Cigna Healthcare Value 4-Tier Prescription Drug List

Coverage as of January 1, 2026

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

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

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 This drug list is subject to change and all prior versions are no longer in effect.

cigna healthcare

What's Inside?	Page
Information about this drug list	3
· Frequently asked questions (FAQs)	3
· Words you may need to know	11
· About this drug list	13
· How to read this drug list	13
· How to find your medication	16
List of prescription medications	19
Exclusions and limitations for coverage	154
Index of medications	155

View your drug list online, 24/7

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

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

Questions?

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

Information about this drug list

Frequently asked questions (FAQs)

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

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

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

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

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

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.

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

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

hours of receiving a non-urgent request and 24 hours of receiving a request based on exigent circumstances, the request will be considered approved and your plan can't deny coverage of the medication. Also, if you've already received approval for your plan to cover your medication, we can't limit or exclude coverage for that medication if your doctor continues to prescribe it to treat your condition (as long as the medication is appropriately prescribed and is safe and effective in treating your condition).

Q. My plan doesn't cover my medication. I need to take it because it's medically necessary for my treatment. How do I get approval (prior authorization) for my medication?
A. If your doctor feels that your medication is necessary for your treatment and an alternative isn't right for you, your doctor can ask us to consider approving coverage of your medication. Ask your doctor's office to contact us to start the coverage review process. They know how the review process works and will take care of everything for you. In case the office asks, they can download a request form from our provider portal at **cignaforhcp.com**.

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

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

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

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

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

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

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

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

Your Step Therapy rights under California State law:

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

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

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

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

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

Q. What happens if I try to fill a prescription that has a quantity limit?
A. Your pharmacist will only fill the amount your plan covers. If you want to fill more than what's allowed, your doctor's office can ask us to cover it through our review process.

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

Information about this drug list

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

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

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

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

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

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

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

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 may[4]:

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

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

Information about this drug list

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

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

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

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

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

Q. Do I have to use home delivery to fill my prescription?
A. It depends on your plan. Some plans require you to fill maintenance medications through Express Scripts® Pharmacy and/or specialty medications through Accredo® Specialty Pharmacy for them to be covered.[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).

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

Here are two easy ways to get started:

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

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

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

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

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

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

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

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

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

Information about this drug list

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

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

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

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

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

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

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

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

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

Information about this drug list

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

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

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

Words you may need to know

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

Information about this drug list

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

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

Information about this drug list

About this drug list

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

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

How to read this drug list

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

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

Tiers

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

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

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

Information about this drug list

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

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

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

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

Information about this drug list

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

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

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

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

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

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

Prescription drug name is the name of the medication.

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

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

Generic medications are in **lowercase italics**.

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

Information about this drug list

How to find your medication

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

Condition	Page
Analgesics (Pain Relief and Inflammatory Disease)	19-23
Analgesics (Urinary Tract Conditions)	23
Anesthetics (Miscellaneous)	24
Anesthetics (Pain Relief and Inflammatory Disease)	24
Anesthetics (Urinary Tract Conditions)	24
Anti-Allergy (Allergy and Nasal Sprays)	24
Anti-Arthritics (Pain Relief and Inflammatory Disease)	25-28
Anti-Asthmatics (Asthma/COPD/Respiratory)	28-30
Antibiotics (Allergy/Nasal Sprays)	30
Antibiotics (Ear Medications)	30, 31
Antibiotics (Eye Conditions)	31, 32
Antibiotics (Infections)	32-37
Antibiotics (Skin Conditions)	37, 38
Anti-Coagulants (Blood Thinners/Anti-Clotting)	38-40
Antidotes (Gastrointestinal/Heartburn)	40
Antidotes (Substance Abuse)	40
Anti-Fungals (Eye Conditions)	40
Anti-Fungals (Feminine Products)	40
Anti-Fungals (Infections)	41
Anti-Fungals (Skin Conditions)	41, 42
Antihistamine and Decongestant Combination (Allergy/Nasal Sprays)	42
Antihistamines (Allergy/Nasal Sprays)	42
Antihistamines (Eye Conditions)	41, 42
Anti-Hyperglycemics (Diabetes)	42-46
Anti-Infectives (Feminine Products)	46
Anti-Infectives (Infections)	46
Anti-Infectives/Miscellaneous (Feminine Products)	46

Condition	Page
Anti-Infectives/Miscellaneous (Infections)	47
Anti-Infectives/Miscellaneous (Miscellaneous)	48
Anti-Infectives/Miscellaneous (Skin Conditions)	48
Anti-Inflammatory Tumor Necrosis Factor Inhibiting Agents (Pain Relief and Inflammatory Disease)	48, 49
Anti-Neoplastics (Cancer)	49-56
Anti-Neoplastics (Skin Conditions)	56
Anti-Obesity Drugs (Weight Management)	57
Anti-Parasitics (Eye Conditions)	57
Anti-Parasitics (Infections)	58
Anti-Parkinson's Drugs (Parkinson's Disease)	58-60
Anti-Platelet Drugs (Blood Thinners/Anti-Clotting)	60
Antivirals (Aids/Hiv)	60-63
Antivirals (Eye Conditions)	63
Antivirals (Infections)	63-65
Antivirals (Skin Conditions)	65
Autonomic Drugs (Allergy/Nasal Sprays)	65
Autonomic Drugs (Alzheimer's Disease)	65
Autonomic Drugs (Attention Deficit Hyperactivity Disorder)	66
Autonomic Drugs (Blood Pressure/Heart Medications)	66
Autonomic Drugs (Urinary Tract Conditions)	66
Biologicals (Allergy/Nasal Sprays)	66, 67
Biologicals (Blood Pressure/Heart Medications)	67
Biologicals (Miscellaneous)	67
Biologicals (Vaccines)	67-69
Blood (Blood Modifiers/Bleeding Disorders)	69, 70
Blood (Blood Thinners/Anti-Clotting)	71
Cardiac Drugs (Blood Pressure/Heart Medications)	70-73

Information about this drug list

How to find your medication *(cont.)*

Condition	Page
Cardiovascular (Asthma/COPD/Respiratory)	73, 74
Cardiovascular (Blood Pressure/ Heart Medications)	74-78
Cardiovascular (Cholesterol Medications)	78
CNS Drugs (Alzheimer's Disease)	78
CNS Drugs (Miscellaneous)	82
CNS Drugs (Multiple Sclerosis)	82,83
CNS Drugs (Pain Relief and Inflammatory Disease)	83
CNS Drugs (Seizure Disorders)	83-86
CNS Drugs (Sleep Disorders/Sedatives)	86
Colony Stimulating Factors (Blood Modifiers/ Bleeding Disorders)	86, 87
Contraceptives (Contraception Products)	87, 88
Cough/Cold Preparations (Allergy/Nasal Sprays)	89
Cough/Cold Preparations (Cough/Cold Medications)	89
DIAGNOSTIC (Diabetes)	89, 90
Diagnostic (Miscellaneous)	90, 91
Diuretics (Diuretics)	91, 92
EENT Preps (Allergy/Nasal Sprays)	92
EENT Preps (Ear Medications)	92, 93
EENT Preps (Eye Conditions)	93-95
Elect/Caloric/H2O (Cholesterol Medications)	96
Elect/Caloric/H2O (Dental Products)	96, 97
Elect/Caloric/H2O (Diabetes)	97
Elect/Caloric/H2O (Miscellaneous)	97
Elect/Caloric/H2O (Nutritional/Dietary)	97, 98
Elect/Caloric/H2O (Urinary Tract Conditions)	99
Gastrointestinal (Cholesterol Medications)	99
Gastrointestinal (Gastrointestinal/Heartburn)	99-104
Gastrointestinal (Pain Relief and Inflammatory Disease)	104
Hormones (Hormonal Agents)	105-110
Hormones (Infertility)	110, 111

Condition	Page
Hormones (Miscellaneous)	111
Hormones (Osteoporosis Products)	111
Immunosuppressants (Pain Relief and Inflammatory Disease)	111, 112
Immunosuppressants (Skin Conditions)	112
Immunosuppressants (Transplant Medications)	112, 113
Miscellaneous Medical Supplies, Devices, Non-Drug (Diabetes)	113-122
Miscellaneous Medical Supplies, Devices, Non-Drug (Miscellaneous)	122, 123
Muscle Relaxants (Pain Relief and Inflammatory Disease)	124
Prenatal Vitamins (Nutritional/Dietary)	124
Psychotherapeutic Drugs (Anxiety/Depression/ Bipolar Disorder)	125-129
Psychotherapeutic Drugs (Attention Deficit Hyperactivity Disorder)	129, 130
Psychotherapeutic Drugs (Miscellaneous)	131
Psychotherapeutic Drugs (Schizophrenia/ Anti-Psychotics)	131-133
Psychotherapeutic Drugs (Sleep Disorders/ Sedatives)	133
Sedative/Hypnotics (Sleep Disorders/Sedatives)	133, 134
Skin Preps (Miscellaneous)	134
Skin Preps (Pain Relief and Inflammatory Disease)	135
Skin Preps (Skin Conditions)	135-142
Smoking Deterrents (Smoking Cessation)	142
Thyroid Prep (Hormonal Agents)	143
Unclassified Drug Products (Aids/Hiv)	144
Unclassified Drug Products (Asthma/COPD/ Respiratory)	144
Unclassified Drug Products (Blood Modifiers/ Bleeding Disorders)	145
Unclassified Drug Products (Blood Pressure/ Heart Medications)	145
Unclassified Drug Products (Cancer)	145
Unclassified Drug Products (Dental Products)	145

Information about this drug list

How to find your medication *(cont.)*

Condition	Page
Unclassified Drug Products (Erectile Dysfunction)	145, 146
Unclassified Drug Products (Gastrointestinal/ Heartburn)	146
Unclassified Drug Products (Hormonal Agents)	146
Unclassified Drug Products (Miscellaneous)	147-149
Unclassified Drug Products (Nutritional/Dietary)	149, 150
Unclassified Drug Products (Osteoporosis Products)	150
Unclassified Drug Products (Pain Relief and Inflammatory Disease)	150
Unclassified Drug Products (Skin Conditions)	150, 151

Condition	Page
Unclassified Drug Products (Substance Abuse)	151
Unclassified Drug Products (Transplant Medications)	151
Unclassified Drug Products (Urinary Tract Conditions)	151, 152
Unclassified Drug Products (Weight Management)	152
Vitamins (Nutritional/Dietary)	152, 153

List of Prescription Medications

ANALGESICS (Pain Relief and Inflammatory Disease)		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
ANALGESIC, NON-SALICYLATE AND BARBITURATE COMBINAT		
butalbital/acetaminophen	T1	
ANALGESIC, SALICYLATE, BARBITURATE, XANTHINE COMB.		
butalb-aspirin-caffe 50-325-40	T1	QL (6 tabs/day)
butalbital-asa-caffeine cap (Fiorinal)	T1	QL (6 caps/day)
FIORINAL (*butalbital-aspirin-caffeine*)	T3	QL (6 caps/day)
ANALGESIC, NON-SALICYLATE, BARBITURATE, XANTHINE COMB.		
butalb/acetaminophen/caffeine	T3	
butalb-acetamin-caff 50-300-40 (Fioricet)	T1	QL (6 caps/day)
butalb-acetamin-caff 50-325-40	T1	QL (6 tabs/day)
ESGIC 50-325-40 MG TABLET (*butalbital-acetaminophen-caffe*)	T3	QL (6 tabs/day)
ESGIC CAPSULE (*zebutal*)	T3	QL (6 caps/day)
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	
naratriptan hcl	T1	QL (9 tabs/30 days)
NURTEC ODT	T2	PA QL (16 tabs/30 days)
rizatriptan 10 mg odt (Maxalt Mlt)	T1	QL(12 tabs/30 days)
rizatriptan 10 mg tablet (Maxalt)	T1	QL(12 tabs/30 days)

T1 – Typically Generics
T2 – Typically Preferred Brands
T3 – Typically Non-Preferred Brands
T4 – Specialty Medications
PA – Prior Authorization
QL – Quantity Limit
ST – Step Therapy
AGE – Age Requirement
SP – Specialty Medication
HD – May require home delivery pharmacy
PPACA – No Cost-Share Preventive Medication
CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

ANALGESICS (Pain Relief and Inflammatory Disease) *(cont.)*		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
ANTI-MIGRAINE PREPARATIONS (*cont.)*		
rizatriptan 5 mg odt	T1	QL(12 tabs/30 days)
rizatriptan 5 mg tablet	T1	QL(12 tabs/30 days)
rizatriptan benzoate	T1	QL (12 tabs/30 days)
rizatriptan benzoate (Maxalt Mlt)	T1	QL (12 tabs/30 days)
rizatriptan benzoate (Maxalt)	T1	QL (12 tabs/30 days)
sumatriptan	T1	QL (2 boxes/30 days)
sumatriptan 4 mg/0.5 ml cart	T1	QL (4ml/30 days)
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 syrng	T1	QL (4ml/30 days)
sumatriptan 6 mg/0.5 ml vial	T1	QL (5ml/30 days)
sumatriptan succ 100 mg tablet	T1	QL (9 tabs/30 days)
sumatriptan succ 25 mg tablet	T1	QL (9 tabs/30 days)
sumatriptan succ 50 mg tablet	T1	QL (9 tabs/30 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 (40mg/30 days)
ketorolac 30 mg/ml carpuject	T1	
ketorolac 30 mg/ml isecure syr	T1	QL (20ml/30 days)
ketorolac 30 mg/ml syringe	T1	QL (20ml/30 days)
ketorolac 30 mg/ml vial	T1	QL(4 mls/day)
ketorolac 300 mg/10 ml vial	T1	
ketorolac 60 mg/2 ml carpuject	T1	QL (20ml/30 days)
ketorolac 60 mg/2 ml syringe	T1	QL (20ml/30 days)
ketorolac 60 mg/2 ml vial	T1	QL (20ml/30 days)
mefenamic acid	T1	HD

T1 – Typically Generics
T2 – Typically Preferred Brands
T3 – Typically Non-Preferred Brands
T4 – Specialty Medications
PA – Prior Authorization
QL – Quantity Limit
ST – Step Therapy
AGE – Age Requirement
SP – Specialty Medication
HD – May require home delivery pharmacy
PPACA – No Cost-Share Preventive Medication
CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

ANALGESICS (Pain Relief and Inflammatory Disease) *(cont.)*		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
OPIOID ANALGESIC AND 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	
hydrocodone/acetaminophen	T1	PA
hydrocodone/acetaminophen (Hydrocodone-acetaminophen)	T1	PA
hydrocodone/acetaminophen (Norco)	T1	PA
HYDROCODONE-ACETAMINOPHEN	T1	PA
LORTAB	T1	PA
NALOCET	T1	PA
NORCO (*lorcet hd*)	T3	PA
NORCO (*lorcet plus*)	T3	PA
NORCO (*lorcet*)	T3	PA
oxycodone hcl/acetaminophen (Nalocet)	T1	PA
oxycodone hcl/acetaminophen (Percocet)	T1	PA
oxycodone hcl/acetaminophen (Primlev)	T1	PA
PRIMLEV	T1	PA
tramadol hcl/acetaminophen (Ultracet)	T1	
ULTRACET (*tramadol hcl-acetaminophen*)	T3	
OPIOID ANALGESIC AND NSAID COMBINATION		
hydrocodone/ibuprofen	T1	PA
hydrocodone/ibuprofen (Ibudone)	T1	PA
IBUDONE	T1	PA
ibuprofen/oxycodone hcl	T1	PA
OPIOID ANALGESIC AND NON-SALICYLATE XANTHINE COMB		
ACETAMIN-CAFF-DIHYDROCODEINE	T1	PA
acetaminophen/caff/dihydrocod (Acetamin-caff-dihydrocodeine)	T1	PA
acetaminophen/caff/dihydrocod (Trezix)	T1	PA
TREZIX	T3	PA

T1 – Typically Generics
T2 – Typically Preferred Brands
T3 – Typically Non-Preferred Brands
T4 – Specialty Medications
PA – Prior Authorization
QL – Quantity Limit
ST – Step Therapy
AGE – Age Requirement
SP – Specialty Medication
HD – May require home delivery pharmacy
PPACA – No Cost-Share Preventive Medication
CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

ANALGESICS (Pain Relief and Inflammatory Disease) *(cont.)*		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
OPIOID ANALGESICS		
ACTIQ (*fentanyl citrate*)	T3	PA
ARYMO ER	T3	PA
BELBUCA	T2	QL (2 films/day)
buprenorphine (Butrans)	T1	QL (4 patches/28 days)
butorphanol tartrate	T1	PA QL (6 bots/30 days)
BUTRANS (*buprenorphine)*	T3	QL (4 patches/28 days)
codeine sulfate	T1	PA
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 (ir) 10 mg tab	T1	PA
oxycodone hcl (ir) 15 mg tab (Roxicodone)	T1	PA
oxycodone hcl (ir) 20 mg tab	T1	PA
oxycodone hcl (ir) 30 mg tab (Roxicodone)	T1	PA

T1 – Typically Generics
T2 – Typically Preferred Brands
T3 – Typically Non-Preferred Brands
T4 – Specialty Medications
PA – Prior Authorization
QL – Quantity Limit
ST – Step Therapy
AGE – Age Requirement
SP – Specialty Medication
HD – May require home delivery pharmacy
PPACA – No Cost-Share Preventive Medication
CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

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

T1 – Typically Generics
T2 – Typically Preferred Brands
T3 – Typically Non-Preferred Brands
T4 – Specialty Medications
PA – Prior Authorization
QL – Quantity Limit
ST – Step Therapy
AGE – Age Requirement
SP – Specialty Medication
HD – May require home delivery pharmacy
PPACA – No Cost-Share Preventive Medication
CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

ANESTHETICS (Miscellaneous)		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
GENERAL ANESTHETICS, INHALANT		
desflurane (Suprane)	T1	
isoflurane	T1	
isoflurane	T3	
sevoflurane (Ultane)	T1	
ULTANE (*sevoflurane*)	T3	
LOCAL ANESTHETICS		
lidocaine hcl	T1	
ANESTHETICS (Pain Relief and Inflammatory Disease)		
TOPICAL LOCAL ANESTHETICS		
desflurane (Suprane)	T1	
isoflurane	T1	
isoflurane	T3	
sevoflurane (Ultane)	T1	
SUPRANE	T3	
ULTANE (*sevoflurane*)	T3	
lidocaine 5% ointment	T1	QL (145gm/30 days)
lidocaine 5% patch (Lidocan II)	T1	
lidocaine 5% patch (Lidoderm)	T1	
lidocaine hcl	T1	
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	
ANTI-ALLERGY (Allergy/Nasal Sprays)		
MAST CELL STABILIZERS		
cromolyn 100 mg/5 ml oral conc (Gastrocrom)	T1	

T1 – Typically Generics
T2 – Typically Preferred Brands
T3 – Typically Non-Preferred Brands
T4 – Specialty Medications
PA – Prior Authorization
QL – Quantity Limit
ST – Step Therapy
AGE – Age Requirement
SP – Specialty Medication
HD – May require home delivery pharmacy
PPACA – No Cost-Share Preventive Medication
CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

ANTI-ARTHRITICS (Pain Relief and Inflammatory Disease)		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
ANALGESIC/ANTIPYRETICS, SALICYLATES		
DISALCID (*salsalate*)	T3	HD
salsalate (Disalcid)	T1	HD
ANTI-ARTHRITIC AND CHELATING AGENTS		
DEPEN (*penicillamine*)	T4	PA SP
penicillamine (Depen)	T4	PA SP
ANTI-ARTHRITIC, FOLATE ANTAGONIST AGENTS		
OTREXUP	T2	PA
ANTI-INFLAMMATORY, PYRIMIDINE SYNTHESIS INHIBITOR		
ARAVA (*leflunomide*)	T3	HD
leflunomide (Arava)	T1	HD
ANTI-INFLAMMATORY, PHOSPHODIESTERASE-4(PDE4) INHIB.		
OTEZLA 10-20 MG STARTER 28 DAY	T4	PA QL(55 tabs/365 days) SP HD
OTEZLA 10-20-30MG START 28 DAY	T4	PA QL(55 tabs/365 days) SP HD
OTEZLA 20 MG TABLET	T4	PA QL(2 tabs/day) SP HD
OTEZLA 30 MG TABLET	T4	PA QL (2 tabs/day) SP HD
ANTI-INFLAMMATORY, SEL.COSTIM.MOD., T-CELL INHIBITOR		
ORENCIA	T4	PA QL (4 syringes/28 days) SP HD
ORENCIA CLICKJECT	T4	PA QL (4 injectors/28 days) SP HD
COLCHICINE		
colchicine 0.6 mg capsule	T1	HD
COLCHICINE	T1	HD
colchicine 0.6 mg capsule (Mitigare)	T1	HD
colchicine 0.6 mg tablet (Colcrys)	T1	HD
COLCRYS (*colchicine*)	T3	HD
MITIGARE	T2	HD
GOLD SALTS		
RIDAURA	T3	
HYPERURICEMIA TX - XANTHINE OXIDASE INHIBITORS		
allopurinol (Zyloprim)	T1	HD
febuxostat 80 mg tablet (Uloric)	T1	HD
LEQSELVI	T4	PA QL(2 tabs/day) SP HD
ULORIC 40 MG TABLET (*febuxostat*)	T3	QL (1 tab/day) HD
ULORIC 80 MG TABLET (*febuxostat*)	T3	HD
ZYLOPRIM (*allopurinol*)	T3	HD

T1 – Typically Generics
T2 – Typically Preferred Brands
T3 – Typically Non-Preferred Brands
T4 – Specialty Medications
PA – Prior Authorization
QL – Quantity Limit
ST – Step Therapy
AGE – Age Requirement
SP – Specialty Medication
HD – May require home delivery pharmacy
PPACA – No Cost-Share Preventive Medication
CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

ANTI-ARTHRITICS (Pain Relief and Inflammatory Disease) *(cont.)*		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
JANUS KINASE (JAK) INHIBITORS		
LITFULO	T4	PA QL(1 cap/day) SP HD
OLUMIANT	T4	PA QL (1 tab/day) SP HD
RINVOQ	T4	PA QL (1 tab/day) SP HD
RINVOQ LQ	T4	PA QL(12 mls/day) SP HD
XELJANZ 1 MG/ML SOLUTION	T4	PA QL (480ml/22 days) SP HD
XELJANZ 10 MG TABLET	T4	PA QL (2 tabs/day) SP HD
XELJANZ 5 MG TABLET	T4	PA QL (2 tabs/day) SP HD
XELJANZ XR	T4	PA QL (1 tab/day) SP HD
NSAIDS AND TOPICAL IRRITANT COUNTER-IRRITANT COMB.		
COMFORT PAC-IBUPROFEN	T3	
COMFORT PAC-MELOXICAM	T3	
COMFORT PAC-NAPROXEN	T3	
NSAIDS(COX NON-SPEC.INHIB) AND PROSTAGLANDIN ANALOG		
ARTHROTEC 50 (*diclofenac sodium-misoprostol*)	T3	ST HD
ARTHROTEC 75 (*diclofenac sodium-misoprostol*)	T3	ST HD
diclofenac sodium/misoprostol (Arthrotec 50)	T1	HD
diclofenac sodium/misoprostol (Arthrotec 75)	T1	HD
NSAIDS, CYCLOOXYGENASE INHIBITOR- TYPE ANALGESICS		
ANAPROX DS (*naproxen sodium ds*)	T3	ST HD
DAYPRO (*oxaprozin*)	T3	ST HD
diclofenac sod dr 25 mg tab	T1	HD
diclofenac sod dr 50 mg tab	T1	HD
diclofenac sod dr 75 mg tab	T1	HD
diclofenac sod ec 25 mg tab	T1	HD
diclofenac sod ec 50 mg tab	T1	HD
diclofenac sod ec 75 mg tab	T1	HD
diclofenac sodium	T1	HD
EC-NAPROSYN (*naproxen*)	T3	ST HD
etodolac	T1	HD
etodolac (Lodine)	T1	HD
FELDENE (*piroxicam*)	T3	ST HD
fenoprofen 600 mg tablet	T1	HD
flurbiprofen	T1	HD
ibuprofen	T1	HD

T1 – Typically Generics
T2 – Typically Preferred Brands
T3 – Typically Non-Preferred Brands
T4 – Specialty Medications
PA – Prior Authorization
QL – Quantity Limit
ST – Step Therapy
AGE – Age Requirement
SP – Specialty Medication
HD – May require home delivery pharmacy
PPACA – No Cost-Share Preventive Medication
CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

ANTI-ARTHRITICS (Pain Relief and Inflammatory Disease) *(cont.)*		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
NSAIDS, CYCLOOXYGENASE INHIBITOR- TYPE ANALGESICS *(cont.)*		
indomethacin	T1	HD
indomethacin 25 mg/5 ml susp	T1	HD
LODINE (*etodolac*)	T3	ST HD
meclofenamate sodium	T1	HD
meloxicam 15 mg tablet	T1	HD
meloxicam 7.5 mg tablet (Mobic)	T1	HD
meloxicam (Mobic)	T1	HD
MOBIC (*meloxicam*)	T3	ST HD
nabumetone	T1	HD
NALFON 600 MG TABLET (*profeno*)	T1	ST HD
NAPROSYN TABLET (*naproxen*)	T3	ST HD
naproxen dr 375 mg tablet (Ec-Naprosyn)	T1	HD
naproxen dr 500 mg tablet (Ec-Naprosyn)	T1	HD
naproxen tablet	T1	HD
naproxen (Ec-naprosyn)	T1	HD
naproxen (Naprosyn)	T1	HD
naproxen sodium (Anaprox Ds)	T1	HD
oxaprozin 600 mg caplet (Daypro)	T1	HD
oxaprozin 600 mg tablet (Daypro)	T1	HD
OXAPROZIN 300 MG CAPSULE	T3	HD
piroxicam (Feldene)	T1	HD
QMIIZ ODT 15 MG TABLET	T3	ST HD
QMIIZ ODT 7.5 MG TABLET	T3	QL (1 tab/day) ST HD
tolmetin sodium	T1	HD
tolmetin sodium (Tolectin 600)	T1	HD
NSAIDS, CYCLOOXYGENASE-2(COX-2) SELECTIVE INHIBITOR		
celecoxib 100 mg capsule (Celebrex)	T1	QL (2 caps/day) HD
celecoxib 200 mg capsule (Celebrex)	T1	QL (2 caps/day) HD
celecoxib 400 mg capsule (Celebrex)	T1	QL (1 cap/day) HD
celecoxib 50 mg capsule (Celebrex)	T1	QL (2 caps/day) HD

T1 – Typically Generics
T2 – Typically Preferred Brands
T3 – Typically Non-Preferred Brands
T4 – Specialty Medications
PA – Prior Authorization
QL – Quantity Limit
ST – Step Therapy
AGE – Age Requirement
SP – Specialty Medication
HD – May require home delivery pharmacy
PPACA – No Cost-Share Preventive Medication
CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

ANTI-ARTHRITICS (Pain Relief and Inflammatory Disease) *(cont.)*		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
URICOSURIC AGENTS		
probenecid	T1	HD
probenecid/colchicine	T1	HD
ANTI-ASTHMATICS (Asthma/COPD/Respiratory)		
5-LIPOXYGENASE INHIBITORS		
zileuton	T1	HD
ANTICHOLINERGICS, ORALLY INHALED LONG ACTING		
INCRUSE ELLIPTA	T2	HD
LONHALA MAGNAIR STARTER & REFILL	T3	PA HD
STRIVERDI RESPIMAT	T2	QL(1 inhaler/30 days) HD
SPIRIVA RESPIMAT	T2	HD
ANTICHOLINERGICS, ORALLY INHALED SHORT ACTING		
ATROVENT HFA	T2	HD
ipratropium bromide	T1	HD
BETA-ADRENERGIC AGENTS		
albuterol sulf 2 mg/5 ml syrup	T1	HD
albuterol 8 mg/20 ml syrup cup	T1	HD
BETA-ADRENERGIC AGENTS, INHALED, SHORT ACTING		
albuterol 15 mg/3 ml solution	T1	
albuterol 75 mg/15 ml soln	T1	
albuterol sulfate 2 mg, 4 mg tab	T1	HD
albuterol sulfate er 8 mg tab	T1	HD
metaproterenol sulfate	T1	HD
terbutaline sulfate	T1	HD
albuterol 2.5 mg/0.5 ml sol	T1	
albuterol 5 mg/ml solution	T1	
albuterol sul 0.63 mg/3 ml sol	T1	
albuterol sul 1.25 mg/3 ml sol	T1	
albuterol sul 2.5 mg/3 ml soln	T1	
albuterol hfa 90 mcg inhaler (Albuterol Sulfate Hfa)	T1	QL (8.5gm/30 days)
ALBUTEROL SULFATE HFA	T1	QL (8.5gm/30 days)
levalbuterol hcl (Xopenex Concentrate)	T1	
levalbuterol hcl (Xopenex)	T1	
XOPENEX (*levalbuterol hcl*)	T3	
XOPENEX CONCENTRATE (*levalbuterol concentrate*)	T3	

T1 – Typically Generics
T2 – Typically Preferred Brands
T3 – Typically Non-Preferred Brands
T4 – Specialty Medications
PA – Prior Authorization
QL – Quantity Limit
ST – Step Therapy
AGE – Age Requirement
SP – Specialty Medication
HD – May require home delivery pharmacy
PPACA – No Cost-Share Preventive Medication
CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

ANTI-ASTHMATICS (Asthma/COPD/Respiratory) *(cont.)*		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
BETA-ADRENERGIC AND ANTICHOLINERGIC COMBO, INHALED		
AIRSUPRA	T2	QL(2 inhalers/28 days) HD
ANORO ELLIPTA	T2	HD
COMBIVENT RESPIMAT	T2	QL(2 inhalers/30 days)
ipratropium/albuterol sulfate	T2	HD
STIOLTO RESPIMAT INHAL SPRAY	T2	HD
BETA-ADRENERGIC AGENTS AND GLUCOCORTICOID COMBO, INHALED		
AIRDUO DIGIHALER	T3	ST HD
budesonide/formoterol fumarate (Symbicort)	T1	QL HD
DULERA	T2	HD
fluticasone propion/salmeterol (Advair Diskus)	T1	QL(1 inhaler/30 days)
fluticasone-salmeterol 100-50 (Advair Diskus)	T1	QL(1 inhaler/30 days) HD
fluticasone-salmeterol 250-50 (Advair Diskus)	T1	QL(1 inhaler/30 days) HD
fluticasone-salmeterol 500-50 (Advair Diskus)	T1	QL(1 inhaler/30 days) HD
FLUTICASONE-SALMETEROL 113-14	T1	QL(1 inhaler/30 days) HD
FLUTICASONE-SALMETEROL 232-14	T1	QL(1 inhaler/30 days) HD
FLUTICASONE-SALMETEROL 55-14	T1	QL(1 inhaler/30 days) HD
BETA-ADRENERGIC AGENTS, ORALLY INHALED, LONG ACTING		
arformoterol tartrate (Brovana)	T1	QL(4 mls/day) HD
formoterol fumarate (Perforomist)	T1	QL(240 mls/30 days) HD
BETA-ADRENERGIC-ANTICHOLINERGIC-GLUCOCORT, INHALED		
BREZTRI AEROSPHERE	T2	
TRELEGY ELLIPTA	T2	
GLUCOCORTICOIDS, ORALLY INHALED		
ALVESCO	T2	QL(1 inhaler/30 days) HD
ASMANEX HFA	T3	QL(1 inhaler/30 days) HD
ASMANEX TWISTHALER	T2	QL
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
FLOVENT DISKUS	T2	HD
FLOVENT HFA	T2	HD

T1 – Typically Generics
T2 – Typically Preferred Brands
T3 – Typically Non-Preferred Brands
T4 – Specialty Medications
PA – Prior Authorization
QL – Quantity Limit
ST – Step Therapy
AGE – Age Requirement
SP – Specialty Medication
HD – May require home delivery pharmacy
PPACA – No Cost-Share Preventive Medication
CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

ANTI-ASTHMATICS (Asthma/COPD/Respiratory) *(cont.)*		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
GLUCOCORTICOIDS, ORALLY INHALED (cont.)		
FLUTICASONE PROP 100MCG DISKUS	T3	QL HD
FLUTICASONE PROP 250 MCG DISK	T3	QL HD
FLUTICASONE PROP 50 MCG DISKUS	T3	QL HD
QVAR REDIHALER	T2	
INTERLEUKIN-5(IL-5) RECEPTOR ALPHA ANTAGONIST, MAB		
FASENRA PEN	T4	PA SP HD
LEUKOTRIENE RECEPTOR ANTAGONISTS		
ACCOLATE (*zafirlukast*)	T3	HD
montelukast sodium (Singulair)	T1	HD
zafirlukast (Accolate)	T1	HD
MAST CELL STABILIZERS, ORALLY INHALED		
cromolyn 20 mg/2 ml neb soln	T1	QL (480ml/30 days) HD
MONOCLONAL ANTIBODIES TO IMMUNOGLOBULIN E (IGE)		
XOLAIR	T4	PA SP HD
MONOCLONAL ANTIBODY - INTERLEUKIN-5 ANTAGONISTS		
NUCALA	T4	PA SP HD
MUCOLYTICS		
acetylcysteine	T1	
PHOSPHODIESTERASE-4 (PDE4) INHIBITORS		
DALIRESP 250 MCG TABLET	T3	QL (28 tabs/180 days) HD
DALIRESP 500 MCG TABLET	T3	QL (2 tabs/day) HD
roflumilast 250 mcg tablet (Daliresp)	T3	QL (28 tabs/180 days) HD
roflumilast 500 mcg tablet (Daliresp)	T3	QL (2 tabs/day) HD
XANTHINES		
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	

T1 – Typically Generics
T2 – Typically Preferred Brands
T3 – Typically Non-Preferred Brands
T4 – Specialty Medications
PA – Prior Authorization
QL – Quantity Limit
ST – Step Therapy
AGE – Age Requirement
SP – Specialty Medication
HD – May require home delivery pharmacy
PPACA – No Cost-Share Preventive Medication
CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

ANTIBIOTICS (Ear Medications) *(cont.)*		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
EAR PREPARATIONS, ANTIBIOTICS *(cont.)*		
neomycin/polymyxin b/hydrocort	T1	
ofloxacin	T1	
OTIC PREPARATIONS, ANTI-INFLAMMATORY-ANTIBIOTICS		
ciprofloxacin hcl/dexameth	T1	
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	T3	
TOBRADEX (*tobramycin-dexamethasone*)	T3	
TOBRADEX EYE OINTMENT	T3	
TOBRADEX ST	T2	
TOBRADEX ST 0.3-0.05% DROP	T2	
tobramycin/dexamethasone (Tobradex)	T1	
ZYLET	T3	
EYE SULFONAMIDES		
BLEPH-10 (*sulfacetamide sodium*)	T3	
BLEPHAMIDE	T3	
sulfacetamide sodium	T1	
sulfacetamide sodium (Bleph-10)	T1	
sulfacetamide/prednisolone sp	T1	
OPHTHALMIC ANTIBIOTICS		
AZASITE	T2	
AZASITE 1% EYEDROPS	T2	
BACIGUENT (*bacitracin*)	T3	
bacitracin	T1	
bacitracin (Baciguent)	T1	
bacitracin/polymyxin b sulfate	T1	
BESIVANCE	T2	

T1 – Typically Generics
T2 – Typically Preferred Brands
T3 – Typically Non-Preferred Brands
T4 – Specialty Medications
PA – Prior Authorization
QL – Quantity Limit
ST – Step Therapy
AGE – Age Requirement
SP – Specialty Medication
HD – May require home delivery pharmacy
PPACA – No Cost-Share Preventive Medication
CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

ANTIBIOTICS (Eye Conditions) *(cont.)*		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
OPHTHALMIC ANTIBIOTICS *(cont.)*		
BESIVANCE 0.6% SUSP	T2	
erythromycin base	T1	
gatifloxacin	T1	
gentamicin sulfate	T1	
levofloxacin	T1	
metronidazole (Flagyl)	T1	
MOXEZA (*moxifloxacin*)	T3	
moxifloxacin hcl (Moxeza)	T1	
moxifloxacin hcl (Vigamox)	T1	
neomycin sulf/bacitracin/poly	T1	
neomycin/polymyxn b/gramicidin	T1	
ofloxacin (*Ocuflox*)	T1	
tobramycin 0.3% eye drop	T1	
ANTIBIOTICS (Infections)		
ABSORBABLE SULFONAMIDE ANTIBACTERIAL AGENTS		
BACTRIM (*sulfamethoxazole-trimethoprim*)	T3	
BACTRIM DS (*sulfamethoxazole-trimethoprim*)	T3	
sulfadiazine	T1	
sulfamethoxazole/trimethoprim	T1	
sulfamethoxazole/trimethoprim (Bactrim Ds)	T1	
sulfamethoxazole/trimethoprim (Bactrim)	T1	
AMINOGLYCOSIDE ANTIBIOTICS		
ARIKAYCE	T4	PA SP
gentamicin sulfate	T1	
gentamicin sulfate/pf	T1	
KITABIS PAK	T4	PA QL (10ml/day) SP HD
neomycin sulfate	T1	
TOBI PODHALER	T4	PA QL (8 caps/day) SP HD
tobramycin 20 mg/2 ml vial	T1	
tobramycin 300 mg/4 ml ampule	T4	QL (8 ml/day) SP HD
tobramycin 300 mg/5 ml ampule	T4	PA QL (10ml/day) SP HD
tobramycin 40 mg/ml vial	T1	
tobramycin 80 mg/2 ml vial	T1	
tobramycin 1.2 gm vial	T1	PA

T1 – Typically Generics
T2 – Typically Preferred Brands
T3 – Typically Non-Preferred Brands
T4 – Specialty Medications
PA – Prior Authorization
QL – Quantity Limit
ST – Step Therapy
AGE – Age Requirement
SP – Specialty Medication
HD – May require home delivery pharmacy
PPACA – No Cost-Share Preventive Medication
CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

