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

Coverage as of January 1, 2026

For the State of California
Exclusive Provider Organization (EPO), LocalPlus (LocalPlus IN/LocalPlus), Open Access Plus (OAPIN/OAP), Preferred Provider Organization (PPO), SureFit

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

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 This drug list is subject to change and all prior versions are no longer in effect.

cigna healthcare

View your drug list online, 24/7

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

- You can use the Price a Medication tool on the myCigna App[1] or **myCigna.com** to see the most up-to-date list of the medications your plan covers.
- You can also see a pdf of this document on **Cigna.com/PDL.** Click on the dropdown next to "Drug Lists for Employer Plans." Scroll down to the section for California Employer Drug Lists; then click on **California Legacy (Performance) 4 Tier (all specialty medications covered on tier 4) (CDI) [PDF]**.

Questions?

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

Information about this drug list

Frequently asked questions (FAQs)

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

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

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

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

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

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

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.

Information about this drug list

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

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

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

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

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

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

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

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

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

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

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

Information about this drug list

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

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

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

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

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

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

Fill maintenance medications through Express Scripts Pharmacy

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

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

Here are two easy ways to get started:

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

Fill specialty medications through Accredo Specialty Pharmacy

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

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

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

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

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

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

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

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

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

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

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

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

Q. Where can I find more information about my pharmacy benefits?
A. Use the online tools and resources on the myCigna App or **myCigna.com**. You can find out how much your medication costs (and what lower-cost options may be available), see which medications your plan covers, find an in-network pharmacy, ask a pharmacist a question, see your pharmacy claims and coverage details, and more. You can also manage your home delivery orders.

Q. How can I find out my cost-share for each tier of the drug list?
A. We put covered medications into tiers (or cost-share levels). Typically, the higher the tier, the higher the price you'll pay for the medication. Here are three places you can go to find out how much you'll pay for your medication based on the tier it's listed in, including the maximum cost-share amount allowed:

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

Information about this drug list

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

Q. What's the difference between medications covered under the pharmacy benefit and medical benefit?
A. Some medications are covered under the pharmacy benefit, some are covered under the medical benefit and others are covered under both benefits. Log in to the myCigna App or **myCigna.com**, or check your plan materials, to learn more about how your plan covers your medication.

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

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

Q. I take an oral cancer medication. How much will it cost me to fill?
A. On January 1, 2015, California passed a bill limiting the cost-share for oral chemotherapy medications. This means that if you have both your medical and pharmacy benefits through Cigna Healthcare, here's how certain oral cancer medications are covered:

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

Q. How are medications, devices and FDA-approved diabetic, contraceptive and federally-mandated products covered under the pharmacy benefit?
A. Here is how these products are covered under the pharmacy benefit:

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

Information about this drug list

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

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

Words you may need to know

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

Information about this drug list

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

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

Information about this drug list

About this drug list

This is a list of the most commonly prescribed medications covered on the Cigna Healthcare Legacy (Performance) 4-Tier Prescription Drug List as of January 1, 2026. **The drug list is updated often**; so, not all of the medications your plan covers may be listed here. Also, your plan may not cover all of these medications. Log in to the myCigna App or **myCigna.com** to see which medications your plan covers.

How to read this drug list

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

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

Tiers

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

Tier 1	**Generics. These medications are covered at your plan's lowest cost-share.** Generics work in the same way and provide the same clinical benefits as their brand-name versions – and typically cost much less.[3]	**$**
Tier 2	**Preferred Brands.** These medications typically have one or more lower-cost generic that treats the same condition.	**$$**
Tier 3	**Non-Preferred Brands.** Non-preferred brands typically have a generic and/or preferred brand alternative(s) that treats the same condition.	**$$$**
Tier 4	**Specialty. These medications are covered at your plan's highest cost-share.** This tier includes both injectable and oral (those you take by mouth) specialty medications.	**$$$$**

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

Information about this drug list

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

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

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

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

Information about this drug list

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

Use the table below to understand how medications are covered on the Cigna Healthcare Legacy (Performance) 4-Tier Prescription Drug List.*

ANALGESICS (Pain Relief and Inflammatory Disease)		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
ANALGESIC, NON-SALICYLATE AND BARBITURATE COMBINAT		
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		
ALLZITAL	T3	PA
BUPAP (*butalbital-acetaminophen*)	T1	PA
butalbital/acetaminophen	T1	
butalbital-acetaminophn 25-325 (Allzital)	T1	PA
butalbital-acetaminophn 50-300	T1	
butalbital-acetaminophn 50-300 (Bupap)	T1	PA
butalbital-acetaminophn 50-325	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 (Esgic)	T3	QL (6 caps/day)
butalb/acetaminophen/caffeine (Vanatol S)	T3	
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	PA QL (6 tabs/day)
ESGIC CAPSULE (*zebutal*)	T3	PA QL (6 caps/day)
FIORICET (*phrenilin forte*)	T3	PA QL (6 caps/day)
VANATOL LQ	T3	PA
VANATOL S	T3	PA
VTOL	T1	PA
ANALGESIC/ANTIPYRETICS, SALICYLATES		
choline salicyl/mag salicylate	T1	HD
diflunisal	T1	HD
ANALGESICS, NON-OPIOID		
JOURNAVX	T3	QL (30 tabs/90 days)
ANALGESIC/ANTIPYRETICS, NON-SALICYLATE		
ACETAMINOPHEN 1000MG/100ML BAG	T3	
acetaminophen 1,000mg/100ml vl (Ofirmev)	T1	
OFIRMEV (*acetaminophen*)	T3	
ANALGESICS, NEURONAL-TYPE CALCIUM CHANNEL BLOCKERS		
PRIALT	T4	SP
clonidine 1,000 mcg/10 ml vial (Duraclon)	T1	

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List of Prescription Medications

ANALGESICS (Pain Relief And Inflammatory Disease) *(cont.)*		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
ANTI-MIGRAINE PREPARATIONS *(cont.)*		
clonidine 5,000 mcg/10 ml vial	T1	
DURACLON (*clonidine hcl*)	T3	
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)
CAMBIA (*diclofenac potassium*)	T3	PA
D.H.E.45 (*dihydroergotamine mesylate*)	T3	PA QL (10 amps/30 days)
diclofenac pot 50 mg powdr pkt (Cambia)	T1	PA
dihydroergotamine 1 mg/ml amp (D.h.e.45)	T1	QL (10 amps/30 days)
dihydroergotamine 4 mg/ml spry (Migranal)	T1	QL (8/30 days)
eletriptan hydrobromide (Relpax)	T1	QL (6 tabs/30 days)
ELYXYB	T3	PA QL (9 bottles/30 days)
EMGALITY PEN	T2	PA
EMGALITY SYRINGE	T2	PA
ERGOMAR	T3	PA
ergotamine tartrate/caffeine	T1	
ergotamine tartrate/caffeine (Cafergot)	T1	QL (40 tabs/28 days)
frovatriptan succinate (Frova)	T1	QL (18 tabs/30 days)
IMITREX 100 MG TABLET (*sumatriptan succinate*)	T3	PA QL (9 tabs/30 days)
IMITREX 20 MG NASAL SPRAY (*sumatriptan*)	T3	PA QL (2 boxes/30 days)
IMITREX 25 MG TABLET (*sumatriptan succinate*)	T3	PA QL (9 tabs/30 days)
IMITREX 4 MG/0.5 ML CARTRIDGES (*sumatriptan succinate*)	T3	PA QL (4ml/30 days)
IMITREX 4 MG/0.5 ML PEN INJECT (*sumatriptan succinate*)	T3	PA QL (4ml/30 days)
IMITREX 5 MG NASAL SPRAY (*sumatriptan*)	T3	PA QL (2 boxes/30 days)
IMITREX 50 MG TABLET (*sumatriptan succinate*)	T3	PA QL (9 tabs/30 days)
IMITREX 6 MG/0.5 ML CARTRIDGES (*sumatriptan succinate*)	T3	PA QL (4ml/30 days)
IMITREX 6 MG/0.5 ML PEN INJECT (*sumatriptan succinate*)	T3	PA QL (4ml/30 days)
IMITREX 6 MG/0.5 ML VIAL (*sumatriptan succinate*)	T3	PA QL (5ml/30 days)
isomethept/dichlphn/acetaminop	T1	
isomethepten/caf/acetaminophen	T1	
MAXALT (*rizatriptan*)	T3	PA QL (12 tabs/30 days)
MAXALT MLT (*rizatriptan*)	T3	PA QL (12 tabs/30 days)

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List of Prescription Medications

ANALGESICS (Pain Relief And Inflammatory Disease) *(cont.)*		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
ANTI-MIGRAINE PREPARATIONS *(cont.)*		
MIGRANAL (*dihydroergotamine mesylate*)	T3	PA QL (8/30 days)
naratriptan hcl	T1	QL(9 tabs/30 days)
NURTEC ODT	T2	PA QL (16 tabs/30 days)
ONZETRA XSAIL	T3	PA QL (1 box/30 days)
RELPAX (*eletriptan hbr*)	T3	PA QL (6 tabs/30 days)
REYVOW	T3	PA QL (8 tabs/30 days)
rizatriptan (Maxalt Mlt)	T1	QL (12 tabs/30 days)
rizatriptan (Maxalt)	T1	QL (12 tabs/30 days)
rizatriptan	T1	QL (12 tabs/30 days)
QULIPTA	T3	PA QL (1 set/day)
sumatriptan (Imitrex)	T1	QL (2 boxes/30 days)
sumatriptan 4 mg/0.5 ml cart (Imitrex)	T1	QL (4ml/30 days)
sumatriptan 4 mg/0.5 ml inject (Imitrex)	T1	QL (4ml/30 days)
sumatriptan 6 mg/0.5 ml cart (Imitrex)	T1	QL (4ml/30 days)
sumatriptan 6 mg/0.5 ml inject (Imitrex)	T1	QL (4ml/30 days)
sumatriptan 6 mg/0.5 ml syrng	T1	QL (4ml/30 days)
sumatriptan 6 mg/0.5 ml vial (Imitrex)	T1	QL (5ml/30 days)
sumatriptan succ 100 mg tablet (Imitrex)	T1	QL (9 tabs/30 days)
sumatriptan succ 25 mg tablet (Imitrex)	T1	QL (18 tabs/28 days)
sumatriptan succ 50 mg tablet (Imitrex)	T1	QL (9 tabs/30 days)
sumatriptan succ/naproxen sod (Treximet)	T1	QL (18 tabs/30 days)
SUMAVEL DOSEPRO	T3	QL (12 injectors/30 days)
SYMBRAVO	T3	PA QL
TOSYMRA	T3	PA QL (2 boxes/30 days)
TREXIMET 10-60 MG TABLET	T3	PA QL (18 tabs/30 days)
TREXIMET 85-500 MG TABLET (*sumatriptan succ-naproxen sod*)	T3	PA QL (18 tabs/28 days)
TRUDHESA	T2	PA QL (2 pkgs/30 days)
UBRELVY	T2	PA QL (0.67 tabs/day)
VYEPTI	T3	PA SP
ZAVAPRET	T2	PA QL(6 units/30 days)
ZEMBRACE SYMTOUCH	T3	PA QL (16 injectors/30 days)
zolmitriptan (Zomig Zmt)	T1	QL (12 tabs/30 days)
zolmitriptan 2.5 mg tablet (Zomig)	T1	QL (12 tabs/30 days)
ZOLMITRIPTAN 5 MG NASAL SPRAY	T3	PA QL (6 spray/22 days)

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List of Prescription Medications

ANALGESICS (Pain Relief And Inflammatory Disease) *(cont.)*		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
ANTI-MIGRAINE PREPARATIONS *(cont.)*		
zolmitriptan 5 mg tablet (Zomig)	T1	QL (12 tabs/30 days)
ZOMIG 2.5 MG TABLET (*zolmitriptan*)	T3	PA QL (12 tabs/30 days)
ZOMIG 5 MG TABLET (*zolmitriptan*)	T3	PA QL (12 tabs/30 days)
ZOMIG ZMT (*zolmitriptan odt*)	T3	PA QL (12 tabs/30 days)
NASAL NSAIDS, COX NON-SELECTIVE, SYSTEMIC ANALGESIC		
SPRIX	T3	PA QL (10 bots/30 days)
NSAIDS, CYCLOOXYGENASE INHIBITOR-TYPE ANALGESICS		
diclofenac pot 25 mg tablet	T1	PA HD
diclofenac potassium	T1	HD
INDOCIN (*indomethacin*)	T3	PA HD
indomethacin 50 mg suppository (Indocin)	T1	HD
ketorolac 10 mg tablet	T1	QL (20 tabs/25 days)
ketorolac 15 mg/ml syringe	T1	QL (40 ml/30 days)
ketorolac 15 mg/ml vial	T1	QL (40 ml/30 days)
ketorolac 30 mg/ml carpuject	T1	
ketorolac 30 mg/ml isecure syr	T1	QL (20ml/30 days)
ketorolac 30 mg/ml syringe	T1	QL (20ml/30 days)
ketorolac 30 mg/ml vial	T1	QL (20ml/30 days)
ketorolac 300 mg/10 ml vial	T1	
ketorolac 60 mg/2 ml carpuject	T1	QL (20ml/30 days)
ketorolac 60 mg/2 ml syringe	T1	QL (20ml/30 days)
ketorolac 60 mg/2 ml vial	T1	QL (20ml/30 days)
mefenamic acid	T1	HD
ZIPSOR	T3	PA HD
OPIOID ANALGESIC AND NON-SALICYLATE ANALGESICS		
acetamin-codein 300-30 mg/12.5	T1	
acetaminop-codeine 120-12 mg/5	T1	
acetaminophen-cod #2 tablet	T1	PA
acetaminophen-cod #3 tablet	T1	PA
acetaminophen-cod #4 tablet	T1	PA
APADAZ	T3	
BENZHYDROCODONE-ACETAMINOPHEN	T1	
CAPITAL W-CODEINE	T3	
hydrocodone/acetaminophen	T1	PA

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List of Prescription Medications

ANALGESICS (Pain Relief And Inflammatory Disease) *(cont.)*		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
OPIOID ANALGESIC AND NON-SALICYLATE ANALGESICS *(cont.)*		
hydrocodone/acetaminophen (Hydrocodone-acetaminophen)	T1	PA
hydrocodone/acetaminophen (Norco)	T1	PA
HYDROCODONE-ACETAMINOPHEN	T1	PA
LORTAB	T1	PA
NALOCET	T1	PA
NORCO *(lorcet hd)*	T3	PA
NORCO *(lorcet plus)*	T3	PA
NORCO *(lorcet)*	T3	PA
oxycodone hcl/acetaminophen (Nalocet)	T1	PA
oxycodone hcl/acetaminophen (Percocet)	T1	PA
oxycodone hcl/acetaminophen (Primlev)	T1	PA
PERCOCET (*oxycodone-acetaminophen*)	T3	PA
PRIMLEV	T1	PA
tramadol hcl/acetaminophen (Ultracet)	T1	
ULTRACET (*tramadol hcl-acetaminophen*)	T3	
OPIOID ANALGESIC AND NSAID COMBINATION		
hydrocodone/ibuprofen	T1	PA
hydrocodone/ibuprofen (Ibudone)	T1	PA
IBUDONE	T1	PA
ibuprofen/oxycodone hcl	T1	PA
SEGLENTIS	T3	PA QL (4 tabs/day)
OPIOID ANALGESIC, ANESTHETIC ADJUNCT AGENTS		
alfentanil 1,000 mcg/2 ml amp (Alfentanil Hcl)	T1	PA
alfentanil 500 mcg/ml ampul (Alfentanil Hcl)	T1	PA
ALFENTANIL 500 MCG/ML AMPULE (*alfentanil hcl*)	T3	PA
fentanyl citrate/pf	T1	
FENTANYL 25 MCG/0.5 ML SYRINGE	T2	
fentanyl 50 mcg/ml vial	T1	
fentanyl 100 mcg/2 ml ampul	T1	
fentanyl 100 mcg/2 ml vial	T1	
fentanyl 250 mcg/5 ml	T1	
fentanyl 500 mcg/10 ml vial	T1	

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List of Prescription Medications

ANALGESICS (Pain Relief And Inflammatory Disease) *(cont.)*		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
OPIOID ANALGESIC, ANESTHETIC ADJUNCT AGENTS *(cont.)*		
fentanyl 1,000 mcg/20 ml vial	T1	
FENTANYL 2, 500 MCG/50 ML BAG	T1	
fentanyl 2, 500 mcg/50 ml vial	T1	
FENTANYL 5,000 MCG/100 ML BAG	T1	
remifentanil hcl (Ultiva)	T1	PA
sufentanil citrate	T1	PA
ULTIVA (*remifentanil hcl*)	T3	PA
OPIOID ANALGESIC AND NON-SALICYLATE XANTHINE COMB		
ACETAMIN-CAFF-DIHYDROCODEINE	T1	PA
acetaminophen/caff/dihydrocod (Acetamin-caff-dihydrocodeine)	T1	PA
acetaminophen/caff/dihydrocod (Trezix)	T1	PA
TREZIX	T3	PA
OPIOID ANALGESICS		
ACTIQ (*fentanyl citrate*)	T3	PA
ARYMO ER	T3	PA
BELBUCA	T2	QL (2 films/day)
BUPRENEX	T3	
buprenorphine (Butrans)	T1	QL (4 patches/28 days)
butorphanol tartrate	T1	PA QL (6 bots/30 days)
BUTRANS (*buprenorphine*)	T3	QL (4 patches/28 days)
codeine sulfate	T1	PA
DILAUDID 0.2 MG/ML SYRINGE	T3	PA
DILAUDID 0.5 MG/0.5 ML SYRINGE	T3	PA
DILAUDID 1 MG/ML SYRINGE	T3	PA
DILAUDID 2 MG TABLET (*hydromorphone hcl*)	T3	PA
DILAUDID 2 MG/ML SYRINGE	T3	PA
DILAUDID 4 MG TABLET (*hydromorphone hcl*)	T3	PA
DILAUDID 4 MG/ML SYRINGE	T3	
DILAUDID 5 MG/5 ML ORAL LIQUID (*hydromorphone hcl*)	T3	PA
DILAUDID 8 MG TABLET (*hydromorphone hcl*)	T3	PA
DURAGESIC (*fentanyl*)	T3	PA
FENTANYL/BUPIVACAINE/NS	T3	
fentanyl (Duragesic)	T1	PA

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List of Prescription Medications

ANALGESICS (Pain Relief And Inflammatory Disease) *(cont.)*		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
OPIOID ANALGESICS *(cont.)*		
FENTANYL CITRATE/NACL/ML-NS	T1	PA
fentanyl citrate	T1	PA
FENTORA	T3	PA
hydrocodone bitartrate (Hysingla Er)	T1	PA
hydrocodone bitartrate (Zohydro Er)	T1	PA
hydromorphone 0.5 mg/0.5ml syr	T1	PA
hydromorphone hcl	T1	PA
hydromorphone hcl (Dilaudid)	T1	PA
HYDROMORPHONE 0.25 MG/0.5 ML	T3	PA
HYSINGLA ER (*hydrocodone bitartrate er*)	T2	PA
KADIAN (*morphine sulfate er*)	T3	PA
LAZANDA	T3	PA
meperidine hcl	T1	PA
methadone hcl	T1	PA
MITIGO	T1	PA
MORPHABOND ER	T2	PA
morphine sulfate	T1	PA
morphine sulfate (Kadian)	T1	PA
morphine sulfate (Ms Contin)	T1	PA
MS CONTIN (*morphine sulfate er*)	T3	PA
nalbuphine hcl	T1	
NUCYNTA	T2	PA
NUCYNTA ER	T3	PA
opium/belladonna alkaloids	T1	PA
OXAYDO	T3	PA
oxycodone hcl	T1	PA
OXYCODONE HCL ER	T1	PA
oxymorphone hcl	T1	PA
pentazocine hcl/naloxone hcl	T1	PA
ROXICODONE (*oxycodone hcl*)	T3	PA
ROXYBOND	T3	PA
SUBSYS	T3	PA
tramadol hcl (Ultram)	T1	QL (8 tabs/day)
TRAMADOL HCL 25 MG TABLET	T3	PA QL(>= 18 yo 4 tabs/day)

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List of Prescription Medications

ANALGESICS (Pain Relief And Inflammatory Disease) *(cont.)*		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
OPIOID ANALGESICS *(cont.)*		
TRAMADOL HCL 75 MG TABLET	T3	QL(< 18 yo 5 tabs/day)
tramadol er 100 mg tablet	T1	QL (1 tab/day)
tramadol er 200 mg tablet	T1	QL (1 tab/day)
tramadol er 300 mg tablet	T1	QL (1 tab/day)
TRAMADOL HCL ER 100 MG CAPSULE	T1	QL (1 cap/day)
tramadol hcl er 100 mg tablet	T1	QL (1 tab/day)
TRAMADOL HCL ER 150 MG CAPSULE	T1	QL (1 cap/day)
TRAMADOL HCL ER 200 MG CAPSULE	T1	QL (1 cap/day)
tramadol hcl er 200 mg tablet	T1	QL (1 tab/day)
TRAMADOL HCL ER 300 MG CAPSULE	T1	QL (1 cap/day)
tramadol hcl er 300 mg tablet	T1	QL (1 tab/day)
ULTRAM (*tramadol hcl*)	T3	QL (8 tabs/day)
XTAMPZA ER	T2	PA
ZOHYDRO ER (*hydrocodone bitartrate er*)	T3	PA
OPIOID AND SALICYLATE ANALGESICS, BARBIT, XANTHINE		
codeine/butalbital/asa/caffein (Fiorinal With Codeine #3)	T1	PA
FIORINAL WITH CODEINE #3 (*butalbital compound-codeine*)	T3	PA
OPIOID, NON-SALICYL. ANALGESIC, BARBITUATE, XANTHINE		
butalbit/acetamin/caff/codeine	T1	PA
butalbit/acetamin/caff/codeine (Fioricet With Codeine)	T1	PA
FIORICET WITH CODEINE (*butalb-acetaminoph-caff-codein*)	T3	PA
SKELETAL MUSCLE RELAXANT, SALICYLAT, OPIOID ANALGES		
carisoprodol/aspirin/codeine	T1	PA
ANALGESICS (Urinary Tract Conditions)		
URINARY TRACT ANALGESIC AGENTS		
ELMIRON	T2	
RIMSO-50	T2	
ANESTHETICS (Miscellaneous)		
GENERAL ANESTHETICS, INHALANT		
desflurane (Suprane)	T1	
isoflurane	T1	
isoflurane	T3	
sevoflurane (Ultane)	T1	

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List of Prescription Medications

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

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ANESTHETICS (Pain Relief And Inflammatory Disease) *(cont.)*		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
LOCAL ANESTHETICS *(cont.)*		
BUPIVACAINE HCL-0.9% NACL	T1	
CARBOCAINE (*polocaine*)	T3	
CARBOCAINE (*polocaine-mpf*)	T3	
chloroprocaine hcl/pf (Nesacaine-mpf)	T1	
CITANEST FORTE DENTAL	T3	
CITANEST PLAIN DENTAL	T3	
CLOROTEKAL	T3	
EXPAREL	T3	
lidocaine hcl (Xylocaine)	T1	
lidocaine hcl 1% vial (Xylocaine-mpf)	T1	
lidocaine hcl 1.5% ampul (Xylocaine-mpf)	T1	
lidocaine hcl 10 mg/ml syringe, 100 mg/10 ml syr	T1	
lidocaine hcl 2% 100 mg/5 ml (Xylocaine-mpf)	T1	
lidocaine hcl 2% 40 mg/2 ml (Xylocaine-mpf)	T1	
lidocaine hcl 2% 40 mg/2 ml vl (Xylocaine-mpf)	T1	
lidocaine hcl 2% ampul (Xylocaine-mpf)	T1	
lidocaine hcl 2% jel urojet ac	T1	
lidocaine hcl 2% jelly	T1	
lidocaine hcl 2% jelly uro-jet	T1	
lidocaine hcl 2% vial (Xylocaine)	T1	
lidocaine hcl 2% vial (Xylocaine-mpf)	T1	
LIDOCAINE HCL 200 MG/10 ML SYR	T1	
LIDOCAINE HCL 30 MG/3 ML SYR	T1	
lidocaine hcl 4% ampul, 4% solution	T1	
lidocaine hcl/dextrose 7.5%/pf	T1	
lidocaine hcl/epinephrine (Xylocaine With Epinephrine)	T1	
lidocaine hcl/epinephrine bit (Lidocaine-epinephrine)	T3	
lidocaine hcl/epinephrine/pf (Xylocaine With Epinephrine)	T1	
lidocaine hcl/epinephrine/pf (Xylocaine-mpf With Epinephrine)	T1	
LIDOCAINE HCL-0.9% NACL	T1	
LIDOCAINE-EPINEPHRINE	T1	
LIDOCAN II *(lidocaine)*	T1	
MARCAINE (*bupivacaine hcl*)	T3	

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ANESTHETICS (Pain Relief And Inflammatory Disease) *(cont.)*		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
LOCAL ANESTHETICS *(cont.)*		
MARCAINE (*sensorcaine*)	T3	
MARCAINE (*sensorcaine-mpf*)	T3	
MARCAINE SPINAL	T3	
MARCAINE-EPINEPHRINE	T3	
MARCAINE-EPINEPHRINE (*bupivacaine hcl-epinephrine*)	T3	
MARCAINE-EPINEPHRINE (*sensorcaine-epinephrine*)	T3	
mepivacaine hcl (Carbocaine)	T1	
mepivacaine hcl/pf	T1	
mepivacaine hcl/pf	T3	
mepivacaine hcl/pf (Carbocaine)	T1	
NAROPIN	T3	
NESACAINE	T3	
NESACAINE-MPF (*chloroprocaine hcl*)	T3	
ORABLOC	T3	
POLOCAINE	T1	
ropivacaine 0.2% 20 mg/10 ml (Naropin)	T1	
ropivacaine 0.2% 200 mg/100 ml (Naropin)	T1	
ropivacaine 0.2% 40 mg/20 ml (Naropin)	T1	
ropivacaine 0.2% 400 mg/200 ml (Naropin)	T1	
ROPIVACAINE 0.2% SYRINGE	T1	
ropivacaine 0.5% 100 mg/20 ml (Naropin)	T1	
ROPIVACAINE 0.5% 1000 MG/200ML	T3	
ropivacaine 0.5% 150 mg/30 ml (Naropin)	T1	
ROPIVACAINE 0.5% 500 MG/100 ML	T3	
ROPIVACAINE 0.5% BAG	T1	
ropivacaine 0.75% 150 mg/20 ml (Naropin)	T1	
ropivacaine 1% 100 mg/10 ml vl (Naropin)	T1	
ropivacaine 1% 200 mg/20 ml vl (Naropin)	T1	
ROPIVACAINE 50 MG/10 ML SYRNG	T1	
ROPIVACAINE HCL 0.2% ON-Q PUMP	T1	
ROPIVACAINE HCL 0.5% SYRINGE	T1	
ROPIVACAINE HCL-0.9% NACL	T1	
ROPIVACAINE HCL-NACL	T1	
SENSORC MPF 0.75%-EPI 1:200000	T3	

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

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List of Prescription Medications

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
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 100 mg/5 ml oral conc (Gastrocrom)	T1	
GASTROCROM (*cromolyn sodium*)	T3	
ANTI-ARTHRITICS (Pain Relief and Inflammatory Disease)		
ANALGESIC/ANTIPYRETICS, SALICYLATES		
DISALCID (*salsalate*)	T3	HD
salsalate (Disalcid)	T1	HD
ANTI-ARTHRITIC AND CHELATING AGENTS		
CUPRIMINE (*penicillamine*)	T4	PA SP
DEPEN (*penicillamine*)	T4	PA SP
penicillamine	T4	PA SP
penicillamine (Depen)	T4	PA SP
ANTI-ARTHRITIC, FOLATE ANTAGONIST AGENTS		
OTREXUP	T2	PA
RASUVO	T3	PA
ANTI-INFLAM. INTERLEUKIN-I RECEPTOR ANTAGONIST		
KINERET	T4	PA QL (28 syringes/28 days) SP
ANTI-INFLAMMATORY, PYRIMIDINE SYNTHESIS INHIBITOR		
ARAVA (*leflunomide*)	T3	HD
leflunomide (Arava)	T1	HD
ANTI-INFLAMMATORY, PHOSPHODIESTERASE-4(PDE4) INHIB.		
OTEZLA 28 DAY STARTER PACK	T4	PA QL (1 pack/180 days) SP HD
OTEZLA TABLET	T4	PA QL (2 tabs/day) SP HD
ANTI-INFLAMMATORY/ANTIARTHRITICS AGENTS, MISC.		
DUROLANE	T4	PA SP HD
EUFLEXXA	T4	PA SP HD
GEL-ONE	T4	PA SP HD
GELSYN-3	T4	PA SP HD
GENVISC 850	T4	PA SP
HYALGAN	T4	PA SP HD
HYMOVIS	T4	PA SP HD

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List of Prescription Medications

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

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ANTI-ARTHRITICS (Pain Relief and Inflammatory Disease) *(cont.)*		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
JANUS KINASE (JAK) INHIBITORS *(cont.)*		
LITFULO	T4	PA QL(1 cap/day) SP HD
OLUMIANT	T4	PA QL (1 tab/day) SP HD
RINVOQ	T4	PA QL (1 tab/day) SP HD
RINVOQ LQ	T4	PA QL(12 mls/day) SP HD
XELJANZ 1 MG/ML SOLUTION	T4	PA QL (480ML/22 Days) SP HD
XELJANZ 10 MG TABLET	T4	PA QL (2 tabs/day) SP HD
XELJANZ 5 MG TABLET	T4	PA QL (2 tabs/day) SP HD
XELJANZ XR	T4	PA QL (1 tab/day) SP HD
NSAID ANALGESIC AND NON-SALICYLATE ANALGESIC COMB		
COMBOGESIC	T3	PA HD
NSAID AND HISTAMINE H2 RECEPTOR ANTAGONIST COMB.		
DUEXIS	T3	PA HD
NSAIDS (COX NON-SPEC.INHIB) AND PROSTAGLANDIN ANALOG		
ARTHROTEC 50 (*diclofenac sodium-misoprostol*)	T3	ST HD
ARTHROTEC 75 (*diclofenac sodium-misoprostol*)	T3	ST HD
diclofenac sodium-misoprostol (Arthrotec 50)	T1	HD
diclofenac sodium-misoprostol (Arthrotec 75)	T1	HD
NSAIDS, CYCLOOXYGENASE INHIBITOR - TYPE ANALGESICS		
ANAPROX DS (*naproxen sodium ds*)	T3	ST HD
CALDOLOR	T3	
COXANTO	T3	PA HD
DAYPRO (*oxaprozin*)	T3	ST HD
diclofenac sod dr 25 mg tab	T1	HD
diclofenac sod dr 50 mg tab	T1	HD
diclofenac sod dr 75 mg tab	T1	HD
diclofenac sod ec 25 mg tab	T1	HD
diclofenac sod ec 50 mg tab	T1	HD
diclofenac sod ec 75 mg tab	T1	HD
diclofenac sodium	T1	HD
EC-NAPROSYN (*naproxen*)	T3	ST HD
etodolac	T1	HD
etodolac (Lodine)	T1	HD
FELDENE (*piroxicam*)	T3	ST HD
FENOPROFEN	T3	PA HD

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ANTI-ARTHRITICS (Pain Relief and Inflammatory Disease) *(cont.)*		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
NSAIDS, CYCLOOXYGENASE INHIBITOR - TYPE ANALGESICS *(cont.)*		
fenoprofen calcium (Nalfon)	T1	HD
flurbiprofen	T1	HD
ibuprofen	T1	HD
indomethacin	T1	HD
ketoprofen 25 mg. 75 mg capsule	T1	PA HD
LODINE (*etodolac*)	T3	ST HD
meclofenamate sodium	T1	HD
meloxicam (Mobic)	T1	HD
MOBIC (*meloxicam*)	T3	ST HD
nabumetone	T1	HD
NALFON 600 MG TABLET (*profeno*)	T1	ST HD
NAPROSYN TABLET (*naproxen*)	T3	ST HD
naproxen (Ec-naprosyn)	T1	HD
naproxen (Naprosyn)	T1	HD
naproxen sodium (Anaprox Ds)	T1	HD
oxaprozin 600 mg (Daypro)	T1	HD
OXAPROZIN 300 MG CAPSULE	T3	PA HD
piroxicam	T1	HD
QMIIZ ODT 15 MG TABLET	T3	ST HD
QMIIZ ODT 7.5 MG TABLET	T3	QL (1 tab/day) ST HD
sulindac	T1	HD
TOLECTIN 600 (*tolmetin sodium*)	T3	PA HD
tolmetin sodium (Tolectin 600)	T1	HD
NSAIDS, CYCLOOXYGENASE-2(COX-2) SELECTIVE INHIBITOR		
CELEBREX 100 MG, 200 MG CAPSULE (*celecoxib*)	T3	QL (2 caps/day) ST HD
CELEBREX 400 MG CAPSULE (*celecoxib*)	T3	QL (1 cap/day) ST HD
CELEBREX 50 MG CAPSULE (*celecoxib*)	T3	QL (2 caps/day) ST HD
celecoxib 100 mg capsule (Celebrex)	T1	QL(2 caps/day) HD
celecoxib 200 mg capsule (Celebrex)	T1	QL (2 caps/day) HD
celecoxib 400 mg capsule (Celebrex)	T1	QL (1 cap/day) HD
celecoxib 50 mg capsule (Celebrex)	T1	QL (2 caps/day) HD
URICOSURIC AGENTS		
probenecid	T1	HD
probenecid/colchicine	T1	HD

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List of Prescription Medications

ANTI-ASTHMATICS (Asthma/COPD/Respiratory)		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
5-LIPOXYGENASE INHIBITORS		
zileuton	T1	HD
ANTICHOLINERGICS, ORALLY INHALED LONG ACTING		
INCRUSE ELLIPTA	T2	HD
SPIRIVA RESPIMAT	T2	HD
ANTICHOLINERGICS, ORALLY INHALED SHORT ACTING		
ATROVENT HFA	T2	HD
ipratropium bromide	T1	HD
BETA-ADRENERGIC AGENTS		
albuterol sulf 2 mg/5 ml syrup	T1	HD
albuterol sulfate tab	T1	HD
albuterol sulfate er 4 mg tab	T1	HD
albuterol sulfate er 8 mg tab	T1	HD
metaproterenol sulfate	T1	HD
terbutaline sulfate	T1	HD
BETA-ADRENERGIC AGENTS, INHALED, SHORT ACTING		
albuterol 100 mg/20 ml soln	T1	
albuterol 2.5 mg/0.5 ml sol	T1	
albuterol 5 mg/ml solution	T1	
albuterol sul 0.63 mg/3 ml sol	T1	
albuterol sul 1.25 mg/3 ml sol	T1	
albuterol sul 2.5 mg/3 ml soln	T1	
albuterol sulfate (Albuterol Sulfate Hfa)	T1	QL (18gm/30 days)
ALBUTEROL SULFATE HFA	T1	QL (18gm/30 days)
levalbuterol hcl (Xopenex Concentrate)	T1	
levalbuterol hcl (Xopenex)	T1	
XOPENEX (*levalbuterol hcl*)	T3	
XOPENEX CONCENTRATE (*levalbuterol concentrate*)	T3	
BETA-ADRENERGIC AGENTS, INHALED, ULTRA-LONG ACTING		
ARCAPTA NEOHALER	T3	HD
STRIVERDI RESPIMAT	T2	QL(1 inhaler/30 days) HD
BETA-ADRENERGIC AGENTS, ORALLY INHALED, LONG ACTING		
BROVANA *(arformoterol tartrate)*		
SEREVENT DISKUS	T3	ST QL(1 blister/30 days) HD
BETA-ADRENERGIC AND ANTICHOLINERGIC COMBO, INHALED		
ANORO ELLIPTA	T2	HD

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ANTI-ASTHMATICS (Asthma/COPD/Respiratory) *(cont.)*		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
BETA-ADRENERGIC AND ANTICHOLINERGIC COMBO, INHALED *(cont.)*		
BEVESPI AEROSPHERE	T3	PA QL(1 inhaler/30 days) HD
COMBIVENT RESPIMAT	T2	HD
ipratropium/albuterol sulfate	T1	HD
UMECLIDINIUM-VILANTEROL	T3	PA QL(1 inhaler/30 days) HD
STIOLTO RESPIMAT INHAL SPRAY	T2	HD
BETA-ADRENERGIC AGENTS AND GLUCOCORTICOID COMBO, INHALED		
ADVAIR HFA	T2	HD
AIRDUO DIGIHALER	T3	ST HD
AIRSUPRA	T2	PA QL(2 inhalers/28 days) HD
BREO ELLIPTA	T2	QL(1 inhaler/30 days) HD
budesonide/formoterol fumarate (Symbicort)	T1	QL HD
DULERA	T2	HD
fluticasone propion/salmeterol (Advair Diskus)	T1	QL(1 inhaler/30 days)
fluticasone-salmeterol 100-50 (Advair Diskus)	T3	QL(1 inhaler/30 days) HD
fluticasone-salmeterol 250-50 (Advair Diskus)	T3	QL(1 inhaler/30 days) HD
fluticasone-salmeterol 500-50 (Advair Diskus)	T3	QL(1 inhaler/30 days) HD
FLUTICASONE-SALMETEROL 113-14	T1	QL(1 inhaler/30 days) HD
FLUTICASONE-SALMETEROL 232-14	T1	QL(1 inhaler/30 days) HD
FLUTICASONE-SALMETEROL 55-14	T1	QL(1 inhaler/30 days) HD
SYMBICORT	T3	ST QL(1 inhaler/30 days) HD
BETA-ADRENERGIC-ANTICHOLINERGIC-GLUCOCORT, INHALED		
BREZTRI AEROSPHERE	T2	
TRELEGY ELLIPTA	T2	
GLUCOCORTICOIDS, ORALLY INHALED		
ALVESCO	T2	HD
budesonide (Pulmicort)	T1	HD
FLOVENT DISKUS	T3	PA QL(1 inhalers/30 days) HD
FLOVENT HFA	T2	PA QL(1 inhalers/30 days) HD
FLUTICASONE FUROATE	T3	ST HD
FLUTICASONE PROP DISKUS	T3	PA QL(1 inhaler/30 days) HD
PULMICORT (*budesonide*)	T3	HD
PULMICORT FLEXHALER	T3	PA HD
QVAR REDIHALER	T2	HD

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ANTI-ASTHMATICS (Asthma/COPD/Respiratory) *(cont.)*		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
INTERLEUKIN-5(IL-5) RECEPTOR ALPHA ANTAGONIST, MAB		
FASENRA PEN	T4	PA SP HD
LEUKOTRIENE RECEPTOR ANTAGONISTS		
ACCOLATE (*zafirlukast*)	T3	HD
montelukast sodium (Singulair)	T1	HD
SINGULAIR (*montelukast sodium*)	T3	HD
zafirlukast (Accolate)	T1	HD
MAST CELL STABILIZERS, ORALLY INHALED		
cromolyn 20 mg/2 ml neb soln	T1	QL (480ml/30 days) HD
MONOCLONAL ANTIBODIES TO IMMUNOGLOBULIN E (IGE)		
XOLAIR	T4	PA SP HD
MONOCLONAL ANTIBODY - INTERLEUKIN-5 ANTAGONISTS		
NUCALA	T4	PA SP HD
MUCOLYTICS		
acetylcysteine	T1	
PHOSPHODIESTERASE-4 (PDE4) INHIBITORS		
DALIRESP 250 MCG TABLET	T3	QL (28 tabs/180 days) HD
DALIRESP 500 MCG TABLET	T3	QL (2 tabs/day) HD
roflumilast 250 mcg tablet (Daliresp)	T3	QL (28 tabs/180 days) HD
roflumilast 500 mcg tablet (Daliresp)	T3	QL (2 tabs/day) HD
XANTHINES		
aminophylline	T1	
THEO-24	T2	HD
theophylline anhydrous	T1	HD
ANTIBIOTICS (Allergy/Nasal Sprays)		
NOSE PREPARATIONS ANTIBIOTICS		
BACTROBAN NASAL	T2	
ANTIBIOTICS (Ear Medications)		
EAR PREPARATIONS, ANTIBIOTICS		
ciprofloxacin hcl	T1	
CORTISPORIN-TC	T3	
neomycin/polymyxin b/hydrocort	T1	
ofloxacin	T1	
OTIC PREPARATIONS, ANTI-INFLAMMATORY-ANTIBIOTICS		
CIPRO HC	T2	

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ANTIBIOTICS (Ear Medications) *(cont.)*		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
OTIC PREPARATIONS, ANTI-INFLAMMATORY-ANTIBIOTICS *(cont.)*		
CIPRODEX (*ciprofloxacin-dexamethasone*)	T3	PA
ciprofloxacin hcl/dexameth (Ciprodex)	T1	
CIPROFLOXACIN HCL-FLUOCINOLONE	T3	
OTOVEL	T3	
ANTIBIOTICS (Eye Conditions)		
EYE ANTIBIOTIC AND GLUCOCORTICOID COMBINATIONS		
MAXITROL (*neomycin-polymyxin-dexameth*)	T3	PA
neomycin/bacit/p-myx/hydrocort	T1	
neomycin/polymyxin b/dexametha (Maxitrol)	T1	
neomycin/polymyxin b/hydrocort	T1	
TOBRADEX EYE DROPS (*tobramycin-dexamethasone*)	T3	PA
TOBRADEX EYE OINTMENT	T2	
TOBRADEX ST	T3	
tobramycin/dexamethasone (Tobradex)	T1	
ZYLET	T3	
EYE SULFONAMIDES		
BLEPH-10 (*sulfacetamide sodium*)	T3	
BLEPHAMIDE	T2	
sulfacetamide sodium	T1	
sulfacetamide sodium (Bleph-10)	T1	
sulfacetamide/prednisolone sp	T1	
OPHTHALMIC ANTIBIOTICS		
AZASITE	T2	
BACIGUENT (*bacitracin*)	T3	
bacitracin (Baciguent)	T1	
bacitracin/polymyxin b sulfate	T1	
BESIVANCE	T2	
CILOXAN	T2	
erythromycin base	T1	
gatifloxacin	T1	
gentamicin sulfate	T1	
levofloxacin	T1	
MOXEZA (*moxifloxacin*)	T3	
moxifloxacin hcl (Moxeza)	T1	

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ANTIBIOTICS (Eye Conditions) *(cont.)*		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
OPHTHALMIC ANTIBIOTICS *(cont.)*		
moxifloxacin hcl (Vigamox)	T1	
neomycin sulf/bacitracin/poly	T1	
neomycin/polymyxn b/gramicidin	T1	
OCUFLOX (*ofloxacin*)	T3	PA
ofloxacin (Ocuflox)	T1	
polymyxin b sulf/trimethoprim	T1	
tobramycin 0.3% eye drop (Tobrex)	T1	
TOBREX	T3	PA
VIGAMOX (*moxifloxacin*)	T3	PA
ANTIBIOTICS (Infections)		
2ND GEN. ANAEROBIC ANTIPROTOZOAL-ANTIBACTERIAL		
SOLOSEC	T2	
ABSORBABLE SULFONAMIDE ANTIBACTERIAL AGENTS		
BACTRIM (*sulfamethoxazole-trimethoprim*)	T3	
BACTRIM DS (*sulfamethoxazole-trimethoprim*)	T3	
sulfadiazine	T1	
sulfamethoxazole/trimethoprim	T1	
sulfamethoxazole/trimethoprim	T3	
sulfamethoxazole/trimethoprim (Bactrim Ds)	T1	
sulfamethoxazole/trimethoprim (Bactrim)	T1	
AMINOGLYCOSIDE ANTIBIOTICS		
amikacin sulfate	T1	
ARIKAYCE	T4	PA SP
BETHKIS (*tobramycin*)	T4	PA QL (8ml/day) SP HD
gentamicin in nacl, iso-osm	T1	
gentamicin sulfate	T1	
GENTAMICIN SULFATE IN NS	T1	
gentamicin sulfate/pf	T1	
KITABIS PAK	T4	PA QL (10ml/day) SP HD
neomycin sulfate	T1	
STREPTOMYCIN SULFATE	T1	
TOBI (*tobramycin*)	T4	PA QL (10ml/day) SP HD
TOBI PODHALER	T4	PA QL (8 caps/day) SP HD
tobramycin 300 mg/4 ml ampule (Bethkis)	T4	PA QL (8ml/day) SP HD

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Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
AMINOGLYCOSIDE ANTIBIOTICS *(cont.)*		
tobramycin 300 mg/5 ml ampule (Tobi)	T4	PA QL (10ml/day) SP HD
TOBRAMYCIN PAK 300 MG/5 ML	T4	PA QL (10ml/day) SP HD
tobramycin sulfate	T1	
tobramycin/sodium chloride	T1	
ZEMDRI	T3	
ANAEROBIC ANTIPROTOZOAL-ANTIBACTERIAL AGENTS		
FLAGYL (*metronidazole*)	T3	
LIKMEZ	T3	PA
metronidazole (Flagyl)	T1	
metronidazole/sodium chloride	T1	
ANTIBIOTIC, ANTIBACTERIAL, MISC.		
fosfomycin tromethamine (Monurol)	T1	
HIPREX (*methenamine hippurate*)	T3	
methenamine hippurate	T1	
methenamine mandelate	T1	
MONUROL (*fosfomycin tromethamine*)	T3	
PRIMSOL	T3	
trimethoprim	T1	
UTA	T3	
ANTIBIOTICS, MISCELLANEOUS, OTHER		
bacitracin	T1	
ANTILEPROTICS		
dapsone 100 mg tablet	T1	
dapsone 25 mg tablet	T1	
THALOMID	T4	PA SP HD
ANTI-MYCOBACTERIUM AGENTS		
ethambutol hcl	T1	HD
ethambutol hcl (Myambutol)	T1	HD
isoniazid	T1	HD
MYAMBUTOL (*ethambutol hcl*)	T3	HD

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ANTIBIOTICS (Infections) *(cont.)*		
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ANTI-MYCOBACTERIUM AGENTS *(cont.)*		
PASER	T2	HD
pyrazinamide	T1	HD
rifabutin (Mycobutin)	T1	HD
TRECATOR	T2	HD
ANTI-TUBERCULAR ANTIBIOTICS		
CAPASTAT SULFATE	T3	
CYCLOSERINE	T1	
cycloserine	T1	
PRETOMANID	T3	PA QL (1 tab/day)
PRIFTIN	T3	
RIFADIN (*rifampin*)	T3	
RIFAMATE	T2	
rifampin	T1	
rifampin (Rifadin)	T1	
RIFATER	T2	
SIRTURO	T3	SP
BETALACTAMS		
AZACTAM (*aztreonam*)	T3	
aztreonam (Azactam)	T1	
CAYSTON	T4	PA QL (3ml/day) SP HD
CARBAPENEM ANTIBIOTICS (THIENAMYCINS)		
ertapenem sodium (Invanz)	T1	
imipenem/cilastatin sodium	T1	
imipenem/cilastatin sodium (Primaxin)	T1	
INVANZ (*ertapenem*)	T3	
meropenem (Merrem)	T1	
MEROPENEM-0.9% NACL	T1	
PRIMAXIN (*imipenem-cilastatin sodium*)	T3	
RECARBRIO	T3	
VABOMERE	T3	
CEPHALOSPORIN ANTIBIOTICS - IST GENERATION		
cefadroxil	T1	
cefazolin sodium	T1	

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ANTIBIOTICS (Infections) *(cont.)*		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
CEPHALOSPORIN ANTIBIOTICS - IST GENERATION *(cont.)*		
cefazolin sodium/dextrose, iso	T1	
cefazolin 3 gm vial	T1	
CEFAZOLIN SODIUM-0.9% NACL	T1	
CEFAZOLIN SODIUM-D5W	T1	
CEFAZOLIN SODIUM-DEXTROSE	T1	
CEFAZOLIN SODIUM-STERILE WATER	T1	
cephalexin	T1	
cephalexin (Keflex)	T1	
DAXBIA	T3	
KEFLEX (*cephalexin*)	T3	
CEPHALOSPORIN ANTIBIOTICS - 2ND GENERATION		
cefaclor	T1	
CEFOTAN	T3	
cefotetan disodium	T1	
cefotetan disodium (Cefotan)	T1	
cefoxitin sodium	T1	
cefoxitin sodium/dextrose, iso	T1	
cefprozil	T1	
cefuroxime axetil	T1	
cefuroxime sodium (Zinacef)	T1	
ZINACEF (*cefuroxime sodium*)	T3	
CEPHALOSPORIN ANTIBIOTICS - 3RD GENERATION		
AVYCAZ	T3	
cefdinir	T1	
cefixime (Suprax)	T1	
cefotaxime sodium	T1	
cefpodoxime proxetil	T1	
ceftazidime	T1	
ceftazidime (Fortaz)	T1	
CEFTRIAXONE	T1	
ceftriaxone in is-osm dextrose	T1	

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ANTIBIOTICS (Infections) *(cont.)*		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
CEPHALOSPORIN ANTIBIOTICS - 3RD GENERATION *(con't)*		
ceftriaxone sodium	T1	
CLAFORAN	T3	
FORTAZ	T3	
FORTAZ (*tazicef*)	T3	
FORTAZ IN ISO-OSMOTIC DEXTROSE	T3	
SUPRAX	T3	
SUPRAX (*cefixime*)	T3	
CEPHALOSPORIN ANTIBIOTICS - 4TH GENERATION		
CEFEPIME HCL	T1	
cefepime hcl (Maxipime)	T1	
cefepime in iso-osm dextrose	T1	
CEFEPIME-DEXTROSE	T1	
MAXIPIME	T3	
MAXIPIME (*cefepime hcl*)	T3	
CEPHALOSPORIN ANTIBIOTICS - SIDEROPHORE		
FETROJA	T3	
CEPHALOSPORINS - 5TH GENERATION		
TEFLARO	T3	
ZERBAXA	T3	
CHLORAMPHENICOL ANTIBIOTICS AND DERIVATIVES		
chloramphenicol sod succinate	T1	
GLYCYLCYCLINES		
tigecycline (Tygacil)	T1	
TYGACIL (*tigecycline*)	T3	
LINCOSAMIDE ANTIBIOTICS		
CLEOCIN HCL 150 MG CAPSULE (*clindamycin hcl*)	T3	
CLEOCIN HCL 300 MG CAPSULE (*clindamycin hcl*)	T3	
CLEOCIN HCL 75 MG CAPSULE (*clindamycin hcl*)	T2	
CLEOCIN PEDIATRIC (*clindamycin (pediatric)*)	T3	
CLEOCIN PHOS 150 MG/ML VIAL (*clindamycin phosphate*)	T3	
CLEOCIN PHOS 300 MG/2 ML VIAL (*clindamycin phosphate*)	T3	
cleocin phos 300 mg/2ml addvan	T1	
CLEOCIN PHOS 600 MG/4 ML VIAL (*clindamycin phosphate*)	T3	
CLEOCIN PHOS 600 MG/4ML ADDVAN (*clindamycin phosphate*)	T3	

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LINCOSAMIDE ANTIBIOTICS *(con't)*		
CLEOCIN PHOS 9 G/60 ML VIAL (*clindamycin phosphate*)	T3	
CLEOCIN PHOS 900 MG/6 ML VIAL (*clindamycin phosphate*)	T3	
CLEOCIN PHOS 900 MG/6ML ADDVAN (*clindamycin phosphate*)	T3	
CLIN SINGLE USE	T3	
clindamycin hcl (Cleocin Hcl)	T1	
clindamycin palmitate hcl (Cleocin Pediatric)	T1	
clindamycin phosphate	T1	
clindamycin phosphate (Cleocin Phosphate)	T1	
clindamycin phosphate/d5w	T3	
CLINDAMYCIN-0.9% NACL	T1	
LINCOCIN	T3	
lincomycin hcl (Lincocin)	T1	
LIPOGLYCOPEPTIDE ANTIBIOTICS		
DALVANCE	T3	
ORBACTIV	T3	
VIBATIV	T3	
MACROLIDE ANTIBIOTICS		
azithromycin 1 gm pwd packet (Zithromax)	T1	
azithromycin 100 mg/5 ml susp (Zithromax)	T1	
azithromycin 200 mg/5 ml susp (Zithromax)	T1	
azithromycin 200 mg/5 ml susp (Zithromax)	T1	
azithromycin 250 mg tablet (Zithromax)	T1	
azithromycin 500 mg add-van vl	T1	
azithromycin 500 mg tablet (Zithromax Tri-pak)	T1	
azithromycin 600 mg tablet	T1	
azithromycin i.v. 500 mg vial (Zithromax)	T1	
clarithromycin	T1	
DIFICID 200 MG TABLET	T3	QL (28 tabs/28 days)
DIFICID 40 MG/ML SUSPENSION	T3	QL (5ml/Day)
E.E.S. 200 (*erythromycin ethylsuccinate*)	T3	PA
ERYPED 200 (*erythromycin ethylsuccinate*)	T3	
ERYPED 400 (*erythromycin ethylsuccinate*)	T3	PA
ERY-TAB (*erythromycin*)	T3	
ERYTHROCIN LACTOBIONATE	T3	

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ANTIBIOTICS (Infections) *(cont.)*		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
MACROLIDE ANTIBIOTICS *(con't)*		
erythromycin base	T1	
erythromycin base	T3	
erythromycin base (Ery-tab)	T1	
erythromycin ethylsuccinate	T1	
erythromycin ethylsuccinate	T3	
erythromycin ethylsuccinate (Eryped 200)	T1	
erythromycin ethylsuccinate (Eryped 400)	T1	
erythromycin stearate	T1	
PCE	T3	
ZITHROMAX 1 GM POWDER PACKET (*azithromycin*)	T3	
ZITHROMAX 100 MG/5 ML SUSP (*azithromycin*)	T3	
ZITHROMAX 200 MG/5 ML SUSP (*azithromycin*)	T3	
ZITHROMAX 200 MG/5 ML SUSP (*azithromycin*)	T3	
ZITHROMAX 250 MG TABLET (*azithromycin*)	T3	
ZITHROMAX 250 MG Z-PAK TABLET (*azithromycin*)	T3	QL (15 tabs/90 days)
ZITHROMAX 500 MG TABLET (*azithromycin*)	T3	QL (15 tabs/90 days)
ZITHROMAX I.V. 500 MG VIAL (*azithromycin*)	T3	
ZITHROMAX TRI-PAK (*azithromycin*)	T3	QL (15 tabs/90 days)
NITROFURAN DERIVATIVES ANTIBACTERIAL AGENTS		
FURADANTIN (*nitrofurantoin*)	T3	
MACROBID (*nitrofurantoin mono-macro*)	T3	
MACRODANTIN (*nitrofurantoin*)	T3	
nitrofurantoin 25 mg/5 ml susp (Furadantin)	T1	
nitrofurantoin 25 mg/5 ml susp (Furadantin)	T1	
nitrofurantoin mcr 100 mg cap (Macrodantin)	T1	
nitrofurantoin mcr 25 mg cap (Macrodantin)	T1	
nitrofurantoin mcr 50 mg cap (Macrodantin)	T1	
nitrofurantoin monohyd/m-cryst (Macrobid)	T1	
OXAZOLIDINONE ANTIBIOTICS		
linezolid in 0.9% sodium chlor	T1	
linezolid in dextrose 5% (Zyvox)	T1	
SIVEXTRO 200 MG TABLET	T3	PA
SIVEXTRO 200 MG VIAL	T3	
ZYVOX 100 MG/5 ML SUSPENSION (*linezolid*)	T3	PA

