Cigna Healthcare National Preferred 3-Tier Prescription Drug List

Coverage as of January 1, 2026

For the State of California
Health Maintenance Organization (HMO), Network, Network Point of Service (POS)

View your drug list online: **Cigna.com/druglist**
24/7 Customer Service: **800.Cigna24 (800.244.6224)**
View your coverage info online: myCigna® App or **myCigna.com®**

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 This drug list is subject to change and all prior versions are no longer in effect.

cigna healthcare

View your drug list online, 24/7

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

- **Cigna.com/druglist.** Choose **National Preferred 3 Tier** from the dropdown list. Then type in your medication name or view the full list.
- **myCigna App[1] or myCigna.com.** Log into your account and use the Price a Medication tool to see how your medication is covered.

Questions?

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

Information about this drug list

Frequently asked questions (FAQs)

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

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

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

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

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

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

Q. How do you decide which medications to cover?
A. The Cigna Healthcare Prescription Drug List is developed with the help of the Cigna Healthcare Pharmacy and Therapeutics (P&T) Committee, which is a group of practicing doctors and pharmacists, most of whom work outside of Cigna Healthcare. The group meets regularly to review medical evidence and information provided by federal agencies, drug manufacturers, medical professional associations, national organizations and peer-reviewed journals about the safety and effectiveness of medications that are newly approved by the FDA and medications already on the market.

The Cigna Healthcare Health Plan Commercial Value Assessment Committee (HVAC) then looks at the results of the P&T Committee's clinical review, as well as the medication's overall value and other factors before adding it to, or removing it from, the drug list.

Q. Why do certain medications need approval before my plan will cover them?
A. The review process helps make sure you're getting coverage for the right medication, at the right cost, in the right amount and for the right situation.

Q. How do I know if a medication needs approval?
A. Check your drug list or log in to the myCigna App or **myCigna.com** and use the Price a Medication tool. If the medication has:

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

Information about this drug list

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

Q. What types of medications typically need approval?
A. Medications that:

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

Q. What types of medications typically have quantity limits?
A. Medications that are often:

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

Q. What medications are part of Step Therapy?
A. They're typically high-cost medications that treat conditions such as:

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

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

Q. How do I get approval (prior authorization) for my medication?
A. Ask your doctor's office to contact us to start the coverage review process. They know how the review process works and will take care of everything for you. In case the office asks, they can download a request form from our provider portal at **cignaforhcp.com**.

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

Q. My medication was just taken off the drug list. My doctor still wants me to take it. What do I have to do to get it covered?
A. You don't need to do anything. If your doctor continues to prescribe the medication, we'll continue to cover it. If your medication already requires prior authorization, your doctor just has to continue to request (and receive) approval for the medication to be covered.

Q. My medication is part of the Step Therapy program. I don't want to try an alternative. How do I get approval (prior authorization) for my medication?
A. If you and your doctor feel an alternative medication won't work for you, your doctor can ask us to consider approving coverage of your current medication. Ask your doctor's office to contact us to start the coverage review process. They know how the review process works and will take care of everything for you. In case the office asks, they can download a request form from our provider portal at **cignaforhcp.com**.

We'll review the information your doctor sends us to make sure you meet the medication's coverage rules (requirements). We'll send you and your doctor a letter with our decision (approved/not approved) and next steps. It can take up to five (5) business days to hear from us. You can always check with your doctor's office to find out if we've made a decision.

Or, you can log in to the myCigna App or **myCigna.com** to see where your medication is in the review process or to read about the decision we made.

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

I. A carrier may impose prior authorization requirements on prescription drug benefits.

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

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

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

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

You can still fill it (without using your plan/insurance), but you'll pay its full price at the pharmacy counter. And, if you do this, your costs can't be applied to your annual deductible or out-of-pocket maximum.

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

A. Your pharmacist will only fill the amount your plan covers. If you want to fill more than what's allowed, your doctor's office can ask us to cover it through our review process.

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

A. Yes.

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

A. We review all recently approved medications and products to see if they should be covered, and if so, at what cost-share (tier). These include, but are not limited to, medications, medical supplies and/or

devices covered under standard pharmacy benefits. It can take up to six months from the date the FDA approved them for us to make a decision.

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

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

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

Q. I see several medications on this drug list that can be used to treat my condition. Will my doctor write me a prescription for all of them?
A. No. Just because a medication is listed on your plan's drug list doesn't mean your doctor will write you a prescription for it. Your doctor will work with you to find the medication he or she feels is best for your specific treatment.

Q. How can I find out how much I'll pay for a specific medication?
A. When you and your doctor are thinking about the right medication for your treatment, knowing how much it costs, what lower-cost options are available, and which pharmacies have the best prices can help you avoid surprises. Log in to the myCigna App or **myCigna.com** and use the Price a Medication tool to see how much your medication costs before you get to the pharmacy counter – or even before you leave your doctor's office.[2]

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

Q. How can I save money on my prescription medications?
A. You should think about using a medication that's covered on a lower tier, such as a generic or preferred brand medication, or by filling a 90-day supply (if your plan allows). Ask your doctor if one of these options may work for you.

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

Q. Do generics work the same as brand-name medications?
A. Yes. A generic medication works in the same way and provides the same clinical benefit as the brand-name medication.[3]

Q. What are the differences between generic and brand-name medications?
A. The generic and brand-name medication may[3]:

- 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.

Information about this drug list

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

Even though biosimilars aren't identical to the original medication, they're used to treat the same conditions, and provide the same clinical outcomes and treatment benefits. There are no clinical differences in how safe they are to use and how well they work. They also typically cost less.[4]

Q. Can I fill my prescription at any pharmacy in my network?
A. It depends. Some plans only allow fills at certain in-network pharmacies or through home delivery. Log in to the myCigna App or **myCigna.com**, or check your plan materials, to learn more about the pharmacies in your plan's network.

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

Q. My pharmacy isn't in my plan's network. Can I continue to fill my prescriptions there?
A. To get the most from your plan coverage, you should use an in-network pharmacy. If your plan offers out-of-network coverage, you'll pay your out-of-network cost-share to fill a prescription there.

Q. Do I have to use home delivery to fill my prescription?
A. It depends on your plan. Some plans require you to fill maintenance medications through Express Scripts® Pharmacy and/or specialty medications through Accredo® Specialty Pharmacy for them to be covered.[5] Log in to the myCigna App or **myCigna.com**, or check your plan materials, to find out what your plan requires.

Q. Can I fill my prescriptions by mail?
A. Yes, as long as your plan offers home delivery.[5]

Fill maintenance medications through Express Scripts Pharmacy

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

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

Here are two easy ways to get started:

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

Fill specialty medications through Accredo Specialty Pharmacy

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

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

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

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

Q. I take a medication every day to treat diabetes. My plan requires me to fill my medication through Express Scripts Pharmacy. How do I get started?
A. Some plans allow one or more fills at a retail pharmacy before you have to switch to home delivery. Check your plan materials to find out if your plan allows retail fills.

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.

Q. I take a specialty medication to treat my multiple sclerosis. My plan requires me to fill my medication through Accredo. How do I get started?
A. Some plans allow one or more fills at a retail pharmacy before switching to Accredo. Check your plan materials to find out if your plan allows retail fills.

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

Q. I take a specialty medication that can only be filled at certain pharmacies in the United States. How do I fill my prescription?
A. Talk with your doctor. He or she should be able to tell you which in-network pharmacies can fill your prescription. Once you find a pharmacy, ask your doctor to send them your prescription.

You may also be able to use Accredo to fill your prescription; they have access to most specialty medications.[5] Call Accredo at **877.826.7657**, Monday–Friday, 7:00 am–10:00 pm CST or Saturdays, 7:00 am–4:00 pm CST, for more information.

Q. How do I fill my prescription?
A. First, you'll need to get a prescription from your doctor. Then, your doctor can either:

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

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

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

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

Q. What's the difference between medications covered under the pharmacy benefit and medical benefit?
A. Some medications are covered under the pharmacy benefit, some are covered under the medical benefit and others are covered under both benefits. 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 you receive approval for coverage, you'll pay your applicable tier cost-share to fill the medication.
- **Vaccines:** Vaccines are now covered under the pharmacy benefit. Not all plans cover vaccines in the same way. Log in to the myCigna App or **myCigna.com**, or check your plan materials, to find out how your specific plan covers them.
- **Compounded medications:** If the medication is more than $200, you'll need approval from Cigna Healthcare before your plan will cover them (prior authorization). coverage, you'll pay your applicable tier cost-share to fill the medication.

Words you may need to know

- **Brand name drug:** A drug that is marketed under a proprietary, trademark-protected name. The brand name drug shall be listed in all CAPITAL letters.
- **Coinsurance:** A percentage of the cost of a covered health care benefit that an enrollee pays after the enrollee has paid the deductible, if a deductible applies to the health care benefit, such as the prescription drug benefit.
- **Copayment:** A fixed dollar amount that an enrollee pays for a covered health care benefit after the enrollee has paid the deductible, if a deductible applies to the health care benefit, such as the prescription drug benefit.
- **Deductible:** The amount an enrollee pays for covered health care benefits before the enrollee's health plan begins payment for all or part of the cost of the health care benefit under the terms of the policy.

Information about this drug list

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

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

Information about this drug list

About this drug list

This is a list of the most commonly prescribed medications covered on the Cigna Healthcare National Preferred 3-Tier Prescription Drug List as of January 1, 2026. **The drug list is updated often**; so, not all of the medications your plan covers may be listed here. Also, your plan may not cover all of these medications. Log in to the myCigna App or **myCigna.com** to see which medications your plan covers.

How to read this drug list

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

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

Tiers

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.	**$$**
Tier 3	**Non-Preferred Brands. These medications are covered at your plan's highest cost-share.** Non-preferred brands typically have a generic and/or preferred brand alternative(s) that treats the same condition.	**$$$**

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

Information about this drug list

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

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

PA	**Prior Authorization*** – This medication needs approval from Cigna Healthcare before your plan will cover it. Your doctor's office will have to send us information to review to make sure you meet the medication's coverage rules (requirements).
QL	**Quantity Limit*** – Your plan will only cover so much of this medication at one time. If your doctor wants you to fill more than what's allowed, your doctor's office can ask us to cover more.
ST	**Step Therapy*** – This is a high-cost medication that has a lower-cost alternative(s) that treats the same condition. Your plan won't cover this medication until you try at least one preferred medication first (typically a generic or preferred brand) and can show that it didn't work for you. If your doctor feels a preferred medication isn't right for you, your doctor's office can ask us to cover the higher-cost medication.
AGE	**Age Requirement*** – Your plan will only cover this medication if you're a certain age or within a certain age range. If you're not within the allowed age range and your doctor wants you to use the medication, your doctor's office can ask us to cover it.
SP	This is a **specialty medication**, which is used to treat a rare and/or complex medical condition. Some plans have extra coverage rules (requirements) for specialty medications. For example, some may only cover up to a 30-day supply and/or require you to fill it at a preferred specialty pharmacy to be covered.
HD	**Home Delivery Medications** – Some plans only cover certain maintenance medications if they're filled through home delivery with Express Scripts Pharmacy. Depending on your plan, you may be able to get coverage for one, two or three fills at an in-network retail pharmacy before you have to switch to home delivery.
PPACA	Health care reform under the **Patient Protection and Affordable Care Act (PPACA)** requires plans to cover the full cost of this preventive medication or product. This means you don't have to pay anything – not even a copay, coinsurance or deductible.
CSL	**Oral Cancer Medications Subject to Cost-Share Limits** – State law in California limits the cost-share (or amount you pay out-of-pocket) for certain oral chemotherapy medications.

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

Information about this drug list

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

Use the table below to understand how medications are covered on the Cigna Healthcare National Preferred 3-Tier Prescription Drug List.*

ANALGESICS (Pain Relief and Inflammatory Disease)		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
ANALGESIC, NON-SALICYLATE AND BARBITURATE COMBINAT		
butalbital/acetaminophen	T1	
ANALGESIC, SALICYLATE, BARBITURATE, XANTHINE COMB.		
butalb-aspirin-caffe 50-325-40	T1	QL (6 tabs/day)
butalbital-asa-caffeine cap (Fiorinal)	T1	QL (6 caps/day)
FIORINAL (*butalbital-aspirin-caffeine*)	T3	QL (6 caps/day)
ANALGESIC, NON-SALICYLATE, BARBITURATE, XANTHINE COMB.		
butalb/acetaminophen/caffeine	T3	
butalb/acetaminophen/caffeine (Esgic)	T3	QL (6 caps/day)
butalb-acetamin-caff 50-300-40 (Fioricet)	T1	QL (6 caps/day)
butalb-acetamin-caff 50-325-40 (Esgic)	T1	QL (6 tabs/day)
ESGIC 50-325-40 MG TABLET (*butalbital-acetaminophen-caffe*)	T3	QL (6 tabs/day)
ESGIC CAPSULE (*zebutal*)	T3	QL (6 caps/day)
FIORICET (*phrenilin forte*)	T1	QL (6 caps/day)
ANALGESIC/ANTIPYRETICS, SALICYLATES		
choline salicyl/mag salicylate	T1	HD
diflunisal	T1	HD
ANTI-MIGRAINE PREPARATIONS		
AIMOVIG AUTOINJECTOR	T2	PA
AJOVY AUTOINJECTOR	T2	PA
AJOVY SYRINGE	T2	PA
almotriptan malate	T1	QL (12 tabs/30 days)
CAFERGOT (*ergotamine-caffeine*)	T3	QL (40 tabs/28 days)
dihydroergotamine 1 mg/ml amp	T1	QL (10 amps/30 days)
eletriptan hydrobromide	T1	QL (6 tabs/30 days)
EMGALITY PEN	T2	PA
EMGALITY SYRINGE	T2	PA
ergotamine tartrate/caffeine	T1	
ergotamine tartrate/caffeine (Cafergot)	T1	QL (40 tabs/28 days)

Therapeutic drug category and class describes the condition the medication is used to treat.

Coverage requirements and limits lets you know if your plan has extra requirements before it will cover the medication.

Drug tier gives you an idea of how much you may pay for a medication.

Prescription drug name is the name of the medication.

Medications are listed in **alphabetical order (A-Z)** within each column.

Brand name medications are in all **CAPITAL** letters.

Generic medications are in ***lowercase italics***.

* 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.

Information about this drug list

How to find your medication *(cont.)*

Information about this drug list

How to find your medication *(cont.)*

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		
acetaminophen w/butalbital	T1	
tencon	T1	
ANALGESIC, SALICYLATE, BARBITURATE, XANTHINE COMB.		
butalbital-asp-caffeine (Fiorinal)	T1	
FIORINAL *(butalbital-aspirin-caffeine)*	T3	PA
ANALGESIC, NON-SALICYLATE, BARBITURATE, XANTHINE COMB.		
butalb/acetaminophen/caffeine	T1	
butalbital/apap/caffeine	T1	
butalbital/apap/caffeine (Esgic)	T1	
ESGIC *(butalbital-acetaminophen-caffe)*	T3	PA
FIORICET *(butalbital-acetaminophen-caffe)*	T3	PA
VANATOL LQ	T3	PA
VANATOL S	T3	PA
vtol lq (Vanatol Lq)	T1	
zebutal (Esgic)	T1	
ANALGESIC/ANTIPYRETICS, SALICYLATES		
aspirin	T1	HD PPACA
aspirin e.c. (Ecotrin)	T1	HD PPACA
buffered aspirin	T1	HD PPACA
bufferin	T1	HD PPACA
choline mag trisalicylate	T1	
diflunisal	T1	HD
ecotrin (Ecotrin)	T1	HD PPACA
ecpirin (Ecotrin)	T1	HD PPACA
tri-buffered aspirin	T1	HD PPACA
ANALGESICS, NON-OPIOID		
JOURNAVX	T3	QL (30 tabs/90 days)
ANTI-MIGRAINE PREPARATIONS		
AIMOVIG AUTOINJECTOR	T2	PA QL (1 inj/23 days)
AJOVY 225 MG/1.5 ML AUTOINJECT	T2	PA QL (1 auto-inj/30 days)
AJOVY 225 MG/1.5 ML AUTOINJECT	T2	PA QL (3 auto-injs/90 days)
AJOVY SYRINGE	T2	PA QL (1 syringe/30 days)
almotriptan malate 12.5 mg tab	T1	ST QL (12 tabs/30 days)

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

PA – Prior Authorization
QL – Quantity Limit
ST – Step Therapy

AGE – Age Requirement
SP – Specialty Medication
HD – May require home delivery pharmacy

PPACA – No Cost-Share Preventive Medication
CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

ANALGESICS (Pain Relief and Inflammatory Disease) (cont.)		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
ANTI-MIGRAINE PREPARATIONS (cont.)		
almotriptan malate 6.25 mg tab	T1	ST QL (6 tabs/30 days)
AMERGE *(naratriptan hcl)*	T3	ST QL
CAFERGOT *(cafergot)*	T3	
CAMBIA	T3	ST QL
D.H.E.45 *(dihydroergotamine mesylate)*	T3	
diclofenac pot powder pack (CAMBIA)	T1	ST QL (9 pkts/30 days)
dihydroergotamine mesylate (D.H.E.45)	T1	
dihydroergotamine mesylate (Migranal)	T1	QL
eletriptan hbr (Relpax)	T1	QL
EMGALITY	T2	PA QL (1 unit/23 days)
EMGALITY SYRINGE	T2	PA QL (1 unit/23 days)
ERGOMAR	T3	
frovatriptan succinate (Frova)	T1	ST QL (9 tabs/30 days)
migergot	T1	
MIGRANAL *(dihydroergotamine mesylate)*	T3	ST QL
naratriptan hcl (Amerge)	T1	QL
NURTEC ODT	T2	PA QL
QULIPTA	T2	PA QL
REYVOW 100MG TABLET	T3	PA QL (8 tabs/treatment)
rizatriptan (Maxalt)	T1	QL
sumatriptan	T1	QL (6 units/30 days)
TOSYMRA	T3	ST QL
UBRELVY 50MG TABLET	T2	PA QL (10 tabs/treatment)
UBRELVY 100MG TABLET	T2	PA QL (10 tabs/treatment)
ZEMBRACE SYMTOUCH	T3	ST QL
zolmitriptan	T1	QL (6 tabs/30 days)
zolmitriptan odt (Zomig ZMT)	T1	QL
ZOMIG 2.5 MG NASAL SPRAY	T2	ST QL (6 units/30 days)
ZOLMITRIPTAN 2.5 MG NASAL SPRY	T3	ST QL (6 units/30 days)
NASAL NSAIDS, COX NON-SELECTIVE,SYSTEMIC ANALGESIC		
SPRIX	T3	ST QL
NSAIDS, CYCLOOXYGENASE INHIBITOR-TYPE ANALGESICS		
diclofenac	T1	QL HD
diclofenac	T1	

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

PA – Prior Authorization
QL – Quantity Limit
ST – Step Therapy

AGE – Age Requirement
SP – Specialty Medication
HD – May require home delivery pharmacy

PPACA – No Cost-Share Preventive Medication
CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

ANALGESICS (Pain Relief and Inflammatory Disease) (cont.)		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
NSAIDS, CYCLOOXYGENASE INHIBITOR-TYPE ANALGESICS (cont.)		
diclofenac pot 25mg tablet	T1	ST HD
diclofenac potassium 25 mg cap (Zipsor)	T1	ST HD
ketorolac 15 mg/ml syringe	T1	
ketorolac 300 mg/10 ml vial	T1	
ketorolac 60 mg/2 ml syringe	T1	
ketorolac 30 mg/ml syringe	T1	
ketorolac 60 mg/2 ml vial	T1	
ketorolac 15 mg/ml vial	T1	
ketorolac 30 mg/ml vial	T1	
mefenamic acid	T1	HD
mefenamic acid	T1	
OPIOID ANALGESIC AND NON-SALICYLATE ANALGESICS		
acetaminophen w/codeine	T1	PA QL
endocet (Endocet)	T1	PA QL
endocet (Percocet)	T1	PA QL
hydrocodone-acetamin 2.5-325	T1	PA QL (12 ds/60 days)
hydrocodone-acetamin 10-300/15 (Lortab)	T1	PA QL (12 ds/60 days)
hydrocodone w/acetaminophen (Norco)	T1	PA QL
lorcet (Norco)	T1	PA QL
lorcet hd (Norco)	T1	PA QL
lorcet plus (Norco)	T1	PA QL
LORTAB *(hydrocodone/acetaminophen)*	T3	PA QL (12 ds/60 days)
NALOCET	T3	PA QL
oxycodone w/acetaminophen (Endocet)	T1	PA QL
oxycodone w/acetaminophen (Percocet)	T1	PA QL
tramadol hcl/acetaminophen	T1	PA QL (12 ds/60 days)
tramadol hcl-acetaminophen (Ultracet)	T1	PA QL
TYLENOL W/CODEINE *(acetaminophen-codeine)*	T3	PA QL
ULTRACET *(tramadol hcl-acetaminophen)*	T3	PA QL
vicodin hp	T1	PA QL
OPIOID ANALGESIC AND NSAID COMBINATION		
hydrocodone bit-ibuprofen	T1	PA QL
oxycodone hcl-ibuprofen	T1	PA QL

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

PA – Prior Authorization
QL – Quantity Limit
ST – Step Therapy

AGE – Age Requirement
SP – Specialty Medication
HD – May require home delivery pharmacy

PPACA – No Cost-Share Preventive Medication
CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

ANALGESICS (Pain Relief and Inflammatory Disease) (cont.)		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
OPIOID ANALGESIC AND NON-SALICYLATE XANTHINE COMB		
apap-caffeine-dihydrocodeine (Trezix)	T1	PA QL
dvorah	T1	PA QL
TREZIX	T3	PA QL
OPIOID ANALGESICS		
ACTIQ *(fentanyl)*	T3	ST QL (90 units/63 days)
ARYMO ER	T3	ST QL (120 tabs/23 days)
BELBUCA	T2	PA QL (60 films/30 days)
belladonna & opium	T1	PA QL
buprenorphine (Butrans)	T1	PA
butorphanol	T1	PA QL (12 ds/180 days)
codeine	T1	PA QL
CONZIP	T3	ST QL (30 units/30 days)
DILAUDID *(hydromorphone hcl)*	T3	PA QL
diskets	T1	
DOLOPHINE HCL *(methadone hcl)*	T3	ST
fentanyl	T1	PA QL (15 patches/30 days)
fentanyl (Actiq)	T1	QL (90 units/63 days)
fentanyl (Duragesic)	T1	QL (15 patches/23 days)
FENTANYL CIT 400 MCG BUCCAL TB	T3	PA QL (90 tabs/30 days)
FENTANYL CIT 600 MCG BUCCAL TB	T3	PA QL (90 tabs/30 days)
FENTANYL CIT 800 MCG BUCCAL TB	T3	PA QL (90 tabs/30 days)
fentanyl cit otfc 1,200 mcg	T1	PA QL (90 lozs/30 days)
fentanyl citrate otfc 200 mcg, 400 mcg, 800 mcg	T1	PA QL (90 lozs/30 days)
hydrocodone bitartrate (Zohydro ER)	T1	QL (90 units/23 days)
hydrocodone er 100 mg tablet (Hysingla Er)	T1	PA QL (60 tabs/30 days)
hydrocodone er 120 mg tablet	T1	PA QL (60 tabs/30 days)
hydrocodone er 20 mg capsule (Zohydro Er)	T1	PA QL (90 caps/30 days)
hydrocodone er 20 mg tablet (Hysingla Er)	T1	PA QL (60 tabs/30 days)
hydrocodone er 30 mg tablet (Hysingla Er)	T1	PA QL (60 tabs/30 days)
hydrocodone er 40 mg tablet (Hysingla Er)	T1	PA QL (60 tabs/30 days)
hydrocodone er 60 mg tablet (Hysingla Er)	T1	PA QL (60 tabs/30 days)
hydrocodone er 80 mg tablet (Hysingla Er)	T1	PA QL (60 tabs/30 days)
hydrocodone er 10 mg capsule	T1	PA QL (90 caps/30 days)
hydrocodone er 15 mg capsule	T1	PA QL (90 caps/30 days)

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

PA – Prior Authorization
QL – Quantity Limit
ST – Step Therapy

AGE – Age Requirement
SP – Specialty Medication
HD – May require home delivery pharmacy

PPACA – No Cost-Share Preventive Medication
CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

ANALGESICS (Pain Relief and Inflammatory Disease) (cont.)		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
OPIOID ANALGESICS *(cont.)*		
hydrocodone er 20 mg capsule	T1	PA QL (90 caps/30 days)
hydrocodone er 30 mg capsule	T1	PA QL (90 caps/30 days)
hydrocodone er 40 mg capsule	T1	PA QL (90 caps/30 days)
hydrocodone er 50 mg capsule	T1	PA QL (90 caps/30 days)
hydromorphone	T1	QL (60 tabs/23 days)
hydromorphone er	T1	QL (60 tabs/23 days)
hydromorphone hcl (Dilaudid)	T1	PA QL
HYSINGLA ER	T2	ST QL (60 units/23 days)
HYSINGLA ER *(hydrocodone bitartrate)*	T2	PA QL (60 tabs/30 days)
KADIAN (morphine er)	T3	ST QL (90 caps/23 days)
LAZANDA 100 MCG NASAL SPRAY	T3	PA QL (23 units/30 days)
LAZANDA 400 MCG NASAL SPRAY	T3	PA QL (23 units/30 days)
levorphanol tartrate	T1	PA QL
methadone hcl	T1	
methadone hcl (Dolophine Hcl)	T1	
methadose	T1	
morphine	T1	PA QL (12 ds/60 days)
MORPHINE	T3	PA QL
morphine cr (Ms Contin)	T1	QL (120 tabs/23 days)
morphine er 10 mg cap	T1	PA QL (90 caps/30 days)
morphine er 20 mg cap	T1	PA QL (90 caps/30 days)
morphine er 30 mg cap	T1	PA QL (90 caps/30 days)
morphine er 30 mg cap	T1	PA QL (60 caps/30 days)
morphine er 45 mg cap	T1	PA QL (60 caps/30 days)
morphine er 60 mg cap	T1	PA QL (60 caps/30 days)
morphine er 50 mg cap	T1	PA QL (90 caps/30 days)
morphine er 60 mg cap	T1	PA QL (90 caps/30 days)
morphine er 100 mg cap	T1	PA QL (90 caps/30 days)
morphine er 75 mg cap	T1	PA QL (60 caps/30 days)
morphine er 90 mg cap	T1	PA QL (60 caps/30 days)
morphine er 120 mg cap	T1	PA QL (60 caps/30 days)
morphine er (Kadian)	T1	QL (90 caps/23 days)
morphine er 15 mg tablet (Ms Contin)	T1	PA QL (120 tabs/30 days)
morphine er 30 mg tablet (Ms Contin)	T1	PA QL (120 tabs/30 days)

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

PA – Prior Authorization
QL – Quantity Limit
ST – Step Therapy

AGE – Age Requirement
SP – Specialty Medication
HD – May require home delivery pharmacy

PPACA – No Cost-Share Preventive Medication
CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

ANALGESICS (Pain Relief and Inflammatory Disease) (cont.)		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
OPIOID ANALGESICS *(cont.)*		
morphine er 60 mg tablet (Ms Contin)	T1	PA QL (120 tabs/30 days)
morphine er 100 mg tablet (Ms Contin)	T1	PA QL (120 tabs/30 days)
morphine er 200 mg tablet (Ms Contin)	T1	PA QL (120 tabs/30 days)
morphine er (MS Contin)	T1	QL (120 tabs/23 days)
MS CONTIN (*morphine*)	T3	PA QL (120 tabs/30 days)
MS CONTIN (*morphine cr, morphine er*)	T3	ST QL (120 tabs/23 days)
MS CONTIN (*morphine er*)	T3	ST QL (120 tabs/23 days)
oxycodone (ir) 5 mg cap	T1	PA QL (12 ds/60 days)
oxycodone 100 mg/5 ml conc	T1	PA QL (12 ds/60 days)
oxycodone 5 mg/5 ml cup, soln	T1	PA QL (12 ds/60 days)
oxycodone (ir) 10 mg tab	T1	PA QL (12 ds/60 days)
oxycodone (ir) 20 mg tab	T1	PA QL (12 ds/60 days)
oxycodone (ir) 5 mg tablet (Roxicodone)	T1	PA QL (12 ds/60 days)
oxycodone (ir) 15 mg tab (Roxicodone)	T1	PA QL (12 ds/60 days)
oxycodone (ir) 30 mg tab (Roxicodone)	T1	PA QL (12 ds/60 days)
OXYCONTIN	T3	PA QL (90 tabs/30 days)
oxymorphone	T1	PA QL (90 tabs/30 days)
oxymorphone er	T1	QL (90 tabs/23 days)
pentazocine and naloxone hcl	T1	PA QL
ROXICODONE *(oxycodone hcl)*	T3	PA QL
SUBSYS	T3	PA QL (90 units/30 days)
tramadol hcl 100 mg tablet	T1	PA QL (12 ds/60 days)
tramadol er 100 mg tablet	T1	PA QL (30 tabs/30 days)
tramadol er 200 mg tablet	T1	PA QL (30 tabs/30 days)
tramadol er 300 mg tablet	T1	PA QL (30 tabs/30 days)
tramadol hcl er 100 mg tablet	T1	PA QL (30 tabs/30 days)
tramadol hcl er 200 mg tablet	T1	PA QL (30 tabs/30 days)
tramadol hcl er 300 mg tablet	T1	PA QL (30 tabs/30 days)
ULTRAM *(tramadol hcl)*	T3	PA QL
OPIOID AND SALICYLATE ANALGESICS, BARBIT, XANTHINE		
asa-butalb-caff-cod (Fiorinal With Codeine #3)	T1	PA QL
ascomp with codeine (Fiorinal With Codeine #3)	T1	PA QL
butalbital compound w/codeine (Fiorinal With Codeine #3)	T1	PA QL
FIORINAL W/CODEINE *(asa-butalb-caffeine-codeine)*	T3	PA QL

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

PA – Prior Authorization
QL – Quantity Limit
ST – Step Therapy

AGE – Age Requirement
SP – Specialty Medication
HD – May require home delivery pharmacy

PPACA – No Cost-Share Preventive Medication
CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

ANALGESICS (Pain Relief and Inflammatory Disease) (cont.)		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
OPIOID, NON-SALICYL. ANALGESIC, BARBITUATE, XANTHINE		
butalbital/caff/apap/codeine (Fioricet With Codeine)	T1	PA QL
FIORICET WITH CODEINE *(butalb-acetaminoph-caff-codein)*	T3	PA QL
SKELETAL MUSCLE RELAXANT, SALICYLAT, OPIOID ANALGES		
carisoprodol-aspirin-codeine	T1	PA QL
ANALGESICS (Urinary Tract Conditions)		
URINARY TRACT ANALGESIC AGENTS		
ELMIRON	T2	
RIMSO-50	T3	
ANESTHETICS (Miscellaneous)		
GENERAL ANESTHETICS, INHALANT		
desflurane (Suprane)	T1	
forane (Forane)	T1	
isoflurane (Forane)	T1	
sevoflurane (Ultane)	T1	
SUPRANE	T3	
terrell (Forane)	T1	
ULTANE *(sevoflurane)*	T3	
ANESTHETICS (Pain Relief and Inflammatory Disease)		
LOCAL ANESTHETICS		
glydo	T1	QL (60 ml/23 days)
lidocaine	T1	
lidocaine hcl	T1	QL (60 ml/23 days)
TOPICAL LOCAL ANESTHETICS		
CETACAINE ANESTHETIC	T3	
DYCLOPRO	T3	
L.E.T. (LIDO-EPINEPH-TETRA)	T3	
LIDOCAN II *(lidocaine)*	T3	PA
*lidocaine (*Lidocan Ii*)*	T1	PA
lidocaine (Lidoderm)	T1	PA
lidocaine 5% ointment	T1	QL (50 gm/21 days)
*lidocaine 5% patch (*Lidocan Ii*)*	T1	PA
lidocaine hcl	T1	
lidocaine-prilocaine cream	T1	QL (30 gms/30 days) PPACA

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

PA – Prior Authorization
QL – Quantity Limit
ST – Step Therapy

AGE – Age Requirement
SP – Specialty Medication
HD – May require home delivery pharmacy

PPACA – No Cost-Share Preventive Medication
CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

ANESTHETICS (Pain Relief and Inflammatory Disease) (cont.)		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
TOPICAL LOCAL ANESTHETICS (cont.)		
lidocaine/racepinep/tetracaine	T1	
SYNERA	T3	
ZTLIDO	T2	PA
ANESTHETICS (Urinary Tract Conditions)		
URINARY TRACT ANESTHETIC/ANALGESIC AGNT (AZO-DYE)		
phenazopyridine hcl (Pyridium)	T1	
PYRIDIUM *(phenazopyridine hcl)*	T3	
ANTI-ALLERGY (Allergy/Nasal Sprays)		
MAST CELL STABILIZERS		
cromolyn (Gastrocrom)	T1	
GASTROCROM *(cromolyn)*	T3	
ANTI-ARTHRITICS (Pain Relief and Inflammatory Disease)		
ANALGESIC/ANTIPYRETICS, SALICYLATES		
salsalate	T1	HD
ANTI-ARTHRITIC AND CHELATING AGENTS		
DEPEN *(penicillamine)*	T3	PA SP
penicillamine (Cuprimine)	T1	PA SP
penicillamine (Depen)	T1	PA SP
ANTI-ARTHRITIC, FOLATE ANTAGONIST AGENTS		
RASUVO	T3	ST
ANTI-INFLAMMATORY, PYRIMIDINE SYNTHESIS INHIBITOR		
ARAVA *(leflunomide)*	T3	QL (30 units/30 days) HD
leflunomide (Arava)	T1	QL (30 units/30 days) HD
ANTI-INFLAMMATORY, PHOSPHODIESTERASE-4(PDE4) INHIB.		
OTEZLA 10-20 MG STARTER 28 DAY	T2	PA QL (55 tabs/365 days) SP HD
OTEZLA 10-20-30 MG START 28 DAY	T2	PA QL (55 tabs/365 days) SP HD
OTEZLA 20 MG TABLET	T2	PA QL (60 tabs/30 days) SP HD
OTEZLA 30 MG TABLET	T2	PA QL (60 tabs/23 days) SP HD
OTEZLA XR	T2	PA SP HD
COLCHICINE		
colchicine (Colcrys)	T1	HD
colchicine 0.6 mg capsule (Mitigare)	T1	ST
GLOPERBA	T3	HD

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

PA – Prior Authorization
QL – Quantity Limit
ST – Step Therapy

AGE – Age Requirement
SP – Specialty Medication
HD – May require home delivery pharmacy

PPACA – No Cost-Share Preventive Medication
CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

ANTI-ARTHRITICS (Pain Relief and Inflammatory Disease) (cont.)		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
COLCHICINE (cont.)		
MITIGARE (*colchicine)*	T2	ST
GOLD SALTS		
febuxostat (Uloric)	T1	HD
RIDAURA	T2	
ZYLOPRIM *(allopurinol)*	T3	HD
HYPERURICEMIA TX - XANTHINE OXIDASE INHIBITORS		
allopurinol	T1	HD
allopurinol (Zyloprim)	T1	HD
JANUS KINASE (JAK) INHIBITORS		
RINVOQ ER 15 MG, 30 MG TABLET	T2	PA QL (30 tabs/30 days) SP
RINVOQ LQ	T2	PA QL (360 mls/30 days) SP HD
XELJANZ	T2	PA QL SP HD
XELJANZ 1mg/ml ORAL SOLUTION	T2	QL (300ml/30 Days)
XELJANZ XR	T2	PA QL (30 units/30 days) SP HD
NSAIDS (COX NON-SPEC.INHIB) AND PROSTAGLANDIN ANALOG		
ARTHROTEC *(diclofenac -misoprostol)*	T3	ST HD
diclofenac -misoprostol (Arthrotec 50)	T1	HD
diclofenac -misoprostol (Arthrotec 75)	T1	HD
NSAIDS, CYCLOOXYGENASE INHIBITOR - TYPE ANALGESICS		
ANAPROX DS *(naproxen)*	T3	ST HD
DAYPRO *(oxaprozin)*	T3	ST HD
EC-NAPROSYN *(ec-naproxen)*	T3	ST HD
ec-naproxen dr 375 mg tablet (Ec-Naprosyn)	T1	HD
ec-naproxen dr 500 mg tablet (Ec-Naprosyn)	T1	ST HD
etodolac (Lodine)	T1	HD
etodolac (Lodine)	T1	
etodolac er	T1	HD
FELDENE *(piroxicam)*	T3	ST HD
FENORTHO 200 MG CAPSULE	T3	ST HD
fenoprofen	T1	HD
flurbiprofen	T1	HD
ibu	T1	HD
ibuprofen	T1	HD

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

PA – Prior Authorization
QL – Quantity Limit
ST – Step Therapy

AGE – Age Requirement
SP – Specialty Medication
HD – May require home delivery pharmacy

PPACA – No Cost-Share Preventive Medication
CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

ANTI-ARTHRITICS (Pain Relief and Inflammatory Disease) (cont.)		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
NSAIDS, CYCLOOXYGENASE INHIBITOR - TYPE ANALGESICS (cont.)		
ibuprofen (Children'S Advil)	T1	HD
INDOCIN	T3	ST HD
indomethacin	T1	HD
INDOMETHACIN 20 MG CAPSULE	T3	ST QL (90 caps/30 days) HD
indomethacin 25 mg/5 ml susp (Indocin)	T1	ST HD
indomethacin 50 mg suppository (Indocin)	T1	HD
ketoprofen	T1	ST HD
LODINE *(etodolac)*	T3	ST HD
meclofenamate	T1	HD
meloxicam 7.5 mg tablet	T1	QL (30 tabs/30 days) HD
meloxicam 15mg tablet (Mobic)	T1	HD
nabumetone (Relafen)	T1	HD
NALFON *(fenoprofen)*	T3	ST HD
NAPRELAN *(naproxen cr)*	T3	ST HD
NAPROSYN *(naproxen)*	T3	ST HD
naproxen	T1	ST HD
naproxen dr 500 mg tablet (Ec-Naprosyn)	T1	ST HD
naproxen er 750mg tablet (Naprelan)	T1	ST
naproxen (Anaprox DS)	T1	HD
naproxen (EC-Naprosyn)	T1	HD
naproxen (Naprosyn)	T1	HD
oxaprozin 600 mg caplet, tablet (Daypro)	T1	HD
piroxicam	T1	HD
piroxicam (Feldene)	T1	HD
QMIIZ ODT 7.5MG TABLET	T3	ST QL (30 units/30 days)
QMIIZ ODT 15 MG TABLET	T3	ST
sulindac	T1	HD
TIVORBEX	T3	ST QL (90 caps/30 days) HD
TOLECTIN 600 *(tolmetin sodium)*	T3	ST HD
tolmetin	T1	HD
tolmetin sodium 600 mg tab (Tolectin 600)	T1	ST HD
NSAIDS, CYCLOOXYGENASE-2(COX-2) SELECTIVE INHIBITOR		
celecoxib (Celebrex)	T1	HD

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

PA – Prior Authorization
QL – Quantity Limit
ST – Step Therapy

AGE – Age Requirement
SP – Specialty Medication
HD – May require home delivery pharmacy

PPACA – No Cost-Share Preventive Medication
CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

ANTI-ARTHRITICS (Pain Relief and Inflammatory Disease) (cont.)		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
NSAIDS, CYCLOOXYGENASE-2(COX-2) SELECTIVE INHIBITOR (cont.)		
celecoxib	T1	HD
URICOSURIC AGENTS		
probenecid	T1	HD
probenecid w/colchicine	T1	HD
ANTI-ASTHMATICS (Asthma/COPD/Respiratory)		
ANTICHOLINERGICS, ORALLY INHALED LONG ACTING		
formoterol fumarate (Perforomist)	T1	
INCRUSE ELLIPTA	T2	QL (1 inhaler/30 days) HD
LONHALA MAGNAIR REFILL	T3	QL HD
LONHALA MAGNAIR STARTER	T3	QL HD
SEEBRI NEOHALER	T3	QL HD
SPIRIVA HANDIHALER 18 MCG CAP *(tiotropium bromide)*	T3	QL (90 caps/30 days) HD
SPIRIVA RESPIMAT	T2	QL HD
YUPELRI	T2	QL (30 units/30 days) HD
ANTICHOLINERGICS, ORALLY INHALED SHORT ACTING		
ATROVENT HFA	T3	QL HD
ipratropium bromide	T1	HD
BETA-ADRENERGIC AGENTS		
albuterol 2 mg/5 ml syrup cup	T1	HD
albuterol 8 mg/20 ml syrup cup	T1	HD
metaproterenol	T1	HD
terbutaline	T1	HD
BETA-ADRENERGIC AGENTS, INHALED, SHORT ACTING		
albuterol	T1	
albuterol hfa 90 mcg inhaler	T1	QL (2 inhalers/30 days)
albuterol 15 mg/3 ml solution	T1	
albuterol 75 mg/15 ml soln	T1	
levalbuterol hcl (Xopenex Concentrate)	T1	
levalbuterol hcl (Xopenex)	T1	
XOPENEX *(levalbuterol concentrate)*	T3	
XOPENEX *(levalbuterol hcl)*	T3	
BETA-ADRENERGIC AGENTS, INHALED, ULTRA-LONG ACTING		
ARCAPTA NEOHALER	T3	QL (30 units/30 days) HD
STRIVERDI RESPIMAT	T2	QL (1 inhaler/30 days) HD

T1 – Typically Generics
T2 – Typically Preferred Brands
T3 – Typically Non-Preferred Brands
PA – Prior Authorization
QL – Quantity Limit
ST – Step Therapy
AGE – Age Requirement
SP – Specialty Medication
HD – May require home delivery pharmacy
PPACA – No Cost-Share Preventive Medication
CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

ANTI-ASTHMATICS (Asthma/COPD/Respiratory) (cont.)		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
BETA-ADRENERGIC AGENTS, ORALLY INHALED, LONG ACTING		
BROVANA	T3	QL HD
FORMOTEROL FUMARATE-NEBULIZER	T2	QL (120 mls/30 days) HD
PERFOROMIST	T3	QL HD
BETA-ADRENERGIC AND ANTICHOLINERGIC COMBO, INHALED		
ANORO ELLIPTA	T2	QL HD
COMBIVENT INHALER	T2	
COMBIVENT RESPIMAT	T2	QL (2 inhalers/30 days)
SEEBRI NEOHALER 15.6MCG INHALER	T3	HD
STIOLTO RESPIMAT	T2	QL HD
UTIBRON NEOHALER 27.5, 15.6MCG (PS 6)	T3	HD
UTIBRON NEOHALER 27.5, 15.6 MCG (PS 60)	T3	HD
BETA-ADRENERGIC AND GLUCOCORTICOID COMBO, INHALED		
ADVAIR HFA	T2	ST QL HD
AIRSUPRA	T2	HD
BREO ELLIPTA 50-25 MCG INHALER	T2	PA QL (60 blisters/fill) HD
BREO ELLIPTA	T2	ST QL HD
breyna 80-4.mcg, 160-4.5 mcg inhaler	T1	PA
budesonide-formoterol 160-4.5, 80-4.5	T1	PA HD QL (1 inhaler/30 days)
DULERA	T2	ST QL HD
fluticasone-salmeterol (Advair Diskus)	T1	PA QL (1 inhaler/30 days)
SYMBICORT *(budesonide/formoterol fumarate)*	T3	PA QL (1 inhaler/30 days) HD
wixela inhub (Advair Diskus)	T1	QL HD
BETA-ADRENERGIC-ANTICHOLINERGIC-GLUCOCORT, INHALED		
TRELEGY ELLIPTA	T2	QL
GLUCOCORTICOIDS, ORALLY INHALED		
ALVESCO	T3	QL HD
ARNUITY ELLIPTA 50 MCG INH	T3	QL (30 blisters/30 days)
ARNUITY ELLIPTA 100 MCG INH	T3	QL (1 inhaler/30 days)
ARNUITY ELLIPTA 200 MCG INH	T3	QL (1 inhaler/30 days)
ASMANEX	T2	QL HD
ASMANEX HFA	T2	QL HD
FLOVENT DISKUS	T2	QL HD
FLOVENT HFA	T2	QL HD

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

PA – Prior Authorization
QL – Quantity Limit
ST – Step Therapy

AGE – Age Requirement
SP – Specialty Medication
HD – May require home delivery pharmacy

PPACA – No Cost-Share Preventive Medication
CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

ANTI-ASTHMATICS (Asthma/COPD/Respiratory) (cont.)		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
GLUCOCORTICOIDS, ORALLY INHALED (cont.)		
QVAR REDIHALER 40 MCG	T2	QL (11 gms/30 days)
QVAR REDIHALER 80 MCG	T2	QL (22 gms/30 days)
INTERLEUKIN-5(IL-5) RECEPTOR ALPHA ANTAGONIST, MAB		
FASENRA PEN	T2	PA ST QL (1 pen/56 days) SP HD
LEUKOTRIENE RECEPTOR ANTAGONISTS		
ACCOLATE *(zafirlukast)*	T3	HD
montelukast (Singulair)	T1	HD
zafirlukast (Accolate)	T1	HD
MAST CELL STABILIZERS, ORALLY INHALED		
cromolyn	T1	HD
MONOCLONAL ANTIBODIES TO IMMUNOGLOBULIN E (IGE)		
XOLAIR 75MG/0.5 ML AUTOINJECT	T2	PA QL (2 auto-injs/28 days) SP HD
XOLAIR 300 MG/2 ML AUTOINJECT	T2	PA QL (2 auto-injs/28 days) SP HD
XOLAIR 150 MG/ML AUTOINJECTOR	T2	PA QL (2 auto-injs/28 days) SP HD
XOLAIR 300 MG/2 ML SYRINGE	T2	PA QL (2 syringes/28 days) SP HD
XOLAIR 150 MG VIAL	T2	PA QL (6 vials/21 days) SP HD
MONOCLONAL ANTIBODY - INTERLEUKIN-5 ANTAGONISTS		
NUCALA	T2	PA QL (1 unit/21 days) SP HD
MUCOLYTICS		
acetylcysteine	T1	
PHOSPHODIESTERASE (PDE) INHIBITORS		
roflumilast 250 mcg tablet (Daliresp)	T1	PA QL (30 tabs/30 days) HD
roflumilast 500 mcg tablet (Daliresp)	T1	PA HD
XANTHINES		
ELIXOPHYLLIN	T3	HD
THEO-24	T3	HD
theophylline anhydrous	T1	HD
theophylline anhydrous (Elixophyllin)	T1	HD
ANTIBIOTICS (Ear Medications)		
EAR PREPARATIONS, ANTIBIOTICS		
ciprofloxacin hcl (Cetraxal)	T1	
COLY-MYCIN S	T3	
neomycin/polymyxin/hc	T1	
ofloxacin	T1	

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

PA – Prior Authorization
QL – Quantity Limit
ST – Step Therapy

AGE – Age Requirement
SP – Specialty Medication
HD – May require home delivery pharmacy

PPACA – No Cost-Share Preventive Medication
CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

ANTIBIOTICS (Ear Medications) (cont.)		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
EAR PREPARATIONS, ANTIBIOTICS (cont.)		
OTIPRIO	T3	QL
OTIC PREPARATIONS, ANTI-INFLAMMATORY-ANTIBIOTICS		
ciprofloxacin hcl/dexameth	T1	
CIPRODEX	T2	
ANTIBIOTICS (Eye Conditions)		
EYE ANTIBIOTIC AND GLUCOCORTICOID COMBINATIONS		
MAXITROL *(neomycin-polymyxin-dexameth)*	T3	
neo/polymyxin/dexamethasone (Maxitrol)	T1	
neomycin/bacitracin/poly/hc	T1	
neomycin/polymyxin/hc	T1	
neomycin-polymyxin-dexamethaso (Maxitrol)	T1	
PRED-G	T3	
PREDNISOLONE ACET-MOXIFLOXACIN	T3	
PREDNISOLONE PHOS-MOXIFLOXACIN	T3	
PREDNISOLONE-GATIFLOXACIN	T3	
TOBRADEX EYE OINTMENT	T3	
tobramycin/dexamethasone	T1	
EYE ANTIBIOTIC AND NSAID COMBINATIONS		
MOXIFLOXACIN-BROMFENAC	T3	
EYE ANTIBIOTIC, GLUCOCORTICOID AND NSAID COMB.		
PREDNISOLONE AC-MOXIFLOX-BROMF	T3	
PREDNISOLONE AC-MOXIFLOX-NEPAF	T3	
PREDNISOLONE PH-MOXIFLOX-KETOR	T3	
PREDNISOLONE-GATIFLOX-BROMFENC	T3	
pred ph-moxi-brom 1-0.5-0.075%	T1	
PRED PH-MOXI-BROM 1-0.5-0.075%	T3	
EYE SULFONAMIDES		
BLEPH-10 *(sulfacetamide)*	T3	
BLEPHAMIDE	T3	
BLEPHAMIDE S.O.P.	T3	
sulfacetamide	T1	
sulfacetamide (Bleph-10)	T1	
sulfacetamide w/prednisolone	T1	

