



Cigna Healthcare Total Savings 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/PDL

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

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

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 This drug list is subject to change and all prior versions are no longer in effect.



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View your drug list online, 24/7

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

- You can use the Price a Medication tool on the myCigna App¹ or **myCigna.com** to see the most up-to-date list of the medications your plan covers.
- You can also see a pdf of this document on **Cigna.com/PDL**. Click on the dropdown next to "Drug Lists for Employer Plans." Scroll down to the section for California Employer Drug Lists; then click on **California Total Savings 3 Tier (CDI) [PDF]**.

Questions?

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

Information about this drug list

Frequently asked questions (FAQs)

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

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

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

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

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

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

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

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

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

- Prescription medications that treat allergies (ex. Allegra, Clarinex, Xyzal and generics) and heartburn/stomach acid conditions (ex. Nexium, Prilosec OTC and generics).
- Medications that treat lifestyle conditions, such as infertility, erectile dysfunction and smoking cessation.²
- Medications that the U.S. Food and Drug Administration (FDA) hasn't approved.

Q. How do you decide which medications to cover?

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

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

Information about this drug list

Frequently asked questions (FAQs) (cont.)

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

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

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

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

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

Q. What types of medications typically need approval?

A. Medications that:

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

Q. What types of medications typically have quantity limits?

A. Medications that are often:

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

Q. What medications are part of Step Therapy?

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

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

Q. Why does my medication have an age requirement?

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

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

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

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

Information about this drug list

Frequently asked questions (FAQs) (cont.)

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

- **For non-urgent requests**, we'll let you and your doctor know within 72 hours of the decision. If approved, coverage will be provided until the prescription runs out (including refills).
- **For urgent requests based on exigent circumstances**, we'll let you and your doctor know within 24 hours of the decision. If approved, coverage will be provided for the duration of the exigency. If we don't respond to a completed prior authorization exception request within 72 hours of receiving a non-urgent request and 24 hours of receiving a request based on exigent circumstances, the request will be considered approved and your plan can't deny coverage of the medication. Also, if you've already received approval for your plan to cover your medication, we can't limit or exclude coverage for that medication if your doctor continues to prescribe it to treat your condition (as long as the medication is appropriately prescribed and is safe and effective in treating your condition).

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

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

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

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

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

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

A. If you and your doctor feel an alternative medication won't work for you, your doctor can ask us to consider approving coverage of your current medication. Ask your doctor's office to contact us

Information about this drug list

Frequently asked questions (FAQs) (cont.)

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

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

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

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

Your Step Therapy rights under California State law:

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

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

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

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

Information about this drug list

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

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

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

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

A. Yes.

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

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

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

Q. What are preventive medications?

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

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

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

To see a list of \$0 medications, go to

Cigna.com/PDL and click on the dropdown next to "Drug Lists for Employer Plans." Under the Preventive Drug Lists section, click on the link for the PPACA No Cost-Share Preventive Drug List.

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

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

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

A. When you and your doctor are thinking about the right medication for your treatment, knowing how much it costs, what lower-cost options are available, and which pharmacies have the best prices can help you avoid surprises. Log in to the myCigna App or **myCigna.com** and use the Price a Medication tool to see how much your medication costs before you get to the pharmacy counter – or even before you leave your doctor's office.³

Q. What's a cost-share?

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

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

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

Information about this drug list

Frequently asked questions (FAQs) (cont.)

Q. What's a generic medication?

A. A generic is the same as its brand-name version. It has the same active ingredient, strength and dosage form, treats the same condition(s), and works in the same way – and typically costs less.⁴ Generics are typically sold under their chemical or scientific name, instead of the brand name.

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

A. Yes. A generic medication works in the same way and provides the same clinical benefit as the brand-name medication.⁴

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

A. The generic and brand-name medication may⁴:

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

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

Q. What is a "biosimilar" medication?

A. A biosimilar is "highly similar" to its original biologic medication, which is also known as a reference product, that the FDA has already approved. Even though biosimilars aren't identical to the original medication, they're used to treat the same conditions, and provide the same clinical outcomes and treatment benefits. There are no clinical differences in how safe they are to use and how well they work. They also typically cost less.⁵

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

A. There are thousands of retail pharmacies in your plan's network. They include local pharmacies, grocery stores, retail chains and wholesale

warehouse stores – all places where you may already shop. And some stores are open 24-hours. To find an in-network pharmacy near you, log in to the myCigna App or **myCigna.com**. Then click on the Prescriptions tab and choose "Find a Pharmacy" from the dropdown list.

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

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

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

A. It depends on your plan. Some plans require you to fill maintenance medications through Express Scripts® Pharmacy and/or specialty medications through Accredo® Specialty Pharmacy for them to be covered.⁶ Log in to the myCigna App or **myCigna.com**, or check your plan materials, to find out what your plan requires.

Q. Can I fill my prescriptions by mail?

A. Yes, as long as your plan offers home delivery.⁶

Fill maintenance medications through Express Scripts Pharmacy

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

- Easily order, manage, track and pay for your medications on your phone or online.
- Get standard shipping at no extra cost.⁷
- Fill up to a 90-day supply at one time.
- Talk with a pharmacist, 24/7.
- Sign up for automatic refills or refill reminders so you don't miss a dose.⁸
- Use a payment plan (if you need it).

Information about this drug list

Frequently asked questions (FAQs) (cont.)

Here are two easy ways to get started:

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

Fill specialty medications through Accredo Specialty Pharmacy

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

- Talk with specially-trained pharmacists and nurses, 24/7.
- Get fast shipping at no extra cost.⁷
- Sign up for refills and reminders. Some refills can be done by text.⁹
- Get help paying for your medication (if you need it).
- Manage and track your medications online.

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

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

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

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

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

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

You may also be able to use Accredo to fill your prescription; they have access to most specialty medications.⁶ Call Accredo at **877.826.7657**, Monday–Friday, 7:00 am–10:00 pm CST or Saturdays, 7:00 am–4:00 pm CST, for more information.

Q. How do I fill my prescription?

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

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

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

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

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

Information about this drug list

Frequently asked questions (FAQs) (cont.)

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

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

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

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

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

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

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

- Medications that you fill at the pharmacy and take yourself are typically covered under the pharmacy benefit.

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

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

Q. I take an oral cancer medication. How much will it cost me to fill?

A. On January 1, 2015, California passed a bill limiting the cost-share for oral chemotherapy medications. This means that if you have both your medical and pharmacy benefits through Cigna Healthcare, here's how certain oral cancer medications are covered:

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

Information about this drug list

Frequently asked questions (FAQs) (cont.)

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

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

- **Preventive care medications and products covered under the Patient Protection and Affordable Care Act (PPACA), also known as “health care reform:”**
 - **Contraceptives:** Covered at 100%, or no cost-share (\$0) to you. Certain prescription contraceptives are available at their applicable cost-share.
 - **Tobacco cessation products:** Up to two (2) 90-day courses of treatment per plan year are covered at 100%, or no cost-share (\$0) to you. Certain prescription tobacco cessation products are available at their applicable cost-share.
 - **Certain vitamins:** Covered at 100%, or no cost-share (\$0) to you. All other prescription vitamins are available at their applicable cost-share and deductible (if applicable).
- **Certain over-the-counter (OTC) products:** If you have a prescription from your doctor, these are covered at 100%, or no cost-share (\$0) to you. All other OTC products are excluded from coverage.
- **Oral fertility medications:** Covered at their applicable tier cost-share. For some plans, injectable fertility medications are covered under the medical benefit.
- **Generic preventive care medications:** Covered at 100%, or no cost-share (\$0) to you before you meet your deductible. You'll pay your deductible and applicable cost-share to fill a preferred brand and/or non-preferred brand preventive care medication.
- **Diabetic supplies:** Covered at their applicable cost-share.
- **Growth Hormones:** Need approval from Cigna Healthcare before your plan will cover them (prior authorization). If approved, you'll pay your applicable tier cost-share to fill the medication.
- **Vaccines:** Vaccines are now covered under the pharmacy benefit. Not all plans cover vaccines in the same way. Log in to the myCigna App or **myCigna.com**, or check your plan materials, to find out how your specific plan covers them.
- **Compounded medications:** If the medication is more than \$200, you'll need approval from Cigna Healthcare before your plan will cover them (prior authorization). If approved, you'll pay your applicable tier cost-share to fill the medication.

Words you may need to know

- **Brand name drug:** A drug that is marketed under a proprietary, trademark-protected name. A brand name drug is listed in this formulary in all CAPITAL letters.
- **Coinurance:** A percentage of the cost of a covered health care benefit that you pay after you have paid the deductible, if a deductible applies to the health care benefit.
- **Copayment:** A fixed dollar amount that you pay for a covered health care benefit after you have paid the deductible, if a deductible applies to the health care benefit.
- **Deductible:** The amount you pay for covered health care benefits that are subject to the deductible before your health insurer begins to pay. If your health insurance policy has a deductible, it may have either one deductible or separate deductibles for medical benefits and prescription drug benefits. After you pay your deductible, you usually pay only a copayment or coinsurance for covered health care benefits. Your insurance company pays the rest.

Information about this drug list

Words you may need to know (cont.)

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

Information about this drug list

About this drug list

This is a list of the most commonly prescribed medications covered on the Cigna Healthcare Total Savings 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.

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

How to read this drug list

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

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

Tiers

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

Tier 1	Generics. These medications are covered at your plan's lowest cost-share. Generics work in the same way and provide the same clinical benefits as their brand-name versions – and typically cost much less. ⁴	\$
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 Total Savings 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 requirements and limits lets you know if your plan has extra requirements before it will cover the medication.
ANALGESIC, NON-SALICYLATE AND BARBITURATE COMBINAT			
<i>butorbital/acetaminophen</i>	T1		
ANALGESIC, SALICYLATE, BARBITURATE, XANTHINE COMB.			
<i>butorbital-aspirin-caffe 50-325-40</i>	T1	QL (6 tabs/day)	
<i>butorbital-asa-cafeine cap</i> (Fiorinal)	T1	QL (6 caps/day)	
FIORINAL (<i>butorbital-aspirin-cafeine</i>)	T3	QL (6 caps/day)	
ANALGESIC, NON-SALICYLATE, BARBITURATE, XANTHINE COMB.			
<i>butorbital/acetaminophen/cafeine</i>	T3		
<i>butorbital/acetaminophen/cafeine</i> (Esgic)	T3	QL (6 caps/day)	
<i>butorbital-acetamin-caff 50-300-40</i> (Fioricet)	T1	QL (6 caps/day)	
<i>butorbital-acetamin-caff 50-325-40</i> (Esgic)	T1	QL (6 tabs/day)	
ESGIC 50-325-40 MG TABLET (<i>butorbital-acetaminophen-caffe</i>)	T3	QL (6 tabs/day)	
ESGIC CAPSULE (<i>zebutorbital</i>)	T3	QL (6 caps/day)	
FIORICET (<i>phrenilin forte</i>)	T1	QL (6 caps/day)	
ANALGESIC/ANTIPYRETICS, SALICYLATES			
<i>choline salicyl/mag salicylate</i>	T1	HD	
<i>diflunisal</i>	T1	HD	
ANTI-MIGRAINE PREPARATIONS			
AIMOVIG AUTOINJECTOR	T2	PA	
AJOVY AUTOINJECTOR	T2	PA	
AJOVY SYRINGE	T2	PA	
<i>almotriptan malate</i>	T1	QL (12 tabs/30 days)	
CAFERGOT (<i>ergotamine-cafeine</i>)	T3	QL (40 tabs/28 days)	
<i>dihydroergotamine 1 mg/ml amp</i>	T1	QL (10 amps/30 days)	
<i>eletriptan hydrobromide</i>	T1	QL (6 tabs/30 days)	
EMGALITY PEN	T2	PA	
EMGALITY SYRINGE	T2	PA	
<i>ergotamine tartrate/cafeine</i>	T1		
<i>ergotamine tartrate/cafeine</i> (Cafergot)	T1	QL (40 tabs/28 days)	

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

Information about this drug list

How to find your medication

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

Condition	Page	Condition	Page
Analgesics (Pain Relief and Inflammatory Disease)	19-23	Anti-Infectives/Miscellaneous (Skin Conditions)	45
Analgesics (Urinary Tract Conditions)	23	Anti-Inflammatory Tumor Necrosis Factor Inhibiting Agents (Pain Relief and Inflammatory Disease)	45, 46
Anesthetics (Miscellaneous)	23,24	Anti-Neoplastics (Cancer)	46-51
Anesthetics (Pain Relief and Inflammatory Disease)	24	Anti-Neoplastics (Skin Conditions)	52
Anesthetics (Urinary Tract Conditions)	24	Anti-Obesity Drugs (Weight Management)	52, 53
Anti-Allergy (Allergy and Nasal Sprays)	24	Anti-Parasitics (Eye Conditions)	53
Anti-Arthritics (Pain Relief and Inflammatory Disease)	24-27	Anti-Parasitics (Infections)	53
Anti-Asthmatics (Asthma/COPD/Respiratory)	27-30	Anti-Parkinson's Drugs (Parkinson's Disease)	53-55
Antibiotics (Allergy/Nasal Sprays)	30	Anti-Platelet Drugs (Blood Thinners/Anti-Clotting)	55
Antibiotics (Ear Medications)	30	Antivirals (Aids/Hiv)	56-58
Antibiotics (Eye Conditions)	30, 31	Antivirals (Eye Conditions)	58
Antibiotics (Infections)	31-36	Antivirals (Infections)	58, 59
Antibiotics (Skin Conditions)	36, 37	Antivirals (Skin Conditions)	59
Anti-Coagulants (Blood Thinners/Anti-Clotting)	37, 38	Autonomic Drugs (Allergy/Nasal Sprays)	59
Antidotes (Gastrointestinal/Heartburn)	38	Autonomic Drugs (Alzheimer's Disease)	60
Antidotes (Substance Abuse)	38	Autonomic Drugs (Attention Deficit Hyperactivity Disorder)	60
Anti-Fungals (Eye Conditions)	38	Autonomic Drugs (Blood Pressure/Heart Medications)	60, 61
Anti-Fungals (Feminine Products)	39	Autonomic Drugs (Urinary Tract Conditions)	61
Anti-Fungals (Infections)	39	Biologicals (Allergy/Nasal Sprays)	61
Anti-Fungals (Skin Conditions)	39, 40	Biologicals (Blood Pressure/Heart Medications)	61
Antihistamines (Allergy/Nasal Sprays)	40	Biologicals (Miscellaneous)	61
Anti-Hyperglycemics (Diabetes)	40-43	Biologicals (Vaccines)	61-64
Anti-Infectives (Feminine Products)	43	Blood (Blood Modifiers/Bleeding Disorders)	64, 65
Anti-Infectives (Infections)	43	Blood (Blood Thinners/Anti-Clotting)	65
Anti-Infectives/Miscellaneous (Feminine Products)	44	Cardiac Drugs (Blood Pressure/Heart Medications)	65-67
Anti-Infectives/Miscellaneous (Infections)	44, 45	Cardiovascular (Asthma/COPD/Respiratory)	67, 68
Anti-Infectives/Miscellaneous (Miscellaneous)	45	Cardiovascular (Blood Pressure/Heart Medications)	68-72

Information about this drug list

How to find your medication (cont.)

Condition	Page	Condition	Page
Cardiovascular (Cholesterol Medications)	72-74	Hormones (Osteoporosis Products)	98
CARDIOVASCULAR (Miscellaneous)	74	Immunosuppressants (Pain Relief and Inflammatory Disease)	98, 99
CNS Drugs (Alzheimer's Disease)	74, 75	Immunosuppressants (Skin Conditions)	99
CNS Drugs (Miscellaneous)	75	Immunosuppressants (Transplant Medications)	99, 100
CNS Drugs (Multiple Sclerosis)	75, 76	Miscellaneous Medical Supplies, Devices, Non-Drug (Diabetes)	100-105
CNS Drugs (Pain Relief and Inflammatory Disease)	76	Miscellaneous Medical Supplies, Devices, Non-Drug (Miscellaneous)	105-107
CNS Drugs (Seizure Disorders)	76-78	Muscle Relaxants (Pain Relief and Inflammatory Disease)	107, 108
CNS Drugs (Sleep Disorders/Sedatives)	78	Prenatal Vitamins (Nutritional/Dietary)	108
Colony Stimulating Factors (Blood Modifiers/Bleeding Disorders)	79	Psychotherapeutic Drugs (Anxiety/Depression/Bipolar Disorder)	109-113
Colony Stimulating Factors (Cancer)	79	Psychotherapeutic Drugs (Attention Deficit Hyperactivity Disorder)	113, 114
Contraceptives (Contraception Products)	79, 80	Psychotherapeutic Drugs (Miscellaneous)	114
Cough/Cold Preparations (Allergy/Nasal Sprays)	80	Psychotherapeutic Drugs (Schizophrenia/Anti-Psychotics)	114-117
Cough/Cold Preparations (Cough/Cold Medications)	80, 81	Psychotherapeutic Drugs (Sleep Disorders/Sedatives)	117
Diagnostic (Diabetes)	81	Sedative/Hypnotics (Sleep Disorders/Sedatives)	117, 118
Diagnostic (Miscellaneous)	81, 82	SKIN PREPS (Cancer)	118
Diuretics (Diuretics)	82, 83	Skin Preps (Miscellaneous)	118
EENT Preps (Allergy/Nasal Sprays)	83, 84	Skin Preps (Pain Relief and Inflammatory Disease)	118, 119
EENT Preps (Ear Medications)	84	Skin Preps (Skin Conditions)	119-124
EENT Preps (Eye Conditions)	84-86	Smoking Deterrents (Smoking Cessation)	124, 125
Elect/Caloric/H2O (Cholesterol Medications)	86	Thyroid Prep (Hormonal Agents)	125
Elect/Caloric/H2O (Dental Products)	87	Unclassified Drug Products (Aids/Hiv)	125
Elect/Caloric/H2O (Diabetes)	87	Unclassified Drug Products (Asthma/COPD/Respiratory)	125, 126
Elect/Caloric/H2O (Miscellaneous)	87	Unclassified Drug Products (Blood Modifiers/Bleeding Disorders)	126
Elect/Caloric/H2O (Nutritional/Dietary)	87, 88	UNCLASSIFIED DRUG PRODUCTS (Blood Pressure/Heart Medications)	126
Elect/Caloric/H2O (Urinary Tract Conditions)	88, 89	UNCLASSIFIED DRUG PRODUCTS (Cancer)	126
Gastrointestinal (Cholesterol Medications)	89	UNCLASSIFIED DRUG PRODUCTS (Dental Products)	126
Gastrointestinal (Gastrointestinal/Heartburn)	89-93		
Gastrointestinal (Pain Relief and Inflammatory Disease)	93, 94		
Hormones (Hormonal Agents)	94-98		
Hormones (Infertility)	98		
Hormones (Miscellaneous)	98		

Information about this drug list

How to find your medication *(cont.)*

Condition	Page
UNCLASSIFIED DRUG PRODUCTS (Erectile Dysfunction)	126, 127
UNCLASSIFIED DRUG PRODUCTS (Gastrointestinal/Heartburn)	127
UNCLASSIFIED DRUG PRODUCTS (Hormonal Agents)	127
UNCLASSIFIED DRUG PRODUCTS (Miscellaneous)	128-130
Unclassified Drug Products (Nutritional/Dietary)	130
Unclassified Drug Products (Osteoporosis Products)	130, 131
UNCLASSIFIED DRUG PRODUCTS (Pain Relief And Inflammatory Disease)	131
UNCLASSIFIED DRUG PRODUCTS (Skin Conditions)	131
Unclassified Drug Products (Substance Abuse)	131
Unclassified Drug Products (Transplant Medications)	131, 132
Unclassified Drug Products (Urinary Tract Conditions)	132
Unclassified Drug Products (Weight Management)	132, 133
Vitamins (Nutritional/Dietary)	131, 132

List of Prescription Medications

ANALGESICS (Pain Relief and Inflammatory Disease)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ANALGESIC, SALICYLATE, BARBITURATE, XANTHINE COMB.		
butalb-aspirin-caffe 50-325-40	T1	QL (6 tabs/day)
butalbital-asa-caffeine cap (Fiorinal)	T1	QL (6 caps/day)
FIORINAL (butalbital-aspirin-caffeine)	T3	QL (6 caps/day)
ANALGESIC, NON-SALICYLATE, BARBITURATE, XANTHINE COMB.		
butalb/acetaminophen/caffeine	T3	
butalb/acetaminophen/caffeine (Esgic)	T3	QL (6 caps/day)
butalb-acetamin-caff 50-300-40 (Fioricet)	T1	QL (6 caps/day)
butalb-acetamin-caff 50-325-40 (Esgic)	T1	QL (6 tabs/day)
ESGIC CAPSULE (zebutal)	T3	QL (6 caps/day)
FIORICET (phrenilin forte)	T1	QL (6 caps/day)
ANALGESIC/ANTIPYRETICS, SALICYLATES		
choline salicyl/mag salicylate	T1	HD
diflunisal	T1	HD
ANTI-MIGRAINE PREPARATIONS		
AIMOVIG AUTOINJECTOR	T2	PA
AJOVY AUTOINJECTOR	T2	PA
AJOVY SYRINGE	T2	PA
almotriptan malate	T1	QL (12 tabs/30 days)
CAFERGOT (ergotamine-caffeine)	T3	QL (40 tabs/28 days)
dihydroergotamine 1 mg/ml amp	T1	QL (10 amps/30 days)
eletriptan hydrobromide	T1	QL (6 tabs/30 days)
EMGALITY PEN	T2	PA
EMGALITY SYRINGE	T2	PA
ergotamine tartrate/caffeine	T1	
ergotamine tartrate/caffeine (Cafergot)	T1	QL (40 tabs/28 days)
frovatriptan succinate	T1	QL (18 tabs/30 days)
isomethept/dichlphn/acetaminop	T1	
isomethepten/caf/acetaminophen	T1	
<i>naratriptan hcl</i>	T1	QL (9 tabs/30 days)
NURTEC ODT	T2	PA QL (16 tabs/30 days)
<i>rizatriptan</i>	T1	QL (12 tabs/30 days)
<i>rizatriptan benzoate</i>	T1	QL (2 boxes/30 days)
<i>sumatriptan</i>	T1	QL (2 boxes/30 days)
<i>sumatriptan 4 mg/0.5 ml cart</i>	T1	QL (4ml/30 days)

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.)		
sumatriptan 4 mg/0.5 ml inject	T1	QL (4ml/30 days)
sumatriptan 6 mg/0.5 ml cart	T1	QL (4ml/30 days)
sumatriptan 6 mg/0.5 ml inject	T1	QL (4ml/30 days)
sumatriptan 6 mg/0.5 ml syring	T1	QL (4ml/30 days)
sumatriptan 6 mg/0.5 ml vial	T1	QL (5ml/30 days)
sumatriptan succ 100 mg tablet	T1	QL (18 tabs/28 days)
sumatriptan succ 25 mg tablet	T1	QL (18 tabs/28 days)
sumatriptan succ/naproxen sod	T1	QL (18 tabs/30 days)
UBRELVY	T2	PA QL (0.67 tabs/day)
ZAVZPRET	T2	PA QL (6 units/30 days)
zolmitriptan	T1	QL (12 tabs/30 days)
NSAIDS, CYCLOOXYGENASE INHIBITOR-TYPE ANALGESICS		
diclofenac potassium	T1	HD
ketorolac 10 mg tablet	T1	QL (20 tabs/25 days)
ketorolac 15 mg/ml syringe	T1	QL (40 ml/30 days)
ketorolac 15 mg/ml vial	T1	QL (40 ml/30 days)
ketorolac 30 mg/ml carpject	T1	
ketorolac 30 mg/ml isecure syr	T1	QL (20ml/30 days)
ketorolac 30 mg/ml syringe	T1	QL (20ml/30 days)
ketorolac 30 mg/ml vial	T1	QL (4ml/ days)
ketorolac 300 mg/10 ml vial	T1	
ketorolac 60 mg/2 ml carpject	T1	QL (20ml/30 days)
ketorolac 60 mg/2 ml syringe	T1	QL (20ml/30 days)
ketorolac 60 mg/2 ml vial	T1	QL (20ml/30 days)
mefenamic acid	T1	HD
OPIOID ANALGESIC AND NON-SALICYLATE ANALGESICS		
acetamin-codein 300-30 mg/12.5	T1	
acetaminop-codeine 120-12 mg/5	T1	
acetaminophen-cod #2 tablet	T1	PA
acetaminophen-cod #3 tablet	T1	PA
acetaminophen-cod #4 tablet	T1	PA
APADAZ	T3	
BENZHYDROCODONE-ACETAMINOPHEN	T1	

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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.)		
<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
PERCOCET (<i>oxycodone-acetaminophen</i>)	T3	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)
<i>buprenorphine</i> (Butrans)	T1	QL (4 patches/28 days)
<i>butorphanol tartrate</i>	T1	PA QL (6 bots/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
OPIOID ANALGESICS (cont.)		
BUTRANS (buprenorphine)	T3	QL (4 patches/28 days)
codeine sulfate	T1	PA
DURAGESIC (fentanyl)	T3	PA
fentanyl	T1	PA
fentanyl (Duragesic)	T1	PA
FENTANYL CITRATE	T1	PA
fentanyl citrate (Actiq)	T1	PA
FENTORA	T3	PA
hydrocodone bitartrate (Hysingla Er)	T1	PA
hydrocodone bitartrate (Zohydro Er)	T1	PA
hydromorphone hcl	T1	PA
hydromorphone hcl (Dilaudid)	T1	PA
HYSINGLA ER (hydrocodone bitartrate er)	T2	PA
KADIAN (morphine sulfate er)	T3	PA
LAZANDA	T3	PA
meperidine hcl	T1	PA
MORPHABOND ER	T2	PA
morphine sulfate	T1	PA
morphine sulfate (Kadian)	T1	PA
morphine sulfate (Ms Contin)	T1	PA
MS CONTIN (morphine sulfate er)	T3	PA
NUCYNTA	T2	PA
NUCYNTA ER	T3	PA
opium/belladonna alkaloids	T1	PA
OXAYDO	T3	PA
oxycodone hcl	T1	PA
OXYCODONE HCL ER	T1	PA
oxymorphone hcl	T1	PA
pentazocine hcl/naloxone hcl	T1	PA