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ANTIBIOTICS (Infections) *(cont.)*		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
OXAZOLIDINONE ANTIBIOTICS *(con't)*		
ZYVOX 200 MG/100 ML-D5W	T3	
ZYVOX 600 MG TABLET (*linezolid*)	T3	PA
ZYVOX 600 MG/300 ML-D5W	T3	
PENICILLIN ANTIBIOTICS		
amoxicillin	T1	
amoxicillin/potassium clav	T1	
amoxicillin/potassium clav (Augmentin Xr)	T1	
amoxicillin/potassium clav (Augmentin)	T1	
ampicillin sodium	T1	
ampicillin sodium/sulbactam na	T1	
ampicillin sodium/sulbactam na (Unasyn)	T1	
ampicillin trihydrate	T1	
AUGMENTIN (*amoxicillin-clavulanate potass*)	T3	PA
AUGMENTIN XR (*amoxicillin-clavulanate pot er*)	T3	PA
BICILLIN C-R	T3	
BICILLIN L-A	T3	
dicloxacillin sodium	T1	
EXTENCILLINE	T3	
LENTOCILIN S	T3	
MOXATAG	T3	
nafcillin in dextrose, iso-osm	T1	
nafcillin sodium	T1	
oxacillin in dextrose (iso-osm)	T1	
oxacillin sodium	T1	
penicillin g potassium	T1	
penicillin g sodium	T1	
PENICILLIN GK-ISO-OSM DEXTROSE	T1	
penicillin v potassium	T1	
piperacillin sodium/tazobactam	T1	
piperacillin sodium/tazobactam (Piperacillin-tazobactam)	T1	
piperacillin sodium/tazobactam (Zosyn)	T1	
PIPERACILLIN-TAZOBACTAM	T1	
UNASYN (*ampicillin-sulbactam*)	T3	
ZOSYN	T3	

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ANTIBIOTICS (Infections) *(cont.)*		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
PENICILLIN ANTIBIOTICS *(con't)*		
ZOSYN (*piperacillin-tazobactam*)	T3	
PLEUROMUTILIN DERIVATIVES		
XENLETA 150 MG/15 ML VIAL	T3	
XENLETA 600 MG TABLET	T3	PA QL (10 tabs/30 days)
POLYMYXIN ANTIBIOTICS AND DERIVATIVES		
colistin (colistimethate na) (Coly-mycin M Parenteral)	T1	
COLY-MYCIN M PARENTERAL (*colistimethate*)	T3	
polymyxin b sulfate	T1	
QUINOLONE ANTIBIOTICS		
AVELOX (*moxifloxacin hcl*)	T3	
AVELOX IV (*moxifloxacin*)	T2	
BAXDELA 300 MG VIAL	T3	
BAXDELA 450 MG TABLET	T3	PA
CIPRO 10% SUSPENSION (*ciprofloxacin*)	T2	
CIPRO 250 MG TABLET (*ciprofloxacin hcl*)	T3	
CIPRO 5% SUSPENSION (*ciprofloxacin*)	T2	
CIPRO 500 MG TABLET (*ciprofloxacin hcl*)	T3	
CIPRO I.V. (*ciprofloxacin-d5w*)	T3	
ciprofloxacin (Cipro)	T1	
ciprofloxacin hcl	T1	
ciprofloxacin hcl (Cipro)	T1	
ciprofloxacin in 5 % dextrose	T1	
ciprofloxacin in 5 % dextrose (Cipro I.v.)	T1	
ciprofloxacin lactate	T1	
ciprofloxacin/ciprofloxa hcl	T1	
FACTIVE	T3	
levofloxacin	T1	
levofloxacin in dextrose 5 %	T1	
MOXIFLOXACIN	T1	
moxifloxacin hcl (Avelox)	T1	
moxifloxacin-sod.chloride (iso) (Avelox Iv)	T1	
ofloxacin	T1	
RIFAMYCINS AND RELATED DERIVATIVE ANTIBIOTICS		
AEMCOLO	T3	QL (12 tabs/3 days)

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

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ANTIBIOTICS (Infections) *(cont.)*		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
TETRACYCLINE ANTIBIOTICS *(con't.)*		
minocycline er 105 mg tablet (Solodyn)	T1	
minocycline er 115 mg tablet (Solodyn)	T1	
minocycline er 135 mg tablet	T1	
minocycline er 45 mg tablet	T1	QL (1 tab/day)
minocycline er 55 mg tablet	T1	
minocycline er 65 mg tablet (Solodyn)	T1	
minocycline er 80 mg tablet (Solodyn)	T1	
minocycline er 90 mg tablet	T1	
minocycline hcl (Minocin)	T1	
MINOLIRA ER	T3	ST
MONODOX (*mondoxyne nl*)	T3	
MONODOX (*okebo*)	T3	
NUZYRA 100 MG VIAL	T4	PA SP
NUZYRA 150 MG TABLET	T4	PA QL (30 tablets/28 days) SP
ORACEA *(doxycycline monohydrate)*	T3	PA
SEYSARA	T3	PA
SOLODYN (*minocycline hcl er*)	T3	PA
SOLOXIDE	T1	PA
TARGADOX	T3	PA
tetracycline hcl	T1	
tetracycline capsule	T1	
tetracycline tablet	T3	PA
XERAVA	T3	
XIMINO	T3	ST
VAGINAL ANTIBIOTICS		
CLEOCIN	T3	PA
CLEOCIN (*clindamycin phosphate*)	T3	PA
clindamycin phosphate (Cleocin)	T1	
CLINDESSE	T3	
METROGEL-VAGINAL (*vandazole*)	T3	PA
metronidazole (Metrogel-vaginal)	T1	
NUVESSA	T3	PA

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ANTIBIOTICS (Infections) *(cont.)*		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
VAGINAL ANTIBIOTICS *(con't)*		
XACIATO	T3	
VANCOMYCIN ANTIBIOTICS AND DERIVATIVES		
FIRVANQ *(vancomycin hcl)*	T2	PA
VANCOCIN HCL (*vancomycin hcl*)	T3	PA
VANCOMYCIN 25 MG/ML SOLUTION	T3	PA
vancomycin 50 mg/ml solution	T1	
VANCOMYCIN	T1	
vancomycin 1 gm vial	T1	
VANCOMYCIN 1 GRAM/200 ML BAG	T3	
VANCOMYCIN 1.25 GM/250 ML BAG	T1	
VANCOMYCIN 1.5 GRAM/300 ML BAG	T3	
VANCOMYCIN 1.75 GM/350 ML BAG	T3	
VANCOMYCIN 2 GRAM/400 ML BAG	T3	
VANCOMYCIN 1.25 GRAM/250ML-D5W	T1	
VANCOMYCIN 1.5 GRAM/250 ML-D5W	T1	
VANCOMYCIN 1.5 GRAM/300 ML-D5W	T3	
VANCOMYCIN-D5W 500 MG/100 ML	T1	
vancomycin 250 mg/5 ml soln (Firvanq)	T1	
vancomycin 50 mg/5 ml soln (Firvanq)	T1	
vancomycin 500 mg vial	T1	
VANCOMYCIN 500 MG/100 ML BAG	T3	
VANCOMYCIN 750 MG/150 ML BAG	T3	
VANCOMYCIN HCL 1.25 GRAM VIAL	T1	
VANCOMYCIN HCL 1.5 GRAM VIAL	T1	
VANCOMYCIN HCL 1.75 GRAM VIAL	T3	
VANCOMYCIN HCL 2 GRAM VIAL	T3	
vancomycin hcl 10 gm vial	T1	
vancomycin hcl 125 mg capsule (Vancocin Hcl)	T1	
VANCOMYCIN HCL 1G/200 ML BAG	T1	
vancomycin hcl 250 mg capsule (Vancocin Hcl)	T1	
VANCOMYCIN HCL 250 MG VIAL	T1	
vancomycin hcl 5 gm vial	T1	
vancomycin hcl 750 mg vial	T1	
VANCOMYCIN HCL-0.9% NACL	T1	

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

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ANTIBIOTICS (Skin Conditions) *(cont.)*		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
TOPICAL SULFONAMIDES *(cont.)*		
AVAR-E	T3	PA
AVAR-E GREEN	T3	PA
mafenide acetate (Sulfamylon)	T1	
ROSANIL (*sodium sulfacetamide-sulfur*)	T1	
SILVADENE (*ssd*)	T3	
silver sulfadiazine (Silvadene)	T1	
sulfacetamide sod/sulfur/urea	T1	
sulfacetamide sodium/sulfur	T1	
sulfacetamide sodium/sulfur (Avar-e Green)	T1	
sulfacetamide sodium/sulfur (Rosanil)	T1	
sulfacetamide/sulfur/cleansr23	T1	
sulfact sod/sulur/avob/otn/oct	T1	
SULFAMYLON (*mafenide acetate*)	T3	
ANTI-COAGULANTS (Blood Thinners/Anti-Clotting)		
ANTI-COAGULANTS, COUMARIN TYPE		
warfarin sodium	T1	HD
CITRATES AS ANTI-COAGULANTS		
ACD SOLUTION A	T3	
ACD-A	T3	
ANTICOAG SODIUM CITRATE 4% SYR	T1	
CITRATE PHOSPHATE DEXTROSE	T1	
TRICITRASOL	T3	
DIRECT FACTOR XA INHIBITORS		
BEVYXXA	T3	QL (42 caps/42 days)
ELIQUIS	T2	
SAVAYSA 15 MG TABLET	T3	PA QL (1 tab/day)
SAVAYSA 30 MG TABLET	T3	PA QL (1 tab/day)
SAVAYSA 60 MG TABLET	T3	PA
XARELTO	T2	
HEPARIN AND RELATED PREPARATIONS		
ARIXTRA (*fondaparinux sodium*)	T4	QL (1 syringe/day) SP
enoxaparin 100 mg/ml syringe (Lovenox)	T4	QL (2 syringes/day) SP
enoxaparin 120 mg/0.8 ml syr (Lovenox)	T4	QL (2 syringes/day) SP
enoxaparin 150 mg/ml syringe (Lovenox)	T4	QL (2 syringes/day) SP

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ANTI-COAGULANTS (Blood Thinners/Anti-Clotting) *(cont.)*		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
HEPARIN AND RELATED PREPARATIONS *(cont.)*		
enoxaparin 30 mg/0.3 ml syr (Lovenox)	T4	QL (2 syringes/day) SP
enoxaparin 300 mg/3 ml vial (Lovenox)	T4	QL (1 vial/day) SP
enoxaparin 40 mg/0.4 ml syr (Lovenox)	T4	QL (2 syringes/day) SP
enoxaparin 60 mg/0.6 ml syr (Lovenox)	T4	QL (2 syringes/day) SP
enoxaparin 80 mg/0.8 ml syr (Lovenox)	T4	QL (2 syringes/day) SP
fondaparinux sodium (Arixtra)	T4	QL (1 syringe/day) SP
FRAGMIN	T4	QL (2ml/day) SP
heparin 1,000 unit/500 ml-ns	T1	
HEPARIN 2,000 UNIT/1,000 ML-NS (heparin sodium,porcine/ns/pf)	T3	
heparin 2,000 unit/1,000 ml-ns (Heparin Sodium-0.9% Nacl)	T1	
HEPARIN 2,500 UNIT/500 ML-NS	T1	
HEPARIN 30,000 UNIT/1,000-NS	T1	
HEPARIN 5,000 UNIT/1,000 ML-NS	T1	
HEPARIN 5,000 UNIT/500 ML-NS	T1	
heparin 10,000 unit/10 ml vial	T1	
heparin 2,000 unit/2 ml vial	T1	
heparin 30,000 unit/30 ml vial	T1	
heparin 40,000 unit/4 ml vial	T1	
heparin 5,000 unit/ml carpujct	T1	
heparin 50,000 unit/10 ml vial	T1	
heparin 50,000 unit/5 ml vial	T1	
heparin sod 1,000 unit/ml vial	T1	
heparin sod 10,000 unit/ml vl	T1	
heparin sod 20,000 unit/ml vl	T1	
heparin sod 5,000 unit/0.5 ml	T1	
HEPARIN SOD 5,000 UNIT/0.5 ML	T3	
heparin sod 5,000 unit/0.5 ml (Heparin Sodium)	T1	
heparin sod 5,000 unit/ml syrg	T3	
heparin sod 5,000 unit/ml vial	T1	
heparin sod, porcine/0.9 % nacl	T1	
heparin sod, pork in 0.45% nacl	T1	
heparin sodium, porcine	T1	
heparin sodium, porcine/d5w	T1	
heparin sodium, porcine/pf	T1	

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ANTI-COAGULANTS (Blood Thinners/Anti-Clotting) *(cont.)*		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
HEPARIN AND RELATED PREPARATIONS *(cont.)*		
HEPARIN SODIUM-0.45% NACL	T1	
LOVENOX 100 MG/ML SYRINGE (*enoxaparin sodium*)	T4	QL (2 syringes/day) SP
LOVENOX 120 MG/0.8 ML SYRINGE (*enoxaparin sodium*)	T4	QL (2 syringes/day) SP
LOVENOX 150 MG/ML SYRINGE (*enoxaparin sodium*)	T4	QL (2 syringes/day) SP
LOVENOX 30 MG/0.3 ML SYRINGE (*enoxaparin sodium*)	T4	QL (2 syringes/day) SP
LOVENOX 300 MG/3 ML VIAL (*enoxaparin sodium*)	T4	QL (1 vial/day) SP
LOVENOX 40 MG/0.4 ML SYRINGE (*enoxaparin sodium*)	T4	QL (2 syringes/day) SP
LOVENOX 60 MG/0.6 ML SYRINGE (*enoxaparin sodium*)	T4	QL (2 syringes/day) SP
LOVENOX 80 MG/0.8 ML SYRINGE (*enoxaparin sodium*)	T4	QL (2 syringes/day) SP
THROMBIN INHIBITORS, SELECTIVE, DIRECT, REVERSIBLE		
ARGATROBAN	T4	SP
ARGATROBAN-0.9% NACL	T4	SP
dabigatran etexilate	T1	
THROMBIN INHIBITORS, SEL, DIRECT, REVERS-HIRUDIN TYPE		
ANGIOMAX (*bivalirudin*)	T3	
BIVALIRUDIN 250 MG ADD-VANT VL	T1	
bivalirudin 250 mg vial (Angiomax)	T1	
BIVALIRUDIN RTU 250 MG/50 ML	T3	
BIVALIRUDIN-0.9% NACL	T1	
ANTIDOTES (Gastrointestinal/Heartburn)		
MU-OPIOID RECEPTOR ANTAGONISTS, PERIPHERALLY-ACTING		
MOVANTIK	T2	PA
RELISTOR	T3	PA
SYMPROIC	T2	PA
ANTIDOTES (Substance Abuse)		
OPIOID ANTAGONISTS		
EVZIO	T3	PA QL (0.8ml/day)
KLOXXADO	T2	PA QL (2 sprays/30 days)
naloxone 0.4 mg/ml carpuject	T1	
naloxone 0.4 mg/ml vial	T1	
NALOXONE 2 MG AUTO-INJECTOR	T3	QL (0.8ml/day)

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ANTIDOTES (Substance Abuse) *(cont.)*		
OPIOID ANTAGONISTS *(cont.)*		
naloxone 0.4 mg/ml vial	T1	
NALOXONE 2 MG AUTO-INJECTOR	T3	QL (0.8ml/day)
naloxone 2 mg/2 ml syringe	T1	
naloxone 4 mg/10 ml vial	T1	
naltrexone hcl	T1	QL(180 tabs/30 days)
NARCAN	T2	QL (2 units/30 days)
OPVEE	T3	QL(2 units/30 days)
REXTOVY	T2	QL(2 units/30 days)
ZIMHI	T3	QL (2 inj/month)
ANTI-FUNGALS (Eye Conditions)		
OPHTHALMIC ANTI-FUNGAL AGENTS		
NATACYN	T2	
ANTI-FUNGALS (Feminine Products)		
VAGINAL ANTI-FUNGALS		
GYNAZOLE 1	T1	
miconazole nitrate	T1	
terconazole	T1	
ANTI-FUNGALS (Infections)		
ANTI-FUNGAL AGENTS		
ANCOBON (*flucytosine*)	T3	
clotrimazole	T1	
CRESEMBA CAPSULE	T3	PA
CRESEMBA 372 MG VIAL	T3	
DIFLUCAN (*fluconazole*)	T3	PA
fluconazole (Diflucan)	T1	
fluconazole in nacl, iso-osm	T1	
flucytosine (Ancobon)	T1	
FULVICIN P-G 165 MG TABLET	T3	PA QL (4 tabs/day)
itraconazole (Sporanox)	T1	
ketoconazole	T1	
NOXAFIL 300 MG/16.7 ML VIAL (*posaconazole*)	T3	PA
NOXAFIL 40 MG/ML SUSPENSION (*posaconazole*)	T3	PA
NOXAFIL DR 100 MG TABLET (*posaconazole*)	T3	PA

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ANTI-FUNGALS (Infections) *(cont.)*		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
ANTI-FUNGAL ANTIBIOTICS		
ORAVIG	T3	
posaconazole (Noxafil)	T1	
SPORANOX (*itraconazole*)	T3	PA
terbinafine hcl	T1	
TOLSURA	T3	
VFEND (*voriconazole*)	T3	PA
VFEND IV (*voriconazole*)	T3	
VIVJOA	T3	PA
voriconazole 200 mg tablet (Vfend)	T1	PA
voriconazole 200 mg vial (Vfend Iv)	T1	
voriconazole 40 mg/ml susp (Vfend)	T1	PA
voriconazole 50 mg tablet (Vfend)	T1	PA
ABELCET	T3	
AMBISOME	T3	
amphotericin b	T1	
BREXAFEMME	T3	PA
CANCIDAS (*caspofungin acetate*)	T3	
caspofungin acetate (Cancidas)	T1	
ERAXIS	T3	
griseofulvin ultramicrosize (Gris-peg)	T1	
griseofulvin, microsize	T1	
GRIS-PEG (*griseofulvin ultramicrosize*)	T3	
micafungin sodium (Mycamine)	T1	
MICAFUNGIN-0.9% NACL	T3	
MYCAMINE (*micafungin*)	T3	
nystatin	T1	
ANTI-FUNGALS (Skin Conditions)		
TOPICAL ANTI-FUNGAL/ANTI-INFLAMMATORY, STEROID AGENT		
clotrimazole/betamethasone dip	T1	
TOPICAL ANTI-FUNGALS		
ciclodan 0.77% cream (Loprox)	T1	
CICLODAN 0.77% CREAM KIT	T3	
ciclodan 8% solution	T1	
ciclopirox (Loprox)	T1	

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ANTI-FUNGALS (Skin Conditions) *(cont.)*		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
TOPICAL ANTI-FUNGALS *(con't.)*		
ciclopirox olamine (Loprox)	T1	
econazole nitrate	T1	
ECOZA	T3	
ERTACZO	T3	PA
EXELDERM	T3	PA
EXODERM	T1	
EXTINA (*ketodan*)	T3	PA
JUBLIA	T3	PA
KERYDIN (*tavaborole*)	T3	PA
ketoconazole	T1	
ketoconazole/skin cleanser 28	T1	
LOPROX 0.77% CREAM (*ciclopirox*)	T3	PA
LOPROX 0.77% TOPICAL SUSP (*ciclopirox*)	T3	
LOPROX 1% SHAMPOO (*ciclopirox*)	T3	PA
LULICONAZOLE	T1	
LUZU	T3	PA
MICONAZOLE-ZINC OXIDE-PETROLTM	T1	PA
naftifine hcl	T1	
naftifine hcl (Naftin)	T1	
NAFTIN (*naftifine hcl*)	T2	
nystatin	T1	
nystatin/triamcinolone acet	T1	
oxiconazole nitrate (Oxistat)	T1	
OXISTAT 1% CREAM (*oxiconazole nitrate*)	T3	PA
OXISTAT 1% LOTION	T2	PA
SULCONAZOLE NITRATE	T3	PA
tavaborole (Kerydin)	T1	PA
VUSION	T3	PA
XOLEGEL	T3	PA
ANTIHISTAMINE AND DECONGESTANT COMBINATION (Allergy/Nasal Sprays)		
1ST GEN ANTIHISTAMINE AND DECONGESTANT COMBINATION		
phenylephrine hcl/prometh hcl	T1	

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List of Prescription Medications

ANTIHISTAMINE AND DECONGESTANT COMBINATION (Allergy/Nasal Sprays) *(cont.)*		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
2ND GEN ANTIHISTAMINE AND DECONGESTANT COMBINATION		
CLARINEX-D 12 HOUR	T3	
ANTIHISTAMINES (Allergy/Nasal Sprays)		
ANTIHISTAMINES - IST GENERATION		
carbinoxamine 4 mg/5 ml liquid	T1	
carbinoxamine maleate 4 mg tab	T1	
carbinoxamine maleate 6 mg tab (Ryvent)	T1	PA
clemastine fumarate	T1	
cyproheptadine hcl (Cyproheptadine Hcl)	T1	
dexchlorpheniramine maleate (Ryclora)	T1	
diphenhydramine hcl	T1	
hydroxyzine hcl	T1	
hydroxyzine pamoate	T1	
hydroxyzine pamoate (Vistaril)	T1	
KARBINAL ER	T3	PA
PHENERGAN (*promethazine hcl*)	T3	
promethazine hcl	T1	
promethazine hcl (Phenergan)	T1	
RYCLORA (*dexchlorpheniramine maleate*)	T3	
RYVENT	T3	PA
VISTARIL (*hydroxyzine pamoate*)	T3	
ANTIHISTAMINES - 2ND GENERATION		
cetirizine hcl	T1	HD
CLARINEX (*desloratadine*)	T3	HD
desloratadine 2.5 mg odt	T1	QL (1 tab/day) HD
desloratadine 5 mg odt	T1	HD
desloratadine 5 mg tablet (Clarinex)	T1	HD
QUZYTTIR	T3	
ANTIHISTAMINES (Eye Conditions)		
EYE ANTIHISTAMINES		
azelastine hcl 0.05% drops	T1	
BEPREVE	T3	PA
epinastine hcl	T1	

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List of Prescription Medications

ANTIHISTAMINES (Eye Conditions) *(cont.)*		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
EYE ANTIHISTAMINES *(con't.)*		
LASTACAFT	T3	
olopatadine hcl 0.1% eye drops	T1	
olopatadine hcl 0.2% eye drop (Pataday)	T1	
PATADAY (*olopatadine hcl*)	T3	
PATANOL 0.1%	T3	PA
PAZEO	T2	
ZERVIATE	T2	
ANTI-HYPERGLYCEMICS (Diabetes)		
ANTIHYPERGLY, DPP-4 ENZYME INHIB.-THIAZOLIDINEDIONE		
ALOGLIPTIN-PIOGLITAZONE	T3	PA QL (1 tab/day) HD
OSENI	T3	PA QL (1 tab/day) HD
ANTIHYPERGLY, INCRETIN MIMETIC (GLP-1 RECEP.AGONIST)		
BYDUREON	T2	QL (4 vials/28 days) ST HD
BYDUREON BCISE	T2	QL (4 pens/28 days) ST
BYDUREON PEN	T2	QL (4 pens/28 days) ST HD
BYETTA	T2	QL (1 pen/30 days) ST
LIRAGLUTIDE	T3	QL(3 pens/30 days) HD
OZEMPIC 0.25-0.5 MG DOSE PEN	T2	QL (2 pens/28 days) ST HD
OZEMPIC 1 MG DOSE PEN (1.5 ML)	T2	QL (2 pens/28 days) ST HD
OZEMPIC 1 MG DOSE PEN (3 ML)	T2	QL (3ML/21 Days) ST HD
REZVOGLAR KWIKPEN	T2	PA
RYBELSUS	T2	QL (1 tab/day) ST
TRULICITY 0.75 MG/0.5 ML PEN	T2	QL (4 pens/28 days) ST
TRULICITY 1.5 MG/0.5 ML PEN	T2	QL (4 pens/28 days) ST
TRULICITY 3 MG/0.5 ML PEN	T2	QL (2 ml/28 Days) ST
TRULICITY 4.5 MG/0.5 ML PEN	T2	QL (2 ml/28 Days) ST
VICTOZA 2-PAK	T3	QL (3 pens/30 days) ST
VICTOZA 3-PAK	T3	QL (3 pens/30 days) ST
ANTI-HYPERGLY, INSULIN, LONG ACT-GLP-1 RECEPT.AGONIST		
SOLIQUA 100-33	T2	HD
XULTOPHY 100-3.6	T3	PA HD
ANTI-HYPERGLYCEMIC-SOD/GLUC COTRANSPORT2(SGLT2) INHIB		
FARXIGA	T2	ST QL(1 tab/day) HD
INVOKANA	T2	QL (1 tab/day) ST HD

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List of Prescription Medications

ANTI-HYPERGLYCEMICS (Diabetes) *(cont.)*		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
ANTI-HYPERGLYCEMIC-SOD/GLUC COTRANSPORT2(SGLT2) INHIB *(con't.)*		
JARDIANCE	T2	QL (1 tab/day) ST HD
STEGLATRO	T2	QL (1 tab/day) ST HD
ANTI-HYPERGLYCEMIC-DOPAMINE RECEPTOR AGONISTS		
CYCLOSET	T3	HD
ANTI-HYPERGLYCEMIC, ALPHA-GLUCOSIDASE INHIBITORS		
acarbose (Precose)	T1	HD
GLYSET (*miglitol*)	T3	HD
miglitol (Glyset)	T1	HD
PRECOSE (*acarbose*)	T3	HD
ANTI-HYPERGLYCEMIC, AMYLIN ANALOG-TYPE		
SYMLINPEN 120	T2	HD
SYMLINPEN 60	T2	
ANTI-HYPERGLYCEMIC, BIGUANIDE TYPE		
FORTAMET (*metformin er osmotic*)	T3	PA HD
GLUCOPHAGE XR (*metformin hcl er*)	T3	HD
GLUMETZA (*metformin er gastric*)	T3	PA
metformin hcl (Fortamet)	T1	PA HD
metformin hcl (Glucophage Xr)	T1	HD
metformin hcl (Glumetza)	T1	PA HD
metformin hcl (Riomet)	T1	HD
METFORMIN HCL 750 MG TABLET	T3	PA HD
RIOMET (*metformin hcl*)	T3	HD
RIOMET ER	T3	HD
ANTI-HYPERGLYCEMIC, DPP-4 INHIBITORS		
ALOGLIPTIN	T3	PA QL (1 tab/day) HD
JANUVIA	T2	QL (1 tab/day) ST HD
NESINA	T3	PA QL (1 tab/day) HD
ONGLYZA	T3	PA QL (1 tab/day) HD
SITAGLIPTIN	T3	PA QL(1 tab/day) HD
TRADJENTA	T3	PA QL (2 tabs/day) HD
ZITUVIO	T3	PA QL(1 tab/day) HD
ANTI-HYPERGLYCEMIC, INSULIN-RELEASE STIMULANT TYPE		
AMARYL (*glimepiride*)	T3	HD
chlorpropamide	T1	HD
glimepiride (Amaryl)	T1	HD

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ANTI-HYPERGLYCEMICS (Diabetes) *(cont.)*		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
ANTI-HYPERGLYCEMIC, INSULIN-RELEASE STIMULANT TYPE *(con't.)*		
GLIMEPIRIDE 3 MG TABLET	T3	HD
glipizide (Glucotrol) (Glucotrol XI)	T1	HD
GLUCOTROL (*glipizide*)	T3	HD
GLUCOTROL XL (*glipizide xl*)	T3	HD
glyburide	T1	HD
GLYNASE (*glyburide micronized*)	T3	HD
nateglinide (Starlix)	T1	HD
repaglinide	T1	HD
STARLIX (*nateglinide*)	T3	HD
tolbutamide	T1	HD
ANTI-HYPERGLYCEMIC, SGLT-2 AND DPP-4 INHIBITOR COMB		
GLYXAMBI	T2	QL (1 tab/day) ST HD
QTERN	T3	QL (1 tab/day) ST HD
STEGLUJAN	T3	QL (1 tab/day) ST HD
ANTI-HYPERGLYCEMIC, THIAZOLIDINEDIONE AND BIGUANIDE		
ACTOPLUS MET (*pioglitazone-metformin*)	T3	HD
pioglitazone hcl/metformin hcl (Actoplus Met)	T1	HD
ANTI-HYPERGLYCEMIC, THIAZOLIDINEDIONE-SULFONYLUREA		
DUETACT (*pioglitazone-glimepiride*)	T3	HD
pioglitazone hcl/glimepiride (Duetact)	T1	HD
ANTI-HYPERGLYCEMIC, DPP-4 INHIBITOR-BIGUANIDE COMBS.		
ALOGLIPTIN-METFORMIN	T3	PA QL (2 tabs/day) HD
JANUMET	T2	QL (2 tabs/day) ST HD
JANUMET XR 100-1,000 MG TABLET	T2	QL (1 tab/day) ST HD
JANUMET XR 50-1,000 MG TABLET	T2	QL (2 tabs/day) ST HD
JANUMET XR 50-500 MG TABLET	T2	QL (1 tab/day) ST HD
JENTADUETO	T3	PA QL (4 tabs/day) HD
JENTADUETO XR 2.5 MG-1,000 MG	T3	PA QL (2 tabs/day) HD
JENTADUETO XR 5 MG-1,000 MG TB	T3	PA QL (1 tab/day) HD
KAZANO	T3	PA QL (2 tabs/day) HD
KOMBIGLYZE XR 2.5-1,000 MG TAB	T3	PA QL (2 tabs/day) HD
KOMBIGLYZE XR 5-1,000 MG TAB	T3	PA QL (1 tab/day) HD
KOMBIGLYZE XR 5-500 MG TABLET	T3	PA QL (1 tab/day) HD
SITAGLIPTIN-METFORMIN	T3	HD
SITAGLIPTIN-METFORMIN ER 50-500 MG, 100-1,000 MG	T3	PA QL(1 tab/day) HD

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ANTI-HYPERGLYCEMICS (Diabetes) *(cont.)*		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
ANTI-HYPERGLYCEMIC, DPP-4 INHIBITOR-BIGUANIDE COMBS.*(con't.)*		
SITAGLIPTIN-METFORMIN ER 50-1,000	T3	PA QL(2 tabs/day) HD
ANTI-HYPERGLYCEMIC, INSULIN-RELEASE STIM.-BIGUANIDE		
glipizide/metformin hcl	T1	HD
glyburide/metformin hcl	T1	HD
repaglinide/metformin hcl	T1	HD
ANTI-HYPERGLYCEMIC, THIAZOLIDINEDIONE (PPARG AGONIST)		
ACTOS (*pioglitazone hcl*)	T3	HD
AVANDIA	T3	HD
pioglitazone hcl (Actos)	T1	HD
ANTI-HYPERGLYCEMIC-GLUCOCORTICOID RECEPTOR BLOCKER		
KORLYM *(mifepristone)*	T4	PA SP
mifepristone 300 mg tablet (Korlym)	T4	PA SP
ANTI-HYPERGLYCEMIC-SGLT2 INHIBITOR-BIGUANIDE COMBS.		
DAPAGLIFLOZIN-METFO ER 10-1000	T3	PA QL(1 tab/day) HD
DAPAGLIFLOZIN-METFOR ER 5-1000	T3	PA QL(2 tabs/day) HD
INVOKAMET	T2	QL (2 tabs/day) ST HD
INVOKAMET XR	T2	QL (2 tabs/day) ST HD
SEGLUROMET	T2	QL (2 tabs/day) ST HD
SYNJARDY	T2	QL (2 tabs/day) ST HD
SYNJARDY XR 10-1,000 MG TABLET	T2	QL (2 tabs/day) ST HD
SYNJARDY XR 12.5-1,000 MG TAB	T2	QL (2 tabs/day) ST HD
SYNJARDY XR 25-1,000 MG TABLET	T2	QL (1 tab/day) ST HD
SYNJARDY XR 5-1,000 MG TABLET	T2	QL (2 tabs/day) ST HD
XIGDUO XR 10 MG-1,000 MG TAB	T2	QL (1 tab/day) ST HD
XIGDUO XR 10 MG-500 MG TABLET	T2	QL (1 tab/day) ST HD
XIGDUO XR 2.5 MG-1,000 MG TAB	T2	QL (2 tabs/day) ST HD
XIGDUO XR 5 MG-1,000 MG TABLET	T2	QL (2 tabs/day) ST HD
XIGDUO XR 5 MG-500 MG TABLET	T2	QL (1 tab/day) ST HD
ANTI-HYPERGLY-SGLT-2 INHIB, DPP-4 INHIB, BIGUANIDE CB		
TRIJARDY XR	T2	QL (1 tab/day) ST HD
ANTIHYPERGLYCEMIC-SOD/GLUC COTRANSPORT2(SGLT2) INH		
BRENZAVVY	T3	PA QL(1 tabs/day) HD
DAPAGLIFLOZIN	T3	PA QL(1 tab/day) HD
INSULINS		

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ANTI-HYPERGLYCEMICS (Diabetes) *(cont.)*		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
INSULINS *(con't.)*		
ADMELOG	T3	QL (1.5ml/day) HD
ADMELOG SOLOSTAR	T3	QL (1.5ml/day) HD
AFREZZA 12 UNIT CARTRIDGE	T3	PA QL (12 cartridges/day) HD
AFREZZA 4 UNIT CARTRIDGE	T3	PA QL (36 cartridges/day) HD
AFREZZA 4 UNIT/8 UNIT/12 UNIT	T3	PA QL (6 cartridges/day) HD
AFREZZA 8 UNIT CARTRIDGE	T3	PA QL (18 cartridges/day) HD
AFREZZA 90-4 UNIT / 90-8 UNIT	T3	PA QL (12 cartridges/day) HD
AFREZZA 90-8 UNIT / 90-12 UNIT	T3	PA QL (6 cartridges/day) HD
APIDRA	T3	QL (1.5ml/day) HD
APIDRA SOLOSTAR	T3	QL (1.5ml/day) HD
BASAGLAR KWIKPEN U-100	T2	QL (1.5ml/day) HD
FIASP	T2	QL (1.5ml/day) HD
FIASP FLEXTOUCH	T2	QL (1.5ml/day) HD
FIASP PENFILL	T2	QL (1.5ml/day) HD
HUMALOG	T2	QL (1.5ml/day) HD
HUMALOG JUNIOR KWIKPEN	T2	QL (1.5ml/day) HD
HUMALOG KWIKPEN U-100	T2	QL (1.5ML/DAY) HD
HUMALOG KWIKPEN U-200	T2	QL (1ML/DAY) HD
HUMALOG MIX 50-50 KWIKPEN	T2	QL (2ml/day) HD
HUMALOG MIX 75-25	T2	QL (2ml/day) HD
HUMALOG MIX 75-25 KWIKPEN	T2	QL (2ml/day) HD
HUMULIN R U-500	T2	QL (1ML/DAY) HD
HUMULIN R U-500 KWIKPEN	T2	QL (1ml/day) HD
INSULIN ASPART	T2	QL (1.5ml/day) HD
INSULIN GLARGINE SOLOSTAR U100	T3	PA QL(1.5 mls/day) HD
INSULIN GLARGINE SOLOSTAR U300	T3	PA QL(0.6 mls/day) HD
INSULIN GLARGINE-YFGN	T3	QL (1.5ml/day) HD
INSULIN LISPRO	T2	QL (1.5ml/day) HD
INSULIN LISPRO PROTAMINE MIX	T2	QL (2ml/day) HD
KIRSTY	T3	QL (1.5ml/day) HD
LANTUS	T3	PA QL (1.5ml/day) HD
LANTUS SOLOSTAR	T3	PA QL (1.5ml/day) HD
LEVEMIR	T3	PA QL (1.5ml/day) HD

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ANTI-HYPERGLYCEMICS (Diabetes) *(cont.)*		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
INSULINS *(con't.)*		
LEVEMIR FLEXTOUCH	T3	PA QL (1.5ml/day) HD
LYUMJEV	T2	QL (1.5ml/day) HD
LYUMJEV KWIKPEN U-100	T2	QL (1.5ml/day) HD
LYUMJEV KWIKPEN U-200	T2	QL (1ml/day) HD
MERILOG	T3	PA QL (1.5ml/day)
NOVOLOG	T2	QL (1.5ml/day) HD
NOVOLOG FLEXPEN	T2	QL (1.5ml/day) HD
NOVOLOG MIX 70-30	T2	QL (2ml/day) HD
NOVOLOG MIX 70-30 FLEXPEN	T2	QL (2ml/day) HD
SEMGLEE (YFGN)	T3	PA QL (1.5ml/day) HD
SEMGLEE PEN	T3	PA QL (1.5ml/day) HD
TOUJEO MAX SOLOSTAR	T3	PA QL (0.6ml/day) HD
TOUJEO SOLOSTAR	T3	PA QL (0.6ml /day) HD
TRESIBA	T2	QL (1.5ml/day) HD
TRESIBA FLEXTOUCH U-100	T2	QL (1.5ml/day) HD
TRESIBA FLEXTOUCH U-200	T2	QL (0.9ml/day) HD
ANTI-INFECTIVES (Feminine Products)		
VAGINAL SULFONAMIDES		
AVC	T3	
ANTI-INFECTIVES (Infections)		
PENICILLIN ANTIBIOTICS		
amoxicillin	T1	
amoxicillin/potassium clav (Augmentin Es-600)	T1	
ampicillin sodium	T1	
AUGMENTIN ES-600 *(amoxicillin/potassium clav)*	T3	PA
nafcillin sodium	T1	
ANTI-INFECTIVES/MISCELLANEOUS (Feminine Products)		
VAGINAL ANTISEPTICS		
acetic acid/oxyquinoline (Relagard)	T1	
RELAGARD (*fem ph*)	T3	
TRIMO-SAN	T3	

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ANTI-INFECTIVES/MISCELLANEOUS (Infections)		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
2ND GEN. ANAEROBIC ANTI-PROTOZOAL-ANTIBACTERIAL		
TINDAMAX (*tinidazole*)	T3	
tinidazole	T1	
tinidazole (Tindamax)	T1	
AMEBICIDES		
paromomycin sulfate	T1	
ANTHELMINTICS		
albendazole (Albenza)	T1	
ALBENZA (*albendazole*)	T3	
BILTRICIDE (*praziquantel*)	T3	
EMVERM	T1	
ivermectin (Stromectol)	T1	PA
praziquantel (Biltricide)	T1	
STROMECTOL (*ivermectin*)	T3	PA
ANTI-MALARIAL DRUGS		
ARAKODA	T3	PA
atovaquone/proguanil hcl (Malarone)	T1	
chloroquine ph 250 mg tablet	T1	QL (56 Tabs/365 days)
chloroquine ph 500 mg tablet	T1	
COARTEM	T3	PA QL (24 tabs/30 days)
DARAPRIM (*pyrimethamine*)	T3	PA SP
hydroxychloroquine sulfate (Plaquenil)	T1	
KRINTAFEL	T3	PA QL (2 tabs/30 days)
MALARONE (*atovaquone-proguanil hcl*)	T3	PA
mefloquine hcl	T1	
PLAQUENIL (*hydroxychloroquine sulfate*)	T3	PA
primaquine phosphate (Primaquine)	T1	
PRIMAQUINE (*primaquine phosphate*)	T1	
pyrimethamine 25 mg tablet (Daraprim)	T1	PA
pyrimethamine 25 mg tablet (Daraprim)	T4	PA SP
QUALAQUIN (*quinine sulfate*)	T3	PA
quinine sulfate (Qualaquin)	T1	
ANTI-PROTOZOAL DRUGS, MISCELLANEOUS		
atovaquone (Mepron)	T1	
BENZNIDAZOLE	T3	

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ANTI-INFECTIVES/MISCELLANEOUS (Infections) *(cont.)*		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
ANTI-PROTOZOAL DRUGS, MISCELLANEOUS *(cont.)*		
IMPAVIDO	T3	PA
LAMPIT	T3	
MEPRON	T3	PA
MEPRON (*atovaquone*)	T3	PA
NEBUPENT (*pentamidine isethionate*)	T3	
PENTAM 300 (*pentamidine isethionate*)	T3	
pentamidine isethionate (Nebupent)	T1	
pentamidine isethionate (Pentam 300)	T1	
ANTI-INFECTIVES/MISCELLANEOUS (Miscellaneous)		
ANTIBACTERIAL AGENTS, MISCELLANEOUS		
glycine urologic solution	T1	
glycine urologic solution	T3	
ANTI-INFECTIVES/MISCELLANEOUS (Skin Conditions)		
TOPICAL ANTI-FUNGALS		
CICLODAN 8% KIT	T3	
ciclopirox/urea/camph/men/euc (Ciclodan)	T1	
ANTI-INFLAM.TUMOR NECROSIS FACTOR INHIBITING AGENTS (Pain Relief And Inflammatory Disease)		
ANTI-INFLAMMATORY TUMOR NECROSIS FACTOR INHIBITOR		
ABRILADA(CF)	T4	PA QL(2 pens/syringes/28 days) SP
ADALIMUMAB-AACF(CF)	T4	PA QL(2 pens/syringes/28 days) SP
ADALIMUMAB-AACF(CF) PEN	T4	PA SP
ADALIMUMAB-AATY(CF)	T4	PA QL SP
ADALIMUMAB-AATY(CF) AUTOINJECT	T4	PA QL SP
ADALIMUMAB-ADBM(CF)	T4	PA QL(2 pens/syringes/28 days) SP HD
ADALIMUMAB-ADBM(CF) PEN CROHNS	T4	PA QL(1 starter kit/365 days) SP HD
ADALIMUMAB-ADAZ	T4	PA QL (2 doses/ 28 days) SP
ADALIMUMAB-FKJP(CF)	T4	PA QL(2 pens/syringes/28 days) SP
ADALIMUMAB-RYVK(CF) AUTOINJECT	T4	PA QL (2 auto-injs/28 days) SP
AMJEVITA(CF)	T4	PA QL(2 syringes/28 days) SP HD
AMJEVITA(CF) AUTOINJECTOR	T4	PA QL(2 auto-injs/28 days) SP HD
AVSOLA	T4	PA SP
CIMZIA 200 MG VIAL KIT	T4	PA QL (1 kit/28 days) SP HD
CIMZIA 2X200 MG/ML SYRINGE KIT	T4	PA QL (1 kit/28 days) SP HD
CIMZIA 2X200 MG/ML (X3) START KT	T4	PA QL (1 kit/year) SP HD

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

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

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ANTI-NEOPLASTICS (Cancer)		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
ANP - SELECTIVE RETINOID X RECEPTOR AGONISTS (RXR)		
bexarotene (Targretin)	T3	PA SP HD
TARGRETIN 75 MG CAPSULE (*bexarotene*)	T3	PA SP HD
ANTIBIOTIC ANTINEOPLASTICS		
adriamycin 10 mg vial	T4	PA SP
adriamycin 20 mg/10 ml vial	T4	PA SP
ADRIAMYCIN (*doxorubicin hcl*)	T4	PA SP
bleomycin sulfate	T4	PA SP
dactinomycin (Cosmegen)	T4	PA SP
daunorubicin hcl	T4	PA SP
DOXIL (*lipodox 50*)	T4	PA SP
doxorubicin hcl	T4	PA SP
doxorubicin hcl peg-liposomal (Doxil)	T4	PA SP
ELLENCE (*epirubicin hcl*)	T4	PA SP
epirubicin vial (Ellence)	T4	PA SP
epirubicin hcl 200 mg vial	T4	SP
IDAMYCIN PFS (*idarubicin hcl*)	T4	PA SP
idarubicin hcl (Idamycin Pfs)	T4	PA SP
mitomycin (Mutamycin)	T4	PA SP
MUTAMYCIN (*mitomycin*)	T4	PA SP
valrubicin (Valstar)	T4	SP
VALSTAR (*valrubicin*)	T4	SP
ZANOSAR	T4	PA SP
ANTI-CD20 (B LYMPHOCYTE) MONOCLONAL ANTIBODY		
GAZYVA	T4	PA SP
RIABNI	T4	PA SP
RITUXAN	T4	PA SP
RITUXAN HYCELA	T4	PA SP
RUXIENCE	T4	PA SP
TRUXIMA	T4	PA SP
ANTINEOPLAST HUM VEGF INHIBITOR RECOMB MC ANTIBODY		
AVASTIN	T4	PA SP
MVASI	T4	PA SP
VEGZELMA	T4	PA SP

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ANTI-NEOPLASTICS (Cancer) *(cont.)*		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
ANTINEOPLAST HUM VEGF INHIBITOR RECOMB MC ANTIBODY *(cont.)*		
ZIRABEV	T4	PA SP
ANTI-NEOPLAST, HISTONE DEACETYLASE (HDAC) INHIBITORS		
BELEODAQ	T4	PA SP
FARYDAK	T4	PA SP HD
ISTODAX	T4	PA SP
ROMIDEPSIN 10 MG KIT	T4	PA SP
ROMIDEPSIN 27.5 MG/5.5 ML VIAL	T4	PA SP
ZOLINZA	T4	PA SP HD
ANTI-NEOPLASTIC - ALKYLATING AGENTS		
ALKERAN 2 MG TABLET (*melphalan*)	T4	SP
ALKERAN 50 MG VIAL (*melphalan hcl*)	T4	PA SP
BELRAPZO	T4	PA SP HD
BENDAMUSTINE 100 MG/4ML VIAL	T4	PA SP HD
BENDEKA	T4	PA SP HD
bendamustine 25 mg vial (Treanda)	T4	PA SP
bendamustine 100 mg vial (Treanda)	T4	PA SP
BICNU (*carmustine*)	T4	SP
busulfan (Busulfex)	T4	SP
BUSULFEX (*busulfan*)	T4	SP
carboplatin	T4	PA SP
carmustine (Bicnu)	T4	SP
cisplatin	T4	PA SP
cyclophosphamide 1 gm vial	T4	SP
CYCLOPHOSPHAMIDE 1 GM/5 ML VL	T4	SP
CYCLOPHOSPHAMIDE 2 GM/20 ML VL	T4	SP
CYCLOPHOSPHAMIDE 500 MG/5ML VL	T4	SP
cyclophosphamide 2 gm vial	T4	SP
cyclophosphamide 25 mg capsule	T4	SP HD
cyclophosphamide 50 mg capsule	T4	SP HD
CYCLOPHOSPHAMIDE 50 MG TABLET	T4	PA SP HD
cyclophosphamide 500 mg vial	T4	SP
CYCLOPHOSPHAMIDE 500 MG/2.5 ML	T4	SP
EVOMELA	T4	PA SP

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ANTI-NEOPLASTICS (Cancer) *(cont.)*		
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ANTI-NEOPLASTIC - ALKYLATING AGENTS *(con't.)*		
GLEOSTINE	T2	
GLIADEL	T4	SP
HYDREA (*hydroxyurea*)	T3	
hydroxyurea (Hydrea)	T1	
IFEX (*ifosfamide*)	T4	PA SP
ifosfamide	T4	PA SP
ifosfamide (Ifex)	T4	PA SP
LEUKERAN	T2	
melphalan hcl (Alkeran)	T3	PA CSL
MYLERAN	T2	
oxaliplatin	T4	PA SP
PEPAXTO	T4	PA SP
TEMODAR	T4	PA SP
temozolomide	T4	PA SP HD
TEPADINA	T4	PA SP
TEPADINA (*thiotepa*)	T4	PA SP
thiotepa (Tepadina)	T4	PA SP
TREANDA *(bendamustine hcl)*	T4	PA SP
YONDELIS	T4	PA SP
ZEPZELCA	T4	PA SP
ANTI-NEOPLASTIC - ANTI-ANDROGENIC AGENTS		
abiraterone acetate (Zytiga)	T4	PA SP HD
bicalutamide (Casodex)	T1	
CASODEX (*bicalutamide*)	T3	
ERLEADA 240 MG TABLET	T4	PA QL(1 tab/day) SP HD CSL
ERLEADA 60 MG TABLET	T4	PA SP HD CSL
flutamide	T1	
NILANDRON (*nilutamide*)	T3	PA QL (4 tabs/day)
nilutamide (Nilandron)	T1	QL (4 tabs/day)
NUBEQA	T4	PA SP HD
XTANDI	T4	PA SP HD
YONSA	T4	PA SP HD
ZYTIGA (*abiraterone acetate*)	T4	PA SP HD

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ANTI-NEOPLASTICS (Cancer) *(cont.)*		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
ANTI-NEOPLASTICS ANTI-BODY/ANTI-BODY-DRUG COMPLEXES		
ZIIHERA	T3	
ANTINEOPLASTIC - ANTIBIOTIC AND ANTIMETABOLITE		
VYXEOS	T4	PA SP
ANTINEOPLASTIC - ANTI-CD38 MONOCLONAL ANTIBODY		
DARZALEX	T4	PA SP HD
DARZALEX FASPRO	T4	PA SP
SARCLISA	T4	PA SP
ANTI-NEOPLASTIC - ANTI-METABOLITES		
ALIMTA	T4	PA SP
ARRANON	T4	PA SP
azacitidine (Vidaza)	T4	PA SP
capecitabine (Xeloda)	T4	PA SP HD
cladribine	T4	PA SP
clofarabine	T4	PA SP
cytarabine	T4	PA SP
cytarabine/pf	T4	PA SP
DACOGEN (*decitabine*)	T4	PA SP
decitabine (Dacogen)	T4	PA SP
floxuridine	T4	PA SP
fludarabine phosphate	T4	PA SP
fluorouracil	T4	PA SP
fluorouracil 1,000 mg/20 ml vl	T4	PA SP
fluorouracil 2, 500 mg/50 ml vl	T4	PA SP
fluorouracil 2.5 gm/50 ml btl	T4	PA SP
fluorouracil 2.5 gm/50 ml vial	T4	PA SP
fluorouracil 5 gm/100 ml btl	T4	PA SP
fluorouracil 5 gm/100 ml vial	T4	PA SP
fluorouracil 5,000 mg/100 ml	T4	PA SP
FOLOTYN 20 MG/ML VIAL	T4	PA SP
FOLOTYN 40 MG/2 ML VIAL	T4	PA SP
gemcitabine hcl	T4	PA SP
INFUGEM	T4	PA SP HD
INQOVI	T4	PA SP HD
LONSURF	T4	PA SP HD

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Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
ANTI-NEOPLASTIC - ANTI-METABOLITES *(cont.)*		
mercaptopurine	T1	
methotrexate sodium	T1	
methotrexate sodium/pf	T1	
NIPENT	T4	PA SP
ONUREG	T4	PA QL (14 tabs/28 days) SP
PEMRYDI RTU	T3	PA
PURIXAN	T4	SP
TABLOID	T3	
TREXALL	T2	
VIDAZA (*azacitidine*)	T4	PA SP
XATMEP	T3	
XELODA (*capecitabine*)	T4	PA SP HD
ZYNYZ	T4	PA SP
ANTINEOPLASTIC - ANTI-SLAMF7 MONOCLONAL ANTIBODY		
EMPLICITI	T4	PA SP HD
ANTI-NEOPLASTIC - AROMATASE INHIBITORS		
anastrozole (Arimidex)	T1	HD PPACA
ARIMIDEX (*anastrozole*)	T3	HD
AROMASIN (*exemestane*)	T3	HD
exemestane (Aromasin)	T1	HD PPACA
FEMARA (*letrozole*)	T3	HD
letrozole (Femara)	T1	HD
ANTI-NEOPLASTIC - BRAF KINASE INHIBITORS		
BRAFTOVI	T3	PA SP HD
OJEMDA TABLET	T4	PA QL(1 packet/28 Days) SP CSL
OJEMDA 25 MG/ML ORAL SUSP	T4	PA QL(8 bottles/28 days) SP CSL
TAFINLAR 10 MG TABLET FOR SUSP	T4	PA QL(30 tabs/day) SP HD CSL
TAFINLAR 50 MG, 75 MG CAPSULE	T4	PA QL(4 caps/day) SP HD CSL
ZELBORAF	T4	PA SP HD
ANTINEOPLASTIC - CD19 (B LYMPHOCYTE) MC ANTIBODY		
MONJUVI	T4	PA SP
ANTINEOPLASTIC - EPOTHILONES AND ANALOGS		
IXEMPRA	T4	PA SP
ANTI-NEOPLASTIC - HEDGEHOG PATHWAY INHIBITOR		
CYCLOPHOSPHAMIDE 25 MG TABLET	T4	PA SP HD

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ANTI-NEOPLASTICS (Cancer) *(cont.)*		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
ANTI-NEOPLASTIC - HEDGEHOG PATHWAY INHIBITOR *(cont.)*		
cyclophosphamide 50 mg capsule	T4	SP HD
CYCLOPHOSPHAMIDE 50 MG TABLET	T4	PA SP HD
cyclophosphamide 500 mg vial	T4	SP
CYCLOPHOSPHAMIDE 500 MG/2.5 ML	T4	SP
DAURISMO	T4	PA SP HD
ERIVEDGE	T4	PA SP HD
EVOMELA	T4	PA SP
ODOMZO	T4	PA SP HD CSL
ANTI-NEOPLASTIC - JANUS KINASE (JAK) INHIBITORS		
JAKAFI	T3	PA SP HD
ANTI-NEOPLASTIC - KRAS PROTEIN INHIBITOR		
KRAZATI	T4	PA QL(6 tabs/day) SP CSL
LUMAKRAS 120 MG TABLET	T4	PA QL(8 tabs/day) SP HD CSL
LUMAKRAS 240 MG TABLET	T3	PA QL(4 tabs/day) SP HD CSL
LUMAKRAS 320 MG TABLET	T4	PA QL(3 tabs/day) SP HD CSL
ANTI-NEOPLASTIC - MEKI AND MEK2 KINASE INHIBITORS		
COTELLIC	T4	PA SP HD
GOMEKLI	T4	PA SP HD
KOSELUGO 10 MG CAPSULE	T4	PA QL (10 capsules/day) SP
KOSELUGO 25 MG CAPSULE	T4	PA QL (4 caps/day) SP
MEKINIST 0.05 MG/ML SOLUTION	T4	PA QL(40 mls/day) SP HD CSL
MEKINIST 0.5 MG TABLET	T4	PA QL(3 tabs/day) SP HD CSL
MEKINIST 2 MG TABLET	T4	PA QL(1 tab/day) SP HD CSL
MEKTOVI	T4	PA SP HD
ANTINEOPLASTIC - MICROTUBULE INHIBITORS		
eribulin mesylate (Halaven)	T4	PA SP
HALAVEN *(eribulin mesylate)*	T4	PA SP
ANTI-NEOPLASTIC - MTOR KINASE INHIBITORS		
AFINITOR (*everolimus*)	T4	PA SP HD
everolimus (Afinitor)	T4	PA QL(1 tab/day) SP CSL
temsirolimus (Torisel)	T4	PA SP
TORISEL (*temsirolimus*)	T4	PA SP
ANTI-NEOPLASTIC - PROTEIN METHYLTRANSFERASE INHIBIT		
TAZVERIK	T4	PA SP

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ANTI-NEOPLASTICS (Cancer) *(cont.)*		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
ANTI-NEOPLASTIC - TOPOISOMERASE I INHIBITORS		
CAMPTOSAR 100 MG/5 ML VIAL (*irinotecan hcl*)	T4	PA SP
CAMPTOSAR 300 MG/15 ML VIAL	T4	PA SP
CAMPTOSAR 40 MG/2 ML VIAL (*irinotecan hcl*)	T4	PA SP
HYCAMTIN 0.25 MG CAPSULE	T4	PA SP HD CSL
HYCAMTIN 1 MG CAPSULE	T4	PA SP HD CSL
HYCAMTIN 4 MG VIAL (*topotecan hcl*)	T4	PA SP HD CSL
irinotecan hcl	T4	PA SP
irinotecan hcl (Camptosar)	T4	PA SP
ONIVYDE	T4	PA SP
topotecan hcl	T4	PA SP HD
topotecan hcl (Hycamtin)	T4	PA SP HD
ANTINEOPLASTIC - VEGF-A, B AND PLGF INHIBITORS		
ZALTRAP	T4	PA SP
ANTINEOPLASTIC - VEGFR ANTAGONIST		
CYRAMZA	T4	PA SP
ANTINEOPLASTIC - VINCA ALKALOIDS		
MARQIBO	T4	PA SP
NAVELBINE (*vinorelbine tartrate*)	T4	PA SP
vinblastine sulfate	T4	PA SP
vincristine sulfate	T4	PA SP
vinorelbine tartrate (Navelbine)	T4	PA SP
ANTINEOPLASTIC- CD22 ANTIBODY-CYTOTOXIC ANTIBIOTIC		
BESPONSA	T4	PA SP
ANTINEOPLASTIC- CD33 ANTIBODY-CYTOTOXIC ANTIBIOTIC		
MYLOTARG	T4	PA SP
ANTI-NEOPLASTIC COMB - KINASE AND AROMATASE INHIBIT		
KISQALI FEMARA CO-PACK	T4	PA QL(1 tab/28 days) SP CSL
ANTI-NEOPLASTIC EGF RECEPTOR BLOCKER MCLON ANTIBODY		
ERBITUX	T4	PA SP
HERCEPTIN	T4	PA SP
HERCEPTIN HYLECTA	T4	PA SP
HERZUMA	T4	PA SP
KANJINTI	T4	PA SP
MARGENZA	T4	PA SP