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

PA – Prior Authorization
QL – Quantity Limit
ST – Step Therapy

AGE – Age Requirement
SP – Specialty Medication
HD – May require home delivery pharmacy

PPACA – No Cost-Share Preventive Medication
CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

ANTIBIOTICS (Eye Conditions) (cont.)		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
OPHTHALMIC ANTIBIOTICS		
ak-poly-bac	T1	
AZASITE	T2	
bacitracin	T1	
bacitracin/polymyxin	T1	
CILOXAN *(ciprofloxacin hcl)*	T3	
ciprofloxacin hcl (Ciloxan)	T1	
erythromycin	T1	
gatifloxacin	T1	
gentak	T1	
gentamicin	T1	QL (300ml/30 days)
KLARITY-A (AZITHROMYCIN-CHONDR)	T3	
levofloxacin hemihydrate	T1	
MOXEZA *(moxifloxacin)*	T3	
moxifloxacin hcl	T1	
moxifloxacin hcl (Moxeza)	T1	
moxifloxacin hcl (Vigamox)	T1	
neomycin/bacitracin/polymyxin	T1	
neomycin/polymyxin/gramicidin	T1	
neo-polycin	T1	
OCUFLOX *(ofloxacin)*	T3	
ofloxacin (Ocuflox)	T1	
polycin	T1	
polymyxin b sul-trimethoprim (Polytrim)	T1	
POLYTRIM *(polymyxin b sul-trimethoprim)*	T3	
tobramycin (Tobrex)	T1	
TOBREX *(tobramycin)*	T3	
VIGAMOX *(moxifloxacin)*	T3	
ANTIBIOTICS (Infections)		
2ND GEN. ANAEROBIC ANTIPROTOZOAL-ANTIBACTERIAL		
SOLOSEC	T2	QL
ABSORBABLE SULFONAMIDE ANTIBACTERIAL AGENTS		
BACTRIM *(sulfamethoxazole-trimethoprim)*	T3	
BACTRIM DS *(sulfamethoxazole-trimethoprim)*	T3	

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

PA – Prior Authorization
QL – Quantity Limit
ST – Step Therapy

AGE – Age Requirement
SP – Specialty Medication
HD – May require home delivery pharmacy

PPACA – No Cost-Share Preventive Medication
CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

ANTIBIOTICS (Infections) (cont.)		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
ABSORBABLE SULFONAMIDE ANTIBACTERIAL AGENTS (cont.)		
sulfadiazine	T1	
sulfamethoxazole/trimethoprim (Bactrim DS)	T1	
sulfamethoxazole/trimethoprim (Bactrim)	T1	
sulfamethoxazole/trimethoprim (Sulfatrim)	T1	
sulfatrim (Sulfatrim)	T1	
AMINOGLYCOSIDE ANTIBIOTICS		
ARIKAYCE	T2	PA SP
BETHKIS	T2	PA QL SP HD
gentamicin	T1	QL (300 ml/30 days)
KITABIS PAK	T2	PA QL SP HD
neomycin	T1	
TOBI PODHALER	T2	PA QL
tobramycin	T1	
TOBRAMYCIN	T3	PA QL SP HD
tobramycin (Tobi)	T1	PA QL SP HD
ANAEROBIC ANTIPROTOZOAL-ANTIBACTERIAL AGENTS		
FLAGYL *(metronidazole)*	T3	
metronidazole 250 mg, 500 mg tablet	T1	
metronidazole 375 mg capsule (Flagyl)	T1	
ANTIBIOTIC, ANTIBACTERIAL, MISC.		
fosfomycin tromethamine	T1	
hyophen	T1	
me-naphos-mb-hyo 1 (Urogesic-Blue)	T1	
methenam/m.blue/salicyl/hyoscy (Uribel Tabs)	T1	
methenamine hippurate	T1	
methenamine mandelate	T1	
MONUROL	T3	
phosphasal (Uretron D-S)	T1	
PRIMSOL	T3	
trimethoprim	T1	
URELLE	T3	
uretron d-s (Uretron D-S)	T1	
URIBEL TABS (*methenam/m.blue/salicyl/hyoscy*)	T3	
urimar-t	T1	

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

PA – Prior Authorization
QL – Quantity Limit
ST – Step Therapy

AGE – Age Requirement
SP – Specialty Medication
HD – May require home delivery pharmacy

PPACA – No Cost-Share Preventive Medication
CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

ANTIBIOTICS (Infections) (cont.)		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
AMINOGLYCOSIDE ANTIBIOTICS (cont.)		
urin d.s. (Uretron D-S)	T1	
uro-458 (Urelle)	T1	
uroav-b (Uribel)	T1	
urogesic (Urogesic-Blue)	T1	
uro-mp (Uribel)	T1	
uryl (Urogesic-Blue)	T1	
ustell	T1	
utira-c (Uretron D-S)	T1	
vilamit mb (Uribel)	T1	
vilevev mb (Urelle)	T1	
ANTILEPROTICS		
dapsone 25 mg tablet	T1	
dapsone 100 mg tablet	T1	
THALOMID 50mg CAPSULES	T2	PA QL (30 caps/30 day) SP HD
THALOMID 100mg CAPSULES	T2	PA QL (30 caps/30 day) SP HD
THALOMID 200mg CAPSULES	T2	PA QL (60 caps/30 day) SP HD
ANTI-MYCOBACTERIUM AGENTS		
isoniazid	T1	HD
MYCOBUTIN *(rifabutin)*	T3	HD
PASER	T3	HD
pyrazinamide	T1	HD
rifabutin (Mycobutin)	T1	HD
TRECATOR	T3	HD
ANTI-TUBERCULAR ANTIBIOTICS		
cycloserine	T1	
PRETOMANID	T3	PA
PRIFTIN	T2	
RIFADIN *(rifadin)*	T3	
RIFADIN *(rifampin)*	T3	
rifampin (Rifadin)	T1	
SIRTURO	T2	PA SP
BETALACTAMS		
CAYSTON	T2	QL SP HD

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

PA – Prior Authorization
QL – Quantity Limit
ST – Step Therapy

AGE – Age Requirement
SP – Specialty Medication
HD – May require home delivery pharmacy

PPACA – No Cost-Share Preventive Medication
CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

ANTIBIOTICS (Infections) (cont.)		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
CEPHALOSPORIN ANTIBIOTICS - 1ST GENERATION		
cefadroxil	T1	
CEPHALOSPORIN ANTIBIOTICS - 2ND GENERATION		
cefaclor	T1	
cefaclor er	T1	
cefprozil	T1	
cefuroxime axetil	T1	
CEPHALOSPORIN ANTIBIOTICS - 3RD GENERATION		
cefdinir	T1	
cefpodoxime proxetil	T1	
ceftriaxone	T1	
SPECTRACEF	T3	
LINCOSAMIDE ANTIBIOTICS		
CLEOCIN HCL *(clindamycin hcl)*	T3	
CLEOCIN PALMITATE *(clindamycin (pediatric))*	T3	
clindamycin hcl (Cleocin Hcl)	T1	
clindamycin palmitate hcl (Cleocin Pediatric)	T1	
clindamycin pediatric (Cleocin Pediatric)	T1	
MACROLIDE ANTIBIOTICS		
azithromycin 100mg/5 ml suspension (Zithromax)	T1	QL (195 ml/68 days)
azithromycin 1gm powder packet (Zithromax)	T1	QL (2 packets/68 days)
azithromycin 200mg/5 ml suspension (Zithromax)	T1	QL (120 ml/68 days)
azithromycin 250mg, 500mg tablet (Zithromax)	T1	QL (15 tabs/ 68 days)
azithromycin 600mg tablet	T1	QL (24 tabs/68 days)
clarithromycin	T1	
clarithromycin er	T1	
DIFICID 200 MG TABLET *(fidaxomicin)*	T3	QL (20 tabs/30 days)
e.e.s.	T1	
E.E.S. *(erythromycin ethyl)*	T3	
ERYPED *(erythromycin ethyl)*	T3	
ery-tab	T1	
erythrocin stearate	T1	
erythromycin	T1	
erythromycin (Ery-Tab)	T1	

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

PA – Prior Authorization
QL – Quantity Limit
ST – Step Therapy

AGE – Age Requirement
SP – Specialty Medication
HD – May require home delivery pharmacy

PPACA – No Cost-Share Preventive Medication
CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

ANTIBIOTICS (Infections) (cont.)		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
MACROLIDE ANTIBIOTICS (cont.)		
erythromycin ethylsuccinate	T1	
erythromycin ethylsuccinate (E.E.S. 200)	T1	
erythromycin ethylsuccinate (Eryped 400)	T1	
erythromycin stearate	T1	
fidaxomicin (Dificid)	T1	QL (20 tabs/30 days)
ZITHROMAX 1 GM POWDER PACKET *(azithromycin)*	T3	QL (2 packets/68 days)
ZITHROMAX 100MG/5 ML SUSPENSION *(azithromycin)*	T3	QL (195 ml/68 days)
ZITHROMAX 200 MG/5 ML SUSPENSION *(azithromycin)*	T3	QL (120 ml/68 days)
ZITHROMAX 250MG, 500MG TABLET *(azithromycin)*	T3	QL (15 tabs/ 68 days)
NITROFURAN DERIVATIVES ANTIBACTERIAL AGENTS		
MACROBID *(nitrofurantoin mono-macro)*	T3	
MACRODANTIN *(nitrofurantoin)*	T3	
nitrofurantoin mcr 25 mg, 50 mg, 100 mg cap	T1	
OXAZOLIDINONE ANTIBIOTICS		
linezolid (Zyvox)	T1	PA
ZYVOX *(linezolid)*	T3	PA
PENICILLIN ANTIBIOTICS		
amoxicillin	T1	
amoxicillin-clavulanate pot er	T1	
amoxicillin-clavulanate potass	T1	
amoxicillin-clavulanate potass (Augmentin ES-600)	T1	
amoxicillin-clavulanate potass (Augmentin)	T1	
ampicillin trihydrate	T1	
AUGMENTIN 125-31.25 MG/5ML	T2	
AUGMENTIN 250-62.5 MG/ML SUSP, 500 MG TAB (*amoxicillin-clavulanate potass)*	T3	
dicloxacillin	T1	
penicillin V	T1	
PLEUROMUTILIN DERIVATIVES		
XENLETA	T3	
QUINOLONE ANTIBIOTICS		
BAXDELA	T2	QL
CIPRO *(ciprofloxacin)*	T3	
ciprofloxacin hcl (Cipro)	T1	
LEVAQUIN *(levofloxacin)*	T3	

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

PA – Prior Authorization
QL – Quantity Limit
ST – Step Therapy

AGE – Age Requirement
SP – Specialty Medication
HD – May require home delivery pharmacy

PPACA – No Cost-Share Preventive Medication
CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

ANTIBIOTICS (Infections) (cont.)		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
QUINOLONE ANTIBIOTICS (cont.)		
levofloxacin hemihydrate	T1	
moxifloxacin hcl	T1	
ofloxacin	T1	
RIFAMYCINS AND RELATED DERIVATIVE ANTIBIOTICS		
AEMCOLO	T3	QL
XIFAXAN	T2	QL
TETRACYCLINE ANTIBIOTICS		
ACTICLATE *(doxycycline hyclate)*	T3	ST
avidoxy	T1	
AVIDOXY DK	T3	ST
coremino	T1	
demeclocycline hcl	T1	
doxycycline 50 mg tablet (Targadox)	T1	ST
doxycycline hyc dr 50 mg tab	T1	ST
doxycycline hyclate (Acticlate)	T1	
doxycycline hyclate (Doryx)	T1	
doxycycline hyclate 100 mg cap	T1	
doxycycline mono 75 mg capsule	T1	ST
doxycycline mono 100 mg cap	T1	
doxycycline mono 50 mg cap	T1	
doxycycline monohydrate (Oracea)	T1	ST
doxycycline monohydrate (Vibramycin)	T1	
MINOCIN *(minocycline hcl)*	T3	ST
minocycline 50 mg capsule	T1	
minocycline 75 mg capsule	T1	
minocycline 100 mg capsule	T1	
minocycline hcl 50 mg tablet	T1	ST
minocycline hcl 75 mg tablet	T1	ST
minocycline hcl 100 mg tablet	T1	ST
minocycline hcl er	T1	
minocycline hcl er (Solodyn)	T1	
MINOLIRA ER	T3	ST
mondoxyne nl	T1	
mondoxyne nl 75 mg capsule	T1	ST

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

PA – Prior Authorization
QL – Quantity Limit
ST – Step Therapy

AGE – Age Requirement
SP – Specialty Medication
HD – May require home delivery pharmacy

PPACA – No Cost-Share Preventive Medication
CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

ANTIBIOTICS (Infections) (cont.)		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
TETRACYCLINE ANTIBIOTICS (cont.)		
mondoxyne nl 100 mg capsule	T1	
morgidox	T1	
MORGIDOX	T3	ST
NUZYRA	T3	QL (30 tabs/30 days) SP
okebo	T1	
ORACEA	T3	ST
SEYSARA	T3	ST
SOLODYN *(minocycline hcl er)*	T3	ST
TARGADOX *(doxycycline hyclate)*	T3	ST
tetracycline 250 mg capsule	T1	
tetracycline 250 mg tablet	T1	ST
tetracycline 500 mg capsule	T1	
tetracycline 500 mg tablet	T1	ST
VIBRAMYCIN *(doxycycline monohydrate)*	T3	
VAGINAL ANTIBIOTICS		
CLEOCIN PHOSPHATE *(clindamycin phosphate)*	T3	
clindamycin phosphate (Cleocin)	T1	
CLINDESSE	T3	
metronidazole	T1	
metronidazole vaginal 0.75% gl	T1	
NUVESSA	T3	
vandazole	T1	
XACIATO	T3	
VANCOMYCIN ANTIBIOTICS AND DERIVATIVES		
VANCOCIN HCL *(vancomycin hcl)*	T3	QL
vancomycin 125mg capsule	T1	PA QL (40 caps/30 days)
vancomycin 250mg capsule	T1	PA QL (80 caps/30 days)
vancomycin hcl (Firvanq)	T1	QL
ANTIBIOTICS (Skin Conditions)		
TOPICAL ANTIBIOTIC AND ANTI-INFLAMMATORY STEROID		
NEO-SYNALAR	T3	
TOPICAL ANTIBIOTICS		
AMZEEQ	T3	ST
BENZAMYCIN *(erythromycin-benzoyl peroxide)*	T3	ST

T1 – Typically Generics
T2 – Typically Preferred Brands
T3 – Typically Non-Preferred Brands
PA – Prior Authorization
QL – Quantity Limit
ST – Step Therapy
AGE – Age Requirement
SP – Specialty Medication
HD – May require home delivery pharmacy
PPACA – No Cost-Share Preventive Medication
CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

ANTIBIOTICS (Skin Conditions) (cont.)		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
TOPICAL ANTIBIOTICS (cont.)		
CENTANY	T3	ST QL (30 units/30 days)
CENTANY AT	T3	ST QL
CLEOCIN T *(clindamycin phosphate)*	T3	ST QL (120 gm/23 days)
CLEOCIN T *(clindamycin phosphate)*	T3	ST QL (120 ml/23 days)
CLINDACIN ETZ	T3	ST
clindacin etz	T1	
clindacin p	T1	
CLINDACIN PAC	T3	ST
clindamycin (Evoclin)	T1	ST QL (100 gms/30 days)
clindamycin 1% foam (Evoclin)	T1	ST QL (100 gms/30 days)
clindamycin 1% gel	T1	
clindamycin 1% lotion (Cleocin T)	T1	QL (120 ml/23 days)
clindamycin 1% solution	T1	QL (120 ml/23 days)
clindamycin capsule	T1	
ery	T1	
erygel (Erygel)	T1	
erythromycin	T1	
erythromycin (Erygel)	T1	
erythromycin-benzoyl peroxide (Benzamycin)	T1	
EVOCLIN *(clindamycin phosphate)*	T3	ST QL (100 gm/23 days)
gentamicin	T1	QL (300 ml/30 days)
mupirocin 2% oint.	T1	QL (1 treatment/30 days)
mupirocin (Centany)	T1	QL
XEPI	T3	ST QL (30 units/30 days)
TOPICAL SULFONAMIDES		
avar	T1	
AVAR LS	T3	ST
AVAR-E	T3	ST
AVAR-E LS CREAM	T3	ST
mafenide acetate (Sulfamylon)	T1	
PLEXION	T3	ST
SILVADENE *(silver sulfadiazine)*	T3	
silver sulfadiazine (Silvadene)	T1	
sod sulfac-sulfur 9.8-4.8% crm	T1	ST

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

PA – Prior Authorization
QL – Quantity Limit
ST – Step Therapy

AGE – Age Requirement
SP – Specialty Medication
HD – May require home delivery pharmacy

PPACA – No Cost-Share Preventive Medication
CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

ANTIBIOTICS (Skin Conditions) (cont.)		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
TOPICAL SULFONAMIDES (cont.)		
sod sulfac-sulfur 9.8-4.8% lot	T1	ST
sod sulface-sulf 9.8-4.8% clsr	T1	ST
sod sulface-sulfur 9-4.5% wash	T1	ST
sod sulfacet-sulfr 9.8-4.8%pad	T1	ST
sod sulfacet-sulfur 10-2% clsr	T1	ST
ss 10-2 (Avar Ls)	T1	
ssd (Silvadene)	T1	
sss 10-5 cream	T1	
sss 10-5 foam	T1	ST
sulfacetamide sodium/sulfur		
sulfacetamide -sulfur	T1	
sulfacetamide-sulfur 9-4% clsr	T1	ST
sulfacetamide-sulfur 10-2% crm	T1	ST
sulfacetamide-sulfur 10-5% lot	T1	ST
sulfacetamide-sulfur 10-5% sus	T1	ST
sulfacetamide-sulfur 8-4% susp	T1	ST
sulfacetamide/sulfur (Avar LS)	T1	
sulfacetamide/sulfur (Avar-E LS)	T1	
sulfacetamide/sulfur (Plexion)	T1	
sulfacetamide/sulfur (Sumadan)	T1	
sulfacetamide/sulfur (Sumaxin)	T1	
sulfacleanse 8/4	T1	
SULFAMYLON 8.5% CREAM	T2	
SULFAMYLON POWDER PACKET *(mafenide)*	T3	
SUMADAN	T3	ST
SUMADAN XLT	T3	ST
SUMAXIN *(sulfacetamide-sulfur)*	T3	ST
SUMAXIN CP	T3	ST
ANTI-COAGULANTS (Blood Thinners/Anti-Clotting)		
ANTI-COAGULANTS, COUMARIN TYPE		
COUMADIN *(jantoven)*	T3	
COUMADIN *(warfarin)*	T3	
jantoven	T1	HD

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

PA – Prior Authorization
QL – Quantity Limit
ST – Step Therapy

AGE – Age Requirement
SP – Specialty Medication
HD – May require home delivery pharmacy

PPACA – No Cost-Share Preventive Medication
CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

ANTI-COAGULANTS (Blood Thinners/Anti-Clotting) (cont.)		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
CITRATES AS ANTI-COAGULANTS		
ACD	T2	
ACD-A	T2	
ANTICOAGULANT SODIUM CITRATE	T3	
CRRT TRISODIUM CITRATE	T3	
sodium citrate 4% lock flush	T1	
SODIUM CITRATE 4% LOCK FLUSH	T3	
SODIUM CITRATE 4% SOLN	T3	
SODIUM CITRATE 4% SYRINGE	T3	
SODIUM CITRATE 4% VIAL	T3	
TRISODIUM CITRATE CRRT	T3	
DIRECT FACTOR XA INHIBITORS		
BEVYXXA	T3	
ELIQUIS 2.5 MG, 5 MG TABLET	T2	
ELIQUIS DVT-PE TREAT START 5MG	T2	
rivaroxaban (Xarelto)	T1	
XARELTO *(rivaroxaban)*	T2	
XARELTO	T2	PA
HEPARIN AND RELATED PREPARATIONS		
ARIXTRA *(fondaparinux)*	T3	SP
enoxaparin (Lovenox)	T1	
fondaparinux (Arixtra)	T1	SP
FRAGMIN	T2	SP
heparin	T1	
ANTIDOTES (Gastrointestinal/Heartburn)		
MU-OPIOID RECEPTOR ANTAGONISTS, PERIPHERALLY-ACTING		
MOVANTIK	T2	QL (30 units/30 days)
RELISTOR 12 MG/0.6 ML SYRINGE	T2	ST
RELISTOR 12 MG/0.6 ML VIAL	T2	ST
RELISTOR 8 MG/0.4 ML SYRINGE	T2	ST
SYMPROIC	T2	
ANTIDOTES (Substance Abuse)		
OPIOID ANTAGONISTS		
naloxone	T1	

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

PA – Prior Authorization
QL – Quantity Limit
ST – Step Therapy

AGE – Age Requirement
SP – Specialty Medication
HD – May require home delivery pharmacy

PPACA – No Cost-Share Preventive Medication
CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ANTIDOTES (Substance Abuse) (cont.)		
OPIOID ANTAGONISTS (cont.)		
naloxone 0.4 mg/ml syringe	T1	
REXTOVY	T2	QL (2 units/30 days)
naltrexone	T1	
NARCAN *(naloxone hcl)*	T3	QL (2 units/30 days)
ANTI-FUNGALS (Eye Conditions)		
OPHTHALMIC ANTI-FUNGAL AGENTS		
NATACYN	T2	
ANTI-FUNGALS (Feminine Products)		
VAGINAL ANTI-FUNGALS		
GYNAZOLE-1	T3	
miconazole 3	T1	
terconazole	T1	
ANTI-FUNGALS (Infections)		
ANTI-FUNGAL AGENTS		
ANCOBON *(flucytosine)*	T3	PA
clotrimazole	T1	QL (60 ml/28 days)
CRESEMBA	T2	PA
DIFLUCAN *(fluconazole)*	T3	
DIFLUCAN 150MG TABLET *(fluconazole)*	T3	QL (2 tabs/episode)
fluconazole 10 mg/ml susp	T1	
fluconazole 100 mg, 200 mg tablet	T1	
fluconazole 150 mg tablet (Diflucan)	T1	QL
flucytosine (Ancobon)	T1	
itraconazole 100mg capsule (Sporanox)	T1	QL (30 units/30 days)
itraconazole 100 mg/10 ml cup	T1	QL (2 bottles/30 days)
itraconazole 10mg/ml solution	T1	QL (2 bottles/30 days)
ketoconazole	T1	
NOXAFIL	T2	PA
NOXAFIL 40MG/ML SUSP	T2	PA SP
ORAVIG	T3	
posaconazole (Noxafil)	T1	PA
SPORANOX *(itraconazole)*	T3	QL (30 caps/30 days)
terbinafine	T1	

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

PA – Prior Authorization
QL – Quantity Limit
ST – Step Therapy

AGE – Age Requirement
SP – Specialty Medication
HD – May require home delivery pharmacy

PPACA – No Cost-Share Preventive Medication
CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

ANTI-FUNGALS (Infections) (cont.)		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
ANTI-FUNGAL AGENTS (cont.)		
VFEND *(voriconazole)*	T3	PA
VIVJOA	T3	PA QL (18 caps/30 days) SP
voriconazole (Vfend)	T1	PA
ANTI-FUNGAL ANTIBIOTICS		
BREXAFEMME 150 MG TABLET	T3	ST QL (4 tabs/treatment)
griseofulvin	T1	
griseofulvin ultramicrosize	T1	
nystatin	T1	QL (60 grams/28 days)
TOPICAL ANTI-FUNGAL/ANTI-INFLAMMATORY, STEROID AGENT		
clotrimazole/betamethasone	T1	QL (45 gm/21 days)
clotrimazole/betamethasone	T1	QL (60 ml/21 days)
ANTI-FUNGALS (Skin Conditions)		
TOPICAL ANTI-FUNGALS		
ciclodan	T1	
ciclopirox 0.77% cream (Loprox)	T1	QL (90 gm/21 days)
ciclopirox 0.77% gel	T1	QL (100 grams/30 days)
ciclopirox 0.77% topical solution (Loprox)	T1	QL (60 ml/21 days)
ciclopirox 1% shampoo	T1	QL (120 mls/28 days)
ciclopirox 8% solution, treatmint kit	T1	
econazole nitrate	T1	QL (85 gm/21 days)
ERTACZO	T3	QL (60 gm/21 days)
EXELDERM	T3	QL (60 units/21 days)
EXTINA *(ketoconazole)*	T3	ST QL (100 gm/21 days)
JUBLIA	T3	ST
ketoconazole 2% cream	T1	QL (60 gm/21 days)
ketoconazole 2% foam (Extina)	T1	ST QL (100 gm/21 days)
ketodan (Extina)	T1	ST QL (100 gm/21 days)
ketodan (Ketodan)	T1	
LOPROX 0.77% CREAM *(ciclopirox)*	T3	QL (90 gm/21 days)
LOPROX 0.77% CREAM KIT	T3	QL (544 gm/23 days)
LOPROX 0.77% SUSPENSION KIT	T3	QL (1 kit/23 days)
LOPROX 0.77% TOPICAL SOLUTION *(ciclopirox)*	T3	QL (60 ml/21 days)
LOPROX 1% SHAMPOO *(ciclopirox)*	T3	QL (120 ml/21 days)
LOTRISONE CREAM	T3	QL (90 grams/28 days)

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

PA – Prior Authorization
QL – Quantity Limit
ST – Step Therapy

AGE – Age Requirement
SP – Specialty Medication
HD – May require home delivery pharmacy

PPACA – No Cost-Share Preventive Medication
CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

ANTI-FUNGALS (Skin Conditions) (cont.)		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
TOPICAL ANTI-FUNGALS (cont.)		
MICONAZOLE-ZINC OXIDE-PETROLTM	T3	QL (50 gm/21 days)
naftifine hcl 1% cream	T1	QL (90 gms/28 days)
naftifine hcl 2% cream	T1	QL (60 gms/28 days)
naftifine hcl 2% gel (Naftin)	T1	QL (60 gms/28 days)
NAFTIN 1% GEL *(naftifine hcl)*	T3	QL (90 gms/28 days)
NAFTIN 2% GEL *(naftifine hcl)*	T3	QL (60 gms/28 days)
NIZORAL *(ketoconazole)*	T3	QL (120 ml/21 days)
nyamyc	T1	QL
nystatin	T1	QL
nystatin w/triamcinolone	T1	QL
nystatin/triamcinolone	T1	QL
nystop	T1	QL
oxiconazole nitrate (Oxistat)	T1	QL (60 units/21 days)
OXISTAT	T3	QL (90 grams/28 days)
VUSION	T3	QL (100 grams/28 days)
ANTIHISTAMINE AND DECONGESTANT COMBINATION (Allergy/Nasal Sprays)		
1ST GEN ANTIHISTAMINE AND DECONGESTANT COMBINATION		
promethazine vc	T1	
2ND GEN ANTIHISTAMINE AND DECONGESTANT COMBINATION		
CLARINEX-D 12 HOUR	T3	QL
SEMPREX-D	T3	
ANTIHISTAMINES (Allergy/Nasal Sprays)		
ANTIHISTAMINES - 1ST GENERATION		
carbinoxamine	T1	
carbinoxamine maleate	T1	ST
carbinoxamine (Ryvent)	T1	
cyproheptadine hcl	T1	
dexchlorpheniramine maleate (Ryclora)	T1	
hydroxyzine hcl	T1	
hydroxyzine pamoate (Vistaril)	T1	
promethazine hcl	T1	
RYCLORA *(dexchlorpheniramine maleate)*	T3	
RYVENT	T3	ST
VISTARIL *(hydroxyzine pamoate)*	T3	

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

PA – Prior Authorization
QL – Quantity Limit
ST – Step Therapy

AGE – Age Requirement
SP – Specialty Medication
HD – May require home delivery pharmacy

PPACA – No Cost-Share Preventive Medication
CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

ANTIHISTAMINES (Allergy/Nasal Sprays) (cont.)		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
ANTIHISTAMINES - 2ND GENERATION		
CLARINEX D 24 HOUR TABLET	T3	
desloratadine (Clarinex)	T1	QL (30 units/30 days) HD
ANTIHISTAMINES (Eye Conditions)		
EYE ANTIHISTAMINES		
azelastine hcl	T1	
epinastine hcl	T1	
LASTACAFT 0.25% EYE DROPS	T3	ST
ANTI-HYPERGLYCEMICS (Diabetes)		
ANTIHYPERGLY,DPP-4 ENZYME INHIB.-THIAZOLIDINEDIONE		
OSENI	T3	QL (30 units/30 days) HD
ANTIHYPERGLY, INCRETIN MIMETIC (GLP-I RECEP.AGONIST)		
ADLYXIN 10-20 MCG STARTER PACK	T3	PA HD QL (1 kit/28 days)
ADLYXIN 20 MCG MAINTENANCE PK	T3	PA HD QL (1 kit/28 days)
BYDUREON BCISE	T2	PA QL (4 auto-injs/28 days)
BYDUREON PEN	T2	PA QL HD
BYETTA	T2	PA QL (1 pen/30 days)
exenatide	T1	PA QL (1 pen/30 days)
liraglutide 2-pak 18 mg/3 ml (Victoza 2-Pak)	T1	PA
liraglutide 2-pak 18 mg/3 ml (Victoza 3-Pak)	T1	PA
liraglutide 3-pak 18 mg/3 ml (Victoza 2-Pak)	T1	PA
liraglutide 3-pak 18 mg/3 ml (Victoza 3-Pak)	T1	PA
MOUNJARO	T2	PA QL
OZEMPIC	T2	PA QL (1 pen/28 days)
RYBELSUS	T2	PA QL (30 tabs/30 days)
TRULICITY	T2	PA QL (4 pens/28 days)
ANTI-HYPERGLY, INSULIN, LONG ACT-GLP-I RECEPT.AGONIST		
SOLIQUA 100-33	T2	QL (15 mls/30 days)
ANTI-HYPERGLYCEMIC-SOD/GLUC COTRANSPORT2(SGLT2) INHIB		
FARXIGA	T2	ST QL (30 tabs/30 days)
JARDIANCE	T2	ST QL (30 units/30 days) HD
ANTI-HYPERGLYCEMIC-DOPAMINE RECEPTOR AGONISTS		
CYCLOSET	T3	HD

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

PA – Prior Authorization
QL – Quantity Limit
ST – Step Therapy

AGE – Age Requirement
SP – Specialty Medication
HD – May require home delivery pharmacy

PPACA – No Cost-Share Preventive Medication
CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

ANTI-HYPERGLYCEMICS (Diabetes) (cont.)		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
ANTI-HYPERGLYCEMIC, ALPHA-GLUCOSIDASE INHIBITORS		
acarbose (Precose)	T1	HD
GLYSET *(miglitol)*	T3	HD
miglitol (Glyset)	T1	HD
PRECOSE *(acarbose)*	T3	HD
ANTI-HYPERGLYCEMIC, AMYLIN ANALOG-TYPE		
SYMLINPEN 60	T2	PA QL (7 pens/30 days)
SYMLINPEN 120	T2	PA QL HD
ANTI-HYPERGLYCEMIC, BIGUANIDE TYPE		
FORTAMET *(metformin er osmotic)*	T3	PA QL HD
metformin hcl	T1	HD
metformin hcl er	T1	QL HD
metformin er 1,000 mg osm-tab	T1	PA QL (60 tabs/30 days) HD
metformin er 500 mg osmotic tb	T1	PA QL (30 tabs/30 days) HD
metformin hcl 750 mg tablet	T1	ST HD
metformin hcl er (Glumetza)	T1	PA QL
RIOMET *(metformin hcl)*	T3	ST HD
ANTI-HYPERGLYCEMIC, DPP-4 INHIBITORS		
JANUVIA	T2	QL (30 units/30 days) HD
*saxagliptin hcl (*Onglyza*)*	T1	ST QL (30 tabs/30 days) HD
ANTI-HYPERGLYCEMIC, INSULIN-RELEASE STIMULANT TYPE		
glimepiride 1 mg tablet	T1	HD
glimepiride 2 mg tablet	T1	HD
glimepiride 4 mg tablet	T1	HD
glipizide (Glucotrol)	T1	HD
glipizide er (Glucotrol XI)	T1	HD
glipizide xl (Glucotrol XI)	T1	HD
GLUCOTROL *(glipizide)*	T3	HD
GLUCOTROL XL *(glipizide er)*	T3	HD
glyburide	T1	HD
glyburide,micronized	T1	HD
glyburide micronized (Glynase)	T1	HD
GLYNASE *(glyburide micronized)*	T3	HD
nateglinide (Starlix)	T1	HD
repaglinide	T1	HD

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

PA – Prior Authorization
QL – Quantity Limit
ST – Step Therapy

AGE – Age Requirement
SP – Specialty Medication
HD – May require home delivery pharmacy

PPACA – No Cost-Share Preventive Medication
CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

ANTI-HYPERGLYCEMICS (Diabetes) (cont.)		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
ANTI-HYPERGLYCEMIC, INSULIN-RELEASE STIMULANT TYPE (cont.)		
STARLIX *(nateglinide)*	T3	HD
ANTI-HYPERGLYCEMIC, SGLT-2 AND DPP-4 INHIBITOR COMB		
GLYXAMBI	T2	ST QL (30 units/30 days) HD
ANTI-HYPERGLYCEMIC, THIAZOLIDINEDIONE AND BIGUANIDE		
ACTOPLUS MET XR 30 1000MG TABLET	T3	ST
pioglitazone-metformin (Actoplus Met)	T1	QL HD
ANTI-HYPERGLYCEMIC, THIAZOLIDINEDIONE-SULFONYLUREA		
DUETACT *(pioglitazone-glimepiride)*	T3	QL (30 tabs/30 days) HD
pioglitazone-glimepiride (Duetact)	T1	QL (30 units/30 days) HD
ANTI-HYPERGLYCEMIC, DPP-4 INHIBITOR-BIGUANIDE COMBS.		
JANUMET	T2	QL HD
JANUMET XR	T2	QL HD
*saxagliptn-metform er 2.5-1000 (*Kombiglyze Xr*)*	T1	ST QL (60 tabs/30 days) HD
*saxagliptin-metformin er 5-500 (*Kombiglyze Xr)	T1	ST QL (30 tabs/30 days) HD
saxagliptin-metformn er 5-1000 (Kombiglyze Xr)	T1	ST QL (30 tabs/30 days) HD
ANTI-HYPERGLYCEMIC, INSULIN-RELEASE STIM.-BIGUANIDE		
glipizide-metformin	T1	HD
glyburide-metformin hcl	T1	HD
ANTI-HYPERGLYCEMIC, THIAZOLIDINEDIONE (PPARG AGONIST)		
ACTOS *(pioglitazone hcl)*	T3	QL (30 tabs/30 days) HD
AVANDIA	T3	ST QL HD
ANTIHYPERGLYCEMIC-GLUCOCORTICOID RECEPTOR BLOCKER		
*mifepristone 300 mg tablet (*Korlym)	T1	PA SP
ANTI-HYPERGLYCEMIC-SGLT2 INHIBITOR-BIGUANIDE COMBS.		
INVOKAMET	T2	ST QL HD
SYNJARDY	T2	ST QL (30 tabs/30 days) HD
SYNJARDY XR	T2	ST QL HD
XIGDUO XR	T2	ST QL HD
INSULINS		
HUMALOG 100 unit/ML CARTRIDGE	T2	HD
HUMALOG JUNIOR KWIKPEN	T2	HD
HUMALOG MIX 75-25	T2	HD
HUMULIN 70/30 KWIKPEN	T2	HD
HUMULIN 70-30	T2	HD

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

PA – Prior Authorization
QL – Quantity Limit
ST – Step Therapy

AGE – Age Requirement
SP – Specialty Medication
HD – May require home delivery pharmacy

PPACA – No Cost-Share Preventive Medication
CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

ANTI-HYPERGLYCEMICS (Diabetes) (cont.)		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
INSULINS (cont.)		
HUMULIN N	T2	HD
HUMULIN N KWIKPEN	T2	HD
HUMULIN R	T2	HD
HUMULIN R U-500 KWIKPEN	T2	HD
INSULIN GLARGINE-YFGN	T2	HD
INSULIN LISPRO 100 UNIT/ML VIAL	T2	HD
INSULIN LISPRO JUNIOR KWIKPEN	T2	HD
INSULIN LISPRO KWIKPEN U-100	T2	HD
INSULIN LISPRO PROTAMINE MIX	T2	HD
LANTUS	T2	HD
LANTUS SOLOSTAR	T2	HD
MYXREDLIN	T3	
SEMGLEE	T2	HD
TOUJEO MAX SOLOSTAR	T2	HD
TOUJEO SOLOSTAR	T2	HD
TRESIBA	T2	HD
TRESIBA FLEXTOUCH U-100, U-200	T2	HD
ANTI-INFECTIVES/MISCELLANEOUS (Feminine Products)		
VAGINAL ANTISEPTICS		
fem ph	T1	
ANTI-INFECTIVES/MISCELLANEOUS (Infections)		
2ND GEN. ANAEROBIC ANTI-PROTOZOAL-ANTIBACTERIAL		
tinidazole	T1	QL (20 tabs/23 days)
tinidazole	T1	QL (40 tabs/23 days)
ANTHELMINTICS		
albendazole (Albenza)	T1	QL (120 tabs/23 days)
ALBENZA *(albendazole)*	T3	QL (120 tabs/23 days)
BILTRICIDE *(praziquantel)*	T3	
EMVERM	T2	QL (6 tabs/23 days)
ivermectin 6 mg tablet	T1	PA QL (8 tabs/30 days)
ivermectin (Stromectol)	T1	PA QL (20 tabs/23 days)
praziquantel (Biltricide)	T1	
STROMECTOL *(ivermectin)*	T3	QL (20 tabs/23 days)

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

PA – Prior Authorization
QL – Quantity Limit
ST – Step Therapy

AGE – Age Requirement
SP – Specialty Medication
HD – May require home delivery pharmacy

PPACA – No Cost-Share Preventive Medication
CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

ANTI-INFECTIVES/MISCELLANEOUS (Infections) (cont.)		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
ANTI-MALARIAL DRUGS		
ARAKODA	T3	QL (20 tabs/365 days)
ARAKODA 100mg tablets	T3	QL (32 tabs/180 days)
atovaquone-proguanil 250-100mg tablet (Malarone)	T1	QL (60 tabs/180 days)
atovaquone-proguanil 62.5-25mg tablet (Malarone)	T1	QL (180 tabs/180 days)
chloroquine 250mg tablet	T1	QL (56 tabs/274 days)
chloroquine 500mg tablet	T1	QL (28 tabs/274 days)
COARTEM	T2	QL (24 tabs/23 days)
DARAPRIM *(pyrimethamine)*	T3	PA SP
hydroxychloroquine (Plaquenil)	T1	QL
KRINTAFEL	T3	QL (2 tabs/23 days)
MALARONE 250-100MG TABLET *(atovaquone-proguanil hcl)*	T3	QL (60 tabs/180 days)
MALARONE 62.5-25MG TABLET *(atovaquone-proguanil hcl)*	T3	QL (180 tabs/180 days)
mefloquine hcl	T1	QL (13 tabs/180 days)
PRIMAQUINE BRAND	T2	QL (120 tabs/180 days)
primaquine generic	T1	QL (120 tabs/180 days)
quinine sulfate	T1	QL (42 caps/30 days)
ANTI-PROTOZOAL DRUGS, MISCELLANEOUS		
atovaquone (Mepron)	T1	
BENZNIDAZOLE	T2	QL (720 tabs/365 days)
IMPAVIDO	T2	QL (84 caps/23 days)
MEPRON *(atovaquone)*	T3	
NEBUPENT	T3	QL (1 vial/21 days)
pentamidine isethionate (Nebupent)	T1	QL (1 vial/21 days)
ANTI-INFECTIVES/MISCELLANEOUS (Miscellaneous)		
ANTIBACTERIAL AGENTS, MISCELLANEOUS		
aminoacetic acid (Aminoacetic Acid)	T1	
glycine (Aminoacetic Acid)	T1	
ANTISEPTICS,GENERAL		
ALCOHOL SWABSTICK	T3	
GS ISOPROPYL ALCOHOL 70% SPRAY	T3	
ISOPROPYL ALCOHOL	T3	

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

PA – Prior Authorization
QL – Quantity Limit
ST – Step Therapy

AGE – Age Requirement
SP – Specialty Medication
HD – May require home delivery pharmacy

PPACA – No Cost-Share Preventive Medication
CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ANTI-INFECTIVES/MISCELLANEOUS (Skin Conditions)		
TOPICAL ANTI-FUNGALS		
CICLODAN	T3	ST
ciclopirox	T1	
ANTI-INFLAM.TUMOR NECROSIS FACTOR INHIBITING AGENTS (Pain Relief And Inflammatory Disease)		
ANTI-INFLAMMATORY TUMOR NECROSIS FACTOR INHIBITOR		
ADALIMUMAB-ADAZ (CF)	T2	PA QL (2 syringes/28 days) SP
ADALIMUMAB-ADAZ(CF) PEN	T2	PA QL (2 pens/28 days) SP
ADALIMUMAB-ADBM(CF)PEN	T2	PA QL (2 kits/28 days) SP HD
ADALIMUMAB-RYVK(CF)	T2	PA QL (4 pens/365 days) SP
ADALIMUMAB-RYVK(CF) AI 40 MG	T2	PA QL (2 auto-injs/28 days) SP HD
CYLTEZO(CF)	T3	PA QL (2 srnge kits/28 days) SP HD
CYLTEZO(CF) PEN	T3	PA QL (2 kits/28 days) SP HD
CYLTEZO(CF) PEN CROHN'S-UC-HS	T3	PA QL (6 pens/365 days) SP HD
CYLTEZO(CF) PEN PSORIASIS-UV	T3	PA QL (4 pens/365 days) SP HD
ENBREL	T2	PA QL SP HD
SIMLANDI(CF) AUTOINJECTOR	T2	PA QL (2 auto-injs/28 days) SP HD
SIMLANDI(CF)	T2	PA QL (2 syringe kits/28 days) SP HD
SIMPONI	T2	PA QL SP HD
SIMPONI ARIA	T3	PA SP HD
ANTI-NEOPLASTICS (Cancer)		
ANP - SELECTIVE RETINOID X RECEPTOR AGONISTS (RXR)		
bexarotene (Targretin)	T1	PA SP HD CSL
ANTI-NEOPLAST, HISTONE DEACETYLASE (HDAC) INHIBITORS		
FARYDAK 10mg, 20mg CAPSULE	T3	PA QL SP HD CSL
FARYDAK 5mg CAPSULE	T3	PA QL
ZOLINZA	T2	PA SP HD CSL
ANTI-NEOPLASTIC - ALKYLATING AGENTS		
ALKERAN *(melphalan)*	T3	SP CSL
cyclophosphamide	T3	SP HD CSL
GLEOSTINE	T2	CSL
HYDREA *(hydroxyurea)*	T3	CSL
hydroxyurea (Hydrea)	T1	CSL
LEUKERAN	T2	CSL
MYLERAN	T2	CSL

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

PA – Prior Authorization
QL – Quantity Limit
ST – Step Therapy

AGE – Age Requirement
SP – Specialty Medication
HD – May require home delivery pharmacy

PPACA – No Cost-Share Preventive Medication
CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

ANTI-NEOPLASTICS (Cancer) (cont.)		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
ANTI-NEOPLASTIC - ANTI-ANDROGENIC AGENTS		
abiraterone acetate (Zytiga)	T1	PA QL (120 tabs/30 days) CSL
bicalutamide (Casodex)	T1	CSL
CASODEX *(bicalutamide)*	T3	CSL
ERLEADA 240 MG TABLET	T2	PA SP HD QL (30 tabs/30 days) CSL
flutamide	T1	CSL
NILANDRON *(nilutamide)*	T3	PA CSL
nilutamide (Nilandron)	T1	PA CSL
NUBEQA	T2	PA QL SP HD CSL
XTANDI	T2	PA QL SP HD CSL
YONSA	T2	PA QL (120 tabs/30 days) SP HD CSL
ANTI-NEOPLASTIC - ANTI-METABOLITES		
ARRANON	T3	
capecitabine (Xeloda)	T1	SP HD CSL
LONSURF	T2	PA SP HD CSL
mercaptopurine 20 mg/ml suspen (Purixan)	T1	ST SP CSL
mercaptopurine 50 mg tablet	T1	CSL
methotrexate	T1	
methotrexate	T1	CSL
PURIXAN *(mercaptopurine)*	T2	ST SP CSL
TABLOID	T3	CSL
TREXALL	T3	CSL
XELODA (capecitabine)	T3	PA QL ST SP HD CSL
XELODA 150MG tablets	T3	PA SP HD QL (56 tabs/30 days) CSL
XELODA 500MG tablets	T3	PA SP HD QL (140 tabs/30 days) CSL
ANTI-NEOPLASTIC - AROMATASE INHIBITORS		
anastrozole (Arimidex)	T1	HD PPACA CSL
AROMASIN *(exemestane)*	T3	HD CSL
exemestane (Aromasin)	T1	HD PPACA CSL
FEMARA *(letrozole)*	T3	HD CSL
letrozole (Femara)	T1	HD CSL
ANTI-NEOPLASTIC - BRAF KINASE INHIBITORS		
BRAFTOVI	T2	PA QL (180 caps/30 days) SP HD CSL
OJEMDA	T2	PA SP CSL
TAFINLAR 10 MG TABLET FOR SUSP	T2	SP PA HD QL (840 ml/30 days) CSL

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

PA – Prior Authorization
QL – Quantity Limit
ST – Step Therapy

AGE – Age Requirement
SP – Specialty Medication
HD – May require home delivery pharmacy

PPACA – No Cost-Share Preventive Medication
CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

ANTI-NEOPLASTICS (Cancer) (cont.)		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
ANTI-NEOPLASTIC - BRAF KINASE INHIBITORS (cont.)		
ZELBORAF	T2	PA QL SP HD CSL
ANTI-NEOPLASTIC - CAR-T CELL IMMUNOTHERAPY		
BREYANZI	T3	PA
ANTI-NEOPLASTIC - HEDGEHOG PATHWAY INHIBITOR		
DAURISMO	T3	PA QL SP HD CSL
ERIVEDGE	T2	PA QL (30 units/30 days) SP HD CSL
ODOMZO	T2	PA QL (30 units/30 days) SP HD CSL
ANTI-NEOPLASTIC - JANUS KINASE (JAK) INHIBITORS		
JAKAFI	T2	PA QL SP HD CSL
ANTI-NEOPLASTIC - KRAS PROTEIN INHIBITOR		
LUMAKRAS	T3	PA SP QL (8 tabs per day) HD
ANTINEOPLASTIC - MEK KINASE INHIBITORS		
COTELLIC	T2	PA QL (63 tabs/30 days) SP HD CSL
GOMEKLI	T2	PA SP CSL
KOSELUGO 10 MG, 25 MG CAPSULE	T3	PA SP CSL
MEKINIST 0.05 MG/ML SOLUTION	T2	PA QL (1080 mls/30 days) SP HD CSL
MEKINIST 0.5 MG TABLET	T2	PA QL (90 tabs/30 days) SP HD CSL
MEKINIST 2 MG TABLET	T2	PA QL (30 tabs/30 days) SP HD CSL
MEKTOVI	T2	PA QL (180 tabs/30 days) SP HD CSL
ANTI-NEOPLASTIC - MTOR KINASE INHIBITORS		
AFINITOR 10MG TABLET	T2	PA QL (30 tabs/30 days) ST SP HD CSL
AFINITOR DISPERZ 2 MG, 3 MG, 5MG TABLET	T3	PA QL ST SP
AFINITOR 2.5MG, 5MG, 7.5MG TABLET *(everolimus)*	T3	PA QL (30 tabs/30 days) ST SP HD CSL
AFINITOR DISPERZ	T2	PA QL (30 tabs/30 days) ST SP CSL
everolimus (Afinitor)	T1	PA QL (30 tabs/30 days) SP CSL
ANTI-NEOPLASTIC - PROTEIN METHYLTRANSFERASE INHIBIT		
TAZVERIK	T3	PA SP CSL
ANTINEOPLASTIC - SYSTEMIC ENZYME INHIBITORS COMBS		
AVMAPKI-FAKZYNJA	T2	PA SP CSL
ANTI-NEOPLASTIC - TOPOISOMERASE I INHIBITORS		
HYCAMTIN	T2	PA SP HD CSL
ANTINEOPLASTIC COMB - KINASE AND AROMATASE INHIBIT		
KISQALI FEMARA 200 MG CO-PACK	T2	PA QL (49 tabs/30 days) SP CSL
KISQALI FEMARA 400 MG CO-PACK	T2	PA QL (70 tabs/30 days) SP CSL
KISQALI FEMARA 600 MG CO-PACK	T2	PA QL (91 tabs/30 days) SP CSL