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

PA – Prior Authorization

QL – Quantity Limit

ST – Step Therapy

AGE – Age Requirement

SP – Specialty Medication

HD – May require home delivery pharmacy

PPACA – No Cost-Share Preventive Medication

CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

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

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
OPIOID ANALGESICS (cont.)		
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)
tramadol hcl (Ultram)	T1	QL (8 tabs/day)
tramadol hcl 50 mg tablet	T1	QL (8 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</i> (Fiorinal With Codeine #3)	T1	PA
FIORINAL WITH CODEINE #3 (<i>butalbital compound-codeine</i>)	T3	PA
OPIOID, NON-SALICYL. ANALGESIC, BARBITUATE, XANTHINE		
<i>butalbit/acetamin/caff/codeine</i>	T1	PA
<i>butalbit/acetamin/caff/codeine</i> (Fioricet With Codeine)	T1	PA
SKELETAL MUSCLE RELAXANT, SALICYLAT, OPIOID ANALGESIC		
<i>carisoprodol/aspirin/codeine</i>	T1	PA
ANALGESICS (Urinary Tract Conditions)		
URINARY TRACT ANALGESIC AGENTS		
ELMIRON	T2	
RIMSO-50	T2	
ANESTHETICS (Miscellaneous)		
GENERAL ANESTHETICS, INHALANT		
<i>desflurane</i> (Suprane)	T1	
<i>isoflurane</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 (Miscellaneous) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
GENERAL ANESTHETICS, INHALANT (cont.)		
sevoflurane (Ultane)	T1	
ULTANE (sevoflurane)	T3	
lidocaine hcl	T1	
ANESTHETICS (Pain Relief and Inflammatory Disease)		
TOPICAL LOCAL ANESTHETICS		
lidocaine 5% ointment	T1	QL (145gm/30 days)
lidocaine hcl	T3	
lidocaine/prilocaine	T1	
LIDODERM (lidocaine)	T3	
PAIN EASE MEDIUM STREAM SPRAY	T3	
ZTLIDO	T2	
ANESTHETICS (Urinary Tract Conditions)		
URINARY TRACT ANESTHETIC/ANALGESIC AGNT (AZO-DYE)		
phenazopyridine hcl (Pyridium)	T1	
PYRIDIUM (phenazopyridine hcl)	T3	
ANTI-ALLERGY (Allergy/Nasal Sprays)		
MAST CELL STABILIZERS		
cromolyn 100 mg/5 ml oral conc (Gastrocrom)	T1	
GASTROCROM (cromolyn sodium)	T3	
ANTI-ARTHRITICS (Pain Relief and Inflammatory Disease)		
ANALGESIC/ANTIPYRETICS, SALICYLATES		
DISALCID (salsalate)	T3	HD
salsalate (Disalcid)	T1	HD
ANTI-ARTHRITIC AND CHELATING AGENTS		
DEPEN (penicillamine)	T3	PA SP
penicillamine	T1	PA SP
penicillamine (Depen)	T1	PA SP
ANTI-ARTHRITIC, FOLATE ANTAGONIST AGENTS		
OTREXUP	T2	PA
ANTI-INFLAM. INTERLEUKIN-I RECEPTOR ANTAGONIST		
KINERET	T3	PA QL (28 syringes/28 days) SP

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List of Prescription Medications

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

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ANTI-INFLAMMATORY, 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 (1 pack/180 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		
<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>)	T3	HD
GOLD SALTS		
RIDAURA	T2	
HYPERURICEMIA TX - XANTHINE OXIDASE INHIBITORS		
<i>allopurinol</i> (Zyloprim)	T1	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		
CIBINQO	T2	PA QL (30 tabs/30 days) SP
LEQSELVI	T3	PA QL(2 tabs/day) SP HD
LITFULO	T3	PA QL(1 cap/day) SP HD
OLUMIANT	T3	PA QL (1 tab/day) SP HD
RINVOQ	T2	PA QL (1 tab/day) SP HD
RINVOQ LQ	T2	PA QL(12 mls/day) SP HD
XELJANZ 1 MG/ML SOLUTION	T2	PA QL (480ml/22 days) SP HD
XELJANZ 10 MG TABLET	T2	PA QL (2 tabs/day) SP 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

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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 (COX NON-SPEC.INHIB) AND PROSTAGLANDIN ANALOG (cont.)		
<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
<i>fenoprofen 600 mg tablet</i> (Nalfon)	T1	HD
<i>flurbiprofen</i>	T1	HD
<i>ibuprofen</i>	T1	HD
<i>indomethacin</i> (Indocin)	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
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 sodium</i> (Anaprox Ds)	T1	HD
<i>piroxicam</i>	T1	HD
QMIIZ ODT 15 MG TABLET	T3	ST HD
QMIIZ ODT 7.5 MG TABLET	T3	QL (1 tab/day) ST HD

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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.)		
OXAPROZIN 300 MG CAPSULE	T3	HD
<i>oxaprozin 600 mg caplet (Daypro)</i>	T1	HD
<i>oxaprozin 600 mg tablet (Daypro)</i>	T1	HD
<i>tolmetin sodium (Tolectin)</i>	T1	HD
NSAIDS, CYCLOOXYGENASE-2(COX-2) SELECTIVE INHIBITOR		
CELEBREX 100 MG CAPSULE (<i>celecoxib</i>)	T3	QL (2 caps/day) ST
CELEBREX 200 MG CAPSULE (<i>celecoxib</i>)	T3	QL (2 caps/day) ST
CELEBREX 400 MG CAPSULE (<i>celecoxib</i>)	T3	QL (1 cap/day) ST
CELEBREX 50 MG CAPSULE (<i>celecoxib</i>)	T3	QL (2 caps/day)
<i>celecoxib 100 mg capsule (Celebrex)</i>	T1	QL (2 caps/day) HD
<i>celecoxib 200 mg capsule (Celebrex)</i>	T1	QL (2 caps/day) HD
<i>celecoxib 400 mg capsule (Celebrex)</i>	T1	QL (1 cap/day) HD
<i>celecoxib 50 mg capsule (Celebrex)</i>	T1	QL (2 caps/day) 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 REFILL	T3	PA HD
LONHALA MAGNAIR STARTER	T3	PA HD
SPIRIVA RESPIMAT	T2	HD
ANTICHOLINERGICS, ORALLY INHALED SHORT ACTING		
ATROVENT HFA	T2	HD
<i>ipratropium bromide</i>	T1	HD
BETA-ADRENERGIC AGENTS		
<i>albuterol sulf 2 mg/5 ml syrup</i>	T1	HD
<i>albuterol sulfate 2 mg tab</i>	T1	HD
<i>albuterol sulfate 4 mg tab</i>	T1	HD
<i>albuterol sulfate er 4 mg tab</i>	T1	HD
<i>albuterol sulfate er 8 mg tab</i>	T1	HD
<i>metaproterenol sulfate</i>	T1	HD

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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 (cont.)		
<i>terbutaline sulfate</i>	T1	HD
BETA-ADRENERGIC AGENTS, INHALED, SHORT ACTING		
<i>albuterol 100 mg/20 ml soln</i>	T1	
<i>albuterol 2.5 mg/0.5 ml sol</i>	T1	
<i>albuterol 5 mg/ml solution</i>	T1	
<i>albuterol 15 mg/3 ml solution</i>	T1	
<i>albuterol 75 mg/15 ml soln</i>	T1	
<i>albuterol sul 0.63 mg/3 ml sol</i>	T1	
<i>albuterol sul 1.25 mg/3 ml sol</i>	T1	
<i>albuterol sul 2.5 mg/3 ml soln</i>	T1	
<i>albuterol hfa 90 mcg inhaler (Proair Hfa)</i>	T1	QL (18gm/30 days)
ALBUTEROL SULFATE HFA	T1	QL (18gm/30 days)
<i>levalbuterol hcl (Xopenex)</i>	T1	
XOPENEX (<i>levalbuterol hcl</i>)	T3	
XOPENEX CONCENTRATE (<i>levalbuterol concentrate</i>)	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		
<i>arformoterol tartrate (Brovana)</i>	T1	QL (4 ml/day) HD
BETA-ADRENERGIC AND ANTICHOLINERGIC COMBO, INHALED		
ANORO ELLIPTA	T2	HD
BEVESPI AEROSPHERE	T2	HD
COMBIVENT RESPIMAT	T2	
<i>ipratropium/albuterol sulfate</i>	T1	HD
STIOLTO RESPIMAT INHAL SPRAY	T2	HD
BETA-ADRENERGIC AGENTS AND GLUCOCORTICOID COMBO, INHALED		
ADVAIR HFA	T2	HD
AIRDUO DIGIHALER	T3	ST HD
BREO ELLIPTA	T2	HD
DULERA	T2	HD
<i>fluticasone-salmeterol 100-50 (Advair Diskus)</i>	T1	QL(1 inhaler/30 days) HD
<i>fluticasone-salmeterol 250-50 (Advair Diskus)</i>	T1	QL(1 inhaler/30 days) HD
<i>fluticasone-salmeterol 500-50 (Advair Diskus)</i>	T1	QL(1 inhaler/30 days) HD

T1 – Typically Generics

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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 (cont.)		
fluticasone propion/salmeterol	T1	QL(1 inhaler/30 days)
BETA-ADRENERGIC-ANTICHOLINERGIC-GLUCOCORT, INHALED		
BREZTRI AEROSPHERE	T2	QL HD
FLUTICASONE PROP	T3	
TRELEGY ELLIPTA	T2	
GLUCOCORTICIDS, ORALLY INHALED		
ALVESCO	T2	HD
ASMANEX HFA	T2	QL(1 inhaler/30 days) HD
ASMANEX TWISTHALER 110 MCG #30	T2	QL(1 inhaler/30 days) HD
ASMANEX TWISTHALER 220 MCG #14	T2	HD
ASMANEX TWISTHALER 220 MCG #30	T2	QL(1 inhaler/30 days) HD
ASMANEX TWISTHALER 220 MCG #60	T2	QL(1 inhaler/30 days) HD
ASMANEX TWISTHALR 220 MCG #120	T2	QL(1 inhaler/30 days) HD
budesonide (Pulmicort)	T1	HD
PULMICORT (budesonide)	T3	HD
PULMICORT FLEXHALER	T2	HD
QVAR REDIHALER	T2	
INTERLEUKIN-5(IL-5) RECEPTOR ALPHA ANTAGONIST, MAB		
FASENRA PEN	T2	PA SP HD
LEUKOTRIENE RECEPTOR ANTAGONISTS		
ACCOLATE (zafirlukast)	T3	HD
montelukast sodium (Singulair)	T1	HD
SINGULAIR (montelukast sodium)	T3	
zafirlukast (Accolate)	T1	HD
MAST CELL STABILIZERS, ORALLY INHALED		
cromolyn 20 mg/2 ml neb soln	T1	QL (480ml/30 days) HD
MONOCLONAL ANTIBODIES TO IMMUNOGLOBULIN E (IGE)		
XOLAIR	T2	PA SP HD
MONOCLONAL ANTIBODY - INTERLEUKIN-5 ANTAGONISTS		
NUCALA	T2	PA SP HD
MUCOLYTICS		
acetylcysteine	T1	
PHOSPHODIESTERASE-4 (PDE4) INHIBITORS		
DALIRESP 250 MCG TABLET	T3	QL (28 tabs/180 days) HD

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List of Prescription Medications

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

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List of Prescription Medications

ANTIBIOTICS (Eye Conditions) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
EYE SULFONAMIDES (cont.)		
<i>sulfacetamide sodium</i> (Bleph-10)	T1	
<i>sulfacetamide/prednisolone sp</i>	T1	
OPHTHALMIC ANTIBIOTICS		
AZASITE	T2	
<i>bacitracin</i> (Baciguent)	T1	
<i>bacitracin/polymyxin b sulfate</i>	T1	
BESIVANCE	T2	
<i>erythromycin base</i>	T1	
<i>gatifloxacin</i>	T1	
<i>gentamicin sulfate</i>	T1	
<i>levofloxacin</i>	T1	
MOXEZA (<i>moxifloxacin</i>)	T3	
<i>moxifloxacin hcl</i> (Moxeza)	T1	
<i>moxifloxacin hcl</i> (Vigamox)	T1	
<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> (Tobrex)	T1	

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>	T3	
<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 (8 caps/day) SP HD
<i>tobramycin 300 mg/4 ml ampule</i>	T1	QL (8ml/day) SP HD

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List of Prescription Medications

ANTIBIOTICS (Infections) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
AMINOGLYCOSIDE ANTIBIOTICS (cont.)		
<i>tobramycin 300 mg/5 ml ampule</i>	T1	PA QL (10ml/day) SP HD
TOBRAMYCIN PAK 300 MG/5 ML	T3	PA QL (10ml/day) SP HD
ANAEROBIC ANTIPROTOZOAL-ANTIBACTERIAL AGENTS		
FLAGYL (<i>metronidazole</i>)	T3	
LIKMEZ	T3	PA
<i>metronidazole</i> (Flagyl)	T1	
ANTI-BIOTIC, ANTIBACTERIAL, MISC.		
<i>fosfomycin tromethamine</i> (Monurol)	T1	
<i>methenamine hippurate</i>	T1	
<i>methenamine mandelate</i>	T1	
MONUROL (<i>fosfomycin tromethamine</i>)	T3	
PRIMSOL	T3	
<i>trimethoprim</i>	T1	
UTA	T3	
ANTI-LEPROTICS		
<i>dapsone</i>	T1	
THALOMID	T2	PA SP HD
ANTI-MYCOBACTERIUM AGENTS		
<i>ethambutol hcl</i>	T1	HD
<i>isoniazid</i>	T1	HD
PASER	T3	HD
<i>pyrazinamide</i>	T1	HD
<i>rifabutin</i>	T1	HD
TRECTOR	T3	HD

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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	
PRETOMANID	T3	PA QL (1 tab/day)
PRIFTIN	T3	
RIFAMATE	T3	
<i>rifampin</i>	T1	
RIFATER	T3	
SIRTURO	T3	SP
BETALACTAMS		
CAYSTON	T3	PA QL (3ml/day) SP HD
CEPHALOSPORIN ANTIBIOTICS - 1ST GENERATION		
<i>cefadroxil</i>	T1	
<i>cephalexin</i>	T1	
<i>cephalexin</i> (Keflex)	T1	
DAXBIA	T3	
KEFLEX (<i>cephalexin</i>)	T3	
CEPHALOSPORIN ANTIBIOTICS - 2ND GENERATION		
<i>cefaclor</i>	T1	
<i>cefprozil</i>	T1	
<i>cefuroxime axetil</i>	T1	
CEPHALOSPORIN ANTIBIOTICS - 3RD GENERATION		
<i>cefditoren pivoxil</i> (Spectracef)	T1	
<i>cefixime</i> (Suprax)	T1	
<i>cefpodoxime proxetil</i>	T1	
SPECTRACEF (<i>cefditoren pivoxil</i>)	T3	
LINCOSAMIDE ANTIBIOTICS		
<i>clindamycin hcl</i> (Cleocin Hcl)	T1	
<i>clindamycin palmitate hcl</i> (Cleocin Pediatric)	T1	
MACROLIDE ANTIBIOTICS		
<i>azithromycin 1 gm pwd packet</i> (Zithromax)	T1	
<i>azithromycin 100 mg/5 ml susp</i> (Zithromax)	T1	
<i>azithromycin 200 mg/5 ml susp</i> (Zithromax)	T1	
<i>azithromycin 250 mg tablet</i> (Zithromax)	T1	
<i>azithromycin 500 mg tablet</i> (Zithromax Tri-pak)	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 (cont.)		
<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>erythromycin base</i>	T1	
<i>erythromycin base</i> (Ery-tab)	T1	
<i>erythromycin ethylsuccinate</i>	T1	
<i>erythromycin ethylsuccinate</i> (Eryped 200)	T1	
<i>erythromycin stearate</i>	T1	
PCE	T3	
ZITHROMAX (<i>azithromycin</i>)	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 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	
MACRODANTIN (<i>nitrofurantoin</i>)	T3	
<i>nitrofurantoin 25 mg/5 ml susp</i> (Furadantin)	T1	
<i>nitrofurantoin macrocrystal</i>	T1	
<i>nitrofurantoin monohyd/m-cryst</i> (Macrobid)	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	

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List of Prescription Medications

ANTIBIOTICS (Infections) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
PENICILLIN ANTIBIOTICS (cont.)		
MOXATAG	T3	
penicillin v potassium	T1	
PLEUROMUTILIN DERIVATIVES		
XENLETA	T3	PA QL (10 tabs/30 days)
QUINOLONE ANTIBIOTICS		
AVELOX (moxifloxacin hcl)	T3	
BAXDELA	T3	PA
ciprofloxacin (Cipro)	T1	
ciprofloxacin hcl	T1	
ciprofloxacin hcl (Cipro)	T1	
ciprofloxacin/ciprofloxacin hcl	T1	
FACTIVE	T3	
levofloxacin	T1	
moxifloxacin hcl (Avelox)	T1	
ofloxacin	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		
coremino er 135 mg tablet	T1	
coremino er 45 mg tablet	T1	QL (1 tab/day)
coremino er 90 mg tablet	T1	
demeclocycline hcl	T1	
doxycycline (Targadox)	T1	
doxycycline hyclate 100 mg cap	T1	
doxycycline monohydrate	T1	
minocycline er 115 mg tablet	T1	
minocycline er 45 mg tablet	T1	QL (1 tab/day)
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	
NUZYRA	T3	PA QL (30 tablets/28 days) SP

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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.)		
tetracycline hcl	T1	
VIBRAMYCIN	T3	
VAGINAL ANTIBIOTICS		
clindamycin phosphate (Cleocin)	T1	
metronidazole (Metrogel-vaginal)	T1	
VANCOMYCIN ANTIBIOTICS AND DERIVATIVES		
vancomycin hcl	T1	
vancomycin hcl (Firvanq)	T1	
ANTIBIOTICS (Skin Conditions)		
TOPICAL ANTIBIOTIC AND ANTI-INFLAMMATORY STEROID		
NEO-SYNALAR	T3	
TOPICAL ANTIBIOTICS		
BENZAMYCIN (erythromycin-benzoyl peroxide)	T3	
CENTANY	T3	
CENTANY AT	T3	
clindacin etz 1% pledget (Cleocin T)	T1	
CLINDACIN ETZ KIT	T3	
CLINDACIN PAC	T3	
clindamycin phosphate (Cleocin T)	T1	
clindamycin phosphate (Evoclin)	T1	
erythromycin base in ethanol	T1	
erythromycin/benzoyl peroxide (Benzamycin)	T1	
EVOCLIN (clindamycin phosphate)	T3	
gentamicin sulfate	T1	
mupirocin calcium	T1	
XEPI	T3	
TOPICAL SULFONAMIDES		
AVAR 9.5-5% CLEANSING PADS	T3	
avar cleanser (Rosanil)	T1	
AVAR LS	T3	
mafenide acetate	T1	
ROSANIL (sodium sulfacetamide-sulfur)	T1	
SILVADENE (ssd)	T3	

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List of Prescription Medications

ANTIBIOTICS (Skin Conditions) (cont.)

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

ANTI-COAGULANTS (Blood Thinners/Anti-Clotting)

ANTI-COAGULANTS, COUMARIN TYPE		
<i>warfarin sodium</i>	T1	HD
CITRATES AS ANTI-COAGULANTS		
ACD SOLUTION A	T3	
ANTICOAGULANT SODIUM CITRATE	T3	
CITRATE PHOSPHATE DEXTROSE	T1	
SODIUM CITRATE	T1	
DIRECT FACTOR XA INHIBITORS		
BEVYXXA	T3	QL (42 caps/42 days)
ELIQUIS	T2	PA
SAVAYSA 15 MG TABLET	T3	PA QL (1 tab/day)
SAVAYSA 30 MG TABLET	T3	PA QL (1 tab/day)
SAVAYSA 60 MG TABLET	T3	PA
XARELTO	T2	PA
HEPARIN AND RELATED PREPARATIONS		
<i>ARIXTRA (fondaparinux sodium)</i>	T3	QL (1 syringe/day) SP
<i>enoxaparin 100 mg/ml syringe (Lovenox)</i>	T1	QL (2 syringes/day) SP
<i>enoxaparin 120 mg/0.8 ml syr (Lovenox)</i>	T1	QL (2 syringes/day) SP
<i>enoxaparin 300 mg/3 ml vial (Lovenox)</i>	T1	QL (1 vial/day) SP
<i>enoxaparin 60 mg/0.6 ml syr (Lovenox)</i>	T1	QL (2 syringes/day) SP
<i>enoxaparin 80 mg/0.8 ml syr (Lovenox)</i>	T1	QL (2 syringes/day) SP
<i>fondaparinux sodium (Arixtra)</i>	T1	QL (1 syringe/day) SP
FRAGMIN	T2	QL (2ml/day) SP
<i>heparin 10,000 unit/10 ml vial</i>	T1	

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T3 – Typically Non-Preferred Brands

ST – Step Therapy

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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.)		
heparin 30,000 unit/30 ml vial	T1	
heparin sod 5,000 unit/ml vial	T1	
LOVENOX 100 MG/ML SYRINGE (enoxaparin sodium)	T3	QL (2 syringes/day) SP
LOVENOX 120 MG/0.8 ML SYRINGE (enoxaparin sodium)	T3	QL (2 syringes/day) SP
LOVENOX 150 MG/ML SYRINGE (enoxaparin sodium)	T3	QL (2 syringes/day) SP
LOVENOX 30 MG/0.3 ML SYRINGE (enoxaparin sodium)	T3	QL (2 syringes/day) SP
LOVENOX 300 MG/3 ML VIAL (enoxaparin sodium)	T3	QL (1 vial/day) SP
LOVENOX 40 MG/0.4 ML SYRINGE (enoxaparin sodium)	T3	QL (2 syringes/day) SP
LOVENOX 60 MG/0.6 ML SYRINGE (enoxaparin sodium)	T3	QL (2 syringes/day) SP
LOVENOX 80 MG/0.8 ML SYRINGE (enoxaparin sodium)	T3	QL (2 syringes/day) SP

ANTIDOTES (Gastrointestinal/Heartburn)

MU-OPIOID RECEPTOR ANTAGONISTS, PERIPHERALLY-ACTING

MOVANTIK	T2	PA
RELISTOR	T3	PA
SYMPROIC	T3	PA

ANTIDOTES (Substance Abuse)

OPIOID ANTAGONISTS

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

ANTI-FUNGALS (Eye Conditions)

OPHTHALMIC ANTI-FUNGAL AGENTS

NATACYN	T3	
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T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

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List of Prescription Medications

ANTI-FUNGALS (Feminine Products)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
VAGINAL ANTI-FUNGALS		
GYNAZOLE 1	T1	
<i>miconazole nitrate</i>	T1	
<i>terconazole</i>	T1	
ANTI-FUNGALS (Infections)		
ANTI-FUNGAL AGENTS		
ANCOBON (<i>flucytosine</i>)	T3	
<i>clotrimazole</i>	T1	
CRESEMBA	T3	PA
<i>fluconazole</i>	T1	
<i>flucytosine</i> (Ancobon)	T1	
<i>itraconazole</i>	T1	
<i>ketoconazole</i>	T1	
ORAVIG	T3	
<i>posaconazole</i> (NOXAFIL)	T1	
<i>terbinafine hcl</i>	T1	
VFEND (<i>voriconazole</i>)	T3	PA
VIVJOA	T3	PA SP
<i>voriconazole</i> (Vfend)	T1	PA
ANTI-FUNGAL ANTIBIOTICS		
<i>griseofulvin ultramicrosize</i> (Gris-peg)	T1	
<i>griseofulvin, microsize</i>	T1	
GRIS-PEG (<i>griseofulvin ultramicrosize</i>)	T3	
<i>nystatin</i>	T1	
ANTI-FUNGALS (Skin Conditions)		
TOPICAL ANTI-FUNGAL/ANTI-INFLAMMATORY, STEROID AGENT		
<i>clotrimazole/betamethasone dip</i>	T1	
TOPICAL ANTI-FUNGALS		
<i>ciclodan 0.77% cream</i>	T1	
CICLODAN 0.77% CREAM KIT	T3	
<i>ciclodan 8% solution</i>	T1	
<i>ciclopirox</i>	T1	
<i>ciclopirox olamine</i> (Loprox)	T1	
<i>econazole nitrate</i>	T1	