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ANTI-NEOPLASTICS (Cancer) *(cont.)*		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
ANTI-NEOPLASTIC EGF RECEPTOR BLOCKER MCLON ANTIBODY *(cont.)*		
OGIVRI	T4	PA SP
ONTRUZANT	T4	PA SP
PERJETA	T4	PA SP
PHESGO	T4	PA SP HD
PORTRAZZA	T4	PA SP
TRAZIMERA	T4	PA SP
VECTIBIX	T4	PA SP
ANTI-NEOPLASTIC IMMUNOMODULATOR AGENTS		
lenalidomide	T4	PA QL(1 tab/day) SP HD CSL
POMALYST	T4	PA QL(21 caps/28 days) SP HD CSL
REVLIMID	T4	PA QL(1 tab/day) SP HD CSL
ANTI-NEOPLASTIC LHRH (GNRH) AGONIST, PITUITARY SUPPR.		
ELIGARD	T4	SP HD
leuprolide acetate	T4	PA SP HD
LEUPROLIDE DEPOT	T4	PA SP
LUPRON DEPOT	T4	PA SP HD
TRELSTAR	T4	SP HD
ZOLADEX	T4	PA SP HD
ANTI-NEOPLASTIC LHRH (GNRH) ANTAGONIST, PITUIT.SUPPRS		
FIRMAGON	T4	PA SP HD
ORGOVYX	T4	PA SP
ANTI-NEOPLASTIC SYSTEMIC ENZYME INHIBITORS		
ALECENSA	T4	PA QL(8 tabs/day) SP HD CSL
ALUNBRIG 30 MG TABLET	T4	PA QL(2 tabs/day) SP CSL
ALUNBRIG 90 MG TABLET	T4	PA QL(1 tab/day) SP CSL
ALUNBRIG 90 MG-180 MG TAB PACK	T4	PA QL(1 tab/day) SP CSL
ALUNBRIG 180 MG TABLET	T4	PA QL(1 tab/day) SP CSL
ALIQOPA	T4	PA SP
ALUNBRIG	T4	PA SP HD
AUGTYRO	T4	PA QL(8 caps/day) SP HD CSL
AVMAPKI-FAKZYNJA	T4	PA SP CSL
AYVAKIT	T4	PA QL (1 tab/day) SP
BALVERSA	T4	PA SP
BORTEZOMIB	T4	PA SP
BORUZU	T3	PA SP

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ANTI-NEOPLASTICS (Cancer) *(cont.)*		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
ANTI-NEOPLASTIC SYSTEMIC ENZYME INHIBITORS *(cont.)*		
BOSULIF	T4	PA QL(3 caps/day) SP HD
BORUZU	T3	PA SP
BRUKINSA	T4	PA QL (4 caps/day) SP
CABOMETYX	T4	PA SP HD
CALQUENCE	T4	PA SP
CAPRELSA	T4	PA SP
COMETRIQ	T4	PA SP HD
COPIKTRA	T4	PA SP
dasatinib 20 mg tablet	T4	PA QL(3 tabs/day) SP HD CSL
dasatinib 70 mg tablet	T4	PA QL(2 tabs/day) SP HD CSL
dasatinib 50 mg, 80 mg, 100 mg, 140 mg tablet	T4	PA QL(1 tab/day) SP HD CSL
ENSACOVE 25 MG CAPSULE	T4	PA QL(9 caps/day) SP CSL
ENSACOVE 100 MG CAPSULE	T4	PA QL (2 caps/day) SP CSL
erlotinib hcl (Tarceva)	T4	PA SP HD
EXKIVITY	T4	PA SP HD
FOTIVDA	T4	PA QL (30 caps/30 days) SP HD
FRUZAQLA 1 MG CAPSULE	T4	PA QL(84 caps/28 days) SP CSL
FRUZAQLA 5 MG CAPSULE	T4	PA QL(21 caps/28 days) SP CSL
GAVRETO	T4	PA QL (4 tabs/day) SP
gefitinib	T4	PA SP HD CSL
GILOTRIF	T4	PA SP HD
GLEEVEC (*imatinib mesylate*)	T4	PA SP HD
IBTROZI	T4	PA SP HD
IBRANCE	T4	PA QL (21/30 days) SP HD
ICLUSIG	T4	PA SP
imatinib mesylate (Gleevec)	T4	PA SP HD
IMBRUVICA	T4	PA SP
IMKELDI	T2	PA SP CSL
INLYTA	T4	PA SP HD
INREBIC	T4	PA SP HD
IRESSA	T4	PA SP HD
ITOVEBI	T4	PA SP HD CSL
OGSIVEO 50 MG, 100 MG, 150 MG TABLET	T4	PA QL SP CSL
OJJAARA	T4	PA QL(1 Tab/day) SP CSL
IWILFIN	T4	PA QL(8 tabs/day) SP CSL

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ANTI-NEOPLASTICS (Cancer) *(cont.)*

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ANTI-NEOPLASTIC SYSTEMIC ENZYME INHIBITORS *(cont.)*		
KISQALI 200 MG	T4	PA QL (21 per 28 days) SP HD CSL
KISQALI 400 MG	T4	PA QL (42 per 28 days) SP HD CSL
KISQALI 800 MG	T4	PA QL (63 per 28 days) SP HD CSL
KISQALI FEMARA CO-PACK	T4	PA QL (1 pack per 28 days) SP HD CSL
KYPROLIS	T4	PA SP HD
lapatinib ditosylate (Tykerb)	T4	PA SP HD
LENVIMA	T4	PA SP HD CSL
LORBRENA	T4	PA SP HD
LYNPARZA	T4	PA SP HD
LYTGOBI 12 MG DOSE (3X 4MG TB)	T4	PA QL(3 tabs/day) SP CSL
LYTGOBI 16 MG DOSE PACK (4X 4MG TB)	T4	PA QL(4 tabs/day) SP CSL
LYTGOBI 20 MG DOSE PACK (5X 4MG TB)	T4	PA QL(5 tabs/day) SP CSL
NERLYNX	T4	PA SP HD
NEXAVAR	T4	PA QL(4 tabs/day) SP HD CSL
NINLARO	T4	PA SP HD
PEMAZYRE	T4	PA QL (14 tabs/21 days) SP
PIQRAY	T4	PA SP HD CSL
pazopanib (Votrient)	T4	PA QL(4 tabs/day) SP HD CSL
QINLOCK	T4	PA QL (3 tabs/day) SP
RETEVMO 40 MG CAPSULE	T4	PA QL (6 caps/day) SP HD
RETEVMO 80 MG CAPSULE	T4	PA QL (4 tabs/day) SP HD
REVUFORJ 25 MG, 110 MG TABLET	T4	PA SP CSL
REVUFORJ 160 MG TABLET	T4	PA QL(2 tabs/day) SP CSL
ROMVIMZA	T4	PA QL (8 caps/28 days) SP CSL
ROZLYTREK	T4	PA SP HD
RUBRACA	T4	PA SP
RYDAPT	T4	PA SP HD
RYTELO	T4	PA SP
SCEMBLIX	T4	PA QL (2 tablets/day) SP HD
SPRYCEL	T4	PA SP HD
STIVARGA	T4	PA QL(84 tabs/28 days) SP HD CSL
SUTENT	T4	PA SP HD
TABRECTA	T4	PA QL (4 tabs/day) SP HD
TAGRISSO	T4	PA SP HD
TRUQAP	T4	PA QL(64 TABS/28 DAYS) SP CSL

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T3 – Typically Non-Preferred Brands
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List of Prescription Medications

ANTI-NEOPLASTICS (Cancer) *(cont.)*		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
ANTI-NEOPLASTIC SYSTEMIC ENZYME INHIBITORS *(cont.)*		
TALZENNA	T4	PA QL(1 cap/day) SP HD CSL
TARCEVA (*erlotinib hcl*)	T4	PA SP HD
TASIGNA	T4	PA QL(4 caps/day) SP HD CSL
TEPMETKO	T4	PA SP QL (2 tabs/day)
TUKYSA	T4	PA SP
TURALIO	T4	PA QL(4 caps/day) SP CSL
TYKERB (*lapatinib*)	T4	PA SP HD
UKONIQ	T4	PA QL (4 tabs/day) SP
VANFLYTA	T4	PA QL(2 tabs/day) SP CSL
VELCADE	T4	PA SP
VERZENIO	T4	PA QL (120mg/day) SP HD
VITRAKVI	T4	PA SP HD
VIZIMPRO	T4	PA SP HD
VOTRIENT *(pazopanib hcl)*	T4	PA QL(4 tabs/day) SP HD CSL
XALKORI	T4	PA SP HD
XOSPATA	T4	PA SP
ZEJULA	T4	PA QL(1 tab/day) SP CSL
ZYDELIG	T4	PA SP HD
ZYKADIA	T4	PA SP HD
ANTI-NEOPLASTIC, ANTI-PROGRAMMED DEATH-I (PD-I) MAB		
KEYTRUDA	T4	PA SP
LIBTAYO	T4	PA SP
LOQTORZI	T4	PA SP
OPDIVO	T4	PA SP HD
TEVIMBRA	T4	PA SP
ANTI-NEOPLASTIC-B CELL LYMPHOMA-2(BCL-2) INHIBITORS		
VENCLEXTA	T4	PA SP
VENCLEXTA STARTING PACK	T4	PA SP
ANTI-NEOPLASTIC-ENZYME INHIB, ANTIANDROGEN COMB.		
AKEEGA	T4	PA QL(2 tabs/day) SP CSL
ANTINEOPLASTIC-CD22 DIRECT ANTIBODY/CYTOTOXIN CONJ		
LUMOXITI	T4	PA SP
ANTINEOPLASTIC-INTERLEUKIN-6 (IL-6) INHIB, ANTIBODY		
SYLVANT	T4	PA SP

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List of Prescription Medications

ANTI-NEOPLASTICS (Cancer) *(cont.)*		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
ANTI-NEOPLASTIC-ISOCITRATE DEHYDROGENASE INHIBITORS		
IDHIFA	T4	PA SP HD
REZLIDHIA	T4	PA QL(2 caps/day) SP CSL
TIBSOVO	T4	PA SP
ANTI-NEOPLASTICS ANTIBODY/ANTIBODY-DRUG COMPLEXES		
ADCETRIS	T4	PA SP
BLENREP	T3	PA
BLINCYTO	T4	PA SP
ENHERTU	T4	PA SP HD
ANTI-NEOPLASTICS ANTIBODY/ANTIBODY-DRUG COMPLEXES *(cont.)*		
IMDELLTRA	T4	PA SP
KADCYLA	T4	PA SP
LUNSUMIO	T4	PA SP
PADCEV	T4	PA SP
POLIVY	T4	PA SP HD
POTELIGEO	T4	PA SP
TRODELVY	T4	PA SP
UNITUXIN	T4	PA SP
VYLOY	T4	PA SP
ZEVALIN	T4	PA SP
ZIIHERA	T3	
ANTI-NEOPLASTICS, MISCELLANEOUS		
ABRAXANE	T4	PA SP
ARSENIC TRIOXIDE	T4	PA SP
arsenic trioxide (Trisenox)	T4	PA SP
ASPARLAS	T4	SP
BCG (TICE STRAIN)	T4	SP
dacarbazine	T4	PA SP
DOCEFREZ	T4	PA SP
docetaxel 160 mg/16 ml vial	T4	PA SP
docetaxel 160 mg/8 ml vial	T4	PA SP HD
docetaxel 20 mg/2 ml vial	T4	PA SP
docetaxel 20 mg/ml vial	T4	PA SP
docetaxel 80 mg/4 ml vial	T4	PA SP
docetaxel 80 mg/8 ml vial	T4	PA SP

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List of Prescription Medications

ANTI-NEOPLASTICS (Cancer) *(cont.)*		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
ANTI-NEOPLASTICS, MISCELLANEOUS *(con't.)*		
DOCIVYX	T4	PA SP
ERWINAZE	T4	PA SP
ETOPOPHOS	T4	PA SP
etoposide	T4	PA SP
JEVTANA	T4	PA SP HD
LYSODREN	T3	
MATULANE	T4	SP
mitoxantrone hcl	T4	PA SP
ONCASPAR	T4	PA SP
paclitaxel	T4	PA SP
TAXOTERE (*docetaxel*)	T4	PA SP
tretinoin 10 mg capsule	T1	PA
TRISENOX (*arsenic trioxide*)	T4	PA SP
ANTI-NEOPLASTIC-SELECT INHIB OF NUCLEAR EXP (SINE)		
XPOVIO	T4	PA SP
ANTI-PROGRAMMED CELL DEATH-LIGAND I (PD-LI) MAB		
BAVENCIO	T4	PA SP
IMFINZI	T4	PA SP
TECENTRIQ	T4	PA SP HD
CYTOTOXIC T-LYMPHOCYTE ANTIGEN (CTLA-4) RMC ANTIBODY		
IMJUDO	T4	PA SP HD
YERVOY	T4	PA SP HD
IMMUNOMODULATORS		
ACTIMMUNE	T4	PA SP HD
ALFERON N	T4	PA SP HD
BESREMI	T4	PA QL (2 syringes/28 days) SP
PROLEUKIN	T4	PA SP
PHOTOACTIVATED, ANTINEOPLASTIC AGENTS (SYSTEMIC)		
PHOTOFRIN	T4	SP
UVADEX	T2	
RADIOACTIVE THERAPEUTIC AGENTS		
AZEDRA DOSIMETRIC	T4	PA SP
AZEDRA THERAPEUTIC	T4	PA SP

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ANTI-NEOPLASTICS (Cancer) *(cont.)*		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
SELECTIVE ESTROGEN RECEPTOR MODULATORS (SERMS)		
FARESTON (*toremifene citrate*)	T3	QL (2 tabs/day) HD
FASLODEX (*fulvestrant*)	T4	PA SP HD
fulvestrant (Faslodex)	T4	PA SP HD
SOLTAMOX	T2	HD
tamoxifen citrate	T1	HD PPACA
toremifene citrate (Fareston)	T1	QL (2 tabs/day) HD
STEROID ANTI-NEOPLASTICS		
EMCYT	T4	SP HD
megestrol acetate	T1	
ANTI-NEOPLASTICS (Skin Conditions)		
PHOTOACT, TOPICAL ANTI-NEOPLAST, PREMALIGNANT LESIONS		
LEVULAN	T4	SP
TOPICAL ANTI-NEOPLASTIC PREMALIGNANT LESION AGENTS		
CARAC	T3	PA
diclofenac sodium 3% gel	T1	PA
EFUDEX (*fluorouracil*)	T3	
FLUOROPLEX	T2	
FLUOROURACIL 0.5% CREAM	T1	
fluorouracil 2% topical soln	T1	
fluorouracil 5% cream (Efudex)	T1	
fluorouracil 5% topical soln	T1	
KLISYRI	T3	PA QL (5 packs/30 Days)
PANRETIN	T4	SP HD
PICATO	T2	
TARGRETIN 1% GEL	T4	PA SP HD
TOLAK	T3	
VALCHLOR	T4	SP HD
ANTI-PARASITICS (Infections)		
ANTI-PARASITICS		
ALINIA (*nitazoxanide*)	T3	
nitazoxanide (Alinia)	T1	
OPHTHALMIC (EYE) ANTIPARASITICS		
XDEMVY	T4	PA QL(4 bottles/30 days) SP

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List of Prescription Medications

ANTI-PARASITICS (Infections) *(con't.)*		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
TOPICAL ANTI-PARASITICS *(con't.)*		
crotamiton (Eurax)	T1	
ELIMITE (*permethrin*)	T3	
EURAX 10% CREAM	T2	
EURAX 10% LOTION	T3	
NATROBA (*spinosad*)	T3	
permethrin (Elimite)	T1	
SKLICE (*ivermectin*)	T3	
spinosad (Natroba)	T1	
ULESFIA	T3	
ANTI-PARKINSON DRUGS (Parkinson's Disease)		
ANTI-PARKINSONISM DRUGS, ANTI-CHOLINERGIC		
benztropine mesylate	T1	HD
trihexyphenidyl hcl	T1	HD
ANTI-PARKINSONISM DRUGS, OTHER		
amantadine hcl	T1	HD
APOKYN	T4	PA SP HD
AZILECT 0.5 MG TABLET (*rasagiline mesylate*)	T3	QL (1 tab/day) HD
AZILECT 1 MG TABLET (*rasagiline mesylate*)	T3	HD
bromocriptine mesylate	T1	HD
carbidopa/levodopa	T1	HD
carbidopa/levodopa (Sinemet 10-100)	T1	HD
carbidopa/levodopa (Sinemet 25-100)	T1	HD
carbidopa/levodopa (Sinemet 25-250)	T1	HD
carbidopa/levodopa/entacapone (Stalevo 100)	T1	HD
carbidopa/levodopa/entacapone (Stalevo 125)	T1	HD
carbidopa/levodopa/entacapone (Stalevo 150)	T1	HD
carbidopa/levodopa/entacapone (Stalevo 200)	T1	HD
carbidopa/levodopa/entacapone (Stalevo 50)	T1	HD
carbidopa/levodopa/entacapone (Stalevo 75)	T1	HD
COMTAN (*entacapone*)	T3	HD
DHIVY	T3	PA
DUOPA	T4	SP HD
entacapone (Comtan)	T1	HD
GOCOVRI	T3	HD

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List of Prescription Medications

ANTI-PARKINSON DRUGS (Parkinson's Disease) *(cont.)*		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
ANTI-PARKINSONISM DRUGS, OTHER *(cont.)*		
INBRIJA	T4	PA SP HD
KYNMOBI	T2	PA HD
MIRAPEX ER 1.5 MG TABLET (*pramipexole er*)	T3	QL (1 tab/day) HD
NEUPRO	T3	HD
NOURIANZ	T4	PA QL (1 tab/day) SP HD
ONAPGO	T4	PA QL(20 mls/day) SP
ONGENTYS	T3	PA QL (1 caps/day) HD
OSMOLEX ER	T3	QL (1 tab/day) HD
PARLODEL (*bromocriptine mesylate*)	T3	HD
pramipexole di-hcl	T1	HD
pramipexole er 0.375 mg tablet	T1	QL (1 tab/day) HD
pramipexole er 0.75 mg tablet	T1	HD
pramipexole er 1.5 mg tablet (Mirapex Er)	T1	QL (1 tab/day) HD
pramipexole er 2.25 mg tablet	T1	QL (1 tab/day) HD
pramipexole er 3 mg tablet	T1	HD
pramipexole er 3.75 mg tablet	T1	HD
rasagiline mesylate 0.5 mg tab (Azilect)	T1	QL (1 tab/day) HD
rasagiline mesylate 1 mg tab (Azilect)	T1	HD
ropinirole hcl	T1	HD
RYTARY	T3	HD
selegiline hcl	T1	HD
SINEMET 10-100 (*carbidopa-levodopa*)	T3	HD
SINEMET 25-100 (*carbidopa-levodopa*)	T3	HD
SINEMET 25-250 (*carbidopa-levodopa*)	T3	HD
STALEVO 100 (*carbidopa-levodopa-entacapone*)	T3	HD
STALEVO 125 (*carbidopa-levodopa-entacapone*)	T3	HD
STALEVO 150 (*carbidopa-levodopa-entacapone*)	T3	HD
STALEVO 200 (*carbidopa-levodopa-entacapone*)	T3	HD
STALEVO 50 (*carbidopa-levodopa-entacapone*)	T3	HD
STALEVO 75 (*carbidopa-levodopa-entacapone*)	T3	HD
TASMAR (*tolcapone*)	T3	HD
tolcapone (Tasmar)	T1	HD
VYALEV	T4	PA SP HD
XADAGO	T3	ST HD

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List of Prescription Medications

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ANTI-PARKINSON DRUGS (Parkinson's Disease) *(cont.)*		
ANTI-PARKINSONISM DRUGS, OTHER *(cont.)*		
ZELAPAR	T3	PA HD
DECARBOXYLASE INHIBITORS		
carbidopa (Lodosyn)	T1	
LODOSYN (*carbidopa*)	T3	PA
ANTI-PLATELET DRUGS (Blood Thinners/Anti-Clotting)		
PLATELET AGGREGATION INHIBITORS		
AGGRASTAT	T3	
aspirin/dipyridamole	T1	HD
ASPIRIN-OMEPRAZOLE	T3	PA HD
BRILINTA	T3	HD
cilostazol	T1	HD
clopidogrel bisulfate (Plavix)	T1	HD
dipyridamole 25 mg tablet	T1	HD
dipyridamole 50 mg tablet	T1	HD
dipyridamole 75 mg tablet	T1	HD
EFFIENT (*prasugrel hcl*)	T3	HD
EPTIFIBATIDE	T1	HD
eptifibatide (Integrilin)	T1	
INTEGRILIN (*eptifibatide*)	T3	HD
PLAVIX (*clopidogrel*)	T3	HD
prasugrel hcl (Effient)	T1	HD
ticlopidine hcl	T1	HD
tirofiban-0.9% sodium chloride	T1	
YOSPRALA DR 325-40 MG TABLET	T3	PA
YOSPRALA DR 81-40 MG TABLET	T3	PA HD
ZONTIVITY	T3	HD
PLATELET REDUCING AGENTS		
AGRYLIN (*anagrelide hcl*)	T3	
anagrelide hcl (Agrylin)	T1	
ANTIVIRALS (AIDS/HIV)		
ANTIRETROVIRAL - ANTI-CD4 DOMAIN 2 MONOCLONAL AB		
TROGARZO	T4	PA SP
ANTI-RETROVIRAL - CAPSID INHIBITORS		
SUNLENCA 463.5 MG/1.5 ML VIAL	T4	PA SP

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List of Prescription Medications

ANTIVIRALS (AIDS/HIV) *(cont.)*		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
ANTI-RETROVIRAL - CAPSID INHIBITORS *(con't.)*		
SUNLENCA TABLET	T4	PA QL(5 tabs/180 days) SP
ANTI-RETROVIRAL - INTEGRASE INHIBITOR AND NNRTI COMB.		
CABENUVA	T4	PA SP
JULUCA	T4	SP
ANTI-RETROVIRAL - INTEGRASE INHIBITOR AND NRTI COMB.		
DOVATO	T4	SP
ANTI-RETROVIRAL - NRTIS AND INTEGRASE INHIBITORS COMB		
TRIUMEQ	T4	QL(1 tab/day) SP
ANTI-RETROVIRAL - NUCLEOSIDE, NUCLEOTIDE, PROTEASE INH.		
SYMTUZA	T4	SP
ANTIVIRALS - HIV-SPEC, NON-PEPTIDIC PROTEASE INHIB		
APTIVUS	T4	PA SP
darunavir (Prezista)	T4	SP
PREZCOBIX	T4	PA SP
PREZISTA	T4	PA SP
ANTIVIRALS - HIV-SPEC, NUCLEOSIDE-NUCLEOTIDE ANALOG		
CIMDUO	T4	PA SP
DESCOVY	T4	SP PPACA
emtricitabine-tenofv 100-150mg (Truvada)	T4	SP
emtricitabine-tenofv 133-200mg (Truvada)	T4	SP
emtricitabine-tenofv 167-250mg (Truvada)	T4	SP
emtricitabine-tenofv 200-300mg (Truvada)	T4	SP PPACA
TEMIXYS	T4	PA SP
TRUVADA (*emtricitabine-tenofovir disop*)	T4	PA SP
ANTIVIRALS - HIV-SPEC, NUCLEOSIDE ANALOG, RTI COMB		
abacavir sulfate/lamivudine (Epzicom)	T4	PA SP
abacavir/lamivudine/zidovudine	T4	PA SP
COMBIVIR (*lamivudine-zidovudine*)	T4	PA SP
EPZICOM (*abacavir-lamivudine*)	T4	PA SP
lamivudine/zidovudine (Combivir)	T4	SP
ANTIVIRALS - HIV-SPECIFIC, CCR5 CO-RECEPTOR ANTAG.		
SELZENTRY 150 MG TABLET (maraviroc)	T4	PA SP
SELZENTRY 20 MG/ML ORAL SOLN	T4	PA SP
SELZENTRY 25 MG TABLET	T4	PA SP
SELZENTRY 300 MG TABLET (maraviroc)	T4	PA SP

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List of Prescription Medications

ANTIVIRALS (AIDS/HIV) *(cont.)*		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
ANTIVIRALS - HIV-SPECIFIC, CCR5 CO-RECEPTOR ANTAG.*(con't.)*		
SELZENTRY 75 MG TABLET	T4	PA SP
ANTIVIRALS - HIV-SPECIFIC, CD4 ATTACHMENT INHIBITOR		
RUKOBIA	T4	PA QL (2 tablets/day) SP
ANTIVIRALS - HIV-SPECIFIC, FUSION INHIBITORS		
FUZEON	T4	PA SP
ANTIVIRALS - HIV-SPECIFIC, NON-NUCLEOSIDE, RTI *(cont.)*		
EDURANT	T4	PA SP
efavirenz	T4	PA SP
INTELENCE	T4	PA SP
ANTIVIRALS - HIV-SPECIFIC, NUCLEOSIDE ANALOG, RTI		
abacavir sulfate	T4	PA SP
nevirapine (Viramune)	T4	PA SP
nevirapine (Viramune Xr)	T4	PA SP
PIFELTRO	T4	PA SP
SUSTIVA (*efavirenz*)	T4	PA SP
VIRAMUNE (*nevirapine*)	T4	PA SP
VIRAMUNE XR (*nevirapine er*)	T4	PA SP
didanosine (Videx Ec)	T4	PA SP
emtricitabine (Emtriva)	T4	PA SP
EMTRIVA 10 MG/ML SOLUTION	T4	PA SP
EMTRIVA 200 MG CAPSULE (*emtricitabine*)	T4	PA SP
EPIVIR (*lamivudine*)	T4	PA SP
lamivudine 10 mg/ml oral soln (Epivir)	T4	SP
lamivudine 150 mg tablet (Epivir)	T4	SP
lamivudine 300 mg tablet (Epivir)	T4	PA SP
RETROVIR (*zidovudine*)	T4	PA SP
stavudine	T4	PA SP
VIDEX EC (*didanosine*)	T4	PA SP
ZIAGEN (*abacavir*)	T4	PA SP
zidovudine (Retrovir)	T4	SP
ANTIVIRALS, HIV-SPECIFIC, NUCLEOTIDE ANALOG, RTI		
tenofovir disoproxil fumarate (Viread)	T4	PA SP
VIREAD 150 MG TABLET	T4	PA SP
VIREAD 200 MG TABLET	T4	PA SP

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ANTIVIRALS (AIDS/HIV) *(cont.)*		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
ANTIVIRALS, HIV-SPECIFIC, NUCLEOTIDE ANALOG, RTI *(con't.)*		
VIREAD 250 MG TABLET	T4	PA SP
VIREAD 300 MG TABLET (*tenofovir disoproxil fumarate*)	T4	PA SP
VIREAD POWDER	T4	PA SP
ANTIVIRALS - HIV-SPECIFIC, PROTEASE INHIBITOR COMB		
KALETRA 100-25 MG TABLET	T4	SP
KALETRA 200-50 MG TABLET	T4	SP
KALETRA 80 MG-20 MG/ML SOLN (*lopinavir-ritonavir*)	T4	PA SP
lopinavir/ritonavir (Kaletra)	T4	SP
ANTIVIRALS - HIV-SPECIFIC, PROTEASE INHIBITORS		
atazanavir sulfate (Reyataz)	T4	PA SP
CRIXIVAN	T4	PA SP
EVOTAZ	T4	PA SP
fosamprenavir calcium (Lexiva)	T4	PA SP
LEXIVA 50 MG/ML SUSPENSION	T4	PA SP
LEXIVA 700 MG TABLET (*fosamprenavir calcium*)	T4	PA SP
NORVIR 100 MG POWDER PACKET	T4	SP
NORVIR 100 MG TABLET (*ritonavir*)	T4	PA SP
REYATAZ 150 MG CAPSULE (*atazanavir sulfate*)	T4	PA SP
REYATAZ 200 MG CAPSULE (*atazanavir sulfate*)	T4	PA SP
REYATAZ 300 MG CAPSULE (*atazanavir sulfate*)	T4	PA SP
REYATAZ 50 MG POWDER PACKET	T4	PA SP
ritonavir (Norvir)	T4	SP
VIRACEPT	T4	PA SP
ANTIVIRALS - HIV-I INTEGRASE STRAND TRANSFER INHIBTR		
APRETUDE	T4	PA SA
ISENTRESS	T4	SP
ISENTRESS HD	T4	PA SP
TIVICAY	T4	SP
TIVICAY PD	T4	SP
ARTV NUCLEOSIDE, NUCLEOTIDE, NON-NUCLEOSIDE RTI COMB		
ATRIPLA (*efavirenz-emtric-tenofov disop*)	T4	PA SP
COMPLERA	T4	PA SP
DELSTRIGO	T4	PA SP
efavirenz/emtricit/tenofovr df (Atripla)	T4	PA SP

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List of Prescription Medications

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ANTIVIRALS (AIDS/HIV) *(cont.)*		
ARTV NUCLEOSIDE, NUCLEOTIDE, NON-NUCLEOSIDE RTI COMB *(cont.)*		
efavirenz/lamivu/tenofov disop (Symfi Lo)	T4	SP
efavirenz/lamivu/tenofov disop (Symfi)	T4	SP
emtricita/rilpivirine/tenof df (Complera)	T4	QL(1 tab/day) SP
ODEFSEY	T4	PA SP
SYMFI (*efavirenz-lamivu-tenofov disop*)	T4	SP
SYMFI LO (*efavirenz-lamivu-tenofov disop*)	T4	SP
ARV-NUCLEOSIDE, NUCLEOTIDE RTI, INTEGRASE INHIBITORS		
BIKTARVY	T4	SP
GENVOYA	T4	SP
STRIBILD	T4	PA SP
ANTIVIRALS (Eye Conditions)		
EYE ANTIVIRALS		
trifluridine	T1	
ZIRGAN	T3	
ANTIVIRALS (Infections)		
ANTIVIRAL MONOCLONAL ANTIBODIES		
SYNAGIS	T4	PA SP HD
ANTIVIRALS, GENERAL		
acyclovir 200 mg capsule	T1	
acyclovir 200 mg/5 ml susp (Zovirax)	T1	
acyclovir 400 mg tablet	T1	
acyclovir 800 mg tablet	T1	
cidofovir	T4	SP
CYTOVENE (*ganciclovir sodium*)	T4	SP
famciclovir	T1	
FLUMADINE (*rimantadine hcl*)	T3	
foscarnet sodium (Foscavir)	T1	
FOSCAVIR	T3	
FOSCAVIR (*foscarnet sodium*)	T3	
GANCICLOVIR	T4	SP
ganciclovir sodium	T4	SP
ganciclovir sodium (Cytovene)	T4	SP
LIVTENCITY	T4	PA QL (4 tabs/day) SP
oseltamivir 6 mg/ml suspension (Tamiflu)	T1	QL (180ml/30 days)

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List of Prescription Medications

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

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List of Prescription Medications

ANTIVIRALS (Infections) *(cont.)*		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
HEP C VIRUS, NUCLEOTIDE ANALOG NS5B POLYMERASE INH *(con't.)*		
LEDIPASVIR-SOFOSBUVIR	T4	PA QL(1 tab/day) SP HD
HEP C VIRUS-NS5B POLYMERASE AND NS5A INHIB. COMBO.		
SOFOSBUVIR-VELPATASVIR	T4	PA QL(1 tab/day) SP HD
HEPATITIS B TREATMENT AGENTS		
adefovir dipivoxil	T4	SP HD
BARACLUDE 0.05 MG/ML SOLUTION	T4	SP HD
BARACLUDE 0.5 MG TABLET (*entecavir*)	T4	PA QL (1 tab/day) SP HD
BARACLUDE 1 MG TABLET (*entecavir*)	T4	PA SP HD
entecavir 0.5 mg tablet (Baraclude)	T4	QL (1 tab/day) SP HD
entecavir 1 mg tablet (Baraclude)	T4	SP HD
EPIVIR HBV 100 MG TABLET (*lamivudine hbv*)	T4	SP
EPIVIR HBV 25 MG/5 ML SOLN	T4	SP
lamivudine (Epivir Hbv)	T4	SP
VEMLIDY	T4	SP HD
HEPATITIS C TREATMENT AGENTS		
PEGASYS	T4	PA SP HD
PEGINTRON	T4	PA SP HD
ribasphere 200 mg capsule	T4	SP HD
ribasphere 200 mg tablet	T4	SP HD
ribasphere 400 mg tablet	T4	SP
ribasphere 600 mg tablet	T4	SP
ribasphere ribapak 200-400 mg	T4	SP HD
ribasphere ribapak 400-400 mg	T4	SP HD
ribasphere ribapak 600-400 mg	T4	SP HD
ribasphere ribapak 600-600 mg	T4	SP HD
ribavirin	T4	SP HD
HEPATITIS C VIRUS- NS5A AND NS3/4A INHIBITOR COMB		
MAVYRET 100-40 MG TABLET	T4	PA QL(3 tabs/day) SP HD
MAVYRET 50-20 MG PELLET PACKET	T4	PA QL(5 packs/day) SP HD
ZEPATIER	T4	PA SP HD
RNA POLYMERASE INHIBITOR		
LAGEVRIO (EUA)	T2	QL (1 pkg/120 days)
MOLNUPIRAVIR	T3	QL (1 pkg/120 days)

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List of Prescription Medications

ANTIVIRALS (Skin Conditions)		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
TOPICAL GENITAL WART-HPV TREATMENT AGENTS		
VEREGEN	T3	PA
AUTONOMIC DRUGS (Allergy/Nasal Sprays)		
ANAPHYLAXIS THERAPY AGENTS		
ADYPHREN	T1	
ADYPHREN AMP	T1	
AUVI-Q	T3	PA QL (2 packs/30 days)
EPINEPHRINE 0.15 MG AUTO-INJCT	T3	PA QL (2 packs/30 days)
epinephrine 0.15 mg auto-injct (Epipen Jr 2-pak)	T1	QL (2 packs/30 days)
EPINEPHRINE 0.3 MG AUTO-INJECT	T1	QL (2 packs/30 days)
epinephrine 0.3 mg auto-inject (Epipen 2-pak)	T1	QL (2 packs/30 days)
EPINEPHRINE PROFESSIONAL EMS	T3	
EPINEPHRINE PROFESSIONAL KIT	T3	
EPINEPHRINESNAP-EMS	T3	
EPINEPHRINESNAP-V	T3	
EPIPEN (*epinephrine*)	T3	PA QL (4 pens/22 days)
EPIPEN 2-PAK (*epinephrine*)	T3	PA QL (2 packs/30 days)
EPIPEN JR (*epinephrine*)	T3	PA QL (4 pens/22 days)
EPIPEN JR 2-PAK (*epinephrine*)	T3	PA QL (2 packs/30 days)
SYMJEPI	T3	PA QL (4 syringes/30 days)
AUTONOMIC DRUGS (Alzheimer's Disease)		
CHOLINESTERASE INHIBITORS		
ARICEPT (*donepezil hcl*)	T3	HD
BLOXIVERZ (*neostigmine methylsulfate*)	T3	
donepezil hcl	T1	HD
donepezil hcl (Aricept)	T1	HD
EXELON (*rivastigmine*)	T3	HD
galantamine er 16 mg capsule (Razadyne Er)	T1	HD
galantamine er 24 mg capsule (Razadyne Er)	T1	HD
galantamine er 8 mg capsule (Razadyne Er)	T1	QL (1 cap/day) HD
galantamine hbr	T1	HD
MESTINON *(pyridostigmine bromide)*	T3	HD
NEOSTIGMINE METHYLSULFATE	T1	
neostigmine methylsulfate (Bloxiverz)	T1	
neostigmine methylsulfate (Neostigmine Methylsulfate)	T1	

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List of Prescription Medications

AUTONOMIC DRUGS (Alzheimer's Disease) *(cont.)*		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
CHOLINESTERASE INHIBITORS *(cont.)*		
NEOSTIGMINE-STERILE WATER	T1	HD
physostigmine salicylate	T1	
pyridostigmine 60 mg/5 ml soln (Mestinon)	T1	
PYRIDOSTIGMINE BR 30 MG TABLET	T3	PA QL (20 tabs/day) HD
pyridostigmine br 60 mg tablet (Mestinon)	T1	HD
pyridostigmine bromide	T3	HD
pyridostigmine bromide (Mestinon)	T1	HD
RAZADYNE ER 16 MG CAPSULE (*galantamine er*)	T3	HD
RAZADYNE ER 24 MG CAPSULE (*galantamine er*)	T3	HD
RAZADYNE ER 8 MG CAPSULE (*galantamine er*)	T3	QL (1 cap/day) HD
rivastigmine (Exelon)	T1	HD
rivastigmine tartrate	T1	HD
ZUNVEYL	T3	PA QL(2 tabs/day) HD
AUTONOMIC DRUGS (Attention Deficit Hyperactivity Disorder)[9]		
ADRENERGICS, AROMATIC, NON-CATECHOLAMINE		
ADDERALL (*dextroamphetamine-amphetamine*)	T3	PA ST
ADDERALL XR 10 MG CAPSULE (*dextroamphetamine-amphet er*)	T3	PA QL (1 cap/day) ST
ADDERALL XR 15 MG CAPSULE (*dextroamphetamine-amphet er*)	T3	PA QL (1 cap/day) ST
ADDERALL XR 20 MG CAPSULE (*dextroamphetamine-amphet er*)	T3	PA QL (1 cap/day) ST
ADDERALL XR 25 MG CAPSULE (*dextroamphetamine-amphet er*)	T3	PA QL (1 per day) ST
ADDERALL XR 30 MG CAPSULE (*dextroamphetamine-amphet er*)	T3	PA QL (1 cap/day) ST
ADDERALL XR 5 MG CAPSULE (*dextroamphetamine-amphet er*)	T3	PA QL (1 cap/day) ST
ADZENYS ER	T3	PA QL (15ml/day)
ADZENYS XR-ODT	T3	PA QL (1 tab/day)
AMPHETAMINE	T3	PA QL (15ml/day)
amphetamine sulfate (Evekeo)	T1	PA
DESOXYN (*methamphetamine hcl*)	T3	PA
DESOXYN 5 MG TABLET (*methamphetamine hcl*)	T3	PA QL(5 tabs/day)
DEXEDRINE (*dextroamphetamine sulfate er*)	T3	PA QL (1 cap/day)
dextroamphetamine er 10 mg cap (Dexedrine)	T1	PA QL (1 cap/day)
dextroamphetamine er 15 mg cap (Dexedrine)	T1	PA QL (3/day)
dextroamphetamine/amphetamine (Adderall Xr)	T1	PA QL(1 cap/day)
dextroamphetamine/amphetamine (Mydayis)	T1	PA QL(1 cap/day)

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List of Prescription Medications

AUTONOMIC DRUGS (Attention Deficit Hyperactivity Disorder)[9] *(cont.)*		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
ADRENERGICS, AROMATIC, NON-CATECHOLAMINE *(cont.)*		
dextroamphetamine sulfate	T3	PA ST
DYANAVEL XR	T3	PA QL (8ml/day)
EVEKEO (*amphetamine sulfate*)	T3	PA ST
EVEKEO ODT	T3	PA
methamphetamine hcl (Desoxyn)	T1	PA
MYDAYIS *(dextroamphetamine/amphetamine)*	T3	PA QL (1 cap/day) ST
XELSTRYM	T3	PA QL(1 patch/day)
ZENZEDI	T3	PA ST
AUTONOMIC DRUGS (Blood Pressure/Heart Medications)		
ADRENERGIC VASOPRESSOR AGENTS		
droxidopa (Northera)	T4	SP HD
midodrine hcl	T1	
NORTHERA (*droxidopa*)	T4	PA SP HD
ALPHA-ADRENERGIC BLOCKING AGENTS		
DIBENZYLINE (*phenoxybenzamine hcl*)	T3	HD
phenoxybenzamine hcl (Dibenzyline)	T1	HD
phentolamine mesylate	T1	HD
prazosin hcl	T1	HD
TEZRULY	T3	PA HD
AUTONOMIC DRUGS (Miscellaneous)		
ADRENERGIC AGENTS, CATECHOLAMINES		
dopamine hcl	T1	
dopamine hcl in dextrose 5 %	T1	
epinephrine	T3	
epinephrine 0.1 mg/ml syringe	T1	
epinephrine 1 mg/10 ml abbojct	T1	
epinephrine 1 mg/10 ml luerjet	T1	
epinephrine 1 mg/ml vial	T1	
epinephrine 1 mg/ml ampul	T1	
epinephrine 30 mg/30 ml vial	T1	
epinephrine hcl in 0.9 % nacl	T1	

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List of Prescription Medications

AUTONOMIC DRUGS (Miscellaneous) *(cont.)*		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
ADRENERGIC AGENTS, CATECHOLAMINES *(cont.)*		
epinephrine hcl in 0.9 % nacl (Epinephrine Hcl-0.9% Nacl)	T1	
epinephrine hcl in dextrose 5% (Epinephrine Hcl-d5w)	T1	
EPINEPHRINE HCL-0.9% NACL	T1	
EPINEPHRINE HCL-0.9% NACL (*epinephrine hcl-0.9% nacl*)	T1	
EPINEPHRINE HCL-D5W	T1	
EPINEPHRINE HCL-D5W (*epinephrine hcl-d5w*)	T1	
isoproterenol hcl	T1	
isoproterenol hcl (Isuprel)	T1	
ISUPREL	T3	
LEVOPHED (*norepinephrine bitartrate*)	T3	
LEVOPHED BITARTRATE (*norepinephrine bitartrate*)	T3	
norepinephrine bit/0.9 % nacl	T1	
norepinephrine bitartrate (Levophed Bitartrate)	T1	
norepinephrine bitartrate (Levophed)	T1	
norepinephrine bitartrate/d5w	T1	
NOREPINEPHRINE BITARTRATE-D5W	T1	
NEUROMUSCULAR BLOCKING AGENTS		
atracurium besylate	T1	
BOTOX 100 UNIT VIAL	T4	PA SP
BOTOX 200 UNIT VIAL	T4	PA SP HD
cisatracurium besylate (Nimbex)	T1	
DAXXIFY	T4	PA SP
DYSPORT	T4	PA SP HD
MIVACRON	T3	
MYOBLOC	T4	PA SP
NIMBEX (*cisatracurium besylate*)	T3	
pancuronium bromide	T1	
NEUROMUSCULAR BLOCKING AGENTS		
QUELICIN (*succinylcholine chloride*)	T3	
rocuronium bromide	T1	
rocuronium bromide (Rocuronium Bromide)	T1	
SUCCINYLCHOLINE CHLORIDE	T1	
succinylcholine chloride (Quelicin)	T1	

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List of Prescription Medications

AUTONOMIC DRUGS (Urinary Tract Conditions)		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
PARASYMPATHETIC AGENTS		
bethanechol chloride	T1	HD
cevimeline hcl (Evoxac)	T1	HD
EVOXAC (*cevimeline hcl*)	T3	HD
guanidine hcl	T1	HD
pilocarpine hcl (Salagen)	T1	HD
SALAGEN (*pilocarpine hcl*)	T3	HD
BIOLOGICALS (Allergy/Nasal Sprays)		
ALLERGENIC EXTRACTS, THERAPEUTIC		
GRASTEK	T3	PA QL (1 tab/day)
ODACTRA	T3	PA QL (1 tab/day)
ORALAIR	T3	PA QL (1 tab/day)
PALFORZIA	T3	PA SP
RAGWITEK	T3	PA QL (1 tab/day)
BIOLOGICALS (Blood Pressure/Heart Medications)		
PLASMA KALLIKREIN INHIBITORS		
TAKHZYRO	T4	PA SP HD
BIOLOGICALS (Miscellaneous)		
ANTISERA		
HYPERRHO S-D	T4	SP
MICRHOGAM ULTRA-FILTERED PLUS	T4	SP
RHOGAM ULTRA-FILTERED PLUS	T4	SP
RHOPHYLAC	T4	SP
WINRHO SDF	T4	SP HD
PKU TREATMENT AGENTS - PHENYLALANINE AMMONIA LYASE		
PALYNZIQ	T4	PA SP HD
BIOLOGICALS (Vaccines)		
COVID-19 VACCINES		
COMIRANTY	T3	PPACA
JANSSEN COVID-19 VACCINE (EUA)	T3	PPACA
MODERNA COVID-19 VACCINE (EUA)	T3	PPACA
NOVAVAX COVID (EUA)	T3	PPACA
PFIZER COVID-19 VACCINE (EUA)	T3	PPACA
SPIKEVAX	T3	PPACA

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List of Prescription Medications

BIOLOGICALS (Vaccines) *(cont.)*		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
ENTERIC VIRUS VACCINES		
IPOL	T3	PPACA
ROTARIX	T3	PPACA
ROTATEQ	T3	PPACA
GRAM NEGATIVE COCCI VACCINES		
BEXSERO	T3	PPACA
MENACTRA	T3	
MENQUADFI	T3	PPACA
MENVEO A-C-Y-W-135-DIP	T3	PPACA
PENBRAYA	T3	PPACA
TRUMENBA	T3	PPACA
GRAM POSITIVE COCCI VACCINES		
CAPVAXIVE	T3	PPACA
PNEUMOVAX 23	T3	PPACA
PREVNAR 13	T3	PPACA
PREVNAR 20	T3	PPACA
INFLUENZA VIRUS VACCINES		
AFLURIA TRIVALENT	T3	PPACA
FLUAD TRIVALENT	T3	PPACA
FLUARIX TRIVALENT	T3	PPACA
FLUARIX TRIVALENT	T3	PPACA
FLUBLOK TRIVALENT	T3	PPACA
FLUCELVAX TRIVALENT	T3	PPACA
FLULAVAL TRIVALENT	T3	PPACA
FLUMIST TRIVALENT	T3	PPACA
FLUZONE TRIVALENT	T3	PPACA
FLUZONE TRIVALENT	T3	PPACA
VACCINE/TOXOID PREPARATIONS, COMBINATIONS		
ACTHIB	T3	PPACA
ADACEL TDAP	T3	PPACA
BOOSTRIX TDAP	T3	PPACA
DAPTACEL DTAP	T3	PPACA
DIPHTHERIA-TETANUS TOXOIDS-PED	T3	PPACA
HIBERIX	T3	PPACA

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BIOLOGICALS (Vaccines) *(cont.)*		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
VACCINE/TOXOID PREPARATIONS, COMBINATIONS *(con't)*		
INFANRIX DTAP	T3	PPACA
KINRIX	T3	PPACA
M-M-R II VACCINE	T3	PPACA
PEDVAXHIB	T3	PPACA
PENTACEL	T3	PPACA
PROQUAD	T3	PPACA
QUADRACEL DTAP-IPV	T3	PPACA
TDVAX	T3	PPACA
TENIVAC	T3	PPACA
VAXELIS	T3	PPACA
VIRAL/TUMORIGENIC VACCINES		
ACAM2000	T3	
ENGERIX-B ADULT	T3	PPACA
ENGERIX-B PEDIATRIC-ADOLESCENT	T3	PPACA
ERVEBO (NATIONAL STOCKPILE)	T3	
GARDASIL 9	T3	PPACA
HEPLISAV-B	T3	PPACA
IXCHIQ	T3	PPACA
JYNNEOS	T3	
MRESVIA	T3	PPACA
PEDIARIX	T3	PPACA
RECOMBIVAX HB	T3	PPACA
SHINGRIX	T3	QL (2 doses/lifetime) PPACA
TWINRIX	T3	PPACA
VARIVAX VACCINE	T3	PPACA
ZOSTAVAX	T3	PPACA
BLOOD (Blood Modifiers/Bleeding Disorders)		
AGENTS TO TX THROMBOTIC THROMBOCYTOPENIC PURPURA		
ADZYNMA	T4	PA SP
CABLIVI	T4	PA SP
ANTI-FIBRINOLYTIC AGENTS		
AMICAR (*aminocaproic acid*)	T4	SP HD
aminocaproic acid	T4	SP HD
CYKLOKAPRON (*tranexamic acid*)	T4	SP

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List of Prescription Medications

BLOOD (Blood Modifiers/Bleeding Disorders) *(cont.)*		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
ANTI-FIBRINOLYTIC AGENTS *(cont.)*		
FIBRYGA	T4	PA SP
LYSTEDA (*tranexamic acid*)	T4	SP
RIASTAP	T4	PA SP
tranexamic acid (Cyklokapron) (Lysteda)	T4	SP
tranexamic 1,000 mg/100ml-nacl	T4	SP
TRANEXAMIC 1,000 MG/100ML-NACL	T4	SP
ANTI-HEMOPHILIC FACTORS		
ALTUVIIIO	T4	PA SP HD
COMPLEMENT (C3) INHIBITORS		
BKEMV	T4	SP
EMPAVELI	T4	PA SP
EPYSQLI	T4	SP
FABHALTA	T4	PA QL(2 caps/day) SP
COAGULANTS		
protamine sulfate	T1	
COMPLEMENT(C5) INHIBITOR		
TAVNEOS	T4	PA QL (6 caps/day)SP HD
FACTOR IX COMPLEX (PCC) PREPARATIONS		
KCENTRA	T4	SP
FACTOR X PREPARATIONS		
COAGADEX	T4	PA SP
FACTOR XIII PREPARATIONS		
CORIFACT	T4	PA SP
TRETTEN	T4	PA SP
HEMOPHILIA TREATMENT AGENTS, NON-FACTOR REPLACEMENT		
ALHEMO PEN	T3	PA SP
HEMLIBRA	T4	PA SP HD
HYMPAVZI PEN	T4	PA SP
QFITLIA	T4	PA SP
HUMAN MONOCLONAL ANTIBODY COMPLEMENT (C5) INHIBITOR		
SOLIRIS	T4	PA SP
ULTOMIRIS	T4	PA SP HD
PROTEIN C PREPARATIONS		
CEPROTIN	T4	PA SP

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List of Prescription Medications

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

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
SICKLE CELL ANEMIA AGENTS		
ADAKVEO	T4	PA SP
DROXIA	T2	
XROMI	T3	PA
SIKLOS	T3	PA
TOPICAL HEMOSTATICS		
ASTRINGYN	T3	
AVITENE	T3	
ENDO-AVITENE	T3	
EVICEL	T3	
gelatin sponge, absorb/porcine (Gelfoam)	T1	
GELFOAM (*surgifoam*)	T3	
GELFOAM COMPRESSED	T3	
MONSEL'S	T3	
RAPLIXA	T3	
RECOTHROM	T3	
SURGIFOAM	T1	
SYRINGE AVITENE	T3	
TACHOSIL	T3	
THROMBI-GEL	T3	
THROMBIN-JMI	T3	
THROMBI-PAD	T3	
ULTRAFOAM	T3	
ANTICOAGULANT REVERSAL AGENT FOR FACTOR XA INHIB.		
ANDEXXA	T4	SP
ANTICOAGULANT REVERSAL AGENT, DIRECT THROMBIN INHIB		
PRAXBIND	T4	SP
HEMORRHEOLOGIC AGENTS		
pentoxifylline	T1	HD
THROMBOLYTIC - NUCLEOTIDE TYPE		
DEFITELIO	T4	PA SP
THROMBOLYTIC ENZYMES		
ACTIVASE	T3	
CATHFLO ACTIVASE	T3	
RETAVASE	T3	
TNKASE	T3	

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List of Prescription Medications

BLOOD (Miscellaneous)		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
CELL/GENE THERAPY AGENTS - HEMATOPOIETIC		
OMISIRGE	T3	
CARDIAC DRUGS (Blood Pressure/Heart Medications)		
ANTI-ANGINAL, ANTI-ISCHEMIC AGENTS, NON-HEMODYNAMIC		
RANEXA (*ranolazine er*)	T3	PA QL (4 tabs/day) HD
ranolazine (Ranexa)	T1	QL (4 tabs/day) HD
ANTI-ARRHYTHMICS		
adenosine	T1	HD
amiodarone hcl	T1	HD
AMIODARONE HCL-D5W	T1	HD
bretylium tosylate	T1	
CORVERT (*ibutilide fumarate*)	T3	PA
disopyramide phosphate (Norpace)	T1	HD
dofetilide 125 mcg capsule (Tikosyn)	T1	QL (8 caps/day) HD
dofetilide 250 mcg capsule (Tikosyn)	T1	QL (4 caps/day) HD
dofetilide 500 mcg capsule (Tikosyn)	T1	QL (2 caps/day) HD
flecainide acetate	T1	HD
ibutilide fumarate (Corvert)	T1	HD
lidocaine hcl 1% abboject	T1	
lidocaine hcl 1% syringe	T1	
lidocaine hcl 2% abboject	T1	
lidocaine hcl 2% luer-jet	T1	
lidocaine hcl 2% syringe	T1	
lidocaine hcl 2% vial	T1	
lidocaine hcl/dextrose 5 %/pf	T1	
mexiletine hcl	T1	
MULTAQ	T2	HD
NEXTERONE	T3	
NORPACE (*disopyramide phosphate*)	T3	PA HD
NORPACE CR	T3	HD
pacerone 100 mg tablet	T3	PA HD
pacerone 200 mg tablet	T1	HD
pacerone 400 mg tablet	T3	PA HD
procainamide hcl	T1	HD

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List of Prescription Medications

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

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List of Prescription Medications

CARDIAC DRUGS (Blood Pressure/Heart Medications) *(cont.)*		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
CALCIUM CHANNEL BLOCKING AGENTS *(cont.)*		
diltiazem 24h er(la) 420 mg tb (Cardizem La)	T1	HD
diltiazem hcl (Cardizem La)	T1	HD
diltiazem hcl (Cardizem)	T1	
diltiazem hcl (Tiazac)	T1	HD
DILTIAZEM HCL-0.7% NACL	T3	
DILTIAZEM HCL-0.9% NACL	T1	
felodipine	T1	HD
isradipine	T1	HD
KATERZIA	T3	PA QL (10ml/day) HD
NICARDIPIN 20MG/200ML-0.9%NACL	T3	
NICARDIPIN 40MG/200ML-0.9%NACL	T3	
NICARDIPINE 1 MG/10 ML-NS SYRG	T1	
nicardipine hcl	T1	
nicardipine hcl (Cardene I.v.)	T1	
NICARDIPINE HCL-D5W	T1	
nifedipine	T1	HD
nifedipine (Adalat Cc)	T1	HD
nifedipine (Procardia XI)	T1	HD
nifedipine (Procardia)	T1	HD
nimodipine	T1	HD
nisoldipine er 17 mg tablet (Sular)	T1	HD
nisoldipine er 20 mg tablet	T1	QL (1 tab/day) HD
nisoldipine er 25.5 mg tablet	T1	HD
nisoldipine er 30 mg tablet	T1	HD
nisoldipine er 34 mg tablet (Sular)	T1	HD
nisoldipine er 40 mg tablet	T1	HD
nisoldipine er 8.5 mg tablet (Sular)	T1	HD
NORVASC (*amlodipine besylate*)	T3	HD
NORLIQVA	T2	PA QL (10ml/day) HD
NYMALIZE	T3	
PROCARDIA (*nifedipine*)	T3	PA HD
PROCARDIA XL (*nifedipine er*)	T3	HD
SULAR (*nisoldipine*)	T3	HD
TIAZAC (*tiadylt er*)	T3	HD