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

PA – Prior Authorization
QL – Quantity Limit
ST – Step Therapy

AGE – Age Requirement
SP – Specialty Medication
HD – May require home delivery pharmacy

PPACA – No Cost-Share Preventive Medication
CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

ANTI-NEOPLASTICS (Cancer) (cont.)		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
ANTI-NEOPLASTIC IMMUNOMODULATOR AGENTS		
POMALYST	T2	PA SP HD CSL
REVLIMID	T2	PA QL (30 caps/30 days)SP HD CSL
SYLATRON	T2	PA
ANTI-NEOPLASTIC LHRH (GNRH) AGONIST, PITUITARY SUPPR.		
leuprolide acetate	T1	PA SP HD
LUPRON DEPOT	T3	PA SP HD
ZOLADEX	T2	SP HD
ANTI-NEOPLASTIC LHRH (GNRH) ANTAGONIST, PITUIT.SUPPRS		
FIRMAGON	T2	PA SP HD
ANTI-NEOPLASTIC SYSTEMIC ENZYME INHIBITORS		
ALECENSA	T2	PA QL SP HD CSL
ALUNBRIG	T2	PA QL SP HD CSL
AUGTYRO	T2	PA SP CSL
AYVAKIT	T3	PA QL (30 tabs/30 days) SP CSL
BALVERSA	T2	PA SP CSL
BOSULIF	T2	PA QL SP HD CSL
BOSULIF 50 MG CAPSULE	T2	PA QL (30 caps/fill) SP HD CSL
BOSULIF 100 MG CAPSULE	T2	PA QL (90 tabs/fill) SP HD CSL
BRUKINSA	T2	PA SP CSL
CALQUENCE	T2	SP
CAPRELSA	T2	PA QL SP CSL
COMETRIQ	T2	PA SP HD CSL
COPIKTRA	T3	PA QL (56 caps/28 days) SP CSL
DANZITEN	T2	PA SP CSL
dasatinib 20 mg tablet (Sprycel)	T1	PA QL (90 tabs/30 days) SP CSL
dasatinib 20 mg tablet (Sprycel)	T1	PA QL (90 tabs/30 days) SP HD CSL
dasatinib 50 mg tablet (Sprycel)	T1	PA QL (30 tabs/30 days) SP CSL
dasatinib 50 mg tablet (Sprycel)	T1	PA QL (30 tabs/30 days) SP HD CSL
dasatinib 70 mg tablet (Sprycel)	T1	PA QL (60 tabs/30 days) SP CSL
dasatinib 70 mg tablet (Sprycel)	T1	PA QL (60 tabs/30 days) SP HD CSL
dasatinib 80 mg tablet (Sprycel)	T1	PA QL (30 tabs/30 days) SP CSL
dasatinib 80 mg tablet (Sprycel)	T1	PA QL (30 tabs/30 days) SP HD CSL
dasatinib 100 mg tablet (Sprycel)	T1	PA QL (30 tabs/30 days) SP CSL
dasatinib 100 mg tablet (Sprycel)	T1	PA QL (30 tabs/30 days) SP HD CSL

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

PA – Prior Authorization
QL – Quantity Limit
ST – Step Therapy

AGE – Age Requirement
SP – Specialty Medication
HD – May require home delivery pharmacy

PPACA – No Cost-Share Preventive Medication
CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

ANTI-NEOPLASTICS (Cancer) (cont.)		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
ANTI-NEOPLASTIC SYSTEMIC ENZYME INHIBITORS (cont.)		
dasatinib 140 mg tablet (Sprycel)	T1	PA QL (30 tabs/30 days) SP CSL
dasatinib 140 mg tablet (Sprycel)	T1	PA QL (30 tabs/30 days) SP HD CSL
ENSACOVE	T2	PA SP CSL
erlotinib 25 mg tablet	T1	PA QL (60 tabs/30 days) SP HD CSL
erlotinib hcl 100 mg, 150 mg tablet	T1	PA QL (30 tabs/30 days) SP HD CSL
FRUZAQLA	T2	PA SP CSL
GAVRETO	T2	PA QL (120 caps/30 days) SP CSL
GILOTRIF	T2	PA QL (30 units/30 days) SP HD CSL
IBRANCE	T2	PA QL (21 tabs/caps/30 days) SP HD CSL
IBTROZI	T2	PA SP CSL
ICLUSIG	T2	PA QL SP CSL
IMKELDI	T2	PA SP CSL
INLYTA	T2	PA QL SP HD CSL
IRESSA (*gefitinib*)	T3	PA QL (30 tabs/30 days) SP HD CSL
IWILFIN	T2	PA SP CSL
KISQALI	T3	PA SP HD QL (1 pack/1 time) CSL
KISQALI FEMARA CO-PACK	T3	PA SP HD QL (1 pack/28 days) CSL
LAZCLUZE	T3	PA SP CSL
LENVIMA 4MG (five 4 mg capsules per card)	T2	PA QL (30 caps/30 days) SP HD CSL
LENVIMA 8MG (ten 4 mg capsules per card)	T2	PA QL (60 caps/30 days) SP HD CSL
LENVIMA 10MG (five 10 mg capsules per card)	T2	PA QL (30 caps/30 days) SP HD CSL
LENVIMA 12MG (fifteen 4 mg capsules per card)	T2	PA QL (90 caps/30 days) SP HD CSL
LENVIMA 14MG (five 10 mg capsules and five 4 mg capsules per card)	T2	PA QL (60 caps/30 days) SP HD CSL
LENVIMA 18MG (five 10 mg capsules and five 4 mg capsules per card)	T2	PA QL (90 caps/30 days) SP HD CSL
LENVIMA 20MG	T2	PA QL (60 caps/30 days) SP HD CSL
LENVIMA 24MG	T2	PA QL (90 caps/30 days) SP HD
LORBRENA	T2	PA QL SP HD CSL
LYNPARZA	T2	PA QL SP HD CSL
LYTGOBI	T2	PA SP CSL
NERLYNX	T2	PA SP HD CSL
NEXAVAR	T3	PA QL (120 tabs/30 days) SP HD CSL
nilotinib 150 mg capsule (Tasigna)	T1	PA QL (112 caps/30 days) SP HD CSL
nilotinib 200 mg capsule (Tasigna)	T1	PA QL (112 caps/30 days) SP HD CSL
nilotinib 50 mg capsule (Tasigna)	T1	PA QL (120 caps/30 days) SP HD CSL

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

PA – Prior Authorization
QL – Quantity Limit
ST – Step Therapy

AGE – Age Requirement
SP – Specialty Medication
HD – May require home delivery pharmacy

PPACA – No Cost-Share Preventive Medication
CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

ANTI-NEOPLASTICS (Cancer) (cont.)		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
ANTI-NEOPLASTIC SYSTEMIC ENZYME INHIBITORS (cont.)		
NINLARO	T2	PA QL SP HD CSL
OGSIVEO	T3	PA SP CSL
pazopanib (Votrient)	T1	PA QL (120 tabs/30 days)SP HD CSL
PEMAZYRE 4.5MG, 9MG, 13.5MG TAB	T2	PA QL (28 tabs/30 days) SP
PIQRAY	T2	PA SP CSL
RETEVMO 40 MG TABLET	T3	PA QL (90 tabs/fill) SP HD CSL
RETEVMO 80 MG, 120 MG TABLET	T3	PA QL (60 tabs/fill) SP HD CSL
RETEVMO 160 MG TABLET	T3	PA QL (60 tabs/fill) SP HD CSL
REVUFORJ	T2	PA SP CSL
ROMVIMZA	T3	PA QL (8 caps/fill) SP CSL
ROZLYTREK	T2	PA QL SP HD CSL
ROZLYTREK 50 MG PELLET PACKET	T2	PA QL (42 packs/fill) SP HD CSL
RYDAPT	T2	PA QL (224 caps/30 days) SP HD CSL
SCEMBLIX 20MG TABLET	T2	PA QL (600 tabs/30 days) SP CSL
SCEMBLIX 40MG TABLET	T2	PA QL (300 tabs/30 days) SP CSL
SCEMBLIX 100 MG TABLET	T2	PA QL (120 tabs/fill) SP CSL
STIVARGA	T2	PA QL SP HD CSL
SUTENT	T3	PA QL SP CSL
TABRECTA	T2	PA SP
TAGRISSO	T2	PA QL (30 units/30 days) SP HD CSL
TALZENNA	T2	PA QL (30 caps/30 days) SP HD CSL
TALZENNA 0.1 MG CAPSULE, SOFTGEL	T2	PA QL (30 caps/fill) SP CSL
TALZENNA 0.25 MG CAPSULE, SOFTGEL	T2	PA QL (30 caps/30 days) SP CSL
TALZENNA 0.35 MG CAPSULE, SOFTGEL	T2	PA QL (30 caps/fill) SP CSL
TALZENNA 0.5 MG CAPSULE, SOFTGEL	T2	PA QL (30 caps/30 days) SP CSL
TALZENNA 0.75 MG CAPSULE, SOFTGEL	T2	PA QL (30 caps/30 days) SP CSL
TALZENNA 1 MG CAPSULE, SOFTGEL	T2	PA QL (30 caps/30 days) SP CSL
TARCEVA *(erlotinib hcl)*	T3	PA QL (30 tabs/30 days) SP HD CSL
TASIGNA 150 MG CAPSULE *(nilotinib hcl)*	T3	PA QL (112 caps/30 days) SP HD CSL
TASIGNA 200 MG CAPSULE *(nilotinib hcl)*	T3	PA QL (112 caps/30 days) SP HD CSL
TASIGNA 50 MG CAPSULE *(nilotinib hcl)*	T3	PA QL (120 caps/30 days) SP HD CSL
TRUQAP	T2	PA SP CSL
TURALIO	T3	PA QL SP CSL
UKONIQ	T3	SP

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

PA – Prior Authorization
QL – Quantity Limit
ST – Step Therapy

AGE – Age Requirement
SP – Specialty Medication
HD – May require home delivery pharmacy

PPACA – No Cost-Share Preventive Medication
CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

ANTI-NEOPLASTICS (Cancer) (cont.)		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
ANTI-NEOPLASTIC SYSTEMIC ENZYME INHIBITORS (cont.)		
VERZENIO	T2	PA QL SP HD CSL
VIKTRAKVI 100 MG CAPSULE	T2	PA QL (60 caps/30 days) SP HD CSL
VIKTRAKVI 20 MG/ML SOLUTION	T2	PA QL (300ml/30 days) SP HD CSL
VIKTRAKVI 25 MG CAPSULE	T2	PA QL (180 caps/30 days) SP HD CSL
VIZIMPRO	T2	PA QL (30 units/30 days) SP HD CSL
VOTRIENT *(pazopanib hcl)*	T3	PA QL (120 tabs/30 days)SP HD CSL
XOSPATA	T2	PA SP CSL
XALKORI 20MG PELLET	T2	PA QL (120 caps/fill) SP HD CSL
XALKORI 50MG PELLET	T2	PA QL (120 caps/fill) SP HD CSL
XALKORI 150MG PELLET	T2	PA QL (120 caps/fill) SP HD CSL
XALKORI 200MG CAPSULE	T2	PA QL (60 caps/30 days) SP HD CSL
XALKORI 250MG CAPSULE	T2	PA QL (60 caps/30 days) SP HD CSL
ZYDELIG	T2	PA QL SP HD CSL
ZYKADIA	T2	PA QL (90 tabs-caps/30 days) SP HD CSL
ANTI-NEOPLASTIC, ANTI-PROGRAMMED DEATH-I (PD-I) MAB		
JEMPERLI 500 MG/10 ML VIAL	T3	PA SP HD
OPDIVO	T2	PA SP HD
ANTI-NEOPLASTIC-B CELL LYMPHOMA-2(BCL-2) INHIBITORS		
VENCLEXTA	T2	PA SP CSL
VENCLEXTA STARTING PACK	T2	PA QL SP CSL
ANTI-NEOPLASTIC-ISOCITRATE DEHYDROGENASE INHIBITOR		
IDHIFA	T2	PA QL (30 units/30 days) SP HD CSL
TIBSOVO	T2	PA SP CSL
VORANIGO	T3	PA SP CSL
ANTI-NEOPLASTICS ANTIBODY/ANTIBODY-DRUG COMPLEXES		
ENHERTU	T3	PA SP HD
ANTI-NEOPLASTICS, MISCELLANEOUS		
etoposide	T1	SP HD CSL
LYSODREN	T2	CSL
MATULANE	T2	SP CSL
RYLAZE 10 MG/0.5 ML VIAL	T3	PA SP
tretinoin	T1	CSL
CYTOTOXIC T-LYMPHOCYTE ANTIGEN (CTLA-4) RMC ANTIBODY		
YERVOY	T2	PA SP HD

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

PA – Prior Authorization
QL – Quantity Limit
ST – Step Therapy

AGE – Age Requirement
SP – Specialty Medication
HD – May require home delivery pharmacy

PPACA – No Cost-Share Preventive Medication
CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

ANTI-NEOPLASTICS (Cancer) (cont.)		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
IMMUNOMODULATORS		
ACTIMMUNE	T2	SP HD
INTRON A	T2	SP HD
SELECTIVE ESTROGEN RECEPTOR MODULATORS (SERMS)		
FARESTON *(toremifene)*	T3	HD CSL
SOLTAMOX	T3	HD CSL
tamoxifen	T1	HD PPACA CSL
toremifene (Fareston)	T1	HD CSL
STEROID ANTI-NEOPLASTICS		
megestrol acetate	T1	CSL
ANTI-NEOPLASTICS (Skin Conditions)		
PHOTOACT, TOPICAL ANTI-NEOPLAST, PREMALIGNANT LESIONS		
LEVULAN	T3	SP
TOPICAL ANTI-NEOPLASTIC PREMALIGNANT LESION AGENTS		
PANRETIN	T3	PA SP HD
PICATO	T2	
TARGRETIN	T2	PA SP HD
VALCHLOR	T2	PA SP HD
ANTI-OBESITY DRUGS (Weight Management)		
ANTI-OBESITY - ANOREXIC AGENTS		
ADIPEX-P (*phentermine hcl*)	T3	PA QL (30 tabs/30 days)
benzphetamine hcl	T1	PA QL (90 tabs/30 days)
diethylpropion 25 mg tablets	T1	PA QL (90 tabs/30 days)
diethylpropion 75 mg tablets	T1	PA QL (30 tabs/30 days)
LOMAIRA	T1	PA QL (90 tabs/30 days)
phendimetrazine tartrate	T1	PA QL (180 tabs/30 days)
phentermine 37.5 mg capsule	T1	PA QL (30 caps/30 days)
phentermine 8 mg tablet	T1	PA QL (90 tabs/30 days)
phentermine/topiramate (Qsymia)	T1	PA QL (30 caps/30 days)
QSYMIA *(phentermine/topiramate)*	T3	PA QL (30 caps/30 days)
REGIMEX (*benzphetamine hcl*)	T3	PA QL (90 tabs/30 days)
ANTI-OBESITY GLUCAGON-LIKE PEPTIDE-I RECEP AGONIST		
liraglutide 18 mg/3 ml pen (Saxenda)	T1	PA QL (5 pens/30 days)
liraglutide 5-pak 18 mg/3 ml (Saxenda)	T1	PA QL (5 pens/30 days)

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

PA – Prior Authorization
QL – Quantity Limit
ST – Step Therapy

AGE – Age Requirement
SP – Specialty Medication
HD – May require home delivery pharmacy

PPACA – No Cost-Share Preventive Medication
CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

ANTI-OBESITY DRUGS (Weight Management) (cont.)		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
ANTI-OBESITY GLUCAGON-LIKE PEPTIDE-1 RECEP AGONIST (cont.)		
SAXENDA *(liraglutide)*	T3	PA QL (5 pens/30 days)
WEGOVY	T2	PA
ANTI-OBESITY - INCRETIN MIMETICS COMBINATION		
ZEPBOUND 2.5 MG/0.5 ML PEN	T2	PA QL (2 mls/28 days)
ZEPBOUND 2.5 MG/0.5 ML VIAL	T3	PA QL (2 mls/28 days)
ZEPBOUND 5 MG/0.5 ML PEN	T2	PA QL (2 mls/28 days)
ZEPBOUND 5 MG/0.5 ML VIAL	T3	PA QL (2 mls/28 days)
ZEPBOUND 7.5 MG/0.5 ML PEN	T2	PA QL (2 mls/28 days)
ZEPBOUND 7.5 MG/0.5 ML VIAL	T3	PA QL (2 mls/28 days)
ZEPBOUND 10 MG/0.5 ML PEN	T2	PA QL (2 mls/28 days)
ZEPBOUND 10 MG/0.5 ML VIAL	T3	PA QL (2 mls/28 days)
ZEPBOUND 12.5 MG/0.5 ML PEN	T2	PA QL (2 mls/28 days)
ZEPBOUND 12.5 MG/0.5 ML VIAL	T3	PA QL (2 mls/28 days)
ZEPBOUND 15 MG/0.5 ML PEN	T2	PA QL (2 mls/28 days)
ZEPBOUND 15 MG/0.5 ML VIAL	T3	PA QL (2 mls/28 days)
ANTI-OBESITY - OPIOID ANTAG-NOREPI, DOPAMINE RU INHIB		
CONTRAVE	T3	PA QL (120 tabs/30 days)
FAT ABSORPTION DECREASING AGENTS		
XENICAL	T3	PA QL (90 tabs/30 days)
ANTI-PARASITICS (Eye Conditions)		
OPHTHALMIC (EYE) ANTIPARASITICS		
XDEMVY	T2	QL (10 mgs/30 days) SP
ANTI-PARASITICS (Infections)		
ANTI-PARASITICS		
ALINIA 100MG/5ML SUSP	T2	QL (180 ml/30 days)
TOPICAL ANTI-PARASITICS		
crotan	T1	
ELIMITE *(permethrin)*	T3	
permethrin (Elimite)	T1	
SKLICE	T3	
spinosad (Natroba)	T1	
ULESFIA	T3	

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

PA – Prior Authorization
QL – Quantity Limit
ST – Step Therapy

AGE – Age Requirement
SP – Specialty Medication
HD – May require home delivery pharmacy

PPACA – No Cost-Share Preventive Medication
CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

ANTI-PARKINSON DRUGS (Parkinson's Disease)		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
ANTI-PARKINSONISM DRUGS, ANTI-CHOLINERGIC		
benztropine mesylate	T1	HD
trihexyphenidyl hcl	T1	HD
ANTI-PARKINSONISM DRUGS, OTHER		
bromocriptine mesylate	T1	HD
carbidopa/levodopa (Sinemet)	T1	HD
carbidopa-levodopa er	T1	HD
carbidopa/levodopa/entacapone	T1	HD
carbidopa-levodopa-entacapone (Stalevo 100)	T1	HD
carbidopa-levodopa-entacapone (Stalevo 150)	T1	HD
carbidopa-levodopa-entacapone (Stalevo 200)	T1	HD
carbidopa-levodopa-entacapone (Stalevo 75)	T1	HD
CREXONT	T3	ST HD
DUOPA	T3	SP HD
entacapone	T1	HD
entacapone (Comtan)	T1	HD
INBRIJA	T2	PA QL (300 caps/30 days) SP HD
MIRAPEX ER *(pramipexole er)*	T3	HD
NEUPRO	T3	HD
NOURIANZ	T3	PA QL (30 units/30 days) SP HD
ONGENTYS	T3	PA QL (30 caps/30 days) HD
pramipexole di-hcl	T1	HD
pramipexole di-hcl (Mirapex)	T1	HD
pramipexole er (Mirapex ER)	T1	HD
rasagiline mesylate (Azilect)	T1	HD
REQUIP XL *(ropinirole er)*	T3	HD
ropinirole hcl	T1	HD
ropinirole hcl (Requip XL)	T1	HD
RYTARY	T3	ST HD
selegiline hcl	T1	HD
SINEMET *(carbidopa-levodopa)*	T3	HD
TASMAR *(tolcapone)*	T3	HD
tolcapone (Tasmar)	T1	HD

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

PA – Prior Authorization
QL – Quantity Limit
ST – Step Therapy

AGE – Age Requirement
SP – Specialty Medication
HD – May require home delivery pharmacy

PPACA – No Cost-Share Preventive Medication
CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

ANTI-PLATELET DRUGS (Blood Thinners/Anti-Clotting)		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
DECARBOXYLASE INHIBITORS		
carbidopa (Lodosyn)	T1	
LODOSYN *(carbidopa)*	T3	
PLATELET AGGREGATION INHIBITORS		
aspirin e.c.	T1	HD PPACA
aspirin-dipyridamole er (Aggrenox)	T1	HD
ASPIRIN-OMEPRAZOLE	T3	PA HD
BRILINTA *(ticagrelor)*	T3	ST HD
children's aspirin (Bayer Chewable Aspirin)	T1	HD PPACA
cilostazol	T1	HD
clopidogrel (Plavix)	T1	HD
dipyridamole	T1	HD
ecotrin	T1	HD PPACA
EFFIENT *(prasugrel hcl)*	T3	HD
enteric coated aspirin	T1	HD PPACA
low dose aspirin	T1	HD PPACA
prasugrel hcl (Effient)	T1	HD
st. joseph aspirin	T1	HD PPACA
ticagrelor (Brilinta)	T1	HD
ZONTIVITY	T3	PA HD
PLATELET REDUCING AGENTS		
AGRYLIN *(anagrelide hcl)*	T3	
anagrelide hydrochloride (Agrylin)	T1	
ANTIVIRALS (AIDS/HIV)		
ANTI-RETROVIRAL - CAPSID INHIBITORS		
SUNLENCA	T3	PA SP
YEZTUGO	T2	SP
ANTIRETROVIRAL-INTEGRASE INHIBITOR AND NNRTI COMB		
JULUCA	T2	SP
ANTIRETROVIRAL-INTEGRASE INHIBITOR AND NRTI COMB		
DOVATO	T2	SP
ANTIRETROVIRAL-NRTIS AND INTEGRASE INHIBITORS COMB		
TRIUMEQ	T2	SP
TRIUMEQ PD 60-5-30 MG TAB SUSP	T2	SP

T1 – Typically Generics
T2 – Typically Preferred Brands
T3 – Typically Non-Preferred Brands
PA – Prior Authorization
QL – Quantity Limit
ST – Step Therapy
AGE – Age Requirement
SP – Specialty Medication
HD – May require home delivery pharmacy
PPACA – No Cost-Share Preventive Medication
CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

ANTIVIRALS (AIDS/HIV) (cont.)		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
ANTI-RETROVIRAL - NUCLEOSIDE, NUCLEOTIDE, PROTEASE INH.		
SYMTUZA	T2	SP
ANTIVIRALS - HIV-SPEC, NON-PEPTIDIC PROTEASE INHIB		
APTIVUS	T2	SP
darunavir 600mg, 800mg tablet	T1	SP
darunavir (Prezista)	T1	SP
PREZISTA 600MG, 800MG TABLET	T2	SP
PREZISTA 600MG, 800MG TABLET *(darunavir)*	T3	SP
ANTIVIRALS - HIV-SPEC, NUCLEOSIDE-NUCLEOTIDE ANALOG		
CIMDUO	T2	SP
DESCOVY	T2	SP PPACA
TEMIXYS	T2	SP
ANTIVIRALS - HIV-SPEC, NUCLEOSIDE ANALOG, RTI COMB		
abacavir-lamivudine (Epzicom)	T1	SP
COMBIVIR *(lamivudine-zidovudine)*	T3	SP
EPZICOM *(abacavir-lamivudine)*	T3	SP
lamivudine-zidovudine (Combivir)	T1	SP
ANTIVIRALS - HIV-SPECIFIC, FUSION INHIBITORS		
FUZEON	T2	SP QL (60 vials/30 days)
ANTIVIRALS - HIV-SPECIFIC, NON-NUCLEOSIDE, RTI		
EDURANT	T2	SP
EDURANT PED	T2	SP
efavirenz (Sustiva)	T1	SP
INTELENCE	T3	SP
nevirapine (Viramune)	T1	SP
PIFELTRO	T2	SP
ANTIVIRALS - HIV-SPECIFIC, NON-NUCLEOSIDE, RTI		
nevirapine er	T1	SP
nevirapine er (Viramune XR)	T1	SP
SUSTIVA *(efavirenz)*	T3	SP
VIRAMUNE *(nevirapine)*	T3	SP
VIRAMUNE XR *(nevirapine er)*	T3	SP
ANTIVIRALS - HIV-SPECIFIC, NUCLEOSIDE ANALOG, RTI		
abacavir	T1	SP
abacavir (Ziagen)	T1	SP

T1 – Typically Generics
T2 – Typically Preferred Brands
T3 – Typically Non-Preferred Brands
PA – Prior Authorization
QL – Quantity Limit
ST – Step Therapy
AGE – Age Requirement
SP – Specialty Medication
HD – May require home delivery pharmacy
PPACA – No Cost-Share Preventive Medication
CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

ANTIVIRALS (AIDS/HIV) (cont.)		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
ANTIVIRALS - HIV-SPECIFIC, NUCLEOSIDE ANALOG, RTI (cont.)		
didanosine	T1	SP
EMTRIVA	T2	SP
EPIVIR *(lamivudine)*	T3	SP
lamivudine (Epivir)	T1	SP
RETROVIR *(zidovudine)*	T3	SP
stavudine (Zerit)	T1	SP
ZIAGEN *(abacavir)*	T3	SP
ANTIVIRALS - HIV-SPECIFIC, NUCLEOTIDE ANALOG, RTI		
tenofovir disoproxil fumarate (Viread)	T1	SP
VIREAD POWDER	T2	SP
VIREAD 150 MG, 200 MG, 250 MG TABLET	T2	SP
VIREAD 300 MG TABLET *(tenofovir disoproxil fumarate)*	T3	SP
ANTIVIRALS - HIV-SPECIFIC, PROTEASE INHIBITORS		
atazanavir (Reyataz)	T1	SP
CRIXIVAN	T2	SP
EVOTAZ	T3	SP
fosamprenavir calcium	T1	SP
lopinavir/ritonavir	T1	SP
KALETRA	T3	SP
KALETRA 100-25 MG TABLET	T3	QL (2 tabs/day) SP
KALETRA 200-50 MG TABLET	T3	QL (56 tabs/274 days) SP
KALETRA 80-20MG/ML SOLUTION *(lopinavir-ritonavir)*	T3	QL (2ml/day) SP
lopinavir-ritonavir (Kaletra)	T1	QL (2ml/day) SP
NORVIR 100 MG TABLET *(ritonavir)*	T3	SP
NORVIR 100 MG POWDER PACKET	T2	SP
REYATAZ CAPSULES (atazanavir)	T3	SP
REYATAZ POWDER PACKET	T2	SP
ritonavir (Norvir)	T1	SP
VIRACEPT	T2	SP
ANTIVIRALS - HIV-I INTEGRASE STRAND TRANSFER INHIBTR		
APRETUDE	T2	SP PPACA
ISENTRESS	T2	SP
ISENTRESS HD	T2	SP
TIVICAY	T2	SP

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

PA – Prior Authorization
QL – Quantity Limit
ST – Step Therapy

AGE – Age Requirement
SP – Specialty Medication
HD – May require home delivery pharmacy

PPACA – No Cost-Share Preventive Medication
CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

ANTIVIRALS (AIDS/HIV) (cont.)		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
ARTV NUCLEOSIDE, NUCLEOTIDE, NON-NUCLEOSIDE RTI COMB		
DELSTRIGO	T2	SP
efavirenz/emtricit/tenofovr df	T1	SP
emtricita/rilpivirine/tenof df (Complera)	T1	SP
ODEFSEY	T2	SP
SYMFI	T2	SP
SYMFI LO	T2	SP
ARV-NUCLEOSIDE, NUCLEOTIDE RTI, INTEGRASE INHIB		
BIKTARVY	T2	SP
GENVOYA	T2	SP
ANTIVIRALS (Eye Conditions)		
EYE ANTIVIRALS		
trifluridine	T1	
ZIRGAN	T3	
ANTIVIRALS (Infections)		
ANTIVIRAL - MAIN PROTEASE (MPRO) INHIBITOR		
PAXLOVID 150-100 MG (MODERATE)	T2	QL (20 tabs/180 days)
PAXLOVID 300/150-100MG(SEVERE)	T2	
ANTIVIRAL MONOCLONAL ANTIBODIES		
BEYFORTUS	T2	PPACA
ENFLONSIA	T2	PPACA
ANTIVIRALS, GENERAL		
acyclovir (Zovirax)	T1	
acyclovir 200 mg/5 ml susp cup	T1	
acyclovir 800 mg/20ml susp cup	T1	
famciclovir	T1	QL
LIVTENCITY 200 MG TABLET	T3	PA SP
oseltamivir phosphate (Tamiflu)	T1	QL
OSELTAMIVIR 6MG/ML SUSPENSION	T3	QL (180 ml/30 days)
oseltamivir 30mg capsule	T1	QL (20 caps/30 days)
oseltamivir 45mg, 75 mg capsule	T1	QL (10 caps/30 days)
PREVYMIS 20 MG, 120 MG PELLET PACKET	T2	SP
PREVYMIS 240 MG, 480 MG TABLET	T2	QL (30 tabs/28 days) SP HD
RELENZA 5 MG	T3	QL (20 blisters/10 days)

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

PA – Prior Authorization
QL – Quantity Limit
ST – Step Therapy

AGE – Age Requirement
SP – Specialty Medication
HD – May require home delivery pharmacy

PPACA – No Cost-Share Preventive Medication
CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

ANTIVIRALS (Infections) (cont.)		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
ANTIVIRALS, GENERAL (cont.)		
ribavirin (Virazole)	T1	SP HD
rimantadine hcl	T1	
SITAVIG	T3	PA QL (2 tabs/30 days)
TAMIFLU *(oseltamivir phosphate)*	T3	QL
valacyclovir (Valtrex)	T1	QL (30 units/30 days)
VALCYTE *(valganciclovir hcl)*	T3	
valganciclovir hcl (Valcyte)	T1	
XOFLUZA	T3	QL
ZOVIRAX *(acyclovir)*	T3	
HEP C - NS5A, NS3/4A, NUCLEOTIDE NS5B INHIB COMBO		
VOSEVI	T2	PA QL (84 tabs/365 days) SP HD
HEP C VIRUS-NS5B POLYMERASE AND NS5A INHIB. COMBO.		
EPCLUSA 200MG/50MG ORAL PELLET PACKET	T2	PA SP HD QL (28 pkts/28 days)
EPCLUSA	T2	PA QL (84 packets/365 days) ST SP HD
HARVONI 45-200 MG TABLET	T2	PA QL (56 tabs/dispense) SP HD
HARVONI 90-400 MG TABLET	T2	PA QL (84 tabs/365 days) SP HD
HEPATITIS B TREATMENT AGENTS		
adefovir dipivoxil	T1	SP HD
BARACLUDE	T2	SP HD
entecavir (Baraclude)	T1	SP HD
EPIVIR	T2	SP
lamivudine	T1	SP
VEMLIDY	T2	SP HD
HEPATITIS C TREATMENT AGENTS		
PEGASYS 180MCG/0.5ML SYRINGE KIT	T2	SP HD
PEGASYS PROCLICK 180MCG/0.5ML	T2	SP HD
PEGASYS SYRINGE	T2	QL (2ml/21 days) SP HD
PEGASYS VIAL	T2	QL (4ml/21 days) SP HD
PEG-INTRON	T3	QL (4 kits/21 days) SP HD
ribavirin	T1	PA SP HD
HEPATITIS C VIRUS- NS5A AND NS3/4A INHIBITOR COMB		
ZEPATIER	T2	PA QL (84 tabs/365 days) SP HD
RNA POLYMERASE INHIBITOR		
MOLNUPIRAVIR	T2	

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

PA – Prior Authorization
QL – Quantity Limit
ST – Step Therapy

AGE – Age Requirement
SP – Specialty Medication
HD – May require home delivery pharmacy

PPACA – No Cost-Share Preventive Medication
CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

ANTIVIRALS (Skin Conditions)		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
TOPICAL ANTIVIRALS		
acyclovir (Zovirax)	T1	PA QL
DENAVIR	T3	
penciclovir	T1	
ZOVIRAX *(acyclovir)*	T3	PA QL
TOPICAL GENITAL WART-HPV TREATMENT AGENTS		
VEREGEN	T3	PA QL (30 grams/treatment)
AUTONOMIC DRUGS (Allergy/Nasal Sprays)		
ANAPHYLAXIS THERAPY AGENTS		
AUVI-Q	T2	QL (2 auto-injs/30 days)
epinephrine (Auvi-Q)	T1	QL
epinephrine (Epipen Jr 2-Pak)	T1	QL
EPINEPHRINE 0.3 MG/0.3 ML SYR	T3	QL (2 syringes/30 days)
EPIPEN *(epinephrine)*	T2	QL
EPIPEN JR. *(epinephrine)*	T2	QL
NEFFY	T2	QL (4 units/fill)
AUTONOMIC DRUGS (Alzheimer's Disease)		
CHOLINESTERASE INHIBITORS		
ARICEPT *(donepezil hcl)*	T3	ST HD
donepezil hcl (Aricept)	T1	HD
EXELON *(rivastigmine)*	T3	ST HD
galantamine	T1	HD
galantamine er (Razadyne ER)	T1	HD
pyridostigmine bromide er (Mestinon)	T1	HD
pyridostigmine er 180 mg tab (Mestinon)	T1	HD
PYRIDOSTIGMINE ER 105 MG TAB	T3	
RAZADYNE *(galantamine hbr)*	T3	ST
RAZADYNE ER *(galantamine er)*	T3	ST HD
rivastigmine	T1	HD
rivastigmine (Exelon)	T1	HD
AUTONOMIC DRUGS (Attention Deficit Hyperactivity Disorder)[9]		
ADRENERGICS, AROMATIC, NON-CATECHOLAMINE		
ADZENYS ER	T3	ST
ADZENYS XR-ODT	T3	ST

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

PA – Prior Authorization
QL – Quantity Limit
ST – Step Therapy

AGE – Age Requirement
SP – Specialty Medication
HD – May require home delivery pharmacy

PPACA – No Cost-Share Preventive Medication
CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

AUTONOMIC DRUGS (Attention Deficit Hyperactivity Disorder)[9] (cont.)		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
ADRENERGICS, AROMATIC, NON-CATECHOLAMINE (cont.)		
amphetamine (Evekeo)	T1	
AMPHETAMINE ER 1.25 MG/ML SUSP	T3	ST
DESOXYN *(methamphetamine hcl)*	T3	
DEXEDRINE (dextroamphetamine er)	T3	ST
dextroamphetamine	T1	
ADRENERGICS, AROMATIC, NON-CATECHOLAMINE		
dextroamphetamine (Zenzedi)	T1	
dextroamphetamine er (Dexedrine)	T1	
dextroamphetamine-amphet er (Adderall XR)	T1	
ADRENERGICS, AROMATIC, NON-CATECHOLAMINE		
dextroamphetamine-amphetamine (Adderall)	T1	
dextroamphetamine/amphetamine (Mydayis)	T1	
EVEKEO (amphetamine)	T3	
EVEKEO ODT	T3	
methamphetamine hcl (Desoxyn)	T1	
MYDAYIS (dextroamphetamine/amphetamine)	T3	ST
procentra	T1	
ZENZEDI	T3	
ZENZEDI 7.5 MG TABLET (dextroamphetamine sulfate)	T3	
zenzedi (Zenzedi)	T1	
AUTONOMIC DRUGS (Blood Pressure/Heart Medications)		
ADRENERGIC VASOPRESSOR AGENTS		
midodrine hcl	T1	
ALPHA-ADRENERGIC BLOCKING AGENTS		
DIBENZYLINE *(phenoxybenzamine hcl)*	T3	PA HD
prazosin	T1	HD
phenoxybenzamine hcl (Dibenzyline)	T1	PA HD
AUTONOMIC DRUGS (Urinary Tract Conditions)		
PARASYMPATHETIC AGENTS		
bethanechol chloride	T1	HD
cevimeline hcl (Evoxac)	T1	HD
EVOXAC *(cevimeline hcl)*	T3	HD
guanidine hcl	T1	HD

T1 – Typically Generics
T2 – Typically Preferred Brands
T3 – Typically Non-Preferred Brands
PA – Prior Authorization
QL – Quantity Limit
ST – Step Therapy
AGE – Age Requirement
SP – Specialty Medication
HD – May require home delivery pharmacy
PPACA – No Cost-Share Preventive Medication
CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

AUTONOMIC DRUGS (Urinary Tract Conditions) (cont.)		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
PARASYMPATHETIC AGENTS (cont.)		
pilocarpine hcl 5 mg, 7.5 mg tablet (Salagen)	T1	HD
SALAGEN *(pilocarpine hcl)*	T3	HD
URECHOLINE *(bethanechol chloride)*	T3	
BIOLOGICALS (Allergy/Nasal Sprays)		
ALLERGENIC EXTRACTS, THERAPEUTIC		
GRASTEK	T2	PA
ODACTRA	T2	PA
ORALAIR	T2	PA
RAGWITEK	T2	PA
BIOLOGICALS (Blood Pressure/Heart Medications)		
PLASMA KALLIKREIN INHIBITORS		
ORLADEYO	T3	PA SP
TAKHZYRO	T2	PA SP ST HD
BIOLOGICALS (Miscellaneous)		
PKU TREATMENT AGENTS - PHENYLALANINE AMMONIA LYASE		
PALYNZIQ	T2	PA QL (8 syringes/30 days) SP HD
BIOLOGICALS (Vaccines)		
COVID-19 VACCINES		
COMIRNATY	T2	PPACA
MNEXSPIKE 2025-2026 (12Y UP)	T2	PPACA
NUVAXOVID 2025-2026	T2	PPACA
MODERNA COVID	T2	PPACA
NOVAVAX COVID	T2	PPACA
PFIZER COVID	T2	PPACA
SPIKEVAX	T2	PPACA
ENTERIC VIRUS VACCINES		
IPOL	T2	PPACA
ROTARIX	T2	HD PPACA
ROTATEQ	T2	PPACA
GRAM (-) BACILLI (NON-ENTERIC) VACCINES		
VIVOTIF	T2	

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

PA – Prior Authorization
QL – Quantity Limit
ST – Step Therapy

AGE – Age Requirement
SP – Specialty Medication
HD – May require home delivery pharmacy

PPACA – No Cost-Share Preventive Medication
CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

BIOLOGICALS (Vaccines) (cont.)		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
GRAM NEGATIVE COCCI VACCINES		
BEXSERO	T2	PPACA
MENACTRA	T2	
MENVEO A-C-Y-W-135-DIP	T3	PPACA
MENQUADFI	T2	PPACA
PENBRAYA	T2	PPACA
PENMENVY MEN A-B-C-W-Y	T2	PPACA
TRUMENBA	T2	PPACA
GRAM POSITIVE COCCI VACCINES		
CAPVAXIVE	T2	PPACA
PNEUMOVAX 23	T2	PPACA
PREVNAR 13	T2	
INFLUENZA VIRUS VACCINES		
AFLURIA	T2	PPACA
AFLURIA QUAD	T2	PPACA
AFLURIA TRIV	T2	PPACA
AFLURIA TRIVALENT	T2	PPACA
AUDENZ (NATIONAL STOCKPILE)	T2	
FLUAD	T2	PPACA
FLUAD QUAD	T2	PPACA
FLUAD TRIVALENT	T2	PPACA
FLUARIX	T2	PPACA
FLUARIX QUAD	T2	PPACA
FLUARIX TRIVALENT	T2	PPACA
FLUBLOK	T2	PPACA
FLUBLOK QUAD	T2	PPACA
FLUBLOK TRIVALENT	T2	PPACA
FLUCELVAX	T2	PPACA
FLUCELVAX QUAD	T2	PPACA
FLUCELVAX TRIVALENT	T2	PPACA
FLULAVAL	T2	PPACA
FLULAVAL QUAD	T2	PPACA
FLULAVAL TRIVALENT	T2	PPACA
FLUMIST	T2	PPACA
FLUMIST HOME	T2	PPACA

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

PA – Prior Authorization
QL – Quantity Limit
ST – Step Therapy

AGE – Age Requirement
SP – Specialty Medication
HD – May require home delivery pharmacy

PPACA – No Cost-Share Preventive Medication
CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

BIOLOGICALS (Vaccines) (cont.)		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
INFLUENZA VIRUS VACCINES (cont.)		
FLUMIST QUAD	T2	PPACA
FLUMIST TRIVALENT	T2	PPACA
FLUZONE	T2	PPACA
FLUZONE HIGH-DOSE	T2	PPACA
FLUZONE HIGH-DOSE QUAD	T2	PPACA
FLUZONE HIGH-DOSE TRIV	T2	PPACA
FLUZONE QUAD	T2	PPACA
FLUZONE TRIVALENT	T2	PPACA
TOXIN-PRODUCING BACILLI VACCINES/TOXOIDS		
BCG VACCINE (TICE STRAIN)	T2	SP
VAXCHORA VACCINE	T2	
VACCINE/TOXOID PREPARATIONS, COMBINATIONS		
ACTHIB	T2	PPACA
ADACEL	T2	PPACA
BOOSTRIX	T2	PPACA
DAPTACEL	T2	PPACA
DIPHTHERIA-TETANUS TOXOIDS-PED	T2	
HIBERIX	T2	PPACA
INFANRIX	T2	PPACA
KINRIX	T2	PPACA
M-M-R II VACCINE W/DILUENT	T2	PPACA
PRIORIX VIAL	T2	PPACA
PEDVAXHIB	T2	PPACA
PENTACEL	T2	PPACA
PROQUAD	T2	PPACA
QUADRACEL DTAP-IPV	T2	PPACA
TENIVAC	T2	PPACA
TETANUS DIPHTHERIA TOXOIDS	T2	PPACA
VAXELIS	T2	PPACA
VIRAL/TUMORIGENIC VACCINES		
ABRYSVO	T2	PPACA
ACAM2000	T2	
AREXVY VIAL KIT	T2	PPACA
ENGERIX-B	T2	PPACA

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

PA – Prior Authorization
QL – Quantity Limit
ST – Step Therapy

AGE – Age Requirement
SP – Specialty Medication
HD – May require home delivery pharmacy

PPACA – No Cost-Share Preventive Medication
CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

BIOLOGICALS (Vaccines) (cont.)		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
VIRAL/TUMORIGENIC VACCINES (cont.)		
ERVEBO (NATIONAL STOCKPILE)	T2	
GARDASIL 9	T2	PPACA
HAVRIX	T2	PPACA
HEPLISAV-B	T2	PPACA
JYNNEOS	T2	
MRESVIA	T2	PPACA
PEDIARIX	T2	PPACA
RECOMBIVAX HB	T2	PPACA
SHINGRIX	T2	PPACA
TWINRIX	T2	PPACA
VAQTA	T2	PPACA
VARIVAX VACCINE	T2	PPACA
BLOOD (Blood Modifiers/Bleeding Disorders)		
AGENTS TO TX THROMBOTIC THROMBOCYTOPENIC PURPURA		
CABLIVI	T2	PA SP
ANTI-FIBRINOLYTIC AGENTS		
AMICAR *(aminocaproic acid)*	T3	SP HD
aminocaproic acid (Amicar)	T1	SP HD
LYSTEDA *(tranexamic acid)*	T3	SP
tranexamic acid (Lysteda)	T1	SP
COMPLEMENT INHIBITORS		
EMPAVELI	T2	PA SP
FABHALTA	T2	PA SP
TAVNEOS	T3	PA QL (180 caps/30 days) SP
VOYDEYA	T2	PA SP
HEMOPHILIA TREATMENT AGENTS, NON-FACTOR REPLACEMENT		
ALHEMO PEN	T2	PA SP
HEMLIBRA	T2	PA SP HD
HYMPAVZI PEN	T2	PA SP
SICKLE CELL ANEMIA AGENTS		
glutamine (Endari)	T1	PA
DROXIA	T2	
ENDARI *(glutamine)*	T3	PA
OXBRYTA	T3	SP

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

PA – Prior Authorization
QL – Quantity Limit
ST – Step Therapy

AGE – Age Requirement
SP – Specialty Medication
HD – May require home delivery pharmacy

PPACA – No Cost-Share Preventive Medication
CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

BLOOD (Blood Modifiers/Bleeding Disorders) (cont.)		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
TOPICAL HEMOSTATICS		
AVITENE	T3	
ENDO-AVITENE	T3	
GEL-FLOW	T3	
GELFOAM	T3	
GELFOAM JMI	T3	
MONSEL'S	T2	
RECOTHROM	T3	
SYRINGE AVITENE	T3	
THROMBI-GEL	T3	
THROMBIN-JMI	T3	
THROMBI-PAD	T3	
ULTRAFOAM	T3	
VISTASEAL FIBRIN SEALANT	T3	
BLOOD (Blood Thinners/Anti-Clotting)		
HEMORRHEOLOGIC AGENTS		
pentoxifylline	T1	HD
CARDIAC DRUGS (Blood Pressure/Heart Medications)		
ANTI-ANGINAL, ANTI-ISCHEMIC AGENTS, NON-HEMODYNAMIC		
ranolazine	T1	HD
ranolazine er (Ranexa)	T1	HD
RANEXA *(ranolazine)*	T3	ST HD
ANTI-ARRHYTHMICS		
amiodarone hcl	T1	HD
amiodarone hcl (Pacerone)	T1	HD
disopyramide phosphate (Norpace)	T1	HD
dofetilide (Tikosyn)	T1	HD
flecainide acetate	T1	HD
mexiletine hcl	T1	HD
MULTAQ	T2	HD
NORPACE *(disopyramide phosphate)*	T3	HD
NORPACE CR	T3	HD
pacerone	T1	HD
propafenone hcl	T1	HD

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

PA – Prior Authorization
QL – Quantity Limit
ST – Step Therapy

AGE – Age Requirement
SP – Specialty Medication
HD – May require home delivery pharmacy

PPACA – No Cost-Share Preventive Medication
CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

CARDIAC DRUGS (Blood Pressure/Heart Medications) (cont.)		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
ANTI-ARRHYTHMICS (cont.)		
quinidine	T1	HD
quinidine gluconate	T1	HD
CALCIUM CHANNEL BLOCKER AND NSAID, COX-2 INHIBITOR		
CONSENSI	T3	
CALCIUM CHANNEL BLOCKING AGENTS		
ADALAT CC *(nifedipine er)*	T3	
amlodipine besylate (Norvasc)	T1	
CALAN SR *(verapamil er)*	T3	HD
CAMZYOS	T3	PA QL (30 caps/30 days) SP
CARDIZEM *(diltiazem hcl)*	T3	HD
CARDIZEM CD *(cartia xt)*	T3	HD
CARDIZEM CD *(diltiazem 24hr er (cd))*	T3	HD
CARDIZEM LA	T3	HD
CARDIZEM LA *(diltiazem 24hr er (la))*	T3	HD
CARDIZEM LA *(matzim la)*	T3	HD
cartia xt (Cardizem CD)	T1	HD
diltiazem 24hr er (cd) (Cardizem CD)	T1	HD
diltiazem 24hr er (la) (Cardizem La)	T1	HD
diltiazem 24hr er (xr)	T1	HD
diltiazem er	T1	HD
diltiazem er (Tiazac)	T1	HD
diltiazem hcl (Cardizem)	T1	HD
dilt-xr	T1	HD
felodipine er	T1	HD
isradipine	T1	
matzim la (Cardizem La)	T1	HD
nicardipine hcl	T1	HD
nifedipine	T1	HD
nifedipine (Procardia)	T1	HD
nifedipine er	T1	HD
nifedipine er (Procardia XI)	T1	HD
nimodipine 30 mg capsule	T1	HD
nimodipine 60 mg/20 ml soln	T1	
nisoldipine	T1	HD

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

PA – Prior Authorization
QL – Quantity Limit
ST – Step Therapy

AGE – Age Requirement
SP – Specialty Medication
HD – May require home delivery pharmacy

PPACA – No Cost-Share Preventive Medication
CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

