyclovir	69, 70
ACZONE.....	181
ADACEL TDAP	75
ADALIMUMAB	54
ADALIMUMAB-ADAZ	54
ADALIMUMAB-ADBIM	54
adapalene	181, 182, 190, 191
ADAPALENE	191
adapalene/benzoyl peroxide.....	181, 182
ADBRY.....	201
ADDYI	175
adefovir	70
ADEK GUMMIES.....	207
ADEMPAS	80
ADIPEX-P	62
ADJUSTABLE LANCING DEVICE	134
ADLARITY.....	71
ADLYXIN.....	48
ADRENALIN CHLORIDE	103
adthya	192
ADULT 50 PLUS EYE HEALTH.....	203
ADULT MULTI.....	207
ADULT ONE DAILY.....	207
ADULTS' DAILY FORMULA.....	207
ADULTS MULTIVITAMIN	207
ADVAIR HFA.....	30
ADVANCED	134, 141, 157, 204, 207, 212, 218

Index of Medications

ADVANCED LANCING DEVICE.....	134	ALINIA	63
ADVANCED MULTI EA.....	207	aliskiren hemifumarate.....	85
ADVANCED TRAVEL LANCETS.....	157	ALIVE	207, 220, 246
ADVOCATE.....	134, 141, 157, 179, 183, 249	ALIVE DAILY	207
ADVOCATE CONTROL SOLUTION.....	134	ALIVE PREMIUM	207
ADVOCATE LANCET	157	ALIVE WOMEN'S	207
ADVOCATE LANCETS	157	ALKALINE BATTERIES.....	134
ADVOCATE LANCING DEVICE.....	134	ALKERAN.....	54
ADVOCATE RAPID-SAFE LANCING DV	134	ALLERGIST TRAY.....	148, 149
ADVOCATE REDI-CODE+ CTRL SOLN.....	134	ALLERGY SYRINGE	149, 153, 154
ADZENYS	71	allopurinol.....	26
AEMCOLO	38	almotriptan.....	19
AEROCHAMBER.....	163	almotriptan malate.....	15
AEROCHAMBER2GO	163	ALOCRIL.....	105
AEROTRACH	163	alosetron.....	123
AEROVENT	163	ALPHA	32, 48, 82, 132, 170, 174, 198, 202, 207
AFLORA	207	ALPHAGAN P.....	105
AFLURIA.....	74	alprazolam.....	170
AFLURIA QUAD	74	ALTABAX.....	186
AGAMATRIX	134, 141	ALTACE	83
AGAMATRIX CONTROL	134	ALTAFLUOR BENOX.....	105
AGRYLIN	65	ALTERNATE.....	134, 141, 157
AIMOVIG	15	ALTERNATE SITE LANCETS	157
AIMOVIG AUTOINJECTOR.....	19	ALTERNATE SITE LANCING DEVICE.....	134
AIRSUPRA	30	ALTRENO	191
AJOVY	15, 19	ALTRIXA	208
AKLIEF	186	ALUNBRIG.....	57
AKTEN.....	105	ALVESCO.....	31
AKTIPAK	40	alvimopan	124
ALA-SCALP.....	186	ALYFTREK.....	192
ALBA-LYBE.....	225	amantadine.....	64
albendazole.....	52	ambrisentan.....	80
ALBENZA	52	amcinonide.....	186
albuterol	29, 30	AMERGE.....	19
ALCAINE.....	105	AMICAR	76
alclometasone	186	amiloride.....	102
ALCOH-GLOVE	162	amino acids/mv,tx,iron,mineral.....	208
alcohol	179, 180, 183, 184, 198, 199, 249, 255, 260, 264, 265, 272, 274, 275, 277, 283	aminocaproic	76
ALCOHOL.....	53, 179, 180, 183, 184, 198, 199, 249, 255, 257, 263, 264, 267, 272, 275, 276, 278	amiodarone	78
ALCOH-WIPE.....	162	amitriptyline.....	173
ALDACTONE	102	amitriptyline/chlordiazepoxide	173
ALECENSA.....	57	AMLADEX	208
alendronate.....	200	amlodipine.....	78, 81, 82, 83, 86
alfuzosin	202	amoxapine	173
ALHEMO	76	amoxicillin	37, 38
		amphetamine.....	71, 72
		ampicillin	38

Index of Medications

AMZEEQ.....	40	ARMOUR THYROID.....	192
ANAFRANIL.....	173	ARNUITY ELLIPTA.....	31
anagrelide.....	65	AROMASIN.....	55
ANA-LEX.....	125	ARTHROTEC 50.....	27
ANALPRAM.....	122, 125, 190, 250	ARTHROTEC 75.....	27
ANAPROX DS.....	27	ARTISS.....	185
anastrozole.....	55	ASACOL.....	122
ANCOBON.....	44	ASCOR.....	235
ANGELIQ.....	128	ascorbate.....	235
ANIMAL SHAPES COMPLETE.....	220	ascorbic.....	114, 115, 235
ANIMI-3.....	208	ASCORBIC ACID.....	235
ANNOVERA.....	95	asenapine.....	176
ANORO ELLIPTA.....	30	ASMANEX.....	31
ANTICOAGULANT SODIUM CITRATE.....	42	ASPIRIN.....	65
ANTIOXIDANT FORMULA.....	203	aspirin/dipyridamole.....	65
APATATE.....	231	ASSURE.....	134, 141, 142, 157, 166
APETEX.....	225	ASSURE 4 CONTROL SOLUTION.....	134
APETIGEN.....	112, 225	ASSURE DOSE.....	134
APETIGEN-PLUS.....	112	ASSURE HAEMOLANCE PLUS.....	157
apomorphine.....	64	ASSURE LANCE.....	157
APO-VARENICLINE.....	191	ASSURE PRISM.....	134
apraclonidine.....	105	ASTAGRAF.....	132
aprepitant.....	120	ASTRINGYN.....	77
APRETUDE.....	68	atazanavir.....	67
APRISO.....	122	ATELVIA.....	200
APTENSIO.....	174	atenolol.....	84, 85
APTIOM.....	91	AT HOME AIC.....	134
APTIVUS.....	65	a thru z.....	206
AQNEURSA.....	118	A THRU Z MEN'S ULTIMATE.....	206
AQUA-E.....	244	A THRU Z SELECT.....	206
AQUA LANCE LANCING DEVICE.....	134	ATIVAN.....	170
AQUASOL A.....	224	atomoxetine.....	175
AQUORAL.....	195	atorvastatin.....	86
ARAKODA.....	52	atovaquone.....	52, 53
ARAVA.....	26	atovaquone-proguanil.....	52
ARAZLO.....	186	atropine.....	107, 119, 121
ARCALYST.....	201	ATROPINE.....	107
AREXVY.....	76	ATROVENT HFA.....	29
arformoterol.....	30	ATTRUBY.....	198
ARGLAES FILM.....	155	AUDENZ.....	74
ARICEPT.....	71	AUGMENTIN.....	38
ARIDOL.....	99	AUGTYRO.....	57
ARIKAYCE.....	34	AURYXIA.....	111
aripiprazole.....	177	AUSTEDO.....	89
ARIXTRA.....	43	AUTOJECT.....	134
ARKALIOX.....	225	AUTO-LANCET.....	134
armodafinil.....	178	AUTOLET.....	134

Index of Medications

AUTOPEN	134	BAL-CARE DHA	166
AUTOSHIELD DUO	146	balsalazide	122
AUTOSOFT	134, 135	BALVERSA	57
AUVELITY	171	BARACLUDE	70
AUVI-Q	70	BARIATRIC MULTIVITAMINS	208
avanafil	194	BAXDELA	38
AVAR-E	41	BCG	75
AVAR LS	41	b comp	225, 230
AVC	52	b complex	217, 218, 225, 227, 228, 229, 230
AVIDOXY	38	b-complex	208, 209, 217, 226, 227, 229, 230
avita	191	B COMPLEX	225, 226, 227, 228
AVITA	191	B-COMPLEX	211, 217, 226
AVITENE	77	B-COMPLEX-VITAMIN C	226
AVMAPKI	56	B-COMPLEX WITH B-12	226
AVONEX	89	BD	142, 146, 147, 149, 157
AYVAKIT	57	BD ECLIPSE	146, 147, 149
AZASAN	132	BELBUCA	22
AZASITE	33	BELSOMRA	178
azathioprine	132, 133	BELVIQ	63
azelaic acid	185	benazepril	81, 83
azelastine	47, 102, 103	benazepril/hydrochlorothiazide	81
AZELEX	181	BENLYSTA	201
AZILECT	64	BENTIVITE BX	112
azithromycin	37	BENZAMYCIN	40
AZSTARYS	174	benzepro	184
AZULFIDINE	122	BENZEPRO	184
B		BENZNIDAZOLE	53
b-12	229, 231, 232, 233, 234	benzonatate	96
bi2	113, 114, 115, 215, 225, 226, 228, 230, 231, 232, 233, 234	benzoyl peroxide	40, 41, 181, 182, 184, 185
B-12	114, 211, 225, 226, 231, 232, 233, 234	benzphetamine	62
Bi2	225, 231, 232, 234	benztropine	64
BI2 ACTIVE	231	bepotastine	47
b-12 er	232	BEPREVE	47
bi2/levomefolate calcium/b-6	225	BEROCCA	208
B-50 COMPLEX	225	beta-carotene	208, 224
BABY DDROPS	239	BETADINE	104
BABY'S SUPER DAILY D3	239	betaine	200
BABY VITAMIN D3	239	betamethasone	45, 186, 188, 190
bacitracin	33, 34	BETAPACE	84
baclofen	165	BETASERON	89
BACLOFEN	165	betaxolol	84, 105
BACMIN	208	bethanechol	72
B ACTIV	225	BETHKIS	34
BACTRIM	34	BETOPTIC S	105
BAFIERTAM	89	bexarotene	54, 62
BALANCED B-100	227	BEXSERO	74
balanced b-100 complex tab sa	225	BEYAZ	95

Index of Medications

BEYFORTUS.....	68	BROMFED DM.....	96
bicalutamide.....	55	bromfenac.....	104
BIKTARVY.....	68	bromocriptine.....	64
BILTRICIDE.....	52	brompheniramine/pseudoephed/dm.....	96
bimatoprost.....	105	BRONCHITOL.....	192
BIMATOPROST.....	105, 106	BROVANA.....	30
BINOSTO.....	200	BRUKINSA.....	57
BIO-35.....	208	BRYHALI.....	187
BIO C.....	235	B-STRESS.....	226
BIO-D-MULSION.....	239	budesonide.....	30, 31, 128, 129
bioflav,lemon/vit bcomp,c.....	204	BULK SYRINGE.....	149
biotect.....	208	BULLSEYE.....	142, 157
BIOTECT.....	203	BULLSEYE MINI SAFETY LANCETS.....	157
biotin.....	212, 214, 225, 226, 227, 228, 229, 230	bumetanide.....	101
BIOTIN.....	219, 226, 227, 228, 229	BUPHENYL.....	119
bisac/nacl/naHco3/kcl/peg 3350.....	123	buprenorphine.....	22, 201
bisoprolol.....	84, 85	bupropion.....	171, 191
BLADDER 2.2.....	208	buspirone.....	171
BLEPH-IO.....	33	butalb-acetamin-caff 50-300-40.....	15
BLEPHAMIDE S.O.P.....	33	butalb-acetamin-caff 50-325-40.....	15
BLOOD.....	76, 77, 98, 135, 142, 147, 157	butalb/acetaminophen/caffeine.....	15, 19
BLOOD GLUCOSE CONTROL.....	135	butalb-aspirin-caffe 50-325-40.....	15
BLOOD-GLUCOSE CONTROL.....	135	butalbit/acetamin/caff/codeine.....	24
BLOOD LANCETS.....	157	butalbital/acetaminophen.....	15, 19
BLUNT.....	147, 152	butalbital-asa-caffeine cap (Fiorinal).....	15
BOCASAL.....	195	butalbital/aspirin/caffeine.....	19
BODY, HAIR, SKIN AND NAILS.....	208	butorphanol.....	22
BONSITY.....	200	BUTTERFLY.....	142, 157
BOOSTNOW.....	246	BUTTERFLY TOUCH LANCET.....	157
BOOSTRIX TDAP.....	75	BYDUREON BCISE.....	48
bosentan.....	80, 252	BYDUREON PEN.....	48
BOSULIF.....	57	BYETTA.....	48
BRAFTOVI.....	56	BYLVAY.....	123
BREATHERITE.....	163	C	
BREATHRITE.....	163	c-l,000.....	235
BREEZE 2.....	135	cabergoline.....	130
BREO.....	30	CADEAU DHA.....	166
BREO ELLIPTA.....	30	CADUET.....	86
BREXAFEMME.....	45	CAFERGOT.....	15
brey-na.....	30	caffeine.....	19, 89, 165
BREZTRI AEROSPHERE.....	31	CALAN.....	78
BRILINTA.....	65	calcipotriene.....	182, 190
brimonidine.....	105, 106	calcitonin,salmon,synthetic.....	131
BRIMONIDINE.....	106	calcitriol.....	182, 239, 241
BRINSUPRI.....	193	calcium acetate.....	111
brinzolamide.....	106	CALCIUM PANTOTHENATE.....	220
BRIVIACT.....	91	CALQUENCE.....	57

