



Cigna Healthcare Advantage 4-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/PDL

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

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

Last updated: 08/01/2025. This drug list is subject to change and all prior versions are no longer in effect.



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View your drug list online, 24/7

This document was last updated on 08/01/2025.*

- You can use the Price a Medication tool on the myCigna App¹ or **myCigna.com** to see the most up-to-date list of the medications your plan covers.
- You can also see a pdf of this document on **Cigna.com/PDL**. Click on the dropdown next to "Drug Lists for Employer Plans." Scroll down to the section for California Employer Drug Lists; then click on **California Advantage 4 Tier (all specialty medications covered on tier 4) (CDI) [PDF]**.

Questions?

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

Information about this drug list

Frequently asked questions (FAQs)

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

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

A. We review and update the drug list on a regular basis to make sure you have coverage for low-cost, safe and effective medications. We make changes for many reasons; for example, when a new medication comes out or is no longer available, or when a medication's price changes. These changes may include:

- **Moving a medication to a lower cost tier.** This can happen at any time during the year.
- **Moving a brand medication to a higher cost tier when a generic comes out.** This can happen at any time during the year.
- **Moving a medication to a higher cost tier and/or no longer covering a medication.** This typically happens twice a year on January 1 and July 1.
- **Adding extra coverage rules (requirements) to a medication.** This typically happens twice a year on January 1 and July 1.

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

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

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

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

For example, your plan doesn't cover (or "excludes"):

- Prescription medications that treat allergies (ex. Allegra, Clarinex, Xyzal and generics) and heartburn/stomach acid conditions (ex. Nexium, Prilosec OTC and generics).
- Medications that treat lifestyle conditions, such as infertility, erectile dysfunction and smoking cessation.²
- 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.

Information about this drug list

Frequently asked questions (FAQs) (cont.)

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.

Q. What types of medications typically need approval?

A. Medications that:

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

Q. What types of medications typically have quantity limits?

A. Medications that are often:

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

Q. What medications are part of Step Therapy?

A. They're typically high-cost medications that treat conditions such as:

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

Q. Why does my medication have an age requirement?

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

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

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

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

Information about this drug list

Frequently asked questions (FAQs) (cont.)

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 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

Information about this drug list

Frequently asked questions (FAQs) (cont.)

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. 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.

Information about this drug list

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

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.

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.³

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.

Information about this drug list

Frequently asked questions (FAQs) (cont.)

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.⁴ 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.⁴

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

A. The generic and brand-name medication may⁴:

- 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.

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.⁵

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.⁶ 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.⁶

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.⁷
- 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.⁸
- Use a payment plan (if you need it).

Information about this drug list

Frequently asked questions (FAQs) (cont.)

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.
- Get fast shipping at no extra cost.⁷
- Sign up for refills and reminders. Some refills can be done by text.⁹
- 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.⁶ 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.

Information about this drug list

Frequently asked questions (FAQs) (cont.)

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

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

A. Some medications are covered under the pharmacy benefit, some are covered under the medical benefit and others are covered under both benefits. 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.

Information about this drug list

Frequently asked questions (FAQs) (cont.)

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

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

- **Preventive care medications and products covered under the Patient Protection and Affordable Care Act (PPACA), also known as “health care reform:”**
 - **Contraceptives:** Covered at 100%, or no cost-share (\$0) to you. Certain prescription contraceptives are available at their applicable cost-share.
 - **Tobacco cessation products:** Up to two (2) 90-day courses of treatment per plan year are covered at 100%, or no cost-share (\$0) to you. Certain prescription tobacco cessation products are available at their applicable cost-share.
 - **Certain vitamins:** Covered at 100%, or no cost-share (\$0) to you. All other prescription vitamins are available at their applicable cost-share and deductible (if applicable).
- **Certain over-the-counter (OTC) products:** If you have a prescription from your doctor, these are covered at 100%, or no cost-share (\$0) to you. All other OTC products are excluded from coverage.
- **Oral fertility medications:** Covered at their applicable tier cost-share. For some plans, injectable fertility medications are covered under the medical benefit.
- **Generic preventive care medications:** Covered at 100%, or no cost-share (\$0) to you before you meet your deductible. You'll pay your deductible and applicable cost-share to fill a preferred brand and/or non-preferred brand preventive care medication.
- **Diabetic supplies:** Covered at their applicable cost-share.
- **Growth Hormones:** Need approval from Cigna Healthcare before your plan will cover them (prior authorization). If 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.
- **Coinurance:** 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.

Information about this drug list

Words you may need to know (cont.)

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

Information about this drug list

About this drug list

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

Important: Your plan doesn't cover prescription medications that treat allergies (ex. Allegra®, Clarinex®, Xyzal® and generics) and heartburn/stomach acid conditions (ex. Nexium®, Prilosec OTC® and generics). Instead, you can buy them as over-the-counter (OTC) products at your local pharmacy or retail store without a prescription.

How to read this drug list

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

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

Tiers

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	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	Preferred Brands. These medications typically have one or more lower-cost generic that treats the same condition.	\$\$
Tier 3	Non-Preferred Brands. Non-preferred brands typically have a generic and/or preferred brand alternative(s) that treats the same condition.	\$\$\$
Tier 4	Specialty. These medications are covered at your plan's highest cost-share. This tier includes both injectable and oral (those you take by mouth) specialty medications.	\$\$\$\$

* 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 Advantage 4-Tier Prescription Drug List.*

ANALGESICS (Pain Relief and Inflammatory Disease)			Therapeutic drug category and class describes the condition the medication is used to treat.
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits	Coverage requirements and limits lets you know if your plan has extra requirements before it will cover the medication.
ANALGESIC, NON-SALICYLATE AND BARBITURATE COMBINAT			
<i>butorbital/acetaminophen</i>	T1		
ANALGESIC, SALICYLATE, BARBITURATE, XANTHINE COMB.			
<i>butorbital-aspirin-caffe 50-325-40</i>	T1	QL (6 tabs/day)	
<i>butorbital-asa-cafeine cap</i> (Fiorinal)	T1	QL (6 caps/day)	
FIORINAL (<i>butorbital-aspirin-cafeine</i>)	T3	QL (6 caps/day)	
ANALGESIC, NON-SALICYLATE, BARBITURATE, XANTHINE COMB.			
<i>butorbital/acetaminophen/cafeine</i>	T3		
<i>butorbital/acetaminophen/cafeine</i> (Esgic)	T3	QL (6 caps/day)	
<i>butorbital-acetamin-caff 50-300-40</i> (Fioricet)	T1	QL (6 caps/day)	
<i>butorbital-acetamin-caff 50-325-40</i> (Esgic)	T1	QL (6 tabs/day)	
ESGIC 50-325-40 MG TABLET (<i>butorbital-acetaminophen-caffe</i>)	T3	QL (6 tabs/day)	
ESGIC CAPSULE (<i>zebutorbital</i>)	T3	QL (6 caps/day)	
FIORICET (<i>phrenilin forte</i>)	T1	QL (6 caps/day)	
ANALGESIC/ANTIPYRETICS, SALICYLATES			
<i>choline salicyl/mag salicylate</i>	T1	HD	
<i>diflunisal</i>	T1	HD	
ANTI-MIGRAINE PREPARATIONS			
AIMOVIG AUTOINJECTOR	T2	PA	
AJOVY AUTOINJECTOR	T2	PA	
AJOVY SYRINGE	T2	PA	
<i>almotriptan malate</i>	T1	QL (12 tabs/30 days)	
CAFERGOT (<i>ergotamine-cafeine</i>)	T3	QL (40 tabs/28 days)	
<i>dihydroergotamine 1 mg/ml amp</i>	T1	QL (10 amps/30 days)	
<i>eletriptan hydrobromide</i>	T1	QL (6 tabs/30 days)	
EMGALITY PEN	T2	PA	
EMGALITY SYRINGE	T2	PA	
<i>ergotamine tartrate/cafeine</i>	T1		
<i>ergotamine tartrate/cafeine</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)	19-27	Anti-Infectives/Miscellaneous (Feminine Products)	60
Analgesics (Urinary Tract Conditions)	27	Anti-Infectives/Miscellaneous (Infections)	60, 61
Anesthetics (Miscellaneous)	27, 28	Anti-Infectives/Miscellaneous (Miscellaneous)	61
Anesthetics(Pain Relief and Inflammatory Disease)	28-31	Anti-Infectives/Miscellaneous (Skin Conditions)	62
Anesthetics (Urinary Tract Conditions)	32	Anti-Inflammatory Tumor Necrosis Factor Inhibiting Agents (Pain Relief and Inflammatory Disease)	62, 63
Anti-Allergy (Allergy and Nasal Sprays)	32	Anti-Neoplastics (Cancer)	63-76
Anti-Arthritics (Pain Relief and Inflammatory Disease)	32-35	Anti-Neoplastics (Skin Conditions)	76
Anti-Asthmatics (Asthma/COPD/Respiratory)	36-38	Anti-Obesity Drugs (Weight Management)	76
Antibiotics (Allergy/Nasal Sprays)	38	Anti-Parasitics (Infections)	76
Antibiotics (Ear Medications)	38	Anti-Parkinson's Drugs (Parkinson's Disease)	77, 78
Antibiotics (Eye Conditions)	38, 39	Anti-Platelet Drugs (Blood Thinners/Anti-Clotting)	78, 79
Antibiotics (Infections)	39-50	Antivirals (Aids/Hiv)	79-81
Antibiotics (Miscellaneous)	50	Antivirals (Eye Conditions)	81
Antibiotics (Skin Conditions)	50, 51	Antivirals (Infections)	82-84
Anti-Coagulants (Blood Thinners/Anti-Clotting)	51-53	Antivirals (Skin Conditions)	84
Antidotes (Gastrointestinal/Heartburn)	53	Autonomic Drugs (Allergy/Nasal Sprays)	84
Antidotes (Substance Abuse)	53, 54	Autonomic Drugs (Alzheimer's Disease)	84, 85
Anti-Fungals (Eye Conditions)	54	Autonomic Drugs (Attention Deficit Hyperactivity Disorder)	85
Anti-Fungals (Feminine Products)	54	Autonomic Drugs (Blood Pressure/Heart Medications)	85
Anti-Fungals (Infections)	54, 55	Autonomic Drugs (Miscellaneous)	85, 86
Anti-Fungals (Skin Conditions)	55, 56	Autonomic Drugs (Urinary Tract Conditions)	87
Antihistamine and Decongestant Combination (Allergy/Nasal Sprays)	56	Biologicals (Allergy/Nasal Sprays)	87
Antihistamines (Allergy/Nasal Sprays)	56	Biologicals (Blood Pressure/Heart Medications)	87
Antihistamines (Eye Conditions)	56, 57	Biologicals (Miscellaneous)	87, 88
Anti-Hyperglycemics (Diabetes)	57-60	Biologicals (Vaccines)	88-90
Anti-Infectives (Feminine Products)	60	Blood (Blood Modifiers/Bleeding Disorders)	90-92
Anti-Infectives (Infections)	60	Blood (Blood Thinners/Anti-Clotting)	92

Information about this drug list

How to find your medication (cont.)

Condition	Page	Condition	Page
Blood (Miscellaneous)	92	Elect/Caloric/H2O (Nutritional/Dietary)	128-131
Cardiac Drugs (Blood Pressure/Heart Medications)	92-96	Elect/Caloric/H2O (Urinary Tract Conditions)	131,132
CARDIOVASCULAR (Allergy/Nasal Sprays)	96, 97	Gastrointestinal (Cholesterol Medications)	132
Cardiovascular (Asthma/COPD/Respiratory)	97, 98	Gastrointestinal (Gastrointestinal/Heartburn)	132-139
Cardiovascular (Blood Pressure/Heart Medications)	98-103	Gastrointestinal (Pain Relief and Inflammatory Disease)	139
Cardiovascular (Cholesterol Medications)	103-105	Gastrointestinal (Skin Conditions)	140
Cardiovascular (Miscellaneous)	105	Hormones (Gastrointestinal/Heartburn)	140
CNS Drugs (Alzheimer's Disease)	105, 106	Hormones (Hormonal Agents)	140-146
CNS Drugs (Miscellaneous)	106, 107	Hormones (Infertility)	147
CNS DRUGS (Multiple Sclerosis)	107	Hormones (Miscellaneous)	147
CNS Drugs (Pain Relief and Inflammatory Disease)	107	HORMONES (Osteoporosis Products)	147
CNS Drugs (Seizure Disorders)	108-III	Immunosuppressants (Miscellaneous)	147
CNS Drugs (Sleep Disorders/Sedatives)	II	Immunosuppressants (Pain Relief and Inflammatory Disease)	148
Colony Stimulating Factors (Blood Modifiers/Bleeding Disorders)	III, II2	Immunosuppressants (Skin Conditions)	148, 149
Colony Stimulating Factors (Cancer)	II2	Immunosuppressants (Transplant Medications)	149, 150
Contraceptives (Contraception Products)	II2, II3	Miscellaneous Medical Supplies, Devices, Non-Drug (Diabetes)	150-159
Cough/Cold Preparations (Allergy/Nasal Sprays)	II4	Miscellaneous Medical Supplies, Devices, Non-Drug (Diagnostic Test Devices, Supplies, and Services Miscellaneous)	159-162
Cough/Cold Preparations (Cough/Cold Medications)	II4	Muscle Relaxants (Pain Relief and Inflammatory Disease)	162, 163
Diagnostic (Diabetes)	II4, II5	Prenatal Vitamins (Nutritional/Dietary)	163
Diagnostic (Miscellaneous)	II5-II9	Psychotherapeutic Drugs (Anxiety/Depression/Bipolar Disorder)	163-168
Diuretics (Diuretics)	II9, I20	Psychotherapeutic Drugs (Attention Deficit Hyperactivity Disorder)	168-170
EENT Preps (Allergy/Nasal Sprays)	I20, I21	Psychotherapeutic Drugs (Schizophrenia/Anti-Psychotics)	170-173
EENT Preps (Ear Medications)	I21	Psychotherapeutic Drugs (Sleep Disorders/Sedatives)	173
EENT Preps (Eye Conditions)	I21-I25	Sedative/Hypnotics (Sleep Disorders/Sedatives)	173-175
Elect/Caloric/H2O (Cholesterol Medications)	I25		
Elect/Caloric/H2O (Dental Products)	I25, I26		
Elect/Caloric/H2O (Diabetes)	I26		
Elect/Caloric/H2O (Miscellaneous)	I26, I27		

Information about this drug list

How to find your medication (cont.)

Condition	Page	Condition	Page
Skin Preps (Miscellaneous)	175	Unclassified Drug Products (Multiple Sclerosis)	192
Skin Preps (Pain Relief and Inflammatory Disease)	175, 176	Unclassified Drug Products (Nutritional/Dietary)	192, 193
Skin Preps (Skin Conditions)	176-183	Unclassified Drug Products (Osteoporosis Products)	193
Thyroid Prep (Hormonal Agents)	183, 184	Unclassified Drug Products (Pain Relief and Inflammatory Disease)	193, 194
Unclassified Drug Products (Aids/Hiv)	184	Unclassified Drug Products (Skin Conditions)	194
Unclassified Drug Products (Asthma/COPD/Respiratory)	184, 185	Unclassified Drug Products (Substance Abuse)	194
Unclassified Drug Products (Blood Modifiers/Bleeding Disorders)	185	Unclassified Drug Products (Transplant Medications)	194, 195
Unclassified Drug Products (Cancer)	185, 186	Unclassified Drug Products (Urinary Tract Conditions)	195
Unclassified Drug Products (Dental Products)	186	Unclassified Drug Products (Weight Management)	196
Unclassified Drug Products (Eye Conditions)	186	Vaccines (Vaccines)	196
Unclassified Drug Products (Gastrointestinal/Heartburn)	186, 187	Vitamins (Nutritional/Dietary)	196, 197
UNCLASSIFIED DRUG PRODUCTS (Hormonal Agents)	187	Vitamins (Vitamins)	197
Unclassified Drug Products (Miscellaneous)	188-192		

List of Prescription Medications

ANALGESICS (Pain Relief and Inflammatory Disease)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ANALGESIC, NON-SALICYLATE AND BARBITURATE COMBINAT		
<i>butalbital/acetaminophen</i>	T1	
ANALGESIC, SALICYLATE, BARBITURATE, XANTHINE COMB.		
<i>butalb-aspirin-caffe 50-325-40</i>	T1	QL (6 tabs/day)
<i>butalbital-asa-cafeine cap</i> (Fiorinal)	T1	QL (6 caps/day)
FIORINAL (<i>butalbital-aspirin-cafeine</i>)	T3	QL (6 caps/day)
ANALGESIC, NON-SALICYLATE, BARBITURATE, XANTHINE COMB.		
<i>butalb/acetaminophen/cafeine</i>	T3	
<i>butalb/acetaminophen/cafeine</i> (Esgic)	T3	QL (6 caps/day)
<i>butalb-acetamin-caff 50-300-40</i> (Fioricet)	T1	QL (6 caps/day)
<i>butalb-acetamin-caff 50-325-40</i> (Esgic)	T1	QL (6 tabs/day)
ANALGESIC/ANTIPYRETICS, SALICYLATES		
<i>choline salicyl/mag salicylate</i>	T1	HD
<i>diflunisal</i>	T1	HD
ANALGESIC/ANTIPYRETICS, NON-SALICYLATES		
ACETAMINOPHEN 1000MG/100ML BAG	T3	
<i>acetaminophen 1,000mg/100ml v1</i> (Ofirmev)	T1	
OFIRMEV (<i>acetaminophen</i>)	T3	
ANALGESICS, NEURONAL-TYPE CALCIUM CHANNEL BLOCKERS		
PRIALT	T4	SP
ANALGESICS, NON-OPIOID		
<i>clonidine 1,000 mcg/10 ml vial</i> (Duraclon)	T1	
<i>clonidine 5,000 mcg/10 ml vial</i>	T1	
ANTI-MIGRAINE PREPARATIONS		
AIMOVIG AUTOINJECTOR	T2	PA
AJOVY AUTOINJECTOR	T2	PA
AJOVY SYRINGE	T2	PA
<i>almotriptan malate</i>	T1	QL (12 tabs/30 days)
CAFERGOT (<i>ergotamine-cafeine</i>)	T3	QL (40 tabs/28 days)
<i>dihydroergotamine 1 mg/ml amp</i>	T1	QL (10 amps/30 days)
DURACLON (<i>clonidine hcl</i>)	T3	
<i>eletriptan hydrobromide</i>	T1	QL (6 tabs/30 days)
EMGALITY PEN	T2	PA
EMGALITY SYRINGE	T2	PA
<i>ergotamine tartrate/cafeine</i>	T1	

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

T4 – Specialty Medications

PA – Prior Authorization

QL – Quantity Limit

ST – Step Therapy

AGE – Age Requirement

SP – Specialty Medication

HD – May require home delivery pharmacy

PPACA – No Cost-Share Preventive Medication

CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

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

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

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

T4 – Specialty Medications

PA – Prior Authorization

QL – Quantity Limit

ST – Step Therapy

AGE – Age Requirement

SP – Specialty Medication

HD – May require home delivery pharmacy

PPACA – No Cost-Share Preventive Medication

CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

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

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

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

T4 – Specialty Medications

PA – Prior Authorization

QL – Quantity Limit

ST – Step Therapy

AGE – Age Requirement

SP – Specialty Medication

HD – May require home delivery pharmacy

PPACA – No Cost-Share Preventive Medication

CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

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

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

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

T4 – Specialty Medications

PA – Prior Authorization

QL – Quantity Limit

ST – Step Therapy

AGE – Age Requirement

SP – Specialty Medication

HD – May require home delivery pharmacy

PPACA – No Cost-Share Preventive Medication

CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

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

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
OPIOID ANALGESICS (cont.)		
BELBUCA 900 MCG FILM	T2	QL (2 films/day)
BUPRENEX	T3	
<i>buprenorphine</i> (Butrans)	T1	QL (4 patches/28 days)
<i>buprenorphine hcl</i>	T1	
<i>butorphanol 1 mg/ml vial</i>	T1	
<i>butorphanol 10 mg/ml spray</i>	T1	PA QL (6 bots/30 days)
<i>butorphanol 2 mg/ml vial</i>	T1	
<i>butorphanol 4 mg/2 ml vial</i>	T1	
BUTRANS (<i>buprenorphine</i>)	T3	QL (4 patches/28 days)
<i>codeine sulfate</i>	T1	PA
DEMEROL	T3	PA
DILAUDID 0.2 MG/ML SYRINGE	T3	PA
DILAUDID 0.5 MG/0.5 ML SYRINGE	T3	PA
DILAUDID 1 MG/ML SYRINGE	T3	PA
DILAUDID 2 MG/ML SYRINGE	T3	PA
DILAUDID 4 MG/ML SYRINGE	T3	
DURAGESIC (<i>fentanyl</i>)	T3	PA
<i>fentanyl</i>	T1	PA
<i>fentanyl</i> (Duragesic)	T1	PA
FENTANYL 1,000 MCG/100 ML-NS	T3	
FENTANYL 1,000 MCG/100 ML-NS	T1	
FENTANYL 1,000 MCG/50-0.9% NACL	T1	
<i>fentanyl 1,250 mcg/250-0.9% nacl</i>	T1	
<i>fentanyl 10 mcg/ml-0.9% nacl</i>	T1	
FENTANYL 100 MCG/2 ML CARPUJCT	T1	
<i>fentanyl 100 mcg/2 ml carpujct</i> (Fentanyl Citrate)	T1	
<i>fentanyl 100 mcg/2 ml syringe</i>	T1	
FENTANYL 2 MCG-BUP 0.0625%-NS	T1	
FENTANYL 2 MCG-BUPIV 0.1%-NS	T1	
FENTANYL 2 MCG-BUPIV 0.125%-NS	T1	
FENTANYL 2 MCG-BUPIV 0.125%-NS	T3	

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

T4 – Specialty Medications

PA – Prior Authorization

QL – Quantity Limit

ST – Step Therapy

AGE – Age Requirement

SP – Specialty Medication

HD – May require home delivery pharmacy

PPACA – No Cost-Share Preventive Medication

CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

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

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
OPIOID ANALGESICS (cont.)		
FENTANYL 2 MCG-BUPIVAC 0.1%-NS	T1	
FENTANYL 2, 000MCG/100-0.9%NACL	T1	
FENTANYL 2, 500MCG/250-0.9%NACL	T1	
FENTANYL 2, 750 MCG/55 ML SYR	T1	
FENTANYL 2.5MG/250ML-0.9% NACL	T1	
FENTANYL 25 MCG/0.5 ML SYRINGE	T3	
FENTANYL 250 MCG/5 ML SYRINGE	T1	
FENTANYL 5, 000MCG/250-0.9%NACL	T1	
FENTANYL 50 MCG/ML SYRINGE	T1	
FENTANYL 500 MCG/50ML-0.9%NACL	T1	
FENTANYL 550 MCG/55ML-0.9%NACL	T1	
FENTANYL CIT 200 MCG BUCCAL TB	T1	PA
FENTANYL CIT 400 MCG BUCCAL TB	T1	PA
FENTANYL CIT 600 MCG BUCCAL TB	T1	PA
FENTANYL CIT 800 MCG BUCCAL TB	T1	PA
<i>fentanyl cit ofc 1, 200 mcg (Actiq)</i>	T1	PA
<i>fentanyl cit ofc 1, 600 mcg (Actiq)</i>	T1	PA
<i>fentanyl citrate ofc 200 mcg (Actiq)</i>	T1	PA
<i>fentanyl citrate ofc 400 mcg (Actiq)</i>	T1	PA
<i>fentanyl citrate ofc 600 mcg (Actiq)</i>	T1	PA
<i>fentanyl citrate ofc 800 mcg</i>	T1	PA
FENTANYL-ROPIVACAINE-0.9% NACL	T1	
<i>fentanyl/ropivacaine/ns/pf</i>	T1	
FENTORA	T3	PA
<i>hydrocodone bitartrate (Hysingla Er)</i>	T1	PA
<i>hydrocodone bitartrate (Zohydro Er)</i>	T1	PA
HYDROMORPHONE 0.25 MG/0.5 ML	T3	PA
HYDROMORPHONE 0.5 MG/ML-NS SYR	T1	PA
HYDROMORPHONE 1 MG/ML-NS SYRNG	T1	PA
HYDROMORPHONE 10 MG/50 ML-NS	T1	PA
<i>hydromorphone 10 mg/50 ml-ns (Hydromorphone Hcl-0.9% Nacl)</i>	T1	PA
<i>hydromorphone syr</i>	T1	PA
HYDROMORPHONE 100 MG/100 ML-NS	T1	PA
HYDROMORPHONE 100 MG/50 ML-NS	T1	PA
<i>hydromorphone 15 mg/30 ml-ns</i>	T1	PA

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

T4 – Specialty Medications

PA – Prior Authorization

QL – Quantity Limit

ST – Step Therapy

AGE – Age Requirement

SP – Specialty Medication

HD – May require home delivery pharmacy

PPACA – No Cost-Share Preventive Medication

CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

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

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
OPIOID ANALGESICS (cont.)		
HYDROMORPHONE 2 MG/10 ML-NS	T1	PA
HYDROMORPHONE 2 MG/ML-NS SYRNG	T1	PA
HYDROMORPHONE 20 MG/100 ML-NS	T1	PA
HYDROMORPHONE 200 MG/100 ML-NS	T1	PA
HYDROMORPHONE 25 MG/50 ML-NS	T1	PA
HYDROMORPHONE 30 MG/30 ML-NS	T1	PA
HYDROMORPHONE 5 MG/25 ML-NS	T1	PA
HYDROMORPHONE 50 MG/50 ML-NS	T1	PA
HYDROMORPHONE 55 MG/55 ML-NS	T1	PA
HYDROMORPHONE 6 MG/30 ML-NS	T1	PA
<i>hydromorphone hcl</i>	T1	PA
<i>hydromorphone hcl</i> (Dilaudid)	T1	PA
<i>hydromorphone hcl/pf</i>	T1	PA
HYDROMORPHONE HCL-WATER	T1	PA
HYDROMORPH-ROPIVA-0.9% NACL	T1	PA
HYSINGLA ER (<i>hydrocodone bitartrate er</i>)	T2	PA
INFUMORPH	T3	PA
KADIAN (<i>morphine sulfate er</i>)	T3	PA
LAZANDA	T3	PA
<i>meperidine hcl</i>	T1	PA
<i>meperidine hcl/pf</i>	T1	PA
<i>meperidine hcl/pf</i>	T3	PA
METHADONE HCL-0.9% NACL	T3	
MITIGO	T1	PA
MORPHABOND ER	T2	PA
<i>morphine 0.5 mg/ml-0.9% nacl</i>	T1	PA
MORPHINE 2 MG/2 ML-0.9% NACL	T1	PA
<i>morphine 2 mg/2 ml-0.9% nacl</i> (Morphine Sulfate-0.9% Nacl)	T1	PA
MORPHINE 2 MG/2 ML-0.9% NACL (<i>morphine sulfate-nacl</i>)	T1	PA
MORPHINE 2 MG/ML-0.9% NACL SYR	T1	PA
MORPHINE 4 MG/ML-0.9% NACL SYR	T1	PA
<i>morphine 5 mg/5 ml-0.9% nacl</i> (Morphine Sulfate-0.9% Nacl)	T1	PA
<i>morphine 50 mg/50 ml-0.9% nacl</i>	T1	PA

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

T4 – Specialty Medications

PA – Prior Authorization

QL – Quantity Limit

ST – Step Therapy

AGE – Age Requirement

SP – Specialty Medication

HD – May require home delivery pharmacy

PPACA – No Cost-Share Preventive Medication

CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

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

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
OPIOID ANALGESICS (cont.)		
MORPHINE 50 MG/50 ML-0.9% NACL	T1	
MORPHINE 55 MG/55 ML-0.9% NACL	T1	PA
MORPHINE 100 MG/100 ML-NS	T3	
<i>morphine 100mg/100ml-0.9% nacl</i>	T1	PA
MORPHINE 275 MG/55 ML-0.9%NACL	T1	PA
MORPHINE 500MG/100ML-0.9% NACL	T1	PA
<i>morphine sulfate (Kadian)</i>	T1	PA
<i>morphine sulfate (Morphine Sulfate)</i>	T1	PA
<i>morphine sulfate (Ms Contin)</i>	T1	PA
<i>morphine sulfate/0.9% nacl/pf (Morphine Sulfate-0.9% Nacl)</i>	T1	PA
<i>morphine sulf 1,000 mg/20 ml</i>	T1	PA
<i>morphine sulfate/pf</i>	T1	PA
<i>morphine sulfate/pf</i>	T3	PA
MS CONTIN (<i>morphine sulfate er</i>)	T3	PA
<i>nalbuphine hcl</i>	T1	
<i>naltrexone 50 mg tablet</i>	T1	QL (180 tabs/30 days)
NUCYNTA	T3	PA
NUCYNTA ER	T3	PA
OLINVYK	T3	PA
OPANA	T3	
<i>opium/belladonna alkaloids</i>	T1	PA
OXAYDO	T3	PA
<i>oxycodone hcl</i>	T1	PA
OXYCODONE HCL ER	T1	PA
<i>oxymorphone hcl</i>	T1	PA
<i>pentazocine hcl/naloxone hcl</i>	T1	PA
ROXYBOND	T3	PA
<i>tramadol hcl (Ultram)</i>	T1	QL (8 tabs/day)
<i>tramadol hcl 50 mg tablet</i>	T1	QL (8 tabs/day)
TRAMADOL HCL 75 MG TABLET	T3	QL (< 18 yo 5 tabs/day)
<i>tramadol er 100 mg tablet</i>	T1	QL (1 tab/day)
<i>tramadol er 200 mg tablet</i>	T1	QL (1 tab/day)
<i>tramadol er 300 mg tablet</i>	T1	QL (1 tab/day)
TRAMADOL HCL ER 100 MG CAPSULE	T1	QL (1 cap/day)
<i>tramadol hcl er 100 mg tablet</i>	T1	QL (1 tab/day)

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

T4 – Specialty Medications

PA – Prior Authorization

QL – Quantity Limit

ST – Step Therapy

AGE – Age Requirement

SP – Specialty Medication

HD – May require home delivery pharmacy

PPACA – No Cost-Share Preventive Medication

CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

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

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
OPIOID ANALGESICS (cont.)		
TRAMADOL HCL ER 150 MG CAPSULE	T1	QL (1 cap/day)
TRAMADOL HCL ER 200 MG CAPSULE	T1	QL (1 cap/day)
<i>tramadol hcl er 200 mg tablet</i>	T1	QL (1 tab/day)
TRAMADOL HCL ER 300 MG CAPSULE	T1	QL (1 cap/day)
<i>tramadol hcl er 300 mg tablet</i>	T1	QL (1 tab/day)
ULTRAM (<i>tramadol hcl</i>)	T3	QL (8 tabs/day)
XTAMPZA ER	T2	PA
ZOHYDRO ER (<i>hydrocodone bitartrate er</i>)	T3	PA
OPIOID, SALICYLATE, ANALGESIC, BARBITUATE, XANTHINE		
<i>codeine/butalbital/asa/cafein</i> (Fiorinal With Codeine #3)	T1	PA
FIORINAL WITH CODEINE #3 (<i>butalbital compound-codeine</i>)	T3	PA
OPIOID, NON-SALICYL, ANALGESIC, BARBITUATE, XANTHINE		
<i>butalbit/acetamin/caff/codeine</i>	T1	PA
<i>butalbit/acetamin/caff/codeine</i> (Fioricet With Codeine)	T1	PA
SKELETAL MUSCLE RELAXANT, SALICYLAT, OPIOID ANALGESIC		
<i>carisoprodol/aspirin/codeine</i>	T1	PA
ANALGESICS (Urinary Tract Conditions)		
URINARY TRACT ANALGESIC AGENTS		
ELMIRON	T3	
RIMSO-50	T3	
ANESTHETICS (Miscellaneous)		
GENERAL ANESTHETICS, INHALANT		
<i>desflurane</i> (Suprane)	T1	
<i>isoflurane</i>	T1	
GENERAL ANESTHETICS, INJECTABLE		
AMIDATE	T3	
AMIDATE (<i>etomidate</i>)	T3	
BREVITAL SODIUM	T3	
DIPRIVAN (<i>propofol</i>)	T3	
<i>etomidate</i> (Amidate)	T1	
KETALAR	T3	
KETALAR (<i>ketamine hcl</i>)	T3	
KETAMINE HCL	T1	

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

T4 – Specialty Medications

PA – Prior Authorization

QL – Quantity Limit

ST – Step Therapy

AGE – Age Requirement

SP – Specialty Medication

HD – May require home delivery pharmacy

PPACA – No Cost-Share Preventive Medication

CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

ANESTHETICS (Miscellaneous) (cont.)

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

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

T4 – Specialty Medications

PA – Prior Authorization

QL – Quantity Limit

ST – Step Therapy

AGE – Age Requirement

SP – Specialty Medication

HD – May require home delivery pharmacy

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List of Prescription Medications

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

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
LOCAL ANESTHETICS (cont.)		
CLOROTEKAL	T3	
EXPAREL	T3	
LIDOCAINE 0.5MG INTRADERM SYST	T1	
<i>lidocaine 100 mg/10 ml (1%) syr</i>	T1	
LIDOCAINE 200 MG/20 ML (1%) SYR	T1	
LIDOCAINE 40 MG/2 ML (2%) SYRG	T1	
<i>lidocaine hcl (Xylocaine)</i>	T1	
<i>lidocaine hcl 1% 20 mg/2 ml (Xylocaine-mpf)</i>	T1	
<i>lidocaine hcl 1% 20 mg/2 ml vI (Xylocaine-mpf)</i>	T1	
<i>lidocaine hcl 1% 100 mg/10 ml (Xylocaine-Mpf)</i>	T1	
<i>lidocaine hcl 1% 300 mg/30 ml (Xylocaine-mpf)</i>	T1	
<i>lidocaine hcl 1% 50 mg/5 ml vI (Xylocaine-mpf)</i>	T1	
<i>lidocaine hcl 1% vial (Xylocaine)</i>	T1	
<i>lidocaine hcl 1.5% ampul (Xylocaine-mpf)</i>	T1	
<i>lidocaine hcl 10 mg/ml syringe</i>	T1	
<i>lidocaine hcl 100 mg/10 ml syr</i>	T1	
<i>lidocaine hcl 2% 100 mg/5 ml (Xylocaine-mpf)</i>	T1	
<i>lidocaine hcl 2% 200 mg/10 ml (Xylocaine-mpf)</i>	T1	
<i>lidocaine hcl 2% 40 mg/2 ml (Xylocaine-mpf)</i>	T1	
<i>lidocaine hcl 2% 40 mg/2 ml vI (Xylocaine-mpf)</i>	T1	
<i>lidocaine hcl 2% jel urojet ac</i>	T1	
<i>lidocaine hcl 2% jelly</i>	T1	
<i>lidocaine hcl 2% jelly uro-jet</i>	T1	
<i>lidocaine hcl 2% vial (Xylocaine)</i>	T1	
<i>lidocaine hcl 2% vial (Xylocaine-mpf)</i>	T1	
LIDOCAINE HCL 200 MG/10 ML SYR	T1	
LIDOCAINE HCL 30 MG/3 ML SYR	T1	
<i>lidocaine hcl 4% ampul</i>	T1	
<i>lidocaine hcl 4% solution</i>	T1	
<i>lidocaine hcl 4% 200 mg/5 ml</i>	T1	
<i>lidocaine hcl/dextrose 7.5%/pf</i>	T1	
<i>lidocaine hcl/epinephrine (Xylocaine With Epinephrine)</i>	T1	
<i>lidocaine hcl/epinephrine bit (Lidocaine-epinephrine)</i>	T3	
<i>lidocaine hcl/epinephrine/pf (Xylocaine With Epinephrine)</i>	T1	

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

T4 – Specialty Medications

PA – Prior Authorization

QL – Quantity Limit

ST – Step Therapy

AGE – Age Requirement

SP – Specialty Medication

HD – May require home delivery pharmacy

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CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

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

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
LOCAL ANESTHETICS (cont.)		
<i>lidocaine hcl/epinephrine/pf</i> (Xylocaine-mpf With Epinephrine)	T1	
LIDOCAINE HCL-0.9% NACL	T1	
<i>lidocaine hcl/pf</i>	T1	
<i>lidocaine hcl/pf</i> (Xylocaine-Mpf)	T1	
<i>lidocaine in nacl,iso-osmot/pf</i>	T1	
MARCAINE (<i>bupivacaine hcl</i>)	T3	
MARCAINE (<i>sensorcaine</i>)	T3	
MARCAINE (<i>sensorcaine-mpf</i>)	T3	
MARCAINE SPINAL	T3	
MARCAINE-EPINEPHRINE	T3	
MARCAINE-EPINEPHRINE (<i>bupivacaine hcl-epinephrine</i>)	T3	
MARCAINE-EPINEPHRINE (<i>sensorcaine-epinephrine</i>)	T3	
<i>mepivacaine hcl</i> (Carbocaine)	T1	
<i>mepivacaine hcl/pf</i>	T1	
<i>mepivacaine hcl/pf</i>	T3	
<i>mepivacaine hcl/pf</i> (Carbocaine)	T1	
NAROPIN	T3	
NESACAINE	T3	
NESACAINE-MPF (<i>chloroprocaine hcl</i>)	T3	
ORABLOC	T3	
POLOCAINE	T1	
<i>ropivacaine 0.2% 20 mg/10 ml</i> (Naropin)	T1	
<i>ropivacaine 0.2% 200 mg/100 ml</i> (Naropin)	T1	
<i>ropivacaine 0.2% 40 mg/20 ml</i> (Naropin)	T1	
<i>ropivacaine 0.2% 400 mg/200 ml</i> (Naropin)	T1	
ROPIVACAINE 0.2% SYRINGE	T1	
<i>ropivacaine 0.5% 100 mg/20 ml</i> (Naropin)	T1	
ROPIVACAINE 0.5% 1000 MG/200ML	T3	
<i>ropivacaine 0.5% 150 mg/30 ml</i> (Naropin)	T1	
ROPIVACAINE 0.5% 500 MG/100 ML	T3	
<i>ropivacaine 0.75% 150 mg/20 ml</i> (Naropin)	T1	
<i>ropivacaine 1% 100 mg/10 ml v/l</i> (Naropin)	T1	
<i>ropivacaine 1% 200 mg/20 ml v/l</i> (Naropin)	T1	
ROPIVACAINE 50 MG/10 ML SYRNG	T1	

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

T4 – Specialty Medications

PA – Prior Authorization

QL – Quantity Limit

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List of Prescription Medications

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

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
LOCAL ANESTHETICS (cont.)		
ROPIVACAINE HCL 0.2% ON-Q PUMP	T1	
ROPIVACAINE HCL 0.5% SYRINGE	T1	
ROPIVACAINE HCL-0.9% NACL	T1	
ROPIVACAINE HCL-NACL	T1	
SENSORC MPF 0.75%-EPI 1:200000	T3	
SENSORCAINE 0.25% VIAL (<i>bupivacaine hcl</i>)	T3	
<i>sensorcaine 0.5% vial (Marcaine)</i>	T1	
SENSORCAINE WITH DEXTROSE	T1	
SENSORCAINE-MPF 0.25% AMPUL (<i>bupivacaine hcl</i>)	T3	
SENSORCAINE-MPF 0.25% VIAL (<i>bupivacaine hcl</i>)	T3	
SENSORCAINE-MPF 0.5% AMPUL (<i>bupivacaine hcl</i>)	T3	
<i>sensorcaine-mpf 0.5% vial (Marcaine)</i>	T1	
SENSORCAINE-MPF 0.75% AMPUL (<i>bupivacaine hcl</i>)	T1	
SENSORCAINE-MPF 0.75% VIAL (<i>marcaine</i>)	T3	
SENSORC-MPF 0.25%-EPI 1:200000 (<i>bupivacaine hcl-epinephrine</i>)	T1	
SENSORCN-MPF 0.5%-EPI 1:200000 (<i>bupivacaine hcl-epinephrine</i>)	T3	
<i>tetracaine hcl/pf</i>	T1	
XYLOCAINE (<i>lidocaine hcl</i>)	T3	
XYLOCAINE WITH EPINEPHRINE (<i>lidocaine hcl-epinephrine</i>)	T3	
XYLOCAINE-MPF	T3	
XYLOCAINE-MPF (<i>lidocaine hcl</i>)	T3	
XYLOCAINE-MPF WITH EPINEPHRINE	T3	
XYLOCAINE-MPF WITH EPINEPHRINE (<i>lidocaine hcl-epinephrine</i>)	T3	
ZINGO	T3	
TOPICAL LOCAL ANESTHETICS		
<i>lidocaine 5% ointment</i>	T1	QL (145gm/30 days)
<i>lidocaine</i>	T1	
<i>lidocaine/prilocaine</i>	T1	
LIDODERM (<i>lidocaine</i>)	T3	
PAIN EASE MEDIUM STREAM SPRAY	T3	
ZTLIDO	T2	

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

T4 – Specialty Medications

PA – Prior Authorization

QL – Quantity Limit

ST – Step Therapy

AGE – Age Requirement

SP – Specialty Medication

HD – May require home delivery pharmacy

PPACA – No Cost-Share Preventive Medication

CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

ANESTHETICS (Urinary Tract Conditions)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
URINARY TRACT ANESTHETIC/ANALGESIC AGNT (AZO-DYE)		
<i>phenazopyridine hcl</i> (Pyridium)	T1	
PYRIDIUM (<i>phenazopyridine hcl</i>)	T3	
ANTI-ALLERGY (Allergy/Nasal Sprays)		
MAST CELL STABILIZERS		
<i>cromolyn 100 mg/5 ml oral conc</i> (Gastrocrom)	T1	
GASTROCROM (<i>cromolyn sodium</i>)	T3	
ANTI-ARTHRITICS (Pain Relief and Inflammatory Disease)		
ANALGESIC/ANTIPYRETICS, SALICYLATES		
DISALCID (<i>salsalate</i>)	T3	HD
<i>salsalate</i> (Disalcid)	T1	HD
ANTI-ARTHRITIC AND CHELATING AGENTS		
DEPEN (<i>penicillamine</i>)	T4	PA SP
<i>penicillamine</i>	T4	PA SP
<i>penicillamine</i> (Depen)	T4	PA SP
ANTI-ARTHRITIC, FOLATE ANTAGONIST AGENTS		
OTREXUP	T2	PA
ANTI-INFLAMMATORY, PYRIMIDINE SYNTHESIS INHIBITOR		
ARAVAL (<i>leflunomide</i>)	T3	HD
<i>leflunomide</i> (Arava)	T1	HD
ANTI-INFLAMMATORY, PHOSPHODIESTERASE-4(PDE4) INHIB.		
OTEZLA 28 DAY STARTER PACK	T4	PA QL (1 pack/180 days) SP HD
OTEZLA 30 MG TABLET	T4	PA QL (2 tabs/day) SP HD
ANTI-INFLAMMATORY/ANTIARTHRITICS AGENTS, MISC.		
DUROLANE	T4	PA SP HD
EUFLEXXA	T4	PA SP HD
GEL-ONE 30MG/3ML SYR	T4	PA SP HD
GELSYN-3	T4	PA SP HD
GENVISC 850 25MG/2.5ML SYR	T4	PA SP
HYALGAN	T4	PA SP HD
HYMOVIS	T4	PA SP HD
MONOVISC	T4	PA SP HD
ORTHOVISC	T4	PA SP HD

T1 – Typically Generics

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List of Prescription Medications

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

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ANTI-INFLAMMATORY/ANTIARTHRITICS AGENTS, MISC. (cont.)		
SUPARTZ FX 25MG/2.5ML SYR	T4	PA SP HD
SYNVISC	T4	PA SP HD
SYNVISC-ONE	T4	PA SP HD
SYNOJOYNT	T4	PA SP
TRILURON	T4	PA SP HD
TRIVISC 25MG/2.5ML SYR	T4	PA SP
VISCO-3	T4	PA SP HD
ANTI-INFLAMMATORY, SEL.COSTIM.MOD., T-CELL INHIBITOR		
ORENCIA 125 MG/ML SYRINGE	T4	PA QL (4 syringes/28 days) SP HD
ORENCIA 250 MG VIAL	T4	PA SP HD
ORENCIA 50 MG/0.4 ML SYRINGE	T4	PA QL (4 syringes/28 days) SP HD
ORENCIA 87.5 MG/0.7 ML SYRINGE	T4	PA QL (4 syringes/28 days) SP HD
ORENCIA CLICKJECT	T4	PA QL (4 injectors/28 days) SP HD
COLCHICINE		
COLCHICINE	T1	HD
<i>colchicine 0.6 mg capsule</i> (Mitigare)	T1	HD
<i>colchicine 0.6 mg tablet</i> (Colcrys)	T1	HD
COLCRYS (colchicine)	T3	HD
MITIGARE (colchicine)	T2	
RIDAURA	T3	
HYPERURICEMIA TX - URATE-OXIDASE ENZYME-TYPE		
ELITEK	T4	SP
KRYSTEXXA	T4	PA SP
HYPERURICEMIA TX - XANTHINE OXIDASE INHIBITORS		
<i>allopurinol</i>	T1	
<i>allopurinol sodium</i>	T1	
<i>febuxostat 80 mg tablet</i> (Uloric)	T1	HD
ULORIC 40 MG TABLET (<i>febuxostat</i>)	T3	QL (1 tab/day) HD
ULORIC 80 MG TABLET (<i>febuxostat</i>)	T3	HD
ZYLOPRIM (<i>allopurinol</i>)	T3	HD
JANUS KINASE (JAK) INHIBITORS		
LITFULO	T4	PA QL (1 cap/day) SP HD
OLUMIANT	T4	PA QL (1 tab/day) SP HD

T1 – Typically Generics
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List of Prescription Medications

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

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
JANUS KINASE (JAK) INHIBITORS (cont.)		
RINVOQ	T4	PA QL (1 tab/day) SP HD
RINVOQ LQ	T4	PA QL (12 mls/day) SP HD
XELJANZ 1 MG/ML SOLUTION	T4	PA QL (480ml/22 days) SP HD
XELJANZ 10 MG TABLET	T4	PA QL (2 tabs/day) SP HD
XELJANZ 5 MG TABLET	T4	PA QL (2 tabs/day) SP HD
XELJANZ XR	T4	PA QL (1 tab/day) SP HD
NSAID ANALGESIC AND NON-SALICYLATE ANALGESIC COMB		
COMBOGESIC IV	T3	
NSAIDS (COX NON-SPEC.INHIB) AND PROSTAGLANDIN ANALOG		
ARTHROTEC 50 (diclofenac sodium-misoprostol)	T3	ST HD
ARTHROTEC 75 (diclofenac sodium-misoprostol)	T3	ST HD
diclofenac sodium/misoprostol (Arthrotec 50)	T1	HD
diclofenac sodium/misoprostol (Arthrotec 75)	T1	HD
NSAIDS, CYCLOOXYGENASE INHIBITOR - TYPE ANALGESICS		
ANAPROX DS (naproxen sodium ds)	T3	ST HD
CALDOLOR	T3	
DAYPRO (oxaprozin)	T3	ST HD
diclofenac sod dr 25 mg tab	T1	HD
diclofenac sod dr 50 mg tab	T1	HD
diclofenac sod dr 75 mg tab	T1	HD
diclofenac sod ec 25 mg tab	T1	HD
diclofenac sod ec 50 mg tab	T1	HD
diclofenac sod ec 75 mg tab	T1	HD
diclofenac sodium	T1	HD
EC-NAPROSYN (naproxen)	T3	ST HD
etodolac	T1	HD
etodolac (Lodine)	T1	HD
FELDENE (piroxicam)	T3	ST HD
fenoprofen calcium (Nalfon)	T1	HD
flurbiprofen	T1	HD
ibuprofen	T1	HD
indomethacin	T1	HD
indomethacin 25 mg capsule	T1	HD
indomethacin 25 mg/5 ml susp (Indocin)	T1	HD

T1 – Typically Generics

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List of Prescription Medications

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

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

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

T4 – Specialty Medications

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List of Prescription Medications

ANTIASTHMATICS (Asthma/COPD/Respiratory)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
5-LIPOXYGENASE INHIBITORS		
<i>zileuton</i>	T1	HD
ANTICHOLINERGICS, ORALLY INHALED LONG ACTING		
INCRUSE ELLIPTA	T2	HD
LONHALA MAGNAIR REFILL	T3	PA HD
LONHALA MAGNAIR STARTER	T3	PA HD
SPIRIVA RESPIMAT	T2	HD
ANTICHOLINERGICS, ORALLY INHALED SHORT ACTING		
ATROVENT HFA	T2	HD
<i>ipratropium bromide</i>	T1	HD
BETA-ADRENERGIC AGENTS		
<i>albuterol sulf 2 mg/5 ml syrup</i>	T1	HD
<i>albuterol sulfate 2 mg tab</i>	T1	HD
<i>albuterol sulfate 4 mg tab</i>	T1	HD
<i>albuterol sulfate er 4 mg tab</i>	T1	HD
<i>albuterol sulfate er 8 mg tab</i>	T1	HD
<i>metaproterenol sulfate</i>	T1	HD
<i>terbutaline sulfate</i>	T1	HD
BETA-ADRENERGIC AGENTS, INHALED, SHORT ACTING		
<i>albuterol 2.5 mg/0.5 ml sol</i>	T1	
<i>albuterol 5 mg/ml solution</i>	T1	
<i>albuterol 15 mg/3 ml solution</i>	T1	
<i>albuterol 75 mg/15 ml soln</i>	T1	
<i>albuterol sul 0.63 mg/3 ml sol</i>	T1	
<i>albuterol sul 1.25 mg/3 ml sol</i>	T1	
<i>albuterol sul 2.5 mg/3 ml soln</i>	T1	
<i>albuterolhfa 90 mcg inhale</i> (Proaire Hfa)	T1	QL (8.5gm/30 days)
ALBUTEROL SULFATE HFA	T1	QL (8.5gm/30 days)
arformoterol tartrate (Brovana)	T1	QL (4 ml/day) HD
BETA-ADRENERGIC AGENTS, INHALED, SHORT ACTING		
<i>levalbuterol hcl</i> (Xopenex / Xopenex Concentrate)	T1	
XOPENEX (<i>levalbuterol hcl</i>)	T3	
XOPENEX CONCENTRATE (<i>levalbuterol concentrate</i>)	T3	
BETA-ADRENERGIC AND ANTICHOLINERGIC COMBO, INHALED		
ANORO ELLIPTA	T2	HD

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

T4 – Specialty Medications

PA – Prior Authorization

QL – Quantity Limit

ST – Step Therapy

AGE – Age Requirement

SP – Specialty Medication

HD – May require home delivery pharmacy

PPACA – No Cost-Share Preventive Medication

CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

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

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
BETA-ADRENERGIC AND ANTICHOLINERGIC COMBO, INHALED (cont.)		
COMBIVENT RESPIMAT	T2	QL (2 inhalers/30 days)
<i>ipratropium/albuterol sulfate</i>	T1	HD
DULERA	T2	HD
<i>fluticasone propion/salmeterol</i>	T1	HD
STIOLTO RESPIMAT INHAL SPRAY	T2	HD
STRIVERDI RESPIMAT	T2	QL
BREZTRI AEROSPHERE	T2	
TRELEGY ELLIPTA	T2	
BETA-ADRENERGIC AND GLUCOCORTICOID COMBO, INHALED		
AIRDUO DIGIHALER	T3	ST HD
AIRSUPRA	T2	QL(2 inhalers/28 days) HD
<i>budesonide/formoterol fumarate (Symbicort)</i>	T1	QL HD
FLUTICASONE-SALMETEROL	T1	QL(1 inhaler/30 days) HD
<i>fluticasone-salmeterol (Advair Diskus)</i>	T1	QL(1 inhaler/30 days)
GLUCOCORTICOID, ORALLY INHALED		
ALVESCO	T2	
ASMANEX HFA	T2	QL (1 inhaler/30days)
ASMANEX TWISTHALER	T2	QL (1 inhaler/30days)
<i>budesonide (Pulmicort)</i>	T1	HD
FLUTICASONE PROP	T3	QL HD
PULMICORT (<i>budesonide</i>)	T3	HD
QVAR REDIHALER	T2	
INTERLEUKIN-5 (IL-5) RECEPTOR ALPHA ANTAGONIST, MAB		
FASENRA	T4	PA SP HD
FASENRA PEN	T4	PA SP HD
LEUKOTRIENE RECEPTOR ANTAGONISTS		
ACCOLATE (<i>zafirlukast</i>)	T3	HD
<i>montelukast sodium</i> (Singulair)	T1	HD
SINGULAIR (<i>montelukast sodium</i>)	T3	
<i>zafirlukast</i> (Accolate)	T1	HD
MAST CELL STABILIZERS, ORALLY INHALED		
<i>cromolyn 20 mg/2 ml neb soln</i>	T1	QL (480ml/30 days) HD
MONOCLONAL ANTIBODIES TO IMMUNOGLOBULIN E (IGE)		
XOLAIR	T4	PA SP HD

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

T4 – Specialty Medications

PA – Prior Authorization

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
MONOCLONAL ANTIBODY - INTERLEUKIN-5 ANTAGONISTS		
CINQAIR	T4	PA SP
NUCALA	T4	PA SP HD
MUCOLYTICS		
acetylcysteine	T1	
PHOSPHODIESTERASE-4 (PDE4) INHIBITORS		
DALIRESP 250 MCG TABLET	T3	QL (28 tabs/180 days) HD
DALIRESP 500 MCG TABLET	T3	QL (2 tabs/day) HD
roflumilast 250 mcg tablet (Daliresp)	T3	QL (28 tabs/180 days) HD
roflumilast 500 mcg tablet (Daliresp)	T3	QL (2 tabs/day) HD
XANTHINES		
aminophylline	T1	
THEO-24	T3	HD
theophylline anhydrous	T1	HD
theophylline in dextrose 5 %	T1	
ANTIBIOTICS (Allergy/Nasal Sprays)		
NOSE PREPARATIONS ANTIBIOTICS		
BACTROBAN NASAL	T3	
ANTIBIOTICS (Ear Medications)		
EAR PREPARATIONS, ANTIBIOTICS		
ciprofloxacin hcl	T1	
CORTISPORIN-TC	T3	
neomycin/polymyxin b/hydrocort	T1	
ofloxacin	T1	
OTIC PREPARATIONS, ANTI-INFLAMMATORY-ANTIBIOTICS		
CIPRO HC	T3	
ciprofloxacin hcl/dexameth	T1	
CIPROFLOXACIN HCL-FLUOCINOLONE	T3	
OTOVEL	T3	
ANTIBIOTICS (Eye Conditions)		
EYE ANTIBIOTIC AND GLUCOCORTICOID COMBINATIONS		
neomycin/bacit/p-myx/hydrocort	T1	
neomycin/polymyxin b/dexametha (Maxitrol)	T1	

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

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

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

HD – May require home delivery pharmacy
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List of Prescription Medications

ANTIBIOTICS (Eye Conditions) (cont.)