ANTIBIOTICS (Infections) *(cont.)*		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
AMINOGLYCOSIDE ANTIBIOTICS *(cont.)*		
tobramycin 1.2 gram/30 ml vial	T1	
TOBRAMYCIN PAK 300 MG/5 ML	T4	PA QL (10ml/day) SP HD
tobramycin 300 mg/5 ml ampule	T4	PA QL (10ml/day) SP HD
tobramycin 40 mg/ml vial	T1	
tobramycin 80 mg/2 ml vial	T1	
TOBRAMYCIN PAK 300 MG/5 ML	T3	PA QL (10ml/day) SP HD
ANAEROBIC ANTIPROTOZOAL-ANTIBACTERIAL AGENTS		
FLAGYL (*metronidazole*)	T3	
LIKMEZ	T3	PA
ANTIBIOTIC, ANTIBACTERIAL, MISC.		
fosfomycin tromethamine (Monurol)	T1	
methen/mblue/sal/sod phos/hyos	T1	
methenam/m.blue/salicyl/hyoscy	T1	
methenamine hippurate	T1	
methenamine mandelate	T1	
MONUROL (*fosfomycin tromethamine*)	T3	
PRIMSOL	T3	
trimethoprim	T1	
UTA	T3	
ANTILEPROTICS		
dapsone	T1	
THALOMID	T4	PA SP HD
ANTI-MYCOBACTERIUM AGENTS		
ethambutol hcl	T1	HD
isoniazid	T1	HD
PASER	T3	HD
pyrazinamide	T1	HD
rifabutin	T1	HD
TRECATOR	T3	HD
ANTI-TUBERCULAR ANTIBIOTICS		
cycloserine	T1	
CYCLOSERINE	T1	
PRETOMANID	T3	PA QL (1 tab/day)
PRIFTIN	T3	

T1 – Typically Generics
T2 – Typically Preferred Brands
T3 – Typically Non-Preferred Brands
T4 – Specialty Medications
PA – Prior Authorization
QL – Quantity Limit
ST – Step Therapy
AGE – Age Requirement
SP – Specialty Medication
HD – May require home delivery pharmacy
PPACA – No Cost-Share Preventive Medication
CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

ANTIBIOTICS (Infections) *(cont.)*		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
ANTI-TUBERCULAR ANTIBIOTICS *(cont.)*		
RIFAMATE	T3	
rifampin	T1	
RIFATER	T3	
SIRTURO	T4	SP
BETALACTAMS		
CAYSTON	T4	PA QL (3ml/day) SP HD
CEPHALOSPORIN ANTIBIOTICS - IST GENERATION		
cefadroxil	T1	
cephalexin	T1	
cephalexin (Keflex)	T1	
DAXBIA	T3	
KEFLEX (*cephalexin*)	T3	
CEPHALOSPORIN ANTIBIOTICS - 2ND GENERATION		
cefaclor	T1	
cefprozil	T1	
cefuroxime axetil	T1	
CEPHALOSPORIN ANTIBIOTICS - 3RD GENERATION		
cefixime (Suprax)	T1	
cefpodoxime proxetil	T1	
LINCOSAMIDE ANTIBIOTICS		
CLEOCIN PEDIATRIC (*clindamycin (pediatric)*)	T3	
clindamycin hcl (Cleocin Hcl)	T1	
clindamycin palmitate hcl (Cleocin Pediatric)	T1	
MACROLIDE ANTIBIOTICS		
azithromycin (Zithromax)	T1	
azithromycin 1 gm pwd packet (Zithromax)	T1	
azithromycin 100 mg/5 ml susp (Zithromax)	T1	
azithromycin 200 mg/5 ml susp (Zithromax)	T1	
azithromycin 200 mg/5 ml susp (Zithromax)	T1	
azithromycin 250 mg tablet (Zithromax)	T1	
azithromycin 500 mg tablet (Zithromax Tri-pak)	T1	
azithromycin 600 mg tablet	T1	
clarithromycin	T1	

T1 – Typically Generics
T2 – Typically Preferred Brands
T3 – Typically Non-Preferred Brands
T4 – Specialty Medications
PA – Prior Authorization
QL – Quantity Limit
ST – Step Therapy
AGE – Age Requirement
SP – Specialty Medication
HD – May require home delivery pharmacy
PPACA – No Cost-Share Preventive Medication
CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

ANTIBIOTICS (Infections) *(cont.)*		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
MACROLIDE ANTIBIOTICS *(cont.)*		
DIFICID 200 MG TABLET	T3	QL (28 tabs/28 days)
DIFICID 40 MG/ML SUSPENSION	T3	QL (5ml/day)
ERYPED 200 (*erythromycin ethylsuccinate*)	T3	
ERY-TAB (*erythromycin*)	T3	
erythromycin base	T1	
erythromycin base	T3	
erythromycin base (Ery-tab)	T1	
erythromycin ethylsuccinate	T1	
erythromycin ethylsuccinate	T3	
erythromycin ethylsuccinate (Eryped 200)	T1	
erythromycin stearate	T1	
PCE	T3	
ZITHROMAX 1 GM POWDER PACKET (*azithromycin*)	T3	
ZITHROMAX 100 MG/5 ML SUSP (*azithromycin*)	T3	
ZITHROMAX 200 MG/5 ML SUSP (*azithromycin*)	T3	
ZITHROMAX 200 MG/5 ML SUSP (*azithromycin*)	T3	
ZITHROMAX 250 MG TABLET (*azithromycin*)	T3	
ZITHROMAX 250 MG Z-PAK TABLET (*azithromycin*)	T3	
ZITHROMAX 500 MG TABLET (*azithromycin*)	T3	
ZITHROMAX TRI-PAK (*azithromycin*)	T3	
NITROFURAN DERIVATIVES ANTIBACTERIAL AGENTS		
FURADANTIN (*nitrofurantoin*)	T3	
MACROBID (*nitrofurantoin mono-macro*)	T3	
nitrofurantoin 25 mg/5 ml susp (Furadantin)	T1	
nitrofurantoin monohyd/m-cryst (Macrobid)	T1	
nitrofurantoin suspension	T1	
nitrofurantoin macrocrystal	T1	
nitrofurantoin monohyd/m-cryst (Macrobid)	T1	
OXAZOLIDINONE ANTIBIOTICS		
linezolid (Zyvox)	T1	PA
SIVEXTRO	T3	PA
ZYVOX (*linezolid*)	T3	PA

T1 – Typically Generics
T2 – Typically Preferred Brands
T3 – Typically Non-Preferred Brands
T4 – Specialty Medications
PA – Prior Authorization
QL – Quantity Limit
ST – Step Therapy
AGE – Age Requirement
SP – Specialty Medication
HD – May require home delivery pharmacy
PPACA – No Cost-Share Preventive Medication
CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

ANTIBIOTICS (Infections) *(cont.)*		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
PENICILLIN ANTIBIOTICS		
amoxicillin	T1	
amoxicillin/potassium clav (Augmentin Es-600)	T1	
ampicillin trihydrate	T1	
dicloxacillin sodium	T1	
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
CIPRO (*ciprofloxacin hcl*)	T3	
CIPRO (*ciprofloxacin*)	T3	
ciprofloxacin (Cipro)	T1	
ciprofloxacin hcl	T1	
ciprofloxacin hcl (Cipro)	T1	
ciprofloxacin/ciprofloxa 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 50 mg tablet (Targadox)	T1	
doxycycline hyclate	T1	
minocycline er 115 mg tablet	T1	

T1 – Typically Generics
T2 – Typically Preferred Brands
T3 – Typically Non-Preferred Brands
T4 – Specialty Medications
PA – Prior Authorization
QL – Quantity Limit
ST – Step Therapy
AGE – Age Requirement
SP – Specialty Medication
HD – May require home delivery pharmacy
PPACA – No Cost-Share Preventive Medication
CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

ANTIBIOTICS (Infections) *(cont.)*		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
TETRACYCLINE ANTIBIOTICS *(cont.)*		
minocycline er 45 mg tablet	T1	QL (1 tab/day)
minocycline er 55 mg, 65 mg, 80 mg, 90mg tablet	T1	
minocycline hcl	T1	
NUZYRA	T4	PA QL (30 tablets/28 days) SP
tetracycline 250 mg capsule	T1	
tetracycline 500 mg capsule	T1	
VIBRAMYCIN	T3	
VIBRAMYCIN (*doxycycline monohydrate*)	T3	
VAGINAL ANTIBIOTICS		
CLEOCIN	T3	
CLEOCIN (*clindamycin phosphate*)	T3	
clindamycin phosphate (Cleocin)	T1	
metronidazole (Metrogel-vaginal)	T1	
VANCOMYCIN ANTIBIOTICS AND DERIVATIVES		
vancomycin 250 mg/5 ml soln	T1	
vancomycin 50 mg/ml solution	T1	
vancomycin hcl 125 mg capsule (Vancocin Hcl)	T1	
vancomycin hcl 250 mg capsule (Vancocin 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	
CLEOCIN T (*clindamycin phosphate*)	T3	
CLINDACIN ETZ KIT	T3	
CLINDACIN PAC	T3	
clindamycin phosphate	T1	
clindamycin phosphate (Cleocin T)	T1	
clindamycin phosphate (Evoclin)	T1	
erythromycin base in ethanol	T1	
erythromycin/benzoyl peroxide (Benzamycin)	T1	

T1 – Typically Generics
T2 – Typically Preferred Brands
T3 – Typically Non-Preferred Brands
T4 – Specialty Medications
PA – Prior Authorization
QL – Quantity Limit
ST – Step Therapy
AGE – Age Requirement
SP – Specialty Medication
HD – May require home delivery pharmacy
PPACA – No Cost-Share Preventive Medication
CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

ANTIBIOTICS (Skin Conditions) *(cont.)*		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
TOPICAL ANTIBIOTICS *(cont.)*		
EVOCLIN (*clindamycin phosphate*)	T3	
gentamicin sulfate	T1	
mupirocin (Centany)	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	
silver sulfadiazine (Silvadene)	T1	
sulfacetamide sod/sulfur/urea	T1	
sulfacetamide sodium/sulfur	T1	
sulfacetamide sodium/sulfur (Avar-e Green)	T1	
sulfacetamide sodium/sulfur (Rosanil)	T1	
sulfacetamide/sulfur/cleansr23	T1	
sulfact sod/sulur/avob/otn/oct	T1	
SULFAMYLON	T3	
ANTI-COAGULANTS (Blood Thinners/Anti-Clotting)		
ANTI-COAGULANTS, COUMARIN TYPE		
warfarin sodium	T1	HD
CITRATES AS ANTI-COAGULANTS		
ACD SOLUTION A	T3	
ACD-A SOLUTION	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	
rivaroxaban	T1	

T1 – Typically Generics
T2 – Typically Preferred Brands
T3 – Typically Non-Preferred Brands
T4 – Specialty Medications
PA – Prior Authorization
QL – Quantity Limit
ST – Step Therapy
AGE – Age Requirement
SP – Specialty Medication
HD – May require home delivery pharmacy
PPACA – No Cost-Share Preventive Medication
CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

ANTI-COAGULANTS (Blood Thinners/Anti-Clotting) *(cont.)*		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
DIRECT FACTOR XA INHIBITORS *(cont.)*		
XARELTO	T2	
HEPARIN AND RELATED PREPARATIONS		
ARIXTRA (*fondaparinux sodium*)	T4	QL (1 syringe/day) SP
enoxaparin 100 mg/ml syringe (Lovenox)	T4	QL (2 syringes/day) SP
enoxaparin 120 mg/0.8 ml syr (Lovenox)	T4	QL (2 syringes/day) SP
enoxaparin 150 mg/ml syringe (Lovenox)	T4	QL (2 syringes/day) SP
enoxaparin 30 mg/0.3 ml syr (Lovenox)	T4	QL (2 syringes/day) SP
enoxaparin 300 mg/3 ml vial (Lovenox)	T4	QL (1 vial/day) SP
enoxaparin 40 mg/0.4 ml syr (Lovenox)	T4	QL (2 syringes/day) SP
enoxaparin 60 mg/0.6 ml syr (Lovenox)	T4	QL (2 syringes/day) SP
enoxaparin 80 mg/0.8 ml syr (Lovenox)	T4	QL (2 syringes/day) SP
fondaparinux sodium (Arixtra)	T4	QL (1 syringe/day) SP
FRAGMIN	T4	QL (2ml/day) SP
heparin 10, 000 unit/10 ml vial	T1	
heparin 30, 000 unit/30 ml vial	T1	
heparin 40, 000 unit/4 ml vial	T1	
heparin 50, 000 unit/10 ml vial	T1	
heparin 50, 000 unit/5 ml vial	T1	
heparin sod 1, 000 unit/ml vial	T1	
heparin sod 10, 000 unit/ml vl	T1	
heparin sod 20, 000 unit/ml vl	T1	
heparin sod 2,000 unit/ml vl	T1	
heparin sod 5, 000 unit/0.5 ml	T1	
HEPARIN SOD 5, 000 UNIT/0.5 ML	T1	
heparin sod 5, 000 unit/0.5 ml (Heparin Sodium)	T1	
heparin sod 5, 000 unit/ml syrg	T3	
heparin sod 5, 000 unit/ml vial	T1	
LOVENOX 100 MG/ML SYRINGE (*enoxaparin sodium*)	T4	QL (2 syringes/day) SP
LOVENOX 120 MG/0.8 ML SYRINGE (*enoxaparin sodium*)	T4	QL (2 syringes/day) SP
LOVENOX 150 MG/ML SYRINGE (*enoxaparin sodium*)	T4	QL (2 syringes/day) SP
LOVENOX 30 MG/0.3 ML SYRINGE (*enoxaparin sodium*)	T4	QL (2 syringes/day) SP
THROMBIN INHIBITORS, SELECTIVE, DIRECT, REVERSIBLE		
dabigatran etexilate	T1	HD

T1 – Typically Generics
T2 – Typically Preferred Brands
T3 – Typically Non-Preferred Brands
T4 – Specialty Medications
PA – Prior Authorization
QL – Quantity Limit
ST – Step Therapy
AGE – Age Requirement
SP – Specialty Medication
HD – May require home delivery pharmacy
PPACA – No Cost-Share Preventive Medication
CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

ANTI-COAGULANTS (Blood Thinners/Anti-Clotting) *(cont.)*		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
HEPARIN AND RELATED PREPARATIONS *(cont.)*		
LOVENOX 300 MG/3 ML VIAL (*enoxaparin sodium*)	T4	QL (1 vial/day) SP
LOVENOX 40 MG/0.4 ML SYRINGE (*enoxaparin sodium*)	T4	QL (2 syringes/day) SP
LOVENOX 60 MG/0.6 ML SYRINGE (*enoxaparin sodium*)	T4	QL (2 syringes/day) SP
LOVENOX 80 MG/0.8 ML SYRINGE (*enoxaparin sodium*)	T4	QL (2 syringes/day) SP
ANTIDOTES (Gastrointestinal/Heartburn)		
MU-OPIOID RECEPTOR ANTAGONISTS, PERIPHERALLY-ACTING		
MOVANTIK	T2	PA
RELISTOR 12 MG/0.6 ML SYRINGE	T3	PA
RELISTOR 12 MG/0.6 ML VIAL	T3	PA
RELISTOR 8 MG/0.4 ML SYRINGE	T3	PA
SYMPROIC	T2	PA
ANTIDOTES (Substance Abuse)		
OPIOID ANTAGONISTS		
naloxone 0.4 mg/ml carpuject	T1	
naloxone 0.4 mg/ml vial	T1	
NALOXONE 2 MG AUTO-INJECTOR	T3	QL (0.8ml/day)
naloxone 2 mg/2 ml syringe	T1	
naloxone 4 mg/10 ml vial	T1	
naltrexone hcl	T1	QL(180 tabs/30 days)
NARCAN	T2	QL (2 units/30 days)
OPVEE	T3	QL(2 units/30 days)
REXTOVY	T2	QL(2 units/30 days)
ZIMHI	T3	QL (2 units/30 days)
ANTI-FUNGALS (Eye Conditions)		
OPHTHALMIC ANTI-FUNGAL AGENTS		
NATACYN	T3	
ANTI-FUNGALS (Feminine Products)		
VAGINAL ANTI-FUNGALS		
GYNAZOLE 1	T1	
miconazole nitrate	T1	
terconazole	T1	

T1 – Typically Generics
T2 – Typically Preferred Brands
T3 – Typically Non-Preferred Brands
T4 – Specialty Medications
PA – Prior Authorization
QL – Quantity Limit
ST – Step Therapy
AGE – Age Requirement
SP – Specialty Medication
HD – May require home delivery pharmacy
PPACA – No Cost-Share Preventive Medication
CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

ANTI-FUNGALS (Infections)		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
ANTI-FUNGAL AGENTS		
ANCOBON (*flucytosine*)	T3	
clotrimazole	T1	
CRESEMBA	T3	PA
fluconazole	T1	
flucytosine (Ancobon)	T1	
itraconazole	T1	
ketoconazole	T1	
NOXAFIL	T3	
NOXAFIL 40 MG/ML SUSPENSION (*posaconazole*)	T3	
ORAVIG	T3	
posaconazole (Noxafil)	T1	
terbinafine hcl	T1	
VFEND (*voriconazole*)	T3	PA
VIVJOA	T4	PA SP
voriconazole (Vfend)	T1	PA
ANTI-FUNGAL ANTIBIOTICS		
GRIS-PEG (*griseofulvin ultramicrosize*)	T3	
griseofulvin ultramicrosize (Gris-peg)	T1	
griseofulvin ultra 125 mg tab	T1	
griseofulvin ultra 165 mg tab	T1	QL(4 tabs/day)
griseofulvin ultra 250 mg tab	T1	
nystatin	T1	
ANTI-FUNGALS (Skin Conditions)		
TOPICAL ANTI-FUNGAL/ANTI-INFLAMMATORY, STEROID AGENT		
clotrimazole/betamethasone dip	T1	
TOPICAL ANTI-FUNGALS		
ciclodan 0.77% cream	T1	
CICLODAN 0.77% CREAM KIT	T3	
CICLODAN 8% KIT		
ciclodan 8% solution	T1	
ciclopirox	T1	
ciclopirox olamine	T1	
ciclopirox olamine (Loprox)	T1	
ciclopirox/urea/camph/men/euc	T1	

T1 – Typically Generics
T2 – Typically Preferred Brands
T3 – Typically Non-Preferred Brands
T4 – Specialty Medications
PA – Prior Authorization
QL – Quantity Limit
ST – Step Therapy
AGE – Age Requirement
SP – Specialty Medication
HD – May require home delivery pharmacy
PPACA – No Cost-Share Preventive Medication
CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

ANTI-FUNGALS (Skin Conditions) *(cont.)*		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
TOPICAL ANTI-FUNGALS *(cont.)*		
econazole nitrate	T1	
ECOZA	T3	
EXODERM	T1	
ketoconazole	T1	
ketoconazole/skin cleanser 28	T1	
LOPROX	T3	
LOPROX (*ciclopirox*)	T3	
LULICONAZOLE	T1	
naftifine hcl	T1	
naftifine hcl (Naftin)	T1	
NAFTIN (*naftifine hcl*)	T3	
nystatin	T1	
nystatin/triamcinolone acet	T1	
ANTIHISTAMINE AND DECONGESTANT COMBINATION (Allergy/Nasal Sprays)		
1ST GEN ANTIHISTAMINE AND DECONGESTANT COMBINATION		
phenylephrine hcl/prometh hcl	T1	
2ND GEN ANTIHISTAMINE AND DECONGESTANT COMBINATION		
CLARINEX-D 12 HOUR	T3	
ANTIHISTAMINES (Allergy/Nasal Sprays)		
ANTIHISTAMINES - 1ST GENERATION		
carbinoxamine maleate	T1	
clemastine fumarate	T1	
cyproheptadine hcl	T1	
hydroxyzine hcl	T1	
hydroxyzine pamoate	T1	
hydroxyzine pamoate (Vistaril)	T1	
promethazine hcl	T1	
VISTARIL (*hydroxyzine pamoate*)	T3	
ANTIHISTAMINES - 2ND GENERATION		
cetirizine hcl	T1	HD
desloratadine 2.5 mg odt	T1	QL (1 tab/day) HD
desloratadine 5 mg odt	T1	HD
desloratadine 5 mg tablet	T1	HD
levocetirizine dihydrochloride	T1	HD

T1 – Typically Generics
T2 – Typically Preferred Brands
T3 – Typically Non-Preferred Brands
T4 – Specialty Medications
PA – Prior Authorization
QL – Quantity Limit
ST – Step Therapy
AGE – Age Requirement
SP – Specialty Medication
HD – May require home delivery pharmacy
PPACA – No Cost-Share Preventive Medication
CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ANTIHISTAMINES (Eye Conditions)		
EYE ANTIHISTAMINES		
azelastine hcl 0.05% drops	T1	
bepotastine besilate	T1	
epinastine hcl	T1	
olopatadine hcl 0.1% eye drops	T1	
olopatadine hcl 0.2% eye drop	T1	
ANTI-HYPERGLYCEMICS (Diabetes)		
ANTIHYPERGLY, INCRETIN MIMETIC (GLP-1 RECEP.AGONIST)		
BYDUREON	T2	QL (4 vials/28 days) ST HD
BYDUREON BCISE	T2	PA QL(4 mls/28 days)
BYDUREON PEN	T2	QL (4 pens/28 days) ST HD
exenatide	T1	PA QL(3 mls/30 days)
OZEMPIC 0.25-0.5 MG DOSE PEN	T2	QL (2 pens/28 days) ST HD
OZEMPIC 1 MG DOSE PEN (1.5 ML)	T2	QL (2 pens/28 days) ST HD
OZEMPIC 1 MG DOSE PEN (3 ML)	T2	QL (3 ml/21 days) ST 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 RECEPT.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
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

T1 – Typically Generics
T2 – Typically Preferred Brands
T3 – Typically Non-Preferred Brands
T4 – Specialty Medications
PA – Prior Authorization
QL – Quantity Limit
ST – Step Therapy
AGE – Age Requirement
SP – Specialty Medication
HD – May require home delivery pharmacy
PPACA – No Cost-Share Preventive Medication
CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

ANTI-HYPERGLYCEMICS (Diabetes) *(cont.)*		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
ANTI-HYPERGLYCEMIC, ALPHA-GLUCOSIDASE INHIBITORS		
PRECOSE (*acarbose*)	T3	HD
ANTI-HYPERGLYCEMIC, AMYLIN ANALOG-TYPE		
SYMLINPEN 60	T2	
SYMLINPEN 120	T2	HD
ANTI-HYPERGLYCEMIC, BIGUANIDE TYPE		
GLUCOPHAGE XR (*metformin hcl er*)	T3	HD
metformin hcl 850 mg tablet	T1	HD
metformin hcl 1,000 mg tablet	T1	HD
metformin hcl (Glucophage Xr)	T1	HD
RIOMET (*metformin hcl*)	T3	HD
RIOMET ER	T3	HD
ANTI-HYPERGLYCEMIC, DPP-4 INHIBITORS		
JANUVIA	T2	QL (1 tab/day) ST HD
ANTI-HYPERGLYCEMIC, INSULIN-RELEASE STIMULANT TYPE		
AMARYL (*glimepiride*)	T3	HD
chlorpropamide	T1	HD
glimepiride (Amaryl)	T1	HD
glimepiride 1 mg tablet (Amaryl)	T1	HD
glimepiride 2 mg tablet	T1	HD
GLIMEPIRIDE 3 MG TABLET	T3	HD
glimepiride 4 mg tablet	T1	HD
GLIPIZIDE 2.5 MG TABLET	T3	HD
glipizide 10 mg tablet	T1	HD
glipizide 5 mg tablet	T1	HD
glipizide (Glucotrol XI)	T1	HD
glipizide (Glucotrol)	T1	HD
GLUCOTROL (*glipizide*)	T3	HD
GLUCOTROL XL (*glipizide xl*)	T3	HD
glyburide	T1	HD
glyburide, micronized (Glynase)	T1	HD
GLYNASE (*glyburide micronized*)	T3	HD
nateglinide (Starlix)	T1	HD
repaglinide	T1	HD
STARLIX (*nateglinide*)	T3	HD

T1 – Typically Generics
T2 – Typically Preferred Brands
T3 – Typically Non-Preferred Brands
T4 – Specialty Medications
PA – Prior Authorization
QL – Quantity Limit
ST – Step Therapy
AGE – Age Requirement
SP – Specialty Medication
HD – May require home delivery pharmacy
PPACA – No Cost-Share Preventive Medication
CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

ANTI-HYPERGLYCEMICS (Diabetes) *(cont.)*		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
ANTI-HYPERGLYCEMIC, INSULIN-RELEASE STIMULANT TYPE (cont.)		
tolbutamide	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 (*pioglitazone-metformin*)	T3	HD
pioglitazone hcl/metformin hcl (Actoplus Met)	T1	HD
ANTI-HYPERGLYCEMIC, THIAZOLIDINEDIONE-SULFONYLUREA		
DUETACT (*pioglitazone-glimepiride*)	T3	HD
pioglitazone hcl/glimepiride (Duetact)	T1	HD
ANTI-HYPERGLYCEMIC, DPP-4 INHIBITOR-BIGUANIDE COMBS.		
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		
glyburide/metformin hcl	T1	HD
repaglinide/metformin hcl	T1	HD
ANTI-HYPERGLYCEMIC, THIAZOLIDINEDIONE (PPARG AGONIST)		
ACTOS (*pioglitazone hcl*)	T3	HD
AVANDIA	T3	HD
pioglitazone hcl (Actos)	T1	HD
ANTI-HYPERGLYCEMIC-GLUCOCORTICOID RECEPTOR BLOCKER		
mifepristone 300 mg tablet	T1	PA SP
ANTI-HYPERGLYCEMIC-SGLT2 INHIBITOR-BIGUANIDE COMBS.		
SYNJARDY	T2	QL (2 tabs/day) ST HD
SYNJARDY XR 10-1, 000 MG TABLET	T2	QL (2 tabs/day) ST HD
SYNJARDY XR 12.5-1, 000 MG TAB	T2	QL (2 tabs/day) ST HD
SYNJARDY XR 25-1, 000 MG TABLET	T2	QL (1 tab/day) ST HD
SYNJARDY XR 5-1, 000 MG TABLET	T2	QL (2 tabs/day) ST HD
XIGDUO XR 10 MG-1, 000 MG TAB	T2	QL (1 tab/day) ST HD
XIGDUO XR 10 MG-500 MG TABLET	T2	QL (1 tab/day) ST HD
XIGDUO XR 2.5 MG-1, 000 MG TAB	T2	QL (2 tabs/day) ST HD
XIGDUO XR 5 MG-1, 000 MG TABLET	T2	QL (2 tabs/day) ST HD
XIGDUO XR 5 MG-500 MG TABLET	T2	QL (1 tab/day) ST HD

T1 – Typically Generics
T2 – Typically Preferred Brands
T3 – Typically Non-Preferred Brands
T4 – Specialty Medications
PA – Prior Authorization
QL – Quantity Limit
ST – Step Therapy
AGE – Age Requirement
SP – Specialty Medication
HD – May require home delivery pharmacy
PPACA – No Cost-Share Preventive Medication
CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

ANTI-HYPERGLYCEMICS (Diabetes) *(cont.)*		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
ANTIHYPERGLY-SGLT-2 INHIB, DPP-4 INHIB, BIGUANIDE CB		
TRIJARDY XR	T2	QL (1 tab/day) ST HD
INSULINS		
BASAGLAR KWIKPEN U-100	T2	QL (1.5ml/day) HD
FIASP PENFILL	T3	QL (1.5ml/day) HD
HUMALOG	T2	QL (1.5ml/day) HD
HUMALOG JUNIOR KWIKPEN	T2	QL (1.5ml/day) HD
HUMALOG KWIKPEN U-100	T2	QL (1.5ml/day) HD
HUMALOG KWIKPEN U-200	T2	QL (1ml/day) HD
HUMALOG MIX 50-50 KWIKPEN	T2	QL (2ml/day) HD
HUMALOG MIX 75-25	T2	QL (2ml/day) HD
HUMALOG MIX 75-25 KWIKPEN	T2	QL (2ml/day) HD
HUMULIN N 100 UNIT/ML VIAL	T2	QL (1.5 ml/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-100	T2	QL (1.5ml/day) HD
LYUMJEV KWIKPEN U-200	T2	QL (1ml/day) HD
TRESIBA	T2	QL (1.5ml/day) HD
TRESIBA FLEXTOUCH U-100	T2	QL (1.5ml/day) HD
TRESIBA FLEXTOUCH U-200	T2	QL (0.9ml/day) HD
ANTI-INFECTIVES (Feminine Products)		
VAGINAL SULFONAMIDES		
AVC	T3	
ANTI-INFECTIVES (Infections)		
PENICILLIN ANTIBIOTICS		
amoxicillin	T1	
ANTI-INFECTIVES/MISCELLANEOUS (Feminine Products)		
VAGINAL ANTISEPTICS		
acetic acid/oxyquinoline (Relagard)	T1	
RELAGARD (*fem ph*)	T3	
TRIMO-SAN	T3	

T1 – Typically Generics
T2 – Typically Preferred Brands
T3 – Typically Non-Preferred Brands
T4 – Specialty Medications
PA – Prior Authorization
QL – Quantity Limit
ST – Step Therapy
AGE – Age Requirement
SP – Specialty Medication
HD – May require home delivery pharmacy
PPACA – No Cost-Share Preventive Medication
CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

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

T1 – Typically Generics
T2 – Typically Preferred Brands
T3 – Typically Non-Preferred Brands
T4 – Specialty Medications
PA – Prior Authorization
QL – Quantity Limit
ST – Step Therapy
AGE – Age Requirement
SP – Specialty Medication
HD – May require home delivery pharmacy
PPACA – No Cost-Share Preventive Medication
CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

ANTI-INFECTIVES/MISCELLANEOUS (Miscellaneous)		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
ANTIBACTERIAL AGENTS, MISCELLANEOUS		
glycine urologic solution	T1	
glycine urologic solution	T3	
ANTISEPTICS, GENERAL		
ALCOHOL SWABSTICK	T3	
GS ISOPROPYL ALCOHOL 70% SPRAY	T1	
ANTI-INFECTIVES/MISCELLANEOUS (Skin Conditions)		
TOPICAL ANTI-FUNGALS		
CICLODAN 8% KIT	T3	
ciclopirox/urea/camph/men/euc (Ciclodan)	T1	
ANTI-INFLAM.TUMOR NECROSIS FACTOR INHIBITING AGENTS (Pain Relief And Inflammatory Disease)		
ANTI-INFLAMMATORY TUMOR NECROSIS FACTOR INHIBITOR		
ADALIMUMAB-ADAZ PEN	T4	PA QL (2 doses/ 28 days) SP HD
ADALIMUMAB-ADBM(CF)PEN	T4	PA QL(2 pens/28 days) SP HD
ADALIMUMAB-ADBM(CF) PEN CROHNS	T4	PA QL(1 starter kit/365 days) SP HD
ADALIMUMAB-ADBM(CF) PEN PS-UV	T4	PA QL(1 starter kit/365 days) SP HD
ADALIMUMAB-RYVK(CF)	T4	PA QL(2pens/syringes/28 days) SP HD
ADALIMUMAB-RYVK(CF) AUTOINJECT	T4	PA QL SP
AVSOLA	T4	PA SP
CIMZIA	T4	PA QL (1 kit/28 days) SP HD
CIMZIA (2 PACK)	T4	PA QL (1 kit/28 days) SP HD
CYLTEZO (CF)	T4	PA QL(2 pens/syringes/28 days) SP HD
CYLTEZO(CF) PEN	T4	PA QL(2 pens/28 days) SP HD
ENBREL 25 MG KIT	T4	PA QL (8 vials/28 days) SP HD
ENBREL 25 MG/0.5 ML SYRINGE	T4	PA QL (8 syringes/28 days) SP HD
ENBREL 25 MG/0.5 ML VIAL	T4	PA QL (4ml/28 days) SP HD
ENBREL 50 MG/ML SYRINGE	T4	PA QL (4 syringes/28 days) SP HD
ENBREL MINI	T4	PA QL (4 cartridges/28 days) SP HD

T1 – Typically Generics
T2 – Typically Preferred Brands
T3 – Typically Non-Preferred Brands
T4 – Specialty Medications
PA – Prior Authorization
QL – Quantity Limit
ST – Step Therapy
AGE – Age Requirement
SP – Specialty Medication
HD – May require home delivery pharmacy
PPACA – No Cost-Share Preventive Medication
CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

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.)*		
ENBREL SURECLICK	T4	PA QL (4 syringes/28 days) SP HD
HUMIRA	T4	PA QL (2 syrings/28 days) SP HD
HUMIRA PEN	T4	PA QL (2 pens/28 days) SP HD
HUMIRA(CF)	T4	PA QL (2 syrings/28 days) SP HD
HUMIRA(CF) PEN 40 MG/0.4 ML	T4	PA QL (2 pens/28 days) SP HD
HUMIRA(CF) PEN 80 MG/0.8 ML	T4	PA QL (1 kit/year) SP HD
HUMIRA(CF) PEN CROHN'S-UC-HS	T4	PA QL (1 kit/year) SP HD
HUMIRA(CF) PEN PEDIATRIC UC	T4	PA QL(1 starter kit/365 days) SP
HUMIRA(CF) PEN PSOR-UV-ADOL HS	T4	PA QL (1 kit/year) SP HD
HYRIMOZ	T4	PA SP
HYRIMOZ PEN	T4	PA SP
INFLECTRA	T4	PA SP HD
REMICADE	T4	PA SP HD
SIMLANDI(CF) AUTOINJECTOR	T4	PA QL(2 auto-injs/28 days) SP HD
SIMPONI 100 MG/ML PEN INJECTOR	T4	PA QL (1 injector/28 days) SP HD
SIMPONI 100 MG/ML SYRINGE	T4	PA QL (1 syringe/28 days) SP HD
SIMPONI ARIA	T4	PA SP HD
ANTI-NEOPLASTICS (Cancer)		
ANP - SELECTIVE RETINOID X RECEPTOR AGONISTS (RXR)		
bexarotene (Targretin)	T4	PA SP HD
ANTI-NEOPLAST, HISTONE DEACETYLASE (HDAC) INHIBITORS		
FARYDAK	T4	PA SP HD
ZOLINZA	T4	PA SP HD
ANTI-NEOPLASTIC - ALKYLATING AGENTS		
ALKERAN (*melphalan*)	T4	SP
cyclophosphamide	T4	SP HD
GLEOSTINE	T2	
HYDREA (*hydroxyurea*)	T3	
hydroxyurea (Hydrea)	T1	
LEUKERAN	T2	
melphalan (Alkeran)	T4	SP CSL
MYLERAN	T2	
temozolomide	T4	PA SP HD CSL

T1 – Typically Generics
T2 – Typically Preferred Brands
T3 – Typically Non-Preferred Brands
T4 – Specialty Medications
PA – Prior Authorization
QL – Quantity Limit
ST – Step Therapy
AGE – Age Requirement
SP – Specialty Medication
HD – May require home delivery pharmacy
PPACA – No Cost-Share Preventive Medication
CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

ANTI-NEOPLASTICS (Cancer) *(cont.)*		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
ANTI-NEOPLASTIC - ANTI-ANDROGENIC AGENTS		
abiraterone 500 mg tablet	T4	SP HD
abiraterone acetate (Zytiga)	T4	SP HD CSL
abiraterone acetate 250 mg tab	T4	PA SP HD
bicalutamide (Casodex)	T1	
CASODEX (*bicalutamide*)	T3	
ERLEADA	T4	PA SP HD CSL
ERLEADA 240 MG TABLET	T4	PA QL(1 tab/day) SP HD CSL
ERLEADA 60 MG TABLET	T4	PA SP HD CSL
flutamide	T1	
nilutamide	T1	QL (4 tabs/day)
NUBEQA	T4	PA SP HD
XTANDI	T4	PA SP HD
ANTI-NEOPLASTIC - ANTI-METABOLITES		
capecitabine (Xeloda)	T4	PA SP HD
INQOVI	T4	PA SP HD
JYLAMVO	T3	CSL
LONSURF	T4	PA SP HD
mercaptopurine	T1	
methotrexate sodium	T1	
methotrexate sodium/pf	T1	
ONUREG	T4	PA QL (14 Tabs/28 Days) SP
PURIXAN *(mercaptopurine)*	T4	SP
TABLOID	T3	
TREXALL	T2	
XATMEP	T3	
XELODA (*capecitabine*)	T4	PA SP HD
ANTI-NEOPLASTIC - AROMATASE INHIBITORS		
anastrozole (Arimidex)	T1	HD PPACA
ARIMIDEX (*anastrozole*)	T3	HD
AROMASIN (*exemestane*)	T3	HD
exemestane (Aromasin)	T1	HD PPACA
letrozole (Femara)	T1	HD CSL

T1 – Typically Generics
T2 – Typically Preferred Brands
T3 – Typically Non-Preferred Brands
T4 – Specialty Medications
PA – Prior Authorization
QL – Quantity Limit
ST – Step Therapy
AGE – Age Requirement
SP – Specialty Medication
HD – May require home delivery pharmacy
PPACA – No Cost-Share Preventive Medication
CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

ANTI-NEOPLASTICS (Cancer) *(cont.)*		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
ANTI-NEOPLASTIC - BRAF KINASE INHIBITORS		
OJEMDA 100 MG TAB (400MG DOSE)	T4	PA QL(1 packet/28 days) SP CSL
OJEMDA 100 MG TAB (500MG DOSE)	T4	PA QL(1 packet/28 days) SP CSL
OJEMDA 100 MG TAB (600MG DOSE)	T4	PA QL(1 packet/28 days) SP CSL
OJEMDA 25 MG/ML ORAL SUSP	T4	PA QL(8 bottles/28 days) SP CSL
TAFINLAR 10 MG TABLET FOR SUSP	T4	PA QL(30 tabs/day) SP HD CSL
TAFINLAR 50 MG CAPSULE	T4	PA QL(4 caps/day) SP HD CSL
TAFINLAR 75 MG CAPSULE	T4	PA QL(4 caps/day) SP HD CSL
ZELBORAF	T4	PA SP HD
ANTI-NEOPLASTIC - ENZYME INHIB, ANTIANDROGEN COMB.		
AKEEGA	T4	PA QL(2 tabs/day) SP CSL
ANTI-NEOPLASTIC - HEDGEHOG PATHWAY INHIBITOR		
DAURISMO	T4	PA SP HD
ERIVEDGE	T4	PA SP HD
ODOMZO	T4	PA SP HD CSL
ANTI-NEOPLASTIC - JANUS KINASE (JAK) INHIBITORS		
JAKAFI	T4	PA SP HD
ANTI-NEOPLASTIC - KRAS PROTEIN INHIBITOR		
LUMAKRAS 120 MG TABLET	T4	PA QL(8 tabs/day) SP HD CSL
LUMAKRAS 240 MG TABLET	T4	PA QL(4 tabs/day) SP HD CSL
LUMAKRAS 320 MG TABLET	T4	PA QL(3 tabs/day) SP HD CSL
ANTI-NEOPLASTIC - MEKI AND MEK2 KINASE INHIBITORS		
COTELLIC	T4	PA SP HD
GOMEKLI	T4	PA SP HD
KOSELUGO 10 MG CAPSULE	T4	PA QL (10 capsules/day) SP
KOSELUGO 25 MG CAPSULE	T4	PA QL (4 caps/day) SP
MEKINIST	T4	PA SP HD
MEKINIST 0.05 MG/ML SOLUTION	T4	PA QL(40 mls/day) SP HD CSL
MEKINIST 0.5 MG TABLET	T4	PA QL(3 tabs/day) SP HD CSL
MEKINIST 2 MG TABLET	T4	PA QL(1 tab/day) SP HD CSL
ANTI-NEOPLASTIC - MTOR KINASE INHIBITORS		
AFINITOR 10 MG TABLET	T4	PA SP HD
AFINITOR 2.5 MG TABLET (*everolimus*)	T4	PA SP HD
AFINITOR 5 MG TABLET (*everolimus*)	T4	PA SP HD
AFINITOR 7.5 MG TABLET (*everolimus*)	T4	PA SP HD
AFINITOR DISPERZ	T4	PA SP