Index of Medications

CAMBIA	19	CEFUROXIME SODIUM-0.9% NACL.....	33
CAMZYOS.....	79	celecoxib	29
candesartan cilexetil.....	83	CELLCEPT	133
candesartan/hydrochlorothiazid.....	83	CELONTIN.....	92
CANNULA.....	147, 149, 152, 153, 154	CENTANY.....	40
CANTHARIDIN-ACETONE	184	CENTRAL-VITE.....	208
CAPCOF	96	CENTRAVITES.....	208
capecitabine.....	55	centrum	209
CAPEX	187	CENTRUM.....	206, 208, 209, 220, 246, 253
CAPHOSOL.....	195	CENTRUM KIDS	220
CAPLYTA.....	176	CENTRUM SILVER	206, 209
CAPRELSA	57	cephalexin.....	36
captopril	81, 83	CEQUA	108
captopril/hydrochlorothiazide.....	81	CEQUR SIMPLICITY	135
CAPVAXIVE	74	CERDELGA	197
CARBAGLU.....	196	CEREFOLIN	226
carbamazepine.....	91, 92, 93	certavite	209
CARBAMAZEPINE	92	CERTAVITE.....	209
CARBATROL.....	92	CERVIDIL.....	129
carbidopa	64, 65	CETACAINE ANESTHETIC.....	25
carbidopa/levodopa	64	cetrorelix	129
carbinoxamine	47	CETROTIDE	129
CARDIOTEK-RX	226	cevimeline.....	72
CARDIZEM	78	CHANTIX.....	191
CARDURA.....	82	CHEK-STIX	100
CAREONE.....	135, 142, 157	CHEMET	197
CAREPOINT.....	147, 149, 150	CHEMO TRANSFER PIN	147
CARESENS.....	135, 142, 157	CHEMSTRIP.....	100, 135
CARETOUCH.....	135, 142, 147, 150, 157, 179, 183, 253	CHENODAL	121
carglumic	196	CHILD CHEWABLE VITAMN	220
carisoprodol	24, 165	CHILD COMPLETE	220
carisoprodol/aspirin/codeine	24	CHILD MULTIVITAMIN PLUS IRON.....	220
CARNITOR.....	200	children multivitamin.....	220
carteolol.....	106	CHILDREN MULTIVITAMIN	220, 222
carvedilol.....	82	CHILDREN'S.....	220, 221
CASODEX	55	CHILDREN'S CHEWABLE	221
CATAPRES.....	84	CHILDREN'S CHEW MULTIVIT-IRON	220
CAVERJECT	194	childrens chew vitamin	221
CAYSTON.....	36	CHILDREN'S MULTI-VIT.....	221
cefaclor	36	CHILDREN'S MULTIVITAMIN GUMMY	221
cefadroxil	36	CHILD'S CHEWABLE	221
cefdinir	36	CHILD'S OMEGA-3.....	221
cefditoren pivoxil	36	chlordiazepoxide.....	119, 170
cefpodoxime proxetil.....	36	chlordiazepoxide/clidinium br	119
cefprozil.....	36	chlorhexidine	194
ceftriaxone	36	chloroquine	52
cefuroxime axetil.....	36	chlorpromazine.....	177

Index of Medications

chlorthalidone	85, 102	clocortolone.....	187
chlorzoxazone.....	165	clodan	187
CHOLBAM.....	121	CLODAN	187
cholecalciferol.....	239	CLODERM.....	187
CHOLECAL DF	239	clomiphene	130
cholestyramine	87	clomipramine.....	173
choline salicyl/mag salicylate.....	15, 19	clonazepam.....	91
CHORIONIC	130, 131	clonidine.....	84, 174
CHORIONIC GONAD	130	clopidogrel	65
CHOSEN.....	135, 142, 157	clorazepate.....	170
CHROMAGEN.....	112	clotrimazole.....	44, 45
CIALIS	194	clozapine.....	176
CIBINQO.....	184	CLOZARIL.....	176
ciclodan.....	45	COAGUCHEK	142, 158
CICLODAN	45, 53	COARTEM	52
ciclopirox.....	45, 46	COBALEFOL	205
ciclopirox 8% treatment kit.....	53	COCAINE.....	103
cilostazol	65	codeine.....	21, 22, 24, 97, 98
CILOXAN	33	CODITUSSIN AC	98
CIMDUO.....	66	CODITUSSIN DAC.....	97
cimetidine.....	122	cod liver oil.....	224, 235, 239, 241, 244
cinacalcet.....	196	COLAZAL	122
CIPRO	38	colchicine	26, 29
ciprofloxacin.....	32, 33, 38	COLCHICINE.....	26
citalopram.....	171	colesevelam.....	87
CITRANATAL	112, 166, 170	COLESTID.....	87
CITRANATAL BLOOM	112	colestipol	87
CITRATE PHOSPHATE DEXTROSE.....	42	COLOR	142, 158
citric.....	118	COLOR LANCETS.....	158
CITRUS BIOFLAVONOIDS.....	204	COMBIGAN.....	106
CLARINEX	46, 47	COMBIPATCH	127
CLARINEX-D.....	46, 47	COMBISTIX REAGENT	100
clarithromycin.....	37	COMBIVENT RESPIMAT	30
CLEOCIN	36, 40	COMBIVIR.....	66
CLEVER	135, 142, 157, 163	COMETRIQ.....	57
CLEVER CHEK LANCETS.....	157	COMFORT ... 27, 140, 142, 144, 145, 146, 158, 160, 161, 162, 164, 183, 184	
CLEVER CHOICE.....	163	COMFORT PAC-IBUPROFEN.....	27
CLEVER CHOICE CONTROL SOLUTION	135	COMFORT PAC-MELOXICAM.....	27
CLIMARA.....	127	COMFORT PAC-NAPROXEN.....	27
clindacin.....	41	COMFORTSEAL	163
CLINDACIN	41	COMIRNATY.....	73
clindamycin.....	36, 40, 41, 181, 182	COMPACT SPACE CHAMBER.....	163
CLINDESSE.....	40	COMPAZINE.....	120
CLINPRO 5000	108, 112	COMPLETE166, 167, 169, 206, 207, 208, 209, 210, 215, 216, 220, 221, 222, 223, 224, 227	
clobazam.....	91	COMPLETIA	209
clobetasol.....	187, 189		
CLOBEX	187		

Index of Medications

COMPLEX B-50	227	CVS PRENATAL	170
complex b-100	227	cvs slow release iron.....	113
COMPLEX B-100.....	227	CVS SLOW RELEASE IRON.....	113
CONCEPT	209	CVS VITAMIN.....	232, 235, 244
CONFORMANT 2.....	155	cvs vitamin a	224
CONSENSI.....	78	cvs vitamin b-12.....	232
CONTOUR.....	135	cvs vitamin c	235
CONTRAVE.....	63	cvs vitamin d3.....	239
CONTROL SOLUTION	134, 135, 136, 137, 138, 139, 140, 141	cvs vitamin e.....	244
COOL CONTROL SOLUTION	135	cvs vit c	235
COPIKTRA.....	57	cvs vit d3	239
CORDRAN.....	187	cyanocobalamin.....	225, 227, 229, 232
COREG	82	cyclobenzaprine.....	165
CORNWALL SYRINGE TIP CONNECTOR.....	150	CYCLOGYL.....	107
CORTANE-B.....	103	CYCLOMYDRIL.....	107
CORTEF.....	128	cyclopentolate.....	107
CORTENEMA.....	125	CYCLOPENTOLATE-TROPICAMIDE-PE.....	107
cortisone.....	128	cyclopentolat/tropic/phenyleph	107
CORTISPORIN.....	32	cyclophosphamide	54
CORVITE.....	112, 209	CYCLOPHOSPHAMIDE	54
CORVITE 150.....	112	cycloserine	36
CORVITE FE.....	112	CYCLOSET	48
COTELLIC	56	cyclosporine.....	108, 133
COTEMPLA	174	CYCLOSPORINE.....	108
CRENESSITY	130	CYFOLEX	239
CREON.....	124	CYLTEZO	54
CRESEMBA	44	cyproheptadine	47
CREXONT	64	CYPROHEPTADINE	47
CRINONE	131	CYSTAGON.....	202
cromolyn	25, 32, 105	CYSTARAN	108
crotamiton.....	63	CYSTO-CONRAY II	100
CRRT TRISODIUM CITRATE.....	42	CYSTOGRAFIN.....	100
CTEXLI	121	CYSTOGRAFIN-DILUTE.....	100
CULTURELLE.....	209, 221	CYTO B-1.....	230
CULTURELLE KIDS	221	CYTO B-2.....	234
CURITY.....	179, 183, 255	CYTO B7	227
CURITY ALCOHOL PREPS	183	CYTO C.....	235
CUROSURF	193	CYTOTEC.....	120
cvs109, 113, 166, 183, 198, 205, 209, 219, 224, 227, 230, 232, 234, 235, 239, 244		D	
CVS .53, 109, 113, 170, 179, 183, 198, 227, 232, 235, 239, 244, 255		D3.....	177, 215, 218, 239, 240, 241, 242, 243, 244
CVS ALCOHOL 70% PREP PADS	183	DAILY	57, 58, 59, 94, 166, 193, 207, 209, 210, 212, 213, 215, 216, 218, 237, 239, 241
cvs glucose.....	109	daily-vite.....	209
CVS GLUCOSE LIQUID	109	danazol.....	130
cvs isopropyl alcohol 70% wipe.....	183	DANTRIUM	165
CVS ISOPROPYL ALCOHOL 91% SPRY	53	dantrolene.....	165
cvs prenatal	166	DANZITEN	57

Index of Medications

dapsone.....	35, 181, 182	desmopressin	126, 127
DAPTACEL DTAP	75	DESMOPRESSIN.....	126
DARAPRIM.....	52	desog.....	95
darifenacin	202	desogestrel-ethinyl estradiol	95
dasatinib.....	57, 58	DESONATE.....	187
DAURISMO	56	desonide	187, 188, 190
DAVIMET	209, 221, 246	desoximetasone.....	188, 189
DAVIMET-M.....	246	DESOXYN.....	71
DAVOL IRRIGATION SYRINGE	150	DESVENLAFAXINE.....	172
DAYAVITE	210	dex4 glucose.....	109, 110
DAYPRO	27	DEX4 GLUCOSE.....	109, 110
DAYTRANA.....	174	dex4 quick dissolve tab chew	110
DAYVIGO	178	dexamethasone.....	33, 104, 128
DDAVP	126	dexchlorpheniramine	47
DDROPS.....	239	DEXCOM.....	135
decara.....	239	DEXCOM G6	135
DECARA	239	DEXEDRINE.....	72
DECUBI	210	dexlansoprazole.....	124
deferasirox.....	197	dexmethylphenidate	174
deferiprone	198	DEXONTO.....	128
deflazacort.....	128	DEXTENZA	104
DEKAS	210, 221	dextroamphetamine	72
DEKAS PLUS	210, 221	dextrose	110, 111
DELESTROGEN	127	DIABETES HEALTH	210
DELSTRIGO.....	68	DIABETIC VITAMIN	210
demeclocycline	38	DIACOMIT	92
DEMSEER.....	84	dialyvite.....	227
DENAVIR.....	70	DIALYVITE.....	210, 227, 240
DENGVAZIA.....	75	DIASTAT	91
DENOVO.....	205	DIASTIX REAGENT	98, 100
DEPAKOTE.....	92	diatrizoate meglumine.....	99
DEPEN	26	DIATROL.....	210
DEPLIN-ALGAL OIL.....	205	DIATRUE.....	135
DEPO-ESTRADIOL.....	127	diazepam.....	91, 170, 171
DEPO-PROVERA	95	diazoxide	110, 111
DEPO-SUBQ PROVERA.....	95	DIBENZYLINE.....	72
DEPO-TESTOSTERONE.....	126	dichlorphenamide	196
DERMACINRX	210, 240, 246	DICLEGIS	120
DERMA-SMOOTHIE-FS.....	187	diclofenac.....	20, 27, 62, 104, 181
DERMASORB	187	dicloxacillin.....	38
DERMATOP	187	dicyclomine.....	119, 256
DERMAVIEW	155	didanosine	67
DERMOTIC	103	diethylpropion	62
DESCOVY	66	DIFFERIN.....	191
desflurane.....	24	DIFICID	37
desipramine	173	DIFLUCAN.....	44
desloratadine	47	diflunisal.....	15, 19

Index of Medications

difluprednate	104	DULERA.....	31
digoxin.....	79	duloxetine.....	173
dihydroergotamine	15, 19, 20	DUOBRII	182
DILANTIN.....	92	DUOPA.....	64
DILAUDID	22	DUPIXENT	132
diltiazem.....	78	dutasteride.....	202
dimethyl.....	196	DYAZIDE	102
diphenoxylate hcl/atropine.....	119	DYCLOPRO	25
DIPHThERIA-TETANUS TOXOIDS-PED	75	DYRENIUM.....	102
DIPROLENE.....	188	E	
dipyridamole	65	EAR HEALTH PLUS.....	204
DISALCID	26	ear health plus caplet	204
disopyramide.....	78	EASIVENT	163
disulfiram	196	EASY	135, 136, 142, 143, 147, 150, 151, 158, 179, 183, 235, 257
DIURIL.....	102	EASY-C.....	235
divalproex	92	EASY COMFORT ALCOHOL PAD	183
dofetilide.....	78	EASY COMFORT LANCETS.....	158
DOJOLVI	108	EASY GLIDE CATHETER.....	150
donepezil.....	71	EASY GLIDE LUER.....	150
DONNATAL.....	121	EASYGLUCO PLUS	136
DOPTELET.....	95	EASYMAX I5	136
dorzolamide.....	106	EASYMAX NORMAL.....	136
DORZOLAMIDE.....	106, 107	EASY MINI EJECT	135
DOSOKAP	240	EASY PLUS II.....	135
DOVATO	65	EASYPOINT.....	147
DOVER BULB SYRINGE	150	EASY STEP	135
DOVONEX.....	182	EASY TALK	135
doxazosin.....	82	EASY TOUCH	136, 147, 150, 151, 158, 183
doxepin	173, 178, 179, 182	EASY TOUCH FLIPLOCK	147, 150
doxercalciferol	196	EASY TRAK.....	136
doxycycline	38, 39, 40, 194	EASY TWIST CAP LANCETS.....	158
doxylamine succinate/vit b6.....	120	EBGLYSS	201
dronabinol	119	ECLIPSE SYRINGE	151
DROPLET	135, 142, 158	EC-NAPROSYN	27
DROPLET GENTEEL LANCING DEVICE.....	135	ec-naproxen	27
DROPLET LANCETS.....	158	econazole.....	46
DROPLET LANCING DEVICE	135	EDECIN.....	101
DROPSAFE	142, 147, 158, 179, 183, 257	EDEX	194
DROPSAFE PREP PADS.....	183	EDLUAR	179
drospir/eth estra/levomefol.....	95	EDURANT.....	66
DROXIA.....	77	E.E.S. 200.....	37
droxidopa.....	72	efavirenz	66, 68
drug mart glucose.....	110	effer-k.....	117
DUAVEE	128	EFFER-K.....	117
DUET	166, 170	EFFIENT	65
DUETACT.....	50	EFUDEX.....	62
DUET DHA	166	EGRIFTA	129