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

ANTIBIOTICS (Infections)

ABSORBABLE SULFONAMIDE ANTIBACTERIAL AGENTS		
BACTRIM (<i>sulfamethoxazole-trimethoprim</i>)	T3	
BACTRIM DS (<i>sulfamethoxazole-trimethoprim</i>)	T3	
<i>sulfadiazine</i>	T1	

T1 – Typically Generics

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List of Prescription Medications

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

T1 – Typically Generics
T2 – Typically Preferred Brands
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T4 – Specialty Medications
PA – Prior Authorization
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ST – Step Therapy
AGE – Age Requirement
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List of Prescription Medications

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

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List of Prescription Medications

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

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List of Prescription Medications

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

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List of Prescription Medications

ANTIBIOTICS (Infections) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
CEPHALOSPORIN ANTIBIOTICS - 4TH GENERATION (cont.)		
<i>cefepime in iso-osm dextrose</i>	T1	
CEFEPIME-DEXTROSE	T1	
MAXIPIME	T3	
MAXIPIME (<i>cefepime hcl</i>)	T3	
CEPHALOSPORIN ANTIBIOTICS - SIDEROPHORE		
FETROJA	T3	
CEPHALOSPORINS - 5TH GENERATION		
TEFLARO	T3	
CHLORAMPHENICOL ANTIBIOTICS AND DERIVATIVES		
<i>chloramphenicol sod succinate</i>	T1	
GLYCYLCYCLES		
<i>tigecycline (Tygacil)</i>	T1	
TYGACIL (<i>tigecycline</i>)	T3	
LINCOSAMIDE ANTIBIOTICS		
CLEOCIN HCL (<i>clindamycin hcl</i>)	T3	
CLEOCIN PEDIATRIC (<i>clindamycin (pediatric)</i>)	T3	
CLEOCIN PHOS 150 MG/ML VIAL (<i>clindamycin phosphate</i>)	T3	
CLEOCIN PHOS 300 MG/2 ML VIAL (<i>clindamycin phosphate</i>)	T3	
<i>cleocin phos 300 mg/2ml addvan</i>	T1	
CLINDAMYCIN 300 MG/50 ML-D5W	T3	
CLEOCIN PHOS 600 MG/4 ML VIAL (<i>clindamycin phosphate</i>)	T3	
CLEOCIN PHOS 600 MG/4ML ADDVAN (<i>clindamycin phosphate</i>)	T3	
CLEOCIN PHOS 9 G/60 ML VIAL (<i>clindamycin phosphate</i>)	T3	
CLEOCIN PHOS 900 MG/6 ML VIAL (<i>clindamycin phosphate</i>)	T3	
CLEOCIN PHOS 900 MG/6ML ADDVAN (<i>clindamycin phosphate</i>)	T3	
CLIN SINGLE USE	T3	
<i>clindamycin hcl</i> (Cleocin Hcl)	T1	
<i>clindamycin palmitate hcl</i> (Cleocin Pediatric)	T1	
<i>clindamycin phosphate</i>	T1	
<i>clindamycin phosphate</i> (Cleocin Phosphate)	T1	
<i>clindamycin phosphate/d5w</i>	T1	
CLINDAMYCIN-0.9% NACL	T1	
LINCOCIN	T3	
<i>lincomycin hcl</i> (Lincocin)	T1	

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List of Prescription Medications

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

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List of Prescription Medications

ANTIBIOTICS (Infections) (cont.)

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

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List of Prescription Medications

ANTIBIOTICS (Infections) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
PENICILLIN ANTIBIOTICS (cont.)		
<i>oxacillin in dextrose (iso-osm)</i>	T1	
<i>oxacillin sodium</i>	T1	
<i>penicillin g potassium</i>	T1	
<i>penicillin g sodium</i>	T1	
PENICILLIN GK-ISO-OSM DEXTROSE	T1	
<i>penicillin v potassium</i>	T1	
<i>piperacillin sodium/tazobactam</i>	T1	
<i>piperacillin sodium/tazobactam (Piperacillin-tazobactam)</i>	T1	
<i>piperacillin sodium/tazobactam (Zosyn)</i>	T1	
PIPERACILLIN-TAZOBACTAM	T1	
UNASYN (<i>ampicillin-sulbactam</i>)	T3	
ZOSYN	T3	
ZOSYN (<i>piperacillin-tazobactam</i>)	T3	
PLEUROMUTILIN DERIVATIVES		
XENLETA 150 MG/15 ML VIAL	T3	
XENLETA 600 MG TABLET	T3	PA QL (10 tabs/30 days)
POLYMYXIN ANTIBIOTICS AND DERIVATIVES		
<i>colistin (colistimethate na) (Coly-mycin M Parenteral)</i>	T1	
COLY-MYCIN M PARENTERAL (<i>colistimethate</i>)	T3	
<i>polymyxin b sulfate</i>	T1	
QUINOLONE ANTIBIOTICS		
AVELOX (<i>moxifloxacin hcl</i>)	T3	
AVELOX IV (<i>moxifloxacin</i>)	T3	
BAXDELA 300 MG VIAL	T3	
BAXDELA 450 MG TABLET	T3	PA
CIPRO (<i>ciprofloxacin hcl</i>)	T3	
CIPRO (<i>ciprofloxacin</i>)	T3	
CIPRO I.V. (<i>ciprofloxacin-d5w</i>)	T3	
<i>ciprofloxacin (Cipro)</i>	T1	
<i>ciprofloxacin hcl</i>	T1	
<i>ciprofloxacin hcl (Cipro)</i>	T1	
<i>ciprofloxacin in 5 % dextrose</i>	T1	
<i>ciprofloxacin in 5 % dextrose (Cipro I.v.)</i>	T1	
<i>ciprofloxacin lactate</i>	T1	

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List of Prescription Medications

ANTIBIOTICS (Infections) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
QUINOLONE ANTIBIOTICS (cont.)		
<i>ciprofloxacin/ciprofloxacin hcl</i>	T1	
FACTIVE	T3	
<i>levofloxacin</i>	T1	
<i>levofloxacin in dextrose 5 %</i>	T1	
MOXIFLOXACIN	T1	
<i>moxifloxacin hcl (Avelox)</i>	T1	
<i>moxifloxacin-sodium chloride (iso) (Avelox Iv)</i>	T1	
<i>ofloxacin</i>	T1	
RIFAMYCINS AND RELATED DERIVATIVE ANTIBIOTICS		
AEMCOLO	T3	QL (12 tabs/3 days)
XIFAXAN 200 MG TABLET	T2	
XIFAXAN 550 MG TABLET	T2	QL (42 tabs/14 days)
STREPTOGRAMIN ANTIBIOTICS		
SYNERCID	T3	
TETRACYCLINE ANTIBIOTICS		
<i>coremimo er 135 mg tablet</i>	T1	
<i>coremimo er 45 mg tablet</i>	T1	QL (1 tab/day)
TETRACYCLINE ANTIBIOTICS		
<i>coremimo er 90 mg tablet</i>	T1	
<i>demeclocycline hcl (Targadox)</i>	T1	
<i>doxycycline hyclate</i>	T1	
<i>doxycycline monohydrate</i>	T1	
<i>doxycycline monohydrate (Vibramycin)</i>	T1	
MINOCIN	T3	
<i>minocycline er 115 mg tablet</i>	T1	
<i>minocycline er 45 mg tablet</i>	T1	QL (1 tab/day)
<i>minocycline er 55 mg tablet</i>	T1	
<i>minocycline er 65 mg tablet</i>	T1	
<i>minocycline er 80 mg tablet</i>	T1	
<i>minocycline er 90 mg tablet</i>	T1	
<i>minocycline hcl</i>	T1	
NUZYRA 100 MG VIAL	T3	SP
NUZYRA 150 MG TABLET	T4	QL (30 tablets/28 days) SP
<i>tetracycline hcl</i>	T1	

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List of Prescription Medications

ANTIBIOTICS (Infections) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
TETRACYCLINE ANTIBIOTICS (cont.)		
VIBRAMYCIN	T3	
XERAVA	T3	
VAGINAL ANTIBIOTICS		
<i>clindamycin phosphate</i> (Cleocin)	T1	
<i>metronidazole</i> (Metrogel-vaginal)	T1	
NUVESSA	T3	
VANCOMYCIN ANTIBIOTICS AND DERIVATIVES		
VANCOMYCIN	T1	
<i>vancomycin</i> 50 mg/ml solution	T1	
<i>vancomycin</i> 250 mg/5 ml soln (Firvanq)	T1	
<i>vancomycin</i> 500 mg add-van vial	T1	
<i>vancomycin</i> 500 mg vial	T1	
VANCOMYCIN 500 MG/100 ML BAG	T3	
VANCOMYCIN 750 MG ADD-VAN VIAL	T1	
VANCOMYCIN 750 MG/150 ML BAG	T3	
<i>vancomycin</i> 1 gm add-van vial	T1	
<i>vancomycin</i> 1 gm vial	T1	
VANCOMYCIN 1 GRAM/200 ML BAG	T3	
VANCOMYCIN 1.25 GM/250 ML BAG	T3	
VANCOMYCIN 1.5 GRAM/300 ML BAG	T3	
VANCOMYCIN 1.75 GM/350 ML BAG	T3	
VANCOMYCIN 2 GRAM/400 ML BAG	T3	
VANCOMYCIN HCL 1.25 GRAM VIAL	T1	
VANCOMYCIN HCL 1.5 GRAM VIAL	T1	
VANCOMYCIN HCL 1.75 GRAM VIAL	T1	
<i>vancomycin hcl</i> 10 gm vial	T1	
<i>vancomycin hcl</i> 125 mg capsule	T1	
VANCOMYCIN HCL 1G/200 ML BAG	T1	
<i>vancomycin hcl</i> 250 mg capsule	T1	
VANCOMYCIN HCL 250 MG VIAL	T1	
<i>vancomycin</i> vial	T1	
VANCOMYCIN HCL-0.9% NACL	T1	
VANCOMYCIN 1.25 GRAM/250ML-D5W	T1	
VANCOMYCIN 1.5 GRAM/250 ML-D5W	T1	
VANCOMYCIN 1.5 GRAM/300 ML-D5W	T3	

T1 – Typically Generics

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List of Prescription Medications

ANTIBIOTICS (Infections) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
VANCOMYCIN ANTIBIOTICS AND DERIVATIVES (cont.)		
VANCOMYCIN HCL 2 GRAM VIAL	T3	
VANCOMYCIN-D5W 500 MG/100 ML	T1	
ANTIBIOTICS (Miscellaneous)		
CYCLIC LIPOPEPTIDES		
DAPTOMYCIN	T1	
ANTIBIOTICS (Skin Conditions)		
TOPICAL ANTIBIOTIC AND ANTI-INFLAMMATORY STEROID		
NEO-SYNALAR	T3	
TOPICAL ANTIBIOTICS		
BENZAMYCIN (<i>erythromycin-benzoyl peroxide</i>)	T3	
CENTANY	T3	
CENTANY AT	T3	
CLEOCIN T (<i>clindamycin phosphate</i>)	T3	
CLINDACIN ETZ KIT	T3	
CLINDACIN PAC	T3	
<i>clindamycin phosphate</i>	T1	
<i>erythromycin base in ethanol</i>	T1	
<i>erythromycin base in ethanol</i>	T3	
<i>erythromycin/benzoyl peroxide</i> (Benzamycin)	T1	
EVOCLIN (<i>clindamycin phosphate</i>)	T3	
<i>gentamicin sulfate</i>	T1	
<i>mupirocin</i> (Centany)	T1	
<i>mupirocin calcium</i>	T1	
XEPI	T3	
TOPICAL SULFONAMIDES		
AVAR 9.5-5% CLEANSING PADS	T3	
<i>avar cleanser</i> (Rosanil)	T1	
AVAR LS	T3	
<i>mafenide acetate</i>	T1	
ROSANIL (<i>sodium sulfacetamide-sulfur</i>)	T1	

T1 – Typically Generics

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List of Prescription Medications

ANTIBIOTICS (Skin Conditions) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
TOPICAL SULFONAMIDES (cont.)		
SILVADENE (ssd)	T3	
silver sulfadiazine (Silvadene)	T1	
sulfacetamide sod/sulfur/urea	T1	
sulfacetamide sodium/sulfur	T1	
sulfacetamide sodium/sulfur (Avar-e Green)	T1	
sulfacetamide sodium/sulfur (Rosanil)	T1	
sulfacetamide/sulfur/cleansr23	T1	
sulfact sod/sulur/avob/otn/oct	T1	
SULFAMYLON	T3	

ANTICOAGULANTS (Blood Thinners/Anti-Clotting)

ANTICOAGULANTS, COUMARIN TYPE		
warfarin sodium	T1	HD
CITRATES AS ANTICOAGULANTS		
ACD SOLUTION A	T3	
ACD-A	T3	
ANTICOAG SODIUM CITRATE 4% SOL	T3	
CITRATE PHOSPHATE DEXTROSE	T1	
TRICITRASOL	T3	
DIRECT FACTOR XA INHIBITORS		
BEVYXXA	T3	QL (42 caps/42 days)
ELIQUIS	T2	PA
SAVAYSA 15 MG TABLET	T3	PA QL (1 tab/day)
SAVAYSA 30 MG TABLET	T3	PA QL (1 tab/day)
SAVAYSA 60 MG TABLET	T3	PA
XARELTO	T2	
HEPARIN AND RELATED PREPARATIONS		
ARIXTRA (fondaparinux sodium)	T4	QL (1 syringe/day) SP
enoxaparin 100 mg/ml syringe (Lovenox)	T4	QL (2 syringes/day) SP
enoxaparin 120 mg/0.8 ml syr (Lovenox)	T4	QL (2 syringes/day) SP
enoxaparin 150 mg/ml syringe (Lovenox)	T4	QL (2 syringes/day) SP
enoxaparin 30 mg/0.3 ml syr (Lovenox)	T4	QL (2 syringes/day) SP
enoxaparin 300 mg/3 ml vial (Lovenox)	T4	QL (1 vial/day) SP
enoxaparin 40 mg/0.4 ml syr (Lovenox)	T4	QL (2 syringes/day) SP

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

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

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

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

List of Prescription Medications

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

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
HEPARIN AND RELATED PREPARATIONS (cont.)		
<i>enoxaparin 60 mg/0.6 ml syr (Lovenox)</i>	T4	QL (2 syringes/day) SP
<i>enoxaparin 80 mg/0.8 ml syr (Lovenox)</i>	T4	QL (2 syringes/day) SP
<i>fondaparinux sodium (Arixtra)</i>	T4	QL (1 syringe/day) SP
FRAGMIN	T4	QL (2ml/day) SP
<i>heparin 10, 000 unit/10 ml vial</i>	T1	
<i>heparin 2, 000 unit/2 ml vial</i>	T1	
<i>heparin 30, 000 unit/30 ml vial</i>	T1	
<i>heparin 40, 000 unit/4 ml vial</i>	T1	
<i>heparin 5, 000 unit/ml carpuct</i>	T1	
<i>heparin 50, 000 unit/10 ml vial</i>	T1	
<i>heparin 50, 000 unit/5 ml vial</i>	T1	
<i>heparin 1,000 unit/500 ml-ns</i>	T1	
HEPARIN 2,000 UNIT/1,000 ML-NS (<i>heparin sodium,porcine/ns/pf</i>)	T3	
<i>heparin 2,000 unit/1,000 ml-ns (Heparin Sodium-0.9% Nacl)</i>	T1	
HEPARIN 2,500 UNIT/500 ML-NS	T1	
HEPARIN 30,000 UNIT/1,000-NS	T1	
HEPARIN 5,000 UNIT/1,000 ML-NS	T1	
HEPARIN 5,000 UNIT/500 ML-NS	T1	
<i>heparin sod 1, 000 unit/ml vial</i>	T1	
<i>heparin sod 10, 000 unit/ml vl</i>	T1	
<i>heparin sod 20, 000 unit/ml vl</i>	T1	
<i>heparin sod 5, 000 unit/0.5 ml</i>	T1	
HEPARIN SOD 5, 000 UNIT/0.5 ML	T3	
<i>heparin sod 5, 000 unit/0.5 ml (Heparin Sodium)</i>	T1	
<i>heparin sod 5, 000 unit/ml syrg</i>	T1	
<i>heparin sod 5, 000 unit/ml vial</i>	T1	
<i>heparin sod, porcine/0.9 % nacl</i>	T1	
<i>heparin sod, pork in 0.45% nacl</i>	T1	
<i>heparin sodium, porcine</i>	T1	
<i>heparin sodium, porcine/pf</i>	T1	
HEPARIN SODIUM-0.45% NACL	T1	
LOVENOX 100 MG/ML SYRINGE (<i>enoxaparin sodium</i>)	T4	QL (2 syringes/day) SP
LOVENOX 120 MG/0.8 ML SYRINGE (<i>enoxaparin sodium</i>)	T4	QL (2 syringes/day) SP
LOVENOX 150 MG/ML SYRINGE (<i>enoxaparin sodium</i>)	T4	QL (2 syringes/day) SP

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

T4 – Specialty Medications

PA – Prior Authorization

QL – Quantity Limit

ST – Step Therapy

AGE – Age Requirement

SP – Specialty Medication

HD – May require home delivery pharmacy

PPACA – No Cost-Share Preventive Medication

CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

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

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
HEPARIN AND RELATED PREPARATIONS (cont.)		
LOVENOX 30 MG/0.3 ML SYRINGE (<i>enoxaparin sodium</i>)	T4	QL (2 syringes/day) SP
LOVENOX 300 MG/3 ML VIAL (<i>enoxaparin sodium</i>)	T4	QL (1 vial/day) SP
LOVENOX 40 MG/0.4 ML SYRINGE (<i>enoxaparin sodium</i>)	T4	QL (2 syringes/day) SP
LOVENOX 60 MG/0.6 ML SYRINGE (<i>enoxaparin sodium</i>)	T4	QL (2 syringes/day) SP
LOVENOX 80 MG/0.8 ML SYRINGE (<i>enoxaparin sodium</i>)	T4	QL (2 syringes/day) SP
THROMBIN INHIBITORS, SELECTIVE, DIRECT, REVERSIBLE		
ARGATROBAN	T4	SP HD
ARGATROBAN 250MG/2.5ML VIAL	T4	SP
ARGATROBAN-0.9% NACL	T4	SP HD
<i>dabigatran etexilate</i>	T1	
PRADAXA	T3	PA HD
THROMBIN INHIBITORS, SEL, DIRECT, REVERS-HIRUDIN TYPE		
ANGIOMAX (<i>bivalirudin</i>)	T3	
BIVALIRUDIN 250 MG ADD-VANT VL	T1	
<i>bivalirudin 250 mg vial</i> (Angiomax)	T1	
BIVALIRUDIN RTU 250 MG/50 ML	T3	
BIVALIRUDIN-0.9% NACL	T1	
ANTIDOTES (Gastrointestinal/Heartburn)		
MU-OPIOID RECEPTOR ANTAGONISTS, PERIPHERALLY-ACTING		
MOVANTIK	T2	PA
RELISTOR	T3	PA
SYMPROIC	T2	PA
ANTIDOTES (Substance Abuse)		
OPIOID ANTAGONISTS		
KLOXXADO	T2	PA QL (2 sprays/30 days)
<i>naloxone 0.4 mg/ml carpject</i>	T1	
<i>naloxone 0.4 mg/ml vial</i>	T1	
NALOXONE 2 MG AUTO-INJECTOR	T3	QL (0.8ml/day)
<i>naloxone 2 mg/2 ml syringe</i>	T1	
<i>naloxone 4 mg/10 ml vial</i>	T1	
<i>naltrexone hcl</i>	T1	QL (180 tabs/30 days)
NARCAN	T2	QL (2 units/30 days)

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List of Prescription Medications

ANTIDOTES (Substance Abuse) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
OPIOID ANTAGONISTS (cont.)		
OPVEE	T2	QL (2 units/30 days)
REXTOVY	T2	QL(2 units/30 days)
ZIMHI	T3	QL (2 inj/month)
ANTIFUNGALS (Eye Conditions)		
OPHTHALMIC ANTIFUNGAL AGENTS		
NATACYN	T3	
ANTIFUNGALS (Feminine Products)		
VAGINAL ANTIFUNGALS		
GYNAZOLE 1	T1	
<i>miconazole nitrate</i>	T1	
<i>terconazole</i>	T1	
ANTIFUNGALS (Infections)		
ANTIFUNGAL AGENTS		
ANCOBON (<i>flucytosine</i>)	T3	
<i>clotrimazole</i>	T1	
CRESEMBA 74.5 MG CAPSULE	T3	PA
CRESEMBA 186 MG CAPSULE	T3	PA
CRESEMBA 372 MG VIAL	T3	
<i>fluconazole</i>	T1	
<i>fluconazole in dextrose, iso-os</i>	T1	
<i>flucytosine</i> (Ancobon)	T1	
<i>itraconazole</i>	T1	
<i>ketoconazole</i>	T1	
ORAVIG	T3	
<i>posaconazole</i> (Noxafil)	T1	
<i>terbinafine hcl</i>	T1	
VFEND (<i>voriconazole</i>)	T3	PA
VFEND IV (<i>voriconazole</i>)	T3	
VIVJOA	T3	PA
<i>voriconazole 200 mg tablet</i> (Vfend)	T1	PA
<i>voriconazole 200 mg vial</i> (Vfend iv)	T1	
<i>voriconazole 40 mg/ml susp</i> (Vfend)	T1	PA
<i>voriconazole 50 mg tablet</i> (Vfend)	T1	PA

T1 – Typically Generics

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List of Prescription Medications

ANTIFUNGALS (Infections) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ANTIFUNGAL ANTIBIOTICS		
ABELCET	T3	
AMBISOME	T3	
<i>amphotericin b</i>	T1	
CANCIDAS (<i>caspofungin acetate</i>)	T3	
<i>caspofungin acetate (Cancidas)</i>	T1	
ERAXIS	T3	
<i>griseofulvin ultramicrosize (Gris-peg)</i>	T1	
<i>griseofulvin, microsize</i>	T1	
GRIS-PEG (<i>griseofulvin ultramicrosize</i>)	T3	
MICAFUNGIN-0.9% NACL	T3	
<i>micafungin sodium (Mycamine)</i>	T1	
MYCAMINE (<i>micafungin</i>)	T3	
<i>nystatin</i>	T1	
ANTIFUNGALS (Skin Conditions)		
TOPICAL ANTIFUNGAL/ANTI-INFLAMMATORY, STEROID AGENT		
<i>clotrimazole/betamethasone dip</i>	T1	
TOPICAL ANTIFUNGALS		
<i>ciclodan 0.77% cream</i>	T1	
CICLODAN 0.77% CREAM KIT	T3	
<i>ciclodan 8% solution</i>	T1	
<i>ciclopirox</i>	T1	
<i>ciclopirox olamine</i>	T1	
<i>ciclopirox olamine (Loprox)</i>	T1	
<i>econazole nitrate</i>	T1	
ECOZA	T3	
EXODERM	T1	
<i>ketoconazole</i>	T1	
<i>ketoconazole/skin cleanser 28</i>	T1	
LOPROX (<i>ciclopirox</i>)	T3	
LULICONAZOLE	T1	
<i>naftifine hcl</i>	T1	
<i>naftifine hcl (Naftin)</i>	T1	
NAFTIN (<i>naftifine hcl</i>)	T3	

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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>nystatin</i>	T1	
<i>nystatin/triamcinolone acet</i>	T1	
ANTIHISTAMINE AND DECONGESTANT COMBINATION (Allergy/Nasal Sprays)		
1ST GEN ANTIHISTAMINE AND DECONGESTANT COMBINATION		
<i>phenylephrine hcl/prometh hcl</i>	T1	
2ND GEN ANTIHISTAMINE AND DECONGESTANT COMBINATION		
CLARINEX-D 12 HOUR	T3	
ANTIHISTAMINES (Allergy/Nasal Sprays)		
ANTIHISTAMINES - 1ST GENERATION		
<i>carbinoxamine maleate</i>	T1	
<i>clemastine fumarate</i>	T1	
<i>cyproheptadine hcl</i>	T1	
<i>cyproheptadine hcl</i> (Cyproheptadine Hcl)	T1	
<i>diphenhydramine hcl</i>	T1	
<i>hydroxyzine hcl</i>	T1	
<i>hydroxyzine pamoate</i>	T1	
<i>hydroxyzine pamoate</i> (Vistaril)	T1	
PHENERGAN (<i>promethazine hcl</i>)	T3	
<i>promethazine hcl</i>	T1	
<i>promethazine hcl</i> (Phenergan)	T1	
VISTARIL (<i>hydroxyzine pamoate</i>)	T3	
ANTIHISTAMINES - 2ND GENERATION		
<i>cetirizine hcl</i>	T1	HD
<i>desloratadine 2.5 mg odt</i>	T1	QL (1 tab/day) HD
<i>desloratadine 5 mg odt</i>	T1	HD
<i>desloratadine 5 mg tablet</i>	T1	HD
<i>levocetirizine dihydrochloride</i>	T1	HD
QUZYTIR	T3	
ANTIHISTAMINES (Eye Conditions)		
<i>azelastine hcl 0.05% drops</i>	T1	
<i>bepotastine besilate</i>	T1	
<i>epinastine hcl</i>	T1	

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List of Prescription Medications

ANTI-HISTAMINES (Eye Conditions) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
EYE ANTIHISTAMINES (cont.)		
<i>olopatadine hcl 0.1% eye drops</i>	T1	
<i>olopatadine hcl 0.2% eye drop</i>	T1	
ANTIHYPERGLYCEMICS (Diabetes)		
ANTIHYPERGLY, INCRETIN MIMETIC (GLP-I RECEPT.AGONIST)		
BYDUREON	T2	QL (4 vials/28 days) ST HD
BYDUREON BCISE	T2	QL (4 pens/28 days) ST
BYDUREON PEN	T2	QL (4 pens/28 days) ST HD
OZEMPIC 0.25-0.5 MG DOSE PEN	T2	QL (2 pens/28 days) ST HD
OZEMPIC 1 MG DOSE PEN (1.5 ML)	T2	QL (2 pens/28 days) ST HD
OZEMPIC 1 MG DOSE PEN (3 ML)	T2	QL (3ml/21 days) ST HD
REZVOGLAR KWIKPEN	T2	QL
RYBELSUS	T2	QL (1 tab/day) ST
TRULICITY 0.75 MG/0.5 ML PEN	T2	QL (4 pens/28 days) ST HD
TRULICITY 1.5 MG/0.5 ML PEN	T2	QL (4 pens/28 days) ST HD
TRULICITY 3 MG/0.5 ML PEN	T2	QL (2 ml/28 days) ST HD
TRULICITY 4.5 MG/0.5 ML PEN	T2	QL (2 ml/28 days) ST HD
ANTIHYPERGLY, INSULIN, LONG ACT-GLP-I RECEPT.AGONIST		
SOLIQUA 100-33	T2	HD
ANTIHYPERGLYCEMIC-SOD/GLUC COTRANSPORT2 (SGLT2) INHIB		
FARXIGA	T2	ST QL(1 tab/day)
JARDIANCE	T2	QL (1 tab/day) ST HD
ANTIHYPERGLYCEMIC - DOPAMINE RECEPTOR AGONISTS		
CYCLOSET	T3	HD
ANTIHYPERGLYCEMIC, ALPHA-GLUCOSIDASE INHIBITORS		
<i>acarbose (Precose)</i>	T1	HD
<i>GLYSET (miglitol)</i>	T3	HD
<i>miglitol (Glyset)</i>	T1	HD
<i>PRECOSE (acarbose)</i>	T3	HD
ANTIHYPERGLYCEMIC, AMYLIN ANALOG-TYPE		
SYMLINPEN 60	T2	
SYMLINPEN 120	T2	HD
ANTIHYPERGLYCEMIC, BIGUANIDE TYPE		
GLUCOPHAGE XR (<i>metformin hcl er</i>)	T3	HD

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

HD – May require home delivery pharmacy
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List of Prescription Medications

ANTIHYPERGLYCEMICS (Diabetes) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ANTIHYPERGLYCEMIC, BIGUANIDE TYPE (cont.)		
<i>metformin hcl</i> (Glucophage Xr)	T1	HD
<i>metformin hcl</i> (Riomet)	T1	HD
RIOMET (<i>metformin hcl</i>)	T3	HD
RIOMET ER	T3	HD
ANTIHYPERGLYCEMIC, DPP-4 INHIBITORS		
JANUVIA	T2	QL (1 tab/day) ST HD
ANTIHYPERGLYCEMIC-GLUCOCORTICOID RECEPTOR BLOCKER		
<i>mifepristone 300 mg tablet</i> (Korlym)	T2	QL (1 tab/day) ST HD
ANTIHYPERGLYCEMIC, INSULIN-RELEASE STIMULANT TYPE		
AMARYL (<i>glimepiride</i>)	T3	HD
<i>chlorpropamide</i>	T1	HD
<i>glimepiride</i> (Amaryl)	T1	HD
GLIMEPIRIDE 3 MG TABLET	T3	HD
<i>glipizide</i> (Glucotrol XL)	T1	HD
<i>glipizide</i> (Glucotrol)	T1	HD
GLIPIZIDE 2.5 MG TABLET	T3	HD
GLUCOTROL (<i>glipizide</i>)	T3	HD
GLUCOTROL XL (<i>glipizide xl</i>)	T3	HD
<i>glyburide</i>	T1	HD
GLYNASE (<i>glyburide micronized</i>)	T3	HD
<i>repaglinide</i>	T1	HD
STARLIX (<i>nateglinide</i>)	T3	HD
<i>tolbutamide</i>	T1	HD
ANTIHYPERGLYCEMIC, SGLT-2 AND DPP-4 INHIBITOR COMB		
GLYXAMBI	T2	QL (1 tab/day) ST HD
ANTIHYPERGLYCEMIC, THIAZOLIDINEDIONE AND BIGUANIDE		
ACTOPLUS MET (<i>pioglitazone-metformin</i>)	T3	HD
<i>pioglitazone hcl/metformin hcl</i> (Actoplus Met)	T1	HD
ANTIHYPERGLYCEMIC, THIAZOLIDINEDIONE-SULFONYLUREA		
DUETACT (<i>pioglitazone-glimepiride</i>)	T3	HD
<i>pioglitazone hcl/glimepiride</i> (Duetact)	T1	HD
ANTIHYPERGLYCEMIC, DPP-4 INHIBITOR-BIGUANIDE COMBS.		
JANUMET	T2	QL (2 tabs/day) ST HD

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

T4 – Specialty Medications

PA – Prior Authorization

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ST – Step Therapy

AGE – Age Requirement

SP – Specialty Medication

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List of Prescription Medications

ANTIHYPERTENSIVES (Diabetes) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ANTIHYPERTENSIVE, DPP-4 INHIBITOR-BIGUANIDE COMBS. (cont.)		
JANUMET XR 100-1,000 MG TABLET	T2	QL (1 tab/day) ST HD
JANUMET XR 50-1,000 MG TABLET	T2	QL (2 tabs/day) ST HD
JANUMET XR 50-500 MG TABLET	T2	QL (1 tab/day) ST HD
ANTIHYPERTENSIVE, INSULIN-RELEASE STIM.-BIGUANIDE		
glipizide/metformin hcl	T1	HD
glyburide/metformin hcl	T1	HD
repaglinide/metformin hcl	T1	HD
ANTIHYPERTENSIVE, THIAZOLIDINEDIONE (PPARG AGONIST)		
ACTOS (pioglitazone hcl)	T3	HD
AVANDIA	T3	HD
pioglitazone hcl (Actos)	T1	HD
ANTIHYPERTENSIVE-SGLT2 INHIBITOR-BIGUANIDE COMBS.		
SYNJARDY	T2	QL (2 tabs/day) ST HD
SYNJARDY XR 10-1,000 MG TABLET	T2	QL (2 tabs/day) ST HD
SYNJARDY XR 12.5-1,000 MG TAB	T2	QL (2 tabs/day) ST HD
SYNJARDY XR 25-1,000 MG TABLET	T2	QL (1 tab/day) ST HD
SYNJARDY XR 5-1,000 MG TABLET	T2	QL (2 tabs/day) ST HD
XIGDUO XR 10 MG-1,000 MG TAB	T2	QL (1 tab/day) ST HD
XIGDUO XR 10 MG-500 MG TABLET	T2	QL (1 tab/day) ST HD
XIGDUO XR 2.5 MG-1,000 MG TAB	T2	QL (2 tabs/day) ST HD
XIGDUO XR 5 MG-1,000 MG TABLET	T2	QL (2 tabs/day) ST HD
XIGDUO XR 5 MG-500 MG TABLET	T2	QL (1 tab/day) ST HD
ANTIHYPERTENSIVE-SGLT-2 INHIB, DPP-4 INHIB, BIGUANIDE CB		
TRIJARDY XR	T2	QL (1 tab/day) ST HD
INSULINS		
BASAGLAR KWIKPEN U-100	T2	QL (1.5ml/day) HD
FIASP PENFILL	T3	QL (1.5ml/day) HD
HUMALOG	T2	QL (1.5 mls/day) HD
HUMALOG KWIKPEN U-200	T2	QL (1ml/day) HD
HUMALOG MIX 50-50 KWIKPEN	T2	QL (2ml/day) HD
HUMALOG MIX 75-25	T2	QL (2ml/day) HD
HUMALOG MIX 75-25 KWIKPEN	T2	QL (2ml/day) HD
HUMULIN R U-500	T2	QL (1ml/day) HD
HUMULIN R U-500 KWIKPEN	T2	QL (1ml/day) HD

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T4 – Specialty Medications

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List of Prescription Medications

ANTIHYPERGLYCEMICS (Diabetes) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
INSULINS (cont.)		
LYUMJEV	T2	QL (1.5ml/day) HD
LYUMJEV KWIKPEN U-100	T2	QL (1.5ml/day) HD
LYUMJEV KWIKPEN U-200	T2	QL (1ml/day) HD
TRESIBA	T2	QL (1.5ml/day) HD
TRESIBA FLEXTOUCH U-100	T2	QL (1.5ml/day) HD
TRESIBA FLEXTOUCH U-200	T2	QL (0.9ml/day) HD

ANTIINFECTIVES (Feminine Products)

VAGINAL SULFONAMIDES		
AVC	T3	

ANTIINFECTIVES (Infections)

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

ANTIINFECTIVES/MISCELLANEOUS (Feminine Products)

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

ANTIINFECTIVES/MISCELLANEOUS (Infections)

2ND GEN. ANAEROBIC ANTIPROTOZOAL-ANTIBACTERIAL		
TINDAMAX (<i>tinidazole</i>)	T3	
<i>tinidazole</i>	T1	
<i>tinidazole</i> (Tindamax)	T1	
AMEBICIDES		
<i>paromomycin sulfate</i>	T1	
ANTHELMINTICS		
<i>albendazole</i> (Albenza)	T1	
ALBENZA (<i>albendazole</i>)	T3	
BILTRICIDE (<i>praziquantel</i>)	T3	
EMVERM	T1	
<i>ivermectin</i> (Stromectol)	T1	PA
<i>praziquantel</i> (Biltricide)	T1	

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

List of Prescription Medications

ANTIINFECTIVES/MISCELLANEOUS (Infections) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ANTHELMINTICS (cont.)		
STROMEKTOL (<i>ivermectin</i>)	T3	PA
ANTIMALARIAL DRUGS		
<i>atovaquone/proguanil hcl</i> (Malarone)	T1	
<i>chloroquine ph 250 mg tablet</i>	T1	QL (56 Tabs/365 Days)
<i>chloroquine ph 500 mg tablet</i>	T1	
COARTEM	T3	PA QL (24 tabs/30 days)
<i>hydroxychloroquine sulfate</i> (Plaquenil)	T1	
KRINTAFEL	T3	PA QL (2 tabs/30 days)
MALARONE (<i>atovaquone-proguanil hcl</i>)	T3	PA
<i>mefloquine hcl</i>	T1	
PLAQUENIL (<i>hydroxychloroquine sulfate</i>)	T3	
PRIMAQUINE (<i>primaquine phosphate</i>)	T1	
<i>primaquine phosphate</i> (Primaquine)	T1	
<i>pyrimethamine 25 mg tablet</i> (Daraprim)	T1	PA
<i>pyrimethamine 25 mg tablet</i> (Daraprim)	T1	PA SP
QUALAQUIN (<i>quinine sulfate</i>)	T3	PA
<i>quinine sulfate</i> (Qualaquin)	T1	
ANTIPROTOZOAL DRUGS, MISCELLANEOUS		
<i>atovaquone</i>	T1	
BENZNIDAZOLE	T3	
IMPAVIDO	T3	PA
LAMPIT	T3	
NEBUPENT (<i>pentamidine isethionate</i>)	T3	
PENTAM 300 (<i>pentamidine isethionate</i>)	T3	
ANTIINFECTIVES/MISCELLANEOUS (Miscellaneous)		
ANTIPROTOZOAL DRUGS, MISCELLANEOUS (cont.)		
<i>pentamidine isethionate</i> (Nebupent)	T1	
<i>pentamidine isethionate</i> (Pentam 300)	T1	
ANTIBACTERIAL AGENTS, MISCELLANEOUS		
<i>glycine urologic solution</i>	T1	
<i>glycine urologic solution</i>	T3	
TOPICAL ANTISEPTIC DRYING AGENTS		
<i>formaldehyde</i>	T1	

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

T4 – Specialty Medications

PA – Prior Authorization

QL – Quantity Limit

ST – Step Therapy

AGE – Age Requirement

SP – Specialty Medication

HD – May require home delivery pharmacy

PPACA – No Cost-Share Preventive Medication

CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

ANTIINFECTIVES/MISCELLANEOUS (SKIN CONDITIONS)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
TOPICAL ANTIFUNGALS		
CICLODAN 8% KIT	T3	
<i>ciclopirox/urea/camph/men/euc</i> (Ciclodan)	T1	
ANTIINFLAM.TUMOR NECROSIS FACTOR INHIBITING AGENTS (Pain Relief And Inflammatory Disease)		
ANTI-INFLAMMATORY TUMOR NECROSIS FACTOR INHIBITOR		
ADALIMUMAB-ADB(M) CF PEN CROHNS	T4	PA QL (1 starter kit/365 days) SP HD
ADALIMUMAB-ADB(M) CF PEN	T4	PA QL (2 pens/syringes/28 days) SP HD
ADALIMUMAB-RYVK(CF)	T4	PA QL (2 auto-injs/28 days) SP
AMJEVITA(CF)	T4	PA QL (2 syringes/28 days) SP HD
AMJEVITA(CF) AUTOINJECTOR	T4	PA QL (2 auto-injs/28 days) SP HD
AVSOLA	T4	PA SP
CIMZIA 200 MG VIAL KIT	T4	PA QL (1 kit/28 days) SP HD
CIMZIA 2X200 MG/ML SYRINGE KIT	T4	PA QL (1 kit/28 days) SP HD
CIMZIA 2X200 MG/ML (X3) START KT	T4	PA QL (1 kit/year) SP HD
CYLTEZO (CF)	T4	PA QL (1 starter kit/365 days) SP
CYLTEZO(CF) PEN	T4	PA QL (2 pens/28 days) SP
CYLTEZO(CF) PEN CROHN'S-UC-HS	T4	PA QL (1 starter kit/365 days) SP
ENBREL 25 MG KIT	T4	PA QL (8 vials/28 days) SP HD
ENBREL 25 MG/0.5 ML SYRINGE	T4	PA QL (8 syringes/28 days) SP HD
ENBREL 25 MG/0.5 ML VIAL	T4	PA QL (4ml/28 days) SP HD
ENBREL 50 MG/ML SYRINGE	T4	PA QL (4 syringes/28 days) SP HD
ENBREL MINI	T4	PA QL (4 cartridges/28 days) SP HD
ENBREL SURECLICK	T4	PA QL (4 syringes/28 days) SP HD
HUMIRA	T4	PA QL (2 syringes/28 days) SP HD
HUMIRA PEN	T4	PA QL (2 pens/28 days) SP HD
HUMIRA PEN CROHN'S-UC-HS	T4	PA QL (1 kit/year) SP HD
HUMIRA PEN PSOR-UEITS-ADOL HS	T4	PA QL (1 kit/year) SP HD
HUMIRA (CF)	T4	PA QL (2 syringes/28 days) SP HD
HUMIRA (CF) PEN 40 MG/0.4 ML	T4	PA QL (2 pens/28 days) SP HD
HUMIRA (CF) PEN 80 MG/0.8 ML	T4	PA QL (1 kit/year) SP HD
HUMIRA (CF) PEN CROHN'S-UC-HS	T4	PA QL (1 kit/year) SP
HUMIRA (CF) PEN PEDIATRIC UC	T4	PA QL (4 KITS/365 DAYS) SP HD

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

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

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

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

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ANTI-INFLAMMATORY TUMOR NECROSIS FACTOR INHIBITOR (cont.)		
HUMIRA (CF) PEN PSOR-UV-ADOL HS	T4	PA QL (1 kit/year) SP HD
HYRIMOZ(CF) PEN	T4	PA QL (2 pens/28 days) SP HD
IBRANCE	T4	PA QL SP
IBTROZI 200 MG CAPSULE	T4	PA SP HD
INFLECTRA	T4	PA SP HD
RENFLEXIS	T4	PA SP HD
SIMLANDI(CF)	T4	PA QL SP
SIMPONI 100 MG/ML PEN INJECTOR	T4	PA QL (1 injector/28 days) SP HD
SIMPONI 100 MG/ML SYRINGE	T4	PA QL (1 syringe/28 days) SP HD
SIMPONI ARIA	T4	PA SP HD

ANTINEOPLASTICS (Cancer)

ANP - SELECTIVE RETINOID X RECEPTOR AGONISTS (RXR)		
<i>bexarotene</i> (Targretin)	T4	PA SP HD
ANTIBIOTIC ANTINEOPLASTICS		
<i>adriamycin 10 mg vial</i>	T4	PA SP
<i>adriamycin 10 mg/5 ml vial</i>	T4	PA SP
<i>adriamycin 20 mg/10 ml vial</i>	T4	PA SP
ADRIAMYCIN (<i>doxorubicin hcl</i>)	T4	PA SP
<i>bleomycin sulfate</i>	T4	PA SP
<i>dactinomycin</i> (Cosmegen)	T4	PA SP
<i>daunorubicin hcl</i>	T4	PA SP
DOXIL (<i>lipodax 50</i>)	T4	PA SP
<i>doxorubicin hcl</i>	T4	PA SP
<i>doxorubicin hcl</i> (Adriamycin)	T4	PA SP
<i>doxorubicin hcl peg-liposomal</i> (Doxil)	T4	PA SP
ELLENCÉ (<i>epirubicin hcl</i>)	T4	PA SP
<i>epirubicin 200 mg/100 ml vial</i> (Ellence)	T4	PA SP
<i>epirubicin 50 mg/25 ml vial</i> (Ellence)	T4	PA SP
<i>epirubicin hcl 200 mg vial</i>	T4	SP
IDAMYCIN PFS (<i>idarubicin hcl</i>)	T4	PA SP
<i>idarubicin hcl</i> (Idamycin Pfs)	T4	PA SP
<i>mitomycin</i> (Mutamycin)	T4	PA SP
MUTAMYCIN (<i>mitomycin</i>)	T4	PA SP