CARDIAC DRUGS (Blood Pressure/Heart Medications) (cont.)		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
CALCIUM CHANNEL BLOCKING AGENTS (cont.)		
nisoldipine (Sular)	T1	HD
NYMALIZE	T3	
PROCARDIA *(nifedipine)*	T3	HD
PROCARDIA XL *(nifedipine er)*	T3	HD
SULAR *(nisoldipine)*	T3	HD
taztia xt (Tiazac)	T1	HD
tiadylt er (Tiazac)	T1	HD
TIAZAC *(diltiazem 24hr er)*	T3	HD
verapamil er (Calan SR)	T1	HD
verapamil er (Verelan)	T1	HD
verapamil er pm (Verelan PM)	T1	HD
verapamil hcl	T1	HD
verapamil hcl (Verelan)	T1	HD
verapamil hcl (Verelan Pm)	T1	ST HD
VERELAN *(verapamil er)*	T3	HD
VERELAN *(verapamil hcl)*	T3	HD
VERELAN PM *(verapamil er pm)*	T3	HD
CARDIOPLEGIC SOLUTIONS		
cardioplegic (Plegisol)	T1	
DIGITALIS GLYCOSIDES		
digitek (Lanoxin)	T1	HD
digoxin (Lanoxin)	T1	HD
LANOXIN	T3	HD
LANOXIN *(digitek)*	T3	HD
HEART RATE REDUCING,SA SELECTIVE I(F) CURRENT INH.		
ivabradine (Corlanor)	T1	PA HD
SOLUBLE GUANYLATE CYCLASE (SGC) STIMULATOR		
VERQUVO	T2	QL (max 30 tabs/30 days)
VASODILATORS, CORONARY		
DILATRATE-SR	T2	HD
GONITRO	T3	
ISORDIL *(isosorbide dinitrate)*	T3	HD
isosorbide dinitrate	T1	HD
isosorbide dinitrate (Isordil Titradose)	T1	HD

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

PA – Prior Authorization
QL – Quantity Limit
ST – Step Therapy

AGE – Age Requirement
SP – Specialty Medication
HD – May require home delivery pharmacy

PPACA – No Cost-Share Preventive Medication
CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

CARDIAC DRUGS (Blood Pressure/Heart Medications) (cont.)		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
VASODILATORS, CORONARY (cont.)		
isosorbide dinitrate (Isordil)	T1	HD
isosorbide mononitrate	T1	HD
nitro-bid	T1	HD
NITRO-DUR	T3	HD
nitroglycerin	T1	HD
nitroglycerin (Nitro-Dur)	T1	HD
nitroglycerin 400 mcg spray (Nitrolingual)	T1	HD
nitroglycerin 0.3 mg tablet sl (Nitrostat)	T1	HD
nitroglycerin 0.4 mg tablet sl (Nitrostat)	T1	HD
nitroglycerin 0.6 mg tablet sl (Nitrostat)	T1	HD
NITROLINGUAL *(nitroglycerin)*	T3	
NITROMIST *(nitroglycerin)*	T3	HD
NITROSTAT *(nitroglycerin)*	T3	HD
nitro-time	T1	HD
CARDIOVASCULAR (Asthma/COPD/Respiratory)		
PULM ANTI-HTN, SOLUBLE GUANYLATE CYCLASE STIMULATOR		
ADEMPAS	T2	PA QL (90 tabs/30 days) SP HD
PULM.ANTI-HTN, SEL.C-GMP PHOSPHODIESTERASE T5 INHIB		
REVATIO *(sildenafil)*	T3	PA QL SP HD
sildenafil (Revatio)	T1	PA QL SP HD
PULMONARY ANTI-HTN, ENDOTHELIN RECEPTOR ANTAGONIST		
ambrisentan (Letairis)	T1	PA SP HD
bosentan 125 mg tablet (Tracleer)	T1	PA QL (60 tabs/30 days) SP HD
bosentan 32 mg tablet for susp (Tracleer)	T1	PA QL (120 tabs/30 days) SP HD
bosentan 62.5 mg tablet (Tracleer)	T1	PA QL (60 tabs/30 days) SP HD
OPSUMIT	T2	PA QL (30 tabs/30 days) SP HD
TRACLEER 32 MG TABLET FOR SUSP *(bosentan)*	T2	PA QL (120 tabs/30 days) SP HD
TRACLEER 62.5 MG, 125 MG TABLET *(bosentan)*	T3	PA QL (60 tabs/30 days) SP HD
PULMONARY ANTIHYPER AGENT, ACTRIIA-FC		
WINREVAIR	T2	PA SP HD
WINREVAIR (2 PACK)	T2	PA SP HD
PULMONARY ANTIHYPERTENSIVES, PROSTACYCLIN-TYPE		
ORENITRAM ER	T3	PA QL (90 tabs/30 days) SP HD
ORENITRAM TITRATION KT MONTH 1	T3	PA SP QL (168 tabs/28 days)

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

PA – Prior Authorization
QL – Quantity Limit
ST – Step Therapy

AGE – Age Requirement
SP – Specialty Medication
HD – May require home delivery pharmacy

PPACA – No Cost-Share Preventive Medication
CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

CARDIOVASCULAR (Asthma/COPD/Respiratory) (cont.)		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
PULMONARY ANTIHYPERTENSIVES, PROSTACYCLIN-TYPE		
ORENITRAM TITRATION KT MONTH 2	T3	PA SP QL (336 tabs/28 days)
ORENITRAM TITRATION KT MONTH 3	T3	PA SP QL (252 tabs/28 days)
TYVASO	T2	PA ST SP HD
UPTRAVI	T2	PA QL (60 tabs/30 days) SP HD
VENTAVIS	T3	PA SP HD
YUTREPIA	T2	PA SP HD
PULMONARY HTN-ENDOTHELIN RECEPT ANTG-CGMP PDE5 INH		
OPSYNVI	T2	PA QL (30 tabs/fill) SP HD
CARDIOVASCULAR (Blood Pressure/Heart Medications)		
ACE INHIBITOR-CALCIUM CHANNEL BLOCKER COMBINATION		
amlodipine besylate-benazepril	T1	HD
amlodipine besylate-benazepril (Lotrel)	T1	HD
PRESTALIA	T3	HD
TARKA *(trandolapril-verapamil er)*	T3	HD
trandolapril-verapamil	T1	HD
trandolapril-verapamil (Tarka)	T1	HD
ACE INHIBITOR-THIAZIDE OR THIAZIDE-LIKE DIURETIC		
ACCURETIC *(quinapril-hydrochlorothiazide)*	T3	HD
benazepril hcl-hctz (Lotensin HCT)	T1	HD
captopril/hydrochlorothiazide	T1	HD
enalapril maleate/hctz (Vaseretic)	T1	HD
fosinopril-hydrochlorothiazide	T1	HD
lisinopril-hctz (Zestoretic)	T1	HD
LOTENSIN HCT *(benazepril-hydrochlorothiazide)*	T3	HD
quinapril-hydrochlorothiazide (Accuretic)	T1	HD
VASERETIC *(enalapril-hydrochlorothiazide)*	T3	HD
ZESTORETIC *(lisinopril-hydrochlorothiazide)*	T3	HD
ALPHA/BETA-ADRENERGIC BLOCKING AGENTS		
CARDURA *(doxazosin mesylate)*	T3	QL HD
CARDURA XL	T3	QL (30 units/30 days) HD
doxazosin mesylate (Cardura)	T1	QL HD
labetalol hcl 100 mg tablet	T1	HD
labetalol hcl 200 mg tablet	T1	HD
labetalol hcl 300 mg tablet	T1	HD

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

PA – Prior Authorization
QL – Quantity Limit
ST – Step Therapy

AGE – Age Requirement
SP – Specialty Medication
HD – May require home delivery pharmacy

PPACA – No Cost-Share Preventive Medication
CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

CARDIOVASCULAR (Blood Pressure/Heart Medications) (cont.)		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
ALPHA/BETA-ADRENERGIC BLOCKING AGENTS (cont.)		
MINIPRESS *(prazosin hcl)*	T3	HD
prazosin hcl (Minipress)	T1	HD
terazosin hcl	T1	QL (30 caps/30 days) HD
ANGIOTEN.RECEPTR ANTAG-CALCIUM CHANL BLKR-THIAZIDE		
amlodipine-valsartan-hctz (Exforge HCT)	T1	HD
olmesartan-amlodipine-hctz (Tribenzor)	T1	HD
ANGIOTENSIN RECEPT-NEPRILYSIN INHIBITOR COMB (ARNI)		
ENTRESTO *(sacubitril/valsartan)*	T3	QL (60 tabs/30 days)
ENTRESTO SPRINKLE	T2	QL (240 caps/fill) HD
sacubitril/valsartan (Entresto)	T1	QL (60 tabs/30 days) HD
ANGIOTENSIN RECEPTOR ANTAG.-THIAZIDE DIURETIC COMB		
candesartan-hydrochlorothiazid (Atacand Hct)	T1	HD
irbesartan-hydrochlorothiazide (Avalide)	T1	HD
losartan-hydrochlorothiazide (Hyzaar)	T1	HD
losartan-hydrochlorothiazide (Hyzaar)	T1	
olmesartan-hydrochlorothiazide (Benicar HCT)	T1	HD
telmisartan-hydrochlorothiazid (Micardis HCT)	T1	HD
valsartan-hydrochlorothiazide (Diovan HCT)	T1	HD
ANGIOTENSIN RECEPTOR BLOCKR-CALCIUM CHANNEL BLOCKR		
amlodipine-olmesartan (Azor)	T1	HD
amlodipine-valsartan (Exforge)	T1	HD
telmisartan-amlodipine (Twynsta)	T1	HD
ANTI-HYPERTENSIVES, ACE INHIBITORS		
ACCUPRIL *(quinapril hcl)*	T3	HD
ALTACE *(ramipril)*	T3	HD
ANTI-HYPERTENSIVES, ACE INHIBITORS		
benazepril hcl (Lotensin)	T1	HD
captopril	T1	HD
enalapril maleate (Vasotec)	T1	HD
fosinopril	T1	HD
lisinopril (Prinivil)	T1	HD
lisinopril (Zestril)	T1	HD
LOTENSIN *(benazepril hcl)*	T3	HD
moexipril hcl	T1	HD

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

PA – Prior Authorization
QL – Quantity Limit
ST – Step Therapy

AGE – Age Requirement
SP – Specialty Medication
HD – May require home delivery pharmacy

PPACA – No Cost-Share Preventive Medication
CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

CARDIOVASCULAR (Blood Pressure/Heart Medications) (cont.)		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
ANTI-HYPERTENSIVES, ACE INHIBITORS (cont.)		
perindopril erbumine	T1	HD
PRINIVIL *(lisinopril)*	T3	HD
quinapril (Accupril)	T1	HD
ramipril	T1	HD
ramipril (Altace)	T1	HD
trandolapril	T1	HD
VASOTEC *(enalapril maleate)*	T3	HD
ZESTRIL *(lisinopril)*	T3	HD
ANTI-HYPERTENSIVES, ANGIOTENSIN RECEPTOR ANTAGONIST		
candesartan cilexetil (Atacand)	T1	HD
eprosartan mesylate	T1	
irbesartan	T1	HD
irbesartan (Avapro)	T1	HD
losartan (Cozaar)	T1	HD
telmisartan	T1	HD
olmesartan medoxomil (Benicar)	T1	HD
telmisartan (Micardis)	T1	HD
valsartan (Diovan)	T1	HD
valsartan 20 mg/5 ml solution	T1	HD
ANTI-HYPERTENSIVES, GANGLIONIC BLOCKERS		
VECAMYL	T3	
ANTI-HYPERTENSIVES, MISCELLANEOUS		
DEMSER	T3	PA HD
ANTI-HYPERTENSIVES, SYMPATHOLYTIC		
CATAPRES-TTS *(clonidine)*	T3	QL (4 patches/21 days) HD
clonidine hcl (Catapres-TTS 1)	T1	QL (4 patches/21 days) HD
clonidine hcl (Catapres-TTS 2)	T1	QL (4 patches/21 days) HD
clonidine hcl (Catapres-TTS 3)	T1	QL (4 patches/21 days) HD
guanfacine hcl	T1	HD
methyldopa	T1	HD
methyldopa/hydrochlorothiazide	T1	HD
ANTI-HYPERTENSIVES, VASODILATORS		
hydralazine hcl	T1	HD
minoxidil	T1	HD

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

PA – Prior Authorization
QL – Quantity Limit
ST – Step Therapy

AGE – Age Requirement
SP – Specialty Medication
HD – May require home delivery pharmacy

PPACA – No Cost-Share Preventive Medication
CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

CARDIOVASCULAR (Blood Pressure/Heart Medications) (cont.)		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
BETA-ADRENERGIC BLOCKING AGENTS		
acebutolol hcl	T1	HD
atenolol (Tenormin)	T1	HD
BETAPACE *(sorine)*	T3	HD
BETAPACE AF *(sorine)*	T3	HD
betaxolol hcl	T1	HD
bisoprolol fumarate 10 mg tab	T1	HD
bisoprolol fumarate 5 mg tab	T1	HD
HEMANGEOL	T2	PA
LOPRESSOR 100 MG TABLET *(metoprolol tartrate)*	T3	ST HD
LOPRESSOR 50 MG TABLET *(metoprolol tartrate)*	T3	ST HD
metoprolol succinate (Toprol XL)	T1	HD
metoprolol tartrate	T1	HD
metoprolol tartrate (Lopressor)	T1	HD
pindolol	T1	HD
propranolol hcl	T1	HD
propranolol hcl er (Inderal La)	T1	HD
sorine	T1	HD
sorine (Betapace)	T1	HD
sotalol	T1	HD
sotalol (Betapace)	T1	HD
sotalol af (Betapace)	T1	HD
SOTYLIZE	T2	HD
TENORMIN *(atenolol)*	T3	HD
timolol maleate 10 mg tablet	T1	HD
timolol maleate 20 mg tablet	T1	HD
timolol maleate 5 mg tablet	T1	HD
BETA-BLOCKERS AND THIAZIDE, THIAZIDE-LIKE DIURETICS		
atenolol w/chlorthalidone (Tenoretic 100)	T1	HD
atenolol w/chlorthalidone (Tenoretic 50)	T1	
atenolol w/chlorthalidone (Tenoretic 50)	T1	HD
bisoprolol fumarate/hctz (Ziac)	T1	HD
bisoprolol/hydrochlorothiazide	T1	HD
metoprolol-hydrochlorothiazide	T1	HD

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

PA – Prior Authorization
QL – Quantity Limit
ST – Step Therapy

AGE – Age Requirement
SP – Specialty Medication
HD – May require home delivery pharmacy

PPACA – No Cost-Share Preventive Medication
CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

CARDIOVASCULAR (Blood Pressure/Heart Medications) (cont.)		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
BETA-BLOCKERS AND THIAZIDE, THIAZIDE-LIKE DIURETICS (cont.)		
metoprolol-hydrochlorothiazide (Lopressor HCT)	T1	HD
propranolol hcl-hctz	T1	HD
TENORETIC *(atenolol-chlorthalidone)*	T3	HD
RENIN INHIBITOR, DIRECT		
aliskiren (Tekturna)	T1	HD
RENIN INHIBITOR, DIRECT AND THIAZIDE DIURETIC COMB		
TEKTURNA HCT	T2	HD
VASODILATORS, COMBINATION		
isosorbide dinit/hydralazine (Bidil)	T1	HD
VASODILATORS, PERIPHERAL		
ergoloid mesylates	T1	
isoxsuprine hcl	T1	
CARDIOVASCULAR (Cholesterol Medications)		
ANTI-HYPERLIP.HMG COA REDUCT INHIB-CHOLEST.AB.INHIB		
ezetimibe-atorvastatin tabs	T1	ST HD QL (30 tabs/30 days)
ezetimibe-simvastatin (Vytorin)	T1	QL (30 units/30 days) HD
ANTI-HYPERLIPID- HMG-COA RI-CALCIUM CHANNEL BLOCKER		
amlodipine-atorvastatin (Caduet)	T1	QL (30 units/30 days) HD
CADUET *(amlodipine-atorvastatin)*	T3	ST QL (30 units/30 days) HD
ANTI-HYPERLIPIDEMIC - ANGIOPOIETIN-LIKE 3 INHIBITOR		
EVKEEZA	T3	PA
ANTI-HYPERLIPIDEMIC - APOLIPOPROTEIN INHIBITOR		
TRYNGOLZA	T3	PA SP
ANTI-HYPERLIPIDEMIC - MTP INHIBITOR		
JUXTAPID	T2	SP HD
ANTI-HYPERLIPIDEMIC - PCSK9 INHIBITORS		
REPATHA	T2	
ANTI-HYPERLIPIDEMIC-HMGCOA REDUCTASE INHIB (STATINS)		
FLOLIPID	T3	ST QL HD
fluvastatin	T1	QL HD PPACA
fluvastatin	T1	QL (30 units/30 days) HD PPACA
fluvastatin er (Lescol XL)	T1	QL (30 units/30 days) HD PPACA
LESCOL XL *(fluvastatin er)*	T3	ST QL (30 units/30 days) HD

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

PA – Prior Authorization
QL – Quantity Limit
ST – Step Therapy

AGE – Age Requirement
SP – Specialty Medication
HD – May require home delivery pharmacy

PPACA – No Cost-Share Preventive Medication
CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

CARDIOVASCULAR (Cholesterol Medications) (cont.)		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
ANTI-HYPERLIPIDEMIC-HMGCOA REDUCTASE INHIB (STATINS) (cont.)		
lovastatin	T1	QL HD PPACA
pitavastatin calcium (Livalo)	T1	QL (30 tabs/30 days) HD PPACA
pravastatin (Pravachol)	T1	QL (30 units/30 days) HD PPACA
simvastatin	T1	QL (30 units/30 days) HD
simvastatin (Zocor)	T1	QL (30 units/30 days) HD PPACA
ZYPITAMAG	T3	ST QL (30 units/30 days) HD
BILE SALT SEQUESTRANTS		
cholestyramine	T1	HD
cholestyramine (Questran)	T1	HD
cholestyramine (Questran Light)	T1	HD
cholestyramine light (Questran Light)	T1	HD
colesevelam hcl (Welchol)	T1	HD
COLESTID *(colestipol hcl)*	T3	HD
colestipol hcl	T1	HD
colestipol hcl (Colestid)	T1	HD
prevalite	T1	HD
prevalite (Questran Light)	T1	HD
QUESTRAN *(cholestyramine)*	T3	HD
QUESTRAN LIGHT (*cholestyramine*)	T3	ST HD
QUESTRAN LIGHT *(cholestyramine light)*	T3	HD
LIPOTROPICS		
ezetimibe (Zetia)	T1	HD
fenofibrate	T1	HD
fenofibrate 130 mg capsule	T1	ST HD
fenofibrate (Fenoglide)	T1	HD
fenofibrate (Tricor)	T1	HD
fenofibric acid	T1	HD
fenofibric acid (choline)	T1	HD
fenofibric acid (Fibricor)	T1	HD
FENOGLIDE *(fenofibrate)*	T3	ST HD
FIBRICOR *(fenofibric acid)*	T3	ST HD
gemfibrozil (Lopid)	T1	HD
LIPOFEN	T2	HD
LOPID *(gemfibrozil)*	T3	HD

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

PA – Prior Authorization
QL – Quantity Limit
ST – Step Therapy

AGE – Age Requirement
SP – Specialty Medication
HD – May require home delivery pharmacy

PPACA – No Cost-Share Preventive Medication
CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

CARDIOVASCULAR (Cholesterol Medications) (cont.)		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
LIPOTROPICS (cont.)		
niacin	T1	HD
niacin er (Niaspan)	T1	HD
NIACOR	T3	HD
NIASPAN *(niacin er)*	T3	HD
rosuvastatin 5mg, 10mg, 20mg, 40mg tab (Crestor)	T1	
TRIGLIDE	T3	ST
CARDIOVASCULAR (Miscellaneous)		
ENDOTHELIN-ANGIOTENSIN RECEPTOR ANTAGONIST		
FILSPARI	T2	PA QL (30 tabs/30 days) SP
CNS DRUGS (Alzheimer's Disease)		
ALZHEIMER'S THERAPY, NMDA RECEPTOR ANTAGONISTS		
memantine hcl	T1	HD
memantine hcl 10 mg/5 ml cup	T1	HD
memantine hcl 5 mg, 10 mg tablet	T1	HD
memantine hcl er (Namenda XR)	T1	HD
NAMENDA	T3	HD
NAMENDA XR	T3	HD
ALZHEIMER'S THX, NMDA RECEPTOR ANTAG-CHOLINES INHIB		
memantine hcl/donepezil hcl (Namzaric)	T1	ST HD
NAMZARIC *(memantine hcl/donepezil hcl)*	T2	ST HD
NAMZARIC	T2	ST HD
CNS DRUGS (Miscellaneous)		
AMYOTROPHIC LATERAL SCLEROSIS AGENTS		
RILUTEK *(riluzole)*	T3	PA SP HD
riluzole (Rilutek)	T1	PA SP HD
TEGLUTIK	T3	PA SP
TIGLUTIK	T3	PA SP
DRUGS TO TREAT MOVEMENT DISORDERS		
AUSTEDO 6 MG TABLET	T3	PA QL (60 tabs/30 days) SP HD
AUSTEDO 9 MG TABLET	T3	PA QL (120 tabs/30 days) SP HD
AUSTEDO 12 MG TABLET	T3	PA QL (120 tabs/30 days) SP HD
AUSTEDO XR 6 MG TABLET	T3	PA QL (210 tabs/30 days) SP HD
AUSTEDO XR 12 MG TABLET	T3	PA QL (90 tabs/30 days) SP HD

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

PA – Prior Authorization
QL – Quantity Limit
ST – Step Therapy

AGE – Age Requirement
SP – Specialty Medication
HD – May require home delivery pharmacy

PPACA – No Cost-Share Preventive Medication
CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

CNS DRUGS (Miscellaneous) (cont.)		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
DRUGS TO TREAT MOVEMENT DISORDERS (cont.)		
AUSTEDO XR 18 MG TABLET	T3	PA QL (30 tabs/fill) SP HD
AUSTEDO XR 24 MG TABLET	T3	PA QL (60 tabs/30 days) SP HD
AUSTEDO XR 30 MG TABLET	T3	PA QL (30 tabs/fill) SP HD
AUSTEDO XR 36 MG TABLET	T3	PA QL (30 tabs/fill) SP HD
AUSTEDO XR 42 MG TABLET	T3	PA QL (30 tabs/fill) SP HD
AUSTEDO XR 48 MG TABLET	T3	PA QL (30 tabs/fill) SP HD
AUSTEDO XR TITRATION KT(WK1-4)	T3	PA QL (28 tabs/fill) SP HD
HORIZANT	T3	ST
INGREZZA	T2	PA QL (30 caps/30 days) SP
INGREZZA SPRINKLE	T2	PA QL (30 caps/fill) SP
INGREZZA INITIATION PK (TARDIV)	T2	PA QL (28 caps/30 days) SP
tetrabenazine 12.5 mg tablet (Xenazine)	T1	
tetrabenazine 25 mg tablet (Xenazine)	T1	
XANTHINES		
caffeine d	T1	HD
CNS DRUGS (Multiple Sclerosis)		
AGENTS TO TREAT MULTIPLE SCLEROSIS		
AUBAGIO	T3	PA SP HD QL (30 tabs/30 days)
AVONEX (4 PACK)	T2	PA QL (1 kit/28 days) SP HD
AVONEX ADMINISTRATION PACK	T2	PA QL (1 kit/21 days) SP HD
AVONEX PEN (4 PACK)	T2	PA QL (4 pens/28 days) SP HD
BAFIERTAM	T2	PA ST (120 caps/30 days) SP HD
BETASERON	T2	PA QL (14 kits/23 days) SP HD
fingolimod	T1	PA ST QL (30 caps/30 days) SP HD
glatiramer acetate 20 mg/ml syringe (Copaxone)	T1	QL (30 syr/23 days) SP HD
glatiramer acetate 40 mg/ml syringe (Copaxone)	T1	QL (12 ml/23 days) SP HD
glatopa 20 mg/ml syringe (Copaxone)	T1	PA QL (30 syr/23 days) SP HD
glatopa 40 mg/ml syringe (Copaxone)	T1	PA QL (12 ml/23 days) SP HD
KESIMPTA PEN	T2	PA ST QL (1 pen/28 days)SP HD
MAVENCLAD 10 MG X 10 TABLET PACK	T3	PA QL (10 tabs/dispense) SP HD
MAVENCLAD 10 MG X 4 TABLET PACK	T3	PA QL (4 tabs/dispense) SP HD
MAVENCLAD 10 MG X 5 TABLET PACK	T3	PA QL (5 tabs/dispense) SP HD
MAVENCLAD 10 MG X 6 TABLET PACK	T3	PA QL (6 tabs/dispense) SP HD

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

PA – Prior Authorization
QL – Quantity Limit
ST – Step Therapy

AGE – Age Requirement
SP – Specialty Medication
HD – May require home delivery pharmacy

PPACA – No Cost-Share Preventive Medication
CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

CNS DRUGS (Multiple Sclerosis) (cont.)		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
AGENTS TO TREAT MULTIPLE SCLEROSIS (cont.)		
MAVENCLAD 10 MG X 7 TABLET PACK	T3	PA QL (7 tabs/dispense) SP HD
MAVENCLAD 10 MG X 8 TABLET PACK	T3	PA QL (8 tabs/dispense) SP HD
MAVENCLAD 10 MG X 9 TABLET PACK	T3	PA QL (9 tabs/dispense) SP HD
MAYZENT	T2	PA QL (30 units/30 days) SP HD
PLEGRIDY PEN/SYRINGE	T2	PA QL (1 ml/21 days) SP HD
PLEGRIDY STARTER PACK	T2	PA QL (1 pack/365 days) SP HD
PONVORY	T2	PA ST QL (30 tabs/30 days) SP
REBIF REBIDOSE SYRINGES	T2	PA ST QL (1 pack/28 days) SP HD
REBIF REBIDOSE TITRATION PACK	T2	PA ST QL (1 pack/28 days) SP HD
REBIF SYRINGES	T2	PA QL (6 ml/21 days) SP HD
REBIF TITRATION PACK	T2	PA QL (5 ml/21 c) SP HD
VUMERITY STARTER PACK	T2	PA QL (106 c/30 days)SP HD
VUMERITY	T2	PA QL (120 caps/30 days)SP HD
ZEPOSIA	T2	PA QL SP HD
ZEPOSIA 0.23-0.46 MG START PCK	T2	PA QL (37 v/30 days) SP HD
ZEPOSIA 0.23-0.46-0.92 MG KIT	T2	PA QL (7 v/7 days) SP HD
ZEPOSIA 0.92 MG CAPSULE	T2	PA QL (30 caps/30 Days) SP HD
AGTS TX NEUROMUSC TRANSMISSION DIS, POT-CHAN BLKR		
AMPYRA ER 10 MG TABLET	T3	PA QL (30 caps/30 days) SP HD
dalfampridine er (Ampyra)	T1	PA SP HD
FIRDAPSE	T2	PA SP
SPHINGOSINE I-PHOSPHATE (SIP) RECEPTOR MODULATOR		
ZEPOSIA 0.92 MG CAPSULE	T2	PA QL (30 caps/30 days) SP HD
ZEPOSIA STARTER KIT (28-DAY)	T2	PA QL (28 caps/30 days) SP HD
ZEPOSIA STARTER PACK (7-DAY)	T2	PA QL (7 caps/30 days) SP HD
CNS DRUGS (Pain Relief And Inflammatory Disease)		
CALCITONIN GENE-RELATED PEPTIDE (CGRP) INHIBITORS		
EMGALITY SYRINGE	T2	PA QL (1 syr/23 days)
POSTHERPETIC NEURALGIA AGENTS		
gabapentin	T1	ST
gabapentin (Gralise)	T1	ST
GRALISE	T3	ST
GRALISE *(gabapentin)*	T3	ST

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

PA – Prior Authorization
QL – Quantity Limit
ST – Step Therapy

AGE – Age Requirement
SP – Specialty Medication
HD – May require home delivery pharmacy

PPACA – No Cost-Share Preventive Medication
CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

CNS DRUGS (Pain Relief And Inflammatory Disease) (cont.)		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
SPHINGOSINE 1-PHOSPHATE (SIP) RECEPTOR MODULATOR		
ZEPOSIA STARTER KIT (28-DAY)	T2	
VELSIPITY	T2	PA QL (30 tabs/30 days) SP HD
CNS DRUGS (Seizure Disorders)		
ANTI-CONVULSANT - BENZODIAZEPINE TYPE		
clobazam (Onfi)	T1	PA HD
clonazepam (Klonopin)	T1	HD
DIASTAT *(diazepam)*	T3	HD
diazepam 10 mg rectal gel syrg	T1	HD
diazepam 10mg rectal gel (2pk)	T1	HD
diazepam 2.5mg rectal gel(2pk) (Diastat)	T1	HD
diazepam 20 mg rectal gel syrg	T1	HD
diazepam 20mg rectal gel (2pk)	T1	HD
KLONOPIN *(clonazepam)*	T3	HD
NAYZILAM	T2	PA QL HD
ONFI *(clobazam)*	T3	PA HD
SYMPAZAN	T3	PA HD
VALTOCO	T2	PA QL (2 units/30 days) HD
ANTI-CONVULSANT - CANNABINOID TYPE		
EPIDIOLEX	T2	PA SP HD
ANTI-CONVULSANTS		
APTIOM (eslicarbazepine acetate)	T3	HD
BANZEL	T3	PA HD
BRIVIACT	T3	ST HD
carbamazepine 100 mg tab chew	T1	HD
carbamazepine 100 mg/5 ml cup	T1	HD
carbamazepine 100 mg/5 ml susp (Tegretol)	T1	HD
carbamazepine 200 mg tablet (Tegretol)	T1	HD
carbamazepine 200 mg/10 ml cup	T1	HD
CARBAMAZEPINE 200 MG TAB CHEW	T3	HD
carbamazepine (Tegretol)	T1	HD
carbamazepine er (Carbatrol)	T1	HD
carbamazepine er (Tegretol XR)	T1	HD
CARBATROL *(carbamazepine er)*	T3	HD

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

PA – Prior Authorization
QL – Quantity Limit
ST – Step Therapy

AGE – Age Requirement
SP – Specialty Medication
HD – May require home delivery pharmacy

PPACA – No Cost-Share Preventive Medication
CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

CNS DRUGS (Seizure Disorders) (cont.)		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
ANTI-CONVULSANTS (cont.)		
CELONTIN (*methsuximide*)	T3	HD
DEPAKOTE *(divalproex)*	T3	ST HD
DEPAKOTE ER *(divalproex er)*	T3	ST HD
DEPAKOTE SPRINKLE *(divalproex)*	T3	ST HD
DIACOMIT	T2	PA SP HD
DILANTIN *(phenytoin)*	T3	HD
DILANTIN 30 MG CAPSULE	T2	HD
divalproex er (Depakote ER)	T1	HD
divalproex (Depakote Sprinkle)	T1	HD
divalproex (Depakote)	T1	HD
epitol (Tegretol)	T1	HD
ELEPSIA XR	T3	ST HD
eslicarbazepine acetate (Aptiom)	T1	HD
ethosuximide (Zarontin)	T1	HD
felbamate (Felbatol)	T1	HD
FELBATOL *(felbamate)*	T3	HD
FYCOMPA	T2	HD
FYCOMPA *(perampanel)*	T2	HD
gabapentin (Neurontin)	T1	HD
LAMICTAL XR	T3	ST HD
lamotrigine (blue) (Lamictal (Blue)	T1	HD
lamotrigine (green) (Lamictal (Green)	T1	HD
lamotrigine (Lamictal XR)	T1	HD
lamotrigine (Lamictal)	T1	HD
lamotrigine (orange) (Lamictal (Orange)	T1	HD
lamotrigine odt (Lamictal ODT)	T1	HD
levetiracetam (Keppra XR)	T1	HD
levetiracetam (Keppra)	T1	HD
LEVETIRACETAM 250 MG TAB SUSP	T3	ST HD
levetiracetam 1,000 mg tablet (Keppra)	T1	HD
levetiracetam 1,000mg/10ml cup (Keppra)	T1	HD
levetiracetam 100 mg/ml soln (Keppra)	T1	HD
levetiracetam 250 mg tablet (Keppra)	T1	HD
levetiracetam 500 mg tablet (Keppra)	T1	HD

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

PA – Prior Authorization
QL – Quantity Limit
ST – Step Therapy

AGE – Age Requirement
SP – Specialty Medication
HD – May require home delivery pharmacy

PPACA – No Cost-Share Preventive Medication
CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

CNS DRUGS (Seizure Disorders) (cont.)		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
ANTI-CONVULSANTS (cont.)		
levetiracetam 500 mg/5 ml cup, soln	T1	HD
levetiracetam 750 mg tablet(Keppra)	T1	HD
MYSOLINE *(primidone)*	T3	HD
oxcarbazepine (Oxtellar Xr)	T1	HD
oxcarbazepine (Trileptal)	T1	HD
OXTELLAR XR (*oxcarbazepine*)	T3	ST HD
PEGANONE	T2	HD
perampanel (Fycompa)	T1	HD
PHENYTEK *(phenytoin extended)*	T3	HD
phenytoin	T1	HD
phenytoin (Dilantin)	T1	HD
phenytoin (Dilantin-125)	T1	HD
phenytoin (Phenytek)	T1	HD
pregabalin (Lyrica)	T1	HD
primidone (Mysoline)	T1	HD
QUDEXY XR	T2	ST HD
roweepra (Keppra)	T1	HD
SABRIL *(vigabatrin)*	T3	PA SP HD
SPRITAM	T3	ST HD
subvenite (Lamictal (Blue)	T1	HD
subvenite (Lamictal (Green)	T1	HD
subvenite (Lamictal (Orange)	T1	HD
subvenite (Lamictal)	T1	HD
TEGRETOL *(carbamazepine)*	T3	HD
TEGRETOL XR *(carbamazepine er)*	T3	HD
tiagabine	T1	HD
topiramate 50 mg sprinkle cap	T1	HD
topiramate 25 mg/ml solution (Eprontia)	T1	HD
topiramate er 25mg, 50mg, 100mg capsule (Trokendi XR)	T1	ST
topiramate 100 mg tablet (Topamax)	T1	HD
topiramate 15 mg sprinkle cap (Topamax)	T1	HD
topiramate 200 mg tablet (Topamax)	T1	HD
topiramate 25 mg sprinkle cap (Topamax)	T1	HD
topiramate 25 mg tablet (Topamax)	T1	HD

T1 – Typically Generics
T2 – Typically Preferred Brands
T3 – Typically Non-Preferred Brands
PA – Prior Authorization
QL – Quantity Limit
ST – Step Therapy
AGE – Age Requirement
SP – Specialty Medication
HD – May require home delivery pharmacy
PPACA – No Cost-Share Preventive Medication
CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

CNS DRUGS (Seizure Disorders) (cont.)		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
ANTI-CONVULSANTS (cont.)		
topiramate 50 mg tablet (Topamax)	T1	HD
TROKENDI XR	T3	ST HD
valproic acid	T1	HD
VIGADRONE	T1	PA SP HD QL (150 pkts/30 days)
vigadrone (Sabril)	T1	PA SP HD
VIMPAT	T2	HD
XCOPRI 25 MG TABLET	T3	QL (30 tabs/fill) HD
ZARONTIN *(ethosuximide)*	T3	HD
zonisamide	T1	HD
zonisamide (Zonegran)	T1	HD
ZTALMY 50 MG/ML SUSPENSION	T2	SP
CNS DRUGS (Sleep Disorders/Sedatives)		
NARCOLEPSY TX-H3-RECEPT.ANTAGONIST/INVERSE AGONIST		
WAKIX	T3	PA QL SP HD
COLONY STIMULATING FACTORS (Blood Modifiers/Bleeding Disorders)		
ERYTHROPOIESIS-STIMULATING AGENTS		
PROCRIT	T2	PA SP
RETACRIT	T2	PA SP
LEUKOCYTE (WBC) STIMULANTS		
FULPHILA	T2	PA QL (2 syr/23 days) SP
LEUKINE	T2	PA SP
NIVESTYM	T2	PA SP HD
ZARXIO	T2	PA SP HD
THROMBOPOIETIN RECEPTOR AGONISTS		
DOPTELET	T2	PA QL SP HD
eltrombopag olamine (Promacta)	T1	PA SP HD
PROMACTA *(eltrombopag olamine)*	T3	PA SP HD
COLONY STIMULATING FACTORS (Cancer)		
CXCR4 CHEMOKINE RECEPTOR ANTAGONIST		
XOLREMDI	T3	PA SP CSL

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

PA – Prior Authorization
QL – Quantity Limit
ST – Step Therapy

AGE – Age Requirement
SP – Specialty Medication
HD – May require home delivery pharmacy

PPACA – No Cost-Share Preventive Medication
CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

CONTRACEPTIVES (Contraception Products)		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
CONTRACEPTIVES, INTRAVAGINAL, SYSTEMIC		
ANNOVERA VAGINAL RING	T3	QL (1 ring)
eluryng (Nuvaring)	T1	PPACA
etonogestrel-ethinyl estradiol (Nuvaring)	T1	PPACA
NUVARING *(eluryng)*	T3	
CONTRACEPTIVES, IMPLANTABLE		
NEXPLANON	T2	SP
CONTRACEPTIVES, INJECTABLE		
DEPO-PROVERA *(medroxyprogesterone acetate)*	T3	QL (1 ml/90 days) PPACA
DEPO-SUBQ PROVERA	T3	QL (1 ml/68 days)
medroxyprogesterone acetate (Depo-Provera)	T1	QL (1 ml/68 days) PPACA
CONTRACEPTIVES, INTRAVAGINAL		
gynol ii	T1	PPACA
TODAY CONTRACEPTIVE SPONGE	T2	PPACA
vcf	T1	PPACA
CONTRACEPTIVES, ORAL		
afirmelle	T1	HD PPACA
AFTERA *(aftera)*	T3	QL HD PPACA
altavera	T1	HD PPACA
alyacen	T1	HD PPACA
amethia (Seasonique)	T1	HD PPACA
amethia lo (Loseasonique)	T1	HD PPACA
amethyst	T1	HD PPACA
apri	T1	HD PPACA
aranelle	T1	HD PPACA
ashlyna (Seasonique)	T1	HD PPACA
aubra	T1	HD PPACA
aubra eq	T1	HD PPACA
aurovela (Loestrin)	T1	HD PPACA
aurovela 24 fe	T1	HD PPACA
aurovela fe (Loestrin Fe)	T1	HD PPACA
aviane	T1	HD PPACA
ayuna	T1	HD PPACA
azurette (Mircette)	T1	HD PPACA
balziva	T1	HD PPACA

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

PA – Prior Authorization
QL – Quantity Limit
ST – Step Therapy

AGE – Age Requirement
SP – Specialty Medication
HD – May require home delivery pharmacy

PPACA – No Cost-Share Preventive Medication
CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

CONTRACEPTIVES (Contraception Products) (cont.)		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
CONTRACEPTIVES, ORAL (cont.)		
bekyree (Mircette)	T1	HD PPACA
BEYAZ *(drospirenone-eth estra-levomef)*	T3	HD
blisovi 24 fe	T1	HD PPACA
blisovi fe (Loestrin Fe)	T1	HD PPACA
briellyn	T1	HD PPACA
camila	T1	HD PPACA
camrese (Seasonique)	T1	HD PPACA
camrese lo (Loseasonique)	T1	HD PPACA
caziant	T1	HD PPACA
chateal	T1	HD PPACA
chateal eq	T1	HD PPACA
cryselle	T1	HD PPACA
cyclafem	T1	HD PPACA
cyred	T1	HD PPACA
cyred eq	T1	HD PPACA
dasetta	T1	HD PPACA
daysee (Seasonique)	T1	HD PPACA
deblitane	T1	HD PPACA
desog-e.estradiol/e.estradiol	T1	HD PPACA
desog-e.estradiol/e.estradiol	T1	PPACA
desogestrel-ethinyl estradiol	T1	
desogestr-eth estrad eth estra (Mircette)	T1	HD PPACA
drospirenone-eth estra-levomef (Beyaz)	T1	HD PPACA
drospirenone-eth estra-levomef (Safyral)	T1	HD PPACA
drospirenone-ethinyl estradiol (Yasmin 28)	T1	HD PPACA
drospirenone-ethinyl estradiol (Yaz)	T1	HD PPACA
econtra ez (Plan B One-Step)	T1	QL HD PPACA
econtra one-step (Plan B One-Step)	T1	QL HD PPACA
elinest	T1	HD PPACA
ELLA	T2	QL HD PPACA
emoquette	T1	HD PPACA
enpresse	T1	HD PPACA
enskyce	T1	HD PPACA
errin	T1	HD PPACA

T1 – Typically Generics
T2 – Typically Preferred Brands
T3 – Typically Non-Preferred Brands
PA – Prior Authorization
QL – Quantity Limit
ST – Step Therapy
AGE – Age Requirement
SP – Specialty Medication
HD – May require home delivery pharmacy
PPACA – No Cost-Share Preventive Medication
CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

CONTRACEPTIVES (Contraception Products) (cont.)		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
CONTRACEPTIVES, ORAL (cont.)		
estarylla	T1	HD PPACA
ethynodiol-ethinyl estradiol	T1	HD PPACA
ethinyl estradiol/drospirenone (Yasmin 28)	T1	PPACA
falmina	T1	HD PPACA
fayosim (Quartette)	T1	HD PPACA
femynor	T1	HD PPACA
gianvi (Yaz)	T1	HD PPACA
hailey (Loestrin)	T1	HD PPACA
hailey 24 fe	T1	HD PPACA
heather	T1	HD PPACA
incassia	T1	HD PPACA
introvale	T1	HD PPACA
isibloom	T1	HD PPACA
jasmiel (Yaz)	T1	HD PPACA
jencycla	T1	
jolessa	T1	HD PPACA
juleber	T1	HD PPACA
junel (Loestrin)	T1	HD PPACA
junel fe	T1	HD PPACA
junel fe (Loestrin Fe)	T1	HD PPACA
kaitlib fe (Generess Fe)	T1	HD PPACA
kalliga	T1	HD PPACA
kariva (Mircette)	T1	HD PPACA
kelnor 1-35	T1	HD PPACA
kelnor 1-50	T1	HD PPACA
l-norgest/e.estradiol-e.estrad	T1	HD PPACA
larin (Loestrin)	T1	HD PPACA
larin fe	T1	HD PPACA
larin fe (Loestrin Fe)	T1	HD PPACA
larissia	T1	HD PPACA
layolis fe (Generess Fe)	T1	HD
leena	T1	HD PPACA
lessina	T1	HD PPACA
levonest	T1	HD PPACA

T1 – Typically Generics
T2 – Typically Preferred Brands
T3 – Typically Non-Preferred Brands
PA – Prior Authorization
QL – Quantity Limit
ST – Step Therapy
AGE – Age Requirement
SP – Specialty Medication
HD – May require home delivery pharmacy
PPACA – No Cost-Share Preventive Medication
CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

CONTRACEPTIVES (Contraception Products) (cont.)		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
CONTRACEPTIVES, ORAL (cont.)		
levonorgestrel (Plan B One-Step)	T1	QL HD PPACA
levonorgestrel-eth estradiol	T1	HD PPACA
levonorgestrel-eth estradiol	T1	
levonorg-eth estrad eth estrad (Loseasonique)	T1	HD PPACA
levonorg-eth estrad eth estrad (Quartette)	T1	HD PPACA
levonorg-eth estrad eth estrad (Seasonique)	T1	HD PPACA
levora	T1	HD PPACA
lillow	T1	HD PPACA
loryna (Yaz)	T1	HD PPACA
low-ogestrel	T1	HD PPACA
lo-zumandimine (Yaz)	T1	HD PPACA
lutera	T1	HD PPACA
lyza	T1	HD PPACA
marlissa	T1	HD PPACA
melodetta 24 fe (Minastrin 24 Fe)	T1	HD PPACA
microgestin (Loestrin)	T1	HD PPACA
microgestin fe (Loestrin Fe)	T1	HD PPACA
mili	T1	HD PPACA
mono-linyah	T1	HD PPACA
my choice (Plan B One-Step)	T1	QL HD PPACA
my way (Plan B One-Step)	T1	QL HD PPACA
necon	T1	HD PPACA
new day (Plan B One-Step)	T1	QL HD PPACA
nikki (Yaz)	T1	HD PPACA
nora-be	T1	HD PPACA
norethindrone ac/eth estradiol (Loestrin)	T1	HD PPACA
norethindrone acetate	T1	HD PPACA
norethindrone-ethin estradiol (Loestrin)	T1	HD PPACA
norethin-eth estra ferrous fum (Generess Fe)	T1	HD PPACA
norethin-eth estra ferrous fum (Loestrin Fe)	T1	HD PPACA
norethin-eth estra ferrous fum (Minastrin 24 Fe)	T1	HD PPACA
norethin-eth estra ferrous fum (Minastrin 24 Fe)	T1	
norgestimate-ethinyl estradiol	T1	HD PPACA
norgestimate-ethinyl estradiol	T1	

T1 – Typically Generics
T2 – Typically Preferred Brands
T3 – Typically Non-Preferred Brands
PA – Prior Authorization
QL – Quantity Limit
ST – Step Therapy
AGE – Age Requirement
SP – Specialty Medication
HD – May require home delivery pharmacy
PPACA – No Cost-Share Preventive Medication
CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

CONTRACEPTIVES (Contraception Products) (cont.)		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
CONTRACEPTIVES, ORAL (cont.)		
norgestrel-ethiny estra	T1	
norlyda	T1	HD PPACA
nortrel	T1	HD PPACA
ocella (Yasmin 28)	T1	HD PPACA
ogestrel	T1	
opcicon one-step (Plan B One-Step)	T1	QL HD PPACA
option 2 (Plan B One-Step)	T1	QL HD PPACA
orsythia	T1	HD PPACA
ORTHO-NOVUM *(alyacen)*	T3	
philith	T1	HD PPACA
pimtrea (Mircette)	T1	HD PPACA
pirmella	T1	HD PPACA
PLAN B ONE-STEP *(aftera)*	T2	QL HD PPACA
portia	T1	HD PPACA
previfem	T1	HD PPACA
reclipsen	T1	HD PPACA
rivelsa (Quartette)	T1	HD PPACA
setlakin	T1	HD PPACA
sharobel	T1	HD PPACA
simliya (Mircette)	T1	HD PPACA
simpesse (Seasonique)	T1	HD PPACA
sprintec	T1	HD PPACA
sronyx	T1	HD PPACA
syeda (Yasmin 28)	T1	HD PPACA
TAKE ACTION *(aftera)*	T3	QL HD PPACA
tarina fe	T1	HD PPACA
tarina fe (Loestrin Fe)	T1	HD PPACA
tilia fe (Estrostep Fe)	T1	HD PPACA
tri femynor	T1	HD PPACA
tri-estarylla	T1	HD PPACA
tri-legest fe (Estrostep Fe)	T1	HD PPACA
tri-linyah	T1	HD PPACA
tri-lo-estarylla	T1	HD PPACA
tri-lo-marzia	T1	HD PPACA

T1 – Typically Generics
T2 – Typically Preferred Brands
T3 – Typically Non-Preferred Brands
PA – Prior Authorization
QL – Quantity Limit
ST – Step Therapy
AGE – Age Requirement
SP – Specialty Medication
HD – May require home delivery pharmacy
PPACA – No Cost-Share Preventive Medication
CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

CONTRACEPTIVES (Contraception Products) (cont.)		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
CONTRACEPTIVES, ORAL (cont.)		
tri-lo-mili	T1	HD PPACA
tri-lo-sprintec	T1	HD PPACA
tri-mili	T1	HD PPACA
tri-previfem	T1	HD PPACA
tri-sprintec	T1	HD PPACA
trivora	T1	HD PPACA
tri-vylibra	T1	HD PPACA
tulana	T1	HD PPACA
tydemy (Safyral)	T1	HD PPACA
velivet	T1	HD PPACA
vienva	T1	HD PPACA
viorele (Mircette)	T1	HD PPACA
vyfemla	T1	HD PPACA
vylibra	T1	HD PPACA
wera	T1	HD PPACA
wymzya fe	T1	HD PPACA
YAZ *(drospirenone-ethinyl estradiol)*	T3	HD
zarah (Yasmin 28)	T1	HD PPACA
zovia	T1	HD PPACA
zumandimine (Yasmin 28)	T1	HD PPACA
CONTRACEPTIVES, TRANSDERMAL		
norelgestromin/ethin.estradiol	T1	PPACA
xulane	T1	HD PPACA
DIAPHRAGMS/CERVICAL CAP		
CAYA CONTOURED	T3	PPACA
FEMCAP	T2	PPACA
WIDE SEAL DIAPHRAGM	T3	PPACA
INTRA-UTERINE DEVICES (IUDS)		
KYLEENA	T2	SP
LILETTA	T3	SP
MIRENA	T2	SP
PARAGARD T 380-A	T3	SP
SKYLA	T2	SP

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

PA – Prior Authorization
QL – Quantity Limit
ST – Step Therapy

AGE – Age Requirement
SP – Specialty Medication
HD – May require home delivery pharmacy

