



Cigna Healthcare Standard 3-Tier Prescription Drug List

Coverage as of January 1, 2026

For the State of California

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

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

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

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

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 This drug list is subject to change and all prior versions are no longer in effect.



What's Inside?	Page
Information about this drug list	3
• Frequently asked questions (FAQs)	3
• Words you may need to know	10
• About this drug list	12
• How to read this drug list	12
• How to find your medication	15
List of prescription medications	18
Exclusions and limitations for coverage	148
Index of medications	149

View your drug list online, 24/7

This document was last updated on 08/01/2025.* Go online to see the most up-to-date information about the medications your plan covers.

- **Cigna.com/druglist.** Choose **Standard 3 Tier** from the dropdown list. Then type in your medication name or view the full list.
- **myCigna App¹ or myCigna.com.** Log into your account and use the Price a Medication tool to see how your medication is covered.

Questions?

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

* Drug list created: originally created 01/01/2004

Last updated: 08/01/2025, for changes starting 01/01/2026

Next planned update: 04/01/2026, for changes starting 07/01/2026

Information about this drug list

Frequently asked questions (FAQs)

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

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

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

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

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

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

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

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

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

Q. How do you decide which medications to cover?

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

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

Q. Why do certain medications need approval before my plan will cover them?

A. The review process helps make sure you're getting coverage for the right medication, at the right cost, in the right amount and for the right situation.

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

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

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

Information about this drug list

Frequently asked questions (FAQs) (cont.)

Q. What types of medications typically need approval?

A. Medications that:

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

Q. What types of medications typically have quantity limits?

A. Medications that are often:

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

Q. What medications are part of Step Therapy?

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

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

Q. Why does my medication have an age requirement?

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

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

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

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

Many times, we don't get all of the information we need from the doctor's office to approve coverage. If we don't approve your medication, your doctor can send us more information to review, using the same process as before. We're happy to review the request again. Depending on what your doctor sends this time, we may be able to approve coverage. Or you and your doctor can appeal the decision by sending us a request, in writing, that explains why we should cover the medication.

- **For non-urgent requests**, we'll let you and your doctor know within 72 hours of the decision. If approved, coverage will be provided until the prescription runs out (including refills).
- **For urgent requests based on exigent circumstances**, we'll let you and your doctor know within 24 hours of the decision. If approved, coverage will be provided for the duration of the exigency. If we don't respond to a completed prior authorization exception request within 72 hours of receiving a non-urgent request and 24

Information about this drug list

Frequently asked questions (FAQs) (cont.)

hours of receiving a request based on exigent circumstances, the request will be considered approved and your plan can't deny coverage of the medication. Also, if you've already received approval for your plan to cover your medication, we can't limit or exclude coverage for that medication if your doctor continues to prescribe it to treat your condition (as long as the medication is appropriately prescribed and is safe and effective in treating your condition).

Q. My plan doesn't cover my medication. I need to take it because it's medically necessary for my treatment. How do I get approval (prior authorization) for my medication?

A. If your doctor feels that your medication is necessary for your treatment and an alternative isn't right for you, your doctor can ask us to consider approving coverage of your medication. Ask your doctor's office to contact us to start the coverage review process. They know how the review process works and will take care of everything for you. In case the office asks, they can download a request form from our provider portal at cignaforhcp.com.

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

Many times, we don't get all of the information we need from the doctor's office to approve coverage. If we don't approve your medication, your doctor can send us more information to review, using the same process as before. We're happy to review the request again. Depending on what your doctor sends this time, we may be able to approve coverage. Or you and your doctor can appeal the decision by sending us a request, in writing, that explains why we should cover the medication.

- **For non-urgent requests**, we'll let you and your doctor know within 72 hours of the decision. If approved, coverage will be provided until the prescription runs out (including refills).
- **For urgent requests based on exigent circumstances**, we'll let you and your doctor know within 24 hours of the decision. If approved, coverage will be provided for the duration of the exigency. **It's important to know that when medications are approved, it's typically for one year of coverage.** If your medication is approved for less time, it's because there's a clinical reason based on our coverage rules (requirements) for the medication and/or the reviewing doctor.

Q. My medication is part of the Step Therapy program. I don't want to try an alternative. How do I get approval (prior authorization) for my medication?

A. If you and your doctor feel an alternative medication won't work for you, your doctor can ask us to consider approving coverage of your current medication. Ask your doctor's office to contact us to start the coverage review process. They know how the review process works and will take care of everything for you. In case the office asks, they can download a request form from our provider portal at cignaforhcp.com.

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

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

Information about this drug list

Frequently asked questions (FAQs) (cont.)

again. Depending on what your doctor sends this time, we may be able to approve coverage. Or you and your doctor can appeal the decision by sending us a request, in writing, that explains why we should cover the medication.

- **For non-urgent requests**, we'll let you and your doctor know within 72 hours of the decision. If approved, coverage will be provided until the prescription runs out (including refills).
- **For urgent requests based on exigent circumstances**, we'll let you and your doctor know within 24 hours of the decision. If approved, coverage will be provided for the duration of the exigency. If we don't respond to a completed prior authorization exception request within 72 hours of receiving a non-urgent request and 24 hours of receiving a request based on exigent circumstances, the request will be considered approved and your plan can't deny coverage of the medication.

Your Step Therapy rights under California State law:

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

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

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

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

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

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

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

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

A. Yes.

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

A. We review all recently approved medications and products to see if they should be covered, and if so, at what cost-share (tier). These include, but are not limited to, medications, medical supplies and/or devices covered under standard pharmacy benefits. It can take up to six months from the date the FDA approved them for us to make a decision.

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

Information about this drug list

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

Q. What are preventive medications?

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

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

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

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

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

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

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

A. When you and your doctor are thinking about the right medication for your treatment, knowing how much it costs, what lower-cost options are available, and which pharmacies have the best prices can help you avoid surprises. Log in to the myCigna App or **myCigna.com** and use the Price a Medication tool to

see how much your medication costs before you get to the pharmacy counter – or even before you leave your doctor's office.²

Q. What's a cost-share?

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

Q. How can I save money on my prescription medications?

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

Q. What's a generic medication?

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

Q. Do generics work the same as brand-name medications?

A. Yes. A generic medication works in the same way and provides the same clinical benefit as the brand-name medication.³

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

A. The generic and brand-name medication may³:

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

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

Information about this drug list

Frequently asked questions (FAQs) (cont.)

Q. What is a "biosimilar" medication?

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

Q. How do I know which pharmacies are in my plan's network?

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

Q. My pharmacy isn't in my plan's network. Can I continue to fill my prescriptions there?

A. To get the most from your plan coverage, you should use an in-network pharmacy. If your plan offers out-of-network coverage, you'll pay your out-of-network cost-share to fill a prescription there.

Q. Do I have to use home delivery to fill my prescription?

A. It depends on your plan. Some plans require you to fill maintenance medications through Express Scripts® Pharmacy and/or specialty medications through Accredo® Specialty Pharmacy for them to be covered.⁵ Log in to the myCigna App or **myCigna.com**, or check your plan materials, to find out what your plan requires.

Q. Can I fill my prescriptions by mail?

A. Yes, as long as your plan offers home delivery.⁵

Fill maintenance medications through Express Scripts Pharmacy

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

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

Here are two easy ways to get started:

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

Fill specialty medications through Accredo Specialty Pharmacy

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

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

Information about this drug list

Frequently asked questions (FAQs) (cont.)

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

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

Q. I take a specialty medication to treat my multiple sclerosis. My plan requires me to fill my medication through Accredo. How do I get started?

A. Some plans allow one or more fills at a retail pharmacy before switching to Accredo. Check your plan materials to find out if your plan allows retail fills.

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

Q. I take a specialty medication that can only be filled at certain pharmacies in the United States. How do I fill my prescription?

A. Talk with your doctor. He or she should be able to tell you which in-network pharmacies can fill your prescription. Once you find a pharmacy, ask your doctor to send them your prescription.

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

Q. How do I fill my prescription?

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

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

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

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

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

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

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

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

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

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

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

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 Standard 3-Tier Prescription Drug List as of January 1, 2026. **The drug list is updated often**; so, not all of the medications your plan covers may be listed here. Also, your plan may not cover all of these medications. Log in to the myCigna App or **myCigna.com** to see which medications your plan covers.

How to read this drug list

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

- The generic version of a brand-name medication is listed in parentheses and 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. These medications are covered at your plan's highest cost-share. Non-preferred brands typically have a generic and/or preferred brand alternative(s) that treats the same condition.	\$\$\$

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

Information about this drug list

How to read this drug list (cont.)

Letters (acronyms) in the Notes column

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

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

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

Information about this drug list

How to read this drug list (cont.)

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

ANALGESICS (Pain Relief and Inflammatory Disease)			Therapeutic drug category and class describes the condition the medication is used to treat.
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits	Coverage requirement) and limits lets you know if your plan has extra requirements before it will cover the medication.
ANALGESIC, NON-SALICYLATE AND BARBITURATE COMBINAT			
<i>butalbital/acetaminophen</i>	T1		
ANALGESIC, SALICYLATE, BARBITURATE, XANTHINE COMB.			
<i>butalb-aspirin-caffe 50-325-40</i>	T1	QL (6 tabs/day)	
<i>butalbital-asa-cafeine cap</i> (Fiorinal)	T1	QL (6 caps/day)	
<i>FIORINAL</i> (<i>butalbital-aspirin-cafeine</i>)	T3	QL (6 caps/day)	
ANALGESIC, NON-SALICYLATE, BARBITURATE, XANTHINE COMB.			
<i>butalb/acetaminophen/cafeine</i>	T3		
<i>butalb/acetaminophen/cafeine</i> (Esgic)	T3	QL (6 caps/day)	
<i>butalb-acetamin-caff 50-300-40</i> (Fioricet)	T1	QL (6 caps/day)	
<i>butalb-acetamin-caff 50-325-40</i> (Esgic)	T1	QL (6 tabs/day)	
<i>ESGIC 50-325-40 MG TABLET</i> (<i>butalbital-acetaminophen-caffe</i>)	T3	QL (6 tabs/day)	
<i>ESGIC CAPSULE</i> (<i>zebutal</i>)	T3	QL (6 caps/day)	
<i>FIORICET</i> (<i>phrenilin forte</i>)	T1	QL (6 caps/day)	
ANALGESIC/ANTIPYRETICS, SALICYLATES			
<i>choline salicyl/mag salicylate</i>	T1	HD	
<i>diflunisal</i>	T1	HD	
ANTI-MIGRAINE PREPARATIONS			
<i>AIMOVIG AUTOINJECTOR</i>	T2	PA	
<i>AJOVY AUTOINJECTOR</i>	T2	PA	
<i>AJOVY SYRINGE</i>	T2	PA	
<i>almotriptan malate</i>	T1	QL (12 tabs/30 days)	
<i>CAFERGOT</i> (<i>ergotamine-cafeine</i>)	T3	QL (40 tabs/28 days)	
<i>dihydroergotamine 1 mg/ml amp</i>	T1	QL (10 amps/30 days)	
<i>eletriptan hydrobromide</i>	T1	QL (6 tabs/30 days)	
<i>EMGALITY PEN</i>	T2	PA	
<i>EMGALITY SYRINGE</i>	T2	PA	
<i>ergotamine tartrate/cafeine</i>	T1		
<i>ergotamine tartrate/cafeine</i> (Cafergot)	T1	QL (40 tabs/28 days)	

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

Information about this drug list

How to find your medication

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

Condition	Page	Condition	Page
Analgesics (Pain Relief and Inflammatory Disease)	19-23	Anti-Infectives (Infections)	45
Analgesics (Urinary Tract Conditions)	22	Anti-Infectives/Miscellaneous (Feminine Products)	45
Anesthetics (Miscellaneous)	22	Anti-Infectives/Miscellaneous (Infections)	45, 46
Anesthetics (Pain Relief and Inflammatory Disease)	24	Anti-Infectives/Miscellaneous (Miscellaneous)	47
Anesthetics (Urinary Tract Conditions)	24	Anti-Inflammatory Tumor Necrosis Factor Inhibiting Agents (Pain Relief and Inflammatory Disease)	47, 48
Anti-Allergy (Allergy and Nasal Sprays)	24	Anti-Neoplastics (Cancer)	48-53
Anti-Arthritics (Pain Relief and Inflammatory Disease)	24-27	Anti-Neoplastics (Skin Conditions)	54
Anti-Asthmatics (Asthma/COPD/Respiratory)	27-30	Anti-Obesity Drugs (Weight Management)	54
Antibiotics (Allergy/Nasal Sprays)	30	Anti-Parasitics (Infections)	55
Antibiotics (Ear Medications)	30	Anti-Parkinson's Drugs (Parkinson's Disease)	55-57
Antibiotics (Eye Conditions)	30, 31	Anti-Platelet Drugs (Blood Thinners/Anti-Clotting)	57
Antibiotics (Infections)	31-36	Antivirals (Aids/Hiv)	57-60
Antibiotics (Skin Conditions)	37	Antivirals (Eye Conditions)	60
Anti-Coagulants (Blood Thinners/Anti-Clotting)	37-39	Antivirals (Infections)	60-62
Antidotes (Gastrointestinal/Heartburn)	39	Antivirals (Skin Conditions)	62
Antidotes (Substance Abuse)	39	Autonomic Drugs (Allergy/Nasal Sprays)	62
Anti-Fungals (Eye Conditions)	39	Autonomic Drugs (Alzheimer's Disease)	62
Anti-Fungals (Feminine Products)	39	Autonomic Drugs (Attention Deficit Hyperactivity Disorder)	62, 63
Anti-Fungals (Infections)	40	Autonomic Drugs (Blood Pressure/Heart Medications)	63
Anti-Fungals (Skin Conditions)	40, 41	Autonomic Drugs (Urinary Tract Conditions)	63, 64
Antihistamine and Decongestant Combination (Allergy/Nasal Sprays)	41	Biologicals (Allergy/Nasal Sprays)	64
Antihistamines (Eye Conditions)	41	Biologicals (Blood Pressure/Heart Medications)	64
Anti-Hyperglycemics (Diabetes)	42-45	Biologicals (Miscellaneous)	64
Anti-Infectives (Feminine Products)	45	Biologicals (Vaccines)	64-66

Information about this drug list

How to find your medication (cont.)

Condition	Page	Condition	Page
Blood (Blood Modifiers/Bleeding Disorders)	66, 67	Elect/Caloric/H2O (Miscellaneous)	94
Blood (Blood Thinners/Anti-Clotting)	67	Elect/Caloric/H2O (Nutritional/Dietary)	95
Cardiac Drugs (Blood Pressure/Heart Medications)	67-70	Elect/Caloric/H2O (Urinary Tract Conditions)	96
Cardiovascular (Asthma/COPD/Respiratory)	70, 71	Gastrointestinal (Cholesterol Medications)	96
Cardiovascular (Blood Pressure/Heart Medications)	71-77	Gastrointestinal (Gastrointestinal/Heartburn)	96-102
Cardiovascular (Cholesterol Medications)	77-79	Gastrointestinal (Pain Relief and Inflammatory Disease)	102
CARDIOVASCULAR (Miscellaneous)	79	Hormones (Hormonal Agents)	102-107
CNS Drugs (Alzheimer's Disease)	79, 80	Hormones (Infertility)	108
CNS Drugs (Miscellaneous)	80	Hormones (Miscellaneous)	108
CNS Drugs (Multiple Sclerosis)	80, 81	Hormones (Osteoporosis Products)	108
CNS Drugs (Pain Relief and Inflammatory Disease)	81	Immunosuppressants (Pain Relief and Inflammatory Disease)	108, 109
CNS Drugs (Seizure Disorders)	81-84	Immunosuppressants (Skin Conditions)	109
CNS Drugs (Sleep Disorders/Sedatives)	84	Immunosuppressants (Transplant Medications)	109, 110
Colony Stimulating Factors (Blood Modifiers/Bleeding Disorders)	84, 85	Miscellaneous Medical Supplies, Devices, Non-Drug (Diabetes)	110-112
COLONY STIMULATING FACTORS (Cancer)	85	Miscellaneous Medical Supplies, Devices, Non-Drug (Miscellaneous)	112-119
Contraceptives (Contraception Products)	85-87	Muscle Relaxants (Pain Relief and Inflammatory Disease)	119, 120
Cough/Cold Preparations (Allergy/Nasal Sprays)	87	Prenatal Vitamins (Nutritional/Dietary)	120, 121
Cough/Cold Preparations (Cough/Cold Medications)	87, 88	Psychotherapeutic (Anxiety/Depression/Bipolar Disorder)	121-125
DIAGNOSTIC (Diabetes)	88	Psychotherapeutic Drugs (Attention Deficit Hyperactivity Disorder)	125, 126
Diagnostic (Miscellaneous)	88, 89	Psychotherapeutic Drugs (Miscellaneous)	126
Diuretics (Diuretics)	89, 90	Psychotherapeutic Drugs (Schizophrenia/Anti-Psychotics)	127-129
EENT Preps (Allergy/Nasal Sprays)	90, 91	Psychotherapeutic Drugs (Sleep Disorders/Sedatives)	129, 130
EENT Preps (Ear Medications)	91	Skin Preps (Miscellaneous)	130
EENT Preps (Eye Conditions)	91-93		
Elect/Caloric/H2O (Cholesterol Medications)	94		
Elect/Caloric/H2O (Dental Products)	94		
Elect/Caloric/H2O (Diabetes)	94		

Information about this drug list

How to find your medication (cont.)

Condition	Page	Condition	Page
Skin Preps (Pain Relief and Inflammatory Disease)	131	Unclassified Drug Products (Miscellaneous)	141-144
Skin Preps (Skin Conditions)	131-137	Unclassified Drug Products (Nutritional/Dietary)	144
Smoking Deterrents (Smoking Cessation)	137	Unclassified Drug Products (Osteoporosis Products)	144
Thyroid Prep (Hormonal Agents)	137	Unclassified Drug Products (Pain Relief and Inflammatory Disease)	144, 145
Unclassified Drug Products (Asthma/COPD/Respiratory)	138, 139	UNCLASSIFIED DRUG PRODUCTS (Skin Conditions)	145
Unclassified Drug Products (Blood Modifiers/Bleeding Disorders)	139	Unclassified Drug Products (Substance Abuse)	145
Unclassified Drug Products (Blood Pressure/Heart Medications)	139	Unclassified Drug Products (Transplant Medications)	145
Unclassified Drug Products (Cancer)	140	Unclassified Drug Products (Urinary Tract Conditions)	145, 146
Unclassified Drug Products (Dental Products)	140	Vitamins (Nutritional/Dietary)	146, 147
Unclassified Drug Products (Erectile Dysfunction)	140, 141		
Unclassified Drug Products (Eye Dysfunction)	141		
Unclassified Drug Products (Gastrointestinal/Heartburn)	141		
Unclassified Drug Products (Hormonal Agents)	141		

List of Prescription Medications

ANALGESICS (Pain Relief and Inflammatory Disease)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ANALGESIC, NON-SALICYLATE AND BARBITURATE COMBINAT		
<i>butalbital/acetaminophen</i>	T1	
ANALGESIC, SALICYLATE, BARBITURATE, XANTHINE COMB.		
<i>butalb-aspirin-caffe 50-325-40 (Esgic)</i>	T1	QL (6 tabs/day)
<i>butalbital-asa-cafeine cap (Fiorinal)</i>	T1	QL (6 caps/day)
FIORINAL (<i>butalbital-aspirin-cafeine</i>)	T3	QL (6 caps/day)
ANALGESIC, NON-SALICYLATE, BARBITURATE, XANTHINE COMB.		
<i>butalb/acetaminophen/cafeine</i>	T3	
<i>butalb/acetaminophen/cafeine (Esgic)</i>	T3	QL (6 caps/day)
<i>butalb-acetamin-caff 50-300-40 (Fioricet)</i>	T1	QL (6 caps/day)
<i>butalb-acetamin-caff 50-325-40 (Esgic)</i>	T1	QL (6 tabs/day)
ANALGESIC/ANTIPYRETICS, SALICYLATES		
<i>choline salicyl/mag salicylate</i>	T1	HD
<i>diflunisal</i>	T1	HD
ANALGESICS, NON-OPIOID		
JOURNAVX	T3	QL
ANTI-MIGRAINE PREPARATIONS		
AIMOVIG AUTOINJECTOR	T2	PA
AJOVY AUTOINJECTOR	T2	PA
AJOVY SYRINGE	T2	PA
<i>almotriptan malate</i>	T1	QL (12 tabs/30 days)
CAFERGOT (<i>ergotamine-cafeine</i>)	T3	QL (40 tabs/28 days)
<i>dihydroergotamine 1 mg/ml amp</i>	T1	QL (10 amps/30 days)
<i>eletriptan hydrobromide</i>	T1	QL (6 tabs/30 days)
EMGALITY PEN	T2	PA
EMGALITY SYRINGE	T2	PA
<i>ergotamine tartrate/cafeine</i>	T1	
<i>ergotamine tartrate/cafeine (Cafergot)</i>	T1	QL (40 tabs/28 days)
<i>frovatriptan succinate</i>	T1	QL (18 tabs/30 days)
<i>isomethept/dichlphn/acetaminop</i>	T1	
<i>isomethepten/cafe/acetaminophen</i>	T1	
<i>naratriptan hcl (Amerge)</i>	T1	QL (9 tabs/30 days)
NURTEC ODT	T2	PA QL (16 tabs/30 days)
REYVOW	T3	PA QL(8 tabs/30 days)
<i>rizatriptan ODT(Maxalt Mlt)</i>	T1	QL(12 tabs/30 days)
<i>rizatriptan tablet (Maxalt)</i>	T1	QL(12 tabs/30 days)

T1 – Typically Generics

PA – Prior Authorization

AGE – Age Requirement

PPACA – No Cost-Share Preventive Medication

T2 – Typically Preferred Brands

QL – Quantity Limit

SP – Specialty Medication

CSL – Oral cancer medication subject to cost-share limits

T3 – Typically Non-Preferred Brands

ST – Step Therapy

HD – May require home delivery pharmacy

List of Prescription Medications

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

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ANTI-MIGRAINE PREPARATIONS (cont.)		
<i>sumatriptan</i>	T1	QL (2 boxes/30 days)
<i>sumatriptan 4 mg/0.5 ml inject</i>	T1	QL (4ml/30 days)
<i>sumatriptan 6 mg/0.5 ml cart</i>	T1	QL (4ml/30 days)
<i>sumatriptan 6 mg/0.5 ml inject</i>	T1	QL (4ml/30 days)
<i>sumatriptan 6 mg/0.5 ml syring</i>	T1	QL (4ml/30 days)
<i>sumatriptan 6 mg/0.5 ml vial</i>	T1	QL (5ml/30 days)
<i>sumatriptan succ 100 mg tablet</i>	T1	QL (18 tabs/28 days)
<i>sumatriptan succ 25 mg tablet</i>	T1	QL (18 tabs/28 days)
<i>sumatriptan succ 50 mg tablet</i>	T1	QL (9 tabs/30 days)
<i>sumatriptan succ/naproxen sod</i>	T1	QL (18 tabs/30 days)
UBRELVY	T2	PA QL (0.67 TABS/DAY)
<i>zolmitriptan</i>	T1	QL (12 tabs/30 days)
NSAIDS, CYCLOOXYGENASE INHIBITOR-TYPE ANALGESICS		
<i>diclofenac potassium</i>	T1	HD
<i>ketorolac 10 mg tablet</i>	T1	QL (20 tabs/25 days) HD
<i>ketorolac 15 mg/ml syringe</i>	T1	QL (40 ml/30 days)
<i>ketorolac 15 mg/ml vial</i>	T1	QL (40 ml/30 days)
<i>ketorolac 30 mg/ml carpject</i>	T1	
<i>ketorolac 30 mg/ml isecure syr</i>	T1	QL (20ml/30 days) HD
<i>ketorolac 30 mg/ml syringe</i>	T1	QL (20ml/30 days)
<i>ketorolac 30 mg/ml vial</i>	T1	QL (20ml/30 days)
<i>ketorolac 300 mg/10 ml vial</i>	T1	
<i>ketorolac 60 mg/2 ml carpject</i>	T1	QL (20ml/30 days)
<i>ketorolac 60 mg/2 ml syringe</i>	T1	QL (20ml/30 days)
<i>ketorolac 60 mg/2 ml vial</i>	T1	QL (20ml/30 days)
<i>mefenamic acid</i>	T1	HD
OPIOID ANALGESIC AND NON-SALICYLATE ANALGESICS		
<i>acetamin-codein 300-30 mg/12.5</i>	T1	
<i>acetaminop-codeine 120-12 mg/5</i>	T1	
<i>acetaminophen-cod #2 tablet</i>	T1	PA
<i>acetaminophen-cod #3 tablet</i>	T1	PA
<i>acetaminophen-cod #4 tablet</i>	T1	PA

T1 – Typically Generics

PA – Prior Authorization

AGE – Age Requirement

PPACA – No Cost-Share Preventive Medication

T2 – Typically Preferred Brands

QL – Quantity Limit

SP – Specialty Medication

CSL – Oral cancer medication subject to cost-share limits

T3 – Typically Non-Preferred Brands

ST – Step Therapy

HD – May require home delivery pharmacy

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.)		
APADAZ	T3	
BENZHYDROCODONE-ACETAMINOPHEN	T1	
<i>hydrocodone/acetaminophen</i>	T1	PA
<i>hydrocodone/acetaminophen</i> (Hydrocodone-acetaminophen)	T1	PA
<i>hydrocodone/acetaminophen</i> (Norco)	T1	PA
HYDROCODONE-ACETAMINOPHEN	T1	PA
LORTAB	T1	PA
NALOCET	T1	PA
NORCO (<i>lorcet hd</i>)	T3	PA
NORCO (<i>lorcet plus</i>)	T3	PA
NORCO (<i>lorcet</i>)	T3	PA
<i>oxycodone hcl/acetaminophen</i> (Nalocet)	T1	PA
<i>oxycodone hcl/acetaminophen</i> (Percocet)	T1	PA
<i>oxycodone hcl/acetaminophen</i> (Primlev)	T1	PA
PRIMLEV	T1	PA
<i>tramadol hcl/acetaminophen</i> (Ultracet)	T1	
ULTRACET (<i>tramadol hcl-acetaminophen</i>)	T3	
OPIOID ANALGESIC AND NSAID COMBINATION		
<i>hydrocodone/ibuprofen</i>	T1	PA
<i>hydrocodone/ibuprofen</i> (Ibudone)	T1	PA
IBUDONE	T1	PA
<i>ibuprofen/oxycodone hcl</i>	T1	PA
OPIOID ANALGESIC AND NON-SALICYLATE XANTHINE COMB		
ACETAMIN-CAFF-DIHYDROCODEINE	T1	PA
<i>acetaminophen/caff/dihydrocod</i> (Acetamin-caff-dihydrocodeine)	T1	PA
<i>acetaminophen/caff/dihydrocod</i> (Trezix)	T1	PA
TREZIX	T3	PA
OPIOID ANALGESICS		
ACTIQ (<i>fentanyl citrate</i>)	T3	PA
ARYMO ER	T3	PA
BELBUCA	T2	QL (2 films/day)

T1 – Typically Generics

PA – Prior Authorization

AGE – Age Requirement

PPACA – No Cost-Share Preventive Medication

T2 – Typically Preferred Brands

QL – Quantity Limit

SP – Specialty Medication

CSL – Oral cancer medication subject to cost-share limits

T3 – Typically Non-Preferred Brands

ST – Step Therapy

HD – May require home delivery pharmacy

List of Prescription Medications

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

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
OPIOID ANALGESICS (cont.)		
<i>buprenorphine</i> (Butrans)	T1	QL (4 patches/28 days)
<i>butorphanol tartrate</i>	T1	PA QL (6 bots/30 days)
BUTRANS (<i>buprenorphine</i>)	T3	QL (4 patches/28 days)
<i>codeine sulfate</i>	T1	PA
DILAUDID 2 MG TABLET (<i>hydromorphone hcl</i>)	T3	PA
DILAUDID 4 MG TABLET (<i>hydromorphone hcl</i>)	T3	PA
DILAUDID 5 MG/5 ML ORAL LIQUID (<i>hydromorphone hcl</i>)	T3	PA
DILAUDID 8 MG TABLET (<i>hydromorphone hcl</i>)	T3	PA
DURAGESIC (<i>fentanyl</i>)	T3	PA
<i>fentanyl</i>	T1	PA
<i>fentanyl</i> (Duragesic)	T1	PA
FENTANYL CITRATE	T1	PA
<i>fentanyl citrate</i> (Actiq)	T1	PA
FENTORA	T3	PA
<i>hydrocodone bitartrate</i> (Hysingla Er)	T1	PA
<i>hydrocodone bitartrate</i> (Zohydro Er)	T1	PA
<i>hydromorphone hcl</i>	T1	PA
<i>hydromorphone hcl</i> (Dilaudid)	T1	PA
HYSINGLA ER (<i>hydrocodone bitartrate er</i>)	T2	PA
KADIAN (<i>morphine sulfate er</i>)	T3	PA
LAZANDA	T3	PA
<i>meperidine hcl</i>	T1	PA
MORPHABOND ER	T2	PA
<i>morphine sulfate</i>	T1	PA
<i>morphine sulfate</i> (Kadian)	T1	PA
<i>morphine sulfate</i> (Ms Contin)	T1	PA
MS CONTIN (<i>morphine sulfate er</i>)	T3	PA
NUCYNTA	T2	PA
NUCYNTA ER	T3	PA
<i>opium/belladonna alkaloids</i>	T1	PA
OXAYDO	T3	PA
<i>oxycodone hcl</i>	T1	PA
OXYCODONE HCL ER	T1	PA

T1 – Typically Generics

PA – Prior Authorization

AGE – Age Requirement

PPACA – No Cost-Share Preventive Medication

T2 – Typically Preferred Brands

QL – Quantity Limit

SP – Specialty Medication

CSL – Oral cancer medication subject to cost-share limits

T3 – Typically Non-Preferred Brands

ST – Step Therapy

HD – May require home delivery pharmacy

List of Prescription Medications

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

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
OPIOID ANALGESICS (cont.)		
<i>oxymorphone hcl</i>	T1	PA
<i>pentazocine hcl/naloxone hcl</i>	T1	PA
ROXYBOND	T3	PA
<i>tramadol er 100 mg tablet</i>	T1	QL (1 tab/day)
<i>tramadol er 200 mg tablet</i>	T1	QL (1 tab/day)
<i>tramadol er 300 mg tablet</i>	T1	QL (1 tab/day)
<i>tramadol hcl 50 mg tablet (Ultram)</i>	T1	QL (8 tabs/day)
<i>tramadol hcl 100 mg tablet</i>	T1	QL (4 tabs/day)
TRAMADOL HCL 75 MG TABLET	T3	QL(< 18 yo 5 tabs/day)
TRAMADOL HCL ER 100 MG CAPSULE	T1	QL (1 cap/day)
<i>tramadol hcl er 100 mg tablet</i>	T1	QL (1 tab/day)
TRAMADOL HCL ER 150 MG CAPSULE	T1	QL (1 cap/day)
TRAMADOL HCL ER 200 MG CAPSULE	T1	QL (1 cap/day)
<i>tramadol hcl er 200 mg tablet</i>	T1	QL (1 tab/day)
TRAMADOL HCL ER 300 MG CAPSULE	T1	QL (1 cap/day)
<i>tramadol hcl er 300 mg tablet</i>	T1	QL (1 tab/day)
ULTRAM (<i>tramadol hcl</i>)	T3	QL (8 tabs/day)
XTAMPZA ER	T2	PA
ZOHYDRO ER (<i>hydrocodone bitartrate er</i>)	T3	PA
OPIOID AND SALICYLATE ANALGESICS, BARBIT, XANTHINE		
<i>codeine/butalbital/asa/cafein (Fiorinal With Codeine #3)</i>	T1	PA
FIORINAL WITH CODEINE #3 (<i>butalbital compound-codeine</i>)	T3	PA
OPIOID, NON-SALICYL. ANALGESIC, BARBITUATE, XANTHINE		
<i>butalbit/acetamin/caff/codeine</i>	T1	PA
<i>butalbit/acetamin/caff/codeine (Fioricet With Codeine)</i>	T1	PA
SKELETAL MUSCLE RELAXANT, SALICYLAT, OPIOID ANALGESIC		
<i>carisoprodol/aspirin/codeine</i>	T1	PA
ANALGESICS (Urinary Tract Conditions)		
URINARY TRACT ANALGESIC AGENTS		
ELMIRON	T2	
RIMSO-50	T2	
ANESTHETICS (Miscellaneous)		
GENERAL ANESTHETICS, INHALANT		
<i>desflurane (Suprane)</i>	T1	

T1 – Typically Generics

PA – Prior Authorization

AGE – Age Requirement

PPACA – No Cost-Share Preventive Medication

T2 – Typically Preferred Brands

QL – Quantity Limit

SP – Specialty Medication

CSL – Oral cancer medication subject to cost-share limits

T3 – Typically Non-Preferred Brands

ST – Step Therapy

HD – May require home delivery pharmacy

List of Prescription Medications

ANESTHETICS (Pain Relief and Inflammatory Disease)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
GENERAL ANESTHETICS, INHALANT		
<i>isoflurane</i>	T1	
<i>isoflurane</i>	T3	
<i>sevoflurane</i> (Ultane)	T1	
ULTANE (<i>sevoflurane</i>)	T3	
LOCAL ANESTHETICS		
<i>lidocaine hcl</i>	T1	
TOPICAL LOCAL ANESTHETICS		
<i>lidocaine 5% ointment</i>	T1	QL (145gm/30 days)
<i>lidocaine hcl</i>	T1	
LIDOCAINE HCL	T3	
<i>lidocaine/prilocaine</i>	T1	
LIDODERM (<i>lidocaine</i>)	T3	
PAIN EASE MEDIUM STREAM SPRAY	T3	
ZTLIDO	T2	
ANESTHETICS (Urinary Tract Conditions)		
URINARY TRACT ANESTHETIC/ANALGESIC AGNT (AZO-DYE)		
<i>phenazopyridine hcl</i> (Pyridium)	T1	
ANTI-ALLERGY (Allergy/Nasal Sprays)		
MAST CELL STABILIZERS		
<i>cromolyn 100 mg/5 ml oral conc</i> (Gastrocrom)	T1	
ANTI-ARTHRITICS (Pain Relief and Inflammatory Disease)		
ANALGESIC/ANTIPYRETICS, SALICYLATES		
DISALCID (<i>salsalate</i>)	T3	HD
<i>salsalate</i> (Disalcid)	T1	HD
ANTI-ARTHRITIC AND CHELATING AGENTS		
DEPEN (<i>penicillamine</i>)	T3	PA SP
<i>penicillamine</i>	T1	PA SP

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

PA – Prior Authorization

QL – Quantity Limit

ST – Step Therapy

AGE – Age Requirement

SP – Specialty Medication

HD – May require home delivery pharmacy

PPACA – No Cost-Share Preventive Medication

CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

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

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ANTI-ARTHRITIC AND CHELATING AGENTS (cont.)		
<i>penicillamine</i> (Depen)	T1	PA SP
ANTI-ARTHRITIC, FOLATE ANTAGONIST AGENTS		
RASUVO	T2	ST
ANTI-INFLAM. INTERLEUKIN-1 RECEPTOR ANTAGONIST		
KINERET	T3	PA QL (28 syringes/28 days) SP
ANTI-INFLAMMATORY, PYRIMIDINE SYNTHESIS INHIBITOR		
ARAVA (<i>leflunomide</i>)	T3	HD
<i>leflunomide</i> (Arava)	T1	HD
ANTI-INFLAMMATORY, PHOSPHODIESTERASE-4(PDE4) INHIB.		
OTEZLA 28 DAY STARTER PACK	T2	PA QL(55 tabs/365 days) SP HD
OTEZLA 30 MG TABLET	T2	PA QL (2 tabs/day) 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	T1	HD
<i>colchicine 0.6 mg capsule</i> (Mitigare)	T1	HD
<i>colchicine 0.6 mg tablet</i> (Colcris)	T1	HD
COLCRYS (<i>colchicine</i>)	T3	HD
MITIGARE (<i>colchicine</i>)	T2	HD
GOLD SALTS		
RIDAURA	T2	
HYPERURICEMIA TX - XANTHINE OXIDASE INHIBITORS		
<i>allopurinol</i>	T1	HD
<i>febuxostat 40 mg tablet</i> (Uloric)	T1	QL (1 tab/day) HD
<i>febuxostat 80 mg tablet</i> (Uloric)	T1	HD
ULORIC 40 MG TABLET (<i>febuxostat</i>)	T3	QL (1 tab/day) HD
ULORIC 80 MG TABLET (<i>febuxostat</i>)	T3	HD
ZYLOPRIM (<i>allopurinol</i>)	T3	HD
JANUS KINASE (JAK) INHIBITORS		
LEQSELVI	T3	PA QL(2 tabs/day) SP HD
LITFULO	T3	PA QL(1 cap/day) SP HD
RINVOQ LQ	T2	PA QL (12 mls/day) SP

T1 – Typically Generics

PA – Prior Authorization

AGE – Age Requirement

PPACA – No Cost-Share Preventive Medication

T2 – Typically Preferred Brands

QL – Quantity Limit

SP – Specialty Medication

CSL – Oral cancer medication subject to cost-share limits

T3 – Typically Non-Preferred Brands

ST – Step Therapy

HD – May require home delivery pharmacy

List of Prescription Medications

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

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
JANUS KINASE (JAK) INHIBITORS		
ZYLOPRIM (<i>allopurinol</i>)	T3	HD
XELJANZ 5 MG TABLET	T2	PA QL (2 tabs/day) SP HD
XELJANZ XR	T2	PA QL (1 tab/day) SP HD
NSAIDS (COX NON-SPEC.INHIB) AND PROSTAGLANDIN ANALOG		
ARTHROTEC 50 (<i>diclofenac sodium-misoprostol</i>)	T3	ST HD
ARTHROTEC 75 (<i>diclofenac sodium-misoprostol</i>)	T3	ST HD
<i>diclofenac sodium/misoprostol</i> (Arthrotec 50)	T1	HD
<i>diclofenac sodium/misoprostol</i> (Arthrotec 75)	T1	HD
NSAIDS, CYCLOOXYGENASE INHIBITOR - TYPE ANALGESICS		
ANAPROX DS (<i>naproxen sodium ds</i>)	T3	ST HD
DAYPRO (<i>oxaprozin</i>)	T3	ST HD
<i>diclofenac sod dr 25 mg tab</i>	T1	HD
<i>diclofenac sod dr 50 mg tab</i>	T1	HD
<i>diclofenac sod dr 75 mg tab</i>	T1	HD
<i>diclofenac sod ec 25 mg tab</i>	T1	HD
<i>diclofenac sod ec 50 mg tab</i>	T1	HD
<i>diclofenac sod ec 75 mg tab</i>	T1	HD
<i>diclofenac sodium</i>	T1	HD
EC-NAPROSYN (<i>naproxen</i>)	T3	ST HD
<i>etodolac</i>	T1	HD
<i>etodolac</i> (Lodine)	T1	HD
FELDENE (<i>piroxicam</i>)	T3	ST HD
FENOPROFEN 600 MG TABLET (Nalfon)	T1	HD
<i>flurbiprofen</i>	T1	HD
<i>ibuprofen</i>	T1	HD
<i>indomethacin</i>	T1	HD
<i>ketoprofen 25 mg. 75 mg capsule</i>	T1	HD
LODINE (<i>etodolac</i>)	T3	ST HD
<i>meclofenamate sodium</i>	T1	HD
<i>meloxicam</i> (Mobic)	T1	HD
MOBIC (<i>meloxicam</i>)	T3	ST HD
<i>nabumetone</i>	T1	HD
NALFON 600 MG TABLET (<i>profeno</i>)	T1	ST HD

T1 – Typically Generics

PA – Prior Authorization

AGE – Age Requirement

PPACA – No Cost-Share Preventive Medication

T2 – Typically Preferred Brands

QL – Quantity Limit

SP – Specialty Medication

CSL – Oral cancer medication subject to cost-share limits

T3 – Typically Non-Preferred Brands

ST – Step Therapy

HD – May require home delivery pharmacy

List of Prescription Medications

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

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
NSAIDS, CYCLOOXYGENASE INHIBITOR - TYPE ANALGESICS (cont.)		
NAPROSYN TABLET (<i>naproxen</i>)	T3	ST HD
<i>naproxen tablet</i>	T1	HD
<i>naproxen</i> (Ec-naprosyn)	T1	HD
<i>naproxen</i> (Naprosyn)	T1	HD
<i>naproxen DR</i> (Ec-Naprosyn)	T1	HD
<i>naproxen sodium</i> (Anaprox Ds)	T1	HD
<i>oxaprozin</i> (Daypro)	T1	HD
OXAPROZIN 300 MG CAPSULE	T3	HD
<i>piroxicam</i> (Feldene)	T1	HD
QMIIZ ODT 15 MG TABLET	T3	ST HD
QMIIZ ODT 7.5 MG TABLET	T3	QL (1 tab/day) ST HD
TOLECTIN 600 (<i>tolmetin sodium</i>)	T3	HD
<i>tolmetin sodium</i> (Tolectin 600)	T1	HD
NSAIDS, CYCLOOXYGENASE-2(COX-2) SELECTIVE INHIBITOR		
<i>arformoterol tartrate</i> (Brovana)	T1	QL(4 mls/day) HD
<i>celecoxib 50 mg capsule</i> (Celebrex)	T1	QL (2 caps/day) HD
<i>celecoxib 100 mg capsule</i> (Celebrex)	T1	QL (2 caps/day) HD
<i>celecoxib 200 mg capsule</i> (Celebrex)	T1	QL (2 caps/day) HD
<i>celecoxib 400 mg capsule</i> (Celebrex)	T1	QL (1 cap/day) HD
<i>formoterol fumarate</i> (Perforomist)	T1	QL(240 mls/30 days) HD
URICOSURIC AGENTS		
<i>probenecid</i>	T1	HD
<i>probenecid/colchicine</i>	T1	HD
ANTI-ASTHMATICS (Asthma/COPD/Respiratory)		
5-LIPOXYGENASE INHIBITORS		
<i>zileuton</i>	T1	HD
ANTICHOLINERGICS, ORALLY INHALED LONG ACTING		
INCRUSE ELLIPTA	T2	HD
LONHALA MAGNAIR	T3	PA HD
SPIRIVA RESPIMAT	T2	HD
ANTICHOLINERGICS, ORALLY INHALED SHORT ACTING		
ATROVENT HFA	T2	HD
<i>ipratropium bromide</i>	T1	HD

T1 – Typically Generics

PA – Prior Authorization

AGE – Age Requirement

PPACA – No Cost-Share Preventive Medication

T2 – Typically Preferred Brands

QL – Quantity Limit

SP – Specialty Medication

CSL – Oral cancer medication subject to cost-share limits

T3 – Typically Non-Preferred Brands

ST – Step Therapy

HD – May require home delivery pharmacy

List of Prescription Medications

ANTI-ASTHMATICS (Asthma/COPD/Respiratory) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
BETA-ADRENERGIC AGENTS		
albuterol 8 mg/20 ml syrup cup	T1	HD
albuterol sulf 2 mg/5 ml syrup	T1	HD
albuterol sulfate 2 mg tab	T1	HD
albuterol sulfate 4 mg 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 2.5 mg/0.5 ml sol	T1	QL (18gm/30 days)
albuterol 5 mg/ml solution	T1	
albuterol 15 mg/3 ml solution	T1	
albuterol 75 mg/15 ml soln	T1	
albuterol hfa 90 mcg inhaler	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 HFA	T1	
levalbuterol hcl (Xopenex)	T1	
levalbuterol hcl (Xopenex Concentrate)	T1	QL (18gm/30 days)
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	T3	HD
BETA-ADRENERGIC AND ANTICHOLINERGIC COMBO, INHALED		
ANORO ELLIPTA	T2	HD
COMBIVENT RESPIMAT	T2	QL(2 inhalers/30 days)
ipratropium/albuterol sulfate	T1	HD
STIOLTO RESPIMAT INHAL SPRAY	T2	HD
BETA-ADRENERGIC AGENTS AND GLUCOCORTICOID COMBO, INHALED		
ADVAIR HFA	T2	HD
AIRDUO DIGIHALER	T3	ST HD

T1 – Typically Generics

PA – Prior Authorization

AGE – Age Requirement

PPACA – No Cost-Share Preventive Medication

T2 – Typically Preferred Brands

QL – Quantity Limit

SP – Specialty Medication

CSL – Oral cancer medication subject to cost-share limits

T3 – Typically Non-Preferred Brands

ST – Step Therapy

HD – May require home delivery pharmacy

List of Prescription Medications

ANTI-ASTHMATICS (Asthma/COPD/Respiratory) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
BETA-ADRENERGIC AGENTS AND GLUCOCORTICOID COMBO, INHALED		
AIRSUPRA	T2	QL (2 inhalers/21 days) HD
BREO ELLIPTA	T2	HD
<i>budesonide/formoterol fumarate</i> (Symbicort)	T2	QL HD
DULERA	T2	HD
<i>fluticasone propion/salmeterol</i>	T1	QL (1 Inhaler/30 days) HD
BETA-ADRENERGIC-ANTICHOLINERGIC-GLUCOCORT, INHALED		
BREZTRI AEROSPHERE	T2	
TRELEGY ELLIPTA	T2	
GLUCOCORTICIDS, ORALLY INHALED		
ARNUITY ELLIPTA	T2	
ASMANEX HFA/TWISTHALER	T3	QL(1 inhaler/30 days) HD
<i>budesonide</i> (Pulmicort)	T1	HD
<i>deflazacort</i> (Emflaza)	T1	PA SP HD
EMFLAZA (deflazacort)	T3	PA SP HD
FLOVENT DISKUS	T2	HD
FLUTICASONE PROP DISKUS	T3	QL HD
PULMICORT (<i>budesonide</i>)	T3	HD
QVAR REDHALER	T2	
INTERLEUKIN-5(IL-5) RECEPTOR ALPHA ANTAGONIST, MAB		
FASENRA PEN	T3	PA SP HD
LEUKOTRIENE RECEPTOR ANTAGONISTS		
ACCOLATE (<i>zafirlukast</i>)	T3	HD
<i>montelukast sodium</i> (Singulair)	T1	HD
<i>zafirlukast</i> (Accolate)	T1	HD
MAST CELL STABILIZERS, ORALLY INHALED		
<i>cromolyn 20 mg/2 ml neb soln</i>	T1	QL (480ml/30 days) HD
MONOCLONAL ANTIBODIES TO IMMUNOGLOBULIN E (IGE)		
XOLAIR	T3	PA SP HD
MONOCLONAL ANTIBODY - INTERLEUKIN-5 ANTAGONISTS		
NUCALA	T3	PA SP HD
MUCOLYTICS		
<i>acetylcysteine</i>	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

T1 – Typically Generics

PA – Prior Authorization

AGE – Age Requirement

PPACA – No Cost-Share Preventive Medication

T2 – Typically Preferred Brands

QL – Quantity Limit

SP – Specialty Medication

CSL – Oral cancer medication subject to cost-share limits

T3 – Typically Non-Preferred Brands

ST – Step Therapy

HD – May require home delivery pharmacy

List of Prescription Medications

ANTI-ASTHMATICS (Asthma/COPD/Respiratory) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
PHOSPHODIESTERASE-4 (PDE4) INHIBITORS		
<i>roflumilast 250 mcg tablet</i> (Daliresp)	T1	QL (28 tabs/180 days) HD
<i>roflumilast 500 mcg tablet</i> (Daliresp)	T1	QL (2 tabs/day) HD
XANTHINES		
THEO-24	T2	HD
<i>theophylline anhydrous</i>	T1	HD
ANTIBIOTICS (Allergy/Nasal Sprays)		
NOSE PREPARATIONS ANTIBIOTICS		
BACTROBAN NASAL	T2	
ANTIBIOTICS (Ear Medications)		
EAR PREPARATIONS, ANTIBIOTICS		
<i>ciprofloxacin hcl</i>	T1	
CORTISPORIN-TC	T3	
<i>neomycin/polymyxin b/hydrocort</i>	T1	
<i>ofloxacin</i>	T1	
OTIC PREPARATIONS, ANTI-INFLAMMATORY-ANTIBIOTICS		
<i>ciprofloxacin hcl/dexameth</i>	T1	
OTOVEL	T3	
ANTIBIOTICS (Eye Conditions)		
EYE ANTIBIOTIC AND GLUCOCORTICOID COMBINATIONS		
<i>neomycin/bacit/p-myx/hydrocort</i>	T1	
<i>neomycin/polymyxin b/dexametha</i> (Maxitrol)	T1	
<i>neomycin/polymyxin b/hydrocort</i>	T1	
TOBRADEX ST	T3	
<i>tobramycin/dexamethasone</i> (Tobradex)	T1	
EYE SULFONAMIDES		
BLEPH-10 (<i>sulfacetamide sodium</i>)	T3	
BLEPHAMIDE	T2	
<i>sulfacetamide sodium</i>	T1	
<i>sulfacetamide sodium</i> (Bleph-10)	T1	
<i>sulfacetamide/prednisolone sp</i>	T1	