T1 – Typically Generics

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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.)		
ECOZA	T3	
EXODERM	T1	
<i>ketoconazole</i>	T1	
<i>ketoconazole/skin cleanser 28</i>	T1	
LOPROX	T3	
LOPROX (<i>ciclopirox</i>)	T3	
LULICONAZOLE	T1	
<i>naftifine hcl</i>	T1	
<i>naftifine hcl</i> (Naftin)	T1	
<i>nystatin</i>	T1	
<i>nystatin/triamcinolone acetate</i>	T1	
ANTIHISTAMINES (Allergy/Nasal Sprays)		
1ST GEN ANTIHISTAMINE AND DECONGESTANT COMBINATION		
<i>phenylephrine hcl/prometh hcl</i>	T1	
2ND GEN ANTIHISTAMINE AND DECONGESTANT COMBINATION		
CLARINEX-D 12 HOUR	T3	
ANTIHISTAMINES - 1ST GENERATION		
<i>carbinoxamine maleate</i>	T1	
<i>clemastine fumarate</i>	T1	
<i>cyproheptadine hcl</i> (Cyproheptadine Hcl)	T1	
<i>hydroxyzine hcl</i>	T1	
<i>hydroxyzine pamoate</i>	T1	
<i>hydroxyzine pamoate</i> (Vistaril)	T1	
<i>promethazine hcl</i>	T1	
VISTARIL (<i>hydroxyzine pamoate</i>)	T3	
ANTI-HYPERGLYCEMICS (Diabetes)		
ANTIHYPERGLY, INCRETIN MIMETIC (GLP-1 RECEPTOR AGONIST)		
BYDUREON	T2	QL (4 vials/28 days) ST
BYDUREON BCISE	T2	PA QL (4 pens/28 days)
BYDUREON PEN	T2	PA QL (4 pens/28 days)
LIRAGLUTIDE	T3	QL(3 pens/30 days) HD
OZEMPIC 0.25-0.5 MG DOSE PEN	T2	PA QL (2 pens/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

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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
ANTIHYPERGLY, INCRETIN MIMETIC (GLP-1 RECEPTOR AGONIST) (cont.)		
OZEMPIC 1 MG DOSE PEN (1.5 ML)	T2	PA QL (3ml/28 days) HD
OZEMPIC 1 MG DOSE PEN (3 ML)	T2	PA QL (3ml/21 days) HD
REZVOGLAR KWIKPEN	T2	QL
RYBELSUS	T2	PA QL (1 tab/day)
TRULICITY 0.75 MG/0.5 ML PEN	T2	PA QL (4 pens/28 days)
TRULICITY 1.5 MG/0.5 ML PEN	T2	PA QL (4 pens/28 days)
TRULICITY 3 MG/0.5 ML PEN	T2	PA QL (2 ml/28 days)
TRULICITY 4.5 MG/0.5 ML PEN	T2	PA QL (2 ml/28 days)
ANTI-HYPERGLY, INSULIN, LONG ACT-GLP-1 RECEPTOR AGONIST		
SOLIQUA 100-33	T2	HD
ANTI-HYPERGLYCEMIC-SOD/GLUC COTRANSPORT2(SGLT2) INHIB		
FARXIGA	T2	ST QL (1 tab/day)
JARDIANCE	T2	QL (1 tab/day) ST HD
STEGLATRO	T2	QL (1 tab/day) ST HD
ANTI-HYPERGLYCEMIC-DOPAMINE RECEPTOR AGONISTS		
CYCLOSET	T3	HD
ANTI-HYPERGLYCEMIC, ALPHA-GLUCOSIDASE INHIBITORS		
acarbose (Precose)	T1	HD
GLYSET (miglitol)	T3	HD
miglitol (Glyset)	T1	HD
PRECOSE (acarbose)	T3	HD
ANTI-HYPERGLYCEMIC, AMYLIN ANALOG-TYPE		
SYMLINPEN 60	T2	HD
SYMLINPEN 120	T2	HD
ANTI-HYPERGLYCEMIC, BIGUANIDE TYPE		
GLUCOPHAGE XR (metformin hcl er)	T3	HD
metformin hcl	T1	HD
metformin hcl (Glucophage Xr)	T1	HD
metformin hcl (Riomet)	T1	HD
RIOMET (metformin hcl)	T3	HD
RIOMET ER	T3	HD
ANTIHYPERGLYCEMIC, DPP-4 INHIBITORS		
JANUVIA	T2	QL (1 tab/day) ST HD
ANTIHYPERGLYCEMIC-GLUCOCORTICOID RECEPTOR BLOCKER		
mifepristone 300 mg tablet (Korlym)	T1	PA SP

T1 – Typically Generics

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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, INSULIN-RELEASE STIMULANT TYPE		
AMARYL (<i>glimepiride</i>)	T3	HD
<i>chlorpropamide</i>	T1	HD
GLIPIZIDE 2.5 MG TABLET	T3	HD
<i>glimepiride</i> (Amaryl)	T1	HD
GLIMEPIRIDE 3 MG TABLET		
<i>glipizide</i> (Glucotrol XL)	T1	HD
<i>glipizide</i> (Glucotrol)	T1	HD
GLUCOTROL (<i>glipizide</i>)	T3	HD
GLUCOTROL XL (<i>glipizide xl</i>)	T3	HD
<i>glyburide</i>	T1	HD
GLYNASE (<i>glyburide micronized</i>)	T3	HD
<i>repaglinide</i>	T1	HD
STARLIX (<i>nateglinide</i>)	T3	HD
<i>tolbutamide</i>	T1	HD
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
ANTIHYPERGLYCEMIC, 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
<i>glyburide/metformin hcl</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</i> (Actos)	T1	HD

T1 – Typically Generics

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T2 – Typically Preferred Brands

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T3 – Typically Non-Preferred Brands

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List of Prescription Medications

ANTI-HYPERGLYCEMICS (Diabetes) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ANTI-HYPERGLYCEMIC-SGLT2 INHIBITOR-BIGUANIDE COMBS.		
SEGLUROMET	T2	QL (2 tabs/day) ST HD
SYNJARDY	T2	QL (2 tabs/day) ST HD
ANTI-HYPERGLYCEMIC-SGLT2 INHIBITOR-BIGUANIDE COMBS. (cont)		
SYNJARDY XR 10-1,000 MG TABLET	T2	QL (2 tabs/day) ST HD
SYNJARDY XR 12.5-1,000 MG TAB	T2	QL (2 tabs/day) ST HD
SYNJARDY XR 25-1,000 MG TABLET	T2	QL (1 tab/day) ST HD
SYNJARDY XR 5-1,000 MG TABLET	T2	QL (2 tabs/day) ST HD
XIGDUO XR 10 MG-1,000 MG TAB	T2	QL (1 tab/day) ST HD
XIGDUO XR 10 MG-500 MG TABLET	T2	QL (1 tab/day) ST HD
XIGDUO XR 2.5 MG-1,000 MG TAB	T2	QL (2 tabs/day) ST HD
XIGDUO XR 5 MG-1,000 MG TABLET	T2	QL (2 tabs/day) ST HD
XIGDUO XR 5 MG-500 MG TABLET	T2	QL (1 tab/day) ST HD
ANTIHYPERGLY-SGLT-2 INHIB, DPP-4 INHIB, BIGUANIDE CB		
TRIJARDY XR	T2	QL (1 tab/day) ST HD
INSULINS		
FIASP PENFILL	T3	QL (1.5ml/day) HD
HUMALOG	T2	QL (1.5mls/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(1.5 mls/day) HD
HUMULIN R U-500	T2	QL (1ml/day) HD
HUMULIN R U-500 KWIKPEN	T2	QL (1ml/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 (1.5ml/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	
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ANTI-INFECTIVES (Infections)

PENICILLIN ANTIBIOTICS

<i>amoxicillin</i>	T1	
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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-INFECTIVES/MISCELLANEOUS (Feminine Products)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
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	
AMEBICIDES		
<i>paromomycin sulfate</i>	T1	
ANTHELMINTICS		
ALBENZA (<i>albendazole</i>)	T3	
BILTRICIDE (<i>praziquantel</i>)	T3	
EMVERM	T1	
<i>ivermectin</i> (Stromectol)	T1	PA
<i>praziquantel</i> (Biltricide)	T1	
STROMECTOL (<i>ivermectin</i>)	T3	PA
ANTI-MALARIAL DRUGS		
<i>atovaquone/proguanil hcl</i> (Malarone)	T1	
<i>chloroquine ph 250 mg tablet</i>	T1	QL (56 tabs/365 days)
<i>chloroquine ph 500 mg tablet</i>	T1	
COARTEM	T3	PA QL (24 tabs/30 days)
<i>hydroxychloroquine sulfate</i> (Plaquenil)	T1	
KRINTAFEL	T3	PA QL (2 tabs/30 days)
MALARONE (<i>atovaquone-proguanil hcl</i>)	T3	PA
<i>mefloquine hcl</i>	T1	
PLAQUENIL (<i>hydroxychloroquine sulfate</i>)	T3	PA
PRIMAQUINE (<i>primaquine phosphate</i>)	T1	
<i>primaquine phosphate</i> (Primaquine)	T1	
<i>pyrimethamine 25 mg tablet</i> (Daraprim)	T1	PA
QUALAQUIN (<i>quinine sulfate</i>)	T3	PA
<i>quinine sulfate</i> (Qualaquin)	T1	

T1 – Typically Generics

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AGE – Age Requirement

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List of Prescription Medications

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

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
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	

ANTI-INFECTIVES/MISCELLANEOUS (Miscellaneous)

ANTIBACTERIAL AGENTS, MISCELLANEOUS		
<i>glycine urologic solution</i>	T1	
TOPICAL ANTISEPTIC DRYING AGENTS		
<i>formaldehyde</i>	T1	

ANTI-INFECTIVES/MISCELLANEOUS (Skin Conditions)

TOPICAL ANTI-FUNGALS		
CICLODAN 8% KIT	T3	
<i>ciclopirox/urea/camph/men/euc</i> (Ciclodan)	T1	

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

ANTI-INFLAMMATORY TUMOR NECROSIS FACTOR INHIBITOR		
ADALIMUMAB-ADAZ	T2	PA QL(2 pens/syringes/28 days) SP HD
ADALIMUMAB-ADBM(CF)	T2	PA QL(2 pens/syringes/28 days) SP HD
ADALIMUMAB-ADBM(CF) PEN	T2	PA QL(1 starter kit/365 days) SP HD
ADALIMUMAB-RYVK(CF) AUTOINJECT	T2	PA QL SP HD
CIMZIA 200 MG VIAL KIT	T2	PA QL (1 kit/28 days) SP HD
CIMZIA 2X200 MG/ML SYRINGE KIT	T2	PA QL (1 kit/28 days) SP HD
CIMZIA 2X200 MG/ML (X3) START KT	T2	PA QL (1 kit/year) SP HD
CYLTEZO(CF)	T2	PA QL (2 doses/ 28 days) SP
CYLTEZO(CF) PEN	T2	PA QL(1 starter kit/365 days) SP
ENBREL 25 MG KIT	T2	PA QL (8 vials/28 days) SP HD
ENBREL 25 MG/0.5 ML SYRINGE	T2	PA QL (8 syringes/28 days) SP HD
ENBREL 25 MG/0.5 ML VIAL	T2	PA QL (4ml/28 days) SP HD
ENBREL 50 MG/ML SYRINGE	T2	PA QL (4 syringes/28 days) SP HD
ENBREL MINI	T2	PA QL (4 cartridges/28 days) SP HD
ENBREL SURECLICK	T2	PA QL (4 syringes/28 days) SP HD
HUMIRA	T2	PA QL (2 syringes/28 days) SP HD

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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.)		
HUMIRA PEN	T2	PA QL (2 pens/28 days) SP HD
SIMLANDI(CF) AUTOINJECTOR	T2	PA QL(2 pens/syringes/28 days) SP
SIMPONI 100 MG/ML PEN INJECTOR	T2	PA QL (1 injector/28 days) SP HD
SIMPONI 100 MG/ML SYRINGE	T2	PA QL (1 syringe/28 days) SP HD
SIMPONI ARIA	T2	PA SP HD
ZYMFENTRA 120 MG/ML PEN KIT	T2	PA QL(2 kits/28 days) SP HD
ZYMFENTRA 120 MG/ML SYRINGE KT	T2	PA QL(2 syringe kits/28 days) SP HD
SIMPONI 100 MG/ML SYRINGE	T2	PA QL (1 syringe/28 days) SP HD
SIMPONI ARIA	T2	PA SP HD
ANTI-NEOPLASTICS (Cancer)		
ANP - SELECTIVE RETINOID X RECEPTOR AGONISTS (RXR)		
bexarotene (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 CSL
ANTI-NEOPLASTIC - ANTI-ANDROGENIC AGENTS		
<i>abiraterone acetate 500 mg tab</i> (Zytiga)	T1	SP HD CSL
<i>bicalutamide</i> (Casodex)	T1	
CASODEX (<i>bicalutamide</i>)	T3	
ERLEADA	T2	PA QL(1 tab/day) SP HD CSL
<i>flutamide</i>	T1	
<i>nilutamide</i>	T1	QL (4 tabs/day)
NUBEQA	T3	PA SP HD
XTANDI	T3	PA SP HD

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List of Prescription Medications

ANTI-NEOPLASTICS (Cancer) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
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
<i>mercaptopurine</i>	T1	
<i>methotrexate sodium</i>	T1	
<i>methotrexate sodium/pf</i>	T1	
ONUREG	T3	PA QL (14 Tabs/28 Days) SP
PURIXAN	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
FEMARA (<i>letrozole</i>)	T3	HD
<i>letrozole</i> (Femara)	T1	HD SL
ANTI-NEOPLASTIC - BRAF KINASE INHIBITORS		
TAFINLAR 10 MG TABLET FOR SUSP	T2	PA QL(30 tabs/day) SP HD CSL
TAFINLAR CAPSULE	T2	PA QL(4 caps/day) SP HD CSL
OJEMDA TABLET	T3	PA QL(1 packet/28 Days) SP CSL
OJEMDA 25 MG/ML ORAL SUSP	T3	PA QL(8 bottles/28 days) SP 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 QL(8 tabs/day) SP HD CSL
LUMAKRAS 240 MG TABLET	T3	PA QL(4 tabs/day) SP HD CSL
LUMAKRAS 320 MG TABLET	T3	PA QL(3 tabs/day) SP HD CSL

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List of Prescription Medications

ANTI-NEOPLASTICS (Cancer) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ANTI-NEOPLASTIC - MEK1 AND MEK2 KINASE INHIBITORS		
COTELLIC	T3	PA SP HD
GOMEKLI	T3	PA SP HD
KOSELUGO 10 MG CAPSULE	T3	PA QL (10 capsules/day) SP
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	PA QL(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 10 MG TABLET	T2	PA SP HD
AFINITOR 2.5 MG TABLET (<i>everolimus</i>)	T3	PA SP HD
AFINITOR 5 MG TABLET (<i>everolimus</i>)	T3	PA SP HD
AFINITOR 7.5 MG TABLET (<i>everolimus</i>)	T3	PA SP HD
AFINITOR DISPERZ	T3	PA SP
<i>everolimus tablet</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 FEMARA CO-PACK	T3	PA QL(1 pack/28 days) SP
ANTI-NEOPLASTIC IMMUNOMODULATOR AGENTS		
<i>lenalidomide</i>	T1	PA QL(1 cap/day) SP HD CSL
REVLIMID	T2	PA QL(1 tab/day) SP HD CSL
ANTI-NEOPLASTIC LHRH (GNRH) ANTAGONIST, PITUIT.SUPPRS		
ORGOVYX	T3	PA SP
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 CSL
BRUKINSA	T2	PA QL (4 caps/day) SP

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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.)		
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
ENSACOVE 25 MG CAPSULE	T2	PA QL(9 caps/day) SP CSL
ENSACOVE 100 MG CAPSULE	T2	PA QL (2 caps/day) SP CSL
<i>erlotinib hcl</i>	T1	PA SP HD 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
<i>gefitinib</i>	T1	PA SP HD CSL
GILOTRIF	T3	PA SP HD
GLEEVEC (<i>imatinib mesylate</i>)	T3	PA SP HD
IBRANCE	T2	PA QL(21 caps/28 days) SP HD CSL
IBTROZI 200 MG CAPSULE	T3	PA SP HD
ICLUSIG	T3	PA SP
<i>imatinib mesylate 100mg tab (Gleevec)</i>	T1	QL(6 tabs/day) SP HD CSL
<i>imatinib mesylate 400mg tab (Gleevec)</i>	T1	QL(2 tabs/day) SP HD CSL
IMBRUVICA	T3	PA SP
INLYTA	T3	PA SP HD
INREBIC	T3	PA SP HD
IRESSA	T3	PA SP HD
IWILFIN	T3	PA QL(8 tabs/day) SP CSL
KISQALI 600MG	T3	PA QL (63/28 days) SP HD
KISQALI 400MG	T3	PA QL (42/28 days) SP HD
KISQALI 200MG	T3	PA QL (21/28 days) SP HD
<i>lapatinib ditosylate (Tykerb)</i>	T1	PA SP HD
LENVIMA	T2	PA SP HD
LORBRENA	T3	PA SP HD

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List of Prescription Medications

ANTI-NEOPLASTICS (Cancer) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ANTI-NEOPLASTIC SYSTEMIC ENZYME INHIBITORS (cont.)		
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
NEXAVAR	T2	PA SP HD
NINLARO	T3	PA SP HD
OGSIVEO	T3	PA QL(6 tabs/day) SP CSL
OJJAARA	T3	PA QL(1 tab/day) SP CSL
<i>pazopanib hcl</i> (Votrient)	T1	PA QL(4 tabs/day) SP HD CSL
PEMAZYRE	T3	PA QL (14 tabs/21 days) SP
PIQRAY	T3	PA SP HD 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
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 HD CSL
SCEMBLIX 40 MG TABLET	T2	PA SP HD CSL
SCEMBLIX 100 MG TABLET	T2	PA SP CSL
STIVARGA	T2	PA SP HD
TABRECTA	T3	PA QL (4 tabs/day) SP HD
TAGRISSO	T3	PA SP HD
TALZENNA 0.1, 0.25, 0.35, 1 MG SOFTGEL	T3	PA QL(1 cap/day) SP HD CSL
TALZENNA 0.5, 0.75 MG SOFTGEL	T3	PA SP HD CSL
TEPMETKO	T3	PA QL (2 tabs/day) SP
TRUQAP	T2	PA QL(64 tabs/28 days) SP CSL
TUKYSA	T3	PA SP
TURALIO 200 MG CAPSULE	T3	PA SP CSL
TURALIO 125 MG CAPSULE	T3	PA QL(4 caps/day) SP CSL
TYKERB (<i>lapatinib</i>)	T3	PA SP HD
UKONIQ	T3	PA QL (4 tabs/day) SP

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List of Prescription Medications

ANTI-NEOPLASTICS (Cancer) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ANTI-NEOPLASTIC SYSTEMIC ENZYME INHIBITORS (cont.)		
VANFLYTA	T3	PA QL(2 tabs/day) SP CSL
VERZENIO	T2	PA QL (120ml/day) SP HD
VITRAKVI	T3	PA SP HD
VIZIMPRO	T3	PA SP HD
XALKORI CAPSULE	T3	PA QL(4 caps/day) SP HD CSL
XALKORI PELLET	T3	PA QL(4 pellets/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-B CELL LYMPHOMA-2(BCL-2) INHIBITORS		
VENCLEXTA	T3	PA SP
VENCLEXTA STARTING PACK	T3	PA SP
ANTI-NEOPLASTIC-ENZYME INHIB, ANTIANDROGEN COMB.		
AKEEGA	T4	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
ANTI-NEOPLASTICS, MISCELLANEOUS		
<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
IMMUNOMODULATORS		
ACTIMMUNE	T2	PA SP HD
POMALYST	T2	PA SP HD
SELECTIVE ESTROGEN RECEPTOR MODULATORS (SERMS)		
FARESTON (<i>toremifene citrate</i>)	T3	QL (2 tabs/day) HD
SOLTAMOX	T2	HD
<i>toremifene citrate</i> (Fareston)	T1	QL (2 tabs/day) HD
STEROID ANTI-NEOPLASTICS		
EMCYT	T2	SP HD

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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
TOPICAL ANTI-NEOPLASTIC PREMALIGNANT LESION AGENTS (cont.)		
<i>megestrol acetate</i>	T1	
EFUDEX (<i>fluorouracil</i>)	T3	
FLUOROPLEX	T2	
<i>fluorouracil</i>	T1	
<i>fluorouracil</i> (Efudex)	T1	
PANRETIN	T3	SP HD
PICATO	T3	
TOLAK	T3	
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>	T1	
<i>benzphetamine hcl</i> (Regimex)	T1	
<i>diethylpropion hcl</i>	T1	
LOMAIRA	T1	
<i>phendimetrazine tartrate</i>	T1	
<i>phentermine hcl</i>	T1	
<i>phentermine hcl</i> (Adipex-p)	T1	
QSYMIA	T3	PA
REGIMEX (<i>benzphetamine hcl</i>)	T3	
ANTI-OBESITY - INCRETIN MIMETICS COMBINATION		
ZEPBOUND 2.5 MG/0.5 ML PEN	T2	PA QL(2 mls/30 days)
ZEPBOUND 5 MG/0.5 ML PEN	T2	PA QL(2 mls/30 days)
ZEPBOUND 7.5 MG/0.5 ML PEN	T2	PA QL(2 mls/30 days)
ZEPBOUND 10 MG/0.5 ML PEN	T2	PA QL(2 mls/30 days)
ZEPBOUND 12.5 MG/0.5 ML PEN	T2	PA QL(2 mls/30 days)
ZEPBOUND 15 MG/0.5 ML PEN	T2	PA QL(2 mls/30 days)
ZEPBOUND 2.5 MG/0.5 ML VIAL	T2	PA QL(2 mls/30 days)
ZEPBOUND 5 MG/0.5 ML VIAL	T2	PA QL(2 mls/30 days)
ANTI-OBESITY GLUCAGON-LIKE PEPTIDE-1 RECEPTOR AGONIST		
WEGOVY	T2	PA QL (1 box/month)
ANTI-OBESITY SEROTONIN 2C RECEPTOR AGONISTS		
BELVIQ	T3	PA
BELVIQ XR	T3	PA

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-OBESITY DRUGS (Weight Management) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ANTI-OBESITY - OPIOID ANTAG-NOREPI, DOPAMINE RU INHIB (con't.)		
CONTRACE	T3	PA
FAT ABSORPTION DECREASING AGENTS		
XENICAL	T3	PA
ANTI-PARASITICS (Eye Conditions)		
OPHTHALMIC (EYE) ANTIPARASITICS		
XDEMVI	T2	PA QL(4 bottles/30 days) SP
ANTI-PARASITICS (Infections)		
ANTI-PARASITICS		
ALINIA	T3	
ALINIA (nitazoxanide)	T3	
nitazoxanide (Alinia)	T1	
TOPICAL ANTI-PARASITICS		
crotamiton (Eurax)	T1	
ELIMITE (permethrin)	T3	
ivermectin cream	T1	
permethrin (Elimite)	T1	
SKLICE (ivermectin)	T3	
spinosad (Natroba)	T1	
ULESFIA	T3	
ANTI-PARKINSON DRUGS (Parkinson's Disease)		
ANTI-PARKINSONISM DRUGS, ANTI-CHOLINERGIC		
benztropine mesylate	T1	HD
trihexyphenidyl hcl	T1	HD
ANTI-PARKINSONISM DRUGS, OTHER		
amantadine hcl	T1	HD
APOKYN	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-PARKINSON DRUGS (Parkinson's Disease) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ANTI-PARKINSONISM DRUGS, OTHER (cont.)		
AZILECT 0.5 MG TABLET (<i>rasagiline mesylate</i>)	T3	QL (1 tab/day) HD
AZILECT 1 MG TABLET (<i>rasagiline mesylate</i>)	T3	HD
<i>carbidopa/levodopa</i>	T1	HD
<i>carbidopa/levodopa</i> (Sinemet 10-100)	T1	HD
<i>carbidopa/levodopa</i> (Sinemet 25-100)	T1	HD
<i>carbidopa/levodopa</i> (Sinemet 25-250)	T1	HD
<i>carbidopa/levodopa/entacapone</i> (Stalevo 100)	T1	HD
<i>carbidopa/levodopa/entacapone</i> (Stalevo 125)	T1	HD
<i>carbidopa/levodopa/entacapone</i> (Stalevo 150)	T1	HD
<i>carbidopa/levodopa/entacapone</i> (Stalevo 200)	T1	HD
<i>carbidopa/levodopa/entacapone</i> (Stalevo 50)	T1	HD
<i>carbidopa/levodopa/entacapone</i> (Stalevo 75)	T1	HD
DUOPA	T3	SP HD
<i>entacapone</i>	T1	HD
INBRIJA	T3	PA SP HD
KYNMOBI	T2	PA HD
MIRAPEX ER 0.375 MG TABLET (<i>pramipexole er</i>)	T3	QL (1 tab/day) HD
MIRAPEX ER 0.75 MG TABLET (<i>pramipexole er</i>)	T3	HD
MIRAPEX ER 1.5 MG TABLET (<i>pramipexole er</i>)	T3	QL (1 tab/day) HD
MIRAPEX ER 2.25 MG TABLET (<i>pramipexole er</i>)	T3	QL (1 tab/day) HD
MIRAPEX ER 3 MG TABLET (<i>pramipexole er</i>)	T3	HD
MIRAPEX ER 3.75 MG TABLET (<i>pramipexole er</i>)	T3	HD
NEUPRO	T3	HD
NOURIANZ	T3	PA QL (1 tab/day) SP HD
OSMOLEX ER 129 MG TABLET	T3	QL (1 tab/day) HD
OSMOLEX ER 193 MG TABLET	T3	QL (1 tab/day) HD
OSMOLEX ER 258 MG TABLET	T3	QL (1 tab/day) HD
OSMOLEX ER 322 MG DAILY DOSE	T3	QL (2 tabs/day) HD
PARLODEL (<i>bromocriptine mesylate</i>)	T3	HD
<i>pramipexole di-hcl</i>	T1	HD
<i>pramipexole er 0.375 mg tablet</i> (Mirapex Er)	T1	QL (1 tab/day) HD
<i>pramipexole er 0.75 mg tablet</i> (Mirapex Er)	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, OTHER (cont.)		
<i>pramipexole</i> er 1.5 mg tablet	T1	QL (1 tab/day) HD
<i>pramipexole</i> er 2.25 mg tablet	T1	QL (1 tab/day) HD
<i>pramipexole</i> er 3 mg tablet	T1	HD
<i>pramipexole</i> er 3.75 mg tablet	T1	HD
<i>rasagiline</i> mesylate 0.5 mg tab (Azilect)	T1	QL (1 tab/day) HD
RYTARY	T3	HD
<i>selegiline</i> hcl	T1	HD
SINEMET 10-100 / 25-100 (<i>carbidopa-levodopa</i>)	T3	HD
SINEMET 25-250 (<i>carbidopa-levodopa</i>)	T3	HD
STALEVO (<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	
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ANTI-PLATELET DRUGS (Blood Thinners/Anti-Clotting)