PPACA – No Cost-Share Preventive Medication
CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

CONTRACEPTIVES (Miscellaneous)		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
CONDOMS		
FC2 FEMALE CONDOM	T2	PPACA
COUGH/COLD PREPARATIONS (Cough/Cold Medications)		
ANTI-TUSSIVES, NON-OPIOID		
benzonatate (Tessalon Perle)	T1	
TESSALON PERLE *(benzonatate)*	T3	
NON-OPIOID ANTI-TUS-IST GEN.ANTIHISTAMINE-DECONGEST		
BROMFED-DM *(bromfed dm)*	T3	
bromipheniramin-pseudoephed-dm	T1	
brompheniramine w/pseudoephed	T1	
NON-OPIOID ANTI-TUSSIVE-IST GEN ANTIHISTAMINE COMB.		
promethazine w/dm	T1	
OPIOID ANTITUSSIV-IST GEN. ANTIHISTAMINE-DECONGEST		
CAPCOF	T3	
HISTEX-AC	T3	
MAXI-TUSS CD	T3	
POLY-TUSSIN AC	T3	
promethazine vc w/codeine	T1	
OPIOID ANTI-TUSSIVE-IST GENERATION ANTIHISTAMINE		
hydrocodone-chlorpheniramine	T1	
promethazine w/codeine	T1	
TUXARIN ER	T3	
TUZISTRA XR	T3	PA
Z-TUSS AC	T3	
OPIOID ANTI-TUSSIVE-ANTI-CHOLINERGIC COMBINATIONS		
hydrocodone compound	T1	
hydrocodone/homatropine	T1	
hydromet	T1	
OPIOID ANTITUSSIVE-DECONGESTANT-EXPECTORANT COMB		
CODITUSSIN DAC	T3	
guaifenesin dac	T1	
lortuss ex	T1	
virtussin dac	T1	
OPIOID ANTI-TUSSIVE-EXPECTORANT COMBINATION		
CODITUSSIN AC	T3	

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

PA – Prior Authorization
QL – Quantity Limit
ST – Step Therapy

AGE – Age Requirement
SP – Specialty Medication
HD – May require home delivery pharmacy

PPACA – No Cost-Share Preventive Medication
CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

COUGH/COLD PREPARATIONS (Cough/Cold Medications) (cont.)		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
OPIOID ANTI-TUSSIVE-EXPECTORANT COMBINATION (cont.)		
g tussin ac (Virtussin Ac)	T1	
guaifenesin ac (Virtussin Ac)	T1	
guaifenesin with codeine (Virtussin Ac)	T1	
guiatussin ac (Virtussin Ac)	T1	
MAR-COF CG	T3	
m-clear wc	T1	
NINJACOF-XG	T3	
virtussin ac (Virtussin Ac)	T1	
DIAGNOSTIC (Diabetes)		
BLOOD SUGAR DIAGNOSTICS		
FREESTYLE TEST STRIPS	T2	
FREESTYLE PRECISION NEO	T2	
HUMANA TRUE METRIX TEST STRIP	T2	
PRECISION XTRA	T2	
RELION TRUE METRIX TEST STRIP	T2	
TRUE METRIX GLUCOSE TEST STRIP	T2	
TRUETRACK GLUCOSE TEST STRIPS	T2	
URINE GLUCOSE TEST AIDS		
DIASTIX REAGENT	T2	
DIAGNOSTIC (Miscellaneous)		
BLOOD TESTING PREPARATIONS		
FORA GTEL KETONE TEST STRIP	T3	
NOVAMAX PLUS	T2	
PRECISION XTRA	T2	
CARDIOVASCULAR DIAGNOSTICS-RADIOPAQUE		
OMNIPAQUE	T3	
DIAGNOSTIC PREPARATIONS, MISCELLANEOUS		
ARIDOL	T3	
PROVOCHOLINE	T3	
TC 99M SULFUR COLLOID PREP	T3	
TOXICOLOGY SALIVA COLLECTION	T3	
VUEBLU	T3	

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

PA – Prior Authorization
QL – Quantity Limit
ST – Step Therapy

AGE – Age Requirement
SP – Specialty Medication
HD – May require home delivery pharmacy

PPACA – No Cost-Share Preventive Medication
CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

DIAGNOSTIC (Miscellaneous) (cont.)		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
DIAGNOSTIC TEST DEVICES AND SUPPLIES		
BD VERITOR SYSTEM SARS-COV[1]2	T2	
BINAXNOW COVD AG CARD HOME TST	T2	
BINAXNOW COVID-19 AG CARD	T2	
BINAXNOW COVID-19 AG SELF TEST	T2	
COVID19 SPECIMEN COLLECT NCPDP	T2	
CVS COVID19 TEST BY PHARMACIST	T2	
ELLUME COVID-19 HOME TEST	T2	
FLOWFLEX COVID-19 AG HOME TEST	T2	
INTELISWAB COVID-19 RAPID TEST	T2	
QUICKVUE AT-HOME COVID-19 TEST	T2	
QUICKVUE SARS ANTIGEN TEST	T2	
RAPID RESPONSE COVID-19 TEST	T2	
SOFIA SARS ANTIGEN FIA TEST	T2	
SOFIA2 FLU-SARS ANTIGEN FIA	T2	
VERITOR SARS-COV-2 AND FLU A-B	T2	
EYE DIAGNOSTIC AGENTS		
bio glo (Fluor-I-Strip At)	T1	
ful-glo (Fluor-I-Strip At)	T1	
glostrips (Fluor-I-Strip At)	T1	
GASTROINTESTINAL RADIOPAQUE DIAGNOSTICS		
SITZMARKS FOR KIDS	T3	
RADIOACTIVE METABOLIC FUNCTION DIAGNOSTICS		
SODIUM IODIDE I-123	T3	
DIURETICS (Diuretics)		
ARGININE VASOPRESSIN (AVP) RECEPTOR ANTAGONISTS		
JYNARQUE	T3	PA QL SP
SAMSCA 15 MG TABLET	T2	PA QL (30 units/30 days) SP
SAMSCA 30 MG TABLET	T3	PA QL SP
CARBONIC ANHYDRASE INHIBITORS		
acetazolamide	T1	HD
methazolamide	T1	HD
LOOP DIURETICS		
bumetanide	T1	HD
EDECRIN *(ethacrynic acid)*	T3	ST

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

PA – Prior Authorization
QL – Quantity Limit
ST – Step Therapy

AGE – Age Requirement
SP – Specialty Medication
HD – May require home delivery pharmacy

PPACA – No Cost-Share Preventive Medication
CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

DIURETICS (Diuretics) (cont.)		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
LOOP DIURETICS (cont.)		
ethacrynic acid (Edecrin)	T1	
furosemide	T1	HD
FUROSEMIDE	T3	HD
furosemide (Lasix)	T1	HD
LASIX *(furosemide)*	T3	HD
torsemide	T1	HD
torsemide	T1	
OSMOTIC DIURETICS		
RESECTISOL	T2	
POLYCYSTIC KIDNEY DISEASE AGENT, AVP RECEP. ANTAG		
tolvaptan 15 mg tablet (Jynarque)	T1	PA SP HD
tolvaptan 15 mg-15 mg tablet (Jynarque)	T1	PA SP HD
tolvaptan 30 mg tablet (Jynarque)	T1	PA SP HD
tolvaptan 30 mg-15 mg tablet (Jynarque)	T1	PA SP HD
tolvaptan 45 mg-15 mg tablet (Jynarque)	T1	PA SP HD
tolvaptan 60 mg-30 mg tablet (Jynarque)	T1	PA SP HD
tolvaptan 90 mg-30 mg tablet (Jynarque)	T1	PA SP HD
JYNARQUE 15 MG TABLET *(tolvaptan)*	T3	PA SP HD
JYNARQUE 15 MG-15 MG TABLET *(tolvaptan)*	T3	PA SP HD
JYNARQUE 30 MG TABLET *(tolvaptan)*	T3	PA SP HD
JYNARQUE 30 MG-15 MG TABLET *(tolvaptan)*	T3	PA SP HD
JYNARQUE 45 MG-15 MG TABLET *(tolvaptan)*	T3	PA SP HD
JYNARQUE 60 MG-30 MG TABLET *(tolvaptan)*	T3	PA SP HD
JYNARQUE 90 MG-30 MG TABLET *(tolvaptan)*	T3	PA SP HD
POTASSIUM SPARING DIURETICS		
ALDACTONE *(spironolactone)*	T3	HD
amiloride hcl	T1	HD
CAROSPIR	T3	PA HD
DYRENIUM *(triamterene)*	T3	HD
eplerenone (Inspra)	T1	HD
INSPRA *(eplerenone)*	T3	HD
KERENDIA 10 MG TABLET	T2	PA QL (30 tabs/30 days)
KERENDIA 20 MG TABLET	T2	PA QL (30 tabs/30 days)
KERENDIA 40 MG TABLET	T2	PA

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

PA – Prior Authorization
QL – Quantity Limit
ST – Step Therapy

AGE – Age Requirement
SP – Specialty Medication
HD – May require home delivery pharmacy

PPACA – No Cost-Share Preventive Medication
CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

DIURETICS (Diuretics) (cont.)		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
POTASSIUM SPARING DIURETICS (cont.)		
spironolactone	T1	HD
spironolactone 100 mg tablet (Aldactone)	T1	HD
spironolactone 25 mg tablet (Aldactone)	T1	HD
spironolactone 25 mg/5 ml susp (Carospir)	T1	
spironolactone 50 mg tablet (Aldactone)	T1	HD
triamterene (Dyrenium)	T1	HD
POTASSIUM SPARING DIURETICS IN COMBINATION		
amiloride hcl w/hctz	T1	HD
DYAZIDE *(triamterene-hydrochlorothiazid)*	T3	HD
JYNARQUE 45-15mg tablets	T3	PA QL (56 tabs/30 days) SP
JYNARQUE 60-30mg tablets	T3	PA QL (56 tabs/30 days) SP
JYNARQUE 90-30mg tablets	T3	PA QL (56 tabs/30 days) SP
spironolact/hctz	T1	HD
spironolactone w/hctz (Aldactazide)	T1	HD
triamterene w/hctz (Dyazide)	T1	HD
THIAZIDE AND RELATED DIURETICS		
chlorthalidone	T1	HD
DIURIL	T3	HD
hydrochlorothiazide	T1	HD
indapamide	T1	HD
metolazone	T1	HD
EENT PREPS (Allergy/Nasal Sprays)		
NASAL ANTIHISTAMINE		
azelastine hcl	T1	QL HD
olopatadine hcl (Patanase)	T1	QL HD
PATANASE *(olopatadine hcl)*	T3	QL HD
NASAL ANTIHISTAMINE AND ANTI-INFLAM. STEROID COMB.		
RYALTRIS 665-25MCG SPRAY	T3	ST QL HD
NASAL ANTI-INFLAMMATORY STEROIDS		
FLONASE ALLERGY RELIEF 50mcg NASAL SPRAY (15.8 PS)	T3	
FLONASE ALLERGY RELIEF 50mcg NASAL SPRAY (9.9 PS)	T2	
FLONASE SENSIMIST 27.5mcg (5.9, 9.9)	T2	
FLONASE SENSIMIST 27.5mcg (9.1, 15.8)	T2	
flunisolide	T1	QL HD

T1 – Typically Generics
T2 – Typically Preferred Brands
T3 – Typically Non-Preferred Brands
PA – Prior Authorization
QL – Quantity Limit
ST – Step Therapy
AGE – Age Requirement
SP – Specialty Medication
HD – May require home delivery pharmacy
PPACA – No Cost-Share Preventive Medication
CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

EENT PREPS (Allergy/Nasal Sprays) (cont.)		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
NASAL ANTI-INFLAMMATORY STEROIDS (cont.)		
fluticasone propionate	T1	QL HD
mometasone (Nasonex)	T1	QL HD
NASACORT ALLERGY 24 hour SPRAY (10.8 PS)	T2	
NASACORT ALLERGY 24 hour SPRAY (16.9 PS)	T2	
NASONEX	T3	ST SP
RHINOCORT ALLERGY RELIEF 50mcg NASAL SPRAY	T2	
RHINOCORT AQUA NASAL SPRAY	T2	
XHANCE	T2	ST QL (32 mls/30 days) HD
NOSE PREPARATIONS, MISCELLANEOUS (RX)		
COCAINE HCL	T3	
GOPRELTO	T3	
ipratropium bromide	T1	QL (30 units/30 days) HD
NUMBRINO	T3	
NOSE PREPARATIONS, VASOCONSTRICTORS (RX)		
ADRENALIN CHLORIDE	T3	
EENT PREPS (Ear Medications)		
EAR PREPARATIONS ANTI-INFLAMMATORY		
DERMOTIC *(flac otic oil)*	T3	
flac otic oil (Dermotic)	T1	
fluocinolone acetonide oil (Dermotic)	T1	
EAR PREPARATIONS, MISC. ANTI-INFECTIVES		
acetic acid	T1	
acetic acid/hydrocortisone	T1	
CORTANE-B *(hc pramoxine)*	T3	
EENT PREPS (Eye Conditions)		
AGENTS FOR CORNEAL COLLAGEN CROSS-LINKING		
PHOTREXA CROSS-LINKING	T3	
PHOTREXA VISCOUS	T3	
ARTIFICIAL TEARS		
KLARITY (CHONDROITIN)	T3	
LACRISERT	T3	PA
MIEBO	T2	PA QL (3 mls/fill)

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

PA – Prior Authorization
QL – Quantity Limit
ST – Step Therapy

AGE – Age Requirement
SP – Specialty Medication
HD – May require home delivery pharmacy

PPACA – No Cost-Share Preventive Medication
CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

EENT PREPS (Eye Conditions) (cont.)		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
EYE ANTI-INFECTIVES (RX ONLY)		
BETADINE	T3	
povidone-iodine	T1	
EYE ANTI-INFLAMMATORY AGENTS		
bromfenac sodium (Bromsite)	T1	
bromfenac sodium (Prolensa)	T1	
DEXTENZA	T3	
DUREZOL	T3	ST
EYSUVIS	T2	PA QL (8.3 mls/30 days)
fluorometholone (Fml)	T1	
flurbiprofen	T1	
FML *(fluorometholone)*	T3	
ILEVRO	T3	
INVELTYS	T3	ST
ketorolac (Acular LS)	T1	
ketorolac (Acular)	T1	
KLARITY-L (LOTEPREDNOL-CHONDR)	T3	
LOTEMAX DROPS *(loteprednol etabonate)*	T3	
LOTEMAX GEL, OINTMENT	T3	ST
LOTEMAX SM	T3	ST
loteprednol etabonate (Alrex)	T1	PA SP HD
loteprednol etabonate (Lotemax)	T1	PA SP HD
PRED FORTE *(prednisolone)*	T3	
prednisolone acetate (Pred Forte)	T1	
PREDNISOLONE-NEPAFENAC	T3	
prednisolone phosphate	T1	
prednisolone sod ph/bromfenac	T1	
PROLENSA *(bromfenac sodium)*	T3	ST
EYE IRRIGATIONS		
balanced salt (BSS)	T1	
EYE LOCAL ANESTHETICS		
AKTEN	T3	
ALCAINE *(proparacaine hcl)*	T3	
altacaine	T1	
ALTAFLUOR BENOX	T3	

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

PA – Prior Authorization
QL – Quantity Limit
ST – Step Therapy

AGE – Age Requirement
SP – Specialty Medication
HD – May require home delivery pharmacy

PPACA – No Cost-Share Preventive Medication
CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

EENT PREPS (Eye Conditions) (cont.)		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
EYE LOCAL ANESTHETICS (cont.)		
proparacaine hcl (Alcaine)	T1	
proparacaine-fluorescein	T1	
tetracaine hcl	T1	
EYE MAST CELL STABILIZERS		
ALOCRIL	T3	ST
cromolyn	T1	
pilocarpine hcl (Isopto Carpine)	T1	HD
SIMBRINZA	T3	HD
timolol maleate (Istalol)	T1	HD
timolol maleate (Timoptic)	T1	HD
timolol maleate (Timoptic-XE)	T1	HD
TIMOLOL-BRIMONIDIN-DORZOLAMIDE	T3	HD
TIMOLOL-BRIMONI-DORZOL-LATANOP	T3	HD
TIMOLOL-DORZOLAMIDE-LATANOPRST	T3	HD
TIMOLOL-LATANOPROST	T3	HD
TIMOPTIC *(timolol maleate)*	T3	ST HD
TIMOPTIC-XE *(timolol maleate)*	T3	ST HD
travoprost (Travatan Z)	T1	HD
TRUSOPT *(dorzolamide hcl)*	T3	ST HD
VYZULTA	T3	ST HD
EYE MYDRIATIC AND NSAID COMBINATIONS		
MYDRIATIC4 (TROP-PROP-PE-KTRLC)	T3	
EYE PREPARATIONS, MISCELLANEOUS (OTC)		
GELFILM	T3	
EYE VASOCONSTRICTORS		
phenylephrine hcl	T1	
MIOTICS AND OTHER INTRAOCULAR PRESSURE REDUCERS		
ALPHAGAN P 0.1% DROPS	T3	ST HD
ALPHAGAN P 0.15% DROPS *(brimonidine tartrate)*	T3	HD
apraclonidine hcl	T1	HD
betaxolol hcl	T1	HD
BETOPTIC S	T3	HD
bimatoprost	T1	HD

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

PA – Prior Authorization
QL – Quantity Limit
ST – Step Therapy

AGE – Age Requirement
SP – Specialty Medication
HD – May require home delivery pharmacy

PPACA – No Cost-Share Preventive Medication
CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

EENT PREPS (Eye Conditions) (cont.)		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
MIOTICS AND OTHER INTRAOCULAR PRESSURE REDUCERS (cont.)		
BIMATOPROST-BRIMONIDINE-DORZOL	T3	HD
BIMATOPROST-DORZOLAMID-TIMOLOL	T3	HD
BRIMONIDINE 0.1%-DORZOLAM 2%	T3	
BRIMONIDINE 0.15%-DORZOLAM 2%	T3	HD
brimonidine tartrate (Alphagan P)	T1	HD
carteolol hcl	T1	HD
COMBIGAN	T3	HD
DORZOLAMIDE HCL	T3	HD
dorzolamide hcl	T1	HD
DORZOLAMIDE-TIMOLOL	T3	HD
dorzolamide-timolol (Cosopt PF)	T1	HD
dorzolamide-timolol (Cosopt)	T1	HD
IOPIDINE	T3	ST HD
ISOPTO CARPINE *(pilocarpine hcl)*	T3	HD
LATANOPROST	T3	HD
latanoprost (Xalatan)	T1	HD
levobunolol hcl	T1	HD
miostat (Miostat)	T1	HD
PHOSPHOLINE IODIDE	T2	HD
pilocarpine 1%, 2% eye drops	T1	HD
pilocarpine 4% eye drops	T1	HD
RHOPRESSA	T3	
ROCKLATAN	T3	PA
timolol (Betimol)	T1	ST HD
timolol 0.25% gel-solution (Timoptic-Xe)	T1	ST HD
timolol 0.5% eye drop (Istalol)	T1	ST HD
timolol 0.5% gel-solution (Timoptic-Xe)	T1	ST HD
timolol 0.5% gfs gel-solution (Timoptic-Xe)	T1	ST HD
TIMOLOL-BIMATOPROST	T3	HD
TIMOLOL-DORZOLAMIDE-BIMATOPRST	T3	HD
timolol maleate 0.25% eye drop	T1	ST HD
timolol maleate 0.25% eye drop (Timoptic)	T1	HD
timolol maleate 0.5% eye drop (Timoptic Ocudose)	T1	ST HD
timolol maleate 0.5% eye drops (Timoptic)	T1	HD

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

PA – Prior Authorization
QL – Quantity Limit
ST – Step Therapy

AGE – Age Requirement
SP – Specialty Medication
HD – May require home delivery pharmacy

PPACA – No Cost-Share Preventive Medication
CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

EENT PREPS (Eye Conditions) (cont.)		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
MYDRIATICS		
atropine	T1	HD
atropine 1% eye drops	T1	PA SP HD
atropine sulf 0.025% eye drop	T1	HD
atropine sulfate 0.01% eye drp	T1	PA SP HD
ATROPINE SULF 0.025% EYE DROP	T3	HD
ATROPINE SULFATE 0.05% EYE DRP	T3	HD
CYCLOGYL *(cyclopentolate hcl)*	T3	HD
CYCLOMYDRIL	T3	HD
cyclopentolate hcl	T1	HD
cyclopentolate hcl (Cyclogyl)	T1	HD
CYCLOPENTOLATE-TROPICAMIDE-PE	T3	HD
homatropaire	T1	HD
MYDCOMBI	T3	HD
MYDRIACYL *(tropicamide)*	T3	HD
PAREMYD	T3	HD
tropicamide	T1	HD
tropicamide (Mydriacyl)	T1	HD
TROPICAMIDE-CYCLOPENTOLATE-PE	T3	
tropicamide 1%-phenylephr 2.5%	T1	
TROPICAMIDE 1%-PHENYLEPHR 2.5%	T3	
OPHTH VASC. ENDOTHELIAL GROWTH FACTOR ANTAGONISTS		
MACUGEN	T3	PA
OPHTH. VEGF-A RECEPTOR ANTAG. RCMB MC ANTIBODY		
LUCENTIS	T3	PA SP
OPHTHALMIC ANTI-FIBROTIC AGENTS		
MITOMYCIN-WATER	T3	
MITOSOL	T3	
OPHTHALMIC ANTI-INFLAMMATORY IMMUNOMODULATOR-TYPE		
CEQUA	T3	PA QL (60 vls/30 days)
CYCLOSPORINE IN KLARITY	T3	HD
RESTASIS	T3	PA QL HD
RESTASIS MULTIDOSE	T2	PA QL HD
XIIDRA	T2	PA QL
VEVYE	T3	PA QL (2 mls/fill) HD

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

PA – Prior Authorization
QL – Quantity Limit
ST – Step Therapy

AGE – Age Requirement
SP – Specialty Medication
HD – May require home delivery pharmacy

PPACA – No Cost-Share Preventive Medication
CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

EENT PREPS (Eye Conditions) (cont.)		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
OPHTHALMIC CYSTINE DEPLETING AGENTS		
CYSTARAN	T2	SP
OPHTHALMIC HUMAN NERVE GROWTH FACTOR (HNGF)		
OXERVATE	T2	PA SP HD
OPHTHALMIC PREPARATIONS, MISCELLANEOUS		
biolon	T1	SP
OPHTHALMIC PROTEOLYTIC ENZYME AGENTS		
JETREA	T2	
OPHTHALMIC SURGICAL AIDS		
ocucoat (Cellugel)	T1	
OPHTHALMIC TRPM8 AGONISTS		
TRYPTYR	T3	PA
ELECT/CALORIC/H2O (Dental Products)		
FLUORIDE PREPARATIONS		
CLINPRO 5000	T3	
denta 5000 plus	T1	
dentagel	T1	
FLUORIDEX DAILY DEFENSE	T3	
FLUORIDEX SENSITIVITY RELIEF	T3	
FRAICHE 5000 PREVI	T3	
fluoritab	T1	PPACA
PREVIDENT	T3	
PREVIDENT 5000 ENAMEL PROTECT	T3	
PREVIDENT 5000 ORTHO DEFENSE	T3	
PREVIDENT 5000 SENSITIVE	T3	
PREVIDENT KIDS	T3	
sf	T1	
sf 5000 plus	T1	
sodium fluoride	T1	
sodium fluoride 5000 plus	T1	
sodium fluoride enamel protect	T1	
sodium fluoride sensitive	T1	
IRON REPLACEMENT		
ACCRUFER 30 MG CAPSULE	T3	
FERAHEME 510 MG/17 ML VIAL	T3	PA

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

PA – Prior Authorization
QL – Quantity Limit
ST – Step Therapy

AGE – Age Requirement
SP – Specialty Medication
HD – May require home delivery pharmacy

PPACA – No Cost-Share Preventive Medication
CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

ELECT/CALORIC/H2O (Diabetes)		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
AGENTS TO TREAT HYPOGLYCEMIA (HYPERGLYCEMICS)		
dex4 glucose	T1	
GLUCAGEN	T2	QL
GLUCAGON EMERGENCY KIT	T2	QL
gluco burst	T1	
GLUCO SHOT	T3	
glucose	T1	
GLUCOSE 2 GRAM GUMMY	T3	
GLUCOSE	T3	
glucose bits	T1	
glucose gel	T1	
glutose	T1	
GLUTOSE *(gluco burst)*	T2	
GVOKE	T2	
GVOKE SYRINGE	T2	QL
GLUCOSE 2 GRAM GUMMY	T3	
INSTA-GLUCOSE	T3	
LIQUID IRON	T3	
PROGLYCEM *(diazoxide)*	T3	
relion	T1	
TRUEPLUS	T3	
TRUEPLUS *(dex4 glucose)*	T3	
ELECT/CALORIC/H2O (Miscellaneous)		
NUCLEIC ACID/NUCLEOTIDE SUPPLEMENTS		
XURIDEN	T2	SP
ELECT/CALORIC/H2O (Nutritional/Dietary)		
CARBOHYDRATES		
ENFAMIL	T2	
GLUTOL	T2	
ELECTROLYTE DEPLETERS		
acetate	T1	
AURYXIA	T3	
CALCIUM 667mg	T3	QL (360 tabs/30 days)
kionex	T1	

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

PA – Prior Authorization
QL – Quantity Limit
ST – Step Therapy

AGE – Age Requirement
SP – Specialty Medication
HD – May require home delivery pharmacy

PPACA – No Cost-Share Preventive Medication
CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

ELECT/CALORIC/H2O (Nutritional/Dietary) (cont.)		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
ELECTROLYTE DEPLETERS (cont.)		
lanthanum carbonate (Fosrenol)	T1	QL (90 tabs/30 days)
LOKELMA	T2	QL (30 units/30 days)
polystyrene sulfonate	T1	
RENVELA *(sevelamer carbonate)*	T3	QL (270 tabs/30 days)
sps	T1	
VELPHORO	T3	QL (120 tabs/30 days)
VELTASSA 1 GM POWDER PACKET	T2	
VELTASSA 16.8 GM POWDER PACKET	T2	QL (30 packs/30 days)
VELTASSA 25.2 GM POWDER PACKET	T2	QL (30 packs/30 days)
VELTASSA 8.4 GM POWDER PACKET	T2	QL (30 packs/30 days)
FLUORIDE PREPARATIONS		
PREVIDENT KIDS	T3	
IODINE CONTAINING AGENTS		
lugol's	T1	
SSKI	T3	
strong iodine	T1	
IRON REPLACEMENT		
cvs iron 27 mg tablet (Fergon)	T1	
cvs iron 65 mg tablet	T1	
eql iron 65 mg tablet	T1	
ferrous fum/vit c/b12-if/folic	T1	PPACA
ferrous fumarate 324 mg tablet	T1	
FERROUS SULF 300 MG/5 ML CUP	T3	
ferrous sulf 15 mg iron/ml drp (Fer-In-Sol)	T1	
ferrous sulf 220 mg/5 ml elix, liq	T1	
ferrous sulf 300 mg/5 ml cup	T1	
ferrous sulf 300 mg/6.8ml soln	T1	
ferrous sulf 44 mg iron/5ml lq	T1	
ferrous sulf ec 324 mg, 325 mg tablet	T1	
ferrous sulfate 325 mg tablet	T1	
ft iron 65 mg tablet	T1	
FT IRON 45 MG TABLET	T3	
gnp iron 45 mg tablet	T1	
gnp iron 65 mg tablet	T1	

T1 – Typically Generics
T2 – Typically Preferred Brands
T3 – Typically Non-Preferred Brands
PA – Prior Authorization
QL – Quantity Limit
ST – Step Therapy
AGE – Age Requirement
SP – Specialty Medication
HD – May require home delivery pharmacy
PPACA – No Cost-Share Preventive Medication
CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

ELECT/CALORIC/H2O (Nutritional/Dietary) (cont.)		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
IRON REPLACEMENT (cont.)		
HEMATOGEN	T3	
iron 27 mg tablet	T1	
iron 27 mg tablet (Fergon)	T1	
iron 28 mg tablet	T1	
iron 45 mg tablet	T1	
iron 65 mg tablet	T1	
iron sucrose complex	T1	PA
NOVAFERRUM YAY IRON	T3	
iron-vitamin c 100-250 mg tab (Icar-C)	T1	PA SP HD
IRON-VITAMIN C 65-125 MG TAB	T2	PA SP HD
NOVAFERRUM ALL GOOD	T3	PA SP HD
NOVAFERRUM WOW	T3	PA SP HD
NOVAFERRUM YUMMY PEDIATRIC	T2	PA SP HD
ra iron 65 mg tablet	T1	
sm iron 65 mg tablet	T1	
sv iron 65 mg tablet	T1	
true ferrous sulf ec 324 mg tb	T1	
TULIVITE	T3	
PEDIATRIC VITAMIN PREPARATIONS		
fluoride	T1	PPACA
fluoritab	T1	PPACA
ludent fluoride	T1	PPACA
POTASSIUM REPLACEMENT		
chloride (Klor-Con 10)	T1	
chloride (Klor-Con 8)	T1	
chloride (K-Tab ER)	T1	
effer-k	T1	
klor-con	T1	
klor-con (Klor-Con 10)	T1	
klor-con (Klor-Con 8)	T1	
klor-con m	T1	
klor-con m (Klor-Con M15)	T1	
klor-con-ef	T1	
K-TAB	T3	

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

PA – Prior Authorization
QL – Quantity Limit
ST – Step Therapy

AGE – Age Requirement
SP – Specialty Medication
HD – May require home delivery pharmacy

PPACA – No Cost-Share Preventive Medication
CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

ELECT/CALORIC/H2O (Nutritional/Dietary) (cont.)		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
POTASSIUM REPLACEMENT (cont.)		
k-tab (Klor-Con 8)	T1	
potassium cl 10% (20 meq/15ml)	T1	
potassium cl 20 meq packet	T1	
potassium cl 20% (40 meq/15ml)	T1	
potassium cl er 10 meq capsule, tablet	T1	
potassium cl er 15 meq tablet	T1	
potassium cl er 20 meq tablet	T1	
potassium cl er 8 meq capsule, tablet	T1	
potassium cl10%(20meq/15ml)cup	T1	
potassium cl10%(40meq/30ml)cup	T1	
potassium cl20%(40meq/15ml)cup	T1	
POTASSIUM CL ER 15 MEQ TABLET	T1	
PROTEIN REPLACEMENT		
AQNEURSA	T2	PA SP
ELECT/CALORIC/H2O (Urinary Tract Conditions)		
URINARY PH MODIFIERS		
citric acid/sodium citrate	T1	HD
er (Urocit-K)	T1	HD
K-PHOS NO.2	T3	HD
K-PHOS ORIGINAL	T2	HD
ORACIT	T3	HD
potassium citrate	T1	HD
RENACIDIN	T2	HD
UROCIT-K *(potassium er)*	T3	HD
GASTROINTESTINAL (Cholesterol Medications)		
LIPOTROPICS		
LOVAZA *(omega-3 acid ethyl esters)*	T3	PA HD
omega-3 acid ethyl esters (Lovaza)	T1	PA HD
VASCEPA	T2	PA HD
GASTROINTESTINAL (Gastrointestinal/Heartburn)		
AMMONIA INHIBITORS		
BUPHENYL *(phenylbutyrate)*	T3	SP HD
enulose	T1	HD

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

PA – Prior Authorization
QL – Quantity Limit
ST – Step Therapy

AGE – Age Requirement
SP – Specialty Medication
HD – May require home delivery pharmacy

PPACA – No Cost-Share Preventive Medication
CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

GASTROINTESTINAL (Gastrointestinal/Heartburn) (cont.)		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
AMMONIA INHIBITORS (cont.)		
generlac	T1	HD
lactulose	T1	HD
LITHOSTAT	T3	HD
OLPRUVA DOSE KIT, DOSE ENVELOPE	T3	SP PA HD
phenylbutyrate (Buphenyl)	T1	SP HD
PHEBURANE	T2	PA SP
RAVICTI	T2	SP HD
ANTI-CHOLINERGICS, QUATERNARY AMMONIUM		
clidinium w/chlordiazepoxide (Librax)	T1	
CUVPOSA	T3	
GLYCATE	T3	
glycopyrrolate (Glycate)	T1	
propantheline bromide	T1	
ANTI-CHOLINERGICS/ANTI-SPASMODICS		
dicyclomine 10 mg capsule	T1	
dicyclomine 10 mg/5 ml soln	T1	
dicyclomine 20 mg tablet	T1	
ANTI-DIARRHEAL - TRYPTOPHAN HYDROXYLASE INHIBITOR		
XERMELO	T2	PA QL (84 tabs/28 days) SP
ANTI-DIARRHEALS		
diphenoxylate w/atropine (Lomotil)	T1	
LOMOTIL *(diphenoxylate-atropine)*	T3	
MOTOFEN	T3	
opium	T1	
ANTI-EMETIC, CANNABINOID-TYPE		
dronabinol (Marinol)	T1	PA
SYNDROS	T3	PA
ANTI-EMETIC/ANTI-VERTIGO AGENTS		
aprepitant	T1	QL
aprepitant (Emend)	T1	QL
BONJESTA	T3	QL (60 tabs/dispense)
compro	T1	
DICLEGIS *(doxylamine succ-pyridoxine hcl)*	T3	QL (720 tabs/365 days)
doxylamine succ-pyridoxine hcl (Diclegis)	T1	QL (720 tabs/365 days)

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

PA – Prior Authorization
QL – Quantity Limit
ST – Step Therapy

AGE – Age Requirement
SP – Specialty Medication
HD – May require home delivery pharmacy

PPACA – No Cost-Share Preventive Medication
CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

GASTROINTESTINAL (Gastrointestinal/Heartburn) (cont.)		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
ANTI-EMETIC/ANTI-VERTIGO AGENTS (cont.)		
fosaprepitant dimeglumine (Emend)	T1	
granisetron hcl	T1	QL
meclizine 50 mg tablet	T1	
ondansetron hcl (Zofran)	T1	QL
ondansetron odt 4 mg tablet	T1	QL (9 tabs/30 days)
ondansetron odt 8 mg tablet	T1	QL (9 tabs/30 days)
phenadoz	T1	
prochlorperazine maleate	T1	
promethazine hcl	T1	
promethegan	T1	
SANCUSO	T3	QL
scopolamine (Transderm-Scop)	T1	
trimethobenzamide hcl	T1	
VARUBI	T2	QL
ZOFRAN *(ondansetron hcl)*	T3	QL
ANTI-ULCER PREPARATIONS		
CYTOTEC *(misoprostol)*	T3	HD
misoprostol (Cytotec)	T1	HD
sucralfate (Carafate)	T1	HD
ANTI-ULCER-H.PYLORI AGENTS		
lansoprazol-amoxicil-clarithro	T1	QL
OMECLAMOX-PAK	T3	QL
TALICIA	T2	QL
VOQUEZNA DUAL PAK	T3	
VOQUEZNA TRIPLE PAK	T3	
BELLADONNA ALKALOIDS		
anaspaz (Anaspaz)	T1	HD
belladonna-phenobarbital (Donnatal)	T1	HD
DONNATAL *(phenohytro)*	T3	HD
ed-spaz (Anaspaz)	T1	HD
hyoscyamine	T1	HD
hyoscyamine (Anaspaz)	T1	HD
hyoscyamine (Levbid)	T1	HD
hyoscyamine (Levsin)	T1	HD

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

PA – Prior Authorization
QL – Quantity Limit
ST – Step Therapy

AGE – Age Requirement
SP – Specialty Medication
HD – May require home delivery pharmacy

PPACA – No Cost-Share Preventive Medication
CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

GASTROINTESTINAL (Gastrointestinal/Heartburn) (cont.)		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
BELLADONNA ALKALOIDS (cont.)		
hyoscyamine (Levsin-SL)	T1	HD
hyosyne	T1	HD
LEVBID (hyoscyamine er)	T3	HD
LEVSIN (hyoscyamine)	T3	HD
LEVSIN-SL (hyoscyamine)	T3	HD
methscopolamine bromide	T1	HD
NULEV *(ed-spaz)*	T3	HD
oscimin (Levsin)	T1	HD
oscimin sl (Levsin-SL)	T1	HD
oscimin sr (Levbid)	T1	HD
PHENOBARBITAL-BELLADONNA *(phenobarb/hyoscy/atropine/scop)*	T3	HD
phenohytro (Donnatal)	T1	HD
SYMAX DUOTAB	T3	HD
symax-sl (Levsin-SL)	T1	HD
symax-sr (Levbid)	T1	HD
BILE SALTS		
ACTIGALL *(ursodiol)*	T3	HD
CHENODAL	T2	PA SP HD
CHOLBAM	T2	PA QL SP HD
CTEXLI	T2	PA SP
URSO FORTE *(ursodiol)*	T3	HD
ursodiol (Actigall)	T1	HD
ursodiol (Urso Forte)	T1	HD
CHRONIC INFLAM. COLON DX, 5-A-SALICYLAT, RECTAL TX		
mesalamine (Canasa)	T1	
mesalamine (Rowasa)	T1	
mesalamine (Sfrowasa)	T1	
ROWASA *(mesalamine)*	T3	
SFROWASA *(mesalamine)*	T3	
DRUG TX-CHRONIC INFLAM. COLON DX, 5-AMINOSALICYLAT		
APRISO *(mesalamine er)*	T3	HD
ASACOL HD (*mesalamine*)	T3	HD
AZULFIDINE *(sulfasalazine dr)*	T3	HD
AZULFIDINE *(sulfasalazine)*	T3	HD

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

PA – Prior Authorization
QL – Quantity Limit
ST – Step Therapy

AGE – Age Requirement
SP – Specialty Medication
HD – May require home delivery pharmacy

PPACA – No Cost-Share Preventive Medication
CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

GASTROINTESTINAL (Gastrointestinal/Heartburn) (cont.)		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
DRUG TX-CHRONIC INFLAM. COLON DX, 5-AMINOSALICYLAT (cont.)		
balsalazide di (Colazal)	T1	HD
COLAZAL *(balsalazide di)*	T3	HD
mesalamine	T1	HD
mesalamine (Asacol Hd)	T1	HD
mesalamine (Lialda)	T1	HD
mesalamine dr (Delzicol)	T1	HD
mesalamine er (Apriso)	T1	HD
PENTASA	T2	HD
sulfasalazine (Azulfidine)	T1	HD
FARNESOID X RECEPTOR (FXR) AGONIST, BILE AC ANALOG		
OCALIVA	T2	PA QL (30 units/30 days) SP HD
FECAL MICROBIOTA TRANSPLANTATION (FMT)		
VOWST CAPSULE	T3	SP
GASTRIC ENZYMES		
SUCRAID	T2	SP
HEMORRHOID PREP,ANTI-INFLAM STEROID-LOCAL ANESTHET		
ANALPRAM HC 1% CREAM	T3	
ANALPRAM HC 2.5%-1% CREAM *(hydrocortisone/pramoxine)*	T3	ST
ANALPRAM HC 2.5%-1% CRM SINGLE *(hydrocortisone/pramoxine)*	T3	ST
hydrocort-pramoxine 1%-1% crm	T1	
hydrocort-pramoxine 2.5-1% crm (Analpram Hc)	T1	ST
PROCORT	T3	
HISTAMINE H2-RECEPTOR INHIBITORS		
cimetidine	T1	HD
famotidine	T1	HD
nizatidine	T1	HD
PEPCID *(famotidine)*	T3	HD
IBS AGENTS, MIXED OPIOID RECEP AGONISTS/ANTAGONISTS		
VIBERZI	T2	HD
IBS-C/CIC AGENTS, GUANYLATE CYCLASE-C AGONIST		
LINZESS	T2	QL (30 units/30 days)
TRULANCE	T2	
INTEGRIN RECEPTOR ANTAGONIST, MONOCLONAL ANTIBODY		
ENTYVIO	T2	PA SP HD

T1 – Typically Generics
T2 – Typically Preferred Brands
T3 – Typically Non-Preferred Brands
PA – Prior Authorization
QL – Quantity Limit
ST – Step Therapy
AGE – Age Requirement
SP – Specialty Medication
HD – May require home delivery pharmacy
PPACA – No Cost-Share Preventive Medication
CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

GASTROINTESTINAL (Gastrointestinal/Heartburn) (cont.)		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
INTESTINAL MOTILITY STIMULANTS		
metoclopramide hcl (Reglan)	T1	
metoclopramide hcl odt	T1	
MOTEGRITY	T3	QL (30 units/30 days)
prucalopride succinate (Motegrity)	T1	QL (30 tabs/30 days)
REGLAN *(metoclopramide hcl)*	T3	
IRRITABLE BOWEL SYND. AGENT, 5-HT4 PARTIAL AGO		
ZELNORM	T3	
IRRITABLE BOWEL SYNDROME AGENTS, 5-HT3 ANTAGONIST		
alosetron hcl (Lotronex)	T1	SP HD
LAXATIVES AND CATHARTICS		
alophen pills (Dulcolax)	T1	PPACA
bisacodyl (Dulcolax)	T1	PPACA
bisa-lax (Dulcolax)	T1	PPACA
citroma (Citroma)	T1	
clearlax (Miralax)	T1	PPACA
clearlax (Miralax)	T1	
constulose	T1	
ducodyl (Dulcolax)	T1	
gavilax (Miralax)	T1	PPACA
gavilyte-g (Golytely)	T1	PPACA
gavilyte-n (Nulytely)	T1	PPACA
gentle laxative (Correctol)	T1	PPACA
gentle laxative (Dulcolax)	T1	PPACA
gentlelax (Miralax)	T1	PPACA
glycolax (Miralax)	T1	PPACA
healthylax (Miralax)	T1	PPACA
KRISTALOSE	T3	
lactulose (Kristalose)	T1	
laxaclear (Miralax)	T1	PPACA
laxative (Dulcolax)	T1	PPACA
laxative peg 3350 (Miralax)	T1	PPACA
lubiprostone	T1	QL (60 caps/30 days)
magnesium (Citroma)	T1	
milk of magnesia	T1	

T1 – Typically Generics
T2 – Typically Preferred Brands
T3 – Typically Non-Preferred Brands
PA – Prior Authorization
QL – Quantity Limit
ST – Step Therapy
AGE – Age Requirement
SP – Specialty Medication
HD – May require home delivery pharmacy
PPACA – No Cost-Share Preventive Medication
CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

GASTROINTESTINAL (Gastrointestinal/Heartburn) (cont.)		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
LAXATIVES AND CATHARTICS (cont.)		
miralax	T1	PPACA
natura-lax (Miralax)	T1	PPACA
NULYTELY WITH FLAVOR Packs *(gavilyte-n)*	T3	PPACA
OSMOPREP	T3	PPACA
peg 3350-electrolyte (Golytely)	T1	PPACA
peg 3350-electrolyte (Nulytely)	T1	PPACA
peg-prep	T1	PPACA
polyethylene glycol (Miralax)	T1	PPACA
powderlax (Miralax)	T1	
PREPOPIK	T2	
purelax (Miralax)	T1	PPACA
smoothlax (Miralax)	T1	PPACA
trilyte with flavor packets (Nulytely)	T1	PPACA
women's gentle laxative (Dulcolax)	T1	PPACA
women's laxative (Correctol)	T1	PPACA
women's laxative (Dulcolax)	T1	PPACA
LOCAL ANORECTAL NITRATE PREPARATIONS		
nitroglycerin 0.4% ointment (Rectiv)	T1	
RECTIV *(nitroglycerin)*	T2	
MU-OPIOID RECEPTOR ANTAGONISTS,PERIPHERALLY-ACTING		
ENTEREG	T3	
PANCREATIC ENZYMES		
CREON	T2	HD
VIOKACE	T2	HD
ZENPEP	T2	HD
POTASSIUM-COMPETITIVE ACID BLOCKERS (PCABS)		
VOQUEZNA	T3	ST
PROTON-PUMP INHIBITORS		
dexlansoprazole dr 30 mg cap	T1	ST QL
esomeprazole dr 2.5 mg packet (Nexium)	T1	ST QL (30 packs/30 days) HD
esomeprazole dr 5 mg packet (Nexium)	T1	ST QL (30 packs/30 days) HD
ESOMEPRAZOLE DR 49.3 MG CAP	T3	ST HD
esomeprazole magnesium (Nexium 24HR)	T1	QL (30 units/30 days) HD
esomeprazole magnesium (Nexium)	T1	HD

T1 – Typically Generics
T2 – Typically Preferred Brands
T3 – Typically Non-Preferred Brands
PA – Prior Authorization
QL – Quantity Limit
ST – Step Therapy
AGE – Age Requirement
SP – Specialty Medication
HD – May require home delivery pharmacy
PPACA – No Cost-Share Preventive Medication
CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

GASTROINTESTINAL (Gastrointestinal/Heartburn) (cont.)		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
PROTON-PUMP INHIBITORS (cont.)		
lansoprazole (Prevacid)	T1	HD
omeprazole	T1	QL (30 caps/30 days) HD
omeprazole-bicarb 20-1,680 pkt (Zegerid)	T1	ST QL (30 packs/30 days) HD
omeprazole-bicarb 40-1,680 pkt (Zegerid)	T1	ST HD
omeprazole-bicarb 40-1,100 cap (Zegerid)	T1	ST HD
omeprazole- bicarbonate (Zegerid)	T1	PA HD
pantoprazole (Protonix)	T1	QL (30 units/30 days) HD
rabeprazole (Aciphex)	T1	HD
RECTAL PREPARATIONS		
anucort-hc (Anucort-HC)	T1	
hemmorex-hc (Anucort-HC)	T1	
hydrocortisone acetate (Anucort-HC)	T1	
hydrocortisone acetate (Proctocort)	T1	
PROCTOCORT *(hydrocortisone)*	T3	ST
SBS - GLUCAGON-LIKE PEPTIDE-2 (GLP-2) ANALOGS		
GATTEX	T3	SP HD
GASTROINTESTINAL (Pain Relief And Inflammatory Disease)		
HEMORRHOID PREP, ANTI-INFLAM STEROID-LOCAL ANESTHET		
ANA-LEX	T3	
ANALPRAM-HC *(hydrocortisone-pramoxine)*	T3	ST
hc pramoxine (Analpram HC)	T1	
lidocaine-hc 3-1% cream kit	T1	
pramoxine hcl w/hydrocortisone (Analpram Hc)	T1	
PROCORT	T3	
HORMONES (Gastrointestinal/Heartburn)		
RECTAL/LOWER BOWEL PREP., GLUCOCORT. (NON-HEMORR)		
colocort (Cortenema)	T1	
CORTENEMA *(hydrocortisone)*	T3	
hydrocortisone (Cortenema)	T1	
UCERIS *(budesonide)*	T3	
HORMONES (Hormonal Agents)		
ADRENOCORTICOTROPHIC HORMONES		
ACTHAR SELFJECT	T3	PA SP HD

T1 – Typically Generics
T2 – Typically Preferred Brands
T3 – Typically Non-Preferred Brands
PA – Prior Authorization
QL – Quantity Limit
ST – Step Therapy
AGE – Age Requirement
SP – Specialty Medication
HD – May require home delivery pharmacy
PPACA – No Cost-Share Preventive Medication
CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

HORMONES (Hormonal Agents) (cont.)		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
ADRENOCORTICOTROPHIC HORMONES		
ACTHAR SELFJECT	T3	PA SP HD
ANDROGENIC AGENTS		
ANADROL-50	T3	
DEPO-TESTOSTERONE *(testosterone cypionate)*	T3	PA
METHITEST	T2	
methyltestosterone	T1	
oxandrolone	T1	
STRIANT	T3	PA QL
testosterone	T1	PA QL
TESTOSTERONE	T3	PA QL
testosterone (Testim)	T1	PA QL
testosterone (Vogelxo)	T1	PA QL
testosterone 1.62% (2.5 g) pkt	T1	QL (60 packs/30 days)
testosterone 1.62%(1.25 g) pkt	T1	QL (30 packs/30 days)
testosterone cypionate (Depo-Testosterone)	T1	PA
testosterone enanthate	T1	PA
testosterone 10 mg gel pump	T1	QL (120 gms/30 days)
VOGELXO *(testosterone)*	T3	PA QL
XYOSTED	T2	QL (2 mls/28 days)
ANTI-DIURETIC AND VASOPRESSOR HORMONES		
DDAVP SOLUTION	T2	
DDAVP 0.1 MG TABLET *(desmopressin acetate)*	T3	HD
DDAVP 0.2 MG TABLET *(desmopressin acetate)*	T3	HD
desmopressin 0.01% solution	T1	HD
DESMOPRESSIN 1.5 MG/ML SPRAY	T2	HD
desmopressin 10 mcg/0.1 ml spr	T1	HD
desmopressin acetate 0.1 mg tb (Ddavp)	T1	HD
desmopressin acetate 0.2 mg tb (Ddavp)	T1	HD
NOCTIVA	T3	
STIMATE	T2	
ESTROGEN/ANDROGEN COMBINATIONS		
covaryx	T1	HD
covaryx h.s.	T1	HD
eemt	T1	HD