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CARDIAC DRUGS (Blood Pressure/Heart Medications) *(cont.)*		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
CALCIUM CHANNEL BLOCKING AGENTS *(cont.)*		
verapamil hcl	T1	HD
verapamil hcl (Calan Sr)	T1	HD
verapamil hcl (Verelan Pm)	T1	HD
verapamil hcl (Verelan)	T1	HD
VERELAN (*verapamil hcl*)	T3	HD
VERELAN PM (*verapamil er pm*)	T3	HD
CARDIOPLEGIC SOLUTIONS		
CARDIOPLEGIA DEL NIDO FORMULA	T3	
CARDIOPLEGIA HIGH POTASSIUM	T3	
CARDIOPLEGIA IND 8:1 NON-ENRCH	T3	
CARDIOPLEGIA INDUCTION 4:1	T3	
CARDIOPLEGIA INDUCTION 8:1	T3	
CARDIOPLEGIA MAINTENANCE 4:1	T3	
CARDIOPLEGIA MAINTENANCE 8:1	T3	
CARDIOPLEGIA REPERFUSATE 4:1	T3	
cardioplegic solution no.1 (Plegisol)	T1	
PLEGISOL	T3	
DIGITALIS GLYCOSIDES		
digoxin	T1	HD
digoxin (Lanoxin)	T1	HD
LANOXIN 125 MCG TABLET (*digoxin*)	T3	PA HD
LANOXIN 187.5 MCG TABLET	T3	PA HD
LANOXIN 250 MCG TABLET (*digoxin*)	T3	PA HD
LANOXIN 500 MCG/2 ML AMPULE (*digoxin*)	T3	HD
LANOXIN 500 MCG/2 ML VIAL	T3	HD
LANOXIN 62.5 MCG TABLET	T3	PA HD
LANOXIN PEDIATRIC	T3	HD
HEART RATE REDUCING, SA SELECTIVE I(F) CURRENT INH.		
CORLANOR TABLET *(ivabradine hcl)*	T2	PA HD
CORLANOR SOLUTION *(ivabradine hcl)*	T4	PA SP HD
ivabradine hcl (Corlanor)	T1	PA HD
INOTROPIC DRUGS		
dobutamine hcl	T1	
dobutamine hcl in dextrose 5 %	T1	

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CARDIAC DRUGS (Blood Pressure/Heart Medications) *(cont.)*		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
INOTROPIC DRUGS *(cont.)*		
milrinone lactate	T1	
milrinone lactate/d5w	T1	
VASODILATORS, CORONARY		
DILATRATE-SR	T3	HD
GONITRO	T3	HD
ISORDIL (*isosorbide dinitrate*)	T3	PA HD
ISORDIL TITRADOSE (*isosorbide dinitrate*)	T3	PA HD
isosorbide dinitrate 10 mg tab	T1	HD
isosorbide dinitrate 20 mg tab	T1	HD
isosorbide dinitrate 30 mg tab	T1	HD
isosorbide dinitrate 40 mg tab (Isordil)	T1	PA HD
isosorbide dinitrate 5 mg tab (Isordil Titradose)	T1	HD
isosorbide mononitrate	T1	HD
MINITRAN	T1	HD
NITRO-DUR 0.1, 0.2, 0.3, 0.4, 0.6, 0.8 MG/HR PATCH	T3	HD
nitroglycerin	T1	HD
nitroglycerin (Nitro-dur)	T1	HD
nitroglycerin (Nitrolingual)	T1	HD
nitroglycerin (Nitromist)	T1	HD
nitroglycerin (Nitrostat)	T1	HD
nitroglycerin in 5 % dextrose	T1	
NITROLINGUAL (*nitroglycerin*)	T3	HD
NITROMIST (*nitroglycerin*)	T3	HD
NITROSTAT (*nitroglycerin*)	T3	HD
CARDIOVASCULAR (Allergy/Nasal Sprays)		
SYMPATHOMIMETIC AGENTS		
AKOVAZ	T3	
BIORPHEN	T3	
EPHEDRINE SULFATE	T1	
ephedrine sulfate (Akovaz)	T1	
EPHEDRINE SULFATE-0.9% NACL	T1	
EPHEDRINE SULFATE-NACL	T1	
phenylephrine hcl (Vazculep)	T1	
phenylephrine hcl in 0.9% nacl (Phenylephrine Hcl-0.9% Nacl)	T1	

List of Prescription Medications

CARDIOVASCULAR (Allergy/Nasal Sprays) *(cont.)*		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
SYMPATHOMIMETIC AGENTS *(cont.)*		
phenylephrine hcl/dextrose 5 %	T1	
PHENYLEPHRINE HCL-0.9% NACL (*phenylephrine hcl-0.9% nacl*)	T1	
PHENYLEPHRINE HCL-D5W	T1	
REZIPRES	T3	
VAZCULEP (*phenylephrine hcl*)	T3	
CARDIOVASCULAR (Asthma/COPD/Respiratory)		
PULM ANTI-HTN, SOLUBLE GUANYLATE CYCLASE STIMULATOR		
ADEMPAS	T4	PA SP HD
VERQUVO	T4	PA QL (1 tab/day)
PULM.ANTI-HTN, SEL.C-GMP PHOSPHODIESTERASE T5 INHIB		
ADCIRCA (*tadalafil*)	T4	PA SP HD
LIQREV	T4	PA SP HD
REVATIO	T4	PA SP HD
REVATIO (*sildenafil citrate*)	T4	PA SP HD
TADLIQ	T4	PA SP HD
sildenafil 10 mg/12.5 ml vial (Revatio)	T4	PA SP HD
sildenafil 10 mg/ml oral susp (Revatio)	T4	PA SP HD
sildenafil 20 mg tablet (Revatio)	T4	PA SP HD
tadalafil (Adcirca)	T4	PA SP HD
tadalafil 20 mg tablet (Adcirca)	T4	PA SP HD
PULMONARY ANTI-HTN, ENDOTHELIN RECEPTOR ANTAGONIST		
ambrisentan (Letairis)	T4	PA SP HD
bosentan (Tracleer)	T4	PA SP HD
LETAIRIS (*ambrisentan*)	T4	PA SP HD
OPSUMIT	T4	PA SP HD
TRACLEER 125 MG TABLET (*bosentan*)	T4	PA SP HD
TRACLEER 32 MG TABLET FOR SUSP	T4	PA SP HD
TRACLEER 62.5 MG TABLET (*bosentan*)	T4	PA SP HD
PULMONARY ANTIHYPER AGENT, ACTRIIA-FC		
WINREVAIR	T4	PA SP HD
PULMONARY ANTIHYPERTENSIVES, PROSTACYCLIN-TYPE		
epoprostenol sodium	T4	PA SP HD
epoprostenol sodium 0.5 mg vl	T4	PA SP HD
epoprostenol sodium 0.5 mg vl (Flolan)	T4	PA SP

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List of Prescription Medications

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

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
PULMONARY ANTIHYPERTENSIVES, PROSTACYCLIN-TYPE *(cont.)*		
epoprostenol sodium 1.5 mg vl (Flolan)	T4	PA SP
FLOLAN	T4	PA SP
ORENITRAM MONTH 1 TITRATION KT	T4	PA QL(168 tabs/180 days) SP HD
ORENITRAM MONTH 2 TITRATION KT	T4	PA QL(336 tabs/180 days) SP HD
ORENITRAM MONTH 3 TITRATION KT	T4	PA QL(252 tabs/180 days) SP HD
ORENITRAM ER	T4	PA SP HD
REMODULIN (*treprostinil*)	T4	PA SP HD
treprostinil sodium (Remodulin)	T4	PA SP HD
TYVASO DPI	T4	PA SP HD
TYVASO INSTITUTIONAL START KIT	T4	PA SP HD
TYVASO REFILL KIT	T4	PA SP HD
TYVASO STARTER KIT	T4	PA SP HD
UPTRAVI	T4	PA SP HD
VELETRI VIAL	T4	PA SP
VENTAVIS	T4	PA SP HD
YUTREPIA	T4	PA SP HD
PULMONARY HTN-ENDOTHELIN RECEPT ANTG-CGMP PDE5 INH		
OPSYNVI	T4	PA QL(1 tab/day) SP HD

CARDIOVASCULAR (Blood Pressure/Heart Medications)

ACE INHIBITOR-CALCIUM CHANNEL BLOCKER COMBINATION		
PRESTALIA 3.5 MG-2.5 MG TABLET	T3	QL (1 tab/day) HD
PRESTALIA 7 MG-5 MG TABLET	T3	QL (1 tab/day) HD
TARKA (*trandolapril-verapamil er*)	T3	HD
trandolapril/verapamil hcl	T1	HD
trandolapril/verapamil hcl (Tarka)	T1	HD
ACE INHIBITOR-THIAZIDE OR THIAZIDE-LIKE DIURETIC		
ACCURETIC (*quinapril-hydrochlorothiazide*)	T3	ST HD
benazepril/hydrochlorothiazide	T1	HD
benazepril/hydrochlorothiazide (Lotensin Hct)	T1	HD
captopril-hctz 25-15 mg tablet	T1	QL (3 tabs/day) HD
captopril-hctz 25-25 mg tablet	T1	QL (2 tabs/day) HD
captopril-hctz 50-15 mg tablet	T1	QL (3 tabs/day) HD
captopril-hctz 50-25 mg tablet	T1	QL (2 tabs/day) HD
enalapril/hydrochlorothiazide	T1	HD

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CARDIOVASCULAR (Blood Pressure/Heart Medications) *(cont.)*		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
ACE INHIBITOR-THIAZIDE OR THIAZIDE-LIKE DIURETIC *(cont.)*		
enalapril/hydrochlorothiazide (Vaseretic)	T1	HD
fosinopril/hydrochlorothiazide	T1	HD
lisinopril/hydrochlorothiazide (Zestoretic)	T1	HD
LOTENSIN HCT (*benazepril-hydrochlorothiazide*)	T3	ST HD
quinapril/hydrochlorothiazide (Accuretic)	T1	HD
VASERETIC (*enalapril-hydrochlorothiazide*)	T3	ST HD
ZESTORETIC (*lisinopril-hydrochlorothiazide*)	T3	ST HD
ALPHA/BETA-ADRENERGIC BLOCKING AGENTS		
carvedilol (Coreg)	T1	HD
carvedilol er 10 mg capsule (Coreg Cr)	T1	QL (1 cap/day) HD
carvedilol er 20 mg capsule (Coreg Cr)	T1	QL (1 cap/day) HD
carvedilol er 40 mg capsule (Coreg Cr)	T1	QL (1 cap/day) HD
carvedilol er 80 mg capsule (Coreg Cr)	T1	HD
COREG (*carvedilol*)	T3	ST HD
COREG CR 10 MG CAPSULE (*carvedilol er*)	T3	QL (1 cap/day) ST HD
COREG CR 20 MG CAPSULE (*carvedilol er*)	T3	QL (1 cap/day) ST HD
COREG CR 40 MG CAPSULE (*carvedilol er*)	T3	QL (1 cap/day) ST HD
COREG CR 80 MG CAPSULE (*carvedilol er*)	T3	ST HD
LABETALOL HCL 10 MG/2 ML SYRNG	T3	
labetalol hcl 100 mg tablet	T1	
labetalol hcl 100 mg/20 ml vl	T1	
labetalol hcl 20 mg/4 ml crpjt	T1	
labetalol hcl 20 mg/4 ml syrng	T1	
labetalol hcl 20 mg/4 ml vial	T1	
labetalol hcl 200 mg tablet	T1	HD
labetalol hcl 200 mg/40 ml vl	T1	HD
labetalol hcl 300 mg tablet	T1	HD
ALPHA-ADRENERGIC BLOCKING AGENTS		
CARDURA (*doxazosin mesylate*)	T3	HD
CARDURA XL	T3	HD
doxazosin mesylate (Cardura)	T1	HD
MINIPRESS (*prazosin hcl*)	T3	HD
prazosin hcl (Minipress)	T1	HD
terazosin hcl	T1	HD

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List of Prescription Medications

CARDIOVASCULAR (Blood Pressure/Heart Medications) *(cont.)*		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
ANGIOTEN.RECEPTR ANTAG-CALCIUM CHANL BLKR-THIAZIDE		
amlodipine/valsartan/hcthiazid (Exforge Hct)	T1	HD
EXFORGE HCT (*amlodipine-valsartan-hctz*)	T3	PA HD
olmesartan/amlodipin/hcthiazid (Tribenzor)	T1	HD
TRIBENZOR (*olmesartan-amlodipine-hctz*)	T3	HD
ANGIOTENSIN RECEPT-NEPRILYSIN INHIBITOR COMB (ARNI)		
ENTRESTO	T3	PA QL(2 tabs/day)
sacubitril/valsartan (Entresto)	T1	QL(2 tabs/day) HD
ANGIOTENSIN RECEPTOR ANTAG.-THIAZIDE DIURETIC COMB		
ATACAND HCT (*candesartan-hydrochlorothiazid*)	T3	ST HD
AVALIDE (*irbesartan-hydrochlorothiazide*)	T3	ST HD
ATACAND HCT (*candesartan-hydrochlorothiazid*)	T3	ST HD
AVALIDE (*irbesartan-hydrochlorothiazide*)	T3	ST HD
BENICAR HCT 20-12.5 MG TABLET (*olmesartan-hydrochlorothiazide*)	T3	QL (1 tab/day) ST HD
BENICAR HCT 40-12.5 MG TABLET (*olmesartan-hydrochlorothiazide*)	T3	ST HD
BENICAR HCT 40-25 MG TABLET (*olmesartan-hydrochlorothiazide*)	T3	ST HD
candesartan/hydrochlorothiazid (Atacand Hct)	T1	HD
DIOVAN HCT (*valsartan-hydrochlorothiazide*)	T3	ST HD
EDARBYCLOR	T3	ST HD
HYZAAR (*losartan-hydrochlorothiazide*)	T3	ST HD
irbesartan/hydrochlorothiazide (Avalide)	T1	HD
losartan/hydrochlorothiazide (Hyzaar)	T1	HD
MICARDIS HCT 40-12.5 MG TABLET (*telmisartan-hydrochlorothiazid*)	T3	QL (1 tab/day) ST HD
MICARDIS HCT 80-12.5 MG TABLET (*telmisartan-hydrochlorothiazid*)	T3	ST HD
MICARDIS HCT 80-25 MG TABLET (*telmisartan-hydrochlorothiazid*)	T3	ST HD
olmesartan-hctz 20-12.5 mg tab (Benicar Hct)	T1	QL (1 tab/day) HD
olmesartan-hctz 40-12.5 mg tab (Benicar Hct)	T1	HD
telmisartan-hctz 40-12.5 mg tb (Micardis Hct)	T1	QL (1 tab/day) HD
telmisartan-hctz 80-12.5 mg tb (Micardis Hct)	T1	HD
telmisartan-hctz 80-25 mg tab (Micardis Hct)	T1	HD
valsartan/hydrochlorothiazide (Diovan Hct)	T1	HD
ANGIOTENSIN RECEPTOR BLOCKR-CALCIUM CHANNEL BLOCKR		
amlodipine besylate/valsartan (Exforge)	T1	HD
amlodipine-olmesartan 10-20 mg (Azor)	T1	HD
amlodipine-olmesartan 10-40 mg (Azor)	T1	HD

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List of Prescription Medications

CARDIOVASCULAR (Blood Pressure/Heart Medications) *(cont.)*		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
ANGIOTENSIN RECEPTOR BLOCKR-CALCIUM CHANNEL BLOCKR *(cont.)*		
amlodipine-olmesartan 5-20 mg (Azor)	T1	QL (1 tab/day) HD
amlodipine-olmesartan 5-40 mg (Azor)	T1	HD
AZOR 10-20 MG TABLET (*amlodipine-olmesartan*)	T3	HD
AZOR 10-40 MG TABLET (*amlodipine-olmesartan*)	T3	HD
AZOR 5-20 MG TABLET (*amlodipine-olmesartan*)	T3	QL (1 tab/day) HD
AZOR 5-40 MG TABLET (*amlodipine-olmesartan*)	T3	HD
EXFORGE (*amlodipine-valsartan*)	T3	PA HD
telmisartan-amlodipine 40-10	T1	HD
telmisartan-amlodipine 40-5 mg	T1	QL (1 tab/day) HD
telmisartan-amlodipine 80-10	T1	HD
telmisartan-amlodipine 80-5 mg	T1	HD
ANTI-HYPERTENSIVES, ACE INHIBITORS		
ACCUPRIL (*quinapril hcl*)	T3	ST HD
benazepril hcl	T1	HD
benazepril hcl (Lotensin)	T1	HD
captopril	T1	HD
enalapril maleate (Vasotec)	T1	HD
enalaprilat dihydrate	T1	
EPANED	T3	PA HD
fosinopril sodium	T1	HD
lisinopril (Zestril)	T1	HD
LOTENSIN (*benazepril hcl*)	T3	ST HD
moexipril hcl	T1	HD
perindopril erbumine	T1	HD
PRINIVIL (*lisinopril*)	T3	ST HD
QBRELIS	T3	PA HD
quinapril hcl (Accupril)	T1	HD
ramipril (Altace)	T1	HD
trandolapril	T1	HD
VASOTEC (*enalapril maleate*)	T3	ST HD
ZESTRIL (*lisinopril*)	T3	PA HD
ANTI-HYPERTENSIVES, ANGIOTENSIN RECEPTOR ANTAGONIST		
ATACAND (*candesartan cilexetil*)	T3	ST HD
AVAPRO (*irbesartan*)	T3	PA HD

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Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
ANTI-HYPERTENSIVES, ANGIOTENSIN RECEPTOR ANTAGONIST *(cont.)*		
BENICAR 20 MG TABLET (*olmesartan medoxomil*)	T3	QL (1 tab/day) ST HD
BENICAR 40 MG TABLET (*olmesartan medoxomil*)	T3	ST HD
BENICAR 5 MG TABLET (*olmesartan medoxomil*)	T3	ST HD
candesartan cilexetil (Atacand)	T1	HD
COZAAR (*losartan potassium*)	T3	PA HD
DIOVAN (*valsartan*)	T3	ST HD
EDARBI 40 MG TABLET	T3	QL (1 tab/day) ST HD
EDARBI 80 MG TABLET	T3	ST HD
eprosartan mesylate	T1	HD
irbesartan (Avapro)	T1	HD
losartan potassium (Cozaar)	T1	HD
MICARDIS 20 MG TABLET (*telmisartan*)	T3	QL (1 tab/day) ST HD
MICARDIS 40 MG TABLET (*telmisartan*)	T3	QL (1 tab/day) ST HD
MICARDIS 80 MG TABLET (*telmisartan*)	T3	ST HD
olmesartan medoxomil 20 mg tab (Benicar)	T1	QL (1 tab/day) HD
olmesartan medoxomil 40 mg tab (Benicar)	T1	HD
olmesartan medoxomil 5 mg tab (Benicar)	T1	HD
telmisartan 20 mg tablet (Micardis)	T1	QL (1 tab/day) HD
telmisartan 40 mg tablet (Micardis)	T1	QL (1 tab/day) HD
telmisartan 80 mg tablet (Micardis)	T1	HD
valsartan (Diovan)	T1	HD
VALSARTAN 20 MG/5 ML SOLUTION	T3	ST HD
ANTIHYPERTENSIVES, GANGLIONIC BLOCKERS		
VECAMYL	T1	
ANTI-HYPERTENSIVES, MISCELLANEOUS		
DEMSER (*metyrosine*)	T3	HD
metyrosine (Demser)	T1	HD
nitroprusside sodium (Nitropress)	T1	
ANTI-HYPERTENSIVES, SYMPATHOLYTIC		
CATAPRES-TTS 1 (*clonidine*)	T3	HD
CATAPRES-TTS 2 (*clonidine*)	T3	HD
CATAPRES-TTS 3 (*clonidine*)	T3	HD

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Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
ANTI-HYPERTENSIVES, SYMPATHOLYTIC *(cont.)*		
clonidine (Catapres-tts 1)	T1	HD
clonidine (Catapres-tts 2)	T1	HD
clonidine (Catapres-tts 3)	T1	HD
clonidine hcl 0.1 mg tablet (Catapres)	T1	HD
clonidine hcl 0.2 mg tablet	T1	HD
clonidine hcl 0.3 mg tablet (Catapres)	T1	HD
guanfacine hcl	T1	HD
methyldopa	T1	HD
methyldopa/hydrochlorothiazide	T1	HD
methyldopate hcl	T1	
ANTI-HYPERTENSIVES, VASODILATORS		
CORLOPAM	T3	HD
hydralazine hcl	T1	HD
minoxidil	T1	HD
BETA-ADRENERGIC BLOCKING AGENTS		
acebutolol hcl	T1	HD
atenolol (Tenormin)	T1	HD
BETAPACE (*sotalol af*)	T3	PA HD
BETAPACE (*sotalol*)	T3	PA HD
BETAPACE AF (*sotalol af*)	T3	PA HD
betaxolol hcl	T1	HD
bisoprolol fumarate	T1	HD
BREVIBLOC	T3	HD
BYSTOLIC 10 MG TABLET	T3	PA QL (1 tab/day) HD
BYSTOLIC 2.5 MG TABLET	T3	PA QL (1 tab/day) HD
BYSTOLIC 20 MG TABLET	T3	PA HD
BYSTOLIC 5 MG TABLET	T2	QL (1 tab/day) ST HD
CORGARD (*nadolol*)	T3	PA HD
esmolol hcl	T1	
esmolol hcl (Brevibloc)	T1	
ESMOLOL HCL-WATER	T1	
esmolol in sodium chloride, iso (Brevibloc)	T1	HD
HEMANGEOL	T3	PA HD
INDERAL LA (*propranolol hcl er*)	T3	PA HD

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Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
BETA-ADRENERGIC BLOCKING AGENTS *(cont.)*		
INDERAL XL	T3	PA HD
INNOPRAN XL	T3	ST HD
KAPSPARGO SPRINKLE	T3	PA HD
LOPRESSOR (*metoprolol tartrate*)	T3	PA HD
metoprolol succinate (Toprol Xl)	T1	HD
metoprolol tartrate	T1	HD
metoprolol tartrate (Lopressor)	T1	HD
nadolol	T1	HD
pindolol	T1	HD
propranolol hcl	T1	HD
propranolol hcl (Inderal La)	T1	HD
SOTALOL HCL	T1	
sotalol hcl (Betapace Af)	T1	HD
sotalol hcl (Betapace)	T1	HD
SOTYLIZE	T3	HD
TENORMIN (*atenolol*)	T3	PA HD
timolol maleate	T1	HD
TOPROL XL (*metoprolol succinate*)	T3	PA HD
BETA-BLOCKERS AND THIAZIDE, THIAZIDE-LIKE DIURETICS		
atenolol/chlorthalidone (Tenoretic 100)	T1	HD
atenolol/chlorthalidone (Tenoretic 50)	T1	HD
bisoprolol/hydrochlorothiazide (Ziac)	T1	HD
DUTOPROL	T3	PA
metoprolol/hydrochlorothiazide	T1	HD
nadolol/bendroflumethiazide	T1	HD
propranolol/hydrochlorothiazid	T1	HD
TENORETIC 100 (*atenolol-chlorthalidone*)	T3	PA HD
TENORETIC 50 (*atenolol-chlorthalidone*)	T3	PA HD
ZIAC (*bisoprolol-hydrochlorothiazide*)	T3	PA HD
MUSCARINIC RECEPTOR ANTAGONISTS (ANTICHOLINERGIC)		
ATROPEN	T3	
PATENT DUCTUS ARTERIOSUS TREAT. AGENTS, NSAID-TYPE		
ibuprofen lysine/pf (Neoprofen)	T1	
indomethacin 1 mg vial	T1	

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Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
PATENT DUCTUS ARTERIOSUS TREAT. AGENTS, NSAID-TYPE *(cont.)*		
NEOPROFEN (*ibuprofen lysine*)	T3	
RENIN INHIBITOR, DIRECT		
aliskiren 150 mg tablet (Tekturna)	T1	QL (1 tab/day) HD
aliskiren 300 mg tablet (Tekturna)	T1	HD
TEKTURNA 150 MG TABLET (*aliskiren*)	T3	PA QL (1 tab/day) HD
TEKTURNA 300 MG TABLET (*aliskiren*)	T3	PA HD
RENIN INHIBITOR, DIRECT AND THIAZIDE DIURETIC COMB		
TEKTURNA HCT	T2	HD
VASODILATORS, COMBINATION		
BIDIL *(isosorbide dinit/hydralazine)*	T3	PA QL (6 tabs/day) HD
isosorbide-dinit hydralazine (Bidil)	T1	QL (6 tabs/day) HD
VASODILATORS, PERIPHERAL		
ergoloid mesylates	T1	
isoxsuprine hcl	T1	
papaverine hcl	T1	
CARDIOVASCULAR (Cholesterol Medications)		
ANTI-HYPERLIP.HMG COA REDUCT INHIB-CHOLEST.AB.INHIB		
ezetimibe/simvastatin (Vytorin)	T1	HD
ROSZET	T3	PA HD
VYTORIN (*ezetimibe-simvastatin*)	T3	ST HD
ANTI-HYPERLIPID- HMG-COA RI-CALCIUM CHANNEL BLOCKER		
amlodipine-atorvast 10-10 mg (Caduet)	T1	HD
amlodipine-atorvast 10-20 mg (Caduet)	T1	HD
amlodipine-atorvast 10-40 mg (Caduet)	T1	HD
amlodipine-atorvast 10-80 mg (Caduet)	T1	HD
amlodipine-atorvast 2.5-10 mg	T1	HD
amlodipine-atorvast 2.5-20 mg	T1	QL (1 tab/day) HD
amlodipine-atorvast 2.5-40 mg	T1	QL (1 tab/day) HD
amlodipine-atorvast 5-10 mg (Caduet)	T1	HD
amlodipine-atorvast 5-20 mg (Caduet)	T1	QL (1 tab/day) HD
amlodipine-atorvast 5-40 mg (Caduet)	T1	QL (1 tab/day) HD
amlodipine-atorvast 5-80 mg (Caduet)	T1	HD
CADUET 10 MG-10 MG TABLET (*amlodipine-atorvastatin*)	T3	HD
CADUET 10 MG-20 MG TABLET (*amlodipine-atorvastatin*)	T3	HD

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CARDIOVASCULAR (Cholesterol Medications) *(cont.)*		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
ANTI-HYPERLIPID- HMG-COA RI-CALCIUM CHANNEL BLOCKER *(cont.)*		
CADUET 10 MG-40 MG TABLET (*amlodipine-atorvastatin*)	T3	HD
CADUET 10 MG-80 MG TABLET (*amlodipine-atorvastatin*)	T3	HD
CADUET 5 MG-10 MG TABLET (*amlodipine-atorvastatin*)	T3	HD
CADUET 5 MG-20 MG TABLET (*amlodipine-atorvastatin*)	T3	QL (1 tab/day) HD
CADUET 5 MG-40 MG TABLET (*amlodipine-atorvastatin*)	T3	QL (1 tab/day) HD
CADUET 5 MG-80 MG TABLET (*amlodipine-atorvastatin*)	T3	HD
ANTIHYPERLIPIDEMIC - ANGIOPOIETIN-LIKE 3 INHIBITOR		
EVKEEZA	T4	PA SP
ANTI-HYPERLIPIDEMIC - APO B-100 SYNTHESIS INHIBITOR		
KYNAMRO	T4	PA SP
ANTI-HYPERLIPIDEMIC - APOLIPOPROTEIN INHIBITOR		
TRYNGOLZA	T3	PA QL SP
ANTI-HYPERLIPIDEMIC - ATP CITRATE LYASE INHIBITOR		
NEXLETOL	T2	PA QL (1 tab/day)
ANTI-HYPERLIPIDEMIC - MTP INHIBITOR		
JUXTAPID	T4	PA SP HD
ANTI-HYPERLIPIDEMIC - PCSK9 INHIBITORS		
PRALUENT PEN	T3	PA
REPATHA PUSHTRONEX	T2	
REPATHA SURECLICK	T2	
REPATHA SYRINGE	T2	
ANTI-HYPERLIPIDEMIC-ACLY AND CHOLES ABSORP INHIB		
NEXLIZET	T2	PA QL (1 syringe/day)
ANTI-HYPERLIPIDEMIC-HMGCOA REDUCTASE INHIB (Statins)		
ALTOPREV 20 MG TABLET	T3	QL (1 tab/day) ST HD
ALTOPREV 40 MG TABLET	T3	ST HD
ALTOPREV 60 MG TABLET	T3	ST HD
atorvastatin 10 mg tablet (Lipitor)	T1	HD PPACA
atorvastatin 20 mg tablet (Lipitor)	T1	HD PPACA
atorvastatin 40 mg tablet (Lipitor)	T1	HD
atorvastatin 80 mg tablet (Lipitor)	T1	HD
CRESTOR 10 MG TABLET (*rosuvastatin calcium*)	T3	QL (1 tab/day) ST HD
CRESTOR 20 MG TABLET (*rosuvastatin calcium*)	T3	QL (1 tab/day) ST HD
CRESTOR 40 MG TABLET (*rosuvastatin calcium*)	T3	ST HD

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Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
ANTI-HYPERLIPIDEMIC-HMGCOA REDUCTASE INHIB (Statins) *(cont.)*		
CRESTOR 5 MG TABLET (*rosuvastatin calcium*)	T3	QL (1 tab/day) ST HD
EZALLOR SPRINKLE 10 MG CAPSULE	T3	QL (1 tab/day) ST HD
EZALLOR SPRINKLE 20 MG CAPSULE	T3	QL (1 tab/day) ST HD
EZALLOR SPRINKLE 40 MG CAPSULE	T3	ST HD
EZALLOR SPRINKLE 5 MG CAPSULE	T3	QL (1 tab/day) ST HD
FLOLIPID	T3	ST HD
fluvastatin sodium	T1	HD PPACA
fluvastatin sodium (Lescol XI)	T1	HD PPACA
LESCOL XL (*fluvastatin er*)	T3	PA HD
LIPITOR (*atorvastatin calcium*)	T3	PA HD
LIVALO 1 MG TABLET	T2	QL (1 tab/day) ST HD
LIVALO 2 MG TABLET	T2	QL (1 tab/day) ST HD
LIVALO 4 MG TABLET	T2	PA HD
lovastatin 10 mg tablet	T1	HD
lovastatin 20 mg tablet	T1	HD PPACA
lovastatin 40 mg tablet	T1	HD PPACA
pitavastatin tablet	T1	QL (1 tab/day) HD PPACA
PRAVACHOL (*pravastatin sodium*)	T3	PA HD
pravastatin sodium	T1	HD PPACA
pravastatin sodium (Pravachol)	T1	HD PPACA
rosuvastatin calcium 10 mg tab (Crestor)	T1	QL (1 tab/day) HD PPACA
rosuvastatin calcium 20 mg tab (Crestor)	T1	QL (1 tab/day) HD
rosuvastatin calcium 40 mg tab (Crestor)	T1	HD
rosuvastatin calcium 5 mg tab (Crestor)	T1	QL (1 tab/day) HD PPACA
simvastatin 10 mg tablet (Zocor)	T1	HD PPACA
simvastatin 20 mg tablet (Zocor)	T1	HD PPACA
SIMVASTATIN 20 MG/5 ML SUSP	T3	ST HD
simvastatin 40 mg tablet (Zocor)	T1	HD PPACA
simvastatin 5 mg tablet	T1	HD
ZOCOR	T3	PA HD
ZYPITAMAG	T3	ST HD
BILE SALT SEQUESTRANTS		
cholestyramine (with sugar) (Questran)	T1	HD
cholestyramine/aspartame	T1	HD

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Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
BILE SALT SEQUESTRANTS *(con't.)*		
COLESTID	T3	HD
COLESTID (*colestipol hcl*)	T3	HD
colestipol hcl (Colestid)	T1	HD
QUESTRAN (*cholestyramine*)	T3	HD
QUESTRAN LIGHT (*prevalite*)	T3	HD
WELCHOL (*colesevelam hcl*)	T3	PA HD
LIPOTROPICS		
ANTARA	T3	PA HD
ezetimibe (Zetia)	T1	HD
fenofibrate 120 mg tablet (Fenoglide)	T1	HD
fenofibrate 130 mg capsule	T1	HD
fenofibrate 134 mg capsule	T1	HD
fenofibrate 145 mg tablet (Tricor)	T1	HD
FENOFIBRATE 150 MG CAPSULE	T1	HD
fenofibrate 160 mg tablet	T1	HD
FENOFIBRATE 160 MG TABLET	T3	PA HD
fenofibrate 200 mg capsule	T1	HD
fenofibrate 40 mg tablet (Fenoglide)	T1	HD
fenofibrate 43 mg capsule	T1	HD
fenofibrate 48 mg tablet (Tricor)	T1	HD
FENOFIBRATE 50 MG CAPSULE	T1	HD
fenofibrate 54 mg tablet	T1	HD
fenofibrate 67 mg capsule	T1	HD
fenofibric acid (choline) (Trilipix)	T1	HD
fenofibric acid (Fibricor)	T1	HD
FENOGLIDE (*fenofibrate*)	T3	PA HD
FIBRICOR (*fenofibric acid*)	T3	ST HD
gemfibrozil (Lopid)	T1	HD
LIPOFEN	T3	ST HD
LOPID (*gemfibrozil*)	T3	HD
niacin (Niacor)	T1	HD
niacin (Niaspan)	T1	HD
NIACOR	T1	HD
NIASPAN (*niacin er*)	T3	HD

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LIPOTROPICS *(con't.)*		
TRICOR (*fenofibrate*)	T3	ST HD
TRIGLIDE	T3	ST HD
TRILIPIX (*fenofibric acid*)	T3	ST HD
ZETIA (*ezetimibe*)	T3	HD
ENDOTHELIN-ANGIOTENSIN RECEPTOR ANTAGONIST		
FILSPARI	T4	PA QL(1 tab/day) SP HD
CARDIOVASCULAR (Miscellaneous)		
VENOSCLEROSING AGENTS		
ASCLERA	T4	PA SP
ETHAMOLIN	T3	
sodium tetradecyl sulfate (Sotradecol)	T1	
SOTRADECOL (*sodium tetradecyl sulfate*)	T3	
CNS DRUGS (Alzheimer's Disease)		
ALZHEIMER'S THERAPY, NMDA RECEPTOR ANTAGONISTS		
memantine hcl	T1	HD
memantine hcl er 7 mg capsule (Namenda Xr)	T1	QL (1 cap/day) HD
memantine hcl er 14 mg capsule (Namenda Xr)	T1	QL (1 cap/day) HD
memantine hcl er 21 mg, 28 mg capsule (Namenda Xr)	T1	HD
NAMENDA 5 MG TABLET (*memantine hcl*)	T3	HD
NAMENDA 10 MG TABLET (*memantine hcl*)	T3	HD
NAMENDA 5-10 MG TITRATION PK	T2	HD
NAMENDA XR 7 MG CAPSULE (*memantine hcl er*)	T3	QL (1 cap/day) HD
NAMENDA XR 14 MG CAPSULE (*memantine hcl er*)	T3	QL (1 cap/day) HD
NAMENDA XR 21 MG CAPSULE (*memantine hcl er*)	T3	HD
NAMENDA XR 28 MG CAPSULE (*memantine hcl er*)	T3	HD
NAMENDA XR TITRATION PACK	T3	QL (112/365 days) HD
ALZHEIMER'S THX, NMDA RECEPTOR ANTAG-CHOLINES INHIB		
NAMZARIC 14 MG-10 MG CAPSULE	T3	QL (2 caps/day) HD
NAMZARIC 21 MG-10 MG CAPSULE	T3	QL (2 caps/day) HD
NAMZARIC 28 MG-10 MG CAPSULE	T3	QL (2 caps/day) HD
NAMZARIC 7 MG-10 MG CAPSULE	T3	QL (2 caps/day) HD
NAMZARIC TITRATION PACK	T3	QL (112/365 days) HD
AMYLOID DIRECTED MONOCLONAL ANTIBODY		
LEQEMBI IQLIK 360 MG/1.8 ML	T3	PA SP

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CNS DRUGS (Miscellaneous)		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
AMYLOID DIRECTED MONOCLONAL ANTIBODY		
KISUNLA	T4	PA SP
ALCOHOL, SYSTEMIC USE		
ALCOHOL, DEHYDRATED	T1	
AMYLOID DIRECTED MONOCLONAL ANTIBODY		
ADUHELM	T4	PA SP
AMYOTROPHIC LATERAL SCLEROSIS AGENTS		
edaravone	T4	PA SP
RADICAVA	T4	PA SP
RADICAVA ORS	T4	PA QL (50ml/28 days) SP
RELYVRIO	T4	PA QL(2 packs/day) SP
RILUTEK (*riluzole*)	T4	PA SP HD
riluzole (Rilutek)	T4	SP HD
TIGLUTIK	T4	PA SP
QALSODY	T3	
CENTRAL NERVOUS SYSTEM STIMULANTS		
DOPRAM	T3	
doxapram hcl (Dopram)	T1	
DRUGS TO TREAT MOVEMENT DISORDERS		
AUSTEDO XR TABLET	T4	PA QL SP HD
AUSTEDO XR 6 MG TABLET	T4	PA QL (90 tabs/30 days) SP HD
AUSTEDO XR 12 MG TABLET	T4	PA QL (30 tabs/30 days) SP HD
AUSTEDO XR 18 MG TABLET	T4	PA QL(1 tab/day) SP HD
AUSTEDO XR 24 MG TABLET	T4	PA QL (60 tabs/30 days) SP HD
AUSTEDO XR TITRATION KT (WK1-4)	T4	PA QL(1 kit/180 days) SP HD
HORIZANT	T3	PA
INGREZZA	T4	PA QL(1 caps/day) SP
INGREZZA INITIATION PK(TARDIV)	T4	PA QL(28 caps/365 days) SP
INGREZZA SPRINKLE	T4	PA QL SP
tetrabenazine (Xenazine)	T4	PA SP HD
XENAZINE (*tetrabenazine*)	T4	PA SP HD
PSEUDOBULBAR AFFECT (PBA) AGENTS, NMDA ANTAGONISTS		
NUEDEXTA	T3	QL (4 caps/day)
XANTHINES		
CAFCIT (*caffeine citrate*)	T3	HD

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List of Prescription Medications

CNS DRUGS (Miscellaneous) *(cont.)*		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
XANTHINES *(cont.)*		
CAFFEINE AND SODIUM BENZOATE	T1	HD
caffeine citrate (Cafcit)	T1	HD
caffeine/sodium benzoate (Caffeine And Sodium Benzoate)	T1	HD
CNS DRUGS (Multiple Sclerosis)		
AGENTS TO TREAT MULTIPLE SCLEROSIS		
AUBAGIO (*teriflunomide*)	T4	PA SP HD
AVONEX	T4	PA SP HD
AVONEX PEN	T4	PA SP HD
BAFIERTAM	T4	PA SP HD
BETASERON	T4	PA SP HD
BRIUMVI	T4	PA SP
COPAXONE (*glatopa*)	T4	PA SP HD
dimethyl fumarate (Tecfidera)	T3	HD
GILENYA 0.25 MG CAPSULE	T4	PA QL(1 cap/day) SP
GILENYA 0.5 MG CAPSULE (*fingolimod hcl*)	T4	PA SP HD
glatiramer	T1	HD
glatopa	T1	HD
glatiramer acetate (Copaxone)	T4	PA SP HD
KESIMPTA PEN	T4	PA SP HD
LEMTRADA	T4	PA SP HD
MAVENCLAD	T4	PA SP HD
MAYZENT	T4	PA SP HD
OCREVUS	T4	PA SP HD
PLEGRIDY	T4	PA SP HD
PLEGRIDY PEN	T4	PA SP HD
PONVORY	T4	PA SP HD
REBIF	T4	PA SP HD
REBIF REBIDOSE	T4	PA SP HD
TASCENSO ODT	T4	PA QL(1 tab/day) SP HD
TECFIDERA (*dimethyl fumarate*)	T4	PA SP HD

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List of Prescription Medications

CNS DRUGS (Multiple Sclerosis) *(cont.)*		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
AGENTS TO TREAT MULTIPLE SCLEROSIS (con't.)		
teriflunomide (Aubagio)	T4	SP HD
VELSIPITY	T4	PA QL(30 tabs/30 days) SP HD
VUMERITY	T4	PA SP HD
ZEPOSIA	T4	PA SP HD
AGTS TX NEUROMUSC TRANSMISSION DIS, POT-CHAN BLKR		
AMPYRA (*dalfampridine er*)	T4	PA SP HD
dalfampridine (Ampyra)	T4	PA SP HD
FIRDAPSE	T4	PA QL (8 tabs/day) SP
RUZURGI	T4	PA SP
CNS DRUGS (Pain Relief And Inflammatory Disease)		
CALCITONIN GENE-RELATED PEPTIDE (CGRP) INHIBITORS		
EMGALITY SYRINGE	T2	PA
GLYPROMATE (GPE) ANALOGS		
DAYBUE	T4	PA QL (120 ml/day) SP
POSTHERPETIC NEURALGIA AGENTS		
GRALISE *(gabapentin)*	T3	PA
SPHINGOSINE 1-PHOSPHATE (SIP) RECEPTOR MODULATOR		
ZEPOSIA	T2	PA SP HD
CNS DRUGS (Seizure Disorders)		
ANTI-CONVULSANT - BENZODIAZEPINE TYPE		
clobazam (Onfi)	T1	HD
clonazepam (Klonopin)	T1	HD
diazepam 10 mg rectal gel syst	T1	HD
diazepam 2.5 mg rectal gel sys (Diastat)	T1	HD
diazepam 20 mg rectal gel syst (Diastat Acudial)	T1	HD
diazepam 20 mg rectal gel syst (Diastat Acudial)	T1	HD
KLONOPIN (*clonazepam*)	T3	PA HD
LIBERVANT	T3	PA QL(10 films/30 days) HD
NAYZILAM	T2	PA QL (5 kits/30 days) HD
ONFI (*clobazam*)	T3	PA HD
SYMPAZAN	T3	PA HD
VALTOCO	T2	PA QL (5 boxes/30 days) HD

List of Prescription Medications

CNS DRUGS (Seizure Disorders) *(cont.)*		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
ANTI-CONVULSANT - CANNABINOID TYPE		
EPIDIOLEX	T4	PA SP HD
ANTI-CONVULSANTS		
APTIOM 200 MG TABLET	T3	PA QL (1 tab/day) HD
APTIOM 400 MG TABLET	T3	PA QL (1 tab/day) HD
APTIOM 600 MG TABLET	T3	PA HD
APTIOM 800 MG TABLET	T3	PA HD
BANZEL 200 MG TABLET	T3	PA QL (16 tabs/day) HD
BANZEL 40 MG/ML SUSPENSION (*rufinamide*)	T3	PA QL (80ml/day) HD
BANZEL 400 MG TABLET	T3	PA QL (8 tabs/day) HD
BRIVIACT 10 MG TABLET	T3	PA HD
BRIVIACT 10 MG/ML ORAL SOLN	T3	PA HD
BRIVIACT 100 MG TABLET	T3	PA HD
BRIVIACT 25 MG TABLET	T3	PA HD
BRIVIACT 50 MG TABLET	T3	PA HD
BRIVIACT 50 MG/5 ML VIAL	T3	HD
BRIVIACT 75 MG TABLET	T3	PA HD
carbamazepine	T1	HD
carbamazepine (Carbatrol)	T1	HD
carbamazepine (Tegretol Xr)	T1	HD
carbamazepine (Tegretol)	T1	HD
CARBATROL (*carbamazepine er*)	T3	PA HD
CELONTIN	T2	HD
CEREBYX (*fosphenytoin sodium*)	T3	
DEPAKOTE (*divalproex sodium*)	T3	PA HD
DEPAKOTE ER (*divalproex sodium er*)	T3	PA HD
DEPAKOTE SPRINKLE (*divalproex sodium*)	T3	PA HD
DIACOMIT	T4	PA SP HD
DILANTIN	T3	PA HD
DILANTIN (*phenytoin sodium extended*)	T3	PA HD
DILANTIN (*phenytoin*)	T3	PA HD
DILANTIN-125 (*phenytoin*)	T3	PA HD
divalproex sodium (Depakote Er)	T1	HD
divalproex sodium (Depakote Sprinkle)	T1	HD
divalproex sodium (Depakote)	T1	HD

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CNS DRUGS (Seizure Disorders) *(cont.)*		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
ANTI-CONVULSANTS *(cont.)*		
ELEPSIA XR	T3	PA
EPRONTIA	T3	PA
ethosuximide (Zarontin)	T1	HD
felbamate (Felbatol)	T1	HD
FELBATOL (*felbamate*)	T3	PA HD
FINTEPLA	T4	PA SP HD
fosphenytoin sodium (Cerebyx)	T1	
FYCOMPA 0.5 MG/ML ORAL SUSP	T2	PA HD
FYCOMPA 2 MG TABLET	T3	PA HD
FYCOMPA 4 MG TABLET	T3	PA QL (1 tab/day) HD
FYCOMPA 6 MG TABLET	T3	PA QL (1 tab/day) HD
FYCOMPA 8 MG TABLET	T3	PA HD
FYCOMPA 10 MG TABLET	T3	PA HD
FYCOMPA 12 MG TABLET	T3	PA HD
GABARONE	T3	PA HD
gabapentin (Neurontin)	T1	HD
KEPPRA 1,000 MG TABLET (*roweepra*)	T3	PA HD
KEPPRA 100 MG/ML ORAL SOLN (*levetiracetam*)	T3	PA HD
KEPPRA 250 MG TABLET (*levetiracetam*)	T3	PA HD
KEPPRA 500 MG TABLET (*roweepra*)	T3	PA HD
KEPPRA 500 MG/5 ML VIAL (*levetiracetam*)	T3	
KEPPRA 750 MG TABLET (*roweepra*)	T3	PA HD
KEPPRA XR (*levetiracetam er*)	T3	PA HD
LAMICTAL (BLUE) (*subvenite (blue)*)	T3	PA HD
LAMICTAL (GREEN) (*subvenite (green)*)	T3	PA HD
LAMICTAL (*lamotrigine*)	T3	PA HD
LAMICTAL (ORANGE) (*subvenite (orange)*)	T3	PA HD
LAMICTAL (*subvenite*)	T3	PA HD
LAMICTAL ODT (BLUE) (*lamotrigine odt (blue)*)	T3	PA HD
LAMICTAL ODT (GREEN) (*lamotrigine odt (green)*)	T3	PA HD
LAMICTAL ODT (*lamotrigine odt*)	T3	PA HD
LAMICTAL ODT (ORANGE) (*lamotrigine odt (orange)*)	T3	PA HD
LAMICTAL XR (BLUE)	T3	PA HD
LAMICTAL XR (GREEN)	T3	PA HD

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Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
ANTI-CONVULSANTS *(cont.)*		
LAMICTAL XR (*lamotrigine er*)	T3	PA HD
LAMICTAL XR (ORANGE)	T3	PA HD
lamotrigine (Lamictal (blue))	T1	HD
lamotrigine (Lamictal (green))	T1	HD
lamotrigine (Lamictal (orange))	T1	HD
lamotrigine (Lamictal Odt (blue))	T1	HD
lamotrigine (Lamictal Odt (green))	T1	HD
lamotrigine (Lamictal Odt (orange))	T1	HD
lamotrigine (Lamictal Odt)	T1	HD
lamotrigine (Lamictal Xr)	T1	HD
lamotrigine (Lamictal)	T1	HD
levetiracetam	T1	HD
levetiracetam (Keppra Xr)	T1	HD
levetiracetam (Keppra)	T1	HD
levetiracetam in nacl (iso-os)	T1	
LYRICA (*pregabalin*)	T3	PA HD
MOTPOLY XR 100 MG CAPSULE	T3	PA QL(1 cap/day) HD
MOTPOLY XR 150 MG CAPSULE	T3	PA QL(2 caps/day) HD
MOTPOLY XR 200 MG CAPSULE	T3	PA QL(2 caps/day) HD
MYSOLINE (*primidone*)	T3	PA HD
NEURONTIN (*gabapentin*)	T3	PA HD
oxcarbazepine	T1	PA HD
OXTELLAR XR	T3	PA HD
PEGANONE	T2	HD
PHENYTEK (*phenytoin sodium extended*)	T3	PA HD
phenytoin	T1	HD
phenytoin (Dilantin)	T1	HD
phenytoin (Dilantin-125)	T1	HD
phenytoin sodium	T1	HD
phenytoin sodium extended (Dilantin)	T1	HD
pregabalin (Lyrica)	T1	HD
PRIMIDONE 125 MG TABLET	T3	PA HD
primidone 250 mg tablet (Mysoline)	T1	HD

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CNS DRUGS (Seizure Disorders) *(cont.)*		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
ANTI-CONVULSANTS *(cont.)*		
primidone 50 mg tablet (Mysoline)	T1	HD
QUDEXY XR (*topiramate er*)	T3	PA HD
rufinamide (Banzel)	T1	PA QL (8 tabs/day) HD
SABRIL (*vigabatrin*)	T4	PA SP HD
SABRIL (*vigadrone*)	T4	PA SP HD
SPRITAM	T3	PA HD
TEGRETOL (*carbamazepine*)	T3	PA HD
TEGRETOL (*epitol*)	T3	PA HD
TEGRETOL XR (*carbamazepine er*)	T3	PA HD
tiagabine hcl 12 mg tablet (Gabitril)	T1	QL (8 tabs/day) HD
tiagabine hcl 16 mg tablet (Gabitril)	T1	QL (6 tabs/day) HD
tiagabine hcl 2 mg tablet (Gabitril)	T1	HD
tiagabine hcl 4 mg tablet (Gabitril)	T1	HD
TOPAMAX (*topiramate*)	T3	PA HD
topiramate (Qudexy Xr)	T1	HD
topiramate (Topamax)	T1	HD
TOPIRAMATE 50 MG SPRINKLE CAP	T3	PA HD
topiramate er 50 mg capsule (Trokendi Xr)	T1	HD
topiramate er 25 mg capsule (Trokendi Xr)	T1	QL(1 cap/day) HD
topiramate er 100 mg capsule (Trokendi Xr)	T1	QL(1 cap/day) HD
topiramate er 200 mg capsule (Trokendi Xr)	T1	HD
TROKENDI XR 25 MG, 100 MG CAPSULE *(topiramate)*	T3	QL(1 cap/day) HD
TROKENDI XR 50 MG, 200 MG CAPSULE *(topiramate)*	T3	HD
TRILEPTAL (*oxcarbazepine*)	T3	PA HD
TROKENDI XR 50 MG CAPSULE (*topiramate*)	T3	PA HD
TROKENDI XR 25 MG CAPSULE (*topiramate*)	T3	PA QL(1 cap/day) HD
TROKENDI XR 100 MG CAPSULE (*topiramate*)	T3	PA QL(1 cap/day) HD
TROKENDI XR 200 MG CAPSULE (*topiramate*)	T3	PA HD
valproic acid	T1	HD
valproic acid (as sodium salt)	T1	HD
vigabatrin (Sabril)	T4	SP HD
VIMPAT 10 MG/ML SOLUTION	T2	PA HD
VIMPAT 100 MG TABLET	T2	PA HD
VIMPAT 150 MG TABLET	T2	PA HD

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CNS DRUGS (Seizure Disorders) *(cont.)*		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
ANTI-CONVULSANTS *(cont.)*		
VIMPAT 50 MG TABLET	T2	PA HD
XCOPRI 250 MG DAILY DOSE PACK	T3	PA QL (1 pack/28 day) HD
XCOPRI 350 MG DAILY DOSE PACK	T3	PA QL (1 pack/28 day) HD
XCOPRI 25 MG TABLET	T3	PA HD
XCOPRI 50 MG TABLET	T3	PA QL (1 tab/day) HD
XCOPRI 100 MG TABLET	T3	PA QL (1 tab/day) HD
XCOPRI 150 MG TABLET	T3	PA QL (1 tab/day) HD
XCOPRI 200 MG TABLET	T3	PA QL (2 tabs/day) HD
XCOPRI 12.5-25 MG TITRATION PK	T3	PA QL (1 pack/28 day) HD
XCOPRI 150-200 MG TITRATION PK	T3	PA QL (1 pack/28 Days) HD
XCOPRI 50-100 MG TITRATION PAK	T3	PA QL (1 pack/28 day) HD
ZARONTIN (*ethosuximide*)	T3	PA HD
ZONEGRAN (*zonisamide*)	T3	PA HD
ZONISADE	T3	PA QL (6 mls/30 days)
zonisamide (Zonegran)	T1	HD
COLONY STIMULATING FACTORS (Blood Modifiers/Bleeding Disorders)		
ERYTHROPOIESIS-STIMULATING AGENTS		
ARANESP	T4	PA SP
EPOGEN	T4	PA SP
MIRCERA	T4	PA SP
PROCRIT	T4	PA SP
RETACRIT	T4	PA SP
LEUKOCYTE (WBC) STIMULANTS		
FULPHILA	T4	PA SP
GRANIX	T4	PA SP
LEUKINE	T4	SP
NEULASTA	T4	PA SP
NEULASTA ONPRO	T4	PA SP HD
NEUPOGEN	T4	PA SP
NIVESTYM	T4	SP
NYPOZI	T3	PA SP
NYVEPRIA	T4	PA SP
ROLVEDON	T4	PA SP
RYZNEUTA	T3	PA SP

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COLONY STIMULATING FACTORS (Blood Modifiers/Bleeding Disorders) *(cont.)*		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
LEUKOCYTE (WBC) STIMULANTS *(cont.)*		
STIMUFEND	T4	PA SP
UDENYCA	T4	PA SP
ZARXIO	T4	SP HD
ZIEXTENZO	T4	PA SP
THROMBOPOIETIN RECEPTOR AGONISTS		
ALVAIZ 18 MG, 54 MG TABLET	T4	PA QL(1 tab/day) SP
ALVAIZ 36 MG, 54 MG TABLET	T4	PA QL(2 tabs/day) SP
DOPTELET	T4	PA SP HD
MULPLETA	T4	PA SP HD
NPLATE	T4	PA SP
PROMACTA	T4	PA SP HD
COLONY STIMULATING FACTORS (Cancer)		
CXCR4 CHEMOKINE RECEPTOR ANTAGONIST		
APHEXDA	T4	PA SP
MOZOBIL	T4	PA SP
XOLREMDI	T4	PA QL(4 caps/day) SP CSL
CONTRACEPTIVES (Contraception Products)		
CONTRACEPTIVES, INTRAVAGINAL, SYSTEMIC		
ANNOVERA	T3	
etonogestrel/ethinyl estradiol (Nuvaring)	T1	PPACA
NUVARING (*etonogestrel-ethinyl estradiol*)	T3	
CONTRACEPTIVES, IMPLANTABLE		
NEXPLANON	T3	SP PPACA
CONTRACEPTIVES, INJECTABLE		
DEPO-PROVERA 150 MG/ML SYRINGE (*medroxyprogesterone acetate*)	T3	
DEPO-PROVERA 150 MG/ML VIAL (*medroxyprogesterone acetate*)	T3	
DEPO-SUBQ PROVERA 104	T3	
medroxyprogesterone 150 mg/ml (Depo-provera)	T1	PPACA
CONTRACEPTIVES, INTRAVAGINAL		
PHEXXI	T3	PA PPACA
CONTRACEPTIVES, ORAL		
BALCOLTRA *(levonorgest/eth.estradiol/iron)*	T3	HD
BEYAZ (*rajani*)	T3	HD
desog-e.estradiol/e.estradiol (Mircette)	T1	HD PPACA

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List of Prescription Medications