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List of Prescription Medications

ANTINEOPLASTICS (Cancer) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ANTIBIOTIC ANTINEOPLASTICS (cont.)		
valrubicin (Valstar)	T4	SP
VALSTAR (valrubicin)	T4	SP
ZANOSAR	T4	PA SP
ANTINEOPLASTICS ANTIBODY/ANTIBODY-DRUG COMPLEXES		
IMDELLTRA	T4	PA SP
LUNSUMIO	T4	PA SP
ANTINEOPLASTIC, ANTI-PROGRAMMED DEATH-1 (PD-1) MAB		
ZYNYZ	T4	PA SP
ANTI-CD20 (B LYMPHOCYTE) MONOCLONAL ANTIBODY		
GAZYVA	T4	PA SP
RIABNI	T4	PA SP
RITUXAN	T4	PA SP
RITUXAN HYCELA	T4	PA SP
RUXIENCE	T4	PA SP
TRUXIMA	T4	PA SP
ANTINEOPLAST HUM VEGF INHIBITOR RECOMB MC ANTIBODY		
AVASTIN	T4	PA SP
MVASI	T4	PA SP
VEGZELMA	T4	PA SP
ZIRABEV	T4	PA SP
ANTINEOPLAST, HISTONE DEACETYLASE (HDAC) INHIBITORS		
BELEODAQ	T4	PA SP
FARYDAK	T4	PA SP HD
ISTODAX	T4	PA SP
ROMIDEPSIN 10 MG KIT	T4	PA SP
ROMIDEPSIN 27.5 MG/5.5 ML VIAL	T4	PA SP
ZOLINZA	T4	PA SP HD
ANTINEOPLASTIC - ALKYLATING AGENTS		
ALKERAN 2 MG TABLET (melphalan)	T4	SP
ALKERAN 50 MG VIAL (melphalan hcl)	T4	PA SP
BELRAPZO	T4	PA SP HD
bendamustine vial	T4	PA SP HD
BENDEKA	T4	PA SP HD

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List of Prescription Medications

ANTINEOPLASTICS (Cancer) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ANTINEOPLASTIC - ALKYLATING AGENTS (cont.)		
BICNU (<i>carmustine</i>)	T4	SP
<i>busulfan</i> (Busulfex)	T4	SP
<i>carboplatin</i>	T4	PA SP
<i>carmustine</i> (Bicnu)	T4	SP
CISPLATIN 50MG VIAL	T4	PA SP
<i>cisplatin vial</i>	T4	PA QL(2 pens/28 days) SP HD
<i>cyclophosphamide 1 gm vial</i>	T4	SP
CYCLOPHOSPHAMIDE 1 GM/10 ML VL	T4	SP
CYCLOPHOSPHAMIDE 2 GM/20 ML VL	T4	SP
CYCLOPHOSPHAMIDE 500 MG/5ML VL	T4	SP
<i>cyclophosphamide 2 gm vial</i>	T4	SP
<i>cyclophosphamide 25 mg capsule</i>	T4	SP HD
<i>cyclophosphamide 500 mg vial</i>	T4	SP
CYCLOPHOSPHAMIDE 500 MG/2.5 ML	T4	SP
EVOMELA	T4	PA SP
GLEOSTINE	T2	
GLIADEL	T4	SP
HYDREA (<i>hydroxyurea</i>)	T3	
<i>hydroxyurea</i> (Hydrea)	T1	
IFEX (<i>ifosfamide</i>)	T4	PA SP
<i>ifosfamide</i>	T4	PA SP
<i>ifosfamide</i> (Ifex)	T4	PA SP
LEUKERAN	T2	
<i>melphalan</i> (Alkeran)	T4	PA SP CSL
MYLERAN	T2	
<i>oxaliplatin</i>	T4	PA SP
PEPAXTO	T4	PA SP
TEMODAR (<i>temozolomide</i>)	T4	PA SP HD
TEMODAR 180 MG CAPSULE (<i>temozolomide</i>)	T4	PA SP HD
TEMODAR 20 MG CAPSULE (<i>temozolomide</i>)	T4	PA SP HD
<i>temozolomide</i>	T4	PA SP HD CSL
TEPADINA	T4	PA SP
TEPADINA (<i>thiotepa</i>)	T4	PA SP
<i>thiotepa</i> (Tepadina)	T4	PA SP
TREANDA	T4	PA SP

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List of Prescription Medications

ANTINEOPLASTICS (Cancer) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ANTINEOPLASTIC - ALKYLATING AGENTS (cont.)		
YONDELIS	T4	PA SP
ZEPZELCA	T4	PA SP
ANTINEOPLASTIC - ANTIANDROGENIC AGENTS		
<i>abiraterone 500 mg tablet</i>	T4	SP HD
<i>abiraterone acetate 250 mg tab</i>	T4	PA SP HD
<i>abiraterone acetate 500 mg tab (Zytiga)</i>	T4	SP HD CSL
<i>bicalutamide (Casodex)</i>	T1	
CASODEX (<i>bicalutamide</i>)	T3	
ERLEADA 240 MG TABLET	T4	PA QL (1 tab/day) SP HD CSL
ERLEADA 60 MG TABLET	T4	PA SP HD CSL
<i>flutamide</i>	T1	
<i>nilutamide</i>	T1	QL (4 tabs/day)
NUBEQA	T4	PA SP HD
XTANDI	T4	PA SP HD
ANTINEOPLASTIC - ANTIBIOTIC AND ANTIMETABOLITE		
VYXEOS	T4	PA SP
ANTINEOPLASTIC - ANTI-CD38 MONOCLONAL ANTIBODY		
DARZALEX	T4	PA SP HD
DARZALEX FASPRO	T4	PA SP
SARCLISA	T4	PA SP
ANTINEOPLASTIC - ANTIMETABOLITES		
ALIMTA	T4	PA SP
ARRANON	T4	PA SP
<i>capecitabine (Xeloda)</i>	T4	PA SP HD
<i>cladribine</i>	T4	PA SP
<i>clofarabine</i>	T4	PA SP
<i>cytarabine</i>	T4	PA SP
<i>cytarabine/pf</i>	T4	PA SP
DACOGEN (<i>decitabine</i>)	T4	PA SP
<i>floxuridine</i>	T4	PA SP
<i>fludarabine phosphate</i>	T4	PA SP
<i>fluorouracil</i>	T4	PA SP
<i>fluorouracil 2.5 gm/50 ml btl</i>	T4	PA SP
<i>fluorouracil 2.5 gm/50 ml vial</i>	T4	PA SP
<i>fluorouracil 5 gm/100 ml btl</i>	T4	PA SP

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

T4 – Specialty Medications

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ST – Step Therapy

AGE – Age Requirement

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List of Prescription Medications

ANTINEOPLASTICS (Cancer) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ANTINEOPLASTIC - ANTIMETABOLITES (cont.)		
<i>fluorouracil 5 gm/100 ml vial</i>	T4	PA SP
<i>fluorouracil 5, 000 mg/100 ml</i>	T4	PA SP
<i>fluorouracil 500 mg/10 ml vial</i>	T4	PA SP
FOLOTYN 20 MG/ML VIAL	T4	PA SP
FOLOTYN 40 MG/2 ML VIAL	T4	PA SP
<i>gemcitabine hcl</i>	T4	PA SP
GEMCITABINE 1GM/10ML VIAL	T4	PA SP
GEMCITABINE 1.5GM/15ML VIAL	T4	PA SP
GEMCITABINE 2GM/20ML VIAL	T4	PA SP
GEMCITABINE 200MG/2ML VIAL	T4	PA SP
INFUGEM	T4	PA SP HD
INQOVI	T4	PA SP HD
JYLAMVO	T3	CSL
LONSURF	T4	PA SP HD
<i>mercaptopurine</i>	T1	
<i>methotrexate sodium</i>	T1	
<i>methotrexate sodium/pf</i>	T1	
NIPENT	T4	PA SP
ONUREG	T4	PA QL (14 Tabs/28 Days) SP
PEMRYDI RTU	T3	PA
PURIXAN	T4	SP
TABLOID	T3	
TREXALL	T2	
VIDAZA (<i>azacitidine</i>)	T4	PA SP
XATMEP	T3	
XELODA (<i>capecitabine</i>)	T4	PA SP HD
ANTINEOPLASTIC - ANTI-SLAMF7 MONOCLONAL ANTIBODY		
EMPLICITI	T4	PA SP HD
<i>anastrozole (Arimidex)</i>	T1	HD PPACA
ARIMIDEX (<i>anastrozole</i>)	T3	HD
AROMASIN (<i>exemestane</i>)	T3	HD
<i>exemestane (Aromasin)</i>	T1	HD PPACA
FEMARA (<i>letrozole</i>)	T3	HD
<i>letrozole (Femara)</i>	T1	HD
TAFINLAR 10 MG TABLET FOR SUSP	T4	PA QL (30 tabs/day) SP HD CSL

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

T4 – Specialty Medications

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List of Prescription Medications

ANTINEOPLASTICS (Cancer) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ANTINEOPLASTIC - AROMATASE INHIBITORS		
TAFINLAR TABLET	T4	PA QL(30 tabs/day) SP HD CSL
OJEMDA TABLET	T4	PA QL(1 packet/28 Days) SP CSL
OJEMDA 25 MG/ML ORAL SUSP	T4	PA QL(8 bottles/28 days) SP CSL
ZELBORAF	T4	PA SP HD
ANTI-NEOPLASTIC-ENZYME INHIB, ANTIANDROGEN COMB.		
AKEEGA	T4	PA QL(2 tabs/day) SP CSL
ANTINEOPLASTIC - CD19 (B LYMPHOCYTE) MC ANTIBODY		
MONJUVI	T4	PA SP
ANTINEOPLASTIC - EPOTHILONES AND ANALOGS		
IXEMPRA	T4	PA SP
ANTINEOPLASTIC - HEDGEHOG PATHWAY INHIBITOR		
DAURISMO	T4	PA SP HD
ERIVEDGE	T4	PA SP HD
ODOMZO	T4	PA SP HD
ANTINEOPLASTIC - IMMUNOTHERAPY, VIRUS-BASED AGENTS		
IMLYGIC	T4	PA SP
ANTINEOPLASTIC - JANUS KINASE (JAK) INHIBITORS		
JAKAFI	T4	PA SP HD
ANTINEOPLASTIC - KRAS PROTEIN INHIBITOR		
LUMAKRAS 120 MG TABLET	T4	PA QL(8 tabs/day) SP HD CSL
LUMAKRAS 240 MG TABLET	T4	PA QL(4 tabs/day) SP HD CSL
LUMAKRAS 320 MG TABLET	T4	PA QL(3 tabs/day) SP HD CSL
ANTINEOPLASTIC - MEK1 AND MEK2 KINASE INHIBITORS		
COTELLIC	T4	PA SP HD
GOMEKLI	T4	PA SP HD
KOSELUGO 10 MG CAPSULE	T4	PA QL (10 capsules/day) SP
KOSELUGO 25 MG CAPSULE	T4	PA QL (4 caps/day) SP
MEKINIST	T4	PA QL SP HD
HALAVEN (<i>eribulin mesylate</i>)	T4	PA SP
AFINITOR (<i>everolimus</i>)	T4	PA SP HD
AFINITOR DISPERZ	T4	PA SP
<i>eribulin mesylate</i> (Halaven)	T4	PA SP
<i>everolimus</i>	T4	PA QL(1 tab/day) SP HD CSL
<i>temsirolimus</i> (Torisel)	T4	PA SP

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List of Prescription Medications

ANTINEOPLASTICS (Cancer) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ANTINEOPLASTIC - MICROTUBULE INHIBITORS		
TORISEL (<i>temsirolimus</i>)	T4	PA SP
ANTINEOPLASTIC - MTOR KINASE INHIBITORS		
everolimus 10 mg tablet (<i>Afinitor</i>)	T4	PA QL(1 tab/day) SP HD CSL
everolimus 7.5 mg tablet (<i>Afinitor</i>)	T4	PA QL(1 tab/day) SP HD CSL
ANTINEOPLASTIC - PROTEIN METHYLTRANSFERASE INHIBIT		
TAZVERIK	T4	PA SP
ANTINEOPLASTIC - TOPOISOMERASE I INHIBITORS		
CAMPTOSAR	T4	PA SP
CAMPTOSAR (<i>irinotecan hcl</i>)	T4	PA SP
HYCAMTIN 0.25 MG CAPSULE	T4	PA SP HD
HYCAMTIN 1 MG CAPSULE	T4	PA SP HD
HYCAMTIN 4 MG VIAL (<i>topotecan hcl</i>)	T4	PA SP HD
<i>irinotecan hcl</i>	T4	PA SP
<i>irinotecan hcl</i> (Camptosar)	T4	PA SP
ONIVYDE	T4	PA SP
<i>topotecan hcl</i>	T4	PA SP HD
<i>topotecan hcl</i> (Hycamtin)	T4	PA SP HD
ANTINEOPLASTIC - VEGF-A, B AND PLGF INHIBITORS		
ZALTRAP	T4	PA SP
ANTINEOPLASTIC - VEGFR ANTAGONIST		
CYRAMZA	T4	PA SP
ANTINEOPLASTIC - VINCA ALKALOIDS		
MARQIBO	T4	PA SP
NAVELBINE (<i>vinorelbine tartrate</i>)	T4	PA SP
<i>vinblastine sulfate</i>	T4	PA SP
<i>vincristine sulfate</i>	T4	PA SP
<i>vinorelbine tartrate</i> (Navelbine)	T4	PA SP
ANTINEOPLASTIC- CD22 ANTIBODY-CYTOTOXIC ANTIBIOTIC		
BESPONS	T4	PA SP
MYLOTARG	T4	PA SP
ANTINEOPLASTIC COMB - KINASE AND AROMATASE INHIBIT		
KISQALI FEMARA CO-PACK	T4	PA QL (1 pack/28 days) SP CSL
ANTINEOPLASTIC EGF RECEPTOR BLOCKER MCLON ANTIBODY		
ERBITUX	T4	PA SP

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List of Prescription Medications

ANTINEOPLASTICS (Cancer) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ANTINEOPLASTIC EGF RECEPTOR BLOCKER MCLON ANTIBODY (con't.)		
HERCEPTIN	T4	PA SP
HERCEPTIN HYLECTA	T4	PA SP
HERZUMA	T4	PA SP
KANJINTI	T4	PA SP
MARGENZA	T4	PA SP
OGIVRI	T4	PA SP
ONTRUZANT	T4	PA SP
PERJETA	T4	PA SP
PHESGO	T4	PA SP HD
PORTRAZZA	T4	PA SP
TRAZIMERA	T4	PA SP
VECTIBIX	T4	PA SP
ANTINEOPLASTIC IMMUNOMODULATOR AGENTS		
<i>lenalidomide</i>	T4	PA QL(1 cap/day) SP HD CSL
POMALYST	T4	PA SP HD
REVLIMID	T4	PA QL(1 tab/day) SP HD CSL
ANTINEOPLASTIC LHRH (GNRH) AGONIST, PITUITARY SUPPR.		
ELIGARD	T4	SP HD
<i>leuprolide acetate</i>	T4	PA SP HD
LEUPROLIDE DEPOT	T4	PA SP HD
TRELSTAR	T4	SP HD
ZOLADEX	T4	PA SP HD
FIRMAGON	T4	PA SP HD
ORGOVYX	T4	PA SP
ALECENSA	T4	PA QL(8 tabs/day) SP HD CSL
ALUNBRIG 30 MG TABLET	T4	PA QL(2 tabs/day) SP CSL
ALUNBRIG 90 MG TABLET	T4	PA QL(1 tab/day) SP CSL
ALUNBRIG 90 MG-180 MG TAB PACK	T4	PA QL(1 tab/day) SP CSL
ALUNBRIG 180 MG TABLET	T4	PA QL(1 tab/day) SP CSL
ALIQOPA	T4	PA SP
AYVAKIT	T4	PA QL (1 tab/day) SP
BALVERSA	T4	PA SP
BORTEZOMIB	T4	PA SP
BORUZU	T4	PA SP

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

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

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

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

List of Prescription Medications

ANTINEOPLASTICS (Cancer) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ANTINEOPLASTIC SYSTEMIC ENZYME INHIBITORS		
BOSULIF	T4	PA SP HD
BRUKINSA	T4	PA QL (4 caps/day) SP
CABOMETYX	T4	PA SP HD
CALQUENCE	T4	PA SP
CAPRELSA	T4	PA SP
COMETRIQ	T4	PA SP HD
COPIKTRA	T4	PA SP
<i>dasatinib 20 mg tablet (Sprycel)</i>	T4	PA QL (3 tabs/day) SP CSL
<i>dasatinib 70 mg tablet (Sprycel)</i>	T4	PA QL (2 tabs/day) SP CSL
<i>dasatinib 50 mg, 80 mg, 100 mg, 140 mg tablet (Sprycel)</i>	T4	PA QL (1 tab/day) SP CSL
DANZITEN	T4	PA SP CSL
ENSACOVE 25 MG CAPSULE	T4	PA QL (9 caps/day) SP CSL
ENSACOVE 100 MG CAPSULE	T4	PA QL (2 caps/day) SP CSL
<i>erlotinib hcl</i>	T4	PA SP HD CSL
EXKIVITY	T4	PA SP HD
FOTIVDA	T4	PA QL (30 caps/30 days) SP HD
FRUZAQLA 1 MG CAPSULE	T4	PA QL (84 caps/28 days) SP CSL
FRUZAQLA 5 MG CAPSULE	T4	PA QL (21 caps/28 days) SP CSL
GAVRETO	T4	PA QL (4 Tabs/Day) SP CSL
<i>gefitinib</i>	T4	PA SP HD CSL
GILOTRIF	T4	PA SP HD
GLEEVEC (<i>imatinib mesylate</i>)	T4	PA SP HD
IBRANCE	T4	PA QL (21 caps/28 days) SP HD CSL
<i>imatinib mesylate 100 mg tab (Gleevec)</i>	T4	QL (6 tabs/day) SP HD CSL
<i>imatinib mesylate 400 mg tab (Gleevec)</i>	T4	QL (2 tabs/day) SP HD CSL
IMBRUVICA	T4	PA SP
IMKELDI	T4	PA SP HD
INLYTA	T4	PA SP HD
INREBIC	T4	PA SP HD
IRESSA	T4	PA SP HD
ITOVEBI	T4	PA SP HD CSL
IWILFIN	T4	PA QL (8 tabs/day) SP CSL
KISQALI 600MG	T4	PA QL (63/28days) SP HD CSL
KISQALI 400MG	T4	PA QL (42/28days) SP HD CSL
KISQALI 200MG	T4	PA QL (21/28days) SP HD CSL
KYPROLIS	T4	PA SP HD

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AGE – Age Requirement

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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>lapatinib ditosylate</i> (Tykerb)	T4	PA SP HD
LENVIMA	T4	PA SP HD
LORBRENA	T4	PA SP HD
LYNPARZA	T4	PA SP HD
LYTGOBI 12 MG DAILY DOSE (3X 4MG TB)	T4	PA QL (3 tabs/day) SP CSL
LYTGOBI 16 MG DAILY DOSE (4X 4MG TB)	T4	PA QL (4 tabs/day) SP CSL
LYTGOBI 20 MG DAILY DOSE (5X 4MG TB)	T4	PA QL (5 tabs/day) SP CSL
NERLYNX	T4	PA SP HD
NEXAVAR	T4	PA SP HD
NINLARO	T4	PA SP HD
OGSIVEO 100 MG TABLET	T4	PA QL SP CSL
OGSIVEO 150 MG TABLET	T4	PA QL SP CSL
OGSIVEO 50 MG TABLET	T4	PA QL (6 Tabs/day) SP CSL
OJJAARA	T4	PA QL (1 tab/day) SP CSL
<i>pazopanib</i> (Votrient)	T4	PA QL (4 tabs/day) SP HD CSL
PEMAZYRE	T4	PA QL (14 tabs/21 days) SP
PIQRAY	T4	PA SP HD CSL
QINLOCK	T4	PA QL (3 tabs/day) SP
RETEVMO 40 MG CAPSULE	T4	PA QL (6 caps/day) SP HD
RETEVMO 80 MG CAPSULE	T4	PA QL (4 tabs/day) SP HD
RETEVMO 120 MG, 160 MG TABLET	T4	PA QL (2 tabs/day) SP HD CSL
ROMVIMZA	T4	PA QL (8 caps/28 days) SP CSL
REVUFORJ	T4	PA QL (2 tabs/day) SP CSL
ROZLYTREK	T4	PA SP HD
RUBRACA	T4	PA SP
RYDAPT	T4	PA SP HD
SCEMBLIX 20 MG TABLET	T4	PA QL (2 tablets/day) SP HD
SCEMBLIX 40 MG, 10 MG TABLET	T4	PA SP HD CSL
STIVARGA	T4	PA QL (84 tabs/28 days) SP HD CSL
TABRECTA	T4	PA QL (4 tabs/day) SP HD
TAGRISSO	T4	PA SP HD
TALZENNA	T4	PA SP HD
TEPMETKO	T4	PA QL (2 tabs/day) SP
TRUQAP	T4	PA QL (64 tabs/28 days) SP CSL
TUKYSA	T4	PA SP

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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.)		
TURALIO 125 MG CAPSULE	T4	PA QL (4 caps/day) SP CSL
TURALIO 200 MG CAPSULE	T4	PA SP CSL
TYKERB (<i>lapatinib</i>)	T4	PA SP HD
UKONIQ	T4	PA QL (4 tabs/day) SP
VELCADE	T4	PA SP
VERZENIO	T4	PA QL (120mg/day) SP HD
VITRAKVI	T4	PA SP HD
VIZIMPRO	T4	PA SP HD
XALKO CAPSULES	T4	PA QL (4 caps/day) SP HD CSL
XALKORI PELLETS	T4	PA QL (4 pellets/day) SP HD CSL
XOSPATA	T4	PA SP
ZEJULA	T4	PA SP
ZYDELIG	T4	PA SP HD
ANTINEOPLASTIC - SYSTEMIC ENZYME INHIBITORS COMBS		
AVMAPKI-FAKZYNJA	T4	PA SP CSL
ANTINEOPLASTIC, ANTI-PROGRAMMED DEATH-1 (PD-1) MAB		
KEYTRUDA	T4	PA SP
LIBTAYO	T4	PA SP
LOQTORZI	T4	PA SP
OPDIVO	T4	PA SP HD
TECENTRIQ HYBREZA	T4	PA SP
OPDIVO	T4	PA SP HD
TEVIMBRA	T4	PA SP
ZYNYZ	T4	PA SP
ANTINEOPLASTIC-B CELL LYMPHOMA-2 (BCL-2) INHIBITORS		
VENCLEXTA	T4	PA SP
VENCLEXTA STARTING PACK	T4	PA SP
ANTINEOPLASTIC-CD22 DIRECT ANTIBODY/CYTOTOXIN CONJ		
LUMOXITI	T4	PA SP
ANTINEOPLASTIC-INTERLEUKIN-6 (IL-6) INHIB, ANTIBODY		
SYLVANT	T4	PA SP
ANTINEOPLASTIC-ISOCITRATE DEHYDROGENASE INHIBITORS		
REZLIDHIA	T4	PA QL (2 caps/day) SP CSL
IDHIFA	T4	PA SP HD

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List of Prescription Medications

ANTINEOPLASTICS (Cancer) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ANTINEOPLASTIC-ISOCITRATE DEHYDROGENASE INHIBITORS (cont.)		
TIBSOVO	T4	PA SP
ANTINEOPLASTIC-ISOCITRATE DEHYDROGENASE INHIBITORS		
ADCETRIS	T4	PA SP
BLENREP	T3	PA
BLINCYTO	T4	PA SP
ANTINEOPLASTIC-ISOCITRATE DEHYDROGENASE INHIBITORS (cont.)		
ENHERTU	T4	PA SP HD
KADCYLA	T4	PA SP
PADCEV	T4	PA SP
POLIVY	T4	PA SP HD
POTELIGEO	T4	PA SP
TRODELVY	T4	PA SP
UNITUXIN	T4	PA SP
ZEVALIN	T4	PA SP
ANTINEOPLASTICS, MISCELLANEOUS		
ABRAXANE	T4	PA SP
ARSENIC TRIOXIDE	T4	PA SP
<i>arsenic trioxide (Trisenox)</i>	T4	PA SP
ASPARLAS	T4	SP
BCG (TICE STRAIN)	T4	SP
<i>dacarbazine</i>	T4	PA SP
DOCEFREZ	T4	PA SP
<i>docetaxel 160 mg/16 ml vial</i>	T4	PA SP
<i>docetaxel 160 mg/8 ml vial</i>	T4	PA SP HD
<i>docetaxel 20 mg/2 ml vial</i>	T4	PA SP
<i>docetaxel 20 mg/ml vial</i>	T4	PA SP
<i>docetaxel 80 mg/4 ml vial (Taxotere)</i>	T4	PA SP
<i>docetaxel 80 mg/8 ml vial (Docivyx)</i>	T4	PA SP
ERWINAZE	T4	PA SP
ETOPOPHOS	T4	PA SP
<i>etoposide</i>	T4	PA SP
<i>etoposide 1,000 mg/50 ml vial</i>	T4	PA SP
<i>etoposide 100 mg/5 ml vial</i>	T4	PA SP
<i>etoposide 50 mg capsule</i>	T4	SP HD
<i>etoposide 500 mg/25 ml vial</i>	T4	PA SP

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List of Prescription Medications

ANTINEOPLASTICS (Cancer) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ANTINEOPLASTICS, MISCELLANEOUS (cont.)		
JEVTANA	T4	PA SP HD
LYSODREN	T2	
MATULANE	T4	SP
<i>mitoxantrone hcl</i>	T4	PA SP
ONCASPAR	T4	PA SP
<i>paclitaxel</i>	T4	PA SP
PACLITAXEL PROTEIN-BOUND 100MG	T4	PA SP
TAXOTERE (<i>docetaxel</i>)	T4	PA SP
<i>tretinoin 10 mg capsule</i>	T1	PA
TRISENOX (<i>arsenic trioxide</i>)	T4	PA SP
ANTINEOPLASTIC-SELECT INHIB OF NUCLEAR EXP (SINE)		
XPOVIO	T4	PA SP
ANTI-PROGRAMMED CELL DEATH-LIGAND 1 (PD-L1) MAB		
BAVENCIO	T4	PA SP
IMFINZI	T4	PA SP
TECENTRIQ	T4	PA SP HD
CYTOTOXIC T-LYMPHOCYTE ANTIGEN (CTLA-4) RMC ANTIBODY		
IMJUDO	T4	PA SP HD
YERVOY	T4	PA SP HD
IMMUNOMODULATORS		
ACTIMMUNE	T4	PA SP HD
ALFERON N	T4	PA SP HD
PROLEUKIN	T4	PA SP
PHOTOACTIVATED, ANTINEOPLASTIC AGENTS (SYSTEMIC)		
PHOTOFRIN	T4	SP
UVADEX	T2	
RADIOACTIVE THERAPEUTIC AGENTS		
AZEDRA	T4	PA SP
SELECTIVE ESTROGEN RECEPTOR MODULATORS (SERMS)		
FARESTON (<i>toremifene citrate</i>)	T3	QL (2 tabs/day) HD
FASLODEX (<i>fulvestrant</i>)	T4	PA SP HD
<i>fulvestrant</i> (Faslodex)	T4	PA SP HD
SOLTAMOX	T2	HD
<i>tamoxifen citrate</i>	T1	HD PPACA
<i>toremifene citrate</i> (Fareston)	T1	QL (2 tabs/day) HD

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List of Prescription Medications

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

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List of Prescription Medications

ANTIPARKINSON DRUGS (Parkinson's Disease)		
ANTIPARKINSONISM DRUGS, ANTICHOLINERGIC		
<i>benztropine mesylate</i>	T1	HD
<i>trihexyphenidyl hcl</i>	T1	HD
ANTIPARKINSONISM DRUGS, OTHER		
<i>amantadine hcl</i>	T1	HD
APOKYN	T4	PA SP HD
AZILECT 0.5 MG TABLET (<i>rasagiline mesylate</i>)	T3	QL (1 tab/day) HD
AZILECT 1 MG TABLET (<i>rasagiline mesylate</i>)	T3	HD
<i>bromocriptine mesylate</i> (Parlodel)	T1	HD
<i>carbidopa/levodopa</i>	T1	HD
<i>carbidopa/levodopa</i> (Sinemet 10-100)	T1	HD
<i>carbidopa/levodopa</i> (Sinemet 25-100)	T1	HD
<i>carbidopa/levodopa</i> (Sinemet 25-250)	T1	HD
<i>carbidopa/levodopa/entacapone</i> (Stalevo 100)	T1	HD
<i>carbidopa/levodopa/entacapone</i> (Stalevo 125)	T1	HD
<i>carbidopa/levodopa/entacapone</i> (Stalevo 50)	T1	HD
<i>carbidopa/levodopa/entacapone</i> (Stalevo 75)	T1	HD
COMTAN (<i>entacapone</i>)	T3	HD
DUOPA	T3	SP HD
<i>entacapone</i> (Comtan)	T1	HD
INBRIJA	T4	PA SP HD
KYNMOBI	T2	PA HD
NEUPRO	T3	HD
NOURIANZ	T3	PA QL (1 tab/day) SP HD
OSMOLEX ER	T3	QL (1 tab/day) HD
OSMOLEX ER 258 MG TABLET	T3	QL (1 tab/day) HD
PARLODEL (<i>bromocriptine mesylate</i>)	T3	HD
<i>pramipexole di-hcl</i>	T1	HD

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List of Prescription Medications

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

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ANTIPARKINSONISM DRUGS, OTHER (cont.)		
<i>pramipexole er 0.375 mg tablet</i>	T1	QL (1 tab/day) HD
<i>pramipexole er 0.75 mg tablet</i>	T1	HD
<i>pramipexole er 1.5 mg tablet</i>	T1	QL (1 tab/day) HD
<i>pramipexole er 2.25 mg tablet</i>	T1	QL (1 tab/day) HD
<i>pramipexole er 3 mg tablet</i>	T1	HD
<i>pramipexole er 3.75 mg tablet</i>	T1	HD
<i>rasagiline mesylate 0.5 mg tab (Azilect)</i>	T1	QL (1 tab/day) HD
RYTARY	T3	HD
<i>selegiline hcl</i>	T1	HD
SINEMET 10-100 (<i>carbidopa-levodopa</i>)	T3	HD
SINEMET 25-100 (<i>carbidopa-levodopa</i>)	T3	HD
SINEMET 25-250 (<i>carbidopa-levodopa</i>)	T3	HD
STALEVO 100 (<i>carbidopa-levodopa-entacapone</i>)	T3	HD
STALEVO 125 (<i>carbidopa-levodopa-entacapone</i>)	T3	HD
STALEVO 50 (<i>carbidopa-levodopa-entacapone</i>)	T3	HD
STALEVO 75 (<i>carbidopa-levodopa-entacapone</i>)	T3	HD
TASMAR (<i>tolcapone</i>)	T3	HD
<i>tolcapone (Tasmar)</i>	T1	HD
XADAGO	T3	ST HD
DECARBOXYLASE INHIBITORS		
<i>carbidopa</i>	T1	
ANTIPLATELET DRUGS (Blood Thinners/Anti-Clotting)		
PLATELET AGGREGATION INHIBITORS		
AGGRASTAT	T3	HD
<i>aspirin/dipyridamole</i>	T1	HD
<i>cilostazol</i>	T1	HD
<i>clopidogrel bisulfate</i>	T1	HD
<i>clopidogrel bisulfate (Plavix)</i>	T1	HD
<i>dipyridamole 25 mg tablet</i>	T1	HD
<i>dipyridamole 50 mg/10 ml vial</i>	T1	

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List of Prescription Medications

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

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
PLATELET AGGREGATION INHIBITORS (cont.)		
dipyridamole 50 mg tablet	T1	HD
dipyridamole 75 mg tablet	T1	HD
EFFIENT (prasugrel hcl)	T3	HD
EPTIFIBATIDE	T1	HD
eptifibatide (Integrilin)	T1	HD
INTEGRILIN (eptifibatide)	T3	HD
PLAVIX (clopidogrel)	T3	HD
prasugrel hcl (Effient)	T1	HD
ticlopidine hcl	T1	HD
tirofiban-0.9% sodium chloride	T1	HD
PLATELET REDUCING AGENTS		
AGRYLIN (anagrelide hcl)	T3	
anagrelide hcl	T1	
anagrelide hcl (Agrylin)	T1	
ANTIVIRALS (AIDS/HIV)		
ANTIRETROVIRAL - ANTI-CD4 DOMAIN 2 MONOCLONAL AB		
TROGARZO	T4	PA SP
ANTIRETROVIRAL - CAPSID INHIBITORS		
SUNLENCA 4- 300 MG TABLET	T4	PA QL(5 tabs/180 days) SP
SUNLENCA 5- 300 MG TABLET	T4	PA QL(5 tabs/180 days) SP
SUNLENCA 463.5 MG/1.5 ML VIAL	T4	PA SP
ANTIRETROVIRAL-INTEGRASE INHIBITOR AND NNRTI COMB.		
CABENUVA	T4	PA SP
JULUCA	T4	SP
ANTIRETROVIRAL-INTEGRASE INHIBITOR AND NRTI COMB.		
DOVATO	T4	SP
ANTIRETROVIRAL-NRTIS AND INTEGRASE INHIBITORS COMB		
TRIUMEQ	T4	QL(1 tab/day) SP
TRIUMEQ PD	T4	QL(1 tab/day) SP
ANTIRETROVIRAL-NUCLEOSIDE, NUCLEOTIDE, PROTEASE INH.		
SYMTOZA	T4	SP
ANTIVIRALS, HIV-SPEC, NON-PEPTIDIC PROTEASE INHIB		
APTIVUS	T4	PA SP
darunavir ethanolate (Prezista)	T4	SP
PREZCOBIX	T4	PA SP

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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		
PREZISTA	T4	SP
ANTIVIRALS, HIV-SPEC, NUCLEOSIDE-NUCLEOTIDE ANALOG		
CIMDUO	T4	PA SP
DESCOVY	T4	SP PPACA
<i>emtricitabine-tenofv 100-150mg</i>	T4	SP
<i>emtricitabine-tenofv 133-200mg</i>	T4	SP
<i>emtricitabine-tenofv 167-250mg</i>	T4	SP
<i>emtricitabine-tenofv 200-300mg</i>	T4	SP PPACA
TEMIXYS	T4	PA SP
ANTIVIRALS, HIV-SPEC., NUCLEOSIDE ANALOG, RTI COMB		
<i>abacavir sulfate/lamivudine</i>	T4	PA SP
<i>abacavir/lamivudine/zidovudine</i>	T4	PA SP
<i>lamivudine/zidovudine</i>	T4	SP
ANTIVIRALS, HIV-SPECIFIC, CCR5 CO-RECEPTOR ANTAG.		
<i>maraviroc (Selzentry)</i>	T4	PA SP
SELZENTRY	T4	PA SP
ANTIVIRALS, HIV-SPECIFIC, CD4 ATTACHMENT INHIBITOR		
RUKOBIA	T4	PA QL (2 tablets/day) SP
ANTIVIRALS, HIV-SPECIFIC, FUSION INHIBITORS		
FUZEON	T4	PA SP
ANTIVIRALS, HIV-SPECIFIC, NON-NUCLEOSIDE, RTI		
EDURANT	T4	PA SP
<i>efavirenz</i>	T4	PA SP
<i>nevirapine</i>	T4	PA SP
PIFELTRO	T4	PA SP
ANTIVIRALS, HIV-SPECIFIC, NUCLEOSIDE ANALOG, RTI		
<i>abacavir sulfate</i>	T4	PA SP
<i>emtricitabine (Emtriva)</i>	T4	PA SP
EMTRIVA 10 MG/ML SOLUTION	T4	PA SP
<i>lamivudine 10 mg/ml oral soln</i>	T4	SP
<i>lamivudine 150 mg tablet</i>	T4	SP
<i>lamivudine 300 mg tablet</i>	T4	PA SP
RETROVIR	T4	PA SP
<i>zidovudine</i>	T4	SP

T1 – Typically Generics
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T4 – Specialty Medications
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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 (cont.)		
<i>tenofovir disoproxil fumarate</i>	T4	PA SP
VIREAD	T4	PA SP
ANTIVIRALS, HIV-SPECIFIC, PROTEASE INHIBITOR COMB		
<i>lopinavir/ritonavir</i>	T1	
ANTIVIRALS, HIV-SPECIFIC, PROTEASE INHIBITORS		
<i>atazanavir sulfate</i>	T4	PA SP
EVOTAZ	T4	PA SP
<i>fosamprenavir calcium</i>	T4	PA SP
LEXIVA	T4	PA SP
REYATAZ	T4	PA SP
<i>ritonavir</i>	T4	SP
ANTIVIRALS, HIV-I INTEGRASE STRAND TRANSFER INHIBTR		
APRETUDE	T4	PA SP
ISENTRISS	T4	SP
ISENTRISS HD	T4	PA SP
TIVICAY	T4	SP
TIVICAY PD	T4	SP
ARTV NUCLEOSIDE, NUCLEOTIDE, NON-NUCLEOSIDE RTI COMB		
DELSTRIGO	T4	PA SP
<i>efavirenz/emtricit/tenofovr df (Atripla)</i>	T4	PA SP
<i>efavirenz</i>	T4	PA SP
<i>efavirenz/lamivu/tenofov disop (Symfi Lo)</i>	T4	SP
<i>efavirenz/lamivu/tenofov disop (Symfi)</i>	T4	SP
<i>emtricit/rilpivirine/tenof df (Complera)</i>	T4	QL (1 tab/day) SP
ODEFSEY	T4	PA SP
ARV-NUCLEOSIDE, NUCLEOTIDE RTI, INTEGRASE INHIBITORS		
BIKTARVY	T4	SP
GENVOYA	T4	SP
STRIBILD	T4	PA SP
ANTIVIRALS (Eye Conditions)		
EYE ANTIVIRALS		
<i>trifluridine</i>	T1	
ZIRGAN	T3	

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List of Prescription Medications

ANTIVIRALS (Infections)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ANTIVIRAL MONOCLONAL ANTIBODIES		
SYNAGIS	T4	PA SP HD
ANTIVIRALS, GENERAL		
<i>acyclovir</i>	T1	
<i>acyclovir sodium</i>	T1	
<i>cidofovir</i>	T4	SP
CYTOVENE (<i>ganciclovir sodium</i>)	T4	SP
<i>famciclovir</i>	T1	
FLUMADINE (<i>rimantadine hcl</i>)	T3	
<i>foscarnet sodium</i> (Foscavir)	T1	
FOSCAVIR	T3	
FOSCAVIR (<i>foscarnet sodium</i>)	T3	
GANCICLOVIR 500MG/250ML BAG	T4	SP
<i>ganciclovir sodium</i>	T4	SP
<i>ganciclovir sodium</i> (Cytovene)	T4	SP
LIVTENCITY	T4	PA QL (4 tabs/day) SP
<i>oseltamivir 6 mg/ml suspension</i> (Tamiflu)	T1	QL (180ml/30 days)
<i>oseltamivir phos 30 mg capsule</i> (Tamiflu)	T1	QL (20 caps/30 days)
<i>oseltamivir phos 45 mg capsule</i> (Tamiflu)	T1	QL (10 caps/30 days)
<i>oseltamivir phos 75 mg capsule</i> (Tamiflu)	T1	QL (10 caps/30 days)
PREVMIS 240 MG TABLET	T4	SP HD
PREVMIS 240 MG/12 ML VIAL	T4	SP
PREVMIS 480 MG TABLET	T4	SP HD
PREVMIS 480 MG/24 ML VIAL	T4	SP
RAPIVAB	T3	
RELENZA	T3	QL (20/30 days)
<i>rimantadine hcl</i> (Flumadine)	T1	
TAMIFLU 30 MG CAPSULE (<i>oseltamivir phosphate</i>)	T3	QL (20/30 days)
TAMIFLU 45 MG CAPSULE (<i>oseltamivir phosphate</i>)	T3	QL (10/30 days)
TAMIFLU 6 MG/ML SUSPENSION (<i>oseltamivir phosphate</i>)	T3	QL (180ml/30 days)
TAMIFLU 75 MG CAPSULE (<i>oseltamivir phosphate</i>)	T3	QL (10/30 days)
<i>valganciclovir hcl</i>	T1	
VALTREX (<i>valacyclovir</i>)	T3	
XOFLUZA	T3	QL (2 tabs/30 days)

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List of Prescription Medications

ANTIVIRALS (Infections) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ANTIVIRAL - RNA POLYMERASE INHIBITOR		
LAGEVRIO (EUA)	T3	QL (1 pack/120 days)
HEP C - NS5A, NS3/4A, NUCLEOTIDE NS5B INHIB COMBO		
VOSEVI	T4	PA SP HD
HEP C VIRUS, NUCLEOTIDE ANALOG NS5B POLYMERASE INH		
SOVALDI 150 MG PELLET PACKET	T4	PA QL (1 tab/day) SP HD
SOVALDI 200 MG PELLET PACKET	T4	PA QL (1 tab/day) SP HD
SOVALDI 200 MG TABLET	T4	PA QL (1 tab/day) SP HD
SOVALDI 400 MG TABLET	T4	PA SP HD
HEP C VIRUS-NS5B POLYMERASE AND NS5A INHIB. COMBO.		
EPCLUSA 200 MG-50 MG TABLET	T4	PA QL (1 tab/Day) SP HD
EPCLUSA 400 MG-100 MG TABLET	T4	PA SP HD
HARVONI 33.75-150 MG PELLET PK	T4	PA QL (1 tab/day) SP HD
HARVONI 45-200 MG PELLET PACKT	T4	PA QL (1 tab/day) SP HD
HARVONI 45-200 MG TABLET	T4	PA QL (1 tab/day) SP HD
HARVONI 90-400 MG TABLET	T4	PA SP HD
HEPATITIS B TREATMENT AGENTS		
<i>adefovir dipivoxil</i> (Hepsera)	T4	SP HD
BARACLUDE	T4	SP HD
<i>entecavir 0.5 mg tablet</i>	T4	QL (1 tab/day) SP HD
<i>entecavir 1 mg tablet</i>	T4	SP HD
<i>EPIVIR HBV (lamivudine hbv)</i>	T4	SP
<i>lamivudine</i> (Epiriv Hbv)	T4	SP
VEMLIDY	T4	SP HD
PEGASYS	T4	PA SP HD
PEGINTRON	T4	PA SP HD
<i>ribasphere 200 mg capsule</i>	T4	SP HD
<i>ribasphere 200 mg tablet</i>	T4	SP HD
<i>ribasphere 400 mg tablet</i>	T4	SP
<i>ribasphere 600 mg tablet</i>	T4	SP
<i>ribasphere ribapak 200-400 mg</i>	T4	SP HD
RIBASPHERE RIBAPAK 400-400 mg	T4	SP HD
RIBASPHERE RIBAPAK 600-400 mg	T4	SP HD
RIBASPHERE RIBAPAK 600-600 mg	T4	SP HD
<i>ribavirin</i>	T4	SP HD

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ANTIVIRALS (Infections) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
HEPATITIS C VIRUS- NS5A AND NS3/4A INHIBITOR COMB		
ZEPATIER	T4	PA SP HD
RNA POLYMERASE INHIBITOR		
LAGEVRIO 200 MG CAP (EUA)	T2	QL (1 pack/120 days)
MOLNUPIRAVIR	T3	QL (1 pkg/120 days)
ANTIVIRALS (Skin Conditions)		
TOPICAL GENITAL WART-HPV TREATMENT AGENTS		
VEREGEN	T3	
AUTONOMIC DRUGS (Allergy/Nasal Sprays)		
ANAPHYLAXIS THERAPY AGENTS		
ADYPHREN	T1	
ADYPHREN AMP	T1	
epinephrine 0.15 mg auto-inject	T1	QL (2 packs/30 days)
EPINEPHRINE 0.3 MG AUTO-INJECT	T1	QL (2 packs/30 days)
epinephrine 0.3 mg auto-inject (Epinephrine)	T1	QL (2 packs/30 days)
EPINEPHRINE PROFESSIONAL EMS	T3	
EPINEPHRINE PROFESSIONAL KIT	T3	
EPINEPHRINESNAP-EMS	T3	
EPINEPHRINESNAP-V	T3	
AUTONOMIC DRUGS (Alzheimer's Disease)		
CHOLINESTERASE INHIBITORS		
ARICEPT (donepezil hcl)	T3	HD
BLOXIVERZ (neostigmine methylsulfate)	T3	
donepezil hcl	T1	HD
donepezil hcl (Aricept)	T1	HD
EXELON (rivastigmine)	T3	HD
galantamine er 16 mg capsule (Razadyne Er)	T1	HD
galantamine er 24 mg capsule (Razadyne Er)	T1	HD
galantamine er 8 mg capsule (Razadyne Er)	T1	QL (1 cap/day) HD
galantamine hbr	T1	HD
neostigmine methylsulfate (Bloxiverz)	T1	
neostigmine methylsulfate (Neostigmine Methylsulfate)	T1	HD
NEOSTIGMINE METHYLSULFATE	T1	
physostigmine salicylate	T1	

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

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
CHOLINESTERASE INHIBITORS (cont.)		
<i>pyridostigmine bromide</i>	T3	
<i>pyridostigmine bromide</i> (Mestinon)	T1	HD
RAZADYNE ER 16 MG CAPSULE (<i>galantamine er</i>)	T3	HD
RAZADYNE ER 24 MG CAPSULE (<i>galantamine er</i>)	T3	HD
RAZADYNE ER 8 MG CAPSULE (<i>galantamine er</i>)	T3	QL (1 cap/day) HD
<i>rivastigmine</i> (Exelon)	T1	HD
<i>rivastigmine tartrate</i>	T1	HD

AUTONOMIC DRUGS (Attention Deficit Hyperactivity Disorder)¹⁰

ADRENERGICS, AROMATIC, NON-CATECHOLAMINE		
ADDERALL (<i>dextroamphetamine-amphetamine</i>)	T3	PA ST
<i>amphetamine sulfate</i> (Evekeo)	T1	PA
<i>dextroamp/amphet</i> (Adderall Xr) (Mydayis)	T1	PA QL (1 cap/day)
<i>dextroamphetamine er 10 mg cap</i>	T1	PA QL (1 cap/day)
<i>dextroamphetamine er 15 mg cap</i>	T1	PA QL (3/day)
<i>dextroamphetamine er 5 mg cap</i>	T1	PA QL (1 cap/day)
<i>dextroamphetamine sulfate</i>	T1	PA
<i>dextroamph-amphet er cp</i> (Mydayis)	T1	QL
EVEKEO (<i>amphetamine sulfate</i>)	T3	PA ST
<i>lisdexamfetamine capsule</i> (Vyvanse)	T1	PA QL(1 cap/day)
<i>lisdexamfetamine tb chew</i> (Vyvanse)	T1	PA QL(1 cap/day)
<i>methamphetamine hcl</i>	T1	PA
XELSTRYM	T3	PA QL(1 patch/day)
ZENZEDI	T3	PA ST

AUTONOMIC DRUGS (Blood Pressure/Heart Medications)

ADRENERGIC VASOPRESSOR AGENTS		
<i>droxidopa</i> (Northera)	T4	SP HD
<i>midodrine hcl</i>	T1	
ALPHA-ADRENERGIC BLOCKING AGENTS		
DIBENZYLINE (<i>phenoxybenzamine hcl</i>)	T3	HD
<i>phenoxybenzamine hcl</i> (Dibenzyliline)	T1	HD
<i>phentolamine mesylate</i>	T1	HD

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List of Prescription Medications

AUTONOMIC DRUGS (Miscellaneous)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ADRENERGIC AGENTS, CATECHOLAMINES		
dopamine hcl	T1	
dopamine hcl in dextrose 5 %	T1	
epinephrine	T3	
epinephrine 1 mg/10 ml luerjet	T1	
epinephrine 1 mg/10 ml abbojct	T1	
epinephrine 1 mg/ml ampul/vial	T1	
epinephrine 30 mg/30 ml vial	T1	
epinephrine hcl in 0.9 % nacl	T1	
epinephrine hcl in 0.9 % nacl (Epinephrine Hcl-0.9% Nacl)	T1	
epinephrine hcl in dextrose 5%	T1	
epinephrine hcl in dextrose 5% (Epinephrine Hcl-d5w)	T1	
EPINEPHRINE HCL-0.9% NACL	T1	
EPINEPHRINE HCL-0.9% NACL (epinephrine hcl-0.9% nacl)	T1	
EPINEPHRINE HCL-D5W	T1	
EPINEPHRINE HCL-D5W (epinephrine hcl-d5w)	T1	
isoproterenol hcl	T1	
isoproterenol hcl (Isuprel)	T1	
ISUPREL	T3	
LEVOPHED (norepinephrine bitartrate)	T3	
LEVOPHED BITARTRATE (norepinephrine bitartrate)	T3	
norepinephrine bit/0.9 % nacl	T1	
norepinephrine bitartrate (Levophed Bitartrate)	T1	
norepinephrine bitartrate (Levophed)	T1	
norepinephrine bitartrate/d5w	T1	
NOREPINEPHRINE BITARTRATE-D5W	T1	
NEUROMUSCULAR BLOCKING AGENTS		
atracurium besylate	T1	
BOTOX 100 UNIT VIAL	T4	PA SP
BOTOX 200 UNIT VIAL	T4	PA SP HD
cisatracurium besylate (Nimbex)	T1	
DAXXIFY	T4	PA SP
DYSPORE	T4	PA SP HD
MIVACRON	T3	
MYOBLOC	T4	PA SP HD