Index of Medications

eldertonic.....	206	ENLYTE	205
ELDERTONIC LIQUID	206	enoxaparin	43
ELEMENT COMPACT	136	ENSACOVE	58
ELEMENT CONTROL	136	ENSPRYNG	132
ELEPSIA	92	ENSTILAR.....	190
eletriptan hydrobromide	15, 19	entacapone	64
ELFOLATE.....	227	entecavir.....	70
ELIMITE	63	ENTEREG	124
ELIQUIS	43, 258	ENTERO VU	99
ELIXOPHYLLIN.....	32	ENTRESTO	82
ELLA	95	ENZOCLEAR	184
ELMIRON	24	EPCLUSA.....	70
ELON	210	EPIDIOLEX.....	91
eltrombopag	95	EPIDUO FORTE	182
EMBRACE	136, 143, 158	EPIFOAM.....	190
EMBRACE EVO LEVEL I.....	136	epinastine	47
EMBRACE GLUC CONTROL SOLN.....	136	epinephrine.....	70, 71, 103
EMBRACE LANCING DEVICE.....	136	EPINEPHRINE.....	71
EMBRACE PRO.....	136	EPIPEN.....	71
EMBRACE TALK CONTROL	136	EPISIL.....	195
EMERGEN.....	221, 235, 236, 258	EPIVIR.....	67
EMERGEN-C.....	221, 235, 236	eplerenone	102
EMERGEN-C KIDZ.....	221	eprosartan	83
EMGALITY.....	15, 19, 90	EPSOLAY	185
EMGALITY PEN	19	EPZICOM	66
EMPAVELI	76	EQ.....	203, 210, 221
EMSAM	171	EQ CHILD	221
emtricitabine.....	68	eql.....	113, 199, 203, 227, 232, 234, 236, 240, 244
emtricitabine	66, 67	eql slow release iron.....	113
emtricitabine-tenofv	66	eql vitamin.....	232, 236, 240, 244
EMTRIVA	67	EQUETRO	171
EMVERM.....	52	EQ VISION	203
enalapril.....	81, 82, 83	ERGOCAL	240
enalapril/hydrochlorothiazide.....	81, 82	ergocalciferol	240
ENBRACE	210	ergoloid	86
ENBREL.....	54	ERGOMAR.....	19
ENDARI.....	77	ergotamine tartrate/caffeine	15, 19
ENDO-AVITENE.....	77	ERIVEDGE	56
ENDOMETRIN.....	131	ERLEADA	55
ENDUR-AMIDE.....	219	erlotinib	58
ENDUR-THINE	219	ERMEZA	192
ENDUR-VM	210	ERVEBO.....	76
ENFAMIL.....	111	ERYPED	37
ENFIT	151, 153, 224, 244, 258, 273	ERY-TAB.....	37
ENFLONSIA.....	68	ery-tab dr	37
ENGERIX-B	76	erythromycin.....	34, 37, 40, 41
ENLITE SERTER.....	136	escitalopram.....	172

Index of Medications

ESGIC	15, 19	EXTENDED RESERVOIR.....	152
ESKATA	182	EXTINA.....	46
eslicarbazepine.....	91, 92	EYE HEALTH AND LUTEIN.....	203
esomeprazole	124	EYE HEALTH PLUS LUTEIN TABLET	203
ESOMEPRAZOLE.....	124	EYE MULTIVITAMIN	203
ESSENCE C.....	236	EYEPROTECT	203
ESSENTIAL	166, 210, 215, 216	EYSUVIS	104
estazolam.....	178	EZ.....	142, 143, 158
ESTER-C.....	236	E-Z DISK.....	99
ESTRACE	127	ezetimibe	86, 87
estradiol.....	95, 96, 127, 130	ezetimibe/simvastatin.....	86
ESTRATEST	127	E-Z-HD.....	99
estrogen,ester/me-testosterone	127	EZ-LETS.....	158
ESTROVEN	211	E-Z-PAQUE	99
eszopiclone.....	179	E-Z-PASTE	99
ethacrynic	101	EZ SMART LANCETS	158
ethambutol.....	36	F	
ethinyl estradiol/drospirenone.....	95, 96	FA-8.....	205
ethosuximide.....	92, 94	FABHALTA	76
ethynodiol d-ethinyl estradiol.....	95	FACTIVE	38
etodolac.....	27, 28	famciclovir	69
etonogestrel/ethinyl estradiol	95	famotidine.....	122
etoposide	61	fa/mv,ca,iron,min/lycopene/lut	211
etravirine	66	FARESTON.....	61
EUCRISA	186	FARXIGA	51
EULEXIN	55	FARYDAK.....	54
EURAX.....	64	FASENRA	32
EVAMIST	127	FATIGUE RELIEF COMPLEX	211
EVEKEO.....	72	febuxostat.....	26
EVENCARE.....	136	felbamate.....	92
everolimus	56, 133	FELBATOL.....	92
EVICEL	77	FELDENE	27
EVISTA.....	200	felodipine.....	78
EVOCLIN	41	FEMARA.....	55
EVOLUTION	136	fenofibrate.....	87, 88
EVOTAZ.....	67	fenofibric.....	87, 88
EVOXAC	72	FENOGLIDE.....	88
EVRYSDI.....	197	fenoprofen	27, 28
EVZIO	44	FENORTHO.....	27
EXEL.....	147, 151, 152	fentanyl.....	22
EXELDERM	46	FENTANYL.....	22
EXEL HUBER	147	feosol	113
EXELON.....	71	FEOSOL	113
exemestane	55	FERAHEME.....	113
exenatide	48	FERGON.....	113
EXPECTA PRENATAL	166	FER-IN-SOL	113

Index of Medications

FERIVA 2I-7	113	FLINTSTONES.....	221
FERIVA FA.....	113	FLOGEN.....	204
FERRACTIV IRON	113	FLOLIPID.....	86
FERRALET	113	FLOMAX.....	202
FERRETTS IPS.....	113	FLORAFOL.....	221
FERRIMIN.....	113	FLORIVA	108, 221
FERRIPROX.....	198	FLORRAXYL.....	211
FERRLECIT	113	FLOVENT.....	31
FERRO-SEQUELS.....	113	FLOW-EZE	147
ferrous.....	113, 114, 213, 214, 225	FLUAD.....	74
FERROUS	113	FLUAD QUAD.....	74
ferrous fumarate.....	113, 114	FLUARIX	74
FERROUS FUMARATE.....	113	FLUARIX QUAD.....	74
ferrous fum/vit c/b12-if/folic	113	FLUBLOK.....	74
ferrous gluconate	113, 213, 214	FLUBLOK QUAD	74
ferrous sulfate.....	113, 114	FLUCELVAX	74
ferumoxytol	113, 114	FLUCELVAX QUAD.....	74
fesoterodine.....	203	fluconazole	44, 45
FETZIMA.....	173	flucytosine.....	44, 45
FEXMID.....	165	fludrocortisone.....	129
FIBRICOR.....	88	FLULAVAL.....	74
fidaxomicin.....	37	FLULAVAL QUAD	74
fifty50.....	179, 183, 260	FLUMADINE	69
FIFTY50.....	143, 158	FLUMIST.....	75
fifty50 alcohol prep pads.....	183	FLUMIST QUAD	75
FIFTY50 SAFETY SEAL LANCETS.....	158	flunisolide	103
FILSPARI	88	fluocinolone.....	103, 187, 188, 189
FILSUVEZ	201	fluocinonide	188
FILTER.....	147, 148, 152, 154	fluorescein.....	99, 105
FILTER ASPIRATOR	147	FLUORESC EIN-BENOXINATE	105
FINACEA	185	fluoride	109, 112, 117, 222, 223
finasteride.....	202	FLUORIDEX.....	109, 112
FINAZOL	211	fluorometholone.....	104
FINE.....	148	FLUOROPLEX.....	62
FINGER GRIP	152	fluorouracil	62
FINGERSTIX	143, 158	fluoxetine	172, 177
FIORICET	15, 19, 24	fluphenazine.....	177
FIORINAL	15	FLURA-DROPS.....	109, 117
FIRDAPSE.....	90	flurandrenolide	187
FIRST-MOUTHWASH BLM.....	195, 196	flurazepam	178
FLAGYL	35	flurbiprofen	27, 104
FLAVOVIT	204	flutamide.....	55
flavoxate	203	fluticasone	31, 103, 188
flecainide	78	fluticasone propion/salmeterol.....	31
FLECTOR	181	fluticasone-salmeterol	31
FLEVOXIN	236	fluticasone-salmeterol 100-50.....	31
FLEXICHAMBER.....	163	fluvastatin.....	86

Index of Medications

fluvoxamine	172	FOSAMAX PLUS D	200
FLUZONE	75	fosamprenavir	67
FLUZONE HIGH-DOSE	75	fosaprepitant	120
FLUZONE HIGH-DOSE QUAD	75	fosfomycin tromethamine	35
FLUZONE QUAD	75	fosinopril	81, 83
FML	104	fosinopril/hydrochlorothiazide	81
FNP	245	FRAGMIN	43
fn vitamin	232	FRAICHE	109
FOLA	227	FREEDAVITE	211
FOLACHEW	211	FREESTYLE	98, 136, 137, 143, 158
FOLAGENT	211	FREESTYLE INSULINX	98
FOLAMAX	211	FREESTYLE LITE	98
FOLAMED	211	FROVA	19
FOLAPRIME	211	frovatriptan succinate	19
FOLAWISE	211	FRUIT C	236
FOLETRA	205	fruit c-100	236
FOLIC	166, 205, 206, 211, 225, 227, 232, 234, 240, 261	FRUIT C-100	236
folic acid	113, 114, 115, 167, 169, 205, 206, 209, 211, 212, 213, 214, 215, 217, 218, 221, 223, 225, 227, 228, 230	FRUZAQLA	58
folic/mvi ther-min/lycop/lut	211	ft 114, 166, 205, 211, 219, 228, 230, 232, 234, 236, 240, 244, 245, 246, 261	
FOLICORE	227	FT	114, 199, 211, 228, 232, 236, 240
FOLIKA	205, 211, 227, 228, 240	ful-glo	99
FOLIKA-BC	227	FUL-GLO	99
FOLIKA-D	240	FULPHILA	95
FOLIKA-NC	227	FURADANTIN	37
FOLIKA-T	228	furosemide	101
FOLIKA-V	205	FUSION	66, 114
FOLINIC-PLUS	228	FUZEON	66
FOLITE	205	FYCOMPA	92
FOLIXAPURE	240	G	
FOLLISTIM AQ	130	gabapentin	90, 91, 92, 261
FOLTRATE	232	GALAFOLD	198
FOLTX	228	galantamine	71
FOLVITA	228	GALZIN	198
FOLVITE-D	240	ganirelix	129
fondaparinux	43	GANIRELIX	129
FORA	98, 136, 143, 158	GARDASIL 9	76
FORACARE	136, 143, 158	GASTROCROM	25
FORACARE LANCETS	158	GASTROGRAFIN	99
FORA GTEL	98, 136	GASTROMARK	99
FORA LANCETS	158	gatifloxacin	34
formaldehyde	53, 181	GATIFLOXACIN-DEXAMETHASONE	33
formoterol	30	GATTEX	125
FORMOTEROL	30	GAVRETO	58
FORTAVIT	211	GEIOO	137
FORTISCARE	136	GELCLAIR	195
FOSAMAX	200	GELFILM	105, 199

Index of Medications

GEL-FLOW	77	gnp.110, 114, 166, 199, 203, 205, 211, 212, 219, 224, 228, 230, 232, 234, 236, 240, 241, 244, 245, 262	
GELFOAM.....	77	GNP179, 199, 211, 212, 224, 228, 232, 236, 240, 244, 246, 262	
GELX.....	195	GNP B-COMPLEX PLUS VIT C TAB.....211	
gemfibrozil	88	gnp glucose.....110	
GEMTESA	202	GNP VITAMIN E	244
GENADEK	211, 221	GOJJI	98, 137, 143, 159
GENICIN	205, 228, 240	GOLYTELY	123
GENICIN VITA-Q	205	GOMEKLI	56
GENICIN VITA-S.....	228	GONAL-F	130
GENOTROPIN.....	129	GONITRO	79
gentamicin	34, 35, 41	GOPRELTO	103
GENTEEL	135, 137	GRALISE.....	91
GENTLE IRON.....	114	granisetron.....	120
GENVOYA.....	68	GRASTEK	73
GEODON	176	griseofulvin	45
GERBER	211, 222	gs	110
GERBER GROW MIGHTY	222	GS	53, 154, 166, 180, 183, 211, 262
GERBER LIL BRAINIES.....	222	GS PRENATAL	166, 211
GERITOL	206	GUAIACOL.....	184
GIALAX	123	guaifen-codeine	98
GILOTRIF	58	GUAIFEN-CODEINE.....	98
glatiramer	89	guanfacine.....	84, 174
glatopa.....	89	GUARDIAN	137
GLEOLAN.....	99	GUMMIES CHILDREN MULTIVITAMIN	222
GLEOSTINE.....	54	GUMMY	110, 207, 221, 222, 232
glimepiride.....	49, 50	GVOKE.....	110
glipizide	49, 50	GYNAZOLE	44
GLOPERBA	26	H	
GLUCAGON.....	63, 125	HAEGARDA.....	196
GLUCO	110	HAIR, SKIN AND NAILS	208, 212, 217
GLUCOCARD.....	137	HAIR-SKIN-NAILS.....	228
GLUCOCOM.....	137, 143, 159	halcinonide	188
glucose.....	109, 110, 111	HALCION.....	178
GLUCOSE.....	110	halobetasol	188
GLUCOSE CONTROL	134, 135, 136, 137, 139	HALOG.....	188
GLUCOSE LIQUID.....	109, 110, 111	haloperidol.....	177
GLUCOTROL	49	HARD NAILS	228
glutamine.....	77	HARVONI.....	70
GLUTOL	111	HAVRIX.....	76
GLUTOSE-I5.....	110	HEALON GV	108
GLUTOSE-45	110	HEALTHPRO GLUCOSE CONTROL SOLN.....	137
glyburide	49, 50	HEALTHY	137, 143, 159, 203, 215, 216
GLYCATE.....	119	HEALTHY ACCENTS AUTOLET	137
glycine urologic solution.....	53	HEALTHY ACCENTS UNILET LANCET	159
glycopyrrolate	119	healthy eyes tablet.....	203
GLYNASE.....	49	HEALTHY EYES TABLET	203
GLYXAMBI.....	49		