PLATELET AGGREGATION INHIBITORS

<i>aspirin/dipyridamole</i>	T1	HD
<i>cilostazol</i>	T1	HD
<i>clopidogrel</i> bisulfate	T1	HD
<i>clopidogrel</i> bisulfate (Plavix)	T1	HD
<i>dipyridamole</i>	T1	HD
EFFIENT (<i>prasugrel</i> hcl)	T3	HD
PLAVIX (<i>clopidogrel</i>)	T3	HD
<i>prasugrel</i> hcl (Effient)	T1	HD
<i>ticlopidine</i> hcl	T1	HD

PLATELET REDUCING AGENTS

AGRYLIN (<i>anagrelide</i> hcl)	T3	
<i>anagrelide</i> hcl	T1	
<i>anagrelide</i> hcl (Agrylin)	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

ANTIVIRALS (AIDS/HIV)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ANTI-RETROVIRAL - INTEGRASE INHIBITOR AND NNRTI COMB.		
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
TRIUMEQ PD 60-5-30 MG TAB SUSP	T2	QL(1 tab/day) SP
ANTI-RETROVIRAL - NUCLEOSIDE, NUCLEOTIDE, PROTEASE INH.		
SYM TUZA	T3	SP
ANTIVIRALS - HIV-SPEC, NON-PEPTIDIC PROTEASE INHIB		
APTIVUS	T2	PA SP
darunavir (Prezista)	T1	HD
PREZCOBIX	T3	PA SP
PREZISTA	T2	SP
ANTIVIRALS - HIV-SPEC, NUCLEOSIDE-NUCLEOTIDE ANALOG		
CIMDUO	T3	PA SP
DESCOVY	T3	SP PPACA
<i>emtricitabine-tenofv 100-150mg</i>	T1	SP
<i>emtricitabine-tenofv 133-200mg</i>	T1	SP
<i>emtricitabine-tenofv 167-250mg</i>	T1	SP
<i>emtricitabine-tenofv 200-300mg</i>	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.		
maraviroc (Selzentry)	T1	PA SP
SELZENTRY	T3	PA SP
ANTIVIRALS - HIV-SPECIFIC, FUSION INHIBITORS		
FUZEON	T2	PA SP
ANTIVIRALS - HIV-SPECIFIC, NON-NUCLEOSIDE, RTI		
EDURANT	T3	PA SP
<i>efavirenz</i>	T1	PA SP
<i>nevirapine</i>	T1	PA SP
PIFELTRO	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, NUCLEOSIDE ANALOG, RTI		
<i>abacavir sulfate</i>	T1	PA SP
<i>emtricitabine</i> (Emtriva)	T1	PA SP
EMTRIVA 10 MG/ML SOLUTION	T2	PA SP
<i>lamivudine 10 mg/ml oral soln</i>	T1	SP
<i>lamivudine 150 mg tablet</i>	T1	SP
<i>lamivudine 300 mg tablet</i>	T1	PA SP
<i>tenofovir disoproxil fumarate</i>	T1	PA SP
VIREAD POWDER	T2	PA SP
<i>zidovudine</i>	T1	SP
ANTIVIRALS - HIV-SPECIFIC, PROTEASE INHIBITOR COMB		
<i>lopinavir/ritonavir</i>	T1	SP
ANTIVIRALS - HIV-SPECIFIC, PROTEASE INHIBITORS		
<i>atazanavir sulfate</i>	T1	PA SP
EVOTAZ	T3	PA SP
<i>fosamprenavir calcium</i>	T1	PA SP
NORVIR	T2	SP
REYATAZ	T2	PA SP
<i>ritonavir</i>	T1	SP
ANTIVIRALS - HIV-I INTEGRASE STRAND TRANSFER INHIBTR		
APRETUDE	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		
DELSTRIGO	T3	PA SP
<i>efavirenz/emtricit/tenofovr df</i> (Atripla)	T1	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

T1 – Typically Generics

PA – Prior Authorization

AGE – Age Requirement

PPACA – No Cost-Share Preventive Medication

T2 – Typically Preferred Brands

QL – Quantity Limit

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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
ARV-NUCLEOSIDE, NUCLEOTIDE RTI, INTEGRASE INHIBITORS (cont.)		
GENVOYA	T2	SP
STRIBILD	T3	PA SP
ANTIVIRALS (Eye Conditions)		
EYE ANTIVIRALS		
trifluridine	T1	
ZIRGAN	T3	
ANTIVIRALS (Infections)		
ANTIVIRALS, GENERAL		
acyclovir	T1	
famciclovir	T1	
FLUMADINE (rimantadine hcl)	T3	
LIVTENCITY	T3	PA QL (4 tabs/day) SP
oseltamivir 6 mg/ml suspension	T1	QL (180ml/30 days)
oseltamivir phos 30 mg capsule	T1	QL (20 caps/30 days)
oseltamivir phos 45 mg capsule	T1	QL (10 caps/30 days)
oseltamivir phos 75 mg capsule	T1	QL (10 caps/30 days)
PREVMIS	T3	SP HD
RELENZA	T3	QL (20/30 days)
rimantadine hcl (Flumadine)	T1	
valganciclovir hcl	T1	
VALTREX (valacyclovir)	T3	
XOFLUZA	T3	QL (2 tabs/30 days)
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 PELLETT PACKET	T2	PA QL (1 tab/day) SP HD
SOVALDI 200 MG PELLETT 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 PELLETT PK	T2	PA QL (1 tab/day) 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

ANTIVIRALS (Infections) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
HEP C VIRUS-NS5B POLYMERASE AND NS5A INHIB. COMBO. (cont.)		
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		
<i>adefovir dipivoxil</i> (Hepsera)	T1	SP HD
BARACLUDE	T2	SP HD
<i>entecavir 0.5 mg tablet</i>	T1	QL (1 tab/day) SP HD
<i>entecavir 1 mg tablet</i>	T1	SP HD
EPIVIR HBV (<i>lamivudine hbv</i>)	T3	SP
<i>lamivudine</i> (EpiVir Hbv)	T1	SP
VEMLIDY	T2	SP HD
HEPATITIS C TREATMENT AGENTS		
PEGASYS	T2	PA SP HD
PEGINTRON	T2	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
RIBASPHERE RIBAPAK	T1	
<i>ribasphere ribapak 200-400 mg</i>	T3	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
HEPATITIS C VIRUS- NS5A AND NS3/4A INHIBITOR COMB		
ZEPATIER	T3	PA SP HD
RNA POLYMERASE INHIBITOR		
LAGEVRIO (EUA)	T2	QL (1 pkg/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		
<i>epinephrine</i> (Epinephrine)	T1	QL (2 packs/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

AUTONOMIC DRUGS (Alzheimer's Disease)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
CHOLINESTERASE INHIBITORS		
ARICEPT (<i>donepezil hcl</i>)	T3	HD
<i>donepezil hcl</i> (Aricept)	T1	HD
EXELON (<i>rivastigmine</i>)	T3	HD
<i>galantamine er 16 mg capsule</i> (Razadyne Er)	T1	HD
<i>galantamine er 24 mg capsule</i> (Razadyne Er)	T1	HD
<i>galantamine er 8 mg capsule</i> (Razadyne Er)	T1	QL (1 cap/day) HD
<i>galantamine hbr</i>	T1	HD
MESTINON (<i>pyridostigmine bromide</i>)	T3	HD
<i>pyridostigmine bromide</i> (Mestinon)	T1	HD
RAZADYNE ER 16 MG CAPSULE (<i>galantamine er</i>)	T3	HD
RAZADYNE ER 24 MG CAPSULE (<i>galantamine er</i>)	T3	HD
RAZADYNE ER 8 MG CAPSULE (<i>galantamine er</i>)	T3	QL (1 cap/day) HD
<i>rivastigmine</i> (Exelon)	T1	HD
<i>rivastigmine tartrate</i>	T1	HD

AUTONOMIC DRUGS (Attention Deficit Hyperactivity Disorder)¹⁰

ADRENERGICS, AROMATIC, NON-CATECHOLAMINE		
ADDERALL (<i>dextroamphetamine-amphetamine</i>)	T3	PA
<i>amphetamine sulfate</i> (Evekeo)	T1	PA
<i>dextroamphetamine/amphetamine</i> (Adderall Xr)	T1	PA QL (1cap/ day)
<i>dextroamphetamine/amphetamine</i> (Mydayis)	T1	PA QL (1cap/ 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 caps/day)
<i>dextroamphetamine er 5 mg cap</i>	T1	PA QL (1 cap/day)
<i>dextroamphetamine sulfate</i>	T1	PA
EVEKEO (<i>amphetamine sulfate</i>)	T3	PA
<i>lisdexamfetamine</i> (Vyvanse)	T1	PA QL (1 cap/day)
<i>methamphetamine hcl</i>	T1	PA
XELSTRYM	T3	PA QL (1 patch/day)
ZENZEDI	T3	PA

AUTONOMIC DRUGS (Blood Pressure/Heart Medications)

ADRENERGIC VASOPRESSOR AGENTS		
<i>droxidopa</i> (Northera)	T1	SP HD
<i>midodrine hcl</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

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

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ALPHA-ADRENERGIC BLOCKING AGENTS		
DIBENZYLINE (<i>phenoxybenzamine hcl</i>)	T3	HD
<i>phenoxybenzamine hcl</i> (Dibenzylamine)	T1	HD

AUTONOMIC DRUGS (Urinary Tract Conditions)

PARASYMPATHETIC AGENTS		
<i>bethanechol chloride</i>	T1	HD
<i>cevimeline hcl</i> (Evoxac)	T1	HD
EVOXAC (<i>cevimeline hcl</i>)	T3	HD
<i>guanidine hcl</i>	T1	HD
<i>pilocarpine hcl</i> (Salagen)	T1	HD
SALAGEN (<i>pilocarpine hcl</i>)	T3	HD

BIOLOGICALS (Allergy/Nasal Sprays)

ALLERGENIC EXTRACTS, THERAPEUTIC		
GRASTEK	T3	PA QL (1 tab/day)
ODACTRA	T3	PA QL (1 tab/day)
ORALAIR	T3	PA QL (1 tab/day)
RAGWITEK	T3	PA QL (1 tab/day)

BIOLOGICALS (Blood Pressure/Heart Medications)

PLASMA KALLIKREIN INHIBITORS		
TAKHZYRO	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
MODERNA COVID(6M-11Y)EUA	T2	PPACA
NOVAVAX COVID (EUA)	T2	PPACA
PFIZER COVID(5-11Y)EUA	T2	PPACA
PFIZER COVID(6M-4Y)EUA	T2	PPACA
SPIKEVAX	T2	PPACA
ENTERIC VIRUS VACCINES		
IPOL	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
ENTERIC VIRUS VACCINES (cont.)		
ROTARIX	T3	PPACA
ROTATEQ	T3	PPACA
GRAM NEGATIVE COCCI VACCINES		
BEXSERO	T2	PPACA
MENACTRA	T2	PPACA
MENQUADFI	T2	PPACA
MENVEO A-C-Y-W-135-DIP	T2	PPACA
TRUMENBA	T2	PPACA
PENBRAYA	T2	PPACA
PNEUMOVAX 23	T2	PPACA
GRAM POSITIVE COCCI VACCINES		
CAPVAXIVE	T2	PPACA
PREVNAR 13	T2	PPACA
PREVNAR 20	T2	
INFLUENZA VIRUS VACCINES		
AFLURIA TRIVALENT	T2	PPACA
EZ FLU (FLUCELVAX)	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
FLUVIRIN	T2	PPACA
FLUZONE TRIVALENT	T2	PPACA
VACCINE/TOXOID PREPARATIONS, COMBINATIONS		
ACTHIB	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
TOXIN-PRODUCING BACILLI VACCINES/TOXOIDS		
BCG VACCINE (TICE STRAIN)	T2	PPACA
VACCINE/TOXOID PREPARATIONS, COMBINATIONS (cont.)		
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
TDVAX	T2	PPACA
TENIVAC	T2	PPACA
VAXELIS	T2	PPACA
VIRAL/TUMORIGENIC VACCINES		
ABRYSVO	T3	PPACA
ACAM2000 (NATIONAL STOCKPILE)	T3	
ENGRIX-B ADULT	T2	PPACA
ENGRIX-B PEDIATRIC-ADOLESCENT	T2	PPACA
ERVEBO (NATIONAL STOCKPILE)	T3	
GARDASIL 9	T2	PPACA
HAVRIX	T2	PPACA
HEPLISAV-B	T2	PPACA
IXCHIQ	T3	PPACA
JYNNEOS (NATIONAL STOCKPILE)	T3	
PEDIARIX	T2	PPACA
RECOMBIVAX HB	T2	PPACA
SHINGRIX	T2	QL (2 doses/lifetime) PPACA
TWINRIX	T2	PPACA
VAQTA	T2	PPACA

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List of Prescription Medications

BIOLOGICALS (Vaccines) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
VIRAL/TUMORIGENIC VACCINES		
VARIVAX VACCINE	T2	PPACA
ZOSTAVAX	T2	PPACA
BLOOD (Blood Modifiers/Bleeding Disorders)		
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
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
HEMOPHILIA TREATMENT AGENTS, NON-FACTOR REPLACEMENT		
ALHEMO PEN	T2	PA SP
HEMLIBRA	T3	PA SP HD
HYMPAVZI PEN	T2	PA SP
SICKLE CELL ANEMIA AGENTS		
DROXIA	T2	
ENDARI	T3	
OXBRYTA 300MG TAB for SUSP	T3	QL (5 tabs/day) SP
SIKLOS	T3	PA
TOPICAL HEMOSTATICS		
ASTRINGYN	T3	
AVITENE	T3	
ENDO-AVITENE	T3	
EVICEL	T3	
<i>gelatin sponge, absorb/porcine</i> (Gelfoam)	T1	
GELFOAM (<i>surgifoam</i>)	T3	
GELFOAM COMPRESSED	T3	
MONSEL'S	T3	
RAPLIXA	T3	
RECOTHROM	T3	
SURGIFOAM	T1	
SYRINGE AVITENE	T3	
TACHOSIL	T3	

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List of Prescription Medications

BLOOD (Blood Modifiers/Bleeding Disorders) (con't.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
TOPICAL HEMOSTATICS		
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</i>	T1	QL (4 tabs/day) HD

ANTI-ARRHYTHMICS		
<i>amiodarone hcl</i>	T1	HD
<i>disopyramide phosphate</i> (Norpace)	T1	HD
<i>dofetilide 125 mcg capsule</i> (Tikosyn)	T1	QL (8 caps/day) HD
<i>dofetilide 250 mcg capsule</i> (Tikosyn)	T1	QL (4 caps/day) HD
<i>dofetilide 500 mcg capsule</i> (Tikosyn)	T1	QL (2 caps/day) HD
<i>flecainide acetate</i>	T1	HD
<i>mexiletine hcl</i>	T1	HD
MULTAQ	T3	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 gluconate</i>	T1	HD
RYTHMOL SR (<i>propafenone hcl er</i>)	T3	PA HD
TIKOSYN 125 MCG CAPSULE (<i>dofetilide</i>)	T3	PA QL (8 caps/day) HD
TIKOSYN 250 MCG CAPSULE (<i>dofetilide</i>)	T3	PA QL (4 caps/day) HD
TIKOSYN 500 MCG CAPSULE (<i>dofetilide</i>)	T3	PA QL (2 caps/day) HD

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

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List of Prescription Medications

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

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
CALCIUM CHANNEL BLOCKING AGENTS (cont.)		
CAMZYOS	T3	PA QL (30 caps/30 days) SP
diltiazem hcl	T1	HD
diltiazem hcl (Cardizem La)	T1	HD
diltiazem hcl (Tiazac)	T1	HD
felodipine	T1	HD
isradipine	T1	
nicardipine hcl	T1	HD
nifedipine	T1	HD
nifedipine (Adalat Cc)	T1	HD
nifedipine (Procardia XI)	T1	HD
nifedipine (Procardia)	T1	HD
nisoldipine er 17 mg tablet (Sular)	T1	HD
nisoldipine er 20 mg tablet	T1	QL (1 tab/day) HD
nisoldipine er 25.5 mg tablet	T1	HD
nisoldipine er 30 mg tablet	T1	HD
nisoldipine er 34 mg tablet (Sular)	T1	HD
nisoldipine er 40 mg tablet	T1	HD
nisoldipine er 8.5 mg tablet (Sular)	T1	HD
NORLIQVA	T2	PA QL(10 mls/day) HD
NORVASC (amlodipine besylate)	T3	
NYMALIZE	T3	HD
PROCARDIA (nifedipine)	T3	HD
SULAR (nisoldipine)	T3	HD
TIAZAC (tiadylt er)	T3	HD
verapamil hcl	T1	HD
verapamil hcl (Calan Sr)	T1	HD
verapamil hcl (Verelan Pm)	T1	HD
verapamil hcl (Verelan)	T1	HD
VERELAN (verapamil hcl)	T3	HD
VERELAN (verapamil sr)	T3	HD
VERELAN PM (verapamil er pm)	T3	HD
DIGITALIS GLYCOSIDES		
digoxin	T1	HD

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List of Prescription Medications

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

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
HEART RATE REDUCING, SA SELECTIVE I(F) CURRENT INH.		
CORLANOR 5 MG/5 ML ORAL SOLN	T2	PA SP HD
CORLANOR TABLET (ivabradine hcl)	T2	PA HD
<i>ivabradine hcl</i> (Corlanor)	T1	PA HD
SOLUBLE GUANYLATE CYCLASE (SGC) STIMULATOR		
VERQUVO	T2	PA QL(1 tab/day)
VASODILATORS, CORONARY		
DILATRATE-SR	T3	HD
<i>isosorbide dinitrate</i>	T1	HD
MINITRAN	T1	HD
<i>nitroglycerin</i> (Minitran)	T1	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	T2	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
LETAIRIS (<i>ambrisentan</i>)	T3	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

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T2 – Typically Preferred Brands

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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		
ORENITRAM ER	T3	PA SP HD
ORENITRAM MONTH 1 TITRATION KT	T3	PA QL(168 tabs/180 days) SP HD
PULMONARY ANTIHYPERTENSIVES, PROSTACYCLIN-TYPE (cont.)		
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 DPI	T3	PA SP HD
TYVASO INSTITUTIONAL START KIT	T3	PA SP HD
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
PULMONARY HTN-ENDOTHELIN RECEPT ANTG-CGMP PDE5 INH		
OPSYNVI	T2	PA QL(1 tab/day) SP HD

CARDIOVASCULAR (Blood Pressure/Heart Medications)

ACE INHIBITOR-CALCIUM CHANNEL BLOCKER COMBINATION		
<i>amlodipine besylate/benazepril</i>	T1	HD
PRESTALIA 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
PRESTALIA 14 MG-10 MG TABLET	T3	HD
<i>trandolapril/verapamil hcl</i>	T1	HD
ACE INHIBITOR-THIAZIDE OR THIAZIDE-LIKE DIURETIC		
<i>captopril-hctz 25-15 mg tablet</i>	T1	QL (3 tabs/day) HD
<i>captopril-hctz 25-25 mg tablet</i>	T1	QL (2 tabs/day) HD
<i>captopril-hctz 50-15 mg tablet</i>	T1	QL (3 tabs/day) HD
<i>captopril-hctz 50-25 mg tablet</i>	T1	QL (2 tabs/day) HD
<i>enalapril/hydrochlorothiazide</i>	T1	HD
<i>fosinopril/hydrochlorothiazide</i>	T1	HD
<i>lisinopril/hydrochlorothiazide</i>	T1	HD
<i>quinapril/hydrochlorothiazide</i>	T1	HD
ALPHA/BETA-ADRENERGIC BLOCKING AGENTS		
<i>carvedilol (Coreg)</i>	T1	HD
<i>carvedilol er 10 mg capsule (Coreg Cr)</i>	T1	QL (1 cap/day) HD
<i>carvedilol er 40 mg capsule (Coreg Cr)</i>	T1	QL (1 cap/day) HD
<i>carvedilol er 80 mg capsule (Coreg Cr)</i>	T1	HD

T1 – Typically Generics

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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)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ALPHA/BETA-ADRENERGIC BLOCKING AGENTS (cont.)		
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
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
MINIPRESS (<i>prazosin hcl</i>)	T3	HD
<i>prazosin hcl</i>	T1	HD
<i>terazosin hcl</i>	T1	HD
ANGIOTEN.RECEPTR ANTAG-CALCIUM CHANL BLKR-THIAZIDE		
<i>amlodipine/valsartan/hcthiazid</i>	T1	HD
<i>olmesartan/amlodipin/hcthiazid</i>	T1	HD
ANGIOTENSIN RECEPT-NEPRILYSIN INHIBITOR COMB (ARNI)		
ENTRESTO SPRINKLE	T2	QL(2 tabs/day) HD
ANGIOTENSIN RECEPTOR ANTAG.-THIAZIDE DIURETIC COMB		
<i>candesartan/hydrochlorothiazid</i>	T1	HD
<i>irbesartan/hydrochlorothiazide</i>	T1	HD
<i>losartan/hydrochlorothiazide</i>	T1	HD
<i>olmesartan-hctz 20-12.5 mg tab</i>	T1	QL (1 tab/day) HD
<i>olmesartan-hctz 40-12.5 mg tab</i>	T1	HD
<i>olmesartan-hctz 40-25 mg tab</i>	T1	HD
<i>telmisartan-hctz 40-12.5 mg tb</i>	T1	QL (1 tab/day) HD
<i>telmisartan-hctz 80-12.5 mg tb</i>	T1	HD
<i>telmisartan-hctz 80-25 mg tab</i>	T1	HD
<i>valsartan/hydrochlorothiazide</i>	T1	HD
ANGIOTENSIN RECEPTOR BLOCKR-CALCIUM CHANNEL BLOCKR		
<i>amlodipine besylate/valsartan</i>	T1	HD
<i>amlodipine-olmesartan 10-20 mg</i>	T1	HD

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

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List of Prescription Medications

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

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ANTI-HYPERTENSIVES, MISCELLANEOUS (cont.)		
<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>clonidine hcl</i>	T1	HD
<i>guanfacine hcl</i>	T1	HD
<i>methyldopa</i>	T1	HD
<i>methyldopa/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 fumarate</i>	T1	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
<i>timolol maleate</i>	T1	HD

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List of Prescription Medications

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

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
BETA-BLOCKERS AND THIAZIDE, THIAZIDE-LIKE DIURETICS		
<i>atenolol/chlorthalidone</i> (Tenoretic 100)	T1	HD
<i>atenolol/chlorthalidone</i> (Tenoretic 50)	T1	HD
<i>bisoprolol/hydrochlorothiazide</i> (Ziac)	T1	HD
<i>metoprolol/hydrochlorothiazide</i>	T1	HD
<i>nadolol/bendroflumethiazide</i>	T1	HD
<i>propranolol/hydrochlorothiazide</i>	T1	HD
RENIN INHIBITOR, DIRECT		
<i>aliskiren</i> 150 mg tablet	T1	QL (1 tab/day) HD
<i>aliskiren</i> 300 mg tablet	T1	HD
VASODILATORS, COMBINATION		
<i>isosorbide dinit/hydralazine</i> (Bidil)	T1	QL(6 tabs/day) HD
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>	T1	HD
ANTI-HYPERLIPID- HMG-COA RI-CALCIUM CHANNEL BLOCKER		
<i>amlodipine-atorvast</i> 10-40 mg (Caduet)	T1	HD
<i>amlodipine-atorvast</i> 10-80 mg (Caduet)	T1	HD
<i>amlodipine-atorvast</i> 2.5-10 mg	T1	HD
<i>amlodipine-atorvast</i> 2.5-20 mg	T1	QL (1 tab/day) HD
<i>amlodipine-atorvast</i> 2.5-40 mg	T1	QL (1 tab/day) HD
<i>amlodipine-atorvast</i> 5-10 mg (Caduet)	T1	HD
<i>amlodipine-atorvast</i> 5-20 mg (Caduet)	T1	QL (1 tab/day) HD
<i>amlodipine-atorvast</i> 5-40 mg (Caduet)	T1	QL (1 tab/day) HD
<i>amlodipine-atorvast</i> 5-80 mg (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