T1 – Typically Generics

PA – Prior Authorization

AGE – Age Requirement

PPACA – No Cost-Share Preventive Medication

T2 – Typically Preferred Brands

QL – Quantity Limit

SP – Specialty Medication

CSL – Oral cancer medication subject to cost-share limits

T3 – Typically Non-Preferred Brands

ST – Step Therapy

HD – May require home delivery pharmacy

List of Prescription Medications

ANTIBIOTICS (Eye Conditions) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
OPHTHALMIC ANTIBIOTICS		
AZASITE	T2	
<i>bacitracin</i> (Baciguent)	T1	
<i>bacitracin/polymyxin b sulfate</i>	T1	
BESIVANCE	T2	
<i>ciprofloxacin hcl</i> (Ciloxan)	T1	
<i>erythromycin base</i>	T1	
<i>gatifloxacin</i>	T1	
<i>gentamicin sulfate</i>	T1	
<i>levofloxacin</i>	T1	
MOXEZA (<i>moxifloxacin</i>)	T3	
<i>moxifloxacin hcl</i> (Moxeza)	T1	
<i>moxifloxacin hcl</i> (Vigamox)	T1	
<i>neomycin sulf/bacitracin/poly</i>	T1	
<i>neomycin/polymyxn b/gramicidin</i>	T1	
<i>ofloxacin</i> (Ocuflox)	T1	
<i>tobramycin 0.3% eye drop</i>	T1	
TOBREX 0.3% EYE OINTMENT	T2	

ANTIBIOTICS (Infections)

ABSORBABLE SULFONAMIDE ANTIBACTERIAL AGENTS

BACTRIM (<i>sulfamethoxazole-trimethoprim</i>)	T3	
BACTRIM DS (<i>sulfamethoxazole-trimethoprim</i>)	T3	
<i>sulfadiazine</i>	T1	
<i>sulfamethoxazole/trimethoprim</i>	T1	
<i>sulfamethoxazole/trimethoprim</i> (Bactrim Ds)	T1	
<i>sulfamethoxazole/trimethoprim</i> (Bactrim)	T1	

AMINOGLYCOSIDE ANTIBIOTICS

ARIKAYCE	T3	PA SP
<i>gentamicin sulfate</i>	T1	
<i>gentamicin sulfate/pf</i>	T1	
KITABIS PAK	T3	PA QL (10ml/day) SP HD
<i>neomycin sulfate</i>	T1	
TOBI PODHALER	T2	PA QL (28 days therapy/56 days) SP HD
<i>tobramycin 1,200 mg/30 ml vial</i>	T1	
<i>tobramycin 1.2 gm vial</i>	T1	PA

T1 – Typically Generics

PA – Prior Authorization

AGE – Age Requirement

PPACA – No Cost-Share Preventive Medication

T2 – Typically Preferred Brands

QL – Quantity Limit

SP – Specialty Medication

CSL – Oral cancer medication subject to cost-share limits

T3 – Typically Non-Preferred Brands

ST – Step Therapy

HD – May require home delivery pharmacy

List of Prescription Medications

ANTIBIOTICS (Infections) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
AMINOGLYCOSIDE ANTIBIOTICS (cont.)		
TOBRAMYCIN PAK 300 MG/5 ML	T3	PA QL (10ml/day) SP HD
<i>tobramycin 300 mg/4 ml ampule</i>	T1	QL (8 ml/day) SP HD
<i>tobramycin 300 mg/5 ml ampule</i>	T1	PA QL (10ml/day) SP HD
<i>tobramycin 10 mg/ml vial</i>	T1	
<i>tobramycin 40 mg/ml vial</i>	T1	
<i>tobramycin 80 mg/2 ml vial</i>	T1	
<i>tobramycin 1.2 gram/30 ml vial</i>	T1	
ANAEROBIC ANTIPROTOZOAL-ANTIBACTERIAL AGENTS		
LIKMEZ	T3	PA
<i>metronidazole</i>	T1	
ANTIBIOTIC, ANTIBACTERIAL, MISC.		
<i>fosfomycin tromethamine</i>	T1	
<i>meth/meblue/sod phos/psal/hyos</i>	T2	
<i>meth/meblue/sod phos/psal/hyos (Uribel)</i>	T1	
<i>methenam/m.blue/salicyl/hyoscy</i>	T1	
<i>methenam/sod phos/mblue/hyoscy</i>	T3	
<i>methenamine hippurate</i>	T1	
<i>methenamine mandelate</i>	T1	
PRIMSOL	T2	
<i>trimethoprim</i>	T1	
TRIMPEX	T2	
URIBEL (<i>methenam/m.blue/salicyl/hyoscy</i>)	T3	
UTA	T3	
ANTILEPROTICS		
<i>dapsone</i>	T1	
THALOMID	T2	PA SP HD
ANTI-MYCOBACTERIUM AGENTS		
<i>ethambutol hcl</i>	T1	HD
<i>isoniazid</i>	T1	HD
PASER	T2	HD
<i>pyrazinamide</i>	T1	HD
<i>rifabutin</i>	T1	HD
TRECTOR	T2	HD

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

PA – Prior Authorization

QL – Quantity Limit

ST – Step Therapy

AGE – Age Requirement

SP – Specialty Medication

HD – May require home delivery pharmacy

PPACA – No Cost-Share Preventive Medication

CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

ANTIBIOTICS (Infections) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ANTI-TUBERCULAR ANTIBIOTICS		
CYCLOSERINE	T1	
ANTI-TUBERCULAR ANTIBIOTICS		
PRETOMANID	T3	PA QL (1 tab/day)
PRIFTIN	T3	
RIFAMATE	T2	
rifampin	T1	
RIFATER	T2	SP
SIRTURO	T3	
BETALACTAMS		
CAYSTON	T3	PA QL (3ml/day) SP HD
CEPHALOSPORIN ANTIBIOTICS - 1ST GENERATION		
cefadroxil	T1	
cephalexin	T1	
cephalexin (Keflex)	T1	
DAXBIA	T3	
KEFLEX (cephalexin)	T3	
CEPHALOSPORIN ANTIBIOTICS - 2ND GENERATION		
cefaclor	T1	
cefprozil	T1	
cefuroxime axetil	T1	
CEPHALOSPORIN ANTIBIOTICS - 3RD GENERATION		
cefdinir	T1	
cefixime (Suprax)	T1	
cefpodoxime proxetil	T1	
ceftriaxone sodium	T1	
SUPRAX	T3	
SUPRAX (cefixime)	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	
clindamycin hcl (Cleocin Hcl)	T1	
clindamycin palmitate hcl (Cleocin Pediatric)	T1	

T1 – Typically Generics

PA – Prior Authorization

AGE – Age Requirement

PPACA – No Cost-Share Preventive Medication

T2 – Typically Preferred Brands

QL – Quantity Limit

SP – Specialty Medication

CSL – Oral cancer medication subject to cost-share limits

T3 – Typically Non-Preferred Brands

ST – Step Therapy

HD – May require home delivery pharmacy

List of Prescription Medications

ANTIBIOTICS (Infections) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
MACROLIDE ANTIBIOTICS		
<i>azithromycin 1 gm pwd packet (Zithromax)</i>	T1	
<i>azithromycin 100 mg/5 ml susp (Zithromax)</i>	T1	
<i>azithromycin 200 mg/5 ml susp (Zithromax)</i>	T1	
<i>azithromycin 200 mg/5 ml susp (Zithromax)</i>	T1	
<i>azithromycin 250 mg tablet (Zithromax)</i>	T1	
<i>azithromycin 500 mg tablet (Zithromax Tri-pak)</i>	T1	
<i>azithromycin 600 mg tablet</i>	T1	
<i>clarithromycin</i>	T1	
DIFICID 200 MG TABLET	T3	QL (28 tabs/28 days)
DIFICID 40 MG/ML SUSPENSION	T3	QL (5ML/Day)
ERYPED 200 (<i>erythromycin ethylsuccinate</i>)	T3	
<i>ery-tab dr 250 mg tablet</i>	T3	
<i>ery-tab dr 333 mg tablet</i>	T2	
ERY-TAB DR 500 MG TABLET (<i>erythromycin</i>)	T3	
<i>erythromycin base</i>	T1	
<i>erythromycin base (Ery-tab)</i>	T1	
<i>erythromycin ethylsuccinate</i>	T1	
<i>erythromycin ethylsuccinate</i>	T2	
<i>erythromycin ethylsuccinate (Eryped 200)</i>	T1	
<i>erythromycin stearate</i>	T1	
PCE	T3	
ZITHROMAX 1 GM POWDER PACKET (<i>azithromycin</i>)	T3	
ZITHROMAX 100 MG/5 ML SUSP (<i>azithromycin</i>)	T3	
ZITHROMAX 200 MG/5 ML SUSP (<i>azithromycin</i>)	T3	
ZITHROMAX 200 MG/5 ML SUSP (<i>azithromycin</i>)	T3	
ZITHROMAX 250 MG TABLET (<i>azithromycin</i>)	T3	
ZITHROMAX 250 MG Z-PAK TABLET (<i>azithromycin</i>)	T3	
ZITHROMAX 500 MG TABLET (<i>azithromycin</i>)	T3	
ZITHROMAX TRI-PAK (<i>azithromycin</i>)	T3	
NITROFURAN DERIVATIVES ANTIBACTERIAL AGENTS		
FURADANTIN (<i>nitrofurantoin</i>)	T3	
MACROBID (<i>nitrofurantoin mono-macro</i>)	T3	
<i>nitrofurantoin 25 mg/5 ml susp (Furadantin)</i>	T1	

T1 – Typically Generics

PA – Prior Authorization

AGE – Age Requirement

PPACA – No Cost-Share Preventive Medication

T2 – Typically Preferred Brands

QL – Quantity Limit

SP – Specialty Medication

CSL – Oral cancer medication subject to cost-share limits

T3 – Typically Non-Preferred Brands

ST – Step Therapy

HD – May require home delivery pharmacy

List of Prescription Medications

ANTIBIOTICS (Infections) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
NITROFURAN DERIVATIVES ANTIBACTERIAL AGENTS		
<i>nitrofurantoin monohyd/m-cryst</i>	T1	
OXAZOLIDINONE ANTIBIOTICS		
<i>linezolid</i> (Zyvox)	T1	PA
SIVEXTRO	T3	PA
ZYVOX (<i>linezolid</i>)	T3	PA
PENICILLIN ANTIBIOTICS		
<i>amoxicillin</i>	T1	
<i>ampicillin trihydrate</i>	T1	
<i>dicloxacillin sodium</i>	T1	
MOXATAG	T3	
<i>penicillin v potassium</i>	T1	
PLEUROMUTILIN DERIVATIVES		
XENLETA	T3	PA QL (10 tabs/30 days)
QUINOLONE ANTIBIOTICS		
AVELOX (<i>moxifloxacin hcl</i>)	T3	
BAXDELA	T3	PA
CIPRO 10% SUSPENSION (<i>ciprofloxacin</i>)	T2	
CIPRO 250 MG TABLET (<i>ciprofloxacin hcl</i>)	T3	
CIPRO 5% SUSPENSION (<i>ciprofloxacin</i>)	T2	
CIPRO 500 MG TABLET (<i>ciprofloxacin hcl</i>)	T3	
<i>ciprofloxacin</i> (Cipro)	T1	
<i>ciprofloxacin hcl</i>	T1	
<i>ciprofloxacin hcl</i> (Cipro)	T1	
<i>ciprofloxacin/ciprofloxacin hcl</i>	T1	
FACTIVE	T3	
<i>levofloxacin</i>	T1	
<i>moxifloxacin hcl</i> (Avelox)	T1	
<i>ofloxacin</i>	T1	
RIFAMYCINS AND RELATED DERIVATIVE ANTIBIOTICS		
AEMCOLO	T3	QL (12 tabs/3 days)
XIFAXAN 200 MG TABLET	T2	
XIFAXAN 550 MG TABLET	T2	QL (126 tabs/year)
TETRACYCLINE ANTIBIOTICS		
<i>coremino er 135 mg tablet</i>	T1	
<i>coremino er 45 mg tablet</i>	T1	QL (1 tab/day)

T1 – Typically Generics

PA – Prior Authorization

AGE – Age Requirement

PPACA – No Cost-Share Preventive Medication

T2 – Typically Preferred Brands

QL – Quantity Limit

SP – Specialty Medication

CSL – Oral cancer medication subject to cost-share limits

T3 – Typically Non-Preferred Brands

ST – Step Therapy

HD – May require home delivery pharmacy

List of Prescription Medications

ANTIBIOTICS (Infections) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
TETRACYCLINE ANTIBIOTICS (cont.)		
coremino er 90 mg tablet	T1	QL (1 tab/day)
demeclocycline hcl	T1	
doxycycline hyclate (Vibramycin)	T1	
minocycline er 135 mg tablet	T1	
minocycline er 45 mg tablet	T1	
minocycline er 55 mg tablet	T1	
minocycline er 65 mg tablet	T1	
minocycline er 80 mg tablet	T1	
minocycline er 90 mg tablet	T1	
minocycline hcl	T1	PA QL (30 tablets/28 days) SP
NUZYRA	T3	
tetracycline hcl	T1	
VIBRAMYCIN 50 MG/5 ML SYRUP	T2	
VAGINAL ANTIBIOTICS		
clindamycin phosphate (Cleocin)	T1	
metronidazole (Metrogel-vaginal)	T1	
VANCOMYCIN ANTIBIOTICS AND DERIVATIVES		
vancomycin hcl	T1	
vancomycin hcl (Firvanq)	T1	
TOPICAL ANTIBIOTIC AND ANTI-INFLAMMATORY STEROID		
NEO-SYNALAR	T3	
TOPICAL ANTIBIOTICS		
BENZAMYCIN (erythromycin-benzoyl peroxide)	T3	
CENTANY	T3	
CENTANY AT	T3	
CLEOCIN T (clindamycin phosphate)	T3	
CLINDACIN ETZ KIT	T3	
CLINDACIN PAC	T3	
clindamycin phosphate	T1	
clindamycin phosphate (Cleocin T)	T1	
clindamycin phosphate (Evoclin)	T1	
erythromycin base in ethanol	T1	

T1 – Typically Generics

PA – Prior Authorization

AGE – Age Requirement

PPACA – No Cost-Share Preventive Medication

T2 – Typically Preferred Brands

QL – Quantity Limit

SP – Specialty Medication

CSL – Oral cancer medication subject to cost-share limits

T3 – Typically Non-Preferred Brands

ST – Step Therapy

HD – May require home delivery pharmacy

List of Prescription Medications

ANTIBIOTICS (Skin Conditions)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
TOPICAL ANTIBIOTICS (cont.)		
<i>erythromycin base in ethanol</i>	T3	
<i>erythromycin/benzoyl peroxide</i> (Benzamycin)	T1	
EVOCLIN (<i>clindamycin phosphate</i>)	T3	
<i>gentamicin sulfate</i>	T1	
<i>mupirocin</i> (Centany)	T1	
<i>mupirocin calcium</i>	T1	
XEPI	T3	
TOPICAL SULFONAMIDES		
AVAR 9.5-5% CLEANSING PADS	T3	
<i>avar cleanser</i> (Rosanil)	T1	
AVAR LS	T3	
AVAR-E	T1	
<i>mafenide acetate</i>	T1	
<i>mafenide acetate</i> (Sulfamylon)	T1	
ROSANIL (<i>sodium sulfacetamide-sulfur</i>)	T1	
SILVADENE (<i>ssd</i>)	T3	
<i>silver sulfadiazine</i> (Silvadene)	T1	
<i>sulfacetamide sod/sulfur/urea</i>	T1	
<i>sulfacetamide sodium/sulfur</i>	T1	
<i>sulfacetamide sodium/sulfur</i> (Avar-e Green)	T1	
<i>sulfacetamide sodium/sulfur</i> (Rosanil)	T1	
<i>sulfacetamide/sulfur/cleansr23</i>	T1	
<i>sulfact sod/sulur/avob/otn/oct</i>	T1	
SULFAMYLON	T2	
ANTI-COAGULANTS (Blood Thinners/Anti-Clotting)		
ANTI-COAGULANTS, COUMARIN TYPE		
<i>warfarin sodium</i>	T1	HD
CITRATES AS ANTI-COAGULANTS		
ACD SOLUTION A	T3	
ACD-A	T3	
ANTICOAG SODIUM CITRATE 4% SOL	T3	
CITRATE PHOSPHATE DEXTROSE	T1	
DIRECT FACTOR XA INHIBITORS		
BEVYXXA	T3	QL (42 caps/42 days)

T1 – Typically Generics

PA – Prior Authorization

AGE – Age Requirement

PPACA – No Cost-Share Preventive Medication

T2 – Typically Preferred Brands

QL – Quantity Limit

SP – Specialty Medication

CSL – Oral cancer medication subject to cost-share limits

T3 – Typically Non-Preferred Brands

ST – Step Therapy

HD – May require home delivery pharmacy

List of Prescription Medications

ANTI-COAGULANTS (Blood Thinners/Anti-Clotting) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
DIRECT FACTOR XA INHIBITORS (cont.)		
ELIQUIS	T2	
<i>rivaroxaban</i> (Xarelto)	T1	
XARELTO	T2	
HEPARIN AND RELATED PREPARATIONS		
ARIXTRA (<i>fondaparinux sodium</i>)	T3	QL (1 syringe/day) SP
<i>enoxaparin 30 mg/0.3 ml syr</i> (Lovenox)	T1	QL (2 syringes/day) SP
<i>enoxaparin 40 mg/0.4 ml syr</i> (Lovenox)	T1	QL (2 syringes/day) SP
<i>enoxaparin 60 mg/0.6 ml syr</i> (Lovenox)	T1	QL (2 syringes/day) SP
<i>enoxaparin 80 mg/0.8 ml syr</i> (Lovenox)	T1	QL (2 syringes/day) SP
<i>enoxaparin 100 mg/ml syringe</i> (Lovenox)	T1	QL (2 syringes/day) SP
<i>enoxaparin 120 mg/0.8 ml syr</i> (Lovenox)	T1	QL (2 syringes/day) SP
<i>enoxaparin 150 mg/ml syringe</i> (Lovenox)	T1	QL (2 syringes/day) SP
<i>enoxaparin 300 mg/3 ml vial</i> (Lovenox)	T1	QL (1 vial/day) SP
<i>fondaparinux sodium</i> (Arixtra)	T1	QL (1 syringe/day) SP
<i>heparin 10,000 unit/10 ml vial</i>	T1	
<i>heparin 30,000 unit/30 ml vial</i>	T1	
<i>heparin 40,000 unit/4 ml vial</i>	T1	
<i>heparin 50,000 unit/10 ml vial</i>	T1	
<i>heparin 50,000 unit/5 ml vial</i>	T1	
<i>heparin sod 1,000 unit/ml vial</i>	T1	
<i>heparin sod 10,000 unit/ml vl</i>	T1	
<i>heparin sod 2,000 unit/2ml vial</i>	T1	
<i>heparin sod 20,000 unit/ml vl</i>	T1	
<i>heparin sod 5,000 unit/0.5 ml</i>	T1	
HEPARIN SOD 5,000 UNIT/0.5 ML	T1	
<i>heparin sod 5,000 unit/0.5 ml</i> (Heparin Sodium)	T1	
<i>heparin sod 5,000 unit/ml syrg</i>	T3	
<i>heparin sod 5,000 unit/ml vial</i>	T1	
LOVENOX 100 MG/ML SYRINGE (<i>enoxaparin sodium</i>)	T3	QL (2 syringes/day) SP
LOVENOX 120 MG/0.8 ML SYRINGE (<i>enoxaparin sodium</i>)	T3	QL (2 syringes/day) SP
LOVENOX 150 MG/ML SYRINGE (<i>enoxaparin sodium</i>)	T3	QL (2 syringes/day) SP

T1 – Typically Generics

PA – Prior Authorization

AGE – Age Requirement

PPACA – No Cost-Share Preventive Medication

T2 – Typically Preferred Brands

QL – Quantity Limit

SP – Specialty Medication

CSL – Oral cancer medication subject to cost-share limits

T3 – Typically Non-Preferred Brands

ST – Step Therapy

HD – May require home delivery pharmacy

List of Prescription Medications

ANTI-COAGULANTS (Blood Thinners/Anti-Clotting) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
HEPARIN AND RELATED PREPARATIONS (cont.)		
LOVENOX 30 MG/0.3 ML SYRINGE (<i>enoxaparin sodium</i>)	T3	QL (2 syringes/day) SP
LOVENOX 40 MG/0.4 ML SYRINGE (<i>enoxaparin sodium</i>)	T3	QL (2 syringes/day) SP
LOVENOX 60 MG/0.6 ML SYRINGE (<i>enoxaparin sodium</i>)	T3	QL (2 syringes/day) SP
LOVENOX 80 MG/0.8 ML SYRINGE (<i>enoxaparin sodium</i>)	T3	QL (2 syringes/day) SP
LOVENOX 300 MG/3 ML VIAL (<i>enoxaparin sodium</i>)	T3	QL (1 vial/day) SP

THROMBIN INHIBITORS, SELECTIVE, DIRECT, REVERSIBLE

<i>dabigatran etexilate</i>	T1	HD
-----------------------------	----	----

ANTIDOTES (Gastrointestinal/Heartburn)

MU-OPIOID RECEPTOR ANTAGONISTS, PERIPHERALLY-ACTING

MOVANTIK	T2	PA
RELISTOR	T3	PA
SYMPROIC	T2	PA

ANTIDOTES (Substance Abuse)

OPIOID ANTAGONISTS

KLOXXADO	T2	PA QL (2 sprays/30 days)
<i>naloxone 0.4 mg/ml carpuject</i>	T1	
<i>naloxone 0.4 mg/ml vial</i>	T1	
NALOXONE 2 MG AUTO-INJECTOR	T3	QL (0.8ml/day)
<i>naloxone 2 mg/2 ml syringe</i>	T1	
<i>naloxone 4 mg/10 ml vial</i>	T1	
<i>naltrexone hcl</i>	T1	QL (180 tabs/30 days)
NARCAN	T2	QL (2 units/30 days)
OPVEE	T3	QL (2 units/30 days)
REXTOVY	T2	QL (2 units/30 days)
ZIMHI	T3	QL (2 units/30 days)

ANTI-FUNGALS (Eye Conditions)

OPHTHALMIC ANTI-FUNGAL AGENTS

NATACYN	T2	
---------	----	--

ANTI-FUNGALS (Feminine Products)

VAGINAL ANTI-FUNGALS

GYNAZOLE 1	T1	
<i>miconazole nitrate</i>	T1	
<i>terconazole</i>	T1	

T1 – Typically Generics

PA – Prior Authorization

AGE – Age Requirement

PPACA – No Cost-Share Preventive Medication

T2 – Typically Preferred Brands

QL – Quantity Limit

SP – Specialty Medication

CSL – Oral cancer medication subject to cost-share limits

T3 – Typically Non-Preferred Brands

ST – Step Therapy

HD – May require home delivery pharmacy

List of Prescription Medications

ANTI-FUNGALS (Infections)					
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits			
ANTI-FUNGAL AGENTS					
ANCOBON (flucytosine)	T3	PA			
clotrimazole	T1				
CRESEMBA	T3				
fluconazole	T1				
flucytosine (Ancobon)	T1				
itraconazole	T1				
ketoconazole	T1				
ORAVIG	T3				
posaconazole (Noxafil)	T1				
terbinafine hcl	T1				
VFEND (voriconazole)	T3	PA	PA SP		
VIVJOA	T3	PA SP			
voriconazole (Vfend)	T1	PA			
ANTI-FUNGAL ANTIBIOTICS					
GRIS-PEG (griseofulvin ultramicrosize)	T3	QL(4 tabs/day)			
griseofulvin ultra 125 mg tab	T1				
griseofulvin ultra 165 mg tab	T1				
griseofulvin ultra 250 mg tab	T1				
nystatin	T1				
ANTI-FUNGALS (Skin Conditions)					
TOPICAL ANTI-FUNGAL/ANTI-INFLAMMATORY, STEROID AGENT					
clotrimazole/betamethasone dip	T1				
TOPICAL ANTI-FUNGALS					
ciclodan 0.77% cream	T1				
CICLODAN 0.77% CREAM KIT	T3				
ciclodan 8% solution	T1				
ciclopirox	T1				
ciclopirox/urea/camph/men/euc (Ciclodan)	T1				
econazole nitrate	T1				
ECOZA	T3				
EXODERM	T1				
ketoconazole	T1				
ketoconazole/skin cleanser 28	T1				
LOPROX	T3				
LOPROX (ciclopirox)	T3				
T1 – Typically Generics	PA – Prior Authorization			AGE – Age Requirement	PPACA – No Cost-Share Preventive Medication
T2 – Typically Preferred Brands	QL – Quantity Limit			SP – Specialty Medication	CSL – Oral cancer medication subject to cost-share limits
T3 – Typically Non-Preferred Brands	ST – Step Therapy	HD – May require home delivery pharmacy			

List of Prescription Medications

ANTI-FUNGALS (Skin Conditions) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
TOPICAL ANTI-FUNGALS (cont.)		
LULICONAZOLE	T1	
naftifine hcl	T1	
naftifine hcl (Naftin)	T1	
NAFTIN (naftifine hcl)	T2	
nystatin	T1	
nystatin/triamcinolone acet	T1	

ANTIHISTAMINE AND DECONGESTANT COMBINATION (Allergy/Nasal Sprays)

1ST GEN ANTIHISTAMINE AND DECONGESTANT COMBINATION		
phenylephrine hcl/prometh hcl	T1	
2ND GEN ANTIHISTAMINE AND DECONGESTANT COMBINATION		
CLARINEX-D 12 HOUR	T3	
ANTIHISTAMINES - 1ST GENERATION		
carbinoxamine maleate	T1	
clemastine fumarate	T1	
cyproheptadine hcl (Cyproheptadine Hcl)	T1	
hydroxyzine hcl	T1	
hydroxyzine pamoate (Vistaril)	T1	
promethazine hcl	T1	
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 (Clarinet)	T1	HD

ANTIHISTAMINES (Eye Conditions)

EYE ANTIHISTAMINES		
azelastine hcl 0.05% drops	T1	
bepotastine besilate (Bepreve)		
epinastine hcl	T1	
LASTACAF	T3	
olopatadine hcl 0.1% eye drops	T1	
olopatadine hcl 0.2% eye drop (Pataday)	T1	
PATADAY (olopatadine hcl)	T3	
PAZEO	T2	

T1 – Typically Generics

PA – Prior Authorization

AGE – Age Requirement

PPACA – No Cost-Share Preventive Medication

T2 – Typically Preferred Brands

QL – Quantity Limit

SP – Specialty Medication

CSL – Oral cancer medication subject to cost-share limits

T3 – Typically Non-Preferred Brands

ST – Step Therapy

HD – May require home delivery pharmacy

List of Prescription Medications

ANTI-HYPERGLYCEMICS (Diabetes)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ANTIHYPERGLY, INCRETIN MIMETIC (GLP-1 RECEPTOR 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
<i>exenatide</i>	T1	PA QL(3 mls/30 days)
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
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 (2ML/28 Days) ST
TRULICITY 4.5 MG/0.5 ML PEN	T2	QL (2ML/28 Days) ST
ANTI-HYPERGLY, INSULIN, LONG ACT-GLP-1 RECEPTOR AGONIST		
SOLIQUA 100-33	T2	
ANTI-HYPERGLYCEMIC-SOD/GLUC COTRANSPORT2(SGLT2) INHIB		
FARXIGA	T2	QL (1 tab/day) ST
JARDIANCE	T2	QL (1 tab/day) ST HD
ANTI-HYPERGLYCEMIC-DOPAMINE RECEPTOR AGONISTS		
CYCLOSET	T3	HD
ANTI-HYPERGLYCEMIC, ALPHA-GLUCOSIDASE INHIBITORS		
<i>acarbose</i> (Precose)	T1	HD
GLYSET (<i>miglitol</i>)	T3	HD
<i>miglitol</i> (Glyset)	T1	HD
PRECOSE (<i>acarbose</i>)	T3	HD
ANTI-HYPERGLYCEMIC, AMYLIN ANALOG-TYPE		
SYMLINPEN 120	T2	HD
SYMLINPEN 60	T2	
ANTI-HYPERGLYCEMIC, BIGUANIDE TYPE		
GLUCOPHAGE XR (<i>metformin hcl er</i>)	T3	HD
<i>metformin hcl</i>	T1	HD
<i>metformin hcl</i> (Glucophage Xr)	T1	HD
<i>metformin hcl</i> (Riomet)	T1	HD
RIOMET (<i>metformin hcl</i>)	T3	HD

T1 – Typically Generics

PA – Prior Authorization

AGE – Age Requirement

PPACA – No Cost-Share Preventive Medication

T2 – Typically Preferred Brands

QL – Quantity Limit

SP – Specialty Medication

CSL – Oral cancer medication subject to cost-share limits

T3 – Typically Non-Preferred Brands

ST – Step Therapy

HD – May require home delivery pharmacy

List of Prescription Medications

ANTI-HYPERGLYCEMICS (Diabetes) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ANTI-HYPERGLYCEMIC, BIGUANIDE TYPE (cont.)		
RIOMET ER	T3	HD
ANTI-HYPERGLYCEMIC, DPP-4 INHIBITORS		
JANUVIA	T2	QL (1 tab/day) ST HD
ANTI-HYPERGLYCEMIC, INSULIN-RELEASE STIMULANT TYPE		
AMARYL (<i>glimepiride</i>)	T3	HD
<i>chlorpropamide</i>	T1	HD
<i>glimepiride</i> (Amaryl)	T1	HD
GLIMEPIRIDE 3 MG TABLET	T3	HD
<i>glipizide</i> (Glucotrol XL)	T1	HD
GLIPIZIDE 2.5 MG TABLET	T3	HD
GLUCOTROL (<i>glipizide</i>)	T3	HD
GLUCOTROL XL (<i>glipizide xl</i>)	T3	HD
<i>glyburide</i>	T1	HD
GLYNASE (<i>glyburide micronized</i>)	T3	HD
<i>repaglinide</i> (Prandin)	T1	HD
STARLIX (<i>nateglinide</i>)	T3	HD
<i>tolbutamide</i>	T1	HD
ANTI-HYPERGLYCEMIC, SGLT-2 AND DPP-4 INHIBITOR COMB		
GLYXAMBI	T2	QL (1 tab/day) ST HD
ANTI-HYPERGLYCEMIC, THIAZOLIDINEDIONE AND BIGUANIDE		
ACTOPLUS MET (<i>pioglitazone-metformin</i>)	T3	HD
<i>pioglitazone hcl/metformin hcl</i> (Actoplus Met)	T1	HD
ANTI-HYPERGLYCEMIC, THIAZOLIDINEDIONE-SULFONYLUREA		
DUETACT (<i>pioglitazone-glimepiride</i>)	T3	HD
<i>pioglitazone hcl/glimepiride</i> (Duetact)	T1	HD
ANTI-HYPERGLYCEMIC, DPP-4 INHIBITOR-BIGUANIDE COMBS.		
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
ANTI-HYPERGLYCEMIC, INSULIN-RELEASE STIM.-BIGUANIDE		
<i>glipizide/metformin hcl</i>	T1	HD

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

PA – Prior Authorization

QL – Quantity Limit

ST – Step Therapy

AGE – Age Requirement

SP – Specialty Medication

HD – May require home delivery pharmacy

PPACA – No Cost-Share Preventive Medication

CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

ANTI-HYPERGLYCEMICS (Diabetes) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ANTI-HYPERGLYCEMIC, INSULIN-RELEASE STIM.-BIGUANIDE (cont.)		
<i>glyburide/metformin hcl</i>	T1	HD
<i>pioglitazone hcl (Actos)</i>	T1	HD
<i>repaglinide/metformin hcl</i>	T1	HD
ANTI-HYPERGLYCEMIC, THIAZOLIDINEDIONE (PPARG AGONIST)		
ACTOS (<i>pioglitazone hcl</i>)	T3	HD
AVANDIA	T3	HD
<i>pioglitazone hcl (Actos)</i>	T1	HD
ANTI-HYPERGLYCEMIC-GLUCOCORTICOID RECEPTOR BLOCKER		
<i>mifepristone 300 mg tablet (Korlym)</i>	T1	PA SP
ANTI-HYPERGLYCEMIC-SGLT2 INHIBITOR-BIGUANIDE COMBS.		
INVOKAMET	T2	QL (2 tabs/day) ST HD
SYNJARDY	T2	QL (2 tabs/day) ST HD
SYNJARDY XR 5-1,000 MG TABLET	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
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-500 MG TABLET	T2	QL (1 tab/day) ST HD
XIGDUO XR 5 MG-1,000 MG TABLET	T2	QL (2 tabs/day) ST HD
ANTIHYPERGLY-SGLT-2 INHIB, DPP-4 INHIB, BIGUANIDE CB		
TRIJARDY XR	T2	QL (1 tab/day) ST HD
INSULINS		
BASAGLAR KWIKPEN U-100	T2	QL (1.5ml/day) HD
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 (1.5ml/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 N 100 UNIT/ML VIAL	T2	QL (1.5ml/day) HD
HUMULIN R U-500	T2	QL (1.5ml/day) HD

T1 – Typically Generics

PA – Prior Authorization

AGE – Age Requirement

PPACA – No Cost-Share Preventive Medication

T2 – Typically Preferred Brands

QL – Quantity Limit

SP – Specialty Medication

CSL – Oral cancer medication subject to cost-share limits

T3 – Typically Non-Preferred Brands

ST – Step Therapy

HD – May require home delivery pharmacy

List of Prescription Medications

ANTI-HYPERGLYCEMICS (Diabetes) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
INSULINS (cont.)		
HUMULIN R U-500 KWIKPEN	T2	QL (1 ml/day) HD
INSULIN ASPART	T2	QL (1.5ml/day) HD
INSULIN ASPART FLEXPEN	T2	QL (1.5ml/day) HD
INSULIN ASPART PENFILL	T2	QL (1.5ml/day) HD
INSULIN ASPART PROT-INSULN ASP	T2	QL (2 ML/DAY) HD
INSULIN GLARGINE YFGN (SEMGLEE-YFGN), VIAL, PEN	T3	QL (1.5ml/day) HD
INSULIN LISPRO (HUMALOG) (U-100 VIAL)	T3	QL (1.5ml/day) HD
INSULIN LISPRO PROTAMINE MIX	T3	QL (2 ml/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 (1 ML/DAY) HD
SEMGLEE (YFGN)	T2	PA QL(1.5 MLS/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

<i>amoxicillin</i>	T1	
--------------------	----	--

ANTI-INFECTIVES/MISCELLANEOUS (Feminine Products)

VAGINAL ANTISEPTICS

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

ANTI-INFECTIVES/MISCELLANEOUS (Infections)

2ND GEN. ANAEROBIC ANTI-PROTOZOAL-ANTIBACTERIAL

TINDAMAX (<i>tinidazole</i>)	T3	
<i>tinidazole</i>	T1	
<i>tinidazole</i> (Tindamax)	T1	

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

PA – Prior Authorization

QL – Quantity Limit

ST – Step Therapy

AGE – Age Requirement

SP – Specialty Medication

HD – May require home delivery pharmacy

PPACA – No Cost-Share Preventive Medication

CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

ANTI-INFECTIVES/MISCELLANEOUS (Infections) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ANTHELMINTICS		
<i>albendazole</i> (Albenza)	T1	
ALBENZA (<i>albendazole</i>)	T3	
BILTRICIDE (<i>praziquantel</i>)	T3	
EMVERM	T1	
<i>ivermectin</i>	T1	
<i>praziquantel</i> (Biltricide)	T1	
STROMEKTOL (<i>ivermectin</i>)	T3	PA
ANTI-MALARIAL DRUGS		
<i>atovaquone/proguanil hcl</i> (Malarone)	T1	
<i>chloroquine ph 250 mg tablet</i>	T1	
<i>chloroquine ph 500 mg tablet</i>	T1	QL (28 tabs/365 days)
COARTEM	T3	PA QL (24 tabs/30 days)
<i>hydroxychloroquine sulfate</i> (Plaquenil)	T1	
KRINTAFEL	T3	PA QL (2 tabs/30 days)
MALARONE (<i>atovaquone-proguanil hcl</i>)	T3	PA
<i>mefloquine hcl</i>	T1	
PRIMAQUINE (<i>primaquine phosphate</i>)	T1	
<i>primaquine phosphate</i> (Primaquine)	T1	
<i>pyrimethamine 25 mg tablet</i> (Daraprim)	T1	PA
<i>pyrimethamine 25 mg tablet</i> (Daraprim)	T1	PA SP
<i>quinine sulfate</i>	T1	
ANTI-PROTOZOAL DRUGS, MISCELLANEOUS		
<i>atovaquone</i>	T1	
BENZNIDAZOLE	T3	
IMPAVIDO	T3	PA
LAMPIT	T3	
NEBUPENT (<i>pentamidine isethionate</i>)	T3	
<i>pentamidine isethionate</i> (Nebupent)	T1	
<i>glycine urologic solution</i>	T3	

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

PA – Prior Authorization

QL – Quantity Limit

ST – Step Therapy

AGE – Age Requirement

SP – Specialty Medication

HD – May require home delivery pharmacy

PPACA – No Cost-Share Preventive Medication

CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

ANTI-INFECTIVES/MISCELLANEOUS (Miscellaneous)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ANTISEPTICS, GENERAL		
ALCOHOL SWABSTICK	T3	
TOPICAL ANTISEPTIC DRYING AGENTS		
<i>formaldehyde</i>	T1	
ANTI-INFLAM.TUMOR NECROSIS FACTOR INHIBITING AGENTS (Pain Relief And Inflammatory Disease)		
ANTI-INFLAMMATORY TUMOR NECROSIS FACTOR INHIBITOR		
ADALIMUMAB-ADB(M)(CF)	T2	PA QL(2 pens/syringes/28 days) SP HD
ADALIMUMAB-RYVK(CF) AUTOINJECT	T2	PA QL (2 auto-injs/28 days) SP HD
AVSOLA	T2	PA SP
CIMZIA	T2	PA QL(1 starter kit/365 days) SP HD
CIMZIA (2 PACK)	T3	PA QL (1 kit/28 days) SP HD
CYLTEZO	T3	PA QL (2 doses/ 28 days) SP
CYLTEZO (CF) PEN	T2	PA QL(1 starter kit/365 days) SP
ENBREL 25 MG KIT	T3	PA QL (8 vials/28 days) SP HD
ENBREL 25 MG/0.5 ML SYRINGE	T3	PA QL (8 syringes/28 days) SP HD
ENBREL 25 MG/0.5 ML VIAL	T3	PA QL (4 ml/28 days) SP HD
ENBREL 50 MG/ML SYRINGE	T3	PA QL (4 syringes/28 days) SP HD
ENBREL MINI	T3	PA QL (4 cartridges/28 days) SP HD
ENBREL SURECLICK	T3	PA QL (4 syringes/28 days) SP HD
HUMIRA	T3	PA QL (2 syringes/28 days) SP HD
HUMIRA PEN	T3	PA QL (2 pens/28 days) SP HD
HUMIRA(CF)	T3	PA QL (2 syringes/28 days) SP
HUMIRA(CF) PEN 40 MG/0.4 ML	T3	PA QL (2 pens/28 days) SP HD
HUMIRA(CF) PEN 80 MG/0.8 ML	T3	PA QL (1 kit/year) SP HD
HUMIRA(CF) PEN CROHN'S-UC-HS	T3	PA QL (1 kit/year) SP HD
HUMIRA(CF) PEN PSOR-UV-ADOL HS	T3	PA QL (1 kit/year) SP HD
INFLECTRA	T2	PA SP HD
REMICADE	T3	PA SP HD
SIMLANDI(CF)	T2	PA QL(2 pens/28 days) SP HD
SIMPONI 100 MG/ML PEN INJECTOR	T3	PA QL (1 injector/28 days) SP HD
SIMPONI 100 MG/ML SYRINGE	T3	PA QL (1 syringe/28 days) SP HD
SIMPONI 50 MG/0.5 ML PEN INJEC	T3	PA QL (1 injector/28 days) SP HD
SIMPONI 50 MG/0.5 ML SYRINGE	T3	PA QL (1 syringe/28 days) SP HD

T1 – Typically Generics

PA – Prior Authorization

AGE – Age Requirement

PPACA – No Cost-Share Preventive Medication

T2 – Typically Preferred Brands

QL – Quantity Limit

SP – Specialty Medication

CSL – Oral cancer medication subject to cost-share limits

T3 – Typically Non-Preferred Brands

ST – Step Therapy

HD – May require home delivery pharmacy

List of Prescription Medications

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.)		
SIMPONI ARIA	T3	PA SP HD
ANTI-NEOPLASTICS (Cancer)		
ANP - SELECTIVE RETINOID X RECEPTOR AGONISTS (RXR)		
<i>bexarotene</i> (Targretin)	T1	PA SP HD
ANTI-NEOPLAST, HISTONE DEACETYLASE (HDAC) INHIBITORS		
FARYDAK	T3	PA SP HD
ZOLINZA	T2	PA SP HD
ANTI-NEOPLASTIC - ALKYLATING AGENTS		
ALKERAN (<i>melphalan</i>)	T3	SP
<i>cyclophosphamide</i>	T1	SP HD
GLEOSTINE	T2	
HYDREA (<i>hydroxyurea</i>)	T3	
<i>hydroxyurea</i> (Hydrea)	T1	
LEUKERAN	T2	
<i>melphalan</i> (Alkeran)	T1	SP CSL
MYLERAN	T2	
<i>temozolomide</i>	T1	PA SP HD
ANTI-NEOPLASTIC - ANTI-ANDROGENIC AGENTS		
<i>abiraterone acetate</i> (Zytiga)	T1	PA SP CSL
<i>bicalutamide</i> (Casodex)	T1	
CASODEX (<i>bicalutamide</i>)	T3	
ERLEADA 240 MG TABLET	T2	PA QL(1 TAB/DAY) SP HD CSL
ERLEADA 60 MG TABLET	T2	PA SP HD CSL
<i>flutamide</i>	T1	
<i>nilutamide</i>	T1	QL (4 tabs/day)
NUBEQA	T2	PA SP HD
XTANDI	T2	PA SP HD
ANTI-NEOPLASTIC - ANTI-METABOLITES		
<i>capecitabine</i> (Xeloda)	T1	PA SP HD
INQOVI	T3	PA SP HD
JYLAMVO	T3	CSL
LONSURF	T3	PA SP HD

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

PA – Prior Authorization

QL – Quantity Limit

ST – Step Therapy

AGE – Age Requirement

SP – Specialty Medication

HD – May require home delivery pharmacy

PPACA – No Cost-Share Preventive Medication

CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

ANTI-NEOPLASTICS (Cancer) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ANTI-NEOPLASTIC - ANTI-METABOLITES (con't.)		
<i>mercaptopurine</i>	T1	SP CSL
<i>methotrexate sodium</i>	T1	
<i>methotrexate sodium/pf</i>	T1	
ONUREG	T3	PA QL (14 tabs/28 Days) SP
PURIXAN (<i>mercaptopurine</i>)	T3	SP
TABLOID	T3	
TREXALL	T2	
XATMEP	T3	
XELODA (<i>capecitabine</i>)	T3	PA SP HD
ANTI-NEOPLASTIC - AROMATASE INHIBITORS		
<i>anastrozole</i> (Arimidex)	T1	HD PPACA
ARIMIDEX (<i>anastrozole</i>)	T3	HD
AROMASIN (<i>exemestane</i>)	T3	HD
<i>exemestane</i> (Aromasin)	T1	HD PPACA
<i>letrozole</i> (Femara)	T1	HD
ANTI-NEOPLASTIC - BRAF KINASE INHIBITORS		
OJEMDA 100 MG TAB	T3	PA QL(1 packet/28 days) SP CSL
TAFINLAR CAPSULE	T2	PA QL(4 caps/day) SP HD CSL
TAFINLAR TABLET	T2	PA QL(30 tabs/day) SP HD CSL
ZELBORAF	T3	PA SP HD
ANTI-NEOPLASTIC - HEDGEHOG PATHWAY INHIBITOR		
DAURISMO	T3	PA SP HD
ERIVEDGE	T2	PA SP HD
ODOMZO	T2	PA SP HD
ANTI-NEOPLASTIC - JANUS KINASE (JAK) INHIBITORS		
JAKAFI	T3	PA SP HD
ANTI-NEOPLASTIC - KRAS PROTEIN INHIBITOR		
LUMAKRAS 120 MG TABLET	T3	PA SP QL (8 tabs per day) HD
LUMAKRAS 240 MG TABLET	T3	PA QL(4 tabs/day) SP HD CSL
LUMAKRAS 320 MG TABLET	T3	PA SP QL (3 tabs per day) HD
ANTI-NEOPLASTIC - MEK KINASE INHIBITORS		
COTELLIC	T3	PA SP HD
GOMEKLI	T3	PA SP HD
KOSELUGO 10 MG CAPSULE	T3	PA QL (10 capsules/day) SP

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

PA – Prior Authorization

QL – Quantity Limit

ST – Step Therapy

AGE – Age Requirement

SP – Specialty Medication

HD – May require home delivery pharmacy

PPACA – No Cost-Share Preventive Medication

CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

ANTI-NEOPLASTICS (Cancer) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ANTI-NEOPLASTIC - MEK KINASE INHIBITORS (cont.)		
KOSELUGO 25 MG CAPSULE	T3	PA QL (4 caps/day) SP
MEKINIST 0.05 MG/ML SOLUTION	T2	PA QL(40 mls/day) SP HD CSL
MEKINIST 0.5 MG TABLET	T2	PAQL(3 tabs/day) SP HD CSL
MEKINIST 2 MG TABLET	T2	PA QL(1 tab/day) SP HD CSL
ANTI-NEOPLASTIC - MTOR KINASE INHIBITORS		
AFINITOR (<i>everolimus</i>)	T3	PA SP HD
AFINITOR DISPERZ	T3	PA SP
<i>everolimus</i> (Afinitor)	T1	PA QL(1 tab/day) SP HD CSL
ANTI-NEOPLASTIC - PROTEIN METHYLTRANSFERASE INHIBIT		
TAZVERIK	T3	PA SP
ANTI-NEOPLASTIC - TOPOISOMERASE I INHIBITORS		
HYCAMTIN	T3	PA SP HD
ANTI-NEOPLASTIC COMB - KINASE AND AROMATASE INHIBIT		
KISQALI 200 MG DAILY DOSE	T2	PA QL (21 per 28 days) SP
KISQALI 400 MG DAILY DOSE	T2	PA QL (42 per 28 days) SP HD
KISQALI 600 MG DAILY DOSE	T2	PA QL (63 per 28 days) SP HD
ANTI-NEOPLASTIC EGF RECEPTOR BLOCKER MCLON ANTIBODY		
PHESGO	T3	PA SP HD
ANTI-NEOPLASTIC IMMUNOMODULATOR AGENTS		
lenalidomide	T1	PA QL(1 tab/day) SP HD CSL
<i>pazopanib hcl</i> (Votrient)	T1	PA QL(4 tabs/day) SP HD CSL
POMALYST	T2	PA QL(21 caps/28 days) SP HD CSL
REVLIMID	T2	PA QL(1 tab/day) SP HD CSL
ANTI-NEOPLASTIC LHRH (GNRH) AGONIST, PITUITARY SUPPR. (cont.)		
<i>leuprolide acetate</i>	T1	PA SP HD
LEUPROLIDE DEPOT	T3	PA SP
LUPRON DEPOT	T2	PA SP HD
LUTRATE DEPOT	T3	PA SP
ZOLADEX	T2	PA SP HD
ANTI-NEOPLASTIC LHRH (GNRH) ANTAGONIST, PITUIT.SUPPRS		
FIRMAGON	T3	PA SP HD
ORGOVYX	T3	PA SP

T1 – Typically Generics

PA – Prior Authorization

AGE – Age Requirement

PPACA – No Cost-Share Preventive Medication

T2 – Typically Preferred Brands

QL – Quantity Limit

SP – Specialty Medication

CSL – Oral cancer medication subject to cost-share limits

T3 – Typically Non-Preferred Brands

ST – Step Therapy

HD – May require home delivery pharmacy

List of Prescription Medications

ANTI-NEOPLASTICS (Cancer) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ANTI-NEOPLASTIC SYSTEMIC ENZYME INHIBITORS		
ALECENSA	T2	PA QL(8 tabs/day) SP HD CSL
ALUNBRIG 30 MG TABLET	T2	PA QL(2 tabs/day) SP CSL
ALUNBRIG 90 MG TABLET	T2	PA QL(1 tab/day) SP CSL
ALUNBRIG 90 MG-180 MG TAB PACK	T2	PA QL(1 tab/day) SP CSL
ALUNBRIG 180 MG TABLET	T2	PA QL(1 tab/day) SP CSL
AYVAKIT	T3	PA QL (1 tab/day) SP
BALVERSA	T3	PA SP
BOSULIF	T3	PA QL(3 caps/day) SP HD
BRUKINSA	T2	PA QL (4 caps/day) SP
CABOMETYX	T3	PA SP HD
CALQUENCE	T3	PA SP
CAPRELSA	T3	PA SP
COMETRIQ	T3	PA SP HD
COPIKTRA	T3	PA SP
<i>dasatinib 20 mg tablet</i>	T1	PA QL(3 tabs/day) SP CSL
<i>dasatinib 70 mg tablet</i>	T1	PA QL(2 tabs/day) SP CSL
<i>dasatinib 50 mg, 80 mg, 100 mg, 140 mg tablet</i>	T1	PA QL(1 tab/day) SP CSL
DANZITEN	T2	PA SP CSL
ENSACOVE 25 MG CAPSULE	T2	PA QL(9 caps/day) SP CSL
ENSACOVE 100 MG CAPSULE	T2	PA QL (2 caps/day) SP CSL
EXKIVITY	T3	PA SP HD
FOTIVDA	T3	PA QL (30 caps/30 days) SP HD
FRUZAQLA 1 MG CAPSULE	T2	PA QL(84 caps/28 days) SP CSL
FRUZAQLA 5 MG CAPSULE	T2	PA QL(21 caps/28 days) SP CSL
GAVRETO	T3	PA QL (4 tabs/Day) SP CSL
<i>gefitinib</i>	T1	PA SP HD CSL
GILOTRIF	T3	PA SP HD
GLEEVEC (<i>imatinib mesylate</i>)	T3	PA SP HD
IBRANCE	T3	PA QL(21 caps/28 days) SP HD
IBTROZI 200 MG CAPSULE	T3	PA SP HD
<i>imatinib mesylate 100 mg tab (Gleevec)</i>	T1	QL (6 tabs/day) SP HD CSL
<i>imatinib mesylate 400 mg tab (Gleevec)</i>	T1	QL (2 tabs/day) SP HD CSL
IMBRUVICA	T2	PA SP
IMKELDI	T2	PA SP CSL