Index of Medications

HEARTBURN ACID REFLUX.....	212	hydrocodone/ibuprofen.....	21
HEMA-COMBISTIX.....	100	hydrocort.....	32, 33, 103, 122, 125, 188, 190, 263, 269, 270
HEMANGEOL.....	85	hydrocortisone.....	103, 125, 128, 186, 188, 189, 190
HEMATEX.....	114	hydrocortisone/acetic acid.....	103
HEMATOGEN.....	114	hydrocort-pramoxine.....	125, 190
HEMATRON-AF.....	114	hydrogen peroxide.....	181
HEMAX.....	114	hydromorphone.....	22
HEMLIBRA.....	76	hydroxocobalamin.....	232
HEMOCYTE.....	114	hydroxychloroquine.....	53
heparin.....	43	HYDROXYCHLOROQUINE.....	52, 53
HEPARIN.....	43	HYDROXYPROPYLCELLULOSE.....	199
HEPLISAV-B.....	76	hydroxyurea.....	54
HETLIOZ.....	178	hydroxyzine.....	47
HIBERIX.....	75	HYFTOR.....	132
high potency multivitamin tab.....	212	HYLAVITE.....	228
HIGH POTENCY MULTIVITAMIN TAB.....	212	HYLAZINC.....	205
HISTEX-AC.....	96	HYMPAVZI.....	76
hm.....	114, 166, 199, 205, 219, 228, 232, 236, 241, 244	hyoscyamine.....	121
HM.....	166, 180, 183, 212, 228, 241, 263	HYPER-SAL.....	197
HM ALCOHOL 70% PREP PADS.....	183	HYPODERMIC NEEDLE.....	147, 154
HM BIOTIN.....	228	HYPOLANCE.....	137
HM HAIR, SKIN AND NAILS TABLET.....	212	HYPROMELLOSE.....	199
hm iron.....	114	HYSINGLA.....	22
HM MEN'S ONE DAILY TABLET.....	212		
HM ONE DAILY PRENATAL.....	166	ibandronate.....	200
hm prenatal.....	166	IBRANCE.....	58
hm slow release iron.....	114	IBTROZI.....	58
hm vit.....	232, 236	ibuprofen.....	21, 27
hm vitamin.....	232, 236, 241, 244	I-CAPS.....	203
HM VITAMIN.....	241	ICAPS.....	203, 204, 212
homatropine.....	107	ICAPS AREDS2.....	204
HOMOCYSTEINE.....	228	ICAR.....	114
HORIZANT.....	89	icatibant.....	193
HORMONES.....	125, 126, 127, 128, 129, 130, 131, 192	ICLUSIG.....	58
HUMALOG.....	51	icosapent.....	118
HUMANA.....	98	IDHIFA.....	61
HUMATIN.....	52	IFE-BIMIX.....	194
HUMULIN.....	51	IGALMI.....	179
HURRICAIN LUER-LOCK.....	147	IHEALTH.....	137
HYCAMTIN.....	56	ILET.....	137, 138
HYCODAN.....	97	ILEVRO.....	104
hydralazine.....	84, 85	I.L.X. B-12.....	114
HYDREA.....	54	IMBRUVICA.....	58
hydrochlorothiazide.....	81, 82, 83, 84, 85, 102	IMCIVREE.....	63
hydrocodone.....	21, 22, 97, 263	imipramine.....	173, 174
hydrocodone-acetamin.....	21	imiquimod.....	184
HYDROCODONE-ACETAMIN.....	21	IMKELDI.....	58

Index of Medications

IMMUNERX	212	INVELTYS.....	104
IMPAVIDO.....	53	iodine/potassium iodide	190
IMPEKLO.....	189	iodine/sodium iodide	190
IMULDOSA	131	IODOFLEX	190
IMURAN.....	133	IODOSORB	190
INBRIJA	64	IOPIDINE.....	106
INCONTROL.....	138, 143, 159, 180, 183, 263	IPOL	73
INCONTROL LANCING DEVICE	138	ipratropium	29, 103
INCRELEX	129	IQIRVO.....	195
indapamide.....	102	irbesartan.....	83
INDICLOR	100	irbesartan/hydrochlorothiazide	83
indomethacin	28	IRESSA.....	58
INDOMETHACIN.....	28	iron.....	95, 96, 113, 114, 115, 116, 117, 167, 168, 169, 206, 208, 209, 211, 213, 214, 215, 217, 218, 220, 221, 222, 223, 224, 230, 249, 255, 258, 259, 263, 264, 269, 270, 272, 275, 277
INFANRIX DTAP	75	IRON ..	112, 113, 114, 115, 116, 117, 166, 170, 209, 210, 216, 217, 218, 220, 221, 222, 223, 224
INFANT-TODDLER MULTIVITAMIN	222	iron bg.....	115, 167
infant-toddler multivit-iron.....	222	IRON BISGLYCINATE.....	115
INFANT-TODDLER MULTIVIT-IRON	222	iron/c.....	115
INFANT-TODDLER TRI-VITAMIN.....	222	iron,carbonyl.....	113, 114, 115
INFASURF	193	iron/folic.....	115, 167, 168, 169, 208, 209, 213, 214, 218
INFED.....	114	iron fum.....	114, 115, 167, 168, 209, 214, 220
INFINITY	138	iron fumarate	115, 167
INFUSION SET	138, 140, 141	iron polysaccharide	114, 115, 116
INFUVITE	212, 222	IRONUP.....	116
INGREZZA.....	89	IRO-PLEX.....	116
INJECT.....	143, 152, 159	IROSPAN.....	116
INJECTAFER.....	115	IS-D.....	241
INJECT EASE.....	159	ISENTRESS.....	68
INJECT-EASE	152	isoflurane	24
INLYTA	58	isoniazid	36
INNER EAR PLUS.....	204	ISOPROPANOL	199
INOVA	184	isopropyl	183, 198, 199
INPEN.....	138	isopropyl alcohol	183, 198, 199
INSPIRACHAMBER.....	163	ISOPROPYL ALCOHOL	183, 198
INSPIRA.....	102	ISOPROPYL ALCOHOL 70% SPRAY	53
INSTACLEAN	199	isopropyl rubbing alcohol.....	199
INSTA-GLUCOSE.....	110	ISOPROPYL RUBBING ALCOHOL.....	199
INSUL-CAP	138	ISOPTO CARPINE.....	106
INSUL-EZE.....	138	ISORDIL	79
INSULIN.....	48, 49, 50, 51, 129, 149, 151, 152, 154, 155	isosorbide.....	79, 85
INSULIN LISPRO	51	isotretinoin.....	181
INSULIN SYRINGE U-500.....	152	isoxsuprine	86
INTEGRA.....	115, 147, 152	isradipine	78
INTELENCE	66	itraconazole.....	45
INTERLINK.....	152	IV 3000	155, 156
INTRINSI	232		
INVACARE	143, 159		
INVEGA	176		

Index of Medications

IV3000	155	KINRIX.....	75
ivabradine.....	79	KISQALI.....	57, 58
IV ADMINISTRATION SET	162	KITABIS PAK	35
IVENIX	162	KLARITY	34, 104, 108
ivermectin.....	52, 185	KLARITY-A(AZITHROMYCIN-CHONDR).....	34
IWILFIN.....	58	KLARON.....	182
J		KLOXXADO	44
JAKAFI	56	KOSELUGO.....	56, 265
JALYN.....	202	KOSHER PRENATAL	166
JANSSEN COVID-19 VACCINE.....	73	K-PAX.....	212
JANUMET.....	50	K-PHOS.....	118
JANUVIA.....	49	KPN PRENATAL	166
JARDIANCE.....	51	KRINTAFEL	53
JATENZO.....	126	KRISTALOSE	123
JOENJA 70 MG TABLET.....	193	kroger glucose.....	110
JORNAY.....	174	kro glucose.....	110
JUBLIA	46	kro isopropyl alcohol 91%	199
JULUCA	65	KYLEENA	96
JUST 4 KIDZ MULTIVIT-PROBIOTIC.....	222	KYNMOBI	64
JUSTRIGHT 5000	109, 112	L	
JUXTAPID	86	labetalol.....	82
JYNARQUE.....	101	LABSTIX REAGENT	100
JYNNEOS	76	lacosamide	92
K		LACRISERT	104
KI-1000	245	lactulose.....	119, 123
K2.....	239, 241, 245, 246	LAMICTAL	92
KADIAN	22	lamivudine.....	66, 67, 70
KALETRA	67	lamivudine/zidovudine.....	66
KALYDECO	192	lamotrigine	92, 93
KAPVAY	174	lancets.....	141, 143, 157, 159
KENALOG	189	LANCETS.....	141, 142, 143, 144, 145, 146, 157, 158, 159, 160, 161
KENDALL	152, 156	LANCING DEVICE.....	134, 135, 136, 137, 138, 139, 140, 141
KENDALL DISINFECTANT CAP.....	152	LANCING SYSTEM	138
KERENDIA	102, 265	LANOXIN.....	79
KESIMPTA	89	lansoprazole.....	120, 124
KETAMINE	179	lansoprazole/amoxicilin/clarith	120
ketoconazole	45, 46	lanthanum carbonate	111
ketodan	46	LANTUS.....	51
KETO-DIASTIX REAGENT.....	100	LANZO	138
KETONE CARE TEST STRIP	100	lapatinib ditosylate.....	58
KETONE TEST STRIP	98, 100	LASIX.....	101
ketoprofen	28	LASTACRAFT	47
ketorolac.....	20, 21, 104	latanoprost	106
KETOSTIX REAGENT	100	LATANOPROST	106, 107
KIDS.....	99, 109, 112, 220, 221, 222, 228	LAZANDA.....	22, 23
KIDS COD LIVER OIL	222	LAZCLUZE.....	58
KIDS MULTIVITAMIN.....	222	leader glucose.....	110

Index of Medications

leader quick dissolve gluc.....	110	lisinopril.....	81, 82, 83
lecithin/pyridoxine/kelp.....	212	lisinopril/hydrochlorothiazide.....	81, 82
leflunomide.....	26	LITE.....	98, 138, 143, 159, 236
lenalidomide.....	57	LITEAIRE.....	163
LENVIMA.....	58, 59	LITE TOUCH.....	138, 159
LEQSELVI.....	201	LITETOUCH.....	163
LESCOL.....	86	LITFULO.....	201
L.E.T.....	25	lithium.....	171
letrozole.....	55	LITHOBID.....	171
leucovorin.....	193	LITHOSTAT.....	119
LEUKERAN.....	54	little.....	222
LEUKINE.....	95	LITTLE ANIMALS.....	222
levalbuterol.....	30	LIVDELZI.....	195
LEVBIID.....	121	LIVITA.....	222, 246
LEVER LOCK CANNULA.....	152	LIVMARLI.....	123
levetiracetam.....	93	LIVTENCITY.....	69
LEVETIRACETAM.....	93	l-mefol/a-cyst/mebl2/algal oil.....	228
LEVITRA.....	194	lmefolate/b3/copp/znsel/chrom.....	212
levobunolol.....	106	L-MESITRAN.....	186
levocarnitine.....	200	L-METHYLFOL.....	228
levofloxacin.....	34, 38	l-norgest/e.estradiol-e.estradiol.....	95
LEVOMEFOL.....	228	LODINE.....	28
levomefolate.....	205, 225, 226, 228, 230	LODOSYN.....	65
LEVOMEFOLATE.....	228	lofexidine.....	201
levonorgestrel/ethin.estradiol.....	95	LOKELMA.....	111
levothyroxine.....	192	LOMAIRA.....	62
LEVSIN.....	121	LOMOTIL.....	119
LEVULAN.....	61	longs glucose.....	110
LICART.....	181	LONHALA MAGNAIR.....	29
lidocaine.....	25, 125, 190, 266	LONSURF.....	55
LIDOCAINE-EPINEPHRIN-TETRACAIN.....	25	LOPID.....	88
LIDOCAN.....	25	lopinavir/ritonavir.....	67
LIFESHIELD BLUNT CANNULA.....	147, 152	LOPRESSOR.....	85
LILETTA.....	96	LOPROX.....	46
lindane.....	190	lorazepam.....	170, 171
linezolid.....	37	LORBRENA.....	59
LINZESS.....	123	LORID.....	228
liothyronine.....	192	LORMATE.....	228
LIPO.....	204	LORTAB.....	21
LIPO-FLAVONOID PLUS.....	204	LORZONE.....	165
LIPOTRIAD.....	204	losartan/hydrochlorothiazide.....	83
LIQUID99, 100, 109, 110, 111, 116, 206, 213, 224, 231, 236, 238, 239, 245, 255, 258, 262, 266, 281		losartan potassium.....	84
LIQUID E-Z PAQUE.....	99	LOTEMAX.....	104
LIQUID POLIBAR PLUS.....	99	LOTENSIN.....	81, 83
liraglutide.....	48, 63, 266	LOTENSIN HCT.....	81
lisdexamphetamine.....	174	loteprednol.....	104
		loteprednol etabonate.....	104

Index of Medications

lovastatin.....	86	meclizine.....	120
loxapine.....	177	meclofenamate.....	28
lubiprostone.....	123	mecobal/levomefolat ca/b6 phos.....	228
LUCENTIS.....	108	MEDI-FIRST ISOPROPYL ALCOHOL.....	53
LUER LOCK.....	150, 151, 152, 153	MEDIHONEY.....	186
LUER-LOK.....	149, 152, 154	MEDISENSE.....	138, 143, 159
LUERSLIP.....	152	medlance.....	143, 159
LUER SLIP TIP.....	152	MEDLANCE.....	143, 159
LUER TIP CAP.....	152, 154	medlance plus.....	159
LUMAKRAS.....	56	MEDLANCE PLUS.....	159
LUMRYZ.....	178	MEDROL.....	128
LUPKYNIS.....	133	medroxyprogesterone.....	95, 130
LUTEIN.....	203, 204, 206, 221	MEDTRONIC.....	138
LYBALVI.....	176	MEDTYCHOLL-B.....	228
LYDIA PINKHAM HERBAL.....	116	mefenamic.....	21
LYMEPAK.....	39	mefloquine.....	53
LYNPARZA.....	59	MEGA BIOTIN.....	228
LYSODREN.....	61	megestrol.....	61, 203
LYSTEDA.....	76	meijer glucose.....	110
LYTGOBI.....	59	MEKINIST.....	56
LYUMJEV.....	51	MEKTOVI.....	56
M		meloxicam.....	28
MACROBID.....	37	melphalan.....	54
MACULAR BENEFITS.....	204	memantine.....	88, 267
MACUVEX.....	204	MEMANTINE.....	88
MACUZIN.....	204	MEN 50.....	206, 209, 212, 217
MAD.....	152	MENACTRA.....	74
mafenide.....	41, 42	MENOPUR.....	130
MAGELLAN.....	152, 153	MENOSTAR.....	127
MALARONE.....	53	MENQUADFI.....	74
malathion.....	190	MEN'S.....	206, 207, 208, 209, 210, 212, 215, 216, 217, 246
maprotiline.....	173	MEN'S 50 PLUS.....	212, 215, 216
maraviroc.....	66	MEN'S DAILY.....	212
MAR-COF CG.....	98	MEN'S MULTIVITAMIN.....	212, 215
MARINOL.....	119	MENVEO.....	74
MARNATAL-F.....	166	MEPHYTON.....	246
MARPLAN.....	171	meprobamate.....	171
MASONATAL.....	166	MEPRON.....	53
MATULANE.....	61	mercaptopurine.....	55
MAVENCLAD.....	89, 90	MERIBIN.....	228
MAXFE.....	116	mesalamine.....	121, 122
MAXIMIN.....	212	mesna.....	193
MAXIMUM D3.....	241	MESNEX.....	193
MAXITROL.....	33	METADATE.....	174
MAXI-TUSS CD.....	96	METANX.....	228, 229
MAYZENT.....	90	METANXPRO.....	229
MEBOLIC.....	212	metaproterenol.....	29