CONTRACEPTIVES (Contraception Products) *(cont.)*		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
CONTRACEPTIVES, ORAL *(cont.)*		
desogestrel-ethinyl estradiol	T1	HD PPACA
drospir/eth estra/levomefol ca	T1	HD PPACA
ELLA	T3	HD PPACA
ESTROSTEP FE (*tri-legest fe*)	T3	HD
ethinyl estradiol/drospirenone (Yasmin 28)	T1	HD PPACA
ethinyl estradiol/drospirenone (Yaz)	T1	HD PPACA
ethynodiol d-ethinyl estradiol	T1	HD PPACA
levonorgestrel/ethin.estradiol	T1	HD PPACA
levonorgest/eth.estradiol/iron (Balcoltra)	T1	HD PPACA
l-norgest/e.estradiol-e.estrad	T1	HD PPACA
l-norgest/e.estradiol-e.estrad (Quartette)	T1	HD PPACA
LO LOESTRIN FE	T3	PA HD
LOESTRIN (*norethindron-ethinyl estradiol*)	T3	HD
LOESTRIN FE (*norethindrone-eth estradiol-fe*)	T3	HD
MICROGESTIN 24 FE (*tarina 24 fe*)	T3	HD
MIRCETTE (*volnea*)	T3	HD
NATAZIA	T3	HD
NEXTSTELLIS	T3	HD
noreth-ethinyl estradiol/iron	T1	HD PPACA
norethind-eth estrad 1-0.02 mg (Loestrin)	T1	HD PPACA
norethindrone (Ortho Micronor)	T1	HD PPACA
norethindrone ac-eth estradiol (Loestrin)	T1	HD PPACA
norethindrone-e.estradiol-iron (Estrostep Fe)	T1	HD PPACA
norethindrone-e.estradiol-iron (Loestrin Fe)	T1	HD PPACA
norethindrone-e.estradiol-iron (Microgestin 24 Fe)	T1	HD PPACA
norethindrone-e.estradiol-iron (Taytulla)	T1	HD PPACA
norethindrone-ethin. estradiol	T1	HD PPACA
norethin-ee 1.5-0.03 mg (21) tb (Loestrin)	T1	HD PPACA
norgestimate-ethinyl estradiol	T1	HD PPACA
norgestrel-ethinyl estradiol	T1	HD PPACA
ORTHO MICRONOR (*tulana*)	T3	HD
QUARTETTE (*rivelsa*)	T3	HD
SAFYRAL (*tydemy*)	T3	HD
SLYND	T3	HD

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CONTRACEPTIVES (Contraception Products) *(cont.)*		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
CONTRACEPTIVES, ORAL *(cont.)*		
TAYTULLA (*norethin-eth estra-ferrous fum*)	T3	HD
TYBLUME	T3	HD
YASMIN 28 (*zumandimine*)	T3	HD
YAZ (*vestura*)	T3	HD
CONTRACEPTIVES, TRANSDERMAL		
norelgestromin/ethin.estradiol	T1	HD PPACA
TWIRLA	T3	HD PPACA
DIAPHRAGMS/CERVICAL CAP		
CAYA CONTOURED	T3	PPACA
FEMCAP	T3	PPACA
WIDE SEAL DIAPHRAGM	T3	PPACA
INTRA-UTERINE DEVICES (IUDS)		
KYLEENA	T4	SP PPACA
LILETTA	T4	SP PPACA
MIRENA	T4	SP PPACA
PARAGARD T 380-A	T4	SP PPACA
SKYLA	T4	SP PPACA
COUGH/COLD PREPARATIONS (Allergy/Nasal Sprays)		
ANTI-TUSSIVES, NON-OPIOID		
benzonatate 100 mg capsule (Tessalon Perle)	T1	
benzonatate 150 mg capsule	T1	PA
benzonatate 200 mg capsule	T1	
benzonatate perle 100 mg cap (Tessalon Perle)	T1	
TESSALON PERLE (*benzonatate*)	T3	
NON-OPIOID ANTI-TUS-IST GEN.ANTIHISTAMINE-DECONGEST		
BROMFED DM (*brompheniramine-pseudoephed-dm*)	T3	PA
brompheniramine/pseudoephed/dm (Bromfed Dm)	T1	
NON-OPIOID ANTI-TUSSIVE-IST GEN ANTIHISTAMINE COMB.		
promethazine/dextromethorphan	T1	
OPIOID ANTI-TUSSIV-IST GEN. ANTIHISTAMINE-DECONGEST		
hydrocodone/cpm/pseudoephed	T1	PA
promethazine/phenyleph/codeine	T1	PA QL (480ml/22 days)
hydrocodone/chlorphen p-stirex	T1	PA
promethazine-codeine	T1	PA QL (480ml/22 days)

T1 – Typically Generics
T2 – Typically Preferred Brands
T3 – Typically Non-Preferred Brands
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List of Prescription Medications

COUGH/COLD PREPARATIONS (Allergy/Nasal Sprays) *(cont.)*		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
OPIOID ANTI-TUSSIVE-IST GENERATION ANTIHISTAMINE		
TUSSICAPS	T2	PA
TUXARIN ER	T3	PA QL (2 tabs/day)
TUZISTRA XR	T3	PA QL (960ml/30 days)
OPIOID ANTI-TUSSIVE-ANTI-CHOLINERGIC COMBINATIONS		
HYCODAN (*hydromet*)	T3	PA QL (480ml/22 days)
hydrocodone bit/homatrop me-br (Hycodan)	T1	PA QL (480ml/22 days)
hydrocodone-homatropine 5-1.5	T1	PA QL (180 tabs/30 days)
hydrocodone-homatropine soln (Hycodan)	T1	PA QL (480ml/30 days)
HYDROCODONE-HOMATROPINE SYRUP	T1	PA QL (480ml/30 days)
OPIOID ANTI-TUSSIVE-EXPECTORANT COMBINATION		
HYDROCODONE-GUAIFENESIN	T1	PA QL (960ml/30 days)
OBREDON	T3	PA QL (960ml/30 days)
COUGH/COLD PREPARATIONS (Cough/Cold Medications)		
IST GEN ANTIHIST-DECONGEST-ANTICHOLINERGIC COMB		
RESPA A.R.	T3	
DIAGNOSTIC (Diabetes)		
BLOOD SUGAR DIAGNOSTICS		
ASSURE 4 TEST STRIPS	T3	
EASY PLUS TEST STRIP	T3	
EASY TALK TEST STRIP	T3	
EASY GLUCOSE TEST STRIP	T3	
EASYMAX TEST STRIP	T3	
EMBRACE EVO TEST STRIPS	T3	
EVENCARE TEST STRIP	T3	
FORA 6CONN-GTEL-TN'G ADV STRIP	T3	
FREESTYLE TEST STRIPS	T2	
GLUCOCARD EXPRESSION/SHINE TEST STRP	T3	
MICRODOT TEST STRIPS	T3	
OPTUMRX TEST STRIP	T3	
PRECISION XTRA TEST STRIPS	T2	
ULTRATRAK TEST STRIP		
ADREVIEW	T3	

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List of Prescription Medications

DIAGNOSTIC (Miscellaneous)		
BILIARY DIAGNOSTICS		
BILIARY DIAGNOSTICS *(cont.)*		
CHOLETEC	T3	
TC99M MEBROFENIN PREP	T1	
BILIARY DIAGNOSTICS, RADIOPAQUE		
indocyanine green	T1	
SINOGRAFIN	T3	
CARDIOVASCULAR DIAGNOSTICS - RADIOACTIVE		
AMMONIA N-13	T3	
MYOVIEW	T3	
TC99M PYROPHOSPHATE PREP	T1	
TC99M SESTAMIBI PREP	T1	
THALLOUS CHLORIDE TL-201	T1	
CARDIOVASCULAR DIAGNOSTICS, NON-RADIOPAQUE AGENTS		
adenosine 60 mg/20 ml vial	T1	
adenosine 90 mg/30 ml vial	T1	
DEFINITY	T3	
dipyridamole 50 mg/10 ml vial	T1	
LEXISCAN	T3	
OPTISON	T3	
regadenoson	T1	
CARDIOVASCULAR DIAGNOSTICS-RADIOPAQUE		
ISOVUE-200	T3	
ISOVUE-250	T3	
ISOVUE-300	T3	
ISOVUE-370	T3	
ISOVUE-M 200	T3	
ISOVUE-M 300	T3	
NEUROLITE	T3	
OMNIPAQUE	T3	
OPTIRAY 240, 300, 320, 350	T3	
ULTRAVIST	T3	
VISIPAQUE	T3	
CEREBRAL SPINAL RADIOACTIVE DIAGNOSTICS		
CERETEC	T3	
INDIUM IN-111 DTPA	T3	

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List of Prescription Medications

DIAGNOSTIC (Miscellaneous) *(cont.)*		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
CEREBRAL SPINAL RADIOPAQUE DIAGNOSTICS		
DOTAREM	T3	
gadoterate meglumine (Dotarem)	T1	
MAGNEVIST	T3	
MULTIHANCE	T3	
MULTIHANCE MULTIPACK	T3	
OMNISCAN	T3	
OMNISCAN PREFILL PLUS	T3	
OPTIMARK	T3	
PROHANCE	T3	
PROHANCE MULTIPACK	T3	
DIAGNOSTIC PREPARATIONS, MISCELLANEOUS		
ADVANCED DNA MEDICATED COLLECT	T3	
ARIDOL	T3	
DMSA	T3	
DRAXIMAGE DTPA	T3	
ful-glo 1 mg opth strip	T1	
FUL-GLO EYE STRIPS	T3	
GADAVIST	T3	
GLUCAGON HCL	T1	
isosulfan blue (Lymphazurin)	T1	
lidocaine hcl/glycerin (Advanced Dna Medicated Collect)	T1	
LIPIODOL	T3	
lissamine green	T1	
LUMASON	T3	
LYMPHAZURIN	T3	
NETSPOT	T3	
PROVOCHOLINE	T3	
TC99M MEDRONATE PREP	T1	
TC99M SULFUR COLLOID PREP	T1	
DIAGNOSTIC RADIOPHARM - AMYLOID/TAU IMAGING		
AMYVID	T3	
VIZAMYL	T3	PA
DIAGNOSTIC RADIOPHARM - DOPAMINE TRANSPORTER (DAT)		
DATSCAN	T3	

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DIAGNOSTIC (Miscellaneous) *(cont.)*		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
EYE DIAGNOSTIC AGENTS		
AK-FLUOR	T3	
AK-FLUOR (*fluorescite*)	T3	
fluorescein sodium	T1	
fluorescein sodium (Ak-fluor)	T3	
FLUORESCENCE CYSTOSCOPY/OPTICAL IMAGING AGENTS		
CYSVIEW	T3	
GASTROINTESTINAL RADIOPAQUE DIAGNOSTICS		
ENTERO VU	T3	
E-Z DISK	T3	
E-Z-HD	T3	
E-Z-PAQUE	T3	
E-Z-PASTE	T3	
GASTROMARK	T3	
LIQUID E-Z PAQUE	T3	
LIQUID POLIBAR PLUS	T3	
NEULUMEX	T3	
POLIBAR ACB	T3	
READI-CAT 2	T3	
SITZMARKS	T3	
TAGITOL V	T3	
VARIBAR HONEY	T3	
VARIBAR NECTAR	T3	
VARIBAR PUDDING	T3	
VARIBAR THIN HONEY	T3	
VARIBAR THIN LIQUID	T3	
HEPATIC DIAGNOSTICS		
EOVIST	T3	
HISTAMINE PREPARATIONS		
HISTATROL INTRADERMAL	T3	
HISTATROL PERCUTANEOUS	T3	
METABOLIC FUNCTION DIAGNOSTICS		
CHIRHOSTIM	T3	
METOPIRONE	T3	
R-GENE 10	T3	

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

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DIURETICS (Diuretics) *(cont.)*		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
CARBONIC ANHYDRASE INHIBITORS *(cont.)*		
methazolamide	T1	HD
LOOP DIURETICS		
bumetanide	T1	HD
EDECRIN (*ethacrynic acid*)	T3	PA
ethacrynate sodium (Sodium Edecrin)	T1	
FUROSCIX	T3	PA QL(2 kits/30 days)
furosemide	T1	HD
furosemide (Lasix)	T1	HD
FUROSEMIDE-0.9% NACL	T1	
LASIX (*furosemide*)	T3	PA HD
SODIUM EDECRIN (*ethacrynate sodium*)	T3	
torsemide	T1	HD
OSMOTIC DIURETICS		
mannitol	T1	
mannitol (Osmitrol)	T1	
OSMITROL 10% IV SOLUTION (*mannitol*)	T3	
osmitrol 15% iv solution	T3	
osmitrol 20% iv solution	T2	
OSMITROL 10% (50 GM/500 ML) (*mannitol*)	T3	
POLYCYSTIC KIDNEY DISEASE AGENT, AVP RECEP. ANTAG		
JYNARQUE	T4	PA SP
POTASSIUM SPARING DIURETICS		
ALDACTONE (*spironolactone*)	T3	PA HD
amiloride hcl	T1	HD
CAROSPIR	T2	PA
DYRENIUM (*triamterene*)	T3	PA HD
eplerenone (Inspra)	T1	HD
KERENDIA	T2	PA QL(1 tab/day)

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List of Prescription Medications

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

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List of Prescription Medications

EENT PREPS (Allergy/Nasal Sprays) *(con't.)*		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
NASAL ANTI-INFLAMMATORY STEROIDS *(cont.)*		
fluticasone prop 50 mcg spray	T1	HD
mometasone furoate 50 mcg spry (Nasonex)	T1	QL (4 bots/30 days) HD
NASONEX (*mometasone furoate*)	T3	QL (4 bots/30 days) ST HD
OMNARIS	T3	ST HD
QNASL	T3	ST HD
QNASL CHILDREN	T3	HD
SINUVA	T4	PA SP
XHANCE	T3	ST HD
ZETONNA	T3	ST HD
NOSE PREPARATIONS, MISCELLANEOUS (RX)		
ipratropium bromide	T1	HD
NOSE PREPARATIONS, VASOCONSTRICTORS (RX)		
ADRENALIN CHLORIDE	T3	
epinephrine hcl (Adrenalin Chloride)	T1	
EENT PREPS (Ear Medications)		
EAR PREPARATIONS ANTI-INFLAMMATORY		
DERMOTIC (*fluocinolone acetonide oil*)	T3	
fluocinolone acetonide oil (Dermotic)	T1	
EAR PREPARATIONS, MISC. ANTI-INFECTIVES		
acetic acid	T1	
hydrocortisone/acetic acid	T1	
EENT PREPS (Eye Conditions)		
ARTIFICIAL TEARS		
LACRISERT	T3	
MIEBO	T3	PA QL(4 bottles/22 days)
EYE ANTI-INFECTIVES (RX ONLY)		
BETADINE	T2	
EYE ANTI-INFLAMMATORY AGENTS		
ACULAR (*ketorolac tromethamine*)	T3	PA
ACULAR LS (*ketorolac tromethamine*)	T3	PA
ACUVAIL	T3	
ALREX *(lotepredrnol etabonate)*	T3	
bromfenac sodium (Bromsite)	T1	
BROMSITE *(bromfenac sodium)*	T2	

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List of Prescription Medications

EENT PREPS (Eye Conditions) *(con't.)*		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
EYE ANTI-INFLAMMATORY AGENTS *(cont.)*		
diclofenac 0.1% eye drops	T1	
DUREZOL	T3	PA
EYSUVIS	T2	QL (8.3ml/14 days)
FLAREX	T2	
fluorometholone (Fml)	T1	
flurbiprofen sodium	T1	
FML (*fluorometholone*)	T3	PA
FML FORTE	T3	PA
ILEVRO	T3	
ILUVIEN	T4	SP
INVELTYS	T2	
ketorolac 0.4% ophth solution (Acular Ls)	T1	
ketorolac 0.5% ophth solution (Acular)	T1	
LOTEMAX 0.5% EYE DROPS	T3	PA
LOTEMAX 0.5% EYE OINTMENT	T2	
LOTEMAX SM 0.38% OPHTH GEL	T3	PA
loteprednol etabonate (Lotemax)	T1	
loteprednol etabonate (Alrex)	T1	
MAXIDEX	T3	PA
MIEBO	T2	QL(4 bottles/30 days)
NEVANAC	T3	PA
OMNIPRED (*prednisolone acetate*)	T3	
OZURDEX	T4	SP
PRED FORTE (*prednisolone acetate*)	T3	PA
PRED MILD	T3	PA
prednisolone acetate (Pred Forte)	T1	
prednisolone sodium phosphate	T1	
PROLENSA	T3	
TRIESENCE	T3	
EYE IRRIGATIONS		
balanced salt irrig soln no.2	T3	
BSS PLUS	T3	
EYE LOCAL ANESTHETICS		
AKTEN	T3	

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List of Prescription Medications

EENT PREPS (Eye Conditions) *(con't.)*		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
EYE LOCAL ANESTHETICS *(cont.)*		
ALCAINE (*proparacaine hcl*)	T3	
ALTAFLUOR BENOX (*flurox*)	T3	
benoxinate hcl/fluorescein sod (Altafluor Benox)	T1	
benoxinate hcl/fluorescein sod (Altafluor Benox)	T3	
proparacaine hcl (Alcaine)	T1	
proparacaine/fluorescein sod	T1	
proparacaine/fluorescein sod	T3	
tetracaine hcl	T1	
TETRAVISC	T2	
TETRAVISC FORTE	T2	
EYE MAST CELL STABILIZERS		
ALOCRIL	T3	PA
ALOMIDE	T3	PA
cromolyn 4% eye drops	T1	
EYE MYDRIATIC AND NSAID COMBINATIONS		
OMIDRIA	T3	
EYE PREPARATIONS, MISCELLANEOUS (OTC)		
GELFILM	T3	
EYE VASOCONSTRICTORS		
phenylephrine hcl	T1	
UPNEEQ	T3	PA
MIOTICS AND OTHER INTRAOCULAR PRESSURE REDUCERS		
apraclonidine hcl (Iopidine)	T1	HD
ALPHAGAN P (brimonidine tartrate)	T3	PA HD
AZOPT (*brinzolamide*)	T3	PA HD
betaxolol hcl	T1	HD
BETIMOL	T3	PA HD
BETOPTIC S	T2	HD
bimatoprost	T1	QL (10 gm/30 days) HD
brimonidine tartrate	T1	HD
brimonidine tartrate (Alphagan P)	T1	HD
brinzolamide (Azopt)	T1	HD
carbachol	T3	HD
carteolol hcl	T1	HD

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EENT PREPS (Eye Conditions) *(con't.)*		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
MIOTICS AND OTHER INTRAOCULAR PRESSURE REDUCERS *(cont.)*		
COMBIGAN	T3	PA HD
COSOPT (*dorzolamide-timolol*)	T3	PA HD
COSOPT PF (*dorzolamide-timolol*)	T3	PA HD
dorzolamide hcl (Trusopt)	T1	HD
dorzolamide hcl/timolol maleat (Cosopt)	T1	HD
dorzolamide/timolol/pf (Cosopt Pf)	T1	HD
DURYSTA	T3	PA SP HD
IOPIDINE 1% EYE DROPS	T3	PA HD
ISOPTO CARPINE (*pilocarpine hcl*)	T3	HD
ISTALOL (*timolol maleate*)	T3	PA HD
IYUZEH	T3	PA QL(30 vials/30 days) HD
latanoprost (Xalatan)	T1	HD
levobunolol hcl	T1	HD
LUMIGAN	T3	PA HD
MIOCHOL-E	T3	HD
PHOSPHOLINE IODIDE	T2	HD
pilocarpine hcl (Isopto Carpine)	T1	HD
QLOSI	T3	PA
RHOPRESSA	T3	HD
ROCKLATAN	T3	HD
SIMBRINZA	T2	HD
timolol maleate (Istalol)	T1	HD
timolol maleate (Timoptic)	T1	HD
timolol maleate (Timoptic-xe)	T1	HD
timolol maleate/pf (Timoptic Ocudose)	T1	HD
TIMOPTIC (*timolol maleate*)	T3	PA HD
TIMOPTIC OCUDOSE (*timolol maleate*)	T3	PA HD
TIMOPTIC-XE (*timolol maleate*)	T3	PA HD
TRAVATAN Z (*travoprost*)	T3	PA HD
travoprost (Travatan Z)	T1	HD
TRUSOPT (*dorzolamide hcl*)	T3	PA HD
VUITY	T3	PA
VYZULTA	T3	PA HD
XALATAN (*latanoprost*)	T3	PA HD

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EENT PREPS (Eye Conditions) *(con't.)*		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
MIOTICS AND OTHER INTRAOCULAR PRESSURE REDUCERS *(cont.)*		
XELPROS	T3	PA HD
ZIOPTAN *(tafluprost/pf)*	T3	PA QL (60 droppers/30 days) HD
MYDRIATICS		
atropine 1%	T1	HD
ATROPINE SULFATE-0.9% NACL	T1	HD
CYCLOGYL 0.5% EYE DROPS (*cyclopentolate hcl*)	T2	HD
CYCLOGYL 1% EYE DROPS (*cyclopentolate hcl*)	T3	HD
CYCLOGYL 2% EYE DROPS (*cyclopentolate hcl*)	T3	HD
CYCLOMYDRIL	T2	HD
MIOTICS AND OTHER INTRAOCULAR PRESSURE REDUCERS		
cyclopentolate hcl (Cyclogyl)	T1	HD
homatropine hbr	T1	HD
ISOPTO ATROPINE (*atropine sulfate*)	T3	HD
MYDRIACYL (*tropicamide*)	T3	HD
PAREMYD	T3	HD
tropicamide	T1	HD
tropicamide (Mydriacyl)	T1	HD
TROPICAMIDE-CYCLOPENTOLATE-PE	T3	HD
OPHTH VASC. ENDOTHELIAL GROWTH FACTOR ANTAGONISTS		
PAVBLU	T3	PA SP
OPHTH VASC. ENDOTHELIAL GROWTH FACTOR ANTAGONISTS		
EYLEA	T4	PA SP
OPHTH. VEGF-A RECEPTOR ANTAG. RCMB MC ANTIBODY		
BEOVU	T4	PA SP
LUCENTIS	T4	PA SP
OPHTHALMIC ANTI-FIBROTIC AGENTS		
MITOSOL	T3	
OPHTHALMIC ANTI-INFLAMMATORY IMMUNOMODULATOR-TYPE		
CEQUA	T2	
RESTASIS	T2	HD
RESTASIS MULTIDOSE	T2	HD
VERKAZIA	T3	PA QL (1 box/month)
VEVYE	T3	PA HD
XIIDRA	T2	HD

T1 – Typically Generics
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List of Prescription Medications

EENT PREPS (Eye Conditions) *(con't.)*		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
OPHTHALMIC COMPLEMENT INHIBITORS		
SYFOVRE	T4	PA SP HD
OPHTHALMIC CYSTINE DEPLETING AGENTS		
CYSTADROPS	T4	PA QL (20ml/21 days) SP
CYSTARAN	T4	PA QL (120ml/28 days) SP
OPHTHALMIC HUMAN NERVE GROWTH FACTOR (HNGF)		
OXERVATE	T4	PA SP HD
OPHTHALMIC PREPARATIONS, MISCELLANEOUS		
AMVISC	T4	SP
AMVISC PLUS	T4	SP
DISCOVISC	T3	
DUOVISC	T3	
HEALON (*biolon*)	T4	SP
HEALON5	T3	
PROVISC	T4	SP
TOTALVISC	T4	SP
VISCOAT	T3	
OPHTHALMIC SURGICAL AIDS		
CELLUGEL	T3	
hypromellose (Cellugel)	T1	
MEMBRANEBLUE	T3	
VISIONBLUE	T3	
ELECT/CALORIC/H2O (Cholesterol Medications)		
ORAL LIPID SUPPLEMENTS		
DOJOLVI	T4	PA SP HD
ELECT/CALORIC/H2O (Dental Products)		
FLUORIDE PREPARATIONS		
CLINPRO 5000	T3	
fluoride (sodium) (Prevident 5000 Ortho Defense)	T1	
fluoride (sodium) (Prevident 5000 Plus)	T1	
fluoride (sodium) (Prevident 5000)	T1	
fluoride (sodium) (Prevident)	T1	
FLUORIDEX	T1	

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List of Prescription Medications

ELECT/CALORIC/H2O (Dental Products) *(con't.)*		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
FLUORIDE PREPARATIONS *(con't.)*		
FLUORIDEX SENSITIVITY RELIEF	T3	
FRAICHE 5000 PREVI	T3	
FRAICHE 5000 SENSITIVE	T3	
PREVIDENT 0.2% RINSE	T3	
PREVIDENT 1.1% GEL (*sodium fluoride*)	T3	
PREVIDENT 5000	T2	
PREVIDENT 5000 BOOSTER PLUS	T2	
PREVIDENT 5000 ENAMEL PROTECT	T2	
PREVIDENT 5000 ORTHO DEFENSE	T2	
PREVIDENT 5000 PLUS (*sodium fluoride 5000 plus*)	T3	
PREVIDENT 5000 SENSITIVE	T2	
PREVIDENT DENTAL RINSE	T3	
PREVIDENT KIDS	T2	
sodium fluoride/potassium nit (Prevident 5000 Sensitive)	T1	
ELECT/CALORIC/H2O (Diabetes)		
AGENTS TO TREAT HYPOGLYCEMIA (HYPERGLYCEMICS)		
BAQSIMI	T2	QL(2 units/30 days)
diazoxide (Proglycem)	T1	
GLUCAGEN	T2	QL(2 vials/30 days)
GLUCAGON 1 MG EMERGENCY KIT	T3	QL (2 pens/30 days)
glucagon 1 mg emergency kit (Glucagon Emergency Kit)	T1	QL (2 pens/30 days)
GVOKE HYPOPEN 1-PACK	T2	QL (2 packs/22 days)
GVOKE HYPOPEN 2-PACK	T2	QL (2 packs/22 days)
GVOKE PFS 1-PACK SYRINGE	T2	QL (2 syringes/30 days)
GVOKE PFS 2-PACK SYRINGE	T2	QL (2 syringes/30 days)
PROGLYCEM (*diazoxide*)	T3	
ZEGALOGUE	T2	QL (2 units/23 days)
ELECT/CALORIC/H2O (Miscellaneous)		
BICARBONATE PRODUCING/CONTAINING AGENTS		
sodium acetate	T1	
sodium bicarbonate	T1	
sodium bicarbonate in d5w	T1	

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List of Prescription Medications

ELECT/CALORIC/H2O (Miscellaneous) *(con't.)*		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
DRUGS USED TO TREAT ACIDOSIS		
THAM	T3	
IV SOLUTIONS: DEXTROSE AND LACTATED RINGERS		
dextrose 5%-lactated ringers	T1	
IV SOLUTIONS: DEXTROSE-SALINE		
dextrose 10 % and 0.2 % nacl	T1	
dextrose 10 % and 0.45 % nacl	T1	
dextrose 2.5 % and 0.45 % nacl	T1	
dextrose 5 % and 0.3 % nacl	T1	
dextrose 5 % and 0.9 % nacl	T1	
dextrose 5 %-0.2 % sod chlorid	T1	
dextrose 5 %-0.45 % sod chlord	T1	
IV SOLUTIONS: DEXTROSE-WATER		
dextrose 10 % in water	T1	
dextrose 20 % in water	T1	
dextrose 25 % in water	T1	
dextrose 30 % in water	T1	
dextrose 40 % in water	T1	
dextrose 50 % in water	T1	
dextrose 70 % in water	T1	
GLUCOSE IN WATER (*dextrose in water*)	T1	
NUCLEIC ACID/NUCLEOTIDE SUPPLEMENTS		
XURIDEN	T4	PA SP
PARENTERAL AMINO ACID SOLUTIONS AND COMBINATIONS		
AMINO ACID 3%-D10W-CALCIUM-HEPARIN	T3	
AMINOSYN	T3	
AMINOSYN II	T3	
AMINOSYN II WITH ELECTROLYTES	T3	
AMINOSYN M	T3	
AMINOSYN WITH ELECTROLYTES	T3	
AMINOSYN-PF	T3	
AMINOSYN-RF	T3	
CLINIMIX	T3	
CLINIMIX E	T3	
CLINISOL	T3	

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ELECT/CALORIC/H2O (Miscellaneous) *(con't.)*		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
PARENTERAL AMINO ACID SOLUTIONS AND COMBINATIONS *(con't.)*		
HEPATAMINE	T3	
KABIVEN	T3	
parenteral amino acid 10% no.4	T3	
parenteral amino acid 10% no.6	T3	
parenteral amino acid 10% no.7	T3	
PERIKABIVEN	T3	
PLENAMINE	T3	
PROCALAMINE	T3	
PROSOL	T3	
TROPHAMINE	T3	
ELECT/CALORIC/H2O (Nutritional/Dietary)		
CALCIUM REPLACEMENT		
calcium chloride	T1	
CALCIUM GLU 2,000MG/100ML-NACL	T3	
CALCIUM GLUC 1,000MG/50ML-NACL	T1	
calcium gluconate	T1	
calcium gluconate in 0.9% nacl (Calcium Gluconate-0.9% Nacl)	T1	
CALCIUM GLUCONATE-0.9% NACL	T1	
CALCIUM GLUCONATE-0.9% NACL (*calcium gluconate-0.9% nacl*)	T1	
CALCIUM GLUCONATE-D5W	T1	
ELECTROLYTE DEPLETERS		
AURYXIA	T3	QL (12 tabs/day)
calcium acetate	T1	
FOSRENOL 1,000 MG POWDER PACK	T2	PA
FOSRENOL 1,000 MG TABLET CHEW (*lanthanum carbonate*)	T3	PA
FOSRENOL 500 MG TABLET CHEW (*lanthanum carbonate*)	T3	PA
FOSRENOL 750 MG POWDER PACKET	T2	PA
FOSRENOL 750 MG TABLET CHEW (*lanthanum carbonate*)	T3	PA
lanthanum carbonate (Fosrenol)	T1	
LOKELMA	T2	
PHOSLYRA	T3	
RENAGEL (*sevelamer hcl*)	T3	PA
RENVELA (*sevelamer carbonate*)	T3	PA

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ELECT/CALORIC/H2O (Nutritional/Dietary) *(con't.)*		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
ELECTROLYTE DEPLETERS *(con't.)*		
sevelamer carbonate (Renvela)	T1	
sevelamer hcl	T1	
sevelamer hcl (Renagel)	T1	
sodium polystyrene sulfon/sorb	T1	
sodium polystyrene sulfonate	T1	
sps 15 gm/60 ml suspension	T1	
sps 30 gm/120 ml enema susp	T3	
VELPHORO	T2	
VELTASSA	T2	
XPHOZAH	T4	PA SP
ELECTROLYTE MAINTENANCE		
electrolyte-48 solution/d5w	T1	
IONOSOL B WITH DEXTROSE 5%	T3	
IONOSOL MB-DEXTROSE 5%	T3	
ISOLYTE P WITH DEXTROSE	T3	
ISOLYTE S	T3	
NORMOSOL-M AND DEXTROSE	T3	
NORMOSOL-R	T3	
NORMOSOL-R AND DEXTROSE	T3	
NORMOSOL-R PH 7.4	T3	
PLASMA-LYTE 148	T3	
PLASMA-LYTE A PH 7.4	T3	
ringer's solution	T1	
ringer's solution, lactated	T1	
TPN ELECTROLYTES	T3	
TPN ELECTROLYTES II	T3	
IODINE CONTAINING AGENTS		
IODOPEN	T3	
potassium iodide/iodine	T1	
SSKI	T1	
IRON REPLACEMENT		
HEMOCYTE PLUS *(mv-mins no.73/iron fum/folic)*	T3	
mv-mins no.73/iron fum/folic (Hemocyte Plus)	T1	

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List of Prescription Medications

ELECT/CALORIC/H2O (Nutritional/Dietary) *(con't.)*		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
MAGNESIUM SALTS REPLACEMENT		
magnesium chloride	T1	
magnesium sulfate	T1	
magnesium sulfate in water	T1	
MAGNESIUM SULFATE-0.9% NACL	T1	
MAGNESIUM SULFATE-D5W	T1	
MAGNESIUM-LACTATED RINGERS	T1	
MINERAL REPLACEMENT, MISCELLANEOUS		
ADDAMEL N	T3	
chromic chloride	T1	
cupric chloride	T1	
manganese chloride	T1	
manganese sulfate	T1	
MULTITRACE-4 CONC VIAL	T1	
multitrace-4 vial	T3	
MULTITRACE-5	T1	
PEDITRACE	T3	
SELENIOUS ACID	T1	
TRALEMENT	T3	
PHOSPHATE REPLACEMENT		
GLYCOPHOS	T3	
potassium phos, m-basic-d-basic	T1	
POTASSIUM PHOSPHATE-0.9% NACL	T1	
POTASSIUM PHOSPHATES	T3	
sod phosphate, monobasic-dibas	T1	
SODIUM PHOSPHATE-0.9% NACL	T1	
POTASSIUM REPLACEMENT		
EFFER-K 10 MEQ TABLET EFF	T3	
EFFER-K 20 MEQ TABLET EFF	T3	
effer-k 25 meq tablet eff	T1	
klor-con 10 meq tablet (K-tab Er)	T1	
klor-con 8 meq tablet	T1	
K-TAB (*potassium chloride*)	T3	
POKONZA	T3	

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List of Prescription Medications

ELECT/CALORIC/H2O (Nutritional/Dietary) *(con't.)*		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
POTASSIUM REPLACEMENT *(con't.)*		
potassium acetate	T1	
potassium bicarbonate/cit ac	T1	
POTASSIUM CL ER 15 MEQ TABLET	T3	
potassium chloride	T1	
potassium chloride	T2	
potassium chloride	T3	
potassium chloride (K-tab Er)	T1	
potassium chloride in 0.9%nacl	T1	
potassium chloride in d5w	T1	
potassium chloride in lr-d5	T1	
potassium chloride in water	T1	
potassium chloride/d5-0.2%nacl	T1	
potassium chloride/d5-0.3%nacl	T1	
potassium chloride/d5-0.45nacl	T1	
potassium chloride/d5-0.9%nacl	T1	
potassium chloride-0.45% nacl	T1	
potassium chloride (K-tab Er)	T1	
PROTEIN REPLACEMENT		
AQNEURSA	T4	PA SP
SODIUM/SALINE PREPARATIONS		
0.9 % sodium chloride	T1	
KENDALL 0.9% NACL WITH CAP	T1	
sodium chloride	T1	
sodium chloride 0.45 %	T1	
sodium chloride 0.9 % (flush)	T1	
sodium chloride 3 %	T1	
sodium chloride 5 %	T1	
SWABFLUSH	T3	
ZINC REPLACEMENT		
zinc chloride	T1	
zinc sulfate 10 mg/10 ml vial	T1	
zinc sulfate 25 mg/5 ml vial	T1	
ZINC SULFATE 30 MG/10 ML VIAL	T3	

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List of Prescription Medications

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ELECT/CALORIC/H2O (Urinary Tract Conditions)		
DIALYSIS SOLUTIONS		
DELFLEX WITH 1.5% DEXTROSE	T3	
DELFLEX-2.5% DEXTROSE	T3	
DIANEAL PD-2 W-1.5% DEXTROSE	T3	
DIANEAL PD-2 W-2.5% DEXTROSE	T2	
DIANEAL PD-2 W-4.25% DEXTROSE	T3	
DIANEAL WITH 1.5% DEXTROSE	T3	
DIANEAL WITH 2.5% DEXTROSE	T3	
DIANEAL WITH 4.25% DEXTROSE	T3	
EXTRANEAL ICODEXTRIN DIALYSIS	T3	
perit. dialysis no.6-1.5 % dex (Dianeal With 1.5% Dextrose)	T3	
periton.dialysis 7-2.5 % dextr (Dianeal With 2.5% Dextrose)	T3	
periton.dialysis 8-4.25 % dext (Dianeal With 4.25% Dextrose)	T3	
PHOXILLUM	T3	
PRISMASOL	T3	
URINARY PH MODIFIERS		
K-PHOS NO.2	T2	HD
K-PHOS ORIGINAL	T2	HD
ORACIT	T3	HD
potassium citrate (Urocit-k)	T1	HD
potassium citrate/citric acid	T1	HD
RENACIDIN	T3	HD
UROCIT-K (*potassium citrate er*)	T3	HD
UROQID-ACID NO.2	T2	HD
GASTROINTESTINAL (Cholesterol Medications)		
LIPOTROPICS		
icosapent ethyl (Vascepa)	T1	HD
LOVAZA (*triklo*)	T3	PA HD
omega-3 acid ethyl esters (Lovaza)	T1	HD
VASCEPA	T2	PA HD
GASTROINTESTINAL (Gastrointestinal/Heartburn)		
AMMONIA INHIBITORS		
AMMONUL (*sodium phenylacet-sod benzoate*)	T3	
CARBAGLU *(carglumic acid)*	T4	SP HD

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List of Prescription Medications

GASTROINTESTINAL (Gastrointestinal/Heartburn) *(con't.)*		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
AMMONIA INHIBITORS *(con't.)*		
carglumic acid (Carbaglu)	T4	SP HD
BUPHENYL (*sodium phenylbutyrate*)	T4	SP HD
lactulose	T1	HD
lactulose 10 gm/15 ml solution	T1	
LITHOSTAT	T2	HD
PHEBURANE	T4	PA QL(8 bottles/30 days) SP HD
RAVICTI	T4	PA SP HD
sodium benzoate/sod phenylacet (Ammonul)	T1	
sodium phenylbutyrate (Buphenyl)	T4	SP
ANTI-CHOLINERGICS, QUATERNARY AMMONIUM		
chlordiazepoxide/clidinium br (Librax)	T1	
CUVPOSA	T3	
DARTISLA	T3	PA
GLYCATE	T3	
glycopyrrolate	T1	
glycopyrrolate (Glycate)	T1	
glycopyrrolate (Robinul Forte)	T1	
glycopyrrolate (Robinul)	T1	
GLYCOPYRROLATE-WATER	T1	
LIBRAX (*chlordiazepoxide-clidinium*)	T3	PA
propantheline bromide	T1	
ROBINUL (*glycopyrrolate*)	T3	
ROBINUL FORTE (*glycopyrrolate*)	T3	
ANTI-CHOLINERGICS/ANTI-SPASMODICS		
BENTYL	T3	
dicyclomine hcl	T1	
dicyclomine hcl (Bentyl)	T1	
ANTI-DIARRHEAL - G.I. CHLORIDE CHANNEL INHIBITORS		
MYTESI	T3	
ANTI-DIARRHEAL - TRYPTOPHAN HYDROXYLASE INHIBITOR		
XERMELO	T4	PA SP
ANTI-DIARRHEALS		
diphenoxylate hcl/atropine	T1	
diphenoxylate hcl/atropine (Lomotil)	T1	

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List of Prescription Medications

GASTROINTESTINAL (Gastrointestinal/Heartburn) *(con't.)*

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ANTI-DIARRHEALS *(con't.)*		
LOMOTIL (*diphenoxylate-atropine*)	T3	PA
loperamide hcl	T1	
MOTOFEN	T3	
opium tincture	T1	PA
paregoric	T1	
ANTI-EMETIC, CANNABINOID-TYPE		
dronabinol (Marinol)	T1	
MARINOL (*dronabinol*)	T3	PA
SYNDROS	T3	PA
ANTI-EMETIC/ANTI-VERTIGO AGENTS		
AKYNZEO 235-0.25 MG VIAL	T3	
AKYNZEO 235-0.25 MG/20 ML VIAL	T3	
AKYNZEO 300-0.5 MG CAPSULE	T3	QL (4 caps/28 days)
ALOXI (*palonosetron hcl*)	T3	PA
ANZEMET	T4	PA QL (5 tabs/30 days) SP
aprepitant 125 mg capsule	T1	QL (4 caps/28 days)
aprepitant 125-80-80 mg pack (Emend)	T1	QL (12 caps/28 days)
aprepitant 40 mg capsule	T1	QL (1 cap/28 days)
aprepitant 80 mg capsule (Emend)	T1	QL (8 caps/28 days)
BARHEMSYS	T3	
BONJESTA	T3	
CINVANTI	T3	
COMPAZINE (*prochlorperazine maleate*)	T3	
COMPAZINE (*prochlorperazine*)	T3	
DICLEGIS (*doxylamine succ-pyridoxine hcl*)	T3	PA QL(4 tabs/day)
dimenhydrinate	T1	
doxylamine succinate/vit b6 (Diclegis)	T1	QL(4 tabs/day)
EMEND 125 MG POWDER PACKET	T3	QL (12 caps/28 days)
EMEND 150 MG VIAL (*fosaprepitant dimeglumine*)	T3	
EMEND 80 MG CAPSULE (*aprepitant*)	T3	QL (8 caps/28 days)
EMEND TRIPACK (*aprepitant*)	T3	QL (12 caps/28 days)
FOCINVEZ	T3	
fosaprepitant dimeglumine (Emend)	T1	
granisetron hcl	T1	

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GASTROINTESTINAL (Gastrointestinal/Heartburn) *(con't.)*		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
ANTI-EMETIC/ANTI-VERTIGO AGENTS *(con't.)*		
granisetron hcl/pf	T1	
ondansetron hcl	T1	
ondansetron hcl (Zofran)	T1	
ONDANSETRON ODT 16 MG TABLET	T3	PA
ondansetron hcl/pf	T1	
ONDANSETRON HCL-0.9% NACL	T1	
ONDANSETRON HCL-D5W	T1	
palonosetron hcl	T1	
palonosetron hcl (Aloxi) (Posfrea)	T1	
POSFREA *(palonosetron hcl)*	T3	
prochlorperazine (Compazine)	T1	
prochlorperazine edisylate	T1	
prochlorperazine maleate (Compazine)	T1	
promethazine hcl	T1	
promethazine hcl	T3	
SANCUSO	T3	PA QL (4 patches/30 days)
scopolamine (Transderm-scop)	T1	
SUSTOL	T3	
TIGAN	T3	
TRANSDERM-SCOP (*scopolamine*)	T3	
trimethobenzamide hcl (Tigan)	T1	
VARUBI	T3	PA QL (4 tabs/28 days)
ZOFRAN 2 MG/ML VIAL (*ondansetron hcl*)	T3	
ZOFRAN 4 MG TABLET (*ondansetron hcl*)	T3	PA
ZOFRAN 8 MG TABLET (*ondansetron hcl*)	T3	PA
ANTI-ULCER PREPARATIONS		
CARAFATE (*sucralfate*)	T3	PA HD
CYTOTEC (*misoprostol*)	T3	HD
misoprostol (Cytotec)	T1	HD
sucralfate (Carafate)	T1	HD
ANTI-ULCER-H.PYLORI AGENTS		
bismuth/metronid/tetracycline (Pylera)	T1	
HELIDAC	T3	PA
lansoprazole/amoxiciln/clarith	T1	

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GASTROINTESTINAL (Gastrointestinal/Heartburn) *(con't.)*		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
ANTI-ULCER-H.PYLORI AGENTS *(con't.)*		
OMECLAMOX-PAK	T3	PA
PYLERA (*bismuth/metronid/tetracycline*)	T3	PA
TALICIA	T3	PA
VOQUEZNA DUAL, TRIPLE PAK	T3	PA
BELLADONNA ALKALOIDS		
atropine 0.4 mg/ml vial	T1	
ATROPINE 0.4 MG/ML VIAL	T3	
atropine 0.5 mg/5 ml abboject	T1	
atropine 1 mg/10 ml abboject	T1	
atropine 1 mg/10 ml syringe	T1	
ATROPINE 1 MG/2.5 ML SYRINGE	T1	
atropine 1 mg/ml vial	T1	
ATROPINE 1 MG/ML VIAL	T3	
ATROPINE 2 MG/5 ML SYRINGE	T3	
ATROPINE SULFATE 0.25 MG/5 ML SYRINGE	T3	
atropine 8 mg/20 ml vial	T1	
DONNATAL	T3	HD
DONNATAL (*phenohytro*)	T3	HD
hyoscyamine 0.125 mg odt (Nulev)	T1	HD
hyoscyamine 0.125 mg tab sl (Levsin-sl)	T1	HD
hyoscyamine 0.125 mg/5 ml elix	T1	HD
hyoscyamine 0.125 mg/ml drop	T1	HD
hyoscyamine sulf 0.125 mg tab (Levsin)	T1	HD
hyoscyamine sulfate	T1	HD
hyoscyamine sulfate (Levbid)	T1	HD
hyoscyamine sulfate (Levsin)	T1	HD
hyoscyamine sulfate (Levsin-sl)	T1	HD
hyoscyamine sulfate (Nulev)	T1	HD
hyoscyamine sulfate (Nulev)	T3	HD
HYOSCYAMINE SULFATE 0.5 MG/ML	T3	HD
LEVBID (*symax-sr*)	T3	HD
LEVSIN	T3	HD
LEVSIN (*oscimin*)	T3	HD

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List of Prescription Medications

GASTROINTESTINAL (Gastrointestinal/Heartburn) *(con't.)*		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
BELLADONNA ALKALOIDS *(con't.)*		
LEVSIN-SL (*symax-sl*)	T3	HD
methscopolamine bromide	T1	HD
NULEV (*symax*)	T1	HD
phenobarb/hyoscy/atropine/scop (Donnatal)	T1	HD
phenobarb/hyoscy/atropine/scop (Phenobarbital-belladonna)	T1	HD
phenobarbital-belladonna elixr (Donnatal)	T1	HD
phenobarbital-belladonna elixr (Phenobarbital-belladonna)	T1	HD
PHENOBARBITAL-BELLADONNA ELIXR (*phenohytro*)	T3	HD
SYMAX DUOTAB	T2	HD
BILE SALTS		
ACTIGALL (*ursodiol*)	T4	HD
CHENODAL	T4	SP HD
CHOLBAM	T4	PA SP HD
CTEXLI	T4	PA SP
RELTONE	T3	PA HD
URSO (*ursodiol*)	T3	HD
URSO FORTE (*ursodiol*)	T3	HD
ursodiol (Actigall)	T1	HD
ursodiol (Urso Forte)	T1	HD
ursodiol (Urso)	T1	HD
CHOLERETICS		
KINEVAC	T3	
CHRONIC INFLAM. COLON DX, 5-A-SALICYLAT, RECTAL TX		
CANASA (*mesalamine*)	T3	PA
mesalamine 1,000 mg supp (Canasa)	T1	
mesalamine 4 gm/60 ml enema (Sfrowasa)	T1	
mesalamine 4 gm/60 ml kit (Rowasa)	T1	
ROWASA (*mesalamine*)	T3	PA
SFROWASA (*mesalamine*)	T3	
DRUG TX-CHRONIC INFLAM. COLON DX, 5-AMINOSALICYLAT		
APRISO (*mesalamine er*)	T3	HD
ASACOL HD (*mesalamine*)	T3	ST HD
AZULFIDINE (*sulfasalazine dr*)	T3	PA HD
AZULFIDINE (*sulfasalazine*)	T3	PA HD

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Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
DRUG TX-CHRONIC INFLAM. COLON DX, 5-AMINOSALICYLAT *(con't.)*		
balsalazide disodium (Colazal)	T1	HD
COLAZAL (*balsalazide disodium*)	T3	ST HD
DELZICOL (*mesalamine dr*)	T3	ST HD
DIPENTUM	T3	ST HD
LIALDA (*mesalamine*)	T3	ST HD
mesalamine (Apriso)	T1	HD
mesalamine (Delzicol)	T1	HD
mesalamine 800 mg dr tablet (Asacol Hd)	T1	HD
mesalamine dr 1.2 gm tablet (Lialda)	T1	HD
PENTASA 250 MG CAPSULE	T3	ST HD
PENTASA 500 MG CAPSULE (mesalamine)	T3	HD
sulfasalazine (Azulfidine)	T1	HD
FARNESOID X RECEPTOR (FXR) AGONIST, BILE AC ANALOG		
OCALIVA	T4	PA SP HD
FECAL MICROBIOTA TRANSPLANTATION (FMT)		
VOWST CAPSULE	T4	PA QL (12 caps/8 weeks) SP HD
GASTRIC ENZYMES		
SUCRAID	T4	PA SP
cimetidine hcl	T1	HD
famotidine	T1	HD
famotidine (Pepcid)	T1	HD
FAMOTIDINE-0.9% NACL	T1	HD
nizatidine	T1	HD
PEPCID (*famotidine*)	T1	PA HD
ranitidine hcl	T1	HD
ranitidine hcl (Zantac)	T1	HD
ZANTAC (*ranitidine hcl*)	T3	HD
IBS AGENTS, MIXED OPIOID RECEP AGONISTS/ANTAGONISTS		
VIBERZI	T2	HD
IBS-C/CIC AGENTS, GUANYLATE CYCLASE-C AGONIST		
LINZESS	T2	
TRULANCE	T2	
ILEAL BILE ACID TRANSPORTER (IBAT) INHIBITOR		
BYLVAY	T4	PA SP HD

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GASTROINTESTINAL (Gastrointestinal/Heartburn) *(con't.)*		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
ILEAL BILE ACID TRANSPORTER (IBAT) INHIBITOR *(con't.)*		
LIVMARLI	T4	PA SP HD
INTESTINAL MOTILITY STIMULANTS		
GIMOTI	T4	PA SP
metoclopramide hcl	T1	
metoclopramide hcl (Reglan)	T1	
MOTEGRITY	T3	PA
REGLAN (*metoclopramide hcl*)	T3	
IRRITABLE BOWEL SYNDROME AGENTS, 5-HT3 ANTAGONIST		
alosetron hcl (Lotronex)	T4	SP HD
LOTRONEX (*alosetron hcl*)	T4	PA SP HD
ZELNORM	T3	PA
IV FAT EMULSIONS		
CLINOLIPID	T3	
fat emulsions (Nutrilipid)	T3	
INTRALIPID	T3	
NUTRILIPID (*intralipid*)	T3	
OMEGAVEN	T3	
SMOFLIPID	T3	
LAXATIVES AND CATHARTICS		
AMITIZA *(lubiprostone)*	T3	PA
bisac/nacl/nahco3/kcl/peg 3350	T1	PPACA
CLENPIQ	T3	PA PPACA
COLYTE WITH FLAVOR PACKETS (*peg 3350-electrolyte*)	T3	PPACA
COLYTE WITH FLAVOR PACKETS (*peg 3350-electrolyte*)	T3	PA PPACA
GOLYTELY	T3	PA PPACA
GOLYTELY (*peg-3350 and electrolytes*)	T3	PA PPACA
KRISTALOSE	T3	
lactulose	T1	
lactulose 10 gm packet (Kristalose)	T1	
lactulose 10 gm/15 ml solution	T1	
lactulose 20 gm/30 ml solution	T1	
lactulose 10 gm/15 ml solution	T1	
lactulose 20 gm/30 ml solution	T1	
lubiprostone	T1	

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GASTROINTESTINAL (Gastrointestinal/Heartburn) *(con't.)*		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
LAXATIVES AND CATHARTICS *(con't.)*		
LUBIPROSTONE	T3	PA
MOVIPREP (*peg3350-sod sul-nacl-kcl-asb-c*)	T3	PA PPACA
NULYTELY	T3	PA PPACA
OSMOPREP	T3	PA PPACA
peg3350/sod sul/nacl/kcl/asb/c (Moviprep)	T1	PPACA
peg3350/sod sulf, bicarb, cl/kcl (Colyte With Flavor Packets)	T1	PPACA
peg3350/sod sulf, bicarb, cl/kcl (Golytely)	T1	PPACA
PLENVU	T3	PA PPACA
PREPOPIK	T2	PPACA
sodium chloride/nahco3/kcl/peg	T1	PPACA
SUFLAVE	T3	PA PPACA
SUPREP	T3	PA PPACA
SUTAB	T3	PA PPACA
LOCAL ANORECTAL NITRATE PREPARATIONS		
nitroglycerin 0.4% ointment (Rectiv)	T1	
RECTIV *(nitroglycerin)*	T3	
PANCREATIC ENZYMES		
CREON	T3	PA HD
PANCREAZE	T2	HD
PERTZYE	T3	PA HD
VIOKACE	T3	HD
ZENPEP	T3	HD
POTASSIUM-COMPETITIVE ACID BLOCKERS (PCABS)		
VOQUEZNA	T3	PA QL(1 tab/day)
PROTON-PUMP INHIBITORS		
ACIPHEX (*rabeprazole sodium*)	T3	QL (30 tabs/30 days) ST HD
ACIPHEX SPRINKLE DR 10 MG CAP	T3	QL (60 caps/30 days) HD
ACIPHEX SPRINKLE DR 5 MG CAP	T3	QL (120 caps/30 days) HD
DEXILANT DR 30 MG CAPSULE (*dexlansoprazole*)	T3	PA QL(2 caps/day)
DEXILANT DR 60 MG CAPSULE	T3	PA QL(1 cap/day)
dexlansoprazole dr 30 mg cap (Dexilant)	T1	QL(2 caps/day)
dexlansoprazole dr 60 mg cap (Dexilant)	T1	QL(1 cap/day)
esomeprazole dr 10 mg packet (Nexium)	T1	QL (4 packets/day) HD
esomeprazole dr 20 mg packet (Nexium)	T1	QL (2 packs/day) HD

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Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
PROTON-PUMP INHIBITORS *(cont.)*		
esomeprazole dr 40 mg packet (Nexium)	T1	QL (1 packet/day) HD
esomeprazole mag dr 20 mg cap (Nexium)	T1	QL (20ml/day) HD
esomeprazole mag dr 40 mg cap (Nexium)	T1	QL (30 caps/30 days) HD
esomeprazole sodium	T1	HD
ESOMEPRAZOLE STRONTIUM	T3	QL (30 caps/30 days) HD
KONVOMEP	T3	PA QL(20 mls/day) HD
lansoprazole dr 15 mg capsule (Prevacid)	T1	QL (2 caps/day) HD
lansoprazole dr 30 mg capsule (Prevacid)	T1	QL (30 caps/30 days) HD
lansoprazole odt 15 mg tablet (Prevacid)	T1	QL (2 tabs/day) HD
lansoprazole odt 30 mg tablet (Prevacid)	T1	QL (30 tabs/30 days) HD
NEXIUM DR 10 MG PACKET (*esomeprazole magnesium*)	T3	PA QL (120 packs/30 days) HD
NEXIUM DR 2.5 MG PACKET	T2	QL (480 packs/30 days) HD
NEXIUM DR 20 MG CAPSULE (*esomeprazole magnesium*)	T3	PA QL (2 caps/day) HD
NEXIUM DR 20 MG PACKET (*esomeprazole magnesium*)	T3	PA QL (2 packs/day) HD
NEXIUM DR 40 MG CAPSULE (*esomeprazole magnesium*)	T3	PA QL (30 caps/30 days) HD
NEXIUM DR 40 MG PACKET (*esomeprazole magnesium*)	T3	PA QL (30 packs/30 days) HD
NEXIUM DR 5 MG PACKET	T2	QL (240 packs/30 days) HD
NEXIUM I.V. (*esomeprazole sodium*)	T3	
omeppi 20 mg-1, 100 mg capsule (Zegerid)	T3	PA QL (60 caps/30 days) HD
omeppi 40 mg-1, 100 mg capsule (Zegerid)	T3	PA QL (30 caps/30 days) HD
omeprazole dr 10 mg capsule	T1	QL (4 caps/day) HD
omeprazole dr 20 mg capsule	T1	QL (60 caps/30 days) HD
omeprazole dr 40 mg capsule	T1	QL (30 caps/30 days) HD
omeprazole-bicarb 20-1, 100 cap (Zegerid)	T1	PA QL (60 caps/30 days) HD
omeprazole-bicarb 20-1, 680 pkt (Zegerid)	T1	PA QL (60 packs/30 days) HD
omeprazole-bicarb 40-1, 100 cap (Zegerid)	T1	PA QL (30 caps/30 days) HD
omeprazole-bicarb 40-1, 680 pkt (Zegerid)	T1	PA QL (30 packs/30 days) HD
pantoprazole 40 mg suspension (Protonix)	T1	QL (1 dose/day) HD
pantoprazole sod dr 20 mg tab (Protonix)	T1	QL (2 tabs/day) HD
pantoprazole sod dr 40 mg tab (Protonix)	T1	QL (30 tabs/30 days) HD
PANTOPRAZOLE SODIUM-0.9% NACL	T3	HD
pantoprazole sodium 40 mg vial (Protonix Iv)	T1	
PREVACID 15 MG SOLUTAB (*lansoprazole*)	T3	PA QL (2 tabs/day) HD
PREVACID 30 MG SOLUTAB (*lansoprazole*)	T3	PA QL (30 tabs/30 days) HD