T1 – Typically Generics
T2 – Typically Preferred Brands
T3 – Typically Non-Preferred Brands
T4 – Specialty Medications
PA – Prior Authorization
QL – Quantity Limit
ST – Step Therapy
AGE – Age Requirement
SP – Specialty Medication
HD – May require home delivery pharmacy
PPACA – No Cost-Share Preventive Medication
CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

ANTI-NEOPLASTICS (Cancer) *(cont.)*		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
ANTI-NEOPLASTIC - MTOR KINASE INHIBITORS (cont.)		
everolimus (Afinitor)	T4	PA QL(1 tab/day) SP CSL
everolimus 2.5 mg tablet	T4	PA SP HD
everolimus 5 mg tablet	T4	PA SP HD
everolimus 7.5 mg tablet	T4	PA QL(1 tab/day) SP HD CSL
everolimus 10 mg tablet	T4	PA QL(1 tab/day) SP HD CSL
ANTI-NEOPLASTIC - PROTEIN METHYLTRANSFERASE INHIBIT		
TAZVERIK	T4	PA SP
ANTI-NEOPLASTIC - TOPOISOMERASE I INHIBITORS		
HYCAMTIN	T4	PA SP HD
ANTI-NEOPLASTIC COMB - KINASE AND AROMATASE INHIBIT		
KISQALI FEMARA CO-PACK	T4	PA QL(1 tab/28 days) SP CSL
ANTI-NEOPLASTIC EGF RECEPTOR BLOCKER MCLON ANTIBODY		
PHESGO	T4	PA SP HD
ANTI-NEOPLASTIC IMMUNOMODULATOR AGENTS		
lenalidomide	T4	PA QL(1 cap/day) SP HD CSL
POMALYST	T4	PA QL(21 caps/28 days) SP HD CSL
REVLIMID	T4	PA QL(1 tab/day) SP HD CSL
ANTI-NEOPLASTIC LHRH (GNRH) AGONIST, PITUITARY SUPPR.		
leuprolide acetate	T4	PA SP HD
LEUPROLIDE DEPOT	T4	PA SP
LUPRON DEPOT 22.5 MG 3MO KIT	T4	PA SP HD
LUPRON DEPOT 45 MG 6MO KIT	T4	PA SP HD
LUPRON DEPOT 7.5 MG KIT	T4	PA SP HD
LUPRON DEPOT-4 MONTH KIT	T4	PA SP HD
ZOLADEX	T4	PA SP HD
ANTI-NEOPLASTIC LHRH (GNRH) ANTAGONIST, PITUIT.SUPPRS		
FIRMAGON	T4	PA SP HD
ORGOVYX	T4	PA SP
ANTI-NEOPLASTIC SYSTEMIC ENZYME INHIBITORS		
ALECENSA	T4	PA QL(8 tabs/day) SP HD CSL
ALUNBRIG 30 MG TABLET	T4	PA QL(2 tabs/day) SP CSL
ALUNBRIG 90 MG TABLET	T4	PA QL(1 tab/day) SP CSL
ALUNBRIG 90 MG-180 MG TAB PACK	T4	PA QL(1 tab/day) SP CSL
ALUNBRIG 180 MG TABLET	T4	PA QL(1 tab/day) SP CSL

T1 – Typically Generics
T2 – Typically Preferred Brands
T3 – Typically Non-Preferred Brands
T4 – Specialty Medications
PA – Prior Authorization
QL – Quantity Limit
ST – Step Therapy
AGE – Age Requirement
SP – Specialty Medication
HD – May require home delivery pharmacy
PPACA – No Cost-Share Preventive Medication
CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

ANTI-NEOPLASTICS (Cancer) *(cont.)*		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
ANTI-NEOPLASTIC SYSTEMIC ENZYME INHIBITORS *(cont.)*		
AYVAKIT	T4	PA QL (1 tab/day) SP
BALVERSA	T4	PA SP
BOSULIF	T4	PA SP HD
BOSULIF 100 MG CAPSULE	T4	PA QL(3 caps/day) SP HD CSL
BOSULIF 50 MG CAPSULE	T4	PA QL SP HD CSL
BRUKINSA	T4	PA QL (4 caps/day) SP
CABOMETYX	T4	PA SP HD
CALQUENCE	T4	PA SP
CAPRELSA	T4	PA SP
COMETRIQ	T4	PA SP HD
COPIKTRA	T4	PA SP
dasatinib 100 mg tablet	T4	PA QL(1 tab/day) SP CSL
dasatinib 140 mg tablet	T4	PA QL(1 tab/day) SP CSL
dasatinib 20 mg tablet	T4	PA QL(3 tabs/day) SP CSL
dasatinib 50 mg tablet	T4	PA QL(1 tab/day) SP CSL
dasatinib 70 mg tablet	T4	PA QL(2 tabs/day) SP CSL
dasatinib 80 mg tablet	T4	PA QL(1 tab/day) SP CSL
DANZITEN	T4	PA SP CSL
ENSACOVE 25 MG CAPSULE	T4	PA QL(9 caps/day) SP CSL
ENSACOVE 100 MG CAPSULE	T4	PA QL (2 caps/day) SP CSL
erlotinib hcl	T4	PA SP HD CSL
EXKIVITY	T4	PA SP HD
FRUZAQLA 1 MG CAPSULE	T4	PA QL(84 caps/28 days) SP CSL
FRUZAQLA 5 MG CAPSULE	T4	PA QL(21 caps/28 days) SP CSL
GAVRETO	T4	PA QL(4 caps/day) SP CSL
gefitinib	T4	PA SP HD CSL
GILOTRIF	T4	PA SP HD
GLEEVEC (*imatinib mesylate*)	T4	PA SP HD
IBRANCE 100 MG CAPSULE	T4	PA QL(21 caps/28 days) SP HD CSL
IBRANCE 100 MG TABLET	T4	PA QL(21 tabs/28 days) SP HD CSL
IBRANCE 125 MG CAPSULE	T4	PA QL(21 caps/28 days) SP HD CSL
IBRANCE 125 MG TABLET	T4	PA QL(21 tabs/28 days) SP HD CSL
IBRANCE 75 MG CAPSULE	T4	PA QL(21 caps/28 days) SP HD CSL
IBRANCE 75 MG TABLET	T4	PA QL(21 tabs/28 days) SP HD CSL

T1 – Typically Generics
T2 – Typically Preferred Brands
T3 – Typically Non-Preferred Brands
T4 – Specialty Medications
PA – Prior Authorization
QL – Quantity Limit
ST – Step Therapy
AGE – Age Requirement
SP – Specialty Medication
HD – May require home delivery pharmacy
PPACA – No Cost-Share Preventive Medication
CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

ANTI-NEOPLASTICS (Cancer) *(cont.)*		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
ANTI-NEOPLASTIC SYSTEMIC ENZYME INHIBITORS *(cont.)*		
imatinib mesylate 100 mg tab (Gleevec)	T4	QL(6 tabs/day) SP HD CSL
imatinib mesylate 400 mg tab (Gleevec)	T4	QL(2 tabs/day) SP HD CSL
imatinib mesylate (Gleevec)	T4	QL(6 tabs/day) SP HD CSL
IMKELDI	T4	PA SP CSL
INLYTA	T4	PA SP HD
INREBIC	T4	PA SP HD
IRESSA	T4	PA SP HD
ITOVEBI	T4	PA SP HD CSL
IWILFIN	T4	PA QL(8 tabs/day) SP CSL
KISQALI 600mg	T4	PA SP QL(63 tabs/28 days)HD CSL
KISQALI 400mg	T4	PA SP QL(42 tabs/28 days) HD CSL
KISQALI 200mg	T4	PA QL(21 tabs/28 days) SP HD CSL
lapatinib ditosylate (Tykerb)	T4	PA SP HD
LENVIMA	T4	PA SP HD CSL
LORBRENA	T4	PA SP HD
LYNPARZA	T4	PA SP HD
LYTGOBI 12 MG DAILY DOSE (3X 4MG TB)	T4	PA QL(3 tabs/day) SP CSL
LYTGOBI 16 MG DAILY DOSE (4X 4MG TB)	T4	PA QL(4 tabs/day) SP CSL
LYTGOBI 20 MG DAILY DOSE (5X 4MG TB)	T4	PA QL(5 tabs/day) SP CSL
NERLYNX	T4	PA SP HD
NINLARO	T4	PA QL(3 caps/28 days) SP HD CSL
pazopanib hcl (Votrient)	T4	PA QL(4 tabs/day) SP HD CSL
PEMAZYRE	T4	PA QL (14 tabs/21 days) SP
PIQRAY	T4	PA SP HD CSL
OGSIVEO 100 MG TABLET	T4	PA QL SP CSL
OGSIVEO 150 MG TABLET	T4	PA QL SP CSL
OGSIVEO 50 MG TABLET	T4	PA QL(6 tabs/day) SP CSL
OJJAARA	T4	PA QL(1 tab/day) SP CSL
QINLOCK	T4	PA QL (3 tabs/day) SP
SCEMBLIX 20 MG TABLET	T4	PA QL(2 tabs/day) SP HD CSL
SCEMBLIX 40 MG TABLET	T4	PA SP HD CSL
SCEMBLIX 100 MG TABLET	T4	PA SP CSL
TURALIO	T4	PA QL(4 caps/day) SP CSL

T1 – Typically Generics
T2 – Typically Preferred Brands
T3 – Typically Non-Preferred Brands
T4 – Specialty Medications
PA – Prior Authorization
QL – Quantity Limit
ST – Step Therapy
AGE – Age Requirement
SP – Specialty Medication
HD – May require home delivery pharmacy
PPACA – No Cost-Share Preventive Medication
CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

ANTI-NEOPLASTICS (Cancer) *(cont.)*		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
ANTI-NEOPLASTIC SYSTEMIC ENZYME INHIBITORS *(cont.)*		
TURALIO 125 MG CAPSULE	T4	PA QL(4 caps/day) SP CSL
TURALIO 200 MG CAPSULE	T4	PA SP CSL
RETEVMO 40 MG CAPSULE	T4	PA QL (6 caps/day) SP HD
RETEVMO 80 MG CAPSULE	T4	PA QL (4 tabs/day) SP HD
RETEVMO 120 MG, 160 MG TABLET	T4	PA QL (2 tabs/day) SP HD CSL
REVUFORJ 25 MG, 110 MG TABLET	T4	PA SP CSL
REVUFORJ 160 MG TABLET	T4	PA QL(2 tabs/day) SP CSL
ROMVIMZA	T4	PA QL (8 caps/28 days) SP CSL
ROZLYTREK	T4	PA SP HD
RUBRACA	T4	PA SP
RYDAPT	T4	PA SP HD
STIVARGA	T4	PA QL(84 tabs/28 days) SP HD CSL
SUTENT	T4	PA SP HD
TABRECTA	T4	PA QL (4 tabs/day) SP HD
TAGRISSO	T4	PA SP HD
TALZENNA	T4	PA QL(1 cap/day) SP HD CSL
TEPMETKO	T4	PA QL (2 tabs/day) SP
TRUQAP	T4	PA QL(64 tabs/28 days) SP CSL
TUKYSA	T4	PA SP
TYKERB (*lapatinib*)	T4	PA SP HD
UKONIQ	T4	PA QL (4 tabs/day) SP
VANFLYTA	T4	PA QL(2 tabs/day) SP CSL
VERZENIO	T4	PA QL(2 tabs/day) SP HD CSL
VITRAKVI	T4	PA SP HD
VIZIMPRO	T4	PA SP HD
XALKORI 150 MG PELLET	T4	PA QL(4 pellets/day) SP HD CSL
XALKORI 20 MG PELLET	T4	PA QL(4 pellets/day) SP HD CSL
XALKORI 200 MG CAPSULE	T4	PA QL(4 caps/day) SP HD CSL
XALKORI 250 MG CAPSULE	T4	PA QL(4 caps/day) SP HD CSL
XALKORI 50 MG PELLET	T4	PA QL(4 pellets/day) SP HD CSL
XALKORI	T4	PA SP HD
XOSPATA	T4	PA SP
ZEJULA	T4	PA QL(1 tab/day) SP CSL
ZYDELIG	T4	PA SP HD

T1 – Typically Generics
T2 – Typically Preferred Brands
T3 – Typically Non-Preferred Brands
T4 – Specialty Medications
PA – Prior Authorization
QL – Quantity Limit
ST – Step Therapy
AGE – Age Requirement
SP – Specialty Medication
HD – May require home delivery pharmacy
PPACA – No Cost-Share Preventive Medication
CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

ANTI-NEOPLASTICS (Cancer) *(cont.)*		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
ANTINEOPLASTIC - SYSTEMIC ENZYME INHIBITORS COMBS		
AVMAPKI-FAKZYNJA	T4	PA SP CSL
ANTI-NEOPLASTIC, ANTI-PROGRAMMED DEATH-I (PD-I) MAB		
OPDIVO	T4	PA SP HD
ANTI-NEOPLASTIC-B CELL LYMPHOMA-2(BCL-2) INHIBITORS		
VENCLEXTA	T4	PA SP
VENCLEXTA STARTING PACK	T4	PA SP
ANTI-NEOPLASTIC-ISOCITRATE DEHYDROGENASE INHIBITORS		
IDHIFA	T4	PA SP HD
REZLIDHIA	T4	PA QL(2 caps/day) SP CSL
TIBSOVO	T4	PA SP
ANTI-NEOPLASTICS ANTIBODY/ANTIBODY-DRUG COMPLEXES		
ENHERTU	T4	PA SP HD
ANTI-NEOPLASTICS, MISCELLANEOUS		
etoposide	T4	SP HD
LYSODREN	T2	
MATULANE	T4	SP
tretinoin 10 mg capsule	T1	PA
ANTI-NEOPLASTIC-SELECT INHIB OF NUCLEAR EXP (SINE)		
XPOVIO	T4	PA SP
CYTOTOXIC T-LYMPHOCYTE ANTIGEN (CTLA-4) RMC ANTIBODY		
YERVOY	T4	PA SP HD
IMMUNOMODULATORS		
ACTIMMUNE	T4	PA SP HD
SELECTIVE ESTROGEN RECEPTOR MODULATORS (SERMS)		
FARESTON (*toremifene citrate*)	T3	QL (2 tabs/day) HD
SOLTAMOX	T2	HD
tamoxifen citrate	T1	HD PPACA
toremifene citrate (Fareston)	T1	QL (2 tabs/day) HD
STEROID ANTI-NEOPLASTICS		
EMCYT	T4	SP HD
megestrol acetate	T3	
ANTI-NEOPLASTICS (Skin Conditions)		
PHOTOACT, TOPICAL ANTI-NEOPLAST, PREMALIGNANT LESIONS		
LEVULAN	T4	SP

T1 – Typically Generics
T2 – Typically Preferred Brands
T3 – Typically Non-Preferred Brands
T4 – Specialty Medications
PA – Prior Authorization
QL – Quantity Limit
ST – Step Therapy
AGE – Age Requirement
SP – Specialty Medication
HD – May require home delivery pharmacy
PPACA – No Cost-Share Preventive Medication
CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

ANTI-OBESITY DRUGS (Weight Management)		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
TOPICAL ANTI-NEOPLASTIC PREMALIGNANT LESION AGENTS *(con't.)*		
EFUDEX (*fluorouracil*)	T3	
FLUOROPLEX	T2	
fluorouracil	T1	
fluorouracil (Efudex)	T1	
PANRETIN	T4	SP HD
PICATO	T3	
TARGRETIN 1% GEL	T4	SP HD
TOLAK	T3	
VALCHLOR	T4	SP HD
ANTI-OBESITY - ANOREXIC AGENTS		
ADIPEX-P (*phentermine hcl*)	T3	PA
benzphetamine hcl	T1	
benzphetamine hcl (Regimex)	T1	
diethylpropion hcl	T1	
LOMAIRA	T3	
phendimetrazine tartrate	T1	
phentermine hcl	T1	
phentermine hcl (Adipex-p)	T1	
QSYMIA	T3	PA
REGIMEX (*benzphetamine hcl*)	T3	
VYKAT XR	T4	SP
ANTI-OBESITY - MELANOCORTIN 4 RECEPTOR AGONISTS		
IMCIVREE	T4	PA QL (9 ml/22 days) SP
ANTI-OBESITY SEROTONIN 2C RECEPTOR AGONISTS		
BELVIQ	T3	PA
BELVIQ XR	T3	PA
ANTI-OBESITY - OPIOID ANTAG-NOREPI, DOPAMINE RU INHIB		
CONTRAVE	T3	PA
FAT ABSORPTION DECREASING AGENTS		
XENICAL	T3	PA
ANTI-PARASITICS (Eye Conditions)		
OPHTHALMIC (EYE) ANTIPARASITICS		
XDEMVY	T4	PA QL(4 bottles/30 days) SP

T1 – Typically Generics
T2 – Typically Preferred Brands
T3 – Typically Non-Preferred Brands
T4 – Specialty Medications
PA – Prior Authorization
QL – Quantity Limit
ST – Step Therapy
AGE – Age Requirement
SP – Specialty Medication
HD – May require home delivery pharmacy
PPACA – No Cost-Share Preventive Medication
CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

ANTI-PARASITICS (Infections)		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
ANTI-PARASITICS		
ALINIA (*nitazoxanide*)	T3	
nitazoxanide (Alinia)	T1	
TOPICAL ANTI-PARASITICS		
crotamiton (Eurax)	T1	
ELIMITE (*permethrin*)	T3	
EURAX	T3	
ivermectin (Sklice)	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	T4	PA SP HD
bromocriptine mesylate	T1	HD
carbidopa/levodopa	T1	HD
carbidopa/levodopa (Sinemet)	T1	HD
carbidopa/levodopa/entacapone	T1	HD

T1 – Typically Generics
T2 – Typically Preferred Brands
T3 – Typically Non-Preferred Brands
T4 – Specialty Medications
PA – Prior Authorization
QL – Quantity Limit
ST – Step Therapy
AGE – Age Requirement
SP – Specialty Medication
HD – May require home delivery pharmacy
PPACA – No Cost-Share Preventive Medication
CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

ANTI-PARKINSON DRUGS (Parkinson's Disease) *(cont.)*		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
ANTI-PARKINSONISM DRUGS, OTHER *(cont.)*		
DUOPA	T4	SP HD
entacapone	T1	HD
INBRIJA	T4	PA SP HD
KYNMOBI	T2	PA HD
MIRAPEX ER 0.375 MG TABLET (*pramipexole er*)	T3	QL (1 tab/day) HD
MIRAPEX ER 0.75 MG TABLET (*pramipexole er*)	T3	HD
MIRAPEX ER 1.5 MG TABLET (*pramipexole er*)	T3	QL (1 tab/day) HD
MIRAPEX ER 2.25 MG TABLET (*pramipexole er*)	T3	QL (1 tab/day) HD
MIRAPEX ER 3 MG TABLET (*pramipexole er*)	T3	HD
MIRAPEX ER 3.75 MG TABLET (*pramipexole er*)	T3	HD
NEUPRO	T3	HD
NOURIANZ	T4	PA QL (1 tab/day) SP HD
OSMOLEX ER	T3	QL (1 tab/day) HD
OSMOLEX ER 258 MG TABLET	T3	QL (1 tab/day) HD
PARLODEL (*bromocriptine mesylate*)	T3	HD
pramipexole di-hcl	T1	HD
pramipexole er 0.375 mg tablet	T1	QL(1 tab/day) HD
pramipexole er 0.75 mg tablet	T1	HD
pramipexole er 2.25 mg tablet	T1	QL(1 tab/day) HD
pramipexole er 3 mg tablet	T1	HD
pramipexole er 3.75 mg tablet	T1	HD
pramipexole er 1.5 mg tablet	T1	QL(1 tab/day) HD
pramipexole er 1.5 mg tablet (Mirapex Er)	T1	QL (1 tab/day) HD
rasagiline mesylate 0.5 mg tab (Azilect)	T1	QL (1 tab/day) HD
RYTARY	T3	HD
selegiline hcl	T1	HD
SINEMET (*carbidopa-levodopa*)	T3	HD
STALEVO 75 (*carbidopa-levodopa-entacapone*)	T3	HD
STALEVO 100 (*carbidopa-levodopa-entacapone*)	T3	HD

T1 – Typically Generics
T2 – Typically Preferred Brands
T3 – Typically Non-Preferred Brands
T4 – Specialty Medications
PA – Prior Authorization
QL – Quantity Limit
ST – Step Therapy
AGE – Age Requirement
SP – Specialty Medication
HD – May require home delivery pharmacy
PPACA – No Cost-Share Preventive Medication
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.)*		
TASMAR (*tolcapone*)	T3	HD
tolcapone (Tasmar)	T1	HD
XADAGO	T3	ST HD
DECARBOXYLASE INHIBITORS		
carbidopa	T1	
ANTI-PLATELET DRUGS (Blood Thinners/Anti-Clotting)		
PLATELET AGGREGATION INHIBITORS		
aspirin/dipyridamole	T1	HD
cilostazol	T1	HD
clopidogrel bisulfate	T1	HD
clopidogrel bisulfate (Plavix)	T1	HD
dipyridamole	T1	HD
EFFIENT (*prasugrel hcl*)	T3	HD
prasugrel hcl (Effient)	T1	HD
ticagrelor	T1	HD
ticlopidine hcl	T1	HD
PLATELET REDUCING AGENTS		
AGRYLIN (*anagrelide hcl*)	T3	
anagrelide hcl	T1	
anagrelide hcl (Agrylin)	T1	
ANTIVIRALS (AIDS/HIV)		
ANTI-RETROVIRAL - CAPSID INHIBITORS		
SUNLENCA 300 MG TABLET	T4	PA QL(5 tabs/180 days) SP
SUNLENCA 463.5 MG/1.5 ML VIAL	T4	PA SP
ANTI-RETROVIRAL - INTEGRASE INHIBITOR AND NNRTI COMB.		
CABENUVA	T4	PA SP
JULUCA	T4	SP
ANTI-RETROVIRAL - INTEGRASE INHIBITOR AND NRTI COMB.		
DOVATO	T4	SP

T1 – Typically Generics
T2 – Typically Preferred Brands
T3 – Typically Non-Preferred Brands
T4 – Specialty Medications
PA – Prior Authorization
QL – Quantity Limit
ST – Step Therapy
AGE – Age Requirement
SP – Specialty Medication
HD – May require home delivery pharmacy
PPACA – No Cost-Share Preventive Medication
CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

ANTIVIRALS (AIDS/HIV) *(cont.)*		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
ANTI-RETROVIRAL - NRTIS AND INTEGRASE INHIBITORS COMB		
TRIUMEQ	T4	SP QL (1 tablet/day)
ANTI-RETROVIRAL - NUCLEOSIDE, NUCLEOTIDE, PROTEASE INH.		
SYMTUZA	T4	SP
ANTIVIRALS - HIV-SPEC, NON-PEPTIDIC PROTEASE INHIB		
APTIVUS	T4	PA SP
darunavir (Prezista)	T4	SP
darunavir ethanolate (Prezista)	T4	SP
PREZCOBIX	T4	PA SP
PREZISTA 100 MG/ML SUSPENSION	T4	SP
PREZISTA 75 MG, 150 MG TABLET	T4	SP
ANTIVIRALS - HIV-SPEC, NUCLEOSIDE-NUCLEOTIDE ANALOG		
CIMDUO	T4	PA SP
DESCOVY	T4	SP PPACA
emtricitabine-tenofv 100-150mg	T4	SP
emtricitabine-tenofv 133-200mg	T4	SP
emtricitabine-tenofv 167-250mg	T4	SP
emtricitabine-tenofv 200-300mg	T4	SP PPACA
TEMIXYS	T4	PA SP
ANTIVIRALS - HIV-SPEC, NUCLEOSIDE ANALOG, RTI COMB		
abacavir sulfate/lamivudine	T4	PA SP
abacavir/lamivudine/zidovudine	T4	PA SP
lamivudine/zidovudine	T4	SP
ANTIVIRALS - HIV-SPECIFIC, CCR5 CO-RECEPTOR ANTAG.		
maraviroc (Selzentry)	T4	PA SP
SELZENTRY 20 MG/ML ORAL SOLN	T4	PA SP
SELZENTRY 25 MG TABLET	T4	PA SP
SELZENTRY 75 MG TABLET	T4	PA SP
ANTIVIRALS - HIV-SPECIFIC, CD4 ATTACHMENT INHIBITOR		
RUKOBIA	T4	PA QL (2 tablets/day) SP
ANTIVIRALS - HIV-SPECIFIC, FUSION INHIBITORS		
FUZEON	T4	PA SP
ANTIVIRALS - HIV-SPECIFIC, NON-NUCLEOSIDE, RTI		
EDURANT	T4	PA SP

T1 – Typically Generics
T2 – Typically Preferred Brands
T3 – Typically Non-Preferred Brands
T4 – Specialty Medications
PA – Prior Authorization
QL – Quantity Limit
ST – Step Therapy
AGE – Age Requirement
SP – Specialty Medication
HD – May require home delivery pharmacy
PPACA – No Cost-Share Preventive Medication
CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

ANTIVIRALS (AIDS/HIV) *(cont.)*		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
ANTIVIRALS - HIV-SPECIFIC, NON-NUCLEOSIDE, RTI (cont.)		
efavirenz	T4	PA SP
nevirapine	T4	PA SP
PIFELTRO	T4	PA SP
ANTIVIRALS - HIV-SPECIFIC, NUCLEOSIDE ANALOG, RTI		
abacavir sulfate	T4	PA SP
emtricitabine (Emtriva)	T4	PA SP
EMTRIVA 10 MG/ML SOLUTION	T4	PA SP
lamivudine 10 mg/ml oral soln	T4	SP
lamivudine 150 mg tablet	T4	SP
lamivudine 300 mg tablet	T4	PA SP
zidovudine	T4	SP
tenofovir disoproxil fumarate	T4	PA SP
VIREAD	T4	PA SP
VIREAD POWDER	T4	PA SP
ANTIVIRALS - HIV-SPECIFIC, PROTEASE INHIBITOR COMB		
KALETRA 100-25 MG TABLET	T2	
KALETRA 200-50 MG TABLET	T2	
KALETRA 80-20 MG SOLUTION	T2	
lopinavir/ritonavir	T1	
ANTIVIRALS - HIV-SPECIFIC, PROTEASE INHIBITORS		
atazanavir sulfate	T4	PA SP
EVOTAZ	T4	PA SP
fosamprenavir calcium	T4	PA SP
NORVIR	T4	SP
REYATAZ	T4	PA SP
ritonavir	T4	SP
ANTIVIRALS - HIV-I INTEGRASE STRAND TRANSFER INHIBTR		
APRETUDE	T4	PA SP
ISENTRESS	T4	SP
ISENTRESS HD	T4	PA SP
TIVICAY	T4	SP
TIVICAY PD	T4	SP

T1 – Typically Generics
T2 – Typically Preferred Brands
T3 – Typically Non-Preferred Brands
T4 – Specialty Medications
PA – Prior Authorization
QL – Quantity Limit
ST – Step Therapy
AGE – Age Requirement
SP – Specialty Medication
HD – May require home delivery pharmacy
PPACA – No Cost-Share Preventive Medication
CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

ANTIVIRALS (AIDS/HIV) *(cont.)*		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
ARTV NUCLEOSIDE, NUCLEOTIDE, NON-NUCLEOSIDE RTI COMB		
DELSTRIGO	T4	PA SP
efavirenz/emtricit/tenofovr df	T4	PA SP
efavirenz/lamivu/tenofov disop (Symfi Lo)	T4	SP
efavirenz/lamivu/tenofov disop (Symfi)	T4	SP
emtricita/rilpivirine/tenof df (Complera)	T4	QL(1 tab/day) SP
ODEFSEY	T4	PA SP
ARV-NUCLEOSIDE, NUCLEOTIDE RTI, INTEGRASE INHIBITORS		
BIKTARVY	T4	SP
GENVOYA	T4	SP
STRIBILD	T4	PA SP
ANTIVIRALS (Eye Conditions)		
EYE ANTIVIRALS		
trifluridine	T1	
ZIRGAN	T3	
ANTIVIRALS (Infections)		
ANTIVIRALS, GENERAL		
acyclovir	T1	
acyclovir susp	T1	
famciclovir	T1	
FLUMADINE (*rimantadine hcl*)	T3	
LIVTENCITY	T4	PA QL (4 tabs/day) SP
oseltamivir 6 mg/ml suspension (Tamiflu)	T1	QL (180ml/30 days)
oseltamivir phos 30 mg capsule (Tamiflu)	T1	QL (20 caps/30 days)
oseltamivir phos 45 mg capsule (Tamiflu)	T1	QL (10/30 days)
oseltamivir phos 75 mg capsule (Tamiflu)	T1	QL (10/30 days)
PREVYMIS PELLET PACKET	T4	SP
PREVYMIS TABLET	T4	SP HD
RELENZA	T3	QL (20/30 days)
rimantadine hcl (Flumadine)	T1	
TAMIFLU 30 MG CAPSULE (*oseltamivir phosphate*)	T3	QL (20/30 days)
TAMIFLU 45 MG CAPSULE (*oseltamivir phosphate*)	T3	QL (10/30 days)
TAMIFLU 6 MG/ML SUSPENSION (*oseltamivir phosphate*)	T3	QL (180ml/30 days)
TAMIFLU 75 MG CAPSULE (*oseltamivir phosphate*)	T3	QL (10/30 days)
valganciclovir hcl	T1	

T1 – Typically Generics
T2 – Typically Preferred Brands
T3 – Typically Non-Preferred Brands
T4 – Specialty Medications
PA – Prior Authorization
QL – Quantity Limit
ST – Step Therapy
AGE – Age Requirement
SP – Specialty Medication
HD – May require home delivery pharmacy
PPACA – No Cost-Share Preventive Medication
CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

ANTIVIRALS (Infections) *(cont.)*		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
ANTIVIRALS, GENERAL *(cont.)*		
VALTREX (*valacyclovir*)	T3	
XOFLUZA	T3	QL (2 tabs/30 days)
HEP C - NS5A, NS3/4A, NUCLEOTIDE NS5B INHIB COMBO		
VOSEVI	T4	PA SP HD
HEP C VIRUS, NUCLEOTIDE ANALOG NS5B POLYMERASE INH		
SOVALDI 150 MG, 200 MG PELLET PACKET	T4	PA QL (1 tab/day) SP HD
SOVALDI 200 MG, 400 MG TABLET	T4	PA QL (1 tab/day) SP HD
HEP C VIRUS-NS5B POLYMERASE AND NS5A INHIB. COMBO.		
EPCLUSA 200 MG-50 MG TABLET	T4	PA QL (1 tab/Day) SP HD
EPCLUSA 400 MG-100 MG TABLET	T4	PA SP HD
HARVONI 33.75-150 MG PELLET PK	T4	PA QL (1 tab/day) SP HD
HARVONI 45-200 MG PELLET PACKT	T4	PA QL (1 tab/day) SP HD
HARVONI 45-200 MG TABLET	T4	PA QL (1 tab/day) SP HD
HARVONI 90-400 MG TABLET	T4	PA SP HD
HEPATITIS B TREATMENT AGENTS		
adefovir dipivoxil (Hepsera)	T4	SP HD
BARACLUDE	T4	SP HD
entecavir 0.5 mg tablet	T4	QL (1 tab/day) SP HD
entecavir 1 mg tablet	T4	SP HD
EPIVIR HBV (*lamivudine hbv*)	T4	SP
lamivudine (Epivir Hbv)	T4	SP
VEMLIDY	T4	SP HD
HEPATITIS C TREATMENT AGENTS		
PEGASYS	T4	PA SP HD
PEGINTRON	T4	PA SP HD
ribasphere 200 mg capsule	T4	SP HD
ribasphere 200 mg tablet	T4	SP HD
ribasphere 400 mg tablet	T4	SP
ribasphere 600 mg tablet	T4	SP
ribasphere ribapak 200-400 mg	T4	SP HD
ribasphere ribapak 400-400 mg	T4	SP HD
ribasphere ribapak 400-400 mg	T4	SP HD
ribasphere ribapak 600-400 mg	T4	SP HD
ribasphere ribapak 600-400 mg	T4	SP HD

T1 – Typically Generics
T2 – Typically Preferred Brands
T3 – Typically Non-Preferred Brands
T4 – Specialty Medications
PA – Prior Authorization
QL – Quantity Limit
ST – Step Therapy
AGE – Age Requirement
SP – Specialty Medication
HD – May require home delivery pharmacy
PPACA – No Cost-Share Preventive Medication
CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ANTIVIRALS (Infections) *(cont.)*		
HEPATITIS C TREATMENT AGENTS *(cont.)*		
ribasphere ribapak 600-600 mg	T4	SP HD
ribasphere ribapak 600-600 mg	T4	SP HD
ribavirin	T4	SP HD
HEPATITIS C VIRUS- NS5A AND NS3/4A INHIBITOR COMB		
ZEPATIER	T4	PA QL(1 tab/day) SP HD
RNA POLYMERASE INHIBITOR		
LAGEVRIO (EUA)	T2	QL(1 pack/120 days)
LAGEVRIO 200 MG CAP (EUA)	T2	QL(1 pack/120 days)
MOLNUPIRAVIR	T3	QL (1 pkg/120 days)
ANTIVIRALS (Skin Conditions)		
TOPICAL GENITAL WART-HPV TREATMENT AGENTS		
VEREGEN	T3	
AUTONOMIC DRUGS (Allergy/Nasal Sprays)		
ANAPHYLAXIS THERAPY AGENTS		
epinephrine	T1	QL (2 packs/30 days)
epinephrine (Epinephrine)	T1	QL (2 packs/30 days)
AUTONOMIC DRUGS (Alzheimer's Disease)		
CHOLINESTERASE INHIBITORS		
ARICEPT (*donepezil hcl*)	T3	HD
donepezil hcl	T1	HD
donepezil hcl (Aricept)	T1	HD
EXELON (*rivastigmine*)	T3	HD
galantamine er 16 mg capsule (Razadyne Er)	T1	HD
galantamine er 24 mg capsule (Razadyne Er)	T1	HD
galantamine er 8 mg capsule (Razadyne Er)	T1	QL (1 cap/day) HD
galantamine hbr	T1	HD
MESTINON (*pyridostigmine bromide er*)	T3	HD
pyridostigmine bromide (Mestinon)	T1	HD
RAZADYNE ER 16 MG CAPSULE (*galantamine er*)	T3	HD
RAZADYNE ER 24 MG CAPSULE (*galantamine er*)	T3	HD
RAZADYNE ER 8 MG CAPSULE (*galantamine er*)	T3	QL (1 cap/day) HD
rivastigmine (Exelon)	T1	HD
rivastigmine tartrate	T1	HD

T1 – Typically Generics
T2 – Typically Preferred Brands
T3 – Typically Non-Preferred Brands
T4 – Specialty Medications
PA – Prior Authorization
QL – Quantity Limit
ST – Step Therapy
AGE – Age Requirement
SP – Specialty Medication
HD – May require home delivery pharmacy
PPACA – No Cost-Share Preventive Medication
CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
AUTONOMIC DRUGS (Attention Deficit Hyperactivity Disorder)[10]		
ADRENERGICS, AROMATIC, NON-CATECHOLAMINE		
ADDERALL (*dextroamphetamine-amphetamine*)	T3	PA ST
amphetamine sulfate (Evekeo)	T1	PA
dextroamphetamine/amphetamine (Adderall Xr)	T1	PA QL(1 cap/day)
dextroamphetamine/amphetamine (Mydayis)	T1	PA QL(1 cap/day)
dextroamphetamine er 10 mg cap	T1	PA QL (1 cap/day)
dextroamphetamine er 15 mg cap	T1	PA QL (3/day)
dextroamphetamine er 5 mg cap	T1	PA QL (1 cap/day)
dextroamphetamine sulfate	T1	PA
dextroamphetamine sulfate	T3	PA ST
EVEKEO (*amphetamine sulfate*)	T3	PA ST
lisdexamfetamine capsule (Vyvanse)	T1	PA QL(1 cap/day)
lisdexamfetamine tb chew (Vyvanse)	T1	PA QL(1 tab/day)
methamphetamine hcl	T1	PA
XELSTRYM	T3	PA QL(1 patch/day)
ZENZEDI	T3	PA ST
AUTONOMIC DRUGS (Blood Pressure/Heart Medications)		
ADRENERGIC VASOPRESSOR AGENTS		
droxidopa (Northera)	T4	SP HD
midodrine hcl	T1	
ALPHA-ADRENERGIC BLOCKING AGENTS		
DIBENZYLINE (*phenoxybenzamine hcl*)	T3	HD
phenoxybenzamine hcl (Dibenzyline)	T1	HD
AUTONOMIC DRUGS (Urinary Tract Conditions)		
PARASYMPATHETIC AGENTS		
bethanechol chloride	T1	HD
cevimeline hcl (Evoxac)	T1	HD
guanidine hcl	T1	HD
pilocarpine hcl (Salagen)	T1	HD
SALAGEN (*pilocarpine hcl*)	T3	HD
BIOLOGICALS (Allergy/Nasal Sprays)		
ALLERGENIC EXTRACTS, THERAPEUTIC		
GRASTEK	T3	PA QL (1 tab/day)