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List of Prescription Medications

AUTONOMIC DRUGS (Miscellaneous) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
NEUROMUSCULAR BLOCKING AGENTS (cont.)		
NIMBEX (<i>cisatracurium besylate</i>)	T3	
<i>pancuronium bromide</i>	T1	
QUELICIN (<i>succinylcholine chloride</i>)	T3	
<i>rocuronium bromide</i>	T1	
<i>rocuronium bromide</i> (Rocuronium Bromide)	T1	
SUCCINYLCHOLINE CHLORIDE	T1	
<i>succinylcholine chloride</i> (Quelicin)	T1	
<i>succinylcholine chloride</i> (Quelicin)	T3	
<i>succinylcholine chloride</i> (Succinylcholine Chloride)	T1	
SUCCINYLCHOLINE CHLORIDE-NACL	T1	
<i>vecuronium bromide</i>	T1	
VECURONIUM BROMIDE-WATER	T1	
XEOMIN	T4	PA SP HD
AUTONOMIC DRUGS (Urinary Tract Conditions)		
PARASYMPATHETIC AGENTS		
<i>bethanechol chloride</i>	T1	HD
<i>cevimeline hcl</i> (Evoxac)	T1	HD
EVOXAC (<i>cevimeline hcl</i>)	T3	HD
<i>guanidine hcl</i>	T1	HD
<i>pilocarpine hcl</i> (Salagen)	T1	HD
SALAGEN (<i>pilocarpine hcl</i>)	T3	HD
BIOLOGICALS (Allergy/Nasal Sprays)		
ALLERGENIC EXTRACTS, THERAPEUTIC		
GRASTEK	T3	PA QL (1 tab/day)
ODACTRA	T3	PA QL (1 tab/day)
ORALAIR	T3	PA QL (1 tab/day)
RAGWITEK	T3	PA QL (1 tab/day)
BIOLOGICALS (Blood Pressure/Heart Medications)		
PLASMA KALLIKREIN INHIBITORS		
TAKHZYRO	T4	PA SP HD
BIOLOGICALS (Miscellaneous)		
ANTISERA		
HYPERRHO S-D	T4	SP

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List of Prescription Medications

BIOLOGICALS (Miscellaneous) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ANTISERA (cont.)		
MICRHOGAM ULTRA-FILTERED PLUS	T4	SP
RHOGAM ULTRA-FILTERED PLUS	T4	SP
RHOPHYLAC	T4	SP
WINRHO SDF	T4	SP HD
PKU TREATMENT AGENTS - PHENYLALANINE AMMONIA LYASE		
PALYNZIQ	T4	PA SP HD
BIOLOGICALS (Vaccines)		
COVID-19 VACCINES		
COMIRNATY	T3	PPACA
MODERNA COVID EUA	T3	PPACA
NOVAVAX	T3	PPACA
PFIZER COVIDEUA	T3	PPACA
SPIKEVAX 2023-2024	T3	PPACA
ENTERIC VIRUS VACCINES		
IPOL	T3	PPACA
ROTARIX	T3	PPACA
ROTATEQ	T3	PPACA
GRAM NEGATIVE COCCI VACCINES		
BEXSERO	T3	PPACA
MENACTRA	T3	PPACA
MENQUADFI	T3	PPACA
MENVEO A-C-Y-W-135-DIP	T3	PPACA
PENBRAYA	T3	PPACA
TRUMENBA	T3	PPACA
GRAM POSITIVE COCCI VACCINES		
CAPVAXIVE	T3	PPACA
PNEUMOVAX 23	T3	PPACA
PREVNAR 13	T3	PPACA
PREVNAR 20	T3	PPACA
INFLUENZA VIRUS VACCINES		
AFLURIA TRIVALENT	T2	PPACA
EZ FLU	T2	PPACA
FLUAD TRIVALENT	T2	PPACA

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List of Prescription Medications

BIOLOGICALS (Vaccines) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
INFLUENZA VIRUS VACCINES (cont.)		
FLUARIX TRIVALENT	T2	PPACA
FLUBLOK TRIVALENT	T2	PPACA
FLUCELVAX TRIVALENT	T2	PPACA
FLULAVAL TRIVALENT	T2	PPACA
FLUMIST TRIVALENT	T3	PPACA
FLUVIRIN	T2	PPACA
FLUZONE TRIVALENT	T2	PPACA
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
PROQUAD	T3	PPACA
QUADRACEL DTAP-IPV	T3	PPACA
TDVAX	T3	PPACA
TENIVAC	T3	PPACA
VAXELIS	T3	PPACA
VIRAL/TUMORIGENIC VACCINES		
ACAM2000	T3	PPACA
ENGRIX-B ADULT	T3	PPACA
ENGRIX-B PEDIATRIC-ADOLESCENT	T3	PPACA
ERVEBO (NATIONAL STOCKPILE)	T3	
GARDASIL 9	T3	PPACA

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BIOLOGICALS (Vaccines) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
VACCINE/TOXOID PREPARATIONS, COMBINATIONS (cont.)		
HEPLISAV-B	T3	PPACA
IXCHIQ	T3	PPACA
JYNNEOS	T3	PPACA
MRESVIA	T3	PPACA
PEDIARIX	T3	PPACA
RECOMBIVAX HB	T3	PPACA
SHINGRIX	T3	PPACA
TWINRIX	T3	PPACA
VARIVAX VACCINE	T3	PPACA
ZOSTAVAX	T3	PPACA
BLOOD (Blood Modifiers/Bleeding Disorders)		
AGENTS TO TX THROMBOTIC THROMBOCYTOPENIC PURPURA		
ADZYNMA	T4	PA SP
CABLIVI	T4	PA SP
ANTIFIBRINOLYTIC AGENTS		
AMICAR (<i>aminocaproic acid</i>)	T4	SP HD
<i>aminocaproic acid</i>	T4	SP HD
<i>aminocaproic acid</i> (Amicar)	T4	SP HD
CYKLOKAPRON (<i>tranexamic acid</i>)	T4	SP
FIBRYGA	T4	PA SP
LYSTEDA (<i>tranexamic acid</i>)	T4	SP
RIASTAP	T4	PA SP
<i>tranexamic acid</i>	T4	SP
<i>tranexamic acid in nacl,iso-os</i>	T4	SP
TRANEXAMIC ACID-NACL	T4	SP
TRANEXAMIC 1,000 MG/100ML-NACL	T4	SP
ANTIHEMOPHILIC FACTORS		
ALTUVILLO	T4	PA SP HD
COMPLEMENT (C3) INHIBITORS		
EMPAVELI	T4	PA SP
FABHALTA	T4	PA QL(2 caps/day) SP
VOYDEYA	T4	PA QL(1 packet/28 days) SP
BLOOD FACTORS, MISCELLANEOUS		
VONVENDI	T4	SP HD

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List of Prescription Medications

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

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
COAGULANTS		
<i>protamine sulfate</i>	T1	
FACTOR IX COMPLEX (PCC) PREPARATIONS		
KCENTRA	T4	SP
FACTOR X PREPARATIONS		
COAGADEX	T4	PA SP
CORIFACT	T4	PA SP
TRETEN	T4	PA SP
HEMOPHILIA TREATMENT AGENTS, NON-FACTOR REPLACEMENT		
ALHEMO PEN	T4	PA SP
HEMLIBRA	T4	PA SP HD
HYMPAVZI PEN	T4	PA SP
HUMAN MONOCLONAL ANTIBODY COMPLEMENT (C5) INHIBITOR		
SOLIRIS	T4	PA SP
ULTOMIRIS	T4	PA SP HD
PROTEIN C PREPARATIONS		
CEPROTIN	T4	PA SP
SICKLE CELL ANEMIA AGENTS		
ADAKVEO	T4	PA SP
DROXIA	T2	
TOPICAL HEMOSTATICS		
OXBRYTA 300MG TAB	T4	PA QL (5 tabs/day) SP
SIKLOS	T3	PA
ASTRINGYN	T3	
AVITENE	T3	
ENDO-AVITENE	T3	
EVICEL	T3	
<i>gelatin sponge, absorb/porcine</i> (Gelfoam)	T1	
GELFOAM	T3	
GELFOAM (<i>surgifoam</i>)	T3	
GELFOAM COMPRESSED	T3	
MONSEL'S	T3	
RAPLIXA	T3	
RECOTHROM	T3	
SURGIFOAM	T1	
SYRINGE AVITENE	T3	
TACHOSIL	T3	

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

T4 – Specialty Medications

PA – Prior Authorization

QL – Quantity Limit

ST – Step Therapy

AGE – Age Requirement

SP – Specialty Medication

HD – May require home delivery pharmacy

PPACA – No Cost-Share Preventive Medication

CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

BLOOD (Blood Modifiers/Bleeding Disorders) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
TOPICAL HEMOSTATICS (cont.)		
THROMBI-GEL	T3	
THROMBIN-JMI	T3	
THROMBI-PAD	T3	
ULTRAFOAM	T3	
BLOOD (Blood Thinners/Anti-Clotting)		
ANTICOAGULANT REVERSAL AGENT FOR FACTOR XA INHIB.		
ANDEXXA	T4	SP
ANTICOAGULANT REVERSAL AGENT, DIRECT THROMBIN INHIB		
PRAXBIND	T4	SP
HEMORRHEOLOGIC AGENTS		
<i>pentoxifylline</i>	T1	HD
THROMBOLYTIC - NUCLEOTIDE TYPE		
DEFITELIO	T4	PA SP
THROMBOLYTIC ENZYMES		
ACTIVASE	T3	
CATHFLO ACTIVASE	T3	
RETAVASE	T3	
TNKASE	T3	
BLOOD (Miscellaneous)		
CELL/GENE THERAPY AGENTS - HEMATOPOIETIC		
OMISIRGE	T3	
CARDIAC DRUGS (Blood Pressure/Heart Medications)		
ANTIANGINAL, ANTI-ISCHEMIC AGENTS, NON-HEMODYNAMIC		
RANEXA (<i>ranolazine er</i>)	T3	QL (4 tabs/day) HD
<i>ranolazine</i> (Ranexa)	T1	QL (4 tabs/day) HD
ANTIARRHYTHMICS		
<i>adenosine</i>	T1	HD
<i>amiodarone hcl</i>	T1	HD
AMIODARONE HCL-D5W	T1	HD
<i>bretylum tosylate</i>	T1	
CORVERT (<i>ibutilide fumarate</i>)	T3	PA
<i>disopyramide phosphate</i> (Norpac)	T1	HD
<i>dofetilide 125 mcg capsule</i> (Tikosyn)	T1	QL (8 caps/day) HD

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

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

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

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

List of Prescription Medications

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

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ANTIARRHYTHMICS (cont.)		
<i>dofetilide 250 mcg capsule</i> (Tikosyn)	T1	QL (4 caps/day) HD
<i>dofetilide 500 mcg capsule</i> (Tikosyn)	T1	QL (2 caps/day) HD
<i>flecainide acetate</i>	T1	HD
<i>ibutilide fumarate</i> (Corvert)	T1	
<i>lidocaine hcl/dextrose 5 %/pf</i>	T1	HD
<i>lidocaine hcl/pf</i>	T1	HD
<i>mexiletine hcl</i>	T1	HD
MULTAQ	T2	
NEXTERONE	T3	
NORPACE (<i>disopyramide phosphate</i>)	T3	PA HD
NORPACE CR	T3	HD
<i>pacerone 100 mg tablet</i>	T3	PA HD
<i>pacerone 200 mg tablet</i>	T1	HD
<i>pacerone 400 mg tablet</i>	T3	PA HD
<i>procainamide hcl</i>	T1	HD
<i>propafenone hcl</i>	T1	HD
<i>propafenone hcl</i> (Rythmol Sr)	T1	HD
<i>quinidine gluconate</i>	T1	HD
RYTHMOL SR (<i>propafenone hcl er</i>)	T3	PA HD
TIKOSYN 125 MCG CAPSULE (<i>dofetilide</i>)	T3	PA QL (8 caps/day) HD
TIKOSYN 250 MCG CAPSULE (<i>dofetilide</i>)	T3	PA QL (4 caps/day) HD
TIKOSYN 500 MCG CAPSULE (<i>dofetilide</i>)	T3	PA QL (2 caps/day) HD
XYLOCAINE IV	T3	
CALCIUM CHANNEL BLOCKING AGENTS		
ADALAT CC (<i>nifedipine er</i>)	T3	HD
<i>amlodipine besylate</i> (Norvasc)	T1	HD
CALAN SR (<i>verapamil er</i>)	T3	HD
CAMZYOS	T4	PA QL (30 caps/30 days) SP
CARDENE I.V. (<i>nicardipine hcl</i>)	T3	

T1 – Typically Generics

T2 – Typically Preferred Brands

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T4 – Specialty Medications

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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.)		
CARDIZEM LA 420 MG TABLET (<i>matzim la</i>)	T3	HD
CLEVIPREX	T3	
<i>diltiazem 24h er(la) 120 mg tb</i> (Cardizem La)	T1	QL(1 tab/day) HD
<i>diltiazem 24h er(la) 180 mg tb</i> (Cardizem La)	T1	HD
<i>diltiazem 24h er(la) 240 mg tb</i> (Cardizem La)	T1	HD
<i>diltiazem 24h er(la) 300 mg tb</i> (Cardizem La)	T1	HD
<i>diltiazem 24h er(la) 360 mg tb</i> (Cardizem La)	T1	HD
<i>diltiazem 24h er(la) 420 mg tb</i> (Cardizem La)	T1	HD
<i>diltiazem hcl</i> (Cardizem)	T1	HD
<i>diltiazem hcl</i> (Cardizem La)	T1	HD
<i>diltiazem hcl</i> (Tiazac)	T1	HD
DILTIAZEM HCL-0.7% NACL	T3	
DILTIAZEM HCL-0.9% NACL	T1	
<i>felodipine</i>	T1	HD
<i>isradipine</i>	T1	
<i>nicardipin 20mg/200ml-0.9%nacl</i>	T3	HD
<i>nicardipin 40mg/200ml-0.9%nacl</i>	T3	HD
NICARDIPINE 1 MG/10 ML-NS SYRG	T1	HD
<i>nicardipine hcl</i>	T1	HD
<i>nicardipine hcl</i> (Cardene I.V.)	T1	HD
NICARDIPINE HCL-D5W	T1	HD
<i>nifedipine</i>	T1	HD
<i>nifedipine</i> (Adalat Cc)	T1	HD
<i>nifedipine</i> (Procardia XI)	T1	HD
<i>nifedipine</i> (Procardia)	T1	HD
<i>nisoldipine er 17 mg tablet</i> (Sular)	T1	HD
<i>nisoldipine er 20 mg tablet</i>	T1	QL (1 tab/day) HD
<i>nisoldipine er 25.5 mg tablet</i>	T1	HD
<i>nisoldipine er 30 mg tablet</i>	T1	HD
<i>nisoldipine er 34 mg tablet</i> (Sular)	T1	HD
<i>nisoldipine er 40 mg tablet</i>	T1	HD
<i>nisoldipine er 8.5 mg tablet</i> (Sular)	T1	HD
NORLIQVA ORAL SOLN	T2	PA QL(10 mls/day) HD
NORVASC (<i>amlodipine besylate</i>)	T3	HD

T1 – Typically Generics

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T4 – Specialty Medications

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AGE – Age Requirement

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List of Prescription Medications

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

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
CALCIUM CHANNEL BLOCKING AGENTS (cont.)		
NYMALIZE	T3	
PROCARDIA (<i>nifedipine</i>)	T3	HD
SULAR (<i>nisoldipine</i>)	T3	HD
TIAZAC (<i>tiadylt er</i>)	T3	HD
<i>verapamil hcl</i>	T1	HD
<i>verapamil hcl</i> (Calan Sr)	T1	HD
<i>verapamil hcl</i> (Verelan Pm)	T1	HD
<i>verapamil hcl</i> (Verelan)	T1	HD
VERELAN (<i>verapamil hcl</i>)	T3	HD
VERELAN (<i>verapamil sr</i>)	T3	HD
VERELAN PM (<i>verapamil er pm</i>)	T3	HD
CARDIOPLEGIC SOLUTIONS		
CARDIOPLEGIA DEL NIDO FORMULA	T3	
CARDIOPLEGIA HIGH POTASSIUM	T3	
CARDIOPLEGIA IND 8:1 NON-ENRCH	T3	
CARDIOPLEGIA INDUCTION 4:1	T3	
CARDIOPLEGIA INDUCTION 8:1	T3	
CARDIOPLEGIA MAINTENANCE 4:1	T3	
CARDIOPLEGIA MAINTENANCE 8:1	T3	
CARDIOPLEGIA REPERFUSATE 4:1	T3	
<i>cardioplegic solution no. 1</i> (Plegisol)	T1	
PLEGISOL	T3	
DIGITALIS GLYCOSIDES		
<i>digoxin</i>	T1	HD
<i>digoxin</i> (Lanoxin)	T1	HD
LANOXIN	T3	HD
LANOXIN (<i>digoxin</i>)	T3	HD
LANOXIN PEDIATRIC	T3	HD
HEART RATE REDUCING, SA SELECTIVE I (F) CURRENT INH.		
CORLANOR 5 MG TABLET (<i>ivabradine hcl</i>)	T2	PA HD
CORLANOR 5 MG/5 ML ORAL SOLN	T4	PA SP HD
CORLANOR 7.5 MG TABLET (<i>ivabradine hcl</i>)	T2	PA HD
<i>ivabradine hcl</i> (Corlanor)	T1	PA HD
INOTROPIC DRUGS		
<i>dobutamine hcl</i>	T1	

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List of Prescription Medications

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

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
INOTROPIC DRUGS (cont.)		
<i>dobutamine hcl in dextrose 5 %</i>	T1	
<i>milrinone lactate</i>	T1	
<i>milrinone lactate/d5w</i>	T1	
VASODILATORS, CORONARY		
DILATRATE-SR	T3	HD
<i>isosorbide dinitrate</i>	T1	HD
MINITRAN	T1	HD
NITRO-DUR	T3	HD
<i>nitroglycerin (Nitro-dur)</i>	T1	HD
<i>nitroglycerin (Nitrolingual)</i>	T1	HD
<i>nitroglycerin (Nitromist)</i>	T1	HD
<i>nitroglycerin (Nitrostat)</i>	T1	HD
<i>nitroglycerin 50 mg/10 ml vial</i>	T1	
<i>nitroglycerin in 5 % dextrose</i>	T1	
NITROLINGUAL (<i>nitroglycerin</i>)	T3	HD
NITROMIST (<i>nitroglycerin</i>)	T3	HD
NITROSTAT (<i>nitroglycerin</i>)	T3	HD
SOLUBLE GUANYLATE CYCLASE (SGC) STIMULATOR		
VERQUVO	T2	PA QL(1 tab/day)
CARDIOVASCULAR (Allergy/Nasal Sprays)		
SYMPATHOMIMETIC AGENTS		
AKOVAZ	T3	
BIORPHEN	T3	
EPHEDRINE SULFATE	T1	
<i>ephedrine sulfate (Akovaz)</i>	T1	
EPHEDRINE SULFATE-0.9% NACL	T1	
EPHEDRINE SULFATE-NACL	T1	
IMMPHENTIV	T3	
<i>phenylephrine hcl (Vazculep)</i>	T1	
<i>phenylephrine hcl in 0.9% nacl (Phenylephrine Hcl-0.9% Nacl)</i>	T1	
<i>phenylephrine hcl/dextrose 5 %</i>	T1	
PHENYLEPHRINE HCL-0.9% NACL	T1	
PHENYLEPHRINE HCL-0.9% NACL (<i>phenylephrine hcl-0.9% nacl</i>)	T1	
PHENYLEPHRINE HCL-D5W	T1	

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

T4 – Specialty Medications

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List of Prescription Medications

CARDIOVASCULAR (Allergy/Nasal Sprays) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
SYMPATHOMIMETIC AGENTS (con't.)		
VAZCULEP (<i>phenylephrine hcl</i>)	T3	
CARDIOVASCULAR (Asthma/COPD/Respiratory)		
PULM ANTI-HTN, SOLUBLE GUANYLATE CYCLASE STIMULATOR		
ADEMPAS	T4	PA SP HD
PULM.ANTI-HTN, SEL.C-GMP PHOSPHODIESTERASE T5 INHIB		
REVATIO 10 MG/12.5 ML VIAL	T4	PA SP HD
<i>sildenafil citrate</i> (Revatio)	T4	PA SP HD
<i>tadalafil</i> (Adcirca)	T4	PA SP HD
PULMONARY ANTI-HTN, ENDOTHELIN RECEPTOR ANTAGONIST		
<i>ambrisentan</i> (Letairis)	T4	PA SP HD
<i>bosentan</i> (Tracleer)	T4	PA SP HD
LETAIRIS (<i>ambrisentan</i>)	T4	PA SP HD
OPSUMIT	T4	PA SP HD
TRACLEER 125 MG TABLET (<i>bosentan</i>)	T4	PA SP HD
TRACLEER 32 MG TABLET FOR SUSP	T4	PA SP HD
TRACLEER 62.5 MG TABLET (<i>bosentan</i>)	T4	PA SP HD
PULMONARY ANTIHYPER AGENT, ACTRIIA-FC		
WINREVAIR	T4	PA SP HD
PULMONARY ANTIHYPERTENSIVES, PROSTACYCLIN-TYPE		
<i>epoprostenol sodium</i>	T4	PA SP HD
<i>epoprostenol sodium 0.5 mg vI</i>	T4	PA SP HD
<i>epoprostenol sodium 0.5 mg vI</i> (Flolan)	T4	PA SP
<i>epoprostenol sodium 1.5 mg vI</i>	T4	PA SP HD
<i>epoprostenol sodium 1.5 mg vI</i> (Flolan)	T4	PA SP
FLOLAN	T4	PA SP
ORENITRAM ER	T4	PA SP HD
ORENITRAM MONTH 1 TITRATION KT	T4	PA QL (168 tabs/180 days) SP HD
ORENITRAM MONTH 2 TITRATION KT	T4	PA QL (336 tabs/180 days) SP HD
ORENITRAM MONTH 3 TITRATION KT	T4	PA QL (252 tabs/180 days) SP HD
REMODULIN (<i>treprostinil</i>)	T4	PA SP HD
<i>treprostinil sodium</i> (Remodulin)	T4	PA SP HD
TYVASO	T4	PA SP HD
TYVASO INSTITUTIONAL START KIT	T4	PA SP HD
TYVASO REFILL KIT	T4	PA SP HD

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

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

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

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

List of Prescription Medications

CARDIOVASCULAR (Asthma/COPD/Respiratory) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
PULMONARY ANTIHYPERTENSIVES, PROSTACYCLIN-TYPE (cont.)		
TYVASO STARTER KIT	T4	PA SP HD
UPTRAVI	T4	PA SP HD
VENTAVIS	T4	PA SP HD
VELETRI VIAL	T4	PA SP
YUTREPIA	T4	PA SP HD
PULMONARY HTN-ENDOTHELIN RECEPT ANTG-CGMP PDE5 INH		
OPSYNVI	T4	PA QL (1 tab/day) SP HD
CARDIOVASCULAR (Blood Pressure/Heart Medications)		
ACE INHIBITOR-CALCIUM CHANNEL BLOCKER COMBINATION		
<i>amlodipine besylate/benazepril</i>	T1	HD
PRESTALIA 14 MG-10 MG TABLET	T3	HD
PRESTALIA 3.5 MG-2.5 MG TABLET	T3	QL (1 tab/day) HD
ACE INHIBITOR-THIAZIDE OR THIAZIDE-LIKE DIURETIC		
PRESTALIA 7 MG-5 MG TABLET	T3	QL (1 tab/day) HD
<i>trandolapril/verapamil hcl</i>	T1	HD
<i>captopril-hctz 25-15 mg tablet</i>	T1	QL (3 tabs/day) HD
<i>captopril-hctz 25-25 mg tablet</i>	T1	QL (2 tabs/day) HD
<i>captopril-hctz 50-15 mg tablet</i>	T1	QL (3 tabs/day) HD
<i>captopril-hctz 50-25 mg tablet</i>	T1	QL (2 tabs/day) HD
<i>enalapril/hydrochlorothiazide</i>	T1	HD
<i>fosinopril/hydrochlorothiazide</i>	T1	HD
<i>lisinopril/hydrochlorothiazide</i>	T1	HD
<i>quinapril/hydrochlorothiazide</i>	T1	HD
ALPHA/BETA-ADRENERGIC BLOCKING AGENTS		
CARDURA (<i>doxazosin mesylate</i>)	T3	HD
CARDURA XL	T3	HD
<i>carvedilol</i> (Coreg)	T1	HD
<i>carvedilol er 10 mg capsule</i> (Coreg Cr)	T1	QL (1 cap/day) HD
<i>carvedilol er 20 mg capsule</i> (Coreg Cr)	T1	QL (1 cap/day) HD
<i>carvedilol er 40 mg capsule</i> (Coreg Cr)	T1	QL (1 cap/day) HD
<i>carvedilol er 80 mg capsule</i> (Coreg Cr)	T1	HD
COREG (<i>carvedilol</i>)	T3	ST HD
COREG CR 10 MG CAPSULE (<i>carvedilol er</i>)	T3	QL (1 cap/day) ST HD
COREG CR 20 MG CAPSULE (<i>carvedilol er</i>)	T3	QL (1 cap/day) ST HD
COREG CR 40 MG CAPSULE (<i>carvedilol er</i>)	T3	QL (1 cap/day) ST HD

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

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

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

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

List of Prescription Medications

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

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ALPHA/BETA-ADRENERGIC BLOCKING AGENTS (cont.)		
COREG CR 80 MG CAPSULE (<i>carvedilol er</i>)	T3	ST HD
<i>doxazosin mesylate</i> (Cardura)	T1	HD
LABELALOL HCL 10 MG/2 ML SYRNG	T3	
<i>labetalol hcl 100 mg tablet</i>	T1	
<i>labetalol hcl 100 mg/20 ml vl</i>	T1	
<i>labetalol hcl 20 mg/4 ml crpjt</i>	T1	
<i>labetalol hcl 20 mg/4 ml syrng</i>	T1	
<i>labetalol hcl 20 mg/4 ml vial</i>	T1	
<i>labetalol hcl 200 mg tablet</i>	T1	HD
<i>labetalol hcl 200 mg/40 ml vl</i>	T1	HD
<i>labetalol hcl 300 mg tablet</i>	T1	HD
MINIPRESS (<i>prazosin hcl</i>)	T3	HD
<i>prazosin hcl</i>	T1	
<i>terazosin hcl</i>	T1	HD
ANGIOTEN.RECEPTR ANTAG-CALCIUM CHANL BLKR-THIAZIDE		
<i>amlodipine/valsartan/hcthiazid</i>	T1	HD
<i>olmesartan/amlodipin/hcthiazid</i>	T1	HD
ANGIOTENSIN RECEPT-NEPRILYSIN INHIBITOR COMB (ARNI)		
ENTRESTO SPRINKLE	T3	QL (2 tabs/day)
ANGIOTENSIN RECEPTOR ANTAG.-THIAZIDE DIURETIC COMB		
<i>candesartan/hydrochlorothiazid</i>	T1	HD
<i>irbesartan/hydrochlorothiazide</i>	T1	HD
<i>losartan/hydrochlorothiazide</i>	T1	HD
<i>olmesartan-hctz 20-12.5 mg tab</i>	T1	QL (1 tab/day) HD
<i>olmesartan-hctz 40-12.5 mg tab</i>	T1	HD
<i>olmesartan-hctz 40-25 mg tab</i>	T1	HD
<i>telmisartan-hctz 40-12.5 mg tb</i>	T1	QL (1 tab/day) HD
<i>telmisartan-hctz 80-12.5 mg tb</i>	T1	HD
<i>telmisartan-hctz 80-25 mg tab</i>	T1	HD
<i>valsartan/hydrochlorothiazide (Diovan Hct)</i>	T1	HD
ANGIOTENSIN RECEPTOR BLOCKR-CALCIUM CHANNEL BLOCKR		
<i>amlodipine besylate/valsartan</i>	T1	HD
<i>amlodipine-olmesartan 10-20 mg</i>	T1	HD
<i>amlodipine-olmesartan 10-40 mg</i>	T1	HD
<i>amlodipine-olmesartan 5-20 mg</i>	T1	QL (1 tab/day) HD

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

T4 – Specialty Medications

PA – Prior Authorization

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AGE – Age Requirement

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List of Prescription Medications

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

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ANGIOTENSIN RECEPTOR BLOCKER-CALCIUM CHANNEL BLOCKER (cont.)		
<i>amlodipine-olmesartan 5-40 mg</i>	T1	HD
<i>telmisartan-amlodipine 40-10</i>	T1	HD
<i>telmisartan-amlodipine 40-5 mg</i>	T1	QL (1 tab/day) HD
<i>telmisartan-amlodipine 80-10</i>	T1	HD
<i>telmisartan-amlodipine 80-5 mg</i>	T1	HD
ANTIHYPERTENSIVES, ACE INHIBITORS		
<i>benazepril hcl</i>	T1	HD
<i>captopril</i>	T1	HD
<i>enalapril maleate (Vasotec)</i>	T1	HD
<i>enalaprilat dihydrate</i>	T1	
<i>fosinopril sodium</i>	T1	HD
<i>lisinopril (Zestril)</i>	T1	HD
<i>moexipril hcl</i>	T1	HD
<i>perindopril erbumine</i>	T1	HD
<i>quinapril hcl</i>	T1	HD
<i>ramipril</i>	T1	HD
<i>trandolapril</i>	T1	HD
ANTIHYPERTENSIVES, ANGIOTENSIN RECEPTOR ANTAGONIST		
<i>candesartan cilexetil</i>	T1	HD
<i>eprosartan mesylate</i>	T1	HD
<i>irbesartan</i>	T1	HD
<i>losartan potassium</i>	T1	HD
<i>olmesartan medoxomil 20 mg tab</i>	T1	QL (1 tab/day) HD
<i>olmesartan medoxomil 40 mg tab</i>	T1	HD
<i>olmesartan medoxomil 5 mg tab</i>	T1	HD
<i>telmisartan 20 mg tablet</i>	T1	QL (1 tab/day) HD
<i>telmisartan 40 mg tablet</i>	T1	QL (1 tab/day) HD
<i>telmisartan 80 mg tablet</i>	T1	HD
<i>valsartan</i>	T1	HD
ANTIHYPERTENSIVES, GANGLIONIC BLOCKERS		
VECAMYL	T1	
ANTIHYPERTENSIVES, MISCELLANEOUS		
DEMSE (metyrosine)	T3	HD
<i>metyrosine (Demser)</i>	T1	HD

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

T4 – Specialty Medications

PA – Prior Authorization

QL – Quantity Limit

ST – Step Therapy

AGE – Age Requirement

SP – Specialty Medication

HD – May require home delivery pharmacy

PPACA – No Cost-Share Preventive Medication

CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

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

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ANTIHYPERTENSIVES, MISCELLANEOUS (cont.)		
<i>nitroprusside sodium</i> (Nitropress)	T1	
ANTIHYPERTENSIVES, SYMPATHOLYTIC		
CATAPRES-TTS 1 (<i>clonidine</i>)	T3	HD
CATAPRES-TTS 2 (<i>clonidine</i>)	T3	HD
CATAPRES-TTS 3 (<i>clonidine</i>)	T3	HD
<i>clonidine</i> (Catapres-tts 1)	T1	HD
<i>clonidine</i> (Catapres-tts 2)	T1	HD
<i>clonidine</i> (Catapres-tts 3)	T1	HD
<i>clonidine hcl 0.1 mg tablet</i> (Catapres)	T1	HD
<i>clonidine hcl 0.2 mg tablet</i>	T1	HD
<i>clonidine hcl 0.3 mg tablet</i> (Catapres)	T1	HD
<i>guanfacine hcl</i>	T1	HD
<i>methyldopa</i>	T1	HD
<i>methyldopa/hydrochlorothiazide</i>	T1	HD
<i>methyldopate hcl</i>	T1	
ANTIHYPERTENSIVES, VASODILATORS		
CORLOPAM	T3	HD
<i>hydralazine hcl</i>	T1	HD
<i>minoxidil</i>	T1	HD
BETA-ADRENERGIC BLOCKING AGENTS		
<i>acebutolol hcl</i>	T1	HD
<i>atenolol</i> (Tenormin)	T1	HD
<i>betaxolol hcl</i>	T1	HD
<i>bisoprolol fumarate</i>	T1	HD
BREVIBLOC	T3	
<i>esmolol hcl</i>	T1	
<i>esmolol hcl</i> (Brevibloc)	T1	
ESMOLOL HCL-WATER	T1	
<i>esmolol in sodium chloride, iso</i> (Brevibloc)	T1	HD
INNOPRAN XL	T3	ST HD
<i>metoprolol succinate</i> (Toprol XL)	T1	HD
<i>metoprolol tartrate</i>	T1	HD

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

T4 – Specialty Medications

PA – Prior Authorization

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ST – Step Therapy

AGE – Age Requirement

SP – Specialty Medication

HD – May require home delivery pharmacy

PPACA – No Cost-Share Preventive Medication

CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

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

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

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

T4 – Specialty Medications

PA – Prior Authorization

QL – Quantity Limit

ST – Step Therapy

AGE – Age Requirement

SP – Specialty Medication

HD – May require home delivery pharmacy

PPACA – No Cost-Share Preventive Medication

CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

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

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
VASODILATORS, PERIPHERAL (cont.)		
<i>isoxsuprine hcl</i>	T1	
<i>papaverine hcl</i>	T1	
CARDIOVASCULAR (Cholesterol Medications)		
ANTIHYPERLIPID:HMG COA REDUCT INHIB-CHOLEST.AB.INHIB		
<i>ezetimibe/simvastatin</i>	T1	HD
ANTIHYPERLIPID- HMG-COA RI-CALCIUM CHANNEL BLOCKER		
<i>amlodipine-atorvast 10-40 mg (Caduet)</i>	T1	HD
<i>amlodipine-atorvast 10-80 mg (Caduet)</i>	T1	HD
<i>amlodipine-atorvast 2.5-10 mg</i>	T1	HD
<i>amlodipine-atorvast 2.5-20 mg</i>	T1	QL (1 tab/day) HD
<i>amlodipine-atorvast 2.5-40 mg</i>	T1	QL (1 tab/day) HD
<i>amlodipine-atorvast 5-10 mg (Caduet)</i>	T1	HD
<i>amlodipine-atorvast 5-20 mg (Caduet)</i>	T1	QL (1 tab/day) HD
<i>amlodipine-atorvast 5-40 mg (Caduet)</i>	T1	QL (1 tab/day) HD
<i>amlodipine-atorvast 5-80 mg (Caduet)</i>	T1	HD
CADUET 10 MG-10 MG TABLET (<i>amlodipine-atorvastatin</i>)	T3	HD
CADUET 10 MG-20 MG TABLET (<i>amlodipine-atorvastatin</i>)	T3	HD
CADUET 10 MG-40 MG TABLET (<i>amlodipine-atorvastatin</i>)	T3	HD
CADUET 10 MG-80 MG TABLET (<i>amlodipine-atorvastatin</i>)	T3	HD
CADUET 5 MG-10 MG TABLET (<i>amlodipine-atorvastatin</i>)	T3	HD
CADUET 5 MG-20 MG TABLET (<i>amlodipine-atorvastatin</i>)	T3	QL (1 tab/day) HD
CADUET 5 MG-40 MG TABLET (<i>amlodipine-atorvastatin</i>)	T3	QL (1 tab/day) HD
CADUET 5 MG-80 MG TABLET (<i>amlodipine-atorvastatin</i>)	T3	HD
ANTIHYPERLIPIDEMIC - ANGIOPOIETIN-LIKE 3 INHIBITOR		
EVKEEZA	T3	PA SP
ANTIHYPERLIPIDEMIC - APO B-100 SYNTHESIS INHIBITOR		
KYNAMRO	T3	PA SP
ANTIHYPERLIPIDEMIC - PCSK9 INHIBITORS		
REPATHA PUSHTRONEX	T2	
REPATHA SURECLICK	T2	
REPATHA SYRINGE	T2	
ANTIHYPERLIPIDEMIC-HMGCOA REDUCTASE INHIB (STATINS)		
<i>atorvastatin 10 mg tablet</i>	T1	HD PPACA
<i>atorvastatin 20 mg tablet</i>	T1	HD PPACA

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

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

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

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

List of Prescription Medications

CARDIOVASCULAR (Cholesterol Medications) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ANTIHYPERTENSIVE-HMGCOA REDUCTASE INHIB (STATINS) (cont.)		
<i>atorvastatin 40 mg tablet</i>	T1	HD
<i>atorvastatin 80 mg tablet</i>	T1	HD
<i>fluvastatin sodium</i>	T1	HD PPACA
<i>lovastatin 10 mg tablet</i>	T1	HD
<i>lovastatin 20 mg tablet</i>	T1	HD PPACA
<i>lovastatin 40 mg tablet</i>	T1	HD PPACA
<i>pitavastatin 1 mg tablet (Livalo)</i>	T1	QL (1 tab/day) HD PPACA
<i>pitavastatin 2 mg tablet (Livalo)</i>	T1	QL (1 tab/day) HD PPACA
<i>pitavastatin 4 mg tablet (Livalo)</i>	T1	HD PPACA
<i>pravastatin sodium</i>	T1	HD PPACA
<i>rosuvastatin calcium 10 mg tab</i>	T1	QL (1 tab/day) HD PPACA
<i>rosuvastatin calcium 20 mg tab (Crestor)</i>	T1	QL (1 tab/day) HD
<i>rosuvastatin calcium 40 mg tab (Crestor)</i>	T1	HD
<i>rosuvastatin calcium 5 mg tab</i>	T1	QL (1 tab/day) HD PPACA
<i>simvastatin 10 mg tablet</i>	T1	HD PPACA
<i>simvastatin 20 mg tablet</i>	T1	HD PPACA
<i>simvastatin 40 mg tablet</i>	T1	HD PPACA
<i>simvastatin 5 mg tablet</i>	T1	HD
BILE SALT SEQUESTRANTS		
<i>cholestyramine (with sugar) (Questran)</i>	T1	HD
<i>cholestyramine/aspartame</i>	T1	HD
<i>cholestyramine/aspartame (Questran Light)</i>	T1	HD
<i>colesevelam hcl (Welchol)</i>	T1	HD
COLESTID	T3	HD
COLESTID (<i>colestipol hcl</i>)	T3	HD
<i>colestipol hcl (Colestid)</i>	T1	HD
QUESTRAN (<i>cholestyramine</i>)	T3	HD
QUESTRAN LIGHT (<i>prevalite</i>)	T3	HD
LIPOTROPICS		
<i>ezetimibe (Zetia)</i>	T1	HD
<i>fenofibrate</i>	T1	HD
<i>fenofibrate nanocrystallized (Tricor)</i>	T1	HD
<i>fenofibrate, micronized</i>	T1	HD
<i>fenofibrate 120 mg tablet (Fenoglide)</i>	T1	HD

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

T4 – Specialty Medications

PA – Prior Authorization

QL – Quantity Limit

ST – Step Therapy

AGE – Age Requirement

SP – Specialty Medication

HD – May require home delivery pharmacy

PPACA – No Cost-Share Preventive Medication

CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

CARDIOVASCULAR (Cholesterol Medications) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
LIPOTROPICS (cont.)		
<i>fenofibrate 40 mg tablet (Fenoglide)</i>	T1	HD
<i>fenofibric acid (choline) (Trilipix)</i>	T1	HD
<i>fenofibric acid (Fibricor)</i>	T1	HD
FIBRICOR (<i>fenofibric acid</i>)	T3	ST HD
<i>gemfibrozil (Lopid)</i>	T1	HD
LIPOFEN	T3	ST HD
LOPID (<i>gemfibrozil</i>)	T3	HD
<i>niacin (Niaspan)</i>	T1	HD
NIASPAN (<i>niacin er</i>)	T3	HD
TRICOR (<i>fenofibrate</i>)	T3	ST HD
TRIGLIDE	T3	ST HD
TRILIPIX (<i>fenofibric acid</i>)	T3	ST HD
ZETIA (<i>ezetimibe</i>)	T3	HD

CARDIOVASCULAR (Miscellaneous)

ENDOTHELIN-ANGIOTENSIN RECEPTOR ANTAGONIST		
FILSPARI	T4	PA QL(1 tab/day) SP
VENOSCLEROSING AGENTS		
ASCLERA	T4	PA SP
ETHAMOLIN	T3	
<i>sodium tetradecyl sulfate (Sotradecol)</i>	T1	
SOTRADECOL	T3	
SOTRADECOL (<i>sodium tetradecyl sulfate</i>)	T3	

CNS DRUGS (Alzheimer's Disease)

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

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

T4 – Specialty Medications

PA – Prior Authorization

QL – Quantity Limit

ST – Step Therapy

AGE – Age Requirement

SP – Specialty Medication

HD – May require home delivery pharmacy

PPACA – No Cost-Share Preventive Medication

CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

CNS DRUGS (Alzheimer's Disease) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ALZHEIMER'S THERAPY, NMDA RECEPTOR ANTAGONISTS (cont.)		
NAMZARIC 28 MG-10 MG CAPSULE	T3	QL (2 caps/day) HD
NAMZARIC 7 MG-10 MG CAPSULE	T3	QL (2 caps/day) HD
NAMZARIC TITRATION PACK	T3	QL (112/365 days) HD
AMYLOID DIRECTED MONOCLONAL ANTIBODY		
ADUHELM	T4	PA SP
CNS DRUGS (Miscellaneous)		
ALCOHOL, SYSTEMIC USE		
ALCOHOL, DEHYDRATED	T1	
<i>ethyl alcohol</i>	T1	
AMYOTROPHIC LATERAL SCLEROSIS AGENTS		
<i>edaravone</i>	T4	PA SP
QALSODY	T3	
RADICAVA ORS	T4	PA SP QL(50ml/28days)
RADICAVA	T4	PA SP
RILUTEK (<i>riluzole</i>)	T4	SP HD
<i>riluzole</i> (Rilutek)	T4	SP HD
TIGLUTIK	T4	PA SP
CENTRAL NERVOUS SYSTEM STIMULANTS		
DOPRAM	T3	
<i>doxapram hcl</i> (Dopram)	T1	
DRUGS TO TREAT MOVEMENT DISORDERS		
AUSTEDO	T4	PA SP HD
AUSTEDO XR	T4	PA QL SP HD
AUSTEDO XR TITRATION KT(WK1-4)	T4	PA QL(1 kit/180 days) SP HD
AUSTEDO XR 6MG	T4	PA QL(1 tab/day) SP HD
AUSTEDO XR 12MG	T4	PA QL(2 tabs/day) SP HD
AUSTEDO XR 18 MG TABLET	T4	PA QL(1 tab/day) SP HD
AUSTEDO XR 24MG	T4	PA QL(3 tabs/day) SP HD
INGREZZA	T4	PA QL(1 tab/day) SP
INGREZZA INITIATION PACK (TARDIV)	T4	PA QL (28 caps/year) SP
<i>tetrabenazine</i>	T4	PA SP HD
PSEUDOBULBAR AFFECT (PBA) AGENTS, NMDA ANTAGONISTS		
NUEDEXTA	T3	QL (4 caps/day)
XANTHINES		
CAFCIT (<i>caffeine citrate</i>)	T3	HD

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

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

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

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

CNS DRUGS (Miscellaneous) (cont.)			
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits	
XANTHINES (cont.)			
CAFFEINE AND SODIUM BENZOATE	T1	HD	
caffeine citrate (Cafcit)	T1	HD	
caffeine/sodium benzoate (Caffeine And Sodium Benzoate)	T1	HD	
CNS DRUGS (Multiple Sclerosis)			
AGENTS TO TREAT MULTIPLE SCLEROSIS			
AVONEX	T4	PA SP HD	
AVONEX PEN	T4	PA SP HD	
BAFIERTAM	T4	PA SP HD	
BETASERON	T4	PA SP HD	
BRIUMVI	T4	PA SP	
dimethyl fumarate	T1	HD	
glatopa	T1	HD	
glatiramer	T1	HD	
glatiramer acetate	T4	PA SP HD	
KESIMPTA PEN	T4	PA SP HD	
LEMTRADA	T4	PA SP HD	
MAVENCLAD	T4	PA SP HD	
MAYZENT	T4	PA SP HD	
OCREVUS	T4	PA SP	
PLEGRIDY	T4	PA SP HD	
PLEGRIDY PEN	T4	PA SP HD	
PONVORY	T4	PA SP HD	
REBIF	T4	PA SP HD	
REBIF REBIDOSE	T4	PA SP HD	
teriflunomide (Aubagio)	T4	SP HD	
VUMERITY	T4	PA SP HD	
AGTS TX NEUROMUSC TRANSMISSION DIS, POT-CHAN BLKR			
dalfampridine	T4	PA SP HD	
FIRDAPSE	T4	PA QL (8 tabs/day) SP	
RUZURGI	T4	PA SP	
CNS DRUGS (Pain Relief And Inflammatory Disease)			
CALCITONIN GENE-RELATED PEPTIDE (CGRP) INHIBITORS			
EMGALITY SYRINGE	T2	PA	
SPHINGOSINE 1-PHOSPHATE (SIP) RECEPTOR MODULATOR			
VELSIPITY	T4	PA QL(30 tabs/30 days) SP HD	
T1 – Typically Generics	T4 – Specialty Medications	ST – Step Therapy	HD – May require home delivery pharmacy
T2 – Typically Preferred Brands	PA – Prior Authorization	AGE – Age Requirement	PPACA – No Cost-Share Preventive Medication
T3 – Typically Non-Preferred Brands	QL – Quantity Limit	SP – Specialty Medication	CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

CNS DRUGS (Seizure Disorders)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ANTICONVULSANT - BENZODIAZEPINE TYPE		
<i>clobazam</i> (Onfi)	T1	HD
<i>clonazepam</i>	T1	HD
<i>clonazepam</i> (Klonopin)	T1	HD
DIASTAT (<i>diazepam</i>)	T3	PA HD
<i>diazepam 10 mg rectal gel syst</i> (Diastat Acudial)	T1	HD
<i>diazepam 2.5 mg rectal gel sys</i> (Diastat)	T1	HD
<i>diazepam 20 mg rectal gel syst</i>	T1	HD
KLONOPIN (<i>clonazepam</i>)	T3	PA HD
NAYZILAM	T2	PA QL (5 kits/30 days) HD
ONFI (<i>clobazam</i>)	T3	PA HD
VALTOCO	T2	PA QL (5 boxes/30 Days) HD
ANTICONVULSANT - CANNABINOID TYPE		
EPIDIOLEX	T4	PA SP HD
ANTICONVULSANTS		
BRIVIACT 10 MG TABLET	T3	PA HD
BRIVIACT 10 MG/ML ORAL SOLN	T3	PA HD
BRIVIACT 100 MG TABLET	T3	PA HD
BRIVIACT 25 MG TABLET	T3	PA HD
BRIVIACT 50 MG TABLET	T3	PA HD
BRIVIACT 50 MG/5 ML VIAL	T3	HD
BRIVIACT 75 MG TABLET	T3	PA HD
<i>carbamazepine</i>	T1	HD
<i>carbamazepine</i> (Carbatrol)	T1	HD
<i>carbamazepine</i> (Tegretol Xr)	T1	HD
<i>carbamazepine</i> (Tegretol)	T1	HD
CARBATROL (<i>carbamazepine er</i>)	T3	PA HD
CELONTIN	T2	HD
CEREBYX (<i>fosphenytoin sodium</i>)	T3	
DIACOMIT	T4	PA SP HD
DILANTIN 100 MG CAPSULE (<i>phenytoin sodium extended</i>)	T3	PA HD