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

PA – Prior Authorization
QL – Quantity Limit
ST – Step Therapy

AGE – Age Requirement
SP – Specialty Medication
HD – May require home delivery pharmacy

PPACA – No Cost-Share Preventive Medication
CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

HORMONES (Hormonal Agents) (cont.)		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
ESTROGEN/ANDROGEN COMBINATIONS (cont.)		
eemt hs	T1	HD
ESTRATEST H.S. (estrogen,ester/me-testosterone)	T3	HD
estrogen,ester/me-testosterone	T1	HD
estrogen & methyltestosterone	T1	HD
ESTROGENIC AGENTS		
ACTIVELLA *(amabelz)*	T3	HD
ALORA	T3	QL (8 patches/21 days) HD
amabelz (Activella)	T1	HD
CLIMARA *(estradiol (once weekly))*	T3	QL (4 patches/21 days) HD
COMBIPATCH	T2	
DELESTROGEN *(estradiol valerate)*	T3	HD
DEPO-ESTRADIOL	T2	HD
dotti (Alora)	T1	QL (8 patches/21 days) HD
dotti (Minivelle)	T1	QL (8 patches/21 days) HD
ESTRACE *(estradiol)*	T3	HD
estradiol (Alora)	T1	QL (8 patches/21 days) HD
estradiol (Climara)	T1	QL (4 patches/21 days) HD
estradiol (Delestrogen)	T1	HD
estradiol (Estrace)	T1	HD
estradiol 0.06% 1.25g gel pump (Estrogel)	T1	QL (50 gms/30 days) HD
estradiol/norethindrone acet	T1	HD
estradiol-norethindrone acetat (Activella)	T1	HD
EVAMIST	T3	QL (17 mls/30 days) HD
FEMHRT *(fyavolv)*	T3	HD
fyavolv (Femhrt)	T1	HD
jinteli	T1	HD
lopreeza (Activella)	T1	
MENOSTAR	T3	QL (4 patches/21 days) HD
mimvey (Activella)	T1	HD
norethindrone ac/eth estradiol	T1	HD
norethindrone-ethin estradiol (Femhrt)	T1	HD
PREFEST	T3	HD
ESTROGEN-PROGESTIN WITH ANTI-MINERALOCORTICOID COMB		
ANGELIQ	T3	HD

T1 – Typically Generics
T2 – Typically Preferred Brands
T3 – Typically Non-Preferred Brands
PA – Prior Authorization
QL – Quantity Limit
ST – Step Therapy
AGE – Age Requirement
SP – Specialty Medication
HD – May require home delivery pharmacy
PPACA – No Cost-Share Preventive Medication
CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

HORMONES (Hormonal Agents) (cont.)		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
ESTROGEN-SELECTIVE ESTROGEN RECEPTOR MOD (SERM) COMB		
DUAVEE	T2	
GLUCOCORTICOIDS		
budesonide ec (Entocort EC)	T1	
budesonide er (Uceris)	T1	
CORTEF *(hydrocortisone)*	T3	
cortisone acetate	T1	
decadron	T1	
deflazacort (Emflaza)	T1	PA SP
dexamethasone	T1	PA
dexamethasone 0.5 mg/5 ml elx	T1	
DEXONTO	T3	
DEXPAK *(dexamethasone)*	T3	PA
ENTOCORT EC *(budesonide ec)*	T3	
hidex	T1	PA
hydrocortisone (Cortef)	T1	
MEDROL *(methylpred dp)*	T3	
MEDROL *(methylprednisolone)*	T3	
methylpred dp (Medrol)	T1	
methylprednisolone (Medrol)	T1	
millipred	T1	
ORAPRED ODT *(prednisolone phos odt)*	T3	
prednisolone	T1	
prednisolone phos odt (Orapred ODT)	T1	
prednisolone phosphate	T1	
prednisolone phosphate (Pediapred)	T1	
prednisone	T1	
RAYOS	T3	PA
TAPERDEX	T3	PA
TARPEYO	T3	PA QL (28 caps/30 days) SP
UCERIS *(budesonide)*	T3	
UCERIS *(budesonide er)*	T3	
GROWTH HORMONE RELEASING HORMONE (GHRH) AND ANALOGS		
EGRIFTA SV	T2	PA SP HD
EGRIFTA WR	T2	PA SP HD

T1 – Typically Generics
T2 – Typically Preferred Brands
T3 – Typically Non-Preferred Brands
PA – Prior Authorization
QL – Quantity Limit
ST – Step Therapy
AGE – Age Requirement
SP – Specialty Medication
HD – May require home delivery pharmacy
PPACA – No Cost-Share Preventive Medication
CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

HORMONES (Hormonal Agents) (cont.)		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
GROWTH HORMONE RELEASING HORMONE (GHRH) AND ANALOGS (cont.)		
GENOTROPIN	T2	PA SP HD
ZORBTIVE	T3	PA SP HD
GROWTH HORMONES		
OMNITROPE	T2	PA SP
SEROSTIM	T2	PA SP HD
INSULIN-LIKE GROWTH FACTOR-I (IGF-I) HORMONES		
INCRELEX	T2	PA SP
LHRH (GNRH) AGONIST ANALOG AND PROGESTIN COMB		
LUPANETA PACK	T2	PA SP HD
LUPRON DEPOT	T2	PA SP HD
LHRH (GNRH) AGONIST ANALOG PITUITARY SUPPRESSANTS		
SYNAREL	T2	PA SP HD
LHRH (GNRH) ANTAGONIST, PITUITARY SUPPRESSANT AGENTS		
cetrorelix acetate	T1	
fyremadel (generic to GANIRELIX)	T1	PA ST
ORILISSA 150 MG TABLET	T2	PA QL (1 tab/day)
ORILISSA 200 MG TABLET	T2	PA QL (360 tabs/365 days)
LHRH (GNRH) AGNST PIT.SUP-CENTRAL PRECOCIOUS PUBERTY		
LUPRON DEPOT-PED	T2	PA SP HD
MINERALOCORTICOIDS		
fludrocortisone acetate	T1	HD
OXYTOCICS		
CERVIDIL	T3	
methergine	T1	PA QL
methylergonovine	T1	QL (240 tabs/30 days)
PREPIDIL	T3	
PARATHYROID HORMONES		
NATPARA	T2	PA SP HD
YORVIPATH	T3	PA SP
PITUITARY SUPPRESSIVE AGENTS		
cabergoline	T1	QL (8 tabs/21 days) HD
CRENESSITY	T3	PA SP
danazol	T1	HD

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

PA – Prior Authorization
QL – Quantity Limit
ST – Step Therapy

AGE – Age Requirement
SP – Specialty Medication
HD – May require home delivery pharmacy

PPACA – No Cost-Share Preventive Medication
CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

HORMONES (Hormonal Agents) (cont.)		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
PROGESTATIONAL AGENTS		
CRINONE 8% GEL	T2	
medroxyprogesterone acetate	T1	HD
medroxyprogesterone acetate (Provera)	T1	HD
norethindrone acetate	T1	HD
progesterone 100 mg capsule (Prometrium)	T1	HD
progesterone 200 mg capsule (Prometrium)	T1	HD
PROMETRIUM *(progesterone)*	T3	HD
PROVERA *(medroxyprogesterone)*	T3	HD
SOMATOSTATIC AGENTS		
MYCAPSSA DR 20 MG CAPSULE	T3	PA SP QL (56 caps/28 days)
octreotide acetate	T1	SP HD
SANDOSTATIN *(octreotide)*	T3	PA ST SP HD
SIGNIFOR	T2	PA SP HD
SOMATULINE DEPOT	T2	PA SP HD
VAGINAL ESTROGEN PREPARATIONS		
estradiol (Estrace)	T1	HD
estradiol (Vagifem)	T1	
yuvafem (Vagifem)	T1	HD
HORMONES (Infertility)		
HUMAN CHORIONIC GONADOTROPIN (HCG)		
CHORIONIC GONAD 10, 000 UNIT VIAL	T3	ST QL (3 vials/30 days) SP
NOVAREL	T3	ST QL (6 vls/30 days) SP
PREGNYL	T2	QL (3 vials/30 days) SP
PREGNANCY FACILITATING/MAINTAINING AGENT,HORMONAL		
ENDOMETRIN	T2	
progesterone 100 mg vag insert	T1	
HORMONES (Miscellaneous)		
LEPTIN HORMONE ANALOGS		
MYALEPT	T2	PA SP HD
HORMONES (Osteoporosis Products)		
BONE FORMATION STIMULATING AGTS - PTH REL PEPTIDES		
TYMLOS	T2	PA QL SP HD

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

PA – Prior Authorization
QL – Quantity Limit
ST – Step Therapy

AGE – Age Requirement
SP – Specialty Medication
HD – May require home delivery pharmacy

PPACA – No Cost-Share Preventive Medication
CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

HORMONES (Osteoporosis Products) (cont.)		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
BONE RESORPTION INHIBITORS		
calcitonin-salmon	T1	HD
MIACALCIN	T3	HD
IMMUNOSUPPRESSANTS (Pain Relief And Inflammatory Disease)		
HUMAN INTERLEUKIN 12/23 (IL-12/13) INHIBITORS, MAB		
IMULDOSA 45 MG/0.5 ML SYRINGE	T2	PA QL (1 syringe/84 days) SP
IMULDOSA 90 MG/ML SYRINGE	T2	PA QL (1 syringe/56 days) SP
SELARSDI 45 MG/0.5 ML SYRINGE	T2	PA QL (1 syringe/84 days) SP
SELARSDI 90 MG/ML SYRINGE	T2	PA QL (1 syringe/56 days) SP
USTEKINUMAB-TTWE 45MG/0.5ML SY	T2	PA SP HD
USTEKINUMAB-TTWE 90 MG/ML SYR	T2	PA SP HD
YESINTEK 45 MG/0.5 ML SYRINGE	T2	PA SP HD
YESINTEK 45 MG/0.5 ML VIAL	T2	PA SP HD
YESINTEK 90 MG/ML SYRINGE	T2	PA SP HD
IL-23 RECEPTOR ANTAGONIST, MONOCLONAL ANTIBODY		
OMVOH 100 MG/ML PEN	T2	PA QL (2 mls/28 days) SP HD
OMVOH 200 MG DOSE - 2 PENS	T2	PA QL (2 mls/28 days) SP HD
OMVOH 300 MG DOSE - 2 PENS	T2	PA QL (3 mls/28 days) SP HD
OMVOH 100 MG/ML SYRINGE	T2	PA QL (2 mls/28 days) SP HD
OMVOH 200 MG DOSE - 2 SYRINGES	T2	PA QL (2 mls/28 days) SP HD
OMVOH 300 MG DOSE - 2 SYRINGES	T2	PA QL (3 mls/28 days) SP HD
TREMFYA 100 MG/ML INJECTOR	T2	PA QL (1 auto-inj/56 days) SP HD
TREMFYA 100 MG/ML PEN	T2	PA SP HD
TREMFYA 200 MG/2 ML PEN	T2	PA SP HD
TREMFYA ONE-PRESS	T2	PA SP HD
TREMFYA PEN INDUCTION (2 PEN)	T2	PA QL (1200 mgs/365 days) SP HD
TREMFYA 100 MG/ML SYRINGE	T2	PA QL (1 syringe/56 days) SP HD
TREMFYA 200 MG/2 ML SYRINGE	T2	PA QL (200 mgs/28 days) SP HD
INTERLEUKIN-4(IL-4) RECEPTOR ALPHA ANTAGONIST, MAB		
DUPIXENT 100MG/0.67ML PREFILLED SYRINGE	T2	PA QL (2 pens/28 days) SP HD
DUPIXENT 200 MG/1.14 ML SYRINGE	T2	PA QL (800 mg/21 days) SP HD
DUPIXENT 300 MG2 ML SYRINGE	T2	PA QL (600 mg/21 days) SP HD
INTERLEUKIN-6 (IL-6) RECEPTOR INHIBITORS		
ACTEMRA	T3	PA QL (3.6 mls/28 days) SP HD
ACTEMRA ACTPEN	T3	PA QL (2 pens/28 days) SP HD

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

PA – Prior Authorization
QL – Quantity Limit
ST – Step Therapy

AGE – Age Requirement
SP – Specialty Medication
HD – May require home delivery pharmacy

PPACA – No Cost-Share Preventive Medication
CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

IMMUNOSUPPRESSANTS (Pain Relief And Inflammatory Disease) (cont.)		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
INTERLEUKIN-6 (IL-6) RECEPTOR INHIBITORS (cont.)		
TYENNE	T2	PA QL (3.6 mls/28 days) SP
TYENNE AUTOINJECTOR	T2	PA QL (2 pens/28 days) SP
MONOCLONAL ANTIBODY-HUMAN INTERLEUKIN 12/23 INHIB		
STELARA	T2	PA QL SP HD
IMMUNOSUPPRESSANTS (Skin Conditions)		
INTERLEUKIN-31(IL-31)RECEPTOR ALPHA ANTAGONIST,MAB		
NEMLUVIO	T2	PA QL (2 pens/28 days) SP HD
TOPICAL IMMUNOSUPPRESSIVE AGENTS		
pimecrolimus (Elidel)	T1	QL (100 gm/23 days)
tacrolimus 0.1% ointment	T1	ST QL (120 gms/30 days)
tacrolimus 0.03% ointment	T1	ST QL (120 gms/30 days)
IMMUNOSUPPRESSANTS (Transplant Medications)		
IMMUNOSUPPRESSIVES		
ASTAGRAF XL	T3	PA SP HD
AZASAN	T3	SP HD
azathioprine (Imuran)	T1	SP HD
CELLCEPT *(mycophenolate mofetil)*	T3	SP HD
cyclosporine (Neoral)	T1	SP HD
cyclosporine (Sandimmune)	T1	SP HD
gengraf (Neoral)	T1	SP HD
IMURAN *(azathioprine)*	T3	SP HD
LUPKYNIS	T3	PA SP QL (180 caps/30 days)
mycophenolate mofetil (Cellcept)	T1	SP HD
mycophenolic acid (Myfortic)	T1	SP HD
MYFORTIC *(mycophenolic acid)*	T3	SP HD
MYHIBBIN	T2	SP
NEORAL *(cyclosporine modified)*	T3	SP HD
PROGRAF CAPSULES *(tacrolimus)*	T3	SP HD
PROGRAF GRANULE PACKETS	T2	SP HD
RAPAMUNE *(sirolimus)*	T3	SP HD
SANDIMMUNE CAPSULES *(cyclosporine)*	T3	SP HD
SANDIMMUNE SOLUTION	T2	SP HD
sirolimus	T1	SP HD

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

PA – Prior Authorization
QL – Quantity Limit
ST – Step Therapy

AGE – Age Requirement
SP – Specialty Medication
HD – May require home delivery pharmacy

PPACA – No Cost-Share Preventive Medication
CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

IMMUNOSUPPRESSANTS (Transplant Medications) (cont.)		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
IMMUNOSUPPRESSIVES (cont.)		
sirolimus (Rapamune)	T1	SP HD
tacrolimus (Prograf)	T1	SP HD
ZORTRESS 0.25MG, 0.5MG, 0.75 MG TABLETS (*everolimus)*	T3	SP HD
ZORTRESS 1 MG TABLET	T3	SP HD
MISCELLANEOUS MEDICAL SUPPLIES, DEVICES, NON-DRUG (Diabetes)		
DIABETIC SUPPLIES		
ACCU-CHEK	T3	
AGAMATRIX CONTROL SOLUTION	T3	
AUTOLET LITE	T2	
AUTOSOFT 30 INFUSION SET PACK	T3	
AUTOSOFT XC INFUSION SET PACK	T3	
CARESENS S CONTROL SOLUTION	T3	
CEQUR SIMPLICITY 2 UNIT PATCH, INSERTER	T2	
CHOSEN LANCING DEVICE	T2	
CONTOUR	T3	
CONTOUR NEXT	T3	
DEXCOM G6 RECEIVER	T2	PA QL (1 unit/365 days)
DEXCOM G6 SENSOR	T2	PA QL (3 kits/30 days)
DEXCOM G6 TRANSMITTER	T2	PA QL (1 kit/90 days)
DEXCOM G7 RECEIVER	T2	PA QL (1 unit/365 days)
DEXCOM G7 SENSOR	T2	PA QL (3 units/30 days)
EASY MINI EJECT LANCING DEVICE	T2	
EASY PLUS II	T3	
EASY STEP CONTROL SOLUTION	T3	
EASY TALK	T3	
EASY TOUCH	T3	
EASY TOUCH BLULINK CTRL SOLN	T3	
EASY TOUCH LANCING DEVICE	T2	
EASY TRAK	T3	
EASYMAX	T3	
EASYMAX N	T3	
EMBRACE	T3	
EMBRACE EVO	T3	

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

PA – Prior Authorization
QL – Quantity Limit
ST – Step Therapy

AGE – Age Requirement
SP – Specialty Medication
HD – May require home delivery pharmacy

PPACA – No Cost-Share Preventive Medication
CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

MISCELLANEOUS MEDICAL SUPPLIES, DEVICES, NON-DRUG (Diabetes) (cont.)		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
DIABETIC SUPPLIES (cont.)		
EMBRACE PRO	T3	
EVENCARE G2	T3	
EVENCARE G3	T3	
EVERSENSE SENSOR-HOLDER	T3	PA QL
EVERSENSE SMART TRANSMITTER	T3	PA QL
FORA	T3	
FORA TN'GO ADV MOBILE MULT MTR	T3	
FORA TN'GO ADVANCE MULTIFN MTR	T3	
FORACARE	T3	
FORTISCARE	T3	
FREESTYLE	T2	
FREESTYLE LIBRE 2 PLUS SENSOR	T2	PA QL (2 units/30 days)
FREESTYLE LIBRE 2 READER	T2	PA QL (1 unit/365 days)
FREESTYLE LIBRE 2 SENSOR	T2	PA QL (2 sensors/28 days)
FREESTYLE LIBRE 3 PLUS SENSOR	T2	PA QL (2 units/30 days)
FREESTYLE LIBRE 3 READER	T2	PA QL (1 unit/365 days)
FREESTYLE LIBRE 3 SENSOR	T2	PA QL (2 units/28 days)
FREESTYLE LIBRE 10 DAY SENSOR	T2	PA
FREESTYLE LIBRE 14 DAY READER	T2	PA
FREESTYLE LIBRE 14 DAY SENSOR	T2	PA QL (2 kits/30 days)
FREESTYLE NAVIGATOR SENSOR KIT	T2	
GENTLE DRAW	T2	
GLUCOCARD	T3	
GLUCOCOM	T3	
GLUCOSE CONTROL	T3	
GLUCOSE CONTROL SOLUTION	T3	
GUARDIAN LINK 3 TRANSMITTER	T3	PA QL (1 transmitter/273 days)
GUARDIAN 4 TRANSMITTER	T3	PA QL (1 transmitter/273 days)
GUARDIAN 4 GLUCOSE SENSOR	T3	PA QL (5 sensors/30 days)
GUARDIAN RT REPLACE MONITOR	T3	
GUARDIAN SENSOR 3	T3	
HEALTHY ACCENTS AUTOLET	T2	
HYPOLANCE	T2	
IHEALTH CONTROL SOLN LEVEL 2	T3	

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

PA – Prior Authorization
QL – Quantity Limit
ST – Step Therapy

AGE – Age Requirement
SP – Specialty Medication
HD – May require home delivery pharmacy

PPACA – No Cost-Share Preventive Medication
CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

MISCELLANEOUS MEDICAL SUPPLIES, DEVICES, NON-DRUG (Diabetes) (cont.)		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
DIABETIC SUPPLIES (cont.)		
ILET INFUSION-CONTACT DETACH	T2	
ILET INFUSION KIT-INSET	T2	
ILET STARTER KIT-INSET	T2	
INCONTROL LANCING DEVICE	T2	
INFINITY CONTROL SOLUTION	T3	
INFINITY VOICE CONTROL SOLN	T3	
LITE TOUCH	T2	
MEDISENSE	T2	
MICROLET	T2	
MINI LANCING DEVICE	T2	
MODD1 PATIENT WELCOME KIT	T3	
MODD1 SUPPLY KIT	T3	
OMNIPOD	T2	
OMNIPOD CLASSIC PDM KIT(GEN 3)	T2	
OMNIPOD DASH	T2	QL (15 pods/30 days)
OMNIPOD GO PODS	T2	QL (10 crtgs/30 days)
OMNIPOD 5 (G6/LIBRE 2 PLUS)	T2	QL (15 crtgs/30 days)
OMNIPOD 5 DEXG7G6 INTRO(GEN 5)	T2	QL (1 kit/720 days)
OMNIPOD 5 DEXG7G6 PODS (GEN 5)	T2	QL (15 crtgs/30 days)
OMNIPOD 5 DEXG7G6 PODS (GEN 5)	T2	QL (15 pods/28 days)
OMNIPOD 5 INTRO(G6/LIBRE2PLUS)	T2	QL (1 kit/720 days)
OMNIPOD 5 G6-G7 INTRO KT(GEN5)	T2	QL (1 kit/720 days)
OMNIPOD 5 G6-G7 PODS (GEN 5)	T2	QL (15 crtgs/30 days)
ONE TOUCH DELICA	T2	
ONE TOUCH ULTRA CONTROL SOLN	T2	
ONETOUCH ULTRA CONTROL SOLN	T3	
ONETOUCH VERIO HIGH CNTRL SOLN	T3	
ONETOUCH VERIO MID CNTRL SOLN	T3	
ONETOUCH DELICA PLUS LANC DEV	T2	
PRODIGY LANCING DEVICE	T2	
T:FLEX	T2	
TANDEM MOBI AUTOSOFT 30	T2	PA SP HD
TANDEM MOBI AUTOSOFT XC	T2	PA SP HD
TANDEM MOBI AUTOSOFT 30 SUPPLY	T2	

T1 – Typically Generics
T2 – Typically Preferred Brands
T3 – Typically Non-Preferred Brands
PA – Prior Authorization
QL – Quantity Limit
ST – Step Therapy
AGE – Age Requirement
SP – Specialty Medication
HD – May require home delivery pharmacy
PPACA – No Cost-Share Preventive Medication
CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

MISCELLANEOUS MEDICAL SUPPLIES, DEVICES, NON-DRUG (Diabetes) (cont.)		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
DIABETIC SUPPLIES (cont.)		
TANDEM MOBI AUTOSOFT XC SUPPLY	T2	
TANDEM MOBI CARTRIDGE	T2	
TANDEM MOBI TRUSTEEL SUPPLY	T2	
TANDEM T:SLIM ASFT 30	T2	
TANDEM T:SLIM ASFT XC	T2	
TANDEM T:SLIM TRUSTL	T2	
TRUE METRIX	T2	
TRUECONTROL	T2	
TRUSTEEL INFUSION SET PACK	T3	
TWIIST REFILL KT(CSST-NDL-SYR)	T2	
TWIIST RFL(INFUS-CSST-NDL-SYR)	T2	
TWIIST STARTER KIT	T2	
ULTI-LANCE	T2	
VGO 20	T2	
VGO 30	T2	
VGO 40	T2	
DURABLE MEDICAL EQUIPMENT,MISC (GROUP I)		
1ST TIER UNILET COMFORTOUCH	T2	
2-IN-1 LANCET DEVICE	T2	
ACCU-CHEK FASTCLIX LANCET DRUM	T2	
ACCU-CHEK SAFE-T-PRO	T2	
ACCU-CHEK SAFE-T-PRO PLUS	T2	
ACCU-CHEK SOFTCLIX	T2	
acti-lance lite 28g lancets	T1	
acti-lance special 17g lancets	T1	
acti-lance univers 23g lancets	T1	
ACTI-LANCE UNIVERS 23G LANCETS	T2	
ADVANCED TRAVEL LANCETS	T2	
ADVOCATE LANCET	T2	
ADVOCATE LANCETS	T2	
ADVOCATE SAFETY LANCET	T2	
AGAMATRIX ULTRA-THIN LANCET	T2	PA SP HD
ALTERNATE SITE LANCETS	T2	
ASSURE HAEMOLANCE PLUS	T2	

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

PA – Prior Authorization
QL – Quantity Limit
ST – Step Therapy

AGE – Age Requirement
SP – Specialty Medication
HD – May require home delivery pharmacy

PPACA – No Cost-Share Preventive Medication
CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

MISCELLANEOUS MEDICAL SUPPLIES, DEVICES, NON-DRUG (Diabetes) (cont.)		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
DURABLE MEDICAL EQUIPMENT,MISC (GROUP I) (cont.)		
ASSURE LANCE	T2	
ASSURE LANCE PLUS	T2	
BD MICROTAINER LANCETS	T2	
BLOOD LANCETS	T2	
BULLSEYE MINI SAFETY LANCETS	T2	
BUTTERFLY TOUCH LANCET	T2	
CAREONE	T2	
CARESENS LANCET	T2	
CARETOUCH SAFETY LANCETS	T2	
CARETOUCH TWIST LANCET	T2	
CHOSEN LANCET	T2	
CHOSEN SAFETY LANCET	T2	
CLEVER CHEK LANCETS	T2	
COAGUCHEK	T2	
COLOR LANCETS	T2	
COMFORT EZ	T2	
COMFORT LANCETS	T2	
COMFORT TOUCH PLUS SAFETY LANC	T2	
COMFORT TOUCH ULT THIN LANCET	T2	
DROPLET LANCETS	T2	
DROPSAFE ACTI-LANCE	T2	
EASY COMFORT LANCETS	T2	
EASY TOUCH PULL-TOP 26G LANCET	T2	
EASY TOUCH PULL-TOP 28G LANCET	T2	
EASY TOUCH PULL-TOP 30G LANCET	T2	
EASY TOUCH PULL-TOP 32G LANCET	T2	
EASY TOUCH SAFETY 21G LANCETS	T2	
EASY TOUCH SAFETY 23G LANCETS	T2	
EASY TOUCH SAFETY 26G LANCETS	T2	
EASY TOUCH SAFETY 28G LANCETS	T2	
EASY TOUCH SAFETY 30G LANCETS	T2	
EASY TOUCH SAFETY 32G LANCETS	T2	
EASY TOUCH TWIST 26G LANCETS	T2	
EASY TOUCH TWIST 28G LANCETS	T2	

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

PA – Prior Authorization
QL – Quantity Limit
ST – Step Therapy

AGE – Age Requirement
SP – Specialty Medication
HD – May require home delivery pharmacy

PPACA – No Cost-Share Preventive Medication
CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

MISCELLANEOUS MEDICAL SUPPLIES, DEVICES, NON-DRUG (Diabetes) (cont.)		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
DURABLE MEDICAL EQUIPMENT,MISC (GROUP I) (cont.)		
EASY TOUCH TWIST 30G LANCETS	T2	
EASY TOUCH TWIST 32G LANCETS	T2	
EASY TOUCH TWIST 33G LANCETS	T2	
EASY TWIST & CAP LANCETS	T2	
EMBRACE 30G LANCETS	T2	
EMBRACE SAFETY LANCET	T2	
EZ SMART LANCETS	T2	
EZ-LETS	T2	
FIFTY50 SAFETY SEAL LANCETS	T2	
FINGERSTIX	T2	
FORA LANCETS	T2	
FORACARE LANCETS	T2	
FREESTYLE LANCETS	T2	
FREESTYLE UNISTIK 2	T2	
GLUCOCOM	T2	
GLUCOCOM LANCETS	T2	
GOJJI LANCETS	T2	
HEALTHY ACCENTS UNILET LANCET	T2	
INCONTROL SUPER THIN LANCETS	T2	
INCONTROL ULTRA THIN LANCETS	T2	
INJECT EASE LANCETS	T2	
INVACARE LANCETS	T2	
lancets	T1	
LANCETS	T2	
LITE TOUCH 28G LANCETS	T2	
LITE TOUCH 30G LANCETS	T2	
LITE TOUCH 33G LANCETS	T2	
MEDISENSE THIN LANCETS	T2	
medlance plus 21g lancets	T1	
MEDLANCE PLUS 21G LANCETS	T2	
medlance plus 30g lancets	T1	
MEDLANCE PLUS 30G LANCETS	T2	
MEDLANCE PLUS EXTRA 21G LANCET	T2	
medlance plus lite 25g lancets	T1	

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

PA – Prior Authorization
QL – Quantity Limit
ST – Step Therapy

AGE – Age Requirement
SP – Specialty Medication
HD – May require home delivery pharmacy

PPACA – No Cost-Share Preventive Medication
CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

MISCELLANEOUS MEDICAL SUPPLIES, DEVICES, NON-DRUG (Diabetes) (cont.)		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
DURABLE MEDICAL EQUIPMENT,MISC (GROUP I) (cont.)		
MEDLANCE PLUS LITE 25G LANCETS	T2	
MICRO THIN LANCET	T2	
MICRO THIN LANCETS	T2	
MICROLET	T2	
MOBILE LANCETS	T2	
MONOLET LANCETS	T2	
MONOLET THIN LANCETS	T2	
MYGLUCOHEALTH LANCETS	T2	
NOVA SAFETY LANCETS	T2	
NOVA SUREFLEX	T2	
ON CALL LANCET	T2	
ON CALL PLUS LANCET	T2	
ONETOUCH DELICA PLUS LANCET	T2	
ONETOUCH DELICA SAFETY LANCET	T2	
ONETOUCH LANCETS	T2	
ONETOUCH SURESOFT	T2	
ONETOUCH ULTRASOFT 2 LANCET	T2	
ON-THE-GO	T2	
PERFECT POINT SAFETY LANCETS	T2	
PIP LANCET	T2	
PRESSURE ACTIVATED LANCETS	T2	
PRO COMFORT LANCET	T2	
PRO COMFORT LANCETS	T2	
PRO COMFORT SAFETY LANCET	T2	
PRODIGY LANCETS	T2	
PRODIGY TWIST TOP LANCET	T2	
PURE COMFORT LANCETS	T2	
PURE COMFORT SAFETY LANCETS	T2	
PUSH BUTTON SAFETY LANCETS	T2	
READYLANCE SAFETY LANCETS	T2	
RELIAMED	T2	
RELIAMED SAFETY SEAL LANCETS	T2	
RIGHTEST GL300 LANCETS	T2	
SAFETY LANCETS	T2	

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

PA – Prior Authorization
QL – Quantity Limit
ST – Step Therapy

AGE – Age Requirement
SP – Specialty Medication
HD – May require home delivery pharmacy

PPACA – No Cost-Share Preventive Medication
CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

MISCELLANEOUS MEDICAL SUPPLIES, DEVICES, NON-DRUG (Diabetes) (cont.)		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
DURABLE MEDICAL EQUIPMENT,MISC (GROUP I) (cont.)		
SAFETY SEAL LANCETS	T2	
SAFETY-LET	T2	
SINGLE-LET	T2	
SMART SENSE	T2	
SMART SENSE LANCETS	T2	
SMARTEST LANCET	T2	
SOLUS V2	T2	
SOLUS V2 LANCETS	T2	
STERILANCE TL	T2	
STERILE LANCETS	T2	
SUPER THIN LANCETS	T2	
SURE COMFORT LANCETS	T2	
SURE-LANCE	T2	
SURE-TOUCH	T2	
TECHLITE LANCETS	T2	
TELCARE ULTRA THIN 30G LANCETS	T2	
THIN LANCETS	T2	
TOPCARE UNIVERSAL1 LANCET	T2	
TOPCARE UNIVERSAL1 THIN LANCET	T2	
TRUE COMFORT LANCET	T2	
TRUE COMFORT SAFETY LANCET	T2	
TRUEPLUS LANCET	T2	
TRUEPLUS LANCETS	T2	
TWIST LANCETS	T2	
TWIST TOP LANCET	T2	
ULTILET BASIC	T2	
ULTILET CLASSIC	T2	
ULTILET LANCETS	T2	
ULTILET SAFETY	T2	
ULTRA THIN LANCET	T2	
ULTRA THIN LANCETS	T2	
ULTRA THIN PLUS LANCETS	T2	
ULTRA-CARE LANCETS	T2	
ULTRALANCE	T2	

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

PA – Prior Authorization
QL – Quantity Limit
ST – Step Therapy

AGE – Age Requirement
SP – Specialty Medication
HD – May require home delivery pharmacy

PPACA – No Cost-Share Preventive Medication
CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

MISCELLANEOUS MEDICAL SUPPLIES, DEVICES, NON-DRUG (Diabetes) (cont.)		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
DURABLE MEDICAL EQUIPMENT,MISC (GROUP I) (cont.)		
ULTRA-THIN II 28G LANCETS	T2	
ULTRA-THIN II 30G LANCETS	T2	
ULTRATLC LANCETS	T2	
UNILET COMFORTOUCH	T2	
UNILET EXCELITE	T2	
UNILET EXCELITE II	T2	
UNILET GP LANCET	T2	
UNILET LANCET	T2	
UNILET LANCETS	T2	
UNISTIK 2 COMFORT	T2	
UNISTIK 2 EXTRA	T2	
UNISTIK 2 NORMAL	T2	
UNISTIK 3	T2	
UNISTIK 3 COMFORT	T2	
UNISTIK 3 DUAL	T2	
UNISTIK 3 EXTRA	T2	
UNISTIK 3 NORMAL	T2	
UNISTIK COMFORT	T2	
UNISTIK CZT	T2	
UNISTIK EXTRA	T2	
UNISTIK NORMAL	T2	
UNISTIK PRO	T2	
UNISTIK SAFETY	T2	
UNISTIK TOUCH	T2	
UNIVERSAL 1	T2	
VERIFINE SAFETY LANCET MINI	T2	
VERIFINE UNIVERSAL LANCET	T2	
VIVAGUARD LANCET	T2	
VIVAGUARD SAFETY LANCET	T2	
NEEDLES/NEEDLELESS DEVICES		
AUTOSHIELD DUO PEN NEEDLE	T2	
BD ECLIPSE NEEDLE 18G 40MM	T3	
BD SAFETYGLIDE NEEDLE	T2	
BD SAFETYGLIDE NEEDLE 18GX1.5"	T2	

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

PA – Prior Authorization
QL – Quantity Limit
ST – Step Therapy

AGE – Age Requirement
SP – Specialty Medication
HD – May require home delivery pharmacy

PPACA – No Cost-Share Preventive Medication
CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

MISCELLANEOUS MEDICAL SUPPLIES, DEVICES, NON-DRUG (Diabetes) (cont.)		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
NEEDLES/NEEDLELESS DEVICES (cont.)		
BD SAFETYGLIDE NEEDLE 21GX1"	T2	
BD SAFETYGLIDE NEEDLE 21GX1.5"	T2	
BD SAFETYGLIDE NEEDLE 22GX1.5"	T2	
BD SAFETYGLIDE NEEDLE 23G 40MM	T3	
BD SAFETYGLIDE NEEDLE 25GX1"	T2	
BD SAFETYGLIDE NEEDLE 27GX5/8"	T2	
CAREPOINT PRECISION NEEDLE	T3	
DROPSAFE SICURA SAFETY NEEDLE	T3	
EXEL HUBER NEEDLE	T2	
exel huber needle (V-Go 20)	T1	
EXEL HYPODERMIC NEEDLE	T2	
EXEL MTI DRAWING NEEDLE	T2	
FILTER NEEDLE	T2	
FLOW-EZE	T2	
HEALTHWISE PEN NEEDLE	T3	
HEALTHY ACCENTS UNIFINE PENTIP	T3	
HURRICAINE LUER-LOCK	T2	
LITE TOUCH	T3	
MINI TRANSFER PIN	T2	
NANO 2ND GEN PEN NEEDLE	T2	
NANO PEN NEEDLE	T2	
NEEDLES	T2	
NOVOFINE	T2	
NOVOTWIST	T2	
PERFECT POINT SAFETY NEEDLE	T3	
PRECISIONGLIDE NEEDLE	T2	
ULTRA-FINE PEN NEEDLE	T2	
SYRINGES AND ACCESSORIES		
BD SAFETYGLIDE TB 1 ML SYR	T2	
BD SAFETYGLIDE TB 1ML 27G 10MM	T3	
BD SAFETYGLIDE TUBERCULIN SYR	T2	
CAREPOINT LUER LOCK SYRINGE	T3	
CAREPOINT LUER LOCK SYRING-NDL	T2	
CAREPOINT PRECISION LUER LOCK	T3	

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

PA – Prior Authorization
QL – Quantity Limit
ST – Step Therapy

AGE – Age Requirement
SP – Specialty Medication
HD – May require home delivery pharmacy

PPACA – No Cost-Share Preventive Medication
CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

MISCELLANEOUS MEDICAL SUPPLIES, DEVICES, NON-DRUG (Diabetes) (cont.)		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
SYRINGES AND ACCESSORIES (cont.)		
CAREPOINT PRECISION SAFETY	T2	
CAREPOINT SAFETY LUER LOCK SYR	T2	
ENFIT CAP	T3	
ENFIT MULTIFIL SYRINGE	T3	
ENFIT POP ON CAP	T3	
ENFIT SCREW-ON CAP	T3	
ENFIT SYRINGE	T3	
ENFIT SYRINGE STERILE	T3	
ENFIT THUMB CONTROL RING SYRIN	T3	
INSULIN SYR 0.5 ML 28G 12.7MM	T2	
INSULIN SYRINGE 1 ML 27G 16MM	T2	
INSULIN SYRINGE 1ML 28G 12.7MM	T2	
INSULIN SYRINGE U-500	T2	
LUER LOCK SYRINGE-NEEDLE	T3	PA SP HD
MAD NASAL ATOMIZER-SYRG-ADAPTR	T3	
MONOJECT TB SAFETY SYRINGE	T2	
SYRINGE LUER LOCK	T2	PA SP HD
SYRINGE SLIP TIP	T2	
TUBERCULIN SLIP-TIP SYRINGE	T3	
ULTRA-FINE INSULIN SYRINGE	T2	
MISCELLANEOUS MEDICAL SUPPLIES, DEVICES, NON-DRUG (Miscellaneous)		
DURABLE MEDICAL EQUIPMENT,MISC (GROUP I)		
ADVOCATE SAFETY LANCET	T2	
AEROCHAMBER2GO	T2	PA SP HD
AGAMATRIX ULTRA-THIN LANCET	T2	PA SP HD
CHOSEN LANCET	T2	
CHOSEN SAFETY LANCET	T2	
CARESENS LANCET	T2	
CARETOUCH SAFETY LANCETS	T2	
DROPSAFE ACTI-LANCE	T2	
PERFECT POINT SAFETY LANCETS	T2	
VIVAGUARD SAFETY LANCET	T2	

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

PA – Prior Authorization
QL – Quantity Limit
ST – Step Therapy

AGE – Age Requirement
SP – Specialty Medication
HD – May require home delivery pharmacy

PPACA – No Cost-Share Preventive Medication
CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

MISCELLANEOUS MEDICAL SUPPLIES, DEVICES, NON-DRUG (Miscellaneous) (cont.)		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
PARENTERAL ADMINISTRATION SETS		
ACCU-CHEK	T3	
IVENIX PRIMARY ADMINISTRAT SET	T3	
RESPIRATORY AIDS, DEVICES, EQUIPMENT		
ACE AEROSOL CLOUD ENHANCER	T2	
AEROCHAMBER	T2	
AEROCHAMBER MECHANICAL VENT	T2	
AEROCHAMBER PLUS	T2	
AEROCHAMBER Z-STAT PLUS	T2	
AEROTRACH PLUS	T2	
AEROVENT PLUS	T2	
CLEVER CHOICE HOLDING CHAMBER	T2	
COMFORTSEAL	T2	
COMPACT SPACE CHAMBER	T2	
EASIVENT	T2	
FLEXICHAMBER	T2	
INSPIRACHAMBER	T2	
LITEAIRE	T2	
LITETOUCH	T2	
MASK	T2	
MICROCHAMBER	T2	
MICROSPACER	T2	
MOUTHPIECE	T2	
ONE WAY MOUTHPIECE	T2	
OPTICHAMBER	T2	
OPTICHAMBER DIAMOND	T2	
PANDA MASK	T2	
PEDIATRIC PANDA MASK	T2	
POCKET CHAMBER	T2	
PRIMEAIRE	T2	
PRO COMFORT SPACER WITH MASK	T2	
PROCHAMBER	T2	
PURECOMFORT PEAK FLOW MOUTHPCE	T2	
RITEFLO	T2	
SIDESTREAM PEDIATRIC	T2	

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

PA – Prior Authorization
QL – Quantity Limit
ST – Step Therapy

AGE – Age Requirement
SP – Specialty Medication
HD – May require home delivery pharmacy

PPACA – No Cost-Share Preventive Medication
CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

MISCELLANEOUS MEDICAL SUPPLIES, DEVICES, NON-DRUG (Miscellaneous) (cont.)		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
RESPIRATORY AIDS, DEVICES, EQUIPMENT (cont.)		
SILICONE MASK	T2	
UNISTIK 2 COMFORT	T2	
UNISTIK 2 EXTRA	T2	
UNISTIK 2 NORMAL	T2	
UNISTIK 3 COMFORT	T2	
UNISTIK 3 DUAL	T2	
VORTEX	T2	
VORTEX VHC PEDIATRIC MASK	T2	
MUSCLE RELAXANTS (Pain Relief And Inflammatory Disease)		
SKELETAL MUSCLE RELAXANTS		
baclofen 5 mg/5 ml solution	T1	PA HD
baclofen 10 mg/5 ml solution	T1	PA HD
baclofen 25 mg/5 ml suspension (Fleqsuvy)	T1	HD
baclofen 5 mg tablet	T1	HD
baclofen 10 mg tablet	T1	HD
baclofen 15 mg tablet	T1	HD
baclofen 20 mg tablet	T1	HD
carisoprodol (Soma)	T1	
carisoprodol-aspirin	T1	
chlorzoxazone (Lorzone)	T1	
CYCLOBENZAPRINE ER	T1	ST
cyclobenzaprine hcl	T1	
cyclobenzaprine hcl (Amrix)	T1	
cyclobenzaprine hcl (Fexmid)	T1	
DANTRIUM *(dantrolene)*	T3	
dantrolene (Dantrium)	T1	
FEXMID *(cyclobenzaprine hcl)*	T3	PA
LORZONE *(chlorzoxazone)*	T3	PA
metaxalone (Skelaxin)	T1	
metaxalone 400 mg tablet	T1	
metaxalone 800 mg tablet	T1	
methocarbamol	T1	
methocarbamol 1,000 mg tablet	T1	
NORGESIC FORTE	T3	

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

PA – Prior Authorization
QL – Quantity Limit
ST – Step Therapy

AGE – Age Requirement
SP – Specialty Medication
HD – May require home delivery pharmacy

PPACA – No Cost-Share Preventive Medication
CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

MUSCLE RELAXANTS (Pain Relief And Inflammatory Disease) (cont.)		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
SKELETAL MUSCLE RELAXANTS (cont.)		
orphenadrine	T1	
orphenadrine-aspirin-caffeine (Norgesic Forte)	T1	
orphengesic forte (Norgesic Forte)	T1	
ROBAXIN *(methocarbamol)*	T3	
SKELAXIN *(metaxalone)*	T3	
SOMA *(carisoprodol)*	T3	
tizanidine hcl (Zanaflex)	T1	
ZANAFLEX 2 MG CAPSULE *(tizanidine hcl)*	T3	
ZANAFLEX 4 MG CAPSULE *(tizanidine hcl)*	T3	
ZANAFLEX 4 MG TABLET *(tizanidine hcl)*	T3	
ZANAFLEX 6 MG CAPSULE *(tizanidine hcl)*	T3	
PRE-NATAL VITAMINS (Nutritional/Dietary)		
PRENATAL VITAMIN PREPARATIONS		
cvs prenatal multivit-dha sfgl	T1	PPACA
daily prenatal	T1	PPACA
ft prenatal tablet	T1	PPACA
gnp prenatal tablet	T1	PPACA
KPN	T2	
MASONATAL PRENATAL	T3	
perry prenatal tablet (Perry Prenatal)	T1	PPACA
pnv no.154/iron fum/folic acid	T1	
prenatal	T1	PPACA
prenatal 12/iron/folic/dss/om3	T1	
prenatal 71/iron/folic ac/dha	T1	
prenatal complete	T1	PPACA
prenatal formula	T1	PPACA
prenatal multi + dha	T1	PPACA
PRENATAL MULTIVITAMIN-DHA SFGL	T2	
pnv no.52/iron/fa/omega-3/dha	T1	PA SP HD
pnv 81/iron ps,edta/folic/omeg3	T1	PA SP HD
prenatal no.42/folic acid (Vitamedmd Redichew Rx)	T1	PA SP HD
prenatal vit 27,calc/iron/fa	T1	PA SP HD
prenatal vit,cal 76/iron/folic	T1	PA SP HD

T1 – Typically Generics
T2 – Typically Preferred Brands
T3 – Typically Non-Preferred Brands
PA – Prior Authorization
QL – Quantity Limit
ST – Step Therapy
AGE – Age Requirement
SP – Specialty Medication
HD – May require home delivery pharmacy
PPACA – No Cost-Share Preventive Medication
CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

PRE-NATAL VITAMINS (Nutritional/Dietary) (cont.)		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
PRENATAL VITAMIN PREPARATIONS (cont.)		
prenatal vit,cal 78/iron/folic	T1	PA SP HD
prenatal vits 86/iron/folic ac	T1	PA SP HD
prenatal,calc 40/iron/folate 1	T1	PA SP HD
PRENATAL FORMULA-DHA *(prenatal vit 116/iron/fa/dha)*	T3	PA SP HD
prenatal vitamin	T1	PPACA
prenavite (Classic Prenatal)	T1	PPACA
SELECT-OB (prenatal vit 128/iron/folic ac)	T3	
ULTRA PRENATAL PLUS DHA	T3	
VITAMEDMD REDICHEW RX *(prenatal no.42/folic acid)*	T3	PA SP HD
PRENATAL VITAMINS WITH LOW OR NO IRON		
CITRANATAL B-CALM	T3	PA SP HD
DUET DHA 400	T3	PA SP HD
P2I PRENATAL WITH CHOLINE	T3	
PRENATE DHA	T3	PA SP HD
PRENATE ELITE	T3	PA SP HD
PRENATE MINI	T3	PA SP HD
PRENATE PIXIE	T3	PA SP HD
PRENATE STAR	T3	PA SP HD
R-NATAL OB	T3	PA SP HD
THERANATAL OVAVITE	T3	PA SP HD
VITAFOL GUMMIES	T3	PA SP HD
PSYCHOTHERAPEUTIC DRUGS (Anxiety/Depression/Bipolar Disorder)[9]		
ALPHA-2 RECEPTOR ANTAGONIST ANTI-DEPRESSANTS		
alprazolam (Xanax)	T1	
alprazolam er (Xanax XR)	T1	
alprazolam intensol	T1	
mirtazapine	T1	HD
mirtazapine (Remeron)	T1	HD
REMERON *(mirtazapine)*	T3	HD
ANTI-ANXIETY - BENZODIAZEPINES		
alprazolam odt	T1	
alprazolam xr (Xanax XR)	T1	
ATIVAN *(lorazepam)*	T3	

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

PA – Prior Authorization
QL – Quantity Limit
ST – Step Therapy

AGE – Age Requirement
SP – Specialty Medication
HD – May require home delivery pharmacy

PPACA – No Cost-Share Preventive Medication
CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

PSYCHOTHERAPEUTIC DRUGS (Anxiety/Depression/Bipolar Disorder)[9] (cont.)		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
ANTI-ANXIETY - BENZODIAZEPINES (cont.)		
chlordiazepoxide hcl	T1	
clorazepate di (Tranxene T-Tab)	T1	
diazepam (Valium)	T1	
lorazepam (Ativan)	T1	
lorazepam intensol	T1	
oxazepam	T1	
TRANXENE T-TAB *(clorazepate dipotassium)*	T3	
ANTI-ANXIETY DRUGS		
buspirone hcl	T1	HD
meprobamate	T1	
ANTIDEPRESSANT - POSTPARTUM DEPRESSION (PPD)		
ZURZUVAE 20 MG, 25 MG CAPSULE	T2	QL (28 caps/365 days) SP HD
ZURZUVAE 30 MG CAPSULE	T2	QL (14 caps/365 days) SP HD
BIPOLAR DISORDER DRUGS		
EQUETRO	T3	HD
lithium	T1	HD
lithium carbonate (Lithobid)	T1	HD
LITHOBID *(lithium carbonate er)*	T3	HD
MAOIS -NON-SELECTIVE, IRREVERSIBLE ANTI-DEPRESSANTS		
MARPLAN	T3	
NARDIL (phenelzine)	T3	
PARNATE (tranylcypromine)	T3	
phenelzine (Nardil)	T1	
tranylcypromine (Parnate)	T1	
MONOAMINE OXIDASE (MAO) INHIBITOR ANTI-DEPRESSANTS		
EMSAM	T3	
NDMA RECEPTOR ANTAGONIST AND NDRI COMB		
AUVELITY	T3	ST QL (60 tabs/30 days)
NOREPINEPHRINE AND DOPAMINE REUPTAKE INHIB (NDRIs)		
bupropion hcl	T1	HD
bupropion hcl er (Wellbutrin SR)	T1	QL HD
bupropion hcl xl 300 mg tablet (Wellbutrin SR)	T1	QL (30 tabs/30 days) HD
BUPROPION HCL XL	T3	ST QL (30 units/30 days) HD
FORFIVO XL	T3	ST QL (30 units/30 days) HD