T1 – Typically Generics

PA – Prior Authorization

QL – Quantity Limit

SP – Specialty Medication

HD – May require home delivery pharmacy

T2 – Typically Preferred Brands

ST – Step Therapy

CSL – Oral cancer medication subject to cost-share limits

T3 – Typically Non-Preferred Brands

List of Prescription Medications

ANTI-NEOPLASTICS (Cancer) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ANTI-NEOPLASTIC SYSTEMIC ENZYME INHIBITORS (cont.)		
INLYTA	T3	PA SP HD
INREBIC	T3	PA SP HD
IRESSA	T3	PA SP HD
ITOVEBI	T3	PA SP HD CSL
IWILFIN	T3	PA QL(8 TABS/DAY) SP CSL
KISQALI 200 MG DAILY DOSE	T2	PA QL (21 per 28 days) SP HD
KISQALI 400 MG DAILY DOSE	T2	PA QL (42 per 28 days) SP HD
KISQALI 600 MG DAILY DOSE	T2	PA QL (63 per 28 days) SP HD
<i>lapatinib ditosylate</i> (Tykerb)	T1	PA SP HD
LENVIMA	T2	PA SP HD
LORBRENA	T3	PA SP HD
LYNPARZA	T2	PA SP HD
LYTGOBI 12 MG DAILY DOSE PACK	T3	PA QL(3 tabs/day) SP CSL
LYTGOBI 16 MG DAILY DOSE PACK	T3	PA QL(4 tabs/day) SP CSL
LYTGOBI 20 MG DAILY DOSE PACK	T3	PA QL(5 tabs/day) SP CSL
NERLYNX	T3	PA SP HD
NINLARO	T3	PA QL(3 caps/28 days) SP HD CSL
OGSIVEO	T3	PA QL(6 tabs/day) SP CSL
OJJAARA	T3	PA QL(1 tabs/day) SP CSL
<i>pazopanib</i> (Votrient)	T1	PA QL (4 tabs/day) SP HD CSL
PEMAZYRE	T3	PA QL (14 tabs/21 days) SP
PIQRAY	T2	PA SP CSL
QINLOCK	T3	PA QL (3 tabs/day) SP
RETEVMO 40 MG CAPSULE	T3	PA QL (6 caps/day) SP HD
RETEVMO 80 MG CAPSULE	T3	PA QL (4 tabs/day) SP HD
RETEVMO 120 MG, 160 MG TABLET	T3	PA QL (2 tabs/day) SP HD CSL
REVUFORJ 25 MG, 110 MG TABLET	T3	PA SP CSL
REVUFORJ 160 MG TABLET	T3	PA QL(2 tabs/day) SP CSL
ROMVIMZA	T3	PA QL (8 caps/28 days) SP CSL
ROZLYTREK	T3	PA SP HD
RUBRACA	T2	PA SP
RYDAPT	T3	PA SP HD
SCEMBLIX 20 MG TABLET	T2	PA QL(2 tabs/day) SP CSL
SCEMBLIX 40 MG TABLET	T2	PA SP CSL

T1 – Typically Generics

PA – Prior Authorization

AGE – Age Requirement

PPACA – No Cost-Share Preventive Medication

T2 – Typically Preferred Brands

QL – Quantity Limit

SP – Specialty Medication

CSL – Oral cancer medication subject to cost-share limits

T3 – Typically Non-Preferred Brands

ST – Step Therapy

HD – May require home delivery pharmacy

List of Prescription Medications

ANTI-NEOPLASTICS (Cancer) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ANTI-NEOPLASTIC SYSTEMIC ENZYME INHIBITORS (cont.)		
SCEMBLIX 100 MG TABLET	T2	PA SP CSL
STIVARGA	T2	PA QL(84 tabs/28 days) SP HD CSL
TABRECTA	T3	PA QL (4 tabs/day) SP HD
TAGRISSO	T3	PA SP HD
TALZENNA 0.1 MG SOFTGEL	T3	PA QL(1 cap/day) SP HD CSL
TALZENNA 0.25 MG SOFTGEL	T3	PA QL(1 cap/day) SP HD CSL
TALZENNA 0.35 MG SOFTGEL	T3	PA QL(1 cap/day) SP HD CSL
TALZENNA 0.5 MG SOFTGEL	T3	PA SP HD CSL
TALZENNA 0.75 MG SOFTGEL	T3	PA SP HD CSL
TALZENNA 1 MG SOFTGEL	T3	PA QL(1 cap/day) SP HD CSL
TEPMETKO	T3	PA QL (2 tabs/day) SP
TRUQAP	T3	PA QL(64 tabs/28 days) SP CSL
TUKYSA	T3	PA SP
TURALIO	T2	PA QL(4 caps/day) SP CSL
TYKERB (<i>lapatinib</i>)	T3	PA SP HD
UKONIQ	T3	PA QL (4 tabs/day) SP
VANFLYTA	T3	PA QL(2 tabs/day) SP CSL
VERZENIO	T2	PA QL SP HD
VITRAKVI	T3	PA SP HD
VIZIMPRO	T3	PA SP HD
XALKORI	T3	PA QL(4/day) SP HD CSL
XOSPATA	T3	PA SP
ZEJULA	T2	PA SP
ZYDELIG	T3	PA SP HD
ANTINEOPLASTIC - SYSTEMIC ENZYME INHIBITORS COMBS		
AVMAPKI-FAKZYNJA	T3	PA SP CSL
ANTI-NEOPLASTIC, ANTI-PROGRAMMED DEATH-I (PD-I) MAB		
OPDIVO	T3	PA SP HD
ANTI-NEOPLASTIC-B CELL LYMPHOMA-2(BCL-2) INHIBITORS		
VENCLEXTA	T3	PA SP
ANTI-NEOPLASTIC-ENZYME INHIB, ANTIANDROGEN COMB.		
AKEEGA	T3	PA QL(2 tabs/day) SP CSL
ANTI-NEOPLASTIC-ISOCITRATE DEHYDROGENASE INHIBITORS		
IDHIFA	T3	PA SP HD
REZLIDHIA	T3	PA QL(2 caps/day) SP CSL
TIBSOVO	T3	PA SP

T1 – Typically Generics

PA – Prior Authorization

AGE – Age Requirement

PPACA – No Cost-Share Preventive Medication

T2 – Typically Preferred Brands

QL – Quantity Limit

SP – Specialty Medication

CSL – Oral cancer medication subject to cost-share limits

T3 – Typically Non-Preferred Brands

ST – Step Therapy

HD – May require home delivery pharmacy

List of Prescription Medications

ANTI-NEOPLASTICS (Skin Conditions)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ANTI-NEOPLASTICS, MISCELLANEOUS (con't.)		
ENHERTU	T3	PA SP HD
<i>etoposide</i>	T1	SP HD
LYSODREN	T2	
MATULANE	T2	SP
<i>tretinoin 10 mg capsule</i>	T1	PA
ANTI-NEOPLASTIC-SELECT INHIB OF NUCLEAR EXP (SINE)		
XPOVIO	T3	PA SP
CYTOTOXIC T-LYMPHOCYTE ANTIGEN (CTLA-4) RMC ANTIBODY		
YERVOY	T3	PA SP HD
IMMUNOMODULATORS		
ACTIMMUNE	T3	PA SP HD
SELECTIVE ESTROGEN RECEPTOR MODULATORS (SERMS)		
FARESTON (<i>toremifene citrate</i>)	T3	QL (2 tabs/day) HD
SOLTAMOX	T3	HD
<i>tamoxifen citrate</i>	T1	HD PPACA
STEROID ANTI-NEOPLASTICS		
EMCYT	T2	SP HD
<i>megestrol acetate</i>	T1	
PHOTOACT, TOPICAL ANTI-NEOPLAST, PREMALIGNANT LESIONS		
LEVULAN	T3	SP
TOPICAL ANTI-NEOPLASTIC PREMALIGNANT LESION AGENTS		
EFUDEX (<i>fluorouracil</i>)	T3	
FLUOROPLEX	T2	
<i>fluorouracil</i>	T1	
<i>fluorouracil</i> (Efudex)	T1	
PANRETIN	T3	SP HD
PICATO	T2	
VALCHLOR	T3	SP HD
ANTI-OBESITY DRUGS (Weight Management)		
ANTI-OBESITY - ANOREXIC AGENTS		
ADIPEX-P (<i>phentermine hcl</i>)	T3	PA
<i>benzphetamine hcl</i> (Regimex)	T1	
<i>diethylpropion hcl</i>	T1	
LOMAIRA	T3	PA

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

PA – Prior Authorization

QL – Quantity Limit

ST – Step Therapy

AGE – Age Requirement

SP – Specialty Medication

HD – May require home delivery pharmacy

PPACA – No Cost-Share Preventive Medication

CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

ANTI-PARASITICS (Infections)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ANTI-OBESITY - ANOREXIC AGENTS (con't.)		
<i>phentermine/topiramate</i> (Qsymia)		
<i>phendimetrazine tartrate</i>	T1	
<i>phentermine hcl</i> (Adipex-p)	T1	
QSYMIA (<i>phentermine/topiramate</i>)	T3	PA
REGIMEX (<i>benzphetamine hcl</i>)	T3	
ANTI-OBESITY - MELANOCORTIN 4 RECEPTOR AGONISTS		
IMCIVREE	T3	PA QL (9 ML/22 DAYS) SP
ANTI-OBESITY GLUCAGON-LIKE PEPTIDE-1 RECEPTOR AGONIST		
SAXENDA	T2	PA
WEGOVY	T2	PA QL (1 BOX/MONTH)
ANTI-OBESITY SEROTONIN 2C RECEPTOR AGONISTS		
BELVIQ	T3	PA
BELVIQ XR	T3	PA
ANTI-OBESITY - OPIOID ANTAG-NOREPI, DOPAMINE RU INHIB		
CONTRACE	T3	PA
OPHTHALMIC (EYE) ANTIPARASITICS		
XDEMY	T2	PA QL(4 bottles/30 days) SP
FAT ABSORPTION DECREASING AGENTS		
XENICAL	T3	PA
ANTI-PARASITICS		
ALINIA 100 MG/5 ML SUSPENSION	T3	
<i>nitazoxanide</i> (Alinia)	T1	
TOPICAL ANTI-PARASITICS		
<i>crotamiton</i> (Eurax)	T1	
ELIMITE (<i>permethrin</i>)	T3	
EURAX 10% CREAM	T2	
EURAX 10% LOTION	T3	
<i>ivermectin tablet</i> (Sklice)	T1	PA
<i>permethrin</i> (Elimite)	T1	
SKLICE (<i>ivermectin</i>)	T3	
<i>spinosad</i> (Natroba)	T1	
ULESFIA	T3	
ANTI-PARKINSON DRUGS (Parkinson's Disease)		
ANTI-PARKINSONISM DRUGS, ANTI-CHOLINERGIC		
<i>benztropine mesylate</i>	T1	HD

T1 – Typically Generics

PA – Prior Authorization

AGE – Age Requirement

PPACA – No Cost-Share Preventive Medication

T2 – Typically Preferred Brands

QL – Quantity Limit

SP – Specialty Medication

CSL – Oral cancer medication subject to cost-share limits

T3 – Typically Non-Preferred Brands

ST – Step Therapy

HD – May require home delivery pharmacy

List of Prescription Medications

ANTI-PARKINSON DRUGS (Parkinson's Disease) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ANTI-PARKINSONISM DRUGS, ANTI-CHOLINERGIC		
<i>trihexyphenidyl hcl</i>	T1	HD
ANTI-PARKINSONISM DRUGS, OTHER		
<i>amantadine hcl</i>	T1	HD
APOKYN	T3	PA SP HD
<i>bromocriptine mesylate</i>	T1	HD
<i>carbidopa/levodopa</i>	T1	HD
<i>carbidopa/levodopa (Sinemet)</i>	T1	HD
<i>carbidopa/levodopa/entacapone (Stalevo 75)</i>	T1	HD
<i>carbidopa/levodopa/entacapone (Stalevo 100)</i>	T1	HD
<i>carbidopa/levodopa/entacapone (Stalevo 150)</i>	T1	HD
<i>carbidopa/levodopa/entacapone (Stalevo 200)</i>	T1	HD
DUOPA	T3	SP HD
<i>entacapone</i>	T1	HD
INBRIJA	T3	PA SP HD
KYNMOBI	T2	PA HD
NEUPRO	T3	HD
NOURIANZ	T3	PA QL (1 tab/day) SP HD
<i>pramipexole di-hcl</i>	T1	HD
<i>pramipexole er 0.375 mg tablet (Mirapex Er)</i>	T1	QL (1 tab/day) HD
<i>pramipexole er 0.75 mg tablet (Mirapex Er)</i>	T1	HD
<i>pramipexole er 1.5 mg tablet (Mirapex Er)</i>	T1	QL (1 tab/day) HD
<i>pramipexole er 2.25 mg tablet</i>	T1	QL (1 tab/day) HD
<i>pramipexole er 3 mg tablet</i>	T1	HD
<i>pramipexole er 3.75 mg tablet</i>	T1	HD
<i>pramipexole er 4.5 mg tablet</i>	T1	HD
<i>rasagiline mesylate 0.5 mg tab (Azilect)</i>	T1	QL (1 tab/day) HD
RYTARY	T3	HD
<i>selegiline hcl</i>	T1	HD
SINEMET (<i>carbidopa-levodopa</i>)	T3	HD

T1 – Typically Generics

PA – Prior Authorization

AGE – Age Requirement

PPACA – No Cost-Share Preventive Medication

T2 – Typically Preferred Brands

QL – Quantity Limit

SP – Specialty Medication

CSL – Oral cancer medication subject to cost-share limits

T3 – Typically Non-Preferred Brands

ST – Step Therapy

HD – May require home delivery pharmacy

List of Prescription Medications

ANTI-PARKINSON DRUGS (Parkinson's Disease) *(cont.)*

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ANTI-PARKINSONISM DRUGS, OTHER <i>(cont.)</i>		
STALEVO 75 (<i>carbidopa-levodopa-entacapone</i>)	T3	HD
STALEVO 100 (<i>carbidopa-levodopa-entacapone</i>)	T3	HD
STALEVO 150 (<i>carbidopa-levodopa-entacapone</i>)	T3	HD
STALEVO 200 (<i>carbidopa-levodopa-entacapone</i>)	T3	HD
TASMAR (<i>tolcapone</i>)	T3	HD
<i>tolcapone</i> (Tasmar)	T1	HD
XADAGO	T3	ST HD
DECARBOXYLASE INHIBITORS		
<i>carbidopa</i>	T1	
ANTI-PLATELET DRUGS (Blood Thinners/Anti-Clotting)		
PLATELET AGGREGATION INHIBITORS		
<i>aspirin/dipyridamole</i>	T1	HD
<i>cilostazol</i>	T1	HD
<i>clopidogrel bisulfate</i>	T1	HD
<i>clopidogrel bisulfate</i> (Plavix)	T1	HD
<i>dipyridamole</i>	T1	HD
EFFIENT (<i>prasugrel hcl</i>)	T3	HD
<i>prasugrel hcl</i> (Effient)	T1	HD
<i>ticagrelor</i> (Brilinta)	T1	HD
<i>ticlopidine hcl</i>	T1	HD
PLATELET REDUCING AGENTS		
AGRYLIN (<i>anagrelide hcl</i>)	T3	
<i>anagrelide hcl</i>	T1	
<i>anagrelide hcl</i> (Agrylin)	T1	
ANTIVIRALS (AIDS/HIV)		
ANTI-RETROVIRAL - CAPSID INHIBITORS		
SUNLENCA 463.5 MG/1.5 ML VIAL	T3	PA SP
SUNLENCA TABLET	T3	PA QL(5 tabs/180 days) SP
YEZTUGO 300 MG TABLET	T3	PA QL SP
YEZTUGO 463.5 MG/1.5 ML VIAL	T3	PA SP

T1 – Typically Generics

PA – Prior Authorization

AGE – Age Requirement

PPACA – No Cost-Share Preventive Medication

T2 – Typically Preferred Brands

QL – Quantity Limit

SP – Specialty Medication

CSL – Oral cancer medication subject to cost-share limits

T3 – Typically Non-Preferred Brands

ST – Step Therapy

HD – May require home delivery pharmacy

List of Prescription Medications

ANTIVIRALS (AIDS/HIV) (con't.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ANTI-RETROVIRAL - INTEGRASE INHIBITOR AND NNRTI COMB.		
CABENUVA	T3	PA SP
JULUCA	T2	SP
ANTI-RETROVIRAL - INTEGRASE INHIBITOR AND NRTI COMB.		
DOVATO	T2	SP
ANTI-RETROVIRAL - NRTIS AND INTEGRASE INHIBITORS COMB		
TRIUMEQ	T2	QL(1 tab/day) SP
ANTI-RETROVIRAL - NUCLEOSIDE, NUCLEOTIDE, PROTEASE INH.		
SYMTUZA	T2	SP
ANTIVIRALS - HIV-SPEC, NON-PEPTIDIC PROTEASE INHIB		
APTIVUS	T2	PA SP
<i>darunavir ethanolate</i> (Prezista)	T1	SP
PREZCOBIX	T3	PA SP
PREZISTA	T2	SP
ANTIVIRALS - HIV-SPEC, NUCLEOSIDE-NUCLEOTIDE ANALOG		
CIMDUO	T3	PA SP
DESCOVY	T2	SP PPACA
<i>emtricitabine-tenofv 100-150mg</i>	T1	SP PPACA
<i>emtricitabine-tenofv 133-200mg</i>	T1	SP PPACA
<i>emtricitabine-tenofv 167-250mg</i>	T1	SP PPACA
<i>emtricitabine-tenofv 200-300mg</i> (Truvada)	T1	SP PPACA
TEMIXYS	T3	PA SP
ANTIVIRALS - HIV-SPEC, NUCLEOSIDE ANALOG, RTI COMB		
<i>abacavir sulfate/lamivudine</i>	T1	PA SP
<i>abacavir/lamivudine/zidovudine</i>	T1	PA SP
<i>lamivudine/zidovudine</i>	T1	SP
ANTIVIRALS - HIV-SPECIFIC, CCR5 CO-RECEPTOR ANTAG.		
<i>maraviroc</i> (Selzentry)	T1	PA SP
ANTIVIRALS - HIV-SPECIFIC, CD4 ATTACHMENT INHIBITOR		
RUKOBIA	T3	PA QL (2 TABLETS/DAY) SP
ANTIVIRALS - HIV-SPECIFIC, FUSION INHIBITORS		
FUZEON	T3	PA SP
ANTIVIRALS - HIV-SPECIFIC, NON-NUCLEOSIDE, RTI		
EDURANT	T3	PA SP
<i>efavirenz</i>	T1	PA SP
INTELENCE	T3	PA SP

T1 – Typically Generics

PA – Prior Authorization

AGE – Age Requirement

PPACA – No Cost-Share Preventive Medication

T2 – Typically Preferred Brands

QL – Quantity Limit

SP – Specialty Medication

CSL – Oral cancer medication subject to cost-share limits

T3 – Typically Non-Preferred Brands

ST – Step Therapy

HD – May require home delivery pharmacy

List of Prescription Medications

ANTIVIRALS (AIDS/HIV) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ANTIVIRALS - HIV-SPECIFIC, NON-NUCLEOSIDE, RTI (con't.)		
nevirapine	T1	PA SP
PIFELTRO	T3	PA SP
ANTIVIRALS - HIV-SPECIFIC, NUCLEOSIDE ANALOG, RTI		
abacavir sulfate	T1	PA SP
emtricitabine (Emtriva)	T1	PA SP
EMTRIVA 10 MG/ML SOLUTION	T2	PA SP
EMTRIVA 200 MG CAPSULE (emtricitabine)	T3	PA SP
lamivudine 10 mg/ml oral soln	T1	SP
lamivudine 150 mg tablet	T1	SP
lamivudine 300 mg/30ml sol cup (EpiVir)	T1	SP
ANTIVIRALS - HIV-SPECIFIC, NUCLEOSIDE ANALOG, RTI		
lamivudine 300 mg tablet	T1	PA SP
zidovudine	T1	SP
ANTIVIRALS - HIV-SPECIFIC, NUCLEOTIDE ANALOG, RTI		
tenofovir disoproxil fumarate	T1	PA SP
VIREAD	T2	PA SP
ANTIVIRALS - HIV-SPECIFIC, PROTEASE INHIBITOR COMB		
lopinavir/ritonavir	T1	SP
ANTIVIRALS - HIV-SPECIFIC, PROTEASE INHIBITORS		
atazanavir sulfate	T1	PA SP
efavirenz	T1	PA SP
EVOTAZ	T3	PA SP
fosamprenavir calcium	T1	PA SP
LEXIVA	T2	PA SP
REYATAZ	T2	PA SP
ritonavir	T1	SP
ANTIVIRALS - HIV-I INTEGRASE STRAND TRANSFER INHIBTR		
APREUDE	T3	PA SP
ISENTRESS	T2	SP
ISENTRESS HD	T2	PA SP
TIVICAY	T2	SP
TIVICAY PD	T2	SP
ARTV NUCLEOSIDE, NUCLEOTIDE, NON-NUCLEOSIDE RTI COMB		
ATRIPLA (efavirenz-emtricitabine-tenofovir disoproxil fumarate)	T3	PA SP
DELSTRIGO	T3	PA SP
T1 – Typically Generics PA – Prior Authorization AGE – Age Requirement PPACA – No Cost-Share Preventive Medication T2 – Typically Preferred Brands QL – Quantity Limit SP – Specialty Medication CSL – Oral cancer medication subject to cost-share limits T3 – Typically Non-Preferred Brands ST – Step Therapy HD – May require home delivery pharmacy		

List of Prescription Medications

ANTIVIRALS (AIDS/HIV) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ARTV NUCLEOSIDE, NUCLEOTIDE, NON-NUCLEOSIDE RTI COMB		
<i>efavirenz/emtricit/tenofovr df</i> (Atripla)	T1	PA SP
<i>efavirenz/lamivu/tenofov disop</i> (Symfi Lo)	T1	SP
<i>efavirenz/lamivu/tenofov disop</i> (Symfi)	T1	SP
<i>emtricit/rilpivirine/tenof df</i> (Complera)	T1	QL(1 tab/day) SP
ODEFSEY	T3	PA SP
ARV-NUCLEOSIDE, NUCLEOTIDE RTI, INTEGRASE INHIBITORS		
BIKTARVY	T2	SP
GENVOYA	T2	SP
STRIBILD	T3	PA SP
ANTIVIRALS (Eye Conditions)		
EYE ANTIVIRALS		
<i>trifluridine</i>	T1	
ZIRGAN	T3	
ANTIVIRALS (Infections)		
ANTIVIRALS, GENERAL		
<i>acyclovir</i>	T1	
<i>famciclovir</i>	T1	
FLUMADINE (<i>rimantadine hcl</i>)	T3	
LIVTENCITY	T3	PA QL (4 tabs/day) SP
<i>oseltamivir 6 mg/ml suspension</i> (Tamiflu)	T1	QL (180ml/30 days)
<i>oseltamivir phos 30 mg capsule</i> (Tamiflu)	T1	QL (20/30 days)
<i>oseltamivir phos 45 mg capsule</i> (Tamiflu)	T1	QL (10 caps/30 days)
<i>oseltamivir phos 75 mg capsule</i> (Tamiflu)	T1	QL (10/30 days)
PREVYMIS	T3	SP HD
RELENZA	T3	QL (20/30 days)
<i>ribavirin</i> (Virazole)	T1	SP HD
<i>rimantadine hcl</i> (Flumadine)	T1	
TAMIFLU 30 MG CAPSULE (<i>oseltamivir phosphate</i>)	T3	QL (20/30 days)
TAMIFLU 45 MG CAPSULE (<i>oseltamivir phosphate</i>)	T3	QL (10/30 days)
TAMIFLU 6 MG/ML SUSPENSION (<i>oseltamivir phosphate</i>)	T3	QL (180ml/30 days)
TAMIFLU 75 MG CAPSULE (<i>oseltamivir phosphate</i>)	T3	QL (10/30 days)
<i>valacyclovir hcl</i> (Valtrex)	T1	
<i>valganciclovir hcl</i>	T1	
VALTREX (<i>valacyclovir</i>)	T3	

T1 – Typically Generics

PA – Prior Authorization

AGE – Age Requirement

PPACA – No Cost-Share Preventive Medication

T2 – Typically Preferred Brands

QL – Quantity Limit

SP – Specialty Medication

CSL – Oral cancer medication subject to cost-share limits

T3 – Typically Non-Preferred Brands

ST – Step Therapy

HD – May require home delivery pharmacy

List of Prescription Medications

ANTIVIRALS (Infections) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ANTIVIRALS, GENERAL (cont.)		
VIRAZOLE	T3	SP HD
XOFLUZA	T3	QL (2 tabs/30 days)
HEP C - NS5A, NS3/4A, NON-NUCLEO.NS5B INHIB COMB.		
VIEKIRA PAK	T3	PA SP HD
HEP C - NS5A, NS3/4A, NUCLEOTIDE NS5B INHIB COMBO		
VOSEVI	T2	PA SP HD
HEP C VIRUS, NUCLEOTIDE ANALOG NS5B POLYMERASE INH		
SOVALDI 150 MG PELLET PACKET	T2	PA QL (1 tab/day) SP HD
SOVALDI 200 MG PELLET PACKET	T2	PA QL (1 tab/day) SP HD
SOVALDI 200 MG TABLET	T2	PA QL (1 tab/day) SP HD
SOVALDI 400 MG TABLET	T2	PA SP HD
HEP C VIRUS-NS5B POLYMERASE AND NS5A INHIB. COMBO.		
EPCLUSA 200 MG-50 MG TABLET	T2	PA QL (1 tab/Day) SP HD
EPCLUSA 400 MG-100 MG TABLET	T2	PA SP HD
HARVONI 33.75-150 MG PELLET PK	T2	PA QL (1 tab/day) SP HD
HARVONI 45-200 MG PELLET PACKT	T2	PA QL (1 tab/day) SP HD
HARVONI 45-200 MG TABLET	T2	PA QL (1 tab/day) SP HD
HARVONI 90-400 MG TABLET	T2	PA SP HD
HEPATITIS B TREATMENT AGENTS		
EPIVIR HBV (<i>lamivudine</i>)	T3	SP
HEPSERA (adefovir dipivoxil)	T3	SP HD
PEGASYS	T3	PA SP HD
PEGINTRON	T3	PA SP HD
<i>ribasphere 200 mg capsule</i>	T1	SP HD
<i>ribasphere 200 mg tablet</i>	T1	SP HD
<i>ribasphere 400 mg tablet</i>	T1	SP
<i>ribasphere 600 mg tablet</i>	T1	SP
<i>ribasphere ribapak 200-400 mg</i>	T1	SP HD
<i>ribasphere ribapak 400-400 mg</i>	T1	SP HD
<i>ribasphere ribapak 600-400 mg</i>	T1	SP HD
<i>ribasphere ribapak 600-600 mg</i>	T1	SP HD
<i>ribavirin</i>	T1	SP HD
HEPATITIS C VIRUS- NS5A AND NS3/4A INHIBITOR COMB		
MAVYRET	T2	PA SP HD
ZEPATIER	T2	PA SP HD

T1 – Typically Generics

PA – Prior Authorization

AGE – Age Requirement

PPACA – No Cost-Share Preventive Medication

T2 – Typically Preferred Brands

QL – Quantity Limit

SP – Specialty Medication

CSL – Oral cancer medication subject to cost-share limits

T3 – Typically Non-Preferred Brands

ST – Step Therapy

HD – May require home delivery pharmacy

List of Prescription Medications

ANTIVIRALS (Infections) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
RNA POLYMERASE INHIBITOR		
LAGEVRIO (EUA)	T2	QL (1 pack/120 days)
MOLNUPIRAVIR	T3	QL (1 pkg/120 days)
ANTIVIRALS (Skin Conditions)		
TOPICAL GENITAL WART-HPV TREATMENT AGENTS		
VEREGEN	T3	
AUTONOMIC DRUGS (Allergy/Nasal Sprays)		
ANAPHYLAXIS THERAPY AGENTS		
epinephrine	T1	QL (2 packs/30 days)
epinephrine (Epinephrine)	T1	QL (2 packs/30 days)
AUTONOMIC DRUGS (Alzheimer's Disease)		
CHOLINESTERASE INHIBITORS		
ADLARITY	T1	PA QL (4 patcher/28 days)
ARICEPT (donepezil hcl)	T3	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
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
AUTONOMIC DRUGS (Attention Deficit Hyperactivity Disorder) ⁹		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ADRENERGICS, AROMATIC, NON-CATECHOLAMINE		
ADDERALL (dextroamphetamine-amphetamine)	T3	PA 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

T1 – Typically Generics

PA – Prior Authorization

AGE – Age Requirement

PPACA – No Cost-Share Preventive Medication

T2 – Typically Preferred Brands

QL – Quantity Limit

SP – Specialty Medication

CSL – Oral cancer medication subject to cost-share limits

T3 – Typically Non-Preferred Brands

ST – Step Therapy

HD – May require home delivery pharmacy

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		
<i>dextroamp-amphet er 5 mg cap</i>	T1	PA QL (1 cap/day)
<i>dextroamp-amphet er 10 mg cap</i>	T1	PA QL (1 per day)
<i>dextroamph-amphet er 12.5mg cp (Mydayis)</i>	T1	PA QL (1 per day)
<i>dextroamp-amphet er 15 mg cap</i>	T1	PA QL (1 cap/day)
<i>dextroamp-amphet er 20 mg cap</i>	T1	PA QL (1 cap/day)
<i>dextroamp-amphet er 25 mg cap</i>	T1	PA QL (1 per day)
<i>dextroamp-amphet er 30 mg cap</i>	T1	PA QL (1 cap/day)
<i>dextroamph-amphet er 37.5mg cp</i>	T1	PA QL (1 cap/day)
<i>dextroamph-amphet er 50 mg cap (Mydayis)</i>	T1	PA QL (1 cap/day)
<i>dextroamphetamine er 10 mg cap</i>	T1	PA QL (1 cap/day)
<i>dextroamphetamine er 15 mg cap</i>	T1	PA QL (3/day)
<i>dextroamphetamine er 5 mg cap</i>	T1	PA QL (1 cap/day)
<i>dextroamphetamine sulfate</i>	T1	PA
<i>dextroamphetamine sulfate</i>	T3	PA ST
DYANAVEL XR	T3	PA QL (8ml/day)
EVEKEO (<i>amphetamine sulfate</i>)	T3	PA ST
EVEKEO ODT	T3	PA
<i>methamphetamine hcl</i>	T1	PA
MYDAYIS (<i>dextroamphetamine/amphetamine</i>)	T3	PA QL (1 cap/day)
XELSTRYM	T3	PA QL (1 PATCH/DAY)
ZENZEDI	T3	PA ST

AUTONOMIC DRUGS (Blood Pressure/Heart Medications)

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

AUTONOMIC DRUGS (Urinary Tract Conditions)

PARASYMPATHETIC AGENTS		
<i>cevimeline hcl (Evoxac)</i>	T1	HD
<i>guanidine hcl</i>	T1	HD

T1 – Typically Generics

PA – Prior Authorization

AGE – Age Requirement

PPACA – No Cost-Share Preventive Medication

T2 – Typically Preferred Brands

QL – Quantity Limit

SP – Specialty Medication

CSL – Oral cancer medication subject to cost-share limits

T3 – Typically Non-Preferred Brands

ST – Step Therapy

HD – May require home delivery pharmacy

List of Prescription Medications

AUTONOMIC DRUGS (Urinary Tract Conditions)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
PARASYMPATHETIC AGENTS		
<i>pilocarpine hcl</i> (Salagen)	T1	HD
SALAGEN (<i>pilocarpine hcl</i>)	T3	HD
URECHOLINE (<i>bethanechol chloride</i>)	T3	HD
BIOLOGICALS (Allergy/Nasal Sprays)		
ALLERGENIC EXTRACTS, THERAPEUTIC		
GRASTEK	T2	PA QL (1 tab/day)
ODACTRA	T3	PA QL (1 tab/day)
ORALAIR	T2	PA QL (1 tab/day)
RAGWITEK	T3	PA QL (1 tab/day)
BIOLOGICALS (Blood Pressure/Heart Medications)		
PLASMA KALLIKREIN INHIBITORS		
TAKHZYRO	T3	PA SP HD
BIOLOGICALS (Miscellaneous)		
PKU TREATMENT AGENTS - PHENYLALANINE AMMONIA LYASE		
PALYNZIQ	T3	PA SP HD
BIOLOGICALS (Vaccines)		
COVID-19 VACCINES		
COMIRNATY	T2	PPACA
JANSSEN COVID-19 VACCINE (EUA)	T2	PPACA
MODERNA COVID-19 VACCINE (EUA)	T2	PPACA
NOVAVAX	T2	PPACA
PFIZER COVID-19 VACCINE (EUA)	T2	PPACA
SPIKEVAX 2024-2025	T2	PPACA
ENTERIC VIRUS VACCINES		
IPOQ	T2	PPACA
ROTARIX	T3	PPACA
ROTATEQ	T3	PPACA
GRAM NEGATIVE COCCI VACCINES		
BEXSERO	T2	PPACA
MENACTRA	T2	
MENQUADFI	T2	PPACA
MENVEO A-C-Y-W-135-DIP	T2	PPACA

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

PA – Prior Authorization

QL – Quantity Limit

ST – Step Therapy

AGE – Age Requirement

SP – Specialty Medication

HD – May require home delivery pharmacy

PPACA – No Cost-Share Preventive Medication

CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

BIOLOGICALS (Vaccines) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
GRAM NEGATIVE COCCI VACCINES		
PENBRAYA	T2	PPACA
TRUMENBA	T2	PPACA
GRAM POSITIVE COCCI VACCINES		
CAPVAXIVE	T2	PPACA
PNEUMOVAX 23	T2	PPACA
PREVNAR 13	T2	PPACA
PREVNAR 20	T2	PPACA
INFLUENZA VIRUS VACCINES		
AFLURIA TRIVALENT	T2	PPACA
FLUAD TRIVALENT	T2	PPACA
FLUARIX TRIVALENT	T2	PPACA
FLUBLOK TRIVALENT	T2	PPACA
FLUCELVAX TRIVALENT	T2	PPACA
FLULAVAL TRIVALENT	T2	PPACA
FLUMIST TRIVALENT	T3	PPACA
FLUZONE HIGH-DOSE TRIV	T2	PPACA
FLUZONE TRIVALENT	T2	PPACA
TOXIN-PRODUCING BACILLI VACCINES/TOXOIDS		
BCG VACCINE (TICE STRAIN)	T2	PPACA
VACCINE/TOXOID PREPARATIONS, COMBINATIONS		
ACTHIB	T2	PPACA
ADACEL TDAP	T2	PPACA
BOOSTRIX TDAP	T2	PPACA
DAPTACEL DTAP	T2	PPACA
DIPHTHERIA-TETANUS TOXOIDS-PED	T2	
HIBERIX	T2	PPACA
INFANRIX DTAP	T2	PPACA
KINRIX	T2	PPACA
M-M-R II VACCINE	T2	PPACA
PEDVAXHIB	T2	PPACA
PENTACEL	T2	PPACA
PENTACEL ACTHIB COMPONENT	T2	PPACA
PROQUAD	T2	PPACA
QUADRACEL DTAP-IPV	T2	PPACA

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

PA – Prior Authorization

QL – Quantity Limit

ST – Step Therapy

AGE – Age Requirement

SP – Specialty Medication

HD – May require home delivery pharmacy

PPACA – No Cost-Share Preventive Medication

CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

BIOLOGICALS (Vaccines) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
VACCINE/TOXOID PREPARATIONS, COMBINATIONS (cont.)		
TDVAX	T2	PPACA
TENIVAC	T2	PPACA
VAXELIS	T2	PPACA
VIRAL/TUMORIGENIC VACCINES		
ABRYSVO	T3	PPACA
ACAM2000 (NATIONAL STOCKPILE)	T3	PPACA
ENGRIX-B	T2	PPACA
ERVEBO (NATIONAL STOCKPILE)	T3	
GARDASIL 9	T2	PPACA
HEPLISAV-B	T2	PPACA
IXCHIQ	T3	PPACA
JYNNEOS	T3	PPACA
MRESVIA	T3	PPACA
PEDIARIX	T2	PPACA
RECOMBIVAX HB	T2	PPACA
SHINGRIX	T2	QL (2 doses/lifetime) PPACA
TWINRIX	T2	PPACA
VARIVAX VACCINE	T2	PPACA
ZOSTAVAX	T2	PPACA
BLOOD (Blood Modifiers/Bleeding Disorders)		
AGENTS TO TX THROMBOTIC THROMBOCYTOPENIC PURPURA		
CABLIVI	T3	PA SP
ANTI-FIBRINOLYTIC AGENTS		
AMICAR (<i>aminocaproic acid</i>)	T3	SP HD
<i>aminocaproic acid</i> (Amicar)	T1	SP HD
LYSTEDA (<i>tranexamic acid</i>)	T3	SP
<i>tranexamic acid</i> (Lysteda)	T1	SP
ANTI-HEMOPHILIC FACTORS		
ALTUVIIIO	T2	PA SP HD
COMPLEMENT (C3) INHIBITORS		
EMPAVELI	T2	PA SP
FABHALTA	T2	PA QL (2 caps/day) SP
TAVNEOS	T3	PA QL (6 caps/day) SP
VOYDEYA	T2	PA QL (1 packet/28 days) SP

T1 – Typically Generics

PA – Prior Authorization

AGE – Age Requirement

PPACA – No Cost-Share Preventive Medication

T2 – Typically Preferred Brands

QL – Quantity Limit

SP – Specialty Medication

CSL – Oral cancer medication subject to cost-share limits

T3 – Typically Non-Preferred Brands

ST – Step Therapy

HD – May require home delivery pharmacy

List of Prescription Medications

BLOOD (Blood Modifiers/Bleeding Disorders)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
HEMOPHILIA TREATMENT AGENTS, NON-FACTOR REPLACEMENT		
ALHEMO PEN	T2	PA SP
HEMLIBRA	T2	PA SP HD
HYMPAVZI PEN	T2	PA SP
SICKLE CELL ANEMIA AGENTS		
DROXIA	T2	
SIKLOS	T3	PA
TOPICAL HEMOSTATICS		
ASTRINGYN	T3	
AVITENE	T3	
ENDO-AVITENE	T3	
EVICEL	T3	
<i>gelatin sponge, absorb/porcine (Gelfoam)</i>	T1	
GELFOAM (<i>surgifoam</i>)	T3	
GELFOAM COMPRESSED	T3	
MONSEL'S	T3	
RAPLIXA	T3	
RECOTHROM	T3	
SURGIFOAM	T1	
SYRINGE AVITENE	T3	
THROMBI-GEL	T3	
THROMBIN-JMI	T3	
THROMBI-PAD	T3	
ULTRAFOAM	T3	
BLOOD (Blood Thinners/Anti-Clotting)		
HEMORRHEOLOGIC AGENTS		
<i>pentoxifylline</i>	T1	HD
CARDIAC DRUGS (Blood Pressure/Heart Medications)		
ANTI-ANGINAL, ANTI-ISCHEMIC AGENTS, NON-HEMODYNAMIC		
<i>ranolazine (Ranexa)</i>	T1	QL (4 tabs/day) HD
ANTI-ARRHYTHMICS		
<i>amiodarone hcl</i>	T1	HD
<i>disopyramide phosphate (Norpace)</i>	T1	HD
<i>dofetilide 125 mcg capsule (Tikosyn)</i>	T1	QL (8 caps/day) HD
<i>dofetilide 250 mcg capsule (Tikosyn)</i>	T1	QL (4 caps/day) HD
<i>dofetilide 500 mcg capsule (Tikosyn)</i>	T1	QL (2 caps/day) HD
T1 – Typically Generics	PA – Prior Authorization	AGE – Age Requirement
T2 – Typically Preferred Brands	QL – Quantity Limit	SP – Specialty Medication
T3 – Typically Non-Preferred Brands	ST – Step Therapy	HD – May require home delivery pharmacy
		PPACA – No Cost-Share Preventive Medication
		CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

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

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ANTI-ARRHYTHMICS (cont.)		
<i>flecainide acetate</i>	T1	HD
<i>mexiletine hcl</i>	T1	HD
MULTAQ	T2	HD
NORPACE (<i>disopyramide phosphate</i>)	T3	PA HD
NORPACE CR	T3	HD
<i>pacerone 100 mg tablet</i>	T3	PA HD
<i>pacerone 200 mg tablet</i>	T1	HD
<i>pacerone 400 mg tablet</i>	T3	PA HD
<i>propafenone hcl</i>	T1	HD
<i>propafenone hcl</i> (Rythmol Sr)	T1	HD
<i>quinidine sulfate</i>	T1	HD
RYTHMOL SR (<i>propafenone hcl er</i>)	T3	PA HD
TIKOSYN 125 MCG CAPSULE (<i>dofetilide</i>)	T3	PA QL (8 caps/day) HD
TIKOSYN 250 MCG CAPSULE (<i>dofetilide</i>)	T3	PA QL (4 caps/day) HD
TIKOSYN 500 MCG CAPSULE (<i>dofetilide</i>)	T3	PA QL (2 caps/day) HD
CALCIUM CHANNEL BLOCKING AGENTS		
ADALAT CC (<i>nifedipine er</i>)	T3	HD
<i>amlodipine besylate</i> (Norvasc)	T1	HD
CALAN SR (<i>verapamil er</i>)	T3	HD
CAMZYOS	T3	PA QL (30caps/30days) SP
<i>diltiazem hcl</i>	T1	HD
<i>diltiazem hcl</i> (Cardizem La)	T1	QL(1 TAB/DAY) HD
<i>diltiazem hcl</i> (Tiazac)	T1	HD
<i>felodipine</i>	T1	HD
<i>isradipine</i>	T1	HD
<i>nicardipine hcl</i>	T1	HD
<i>nifedipine</i>	T1	HD
<i>nifedipine</i> (Adalat Cc)	T1	HD
<i>nifedipine</i> (Procardia XL)	T1	HD
<i>nifedipine</i> (Procardia)	T1	HD
<i>nisoldipine er 17 mg tablet</i> (Sular)	T1	HD

T1 – Typically Generics

PA – Prior Authorization

AGE – Age Requirement

PPACA – No Cost-Share Preventive Medication

T2 – Typically Preferred Brands

QL – Quantity Limit

SP – Specialty Medication

CSL – Oral cancer medication subject to cost-share limits

T3 – Typically Non-Preferred Brands

ST – Step Therapy

HD – May require home delivery pharmacy

List of Prescription Medications

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

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
CALCIUM CHANNEL BLOCKING AGENTS (cont.)		
<i>nisoldipine er 20 mg tablet</i>	T1	QL (1 tab/day) HD
<i>nisoldipine er 25.5 mg tablet</i>	T1	HD
<i>nisoldipine er 30 mg tablet</i>	T1	HD
<i>nisoldipine er 34 mg tablet (Sular)</i>	T1	HD
<i>nisoldipine er 40 mg tablet</i>	T1	HD
<i>nisoldipine er 8.5 mg tablet (Sular)</i>	T1	HD
NORLIQVA ORAL SOLN	T2	PA QL(10 mls/day) HD
NYMALIZE	T3	
PROCARDIA (<i>nifedipine</i>)	T3	HD
SULAR (<i>nisoldipine</i>)	T3	HD
TIAZAC (<i>tiadylt er</i>)	T3	HD
<i>verapamil hcl</i>	T1	HD
<i>verapamil hcl (Calan Sr)</i>	T1	HD
<i>verapamil hcl (Verelan Pm)</i>	T1	HD
<i>verapamil hcl (Verelan)</i>	T1	HD
VERELAN (<i>verapamil hcl</i>)	T3	HD
VERELAN (<i>verapamil sr</i>)	T3	HD
VERELAN PM (<i>verapamil er pm</i>)	T3	HD
DIGITALIS GLYCOSIDES		
<i>digoxin</i>	T1	HD
HEART RATE REDUCING, SA SELECTIVE I(F) CURRENT INH.		
CORLANOR (<i>ivabradine hcl</i>)	T2	PA HD
<i>ivabradine hcl (Corlanor)</i>		
SOLUBLE GUANYLATE CYCLASE (SGC) STIMULATOR		
VERQUVO	T2	PA QL HD
VASODILATORS, CORONARY		
DILATRATE-SR	T3	HD
<i>isosorbide dinitrate</i>	T1	HD
MINITRAN	T1	HD
NITRO-DUR 0.1 MG/HR PATCH	T3	HD
NITRO-DUR 0.2 MG/HR PATCH	T3	HD
NITRO-DUR 0.3 MG/HR PATCH	T2	HD
NITRO-DUR 0.4 MG/HR PATCH	T3	HD

T1 – Typically Generics

PA – Prior Authorization

AGE – Age Requirement

PPACA – No Cost-Share Preventive Medication

T2 – Typically Preferred Brands

QL – Quantity Limit

SP – Specialty Medication

CSL – Oral cancer medication subject to cost-share limits

T3 – Typically Non-Preferred Brands

ST – Step Therapy

HD – May require home delivery pharmacy

List of Prescription Medications

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

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
VASODILATORS, CORONARY (cont.)		
NITRO-DUR 0.6 MG/HR PATCH	T3	HD
NITRO-DUR 0.8 MG/HR PATCH	T2	HD
<i>nitroglycerin</i> (Nitro-dur)	T1	HD
<i>nitroglycerin</i> (Nitrolingual)	T1	HD
<i>nitroglycerin</i> (Nitromist)	T1	HD
<i>nitroglycerin</i> (Nitrostat)	T1	HD
NITROLINGUAL (<i>nitroglycerin</i>)	T3	HD
NITROMIST (<i>nitroglycerin</i>)	T3	HD
NITROSTAT (<i>nitroglycerin</i>)	T3	HD
CARDIOVASCULAR (Asthma/COPD/Respiratory)		
PULM ANTI-HTN, SOLUBLE GUANYLATE CYCLASE STIMULATOR		
ADEMPAS	T3	PA SP HD
PULM.ANTI-HTN, SEL.C-GMP PHOSPHODIESTERASE T5 INHIB		
<i>sildenafil 10 mg/ml oral susp</i> (Revatio)	T1	PA SP HD
<i>sildenafil 20 mg tablet</i> (Revatio)	T1	PA SP HD
<i>tadalafil</i> (Adcirca)	T1	PA SP HD
<i>tadalafil 20 mg tablet</i> (Adcirca)	T1	PA SP HD
PULMONARY ANTI-HTN, ENDOTHELIN RECEPTOR ANTAGONIST		
<i>ambrisentan</i> (Letairis)	T1	PA SP HD
<i>bosentan</i> (Tracleer)	T1	PA SP HD
OPSUMIT	T2	PA SP HD
TRACLEER 125 MG TABLET (<i>bosentan</i>)	T3	PA SP HD
TRACLEER 32 MG TABLET FOR SUSP	T2	PA SP HD
TRACLEER 62.5 MG TABLET (<i>bosentan</i>)	T3	PA SP HD
PULMONARY ANTIHYPER AGENT, ACTRIIA-FC		
WINREVAIR	T3	PA SP HD
PULMONARY ANTIHYPERTENSIVES, PROSTACYCLIN-TYPE		
ORENITRAM ER	T3	PA SP HD
ORENITRAM MONTH 1 TITRATION KT	T3	PA QL(168 tabs/180 days) SP HD
ORENITRAM MONTH 2 TITRATION KT	T3	PA QL(336 tabs/180 days) SP HD
ORENITRAM MONTH 3 TITRATION KT	T3	PA QL(252 tabs/180 days) SP HD
TYVASO	T3	PA SP HD
TYVASO DPI	T2	PA SP HD
TYVASO INSTITUTIONAL START KIT	T3	PA SP HD

T1 – Typically Generics

PA – Prior Authorization

AGE – Age Requirement

PPACA – No Cost-Share Preventive Medication

T2 – Typically Preferred Brands

QL – Quantity Limit

SP – Specialty Medication

CSL – Oral cancer medication subject to cost-share limits

T3 – Typically Non-Preferred Brands

ST – Step Therapy

HD – May require home delivery pharmacy

List of Prescription Medications

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

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
PULMONARY ANTIHYPERTENSIVES, PROSTACYCLIN-TYPE (cont.)		
TYVASO REFILL KIT	T3	PA SP HD
TYVASO STARTER KIT	T3	PA SP HD
UPTRAVI	T2	PA SP HD
VENTAVIS	T3	PA SP HD
YUTREPIA	T2	PA SP HD

CARDIOVASCULAR (Blood Pressure/Heart Medications)