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

T4 – Specialty Medications

PA – Prior Authorization

QL – Quantity Limit

ST – Step Therapy

AGE – Age Requirement

SP – Specialty Medication

HD – May require home delivery pharmacy

PPACA – No Cost-Share Preventive Medication

CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

CNS DRUGS (Seizure Disorders) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ANTICONVULSANTS (cont.)		
DILANTIN 30 MG CAPSULE	T2	PA HD
DILANTIN 50 MG INFATAB (<i>phenytoin</i>)	T3	PA HD
DILANTIN-125 (<i>phenytoin</i>)	T3	PA HD
<i>divalproex sodium</i> (Depakote Er)	T1	HD
<i>divalproex sodium</i> (Depakote Sprinkle)	T1	HD
<i>divalproex sodium</i> (Depakote)	T1	HD
<i>ethosuximide</i> (Zarontin)	T1	HD
<i>felbamate</i>	T1	HD
FINTEPLA	T4	PA SP HD
<i>fosphephenytoin sodium</i> (Cerebyx)		
FYCOMPA 0.5 MG/ML ORAL SUSP	T2	PA HD
<i>gabapentin</i> (Gralise)	T1	HD
<i>gabapentin</i> (Neurontin)	T1	HD
KEPPRA (<i>levetiracetam</i>)	T3	HD
<i>lacosamide</i> (Vimpat)	T1	HD
<i>lamotrigine</i>	T1	HD
<i>levetiracetam</i> (Keppra)	T1	HD
<i>levetiracetam in nacl (iso-os)</i>	T1	
LEVETIRACETAM-NACL 250 MG/50ML		
LYRICA (<i>pregabalin</i>)	T3	PA HD
NEURONTIN (<i>gabapentin</i>)	T3	PA HD
<i>oxcarbazepine</i>	T1	PA HD
OXTELLAR XR (<i>Oxtellar Xr</i>)	T3	PA HD
PEGANONE	T2	HD
PHENYTEK (<i>phenytoin sodium extended</i>)	T3	PA HD
<i>phenytoin</i>	T1	HD
<i>phenytoin</i> (Dilantin)	T1	HD
<i>phenytoin</i> (Dilantin-125)	T1	HD
<i>phenytoin sodium</i>	T1	HD
<i>phenytoin sodium extended</i> (Dilantin)	T1	HD
<i>phenytoin sodium extended</i> (Phenytek)	T1	HD
<i>pregabalin</i>	T1	HD
<i>pregabalin</i> (Lyrica)	T1	HD
<i>primidone</i>	T1	HD

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

T4 – Specialty Medications

PA – Prior Authorization

QL – Quantity Limit

ST – Step Therapy

AGE – Age Requirement

SP – Specialty Medication

HD – May require home delivery pharmacy

PPACA – No Cost-Share Preventive Medication

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List of Prescription Medications

CNS DRUGS (Seizure Disorders) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ANTICONVULSANTS (cont.)		
<i>primidone 250 mg tablet (Mysoline)</i>	T1	HD
<i>primidone 50 mg tablet (Mysoline)</i>	T1	HD
<i>rufinamide 200 mg tablet (Banzel)</i>	T1	PA QL (16 tabs/day) HD
<i>rufinamide 400 mg tablet (Banzel)</i>	T1	PA QL (8 tabs/day) HD
SPRITAM	T3	PA HD
TEGRETOL (<i>carbamazepine</i>)	T3	PA HD
TEGRETOL (<i>epitol</i>)	T3	PA HD
TEGRETOL XR (<i>carbamazepine er</i>)	T3	PA HD
<i>tiagabine hcl 12 mg tablet</i>	T1	QL (8 tabs/day) HD
<i>tiagabine hcl 16 mg tablet</i>	T1	QL (6 tabs/day) HD
<i>tiagabine hcl 2 mg tablet</i>	T1	HD
<i>tiagabine hcl 4 mg tablet</i>	T1	HD
<i>topiramate er (Qudexy Xr)</i>	T1	HD
<i>topiramate er (Trokendi XR)</i>	T1	QL (1 cap/day) HD
TROKENDI XR 25 MG, 100 MG CAPSULE (<i>topiramate</i>)	T3	QL (1 cap/day) HD
TROKENDI XR 50 MG, 200 MG CAPSULE (<i>topiramate</i>)	T3	HD
<i>valproic acid</i>	T1	HD
<i>valproic acid (as sodium salt)</i>	T1	HD
<i>vigabatrin</i>	T1	SP HD
VIMPAT 10 MG/ML SOLUTION	T2	PA HD
VIMPAT 100 MG TABLET	T2	PA HD
VIMPAT 150 MG TABLET	T2	PA HD
VIMPAT 200 MG TABLET	T2	PA HD
VIMPAT 200 MG/20 ML VIAL	T3	HD
VIMPAT 50 MG TABLET	T2	PA HD
XCOPRI 25 MG TABLET	T3	PA HD
XCOPRI 100 MG TABLET	T3	PA QL (1 tab/day) HD
XCOPRI 12.5-25 MG TITRATION PK	T3	PA QL (1/28 days) HD
XCOPRI 150 MG TABLET	T3	PA QL (1/day) HD
XCOPRI 150-200 MG TITRATION PK	T3	PA QL (1/28 days) HD

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

T4 – Specialty Medications

PA – Prior Authorization

QL – Quantity Limit

ST – Step Therapy

AGE – Age Requirement

SP – Specialty Medication

HD – May require home delivery pharmacy

PPACA – No Cost-Share Preventive Medication

CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

CNS DRUGS (Seizure Disorders) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ANTICONVULSANTS (cont.)		
XCOPRI 200 MG TABLET	T3	PA QL (2/day) HD
XCOPRI 250 MG DAILY DOSE PACK	T3	PA QL (1/28 days) HD
XCOPRI 350 MG DAILY DOSE PACK	T3	PA QL (1/28 days) HD
XCOPRI 50 MG TABLET	T3	PA QL (1/day) HD
XCOPRI 50-100 MG TITRATION PAK	T3	PA QL (1/28 days) HD
ZARONTIN (<i>ethosuximide</i>)	T3	PA HD
zonisamide	T1	HD
CNS DRUGS (Sleep Disorders/Sedatives)		
NARCOLEPSY TX-H3-RECEPT.ANTAGONIST/INVERSE AGONIST		
WAKIX	T3	PA QL (2 tabs/day) SP HD
COLONY STIMULATING FACTORS (Blood Modifiers/Bleeding Disorders)		
ERYTHROPOIESIS-STIMULATING AGENTS		
ARANESP	T4	PA SP
EPOGEN	T4	PA SP
MIRCERA	T4	PA SP
PROCRIT	T4	PA SP
RETACRIT	T4	PA SP
LEUKOCYTE (WBC) STIMULANTS		
FULPHILA	T4	PA SP
GRANIX	T4	PA SP
LEUKINE	T4	SP
NEULASTA	T4	PA SP
NEULASTA ONPRO	T4	PA SP HD
NEUPOGEN	T4	PA SP
NIVESTYM	T4	SP
NYPOZI	T4	PA SP
NYVEPRIA	T4	PA SP
ROLVEDON	T4	PA SP
STIMUFEND	T4	PA SP
UDENYCA	T4	PA SP
ZARXIO	T4	SP HD
ZIEXTENZO	T4	PA SP
THROMBOPOIETIN RECEPTOR AGONISTS		
DOPTelet	T4	PA SP HD

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List of Prescription Medications

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

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
LEUKOCYTE (WBC) STIMULANTS (cont.)		
MULPLETA	T4	PA SP HD
NPLATE	T4	PA SP

COLONY STIMULATING FACTORS (Cancer)

CXCR4 CHEMOKINE RECEPTOR ANTAGONIST		
MOZOBIL	T4	PA SP
XOLREMDI	T4	PA QL (4 caps/day) SP CSL

CONTRACEPTIVES (Contraception Products)

CONTRACEPTIVES, INTRAVAGINAL, SYSTEMIC		
ANNOVERA	T3	
etonogestrel/ethinyl estradiol (Nuvaring)	T1	PPACA
NUVARING (etonogestrel-ethinyl estradiol)	T3	
CONTRACEPTIVES, IMPLANTABLE		
NEXPLANON	T4	SP PPACA
CONTRACEPTIVES, INJECTABLE		
DEPO-PROVERA 150 MG/ML SYRINGE (medroxyprogesterone acetate)	T3	
DEPO-PROVERA 150 MG/ML VIAL (medroxyprogesterone acetate)	T3	
DEPO-SUBQ PROVERA 104	T3	
CONTRACEPTIVES, ORAL		
BEYAZ (rajani)	T3	HD
desogestrel-ethinyl estradiol	T1	HD PPACA
drospir/eth estra/levomefol ca (Beyaz)	T1	HD PPACA
drospir/eth estra/levomefol ca (Safyral)	T1	HD PPACA
ELLA	T3	HD PPACA
ESTROSTEP FE (tri-legest fe)	T3	HD
ethinyl estradiol/drospirenone (Yasmin 28)	T1	HD PPACA
ethinyl estradiol/drospirenone (Yaz)	T1	HD PPACA
ethynodiol d-ethinyl estradiol	T1	HD PPACA
levonorgest/eth.estradiol/iron (Balcoltra)	T1	HD PPACA
l-norgest/e.estradiol-e.estrad	T1	HD PPACA
l-norgest/e.estradiol-e.estrad (Quartette)	T1	HD PPACA
LOESTRIN (norethindron/ethinyl estradiol)	T3	HD
LOESTRIN FE (norethindrone/eth estradiol-fe)	T3	HD
LOESTRIN FE (tarina fe 1-20 eq)	T3	HD

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List of Prescription Medications

CONTRACEPTIVES (Contraception Products) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
CONTRACEPTIVES, ORAL (cont.)		
MICROGESTIN 24 FE (<i>tarina 24 fe</i>)	T3	HD
<i>noreth-ethinyl estradiol/iron</i>	T1	HD PPACA
<i>noreth-ethinyl estradiol/iron</i> (Generess Fe)	T1	HD PPACA
<i>noreth-ethinyl estradiol/iron</i> (Generess Fe)	T3	HD PPACA
<i>norethindrone</i> (Ortho Micronor)	T1	HD PPACA
<i>norethindrone ac/eth estradiol</i> (Loestrin)	T1	HD PPACA
<i>norethindrone-e.estradiol-iron</i>	T1	HD PPACA
<i>norethindrone-e.estradiol-iron</i> (Estrostep Fe)	T1	HD PPACA
<i>norethindrone-e.estradiol-iron</i> (Loestrin Fe)	T1	HD PPACA
<i>norethindrone-e.estradiol-iron</i> (Microgestin 24 Fe)	T1	HD PPACA
<i>norethindrone-ethin. estradiol</i>	T1	HD PPACA
<i>norethin-ee 1.5-0.03 mg (21) tb</i> (Loestrin)	T1	HD PPACA
<i>norgestrel-ethinyl estradiol</i>	T1	HD PPACA
ORTHO MICRONOR (<i>tulana</i>)	T3	HD
QUARTETTE (<i>rivelsa</i>)	T3	HD
SAFYRAL (<i>tydemy</i>)	T3	HD
TYBLUME	T3	HD
YASMIN 28 (<i>zumandimine</i>)	T3	HD
YAZ (<i>vestura</i>)	T3	HD
CONTRACEPTIVES, TRANSDERMAL		
<i>norelgestromin/ethin.estradiol</i>	T1	HD PPACA
DIAPHRAGMS/CERVICAL CAP		
CAYA CONTOURED	T3	PPACA
FEMCAP	T3	PPACA
WIDE SEAL DIAPHRAGM	T3	PPACA
INTRA-UTERINE DEVICES (IUDS)		
KYLEENA	T4	SP PPACA
LILETTA	T4	SP PPACA
MIRENA	T4	SP PPACA
PARAGARD T 380-A	T4	SP PPACA
SKYLA	T4	SP PPACA

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List of Prescription Medications

COUGH/COLD PREPARATIONS (Allergy/Nasal Sprays)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
IST GEN ANTIHIST-DECONGEST-ANTICHOLINERGIC COMB		
RESPA A.R.	T3	
COUGH/COLD PREPARATIONS (Cough/Cold Medications)		
ANTITUSSIVES, NON-OPIOID		
<i>benzonatate</i>	T1	
<i>benzonatate</i> (Tessalon Perle)	T1	
TESSALON PERLE (<i>benzonatate</i>)	T3	
NON-OPIOID ANTITUS-IST GEN.ANTIHISTAMINE-DECONGEST		
<i>brompheniramine/pseudoephed/dm</i> (Bromfed Dm)	T1	
NON-OPIOID ANTITUSSIVE-IST GEN ANTIHISTAMINE COMB.		
<i>promethazine/dextromethorphan</i>	T1	
OPIOID ANTITUSSIV-IST GEN. ANTIHISTAMINE-DECONGEST		
<i>hydrocodone/cpm/pseudoephed</i>	T1	PA
<i>promethazine/phenyleph/codeine</i>	T1	PA QL (480ml/22 days)
<i>promethazine/phenyleph/codeine</i>	T1	PA QL (480ml/30 days)
OPIOID ANTITUSSIVE-IST GENERATION ANTIHISTAMINE		
<i>hydrocodone/chlorphen p-stirex</i>	T1	PA
<i>promethazine-codeine solution</i>	T1	PA QL (480ml/22 days)
<i>promethazine-codeine syrup</i>	T1	PA QL (480ml/30 days)
TUXARIN ER	T3	PA QL (2 tabs/day)
TUZISTRA XR	T3	PA QL (960ml/30 days)
OPIOID ANTITUSSIVE-ANTICHOLINERGIC COMBINATIONS		
HYCODAN (<i>hydromet</i>)	T3	PA QL (480ml/22 days)
<i>hydrocodone bit/homatrop me-br</i> (Hycodan)	T1	PA QL (480ml/22 days)
<i>hydrocodone-homatropine 5-1.5</i>	T1	PA QL (180 tabs/30 days)
OPIOID ANTITUSSIVE-ANTICHOLINERGIC COMBINATIONS (cont.)		
<i>hydrocodone-homatropine soln</i> (Hycodan)	T1	PA QL (480ml/30 days)
HYDROCODONE-HOMATROPINE SYRUP	T1	PA QL (480ml/30 days)
OPIOID ANTITUSSIVE-EXPECTORANT COMBINATION		
HYDROCODONE-GUAIFENESIN	T1	PA QL (960ml/30 days)
OBREDON	T3	PA QL (960ml/30 days)
DIAGNOSTIC (Diabetes)		
BLOOD SUGAR DIAGNOSTICS		
FREESTYLE INSULINX	T2	
FREESTYLE INSULINX TEST STRIPS	T2	

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

T4 – Specialty Medications

PA – Prior Authorization

QL – Quantity Limit

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List of Prescription Medications

DIAGNOSTIC (Diabetes) (con't.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
BLOOD SUGAR DIAGNOSTICS (con't.)		
FREESTYLE LITE TEST STRIP	T2	
FREESTYLE PRECISION NEO	T2	
FREESTYLE TEST STRIPS	T2	
ONETOUGH ULTRA TEST STRIP	T2	
ONETOUGH VERIO TEST STRIP	T2	
PRECISION XTRA TEST STRIPS	T2	
TRUE METRIX TEST STRIP	T2	
DIAGNOSTIC (Miscellaneous)		
ADRENAL RADIOACTIVE DIAGNOSTICS		
ADREVIEW	T3	
BILIARY DIAGNOSTICS		
CHOLETEC	T3	
TC99M MEBROFENIN PREP	T1	
BILIARY DIAGNOSTICS, RADIOPAQUE		
<i>indocyanine green</i>	T1	
SINOGRAFIN	T3	
CARDIOVASCULAR DIAGNOSTICS - RADIOACTIVE		
AMMONIA N-13	T3	
MYOVUE	T3	
TC99M PYROPHOSPHATE PREP	T1	
TC99M SESTAMIBI PREP	T1	
THALLOUS CHLORIDE TL-201	T1	
CARDIOVASCULAR DIAGNOSTICS, NON-RADIOPAQUE AGENTS		
<i>adenosine 60 mg/20 ml vial</i>	T1	
<i>adenosine 90 mg/30 ml vial</i>	T1	
DEFINITY	T3	
<i>dipyridamole 50 mg/10 ml vial</i>	T1	
LEXISCAN	T3	
OPTISON	T3	
<i>regadenoson 0.4 mg/5 ml syring</i>	T1	
CARDIOVASCULAR DIAGNOSTICS-RADIOPAQUE		
ISOVUE-200	T3	

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

T4 – Specialty Medications

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List of Prescription Medications

DIAGNOSTIC (Miscellaneous) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
CARDIOVASCULAR DIAGNOSTICS-RADIOPAQUE (cont.)		
ISOVUE-250	T3	
ISOVUE-300	T3	
ISOVUE-370	T3	
ISOVUE-M 200	T3	
ISOVUE-M 300	T3	
OMNIPAQUE	T3	
OPTIRAY 240	T3	
OPTIRAY 300	T3	
OPTIRAY 320	T3	
OPTIRAY 350	T3	
ULTRAVIST	T3	
VISIPAQUE	T3	
CEREBRAL SPINAL RADIOACTIVE DIAGNOSTICS		
CERETEC	T3	
INDIUM IN-111 DTPA	T3	
DOTAREM	T3	
<i>gadoterate meglumine (Dotarem)</i>	T1	
MAGNEVIST	T3	
MULTIHANCE	T3	
MULTIHANCE MULTIPACK	T3	
OMNISCAN	T3	
OMNISCAN PREFILL PLUS	T3	
OPTIMARK	T3	
PROHANCE	T3	
PROHANCE MULTIPACK	T3	
DIAGNOSTIC PREPARATIONS, MISCELLANEOUS		
ADVANCED DNA MEDICATED COLLECT	T3	
ARIDOL	T3	
DMSA	T3	
DRAXIMAGE DTPA	T3	
GADAVIST	T3	
<i>gadobutrol</i>	T1	
GLUCAGON HCL	T1	
<i>isosulfan blue (Lymphazurin)</i>	T1	

T1 – Typically Generics

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List of Prescription Medications

DIAGNOSTIC (Miscellaneous) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
DIAGNOSTIC PREPARATIONS, MISCELLANEOUS (cont.)		
<i>lidocaine hcl/glycerin</i> (Advanced Dna Medicated Collect)	T1	
LIPIODOL	T3	
LUMASON	T3	
LYMPHAZURIN	T3	
NETSPOT	T3	
PROVOCHOLINE	T3	
TC99M MEDRONATE PREP	T1	
TC99M SULFUR COLLOID PREP	T1	
DIAGNOSTIC RADIOPHARM - AMYLOID/TAU IMAGING		
AMYVID	T3	
VIZAMYL	T3	PA
DIAGNOSTIC RADIOPHARM - DOPAMINE TRANSPORTER (DAT)		
DATSCAN	T3	
EYE DIAGNOSTIC AGENTS		
AK-FLUOR	T3	
AK-FLUOR (<i>fluorescite</i>)	T3	
<i>fluorescein sodium</i>	T1	
<i>fluorescein sodium</i> (Ak-fluor)	T1	
<i>ful-glo 1 mg ophth strip</i>	T1	
FUL-GLO EYE STRIPS	T3	
<i>lissamine green</i>	T1	
FLUORESCENCE CYSTOSCOPY/OPTICAL IMAGING AGENTS		
CYSVIEW	T3	
GASTROINTESTINAL RADIOPAQUE DIAGNOSTICS		
ENTERO VU	T3	
E-Z DISK	T3	
E-Z-HD	T3	
E-Z-PAQUE	T3	
E-Z-PASTE	T3	
GASTROMARK	T3	
LIQUID E-Z PAQUE	T3	
LIQUID POLIBAR PLUS	T3	
NEULUMEX	T3	
POLIBAR ACB	T3	

T1 – Typically Generics

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T4 – Specialty Medications

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List of Prescription Medications

DIAGNOSTIC (Miscellaneous) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
GASTROINTESTINAL RADIOPAQUE DIAGNOSTICS (cont.)		
READI-CAT 2	T3	
SITZMARKS	T3	
TAGITOL V	T3	
VARIBAR HONEY	T3	
VARIBAR NECTAR	T3	
VARIBAR PUDDING	T3	
VARIBAR THIN HONEY	T3	
VARIBAR THIN LIQUID	T3	
HEPATIC DIAGNOSTICS		
EOVIST	T3	
HISTAMINE PREPARATIONS		
HISTATROL INTRADERMAL	T3	
HISTATROL PERCUTANEOUS	T3	
METABOLIC FUNCTION DIAGNOSTICS		
CHIRHOSTIM	T3	
METOPIRONE	T3	
R-GENE 10	T3	
NEOPLASM MONOCLONAL DIAGNOSTIC AGENTS		
PROTASCINT	T3	
RADIOACTIVE DIAGNOSTICS, GENERAL		
OCTREOSCAN	T3	
RADIOACTIVE DX RADIOLABEL OF AUTOLOGOUS LEUKOCYTES		
INDIUM IN-111 OXYQUINOLINE	T1	
RADIOACTIVE DX RADIOLABEL OF SYNTHETIC AMINO ACIDS		
AXUMIN	T3	
RADIOACTIVE METABOLIC FUNCTION DIAGNOSTICS		
FLUDEOXYGLUCOSE F-18	T3	
RADIOPHARMACEUTICALS ELEMENTS		
GA 68 DOTATOC	T3	
INDICLOR	T3	
RENAL FUNCTION DIAGNOSTICS AGENTS		
<i>indigotindisulfonate sodium</i>	T3	
URINARY TRACT RADIOPAQUE DIAGNOSTICS		
CONRAY	T3	

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List of Prescription Medications

DIAGNOSTIC (Miscellaneous) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
URINARY TRACT RADIOPAQUE DIAGNOSTICS (cont.)		
CONRAY-30	T3	
CONRAY-43	T3	
CYSTO-CONRAY II	T3	
CYSTOGRAFIN	T3	
CYSTOGRAFIN-DILUTE	T3	
diatrizoate meglumine, sodium	T3	
diatrizoate meglumine, sodium (Gastrografin)	T1	
GASTROGRAFIN (md-gastroview)	T3	
DIURETICS (Diuretics)		
ARGININE VASOPRESSIN (AVP) RECEPTOR ANTAGONISTS		
TOLVAPTAN 15 MG TABLET	T4	SP
tolvaptan 30 mg tablet (Samsca)	T4	SP
VAPRISOL-5% DEXTROSE	T3	
CARBONIC ANHYDRASE INHIBITORS		
acetazolamide	T1	
acetazolamide sodium	T1	HD
methazolamide	T1	HD
LOOP DIURETICS		
bumetanide	T1	HD
ethacrynate sodium (Sodium Edecrin)	T1	
furosemide	T1	HD
furosemide (Lasix)	T1	HD
FUROSEMIDE-0.9% NACL	T1	
SODIUM EDECRIN (ethacrynate sodium)	T3	
torsemide	T1	HD
OSMOTIC DIURETICS		
mannitol	T3	
mannitol (Osmitol)	T1	
OSMITROL (mannitol)	T3	

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List of Prescription Medications

DIURETICS (Diuretics) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
POTASSIUM SPARING DIURETICS		
<i>amiloride hcl</i>	T1	HD
CAROSPIR SUSP	T2	PA
CAROSPIR (<i>spironolactone</i>)	T1	HD
<i>eplerenone</i> (Inspra)	T1	HD
INSPIRA (<i>eplerenone</i>)	T3	HD
KERENDIA	T2	PA QL (1 tab/day)
<i>spironolactone</i>	T1	HD
<i>spironolactone</i> (Aldactone) (Carospir)	T1	HD
<i>triamterene</i> (Dyrenium)	T1	HD
POTASSIUM SPARING DIURETICS IN COMBINATION		
ALDACTAZIDE	T3	HD
ALDACTAZIDE (<i>spironolactone-hctz</i>)	T3	HD
<i>amiloride/hydrochlorothiazide</i>	T1	HD
DYAZIDE (<i>triamterene-hydrochlorothiazid</i>)	T3	HD
<i>spironolact/hydrochlorothiazid</i> (Aldactazide)	T1	HD
<i>triamterene/hydrochlorothiazid</i> (Dyazide)	T1	HD
THIAZIDE AND RELATED DIURETICS		
<i>chlorothiazide sodium</i> (Sodium Diuril)	T1	
<i>chlorthalidone</i>	T1	HD
DIURIL	T3	HD
<i>hydrochlorothiazide</i>	T1	HD
<i>indapamide</i>	T1	HD
<i>metolazone</i>	T1	HD
SODIUM DIURIL (<i>chlorothiazide sodium</i>)	T3	HD
EENT PREPS (Allergy/Nasal Sprays)		
NASAL ANTIHISTAMINE		
<i>azelastine 0.1% (137 mcg) spray</i>	T1	HD
<i>azelastine 0.15% nasal spray</i>	T1	HD
<i>olopatadine 665 mcg nasal spray</i> (Patanase)	T1	HD

T1 – Typically Generics

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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.)		
PATANASE (<i>olopatadine hcl</i>)	T3	HD
NASAL ANTIHISTAMINE AND ANTI-INFLAM. STEROID COMB.		
azelastine/fluticasone	T1	HD
NASAL ANTI-INFLAMMATORY STEROIDS		
flunisolide	T1	HD
fluticasone prop 50 mcg spray	T1	HD
mometasone furoate 50 mcg spray	T1	QL (4 bots/30 days) HD
NOSE PREPARATIONS, MISCELLANEOUS (RX)		
ipratropium bromide	T1	HD
NOSE PREPARATIONS, VASOCONSTRICTORS (RX)		
ADRENALIN CHLORIDE	T3	
epinephrine hcl (Adrenalin Chloride)	T1	
EENT PREPS (Ear Medications)		
EAR PREPARATIONS ANTI-INFLAMMATORY		
DERMOTIC (<i>fluocinolone acetonide oil</i>)	T3	
fluocinolone acetonide oil (Dermotic)	T1	
EAR PREPARATIONS, MISC. ANTI-INFECTIVES		
hydrocortisone/acetic acid	T1	
EENT PREPS (Eye Conditions)		
ARTIFICIAL TEARS		
LACRISERT	T3	
MIEBO	T2	QL (4 bottles/30 days)
EYE ANTI-INFECTIVES (RX ONLY)		
BETADINE	T3	
EYE ANTI-INFLAMMATORY AGENTS		
ACUVAIL	T3	
ALREX	T3	
bromfenac sodium (Bromsite)	T1	
BROMSITE .(bromfenac sodium)	T2	
dexamethasone 0.1% eye drop	T1	
diclofenac 0.1% eye drops	T1	
EYSUVIS	T2	QL (8.3ml/14 days)
FLAREX 0.1% EYE DROPS	T2	
fluorometholone (Fml)	T1	

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

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

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

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

List of Prescription Medications

EENT PREPS (Eye Conditions) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
EYE ANTI-INFLAMMATORY AGENTS (cont.)		
<i>flurbiprofen sodium</i>	T1	
ILEVRO	T3	
ILUVIEN	T4	SP
INVELTYS 1% EYE DROP	T2	
<i>ketorolac 0.4% ophth solution (Acular Ls)</i>	T1	
<i>ketorolac 0.5% ophth solution (Acular)</i>	T1	
LOTEMAX 0.5% EYE OINTMENT	T2	
LOTEMAX (<i>loteprednol etabonate</i>)	T3	
LOTEMAX SM 0.38% OPTH GEL	T2	
<i>loteprednol etabonate (Lotemax)</i>	T1	
OMNIPRED (<i>prednisolone acetate</i>)	T3	
OZURDEX	T4	SP
<i>prednisolone acetate (Pred Forte)</i>	T1	
<i>prednisolone sodium phosphate</i>	T1	
PROLENSA	T3	
TRIESENCE	T3	
EYE IRRIGATIONS		
BSS PLUS	T3	
EYE LOCAL ANESTHETICS		
AKTEN	T3	
ALCAINE (<i>proparacaine hcl</i>)	T3	
ALTAFLUOR BENOX (<i>flurox</i>)	T3	
<i>benoxinate hcl/fluorescein sod (Altafluor Benox)</i>	T1	
<i>benoxinate hcl/fluorescein sod (Altafluor Benox)</i>	T3	
<i>proparacaine hcl (Alcaine)</i>	T1	
<i>proparacaine/fluorescein sod</i>	T1	
<i>proparacaine/fluorescein sod</i>	T3	
<i>tetracaine hcl</i>	T1	
TETRAVISC	T3	
TETRAVISC FORTE	T3	

T1 – Typically Generics

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List of Prescription Medications

EENT PREPS (Eye Conditions) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
EYE MAST CELL STABILIZERS		
<i>cromolyn 4% eye drops</i>	T1	
EYE MYDRIATIC AND NSAID COMBINATIONS		
OMIDRIA	T3	
EYE PREPARATIONS, MISCELLANEOUS (OTC)		
GELFILM	T3	
EYE VASOCONSTRICTORS		
<i>phenylephrine hcl</i>	T1	
MIOTICS AND OTHER INTRAOCULAR PRESSURE REDUCERS		
<i>apraclonidine hcl</i> (Iopidine)	T1	HD
AZOPT (<i>brinzolamide</i>)	T3	HD
<i>betaxolol hcl</i>	T1	HD
BETOPTIC S 0.25% DROPS	T2	HD
<i>bimatoprost</i>	T1	QL (10 gm/30 days) HD
<i>brimonidine tartrate</i>	T1	HD
<i>brimonidine tartrate</i> (Alphagan P)	T1	HD
<i>brimonidine tartrate/timolol</i> (Combigan)	T1	HD
<i>brinzolamide</i> (Azopt)	T1	HD
<i>carbachol</i>	T3	HD
<i>carteolol hcl</i>	T1	HD
COMBIGAN	T2	HD
<i>dorzolamide hcl</i> (Trusopt)	T1	HD
<i>dorzolamide hcl/timolol maleat</i> (Cosopt)	T1	HD
<i>dorzolamide/timolol/pf</i> (Cosopt Pf)	T1	HD
DURYSTA	T4	PA SP HD
IOPIDINE	T3	HD
IOPIDINE (<i>apraclonidine hcl</i>)	T3	HD
ISOPTO CARPINE (<i>pilocarpine hcl</i>)	T3	HD
<i>latanoprost</i>	T1	HD
<i>levobunolol hcl</i>	T1	HD
MIOCHOL-E	T3	HD
PHOSPHOLINE IODIDE	T3	HD
<i>pilocarpine hcl</i> (Isopto Carpine)	T1	HD
RHOPRESSA	T3	
ROCKLATAN	T3	

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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.)		
SIMBRINZA	T2	HD
<i>timolol maleate</i> (Istalol)	T1	HD
<i>timolol maleate</i> (Timoptic)	T1	HD
<i>timolol maleate</i> (Timoptic-xe)	T1	HD
<i>timolol maleate/pf</i> (Timoptic Ocudose)	T1	HD
<i>travoprost</i>	T1	HD
TRUSOPT (<i>dorzolamide hcl</i>)	T3	HD
MYDRIATICS		
<i>atropine 1% eye drops</i> (Isopto Atropine)	T1	HD
<i>atropine 1% eye ointment</i>	T1	HD
ATROPINE SULFATE-0.9% NACL	T3	HD
CYCLOGYL	T3	HD
CYCLOGYL (<i>cyclopentolate hcl</i>)	T3	HD
CYCLOMYDRIL	T3	HD
<i>cyclopentolate hcl</i> (Cyclogyl)	T1	HD
<i>homatropine hbr</i>	T1	HD
MYDRIACYL (<i>tropicamide</i>)	T3	HD
PAREMYD	T3	HD
<i>tropicamide</i>	T1	HD
<i>tropicamide</i> (Mydracyl)	T1	HD
OPHTH VASC. ENDOTHELIAL GROWTH FACTOR ANTAGONISTS		
EYLEA	T4	PA SP
PAVBLU	T4	PA SP
OPHTH. VEGF-A RECEPTOR ANTAG. RCMB MC ANTIBODY		
BEOVU	T4	PA SP
LUCENTIS	T4	PA SP
OPHTHALMIC ANTIFIBROTIC AGENTS		
MITOSOL	T3	
OPHTHALMIC ANTI-INFLAMMATORY IMMUNOMODULATOR-TYPE		
CEQUA	T2	
RESTASIS	T2	HD
XIIDRA	T2	HD
OPHTHALMIC COMPLEMENT INHIBITORS		
SYFOVRE	T4	PA SP HD

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List of Prescription Medications

EENT PREPS (Eye Conditions) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
OPHTHALMIC CYSTINE DEPLETING AGENTS		
CYSTADROPS	T4	PA QL (20ml/21 days) SP
CYSTARAN	T4	PA QL (120ml/28 days) SP
OPHTHALMIC HUMAN NERVE GROWTH FACTOR (HNGF)		
OXERVATE	T4	PA SP HD
OPHTHALMIC PREPARATIONS, MISCELLANEOUS		
AMVISC	T4	SP
AMVISC PLUS	T4	SP
DISCOVISC	T3	
DUOVISC	T3	
HEALON (<i>biolon</i>)	T4	SP
HEALON5	T3	
PROVISC 10MG/ML DISP SYR	T4	SP
TOTALVISC	T4	SP
VISCOAT	T3	
OPHTHALMIC SURGICAL AIDS		
CELLUGEL	T3	
<i>hypromellose</i> (Cellugel)	T1	
MEMBRANEBLUE	T3	
VISIONBLUE	T3	

ELECT/CALORIC/H2O (Cholesterol Medications)

ORAL LIPID SUPPLEMENTS		
DOJOLVI	T4	PA SP HD

ELECT/CALORIC/H2O (Dental Products)

FLUORIDE PREPARATIONS		
CLINPRO 5000	T3	
<i>fluoride (sodium)</i> (Prevident 5000 Ortho Defense)	T1	
<i>fluoride (sodium)</i> (Prevident 5000 Plus)	T1	
<i>fluoride (sodium)</i> (Prevident 5000)	T1	
<i>fluoride (sodium)</i> (Prevident)	T1	
FLUORIDEX	T1	
FLUORIDEX SENSITIVITY RELIEF	T3	
FRAICHE 5000 PREVI	T3	

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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.)		
FRAICHE 5000 SENSITIVE	T3	
PREVIDENT	T3	
PREVIDENT (sodium fluoride)	T3	
PREVIDENT KIDS	T3	
PREVIDENT 5000	T3	
PREVIDENT 5000 ENAMEL PROTECT	T3	
PREVIDENT 5000 ORTHO DEFENSE	T3	
PREVIDENT 5000 PLUS (sodium fluoride 5000 plus)	T3	
PREVIDENT 5000 SENSITIVE	T3	
sodium fluoride/potassium nit (Prevident 5000 Sensitive)	T1	
ELECT/CALORIC/H2O (Diabetes)		
AGENTS TO TREAT HYPOGLYCEMIA (HYPERGLYCEMICS)		
BAQSIMI	T2	QL (2 units/30 days)
diazoxide (Proglycem)	T1	
glucagon 1 mg emergency kit	T1	QL (2 pens/30 days)
GLUCAGON 1 MG EMERGENCY KIT	T3	QL (2 pens/30 days)
PROGLYCEM (diazoxide)	T3	
ZEGALOGUE	T2	QL (2 units/23 days)
ELECT/CALORIC/H2O (Miscellaneous)		
BICARBONATE PRODUCING/CONTAINING AGENTS		
sodium acetate	T1	
sodium bicarbonate	T1	
sodium bicarbonate in d5w	T1	
DRUGS USED TO TREAT ACIDOSIS		
THAM	T3	
IV SOLUTIONS: DEXTROSE AND LACTATED RINGERS		
dextrose 5%-lactated ringers	T1	
IV SOLUTIONS: DEXTROSE-SALINE		
dextrose 10 % and 0.2 % nacl	T1	
dextrose 10 % and 0.45 % nacl	T1	
dextrose 2.5 % and 0.45 % nacl	T1	
dextrose 5 % and 0.3 % nacl	T1	
dextrose 5 % and 0.9 % nacl	T1	

T1 – Typically Generics

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T3 – Typically Non-Preferred Brands

T4 – Specialty Medications

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List of Prescription Medications

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

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
IV SOLUTIONS: DEXTROSE-SALINE (cont.)		
dextrose 5 %-0.2 % sod chlorid	T1	
dextrose 5 %-0.45 % sod chlrd	T1	
GLUCOSE IN WATER (dextrose in water)	T1	
IV SOLUTIONS: DEXTROSE-WATER		
dextrose 70%-water 3,000 ml	T1	
dextrose in water	T1	
GLUCOSE 5%-WATER (dextrose 5 % in water)	T1	
NUCLEIC ACID/NUCLEOTIDE SUPPLEMENTS		
XURIDEN	T4	PA SP
PARENTERAL AMINO ACID SOLUTIONS AND COMBINATIONS		
AMINO ACID 3%-D10W-CALCIUM-HEPARIN	T3	
AMINOSYN	T3	
AMINOSYN II	T3	
AMINOSYN II WITH ELECTROLYTES	T3	
AMINOSYN M	T3	
AMINOSYN WITH ELECTROLYTES	T3	
AMINOSYN-PF	T3	
AMINOSYN-RF	T3	
CLINIMIX	T3	
CLINIMIX E	T3	
CLINISOL	T3	
HEPATAMINE	T3	
KABIVEN	T3	
parenteral amino acid 10% no.4	T3	
parenteral amino acid 10% no.6	T3	
parenteral amino acid 10% no.7	T3	
PERIKABIVEN	T3	
PLENAMINE	T3	
PROCALAMINE	T3	
PROSOL	T3	
TROPHAMINE	T3	

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List of Prescription Medications

ELECT/CALORIC/H2O (Nutritional/Dietary)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
CALCIUM REPLACEMENT		
<i>calcium chloride</i>	T1	
<i>calcium gluc 1,000mg/50ml-nacl</i>	T1	
<i>calcium glu 2,000mg/100ml-nacl</i>	T1	
<i>calcium gluconate</i>	T1	
<i>calcium gluconate in 0.9% nacl</i> (Calcium Gluconate-0.9% NaCl)	T1	
CALCIUM GLUCONATE-0.9% NACL	T1	
CALCIUM GLUCONATE-0.9% NACL (<i>calcium gluconate-0.9% nacl</i>)	T1	
CALCIUM GLUCONATE-D5W	T1	
ELECTROLYTE MAINTENANCE		
AURYXIA	T3	QL (12 tabs/day)
<i>calcium acetate</i>	T1	
<i>electrolyte-48 solution/d5w</i>	T1	
FOSRENOL 1,000 MG POWDER PACK	T2	
FOSRENOL 1,000 MG TABLET CHEW (<i>lanthanum carbonate</i>)	T3	
FOSRENOL 500 MG TABLET CHEW (<i>lanthanum carbonate</i>)	T3	
FOSRENOL 750 MG POWDER PACKET	T2	
FOSRENOL 750 MG TABLET CHEW (<i>lanthanum carbonate</i>)	T3	
IONOSOL B WITH DEXTROSE 5%	T3	
IONOSOL MB-DEXTROSE 5%	T3	
ISOLYTE P WITH DEXTROSE	T3	
ISOLYTE S	T3	
<i>lanthanum carbonate</i> (Fosrenol)	T1	
LOKELMA	T2	
NORMOSOL-M AND DEXTROSE	T3	
NORMOSOL-R	T3	
NORMOSOL-R AND DEXTROSE	T3	
NORMOSOL-R PH 7.4	T3	
PLASMA-LYTE 148	T3	
PLASMA-LYTE A PH 7.4	T3	
<i>ringer's solution</i>	T1	
<i>ringer's solution, lactated</i>	T1	
<i>sevelamer carbonate</i> (Renvela)	T1	
<i>sevelamer hcl</i>	T1	
<i>sevelamer hcl</i> (Renagel)	T1	

T1 – Typically Generics

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T4 – Specialty Medications

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List of Prescription Medications

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

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ELECTROLYTE MAINTENANCE (cont.)		
sodium polystyrene sulfon/sorb	T1	
sodium polystyrene sulfonate	T1	
sps 15 gm/60 ml suspension	T1	
sps 30 gm/120 ml enema susp	T3	
TPN ELECTROLYTES	T3	
TPN ELECTROLYTES II	T3	
VELPHORO	T2	
VELTASSA	T2	
IODINE CONTAINING AGENTS		
IODOPEN	T3	
potassium iodide/iodine	T1	
SSKI	T1	
IRON REPLACEMENT		
CITRANATAL BLOOM	T3	
FERAHEME	T3	PA
FERRLECIT (sod ferric gluconate complex)	T3	
INFED	T3	
INJECTAFER	T3	PA
iron dextran complex (Infed)	T3	
MONOFERRIC	T3	PA
mv-mins no.73/iron fum/folic (Hemocyte Plus)	T1	
sodium ferric gluconat/sucrose (Ferrlecit)	T1	
TRIFERIC	T3	
VENOFER	T3	
MAGNESIUM SALTS REPLACEMENT		
magnesium chloride	T1	
magnesium sulfate	T1	
magnesium sulfate in water	T1	
MAGNESIUM SULFATE-0.9% NACL	T1	
MAGNESIUM SULFATE-D5W	T1	
MAGNESIUM-LACTATED RINGERS	T1	
MINERAL REPLACEMENT, MISCELLANEOUS		
ADDAMEL N	T3	
chromic chloride	T1	

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List of Prescription Medications

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

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
MINERAL REPLACEMENT, MISCELLANEOUS (cont.)		
cupric chloride	T1	
manganese chloride	T1	
manganese sulfate	T1	
MULTITRACE-4 CONC VIAL	T1	
multitrace-4 vial	T3	
MULTITRACE-4 VIAL	T1	
MULTITRACE-5	T1	
PEDITRACE	T3	
SELENIOS ACID	T1	
TRALEMENT	T3	
PHOSPHATE REPLACEMENT		
GLYCOPHOS	T3	
potassium phos, m-basic-d-basic	T1	
POTASSIUM PHOSPHATE-0.9% NACL	T1	
POTASSIUM PHOSPHATES	T3	
potassium phos,m-basic-d-basic	T1	
potassium cl er 15 meq tablet	T1	
sod phosphate, monobasic-dibas	T1	
SODIUM PHOSPHATE-0.9% NACL	T1	
POTASSIUM REPLACEMENT		
EFFER-K 10 MEQ TABLET EFF	T3	
EFFER-K 20 MEQ TABLET EFF	T3	
effer-k 25 meq tablet eff	T1	
klor-con 10 meq tablet (K-tab Er)	T1	
klor-con 10 meq tablet (K-tab Er)	T3	
klor-con 8 meq tablet	T1	
klor-con 8 meq tablet	T3	
potassium acetate	T1	
potassium bicarbonate/cit ac	T1	
POTASSIUM CL ER 15 MEQ TABLET	T3	
potassium chloride	T1	
potassium chloride	T3	
potassium chloride (K-tab Er)	T1	
potassium chloride in 0.9%nacl	T1	
potassium chloride in d5w	T1	

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List of Prescription Medications

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

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
POTASSIUM REPLACEMENT (cont.)		
<i>potassium chloride in Ir-d5</i>	T1	
<i>potassium chloride in water</i>	T1	
<i>potassium chloride/d5-0.2%nacl</i>	T1	
<i>potassium chloride/d5-0.3%nacl</i>	T1	
<i>potassium chloride/d5-0.45nacl</i>	T1	
<i>potassium chloride/d5-0.9%nacl</i>	T1	
<i>potassium chloride-0.45% nacl</i>	T1	
POTASSIUM CHLORIDE-0.9% NACL	T1	
<i>potassium cl/lido/0.9 % nacl (Potassium Cl-lidocaine-ns)</i>	T1	
POTASSIUM CL-LIDOCAINE-NS (<i>potassium cl-lidocaine-ns</i>)	T1	
PROTEIN REPLACEMENT		
AQNEURSA	T4	PA SP
SODIUM/SALINE PREPARATIONS		
<i>0.9 % sodium chloride</i>	T1	
KENDALL 0.9% NACL WITH CAP	T1	
<i>sodium chloride 0.45 %</i>	T1	
<i>sodium chloride 0.9 % (flush)</i>	T1	
<i>sodium chloride 3 %</i>	T1	
<i>sodium chloride 5 %</i>	T1	
SWABFLUSH	T3	
ZINC REPLACEMENT		
<i>zinc chloride</i>	T1	
<i>zinc sulfate</i>	T1	

ELECT/CALORIC/H2O (Urinary Tract Conditions)

DIALYSIS SOLUTIONS		
DELFLEX WITH 1.5% DEXTROSE	T3	
DELFLEX-2.5% DEXTROSE	T3	
DIANEAL PD-2 W-1.5% DEXTROSE	T3	
DIANEAL PD-2 W-2.5% DEXTROSE	T2	
DIANEAL PD-2 W-4.25% DEXTROSE	T3	
DIANEAL WITH 1.5% DEXTROSE	T3	
DIANEAL WITH 2.5% DEXTROSE	T3	
DIANEAL WITH 4.25% DEXTROSE	T3	
EXTRANEAL ICODextrin DIALYSIS	T3	
<i>perit. dialysis no.6-1.5 % dex (Dianeal With 1.5% Dextrose)</i>	T3	

T1 – Typically Generics

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T3 – Typically Non-Preferred Brands

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List of Prescription Medications

ELECT/CALORIC/H2O (Urinary Tract Conditions) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
DIALYSIS SOLUTIONS (cont.)		
<i>periton.dialysis 7-2.5 % dextr</i> (Dianeal With 2.5% Dextrose)	T3	
<i>periton.dialysis 8-4.25 % dext</i> (Dianeal With 4.25% Dextrose)	T3	
PHOXILLUM	T3	
PRISMASOL	T3	
URINARY PH MODIFIERS		
K-PHOS NO.2	T3	HD
K-PHOS ORIGINAL	T3	HD
ORACIT	T3	HD
<i>potassium citrate</i> (Urocit-k)	T1	HD
<i>potassium citrate/citric acid</i>	T1	HD
RENACIDIN	T3	HD
UROCIT-K (<i>potassium citrate er</i>)	T3	HD
UROQID-ACID NO.2	T3	HD
GASTROINTESTINAL (Cholesterol Medications)		
LIPOTROPICS		
<i>icosapent ethyl</i> (Vascepa)	T1	HD
LOVAZA (<i>triklo</i>)	T3	HD
<i>omega-3 acid ethyl esters</i> (Lovaza)	T1	HD
VASCEPA	T2	PA HD
GASTROINTESTINAL (Gastrointestinal/Heartburn)		
AMMONIA INHIBITORS		
AMMONUL (<i>sodium phenylacet-sod benzoate</i>)	T3	
<i>lactulose</i>	T1	HD
<i>lactulose 10 gm/15 ml solution</i>	T1	
LITHOSTAT	T3	HD
OLPRUVA	T3	PA SP HD
PHEBURANE	T4	PA QL(8 Bottles/30 Days) SP HD
<i>sodium benzoate/sod phenylacet</i> (Ammonul)	T1	
<i>sodium phenylbutyrate</i> (Buphenyl)	T4	SP HD
ANTICHOLINERGICS, QUATERNARY AMMONIUM		
<i>chlordiazepoxide/clidinium br</i>	T1	
CUVPOSA	T3	
GLYCATE	T3	

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

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

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

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

List of Prescription Medications

GASTROINTESTINAL (Gastrointestinal/Heartburn) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ANTICHOLINERGICS, QUATERNARY AMMONIUM (cont.)		
<i>glycopyrrolate</i>	T1	
GLYCOPYRROLATE 1 MG/5 ML SYRNG	T1	
<i>glycopyrrolate 1 mg/5 ml vial</i>	T1	
<i>glycopyrrolate</i> (Glycate)	T1	
<i>glycopyrrolate</i> (Robinul Forte)	T1	
<i>glycopyrrolate</i> (Robinul)	T1	
GLYCOPYRROLATE-WATER	T1	
<i>propantheline bromide</i>	T1	
ROBINUL (<i>glycopyrrolate</i>)	T3	
ROBINUL FORTE (<i>glycopyrrolate</i>)	T3	
ANTICHOLINERGICS/ANTISPASMODICS		
BENTYL	T3	
<i>dicyclomine hcl</i>	T1	
<i>dicyclomine hcl</i> (Bentyl)	T1	
ANTIDIARRHEAL - G.I. CHLORIDE CHANNEL INHIBITORS		
MYTESI	T3	
ANTIDIARRHEAL - TRYPTOPHAN HYDROXYLASE INHIBITOR		
XERMELO	T4	PA SP
ANTIDIARRHEALS		
<i>diphenoxylate hcl/atropine</i>	T1	
<i>diphenoxylate hcl/atropine</i> (Lomotil)	T1	
<i>loperamide hcl</i>	T1	
MOTOFEN	T3	
<i>opium tincture</i>	T1	PA
<i>paregoric</i>	T1	
ANTIEMETIC, CANNABINOID-TYPE		
<i>dronabinol</i>	T1	
ANTIEMETIC/ANTIVERTIGO AGENTS		
AKYNZEO 235-0.25 MG VIAL	T3	
AKYNZEO 235-0.25 MG/20 ML VIAL	T3	PA
AKYNZEO 300-0.5 MG CAPSULE	T3	PA QL (4 caps/28 days)
ALOXI (<i>palonosetron hcl</i>)	T3	PA
ANZEMET	T4	PA QL (5 tabs/30 days) SP

T1 – Typically Generics

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T4 – Specialty Medications

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AGE – Age Requirement

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List of Prescription Medications