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-HYPERLIPID- HMG-COA RI-CALCIUM CHANNEL BLOCKER (cont.)		
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
ANTI-HYPERLIPIDEMIC - PCSK9 INHIBITORS		
REPATHA PUSHTRONEX	T2	
REPATHA SURECLICK	T2	
REPATHA SYRINGE	T2	
ANTI-HYPERLIPIDEMIC-HMGCOA REDUCTASE INHIB (Statins)		
<i>pitavastatin 1 mg tablet (Livalo)</i>	T1	QL(1 tab/day) HD PPACA
<i>pitavastatin 2 mg tablet (Livalo)</i>	T1	QL(1 tab/day) HD PPACA
<i>pitavastatin 4 mg tablet (Livalo)</i>	T1	HD PPACA
<i>atorvastatin 10 mg tablet</i>	T1	HD PPACA
<i>atorvastatin 20 mg tablet</i>	T1	HD PPACA
<i>atorvastatin 40 mg tablet</i>	T1	HD
<i>atorvastatin 80 mg tablet</i>	T1	HD
<i>fluvastatin sodium</i>	T1	HD PPACA
<i>lovastatin 10 mg tablet</i>	T1	HD
<i>lovastatin 20 mg tablet</i>	T1	HD PPACA
<i>lovastatin 40 mg tablet</i>	T1	HD PPACA
<i>pravastatin sodium</i>	T1	HD PPACA
<i>rosuvastatin calcium 10 mg tab</i>	T1	QL (1 tab/day) HD PPACA
<i>rosuvastatin calcium 20 mg tab</i>	T1	QL (1 tab/day) HD
<i>rosuvastatin calcium 40 mg tab</i>	T1	HD
<i>rosuvastatin calcium 5 mg tab</i>	T1	QL (1 tab/day) HD PPACA
<i>simvastatin 10 mg tablet</i>	T1	HD PPACA
<i>simvastatin 20 mg tablet</i>	T1	HD PPACA
<i>simvastatin 40 mg tablet</i>	T1	HD PPACA
<i>simvastatin 5 mg tablet</i>	T1	HD
<i>simvastatin 80 mg tablet</i>	T1	QL (1 tab/day) HD
BILE SALT SEQUESTRANTS		
<i>cholestyramine (with sugar) (Questran)</i>	T1	HD
<i>cholestyramine/aspartame</i>	T1	HD
<i>cholestyramine/aspartame (Questran Light)</i>	T1	HD

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>colestevlam hcl</i> (Welchol)	T1	HD
<i>colestipol hcl</i> (Colestid)	T1	HD
QUESTRAN (<i>cholestyramine</i>)	T3	HD
QUESTRAN LIGHT (<i>prevalite</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 (choline)</i> (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
LIPOTROPICS		
TRICOR (<i>fenofibrate</i>)	T3	ST HD
TRIGLIDE	T3	ST HD
TRILIPIX (<i>fenofibric acid</i>)	T3	ST HD
ZETIA (<i>ezetimibe</i>)	T3	HD
CARDIOVASCULAR (Miscellaneous)		
ENDOTHELIN-ANGIOTENSIN RECEPTOR ANTAGONIST		
FILSPARI	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 er 14 mg capsule</i> (Namenda Xr)	T1	QL (1 cap/day) HD
<i>memantine hcl er 28 mg capsule</i> (Namenda Xr)	T1	HD
NAMENDA XR 14 MG CAPSULE (<i>memantine hcl er</i>)	T3	QL (1 cap/day) HD
NAMENDA XR 21 MG CAPSULE (<i>memantine hcl er</i>)	T3	HD
NAMENDA XR 28 MG CAPSULE (<i>memantine hcl er</i>)	T3	HD
NAMENDA XR 7 MG CAPSULE (<i>memantine hcl er</i>)	T3	QL (1 cap/day) HD
NAMENDA XR TITRATION PACK	T3	QL (112/365 days) HD

T2 – Typically Preferred Brands QL – Quantity Limit

T3 – Typically Non-Preferred Brands ST – Step Therapy

SP – Specialty Medication

HD – May require home delivery pharmacy

CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

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

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ALZHEIMER'S THX, NMDA RECEPTOR ANTAG-CHOLINES INHIB (cont.)		
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 SP QL (50ml/28days)
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 6MG	T3	PA QL(3 tabs/day) SP HD
AUSTEDO XR 12MG	T3	PA QL(1 tab/day) SP HD
AUSTEDO XR 18 MG TABLET	T3	PA QL(1 tab/day) SP HD
AUSTEDO XR 24MG	T3	PA QL(2 tabs/day) SP HD
AUSTEDO XR 30 MG TABLET	T3	PA QL SP HD
AUSTEDO XR 48 MG TABLET	T3	PA QL SP HD
AUSTEDO XR TITRATION KT(WK1-4)	T3	PA QL(1 kit/180 days) SP HD
INGREZZA	T3	PA QL (1 tab/day) SP
INGREZZA INITIATION PK (TARDIV)	T3	PA QL (28 caps/year) SP
<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
AVONEX PEN	T2	PA SP HD
BAFIERTAM	T2	PA SP HD
BETASERON	T2	PA SP HD
<i>dimethyl fumarate</i>	T1	HD
<i>glatopa</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 (Multiple Sclerosis) (con't.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
AGENTS TO TREAT MULTIPLE SCLEROSIS		
<i>glatiramer acetate</i>	T1	PA SP HD
KESIMPTA PEN	T2	PA SP HD
MAVENCLAD	T2	PA SP HD
PLEGRIDY	T2	PA SP HD
REBIF	T2	PA SP HD
REBIF REBIDOSE	T2	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

CNS DRUGS (Seizure Disorders)

ANTI-CONVULSANT - BENZODIAZEPINE TYPE		
<i>clobazam</i>	T1	HD
<i>clonazepam</i>	T1	HD
<i>clonazepam</i> (Klonopin)	T1	HD
DIASTAT (<i>diazepam</i>)	T3	PA HD
DIASTAT ACUDIAL (<i>diazepam</i>)	T3	PA HD
<i>diazepam 2.5 mg rectal gel sys</i> (Diastat)	T1	HD
<i>diazepam 10 mg rectal gel syst</i> (Diastat Acudial)	T1	HD
<i>diazepam 20 mg rectal gel syst</i> (Diastat Acudial)	T1	HD
KLONOPIN (<i>clonazepam</i>)	T3	PA HD
NAYZILAM	T2	PA QL (5 kits/30 days) 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
CARBAMAZEPINE 200 MG TAB CHEW	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

CNS DRUGS (Seizure Disorders) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ANTI-CONVULSANTS (cont.)		
<i>carbamazepine</i> (Tegretol)	T1	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>	T1	HD
<i>ethosuximide</i> (Zarontin)	T1	HD
<i>felbamate</i>	T1	HD
FINTEPLA	T3	PA SP HD
FYCOMPA 0.5 MG/ML ORAL SUSP	T2	PA HD
<i>gabapentin</i> (Gralise)	T1	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>	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

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.)		
<i>rufinamide 400 mg tablet (Banzel)</i>	T1	PA QL(8 tabs/day) HD
SPRITAM	T3	PA HD
TEGRETOL (<i>carbamazepine</i>)	T3	PA HD
<i>tiagabine hcl 12 mg tablet</i>	T1	QL (8 tabs/day) HD
<i>tiagabine hcl 16 mg tablet</i>	T1	QL (6 tabs/day) HD
<i>tiagabine hcl 2 mg tablet</i>	T1	HD
<i>tiagabine hcl 4 mg tablet</i>	T1	HD
<i>topiramate</i>	T1	HD
<i>topiramate er capsule (Trokendi Xr)</i>	T1	QL(1 cap/day) HD
<i>topiramate er sprinkle capsule (Trokendi Xr)</i>	T1	HD
TROKENDI XR 25 MG, 100 MG CAPSULE (<i>topiramate</i>)	T3	QL(1 cap/day) HD
TROKENDI XR 50 MG, 200 MG CAPSULE (<i>topiramate</i>)	T3	HD
<i>valproic acid</i>	T1	HD
<i>valproic acid (as sodium salt)</i>	T1	HD
<i>vigabatrin</i>	T1	SP HD
VIMPAT	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
<i>zonisamide</i>	T1	HD

CNS DRUGS (Sleep Disorders/Sedatives)

NARCOLEPSY TX-H3-RECEPT.ANTAGONIST/INVERSE AGONIST

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

COLONY STIMULATING FACTORS (Blood Modifiers/Bleeding Disorders)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
LEUKOCYTE (WBC) STIMULANTS		
FULPHILA	T2	PA SP
GRANIX	T3	PA SP
LEUKINE	T2	SP
NEUPOGEN	T3	PA SP
NIVESTYM	T2	SP HD
NYVEPRIA	T2	PA SP
RELEUKO	T3	PA SP
STIMUFEND	T3	PA SP
UDENYCA	T2	PA SP
ZARXIO	T2	SP HD
ZIEXTENZO	T2	PA SP
THROMBOPOIETIN RECEPTOR AGONISTS		
DOPTELET	T2	PA SP HD
MULPLETA	T3	PA SP HD
PROMACTA	T2	PA SP HD

COLONY STIMULATING FACTORS (Cancer)

THROMBOPOIETIN RECEPTOR AGONISTS		
XOLREMDI	T3	PA QL(4 caps/day) SP CSL

CONTRACEPTIVES (Contraception Products)

CONTRACEPTIVES, INTRAVAGINAL, SYSTEMIC		
ANNOVERA	T3	
<i>etonogestrel/ethinyl estradiol (Nuvaring)</i>	T1	PPACA
CONTRACEPTIVES, IMPLANTABLE		
NEXPLANON	T2	SP PPACA
CONTRACEPTIVES, INJECTABLE		
DEPO-SUBQ PROVERA 104	T2	
CONTRACEPTIVES, ORAL		
<i>desog-e.estradiol/e.estradiol</i>	T1	HD PPACA
<i>desogestrel-ethinyl estradiol</i>	T1	HD PPACA
<i>drospir/eth estro/levomefol ca</i>	T1	HD PPACA
ELLA	T3	HD PPACA
<i>ethinyl estradiol/drospirenone</i>	T1	HD PPACA
<i>ethynodiol d-ethinyl estradiol</i>	T1	HD PPACA
<i>ethinyl estradiol/drospirenone (Yasmin 28)</i>	T1	PPACA

T1 – Typically Generics

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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 (cont.)		
<i>levonorgest/eth.estradiol/iron (Balcoltra)</i>	T1	HD PPACA
<i>l-norgest/e.estradiol-e.estrad</i>	T1	HD PPACA
MICROGESTIN 24 FE (<i>tarina 24 fe</i>)	T3	HD
<i>noreth-ethinyl estradiol/iron</i>	T1	HD PPACA
<i>norethind-eth estrad 1-0.02 mg</i>	T1	HD PPACA
<i>norethindrone</i>	T1	HD PPACA
<i>norethindrone ac/eth estradiol</i>	T1	HD PPACA
<i>norethindrone-e.estradiol-iron</i>	T1	HD PPACA
<i>norethindrone-e.estradiol-iron (Microgestin 24 Fe)</i>	T1	HD PPACA
<i>norethindrone-ethin. estradiol</i>	T1	HD PPACA
<i>norethin-ee 1.5-0.03 mg (21) tb</i>	T1	HD PPACA
<i>norgestrel-ethinyl estradiol</i>	T1	HD PPACA
TYBLUME	T3	HD
CONTRACEPTIVES, TRANSDERMAL		
<i>norelgestromin/ethin.estradiol</i>	T1	HD PPACA
DIAPHRAGMS/CERVICAL CAP		
CAYA CONTOURED	T1	PPACA
FEMCAP	T1	PPACA
WIDE SEAL DIAPHRAGM	T1	PPACA
INTRA-UTERINE DEVICES (IUDS)		
KYLEENA	T3	SP PPACA
LILETTA	T3	SP PPACA
MIRENA	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>	T1	
<i>benzonatate (Tessalon Perle)</i>	T1	
TESSALON PERLE (<i>benzonatate</i>)	T3	
NON-OPIOID ANTI-TUS-IST GEN.ANTIHISTAMINE-DECONGEST		
<i>brompheniramine/pseudoephed/dm (Bromfed Dm)</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

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

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
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)
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 TEST STRIPS	T2	
PRECISION XTRA TEST STRIPS	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	

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
EYE DIAGNOSTIC AGENTS (con't.)		
FUL-GLO EYE STRIPS	T3	
<i>lissamine green</i>	T1	
GASTROINTESTINAL RADIOPAQUE DIAGNOSTICS		
ENTERO VU	T3	
E-Z DISK	T3	
E-Z-HD	T3	
E-Z-PAQUE	T3	
E-Z-PASTE	T3	
GASTROMARK	T3	
LIQUID E-Z PAQUE	T3	
LIQUID POLIBAR PLUS	T3	
NEULUMEX	T3	
POLIBAR ACB	T3	
READI-CAT 2	T3	
SITZMARKS	T3	
TAGITOL	T3	
VARIBAR HONEY	T3	
VARIBAR NECTAR	T3	
VARIBAR PUDDING	T3	
VARIBAR THIN HONEY	T3	
VARIBAR THIN LIQUID	T3	
METABOLIC FUNCTION DIAGNOSTICS		
METOPIRONE	T3	
RADIOPHARMACEUTICALS ELEMENTS		
INDICLOR	T3	
URINARY TRACT RADIOPAQUE DIAGNOSTICS		
CYSTO-CONRAY II	T3	
CYSTOGRAFIN	T3	
CYSTOGRAFIN-DILUTE	T3	
<i>diatrizoate meglumine, sodium</i> (Gastrografin)	T1	
GASTROGRAFIN (<i>md-gastroview</i>)	T3	
DIURETICS (Diuretics)		
ARGININE VASOPRESSIN (AVP) RECEPTOR ANTAGONISTS		
TOLVAPTAN 15 MG TABLET	T3	SP
<i>tolvaptan 30 mg tablet</i> (Samsca)	T1	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

DIURETICS (Diuretics) (cont.)			
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits	
ARGININE VASOPRESSIN (AVP) RECEPTOR ANTAGONISTS (con't.)			
acetazolamide	T1	HD	
methazolamide	T1	HD	
LOOP DIURETICS			
bumetanide	T1	HD	
furosemide (Lasix)	T1	HD	
torsemide	T1	HD	
POTASSIUM SPARING DIURETICS			
amiloride hcl	T1	HD	
CAROSPIR (spironolactone)	T2	PA	
eplerenone (Inspra)	T1	HD	
KERENDIA	T2	PA QL(1 tab/day)	
INSPIRA (eplerenone)	T3	HD	
spironolactone	T1	HD	
spironolactone (Aldactone)	T1	HD	
spironolactone (Carospir)	T1	HD	
spironolact/hydrochlorothiazid	T1	HD	
triamterene (Dyrenium)	T1	HD	
POTASSIUM SPARING DIURETICS IN COMBINATION			
ALDACTAZIDE	T3	HD	
ALDACTAZIDE (spironolactone-hctz)	T3	HD	
amiloride/hydrochlorothiazide	T1	HD	
DYAZIDE (triamterene-hydrochlorothiazid)	T3	HD	
spironolact/hydrochlorothiazid (Aldactazide)	T1	HD	
triamterene/hydrochlorothiazid (Dyazide)	T1	HD	
THIAZIDE AND RELATED DIURETICS			
chlorthalidone	T1	HD	
DIURIL	T3	HD	
hydrochlorothiazide	T1	HD	
indapamide	T1	HD	
metolazone	T1	HD	
EENT PREPS (Allergy/Nasal Sprays)			
NASAL ANTIHISTAMINE			
PATANASE (olopatadine hcl)	T3	HD	
NOSE PREPARATIONS, MISCELLANEOUS (RX)			
ipratropium bromide	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

EENT PREPS (Allergy/Nasal Sprays) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
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>hydrocortisone/acetic acid</i>	T1	
EENT PREPS (Eye Conditions)		
ARTIFICIAL TEARS		
LACRISERT	T3	
MIEBO	T2	QL(4 bottles/30 days)
EYE ANTI-INFECTIVES (RX ONLY)		
BETADINE	T3	
EYE ANTI-INFLAMMATORY AGENTS		
ACUVAIL	T3	
ALREX	T3	
<i>bromfenac sodium</i>	T1	
BROMSITE (<i>bromfenac sodium</i>)	T2	
<i>dexamethasone sodium phosphate</i>	T1	
<i>diclofenac 0.1% eye drops</i>	T1	
EYSUVIS	T2	QL (10 gm/30 days) HD
FLAREX 0.1% EYE DROPS	T2	
<i>fluorometholone</i>	T1	
<i>flurbiprofen sodium</i>	T1	
ILEVRO	T3	
INVELTYS	T2	
<i>ketorolac 0.4% ophth solution</i> (Acular Ls)	T1	
<i>ketorolac 0.5% ophth solution</i> (Acular)	T1	
<i>loteprednol etabonate</i> (Alrex)	T1	
OMNIPRED (<i>prednisolone acetate</i>)	T3	
<i>prednisolone acetate</i> (Omnipred)	T1	
<i>prednisolone sodium phosphate</i>	T1	

T1 – Typically Generics

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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
EYE ANTI-INFLAMMATORY AGENTS (cont.)		
PROLENSA	T3	
EYE LOCAL ANESTHETICS		
AKTEN	T3	
ALCAINE (<i>proparacaine hcl</i>)	T3	
ALTAFLUOR BENOX (<i>flurox</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	T3	
TETRAVISC FORTE	T3	
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	T2	
<i>bimatoprost</i>	T1	QL (10 gm/30 days) HD
<i>brimonidine tartrate</i>	T1	HD
<i>brimonidine tartrate</i> (Alphagan P)	T1	HD
<i>brimonidine tartrate/timolol</i> (Combigan)	T1	
<i>brinzolamide</i> (Azopt)	T1	HD
<i>carteolol hcl</i>	T1	HD
COMBIGAN	T2	HD
<i>dorzolamide hcl</i> (Trusopt)	T1	HD
<i>dorzolamide hcl/timolol maleat</i> (Cosopt)	T1	HD
<i>dorzolamide/timolol/pf</i> (Cosopt Pf)	T1	HD
ISOPTO CARPINE (<i>pilocarpine hcl</i>)	T3	HD
<i>latanoprost</i>	T1	HD
<i>levobunolol hcl</i>	T1	HD

T1 – Typically Generics

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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 (cont.)		
PHOSPHOLINE IODIDE	T3	HD
<i>pilocarpine hcl</i> (Isopto Carpine)	T1	HD
RHOPRESSA	T3	
ROCKLATAN	T3	
SIMBRINZA	T2	HD
<i>timolol maleate</i> (Istalol)	T1	HD
<i>timolol maleate</i> (Timoptic)	T1	HD
<i>timolol maleate</i> (Timoptic-Xe)	T1	HD
<i>timolol maleate/pf</i> (Timoptic Ocudose)	T1	HD
<i>travoprost</i>	T1	HD
TRUSOPT (<i>dorzolamide hcl</i>)	T3	HD
MYDRIATICS		
<i>atropine 1% eye drops</i>	T1	HD
<i>atropine sulfate</i> (Isopto Atropine)	T1	HD
CYCLOMYDRIL	T3	HD
<i>cyclopentolate hcl</i> (Cyclogyl)	T1	HD
<i>homatropine hbr</i>	T1	HD
MYDRIACYL (<i>tropicamide</i>)	T3	HD
PAREMYD	T3	HD
<i>tropicamide</i>	T1	HD
<i>tropicamide</i> (Mydriacyl)	T1	HD
OPHTHALMIC ANTI-FIBROTIC AGENTS		
MITOSOL	T3	
OPHTHALMIC ANTI-INFLAMMATORY IMMUNOMODULATOR-TYPE		
CEQUA	T2	
RESTASIS	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
ELECT/CALORIC/H2O (Cholesterol Medications)		
ORAL LIPID SUPPLEMENTS		
DOJOLVI	T3	PA SP HD

T1 – Typically Generics

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T2 – Typically Preferred Brands

QL – Quantity Limit

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T3 – Typically Non-Preferred Brands

ST – Step Therapy

HD – May require home delivery pharmacy

List of Prescription Medications

ELECT/CALORIC/H2O (Dental Products)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
FLUORIDE PREPARATIONS		
CLINPRO 5000	T3	
<i>fluoride (sodium)</i> (Prevident 5000 Plus)	T1	
<i>fluoride (sodium)</i> (Prevident 5000)	T1	
FLUORIDEX	T1	
FLUORIDEX SENSITIVITY RELIEF	T3	
FRAICHE 5000 PREVI	T3	
FRAICHE 5000 SENSITIVE	T3	
PREVIDENT 5000 ENAMEL PROTECT	T3	
PREVIDENT 5000 ORTHO DEFENSE	T3	
PREVIDENT 5000 SENSITIVE	T3	
PREVIDENT KIDS	T3	
<i>sodium fluoride/potassium nit</i> (Prevident 5000 Sensitive)	T1	
ELECT/CALORIC/H2O (Diabetes)		
AGENTS TO TREAT HYPOGLYCEMIA (HYPERGLYCEMICS)		
BAQSIMI	T2	QL (2 units/30 days)
<i>diazoxide</i> (Proglycem)	T1	
<i>glucagon 1 mg emergency kit</i>	T1	QL (2 pens/30 days)
PROGLYCEM (<i>diazoxide</i>)	T3	
ELECT/CALORIC/H2O (Miscellaneous)		
NUCLEIC ACID/NUCLEOTIDE SUPPLEMENTS		
XURIDEN	T3	PA SP
ELECT/CALORIC/H2O (Nutritional/Dietary)		
ELECTROLYTE DEPLETERS		
AURYXIA	T3	QL (12 tabs/day)
<i>calcium acetate</i>	T1	
FOSRENOL 1,000 MG POWDER PACK	T2	
FOSRENOL 1,000 MG TABLET CHEW (<i>lanthanum carbonate</i>)	T3	
FOSRENOL 500 MG TABLET CHEW (<i>lanthanum carbonate</i>)	T3	
FOSRENOL 750 MG POWDER PACKET	T2	
FOSRENOL 750 MG TABLET CHEW (<i>lanthanum carbonate</i>)	T3	
<i>lanthanum carbonate</i> (Fosrenol)	T1	
LOKELMA	T2	
PHOSLYRA	T3	

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T3 – Typically Non-Preferred Brands

ST – Step Therapy

HD – May require home delivery pharmacy

List of Prescription Medications

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

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ELECTROLYTE DEPLETERS (cont.)		
<i>sevelamer carbonate</i> (Renvela)	T1	
<i>sevelamer hcl</i>	T1	
<i>sevelamer hcl</i> (Renagel)	T1	
<i>sodium polystyrene sulfon/sorb</i>	T1	
<i>sodium polystyrene sulfonate</i>	T1	
<i>sps 15 gm/60 ml suspension</i>	T1	
<i>sps 30 gm/120 ml enema susp</i>	T3	
VELPHORO	T3	
VELTASSA	T2	
IODINE CONTAINING AGENTS		
<i>potassium iodide/iodine</i>	T1	
SSKI	T1	
IRON REPLACEMENT		
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	
<i>effer-k 25 meq tablet eff</i>	T1	
<i>klor-con 10 meq tablet</i> (K-tab Er)	T1	
<i>klor-con 8 meq tablet</i>	T1	
K-TAB ER (<i>potassium chloride</i>)	T3	
<i>potassium bicarbonate/cit ac</i>	T1	
<i>potassium chloride</i>	T1	
<i>potassium chloride</i> (K-tab Er)	T1	
ELECT/CALORIC/H2O (Urinary Tract Conditions)		
DIALYSIS SOLUTIONS		
PRISMASOL	T3	
URINARY PH MODIFIERS		
K-PHOS NO.2	T3	HD
K-PHOS ORIGINAL	T3	HD
ORACIT	T3	HD
<i>potassium citrate</i> (Urocit-k)	T1	HD
<i>potassium citrate/citric acid</i>	T1	HD
RENACIDIN	T3	HD

T1 – Typically Generics

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T3 – Typically Non-Preferred Brands

ST – Step Therapy

HD – May require home delivery pharmacy

List of Prescription Medications

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

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
URINARY PH MODIFIERS (cont.)		
UROCIT-K (<i>potassium citrate er</i>)	T3	HD
UROQID-ACID NO.2	T3	HD

GASTROINTESTINAL (Cholesterol Medications)

LIPOTROPICS		
<i>icosapent ethyl</i> (Vascepa)	T1	HD
<i>omega-3 acid ethyl esters</i>	T1	HD
VASCEPA	T2	PA HD

GASTROINTESTINAL (Gastrointestinal/Heartburn)

AMMONIA INHIBITORS		
CARBAGLU (<i>carglumic acid</i>)	T3	SP HD
<i>carglumic acid</i> (Carbaglu)	T1	SP HD
<i>lactulose</i>	T1	HD
<i>lactulose 10 gm/15 ml solution</i>	T1	HD
LITHOSTAT	T3	HD
OLPRUVA	T3	PA SP HD
PHEBURANE	T2	PA QL(8 Bottles/30 Days) 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	
ROBINUL (<i>glycopyrrolate</i>)	T3	
ROBINUL FORTE (<i>glycopyrrolate</i>)	T3	

ANTI-CHOLINERGICS/ANTI-SPASMODICS

<i>dicyclomine hcl</i>	T1	
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ANTI-DIARRHEAL - G.I. CHLORIDE CHANNEL INHIBITORS

MYTESI	T3	
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ANTI-DIARRHEAL - TRYPTOPHAN HYDROXYLASE INHIBITOR

XERMELO	T3	PA SP
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T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

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AGE – Age Requirement

SP – Specialty Medication

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List of Prescription Medications

GASTROINTESTINAL (Gastrointestinal/Heartburn) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ANTI-DIARRHEALS		
<i>diphenoxylate hcl/atropine</i>	T1	
<i>diphenoxylate hcl/atropine</i> (Lomotil)	T1	
LOMOTIL (<i>diphenoxylate-atropine</i>)	T3	
<i>loperamide hcl</i>	T1	
MOTOFEN	T3	
<i>opium tincture</i>	T1	ST
<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</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	PA
<i>granisetron hcl</i>	T1	
<i>granisetron hcl/pf</i>	T1	
<i>ondansetron hcl</i>	T1	
<i>ondansetron hcl/pf</i>	T1	
<i>ondansetron odt</i>		
<i>prochlorperazine</i> (Compazine)	T1	
<i>prochlorperazine maleate</i> (Compazine)	T1	
<i>promethazine hcl</i>	T1	
SANCUSO	T3	PA QL (4 patches/30 days)