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

PA – Prior Authorization
QL – Quantity Limit
ST – Step Therapy

AGE – Age Requirement
SP – Specialty Medication
HD – May require home delivery pharmacy

PPACA – No Cost-Share Preventive Medication
CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

PSYCHOTHERAPEUTIC DRUGS (Anxiety/Depression/Bipolar Disorder)[9] (cont.)		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
SELECTIVE SEROTONIN 5-HT2A INVERSE AGONISTS (SSIAs)		
NUPLAZID	T3	PA QL SP HD
SELECTIVE SEROTONIN REUPTAKE INHIBITOR (SSRIs)		
citalopram hbr 20 mg/10 ml cup	T1	PA SP HD
escitalopram 10 mg/10 ml cup	T1	PA SP HD
fluoxetine dr	T1	QL ST HD
fluoxetine (Sarafem)	T1	HD
fluoxetine 20 mg/5 ml soln cup	T1	HD
fluvoxamine maleate	T1	QL HD
paroxetine er (Paxil CR)	T1	QL HD
paroxetine hcl (Paxil)	T1	ST HD
PAXIL *(paroxetine hcl)*	T3	ST QL HD
PAXIL CR *(paroxetine cr)*	T3	ST QL HD
SARAFEM *(fluoxetine hcl)*	T3	ST QL (30 units/30 days) HD
sertraline 150 mg capsule	T1	QL (30 caps/30 days) HD
sertraline 150 mg capsule	T1	ST QL (30 caps/30 days) HD
sertraline 200 mg capsule	T1	QL (30 caps/30 days) HD
sertraline 200 mg capsule	T1	ST QL (30 caps/30 days) HD
vilazodone-hctz tablets	T1	QL ST
SEROTONIN-2 ANTAGONIST/REUPTAKE INHIBITORS (SARIs)		
nefazodone hcl	T1	HD
trazodone hcl	T1	HD
SEROTONIN-NOREPINEPHRINE REUPTAKE-INHIB (SNRIs)		
desvenlafaxine succinate er (Pristiq)	T1	QL (30 units/30 days) HD
duloxetine hcl	T1	QL (30 units/30 days) HD
duloxetine hcl (Cymbalta)	T1	QL HD
FETZIMA 20-40 MG TITRATION PAK	T2	ST QL (28 caps/30 days)
FETZIMA ER 120 MG CAPSULE	T2	ST QL (30 caps/30 days)
FETZIMA ER 20 MG CAPSULE	T2	ST QL (30 caps/30 days)
FETZIMA ER 40 MG CAPSULE	T2	ST QL (30 caps/30 days)
FETZIMA ER 80 MG CAPSULE	T2	ST QL (30 caps/30 days)
FETZIMA ER TITRATION PACK	T2	ST QL (1 pack/30 days) HD
venlafaxine hcl	T1	QL HD
venlafaxine hcl er	T1	QL (30 units/30 days) HD

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

PA – Prior Authorization
QL – Quantity Limit
ST – Step Therapy

AGE – Age Requirement
SP – Specialty Medication
HD – May require home delivery pharmacy

PPACA – No Cost-Share Preventive Medication
CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

PSYCHOTHERAPEUTIC DRUGS (Anxiety/Depression/Bipolar Disorder)[9] (cont.)		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
SSRI, SEROTONIN RECEPTOR MODULATOR ANTI-DEPRESSANTS		
TRINTELLIX	T3	ST QL (30 tabs/30 days)
TRICYCLIC ANTI-DEPRESSANT-BENZODIAZEPINE COMBINATNS		
amitriptyline/chlordiazepoxide	T1	HD
amitriptyline-perphenazine	T1	HD
TRICYCLIC ANTI-DEPRESSANTS, REL.NON-SEL.REUPT-INHIB		
amitriptyline hcl	T1	HD
amoxapine	T1	HD
ANAFRANIL *(clomipramine hcl)*	T3	HD
clomipramine hcl (Anafranil)	T1	HD
desipramine hcl	T1	HD
doxepin hcl	T1	HD
imipramine hcl	T1	HD
imipramine pamoate	T1	HD
maprotiline hcl	T1	HD
nortriptyline hcl	T1	HD
nortriptyline hcl (Pamelor)	T1	HD
PAMELOR *(nortriptyline hcl)*	T3	HD
protriptyline hcl	T1	HD
trimipramine maleate	T1	HD
PSYCHOTHERAPEUTIC DRUGS (Attention Deficit Hyperactivity Disorder)[9]		
ADRENERGICS, AROMATIC, NON-CATECHOLAMINE		
lisdexamfetamine 10 mg capsule (Vyvanse)	T1	
lisdexamfetamine 20 mg capsule (Vyvanse)	T1	
lisdexamfetamine 30 mg capsule (Vyvanse)	T1	
lisdexamfetamine 40 mg capsule (Vyvanse)	T1	
lisdexamfetamine 50 mg capsule (Vyvanse)	T1	
lisdexamfetamine 60 mg capsule (Vyvanse)	T1	
lisdexamfetamine 70 mg capsule (Vyvanse)	T1	
lisdexamfetamine 10 mg tb chew (Vyvanse)	T1	ST
lisdexamfetamine 20 mg tb chew (Vyvanse)	T1	ST
lisdexamfetamine 30 mg tb chew (Vyvanse)	T1	ST
lisdexamfetamine 40 mg tb chew (Vyvanse)	T1	ST
lisdexamfetamine 50 mg tb chew (Vyvanse)	T1	ST

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

PA – Prior Authorization
QL – Quantity Limit
ST – Step Therapy

AGE – Age Requirement
SP – Specialty Medication
HD – May require home delivery pharmacy

PPACA – No Cost-Share Preventive Medication
CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

PSYCHOTHERAPEUTIC DRUGS (Attention Deficit Hyperactivity Disorder)[9] (cont.)		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
ADRENERGICS, AROMATIC, NON-CATECHOLAMINE (cont.)		
lisdexamfetamine 60 mg tb chew (Vyvanse)	T1	ST
VYVANSE *(lisdexamfetamine dimesylate)*	T3	ST
TX FOR ADHD - SELECTIVE ALPHA-2 RECEPTOR AGONIST		
clonidine hcl er (Kapvay)	T1	
guanfacine hcl (Intuniv)	T1	HD
guanfacine hcl er (Intuniv)	T1	
KAPVAY *(clonidine hcl er)*	T3	ST
TX FOR ATTENTION DEFICIT-HYPERACT (ADHD)/NARCOLEPSY		
APTENSIO XR	T3	ST
AZSTARYS	T2	ST
COTEMPLA XR-ODT	T3	ST
DAYTRANA	T2	ST
dexmethylphenidate hcl (Focalin)	T1	
dexmethylphenidate hcl er (Focalin XR)	T1	
JORNAY PM	T3	ST
METADATE CD *(methylphenidate hcl)*	T3	ST
METHYLIN *(methylphenidate hcl)*	T3	
methylphenidate er	T1	
methylphenidate er (Concerta)	T1	
methylphenidate er 72 mg tab	T1	
*methylphenidate er 18 mg tab (*Relexxii*)*	T1	
*methylphenidate er 27 mg tab (*Relexxii*)*	T1	
*methylphenidate er 36 mg tab (*Relexxii*)*	T1	
*methylphenidate er 54 mg tab (*Relexxii*)*	T1	
methylphenidate er (Ritalin LA)	T1	
methylphenidate hcl	T1	
methylphenidate hcl (Metadate Cd)	T1	
methylphenidate hcl (Methylin)	T1	
methylphenidate hcl (Ritalin)	T1	
methylphenidate hcl cd	T1	
methylphenidate la	T1	
methylphenidate la (Ritalin La)	T1	
QELBREE ER	T3	ST

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

PA – Prior Authorization
QL – Quantity Limit
ST – Step Therapy

AGE – Age Requirement
SP – Specialty Medication
HD – May require home delivery pharmacy

PPACA – No Cost-Share Preventive Medication
CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

PSYCHOTHERAPEUTIC DRUGS (Attention Deficit Hyperactivity Disorder)[9] (cont.)		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
TX FOR ATTENTION DEFICIT-HYPERACT (ADHD)/NARCOLEPSY (cont.)		
RITALIN *(methylphenidate hcl)*	T3	
RITALIN LA *(methylphenidate er (la))*	T3	ST
TX FOR ATTENTION DEFICIT-HYPERACT.(ADHD), NRI-TYPE		
atomoxetine hcl (Strattera)	T1	HD
QELBREE	T3	ST
PSYCHOTHERAPEUTIC DRUGS (Schizophrenia/Anti-Psychotics)[9]		
ANTI-PSYCH, DOPAMINE ANTAG., DIPHENYLBUTYLPIPERIDINES		
pimozide	T1	
ANTI-PSYCHOTIC,ATYPICAL,DOPAMINE,SEROTONIN ANTAGNST		
clozapine (Clozaril)	T1	
clozapine odt	T1	
CLOZAPINE ODT	T3	
CLOZARIL *(clozapine)*	T3	
GEODON *(ziprasidone hcl)*	T3	QL
INVEGA *(paliperidone er)*	T3	QL
LYBALVI	T3	QL (30 tabs/30 days)
olanzapine	T1	PA SP HD
olanzapine odt (Zyprexa Zydis)	T1	QL (30 units/30 days)
quetiapine fumarate er (Seroquel XR)	T1	QL
RISPERDAL *(risperidone)*	T3	QL
risperidone (Risperdal)	T1	QL
risperidone odt	T1	QL
SECUADO	T3	QL
VERSACLOZ	T3	
ziprasidone hcl (Geodon)	T1	QL
ZYPREXA *(olanzapine)*	T3	QL (30 units/30 days)
ZYPREXA ZYDIS *(olanzapine odt)*	T3	QL (30 units/30 days)
ANTI-PSYCHOTIC-ATYPICAL, D3/D2 PARTIAL AG-5HT MIXED		
CAPLYTA 10.5MG CAPSULE	T3	QL (30 caps/30 days)
CAPLYTA 21MG CAPSULE	T3	QL (30 caps/30 days)
VRAYLAR	T3	QL (30 caps/30 days)
ANTIPSYCHOTICS, ATYP, D2 PARTIAL AGONIST/5HT MIXED		
ABILIFY ASIMTUFII 720MG/2.4ML, 960MG/3.2ML	T3	
ABILIFY MYCITE	T3	QL (30 units/30 days)

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

PA – Prior Authorization
QL – Quantity Limit
ST – Step Therapy

AGE – Age Requirement
SP – Specialty Medication
HD – May require home delivery pharmacy

PPACA – No Cost-Share Preventive Medication
CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

PSYCHOTHERAPEUTIC DRUGS (Schizophrenia/Anti-Psychotics)[9] (cont.)		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
ANTIPSYCHOTICS, ATYP, D2 PARTIAL AGONIST/5HT MIXED (cont.)		
aripiprazole	T1	
aripiprazole (Abilify)	T1	QL (30 units/30 days)
aripiprazole odt	T1	QL
REXULTI	T3	QL (30 units/30 days)
ANTI-PSYCHOTICS, DOPAMINE AND SEROTONIN ANTAGONISTS		
ADASUVE	T3	
loxapine succinate	T1	
ANTI-PSYCHOTICS, DOPAMINE ANTAGONISTS, THIOXANTHENES		
thiothixene	T1	
ANTI-PSYCHOTICS, DOPAMINE ANTAGONISTS, BUTYROPHENONES		
haloperidol	T1	
haloperidol lactate	T1	
ANTI-PSYCHOTICS, DOPAMINE ANTAGONST, DIHYDROINDOLONES		
molindone hcl	T1	
ANTI-PSYCHOTICS, PHENOTHIAZINES		
chlorpromazine hcl	T1	
fluphenazine hcl	T1	
perphenazine	T1	
thioridazine hcl	T1	
trifluoperazine hcl	T1	
PSYCHOTHERAPEUTIC DRUGS (Sleep Disorders/Sedatives)		
NARCOLEPSY AND SLEEP DISORDER THERAPY AGENTS		
armodafinil (Nuvigil)	T1	PA QL (30 units/30 days)
SUNOSI	T2	PA QL (30 units/30 days)
SEDATIVE/HYPNOTICS (Sleep Disorders/Sedatives)		
ANTI-NARCOLEPSY, ANTI-CATAPLEXY, SEDATIVE-TYPE AGENT		
LUMRYZ STARTER PACK	T2	
LUMRYZ ER	T3	PA SP HD QL (30 packets/30 days)
SODIUM OXYBATE	T2	PA SP HD QL (540 ml/30 days)
XYREM	T2	QL (540 ml/ 30 days) SP HD
XYWAV	T2	QL (540 ml/ 30 days)
BARBITURATES		
phenobarbital	T1	

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

PA – Prior Authorization
QL – Quantity Limit
ST – Step Therapy

AGE – Age Requirement
SP – Specialty Medication
HD – May require home delivery pharmacy

PPACA – No Cost-Share Preventive Medication
CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

SEDATIVE/HYPNOTICS (Sleep Disorders/Sedatives)		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
BARBITURATES (cont.)		
seconal (Seconal Sodium)	T1	QL (30 units/30 days)
HYPNOTICS, MELATONIN MT1/MT2 RECEPTOR AGONISTS		
HETLIOZ	T3	PA QL (30 units/30 days) SP HD
ramelteon (Rozerem)	T1	QL (30 units/30 days)
SEDATIVE-HYPNOTICS - BENZODIAZEPINES		
estazolam	T1	QL (15 tabs/fill)
flurazepam hcl	T1	
HALCION *(triazolam)*	T3	
midazolam hcl	T1	
RESTORIL *(temazepam)*	T3	QL (15 caps/fill)
temazepam (Restoril)	T1	QL (15 caps/fill)
triazolam (Halcion)	T1	QL (15 tabs/fill)
SEDATIVE-HYPNOTICS, NON-BARBITURATE		
BELSOMRA	T3	ST QL (30 units/30 days)
doxepin hcl (Silenor)	T1	QL (30 units/30 days)
DAYVIGO	T3	ST QL (30 tabs/fill)
EDLUAR	T3	ST QL (30 units/30 days)
eszopiclone (Lunesta)	T1	QL (30 units/30 days)
INTERMEZZO *(zolpidem tartrate)*	T3	ST QL (30 units/30 days)
MKO (MIDAZOLAM-KETAMINE-ONDAN)	T3	
QUVIVIQ	T3	ST QL (30 tabs/fill)
SILENOR *(doxepin hcl)*	T3	ST QL (30 units/30 days)
zaleplon	T1	QL
zolpidem tartrate	T1	QL (30 units/30 days)
zolpidem tartrate (Ambien)	T1	QL (30 units/30 days)
zolpidem tartrate (Intermezzo)	T1	QL (30 units/30 days)
zolpidem tartrate er (Ambien CR)	T1	QL (30 units/30 days)
ZOLPIMIST	T3	ST QL (1 canister/30 days)
SKIN PREPS (Miscellaneous)		
ANTISEPTICS,GENERAL		
ADVOCATE ALCOHOL 70% PREP PADS	T2	
ALCOHOL 70% PREP PADS	T2	
alcohol 70% swabs	T1	

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

PA – Prior Authorization
QL – Quantity Limit
ST – Step Therapy

AGE – Age Requirement
SP – Specialty Medication
HD – May require home delivery pharmacy

PPACA – No Cost-Share Preventive Medication
CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

SKIN PREPS (Miscellaneous) (cont.)		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
ANTISEPTICS,GENERAL (cont.)		
ALCOHOL 70% SWABS	T2	
ALCOHOL 70% WIPES	T2	
alcohol antiseptic pads	T1	
alcohol prep pads	T1	
alcohol swab	T1	
alcohol swabs	T1	
CARETOUCH ALCOHOL PREP PAD	T2	
CURITY ALCOHOL PREPS	T2	
CVS ALCOHOL 70% PREP PADS	T2	
cvs isopropyl alcohol 70% wipe	T1	
DROPSAFE PREP PADS	T2	
EASY COMFORT ALCOHOL PAD	T2	
EASY TOUCH ALCOHOL PREP PADS	T2	
fifty50 alcohol prep pads	T1	
GNP ALCOHOL SWAB	T2	
GS ALCOHOL 70% SWABS	T2	
HM ALCOHOL 70% PREP PADS	T2	
INCONTROL ALCOHOL PADS	T2	
pharm choice alcohol prep pads	T1	
PHARM CHOICE ALCOHOL PREP PADS	T2	
PRO COMFORT ALCOHOL PADS	T2	
PURE COMFORT ALCOHOL PAD	T2	
ra alcohol swabs	T1	
RA ISOPROPYL ALCOHOL 70% WIPES	T2	
RELION ALCOHOL 70% SWABS	T2	
SAPS ALCOHOL 70% PREP PADS	T2	
SINGLE USE SWAB	T2	
SURE COMFORT ALCOHOL	T2	
SURE-PREP ALCOHOL PREP PADS	T2	
SWI ALCOHOL 70% PREP PADS	T2	
TRUE COMFORT ALCOHOL PADS	T2	
TRUE COMFORT PRO ALCOHOL PADS	T2	
ULTILET ALCOHOL SWAB	T2	
WEBCOL	T2	

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

PA – Prior Authorization
QL – Quantity Limit
ST – Step Therapy

AGE – Age Requirement
SP – Specialty Medication
HD – May require home delivery pharmacy

PPACA – No Cost-Share Preventive Medication
CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

SKIN PREPS (Miscellaneous) (cont.)		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
IRRIGANTS		
acetic acid	T1	
neomycin-polymyxin b	T1	
PHYSIOLYTE	T3	
PHYSIOSOL	T3	
sodium chloride 0.9% irrig	T1	
sodium chloride 0.9% prcss sol	T1	
SODIUM CHLORIDE 0.9% IRRIG.	T3	
OXIDIZING AGENTS		
hydrogen peroxide	T1	
SKIN PREPS (Pain Relief And Inflammatory Disease)		
ANTI-PSORIATIC AGENTS, SYSTEMIC		
acitretin	T1	
methoxsalen (Oxsoralen-Ultra)	T1	
OXSORALEN-ULTRA *(methoxsalen)*	T3	
SKYRIZI (2 SYRINGES) KIT	T2	PA QL (1 kit/30 days) SP HD
SORIATANE *(acitretin)*	T3	
SOTYKTU	T2	PA QL (30 tabs/30 days) SP HD
SPEVIGO	T3	PA SP HD
TALTZ 20 MG/0.25 ML SYRINGE	T2	PA QL (1 syringe/28 days) SP HD
TALTZ 40 MG/0.5 ML SYRINGE	T2	PA QL (1 syringe/28 days) SP HD
TALTZ 80 MG/ML SYRINGE	T2	PA QL (1 ml/28 days) SP HD
TREMFYA	T2	PA QL SP HD
TOPICAL ANTI-INFLAMMATORY, NSAIDS		
diclofenac sodium 1% gel	T1	QL (500 gms/28 days) HD
FLECTOR	T2	ST QL
VOLTAREN *(arthritis pain)*	T3	ST QL (500gm/21 days) HD
SKIN PREPS (Skin Conditions)		
ACNE AGENTS, SYSTEMIC		
ABSORICA	T2	ST
ABSORICA LD	T3	
amnesteem (Absorica)	T1	
claravis (Absorica)	T1	
isotretinoin (Absorica)	T1	

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

PA – Prior Authorization
QL – Quantity Limit
ST – Step Therapy

AGE – Age Requirement
SP – Specialty Medication
HD – May require home delivery pharmacy

PPACA – No Cost-Share Preventive Medication
CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

SKIN PREPS (Skin Conditions) (cont.)		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
ACNE AGENTS, SYSTEMIC (cont.)		
isotretinoin authorized generics by Sun pharmaceuticals	T1	ST
myorisan (Absorica)	T1	
zenatane (Absorica)	T1	
ACNE AGENTS, TOPICAL		
ACZONE *(dapsone)*	T3	ST
adapalene-benzoyl peroxide (Epiduo)	T1	
AZELEX	T3	ST
BENZACLIN *(clindamycin-benzoyl peroxide)*	T3	ST
clindamycin phos-tretinoin (Veltin)	T1	PA
clindamycin-benzoyl peroxide	T1	
clindamycin-benzoyl peroxide (Acanya)	T1	
clindamycin-benzoyl peroxide (Benzaclin)	T1	
clindamycin/tretinoin (Veltin)	T1	
dapsone 5% gel (Aczone)	T1	PA SP HD
dapsone 7.5% gel pump (Aczone)	T1	PA SP HD
DAPSONE 7.5% GEL	T3	PA SP HD
EPIDUO FORTE GEL PUMP	T3	ST
KLARON *(sulfacetamide)*	T3	ST
neuac	T1	
ONEXTON *(clindamycin phos/benzoyl perox)*	T3	ST
ONEXTON	T2	ST
sulfacetamide (Klaron)	T1	
ZIANA *(clindamycin phos-tretinoin)*	T3	PA ST
ANTI-PRURITICS, TOPICAL		
doxepin hcl (Prudoxin)	T1	QL (45 gm/23 days)
prudoxin (Prudoxin)	T1	QL (45 gm/23 days)
ZONALON *(doxepin hcl)*	T3	ST QL (90 grams/30 days)
ANTI-PSORIATICS AGENTS		
calcipotriene (Dovonex)	T1	QL (120/23 days)
calcitriol (Vectical)	T1	
DOVONEX *(calcipotriene)*	T3	QL (120/23 days)
DUOBRII	T3	ST QL (200 gm/23 days)
tazarotene 0.05% cream (Tazorac)	T1	PA
TAZORAC	T2	PA

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

PA – Prior Authorization
QL – Quantity Limit
ST – Step Therapy

AGE – Age Requirement
SP – Specialty Medication
HD – May require home delivery pharmacy

PPACA – No Cost-Share Preventive Medication
CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

SKIN PREPS (Skin Conditions) (cont.)		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
ANTI-PSORIATICS AGENTS (cont.)		
VECTICAL *(calcitriol)*	T3	
VTAMA	T2	PA QL (60 gms/28 days)
ZORYVE 0.3% CREAM	T3	PA QL (60 gms/30 days)
ANTI-SEBORRHEIC AGENTS		
ESKATA	T3	
OVACE *(sulfacetamide)*	T3	
OVACE PLUS	T3	
selenium sulfide (Selrx)	T1	
sulfacetamide (Ovace Plus Wash)	T1	
sulfacetamide (Ovace Plus)	T1	
sulfacetamide (Ovace)	T1	
VTAMA	T3	PA QL
ZORYVE	T3	PA QL (60 grams/21 days)
ANTISEPTICS,GENERAL		
GS ALCOHOL 70% SWABS	T2	
IMMUNOMODULATORS		
ALDARA *(imiquimod)*	T3	
imiquimod (Aldara)	T1	
IRRITANTS/COOOUNTER-IRRITANTS		
YCANTH	T3	SP
KERATOLYTICS		
benzepro	T1	
BENZEPRO *(benzepro)*	T3	ST
benzoyl peroxide	T1	
CONDYLOX	T3	ST QL (7 grams/30 days)
ENZOCLEAR	T3	ST
INOVA	T3	ST
INOVA 4-1	T3	ST
INOVA 8-2	T3	ST
podofilox 0.5% gel (Condylox)	T1	ST QL (7 gms/30 days)
podofilox 0.5% topical soln	T1	
PR BENZOYL PEROXIDE *(benzepro)*	T3	ST

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

PA – Prior Authorization
QL – Quantity Limit
ST – Step Therapy

AGE – Age Requirement
SP – Specialty Medication
HD – May require home delivery pharmacy

PPACA – No Cost-Share Preventive Medication
CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

SKIN PREPS (Skin Conditions) (cont.)		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
PROTECTIVES		
PHARMABASE *(pharmabase barrier)*	T3	
zinc oxide	T1	
ROSACEA AGENTS, TOPICAL		
azelaic acid (Finacea)	T1	
EPSOLAY	T3	
FINACEA *(azelaic acid)*	T3	ST
ivermectin 1% cream (Soolantra)	T1	QL (45 gms/30 days)
METROCREAM *(metronidazole)*	T3	ST
METROGEL *(metronidazole)*	T3	ST
METROLOTION *(metronidazole)*	T3	ST
metronidazole 0.75% cream (Metrocream)	T1	
metronidazole 0.75% lotion	T1	
metronidazole top 1% gel pump	T1	
metronidazole topical 0.75% gl	T1	
metronidazole topical 1% gel (Metrogel)	T1	
metronidazole (Metrolotion)	T1	
MIRVASO	T2	PA
NORITATE	T3	ST
RHOFADE	T3	PA
ROSADAN	T3	ST
rosadan (Metrocream)	T1	
TISSUE/WOUND ADHESIVES		
ARTISS	T3	
TISSEEL VHSD	T3	
TOP. ANTI-INFLAM., PHOSPHODIESTERASE-4 (PDE4) INHIB		
EUCRISA	T2	ST QL (120 gms/30 days)
ZORYVE 0.3% FOAM	T3	ST QL (60 GMS/30 DAYS)
ZORYVE 0.15% CREAM	T2	ST QL (60 gms/30 days)
TOPICAL AGENTS, MISCELLANEOUS		
HYFTOR 0.2% GEL	T3	PA
L-MESITRAN SOFT	T3	
TOPICAL ANTIBIOTIC PLEUROMUTILIN DERIVATIVES		
ALTABAX	T3	ST QL (30 units/30 days)

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

PA – Prior Authorization
QL – Quantity Limit
ST – Step Therapy

AGE – Age Requirement
SP – Specialty Medication
HD – May require home delivery pharmacy

PPACA – No Cost-Share Preventive Medication
CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

SKIN PREPS (Skin Conditions) (cont.)		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
TOPICAL ANTICHOLINERGIC HYPERHIDROSIS TX AGENTS		
QBREXZA	T3	PA
TOPICAL ANTI-INFLAMMATORY STEROIDAL		
ALA-SCALP HP *(hydrocortisone)*	T3	ST
alclometasone dipropionate	T1	
amcinonide	T1	
apexicon e	T1	
beser (Cutivate)	T1	
betamethasone	T1	
betamethasone dipropionate	T1	
betamethasone valer 0.12% foam	T1	ST
BRYHALI	T3	ST
CAPEX SHAMPOO	T3	ST
clobetasol e	T1	QL (120gm/23 days)
clobetasol clobetasol 0.05% cream	T1	QL (120 gms/30 days)
clobetasol emollnt 0.05% foam	T1	ST QL (100 gms/30 days)
clobetasol propionate/emoll	T1	ST QL (100 gms/30 days)
clobetasol emulsion (Olux-E)	T1	QL (100 units/23 days)
clobetasol propionate	T1	QL
CLOBEX SHAMPOO *(clobetasol propionate)*	T3	ST QL (263ml/23 days)
CLOBEX SPRAY *(clobetasol propionate)*	T3	ST QL (125ml/23 days)
CLOBEX TOPICAL LOTION *(clobetasol propionate)*	T3	ST QL (118ml/23 days)
CLODAN	T3	ST
clodan (Clobex)	T1	QL (263ml/23 days)
CLODERM	T3	ST
CORDRAN	T3	ST QL
CUTIVATE *(beser)*	T3	ST
DERMA-SMOOTHE-FS *(fluocinolone acetonide)*	T3	ST
DESONATE	T3	ST
desonide (Desowen)	T1	
desoximetasone (Topicort)	T1	
DIPROLENE *(betamethasone diprop augmented)*	T3	ST
fluocinolone acetonide	T1	
fluocinonide	T1	QL
fluocinonide-e	T1	QL (120 gm/23 days)

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

PA – Prior Authorization
QL – Quantity Limit
ST – Step Therapy

AGE – Age Requirement
SP – Specialty Medication
HD – May require home delivery pharmacy

PPACA – No Cost-Share Preventive Medication
CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

SKIN PREPS (Skin Conditions) (cont.)		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
TOPICAL ANTI-INFLAMMATORY STEROIDAL (cont.)		
fluticasone prop 0.05% cream	T1	
fluticasone prop 0.05% lotion	T1	ST
fluticasone propionate	T1	ST
halobetasol prop 0.05% cream	T1	
halobetasol prop 0.05% foam	T1	ST
halobetasol prop 0.05% ointmnt	T1	
HALOG *(halcinonide)*	T3	ST
hydrocortisone	T1	
hydrocortisone butyrate	T1	ST QL (10gm/28 days)
hydrocortisone butyr 0.1% lotn	T1	PA SP HD
IMPEKLO	T3	ST QL (136 gm/28 days)
IMPOYZ	T3	ST QL (120 gm/23 days)
KENALOG *(triamcinolone acetonide)*	T3	ST QL
mometasone	T1	
NUCORT	T3	ST
OLUX *(clobetasol propionate)*	T3	ST QL (100 units/23 days)
PANDEL	T3	ST
prednicarbate	T1	
procto-med hc	T1	
procto-pak	T1	
proctosol-hc	T1	
proctozone-hc	T1	
PSORCON *(diflorasone di)*	T3	ST QL (120gm/23 days)
SCALACORT DK	T3	ST
SERNIVO	T3	ST
SYNALAR *(fluocinolone acetonide)*	T3	ST
SYNALAR TS	T3	ST
TEMOVATE *(clobetasol propionate)*	T3	ST QL (120 gm/23 days)
TEXACORT	T3	ST
TOPICORT *(desoximetasone)*	T3	ST
tovet emollient (Olux-E)	T1	QL (100 units/23 days)
triamcinolone acetonide	T1	
triamcinolone acetonide (Kenalog)	T1	QL

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

PA – Prior Authorization
QL – Quantity Limit
ST – Step Therapy

AGE – Age Requirement
SP – Specialty Medication
HD – May require home delivery pharmacy

PPACA – No Cost-Share Preventive Medication
CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

SKIN PREPS (Skin Conditions) (cont.)		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
TOPICAL ANTI-INFLAMMATORY STEROIDAL (cont.)		
trianex	T1	
triderm	T1	
TRIDESILON *(desonide)*	T3	ST
ULTRAVATE	T3	ST
TOPICAL ANTI-INFLAMMATORY STEROID-LOCAL ANESTHETIC		
EPIFOAM	T3	ST
EPIFOAM	T3	ST
hc pramoxine (Pramosone)	T1	
lidocaine-hc	T1	
PRAMOSONE	T3	ST
TOPICAL ANTI-PARASITICS		
lindane	T1	
malathion (Ovide)	T1	
OVIDE *(malathion)*	T3	
TOPICAL PREPARATIONS, ANTIBACTERIALS		
iodine	T1	
iodine (Lugol'S)	T1	
IODOFLEX	T3	
IODOSORB	T3	
NORMLGEL AG	T3	
TOPICAL VIT D ANALOG/ANTI-INFLAMMATORY STEROID		
calcipotriene-betamethasone (Taclonex)	T1	QL (60 gm/23 days)
calcipotriene-betamethasone dp (Taclonex)	T1	QL (60 gm/23 days)
ENSTILAR	T2	QL (60 gm/23 days)
ENSTILAR FOAM	T2	QL ST
TOPICAL/MUCOUS MEMBR./SUBCUT. ENZYMES		
SANTYL	T2	QL
VITAMIN A DERIVATIVES		
adapalene (Differin)	T1	
AKLIEF	T3	PA ST
ALTRENO	T3	PA
AVITA	T3	PA
avita (Avita)	T1	PA
DIFFERIN *(adapalene)*	T3	ST

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

PA – Prior Authorization
QL – Quantity Limit
ST – Step Therapy

AGE – Age Requirement
SP – Specialty Medication
HD – May require home delivery pharmacy

PPACA – No Cost-Share Preventive Medication
CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

SKIN PREPS (Skin Conditions) (cont.)		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
VITAMIN A DERIVATIVES (cont.)		
RETIN-A *(tretinoin)*	T3	PA
tretinoin	T1	
tretinoin (Atralin)	T1	PA
tretinoin (Avita)	T1	PA
tretinoin microsphere (Retin-A Micro Pump)	T1	PA
tretinoin microsphere (Retin-A Micro)	T1	PA
VITAMIN A DERIVATIVES, TOPICAL ACNE AGENTS		
FABIOR	T3	PA
SMOKING DETERRENTS (Smoking Cessation)[8]		
SMOKING DETERRENT AGENTS (GANGLIONIC STIM, OTHERS)		
NICODERM CQ *(nicoderm cq)*	T2	QL (180 days supply/365 days) PPACA
NICODERM CQ *(nicotine patch)*	T2	QL (180 days supply/365 days) PPACA
nicorelief (Nicorette)	T1	QL (180 days supply/365 days) PPACA
NICORETTE	T2	QL (180 days supply/365 days) PPACA
NICORETTE *(nicorelief)*	T2	QL (180 days supply/365 days) PPACA
NICORETTE *(nicotine gum)*	T2	QL (180 days supply/365 days) PPACA
nicotine	T1	QL (180 days supply/365 days) PPACA
nicotine (Nicoderm CQ)	T1	QL (180 days supply/365 days) PPACA
nicotine (Nicorette)	T1	QL (180 days supply/365 days) PPACA
nicotine gum (Nicorette)	T1	QL (180 days supply/365 days) PPACA
NICOTROL	T3	QL (180 days supply/365 days)
NICOTROL NS	T3	QL (180 days supply/365 days)
quit 2 (Nicorette)	T1	QL (180 days supply/365 days) PPACA
quit 4 (Nicorette)	T1	QL (180 days supply/365 days) PPACA
stop smoking aid (Nicorette)	T1	QL (180 days supply/365 days) PPACA
varenicline 0.5 mg tablet	T1	
varenicline 1 mg tablet	T1	
varenicline starting month box	T1	
SMOKING DETERRENT-NICOTINIC RECEPT.PARTIAL AGONIST		
CHANTIX	T3	QL (180 Days Supply/365 Days)
varenicline starting month box	T1	
SMOKING DETERRENTS, OTHER		
bupropion sr	T1	QL (180 days supply/365 days) PPACA

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

PA – Prior Authorization
QL – Quantity Limit
ST – Step Therapy

AGE – Age Requirement
SP – Specialty Medication
HD – May require home delivery pharmacy

PPACA – No Cost-Share Preventive Medication
CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

THYROID PREPS (Hormonal Agents)		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
ANTI-THYROID PREPARATIONS		
methimazole	T1	HD
propylthiouracil	T1	HD
THYROID HORMONES		
adthyza 15 mg tablet	T1	HD
adthyza 30 mg tablet	T1	HD
adthyza 60 mg tablet	T1	HD
adthyza 90 mg tablet	T1	HD
adthyza 120 mg tablet	T1	HD
ERMEZA SOLUTION	T3	ST HD
EUTHYROX (Euthyroxlevothyroxine)	T1	HD
LEVO-T (Euthyroxlevothyroxine)	T1	HD
LEVO-T (Levo-Tlevothyroxine)	T1	HD
levothyroxine	T1	HD
levoxyl (Euthyrox)	T1	HD
liothyronine (Cytomel)	T1	HD
nature-throid	T1	
np thyroid (Armour Thyroid)	T1	HD
thyroid (Armour Thyroid)	T1	
unithroid (Euthyrox)	T1	HD
unithroid (Levo-T)	T1	HD
westhroid	T1	HD
UNCLASSIFIED DRUG PRODUCTS (AIDS/HIV)		
CYTOCHROME P450 INHIBITORS		
TYBOST	T3	SP
UNCLASSIFIED DRUG PRODUCTS (Asthma/COPD/Respiratory)		
CYSTIC FIBROSIS-CFTR POTENTIATOR-CORRECTOR COMBIN.		
ALYFTREK 10-50-125 MG TABLET	T2	PA QL (56 tabs/fill) SP HD
ALYFTREK 4-20-50 MG TABLET	T2	PA QL (84 tabs/fill) SP HD
BRONCHITOL 40 MG INHALE CAPSULE	T3	PA SP
ORKAMBI	T2	PA QL (56 packets/28 days) SP HD
SYMDEKO	T2	PA QL SP HD
TRIKAFTA 80-40-60MG/59.5MG PKT	T2	SP PA HD QL (56 packets/28 days)
TRIKAFTA 100-50-75 MG/75MG PKT	T2	SP PA HD QL (56 packets/28 days)

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

PA – Prior Authorization
QL – Quantity Limit
ST – Step Therapy

AGE – Age Requirement
SP – Specialty Medication
HD – May require home delivery pharmacy

PPACA – No Cost-Share Preventive Medication
CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

UNCLASSIFIED DRUG PRODUCTS (Asthma/COPD/Respiratory) (cont.)		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
CYSTIC FIB-TRANSMEMB CONDUCT.REG.(CFTR) POTENTIATOR		
KALYDECO 5.8 MG GRANULES PKT	T2	PA QL (56 packs/fill) SP HD
KALYDECO 13.4MG GRANULES PKT	T2	PA SP QL (56 packets/28 days)
DIPEPTIDYL PEPTIDASE I (DPPI) INHIBITOR		
BRINSUPRI	T3	PA SP
LUNG SURFACTANTS		
CUROSURF	T3	
INFASURF	T3	
SURVANTA	T3	
MUCOLYTICS		
PULMOZYME	T2	SP HD
PULMONARY FIBROSIS - SYSTEMIC ENZYME INHIBITORS		
OFEV	T2	PA QL SP HD
SYSTEMIC ENZYME INHIBITORS		
JOENJA 70 MG TABLET	T3	PA SP QL (60 tabs/30 days)
VIJOICE	T2	SP PA QL (28 tabs/30 days)
VIJOICE 50 MG GRANULE PACKET	T2	PA QL (28 Packs/28 days) SP
ZOKINVY	T3	PA QL (max 120 caps/30 days)
THYMIC STROMAL LYMPHOPOIETIN (TSLP) INHIBITORS		
TEZSPIRE 210 MG/1.91 ML PEN	T2	SP PA HD QL (1 pen/28 days)
TEZSPIRE 210 MG/1.91 ML SYRING	T2	SP PA HD QL (1 syringe/28 days)
UNCLASSIFIED DRUG PRODUCTS (Blood Modifiers/Bleeding Disorders)		
SPLEEN/BRUTON'S TYROSINE KINASE INHIBITORS		
TAVALISSE	T2	PA QL (60 tabs/30 days) SP
UNCLASSIFIED DRUG PRODUCTS (Blood Pressure/Heart Medications)		
BRADYKININ B2 RECEPTOR ANTAGONISTS		
icatibant (Firazyr)	T1	PA SP HD
PLASMA KALLIKREIN INHIBITORS		
KALBITOR	T3	PA SP HD
ORLADEYO 110MG, 150MG CAPSULE	T3	PA SP QL (28 caps/28 days)
TAKHZYRO 300MG/2ML	T2	PA SP HD QL (2 units/28 days)
UNCLASSIFIED DRUG PRODUCTS (Cancer)		
ANTINEOPLASTIC - ANTIMETABOLITES		
FLUOROURACIL	T2	

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

PA – Prior Authorization
QL – Quantity Limit
ST – Step Therapy

AGE – Age Requirement
SP – Specialty Medication
HD – May require home delivery pharmacy

PPACA – No Cost-Share Preventive Medication
CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

UNCLASSIFIED DRUG PRODUCTS (Cancer) (cont.)		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
CHEMOTHERAPY RESCUE/ANTIDOTE AGENTS		
leucovorin	T1	
mesna (Mesnex)	T1	SP CSL
MESNEX (*mesna*)	T2	SP CSL
VISTOGARD 10GM PKT	T2	PA QL (20 pkts/30days) SP
UNCLASSIFIED DRUG PRODUCTS (Dental Products)		
DENTAL AIDS AND PREPARATIONS		
chlorhexidine gluconate	T1	
DENTAL AIDS AND PREPARATIONS (cont.)		
oralone	T1	
PERIDEX *(chlorhexidine gluconate)*	T3	
periogard	T1	
triamcinolone acetonide	T1	
PERIODONTAL COLLAGENASE INHIBITORS		
doxycycline hyclate	T1	
UNCLASSIFIED DRUG PRODUCTS (Erectile Dysfunction)		
DRUGS TO TREAT ERECTILE DYSFUNCTION (ED)		
avanafil (Stendra)	T1	PA QL (8 tabs/30 days)
CIALIS *(tadalafil)*	T3	PA QL (8 tabs/30 days)
sildenafil 25 mg tablet (Viagra)	T1	PA QL (8 tabs/30 days) HD
sildenafil 50 mg tablet (Viagra)	T1	PA QL (8 tabs/30 days) HD
sildenafil 100 mg tablet (Viagra)	T1	PA QL (8 tabs/30 days) HD
STENDRA *(avanafil)*	T3	PA QL (8 tabs/30 days)
tadalafil 2.5 mg tablet	T1	PA QL (30 tabs/30 days) HD
tadalafil 5 mg tablet (Cialis)	T1	PA QL (8 tabs/30 days) HD
tadalafil 10 mg tablet (Cialis)	T1	PA QL (8 tabs/30 days) HD
tadalafil 20 mg tablet (Cialis)	T1	PA QL (8 tabs/30 days) HD
UNCLASSIFIED DRUG PRODUCTS (Eye Conditions)		
NICOTINIC RECEPT.PARTIAL AGONIST, ALPHA4BETA2 SPEC		
TYRVAYA 0.03 MG NASAL SPRAY	T3	PA
UNCLASSIFIED DRUG PRODUCTS (Gastrointestinal/Heartburn)		
AGENTS FOR STOMATOLOGICAL USE		
PROTHELIAL	T3	

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

PA – Prior Authorization
QL – Quantity Limit
ST – Step Therapy

AGE – Age Requirement
SP – Specialty Medication
HD – May require home delivery pharmacy

PPACA – No Cost-Share Preventive Medication
CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

UNCLASSIFIED DRUG PRODUCTS (Gastrointestinal/Heartburn) (cont.)		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
CALCIMIMETIC, PARATHYROID CALCIUM ENHANCER		
cinacalcet hcl (Sensipar)	T1	SP
ORAL MUCOSITIS/STOMATITIS AGENTS		
GELCLAIR	T3	
ORAMAGICRX	T3	
ORAL MUCOSITIS/STOMATITIS ANTI-INFLAMMATORY AGENT		
EPISIL	T3	
PPAR AGONIST		
IQIRVO	T2	PA SP HD
LIVDELZI	T2	PA SP
SALIVA STIMULANT AGENTS		
NUMOISYN	T3	
SALIVA SUBSTITUTE AGENTS		
AQUORAL	T3	
BOCASAL	T3	
CAPHOSOL	T3	
MUCOSITISRX	T3	
NEUTRASAL	T3	
NUMOISYN	T3	
SALIVAMAX	T3	
THYROID HORMONE RECEPTOR (THR) AGONIST		
REZDIFFRA	T2	PA QL (30 tabs/30 days) SP HD
UNCLASSIFIED DRUG PRODUCTS (Hormonal Agents)		
BONE FORMATION STIM. AGENTS - PARATHYROID HORMONE		
FORTEO	T2	PA QL (1 pen/21 days) SP HD
teriparatide 600 mcg/2.4ml pen	T1	PA QL (1 pen/28 days) SP HD
TERIPARATIDE 620 MCG/2.48 ML	T3	PA QL (1 pen/28 days) SP
BONE RESORPTION INHIBITORS		
ibandronate	T1	QL (1 tab/30 days) HD
GROWTH HORMONE RECEPTOR ANTAGONISTS		
SOMAVERT	T2	SP HD
HYPERPARATHYROID TX AGENTS - VITAMIN D ANALOG-TYPE		
doxercalciferol	T1	
paricalcitol	T1	SP HD
paricalcitol (Zemplar)	T1	SP HD

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

PA – Prior Authorization
QL – Quantity Limit
ST – Step Therapy

AGE – Age Requirement
SP – Specialty Medication
HD – May require home delivery pharmacy

PPACA – No Cost-Share Preventive Medication
CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

UNCLASSIFIED DRUG PRODUCTS (Hormonal Agents) (cont.)		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
HYPERPARATHYROID TX AGENTS - VITAMIN D ANALOG-TYPE (cont.)		
RAYALDEE	T3	
ZEMPLAR *(paricalcitol)*	T3	SP HD
UNCLASSIFIED DRUG PRODUCTS (Miscellaneous)		
ABORTIFACIENT-PROGESTERONE RECEPTOR ANTAGONISTS		
MIFEPREX	T3	
mifepristone 200 mg tablet	T1	
mifepristone (Mifeprex)	T1	
AGENTS TO TX PERIODIC PARALYSIS - CARBON ANHYD INH		
dichlorphenamide (Keveyis)	T1	PA SP
AMMONIA INHIBITORS		
CARBAGLU (*carglumic acid*)	T2	PA SP HD
carglumic acid (Carbaglu)	T1	PA SP HD
ANTI-ALCOHOLIC PREPARATIONS		
acamprosate	T1	
ANTABUSE *(disulfiram)*	T3	
disulfiram (Antabuse)	T1	
ANTI-FIBROTIC THERAPY - PYRIDONE ANALOGS		
ESBRIET	T3	PA QL (90 tabs/30 days) SP ST HD
pirfenidone 267mg capsules	T1	PA SP HD QL (270 caps/30 days)
CI ESTERASE INHIBITORS		
CINRYZE	T2	PA SP HD
HAEGARDA 2,000UNIT VIAL	T2	PA QL (24 vls/28 days) SP HD
HAEGARDA 3,000UNIT VIAL	T2	PA QL (16 vls/28 days) SP HD
RUCONEST	T2	PA SP HD
COLORING AGENTS AND DYES		
methylene blue	T1	
CRYOPRESERVATIVE AGENTS		
cryoserv	T1	
DRUGS TO TX GAUCHER DX-TYPE I, SUBSTRATE REDUCING		
CERDELGA	T2	PA SP HD QL (56 caps/28 days)
GENERAL INHALATION AGENTS		
chloride	T1	
HYPER-SAL	T3	

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

PA – Prior Authorization
QL – Quantity Limit
ST – Step Therapy

AGE – Age Requirement
SP – Specialty Medication
HD – May require home delivery pharmacy

PPACA – No Cost-Share Preventive Medication
CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

UNCLASSIFIED DRUG PRODUCTS (Miscellaneous) (cont.)		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
GENERAL INHALATION AGENTS (cont.)		
nebusal	T1	
NEBUSAL	T3	
pulmosal	T1	
sodium chloride 0.9% inhal vl	T1	
sodium chloride 10% vial	T1	
sodium chloride 3%, 7% vial	T1	
GENETIC D/O TX - SMN PROTEIN DEFICIENCY TREATMENT		
EVRYSDI	T3	PA SP HD
GLUCOSYLCERAMIDE SYNTHASE (GCS) INHIBITOR		
miglustat (Zavesca)	T1	PA QL (90 caps/30 days) SP
OPFOLDA	T3	PA QL (8 caps/fill) SP HD
HYDROXYPHENYL-PYRUVATE DIOXYGENASE(HPPD) INHIBITOR		
nitisinone (Orfadin)	T1	PA SP HD
NITYR	T2	PA SP
ORFADIN	T3	PA SP
ORFADIN *(nitisinone)*	T3	PA SP
MENOPAUSAL SYMPTOMS SUPPRESSANT-NK RECEPTOR ANTAG		
VEOZAH	T3	
MENOPAUSAL SYMPTOMS SUPPRESSANT - SSRIs		
paroxetine mesylate (Brisdelle)	T1	QL (30 units/30 days) HD
METABOLIC DISEASE ENZYME REPLACE, HYPOPHOSPHATASIA		
STRENSIQ	T2	PA SP
METABOLIC DISEASE ENZYME REPLACEMENT, MOCD		
NULIBRY 9.5 MG VIAL	T3	PA
METABOLIC DISEASE ENZYME REPLACEMENT, POMPE DISEASE		
NEXVIAZYME 100 MG VIAL	T3	PA
METALLIC POISON, AGENTS TO TREAT		
CHEMET	T2	PA
clovique (Syprine)	T1	PA SP HD
deferasirox (Exjade)	T1	PA SP HD
deferasirox (Jadenu)	T1	PA SP HD
*deferiprone (*Ferriprox (3 Times A Day)	T1	PA SP HD
FERRIPROX	T3	PA SP
GALZIN	T3	SP