GASTROINTESTINAL (Gastrointestinal/Heartburn) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ANTIEMETIC/ANTIVERTIGO AGENTS (cont.)		
<i>aprepitant 125 mg capsule</i>	T1	QL (4 caps/28 days)
<i>aprepitant 125-80-80 mg pack (Emend)</i>	T1	QL (12 caps/28 days)
<i>aprepitant 40 mg capsule</i>	T1	QL (1 cap/28 days)
<i>aprepitant 80 mg capsule (Emend)</i>	T1	QL (8 caps/28 days)
BARHEMSYS	T3	
BONJESTA	T3	
CINVANTI	T3	
COMPAZINE (<i>prochlorperazine maleate</i>)	T3	
COMPAZINE (<i>prochlorperazine</i>)	T3	
<i>dimenhydrinate</i>	T1	
<i>doxylamine succinate/vit b6 (Diclegis)</i>	T1	QL (4 tabs/day)
EMEND 125 MG POWDER PACKET	T3	QL (12 caps/28 days)
EMEND 150 MG VIAL (<i>fosaprepitant dimeglumine</i>)	T3	
FOCINVEZ	T3	
<i>fosaprepitant dimeglumine (Emend)</i>	T1	
<i>granisetron hcl</i>	T1	
<i>granisetron hcl/pf</i>	T1	
<i>ondansetron</i>	T1	
<i>ondansetron hcl/pf</i>	T1	
ONDANSETRON HCL-0.9% NACL	T1	
ONDANSETRON HCL-D5W	T1	
<i>palonosetron hcl</i>	T1	
<i>palonosetron hcl (Aloxi)</i>	T1	
POSFREA	T3	
<i>prochlorperazine (Compazine)</i>	T1	
<i>prochlorperazine edisylate</i>	T1	
<i>prochlorperazine maleate (Compazine)</i>	T1	
<i>promethazine hcl</i>	T1	
<i>promethazine hcl</i>	T3	
SANCUSO	T3	PA QL (4 patches/30 days)
<i>scopolamine (Transderm-scop)</i>	T1	
SUSTOL	T3	

T1 – Typically Generics

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List of Prescription Medications

GASTROINTESTINAL (Gastrointestinal/Heartburn) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ANTIEMETIC/ANTIVERTIGO AGENTS (cont.)		
TIGAN (<i>trimethobenzamide hcl</i>)	T3	
TRANSDERM-SCOP (<i>scopolamine</i>)	T3	
<i>trimethobenzamide hcl</i> (Tigan)	T1	
VARUBI	T3	PA QL (4 tabs/28 days)
ANTI-ULCER PREPARATIONS		
CYTOTEC (<i>misoprostol</i>)	T3	HD
<i>misoprostol</i> (Cytotec)	T1	HD
<i>sucralfate</i> (Carafate)	T1	HD
ANTI-ULCER-H.PYLORI AGENTS		
<i>bismuth/metronid/tetracycline</i> (Pylera)	T1	
<i>lansoprazole/amoxiciln/clarith</i>	T1	
BELLADONNA ALKALOIDS		
<i>atropine 0.4 mg/ml vial</i>	T1	
ATROPINE 0.4 MG/ML VIAL	T3	
ATROPINE SULFATE-0.9% NACL	T3	
<i>atropine 0.5 mg/5 ml abboject</i>	T1	
<i>atropine 1 mg/10 ml abboject</i>	T1	
<i>atropine 1 mg/10 ml syringe</i>	T1	
ATROPINE 1 MG/2.5 ML SYRINGE	T3	
<i>atropine 1 mg/ml vial</i>	T1	
ATROPINE 1 MG/ML VIAL	T3	
ATROPINE 2 MG/5 ML SYRINGE	T3	
<i>atropine 8 mg/20 ml vial</i>	T1	
DONNATAL	T3	HD
DONNATAL (<i>phenohydro</i>)	T3	HD
<i>hyoscyamine 0.125 mg odt</i> (Nulev)	T1	HD
<i>hyoscyamine 0.125 mg tab sl</i> (Levsin-sl)	T1	HD
<i>hyoscyamine 0.125 mg/5 ml elix</i>	T1	HD
<i>hyoscyamine 0.125 mg/ml drop</i>	T1	HD
<i>hyoscyamine sulf 0.125 mg tab</i> (Levsin)	T1	HD
<i>hyoscyamine sulfate</i>	T1	HD
<i>hyoscyamine sulfate</i> (Levbid)	T1	HD

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List of Prescription Medications

GASTROINTESTINAL (Gastrointestinal/Heartburn) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
BELLADONNA ALKALOIDS (cont.)		
<i>hyoscyamine sulfate</i> (Levsin)	T1	HD
<i>hyoscyamine sulfate</i> (Levsin-sl)	T1	HD
<i>hyoscyamine sulfate</i> (Nulev)	T1	HD
<i>hyoscyamine sulfate</i> (Nulev)	T3	HD
HYOSCYAMINE SULFATE 0.5 MG/ML	T3	HD
LEVBIID (<i>symax-sr</i>)	T3	HD
LEVSIN	T3	HD
LEVSIN (<i>oscimin</i>)	T3	HD
LEVSIN-SL (<i>symax-sl</i>)	T3	HD
<i>methscopolamine bromide</i>	T1	HD
NULEV (<i>symax</i>)	T1	HD
<i>phenobarb/hyoscy/atropine/scop</i> (Donnatal)	T1	HD
<i>phenobarb/hyoscy/atropine/scop</i> (Phenobarbital-belladonna)	T1	HD
<i>phenobarbital-belladonna elixr</i> (Donnatal)	T1	HD
<i>phenobarbital-belladonna elixr</i> (Phenobarbital-belladonna)	T1	HD
PHENOBARBITAL-BELLADONNA ELIXR (<i>phenohydro</i>)	T3	HD
SYMAX DUOTAB	T3	HD
BILE SALTS		
ACTIGALL (<i>ursodiol</i>)	T3	HD
CHENODAL	T4	SP HD
CTEXLI	T4	PA SP
CHOLBAM	T4	PA SP HD
URSO FORTE (<i>ursodiol</i>)	T3	HD
<i>ursodiol</i> (Actigall)	T1	HD
<i>ursodiol</i> (Urso Forte)	T1	HD
CHOLERETICS		
KINEVAC	T3	
CHRONIC INFLAM. COLON DX, 5-A-SALICYLAT, RECTAL TX		
<i>mesalamine 1,000 mg supp</i> (Canasa)	T1	
<i>mesalamine 4 gm/60 ml enema</i> (Sfrowasa)	T1	
<i>mesalamine 4 gm/60 ml kit</i>	T1	

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List of Prescription Medications

SFROWASA (<i>mesalamine</i>)	T3	
GASTROINTESTINAL (Gastrointestinal/Heartburn) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
DRUG TX-CHRONIC INFLAM. COLON DX, 5-AMINOSALICYLAT		
APRISO (<i>mesalamine er</i>)	T3	HD
<i>balsalazide disodium (Colazal)</i>	T1	HD
LIALDA (<i>mesalamine</i>)	T3	HD
<i>mesalamine</i>	T1	HD
<i>mesalamine (Apriso)</i>	T1	HD
<i>mesalamine 800 mg dr tablet</i>	T1	HD
<i>mesalamine dr 1.2 gm tablet (Lialda)</i>	T1	HD
PENTASA 500 MG CAPSULE (<i>mesalamine</i>)	T3	HD
<i>sulfasalazine (Azulfidine)</i>	T1	HD
FARNESOID X RECEPTOR (FXR) AGONIST, BILE AC ANALOG		
OCALIVA	T4	PA SP HD
FECAL MICROBIOTA TRANSPLANTATION (FMT)		
VOWST	T4	PA QL (12 caps/56 days) SP
GASTRIC ENZYMES		
SUCRAID	T4	PA SP
HISTAMINE H2-RECEPTOR INHIBITORS		
<i>cimetidine hcl</i>	T1	HD
<i>famotidine</i>	T1	HD
<i>ranitidine hcl</i>	T1	HD
IBS AGENTS, MIXED OPIOID RECEPTOR AGONISTS/ANTAGONISTS		
VIBERZI	T2	HD
IBS-C/CIC AGENTS, GUANYLATE CYCLASE-C AGONIST		
LINZESS	T2	
TRULANCE	T2	
INTESTINAL MOTILITY STIMULANTS		
<i>metoclopramide hcl</i>	T1	
<i>metoclopramide hcl (Reglan)</i>	T1	
REGLAN (<i>metoclopramide hcl</i>)	T3	
IRRITABLE BOWEL SYNDROME AGENTS, 5-HT3 ANTAGONIST		
<i>alosetron hcl</i>	T4	SP HD
IV FAT EMULSIONS		
CLINOLIPID	T3	
<i>fat emulsions (Nutralipid)</i>	T3	

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List of Prescription Medications

INTRALIPID	T3	
GASTROINTESTINAL (Gastrointestinal/Heartburn) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
IV FAT EMULSIONS (cont.)		
NUTRILIPID (<i>intralipid</i>)	T3	
OMEGAVEN	T3	
SMOFLIPID	T3	
LAXATIVES AND CATHARTICS		
<i>bisac/nac/nahco3/kcl/peg 3350</i>	T1	PPACA
<i>lactulose</i>	T1	
<i>lactulose 10 gm/15 ml solution</i>	T1	
<i>lubiprostone (Amitiza)</i>	T1	
NULYTELY	T3	PPACA
<i>peg3350/sod sul/nac/kcl/asb/c</i>	T1	PPACA
<i>peg3350/sod sulf, bicarb, cl/kcl</i>	T1	PPACA
PREPOIK	T2	PPACA
<i>sodium chloride/nahco3/kcl/peg</i>	T2	PPACA
SUPREP	T2	PPACA
LOCAL ANORECTAL NITRATE PREPARATIONS		
<i>nitroglycerin 0.4% ointment (Rectiv)</i>	T1	
RECTIV (<i>nitroglycerin</i>)	T3	
PANCREATIC ENZYMES		
PANCREAZE	T2	HD
VIOKACE	T3	HD
ZENPEP	T2	HD
POTASSIUM-COMPETITIVE ACID BLOCKERS (PCABS)		
VOQUEZNA	T3	PA QL(1 tab/day)
PROTON-PUMP INHIBITORS		
<i>dexlansoprazole dr 30 mg cap</i>	T1	QL (2 caps/day) HD
<i>dexlansoprazole dr 60 mg cap</i>	T1	QL(1 cap/day) HD
<i>esomeprazole sodium</i>	T1	
<i>esomeprazole dr 10 mg packet</i>	T1	QL (4 packets/day) HD
<i>esomeprazole dr 20 mg packet (Nexium)</i>	T1	QL (2 packs/day) HD
<i>esomeprazole dr 40 mg packet (Nexium)</i>	T1	QL (1 packet/day) HD
<i>esomeprazole mag dr 20 mg cap</i>	T1	QL (2 caps/day) HD

T1 – Typically Generics

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List of Prescription Medications

GASTROINTESTINAL (Gastrointestinal/Heartburn) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
PROTON-PUMP INHIBITORS (cont.)		
<i>esomeprazole mag dr 40 mg cap</i>	T1	QL (1 cap/day) HD
<i>pantoprazole sodium 40 mg vial</i>	T1	HD
<i>lansoprazole dr 15 mg capsule</i>	T1	QL (2 caps/day) HD
<i>lansoprazole dr 30 mg capsule</i>	T1	QL (30 caps/30 days) HD
<i>lansoprazole odt 15 mg tablet</i>	T1	QL (2 tabs/day) HD
<i>lansoprazole odt 30 mg tablet</i>	T1	QL (30 tabs/30 days) HD
NEXIUM DR 2.5 MG PACKET	T2	QL (480 packs/30 days) HD
NEXIUM DR 5 MG PACKET	T2	QL (240 packs/30 days) HD
<i>omeppi 20 mg-1, 100 mg capsule</i>	T1	PA QL (60 caps/30 days) HD
<i>omeppi 40 mg-1, 100 mg capsule</i>	T1	PA QL (30 caps/30 days) HD
<i>omeprazole dr 10 mg capsule</i>	T1	QL (4 caps/day) HD
<i>omeprazole dr 20 mg capsule</i>	T1	QL (60 caps/30 days) HD
<i>omeprazole dr 40 mg capsule</i>	T1	QL (30 caps/30 days) HD
<i>omeprazole-bicarb 20-1, 100 cap</i>	T1	PA QL (60 caps/30 days) HD
<i>omeprazole-bicarb 20-1, 680 pkt</i>	T1	PA QL (60 packs/30 days) HD
<i>omeprazole-bicarb 40-1, 100 cap</i>	T1	PA QL (30 caps/30 days) HD
<i>omeprazole-bicarb 40-1, 680 pkt</i>	T1	PA QL (30 packs/30 days) HD
<i>pantoprazole 40 mg suspension</i>	T1	QL (1 dose/day) HD
<i>pantoprazole sod dr 20 mg tab</i>	T1	QL (2 tabs/day) HD
<i>pantoprazole sod dr 40 mg tab</i>	T1	QL (30 tabs/30 days) HD
<i>pantoprazole sodium 40 mg vial</i>	T1	HD
<i>rabeprazole sodium</i>	T1	QL (1 tab/day) HD
SBS - GLUCAGON-LIKE PEPTIDE-2 (GLP-2) ANALOGS		
GATTEX	T4	PA SP HD

GASTROINTESTINAL (Pain Relief And Inflammatory Disease)

HEMORRHOID PREP, ANTI-INFLAM STEROID-LOCAL ANESTHET

ANA-LEX	T1	
<i>hydrocortisone/lidocaine/aloe</i>	T1	
<i>hydrocortisone/pramoxine (Analpram Hc)</i>	T1	
<i>lidocaine/hydrocortisone ac</i>	T1	
LIDOCAINE-HYDROCORTISONE	T1	
PROCORT	T3	
PROCTOFOAM-HC	T3	

T1 – Typically Generics

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List of Prescription Medications

GASTROINTESTINAL (Skin Conditions)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
KERATINOCYTE GROWTH FACTOR (KGF)		
KEPIVANCE	T4	SP
HORMONES (Gastrointestinal/Heartburn)		
RECTAL/LOWER BOWEL PREP., GLUCOCORT. (NON-HEMORR)		
<i>budesonide 2 mg rectal foam</i>	T1	
CORTENEMA (<i>hydrocortisone</i>)	T3	
<i>hydrocortisone</i> (Cortenema)	T1	
HORMONES (Hormonal Agents)		
ADRENOCORTICOTROPHIC HORMONES		
ACTHAR	T4	PA SP HD
ACTHREL	T4	SP
<i>cosyntropin</i>	T1	
ANDROGEN/ESTROGEN PREPS FOR FEMALE SEXUAL DYSFUNC		
INTRAROSA	T3	
ANDROGENIC AGENTS		
ANADROL-50	T3	PA
ANDRODERM	T3	PA QL (1 patch/day)
ANDROGEL 1% (25 MG/2.5 G) PKT (<i>testosterone</i>)	T3	PA QL (150gm/30 days)
ANDROGEL 1% (50 MG/5 G) PKT (<i>testosterone</i>)	T3	PA QL (2 packs/day)
ANDROGEL 1.62% GEL PUMP (<i>testosterone</i>)	T3	PA QL (150gm/30 days)
ANDROGEL 1.62% (1.25G) GEL PCKT (<i>testosterone</i>)	T3	PA QL (2 packs/day)
AVEED	T3	PA SP
AZMIRO	T3	
DEPO-TESTOSTERONE (<i>testosterone cypionate</i>)	T3	
METHITEST	T1	
<i>methyltestosterone</i>	T1	
<i>oxandrolone</i>	T1	PA
TESTOPEL	T3	PA
<i>testosterone 1% (25mg/2.5g) pk</i> (Androgel)	T1	PA QL (150gm/30 days)
<i>testosterone 1% (50 mg/5 g) pk</i> (Testosterone)	T1	PA QL (2 packs/day)
<i>testosterone 1.62% (2.5 g) pkt</i> (Androgel)	T1	PA QL (150gm/30 days)
<i>testosterone 1.62% gel pump</i> (Androgel)	T1	PA QL (150gm/30 days)
<i>testosterone 1.62% (1.25 g) pkt</i> (Androgel)	T1	PA QL (2 packs/day)

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List of Prescription Medications

HORMONES (Hormonal Agents) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ANDROGENIC AGENTS (cont.)		
<i>testosterone 10 mg gel pump</i>	T1	PA QL (120 gm/30 days)
TESTOSTERONE 12.5 MG/1.25 GRAM	T1	PA QL (150gm/30 days)
<i>testosterone 12.5 mg/1.25 gram (Testosterone)</i>	T1	PA QL (150gm/30 days)
<i>testosterone 30 mg/1.5 ml pump</i>	T1	PA QL (180ml/30 days)
<i>testosterone 50 mg/5 gram gel</i>	T1	PA QL (2 tubes/day)
TESTOSTERONE 50 MG/5 GRAM PKT	T1	PA QL (2 packs/day)
ANTIDIURETIC AND VASOPRESSOR HORMONES		
<i>desmopressin 0.01% solution</i>	T1	HD
<i>desmopressin 0.01% spray</i>	T1	HD
<i>desmopressin 10 mcg/0.1 ml spr</i>	T1	HD
<i>desmopressin 40 mcg/10 ml vial</i>	T1	SP
<i>desmopressin ac 4 mcg/ml ampul</i>	T4	SP
<i>desmopressin ac 4 mcg/ml vial</i>	T4	SP
<i>desmopressin acetate 0.1 mg tb (Ddvp)</i>	T1	
<i>desmopressin acetate 0.2 mg tb (Ddvp)</i>	T1	
NOCTIVA	T3	PA
STIMATE	T4	SP
<i>vasopressin</i>	T1	
VASOPRESSIN-D5W	T1	
VASOSTRICT	T3	
ESTROGEN AND PROGESTIN COMBINATIONS		
BIJUVA	T3	
ESTROGEN/ANDROGEN COMBINATIONS		
<i>estrogen, ester/me-testosterone (Estratest F.S.)</i>	T1	HD
ESTROGENIC AGENTS		
ACTIVELLA (<i>mimvey lo</i>)	T3	HD
ACTIVELLA (<i>mimvey</i>)	T3	HD
ALORA	T3	QL (16 patches/28 days) HD
CLIMARA (<i>estradiol (once weekly)</i>)	T3	HD
CLIMARA PRO	T3	HD
COMBIPATCH	T3	
DEPO-ESTRADIOL	T3	HD

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List of Prescription Medications

HORMONES (Hormonal Agents) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ESTROGENIC AGENTS (cont.)		
DIVIGEL	T3	HD
ELESTRIN	T3	HD
estradiol (Climara)	T1	HD
estradiol 0.06% 1.25g gel pump (EstroGel)	T1	HD
estradiol 0.1% (0.5mg) gel pkt (Divigel)	T1	HD
estradiol patch (Minivelle)	T1	QL (16 patches/28 days) HD
estradiol patch (Vivelle-Dot)	T1	QL (16 patches/28 days) HD
estradiol tablet (Estrace)	T1	HD
estradiol valerate (Delestrogen)	T1	HD
estradiol/norethindrone acet (Activella)	T1	HD
ESTROGEL (estradiol)	T3	HD
EVAMIST	T3	HD
FEMHRT (norethindron-ethinyl estradiol)	T3	HD
MENEST	T3	HD
MENOSTAR	T3	QL (8 patches/28 days) HD
MINIVELLE (Iyllana)	T3	QL (16 patches/28 days) HD
norethind-eth estrad 0.5-2.5 (Femhrt)	T1	HD
norethindrone ac/eth estradiol	T1	HD
norethindrone ac/eth estradiol (Femhrt)	T1	HD
norethin-eth estrad 1 mg-5 mcg	T1	HD
PREMARIN	T2	HD
PREMPHASE	T2	HD
PREMPRO	T2	HD
VIVELLE-DOT (Iyllana)	T3	QL (16 patches/28 days) HD
ESTROGEN-PROGESTIN WITH ANTIMINERALOCORTICOID COMB		
ANGELIQ	T3	HD
ESTROGEN-SELECTIVE ESTROGEN RECEPTOR MOD (SERM) COMB		
DUAVEE	T2	
GLUCOCORTICOIDS		
BETA 1	T3	
betamethasone acetate, sod phos (Celestone)	T1	
BSP 0820	T3	

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

T4 – Specialty Medications

PA – Prior Authorization

QL – Quantity Limit

ST – Step Therapy

AGE – Age Requirement

SP – Specialty Medication

HD – May require home delivery pharmacy

PPACA – No Cost-Share Preventive Medication

CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

HORMONES (Hormonal Agents) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
GLUCOCORTICOIDS (cont.)		
<i>budesonide</i>	T1	PA QL (56 tabs/180 days)
<i>budesonide</i> (Entocort Ec)	T1	
CELESTONE (<i>betamethasone sod phos-acetate</i>)	T3	
<i>cortisone acetate</i>	T1	
<i>deflazacort</i> (Emflaza)	T4	PA SP HD
DEPO-MEDROL	T3	
<i>dexamethasone</i>	T1	
<i>dexamethasone sodium phosp/pf</i>	T1	
<i>dexamethasone tablet</i>	T1	
DEXAMETHASONE 10 MG/ML SYRING	T3	
<i>dexamethasone 10 mg/ml vial</i>	T1	
<i>dexamethasone 100 mg/10 ml vl</i>	T1	
<i>dexamethasone 120 mg/30 ml vl</i>	T1	
<i>dexamethasone 20 mg/5 ml vial</i>	T1	
<i>dexamethasone 4 mg/ml syringe</i>	T1	
<i>dexamethasone 4 mg/ml vial</i>	T1	
<i>dexamethasone in 0.9 % sod chl</i>	T1	
EMFLAZA	T4	PA SP HD
ENTOCORT EC (<i>budesonide ec</i>)	T3	
<i>hydrocortisone</i>	T1	
<i>hydrocortisone sod succinate</i> (Solu-cortef)	T1	
KENALOG-10	T3	
KENALOG-40 (<i>triamcinolone acetonide</i>)	T3	
KENALOG-80	T3	
LOCORT	T1	
MEDROL	T3	
MEDROL (<i>methylprednisolone</i>)	T3	
MEDROLOAN II SUIK	T3	
<i>methylprednisolone</i> (Medrol)	T1	
<i>methylprednisolone acetate</i> (Depo-medrol)	T1	
<i>methylprednisolone sod succ</i>	T1	
<i>methylprednisolone sod succ</i> (Solu-medrol)	T1	
MILLIPRED 10 MG/5 ML SOLUTION (<i>prednisolone sodium phosphate</i>)	T3	

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

T4 – Specialty Medications

PA – Prior Authorization

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ST – Step Therapy

AGE – Age Requirement

SP – Specialty Medication

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List of Prescription Medications

HORMONES (Hormonal Agents) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
GLUCOCORTICOIDS (cont.)		
millipred 5 mg tablet	T1	
ORAPRED ODT (<i>prednisolone sodium phos odt</i>)	T3	
P-CARE D80G	T1	
P-CARE K80	T1	
POD-CARE 100C	T1	
<i>prednisolone</i>	T1	
<i>prednisolone sodium phosphate</i> (Millipred)	T1	
<i>prednisolone sodium phosphate</i> (Orapred Odt)	T1	
<i>prednisone</i>	T1	
PRO-C-DURE 5	T3	
PRO-C-DURE 6	T3	
READYSHARP BETAMETHASONE	T1	
SOLU-CORTEF	T3	
SOLU-MEDROL	T3	
UCERIS 9 MG ER TABLET (budesonide)	T3	PA QL(1 tab/day)
ZILRETTA	T3	PA
GROWTH HORMONES		
GENOTROPIN	T4	PA SP HD
NORDITROPIN FLEXPRO	T4	PA SP HD
OMNITROPE	T4	PA SP HD
SEROSTIM	T4	PA SP
SKYTROFA	T4	PA SP
SOGROYA	T4	PA SP
ZORBTIVE	T4	PA SP HD
GROWTH HORMONE RELEASING HORMONE (GHRH) AND ANALOGS		
EGRIFTA	T4	PA SP HD
EGRIFTA SV	T4	PA SP HD
LHRH (GNRH) AGONIST ANALOG AND PROGESTIN COMB		
LUPANETA PACK	T4	PA SP HD
LHRH (GNRH) AGONIST ANALOG PITUITARY SUPPRESSANTS		
LUPRON DEPOT	T4	PA SP HD
LHRH (GNRH) ANTAGONIST, ESTROGEN AND PROGESTIN COMB		
MYFEMBREE	T2	PA QL (24 month therapy)
ORIAHNN	T2	PA QL (2 capsules/day)
LHRH (GNRH) ANTAGONIST, PITUITARY SUPPRESSANT AGENTS		
CETROTIDE	T4	PA SP

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

T4 – Specialty Medications

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AGE – Age Requirement

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PPACA – No Cost-Share Preventive Medication

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List of Prescription Medications

HORMONES (Hormonal Agents) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
LHRH (GNRH) ANTAGONIST, PITUITARY SUPPRESSANT AGENTS (cont.)		
<i>ganirelix acet 250 mcg/0.5 ml</i> (Ganirelix Acetate)	T4	PA SP
GANIRELIX ACET 250 MCG/0.5 ML (<i>ganirelix acetate</i>)	T4	PA SP
ORILISSA 150 MG TABLET	T2	PA QL (24 months of treatment/lifetime)
ORILISSA 200 MG TABLET	T2	PA QL (2 tabs/day)
LHRH (GNRH) AGNST PIT.SUP-CENTRAL PRECOCIOUS PUBERTY		
FENSOLVI	T4	PA SP
LUPRON DEPOT-PED	T4	PA SP HD
TRIPTODUR	T4	PA SP
MINERALOCORTICIDS		
<i>fludrocortisone acetate</i>	T1	HD
OXYTOCICS		
CARBOPROST	T3	
<i>carboprost tromethamine</i>	T1	
CERVIDIL	T3	
HEMABATE	T3	
<i>methylergonovine maleate</i>	T1	
<i>oxytocin</i> (Pitocin)	T1	
OXYTOCIN-D5-LACTATED RINGERS	T1	
OXYTOCIN-D5W	T1	
OXYTOCIN-LACTATED RINGERS	T1	
PITOCIN (<i>oxytocin</i>)	T3	
PREPIDIL	T3	
PROSTIN E2 VAGINAL SUPPOSITORY	T3	
PITUITARY SUPPRESSIVE AGENTS		
<i>cabergoline</i>	T1	QL (16 tabs/28 days) HD
CRENESSITY 50 MG CAPSULE	T4	PA QL(2 caps/day) SP
CRENESSITY 100 MG CAPSULE	T4	PA QL SP
CRENESSITY 50 MG/ML SOLUTION	T4	PA QL(8 mls/day) SP
<i>danazol</i>	T1	HD
PROGESTATIONAL AGENTS		
CRINONE 4% GEL	T3	PA HD
DEPO-PROVERA 400 MG/ML VIAL	T2	HD
<i>hydroxyprogesterone caproate</i>	T1	PA

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

T4 – Specialty Medications

PA – Prior Authorization

QL – Quantity Limit

ST – Step Therapy

AGE – Age Requirement

SP – Specialty Medication

HD – May require home delivery pharmacy

PPACA – No Cost-Share Preventive Medication

CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

HORMONES (Hormonal Agents) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
PROGESTATIONAL AGENTS (cont.)		
<i>medroxyprogesterone</i> (Provera)	T1	HD
<i>norethindrone acetate</i>	T1	HD
<i>progesterone 100 mg capsule</i> (Prometrium)	T1	HD
<i>progesterone 200 mg capsule</i> (Prometrium)	T1	HD
<i>progesterone 500 mg/10 ml vial</i>	T4	SP HD
RENIN-ANGIOTENSIN-ALDOSTERONE SYS. (RAAS) HORMONES		
GIAPREZA	T4	SP
SOMATOSTATIC AGENTS		
<i>lanreotide</i>	T1	
LANREOTIDE	T3	
<i>octreotide acetate</i>	T4	PA SP HD
<i>octreotide acetate</i> (Sandostatin)	T4	PA SP HD
SANDOSTATIN 0.05 MG/ML AMPUL (<i>octreotide acetate</i>)	T4	PA SP HD
SANDOSTATIN 0.1 MG/ML AMPUL (<i>octreotide acetate</i>)	T4	PA SP HD
SANDOSTATIN 0.5 MG/ML AMPUL (<i>octreotide acetate</i>)	T4	PA SP HD
SANDOSTATIN LAR DEPOT	T4	PA SP
SIGNIFOR	T4	PA SP
SIGNIFOR LAR	T4	PA SP
SOMATULINE DEPOT	T4	PA SP HD
VAGINAL ESTROGEN FOR SEXUAL DYSFUNCTION		
IMVEXXY 10 MCG MAINTENANCE PAK	T3	QL (16/28 days) HD
OXYTOCIN-LACTATED RINGERS	T1	
IMVEXXY 4 MCG MAINTENANCE PACK	T3	QL (16/28 days) HD
IMVEXXY 4 MCG STARTER PACK	T3	QL (36/28 days) HD
VAGINAL ESTROGEN PREPARATIONS		
ESTRACE (<i>estradiol</i>)	T3	HD
<i>estradiol</i> (Vagifem)	T1	QL (36 tabs/28 days)
<i>estradiol 0.01% cream</i> (Estrace)	T1	HD
<i>estradiol 10 mcg vaginal insrt</i> (Vagifem)	T1	QL (36 tabs/28 days) HD
ESTRING	T3	QL (2 rings/90 days) HD
FEMRING	T3	HD
PREMARIN	T2	HD
VAGIFEM (<i>yuvafem</i>)	T3	QL (36 tabs/28 days) HD
I1 – Typically Generics T2 – Typically Preferred Brands T3 – Typically Non-Preferred Brands I4 – Specialty Medications PA – Prior Authorization QL – Quantity Limit S1 – Step Therapy AGE – Age Requirement SP – Specialty Medication HD – May require home delivery pharmacy PPACA – No Cost-Share Preventive Medication CSL – Oral cancer medication subject to cost-share limits		

List of Prescription Medications

HORMONES (Infertility)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
FERTILITY STIMULATING PREPARATIONS, NON-FSH		
<i>clomiphene citrate</i>	T1	
FOLLICLE-STIMULATING AND LUTEINIZING HORMONES		
MENOPUR	T4	PA SP
FOLLICLE-STIMULATING HORMONE (FSH)		
FOLLISTIM AQ	T4	PA SP
GONAL-F	T4	PA SP
GONAL-F RFF	T4	PA SP
GONAL-F RFF REDI-JECT	T4	PA SP
HUMAN CHORIONIC GONADOTROPIN (HCG)		
CHORIONIC GONAD 12,000 UNIT VL	T4	SP
CHORIONIC GONAD 6,000 UNIT VL	T4	SP
CHORIONIC GONADOTROPIN	T4	PA SP
NOVAREL	T4	PA SP
OVIDREL	T4	PA SP
PREGNYL	T4	PA SP
PREGNANCY FACILITATING/MAINTAINING AGENT, HORMONAL		
CRINONE 8% GEL	T2	PA
ENDOMETRIN	T2	
PREGNANCY MAINTAINING AGENT, HORMONAL		
<i>hydroxyprogesterone 250 mg/ml vial (Makena)</i>	T1	PA
MAKENA (<i>hydroxyprogesterone caproate</i>)	T3	PA
HORMONES (Miscellaneous)		
LEPTIN HORMONE ANALOGS		
MYALEPT	T4	PA SP HD
HORMONES (Osteoporosis Products)		
BONE RESORPTION INHIBITORS		
<i>calcitonin, salmon, synthetic</i>	T1	HD
JUBBONTI	T4	PA SP
MIACALCIN	T3	HD
WYOST	T4	PA SP
IMMUNOSUPPRESSANTS (Miscellaneous)		
IMMUNOSUPPRESSANT-INTERFERON GAMMA INHIBITOR, MAB		
GAMIFANT	T4	PA SP

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

T4 – Specialty Medications

PA – Prior Authorization

QL – Quantity Limit

ST – Step Therapy

AGE – Age Requirement

SP – Specialty Medication

HD – May require home delivery pharmacy

PPACA – No Cost-Share Preventive Medication

CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

IMMUNOSUPPRESSANTS (Pain Relief And Inflammatory Disease)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ANTI-CD19 (B LYMPHOCYTE) MONOCLONAL ANTIBODY		
UPLIZNA	T4	PA SP
IL-23 RECEPTOR ANTAGONIST, MONOCLONAL ANTIBODY		
OMVOH	T4	SP HD
OMVOH PEN	T4	PA QL (2 pens/28 days) SP HD
IL-23 RECEPTOR ANTAGONIST, MONOCLONAL ANTIBODY		
OMVOH 100 MG/ML SYRINGE	T4	PA QL SP HD
OMVOH 300 MG/15 ML VIAL	T4	PA SP HD
INTERLEUKIN-4 (IL-4) RECEPTOR ALPHA ANTAGONIST, MAB		
DUPIXENT PEN	T4	PA SP HD
DUPIXENT SYRINGE	T4	PA SP HD
INTERLEUKIN-6 (IL-6) RECEPTOR INHIBITORS		
ACTEMRA 162 MG/0.9 ML SYRINGE	T4	PA QL (4 syringes/28 days) SP HD
ACTEMRA 200 MG/10 ML VIAL	T4	PA SP HD
ACTEMRA 400 MG/20 ML VIAL	T4	PA SP HD
ACTEMRA 80 MG/4 ML VIAL	T4	PA SP HD
ACTEMRA ACTPEN	T4	PA QL (4 pens/28 days) SP HD
ENSPRYNG	T4	PA SP HD
KEVZARA 150 MG/1.14 ML PEN INJ	T4	PA QL (2 pens/28 days) SP HD
KEVZARA 150 MG/1.14 ML SYRINGE	T4	PA QL (2 syringes/28 days) SP HD
KEVZARA 200 MG/1.14 ML PEN INJ	T4	PA QL (2 pens/28 days) SP HD
KEVZARA 200 MG/1.14 ML SYRINGE	T4	PA QL (2 syringes/28 days) SP HD
TYENNE	T4	PA SP
TYENNE AUTOINJECTOR	T4	PA QL (3.6 ml/28 days) SP
MONOCLONAL ANTIBODY-HUMAN INTERLEUKIN 12/23 INHIB		
STELARA 130 MG/26 ML VIAL	T4	PA SP HD
STELARA 45 MG/0.5 ML SYRINGE	T4	PA QL (1 syringe/84 days) SP HD
STELARA 45 MG/0.5 ML VIAL	T4	PA QL (1 vial/84 days) SP HD
STELARA 90 MG/ML SYRINGE	T4	PA QL (1 syringe/84 days) SP HD
IMMUNOSUPPRESSANTS (Skin Conditions)		
TOPICAL IMMUNOSUPPRESSIVE AGENTS		
ELIDEL (<i>pimecrolimus</i>)	T3	
NEMLUVIO	T4	PA SP

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

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

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

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

List of Prescription Medications

IMMUNOSUPPRESSANTS (Skin Conditions)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
TOPICAL IMMUNOSUPPRESSIVE AGENTS		
<i>pimecrolimus</i> (Elidel)	T1	
PROTOPIC (<i>tacrolimus</i>)	T3	
<i>tacrolimus</i> 0.03% ointment	T1	
<i>tacrolimus</i> 0.1% ointment	T1	
USTEKINUMAB-TTWE	T4	PA QL(1 syringe/84 days) SP HD
YESINTEK	T4	PA QL(1 syringe/84 days) SP

IMMUNOSUPPRESSANTS (Transplant Medications)

IMMUNOSUPP - MONOCLONAL AB INHIBITING T LYMPH FXN		
SIMULECT	T4	SP
IMMUNOSUPPRESSIVES		
ASTAGRAF XL	T4	SP HD
AZASAN	T4	SP HD
<i>azathioprine</i> (Imuran)	T4	SP HD
<i>azathioprine</i> sodium	T1	
CELLCEPT 200 MG/ML ORAL SUSP (<i>mycophenolate mofetil</i>)	T4	SP HD
CELLCEPT 250 MG CAPSULE (<i>mycophenolate mofetil</i>)	T4	SP HD
CELLCEPT 500 MG TABLET (<i>mycophenolate mofetil</i>)	T4	SP HD
CELLCEPT 500 MG VIAL (<i>mycophenolate mofetil</i>)	T4	SP
<i>cyclosporine</i> 100 mg capsule (Sandimmune)	T4	SP HD
<i>cyclosporine</i> 25 mg capsule (Sandimmune)	T4	SP HD
<i>cyclosporine</i> 250 mg/5 ml ampul (Sandimmune)	T4	SP
<i>cyclosporine</i> , modified	T4	SP HD
<i>cyclosporine</i> , modified (Neoral)	T4	SP HD
ENVARUSUS XR	T4	SP HD
<i>everolimus</i> 0.25 mg tablet (Zortress)	T4	SP HD
<i>everolimus</i> 0.5 mg tablet (Zortress)	T4	SP HD
<i>everolimus</i> 0.75 mg tablet (Zortress)	T4	SP HD
IMURAN (<i>azathioprine</i>)	T4	SP HD
LUPKYNIS	T4	PA QL(6 caps/day) SP
<i>mycophenolate</i> 200 mg/ml susp (Cellcept)	T4	SP HD
<i>mycophenolate</i> 250 mg capsule (Cellcept)	T4	SP HD
<i>mycophenolate</i> 500 mg tablet (Cellcept)	T4	SP HD
<i>mycophenolate</i> 500 mg vial (Cellcept)	T4	SP
NULOJIX	T4	SP
PROGRAF 0.2 MG GRANULE PACKET	T4	SP HD

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

T4 – Specialty Medications

PA – Prior Authorization

QL – Quantity Limit

ST – Step Therapy

AGE – Age Requirement

SP – Specialty Medication

HD – May require home delivery pharmacy

PPACA – No Cost-Share Preventive Medication

CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

IMMUNOSUPPRESSANTS (Transplant Medications) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
IMMUNOSUPPRESSIVES (cont.)		
PROGRAF 0.5 MG CAPSULE (<i>tacrolimus</i>)	T4	SP HD
PROGRAF 1 MG CAPSULE (<i>tacrolimus</i>)	T4	SP HD
PROGRAF 1 MG GRANULE PACKET	T4	SP HD
PROGRAF 5 MG CAPSULE (<i>tacrolimus</i>)	T4	SP HD
PROGRAF 5 MG/ML AMPULE	T4	SP
<i>sirolimus</i> (Rapamune)	T4	SP HD
<i>tacrolimus</i> 0.5 mg capsule (ir) (Prograf)	T4	SP HD
<i>tacrolimus</i> 1 mg capsule (ir) (Prograf)	T4	SP HD
<i>tacrolimus</i> 5 mg capsule (ir) (Prograf)	T4	SP HD
ZORTRESS	T4	SP HD
ZORTRESS (<i>everolimus</i>)	T4	SP HD

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

DIABETIC SUPPLIES		
2TEK CONTROL SOLUTION	T1	
2TEK GLUCOSE-WRIST MONITOR KIT	T1	
ACCU-CHEK	T1	
ACCUTREND GLUCOSE CONTROL	T1	
ADJUSTABLE LANCING DEVICE	T1	
ADVANCED LANCING DEVICE	T1	
ADVOCATE CONTROL SOLUTION	T1	
ADVOCATE LANCING DEVICE	T1	
ADVOCATE RAPID-SAFE LANCING DV	T1	
ADVOCATE REDI-CODE+ CTRL SOLN	T1	
AGAMATRIX CONTROL	T1	
ALKALINE BATTERIES	T1	
ALTERNATE SITE LANCING DEVICE	T1	
AQUA LANCE LANCING DEVICE	T1	
ASSURE	T1	
AT HOME A1C	T1	
AUTOJECT 2	T1	
AUTO-LANCET MINI	T1	
AUTOLET	T1	
BLOOD GLUCOSE CONTROL	T1	
BLULINK DIABETIC TEST BUNDLE	T3	
BLULINK GLUCOSE MONITOR SYSTEM	T3	

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

T4 – Specialty Medications

PA – Prior Authorization

QL – Quantity Limit

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AGE – Age Requirement

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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

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

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
DIABETIC SUPPLIES (cont.)		
BREEZE 2	T1	
CAREONE	T1	
CARESENS	T1	
CARETOUCH	T1	
CEQUR SIMPLICITY	T2	
CEQUR SIMPLICITY INSERTER	T2	
CHEMSTRIP BG DIARY	T1	
CHOSEN LANCING DEVICE	T1	
CLEVER CHOICE CONTROL SOLUTION	T1	
CONTOUR SOLUTION/METER/NEXT CONTROL SOLUTION	T1	
CONTROL SOLUTION	T1	
COOL CONTROL SOLUTION	T1	
DEXCOM G7 RECEIVER	T2	PA QL (1 unit/365 days)
DEXCOM G7 SENSOR	T2	PA QL (3 sensors/30 days)
DEXCOM	T3	
DEXCOM G4	T3	
DEXCOM G5	T3	
DEXCOM G5-G4 SENSOR	T3	
DEXCOM G6 RECEIVER	T2	PA QL (1 syringe/365 days)
DEXCOM G6 SENSOR	T2	PA QL (3/30 days)
DEXCOM G6 TRANSMITTER	T2	PA QL (1 syringe/67 days)
DIATRUE	T1	
DROPLET GENTEEL LANCING DEVICE	T1	
DROPLET LANCING DEVICE	T1	
EASY MINI EJECT LANCING DEVICE	T1	
EASYMAX T1	T3	
EASY PLUS II CONTROL SOLN HIGH/ LOW	T1	
EASY STEP CONTROL SOLUTION	T1	
EASY TALK CONTROL SOLN LOW / HIGH CONTROL SOLN	T1	
EASY TALK PLUS II HIGH CONTROL/ LOW CTRL SLN	T1	
EASY TOUCH	T1	
EASY TOUCH BLULINK CTRL SOLN	T1	
EASY TOUCH BLULINK GLUC SYST	T3	
EASY TRAK	T1	
EASYGLUCO PLUS CONTROL NORMAL	T1	

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

T4 – Specialty Medications

PA – Prior Authorization

QL – Quantity Limit

ST – Step Therapy

AGE – Age Requirement

SP – Specialty Medication

HD – May require home delivery pharmacy

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CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

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

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
DIABETIC SUPPLIES (cont.)		
EASYMAX	T1	
ELEMENT	T1	
EMBRACE	T1	
ENLITE	T3	
ENLITE GLUCOSE SENSOR	T3	
ENLITE SERTER	T3	
EVENCARE SOLUTION	T1	
EVERSENSE	T3	
EVOLUTION CONTROL SOLUTION	T1	
EZ-VAC	T1	
FORA CONTROL SOLUTION/ LANCING DEVICE	T1	
FORA TN'GO ADV MOBILE MULT MTR	T3	
FORACARE GDH	T1	
FORTISCARE	T1	
FREESTYLE CONTROL SOLUTION	T1	
FREESTYLE LIBRE 2 PLUS SENSOR	T2	PA QL (2 units/30 days)
FREESTYLE LIBRE 2 READER	T2	PA QL (1 reader/day)
FREESTYLE LIBRE 2 SENSOR	T2	PA QL (2 sensors/21 days)
FREESTYLE LIBRE 3 READER	T2	PA QL (1 unit/720 days)
FREESTYLE LIBRE 3 PLUS SENSOR	T2	PA QL (2 units/28 days)
FREESTYLE LIBRE 10 DAY READER	T2	PA QL (1 reader/day)
FREESTYLE LIBRE 10 DAY SENSOR	T2	PA QL (3/30 days)
FREESTYLE LIBRE 14 DAY READER	T2	PA QL (1 reader/day)
FREESTYLE LIBRE 14 DAY SENSOR	T2	PA QL (2/28 days)
FREESTYLE NAVIGATOR	T3	
GE100 CONTROL SOLUTION NORMAL	T1	
GE333 BLOOD GLUCOSE SYSTEM	T3	
GENTEEL VACUUM LANCING DEVICE	T1	
GLUCOCARD	T1	
GLUCOCOM	T1	
GLUCOSE	T1	
GOJJI GLUCOSE CONTROL SOLUTION/ LANCING DEVICE	T1	
GUARDIAN	T3	
GUARDIAN RT CHARGER	T1	
GUARDIAN RT STARTER KIT	T3	

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

T4 – Specialty Medications

PA – Prior Authorization

QL – Quantity Limit

ST – Step Therapy

AGE – Age Requirement

SP – Specialty Medication

HD – May require home delivery pharmacy

PPACA – No Cost-Share Preventive Medication

CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

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

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
DIABETIC SUPPLIES (cont.)		
GUARDIAN SENSOR 3	T3	
GUARDIAN TEST PLUG	T1	
GUARDIAN TRANSMITTER TAPE	T1	
HEALTHPRO GLUCOSE CONTROL SOLN	T1	
HEALTHY ACCENTS AUTOLET	T1	
HUMAPEN LUXURA HD	T3	
HYPOLANCE	T1	
INCONTROL LANCING DEVICE	T1	
INFINITY CONTROL SOLUTION / VOICE CONTROL SOLN	T1	
INPEN (FOR HUMALOG) / (FOR NOVOLOG OR FIASP)	T1	
INSUL-CAP	T1	
INSUL-EZE	T1	
LANCING DEVICE/ SYSTEM	T1	
LANZO	T1	
LITE TOUCH	T1	
MAGNI-GUIDE MAGNIFIER	T1	
MEDISENSE	T1	
MEDTRONIC REMOTE CONTROL	T1	
MICRODOT HIGH-LOW CONTROL SOL / NORMAL CONTROL SOLUT	T1	
MICROLET 2/ NEXT LANCING DEVICE	T1	
MINI LANCING DEVICE	T1	
MINILINK REAL-TIME TRANSMITTER	T2	
MINIMED QUICK-SERTER	T1	
MINIMED 630G GUARDIAN START KT	T3	
MOBILE LANCETS	T2	
MYGLUCOHEALTH CONTROL SOLUTION	T1	
MOBILE	T1	
NOVA MAX GLUCOSE CONTROL SOLN/ PLUS GLU-KET	T1	
NOVOPEN ECHO	T1	
OMNIPOD CLASSIC (GEN 3 & 4) KIT	T2	QL (1 kit/365 days)
OMNIPOD CLASSIC (GEN 3 & 4) PODS	T2	QL (30 pods/30 days)
OMNIPOD 5 (GEN 5) KIT	T2	QL (1 kit/365 days)
OMNIPOD 5 (GEN 5) PODS	T2	QL (30 pods/30 days)
OMNIPOD 5 G6-G7 INTRO KT(GEN5)	T2	QL
OMNIPOD 5 G6-G7 PODS (GEN 5)	T2	QL

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

T4 – Specialty Medications

PA – Prior Authorization

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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.)		
OMNIPOD DASH 5 PACK POD	T2	QL (6 boxes/30 days)
ON CALL	T1	
ONETOUCH DELICA PLUS LANC DEV	T1	
ONETOUCH ULTRA CONTROL SOLN	T1	
ONETOUCH ULTRASOFT 2 LANCET	T3	
ONETOUCH VERIO	T3	
OPTUMRX GLUCOSE CONTROL SOLN	T1	
OVAL TAPE	T1	
PARADIGM REAL-TIME	T2	
PIP GLUCOSE CONTROL SOLUTION	T1	
PRO COMFORT SAFETY LANCET	T2	
PRODIGY CONTROL SOLUTION / LANCING DEVICE	T1	
REFUAH PLUS GLUCOSE CONTROL	T1	
RELIAMED MINI LANCING DEVICE	T1	
REPLACEMENT PEDIATRIC MONITOR	T3	
RIGHTEST CONTROL SOLUTION/ GD500	T1	
SAFE-CLIP	T1	
SIL-SERTER	T1	
SEN-SERTER	T2	
SMARTDIABETES VANTAGE	T1	
SMARTEST	T1	
SOF-SENSOR	T2	
SOLUS V2 CONTROL SOLUTION / LANCING DEVICE	T1	
SURE COMFORT LANCING PEN	T1	
SUREFLEX	T1	
SURE-PEN	T1	
SURE-TEST EASYPLUS MINI SOLN	T1	
TELCARE CONTROL SOLUTION	T1	
TRUE METRIX	T1	
TRUECONTROL	T1	
TRUEDRAW	T1	
TWIIST REFILL	T1	Refill Kit: 30 units/30 days
TWIIST STARTER KIT	T1	Starter Kit: 1 kit/365 days; Refill Kit: 30 units/30 days
ULTI-LANCE	T1	

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

T4 – Specialty Medications

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
DIABETIC SUPPLIES (cont.)		
ULTRATRAK	T1	
UNISTIK	T1	
UNISTRIP	T1	
VERASENS CONTROL SOLUTION	T1	
V-GO	T2	
VIVAGUARD	T1	
WAVESENSE CONTROL SOLUTION	T1	
NEEDLES/NEEDLELESS DEVICES		
1ST TIER UNIFINE PENTIPS / PLUS	T1	
ABOUTIME PEN NEEDLE	T1	
ADVOCATE PEN NEEDLES	T1	
AQINJECT PEN NEEDLE	T1	
ASSURE ID PEN NEEDLE	T1	
AUTOSHIELD DUO PEN NEEDLE	T1	
BD NEEDLES		
BLUNT NEEDLE	T1	
CAREFINE PEN NEEDLE	T1	
CARETOUCH HYPODERMIC NEEDLE / PEN NEEDLE	T1	
CAREPOINT PRECISION NEEDLE	T1	
CLICKFINE	T1	
COMFORT EZ PEN NEEDLE / EZ PRO SAFETY PEN NDL	T1	
COMFORT TOUCH PEN NEEDLE	T1	
DROPLET MICRON PEN NEEDLE / PEN NEEDLE	T1	
DROPSAFE PEN NEEDLE	T1	
DROPSAFE SICURA SAFETY NEEDLE	T1	
EASY COMFORT PEN NEEDLES	T1	
EASY GLIDE PEN NEEDLE	T1	
EASY TOUCH	T1	
EASYPPOINT NEEDLE	T1	
ECLIPSE NEEDLE	T1	
EMBRACE PEN NEEDLE	T1	
EXEL HUBER NEEDLE/ HYPODERMIC NEEDLE	T1	
FILTER NEEDLE / ASPIRATOR NEEDLE	T1	
FLOW-EZE	T1	
HEALTHWISE PEN NEEDLE	T1	