Index of Medications

metaxalone.....	165	MICROLET	138, 144, 159
metformin	49, 50	MICRONEX	212
METHACHOLINE	99	MICROSPACER	164
methadone.....	23	MICROTAINER	157, 159
methamphetamine	71, 72	MICRO THIN LANCET	159
METHAVER	229	MICRO THIN LANCETS	159
methazolamide.....	101	midazolam.....	178
methenamine hippurate	35	MIDAZOLAM.....	178, 179
methenamine mandelate	35	midodrine	72
methenam/m.blue/salicyl/hyoscy	35	MIEBO.....	104
methenam/sod phos/mbblue/hyoscy	35	MIFEPREX.....	196
methen/mbblue/sal/sod phos/hyos.....	35	mifepristone	50, 196
methimazole.....	192	miglitol.....	48
METHITEST	126	miglustat	197
meth/meblue/sod phos/psal/hyos	35	MIGRANAL	20
methocarbamol	165	MINCORA	229
methotrexate.....	55	MINI LANCING DEVICE.....	138, 139
methoxsalen.....	181	MINIMED.....	138, 152
methscopolamine.....	121	MINIMED RESERVOIR.....	152
METHYL B-12	232	MINI PRENATAL	166
METHYLCOBALAMIN	232, 233	MINIPRESS.....	82
methyldopa.....	84	minocycline	39, 40
methylene.....	196	MINOLIRA.....	39
methylergonovine.....	129	minoxidil.....	84
METHYLFOLATE.....	205	mirabegron.....	202
METHYLIN.....	174	MIRENA	96
methylphenidate.....	174, 175	mirtazapine	170
METHYLPHENIDATE	175	MIRVASO	185
methylprednisolone	128	misoprostol	27, 120
METHYL PROTECT	229	MITIGARE	26
methyl salicylate	184	MITOMYCIN.....	108
methyltestosterone	126	MITOSOL	108
metoclopramide	123	MI-VITE.....	205
metolazone.....	102	MIXED TOCOTRIENOLS	244
METOPIRONE	100	MKO.....	179
metoprolol.....	85	M-M-R II VACCINE	75
METOPROLOL SUCCINATE ER-HCTZ	85	MNEXSPIKE.....	73
METROCREAM	185	MOBILE.....	144
METROGEL	185	modafinil	178
metronidazole.....	35, 40, 185	MODDI.....	138
metyrosine	84	MODERNA COVID.....	73
mexiletine.....	78	MODERNA COVID-19 BOOSTER	73
MIACALCIN	131	moexipril.....	83
miconazole.....	44	molindone.....	177
MICRO	140, 144, 148, 159, 191	mometasone	103, 189
MICROCHAMBER.....	163	mondoxyne	39
MICRODOT	138	MONOCAPS	213

Index of Medications

MONOFERRIC.....	116	MURI-LUBE.....	199
MONOJECT.....	147, 148, 152, 153	MUSE.....	194
MONOLET.....	144, 159	mv.....	114, 115, 208, 211, 214, 216
MONSEL'S.....	77	M.V.I. PEDIATRIC.....	222
montelukast.....	32	mvn.....	209, 214
morgidox.....	39	MVW.....	214, 222, 223
MORGIDOX.....	39	MVW COMPLETE.....	222, 223
morphine.....	22, 23	MYALEPT.....	131
MOTOFEN.....	119	MYCAPSSA.....	130
MOUNJARO.....	48	MYCOBUTIN.....	36
MOUTHPIECE.....	164	mycophenolate.....	133
MOVANTIK.....	43	MYDAYIS.....	72
MOXATAG.....	38	MYDCOMBI.....	107
moxifloxacin.....	34, 38	MYDRIACYL.....	107
MOXIFLOXACIN.....	33	MYDRIATIC4.....	105
MRESVIA.....	76	MYFEMBREE.....	129
MS CONTIN.....	23	MYFORTIC.....	133
ms glucose.....	110	MYGLUCOHEALTH.....	138, 144, 159
ms quick dissolve glucose.....	111	MYHIBBIN.....	133
MTERYTI.....	166	MYLERAN.....	55
MTX.....	233	MYRBETRIQ.....	202
MUCOSITISRX.....	195	MYSOLINE.....	93
MULTAQ.....	78	MYXREDLIN.....	51
MULTIA.....	213	N	
MULTI-DAY PLUS MINERALS.....	213	nabumetone.....	28, 29
multi for her.....	213	naftifine.....	46
MULTI FOR HER.....	213	NAFTIN.....	46
MULTI-LANCET.....	138	NALFON.....	28
multilex.....	213	NALOCET.....	21
MULTILEX.....	213	naloxone.....	24, 44, 201
MULTI PRO.....	213	naltrexone.....	44
MULTISTIX.....	101	NAMENDA.....	88
MULTITOL-M.....	246	NAMZARIC.....	88, 269
multivit... 166, 206, 208, 209, 211, 213, 214, 215, 217, 218, 220, 221, 222, 223, 224		NANO.....	148, 169, 223
multivitamin 168, 209, 212, 213, 214, 215, 218, 220, 221, 222, 223, 224		NANOVN.....	223, 246
MULTIVITAMIN 168, 203, 204, 206, 207, 208, 209, 210, 211, 212, 213, 214, 215, 216, 217, 218, 219, 220, 221, 222, 229, 246		NAPRELAN.....	28
MULTIVITAMIN-MULTIMINERAL.....	213	NAPROSYN.....	27, 28
MULTI-VITE.....	214	naproxen.....	27, 28
MULTI-VIT-FLOR.....	222	naratriptan.....	19, 20
MULTIVIT-FLUOR.....	222	NARCAN.....	44
MULTIVIT-FLUORIDE.....	222	NARDIL.....	171
multivit-min/fa/lycopen/lutein.....	209, 214	NASCOBAL.....	233
multivit-min/iron/folic acid.....	214	NATACHEW.....	166
mupirocin.....	41	NATACYN.....	44
		nateglinide.....	49
		NATPARA.....	129
		NAYZILAM.....	91

Index of Medications

nebivolol.....	85	NIFEREX.....	116
NEBUPENT	53	NILANDRON.....	55
nebusal	197	nilotinib	59
NEBUSAL	197	nilutamide.....	55
NEEDLE.....	146, 147, 148, 149, 151, 152, 153, 154	nimodipine	79
needles,safety huber,disposabl.....	148	NINJACOF-XG	98
NEEVODHA	214	NINLARO	59
nefazodone	172	nisoldipine	79
NEFFY	71	nitisinone.....	197
NEMLUVIO	132	NITRO-DUR.....	80
neomycin.....	32, 33, 34, 35, 180	nitrofurantoin	37
neomycin/bacit/p-myx/hydrocort.....	33	nitroglycerin	80, 124
neomycin/bacitracin/polymyxinb.....	34	NITROLINGUAL	80
neomycin/polymyxin b/dexametha.....	33	NITROMIST	80
neomycin/polymyxin b/hydrocort	32, 33	NITROSTAT	80
neomycin/polymyxn b/gramicidin	34	NITYR.....	197
neomycin sulfate	35	NIVA-FOL.....	229
NEONATAL	116, 166	NIVA-PLUS	215
NEONATAL FE.....	116	NIVESTYM	95
NEORAL.....	133	nizatidine	122
NEO-SYNALAR.....	40	NOCTIVA	127
NEOVITE.....	214	NO FLUSH NIACIN.....	220
NEPHRON FA	229	NOKOR.....	148
NEPHRO-VITE.....	229	norelgestromin/ethin.estradiol.....	96
NERIA	163	noreth-ethinyl estradiol/iron.....	95
NERLYNX.....	59	norethind-eth estrad.....	96, 127
NESTABS	167, 214	norethindrone.....	96, 127, 130
NEUAC	182	norethin-ee.....	96
neuac gel.....	182	norethin-eth estrad	127
NEULUMEX	99	NORGESIC	165
NEUPRO	64	norgestimate-ethinyl estradiol.....	96
NEURIN-SL	233	norgestrel-ethinyl estradiol.....	96
NEUTRASAL	195	NORM-JECT	153
nevirapine	66	NORMLGEL.....	190
NEXAVAR	59	nortriptyline	173
NEXCARE TEGADERM	156	NORVIR	67
NEXLETOL	86	NORWEGIAN COD LIVER OIL	224
NEXLIZET	86	NOURIANZ.....	64
niacin.....	88, 219, 220	NOVA	138, 144, 159
NIACIN	219, 220	NOVAFERRUM	116, 223, 270
niacinamide.....	220	NOVAMAX PLUS.....	98, 138
NIACINAMIDE.....	220	NOVAMV	223
NIACOR	88	NOVAREL	130
nicardipine.....	78	NOVAVAX COVID-19 VACC,ADJ	73
NICOMIDE.....	214	NOVOPEN 3.....	139
NICOTROL	191	NOVOPEN ECHO.....	139
nifedipine.....	78, 79	NOXAFIL.....	45

Index of Medications

NOXIFOL-D3.....	241	om-3.....	215
NUBEQA.....	55	OMECLAMOX-PAK.....	120
NUCALA.....	31	omega-3 acid.....	118
NUCORT.....	189	omeprazole.....	124
NUEDEXTA.....	89	OMNIPAQUE.....	98
NUFERA.....	116	OMNIPOD.....	139
NUFOLA.....	229	OMNITROPE.....	129
NU-IRON.....	116	OMNIVEX.....	215
NULEV.....	121	OMVOH.....	131, 132, 271
NULYTELY.....	123	ON CALL.....	139, 144, 159
NUMBRINO.....	103	ONCOVITE.....	215
NUMOISYN.....	195	ondansetron.....	120
NUPLAZID.....	171	one 3, 5, 6, 7, 8, 9, 11, 12, 13, 14, 169, 209, 211, 212, 215, 216, 217, 247, 271, 275	
NURTEC ODT.....	20	ONE.....	164, 166, 167, 169, 207, 210, 212, 214, 215, 216, 217, 223, 224
NUTRALYN.....	215	one-a-day.....	216
NUTRIVIT.....	215	ONE A DAY.....	167, 224
NUVAXOVID.....	73	ONE-A-DAY.....	167, 215, 216, 223
NUVESSA.....	40	one daily.....	169, 209, 212, 215, 217
NUZYRA.....	40	ONE DAILY.....	166, 207, 210, 212, 215
NYMALIZE.....	79	ONE-DAILY.....	216
nystatin.....	45, 46	ONETOUCH.....	139, 144, 160
O		ONETOUCH DELICA.....	139, 160
OB COMPLETE.....	167, 215	ONETOUCH ULTRA.....	139
OBREDON.....	98	ONETOUCH VERIO.....	139
OBSTETRIX EC.....	167	ONEVITE.....	216
OBSTETRIX ONE.....	215	ONE WAY MOUTHPIECE.....	164
OBTREX DHA.....	167	ONEXTON.....	182
OCALIVA.....	122	ONGENTYS.....	64
OCUFLOX.....	34	ON-THE-GO.....	144, 160
OCULAR VITAMINS.....	204	OPFOLDA.....	197
OCUVEL.....	204	opium/belladonna.....	23
OCUVITE.....	204, 215	opium tincture.....	119
ODACTRA.....	73	OPSITE.....	156
ODEFSEY.....	68	OPSUMIT.....	80
ODOMZO.....	56	OPSYNVI.....	81
OFEV.....	193	OPTICHAMBER.....	164
ofloxacin.....	32, 34, 38	OPTIFAST.....	216
OGSIVEO.....	59	OPTIMAL D3 M.....	241
OJEMDA.....	56	OPTISOURCE.....	216
olanzapine.....	176, 177	OPTUMRX.....	139
olmesartan/amlodipin/hcthiazid.....	82	OPURITY.....	216, 233
olmesartan/hydrochlorothiazide.....	83	OPZELURA.....	190
olmesartan medoxomil.....	84	ORACIT.....	118
olopatadine.....	103	ORALAIR.....	73
OLPRUVA.....	119	ORAMAGICRX.....	195
OLUX.....	189		