T1 – Typically Generics
T2 – Typically Preferred Brands
T3 – Typically Non-Preferred Brands
T4 – Specialty Medications
PA – Prior Authorization
QL – Quantity Limit
ST – Step Therapy
AGE – Age Requirement
SP – Specialty Medication
HD – May require home delivery pharmacy
PPACA – No Cost-Share Preventive Medication
CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
BIOLOGICALS (Allergy/Nasal Sprays) (cont.)		
ALLERGENIC EXTRACTS, THERAPEUTIC (cont.)		
ODACTRA	T3	PA QL (1 tab/day)
ORALAIR	T3	PA QL (1 tab/day)
RAGWITEK	T3	PA QL (1 tab/day)
BIOLOGICALS (Blood Pressure/Heart Medications)		
PLASMA KALLIKREIN INHIBITORS		
TAKHZYRO	T4	PA SP HD
BIOLOGICALS (Miscellaneous)		
PKU TREATMENT AGENTS - PHENYLALANINE AMMONIA LYASE		
PALYNZIQ	T4	PA SP HD
BIOLOGICALS (Vaccines)		
COVID-19 VACCINES		
COMIRNATY COVID-19 VACCINE	T2	PPACA
JANSSEN COVID-19 VACCINE	T2	PPACA
MODERNA COVID-19 VACCINE	T2	PPACA
NOVAVAX COVID-19 VACCINE	T2	PPACA
PFIZER COVID-19 VACCINE	T2	PPACA
SPIKEVAX	T2	PPACA
ENTERIC VIRUS VACCINES		
IPOL	T2	PPACA
ROTARIX	T3	PPACA
ROTATEQ	T3	PPACA
GRAM NEGATIVE COCCI VACCINES		
BEXSERO	T2	PPACA
MENACTRA	T2	
MENQUADFI	T2	PPACA
MENVEO A-C-Y-W-135-DIP	T2	PPACA
PENBRAYA	T2	PPACA
TRUMENBA	T2	PPACA
GRAM POSITIVE COCCI VACCINES		
CAPVAXIVE	T2	PPACA
PNEUMOVAX 23	T2	PPACA
PREVNAR 13	T2	
PREVNAR 20	T2	

T1 – Typically Generics
T2 – Typically Preferred Brands
T3 – Typically Non-Preferred Brands
T4 – Specialty Medications
PA – Prior Authorization
QL – Quantity Limit
ST – Step Therapy
AGE – Age Requirement
SP – Specialty Medication
HD – May require home delivery pharmacy
PPACA – No Cost-Share Preventive Medication
CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

BIOLOGICALS (Vaccines) *(cont.)*		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
INFLUENZA VIRUS VACCINES		
AFLURIA	T2	PPACA
AFLURIA QUAD	T2	PPACA
AFLURIA TRIV	T2	PPACA
AFLURIA TRIVALENT	T2	PPACA
EZ FLU	T2	PPACA
FLUAD QUAD	T2	PPACA
FLUAD TRIVALENT	T2	PPACA
FLUARIX QUAD	T2	PPACA
FLUARIX TRIVALENT	T2	PPACA
FLUBLOK	T2	PPACA
FLUBLOK QUAD	T2	PPACA
FLUBLOK TRIVALENT	T2	PPACA
FLUCELVAX QUAD	T2	PPACA
FLUCELVAX TRIVALENT	T2	PPACA
FLULAVAL QUAD	T2	PPACA
FLULAVAL TRIVALENT	T2	PPACA
FLUMIST QUAD	T3	PPACA
FLUMIST TRIVALENT	T3	PPACA
FLUVIRIN	T2	PPACA
FLUZONE	T2	PPACA
FLUZONE HIGH-DOSE	T2	PPACA
FLUZONE HIGH-DOSE TRIV	T2	PPACA
FLUZONE INTRADERM QUAD	T2	PPACA
FLUZONE QUAD	T2	PPACA
FLUZONE QUAD PEDI	T2	PPACA
FLUZONE TRIVALENT	T2	PPACA
TOXIN-PRODUCING BACILLI VACCINES/TOXOIDS		
BCG VACCINE (TICE STRAIN)	T4	SP
VACCINE/TOXOID PREPARATIONS, COMBINATIONS		
ACTHIB	T2	PPACA
ADACEL TDAP	T2	PPACA
BOOSTRIX TDAP	T2	PPACA
DAPTACEL DTAP	T2	PPACA
DIPHTHERIA-TETANUS TOXOIDS-PED	T2	PPACA

T1 – Typically Generics
T2 – Typically Preferred Brands
T3 – Typically Non-Preferred Brands
T4 – Specialty Medications
PA – Prior Authorization
QL – Quantity Limit
ST – Step Therapy
AGE – Age Requirement
SP – Specialty Medication
HD – May require home delivery pharmacy
PPACA – No Cost-Share Preventive Medication
CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

BIOLOGICALS (Vaccines) *(cont.)*		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
VACCINE/TOXOID PREPARATIONS, COMBINATIONS *(cont.)*		
ERVEBO (NATIONAL STOCKPILE)	T3	
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	T3	
ENGERIX-B ADULT	T2	PPACA
ENGERIX-B PEDIATRIC-ADOLESCENT	T2	PPACA
GARDASIL 9	T2	PPACA
HEPLISAV-B	T2	PPACA
IXCHIQ	T3	PPACA
JYNNEOS	T3	
MRESVIA	T3	PPACA
PEDIARIX	T2	PPACA
RECOMBIVAX HB	T2	PPACA
SHINGRIX	T2	QL (2 doses/lifetime) PPACA
TWINRIX	T2	PPACA
VARIVAX VACCINE	T2	PPACA
ZOSTAVAX	T2	PPACA
BLOOD (Blood Modifiers/Bleeding Disorders)		
AGENTS TO TX THROMBOTIC THROMBOCYTOPENIC PURPURA		
CABLIVI	T4	PA SP

T1 – Typically Generics
T2 – Typically Preferred Brands
T3 – Typically Non-Preferred Brands
T4 – Specialty Medications
PA – Prior Authorization
QL – Quantity Limit
ST – Step Therapy
AGE – Age Requirement
SP – Specialty Medication
HD – May require home delivery pharmacy
PPACA – No Cost-Share Preventive Medication
CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

BLOOD (Blood Modifiers/Bleeding Disorders) *(cont.)*		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
ANTI-FIBRINOLYTIC AGENTS		
AMICAR (*aminocaproic acid*)	T4	SP HD
aminocaproic acid (Amicar)	T4	SP HD
LYSTEDA (*tranexamic acid*)	T4	SP
tranexamic acid (Lysteda)	T4	SP
ANTI-HEMOPHILIC FACTORS		
ALTUVIIIO	T4	PA SP HD
COMPLEMENT INHIBITORS		
FABHALTA	T4	PA QL(2 caps/day) SP
TAVNEOS	T4	PA QL(6 caps/day) SP
VOYDEYA	T4	PA QL(1 packet/28 days) SP
HEMOPHILIA TREATMENT AGENTS, NON-FACTOR REPLACEMENT		
ALHEMO PEN	T4	PA SP
HEMLIBRA	T4	PA SP HD
HYMPAVZI PEN	T4	PA SP
SICKLE CELL ANEMIA AGENTS		
DROXIA	T2	
ENDARI	T3	
SIKLOS	T3	PA
TOPICAL HEMOSTATICS		
ASTRINGYN	T3	
AVITENE	T3	
ENDO-AVITENE	T3	
EVICEL	T3	
gelatin sponge, absorb/porcine (Gelfoam)	T1	
GELFOAM (*surgifoam*)	T3	
GELFOAM COMPRESSED	T3	
MONSEL'S	T3	
RAPLIXA	T3	
RECOTHROM	T3	
SURGIFOAM	T1	
SYRINGE AVITENE	T3	
THROMBI-GEL	T3	
THROMBIN-JMI	T3	
THROMBI-PAD	T3	

T1 – Typically Generics
T2 – Typically Preferred Brands
T3 – Typically Non-Preferred Brands
T4 – Specialty Medications
PA – Prior Authorization
QL – Quantity Limit
ST – Step Therapy
AGE – Age Requirement
SP – Specialty Medication
HD – May require home delivery pharmacy
PPACA – No Cost-Share Preventive Medication
CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

BLOOD (Blood Thinners/Anti-Clotting)		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
HEMORRHEOLOGIC AGENTS		
ULTRAFOAM	T3	
pentoxifylline	T1	HD
CARDIAC DRUGS (Blood Pressure/Heart Medications)		
ANTI-ANGINAL, ANTI-ISCHEMIC AGENTS, NON-HEMODYNAMIC		
ranolazine (Ranexa)	T1	QL (4 tabs/day) HD
ANTI-ARRHYTHMICS		
amiodarone hcl	T1	HD
MULTAQ	T2	HD
NORPACE (*disopyramide phosphate*)	T3	PA HD
NORPACE CR	T3	HD
pacerone 100 mg tablet	T3	PA HD
pacerone 200 mg tablet	T1	HD
pacerone 400 mg tablet	T3	PA HD
propafenone hcl	T1	HD
propafenone hcl (Rythmol Sr)	T1	HD
quinidine gluconate	T1	HD
RYTHMOL SR (*propafenone hcl er*)	T3	PA HD
TIKOSYN 125 MCG CAPSULE (*dofetilide*)	T3	PA QL (8 caps/day) HD
TIKOSYN 250 MCG CAPSULE (*dofetilide*)	T3	PA QL (4 caps/day) HD
TIKOSYN 500 MCG CAPSULE (*dofetilide*)	T3	PA QL (2 caps/day) HD
CALCIUM CHANNEL BLOCKING AGENTS		
ADALAT CC (*nifedipine er*)	T3	HD
amlodipine besylate (Norvasc)	T1	HD
CALAN SR (*verapamil er*)	T3	HD
CAMZYOS	T4	PA QL (30caps/30days) SP
CARDIZEM LA 180 MG TABLET (*matzim la*)	T3	HD
CARDIZEM LA 240 MG TABLET (*matzim la*)	T3	HD
CARDIZEM LA 300 MG TABLET (*matzim la*)	T3	HD
CARDIZEM LA 360 MG TABLET (*matzim la*)	T3	HD
CARDIZEM LA 420 MG TABLET (*matzim la*)	T3	HD
diltiazem 24h er(la) 120 mg tb (Cardizem La)	T1	QL(1 tab/day) HD
diltiazem 24h er(la) 180 mg tb (Cardizem La)	T1	HD
diltiazem 24h er(la) 240 mg tb (Cardizem La)	T1	HD
diltiazem 24h er(la) 300 mg tb (Cardizem La)	T1	HD

T1 – Typically Generics
T2 – Typically Preferred Brands
T3 – Typically Non-Preferred Brands
T4 – Specialty Medications
PA – Prior Authorization
QL – Quantity Limit
ST – Step Therapy
AGE – Age Requirement
SP – Specialty Medication
HD – May require home delivery pharmacy
PPACA – No Cost-Share Preventive Medication
CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

CARDIAC DRUGS (Blood Pressure/Heart Medications) *(cont.)*		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
CALCIUM CHANNEL BLOCKING AGENTS *(cont.)*		
diltiazem 24h er(la) 360 mg tb (Cardizem La)	T1	HD
diltiazem 24h er(la) 420 mg tb (Cardizem La)	T1	HD
diltiazem hcl	T1	HD
diltiazem hcl (Cardizem La)	T1	HD
diltiazem hcl (Tiazac)	T1	HD
felodipine	T1	HD
isradipine	T1	
KATERZIA	T3	QL (10ml/day) HD
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
NYMALIZE	T3	HD
PROCARDIA (*nifedipine*)	T3	HD
SULAR (*nisoldipine*)	T3	HD
TIAZAC (*tiadylt er*)	T3	HD
verapamil hcl	T1	HD
VERELAN (*verapamil hcl*)	T3	HD
VERELAN (*verapamil sr*)	T3	HD
VERELAN PM (*verapamil er pm*)	T3	HD
DIGITALIS GLYCOSIDES		
digoxin	T1	HD
HEART RATE REDUCING, SA SELECTIVE I(F) CURRENT INH.		
CORLANOR 5 MG TABLET *(ivabradine hcl)*	T2	PA HD

T1 – Typically Generics
T2 – Typically Preferred Brands
T3 – Typically Non-Preferred Brands
T4 – Specialty Medications
PA – Prior Authorization
QL – Quantity Limit
ST – Step Therapy
AGE – Age Requirement
SP – Specialty Medication
HD – May require home delivery pharmacy
PPACA – No Cost-Share Preventive Medication
CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

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. *(cont.)*		
CORLANOR 7.5 MG TABLET *(ivabradine hcl)*	T2	PA HD
CORLANOR 5 MG/5 ML ORAL SOLN	T4	PA SP HD
ivabradine hcl (Corlanor)	T1	PA.HD
VASODILATORS, CORONARY		
DILATRATE-SR	T3	HD
isosorbide dinitrate	T1	HD
MINITRAN	T1	HD
NITRO-DUR	T3	HD
nitroglycerin 0.3 mg tablet sl (Nitrostat)	T1	HD
nitroglycerin 0.4 mg tablet sl (Nitrostat)	T1	HD
nitroglycerin 0.6 mg tablet sl (Nitrostat)	T1	HD
nitroglycerin 400 mcg spray (Nitrolingual)	T1	HD
nitroglycerin (Nitro-dur)	T1	HD
nitroglycerin (Nitromist)	T1	HD
NITROLINGUAL (*nitroglycerin*)	T3	HD
NITROMIST (*nitroglycerin*)	T3	HD
NITROSTAT (*nitroglycerin*)	T3	HD
CARDIOVASCULAR (Asthma/COPD/Respiratory)		
PULM ANTI-HTN, SOLUBLE GUANYLATE CYCLASE STIMULATOR		
ADEMPAS	T4	PA SP HD
VERQUVO	T3	QL(1 tab/day)
PULM.ANTI-HTN, SEL.C-GMP PHOSPHODIESTERASE T5 INHIB		
sildenafil 10 mg/ml oral susp (Revatio)	T4	PA SP HD
sildenafil 20 mg tablet (Revatio)	T4	PA SP HD
tadalafil (Adcirca)	T4	PA SP HD
tadalafil 20 mg tablet (Adcirca)	T4	PA SP HD
PULMONARY ANTI-HTN, ENDOTHELIN RECEPTOR ANTAGONIST		
ambrisentan (Letairis)	T4	PA SP HD
bosentan (Tracleer)	T4	PA SP HD
OPSUMIT	T4	PA SP HD
TRACLEER 125 MG TABLET (*bosentan*)	T4	PA SP HD
TRACLEER 32 MG TABLET FOR SUSP	T4	PA SP HD
TRACLEER 62.5 MG TABLET (*bosentan*)	T4	PA SP HD

T1 – Typically Generics
T2 – Typically Preferred Brands
T3 – Typically Non-Preferred Brands
T4 – Specialty Medications
PA – Prior Authorization
QL – Quantity Limit
ST – Step Therapy
AGE – Age Requirement
SP – Specialty Medication
HD – May require home delivery pharmacy
PPACA – No Cost-Share Preventive Medication
CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

CARDIOVASCULAR (Asthma/COPD/Respiratory) *(cont.)*		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
PULMONARY ANTIHYPER AGENT, ACTRIIA-FC		
WINREVAIR	T4	PA SP HD
PULMONARY ANTIHYPERTENSIVES, PROSTACYCLIN-TYPE		
ORENITRAM ER	T4	PA SP HD
ORENITRAM MONTH 1 TITRATION KT	T4	PA QL(168 tabs/180 days) SP HD
ORENITRAM MONTH 2 TITRATION KT	T4	PA QL(336 tabs/180 days) SP HD
ORENITRAM MONTH 3 TITRATION KT	T4	PA QL(252 tabs/180 days) SP HD
TYVASO	T4	PA SP HD
TYVASO DPI	T4	PA SP HD
TYVASO INSTITUTIONAL START KIT	T4	PA SP HD
TYVASO REFILL KIT	T4	PA SP HD
TYVASO STARTER KIT	T4	PA SP HD
UPTRAVI	T4	PA SP HD
VENTAVIS	T4	PA SP HD
PULMONARY ANTIHYPERTENSIVES, PROSTACYCLIN-TYPE		
OPSYNVI	T4	PA QL(1 tab/day) SP HD
SOLUBLE GUANYLATE CYCLASE (SGC) STIMULATOR		
VERQUVO	T2	PA QL(1 tab/day)
CARDIOVASCULAR (Blood Pressure/Heart Medications)		
ACE INHIBITOR-CALCIUM CHANNEL BLOCKER COMBINATION		
amlodipine besylate/benazepril	T1	HD
PRESTALIA 14 MG-10 MG TABLET	T3	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
trandolapril/verapamil hcl	T1	HD
ACE INHIBITOR-THIAZIDE OR THIAZIDE-LIKE DIURETIC		
benazepril/hydrochlorothiazide	T1	HD
captopril-hctz 25-15 mg tablet	T1	QL (3 tabs/day) HD
captopril-hctz 25-25 mg tablet	T1	QL (2 tabs/day) HD
captopril-hctz 50-15 mg tablet	T1	QL (3 tabs/day) HD
captopril-hctz 50-25 mg tablet	T1	QL (2 tabs/day) HD
enalapril/hydrochlorothiazide	T1	HD
fosinopril/hydrochlorothiazide	T1	HD
lisinopril/hydrochlorothiazide	T1	HD
quinapril/hydrochlorothiazide	T1	HD

T1 – Typically Generics
T2 – Typically Preferred Brands
T3 – Typically Non-Preferred Brands
T4 – Specialty Medications
PA – Prior Authorization
QL – Quantity Limit
ST – Step Therapy
AGE – Age Requirement
SP – Specialty Medication
HD – May require home delivery pharmacy
PPACA – No Cost-Share Preventive Medication
CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

CARDIOVASCULAR (Blood Pressure/Heart Medications) *(cont.)*		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
ALPHA/BETA-ADRENERGIC BLOCKING AGENTS		
carvedilol (Coreg)	T1	HD
carvedilol er 10 mg capsule (Coreg Cr)	T1	QL (1 cap/day) HD
carvedilol er 40 mg capsule (Coreg Cr)	T1	QL (1 cap/day) HD
carvedilol er 80 mg capsule (Coreg Cr)	T1	HD
COREG (*carvedilol*)	T3	ST HD
COREG CR 10 MG CAPSULE (*carvedilol er*)	T3	QL (1 cap/day) ST HD
COREG CR 20 MG CAPSULE (*carvedilol er*)	T3	QL (1 cap/day) ST HD
COREG CR 40 MG CAPSULE (*carvedilol er*)	T3	QL (1 cap/day) ST HD
COREG CR 80 MG CAPSULE (*carvedilol er*)	T3	ST HD
labetalol hcl	T1	HD
CARDURA (*doxazosin mesylate*)	T3	HD
CARDURA XL	T3	HD
MINIPRESS (*prazosin hcl*)	T3	HD
prazosin hcl	T1	HD
terazosin hcl	T1	HD
ANGIOTEN.RECEPTR ANTAG-CALCIUM CHANL BLKR-THIAZIDE		
amlodipine/valsartan/hcthiazid	T1	HD
olmesartan/amlodipin/hcthiazid	T1	HD
valsartan/hydrochlorothiazide (Diovan Hct)	T1	HD
ANGIOTENSIN RECEPT-NEPRILYSIN INHIBITOR COMB (ARNI)		
ENTRESTO SPRINKLE	T2	QL(2 tabs/day)
sacubitril/valsartan (Entresto)	T1	QL(2 tabs/day) HD
ANGIOTENSIN RECEPTOR ANTAG.-THIAZIDE DIURETIC COMB		
candesartan/hydrochlorothiazid	T1	HD
irbesartan/hydrochlorothiazide	T1	HD
losartan/hydrochlorothiazide	T1	HD
olmesartan-hctz 20-12.5 mg tab	T1	QL (1 tab/day) HD
olmesartan-hctz 40-12.5 mg tab	T1	HD
olmesartan-hctz 40-25 mg tab	T1	HD
telmisartan-hctz 40-12.5 mg tb	T1	QL (1 tab/day) HD
telmisartan-hctz 80-12.5 mg tb	T1	HD
telmisartan-hctz 80-25 mg tab	T1	HD
valsartan/hydrochlorothiazide	T1	HD

T1 – Typically Generics
T2 – Typically Preferred Brands
T3 – Typically Non-Preferred Brands
T4 – Specialty Medications
PA – Prior Authorization
QL – Quantity Limit
ST – Step Therapy
AGE – Age Requirement
SP – Specialty Medication
HD – May require home delivery pharmacy
PPACA – No Cost-Share Preventive Medication
CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

CARDIOVASCULAR (Blood Pressure/Heart Medications) *(cont.)*		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
ANGIOTENSIN RECEPTOR BLOCKR-CALCIUM CHANNEL BLOCKR *(cont.)*		
amlodipine besylate/valsartan	T1	HD
amlodipine-olmesartan 10-20 mg	T1	HD
amlodipine-olmesartan 10-40 mg	T1	HD
amlodipine-olmesartan 5-20 mg	T1	QL (1 tab/day) HD
amlodipine-olmesartan 5-40 mg	T1	HD
telmisartan-amlodipine 40-10	T1	HD
telmisartan-amlodipine 40-5 mg	T1	QL (1 tab/day) HD
telmisartan-amlodipine 80-10	T1	HD
telmisartan-amlodipine 80-5 mg	T1	HD
ANTI-HYPERTENSIVES, ACE INHIBITORS		
benazepril hcl	T1	HD
captopril	T1	HD
enalapril maleate (Vasotec)	T1	HD
EPANED	T3	HD
fosinopril sodium	T1	HD
lisinopril (Zestril)	T1	HD
moexipril hcl	T1	HD
perindopril erbumine	T1	HD
quinapril hcl	T1	HD
ramipril	T1	HD
trandolapril	T1	HD
ANTI-HYPERTENSIVES, ANGIOTENSIN RECEPTOR ANTAGONIST		
candesartan cilexetil	T1	HD
eprosartan mesylate	T1	HD
irbesartan	T1	HD
losartan potassium	T1	HD
olmesartan medoxomil 20 mg tab (Benicar)	T1	QL (1 tab/day) HD
olmesartan medoxomil 40 mg tab (Benicar)	T1	HD
olmesartan medoxomil 5 mg tab (Benicar)	T1	HD
telmisartan 20 mg tablet	T1	QL (1 tab/day) HD
telmisartan 40 mg tablet	T1	QL (1 tab/day) HD
telmisartan 80 mg tablet	T1	HD
valsartan	T1	HD

T1 – Typically Generics
T2 – Typically Preferred Brands
T3 – Typically Non-Preferred Brands
T4 – Specialty Medications
PA – Prior Authorization
QL – Quantity Limit
ST – Step Therapy
AGE – Age Requirement
SP – Specialty Medication
HD – May require home delivery pharmacy
PPACA – No Cost-Share Preventive Medication
CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

CARDIOVASCULAR (Blood Pressure/Heart Medications) *(cont.)*		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
ANTI-HYPERTENSIVES, GANGLIONIC BLOCKERS		
VECAMYL	T1	
ANTI-HYPERTENSIVES, MISCELLANEOUS		
DEMSER (*metyrosine*)	T3	HD
metyrosine (Demser)	T1	HD
ANTI-HYPERTENSIVES, SYMPATHOLYTIC		
CATAPRES-TTS 1 (*clonidine*)	T3	HD
CATAPRES-TTS 2 (*clonidine*)	T3	HD
CATAPRES-TTS 3 (*clonidine*)	T3	HD
clonidine (Catapres-tts 1)	T1	HD
clonidine (Catapres-tts 2)	T1	HD
clonidine (Catapres-tts 3)	T1	HD
guanfacine hcl	T1	HD
methyldopa	T1	HD
methyldopa/hydrochlorothiazide	T1	HD
ANTI-HYPERTENSIVES, VASODILATORS		
hydralazine hcl	T1	HD
minoxidil	T1	HD
BETA-ADRENERGIC BLOCKING AGENTS		
acebutolol hcl	T1	HD
atenolol (Tenormin)	T1	HD
betaxolol hcl	T1	HD
INNOPRAN XL	T3	ST HD
metoprolol succinate (Toprol Xl)	T1	HD
metoprolol tartrate	T1	HD
metoprolol tartrate (Lopressor)	T1	HD
nadolol	T1	HD
pindolol	T1	HD
propranolol hcl	T1	HD
propranolol hcl (Inderal La)	T1	HD
sotalol hcl	T1	HD
sotalol hcl (Betapace Af)	T1	HD
SOTYLIZE	T3	HD
timolol maleate	T1	HD

T1 – Typically Generics
T2 – Typically Preferred Brands
T3 – Typically Non-Preferred Brands
T4 – Specialty Medications
PA – Prior Authorization
QL – Quantity Limit
ST – Step Therapy
AGE – Age Requirement
SP – Specialty Medication
HD – May require home delivery pharmacy
PPACA – No Cost-Share Preventive Medication
CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

CARDIOVASCULAR (Blood Pressure/Heart Medications) *(cont.)*		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
BETA-BLOCKERS AND THIAZIDE, THIAZIDE-LIKE DIURETICS		
atenolol/chlorthalidone (Tenoretic 100)	T1	HD
atenolol/chlorthalidone (Tenoretic 50)	T1	HD
bisoprolol/hydrochlorothiazide (Ziac)	T1	HD
metoprolol/hydrochlorothiazide	T1	HD
nadolol/bendroflumethiazide	T1	HD
propranolol/hydrochlorothiazid	T1	HD
RENIN INHIBITOR, DIRECT		
aliskiren 150 mg tablet	T1	QL (1 tab/day) HD
aliskiren 300 mg tablet	T1	HD
VASODILATORS, COMBINATION		
isosorbide-hydralazine 20-37.5 (Bidil)	T1	QL(6 tabs/day) HD
isosorbide-hydralazine (Bidil)	T1	QL(6 tabs/day) HD
VASODILATORS, PERIPHERAL		
ergoloid mesylates	T1	
isoxsuprine hcl	T1	
CARDIOVASCULAR (Cholesterol Medications)		
ANTI-HYPERLIP.HMG COA REDUCT INHIB-CHOLEST.AB.INHIB		
ezetimibe/simvastatin	T1	HD
ANTI-HYPERLIPID- HMG-COA RI-CALCIUM CHANNEL BLOCKER		
amlodipine-atorvast 10-40 mg (Caduet)	T1	HD
amlodipine-atorvast 10-80 mg (Caduet)	T1	HD
amlodipine-atorvast 2.5-10 mg	T1	HD
amlodipine-atorvast 2.5-20 mg	T1	QL (1 tab/day) HD
amlodipine-atorvast 2.5-40 mg	T1	QL (1 tab/day) HD
amlodipine-atorvast 5-10 mg (Caduet)	T1	HD
amlodipine-atorvast 5-20 mg (Caduet)	T1	QL (1 tab/day) HD
amlodipine-atorvast 5-40 mg (Caduet)	T1	QL (1 tab/day) HD
amlodipine-atorvast 5-80 mg (Caduet)	T1	HD
CADUET 10 MG-10 MG TABLET (*amlodipine-atorvastatin*)	T3	HD
CADUET 10 MG-20 MG TABLET (*amlodipine-atorvastatin*)	T3	HD
CADUET 10 MG-40 MG TABLET (*amlodipine-atorvastatin*)	T3	HD
CADUET 10 MG-80 MG TABLET (*amlodipine-atorvastatin*)	T3	HD
CADUET 5 MG-10 MG TABLET (*amlodipine-atorvastatin*)	T3	HD
CADUET 5 MG-20 MG TABLET (*amlodipine-atorvastatin*)	T3	QL (1 tab/day) HD

T1 – Typically Generics
T2 – Typically Preferred Brands
T3 – Typically Non-Preferred Brands
T4 – Specialty Medications
PA – Prior Authorization
QL – Quantity Limit
ST – Step Therapy
AGE – Age Requirement
SP – Specialty Medication
HD – May require home delivery pharmacy
PPACA – No Cost-Share Preventive Medication
CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

CARDIOVASCULAR (Cholesterol Medications) *(cont.)*		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
ANTI-HYPERLIPID- HMG-COA RI-CALCIUM CHANNEL BLOCKER *(cont.)*		
CADUET 5 MG-40 MG TABLET (*amlodipine-atorvastatin*)	T3	QL (1 tab/day) HD
CADUET 5 MG-80 MG TABLET (*amlodipine-atorvastatin*)	T3	HD
ANTI-HYPERLIPIDEMIC - APO B-100 SYNTHESIS INHIBITOR		
KYNAMRO	T4	PA SP
ANTIHYPERLIPIDEMIC - APOLIPOPROTEIN INHIBITOR		
TRYNGOLZA	T3	PA QL SP
ANTI-HYPERLIPIDEMIC - PCSK9 INHIBITORS		
REPATHA PUSHTRONEX	T2	
REPATHA SURECLICK	T2	
REPATHA SYRINGE	T2	
ANTI-HYPERLIPIDEMIC-HMGCOA REDUCTASE INHIB (Statins)		
atorvastatin 10 mg tablet	T1	HD PPACA
atorvastatin 20 mg tablet	T1	HD PPACA
atorvastatin 40 mg tablet	T1	HD
atorvastatin 80 mg tablet	T1	HD
fluvastatin sodium	T1	HD PPACA
lovastatin 10 mg tablet	T1	HD
lovastatin 20 mg tablet	T1	HD PPACA
lovastatin 40 mg tablet	T1	HD PPACA
pitavastatin 1 mg tablet	T1	QL(1 tab/day) HD PPACA
pitavastatin 2 mg tablet	T1	QL(1 tab/day) HD PPACA
pitavastatin 4 mg tablet	T1	HD PPACA
pravastatin sodium	T1	HD PPACA
rosuvastatin calcium 20 mg tab (Crestor)	T1	QL(1 tab/day) HD
rosuvastatin calcium 40 mg tab (Crestor)	T1	HD
rosuvastatin calcium 10 mg tab	T1	QL (1 tab/day) HD PPACA
rosuvastatin calcium 20 mg tab	T1	QL (1 tab/day) HD
rosuvastatin calcium 40 mg tab	T1	HD
rosuvastatin calcium 5 mg tab	T1	QL (1 tab/day) HD PPACA
simvastatin 10 mg tablet	T1	HD PPACA
simvastatin 20 mg tablet	T1	HD PPACA
amlodipine-atorvast 2.5-10 mg	T1	HD
amlodipine-atorvast 2.5-20 mg	T1	QL (1 tab/day) HD
amlodipine-atorvast 2.5-40 mg	T1	QL (1 tab/day) HD

T1 – Typically Generics
T2 – Typically Preferred Brands
T3 – Typically Non-Preferred Brands
T4 – Specialty Medications
PA – Prior Authorization
QL – Quantity Limit
ST – Step Therapy
AGE – Age Requirement
SP – Specialty Medication
HD – May require home delivery pharmacy
PPACA – No Cost-Share Preventive Medication
CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

CARDIOVASCULAR (Cholesterol Medications) *(cont.)*		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
ANTI-HYPERLIPIDEMIC-HMGCOA REDUCTASE INHIB (Statins) *(cont.)*		
amlodipine-atorvast 5-10 mg (Caduet)	T1	HD
amlodipine-atorvast 5-20 mg (Caduet)	T1	QL (1 tab/day) HD
amlodipine-atorvast 5-40 mg (Caduet)	T1	QL (1 tab/day) HD
amlodipine-atorvast 5-80 mg (Caduet)	T1	HD
CADUET 10 MG-10 MG TABLET (*amlodipine-atorvastatin*)	T3	HD
CADUET 10 MG-20 MG TABLET (*amlodipine-atorvastatin*)	T3	HD
CADUET 10 MG-40 MG TABLET (*amlodipine-atorvastatin*)	T3	HD
CADUET 10 MG-80 MG TABLET (*amlodipine-atorvastatin*)	T3	HD
CADUET 5 MG-10 MG TABLET (*amlodipine-atorvastatin*)	T3	HD
CADUET 5 MG-20 MG TABLET (*amlodipine-atorvastatin*)	T3	QL (1 tab/day) HD
CADUET 5 MG-40 MG TABLET (*amlodipine-atorvastatin*)	T3	QL (1 tab/day) HD
CADUET 5 MG-80 MG TABLET (*amlodipine-atorvastatin*)	T3	HD
CADUET 10 MG-40 MG TABLET (*amlodipine-atorvastatin*)	T3	HD
CADUET 10 MG-80 MG TABLET (*amlodipine-atorvastatin*)	T3	HD
CADUET 5 MG-10 MG TABLET (*amlodipine-atorvastatin*)	T3	HD
CADUET 5 MG-20 MG TABLET (*amlodipine-atorvastatin*)	T3	QL (1 tab/day) HD
CADUET 5 MG-40 MG TABLET (*amlodipine-atorvastatin*)	T3	QL (1 tab/day) HD
CADUET 5 MG-80 MG TABLET (*amlodipine-atorvastatin*)	T3	HD
simvastatin 40 mg tablet	T1	HD PPACA
simvastatin 5 mg tablet	T1	HD
simvastatin 80 mg tablet	T1	QL (1 tab/day) HD
BILE SALT SEQUESTRANTS		
cholestyramine (with sugar) (Questran)	T1	HD
cholestyramine/aspartame	T1	HD
cholestyramine/aspartame (Questran Light)	T1	HD
colesevelam hcl (Welchol)	T1	HD
COLESTID (*colestipol hcl*)	T3	HD
colestipol hcl (	T1	HD
QUESTRAN (*cholestyramine*)	T3	HD
QUESTRAN LIGHT (*prevalite*)	T3	HD
LIPOTROPICS		
ezetimibe (Zetia)	T1	HD
fenofibrate 40 mg, 120 mg tablet (Fenoglide)	T1	HD
fenofibrate	T1	HD

T1 – Typically Generics
T2 – Typically Preferred Brands
T3 – Typically Non-Preferred Brands
T4 – Specialty Medications
PA – Prior Authorization
QL – Quantity Limit
ST – Step Therapy
AGE – Age Requirement
SP – Specialty Medication
HD – May require home delivery pharmacy
PPACA – No Cost-Share Preventive Medication
CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

CARDIOVASCULAR (Cholesterol Medications) *(cont.)*		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
BILE SALT SEQUESTRANTS *(cont.)*		
fenofibrate nanocrystallized (Tricor)	T1	HD
fenofibrate, micronized	T1	HD
fenofibric acid (choline) (Trilipix)	T1	HD
fenofibric acid (Fibricor)	T1	HD
FIBRICOR (*fenofibric acid*)	T3	ST HD
gemfibrozil (Lopid)	T1	HD
LIPOFEN	T3	ST HD
LOPID (*gemfibrozil*)	T3	HD
niacin (Niaspan)	T1	HD
NIASPAN (*niacin er*)	T3	HD
TRICOR (*fenofibrate*)	T3	ST HD
TRIGLIDE	T3	ST HD
TRILIPIX (*fenofibric acid*)	T3	ST HD
CARDIOVASCULAR (Miscellaneous)		
ENDOTHELIN-ANGIOTENSIN RECEPTOR ANTAGONIST		
FILSPARI	T4	PA QL(1 tab/day) SP
CNS DRUGS (Alzheimer's Disease)		
ALZHEIMER'S THERAPY, NMDA RECEPTOR ANTAGONISTS		
memantine hcl	T1	HD
memantine hcl er 14 mg capsule (Namenda Xr)	T1	QL (1 cap/day) HD
memantine hcl er 28 mg capsule (Namenda Xr)	T1	HD
NAMENDA	T3	HD
NAMENDA XR 14 MG CAPSULE (*memantine hcl er*)	T3	QL (1 cap/day) HD
NAMENDA XR 28 MG CAPSULE (*memantine hcl er*)	T3	HD
NAMENDA XR 7 MG CAPSULE (*memantine hcl er*)	T3	QL (1 cap/day) HD
NAMENDA XR TITRATION PACK	T3	QL (112/365 days) HD
ALZHEIMER'S THX, NMDA RECEPTOR ANTAG-CHOLINES INHIB		
NAMZARIC 14 MG-10 MG CAPSULE	T3	QL (2 caps/day) HD
NAMZARIC 21 MG-10 MG CAPSULE	T3	QL (2 caps/day) HD
NAMZARIC 28 MG-10 MG CAPSULE	T3	QL (2 caps/day) HD
NAMZARIC 7 MG-10 MG CAPSULE	T3	QL (2 caps/day) HD
NAMZARIC TITRATION PACK	T3	QL (112/365 days) HD

T1 – Typically Generics
T2 – Typically Preferred Brands
T3 – Typically Non-Preferred Brands
T4 – Specialty Medications
PA – Prior Authorization
QL – Quantity Limit
ST – Step Therapy
AGE – Age Requirement
SP – Specialty Medication
HD – May require home delivery pharmacy
PPACA – No Cost-Share Preventive Medication
CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

CNS DRUGS (Miscellaneous)		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
AMYOTROPHIC LATERAL SCLEROSIS AGENTS		
RILUTEK (*riluzole*)	T3	SP HD
RADICAVA ORS	T3	PA QL (50ml/28days) SP
riluzole (Rilutek)	T1	SP HD
TIGLUTIK	T3	PA SP
DRUGS TO TREAT MOVEMENT DISORDERS		
AUSTEDO	T4	PA SP HD
AUSTEDO XR 6MG	T4	PA QL(3 tabs/day) SP HD
AUSTEDO XR 12MG	T4	PA QL(1 tab/day) SP HD
AUSTEDO XR 18MG	T4	PA QL(1 tab/day) SP HD
AUSTEDO XR 24MG	T4	PA QL(2 tabs/day) SP HD
AUSTEDO XR 48 MG TABLET	T4	PA QL SP HD
AUSTEDO XR TITRATION KT(WK1-4)	T4	PA QL(1 kit/180 days) SP HD
INGREZZA INITIATION PK(TARDIV)	T4	PA QL(28 caps/365 days) SP
INGREZZA	T4	PA QL(1 cap/day) SP
tetrabenazine	T4	PA SP HD
PSEUDOBULBAR AFFECT (PBA) AGENTS, NMDA ANTAGONISTS		
NUEDEXTA	T3	QL (4 caps/day)
XANTHINES		
caffeine citrate	T1	HD
CNS DRUGS (Multiple Sclerosis)		
AGENTS TO TREAT MULTIPLE SCLEROSIS		
AVONEX	T4	PA SP HD
AVONEX PEN	T4	PA SP HD
BAFIERTAM	T4	PA SP HD
BETASERON	T4	PA SP HD
dimethyl fumarate	T4	HD
glatiramer	T4	HD
glatiramer acetate	T4	PA SP HD
glatopa	T4	HD
KESIMPTA PEN	T4	PA SP HD
MAVENCLAD	T4	PA SP HD