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

T4 – Specialty Medications

PA – Prior Authorization

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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.)		
HEALTHY ACCENTS UNIFINE PENTIP	T1	
HYPODERMIC NEEDLE	T1	
INCONTROL PEN NEEDLE	T1	
INSULIN PEN NEEDLE	T1	
INSUPEN	T1	
INTEGRA	T1	
LIFESHIELD BLUNT CANNULA	T1	
LITE TOUCH	T1	
MAXICOMFORT	T1	
MICRODOT INSULIN PEN NEEDLE	T1	
MINI PEN NEEDLE/ MINI ULTRA-THIN II	T1	
MONOJECT BLOOD COLLECTION / FILTER NEEDLE	T1	
NANO 2ND GEN PEN NEEDLE	T1	
NEEDLES	T1	
<i>needles,safety huber,disposabl</i>	T1	
NOKOR	T1	
NOVOFINE	T1	
NOVOTWIST	T1	
PEN NEEDLES	T1	
PHASEAL PROTECTOR	T2	
PENTIPS	T1	
PIP PEN NEEDLE	T1	
POLY HUB NEEDLE	T1	
PRECISIONGLIDE	T1	
PREVENT DROPSAFE PEN NEEDLE	T1	
PRO COMFORT PEN NEEDLE	T1	
PURE COMFORT PEN NEEDLE / SAFETY PEN NEEDLE	T1	
RAYA SURE PEN NEEDLE	T1	
REGULAR BEVEL NEEDLES	T1	
RELION PEN NEEDLES	T1	
SAFETY PEN NEEDLE	T1	
SAFETYGLIDE NEEDLE	T1	
SECURESAFE PEN NEEDLE	T1	
SHORT BEVEL NEEDLES	T1	

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

T4 – Specialty Medications

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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.)		
SKY SAFETY PEN NEEDLE	T1	
SPECIALTY USE NEEDLES	T1	
SURE COMFORT	T1	
SURE-FINE PEN NEEDLES	T1	
TECHLITE PEN NEEDLE	T1	
TERUMO SURGUARD2	T1	
THIN WALL NEEDLES	T1	
TOPCARE CLICKFINE	T1	
TRANSFER NEEDLE	T1	
TRUE COMFORT	T1	
TRUEPLUS PEN NEEDLE	T1	
ULTICARE PEN NEEDLE / SAFETY PEN NEEDLE	T1	
ULTIGUARD SAFEPACK-PEN NEEDLE	T1	
ULTILET PEN NEEDLE	T1	
ULTRA FLO PEN NEEDLE	T1	
ULTRA THIN / ULTRA-THIN II	T1	
ULTRACARE PEN NEEDLE	T1	
ULTRA-FINE	T1	
UNIFINE	T1	
VERIFINE	T1	
YALE NEEDLES	T1	
SYRINGES AND ACCESSORIES		
ADVOCATE SYRINGES	T1	
ASSURE ID INSULIN SAFETY	T1	
CARETOUCH INSULIN SYRINGE	T1	
COMFORT EZ INSULIN SYRINGE	T1	
DROPLET INSULIN SYRINGE	T1	
DROPSAFE INSULIN SYRINGE	T1	
EASY COMFORT INSULIN SYRINGE	T1	
EASY GLIDE INSULIN SYRINGE	T1	
EASY TOUCH	T1	
ECLIPSE SYRINGE	T1	
FREESTYLE PRECISION	T1	
HEALTHWISE INSULIN SYRINGE	T1	

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-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
SYRINGES AND ACCESSORIES (cont.)		
INSULIN SYRINGE	T1	
INSULIN SYRINGE U-500	T1	
LITE TOUCH	T1	
LITETOUCH INSULIN SYRINGE	T1	
LUER-LOK SYRINGE	T1	
MAGELLAN INSULIN SAFETY SYRNG	T1	
MAGELLAN INSULIN SYRINGE	T1	
MAXI-COMFORT	T1	
MAXICOMFORT INSULIN SYRINGE	T1	
MINIMED RESERVOIR	T1	
MONOJECT	T1	
MONOJECT INSULIN SYRINGE	T1	
PARADIGM	T1	
PRO COMFORT INSULIN SYRINGE	T1	
PRODIGY INSULIN SYRINGE	T1	
SAFESNAP INSULIN SYRINGE	T1	
SAFETYGLIDE	T1	
SECURESAFE INSULIN SYRINGE	T1	
SURE COMFORT	T1	
SURE-JECT INSULIN SYRINGE	T1	
<i>syringe and needle,insulin,1ml</i>	T1	
<i>syring-needl,disp,insul</i>	T1	
TECHLITE INSULIN SYRINGE	T1	
TERUMO INSULIN SYRINGE	T1	
THINPRO INSULIN SYRINGE	T1	
TOPCARE ULTRA COMFORT	T1	
TRUE COMFORT INSULIN SYRINGE / PRO INS SYRINGE	T1	
TRUEPLUS INSULIN SYRINGE	T1	
ULTICARE	T1	
ULTICARE INSULIN SYRINGE	T1	
ULTIGUARD SAFE	T1	
ULTILET INSULIN SYRINGE	T1	
ULTRA COMFORT / FLO INSULIN SYRINGE	T1	
ULTRACARE INSULIN SYRINGE	T1	

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

T4 – Specialty Medications

PA – Prior Authorization

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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
SYRINGES AND ACCESSORIES (cont.)		
ULTRA-THIN II	T1	
VANISHPOINT	T1	
VEO INSULIN SYRINGE	T1	
VERIFINE INSULIN SYRINGE	T1	

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

DURABLE MEDICAL EQUIPMENT,MISC (GROUP I)		
1ST TIER UNILET COMFORTOUCH	T1	
2-IN-1 LANCET DEVICE	T1	
ACCU-CHEK	T1	
ACTI-LANCE	T1	
ADVANCED TRAVEL LANCETS	T1	
ADVOCATE LANCETS	T1	
ALTERNATE SITE LANCETS	T1	
ASSURE HAEMOLANCE PLUS	T1	
ASSURE LANCE	T1	
BD MICROTAINER LANCETS	T1	
BD ULTRA-FINE	T1	
BD ULTRA-FINE II	T1	
BLOOD LANCETS	T1	
BLULINK BG SYSTEM REFILL	T3	
BULLSEYE MINI SAFETY LANCETS	T1	
BUTTERFLY TOUCH LANCET	T1	
CAREONE	T1	
CARETOUCH TWIST LANCET	T1	
CHOSEN LANCING DEVICE		
CHOSEN LANCET		
CLEVER CHEK LANCETS	T1	
COAGUCHEK	T1	
COLOR LANCETS	T1	
COMFORT EZ	T1	
COMFORT LANCETS	T1	
COMFORT TOUCH PLUS SAFETY LANC / ULT THIN LANCET	T1	
DROPLET LANCETS	T1	

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

T4 – Specialty Medications

PA – Prior Authorization

QL – Quantity Limit

ST – Step Therapy

AGE – Age Requirement

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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.)		
EASY COMFORT LANCETS	T1	
EASY TOUCH	T1	
EASY TWIST & CAP LANCETS	T1	
EMBRACE 30G LANCETS / SAFETY LANCET	T1	
EZ SMART LANCETS	T1	
EZ-LETS	T1	
FIFTY50 SAFETY SEAL LANCETS	T1	
FINE 30 UNIVERSAL LANCETS	T1	
FINGERSTIX	T1	
FORA LANCETS	T1	
FORACARE LANCETS	T1	
FREESTYLE LANCETS / UNISTIK 2	T1	
GLUCOCOM	T1	
GOJJI LANCETS	T1	
HEALTHY ACCENTS UNILET LANCET	T1	
INCONTROL SUPER THIN LANCETS / ULTRA THIN LANCETS	T1	
INJECT EASE LANCETS	T1	
INVACARE LANCETS	T1	
lancets	T1	
LANCETS	T1	
LITE TOUCH	T1	
MEDISENSE THIN LANCETS	T1	
MEDLANCE PLUS	T1	
MICRO THIN LANCETS	T1	
MICROLET	T1	
MICROTAINER LANCETS	T1	
MOBILE LANCETS	T1	
MONOLET LANCETS / THIN LANCETS	T1	
MYGLUCOHEALTH LANCETS	T1	
NOVA SAFETY LANCETS	T1	
NOVA SUREFLEX	T1	
ON CALL LANCET / PLUS LANCET	T1	
ONETOUCH	T1	
ON-THE-GO	T1	

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

T4 – Specialty Medications

PA – Prior Authorization

QL – Quantity Limit

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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.)		
PERFECT POINT SAFETY LANCETS	T1	
PIP LANCET	T1	
PRESSURE ACTIVATED LANCETS	T1	
PRO COMFORT LANCETS / SAFETY LANCET	T1	
PRODIGY LANCETS / TWIST TOP LANCET	T1	
PURE COMFORT LANCETS / SAFETY LANCETS	T1	
PUSH BUTTON SAFETY LANCETS	T1	
READYLANCE SAFETY LANCETS	T1	
RELIAMED	T1	
RIGHTEST GL300 LANCETS	T1	
SAFETY LANCETS / SEAL LANCETS	T1	
SAFETY-LET	T1	
SINGLE-LET	T1	
SMART SENSE/ SENSE LANCETS	T1	
SMARTEST LANCET	T1	
SOLUS V2 LANCETS / 28G LANCETS	T1	
STERILANCE TL	T1	
STERILE LANCETS	T1	
SUPER THIN LANCETS	T1	
SURE COMFORT LANCETS	T1	
SURE-LANCE	T1	
SURE-TOUCH	T1	
TECHLITE LANCETS	T1	
TELCARE ULTRA THIN 30G LANCETS	T1	
THIN LANCETS	T1	
TOPCARE UNIVERSAL1 THIN LANCET / UNIVERSAL1 LANCET	T1	
TRUE COMFORT LANCET / SAFETY LANCET	T1	
TRUEPLUS LANCETS	T1	
TWIST LANCETS / TOP LANCET	T1	
ULTILET	T1	
ULTRA THIN	T1	
ULTRA-CARE LANCETS	T1	
ULTRALANCE	T1	

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

T4 – Specialty Medications

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ST – Step Therapy

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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.)		
ULTRA-THIN II	T1	
ULTRATLC LANCETS	T1	
UNILET	T1	
UNISTIK	T1	
UNIVERSAL 1	T1	
VERIFINE SAFETY LANCET MINI / UNIVERSAL LANCET	T1	
VIVAGUARD LANCET	T1	
NEEDLES/NEEDLELESS DEVICES		
NEEDLES	T1	
PERFECT POINT SAFETY NEEDLE	T1	
TISSUE BULKING IMPLANTS		
BARRIGEL (hyaluronate sodium, stabilized)	T4	PA SP HD
MUSCLE RELAXANTS (Pain Relief And Inflammatory Disease)		
SKELETAL MUSCLE RELAXANTS		
<i>baclofen</i>	T1	
<i>carisoprodol/aspirin</i>	T1	
<i>chlorzoxazone</i>	T1	
<i>cyclobenzaprine hcl</i>	T1	
<i>cyclobenzaprine hcl (Fexmid)</i>	T1	
DANTRIUM	T3	
DANTRIUM (<i>dantrolene sodium</i>)	T3	
<i>dantrolene sodium</i>	T1	
<i>dantrolene sodium (Dantrium)</i>	T1	
FEXMID (<i>cyclobenzaprine hcl</i>)	T3	
FLEQSUVY (<i>baclofen</i>)	T3	HD
GABLOFEN	T3	
GABLOFEN (<i>baclofen</i>)	T3	
LIORESAL INTRATHECAL	T3	
<i>metaxalone</i>	T1	
<i>metaxalone (Skelaxin)</i>	T1	
<i>methocarbamol</i>	T1	
<i>orphenadrine citrate</i>	T1	
OZOBAX DS	T3	
ROBAXIN	T3	

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

T4 – Specialty Medications

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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 (cont.)		
ROBAXIN-750 (<i>methocarbamol</i>)	T3	
RYANODEX	T3	
SKELAXIN (<i>metaxalone</i>)	T3	
<i>tizanidine hcl</i> (Zanaflex)	T1	
ZANAFLEX (<i>tizanidine hcl</i>)	T3	

PRE-NATAL VITAMINS (Nutritional/Dietary)

PRENATAL VITAMIN PREPARATIONS		
ATABEX EC	T3	
CITRANATAL 90 DHA	T3	
CITRANATAL ASSURE	T3	
CITRANATAL DHA	T3	
CITRANATAL HARMONY	T3	
CITRANATAL RX	T3	
OBSTETRIX EC	T3	
OBTREX DHA	T3	
<i>pnv 22/iron, gluc/folic/dss/dha</i>	T1	
<i>pnv 66/iron/folic/docusate/dha</i>	T1	
<i>pnv 69/iron/folic/docusate/dha</i>	T1	
<i>pnv 80/iron fum/folic/dss/dha</i>	T1	
<i>pnv/ferrous fum/docusate/folic</i>	T1	
<i>pnv/iron, carb/docusat/folic ac</i>	T1	
<i>prenatal 12/iron/folic/dss/om3</i> (Obtrex Dha)	T1	
PRENATAL 19	T1	
<i>prenatal 34/iron/folic/dss/dha</i>	T1	
<i>prenatal vits 15/iron/folic/dss</i>	T1	
VITAFOL FE+	T3	

PSYCHOTHERAPEUTIC DRUGS (Anxiety/Depression/Bipolar Disorder)¹⁰

ALPHA-2 RECEPTOR ANTAGONIST ANTIDEPRESSANTS		
<i>mirtazapine</i>	T1	HD
<i>mirtazapine</i> (Remeron)	T1	HD
ANTI-ANXIETY - BENZODIAZEPINES		
<i>alprazolam</i>	T1	
<i>alprazolam</i> (Xanax Xr)	T1	

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

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

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

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List of Prescription Medications

PSYCHOTHERAPEUTIC DRUGS (Anxiety/Depression/Bipolar Disorder)¹⁰ (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ANTI-ANXIETY - BENZODIAZEPINES (cont.)		
<i>alprazolam</i> (Xanax)	T1	
<i>chlordiazepoxide hcl</i>	T1	
<i>clorazepate dipotassium</i>	T1	
<i>clorazepate dipotassium</i> (Tranxene T-tab)	T1	
<i>diazepam 10 mg tablet</i> (Valium)	T1	
<i>diazepam 10 mg/2 ml carpuject</i>	T1	
<i>diazepam 10 mg/2 ml syringe</i>	T1	
<i>diazepam 2 mg tablet</i> (Valium)	T1	
<i>diazepam 5 mg tablet</i> (Valium)	T1	
<i>diazepam 5 mg/5 ml solution</i>	T1	
<i>diazepam 5 mg/ml oral conc</i>	T1	
<i>diazepam 50 mg/10 ml vial</i>	T1	
<i>lorazepam</i>	T1	
<i>oxazepam</i>	T1	
TRANXENE T-TAB (<i>clorazepate dipotassium</i>)	T3	
ANTI-ANXIETY DRUGS		
<i>buspirone hcl</i>	T1	HD
<i>meprobamate</i>	T1	
ANTIDEPRESSANT - NMDA RECEPTOR ANTAGONIST		
SPRAVATO	T4	PA SP
ANTIDEPRESSANT - POSTPARTUM DEPRESSION (PPD)		
ZURZUVAE 20 MG CAPSULE	T4	PA QL(28 caps/270 days) SP HD
ZURZUVAE 25 MG CAPSULE	T4	PA QL(28 caps/270 day) SP HD
ZURZUVAE 30 MG CAPSULE	T4	PA QL(14 caps/270 day) SP HD
BIPOLAR DISORDER DRUGS		
EQUETRO	T3	HD
<i>lithium carbonate</i>	T1	HD
<i>lithium carbonate</i> (Lithobid)	T1	HD
<i>lithium citrate</i>	T1	HD
MAOIS -NON-SELECTIVE, IRREVERSIBLE ANTIDEPRESSANTS		
MARPLAN	T3	QL (12 tabs/day)

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

T4 – Specialty Medications

PA – Prior Authorization

QL – Quantity Limit

ST – Step Therapy

AGE – Age Requirement

SP – Specialty Medication

HD – May require home delivery pharmacy

PPACA – No Cost-Share Preventive Medication

CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

PSYCHOTHERAPEUTIC DRUGS (Anxiety/Depression/Bipolar Disorder)¹⁰ (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
MAOIS -NON-SELECTIVE, IRREVERSIBLE ANTIDEPRESSANTS (con't.)		
<i>phenelzine sulfate</i> (Nardil)	T1	
<i>tranylcypromine sulfate</i>	T1	
MONOAMINE OXIDASE (MAO) INHIBITOR ANTIDEPRESSANTS		
EMSAM 12 MG/24 HOURS PATCH	T3	QL (1 patch/day)
EMSAM 6 MG/24 HOURS PATCH	T3	QL (2 patches/day)
EMSAM 9 MG/24 HOURS PATCH	T3	QL (1 patch/day)
NOREPINEPHRINE AND DOPAMINE REUPTAKE INHIB (NDRIS)		
<i>bupropion hcl 100 mg tablet</i>	T1	QL (4 tabs/day) HD
<i>bupropion hcl 75 mg tablet</i>	T1	QL (6 tabs/day) HD
<i>bupropion hcl sr 100 mg tablet</i> (Wellbutrin Sr)	T1	QL (4 tabs/day) HD
<i>bupropion hcl sr 150 mg tablet</i> (Wellbutrin Sr)	T1	QL (2 tabs/day) HD
<i>bupropion hcl sr 200 mg tablet</i> (Wellbutrin Sr)	T1	QL (2 tabs/day) HD
<i>bupropion hcl xl 150 mg tablet</i>	T1	QL (3 tabs/day) HD
<i>bupropion hcl xl 300 mg tablet</i>	T1	QL (1 tab/day) HD
SELECTIVE SEROTONIN 5-HT_{2A} INVERSE AGONISTS (SSIA)		
NUPLAZID	T3	PA SP HD
SELECTIVE SEROTONIN REUPTAKE INHIBITOR (SSRIS)		
<i>citalopram hbr 10 mg tablet</i> (Celexa)	T1	QL (6 tabs/day) HD
<i>citalopram hbr 10 mg/5 ml soln</i>	T1	QL (30ml/day) HD
<i>citalopram hbr 20 mg tablet</i> (Celexa)	T1	QL (3 tabs/day) HD
<i>citalopram hbr 20 mg/10 ml sol</i>	T1	QL (30ml/day) HD
<i>citalopram hbr 40 mg tablet</i> (Celexa)	T1	QL (1 tab/day) HD
<i>escitalopram 10 mg tablet</i>	T1	QL (2 tabs/day) HD
<i>escitalopram 5 mg tablet</i>	T1	QL (4 tabs/day) HD
<i>escitalopram oxalate 5 mg/5 ml</i>	T1	QL (20ml/day) HD
<i>fluoxetine 20 mg/5 ml solution</i>	T1	QL (20ml/day) HD
<i>fluoxetine 20 mg/5 ml soln cup</i>	T1	QL (20 mls/day) HD
<i>fluoxetine hcl</i>	T1	QL (4 caps/28 days) HD
<i>fluoxetine hcl 10 mg capsule</i> (Prozac)	T1	QL (8 caps/day) HD
<i>fluoxetine hcl 10 mg tablet</i> (Sarafem)	T1	HD
<i>fluoxetine hcl 20 mg capsule</i> (Prozac)	T1	QL (4 caps/day) HD
<i>fluoxetine hcl 20 mg tablet</i>	T1	HD
<i>fluoxetine hcl 40 mg capsule</i> (Prozac)	T1	QL (2 caps/day) HD
<i>fluoxetine hcl 60 mg tablet</i>	T1	QL (1 tab/day) HD

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List of Prescription Medications

PSYCHOTHERAPEUTIC DRUGS (Anxiety/Depression/Bipolar Disorder)¹⁰ (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
SELECTIVE SEROTONIN REUPTAKE INHIBITOR (SSRIS) (cont.)		
<i>fluvoxamine er 100 mg capsule</i>	T1	QL (3 caps/day) HD
<i>fluvoxamine er 150 mg capsule</i>	T1	QL (2 caps/day) HD
<i>fluvoxamine maleate 100 mg tab</i>	T1	QL (3 tabs/day) HD
<i>fluvoxamine maleate 25 mg tab</i>	T1	QL (12 tabs/day) HD
<i>fluvoxamine maleate 50 mg tab</i>	T1	QL (6 tabs/day) HD
<i>paroxetine cr 12.5 mg tablet (Paxil Cr)</i>	T1	QL (1 tab/day) HD
<i>paroxetine cr 25 mg tablet (Paxil Cr)</i>	T1	QL (3 tabs/day) HD
<i>paroxetine cr 37.5 mg tablet (Paxil Cr)</i>	T1	QL (2 tabs/day) HD
<i>paroxetine er 12.5 mg tablet (Paxil Cr)</i>	T1	QL (1 tab/day) HD
<i>paroxetine er 25 mg tablet (Paxil Cr)</i>	T1	QL (3 tabs/day) HD
<i>paroxetine er 37.5 mg tablet (Paxil Cr)</i>	T1	QL (2 tabs/day) HD
<i>paroxetine hcl 10 mg tablet (Paxil)</i>	T1	QL (6 tabs/day) HD
<i>paroxetine hcl 20 mg tablet (Paxil)</i>	T1	QL (3 tabs/day) HD
<i>paroxetine hcl 30 mg tablet (Paxil)</i>	T1	QL (2 tabs/day) HD
<i>paroxetine hcl 40 mg tablet (Paxil)</i>	T1	QL (1 tab/day) HD
PAXIL CR 12.5 MG TABLET (<i>paroxetine er</i>)	T3	QL (1 tab/day) ST HD
PAXIL CR 25 MG TABLET (<i>paroxetine er</i>)	T3	QL (3 tabs/day) ST HD
SARAFEM (<i>fluoxetine hcl</i>)	T3	ST HD
<i>sertraline 20 mg/ml oral conc (Zoloft)</i>	T1	QL (10ml/day) HD
<i>sertraline hcl 100 mg tablet (Zoloft)</i>	T1	QL (2 tabs/day) HD
<i>sertraline hcl 25 mg tablet (Zoloft)</i>	T1	QL (8 tabs/day) HD
<i>sertraline hcl 50 mg tablet (Zoloft)</i>	T1	QL (4 tabs/day) HD
SEROTONIN-2 ANTAGONIST/REUPTAKE INHIBITORS (SARIS)		
<i>nefazodone hcl</i>	T1	HD
<i>trazodone hcl</i>	T1	HD
SEROTONIN-NOREPINEPHRINE REUPTAKE-INHIB (SNRIS)		
<i>desvenlafaxine succnt er 100mg</i>	T1	QL (4 tabs/day) HD
<i>desvenlafaxine succnt er 25 mg</i>	T1	QL (16 tabs/day) HD
<i>desvenlafaxine succnt er 50 mg</i>	T1	QL (1 tab/day) HD
<i>duloxetine hcl dr 20 mg cap</i>	T1	QL (6 caps/day) HD
<i>duloxetine hcl dr 30 mg cap</i>	T1	QL (4 caps/day) HD
<i>duloxetine hcl dr 40 mg cap</i>	T1	QL (3 caps/day) HD
<i>duloxetine hcl dr 60 mg cap</i>	T1	QL (2 caps/day) HD
FETZIMA 20-40 MG TITRATION PAK	T3	QL (28 caps/180 days) ST

T1 – Typically Generics

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T3 – Typically Non-Preferred Brands

T4 – Specialty Medications

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ST – Step Therapy

AGE – Age Requirement

SP – Specialty Medication

HD – May require home delivery pharmacy

PPACA – No Cost-Share Preventive Medication

CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

PSYCHOTHERAPEUTIC DRUGS (Anxiety/Depression/Bipolar Disorder)¹⁰ (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
SEROTONIN-NOREPINEPHRINE REUPTAKE-INHIB (SNRIS) (cont.)		
FETZIMA ER 120 MG CAPSULE	T3	QL (1 cap/day) ST
FETZIMA ER 20 MG CAPSULE	T3	QL (6 caps/day) ST
FETZIMA ER 40 MG CAPSULE	T3	QL (3 caps/day) ST
FETZIMA ER 80 MG CAPSULE	T3	QL (1 cap/day) ST
<i>venlafaxine hcl 100 mg tablet</i>	T1	QL (3 tabs/day) HD
<i>venlafaxine hcl 25 mg tablet</i>	T1	QL (15 tabs/day) HD
<i>venlafaxine hcl 37.5 mg tablet</i>	T1	QL (10 tabs/day) HD
<i>venlafaxine hcl 50 mg tablet</i>	T1	QL (7 tabs/day) HD
<i>venlafaxine hcl 75 mg tablet</i>	T1	QL (5 tabs/day) HD
<i>venlafaxine hcl er 150 mg cap (Effexor Xr)</i>	T1	QL (2 caps/day) HD
<i>venlafaxine hcl er 150 mg tab</i>	T1	QL (2 tabs/day) HD
<i>venlafaxine hcl er 225 mg tab</i>	T1	QL (1 tab/day) HD
<i>venlafaxine hcl er 37.5 mg cap (Effexor Xr)</i>	T1	QL (8 caps/day) HD
<i>venlafaxine hcl er 37.5 mg tab</i>	T1	QL (8 tabs/day) HD
<i>venlafaxine hcl er 75 mg cap (Effexor Xr)</i>	T1	QL (4 caps/day) HD
<i>venlafaxine hcl er 75 mg tab</i>	T1	QL (4 tabs/day) HD
SSRI AND 5HT1A PARTIAL AGONIST ANTIDEPRESSANTS		
VIIBRYD 10-20 MG STARTER PACK	T3	ST HD
<i>vilazodone hcl 10 mg tablet (Viibryd)</i>	T1	QL (1 tab/day) ST HD
<i>vilazodone hcl 20 mg tablet (Viibryd)</i>	T1	QL (1 tab/day) ST HD
<i>vilazodone hcl 40 mg tablet (Viibryd)</i>	T1	HD
SSRI, SEROTONIN RECEPTOR MODULATOR ANTIDEPRESSANTS		
TRINTELLIX 10 MG TABLET	T2	QL (1 tab/day) ST
TRINTELLIX 20 MG TABLET	T2	ST
TRINTELLIX 5 MG TABLET	T2	QL (1 tab/day) ST
TRICYCLIC ANTIDEPRESSANT-BENZODIAZEPINE COMBINATNS		
<i>amitriptyline/chlordiazepoxide</i>	T1	HD
TRICYCLIC ANTIDEPRESSANT-PHENOTHIAZINE COMBINATNS		
<i>perphenazine/amitriptyline hcl</i>	T1	HD
TRICYCLIC ANTIDEPRESSANTS, REL.NON-SEL.REUPT-INHIB		
<i>amitriptyline hcl</i>	T1	HD
<i>amoxapine</i>	T1	HD
<i>clomipramine hcl</i>	T1	HD
<i>desipramine hcl</i>	T1	HD

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

T4 – Specialty Medications

PA – Prior Authorization

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ST – Step Therapy

AGE – Age Requirement

SP – Specialty Medication

HD – 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)¹⁰ (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
TRICYCLIC ANTIDEPRESSANTS, REL.NON-SEL.REUPT-INHIB (cont.)		
<i>doxepin 10 mg capsule</i>	T1	HD
<i>doxepin 10 mg/ml oral conc</i>	T1	HD
<i>doxepin capsule</i>	T1	HD
<i>imipramine hcl</i>	T1	HD
<i>imipramine pamoate</i>	T1	HD
<i>maprotiline hcl</i>	T1	HD
<i>nortriptyline hcl</i>	T1	HD
<i>protriptyline hcl</i>	T1	HD
<i>trimipramine maleate</i>	T1	HD

PSYCHOTHERAPEUTIC DRUGS (Attention Deficit Hyperactivity Disorder)⁹

TX FOR ADHD - SELECTIVE ALPHA-2 RECEPTOR AGONIST		
<i>clonidine hcl (Kapvay)</i>	T1	
<i>guanfacine hcl (Intuniv)</i>	T1	HD
INTUNIV (<i>guanfacine hcl er</i>)	T3	
TX FOR ATTENTION DEFICIT-HYPERACT (ADHD) /NARCOLEPSY		
DAYTRANA 10 MG/9 HR PATCH	T3	PA QL (1 patch/day)
DAYTRANA 15 MG/9 HR PATCH	T3	PA QL (1 per day)
DAYTRANA 20 MG/9 HOUR PATCH	T3	PA QL (1 patch/day)
DAYTRANA 30 MG/9 HOUR PATCH	T3	PA QL (1 patch/day)
<i>dexmethylphenidate er 10 mg cp</i>	T1	PA QL (1 cap/day)
<i>dexmethylphenidate er 15 mg cp</i>	T1	PA QL (1 per day)
<i>dexmethylphenidate er 20 mg cp</i>	T1	PA QL (1 cap/day)
<i>dexmethylphenidate er 25 mg cp</i>	T1	PA QL (1 cap/day)
<i>dexmethylphenidate er 30 mg cp</i>	T1	PA QL (1 cap/day)
<i>dexmethylphenidate er 35 mg cp</i>	T1	PA QL (1 cap/day)
<i>dexmethylphenidate er 40 mg cp</i>	T1	PA QL (1 cap/day)
<i>dexmethylphenidate er 5 mg cap</i>	T1	PA QL (1 cap/day)
<i>dexmethylphenidate hcl (Focalin)</i>	T1	PA
FOCALIN (<i>dexmethylphenidate hcl</i>)	T3	PA ST
METHYLIN (<i>methylphenidate hcl</i>)	T3	PA
<i>methylphenidate (Daytrana)</i>	T1	PA QL (1 patch/day)
<i>methylphenidate er 18, 27, 54mg cap</i>	T1	PA QL (1 tab/day)
<i>methylphenidate er 36mg cap</i>	T1	PA QL (2 tab/day)

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

T4 – Specialty Medications

PA – Prior Authorization

QL – Quantity Limit

ST – Step Therapy

AGE – Age Requirement

SP – Specialty Medication

HD – May require home delivery pharmacy

PPACA – No Cost-Share Preventive Medication

CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

PSYCHOTHERAPEUTIC DRUGS (Attention Deficit Hyperactivity Disorder)¹⁰ (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
TX FOR ATTENTION DEFICIT-HYPERACT (ADHD) /NARCOLEPSY (cont.)		
<i>methylphenidate er 10 mg cap</i>	T1	QL (1 per day)
<i>methylphenidate er 10 mg tab</i>	T1	PA QL (2/day)
<i>methylphenidate 10 mg/9hr ptch (Daytrana)</i>	T1	PA QL (1 patch/day)
<i>methylphenidate er 15 mg cap</i>	T1	QL (1 per day)
<i>methylphenidate 15 mg/9hr ptch (Daytrana)</i>	T1	PA QL (1 patch/day)
<i>methylphenidate er 18 mg tab</i>	T1	PA QL (1 per day)
<i>methylphenidate er 20 mg cap</i>	T1	QL (1 per day)
<i>methylphenidate er 20 mg tab</i>	T1	PA QL (3/day)
<i>methylphenidate 20 mg/9hr ptch (Daytrana)</i>	T1	PA QL (1 patch/day)
<i>methylphenidate er 27 mg tab</i>	T1	PA QL (1 tab/day)
<i>methylphenidate er 30 mg cap</i>	T1	QL (1 per day)
<i>methylphenidate 30 mg/9hr ptch (Daytrana)</i>	T1	PA QL (1 patch/day)
<i>methylphenidate er 36 mg tab</i>	T1	PA QL (1 per day)
<i>methylphenidate er 40 mg cap</i>	T1	QL (1 per day)
<i>methylphenidate er 50 mg cap</i>	T1	QL (1 per day)
<i>methylphenidate er 54 mg tab</i>	T1	PA QL (1 tab/day)
<i>methylphenidate er 60 mg cap</i>	T1	QL (1 per day)
<i>methylphenidate hcl</i>	T1	PA
<i>methylphenidate hcl (Metadate CD)</i>	T1	PA QL (1 cap/day)
<i>methylphenidate hcl (Methylin)</i>	T1	PA
<i>methylphenidate hcl (Ritalin)</i>	T1	PA
<i>methylphenidate la 10 mg cap</i>	T1	PA QL (1 cap/day)
<i>methylphenidate la 20 mg cap</i>	T1	PA QL (1 cap/day)
<i>methylphenidate la 30 mg cap</i>	T1	PA QL (1 per day)
<i>methylphenidate la 40 mg cap</i>	T1	PA QL (1 cap/day)
<i>methylphenidate la 60 mg cap</i>	T1	PA QL (1 cap/day)
QUILLIVANT XR	T3	PA QL (12ml/day)
RITALIN (<i>methylphenidate hcl</i>)	T3	PA ST
TX FOR ATTENTION DEFICIT-HYPERACT. (ADHD) , NRI-TYPE		
<i>atomoxetine hcl 10 mg capsule (Strattera)</i>	T1	HD
<i>atomoxetine hcl 100 mg capsule (Strattera)</i>	T1	HD
<i>atomoxetine hcl 18 mg capsule (Strattera)</i>	T1	HD
<i>atomoxetine hcl 25 mg capsule (Strattera)</i>	T1	HD
<i>atomoxetine hcl 40 mg capsule (Strattera)</i>	T1	QL (1 cap/day) HD

T1 – Typically Generics

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T3 – Typically Non-Preferred Brands

T4 – Specialty Medications

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ST – Step Therapy

AGE – Age Requirement

SP – Specialty Medication

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List of Prescription Medications

PSYCHOTHERAPEUTIC DRUGS (Attention Deficit Hyperactivity Disorder)¹⁰ (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
TX FOR ATTENTION DEFICIT-HYPERACT. (ADHD) , NRI-TYPE (cont.)		
<i>atomoxetine hcl 60 mg capsule</i> (Strattera)	T1	HD
<i>atomoxetine hcl 80 mg capsule</i> (Strattera)	T1	HD
STRATTERA 10 MG CAPSULE (<i>atomoxetine hcl</i>)	T3	HD
STRATTERA 100 MG CAPSULE (<i>atomoxetine hcl</i>)	T3	HD
STRATTERA 18 MG CAPSULE (<i>atomoxetine hcl</i>)	T3	HD
STRATTERA 25 MG CAPSULE (<i>atomoxetine hcl</i>)	T3	HD
STRATTERA 40 MG CAPSULE (<i>atomoxetine hcl</i>)	T3	QL (1 cap/day) HD
STRATTERA 60 MG CAPSULE (<i>atomoxetine hcl</i>)	T3	HD
STRATTERA 80 MG CAPSULE (<i>atomoxetine hcl</i>)	T3	HD

PSYCHOTHERAPEUTIC DRUGS (Schizophrenia/Anti-Psychotics)¹⁰

ANTIPSYCH, DOPAMINE ANTAG., DIPHENYLBUTYLPIPERIDINES		
<i>pimozide</i>	T1	
ANTIPSYCHOTIC, ATYPICAL, DOPAMINE, SEROTONIN ANTAGNST		
<i>asenapine maleate</i> (Saphris)	T1	
CAPLYTA	T3	ST QL(1 tabs/caps/day)
<i>clozapine</i>	T1	
<i>clozapine</i> (Clozapine Odt)	T1	
<i>clozapine</i> (Clozaril)	T1	
CLOZAPINE ODT	T1	
CLOZARIL (<i>clozapine</i>)	T3	ST
GEODON	T3	
INVEGA ER 1.5 MG TABLET (<i>paliperidone er</i>)	T3	ST
INVEGA ER 3 MG TABLET (<i>paliperidone er</i>)	T3	QL (1 tab/day) ST
INVEGA ER 6 MG TABLET (<i>paliperidone er</i>)	T3	ST
INVEGA ER 9 MG TABLET (<i>paliperidone er</i>)	T3	ST

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SP – Specialty Medication

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List of Prescription Medications

PSYCHOTHERAPEUTIC DRUGS (Schizophrenia/Anti-Psychotics)¹⁰ (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ANTIPSYCHOTIC, ATYPICAL, DOPAMINE, SEROTONIN ANTAGNIST (cont.)		
INVEGA SUSTENNA 117 MG/0.75 ML	T3	QL (2 syring/28 days)
INVEGA SUSTENNA 156 MG/ML SYRG	T3	QL (1 syringe/28 days)
INVEGA SUSTENNA 234 MG/1.5 ML	T3	QL (1 syringe/28 days)
INVEGA SUSTENNA 39 MG/0.25 ML	T3	QL (2 syring/28 days)
INVEGA SUSTENNA 78 MG/0.5 ML	T3	QL (2 syring/28 days)
INVEGA TRINZA	T3	QL (2 injectors/90 days)
<i>lurasidone hcl 120 mg tablet (Latuda)</i>	T1	
<i>lurasidone hcl 20 mg tablet (Latuda)</i>	T1	
<i>lurasidone hcl 40 mg tablet (Latuda)</i>	T1	QL (1 tab/day)
<i>lurasidone hcl 60 mg tablet (Latuda)</i>	T1	QL (1 tab/day)
<i>lurasidone hcl 80 mg tablet (Latuda)</i>	T1	
<i>olanzapine</i>	T1	
<i>olanzapine (Zyprexa)</i>	T1	
<i>paliperidone er 1.5 mg tablet (Invega)</i>	T1	
<i>paliperidone er 3 mg tablet (Invega)</i>	T1	QL (1 tab/day)
<i>paliperidone er 9 mg tablet (Invega)</i>	T1	
PERSERIS	T3	QL (1 kit/28 days)
<i>quetiapine fumarate (Seroquel Xr)</i>	T1	
<i>quetiapine fumarate 400 mg tab (Seroquel)</i>	T1	
<i>risperidone</i>	T1	QL
<i>risperidone (Risperdal)</i>	T1	
SAPHRIS (<i>asenapine maleate</i>)	T3	ST
SECUADO	T3	ST
SEROQUEL (<i>quetiapine fumarate</i>)	T3	ST
SEROQUEL XR (<i>quetiapine fumarate er</i>)	T3	ST
<i>ziprasidone hcl</i>	T1	
<i>ziprasidone mesylate (Geodon)</i>	T1	
ZYPREXA (<i>olanzapine</i>)	T2	
ZYPREXA RELPREVV 210 MG VIAL	T3	QL (4 vials/28 days)
ZYPREXA RELPREVV 210 MG VL KIT	T3	QL (4 vials/28 days)
ZYPREXA RELPREVV 300 MG VIAL	T3	QL (4 vials/28 days)
ZYPREXA RELPREVV 300 MG VL KIT	T3	QL (4 vials/28 days)
ZYPREXA RELPREVV 405 MG VIAL	T3	QL (2 vials/28 days)
ZYPREXA RELPREVV 405 MG VL KIT	T3	QL (2 vials/28 days)

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

T4 – Specialty Medications

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AGE – Age Requirement

SP – Specialty Medication

HD – May require home delivery pharmacy

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CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

PSYCHOTHERAPEUTIC DRUGS (Schizophrenia/Anti-Psychotics)^o (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ANTIPSYCHOTIC-ATYPICAL, D3/D2 PARTIAL AG-5HT MIXED		
VRAYLAR 1.5 MG CAPSULE	T3	QL (1 cap/day) ST
VRAYLAR 3 MG CAPSULE	T3	QL (1 cap/day) ST
VRAYLAR 4.5 MG CAPSULE	T3	ST
VRAYLAR 6 MG CAPSULE	T3	ST
ANTIPSYCHOTICS, ATYP, D2 PARTIAL AGONIST/5HT MIXED		
ABILIFY ASIMTUFII	T3	
ABILIFY MAINTENA ER 300 MG SYR	T2	QL (2 injectors/30 days)
ABILIFY MAINTENA ER 300 MG VL	T2	QL (2 injectors/30 days)
ABILIFY MAINTENA ER 400 MG SYR	T2	QL (2 injectors/30 days)
ABILIFY MAINTENA ER 400 MG VL	T2	
<i>aripiprazole</i>	T1	
<i>aripiprazole 10 mg tablet</i>	T1	
<i>aripiprazole 15 mg tablet</i>	T1	
<i>aripiprazole 2 mg tablet</i>	T1	
<i>aripiprazole 20 mg tablet</i>	T1	
<i>aripiprazole 30 mg tablet</i>	T1	
<i>aripiprazole 5 mg tablet</i>	T1	QL (1 tab/day)
ARISTADA ER 1064 MG/3.9 ML SYR	T3	
ARISTADA ER 441 MG/1.6 ML SYRN	T3	QL (2 syring/30 days)
ARISTADA ER 662 MG/2.4 ML SYRN	T3	QL (2 syring/30 days)
ARISTADA ER 882 MG/3.2 ML SYRN	T3	QL (2 syring/30 days)
ARISTADA INITIO	T3	
REXULTI 0.25 MG TABLET	T3	QL (1 tab/day) ST
REXULTI 0.5 MG TABLET	T3	QL (1 tab/day) ST
REXULTI 1 MG TABLET	T3	QL (1 tab/day) ST
REXULTI 2 MG TABLET	T3	QL (1 tab/day) ST
REXULTI 3 MG TABLET	T3	ST
REXULTI 4 MG TABLET	T3	ST
ANTIPSYCHOTICS, DOPAMINE AND SEROTONIN ANTAGONISTS		
<i>loxapine succinate</i>	T1	
ANTIPSYCHOTICS, DOPAMINE ANTAGONISTS, BUTYROPHENONES		
<i>droperidol</i>	T1	
HALDOL (<i>haloperidol lactate</i>)	T3	

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

T4 – Specialty Medications

PA – Prior Authorization

QL – Quantity Limit

ST – Step Therapy

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List of Prescription Medications

PSYCHOTHERAPEUTIC DRUGS (Schizophrenia/Anti-Psychotics)¹⁰ (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ANTIPSYCHOTICS, DOPAMINE ANTAGONISTS, BUTYROPHENONES (cont.)		
HALDOL DECANOATE 100 (<i>haloperidol decanoate 100</i>)	T3	
HALDOL DECANOATE 50 (<i>haloperidol decanoate</i>)	T3	
<i>haloperidol</i>	T1	
<i>haloperidol decanoate</i>	T1	
<i>haloperidol decanoate</i> (Haldol Decanoate 100)	T1	
<i>haloperidol decanoate</i> (Haldol Decanoate 50)	T1	
<i>haloperidol lactate</i>	T1	
<i>haloperidol lactate</i> (Haldol)	T1	
ANTIPSYCHOTICS, DOPAMINE ANTAGONST, DIHYDROINDOLONES		
<i>molindone hcl</i>	T1	
ANTIPSYCHOTICS, PHENOTHIAZINES		
<i>chlorpromazine hcl</i>	T1	
<i>fluphenazine decanoate</i>	T1	
<i>fluphenazine hcl</i>	T1	
<i>perphenazine</i>	T1	
<i>thioridazine hcl</i>	T1	
<i>trifluoperazine hcl</i>	T1	
SSRI-ANTIPSYCH, ATYPICAL, DOPAMINE, SEROTONIN ANTAG		
<i>olanzapine/fluoxetine hcl</i>	T1	
<i>olanzapine/fluoxetine hcl</i> (Symbyax)	T1	
PSYCHOTHERAPEUTIC DRUGS (Sleep Disorders/Sedatives)		
NARCOLEPSY AND SLEEP DISORDER THERAPY AGENTS		
<i>armodafinil</i>	T1	PA
<i>modafinil</i> (Provigil)	T1	PA
SUNOSI	T2	PA QL (1 tab/day)
SEDATIVE/HYPNOTICS (Sleep Disorders/Sedatives)		
ANTI-NARCOLEPSY, ANTI-CATAPLEXY, SEDATIVE-TYPE AGENT		
LUMRYZ	T4	PA QL (1 pack/day) SP HD
SODIUM OXYBATE	T4	PA QL(18 mls/day) SP HD
BARBITURATES		
AMYTAL SODIUM	T3	
NEMBUTAL SODIUM (<i>pentobarbital sodium</i>)	T3	PA
<i>pentobarbital sodium</i> (Nembutal Sodium)	T1	PA

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List of Prescription Medications

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

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
BARBITURATES (cont.)		
<i>phenobarbital</i>	T1	
<i>phenobarbital sodium</i>	T1	
<i>secobarbital sodium</i>	T3	PA
HYPNOTICS, MELATONIN MT1/MT2 RECEPTOR AGONISTS		
<i>ramelteon 8 mg tablet</i> (Rozerem)	T1	QL (1 tab/day)
SEDATIVE-HYPNOTICS, NON-BARBITURATE		
HETLIOZ	T4	PA SP HD
HETLIOZ LQ	T4	PA SP HD
<i>ramelteon 8 mg tablet</i> (Rozerem)	T1	QL (1 tab/day)
<i>tasimelteon</i>	T4	PA SP
SEDATIVE-HYPNOTICS - BENZODIAZEPINES		
DORAL	T3	
<i>estazolam</i>	T1	
<i>flurazepam hcl</i>	T1	
HALCION (<i>triazolam</i>)	T3	
<i>lorazepam</i>	T1	
LORAZEPAM-0.9% NACL	T1	
LORAZEPAM-D5W	T1	
QUAZEPAM	T1	
<i>quazepam</i> (Quazepam)	T1	
<i>temazepam</i>	T1	
<i>triazolam</i>	T1	
<i>triazolam</i> (Halcion)	T1	
SEDATIVE-HYPNOTICS, NON-BARBITURATE		
DAYVIGO	T2	QL (1 tab/day) ST
DEXMEDETOMIDINE HCL	T1	
<i>dexmedetomidine hcl</i> (Precedex)	T1	
<i>dexmedetomidine in 0.9 % nacl</i>	T1	
<i>doxepin hcl 3 mg tablet</i> (Silenor)	T1	QL (1 tab/day)
<i>doxepin hcl 6 mg tablet</i> (Silenor)	T1	
<i>eszopiclone</i> (Lunesta)	T1	
PRECEDEX	T3	
<i>zaleplon</i>	T1	
<i>zolpidem tartrate 10 mg tablet</i> (Ambien)	T1	

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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.)		
zolpidem tartrate 5 mg tablet (Ambien)	T1	
zolpidem tart er 12.5 mg tab	T1	
zolpidem tart er 6.25 mg tab	T1	QL (1 tab/day)
zolpidem tartrate	T1	

SKIN PREPS (Miscellaneous)

IRRIGANTS		
acetic acid	T1	
neomycin sulf/polymyxin b sulf	T1	
PHYSIOLYTE	T3	
PHYSIOSOL	T3	
ringer's solution	T1	
ringer's solution, lactated	T1	
sod, pot chlor/mag/sod, pot phos	T3	
sodium chloride irrig solution	T1	
SORBITOL	T1	
SORBITOL-MANNITOL	T1	
water for irrigation, sterile	T1	

OXIDIZING AGENTS		
hydrogen peroxide	T1	

SKIN PREPS (Pain Relief And Inflammatory Disease)

ANTIPSORIATIC AGENTS, SYSTEMIC		
acitretin	T1	
BIMZELX 160 MG/ML AUTOINJECTOR	T4	PA QL (2 mls/28 days) SP HD
BIMZELX 160 MG/ML SYRINGE	T4	PA QL (2 mls/28 days) SP HD
COSENTYX	T4	PA SP HD
ILUMYA	T4	PA QL (1 syringe/84 days) SP HD
methoxsalen (Oxsoralen-ultra)	T1	
OXSORALEN-ULTRA (methoxsalen)	T3	
SKYRIZI (2 SYRINGES) KIT	T4	PA QL (1 kit/84 days) SP HD
SILIQ	T4	PA QL (2 inj/15 days) SP HD
SOTYKTU	T4	PA QL (1 tab/day) SP HD
SPEVIGO 450 MG/7.5 ML VIAL	T4	PA SP HD
TALTZ AUTOINJECTOR	T4	PA QL (1 injector/28 days) SP HD

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List of Prescription Medications