PULMONARY HTN-ENDOTHELIN RECEPT ANTG-CGMP PDE5 INH		
OPSYNVI	T2	PA QL(1 tab/day) SP HD
ACE INHIBITOR-CALCIUM CHANNEL BLOCKER COMBINATION		
<i>amlodipine besylate/benazepril</i>	T1	HD
<i>amlodipine besylate/benazepril (Lotrel)</i>	T1	HD
LOTREL (<i>amlodipine besylate-benazepril</i>)	T3	HD
PRESTALIA 14 MG-10 MG TABLET	T3	HD
ACE INHIBITOR-CALCIUM CHANNEL BLOCKER COMBINATION (cont.)		
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 (<i>trandolapril-verapamil er</i>)	T3	HD
<i>trandolapril/verapamil hcl</i>	T1	HD
<i>trandolapril/verapamil hcl (Tarka)</i>	T1	HD
ACE INHIBITOR-THIAZIDE OR THIAZIDE-LIKE DIURETIC		
ACCURETIC (<i>quinapril-hydrochlorothiazide</i>)	T3	ST HD
<i>benazepril/hydrochlorothiazide (Lotensin Hct)</i>	T1	HD
<i>captopril-hctz 25-15 mg tablet</i>	T1	QL (3 tabs/day) HD
<i>captopril-hctz 25-25 mg tablet</i>	T1	QL (2 tabs/day) HD
<i>captopril-hctz 50-15 mg tablet</i>	T1	QL (3 tabs/day) HD
<i>captopril-hctz 50-25 mg tablet</i>	T1	QL (2 tabs/day) HD
<i>enalapril/hydrochlorothiazide</i>	T1	HD
<i>enalapril/hydrochlorothiazide (Vaseretic)</i>	T1	HD
<i>fosinopril/hydrochlorothiazide</i>	T1	HD
<i>lisinopril/hydrochlorothiazide (Zestoretic)</i>	T1	HD
LOTENSIN HCT (<i>benazepril-hydrochlorothiazide</i>)	T3	ST HD
<i>quinapril/hydrochlorothiazide (Accuretic)</i>	T1	HD
VASERETIC (<i>enalapril-hydrochlorothiazide</i>)	T3	ST HD
ZESTORETIC (<i>lisinopril-hydrochlorothiazide</i>)	T3	ST HD

T1 – Typically Generics

PA – Prior Authorization

AGE – Age Requirement

PPACA – No Cost-Share Preventive Medication

T2 – Typically Preferred Brands

QL – Quantity Limit

SP – Specialty Medication

CSL – Oral cancer medication subject to cost-share limits

T3 – Typically Non-Preferred Brands

ST – Step Therapy

HD – May require home delivery pharmacy

List of Prescription Medications

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

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ALPHA/BETA-ADRENERGIC BLOCKING AGENTS		
<i>carvedilol</i> (Coreg)	T1	HD
<i>carvedilol er 10 mg capsule</i> (Coreg Cr)	T1	QL (1 cap/day) HD
<i>carvedilol er 40 mg capsule</i> (Coreg Cr)	T1	QL (1 cap/day) HD
<i>carvedilol er 80 mg capsule</i> (Coreg Cr)	T1	HD
COREG (<i>carvedilol</i>)	T3	ST HD
COREG CR 10 MG CAPSULE (<i>carvedilol er</i>)	T3	QL (1 cap/day) ST HD
COREG CR 20 MG CAPSULE (<i>carvedilol er</i>)	T3	QL (1 cap/day) ST HD
COREG CR 40 MG CAPSULE (<i>carvedilol er</i>)	T3	QL (1 cap/day) ST HD
COREG CR 80 MG CAPSULE (<i>carvedilol er</i>)	T3	ST HD
<i>labetalol hcl</i>	T1	HD
ALPHA-ADRENERGIC BLOCKING AGENTS		
CARDURA (<i>doxazosin mesylate</i>)	T3	HD
CARDURA XL	T3	HD
<i>doxazosin mesylate</i> (Cardura)	T1	HD
MINIPRESS (<i>prazosin hcl</i>)	T3	HD
<i>terazosin hcl</i>	T1	HD
<i>prazosin</i>	T1	HD
ANGIOTEN.RECEPTR ANTAG-CALCIUM CHANL BLKR-THIAZIDE		
<i>amlodipine/valsartan/hcthiazid</i> (Exforge Hct)	T1	HD
<i>olmesartan/amlodipin/hcthiazid</i> (Tribenzor)	T1	HD
TRIBENZOR (<i>olmesartan-amlodipine-hctz</i>)	T3	HD
ANGIOTENSIN RECEPT-NEPRILYSIN INHIBITOR COMB (ARNI)		
ENTRESTO SPRINKLE	T2	QL(2 tabs/day)
ANGIOTENSIN RECEPTOR ANTAG.-THIAZIDE DIURETIC COMB		
ATACAND HCT (<i>candesartan-hydrochlorothiazid</i>)	T3	ST HD
AVALIDE (<i>irbesartan-hydrochlorothiazide</i>)	T3	ST HD
<i>candesartan/hydrochlorothiazid</i> (Atacand Hct)	T1	HD
HYZAAR (<i>losartan-hydrochlorothiazide</i>)	T3	ST HD

T1 – Typically Generics

PA – Prior Authorization

AGE – Age Requirement

PPACA – No Cost-Share Preventive Medication

T2 – Typically Preferred Brands

QL – Quantity Limit

SP – Specialty Medication

CSL – Oral cancer medication subject to cost-share limits

T3 – Typically Non-Preferred Brands

ST – Step Therapy

HD – May require home delivery pharmacy

List of Prescription Medications

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

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ANGIOTENSIN RECEPTOR ANTAG.-THIAZIDE DIURETIC COMB (cont.)		
<i>irbesartan/hydrochlorothiazide</i> (Avalide)	T1	HD
<i>losartan/hydrochlorothiazide</i> (Hyzaar)	T1	HD
MICARDIS HCT 40-12.5 MG TABLET (<i>telmisartan-hydrochlorothiazid</i>)	T3	QL (1 tab/day) ST HD
MICARDIS HCT 80-12.5 MG TABLET (<i>telmisartan-hydrochlorothiazid</i>)	T3	ST HD
MICARDIS HCT 80-25 MG TABLET (<i>telmisartan-hydrochlorothiazid</i>)	T3	ST HD
<i>olmesartan-hctz 20-12.5 mg tab</i> (Benicar Hct)	T1	QL (1 tab/day) HD
<i>olmesartan-hctz 40-12.5 mg tab</i> (Benicar Hct)	T1	HD
<i>olmesartan-hctz 40-25 mg tab</i> (Benicar Hct)	T1	HD
<i>telmisartan-hctz 40-12.5 mg tb</i> (Micardis Hct)	T1	QL (1 tab/day) HD
<i>telmisartan-hctz 80-12.5 mg tb</i> (Micardis Hct)	T1	HD
<i>telmisartan-hctz 80-25 mg tab</i> (Micardis Hct)	T1	HD
<i>valsartan/hydrochlorothiazide</i> (Diovan Hct)	T1	HD
ANGIOTENSIN RECEPTOR BLOCKR-CALCIUM CHANNEL BLOCKR		
<i>amlodipine besylate/valsartan</i> (Exforge)	T1	HD
<i>amlodipine-olmesartan 10-20 mg</i> (Azor)	T1	HD
<i>amlodipine-olmesartan 10-40 mg</i> (Azor)	T1	HD
<i>amlodipine-olmesartan 5-20 mg</i> (Azor)	T1	QL (1 tab/day) HD
<i>amlodipine-olmesartan 5-40 mg</i> (Azor)	T1	HD
AZOR 10-20 MG TABLET (<i>amlodipine-olmesartan</i>)	T3	HD
AZOR 10-40 MG TABLET (<i>amlodipine-olmesartan</i>)	T3	HD
AZOR 5-20 MG TABLET (<i>amlodipine-olmesartan</i>)	T3	QL (1 tab/day) HD
AZOR 5-40 MG TABLET (<i>amlodipine-olmesartan</i>)	T3	HD
EXFORGE (<i>amlodipine-valsartan</i>)	T3	HD
<i>telmisartan-amlodipine 40-10</i>	T1	HD
<i>telmisartan-amlodipine 40-5 mg</i>	T1	QL (1 tab/day) HD
<i>telmisartan-amlodipine 80-10</i>	T1	HD
<i>telmisartan-amlodipine 80-5 mg</i>	T1	HD
ANTI-HYPERTENSIVES, ACE INHIBITORS		
ACCUPRIL (<i>quinapril hcl</i>)	T3	ST HD
<i>benazepril hcl</i>	T1	HD
<i>benazepril hcl</i> (Lotensin)	T1	HD
<i>captopril</i>	T1	HD

T1 – Typically Generics

PA – Prior Authorization

AGE – Age Requirement

PPACA – No Cost-Share Preventive Medication

T2 – Typically Preferred Brands

QL – Quantity Limit

SP – Specialty Medication

CSL – Oral cancer medication subject to cost-share limits

T3 – Typically Non-Preferred Brands

ST – Step Therapy

HD – May require home delivery pharmacy

List of Prescription Medications

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

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ANTI-HYPERTENSIVES, ACE INHIBITORS (cont.)		
<i>enalapril maleate</i> (Vasotec)	T1	HD
<i>fosinopril sodium</i>	T1	HD
<i>lisinopril</i> (Zestril)	T1	HD
LOTENSIN (<i>benazepril hcl</i>)	T3	ST HD
<i>moexipril hcl</i>	T1	HD
<i>perindopril erbumine</i>	T1	HD
PRINIVIL (<i>lisinopril</i>)	T3	ST HD
<i>quinapril hcl</i> (Accupril)	T1	HD
<i>ramipril</i> (Altace)	T1	HD
<i>trandolapril</i>	T1	HD
VASOTEC (<i>enalapril maleate</i>)	T3	ST HD
ANTI-HYPERTENSIVES, ANGIOTENSIN RECEPTOR ANTAGONIST		
ARB LI	T3	PA HD
ATACAND (<i>candesartan cilexetil</i>)	T3	ST HD
BENICAR 20 MG TABLET (<i>olmesartan medoxomil</i>)	T3	QL (1 tab/day) ST HD
BENICAR 40 MG TABLET (<i>olmesartan medoxomil</i>)	T3	ST HD
BENICAR 5 MG TABLET (<i>olmesartan medoxomil</i>)	T3	ST HD
<i>candesartan cilexetil</i> (Atacand)	T1	HD
DIOVAN (<i>valsartan</i>)	T3	ST HD
EDARBI 40 MG TABLET	T3	QL (1 tab/day) ST HD
EDARBI 80 MG TABLET	T3	ST HD
<i>eprosartan mesylate</i>	T1	HD
<i>irbesartan</i> (Avapro)	T1	HD
<i>losartan potassium</i> (Cozaar)	T1	HD
MICARDIS 40 MG TABLET (<i>telmisartan</i>)	T3	QL (1 tab/day) ST HD
MICARDIS 80 MG TABLET (<i>telmisartan</i>)	T3	ST HD
<i>olmesartan medoxomil 20 mg tab</i> (Benicar)	T1	QL (1 tab/day) HD
<i>olmesartan medoxomil 40 mg tab</i> (Benicar)	T1	HD
<i>olmesartan medoxomil 5 mg tab</i> (Benicar)	T1	HD

T1 – Typically Generics

PA – Prior Authorization

AGE – Age Requirement

PPACA – No Cost-Share Preventive Medication

T2 – Typically Preferred Brands

QL – Quantity Limit

SP – Specialty Medication

CSL – Oral cancer medication subject to cost-share limits

T3 – Typically Non-Preferred Brands

ST – Step Therapy

HD – May require home delivery pharmacy

List of Prescription Medications

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

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ANTI-HYPERTENSIVES, ANGIOTENSIN RECEPTOR ANTAGONIST (cont.)		
<i>telmisartan 20 mg tablet</i>	T1	QL (1 tab/day) HD
<i>telmisartan 40 mg tablet</i> (Micardis)	T1	QL (1 tab/day) HD
<i>telmisartan 80 mg tablet</i> (Micardis)	T1	HD
<i>valsartan</i> (Diovan)	T1	ST HD
ANTI-HYPERTENSIVES, GANGLIONIC BLOCKERS		
VECAMYL	T1	
ANTI-HYPERTENSIVES, MISCELLANEOUS		
DEMSEER (<i>metirosine</i>)	T3	HD
<i>metirosine</i> (Demser)	T1	HD
ANTI-HYPERTENSIVES, SYMPATHOLYTIC		
CATAPRES-TTS 1 (<i>clonidine</i>)	T3	HD
CATAPRES-TTS 2 (<i>clonidine</i>)	T3	HD
CATAPRES-TTS 3 (<i>clonidine</i>)	T3	HD
<i>clonidine</i> (Catapres-tts 1)	T1	HD
<i>clonidine</i> (Catapres-tts 2)	T1	HD
<i>clonidine</i> (Catapres-tts 3)	T1	HD
<i>guanfacine hcl</i>	T1	HD
<i>methyl dopa</i>	T1	HD
<i>methyl dopa/hydrochlorothiazide</i>	T1	HD
ANTI-HYPERTENSIVES, VASODILATORS		
<i>hydralazine hcl</i>	T1	HD
<i>minoxidil</i>	T1	HD
BETA-ADRENERGIC BLOCKING AGENTS		
<i>acebutolol hcl</i>	T1	HD
<i>atenolol</i> (Tenormin)	T1	HD
<i>betaxolol hcl</i>	T1	HD
<i>bisoprolol 5 mg, 10 mg tablet</i>	T1	HD
BYSTOLIC 10 MG TABLET	T2	QL (1 tab/day) ST HD
BYSTOLIC 2.5 MG TABLET	T2	QL (1 tab/day) ST HD
BYSTOLIC 20 MG TABLET	T2	ST HD
BYSTOLIC 5 MG TABLET	T2	QL (1 tab/day) ST HD
INDERAL LA (<i>propranolol hcl er</i>)	T3	ST HD

T1 – Typically Generics

PA – Prior Authorization

AGE – Age Requirement

PPACA – No Cost-Share Preventive Medication

T2 – Typically Preferred Brands

QL – Quantity Limit

SP – Specialty Medication

CSL – Oral cancer medication subject to cost-share limits

T3 – Typically Non-Preferred Brands

ST – Step Therapy

HD – May require home delivery pharmacy

List of Prescription Medications

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

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
BETA-ADRENERGIC BLOCKING AGENTS (cont.)		
INDERAL XL	T3	ST HD
INNOPRAN XL	T3	ST HD
<i>metoprolol succinate</i> (Toprol XL)	T1	HD
<i>metoprolol tartrate</i>	T1	HD
<i>metoprolol tartrate</i> (Lopressor)	T1	HD
<i>nadolol</i>	T1	HD
<i>pindolol</i>	T1	HD
<i>propranolol hcl</i>	T1	HD
<i>propranolol hcl</i> (Inderal La)	T1	HD
<i>sotalol hcl</i>	T1	HD
<i>sotalol hcl</i> (Betapace Af)	T1	HD
SOTYLIZE	T3	HD
TENORMIN (<i>atenolol</i>)	T3	ST HD
<i>timolol maleate</i>	T1	HD
BETA-BLOCKERS AND THIAZIDE, THIAZIDE-LIKE DIURETICS		
<i>atenolol/chlorthalidone</i> (Tenoretic 100)	T1	HD
<i>atenolol/chlorthalidone</i> (Tenoretic 50)	T1	HD
<i>bisoprolol/hydrochlorothiazide</i> (Ziac)	T1	HD
METOPROLOL SUCCINATE ER-HCTZ	T1	HD
<i>metoprolol/hydrochlorothiazide</i>	T1	HD
<i>nadolol/bendroflumethiazide</i>	T1	HD
<i>propranolol/hydrochlorothiazide</i>	T1	HD
RENIN INHIBITOR, DIRECT		
<i>aliskiren 150 mg tablet</i> (Tekturna)	T1	QL (1 tab/day) HD
<i>aliskiren 300 mg tablet</i> (Tekturna)	T1	HD
RENIN INHIBITOR, DIRECT AND THIAZIDE DIURETIC COMB		
TEKTURNA HCT	T2	QL (1 tab/day) HD
VASODILATORS, COMBINATION		
<i>isosorbide-hydralazine 20-37.5</i> (Bidil)	T1	QL (6 tabs/day) HD

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

PA – Prior Authorization

QL – Quantity Limit

ST – Step Therapy

AGE – Age Requirement

SP – Specialty Medication

HD – May require home delivery pharmacy

PPACA – No Cost-Share Preventive Medication

CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

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

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
VASODILATORS, PERIPHERAL		
<i>ergoloid mesylates</i>	T1	
<i>isoxsuprine hcl</i>	T1	
CARDIOVASCULAR (Cholesterol Medications)		
ANTI-HYPERLIPID-HMG COA REDUCT INHIB-CHOLEST.AB.INHIB		
<i>ezetimibe/simvastatin</i> (Vytorin)	T1	HD
ROSZET	T3	PA HD
ANTI-HYPERLIPID- HMG-COA RI-CALCIUM CHANNEL BLOCKER		
<i>amlodipine-atorvast 10-10 mg</i> (Caduet)	T1	HD
<i>amlodipine-atorvast 10-20 mg</i> (Caduet)	T1	HD
<i>amlodipine-atorvast 10-40 mg</i> (Caduet)	T1	HD
<i>amlodipine-atorvast 10-80 mg</i> (Caduet)	T1	HD
<i>amlodipine-atorvast 2.5-10 mg</i>	T1	HD
<i>amlodipine-atorvast 2.5-20 mg</i>	T1	QL (1 tab/day) HD
<i>amlodipine-atorvast 2.5-40 mg</i>	T1	QL (1 tab/day) HD
<i>amlodipine-atorvast 5-10 mg</i> (Caduet)	T1	HD
<i>amlodipine-atorvast 5-20 mg</i> (Caduet)	T1	QL (1 tab/day) HD
<i>amlodipine-atorvast 5-40 mg</i> (Caduet)	T1	QL (1 tab/day) HD
<i>amlodipine-atorvast 5-80 mg</i> (Caduet)	T1	HD
CADUET 10 MG-10 MG TABLET (<i>amlodipine-atorvastatin</i>)	T3	HD
CADUET 10 MG-20 MG TABLET (<i>amlodipine-atorvastatin</i>)	T3	HD
CADUET 10 MG-40 MG TABLET (<i>amlodipine-atorvastatin</i>)	T3	HD
CADUET 10 MG-80 MG TABLET (<i>amlodipine-atorvastatin</i>)	T3	HD
CADUET 5 MG-10 MG TABLET (<i>amlodipine-atorvastatin</i>)	T3	HD
CADUET 5 MG-20 MG TABLET (<i>amlodipine-atorvastatin</i>)	T3	QL (1 tab/day) HD
CADUET 5 MG-40 MG TABLET (<i>amlodipine-atorvastatin</i>)	T3	QL (1 tab/day) HD
CADUET 5 MG-80 MG TABLET (<i>amlodipine-atorvastatin</i>)	T3	HD
ANTI-HYPERLIPIDEMIC - APO B-100 SYNTHESIS INHIBITOR		
KYNAMRO	T3	PA SP
ANTIHYPERLIPIDEMIC - APOLIPOPROTEIN INHIBITOR		
TRYNGOLZA	T3	PA QL SP
ANTI-HYPERLIPIDEMIC - ATP CITRATE LYASE INHIBITOR		
NEXLETOL	T2	PA QL (1 tab/day)
ANTI-HYPERLIPIDEMIC - PCSK9 INHIBITORS		
REPATHA PUSHTRONEX	T2	

T1 – Typically Generics

PA – Prior Authorization

AGE – Age Requirement

PPACA – No Cost-Share Preventive Medication

T2 – Typically Preferred Brands

QL – Quantity Limit

SP – Specialty Medication

CSL – Oral cancer medication subject to cost-share limits

T3 – Typically Non-Preferred Brands

ST – Step Therapy

HD – May require home delivery pharmacy

List of Prescription Medications

CARDIOVASCULAR (Cholesterol Medications) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ANTI-HYPERLIPIDEMIC - PCSK9 INHIBITORS (cont.)		
REPATHA SURECLICK	T2	PA
REPATHA SYRINGE	T2	PA
ANTI-HYPERLIPIDEMIC-ACLY AND CHOLEST 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	T1	HD PPACA
atorvastatin 20 mg tablet	T1	HD PPACA
atorvastatin 40 mg tablet	T1	HD
atorvastatin 80 mg tablet	T1	HD
fluvastatin sodium	T1	HD PPACA
fluvastatin sodium (Lescol XL)	T1	HD PPACA
LIVALO (pitavastatin calcium)	T2	ST QL(1 tab/day) HD
lovastatin 10 mg tablet	T1	HD
lovastatin 20 mg tablet	T1	HD PPACA
lovastatin 40 mg tablet	T1	HD PPACA
pitavastatin (Livalo) 1 mg tablet	T1	QL HD PPACA
pitavastatin (Livalo) 2 mg tablet	T1	QL HD PPACA
pitavastatin (Livalo) 4 mg tablet	T1	HD PPACA
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 40 mg tablet (Zocor)	T1	HD PPACA
simvastatin 5 mg tablet	T1	HD
BILE SALT SEQUESTRANTS		
cholestyramine (with sugar) (Questran)	T1	HD
cholestyramine/aspartame	T1	HD

T1 – Typically Generics

PA – Prior Authorization

AGE – Age Requirement

PPACA – No Cost-Share Preventive Medication

T2 – Typically Preferred Brands

QL – Quantity Limit

SP – Specialty Medication

CSL – Oral cancer medication subject to cost-share limits

T3 – Typically Non-Preferred Brands

ST – Step Therapy

HD – May require home delivery pharmacy

List of Prescription Medications

CARDIOVASCULAR (Cholesterol Medications) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
BILE SALT SEQUESTRANTS (cont.)		
<i>colesevelam hcl</i> (Welchol)	T1	HD
COLESTID 1 GM TABLET (<i>colestipol hcl</i>)	T3	HD
COLESTID FLAVORED GRANULES	T2	HD
COLESTID GRANULES	T3	HD
COLESTID GRANULES (<i>colestipol hcl</i>)	T3	HD
COLESTID GRANULES PACKET (<i>colestipol hcl</i>)	T3	HD
<i>colestipol hcl</i>	T1	HD
QUESTRAN (<i>cholestyramine</i>)	T3	HD
QUESTRAN LIGHT (<i>cholestyramine</i>)	T3	HD
LIPOTROPICS		
<i>ezetimibe</i> (Zetia)	T1	HD
<i>fenofibrate</i>	T1	HD
<i>fenofibrate nanocrystallized</i> (Tricor)	T1	HD
<i>fenofibrate, micronized</i>	T1	HD
<i>fenofibric acid</i> (choline) (Trilipix)	T1	HD
<i>fenofibric acid</i> (Fibricor)	T1	HD
FIBRICOR (<i>fenofibric acid</i>)	T3	ST HD
<i>gemfibrozil</i> (Lopid)	T1	HD
LIPOFEN	T3	ST HD
LOPID (<i>gemfibrozil</i>)	T3	HD
<i>niacin</i> (Niaspan)	T1	HD
NIASPAN (<i>niacin er</i>)	T3	HD
TRICOR (<i>fenofibrate</i>)	T3	ST HD
TRIGLIDE	T3	ST HD
TRILIPIX (<i>fenofibric acid</i>)	T3	ST HD
CARDIOVASCULAR (Miscellaneous)		
ENDOTHELIN-ANGIOTENSIN RECEPTOR ANTAGONIST		
FILSPARI	T2	PA QL(1 tab/day) SP
CNS DRUGS (Alzheimer's Disease)		
ALZHEIMER'S THERAPY, NMDA RECEPTOR ANTAGONISTS		
<i>memantine hcl</i>	T1	HD
<i>memantine hcl</i> (Namenda)	T1	HD
<i>memantine hcl er 14 mg capsule</i> (Namenda Xr)	T1	QL (1 cap/day) HD
<i>memantine hcl er 21 mg capsule</i>	T1	HD

T1 – Typically Generics

PA – Prior Authorization

AGE – Age Requirement

PPACA – No Cost-Share Preventive Medication

T2 – Typically Preferred Brands

QL – Quantity Limit

SP – Specialty Medication

CSL – Oral cancer medication subject to cost-share limits

T3 – Typically Non-Preferred Brands

ST – Step Therapy

HD – May require home delivery pharmacy

List of Prescription Medications

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

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ALZHEIMER'S THERAPY, NMDA RECEPTOR ANTAGONISTS (cont.)		
<i>memantine hcl er 28 mg capsule</i> (Namenda Xr)	T1	HD
NAMENDA	T3	HD
NAMENDA XR 14 MG CAPSULE (<i>memantine hcl er</i>)	T3	QL (1 cap/day) HD
NAMENDA XR 28 MG CAPSULE (<i>memantine hcl er</i>)	T3	HD
NAMENDA XR 7 MG CAPSULE (<i>memantine hcl er</i>)	T3	QL (1 cap/day) HD
NAMENDA XR TITRATION PACK	T3	QL (112/365 days) HD
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
CNS DRUGS (Miscellaneous)		
AMYOTROPHIC LATERAL SCLEROSIS AGENTS		
RADICAVA ORS	T3	PA QL (50ml/28 days) SP
RILUTEK (<i>riluzole</i>)	T3	SP HD
<i>riluzole</i> (Rilutek)	T1	SP HD
TIGLUTIK	T3	PA SP
DRUGS TO TREAT MOVEMENT DISORDERS		
AUSTEDO	T3	PA SP HD
AUSTEDO XR 12 MG TABLET	T3	PA QL(1 tab/day) SP HD
AUSTEDO XR 18 MG TABLET	T3	PA QL(1 tab/day) SP HD
AUSTEDO XR 24 MG TABLET	T3	PA QL(2 tabs/day) SP HD
AUSTEDO XR 6 MG TABLET	T3	PA QL(3 tabs/day) SP HD
AUSTEDO XR TITRATION KIT(WK1-4)	T3	PA QL(1 kit/180 days) SP HD
INGREZZA INITIATION PK(TARDIV)	T3	PA QL(28 caps/365 days) SP
INGREZZA SPRINKLE	T3	PA QLSP
<i>tetrabenazine</i>	T1	PA SP HD
PSEUDOBULBAR AFFECT (PBA) AGENTS, NMDA ANTAGONISTS		
NUEDEXTA	T3	QL (4 caps/day)
XANTHINES		
<i>caffeine citrate</i>	T1	HD

CNS DRUGS (Multiple Sclerosis)

AGENTS TO TREAT MULTIPLE SCLEROSIS

AVONEX	T2	PA SP HD
--------	----	----------

T1 – Typically Generics

PA – Prior Authorization

AGE – Age Requirement

PPACA – No Cost-Share Preventive Medication

T2 – Typically Preferred Brands

QL – Quantity Limit

SP – Specialty Medication

CSL – Oral cancer medication subject to cost-share limits

T3 – Typically Non-Preferred Brands

ST – Step Therapy

HD – May require home delivery pharmacy

List of Prescription Medications

CNS DRUGS (Multiple Sclerosis) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
AGENTS TO TREAT MULTIPLE SCLEROSIS (cont.)		
AVONEX PEN	T2	PA SP HD
BAFIERTAM	T2	PA SP HD
BETASERON	T3	PA SP HD
<i>dimethyl fumarate</i>	T1	SP HD
GILENYA	T2	PA SP HD
<i>glatiramer acetate</i>	T3	HD
<i>glatopa</i>	T3	HD
KESIMPTA PEN	T3	PA SP HD
MAVENCLAD	T3	PA SP HD
MAYZENT	T2	PA SP HD
PLEGRIDY	T3	PA SP HD
PLEGRIDY PEN	T3	PA SP HD
REBIF	T3	PA SP HD
REBIF REBIDOSE	T3	PA SP HD
<i>teriflunomide</i> (Aubagio)	T1	SP HD
VUMERITY	T2	PA SP HD
AGTS TX NEUROMUSC TRANSMISSION DIS, POT-CHAN BLKR		
<i>dalfampridine</i>	T1	PA SP HD
FIRDAPSE	T3	PA QL (8 tabs/day) SP
RUZURGI	T3	PA SP
CNS DRUGS (Pain Relief And Inflammatory Disease)		
CALCITONIN GENE-RELATED PEPTIDE (CGRP) INHIBITORS		
EMGALITY SYRINGE	T2	PA
SPHINGOSINE 1-PHOSPHATE (SIP) RECEPTOR MODULATOR		
VELSIPITY	T2	PA QL(30 tabs/30 days) SP HD
CNS DRUGS (Seizure Disorders)		
ANTI-CONVULSANT - BENZODIAZEPINE TYPE		
<i>clobazam</i> (Onfi)	T1	HD
<i>clonazepam</i>	T1	HD
<i>clonazepam</i> (Klonopin)	T1	HD
DIASTAT (<i>diazepam</i>)	T3	PA HD
<i>diazepam 10 mg rectal gel syst</i> (Diastat Acudial)	T1	HD

T1 – Typically Generics

PA – Prior Authorization

AGE – Age Requirement

PPACA – No Cost-Share Preventive Medication

T2 – Typically Preferred Brands

QL – Quantity Limit

SP – Specialty Medication

CSL – Oral cancer medication subject to cost-share limits

T3 – Typically Non-Preferred Brands

ST – Step Therapy

HD – May require home delivery pharmacy

List of Prescription Medications

CNS DRUGS (Seizure Disorders) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ANTI-CONVULSANT - BENZODIAZEPINE TYPE (cont.)		
<i>diazepam 2.5 mg rectal gel sys</i> (Diastat)	T1	HD
<i>diazepam 10 mg rectal gel sys</i> (Diastat)	T1	HD
<i>diazepam 20 mg rectal gel syst</i>	T1	HD
LIBERVANT	T3	QL(10 films/30 days) HD
KLONOPIN (<i>clonazepam</i>)	T3	PA HD
NAYZILAM	T2	PA QL (5 kits/30 days) HD
ONFI (<i>clobazam</i>)	T3	PA HD
VALTOCO	T2	PA QL (5 boxes/30 Days) HD
ANTI-CONVULSANT - CANNABINOID TYPE		
EPIDIOLEX	T3	PA SP HD
ANTI-CONVULSANTS		
BRIVIACT	T3	PA HD
<i>carbamazepine</i>	T1	HD
<i>carbamazepine</i> (Carbatrol)	T1	HD
<i>carbamazepine</i> (Tegretol Xr)	T1	HD
<i>carbamazepine</i> (Tegretol)	T1	HD
CARBATROL (<i>carbamazepine er</i>)	T3	PA HD
CELONTIN	T2	HD
DIACOMIT	T3	PA SP HD
DILANTIN 100 MG CAPSULE (<i>phenytoin sodium extended</i>)	T3	PA HD
DILANTIN 30 MG CAPSULE	T2	PA HD
DILANTIN 50 MG INFATAB (<i>phenytoin</i>)	T3	PA HD
DILANTIN-125 (<i>phenytoin</i>)	T3	PA HD
<i>divalproex sodium</i> (Depakote Er)	T1	HD
<i>divalproex sodium</i> (Depakote Sprinkle)	T1	HD
<i>divalproex sodium</i> (Depakote)	T1	HD
<i>ethosuximide</i> (Zarontin)	T1	HD
<i>eslicarbazepine 200 mg, 400 mg tablet</i>	T1	PA QL HD
<i>eslicarbazepine 600 mg, 800 mg tablet</i>	T1	PA HD
<i>felbamate</i>	T1	HD

T1 – Typically Generics

PA – Prior Authorization

AGE – Age Requirement

PPACA – No Cost-Share Preventive Medication

T2 – Typically Preferred Brands

QL – Quantity Limit

SP – Specialty Medication

CSL – Oral cancer medication subject to cost-share limits

T3 – Typically Non-Preferred Brands

ST – Step Therapy

HD – May require home delivery pharmacy

List of Prescription Medications

CNS DRUGS (Seizure Disorders) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ANTI-CONVULSANTS (cont.)		
FINTEPLA	T3	PA SP HD
FYCOMPA 6 MG TABLET	T2	PA QL (1 tab/day) HD
FYCOMPA 8 MG TABLET	T2	PA HD
<i>gabapentin</i> (Neurontin)	T1	HD
<i>lamotrigine</i>	T1	HD
LYRICA (<i>pregabalin</i>)	T3	PA HD
NEURONTIN (<i>gabapentin</i>)	T3	PA HD
<i>oxcarbazepine</i> (Oxtellar Xr)	T1	PA HD
OXTELLAR XR (<i>oxcarbazepine</i>)	T3	PA HD
PEGANONE	T2	HD
PHENYTEK (<i>phenytoin sodium extended</i>)	T3	PA HD
<i>phenytoin</i>	T1	HD
<i>phenytoin</i> (Dilantin)	T1	HD
<i>phenytoin</i> (Dilantin-125)	T1	HD
<i>phenytoin sodium extended</i> (Dilantin)	T1	HD
<i>phenytoin sodium extended</i> (Phenytek)	T1	HD
<i>pregabalin</i> (Lyrica)	T1	HD
<i>primidone</i> (Mysoline)	T1	HD
<i>rufinamide 200 mg tablet</i> (Banzel)	T1	PA QL(16 TABS/DAY) HD
<i>rufinamide 400 mg tablet</i> (Banzel)	T1	PA QL (8 TABS/DAY) HD
SPRITAM	T3	PA HD
TEGRETOL (<i>carbamazepine</i>)	T3	PA HD
TEGRETOL XR (<i>carbamazepine er</i>)	T3	PA HD
<i>tiagabine hcl 12 mg tablet</i> (Gabitril)	T1	QL (8 tabs/day) HD
<i>tiagabine hcl 16 mg tablet</i> (Gabitril)	T1	QL (6 tabs/day) HD
<i>tiagabine hcl 2 mg tablet</i> (Gabitril)	T1	HD
<i>tiagabine hcl 4 mg tablet</i> (Gabitril)	T1	HD
<i>topiramate</i>	T1	HD
<i>topiramate er</i> (Trokendi XR)	T1	QL(1 cap/day) HD
<i>topiramate er 25 mg capsule</i> (Trokendi Xr)	T1	QL(1 cap/day) HD
<i>topiramate er 50 mg capsule</i> (Trokendi Xr)	T1	HD
<i>topiramate er 100 mg capsule</i> (Trokendi Xr)	T1	QL(1 cap/day) HD
<i>topiramate er 200 mg capsule</i> (Trokendi Xr)	T1	HD

T1 – Typically Generics

PA – Prior Authorization

AGE – Age Requirement

PPACA – No Cost-Share Preventive Medication

T2 – Typically Preferred Brands

QL – Quantity Limit

SP – Specialty Medication

CSL – Oral cancer medication subject to cost-share limits

T3 – Typically Non-Preferred Brands

ST – Step Therapy

HD – May require home delivery pharmacy

List of Prescription Medications

CNS DRUGS (Seizure Disorders) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ANTI-CONVULSANTS (cont.)		
TROKENDI XR 25 MG, 100 MG CAPSULE (<i>topiramate</i>)	T3	QL(1 cap/day) HD
TROKENDI XR 50 MG, 200 MG CAPSULE (<i>topiramate</i>)	T3	HD
<i>valproic acid</i> (as sodium salt)	T1	HD
<i>vigabatrin</i>	T1	SP HD
VIMPAT	T2	PA HD
XCOPRI 25 MG TABLET	T3	PA HD
XCOPRI 100 MG TABLET	T3	PA QL (1 tab/day) HD
XCOPRI 12.5-25 MG TITRATION PK	T3	PA QL (1/28 Days) HD
XCOPRI 150 MG TABLET	T3	PA QL (1/Day) HD
XCOPRI 150-200 MG TITRATION PK	T3	PA QL (1/28 Days) HD
XCOPRI 200 MG TABLET	T3	PA QL (2/Day) HD
XCOPRI 250 MG DAILY DOSE PACK	T3	PA QL (1/28 Days) HD
XCOPRI 350 MG DAILY DOSE PACK	T3	PA QL (1/28 Days) HD
XCOPRI 50 MG TABLET	T3	PA QL (1/Day) HD
XCOPRI 50-100 MG TITRATION PAK	T3	PA QL (1/28 Days) HD
ZARONTIN (<i>ethosuximide</i>)	T3	PA HD
ZEPOSIA	T2	PA SP HD
<i>zonisamide</i>	T1	HD
ZTALMY	T3	PA QL (1800mg/day) SP

CNS DRUGS (Sleep Disorders/Sedatives)

NARCOLEPSY TX-H3-RECEPT.ANTAGONIST/INVERSE AGONIST

WAKIX	T3	PA QL (2 tabs/day) SP HD
-------	----	--------------------------

COLONY STIMULATING FACTORS (Blood Modifiers/Bleeding Disorders)

CXCR4 CHEMOKINE RECEPTOR ANTAGONIST

XOLREMDI	T3	PA QL(4 caps/day) SP CSL
----------	----	--------------------------

ERYTHROPOIESIS-STIMULATING AGENTS

ARANESP	T2	PA SP
EPOGEN	T2	PA SP
MIRCERA	T3	PA SP
PROCRIT	T2	PA SP
RETACRIT	T2	PA SP

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

PA – Prior Authorization

QL – Quantity Limit

ST – Step Therapy

AGE – Age Requirement

SP – Specialty Medication

HD – May require home delivery pharmacy

PPACA – No Cost-Share Preventive Medication

CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

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

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
LEUKOCYTE (WBC) STIMULANTS		
FULPHILA	T3	PA SP
GRANIX	T3	PA SP
LEUKINE	T2	SP
NEULASTA	T3	PA SP
NEULASTA ONPRO	T3	PA SP HD
NEUPOGEN	T3	PA SP
NIVESTYM	T2	SP
NYPOZI	T3	PA SP
NYVEPRIA	T3	PA SP
ROLVEDON	T2	PA SP
STIMUFEND	T3	PA SP
UDENYCA	T2	PA SP
ZARXIO	T2	SP HD
ZIEXTENZO	T3	PA SP
THROMBOPOIETIN RECEPTOR AGONISTS		
DOPTELET	T2	PA SP HD
MULPLETA	T3	PA SP HD
COLONY STIMULATING FACTORS (Cancer)		
CXCR4 CHEMOKINE RECEPTOR ANTAGONIST		
XOLREMDI	T3	PA QL(4 caps/day) SP CSL
CONTRACEPTIVES (Contraception Products)		
CONTRACEPTIVES, INTRAVAGINAL, SYSTEMIC		
<i>etonogestrel</i>	T3	
<i>etonogestrel/ethinyl estradiol</i> (Nuvaring)	T1	PPACA
NUVARING (<i>etonogestrel-ethinyl estradiol</i>)	T3	PPACA
CONTRACEPTIVES, IMPLANTABLE		
NEXPLANON	T3	SP PPACA
CONTRACEPTIVES, INJECTABLE		
DEPO-PROVERA 150 MG/ML SYRINGE (<i>medroxyprogesterone acetate</i>)	T3	PPACA
DEPO-PROVERA 150 MG/ML VIAL (<i>medroxyprogesterone acetate</i>)	T3	PPACA
DEPO-SUBQ PROVERA 104	T3	PPACA
CONTRACEPTIVES, ORAL		
<i>desog-e.estradiol/e.estradiol</i>	T1	HD PPACA
<i>desogestrel-ethinyl estradiol</i>	T1	HD PPACA

T1 – Typically Generics

PA – Prior Authorization

AGE – Age Requirement

PPACA – No Cost-Share Preventive Medication

T2 – Typically Preferred Brands

QL – Quantity Limit

SP – Specialty Medication

CSL – Oral cancer medication subject to cost-share limits

T3 – Typically Non-Preferred Brands

ST – Step Therapy

HD – May require home delivery pharmacy

List of Prescription Medications

CONTRACEPTIVES (Contraception Products) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
CONTRACEPTIVES, ORAL (con't.)		
<i>drospir/eth estra/levomefol ca</i> (Beyaz)	T1	HD PPACA
<i>drospir/eth estra/levomefol ca</i> (Safyral)	T1	HD PPACA
ELLA	T3	HD PPACA
ESTROSTEP FE (<i>tri-legest fe</i>)	T3	HD
<i>ethinyl estradiol/drospirenone</i> (Yasmin 28)	T1	HD PPACA
<i>ethinyl estradiol/drospirenone</i> (Yaz)	T1	HD PPACA
<i>ethynodiol d-ethinyl estradiol</i>	T1	HD PPACA
<i>levonorgestrel/ethin.estradiol</i>	T1	HD PPACA
<i>l-norgest/e.estradiol-e.estrad</i>	T1	HD PPACA
<i>l-norgest/e.estradiol-e.estrad</i> (Quartette)	T1	HD PPACA
LOESTRIN FE (<i>tarina fe 1-20 eq</i>)	T3	HD
MICROGESTIN 24 FE (<i>tarina 24 fe</i>)	T3	HD
<i>noreth-ethinyl estradiol/iron</i>	T1	HD PPACA
<i>noreth-ethinyl estradiol/iron</i> (Generess Fe)	T1	HD PPACA
<i>noreth-ethinyl estradiol/iron</i> (Generess Fe)	T3	HD PPACA
<i>norethind-eth estrad 1-0.02 mg</i> (Loestrin)	T1	HD PPACA
<i>norethindrone</i> (Ortho Micronor)	T1	HD PPACA
<i>norethindrone ac-eth estradiol</i> (Loestrin)	T1	HD PPACA
<i>norethindrone-e.estradiol-iron</i> (Estrostep Fe)	T1	HD PPACA
<i>norethindrone-e.estradiol-iron</i> (Loestrin Fe)	T1	HD PPACA
<i>norethindrone-e.estradiol-iron</i> (Microgestin 24 Fe)	T1	HD PPACA
<i>norethindrone-e.estradiol-iron</i> (Taytulla)	T1	HD PPACA
<i>norethindrone-ethin. estradiol</i>	T1	HD PPACA
<i>norethin-ee 1.5-0.03 mg(21) tb</i> (Loestrin)	T1	HD PPACA
<i>norgestrel-ethinyl estradiol</i>	T1	HD PPACA
ORTHO MICRONOR (<i>tulana</i>)	T3	HD
QUARTETTE (<i>rivelsa</i>)	T3	HD

T1 – Typically Generics

PA – Prior Authorization

AGE – Age Requirement

PPACA – No Cost-Share Preventive Medication

T2 – Typically Preferred Brands

QL – Quantity Limit

SP – Specialty Medication

CSL – Oral cancer medication subject to cost-share limits

T3 – Typically Non-Preferred Brands

ST – Step Therapy

HD – May require home delivery pharmacy

List of Prescription Medications

CONTRACEPTIVES (Contraception Products) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
CONTRACEPTIVES, TRANSDERMAL		
<i>norelgestromin/ethin.estradiol</i>	T1	HD PPACA
DIAPHRAGMS/CERVICAL CAP		
CAYA CONTOURED	T2	PPACA
FEMCAP	T2	PPACA
WIDE SEAL DIAPHRAGM	T3	PPACA
INTRA-UTERINE DEVICES (IUDS)		
KYLEENA	T3	SP PPACA
LILETTA	T3	SP PPACA
MIRENA	T3	SP PPACA
MIUDELLA	T3	SP PPACA
PARAGARD T 380-A	T3	SP PPACA
SKYLA	T3	SP PPACA
COUGH/COLD PREPARATIONS (Allergy/Nasal Sprays)		
IST GEN ANTIHIST-DECONGEST-ANTICHOLINERGIC COMB		
RESPA A.R.	T3	
COUGH/COLD PREPARATIONS (Cough/Cold Medications)		
ANTI-TUSSIVES, NON-OPIOID		
<i>benzonatate</i> (Tessalon Perle)	T1	
ANTI-TUSSIVES, NON-OPIOID (cont.)		
TESSALON PERLE (<i>benzonatate</i>)	T3	
NON-OPIOID ANTI-TUS-IST GEN.ANTIHISTAMINE-DECONGEST		
<i>brompheniramine/pseudoephed/dm</i> (Bromfed Dm)	T1	
NON-OPIOID ANTI-TUSSIVE-IST GEN ANTIHISTAMINE COMB.		
<i>promethazine/dextromethorphan</i>	T1	
OPIOID ANTI-TUSSIV-IST GEN. ANTIHISTAMINE-DECONGEST		
<i>hydrocodone/cpm/pseudoephed</i>	T1	PA
<i>promethazine/phenyleph/codeine</i>	T1	PA QL (480ml/22 days)
OPIOID ANTI-TUSSIVE-IST GENERATION ANTIHISTAMINE		
<i>hydrocodone/chlorphen p-stirex</i>	T1	PA
<i>promethazine-codeine solution</i>	T1	PA QL (480ML/22 Days)
<i>promethazine-codeine syrup</i>	T1	PA QL (480ml/30 days)
TUXARIN ER	T3	PA QL (2 tabs/day)
TUZISTRA XR	T3	PA QL (960ml/30 days)
T1 – Typically Generics	PA – Prior Authorization	AGE – Age Requirement
T2 – Typically Preferred Brands	QL – Quantity Limit	SP – Specialty Medication
T3 – Typically Non-Preferred Brands	ST – Step Therapy	HD – May require home delivery pharmacy
		PPACA – No cost-share preventive medication
		CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

COUGH/COLD PREPARATIONS (Cough/Cold Medications) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
OPIOID ANTI-TUSSIVE-ANTI-CHOLINERGIC COMBINATIONS		
HYCODAN (<i>hydromet</i>)	T3	PA QL (480ml/22 days)
<i>hydrocodone bit/homatrop me-br</i> (Hycodan)	T1	PA QL (480ml/22 days)
<i>hydrocodone-homatropine 5-1.5</i>	T1	PA QL (180 tabs/30 days)
<i>hydrocodone-homatropine soln</i> (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)
DIAGNOSTIC (Diabetes)		
BLOOD SUGAR DIAGNOSTICS		
FREESTYLE INSULINX	T2	
FREESTYLE INSULINX TEST STRIPS	T2	
FREESTYLE LITE TEST STRIP	T2	
FREESTYLE PRECISION NEO	T2	
FREESTYLE TEST STRIPS	T2	
PRECISION XTRA TEST STRIPS	T2	
RELION TRUE METRIX TEST STRIP	T2	
TRUE METRIX GLUCOSE TEST STRIP	T2	
DIAGNOSTIC (Miscellaneous)		
DIAGNOSTIC PREPARATIONS, MISCELLANEOUS		
ADVANCED DNA MEDICATED COLLECT	T3	
ARIDOL	T3	
<i>lidocaine hcl/glycerin</i> (Advanced Dna Medicated Collect)	T1	
PROVOCHOLINE	T3	
TC99M SULFUR COLLOID PREP	T1	
EYE DIAGNOSTIC AGENTS		
<i>fluorescein sodium</i>	T1	
<i>ful-glo 1 mg opth strip</i>	T1	
FUL-GLO EYE STRIPS	T3	
<i>lissamine green</i>	T1	
GASTROINTESTINAL RADIOPAQUE DIAGNOSTICS		
ENTERO VU	T3	
E-Z DISK	T3	

T1 – Typically Generics

PA – Prior Authorization

AGE – Age Requirement

PPACA – No Cost-Share Preventive Medication

T2 – Typically Preferred Brands

QL – Quantity Limit

SP – Specialty Medication

CSL – Oral cancer medication subject to cost-share limits

T3 – Typically Non-Preferred Brands

ST – Step Therapy

HD – May require home delivery pharmacy

List of Prescription Medications

DIAGNOSTIC (Miscellaneous) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
GASTROINTESTINAL RADIOPAQUE DIAGNOSTICS (con't.)		
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	T3	
VARIBAR THIN	T3	
METABOLIC FUNCTION DIAGNOSTICS		
METOPIRONE	T2	
RADIOPHARMACEUTICALS ELEMENTS		
INDICLOR	T3	
URINARY TRACT RADIOPAQUE DIAGNOSTICS		
CYSTO-CONRAY II	T3	
CYSTOGRAFIN	T3	
CYSTOGRAFIN-DILUTE	T3	
diatrizoate meglumine, sodium (Gastrografin)	T1	
GASTROGRAFIN (md-gastroview)	T3	
DIURETICS (Diuretics)		
ARGININE VASOPRESSIN (AVP) RECEPTOR ANTAGONISTS		
TOLVAPTAN 15 MG TABLET	T3	SP
tolvaptan 30 mg tablet (Samsca)	T1	SP
CARBONIC ANHYDRASE INHIBITORS		
acetazolamide	T1	HD
methazolamide	T1	HD
LOOP DIURETICS		
bumetanide	T1	HD
furosemide	T1	HD
torseamide	T1	HD

T1 – Typically Generics

PA – Prior Authorization

AGE – Age Requirement

PPACA – No Cost-Share Preventive Medication

T2 – Typically Preferred Brands

QL – Quantity Limit

SP – Specialty Medication

CSL – Oral cancer medication subject to cost-share limits

T3 – Typically Non-Preferred Brands

ST – Step Therapy

HD – May require home delivery pharmacy

List of Prescription Medications

DIURETICS (Diuretics)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
POTASSIUM SPARING DIURETICS		
<i>amiloride hcl</i>	T1	HD
CAROSPIR (<i>spironolactone</i>)	T2	PA
<i>eplerenone</i> (Inspra)	T1	HD
INSPIRA (<i>eplerenone</i>)	T3	HD
KERENDIA	T2	PA QL (30 tabs/30 days)
<i>spironolactone</i> (Aldactone)	T1	HD
<i>triamterene</i> (Dyrenium)	T1	HD
POTASSIUM SPARING DIURETICS IN COMBINATION		
ALDACTAZIDE	T3	HD
ALDACTAZIDE (<i>spironolactone-hctz</i>)	T3	HD
<i>amiloride/hydrochlorothiazide</i>	T1	HD
DYAZIDE (<i>triamterene-hydrochlorothiazid</i>)	T3	HD
<i>spironolact/hydrochlorothiazid</i>	T1	HD
<i>triamterene/hydrochlorothiazid</i> (Dyazide)	T1	HD
THIAZIDE AND RELATED DIURETICS		
<i>chlorthalidone</i>	T1	HD
DIURIL	T2	HD
<i>hydrochlorothiazide</i>	T1	HD
<i>indapamide</i>	T1	HD
<i>metolazone</i>	T1	HD
EENT PREPS (Allergy/Nasal Sprays)		
NASAL ANTIHISTAMINE		
<i>azelastine 0.1% (137 mcg) spry</i>	T1	HD
<i>azelastine 0.15% nasal spray</i>	T1	HD
<i>olopatadine 665 mcg nasal spry</i> (Patanase)	T1	HD
PATANASE (<i>olopatadine hcl</i>)	T3	HD
NASAL ANTIHISTAMINE AND ANTI-INFLAM. STEROID COMB.		
<i>azelastine/fluticasone</i>	T1	HD
NASAL ANTI-INFLAMMATORY STEROIDS		
<i>flunisolide</i>	T1	HD
<i>fluticasone prop 50 mcg spray</i>	T1	HD
<i>mometasone furoate 50 mcg spry</i>	T1	QL (4 bots/30 days) HD