Index of Medications

ORAPRED ODT.....	128	PANDEL.....	189
ORAVIG.....	45	PANRETIN.....	62
ORENITRAM.....	80	PANTETHINE.....	220
ORFADIN.....	197	pantoprazole.....	124, 125
ORGOVYX.....	57	PANTOTHENIC.....	220
ORIAHNN.....	129	PAPAVERINE-PHENTOLAMINE.....	194
ORLISSA.....	129	PAPAVERINE-PHENTOLMN-ALPROSTD.....	194
ORKAMBI.....	192	PARADIGM.....	153, 163
ORLADEYO.....	193	paregoric.....	119
ORLISTAT.....	63	PAREMYD.....	107
orphenadrine.....	165	paricalcitol.....	196
ORTHO DF.....	241	PARNATE.....	171
oseltamivir.....	69	paroxetine.....	172, 197
OSENI.....	48	PARVLEX.....	116
OSMOPREP.....	123	PASER.....	36
OSTACHOL.....	241	PATANASE.....	103
OTEZLA.....	26	PAXIL.....	172
OTIPRIO.....	32	PAXLOVID.....	68
OTOVEL.....	32	PAXLYTE.....	233
OVACE.....	182, 183	pazopanib.....	59
OVAL TAPE.....	139	PEDIA POLY-VITE.....	223
OVIDE.....	190	pedia poly-vite iron.....	223
OVIDREL.....	131	PEDIATRIC MASK.....	164
oxandrolone.....	126	PEDIATRIC MONITOR.....	139
oxaprozin.....	27, 28	pediatric multivit.....	223
oxazepam.....	171	pediatric multivitamin.....	220, 223, 224
OXBRYTA.....	77	PEDIATRIC PANDA MASK.....	164
oxcarbazepine.....	93	PEDIATRIC POLY-VITAMIN.....	223
OXERVATE.....	108	PEDIATRIC POLY-VITE.....	223
oxiconazole.....	46	PEDIATRIC TRI-VITAMIN.....	223
OXTELLAR.....	93	PEDIATRIC TRI-VITE.....	223
oxybutynin.....	203	PEDIA TRI-VITE.....	223
oxycodone.....	21, 23, 24	pedi multivit.....	220, 221, 223
oxycodone hcl/acetaminophen.....	21	ped mvit.....	223
OXYCONTIN.....	24	PEDVAXHIB.....	75
oxymorphone.....	24	peg3350/sod sulf,bicarb,cl/kcl.....	123
OXYTROL.....	203	peg3350/sod sul/nacl/kcl/asb/c.....	123
OZEMPIC.....	48	PEGASYS.....	70
P		PEMAZYRE.....	59
P21.....	170	PENBRAYA.....	74
PACNEX.....	184	penciclovir.....	70
paliperidone.....	176	penicillamine.....	26
PALYNZIQ.....	73	penicillin.....	38
PAMELOR.....	173	PENMENVY.....	74
PAN-C.....	236	PENTACEL.....	75
PANCREAZE.....	124	pentamidine.....	53
PANDA.....	164	PENTASA.....	122

Index of Medications

pentazocine	24	piroxicam	27, 28
pentoxifylline.....	77	PISTON ENFIT	153
PEPCID	122	pitavastatin.....	86
perampanel	92, 93	PLEGRIDY	90
PERFECT	116, 144, 148, 160	PLEXION	41, 183
PERFECT IRON	116	PNEUMOVAX 23	74
PERIDEX.....	194	pnv	167, 169
PERIDIN-C.....	236	POCKET CHAMBER.....	164
perindopril erbumine.....	83	PODIAPN	229
permethrin.....	63, 64	podofilox.....	184, 185
perphenazine.....	177	POLIBAR ACB.....	99
perphenazine/amitriptyline hcl.....	173	polyethylene	199
PFIZER COVID	73	POLY HUB	148
pharm.....	180, 183, 272	polymyxin b sulf/trimethoprim	34
PHARM.....	180, 183, 272	POLYSKIN II.....	156
PHARMABASE BARRIER.....	185	POLYTRIM.....	34
pharm choice alcohol prep pads	183	POLY-TUSSIN AC	97
PHARM CHOICE ALCOHOL PREP PADS.....	183	POLY-VI-FLOR	223, 224
PHASEAL	148	poly-vi-sol	224
PHEBURANE	119	POLY-VI-SOL	224
phenazopyridine	25	POLY-VITA.....	224
phendimetrazine.....	62	POLY VITAMIN-IRON.....	216
phenelzine.....	171	POLY-VITE	223
phenobarb/hyoscy/atropine/scop	121	POMALYST	57
phenobarbital	178	POSACONAZOLE.....	45
PHENOBARBITAL-BELLADONNA ELIXR	121	posaconazole dr	45
phenoxybenzamine.....	72	potassium	20, 37, 38, 84, 109, 112, 117, 118, 124, 190
phentermine	62	POTASSIUM	102, 117, 118, 124
phenylephrine.....	46, 105	potassium bicarbonate/cit ac.....	117
PHENYTEK.....	93	potassium chloride	117
phenytoin	92, 93	potassium citrate	118
PHOSPHOLINE IODIDE	106	potassium iodide	112, 190
PHOTREXA.....	103	potassium iodide/iodine	112
PHYSIOLYTE.....	180	povidone.....	104
PHYSIOSOL	180	pramipexole	64
phytonadione	246	PRAMOSONE	190
PHYTONADIONE.....	246	PRANDIN.....	49
PIFELTRO	66	prasugrel	65
pilocarpine.....	72, 106, 273	pravastatin.....	86
pimecrolimus.....	132	praziquantel	52
pimozide.....	176	prazosin.....	82
pindolol.....	85	PR BENZOYL PEROXIDE.....	185
pioglitazone	50	PRECISIONGLIDE.....	147, 148, 153, 154
PIP	139, 144, 160	PRECISION XTRA	98, 139
PIP GLUCOSE CONTROL SOLUTION	139	PRECOSE	48
PIP LANCET	160	pred.....	33
PIQRAY	59	PRED.....	33, 104

Index of Medications

PRED FORTE.....	104	probenecid.....	29
PRED-G.....	33	PROCARDIA.....	79
prednicarbate.....	187, 189	PROCARE SPACER.....	164
prednisolone.....	33, 104, 105, 128	PROCERV HP.....	217
PREDNISOLONE.....	33, 104, 105	PROCHAMBER.....	164
PREDNISOLONE ACET-GATIFLO-BROM.....	33	prochlorperazine.....	120
PREDNISOLONE ACET-MOXIFLOXACIN.....	33	PRO COMFORT.....	144, 160, 164, 183
PREDNISOLONE AC-MOXIFLOX-BROMF.....	33	PROCORT.....	122, 125, 274
PREDNISOLONE AC-MOXIFLOX-NEPAF.....	33	PROCTOCORT.....	125
PREDNISOLONE PHOS-GATIFLO-BROM.....	33	PRODIGY.....	139, 144, 153, 160
PREDNISOLONE PHOS-GATIFLOXACIN.....	33	PRODIGY COUNT-A-DOSE.....	153
PREDNISOLONE PHOS-MOXIFLOXACIN.....	33	PRO FE.....	116
prednisone.....	128	PROFERRIN.....	116
preferred plus glucose.....	III	PROFOLA.....	217
pregabalin.....	93, 201	progesterone.....	130, 131, 274
PREGNYL.....	131	PROGLYCEM.....	III
PREHEVBRIO.....	76	PROGRAF.....	133
PREMARIN.....	130	PROLENSA.....	105
PRENATA.....	167	PROMACTA.....	95
prenatal.....	166, 167, 168, 169, 247	promethazine.....	47, 96, 97, 120
PRENATAL.....	166, 167, 168, 169, 170, 207, 211, 216, 218	PROMETRIUM.....	130
prenatal71.....	169	propafenone.....	78
PRENATE.....	169, 170, 216	proparacaine.....	105
PREPIDIL.....	129	propranolol.....	85
PRESERVISION.....	203, 204, 274	propylthiouracil.....	192
PRESSURE.....	105, 106, 107, 144, 160	PROQUAD.....	75
PRESSURE ACTIVATED LANCETS.....	160	PRORENAL.....	217, 229
PRESTALIA.....	81	PROSCAR.....	202
PRETOMANID.....	36	PROTECT.....	109, 116, 217, 229
PREV.....	216	PROTECT IRON.....	116, 217
PREVENT.....	225	PROTHELIAL.....	195
PREVIDENT.....	109, 112	protiptyline.....	174
PREVNAR 13.....	74	PROVERA.....	95, 130
PREVNAR 20.....	74	PROVIDA OB.....	169
PREVYMIS.....	69	PROVOCHOLINE.....	99
PREZISTA.....	65, 66	prucalopride.....	123
PRIFTIN.....	36	PSV SET.....	163
PRIMACARE.....	169	pub glucose.....	III
primaquine.....	53	PULMOZYME.....	193
PRIMAQUINE.....	53	PURE.....	144, 160, 164, 180, 183, 274
PRIMEAIRE.....	164	PURE COMFORT.....	160, 164, 183
primidone.....	93	PURECOMFORT.....	164
PRIMSOL.....	35	PUREFE.....	217
PRIORIX.....	75	purevita.....	241
PRISMASOL.....	118	PUREVITA.....	206, 220, 225, 229, 230, 233, 234, 236, 241, 244
PRO 116, 136, 141, 144, 146, 157, 160, 162, 164, 180, 183, 184, 213, 221, 258, 269, 274		PURIXAN.....	55
		PUSH.....	144, 160

Index of Medications

PUSH BUTTON	160	RANEXA	78
pyrazinamide.....	36	RA NIACIN	220
pyridostigmine	71	ranitidine.....	122
PYRIDOSTIGMINE	71	ranolazine.....	78
pyridoxine.....	212, 234, 235	ra one daily prenatal dha pack	169
PYRIDOXINE.....	234, 235	RAPAMUNE.....	133
pyrimethamine.....	52, 53	RAPID B-12 ENERGY	233
PYRUKYND	76, 77	ra prenatal tablet.....	169
Q		rasagiline	64
QELBREE	175	RASUVO.....	26
QSYMIA.....	62	RAVICTI	119
Q-SYTE.....	163	ra vit.....	233, 236
QUADRACEL DTAP-IPV	75	RA VIT	233
QUDEXY	93	ra vitamin.....	225, 233, 236, 237, 241, 244
QUERCETIN	204	ra vitamin a.....	225
QUESTRAN	87	RA VITAMIN C	237
quetiapine.....	176	RAYALDEE	196
QUFLORA.....	224	RAYA SURE	148
QUICK RELEASE SOFT TEFLON	139	RAYOS.....	128
quinapril.....	81, 83	RAZADYNE.....	71
quinapril/hydrochlorothiazide.....	81	READI-CAT 2	99
QUIN B STRONG	229	READYLANCE.....	144, 160
QUINCE SPINAL	148	REBIF.....	90
quinidine	78	RECOMBIVAX HB.....	76
quinine.....	53	RECOTHROM.....	77
QUINTABS.....	217	RECTIV	124
QULIPTA.....	20	REFUAH.....	139
QUVIVIQ	179	REGLAN	123
QVAR REDHALER.....	31	REGULAR BEVEL	148
R		RELAFEN.....	29
ra.... III, 116, 169, 183, 199, 206, 217, 220, 225, 229, 230, 233, 235, 236, 237, 241, 244		RELAGARD.....	52
ra alcohol swabs.....	183	RELCARE.....	229
ra balanced.....	229	RELENZA	69
rabeprazole	125	RELEXXII.....	175
RADICAVA ORS	88	RELIAMED	139, 144, 160
RADIOGARDASE	198	RELION	98, III, 180, 183, 275
ra glucose.....	III	reli-on glucose	III
RAGWITEK	73	relion glucose	III
ra high potency iron	116	RELION GLUCOSE	III
RA HIGH POTENCY IRON.....	116	RELISTOR.....	43
ra isopropyl alcohol 70%.....	199	REMEDIENT	217
RA ISOPROPYL ALCOHOL 70% WIPES	183	REMERON	170
ra isopropyl alcohol 91%.....	199	RENACIDIN.....	118
raloxifene.....	200	RENAL VITAMIN.....	229
ramelteon.....	178	RENAL-VITE.....	229
ramipril.....	83	RENAPLEX.....	229
		RENVELA.....	III

Index of Medications

repaglinide	49	rizatriptan	20
REPATHA	86	R-NATAL	170
REPLACEMENT	76, 112, 113, 114, 115, 116, 117	ROBINUL	119
REPLACEMENT PEDIATRIC MONITOR	139	ROCALTROL	241
REPLESTA	241	ROCKLATAN	106
REQ49+	206	roflumilast	32
RESPA A.R.	96	ROMVIMZA	59
RESTASIS	108	ropinirole	64
RESTORIL	178	rosadan	185
RETEVMO	59	ROSADAN	185
RETIN-A	191	rosula	41
RETROVIR	67	ROSULA	41
REVATIO	80	ROSZET	86
REVESTA	241	ROTARIX	73
REVLIMID	57	ROTATEQ	73
REVUFORJ	59	ROWASA	121
REXTOVY	44	ROXICODONE	24
REXULTI	177	ROXIFOL	241
REYATAZ	67, 68	ROZLYTREK	59
REYVOW	20	rufinamide	93
REZDIFFRA	196	rutin	204
REZUROCK	202	RYALTRIS	103
RHOFADE	185	RYBELSUS	48
RHOPRESSA	106	RYCLORA	47
ribasphere	70	RYDAPT	59
ribavirin	70	RYTARY	64
riboflavin	234	RYVENT	47
RIBOFLAVIN	234	S	
RIBOZEL	229	sacubitril	82
RIDAURA	26	SAFE-CLIP	140
rifabutin	36	SAFESNAP	153
rifampin	36	SAFETY I42, I43, I44, I45, I46, I49, I52, I53, I55, I57, I58, I59, I60, I61, I62	
RIGHTTEST	140, 144, 160	SAFETYGLIDE	149, I53, I54
RILUTEK	88	SAFETY LANCETS	I57, I59, I60
riluzole	88	SAFETY-LET	160
rimantadine	69	SAFETY SEAL LANCETS	I58, I60
RIMSO-50	24	SAFETY SYRINGE	I52, I53, I55
ringer's solution	180	SALAGEN	72
RINVOQ	26	SALIVAMAX	195
RIOMET	49	salsalate	26
risedronate	200	SAMBUCUS	237
RISPERDAL	176	SANCUSO	120
risperidone	176	SANDIMMUNE	133
RITEFLO	164	SANTYL	190
ritonavir	67, 68	sapropterin	198
rivaroxaban	43	SAPS	180, 184, 276
rivastigmine	71		