T1 – Typically Generics

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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.)		
<i>scopolamine</i> (Transderm-scop)	T1	
TRANSDERM-SCOP (<i>scopolamine</i>)	T3	
<i>trimethobenzamide hcl</i>	T1	
VARUBI	T3	PA QL (4 tabs/28 days)
ANTI-ULCER PREPARATIONS		
CYTOTEC (<i>misoprostol</i>)	T3	HD
<i>misoprostol</i> (Cytotec)	T1	HD
<i>sucralfate</i>	T1	HD
ANTI-ULCER-H.PYLORI AGENTS		
<i>bismuth/metronid/tetracycline</i> (Pylera)	T1	
<i>lansoprazole/amoxicilin/clarith</i>	T1	
BELLADONNA ALKALOIDS		
DONNATAL	T3	HD
DONNATAL (<i>phenohydro</i>)	T3	HD
<i>hyoscyamine sulfate</i>	T1	HD
<i>hyoscyamine sulfate</i> (Levbid)	T1	HD
<i>hyoscyamine sulfate</i> (Levsin)	T1	HD
<i>hyoscyamine sulfate</i> (Levsin-sl)	T1	HD
<i>hyoscyamine sulfate</i> (Nulev)	T1	HD
LEVBIID (<i>symax-sr</i>)	T3	HD
LEVSIN (<i>oscimin</i>)	T3	HD
LEVSIN-SL (<i>symax-sl</i>)	T3	HD
<i>methscopolamine bromide</i>	T1	HD
NULEV (<i>symax</i>)	T1	HD
<i>phenobarb/hyoscy/atropine/scop</i> (Donnatal)	T1	HD
<i>phenobarbital-belladonna elixir</i> (Donnatal)	T1	HD
PHENOBARBITAL-BELLADONNA ELIXR (<i>phenohydro</i>)	T3	HD
SYMAX DUOTAB	T3	HD
BILE SALTS		
ACTIGALL (<i>ursodiol</i>)	T3	HD
CHENODAL	T3	PA SP HD
CHOLBAM	T3	PA SP HD
CTEXLI	T3	PA SP
URSO (<i>ursodiol</i>)	T3	HD
<i>ursodiol</i> (Urso)	T1	HD

T1 – Typically Generics

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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
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</i>)	T3	HD
<i>balsalazide disodium</i> (Colazal)	T1	HD
<i>mesalamine</i>	T1	HD
<i>mesalamine 800 mg dr tablet</i>	T1	HD
<i>mesalamine dr 1.2 gm tablet</i> (Lialda)	T1	HD
PENTASA 500 MG CAPSULE (<i>mesalamine</i>)	T3	HD
<i>sulfasalazine</i> (Azulfidine)	T1	HD
FECAL MICROBIOTA TRANSPLANTATION		
VOWST	T3	PA QL(12 caps/56 days) SP
GASTRIC ENZYMES		
SUCRAID	T3	PA SP
HISTAMINE H2-RECEPTOR INHIBITORS		
<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		
TRULANCE	T2	
INTEGRIN RECEPTOR ANTAGONIST, MONOCLONAL ANTIBODY		
ENTYVIO PEN	T3	PA QL(2 pens/30 days) SP HD
INTESTINAL MOTILITY STIMULANTS		
<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/nal/nahco3/kcl/peg 3350</i>	T1	PPACA

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

PA – Prior Authorization

QL – Quantity Limit

ST – Step Therapy

AGE – Age Requirement

SP – Specialty Medication

HD – May require home delivery pharmacy

PPACA – No Cost-Share Preventive Medication

CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

GASTROINTESTINAL (Gastrointestinal/Heartburn) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
LAXATIVES AND CATHARTICS (con't)		
KRISTALOSE	T3	
<i>lactulose</i>	T1	
<i>lactulose 10 gm packet (Kristalose)</i>	T1	
<i>lactulose 10 gm/15 ml solution</i>	T1	
<i>lactulose 20 gm/30 ml solution</i>	T1	
NULYTELY	T3	PPACA
<i>peg3350/sod sul/nacl/kcl/asb/c</i>	T1	PPACA
<i>peg3350/sod sulf, bicarb, cl/kcl</i>	T1	PPACA
PREPOPIK	T2	PPACA
<i>sodium chloride/nahco3/kcl/peg</i>	T1	PPACA
SUPREP	T2	PPACA
LOCAL ANORECTAL NITRATE PREPARATIONS		
<i>nitroglycerin 0.4% ointment (Rectiv)</i>	T1	
RECTIV (<i>nitroglycerin</i>)	T3	
PANCREATIC ENZYMES		
PANCREAZE	T2	HD
VIOKACE	T3	HD
ZENPEP	T2	HD
POTASSIUM-COMPETITIVE ACID BLOCKERS (PCABS)		
VOQUEZNA	T3	PA QL(1 tab/day)
PROTON-PUMP INHIBITORS		
<i>esomeprazole dr 10 mg packet (Nexium)</i>	T1	QL (4 packets/day) HD
<i>esomeprazole dr 20 mg packet (Nexium)</i>	T1	QL(2 packets/day) HD
<i>esomeprazole dr 40 mg packet</i>	T1	QL(1 packets/day) 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
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	
ANALPRAM HC 1% CREAM	T3	

T1 – Typically Generics

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T3 – Typically Non-Preferred Brands

ST – Step Therapy

HD – May require home delivery pharmacy

List of Prescription Medications

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

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
RECTAL/LOWER BOWEL PREP., GLUCOCORT. (NON-HEMORR)		
budesonide 2 mg rectal foam	T1	QL HD
CORTENEMA (hydrocortisone)	T3	
hydrocortisone (Cortenema)	T1	
HORMONES (Hormonal Agents)		
ANDROGEN/ESTROGEN PREPS FOR FEMALE SEXUAL DYSFUNC		
INTRAROSA	T2	
ANDROGENIC AGENTS		
ANADROL-50	T3	PA
ANDROGEL 1% (25 MG/2.5 G) PKT (testosterone)	T3	PA QL (150 gms/30 days)
ANDROGEL 1% (50 MG/5 G) PKT (testosterone)	T3	QL (2 packets/day) ST
ANDROGEL 1.62% GEL PUMP (testosterone)	T3	QL (150gm/30 days) ST
ANDROGEL 1.62% (1.25G) GEL PCKT (testosterone)	T3	QL (2 packs/day) ST
ANDROGEL 1.62% (2.5G) GEL PCKT (testosterone)	T3	QL (150gm/30 days) ST
DEPO-TESTOSTERONE	T3	
DEPO-TESTOSTERONE (testosterone cypionate)	T3	
METHITEST	T1	
methyltestosterone	T1	
oxandrolone	T1	PA
testosterone 1% (25mg/2.5g) pk (Androgel)	T1	QL (2 packets/day) ST
testosterone 1% (50 mg/5 g) pk (Testosterone)	T1	QL (2 packets/day) ST
testosterone 1.62% (2.5 g) pkt (Androgel)	T1	QL (150gm/30 days) ST
testosterone 1.62% gel pump (Androgel)	T1	QL (150gm/30 days) ST
testosterone 1.62% (1.25 g) pkt (Androgel)	T1	QL (2 packs/day) ST
testosterone 10 mg gel pump	T1	QL (120 gm/30 days) ST
TESTOSTERONE 12.5 MG/1.25 GRAM	T1	QL (150gm/30 days) ST
testosterone 12.5 mg/1.25 gram (Testosterone)	T1	QL (150gm/30 days) ST
testosterone 30 mg/1.5 ml pump	T1	QL (180ml/30 days) ST
testosterone 50 mg/5 gram gel	T1	QL (2 tubes/day) ST
TESTOSTERONE 50 MG/5 GRAM PKT	T1	QL (2 packs/day) ST
testosterone cypionate (Depo-testosterone)	T1	
testosterone enanthate	T1	

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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
ANTI-DIURETIC AND VASOPRESSOR HORMONES		
<i>desmopressin (nonrefrigerated)</i>	T1	
<i>desmopressin AC vial</i>	T1	SP HD
NOCTIVA	T3	PA
STIMATE	T3	SP
ESTROGEN AND PROGESTIN COMBINATIONS		
BIJUVA	T3	
ESTROGEN/ANDROGEN COMBINATIONS		
<i>estrogen, ester/me-testosterone (Estratest H.S.)</i>	T1	HD
ESTROGENIC AGENTS		
ACTIVELLA (<i>mimvey lo</i>)	T3	HD
ACTIVELLA (<i>mimvey</i>)	T3	HD
ALORA	T3	QL (16 patches/28 days) HD
CLIMARA (<i>estradiol (once weekly)</i>)	T3	HD
CLIMARA PRO	T3	HD
COMBIPATCH	T3	
DEPO-ESTRADIOL	T3	HD
DIVIGEL	T3	HD
ELESTRIN	T3	HD
<i>estradiol</i>	T1	QL (16 patches/28 days) HD
<i>estradiol (Alora)</i>	T1	QL (16 patches/28 days) HD
<i>estradiol (Climara)</i>	T1	HD
<i>estradiol 0.06% 1.25g gel pump (Estrogel)</i>	T1	HD
<i>estradiol 0.5 mg tablet (Estrace)</i>	T1	HD
<i>estradiol 1 mg tablet (Estrace)</i>	T1	HD
<i>estradiol 2 mg tablet (Estrace)</i>	T1	HD
<i>estradiol valerate (Delestrogen)</i>	T1	HD
<i>estradiol/norethindrone acet (Activella)</i>	T1	HD
ESTROGEL (<i>estradiol</i>)	T3	HD
EVAMIST	T3	HD
FEMHRT (<i>norethindron-ethinyl estradiol</i>)	T3	HD
MENEST	T3	HD
MENOSTAR	T3	QL (8 patches/28 days) HD
<i>norethind-eth estrad 0.5-2.5 (Femhrt)</i>	T1	HD

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List of Prescription Medications

HORMONES (Hormonal Agents) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ESTROGENIC AGENTS (cont.)		
<i>norethindrone ac-eth estradiol</i>	T1	HD
<i>norethindrone ac-eth estradiol (Femhrt)</i>	T1	HD
<i>norethin-eth estrad 1 mg-5 mcg</i>	T1	HD
PREMARIN	T2	HD
PREMPHASE	T2	HD
PREMPRO	T2	HD
ESTROGEN-PROGESTIN WITH ANTI-MINERALOCORTICOID COMB		
ANGELIQ	T3	HD
ESTROGEN-SELECTIVE ESTROGEN RECEPTOR MOD (SERM) COMB		
DUAVEE	T2	
GLUCOCORTICOIDS		
<i>budesonide</i>	T1	PA QL (1 tab/day)
<i>budesonide (Entocort Ec)</i>	T1	
<i>cortisone acetate</i>	T1	
<i>dexamethasone</i>	T1	
<i>deflazacort (Emflaza)</i>	T1	PA SP HD
EMFLAZA	T3	PA SP HD
ENTOCORT EC (<i>budesonide ec</i>)	T3	
<i>hydrocortisone</i>	T1	
LOCORT	T1	
<i>methylprednisolone (Medrol)</i>	T1	
MILLIPRED 10 MG/5 ML SOLUTION (<i>prednisolone sodium phosphate</i>)	T3	
<i>millipred 5 mg tablet</i>	T1	
ORAPRED ODT (<i>prednisolone sodium phos odt</i>)	T3	
<i>prednisolone</i>	T1	
<i>prednisolone sodium phosphate</i>	T1	
<i>prednisolone sodium phosphate (Millipred)</i>	T1	
<i>prednisolone sodium phosphate (Orapred Odt)</i>	T1	
<i>prednisone</i>	T1	
UCERIS 9 MG ER TABLET (<i>budesonide</i>)	T3	PA QL(1 tab/day)
GROWTH HORMONE RELEASING HORMONE (GHRH) AND ANALOGS		
EGRIFTA	T3	PA SP HD
EGRIFTA SV	T3	PA SP HD

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List of Prescription Medications

HORMONES (Hormonal Agents) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
GROWTH HORMONES		
GENOTROPIN	T2	PA SP HD
OMNITROPE	T2	PA SP HD
SEROSTIM	T2	PA SP
SKYTROFA	T3	SP HD
INSULIN-LIKE GROWTH FACTOR-I (IGF-I) HORMONES		
INCRELEX	T2	PA SP HD
LHRH (GNRH) ANTAGONIST, ESTROGEN AND PROGESTIN COMB		
MYFEMBREE	T2	PA QL (24 month therapy)
LHRH (GNRH) AGONIST ANALOG PITUITARY SUPPRESSANTS		
ORILISSA 150 MG TABLET	T2	PA QL (1 tab/day)
ORILISSA 200 MG TABLET	T2	PA QL (6 months therapy/lifetime)
MINERALOCORTICIDS		
<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
<i>danazol</i>	T1	HD
PROGESTATIONAL AGENTS		
CRINONE 4% GEL	T3	PA HD
DEPO-PROVERA	T3	HD
<i>medroxyprogesterone 10 mg tab (Provera)</i>	T1	HD
<i>medroxyprogesterone 2.5 mg tab (Provera)</i>	T1	HD
<i>medroxyprogesterone 5 mg tab (Provera)</i>	T1	HD
<i>norethindrone acetate</i>	T1	HD
<i>progesterone, micronized (Prometrium)</i>	T1	HD
SOMATOSTATIC AGENTS		
SIGNIFOR	T3	PA SP

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

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List of Prescription Medications

HORMONES (Hormonal Agents) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
VAGINAL ESTROGEN FOR SEXUAL DYSFUNCTION		
IMVEXXY 10 MCG MAINTENANCE PAK	T2	QL (16/28 days) HD
IMVEXXY 10 MCG STARTER PACK	T2	QL (36/28 days) HD
IMVEXXY 4 MCG MAINTENANCE PACK	T2	QL (16/28 days) HD
IMVEXXY 4 MCG STARTER PACK	T2	QL (36/28 days) HD
VAGINAL ESTROGEN PREPARATIONS		
estradiol (Vagifem)	T1	QL (36 tabs/28 days)
estradiol 0.01% cream (Estrace)	T1	HD
estradiol 10 mcg vaginal insrt (Vagifem)	T1	QL (36 tabs/28 days) HD
FEMRING	T3	HD
estradiol 10 mcg vaginal insrt (Vagifem)	T1	QL (36 tabs/28 days) HD
FEMRING	T3	HD
HORMONES (Infertility)		
FERTILITY STIMULATING PREPARATIONS, NON-FSH		
clomiphene citrate	T1	
PREGNANCY FACILITATING/MAINTAINING AGENT, HORMONAL		
CRINONE 8% GEL	T2	
ENDOMETRIN	T2	
HORMONES (Miscellaneous)		
LEPTIN HORMONE ANALOGS		
MYALEPT	T3	PA SP HD
HORMONES (Osteoporosis Products)		
BONE RESORPTION INHIBITORS		
calcitonin, salmon, synthetic	T1	HD
MIACALCIN	T2	HD
IMMUNOSUPPRESSANTS (Pain Relief And Inflammatory Disease)		
IL-23 RECEPTOR ANTAGONIST, MONOCLONAL ANTIBODY		
OMVOH	T2	PA QL SP HD
TREMFYA 100 MG/ML INJECTOR	T2	PA QL(1 AUTO-INJ/56 DAYS) SP HD
TREMFYA SYRINGE	T2	PA QL(1 SYRINGE/56 DAYS) SP HD
INTERLEUKIN-4(IL-4) RECEPTOR ALPHA ANTAGONIST, MAB		
DUPIXENT PEN	T3	PA SP HD
DUPIXENT SYRINGE	T3	PA SP HD
INTERLEUKIN-6 (IL-6) RECEPTOR INHIBITORS		
ACTEMRA	T2	PA QL (4 syringes/28 days) SP HD

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PPACA – No Cost-Share Preventive Medication

T2 – Typically Preferred Brands

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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
INTERLEUKIN-6 (IL-6) RECEPTOR INHIBITORS (cont.)		
ACTEMRA ACTPEN	T2	PA QL (4 pens/28 days) SP HD
TYENNE	T2	PA QL(3.6 ml/28 days) SP
TYENNE AUTOINJECTOR	T3	PA QL(3.6 ml/28 days) SP
ENSPRYNG	T3	PA SP HD

MONOCLONAL ANTIBODY-HUMAN INTERLEUKIN 12/23 INHIB

STELARA 45 MG/0.5 ML SYRINGE	T2	PA QL (1 syringe/84 days) SP HD
STELARA 45 MG/0.5 ML VIAL	T2	PA QL (1 vial/84 days) SP HD
STELARA 90 MG/ML SYRINGE	T2	PA QL (1 syringe/84 days) SP HD

IMMUNOSUPPRESSANTS (Skin Conditions)

TOPICAL IMMUNOSUPPRESSIVE AGENTS

<i>pimecrolimus</i>	T1	
PROTOPIC (<i>tacrolimus</i>)	T3	
<i>tacrolimus 0.03% ointment</i>	T1	
<i>tacrolimus 0.1% 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
<i>everolimus 2.5 mg tablet</i>	T1	PA QL(1 tab/day) SP HD
<i>everolimus 5 mg tablet</i>	T1	PA QL(1 tab/day) SP HD
<i>everolimus 7.5 mg tablet</i>	T1	PA QL(1 tab/day) SP HD
<i>everolimus 10 mg tablet</i>	T1	PA QL(1 tab/day) SP HD
IMURAN (<i>azathioprine</i>)	T3	SP HD
LUPKYNIS	T3	PA QL(6 caps/day) SP
<i>mycophenolate mofetil</i> (Cellcept)	T1	SP HD
OMVOH PEN	T2	PA QL(2 pens/28 days) SP HD
PROGRAF	T3	SP HD
<i>sirolimus</i> (Rapamune)	T1	SP HD
<i>tacrolimus (ir)</i>	T1	SP HD

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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.)		
ZORTRESS (<i>everolimus</i>)	T3	SP HD
MISCELLANEOUS MEDICAL SUPPLIES, DEVICES, NON-DRUG (Diabetes)		
DIABETIC SUPPLIES		
BLULINK BG SYSTEM REFILL	T3	
BLULINK DIABETIC TEST BUNDLE	T3	
BLULINK GLUCOSE MONITOR SYSTEM	T3	
CARESENS	T1	
CARETOUCH CONTROL SOLUTION	T1	
CEQUR SIMPLICITY	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)
ENLITE SERTER	T1	
EASY TOUCH BLULINK CTRL SOLN	T1	
EASY TRAK II CONTROL SOLUTION	T1	
FORA TN'GO ADV MOBILE MULT MTR	T3	
FREESTYLE LIBRE 10 DAY READER	T2	PA QL (1 reader/day)
FREESTYLE LIBRE 14 DAY READER	T2	PA QL (1 reader/day)
FREESTYLE LIBRE 2 READER	T2	PA QL (1 reader/day)
FREESTYLE LIBRE 3 READER	T2	PA QL (1 unit/720 days)
FREESTYLE LIBRE 10 DAY SENSOR	T2	PA QL (3/30 days)
FREESTYLE LIBRE 14 DAY SENSOR	T2	PA QL (2/28 days)
FREESTYLE LIBRE 2 SENSOR	T2	PA QL (2/28 days)
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	T1	
NOVOPEN ECHO	T1	

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T3 – Typically Non-Preferred Brands

ST – Step Therapy

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List of Prescription Medications

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

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
DIABETIC SUPPLIES (cont.)		
OMNIPOD 5 (G6/LIBRE 2 PLUS)	T2	QL(30 crtgs/30 days)
OMNIPOD 5 (GEN 5) KIT	T2	PA QL (1 kit/365 days)
OMNIPOD 5 (GEN 5) POD	T2	PA QL (30 pods/30 days)
OMNIPOD 5 G6-G7 INTRO KT(GEN5)	T2	QL(1 unit/365 days)
OMNIPOD 5 G6-G7 PODS (GEN 5)	T2	QL(30 crtgs/30 days)
OMNIPOD CLASSIC (GEN 3 & 4) KIT	T2	PA QL(1 kit/365 days)
OMNIPOD CLASSIC (GEN 3 & 4) PODS	T2	PA QL (30 pods/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	
REPLACEMENT PEDIATRIC MONITOR	T1	
SEN-SERTER	T1	
V-GO 20-40	T2	
DURABLE MEDICAL EQUIPMENT,MISC (GROUP I)		
1ST TIER UNILET COMFORTOUCH	T1	
1ST TIER UNILET COMFORTOUCH	T1	
2-IN-1 LANCET DEVICE	T1	
ACCU-CHEK FASTCLIX LANCET DRUM	T1	
ACCU-CHEK SAFE-T-PRO	T1	
ACCU-CHEK SAFE-T-PRO PLUS	T1	
ACCU-CHEK SOFTCLIX	T1	
ACTI-LANCE	T1	
ADVANCED TRAVEL LANCETS	T1	
ADVOCATE 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	

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List of Prescription Medications

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

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
DURABLE MEDICAL EQUIPMENT,MISC (GROUP I) (cont.)		
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	
EMBRACE SAFETY LANCET	T1	
EZ SMART LANCETS	T1	
EZ-LETS	T1	
FIFTY50 SAFETY SEAL LANCETS	T1	
FINE 30 UNIVERSAL LANCETS	T1	
FINGERSTIX	T1	
FORA LANCETS	T1	
FORACARE LANCETS	T1	
FREESTYLE LANCETS	T1	
FREESTYLE UNISTIK 2	T1	
GLUCOCOM	T1	
GLUCOCOM LANCETS	T1	
GOJJI LANCETS	T1	
HEALTHY ACCENTS UNILET LANCET	T1	
INCONTROL SUPERTHIN 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 LANCETS	T1	
MEDISENSE THIN 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 (Diabetes) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
DURABLE MEDICAL EQUIPMENT,MISC (GROUP I) (cont.)		
MEDLANCE PLUS	T1	
MICRO THIN LANCETS	T1	
MICROLET	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	
ON-THE-GO	T1	
OMNIPOD 5 G6-G7 INTRO KT(GEN5)	T2	QL
OMNIPOD 5 G6-G7 PODS (GEN 5)	T2	QL
PERFECT POINT SAFETY LANCETS	T1	
PIP LANCET	T1	
PRESSURE ACTIVATED LANCETS	T1	
PRO COMFORT LANCETS	T1	
PRO COMFORT SAFETY LANCET	T1	
PRODIGY LANCETS	T1	
PRODIGY TWIST TOP LANCET	T1	
PURE COMFORT LANCETS	T1	
PURE COMFORT SAFETY LANCETS	T1	
PUSH BUTTON SAFETY LANCETS	T1	
READYLANCE SAFETY LANCETS	T1	
RELIAMED	T1	
RELIAMED SAFETY SEAL LANCETS	T1	
RIGHTEST GL300 LANCETS	T1	
SAFETY LANCETS	T1	
SAFETY SEAL LANCETS	T1	
SAFETY-LET	T1	
SINGLE-LET	T1	

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List of Prescription Medications

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

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
DURABLE MEDICAL EQUIPMENT,MISC (GROUP I) (cont.)		
SMARTEST LANCET	T1	
SOLUS V2	T1	
SOLUS V2 LANCETS	T1	
STERILANCET L	T1	
STERILE LANCETS	T1	
SUPER THIN LANCETS	T1	
SURE COMFORT LANCETS	T1	
SURE-LANCE	T1	
SURE-TOUCH	T1	
TECHLITE LANCETS	T1	
TELCARE ULTRA THIN 30G LANCETS	T1	
THIN LANCETS	T1	
TOPCARE UNIVERSAL1 LANCET / THIN LANCET	T1	
TRUE COMFORT LANCET / SAFETY LANCET	T1	
TRUEPLUS LANCETS	T1	
TWIST LANCETS / TOP LANCET	T1	
ULTILET	T1	
ULTRA THIN LANCETS	T1	
ULTRA-CARE LANCETS	T1	
ULTRALANCE	T1	
ULTRA-THIN II LANCETS	T1	
ULTRATLC LANCETS	T1	
UNISTIK 3 NORMAL	T1	
UNILET	T1	
UNISTIK	T1	
UNISTIK 2	T1	
UNISTIK 3	T1	
UNIVERSAL 1	T1	
VERIFINE SAFETY LANCET MINI	T1	
VERIFINE UNIVERSAL LANCET	T1	
VIVAGUARD LANCET	T1	

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List of Prescription Medications

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

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
DURABLE MEDICAL EQUIPMENT,MISC (GROUP I) (cont.)		
VIVAGUARD SAFETY LANCET	T1	
NEEDLES/NEEDLELESS DEVICES		
ASSURE ID INSULIN SAFETY	T1	
BLUNT NEEDLE	T1	
CAREPOINT PRECISION NEEDLE	T1	
DROPSAFE SICURA SAFETY NEEDLE	T1	
ECLIPSE NEEDLE	T1	
FILTER NEEDLE	T1	
HYPODERMIC NEEDLE	T1	
MONOJECT BLOOD COLLECTION	T1	
NEEDLES	T1	
PERFECT POINT SAFETY NEEDLE	T1	
PHASEAL PROTECTOR	T1	
PRECISIONGLIDE NEEDLE	T1	
TERUMO SURGUARD2	T1	
SYRINGES AND ACCESSORIES		
EASY COMFORT INSULIN SYRINGE	T1	
INSULIN SYRINGE	T1	
LITE TOUCH INSULIN SYRINGE	T1	
MAGELLAN INSULIN SYRINGE / SAFETY SYRNG	T1	
MINIMED RESERVOIR	T1	
MONOJECT	T1	
MONOJECT INSULIN SYRINGE	T1	
PARADIGM	T1	
SECURESAFE INSULIN SYRINGE	T1	
SURE COMFORT INDULIN SYRINGE	T1	
TRUE COMFORT SAFE INSULIN SYRG	T1	
ULTRA THIN II INS SYRINGE	T1	
VERIFINE INSULIN SYRINGE	T1	
MISCELLANEOUS MEDICAL SUPPLIES, DEVICES, NON-DRUG (Miscellaneous)		
DURABLE MEDICAL EQUIPMENT,MISC (GROUP I)		
MOBILE LANCETS	T2	QL (1 unit/year)
ONETOUCH ULTRASOFT 2 LANCET	T2	