SKIN PREPS (Pain Relief And Inflammatory Disease) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ANTIPSORIATIC AGENTS, SYSTEMIC (cont.)		
TALTZ AUTOINJECTOR (2 PACK)	T4	PA QL (1 injector/28 days) SP HD
TALTZ AUTOINJECTOR (3 PACK)	T4	PA QL (1 injector/28 days) SP HD
TALTZ SYRINGE	T4	PA QL (1 syringe/28 days) SP HD
TREMFYA 100 MG/ML INJECTOR	T4	PA QL (1 injector/56 days) SP HD
TREMFYA 100 MG/ML SYRINGE	T4	PA QL (1 syringe/56 days) SP HD
TREMFYA 200 MG/2 ML SYRINGE	T4	PA QL (2 mls/28 days) SP HD
TREMFYA PEN	T4	PA QL (2 syringe/28 days) SP HD
TOPICAL ANTI-INFLAMMATORY, NSAIDS		
DICLAREAL	T3	HD
<i>diclofenac sodium 1% gel</i>	T1	QL (1000gm/30 days) HD
SKIN PREPS (Skin Conditions)		
ACNE AGENTS, SYSTEMIC		
ABSORICA (isotretinoin)	T3	
ACUTANE	T1	
AMNESTEEM	T1	
CLARAVIS	T1	
isotretinoin (Absorica)	T1	
MYORISAN	T1	
ZENATANE	T1	
ACNE AGENTS, TOPICAL		
ACZONE 7.5% GEL PUMP	T3	
<i>adapalene/benzoyl peroxide</i>	T1	
<i>clindamycin-benzoyl perox 1-5%</i>	T1	
<i>clindamycin-bnz perox 1-5% pmp</i>	T1	
<i>clindamycin/tretinoin</i>	T1	
<i>dapsone (Aczone)</i>	T1	
KLARON (<i>sulfacetamide sodium</i>)	T3	
ONEXTON (<i>clindamycin phos/benzoyl perox</i>)	T3	
<i>sulfacetamide sodium (Klaron)</i>	T1	
ANTIPERSPIRANTS		
DRYSOL	T3	
ANTIPSORIATICS AGENTS		
<i>anthralin</i>	T1	
<i>calcipotriene</i>	T1	
<i>calcipotriene 0.005% cream</i>	T1	

T1 – Typically Generics
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List of Prescription Medications

SKIN PREPS (Skin Conditions) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ANTISEPTICS, GENERAL (cont.)		
CALCIPOTRIENE 0.005% FOAM	T3	
<i>tazarotene 0.05% cream (Tazorac)</i>	T1	
<i>calcipotriene 0.005% ointment</i>	T1	
<i>calcipotriene 0.005% solution</i>	T1	
<i>calcitriol 3 mcg/g ointment</i>	T1	QL (800gm/30 days)
OVACE PLUS	T3	
PROMISEB	T2	
<i>selenium sulfide</i>	T1	
<i>sulfacetamide sodium</i>	T1	
<i>tazarotene (Tazorac)</i>	T1	
TERSI FOAM	T3	
<i>alcohol antiseptic pads</i>	T1	
ALCOHOL PREP PADS / SWABS/WIPES	T1	
CARETOUCH ALCOHOL PREP PAD	T1	
CURITY ALCOHOL PREPS	T1	
DROPSAFE PREP PADS	T1	
EASY COMFORT ALCOHOL PAD	T1	
EASY TOUCH ALCOHOL PREP PADS	T1	
INCONTROL ALCOHOL PADS	T1	
PRO COMFORT ALCOHOL PADS	T1	
PURE COMFORT ALCOHOL PAD	T1	
SINGLE USE SWAB	T1	
SURE COMFORT ALCOHOL	T1	
SURE-PREP ALCOHOL PREP PADS	T1	
TRUE COMFORT ALCOHOL PADS / PRO ALCOHOL PADS	T1	
ULTILET ALCOHOL SWAB	T1	
WEBCOL	T1	
ANTISEPTICS, MISCELLANEOUS		
GUAIACOL	T3	
DIABETIC ULCER PREPARATIONS, TOPICAL		
REGRANEX	T3	PA QL (2 tubs/30 days)
EMOLLIENTS		
<i>ammonium lactate</i>	T1	
ATOPICLAIR	T3	
BIAFINE (<i>sonafine</i>)	T3	

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List of Prescription Medications

SKIN PREPS (Skin Conditions) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
EMOLLIENTS (cont.)		
<i>emollient combination no. 10</i> (Biafine)	T1	
<i>emollient combination no.35</i> (Mimyx)	T1	
<i>emollient combination no.44</i>	T1	
HALUCORT	T3	
MIMYX (<i>prumyx</i>)	T3	
RESTIZAN	T1	
<i>vite ac/grape/hyaluronic acid</i> (Atopiclair)	T1	
XCLAIR	T3	
IMMUNOMODULATORS		
<i>imiquimod</i>	T1	
IRRITANTS/COUNTER-IRRITANTS		
<i>methyl salicylate</i>	T1	
QUTENZA	T3	
JANUS KINASE (JAK) INHIBITORS		
CIBINQO	T4	PA QL (30 tabs/30 days) SP
LEQSELVI	T4	PA QL (2 tabs/day) SP HD
KERATOLYTICS		
BENZEFOAM	T3	
BENZEPRO	T1	
<i>benzoyl peroxide</i>	T1	
<i>benzoyl peroxide</i> (Enzoclear)	T1	
<i>benzoyl peroxide</i> (Pacnex)	T1	
ENZOCLEAR	T3	
HYDRO 35	T3	
HYDRO 40 (<i>umecta</i>)	T3	
INOVA	T3	
KERAFOAM	T3	
KERALYT 6% GEL (<i>salicylic acid</i>)	T3	
<i>keralyt 6% shampoo</i>	T1	
KERALYT SCALP	T3	
KERALYT SCALP (<i>salicylic acid</i>)	T3	
PACNEX (<i>benzoyl peroxide</i>)	T3	
PODOCON-25	T1	
<i>podofilox</i>	T1	
PR BENZOYL PEROXIDE	T1	

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List of Prescription Medications

SKIN PREPS (Skin Conditions) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
KERATOLYTICS (cont.)		
SALICATE	T3	
<i>salicylic acid</i>	T1	
<i>salicylic acid</i> (Keralyt Scalp)	T1	
<i>salicylic acid/ceramide comb 1</i>	T1	
SALIMEZ FORTE	T1	
SALKERA	T3	
SALVAX DUO PLUS	T3	
<i>silver nitrate</i>	T1	
<i>silver nitrate applicator</i>	T1	
URAMAXIN	T3	
URAMAXIN (<i>urea</i>)	T3	
<i>urea</i>	T1	
<i>urea</i> (Hydro 35)	T1	
<i>urea</i> (Hydro 40)	T3	
<i>urea</i> (Uramaxin)	T1	
<i>urea</i> (Xurea)	T1	
XUREA	T3	
PROTECTIVES		
BIONECT	T3	
PHARMABASE BARRIER	T1	
<i>polydimethylsiloxanes/silicon</i>	T1	
<i>protectives2/ceramide 1, 3, 6-ii</i>	T1	
RADIAPLEXRX	T3	
<i>zinc oxide</i>	T1	
ROSACEA AGENTS, TOPICAL		
<i>azelaic acid</i>	T1	
<i>ivermectin</i>	T1	
<i>metronidazole</i>	T1	
SOOLANTRA (<i>ivermectin</i>)	T3	
TISSUE/WOUND ADHESIVES		
ARTISS	T3	
SURGISEAL STYLUS	T3	
SURGISEAL TEARDROP	T3	
SURGISEAL TWIST	T3	

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List of Prescription Medications

SKIN PREPS (Skin Conditions) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
TISSUE/WOUND ADHESIVES (cont.)		
TISSEEL VHSD	T3	
TOP. ANTI-INFLAM., PHOSPHODIESTERASE-4 (PDE4) INHIB		
EUCRISA	T2	
ZORYVE 0.15% CREAM	T2	PA QL (60 gms/30 days)
TOPICAL AGENTS, MISCELLANEOUS		
GORDON'S UREA	T3	
HYFTOR	T4	PA SP
L-MESITRAN SOFT	T3	
MEDIHONEY	T3	
SAF-CLENS AF	T3	
<i>trichloroacetic acid</i>	T3	
TRICHLOROACETIC ACID	T1	
TOPICAL ANTIBIOTIC PLEUROMUTILIN DERIVATIVES		
ALTABAX	T3	
TOPICAL ANTI-INFLAMMATORY STEROIDAL		
ALA-SCALP (<i>scalacort</i>)	T3	ST
ACIOXIA	T3	
<i>alclometasone dipropionate</i>	T1	
<i>amcinonide 0.1% cream/ lotion</i>	T1	
AQUA GLYCOLIC HC	T3	
<i>betamethasone dipropionate</i>	T1	
<i>betamethasone valerate</i>	T1	
<i>betamethasone valerate (Luxiq)</i>	T1	
<i>betamethasone/propylene glyc</i>	T1	
<i>betamethasone/propylene glyc (Diprolene)</i>	T1	
BRYHALI	T3	ST
CAPEX SHAMPOO	T3	ST
<i>clobetasol propionate</i>	T1	
<i>clobetasol propionate (Clobex) (Temovate)</i>	T1	
<i>clobetasol propionate/emoll</i>	T1	
CLOCORTOLONE PIVALATE	T1	
CLODAN 0.05% KIT	T3	ST
<i>clodan 0.05% shampoo</i>	T1	
CLODERM	T3	ST
DERMA-SMOOTHIE-FS (<i>fluocinolone acetonide</i>)	T3	ST

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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.)		
DERMATOP (<i>prednicarbate</i>)	T3	ST
<i>desonide</i>	T1	
<i>desonide</i> (Desowen)	T1	
DESOWEN (<i>desonide</i>)	T3	ST
<i>desoximetasone</i> (Topicort)	T1	
DIPROLENE (<i>betamethasone diprop augmented</i>)	T3	ST
<i>fluocinolone acetonide</i>	T1	
<i>fluocinolone acetonide</i> (Derma-smoothe-fs)	T1	
<i>fluocinolone acetonide</i> (Synalar)	T1	
<i>fluocinolone/shower cap</i> (Derma-smoothe-fs)	T1	
<i>fluocinonide</i>	T1	
<i>fluocinonide/emollient base</i>	T1	
<i>fluticasone prop 0.005% oint</i>	T1	
<i>fluticasone prop 0.05% cream</i>	T1	
<i>fluticasone prop 0.05% lotion</i>	T1	
<i>fluticasone propionate</i>	T1	
<i>halobetasol propionate</i> (Ultravate)	T1	
<i>halobetasol prop 0.05% cream</i>	T1	
<i>halobetasol prop 0.05% foam</i>	T1	
<i>halobetasol prop 0.05% ointmnt</i>	T1	
<i>hydrocortisone</i>	T1	
<i>hydrocortisone</i> (Ala-scalp)	T1	
<i>hydrocortisone butyrate</i>	T1	
<i>hydrocortisone valerate</i>	T1	
LUXIQ (<i>betamethasone valerate</i>)	T3	ST
MOMETACURE	T3	
<i>mometasone furoate 0.1% cream</i>	T1	
<i>mometasone furoate 0.1% oint</i>	T1	
<i>mometasone furoate 0.1% soln</i>	T1	
NUCORT	T3	ST
<i>prednicarbate</i> (Dermatop)	T1	
SCALACORT DK	T3	ST
SYNALAR (<i>fluocinolone acetonide</i>)	T3	ST
SYNALARTS	T3	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.)		
TACLONEX 0.005%-0.064% SUSPENS (<i>calcipotriene/betamethasone</i>)	T3	
TEMOVATE (<i>clobetasol propionate</i>)	T3	ST
TEXACORT	T3	ST
TOPICORT (<i>desoximetasone</i>)	T3	ST
ULTRAVATE (<i>halobetasol propionate</i>)	T3	ST
TOPICAL ANTI-INFLAMMATORY STEROID-LOCAL ANESTHETIC		
ANALPRAM HC	T3	
EPIFOAM	T2	
<i>hydrocortisone/pramoxine</i> (Pramosone)	T1	
<i>lidocaine/hydrocortisone ac</i>	T1	
MEZPAROX-HC	T1	
PRAMOSONE	T3	
TOPICAL ANTIPARASITICS		
<i>lindane</i>	T1	
<i>malathion</i> (Ovide)	T1	
OVIDE (<i>malathion</i>)	T3	
TOPICAL PREPARATIONS, ANTIBACTERIALS		
<i>dermazene cream</i>	T1	
DERMAZENE CREAM PACKET	T3	
<i>hydrocortisone/iodoquinol</i>	T1	
<i>hydrocortisone/iodoquinol/aloe</i>	T1	
<i>iodine/potassium iodide</i>	T1	
<i>iodine/sodium iodide</i>	T1	
IODOFLEX	T3	
IODOSORB	T3	
<i>silver nitrate</i>	T1	
TOPICAL VIT D ANALOG/ANTI-INFLAMMATORY STEROID		
<i>calcipotriene/betamethasone</i>	T1	
TOPICAL/MUCOUS MEMBR./SUBCUT. ENZYMES		
AMPHADASE	T3	
SANTYL	T3	QL (60gm/30 days)
VITRASE	T3	
VITAMIN A DERIVATIVES		
<i>adapalene</i> (Plixda)	T1	PA

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

T4 – Specialty Medications

PA – Prior Authorization

QL – Quantity Limit

ST – Step Therapy

AGE – Age Requirement

SP – Specialty Medication

HD – May require home delivery pharmacy

PPACA – No Cost-Share Preventive Medication

CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

SKIN PREPS (Skin Conditions) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
VITAMIN A DERIVATIVES		
PLIXDA	T1	PA
RETIN-A MICRO PUMP 0.08% GEL (<i>tretinoin microspheres</i>)	T3	PA
<i>tretinoin 0.01% gel</i>	T1	
<i>tretinoin 0.025% cream</i>	T1	PA
<i>tretinoin 0.025% gel</i>	T1	
<i>tretinoin 0.05% cream</i>	T1	PA
<i>tretinoin 0.05% gel</i>	T1	PA
<i>tretinoin 0.1% cream</i>	T1	PA
<i>tretinoin microspheres</i>	T1	PA

THYROID PREPS (Hormonal Agents)

ANTITHYROID PREPARATIONS		
<i>methimazole</i> (Tapazole)	T1	HD
<i>propylthiouracil</i>	T1	HD
TAPAZOLE (<i>methimazole</i>)	T3	HD
THYROID FUNCTION DIAGNOSTIC AGENTS		
THYROGEN	T4	SP
THYROID HORMONES		
ARMOUR THYROID	T3	HD
CYTOMEL (<i>liothyronine sodium</i>)	T3	HD
LEVOTHYROXINE	T3	PA HD
<i>levothyroxine sodium</i>	T1	HD
<i>levothyroxine sodium</i> (Synthroid)	T1	HD
<i>liothyronine sodium</i> (Cytomel)	T1	HD
<i>liothyronine sodium</i> (Triostat)	T1	HD
SYNTHROID (<i>unithroid</i>)	T3	HD
<i>thyroid, pork</i>	T1	HD
<i>thyroid, pork</i> (Armour Thyroid)	T1	HD
<i>thyroid, pork</i> (Wp Thyroid)	T1	HD
THYROLAR-1	T3	HD
THYROLAR-1/2	T3	HD
THYROLAR-1/4	T3	HD
THYROLAR-2	T3	HD
THYROLAR-3	T3	HD
TIROSINT	T3	PA HD
TIROSINT-SOL	T3	PA HD

T1 – Typically Generics

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List of Prescription Medications

THYROID PREPS (Hormonal Agents) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
THYROID HORMONES (cont.)		
TRIOSTAT (<i>liothyronine sodium</i>)	T3	HD
WP THYROID	T1	HD
WP THYROID (<i>nature-throid</i>)	T1	HD
WP THYROID (<i>westhroid</i>)	T1	HD
UNCLASSIFIED DRUG PRODUCTS (AIDS/HIV)		
CYTOCHROME P450 INHIBITORS		
TYBOST	T4	SP
UNCLASSIFIED DRUG PRODUCTS (Asthma/COPD/Respiratory)		
CYSTIC FIBROSIS-CFTR POTENTIATOR-CORRECTOR COMBIN.		
ALYFTREK 10-50-125 MG TABLET	T4	PA QL (2 tabs/day) SP HD
ALYFTREK 4-20-50 MG TABLET	T4	PA QL (3 tabs/day) SP HD
BRONCHITOL 40 MG INHALE CAP	T4	PA SP
ORKAMBI 100 MG-125 MG TABLET	T4	PA QL (4 tabs/day) SP HD
ORKAMBI 100-125 MG GRANULE PKT	T4	PA QL (2 packs/day) SP HD
ORKAMBI 150-188 MG GRANULE PKT	T4	PA QL (2 packs/day) SP HD
ORKAMBI 200 MG-125 MG TABLET	T4	PA QL (4 tabs/day) SP HD
SYMDEKO	T4	PA QL (2 tabs/day) SP HD
TRIKAFTA 100-50-75 MG/150 MG	T4	PA QL (3 tabs/day) SP HD
TRIKAFTA 100-50-75 MG/75MG PKT	T4	PA QL (3 tabs/day) HD
TRIKAFTA 50-25-37.5 MG/75 MG	T4	PA QL (3 tabs/day) SP HD
TRIKAFTA 80-40-60MG/59.5MG PKT	T4	PA QL (3 tabs/day) HD
CYSTIC FIB-TRANSMEMB CONDUCT.REG. (CFTR) POTENTIATOR		
KALYDECO 150 MG TABLET	T4	PA QL (2 tabs/day) SP HD
KALYDECO 5.8 MG GRANULES PACKET	T4	PA QL (2 tabs/day) SP
KALYDECO 25 MG GRANULES PACKET	T4	PA QL (2 packs/day) SP HD
KALYDECO 50 MG GRANULES PACKET	T4	PA QL (2 packs/day) SP HD
KALYDECO 75 MG GRANULES PACKET	T4	PA QL (2 packs/day) SP HD
LUNG SURFACTANTS		
CUROSURF	T3	
INFASURF	T3	
SURVANTA	T3	
MUCOLYTICS		
PULMOZYME	T4	PA SP HD
PULMONARY FIBROSIS - SYSTEMIC ENZYME INHIBITORS		
OFEV	T4	PA 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
SYSTEMIC ENZYME INHIBITORS		
ARALAST NP	T4	PA SP
GLASSIA	T4	PA QL (2 tabs/day) SP
JOENJA	T4	PA QL SP
PROLASTIN C	T4	PA SP HD
VIJOICE 50 MG GRANULE PACKET	T4	PA QL (30 tabs/30 days) SP
VIJOICE 125mg, 50mg	T4	PA QL (30 tabs/30 days) SP
VIJOICE 250mg dose pack	T4	PA QL (2 tabs/30 days) SP
ZEMAIRA	T4	PA SP HD
ZOKINVY	T4	PA QL (4 caps/day) SP

UNCLASSIFIED DRUG PRODUCTS (Blood Modifiers/Bleeding Disorders)

ANTIPOPHYRIA FACTORS		
PANHEMATIN	T4	SP
ERYTHROID MATURATION AGENTS		
REBLOZYL	T4	PA SP
SPLEEN TYROSINE KINASE INHIBITORS		
TAVALLISSE	T4	PA SP
BRADYKININ B2 RECEPTOR ANTAGONISTS		
<i>icatibant acetate</i>	T4	PA SP HD
CI ESTERASE INHIBITORS		
BERINERT	T4	PA SP HD
CINRYZE	T4	PA SP HD
HAEGARDA	T4	PA SP HD
RUCONEST	T4	PA SP HD
PLASMA KALLIKREIN INHIBITORS		
KALBITOR	T4	PA SP HD
ORLADEYO	T4	PA QL (1 caps/day) SP

UNCLASSIFIED DRUG PRODUCTS (Cancer)

CHEMOTHERAPY RESCUE/ANTIDOTE AGENTS		
<i>amifostine crystalline</i> (Ethyol)	T4	SP
<i>dexrazoxane hcl</i> (Zinecard)	T4	SP
ETHYOL (<i>amifostine</i>)	T4	SP
CHEMOTHERAPY RESCUE/ANTIDOTE AGENTS		
KHAPZORY	T3	PA
<i>leucovorin calcium</i>	T1	

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List of Prescription Medications

UNCLASSIFIED DRUG PRODUCTS (Cancer) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
CHEMOTHERAPY RESCUE/ANTIDOTE AGENTS (cont.)		
<i>mesna</i> (Mesnex)	T4	SP
MESNEX	T4	SP
MESNEX (<i>mesna</i>)	T4	SP
VISTOGARD	T4	SP
VORAXAZE	T4	PA SP
ZINECARD (<i>dexrazoxane</i>)	T4	SP
INTRAPLEURAL SCLEROSING AGENTS, ANTINEOPLAST. ADJ.		
SCLEROSOL	T3	
STERILE TALC	T1	
STERITALC	T3	
RADIOACTIVE THERAPEUTIC AGENTS		
LUTATHERA	T4	PA SP
METASTRON	T3	PA
QUADRAMET	T3	PA
<i>strontium-89 chloride</i> (Metastron)	T1	PA
XOFIGO	T3	PA
TISSUE PROTECTIVE TX OF CHEMOTHERAPY EXTRAVASATION		
TOTECT	T3	
UNCLASSIFIED DRUG PRODUCTS (Dental Products)		
DENTAL AIDS AND PREPARATIONS		
<i>chlorhexidine gluconate</i> (Peridex)	T1	
PERIDEX (<i>periogard</i>)	T1	
<i>triamcinolone acetonide</i>	T1	
PERIODONTAL COLLAGENASE INHIBITORS		
<i>doxycycline hyclate</i>	T1	
UNCLASSIFIED DRUG PRODUCTS (Eye Conditions)		
INSULIN-LIKE GROWTH FACTOR RECEPTOR (IGF-R) INHIB		
TEPEZZA	T4	PA SP HD
OCULAR PHOTOACTIVATED VESSEL-OCCLUDING AGENTS		
VISUDYNE	T4	SP
UNCLASSIFIED DRUG PRODUCTS (Gastrointestinal/Heartburn)		
CALCIMIMETIC, PARATHYROID CALCIUM ENHANCER		
<i>cinacalcet hcl</i>	T4	SP

T1 – Typically Generics
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T3 – Typically Non-Preferred Brands

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

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List of Prescription Medications

UNCLASSIFIED DRUG PRODUCTS (Gastrointestinal/Heartburn) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
CALCIMIMETIC, PARATHYROID CALCIUM ENHANCER (cont.)		
PARSABIV	T4	PA SP
ORAL MUCOSITIS/STOMATITIS AGENTS		
GELCLAIR	T3	
ORAMAGICRX	T3	
PPAR AGONIST		
IQIRVO	T2	
SALIVA STIMULANT AGENTS		
NUMOISYN	T3	
teriparatide 600 mcg/2.4ml pen	T4	PA QL (0.09 mls/day) SP HD
TERIPARATIDE 620 MCG/2.48 ML	T4	PA QL (0.09 mls/day) SP HD
THYROID HORMONE RECEPTOR (THR) AGONIST		
REZDIFFRA	T4	PA QL(1 tab/day) SP HD

UNCLASSIFIED DRUG PRODUCTS (Hormonal Agents)

GROWTH HORMONE RECEPTOR ANTAGONISTS		
SOMAVERT	T4	PA SP HD
HYPERPARATHYROID TX AGENTS - VITAMIN D ANALOG-TYPE		
doxercalciferol	T1	
paricalcitol 1 mcg capsule (Zemplar)	T4	SP HD
PARICALCITOL 10 MCG/2 ML VIAL	T4	SP
PARICALCITOL 2MCG/ML VIAL	T4	SP
PARICALCITOL 5MCG/ML VIAL	T4	SP
paricalcitol 10 mcg/2 ml vial (Zemplar)	T4	SP
paricalcitol 2 mcg capsule (Zemplar)	T4	SP HD
PARICALCITOL 2 MCG/ML VIAL	T4	SP
paricalcitol 2 mcg/ml vial (Zemplar)	T4	SP
paricalcitol 4 mcg capsule	T4	SP HD
PARICALCITOL 5 MCG/ML VIAL	T4	SP
paricalcitol 5 mcg/ml vial (Zemplar)	T4	SP
RAYALDEE	T3	
ZEMPLAR 1 MCG CAPSULE (paricalcitol)	T4	SP HD
ZEMPLAR 10 MCG/2 ML VIAL (paricalcitol)	T4	SP
ZEMPLAR 2 MCG CAPSULE (paricalcitol)	T4	SP HD
ZEMPLAR 2 MCG/ML VIAL (paricalcitol)	T4	SP
ZEMPLAR 5 MCG/ML VIAL (paricalcitol)	T4	SP
MENOPAUSAL SYMPT SUPP-SEL ESTROGEN RECEPT MODULATOR		
OSPHENA	T3	QL(30 tabs/30 days) HD

I1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

I4 – Specialty Medications

PA – Prior Authorization

QL – Quantity Limit

S1 – Step Therapy

AGE – Age Requirement

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List of Prescription Medications

UNCLASSIFIED DRUG PRODUCTS (Miscellaneous)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ABORTIFACIENT-PROGESTERONE RECEPTOR ANTAGONISTS		
MIFEPREX	T3	
<i>mifepristone</i> (Mifeprex)	T1	
ACID AND ALKALI POISON ANTIDOTES		
<i>methylene blue</i> (antidotes)	T1	
PROVAYBLUE	T3	
AGENTS TO TX PERIODIC PARALYSIS - CARBON ANHYD INH		
<i>dichlorphenamide</i> (Keveyis))	T4	PA SP
AMMONIA INHIBITORS		
CARBAGLU (<i>carglumic acid</i>)	T4	SP HD
<i>carglumic acid</i> (Carbaglu)	T4	SP HD
AMYLOIDOSIS AGENTS-TRANSTHYRETIN (TTR) SUPPRESSION		
ONPATTRO	T4	PA SP
TEGSEDI	T4	PA SP HD
ANTI-ALCOHOLIC PREPARATIONS		
<i>acamprosate calcium</i>	T1	
ANTABUSE (<i>disulfiram</i>)	T3	
<i>disulfiram</i> (Antabuse)	T1	
VIVITROL	T4	SP HD
ANTIDOTES, MISCELLANEOUS		
ACETADOTE (<i>acetylcysteine</i>)	T3	
<i>acetylcysteine</i> (Acetadote)	T1	
CETYLEV	T3	
CYANOKIT	T3	
DIGIFAB	T3	
<i>fomepizole</i>	T1	
SODIUM NITRITE	T1	
ANTIFIBROTIC THERAPY - PYRIDONE ANALOGS		
<i>pirfenidone</i> (Esbriet)	T4	PA SP HD
BENZODIAZEPINE ANTAGONISTS		
<i>flumazenil</i>	T1	
CATHETER LOCK SOLUTIONS		
DEFENCATH	T3	
CHOLINESTERASE REACTIVAT.-MUSCARINIC ANTG.ANTIDOTE		
DUODOTE	T3	
PRALIDOXIME CHLORIDE	T1	
PROTOPAM CHLORIDE	T3	

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List of Prescription Medications

UNCLASSIFIED DRUG PRODUCTS (Miscellaneous) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
COMPLEMENT INHIBITORS		
BKEMV	T4	SP
EPYSQI	T4	SP
VEOPOZ	T4	SP
CRYOPRESERVATIVE AGENTS		
<i>dimethyl sulfoxide</i>	T3	
DILUENT SOLUTIONS		
<i>diluent for epoprostenol (glyc)</i>	T1	
DILUENT FOR REMODULIN	T3	
<i>diluent for treprostinil (gly)</i> (Diluent For Remodulin)	T1	
ELLIOTTS B	T3	
PH 12 DILUENT FOR FLOLAN	T3	
DRUGS TO TREAT ACUTE HEPATIC PORPHYRIA (AHP)		
GIVLAARI	T4	PA SP HD
DRUGS TO TREAT HEREDITARY TYROSINEMIA		
<i>nitisinone</i> (Orfadin)	T4	PA SP HD
NITYR	T4	PA SP
ORFADIN (<i>nitisinone</i>)	T4	PA SP
DRUGS TO TX GAUCHER DX-TYPE I, SUBSTRATE REDUCING		
CERDELGA	T4	PA SP HD
<i>miglustat</i> (Zavesca)	T4	PA SP HD
ZAVESCA (<i>miglustat</i>)	T4	PA SP HD
GENERAL INHALATION AGENTS		
HYPER-SAL	T3	
<i>nebusal 3% vial</i>	T1	
NEBUSAL 6% VIAL	T3	
<i>sodium chloride for inhalation</i> (Hyper-sal)	T1	
GENETIC D/O TX - SMN PROTEIN DEFICIENCY TREATMENT		
EVRYSDI	T4	PA SP HD
SPINRAZA	T4	PA SP HD
GENETIC D/O TX-EXON SKIPPING ANTISENSE OLIGONUCLEO		
AMONDYS-45	T4	PA SP
EXONDYS-51	T4	PA SP
VILTEPSO	T4	PA SP
VYONDYS-53	T4	PA SP
GLUCOSYLCERAMIDE SYNTHASE (GCS) INHIBITOR		
<i>miglustat</i> (Zavesca)	T4	PA SP

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List of Prescription Medications

UNCLASSIFIED DRUG PRODUCTS (Miscellaneous) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
GLUCOSYLCERAMIDE SYNTHASE (GCS) INHIBITOR (cont.)		
OPFOLDA	T4	PA QL(8 caps/30 days) SP HD
LEAD POISONING, AGENTS TO TREAT (CHELATING-TYPE)		
CALCIUM DISODIUM VERSENATE	T1	PA
MENOPAUSAL SYMPTOMS SUPPRESSANT - SSRIS		
<i>paroxetine mesylate</i>	T1	QL (1 cap/day) HD
METABOLIC DX ENZYME REPLACEMENT,ALPHA-MANNOSIDOSIS		
LAMZEDE	T4	PA SP
METABOLIC DISEASE ENZYME REPLACE, HYPOPHOSPHATASIA		
STRENSIQ	T4	PA SP
BRINEURA	T4	PA SP
METABOLIC DISEASE ENZYME REPLACEMENT, FABRY'S DX		
ELFABRIO	T4	PA SP
FABRAZYME	T4	PA SP HD
CEREZYME	T4	PA SP HD
ELELYSO	T4	PA SP
VPRIV	T4	PA SP HD
METABOLIC DISEASE ENZYME REPLACEMENT, MOCD		
NULIBRY	T3	PA SP
METABOLIC DISEASE ENZYME REPLACEMENT, POMPE DISEASE		
POMBILTI	T4	PA SP HD
METABOLIC DX ENZYME REPLACE, MUCOPOLYSACCHARIDOSIS		
ALDURAZYME	T4	PA SP HD
ELAPRASE	T4	PA SP
MEPSEVII	T4	PA SP
NAGLAZYME	T4	PA SP
VIMIZIM	T4	PA SP
METABOLIC DX ENZYME REPLACEMENT, LYSO.ACID LIP.DEF.		
KANUMA	T4	PA SP
METABOLIC DX ENZYME REPLACEMT, SEV.COMB.IMMUNE DEF.		
ADAGEN	T4	PA SP
REVCIVI	T4	PA SP
METALLIC POISON, AGENTS TO TREAT		
BAL IN OIL	T3	PA
CHEMET	T3	

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List of Prescription Medications

UNCLASSIFIED DRUG PRODUCTS (Miscellaneous) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
METALLIC POISON, AGENTS TO TREAT (cont.)		
<i>deferasirox</i> (Exjade)	T4	SP HD
<i>deferasirox</i> (Jadenu Sprinkle)	T4	SP HD
<i>deferasirox</i> (Jadenu)	T4	SP HD
<i>deferiprone</i> (Feriprox)	T4	PA SP
<i>deferoxamine mesylate</i> (Desferal Mesylate)	T1	
DESFERAL MESYLATE (<i>deferoxamine mesylate</i>)	T3	
EXJADE (<i>deferasirox</i>)	T4	PA SP HD
FERRIPROX	T4	PA SP
FERRIPROX (2 TIMES A DAY)	T4	PA SP
GALZIN	T3	
NITHIODOTE	T3	
PENTETATE CALCIUM TRISODIUM	T1	
PENTETATE ZINC TRISODIUM	T1	
RADIOGARDASE	T3	
<i>sodium thiosulf</i> (<i>poison treat</i>)	T1	
<i>trientine hcl 250 mg capsule</i> (Syprine)	T4	PA SP HD
TRIENTINE HCL 500 MG CAPSULE	T4	PA SP HD
MISCELLANEOUS AGENTS		
NEXAVIR	T4	SP
NATRIURETIC PEPTIDES		
VOXZOGO	T4	PA SP HD
OINTMENT/CREAM BASES		
RADIAGEL	T3	
PHARMACOLOGICAL CHAPERONE-ALPHA-GALACTOSID.A STABZ		
GALAFOLD	T4	PA SP HD
PKU TX AGENT-COFACTOR OF PHENYLALANINE HYDROXYLASE		
<i>javygtor 100 mg powder packet</i> (Kuvan)	T4	PA SP
<i>javygtor 100 mg tablet</i> (Kuvan)	T4	PA SP HD
<i>javygtor 500 mg powder packet</i> (Kuvan)	T4	PA SP
PROTEIN STABILIZERS		
ATTRUBY	T4	PA SP
VYNDAMAX	T4	PA QL (1 cap/day) SP HD

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List of Prescription Medications

UNCLASSIFIED DRUG PRODUCTS (Miscellaneous) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
PROTEIN STABILIZERS (cont.)		
VYNDAQEL	T4	PA QL (4 caps/day) SP HD
RADIOPHARMACEUTICALS ELEMENTS		
TECHNELITE TC-99M GENERATOR	T3	
RETINOIC ACID RECEPTOR (RAR) AGONISTS		
SOHONOS	T4	PA SP
SODIUM/SALINE PREPARATIONS		
<i>bacteriostatic sodium chloride</i>	T1	
SOLVENTS		
ISOPROPYL ALCOHOL	T3	
MURI-LUBE MINERAL OIL	T3	
SUSPENDING AGENTS		
GELFILM	T3	
HYDROXYPROPYLCELLULOSE	T3	
HYPROMELLOSE	T3	
UNCLASSIFIED DRUG PRODUCTS (Multiple Sclerosis)		
LEUKOCYTE ADHESION INHIB, ALPHA4-MEDIAT IGG4K MC AB		
TYSABRI	T4	PA SP HD
UNCLASSIFIED DRUG PRODUCTS (Nutritional/Dietary)		
METABOLIC DEFICIENCY AGENTS		
CYSTADANE	T4	SP
<i>levocarnitine</i> (Carnitor Sf)	T1	
<i>levocarnitine</i> (Carnitor)	T1	
<i>levocarnitine (with sugar)</i> (Carnitor)	T1	
BONE FORMATION AGENTS - SCLEROSTIN INHIBITOR, MONO		
EVENITY	T4	PA QL (2 syringes/month) SP
EVENITY (2 SYRINGES)	T4	PA QL (2 syringes/month) SP
BONE RESORPTION INHIBITOR AND VITAMIN D COMBS.		
FOSAMAX PLUS D	T3	ST HD
BONE RESORPTION INHIBITORS		
ACTONEL (<i>risedronate sodium</i>)	T3	ST HD
<i>alendronate sodium</i>	T1	HD
<i>alendronate sodium</i> (FOSAMAX)	T1	HD
ATELVIA (<i>risedronate sodium dr</i>)	T3	ST HD
BINOSTO	T3	ST HD

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

T4 – Specialty Medications

PA – Prior Authorization

QL – Quantity Limit

ST – Step Therapy

AGE – Age Requirement

SP – Specialty Medication

HD – May require home delivery pharmacy

PPACA – No Cost-Share Preventive Medication

CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

UNCLASSIFIED DRUG PRODUCTS (Nutritional/Dietary) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
BONE RESORPTION INHIBITORS (cont.)		
BONIVA 150 MG TABLET (<i>ibandronate sodium</i>)	T3	ST HD
BONIVA 3 MG/3 ML SYRINGE (<i>ibandronate sodium</i>)	T4	SP HD
EVISTA (<i>raloxifene hcl</i>)	T3	HD
FOSAMAX (<i>alendronate sodium</i>)	T3	ST HD
<i>ibandronate 3 mg/3 ml syringe</i> (Boniva)	T4	SP HD
<i>ibandronate 3 mg/3 ml vial</i>	T4	SP HD
<i>ibandronate sodium 150 mg tab</i> (Boniva)	T1	HD
<i>pamidronate disodium</i>	T4	SP HD
PROLIA	T4	PA SP HD
<i>raloxifene hcl</i> (Evista)	T1	HD PPACA
RECLAST (<i>zoledronic acid</i>)	T4	SP HD
<i>risedronate sodium</i>	T1	HD
<i>risedronate sodium</i> (Actonel)	T1	HD
<i>risedronate sodium</i> (Atelvia)	T1	HD
XGEVA	T4	PA SP HD
ZOLEDRONIC ACID 4MG/100ML	T4	SP HD
<i>zoledronic acid/mannitol-water</i>	T4	SP HD
<i>zoledronic acid/mannitol-water</i> (Reclast)	T4	SP HD
UNCLASSIFIED DRUG PRODUCTS (Osteoporosis Products)		
THYMIC STROMAL LYMPHOPOIETIN (TSLP) INHIBITORS		
TEZSPIRE 210 MG/1.91 ML PEN	T4	PA QL(1 pen/28 days) SP HD
TEZSPIRE 210 MG/1.91 ML SYRING	T4	PA SP HD
TREATMENT OF HYPERPHAGIA IN PRADER-WILLI SYNDROME		
VYKAT XR	T4	PA SP
TOPICAL/MUCOUS MEMBR./SUBCUT. ENZYMES		
HYLENEX	T4	SP HD
WATER		
<i>water for inj., bacteriostatic</i>	T1	
<i>water for injection, sterile</i>	T1	
<i>water/me-paraben/propylparaben</i>	T1	
UNCLASSIFIED DRUG PRODUCTS (Pain Relief And Inflammatory Disease)		
ANTI-INFLAM. INTERLEUKIN-I RECEPTOR ANTAGONIST		
ARCALYST	T4	PA SP HD
ANTI-INFLAMMATORY, INTERLEUKIN-I BETA BLOCKERS		
ILARIS	T4	PA SP HD

T1 – Typically Generics
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T3 – Typically Non-Preferred Brands

T4 – Specialty Medications
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List of Prescription Medications

UNCLASSIFIED DRUG PRODUCTS (Pain Relief And Inflammatory Disease) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
FIBROMYALGIA AGENTS, SEROTONIN-NOREPINEPH RU INHIB		
SAVELLA	T3	
IMMUNOMODULATOR, B-LYMPHOCYTE STIM (BLYS) -SPEC INHIB		
BENLYSTA 120 MG VIAL	T4	PA SP
BENLYSTA 200 MG/ML AUTOINJECT	T4	PA SP HD
BENLYSTA 200 MG/ML SYRINGE	T4	PA SP HD
BENLYSTA 400 MG VIAL	T4	PA SP
JOINT CONTRACTURE THERAPY, COLLAGENASE ENZYME		
XIAFLEX	T4	PA SP

UNCLASSIFIED DRUG PRODUCTS (Skin Conditions)

INTERLEUKIN-13 (IL-13) INHIBITORS, MAB		
ADBRY	T4	PA SP HD
EBGLYSS PEN	T4	PA SP
WOUND HEALING AGENTS, LOCAL		
<i>balsam peru/castor oil</i> (Venelex)	T1	
BALSAM PERU-CASTOR OIL	T1	
DERMULCERA	T1	
FILSUEZ	T4	PA SP
VENELEX	T3	

UNCLASSIFIED DRUG PRODUCTS (Substance Abuse)

OPIOID WITHDRAWAL THER, ALPHA-2 ADRENERGIC AGONIST		
<i>lofexidine</i>	T1	QL (192 tabs/30 days)
LUCEMYRA (<i>Lucemyra</i>)	T2	QL (168 tabs/14 days)
OPIOID WITHDRAWAL THERAPY AGENTS, OPIOID-TYPE		
BUNAVAIL	T3	
<i>buprenorphine hcl</i>	T1	
<i>buprenorphine hcl/naloxone hcl</i>	T1	
<i>buprenorphine hcl/naloxone hcl</i> (Suboxone)	T1	
PROBUPHINE	T3	
SUBLOCADE	T4	SP
SUBOXONE (<i>buprenorphine-naloxone</i>)	T3	
ZUBSOLV	T2	

UNCLASSIFIED DRUG PRODUCTS (Transplant Medications)

ORGAN TRANSPLANTATION PRESERVATION SOLUTIONS		
VIASPAN BELZER-UW	T3	

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

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

UNCLASSIFIED DRUG PRODUCTS (Transplant Medications) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
RHO KINASE INHIBITOR		
REZUROCK	T4	PA SP HD
UNCLASSIFIED DRUG PRODUCTS (Urinary Tract Conditions)		
BENIGN PROSTATIC HYPERTROPHY/MICTURITION AGENTS		
<i>alfuzosin hcl</i> (Uroxatral)	T1	HD
<i>dutasteride</i> (Avodart)	T1	HD
<i>finasteride</i> (Proscar)	T1	HD
PROSCAR (<i>finasteride</i>)	T3	HD
RAPAFLO 4 MG CAPSULE (<i>silodosin</i>)	T3	QL (1 cap/day) HD
RAPAFLO 8 MG CAPSULE (<i>silodosin</i>)	T3	HD
<i>silodosin 4 mg capsule</i> (Rapaflo)	T1	QL (1 cap/day) HD
<i>silodosin 8 mg capsule</i> (Rapaflo)	T1	HD
<i>tamsulosin hcl</i> (Flomax)	T1	HD
UROXATRAL (<i>alfuzosin hcl er</i>)	T3	HD
VANRAFIA	T4	PA QL(1 tab/day) SP
BPH 5-ALPHA-REDUCTASE INHIB-ALPHA1-ADRENOCEP ANTAG		
<i>dutasteride/tamsulosin hcl</i> (	T1	HD
CYSTINE-DEPLETING AGENTS, NEPHROPATHIC CYSTINOSIS		
CYSTAGON	T4	SP
KIDNEY STONE AGENTS		
<i>mirabegron er 25 mg tablet</i> (Myrbetriq)	T1	QL(1 tab/day) HD
<i>mirabegron er 50 mg tablet</i> (Myrbetriq)	T1	HD
<i>tiopronin</i>	T4	SP HD
URINARY TRACT ANTISPASMODIC, M (3) SELECTIVE ANTAG.		
<i>darifenacin er 15 mg tablet</i>	T1	HD
<i>darifenacin er 7.5 mg tablet</i>	T1	QL (1 tab/day) HD
<i>solifenacin 10 mg tablet</i>	T1	HD
<i>solifenacin 5 mg tablet</i>	T1	QL (1 tab/day) HD
URINARY TRACT ANTISPASMODIC/ANTIINCONTINENCE AGENT		
<i>flavoxate hcl</i>	T1	HD
<i>oxybutynin 5 mg/5 ml solution</i>	T1	HD
<i>oxybutynin 5 mg/5 ml syrup</i>	T1	HD
<i>oxybutynin chloride er</i>	T1	HD
<i>tolterodine tart er 2 mg cap</i>	T1	QL (1 cap/day) HD
<i>tolterodine tart er 4 mg cap</i>	T1	HD
<i>tolterodine tartrate</i>	T1	HD
<i>tropium chloride</i>	T1	HD

T1 – Typically Generics

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T3 – Typically Non-Preferred Brands

T4 – Specialty Medications

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List of Prescription Medications

UNCLASSIFIED DRUG PRODUCTS (Weight Management)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
APPETITE STIM. FOR ANOREXIA, CACHEXIA, WASTING SYND.		
<i>megestrol acetate</i>	T1	
VACCINES (Vaccines)		
COVID-19 VACCINES		
JANSSEN COVID-19 VACCINE (EUA)	T3	PPACA
MODERNA COVID-19 VACCINE (EUA)	T3	PPACA
PFIZER COVID-19 VACCINE (EUA)	T3	PPACA
VITAMINS (Nutritional/Dietary)		
FOLIC ACID PREPARATIONS		
<i>folic acid</i>	T1	
MULTIVITAMIN PREPARATIONS		
CITRANATAL MEDLEY	T3	
FOLET ONE	T3	
INFUVITE ADULT	T3	
<i>multivit infusn, adult 1, vit k</i>	T3	
<i>mvn no.53/iron/folic/dss/dha</i>	T1	
OBSTETRIX ONE	T1	
PEDIATRIC VITAMIN PREPARATIONS		
INFUVITE PEDIATRIC	T3	
<i>multivit-fluor 0.25 mg/ml drop (Soluvita Multivitamin Fluoride)</i>	T1	PPACA
M.V.I. PEDIATRIC	T3	
SOLUVITA MULTIVITAMIN FLUORIDE (<i>pedi multivit no.82 w-fluoride</i>)	T3	PPACA
VITALIPID N INFANT	T3	
VITLIPID N INFANT	T3	
VITAMIN A PREPARATIONS		
AQUASOL A	T3	
VITAMIN B PREPARATIONS		
<i>vitamins b1, b2, b3, b5, and b6</i>	T1	HD
VITAMIN B1 PREPARATIONS		
<i>thiamine hcl</i>	T1	
VITAMIN B12 PREPARATIONS		
B-12 COMPLIANCE	T1	
<i>cyanocobalamin (vitamin b-12) (Nascobal)</i>	T1	
<i>hydroxocobalamin</i>	T1	
PHYSICIANS EZ USE B-12	T3	

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

T4 – Specialty Medications

PA – Prior Authorization

QL – Quantity Limit

ST – Step Therapy

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List of Prescription Medications

VITAMINS (Nutritional/Dietary) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
VITAMIN B6 PREPARATIONS		
<i>pyridoxine hcl (vitamin b6)</i>	T1	
VITAMIN C PREPARATIONS		
ASCOR	T3	
<i>ascorbic acid</i>	T1	
VITAMIN D PREPARATIONS		
<i>calcitriol 0.25 mcg capsule (Rocaltrol)</i>	T1	
<i>calcitriol 1 mcg/ml vial (Rocaltrol)</i>	T1	HD
<i>calcitriol 0.5 mcg capsule (Rocaltrol)</i>	T1	
<i>calcitriol 1 mcg/ml ampul</i>	T1	
<i>calcitriol 1 mcg/ml solution (Rocaltrol)</i>	T1	HD
DRISDOL (<i>vitamin d2</i>)	T3	HD
<i>ergocalciferol (vitamin d2) (Drisdol)</i>	T1	HD
ROCALTROL	T3	HD
VITAMIN K PREPARATIONS		
MEPHYTON (<i>phytonadione</i>)	T3	
PHYTONADIONE	T1	
<i>phytonadione (vit k1)</i>	T1	
<i>phytonadione (vit k1) (Mephyton)</i>	T1	
VITAMINS (Vitamins)		
MULTIVITAMIN PREPARATIONS		
VITLIPID N ADULT	T3	

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

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

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

HD – May require home delivery pharmacy
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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:¹¹

- 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,¹² sexual dysfunction, cosmetic purposes, weight loss, smoking cessation,¹² or athletic enhancement.
 - Prescription vitamins (other than prenatal vitamins) or dietary supplements unless state or federal law requires coverage of such products.
 - Immunization agents, biological products for allergy immunization, biological sera, blood, blood plasma and other blood products or fractions and medications used for travel prophylaxis.
 - Replacement of prescription medications and related supplies due to loss or theft.
 - Medications which are to be taken by or administered to a covered person while they are a patient in a licensed hospital, skilled nursing facility, rest home or similar institution which operates on its premises or allows to be operated on its premises a facility for dispensing pharmaceuticals.
 - Prescriptions more than one year from the date of issue.
 - Coverage for prescription medication products for the amount dispensed (days' supply) which is more than the applicable supply limit, or is less than any applicable supply minimum set forth in The Schedule, or which is more than the quantity limit(s) or dosage limit(s) set by the P&T Committee.
 - More than one prescription order or refill for a given prescription supply period for the same prescription medication product prescribed by one or more doctors and dispensed by one or more pharmacies.
 - Prescription medication products dispensed outside the jurisdiction of the United States, except as required for emergency or urgent care treatment.
- In addition to the plan's standard pharmacy exclusions, certain new FDA-approved medication products (including, but not limited to, medications, medical supplies or devices that are covered under standard pharmacy benefit plans) may not be covered for the first six months of market availability unless approved by Cigna Healthcare as medically necessary.

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

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



1. App/online store terms and mobile phone carrier/data charges apply. Customers under age 13 (and/or their parent/guardian) will not be able to register at myCigna.com.
2. Smoking cessation medications are not usually covered under the plan, except as required by law or by the terms of your specific plan. Costs and complete details of the plan's prescription drug coverage, including a full list of exclusions and limitations, are set forth in the plan documents. If there are any differences between the information provided here and the plan documents, the information in the plan documents takes complete precedence.
3. Prices shown on myCigna are not guaranteed and coverage is subject to your plan terms and conditions. Visit myCigna for more information.
4. U.S. Food and Drug Administration (FDA) website, "Generic 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).
5. 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).
6. **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).
7. Your plan pays the cost for standard shipping.
8. 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.
9. 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.
10. **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.
11. 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.
12. **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.

Medical coverage

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

Cigna Healthcare:

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

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

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

Cigna Healthcare

Nondiscrimination Complaint Coordinator
P.O. Box 188016
Chattanooga, TN 37422

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

U.S. Department of Health and Human Services

200 Independence Avenue, SW
Room 509F, HHH Building
Washington, DC 20201
1.800.368.1019, 800.537.7697 (TDD)

Complaint forms are available at
<http://www.hhs.gov/ocr/office/file/index.html>



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Proficiency of Language Assistance Services

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

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

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

Vietnamese – XIN 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 ناشنویان: شماره 711 را شماره‌گیری کنید).