T1 – Typically Generics
T2 – Typically Preferred Brands
T3 – Typically Non-Preferred Brands
T4 – Specialty Medications
PA – Prior Authorization
QL – Quantity Limit
ST – Step Therapy
AGE – Age Requirement
SP – Specialty Medication
HD – May require home delivery pharmacy
PPACA – No Cost-Share Preventive Medication
CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

CNS DRUGS (Multiple Sclerosis) *(cont.)*		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
AGENTS TO TREAT MULTIPLE SCLEROSIS *(cont.)*		
MAYZENT	T4	PA SP HD
PLEGRIDY	T4	PA SP HD
PLEGRIDY PEN	T4	PA SP HD
REBIF	T4	PA SP HD
REBIF REBIDOSE	T4	PA SP HD
teriflunomide (Aubagio)	T4	SP HD
VUMERITY	T4	PA SP HD
AGTS TX NEUROMUSC TRANSMISSION DIS, POT-CHAN BLKR		
dalfampridine	T4	PA SP HD
FIRDAPSE	T4	PA QL (8 tabs/day) SP
RUZURGI	T4	PA SP
CNS DRUGS (Pain Relief And Inflammatory Disease)		
CALCITONIN GENE-RELATED PEPTIDE (CGRP) INHIBITORS		
EMGALITY SYRINGE	T2	PA
SPHINGOSINE I-PHOSPHATE (SIP) RECEPTOR MODULATOR		
VELSIPITY	T4	PA QL(30 tabs/30 days) SP HD
SPHINGOSINE I-PHOSPHATE (SIP) RECEPTOR MODULATOR		
ZEPOSIA	T4	PA SP HD
POSTHERPETIC NEURALGIA AGENTS		
gabapentin (Gralise)	T1	
CNS DRUGS (Seizure Disorders)		
ANTI-CONVULSANT - BENZODIAZEPINE TYPE		
clobazam (Onfi)	T1	HD
clonazepam (Klonopin)	T1	HD
DIASTAT (*diazepam*)	T3	PA HD
diazepam 10 mg rectal gel syst	T1	HD
diazepam 2.5 mg rectal gel sys (Diastat)	T1	HD
diazepam 20 mg rectal gel syst	T1	HD
KLONOPIN (*clonazepam*)	T3	PA HD
LIBERVANT	T3	QL(10 films/30 days) HD
NAYZILAM	T2	PA QL (5 kits/30 days) HD
ONFI (*clobazam*)	T3	PA HD
VALTOCO	T2	PA QL (10 packs/22 days) HD

T1 – Typically Generics
T2 – Typically Preferred Brands
T3 – Typically Non-Preferred Brands
T4 – Specialty Medications
PA – Prior Authorization
QL – Quantity Limit
ST – Step Therapy
AGE – Age Requirement
SP – Specialty Medication
HD – May require home delivery pharmacy
PPACA – No Cost-Share Preventive Medication
CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

CNS DRUGS (Seizure Disorders) *(cont.)*		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
ANTI-CONVULSANT - CANNABINOID TYPE		
EPIDIOLEX	T4	PA SP HD
ANTI-CONVULSANTS		
APTIOM 200 MG, 400 MG TABLET	T3	PA QL (1 tab/day) HD
APTIOM 600 MG, 800 MG TABLET	T3	PA HD
BANZEL 200 MG TABLET	T3	PA QL (16 tabs/day) HD
BANZEL 400 MG TABLET	T3	PA QL (8 tabs/day) HD
BRIVIACT	T3	PA HD
carbamazepine	T1	HD
CARBAMAZEPINE 200 MG TAB CHEW	T3	HD
carbamazepine (Carbatrol)	T1	HD
carbamazepine (Tegretol Xr)	T1	HD
carbamazepine (Tegretol)	T1	HD
CARBATROL (*carbamazepine er*)	T3	PA HD
CELONTIN	T2	HD
DIACOMIT	T4	PA SP HD
DILANTIN 100 MG CAPSULE (*phenytoin sodium extended*)	T3	PA HD
DILANTIN 30 MG CAPSULE	T2	PA HD
DILANTIN 50 MG INFATAB (*phenytoin*)	T3	PA HD
DILANTIN-125 (*phenytoin*)	T3	PA HD
divalproex sodium (Depakote Er)	T1	HD
divalproex sodium (Depakote Sprinkle)	T1	HD
divalproex sodium (Depakote)	T1	HD
ethosuximide (Zarontin)	T1	HD
eslicarbazepine 200 mg, 400 mg tablet	T1	PA QL HD
eslicarbazepine 600 mg, 800 mg tablet	T1	PA HD
felbamate	T1	HD
FINTEPLA	T4	PA SP HD
FYCOMPA 0.5 MG/ML ORAL SUSP	T2	PA HD
gabapentin	T1	HD
gabapentin (Neurontin)	T1	HD
lamotrigine	T1	HD
LYRICA (*pregabalin*)	T3	PA HD
NEURONTIN (*gabapentin*)	T3	PA HD
oxcarbazepine (Oxtellar Xr)	T1	PA HD

T1 – Typically Generics
T2 – Typically Preferred Brands
T3 – Typically Non-Preferred Brands
T4 – Specialty Medications
PA – Prior Authorization
QL – Quantity Limit
ST – Step Therapy
AGE – Age Requirement
SP – Specialty Medication
HD – May require home delivery pharmacy
PPACA – No Cost-Share Preventive Medication
CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

CNS DRUGS (Seizure Disorders) *(cont.)*		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
ANTI-CONVULSANTS *(cont.)*		
OXTELLAR XR	T3	PA HD
PEGANONE	T2	HD
PHENYTEK (*phenytoin sodium extended*)	T3	PA HD
phenytoin (Dilantin)	T1	HD
phenytoin (Dilantin-125)	T1	HD
phenytoin sodium extended (Dilantin)	T1	HD
phenytoin sodium extended (Phenytek)	T1	HD
pregabalin	T1	HD
pregabalin (Lyrica)	T1	HD
primidone	T1	HD
primidone 250 mg tablet (Mysoline)	T1	HD
primidone 50 mg tablet (Mysoline)	T1	HD
rufinamide (Banzel)	T1	PA QL (80ml/day) HD
rufinamide 200 mg tablet (Banzel)	T1	PA QL(16 tabs/day) HD
rufinamide 400 mg tablet (Banzel)	T1	PA QL(8 tabs/day) HD
SPRITAM	T3	PA HD
TEGRETOL (*carbamazepine*)	T3	PA HD
TEGRETOL (*epitol*)	T3	PA HD
TEGRETOL XR (*carbamazepine er*)	T3	PA HD
tiagabine hcl 12 mg tablet	T1	QL (8 tabs/day) HD
tiagabine hcl 16 mg tablet	T1	QL (6 tabs/day) HD
tiagabine hcl 2 mg tablet	T1	HD
tiagabine hcl 4 mg tablet	T1	HD
topiramate (Qudexy Xr)	T1	HD
topiramate er 200 mg capsule (Trokendi Xr)	T1	HD
topiramate er 100 mg capsule (Trokendi Xr)	T1	QL(1 cap/day) HD
topiramate er 50 mg capsule (Trokendi Xr)	T1	HD
topiramate er 25 mg capsule (Trokendi Xr)	T1	QL(1 cap/day) HD
TROKENDI XR 25 MG, 100 MG CAPSULE *(topiramate)*	T3	QL(1 cap/day) HD
TROKENDI XR 50 MG, 200 MG CAPSULE *(topiramate)*	T3	HD
valproic acid	T1	HD
valproic acid (as sodium salt)	T1	HD
vigabatrin	T4	SP HD
VIMPAT	T2	PA HD

T1 – Typically Generics
T2 – Typically Preferred Brands
T3 – Typically Non-Preferred Brands
T4 – Specialty Medications
PA – Prior Authorization
QL – Quantity Limit
ST – Step Therapy
AGE – Age Requirement
SP – Specialty Medication
HD – May require home delivery pharmacy
PPACA – No Cost-Share Preventive Medication
CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

CNS DRUGS (Seizure Disorders) *(cont.)*		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
ANTI-CONVULSANTS *(cont.)*		
XCOPRI 25 MG TABLET	T3	PA QL 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, 300 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 (*ethosuximide*)	T3	PA HD
zonisamide	T1	HD
CNS DRUGS (Sleep Disorders/Sedatives)		
NARCOLEPSY TX-H3-RECEPT.ANTAGONIST/INVERSE AGONIST		
WAKIX	T4	PA QL (2 tabs/day) SP HD
COLONY STIMULATING FACTORS (Blood Modifiers/Bleeding Disorders)		
CXCR4 CHEMOKINE RECEPTOR ANTAGONIST		
XOLREMDI	T4	PA QL(4 caps/day) SP CSL
ERYTHROPOIESIS-STIMULATING AGENTS		
PROCRIT	T4	PA SP
RETACRIT	T4	PA SP
LEUKOCYTE (WBC) STIMULANTS		
FULPHILA	T4	PA SP
GRANIX	T4	PA SP
LEUKINE	T4	SP
NEULASTA	T4	PA SP
NEULASTA ONPRO	T4	PA SP HD
NEUPOGEN	T4	PA SP
NIVESTYM	T4	SP HD
NYPOZI	T4	PA SP
NYVEPRIA	T4	PA SP
ROLVEDON	T4	PA SP
STIMUFEND	T4	PA SP
UDENYCA	T4	PA SP
UDENYCA AUTOINJECTOR	T4	PA SP

T1 – Typically Generics
T2 – Typically Preferred Brands
T3 – Typically Non-Preferred Brands
T4 – Specialty Medications
PA – Prior Authorization
QL – Quantity Limit
ST – Step Therapy
AGE – Age Requirement
SP – Specialty Medication
HD – May require home delivery pharmacy
PPACA – No Cost-Share Preventive Medication
CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

COLONY STIMULATING FACTORS (Blood Modifiers/Bleeding Disorders) *(con't.)*		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
LEUKOCYTE (WBC) STIMULANTS *(con't.)*		
ZARXIO	T4	SP HD
ZIEXTENZO	T4	PA SP
THROMBOPOIETIN RECEPTOR AGONISTS		
DOPTELET	T4	PA SP HD
MULPLETA	T4	PA SP HD
CONTRACEPTIVES (Contraception Products)		
CONTRACEPTIVES, INTRAVAGINAL, SYSTEMIC		
etonogestrel/ethinyl estradiol (Nuvaring)	T1	PPACA
NUVARING (*etonogestrel-ethinyl estradiol*)	T3	
CONTRACEPTIVES, IMPLANTABLE		
NEXPLANON	T4	SP PPACA
CONTRACEPTIVES, INJECTABLE		
DEPO-PROVERA *(medroxyprogesterone acetate)*	T3	
DEPO-PROVERA 150 MG/ML SYRINGE (*medroxyprogesterone acetate*)	T3	
DEPO-PROVERA 150 MG/ML VIAL (*medroxyprogesterone acetate*)	T3	
DEPO-SUBQ PROVERA 104	T2	
CONTRACEPTIVES, ORAL		
desog-e.estradiol/e.estradiol	T1	HD PPACA
desogestrel-ethinyl estradiol	T1	HD PPACA
drospir/eth estra/levomefol ca (Beyaz)	T1	HD PPACA
drospir/eth estra/levomefol ca (Safyral)	T1	HD PPACA
ELLA	T3	HD PPACA
ESTROSTEP FE (*tri-legest fe*)	T3	HD
ethinyl estradiol/drospirenone (Yasmin 28)	T1	HD PPACA
ethinyl estradiol/drospirenone (Yaz)	T1	HD PPACA
ethynodiol d-ethinyl estradiol	T1	HD PPACA
GENERESS FE (*norethin-eth estra-ferrous fum*)	T3	HD
levonorgestrel/ethin.estradiol	T1	HD PPACA
levonorgest/eth.estradiol/iron (Balcoltra)	T1	HD PPACA
l-norgest/e.estradiol-e.estrad	T1	HD PPACA
l-norgest/e.estradiol-e.estrad (Quartette)	T1	HD PPACA
LOESTRIN (*norethindrone ac/eth estradiol*)	T3	HD

T1 – Typically Generics
T2 – Typically Preferred Brands
T3 – Typically Non-Preferred Brands
T4 – Specialty Medications
PA – Prior Authorization
QL – Quantity Limit
ST – Step Therapy
AGE – Age Requirement
SP – Specialty Medication
HD – May require home delivery pharmacy
PPACA – No Cost-Share Preventive Medication
CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

CONTRACEPTIVES (Contraception Products) *(cont.)*		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
CONTRACEPTIVES, ORAL *(cont.)*		
LOESTRIN FE (*tarina fe 1-20 eq*)	T3	HD
LOSEASONIQUE (*lojaimiess*)	T3	HD
MICROGESTIN 24 FE (*tarina 24 fe*)	T3	HD
noreth-ethinyl estradiol/iron	T1	HD PPACA
noreth-ethinyl estradiol/iron (Generess Fe)	T1	HD PPACA
noreth-ethinyl estradiol/iron (Generess Fe)	T3	HD PPACA
norethind-eth estrad 1-0.02 mg (Loestrin)	T1	HD PPACA
norethindrone (Ortho Micronor)	T1	HD PPACA
norethindrone ac/eth estradiol (Loestrin)	T1	HD PPACA
norethindrone-e.estradiol-iron	T1	HD PPACA
norethindrone-e.estradiol-iron (Estrostep Fe)	T1	HD PPACA
norethindrone-e.estradiol-iron (Loestrin Fe)	T1	HD PPACA
norethindrone-e.estradiol-iron (Microgestin 24 Fe)	T1	HD PPACA
norethindrone-e.estradiol-iron (Minastrin 24 Fe)	T1	HD PPACA
norethindrone-ethin. estradiol	T1	HD PPACA
norethin-ee 1.5-0.03 mg(21) *tb* (Loestrin)	T1	HD PPACA
norgestrel-ethinyl estradiol	T1	HD PPACA
ORTHO MICRONOR (*tulana*)	T3	HD
QUARTETTE (*rivelsa*)	T3	HD
CONTRACEPTIVES, TRANSDERMAL		
norelgestromin/ethin.estradiol	T1	HD PPACA
DIAPHRAGMS/CERVICAL CAP		
CAYA CONTOURED	T2	PPACA
FEMCAP	T2	PPACA
WIDE SEAL DIAPHRAGM	T3	PPACA
INTRA-UTERINE DEVICES (IUDS)		
KYLEENA	T4	SP PPACA
LILETTA	T4	SP PPACA
MIRENA	T4	SP PPACA
MIUDELLA	T4	SP PPACA
PARAGARD T 380-A	T4	SP PPACA
SKYLA	T4	SP PPACA

T1 – Typically Generics
T2 – Typically Preferred Brands
T3 – Typically Non-Preferred Brands
T4 – Specialty Medications
PA – Prior Authorization
QL – Quantity Limit
ST – Step Therapy
AGE – Age Requirement
SP – Specialty Medication
HD – May require home delivery pharmacy
PPACA – No Cost-Share Preventive Medication
CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
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		
benzonatate	T1	
benzonatate (Tessalon Perle)	T1	
TESSALON PERLE (*benzonatate*)	T3	
NON-OPIOID ANTI-TUS-IST GEN.ANTIHISTAMINE-DECONGEST		
brompheniramine/pseudoephed/dm (Bromfed Dm)	T1	
NON-OPIOID ANTI-TUSSIVE-IST GEN ANTIHISTAMINE COMB.		
promethazine/dextromethorphan	T1	
OPIOID ANTI-TUSSIV-IST GEN. ANTIHISTAMINE-DECONGEST		
hydrocodone/cpm/pseudoephed	T1	PA
promethazine/phenyleph/codeine	T1	PA QL (480ml/22 days)
OPIOID ANTI-TUSSIVE-IST GENERATION ANTIHISTAMINE		
hydrocodone/chlorphen p-stirex	T1	PA
promethazine-codeine solution	T1	PA QL (480ml/22 days)
promethazine-codeine syrup	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 (hydromet)	T3	PA QL (480ml/22 days)
hydrocodone bit/homatrop me-br (Hycodan)	T1	PA QL (480ml/22 days)
hydrocodone-homatropine 5-1.5	T1	PA QL (180 tabs/30 days)
hydrocodone-homatropine soln (Hycodan)	T1	PA QL (480ml/30 days)
HYDROCODONE-HOMATROPINE SYRUP	T1	PA QL (480ml/30 days)
OPIOID ANTI-TUSSIVE-EXPECTORANT COMBINATION		
HYDROCODONE-GUAIFENESIN	T1	PA QL (960ml/30 days)
OBREDON	T3	PA QL (960ml/30 days)
DIAGNOSTIC (Diabetes)		
BLOOD SUGAR DIAGNOSTICS		
FREESTYLE INSULINX	T2	
FREESTYLE INSULINX TEST STRIPS	T2	
FREESTYLE LITE TEST STRIP	T2	

T1 – Typically Generics
T2 – Typically Preferred Brands
T3 – Typically Non-Preferred Brands
T4 – Specialty Medications
PA – Prior Authorization
QL – Quantity Limit
ST – Step Therapy
AGE – Age Requirement
SP – Specialty Medication
HD – May require home delivery pharmacy
PPACA – No Cost-Share Preventive Medication
CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

DIAGNOSTIC (Diabetes)		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
BLOOD SUGAR DIAGNOSTICS		
FREESTYLE PRECISION NEO	T2	
FREESTYLE TEST STRIPS	T2	
PRECISION XTRA TEST STRIPS	T2	
RELION TRUE METRIX TEST STRIP	T2	
TRUE METRIX GLUCOSE TEST STRIP	T2	
DIAGNOSTIC (Miscellaneous)		
DIAGNOSTIC PREPARATIONS, MISCELLANEOUS		
ADVANCED DNA MEDICATED COLLECT	T3	
ARIDOL	T3	
lidocaine hcl/glycerin (Advanced Dna Medicated Collect)	T1	
PROVOCHOLINE	T3	
TC99M SULFUR COLLOID PREP	T1	
EYE DIAGNOSTIC AGENTS		
fluorescein sodium	T1	
ful-glo 1 mg opth strip	T1	
FUL-GLO EYE STRIPS	T3	
lissamine green	T1	
GASTROINTESTINAL RADIOPAQUE DIAGNOSTICS		
ENTERO VU	T3	
E-Z DISK	T3	
E-Z-HD, E-Z-PAQUE, E-Z-PASTE	T3	
GASTROMARK	T3	
LIQUID E-Z PAQUE	T3	
LIQUID POLIBAR PLUS	T3	
NEULUMEX	T3	
POLIBAR ACB	T3	
READI-CAT 2	T3	
SITZMARKS	T3	
TAGITOL V	T3	
VARIBAR HONEY	T3	
VARIBAR NECTAR	T3	
VARIBAR PUDDING	T3	
VARIBAR THIN HONEY	T3	
VARIBAR THIN LIQUID	T3	

T1 – Typically Generics
T2 – Typically Preferred Brands
T3 – Typically Non-Preferred Brands
T4 – Specialty Medications
PA – Prior Authorization
QL – Quantity Limit
ST – Step Therapy
AGE – Age Requirement
SP – Specialty Medication
HD – May require home delivery pharmacy
PPACA – No Cost-Share Preventive Medication
CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

DIAGNOSTIC (Miscellaneous) *(cont.)*		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
METABOLIC FUNCTION DIAGNOSTICS		
METOPIRONE	T3	
RADIOPHARMACEUTICALS ELEMENTS		
INDICLOR	T3	
URINARY TRACT RADIOPAQUE DIAGNOSTICS		
CYSTO-CONRAY II	T3	
CYSTOGRAFIN	T3	
CYSTOGRAFIN-DILUTE	T3	
diatrizoate meglumine, sodium (Gastrografin)	T1	
GASTROGRAFIN (*md-gastroview*)	T3	
DIURETICS (Diuretics)		
ARGININE VASOPRESSIN (AVP) RECEPTOR ANTAGONISTS		
TOLVAPTAN 15 MG TABLET	T4	SP
tolvaptan 30 mg tablet (Samsca)	T4	SP
CARBONIC ANHYDRASE INHIBITORS		
acetazolamide	T1	HD
methazolamide	T1	HD
LOOP DIURETICS		
bumetanide	T1	HD
furosemide	T1	HD
torsemide	T1	HD
POTASSIUM SPARING DIURETICS		
amiloride hcl	T1	HD
CAROSPIR *(spironolactone)*	T2	PA HD
eplerenone (Inspra)	T1	HD
INSPRA (*eplerenone*)	T3	HD
KERENDIA	T2	PA QL (1 tab/day)
spironolactone	T1	HD
spironolact/hydrochlorothiazid	T1	HD
triamterene (Dyrenium)	T1	HD
POTASSIUM SPARING DIURETICS IN COMBINATION		
ALDACTAZIDE	T3	HD
amiloride/hydrochlorothiazide	T1	HD
DYAZIDE (*triamterene-hydrochlorothiazid*)	T3	HD

T1 – Typically Generics
T2 – Typically Preferred Brands
T3 – Typically Non-Preferred Brands
T4 – Specialty Medications
PA – Prior Authorization
QL – Quantity Limit
ST – Step Therapy
AGE – Age Requirement
SP – Specialty Medication
HD – May require home delivery pharmacy
PPACA – No Cost-Share Preventive Medication
CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

DIURETICS (Diuretics) *(cont.)*		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
POTASSIUM SPARING DIURETICS IN COMBINATION *(con't.)*		
spironolact/hydrochlorothiazid (Aldactazide)	T1	HD
triamterene/hydrochlorothiazid (Dyazide)	T1	HD
THIAZIDE AND RELATED DIURETICS		
chlorthalidone	T1	HD
DIURIL	T3	HD
HEMICLOR	T3	HD
hydrochlorothiazide	T1	HD
indapamide	T1	HD
metolazone	T1	HD
EENT PREPS (Allergy/Nasal Sprays)		
NASAL ANTIHISTAMINE		
azelastine 0.1% (137 mcg) *spry*	T1	HD
azelastine 0.15% nasal spray	T1	HD
olopatadine 665 mcg nasal spry (Patanase)	T1	HD
PATANASE (*olopatadine hcl*)	T3	HD
NASAL ANTIHISTAMINE AND ANTI-INFLAM. STEROID COMB.		
azelastine/fluticasone	T1	HD
NASAL ANTI-INFLAMMATORY STEROIDS		
flunisolide	T1	HD
fluticasone prop 50 mcg spray	T1	HD
mometasone furoate 50 mcg spry	T1	QL (4 bots/30 days) HD
NOSE PREPARATIONS, MISCELLANEOUS (RX)		
ipratropium bromide	T1	HD
NOSE PREPARATIONS, VASOCONSTRICTORS (RX)		
ADRENALIN CHLORIDE	T3	
epinephrine hcl (Adrenalin Chloride)	T1	
EENT PREPS (Ear Medications)		
EAR PREPARATIONS ANTI-INFLAMMATORY		
DERMOTIC (*fluocinolone acetonide oil*)	T3	
fluocinolone acetonide oil (Dermotic)	T1	
EAR PREPARATIONS, MISC. ANTI-INFECTIVES		
hydrocortisone/acetic acid	T1	

T1 – Typically Generics
T2 – Typically Preferred Brands
T3 – Typically Non-Preferred Brands
T4 – Specialty Medications
PA – Prior Authorization
QL – Quantity Limit
ST – Step Therapy
AGE – Age Requirement
SP – Specialty Medication
HD – May require home delivery pharmacy
PPACA – No Cost-Share Preventive Medication
CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

EENT PREPS (Eye Conditions)		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
ARTIFICIAL TEARS		
LACRISERT	T3	
EYE ANTI-INFECTIVES (RX ONLY)		
BETADINE	T3	
EYE ANTI-INFLAMMATORY AGENTS		
ACULAR (*ketorolac tromethamine*)	T3	
ACULAR LS (*ketorolac tromethamine*)	T3	
bromfenac sodium	T1	
bromfenac sodium (Bromsite)	T1	
BROMSITE .075%	T2	
dexamethasone sodium phosphate	T1	
diclofenac 0.1% eye drops	T1	
EYSUVIS	T2	QL (8.3ml/14 days)
fluorometholone (Fml)	T1	
flurbiprofen sodium	T1	
ILEVRO	T3	
ketorolac 0.4% ophth solution (Acular Ls)	T1	
ketorolac 0.5% ophth solution (Acular)	T1	
loteprednol etabonate (Alrex)	T1	
loteprednol etabonate (Lotemax)	T1	
MIEBO	T2	QL(4 bottles/30 days)
OMNIPRED (*prednisolone acetate*)	T3	
prednisolone acetate (Pred Forte)	T1	
prednisolone sodium phosphate	T1	
PROLENSA	T3	
EYE LOCAL ANESTHETICS		
AKTEN	T3	
ALCAINE (*proparacaine hcl*)	T3	
ALTAFLUOR BENOX (*flurox*)	T3	
benoxinate hcl/fluorescein sod (Altafluor Benox)	T1	
benoxinate hcl/fluorescein sod (Altafluor Benox)	T3	
proparacaine hcl (Alcaine)	T1	

T1 – Typically Generics
T2 – Typically Preferred Brands
T3 – Typically Non-Preferred Brands
T4 – Specialty Medications
PA – Prior Authorization
QL – Quantity Limit
ST – Step Therapy
AGE – Age Requirement
SP – Specialty Medication
HD – May require home delivery pharmacy
PPACA – No Cost-Share Preventive Medication
CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

EENT PREPS (Eye Conditions) *(cont.)*		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
EYE LOCAL ANESTHETICS *(cont.)*		
proparacaine/fluorescein sod	T1	
proparacaine/fluorescein sod	T3	
tetracaine hcl	T1	
TETRAVISC	T3	
TETRAVISC FORTE	T3	
EYE MAST CELL STABILIZERS		
cromolyn 4% eye drops	T1	
EYE PREPARATIONS, MISCELLANEOUS (OTC)		
GELFILM	T3	
EYE VASOCONSTRICTORS		
phenylephrine hcl	T1	
MIOTICS AND OTHER INTRAOCULAR PRESSURE REDUCERS		
apraclonidine hcl (Iopidine)	T1	HD
betaxolol hcl	T1	HD
BETIMOL	T3	HD
BETOPTIC S	T2	HD
BETOPTIC S 0.25% DROPS	T2	HD
bimatoprost	T1	QL (10 gm/30 days) HD
bimatoprost 0.03% eye drops	T1	QL(10 mls/30 days) HD
brimonidine tartrate	T1	HD
brimonidine tartrate (Alphagan P)	T1	HD
brimonidine tartrate/timolol (Combigan)	T1	HD
brinzolamide (Azopt)	T1	HD
carteolol hcl	T1	HD
COMBIGAN	T2	HD
dorzolamide hcl (Trusopt)	T1	HD
dorzolamide hcl/timolol maleat (Cosopt)	T1	HD
dorzolamide/timolol/pf (Cosopt Pf)	T1	HD
IOPIDINE	T3	HD
ISOPTO CARPINE (*pilocarpine hcl*)	T3	HD
latanoprost	T1	HD
levobunolol hcl	T1	HD
PHOSPHOLINE IODIDE	T3	HD
pilocarpine hcl (Isopto Carpine)	T1	HD

T1 – Typically Generics
T2 – Typically Preferred Brands
T3 – Typically Non-Preferred Brands
T4 – Specialty Medications
PA – Prior Authorization
QL – Quantity Limit
ST – Step Therapy
AGE – Age Requirement
SP – Specialty Medication
HD – May require home delivery pharmacy
PPACA – No Cost-Share Preventive Medication
CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

EENT PREPS (Eye Conditions) *(cont.)*		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
MIOTICS AND OTHER INTRAOCULAR PRESSURE REDUCERS (cont.)		
RHOPRESSA	T3	
ROCKLATAN	T3	
SIMBRINZA	T2	HD
timolol maleate	T1	HD
timolol maleate (Timoptic)	T1	HD
timolol maleate/pf (Timoptic Ocudose)	T1	HD
travoprost	T1	HD
TRUSOPT (dorzolamide hcl)	T3	HD
MYDRIATICS		
atropine sulfate	T1	HD
atropine sulfate (Isopto Atropine)	T1	HD
CYCLOGYL	T3	HD
CYCLOGYL (*cyclopentolate hcl*)	T3	HD
CYCLOMYDRIL	T3	HD
cyclopentolate hcl (Cyclogyl)	T1	HD
homatropine hbr	T1	HD
MYDRIACYL (*tropicamide*)	T3	HD
PAREMYD	T3	HD
tropicamide	T1	HD
tropicamide (Mydriacyl)	T1	HD
OPHTHALMIC ANTI-FIBROTIC AGENTS		
MITOSOL	T3	
OPHTHALMIC ANTI-INFLAMMATORY IMMUNOMODULATOR-TYPE		
CEQUA	T2	
RESTASIS	T2	HD
VEVYE	T3	QL HD
OPHTHALMIC CYSTINE DEPLETING AGENTS		
CYSTADROPS	T4	PA QL (20ml/21 days) SP
CYSTARAN	T4	PA QL (120ml/28 days) SP
OPHTHALMIC HUMAN NERVE GROWTH FACTOR (HNGF)		
OXERVATE	T4	PA SP HD

T1 – Typically Generics
T2 – Typically Preferred Brands
T3 – Typically Non-Preferred Brands
T4 – Specialty Medications
PA – Prior Authorization
QL – Quantity Limit
ST – Step Therapy
AGE – Age Requirement
SP – Specialty Medication
HD – May require home delivery pharmacy
PPACA – No Cost-Share Preventive Medication
CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

ELECT/CALORIC/H2O (Cholesterol Medications)		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
ORAL LIPID SUPPLEMENTS		
DOJOLVI	T4	PA SP HD
ELECT/CALORIC/H2O (Dental Products)		
FLUORIDE PREPARATIONS		
FLUORIDEX	T1	
FLUORIDEX SENSITIVITY RELIEF	T3	
FRAICHE 5000 PREVI	T3	
PREVIDENT	T3	
PREVIDENT (*sodium fluoride*)	T3	
PREVIDENT 5000 ENAMEL PROTECT	T3	
PREVIDENT 5000 ORTHO DEFENSE	T3	
PREVIDENT 5000 PLUS (*sodium fluoride 5000 plus*)	T3	
PREVIDENT 5000 SENSITIVE	T3	
PREVIDENT KIDS	T3	
sodium fluoride/potassium nit (Prevident 5000 Sensitive)	T1	
ELECT/CALORIC/H2O (Diabetes)		
AGENTS TO TREAT HYPOGLYCEMIA (HYPERGLYCEMICS)		
BAQSIMI	T2	QL (2 units/30 days)
diazoxide (Proglycem)	T1	
glucagon 1 mg emergency kit	T1	QL (2 pens/30 days)
GLUCAGON 1 MG EMERGENCY KIT	T3	QL (2 pens/30 days)
PROGLYCEM (*diazoxide*)	T3	
BAQSIMI	T2	QL (2/30 days)
diazoxide (Proglycem)	T1	
glucagon 1 mg emergency kit	T1	QL (2 pens/30 days)
GLUCAGON 1 MG EMERGENCY KIT	T3	QL (2 pens/30 days)
PROGLYCEM (*diazoxide*)	T3	
BAQSIMI	T2	QL (2/30 days)
diazoxide (Proglycem)	T1	
glucagon 1 mg emergency kit	T1	QL (2 pens/30 days)
GLUCAGON 1 MG EMERGENCY KIT	T3	QL (2 pens/30 days)
PROGLYCEM (*diazoxide*)	T3	

T1 – Typically Generics
T2 – Typically Preferred Brands
T3 – Typically Non-Preferred Brands
T4 – Specialty Medications
PA – Prior Authorization
QL – Quantity Limit
ST – Step Therapy
AGE – Age Requirement
SP – Specialty Medication
HD – May require home delivery pharmacy
PPACA – No Cost-Share Preventive Medication
CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

ELECT/CALORIC/H2O (Diabetes) *(cont.)*		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
AGENTS TO TREAT HYPOGLYCEMIA (HYPERGLYCEMICS) *(cont.)*		
BAQSIMI	T2	QL (2/30 days)
diazoxide (Proglycem)	T1	
glucagon 1 mg emergency kit	T1	QL (2 pens/30 days)
GLUCAGON 1 MG EMERGENCY KIT	T3	QL (2 pens/30 days)
PROGLYCEM (*diazoxide*)	T3	
ELECT/CALORIC/H2O (Miscellaneous)		
NUCLEIC ACID/NUCLEOTIDE SUPPLEMENTS		
XURIDEN	T4	PA SP
ELECT/CALORIC/H2O (Nutritional/Dietary)		
ELECTROLYTE DEPLETERS		
AURYXIA	T3	QL (12 tabs/day)
calcium acetate	T1	
lanthanum carbonate (Fosrenol)	T1	
LOKELMA	T2	
PHOSLYRA	T3	
sevelamer carbonate (Renvela)	T1	
sevelamer hcl	T1	
sevelamer hcl (Renagel)	T1	
sodium polystyrene sulfon/sorb	T1	
sodium polystyrene sulfonate	T1	
sps 15 gm/60 ml suspension	T1	
sps 30 gm/120 ml enema susp	T3	
VELPHORO	T2	
VELTASSA	T2	
PHOSLYRA	T3	
sevelamer carbonate (Renvela)	T1	
sevelamer hcl	T1	
sevelamer hcl (Renagel)	T1	
sodium polystyrene sulfon/sorb	T1	
sodium polystyrene sulfonate	T1	
sps 15 gm/60 ml suspension	T1	
sps 30 gm/120 ml enema susp	T3	

T1 – Typically Generics
T2 – Typically Preferred Brands
T3 – Typically Non-Preferred Brands
T4 – Specialty Medications
PA – Prior Authorization
QL – Quantity Limit
ST – Step Therapy
AGE – Age Requirement
SP – Specialty Medication
HD – May require home delivery pharmacy
PPACA – No Cost-Share Preventive Medication
CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

ELECT/CALORIC/H2O (Nutritional/Dietary) *(cont.)*		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
ELECTROLYTE DEPLETERS *(cont.)*		
VELPHORO	T2	
VELTASSA	T2	
IODINE CONTAINING AGENTS		
potassium iodide/iodine	T1	
SSKI	T1	
IRON REPLACEMENT		
mv-mins no.73/iron fum/folic (Hemocyte Plus)	T1	
CITRANATAL BLOOM	T3	
POTASSIUM REPLACEMENT		
EFFER-K 10 MEQ TABLET EFF	T3	
EFFER-K 20 MEQ TABLET EFF	T3	
effer-k 25 meq tablet eff	T1	
klor-con 10 meq tablet (K-tab Er)	T1	
klor-con 10 meq tablet (K-tab Er)	T3	
klor-con 8 meq tablet	T1	
klor-con 8 meq tablet	T3	
K-TAB ER (*potassium chloride*)	T3	
potassium bicarbonate/cit ac	T1	
potassium chloride	T1	
potassium cl 10% (20 meq/15ml)	T1	
potassium cl 10% (40 meq/30ml)	T1	
potassium cl 20 meq packet	T1	
potassium cl 20% (40 meq/15ml)	T1	
potassium cl er 10 meq	T1	
potassium cl er 15 meq tablet	T1	
POTASSIUM CL ER 15 MEQ TABLET	T3	
potassium cl er 20 meq tablet (K-Tab Er)	T1	
potassium cl er 8 meq capsule	T1	
potassium cl er 8 meq tablet	T1	
potassium cl10%(20meq/15ml)cup	T1	
potassium cl10%(40meq/30ml)cup	T1	
potassium cl20%(40meq/15ml)cup	T1	
PROTEIN REPLACEMENT		
AQNEURSA	T4	PA SP

T1 – Typically Generics
T2 – Typically Preferred Brands
T3 – Typically Non-Preferred Brands
T4 – Specialty Medications
PA – Prior Authorization
QL – Quantity Limit
ST – Step Therapy
AGE – Age Requirement
SP – Specialty Medication
HD – May require home delivery pharmacy
PPACA – No Cost-Share Preventive Medication
CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
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
potassium citrate (Urocit-k)	T1	HD
potassium citrate/citric acid	T1	HD
RENACIDIN	T3	HD
UROCIT-K (*potassium citrate er*)	T3	HD
UROQID-ACID NO.2	T3	HD
GASTROINTESTINAL (Cholesterol Medications)		
LIPOTROPICS		
icosapent ethyl (Vascepa)	T1	HD
omega-3 acid ethyl esters (Lovaza)	T1	HD
VASCEPA	T2	PA HD
GASTROINTESTINAL (Gastrointestinal/Heartburn)		
AMMONIA INHIBITORS		
lactulose	T1	HD
lactulose 10 gm/15 ml solution	T1	HD
LITHOSTAT	T3	HD
sodium phenylbutyrate (Buphenyl)	T4	SP HD
ANTI-CHOLINERGICS, QUATERNARY AMMONIUM		
chlordiazepoxide/clidinium br	T1	
CUVPOSA	T3	
GLYCATE	T3	
glycopyrrolate (Glycate)	T1	
glycopyrrolate (Robinul Forte)	T1	
glycopyrrolate (Robinul)	T1	
PHEBURANE	T4	PA QL(8 Bottles/30 Days) SP HD
propantheline bromide	T1	
ROBINUL (*glycopyrrolate*)	T3	
ROBINUL FORTE (*glycopyrrolate*)	T3	
OLPRUVA	T4	PA SP HD

T1 – Typically Generics
T2 – Typically Preferred Brands
T3 – Typically Non-Preferred Brands
T4 – Specialty Medications
PA – Prior Authorization
QL – Quantity Limit
ST – Step Therapy
AGE – Age Requirement
SP – Specialty Medication
HD – May require home delivery pharmacy
PPACA – No Cost-Share Preventive Medication
CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