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Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
PROTON-PUMP INHIBITORS *(cont.)*		
PREVACID DR 15 MG CAPSULE (*lansoprazole*)	T3	QL (60 caps/30 days) ST HD
PREVACID DR 30 MG CAPSULE (*lansoprazole*)	T3	QL (30 caps/30 days) ST HD
PRILOSEC DR 10 MG SUSPENSION	T3	QL (120 packs/30 days) HD
PRILOSEC DR 2.5 MG SUSPENSION	T3	QL (480 packs/30 days) HD
PROTONIX 40 MG SUSPENSION (*pantoprazole sodium*)	T3	QL (30 packs/30 days) ST HD
PROTONIX DR 20 MG TABLET (*pantoprazole sodium*)	T3	QL (60 tabs/30 days) ST HD
PROTONIX DR 40 MG TABLET (*pantoprazole sodium*)	T3	QL (30 tabs/30 days) ST HD
PROTONIX IV (*pantoprazole sodium*)	T3	HD
RABEPRAZOLE DR 10 MG SPRNKL CP	T3	QL (2 caps/day) HD
rabeprazole sod dr 20 mg tab (Aciphex)	T1	QL (1 tab/day) HD
ZEGERID 20 MG CAPSULE (*omeprazole-sodium bicarbonate*)	T3	PA QL (60 caps/30 days) HD
ZEGERID 20 MG PACKET (*omeprazole-sodium bicarbonate*)	T3	PA QL (60 packs/30 days) HD
ZEGERID 40 MG CAPSULE (*omeprazole-sodium bicarbonate*)	T3	PA QL (30 caps/30 days) HD
ZEGERID 40 MG PACKET (*omeprazole-sodium bicarbonate*)	T3	PA QL (30 packs/30 days) HD
RECTAL PREPARATIONS		
ANUSOL-HC 25 MG SUPPOSITORY (*hydrocortisone acetate*)	T3	PA
hydrocortisone acetate	T1	
SBS - GLUCAGON-LIKE PEPTIDE-2 (GLP-2) ANALOGS		
GATTEX	T4	PA SP HD
GASTROINTESTINAL (Pain Relief And Inflammatory Disease)		
HEMORRHOID PREP, ANTI-INFLAM STEROID-LOCAL ANESTHET		
ANA-LEX	T1	
ANALPRAM HC	T3	PA
ANALPRAM HC (*hydrocortisone-pramoxine*)	T3	
hydrocortisone/lidocaine/aloe	T1	
hydrocortisone/pramoxine (Analpram Hc)	T1	
lidocaine/hydrocortisone ac	T1	
LIDOCAINE-HYDROCORTISONE	T1	
PROCORT	T3	
PROCTOFOAM-HC	T2	
KERATINOCYTE GROWTH FACTOR (KGF)		
KEPIVANCE	T4	SP
RECTAL/LOWER BOWEL PREP., GLUCOCORT. (NON-HEMORR)		
budesonide 2 mg rectal foam	T1	QL(2 kits/180 days)

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GASTROINTESTINAL (Pain Relief And Inflammatory Disease) *(con't.)*		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
RECTAL/LOWER BOWEL PREP., GLUCOCORT. (NON-HEMORR) *(cont.)*		
CORTENEMA (*hydrocortisone*)	T3	
CORTIFOAM	T3	PA
hydrocortisone (Cortenema)	T1	
TARPEYO	T4	PA QL (4 caps/day) SP
UCERIS 2 MG RECTAL FOAM	T3	PA QL (2 kits/180 days)
HEMATOPOIETIC GROWTH FACTORS (MISCELLANEOUS)		
HYPOXIA INDUCIBLE FACTOR PROLYL HYDROXYLASE INH.		
VAFSEO 150 MG TABLET	T3	PA QL(1 TAB/DAY)
VAFSEO 300 MG TABLET	T3	PA QL(2 TABS/DAY)
HORMONES (Hormonal Agents)		
ADRENAL STEROID INHIBITORS		
ISTURISA	T4	PA QL (2 tabs/day) SP
RECORLEV	T4	PA QL (8 tabs/day) SP
ADRENOCORTICOTROPHIC HORMONES		
ACTHAR	T4	PA SP HD
ACTHREL	T4	SP
CORTROSYN (*cosyntropin*)	T3	
cosyntropin (Cortrosyn)	T1	
ANDROGEN/ESTROGEN PREPS FOR FEMALE SEXUAL DYSFUNC		
INTRAROSA	T3	
ANDROGENIC AGENTS		
ANADROL-50	T2	PA
ANDRODERM	T2	PA QL (1 patch/day)
ANDROGEL 1% (25 MG/2.5 G) PKT (*testosterone*)	T3	PA QL (150gm/30 days)
ANDROGEL 1% (50 MG/5 G) PKT (*testosterone*)	T3	PA QL (2 packs/day)
ANDROGEL 1.62% GEL PUMP (*testosterone*)	T3	PA QL (150gm/30 days)
ANDROGEL 1.62% (1.25G) GEL PCKT (*testosterone*)	T3	PA QL (2 packs/day)
ANDROGEL 1.62% (2.5G) GEL PCKT (*testosterone*)	T3	PA QL (150gm/30 days)
AVEED	T3	PA SP
AZMIRO	T3	
JATENZO 158, 198 MG CAPSULE	T3	PA QL (4 caps/day)
JATENZO 237 MG CAPSULE	T3	PA QL (2 caps/day)
KYZATREX	T3	PA QL (60 tabs/30 days)

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HORMONES (Hormonal Agents) *(con't.)*		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
ANDROGENIC AGENTS *(cont.)*		
METHITEST	T1	
methyltestosterone	T1	
NATESTO	T3	PA QL (3 bots/30 days)
oxandrolone	T1	PA
TESTIM (*testosterone*)	T3	PA QL (2 tubes/day)
TESTOPEL	T3	PA
testosterone 1% (25mg/2.5g) pk (Androgel)	T1	PA QL (150gm/30 days)
testosterone 1% (50 mg/5 g) pk (Vogelxo)	T1	PA QL (2 packs/day)
testosterone 1.62% (2.5 g) pkt (Androgel)	T1	PA QL (150gm/30 days)
testosterone 1.62% gel pump (Androgel)	T1	PA QL (150gm/30 days)
testosterone 1.62% (1.25 g) pkt (Androgel)	T1	PA QL (2 packs/day)
testosterone 10 mg gel pump	T1	PA QL (120 gm/30 days)
TESTOSTERONE 12.5 MG/1.25 GRAM	T1	PA QL (150gm/30 days)
testosterone 12.5 mg/1.25 gram (Vogelxo)	T1	PA QL (150gm/30 days)
testosterone 30 mg/1.5 ml pump	T1	PA QL (180ml/30 days)
testosterone 50 mg/5 gram gel (Vogelxo)	T1	PA QL (2 tubes/day)
TESTOSTERONE 50 MG/5 GRAM PKT	T1	PA QL (2 packs/day)
TESTRED (*methyltestosterone*)	T3	
TLANDO	T3	PA QL (4/day)
UNDECATREX	T3	PA
VOGELXO 12.5 MG/1.25 GRAM PUMP	T3	PA QL (150gm/30 days)
VOGELXO 50 MG/5 GRAM GEL (*testosterone*)	T3	PA QL (2 tubes/day)
VOGELXO 50 MG/5 GRAM GEL PACKT	T3	PA QL (2 packs/day)
XYOSTED	T3	PA QL (4 injectors/28 days)
ANTI-DIURETIC AND VASOPRESSOR HORMONES		
DDAVP 0.01% NASAL SPRAY (*desmopressin acetate*)	T3	PA
DDAVP 0.1 MG TABLET (*desmopressin acetate*)	T3	PA HD
DDAVP 0.2 MG TABLET (*desmopressin acetate*)	T3	PA HD
DDAVP 10 MCG/0.1 ML SOLUTION	T3	PA
DDAVP 4 MCG/ML AMPUL (*desmopressin acetate*)	T4	PA SP
DDAVP 4 MCG/ML VIAL (*desmopressin acetate*)	T4	PA SP
desmopressin 0.01% (Ddavp)	T1	HD
desmopressin 10 mcg/0.1 ml spr (Ddavp)	T1	HD
desmopressin 40 mcg/10 ml vial (Ddavp)	T4	SP

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HORMONES (Hormonal Agents) *(con't.)*		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
ANTI-DIURETIC AND VASOPRESSOR HORMONES *(cont.)*		
desmopressin ac 4 mcg/ml ampul (Ddavp)	T4	SP
desmopressin ac 4 mcg/ml vial (Ddavp)	T4	SP
desmopressin acetate 0.1 mg tb (Ddavp)	T1	
desmopressin acetate 0.2 mg tb (Ddavp)	T1	
NOCDURNA	T3	PA
NOCTIVA	T3	PA
STIMATE	T4	SP
vasopressin in 0.9 % nacl	T1	
VASOPRESSIN-0.9% NACL	T3	
VASOPRESSIN-D5W	T1	
VASOSTRICT	T3	
ESTROGEN AND PROGESTIN COMBINATIONS		
BIJUVA	T3	
ESTROGEN/ANDROGEN COMBINATIONS		
ESTRATEST F.S. (estrogen,ester/me-testosterone)	T3	PA HD
estrogen, ester/me-testosterone (Estratest F.S.)	T1	HD
ESTROGENIC AGENTS		
ACTIVELLA (*mimvey*)	T3	HD
ALORA	T3	QL (16 patches/28 days) HD
CLIMARA (*estradiol (once weekly)*)	T3	HD
CLIMARA PRO	T3	HD
COMBIPATCH	T3	HD
DELESTROGEN (*estradiol valerate*)	T3	PA HD
DEPO-ESTRADIOL	T3	HD
DIVIGEL	T2	HD
ELESTRIN	T3	HD
ESTRACE (*estradiol*)	T3	HD
estradiol 0.06% 1.25g gel pump (Estrogel)	T1	HD
estradiol (Climara)	T1	HD
estradiol (Vivelle-dot)	T1	QL (16 patches/28 days) HD
estradiol 0.025 mg patch(2/wk) (Minivelle)	T1	QL (16 patches/28 days) HD
estradiol 0.025 mg patch(2/wk) (Vivelle-Dot)	T1	QL (16 patches/28 days) HD
estradiol 0.0375mg patch(2/wk) (Minivelle)	T1	QL (16 patches/28 days) HD
estradiol 0.0375mg patch(2/wk) (Vivelle-Dot)	T1	QL (16 patches/28 days) HD

T1 – Typically Generics
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List of Prescription Medications

HORMONES (Hormonal Agents) *(con't.)*		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
ESTROGENIC AGENTS *(cont.)*		
estradiol 0.05 mg patch (2/wk) (Minivelle)	T1	QL (16 patches/28 days) HD
estradiol 0.075 mg patch(2/wk) (Minivelle)	T1	QL (16 patches/28 days) HD
estradiol 0.075 mg patch(2/wk) (Vivelle-Dot)	T1	QL (16 patches/28 days) HD
estradiol 0.1 mg patch (2/wk) (Minivelle)	T1	QL (16 patches/28 days) HD
estradiol 0.1 mg patch (2/wk) (Vivelle-Dot)	T1	QL (16 patches/28 days) HD
estradiol 0.5 mg tablet (Estrace)	T1	HD
estradiol 1 mg tablet (Estrace)	T1	HD
estradiol 2 mg tablet (Estrace)	T1	HD
estradiol valerate (Delestrogen)	T1	HD
estradiol/norethindrone acet (Activella)	T1	HD
ESTROGEL *(estradiol)*	T2	HD
EVAMIST	T3	HD
FEMHRT (*norethindron-ethinyl estradiol*)	T3	HD
MENEST	T3	HD
MENOSTAR	T3	QL (8 patches/28 days) HD
MINIVELLE (*Iyllana*)	T3	QL (16 patches/28 days) HD
norethind-eth estrad 0.5-2.5 (Femhrt)	T1	HD
norethindrone ac/eth estradiol	T1	HD
norethindrone ac-eth estradiol (Femhrt)	T1	HD
norethin-eth estrad 1 mg-5 mcg	T1	HD
PREMARIN	T2	HD
PREMPHASE	T2	HD
PREMPRO	T2	HD
VIVELLE-DOT (*estradiol*)	T3	QL (16 patches/28 days) HD
ESTROGEN-PROGESTIN WITH ANTI-MINERALOCORTICOID COMB		
ANGELIQ	T3	HD
ESTROGEN-SELECTIVE ESTROGEN RECEPTOR MOD (SERM) COMB		
DUAVEE	T2	
GLUCOCORTICOIDS		
AGAMREE	T4	PA QL(10 mls/day) SP
ALKINDI SPRINKLE	T3	PA
BETA 1	T3	
betamethasone acetate, sod phos (Celestone)	T1	
BSP 0820	T3	

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HORMONES (Hormonal Agents) *(con't.)*		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
GLUCOCORTICOIDS *(cont.)*		
budesonide (Entocort Ec)	T1	
budesonide (Uceris)	T1	PA QL (56 tabs/180 days)
CELESTONE (*betamethasone sod phos-acetate*)	T2	
CORTEF (*hydrocortisone*)	T3	PA
cortisone acetate	T1	
deflazacort	T4	PA SP HD
DEPO-MEDROL	T3	
dexamethasone (Dxevo)	T1	
dexamethasone 0.5 mg tablet	T1	
dexamethasone 0.5 mg/5 ml elx	T1	
dexamethasone 0.5 mg/5 ml liq	T1	
dexamethasone 0.75 mg tablet	T1	
dexamethasone 1 mg tablet	T1	
dexamethasone 1.5 mg tablet	T1	
dexamethasone 10 day 1.5 mg tb	T1	PA
DEXAMETHASONE 10 MG/ML SYRING	T3	
dexamethasone 10 mg/ml vial	T1	
dexamethasone 100 mg/10 ml vl	T1	
dexamethasone 120 mg/30 ml vl	T1	
dexamethasone 13 day 1.5 mg tb	T1	PA
dexamethasone 2 mg tablet	T1	
dexamethasone 20 mg/5 ml vial	T1	
dexamethasone 4 mg tablet	T1	
dexamethasone 4 mg/ml syringe	T1	
dexamethasone 4 mg/ml vial	T1	
dexamethasone 6 day 1.5 mg tab (Taperdex)	T1	PA
dexamethasone 6 mg tablet	T1	
dexamethasone in 0.9 % sod chl	T1	
DXEVO	T3	
EMFLAZA	T4	PA SP HD
ENTOCORT EC (*budesonide ec*)	T3	
EOHILIA	T3	PA QL(1800 mls/180 days)
HEMADY	T3	
hydrocortisone (Cortef)	T1	

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HORMONES (Hormonal Agents) *(con't.)*		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
GLUCOCORTICOIDS *(cont.)*		
KENALOG-10	T3	
KENALOG-40 (*triamcinolone acetonide*)	T3	
KENALOG-80	T3	
KHINDIVI	T4	PA SP
LOCORT	T1	
MEDROL 16 MG TABLET (*methylprednisolone*)	T3	
MEDROL 2 MG TABLET	T2	
MEDROL 32 MG TABLET (*methylprednisolone*)	T3	
MEDROL 4 MG DOSEPAK (*methylprednisolone*)	T3	
MEDROL 4 MG TABLET (*methylprednisolone*)	T3	
MEDROL 8 MG TABLET (*methylprednisolone*)	T3	
MEDROLOAN II SUIK	T3	
methylprednisolone (Medrol)	T1	
methylprednisolone acetate (Depo-medrol)	T1	
methylprednisolone sod succ	T1	
methylprednisolone sod succ (Solu-medrol)	T1	
MILLIPRED 10 MG/5 ML SOLUTION (*prednisolone sodium phosphate*)	T3	
millipred 5 mg tablet	T1	
NGENLA	T4	PA SP
ORAPRED ODT (*prednisolone sodium phos odt*)	T3	
P-CARE D80G	T1	
P-CARE K80	T1	
POD-CARE 100C	T1	
prednisolone	T1	
prednisolone sodium phosphate	T1	
prednisolone sodium phosphate (Millipred)	T1	
prednisolone sodium phosphate (Orapred Odt)	T1	
prednisone	T1	
PRO-C-DURE 5	T3	
PRO-C-DURE 6	T3	
RAYOS	T3	PA
READYSHARP BETAMETHASONE	T1	
SOLU-CORTEF	T3	
SOLU-MEDROL	T3	

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HORMONES (Hormonal Agents) *(con't.)*		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
GLUCOCORTICOIDS *(cont.)*		
TAPERDEX	T1	PA
triamcinolone acetonide (Kenalog-40)	T1	
UCERIS 9 MG ER TABLET (*budesonide er*)	T3	PA QL (1 tab/day)
ZCORT	T3	PA
ZILRETTA	T3	PA
ZONACORT	T3	
GROWTH HORMONE RELEASING HORMONE (GHRH) AND ANALOGS		
EGRIFTA	T4	PA SP HD
EGRIFTA SV	T4	PA SP HD
GROWTH HORMONES		
GENOTROPIN	T4	PA SP HD
HUMATROPE	T4	PA SP HD
NGENLA	T4	PA SP
NORDITROPIN FLEXPRO	T4	PA SP HD
NUTROPIN AQ NUSPIN	T4	PA SP HD
OMNITROPE	T4	PA SP HD
SAIZEN	T4	PA SP HD
SAIZEN-SAIZENPREP	T4	PA HD
SEROSTIM	T4	PA SP HD
SKYTROFA	T4	PA SP HD
SOGROYA	T4	PA SP
ZOMACTON	T4	PA SP HD
INSULIN-LIKE GROWTH FACTOR-I (IGF-I) HORMONES		
INCRELEX	T4	PA SP HD
LHRH (GNRH) AGONIST ANALOG AND PROGESTIN COMB		
LUPANETA PACK	T4	PA SP HD
LHRH (GNRH) AGONIST ANALOG PITUITARY SUPPRESSANTS		
LUPRON DEPOT	T4	PA SP HD
SYNAREL	T4	PA SP HD
LHRH (GNRH) ANTAGONIST, ESTROGEN AND PROGESTIN COMB		
MYFEMBREE	T2	PA QL (24 month therapy)
ORIAHNN	T2	PA QL (2 caps/day)
LHRH (GNRH) ANTAGONIST, PITUITARY SUPPRESSANT AGENTS		
CETROTIDE	T4	PA SP

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HORMONES (Hormonal Agents) *(con't.)*		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
LHRH (GNRH) ANTAGONIST, PITUITARY SUPPRESSANT AGENTS *(con't.)*		
ganirelix acet 250 mcg/0.5 ml (Ganirelix Acetate)	T4	PA SP
GANIRELIX ACET 250 MCG/0.5 ML (*ganirelix acetate*)	T4	PA SP
ORILISSA 150 MG TABLET	T2	PA QL (24 months of treament/lifetime)
ORILISSA 200 MG TABLET	T2	PA QL (2 tabs/day)
LHRH (GNRH) AGNST PIT.SUP-CENTRAL PRECOCIOUS PUBERTY		
FENSOLVI	T4	PA SP
LUPRON DEPOT-PED	T4	PA SP HD
SUPPRELIN LA	T4	PA SP HD
TRIPTODUR	T4	PA SP
MINERALOCORTICOIDS		
fludrocortisone acetate	T1	HD
OXYTOCICS		
CARBOPROST TROMETHAMINE	T3	
CERVIDIL	T3	
HEMABATE	T3	
methylergonovine maleate	T1	
oxytocin (Pitocin)	T1	
OXYTOCIN-D5-LACTATED RINGERS	T1	
OXYTOCIN-D5W	T1	
OXYTOCIN-LACTATED RINGERS	T1	
PITOCIN (*oxytocin*)	T3	
PREPIDIL	T3	
PROSTIN E2 VAGINAL SUPPOSITORY	T3	
PITUITARY SUPPRESSIVE AGENTS		
cabergoline	T1	QL (16 tabs/28 days) HD
CRENESSITY 50 MG CAPSULE	T3	PA QL(2 caps/day) SP
CRENESSITY 100 MG CAPSULE	T3	PA QL SP
CRENESSITY 50 MG/ML SOLUTION	T3	PA QL(8 mls/day) SP
danazol	T1	HD
PROGESTATIONAL AGENTS		
CRINONE 4% GEL	T3	PA HD
DEPO-PROVERA 400 MG/ML VIAL	T2	HD
hydroxyprogesterone caproat/pf	T1	PA

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List of Prescription Medications

HORMONES (Hormonal Agents) *(con't.)*		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
PROGESTATIONAL AGENTS *(con't.)*		
hydroxyprogesterone caproate	T1	PA
medroxyprogesterone 2.5 mg, 5 mg, 10 mg tab (Provera)	T1	HD
norethindrone acetate	T1	HD
progesterone capsule (Prometrium)	T1	HD
progesterone 500 mg/10 ml vial	T4	SP HD
PROMETRIUM (*progesterone*)	T3	PA HD
PROVERA (*medroxyprogesterone acetate*)	T3	PA HD
RENIN-ANGIOTENSIN-ALDOSTERONE SYS. (RAAS) HORMONES		
GIAPREZA	T4	SP
SOMATOSTATIC AGENTS		
lanreotide 120 mg/0.5 ml syrng	T4	PA SP HD
LANREOTIDE 120 MG/0.5 ML SYRNG	T4	PA SP HD
MYCAPSSA	T4	PA QL (4 caps/day) SP
octreotide acetate (Sandostatin)	T4	PA SP HD
SANDOSTATIN 0.05 MG/ML AMPUL (*octreotide acetate*)	T4	PA SP HD
SANDOSTATIN 0.1 MG/ML AMPUL (*octreotide acetate*)	T4	PA SP HD
SANDOSTATIN 0.5 MG/ML AMPUL (*octreotide acetate*)	T4	PA SP HD
SANDOSTATIN LAR DEPOT	T4	PA SP
SIGNIFOR	T4	PA SP
SIGNIFOR LAR	T4	PA SP
SOMATULINE DEPOT	T4	PA SP HD
VAGINAL ESTROGEN FOR SEXUAL DYSFUNCTION		
IMVEXXY 10 MCG MAINTENANCE PAK	T3	QL (16/28 days) HD
IMVEXXY 10 MCG STARTER PACK	T3	QL (36/28 days) HD
IMVEXXY 4 MCG MAINTENANCE PACK	T3	QL (16/28 days) HD
IMVEXXY 4 MCG STARTER PACK	T3	QL (36/28 days) HD
VAGINAL ESTROGEN PREPARATIONS		
ESTRACE (*estradiol*)	T3	HD
estradiol (Vagifem)	T1	QL (36 tabs/28 days) HD
estradiol 0.01% cream (Estrace)	T1	HD
estradiol 10 mcg vaginal insrt (Vagifem)	T1	QL (36 tabs/28 days) HD
ESTRING	T2	QL (2 rings/90 days) HD
FEMRING	T3	HD
PREMARIN	T2	HD
VAGIFEM (*yuvafem*)	T3	QL (36 tabs/28 days) HD

List of Prescription Medications

HORMONES (Infertility)		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
FERTILITY STIMULATING PREPARATIONS, NON-FSH		
clomiphene citrate	T1	
FOLLICLE-STIMULATING AND LUTEINIZING HORMONES		
MENOPUR	T4	PA SP
FOLLICLE-STIMULATING HORMONE (FSH)		
FOLLISTIM AQ	T4	PA SP
GONAL-F	T4	PA SP
GONAL-F RFF	T4	PA SP
GONAL-F RFF REDI-JECT	T4	PA SP
HUMAN CHORIONIC GONADOTROPIN (HCG)		
CHORIONIC GONAD 10,000 UNIT VL	T4	PA SP
CHORIONIC GONAD 12,000 UNIT VL	T4	SP
CHORIONIC GONAD 6,000 UNIT VL	T4	SP
NOVAREL 10,000 UNITS VIAL	T4	PA SP
NOVAREL 5,000 UNIT VIAL	T4	PA SP
OVIDREL	T4	PA SP
PREGNYL	T4	PA SP
FACILITATING/MAINTAINING AGENT, HORMONAL		
CRINONE 8% GEL	T2	
ENDOMETRIN	T2	
PREGNANCY FACILITATING/MAINTAINING AGENT, HORMONAL		
hydroxyprogest 1, 250 mg/5 ml	T1	PA
hydroxyprogest 250 mg/ml vial	T1	PA
MAKENA	T3	PA
MAKENA (*hydroxyprogesterone caproate*)	T4	PA SP
HORMONES (Miscellaneous)		
LEPTIN HORMONE ANALOGS		
MYALEPT	T4	PA SP HD
HORMONES (Osteoporosis Products)		
BONE FORMATION STIMULATING AGTS - PTH REL PEPTIDES		
TYMLOS	T4	PA QL (1 pen/30 days) SP HD
BONE RESORPTION INHIBITORS		
JESDUVROQ 1 MG, 2 MG, 4 MG TABLET	T3	PA QL(1 tab/day)
JESDUVROQ 6 MG TABLET	T3	PA QL(2 tabs/day)
JESDUVROQ 8 MG TABLET	T3	PA QL(3 tabs/day)

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List of Prescription Medications

HORMONES (Osteoporosis Products) *(con't.)*		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
BONE RESORPTION INHIBITORS *(con't.)*		
calcitonin, salmon, synthetic	T1	HD
WYOST	T2	PA SP
IMMUNOSUPPRESSANTS (Miscellaneous)		
IMMUNOSUPPRESSANT-INTERFERON GAMMA INHIBITOR, MAB		
GAMIFANT	T4	PA SP
IMMUNOSUPPRESSANTS (Pain Relief And Inflammatory Disease)		
ANTI-CD19 (B LYMPHOCYTE) MONOCLONAL ANTIBODY		
UPLIZNA	T4	PA SP
IL-23 RECEPTOR ANTAGONIST, MONOCLONAL ANTIBODY		
OMVOH 100 MG/ML SYRINGE	T4	PA QL SP HD
OMVOH 300 MG/15 ML VIAL	T4	PA SP HD
OMVOH PEN	T4	PA QL(2 pens/28 days) SP HD
INTERLEUKIN-4(IL-4) RECEPTOR ALPHA ANTAGONIST, MAB		
DUPIXENT PEN	T4	PA SP HD
DUPIXENT SYRINGE	T4	PA SP HD
INTERLEUKIN-6 (IL-6) RECEPTOR INHIBITORS		
ACTEMRA 80 MG/4 ML VIAL	T4	PA SP HD
ACTEMRA 162 MG/0.9 ML SYRINGE	T4	PA QL (4 syringes/28 days) SP HD
ACTEMRA 200 MG/10 ML VIAL	T4	PA SP HD
ACTEMRA 400 MG/20 ML VIAL	T4	PA SP HD
ACTEMRA ACTPEN	T4	PA QL (4 pens/28 days) SP HD
ENSPRYNG	T4	PA SP HD
KEVZARA 150 MG/1.14 ML PEN INJ	T4	PA QL (2 pens/28 days) SP HD
KEVZARA 150 MG/1.14 ML SYRINGE	T4	PA QL (2 syrings/28 days) SP HD
KEVZARA 200 MG/1.14 ML PEN INJ	T4	PA QL (2 pens/28 days) SP HD
KEVZARA 200 MG/1.14 ML SYRINGE	T4	PA QL (2 syrings/28 days) SP HD
TOFIDENCE	T4	PA SP
TYENNE	T4	PA QL(3.6 ml/28 days) SP
IMMUNOSUPPRESSANTS (Transplant Medications)		
MONOCLONAL ANTIBODY-HUMAN INTERLEUKIN 12/23 INHIB		
IMULDOSA	T4	PA QL(1 syringe/84 days) SP
OTULFI	T4	PA QL(1 syringe/84 days) SP
PYZCHIVA	T4	PA QL(1 syringe/84 days) SP

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IMMUNOSUPPRESSANTS (Transplant Medications) *(con't.)*		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
MONOCLONAL ANTIBODY-HUMAN INTERLEUKIN 12/23 INHIB *(con't.)*		
SELARSDI	T4	PA QL(1 syringe/84 days) SP
STELARA 130 MG/26 ML VIAL	T4	PA SP HD
STELARA 45 MG/0.5 ML SYRINGE	T4	PA QL (1 syringe/84 days) SP HD
STELARA 45 MG/0.5 ML VIAL	T4	PA QL (1 vial/84 days) SP HD
STELARA 90 MG/ML SYRINGE	T4	PA QL (1 syringe/84 days) SP HD
STEQEYMA	T4	PA QL(1 syringe/84 days) SP
USTEKINUMAB-AEKN SC	T4	PA QL(1 syringe/84 days) SP
USTEKINUMAB SC	T4	PA QL(1 syringe/84 days) SP
USTEKINUMAB-TTWE	T4	PA QL(1 syringe/84 days) SP HD
YESINTEK	T4	PA QL(1 syringe/84 days) SP
TOPICAL IMMUNOSUPPRESSIVE AGENTS		
ELIDEL (*pimecrolimus*)	T3	
pimecrolimus (Elidel)	T1	
PROTOPIC (*tacrolimus*)	T3	
tacrolimus 0.03% ointment (Protopic)	T1	
tacrolimus 0.1% ointment (Protopic)	T1	
IMMUNOSUPP - MONOCLONAL AB INHIBITING T LYMPH FXN		
SIMULECT	T4	SP
IMMUNOSUPPRESSIVES		
ASTAGRAF XL	T4	SP HD
AZASAN	T4	SP HD
azathioprine (Imuran)	T4	PA SP HD
azathioprine sodium	T1	PA
CELLCEPT 200 MG/ML ORAL SUSP (*mycophenolate mofetil*)	T4	PA SP HD
CELLCEPT 250 MG CAPSULE (*mycophenolate mofetil*)	T4	PA SP HD
CELLCEPT 500 MG TABLET (*mycophenolate mofetil*)	T4	PA SP HD
CELLCEPT 500 MG VIAL (*mycophenolate mofetil*)	T4	SP
cyclosporine 100 mg capsule (Sandimmune)	T4	SP HD
cyclosporine 25 mg capsule (Sandimmune)	T4	SP HD
cyclosporine 250 mg/5 ml ampul (Sandimmune)	T4	SP
cyclosporine, modified	T4	SP HD
cyclosporine, modified (Neoral)	T4	SP HD
ENVARSUS XR	T4	SP HD
everolimus (Zortress)	T4	SP HD

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IMMUNOSUPPRESSANTS (Transplant Medications) *(con't.)*		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
IMMUNOSUPPRESSIVES *(cont.)*		
IMURAN (*azathioprine*)	T4	SP HD
LUPKYNIS	T4	PA SP QL (6 caps/day)
mycophenolate 200 mg/ml susp (Cellcept)	T4	SP HD
mycophenolate 250 mg capsule (Cellcept)	T4	SP HD
mycophenolate 500 mg tablet (Cellcept)	T4	SP HD
mycophenolate 500 mg vial (Cellcept)	T4	SP
mycophenolate sodium (Myfortic)	T4	SP HD
MYFORTIC (*mycophenolic acid*)	T4	PA SP HD
MYHIBBIN	T4	PA SP
NEORAL (*gengraf*)	T1	PA SP HD
NULOJIX	T4	SP
PROGRAF 0.2 MG GRANULE PACKET	T4	SP HD
PROGRAF 0.5 MG CAPSULE (*tacrolimus*)	T4	SP HD
PROGRAF 1 MG CAPSULE (*tacrolimus*)	T4	SP HD
PROGRAF 1 MG GRANULE PACKET	T4	SP HD
PROGRAF 5 MG CAPSULE (*tacrolimus*)	T4	SP HD
PROGRAF 5 MG/ML AMPULE	T4	SP
RAPAMUNE (*sirolimus*)	T4	PA SP HD
SANDIMMUNE 100 MG CAPSULE (*cyclosporine*)	T4	PA SP HD
SANDIMMUNE 100 MG/ML SOLN	T4	SP HD
SANDIMMUNE 25 MG CAPSULE (*cyclosporine*)	T1	PA SP HD
SANDIMMUNE 50 MG/ML AMPUL (*cyclosporine*)	T4	PA SP
sirolimus (Rapamune)	T4	SP HD
tacrolimus capsule (ir) (Prograf)	T4	SP HD
ZORTRESS	T4	SP HD
MISCELLANEOUS MEDICAL SUPPLIES, DEVICES, NON-DRUG (Diabetes)		
BLOOD SUGAR DIAGNOSTICS		
BLULINK GLUCOSE TEST STRIP	T3	
CONTOUR PLUS TEST STRIP	T3	
EASY TOUCH BLULINK TEST STRIP	T3	
DIABETIC SUPPLIES		
2TEK CONTROL SOLUTION	T1	
2TEK GLUCOSE-WRIST MONITOR KIT	T3	
ACCU-CHEK	T1	

List of Prescription Medications

MISCELLANEOUS MEDICAL SUPPLIES, DEVICES, NON-DRUG (Diabetes) *(con't.)*

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
DIABETIC SUPPLIES *(cont.)*		
ACCU-CHEK FASTCLIX LANCING DEV	T1	
ACCU-CHEK GUIDE CONTROL SOLN	T1	
ACCU-CHEK SMARTVIEW CONTRL SOL	T1	
ACCU-CHEK SOFTCLIX	T1	
ACCUTREND GLUCOSE CONTROL	T1	
ADJUSTABLE LANCING DEVICE	T1	
ADVANCED LANCING DEVICE	T1	
ADVOCATE CONTROL SOLUTION	T1	
ADVOCATE LANCING DEVICE	T1	
ADVOCATE RAPID-SAFE LANCING DV	T1	
ADVOCATE REDI-CODE+ CTRL SOLN	T1	
AGAMATRIX CONTROL	T1	
ALKALINE BATTERIES	T1	
ALTERNATE SITE LANCING DEVICE	T1	
AQUA LANCE LANCING DEVICE	T1	
ASSURE 4 CONTROL SOLUTION	T1	
ASSURE DOSE	T1	
ASSURE PRISM	T1	
AT HOME A1C	T1	
AUTOJECT 2	T1	
AUTO-LANCET MINI	T1	
AUTOLET IMPRESSION	T1	
AUTOLET LANCING DEVICE	T1	
AUTOLET PLUS	T1	
AUTOPEN	T1	
BLOOD-GLUCOSE CONTROL	T1	
BLULINK DIABETIC TEST BUNDLE	T3	
BLULINK DIABETIC TEST BUNDLE	T3	
BREEZE 2	T1	
CAREONE	T1	
CARESENS	T3	
CARETOUCH CONTROL SOLUTION	T1	
CARETOUCH LANCING DEVICE	T1	
CEQUR SIMPLICITY	T2	

List of Prescription Medications

MISCELLANEOUS MEDICAL SUPPLIES, DEVICES, NON-DRUG (Diabetes) *(con't.)*

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
DIABETIC SUPPLIES *(cont.)*		
CHOSEN LANCING DEVICE	T1	
CLEVER CHOICE CONTROL SOLUTION	T1	
CONTOUR	T1	
CONTOUR METER	T1	
CONTOUR NEXT CONTROL SOLUTION	T1	
CONTROL SOLUTION	T1	
COOL CONTROL SOLUTION	T1	
DEXCOM	T3	
DEXCOM G4	T3	
DEXCOM G5	T3	
DEXCOM G5-G4 SENSOR	T3	
DEXCOM G6 RECEIVER	T2	PA QL (1 syringe/365 days)
DEXCOM G6 SENSOR	T2	PA QL (3/30 days)
DEXCOM G6 TRANSMITTER	T2	PA QL (1 syringe/67 days)
DEXCOM G7 SENSOR	T2	PA QL(3 sensors/30 days)
DEXCOM G7 RECEIVER	T2	PA QL(1 unit/365 days)
DIATRUE	T1	
DROPLET GENTEEL LANCING DEVICE	T1	
DROPLET LANCING DEVICE	T1	
EASY MINI EJECT LANCING DEVICE	T1	
EASY PLUS II BLOOD GLUCOSE SYS	T1	
EASY PLUS II CONTROL SOLN HIGH	T1	
EASY PLUS II CONTROL SOLN LOW	T1	
EASY STEP CONTROL SOLUTION	T1	
EASY TALK BLOOD GLUCOSE METER	T1	
EASY TALK CONTROL SOLN LOW	T1	
EASY TALK HIGH CONTROL SOLN	T1	
EASY TALK PLUS II HIGH CONTROL	T1	
EASY TALK PLUS II LOW CTRL SLN	T1	
EASY TOUCH BLULINK CTRL SOLN	T1	
EASY TOUCH BLULINK GLUC SYST	T3	
EASY TOUCH CONTROL SOLUTION	T1	
EASY TOUCH LANCING DEVICE	T1	
EASY TRAK BLOOD GLUCOSE METER	T1	

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MISCELLANEOUS MEDICAL SUPPLIES, DEVICES, NON-DRUG (Diabetes) *(con't.)*		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
DIABETIC SUPPLIES *(cont.)*		
EASY TRAK CONTROL SOLN HIGH	T1	
EASY TRAK CONTROL SOLN LOW	T1	
EASYGLUCO PLUS CONTROL NORMAL	T1	
EASYMAX 15 LEVEL 2 SOLUTION	T1	
EASYMAX NORMAL CONTROL SOLN	T1	
ELEMENT COMPACT CONTROL SOLN	T1	
ELEMENT CONTROL SOLUTION	T1	
EMBRACE EVO BLOOD GLUCOSE KIT	T1	
EMBRACE EVO BLOOD GLUCOSE MTR	T1	
EMBRACE EVO LEVEL 1 CTRL SOLN	T1	
EMBRACE GLUC CONTROL SOLN HIGH	T1	
EMBRACE GLUCOSE CONTROL SOLN	T1	
EMBRACE LANCING DEVICE	T1	
EMBRACE PRO	T1	
EMBRACE TALK CONTROL SOLUTION	T1	
EMBRACE WAVE PLUS GLUCOSE MTR	T1	
ENLITE	T1	
ENLITE GLUCOSE SENSOR	T1	
ENLITE SERTER	T1	
EVENCARE G2 BLOOD GLUCOSE SYS	T1	
EVENCARE G2 CONTROL SOLUTION	T1	
EVENCARE G3 BLOOD GLUCOSE SYS	T1	
EVENCARE G3 CONTROL SOLUTION	T1	
EVERSENSE SENSOR-HOLDER	T3	
EVERSENSE SMART TRANSMITTER	T3	
EVOLUTION CONTROL SOLUTION	T1	
EZ-VAC	T1	
FORA CONTROL SOLUTION	T1	
FORA LANCING DEVICE	T1	
FORACARE GDH	T1	
FORA TN'GO ADVANCE MULTIFN MTR	T3	
FORTISCARE	T1	
FREESTYLE CONTROL SOLUTION	T1	
FREESTYLE LIBRE 2 READER	T2	PA QL (1 reader/day)

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MISCELLANEOUS MEDICAL SUPPLIES, DEVICES, NON-DRUG (Diabetes) *(con't.)*

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
DIABETIC SUPPLIES *(cont.)*		
FREESTYLE LIBRE 2 SENSOR	T2	PA QL (2 sensors/21 days)
FREESTYLE LIBRE 3 READER	T2	PA QL(1 unit/720 days)
FREESTYLE LIBRE 3 PLUS SENSOR	T2	PA QL(2 units/28 days)
FREESTYLE LIBRE 10 DAY READER	T2	PA QL (1 reader/day)
FREESTYLE LIBRE 10 DAY SENSOR	T2	PA QL (3/30 days)
FREESTYLE LIBRE 14 DAY READER	T2	PA QL (1 reader/day)
FREESTYLE LIBRE 14 DAY SENSOR	T2	PA QL (2/28 days)
FREESTYLE NAVIGATOR	T3	
GE100 CONTROL SOLUTION NORMAL	T1	
GE333 BLOOD GLUCOSE TEST STRIP	T3	
GE333 BLOOD GLUCOSE SYSTEM	T3	
GENTEEL VACUUM LANCING DEVICE	T1	
GLUCOCARD 01 CONTROL	T1	
GLUCOCARD EXPRESSION CNTRL SLN	T1	
GLUCOCARD EXPRESSION METER	T1	
GLUCOCARD EXPRESSION METER KIT	T1	
GLUCOCARD SHINE CONTROL SOLN	T1	
GLUCOCARD SHINE METER	T1	
GLUCOCARD SHINE METER KIT	T1	
GLUCOCOM AUTOLINK	T1	
GLUCOCOM CONTROL SOLUTION	T1	
GLUCOSE CONTROL	T1	
GLUCOSE CONTROL SOLUTION	T1	
GOJJI GLUCOSE CONTROL SOLUTION	T1	
GOJJI LANCING DEVICE	T1	
GUARDIAN CONNECT TRANSMITTER	T3	
GUARDIAN LINK 3	T3	
GUARDIAN REAL-TIME	T3	
GUARDIAN RT CHARGER	T1	
GUARDIAN RT STARTER KIT	T3	
GUARDIAN SENSOR 3	T3	
GUARDIAN TEST PLUG	T1	
HUMAPEN LUXURA HD	T3	
INPEN (FOR HUMALOG)	T1	

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MISCELLANEOUS MEDICAL SUPPLIES, DEVICES, NON-DRUG (Diabetes) *(con't.)*		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
DIABETIC SUPPLIES *(cont.)*		
INPEN (FOR NOVOLOG OR FIASP)	T1	
LITE TOUCH LANCING PEN	T1	
MOBILE LANCETS	T2	
MINILINK REAL-TIME TRANSMITTER	T2	
MINIMED 630G GUARDIAN START KT	T3	
NOVA MAX GLUCOSE CONTROL SOLN	T3	
NOVOPEN ECHO	T3	
ON CALL EXPRESS CONTROL SOLN	T1	
ON CALL LANCING DEVICE	T1	
ON CALL PLUS CONTROL	T1	
ON CALL PLUS LANCING DEVICE	T1	
ON CALL VIVID CONTROL	T1	
ONETOUCH DELICA PLUS LANC DEV	T1	
ONETOUCH ULTRA CONTROL SOLN	T1	
ONETOUCH VERIO HIGH CNTRL SOLN	T1	
ONETOUCH VERIO MID CNTRL SOLN	T1	
OMNIPOD DASH 5 PACK POD	T2	PA QL (6 boxes/30 days)
OMNIPOD 5 G6-G7 INTRO KT(GEN5)	T2	QL
OMNIPOD 5 G6-G7 PODS (GEN 5)	T2	QL
ONETOUCH ULTRASOFT 2 LANCET	T2	
OPTUMRX BLOOD GLUCOSE METER	T3	
OPTUMRX BLOOD GLUCOSE SYSTEM	T3	
OPTUMRX GLUCOSE CONTROL SOLN	T1	
OVAL TAPE	T1	
PARADIGM REAL-TIME	T2	
PIP GLUCOSE CONTROL SOLUTION	T1	
PRODIGY CONTROL SOLUTION	T1	
PRODIGY LANCING DEVICE	T1	
REFUAH PLUS GLUCOSE CONTROL	T1	
RELIAMED MINI LANCING DEVICE	T1	
REPLACEMENT PEDIATRIC MONITOR	T3	
RIGHTEST CONTROL SOLUTION	T1	
RIGHTEST GD500	T1	
SAFE-CLIP	T1	

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Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
DIABETIC SUPPLIES *(cont.)*		
SEN-SERTER	T2	
SIL-SERTER	T1	
SMARTDIABETES VANTAGE	T1	
SMARTEST	T1	
SOF-SENSOR	T2	
SOLUS V2 CONTROL SOLUTION	T1	
SOLUS V2 LANCING DEVICE	T1	
SURE COMFORT LANCING PEN	T1	
SUREFLEX	T1	
SURE-PEN	T1	
SURE-TEST EASYPLUS	T1	
TELCARE CONTROL SOLUTION	T1	
TRUE METRIX	T1	
TRUECONTROL	T1	
TRUEDRAW	T1	
ULTI-LANCE	T1	
ULTRATRAK BLOOD GLUCOSE METER	T1	
ULTRATRAK CONTROL SOL NORMAL	T1	
ULTRATRAK CONTROL SOLUTION	T1	
ULTRATRAK ULTIMATE CNTRL SOLN	T1	
ULTRATRAK ULTIMATE GLUCOSE MTR	T3	
UNISTIK 2	T1	
UNISTIK 2 NORMAL	T1	
UNISTIK 3	T1	
UNISTIK 3 COMFORT	T1	
UNISTIK 3 NEONATAL	T1	
UNISTRIP	T1	
V-GO 20	T2	
V-GO 30	T2	
V-GO 40	T2	
VERASENS CONTROL SOLUTION	T1	
VIVAGUARD INO CONTROL SOLUTION	T1	
VIVAGUARD LANCING DEVICE	T1	
WAVESENSE CONTROL SOLUTION	T1	

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MISCELLANEOUS MEDICAL SUPPLIES, DEVICES, NON-DRUG (Diabetes) *(con't.)*		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
DURABLE MEDICAL EQUIPMENT,MISC (GROUP I)		
ADVOCATE SAFETY LANCET	T1	
BLULINK BG SYSTEM REFILL	T3	
CARESENS LANCET	T1	
CARETOUCH SAFETY LANCETS	T1	
LITE TOUCH LANCETS	T1	
ULTRA-THIN II 28G LANCETS	T1	
NEEDLES/NEEDLELESS DEVICES		
1ST TIER UNIFINE PENTIPS	T1	
1ST TIER UNIFINE PENTIPS PLUS	T1	
ABOUTTIME PEN NEEDLE	T1	
ADVOCATE PEN NEEDLES	T1	
AQINJECT PEN NEEDLE	T1	
ASSURE ID PEN NEEDLE	T1	
AUTOSHIELD DUO PEN NEEDLE	T1	
BLUNT NEEDLE	T1	
CAREFINE PEN NEEDLE	T1	
CARETOUCH HYPODERMIC NEEDLE	T1	
CARETOUCH PEN NEEDLE	T1	
CLICKFINE	T1	
COMFORT EZ PEN NEEDLE	T1	
COMFORT EZ PRO SAFETY PEN NDL	T1	
COMFORT TOUCH PEN NEEDLE	T1	
DROPLET MICRON PEN NEEDLE	T1	
DROPLET PEN NEEDLE	T1	
DROPSAFE PEN NEEDLE	T1	
DROPSAFE SICURA SAFETY NEEDLE	T1	
EASY COMFORT PEN NEEDLES	T1	
EASY GLIDE PEN NEEDLE	T1	
EASY TOUCH FLIPLOCK NEEDLE	T1	
EASY TOUCH FLIPLOCK NEEDLES	T1	
EASY TOUCH HYPODERMIC NEEDLE	T1	
EASY TOUCH PEN NEEDLE	T1	
EASY TOUCH SAFETY PEN NEEDLE	T1	
EASYPOINT NEEDLE	T1	

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Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
NEEDLES/NEEDLELESS DEVICES *(con't.)*		
ECLIPSE NEEDLE	T1	
EMBRACE PEN NEEDLE	T1	
EXEL HUBER NEEDLE	T1	
EXEL HYPODERMIC NEEDLE	T1	
FILTER ASPIRATOR NEEDLE	T1	
FILTER NEEDLE	T1	
FLOW-EZE	T1	
HEALTHWISE PEN NEEDLE	T1	
HEALTHY ACCENTS UNIFINE PENTIP	T1	
HYPODERMIC NEEDLE	T1	
INCONTROL PEN NEEDLE	T1	
INSULIN PEN NEEDLE	T1	
INSUPEN	T1	
INSUPEN PEN NEEDLE	T1	
INTEGRA NEEDLE	T1	
INTEGRA PRECISIONGLIDE NEEDLE	T1	
LIFESHIELD BLUNT CANNULA	T1	
LITE TOUCH	T1	
MAXICOMFORT II PEN NEEDLE	T1	
MAXICOMFORT SAFETY PEN NEEDLE	T1	
MINI PEN NEEDLE	T1	
MINI ULTRA-THIN II	T1	
MONOJECT FILTER NEEDLE	T1	
NANO 2ND GEN PEN NEEDLE	T1	
NEEDLES	T1	
NOKOR ADMIX NEEDLE	T1	
NOKOR NEEDLE	T1	
NOVOFINE 32	T1	
NOVOFINE AUTOCOVER	T1	
NOVOFINE PLUS	T1	
NOVOTWIST	T1	
PEN NEEDLE	T1	

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Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
NEEDLES/NEEDLELESS DEVICES *(con't.)*		
PENTIPS	T1	
PIP PEN NEEDLE	T1	
POLY HUB NEEDLE	T1	
PRECISIONGLIDE	T1	
PREVENT DROPSAFE PEN NEEDLE	T1	
PRO COMFORT PEN NEEDLE	T1	
PURE COMFORT PEN NEEDLE	T1	
PURE COMFORT SAFETY PEN NEEDLE	T1	
RAYA SURE PEN NEEDLE	T1	
REGULAR BEVEL NEEDLES	T1	
SAFETY PEN NEEDLE	T1	
SAFETYGLIDE NEEDLE	T1	
SECURESAFE PEN NEEDLE	T1	
SHORT BEVEL NEEDLES	T1	
SKY SAFETY PEN NEEDLE	T1	
SPECIALTY USE NEEDLES	T1	
SURE COMFORT	T1	
SURE COMFORT PEN NEEDLE	T1	
SURE COMFORT SAFETY PEN NEEDLE	T1	
SURE-FINE PEN NEEDLES	T1	
TECHLITE PEN NEEDLE	T1	PA
TERUMO SURGUARD2	T1	
THIN WALL NEEDLES	T1	
TOPCARE CLICKFINE	T1	
TRANSFER NEEDLE	T1	
TRUE COMFORT PEN NEEDLE	T1	
TRUE COMFORT PRO PEN NEEDLE	T1	
TRUE COMFORT SAFETY PEN NEEDLE	T1	
TRUEPLUS PEN NEEDLE	T1	
ULTICARE PEN NEEDLE	T1	
ULTICARE SAFETY PEN NEEDLE	T1	
ULTIGUARD SAFEPACK-PEN NEEDLE	T1	
ULTILET PEN NEEDLE	T1	

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MISCELLANEOUS MEDICAL SUPPLIES, DEVICES, NON-DRUG (Diabetes) *(con't.)*

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
NEEDLES/NEEDLELESS DEVICES *(con't.)*		
ULTRA FLO PEN NEEDLE	T1	
ULTRA THIN	T1	
ULTRACARE PEN NEEDLE	T1	
ULTRA-FINE MICRO PEN NEEDLE	T1	
ULTRA-FINE MINI PEN NEEDLE	T1	
ULTRA-FINE NANO PEN NEEDLE	T1	
ULTRA-FINE ORIGINAL PEN NEEDLE	T1	
ULTRA-FINE SHORT PEN NEEDLE	T1	
ULTRA-THIN II	T1	
UNIFINE PEN NEEDLE	T1	
UNIFINE PENTIPS	T1	
UNIFINE PENTIPS MAXFLOW	T1	
UNIFINE PENTIPS PLUS	T1	
UNIFINE PENTIPS PLUS MAXFLOW	T1	
UNIFINE SAFECONTROL	T1	
UNIFINE ULTRA PEN NEEDLE	T1	
VERIFINE PEN NEEDLE	T1	
VERIFINE PLUS PEN NEEDLE	T1	
YALE NEEDLE	T1	
SYRINGES AND ACCESSORIES		
ASSURE ID INSULIN SAFETY	T1	
CARETOUCH INSULIN SYRINGE	T1	
COMFORT EZ INSULIN SYRINGE	T1	
DROPLET INSULIN SYRINGE	T1	
DROPSAFE INSULIN SYRINGE	T1	
EASY COMFORT INSULIN SYRINGE	T1	
EASY GLIDE INSULIN SYRINGE	T1	
EASY TOUCH	T1	
EASY TOUCH FLIPLOCK INSULIN	T1	
EASY TOUCH INSULIN SAFETY	T1	
EASY TOUCH INSULIN SYRINGE	T1	
EASY TOUCH LUER LOCK INSULIN	T1	
EASY TOUCH SHEATHLOCK INSULIN	T1	
EASY TOUCH UNI-SLIP	T1	

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Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
SYRINGES AND ACCESSORIES *(con't.)*		
EASY-TOUCH INSULIN SYRINGE	T1	
ECLIPSE SYRINGE	T1	
FREESTYLE PRECISION	T1	
HEALTHWISE INSULIN SYRINGE	T1	
INSULIN SYRINGE	T2	
INSULIN SYRINGE U-500	T1	
LITETOUCH INSULIN SYRINGE	T1	
LUER-LOK SYRINGE	T1	
MAGELLAN INSULIN SAFETY SYRNG	T1	
MAGELLAN INSULIN SYRINGE	T1	
MINIMED RESERVOIR	T1	
MONOJECT INSULIN SYRINGE	T1	
PARADIGM	T3	
SECURESAFE INSULIN SYRINGE	T2	
SURE COMFORT INSULIN SYRINGE	T1	
SURE-JECT INSULIN SYRINGE	T1	
syringe and needle,insulin,1ml	T1	
syringe-needle,insulin,0.5 ml	T1	
syring-needl,disp,insul,0.3 ml	T1	
TECHLITE INSULIN SYRINGE	T1	
TERUMO INSULIN SYRINGE	T1	
THINPRO INSULIN SYRINGE	T1	
TOPCARE ULTRA COMFORT	T1	
TRUE COMFORT INSULIN SYRINGE	T1	
TRUEPLUS INSULIN SYRINGE	T1	
ULTICARE INSULIN SYRINGE	T1	
ULTIGUARD SAFE 1ML 30G 12.7MM	T1	
ULTIGUARD SAFE0.3ML 30G 12.7MM	T1	
ULTIGUARD SAFE0.5ML 30G 12.7MM	T1	
ULTIGUARD SAFEPACK 1ML 31G 8MM	T1	
ULTIGUARD SAFEPK 0.3ML 31G 8MM	T1	
ULTIGUARD SAFEPK 0.5ML 31G 8MM	T1	
ULTILET INSULIN SYRINGE	T1	
ULTRA COMFORT	T1	

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Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
SYRINGES AND ACCESSORIES *(con't.)*		
ULTRA FLO INSULIN SYRINGE	T1	
ULTRACARE INSULIN SYRINGE	T1	
ULTRA-THIN II	T1	
VANISHPOINT INSULIN SYRINGE	T1	
VEO INSULIN SYRINGE	T1	
VERIFINE INSULIN SYRINGE	T1	
MISCELLANEOUS MEDICAL SUPPLIES, DEVICES, NON-DRUG (Miscellaneous)		
DURABLE MEDICAL EQUIPMENT,MISC (GROUP I)		
1ST TIER UNILET COMFORTOUCH	T1	
2-IN-1 LANCET DEVICE	T1	
ACCU-CHEK FASTCLIX LANCET DRUM	T1	
ACCU-CHEK SAFE-T-PRO	T1	
ACCU-CHEK SAFE-T-PRO PLUS	T1	
ACCU-CHEK SOFTCLIX	T1	
ACTI-LANCE	T1	
ADVANCED TRAVEL LANCETS	T1	
ADVOCATE LANCET	T1	
ADVOCATE LANCETS	T1	
ALTERNATE SITE LANCETS	T1	
ASSURE HAEMOLANCE PLUS	T1	
ASSURE LANCE	T1	
ASSURE LANCE PLUS	T1	
BD MICROTAINER LANCETS	T1	
BD ULTRA-FINE	T1	
BD ULTRA-FINE II	T1	
BLOOD LANCETS	T1	
BULLSEYE MINI SAFETY LANCETS	T1	
BUTTERFLY TOUCH LANCET	T1	
CAREONE	T1	
CARESENS LANCET	T1	
CARETOUCH TWIST LANCET	T1	
CLEVER CHEK LANCETS	T1	
COAGUCHEK	T1	
COLOR LANCETS	T1	