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

PA – Prior Authorization
QL – Quantity Limit
ST – Step Therapy

AGE – Age Requirement
SP – Specialty Medication
HD – May require home delivery pharmacy

PPACA – No Cost-Share Preventive Medication
CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

UNCLASSIFIED DRUG PRODUCTS (Miscellaneous) (cont.)		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
METALLIC POISON, AGENTS TO TREAT (cont.)		
RADIOGARDASE	T3	
SYPRINE *(clovique)*	T3	PA SP HD
NATRIURETIC PEPTIDES		
VOXZOGO 0.4 MG VIAL	T3	PA SP
NEONATAL FC RECEPTOR (FCRN) INHIBITORS		
VYVGART HYTRULO	T3	PA SP HD
NUCLEAR FACTOR ERYTHROID 2-REL. FACTOR 2 ACTIVATOR		
SKYCLARYS	T3	PA SP
PHARMACOLOGICAL CHAPERONE-ALPHA-GALACTOSID.A STABZ		
GALAFOLD	T3	PA QL SP HD
PKU TX AGENT-COFACTOR OF PHENYLALANINE HYDROXYLASE		
sapropterin dihydrochloride (Kuvan)	T1	PA SP
PROTEIN STABILIZERS		
ATTRUBY	T2	PA SP
VYNDAMAX	T2	PA SP HD
VYNDAQEL	T2	PA SP HD
RETINOIC ACID RECEPTOR (RAR) AGONISTS		
SOHONOS 1 MG CAPSULE	T3	PA QL (112 caps/fill) SP
SOHONOS 1.5 MG CAPSULE	T3	PA QL (112 caps/fill) SP
SOHONOS 2.5 MG CAPSULE	T3	PA QL (140 caps/fill) SP
SOHONOS 5 MG CAPSULE	T3	PA QL (84 caps/fill) SP
SOHONOS 10 MG CAPSULE	T3	PA QL (56 caps/fill) SP
SOLVENTS		
dy-o-derm	T1	
FT ISOPROPYL ALCOHOL 91%	T3	
FT ISOPROPYL RUB ALCOHOL 70%	T3	
GS ISOPROPYL ALCOHOL 91%	T3	
GNP ISOPROPYL ALCOHOL 70%	T3	
INSTACLEAN	T2	
ISOPROPANOL	T2	
isopropyl alcohol	T1	
ISOPROPYL ALCOHOL	T3	
ISOPROPYL ALCOHOL 70%	T3	
MURI-LUBE MINERAL OIL	T2	

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

PA – Prior Authorization
QL – Quantity Limit
ST – Step Therapy

AGE – Age Requirement
SP – Specialty Medication
HD – May require home delivery pharmacy

PPACA – No Cost-Share Preventive Medication
CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

UNCLASSIFIED DRUG PRODUCTS (Miscellaneous) (cont.)		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
SUSPENDING AGENTS		
GELFILM	T3	
HYDROXYPROPYLCELLULOSE	T2	
HYPROMELLOSE	T2	
TREATMENT OF HYPERPHAGIA IN PRADER-WILLI SYNDROME		
VYKAT XR	T3	PA SP
UNCLASSIFIED DRUG PRODUCTS (Multiple Sclerosis)		
LEUKOCYTE ADHESION INHIB,ALPHA4-MEDIAT IGG4K MC AB		
TYSABRI 300 MG/15 ML VIAL	T2	PA QL (15 mL/30 days) HD
UNCLASSIFIED DRUG PRODUCTS (Nutritional/Dietary)		
METABOLIC DEFICIENCY AGENTS		
betaine (Cystadane)	T1	PA SP
CARNITOR *(levocarnitine)*	T3	
CARNITOR SF *(levocarnitine sf)*	T3	
CYSTADANE	T2	PA ST SP
levocarnitine (Carnitor)	T1	
levocarnitine sf (Carnitor SF)	T1	
levocarnitine 4 gm/20 ml vial	T1	
UNCLASSIFIED DRUG PRODUCTS (Osteoporosis Products)		
BONE FORMATION STIM. AGENTS - PARATHYROID HORMONE		
BONSITY *(teriparatide)*	T3	PA QL (1 pens/28 days) SP
teriparatide (Bonsity)	T1	PA QL (1 pens/28 days) SP HD
teriparatide (Forteo)	T1	PA QL (1 pens/28 days) SP HD
BONE RESORPTION INHIBITOR AND VITAMIN D COMBS.		
FOSAMAX PLUS D	T3	ST QL (4 tabs/21 days) HD
BONE RESORPTION INHIBITORS		
ACTONEL 150 MG TABLET *(risedronate)*	T3	ST QL (1 tab/23 days) HD
ACTONEL 35 MG TABLET *(risedronate)*	T3	ST QL (4 tabs/21 days) HD
ACTONEL 5 MG TABLET *(risedronate)*	T3	ST QL (30 units/30 days)
alendronate 10mg tablet	T1	QL (30 units/30 days) HD
alendronate sodium 40mg tablet	T1	HD
alendronate 35mg, 70mg tablets (Fosamax)	T1	QL (4 tabs/ 21 days) HD
alendronate 70 mg/75 ml	T1	QL (4 bottles/21 days) HD

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

PA – Prior Authorization
QL – Quantity Limit
ST – Step Therapy

AGE – Age Requirement
SP – Specialty Medication
HD – May require home delivery pharmacy

PPACA – No Cost-Share Preventive Medication
CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

UNCLASSIFIED DRUG PRODUCTS (Osteoporosis Products) (cont.)		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
BONE RESORPTION INHIBITORS (cont.)		
ATELVIA *(risedronate dr)*	T3	ST QL (4 tabs/21 days) HD
BINOSTO	T3	ST QL (4 tabs/21 days) HD
EVISTA *(raloxifene hcl)*	T3	HD
FOSAMAX *(alendronate)*	T3	ST QL (4 tabs/21 days) HD
raloxifene hcl (Evista)	T1	HD PPACA
risedronate	T1	QL HD
risedronate dr (Atelvia)	T1	QL (4 tabs/21 days) HD
UNCLASSIFIED DRUG PRODUCTS (Pain Relief And Inflammatory Disease)		
ANTI-INFLAM. INTERLEUKIN-I RECEPTOR ANTAGONIST		
ARCALYST	T3	PA SP HD
ANTI-INFLAMMATORY, INTERLEUKIN-I BETA BLOCKERS		
ILARIS	T2	PA SP HD
FIBROMYALGIA AGENTS, SEROTONIN-NOREPINEPH RU INHIB		
SAVELLA 100 MG TABLET	T2	ST QL (60 tabs/30 days)
SAVELLA 12.5 MG TABLET	T2	ST QL (60 tabs/30 days)
SAVELLA 25 MG TABLET	T2	ST QL (60 tabs/30 days)
SAVELLA 50 MG TABLET	T2	ST QL (60 tabs/30 days)
SAVELLA TITRATION PACK	T2	ST QL (55 tabs/30 days)
IMMUNOMODULATOR, B-LYMPHOCYTE STIM (BLYS)-SPEC INHIB		
BENLYSTA	T2	PA QL (4ml/28 days) SP HD
UNCLASSIFIED DRUG PRODUCTS (Skin Conditions)		
INTERLEUKIN-13 (IL-13) INHIBITORS, MAB		
ADBRY AUTOINJECTOR	T2	PA QL (2 auto-injs/28 days) SP HD
ADBRY 150MG/ML SYRINGE	T2	PA SP
EBGLYSS PEN	T2	PA QL (4 mls/28 days) SP
EBGLYSS SYRINGE	T2	PA SP
JANUS KINASE (JAK) INHIBITORS		
LEQSELVI	T3	PA SP HD
LITFULO	T3	PA QL (28 caps/28 days) SP HD
WOUND HEALING AGENTS, LOCAL		
FILSUVEZ	T3	PA SP

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

PA – Prior Authorization
QL – Quantity Limit
ST – Step Therapy

AGE – Age Requirement
SP – Specialty Medication
HD – May require home delivery pharmacy

PPACA – No Cost-Share Preventive Medication
CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

UNCLASSIFIED DRUG PRODUCTS (Substance Abuse)		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
OPIOID WITHDRAWAL THER, ALPHA-2 ADRENERGIC AGONIST		
lofexidine (Lucemyra)	T1	PA QL (224 tabs/30 days)
OPIOID WITHDRAWAL THERAPY AGENTS, OPIOID-TYPE		
buprenorphine	T1	
buprenorphine-naloxone (Suboxone)	T1	QL
PROBUPHINE	T3	
SUBOXONE *(buprenorphine-naloxone)*	T3	QL
ZUBSOLV	T2	QL
UNCLASSIFIED DRUG PRODUCTS (Transplant Medications)		
RHO KINASE INHIBITOR		
REZUROCK 200 MG TABLET	T3	PA QL (30 tabs/30 days)
UNCLASSIFIED DRUG PRODUCTS (Urinary Tract Conditions)		
BENIGN PROSTATIC HYPERTROPHY/MICTURITION AGENTS		
alfuzosin hcl er (Uroxatral)	T1	HD
dutasteride (Avodart)	T1	HD
finasteride (Proscar)	T1	HD
FLOMAX *(tamsulosin hcl)*	T3	HD
PROSCAR *(finasteride)*	T3	ST HD
silodosin (Rapaflo)	T1	HD
tamsulosin hcl (Flomax)	T1	HD
BPH 5-ALPHA-REDUCTASE INHIB-ALPHA1-ADRENOCEP ANTAG		
dutasteride/tamsulosin hcl (Jalyn)	T1	ST HD
JALYN *(dutasteride/tamsulosin hcl)*	T3	ST HD
CYSTINE-DEPLETING AGENTS, NEPHROPATHIC CYSTINOSIS		
CYSTAGON	T2	SP
ENDOTHELIN RECEPTOR ANTAGONISTS		
VANRAFIA	T2	PA SP
KIDNEY STONE AGENTS		
THIOLA	T3	SP
tiopronin 100 mg tablet (Thiola)	T1	PA SP
tiopronin dr 100 mg tablet (Thiola Ec)	T1	PA SP
tiopronin dr 100 mg tablet (Thiola Ec)	T1	PA SP HD
tiopronin dr 300 mg tablet (Thiola Ec)	T1	PA SP
tiopronin dr 300 mg tablet (Thiola Ec)	T1	PA SP HD

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

PA – Prior Authorization
QL – Quantity Limit
ST – Step Therapy

AGE – Age Requirement
SP – Specialty Medication
HD – May require home delivery pharmacy

PPACA – No Cost-Share Preventive Medication
CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

UNCLASSIFIED DRUG PRODUCTS (Urinary Tract Conditions) (cont.)		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
KIDNEY STONE AGENTS (cont.)		
tiopronin (Thiola Ec)	T1	PA SP
THIOLA EC *(tiopronin)*	T3	PA SP
OVERACTIVE BLADDER AGENTS, BETA-3 ADRENERGIC RECEP		
GEMTESA	T3	
mirabegron (Myrbetriq)	T1	HD
MYRBETRIQ	T2	HD
MYRBETRIQ (*mirabegron*)	T2	HD
URINARY TRACT ANTI-SPASMODIC, M(3) SELECTIVE ANTAG.		
darifenacin er	T1	HD
ENABLEX *(darifenacin er)*	T3	ST
fesoterodine er tablets (generic)	T1	ST
solifenacin succinate (Vesicare)	T1	HD
URINARY TRACT ANTI-SPASMODIC/ANTI-INCONTINENCE AGENT		
DITROPAN XL *(oxybutynin chloride er)*	T3	ST HD
flavoxate hcl	T1	HD
oxybutynin	T1	HD
oxybutynin chloride er (Ditropan XL)	T1	HD
oxybutynin 5 mg/5 ml soln cup	T1	HD
OXYTROL	T3	ST QL (8 patches/21 days) HD
tolterodine tartrate (Detrol)	T1	HD
tolterodine tartrate er (Detrol LA)	T1	HD
TOVIAZ	T3	ST HD
TOVIAZ ER	T3	HD
trospium chloride	T1	HD
UNCLASSIFIED DRUG PRODUCTS (Weight Management)		
APPETITE STIM. FOR ANOREXIA, CACHEXIA, WASTING SYND.		
megestrol acetate	T1	
VITAMINS (Nutritional/Dietary)		
ANTIOXIDANT MULTIVITAMIN COMBINATIONS		
BIOTECT PLUS SOFTGEL	T3	
EYE HEALTH WITH LUTEIN	T3	
LUTEIN PLUS WITH ZEAXANTHIN	T3	
PRESERVISION AREDS 2 CO Q-10	T3	

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

PA – Prior Authorization
QL – Quantity Limit
ST – Step Therapy

AGE – Age Requirement
SP – Specialty Medication
HD – May require home delivery pharmacy

PPACA – No Cost-Share Preventive Medication
CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

VITAMINS (Nutritional/Dietary) (cont.)		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
ANTIOXIDANT MULTIVITAMIN COMBINATIONS (cont.)		
VISION OPTIMIZER	T3	
VITEYES AREDS 2 PLUS MULTIVIT	T3	
BIOFLAVONOIDS		
FLAVOVIT	T3	
LIPO FLAVONOID	T3	
FOLIC ACID PREPARATIONS		
COBALEFOL	T3	
FOLETRA	T3	
DEPLIN FC	T3	
folic acid	T1	PPACA
ft folic acid 400 mcg, 800 mcg tablet	T1	PPACA
MI-VITE RX	T3	
purevita folic acid 400 mcg tb	T1	PPACA
PUREVITA FOLIC ACID 400MCG/2ML	T3	
true folic acid 667 mcg dfe tb	T1	PPACA
true folic acid 1600mcg dfe tb	T1	
MULTIVITAMIN PREPARATIONS		
ABC COMPLETE ADULT	T2	
ABC COMPLETE MEN'S	T2	
ACTIVNUTRIENTS PERFORMANCE	T3	
ADULT MULTI	T3	
AFLORA	T3	
ALIVE ADULT ULTRA POTENCY	T3	
ALIVE COMPLETE PREMIUM PRENATL	T3	
ALIVE MAX6 POTENCY	T3	
ALIVE WOMEN'S 50 PLUS COMPLETE	T3	
ALIVE WOMEN'S MULTIVITAMIN	T3	
ALIVE DAILY ENERGY	T3	
ALIVE HAIR, SKIN AND NAILS	T3	
ALIVE MEN'S 50 PLUS GUMMY	T3	
ALIVE MEN'S 50 PLUS ULTRA	T3	
ALIVE MEN'S ULTRA POTENCY	T3	
ALIVE PREMIUM ADULT	T3	
ALIVE MEN'S ENERGY	T3	

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

PA – Prior Authorization
QL – Quantity Limit
ST – Step Therapy

AGE – Age Requirement
SP – Specialty Medication
HD – May require home delivery pharmacy

PPACA – No Cost-Share Preventive Medication
CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

VITAMINS (Nutritional/Dietary) (cont.)		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
MULTIVITAMIN PREPARATIONS (cont.)		
ALIVE MEN'S GUMMY	T3	
ALPHA BETIC MULTIVITAMIN	T3	
ALTRIXA	T3	
b complex w-vitamin c	T1	PPACA
biotect plus liquid	T1	
CENTRUM ADULT 50 PLUS	T3	
CENTRUM CENTRUM WOMEN IMMUNE MINIS	T3	
CENTRUM MEN 50 PLUS	T3	
CENTRUM MEN MULTIGUMMY	T3	
CENTRUM MENOPAUSE MULTIVITAMIN	T3	
CENTRUM MEN'S TABLET	T2	
CENTRUM MULTI MENTAL FOCUS	T3	
CENTRUM MULTI PLUS BEAUTY	T3	
CENTRUM MULTI PLUS OMEGA-3	T3	
CENTRUM POSTNATAL	T3	
CENTRUM PRENATAL	T3	
CENTRUM WOMEN 50 PLUS	T3	
CENTRUM WOMEN MULTIGUMMY	T3	
centrum women tablet (Certavite-Antioxidant)	T1	
centrum women tablet (Tab-A-Vite Multivit With Iron)	T1	
COMPLETIA DIABETIC MULTIVIT	T3	
cvs adult multivitamin gummy	T1	
DAILY MULTIPLE	T2	
DAVIMET WITH IRON	T3	
DIABETES HEALTH PACK	T3	
DIATROL	T3	
EQ ONE DAILY MEN'S TABLET	T2	
FINAZOL	T3	
FOLACHEW	T3	
FOLAPRIME	T3	
FOLAWISE	T3	
FLORRAXYL	T3	
ft b complex plus vit c tablet	T1	
ft century men tablet	T1	

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

PA – Prior Authorization
QL – Quantity Limit
ST – Step Therapy

AGE – Age Requirement
SP – Specialty Medication
HD – May require home delivery pharmacy

PPACA – No Cost-Share Preventive Medication
CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

VITAMINS (Nutritional/Dietary) (cont.)		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
MULTIVITAMIN PREPARATIONS (cont.)		
ft century women tablet (Certavite-Antioxidant)	T1	
ft century women tablet (Tab-A-Vite Multivit With Iron)	T1	
FT HAIR, SKIN AND NAILS TABLET	T3	
ft one daily men's tablet	T1	
ft one daily women's tablet	T1	
GNP CENTURY ADULT FORMULA TAB	T3	
gnp century adult formula tab (Certavite-Antioxidant)	T1	
gnp century adult formula tab (Tab-A-Vite Multivit With Iron)	T1	
GNP CENTURY MEN TABLET	T3	
GNP CENTURY WOMEN TABLET	T3	
GNP ONE DAILY MAXIMUM TABLET	T3	
MEN'S DAILY MULTIVITAMIN	T2	
MICRONEX	T3	
multivit no.18/iron no.1/folic (Tandem Plus)	T1	
MEN'S ONE DAILY	T2	
MULTIA DAILY MULTIVITAMIN	T3	
multivit-minerals/folic acid	T1	
MULTIVITAMIN-MULTIMINERAL	T3	
mv-mn/folic ac/calcium/vit k1	T1	
mv-min 59/iron/folic/docusate	T1	
MVW MODULATR FORM MINI MULTIVT	T3	
NIVA-PLUS *(multivit-min 60/iron fum/folic)*	T3	
NUTRALYN	T3	
ONE-A-DAY TRIPLE IMMUNE SUPPRT	T3	
ONE-A-DAY WOMEN'S 50 PLUS TAB	T3	
one-a-day women's 50 plus tab (One-A-Day)	T1	
ONE DAILY ESSENTIALS	T3	
one daily maximum tablet	T1	
one daily multivit-mineral tab	T1	
ONE DAILY MULTIVIT-MINERAL TAB	T3	
PRENATAL GUMMIES	T3	
PREV-RX	T3	
ra one daily maximum tablet	T1	
super b-complex w/vitamin c	T1	PPACA

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

PA – Prior Authorization
QL – Quantity Limit
ST – Step Therapy

AGE – Age Requirement
SP – Specialty Medication
HD – May require home delivery pharmacy

PPACA – No Cost-Share Preventive Medication
CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

VITAMINS (Nutritional/Dietary) (cont.)		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
MULTIVITAMIN PREPARATIONS (cont.)		
SUPERIOR MEN'S MULTI	T3	
TANDEM PLUS *(multivit no.18/iron no.1/folic)*	T3	
thera-m caplet, tablett	T1	
THERA-M CAPLET	T3	
TRIVIA COMPLETE	T3	
TRUE MULTIVITAMIN	T3	
VITACORE	T3	
VITAFUSION PRENATAL	T3	
VITAJOY ADULT MULTI	T3	
vitamin b complex with c	T1	HD PPACA
NIACIN PREPARATIONS		
ft niacin 400 mg capsule	T1	
NIACIN 100 MG CAPSULE	T3	
NIACINAMIDE 500 MG CAPSULE	T3	
PUREVITA VITAMIN B3	T3	
true vitamin b3 50 mg tablet	T1	
true vitamin b3 500 mg tablet	T1	
TRUE VITAMIN B3 250 MG TABLET	T3	
PANTHENOL PREPARATIONS		
PANTOTHENIC ACID	T3	
PUREVITA VITAMIN B5	T3	
PEDIATRIC VITAMIN PREPARATIONS		
ALIVE KIDS MULTIVITAMIN	T3	
DAVIMET WITH FLUORIDE	T3	
EMERGEN-C KIDZ DAILY IMMUNE	T3	
EMERGEN-C KIDZ IMMUNE PLUS	T3	
FLINTSTONES IMMUNITY SUPPORT	T3	
FLORAFOL PEDIATRIC	T3	
FLORAFOL FE PEDIATRIC	T3	
GUMMY DINOS	T3	
little animals child tb chw (Flintstones With Extra C)	T1	
little animals child tb chw (Flintstones)	T1	
LITTLE ANIMALS CHILD TB CHW	T3	
LIVITA FOR CHILDREN	T3	

T1 – Typically Generics
T2 – Typically Preferred Brands
T3 – Typically Non-Preferred Brands
PA – Prior Authorization
QL – Quantity Limit
ST – Step Therapy
AGE – Age Requirement
SP – Specialty Medication
HD – May require home delivery pharmacy
PPACA – No Cost-Share Preventive Medication
CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

VITAMINS (Nutritional/Dietary) (cont.)		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
PEDIATRIC VITAMIN PREPARATIONS (cont.)		
MVW MODULATR FORMLTN PEDIATRIC	T3	
NOVAFERRUM YUM PEDIATR MV-IRON	T3	
NOVAMV MMM PEDIATRIC MULTIVIT	T3	
pedi multivit no.17 w-fluoride	T1	PPACA
pediatric multivitamin no.111	T1	
pediatric multivitamin no.212	T1	
MULTIVIT-FLUOR 0.5 MG TAB CHEW	T3	
MULTIVIT-FLUORIDE 1 MG TAB CHW	T3	
multivitamin with fluoride	T1	PPACA
mvc-fluoride	T1	PPACA
SOLUVITA MULTIVITAMIN FLUORIDE	T3	
SOLUVITA MULTIVITAMIN FLUORIDE (pedi multivit no.82 w-fluoride)	T3	
tri-vit-fluor 0.25 mg/ml drop	T1	PPACA
TRI-VIT-FLUOR 0.25 MG/ML DROP	T3	
tri-vit-fluor 0.5 mg/ml drop	T1	PPACA
tri-vitamin with fluoride	T1	PPACA
vitamins a, c, d & fluoride	T1	PPACA
VITAMIN A PREPARATIONS		
FT VITAMIN A 3,000 MCG SOFTGEL	T3	
GNP VITAMIN A 3,000 MCG SOFTGL	T3	
PUREVITA VITAMIN A	T3	
VITAMIN B PREPARATIONS		
acetylcyst/methylb12/levomefol (Cerefolin Brain Wellness)	T1	HD
B-100 COMPLEX CAPSULE	T3	HD
b-100 complex tr caplet	T1	HD
b complex, c no.20/folic acid (Virt-Caps)	T1	HD
b complex w-vitamin c	T1	HD PPACA
b-complex tablet (Vitamin B Complex-Electrolytes)	T1	HD PPACA
B-COMPLEX 100	T3	HD
B-COMPLEX FAST DISSOLVE TABLET	T3	HD
balance b	T1	HD PPACA
balanced b-complex	T1	HD PPACA
CEREFOLIN BRAIN WELLNESS *(acetylcyst/methylb12/levomefol)*	T3	HD
COMPLETE LIVER CLEANSE	T3	HD

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

PA – Prior Authorization
QL – Quantity Limit
ST – Step Therapy

AGE – Age Requirement
SP – Specialty Medication
HD – May require home delivery pharmacy

PPACA – No Cost-Share Preventive Medication
CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

VITAMINS (Nutritional/Dietary) (cont.)		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
VITAMIN B PREPARATIONS (cont.)		
CVS BIOTIN 5,000 MCG TABLET	T3	HD
dialyvite 800 (Nephro-Vite)	T1	HD PPACA
FOLA-B COMPLEX	T3	HD
FOLIC ACID-B6-B12	T3	HD
FOLICORE B COMPLEX	T3	HD
FOLIKA-BC	T3	HD
FOLVITA COMPLEX	T3	HD
foltabs 800	T1	HD PPACA
ft b-100 complex er tablet	T1	HD
ft biotin 5,000 mcg capsule (Meribin)	T1	HD
FT BIOTIN 10,000 MCG TABLET	T2	HD
FT BIOTIN 2,500 MCG GUMMY	T3	HD
full spectrum b (Nephro-Vite)	T1	HD PPACA
gnp b-100 complex tablet	T1	HD
GNP BIOTIN 10,000 MCG TABLET	T2	HD
GNP BIOTIN 2,500 MCG GUMMY	T3	HD
KIDS BRAIN BUILDER	T3	HD
METANXPRO NERVE HEALTH	T3	HD
METANX FC	T3	HD
METANX RR	T3	HD
MINCORA	T3	HD
PUREVITA SUPER B-COMPLEX	T3	HD
ra balanced b-100 tablet (Vitamin B Complex-Electrolytes)	T1	HD PPACA
RELCARE	T3	HD
rena-vite (Nephro-Vite)	T1	HD PPACA
RENAL MULTIVITAMIN	T3	HD
super quints b-50 tablet (Vitamin B Complex-Electrolytes)	T1	HD PPACA
super b complex-vitamin c	T1	HD PPACA
super b-50 complex capsule	T1	HD
super b-50 complex capsule	T1	HD PPACA
vit b comp c 19/folic acid/d3	T1	HD PPACA
VITAJOY BIOTIN	T3	HD
vitamin b complex tablet (Vitamin B Complex-Electrolytes)	T1	HD PPACA
vitamin b complex/folic acid (Vitamin B Complex-Electrolytes)	T1	HD PPACA

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

PA – Prior Authorization
QL – Quantity Limit
ST – Step Therapy

AGE – Age Requirement
SP – Specialty Medication
HD – May require home delivery pharmacy

PPACA – No Cost-Share Preventive Medication
CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

VITAMINS (Nutritional/Dietary) (cont.)		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
VITAMIN B PREPARATIONS (cont.)		
VITAMIN B COMPLEX-ELECTROLYTES *(vitamin b complex/folic acid)*	T3	HD
vit b comp/folic/choline/inosi	T1	HD PPACA
VIRT-CAPS *(b complex, c no.20/folic acid)*	T3	HD
vitamin b-complex & c	T1	HD PPACA
VITAMIN BI PREPARATIONS		
cvs vitamin b-1 100 mg tablet	T1	
ft vitamin b-1 100 mg tablet	T1	
gnp vitamin b-1 100 mg tablet	T1	
PUREVITA VITAMIN B1	T3	
ra vitamin b-1 100 mg tablet	T1	
THIAMINE HCL-0.9% NACL	T3	
true vitamin b-1 100 mg tablet	T1	
TRUE VITAMIN B-1 250 MG TABLET	T3	
TRUE VITAMIN B-1 50 MG TABLET	T3	
VITAMIN B-1 100 MG CAPSULE	T3	
vitamin b-1 100 mg tablet	T1	
vitamin b-1 250 mg tablet	T1	
vitamin b-1 50 mg tablet	T1	
VITAMIN BI2 PREPARATIONS		
cvs vitamin b12 5,000 mcg chew	T1	
CVS VIT B12 2,500 MCG SOFT CHW	T3	
CVS VITAMIN B12 5,000 MCG TAB	T3	
cyanocobalamin	T1	
cyanocobalamin (vitamin b-12) (Nascobal)	T1	ST QL (4 units/30 days)
ft vit b-12 2,500 mcg tab sl	T1	
FT VITAMIN B-12 1500 MCG GUMMY	T3	
FT VITAMIN B-12 5,000 MCG TAB	T2	
ft vitamin b-12 500 mcg tablet	T1	
ft vitamin b12 er 1,000 mcg tb	T1	
GNP VITAMIN B-12 1500MCG GUMMY	T3	
GNP VITAMIN B-12 5,000 MCG TAB	T3	
hydroxocobalamin	T1	
NASCOBAL *(cyanocobalamin (vitamin b-12))*	T2	ST QL (4 units/30 days)
PAXLYTE	T3	

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

PA – Prior Authorization
QL – Quantity Limit
ST – Step Therapy

AGE – Age Requirement
SP – Specialty Medication
HD – May require home delivery pharmacy

PPACA – No Cost-Share Preventive Medication
CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

VITAMINS (Nutritional/Dietary) (cont.)		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
VITAMIN B12 PREPARATIONS (cont.)		
PUREVITA VITAMIN B12	T3	
true vitamin b-12 1000 mcg tab	T1	
true vitamin b-12 500 mcg tab	T1	
VITAMIN B12 2,500 MCG TABLET	T3	
vitamin b-12 er 1,000 mcg tab	T1	
VITAMIN B2 PREPARATIONS		
PUREVITA VITAMIN B2	T3	
RIBOFLAVIN 100 MG CAPSULE	T3	
VITAMIN B6 PREPARATIONS		
cvs vitamin b-6 100 mg tablet	T1	
eql vitamin b-6 100 mg tablet	T1	
ft vitamin b-6 100 mg tablet	T1	
gnp vitamin b-6 100 mg tablet	T1	
PUREVITA VITAMIN B6	T3	
pyridoxine hcl (vitamin b6) (Pyridoxine Hcl)	T1	
ra vitamin b-6 100 mg tablet	T1	
ra vitamin b-6 50 mg tablet	T1	
sm vitamin b-6 100 mg tablet	T1	
sv vitamin b-6 100 mg tablet	T1	
true vitamin b-6 100 mg tablet	T1	
true vitamin b-6 25 mg tablet	T1	
true vitamin b-6 50 mg tablet	T1	
TRUE VITAMIN B-6 10 MG TABLET	T3	
vitamin b-6 100 mg tablet	T1	
vitamin b-6 25 mg tablet	T1	
vitamin b-6 250 mg tablet	T1	
vitamin b-6 50 mg tablet	T1	
VITAMIN C PREPARATIONS		
ascorbic acid 500 mg/5 ml cup	T1	
cvs vit c-rose hip 500 mg cplt	T1	
EASY-C IMMUNE HEALTH	T3	
EMERGEN-C APPLE CIDER VINEGAR	T3	
EMERGEN-C ASHWAGANDHA	T3	
EMERGEN-C ELDERBERRY	T3	

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

PA – Prior Authorization
QL – Quantity Limit
ST – Step Therapy

AGE – Age Requirement
SP – Specialty Medication
HD – May require home delivery pharmacy

PPACA – No Cost-Share Preventive Medication
CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

VITAMINS (Nutritional/Dietary) (cont.)		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
VITAMIN B6 PREPARATIONS (cont.)		
EMERGEN-C ENERGY PLUS	T3	
EMERGEN-C TURMERIC GINGER	T3	
FLEVOXIN	T3	
ft vit c-rose hip 1,000 mg tab	T1	
ft vit c-rose hips 500 mg tab	T1	
FT VITAMIN C 500 MG CHEW TAB	T2	
ft vitamin c 1,000 mg tablet	T1	
GNP VITAMIN C 125 MG GUMMY	T3	
LIQUID-C	T3	
PUREVITA VITAMIN C	T3	
SAMBUCUS ELDERBERRY-VITAMIN C	T3	
true vitamin c 1,000 mg tablet	T1	
true vitamin c 250 mg tablet	T1	
true vitamin c 500 mg tablet	T1	
vit c-rose hips 500 mg capsule	T1	
VIT C-ROSE HIPS 500 MG CAPSULE	T1	
well vitamin c 1,000 mg tablet	T1	
well vitamin c 500 mg tablet	T1	
VITAMIN D PREPARATIONS		
calcitriol (Rocaltrol)	T1	HD
calcitriol 1 mcg/ml ampul	T1	
calcitriol 1 mcg/ml solution (Rocaltrol)	T1	
calcitriol 0.25 mcg capsule	T1	
calcitriol 0.5 mcg capsule	T1	
CVS VITAMIN D3 250 MCG SOFTGEL	T3	HD
DERMACINRX FOLIXATE	T3	HD
DRISDOL *(vitamin d2)*	T3	HD
ft vitamin d3 25 mcg softgel	T1	HD
ft vitamin d3 50 mcg softgel	T1	HD
ft vitamin d3 125 mcg softgel	T1	HD
FT VITAMIN D3 250 MCG SOFTGEL	T3	HD
ft vitamin d3 25 mcg tablet	T1	HD
ft vitamin d3 50 mcg tablet	T1	HD
ft vitamin d3 125 mcg tablet	T1	HD

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

PA – Prior Authorization
QL – Quantity Limit
ST – Step Therapy

AGE – Age Requirement
SP – Specialty Medication
HD – May require home delivery pharmacy

PPACA – No Cost-Share Preventive Medication
CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

VITAMINS (Nutritional/Dietary) (cont.)		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
VITAMIN D PREPARATIONS (cont.)		
FT VITAMIN D3 250 MCG TABLET	T3	HD
gnp vitamin d3 50 mcg, 125 mcg softgel	T1	HD
GNP VITAMIN D3 250 MCG SOFTGEL, TABLET	T3	HD
K2-D3 MAX	T3	HD
purevita vitamin d3 25 mcg tab	T1	HD
PUREVITA VITAMIN D3 10 MCG/2ML	T3	HD
ROCALTROL (*calcitriol*)	T3	ST
true vitamin d3 1,250 mcg tab	T1	HD
true vitamin d3 10 mcg capsule	T1	HD
true vitamin d3 10 mcg tablet	T1	HD
true vitamin d3 50 mcg tablet	T1	HD
true vitamin d3 125 mcg cap, tablet	T1	HD
true vitamin d3 25 mcg capsule	T1	HD
true vitamin d3 50 mcg capsule	T1	HD
true vitamin d3 25 mcg tablet	T1	HD
TRUE VITAMIN D3 1,250 MCG CAP	T3	HD
TRUE VITAMIN D3 250 MCG CAP	T3	HD
TRUE VITAMIN D3 250 MCG TABLET	T3	HD
vitamin d2 (Drisdol)	T1	HD
vitamin d2 1.25mg (50,000 unit)	T1	HD
VITAMIN D2-VITAMIN K1	T3	HD
VITAMIN D2-VITAMIN K2	T3	HD
VITAMIN D3 50,000 UNIT CAPSULE	T3	HD
VITAMIN D3 50 MCG DISSOLVE TAB	T3	HD
VITAMIN D3 62.5 MCG SOFTGEL	T3	HD
VITAMIN D3 10 MCG/ML ENFIT SYR	T3	HD
well vitamin d3 125 mcg softgl	T1	HD
well vitamin d3 25 mcg softgel	T1	HD
well vitamin d3 50 mcg softgel	T1	HD
VITAMIN E PREPARATIONS		
ft vitamin e 180 mg softgel	T1	
true vitamin e 180 mg capsule	T1	
PUREVITA VITAMIN E	T3	
TRUE VITAMIN E 450 MG CAPSULE	T3	

T1 – Typically Generics
T2 – Typically Preferred Brands
T3 – Typically Non-Preferred Brands
PA – Prior Authorization
QL – Quantity Limit
ST – Step Therapy
AGE – Age Requirement
SP – Specialty Medication
HD – May require home delivery pharmacy
PPACA – No Cost-Share Preventive Medication
CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

VITAMINS (Nutritional/Dietary) (cont.)		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
VITAMIN K PREPARATIONS		
FNP VITAMIN K2 40 MCG TABLET	T3	
ft vitamin k2 100 mcg capsule	T1	
gnp vitamin k2 100 mcg capsule	T1	
MEPHYTON *(phytonadione)*	T3	QL
phytonadione	T1	
phytonadione 1 mg/0.5 ml syr	T1	
vitamin k	T1	
VITAMIN K2 100 MCG SOFTGEL	T3	
VITAMINS (Vitamins)		
MULTIVITAMIN PREPARATIONS		
ALIVE MEN'S MAX3 POTENCY	T3	
BOOSTNOW IMMUNE SUPPORT	T3	
CENTRUM ADULTS 50 PLUS MINIS	T3	
CENTRUM MEN 50 PLUS MINIS	T3	
DAVIMET-M	T3	
DERMACINRX MULTIVITAMIN	T3	
LIVITA FOR ADULT	T3	
MULTITOL-M	T3	
NANOVM ADULT	T3	
SUPERIOR WOMEN'S MULTI	T3	
PEDIATRIC VITAMIN PREPARATIONS		
ft children's multi gummy	T1	
GNP CHILDREN'S MULTI GUMMY	T3	
multivit-fluor 0.5 mg tab chew	T1	PPACA

T1 – Typically Generics
T2 – Typically Preferred Brands
T3 – Typically Non-Preferred Brands
PA – Prior Authorization
QL – Quantity Limit
ST – Step Therapy
AGE – Age Requirement
SP – Specialty Medication
HD – May require home delivery pharmacy
PPACA – No Cost-Share Preventive Medication
CSL – Oral cancer medication subject to cost-share limits

Exclusions and limitations for coverage

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

Plans generally do not provide coverage for the following under the pharmacy benefit, except as required by state or federal law, or by the terms of your specific plan:[10]

- Over-the-counter (OTC) medicines (those that do not require a prescription) except insulin unless state or federal law requires coverage of such medicines.
- Prescription medications or supplies for which there is a prescription or OTC therapeutic equivalent or therapeutic alternative.
- Doctor-administered injectable medications covered under the Plan's medical benefit, unless otherwise covered under the Plan's prescription drug list or approved by Cigna Healthcare.
- Implantable contraceptive devices covered under the Plan's medical benefit.
- Medications that are not medically necessary.
- Experimental or investigational medications, including U.S. Food and Drug Administration (FDA)-approved medications used for purposes other than those approved by the FDA unless the medication is recognized for the treatment of the particular indication.
- Medications that are not approved by the FDA.
- Prescription and non-prescription devices, supplies, and appliances other than those supplies specifically listed as covered.
- Medications used for fertility,[11] sexual dysfunction, cosmetic purposes, weight loss, smoking cessation,[11] or athletic enhancement.
- Prescription vitamins (other than prenatal vitamins) or dietary supplements unless state or federal law requires coverage of such products.
- Immunization agents, biological products for allergy immunization, biological sera, blood, blood plasma and other blood products or fractions and medications used for travel prophylaxis.
- Replacement of prescription medications and related supplies due to loss or theft.
- Medications which are to be taken by or administered to a covered person while they are a patient in a licensed hospital, skilled nursing facility, rest home or similar institution which operates on its premises or allows to be operated on its premises a facility for dispensing pharmaceuticals.
- Prescriptions more than one year from the date of issue.
- Coverage for prescription medication products for the amount dispensed (days' supply) which is more than the applicable supply limit, or is less than any applicable supply minimum set forth in The Schedule, or which is more than the quantity limit(s) or dosage limit(s) set by the P&T Committee.
- More than one prescription order or refill for a given prescription supply period for the same prescription medication product prescribed by one or more doctors and dispensed by one or more pharmacies.
- Prescription medication products dispensed outside the jurisdiction of the United States, except as required for emergency or urgent care treatment.

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

Index of Medications

Symbols

A

Index of Medications

Index of Medications

B

Index of Medications

Index of Medications

Index of Medications

Index of Medications

D

Index of Medications

Index of Medications

E

Index of Medications

Index of Medications

Index of Medications

G

Index of Medications

H

Index of Medications

Index of Medications

Index of Medications

Index of Medications

Index of Medications

Index of Medications

Index of Medications

O

Index of Medications

P

Index of Medications

Index of Medications

Index of Medications

Q

R

Index of Medications

S

Index of Medications

Index of Medications

T

Index of Medications

Index of Medications

U

Index of Medications

Index of Medications

Index of Medications

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

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

1. App/online store terms and mobile phone carrier/data charges apply. Customers under age 13 (and/or their parent/guardian) will not be able to register at myCigna.com.
2. Prices shown on myCigna are not guaranteed and coverage is subject to your plan terms and conditions. Visit myCigna for more information.
3. U.S. Food and Drug Administration (FDA) website, "Generic Drug Facts." Content current as of 11/01/21. fda.gov/drugs/generic-drugs/generic-drug-facts.
4. U.S. Food and Drug Administration (FDA) website, "Biosimilar Basics for Patients." Last updated 08/01/24. fda.gov/drugs/biosimilars/biosimilars-basics-patients.
5. **Not all plans offer Express Scripts Pharmacy and Accredo as covered pharmacy options.** Log in to the myCigna App or myCigna.com, or check your plan materials, to learn more about the pharmacies in your plan's network. Cigna Healthcare, Evernorth Health Services, Express Scripts and Accredo are all part of The Cigna Group. This means we have an ownership interest in Express Scripts Pharmacy's home delivery services and Accredo's specialty pharmacy services. However, you have the right to fill prescriptions at any pharmacy in your plan's network (as your plan allows).
6. Your plan pays the cost for standard shipping.
7. Express Scripts Pharmacy can automatically refill certain medications. Log in to the myCigna App or myCigna.com, or call 800.835.3784, to sign up. You can sign up to get emails and/or texts from Express Scripts Pharmacy. To get text messages, you'll have to sign up for the Express Scripts texting service. You can do this online or when you call 800.835.3784 to refill your prescription. Once you sign up, just reply to their welcome text to get started. Standard text messaging rates apply.
8. You can only refill certain specialty medications by text. To get text messages, you'll have to sign up for Accredo's texting service. You can do this when you call Accredo to refill your prescription. Once you sign up, just reply to their welcome text to get started. Standard text messaging rates apply.
9. **For insured plans that must follow Delaware's state insurance laws:** Brand-name antidepressants, smoking cessation, attention deficit hyperactivity disorder (ADHD) and anti-psychotic medications that don't have a generic equivalent available will be covered as Tier 2 (preferred brand). This is true even if the medication is listed as Tier 3 (non-preferred brand) on your plan's drug list. To find out how your specific plans covers these medications, log in to the myCigna App or myCigna.com, or call the number on your ID card.
10. Costs and complete details of the plan's prescription drug coverage are set forth in the plan documents. If there are any differences between the information provided here and the plan documents, the information in the plan documents takes complete precedence.
11. **For plans that must follow state insurance laws, such as Delaware:** Your plan may provide coverage for infertility medications and smoking cessation medications even if this drug list states that your plan may not cover them. To find out if your specific plan covers these medications, log in to the myCigna App or myCigna.com, or check your plan materials.

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

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

Discrimination is against the law

Cigna Healthcare® complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, sex, ancestry, religion, marital status, gender, sexual orientation, gender identity or sexual stereotypes.

Cigna Healthcare does not exclude people or treat them less favorably differently because of race, color, national origin, age, disability, sex, ancestry, religion, marital status, gender, sexual orientation, gender identity or sexual stereotypes.

Cigna Healthcare:

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

If you need reasonable modifications, appropriate auxiliary aids and services or language assistance services, contact the Civil Rights Coordinator.

If you believe that Cigna Healthcare has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, sex, ancestry, religion, marital status, gender, sexual orientation, gender identity or sexual stereotypes, you can file a grievance with the Civil Rights Coordinator
P.O. Box 188016, Chattanooga, TN 37422,
877.822.6561 (TTY: Dial 711)

ACAGrievance@CignaHealthcare.com

You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, the Civil Rights Coordinator is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at **https://ocrportal.hhs.gov/ocr/portal/lobby.jsf**, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue,
SW Room 509F, HHH Building
Washington, DC 20201
1.800.368.1019, 800.537.7697 (TDD)

Complaint forms are available at **https://www.hhs.gov/civil-rights/filing-a-complaint/complaint-process/index.html**

Proficiency of Language Assistance Services

English – ATTENTION: If you speak English, free language assistance services are available to you. Appropriate auxiliary aids and services to provide information in accessible formats are also available free of charge. Call 1-800-244-6224 (TTY: Dial 711) or speak to your provider.

Spanish – ATENCIÓN: Si habla español, los servicios de asistencia lingüística gratuitos están disponibles para usted. También están disponibles de forma gratuita ayudas y servicios auxiliares adecuados para proporcionar información en formatos accesibles. Llame al 1-800-244-6224 (TTY: Marque 711) o hable con su proveedor.

Chinese – 注意：如果您讲中文，我们提供免费的语言援助服务。适当的辅助设备和服务也可以免费提供，以提供无障碍格式的信息。请拨打 1-800-244-6224（TTY：拨打 711）或与您的服务提供者联系。

Vietnamese – XIN LƯU Ý: Nếu bạn nói tiếng Viet, dịch vụ hỗ trợ ngôn ngữ miễn phí có sẵn cho bạn. Các thiết bị và dịch vụ hỗ trợ phù hợp để cung cấp thông tin ở định dạng có thể tiếp cận cũng có sẵn miễn phí. Gọi số 1-800-244-6224 (TTY: Gọi 711) hoặc nói chuyện với nhà cung cấp của bạn).

Korean – 주의: 한국어를 사용하시는 경우, 무료 언어 지원 서비스가 제공됩니다. 접근 가능한 형식으로 정보를 제공하기 위한 적절한 보조 기기 및 서비스도 무료로 제공됩니다. 1-800-244-6224 (TTY: 711 로 전화) 로 전화하시거나 제공자에게 문의하십 시오.

Tagalog – PAUNAWA: Kung ikaw ay nagsasalita ng Tagalog, ang mga libreng serbisyo ng tulong sa wika ay magagamit para sa iyo. Ang mga angkop na pantulong na kagamitan at serbisyo upang magbigay ng impormasyon sa mga naa-access na format ay magagamit din ng libre. Tumawag sa 1-800-244-6224 (TTY: Tumawag sa 711) o makipag-usap sa iyong tagapagbigay.

Russian – ВНИМАНИЕ: Если вы говорите на русском, доступны бесплатные услуги языковой помощи. Также бесплатно предоставляются соответствующие вспомогательные средства и услуги для предоставления информации в доступных форматах. Позвоните по телефону 1-800-244-6224 (TTY: Наберите 711) или обратитесь к вашему провайдеру.

Arabic - تنبيه: إذا كنت تتحدث العربية، تتوفر لك خدمات المساعدة اللغوية المجانية. كما تتوفر أيضًا مساعدات قابلة للوصول إليها، وذلك مجانًا. اتصل بالرقم 1-800-244-6224 (TTY: 711 اطلب) أو تحدث إلى مقدم الخدمة الخاص بك.

French Creole – ATANSYON: Si ou pale Kreyòl Ayisyen, sèvis asistans lang gratis yo disponib pou ou. Ekipman ak sèvis adisyonèl ki apwopriye pou bay enfòmasyon nan fòma ki aksesib yo disponib tou gratis. Rele 1-800-244-6224 (TTY: Rele 711) oswa pale ak founisè ou a.

French – ATTENTION : Si vous parlez français, des services d'assistance linguistique gratuits sont disponibles pour vous. Des aides et des services auxiliaires appropriés pour fournir des informations dans des formats accessibles sont également disponibles gratuitement. Appelez le 1-800-244-6224 (TTY : composez le 711) ou parlez à votre fournisseur.

Portuguese – ATENÇÃO: Se você fala português, serviços gratuitos de assistência linguística estão disponíveis para você. Auxílios e serviços apropriados para fornecer informações em formatos acessíveis também estão disponíveis gratuitamente. Ligue para 1-800-244-6224 (TTY: disque 711) ou fale com seu prestador de serviços.

Polish – UWAGA: Jeśli mówisz po polsku, dostępne są bezpłatne usługi pomocy językowej. Odpowiednie pomoce i usługi wspierające w celu dostarczenia informacji w dostępnych formatach są również dostępne bezpłatnie. Zadzwoń pod numer 1-800-244-6224 (TTY: wybierz 711) lub skontaktuj się ze swoim dostawcą usług.

Japanese – 注意: 日本語を話す場合は、無料の言語支援サービスが利用できます。アクセス可能な形式で情報を提供するための適切な補助機器やサービスも無料で利用できます。1-800-244-6224（TTY: 711 にダイヤル）に電話するか、提供者に話してください。

Italian – ATTENZIONE: Se parli italiano, sono disponibili per te servizi gratuiti di assistenza linguistica. Sono disponibili gratuitamente anche ausili e servizi appropriati per fornire informazioni in formati accessibili. Chiama il numero
1-800-244-6224 (TTY: comporre il 711) o parla con il tuo fornitore.

German – Achtung: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlose Sprachassistenzdienste zur Verfügung. Geeignete Hilfsmittel und Dienste, um Informationen in barrierefreien Formaten bereitzustellen, sind ebenfalls kostenlos verfügbar. Rufen Sie 1-800-244-6224 an (TTY: Wählen Sie 711) oder sprechen Sie mit Ihrem Anbieter.

Persian (Farsi) - توجه: همچنین، وسایل و خدمات کمکی مناسب برای در دسترس است. خدمات رایگان کمک زبان برای شما صحبت می‌کنید، اگر به فارسی تماس بگیرید یا با (شماره 711 را بگیرید :TTY) ارائه اطلاعات در قالبهای قابل دسترس به صورت رایگان در دسترس هستند. با شماره 1-800-244-6224 ارائه‌دهنده خود صحبت کنید.