T1 – Typically Generics

PA – Prior Authorization

AGE – Age Requirement

PPACA – No Cost-Share Preventive Medication

T2 – Typically Preferred Brands

QL – Quantity Limit

SP – Specialty Medication

CSL – Oral cancer medication subject to cost-share limits

T3 – Typically Non-Preferred Brands

ST – Step Therapy

HD – May require home delivery pharmacy

List of Prescription Medications

EENT PREPS (Allergy/Nasal Sprays)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
NOSE PREPARATIONS, MISCELLANEOUS (RX)		
<i>ipratropium bromide</i>	T1	HD
NOSE PREPARATIONS, VASOCONSTRICTORS (RX)		
ADRENALIN CHLORIDE	T3	
<i>epinephrine hcl</i> (Adrenalin Chloride)	T1	
EENT PREPS (Ear Medications)		
EAR PREPARATIONS ANTI-INFLAMMATORY		
DERMOTIC (<i>fluocinolone acetonide oil</i>)	T3	
<i>fluocinolone acetonide oil</i> (Dermotic)	T1	
EAR PREPARATIONS, MISC. ANTI-INFECTIVES		
<i>acetic acid</i>	T1	
<i>hydrocortisone/acetic acid</i>	T1	
EENT PREPS (Eye Conditions)		
ARTIFICIAL TEARS		
LACRISERT	T2	
MIEBO	T2	QL(4 bottles/30 days)
EYE ANTI-INFECTIVES (RX ONLY)		
BETADINE	T2	
EYE ANTI-INFLAMMATORY AGENTS		
<i>bromfenac sodium</i>	T1	QL (8.3ML/14 DAYS)
BROMSITE (<i>bromfenac sodium</i>)	T2	
<i>dexamethasone sodium phosphate</i>	T1	
<i>diclofenac 0.1% eye drops</i>	T1	
EYSUVIS	T2	
FLAREX	T2	
<i>fluorometholone</i> (Fml)	T1	
<i>flurbiprofen sodium</i>	T1	
ILEVRO	T3	
<i>ketorolac 0.4% ophth solution</i> (Acular Ls)	T1	
<i>ketorolac 0.5% ophth solution</i> (Acular)	T1	
<i>loteprednol etabonate</i> (Lotemax)	T1	
OMNIPRED (<i>prednisolone acetate</i>)	T3	
<i>prednisolone acetate</i> (Pred Forte)	T1	
<i>prednisolone sodium phosphate</i>	T1	
PROLENSA	T3	

T1 – Typically Generics

PA – Prior Authorization

AGE – Age Requirement

PPACA – No Cost-Share Preventive Medication

T2 – Typically Preferred Brands

QL – Quantity Limit

SP – Specialty Medication

CSL – Oral cancer medication subject to cost-share limits

T3 – Typically Non-Preferred Brands

ST – Step Therapy

HD – May require home delivery pharmacy

List of Prescription Medications

EENT PREPS (Eye Conditions)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
EYE LOCAL ANESTHETICS		
AKTEN	T3	
ALCAINE (<i>proparacaine hcl</i>)	T3	
ALTAFLUOR BENOX (<i>fluox</i>)	T3	
<i>benoxinate hcl/fluorescein sod</i> (Altafluor Benox)	T1	
<i>proparacaine hcl</i> (Alcaine)	T1	
<i>proparacaine/fluorescein sod</i>	T1	
<i>tetracaine hcl</i>	T1	
TETRAVISC	T2	
TETRAVISC FORTE	T2	
EYE MAST CELL STABILIZERS		
<i>cromolyn 4% eye drops</i>	T1	
EYE PREPARATIONS, MISCELLANEOUS (OTC)		
GELFILM	T3	
EYE VASOCONSTRICTORS		
<i>phenylephrine hcl</i>	T1	
MIOTICS AND OTHER INTRAOCULAR PRESSURE REDUCERS		
<i>apraclonidine hcl</i> (Iopidine)	T1	HD
<i>betaxolol hcl</i>	T1	HD
BETOPTIC S	T3	HD
<i>bimatoprost</i>	T1	QL (10 gm/30 days) HD
<i>brimonidine tartrate</i>	T1	HD
<i>brimonidine tartrate</i> (Alphagan P)	T1	HD
<i>brinzolamide</i> (Azopt)	T1	HD
<i>carteolol hcl</i>	T1	HD
<i>dorzolamide hcl</i> (Trusopt)	T1	HD
<i>dorzolamide hcl/timolol maleat</i> (Cosopt)	T1	HD
<i>dorzolamide/timolol/pf</i> (Cosopt Pf)	T1	HD
IOPIDINE 0.5% EYE DROPS (<i>apraclonidine hcl</i>)	T3	HD
ISOPTO CARPINE (<i>pilocarpine hcl</i>)	T3	HD
<i>latanoprost</i>	T1	HD
<i>levobunolol hcl</i>	T1	HD
PHOSPHOLINE IODIDE	T2	HD
<i>pilocarpine hcl</i> (Isopto Carpine)	T1	HD
RHOPRESSA	T3	

T1 – Typically Generics

PA – Prior Authorization

AGE – Age Requirement

PPACA – No Cost-Share Preventive Medication

T2 – Typically Preferred Brands

QL – Quantity Limit

SP – Specialty Medication

CSL – Oral cancer medication subject to cost-share limits

T3 – Typically Non-Preferred Brands

ST – Step Therapy

HD – May require home delivery pharmacy

List of Prescription Medications

EENT PREPS (Eye Conditions) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
MIOTICS AND OTHER INTRAOCULAR PRESSURE REDUCERS (con't.)		
ROCKLATAN	T3	
SIMBRINZA	T3	HD
<i>timolol maleate</i>	T1	HD
<i>timolol maleate</i> (Timoptic)	T1	HD
<i>timolol maleate</i> (Timoptic-xe)	T1	HD
<i>timolol maleate/pf</i> (Timoptic Ocudose)	T1	HD
<i>travoprost</i>	T1	HD
TRUSOPT (<i>dorzolamide hcl</i>)		
MYDRIATICS		
<i>atropine sulfate</i>	T1	HD
<i>atropine sulfate</i> (Isopto Atropine)	T1	HD
CYCLOGYL 0.5% EYE DROPS (<i>cyclopentolate hcl</i>)	T2	HD
CYCLOGYL 1% EYE DROPS (<i>cyclopentolate hcl</i>)	T3	HD
CYCLOGYL 2% EYE DROPS (<i>cyclopentolate hcl</i>)	T3	HD
CYCLOMYDRIL	T2	HD
<i>cyclopentolate hcl</i> (Cyclogyl)	T1	HD
<i>homatropine hbr</i>	T1	HD
MYDRIACYL (<i>tropicamide</i>)	T3	HD
PAREMYD	T3	HD
<i>tropicamide</i>	T1	HD
<i>tropicamide</i> (Mydracyl)	T1	HD
OPHTHALMIC ANTI-FIBROTIC AGENTS		
MITOSOL	T3	
OPHTHALMIC ANTI-INFLAMMATORY IMMUNOMODULATOR-TYPE		
CEQUA	T2	
RESTASIS	T2	HD
RESTASIS MULTIDOSE	T2	HD
VEVYE	T3	QL HD
XIIDRA	T2	HD
OPHTHALMIC CYSTINE DEPLETING AGENTS		
CYSTADROPS	T3	PA QL (20ML/21 DAYS) SP
CYSTARAN	T3	PA QL (120ml/28 days) SP
OPHTHALMIC HUMAN NERVE GROWTH FACTOR (HNGF)		
OXERVATE	T3	PA SP HD

T1 – Typically Generics

PA – Prior Authorization

AGE – Age Requirement

PPACA – No Cost-Share Preventive Medication

T2 – Typically Preferred Brands

QL – Quantity Limit

SP – Specialty Medication

CSL – Oral cancer medication subject to cost-share limits

T3 – Typically Non-Preferred Brands

ST – Step Therapy

HD – May require home delivery pharmacy

List of Prescription Medications

ELECT/CALORIC/H2O (Cholesterol Medications)			
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits	
ORAL LIPID SUPPLEMENTS			
DOJOLVI	T3	PA SP HD	
ELECT/CALORIC/H2O (Dental Products)			
FLUORIDE PREPARATIONS			
FRAICHE 5000 PREVI	T3		
CLINPRO 5000	T3		
fluoride (sodium) (Prevident 5000 Ortho Defense)	T1		
fluoride (sodium) (Prevident 5000 Plus)	T1		
fluoride (sodium) (Prevident)	T1		
FLUORIDEX	T1		
FLUORIDEX SENSITIVITY RELIEF	T3		
PREVIDENT 0.2% RINSE	T2		
PREVIDENT 1.1% GEL (sodium fluoride)	T3		
PREVIDENT 5000	T3		
PREVIDENT 5000 BOOSTER PLUS	T3		
PREVIDENT 5000 ENAMEL PROTECT	T3		
PREVIDENT 5000 ORTHO DEFENSE	T3		
PREVIDENT 5000 SENSITIVE	T3		
PREVIDENT DENTAL RINSE	T2		
PREVIDENT KIDS	T3		
sodium fluoride/potassium nit (Prevident 5000 Sensitive)	T1		
ELECT/CALORIC/H2O (Diabetes)			
AGENTS TO TREAT HYPOGLYCEMIA (HYPERGLYCEMICS)			
BAQSIMI	T2	QL (2/30 days)	
diazoxide (Proglycem)	T1		
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		
ELECT/CALORIC/H2O (Miscellaneous)			
NUCLEIC ACID/NUCLEOTIDE SUPPLEMENTS			
XURIDEN	T3	PA SP	

T1 – Typically Generics

PA – Prior Authorization

AGE – Age Requirement

PPACA – No Cost-Share Preventive Medication

T2 – Typically Preferred Brands

QL – Quantity Limit

SP – Specialty Medication

CSL – Oral cancer medication subject to cost-share limits

T3 – Typically Non-Preferred Brands

ST – Step Therapy

HD – May require home delivery pharmacy

List of Prescription Medications

ELECT/CALORIC/H2O (Nutritional/Dietary)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ELECTROLYTE DEPLETERS		
AURYXIA	T3	QL (12 tabs/day)
calcium acetate	T1	
lanthanum carbonate (Fosrenol)	T1	
LOKELMA	T2	QL (12 tabs/day)
AURYXIA	T3	
calcium acetate	T1	
lanthanum carbonate (Fosrenol)	T1	
LOKELMA	T2	
PHOSLYRA	T3	
sevelamer carbonate (Renvela)	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	
IODINE CONTAINING AGENTS		
potassium iodide/iodine	T1	
SSKI	T1	
IRON REPLACEMENT		
CITRANATAL BLOOM	T3	
mv-mins no.73/iron fum/folic (Hemocyte Plus)	T1	
POTASSIUM REPLACEMENT		
EFFER-K 10 MEQ TABLET EFF	T3	
EFFER-K 20 MEQ TABLET EFF	T3	
effe-r-k 25 meq tablet eff	T1	
klor-con (K-tab Er)	T1	
klor-con 8 meq tablet	T1	
K-TAB ER (potassium chloride)	T3	
potassium bicarbonate/cit ac	T1	
POTASSIUM CL ER	T3	
potassium chloride (K-tab Er)	T1	
PROTEIN REPLACEMENT		
AQNEURSA	T3	PA SP

T1 – Typically Generics

PA – Prior Authorization

AGE – Age Requirement

PPACA – No Cost-Share Preventive Medication

T2 – Typically Preferred Brands

QL – Quantity Limit

SP – Specialty Medication

CSL – Oral cancer medication subject to cost-share limits

T3 – Typically Non-Preferred Brands

ST – Step Therapy

HD – May require home delivery pharmacy

List of Prescription Medications

ELECT/CALORIC/H2O (Urinary Tract Conditions)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
DIALYSIS SOLUTIONS		
PRISMASOL	T3	
URINARY PH MODIFIERS		
K-PHOS NO.2	T2	HD
K-PHOS ORIGINAL	T2	HD
ORACIT	T3	HD
<i>potassium citrate</i> (Urocit-k)	T1	HD
<i>potassium citrate/citric acid</i>	T1	HD
RENACIDIN	T3	HD
UROCIT-K (<i>potassium citrate er</i>)	T3	HD
UROQID-ACID NO.2	T2	HD
GASTROINTESTINAL (Cholesterol Medications)		
LIPOTROPICS		
<i>icosapent ethyl</i> (Vascepa)	T1	HD
<i>omega-3 acid ethyl esters</i> (Lovaza)	T1	HD
VASCEPA	T2	PA HD
GASTROINTESTINAL (Gastrointestinal/Heartburn)		
AMMONIA INHIBITORS		
<i>lactulose</i>	T1	HD
<i>lactulose 10 gm/15 ml solution</i>	T1	HD
LITHOSTAT	T2	HD
OLPRUVA	T3	PA SP HD
RAVICTI	T3	PA SP HD
<i>sodium phenylbutyrate</i> (Buphenyl)	T1	SP HD
ANTI-CHOLINERGICS, QUATERNARY AMMONIUM		
<i>chlordiazepoxide/clidinium br</i>	T1	
CUVPOSA	T3	
GLYCAT	T3	
<i>glycopyrrolate</i> (Glycate)	T1	
<i>glycopyrrolate</i> (Robinul Forte)	T1	
<i>glycopyrrolate</i> (Robinul)	T1	
<i>propantheline bromide</i>	T1	

T1 – Typically Generics

PA – Prior Authorization

AGE – Age Requirement

PPACA – No Cost-Share Preventive Medication

T2 – Typically Preferred Brands

QL – Quantity Limit

SP – Specialty Medication

CSL – Oral cancer medication subject to cost-share limits

T3 – Typically Non-Preferred Brands

ST – Step Therapy

HD – May require home delivery pharmacy

List of Prescription Medications

GASTROINTESTINAL (Gastrointestinal/Heartburn) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ANTI-CHOLINERGICS, QUATERNARY AMMONIUM (cont.)		
ROBINUL (<i>glycopyrrolate</i>)	T3	
ROBINUL FORTE (<i>glycopyrrolate</i>)	T3	
ANTI-CHOLINERGICS/ANTI-SPASMODICS		
<i>dicyclomine hcl</i>	T1	
ANTI-DIARRHEAL - G.I. CHLORIDE CHANNEL INHIBITORS		
MYTESI	T3	
ANTI-DIARRHEAL - TRYPTOPHAN HYDROXYLASE INHIBITOR		
XERMELO	T3	PA SP
ANTI-DIARRHEALS		
<i>diphenoxylate hcl/atropine</i>	T1	
<i>diphenoxylate hcl/atropine</i> (Lomotil)	T1	
<i>loperamide hcl</i>	T1	
MOTOFEN	T3	
<i>opium tincture</i>	T1	PA
<i>paregoric</i>	T1	
ANTI-EMETIC, CANNABINOID-TYPE		
<i>dronabinol</i>	T1	
ANTI-EMETIC/ANTI-VERTIGO AGENTS		
AKYNZEO	T3	PA QL (4 caps/28 days)
ANZEMET	T3	PA QL (5 tabs/30 days) SP
<i>aprepitant 125 mg capsule</i>	T1	QL (4 caps/28 days)
<i>aprepitant 125-80-80 mg pack</i> (Emend)	T1	QL (12 caps/28 days)
<i>aprepitant 40 mg capsule</i>	T1	QL (1 cap/28 days)
<i>aprepitant 80 mg capsule</i> (Emend)	T1	QL (8 caps/28 days)
BONJESTA	T3	
COMPAZINE (<i>prochlorperazine maleate</i>)	T3	
COMPAZINE (<i>prochlorperazine</i>)	T3	
<i>doxylamine succinate/vit b6</i> (Diclegis)	T1	QL(4 tabs/day)
EMEND 125 MG POWDER PACKET	T3	PA QL (12 caps/28 days)
EMEND 150 MG VIAL (<i>fosaprepitant dimeglumine</i>)	T3	

T1 – Typically Generics

PA – Prior Authorization

AGE – Age Requirement

PPACA – No Cost-Share Preventive Medication

T2 – Typically Preferred Brands

QL – Quantity Limit

SP – Specialty Medication

CSL – Oral cancer medication subject to cost-share limits

T3 – Typically Non-Preferred Brands

ST – Step Therapy

HD – May require home delivery pharmacy

List of Prescription Medications

GASTROINTESTINAL (Gastrointestinal/Heartburn) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ANTI-EMETIC/ANTI-VERTIGO AGENTS (cont.)		
fosaprepitant dimeglumine (Emend)	T1	PA QL (4 patches/30 days)
granisetron hcl	T1	
granisetron hcl/pf	T1	
ondansetron	T1	
ondansetron hcl/pf	T1	
prochlorperazine (Compazine)	T1	
prochlorperazine maleate (Compazine)	T1	
promethazine hcl	T1	
promethazine hcl	T3	
SANCUSO	T3	
scopolamine (Transderm-scop)	T1	PA QL (4 tabs/28 days)
TRANSDERM-SCOP (scopolamine)	T3	
trimethobenzamide hcl	T1	
VARUBI	T3	
ANTI-ULCER PREPARATIONS		
CYTOTEC (misoprostol)	T3	HD
misoprostol (Cytotec)	T1	HD
sucralfate (Carafate)	T1	HD
ANTI-ULCER-H.PYLORI AGENTS		
bismuth/metronid/tetracycline (Pylera)	T1	
lansoprazole/amoxiciln/clarith	T1	
BELLADONNA ALKALOIDS		
DONNATAL	T3	HD
DONNATAL (phenohytro)	T3	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

T1 – Typically Generics

PA – Prior Authorization

AGE – Age Requirement

PPACA – No Cost-Share Preventive Medication

T2 – Typically Preferred Brands

QL – Quantity Limit

SP – Specialty Medication

CSL – Oral cancer medication subject to cost-share limits

T3 – Typically Non-Preferred Brands

ST – Step Therapy

HD – May require home delivery pharmacy

List of Prescription Medications

GASTROINTESTINAL (Gastrointestinal/Heartburn) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
BELLADONNA ALKALOIDS (cont.)		
LEVSIN (<i>oscimin</i>)	T3	HD
<i>methscopolamine bromide</i>	T1	HD
NULEV (<i>symax</i>)	T1	HD
<i>phenobarb/hyoscy/atropine/scop</i> (Donnatal)	T1	HD
<i>phenobarb/hyoscy/atropine/scop</i> (Phenobarbital-belladonna)	T1	HD
<i>phenobarbital-belladonna elixr</i> (Donnatal)	T1	HD
<i>phenobarbital-belladonna elixr</i> (Phenobarbital-belladonna)	T1	HD
PHENOBARBITAL-BELLADONNA ELIXR (<i>phenohygro</i>)	T3	HD
SYMAX DUOTAB	T2	HD
BILE SALTS		
ACTIGALL (<i>ursodiol</i>)	T3	HD
CHENODAL	T3	SP HD
CHOLBAM	T3	PA SP HD
CTEXLI	T3	PA SP
URSO FORTE (<i>ursodiol</i>)	T3	HD
<i>ursodiol</i> (Actigall)	T1	HD
<i>ursodiol</i> (Urso Forte)	T1	HD
<i>ursodiol</i>	T1	HD
CHRONIC INFLAM. COLON DX, 5-A-SALICYLAT, RECTAL TX		
<i>mesalamine 1,000 mg supp</i> (Canasa)	T1	
<i>mesalamine 4 gm/60 ml enema</i> (Sfrowasa)	T1	
<i>mesalamine 4 gm/60 ml kit</i>	T1	
SFROWASA (<i>mesalamine</i>)	T3	
DRUG TX-CHRONIC INFLAM. COLON DX, 5-AMINOSALICYLAT		
APRISO (<i>mesalamine er</i>)	T3	HD
AZULFIDINE (<i>sulfasalazine dr</i>)	T3	HD
<i>balsalazide disodium</i>	T1	HD
<i>mesalamine</i>	T1	HD
<i>mesalamine</i> (Apriso)	T1	HD
<i>mesalamine 800 mg dr tablet</i>	T1	HD
<i>mesalamine dr 1.2 gm tablet</i> (Lialda)	T1	HD

T1 – Typically Generics

PA – Prior Authorization

AGE – Age Requirement

PPACA – No Cost-Share Preventive Medication

T2 – Typically Preferred Brands

QL – Quantity Limit

SP – Specialty Medication

CSL – Oral cancer medication subject to cost-share limits

T3 – Typically Non-Preferred Brands

ST – Step Therapy

HD – May require home delivery pharmacy

List of Prescription Medications

GASTROINTESTINAL (Gastrointestinal/Heartburn) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
DRUG TX-CHRONIC INFLAM. COLON DX, 5-AMINOSALICYLAT (cont.)		
PENTASA 500 MG CAPSULE (<i>mesalamine</i>)	T3	HD
<i>sulfasalazine</i> (Azulfidine)	T1	HD
FARNESOID X RECEPTOR (FXR) AGONIST, BILE AC ANALOG		
OCALIVA	T3	PA SP HD
FECAL MICROBIOTA TRANSPLANTATION (FMT)		
VOWST	T3	PA QL(12 caps/56 days) SP
GASTRIC ENZYMES		
SUCRAID	T3	PA SP
HISTAMINE H2-RECEPTOR INHIBITORS		
<i>cimetidine</i>	T1	HD
<i>cimetidine hcl</i>	T1	HD
<i>famotidine</i>	T1	HD
<i>nizatidine</i>	T1	HD
<i>ranitidine hcl</i>	T1	HD
IBS AGENTS, MIXED OPIOID RECEPTOR AGONISTS/ANTAGONISTS		
VIBERZI	T2	HD
IBS-C/CIC AGENTS, GUANYLATE CYCLASE-C AGONIST		
LINZESS	T2	
TRULANCE	T2	
INTESTINAL MOTILITY STIMULANTS		
<i>metoclopramide hcl</i>	T1	
<i>metoclopramide hcl</i> (Reglan)	T1	
REGLAN (<i>metoclopramide hcl</i>)	T3	
IRRITABLE BOWEL SYNDROME AGENTS, 5-HT₃ ANTAGONIST		
<i>alosetron hcl</i>	T1	SP HD
LAXATIVES AND CATHARTICS		
<i>bisac/nalcl/naHCO₃/kcl/peg 3350</i>	T1	PPACA
<i>lactulose</i>	T1	
<i>lactulose 10 gm/15 ml solution</i>	T1	
<i>lactulose 20 gm/30 ml solution</i>	T1	
<i>lubiprostone</i> (Amitiza)	T1	
NULYTELY	T3	PPACA
<i>peg3350/sod sul/nacl/kcl/asb/c</i>	T1	PPACA

T1 – Typically Generics

PA – Prior Authorization

AGE – Age Requirement

PPACA – No Cost-Share Preventive Medication

T2 – Typically Preferred Brands

QL – Quantity Limit

SP – Specialty Medication

CSL – Oral cancer medication subject to cost-share limits

T3 – Typically Non-Preferred Brands

ST – Step Therapy

HD – May require home delivery pharmacy

List of Prescription Medications

GASTROINTESTINAL (Gastrointestinal/Heartburn) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
LAXATIVES AND CATHARTICS (cont.)		
<i>peg3350/sod sulf, bicarb, cl/kcl</i>	T1	PPACA
PREPOIK	T2	PPACA
<i>sodium chloride/nahco3/kcl/peg</i>	T1	PPACA
LOCAL ANORECTAL NITRATE PREPARATIONS		
<i>nitroglycerin 0.4% ointment (Rectiv)</i>	T1	
RECTIV (<i>nitroglycerin</i>)	T3	
PANCREATIC ENZYMES		
PANCREAZE	T2	HD
VIOKACE	T3	HD
ZENPEP	T2	HD
POTASSIUM-COMPETITIVE ACID BLOCKERS (PCABS)		
VOQUEZNA	T3	PA QL(1 tab/day)
PROTON-PUMP INHIBITORS		
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
<i>dexlansoprazole dr 30 mg cap (Dexilant)</i>	T1	QL(2 caps/day) HD
<i>dexlansoprazole dr 60 mg cap (Dexilant)</i>	T1	QL(1 caps/day) HD
<i>esomeprazole dr 10 mg packet</i>	T1	QL (4 packets/day) HD
<i>esomeprazole dr 20 mg packet</i>	T1	QL (2 packs/day) HD
<i>esomeprazole dr 40 mg packet</i>	T1	QL (1 packet/day) HD
<i>esomeprazole mag dr 20 mg cap</i>	T1	QL (20ml/day) HD
<i>esomeprazole mag dr 40 mg cap</i>	T1	QL (1 cap/day) HD
ESOMEPRAZOLE STRONTIUM	T3	QL (1 cap/day) HD
<i>lansoprazole dr 15 mg capsule (Prevacid)</i>	T1	QL (2 caps/day) HD
<i>lansoprazole dr 30 mg capsule (Prevacid)</i>	T1	QL (30 caps/30 days) HD
<i>lansoprazole odt 15 mg tablet</i>	T1	QL (2 tabs/day) HD
<i>lansoprazole odt 30 mg tablet</i>	T1	QL (30 tabs/30 days) HD
NEXIUM DR 2.5 MG PACKET	T2	QL (480 packs/30 days) HD
NEXIUM DR 5 MG PACKET	T2	QL (240 packs/30 days) HD
<i>omeprazole dr 10 mg capsule</i>	T1	QL (120 caps/30 days) HD
<i>omeprazole dr 20 mg capsule</i>	T1	HD
<i>omeprazole dr 40 mg capsule</i>	T1	QL (1 cap/day) HD
<i>pantoprazole 40 mg suspension (Protonix)</i>	T1	QL (1 dose/day) HD

T1 – Typically Generics

PA – Prior Authorization

AGE – Age Requirement

PPACA – No Cost-Share Preventive Medication

T2 – Typically Preferred Brands

QL – Quantity Limit

SP – Specialty Medication

CSL – Oral cancer medication subject to cost-share limits

T3 – Typically Non-Preferred Brands

ST – Step Therapy

HD – May require home delivery pharmacy

List of Prescription Medications

GASTROINTESTINAL (Gastrointestinal/Heartburn) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
PROTON-PUMP INHIBITORS (cont.)		
<i>pantoprazole sod dr 20 mg tab</i> (Protonix)	T1	QL (2 tabs/day) HD
<i>pantoprazole sod dr 40 mg tab</i> (Protonix)	T1	QL (1 tab/day) HD
PREVACID DR 15 MG CAPSULE (<i>lansoprazole</i>)	T3	QL (60 caps/30 days) ST
PREVACID DR 30 MG CAPSULE (<i>lansoprazole</i>)	T3	QL (30 caps/30 days) ST
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 (<i>pantoprazole sodium</i>)	T3	QL (30 packs/30 days) ST
PROTONIX DR 20 MG TABLET (<i>pantoprazole sodium</i>)	T3	QL (60 tabs/30 days) ST
PROTONIX DR 40 MG TABLET (<i>pantoprazole sodium</i>)	T3	QL (30 tabs/30 days) ST
<i>rabeprazole sodium</i> (Aciphex)	T1	QL (30 tabs/30 days) HD
RECTAL PREPARATIONS		
<i>hydrocortisone ac 25 mg supp</i>	T1	
SBS - GLUCAGON-LIKE PEPTIDE-2 (GLP-2) ANALOGS		
GATTEX	T3	PA SP HD
GASTROINTESTINAL (Pain Relief And Inflammatory Disease)		
HEMORRHOID PREP, ANTI-INFLAM STEROID-LOCAL ANESTHET		
ANA-LEX	T1	
<i>hydrocortisone/lidocaine/aloe</i>	T1	
<i>hydrocortisone/pramoxine</i> (Analpram Hc)	T1	
<i>lidocaine/hydrocortisone ac</i>	T1	
LIDOCAINE-HYDROCORTISONE	T1	
PROCORT	T3	
PROCTOFOAM-HC	T2	
RECTAL/LOWER BOWEL PREP., GLUCOCORT. (NON-HEMORR)		
<i>budesonide 2 mg rectal foam</i>	T1	QL(2 KITS/180 DAYS)
CORTENEMA (<i>hydrocortisone</i>)	T3	
<i>hydrocortisone</i> (Cortenema)	T1	
HORMONES (Hormonal Agents)		
ANDROGEN/ESTROGEN PREPS FOR FEMALE SEXUAL DYSFUNC		
INTRAROSA	T3	
ANDROGENIC AGENTS		
ANADROL-50	T2	PA

T1 – Typically Generics

PA – Prior Authorization

AGE – Age Requirement

PPACA – No Cost-Share Preventive Medication

T2 – Typically Preferred Brands

QL – Quantity Limit

SP – Specialty Medication

CSL – Oral cancer medication subject to cost-share limits

T3 – Typically Non-Preferred Brands

ST – Step Therapy

HD – May require home delivery pharmacy

List of Prescription Medications

HORMONES (Hormonal Agents) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ANDROGENIC AGENTS (cont.)		
ANDROGEL 1% (50 MG/5 G) PKT (<i>testosterone</i>)	T3	PA QL (2 packs/day)
ANDROGEL 1.62% GEL PUMP (<i>testosterone</i>)	T3	PA QL (150gm/30 days)
ANDROGEL 1.62%(1.25G) GEL PCKT (<i>testosterone</i>)	T3	PA QL (2 packs/day)
ANDROGEL 1.62%(2.5G) GEL PCKT (<i>testosterone</i>)	T3	PA QL (150gm/30 days)
DEPO-TESTOSTERONE	T3	
DEPO-TESTOSTERONE (<i>testosterone cypionate</i>)	T3	
METHITEST	T1	
<i>methyltestosterone</i>	T1	
<i>oxandrolone</i>	T1	PA
<i>testosterone 1% (25mg/2.5g) pk</i> (Androgel)	T1	PA QL (150gm/30 days)
<i>testosterone 1% (50 mg/5 g) pk</i> (Testosterone)	T1	PA QL (2 packs/day)
<i>testosterone 1.62% (2.5 g) pkt</i> (Androgel)	T1	PA QL (150gm/30 days)
<i>testosterone 1.62% gel pump</i> (Androgel)	T1	PA QL (150gm/30 days)
<i>testosterone 1.62%(1.25 g) pkt</i> (Androgel)	T1	PA QL (2 packs/day)
<i>testosterone 10 mg gel pump</i>	T1	PA QL (120 gm/30 days)
TESTOSTERONE 12.5 MG/1.25 GRAM	T1	PA QL (150gm/30 days)
<i>testosterone 12.5 mg/1.25 gram</i> (Testosterone)	T1	PA QL (150gm/30 days)
<i>testosterone 30 mg/1.5 ml pump</i>	T1	PA QL (180ml/30 days)
<i>testosterone 50 mg/5 gram gel</i>	T1	PA QL (2 tubes/day)
TESTOSTERONE 50 MG/5 GRAM PKT	T1	PA QL (2 packs/day)
XYOSTED	T3	PA QL(2 ML/28 DAYS)
ANTI-DIURETIC AND VASOPRESSOR HORMONES		
<i>desmopressin</i> (nonrefrigerated)	T1	
<i>desmopressin acetate</i>	T1	
NOCTIVA	T3	PA
STIMATE	T2	SP
ESTROGEN AND PROGESTIN COMBINATIONS		
BIJUVA	T3	
ESTROGEN/ANDROGEN COMBINATIONS		
<i>estrogen, ester/me-testosterone</i> (Estratest F.S.)	T1	HD
ESTROGENIC AGENTS		
ACTIVELLA (<i>mimvey lo</i>)	T3	HD

T1 – Typically Generics

PA – Prior Authorization

AGE – Age Requirement

PPACA – No Cost-Share Preventive Medication

T2 – Typically Preferred Brands

QL – Quantity Limit

SP – Specialty Medication

CSL – Oral cancer medication subject to cost-share limits

T3 – Typically Non-Preferred Brands

ST – Step Therapy

HD – May require home delivery pharmacy

List of Prescription Medications

HORMONES (Hormonal Agents) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ESTROGENIC AGENTS (cont.)		
ACTIVELLA (<i>mimvey</i>)	T3	HD
ALORA	T3	QL (16 patches/28 days) HD
CLIMARA (<i>estradiol (once weekly)</i>)	T3	HD
CLIMARA PRO	T3	HD
COMBIPATCH	T3	
DEPO-ESTRADIOL	T3	HD
DIVIGEL	T2	HD
ELESTRIN	T3	HD
ESTRACE (<i>estradiol</i>)	T3	HD
<i>estradiol</i> (Climara)	T1	HD
<i>estradiol 0.06% 1.25g gel pump</i> (Estrogel)	T1	HD
<i>estradiol 0.5 mg tablet</i> (Estrace)	T1	HD
<i>estradiol 1 mg tablet</i> (Estrace)	T1	HD
<i>estradiol 2 mg tablet</i> (Estrace)	T1	HD
<i>estradiol valerate</i>	T1	HD
<i>estradiol/norethindrone acet</i> (Activella)	T1	HD
EVAMIST	T3	HD
FEMHRT (<i>norethindron-ethinyl estradiol</i>)	T3	HD
MENEST	T3	HD
MENOSTAR	T3	QL (8 patches/28 days) HD
MINIVELLE (<i>lyllana</i>)	T3	QL (16 patches/28 days) HD
<i>norethind-eth estrad 0.5-2.5</i> (Femhrt)	T1	HD
<i>norethindrone ac-eth estradiol</i>	T1	HD
<i>norethindrone ac/eth estradiol</i> (Femhrt)	T1	HD
<i>norethin-eth estrad 1 mg-5 mcg</i>	T1	HD
PREMARIN	T2	HD
PREMPHASE	T2	HD
PREMPRO	T2	HD
VIVELLE-DOT (<i>lyllana</i>)	T3	QL (16 patches/28 days) HD

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

PA – Prior Authorization

QL – Quantity Limit

ST – Step Therapy

AGE – Age Requirement

SP – Specialty Medication

HD – May require home delivery pharmacy

PPACA – No Cost-Share Preventive Medication

CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

HORMONES (Hormonal Agents) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ESTROGEN-PROGESTIN WITH ANTI-MINERALOCORTICOID COMB		
ANGELIQ	T3	HD
ESTROGEN-SELECTIVE ESTROGEN RECEPTOR MOD (SERM) COMB		
DUAVEE	T2	
GLUCOCORTICOIDS		
budesonide	T1	PA QL (56 tabs/180 days)
budesonide (Entocort Ec)	T1	
cortisone acetate	T1	
deflazacort	T1	PA SP HD
deflazacort (Emflaza)	T1	PA SP HD
dexamethasone	T1	
ENTOCORT EC (budesonide ec)	T3	
hydrocortisone (Cortef)	T1	
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	
methylprednisolone (Medrol)	T1	
MILLIPRED 10 MG/5 ML SOLUTION (prednisolone sodium phosphate)	T3	
millipred 5 mg tablet	T1	
ORAPRED ODT (prednisolone sodium phos odt)	T3	
prednisolone	T1	
prednisolone sodium phosphate (Millipred)	T1	
prednisolone sodium phosphate (Orapred Odt)	T1	
prednisone	T1	
UCERIS 9 MG ER TABLET (budesonide)	T3	PA QL(1 tab/day)
GROWTH HORMONE RELEASING HORMONE (GHRH) AND ANALOGS		
EGRIFTA	T3	PA SP HD
EGRIFTA SV	T3	PA SP HD
GROWTH HORMONES		
GENOTROPIN	T3	PA SP HD
NGENLA	T2	PA SP
NORDITROPIN FLEXPRO	T3	PA SP HD

T1 – Typically Generics

PA – Prior Authorization

AGE – Age Requirement

PPACA – No Cost-Share Preventive Medication

T2 – Typically Preferred Brands

QL – Quantity Limit

SP – Specialty Medication

CSL – Oral cancer medication subject to cost-share limits

T3 – Typically Non-Preferred Brands

ST – Step Therapy

HD – May require home delivery pharmacy

List of Prescription Medications

HORMONES (Hormonal Agents) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
GROWTH HORMONES (cont.)		
OMNITROPE	T2	PA SP HD
SEROSTIM	T3	PA SP
SOGROYA	T3	PA SP
INSULIN-LIKE GROWTH FACTOR-I (IGF-I) HORMONES		
INCRELEX	T3	PA SP HD
LHRH (GNRH) AGONIST ANALOG AND PROGESTIN COMB		
LUPANETA PACK	T3	PA SP HD
LHRH (GNRH) AGONIST ANALOG PITUITARY SUPPRESSANTS		
LUPRON DEPOT	T2	PA SP HD
LUPRON DEPOT-PED	T3	PA SP HD
LHRH (GNRH) ANTAGONIST, ESTROGEN AND PROGESTIN COMB		
MYFEMBREE	T2	PA QL (24 month therapy)
ORIAHNN	T2	PA QL (2 capsules/day)
LHRH (GNRH) ANTAGONIST, PITUITARY SUPPRESSANT AGENTS		
CETROTIDE	T2	PA SP
<i>ganirelix acet 250 mcg/0.5 ml (Ganirelix Acetate)</i>	T1	PA SP
GANIRELIX ACET 250 MCG/0.5 ML (<i>ganirelix acetate</i>)	T2	PA SP
ORILISSA 150 MG TABLET	T2	PA QL (1 tab/day)
ORILISSA 200 MG TABLET	T2	PA QL (6 months therapy/lifetime)
LHRH (GNRH) AGNST PIT.SUP-CENTRAL PRECOCIOUS PUBERTY		
FENSOLVI	T3	PA SP
LUPRON DEPOT-PED	T2	PA SP HD
MINERALOCORTICOIDS		
<i>fludrocortisone acetate</i>	T1	HD
OXYTOCICS		
CERVIDIL	T3	
<i>methylergonovine maleate</i>	T1	
PREPIDIL	T3	
PROSTIN E2 VAGINAL SUPPOSITORY	T3	
PITUITARY SUPPRESSIVE AGENTS		
<i>cabergoline</i>	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
<i>danazol</i>	T1	HD

T1 – Typically Generics

PA – Prior Authorization

AGE – Age Requirement

PPACA – No Cost-Share Preventive Medication

T2 – Typically Preferred Brands

QL – Quantity Limit

SP – Specialty Medication

CSL – Oral cancer medication subject to cost-share limits

T3 – Typically Non-Preferred Brands

ST – Step Therapy

HD – May require home delivery pharmacy

List of Prescription Medications

HORMONES (Hormonal Agents) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
PROGESTATIONAL AGENTS		
AYGESTIN (<i>norethindrone acetate</i>)	T3	HD
CRINONE 4% GEL	T3	PA HD
DEPO-PROVERA 400 MG/ML VIAL	T3	HD
<i>medroxyprogesterone 10 mg tab</i> (Provera)	T1	HD
<i>medroxyprogesterone 2.5 mg tab</i> (Provera)	T1	HD
<i>medroxyprogesterone 5 mg tab</i> (Provera)	T1	HD
<i>norethindrone acetate</i>	T1	HD
<i>progesterone, micronized</i> (Prometrium)	T1	HD
SOMATOSTATIC AGENTS		
BYNFEZIA	T3	PA SP
SANDOSTATIN (<i>octreotide acetate</i>)	T3	PA SP HD
SANDOSTATIN LAR DEPOT	T2	PA SP
SIGNIFOR	T3	PA SP
SIGNIFOR LAR	T3	PA SP
SOMATULINE DEPOT	T2	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 (<i>estradiol</i>)	T3	HD
<i>estradiol</i> (Vagifem)	T1	QL (36 tabs/28 days) HD
<i>estradiol 0.01% cream</i> (Estrace)	T1	HD
<i>estradiol 10 mcg vaginal insrt</i> (Vagifem)	T1	QL (36 tabs/28 days)
FEMRING	T3	HD
PREMARIN	T2	HD
VAGIFEM (<i>yuvaferm</i>)	T3	QL (36 tabs/28 days) HD

T1 – Typically Generics

PA – Prior Authorization

AGE – Age Requirement

PPACA – No Cost-Share Preventive Medication

T2 – Typically Preferred Brands

QL – Quantity Limit

SP – Specialty Medication

CSL – Oral cancer medication subject to cost-share limits

T3 – Typically Non-Preferred Brands

ST – Step Therapy

HD – May require home delivery pharmacy

List of Prescription Medications

HORMONES (Infertility)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
FERTILITY STIMULATING PREPARATIONS, NON-FSH		
<i>clomiphene citrate</i>	T1	
FOLLICLE-STIMULATING AND LUTEINIZING HORMONES		
MENOPUR	T2	PA SP
FOLLICLE-STIMULATING HORMONE (FSH)		
FOLLISTIM AQ	T3	PA SP
GONAL-F	T2	PA SP
GONAL-F RFF	T2	PA SP
GONAL-F RFF REDI-JECT	T2	PA SP
HUMAN CHORIONIC GONADOTROPIN (HCG)		
CHORIONIC GONAD 10,000 UNIT VL	T3	PA SP
CHORIONIC GONAD 12,000 UNIT VL	T1	SP
CHORIONIC GONAD 6,000 UNIT VL	T1	SP
NOVAREL	T2	PA SP
OVIDREL	T2	PA SP
PREGNYL	T2	PA SP
PREGNANCY FACILITATING/MAINTAINING AGENT, HORMONAL		
CRINONE 8% GEL	T3	PA
ENDOMETRIN	T2	
HORMONES (Miscellaneous)		
LEPTIN HORMONE ANALOGS		
MYALEPT	T3	PA SP HD
HORMONES (Osteoporosis Products)		
BONE FORMATION STIM. AGENTS - PARATHYROID HORMONE		
<i>teriparatide 560mcg/2.24ml pen (Forteo)</i>	T1	PA QL(0.09 mls/day) SP HD
TERIPARATIDE 620 MCG/2.48 ML	T3	PA QL(0.09 mls/day) SP HD
BONE RESORPTION INHIBITORS		
<i>ibandronate sodium</i>	T1	HD
<i>calcitonin, salmon, synthetic</i>	T1	HD
MIACALCIN	T2	HD
IMMUNOSUPPRESSANTS (Pain Relief And Inflammatory Disease)		
INTERLEUKIN-4(IL-4) RECEPTOR ALPHA ANTAGONIST, MAB		
DUPIXENT PEN	T3	PA SP HD
DUPIXENT SYRINGE	T3	PA SP HD

T1 – Typically Generics

PA – Prior Authorization

AGE – Age Requirement

PPACA – No Cost-Share Preventive Medication

T2 – Typically Preferred Brands

QL – Quantity Limit

SP – Specialty Medication

CSL – Oral cancer medication subject to cost-share limits

T3 – Typically Non-Preferred Brands

ST – Step Therapy

HD – May require home delivery pharmacy

List of Prescription Medications

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

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
IL-23 RECEPTOR ANTAGONIST, MONOCLONAL ANTIBODY		
OMVOH 100 MG/ML PEN	T2	PA QL(2 pens/28 days) SP HD
OMVOH 100 MG/ML SYRINGE	T2	PA QL(2 syringes/28 days) SP HD
OMVOH 300 MG DOSE – 2 PENS	T2	PA QL(3 mls/28 days) SP HD
INTERLEUKIN-6 (IL-6) RECEPTOR INHIBITORS		
ACTEMRA	T3	PA QL (4 syringes/28 days) SP HD
ACTEMRA ACTPEN	T3	PA QL (4 pens/28 days) SP HD
ENSPRYNG	T3	PA SP HD
KEVZARA 150 MG/1.14 ML PEN INJ	T3	PA QL (2 pens/28 days) SP HD
KEVZARA 150 MG/1.14 ML SYRINGE	T3	PA QL (2 syringes/28 days) SP HD
KEVZARA 200 MG/1.14 ML PEN INJ	T3	PA QL (2 pens/28 days) SP HD
KEVZARA 200 MG/1.14 ML SYRINGE	T3	PA QL (2 syringes/28 days) SP HD
TYENNE	T2	PA QL(3.6 ml/28 days) SP
MONOCLONAL ANTIBODY-HUMAN INTERLEUKIN 12/23 INHIB		
STELARA 45 MG/0.5 ML SYRINGE	T3	PA QL (1 syringe/84 days) SP HD
STELARA 45 MG/0.5 ML VIAL	T3	PA QL (1 vial/84 days) SP HD
STELARA 90 MG/ML SYRINGE	T3	PA QL (1 syringe/84 days) SP HD
SELARSDI	T2	PA QL(1 syringe/84 days) SP
USTEKINUMAB-TTWE	T2	PA QL(1 syringe/84 days) SP HD
YESINTEK	T2	PA QL(1 syringe/84 days) SP

IMMUNOSUPPRESSANTS (Skin Conditions)

TOPICAL IMMUNOSUPPRESSIVE AGENTS		
ELIDEL (<i>pimecrolimus</i>)	T3	
<i>pimecrolimus</i> (Elidel)	T1	
PROTOPIC (<i>tacrolimus</i>)	T3	
<i>tacrolimus ointment</i>	T1	

IMMUNOSUPPRESSANTS (Transplant Medications)

IMMUNOSUPPRESSIVES		
ASTAGRAF XL	T3	SP HD
AZASAN	T2	SP HD
<i>azathioprine</i> (Imuran)	T1	SP HD
<i>cyclosporine</i> (Sandimmune)	T1	SP HD
<i>cyclosporine, modified</i>	T1	SP HD
<i>cyclosporine, modified</i> (Neoral)	T1	SP HD
ENVARUS XR	T3	SP HD

T1 – Typically Generics

PA – Prior Authorization

AGE – Age Requirement

PPACA – No Cost-Share Preventive Medication

T2 – Typically Preferred Brands

QL – Quantity Limit

SP – Specialty Medication

CSL – Oral cancer medication subject to cost-share limits

T3 – Typically Non-Preferred Brands

ST – Step Therapy

HD – May require home delivery pharmacy

List of Prescription Medications

IMMUNOSUPPRESSANTS (Transplant Medications) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
IMMUNOSUPPRESSIVES (cont.)		
<i>everolimus 0.25 mg tablet</i> (Zortress)	T1	SP HD
<i>everolimus 0.5 mg tablet</i> (Zortress)	T1	SP HD
<i>everolimus 0.75 mg tablet</i> (Zortress)	T1	SP HD
LUPKYNIS	T3	PA QL(6 caps/day) SP
<i>mycophenolate mofetil</i> (Cellcept)	T1	SP HD
NEORAL (<i>gengraf</i>)	T3	SP HD
PROGRAF	T3	SP HD
PROGRAF (<i>tacrolimus</i>)	T3	SP HD
<i>sirolimus</i> (Rapamune)	T1	SP HD
<i>tacrolimus 0.5 mg capsule</i> (ir) (Prograf)	T1	SP HD
<i>tacrolimus 1 mg capsule</i> (ir) (Prograf)	T1	SP HD
<i>tacrolimus 5 mg capsule</i> (ir) (Prograf)	T1	SP HD
ZORTRESS (<i>everolimus</i>)	T3	SP HD

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

DIABETIC SUPPLIES		
AGAMATRIX CONTROL SOLUTION	T1	
AUTOLET LITE	T1	
CARESENS	T1	
CARETOUCH CONTROL SOLUTION	T1	
CEQR SIMPLICITY	T2	
CEQR SIMPLICITY INSERTER	T2	
CHOSEN LANCING DEVICE	T1	
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 RECEIVER	T2	PA QL(1 unit/365 days)
DEXCOM G7 SENSOR	T2	PA QL(3 sensors/30 days)
EASY TOUCH BLU LINK CTRL SOLN	T1	
EASY TRAK II CONTROL SOLUTION	T1	
ENLITE SERTER	T1	
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 LIBRE 2 READER	T2	PA QL (1 READER/DAY)