GASTROINTESTINAL (Gastrointestinal/Heartburn) *(cont.)*		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
ANTI-CHOLINERGICS/ANTI-SPASMODICS		
dicyclomine hcl	T1	
ANTI-DIARRHEAL - G.I. CHLORIDE CHANNEL INHIBITORS		
MYTESI	T3	
ANTI-DIARRHEAL - TRYPTOPHAN HYDROXYLASE INHIBITOR		
XERMELO	T4	PA SP
ANTI-DIARRHEALS		
diphenoxylate hcl/atropine	T1	
diphenoxylate hcl/atropine (Lomotil)	T1	
loperamide hcl	T1	
MOTOFEN	T3	
opium tincture	T1	PA
paregoric	T1	
ANTI-EMETIC, CANNABINOID-TYPE		
dronabinol	T1	
ANTI-EMETIC/ANTI-VERTIGO AGENTS		
AKYNZEO	T3	PA QL (4 caps/28 days)
ANZEMET	T4	PA QL (5 tabs/30 days) SP
aprepitant 125 mg capsule	T1	QL (4 caps/28 days)
aprepitant 125-80-80 mg pack (Emend)	T1	QL (12 caps/28 days)
aprepitant 40 mg capsule	T1	QL (1 cap/28 days)
aprepitant 80 mg capsule (Emend)	T1	QL (8 caps/28 days)
BONJESTA	T3	
COMPAZINE (*prochlorperazine maleate*)	T3	
COMPAZINE (*prochlorperazine*)	T3	
DICLEGIS (*doxylamine succ-pyridoxine hcl*)	T3	
doxylamine succinate/vit b6 (Diclegis)	T1	QL(4 tabs/day)
EMEND 125 MG POWDER PACKET	T3	PA QL (12 caps/28 days)
EMEND 150 MG VIAL (*fosaprepitant dimeglumine*)	T3	
fosaprepitant dimeglumine (Emend)	T1	
granisetron hcl	T1	
granisetron hcl/pf	T1	
ondansetron hcl	T1	
ondansetron hcl/pf	T1	

T1 – Typically Generics
T2 – Typically Preferred Brands
T3 – Typically Non-Preferred Brands
T4 – Specialty Medications
PA – Prior Authorization
QL – Quantity Limit
ST – Step Therapy
AGE – Age Requirement
SP – Specialty Medication
HD – May require home delivery pharmacy
PPACA – No Cost-Share Preventive Medication
CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

GASTROINTESTINAL (Gastrointestinal/Heartburn) *(cont.)*

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ANTI-EMETIC/ANTI-VERTIGO AGENTS *(cont.)*		
prochlorperazine (Compazine)	T1	
prochlorperazine maleate (Compazine)	T1	
promethazine hcl	T1	
promethazine hcl	T3	
SANCUSO	T3	PA QL (4 patches/30 days)
scopolamine (Transderm-scop)	T1	
TRANSDERM-SCOP (*scopolamine*)	T3	
trimethobenzamide	T1	
VARUBI	T3	PA QL (4 tabs/28 days)
ANTI-ULCER PREPARATIONS		
CYTOTEC (*misoprostol*)	T3	HD
misoprostol (Cytotec)	T1	HD
sucralfate (Carafate)	T1	HD
ANTI-ULCER-H.PYLORI AGENTS		
bismuth/metronid/tetracycline (Pylera)	T1	
lansoprazole/amoxiciln/clarith	T1	
BELLADONNA ALKALOIDS		
methscopolamine bromide	T1	HD
NULEV (*symax*)	T1	HD
phenobarb/hyoscy/atropine/scop (Donnatal)	T1	HD
phenobarb/hyoscy/atropine/scop (Phenobarbital-belladonna)	T1	HD
phenobarbital-belladonna elixr (Donnatal)	T1	HD
phenobarbital-belladonna elixr (Phenobarbital-belladonna)	T1	HD
PHENOBARBITAL-BELLADONNA ELIXR (*phenohytro*)	T3	HD
SYMAX DUOTAB	T3	HD
BILE SALTS		
ACTIGALL (*ursodiol*)	T3	HD
CHENODAL	T4	SP HD
CHOLBAM	T4	PA SP HD
CTEXLI	T4	PA SP
URSO FORTE (*ursodiol*)	T3	HD
ursodiol	T1	HD
ursodiol (Actigall)	T1	HD
ursodiol (Urso Forte)	T1	HD

T1 – Typically Generics
T2 – Typically Preferred Brands
T3 – Typically Non-Preferred Brands
T4 – Specialty Medications
PA – Prior Authorization
QL – Quantity Limit
ST – Step Therapy
AGE – Age Requirement
SP – Specialty Medication
HD – May require home delivery pharmacy
PPACA – No Cost-Share Preventive Medication
CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

GASTROINTESTINAL (Gastrointestinal/Heartburn) *(cont.)*		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
CHRONIC INFLAM. COLON DX, 5-A-SALICYLAT, RECTAL TX		
mesalamine 1, 000 mg supp (Canasa)	T1	
mesalamine 4 gm/60 ml enema (Sfrowasa)	T1	
mesalamine 4 gm/60 ml kit	T1	
SFROWASA (*mesalamine*)	T3	
DRUG TX-CHRONIC INFLAM. COLON DX, 5-AMINOSALICYLAT		
APRISO (*mesalamine er*)	T3	HD
balsalazide disodium	T1	HD
balsalazide disodium (Colazal)	T1	HD
mesalamine	T1	HD
mesalamine (Apriso)	T1	HD
mesalamine 800 mg dr tablet	T1	HD
mesalamine dr 1.2 gm tablet (Lialda)	T1	HD
PENTASA 500 MG CAPSULE (mesalamine)	T3	HD
sulfasalazine (Azulfidine)	T1	HD
FARNESOID X RECEPTOR (FXR) AGONIST, BILE AC ANALOG		
OCALIVA	T4	PA SP HD
FECAL MICROBIOTA TRANSPLANTATION (FMT)		
VOWST	T4	PA QL(12 caps/56 days) SP
GASTRIC ENZYMES		
SUCRAID	T4	PA SP
HISTAMINE H2-RECEPTOR INHIBITORS		
cimetidine hcl	T1	HD
famotidine	T1	HD
ranitidine hcl	T1	HD
IBS AGENTS, MIXED OPIOID RECEP AGONISTS/ANTAGONISTS		
VIBERZI	T2	HD
IBS-C/CIC AGENTS, GUANYLATE CYCLASE-C AGONIST		
TRULANCE	T2	
INTESTINAL MOTILITY STIMULANTS		
metoclopramide hcl	T1	
metoclopramide hcl (Reglan)	T1	
REGLAN (*metoclopramide hcl*)	T3	
IRRITABLE BOWEL SYNDROME AGENTS, 5-HT3 ANTAGONIST		
alosetron hcl	T4	SP HD

T1 – Typically Generics
T2 – Typically Preferred Brands
T3 – Typically Non-Preferred Brands
T4 – Specialty Medications
PA – Prior Authorization
QL – Quantity Limit
ST – Step Therapy
AGE – Age Requirement
SP – Specialty Medication
HD – May require home delivery pharmacy
PPACA – No Cost-Share Preventive Medication
CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

GASTROINTESTINAL (Gastrointestinal/Heartburn) *(cont.)*		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
LAXATIVES AND CATHARTICS		
bisac/nacl/nahco3/kcl/peg 3350	T1	PPACA
lactulose	T1	
lactulose 10 gm/15 ml solution	T1	
lactulose 20 gm/30 ml solution	T1	
lubiprostone (Amitiza)	T1	
NULYTELY	T3	PPACA
peg3350/sod sul/nacl/kcl/asb/c	T1	PPACA
peg3350/sod sulf, bicarb, cl/kcl	T1	PPACA
PREPOPIK	T2	PPACA
sodium chloride/nahco3/kcl/peg	T1	PPACA
LOCAL ANORECTAL NITRATE PREPARATIONS		
nitroglycerin 0.4% ointment (Rectiv)	T1	
RECTIV *(nitroglycerin)*	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		
dexlansoprazole dr 30 mg cap	T1	QL(2 caps/day) HD
dexlansoprazole dr 60 mg cap	T1	QL(1 cap/day) HD
esomeprazole dr 10 mg packet	T1	QL (4 packets/day) HD
esomeprazole dr 20 mg packet	T1	QL (2 packs/day) HD
esomeprazole dr 40 mg packet	T1	QL (1 packet/day) HD
esomeprazole dr 20 mg packet (Nexium)	T1	QL(2 packs/day) HD
esomeprazole dr 40 mg packet (Nexium)	T1	QL(1 pack/day) HD
esomeprazole mag dr 20 mg cap	T1	QL(2 caps/day) HD
esomeprazole mag dr 40 mg cap	T1	QL(1 cap/day) HD
esomeprazole sodium	T1	HD
lansoprazole dr 15 mg capsule	T1	QL (2 caps/day) HD
lansoprazole dr 30 mg capsule	T1	QL (1 cap/day) HD
lansoprazole odt 15 mg tablet	T1	QL (2 tabs/day) HD
lansoprazole odt 30 mg tablet	T1	QL (30 tabs/30 days) HD

T1 – Typically Generics
T2 – Typically Preferred Brands
T3 – Typically Non-Preferred Brands
T4 – Specialty Medications
PA – Prior Authorization
QL – Quantity Limit
ST – Step Therapy
AGE – Age Requirement
SP – Specialty Medication
HD – May require home delivery pharmacy
PPACA – No Cost-Share Preventive Medication
CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

GASTROINTESTINAL (Gastrointestinal/Heartburn) *(cont.)*		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
PROTON-PUMP INHIBITORS *(cont.)*		
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
omeppi 20 mg-1, 100 mg capsule	T1	PA QL (60 caps/30 days) HD
omeppi 40 mg-1, 100 mg capsule	T1	PA QL (30 caps/30 days) HD
omeprazole dr 10 mg capsule	T1	QL (120 caps/30 days) HD
omeprazole dr 20 mg capsule	T1	QL (60 caps/30 days) HD
omeprazole dr 40 mg capsule	T1	QL (30 caps/30 days) HD
omeprazole-bicarb 20-1, 100 cap	T1	PA QL (60 caps/30 days) HD
omeprazole-bicarb 20-1, 680 pkt	T1	PA QL (60 packs/30 days) HD
omeprazole-bicarb 40-1, 100 cap	T1	PA QL (1 cap/day) HD
omeprazole-bicarb 40-1, 680 pkt	T1	PA QL (30 packs/30 days) HD
pantoprazole 40 mg suspension	T1	QL (1 dose/day) HD
pantoprazole sod dr 20 mg tab	T1	QL (2 tabs/day) HD
pantoprazole sod dr 40 mg tab	T1	QL (1 tab/day) HD
pantoprazole sodium 40 mg vial	T1	HD
rabeprazole sodium	T1	QL (30 tabs/30 days) HD
SBS - GLUCAGON-LIKE PEPTIDE-2 (GLP-2) ANALOGS		
GATTEX	T4	PA SP HD
GASTROINTESTINAL (Pain Relief And Inflammatory Disease)		
HEMORRHOID PREP, ANTI-INFLAM STEROID-LOCAL ANESTHET		
ANA-LEX	T1	
ANALPRAM HC 1% CREAM	T3	
hydrocortisone/lidocaine/aloe	T1	
hydrocortisone/pramoxine (Analpram Hc)	T1	
HEMORRHOID PREP, ANTI-INFLAM STEROID-LOCAL ANESTHET		
lidocaine/hydrocortisone ac	T1	
LIDOCAINE-HYDROCORTISONE	T1	
PROCORT	T3	
PROCTOFOAM-HC	T3	
RECTAL/LOWER BOWEL PREP., GLUCOCORT. (NON-HEMORR)		
budesonide 2 mg rectal foam	T1	QL(2 kits/180 days)
CORTENEMA (*hydrocortisone*)	T3	
hydrocortisone (Cortenema)	T1	

T1 – Typically Generics
T2 – Typically Preferred Brands
T3 – Typically Non-Preferred Brands
T4 – Specialty Medications
PA – Prior Authorization
QL – Quantity Limit
ST – Step Therapy
AGE – Age Requirement
SP – Specialty Medication
HD – May require home delivery pharmacy
PPACA – No Cost-Share Preventive Medication
CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

HORMONES (Hormonal Agents)		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
ADRENAL STEROID INHIBITORS		
ISTURISA	T4	PA QL (2 tabs/day) SP
ANDROGEN/ESTROGEN PREPS FOR FEMALE SEXUAL DYSFUNC		
INTRAROSA	T3	
ANDROGENIC AGENTS		
ANADROL-50	T3	PA
DEPO-TESTOSTERONE	T3	
DEPO-TESTOSTERONE (*testosterone cypionate*)	T3	
METHITEST	T1	
methyltestosterone	T1	
oxandrolone	T1	PA
testosterone 1% (25mg/2.5g) *pk* (Androgel)	T1	PA QL (150gm/30 days)
testosterone 1% (50 mg/5 g) *pk* (Testosterone)	T1	PA QL (2 packs/day)
testosterone 1.62% (2.5 g) *pkt* (Androgel)	T1	PA QL (150gm/30 days)
testosterone 1.62%(1.25 g) *pkt* (Androgel)	T1	PA QL (2 packs/day)
testosterone 10 mg gel pump	T1	PA QL (120 gm/30 days)
TESTOSTERONE 12.5 MG/1.25 GRAM	T1	PA QL (150gm/30 days)
testosterone 12.5 mg/1.25 gram (Testosterone)	T1	PA QL (150gm/30 days)
testosterone 30 mg/1.5 ml pump	T1	PA QL (180ml/30 days)
testosterone 50 mg/5 gram gel	T1	PA QL (2 tubes/day)
TESTOSTERONE 50 MG/5 GRAM PKT	T1	PA QL (2 packs/day)
testosterone cypionate (Depo-testosterone)	T1	
testosterone enanthate	T1	
XYOSTED	T3	PA QL(2 ml/28 days)
ANTI-DIURETIC AND VASOPRESSOR HORMONES		
desmopressin 0.01% solution	T1	HD
desmopressin 10 mcg/0.1 ml spr	T1	HD
desmopressin (nonrefrigerated)	T1	
desmopressin 0.01% solution (Ddavp)	T1	
desmopressin 10 mcg/0.1 ml spr (Ddavp)	T1	

T1 – Typically Generics
T2 – Typically Preferred Brands
T3 – Typically Non-Preferred Brands
T4 – Specialty Medications
PA – Prior Authorization
QL – Quantity Limit
ST – Step Therapy
AGE – Age Requirement
SP – Specialty Medication
HD – May require home delivery pharmacy
PPACA – No Cost-Share Preventive Medication
CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

HORMONES (Hormonal Agents) *(cont.)*		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
ANTI-DIURETIC AND VASOPRESSOR HORMONES (cont.)		
*desmopressin 40 mcg/10 ml vial (*Ddavp*)*	T4	SP
*desmopressin ac 4 mcg/ml ampul (*Ddavp*)*	T4	SP
*desmopressin ac 4 mcg/ml vial (*Ddavp*)*	T4	SP
desmopressin acetate	T1	
desmopressin acetate 0.1 mg tb (Ddavp)	T1	
desmopressin acetate 0.2 mg tb (Ddavp)	T1	
NOCTIVA	T3	PA
STIMATE	T4	SP
ESTROGEN AND PROGESTIN COMBINATIONS		
BIJUVA	T3	
ESTROGEN/ANDROGEN COMBINATIONS		
estrogen, ester/me-testosterone (Estratest F.S.)	T1	HD
ESTROGENIC AGENTS		
ACTIVELLA (*mimvey lo*)	T3	HD
ACTIVELLA (*mimvey*)	T3	HD
ALORA	T3	QL (16 patches/28 days) HD
CLIMARA (*estradiol (once weekly)*)	T3	HD
CLIMARA PRO	T3	HD
COMBIPATCH	T3	
DEPO-ESTRADIOL	T3	HD
DIVIGEL	T3	HD
ELESTRIN	T3	HD
ESTRACE (*estradiol*)	T3	HD
estradiol (Climara)	T1	HD
estradiol (Vivelle-dot)	T1	QL (8 patches/21 days) HD
estradiol 0.06% 1.25g gel pump (Estrogel)	T1	HD
estradiol 0.5 mg tablet (Estrace)	T1	HD
estradiol 1 mg tablet (Estrace)	T1	HD
estradiol 2 mg tablet (Estrace)	T1	HD
estradiol 0.025 mg patch(2/wk) (Minivelle)	T1	QL(16 patches/28 days) HD
estradiol 0.025 mg patch(2/wk) (Vivelle-Dot)	T1	QL(16 patches/28 days) HD
estradiol 0.0375mg patch(2/wk) (Minivelle)	T1	QL(16 patches/28 days) HD

T1 – Typically Generics
T2 – Typically Preferred Brands
T3 – Typically Non-Preferred Brands
T4 – Specialty Medications
PA – Prior Authorization
QL – Quantity Limit
ST – Step Therapy
AGE – Age Requirement
SP – Specialty Medication
HD – May require home delivery pharmacy
PPACA – No Cost-Share Preventive Medication
CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

HORMONES (Hormonal Agents) *(cont.)*		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
ESTROGENIC AGENTS *(cont.)*		
estradiol 0.0375mg patch(2/wk) (Vivelle-Dot)	T1	QL(16 patches/28 days) HD
estradiol 0.05 mg patch (2/wk) (Minivelle)	T1	QL(16 patches/28 days) HD
estradiol 0.05 mg patch (2/wk) (Vivelle-Dot)	T1	QL(16 patches/28 days) HD
estradiol 0.075 mg patch(2/wk) (Minivelle)	T1	QL(16 patches/28 days) HD
estradiol 0.075 mg patch(2/wk) (Vivelle-Dot)	T1	QL(16 patches/28 days) HD
estradiol 0.1 mg patch (2/wk) (Minivelle)	T1	QL(16 patches/28 days) HD
estradiol 0.1 mg patch (2/wk) (Vivelle-Dot)	T1	QL(16 patches/28 days) HD
estradiol 0.1% (0.5mg) gel pkt (Divigel)	T1	HD
estradiol valerate (Delestrogen)	T1	HD
estradiol/norethindrone acet	T1	HD
estradiol/norethindrone acet (Activella)	T1	HD
ESTROGEL	T3	HD
EVAMIST	T3	HD
FEMHRT (*norethindron-ethinyl estradiol*)	T3	HD
MENEST	T3	HD
MENOSTAR	T3	QL (8 patches/28 days) HD
MINIVELLE (*Iyllana*)	T3	QL (16 patches/28 days) HD
norethind-eth estrad 0.5-2.5 (Femhrt)	T1	HD
norethindrone ac/eth estradiol	T1	HD
norethindrone ac-eth estradiol (Femhrt)	T1	HD
norethin-eth estrad 1 mg-5 mcg	T1	HD
PREMARIN	T2	HD
PREMPHASE	T2	HD
PREMPRO	T2	HD
VIVELLE-DOT (*Iyllana*)	T3	QL (16 patches/28 days) HD
ESTROGEN-PROGESTIN WITH ANTI-MINERALOCORTICOID COMB		
ANGELIQ	T3	HD
ESTROGEN-SELECTIVE ESTROGEN RECEPTOR MOD (SERM) COMB		
DUAVEE	T2	
GLUCOCORTICOIDS		
budesonide	T1	PA QL (1 tab/day)
budesonide (Entocort Ec)	T1	
cortisone acetate	T1	
deflazacort	T4	PA SP HD

T1 – Typically Generics
T2 – Typically Preferred Brands
T3 – Typically Non-Preferred Brands
T4 – Specialty Medications
PA – Prior Authorization
QL – Quantity Limit
ST – Step Therapy
AGE – Age Requirement
SP – Specialty Medication
HD – May require home delivery pharmacy
PPACA – No Cost-Share Preventive Medication
CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

HORMONES (Hormonal Agents) *(cont.)*		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
GLUCOCORTICOIDS *(cont.)*		
deflazacort (Emflaza)	T4	PA SP HD
dexamethasone	T1	
dexamethasone 1.5 mg tablet	T1	
dexamethasone 2 mg tablet	T1	
dexamethasone 4 mg tablet	T1	
dexamethasone 6 mg tablet	T1	
ENTOCORT EC (*budesonide ec*)	T3	
hydrocortisone (Cortef)	T1	
LOCORT	T1	
MEDROL	T3	
MEDROL (*methylprednisolone*)	T3	
methylprednisolone (Medrol)	T1	
MILLIPRED 10 MG/5 ML SOLUTION (*prednisolone sodium phosphate*)	T3	
millipred 5 mg tablet	T1	
ORAPRED ODT (*prednisolone sodium phos odt*)	T3	
prednisolone	T1	
prednisolone sodium phosphate	T1	
prednisolone sodium phosphate (Millipred)	T1	
prednisolone sodium phosphate (Orapred Odt)	T1	
prednisone	T1	
UCERIS 9 MG ER TABLET *(budesonide)*	T3	PA QL(1 tab/day)
GROWTH HORMONE RELEASING HORMONE (GHRH) AND ANALOGS		
EGRIFTA	T4	PA SP HD
EGRIFTA SV	T4	PA SP HD
GROWTH HORMONES		
GENOTROPIN	T4	PA SP HD
NORDITROPIN FLEXPRO	T4	PA SP HD
OMNITROPE	T4	PA SP HD
SEROSTIM	T4	PA SP HD
SKYTROFA	T4	PA SP HD
SOGROYA	T4	PA SP

T1 – Typically Generics
T2 – Typically Preferred Brands
T3 – Typically Non-Preferred Brands
T4 – Specialty Medications
PA – Prior Authorization
QL – Quantity Limit
ST – Step Therapy
AGE – Age Requirement
SP – Specialty Medication
HD – May require home delivery pharmacy
PPACA – No Cost-Share Preventive Medication
CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

HORMONES (Hormonal Agents) *(cont.)*		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
INSULIN-LIKE GROWTH FACTOR-I (IGF-I) HORMONES		
INCRELEX	T4	PA SP HD
LHRH (GNRH) AGONIST ANALOG AND PROGESTIN COMB		
LUPANETA PACK	T4	PA SP HD
LHRH (GNRH) AGONIST ANALOG PITUITARY SUPPRESSANTS		
LUPRON DEPOT 3.75 MG KIT	T4	PA SP HD
LUPRON DEPOT 11.25 MG 3MO KIT	T4	PA SP HD
SYNAREL	T4	PA SP HD
LHRH (GNRH) ANTAGONIST, ESTROGEN AND PROGESTIN COMB		
ORIAHNN	T2	PA QL (2 capsules/day)
LHRH (GNRH) ANTAGONIST, PITUITARY SUPPRESSANT AGENTS		
CETROTIDE	T4	PA SP
ganirelix acet 250 mcg/0.5 ml (Ganirelix Acetate)	T4	PA SP
GANIRELIX ACET 250 MCG/0.5 ML (*ganirelix acetate*)	T4	PA SP
ORILISSA 150 MG TABLET	T2	PA QL (1 tab/day)
ORILISSA 200 MG TABLET	T2	PA QL (2 tabs/day)
LHRH (GNRH) AGNST PIT.SUP-CENTRAL PRECOCIOUS PUBERTY		
FENSOLVI	T4	PA SP
LUPRON DEPOT-PED	T4	PA SP HD
MINERALOCORTICOIDS		
fludrocortisone acetate	T1	HD
OXYTOCICS		
CERVIDIL	T3	
methylergonovine maleate	T1	
PREPIDIL	T3	
PROSTIN E2 VAGINAL SUPPOSITORY	T3	
PITUITARY SUPPRESSIVE AGENTS		
cabergoline	T1	QL (16 tabs/28 days) HD
CRENESSITY 50 MG CAPSULE	T4	PA QL(2 caps/day) SP
CRENESSITY 100 MG CAPSULE	T4	PA QL SP
CRENESSITY 50 MG/ML SOLUTION	T4	PA QL(8 mls/day) SP
danazol	T1	HD
PROGESTATIONAL AGENTS		
CRINONE 4% GEL	T3	PA HD
DEPO-PROVERA 400 MG/ML VIAL	T3	HD
medroxyprogesterone 10 mg tab (Provera)	T1	HD

T1 – Typically Generics
T2 – Typically Preferred Brands
T3 – Typically Non-Preferred Brands
T4 – Specialty Medications
PA – Prior Authorization
QL – Quantity Limit
ST – Step Therapy
AGE – Age Requirement
SP – Specialty Medication
HD – May require home delivery pharmacy
PPACA – No Cost-Share Preventive Medication
CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

HORMONES (Hormonal Agents) *(cont.)*		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
PROGESTATIONAL AGENTS *(cont.)*		
medroxyprogesterone 2.5 mg tab (Provera)	T1	HD
medroxyprogesterone 5 mg tab (Provera)	T1	HD
norethindrone acetate	T1	HD
progesterone, micronized (Prometrium)	T1	HD
PROMETRIUM (*progesterone*)	T3	HD
SOMATOSTATIC AGENTS		
lanreotide 120 mg/0.5 ml syrng	T4	PA SP HD
LANREOTIDE 120 MG/0.5 ML SYRNG	T4	PA SP HD
octreotide acetate	T4	PA SP HD
octreotide acetate (Sandostatin)	T4	PA SP HD
SANDOSTATIN (*octreotide acetate*)	T4	PA SP HD
SANDOSTATIN LAR DEPOT	T4	PA SP
SIGNIFOR	T4	PA SP
SIGNIFOR LAR	T4	PA SP
SOMATULINE DEPOT	T4	PA SP HD
VAGINAL ESTROGEN FOR SEXUAL DYSFUNCTION		
IMVEXXY 10 MCG MAINTENANCE PAK	T3	QL (16/28 days) HD
IMVEXXY 10 MCG STARTER PACK	T3	QL (36/28 days) HD
IMVEXXY 4 MCG MAINTENANCE PACK	T3	QL (16/28 days) HD
IMVEXXY 4 MCG STARTER PACK	T3	QL (36/28 days) HD
VAGINAL ESTROGEN PREPARATIONS		
ESTRACE (*estradiol*)	T3	HD
estradiol (Vagifem)	T1	QL (36 tabs/28 days)
estradiol 0.01% cream (Estrace)	T1	HD
estradiol 10 mcg vaginal insrt (Vagifem)	T1	QL (36 tabs/28 days) HD
FEMRING	T3	HD
PREMARIN	T2	HD
VAGIFEM (*yuvafem*)	T3	QL (36 tabs/28 days) HD
HORMONES (Infertility)		
FERTILITY STIMULATING PREPARATIONS, NON-FSH		
clomiphene citrate	T1	
FOLLICLE-STIMULATING AND LUTEINIZING HORMONES		
MENOPUR	T4	PA SP

T1 – Typically Generics
T2 – Typically Preferred Brands
T3 – Typically Non-Preferred Brands
T4 – Specialty Medications
PA – Prior Authorization
QL – Quantity Limit
ST – Step Therapy
AGE – Age Requirement
SP – Specialty Medication
HD – May require home delivery pharmacy
PPACA – No Cost-Share Preventive Medication
CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
HORMONES (Infertility) *(cont.)*		
FOLLICLE-STIMULATING HORMONE (FSH)		
FOLLISTIM AQ	T4	PA SP
GONAL-F	T4	PA SP
GONAL-F RFF	T4	PA SP
GONAL-F RFF REDI-JECT	T4	PA SP
HUMAN CHORIONIC GONADOTROPIN (HCG)		
CHORIONIC GONADOTROPIN	T4	PA SP
CHORIONIC GONAD 10, 000 UNIT VL	T4	PA SP
CHORIONIC GONAD 12, 000 UNIT VL	T4	SP
CHORIONIC GONAD 6, 000 UNIT VL	T4	SP
NOVAREL	T4	PA SP
OVIDREL	T4	PA SP
PREGNYL	T4	PA SP
PREGNANCY FACILITATING/MAINTAINING AGENT, HORMONAL		
CRINONE 8% GEL	T2	
ENDOMETRIN	T2	
HORMONES (Miscellaneous)		
LEPTIN HORMONE ANALOGS		
MYALEPT	T4	PA SP HD
HORMONES (Osteoporosis Products)		
BONE FORMATION STIM. AGENTS - PARATHYROID HORMONE		
teriparatide 560mcg/2.4ml pen	T4	PA QL(0.09 mls/day) SP HD
TERIPARATIDE 620 MCG/2.48 ML	T4	PA QL(0.09 mls/day) SP HD
BONE RESORPTION INHIBITORS		
calcitonin, salmon, synthetic	T1	HD
ibandronate sodium	T1	HD
MIACALCIN	T2	HD
IMMUNOSUPPRESSANTS (Pain Relief And Inflammatory Disease)		
IL-23 RECEPTOR ANTAGONIST, MONOCLONAL ANTIBODY		
OMVOH	T4	PA QL SP HD
OMVOH PEN	T4	PA QL(2 pens/28 days) SP HD
INTERLEUKIN-4(IL-4) RECEPTOR ALPHA ANTAGONIST, MAB		
DUPIXENT PEN	T4	PA SP HD
DUPIXENT SYRINGE	T4	PA SP HD

T1 – Typically Generics
T2 – Typically Preferred Brands
T3 – Typically Non-Preferred Brands
T4 – Specialty Medications
PA – Prior Authorization
QL – Quantity Limit
ST – Step Therapy
AGE – Age Requirement
SP – Specialty Medication
HD – May require home delivery pharmacy
PPACA – No Cost-Share Preventive Medication
CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

IMMUNOSUPPRESSANTS (Pain Relief And Inflammatory Disease) (cont.)		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
INTERLEUKIN-6 (IL-6) RECEPTOR INHIBITORS		
ACTEMRA	T4	PA QL (4 syringes/28 days) SP HD
ACTEMRA ACTPEN	T4	PA QL (4 pens/28 days) SP HD
ENSPRYNG	T4	PA SP HD
KEVZARA 150 MG/1.14 ML PEN INJ	T4	PA QL (2 pens/28 days) SP HD
KEVZARA 150 MG/1.14 ML SYRINGE	T4	PA QL (2 syrings/28 days) SP HD
KEVZARA 200 MG/1.14 ML PEN INJ	T4	PA QL (2 pens/28 days) SP HD
KEVZARA 200 MG/1.14 ML SYRINGE	T4	PA QL (2 syrings/28 days) SP HD
KEVZARA 150 MG/1.14 ML PEN INJ	T4	PA QL (2 pens/28 days) SP HD
KEVZARA 150 MG/1.14 ML SYRINGE	T4	PA QL (2 syrings/28 days) SP HD
KEVZARA 200 MG/1.14 ML PEN INJ	T4	PA QL (2 pens/28 days) SP HD
KEVZARA 200 MG/1.14 ML SYRINGE	T4	PA QL (2 syrings/28 days) SP HD
TYENNE	T4	PA QL(3.6 ml/28 days) SP
TYENNE AUTOINJECTOR	T4	PA QL(3.6 ml/28 days) SP
MONOCLONAL ANTIBODY-HUMAN INTERLEUKIN 12/23 INHIB		
STELARA 45 MG/0.5 ML SYRINGE	T4	PA QL (1 syringe/84 days) SP HD
STELARA 45 MG/0.5 ML VIAL	T4	PA QL (1 vial/84 days) SP HD
STELARA 90 MG/ML SYRINGE	T4	PA QL (1 syringe/84 days) SP HD
SELARSDI	T4	PA QL(1 syringe/84 days) SP
USTEKINUMAB-TTWE	T4	PA QL(1 syringe/84 days) SP HD
YESINTEK	T4	PA QL(1 syringe/84 days) SP
IMMUNOSUPPRESSANTS (Skin Conditions)		
TOPICAL IMMUNOSUPPRESSIVE AGENTS		
ELIDEL (*pimecrolimus*)	T3	
pimecrolimus (Elidel)	T1	
PROTOPIC (*tacrolimus*)	T3	
tacrolimus 0.03% ointment	T1	
tacrolimus 0.1% ointment	T1	
IMMUNOSUPPRESSANTS (Transplant Medications)		
IMMUNOSUPPRESSIVES		
ASTAGRAF XL	T4	SP HD
AZASAN	T4	SP HD
azathioprine (Imuran)	T4	SP HD
cyclosporine (Sandimmune)	T4	SP HD

T1 – Typically Generics
T2 – Typically Preferred Brands
T3 – Typically Non-Preferred Brands
T4 – Specialty Medications
PA – Prior Authorization
QL – Quantity Limit
ST – Step Therapy
AGE – Age Requirement
SP – Specialty Medication
HD – May require home delivery pharmacy
PPACA – No Cost-Share Preventive Medication
CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

IMMUNOSUPPRESSANTS (Transplant Medications) *(cont.)*		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
IMMUNOSUPPRESSIVES *(cont.)*		
cyclosporine, modified	T4	SP HD
cyclosporine, modified (Neoral)	T4	SP HD
ENVARSUS XR	T4	SP HD
everolimus 0.25 mg tablet (Zortress)	T4	SP HD
everolimus 0.5 mg tablet (Zortress)	T4	SP HD
everolimus 0.75 mg tablet (Zortress)	T4	SP HD
LUPKYNIS	T4	PA QL(6 caps/day) SP
mycophenolate mofetil (Cellcept)	T4	SP HD
PROGRAF (*tacrolimus*)	T4	SP HD
sirolimus (Rapamune)	T4	SP HD
tacrolimus 0.5 mg capsule (ir) (Prograf)	T4	SP HD
tacrolimus 1 mg capsule (ir) (Prograf)	T4	SP HD
tacrolimus 5 mg capsule (ir) (Prograf)	T4	SP HD
ZORTRESS	T4	SP HD
ZORTRESS (everolimus)	T4	SP HD
MISCELLANEOUS MEDICAL SUPPLIES, DEVICES, NON-DRUG (Diabetes)		
DIABETIC SUPPLIES		
AGAMATRIX CONTROL SOLUTION	T1	
AUTOLET LITE	T1	
CARESENS	T1	
CARETOUCH CONTROL SOLUTION	T1	
CEQUR SIMPLICITY	T2	
CEQUR SIMPLICITY INSERTER	T2	
CHOSEN LANCING DEVICE	T1	
DEXCOM G6 RECEIVER	T2	PA QL (1 syringe/365 days)
DEXCOM G6 SENSOR	T2	PA QL (3/30 days)
DEXCOM G6 TRANSMITTER	T2	PA QL (1 syringe/67 days)
DEXCOM G7 RECIEVER	T2	PA QL(1 unit/365 days)
DEXCOM G7 SENSOR	T2	PA QL(3 sensors/30 days)
EASY TOUCH BLULINK CTRL SOLN	T1	
EASY TRAK II CONTROL SOLUTION	T1	
ENLITE SERTER	T1	
FREESTYLE LIBRE 2 PLUS SENSOR	T2	PA QL(2 units/30 days)

T1 – Typically Generics
T2 – Typically Preferred Brands
T3 – Typically Non-Preferred Brands
T4 – Specialty Medications
PA – Prior Authorization
QL – Quantity Limit
ST – Step Therapy
AGE – Age Requirement
SP – Specialty Medication
HD – May require home delivery pharmacy
PPACA – No Cost-Share Preventive Medication
CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

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

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
DIABETIC SUPPLIES *(cont.)*		
FREESTYLE LIBRE 2 READER	T2	PA QL (1 reader/day)
FREESTYLE LIBRE 2 SENSOR	T2	PA QL(2 sensors/21 days)
FREESTYLE LIBRE 3 PLUS SENSOR	T2	PA QL(2 units/28 days)
FREESTYLE LIBRE 3 READER	T2	PA QL(1 unit/720 days)
FREESTYLE LIBRE 10 DAY READER	T2	PA QL (1 reader/day)
FREESTYLE LIBRE 10 DAY SENSOR	T2	PA QL (3/30 days)
FREESTYLE LIBRE 14 DAY READER	T2	PA QL (1 reader/day)
FREESTYLE LIBRE 14 DAY SENSOR	T2	PA QL (2/28 days)
GLUCOCOM AUTOLINK	T1	
GUARDIAN RT CHARGER	T1	
GUARDIAN RT STARTER KIT	T1	
GUARDIAN TEST PLUG	T1	
FORA TN'GO ADV MOBILE MULTIFN MTR	T3	
FORA TN'GO ADVANCE MULTIFN MTR	T3	
HUMAPEN LUXURA HD	T1	
IHEALTH CONTROL SOLN LEVEL 2	T1	
INPEN (*FOR HUMALOG*)	T1	
INPEN (*FOR NOVOLOG OR FIASP*)	T1	
LITE TOUCH LANCING PEN	T1	
MOBILE LANCETS	T1	
NOVOPEN ECHO	T1	
OMNIPOD 5 (G6/LIBRE 2 PLUS)	T2	QL(30 crtgs/30 days)
OMNIPOD 5 (GEN 5) KIT	T2	QL (1 kit/365 days)
OMNIPOD 5 (GEN 5) PODS	T2	QL (30 pods/30 days)
OMNIPOD 5 G6-G7 PODS (GEN 5)	T2	QL
OMNIPOD CLASSIC (GEN 3) KIT	T2	QL (1 kit/365 days)
OMNIPOD CLASSIC (GEN 4) KIT	T2	QL (1 kit/365 days)
OMNIPOD CLASSIC (GEN 3) PODS	T2	QL (30 pods/30 days)
OMNIPOD CLASSIC (GEN 4) PODS	T2	QL (30 pods/30 days)
OMNIPOD DASH 5 PACK POD	T2	PA QL (6 boxes/30 days)
OMNIPOD 5 DEXG7G6 INTRO(GEN 5)	T2	QL(1 unit/365 days)
OMNIPOD 5 DEXG7G6 PODS (GEN 5)	T2	QL(30 crtgs/30 days)
ONETOUCH DELICA PLUS LANCET	T1	
ONETOUCH DELICA PLUS LANC DEV	T1	

T1 – Typically Generics
T2 – Typically Preferred Brands
T3 – Typically Non-Preferred Brands
T4 – Specialty Medications
PA – Prior Authorization
QL – Quantity Limit
ST – Step Therapy
AGE – Age Requirement
SP – Specialty Medication
HD – May require home delivery pharmacy
PPACA – No Cost-Share Preventive Medication
CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