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List of Prescription Medications

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

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
DURABLE MEDICAL EQUIPMENT,MISC (GROUP I) (cont.)		
ONETOUCH ULTRA TEST STRIP	T2	QL (1 unit/year)
ONETOUCH VERIO TEST STRIP	T2	
PRO COMFORT SAFETY LANCET	T2	
UNISTIK 2	T1	
UNISTIK 3	T1	
RESPIRATORY AIDS, DEVICES, EQUIPMENT		
ACE AEROSOL CLOUD ENHANCER	T2	QL (1 unit/year)
AEROCHAMBER MECHANICAL VENT	T2	QL(1 spacer/365 days)
AEROCHAMBER MV & MINI	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)
BREATHRITE	T2	QL (1 unit/year)
CLEVER CHOICE HOLDING CHAMBER	T2	QL (1 unit/year)
COMFORTSEAL	T2	QL
COMPACT SPACE CHAMBER	T2	QL (1 unit/year)
EASIVENT	T2	QL (1 unit/year)
E-Z SPACER	T2	QL (1 unit/year)
FLEXICHAMBER	T2	QL (1 unit/year)
FLEXICHAMBER MASK	T2	QL (1 unit/year)
INSPIRACHAMBER	T2	QL (1 unit/year)
LITEAIRE	T2	QL (1 unit/year)
LITETOUGH	T2	QL (1 unit/year)
MICROCHAMBER	T2	QL (1 unit/year)
MICROSPACER	T2	QL (1 unit/year)

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List of Prescription Medications

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

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
RESPIRATORY AIDS, DEVICES, EQUIPMENT (cont.)		
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	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)

MUSCLE RELAXANTS (Pain Relief And Inflammatory Disease)

SKELETAL MUSCLE RELAXANTS		
<i>baclofen</i>	T1	HD
<i>baclofen 10 mg tablet</i>	T1	HD
<i>baclofen 20 mg tablet</i>	T1	HD
<i>baclofen 5 mg tablet</i>	T1	HD
<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</i>	T1	
<i>dantrolene sodium (Dantrium)</i>	T1	
FEXMID (<i>cyclobenzaprine hcl</i>)	T3	

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List of Prescription Medications

MUSCLE RELAXANTS (Pain Relief And Inflammatory Disease) (cont)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
SKELETAL MUSCLE RELAXANTS (cont.)		
<i>metaxalone</i>	T1	
<i>metaxalone</i> (Skelaxin)	T1	
<i>methocarbamol</i>	T1	
<i>methocarbamol</i> (Robaxin-750)	T1	
<i>orphenadrine citrate</i>	T1	
OZOBAX DS	T3	
ROBAXIN-750 (<i>methocarbamol</i>)	T3	
SKELAXIN (<i>metaxalone</i>)	T3	
<i>tizanidine hcl</i>	T1	
<i>tizanidine hcl</i> (Zanaflex)	T1	
ZANAFLEX (<i>tizanidine hcl</i>)	T3	

PRE-NATAL VITAMINS (Nutritional/Dietary)

PRENATAL VITAMIN PREPARATIONS		
ATABEX EC	T3	
CITRANATAL 90 DHA	T3	
CITRANATAL ASSURE	T3	
CITRANATAL DHA	T3	
CITRANATAL HARMONY	T3	
CITRANATAL RX	T3	
OBSTETRIX EC	T3	
OBTREX DHA	T3	
<i>pnv 22/iron, gluc/folic/dss/dha</i>	T1	
<i>pnv 66/iron/folic/docusate/dha</i>	T1	
<i>pnv 69/iron/folic/docusate/dha</i>	T1	
<i>pnv 80/iron fum/folic/dss/dha</i>	T1	
<i>pnv/ferrous fum/docusate/folic</i>	T1	
<i>pnv/iron, carb/docusat/folic ac</i>	T1	
<i>pnv no. 154/iron fum/folic acid</i>	T1	
<i>prenatal 12/iron/folic/dss/om3</i> (Obtrex Dha)	T1	
PRENATAL 19	T1	
<i>prenatal 34/iron/folic/dss/dha</i>	T1	
<i>prenatal vits15/iron/folic/dss</i>	T1	
VITAFOL FE+	T3	

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List of Prescription Medications

PSYCHOTHERAPEUTIC DRUGS (Anxiety/Depression/Bipolar Disorder)¹⁰

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ALPHA-2 RECEPTOR ANTAGONIST ANTI-DEPRESSANTS		
<i>mirtazapine</i>	T1	HD
<i>mirtazapine</i> (Remeron)	T1	HD
ANTI-ANXIETY - BENZODIAZEPINES		
<i>alprazolam</i>	T1	
<i>alprazolam</i> (Xanax Xr)	T1	
<i>alprazolam</i> (Xanax)	T1	
<i>chlordiazepoxide hcl</i>	T1	
<i>clorazepate dipotassium</i>	T1	
<i>clorazepate dipotassium</i> (Tranxene T-tab)	T1	
<i>diazepam 10 mg tablet</i> (Valium)	T1	
<i>diazepam 2 mg tablet</i> (Valium)	T1	
<i>diazepam 5 mg tablet</i> (Valium)	T1	
<i>diazepam 5 mg/5 ml solution</i>	T1	
<i>diazepam 5 mg/ml oral conc</i>	T1	
<i>lorazepam</i>	T1	
<i>oxazepam</i>	T1	
TRANXENE T-TAB (<i>clorazepate dipotassium</i>)	T3	
ANTI-ANXIETY DRUGS		
<i>buspirone hcl</i>	T1	
<i>meprobamate</i>	T1	
ANTIDEPRESSANT - NMDA RECEPTOR ANTAGONIST		
SPRAVATO	T3	PA SP
BIPOLAR DISORDER DRUGS		
EQUETRO	T3	HD
<i>lithium carbonate</i>	T1	HD
<i>lithium carbonate</i> (Lithobid)	T1	HD
<i>lithium citrate</i>	T1	HD
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 day) SP HD
ZURZUVAE 30 MG CAPSULE	T3	PA QL(14 caps/270 day) SP HD

T1 – Typically Generics

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List of Prescription Medications

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

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
MAOIS -NON-SELECTIVE, IRREVERSIBLE ANTI-DEPRESSANTS		
MARPLAN	T3	QL (12 tabs/day)
<i>phenelzine sulfate</i> (Nardil)	T1	
<i>tranylcypromine sulfate</i>	T1	
MONOAMINE OXIDASE (MAO) INHIBITOR ANTI-DEPRESSANTS		
EMSAM 12 MG/24 HOURS PATCH	T3	QL (1 patch/day)
EMSAM 6 MG/24 HOURS PATCH	T3	QL (2 patches/day)
EMSAM 9 MG/24 HOURS PATCH	T3	QL (1 patch/day)
NOREPINEPHRINE AND DOPAMINE REUPTAKE INHIB (NDRIs)		
<i>bupropion hcl 100 mg tablet</i>	T1	QL (4 tabs/day) HD
<i>bupropion hcl 75 mg tablet</i>	T1	QL (6 tabs/day) HD
<i>bupropion hcl sr 200 mg tablet</i> (Wellbutrin Sr)	T1	QL (2 tabs/day) HD
SELECTIVE SEROTONIN 5-HT_{2A} INVERSE AGONISTS (SSiAs)		
NUPLAZID	T3	PA SP HD
SELECTIVE SEROTONIN REUPTAKE INHIBITOR (SSRIs)		
<i>citalopram hbr 10 mg tablet</i> (Celexa)	T1	QL (6 tabs/day) HD
<i>citalopram hbr 20 mg tablet</i> (Celexa)	T1	QL (3 tabs/day) HD
<i>citalopram hbr 20 mg/10 ml sol</i>	T1	QL (30ml/day) HD
<i>citalopram hbr 40 mg tablet</i> (Celexa)	T1	QL (1 tab/day) HD
<i>escitalopram 10 mg tablet</i>	T1	QL (2 tabs/day) HD
<i>escitalopram 5 mg tablet</i>	T1	QL (4 tabs/day) HD
<i>escitalopram oxalate 5 mg/5 ml</i>	T1	QL (20ml/day) HD
<i>fluoxetine hcl</i>	T1	QL (4 caps/28 days) HD
<i>fluoxetine 20 mg/5 ml soln cup</i>	T1	QL (20 mls/day) HD
<i>fluoxetine hcl 10 mg capsule</i> (Prozac)	T1	QL (8 caps/day) HD
<i>fluoxetine hcl 20 mg capsule</i> (Prozac)	T1	QL (4 caps/day) HD
<i>fluoxetine hcl 40 mg capsule</i> (Prozac)	T1	QL (2 caps/day) HD
<i>fluoxetine hcl 10 mg tablet</i> (Sarafem)	T1	HD
<i>fluoxetine hcl 20 mg tablet</i>	T1	HD
<i>fluoxetine hcl 60 mg tablet</i>	T1	QL (1 tab/day) HD
<i>fluvoxamine er 100 mg capsule</i>	T1	QL (3 caps/day) HD
<i>fluvoxamine er 150 mg capsule</i>	T1	QL (2 caps/day) HD
<i>fluvoxamine maleate 100 mg tab</i>	T1	QL (3 tabs/day) HD
<i>fluvoxamine maleate 25 mg tab</i>	T1	QL (12 tabs/day) HD
<i>fluvoxamine maleate 50 mg tab</i>	T1	QL (6 tabs/day) HD
<i>paroxetine cr 12.5 mg tablet</i>	T1	QL (1 tab/day) HD

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List of Prescription Medications

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

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
SELECTIVE SEROTONIN REUPTAKE INHIBITOR (SSRIs) (cont)		
<i>paroxetine cr 25 mg tablet</i>	T1	QL (3 tabs/day) HD
<i>paroxetine cr 37.5 mg tablet</i>	T1	QL (2 tabs/day) HD
<i>paroxetine er 12.5 mg tablet</i>	T1	QL (1 tab/day) HD
<i>paroxetine er 25 mg tablet</i>	T1	QL (3 tabs/day) HD
<i>paroxetine er 37.5 mg tablet</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</i>	T1	QL (2 Tabs/day) HD
<i>desvenlafaxine succnt er 25 mg</i>	T1	QL (2 Tabs/day) HD
<i>desvenlafaxine succnt er 50 mg</i>	T1	QL (1 tab/day) HD
<i>duloxetine hcl dr 20 mg cap</i>	T1	QL (6 caps/day) HD
<i>duloxetine hcl dr 30 mg cap</i>	T1	QL (4 caps/day) HD
<i>duloxetine hcl dr 40 mg cap</i>	T1	QL (3 caps/day) HD
<i>duloxetine hcl dr 60 mg cap</i>	T1	QL (2 caps/day) HD
FETZIMA 20-40 MG TITRATION PAK	T3	QL (28 caps/180 days) ST
FETZIMA ER 120 MG CAPSULE	T3	QL (1 cap/day) ST
FETZIMA ER 20 MG CAPSULE	T3	QL (6 caps/day) ST
FETZIMA ER 40 MG CAPSULE	T3	QL (3 caps/day) ST
FETZIMA ER 80 MG CAPSULE	T3	QL (1 cap/day) ST
<i>venlafaxine hcl 100 mg tablet</i>	T1	QL (3 tabs/day) HD
<i>venlafaxine hcl 25 mg tablet</i>	T1	QL (15 tabs/day) HD
<i>venlafaxine hcl 37.5 mg tablet</i>	T1	QL (10 tabs/day) HD
<i>venlafaxine hcl 50 mg tablet</i>	T1	QL (7 tabs/day) HD

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List of Prescription Medications

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

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
SEROTONIN-NOREPINEPHRINE REUPTAKE-INHIB (SNRIs) (cont)		
<i>venlafaxine hcl 75 mg tablet</i>	T1	QL (5 tabs/day) HD
<i>venlafaxine hcl er 150 mg cap (Effexor Xr)</i>	T1	QL (2 caps/day) HD
<i>venlafaxine hcl er 150 mg tab</i>	T1	QL (2 tabs/day) HD
<i>venlafaxine hcl er 225 mg tab</i>	T1	QL (1 tab/day) HD
<i>venlafaxine hcl er 37.5 mg cap (Effexor Xr)</i>	T1	QL (8 caps/day) HD
<i>venlafaxine hcl er 37.5 mg tab</i>	T1	QL (8 tabs/day) HD
<i>venlafaxine hcl er 75 mg cap (Effexor Xr)</i>	T1	QL (4 caps/day) HD
<i>venlafaxine hcl er 75 mg tab</i>	T1	QL (4 tabs/day) HD
SSRI AND 5HT1A PARTIAL AGONIST ANTI-DEPRESSANTS		
<i>VIIBRYD 10 MG TABLET</i>	T3	QL (1 tab/day) ST HD
<i>VIIBRYD 10-20 MG STARTER PACK</i>	T3	ST HD
<i>VIIBRYD 20 MG TABLET</i>	T3	QL (1 tab/day) ST HD
<i>VIIBRYD 40 MG TABLET</i>	T3	ST HD
<i>vilazodone hcl 10 mg tablet (Viibryd)</i>	T1	QL (1 tab/day) HD
<i>vilazodone hcl 20 mg tablet (Viibryd)</i>	T1	QL (1 tab/day) HD
<i>vilazodone hcl 40 mg tablet (Viibryd)</i>	T1	HD
SSRI, SEROTONIN RECEPTOR MODULATOR ANTI-DEPRESSANTS		
<i>TRINTELLIX 10 MG TABLET</i>	T2	QL(1 TAB/DAY)
<i>TRINTELLIX 20 MG TABLET</i>	T2	
<i>TRINTELLIX 5 MG TABLET</i>	T2	QL(1 TAB/DAY)
TRICYCLIC ANTI-DEPRESSANT-PHENOTHIAZINE COMBINATNS		
<i>perphenazine/amitriptyline hcl</i>	T1	HD
TRICYCLIC ANTI-DEPRESSANTS, REL.NON-SEL.REUPT-INHIB		
<i>amoxapine</i>	T1	HD
<i>clomipramine hcl</i>	T1	HD
<i>desipramine hcl</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
<i>doxepin 50 mg capsule</i>	T1	HD
<i>doxepin 75 mg capsule</i>	T1	HD
<i>imipramine 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

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

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
TRICYCLIC ANTI-DEPRESSANTS, REL.NON-SEL.REUPT-INHIB (con't)		
<i>imipramine pamoate</i>	T1	HD
<i>maprotiline hcl</i>	T1	HD
<i>nortriptyline hcl</i>	T1	HD
<i>protriptyline hcl</i>	T1	HD
<i>trimipramine maleate</i>	T1	HD

PSYCHOTHERAPEUTIC DRUGS (Attention Deficit Hyperactivity Disorder)¹⁰

TX FOR ADHD - SELECTIVE ALPHA-2 RECEPTOR AGONIST		
<i>clonidine hcl (Kapvay)</i>	T1	
<i>guanfacine hcl (Intuniv)</i>	T1	
TX FOR ATTENTION DEFICIT-HYPERACT (ADHD)/NARCOLEPSY		
DAYTRANA	T3	PA QL (1 patch/day)
<i>dexmethylphenidate hcl</i>	T1	PA QL (1 cap/day)
<i>dexmethylphenidate hcl (Focalin)</i>	T1	PA
FOCALIN (<i>dexmethylphenidate hcl</i>)	T3	PA
METHYLIN (<i>methylphenidate hcl</i>)	T3	PA
<i>methylphenidate (Daytrana)</i>	T1	PA QL (1 patch/day)
<i>methylphenidate 10, 15, 20, 30mg/9hr ptch (Daytrana)</i>	T1	PA QL (1 patch/day)
<i>methylphenidate er 18, 27, 36, 54 mg tab (Relexxii)</i>	T1	PA QL (1 tab/day)
<i>methylphenidate er 10 mg cap</i>	T1	QL (1 cap/day)
<i>methylphenidate er 10 mg tab</i>	T1	PA QL (2 tabs/day)
<i>methylphenidate er 15 mg cap</i>	T1	QL (1 per day)
<i>methylphenidate er 18 mg tab</i>	T1	PA QL (1 tab/day)
<i>methylphenidate er 20 mg cap</i>	T1	QL (1 per day)
<i>methylphenidate er 20 mg tab</i>	T1	PA QL (3/day)
<i>methylphenidate er 27 mg tab</i>	T1	PA QL (1 tab/day)
<i>methylphenidate er 30 mg cap</i>	T1	QL (1 per day)
<i>methylphenidate er 36 mg tab</i>	T1	PA QL (2 tabs/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)
METHYLPHENIDATE ER 72 MG TAB	T1	PA QL (1 tab/day)
<i>methylphenidate hcl (Metadate Cd)</i>	T1	PA
<i>methylphenidate hcl (Methylin)</i>	T1	PA

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ST – Step Therapy

HD – May require home delivery pharmacy

List of Prescription Medications

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

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
TX FOR ATTENTION DEFICIT-HYPERACT (ADHD)/NARCOLEPSY (cont.)		
<i>methylphenidate hcl</i> (Ritalin)	T1	PA
<i>methylphenidate la</i> 10 mg cap	T1	PA QL (1 cap/day)
<i>methylphenidate la</i> 20 mg cap	T1	PA QL (1 cap/day)
<i>methylphenidate la</i> 30 mg cap	T1	PA QL (1 per day)
<i>methylphenidate la</i> 40 mg cap	T1	PA QL (1 per day)
<i>methylphenidate la</i> 60 mg cap	T1	PA QL (1 cap/day)
QUILLIVANT XR	T3	PA QL (12ml/day)
RITALIN (<i>methylphenidate hcl</i>)	T3	PA
TX FOR ATTENTION DEFICIT-HYPERACT.(ADHD), NRI-TYPE		
<i>atomoxetine hcl</i> 10 mg capsule	T1	HD
<i>atomoxetine hcl</i> 100 mg capsule	T1	HD
<i>atomoxetine hcl</i> 18 mg capsule	T1	HD
<i>atomoxetine hcl</i> 25 mg capsule	T1	HD
<i>atomoxetine hcl</i> 40 mg capsule	T1	QL (1 cap/day) HD
<i>atomoxetine hcl</i> 60 mg capsule	T1	HD
<i>atomoxetine hcl</i> 80 mg capsule	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
PSYCHOTHERAPEUTIC DRUGS (Schizophrenia/Anti-Psychotics)¹⁰		
ANTI-PSYCH, DOPAMINE ANTAG., DIPHENYLBUTYLPIPERIDINES		
<i>pimozide</i>	T1	
ANTI-PSYCHOTIC, ATYPICAL, DOPAMINE, SEROTONIN ANTAGNIST		
<i>asenapine maleate</i> (Saphris)	T1	
CAPLYTA	T3	ST QL (1 tabs/caps/day)
<i>clozapine</i>	T1	
<i>clozapine</i> (Clozapine Odt)	T1	
<i>clozapine</i> (Clozaril)	T1	
CLOZAPINE ODT	T1	

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List of Prescription Medications

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

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ANTI-PSYCHOTIC, ATYPICAL, DOPAMINE, SEROTONIN ANTAGNIST (cont.)		
INVEGA ER 1.5 MG TABLET (<i>paliperidone er</i>)	T3	ST
INVEGA ER 3 MG TABLET (<i>paliperidone er</i>)	T3	QL (1 tab/day) ST
INVEGA ER 6 MG TABLET (<i>paliperidone er</i>)	T3	ST
INVEGA ER 9 MG TABLET (<i>paliperidone er</i>)	T3	ST
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 120 mg tablet</i>	T1	
<i>lurasidone hcl 20 mg tablet</i>	T1	
<i>lurasidone hcl 40 mg tablet</i>	T1	QL(1 tab/day)
<i>lurasidone hcl 60 mg tablet</i>	T1	QL(1 tab/day)
<i>lurasidone hcl 80 mg tablet</i>	T1	
<i>olanzapine (Zyprexa)</i>	T1	
<i>paliperidone er 1.5 mg tablet</i>	T1	
<i>paliperidone er 1.5 mg tablet (Invega)</i>	T1	
<i>paliperidone er 3 mg tablet (Invega)</i>	T1	QL (1 tab/day)
<i>paliperidone er 9 mg tablet (Invega)</i>	T1	
<i>quetiapine fumarate (Seroquel Xr)</i>	T1	
<i>quetiapine fumarate (Seroquel)</i>	T1	
<i>risperidone</i>	T1	
<i>risperidone (Risperdal)</i>	T1	
SAPHRIS (<i>asenapine maleate</i>)	T3	ST
SECUADO	T3	ST
SEROQUEL (<i>quetiapine fumarate</i>)	T3	ST
SEROQUEL XR (<i>quetiapine fumarate er</i>)	T3	ST
SODIUM OXYBATE 0.5 G/ML SOLN	T3	PA QL(18 mls/day) SP HD
<i>ziprasidone hcl</i>	T1	

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List of Prescription Medications

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

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ANTI-PSYCHOTIC-ATYPICAL, D3/D2 PARTIAL AG-5HT MIXED		
VRAYLAR 1.5 MG CAPSULE	T3	QL (1 cap/day) ST
VRAYLAR 3 MG CAPSULE	T3	QL (1 cap/day) ST
VRAYLAR 4.5 MG CAPSULE	T3	ST
VRAYLAR 6 MG CAPSULE	T3	ST
ANTIPSYCHOTICS, ATYP, D2 PARTIAL AGONIST/5HT MIXED		
<i>aripiprazole</i>	T1	
<i>aripiprazole 1 mg/ml solution</i>	T1	
<i>aripiprazole 15 mg tablet</i>	T1	
<i>aripiprazole 2 mg tablet</i>	T1	
<i>aripiprazole 20 mg tablet</i>	T1	
<i>aripiprazole 30 mg tablet</i>	T1	
<i>aripiprazole 5 mg tablet</i>	T1	QL (1 tab/day)
REXULTI 0.25 MG TABLET	T3	QL (1 tab/day) ST
REXULTI 0.5 MG TABLET	T3	QL (1 tab/day) ST
REXULTI 1 MG TABLET	T3	QL (1 tab/day) ST
REXULTI 2 MG TABLET	T3	QL (1 tab/day) ST
REXULTI 3 MG TABLET	T3	ST
REXULTI 4 MG TABLET	T3	ST
ANTI-PSYCHOTICS, DOPAMINE AND SEROTONIN ANTAGONISTS		
<i>loxapine succinate</i>	T1	
ANTI-PSYCHOTICS, DOPAMINE ANTAGONISTS, BUTYROPHENONES		
<i>haloperidol</i>	T1	
<i>haloperidol lactate</i>	T1	
ANTI-PSYCHOTICS, DOPAMINE ANTAGONST, DIHYDROINDOLONES		
<i>molindone hcl</i>	T1	
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	

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List of Prescription Medications

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

Prescription Drug Name **Drug Tier** **Coverage Requirements and Limits**

SSRI-ANTI-PSYCH, ATYPICAL, DOPAMINE, SEROTONIN ANTAG (cont.)

olanzapine/fluoxetine hcl (Symbyax)

T1

PSYCHOTHERAPEUTIC DRUGS (Sleep Disorders/Sedatives)

NARCOLEPSY AND SLEEP DISORDER THERAPY AGENTS

armodafinil

T1

PA

modafinil (Provigil)

T1

PA

SUNOSI

T2

PA QL (1 tab/day)

SEDATIVE/HYPNOTICS (Sleep Disorders/Sedatives)

ANTI-NARCOLEPSY, ANTI-CATAPLEXY, SEDATIVE-TYPE AGENT

LUMRYZ

T3

PA QL (30 pkts/30 days) SP

LUMRYZ STARTER PACK

T3

PA SP HD

SODIUM OXYBATE

T3

PA QL (18 mls/day) SP HD

XYWAV

T3

PA SP HD

BARBITURATES

phenobarbital

T1

secobarbital sodium

T3

PA

HYPNOTICS, MELATONIN MT1/MT2 RECEPTOR AGONISTS

HETLIOZ

T3

PA SP HD

HETLIOZ LQ

T3

PA SP HD

ramelteon (Rozerem)

T1

QL (1 tab/day)

SEDATIVE-HYPNOTICS - BENZODIAZEPINES

flurazepam hcl

T1

triazolam

T1

triazolam (Halcion)

T1

SEDATIVE-HYPNOTICS, NON-BARBITURATE

DAYVIGO

T2

QL (1 tab/day) ST

doxepin hcl 3 mg tablet (Silenor)

T1

QL (1 tab/day)

doxepin hcl 6 mg tablet (Silenor)

T1

eszopiclone (Lunesta)

T1

zaleplon

T1

zolpidem tartrate 5, 10mg tablet (Ambien)

T1

zolpidem tart er 12.5 mg tab

T1

zolpidem tart er 6.25 mg tab

T1

QL (1 tab/day)

zolpidem tartrate

T1

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List of Prescription Medications

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

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ANTI-NARCOLEPSY, ANTI-CATAPLEXY, SEDATIVE-TYPE AGENT		
LUMRYZ	T3	PA QL (1 pack/day) SP HD
SKIN PREPS (Cancer)		
IMMUNOMODULATORS		
<i>imiquimod</i>	T1	
SKIN PREPS (Miscellaneous)		
ANTISEPTICS, MISCELLANEOUS		
GUAIALCOL	T1	
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	
<i>water for irrigation, sterile</i>	T1	
OXIDIZING AGENTS		
<i>hydrogen peroxide</i>	T1	
SKIN PREPS (Pain Relief And Inflammatory Disease)		
ANTI-PSORIATIC AGENTS, SYSTEMIC		
<i>acitretin</i>	T1	
BIMZELX SYRING	T3	PA QL(2 mls/28 days) SP HD
BIMZELX AUTOINJECTOR	T3	PA QL(2 mls/28 days) SP HD
COSENTYX	T3	PA QL
<i>methoxsalen (Oxsoralen-ultra)</i>	T1	
OXSORALEN-ULTRA (<i>methoxsalen</i>)	T3	
SOTYKTU	T2	PA QL(1 tab/day) SP HD
SPEVIGO	T3	PA QL(2 mls/28 days) SP HD
TALTZ	T2	PA QL (1 injector/28 days) SP HD
TREMFYA 100 MG/ML INJECTOR	T2	PA QL (1 injector/56 days) SP HD