T1 – Typically Generics

PA – Prior Authorization

AGE – Age Requirement

PRACA – No Cost-Share Preventive Medication

T2 – Typically Preferred Brands

QL – Quantity Limit

SP – Specialty Medication

CSL – Oral cancer medication subject to cost-share limits

T3 – Typically Non-Preferred Brands

ST – Step Therapy

HD – May require home delivery pharmacy

List of Prescription Medications

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

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
DIABETIC SUPPLIES (cont.)		
FREESTYLE LIBRE 2 PLUS SENSOR	T2	PA QL(2 units/30 days)
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)
FORA TN'GO ADVANCE MULTIFN MTR	T3	
GLUCOCOM AUTOLINK	T1	
GUARDIAN RT CHARGER	T1	
GUARDIAN RT STARTER KIT	T1	
GUARDIAN TEST PLUG	T1	
HUMAPEN LUXURA HD	T1	
IHEALTH CONTROL SOLN LEVEL 2	T1	
INPEN (FOR HUMALOG)	T1	
LITE TOUCH LANCING PEN	T1	
NOVOPEN ECHO	T1	
OMNIPOD 5 (G6/LIBRE 2 PLUS)	T2	QL(30 crtgs/30 days)
OMNIPOD 5 (GEN 5) KIT	T2	QL (1 kit/365 days)
OMNIPOD 5 (GEN 5) PODS	T2	QL (30 pods/30 days)
OMNIPOD 5 G6-G7 PODS (GEN 5)	T2	QL
OMNIPOD CLASSIC (GEN 3) KIT	T2	QL (1 kit/365 days)
OMNIPOD CLASSIC (GEN 4) KIT	T2	QL (1 kit/365 days)
OMNIPOD CLASSIC (GEN 3) PODS	T2	QL (30 pods/30 days)
OMNIPOD CLASSIC (GEN 4) PODS	T2	QL (30 pods/30 days)
OMNIPOD DASH 5 PACK POD	T2	PA QL (6 boxes/30 days)
OMNIPOD 5 DEXG7G6 INTRO(GEN 5)	T2	QL(1 unit/365 days)
OMNIPOD 5 DEXG7G6 PODS (GEN 5)	T2	QL(30 crtgs/30 days)
OMNIPOD DASH 5 PACK POD	T2	PA QL (6 boxes/30 days)
ONETOUCH DELICA PLUS LANC DEV	T1	
ONETOUCH ULTRA CONTROL SOLN	T1	
ONETOUCH VERIO HIGH CNTRL SOLN	T1	
ONETOUCH VERIO MID CNTRL SOLN	T1	
REPLACEMENT PEDIATRIC MONITOR	T1	
SEN-SERTER	T1	
V-GO 20, 30, 40	T2	
DURABLE MEDICAL EQUIPMENT,MISC (GROUP I)		
CHOSEN LANCET	T1	
EASY TOUCH	T1	
I1 – Typically Generics	PA – Prior Authorization	AGE – Age Requirement
T2 – Typically Preferred Brands	QL – Quantity Limit	SP – Specialty Medication
T3 – Typically Non-Preferred Brands	ST – Step Therapy	HD – May require home delivery pharmacy
		PPACA – No Cost-Share Preventive Medication
		CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

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

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
PERFECT POINT SAFETY LANCETS	T1	
VIVAGUARD SAFETY LANCET	T1	
NEEDLES/NEEDLELESS DEVICES		
AUTOSHIELD DUO PEN NEEDLE	T1	
NEEDLES	T1	
PERFECT POINT SAFETY NEEDLE	T1	
PRECISIONGLIDE NEEDLE	T1	
NANO 2ND GEN PEN NEEDLE	T1	
NANO PEN NEEDLE	T1	
ULTRA-FINE PEN NEEDLE	T1	
SYRINGES AND ACCESSORIES		
ASSURE ID INSULIN SAFETY	T1	
EASY COMFORT INSULIN SYRINGE	T1	
INSULIN SYRINGE	T1	
INSULIN SYRINGE U-500	T1	
MAGELLAN INSULIN SAFETY SYRNG	T1	
MAGELLAN INSULIN SYRINGE	T1	
MINIMED RESERVOIR	T1	
MISCELLANEOUS MEDICAL SUPPLIES, DEVICES, NON-DRUG (Miscellaneous)		
SYRINGES AND ACCESSORIES (cont.)		
MONOJECT	T1	
PARADIGM	T1	
SECURESAFE INSULIN SYRINGE	T1	
TRUE COMFORT SAFE INSULIN SYRG		
UNIFINE SAFECONTROL	T3	
VERIFINE PEN NEEDLE	T1	
DURABLE MEDICAL EQUIPMENT, MISC (GROUP I)		
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	

T1 – Typically Generics

PA – Prior Authorization

AGE – Age Requirement

PPACA – No Cost-Share Preventive Medication

T2 – Typically Preferred Brands

QL – Quantity Limit

SP – Specialty Medication

CSL – Oral cancer medication subject to cost-share limits

T3 – Typically Non-Preferred Brands

ST – Step Therapy

HD – May require home delivery pharmacy

List of Prescription Medications

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

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
DURABLE MEDICAL EQUIPMENT, MISC (GROUP I)		
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	
CHOSEN LANCET	T1	
CHOSEN SAFETY LANCET	T1	
CLEVER CHEK LANCETS	T1	
COAGUCHEK	T1	
COLOR LANCETS	T1	
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 LANCETS	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	

T1 – Typically Generics

PA – Prior Authorization

AGE – Age Requirement

PPACA – No Cost-Share Preventive Medication

T2 – Typically Preferred Brands

QL – Quantity Limit

SP – Specialty Medication

CSL – Oral cancer medication subject to cost-share limits

T3 – Typically Non-Preferred Brands

ST – Step Therapy

HD – May require home delivery pharmacy

List of Prescription Medications

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

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
DURABLE MEDICAL EQUIPMENT, MISC (GROUP I)		
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 THIN	T1	
LANCETS ULTRA THIN	T1	
LITE TOUCH	T1	
MEDISENSE THIN LANCETS	T1	
MEDLANCE PLUS	T1	
MICRO THIN LANCET	T1	
MICRO THIN LANCETS	T1	
MICROLET	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	
PERFECT POINT SAFETY LANCETS	T1	
PIP LANCET	T1	

T1 – Typically Generics

PA – Prior Authorization

AGE – Age Requirement

PPACA – No Cost-Share Preventive Medication

T2 – Typically Preferred Brands

QL – Quantity Limit

SP – Specialty Medication

CSL – Oral cancer medication subject to cost-share limits

T3 – Typically Non-Preferred Brands

ST – Step Therapy

HD – May require home delivery pharmacy

List of Prescription Medications

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

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
DURABLE MEDICAL EQUIPMENT, MISC (GROUP I)		
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	
READYLANCER SAFETY LANCETS	T1	
RELIAMED	T1	
RELIAMED SAFETY SEAL LANCETS	T1	
RIGHTTEST GL300 LANCETS	T1	
SAFETY LANCETS	T1	
SAFETY SEAL LANCETS	T1	
SAFETY-LET	T1	
SINGLE-LET	T1	
SMART SENSE	T1	
SMART SENSE LANCETS	T1	
SMARTTEST LANCET	T1	
SOLUS V2	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 UNIVERSAL 1 LANCET	T1	
TOPCARE UNIVERSAL 1 THIN LANCET	T1	
TRUE COMFORT LANCET	T1	
TRUE COMFORT SAFETY LANCET	T1	

T1 – Typically Generics

PA – Prior Authorization

AGE – Age Requirement

PPACA – No Cost-Share Preventive Medication

T2 – Typically Preferred Brands

QL – Quantity Limit

SP – Specialty Medication

CSL – Oral cancer medication subject to cost-share limits

T3 – Typically Non-Preferred Brands

ST – Step Therapy

HD – May require home delivery pharmacy

List of Prescription Medications

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

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
DURABLE MEDICAL EQUIPMENT, MISC (GROUP I)		
TRUEPLUS LANCET	T1	
TRUEPLUS LANCETS	T1	
TWIST LANCETS	T1	
ULTILET BASIC	T1	
ULTILET CLASSIC	T1	
ULTILET LANCETS	T1	
ULTILET SAFETY	T1	
ULTRA THIN LANCET	T1	
ULTRA THIN PLUS LANCETS	T1	
ULTRA-CARE LANCETS	T1	
ULTRALANCE	T1	
ULTRA-THIN II LANCETS	T1	
ULTRATLC LANCETS	T1	
UNILET COMFORTOUCH	T1	
UNILET EXCELITE	T1	
UNILET EXCELITE II	T1	
UNILET GP LANCET	T1	
UNILET LANCETS	T1	
UNISTIK 2 COMFORT	T1	
UNISTIK 2 EXTRA	T1	
UNISTIK 2 NORMAL	T1	
UNISTIK 3	T1	
UNISTIK 3 COMFORT	T1	
UNISTIK 3 DUAL	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	

T1 – Typically Generics

PA – Prior Authorization

AGE – Age Requirement

PPACA – No Cost-Share Preventive Medication

T2 – Typically Preferred Brands

QL – Quantity Limit

SP – Specialty Medication

CSL – Oral cancer medication subject to cost-share limits

T3 – Typically Non-Preferred Brands

ST – Step Therapy

HD – May require home delivery pharmacy

List of Prescription Medications

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

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
DURABLE MEDICAL EQUIPMENT, MISC (GROUP I)		
VIVAGUARD LANCET	T1	
VIVAGUARD SAFETY LANCET	T1	
NEEDLES/NEEDLELESS DEVICES		
BD NEEDLES	T1	
CAREPOINT PRECISION NEEDLE	T1	
DROPSAFE SICURA SAFETY NEEDLE	T1	
RESPIRATORY AIDS, DEVICES, EQUIPMENT		
ACE AEROSOL CLOUD ENHANCER	T2	QL (1 unit/year)
AEROCHAMBER MINI	T2	QL (1 unit/year)
AEROCHAMBER MV	T2	QL (1 unit/year)
AEROCHAMBER PLUS FLOW-VU	T2	QL (1 unit/year)
AEROCHAMBER WITH FLOWSIGNAL	T2	QL (1 unit/year)
AEROCHAMBER Z-STAT PLUS	T2	QL (1 unit/year)
AEROTRACH PLUS	T2	QL (1 unit/year)
AEROVENT PLUS	T2	QL (1 unit/year)
BREATHERITE	T2	QL (1 unit/year)
BREATHERITE SPACER-ADULT MASK	T2	QL (1 unit/year)
BREATHERITE SPACER-INFANT MASK	T2	QL (1 unit/year)
BREATHERITE SPACER-LARGE MASK	T2	QL (1 mask/365 days)
BREATHERITE SPACER-LG CHLD MSK	T2	QL (1 unit/year)
BREATHERITE SPACER-MEDIUM MASK	T2	QL (1 mask/365 days)
BREATHERITE SPACER-NEONATE MSK	T2	QL (1 unit/year)
BREATHERITE SPACER-SM CHLD MSK	T2	QL (1 unit/year)
BREATHERITE SPACER-SMALL MASK	T2	QL (1 mask/365 days)
CLEVER CHOICE HOLDING CHAMBER	T2	QL (1 unit/year)
COMFORTSEAL	T2	QL (1 unit/year)
COMPACT SPACE CHAMBER	T2	QL (1 unit/year)
EASIVENT	T2	QL (1 unit/year)
E-Z SPACER	T2	QL (1 unit/year)
FLEXICHAMBER MASK	T2	QL (1 unit/year)
INSPIRACHAMBER	T2	QL (1 unit/year)
LITEAIRE	T2	QL (1 unit/year)
LITETOUCH	T2	QL (1 unit/year)
MICROCHAMBER	T2	QL (1 unit/year)
MICROSPACER	T2	QL (1 unit/year)

T1 – Typically Generics

PA – Prior Authorization

AGE – Age Requirement

PPACA – No Cost-Share Preventive Medication

T2 – Typically Preferred Brands

QL – Quantity Limit

SP – Specialty Medication

CSL – Oral cancer medication subject to cost-share limits

T3 – Typically Non-Preferred Brands

ST – Step Therapy

HD – May require home delivery pharmacy

List of Prescription Medications

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

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
RESPIRATORY AIDS, DEVICES, EQUIPMENT (con't.)		
OPTICHAMBER	T2	QL (1 unit/year)
OPTICHAMBER DIAMOND	T2	QL (1 unit/year)
POCKET CHAMBER	T2	QL (1 unit/year)
PRIMEAIRE	T2	QL (1 unit/year)
PRO COMFORT SPACER WITH MASK	T2	QL (1 unit/year)
PROCARE SPACER WITH ADULT MASK	T2	QL (1 unit/year)
PROCARE SPACER WITH CHILD MASK	T2	QL (1 unit/year)
PROCHAMBER	T2	QL (1 unit/year)
RITEFLO	T2	QL (1 unit/year)
SILICONE MASK	T2	QL (1 unit/year)
SPACE CHAMBER	T2	QL (1 unit/year)
SPACE CHAMBER-LARGE MASK	T2	QL (1 unit/year)
SPACE CHAMBER-MEDIUM MASK	T2	QL (1 unit/year)
SPACE CHAMBER-SMALL MASK	T2	QL (1 unit/year)
VORTEX HOLDING CHAMBER-CHILD	T2	QL (1 unit/year)
VORTEX HOLDING CHAMBER-TODDLER	T2	QL (1 unit/year)
VORTEX VHC FROG MASK	T2	QL (1 unit/year)
VORTEX VHC LADYBUG MASK	T2	QL (1 unit/year)
VORTEX VHC PEDIATRIC MASK	T2	QL(1 spacer/365 days)
SYRINGES AND ACCESSORIES		
BD INS SYR 0.3 ML 8MMX31G(1/2)	T1	
BD INS SYR UF 0.3ML 12.7MMX30G	T1	
BD INS SYR UF 0.5ML 12.7MMX30G	T1	
BD INS SYRN UF 1 ML 12.7MMX30G	T1	
BD INS SYRN UF 1 ML 30G 12.7MM	T1	
BD INS SYRNG 0.3 ML 29GX12.7MM	T1	
BD INS SYRNG 0.5 ML 29GX12.7MM	T1	
BD INS SYRNG UF 0.3 ML 8MMX31G	T1	
BD INS SYRNG UF 0.5 ML 8MMX31G	T1	
BD INSULIN SYR 0.5 ML 28GX1/2"	T1	
BD INSULIN SYR 1 ML 25GX1"	T1	
BD INSULIN SYR 1 ML 25GX5/8"	T1	
BD INSULIN SYR 1 ML 26GX1/2"	T1	
BD INSULIN SYR 1 ML 27GX12.7MM	T1	

T1 – Typically Generics

PA – Prior Authorization

AGE – Age Requirement

PPACA – No Cost-Share Preventive Medication

T2 – Typically Preferred Brands

QL – Quantity Limit

SP – Specialty Medication

CSL – Oral cancer medication subject to cost-share limits

T3 – Typically Non-Preferred Brands

ST – Step Therapy

HD – May require home delivery pharmacy

List of Prescription Medications

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

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
SYRINGES AND ACCESSORIES (con't.)		
BD INSULIN SYR 1 ML 27GX5/8"	T1	
BD INSULIN SYR 1 ML 28GX1/2"	T1	
BD INSULIN SYR 1 ML 29GX12.7MM	T1	
BD INSULIN SYR UF 1 ML 8MMX31G	T1	
BD INSULIN SYRINGE 1 ML	T1	
DROPLET 0.3 ML 29G 12.7MM(1/2)	T1	
DROPLET 0.3 ML 30G 12.7MM(1/2)	T1	
DROPLET INS 0.3ML 30G 8MM(1/2)	T1	
DROPLET INS 0.3ML 31G 6MM(1/2)	T1	
DROPLET INS 0.3ML 31G 8MM(1/2)	T1	
DROPLET INS 0.5 ML 29G 12.7MM	T1	
DROPLET INS 0.5 ML 30G 12.7MM	T1	
DROPLET INS SYR 0.5 ML 31G 6MM	T1	
DROPLET INS SYR 0.5 ML 31G 8MM	T1	
DROPLET INS SYR 0.5ML 30G 8MM	T1	
DROPLET INS SYR 1 ML 30G 8MM	T1	
DROPLET INS SYR 1 ML 31G 6MM	T1	
DROPLET INS SYR 1 ML 31G 8MM	T1	
DROPLET INS SYR 1ML 29G 12.7MM	T1	
DROPLET INS SYR 1ML 30G 12.7MM	T1	
EASY COMFORT SYR 0.5ML 29G 8MM	T1	
EASY COMFORT SYR 1 ML 29G 8MM	T1	
INSULIN SYR 0.5 ML 28G 12.7MM	T1	
INSULIN SYRINGE 1ML 28G 12.7MM	T1	
ULTRA-FINE 0.3 ML 30G 12.7MM	T1	
ULTRA-FINE 0.3ML 31G 6MM (1/2)	T1	
ULTRA-FINE 0.3ML 31G 8MM (1/2)	T1	
ULTRA-FINE 0.5 ML 30G 12.7MM	T1	
ULTRA-FINE INS SYR 1ML 31G 6MM	T1	
ULTRA-FINE INS SYR 1ML 31G 8MM	T1	

MUSCLE RELAXANTS (Pain Relief And Inflammatory Disease)

SKELETAL MUSCLE RELAXANTS

<i>baclofen tablet</i>			T1	HD
I1 – typically Generics	PA – Prior Authorization	AGE – Age Requirement		PPACA – No Cost-Share Preventive Medication
T2 – Typically Preferred Brands	QL – Quantity Limit	SP – Specialty Medication		CSL – Oral cancer medication subject to cost-share limits
T3 – Typically Non-Preferred Brands	ST – Step Therapy	HD – May require home delivery pharmacy		

List of Prescription Medications

MUSCLE RELAXANTS (Pain Relief And Inflammatory Disease)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
SKELETAL MUSCLE RELAXANTS		
<i>carisoprodol/aspirin</i>	T1	
<i>chlorzoxazone</i>	T1	
<i>cyclobenzaprine hcl</i>	T1	
<i>cyclobenzaprine hcl (Fexmid)</i>	T1	
DANTRIUM (<i>dantrolene sodium</i>)	T3	
<i>dantrolene sodium (Dantrium)</i>	T1	
FEXMID (<i>cyclobenzaprine hcl</i>)	T3	
<i>metaxalone tablet (Skelaxin)</i>	T1	
<i>methocarbamol (Robaxin-750)</i>	T1	
<i>orphenadrine citrate</i>	T1	
ROBAXIN-750 (<i>methocarbamol</i>)	T3	
SOMA (<i>vanadom</i>)	T3	
<i>tizanidine hcl (Zanaflex)</i>	T1	
ZANAFLEX (<i>tizanidine hcl</i>)	T3	

PRE-NATAL VITAMINS (Nutritional/Dietary)

PRENATAL VITAMIN PREPARATIONS		
ATABEX EC	T2	
CITRANATAL 90 DHA	T2	
CITRANATAL ASSURE	T2	
CITRANATAL HARMONY	T2	
CITRANATAL RX	T2	
OBSTETRIX EC	T2	
OBTREX DHA	T2	
<i>pnv 22/iron, gluc/folic/dss/dha</i>	T1	
<i>pnv 66/iron/folic/docusate/dha</i>	T1	
<i>pnv 69/iron/folic/docusate/dha</i>	T1	
<i>pnv 80/iron fum/folic/dss/dha</i>	T1	
<i>pnv no. 154/iron fum/folic acid</i>	T1	
<i>pnv/ferrous fum/docusate/folic</i>	T1	
<i>pnv/iron, carb/docusat/folic ac</i>	T1	
<i>12/iron/folic/dss/om3</i>	T1	
PRENATAL 19	T1	
<i>prenatal 34/iron/folic/dss/dha</i>	T1	

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

PA – Prior Authorization

QL – Quantity Limit

ST – Step Therapy

AGE – Age Requirement

SP – Specialty Medication

HD – May require home delivery pharmacy

PPACA – No Cost-Share Preventive Medication

CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

PRE-NATAL VITAMINS (Nutritional/Dietary)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
PRENATAL VITAMIN PREPARATIONS		
<i>prenatal vits 15/iron/folic/dss</i>	T1	
VITAFOL FE+	T2	
PSYCHOTHERAPEUTIC DRUGS (Anxiety/Depression/Bipolar Disorder)⁹		
ALPHA-2 RECEPTOR ANTAGONIST ANTI-DEPRESSANTS		
<i>mirtazapine</i>	T1	HD
<i>mirtazapine (Remeron)</i>	T1	HD
ANTI-ANXIETY - BENZODIAZEPINES		
<i>alprazolam (Xanax Xr)</i>	T1	
<i>alprazolam (Xanax)</i>	T1	
<i>chlordiazepoxide hcl</i>	T1	
<i>clorazepate dipotassium (Tranxene T-tab)</i>	T1	
<i>diazepam 20 mg rectal gel syst diazepam 20 mg rectal gel syst 10 mg tablet (Valium)</i>	T1	
<i>diazepam tablet (Valium)</i>	T1	
<i>diazepam 5 mg/5 ml solution</i>	T1	
<i>diazepam 5 mg/ml oral conc</i>	T1	
<i>lorazepam</i>	T1	
<i>oxazepam</i>	T1	
TRANXENET-TAB (<i>clorazepate dipotassium</i>)	T3	
XANAX XR 2 MG TABLET (<i>alprazolam xr</i>)	T3	
ANTI-ANXIETY DRUGS		
<i>buspirone hcl</i>	T1	
<i>meprobamate</i>	T1	
ANTIDEPRESSANT - POSTPARTUM DEPRESSION (PPD)		
ZURZUVAE 20 MG CAPSULE	T3	PA QL(28 caps/270 days) SP HD
ZURZUVAE 25 MG CAPSULE	T3	PA QL(28 caps/270 days) SP HD
ZURZUVAE 30 MG CAPSULE	T3	PA QL(14 caps/270 days) SP HD
BIPOLAR DISORDER DRUGS		
EQUETRO	T3	HD
<i>lithium carbonate</i>	T1	HD
<i>lithium carbonate (Lithobid)</i>	T1	HD
<i>lithium citrate</i>	T1	HD
MAOIS -NON-SELECTIVE, IRREVERSIBLE ANTI-DEPRESSANTS		
MARPLAN	T3	QL (12 tabs/day)
<i>phenelzine sulfate (Nardil)</i>	T1	
<i>tranylcypromine sulfate</i>	T1	

T1 – Typically Generics

PA – Prior Authorization

AGE – Age Requirement

PPACA – No Cost-Share Preventive Medication

T2 – Typically Preferred Brands

QL – Quantity Limit

SP – Specialty Medication

CSL – Oral cancer medication subject to cost-share limits

T3 – Typically Non-Preferred Brands

ST – Step Therapy

HD – May require home delivery pharmacy

List of Prescription Medications

PSYCHOTHERAPEUTIC DRUGS (Anxiety/Depression/Bipolar Disorder)⁹ (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
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)
NOREPINEPHRINE AND DOPAMINE REUPTAKE INHIB (NDRIs)		
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	T1	QL (3 tabs/day) HD
bupropion hcl xl 300 mg tablet	T1	QL (1 tab/day) HD
BUPROPION HCL XL 450 MG TABLET	T1	QL (1 tab/day) HD
SELECTIVE SEROTONIN 5-HT_{2A} INVERSE AGONISTS (SSiAs)		
NUPLAZID	T3	PA SP HD
SELECTIVE SEROTONIN REUPTAKE INHIBITOR (SSRIs)		
citalopram hbr 10 mg tablet (Celexa)	T1	QL (6 tabs/day) HD
citalopram hbr 20 mg/10 ml sol	T1	QL (30ml/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 40 mg tablet (Celexa)	T1	QL (1 tab/day) HD
escitalopram 10 mg/10 ml cup	T1	QL (20 mls/day) HD
escitalopram 10 mg tablet	T1	QL (2 tabs/day) HD
escitalopram 5 mg tablet	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 (20ml/day) HD
fluoxetine hcl	T1	QL (4 caps/28 days) 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

T1 – Typically Generics

PA – Prior Authorization

AGE – Age Requirement

PPACA – No Cost-Share Preventive Medication

T2 – Typically Preferred Brands

QL – Quantity Limit

SP – Specialty Medication

CSL – Oral cancer medication subject to cost-share limits

T3 – Typically Non-Preferred Brands

ST – Step Therapy

HD – May require home delivery pharmacy

List of Prescription Medications

PSYCHOTHERAPEUTIC DRUGS (Anxiety/Depression/Bipolar Disorder)⁹ (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
SELECTIVE SEROTONIN REUPTAKE INHIBITOR (SSRIs) (cont.)		
<i>fluvoxamine maleate 25 mg tab</i>	T1	QL (12 tabs/day) HD
<i>fluvoxamine maleate 50 mg tab</i>	T1	QL (6 tabs/day) HD
<i>paroxetine cr 12.5 mg tablet (Paxil Cr)</i>	T1	QL (6 tabs/day) HD
<i>paroxetine cr 25 mg tablet (Paxil Cr)</i>	T1	QL (3 tabs/day) HD
<i>paroxetine cr 37.5 mg tablet (Paxil Cr)</i>	T1	QL (2 tabs/day) HD
<i>paroxetine er 12.5 mg tablet (Paxil Cr)</i>	T1	QL (1 tab/day) HD
<i>paroxetine er 25 mg tablet (Paxil Cr)</i>	T1	QL (3 tabs/day) HD
<i>paroxetine er 37.5 mg tablet (Paxil Cr)</i>	T1	QL (2 tabs/day) HD
<i>paroxetine hcl 10 mg tablet (Paxil)</i>	T1	QL (6 tabs/day) HD
<i>paroxetine hcl 20 mg tablet (Paxil)</i>	T1	QL (3 tabs/day) HD
<i>paroxetine hcl 30 mg tablet (Paxil)</i>	T1	QL (2 tabs/day) HD
<i>paroxetine hcl 40 mg tablet (Paxil)</i>	T1	QL (1 tab/day) HD
<i>SARAFEM (fluoxetine hcl)</i>	T3	ST HD
<i>sertraline 20 mg/ml oral conc (Zoloft)</i>	T1	QL (10ml/day) HD
<i>sertraline hcl 100 mg tablet (Zoloft)</i>	T1	QL (2 tabs/day) HD
<i>sertraline hcl 25 mg tablet (Zoloft)</i>	T1	QL (8 tabs/day) HD
<i>sertraline hcl 50 mg tablet (Zoloft)</i>	T1	QL (4 tabs/day) HD
SEROTONIN-2 ANTAGONIST/REUPTAKE INHIBITORS (SARIs)		
<i>nefazodone hcl</i>	T1	HD
<i>trazodone hcl</i>	T1	HD
SEROTONIN-NOREPINEPHRINE REUPTAKE-INHIB (SNRIs)		
<i>desvenlafaxine succnt er 100mg (Pristiq)</i>	T1	QL (4 tabs/day) HD
<i>desvenlafaxine succnt er 25 mg (Pristiq)</i>	T1	QL (16 tabs/day) HD
<i>desvenlafaxine succnt er 50 mg (Pristiq)</i>	T1	QL (1 tab/day) HD
<i>duloxetine hcl dr 20 mg cap</i>	T1	QL (6 caps/day) HD
<i>duloxetine hcl dr 30 mg cap</i>	T1	QL (4 caps/day) HD
<i>duloxetine hcl dr 40 mg cap</i>	T1	QL (3 caps/day) HD
<i>duloxetine hcl dr 60 mg cap</i>	T1	QL (2 caps/day) HD
FETZIMA 20-40 MG TITRATION PAK	T3	QL (28 caps/180 days) ST
FETZIMA ER 120 MG CAPSULE	T3	QL (1 cap/day) ST
FETZIMA ER 20 MG CAPSULE	T3	QL (6 caps/day) ST
FETZIMA ER 40 MG CAPSULE	T3	QL (3 caps/day) ST
FETZIMA ER 80 MG CAPSULE	T3	QL (1 cap/day) ST
PRISTIQ ER 50 MG TABLET (<i>desvenlafaxine succinate er</i>)	T3	QL (1 tab/day) ST HD
<i>venlafaxine hcl 100 mg tablet</i>	T1	QL (3 tabs/day) HD

T1 – Typically Generics

PA – Prior Authorization

AGE – Age Requirement

PPACA – No Cost-Share Preventive Medication

T2 – Typically Preferred Brands

QL – Quantity Limit

SP – Specialty Medication

CSL – Oral cancer medication subject to cost-share limits

T3 – Typically Non-Preferred Brands

ST – Step Therapy

HD – May require home delivery pharmacy

List of Prescription Medications

PSYCHOTHERAPEUTIC DRUGS (Anxiety/Depression/Bipolar Disorder)⁹ (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
SEROTONIN-NOREPINEPHRINE REUPTAKE-INHIB (SNRIs) (cont.)		
<i>venlafaxine hcl 25 mg tablet</i>	T1	QL (15 tabs/day) HD
<i>venlafaxine hcl 37.5 mg tablet</i>	T1	QL (10 tabs/day) HD
<i>venlafaxine hcl 50 mg tablet</i>	T1	QL (7 tabs/day) HD
<i>venlafaxine hcl 75 mg tablet</i>	T1	QL (5 tabs/day) HD
<i>venlafaxine hcl er 150 mg cap (Effexor Xr)</i>	T1	QL (2 caps/day) HD
<i>venlafaxine hcl er 150 mg tab</i>	T1	QL (2 tabs/day) HD
<i>venlafaxine hcl er 225 mg tab</i>	T1	QL (1 tab/day) HD
<i>venlafaxine hcl er 37.5 mg cap (Effexor Xr)</i>	T1	QL (8 caps/day) HD
<i>venlafaxine hcl er 37.5 mg tab</i>	T1	QL (8 tabs/day) HD
<i>venlafaxine hcl er 75 mg cap (Effexor Xr)</i>	T1	QL (4 caps/day) HD
<i>venlafaxine hcl er 75 mg tab</i>	T1	QL (4 tabs/day) HD
VIIBRYD 10 MG TABLET	T3	QL (1 tab/day) ST HD
VIIBRYD 10-20 MG STARTER PACK	T3	ST HD
VIIBRYD 20 MG TABLET	T3	QL (1 tab/day) ST HD
VIIBRYD 40 MG TABLET	T3	ST HD
<i>vilazodone hcl tablet (Viibryd)</i>	T1	QL(1 tab/day) HD
SSRI, SEROTONIN RECEPTOR MODULATOR ANTI-DEPRESSANTS		
TRINTELLIX 10 MG TABLET	T2	QL (1 tab/day) ST
TRINTELLIX 20 MG TABLET	T2	ST
TRINTELLIX 5 MG TABLET	T2	QL (1 tab/day) ST
TRICYCLIC ANTI-DEPRESSANT-BENZODIAZEPINE COMBINATNS		
<i>amitriptyline/chlordiazepoxide</i>	T1	HD
TRICYCLIC ANTI-DEPRESSANT-PHENOTHIAZINE COMBINATNS		
<i>perphenazine/amitriptyline hcl</i>	T1	HD
TRICYCLIC ANTI-DEPRESSANTS, REL.NON-SEL.REUPT-INHIB		
<i>amitriptyline hcl</i>	T1	HD
<i>amoxapine</i>	T1	HD
<i>clomipramine hcl</i>	T1	HD
<i>desipramine hcl</i>	T1	HD
<i>desipramine hcl (Norpramin)</i>	T1	HD
<i>doxepin 10 mg capsule</i>	T1	HD
<i>doxepin 10 mg/ml oral conc</i>	T1	HD
<i>doxepin 100 mg capsule</i>	T1	HD
<i>doxepin 150 mg capsule</i>	T1	HD
<i>doxepin 25 mg capsule</i>	T1	HD

T1 – Typically Generics

PA – Prior Authorization

AGE – Age Requirement

PPACA – No Cost-Share Preventive Medication

T2 – Typically Preferred Brands

QL – Quantity Limit

SP – Specialty Medication

CSL – Oral cancer medication subject to cost-share limits

T3 – Typically Non-Preferred Brands

ST – Step Therapy

HD – May require home delivery pharmacy

List of Prescription Medications

PSYCHOTHERAPEUTIC DRUGS (Anxiety/Depression/Bipolar Disorder)⁹ (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
TRICYCLIC ANTI-DEPRESSANTS, REL.NON-SEL.REUPT-INHIB (con't.)		
<i>doxepin 50 mg capsule</i>	T1	HD
<i>doxepin 75 mg capsule</i>	T1	HD
<i>imipramine hcl</i>	T1	HD
<i>imipramine pamoate</i>	T1	HD
<i>maprotiline hcl</i>	T1	HD
<i>nortriptyline hcl</i>	T1	HD
PSYCHOTHERAPEUTIC DRUGS (Attention Deficit Hyperactivity Disorder)⁹		
ADRENERGICS, AROMATIC, NON-CATECHOLAMINE		
<i>protriptyline hcl</i>	T1	HD
<i>trimipramine maleate</i>	T1	HD
ADRENERGICS, AROMATIC, NON-CATECHOLAMINE		
MYDAYIS	T2	QL
TX FOR ADHD – SELECTIVE ALPHA-2 RECEPTOR AGONIST		
<i>clonidine hcl (Kapvay)</i>	T1	
<i>guanfacine hcl (Intuniv)</i>	T1	HD
TX FOR ATTENTION DEFICIT-HYPERACT (ADHD)/NARCOLEPSY		
DAYTRANA 10 MG/9 HR PATCH	T3	PA QL (1 patch/day)
DAYTRANA 15 MG/9 HR PATCH	T3	PA QL (1 per day)
DAYTRANA 20 MG/9 HOUR PATCH	T3	PA QL (1 patch/day)
DAYTRANA 30 MG/9 HOUR PATCH	T3	PA QL (1 patch/day)
<i>dexmethylphenidate hcl</i>	T1	PA QL (1 cap/day)
<i>dexmethylphenidate hcl (Focalin XR)</i>	T1	PA
FOCALIN (<i>dexmethylphenidate hcl</i>)	T3	PA ST
METHYLIN (<i>methylphenidate hcl</i>)	T3	PA
<i>methylphenidate er 10 mg cap</i>	T1	QL (1 per day)
<i>methylphenidate er 15 mg cap</i>	T1	QL (1 per day)
<i>methylphenidate er 20 mg cap</i>	T1	QL (1 cap/day)
<i>methylphenidate er 10 mg tab</i>	T1	PA QL (2 tabs/day)
<i>methylphenidate er 18 mg tab</i>	T1	PA QL (1 tab/day)
<i>methylphenidate er 20 mg tab</i>	T1	PA QL (3 tabs/day)
<i>methylphenidate er 27 mg tab</i>	T1	PA QL (1 per day)
<i>methylphenidate er 30 mg cap</i>	T1	QL (1 per day)

T1 – Typically Generics

PA – Prior Authorization

AGE – Age Requirement

PPACA – No Cost-Share Preventive Medication

T2 – Typically Preferred Brands

QL – Quantity Limit

SP – Specialty Medication

CSL – Oral cancer medication subject to cost-share limits

T3 – Typically Non-Preferred Brands

ST – Step Therapy

HD – May require home delivery pharmacy

List of Prescription Medications

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

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
TX FOR ATTENTION DEFICIT-HYPERACT (ADHD)/NARCOLEPSY (cont.)		
<i>methylphenidate er 36 mg tab</i>	T1	PA QL (1 per day)
<i>methylphenidate er 40 mg cap</i>	T1	QL (1 per day)
<i>methylphenidate er 50 mg cap</i>	T1	QL (1 per day)
<i>methylphenidate er 54 mg tab</i>	T1	PA QL (1 tab/day)
<i>methylphenidate er 60 mg cap</i>	T1	QL (1 per day)
<i>methylphenidate hcl ptch</i>	T1	PA QL (1 patch/day)
<i>methylphenidate hcl (Metadate Cd)</i>	T1	PA QL (1 cap/day)
<i>methylphenidate hcl (Methylin)</i>	T1	PA
<i>methylphenidate</i>	T1	PA
QUILLICHEW ER	T3	PA QL (1 tab/day)
QUILLIVANT XR	T3	PA QL (12ml/day)
RITALIN (<i>methylphenidate hcl</i>)	T3	PA ST
TX FOR ATTENTION DEFICIT-HYPERACT.(ADHD), NRI-TYPE		
<i>atomoxetine hcl 10 mg capsule (Strattera)</i>	T1	HD
<i>atomoxetine hcl 100 mg capsule (Strattera)</i>	T1	HD
<i>atomoxetine hcl 18 mg capsule (Strattera)</i>	T1	HD
TX FOR ATTENTION DEFICIT-HYPERACT.(ADHD), NRI-TYPE		
<i>atomoxetine hcl 25 mg capsule (Strattera)</i>	T1	HD
<i>atomoxetine hcl 40 mg capsule (Strattera)</i>	T1	QL (1 cap/day) HD
<i>atomoxetine hcl 60 mg capsule (Strattera)</i>	T1	HD
<i>atomoxetine hcl 80 mg capsule (Strattera)</i>	T1	HD
PSYCHOTHERAPEUTIC DRUGS (Miscellaneous)		
HYPOACTIVE SEXUAL DESIRE DISORDER (HSDD) TX AGENTS		
ADDYI	T3	PA QL (1 tab/day)
VYLEESI	T3	PA QL (8 injectors/30 days) SP
ANTI-PSYCH, DOPAMINE ANTAG., DIPHENYLBUTYLPIPERIDINES		
<i>pimozide</i>	T1	

T1 – Typically Generics

PA – Prior Authorization

AGE – Age Requirement

PPACA – No Cost-Share Preventive Medication

T2 – Typically Preferred Brands

QL – Quantity Limit

SP – Specialty Medication

CSL – Oral cancer medication subject to cost-share limits

T3 – Typically Non-Preferred Brands

ST – Step Therapy

HD – May require home delivery pharmacy

List of Prescription Medications

PSYCHOTHERAPEUTIC DRUGS (Schizophrenia/Anti-Psychotics)⁹

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ANTI-PSYCHOTIC, ATYPICAL, DOPAMINE, SEROTONIN ANTAGNIST (cont.)		
<i>asenapine maleate</i> (Saphris)	T1	
CAPLYTA	T3	QL(1 tabs/caps/day)
<i>clozapine</i>	T1	
<i>clozapine</i> (Clozapine Odt)	T1	
<i>clozapine</i> (Clozaril)	T1	
CLOZAPINE ODT	T1	
CLOZARIL (clozapine)	T3	ST
INVEGA ER 3 MG TABLET (<i>paliperidone er</i>)	T3	QL (1 tab/day) ST
INVEGA ER 6 MG TABLET (<i>paliperidone er</i>)	T3	ST
INVEGA ER 9 MG TABLET (<i>paliperidone er</i>)	T3	ST
LATUDA 120 MG TABLET	T2	
LATUDA 20 MG TABLET	T2	
LATUDA 40 MG TABLET	T2	QL (1 tab/day)
LATUDA 60 MG TABLET	T2	QL (1 tab/day)
LATUDA 80 MG TABLET	T2	
<i>lurasidone hcl tablet</i>	T1	QL(1 tab/day)
LYBALVI	T3	QL(1 tab/day)
<i>olanzapine</i> (Zyprexa)	T1	
<i>paliperidone er 1.5 mg tablet</i>	T1	
<i>paliperidone er 3 mg tablet</i> (Invega)	T1	QL (1 tab/day)
<i>paliperidone er 9 mg tablet</i> (Invega)	T1	
<i>quetiapine fumarate</i> (Seroquel Xr)	T1	
<i>quetiapine fumarate</i> (Seroquel)	T1	
<i>risperidone</i>	T1	
<i>risperidone</i> (Risperdal)	T1	

T1 – Typically Generics

PA – Prior Authorization

AGE – Age Requirement

PPACA – No Cost-Share Preventive Medication

T2 – Typically Preferred Brands

QL – Quantity Limit

SP – Specialty Medication

CSL – Oral cancer medication subject to cost-share limits

T3 – Typically Non-Preferred Brands

ST – Step Therapy

HD – May require home delivery pharmacy

List of Prescription Medications

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

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ANTI-PSYCHOTIC, ATYPICAL, DOPAMINE, SEROTONIN ANTAGONIST (cont.)		
SAPHRIS (<i>asenapine maleate</i>)	T3	ST
SECUADO	T3	ST
SEROQUEL (<i>quetiapine fumarate</i>)	T3	ST
SEROQUEL XR (<i>quetiapine fumarate er</i>)	T3	ST
ziprasidone hcl	T1	
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	
VRAYLAR 6 MG CAPSULE	T3	
ANTIPSYCHOTICS, ATYP, D2 PARTIAL AGONIST/5HT MIXED		
aripiprazole	T1	
aripiprazole 1 mg/ml solution	T1	
aripiprazole 15 mg tablet	T1	
aripiprazole 2 mg tablet	T1	
aripiprazole 20 mg tablet	T1	
aripiprazole 30 mg tablet	T1	
aripiprazole 5 mg tablet	T1	QL (1 tab/day)
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	
REXULTI 4 MG TABLET	T3	
ANTI-PSYCHOTICS, DOPAMINE AND SEROTONIN ANTAGONISTS		
loxapine succinate	T1	
ANTI-PSYCHOTICS, DOPAMINE ANTAGONISTS, BUTYROPHENONES		
haloperidol	T1	
haloperidol lactate	T1	
ANTI-PSYCHOTICS, DOPAMINE ANTAGONIST, DIHYDROINDOLONES		
molindone hcl	T1	

T1 – Typically Generics

PA – Prior Authorization

AGE – Age Requirement

PPACA – No Cost-Share Preventive Medication

T2 – Typically Preferred Brands

QL – Quantity Limit

SP – Specialty Medication

CSL – Oral cancer medication subject to cost-share limits

T3 – Typically Non-Preferred Brands

ST – Step Therapy

HD – May require home delivery pharmacy

List of Prescription Medications

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

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ANTI-PSYCHOTICS, PHENOTHIAZINES		
<i>chlorpromazine hcl</i>	T1	
<i>fluphenazine hcl</i>	T1	
<i>perphenazine</i>	T1	
<i>thioridazine hcl</i>	T1	
<i>trifluoperazine hcl</i>	T1	
SSRI-ANTI-PSYCH, ATYPICAL, DOPAMINE, SEROTONIN ANTAG		
<i>olanzapine/fluoxetine hcl</i>	T1	
<i>olanzapine/fluoxetine hcl</i> (Symbyax)	T1	
PSYCHOTHERAPEUTIC DRUGS (Sleep Disorders/Sedatives)		
NARCOLEPSY AND SLEEP DISORDER THERAPY AGENTS		
<i>armodafinil</i>	T1	PA
<i>modafinil</i> (Provigil)	T1	PA
SUNOSI	T2	PA QL (1 tab/day)
ANTI-NARCOLEPSY, ANTI-CATAPLEXY, SEDATIVE-TYPE AGENT		
LUMRYZ	T3	PA QL (30 pkts/30 days) SP
LUMRYZ STARTER PACK	T3	PA SP HD
XYWAV	T3	PA SP HD
BARBITURATES		
<i>phenobarbital</i>	T1	
<i>secobarbital sodium</i>	T3	PA
HYPNOTICS, MELATONIN MT1/MT2 RECEPTOR AGONISTS		
HETLIOZ	T3	PA SP HD
HETLIOZ LQ	T3	PA SP HD
<i>ramelteon 8 mg tablet</i> (Rozerem)	T1	QL (1 tab/day)
<i>tasimelteon</i>	T1	PA SP HD
SEDATIVE-HYPNOTICS - BENZODIAZEPINES		
DORAL	T3	
<i>estazolam</i>	T1	
<i>flurazepam hcl</i>	T1	
HALCION (<i>triazolam</i>)	T3	
<i>midazolam hcl</i>	T1	
QUAZEPAM	T1	
<i>quazepam</i> (Quazepam)	T1	
<i>temazepam</i>	T1	

T1 – Typically Generics

PA – Prior Authorization

AGE – Age Requirement

PPACA – No Cost-Share Preventive Medication

T2 – Typically Preferred Brands

QL – Quantity Limit

SP – Specialty Medication

CSL – Oral cancer medication subject to cost-share limits

T3 – Typically Non-Preferred Brands

ST – Step Therapy

HD – May require home delivery pharmacy

List of Prescription Medications

PSYCHOTHERAPEUTIC DRUGS (Sleep Disorders/Sedatives) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
SEDATIVE-HYPNOTICS - BENZODIAZEPINES (cont.)		
<i>triazolam</i>	T1	
<i>triazolam</i> (Halcion)	T1	
SEDATIVE-HYPNOTICS, NON-BARBITURATE		
DAYVIGO	T2	QL (1 tab/day) ST
<i>doxepin hcl 3 mg tablet</i> (Silenor)	T1	QL (1 tab/day)
<i>doxepin hcl 6 mg tablet</i> (Silenor)	T1	
<i>eszopiclone</i> (Lunesta)	T1	
SILENOR 6 MG TABLET (<i>doxepin hcl</i>)	T3	ST
<i>zaleplon</i>	T1	
<i>zolpidem tart er 12.5 mg tab</i>	T1	
<i>zolpidem tart er 6.25 mg tab</i>	T1	QL (1 tab/day)
<i>zolpidem tartrate</i>	T1	
ANTI-NARCOLEPSY, ANTI-CATAPLEXY, SEDATIVE-TYPE AGENT		
SODIUM OXYBATE 0.5 G/ML SOLN	T3	PA QL(18 mls/day) SP HD
SKIN PREPS (Miscellaneous)		
IRRIGANTS		
<i>acetic acid</i>	T1	
<i>neomycin sulf/polymyxin b sulf</i>	T1	
PHYSIOLYTE	T3	
PHYSIOSOL	T3	
<i>ringer's solution</i>	T1	
<i>ringer's solution, lactated</i>	T1	
<i>sod, pot chlor/mag/sod, pot phos</i>	T3	
<i>sodium chloride irrig solution</i>	T1	
SORBITOL	T1	
SORBITOL-MANNITOL	T1	
VASHE WOUND	T3	
VASHE WOUND THERAPY	T3	
<i>water for irrigation, sterile</i>	T1	
OXIDIZING AGENTS		
<i>hydrogen peroxide</i>	T1	

T1 – Typically Generics

PA – Prior Authorization

AGE – Age Requirement

PPACA – No Cost-Share Preventive Medication

T2 – Typically Preferred Brands

QL – Quantity Limit

SP – Specialty Medication

CSL – Oral cancer medication subject to cost-share limits

T3 – Typically Non-Preferred Brands

ST – Step Therapy

HD – May require home delivery pharmacy

List of Prescription Medications

SKIN PREPS (Pain Relief And Inflammatory Disease)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ANTI-PSORIATIC AGENTS, SYSTEMIC		
<i>acitretin</i>	T1	
BIMZELX	T3	PA QL(2 mls/28 days) SP HD
COSENTYX	T3	PA QL SP
ILUMYA	T3	PA QL (1 syringe/84 days) SP HD
SILIQ	T3	PA QL (2 syringes/15 days) SP
<i>methoxsalen</i> (Oxsoralen-ultra)	T1	
OXSORALEN-ULTRA (<i>methoxsalen</i>)	T3	
SKYRIZI (2 SYRINGES) KIT	T3	PA QL (1 kit/84 days) SP HD
SOTYKTU	T2	PA QL (1 tab/day) SP
TALTZ AUTOINJECTOR	T3	PA QL (1 injector/28 days) SP HD
TALTZ AUTOINJECTOR (2 PACK)	T3	PA QL (1 injector/28 days) SP HD
TALTZ AUTOINJECTOR (3 PACK)	T3	PA QL (1 injector/28 days) SP HD
TALTZ SYRINGE	T3	PA QL (1 syringe/28 days) SP HD
TREMFYA 100 MG/ML PEN	T2	PA QL (1 ml/56 days) SP HD
TREMFYA 200 MG/2 ML PEN	T2	PA QL(2 syringe/28 days) SP HD
TREMFYA PEN INDUCTION PK-CROHN	T2	PA QL(2 syringe/28 days) SP HD
TOPICAL ANTI-INFLAMMATORY, NSAIDS		
DICLAREAL	T3	HD
<i>diclofenac sodium 1% gel</i> (Voltaren)	T1	QL (1000gm/30 days) HD
LICART	T2	PA QL (1 patch/day) HD
SKIN PREPS (Skin Conditions)		
ACNE AGENTS, SYSTEMIC		
ACUTANE	T1	
AMNESTEEM	T1	
CLARAVIS	T1	
clindamycin/tretinoin (Veltin)	T3	
<i>isotretinoin</i> (Absorica)	T1	
MYORISAN	T1	
ZENATANE	T1	
ACNE AGENTS, TOPICAL		
ACZONE 7.5% GEL PUMP	T3	
<i>adapalene/benzoyl peroxide</i>	T1	
<i>clindamycin phos/benzoyl perox</i>	T1	
<i>clindamycin/tretinoin</i>	T1	

T1 – Typically Generics

PA – Prior Authorization

AGE – Age Requirement

PPACA – No Cost-Share Preventive Medication

T2 – Typically Preferred Brands

QL – Quantity Limit

SP – Specialty Medication

CSL – Oral cancer medication subject to cost-share limits

T3 – Typically Non-Preferred Brands

ST – Step Therapy

HD – May require home delivery pharmacy

List of Prescription Medications

SKIN PREPS (Skin Conditions) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ACNE AGENTS, TOPICAL		
<i>dapsone 5% gel</i> (Aczone)	T1	
KLARON (<i>sulfacetamide sodium</i>)	T3	
ONEXTON (<i>clindamycin phos/benzoyl perox</i>)	T3	
<i>sulfacetamide sodium</i> (Klaron)	T1	
ANTI-PERSPIRANTS		
DRYSOL	T2	
ANTI-PRURITICS, TOPICAL		
ALEVICYN PLUS	T3	
ANTI-PSORIATICS AGENTS		
<i>anthralin</i>	T1	
DOVONEX (<i>calcipotriene</i>)	T3	
<i>tazarotene 0.05% cream</i>	T1	
<i>tazarotene 0.05% gel</i> (Tazorac)	T1	
ANTI-SEBORRHEIC AGENTS		
<i>tazarotene</i>	T1	
VECTICAL (<i>calcitriol</i>)	T3	QL (800gm/30 days)
OVACE PLUS	T3	
<i>selenium sulfide</i>	T1	
<i>sulfacetamide sodium</i>	T1	
TERSI FOAM	T3	
ANTISEPTICS, MISCELLANEOUS		
GUAIACOL	T1	
DIABETIC ULCER PREPARATIONS, TOPICAL		
REGRANEX	T3	PA QL (2 tubs/30 days)
EMOLLIENTS		
ATOPICLAIR	T3	
<i>emollient combination no.35</i> (Mimyx)	T1	
<i>emollient combination no.60</i> (Restizan)	T1	
HALUCORT	T3	
MIMYX (<i>prumyx</i>)	T3	
RESTIZAN	T1	
<i>vite ac/grape/hyaluronic acid</i> (Atopiclair)	T1	
XCLAIR	T3	
IMMUNOMODULATORS		
<i>imiquimod</i>	T1	