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Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
DURABLE MEDICAL EQUIPMENT,MISC (GROUP I) *(con't.)*		
COMFORT EZ	T1	
COMFORT LANCETS	T1	
COMFORT TOUCH PLUS SAFETY LANC	T1	
COMFORT TOUCH ULT THIN LANCET	T1	
DROPLET LANCETS	T1	
EASY COMFORT LANCETS	T1	
EASY TOUCH	T1	
EASY TWIST & CAP LANCETS	T1	
EMBRACE 30G LANCETS	T1	
EMBRACE SAFETY LANCET	T1	
EZ SMART LANCETS	T1	
EZ-LETS	T1	
FIFTY50 SAFETY SEAL LANCETS	T1	
FINE 30 UNIVERSAL LANCETS	T1	
FINGERSTIX	T1	
FORA LANCETS	T1	
FORACARE LANCETS	T1	
FREESTYLE LANCETS	T1	
FREESTYLE UNISTIK 2	T1	
GLUCOCOM	T1	
GLUCOCOM LANCETS	T1	
GOJJI LANCETS	T1	
HEALTHY ACCENTS UNILET LANCET	T1	
INCONTROL SUPER THIN LANCETS	T1	
INCONTROL ULTRA THIN LANCETS	T1	
INJECT EASE LANCETS	T1	
INVACARE LANCETS	T1	
lancets	T1	
LANCETS	T1	
LANCETS THIN	T1	
LANCETS ULTRA THIN	T1	
LITE TOUCH	T1	
MEDISENSE THIN LANCETS	T1	
MEDLANCE PLUS	T1	

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List of Prescription Medications

MISCELLANEOUS MEDICAL SUPPLIES, DEVICES, NON-DRUG (Miscellaneous) *(con't.)*		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
DURABLE MEDICAL EQUIPMENT,MISC (GROUP I) *(con't.)*		
MEDLANCE PLUS SPECIAL BLADE	T1	
MICRO THIN LANCET	T1	
MICRO THIN LANCETS	T1	
MICROLET	T1	
MICROTAINER LANCETS	T1	
MOBILE LANCETS	T1	
MONOLET LANCETS	T1	
MONOLET THIN LANCETS	T1	
MYGLUCOHEALTH LANCETS	T1	
NOVA SAFETY LANCETS	T1	
NOVA SUREFLEX	T1	
ON CALL LANCET	T1	
ON CALL PLUS LANCET	T1	
ONETOUCH DELICA PLUS LANCET	T1	
ONETOUCH DELICA SAFETY LANCET	T1	
ONETOUCH LANCETS	T1	
ONETOUCH SURESOFT	T1	
ONETOUCH ULTRASOFT 2 LANCET	T1	
ON-THE-GO	T1	
PIP LANCET	T1	
PRESSURE ACTIVATED LANCETS	T1	
PRO COMFORT LANCET	T1	
PRO COMFORT LANCETS	T1	
PRO COMFORT SAFETY LANCET	T1	
PRODIGY LANCETS	T1	
PRODIGY TWIST TOP LANCET	T1	
PURE COMFORT LANCETS	T1	
PURE COMFORT SAFETY LANCETS	T1	
PUSH BUTTON SAFETY LANCETS	T1	
READYLANCE SAFETY LANCETS	T1	
RELIAMED	T1	
RELIAMED SAFETY SEAL LANCETS	T1	
RIGHTEST GL300 LANCETS	T1	

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MISCELLANEOUS MEDICAL SUPPLIES, DEVICES, NON-DRUG (Miscellaneous) *(con't.)*		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
DURABLE MEDICAL EQUIPMENT,MISC (GROUP I) *(con't.)*		
SAFETY LANCETS	T1	
SAFETY SEAL LANCETS	T1	
SAFETY-LET	T1	
SINGLE-LET	T1	
SMART SENSE	T1	
SMART SENSE LANCETS	T1	
SMARTEST LANCET	T1	
SOFT TOUCH	T1	
SOLUS V2 28G LANCETS	T1	
SOLUS V2 LANCETS	T1	
STERILANCE TL	T1	
STERILE LANCETS	T1	
SUPER THIN LANCETS	T1	
SURE COMFORT LANCETS	T1	
SURE-LANCE	T1	
SURE-TOUCH	T1	
TECHLITE LANCETS	T1	
TELCARE ULTRA THIN 30G LANCETS	T1	
THIN LANCETS	T1	
TOPCARE UNIVERSAL1 LANCET	T1	
TOPCARE UNIVERSAL1 THIN LANCET	T1	
TRUE COMFORT LANCET	T1	
TRUE COMFORT SAFETY LANCET	T1	
TRUEPLUS LANCET	T1	
TRUEPLUS LANCETS	T1	
TWIST LANCETS	T1	
TWIST TOP LANCET	T1	
ULTILET BASIC	T1	
ULTILET CLASSIC	T1	
ULTILET LANCETS	T1	
ULTILET SAFETY	T1	
ULTRA THIN LANCET	T1	
ULTRA THIN LANCETS	T1	

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Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
DURABLE MEDICAL EQUIPMENT,MISC (GROUP I) *(con't.)*		
ULTRA-CARE LANCETS	T1	
ULTRALANCE	T1	
ULTRA-THIN II	T1	
ULTRATLC LANCETS	T1	
UNILET COMFORTOUCH	T1	
UNILET EXCELITE	T1	
UNILET EXCELITE II	T1	
UNILET GP LANCET	T1	
UNILET LANCET	T1	
UNILET LANCETS	T1	
UNISTIK 3	T1	
UNISTIK 3 EXTRA	T1	
UNISTIK 3 NORMAL	T1	
UNISTIK COMFORT	T1	
UNISTIK CZT	T1	
UNISTIK EXTRA	T1	
UNISTIK NORMAL	T1	
UNISTIK PRO	T1	
UNISTIK SAFETY	T1	
UNISTIK TOUCH	T1	
UNIVERSAL 1	T1	
VERIFINE SAFETY LANCET MINI	T1	
VERIFINE UNIVERSAL LANCET	T1	
VIVAGUARD LANCET	T1	
TISSUE BULKING IMPLANTS		
BARRIGEL *(hyaluronate sodium, stabilized)*	T4	PA SP HD
MUSCLE RELAXANTS (Pain Relief And Inflammatory Disease)		
SKELETAL MUSCLE RELAXANTS		
AMRIX ER 15 MG CAPSULE (*cyclobenzaprine hcl er*)	T3	PA QL (1 cap/day)
AMRIX ER 30 MG CAPSULE (*cyclobenzaprine hcl er*)	T3	PA
baclofen	T1	HD
BACLOFEN 25 MG/5 ML SUSPENSION	T3	PA HD
BACLOFEN 15 MG TABLET	T1	PA HD

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MUSCLE RELAXANTS (Pain Relief And Inflammatory Disease) *(con't.)*		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
SKELETAL MUSCLE RELAXANTS *(con't.)*		
BACLOFEN 10 MG/5 ML SOLUTION	T3	PA HD
baclofen 10 mg tablet	T1	
baclofen 20 mg tablet	T1	
baclofen 25 mg/5 ml suspension (Fleqsuvy)	T1	PA
baclofen 5 mg tablet	T1	
baclofen (Gablofen)	T1	
carisoprodol (Soma)	T1	
carisoprodol/aspirin	T1	
chlorzoxazone 250 mg tablet	T1	PA
chlorzoxazone 375 mg tablet (Lorzone)	T1	PA
chlorzoxazone 500 mg tablet	T1	
chlorzoxazone 750 mg tablet (Lorzone)	T1	PA
cyclobenzaprine er 15 mg cap (Amrix)	T1	PA QL (1 cap/day)
cyclobenzaprine er 30 mg cap (Amrix)	T1	PA
cyclobenzaprine hcl	T1	
cyclobenzaprine hcl (Fexmid)	T1	
DANTRIUM	T3	
DANTRIUM (*dantrolene sodium*)	T3	
dantrolene sodium	T1	
dantrolene sodium (Dantrium)	T1	
FEXMID (*cyclobenzaprine hcl*)	T3	
FLEQSUVY *(baclofen)*	T3	PA HD
GABLOFEN	T3	
GABLOFEN (*baclofen*)	T3	
LIORESAL INTRATHECAL	T3	
LORZONE (*chlorzoxazone*)	T3	PA
LYVISPAH	T3	PA
metaxalone	T1	
metaxalone (Skelaxin)	T1	
methocarbamol	T1	
methocarbamol (Robaxin)	T1	
methocarbamol (Robaxin-750)	T1	
NORGESIC FORTE	T3	
orphenadrine citrate	T1	

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SKELETAL MUSCLE RELAXANTS *(con't.)*		
orphenadrine/aspirin/caffeine (Norgesic Forte)	T1	
OZOBAX	T3	PA HD
OZOBAX DS	T3	PA HD
ROBAXIN	T3	
ROBAXIN-750 (*methocarbamol*)	T3	
RYANODEX	T3	
SKELAXIN (*metaxalone*)	T3	
SOMA (*carisoprodol*)	T3	PA
tizanidine hcl	T1	PA
tizanidine hcl (Zanaflex)	T1	PA
ZANAFLEX (*tizanidine hcl*)	T3	
PRE-NATAL VITAMINS (Nutritional/Dietary)		
PRENATAL VITAMIN PREPARATIONS		
ATABEX EC	T3	
CITRANATAL 90 DHA	T2	
CITRANATAL ASSURE	T2	
CITRANATAL DHA	T2	
CITRANATAL HARMONY	T2	
CITRANATAL RX	T2	
OBSTETRIX EC	T2	
OBTREX DHA	T3	
pnv 22/iron, gluc/folic/dss/dha	T1	
pnv 66/iron/folic/docusate/dha	T1	
pnv 69/iron/folic/docusate/dha	T1	
pnv 80/iron fum/folic/dss/dha	T1	
pnv/ferrous fum/docusate/folic	T1	
pnv/iron, carb/docusat/folic ac	T1	
prenatal 12/iron/folic/dss/om3 (Obtrex Dha)	T1	
PRENATAL 19	T1	
prenatal 34/iron/folic/dss/dha	T1	
prenatal vits15/iron/folic/dss	T1	
VITAFOL FE+	T2	

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PSYCHOTHERAPEUTIC DRUGS (Anxiety/Depression/Bipolar Disorder)[9]

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ALPHA-2 RECEPTOR ANTAGONIST ANTI-DEPRESSANTS		
mirtazapine	T1	HD
mirtazapine (Remeron)	T1	HD
QELBREE	T3	PA QL
QELBREE ER	T3	PA QL(2 caps/day) HD
REMERON (*mirtazapine*)	T3	PA HD
ANTI-ANXIETY - BENZODIAZEPINES		
ATIVAN (*lorazepam*)	T3	PA
chlordiazepoxide hcl	T1	
clorazepate dipotassium	T1	
clorazepate dipotassium (Tranxene T-tab)	T1	
diazepam 10 mg tablet (Valium)	T1	
diazepam 10 mg/2 ml carpuject	T1	
diazepam 10 mg/2 ml syringe	T1	
diazepam 2 mg tablet (Valium)	T1	
diazepam 5 mg tablet (Valium)	T1	
diazepam 5 mg/5 ml solution	T1	
diazepam 5 mg/ml oral conc	T1	
diazepam 50 mg/10 ml vial	T1	
lorazepam	T1	
lorazepam (Ativan)	T1	
LOREEV XR	T4	PA QL (30 tabs/30 days) SP
oxazepam	T1	
TRANXENE T-TAB (*clorazepate dipotassium*)	T3	PA
VALIUM (*diazepam*)	T3	PA
XANAX (*alprazolam*)	T3	PA
XANAX XR (*alprazolam xr*)	T3	PA
ANTI-ANXIETY DRUGS		
buspirone hcl	T1	
meprobamate	T1	
ANTIDEPRESSANT - NMDA RECEPTOR ANTAGONIST		
SPRAVATO	T4	PA SP
ANTIDEPRESSANT - POSTPARTUM DEPRESSION (PPD)		
ZURZUVAE 20 MG CAPSULE	T4	PA QL(28 caps/270 days) SP HD
ZURZUVAE 25 MG CAPSULE	T4	PA QL(28 caps/270 day) SP HD
ZURZUVAE 30 MG CAPSULE	T4	PA QL(14 caps/270 day) SP HD

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PSYCHOTHERAPEUTIC DRUGS (Anxiety/Depression/Bipolar Disorder)[9] *(con't.)*		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
BIPOLAR DISORDER DRUGS		
EQUETRO	T3	HD
lithium carbonate (Lithobid)	T1	HD
lithium citrate	T1	HD
LITHOBID (*lithium carbonate er*)	T3	PA HD
MAOIS -NON-SELECTIVE, IRREVERSIBLE ANTI-DEPRESSANTS		
MARPLAN	T3	QL (12 tabs/day)
NARDIL (*phenelzine sulfate*)	T3	PA
PARNATE (*tranylcypromine sulfate*)	T3	PA
phenelzine sulfate (Nardil)	T1	
tranylcypromine sulfate (Parnate)	T1	
MONOAMINE OXIDASE (MAO) INHIBITOR ANTI-DEPRESSANTS		
EMSAM 12 MG/24 HOURS PATCH	T3	QL (1 patch/day)
EMSAM 6 MG/24 HOURS PATCH	T3	QL (2 patches/day)
EMSAM 9 MG/24 HOURS PATCH	T3	QL (1 patch/day)
NDMA RECEPTOR ANTAGONIST AND NDRI COMB		
AUVELITY	T3	PA QL (60 tabs/30days)
NOREPINEPHRINE AND DOPAMINE REUPTAKE INHIB (NDRIs)		
APLENZIN ER 174 MG TABLET	T3	PA QL (3 tabs/day) HD
APLENZIN ER 348 MG TABLET	T3	PA QL (1 tab/day) HD
APLENZIN ER 522 MG TABLET	T3	PA QL (1 tab/day) HD
bupropion hcl 100 mg tablet	T1	QL (4 tabs/day) HD
bupropion hcl 75 mg tablet	T1	QL (6 tabs/day) HD
bupropion hcl sr 100 mg tablet (Wellbutrin Sr)	T1	QL (4 tabs/day) HD
bupropion hcl sr 150 mg tablet (Wellbutrin Sr)	T1	QL (2 tabs/day) HD
bupropion hcl sr 200 mg tablet (Wellbutrin Sr)	T1	QL (2 tabs/day) HD
bupropion hcl xl 150 mg tablet (Wellbutrin XI)	T1	QL (3 tabs/day) HD
bupropion hcl xl 300 mg tablet (Wellbutrin XI)	T1	QL (1 tab/day) HD
BUPROPION HCL XL 450 MG TABLET	T1	QL (1 tab/day) HD
FORFIVO XL	T3	QL (1 tab/day) ST HD
WELLBUTRIN SR 100 MG TABLET (*bupropion hcl sr*)	T3	PA QL (4 tabs/day) HD
WELLBUTRIN SR 150 MG TABLET (*bupropion hcl sr*)	T3	PA QL (2 tabs/day) HD
WELLBUTRIN SR 200 MG TABLET (*bupropion hcl sr*)	T3	PA QL (2 tabs/day) HD
WELLBUTRIN XL 150 MG TABLET (*bupropion xl*)	T3	PA QL (3 tabs/day) HD
WELLBUTRIN XL 300 MG TABLET (*bupropion xl*)	T3	PA QL (1 tab/day) HD

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PSYCHOTHERAPEUTIC DRUGS (Anxiety/Depression/Bipolar Disorder)[9] *(con't.)*		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
SELECTIVE SEROTONIN 5-HT2A INVERSE AGONISTS (SSIAs)		
NUPLAZID	T3	PA SP HD
SELECTIVE SEROTONIN REUPTAKE INHIBITOR (SSRIs)		
CELEXA 10 MG TABLET (*citalopram hbr*)	T3	PA QL (6 tabs/day) HD
CELEXA 20 MG TABLET (*citalopram hbr*)	T3	PA QL (3 tabs/day) HD
CELEXA 40 MG TABLET (*citalopram hbr*)	T3	PA QL (1 tab/day) HD
citalopram hbr 10 mg tablet (Celexa)	T1	QL (6 tabs/day) HD
citalopram hbr 10 mg/5 ml soln	T1	QL (30ml/day) HD
citalopram hbr 20 mg tablet (Celexa)	T1	QL (3 tabs/day) HD
citalopram hbr 20 mg/10 ml sol	T1	QL (30ml/day) HD
citalopram hbr 40 mg tablet (Celexa)	T1	QL (1 tab/day) HD
escitalopram 10 mg tablet (Lexapro)	T1	QL (2 tabs/day) HD
escitalopram 20 mg tablet (Lexapro)	T1	QL (1 tab/day) HD
escitalopram 5 mg tablet (Lexapro)	T1	QL (4 tabs/day) HD
escitalopram oxalate 5 mg/5 ml	T1	QL (20ml/day) HD
fluoxetine 20 mg/5 ml solution	T1	QL (20 mls/day) HD
fluoxetine hcl 10 mg capsule (Prozac)	T1	QL (8 caps/day) HD
fluoxetine hcl 10 mg tablet (Sarafem)	T1	HD
fluoxetine hcl 20 mg capsule (Prozac)	T1	QL (4 caps/day) HD
fluoxetine hcl 20 mg tablet	T1	HD
fluoxetine hcl 40 mg capsule (Prozac)	T1	QL (2 caps/day) HD
fluoxetine hcl 60 mg tablet	T1	QL (1 tab/day) HD
fluvoxamine er 100 mg capsule	T1	QL (3 caps/day) HD
fluvoxamine er 150 mg capsule	T1	QL (2 caps/day) HD
fluvoxamine maleate 100 mg tab	T1	QL (3 tabs/day) HD
fluvoxamine maleate 25 mg tab	T1	QL (12 tabs/day) HD
fluvoxamine maleate 50 mg tab	T1	QL (6 tabs/day) HD
LEXAPRO 10 MG TABLET (*escitalopram oxalate*)	T3	PA QL (2 tabs/day) HD
LEXAPRO 20 MG TABLET (*escitalopram oxalate*)	T3	PA QL (1 tab/day) HD
LEXAPRO 5 MG TABLET (*escitalopram oxalate*)	T3	PA QL (4 tabs/day) HD
paroxetine cr 12.5 mg tablet (Paxil Cr)	T1	QL (1 tab/day) HD
paroxetine cr 25 mg tablet (Paxil Cr)	T1	QL (3 tabs/day) HD
paroxetine cr 37.5 mg tablet (Paxil Cr)	T1	QL (2 tabs/day) HD
paroxetine er 12.5 mg tablet (Paxil Cr)	T1	QL (1 tab/day) HD
paroxetine er 25 mg tablet (Paxil Cr)	T1	QL (3 tabs/day) HD

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Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
SELECTIVE SEROTONIN REUPTAKE INHIBITOR (SSRIs) *(con't.)*		
paroxetine er 37.5 mg tablet (Paxil Cr)	T1	QL (2 tabs/day) HD
paroxetine hcl 10 mg tablet (Paxil)	T1	QL (6 tabs/day) HD
paroxetine hcl 20 mg tablet (Paxil)	T1	QL (3 tabs/day) HD
paroxetine hcl 30 mg tablet (Paxil)	T1	QL (2 tabs/day) HD
paroxetine hcl 40 mg tablet (Paxil)	T1	QL (1 tab/day) HD
PAXIL 10 MG TABLET (*paroxetine hcl*)	T3	PA QL (6 tabs/day) HD
PAXIL 10 MG/5 ML SUSPENSION	T3	PA QL (30ml/day) HD
PAXIL 20 MG TABLET (*paroxetine hcl*)	T3	PA QL (3 tabs/day) HD
PAXIL 30 MG TABLET (*paroxetine hcl*)	T3	PA QL (2 tabs/day) HD
PAXIL 40 MG TABLET (*paroxetine hcl*)	T3	PA QL (1 tab/day) HD
PAXIL CR 12.5 MG TABLET (*paroxetine er*)	T3	PA QL (1 tab/day) HD
PAXIL CR 25 MG TABLET (*paroxetine er*)	T3	PA QL (3 tabs/day) ST HD
PAXIL CR 37.5 MG TABLET (*paroxetine er*)	T3	PA QL (2 tabs/day) ST HD
PROZAC 10 MG PULVULE (*fluoxetine hcl*)	T3	PA QL (8 caps/day) HD
PROZAC 20 MG PULVULE (*fluoxetine hcl*)	T3	PA QL (4 caps/day) HD
PROZAC 40 MG PULVULE (*fluoxetine hcl*)	T3	PA QL (2 caps/day) HD
SARAFEM (*fluoxetine hcl*)	T3	ST HD
sertraline 20 mg/ml oral conc (Zoloft)	T1	QL (10ml/day) HD
sertraline hcl 100 mg tablet (Zoloft)	T1	QL (2 tabs/day) HD
sertraline hcl 25 mg tablet (Zoloft)	T1	QL (8 tabs/day) HD
sertraline hcl 50 mg tablet (Zoloft)	T1	QL (4 tabs/day) HD
ZOLOFT 100 MG TABLET (*sertraline hcl*)	T3	PA QL (2 tabs/day) HD
ZOLOFT 20 MG/ML ORAL CONC (*sertraline hcl*)	T3	PA QL (10ml/day) HD
ZOLOFT 25 MG TABLET (*sertraline hcl*)	T3	PA QL (8 tabs/day) HD
ZOLOFT 50 MG TABLET (*sertraline hcl*)	T3	PA QL (4 tabs/day) HD
SEROTONIN-2 ANTAGONIST/REUPTAKE INHIBITORS (SARIs)		
nefazodone hcl	T1	HD
RALDESY	T3	PA HD
trazodone hcl	T1	HD
SEROTONIN-NOREPINEPHRINE REUPTAKE-INHIB (SNRIs)		
CYMBALTA 20 MG CAPSULE (*duloxetine hcl*)	T3	PA QL (6 caps/day) HD
CYMBALTA 30 MG CAPSULE (*duloxetine hcl*)	T3	PA QL (4 caps/day) HD
CYMBALTA 60 MG CAPSULE (*duloxetine hcl*)	T3	PA QL (2 caps/day) HD
DESVENLAFAXINE ER 100 MG TAB	T3	PA QL (4 tabs/day) HD

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
SEROTONIN-NOREPINEPHRINE REUPTAKE-INHIB (SNRIs) *(con't.)*		
DESVENLAFAXINE ER 50 MG TAB	T3	PA QL (8 tabs/day) HD
desvenlafaxine succnt er 100mg (Pristiq)	T1	QL (4 tabs/day) HD
desvenlafaxine succnt er 25 mg (Pristiq)	T1	QL (16 tabs/day) HD
desvenlafaxine succnt er 50 mg (Pristiq)	T1	QL (1 tab/day) HD
DRIZALMA SPRINKLE DR 20 MG CAP	T3	QL (1 cap/day) ST HD
DRIZALMA SPRINKLE DR 30 MG CAP	T3	QL (1 cap/day) ST HD
DRIZALMA SPRINKLE DR 40 MG CAP	T3	QL (1 cap/day) ST HD
DRIZALMA SPRINKLE DR 60 MG CAP	T3	QL (2 caps/day) ST HD
duloxetine hcl dr 20 mg cap (Cymbalta)	T1	QL (6 caps/day) HD
duloxetine hcl dr 30 mg cap (Cymbalta)	T1	QL (4 caps/day) HD
duloxetine hcl dr 40 mg cap	T1	QL (3 caps/day) HD
duloxetine hcl dr 60 mg cap (Cymbalta)	T1	QL (2 caps/day) HD
EFFEXOR XR 150 MG CAPSULE (*venlafaxine hcl er*)	T3	PA QL (2 caps/day) HD
EFFEXOR XR 37.5 MG CAPSULE (*venlafaxine hcl er*)	T3	PA QL (8 caps/day) HD
EFFEXOR XR 75 MG CAPSULE (*venlafaxine hcl er*)	T3	PA QL (4 caps/day) HD
FETZIMA 20-40 MG TITRATION PAK	T3	QL (28 caps/180 days) ST HD
FETZIMA ER 120 MG CAPSULE	T3	QL (1 cap/day) ST HD
FETZIMA ER 20 MG CAPSULE	T3	QL (6 caps/day) ST HD
FETZIMA ER 40 MG CAPSULE	T3	QL (3 caps/day) ST HD
FETZIMA ER 80 MG CAPSULE	T3	QL (1 cap/day) ST HD
PRISTIQ ER 25 MG TABLET (*desvenlafaxine succinate er*)	T3	PA QL (16 tabs/day) HD
PRISTIQ ER 50 MG TABLET (*desvenlafaxine succinate er*)	T3	PA QL (1 tab/day) HD
PRISTIQ ER 100 MG TABLET (*desvenlafaxine succinate er*)	T3	PA QL (4 tabs/day) HD
venlafaxine hcl 100 mg tablet	T1	QL (3 tabs/day) HD
venlafaxine hcl 37.5 mg tablet	T1	QL (10 tabs/day) HD
venlafaxine hcl 50 mg tablet	T1	QL (7 tabs/day) HD
venlafaxine hcl 75 mg tablet	T1	QL (5 tabs/day) HD
venlafaxine hcl 25 mg tablet	T1	QL (15 tabs/day) HD
venlafaxine hcl er 150 mg cap (Effexor Xr)	T1	QL (2 caps/day) HD
venlafaxine hcl er 150 mg tab	T1	QL (2 tabs/day) HD
venlafaxine hcl er 225 mg tab	T1	QL (1 tab/day) HD
venlafaxine hcl er 37.5 mg cap (Effexor Xr)	T1	QL (8 caps/day) HD
venlafaxine hcl er 37.5 mg tab	T1	QL (8 tabs/day) HD
venlafaxine hcl er 75 mg cap (Effexor Xr)	T1	QL (4 caps/day) HD

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List of Prescription Medications

PSYCHOTHERAPEUTIC DRUGS (Anxiety/Depression/Bipolar Disorder)[9] *(con't.)*		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
SSRI AND 5HTIA PARTIAL AGONIST ANTI-DEPRESSANTS		
VIIBRYD 10 MG TABLET	T3	PA QL (1 tab/day) HD
VIIBRYD 20 MG TABLET	T3	PA QL (1 tab/day) HD
VIIBRYD 40 MG TABLET	T3	PA HD
SSRI, SEROTONIN RECEPTOR MODULATOR ANTI-DEPRESSANTS		
TRINTELLIX 10 MG TABLET	T3	QL (1 tab/day) ST HD
TRINTELLIX 20 MG TABLET	T3	HD
TRINTELLIX 5 MG TABLET	T3	QL (1 tab/day) ST HD
TRICYCLIC ANTI-DEPRESSANT-BENZODIAZEPINE COMBINATNS		
amitriptyline/chlordiazepoxide	T1	HD
TRICYCLIC ANTI-DEPRESSANT-PHENOTHIAZINE COMBINATNS		
perphenazine/amitriptyline hcl	T1	HD
TRICYCLIC ANTI-DEPRESSANTS, REL.NON-SEL.REUPT-INHIB		
amitriptyline hcl	T1	HD
amoxapine	T1	HD
ANAFRANIL (*clomipramine hcl*)	T3	PA HD
clomipramine hcl (Anafranil)	T1	HD
desipramine hcl	T1	HD
desipramine hcl (Norpramin)	T1	HD
doxepin 10 mg capsule	T1	HD
doxepin 10 mg/ml oral conc	T1	HD
doxepin 100 mg capsule	T1	HD
TRICYCLIC ANTI-DEPRESSANTS, REL.NON-SEL.REUPT-INHIB		
PRISTIQ ER 50 MG TABLET (*desvenlafaxine succinate er*)	T3	PA QL (1 tab/day) HD
venlafaxine hcl 100 mg tablet	T1	QL (3 tabs/day) HD
venlafaxine hcl 25 mg tablet	T1	QL (15 tabs/day) HD
venlafaxine hcl 37.5 mg tablet	T1	QL (10 tabs/day) HD
venlafaxine hcl 50 mg tablet	T1	QL (7 tabs/day) HD
venlafaxine hcl 75 mg tablet	T1	QL (5 tabs/day) HD
imipramine pamoate	T1	HD
maprotiline hcl	T1	HD
NORPRAMIN (*desipramine hcl*)	T3	PA HD
nortriptyline hcl	T1	HD
nortriptyline hcl (Pamelor)	T1	HD
PAMELOR (*nortriptyline hcl*)	T3	PA HD

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PSYCHOTHERAPEUTIC DRUGS (Anxiety/Depression/Bipolar Disorder)[9] *(con't.)*		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
TRICYCLIC ANTI-DEPRESSANTS, REL.NON-SEL.REUPT-INHIB *(con't.)*		
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	PA QL(1 cap/day)
lisdexamfetamine 20 mg capsule (Vyvanse)	T1	PA QL(1 cap/day)
lisdexamfetamine 30 mg capsule (Vyvanse)	T1	PA QL(1 cap/day)
lisdexamfetamine 40 mg capsule (Vyvanse)	T1	PA QL(1 cap/day)
lisdexamfetamine 50 mg capsule (Vyvanse)	T1	PA QL(1 cap/day)
lisdexamfetamine 60 mg capsule (Vyvanse)	T1	PA QL(1 cap/day)
lisdexamfetamine 70 mg capsule (Vyvanse)	T1	PA QL(1 cap/day)
VYVANSE 10 MG CAPSULE *(lisdexamfetamine dimesylate)*	T3	PA QL (1 cap/day)
VYVANSE 10 MG CHEWABLE TABLET	T3	PA QL (1 tab/day)
VYVANSE 20 MG CAPSULE *(lisdexamfetamine dimesylate)*	T3	PA QL (1 per day)
VYVANSE 20 MG CHEWABLE TABLET	T3	PA QL (1 tab/day)
VYVANSE 30 MG CAPSULE *(lisdexamfetamine dimesylate)*	T3	PA QL (1 per day)
VYVANSE 30 MG CHEWABLE TABLET	T3	PA QL (1 tab/day)
VYVANSE 40 MG CAPSULE *(lisdexamfetamine dimesylate)*	T3	PA QL (1 cap/day)
VYVANSE 40 MG CHEWABLE TABLET	T3	PA QL (1 tab/day)
VYVANSE 50 MG CAPSULE *(lisdexamfetamine dimesylate)*	T3	PA QL (1 cap/day)
VYVANSE 50 MG CHEWABLE TABLET	T3	PA QL (1 tab/day)
VYVANSE 60 MG CAPSULE *(lisdexamfetamine dimesylate)*	T3	PA QL (1 cap/day)
VYVANSE 60 MG CHEWABLE TABLET	T3	PA QL (1 tab/day)
VYVANSE 70 MG CAPSULE *(lisdexamfetamine dimesylate)*	T3	PA QL (1 cap/day)
TX FOR ADHD - SELECTIVE ALPHA-2 RECEPTOR AGONIST		
clonidine hcl (Kapvay)	T1	
guanfacine hcl (Intuniv)	T1	HD
INTUNIV (*guanfacine hcl er*)	T3	PA HD
KAPVAY (*clonidine hcl er*)	T3	PA
TX FOR ATTENTION DEFICIT-HYPERACT (ADHD)/NARCOLEPSY		
ADHANSIA XR	T3	PA QL (1 cap/day) ST
APTENSIO XR (*methylphenidate er*)	T3	PA QL (1 cap/day) ST
CONCERTA (*methylphenidate er*)	T3	PA QL (1 tab/day) ST

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PSYCHOTHERAPEUTIC DRUGS (Attention Deficit Hyperactivity Disorder)[9] *(con't.)*		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
TX FOR ATTENTION DEFICIT-HYPERACT (ADHD)/NARCOLEPSY *(con't.)*		
COTEMPLA XR-ODT 17.3 MG TABLET	T3	PA QL (1 tab/day)
COTEMPLA XR-ODT 25.9 MG TABLET	T3	PA QL (2 tabs/day)
COTEMPLA XR-ODT 8.6 MG TABLET	T3	PA QL (1 tab/day)
DAYTRANA 10 MG/9 HR PATCH *(methylphenidate)*	T3	PA QL (1 patch/day)
DAYTRANA 15 MG/9 HR PATCH *(methylphenidate)*	T3	PA QL (1 per day)
DAYTRANA 20 MG/9 HOUR PATCH *(methylphenidate)*	T3	PA QL (1 patch/day)
DAYTRANA 30 MG/9 HOUR PATCH *(methylphenidate)*	T3	PA QL (1 patch/day)
dexmethylphenidate er 10 mg cp (Focalin Xr)	T1	PA QL (1 cap/day)
dexmethylphenidate er 15 mg cp (Focalin Xr)	T1	PA QL (1 per day)
dexmethylphenidate er 20 mg cp (Focalin Xr)	T1	PA QL (1 cap/day)
dexmethylphenidate er 25 mg cp (Focalin Xr)	T1	PA QL (1 cap/day)
dexmethylphenidate er 30 mg cp (Focalin Xr)	T1	PA QL (1 cap/day)
dexmethylphenidate er 35 mg cp (Focalin Xr)	T1	PA QL (1 cap/day)
dexmethylphenidate er 40 mg cp (Focalin Xr)	T1	PA QL (1 cap/day)
dexmethylphenidate er 5 mg cap (Focalin Xr)	T1	PA QL (1 cap/day)
dexmethylphenidate hcl (Focalin)	T1	PA
FOCALIN (*dexmethylphenidate hcl*)	T3	PA ST
FOCALIN XR (*dexmethylphenidate hcl er*)	T3	PA QL (1 cap/day) ST
JORNAY PM	T3	PA QL (1 cap/day) ST
METADATE CD (methylphenidate hcl)	T3	PA QL(1 cap/day)
METHYLIN (*methylphenidate hcl*)	T3	PA
methylphenidate er 10 mg cap (Aptensio Xr)	T1	PA QL (1 per day)
methylphenidate er 10 mg tab	T1	PA QL (2/day)
methylphenidate er 15 mg cap (Aptensio Xr)	T1	PA QL (1 per day)
methylphenidate er 18 mg tab	T1	PA QL (1 per day)
methylphenidate er 20 mg cap (Aptensio Xr)	T1	PA QL (1 per day)
methylphenidate er 20 mg tab	T1	PA QL (3/day)
methylphenidate er 27 mg tab	T1	PA QL (1 tab/day)
methylphenidate er 30 mg cap (Aptensio Xr)	T1	PA QL (1 per day)
methylphenidate er 36 mg tab	T1	PA QL (1 per day)
methylphenidate er 40 mg cap (Aptensio Xr)	T1	PA QL (1 per day)
methylphenidate er 50 mg cap (Aptensio Xr)	T1	PA QL (1 per day)
methylphenidate er 54 mg tab	T1	PA QL (1 tab/day)
methylphenidate er 60 mg cap (Aptensio Xr)	T1	PA QL (1 per day)

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PSYCHOTHERAPEUTIC DRUGS (Attention Deficit Hyperactivity Disorder)[9] *(con't.)*		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
TX FOR ATTENTION DEFICIT-HYPERACT (ADHD)/NARCOLEPSY *(con't.)*		
METHYLPHENIDATE ER 72 MG TAB	T1	PA QL (1 tab/day)
methylphenidate hcl (Metadate CD)	T1	PA QL (1 cap/day)
methylphenidate hcl (Methylin)	T1	PA
methylphenidate hcl (Ritalin La)	T1	PA QL (1 cap/day)
methylphenidate hcl (Ritalin)	T1	PA
methylphenidate la 10 mg cap (Ritalin La)	T1	PA QL (1 cap/day)
methylphenidate la 20 mg cap (Ritalin La)	T1	PA QL (1 cap/day)
methylphenidate la 30 mg cap (Ritalin La)	T1	PA QL (1 per day)
methylphenidate la 40 mg cap (Ritalin La)	T1	PA QL (1 cap/day)
methylphenidate la 60 mg cap	T1	PA QL (1 cap/day)
QUILLICHEW ER	T3	PA QL (1 tab/day)
QUILLIVANT XR	T3	PA QL (12ml/day)
RELEXXII	T3	PA QL (1 tab/day)
RITALIN (*methylphenidate hcl*)	T3	PA ST
RITALIN LA (*methylphenidate la*)	T3	PA QL (1 cap/day) ST
TX FOR ATTENTION DEFICIT-HYPERACT.(ADHD), NRI-TYPE		
atomoxetine hcl 10 mg capsule (Strattera)	T1	HD
atomoxetine hcl 100 mg capsule (Strattera)	T1	HD
atomoxetine hcl 18 mg capsule (Strattera)	T1	HD
atomoxetine hcl 25 mg capsule (Strattera)	T1	HD
atomoxetine hcl 40 mg capsule (Strattera)	T1	QL (1 cap/day) HD
atomoxetine hcl 60 mg capsule (Strattera)	T1	HD
atomoxetine hcl 80 mg capsule (Strattera)	T1	HD
STRATTERA 10 MG CAPSULE (*atomoxetine hcl*)	T3	PA HD
STRATTERA 100 MG CAPSULE (*atomoxetine hcl*)	T3	PA HD
STRATTERA 18 MG CAPSULE (*atomoxetine hcl*)	T3	PA HD
STRATTERA 25 MG CAPSULE (*atomoxetine hcl*)	T3	PA HD
STRATTERA 40 MG CAPSULE (*atomoxetine hcl*)	T3	PA QL (1 cap/day) HD
STRATTERA 60 MG CAPSULE (*atomoxetine hcl*)	T3	PA HD
STRATTERA 80 MG CAPSULE (*atomoxetine hcl*)	T3	PA HD
PSYCHOTHERAPEUTIC DRUGS (Miscellaneous)		
HYPOACTIVE SEXUAL DESIRE DISORDER (HSDD) TX AGENTS		
ADDYI	T3	QL (1 tab/day)
VYLEESI	T3	PA QL (8 injectors/30 days) SP

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List of Prescription Medications

PSYCHOTHERAPEUTIC DRUGS (Schizophrenia/Anti-Psychotics)[9]		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
ANTI-PSYCH, DOPAMINE ANTAG., DIPHENYLBUTYLPIPERIDINES		
pimozide	T1	
ANTI-PSYCHOTIC,ATYPICAL,DOPAMINE,SEROTONIN ANTAGNST		
asenapine maleate (Saphris)	T1	
CAPLYTA	T3	QL (1 caps/day) ST
clozapine	T1	
clozapine (Clozapine Odt)	T1	
clozapine (Clozaril)	T1	
clozapine (Fazaclo)	T1	
CLOZAPINE ODT	T1	
CLOZARIL (*clozapine*)	T3	PA
FANAPT 1 MG TABLET	T3	QL (4 tabs/day) ST
FANAPT 2 MG TABLET	T3	QL (4 tabs/day) ST
FANAPT 4 MG TABLET	T3	QL (4 tabs/day) ST
FANAPT 6 MG TABLET	T3	QL (4 tabs/day) ST
FANAPT 8 MG TABLET	T3	QL (4 tabs/day) ST
FANAPT 10 MG TABLET	T3	QL (4 tabs/day) ST
FANAPT 12 MG TABLET	T3	ST
FANAPT TITRATION PACK	T3	PA QL (4 packs/year) ST
FAZACLO (*clozapine odt*)	T3	PA
GEODON 20 MG CAPSULE (*ziprasidone hcl*)	T3	PA
GEODON 20 MG/ML VIAL	T3	
GEODON 40 MG CAPSULE (*ziprasidone hcl*)	T3	PA
GEODON 60 MG CAPSULE (*ziprasidone hcl*)	T3	PA
GEODON 80 MG CAPSULE (*ziprasidone hcl*)	T3	PA
INVEGA ER 1.5 MG TABLET (*paliperidone er*)	T3	ST
INVEGA ER 3 MG TABLET (*paliperidone er*)	T3	QL (1 tab/day) ST
INVEGA ER 6 MG TABLET (*paliperidone er*)	T3	ST
INVEGA ER 9 MG TABLET (*paliperidone er*)	T3	ST
INVEGA SUSTENNA 117 MG/0.75 ML	T3	QL (2 syrings/28 days)
INVEGA SUSTENNA 156 MG/ML SYRG	T3	QL (1 syringe/28 days)
INVEGA SUSTENNA 234 MG/1.5 ML	T3	QL (1 syringe/28 days)
INVEGA SUSTENNA 39 MG/0.25 ML	T3	QL (2 syrings/28 days)
INVEGA SUSTENNA 78 MG/0.5 ML	T3	QL (2 syrings/28 days)
INVEGA TRINZA	T3	QL (2 injectors/90 days)

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Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
ANTI-PSYCHOTIC, ATYPICAL, DOPAMINE, SEROTONIN ANTAGNST *(con't.)*		
LATUDA 120 MG TABLET (*lurasidone hcl*)	T3	PA
LATUDA 20 MG TABLET (*lurasidone hcl*)	T3	PA
LATUDA 40 MG TABLET (*lurasidone hcl*)	T3	PA QL (1 tab/day)
LATUDA 40 MG TABLET (*lurasidone hcl*)	T3	PA QL (1 tab/day)
LATUDA 60 MG TABLET (*lurasidone hcl*)	T3	PA QL (1 tab/day)
LATUDA 80 MG TABLET (*lurasidone hcl*)	T3	
*lurasidone hcl 80 mg tablet (*Latuda*)*	T1	
*lurasidone hcl 60 mg tablet (*Latuda*)*	T1	QL(1 tab/day)
*lurasidone hcl 40 mg tablet (*Latuda*)*	T1	QL(1 tab/day)
*lurasidone hcl 20 mg tablet (*Latuda*)*	T1	
*lurasidone hcl 120 mg tablet (*Latuda*)*	T1	
olanzapine (Zyprexa Zydis)	T1	
olanzapine (Zyprexa)	T1	
paliperidone er 1.5 mg tablet (Invega)	T1	
paliperidone er 3 mg tablet (Invega)	T1	QL (1 tab/day)
paliperidone er 6 mg tablet (Invega)	T1	
paliperidone er 9 mg tablet (Invega)	T1	
PERSERIS	T3	QL (1 kit/28 days)
quetiapine fumarate (Seroquel Xr)	T1	
quetiapine fumarate (Seroquel)	T1	
RISPERDAL (*risperidone*)	T3	PA
RISPERDAL CONSTA	T3	PA QL(4 vials/28 days)
risperidone	T1	
risperidone (Risperdal)	T1	
risperidone microspheres	T1	QL
SAPHRIS (*asenapine maleate*)	T3	ST
SECUADO	T3	ST
SEROQUEL (*quetiapine fumarate*)	T3	ST
SEROQUEL XR (*quetiapine fumarate er*)	T3	ST
VERSACLOZ	T3	PA
ziprasidone hcl (Geodon)	T1	
ziprasidone mesylate (Geodon)	T1	
ZYPREXA 10 MG TABLET (*olanzapine*)	T3	PA
ZYPREXA 10 MG VIAL (*olanzapine*)	T3	

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Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
ANTI-PSYCHOTIC, ATYPICAL, DOPAMINE, SEROTONIN ANTAGNST *(con't.)*		
ZYPREXA 15 MG TABLET (*olanzapine*)	T3	PA
ZYPREXA 2.5 MG TABLET (*olanzapine*)	T3	PA
ZYPREXA 20 MG TABLET (*olanzapine*)	T3	PA
ZYPREXA 5 MG TABLET (*olanzapine*)	T3	PA
ZYPREXA 7.5 MG TABLET (*olanzapine*)	T3	PA
ZYPREXA RELPREVV 210 MG VIAL	T3	QL (4 vials/28 days)
ZYPREXA RELPREVV 210 MG VL KIT	T3	QL (4 vials/28 days)
ZYPREXA RELPREVV 300 MG VIAL	T3	QL (4 vials/28 days)
ZYPREXA RELPREVV 300 MG VL KIT	T3	QL (4 vials/28 days)
ZYPREXA RELPREVV 405 MG VIAL	T3	QL (2 vials/28 days)
ZYPREXA RELPREVV 405 MG VL KIT	T3	QL (2 vials/28 days)
ZYPREXA ZYDIS (*olanzapine odt*)	T3	PA
ANTI-PSYCHOTIC-ATYPICAL, D3/D2 PARTIAL AG-5HT MIXED		
VRAYLAR 1.5 MG CAPSULE	T3	QL (1 cap/day) ST
VRAYLAR 3 MG CAPSULE	T3	QL (1 cap/day) ST
VRAYLAR 4.5 MG CAPSULE	T3	ST
VRAYLAR 6 MG CAPSULE	T3	ST
ANTIPSYCHOTICS, ATYP, D2 PARTIAL AGONIST/5HT MIXED		
ABILIFY 10 MG TABLET (*aripiprazole*)	T3	ST
ABILIFY 15 MG TABLET (*aripiprazole*)	T3	ST
ABILIFY 2 MG TABLET (*aripiprazole*)	T3	ST
ABILIFY 20 MG TABLET (*aripiprazole*)	T3	ST
ABILIFY 30 MG TABLET (*aripiprazole*)	T3	ST
ABILIFY 5 MG TABLET (*aripiprazole*)	T3	QL (1 tab/day) ST
ABILIFY ASIMTUFII	T3	
ABILIFY MAINTENA ER 300 MG SYR	T2	QL (2 injectors/30 days)
ABILIFY MAINTENA ER 300 MG VL	T2	QL (2 injectors/30 days)
ABILIFY MAINTENA ER 400 MG SYR	T2	QL (2 injectors/30 days)
ABILIFY MAINTENA ER 400 MG VL	T2	
ABILIFY MYCITE	T3	PA
aripiprazole	T1	
aripiprazole 1 mg/ml solution	T1	
aripiprazole 10 mg tablet (Abilify)	T1	

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Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
ANTIPSYCHOTICS, ATYP, D2 PARTIAL AGONIST/5HT MIXED *(con't.)*		
aripiprazole 15 mg tablet (Abilify)	T1	
aripiprazole 2 mg tablet (Abilify)	T1	
aripiprazole 20 mg tablet (Abilify)	T1	
aripiprazole 30 mg tablet (Abilify)	T1	
aripiprazole 5 mg tablet (Abilify)	T1	QL (1 tab/day)
ARISTADA ER 1064 MG/3.9 ML SYR	T3	
ARISTADA ER 441 MG/1.6 ML SYRN	T3	QL (2 syrings/30 days)
ARISTADA ER 662 MG/2.4 ML SYRN	T3	QL (2 syrings/30 days)
ARISTADA ER 882 MG/3.2 ML SYRN	T3	QL (2 syrings/30 days)
ARISTADA INITIO	T3	
COBENFY	T3	PA
REXULTI 0.25 MG TABLET	T3	QL (1 tab/day) ST
REXULTI 0.5 MG TABLET	T3	QL (1 tab/day) ST
REXULTI 1 MG TABLET	T3	QL (1 tab/day) ST
REXULTI 2 MG TABLET	T3	QL (1 tab/day) ST
REXULTI 3 MG TABLET	T3	ST
REXULTI 4 MG TABLET	T3	ST
OPIPZA 2 MG FILM	T3	PA QL(1 film/day)
OPIPZA 5 MG, 10 MG FILM	T3	PA QL(3 films/day)
ANTI-PSYCHOTICS, DOPAMINE AND SEROTONIN ANTAGONISTS		
loxapine succinate	T1	
ANTI-PSYCHOTICS, DOPAMINE ANTAGONISTS, THIOXANTHENES		
thiothixene	T1	
droperidol	T1	
HALDOL (*haloperidol lactate*)	T3	
haloperidol	T1	
haloperidol decanoate	T1	
haloperidol decanoate (Haldol Decanoate 100)	T1	
haloperidol decanoate (Haldol Decanoate 50)	T1	
haloperidol lactate	T1	
haloperidol lactate (Haldol)	T1	
ANTI-PSYCHOTICS, DOPAMINE ANTAGONST, DIHYDROINDOLONES		
molindone hcl	T1	
ANTI-PSYCHOTICS, PHENOTHIAZINES		
chlorpromazine hcl	T1	

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PSYCHOTHERAPEUTIC DRUGS (Schizophrenia/Anti-Psychotics)[9] *(con't.)*		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
ANTIPSYCHOTICS, ATYP, D2 PARTIAL AGONIST/5HT MIXED *(con't.)*		
fluphenazine decanoate	T1	
fluphenazine hcl	T1	
perphenazine	T1	
thioridazine hcl	T1	
trifluoperazine hcl	T1	
SSRI-ANTI-PSYCH, ATYPICAL, DOPAMINE, SEROTONIN ANTAG		
olanzapine/fluoxetine hcl	T1	
olanzapine/fluoxetine hcl (Symbyax)	T1	
SYMBYAX (*olanzapine-fluoxetine hcl*)	T3	PA
PSYCHOTHERAPEUTIC DRUGS (Sleep Disorders/Sedatives)		
NARCOLEPSY AND SLEEP DISORDER THERAPY AGENTS		
armodafinil (Nuvigil)	T1	PA
modafinil (Provigil)	T1	PA
NUVIGIL (*armodafinil*)	T3	PA
PROVIGIL (*modafinil*)	T3	PA
SUNOSI	T2	PA QL (1 tab/day)
SEDATIVE/HYPNOTICS (Sleep Disorders/Sedatives)		
ANTI-NARCOLEPSY, ANTI-CATAPLEXY, SEDATIVE-TYPE AGENT		
SODIUM OXYBATE	T4	PA QL(18 mls/day) SP HD
LUMRYZ	T4	PA QL (30 pkts/30 days) SP
XYREM	T4	PA SP HD
XYWAV	T4	PA SP HD
BARBITURATES		
AMYTAL SODIUM	T3	
NEMBUTAL SODIUM (*pentobarbital sodium*)	T3	PA
pentobarbital sodium (Nembutal Sodium)	T1	PA
phenobarbital sodium	T1	
secobarbital sodium	T3	PA
HYPNOTICS, MELATONIN MT1/MT2 RECEPTOR AGONISTS		
HETLIOZ	T4	PA SP HD
HETLIOZ LQ	T4	PA SP HD
ramelteon (Rozerem)	T1	QL (1 tab/day)
ROZEREM (*ramelteon*)	T3	PA QL (1 tab/day)

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SEDATIVE/HYPNOTICS (Sleep Disorders/Sedatives) *(con't.)*		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
HYPNOTICS, MELATONIN MT1/MT2 RECEPTOR AGONISTS *(con't.)*		
tasimelteon	T4	PA SP
SEDATIVE-HYPNOTICS - BENZODIAZEPINES		
ATIVAN (*lorazepam*)	T3	PA
DORAL	T3	
estazolam	T1	
HALCION (*triazolam*)	T3	
lorazepam	T1	
lorazepam (Ativan)	T1	
LORAZEPAM-0.9% NACL	T1	
LORAZEPAM-D5W	T1	
QUAZEPAM	T1	
quazepam (Quazepam)	T1	
RESTORIL (*temazepam*)	T3	PA
temazepam (Restoril)	T1	
triazolam	T1	
triazolam (Halcion)	T1	
SEDATIVE-HYPNOTICS, NON-BARBITURATE		
AMBIEN (*zolpidem tartrate*)	T3	PA
AMBIEN CR 12.5 MG TABLET (*zolpidem tartrate er*)	T3	PA
AMBIEN CR 6.25 MG TABLET (*zolpidem tartrate er*)	T3	PA QL (1 tab/day)
BELSOMRA	T3	PA
DAYVIGO	T2	QL (1 tab/day) ST
DEXMEDETOMIDINE HCL	T1	
dexmedetomidine hcl (Precedex)	T1	
dexmedetomidine in 0.9 % nacl (Precedex)	T1	
doxepin hcl 3 mg tablet (Silenor)	T1	QL (1 tab/day)
doxepin hcl 6 mg tablet (Silenor)	T1	
EDLUAR 10 MG SL TABLET	T3	PA
EDLUAR 5 MG SL TABLET	T3	PA QL (1 tab/day)
eszopiclone (Lunesta)	T1	
LUNESTA (*eszopiclone*)	T3	PA
PRECEDEX	T3	
QUVIVIQ	T3	PA QL (1 tab/day)
SILENOR 3 MG TABLET (*doxepin hcl*)	T3	PA QL (1 tab/day)

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SEDATIVE-HYPNOTICS, NON-BARBITURATE *(con't.)*		
SILENOR 6 MG TABLET (*doxepin hcl*)	T3	PA
zaleplon	T1	
zolpidem tart er 12.5 mg tab (Ambien Cr)	T1	
zolpidem tart er 6.25 mg tab (Ambien Cr)	T1	QL (1 tab/day)
zolpidem tartrate	T1	
zolpidem tartrate (Ambien)	T1	
ZOLPIMIST	T3	PA
SEDATIVE-HYPNOTICS - BENZODIAZEPINES		
flurazepam hcl	T1	
SKIN PREPS (Miscellaneous)		
IRRIGANTS		
acetic acid	T1	
neomycin sulf/polymyxin b sulf	T1	
PHYSIOLYTE	T3	
PHYSIOSOL	T3	
ringer's solution	T1	
ringer's solution, lactated	T1	
sod, pot chlor/mag/sod, pot phos	T3	
sodium chloride irrig solution	T1	
SORBITOL	T1	
SORBITOL-MANNITOL	T1	
water for irrigation, sterile	T1	
OXIDIZING AGENTS		
hydrogen peroxide	T1	
SKIN PREPS (Pain Relief And Inflammatory Disease)		
ANTI-PSORIATIC AGENTS, SYSTEMIC		
acitretin	T1	
acitretin (Soriatane)	T1	
BIMZELX AUTOINJECTOR	T4	PA QL(2 mls/28 days) SP HD
COSENTYX (2 SYRINGES)	T4	PA QL (2 syrings/28 days) SP HD
COSENTYX PEN	T4	PA QL (1 pen/28 days) SP HD
COSENTYX PEN (2 PENS)	T4	PA QL (2 pens/28 days) SP HD

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SKIN PREPS (Pain Relief And Inflammatory Disease) *(con't.)*		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
ANTI-PSORIATIC AGENTS, SYSTEMIC *(con't.)*		
COSENTYX SYRINGE	T4	PA QL (1 syringe/28 days) SP HD
ILUMYA	T4	PA QL (1 syringe/84 days) SP HD
methoxsalen (Oxsoralen-ultra)	T1	
OXSORALEN-ULTRA (*methoxsalen*)	T3	
SKYRIZI (2 SYRINGES) KIT	T4	PA QL (1 kit/84 days) SP HD
SORIATANE (*acitretin*)	T3	PA
SOTYKTU	T4	PA QL(1 tab/day) SP HD
SPEVIGO 150 MG/ML SYRINGE	T4	PA QL(2 mls/28 days) SP HD
SPEVIGO 450 MG/7.5 ML VIAL	T4	PA SP HD
TALTZ AUTOINJECTOR	T4	PA QL (1 injector/28 days) SP HD
TALTZ AUTOINJECTOR (2 PACK)	T4	PA QL (1 injector/28 days) SP HD
TALTZ AUTOINJECTOR (3 PACK)	T4	PA QL (1 injector/28 days) SP HD
TALTZ SYRINGE	T4	PA QL (1 syringe/28 days) SP HD
TREMFYA 100 MG/ML INJECTOR	T4	PA SP HD
TREMFYA 100 MG/ML SYRINGE	T4	PA SP HD
TOPICAL ANTI-INFLAMMATORY, NSAIDS		
DICLAREAL	T3	HD
diclofenac 1.5% topical soln	T1	PA HD
DICLOFENAC EPOLAMINE	T3	PA QL (2 patches/day) HD
diclofenac sodium 1% gel (Voltaren)	T1	QL (1000gm/30 days) HD
FLECTOR	T2	PA QL (2 patches/day) HD
LICART	T2	PA QL (1 patch/day) HD
PENNSAID	T3	PA HD
VOLTAREN (*diclofenac sodium*)	T3	PA QL (1000gm/30 days) HD
SKIN PREPS (Skin Conditions)		
ACNE AGENTS, SYSTEMIC		
ABSORICA	T3	
ABSORICA LD	T3	ST
ACCUTANE	T1	
AMNESTEEM	T1	
CABTREO	T3	PA
CLARAVIS	T1	
isotretinoin	T1	
MYORISAN	T1	