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

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
DIABETIC SUPPLIES *(cont.)*		
ONETOUCH ULTRA CONTROL SOLN	T1	
ONETOUCH ULTRA TEST STRIP	T2	
ONETOUCH ULTRASOFT 2 LANCET	T1	
ONETOUCH VERIO HIGH CNTRL SOLN	T1	
ONETOUCH VERIO MID CNTRL SOLN	T1	
ONETOUCH VERIO TEST STRIP	T2	
PRO COMFORT SAFETY LANCET	T1	
REPLACEMENT PEDIATRIC MONITOR	T1	
SEN-SERTER	T1	
UNIFINE SAFECONTROL	T1	
V-GO 20, V-GO 30, V-GO 40	T2	
DURABLE MEDICAL EQUIPMENT, MISC (GROUP I)		
1ST TIER UNILET COMFORTOUCH	T1	
2-IN-1 LANCET DEVICE	T1	
ACCU-CHEK FASTCLIX LANCET DRUM	T1	
ACCU-CHEK SAFE-T-PRO	T1	
ACCU-CHEK SAFE-T-PRO PLUS	T1	
ACCU-CHEK SOFTCLIX	T1	
ACTI-LANCE	T1	
ADVANCED TRAVEL LANCETS	T1	
ADVOCATE LANCET	T1	
ADVOCATE SAFETY LANCET	T1	
ALTERNATE SITE LANCETS	T1	
ASSURE HAEMOLANCE PLUS	T1	
ASSURE LANCE	T1	
ASSURE LANCE PLUS	T1	
BD MICROTAINER LANCETS	T1	
BD ULTRA-FINE	T1	
BD ULTRA-FINE II	T1	
BLOOD LANCETS	T1	
BULLSEYE MINI SAFETY LANCETS	T1	
BUTTERFLY TOUCH LANCET	T1	
CAREONE	T1	
CARESENS LANCET	T1	

T1 – Typically Generics
T2 – Typically Preferred Brands
T3 – Typically Non-Preferred Brands
T4 – Specialty Medications
PA – Prior Authorization
QL – Quantity Limit
ST – Step Therapy
AGE – Age Requirement
SP – Specialty Medication
HD – May require home delivery pharmacy
PPACA – No Cost-Share Preventive Medication
CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

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

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
DURABLE MEDICAL EQUIPMENT, MISC (GROUP I) *(cont.)*		
CARETOUCH SAFETY LANCETS	T1	
CARETOUCH TWIST LANCET	T1	
CHOSEN LANCET	T1	
CLEVER CHEK LANCETS	T1	
COAGUCHEK	T1	
COLOR LANCETS	T1	
COMFORT EZ	T1	
COMFORT LANCETS	T1	
COMFORT TOUCH PLUS SAFETY LANC	T1	
COMFORT TOUCH ULT THIN LANCET	T1	
DROPLET LANCETS	T1	
EASY COMFORT LANCETS	T1	
EASY TOUCH	T1	
EASY TWIST & CAP LANCETS	T1	
EMBRACE 30G LANCETS	T1	
EMBRACE SAFETY LANCET	T1	
EZ SMART LANCETS	T1	
EZ-LETS	T1	
FIFTY50 SAFETY SEAL LANCETS	T1	
FINE 30 UNIVERSAL LANCETS	T1	
FINGERSTIX	T1	
FORA LANCETS	T1	
FORACARE LANCETS	T1	
FREESTYLE LANCETS	T1	
FREESTYLE UNISTIK 2	T1	
GLUCOCOM	T1	
GLUCOCOM LANCETS	T1	
GOJJI LANCETS	T1	
HEALTHY ACCENTS UNILET LANCET	T1	
INCONTROL SUPER THIN LANCETS	T1	
INCONTROL ULTRA THIN LANCETS	T1	
INJECT EASE LANCETS	T1	

T1 – Typically Generics
T2 – Typically Preferred Brands
T3 – Typically Non-Preferred Brands
T4 – Specialty Medications
PA – Prior Authorization
QL – Quantity Limit
ST – Step Therapy
AGE – Age Requirement
SP – Specialty Medication
HD – May require home delivery pharmacy
PPACA – No Cost-Share Preventive Medication
CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

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

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
DURABLE MEDICAL EQUIPMENT, MISC (GROUP I) *(cont.)*		
INVACARE LANCETS	T1	
LANCETS	T1	
LANCETS THIN	T1	
LANCETS ULTRA THIN	T1	
LITE TOUCH	T1	
LITE TOUCH 28G LANCETS	T1	
LITE TOUCH 30G LANCETS	T1	
LITE TOUCH 33G LANCETS	T1	
MEDISENSE THIN LANCETS	T1	
MEDLANCE PLUS	T1	
MICRO THIN LANCET	T1	
MICRO THIN LANCETS	T1	
MICROLET	T1	
MOBILE LANCETS	T1	
MONOLET LANCETS	T1	
MONOLET THIN LANCETS	T1	
MYGLUCOHEALTH LANCETS	T1	
NOVA SAFETY LANCETS	T1	
NOVA SUREFLEX	T1	
ON CALL LANCET	T1	
ON CALL PLUS LANCET	T1	
ONETOUCH DELICA PLUS LANCET	T1	
ONETOUCH DELICA SAFETY LANCET	T1	
ONETOUCH LANCETS	T1	
ONETOUCH SURESOFT	T1	
ONETOUCH ULTRASOFT 2 LANCET	T1	
ON-THE-GO	T1	
PERFECT POINT SAFETY LANCETS	T1	
PIP LANCET	T1	
PRESSURE ACTIVATED LANCETS	T1	
PRO COMFORT LANCET	T1	
PRO COMFORT LANCETS	T1	
PRO COMFORT SAFETY LANCET	T1	
PRODIGY LANCETS	T1	

T1 – Typically Generics
T2 – Typically Preferred Brands
T3 – Typically Non-Preferred Brands
T4 – Specialty Medications
PA – Prior Authorization
QL – Quantity Limit
ST – Step Therapy
AGE – Age Requirement
SP – Specialty Medication
HD – May require home delivery pharmacy
PPACA – No Cost-Share Preventive Medication
CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

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

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
DURABLE MEDICAL EQUIPMENT, MISC (GROUP I) *(cont.)*		
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	
SMART SENSE	T1	
SMART SENSE LANCETS	T1	
SMARTEST LANCET	T1	
SOLUS V2	T1	
SOLUS V2 LANCETS	T1	
STERILANCE TL	T1	
STERILE LANCETS	T1	
SUPER THIN LANCETS	T1	
SURE COMFORT LANCETS	T1	
SURE-LANCE	T1	
SURE-TOUCH	T1	
TECHLITE LANCETS	T1	
TELCARE ULTRA THIN 30G LANCETS	T1	
THIN LANCETS	T1	
TOPCARE UNIVERSAL 1 LANCET	T1	
TOPCARE UNIVERSAL 1 THIN LANCET	T1	
TRUE COMFORT LANCET	T1	
TRUE COMFORT SAFETY LANCET	T1	
TRUEPLUS LANCET	T1	
TRUEPLUS LANCETS	T1	
TWIST LANCETS	T1	
TWIST TOP LANCET	T1	

T1 – Typically Generics
T2 – Typically Preferred Brands
T3 – Typically Non-Preferred Brands
T4 – Specialty Medications
PA – Prior Authorization
QL – Quantity Limit
ST – Step Therapy
AGE – Age Requirement
SP – Specialty Medication
HD – May require home delivery pharmacy
PPACA – No Cost-Share Preventive Medication
CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

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

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
DURABLE MEDICAL EQUIPMENT, MISC (GROUP I) *(cont.)*		
ULTILET BASIC	T1	
ULTILET CLASSIC	T1	
ULTILET LANCETS	T1	
ULTILET SAFETY	T1	
ULTRA-THIN II LANCETS	T1	
ULTRA THIN LANCETS	T1	
ULTRA THIN PLUS LANCETS	T1	
ULTRA-CARE LANCETS	T1	
ULTRALANCE	T1	
ULTRA-THIN II	T1	
ULTRATLC LANCETS	T1	
UNILET COMFORTOUCH	T1	
UNILET EXCELITE	T1	
UNILET EXCELITE II	T1	
UNILET GP LANCET	T1	
UNILET LANCET	T1	
UNILET LANCETS	T1	
UNISTIK 2 COMFORT	T1	
UNISTIK 2 EXTRA	T1	
UNISTIK 2 NORMAL	T1	
UNISTIK 3	T1	
UNISTIK 3 COMFORT	T1	
UNISTIK 3 DUAL	T1	
UNISTIK 3 EXTRA	T1	
UNISTIK 3 NORMAL	T1	
UNISTIK COMFORT	T1	
UNISTIK CZT	T1	
UNISTIK EXTRA	T1	
UNISTIK NORMAL	T1	
UNISTIK PRO	T1	
UNISTIK SAFETY	T1	
UNISTIK TOUCH	T1	
UNIVERSAL 1	T1	
UNISTIK 2 COMFORT	T1	

T1 – Typically Generics
T2 – Typically Preferred Brands
T3 – Typically Non-Preferred Brands
T4 – Specialty Medications
PA – Prior Authorization
QL – Quantity Limit
ST – Step Therapy
AGE – Age Requirement
SP – Specialty Medication
HD – May require home delivery pharmacy
PPACA – No Cost-Share Preventive Medication
CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

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

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
DURABLE MEDICAL EQUIPMENT, MISC (GROUP I) *(cont.)*		
UNISTIK 2 EXTRA	T1	
UNISTIK 2 NORMAL	T1	
UNISTIK 3 COMFORT	T1	
UNISTIK 3 DUAL	T1	
VERIFINE SAFETY LANCET MINI	T1	
VERIFINE UNIVERSAL LANCET	T1	
VIVAGUARD LANCET	T1	
VIVAGUARD SAFETY LANCET	T1	
NEEDLES/NEEDLELESS DEVICES		
AUTOSHIELD DUO PEN NEEDLE	T1	
BLUNT NEEDLE	T1	
CAREPOINT PRECISION NEEDLE	T1	
DROPSAFE SICURA SAFETY NEEDLE	T1	
ECLIPSE NEEDLE	T1	
EMBRACE PEN NEEDLE	T1	
FILTER NEEDLE	T1	
HYPODERMIC NEEDLE	T1	
INSUPEN PEN NEEDLE	T1	
MONOJECT BLOOD COLLECTION	T1	
NEEDLES	T1	
PERFECT POINT SAFETY NEEDLE	T1	
PRECISIONGLIDE NEEDLE	T1	
NANO 2ND GEN PEN NEEDLE	T1	
NANO PEN NEEDLE	T1	
ULTRA-FINE PEN NEEDLE	T1	
SYRINGES AND ACCESSORIES		
BD INS SYR 0.3 ML 8MMX31G(1/2)	T1	
BD INS SYR UF 0.3ML 12.7MMX30G	T1	
BD INS SYR UF 0.5ML 12.7MMX30G	T1	
BD INS SYRN UF 1 ML 12.7MMX30G	T1	
BD INS SYRN UF 1 ML 30G 12.7MM	T1	
BD INS SYRNG 0.3 ML 29GX12.7MM	T1	
BD INS SYRNG 0.5 ML 29GX12.7MM	T1	
BD INS SYRNG UF 0.3 ML 8MMX31G	T1	

T1 – Typically Generics
T2 – Typically Preferred Brands
T3 – Typically Non-Preferred Brands
T4 – Specialty Medications
PA – Prior Authorization
QL – Quantity Limit
ST – Step Therapy
AGE – Age Requirement
SP – Specialty Medication
HD – May require home delivery pharmacy
PPACA – No Cost-Share Preventive Medication
CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

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

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
SYRINGES AND ACCESSORIES *(cont.)*		
BD INS SYRNG UF 0.5 ML 8MMX31G	T1	
BD INSULIN SYR 0.5 ML 28GX1/2"	T1	
BD INSULIN SYR 1 ML 25GX1"	T1	
BD INSULIN SYR 1 ML 25GX5/8"	T1	
BD INSULIN SYR 1 ML 26GX1/2"	T1	
BD INSULIN SYR 1 ML 27GX12.7MM	T1	
BD INSULIN SYR 1 ML 27GX5/8"	T1	
BD INSULIN SYR 1 ML 28GX1/2"	T1	
BD INSULIN SYR 1 ML 29GX12.7MM	T1	
BD INSULIN SYR UF 1 ML 8MMX31G	T1	
BD INSULIN SYRINGE 1 ML	T1	
DROPLET 0.3 ML 29G 12.7MM(1/2)	T1	
DROPLET 0.3 ML 30G 12.7MM(1/2)	T1	
DROPLET INS 0.3ML 30G 8MM(1/2)	T1	
DROPLET INS 0.3ML 31G 6MM(1/2)	T1	
DROPLET INS 0.3ML 31G 8MM(1/2)	T1	
DROPLET INS 0.5 ML 29G 12.7MM	T1	
DROPLET INS 0.5 ML 30G 12.7MM	T1	
DROPLET INS SYR 0.5 ML 31G 6MM	T1	
DROPLET INS SYR 0.5 ML 31G 8MM	T1	
DROPLET INS SYR 0.5ML 30G 8MM	T1	
DROPLET INS SYR 1 ML 30G 8MM	T1	
DROPLET INS SYR 1 ML 31G 6MM	T1	
DROPLET INS SYR 1 ML 31G 8MM	T1	
DROPLET INS SYR 1ML 29G 12.7MM	T1	
DROPLET INS SYR 1ML 30G 12.7MM	T1	
EASY COMFORT SYR 0.5ML 29G 8MM	T1	
EASY COMFORT SYR 1 ML 29G 8MM	T1	
INSULIN SYRINGE	T1	
INSULIN SYRINGE U-500	T1	
MINIMED RESERVOIR	T1	
PARADIGM	T1	
TRUE COMFORT SAFE INSULIN SYRG	T1	
ULTRA-THIN II 1 ML 31GX5/16"	T1	
ULTRA-THIN II INS 0.3 ML 30G	T1	

T1 – Typically Generics
T2 – Typically Preferred Brands
T3 – Typically Non-Preferred Brands
T4 – Specialty Medications
PA – Prior Authorization
QL – Quantity Limit
ST – Step Therapy
AGE – Age Requirement
SP – Specialty Medication
HD – May require home delivery pharmacy
PPACA – No Cost-Share Preventive Medication
CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

MISCELLANEOUS MEDICAL SUPPLIES, DEVICES, NON-DRUG (Diabetes) *(cont.)*		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
SYRINGES AND ACCESSORIES *(cont.)*		
ULTRA-THIN II INS 0.3 ML 31G	T1	
ULTRA-THIN II INS 0.5 ML 29G	T1	
ULTRA-THIN II INS 0.5 ML 30G	T1	
ULTRA-THIN II INS 0.5 ML 31G	T1	
ULTRA-THIN II INS SYR 1 ML 29G	T1	
ULTRA-THIN II INS SYR 1 ML 30G	T1	
VERIFINE INSULIN SYRINGE	T1	
MISCELLANEOUS MEDICAL SUPPLIES, DEVICES, NON-DRUG (Miscellaneous)		
RESPIRATORY AIDS, DEVICES, EQUIPMENT		
ACE AEROSOL CLOUD ENHANCER	T2	QL (1 unit/year)
AEROCHAMBER MECHANICAL VENT	T2	QL(1 spacer/365 days)
AEROCHAMBER MINI	T2	QL (1 unit/year)
AEROCHAMBER MV	T2	QL (1 unit/year)
AEROCHAMBER PLUS FLOW-VU	T2	QL (1 unit/year)
AEROCHAMBER WITH FLOWSIGNAL	T2	QL (1 unit/year)
AEROCHAMBER Z-STAT PLUS	T2	QL (1 unit/year)
AEROTRACH PLUS	T2	QL (1 unit/year)
AEROVENT PLUS	T2	QL (1 unit/year)
BREATHERITE	T2	QL (1 unit/year)
BREATHERITE SPACER-ADULT MASK, INFANT MASK	T2	QL (1 unit/year)
BREATHERITE SPACER-LARGE MASK	T2	QL (1 mask/365 days)
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)
LITETOUCH	T2	QL (1 unit/year)

T1 – Typically Generics
T2 – Typically Preferred Brands
T3 – Typically Non-Preferred Brands
T4 – Specialty Medications
PA – Prior Authorization
QL – Quantity Limit
ST – Step Therapy
AGE – Age Requirement
SP – Specialty Medication
HD – May require home delivery pharmacy
PPACA – No Cost-Share Preventive Medication
CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

MISCELLANEOUS MEDICAL SUPPLIES, DEVICES, NON-DRUG (Miscellaneous) *(cont.)*		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
RESPIRATORY AIDS, DEVICES, EQUIPMENT *(cont.)*		
MICROCHAMBER	T2	QL (1 unit/year)
MICROSPACER	T2	QL (1 unit/year)
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-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)
UNISTIK 3 NORMAL	T1	
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)
SKELETAL MUSCLE RELAX. TOP IRRITANT COUNTER-IRRIT		
COMFORT PAC-CYCLOBENZAPRINE	T3	
COMFORT PAC-TIZANIDINE	T3	
SKELETAL MUSCLE RELAXANTS		
baclofen	T1	HD
carisoprodol/aspirin	T1	
chlorzoxazone	T1	
cyclobenzaprine hcl	T1	
DANTRIUM (*dantrolene sodium*)	T3	
dantrolene sodium	T1	
FEXMID (*cyclobenzaprine hcl*)	T3	
metaxalone tablet (Skelaxin)	T1	

T1 – Typically Generics
T2 – Typically Preferred Brands
T3 – Typically Non-Preferred Brands
T4 – Specialty Medications
PA – Prior Authorization
QL – Quantity Limit
ST – Step Therapy
AGE – Age Requirement
SP – Specialty Medication
HD – May require home delivery pharmacy
PPACA – No Cost-Share Preventive Medication
CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

MUSCLE RELAXANTS (Pain Relief And Inflammatory Disease)		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
SKELETAL MUSCLE RELAX. TOP IRRITANT COUNTER-IRRIT		
methocarbamol	T1	
methocarbamol 1,000 mg tablet	T1	
orphenadrine citrate	T1	
OZOBAX DS	T3	
ROBAXIN-750 (*methocarbamol*)	T3	
SKELAXIN (*metaxalone*)	T3	
SOMA (*vanadom*)	T3	
tizanidine hcl	T1	
tizanidine hcl (Zanaflex)	T1	
ZANAFLEX (*tizanidine hcl*)	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	
pnv 22/iron, gluc/folic/dss/dha	T1	
pnv 66/iron/folic/docusate/dha	T1	
pnv 69/iron/folic/docusate/dha	T1	
pnv 80/iron fum/folic/dss/dha	T1	
pnv no.154/iron fum/folic acid	T1	
pnv/ferrous fum/docusate/folic	T1	
pnv/iron, carb/docusat/folic ac	T1	
prenatal 12/iron/folic/dss/om3 (Obtrex Dha)	T1	
PRENATAL 19	T1	
prenatal 34/iron/folic/dss/dha	T1	
prenatal vits15/iron/folic/dss	T1	
VITAFOL FE+	T3	

T1 – Typically Generics
T2 – Typically Preferred Brands
T3 – Typically Non-Preferred Brands
T4 – Specialty Medications
PA – Prior Authorization
QL – Quantity Limit
ST – Step Therapy
AGE – Age Requirement
SP – Specialty Medication
HD – May require home delivery pharmacy
PPACA – No Cost-Share Preventive Medication
CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

PSYCHOTHERAPEUTIC DRUGS (Anxiety/Depression/Bipolar Disorder)[10]		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
ALPHA-2 RECEPTOR ANTAGONIST ANTI-DEPRESSANTS		
mirtazapine	T1	HD
mirtazapine (Remeron)	T1	HD
ANTIDEPRESSANT - POSTPARTUM DEPRESSION (PPD)		
ZURZUVAE 20 MG CAPSULE	T4	PA QL(28 caps/270 days) SP HD
ZURZUVAE 25 MG CAPSULE	T4	PA QL(28 caps/270 days) SP HD
ZURZUVAE 30 MG CAPSULE	T4	PA QL(14 caps/270 days) SP HD
ANTI-ANXIETY - BENZODIAZEPINES		
alprazolam	T1	
alprazolam (Xanax Xr)	T1	
alprazolam (Xanax)	T1	
chlordiazepoxide hcl	T1	
clorazepate dipotassium	T1	
clorazepate dipotassium (Tranxene T-tab)	T1	
diazepam 10 mg tablet (Valium)	T1	
diazepam 2 mg tablet (Valium)	T1	
diazepam 5 mg tablet (Valium)	T1	
diazepam 5 mg/5 ml solution	T1	
diazepam 5 mg/ml oral conc	T1	
lorazepam	T1	
oxazepam	T1	
TRANXENE T-TAB (*clorazepate dipotassium*)	T3	
XANAX XR 2 MG TABLET *(alprazolam)*	T3	
ANTI-ANXIETY DRUGS		
buspirone hcl	T1	HD
meprobamate	T1	
BIPOLAR DISORDER DRUGS		
EQUETRO	T3	HD
lithium carbonate	T1	HD
lithium carbonate (Lithobid)	T1	HD
lithium citrate	T1	HD
MAOIS -NON-SELECTIVE, IRREVERSIBLE ANTI-DEPRESSANTS		
MARPLAN	T3	QL (12 tabs/day)
phenelzine sulfate (Nardil)	T1	
tranylcypromine sulfate	T1	

T1 – Typically Generics
T2 – Typically Preferred Brands
T3 – Typically Non-Preferred Brands
T4 – Specialty Medications
PA – Prior Authorization
QL – Quantity Limit
ST – Step Therapy
AGE – Age Requirement
SP – Specialty Medication
HD – May require home delivery pharmacy
PPACA – No Cost-Share Preventive Medication
CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

PSYCHOTHERAPEUTIC DRUGS (Anxiety/Depression/Bipolar Disorder)[10] *(cont.)*		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
MONOAMINE OXIDASE (MAO) INHIBITOR ANTI-DEPRESSANTS		
EMSAM 12 MG/24 HOURS PATCH	T3	QL (1 patch/day)
EMSAM 6 MG/24 HOURS PATCH	T3	QL (2 patches/day)
EMSAM 9 MG/24 HOURS PATCH	T3	QL (1 patch/day)
NOREPINEPHRINE AND DOPAMINE REUPTAKE INHIB (NDRIs)		
bupropion hcl 100 mg tablet	T1	QL (4 tabs/day) HD
bupropion hcl 75 mg tablet	T1	QL (6 tabs/day) HD
bupropion hcl sr 100 mg tablet (Wellbutrin Sr)	T1	QL (4 tabs/day) HD
bupropion hcl sr 150 mg tablet (Wellbutrin Sr)	T1	QL (2 tabs/day) HD
bupropion hcl sr 200 mg tablet (Wellbutrin Sr)	T1	QL (2 tabs/day) HD
bupropion hcl xl 150 mg tablet	T1	QL (3 tabs/day) HD
bupropion hcl xl 300 mg tablet	T1	QL (1 tab/day) HD
bupropion hcl xl 150 mg tablet (Wellbutrin Xl)	T1	QL(3 tabs/day) HD
bupropion hcl xl 300 mg tablet (Wellbutrin Xl)	T1	QL(1 tab/day) HD
WELLBUTRIN SR 100 MG TABLET (*bupropion hcl sr*)	T3	QL (4 tabs/day) ST HD
WELLBUTRIN SR 150 MG TABLET (*bupropion hcl sr*)	T3	QL (2 tabs/day) ST HD
WELLBUTRIN SR 200 MG TABLET (*bupropion hcl sr*)	T3	QL (2 tabs/day) ST HD
SELECTIVE SEROTONIN 5-HT2A INVERSE AGONISTS (SSIAs)		
NUPLAZID	T4	PA SP HD
SELECTIVE SEROTONIN REUPTAKE INHIBITOR (SSRIs)		
citalopram hbr 10 mg tablet (Celexa)	T1	QL(6 tabs/day) HD
citalopram hbr 20 mg tablet (Celexa)	T1	QL(3 tabs/day) HD
citalopram hbr 40 mg tablet (Celexa)	T1	QL (1 tab/day) HD
escitalopram oxalate 5 mg/5 ml	T1	QL (20ml/day) HD
escitalopram 5 mg tablet	T1	QL (4 tabs/day) HD
escitalopram 10 mg tablet	T1	QL (2 tabs/day) HD
escitalopram 20 mg tablet	T1	QL (1 tab/day) HD
fluoxetine hcl	T1	QL (4 caps/28 days) HD
fluoxetine hcl 10 mg capsule (Prozac)	T1	QL (8 caps/day) HD
fluoxetine hcl 10 mg tablet (Sarafem)	T1	HD
fluoxetine hcl 20 mg capsule (Prozac)	T1	QL (4 caps/day) HD
fluoxetine 20 mg/5 ml soln cup	T1	QL(20 mls/day) HD
fluoxetine hcl 20 mg tablet	T1	HD
fluoxetine hcl 40 mg capsule (Prozac)	T1	QL (2 caps/day) HD
fluoxetine hcl 60 mg tablet	T1	QL (1 tab/day) HD

T1 – Typically Generics
T2 – Typically Preferred Brands
T3 – Typically Non-Preferred Brands
T4 – Specialty Medications
PA – Prior Authorization
QL – Quantity Limit
ST – Step Therapy
AGE – Age Requirement
SP – Specialty Medication
HD – May require home delivery pharmacy
PPACA – No Cost-Share Preventive Medication
CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

PSYCHOTHERAPEUTIC DRUGS (Anxiety/Depression/Bipolar Disorder)[10] *(cont.)*		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
SELECTIVE SEROTONIN REUPTAKE INHIBITOR (SSRIs) *(cont.)*		
fluvoxamine er 100 mg capsule	T1	QL (3 caps/day) HD
fluvoxamine er 150 mg capsule	T1	QL (2 caps/day) HD
fluvoxamine maleate 100 mg tab	T1	QL (3 tabs/day) HD
fluvoxamine maleate 25 mg tab	T1	QL (12 tabs/day) HD
fluvoxamine maleate 50 mg tab	T1	QL (6 tabs/day) HD
paroxetine cr 12.5 mg tablet (Paxil Cr)	T1	QL (1 tab/day) HD
paroxetine cr 25 mg tablet (Paxil Cr)	T1	QL (3 tabs/day) HD
paroxetine cr 37.5 mg tablet (Paxil Cr)	T1	QL (2 tabs/day) HD
paroxetine er 12.5 mg tablet (Paxil Cr)	T1	QL (1 tab/day) HD
paroxetine er 25 mg tablet (Paxil Cr)	T1	QL (3 tabs/day) HD
paroxetine er 37.5 mg tablet (Paxil Cr)	T1	QL (2 tabs/day) HD
paroxetine hcl 10 mg tablet (Paxil)	T1	QL (6 tabs/day) HD
paroxetine hcl 20 mg tablet (Paxil)	T1	QL (3 tabs/day) HD
paroxetine hcl 30 mg tablet (Paxil)	T1	QL (2 tabs/day) HD
paroxetine hcl 40 mg tablet (Paxil)	T1	QL (1 tab/day) HD
SARAFEM (*fluoxetine hcl*)	T3	ST HD
sertraline 20 mg/ml oral conc (Zoloft)	T1	QL (10ml/day) HD
sertraline hcl 100 mg tablet (Zoloft)	T1	QL (2 tabs/day) HD
sertraline hcl 25 mg tablet (Zoloft)	T1	QL (8 tabs/day) HD
sertraline hcl 50 mg tablet (Zoloft)	T1	QL (4 tabs/day) HD
SEROTONIN-2 ANTAGONIST/REUPTAKE INHIBITORS (SARIs)		
nefazodone hcl	T1	HD
trazodone hcl	T1	HD
SEROTONIN-NOREPINEPHRINE REUPTAKE-INHIB (SNRIs)		
desvenlafaxine succnt er 100mg	T1	QL (4 tabs/day) HD
desvenlafaxine succnt er 25 mg	T1	QL (16 tabs/day) HD
desvenlafaxine succnt er 50 mg	T1	QL (1 tab/day) HD
duloxetine hcl dr 20 mg cap	T1	QL (6 caps/day) HD
duloxetine hcl dr 30 mg cap	T1	QL (4 caps/day) HD
duloxetine hcl dr 40 mg cap	T1	QL (3 caps/day) HD
duloxetine hcl dr 60 mg cap	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

T1 – Typically Generics
T2 – Typically Preferred Brands
T3 – Typically Non-Preferred Brands
T4 – Specialty Medications
PA – Prior Authorization
QL – Quantity Limit
ST – Step Therapy
AGE – Age Requirement
SP – Specialty Medication
HD – May require home delivery pharmacy
PPACA – No Cost-Share Preventive Medication
CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

PSYCHOTHERAPEUTIC DRUGS (Anxiety/Depression/Bipolar Disorder)[10] *(cont.)*		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
SEROTONIN-NOREPINEPHRINE REUPTAKE-INHIB (SNRIs)*(con't.)*		
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
venlafaxine hcl 100 mg tablet	T1	QL (3 tabs/day) HD
venlafaxine hcl 25 mg tablet	T1	QL (15 tabs/day) HD
venlafaxine hcl 37.5 mg tablet	T1	QL (10 tabs/day) HD
venlafaxine hcl 50 mg tablet	T1	QL (7 tabs/day) HD
venlafaxine hcl 75 mg tablet	T1	QL (5 tabs/day) HD
venlafaxine hcl er 150 mg cap (Effexor Xr)	T1	QL (2 caps/day) HD
venlafaxine hcl er 150 mg tab	T1	QL (2 tabs/day) HD
venlafaxine hcl er 225 mg tab	T1	QL (1 tab/day) HD
venlafaxine hcl er 37.5 mg cap (Effexor Xr)	T1	QL (8 caps/day) HD
venlafaxine hcl er 37.5 mg tab	T1	QL (8 tabs/day) HD
venlafaxine hcl er 75 mg cap (Effexor Xr)	T1	QL (4 caps/day) HD
venlafaxine hcl er 75 mg tab	T1	QL (4 tabs/day) HD
SSRI AND 5HTIA PARTIAL AGONIST ANTI-DEPRESSANTS		
vilazodone hcl 10 mg tablet (Viibryd)	T1	QL(1 tab/day) HD
vilazodone hcl 20 mg tablet (Viibryd)	T1	QL(1 tab/day) HD
vilazodone hcl 40 mg tablet (Viibryd)	T1	HD
VIIBRYD 10 MG TABLET	T3	QL (1 tab/day) ST HD
VIIBRYD 10-20 MG STARTER PACK	T3	ST HD
VIIBRYD 20 MG TABLET	T3	QL (1 tab/day) ST HD
VIIBRYD 40 MG TABLET	T3	ST HD
SSRI, SEROTONIN RECEPTOR MODULATOR ANTI-DEPRESSANTS		
TRINTELLIX 10 MG TABLET	T2	QL(1 tab/day)
TRINTELLIX 20 MG TABLET	T2	
TRINTELLIX 5 MG TABLET	T2	QL(1 tab/day)
TRICYCLIC ANTI-DEPRESSANT-BENZODIAZEPINE COMBINATNS		
amitriptyline/chlordiazepoxide	T1	HD
TRICYCLIC ANTI-DEPRESSANT-PHENOTHIAZINE COMBINATNS		
perphenazine/amitriptyline hcl	T1	HD
TRICYCLIC ANTI-DEPRESSANTS, REL.NON-SEL.REUPT-INHIB		
amoxapine	T1	HD
clomipramine hcl	T1	HD

T1 – Typically Generics
T2 – Typically Preferred Brands
T3 – Typically Non-Preferred Brands
T4 – Specialty Medications
PA – Prior Authorization
QL – Quantity Limit
ST – Step Therapy
AGE – Age Requirement
SP – Specialty Medication
HD – May require home delivery pharmacy
PPACA – No Cost-Share Preventive Medication
CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

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		
desipramine hcl	T1	HD
doxepin 10 mg capsule	T1	HD
doxepin 10 mg/ml oral conc	T1	HD
doxepin 100 mg, 150 mg capsule	T1	HD
doxepin 25 mg capsule	T1	HD
doxepin 50 mg capsule	T1	HD
doxepin 75 mg capsule	T1	HD
imipramine hcl	T1	HD
imipramine pamoate	T1	HD
maprotiline hcl	T1	HD
nortriptyline hcl	T1	HD
protriptyline hcl	T1	HD
trimipramine maleate	T1	HD
PSYCHOTHERAPEUTIC DRUGS (Attention Deficit Hyperactivity Disorder)[10]		
TX FOR ADHD - SELECTIVE ALPHA-2 RECEPTOR AGONIST		
clonidine hcl (Kapvay)	T1	
guanfacine hcl (Intuniv)	T1	HD
TX FOR ATTENTION DEFICIT-HYPERACT (ADHD)/NARCOLEPSY		
DAYTRANA	T3	PA QL (1 patch/day)
dexmethylphenidate er 10 mg cp	T1	PA QL (1 cap/day)
dexmethylphenidate er 15 mg cp	T1	PA QL (1 per day)
dexmethylphenidate er 20 mg cp	T1	PA QL (1 cap/day)
dexmethylphenidate er 25 mg cp	T1	PA QL (1 cap/day)
dexmethylphenidate er 30 mg cp	T1	PA QL (1 cap/day)
dexmethylphenidate er 35 mg cp	T1	PA QL (1 cap/day)
dexmethylphenidate er 40 mg cp	T1	PA QL (1 cap/day)
dexmethylphenidate hcl (Focalin)	T1	PA
FOCALIN (*dexmethylphenidate hcl*)	T3	PA ST
METHYLIN (*methylphenidate hcl*)	T3	PA
methylphenidate hcl (Metadate Cd)	T1	PA QL(1 cap/day)
methylphenidate (Daytrana)	T1	PA QL(1 patch/day)
methylphenidate 10 mg/9hr ptch (Daytrana)	T1	PA QL(1 patch/day)
methylphenidate 15 mg/9hr ptch (Daytrana)	T1	PA QL(1 patch/day)

T1 – Typically Generics
T2 – Typically Preferred Brands
T3 – Typically Non-Preferred Brands
T4 – Specialty Medications
PA – Prior Authorization
QL – Quantity Limit
ST – Step Therapy
AGE – Age Requirement
SP – Specialty Medication
HD – May require home delivery pharmacy
PPACA – No Cost-Share Preventive Medication
CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

PSYCHOTHERAPEUTIC DRUGS (Attention Deficit Hyperactivity Disorder)[10] *(cont.)*		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
TX FOR ATTENTION DEFICIT-HYPERACT (ADHD)/NARCOLEPSY *(cont.)*		
methylphenidate 20 mg/9hr ptch (Daytrana)	T1	PA QL(1 patch/day)
methylphenidate 30 mg/9hr ptch (Daytrana)	T1	PA QL(1 patch/day)
methylphenidate er 10 mg tab	T1	PA QL (2 tabs/day)
methylphenidate er 18 mg tab	T1	PA QL (1 tab/day)
methylphenidate er 18 mg tab (Relexxii)	T1	PA QL (1 tab/day)
methylphenidate er 10, 15, 20 mg cap	T1	QL (1 per day)
methylphenidate er 20 mg tab	T1	PA QL (3/day)
methylphenidate er 27 mg tab	T1	PA QL (1 tab/day)
methylphenidate er 30 mg cap	T1	QL (1 per day)
methylphenidate er 36 mg tab	T1	PA QL (2 tabs/day)
methylphenidate er 40 mg cap	T1	QL (1 per day)
methylphenidate er 50 mg cap	T1	QL (1 per day)
methylphenidate er 54 mg tab	T1	PA QL (1 per day)
methylphenidate er 60 mg cap	T1	QL (1 per day)
methylphenidate hcl	T1	PA QL (1 cap/day)
methylphenidate hcl (Methylin)	T1	PA
methylphenidate hcl (Ritalin)	T1	PA
methylphenidate la 10 mg cap	T1	PA QL (1 cap/day)
methylphenidate la 20 mg cap	T1	PA QL (1 per day)
methylphenidate la 30 mg cap	T1	PA QL (1 per day)
methylphenidate la 40 mg cap	T1	PA QL (1 cap/day)
methylphenidate la 60 mg cap	T1	PA QL (1 cap/day)
QUILLIVANT XR	T3	PA QL (12ml/day)
RITALIN (*methylphenidate hcl*)	T3	PA ST
TX FOR ATTENTION DEFICIT-HYPERACT.(ADHD), NRI-TYPE		
atomoxetine hcl 10 mg capsule (Strattera)	T1	HD
atomoxetine hcl 100 mg capsule (Strattera)	T1	HD
atomoxetine hcl 18 mg capsule (Strattera)	T1	HD
atomoxetine hcl 25 mg capsule (Strattera)	T1	HD
atomoxetine hcl 40 mg capsule (Strattera)	T1	QL (1 cap/day) HD
atomoxetine hcl 60 mg capsule (Strattera)	T1	HD
atomoxetine hcl 80 mg capsule (Strattera)	T1	HD

T1 – Typically Generics
T2 – Typically Preferred Brands
T3 – Typically Non-Preferred Brands
T4 – Specialty Medications
PA – Prior Authorization
QL – Quantity Limit
ST – Step Therapy
AGE – Age Requirement
SP – Specialty Medication
HD – May require home delivery pharmacy
PPACA – No Cost-Share Preventive Medication
CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

PSYCHOTHERAPEUTIC DRUGS (Miscellaneous)		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
HYPOACTIVE SEXUAL DESIRE DISORDER (HSDD) TX AGENTS		
ADDYI	T3	PA QL (1 tab/day)
VYLEESI	T4	PA QL (8 injectors/30 days) SP
PSYCHOTHERAPEUTIC DRUGS (Schizophrenia/Anti-Psychotics)[10]		
ANTI-PSYCH, DOPAMINE ANTAG., DIPHENYLBUTYLPIPERIDINES		
pimozide	T1	
ANTI-PSYCHOTIC,ATYPICAL,DOPAMINE,SEROTONIN ANTAGNST		
asenapine maleate (Saphris)	T1	
CAPLYTA	T3	ST QL(1 tabs/caps/day)
clozapine	T1	
clozapine (Clozapine Odt)	T1	
clozapine (Clozaril)	T1	
CLOZAPINE ODT	T1	
CLOZARIL (*clozapine*)	T3	ST
INVEGA ER 1.5 MG TABLET (*paliperidone er*)	T3	ST
INVEGA ER 3 MG TABLET (*paliperidone er*)	T3	QL (1 tab/day) ST
INVEGA ER 6 MG TABLET (*paliperidone er*)	T3	ST
INVEGA ER 9 MG TABLET (*paliperidone er*)	T3	ST
lurasidone hcl 120 mg tablet (Latuda)	T1	
lurasidone hcl 20 mg tablet (Latuda)	T1	
lurasidone hcl 40 mg tablet (Latuda)	T1	QL(1 tab/day)
lurasidone hcl 60 mg tablet (Latuda)	T1	QL(1 tab/day)
lurasidone hcl 80 mg tablet (Latuda)	T1	
olanzapine	T1	
olanzapine (Zyprexa)	T1	
paliperidone er 1.5 mg tablet	T1	
paliperidone er 3 mg tablet (Invega)	T1	QL (1 tab/day)
paliperidone er 9 mg tablet (Invega)	T1	
quetiapine fumarate (Seroquel Xr)	T1	
quetiapine fumarate 400 mg tab (Seroquel)	T1	
quetiapine fumarate (Seroquel)	T1	
risperidone	T1	
risperidone (Risperdal)	T1	
SAPHRIS (*asenapine maleate*)	T3	ST