T1 – Typically Generics

PA – Prior Authorization

AGE – Age Requirement

PPACA – No Cost-Share Preventive Medication

T2 – Typically Preferred Brands

QL – Quantity Limit

SP – Specialty Medication

CSL – Oral cancer medication subject to cost-share limits

T3 – Typically Non-Preferred Brands

ST – Step Therapy

HD – May require home delivery pharmacy

List of Prescription Medications

SKIN PREPS (Skin Conditions) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
IRRITANTS/COUNTER-IRRITANTS		
<i>methyl salicylate</i>	T1	
QUTENZA	T3	
KERATOLYTICS		
BENZEFOAM	T3	
BENZEPRO	T1	
<i>benzoyl peroxide</i>	T1	
<i>benzoyl peroxide</i> (Enzoclear)	T1	
<i>benzoyl peroxide</i> (Pacnex)	T1	
ENZOCLEAR	T3	
HYDRO 35	T3	
HYDRO 40 (<i>umecta</i>)	T3	
INOVA	T3	
KERAFOAM	T3	
KERALYT 6% GEL (<i>salicylic acid</i>)	T3	
<i>keralyt 6% shampoo</i>	T1	
KERALYT SCALP	T3	
KERALYT SCALP (<i>salicylic acid</i>)	T3	
PACNEX (<i>benzoyl peroxide</i>)	T3	
PODOCON-25	T1	
<i>podofilox</i>	T1	
PR BENZOYL PEROXIDE	T1	
<i>salicylic acid</i>	T1	
<i>salicylic acid</i>	T3	
<i>salicylic acid</i> (Keralyt Scalp)	T1	
<i>salicylic acid/ceramide comb 1</i>	T1	
SALIMEZ FORTE	T1	
SALKERA	T3	
SALVAX DUO PLUS	T3	
<i>silver nitrate</i>	T1	
<i>silver nitrate applicator</i>	T1	
URAMAXIN	T3	
URAMAXIN (<i>urea</i>)	T3	
<i>urea</i> (Hydro 35)	T1	
<i>urea</i> (Hydro 40)	T3	
<i>urea</i> (Uramaxin)	T1	

T1 – Typically Generics

PA – Prior Authorization

AGE – Age Requirement

PPACA – No Cost-Share Preventive Medication

T2 – Typically Preferred Brands

QL – Quantity Limit

SP – Specialty Medication

CSL – Oral cancer medication subject to cost-share limits

T3 – Typically Non-Preferred Brands

ST – Step Therapy

HD – May require home delivery pharmacy

List of Prescription Medications

SKIN PREPS (Skin Conditions) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
KERATOLYTICS		
<i>urea</i> (Xurea)	T1	
XUREA	T3	
PROTECTIVES		
RADIAPLEXRX	T3	
<i>zinc oxide</i>	T1	
ROSACEA AGENTS, TOPICAL		
<i>azelaic acid</i>	T1	
<i>ivermectin</i>	T1	
<i>metronidazole</i>	T1	
SOOLANTRA (<i>ivermectin</i>)	T3	
TISSUE/WOUND ADHESIVES		
ARTISS	T3	
SURGISEAL STYLUS	T3	
SURGISEAL TEARDROP	T3	
SURGISEAL TWIST	T3	
TISSEEL VHSD	T3	
TOP. ANTI-INFLAM., PHOSPHODIESTERASE-4 (PDE4) INHIB		
EUCRISA	T2	
ZORYVE 0.15% CREAM	T2	ST QL(60 gms/30 days)
TOPICAL AGENTS, MISCELLANEOUS		
GORDON'S UREA	T3	
L-MESITRAN SOFT	T3	
MEDIHONEY	T3	
SAF-CLENS AF	T1	
<i>trichloroacetic acid</i>	T3	
TRICHLOROACETIC ACID	T1	
TOPICAL ANTIBIOTIC PLEUROMUTILIN DERIVATIVES		
ALTABAX	T3	
TOPICAL ANTICHOLINERGIC HYPERHIDROSIS TX AGENTS		
QBREXZA	T3	PA
TOPICAL ANTI-INFLAMMATORY STEROIDAL		
ALA-SCALP (<i>scalacort</i>)	T3	ST
<i>alclometasone dipropionate</i>	T1	
<i>amcinonide</i>	T1	
AQUA GLYCOLIC HC	T3	
<i>betamethasone valerate</i>	T1	

T1 – Typically Preferred Brands

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

QL – Quantity Limit

ST – Step Therapy

SP – Specialty Medication

HD – May require home delivery pharmacy

PA – No cost share preventive medication

CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

SKIN PREPS (Skin Conditions) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
TOPICAL ANTI-INFLAMMATORY STEROIDAL (cont.)		
<i>betamethasone valerate</i> (Luxiq)	T1	
<i>betamethasone/propylene glyc</i>	T1	
<i>betamethasone/propylene glyc</i> (Diprolene)	T1	
BRYHALI	T3	ST
CAPEX SHAMPOO	T3	ST
<i>clobetasol propionate</i>	T1	
<i>clobetasol propionate</i> (Temovate)	T1	
CLODAN 0.05% KIT	T3	ST
<i>clodan 0.05% shampoo</i>	T1	
CLODERM	T3	ST
DERMA-SMOOTHIE-FS (<i>fluocinolone acetonide</i>)	T3	ST
DERMATOP (<i>prednicarbate</i>)	T3	ST
DESONATE (<i>desonide</i>)	T3	ST
<i>desonide</i>	T1	
<i>desoximetasone</i> (Topicort)	T1	
DIPROLENE (<i>betamethasone diprop augmented</i>)	T3	ST
<i>fluocinolone acetonide</i>	T1	
<i>fluocinolone acetonide</i> (Derma-smoothe-fs)	T1	
<i>fluocinolone acetonide</i> (Synalar)	T1	
<i>fluocinolone/shower cap</i> (Derma-smoothe-fs)	T1	
<i>fluocinonide</i>	T1	
<i>fluocinonide/emollient base</i>	T1	
<i>fluticasone prop 0.005% oint</i>	T1	
<i>fluticasone prop 0.05% cream</i>	T1	
<i>fluticasone prop 0.05% lotion</i>	T1	
<i>fluticasone propionate</i>	T1	
<i>halcinonide 0.1% solution</i>	T1	
<i>halobetasol prop 0.05% foam</i>	T1	
<i>halobetasol prop 0.05% cream</i>	T1	
<i>halobetasol prop 0.05% ointmnt</i>	T1	

T1 – Typically Generics

PA – Prior Authorization

AGE – Age Requirement

PPACA – No Cost-Share Preventive Medication

T2 – Typically Preferred Brands

QL – Quantity Limit

SP – Specialty Medication

CSL – Oral cancer medication subject to cost-share limits

T3 – Typically Non-Preferred Brands

ST – Step Therapy

HD – May require home delivery pharmacy

List of Prescription Medications

SKIN PREPS (Skin Conditions) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
TOPICAL ANTI-INFLAMMATORY STEROIDAL (cont.)		
<i>hydrocortisone</i>	T1	
<i>hydrocortisone</i> (Ala-scalp)	T1	
<i>hydrocortisone butyrate</i>	T1	
<i>hydrocortisone valerate</i>	T1	
MOMETACURE	T3	
<i>mometasone furoate 0.1% cream</i>	T1	
<i>mometasone furoate 0.1% oint</i>	T1	
<i>mometasone furoate 0.1% soln</i>	T1	
NUCORT	T3	ST
<i>prednicarbate</i> (Dermatop)	T1	
SCALACORT DK	T3	ST
SYNALAR	T3	ST
SYNALAR (<i>fluocinolone acetonide</i>)	T3	ST
SYNALARTS	T3	ST
TEMOVATE (<i>clobetasol propionate</i>)	T3	ST
TEXACORT	T3	ST
TOPICORT (<i>desoximetasone</i>)	T3	ST
TOPICAL ANTI-INFLAMMATORY STEROID-LOCAL ANESTHETIC		
ANALPRAM HC	T3	
EPIFOAM	T3	
<i>hydrocortisone/pramoxine</i> (Pramosone)	T1	
<i>lidocaine/hydrocortisone ac</i>	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		
<i>lindane</i>	T1	

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

PA – Prior Authorization

QL – Quantity Limit

ST – Step Therapy

AGE – Age Requirement

SP – Specialty Medication

HD – May require home delivery pharmacy

PPACA – No Cost-Share Preventive Medication

CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

SKIN PREPS (Skin Conditions) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
TOPICAL PREPARATIONS, ANTIBACTERIALS		
<i>dermazene cream</i>	T1	
DERMAZENE CREAM PACKET	T3	
<i>hydrocortisone/iodoquinol</i>	T1	
<i>hydrocortisone/iodoquinol/aloe</i>	T1	
<i>iodine/potassium iodide</i>	T1	
<i>iodine/sodium iodide</i>	T1	
IODOFLEX	T3	
IODOSORB	T3	
<i>silver nitrate</i>	T1	
TOPICAL VIT D ANALOG/ANTI-INFLAMMATORY STEROID		
<i>calcipotriene/betamethasone</i>	T1	
TOPICAL/MUCOUS MEMBR./SUBCUT. ENZYMES		
SANTYL	T2	QL (60gm/30 days)
VITAMIN A DERIVATIVES		
<i>adapalene</i>	T1	PA
<i>adapalene (Plixda)</i>	T1	PA
PLIXDA	T1	PA
RETIN-A MICRO PUMP 0.08% GEL (<i>tretinoin microspheres</i>)	T3	PA
<i>tretinoin 0.01% gel</i>	T1	
<i>tretinoin 0.025% cream</i>	T1	PA
<i>tretinoin 0.025% gel</i>	T1	
<i>tretinoin 0.05% cream</i>	T1	PA
<i>tretinoin 0.05% gel</i>	T1	PA
<i>tretinoin 0.1% cream</i>	T1	PA
<i>tretinoin microspheres</i>	T1	PA
SMOKING DETERRENTS (Smoking Cessation)		
SMOKING DETERRENT AGENTS (GANGLIONIC STIM, OTHERS)		
NICOTROL	T2	PPACA
NICOTROL NS	T2	PPACA
SMOKING DETERRENT-NICOTINIC RECEPT.PARTIAL AGONIST		
CHANTIX	T2	
<i>varenicline</i>	T1	PPACA
SMOKING DETERRENTS, OTHER		
<i>bupropion hcl sr 150 mg tablet</i>	T1	PPACA

T1 – Typically Generics

PA – Prior Authorization

AGE – Age Requirement

PPACA – No Cost-Share Preventive Medication

T2 – Typically Preferred Brands

QL – Quantity Limit

SP – Specialty Medication

CSL – Oral cancer medication subject to cost-share limits

T3 – Typically Non-Preferred Brands

ST – Step Therapy

HD – May require home delivery pharmacy

List of Prescription Medications

THYROID PREPS (Hormonal Agents)			
Prescription Drug Name		Drug Tier	Coverage Requirements and Limits
ANTI-THYROID PREPARATIONS			
methimazole (Tapazole)		T1	HD
propylthiouracil		T1	HD
TAPAZOLE (methimazole)		T3	HD
THYROID HORMONES			
ARMOUR THYROID		T3	HD
CYTOMEL (liothyronine sodium)		T3	HD
LEVOTHYROXINE		T3	HD
levothyroxine sodium (Synthroid) (Cytomel)		T3	HD
SYNTHROID (unithroid)		T3	HD
thyroid, pork		T1	HD
thyroid, pork (Armour Thyroid) (Wp Thyroid)		T1	HD
THYROLAR-1/4		T2	HD
THYROLAR-1/2		T2	HD
THYROLAR-1		T2	HD
THYROLAR-2		T2	HD
THYROLAR-3		T2	HD
TIROSINT		T3	HD
TIROSINT-SOL		T3	HD
WP THYROID (nature-throid)		T1	HD
WP THYROID (westhroid)		T1	HD
UNCLASSIFIED DRUG PRODUCTS (AIDS/HIV)			
CYTOCHROME P450 INHIBITORS			
TYBOST		T3	SP
UNCLASSIFIED DRUG PRODUCTS (Asthma/COPD/Respiratory)			
CYSTIC FIBROSIS-CFTR POTENTIATOR-CORRECTOR COMBIN.			
ALYFTREK 10-50-125 MG TABLET		T3	PA QL (2 tabs/day) SP HD
ALYFTREK 4-20-50 MG TABLET		T3	PA QL (3 tabs/day) SP HD
BRONCHITOL 40 MG INHALE CAP		T3	PA SP HD
ORKAMBI 100 MG-125 MG TABLET		T3	PA QL (4 tabs/day) SP HD
ORKAMBI 100-125 MG GRANULE PKT		T3	PA QL (2 packs/day) SP HD
ORKAMBI 150-188 MG GRANULE PKT		T3	PA QL (2 packs/day) SP HD
ORKAMBI 200 MG-125 MG TABLET		T3	PA QL (4 tabs/day) SP HD
SYMDEKO		T3	PA QL (2 tabs/day) SP HD
TRIKAFTA		T3	PA QL (3 tabs/day) SP HD
T1 – Typically Generics	PA – Prior Authorization	AGE – Age Requirement	PPACA – No Cost-Share Preventive Medication
T2 – Typically Preferred Brands	QL – Quantity Limit	SP – Specialty Medication	CSL – Oral cancer medication subject to cost-share limits
T3 – Typically Non-Preferred Brands	ST – Step Therapy	HD – May require home delivery pharmacy	

List of Prescription Medications

UNCLASSIFIED DRUG PRODUCTS (Asthma/COPD/Respiratory)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
CYSTIC FIB-TRANSMEMB CONDUCT.REG.(CFTR) POTENTIATOR		
KALYDECO 150 MG TABLET	T3	PA QL (2 tabs/day) SP HD
KALYDECO 25 MG GRANULES PACKET	T3	PA QL (2 packs/day) SP HD
KALYDECO 50 MG GRANULES PACKET	T3	PA QL (2 packs/day) SP HD
KALYDECO 75 MG GRANULES PACKET	T3	PA QL (2 packs/day) SP HD
LUNG SURFACTANTS		
CUROSURF	T3	
INFASURF	T3	
SURVANTA	T3	
MUCOLYTICS		
PULMOZYME	T2	PA SP HD
PULMONARY FIBROSIS - SYSTEMIC ENZYME INHIBITORS		
OFEV	T2	PA SP HD
SYSTEMIC ENZYME INHIBITORS		
JOENJA	T3	PA QL (2 tabs/day) SP
VIJOICE 50 MG GRANULE PACKET	T3	PA SP HD
VIJOICE 125mg,50mg	T3	PA QL (30tabs/30days) SP
VIJOICE 250mg	T3	PA QL (2 tabs/30 days) SP
ZOKINVY	T3	PA QL (4 caps/day) SP
UNCLASSIFIED DRUG PRODUCTS (Blood Modifiers/Bleeding Disorders)		
SPLEEN TYROSINE KINASE INHIBITORS		
TAVALISSE	T2	PA SP
UNCLASSIFIED DRUG PRODUCTS (Blood Pressure/Heart Medications)		
BRADYKININ B2 RECEPTOR ANTAGONISTS		
<i>icatibant acetate</i>	T3	PA SP HD
CI ESTERASE INHIBITORS		
BERINERT	T3	PA SP HD
CINRYZE	T3	PA SP HD
HAEGARDA	T3	PA SP HD
RUCONEST	T3	PA SP HD
PLASMA KALLIKREIN INHIBITORS		
KALBITOR	T3	PA SP HD
ORLADEYO	T3	PA QL (1 caps/day) SP

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

PA – Prior Authorization

QL – Quantity Limit

ST – Step Therapy

AGE – Age Requirement

SP – Specialty Medication

HD – May require home delivery pharmacy

PPACA – No Cost-Share Preventive Medication

CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

UNCLASSIFIED DRUG PRODUCTS (Cancer)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
CHEMOTHERAPY RESCUE/ANTIDOTE AGENTS		
<i>leucovorin calcium</i>	T1	
<i>mesna</i> (Mesnex)	T1	SP CSL
MESNEX (<i>mesna</i>)	T3	SP
VISTOGARD	T3	SP

UNCLASSIFIED DRUG PRODUCTS (Dental Products)

DENTAL AIDS AND PREPARATIONS		
<i>chlorhexidine gluconate</i> (Peridex)	T1	
PERIDEX (<i>periogard</i>)	T1	
<i>triamcinolone acetonide</i>	T1	
PERIODONTAL COLLAGENASE INHIBITORS		
<i>doxycycline hyclate</i>	T1	

UNCLASSIFIED DRUG PRODUCTS (Erectile Dysfunction)

DRUGS TO TREAT ERECTILE DYSFUNCTION (ED)		
<i>avanafil</i> (Stendra)	T1	QL(8 tabs/30 days)
CAVERJECT	T3	PA QL (6 injectors/30 days)
CIALIS 10 MG TABLET (<i>tadalafil</i>)	T3	QL (6 tabs/30 days) ST HD
CIALIS 20 MG TABLET (<i>tadalafil</i>)	T3	QL (6 tabs/30 days) ST HD
CIALIS 5 MG TABLET (<i>tadalafil</i>)	T3	QL (8 tabs/30 days) ST HD
EDEX	T3	PA QL (6 injectors/30 days)
IFE-BIMIX 30/1	T2	
IFE-PG20	T2	
LEVITRA (<i>varafenafil hcl</i>)	T3	QL (10 tabs/30 days) ST
MUSE	T2	PA QL (6/30 days)
PAPAVERINE-PHENTOLMN-ALPROSTDIL	T1	
PHENTOLAMINE-ALPROSTADIL	T1	
<i>sildenafil 100 mg tablet</i> (Viagra)	T1	QL (10 tabs/30 days) HD
<i>sildenafil 25 mg tablet</i> (Viagra)	T1	QL (6 tabs/30 days) HD
<i>sildenafil 50 mg tablet</i> (Viagra)	T1	QL (6 tabs/30 days) HD
STENDRA (<i>avanafil</i>)	T3	QL (8 tabs/30 days) ST
<i>tadalafil 2.5 mg tablet</i>	T1	QL(1 tab/day)
<i>tadalafil 5 mg tablet</i> (Cialis)	T1	QL (8 tabs/30 days) HD
<i>tadalafil 10 mg tablet</i> (Cialis)	T1	QL (8 tabs/30 days) HD
<i>tadalafil 20 mg tablet</i> (Cialis)	T1	PA QL (8 tabs/30 days) HD

T1 – Typically Generics

PA – Prior Authorization

AGE – Age Requirement

PPACA – No Cost-Share Preventive Medication

T2 – Typically Preferred Brands

QL – Quantity Limit

SP – Specialty Medication

CSL – Oral cancer medication subject to cost-share limits

T3 – Typically Non-Preferred Brands

ST – Step Therapy

HD – May require home delivery pharmacy

List of Prescription Medications

UNCLASSIFIED DRUG PRODUCTS (Erectile Dysfunction) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
DRUGS TO TREAT ERECTILE DYSFUNCTION (ED) (cont.)		
<i>varденаfil hcl</i> (Levitra)	T1	QL (10 tabs/30 days)
VIAGRA (<i>sildenafil citrate</i>)	T3	QL (8 tabs/30 days) ST
UNCLASSIFIED DRUG PRODUCTS (Eye Dysfunction)		
ORAL MUCOSITIS/STOMATITIS AGENTS		
GELCLAIR	T3	
TYRVAYA	T2	QL(8.4 mls/30 days)
UNCLASSIFIED DRUG PRODUCTS (Gastrointestinal/Heartburn)		
ORAL MUCOSITIS/STOMATITIS AGENTS		
ORAMAGICRX	T3	
SALIVA STIMULANT AGENTS		
NUMOISYN	T3	
THYROID HORMONE RECEPTOR (THR) AGONIST		
REZDIFFRA	T3	PA QL(1 tab/day) SP HD
UNCLASSIFIED DRUG PRODUCTS (Hormonal Agents)		
BONE FORMATION STIM. AGENTS - PARATHYROID HORMONE		
<i>teriparatide 600 mcg/2.4ml pen</i> (Forteo)	T1	PA QL(0.09 mls/day) SP HD
GROWTH HORMONE RECEPTOR ANTAGONISTS		
SOMAVERT	T3	PA SP HD
HYPERPARATHYROID TX AGENTS - VITAMIN D ANALOG-TYPE		
<i>doxercalciferol</i>	T1	
<i>paricalcitol</i> (Zemlar)	T1	SP HD
RAYALDEE	T3	
ZEMPLAR (<i>paricalcitol</i>)	T3	SP HD
MENOPAUSAL SYMPT SUPP-SEL ESTROGEN RECEP MODULATOR		
OSPHENA	T3	QL(30 tabs/30 days) HD
UNCLASSIFIED DRUG PRODUCTS (Miscellaneous)		
ABORTIFACIENT-PROGESTERONE RECEPTOR ANTAGONISTS		
MIFEPREX	T3	
<i>mifepristone</i> (Mifeprex)	T1	
AGENTS TO TX PERIODIC PARALYSIS - CARBON ANHYD INH		
<i>dichlorphenamide</i> (Keveyis)	T1	PA SP
AMMONIA INHIBITORS		
CARBAGLU (<i>carglumic acid</i>)	T3	SP HD
<i>carglumic acid</i> (Carbaglu)	T1	SP HD
PHEBURANE	T2	PA QL(8 Bottles/30 Days) SP HD

T1 – Typically Preferred Brands

T2 – Typically Non-Preferred Brands

T3 – Typically Non-Preferred Brands

QL – Quantity Limit

ST – Step Therapy

SP – Specialty Medication

HD – May require home delivery pharmacy

PA QL – Oral cancer medication subject to cost-share limits

CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

UNCLASSIFIED DRUG PRODUCTS (Miscellaneous)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
AMYLOIDOSIS AGENTS-TRANSTHYRETIN (TTR) SUPPRESSION		
TEGSEDI	T3	PA SP HD
ANTI-ALCOHOLIC PREPARATIONS		
<i>acamprosate calcium</i>	T1	
ANTABUSE (<i>disulfiram</i>)	T3	
<i>disulfiram</i> (Antabuse)	T1	
ANTIDOTES, MISCELLANEOUS		
CETYLEV	T3	
ANTI-FIBROTIC THERAPY - PYRIDONE ANALOGS		
<i>pirfenidone 267 mg capsule</i> (Esbriet)	T1	PA SP HD
<i>pirfenidone 801 mg tablet</i> (Esbriet)	T1	PA SP HD
CRYOPRESERVATIVE AGENTS		
<i>dimethyl sulfoxide</i>	T1	
DRUGS TO TREAT HEREDITARY TYROSINEMIA		
<i>nitisinone</i> (Orfadin)	T1	PA SP HD
NITYR	T2	PA SP
ORFADIN (<i>nitisinone</i>)	T3	PA SP
GENERAL INHALATION AGENTS		
HYPER-SAL	T3	
<i>nebusal 3% vial</i>	T1	
NEBUSAL 6% VIAL	T3	
<i>sodium chloride 0.9% inhal vl</i>		
<i>sodium chloride 10% vial</i>		
<i>sodium chloride 3% vial</i>		
<i>sodium chloride 7% vial</i>		
<i>sodium chloride for inhalation</i>	T1	
<i>sodium chloride for inhalation</i> (Hyper-sal)	T1	
GENETIC D/O TX - SMN PROTEIN DEFICIENCY TREATMENT		
EVRYSDI 5 MG TABLET	T3	PA SP HD
EVRYSDI 60 MG/80 ML(0.75MG/ML)	T3	PA SP HD
GLUCOSYLCERAMIDE SYNTHASE (GCS) INHIBITOR		
CERDELGA	T2	PA SP HD
<i>miglustat</i> (Zavesca)	T1	PA SP HD
OPFOLDA	T3	PA QL(8 caps/30 days) SP HD
INTERLEUKIN-I3 (IL-I3) INHIBITORS, MAB		
ADBRY	T3	PA SP HD
EBGLYSS	T2	PA SP

T1 – Typically Generics

PA – Prior Authorization

AGE – Age Requirement

PPACA – No Cost-Share Preventive Medication

T2 – Typically Preferred Brands

QL – Quantity Limit

SP – Specialty Medication

CSL – Oral cancer medication subject to cost-share limits

T3 – Typically Non-Preferred Brands

ST – Step Therapy

HD – May require home delivery pharmacy

List of Prescription Medications

UNCLASSIFIED DRUG PRODUCTS (Miscellaneous) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
MENOPAUSAL SYMPTOMS SUPPRESSANT-RECEPTOR ANTAG		
VEOZAH	T3	QL(1 tab/day)
MENOPAUSAL SYMPTOMS SUPPRESSANT - SSRIs		
<i>paroxetine mesylate</i>	T1	QL (1 cap/day) HD
METABOLIC DISEASE ENZYME REPLACE, HYPOPHOSPHATASIA		
STRENSIQ	T3	PA SP
METABOLIC DISEASE ENZYME REPLACEMENT, MOCD		
NULIBRY	T3	PA SP
METALLIC POISON, AGENTS TO TREAT		
CHEMET	T3	
<i>deferasirox</i> (Exjade)	T1	SP HD
<i>deferasirox</i> (Jadenu) (Jadenu Sprinkle)	T1	SP HD
<i>deferiprone</i> (Ferriprox)	T1	PA SP
EXJADE (<i>deferasirox</i>)	T3	PA SP HD
FERRIPROX	T3	PA SP
FERRIPROX (2 TIMES A DAY)	T3	PA SP
GALZIN	T3	SP
RADIOGARDASE	T3	
<i>trientine hcl</i>	T1	PA SP HD
TRIENTINE HCL	T3	PA SP HD
NATRIURETIC PEPTIDES		
VOXZOGO	T3	PA SP HD
NEONATAL FC RECEPTOR (FCRN) INHIBITORS		
VYVGART HYTRULO	T3	PA SP HD
OINTMENT/CREAM BASES		
RADIAGEL	T1	
PHARMACOLOGICAL CHAPERONE-ALPHA-GALACTOSID.A STABZ		
GALAFOLD	T3	PA SP HD
PKU TX AGENT-COFACTOR OF PHENYLALANINE HYDROXYLASE		
<i>javygtor powder pkt</i>	T1	PA SP
<i>javygtor tablet</i>	T1	PA SP HD
PROTEIN STABILIZERS		
ATTRUBY	T3	
VYNDAMAX	T3	PA QL (1 cap/day) SP HD
VYNDAQEL	T3	PA QL (4 caps/day) SP HD
RETINOIC ACID RECEPTOR (RAR) AGONISTS		
SOHONOS	T3	PA SP

T1 – Typically Generics

PA – Prior Authorization

AGE – Age Requirement

PPACA – No Cost-Share Preventive Medication

T2 – Typically Preferred Brands

QL – Quantity Limit

SP – Specialty Medication

CSL – Oral cancer medication subject to cost-share limits

T3 – Typically Non-Preferred Brands

ST – Step Therapy

HD – May require home delivery pharmacy

List of Prescription Medications

UNCLASSIFIED DRUG PRODUCTS (Miscellaneous) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
SOLVENTS		
FT ISOPROPYL ALCOHOL 91%	T1	
FT ISOPROPYL RUB ALCOHOL 70%	T3	
<i>isopropyl alcohol</i>	T1	
MURI-LUBE MINERAL OIL	T1	
THYMIC STROMAL LYPHOPOIETIN (TSLP) INHIBITORS		
TEZSPIRE 210 MG/1.91 ML PEN	T3	PA QL (1 pen/28 days) SP HD
TEZSPIRE 210 MG/1.91 ML SYRING	T3	PA SP HD
TREATMENT OF HYPERPHAGIA IN PRADER-WILLI SYNDROME		
VYKAT XR	T3	PA SP

UNCLASSIFIED DRUG PRODUCTS (Nutritional/Dietary)

METABOLIC DEFICIENCY AGENTS		
<i>betaine</i> (Cystadane)	T1	SP
CYSTADANE	T2	SP
<i>levocarnitine</i> (Carnitor Sf)	T1	
<i>levocarnitine</i> (Carnitor)	T1	
<i>levocarnitine</i> (with sugar) (Carnitor)	T1	

UNCLASSIFIED DRUG PRODUCTS (Osteoporosis Products)

BONE RESORPTION INHIBITOR AND VITAMIN D COMBS.		
FOSAMAX PLUS D	T3	ST HD
BONE RESORPTION INHIBITORS		
ACTONEL (<i>risedronate sodium</i>)	T3	ST HD
<i>alendronate sodium</i> (Fosamax)	T1	HD
ATELVIA (<i>risedronate sodium dr</i>)	T3	ST HD
BINOSTO	T3	ST HD
BONIVA (<i>ibandronate sodium</i>)	T3	ST HD
EVISTA (<i>raloxifene hcl</i>)	T3	HD
FOSAMAX (<i>alendronate sodium</i>)	T3	ST HD
<i>ibandronate sodium</i> (Boniva)	T1	HD
<i>raloxifene hcl</i> (Evista)	T1	HD PPACA
<i>risedronate sodium</i> (Actonel)	T1	HD
<i>risedronate sodium</i> (Atelvia)	T1	HD

UNCLASSIFIED DRUG PRODUCTS (Pain Relief And Inflammatory Disease)

ANTI-INFLAM. INTERLEUKIN-1 RECEPTOR ANTAGONIST		
ARCALYST	T3	PA SP HD

T1 – Typically Generics

PA – Prior Authorization

AGE – Age Requirement

PPACA – No Cost-Share Preventive Medication

T2 – Typically Preferred Brands

QL – Quantity Limit

SP – Specialty Medication

CSL – Oral cancer medication subject to cost-share limits

T3 – Typically Non-Preferred Brands

ST – Step Therapy

HD – May require home delivery pharmacy

List of Prescription Medications

UNCLASSIFIED DRUG PRODUCTS (Pain Relief And Inflammatory Disease)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ANTI-INFLAMMATORY, INTERLEUKIN-1 BETA BLOCKERS		
ILARIS	T3	PA SP HD
FIBROMYALGIA AGENTS, SEROTONIN-NOREPINEPH RU INHIB		
SAVELLA	T2	
IMMUNOMODULATOR, B-LYMPHOCYTE STIM (BLYS)-SPEC INHIB		
BENLYSTA	T3	PA SP HD
WOUND HEALING AGENTS, LOCAL		
FILSUEZ	T3	PA SP

UNCLASSIFIED DRUG PRODUCTS (Substance Abuse)

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

UNCLASSIFIED DRUG PRODUCTS (Transplant Medications)

RHO KINASE INHIBITOR		
REZUROCK	T3	PA SP HD

UNCLASSIFIED DRUG PRODUCTS (Urinary Tract Conditions)

BENIGN PROSTATIC HYPERTROPHY/MICTURITION AGENTS		
<i>alfuzosin hcl</i> (Uroxatral)	T1	HD
<i>dutasteride</i> (Avodart)	T1	HD
<i>finasteride</i> (Proscar)	T1	HD
PROSCAR (<i>finasteride</i>)	T3	HD
RAPAFLO 4 MG CAPSULE (<i>silodosin</i>)	T3	QL (1 cap/day) HD
RAPAFLO 8 MG CAPSULE (<i>silodosin</i>)	T3	HD
<i>silodosin 4 mg capsule</i> (Rapaflo)	T1	QL (1 cap/day) HD
<i>silodosin 8 mg capsule</i> (Rapaflo)	T1	HD
<i>tamsulosin hcl</i> (Flomax)	T1	HD
VANRAFIA	T2	PA QL (1 tab/day) SP
BPH 5-ALPHA-REDUCTASE INHIB-ALPHA1-ADRENOCEP ANTAG		
<i>dutasteride/tamsulosin hcl</i> (Jalyn)	T1	HD

T1 – Typically Generics

PA – Prior Authorization

AGE – Age Requirement

PPACA – No Cost-Share Preventive Medication

T2 – Typically Preferred Brands

QL – Quantity Limit

SP – Specialty Medication

CSL – Oral cancer medication subject to cost-share limits

T3 – Typically Non-Preferred Brands

ST – Step Therapy

HD – May require home delivery pharmacy

List of Prescription Medications

UNCLASSIFIED DRUG PRODUCTS (Urinary Tract Conditions) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
CYSTINE-DEPLETING AGENTS, NEPHROPATHIC CYSTINOSIS		
CYSTAGON	T2	SP
KIDNEY STONE AGENTS		
tiopronin	T1	SP
OVERACTIVE BLADDER AGENTS, BETA-3 ADRENERGIC RECEPTOR		
silodosin 4 mg capsule (Rapaflo)	T1	QL (1 cap/day) HD
silodosin 8 mg capsule (Rapaflo)	T1	HD
URINARY TRACT ANTI-SPASMODIC, M(3) SELECTIVE ANTAGONIST		
mirabegron er 25 mg tablet (Myrbetriq)	T1	QL (1 tab/day) HD
mirabegron er 50 mg tablet (Myrbetriq)	T1	HD
solifenacin 10 mg tablet	T1	HD
solifenacin 5 mg tablet	T1	QL (1 tab/day) HD
URINARY TRACT ANTI-SPASMODIC/ANTI-INCONTINENCE AGENT		
flavoxate hcl	T1	HD
oxybutynin	T1	HD
tolterodine tart er 2 mg cap	T1	QL (1 cap/day) HD
tolterodine tart er 4 mg cap	T1	HD
URINARY TRACT ANTI-SPASMODIC/ANTI-INCONTINENCE AGENT (cont.)		
tolterodine tartrate	T1	HD
trospium chloride	T1	HD
VITAMINS (Nutritional/Dietary)		
FOLIC ACID PREPARATIONS		
folic acid	T1	
true folic acid 1600mcg dfe tb	T1	
MULTIVITAMIN PREPARATIONS		
CITRANATAL MEDLEY	T3	
CONCEPT DHA CAPSULE	T3	
FOLET ONE	T2	
mvn no.53/iron/folic/dss/dha	T1	
OBSTETRIX ONE	T1	
VITAMIN B12 PREPARATIONS		
cyanocobalamin (vitamin b-12)	T1	
VITAMINS (Nutritional/Dietary)		

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

PA – Prior Authorization

QL – Quantity Limit

ST – Step Therapy

AGE – Age Requirement

SP – Specialty Medication

HD – May require home delivery pharmacy

PPACA – No Cost-Share Preventive Medication

CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
VITAMIN D PREPARATIONS		
<i>calcitriol 0.25 mcg capsule</i>	T1	
<i>calcitriol 0.5 mcg capsule</i>	T1	
<i>calcitriol 1 mcg/ml solution (Rocaltrol)</i>	T1	HD
<i>ergocalciferol (vitamin d2)</i>	T1	HD
ROCALTROL (<i>calcitriol</i>)	T3	HD
VITAMIN K PREPARATIONS		
MEPHYTON (<i>phytonadione</i>)	T3	

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

PA – Prior Authorization

QL – Quantity Limit

ST – Step Therapy

AGE – Age Requirement

SP – Specialty Medication

HD – May require home delivery pharmacy

PPACA – No Cost-Share Preventive Medication

CSL – Oral cancer medication subject to cost-share limits

Exclusions and limitations for coverage

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

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

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

Index of Medications

A

abacavir	58, 59	ADIPEX-P	54
abacavir/lamivudine/zidovudine	58	ADLARTY	62
abacavir sulfate/lamivudine	58	ADRENALIN	91
abiraterone	48	ADVAIR	28
ABRYVO	66	ADVANCED	88, 112
ACAM2000	66	ADVANCED DNA MEDICATED COLLECT	88
acamprosate	142	ADVOCATE	113
acarbose	42	ADZENYS	62
ACCOLATE	29	AEMCOLO	35
ACCU-CHEK	112	AEROCHAMBER	117
ACCUPRIL	73	AEROTRACH	117
ACCURETIC	71	AEROVENT	117
ACCUTANE	131	AFINITOR	50
ACD	37	AFLURIA	65
ACE	117	AGAMATRIX	110
acebutolol	75	AGRYLIN	57
ACETAMIN-CAFF-DIHYDROCODEINE	21	AIMOVIG	15, 19
acetamin-codein	20	AIRDUO	28
acetaminop-codeine	20	AIRDUO DIGIHALER	28
acetaminophen/caff/dihydrocod	21	AIRSUPRA	29
acetaminophen-cod	20	AJOVY	15, 19
acetazolamide	89	AKEEGA	53
acetic	45, 91, 130	AKTEN	92
acetic acid/oxyquinoline	45	AKYNZEO	97
acetylcysteine	29	ALA-SCALP	134
ACIPHEX	101	albendazole	46
acitretin	131	ALBENZA	46
ACTEMRA	109	albuterol	28
ACTHIB	65	ALBUTEROL	28
ACTIGALL	99	ALCAINE	92
ACTI-LANCE	112	alclometasone	134
ACTIMMUNE	54	ALCOHOL SWABSTICK	47
ACTIQ	21	ALDACTAZIDE	90
ACTIVELLA	103, 104	ALECENSA	51
ACTONEL	144	alendronate	144
ACTOPLUS	43	ALEVICYN	132
ACTOS	44	alfuzosin	145
acyclovir	60	ALHEMO	67
ACZONE	131	ALINIA	55
ADACEL	65	aliskiren	76
ADALAT	68	ALKERAN	48
ADALIMUMAB	47	allopurinol	25, 26
adapalene	131, 137	almotriptan	19
adapalene/benzoyl peroxide	131	almotriptan malate	15
ADBRY	142	ALORA	104
ADDERALL	62	alosectron	100
ADDYI	126	alprazolam	121
ADEMPAS	70	ALTABAX	134
		ALTAFLUOR	92

Index of Medications

ALTERNATE	113	ARCAPTA	28
ALTOPREV	78	arformoterol	27
ALTUVIIIIO	66	ARICEPT	62
ALUNBRIG	51	ARIDOL	88
ALYFTREK	138	ARIKAYCE	31
amantadine	56	ARIMIDEX	49
AMARYL	43	aripiprazole	128
ambrisentan	70	ARIXTRA	38
amcinonide	134	armodafinil	129
AMICAR	66	ARMOUR	138
amiloride	90	ARNUITY	29
aminocaproic	66	AROMASIN	49
amiodarone	67	ARTHROTEC	26
amitriptyline	124	ARTISS	134
amlodipine	68, 71, 72, 73, 77	ARYMO ER	21
amlodipine/valsartan/hcthiazid	72	asenapine	127, 128
AMNESTEEM	131	ASMANEX	29
amoxapine	124	aspirin/dipyridamole	57
amoxicillin	35, 45	ASSURE	112, 113, 120
amphetamine	62, 63	ASTAGRAF	109
AMPHETAMINE	62	ASTRINGYN	67
ampicillin	35	ATABEX	120
ANADROL	102	ATACAND	72, 74
anagrelide	57	atazanavir	59
ANA-LEX	102	ATELVIA	144
ANALPRAM	136	atenolol	75, 76
ANAPROX	26	atomoxetine	126
anastrozole	49	ATOPICLAIR	132
ANCOBON	40	atorvastatin	77, 78
ANDROGEL	103	atovaquone	46
ANGELIQ	105	atovaquone/proguanil	46
ANORO	28	ATRIPLA	59
ANTABUSE	142	atropine	93, 97, 99
anthralin	132	ATROVENT	27
ANTICOAG	37	ATTRUBY	143
ANZEMET	97	AURYXIA	95
APADAZ	21	AUSTEDO	80
APOKYN	56	AUTOLET	110
apraclonidine	92	AUTOSHIELD	112
aprepitant	97	AVALIDE	72
APRETUDE	59	avanafil	140
APRISO	99	AVANDIA	44
APTIVUS	58	avar	37
AQNEURSA	95	AVAR	37
AQUA GLYCOLIC	134	AVC	45
ARANESP	84	AVELOX	35
ARAVA	25	AVITENE	67
ARBLI	74	AVMAPKI	53
ARCALYST	145	AVONEX	80, 81

Index of Medications

AVSOLA	47
AYGESTIN	107
AYVAKIT	51
AZASAN	109
AZASITE	31
azathioprine	109
azelaic	134
azelastine	41, 90
azithromycin	34
AZOR	73
AZULFIDINE	99
B	
bacitracin	31
baclofen	119
BACTRIM	31
BACTROBAN	30
BAFIERTAM	81
balsalazide	99
BALVERSA	51
BAQSIMI	94
BASAGLAR	44
BAXDELA	35
BCG	65
BD	113, 117, 118, 119
BD NEEDLES	117
BELBUCA	21
BELVIQ	55
benazepril	71, 73, 74
benazepril/hydrochlorothiazide	71
BENICAR	74
BENLYSTA	145
benoxinate	92
BENZAMYCIN	36
BENZEFOAM	133
BENZEPRO	133
BENZHYDROCODONE-ACETAMINOPHEN	21
BENZNIDAZOLE	46
benzonatate	87
benzoyl peroxide	36, 37, 131, 133
BENZOYL PEROXIDE	133
benzphetamine	54, 55
benztropine	55
bepotastine	41
BERINERT	139
BESIVANCE	31
BETADINE	91
betaine	144
betamethasone	40, 134, 135, 137
BETASERON	81

betaxolol	75, 92
bethanechol	64
BETOPTIC	92
BEVYXXA	37
bexarotene	48
BEXSERO	64
bicalutamide	48
BIJUVA	103
BIKTARVY	60
BILTRICIDE	46
bimatoprost	92
BIMZELX	131
BINOSTO	144
bisac/nac1/nahco3/kcl/peg	100
bismuth	98
bisoprolol	75, 76
BLEPH-10	30
BLEPHAMIDE	30
BLOOD LANCETS	113
BONIVA	144
BONJESTA	97
BOOSTRIX	65
bosentan	70
BOSULIF	51
BREATHERITE	117
BREO ELLIPTA	29
BREZTRI	29
brimonidine	92
brinzolamide	92
BRIVIACT	82
bromfenac	91
bromocriptine	56
brompheniramine/pseudoephed/dm	87
BROMSITE	91
BRONCHITOL	138
BROVANA	28
BRUKINSA	51
BRYHALI	135
budesonide	29, 102, 105
budesonide 2 mg rectal foam	102
BULLSEYE	113
bumetanide	89
BUNAVAIL	145
buprenorphine	22, 145
bupropion	122, 137
BUPROPION	122
buspirone	121
butalb-acetamin-caff 50-300-40	15, 19
butalb-acetamin-caff 50-325-40	15, 19

Index of Medications

butalb/acetaminophen/caffeine	15, 19	carisoprodol	23, 120
butalb-aspirin-caffe	19	carisoprodol/aspirin/codeine	23
butalb-aspirin-caffe 50-325-40	15	CAROSPIR	90
butalbit/acetamin/caff/codeine	23	carteolol	92
butalbital/acetaminophen	15, 19	carvedilol	72
butalbital-asa-caffeine cap	19	CASODEX	48
butalbital-asa-caffeine cap (Fiorinal)	15	CATAPRES	75
butorphanol	22	CAVERJECT	140
BUTRANS	22	CAYA CONTOURED	87
BUTTERFLY	113	CAYSTON	33
BYDUREON	42	cefaclor	33
BYNFEZIA	107	cefadroxil	33
BYSTOLIC	75	cefdinir	33
C		cefixime	33
CABENUVA	58	cefepodoxime	33
cabergoline	106	cefprozil	33
CABLIVI	66	ceftriaxone	33
CABOMETYX	51	cefuroxime	33
CADUET	77	celecoxib	27
CAFERGOT	15, 19	CELONTIN	82
caffeine	19, 80	CENTANY	36
CALAN	68	cephalexin	33
calcipotriene	132, 137	CEQUA	93
calcitonin	108	CEQR	110
calcitriol	132, 147	CERDELGA	142
calcium	37, 59, 78, 95, 140, 142	CERVIDIL	106
CALQUENCE	51	cetirizine	41
CAMZYOS	68	CETROTIDE	106
candesartan	72, 74	CETYLEV	142
candesartan/hydrochlorothiazid	72	cevimeline	63
capecitabine	48, 49	CHANTIX	137
CAPEX	135	CHEMET	143
CAPLYTA	127	CHENODAL	99
CAPRELSA	51	chlordiazepoxide	96, 121, 124
captopril	71, 73	chlordiazepoxide/clidinium	96
CAPVAXIVE	65	chlorhexidine	140
CARBAGLU	141	chloroquine	46
carbamazepine	82, 83	chlorpromazine	129
CARBATROL	82	chlorpropamide	43
carbidopa	56, 57	chlorthalidone	76, 90
carbidopa/levodopa	56	chlorzoxazone	120
carbidopa/levodopa/entacapone	56	CHOLBAM	99
carbinoxamine	41	cholestyramine	78, 79
CARDURA	72	cholestyramine/aspartame	78
CAREONE	113	choline salicyl/mag salicylate	15, 19
CAREPOINT	117	CHORIONIC GONAD	108
CARESENS	110, 113	CHOSEN	110, 111, 113
CARETOUCH	110, 113	CIALIS	140
carglumic	141	ciclodan	40

Index of Medications

CICLODAN	40	COMBIVENT	28
ciclopirox	40	COMETRIQ	51
cilostazol	57	COMFORT	112, 113, 115, 116, 118
CIMDUO	58	COMFORTSEAL	117
cimetidine	100	COMIRNATY	64
CIMZIA	47	COMPACT SPACE CHAMBER	117
CINRYZE	139	COMPAZINE	97
CIPRO	35	CONCEPT	146
ciprofloxacin	30, 31, 35	CONCEPT DHA CAPSULE	146
citalopram	122	CONTRAVE	55
CITRANATAL	95, 120	COPIKTRA	51
CITRATE	22, 37	COREG	72
CLARAVIS	131	coremino	35, 36
CLARINEX	41	CORLANOR	69
CLARINEX-D	41	CORTENEMA	102
clarithromycin	34	cortisone	105
demastine	41	CORTISPORIN	30
CLEOCIN	33, 36	COSENTYX	131
CLEVER	117	COTELLIC	49
CLEVER CHEK LANCETS	113	CRENESSITY	106
CLIMARA	104	CRESEMBA	40
CLINDACIN	36	CRINONE	107, 108
clindamycin	33, 36, 37, 131	cromolyn	24, 29, 92
CLINPRO	94	crotamiton	55
clobazam	81, 82	CTEXLI	99
clobetasol	135, 136	CUROSURF	139
clodan	135	CUVPOSA	96
CLODAN	135	cyanocobalamin	146
CLODERM	135	cyclobenzaprine	120
clomiphene	108	CYCLOGYL	93
clomipramine	124	CYCLOMYDRIL	93
clonazepam	81, 82	cyclopentolate	93
clonidine	75, 125	cyclophosphamide	48
clopidogrel	57	CYCLOSERINE	33
clorazepate	121	CYCLOSET	42
clotrimazole	40	cyclosporine	109
clozapine	127	CYLTEZO	47
CLOZAPINE	127	cyproheptadine	41
COAGUCHEK	113	CYSTADANE	144
COARTEM	46	CYSTADROPS	93
codeine	20, 22, 23, 87	CYSTAGON	146
colchicine	25, 27	CYSTARAN	93
COLCHICINE	25	CYSTO-CONRAY	89
COLCRYS	25	CYSTOGRAFIN	89
colesevelam	79	CYTOMEL	138
COLESTID	79	CYTOTEC	98
colestipol	79	D	
COLOR LANCETS	113	dabigatran	39
COMBIPATCH	104	dalfampridine	81

Index of Medications

DALIRESP	29	DIASTAT	81
danazol	106	diatrizoate	89
DANTRIUM	120	diazepam	81, 82, 121
dantrolene	120	diazoxide	94
DANZITEN	51	DIBENZYLINE	63
dapsone	32, 132	dichlorphenamide	141
DAPTACEL	65	DICLAREAL	131
darunavir	58	diclofenac	20, 26, 91, 131
dasatinib	51	dicloxacillin	35
DAURISMO	49	dicyclomine	97
DAXBIA	33	diethylpropion	54
DAYPRO	26	DIFICID	34
DAYTRANA	125	diflunisal	15, 19
DAYVIGO	130	digoxin	69
deferasirox	143	dihydroergotamine	15, 19
deferiprone	143	DILANTIN	82
deflazacort	29, 105	DILATRATE	69
DELSTRIGO	59	DILAUDID	22
demeclocycline	36	diltiazem	68
DEMSEER	75	dimethyl	81, 142
DEPEN	24	DIOVAN	74
DEPO-ESTRADIOL	104	diphenoxylate	97
DEPO-PROVERA	85, 107	DIPHThERIA	65
DEPO-SUBQ PROVERA	85	DIPROLENE	135
DEPO-TESTOSTERONE	103	dipyridamole	57
DERMA	135	DISALCID	24
DERMATOP	135	disopyramide	67, 68
dermazene	137	disulfiram	142
DERMAZENE	137	DIURIL	90
DERMOTIC	91	divalproex	82
DESCOVY	58	DIVIGEL	104
desflurane	23	dofetilide	67, 68
desipramine	124	DOJOLVI	94
desloratadine	41	donepezil	62
desmopressin	103	DONNATAL	98
desog-e.estradiol/e.estradiol	85	DOPTLET	85
desogestrel-ethinyl	85	DORAL	129
DESONATE	135	dorzolamide	92
desonide	135	DOVATO	58
desoximetasone	135, 136	DOVONEX	132
desvenlafaxine	123	doxazosin	72
dexamethasone	30, 91, 105	doxepin	124, 125, 130
DEXCOM	110	doxercalciferol	141
dexlansoprazole	101	doxycycline	36, 140
dexmethylphenidate	125	doxylamine	97
dextroamp-amphet	63	dronabinol	97
dextroamph-amphet	63	DROPLET	113, 119
dextroamphetamine	62, 63	DROPSAFE	117
DIACOMIT	82	drosipir/eth estro/levomefol ca	86