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SKIN PREPS (Skin Conditions) *(con't.)*		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
ACNE AGENTS, SYSTEMIC *(con't.)*		
ZENATANE	T1	
ACNE AGENTS, TOPICAL		
ACANYA (*clindamycin phos-benzoyl perox*)	T3	
ACZONE 5% GEL (*dapsone*)	T3	
ACZONE 7.5% GEL PUMP	T2	
adapalene/benzoyl peroxide	T1	
AZELEX	T2	
BENZACLIN (*clindamycin-benzoyl peroxide*)	T3	PA
clindamyc-bnz perox 1.2-3.75% (Onexton)	T1	PA
clindamycin phos/benzoyl perox	T1	
clindamycin phos/benzoyl perox (Acanya) (Benzaclin)	T1	
clindamycin/tretinoin (Veltin)	T1	
clindamycin/tretinoin (Ziana)	T1	
dapsone 5% gel (Aczone)	T1	
DAPSONE 7.5% GEL PUMP	T3	PA
dapsone 7.5% gel pump (Dapsone)	T1	
KLARON (*sulfacetamide sodium*)	T3	
NEUAC 1.2-5% KIT	T3	
neuac gel	T1	
ONEXTON	T3	
sulfacetamide sodium (Klaron)	T1	
VELTIN	T3	PA
ZIANA (*clindamycin phos-tretinoin*)	T3	PA
ANTI-PERSPIRANTS		
DRYSOL	T3	
ANTI-PRURITICS, TOPICAL		
doxepin hcl (Zonalon)	T3	PA QL (90gm/30 days)
ZONALON (*prudoxin*)	T3	PA QL (90gm/30 days)
ANTI-PSORIATICS AGENTS		
anthralin	T1	
calcipotriene 0.005% cream (Dovonex)	T1	
CALCIPOTRIENE 0.005% FOAM	T3	PA
calcipotriene 0.005% ointment	T1	
calcipotriene 0.005% solution	T1	

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ANTI-PSORIATICS AGENTS		
calcitriol 3 mcg/g ointment (Vectical)	T1	QL (800gm/30 days)
DOVONEX (*calcipotriene*)	T3	
DUOBRII	T3	
SORILUX	T3	PA
tazarotene 0.1% cream (Tazorac)	T1	
TAZORAC 0.05% CREAM	T2	
TAZORAC 0.05% GEL	T2	
TAZORAC 0.1% CREAM (*tazarotene*)	T3	
TAZORAC 0.1% GEL	T2	
VECTICAL (*calcitriol*)	T3	QL (800gm/30 days)
ZORYVE 0.3% FOAM	T2	PA QL(1 gm/30 days)
ANTI-SEBORRHEIC AGENTS		
OVACE PLUS	T3	
PROMISEB	T2	
selenium sulfide	T1	
sulfacetamide sodium	T1	
TERSI FOAM	T3	
ANTISEPTICS, GENERAL		
alcohol antiseptic pads	T1	
ALCOHOL PREP PADS	T1	
ALCOHOL SWAB	T1	
ALCOHOL WIPES	T1	
CARETOUCH ALCOHOL PREP PAD	T1	
CURITY ALCOHOL PREPS	T1	
DROPSAFE PREP PADS	T1	
EASY COMFORT ALCOHOL PAD	T1	
EASY TOUCH ALCOHOL PREP PADS	T1	
INCONTROL ALCOHOL PADS	T1	
PRO COMFORT ALCOHOL PADS	T1	
PURE COMFORT ALCOHOL PAD	T1	
SINGLE USE SWAB	T1	
SURE COMFORT ALCOHOL	T1	
SURE-PREP ALCOHOL PREP PADS	T1	
TRUE COMFORT ALCOHOL PADS	T1	

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SKIN PREPS (Skin Conditions) *(con't.)*		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
ANTISEPTICS, GENERAL *(con't.)*		
TRUE COMFORT PRO ALCOHOL PADS	T1	
ULTILET ALCOHOL SWAB	T1	
WEBCOL	T1	
ANTISEPTICS, MISCELLANEOUS		
GUAIACOL	T3	
DIABETIC ULCER PREPARATIONS, TOPICAL		
REGRANEX	T3	PA QL (2 tubs/30 days)
EMOLLIENTS		
ammonium lactate	T1	
ATOPICLAIR	T3	
BIAFINE (*sonafine*)	T3	
emollient combination no.10 (Biafine)	T1	
emollient combination no.35 (Mimyx)	T1	
emollient combination no.44	T1	
emollient combination no.60 (Restizan)	T3	
HALUCORT	T3	
MIMYX (*prumyx*)	T3	
RESTIZAN	T1	
vite ac/grape/hyaluronic acid (Atopiclair)	T1	
XCLAIR	T3	
IMMUNOMODULATORS		
ALDARA (*imiquimod*)	T3	PA
imiquimod 3.75% cream (Zyclara)	T1	PA QL (112 packets/67 days)
IMIQUIMOD 3.75% CREAM PUMP	T1	PA
imiquimod 5% cream packet (Aldara)	T1	
ZYCLARA 2.5% CREAM PUMP	T3	PA QL (4 bots/30 days)
ZYCLARA 3.75% CREAM (*imiquimod*)	T3	PA QL (112 packs/30 days)
ZYCLARA 3.75% CREAM PUMP	T3	PA
IRRITANTS/COUNTER-IRRITANTS		
methyl salicylate	T1	
QUTENZA	T3	
KERATOLYTICS		
BENSAL HP	T1	PA
BENZEFOAM	T3	

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SKIN PREPS (Skin Conditions) *(con't.)*		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
KERATOLYTICS *(con't.)*		
BENZEPRO	T1	
benzoyl peroxide	T1	
benzoyl peroxide (Enzoclear)	T1	
benzoyl peroxide (Pacnex)	T1	
CONDYLOX *(podofilox)*	T3	PA
ENZOCLEAR	T3	
HYDRO 35	T3	
HYDRO 40 (*umecta*)	T3	
INOVA	T3	
KERAFOAM	T3	
KERALYT 6% GEL (*salicylic acid*)	T3	
keralyt 6% shampoo	T1	
KERALYT SCALP	T3	
KERALYT SCALP (*salicylic acid*)	T3	
PACNEX (*benzoyl peroxide*)	T3	
PODOCON-25	T1	
podofilox	T1	
PR BENZOYL PEROXIDE	T1	
SALICATE	T3	
salicylic acid	T1	
salicylic acid	T3	
salicylic acid (Keralyt Scalp)	T1	
salicylic acid/ceramide comb 1	T1	
SALIMEZ FORTE	T1	
SALKERA	T3	
SALVAX DUO PLUS	T3	
silver nitrate	T1	
silver nitrate applicator	T1	
URAMAXIN	T3	
URAMAXIN (*urea*)	T3	
urea	T1	
urea (Hydro 35)	T1	
urea (Hydro 40)	T3	
urea (Uramaxin)	T1	

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SKIN PREPS (Skin Conditions) *(con't.)*		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
KERATOLYTICS *(con't.)*		
urea (Xurea)	T1	
XUREA	T3	
PROTECTIVES		
BIONECT	T3	
PHARMABASE BARRIER	T1	
polydimethylsiloxanes/silicon	T1	
protectives2/ceramide 1, 3, 6-ii	T1	
RADIAPLEXRX	T3	
zinc oxide	T1	
ROSACEA AGENTS, TOPICAL		
azelaic acid (Finacea)	T1	
FINACEA	T3	PA
FINACEA (*azelaic acid*)	T3	PA
ivermectin (Soolantra)	T1	
METROCREAM (*rosadan*)	T3	PA
METROGEL (*metronidazole*)	T3	PA
metronidazole	T3	PA
NORITATE	T3	PA
SOOLANTRA (*ivermectin*)	T3	
TISSUE/WOUND ADHESIVES		
ARTISS	T3	
SURGISEAL STYLUS	T3	
SURGISEAL TEARDROP	T3	
SURGISEAL TWIST	T3	
TISSEEL VHSD	T3	
TOP. ANTI-INFLAM., PHOSPHODIESTERASE-4 (PDE4) INHIB		
EUCRISA	T2	
TOPICAL AGENTS, MISCELLANEOUS		
GORDON'S UREA	T3	
HYFTOR	T4	PA SP
L-MESITRAN SOFT	T3	
MEDIHONEY	T3	

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TOPICAL AGENTS, MISCELLANEOUS *(con't.)*		
SAF-CLENS AF	T3	
trichloroacetic acid	T3	
TRICHLOROACETIC ACID	T1	
TOPICAL ANTIANDROGENIC AGENTS		
WINLEVI	T3	PA
TOPICAL ANTIBIOTIC PLEUROMUTILIN DERIVATIVES		
ALTABAX	T3	
TOPICAL ANTICHOLINERGIC HYPERHIDROSIS TX AGENTS		
QBREXZA	T3	
TOPICAL ANTI-INFLAMMATORY STEROIDAL		
ALA-SCALP (*scalacort*)	T3	ST
alclometasone dipropionate	T1	
amcinonide 0.1% cream, ointment, lotion	T1	PA
ANUSOL-HC 2.5% CREAM (*proctozone-hc*)	T1	PA
AQUA GLYCOLIC HC	T3	
betamethasone dipropionate	T1	
betamethasone valerate	T1	
betamethasone valerate (Luxiq)	T1	
betamethasone/propylene glyc	T1	
betamethasone/propylene glyc (Diprolene)	T1	
BRYHALI	T3	ST
CAPEX SHAMPOO	T3	ST
clobetasol propionate	T1	
clobetasol propionate (Clobex)	T1	
clobetasol propionate (Olux)	T1	
clobetasol propionate (Temovate)	T1	
clobetasol propionate/emoll	T1	
clobetasol propionate/emoll (Olux-e)	T1	
CLOBEX (*clobetasol propionate*)	T3	PA
CLOBEX (*clodan*)	T3	PA
CLOCORTOLONE PIVALATE	T1	
CLODAN 0.05% KIT	T3	ST
clodan 0.05% shampoo (Clobex)	T1	
CLODERM	T3	ST

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SKIN PREPS (Skin Conditions) *(con't.)*		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
TOPICAL ANTI-INFLAMMATORY STEROIDAL *(con't.)*		
CORDRAN	T3	PA
CORDRAN (*flurandrenolide*)	T3	PA
CORDRAN (*nolix*)	T3	PA
CUTIVATE 0.05% CREAM (*fluticasone propionate*)	T3	ST
CUTIVATE 0.05% LOTION (*fluticasone propionate*)	T3	PA
DERMA-SMOOTHE-FS (*fluocinolone acetonide*)	T3	ST
DERMATOP (*prednicarbate*)	T3	ST
desonide	T1	
desonide (Desowen)	T1	
desonide (Tridesilon)	T1	
DESOWEN (*desonide*)	T3	PA
desoximetasone (Topicort)	T1	
diflorasone diacetate	T1	PA
diflorasone diacetate (Psorcon)	T1	PA
diflorasone diacetate/emoll	T1	PA
DIPROLENE (*betamethasone diprop augmented*)	T3	ST
fluocinolone acetonide	T1	
fluocinolone acetonide (Derma-smoothe-fs)	T1	
fluocinolone acetonide (Synalar)	T1	
fluocinolone/shower cap (Derma-smoothe-fs)	T1	
fluocinonide	T1	
fluocinonide (Vanos)	T1	
fluocinonide/emollient base	T1	
flurandrenolide (Cordran)	T1	PA
fluticasone prop 0.005% oint	T1	
fluticasone prop 0.05% cream (Cutivate)	T1	
fluticasone prop 0.05% lotion (Cutivate)	T1	
fluticasone propionate (Cutivate)	T1	
halcinonide (Halog)	T1	PA
HALOBETASOL PROPIONATE	T1	
halobetasol prop 0.05% foam	T1	
halobetasol propionate (Ultravate)	T1	
HALOG 0.1% CREAM (*halcinonide*)	T3	PA
HALOG 0.1% OINTMENT	T3	PA

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SKIN PREPS (Skin Conditions) *(con't.)*		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
TOPICAL ANTI-INFLAMMATORY STEROIDAL *(con't.)*		
HALOG 0.1% SOLUTION	T3	ST
hydrocort buty 0.1% lipid crm (Locoid Lipocream)	T1	PA
hydrocort buty 0.1% lipo cream (Locoid Lipocream)	T1	PA
hydrocortisone	T1	
hydrocortisone (Ala-scalp)	T1	
hydrocortisone (Anusol-hc)	T1	
hydrocortisone buty 0.1% cream	T1	
hydrocortisone butyr 0.1% lotn (Locoid)	T1	PA
hydrocortisone butyr 0.1% oint (Locoid)	T1	
hydrocortisone butyr 0.1% soln	T1	
hydrocortisone valerate	T1	
IMPEKLO	T3	PA
IMPOYZ	T3	PA
KENALOG (*triamcinolone acetonide*)	T3	PA
LEXETTE	T3	ST
LOCOID 0.1% LOTION (*hydrocortisone butyrate*)	T3	PA
LOCOID 0.1% OINTMENT (*hydrocortisone butyrate*)	T3	
LOCOID LIPOCREAM	T3	PA
LOCOID LIPOCREAM (*hydrocortisone butyrate*)	T3	PA
LUXIQ (*betamethasone valerate*)	T3	ST
MOMETACURE	T3	
mometasone furoate 0.1% cream	T1	
mometasone furoate 0.1% oint	T1	
mometasone furoate 0.1% soln	T1	
NUCORT	T3	ST
OLUX (*clobetasol propionate*)	T3	PA
OLUX-E (*tovet emollient*)	T3	PA
PANDEL	T3	PA
prednicarbate (Dermatop)	T1	
PSORCON (*diflorasone diacetate*)	T3	PA
SCALACORT DK	T3	ST
SERNIVO	T3	PA
SYNALAR (*fluocinolone acetonide*)	T3	ST

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SKIN PREPS (Skin Conditions) *(con't.)*		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
TOPICAL ANTI-INFLAMMATORY STEROIDAL *(con't.)*		
SYNALAR TS	T3	ST
TEMOVATE (*clobetasol propionate*)	T3	ST
TEXACORT	T3	ST
TOPICORT (*desoximetasone*)	T3	ST
triamcinolone acetonide	T1	PA
triamcinolone acetonide (Kenalog)	T1	
TRIDESILON (*desonide*)	T3	PA
ULTRAVATE	T3	ST
VANOS (*fluocinonide*)	T3	PA
VERDESO	T3	PA
TOPICAL ANTI-INFLAMMATORY STEROID-LOCAL ANESTHETIC		
ANALPRAM HC	T3	
EPIFOAM	T3	
hydrocortisone/pramoxine (Pramosone)	T1	
lidocaine/hydrocortisone ac	T1	
MEZPAROX-HC	T1	
PRAMOSONE 1% LOTION	T2	
PRAMOSONE 1%-1% CREAM	T2	
PRAMOSONE 1%-1% OINTMENT	T2	
PRAMOSONE 2.5%-1% CREAM	T3	
PRAMOSONE 2.5%-1% LOTION	T3	
PRAMOSONE 2.5%-1% OINTMENT	T2	
TOPICAL ANTI-PARASITICS		
malathion (Ovide)	T1	
OVIDE (*malathion*)	T3	
TOPICAL NITRIC OXIDE RELEASING AGENTS		
ZELSUVMI 10.3% GEL	T3	PA
TOPICAL PREPARATIONS, ANTIBACTERIALS		
dermazene cream	T1	
DERMAZENE CREAM PACKET	T3	
hydrocortisone/iodoquinol	T1	
hydrocortisone/iodoquinol/aloe	T1	
iodine/potassium iodide	T1	
iodine/sodium iodide	T1	

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

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SKIN PREPS (Skin Conditions) *(con't.)*		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
VITAMIN A DERIVATIVES *(con't.)*		
tretinoin 0.025% cream (Retin-a)	T1	PA
tretinoin 0.025% gel (Retin-a)	T1	
tretinoin 0.05% cream (Retin-a)	T1	PA
tretinoin 0.05% gel (Atralin)	T1	PA
tretinoin 0.1% cream (Retin-a)	T1	PA
tretinoin microspheres (Retin-a Micro Pump)	T1	PA
tretinoin microspheres (Retin-a Micro)	T1	PA
TRETIN-X	T3	PA
VITAMIN A DERIVATIVES, TOPICAL ACNE AGENTS		
ARAZLO	T2	
FABIOR	T3	
TAZAROTENE 0.1% FOAM	T3	
SMOKING DETERRENTS (Smoking Cessation)[8]		
SMOKING DETERRENT AGENTS (GANGLIONIC STIM, OTHERS)		
NICOTROL	T2	PPACA
NICOTROL NS	T2	PPACA
SMOKING DETERRENT-NICOTINIC RECEPT.PARTIAL AGONIST		
CHANTIX	T2	
varenicline 1 mg cont month bx	T1	PPACA
SMOKING DETERRENTS, OTHER		
bupropion hcl sr 150 mg tablet	T1	PPACA
THYROID PREPS (Hormonal Agents)		
ANTI-THYROID PREPARATIONS		
methimazole (Tapazole)	T1	HD
propylthiouracil	T1	HD
TAPAZOLE (*methimazole*)	T3	HD
THYROID FUNCTION DIAGNOSTIC AGENTS		
THYROGEN	T4	SP
THYROID HORMONES		
ADTHYZA	T3	PA HD
ARMOUR THYROID	T3	HD
CYTOMEL (*liothyronine sodium*)	T3	HD
ERMEZA	T3	PA HD
LEVOTHYROXINE 100 MCG CAPSULE	T3	HD

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THYROID PREPS (Hormonal Agents) *(con't.)*		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
THYROID HORMONES *(con't.)*		
LEVOTHYROXINE 112 MCG CAPSULE	T3	HD
LEVOTHYROXINE 125 MCG CAPSULE	T3	HD
LEVOTHYROXINE 13 MCG CAPSULE	T3	HD
LEVOTHYROXINE 137 MCG CAPSULE	T3	HD
LEVOTHYROXINE 150 MCG CAPSULE	T3	HD
LEVOTHYROXINE 175 MCG CAPSULE	T3	HD
LEVOTHYROXINE 200 MCG CAPSULE	T3	HD
LEVOTHYROXINE 25 MCG CAPSULE	T3	HD
LEVOTHYROXINE 50 MCG CAPSULE	T3	HD
LEVOTHYROXINE 75 MCG CAPSULE	T3	HD
LEVOTHYROXINE 88 MCG CAPSULE	T3	HD
levothyroxine sodium	T1	HD
levothyroxine sodium (Synthroid)	T3	HD
liothyronine sodium (Cytomel)	T1	HD
liothyronine sodium (Triostat)	T1	HD
SYNTHROID (*unithroid*)	T3	HD
THYQUIDITY	T3	PA HD
thyroid, pork	T1	HD
thyroid, pork (Armour Thyroid)	T1	HD
thyroid, pork (Wp Thyroid)	T1	HD
THYROLAR-1	T2	HD
THYROLAR-1/2	T2	HD
THYROLAR-1/4	T2	HD
THYROLAR-2	T2	HD
THYROLAR-3	T2	HD
TIROSINT	T3	HD
TIROSINT-SOL	T3	HD
TRIOSTAT (*liothyronine sodium*)	T3	
WP THYROID	T1	HD
WP THYROID (*nature-throid*)	T1	HD
WP THYROID (*westhroid*)	T1	HD
CYTOCHROME P450 INHIBITORS		
TYBOST	T4	SP

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UNCLASSIFIED DRUG PRODUCTS (Asthma/COPD/Respiratory)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
CYSTIC FIBROSIS-CFTR POTENTIATOR-CORRECTOR COMBIN.		
ALYFTREK 10-50-125 MG TABLET	T4	PA QL(2 tabs/day) SP HD
ALYFTREK 4-20-50 MG TABLET	T4	PA QL(3 tabs/day) SP HD
BRONCHITOL	T4	PA SP
ORKAMBI 100 MG-125 MG TABLET	T4	PA QL (4 tabs/day) SP HD
ORKAMBI 100-125 MG GRANULE PKT	T4	PA QL (2 packs/day) SP HD
ORKAMBI 150-188 MG GRANULE PKT	T4	PA QL (2 packs/day) SP HD
ORKAMBI 200 MG-125 MG TABLET	T4	PA QL (4 tabs/day) SP HD
SYMDEKO	T4	PA QL (2 tabs/day) SP HD
TRIKAFTA 100-50-75 MG/150 MG	T4	PA QL(3 tabs/day) SP HD
TRIKAFTA 100-50-75 MG/75MG PKT	T4	PA QL(3 tabs/day) HD
TRIKAFTA 50-25-37.5 MG/75 MG	T4	PA QL(3 tabs/day) SP HD
TRIKAFTA 80-40-60MG/59.5MG PKT	T4	PA QL(3 tabs/day) HD
CYSTIC FIB-TRANSMEMB CONDUCT.REG.(CFTR) POTENTIATOR		
KALYDECO 150 MG TABLET	T4	PA QL (2 tabs/day) SP HD
KALYDECO 25 MG GRANULES PACKET	T4	PA QL (2 packs/day) SP HD
KALYDECO 5.8 MG GRANULES PACKET	T4	PA QL (2 packs/day) SP HD
KALYDECO 50 MG GRANULES PACKET	T4	PA QL (2 packs/day) SP HD
KALYDECO 75 MG GRANULES PACKET	T4	PA QL (2 packs/day) SP HD
LUNG SURFACTANTS		
CUROSURF	T3	
INFASURF	T3	
SURVANTA	T3	
MUCOLYTICS		
PULMOZYME	T4	PA SP HD
PULMONARY FIBROSIS - SYSTEMIC ENZYME INHIBITORS		
OFEV	T4	PA SP HD
SYSTEMIC ENZYME INHIBITORS		
ARALAST NP	T4	PA SP
GLASSIA	T4	PA SP
PROLASTIN C	T4	PA SP HD
JOENJA	T4	PA QL(2 tabs/day) SP
VIJOICE 125mg, 50mg	T4	PA QL (30 tabs/30 days) SP
VIJOICE 250mg dose pack	T4	PA QL (2 tabs/30 days) SP
ZEMAIRA	T4	PA SP
ZOKINVY	T4	PA QL (4 caps/day) SP

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UNCLASSIFIED DRUG PRODUCTS (Blood Modifiers/Bleeding Disorders)		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
ANTI-INFLAMMATORY - ANTIMITOTICS		
LODOCO	T3	PA
ANTIPORPHYRIA FACTORS		
PANHEMATIN	T4	SP
ERYTHROID MATURATION AGENTS		
REBLOZYL	T4	PA SP
UNCLASSIFIED DRUG PRODUCTS (Blood Pressure/Heart Medications)		
SPLEEN TYROSINE KINASE INHIBITORS		
TAVALISSE	T4	PA SP
BRADYKININ B2 RECEPTOR ANTAGONISTS		
FIRAZYR (*icatibant acetate*)	T4	PA SP
icatibant acetate (Firazyr)	T4	PA SP HD
CI ESTERASE INHIBITORS		
BERINERT	T4	PA SP HD
CINRYZE	T4	PA SP HD
HAEGARDA	T4	PA SP HD
RUCONEST	T4	PA SP HD
PLASMA KALLIKREIN INHIBITORS		
KALBITOR	T4	PA SP HD
ORLADEYO	T4	PA QL (1 caps/day) SP
UNCLASSIFIED DRUG PRODUCTS (Cancer)		
CHEMOTHERAPY RESCUE/ANTIDOTE AGENTS		
amifostine crystalline (Ethyol)	T4	SP
dexrazoxane hcl (Zinecard)	T4	SP
ETHYOL (*amifostine*)	T4	SP
KHAPZORY	T3	PA
leucovorin calcium	T1	
levoleucovorin calcium	T1	PA
mesna (Mesnex)	T4	SP
MESNEX	T4	SP
MESNEX (*mesna*)	T4	SP
VISTOGARD	T4	SP
VORAXAZE	T4	PA SP
ZINECARD (*dexrazoxane*)	T4	SP

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UNCLASSIFIED DRUG PRODUCTS (Cancer) *(cont.)*		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
INTRAPLEURAL SCLEROSING AGENTS, ANTINEOPLAST. ADJ.		
SCLEROSOL	T3	
STERILE TALC	T1	
STERITALC	T3	
RADIOACTIVE THERAPEUTIC AGENTS		
LUTATHERA	T4	PA SP
METASTRON	T3	PA
QUADRAMET	T3	PA
strontium-89 chloride (Metastron)	T1	PA
XOFIGO	T3	PA
TISSUE PROTECTIVE TX OF CHEMOTHERAPY EXTRAVASATION		
TOTECT	T3	
UNCLASSIFIED DRUG PRODUCTS (Dental Products)		
DENTAL AIDS AND PREPARATIONS		
chlorhexidine gluconate (Peridex)	T1	
PERIDEX (*periogard*)	T1	
triamcinolone acetonide	T1	
PERIODONTAL COLLAGENASE INHIBITORS		
doxycycline hyclate 20 mg tab	T1	
UNCLASSIFIED DRUG PRODUCTS (Diabetes)		
ANTIHYPERGLYCEMIC-SOD/GLUC COTRANSPORT2(SGLT2) INH		
INPEFA	T3	PA QL(1 tab/day) HD
UNCLASSIFIED DRUG PRODUCTS (Erectile Dysfunction)		
DRUGS TO TREAT ERECTILE DYSFUNCTION (ED)		
CAVERJECT	T3	QL (6 injectors/30 days)
CIALIS 10 MG TABLET (*tadalafil*)	T3	QL (6 tabs/30 days) ST HD
CIALIS 20 MG TABLET (*tadalafil*)	T3	QL (6 tabs/30 days) ST HD
CIALIS 5 MG TABLET (*tadalafil*)	T3	QL (8 tabs/30 days) ST HD
EDEX	T3	QL (6 injectors/30 days)
LEVITRA (*vardenafil hcl*)	T3	QL (10 tabs/30 days) ST
MUSE	T2	QL (6/30 days)
sildenafil 100 mg tablet (Viagra)	T1	QL (6 tabs/30 days) HD
sildenafil 25 mg tablet (Viagra)	T1	QL (10 tabs/30 days) HD
sildenafil 50 mg tablet (Viagra)	T1	QL (6 tabs/30 days) HD

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UNCLASSIFIED DRUG PRODUCTS (Erectile Dysfunction) *(cont.)*		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
DRUGS TO TREAT ERECTILE DYSFUNCTION (ED) *(cont.)*		
STENDRA	T3	QL (8 tabs/30 days) ST
tadalafil 2.5 mg tablet	T1	QL(1 tab/day) HD
tadalafil 10 mg tablet (Cialis)	T1	QL(8 tabs/30 days) HD
tadalafil 20 mg tablet (Cialis)	T1	QL(8 tabs/30 days) HD
tadalafil 5 mg tablet (Cialis)	T1	QL(1 tab/day) HD
vardenafil hcl	T1	QL (10 tabs/30 days)
vardenafil hcl (Levitra)	T1	QL (10 tabs/30 days)
VIAGRA (*sildenafil citrate*)	T3	QL (6 tabs/30 days) ST HD
UNCLASSIFIED DRUG PRODUCTS (Eye Conditions)		
INSULIN-LIKE GROWTH FACTOR RECEPTOR (IGF-R) INHIB		
TEPEZZA	T4	PA SP HD
OCULAR PHOTOACTIVATED VESSEL-OCCLUDING AGENTS		
VISUDYNE	T4	SP
UNCLASSIFIED DRUG PRODUCTS (Gastrointestinal/Heartburn)		
CALCIMIMETIC, PARATHYROID CALCIUM ENHANCER		
cinacalcet hcl (Sensipar)	T4	SP
PARSABIV	T4	PA SP
SENSIPAR (*cinacalcet hcl*)	T4	PA SP
ORAL MUCOSITIS/STOMATITIS AGENTS		
ORAMAGICRX	T3	
REZDIFFRA	T4	PA QL(1 tab/day) SP HD
SALIVA STIMULANT AGENTS		
NUMOISYN	T2	
UNCLASSIFIED DRUG PRODUCTS (Hormonal Agents)		
BONE FORMATION STIM. AGENTS - PARATHYROID HORMONE		
FORTEO	T4	PA QL (3ml/21 days) SP HD
teriparatide 600 mcg/2.4ml pen (Forteo)	T4	PA QL (1 pen/28 days) SP HD
GROWTH HORMONE RECEPTOR ANTAGONISTS		
SOMAVERT	T4	PA SP HD
HYPERPARATHYROID TX AGENTS - VITAMIN D ANALOG-TYPE		
doxercalciferol	T1	
doxercalciferol (Hectorol)	T1	
HECTOROL (*doxercalciferol*)	T3	

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UNCLASSIFIED DRUG PRODUCTS (Hormonal Agents) *(cont.)*		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
HYPERPARATHYROID TX AGENTS - VITAMIN D ANALOG-TYPE *(cont.)*		
paricalcitol 1 mcg capsule (Zemplar)	T4	SP HD
PARICALCITOL 10 MCG/2 ML VIAL	T4	SP
paricalcitol 10 mcg/2 ml vial (Zemplar)	T4	SP
paricalcitol 2 mcg capsule (Zemplar)	T4	SP HD
PARICALCITOL 2 MCG/ML VIAL	T4	SP
paricalcitol 2 mcg/ml vial (Zemplar)	T4	SP
paricalcitol 4 mcg capsule	T4	SP HD
PARICALCITOL 5 MCG/ML VIAL	T4	SP
paricalcitol 5 mcg/ml vial (Zemplar)	T4	SP
RAYALDEE	T3	
ZEMPLAR 1 MCG CAPSULE (*paricalcitol*)	T4	SP HD
ZEMPLAR 10 MCG/2 ML VIAL (*paricalcitol*)	T4	SP
ZEMPLAR 2 MCG CAPSULE (*paricalcitol*)	T4	SP HD
ZEMPLAR 2 MCG/ML VIAL (*paricalcitol*)	T4	SP
ZEMPLAR 5 MCG/ML VIAL (*paricalcitol*)	T4	SP
MENOPAUSAL SYMPT SUPP-SEL ESTROGEN RECEP MODULATOR		
OSPHENA	T3	HD
UNCLASSIFIED DRUG PRODUCTS (Miscellaneous)		
ABORTIFACIENT-PROGESTERONE RECEPTOR ANTAGONISTS		
MIFEPREX	T3	
mifepristone (Mifeprex)	T1	
ACID AND ALKALI POISON ANTIDOTES		
methylene blue (antidotes)	T1	
PROVAYBLUE	T3	
AGENTS TO TX PERIODIC PARALYSIS - CARBON ANHYD INH		
dichlorphenamide (Keveyis)	T4	PA SP
KEVEYIS (*dichlorphenamide*)	T4	PA SP
AMMONIA INHIBITORS		
CARBAGLU	T4	SP HD
PHEBURANE	T4	PA QL (8 bottles/30days) SP
AMYLOIDOSIS AGENTS-TRANSTHYRETIN (TTR) SUPPRESSION		
ONPATTRO	T4	PA SP
TEGSEDI	T4	PA SP HD
WAINUA	T4	PA QL(1 auto-inj/28 days) SP

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UNCLASSIFIED DRUG PRODUCTS (Miscellaneous) *(cont.)*

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ANTI-ALCOHOLIC PREPARATIONS		
acamprosate calcium	T1	
ANTABUSE (*disulfiram*)	T3	
disulfiram (Antabuse)	T1	
VIVITROL	T4	SP HD
ANTIDOTES, MISCELLANEOUS		
ACETADOTE (*acetylcysteine*)	T3	
acetylcysteine (Acetadote)	T1	
CETYLEV	T3	
CYANOKIT	T3	
DIGIFAB	T3	
fomepizole	T1	
SODIUM NITRITE	T1	
ANTI-FIBROTIC THERAPY - PYRIDONE ANALOGS		
pirfenidone 267 mg capsule (Esbriet)	T4	PA SP HD
BENZODIAZEPINE ANTAGONISTS		
flumazenil	T1	
CATHETER LOCK SOLUTIONS		
DEFENCATH	T3	
CHOLINESTERASE REACTIVAT.-MUSCARINIC ANTG.ANTIDOTE		
DUODOTE	T3	
CHOLINESTERASE REACTIVATING, ORGANOPHOS. ANTIDOTES		
PRALIDOXIME CHLORIDE	T1	
PROTOPAM CHLORIDE	T3	
COMPLEMENT INHIBITORS		
PIASKY	T4	PA SP
VEOPOZ	T4	SP
VOYDEYA	T4	PA QL(1 packet/28 days) SP
ZILBRYSQ	T4	PA QL(1 syringe/day) SP
CRYOPRESERVATIVE AGENTS		
dimethyl sulfoxide	T3	
DILUENT SOLUTIONS		
diluent for epoprostenol (glyc)	T1	
DILUENT FOR REMODULIN	T3	
diluent for treprostinil (gly) (Diluent For Remodulin)	T1	
ELLIOTTS B	T3	

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List of Prescription Medications

UNCLASSIFIED DRUG PRODUCTS (Miscellaneous) *(cont.)*		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
DRUGS TO TREAT ACUTE HEPATIC PORPHYRIA (AHP)		
GIVLAARI	T4	PA SP HD
DRUGS TO TREAT HEREDITARY TYROSINEMIA		
nitisinone (Orfadin)	T4	PA SP HD
NITYR	T4	PA SP
ORFADIN	T4	PA SP
ORFADIN (*nitisinone*)	T4	PA SP
GENERAL INHALATION AGENTS		
HYPER-SAL	T3	
nebusal 3% vial	T1	
NEBUSAL 6% VIAL	T3	
sodium chloride for inhalation	T1	
sodium chloride for inhalation (Hyper-sal)	T1	
GENETIC D/O TX - SMN PROTEIN DEFICIENCY TREATMENT		
EVRYSDI	T4	PA SP HD
GENETIC D/O TX - SMN PROTEIN DEFICIENCY TREATMENT		
AMONDYS-45	T4	PA SP
EVRYSDI	T4	PA SP HD
EXONDYS-51	T4	PA SP
SPINRAZA	T4	PA SP HD
VILTEPSO	T4	PA SP
VYONDYS-53	T4	PA SP
GLUCOSYLCERAMIDE SYNTHASE (GCS) INHIBITOR		
CERDELGA	T4	PA SP HD
miglustat (Zavesca)	T4	PA SP HD
OPFOLDA	T4	PA QL(8 caps/30 days) SP HD
ZAVESCA (*miglustat*)	T4	PA SP HD
KIDNEY STONE AGENTS		
tiopronin	T4	SP
LEAD POISONING, AGENTS TO TREAT (CHELATING-TYPE)		
CALCIUM DISODIUM VERSENATE	T1	PA
MENOPAUSAL SYMPTOMS SUPPRESSANT - SSRIs		
paroxetine mesylate	T1	QL (1 cap/day) HD
VEOZAH	T3	QL(1 tab/day)
METABOLIC DISEASE ENZYME REPLACE, HYPOPHOSPHATASIA		
STRENSIQ	T4	PA SP

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UNCLASSIFIED DRUG PRODUCTS (Miscellaneous) *(cont.)*		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
METABOLIC DISEASE ENZYME REPLACEMENT, BATTEN DISEA		
BRINEURA	T4	PA SP
METABOLIC DISEASE ENZYME REPLACEMENT, FABRY'S DX		
FABRAZYME	T4	PA SP HD
METABOLIC DISEASE ENZYME REPLACEMENT, GAUCHER'S DX		
CEREZYME	T4	PA SP HD
ELELYSO	T4	PA SP
VPRIV	T4	PA SP HD
METABOLIC DISEASE ENZYME REPLACEMENT, MOCD		
NULIBRY	T4	PA SP
METABOLIC DISEASE ENZYME REPLACEMENT, POMPE DISEASE		
LUMIZYME	T4	PA SP
POMBILITI	T4	PA SP HD
METABOLIC DX ENZYME REPLACEMENT,ALPHA-MANNOSIDOSIS		
LAMZEDE	T4	PA SP
METABOLIC DX ENZYME REPLACE, MUCOPOLYSACCHARIDOSIS		
ALDURAZYME	T4	PA SP HD
ELAPRASE	T4	PA SP
MEPSEVII	T4	PA SP
NAGLAZYME	T4	PA SP
VIMIZIM	T4	PA SP
METABOLIC DX ENZYME REPLACEMENT, LYSO.ACID LIP.DEF.		
KANUMA	T4	PA SP
METABOLIC DX ENZYME REPLACEMT, SEV.COMB.IMMUNE DEF.		
ADAGEN	T4	PA SP
REVCOVI	T4	PA SP
METALLIC POISON, AGENTS TO TREAT		
BAL IN OIL	T3	PA
CHEMET	T3	
CUVRIOR	T4	PA SP
deferasirox (Exjade)	T4	SP HD
deferasirox (Jadenu Sprinkle)	T4	SP HD
deferasirox (Jadenu)	T4	SP HD
deferiprone (Ferriprox)	T4	PA SP HD
deferoxamine mesylate	T1	

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UNCLASSIFIED DRUG PRODUCTS (Miscellaneous) *(cont.)*		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
METALLIC POISON, AGENTS TO TREAT *(cont.)*		
deferoxamine mesylate (Desferal Mesylate)	T1	
DESFERAL MESYLATE (*deferoxamine mesylate*)	T3	
EXJADE (*deferasirox*)	T4	PA SP HD
FERRIPROX	T4	PA SP
FERRIPROX (2 TIMES A DAY)	T4	PA SP
GALZIN	T3	
JADENU (*deferasirox*)	T4	PA SP HD
JADENU SPRINKLE (*deferasirox*)	T4	PA SP HD
NITHIODOTE	T3	
PENTETATE CALCIUM TRISODIUM	T1	
ZINC TRISODIUM	T1	
RADIOGARDASE	T3	
sodium thiosulf (poison treat)	T1	
SYPRINE (*trientine hcl*)	T4	PA SP HD
trientine hcl (Syprine)	T4	PA SP HD
TRIENTINE HCL 500 MG CAPSULE	T4	PA SP HD
MISCELLANEOUS AGENTS		
NEXAVIR	T4	SP
NATRIURETIC PEPTIDES		
VOXZOGO	T4	PA SP HD
NICOTINIC RECEPT.PARTIAL AGONIST, ALPHA4BETA2 SPEC		
TYRVAYA	T3	QL (2/month) HD
NUCLEAR FACTOR ERYTHROID 2-REL. FACTOR 2 ACTIVATOR		
SKYCLARYS	T4	PA QL(3 caps/day) SP
OINTMENT/CREAM BASES		
RADIAGEL	T3	
OXALOSIS AGENT - OXALATE INHIBITOR, SIRNA BASED		
RIVFLOZA 128 MG/0.8 ML SYRINGE	T4	PA QL(1 syringe/30 days) SP
RIVFLOZA 160 MG/ML SYRINGE	T4	PA QL(1 syringe/30 days) SP
RIVFLOZA 80 MG/0.5 ML VIAL	T4	PA SP
PHARMACOLOGICAL CHAPERONE-ALPHA-GALACTOSID.A STABZ		
GALAFOLD	T4	PA SP HD
PKU TX AGENT-COFACTOR OF PHENYLALANINE HYDROXYLASE		
javygtor 100 mg powder packet (Kuvan)	T1	

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UNCLASSIFIED DRUG PRODUCTS (Miscellaneous) *(cont.)*		
PKU TX AGENT-COFACTOR OF PHENYLALANINE HYDROXYLASE *(cont.)*		
javygtor 100 mg tablet (Kuvan)	T1	
javygtor 500 mg powder packet (Kuvan)	T1	
KUVAN (*sapropterin dihydrochloride*)	T4	PA SP HD
sapropterin dihydrochloride (Kuvan)	T4	PA SP HD
PROTEIN STABILIZERS		
ATTRUBY	T4	PA QL (4 ml/day) SP HD
VYNDAMAX	T4	PA QL (1 cap/day) SP HD
VYNDAQEL	T4	PA QL (4 caps/day) SP HD
RADIOPHARMACEUTICALS ELEMENTS		
TECHNELITE TC-99M GENERATOR	T3	
RETINOIC ACID RECEPTOR (RAR) AGONISTS		
SOHONOS	T4	PA SP
SODIUM/SALINE PREPARATIONS		
bacteriostatic sodium chloride	T1	
SOLVENTS		
isopropyl alcohol	T3	
MURI-LUBE MINERAL OIL	T3	
TOPICAL/MUCOUS MEMBR./SUBCUT. ENZYMES		
HYLENEX	T4	SP HD
TREATMENT OF HYPERPHAGIA IN PRADER-WILLI SYNDROME		
VYKAT XR	T3	PA SP
WATER		
water for injection, sterile	T1	
water/me-paraben/propylparaben	T1	
UNCLASSIFIED DRUG PRODUCTS (Multiple Sclerosis)		
LEUKOCYTE ADHESION INHIB, ALPHA4-MEDIAT IGG4K MC AB		
TYSABRI	T4	PA SP HD
UNCLASSIFIED DRUG PRODUCTS (Nutritional/Dietary)		
METABOLIC DEFICIENCY AGENTS		
CARNITOR 1 GM/5 ML VIAL	T3	PA
CARNITOR 100 MG/ML ORAL SOLN (*levocarnitine*)	T3	PA
CARNITOR 330 MG TABLET (*levocarnitine*)	T3	PA
CARNITOR SF (*levocarnitine sf*)	T3	PA
CYSTADANE	T4	SP

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UNCLASSIFIED DRUG PRODUCTS (Nutritional/Dietary)		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
METABOLIC DEFICIENCY AGENTS		
levocarnitine (Carnitor)	T1	
levocarnitine (with sugar) (Carnitor)	T1	
UNCLASSIFIED DRUG PRODUCTS (Osteoporosis Products)		
BONE FORMATION AGENTS - SCLEROSTIN INHIBITOR, MONO		
EVENITY	T4	PA QL (2 syringes/month) SP
EVENITY (2 SYRINGES)	T4	PA QL (2 syringes/month) SP
BONE RESORPTION INHIBITOR AND VITAMIN D COMBS.		
FOSAMAX PLUS D	T3	ST HD
BONE RESORPTION INHIBITORS		
ACTONEL (*risedronate sodium*)	T3	ST HD
alendronate sodium	T1	HD
alendronate sodium (Fosamax)	T1	HD
ATELVIA (*risedronate sodium dr*)	T3	ST HD
BINOSTO	T3	ST HD
BONIVA 150 MG TABLET (*ibandronate sodium*)	T3	ST HD
BONIVA 3 MG/3 ML SYRINGE (*ibandronate sodium*)	T4	SP HD
CONEXXENCE	T4	PA SP
EVISTA (*raloxifene hcl*)	T3	HD
FOSAMAX (*alendronate sodium*)	T3	ST HD
ibandronate 3 mg/3 ml syringe (Boniva)	T4	SP HD
ibandronate 3 mg/3 ml vial	T4	SP HD
ibandronate sodium 150 mg tab (Boniva)	T1	HD
JUBBONTI	T3	PA SP
OSENVELT	T3	PA SP
pamidronate disodium	T4	SP HD
PROLIA	T4	PA SP
raloxifene hcl (Evista)	T1	HD PPACA
RECLAST (*zoledronic acid*)	T4	SP HD
risedronate sodium (Actonel)	T1	HD
risedronate sodium (Atelvia)	T1	HD
STOBOCLO	T4	SP HD
XGEVA	T4	PA SP
zoledronic acid	T4	SP HD
zoledronic acid/mannitol-water (Reclast)	T4	SP HD

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UNCLASSIFIED DRUG PRODUCTS (Pain Relief And Inflammatory Disease)		
ANTI-INFLAM. INTERLEUKIN-I RECEPTOR ANTAGONIST		
ARCALYST	T4	PA SP HD
ANTI-INFLAMMATORY, INTERLEUKIN-I BETA BLOCKERS		
ILARIS	T4	PA SP HD
FIBROMYALGIA AGENTS, SEROTONIN-NOREPINEPH RU INHIB		
SAVELLA	T2	HD
IMMUNOMODULATOR, B-LYMPHOCYTE STIM (BLYS)-SPEC INHIB		
BENLYSTA 120 MG VIAL	T4	PA SP
BENLYSTA 200 MG/ML AUTOINJECT	T4	PA SP HD
BENLYSTA 200 MG/ML SYRINGE	T4	PA SP HD
BENLYSTA 400 MG VIAL	T4	PA SP
JOINT CONTRACTURE THERAPY, COLLAGENASE ENZYME		
XIAFLEX	T3	PA SP
UNCLASSIFIED DRUG PRODUCTS (Seizure Disorders)		
NEUROPATHIC AGENTS		
LYRICA CR	T3	HD
UNCLASSIFIED DRUG PRODUCTS (Skin Conditions)		
INTERLEUKIN-13 (IL-13) INHIBITORS, MAB		
EBGLYSS	T4	PA SP
ADBRY	T4	PA SP HD
WOUND HEALING AGENTS, LOCAL		
balsam peru/castor oil (Venelex)	T1	
BALSAM PERU-CASTOR OIL	T1	
DERMULCERA	T1	
FILSUVEZ	T4	PA SP
VENELEX	T3	
UNCLASSIFIED DRUG PRODUCTS (Substance Abuse)		
OPIOID WITHDRAWAL THER, ALPHA-2 ADRENERGIC AGONIST		
lofexidine hcl (Lucemyra)	T1	QL(192 tabs/30 days)
LUCEMYRA *(lofexidine hcl)*	T2	QL (168 tabs/14 days)
OPIOID WITHDRAWAL THERAPY AGENTS, OPIOID-TYPE		
BUNAVAIL	T3	
buprenorphine hcl	T1	
buprenorphine hcl/naloxone hcl (Suboxone)	T1	

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UNCLASSIFIED DRUG PRODUCTS (Substance Abuse)		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
OPIOID WITHDRAWAL THERAPY AGENTS, OPIOID-TYPE *(con't.)*		
PROBUPHINE	T3	
SUBLOCADE	T4	SP
SUBOXONE (*buprenorphine-naloxone*)	T3	
ZUBSOLV	T2	
UNCLASSIFIED DRUG PRODUCTS (Transplant Medications)		
RHO KINASE INHIBITOR		
REZUROCK	T4	PA SP HD
UNCLASSIFIED DRUG PRODUCTS (Urinary Tract Conditions)		
BENIGN PROSTATIC HYPERTROPHY/MICTURITION AGENTS		
alfuzosin hcl (Uroxatral)	T1	HD
AVODART (*dutasteride*)	T3	PA HD
dutasteride (Avodart)	T1	HD
finasteride (Proscar)	T1	HD
FLOMAX (*tamsulosin hcl*)	T3	HD
PROSCAR (*finasteride*)	T3	PA HD
RAPAFLO 4 MG CAPSULE (*silodosin*)	T3	QL (1 cap/day) HD
RAPAFLO 8 MG CAPSULE (*silodosin*)	T3	HD
silodosin 4 mg capsule (Rapaflo)	T1	QL (1 cap/day) HD
silodosin 8 mg capsule (Rapaflo)	T1	HD
tamsulosin hcl (Flomax)	T1	HD
UROXATRAL (*alfuzosin hcl er*)	T3	HD
VANRAFIA	T4	PA QL(1 tab/day) SP
BPH AGENT-5-ALPHA-REDUCTASE INH AND PDE5 INH COMB		
ENTADFI	T3	PA QL(1 cap/day)
BPH 5-ALPHA-REDUCTASE INHIB-ALPHAI-ADRENOCEP ANTAG		
dutasteride/tamsulosin hcl	T1	HD
CYSTINE-DEPLETING AGENTS, NEPHROPATHIC CYSTINOSIS		
CYSTAGON	T4	SP
PROCYSBI	T4	PA SP HD
OVERACTIVE BLADDER AGENTS, BETA-3 ADRENERGIC RECEP		
GEMTESA	T3	QL (1 tab/day) ST HD
mirabegron er 25 mg tablet (Myrbetriq)	T1	QL(1 tab/day) HD
mirabegron er 50 mg tablet (Myrbetriq)	T1	HD

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UNCLASSIFIED DRUG PRODUCTS (Urinary Tract Conditions) *(cont.)*		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
OVERACTIVE BLADDER AGENTS, BETA-3 ADRENERGIC RECEP *(con't.)*		
MYRBETRIQ ER 25 MG TABLET *(mirabegron)*	T3	ST QL(1 tab/day) HD
MYRBETRIQ ER 50 MG TABLET *(mirabegron)*	T3	ST HD
URINARY TRACT ANTI-SPASMODIC, M(3) SELECTIVE ANTAG.		
darifenacin er 15 mg tablet	T1	HD
darifenacin er 7.5 mg tablet (Enablex)	T1	QL (1 tab/day) HD
ENABLEX (*darifenacin er*)	T3	QL (1 tab/day) ST HD
solifenacin 10 mg tablet (Vesicare)	T1	HD
solifenacin 5 mg tablet (Vesicare)	T1	QL (1 tab/day) HD
URINARY TRACT ANTI-SPASMODIC, M(3) SELECTIVE ANTAG. *(con't.)*		
VESICARE TABLET (*solifenacin succinate*)	T3	ST QL (1 tab/day) HD
VESICARE LS	T3	ST HD
URINARY TRACT ANTI-SPASMODIC/ANTI-INCONTINENCE AGENT		
DETROL (*tolterodine tartrate*)	T3	ST HD
DETROL LA 2 MG CAPSULE (*tolterodine tartrate er*)	T3	QL (1 cap/day) ST HD
DETROL LA 4 MG CAPSULE (*tolterodine tartrate er*)	T3	ST HD
DITROPAN XL (*oxybutynin chloride er*)	T3	ST HD
flavoxate hcl	T1	HD
OXYBUTYNIN 2.5 MG TABLET	T3	PA HD
oxybutynin 5 mg tablet	T1	HD
oxybutynin 5 mg/5 ml solution	T1	HD
oxybutynin 5 mg/5 ml syrup	T1	HD
oxybutynin chloride	T1	HD
oxybutynin chloride (Ditropan XI)	T1	HD
OXYTROL	T3	ST HD
tolterodine tart er 2 mg cap (Detrol La)	T1	QL (1 cap/day) HD
tolterodine tart er 4 mg cap (Detrol La)	T1	HD
tolterodine tartrate (Detrol)	T1	HD
TOVIAZ ER 4 MG TABLET	T2	QL (1 tab/day) HD
TOVIAZ ER 8 MG TABLET	T2	HD
trospium chloride	T1	HD
UNCLASSIFIED DRUG PRODUCTS (Weight Management)		
APPETITE STIM. FOR ANOREXIA, CACHEXIA, WASTING SYND.		
megestrol acetate	T1	

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VITAMINS (Nutritional/Dietary)		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
FOLIC ACID PREPARATIONS		
folic acid	T1	
MULTIVITAMIN PREPARATIONS		
CITRANATAL MEDLEY	T3	
FOLET ONE	T2	
INFUVITE ADULT	T3	
multivit infusn, adult 1, vit k	T3	
mvn no.53/iron/folic/dss/dha	T1	
OBSTETRIX ONE	T1	
PEDIATRIC VITAMIN PREPARATIONS		
INFUVITE PEDIATRIC	T3	
M.V.I. PEDIATRIC	T3	
VITALIPID N INFANT	T3	
VITLIPID N INFANT	T3	
VITAMIN A PREPARATIONS		
AQUASOL A	T3	
VITAMIN B PREPARATIONS		
vitamins b1, b2, b3, b5, and b6	T1	HD
VITAMIN BI PREPARATIONS		
thiamine hcl	T1	
VITAMIN BI2 PREPARATIONS		
B-12 COMPLIANCE	T1	
cyanocobalamin (vitamin b-12)	T1	PA
hydroxocobalamin	T1	
NASCOBAL	T3	PA
PHYSICIANS EZ USE B-12	T3	
VITAMIN C PREPARATIONS		
ASCOR	T3	
ascorbic acid	T1	
VITAMIN D PREPARATIONS		
calcitriol 0.25 mcg capsule	T1	
calcitriol 0.5 mcg capsule	T1	
calcitriol 1 mcg/ml ampul	T1	
calcitriol 1 mcg/ml vial	T1	HD
calcitriol 1 mcg/ml solution (Rocaltrol)	T1	HD

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VITAMINS (Nutritional/Dietary) *(cont.)*		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
VITAMIN D PREPARATIONS		
ergocalciferol (vitamin d2)	T1	HD
ROCALTROL (*calcitriol*)	T3	
MEPHYTON (*phytonadione*)	T3	
PHYTONADIONE	T1	
phytonadione (vit k1)	T1	
VITAMIN K PREPARATIONS		
phytonadione (vit k1) (Mephyton)	T1	
MULTIVITAMIN PREPARATIONS		
VITLIPID N ADULT	T3	

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Exclusions and limitations for coverage

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

Plans generally do not provide coverage for the following under the pharmacy benefit, except as required by state or federal law, or by the terms of your specific plan:[10]

- Over-the-counter (OTC) medicines (those that do not require a prescription) except insulin unless state or federal law requires coverage of such medicines.
- Prescription medications or supplies for which there is a prescription or OTC therapeutic equivalent or therapeutic alternative.
- Doctor-administered injectable medications covered under the Plan's medical benefit, unless otherwise covered under the Plan's prescription drug list or approved by Cigna Healthcare.
- Implantable contraceptive devices covered under the Plan's medical benefit.
- Medications that are not medically necessary.
- Experimental or investigational medications, including U.S. Food and Drug Administration (FDA)-approved medications used for purposes other than those approved by the FDA unless the medication is recognized for the treatment of the particular indication.
- Medications that are not approved by the FDA.
- Prescription and non-prescription devices, supplies, and appliances other than those supplies specifically listed as covered.
- Medications used for fertility,[11] sexual dysfunction, cosmetic purposes, weight loss, smoking cessation,[11] or athletic enhancement.
- Prescription vitamins (other than prenatal vitamins) or dietary supplements unless state or federal law requires coverage of such products.
- Immunization agents, biological products for allergy immunization, biological sera, blood, blood plasma and other blood products or fractions and medications used for travel prophylaxis.
- Replacement of prescription medications and related supplies due to loss or theft.
- Medications which are to be taken by or administered to a covered person while they are a patient in a licensed hospital, skilled nursing facility, rest home or similar institution which operates on its premises or allows to be operated on its premises a facility for dispensing pharmaceuticals.
- Prescriptions more than one year from the date of issue.
- Coverage for prescription medication products for the amount dispensed (days' supply) which is more than the applicable supply limit, or is less than any applicable supply minimum set forth in The Schedule, or which is more than the quantity limit(s) or dosage limit(s) set by the P&T Committee.
- More than one prescription order or refill for a given prescription supply period for the same prescription medication product prescribed by one or more doctors and dispensed by one or more pharmacies.
- Prescription medication products dispensed outside the jurisdiction of the United States, except as required for emergency or urgent care treatment.

In addition to the plan's standard pharmacy exclusions, certain new FDA-approved medication products (including, but not limited to, medications, medical supplies or devices that are covered under standard pharmacy benefit plans) may not be covered for the first six months of market availability unless approved by Cigna Healthcare as medically necessary.

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

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

1. App/online store terms and mobile phone carrier/data charges apply. Customers under age 13 (and/or their parent/guardian) will not be able to register at myCigna.com.
2. Prices shown on myCigna are not guaranteed and coverage is subject to your plan terms and conditions. Visit myCigna for more information.
3. U.S. Food and Drug Administration (FDA) website, "Generic 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.

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Discrimination is against the law

Cigna Healthcare® complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, sex, ancestry, religion, marital status, gender, sexual orientation, gender identity or sexual stereotypes.

Cigna Healthcare does not exclude people or treat them less favorably differently because of race, color, national origin, age, disability, sex, ancestry, religion, marital status, gender, sexual orientation, gender identity or sexual stereotypes.

Cigna Healthcare:

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

If you need reasonable modifications, appropriate auxiliary aids and services or language assistance services, contact the Civil Rights Coordinator.

If you believe that Cigna Healthcare has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, sex, ancestry, religion, marital status, gender, sexual orientation, gender identity or sexual stereotypes, you can file a grievance with the Civil Rights Coordinator
P.O. Box 188016, Chattanooga, TN 37422,
877.822.6561 (TTY: Dial 711)

ACAGrievance@CignaHealthcare.com

You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, the Civil Rights Coordinator is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at **https://ocrportal.hhs.gov/ocr/portal/lobby.jsf**, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue,
SW Room 509F, HHH Building
Washington, DC 20201
1.800.368.1019, 800.537.7697 (TDD)

Complaint forms are available at
https://www.hhs.gov/civil-rights/filing-a-complaint/complaint-process/index.html

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.