Index of Medications

SAPS ALCOHOL 70% PREP PADS	184	SITAVIG	69
SAVELLA.....	201	SITZMARKS.....	99
saxagliptin.....	49, 50	SKYCLARYS	198
saxagliptn.....	50	SKYLA	96
SAXENDA.....	63	SKYRIZI	132, 181
SCALACORT	189	SLIP-TIP.....	154
SCEMBLIX.....	59	slo-niacin.....	220
SCOOBY-DOO ONE A DAY	224	SLO-NIACIN	220
scopolamine.....	120	SLOW FE.....	116
SECUADO.....	176	slow release iron.....	113, 114, 116
SEEBRI	30	SLOW RELEASE IRON.....	113, 116, 117
SELARSDI.....	131	sm.....	117, 169, 184, 199, 206, 217, 229, 233, 235, 237, 241
SELECT-OB.....	169	sm alcohol prep pads	184
selegiline	64	SMART	143, 145, 158, 160
selenium.....	183	SMARTDIABETES VANTAGE	140
SELZENTRY	66	SMARTEST	140, 145, 160
SEMGLEE.....	51	smart sense.....	111
SEN-SERTER.....	140	SMART SENSE	160
SEROSTIM	129	sm iron.....	117
sertraline	172, 277	sm isopropyl alcohol 70%.....	199
sevelamer.....	111	sm prenatal vitamins tablet.....	169
sevoflurane.....	24, 25	SM SLOW RELEASE IRON 45 MG TAB.....	117
SEYSARA.....	40	sm vitamin.....	233, 237, 241
SFROWASA.....	121	sodium.....	25, 27, 28, 29, 32, 33, 36, 38, 42, 43, 55, 62, 83, 86, 92, 93, 94, 99, 104, 105, 109, 111, 112, 113, 117, 118, 119, 123, 124, 128, 133, 165, 180, 181, 182, 183, 190, 192, 197, 200, 235
SHINGRIX.....	76	SODIUM	33, 42, 43, 100, 178, 180, 183
SHORT BEVEL	148	sodium chloride.....	123, 124, 180, 197
SIDEROL.....	116	sodium chloride/nahco3/kcl/peg.....	123, 124
SIDESTREAM.....	164	SODIUM CITRATE	42
sildenafil.....	80, 194	sodium ferric gluconat/sucrose.....	113, 117
SILENOR	179	sodium fluoride.....	109, 112, 117
SILHOUETTE	138, 163	SODIUM OXYBATE	178
SILICONE MASK.....	164	sodium phenylbutyrate.....	119
silodosin.....	202	sodium polystyrene sulfonate	111
SIL-SERTER.....	140	sodium polystyrene sulfon/sorb.....	111
SILVADENE	41	sodium, potassium, mag sulfates.....	124
silver sulfadiazine.....	41	sodium sulfacetamide.....	183
SIMBRINZA	106	SODIUM SULFACETAMIDE 10% WASH.....	183
SIMILAC PRENATAL	169	sod,pot chlor/mag/sod,pot phos	180
SIMLANDI.....	54	sod surface-sulf	41
SIMPONI	54	sod surface-sulfur.....	41
simvastatin.....	86, 87	sod sulfacetam 10% clnsng gel	183
SIMVASTATIN.....	87	sod sulfacetamide 9.8% shampoo	183
SINGLE.....	122, 125, 145, 160, 180, 184, 277	sod sulfacetamide 10% shampoo.....	183
SINGLE-LET.....	160	sod sulfacet-sulfr.....	41
SINGLE USE SWAB	184	sod sulfacet-sulfur	42
sirolimus.....	133		
SIRTURO.....	36		

Index of Medications

sod sulfac-sulfur.....	42	STERILE LANCETS.....	160
SOF-SERTER.....	140	STIOLTO RESPIMAT.....	30
SOF-SET.....	140	STRENSIQ.....	197
SOFT.....	139, 160	STRESS B-COMPLEX.....	217
SOFT TOUCH.....	160	stress-c.....	217
SOHONOS.....	198	stress formula.....	213, 217, 229
solifenacin.....	202	STRESS FORMULA.....	217
SOLQUA.....	48	STRIVERDI.....	30
SOLO.....	217	STROMECTOL.....	52
SOLODYN.....	40	STROVITE.....	217
SOLOSEC.....	34	STUART ONE.....	169
SOLTAMOX.....	61	SUBSYS.....	24
SOLUS.....	140, 145, 160	SUCRAID.....	122
SOLUS V2.....	140, 160	sucrafate.....	120
SOLUVITA.....	224	SULAR.....	79
SOMA.....	165	sulfacetamide.....	33, 42, 182, 183
SOMAVERT.....	196	sulfadiazine.....	34, 41
SOOLANTRA.....	185	sulfamethoxazole/trimethoprim.....	34
sorafenib tosylate.....	59	SULFAMYLON.....	42
SORBITOL.....	180	sulfasalazine.....	122
sotalol.....	84, 85	sulindac.....	29
SOTYKTU.....	181	SUMADAN.....	42
SOTYLIZE.....	85	sumatriptan.....	20
SPACE CHAMBER.....	163, 164	SUMAXIN.....	42
SPAN C.....	237	sunitinib malate.....	60
SPECIALTY USE NEEDLES.....	148	SUNLENCA.....	66
SPECTRACEF.....	36	SUNOSI.....	178
SPECTRAVITE.....	206, 217	super.....	217, 227, 229
SPEVIGO.....	181	SUPER.....	143, 145, 159, 160, 217, 239, 241
SPIKEVAX COVID.....	73	super b complex-vit c.....	229
spinosad.....	64	SUPER DAILY D3.....	239, 241
SPIRIVA HANDIHALER.....	29	SUPER GINSENG.....	217
SPIRIVA RESPIMAT.....	29	SUPERIOR.....	217, 246
spironolact/hydrochlorothiazid.....	102	super quints.....	229
spironolactone.....	102	SUPER THIN LANCETS.....	159, 160
SPORANOX.....	45	SUPOR.....	154
SPRITAM.....	93	SUPPORT-500.....	217
SPRIX.....	20	SUPRANE.....	25
SSKI.....	112	SURE.....	138, 140, 145, 148, 161, 163, 180, 184, 275, 278
sss.....	42	SURE COMFORT.....	140, 161, 184
STALEVO.....	64	SUREFLEX.....	140, 159
stavudine.....	67	SURE-LANCE.....	161
STELARA.....	131	SURE-PEN.....	140
STENDRA.....	194	SURE-PREP ALCOHOL PREP PADS.....	184
STERILANCE.....	145, 160	SURESITE.....	156
STERILANCE TL.....	160	SURE-T.....	163
STERILE.....	145, 154, 160	SURE-TEST EASYPLUS.....	140

Index of Medications

SURE-TOUCH.....	161	SYRINGE TIP CAP.....	154
SURGICEL.....	77	SYRINGE WITH NEEDLE DISP.....	154
surgifoam.....	77	SYRINGE WITHOUT NEEDLE.....	154
SURGIFOAM.....	77	T	
SURGISEAL.....	185	TAB-A-VITE.....	217, 218
SURMONTIL.....	174	TABLOID.....	55
SURVANTA.....	193	TABRECTA.....	60
SUSTIVA.....	66	tacrolimus.....	132, 133
SUTENT.....	60	tadalafil.....	80, 194, 195
sv.....	117, 169, 206, 220, 229, 233, 235, 237, 241, 242, 244, 245	TAFINLAR.....	56
sv b-12.....	233	TAGITOL.....	99
sv biotin.....	229	TAGRISSO.....	60
SV BIOTIN.....	229	TAKHZYRO.....	73, 193
SV COD LIVER OIL.....	224	TALICIA.....	120
sv folic acid.....	206	TALTZ.....	181
SV HAIR, SKIN AND NAILS.....	217	TALZENNA.....	60
sv niacin.....	220	TAMIFLU.....	69
sv prenatal tablet.....	169	tamoxifen.....	61
SV PRENATAL VITAMINS TABLET.....	169	tamsulosin.....	202
SV SLOW RELEASE IRON 45 MG TAB.....	117	TANDEM.....	117, 140, 218, 279
sv vitamin.....	233, 237, 241, 242, 244, 245	TANDEM DUAL ACTION.....	117
sv vitamin b-12.....	233	TAPERDEX.....	128
sv vitamin c.....	237	TARGADOX.....	40
SV VIT B.....	233	TARGRETIN.....	62
sv vit c.....	237	TARPEYO.....	128
SWI.....	180	TASIGNA.....	60
SYMAX DUOTAB.....	121	TASMAR.....	64
SYMBICORT.....	31	tavaborole.....	46
SYMDEKO.....	192	TAVALISSE.....	193
SYMFI.....	68	TAVNEOS.....	76
SYMLINPEN.....	48	tazarotene.....	182
SYMPAZAN.....	91	TAZVERIK.....	56
SYMPROIC.....	43	TB SYRINGE.....	153, 154
SYMTUZA.....	65	TC 99M.....	99
SYNALAR.....	40, 189	TDVAX.....	75
SYNAREL.....	129	TECHLITE.....	145, 161
SYNDROS.....	119	TEGADERM.....	156
SYNERA.....	25	TEGLUTIK.....	88
SYNJARDY.....	50	TEGRETOL.....	93
SYPRINE.....	198	TEKTRNA HCT.....	85
SYRINGE I9, 31, 32, 54, 70, 73, 77, 86, 90, 110, 132, 149, 150, 151, 152, 153, 154, 155, 224		TELCARE.....	140, 145, 161
SYRINGE AVITENE.....	77	TELCARE CONTROL SOLUTION.....	140
SYRINGE BULK.....	154	TELCARE ULTRA THIN.....	161
SYRINGE CATHETER.....	154	telmisartan.....	83, 84
SYRINGE FILTER.....	154	telmisartan/amlodipine.....	83
SYRINGE SLIP TIP.....	154	telmisartan/hydrochlorothiazid.....	83
		temazepam.....	178

Index of Medications

TEMIXYS.....	66	thyroid,pork.....	192
TEMOVATE.....	189	tiagabine.....	94
temozolomide.....	55	TIAZAC.....	79
TENIVAC.....	75	TIBSOVO.....	61
tenofovir.....	67	ticagrelor.....	65
TENORETIC.....	85	TIGLUTIK.....	88
TENORMIN.....	85	timolol.....	85, 106, 107
terazosin.....	82	TIMOLOL.....	106, 107, 280
terbinafine.....	45	TIMOLOL-BRIMONIDIN-DORZOLAMIDE.....	107
terbutaline.....	29	TIMOLOL-BRIMONI-DORZOL-LATANOP.....	107
terconazole.....	44	TIMOLOL-DORZOLAMIDE.....	107
teriparatide.....	200	TIMOLOL-LATANOPROST.....	107
TERUMO.....	148, 154	TIMOPTIC.....	107
TERUMO SURGUARD2.....	148, 154	tinidazole.....	52
TERUMO SYRINGE.....	154	tiopronin.....	202
testosterone.....	126, 127	TISSEEL VHSD.....	185
TESTOSTERONE.....	126	TIVICAY.....	68
tetrabenazine.....	89	TIVORBEX.....	29
tetracaine.....	105	tizanidine.....	165
TETRACAINE.....	105	TL-HEM 150.....	117
tetracycline.....	40	TOBAKIENT.....	218
TETRAVISC.....	105	TOBI PODHALER.....	35
TEXACORT.....	189	TOBRADEX.....	33
T:FLEX.....	140	tobramycin.....	33, 34, 35
THALOMID.....	35	tobramycin/dexamethasone.....	33
THEO-24.....	32	TOBRAMYCIN PAK.....	35
theophylline anhydrous.....	32	TOBEX.....	34
thera-d.....	242	TOFRANIL.....	174
THERA-D.....	242	tolcapone.....	64
THERAGRAN.....	218	TOLECTIN.....	29
thera-m.....	218	tolmetin.....	29
THERA-M.....	218	tolterodine.....	203
THERAMILL FORTE.....	218	tolvaptan.....	101, 102
THERANATAL.....	169, 170, 218	TOOMEY SYRINGE.....	154
THEREMS-H.....	218	TOPCARE.....	145, 161
thiamine.....	230, 231	TOPICORT.....	189
THIAMINE.....	230, 231	topiramate.....	93, 94
THIN.....	100, 142, 143, 144, 145, 148, 157, 159, 160, 161	toremifene.....	61
THIN LANCETS.....	159, 160, 161	torsemide.....	101
THIN WALL NEEDLES.....	148	TOSYMRA.....	20
THIOLA EC.....	202	TOUJEO.....	51
thioridazine.....	177	TOXICOLOGY SALIVA COLLECTION.....	99
thiothixene.....	177	TRACLEER.....	80
THRIVITE.....	169	tramadol.....	21, 24
THROMBI-GEL.....	77	trandolapril.....	81, 83
THROMBIN-JMI.....	77	trandolapril/verapamil.....	81
THROMBI-PAD.....	77	tranexamic.....	76

Index of Medications

TRANSFER.....	68, 147, 148	tropicamide.....	107, 108
TRANSPARENT.....	156, 157	TROPICAMIDE.....	107, 108
tranlycypromine.....	171	TROPICAMIDE-CYCLOPENTOLATE-PE.....	108
travoprost.....	107	TROPICAMIDE-CYCLOPENT-PE-KTRLC.....	108
trazodone.....	172	TROPIC-CYCLOPENT-PE-KTRLC-PROP.....	107
TRECATOR.....	36	tropium.....	203
TRELEGY ELLIPTA.....	31	true.....	114, 206, 220, 231, 233, 235, 237, 242, 245
TREMFYA.....	132	TRUE.. 98, 140, 145, 161, 180, 184, 218, 220, 231, 235, 242, 245, 281	
TRESIBA.....	51, 52	TRUE COMFORT.....	161, 184
tretinoin.....	61, 182, 191	TRUECONTROL.....	140
TREXALL.....	55	TRUEDRAW.....	140
TREZIX.....	21	TRUE METRIX.....	140
triamcinolone.....	189, 190, 194	TRUEPLUS.....	100, 111, 145, 161, 218
triamterene.....	102	TRUEPLUS GLUCOSE.....	111
triamterene/hydrochlorothiazid.....	102	TRUEPLUS KETONE TEST STRIP.....	100
triazolam.....	178	T.R.U.E. TEST.....	197
TRICARE.....	169	TRUETRACK.....	98
trichloroacetic acid.....	186	TRULANCE.....	123
TRICHLOROACETIC ACID.....	186	TRULICITY.....	48
triderm.....	190	TRUMENBA.....	74
TRIDESILON.....	190	TRUQAP.....	60
trientine.....	198	TRUSTEEL INFUSION SET.....	140
TRIFERIC.....	117	TRYNGOLZA.....	86
trifluoperazine.....	177	T:SLIM.....	140
trifluridine.....	68	TUBERCULIN SYRINGE.....	152, 153, 154
trihexyphenidyl.....	64	TUKYSA.....	60
TRIJARDY.....	51	TULIVITE.....	117
TRIKAFTA.....	192	TURALIO.....	60
trimethobenzamide.....	120	TUXARIN.....	97
trimethoprim.....	34, 35	TUZISTRA.....	97
trimipramine.....	174	TWIIST.....	140, 141
TRI-MIX.....	195	TWINPAK DUAL CANNULA.....	154
TRIMO-SAN.....	52	TWINRIX.....	76
TRIMPEX.....	35	TWIST.....	142, 143, 144, 145, 157, 158, 160, 161, 185
TRINAZ.....	170	TWYNEO.....	182
TRINTELLIX.....	173	TYBOST.....	192
TRISODIUM CITRATE CRRT.....	43	TYENNE.....	132
TRISTART.....	169	TYMLOS.....	131
TRIUMEQ.....	65	TYRVAYA.....	195
TRIVIA.....	218	TYVASO.....	81
TRI-VI-FLOR.....	224	U	
TRI-VI-SOL.....	224	UBRELVY.....	20
tri-vit-fluor.....	224	UCERIS.....	125, 129
TRI-VIT-FLUOR.....	224	UDAMIN SP.....	218
TROKENDI.....	94	ULESFIA.....	64
TRONVITE.....	229	ULTANE.....	25
TROPICAL LIQUID.....	224	ULTICARE LDS SYR.....	154