Index of Medications

DROXIA	67	EMTRIVA	59
droxidopa	63	EMVERM	46
DRYSOL	132	enalapril	71, 74
DUAVEE	105	enalapril/hydrochlorothiazide	71
DUETACT	43	ENBREL	47
DULERA	29	ENDO-AVITENE	67
duloxetine	123	ENDOMETRIN	108
DUOPA	56	ENERGIX-B	66
DUPIXENT	108	ENHERTU	54
DURAGESIC	22	ENLITE	110
dutasteride	145, 146	enoxaparin	38, 39
DYANAVAL	63	ENSACOVE	51
DYAZIDE	90	ENSPRYNG	109
E		entacapone	56, 57
EASIVENT	117	ENTERO	88
EASY	110, 112, 113	ENTOCORT	105
EASY COMFORT	112, 113, 119	ENTRESTO	72
EASY TOUCH	110, 111, 113	ENVARUSUS	109
EBGLYSS	143	ENZOCLEAR	133
EC-NAPROSYN	26	EPCLUSA	61
econazole	40	EPIDIOLEX	82
ECOZA	40	EPIFOAM	136
EDARBI	74	epinastine	41
EDEX	140	epinephrine	62, 91
EDURANT	58	EPIVIR	61
efavirenz	58, 59, 60	eplerenone	90
effer-k	95	EPOGEN	84
EFFER-K	95	eprosartan	74
EFFIENT	57	EQUETRO	121
EFUDEX	54	ergocalciferol	147
EGRIFTA	105	ergoloid	77
ELESTRIN	104	ergotamine tartrate/caffeine	15, 19
eletriptan	19	ERIVEDGE	49
eletriptan hydrobromide	15	ERLEADA	48
ELIDEL	109	ERVEBO	66
ELIMITE	55	ERYPED	34
ELIQUIS	38	ery-tab dr	34
ELLA	86	ERY-TAB DR	34
ELMIRON	23	erythromycin	31, 34, 36, 37
EMBRACE	113	escitalopram	122
EMCYT	54	ESGIC	15
EMEND	97	eslicarbazepine	82
EMFLAZA	29	esomeprazole	101
EMGALITY	15, 19, 81	ESOMEPRAZOLE	101
emollient	132, 135	estazolam	129
Empaveli	66	ESTRACE	104, 107
EMSAM	122	estradiol	85, 86, 87, 104, 107
emtricitra	60	estrogen	103
emtricitabine	58, 59	ESTROSTEP	86

Index of Medications

eszopiclone	130	FENOPROFEN	26
ethambutol	32	FENSOLVI	106
ethinyl	85, 86, 104	fentanyl	21, 22
ethinyl estradiol/drospirenone	86	FENTANYL	22
ethosuximide	82, 84	FENTORA	22
ethynodiol	86	FERRIPROX	143
etodolac	26	FETZIMA	123
etonogestrel/ethinyl estradiol	85	FEXMID	120
etoposide	54	FIBRICOR	79
EUCRISA	134	FIFTY50	113
EURAX	55	FILSPARI	79
EVAMIST	104	FILSUEVZ	145
EVEKEO	63	finasteride	145
everolimus	50, 110	FINE	113
EVICEL	67	FINGERSTIX	113
EVISTA	144	FINTEPLA	83
EVOCLIN	37	FIORICET	15
EVOTAZ	59	FIORINAL	15, 19, 23
EVRYSDI	142, 156	FIRDAPSE	81
EXELON	62	FIRMAGON	50
exemestane	49	FLAREX	91
exenatide	42	flavoxate	146
EXFORGE	73	flecainide	68
EXJADE	143	FLEXICHAMBER	117
EXKIVITY	51	FLOVENT	29
EXODERM	40	FLUAD	65
EYSUVIS	91	FLUARIX	65
E-Z	88, 89, 117	FLUBLOK	65
EZ	113	FLUCELVAX	65
ezetimibe	77, 79	fluconazole	40
ezetimibe/simvastatin	77	flucytosine	40
F		fludrocortisone	106
FABHALTA	66	FLULAVAL	65
FACTIVE	35	FLUMADINE	60
famciclovir	60	FLUMIST	65
famotidine	100	flunisolide	90
FARESTON	54	fluocinolone	91, 135, 136
FARXIGA	42	fluocinonide	135
FARYDAK	48	fluorescein	88, 92
FASENRA	29	fluoride	94
febuxostat	25	FLUORIDEX	94
felbamate	82	fluorometholone	91
FELDENE	26	FLUOROPLEX	54
felodipine	68	fluorouracil	54
FEMCAP	87	fluoxetine	122, 123, 129
FEMHRT	104	fluphenazine	129
FEMRING	107	flurazepam	129
fenofibrate	79	flurbiprofen	26, 91
fenofibric	79	flutamide	48

Index of Medications

fluticasone	29, 90, 135	GELCLAIR	141
FLUTICASONE	29	GELFILM	92
fluvastatin	78	GELFOAM	67
fluvoxamine	122, 123	gemfibrozil	79
FLUZONE	65	GENOTROPIN	105
FOCALIN	125	gentamicin	31, 37
FOLET	146	GENVOYA	60
folic	120, 121, 146	GILENYA	81
FOLLISTIM	108	GILOTRIF	51
fondaparinux	38	glatiramer	81
FORA	111, 113	glatopa	81
FORACARE	113	GLEEVEC	51
formaldehyde	47	GLEOSTINE	48
formoterol	27, 29	glimepiride	43
FOSAMAX	144	GLIMEPIRIDE	43
fosamprenavir	59	glipizide	43
fosaprepitant	97, 98	GLIPIZIDE	43
fosfomycin	32	glucagon	94
fosinopril	71, 74	GLUCOCOM	111, 114
fosinopril/hydrochlorothiazide	71	GLUCOPHAGE	42
Fotivda	51	GLUCOTROL	43
FRAICHE	94	glyburide	43, 44
FREESTYLE	88, 110, 111, 114	GLYCATE	96
frovatriptan	19	glycine urologic solution	46
FRUZAQLA	51	glycopyrrolate	96, 97
FT ISOPROPYL ALCOHOL	144	GLYNASE	43
FT ISOPROPYL RUB ALCOHOL	144	GLYSET	42
ful-glo	88	GLYXAMBI	43
FUL-GLO	88	GOJJI	114
FULPHILA	85	GOMEKLI	49
FURADANTIN	34	GONAL	108
furosemide	89	GORDON'S	134
FUZEON	58	granisetron	98
FYCOMPA	83	GRANIX	85
G		GRASTEK	64
gabapentin	83	griseofulvin	40
GALAFOLD	143	GRIS-PEG	40
galantamine	62	GUAIACOL	132
GALZIN	143	guanfacine	75, 125
ganirelix acet	106	guanidine	63
GANIRELIX ACET	106	GUARDIAN	111
GARDASIL	66	GVOKE	94
GASTROGRAFIN	89	GYNAZOLE	39
GASTROMARK	89	H	
gatifloxacin	31	HAEGARDA	139
GATTEX	102	halcinonide	135
GAVRETO	51	HALCION	129
gefitinib	51	halobetasol	135
gelatin sponge	67	haloperidol	128

Index of Medications

HALUCORT	132	ILARIS	145
HARVONI	61	ILEVRO	91
HEALTHY	114	ILUMYA	131
HEMLIBRA	67	imatinib	51
HEMOPHILIA	67	IMBRUVICA	51
heparin	38	IMCIVREE	55
HEPARIN	38	imipramine	125
HEPLISAV	66	imiquimod	132
HEPSERA	61	IMKELDI	51
HETLIOZ	129	IMPAVIDO	46
HIBERIX	65	IMVEXXY	107
homatropine	93	INBRIJA	56
HUMALOG	44, 111	INCONTROL	114
HUMAPEN	111	INCRELEX	106
HUMIRA	47	INCRUSE ELLIPTA	27
HUMULIN	44, 45	indapamide	90
HYCAMTIN	50	INDERAL	75, 76
hydralazine	75	INDICLOR	89
HYDREA	48	indomethacin	26
HYDRO	133	INFANRIX	65
hydrochlorothiazide	71, 72, 73, 75, 76, 90	INFASURF	139
hydrocodone	21, 22, 23, 87, 88	INFLECTRA	47
HYDROCODONE	21, 88	INGREZZA	80
hydrocodone/acetaminophen	21	INJECT	114
HYDROCODONE-ACETAMINOPHEN	21	INLYTA	52
hydrocodone/ibuprofen	21	INNOPRAN	76
hydrocortisone	91, 102, 105, 136, 137	INOVA	133
hydrogen peroxide	130	INPEN	111
hydromorphone	22	INQOVI	48
hydroxychloroquine	46	INREBIC	52
hydroxyurea	48	INSPIRACHAMBER	117
hydroxyzine	41	INSPIRA	90
HYMPAVZI	67	INSULIN	42, 43, 44, 45, 106, 112, 118, 119
hyoscyamine	98	INSULIN ASPART	45
HYPER-SAL	142	INSULIN SYRINGE	112
HYSINGLA	22	INTELENCE	58
HYZAAR	72	INTRAROSA	102
I		INVACARE	114
ibandronate	144	INVEGA	127
IBRANCE	51	INVOKAMET	44
IBTROZI	51	iodine	95, 137
IBUDONE	21	IODOFLEX	137
ibuprofen	21, 26	IODOSORB	137
ibuprofen/oxycodone	21	IOPIDINE	92
icatibant	139	IPOL	64
icosapent	96	ipratropium	27, 28, 91
IDHIFA	53	irbesartan	72, 73, 74
IFE	140	irbesartan/hydrochlorothiazide	73
IHEALTH	111	IRESSA	52

Index of Medications

ISENTRESS	59	klor-con	95
isoflurane	24	Kloxxado	39
isomethept/dichlphn/acetaminop	19	KOSELUGO	49, 50
isomethepten/cafi/acetaminophen	19	K-PHOS	96
isoniazid	32	KRINTAFEL	46
isopropyl alcohol	144	K-TAB	95
ISOPTO	92	KYLEENA	87
isosorbide	69, 76	KYNAMRO	77
isotretinoin	131	KYNMOBI	56
isoxsuprine	77	L	
isradipine	68	LACRISERT	91
ITOVEBI	52	lactulose	96, 100
itraconazole	40	LAGEVRIO	62
ivabradine	69	lamivudine	58, 59, 61
ivermectin	46, 55, 134	lamivudine/zidovudine	58
IWILFIN	52	lamotrigine	83
IXCHIQ	66	LAMPIT	46
J		LANCETS	112, 113, 114, 115, 116
JAKAFI	49	lansoprazole	98, 101, 102
JANSSEN	64	lansoprazole/amoxiciln/clarith	98
JANUMET	43	lanthanum	95
JANUVIA	43	lapatinib	52, 53
JARDIANCE	42	LASTACRAFT	41
javygtor	143	latanoprost	92
JOENJA	139	LATUDA	127
JOURNAVX	19	LAZANDA	22
JULUCA	58	leflunomide	25
JYLAMVO	48	lenalidomide	50
JYNNEOS	66	LENVIMA	52
K		LEQSELVI	25
KADIAN	22	letrozole	49
KALBITOR	139	leucovorin	140
KALYDECO	139	LEUKERAN	48
KEFLEX	33	LEUKINE	85
KERAFOAM	133	leuprolide	50
keralyt	133	LEUPROLIDE	50
KERALYT	133	levabuterol	28
KERENDIA	90	LEVITRA	140
KESIMPTA	81	levobunolol	92
ketoconazole	40	levocarnitine	144
ketoprofen	26	levofloxacin	31, 35
ketorolac	20, 91	levonorgestrel	86
KEVZARA	109	levothyroxine	138
KINERET	25	LEVOTHYROXINE	138
KINRIX	65	LEVSIN	99
KISQALI	50, 52	LEVULAN	54
KITABIS	31	LEXIVA	59
KLARON	132	LIBERVANT	82
KLONOPIN	82	LICART	131

Index of Medications

lidocaine	24, 88, 102, 136	lubiprostone	100
LIDOCAINE	102	LUCEMYRA	145
lidocaine hcl	24	LULICONAZOLE	41
LIDODERM	24	Lumakras	49
LIKMEZ	32	LUMAKRAS	49
LILETTA	87	LUMRYZ	129
lindane	136	LUPANETA	106
linezolid	35	LUPKYNIS	110
LINZESS	100	LUPRON	50, 106
liothyronine	138	lurasidone	127
LIPOFEN	79	LUTRATE	50
LIQUID	22, 89	LYBALVI	127
lisinopril	71, 74	LYNPARZA	52
lisinopril/hydrochlorothiazide	71	LYRICA	83
lissamine	88	LYSODREN	54
LITE	114	LYSTEDA	66
LITEAIRE	117	LYTGOBI	52
LITE TOUCH	111, 114	LYTGOBI 12 MG DAILY DOSE PACK	52
LITETOUCH	117	LYUMJEV	45
LITFULO	25	M	
lithium	121	MACROBID	34
LITHOSTAT	96	mafenide	37
LIVALO	78	MAGELLAN	112
LIVTENCITY	60	MALARONE	46
L-MESITRAN SOFT	134	maprotiline	125
l-norgest	86	maraviroc	58
LOCORT	105	MARPLAN	121
LODINE	26	MATULANE	54
LOESTRIN	86	MAVENCLAD	81
lofexidine	145	MAVYRET	61
LOKELMA	95	MAYZENT	81
LOMAIRA	54	meclofenamate	26
LONHALA	27	MEDIHONEY	134
LONSURF	48	MEDISENSE	114
loperamide	97	MEDLANCE	114
LOPID	79	MEDROL	105
lopinavir/ritonavir	59	medroxyprogesterone	85, 107
LOPROX	40	mefenamic	20
lorazepam	121	mefloquine	46
LORBRENA	52	megestrol	54
LORTAB	21	MEKINIST	50
losartan	72, 73, 74	meloxicam	26
losartan/hydrochlorothiazide	73	mephalan	48
LOTENSIN	71, 74	memantine	79, 80
loteprednol	91	MENACTRA	64
LOTREL	71	MENEST	104
lovastatin	78	MENOPUR	108
LOVENOX	38, 39	MENOSTAR	104
loxapine	128	MENQUADFI	64

Index of Medications

MENVEO	64	midazolam	129
meperidine	22	midodrine	63
MEPHYTON	147	MIEBO	91
meprobamate	121	MIFEPREX	141
mercaptopurine	49	mifepristone	44, 141
mesalamine	99	miglitol	42
mesna	140	miglustat	142
MESNEX	140	millipred	105
metaproterenol	28	MILLIPRED	105
metaxalone	120	MIMYX	132
metformin	42, 43, 44	MINIMED	112
methamphetamine	63	MINIPRESS	72
methazolamide	89	MINITRAN	69
methenamine	32	MINIVELLE	104
methenamine hippurate	32	minocycline	36
methenam/m.blue/salicyl/hyoscy	32	minocycline er	36
methenam/sod phos/mblue/hyoscy	32	minoxidil	75
methimazole	138	mirabegron	146
METHITEST	103	MIRCERA	84
meth/meblue/sod phos/psal/hyos	32	MIRENA	87
methocarbamol	120	mirtazapine	121
methotrexate	49	misoprostol	26, 98
methoxsalen	131	MITIGARE	25
methscopolamine	99	MITOSOL	93
methyl	133	MIUDELLA	87
methyl dopa	75	M-M-R II VACCINE	65
methyl dopa/hydrochlorothiazide	75	MOBIC	26
methyl ergonovine	106	MOBILE	114
METHYLIN	125	modafinil	129
methylphenidate	125, 126	MODERNA	64
methylprednisolone	105	moexipril	74
methyltestosterone	103	molindone	128
metoclopramide	100	MOLNUPIRAVIR	62
metolazone	90	MOMETACURE	136
METOPIRONE	89	mometasone	90, 136
metoprolol	76	MONOJECT	112
METOPROLOL	76	MONOLET	114
metronidazole	32, 36, 134	MONSEL'S	67
metyrosine	75	montelukast	29
mexiletine	68	MORPHABOND	22
MEZPAROX	136	morphine	22
MIACALCIN	108	MOTOFEN	97
MICARDIS	73, 74	MOVANTIK	39
miconazole	39	MOXATAG	35
MICRO	114	MOXEZA	31
MICROCHAMBER	117	moxifloxacin	31, 35
MICROGESTIN	86	MRESVIA	66
MICROLET	114	MS CONTIN	22
MICROSPACER	117	MULPLETA	85

Index of Medications

MULTAQ	68	NEULUMEX	89
mupirocin	37	NEUPOGEN	85
MURI-LUBE	144	NEUPRO	56
MUSE	140	NEURONTIN	83
mv-mins no.73/iron fum/folic	95	nevirapine	59
mvn	146	NEXIUM	101
MYALEPT	108	NEXLETOL	77
mycophenolate	110	NEXLIZET	78
MYDAYIS	63, 125	NEXPLANON	85
MYDRIACYL	93	NGENLA	105
Myfembree	106	niacin	79
MYGLUCOHEALTH	114	NIASPAN	79
MYLERAN	48	nicardipine	68
MYORISAN	131	NICOTROL	137
MYTESI	97	nifedipine	68, 69
N		nilutamide	48
nabumetone	26	NINLARO	52
nadolol	76	nisoldipine	68, 69
naftifine	41	nitazoxanide	55
NAFTIN	41	nitisinone	142
NALFON	26	NITRO-DUR	69, 70
NALOCET	21	nitrofurantoin	34, 35
naloxone	23, 39, 145	nitroglycerin	70, 101
NALOXONE	39	NITROLINGUAL	70
naltrexone	39	NITROMIST	70
NAMENDA	80	NITROSTAT	70
NAMZARIC	80	NITYR	142
NANO	112	NIVESTYM	85
NAPROSYN	26, 27	nizatidine	100
naproxen	20, 26, 27	NOCTIVA	103
naratriptan	19	NORCO	21
NARCAN	39	NORDITROPIN	105
NATACYN	39	norelgestromin	87
nateglinide	43	noreth-ethinyl estradiol/iron	86
NAYZILAM	82	norethind-eth estrad	86, 104
NEBUPENT	46	norethind-eth estrad 1-0.02 mg	86
nebusal	142	norethindrone	86, 104, 107
NEBUSAL	142	norethindrone ac-eth estradiol	86, 104
NEEDLES	112, 117	norethin-ee	86
nefazodone	123	norethin-eth estrad	104
neomycin	30, 31, 130	norgestrel	86
neomycin/bacit/p-myx/hydrocort	30	NORLIQVA	69
neomycin/polymyxin b/dexametha	30	NORPACE	68
neomycin/polymyxin b/hydrocort	30	nortriptyline	125
neomycin sulf/bacitracin/poly	31	NOURIANZ	56
NEORAL	110	NOVA	114
NEO-SYNALAR	36	NOVAREL	108
NERLYNX	52	NOVAVAX	64
NEULASTA	85	NOVOPEN	111

Index of Medications

NUBEQA	48	ON CALL	114
NUCALA	29	ondansetron	98
NUCORT	136	ONETOUCH	111, 114
NUCYNTA	22	ONEXTON	132
NUEDEXTA	80	ONFI	82
NULEV	99	ON-THE-GO	114
NULIBRY	143	ONUREG	49
NULYTELY	100	OPDIVO	53
NUMOISYN	141	OPFOLDA	142
NUPLAZID	122	opium	22, 97
NURTEC	19	opium/belladonna alkaloids	22
NUVARING	85	OPSUMIT	70
NUZYRA	36	OPSYNVI	71
NYMALIZE	69	OPTICHAMBER	118
NYPOZI	85	OPVEE	39
nystatin	40, 41	ORACIT	96
NYVEPRIA	85	ORALAIR	64
O		ORAMAGICRX	141
OBREDON	88	ORAPRED	105
OBSTETRIX	120, 146	ORAVIG	40
OBTREX	120	ORENCIA	25
OCALIVA	100	ORENITRAM	70
octreotide	107	ORFADIN	142
ODACTRA	64	ORGOVYX	50
ODEFSEY	60	ORIAHNN	106
ODOMZO	49	ORILISSA	106
OFEV	139	ORKAMBI	138
ofloxacin	30, 31, 35	ORLADEYO	139
OGSIVEO	52	orphenadrine	120
OJEMDA	49	ORTHO	86, 94
OJJAARA	52	oseltamivir	60
olanzapine	127, 129	OSPHENA	141
olmesartan	72, 73, 74	OTEZLA	25
olmesartan/amlodipin/hcthiazid	72	OTOVEL	30
olmesartan-hctz	73	OVACE	132
olopatadine	41, 90	OVIDREL	108
OLPRUVA	96	oxandrolone	103
omega-3 acid	96	oxaprozin	26, 27
omeprazole	101	OXAPROZIN	27
OMNIPOD	111	OXAYDO	22
OMNIPOD 5 (GEN 5) KIT	111	oxazepam	121
OMNIPOD 5 (GEN 5) POD	111	oxcarbazepine	83
OMNIPOD CLASSIC (GEN 3) kit	111	OXERVATE	93
OMNIPOD CLASSIC (GEN 3) KIT	111	OXSORALEN	131
OMNIPOD CLASSIC (GEN 3) PODS	111	OXTELLAR	83
OMNIPOD CLASSIC (GEN 4) KIT	111	oxybutynin	146
OMNIPOD CLASSIC (GEN 4) PODS	111	oxycodone	21, 22
OMNITROPE	106	OXYCODONE	22
OMVOH	109	oxycodone hcl/acetaminophen	21

Index of Medications

oxymorphone	23	phendimetrazine	55
OZEMPIC	42	phenelzine	121
P		phenobarb/hyoscy/atropine/scop	99
pacerone	68	phenobarbital	99, 129
PACNEX	133	phenobarbital-belladonna	99
PAIN	24	PHENOBARBITAL-BELLADONNA	99
paliperidone	127	phenoxybenzamine	63
PALYNZIQ	64	phentermine	54, 55
PANCREAZE	101	PHENTOLAMINE	140
PANRETIN	54	phenylephrine	41, 92
pantoprazole	101, 102	phenylephrine hcl/prometh	41
PAPAVERINE	140	PHENYTEK	83
PARADIGM	112	phenytoin	82, 83
PARAGARD	87	PHESGO	50
paregoric	97	PHOSLYRA	95
PAREMYD	93	PHOSPHOLINE	92
paricalcitol	141	PHYSIOLYTE	130
paroxetine	123, 143	PHYSIOSOL	130
PASER	32	phytonadione	147
PATADAY	41	PICATO	54
PAZEO	41	PIFELTRO	59
pazopanib	52	pilocarpine	64, 92
pazopanib hcl	50	pimecrolimus	109
PCE	34	pimozide	126
PEDIARIX	66	pindolol	76
PEDVAXHIB	65	pioglitazone	43, 44
peg3350/sod sulf, bicarb	101	pioglitazone hcl/glimepiride	43
peg3350/sod sul/nacl/kcl/asb/c	100	pioglitazone hcl/metformin hcl	43
PEGANONE	83	PIP LANCET	114
PEGASYS	61	PIQRAY	52
PEGINTRON	61	pirfenidone	142
PEMAZYRE	52	piroxicam	26, 27
PENBRAYA	65	pitavastatin	78
penicillamine	24, 25	PLEGRIDY	81
penicillin v potassium	35	PLIXDA	137
PENTACEL	65	PNEUMOVAX	65
pentamidine	46	pnv	120
PENTASA	100	POCKET CHAMBER	118
pentazocine hcl/naloxone hcl	23	PODOCON	133
pentoxifylline	67	podofilox	133
PERFECT	112, 114	POLIBAR	89
PERFECT POINT	112	POMALYST	50
PERIDEX	140	posaconazole	40
perindopril	74	potassium	20, 35, 74, 94, 95, 96, 137
permethrin	55	POTASSIUM CL ER	95
perphenazine	124, 129	potassium iodide	95, 137
PFIZER	64	pramipexole	56
PHEBURANE	141	PRAMOSONE	136
phenazopyridine	24	prasugrel	57

Index of Medications

pravastatin	78	progesterone	107
praziquantel	46	PROGLYCEM	94
prazosin	72	PROGRAF	110
PRECISION	88, 117	PROLENSA	91
PRECISIONGLIDE	112	promethazine	41, 87, 98
PRECOSE	42	propafenone	68
prednicarbate	135, 136	propantheline	96
prednisolone	30, 91, 105	proparacaine	92
prednisone	105	propranolol	75, 76
pregabalin	83	propylthiouracil	138
PREGNYL	108	PROQUAD	65
PREMARIN	104, 107	PROSCAR	145
PREMPHASE	104	PROSTIN	106
PREMPRO	104	PROTONIX	102
prenatal	120, 121	PROTOPIC	109
PRENATAL	120	protriptyline	125
PREPIDIL	106	PROVERA	85, 107
PREPOPIK	101	PROVOCHOLINE	88
PRESSURE	92, 93, 115	PULMICORT	29
PRESTALIA	71	PULMOZYME	139
PRETOMANID	33	PURE	115
PREVACID	102	PURIXAN	49
PREVIDENT	94	PUSH	115
PREVNAR	65	pyrazinamide	32
PREVYMIS	60	pyridostigmine	62
PREZCOBIX	58	pyrimethamine	46
PREZISTA	58	Q	
PRIFTIN	33	QBREXZA	134
PRIOLOSEC	102	QINLOCK	52
primaquine	46	QMIIZ	27
PRIMAQUINE	46	QSYMIA	55
PRIMEAIRE	118	QUADRACEL	65
primidone	83	QUARTETTE	86
PRIMLEV	21	quazepam	129
PRIMSOL	32	QUAZEPAM	129
PRINIVIL	74	QUESTRAN	79
PRISMASOL	96	quetiapine	127, 128
PRISTIQ	123	QUILLICHEW	126
PRO	104, 112, 115, 116, 118	QUILLIVANT	126
probenecid	27	quinapril	71, 73, 74
PROCARDIA	69	quinapril/hydrochlorothiazide	71
PROCARE	118	quinidine	68
PROCHAMBER	118	quinine	46
prochlorperazine	97, 98	QUTENZA	133
PRO COMFORT	118	QVAR	29
PROCORT	102	R	
PROCRIT	84	rabeprazole	102
PROCTOFOAM	102	RADIAGEL	143
PRODIGY	115	RADIAPLEXRX	134

Index of Medications

RADICAVA	80	ribasphere	61
RADIOGARDASE	143	ribavirin	60, 61
RAGWITEK	64	RIDAURA	25
raloxifene	144	rifabutin	32
ramelteon	129	RIFAMATE	33
ramipril	74	rifampin	33
ranitidine	100	RIFATER	33
ranolazine	67	RIGHTEST	115
RAPAFLO	145	RILUTEK	80
RAPLIXA	67	riluzole	80
rasagiline	56	rimantadine	60
RASUVO	25	RIMSO	23
RAVICTI	96	ringer's	130
RAYALDEE	141	RINVOQ	25
RAZADYNE	62	RIOMET	42, 43
READI-CAT	89	risedronate	144
READYLANCE	115	risperidone	127
REBIF	81	RITALIN	126
RECOMBIVAX	66	RITEFLO	118
RECOTHROM	67	ritonavir	59
RECTIV	101	rivaroxaban	38
REGIMEX	55	rivastigmine	62
REGLAN	100	rizatriptan	19
REGRANEX	132	ROBAXIN	120
RELAGARD	45	ROBINUL	97
RELENZA	60	ROCALTROL	147
RELIAMED	115	ROCKLATAN	93
RELION	88	roflumilast	30
RELISTOR	39	ROLVEDON	85
REMICADE	47	ROMVIMZA	52
RENACIDIN	96	ROSANIL	37
repaglinide	43, 44	rosuvastatin	78
REPATHA	77, 78	Roszet	77
REPLACEMENT PEDIATRIC MONITOR	111	ROTARIX	64
RESPA	87	ROTATEQ	64
RESTASIS	93	ROXYBOND	23
RESTIZAN	132	ROZLYTREK	52
RETACRIT	84	RUBRACA	52
RETEVMO	52	RUCONEST	139
RETIN	137	rufinamide	83
REVLIMID	50	RUKOBIA	58
REVUFORJ	52	RUZURGI	81
REXTOVY	39	RYBELSUS	42
REXULTI	128	RYDAPT	52
REYATAZ	59	RYTARY	56
REYVOW	19	RYTHMOL	68
REZLIDHIA	53	S	
REZUROCK	145	SAF-CLENS	134
RHOPRESSA	92	SAFETY	112, 113, 114, 115, 116

Index of Medications

SALAGEN	64	SITZMARKS	89
salicylic	133	SIVEXTRO	35
SALIMEZ	133	SKLICE	55
SALKERA	133	SKYLA	87
salsalate	24	SKYRIZI	131
SALVAX	133	SMART	113, 115
SANCUSO	98	SMARTEST	115
SANDOSTATIN	107	SODIUM	37
SANTYL	137	sodium chloride	101, 130, 142
SAPHRIS	128	sodium chloride/nahco3/kcl/peg	101
SARAFEM	123	sodium fluoride/potassium	94
SAVELLA	145	SODIUM OXYBATE	130
SAXENDA	55	sodium phenylbutyrate	96
SCALACORT	136	sodium polystyrene	95
SCEMBLIX	52, 53	sod, pot chlor/mag/sod	130
scopolamine	98	SOGROYA	106
secobarbital	129	SOHONOS	144
SECUADO	128	solifenacin	146
SECURESAFE INSULIN SYRINGE	112	SOLQUA	42
SELARSDI	109	SOLTAMOX	54
selegiline	56	SOLUS	115
selenium	132	SOMA	120
SEMGLEE	45	SOMATULINE	107
SEN-SERTER	111	SOMAVERT	141
SEROQUEL	128	SOOLANTRA	134
SEROSTIM	106	SORBITOL	130
sertraline	123	sotalol	76
sevelamer	95	SOTYKTU	131
sevoflurane	24	SOTYLIZE	76
SFROWASA	99	SOVALDI	61
SHINGRIX	66	SPACE CHAMBER	117, 118
SIGNIFOR	107	SPIKEVAX	64
SIKLOS	67	spinosad	55
sildenafil	70, 140, 141	SPIRIVA	27
SILENOR	130	spironolact/hydrochlorothiazid	90
SILICONE MASK	118	spironolactone	90
SILIQ	131	SPRITAM	83
silodosin	145, 146	sps	95
SILVADENE	37	SSKI	95
silver nitrate	133, 137	STALEVO	57
silver sulfadiazine	37	STARLIX	43
SIMBRINZA	93	STELARA	109
SIMLANDI	47	STENDRA	140
SIMPONI	47, 48	STERILANCE	115
simvastatin	77, 78	STERILE	115
SINEMET	56	STIMATE	103
SINGLE	115	STIMUFEND	85
sirolimus	110	STIOLTO	28
SIRTURO	33	STIVARGA	53

Index of Medications

STRENSIQ	143	TASMAR	57
STRIBILD	60	TAVALISSE	139
STRIVERDI	28	TAVNEOS	66
STROMEKTOL	46	tazarotene	132
SUBOXONE	145	TAZVERIK	50
SUCRAID	100	TC99M SULFUR COLLOID PREP	88
sucralfate	98	TDVAX	66
SULAR	69	TECHLITE	115
sulfacetamide	30, 37, 132	TEGRETOL	83
sulfact sod/sulur/avob/otn/oct	37	TEGSEDI	142
sulfadiazine	31, 37	TEKTURNA	76
sulfamethoxazole/trimethoprim	31	TELCARE	115
SULFAMYLON	37	telmisartan	73, 74, 75
sulfasalazine	99, 100	telmisartan-hctz	73
sumatriptan	20	temazepam	129
SUNLENCA	57	TEMIXYS	58
SUNOSI	129	TEMOVATE	136
SUPER	114, 115	temozolomide	48
SUPRAX	33	TENIVAC	66
SURE	115	tenofovir disoproxil	59
SURE COMFORT	115	TENORMIN	76
SURGIFOAM	67	TEPMETKO	53
SURGISEAL	134	terazosin	72
SURVANTA	139	terbinafine	40
SYMAX	99	terbutaline	28
SYMDEKO	138	terconazole	39
SYMLINPEN	42	teriflunomide	81
SYMPROIC	39	teriparatide	108, 141
SYMTUZA	58	TERIPARATIDE	108
SYNALAR	36, 136	TERSI	132
SYNJARDY	44	TESSALON	87
SYNTHROID	138	testosterone	103
T		TESTOSTERONE	103
TABLOID	49	tetrabenazine	80
TABRECTA	53	tetracaine	92
tacrolimus	109, 110	tetracycline	36
tadalafil	70, 140	TETRAVISC	92
TAFINLAR	49	TEXACORT	136
TAGITOL	89	TEZSPIRE	144
TAGRISSO	53	THALOMID	32
TAKHZYRO	64	THEO	30
TALTZ	131	theophylline	30
TALZENNA	53	THIN	89, 113, 114, 115, 116
TAMIFLU	60	thioridazine	129
tamoxifen	54	THROMBI	67
tamsulosin	145, 146	THROMBI-GEL	67
TAPAZOLE	138	THROMBIN	67
TARKA	71	thyroid	138
tasimelteon	129	THYROID	138

Index of Medications

THYROLAR	138	tretinoin	54, 131, 137
tiagabine	83	TREXALL	49
TIAZAC	69	TREZIX	21
TIBSOVO	53	triamcinolone	140
ticagrelor	57	triamterene	90
ticlopidine	57	triazolam	129, 130
TIGLUTIK	80	TRIBENZOR	72
TIKOSYN	68	trichloroacetic	134
timolol	76, 92, 93	TRICHLOROACETIC	134
TINDAMAX	45	TRICOR	79
tinidazole	45	trientine	143
tiopronin	146	TRIENTINE	143
TIROSINT	138	trifluoperazine	129
TISSEEL	134	trifluridine	60
TIVICAY	59	TRIGLIDE	79
tizanidine	120	trihexyphenidyl	56
TOBI	31	TRIJARDY	44
TOBRADEX	30	TRIKAFTA	138
tobramycin	30, 31, 32	TRILIPIX	79
TOBRAMYCIN	32	trimethobenzamide	98
tobramycin/dexamethasone	30	trimethoprim	31, 32
TOBREX	31	trimipramine	125
tolbutamide	43	TRIMO-SAN	45
tolcapone	57	TRIMPEX	32
TOLECTIN	27	TRINTELLIX	124
tolmetin	27	TRIUMEQ	58
tolterodine	146	TROKENDI	84
tolvaptan	89	tropicamide	93
TOLVAPTAN	89	trospium	146
TOPCARE	115	TRUE	115
TOPICORT	136	TRUE COMFORT	112, 115
topiramate	83	true folic acid	146
toremifene	54	TRUE METRIX	88
toremide	89	TRUEPLUS	116
TRACLEER	70	TRULANCE	100
tramadol	21, 23	TRULICITY	42
TRAMADOL	23	TRUMENBA	65
tramadol hcl/acetaminophen	21	TRUQAP	53
trandolapril	71, 74	TRUSOPT	93
tranexamic	66	TRYNGOLZA	77
TRANSDERM	98	TUKYSA	53
TRANXENE	121	TURALIO	53
tranylcypromine	121	TUXARIN	87
travoprost	93	TUZISTRA	87
trazodone	123	TWINRIX	66
TRECTOR	32	TWIST	113, 115, 116, 134
TRELEGY	29	TYBOST	138
TREMFYA	131	TYENNE	109
TRESIBA	45	TYKERB	53

Index of Medications

TYRVAYA	141
TYVASO	70, 71
U	
UBRELVY	20
UCERIS	105
UDENYCA	85
UKONIQ	53
ULESFIA	55
ULORIC	25
ULTANE	24
ULTILET	116
ULTRA	28, 111, 112, 113, 114, 115, 116, 131
ULTRACET	21
ULTRA-FINE	112, 113, 119
ULTRAFOAM	67
ULTRALANCE	116
ULTRAM	23
ULTRA-THIN	116
ULTRATLC	116
UNILET	114, 116
UNISTIK	114, 116
UNIVERSAL	113, 116
UPTRAVI	71
URAMAXIN	133
urea	37, 40, 133, 134
URECHOLINE	64
URIBEL	32
UROCIT-K	96
UROQID	96
URSO	99
ursodiol	99
USTEKINUMAB	109
UTA	32
V	
valacyclovir	60
VALCHLOR	54
valganciclovir	60
valproic	84
valsartan	72, 73, 74, 75
valsartan/hydrochlorothiazide	73
VALTOCO	82
VALTREX	60
vancomycin	36
VANFLYTA	53
VANRAFIA	145
ildenafil	140, 141
varenicline	137
VARIBAR	89
VARIVAX	66

VARUBI	98
VASCEPA	96
VASERETIC	71
VASHE	130
VASOTEC	74
VAXELIS	66
VECAMEYL	75
VECTICAL	132
VELPHORO	95
VELSIPITY	81
VELTASSA	95
VENCLEXTA	53
venlafaxine	123, 124
VENTAVIS	71
VEOZAH	143
verapamil	68, 69, 71
VEREGEN	62
VERELAN	69
VERIFINE	112, 116
VERQUVO	69
VERZENIO	53
VEVYE	93
VFEND	40
V-GO	111
VIAGRA	141
VIBERZI	100
VIBRAMYCIN	36
VIEKIRA	61
vigabatrin	84
VIIBRYD	124
VIJOICE	139
vilazodone	124
VIMPAT	84
VIKACE	101
VIRAZOLE	61
VIREAD	59
VISTARIL	41
VISTOGARD	140
VITAFOL	121
vite ac/grape/hyaluronic acid	132
VITRAKVI	53
VIVAGUARD	112, 117
VIVELLE	104
VIVJOA	40
VIZIMPRO	53
VOQUEZNA	101
voriconazole	40
VORTEX	118
VOSEVI	61

Index of Medications

VOWST	100
VOXZOGO	143
VOYDEYA	66
VRAYLAR	128
VUMERITY	81
VYKAT	144
VYLEESI	126
VYNDAMAX	143
VYNDAQEL	143
VYVGART	143

W

WAKIX	84
warfarin	37
water for irrigation	130
Wegovy	55
WIDE SEAL DIAPHRAGM	87
WINREVAIR	70
WP	138

X

XADAGO	57
XALKORI	53
XANAX	121
XARELTO	38
XATMEP	49
XCLAIR	132
XCOPRI	84
XDEMY	55
XELJANZ	26
XELODA	49
XELSTRYM	63
XENICAL	55
XENLETA	35
XEPI	37
XERMELO	97
XIFAXAN	35
XIGDUO	44
XIIDRA	93
XOFLUZA	61
XOLAIR	29
XOLREMDI	84, 85
XOPENEX	28
XOSPATA	53
XPOVIO	54
XTAMPZA	23
XTANDI	48
XUREA	134
XURIDEN	94
XYOSTED	103
XYWAV	129

Y

YERVOY	54
YESINTEK	109
YEZTUGO	57
YUTREPIA	71

Z

zafirlukast	29
zaleplon	130
ZANAFLEX	120
ZARONTIN	84
ZARXIO	85
ZEJULA	53
ZELBORAF	49
ZEMPLAR	141
ZENATANE	131
ZENPEP	101
ZENZEDI	63
ZEPATIER	61
ZEPOSIA	84
ZESTORETIC	71
zidovudine	58, 59
ZIEXTENZO	85
zileuton	27
ZIMHI	39
zinc	134
ziprasidone	128
ZIRGAN	60
ZITHROMAX	34
ZOHYDRO	23
ZOKINVY	139
ZOLADEX	50
ZOLINZA	48
zolmitriptan	20
zolpidem	130
zonisamide	84
ZORTRESS	110
ZORYVE	134
ZOSTAVAX	66
ZTALMY	84
ZTLIDO	24
ZUBSOLV	145
ZURZUVAE	121
ZYDELIG	53
ZYLOPRIM	25, 26
ZYVOX	35

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

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



1. App/online store terms and mobile phone carrier/data charges apply. Customers under age 13 (and/or their parent/guardian) will not be able to register at myCigna.com.
2. Prices shown on myCigna are not guaranteed and coverage is subject to your plan terms and conditions. Visit myCigna for more information.
3. U.S. Food and Drug Administration (FDA) website, "Generic Drug Facts." Content current as of 11/01/21. [fda.gov/drugs/generic-drugs/generic-drug-facts](https://www.fda.gov/drugs/generic-drugs/generic-drug-facts).
4. U.S. Food and Drug Administration (FDA) website, "Biosimilar Basics for Patients." Last updated 08/01/24. [fda.gov/drugs/biosimilars/biosimilars-basics-patients](https://www.fda.gov/drugs/biosimilars/biosimilars-basics-patients).
5. **Not all plans offer Express Scripts Pharmacy and Accredo as covered pharmacy options.** Log in to the myCigna App or myCigna.com, or check your plan materials, to learn more about the pharmacies in your plan's network. Cigna Healthcare, Evernorth Health Services, Express Scripts and Accredo are all part of The Cigna Group. This means we have an ownership interest in Express Scripts Pharmacy's home delivery services and Accredo's specialty pharmacy services. However, you have the right to fill prescriptions at any pharmacy in your plan's network (as your plan allows).
6. Your plan pays the cost for standard shipping.
7. Express Scripts Pharmacy can automatically refill certain medications. Log in to the myCigna App or myCigna.com, or call 800.835.3784, to sign up. You can sign up to get emails and/or texts from Express Scripts Pharmacy. To get text messages, you'll have to sign up for the Express Scripts texting service. You can do this online or when you call 800.835.3784 to refill your prescription. Once you sign up, just reply to their welcome text to get started. Standard text messaging rates apply.
8. You can only refill certain specialty medications by text. To get text messages, you'll have to sign up for Accredo's texting service. You can do this when you call Accredo to refill your prescription. Once you sign up, just reply to their welcome text to get started. Standard text messaging rates apply.
9. **For insured plans that must follow Delaware's state insurance laws:** Brand-name antidepressants, smoking cessation, attention deficit hyperactivity disorder (ADHD) and anti-psychotic medications that don't have a generic equivalent available will be covered as Tier 2 (preferred brand). This is true even if the medication is listed as Tier 3 (non-preferred brand) on your plan's drug list. To find out how your specific plans covers these medications, log in to the myCigna App or myCigna.com, or call the number on your ID card.
10. Costs and complete details of the plan's prescription drug coverage are set forth in the plan documents. If there are any differences between the information provided here and the plan documents, the information in the plan documents takes complete precedence.
11. **For plans that must follow state insurance laws, such as Delaware:** Your plan may provide coverage for infertility medications and smoking cessation medications even if this drug list states that your plan may not cover them. To find out if your specific plan covers these medications, log in to the myCigna App or myCigna.com, or check your plan materials.

Para obtener ayuda en español llame al número en su tarjeta de Cigna Healthcare.

Cigna Healthcare products and services are provided exclusively by or through operating subsidiaries of The Cigna Group.

Discrimination is against the law

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

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

Cigna Healthcare:

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



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

If you believe that Cigna Healthcare has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, sex, ancestry, religion, marital status, gender, sexual orientation, gender identity or sexual stereotypes, you can file a grievance with the Civil Rights Coordinator

P.O. Box 188016, Chattanooga, TN 37422,
877.822.6561 (TTY: Dial 711)

ACAGrievance@CignaHealthcare.com

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

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

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

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

Cigna Healthcare products and services are provided exclusively by or through operating subsidiaries of The Cigna Group, including Cigna Health and Life Insurance Company, Connecticut General Life Insurance Company, Evernorth Behavioral Health, Inc., Evernorth Care Solutions, Inc. and HMO or service company subsidiaries of Cigna Health Corporation, including Cigna HealthCare of Arizona, Inc. Cigna HealthCare of California, Inc. Cigna HealthCare of Colorado, Inc. Cigna HealthCare of Connecticut, Inc. Cigna HealthCare of Florida, Inc. Cigna HealthCare of Georgia, Inc. Cigna HealthCare of Illinois, Inc., Cigna HealthCare of Indiana, Inc., Cigna HealthCare of St. Louis, Inc., Cigna HealthCare of North Carolina, Inc., Cigna HealthCare of New Jersey, Inc., Cigna HealthCare of South Carolina, Inc., Cigna HealthCare of Tennessee, Inc., and Cigna HealthCare of Texas, Inc. ATTENTION: If you speak languages other than English, language assistance service, free of charge are available to you. For current Cigna Healthcare customers, call the number on the back of your ID card. Otherwise, call 1.800.244.6224 (TTY: Dial 711). ATENCIÓN: Si usted habla un idioma que no sea inglés, tiene a su disposición servicios gratuitos de asistencia lingüística. Si es un cliente actual de Cigna

Proficiency of Language Assistance Services

English – ATTENTION: If you speak English, free language assistance services are available to you. Appropriate auxiliary aids and services to provide information in accessible formats are also available free of charge. Call 1-800-244-6224 (TTY: Dial 711) or speak to your provider.

Spanish – ATENCIÓN: Si habla español, los servicios de asistencia lingüística gratuitos están disponibles para usted. También están disponibles de forma gratuita ayudas y servicios auxiliares adecuados para proporcionar información en formatos accesibles. Llame al 1-800-244-6224 (TTY: Marque 711) o hable con su proveedor.

Chinese – 注意: 如果您讲中文，我们提供免费的语言援助服务。适当的辅助设备和服务也可以免费提供，以提供无障碍格式的信息。请拨打 1-800-244-6224 (TTY: 拨打 711) 或与您的服务提供者联系。

Vietnamese – XIN LƯU Ý: Nếu bạn nói tiếng 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 문의하십시오.

Tagalog – PAUNAWA: Kung ikaw ay nagsasalita ng Tagalog, ang mga libreng serbisyo ng tulong sa wika ay magagamit para sa iyo. Ang mga angkop na pantulong na kagamitan at serbisyo upang magbigay ng impormasyon sa mga naa-access na format ay magagamit din ng libre. Tumawag sa 1-800-244-6224 (TTY: Tumawag sa 711) o makipag-usap sa iyong tagapagbigay.

Russian – ВНИМАНИЕ: Если вы говорите на русском, доступны бесплатные услуги языковой помощи. Также бесплатно предоставляются соответствующие вспомогательные средства и услуги для предоставления информации в доступных форматах. Позвоните по телефону 1-800-244-6224 (TTY: Наберите 711) или обратитесь к вашему провайдеру.

Arabic - تنبيه: إذا كنت تتحدث العربية، تتوفر لك خدمات المساعدة اللغوية المجانية. كما تتوفر أيضًا مساعدات قابلة للوصول إليها، وذلك مجانًا. اتصل بالرقم 1-800-244-6224 (TTY: اطلب 711) أو تحدث إلى مقدم الخدمة الخاص بك (اطلب 711).

French Creole – ATANSYON: Si ou pale Kreyòl Ayisyen, sèvis asistans lang gratis yo disponib pou ou. Ekipman ak sèvis adisyonèl ki apwopriye pou bay enfòmasyon nan fòm ki aksesib yo disponib tou gratis. Rele 1-800-244-6224 (TTY: Rele 711) oswa pale ak founisè ou a.

French – ATTENTION : Si vous parlez français, des services d'assistance linguistique gratuits sont disponibles pour vous. Des aides et des services auxiliaires appropriés pour fournir des informations dans des formats accessibles sont également disponibles gratuitement. Appelez le 1-800-244-6224 (TTY : composez le 711) ou parlez à votre fournisseur.

Portuguese – ATENÇÃO: Se você fala português, serviços gratuitos de assistência linguística estão disponíveis para você. Auxílios e serviços apropriados para fornecer informações em formatos acessíveis também estão disponíveis gratuitamente. Ligue para 1-800-244-6224 (TTY: disque 711) ou fale com seu prestador de serviços.

Polish – UWAGA: Jeśli mówisz po polsku, dostępne są bezpłatne usługi pomocy językowej. Odpowiednie pomoce i usługi wspierające w celu dostarczenia informacji w dostępnych formatach są również dostępne bezpłatnie. Zadzwoń pod numer 1-800-244-6224 (TTY: wybierz 711) lub skontaktuj się ze swoim dostawcą usług.

Japanese – 注意: 日本語を話す場合は、無料の言語支援サービスが利用できます。アクセス可能な形式で情報を提供するための適切な補助機器やサービスも無料で利用できます。1-800-244-6224 (TTY: 711 にダイヤル) に電話するか、提供者に話してください。

Italian – ATTENZIONE: Se parli italiano, sono disponibili per te servizi gratuiti di assistenza linguistica. Sono disponibili gratuitamente anche ausili e servizi appropriati per fornire informazioni in formati accessibili. Chiama il numero 1-800-244-6224 (TTY: comporre il 711) o parla con il tuo fornitore.

German – Achtung: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlose Sprachassistentendienste zur Verfügung. Geeignete Hilfsmittel und Dienste, um Informationen in barrierefreien Formaten bereitzustellen, sind ebenfalls kostenlos verfügbar. Rufen Sie 1-800-244-6224 an (TTY: Wählen Sie 711) oder sprechen Sie mit Ihrem Anbieter.

Persian (Farsi) - همچنین، وسایل و خدمات کمکی مناسب برای در دسترس است. خدمات رایگان کمک زبان برای شما صحبت می‌کنید، توجه: اگر به فارسی تماس بگیرید یا با (شماره 711 را بگیرید (TTY: ارائه اطلاعات در قالبهای قابل دسترس به صورت رایگان در دسترس هستند. با شماره 1-800-244-6224 ارائه‌دهنده خود صحبت کنید