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List of Prescription Medications

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

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ANTI-PSORIATIC AGENTS, SYSTEMIC (cont.)		
TREMFYA 100 MG/ML SYRINGE	T2	PA QL (1 syringe/56 days) SP HD
TOPICAL ANTI-INFLAMMATORY, NSAIDS		
DICLAREAL	T3	HD
<i>diclofenac sodium 1% gel</i>	T1	QL (1000gm/30 days) HD
SKIN PREPS (Skin Conditions)		
ACNE AGENTS, SYSTEMIC		
ABSORICA (<i>isotretinoin</i>)	T3	
ACUTANE	T1	
AMNESTEEM	T1	
CLARAVIS	T1	
MYORISAN	T1	
ZENATANE	T1	
ACNE AGENTS, TOPICAL		
ACZONE 7.5% GEL PUMP	T3	
<i>adapalene/benzoyl peroxide</i>	T1	
<i>clindamycin-benzoyl perox 1-5%</i>	T1	
<i>clindamycin/tretinoin (Veltin)</i>	T1	
<i>dapsone (Aczone)</i>	T1	
KLARON (<i>sulfacetamide sodium</i>)	T3	
ONEXTON (<i>clindamycin phos/benzoyl perox</i>)	T3	
<i>sulfacetamide sodium (Klaron)</i>	T1	
ANTI-PERSPIRANTS		
DRYSOL	T3	
ANTI-PRURITICS, TOPICAL		
ALEVICYN PLUS	T3	
ANTI-PSORIATICS AGENTS		
<i>calcipotriene 0.005% ointment</i>	T1	
<i>calcipotriene 0.005% solution</i>	T1	
<i>calcitriol 3 mcg/g ointment</i>	T1	QL (800gm/30 days)
<i>tazarotene (Tazorac)</i>	T1	
ANTI-SEBORRHEIC AGENTS		
OVACE PLUS	T3	
<i>selenium sulfide</i>	T1	
<i>sulfacetamide sodium</i>	T1	
TERSI FOAM	T3	

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List of Prescription Medications

SKIN PREPS (Skin Conditions) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
DIABETIC ULCER PREPARATIONS, TOPICAL		
REGRANEX	T3	PA QL (2 tubs/30 days)
EMOLLIENTS		
ATOPICLAIR	T3	
<i>emollient combination no.35 (Mimyx)</i>	T1	
<i>emollient combination no.60 (Restizan)</i>	T1	
HALUCORT	T3	
MIMYX (<i>prumyx</i>)	T3	
RESTIZAN	T1	
<i>vite ac/grape/hyaluronic acid (Atopiclair)</i>	T1	
XCLAIR	T3	
IRRITANTS/COUNTER-IRRITANTS		
<i>methyl salicylate</i>	T1	
QUTENZA	T3	
KERATOLYTICS		
BENZEFOAM	T3	
BENZEPRO	T1	
<i>benzoyl peroxide (Enzoclear)</i>	T1	
<i>benzoyl peroxide (Pacnex)</i>	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 (<i>salicylic acid</i>)	T3	
PACNEX (<i>benzoyl peroxide</i>)	T3	
PODOCON-25	T1	
<i>podoflox</i>	T1	
PR BENZOYL PEROXIDE	T1	
SALICATE	T3	
<i>salicylic acid</i>	T1	
<i>salicylic acid (Keralyt Scalp)</i>	T1	
<i>salicylic acid/ceramide comb 1</i>	T1	

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List of Prescription Medications

SKIN PREPS (Skin Conditions) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
KERATOLYTICS (cont.)		
SALIMEZ FORTE	T1	
SALKERA	T3	
SALVAX DUO PLUS	T3	
<i>silver nitrate</i>	T1	
<i>silver nitrate applicator</i>	T1	
URAMAXIN	T3	
URAMAXIN (urea)	T3	
<i>urea</i> (Hydro 35)	T1	
<i>urea</i> (Hydro 40)	T3	
<i>urea</i> (Uramaxin)	T1	
<i>urea</i> (Xurea)	T1	
XUREA	T3	
PROTECTIVES		
BIONECT	T3	
PHARMABASE BARRIER	T1	
<i>polydimethylsiloxanes/silicon</i>	T1	
<i>protectives2/ceramide 1, 3, 6-ii</i>	T1	
RADIAPLEXRX	T3	
SCARTRATE	T3	
<i>zinc oxide</i>	T1	
ROSACEA AGENTS, TOPICAL		
<i>azelaic acid</i>	T1	
<i>ivermectin</i>	T1	
<i>metronidazole</i>	T1	
SOOLANTRA (ivermectin)	T3	
TISSUE/WOUND ADHESIVES		
ARTISS	T3	
SURGISEAL STYLUS	T3	
SURGISEAL TEARDROP	T3	
SURGISEAL TWIST	T3	
TISSEEL VHSD	T3	
TOP. ANTI-INFLAM., PHOSPHODIESTERASE-4 (PDE4) INHIB		
EUCRISA	T2	
TOPICAL AGENTS, MISCELLANEOUS		
GORDON'S UREA	T3	

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List of Prescription Medications

SKIN PREPS (Skin Conditions) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
TOPICAL AGENTS, MISCELLANEOUS (cont.)		
HYFTOR	T3	PA SP
L-MESITRAN SOFT	T3	
MEDIHONEY	T3	
SAF-CLENS AF	T1	
<i>trichloroacetic acid</i>	T3	
TOPICAL ANTIBIOTIC PLEUROMUTILIN DERIVATIVES		
ALTABAX	T3	
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 dipropionate</i>	T1	
<i>betamethasone valerate</i>	T1	
<i>betamethasone valerate (Luxiq)</i>	T1	
<i>betamethasone/propylene glyc</i>	T1	
<i>betamethasone/propylene glyc (Diprolene)</i>	T1	
BRYHALI	T3	ST
CAPEX SHAMPOO	T3	ST
<i>clobetasol propionate</i>	T1	
<i>clobetasol propionate (Clobex)</i>	T1	
<i>clobetasol propionate (Olux)</i>	T1	
<i>clobetasol propionate (Temovate)</i>	T1	
<i>clobetasol propionate/emoll</i>	T1	
CLOCORTOLONE PIVALATE	T1	
CLODAN 0.05% KIT	T3	ST
<i>clodan 0.05% shampoo</i>	T1	
CLODERM	T3	ST
DERMA-SMOOTHIE-FS (<i>fluocinolone acetonide</i>)	T3	ST
DERMATOP (<i>prednicarbate</i>)	T3	ST
<i>desonide</i>	T1	
<i>desonide (Desowen)</i>	T1	
DESOWEN (<i>desonide</i>)	T3	ST
<i>desoximetasone (Topicort)</i>	T1	
DIPROLENE (<i>betamethasone diprop augmented</i>)	T3	ST

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>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>halobetasol prop 0.05% cream</i>	T1	
<i>halobetasol prop 0.05% ointmnt</i>	T1	
<i>halobetasol prop 0.05% foam</i>	T1	
<i>halobetasol propionate</i> (Ultravate)	T1	
<i>hydrocortisone</i>	T1	
<i>hydrocortisone</i> (Ala-scalp)	T1	
<i>hydrocortisone butyrate</i>	T1	
<i>hydrocortisone valerate</i>	T1	
LUXIQ (<i>betamethasone valerate</i>)	T3	ST
MOMETACURE	T3	
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
ULTRAVATE (<i>halobetasol propionate</i>)	T3	ST
TOPICAL ANTI-INFLAMMATORY STEROID-LOCAL ANESTHETIC		
EPIFOAM	T2	
<i>hydrocortisone/pramoxine</i> (Pramosone)	T1	
<i>lidocaine/hydrocortisone ac</i>	T1	
MEZPAROX-HC	T1	
TOPICAL ANTI-PARASITICS		
<i>lindane</i>	T1	
<i>malathion</i> (Ovide)	T1	
OVIDE (<i>malathion</i>)	T3	

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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	
TACLONEX 0.005%–0.064% SUSPENS (<i>calcipotriene/betamethasone</i>)		
TOPICAL/MUCOUS MEMBR./SUBCUT. ENZYMES		
SANTYL	T3	QL (60gm/30 days)
VITAMIN A DERIVATIVES		
PLIXDA	T1	PA
RETIN-A MICRO PUMP 0.08% GEL (<i>tretinoin microspheres</i>)	T3	PA
<i>tretinoin 0.01% gel</i>	T1	
<i>tretinoin 0.025% cream</i>	T1	PA
<i>tretinoin 0.025% gel</i>	T1	
<i>tretinoin 0.05% cream</i>	T1	PA
<i>tretinoin 0.05% gel</i>	T1	PA
<i>tretinoin 0.1% cream</i>	T1	PA
<i>tretinoin microspheres</i>	T1	PA
SMOKING DETERRENTS (Smoking Cessation)⁹		
SMOKING DETERRENT AGENTS (GANGLIONIC STIM, OTHERS)		
NICODERM CQ 14 MG/24HR PATCH (nicotine)	T3	PPACA
NICODERM CQ 21 MG/24HR PATCH (nicotine)	T1	PPACA
NICODERM CQ 7 MG/24HR PATCH (nicotine)	T3	PPACA
NICORETTE (nicotine polacrilex)	T3	PPACA
<i>nicotine</i> (Nicoderm Cq)	T1	PPACA
NICOTINE LOZENGE	T1	PPACA
<i>nicotine polacrilex</i> (Nicorette)	T1	PPACA
NICOTROL	T3	PPACA
NICOTROL NS	T3	PPACA

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List of Prescription Medications

SMOKING DETERRENTS (Smoking Cessation) ⁹		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
SMOKING DETERRENT-NICOTINIC RECEPT.PARTIAL AGONIST		
CHANTIX	T3	
varenicline 0.5mg & 1 mg tablet	T1	PPACA
varenicline 1 mg cont month bx	T1	PPACA
varenicline starting month box	T1	PPACA
SMOKING DETERRENTS, OTHER		
bupropion hcl sr 150 mg tablet	T1	PPACA
THYROID PREPS (Hormonal Agents)		
ANTI-THYROID PREPARATIONS		
methimazole (Tapazole)	T1	HD
propylthiouracil	T1	HD
TAPAZOLE (methimazole)	T3	HD
THYROID HORMONES		
LEVOTHYROXINE CAPSULE	T3	HD
levothyroxine 25-200 mcg tablet (Synthroid)	T1	HD
levothyroxine sodium	T1	HD
liothyronine sodium	T1	HD
thyroid, pork	T1	HD
thyroid, pork (Wp Thyroid)	T1	HD
THYROLAR-1	T3	HD
THYROLAR-1/2	T3	HD
THYROLAR-1/4	T3	HD
THYROLAR-2	T3	HD
THYROLAR-3	T3	HD
WP THYROID	T1	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)		
SYSTEMIC ENZYME INHIBITORS		
JOENJA	T3	PA QL(2 tabs/day) SP
VIJOICE 125 mg, 50 mg	T3	PA QL (30 tabs/30days) SP
VIJOICE 250 mg dose pack	T3	PA QL (2 tabs/30days) SP

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List of Prescription Medications

UNCLASSIFIED DRUG PRODUCTS (Asthma/COPD/Respiratory) (con't.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
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>	T1	PA SP HD
CI ESTERASE INHIBITORS		
HAEGARDA	T3	PA SP HD
PLASMA KALLIKREIN INHIBITORS		
ORLADEYO	T3	PA QL (1 caps/day) SP
UNCLASSIFIED DRUG PRODUCTS (Cancer)		
CHEMOTHERAPY RESCUE/ANTIDOTE AGENTS		
<i>leucovorin calcium</i>	T1	
MESNEX	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)		
CAVERJECT	T3	PA QL (6 injectors/30 days)
CAVERJECT	T3	PA QL (6 injectors/30 days)
CIALIS 10 MG TABLET (<i>tadalafil</i>)	T3	QL (6 tabs/30 days) ST
CIALIS 20 MG TABLET (<i>tadalafil</i>)	T3	QL (6 tabs/30 days) ST
CIALIS 5 MG TABLET (<i>tadalafil</i>)	T3	QL (8 tabs/30 days) ST
EDEX	T3	PA QL (6 injectors/30 days)
IFE-BIMIX 30/1	T2	
IFE-PG20	T2	
LEVITRA (<i> sildenafil hcl</i>)	T3	QL (10 tabs/30 days) ST

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List of Prescription Medications

UNCLASSIFIED DRUG PRODUCTS (Erectile Dysfunction) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
DRUGS TO TREAT ERECTILE DYSFUNCTION (ED) (cont.)		
MUSE	T3	PA QL (6/30 days)
PAPAVERINE-ALPROSTADIL	T1	
PHENTOLAMINE-ALPROSTADIL	T1	
<i>sildenafil 100 mg tablet</i> (Viagra)	T1	QL (6 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	ST QL (8 tabs/30 days)
<i>tadalafil 2.5 mg tablet</i>	T1	QL (1 tab/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
<i>tadalafil 5 mg tablet</i> (Cialis)	T1	QL (1 tab/day) HD
TRI-MIX	T3	
<i>varденаfil hcl</i> (Levitra)	T1	QL (10 tabs/30 days)
VIAGRA (<i>sildenafil citrate</i>)	T3	QL (6 tabs/30 days) ST

UNCLASSIFIED DRUG PRODUCTS (Gastrointestinal/Heartburn)

ORAL MUCOSITIS/STOMATITIS AGENTS		
GELCLAIR	T3	
ORAMAGICRX	T3	
SALIVA STIMULANT AGENTS		
NUMOISYN	T3	
NEUTRASAL	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)		
GROWTH HORMONE RECEPTOR ANTAGONISTS		
SOMAVERT	T2	PA SP HD
HYPERPARATHYROID TX AGENTS - VITAMIN D ANALOG-TYPE		
<i>doxercalciferol</i>	T1	
<i>paricalcitol</i>	T1	SP HD
<i>paricalcitol</i> (Zemplar)	T1	SP HD
RAYALDEE	T3	
ZEMPLAR (<i>paricalcitol</i>)	T3	SP HD

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List of Prescription Medications

UNCLASSIFIED DRUG PRODUCTS (Miscellaneous)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ABORTIFACIENT-PROGESTERONE RECEPTOR ANTAGONISTS		
MIFEPREX	T3	
<i>mifepristone</i> (Mifeprex)	T1	
AGENTS TO TX PERIODIC PARALYSIS - CARBON ANHYD INH		
<i>dichlorphenamide</i> (Keveyis)	T1	PA SP
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>	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	T3	PA SP
ORFADIN (<i>nitisinone</i>)	T3	PA SP
DRUGS TO TX GAUCHER DX-TYPE I, SUBSTRATE REDUCING		
CERDELGA	T2	PA SP HD
<i>miglustat</i> (Zavesca)	T1	PA SP HD
ZAVESCA (<i>miglustat</i>)	T3	PA SP HD
GENERAL INHALATION AGENTS		
HYPER-SAL	T3	
<i>nebusal 3% vial</i>	T1	
NEBUSAL 6% VIAL	T3	
<i>sodium chloride for inhalation</i>	T1	
<i>sodium chloride for inhalation</i> (Hyper-sal)	T1	
GLUCOSYLCERAMIDE SYNTHASE (GCS) INHIBITOR		
<i>miglustat</i> (Zavesca)	T1	PA SP
OPFOLDA	T3	PA QL(8 caps/30 days) SP HD

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List of Prescription Medications

UNCLASSIFIED DRUG PRODUCTS (Miscellaneous) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
MENOPAUSAL SYMPTOMS SUPPRESSANT - SSRIs		
<i>paroxetine mesylate</i>	T1	QL(1 cap/day) HD
METABOLIC DISEASE ENZYME REPLACE, HYPOPHOSPHATASIA		
STRENSIQ	T2	PA SP
METALLIC POISON, AGENTS TO TREAT		
CHEMET	T3	
<i>deferiasirox</i> (Exjade)	T1	SP HD
<i>deferiasirox</i> (Jadenu Sprinkle)	T1	SP HD
<i>deferiasirox</i> (Jadenu)	T1	SP HD
<i>deferiprone</i> (Ferriprox)	T1	PA SP
EXJADE (<i>deferiasirox</i>)	T3	PA SP HD
FERRIPROX	T3	PA SP
FERRIPROX (2 TIMES A DAY)	T3	PA SP
GALZIN	T3	
RADIOGARDASE	T3	
<i>trientine hcl</i>	T1	PA SP HD
TRIENTINE HCL 500 MG CAPSULE	T3	PA SP HD
NATRIURETIC PEPTIDES		
VOXZOGO	T3	PA SP HD
NICOTINIC RECEPT.PARTIAL AGONIST, ALPHA4BETA2 SPEC		
TYRVAYA	T2	QL(8.4 mls/30 days)
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 packet</i> (Kuvan)	T1	PA SP
<i>javygtor tablet</i> (Kuvan)	T1	PA SP HD
PROTEIN STABILIZERS		
ATTRUBY	T3	
VYNDAMAX	T3	PA QL (1 cap/day) SP HD
VYENDAQEL	T3	PA QL (4 caps/day) SP HD
RETINOIC ACID RECEPTOR (RAR) AGONISTS		
SOHONOS	T3	PA SP
SOLVENTS		
FT ISOPROPYL ALCOHOL 91%	T1	
FT ISOPROPYL RUB ALCOHOL 70%	T3	

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List of Prescription Medications

UNCLASSIFIED DRUG PRODUCTS (Miscellaneous) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
SOLVENTS (cont.)		
GS ISOPROPYL ALCOHOL 70%	T3	
isopropyl alcohol	T1	
MURI-LUBE MINERAL OIL	T1	
sm isopropyl alcohol 91%	T1	
THYMIC STROMAL LYMPHOPOIETIN (TSLP) INHIBITORS		
TEZSPIRE 210 MG/1.91 ML PEN	T2	PA QL(1 pen/28 days) SP HD
TEZSPIRE 210 MG/1.91 ML SYRING	T2	PA SP HD
TREATMENT OF HYPERPHAGIA IN PRADER-WILLI SYNDROME		
VYKAT XR	T3	PA SP
METABOLIC DEFICIENCY AGENTS		
TEZSPIRE 210 MG/1.91 ML PEN	T2	PA QL(1 pen/28 days) SP HD
TEZSPIRE 210 MG/1.91 ML SYRING	T2	PA SP HD
levocarnitine (with sugar) (Carnitor)	T1	
UNCLASSIFIED DRUG PRODUCTS (Osteoporosis Products)		
BONE FORMATION STIM. AGENTS - PARATHYROID HORMONE		
teriparatide 600 mcg/2.4ml pen	T1	PA QL(0.09 mls/day) SP HD
BONE RESORPTION INHIBITOR AND VITAMIN D COMBS.		
FOSAMAX PLUS D	T2	ST HD
BONE RESORPTION INHIBITORS		
ACTONEL (risedronate sodium)	T3	ST HD
alendronate sodium (Fosamax)	T1	HD
ATELVIA (risedronate sodium dr)	T3	ST HD
BINOSTO	T3	ST HD
BONIVA (ibandronate sodium)	T3	ST HD
EVISTA (raloxifene hcl)	T3	HD
FOSAMAX (alendronate sodium)	T3	ST HD
ibandronate sodium	T1	HD
ibandronate sodium (Boniva)	T1	HD
raloxifene hcl (Evista)	T1	HD PPACA
risedronate sodium	T1	HD
risedronate sodium (Actonel)	T1	HD
risedronate sodium (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 T2 – Typically Preferred Brands T3 – Typically Non-Preferred Brands		
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List of Prescription Medications

UNCLASSIFIED DRUG PRODUCTS (Pain Relief And Inflammatory Disease) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
FIBROMYALGIA AGENTS, SEROTONIN-NOREPINEPH RU INHIB		
SAVELLA	T3	
IMMUNOMODULATOR, B-LYMPHOCYTE STIM (BLYS)-SPEC INHIB		
BENLYSTA	T3	PA SP HD
UNCLASSIFIED DRUG PRODUCTS (Skin Conditions)		
INTERLEUKIN-13 (IL-13) INHIBITORS, MAB		
ADBRY	T2	PA SP HD
EBGLYSS PEN	T2	PA SP
WOUND HEALING AGENTS, LOCAL		
FILSUEZ	T3	PA SP
UNCLASSIFIED DRUG PRODUCTS (Substance Abuse)		
OPIOID WITHDRAWAL THER, ALPHA-2 ADRENERGIC AGONIST		
lofexidine	T1	QL(192 tabs/30 days)
LUCEMYRA	T2	QL (168 tabs/14 days)
OPIOID WITHDRAWAL THERAPY AGENTS, OPIOID-TYPE		
BUNAVAIL	T3	
buprenorphine 2 mg tablet sl	T1	
buprenorphine 8 mg tablet sl	T1	
buprenorphine hcl	T1	
buprenorphine hcl/naloxone hcl	T1	
buprenorphine hcl/naloxone hcl (Suboxone)	T1	
SUBOXONE (buprenorphine-naloxone)	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		
alfuzosin hcl (Uroxatral)	T1	HD
dutasteride (Avodart)	T1	HD
finasteride (Proscar)	T1	HD
PROSCAR (finasteride)	T3	HD
RAPAFLO 4 MG CAPSULE (silodosin)	T3	QL (1 cap/day) HD
RAPAFLO 8 MG CAPSULE (silodosin)	T3	HD
silodosin 4 mg capsule (Rapaflo)	T1	QL (1 cap/day) HD
T1 – Typically Generics T2 – Typically Preferred Brands T3 – Typically Non-Preferred Brands PA – Prior Authorization QL – Quantity Limit ST – Step Therapy AGE – Age Requirement SP – Specialty Medication HD – May require home delivery pharmacy PPACA – No Cost-Share Preventive Medication CSL – Oral cancer medication subject to cost-share limits		

List of Prescription Medications

UNCLASSIFIED DRUG PRODUCTS (Urinary Tract Conditions) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
BENIGN PROSTATIC HYPERTROPHY/MICTURITION AGENTS (con't.)		
<i>silodosin 8 mg capsule</i> (Rapaflo)	T1	HD
<i>tamsulosin hcl</i> (Flomax)	T1	HD
<i>tiopronin dr tablet</i>	T1	SP
UROXATRAL (<i>alfuzosin hcl er</i>)	T3	HD
VANRAFIA	T2	PA QL(1 tab/day) SP
BPH 5-ALPHA-REDUCTASE INHIB-ALPHA1-ADRENOCEP ANTAG		
<i>dutasteride/tamsulosin hcl</i>	T1	HD
CYSTINE-DEPLETING AGENTS, NEPHROPATHIC CYSTINOSIS		
CYSTAGON	T2	SP
KIDNEY STONE AGENTS		
<i>tiopronin</i>	T1	SP HD
OVERACTIVE BLADDER AGENTS, BETA-3 ADRENERGIC RECEPTOR		
<i>mirabegron er 25 mg tablet</i> (Myrbetriq)	T1	QL(1 tab/day) HD
<i>mirabegron er 50 mg tablet</i> (Myrbetriq)	T1	HD
URINARY TRACT ANTI-SPASMODIC, M(3) SELECTIVE ANTAG.		
<i>darifenacin er 15 mg tablet</i>	T1	HD
<i>darifenacin er 7.5 mg tablet</i>	T1	QL (1 tab/day) HD
<i>solifenacin 10 mg tablet</i>	T1	HD
<i>solifenacin 5 mg tablet</i>	T1	QL (1 tab/day) HD
URINARY TRACT ANTI-SPASMODIC/ANTI-INCONTINENCE AGENT		
<i>flavoxate hcl</i>	T1	HD
<i>tolterodine tart er 2 mg cap</i>	T1	QL (1 cap/day) HD
<i>tolterodine tart er 4 mg cap</i>	T1	HD
<i>tolterodine tartrate</i>	T1	HD
<i>tropium chloride</i>	T1	HD

UNCLASSIFIED DRUG PRODUCTS (Weight Management)

APPETITE STIM. FOR ANOREXIA, CACHEXIA, WASTING SYND.

<i>megestrol acetate</i>	T1	
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VITAMINS (Nutritional/Dietary)

VITAMIN B12 PREPARATIONS

<i>cyanocobalamin (vitamin b-12)</i> (Nascobal)	T1	
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VITAMIN D PREPARATIONS

<i>calcitriol 0.25 mcg capsule</i> (Rocaltrol)	T1	
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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

VITAMINS (Nutritional/Dietary) (con't.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
VITAMIN D PREPARATIONS (con't.)		
<i>calcitriol 0.5 mcg capsule</i> (Rocaltrol)	T1	
<i>calcitriol 1 mcg/ml solution</i> (Rocaltrol)	T1	HD
DRISDOL (<i>vitamin d2</i>)	T3	HD
<i>ergocalciferol (vitamin d2)</i>	T1	HD
ROCALTROL (<i>calcitriol</i>)	T3	HD
VITAMIN K PREPARATIONS		
MEPHYTON (<i>phytonadione</i>)	T3	
<i>phytonadione (vit k1)</i> (Mephyton)	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

Exclusions and limitations for coverage

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

Plans generally do not provide coverage for the following under the pharmacy benefit, except as required by state or federal law, or by the terms of your specific plan:¹¹

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

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



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

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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)

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

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