Index of Medications

ULTICARE SAFETY SYRINGE	155	V	
ULTICARE SYRINGE	155	valacyclovir	69
ULTICARE TB SAFETY	155	VALCHLOR	62
ULTIGUARD SAFE	155	VALCYTE	69
ULTIGUARD SAFEPACK	155	valganciclovir	69
ULTI-LANCE	141	valproic	94
ULTILET	145, 161, 180, 184, 281	valsartan	82, 83, 84
ULTRA ... 30, 139, 141, 143, 145, 148, 155, 157, 159, 161, 169, 207, 209, 217, 218, 227, 229, 265, 271, 279, 282		valsartan/hydrochlorothiazide	83
ultra b-100	229	VALTOCO	91
ULTRA B-100 COMPLEX	229	VANOCIN	40
ULTRA-CARE	161	vancomycin	40
ULTRA-FINE	148, 155	VANILLA SILQ	99
ULTRA-FINE MICRO	148	VANISHPOINT	155
ULTRA-FINE MINI	148	VANOXIDE-HC	184
ULTRA-FINE NANO	148	VANRAFIA	202
ULTRA-FINE ORIGINAL	148	VAQTA	76
ULTRA-FINE SHORT	148	vardenafil	194, 195
ULTRAFOAM	77	varenicline	191
ULTRA FREEDA	218	VARIBAR	99, 100
ULTRALANCE	145, 161	VARISOFT	141
ULTRA THIN	159, 161	VARIVAX VACCINE	76
ULTRA-THIN II	161	VARUBI	120
ULTRA THIN PLUS	161	VASCEPA	118
ULTRATLC	146, 161	VASCULERA	205
ULTRATRAK CONTROL	141	VASERETIC	82
ULTRATRAK ULTIMATE	141	VASOFLEX	205
ULTRAVATE X	190	VASOTEC	83
UNILET	141, 143, 146, 157, 159, 161	VAXELIS	75
UNISTIK	141, 143, 146, 158, 161, 162	VAXNEUVANCE	74
UNISTRIP	141	VB6 P5P	235
UNIVERSAL	146, 155, 162	VECAMYL	84
UNIVERSAL I	162	VECTICAL	182
UNIVERSAL SYRINGE	155	VELPHORO	111
UPTRAVI	81	VELSIPITY	91
upup	111	VELTASSA	111, 112
URECHOLINE	72	VEMLIDY	70
URELLE	35	VENALIV	205
URIBEL	35	VENCLEXTA	61
URISTIX	101	venlafaxine	173
UROCIT-K	118	VENOFER	117
UROQID-ACID	118	VENTAVIS	81
URSO	121	VEO INSULIN SYRINGE	155
ursodiol	121	VEOZAH	197
USTEKINUMAB	131	verapamil	78, 79, 81
UTIBRON NEOHALER	30	VERELAN	79
		VERIFINE	146

Index of Medications

VERQUVO.....	79	vitamin d2.....	240, 242
VERSACLOZ.....	177	VITAMIN D2.....	242
VERTIGOHEEL.....	197	vitamin d3.....	110, 239, 240, 241, 242, 243, 244
VERZENIO.....	60	VITAMIN D3.....	218, 239, 240, 241, 242, 243
VEVYE.....	108	VITAMIN D3-ALOE.....	218
VFEND.....	45	vitamin e.....	244, 245
V-GO.....	141	VITAMIN E.....	244, 245
VIBERZI.....	123	VITAMIN K.....	246
VIBRAMYCIN.....	40	VITAMIN K2.....	246
VICTOZA.....	48	VITAMINS A D.....	225
vigabatrin.....	94	VITAMINS A-D-E.....	218
VIGADRONE.....	94	VITAPEARL.....	169
VIGAMOX.....	34	VITA-RESPA.....	230
VIJOICE.....	193	VITASURE.....	230
VIOKACE.....	124	VITATRUE.....	170
VIRACEPT.....	68	vit a/vit c/vit e/zinc/copper.....	204
VIREAD.....	67	vit b.....	227, 228, 230, 232
VIRT-CAPS.....	230	VIT B-12.....	211, 232, 233
virt-fefa plus.....	117	vit b12/levomefolate/vit b6/b2.....	226, 230
VIRT-FEFA PLUS.....	117	vit c-rose hip.....	235, 236, 237
VISION FORMULA.....	203, 204	vit c-rose hips.....	235, 236, 237
VISION PLUS.....	206	VIT C-ROSE HIPS.....	237
VISTA ADVANCED AREDS2.....	204	vit d3.....	224, 239, 240, 242
VISTARIL.....	47	VIT D3 5,000 UNIT FAST DISSOLV.....	242
VISTASEAL.....	77	VITEYES.....	204
VISTOGARD.....	193	VITRAKVI.....	60
vit a.....	204, 224	VITREXYL.....	218
VITA-BEE.....	230	VITRON-C.....	117
VITABEX.....	117, 218	VITRUM 50.....	218
VITACORE.....	218	vits a,c,e/lutein/minerals.....	204
VITAFOL.....	117, 169, 170	VIVAGUARD.....	141, 146, 162
VITAFUSION.....	218	VIVJOA.....	45
VITAJOY.....	218, 230, 237	VIZIMPRO.....	60
VITAL-D.....	230	VOGELXO.....	126
VITAMEDMD.....	169	VOLUMEN.....	100
vitamin a.....	224, 225	VONJO.....	60
VITAMIN A.....	190, 191, 224, 225, 226, 227, 228, 229, 230, 231, 232, 233, 234, 235, 236, 237, 238, 239, 240, 241, 242, 243, 244, 245, 246	VOQUEZNA.....	121, 124
vitamin b-12.....	229, 232, 233, 234	VORANIGO.....	61
vitamin b12.....	233, 234	voriconazole.....	45
VITAMIN B-12.....	232, 233, 234	VORTEX.....	164
VITAMIN B12.....	231, 234	VOSEVI.....	69
vitamin b complex.....	218, 225, 230	VOTRIENT.....	60
vitamin b-complex.....	230	VOWST.....	122
vitamin c.....	208, 217, 218, 226, 230, 235, 236, 237, 238	VOXZOGO.....	198
VITAMIN C.....	225, 226, 235, 237, 238, 239	VOYDEYA.....	76
		v-r alcohol prep pads.....	184
		VRAYLAR.....	177

Index of Medications

VRAYLAR 1.5 MG CAPSULE.....	177	XIFAXAN	38
v-r cod liver oil capsule	244	XIGDUO	50
v-r vitamin c	238	XIIDRA	108
VTAMA.....	182	XOFLUZA	69
VUEBLU.....	99	XOLAIR.....	32
VUMERITY.....	90	XOLREMDI	95
VYKAT	199	XOPENEX.....	30
VYLEESI.....	175	XOSPATA.....	61
VYNDAMAX	198	XTANDI.....	55
VYNDAQEL.....	198	XURIDEN.....	III
VYVANSE.....	174	XVITE.....	230
VYVGART	198	XYOSTED	126
W		XYREM	178
WAKIX	94	XYWAV.....	178
water	180	XYZBAC.....	219
WAVESENSE	141	Y	
WEBCOL	180, 184, 284	YALE.....	148
WEGOVI.....	63	YAZ.....	96
WELIREG	61	YCANTH.....	184
well	238, 244	YESINTEK	131
WHEAT GERM	245	YEZTUGO.....	65
WINDOW BANDAGES.....	157	YONSA.....	55
WINREVAIR.....	80	YORVIPATH.....	129
WOMEN'S 50.....	207, 215, 218	YUPELRI.....	29
women's daily	218	YUTREPIA	81
WOMEN'S DAILY	218	Z	
WOMENS DAILY GUMMIES	218	zafirlukast.....	32
WOMEN'S MULTIVITAMIN	215, 218, 219	zaleplon.....	179
WOMEN'S PRENATAL PLUS DHA.....	170	ZANAFLEX.....	165, 166, 284
WYNZORA.....	190	ZARONTIN	94
X		ZCORT	129
XACIATO	40	ZELBORAF.....	56
XALKORI	60, 61	ZELDANA	230
XAQUIL.....	206	ZELNORM.....	123
XARELTO	43	ZEMBRACE SYMTOUCH	20
XCELLENT.....	238, 245	ZEMPLAR	196
XCELLENT C.....	238	ZENPEP	124
XCOPRI	94	zenzedi.....	72
XDEMVI.....	63	ZENZEDI.....	72
XELJANZ.....	27	ZEPATIER.....	70
XELODA	55	ZEPBOUND.....	62, 63, 284
XENICAL	63	ZEPOSIA	90, 91, 284
XENLETA.....	38	ZESTORETIC.....	82
XENON XE-133.....	100	ZESTRIL	83
XEPI	41	ZIAGEN.....	67
XERMELO	119	ZIANA	182
XHANCE.....	103	zidovudine	66, 67

Index of Medications

zinc oxide	185
ZINC OXIDE PASTE	185
ZINC PLUS.....	239
ziprasidone.....	176, 177
ZIRGAN.....	68
ZITHROMAX.....	37
ZODRYL AC	97
ZODRYL DAC	97
ZODRYL DEC.....	97, 98
ZOKINVY	193
ZOLINZA	54
zolmitriptan	20
zolpidem.....	179
ZOLPIMIST.....	179
ZOMIG.....	20
ZONALON	182
zonisamide	94
ZONTIVITY.....	65
ZOO FRIENDS.....	224
ZORBTIVE.....	129
ZORTRESS.....	133
ZORYVE	182, 186
ZOVIRAX	69, 70
ZTALMY.....	178
ZTLIDO	25
ZUBSOLV	201
ZURZUVAE.....	171
ZYDELIG.....	61
ZYKADIA.....	61
ZYLOPRIM	26
ZYPITAMAG	87
ZYPREXA.....	177
ZYVANA	219
ZYVIT	219
ZYVOX.....	37

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.

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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>

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Proficiency of Language Assistance Services

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

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

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

Vietnamese – XIN LƯU Ý: Quý vị được cấp dịch vụ trợ giúp về ngôn ngữ miễn phí. Dành cho khách hàng hiện tại của Cigna, vui lòng gọi số ở mặt sau thẻ Hội viên. Các trường hợp khác xin gọi số 1.800.244.6224 (TTY: Quay số 711).

Korean – 주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 현재 Cigna 가입자님들께서는 ID 카드 뒷면에 있는 전화번호로 연락해주시시오. 기타 다른 경우에는 1.800.244.6224 (TTY: 다이얼 711)번으로 전화해주시시오.

Tagalog – PAUNAWA: Makakakuha ka ng mga serbisyo sa tulong sa wika nang libre. Para sa mga kasalukuyang customer ng Cigna, tawagan ang numero sa likuran ng iyong ID card. O kaya, tumawag sa 1.800.244.6224 (TTY: I-dial ang 711).

Russian – ВНИМАНИЕ: вам могут предоставить бесплатные услуги перевода. Если вы уже участвуете в плане Cigna, позвоните по номеру, указанному на обратной стороне вашей идентификационной карточки участника плана. Если вы не являетесь участником одного из наших планов, позвоните по номеру 1.800.244.6224 (TTY: 711).

Arabic – برجاء الانتباه خدمات الترجمة المجانية متاحة لكم. لعملاء Cigna الحاليين برجاء الاتصال بالرقم المدون علي ظهر بطاقتكم الشخصية. او اتصل ب 1.800.244.6224 (TTY: اتصل ب 711).

French Creole – ATANSYON: Gen sèvis èd nan lang ki disponib gratis pou ou. Pou kliyan Cigna yo, rele nimewo ki dèyè kat ID ou. Sinon, rele nimewo 1.800.244.6224 (TTY: Rele 711).

French – ATTENTION: Des services d'aide linguistique vous sont proposés gratuitement. Si vous êtes un client actuel de Cigna, veuillez appeler le numéro indiqué au verso de votre carte d'identité. Sinon, veuillez appeler le numéro 1.800.244.6224 (ATS : composez le numéro 711).

Portuguese – ATENÇÃO: Tem ao seu dispor serviços de assistência linguística, totalmente gratuitos. Para clientes Cigna atuais, ligue para o número que se encontra no verso do seu cartão de identificação. Caso contrário, ligue para 1.800.244.6224 (Dispositivos TTY: marque 711).

Polish – UWAGA: w celu skorzystania z dostępnej, bezpłatnej pomocy językowej, obecni klienci firmy Cigna mogą dzwonić pod numer podany na odwrocie karty identyfikacyjnej. Wszystkie inne osoby prosimy o skorzystanie z numeru 1 800 244 6224 (TTY: wybierz 711).

Japanese – 注意事項: 日本語を話される場合、無料の言語支援サービスをご利用いただけます。現在のCignaのお客様は、IDカード裏面の電話番号まで、お電話にてご連絡ください。その他の方は、1.800.244.6224 (TTY: 711)まで、お電話にてご連絡ください。

Italian – ATTENZIONE: Sono disponibili servizi di assistenza linguistica gratuiti. Per i clienti Cigna attuali, chiamare il numero sul retro della tessera di identificazione. In caso contrario, chiamare il numero 1.800.244.6224 (utenti TTY: chiamare il numero 711).

German – ACHTUNG: Die Leistungen der Sprachunterstützung stehen Ihnen kostenlos zur Verfügung. Wenn Sie gegenwärtiger Cigna-Kunde sind, rufen Sie bitte die Nummer auf der Rückseite Ihrer Krankenversicherungskarte an. Andernfalls rufen Sie 1.800.244.6224 an (TTY: Wählen Sie 711).

Persian (Farsi) – توجه: خدمات کمک زبانی، به صورت رایگان به شما ارائه می‌شود. برای مشتریان فعلی Cigna، لطفاً با شماره‌ای که در پشت کارت شناسایی شماست تماس بگیرید. در غیر اینصورت با شماره 1.800.244.6224 تماس بگیرید (شماره تلفن ویژه ناشنوايان: شماره 711 را شماره‌گیری کنید).