T1 – Typically Generics
T2 – Typically Preferred Brands
T3 – Typically Non-Preferred Brands
T4 – Specialty Medications
PA – Prior Authorization
QL – Quantity Limit
ST – Step Therapy
AGE – Age Requirement
SP – Specialty Medication
HD – May require home delivery pharmacy
PPACA – No Cost-Share Preventive Medication
CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

PSYCHOTHERAPEUTIC DRUGS (Schizophrenia/Anti-Psychotics)[10] *(cont.)*		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
ANTI-PSYCHOTIC,ATYPICAL,DOPAMINE,SEROTONIN ANTAGNST *(cont.)*		
SECUADO	T3	ST
SEROQUEL (*quetiapine fumarate*)	T3	ST
SEROQUEL XR (*quetiapine fumarate er*)	T3	ST
ziprasidone hcl	T1	
ANTI-PSYCHOTIC-ATYPICAL, D3/D2 PARTIAL AG-5HT MIXED		
VRAYLAR 1.5 MG CAPSULE	T3	QL (1 cap/day) ST
VRAYLAR 3 MG CAPSULE	T3	QL (1 cap/day) ST
VRAYLAR 4.5 MG CAPSULE	T3	ST
VRAYLAR 6 MG CAPSULE	T3	ST
ANTIPSYCHOTICS, ATYP, D2 PARTIAL AGONIST/5HT MIXED		
aripiprazole	T1	
aripiprazole 1 mg/ml solution	T1	
aripiprazole 2 mg tablet	T1	
aripiprazole 5 mg tablet	T1	QL (1 tab/day)
aripiprazole 10 mg tablet	T1	
aripiprazole 15 mg tablet	T1	
aripiprazole 20 mg tablet	T1	
aripiprazole 30 mg tablet	T1	
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, 4 MG TABLET	T3	ST
ANTI-PSYCHOTICS, DOPAMINE AND SEROTONIN ANTAGONISTS		
loxapine succinate	T1	
ANTI-PSYCHOTICS, DOPAMINE ANTAGONISTS, BUTYROPHENONES		
haloperidol	T1	
haloperidol lactate	T1	
ANTI-PSYCHOTICS, DOPAMINE ANTAGONST, DIHYDROINDOLONES		
molindone hcl	T1	
ANTI-PSYCHOTICS, PHENOTHIAZINES		
chlorpromazine hcl	T1	
fluphenazine hcl	T1	
perphenazine	T1	
thioridazine hcl	T1	

T1 – Typically Generics
T2 – Typically Preferred Brands
T3 – Typically Non-Preferred Brands
T4 – Specialty Medications
PA – Prior Authorization
QL – Quantity Limit
ST – Step Therapy
AGE – Age Requirement
SP – Specialty Medication
HD – May require home delivery pharmacy
PPACA – No Cost-Share Preventive Medication
CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

PSYCHOTHERAPEUTIC DRUGS (Schizophrenia/Anti-Psychotics)[10] *(cont.)*		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
ANTI-PSYCHOTICS, PHENOTHIAZINES *(con't.)*		
trifluoperazine hcl	T1	
SSRI-ANTI-PSYCH, ATYPICAL, DOPAMINE, SEROTONIN ANTAG		
olanzapine/fluoxetine hcl	T1	
olanzapine/fluoxetine hcl (Symbyax)	T1	
PSYCHOTHERAPEUTIC DRUGS (Sleep Disorders/Sedatives)		
NARCOLEPSY AND SLEEP DISORDER THERAPY AGENTS		
armodafinil	T1	PA
modafinil	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	T4	PA QL(1 pack/day) SP HD
LUMRYZ STARTER PACK	T4	PA SP HD
SODIUM OXYBATE 0.5 G/ML SOLN	T4	PA QL(18 mls/day) SP HD
XYWAV	T4	PA SP HD
BARBITURATES		
phenobarbital	T1	
secobarbital sodium	T3	PA
HYPNOTICS, MELATONIN MT1/MT2 RECEPTOR AGONISTS		
HETLIOZ	T4	PA SP HD
HETLIOZ LQ	T4	PA SP HD
ramelteon (Rozerem)	T1	QL (1 tab/day)
tasimelteon	T4	PA SP
SEDATIVE-HYPNOTICS - BENZODIAZEPINES		
DORAL	T3	
estazolam	T1	
flurazepam hcl	T1	
HALCION (*triazolam*)	T3	
midazolam hcl	T1	
QUAZEPAM	T1	

T1 – Typically Generics
T2 – Typically Preferred Brands
T3 – Typically Non-Preferred Brands
T4 – Specialty Medications
PA – Prior Authorization
QL – Quantity Limit
ST – Step Therapy
AGE – Age Requirement
SP – Specialty Medication
HD – May require home delivery pharmacy
PPACA – No Cost-Share Preventive Medication
CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

SEDATIVE/HYPNOTICS (Sleep Disorders/Sedatives) *(cont.)*		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
SEDATIVE-HYPNOTICS - BENZODIAZEPINES *(con't.)*		
quazepam (Quazepam)	T1	
temazepam	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	
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	
zaleplon	T1	
zolpidem tart er 12.5 mg tab	T1	
zolpidem tart er 6.25 mg tab	T1	QL (1 tab/day)
zolpidem tartrate	T1	
zolpidem tartrate 5 mg tablet (Ambien)	T1	
zolpidem tartrate 10 mg tablet (Ambien)	T1	
SKIN PREPS (Miscellaneous)		
IRRIGANTS		
acetic acid	T1	
neomycin sulf/polymyxin b sulf	T1	
PHYSIOLYTE	T3	
PHYSIOSOL	T3	
ringer's solution	T1	
ringer's solution, lactated	T1	
sod, pot chlor/mag/sod, pot phos	T3	
sodium chloride irrig solution	T1	
SORBITOL	T1	
SORBITOL-MANNITOL	T1	
VASHE WOUND	T3	
VASHE WOUND THERAPY	T3	
water for irrigation, sterile	T1	
OXIDIZING AGENTS		
hydrogen peroxide	T1	

T1 – Typically Generics
T2 – Typically Preferred Brands
T3 – Typically Non-Preferred Brands
T4 – Specialty Medications
PA – Prior Authorization
QL – Quantity Limit
ST – Step Therapy
AGE – Age Requirement
SP – Specialty Medication
HD – May require home delivery pharmacy
PPACA – No Cost-Share Preventive Medication
CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

SKIN PREPS (Pain Relief And Inflammatory Disease)		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
ANTI-PSORIATIC AGENTS, SYSTEMIC		
acitretin	T1	
BIMZELX *(dapsone)*	T4	PA QL(2 mls/28 days) SP HD
COSENTYX	T4	PA QL SP
ILUMYA	T4	PA QL (1 syringe/84 days) SP HD
SILIQ	T4	PA QL SP
methoxsalen (Oxsoralen-ultra)	T1	
OXSORALEN-ULTRA (*methoxsalen*)	T3	
SKYRIZI (2 SYRINGES) KIT	T4	PA QL (1 kit/84 days) SP HD
SOTYKTU	T4	PA QL (1 tab/day) SP HD
SPEVIGO	T4	PA QL(2 mls/28 days) SP HD
TALTZ AUTOINJECTOR	T4	PA QL (1 injector/28 days) SP HD
TALTZ AUTOINJECTOR (2 PACK)	T4	PA QL (1 injector/28 days) SP HD
TALTZ AUTOINJECTOR (3 PACK)	T4	PA QL (1 injector/28 days) SP HD
TALTZ SYRINGE	T4	PA QL (1 syringe/28 days) SP HD
TREMFYA 100 MG/ML PEN	T4	PA QL (1 ml/56 days) SP HD
TREMFYA 200 MG/2 ML PEN	T4	PA QL(2 syringe/28 days) SP HD
TREMFYA PEN INDUCTION PK-CROHN	T4	PA QL(2 syringe/28 days) SP HD
TOPICAL ANTI-INFLAMMATORY, NSAIDS		
DICLAREAL	T3	HD
diclofenac sodium 1% gel	T1	QL (1000gm/30 days) HD
SKIN PREPS (Skin Conditions)		
ACNE AGENTS, SYSTEMIC		
ACCUTANE	T1	
AMNESTEEM	T1	
CLARAVIS	T1	
isotretinoin	T1	
isotretinoin (Absorica)	T1	
MYORISAN	T1	
ZENATANE	T1	
ACNE AGENTS, TOPICAL		
ACZONE 7.5% GEL PUMP	T3	
adapalene/benzoyl peroxide	T1	

T1 – Typically Generics
T2 – Typically Preferred Brands
T3 – Typically Non-Preferred Brands
T4 – Specialty Medications
PA – Prior Authorization
QL – Quantity Limit
ST – Step Therapy
AGE – Age Requirement
SP – Specialty Medication
HD – May require home delivery pharmacy
PPACA – No Cost-Share Preventive Medication
CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

SKIN PREPS (Skin Conditions)		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
ACNE AGENTS, SYSTEMIC		
clindamycin phos/benzoyl perox	T1	
clindamycin-benzoyl perox 1-5% pmp	T1	
clindamycin/tretinoin	T1	
dapsone 5% gel (Aczone)	T1	
DAPSONE 7.5% GEL	T3	
KLARON (*sulfacetamide sodium*)	T3	
ONEXTON *(clindamycin phos/benzoyl perox)*	T3	
sulfacetamide sodium (Klaron)	T1	
ANTI-PERSPIRANTS		
DRYSOL	T3	
ANTI-PRURITICS, TOPICAL		
ALEVICYN PLUS	T3	
ANTI-PSORIATICS AGENTS		
anthralin	T1	
calcipotriene	T1	
calcipotriene 0.005% cream	T1	
CALCIPOTRIENE 0.005% FOAM	T3	
calcipotriene 0.005% ointment	T1	
calcipotriene 0.005% solution	T1	
calcitriol 3 mcg/g ointment	T1	QL (800gm/30 days)
tazarotene (Tazorac)	T1	
tazarotene 0.05% cream	T1	
ANTI-SEBORRHEIC AGENTS		
OVACE PLUS	T3	
selenium sulfide	T1	
sulfacetamide sodium	T1	
TERSI FOAM	T3	
ANTISEPTICS, MISCELLANEOUS		
GUAIACOL	T1	
DIABETIC ULCER PREPARATIONS, TOPICAL		
REGRANEX	T3	PA QL (2 tubs/30 days)
EMOLLIENTS		
ammonium lactate	T1	

T1 – Typically Generics
T2 – Typically Preferred Brands
T3 – Typically Non-Preferred Brands
T4 – Specialty Medications
PA – Prior Authorization
QL – Quantity Limit
ST – Step Therapy
AGE – Age Requirement
SP – Specialty Medication
HD – May require home delivery pharmacy
PPACA – No Cost-Share Preventive Medication
CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

SKIN PREPS (Skin Conditions) *(cont.)*		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
EMOLLIENTS *(con't.)*		
ATOPICLAIR	T3	
emollient combination no.35 (Mimyx)	T1	
emollient combination no.60 (Restizan)	T1	
emollient combination no.60 (Restizan)	T3	
HALUCORT	T3	
HPR PLUS-MB HYDROGEL	T1	
MIMYX (*prumyx*)	T3	
RESTIZAN	T1	
vite ac/grape/hyaluronic acid (Atopiclair)	T1	
XCLAIR	T3	
IMMUNOMODULATORS		
imiquimod	T1	
IRRITANTS/COUNTER-IRRITANTS		
methyl salicylate	T1	
QUTENZA	T3	
JANUS KINASE (JAK) INHIBITORS		
CIBINQO	T4	PA QL(30 tabs/30 days) SP
KERATOLYTICS		
BENZEFOAM	T3	
BENZEPRO	T1	
benzoyl peroxide	T1	
benzoyl peroxide (Enzoclear)	T1	
benzoyl peroxide (Pacnex)	T1	
ENZOCLEAR	T3	
HYDRO 35	T3	
HYDRO 40 (*umecta*)	T3	
INOVA	T3	
KERAFOAM	T3	
KERALYT 6% GEL (*salicylic acid*)	T3	
keralyt 6% shampoo	T1	
KERALYT SCALP (*salicylic acid*)	T3	
PACNEX (*benzoyl peroxide*)	T3	
PODOCON-25	T1	
podofilox	T1	

T1 – Typically Generics
T2 – Typically Preferred Brands
T3 – Typically Non-Preferred Brands
T4 – Specialty Medications
PA – Prior Authorization
QL – Quantity Limit
ST – Step Therapy
AGE – Age Requirement
SP – Specialty Medication
HD – May require home delivery pharmacy
PPACA – No Cost-Share Preventive Medication
CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

SKIN PREPS (Skin Conditions) *(cont.)*		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
KERATOLYTICS *(con't.)*		
podofilox (Condylox)	T1	
PR BENZOYL PEROXIDE	T1	
SALICATE	T3	
salicylic acid	T3	
salicylic acid (Keralyt Scalp)	T1	
salicylic acid/ceramide comb 1	T1	
SALIMEZ FORTE	T1	
SALKERA	T3	
SALVAX DUO PLUS	T3	
silver nitrate	T1	
silver nitrate applicator	T1	
URAMAXIN	T3	
URAMAXIN (*urea*)	T3	
urea (Hydro 35)	T1	
urea (Hydro 40)	T3	
urea (Uramaxin)	T1	
urea (Xurea)	T1	
XUREA	T3	
PROTECTIVES		
BIONECT	T3	
PHARMABASE BARRIER	T1	
polydimethylsiloxanes/silicon	T1	
protectives2/ceramide 1, 3, 6-ii	T1	
RADIAPLEXRX	T3	
zinc oxide	T1	
ROSACEA AGENTS, TOPICAL		
azelaic acid	T1	
ivermectin	T1	
metronidazole	T1	
SOOLANTRA *(ivermectin)*	T3	
TISSUE/WOUND ADHESIVES		
ARTISS	T3	
SURGISEAL STYLUS	T3	
SURGISEAL TEARDROP	T3	

T1 – Typically Generics
T2 – Typically Preferred Brands
T3 – Typically Non-Preferred Brands
T4 – Specialty Medications
PA – Prior Authorization
QL – Quantity Limit
ST – Step Therapy
AGE – Age Requirement
SP – Specialty Medication
HD – May require home delivery pharmacy
PPACA – No Cost-Share Preventive Medication
CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

SKIN PREPS (Skin Conditions) *(cont.)*		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
TISSUE/WOUND ADHESIVES *(con't.)*		
SURGISEAL TWIST	T3	
TISSEEL VHSD	T3	
TOP. ANTI-INFLAM., PHOSPHODIESTERASE-4 (PDE4) INHIB		
EUCRISA	T2	
ZORYVE 0.15% CREAM	T2	ST QL(60 gms/30 days)
TOPICAL AGENTS, MISCELLANEOUS		
GORDON'S UREA	T3	
HYFTOR	T4	PA SP
L-MESITRAN SOFT	T3	
MEDIHONEY	T3	
SAF-CLENS AF	T1	
trichloroacetic acid	T3	
TRICHLOROACETIC ACID	T1	
urea	T1	
TOPICAL ANTIBIOTIC PLEUROMUTILIN DERIVATIVES		
ALTABAX	T3	
TOPICAL ANTI-INFLAMMATORY STEROIDAL		
ALA-SCALP (*scalacort*)	T3	ST
alclometasone dipropionate	T1	
amcinonide 0.1% cream	T1	
amcinonide 0.1% lotion	T1	
amcinonide	T1	
AQUA GLYCOLIC HC	T3	
betamethasone dipropionate	T1	
betamethasone valerate	T1	
betamethasone valerate (Luxiq)	T1	
betamethasone/propylene glyc	T1	
betamethasone/propylene glyc (Diprolene)	T1	
BRYHALI	T3	ST
CAPEX SHAMPOO	T3	ST
clobetasol 0.05% cream (Temovate)	T1	
clobetasol 0.05% gel	T1	
clobetasol 0.05% ointment (Temovate)	T1	
clobetasol 0.05% shampoo (Clobex)	T1	

T1 – Typically Generics
T2 – Typically Preferred Brands
T3 – Typically Non-Preferred Brands
T4 – Specialty Medications
PA – Prior Authorization
QL – Quantity Limit
ST – Step Therapy
AGE – Age Requirement
SP – Specialty Medication
HD – May require home delivery pharmacy
PPACA – No Cost-Share Preventive Medication
CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

SKIN PREPS (Skin Conditions) *(cont.)*		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
TOPICAL ANTI-INFLAMMATORY STEROIDAL *(cont.)*		
clobetasol 0.05% solution	T1	
clobetasol 0.05% topical lotn	T1	
clobetasol prop 0.05% foam (Olux)	T1	
clobetasol prop 0.05% spray (Clobex)	T1	
clobetasol propionate/emoll	T1	
CLOCORTOLONE PIVALATE	T1	
CLODAN 0.05% KIT	T3	ST
clodan 0.05% shampoo	T1	
CLODERM	T3	ST
DERMA-SMOOTHE-FS (*fluocinolone acetonide*)	T3	ST
DERMATOP (*prednicarbate*)	T3	ST
desonide	T1	
desoximetasone (Topicort)	T1	
DESOWEN 0.05% CREAM	T3	ST
DIPROLENE (*betamethasone diprop augmented*)	T3	ST
fluocinolone acetonide (Derma-Smoothe-Fs)	T1	
fluocinolone/shower cap (Derma-Smoothe-Fs)	T1	
fluocinolone acetonide	T1	
fluocinolone acetonide (Derma-smoothe-fs)	T1	
fluocinolone acetonide (Synalar)	T1	
fluocinolone/shower cap (Derma-smoothe-fs)	T1	
fluocinonide	T1	
fluocinonide/emollient base	T1	
fluticasone prop 0.005% oint	T1	
fluticasone prop 0.05% cream	T1	
fluticasone prop 0.05% lotion	T1	
fluticasone propionate	T1	
halcinonide 0.1% solution	T1	
halobetasol prop 0.05% cream	T1	
halobetasol prop 0.05% foam	T1	
halobetasol prop 0.05% ointmnt	T1	
halobetasol propionate	T1	
halobetasol propionate (Ultravate)	T1	
hydrocortisone	T1	

T1 – Typically Generics
T2 – Typically Preferred Brands
T3 – Typically Non-Preferred Brands
T4 – Specialty Medications
PA – Prior Authorization
QL – Quantity Limit
ST – Step Therapy
AGE – Age Requirement
SP – Specialty Medication
HD – May require home delivery pharmacy
PPACA – No Cost-Share Preventive Medication
CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

SKIN PREPS (Skin Conditions) *(cont.)*		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
TOPICAL ANTI-INFLAMMATORY STEROIDAL *(cont.)*		
hydrocortisone (Ala-scalp)	T1	
hydrocortisone butyrate	T1	
hydrocortisone valerate	T1	
LUXIQ (*betamethasone valerate*)	T3	ST
MOMETACURE	T3	
mometasone furoate 0.1% cream	T1	
mometasone furoate 0.1% oint	T1	
mometasone furoate 0.1% soln	T1	
NUCORT	T3	ST
prednicarbate (Dermatop)	T1	
SCALACORT DK	T3	ST
SYNALAR	T3	ST
SYNALAR (*fluocinolone acetonide*)	T3	ST
SYNALAR TS	T3	ST
TEMOVATE (*clobetasol propionate*)	T3	ST
TEXACORT	T3	ST
TOPICORT (*desoximetasone*)	T3	ST
ULTRAVATE (*halobetasol propionate*)	T3	ST
TOPICAL ANTI-INFLAMMATORY STEROID-LOCAL ANESTHETIC		
ANALPRAM HC	T3	
ANALPRAM HC 1% CREAM	T3	
EPIFOAM	T2	
hydrocortisone/pramoxine (Pramosone)	T1	
lidocaine/hydrocortisone ac	T1	
MEZPAROX-HC	T1	
PRAMOSONE	T3	
TOPICAL ANTI-CHOLINERGIC HYPERHIDROSIS TX AGENTS		
QBREXZA	T3	PA
TOPICAL ANTI-PARASITICS		
lindane	T1	
TOPICAL PREPARATIONS, ANTIBACTERIALS		
dermazene cream	T1	
DERMAZENE CREAM PACKET	T3	
hydrocortisone/iodoquinol	T1	

T1 – Typically Generics
T2 – Typically Preferred Brands
T3 – Typically Non-Preferred Brands
I4 – Specialty Medications
PA – Prior Authorization
QL – Quantity Limit
ST – Step Therapy
AGE – Age Requirement
SP – Specialty Medication
HD – May require home delivery pharmacy
PPACA – No Cost-Share Preventive Medication
CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

SKIN PREPS (Skin Conditions) *(cont.)*		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
TOPICAL PREPARATIONS, ANTIBACTERIALS		
hydrocortisone/iodoquinol/aloe	T1	
iodine/potassium iodide	T1	
iodine/sodium iodide	T1	
IODOFLEX	T3	
IODOSORB	T3	
silver nitrate	T1	
TOPICAL VIT D ANALOG/ANTI-INFLAMMATORY STEROID		
calcipotriene/betamethasone	T1	
TOPICAL/MUCOUS MEMBR./SUBCUT. ENZYMES		
SANTYL	T3	QL (60gm/30 days)
VITAMIN A DERIVATIVES		
adapalene (Plixda)	T1	PA
PLIXDA	T1	PA
tretinoin 0.01% gel	T1	
tretinoin 0.025% cream	T1	PA
tretinoin 0.025% gel	T1	
tretinoin 0.05% cream	T1	PA
tretinoin 0.05% gel	T1	PA
tretinoin 0.1% cream	T1	PA
tretinoin microspheres	T1	PA
SMOKING DETERRENTS (Smoking Cessation)[9]		
SMOKING DETERRENT AGENTS (GANGLIONIC STIM, OTHERS)		
NICOTROL	T3	PPACA
NICOTROL NS	T3	PPACA
SMOKING DETERRENT-NICOTINIC RECEPT.PARTIAL AGONIST		
CHANTIX	T3	
varenicline 0.5 mg tablet	T1	PPACA
varenicline 1 mg cont month bx	T1	PPACA
varenicline 1 mg tablet	T1	PPACA
varenicline starting month box	T1	PPACA
SMOKING DETERRENTS, OTHER		
bupropion hcl sr 150 mg tablet	T1	PPACA

T1 – Typically Generics
T2 – Typically Preferred Brands
T3 – Typically Non-Preferred Brands
T4 – Specialty Medications
PA – Prior Authorization
QL – Quantity Limit
ST – Step Therapy
AGE – Age Requirement
SP – Specialty Medication
HD – May require home delivery pharmacy
PPACA – No Cost-Share Preventive Medication
CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

THYROID PREPS (Hormonal Agents)		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
ANTI-THYROID PREPARATIONS		
methimazole (Tapazole)	T1	HD
propylthiouracil	T1	HD
TAPAZOLE (*methimazole*)	T3	HD
THYROID HORMONES		
ARMOUR THYROID	T3	HD
CYTOMEL (*liothyronine sodium*)	T3	HD
LEVOTHYROXINE	T3	PA HD
levothyroxine 100 mcg tablet (Synthroid)	T1	HD
levothyroxine 112 mcg tablet (Synthroid)	T1	HD
levothyroxine 125 mcg tablet (Synthroid)	T1	HD
levothyroxine 137 mcg tablet (Synthroid)	T1	HD
levothyroxine 150 mcg tablet (Synthroid)	T1	HD
levothyroxine 175 mcg tablet (Synthroid)	T1	HD
levothyroxine 200 mcg tablet (Synthroid)	T1	HD
levothyroxine 25 mcg tablet (Synthroid)	T1	HD
levothyroxine 300 mcg tablet (Synthroid)	T1	HD
levothyroxine 50 mcg tablet (Synthroid)	T1	HD
levothyroxine 75 mcg tablet (Synthroid)	T1	HD
levothyroxine 88 mcg tablet (Synthroid)	T1	HD
levothyroxine sodium (Synthroid)	T1	HD
liothyronine sodium (Cytomel)	T1	HD
SYNTHROID (*unithroid*)	T3	HD
thyroid, pork	T1	HD
thyroid, pork (Armour Thyroid)	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
TIROSINT	T3	PA HD
TIROSINT-SOL	T3	PA HD
WP THYROID	T1	HD
WP THYROID (*nature-throid*) (*westhroid*)	T1	HD

T1 – Typically Generics
T2 – Typically Preferred Brands
T3 – Typically Non-Preferred Brands
T4 – Specialty Medications
PA – Prior Authorization
QL – Quantity Limit
ST – Step Therapy
AGE – Age Requirement
SP – Specialty Medication
HD – May require home delivery pharmacy
PPACA – No Cost-Share Preventive Medication
CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

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

T1 – Typically Generics
T2 – Typically Preferred Brands
T3 – Typically Non-Preferred Brands
T4 – Specialty Medications
PA – Prior Authorization
QL – Quantity Limit
ST – Step Therapy
AGE – Age Requirement
SP – Specialty Medication
HD – May require home delivery pharmacy
PPACA – No Cost-Share Preventive Medication
CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
UNCLASSIFIED DRUG PRODUCTS (Blood Modifiers/Bleeding Disorders)		
SPLEEN TYROSINE KINASE INHIBITORS		
TAVALISSE	T4	PA SP
UNCLASSIFIED DRUG PRODUCTS (Blood Pressure/Heart Medications)		
BRADYKININ B2 RECEPTOR ANTAGONISTS		
icatibant acetate	T4	PA SP HD
CI ESTERASE INHIBITORS		
BERINERT	T4	PA SP HD
CINRYZE	T4	PA SP HD
HAEGARDA	T4	PA SP HD
RUCONEST	T4	PA SP HD
PLASMA KALLIKREIN INHIBITORS		
KALBITOR	T4	PA SP HD
ORLADEYO	T4	PA QL (1 caps/day) SP
UNCLASSIFIED DRUG PRODUCTS (Cancer)		
CHEMOTHERAPY RESCUE/ANTIDOTE AGENTS		
leucovorin calcium	T1	
mesna (Mesnex)	T4	SP CSL
MESNEX	T4	SP
VISTOGARD	T4	SP
UNCLASSIFIED DRUG PRODUCTS (Dental Products)		
DENTAL AIDS AND PREPARATIONS		
chlorhexidine gluconate (Peridex)	T1	
PERIDEX (*periogard*)	T1	
triamcinolone acetonide	T1	
PERIODONTAL COLLAGENASE INHIBITORS		
doxycycline hyclate	T1	
UNCLASSIFIED DRUG PRODUCTS (Erectile Dysfunction)		
DRUGS TO TREAT ERECTILE DYSFUNCTION (ED)		
avanafil (Stendra)	T1	QL(8 tabs/30 days)
CAVERJECT	T3	PA QL (6 injectors/30 days)
CIALIS 10 MG TABLET (*tadalafil*)	T3	QL (8 tabs/30 days) ST
CIALIS 20 MG TABLET (*tadalafil*)	T3	QL (8 tabs/30 days) ST
CIALIS 5 MG TABLET (*tadalafil*)	T3	QL (1 tabs/30 days) ST
EDEX	T3	PA QL (6 injectors/30 days)

T1 – Typically Generics
T2 – Typically Preferred Brands
T3 – Typically Non-Preferred Brands
T4 – Specialty Medications
PA – Prior Authorization
QL – Quantity Limit
ST – Step Therapy
AGE – Age Requirement
SP – Specialty Medication
HD – May require home delivery pharmacy
PPACA – No Cost-Share Preventive Medication
CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

UNCLASSIFIED DRUG PRODUCTS (Erectile Dysfunction)		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
DRUGS TO TREAT ERECTILE DYSFUNCTION (ED)		
IFE-BIMIX 30/1	T2	
IFE-PG20	T2	
LEVITRA (*vardenafil hcl*)	T3	QL (10 tabs/30 days) ST
MUSE	T3	PA QL (6/30 days)
PAPAVERINE-ALPROSTADIL	T1	
PHENTOLAMINE-ALPROSTADIL	T1	
sildenafil 100 mg tablet (Viagra)	T1	QL(8 tabs/30 days) HD
sildenafil 25 mg tablet (Viagra)	T1	QL(8 tabs/30 days) HD
sildenafil 50 mg tablet (Viagra)	T1	QL(8 tabs/30 days) HD
STENDRA *(avanafil)*	T3	QL (8 tabs/30 days) ST
tadalafil 10 mg tablet (Cialis)	T1	QL(8 Tabs/30 days) HD
tadalafil 2.5 mg tablet	T1	QL(1 tab/day) HD
tadalafil 20 mg tablet (Cialis)	T1	QL(8 tabs/30 days) HD
tadalafil 5 mg tablet (Cialis)	T1	QL(1 tab/day) HD
vardenafil hcl (Levitra)	T1	QL (10 tabs/30 days)
VIAGRA (*sildenafil citrate*)	T3	ST QL(8 tabs/30 days)
UNCLASSIFIED DRUG PRODUCTS (Gastrointestinal/Heartburn)		
CALCIMIMETIC, PARATHYROID CALCIUM ENHANCER		
cinacalcet hcl	T4	SP
ORAL MUCOSITIS/STOMATITIS AGENTS		
GELCLAIR	T3	
MUGARD	T3	
ORAMAGICRX	T3	
SALIVA STIMULANT AGENTS		
NUMOISYN	T3	
SALIVA SUBSTITUTE AGENTS		
NEUTRASAL	T3	
THYROID HORMONE RECEPTOR (THR) AGONIST		
REZDIFFRA	T4	PA QL(1 tab/day) SP HD
UNCLASSIFIED DRUG PRODUCTS (Hormonal Agents)		
BONE FORMATION STIM. AGENTS - PARATHYROID HORMONE		
FORTEO	T4	PA QL (3ml/21 days) SP HD
teriparatide 600 mcg/2.4ml pen (Forteo)	T4	PA QL(0.09 mls/day) SP HD

T1 – Typically Generics
T2 – Typically Preferred Brands
T3 – Typically Non-Preferred Brands
T4 – Specialty Medications
PA – Prior Authorization
QL – Quantity Limit
ST – Step Therapy
AGE – Age Requirement
SP – Specialty Medication
HD – May require home delivery pharmacy
PPACA – No Cost-Share Preventive Medication
CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

UNCLASSIFIED DRUG PRODUCTS (Miscellaneous)		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
GROWTH HORMONE RECEPTOR ANTAGONISTS		
SOMAVERT	T4	PA SP HD
HYPERPARATHYROID TX AGENTS - VITAMIN D ANALOG-TYPE		
doxercalciferol	T1	
paricalcitol (Zemplar)	T4	SP HD
RAYALDEE	T3	
ZEMPLAR (*paricalcitol*)	T4	SP HD
MENOPAUSAL SYMPT SUPP-SEL ESTROGEN RECEP MODULATOR		
OSPHENA	T3	QL(30 tabs/30 days) HD
ABORTIFACIENT-PROGESTERONE RECEPTOR ANTAGONISTS		
MIFEPREX	T3	
mifepristone (Mifeprex)	T1	
mifepristone 200 mg tablet	T1	
mifepristone 300 mg tablet (Korlym)	T4	PA SP
AGENTS TO TX PERIODIC PARALYSIS - CARBON ANHYD INH		
dichlorphenamide (Keveyis)	T4	PA SP
AMMONIA INHIBITORS		
CARBAGLU *(carglumic acid)*	T4	SP HD
carglumic acid (Carbaglu)	T4	SP HD
AMYLOIDOSIS AGENTS-TRANSTHYRETIN (TTR) SUPPRESSION		
TEGSEDI	T4	PA SP HD
ANTI-ALCOHOLIC PREPARATIONS		
acamprosate calcium	T1	
ANTABUSE (*disulfiram*)	T3	
disulfiram (Antabuse)	T1	
ANTIDOTES, MISCELLANEOUS		
CETYLEV	T3	
ANTI-FIBROTIC THERAPY - PYRIDONE ANALOGS		
pirfenidone 267 mg capsule (Esbriet)	T4	PA SP HD
pirfenidone 801 mg capsule (Esbriet)	T4	PA SP HD
CRYOPRESERVATIVE AGENTS		
dimethyl sulfoxide	T1	
DRUGS TO TREAT HEREDITARY TYROSINEMIA		
nitisinone (Orfadin)	T4	PA SP HD
NITYR	T4	PA SP

T1 – Typically Generics
T2 – Typically Preferred Brands
T3 – Typically Non-Preferred Brands
T4 – Specialty Medications
PA – Prior Authorization
QL – Quantity Limit
ST – Step Therapy
AGE – Age Requirement
SP – Specialty Medication
HD – May require home delivery pharmacy
PPACA – No Cost-Share Preventive Medication
CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

UNCLASSIFIED DRUG PRODUCTS (Miscellaneous) *(cont.)*		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
DRUGS TO TREAT HEREDITARY TYROSINEMIA		
ORFADIN	T4	PA SP
ORFADIN (*nitisinone*)	T4	PA SP
DRUGS TO TX GAUCHER DX-TYPE I, SUBSTRATE REDUCING		
CERDELGA	T4	PA SP HD
miglustat (Zavesca)	T4	PA SP
ZAVESCA (*miglustat*)	T4	PA SP HD
GENERAL INHALATION AGENTS		
HYPER-SAL	T3	
nebusal 3% vial	T1	
NEBUSAL 6% VIAL	T3	
sodium chloride for inhalation	T1	
sodium chloride for inhalation (Hyper-sal)	T1	
GENETIC D/O TX - SMN PROTEIN DEFICIENCY TREATMENT		
EVRYSDI	T4	PA SP HD
GLUCOSYLCERAMIDE SYNTHASE (GCS) INHIBITOR		
miglustat (Zavesca)	T4	PA SP HD
OPFOLDA	T4	PA QL(8 caps/30 days) SP HD
INTERLEUKIN-13 (IL-13) INHIBITORS, MAB		
ADBRY	T4	PA SP HD
MENOPAUSAL SYMPTOMS SUPPRESSANT - SSRIs		
paroxetine mesylate	T1	QL(1 cap/day) HD
METABOLIC DISEASE ENZYME REPLACE, HYPOPHOSPHATASIA		
STRENSIQ	T4	PA SP
METABOLIC DISEASE ENZYME REPLACEMENT, MOCD		
NULIBRY	T4	PA SP
METALLIC POISON, AGENTS TO TREAT		
CHEMET	T3	
deferasirox (Exjade)	T4	SP HD
deferasirox (Jadenu Sprinkle)	T4	SP HD
deferasirox (Jadenu)	T4	SP HD
deferiprone (Ferriprox)	T4	PA SP HD
EXJADE (*deferasirox*)	T4	PA SP HD
FERRIPROX	T4	PA SP
FERRIPROX (2 TIMES A DAY)	T4	PA SP

T1 – Typically Generics
T2 – Typically Preferred Brands
T3 – Typically Non-Preferred Brands
T4 – Specialty Medications
PA – Prior Authorization
QL – Quantity Limit
ST – Step Therapy
AGE – Age Requirement
SP – Specialty Medication
HD – May require home delivery pharmacy
PPACA – No Cost-Share Preventive Medication
CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

UNCLASSIFIED DRUG PRODUCTS (Miscellaneous) *(cont.)*		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
METALLIC POISON, AGENTS TO TREAT		
GALZIN	T4	SP
RADIOGARDASE	T3	
TRIENTINE HCL 500 MG CAPSULE	T4	PA SP HD
trientine hcl	T4	PA SP HD
NATRIURETIC PEPTIDES		
VOXZOGO	T4	PA SP HD
NEONATAL FC RECEPTOR (FCRN) INHIBITORS		
VYVGART HYTRULO	T4	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	T4	PA SP HD
PKU TX AGENT-COFACTOR OF PHENYLALANINE HYDROXYLASE		
javygtor 100 mg powder packet (Kuvan)	T4	PA SP
javygtor 100 mg tablet (Kuvan)	T4	PA SP HD
javygtor 500 mg powder packet (Kuvan)	T4	PA SP
sapropterin dihydrochloride	T4	PA SP HD
UNCLASSIFIED DRUG PRODUCTS (Miscellaneous) *(cont.)*		
PROTEIN STABILIZERS		
ATTRUBY	T3	
VYNDAMAX	T4	PA QL (1 cap/day) SP HD
VYNDAQEL	T4	PA QL (4 caps/day) SP HD
SOLVENTS		
FT ISOPROPYL ALCOHOL 91%	T1	
FT ISOPROPYL RUB ALCOHOL 70%	T3	
GS ISOPROPYL ALCOHOL 70%	T3	
isopropyl alcohol	T1	
MURI-LUBE MINERAL OIL	T1	
UNCLASSIFIED DRUG PRODUCTS (Nutritional/Dietary)		
METABOLIC DEFICIENCY AGENTS		
betaine (Cystadane)	T4	SP
CYSTADANE	T4	SP

T1 – Typically Generics
T2 – Typically Preferred Brands
T3 – Typically Non-Preferred Brands
T4 – Specialty Medications
PA – Prior Authorization
QL – Quantity Limit
ST – Step Therapy
AGE – Age Requirement
SP – Specialty Medication
HD – May require home delivery pharmacy
PPACA – No Cost-Share Preventive Medication
CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
UNCLASSIFIED DRUG PRODUCTS (Nutritional/Dietary)		
METABOLIC DEFICIENCY AGENTS		
levocarnitine (Carnitor Sf)	T1	
levocarnitine (Carnitor)	T1	
levocarnitine (with sugar) (Carnitor)	T1	
THYMIC STROMAL LYMPHOPOIETIN (TSLP) INHIBITORS		
TEZSPIRE 210 MG/1.91 ML PEN	T4	PA QL(1 pen/28 days) SP HD
TEZSPIRE 210 MG/1.91 ML SYRING	T4	PA SP HD
UNCLASSIFIED DRUG PRODUCTS (Osteoporosis Products)		
BONE RESORPTION INHIBITOR AND VITAMIN D COMBS.		
FOSAMAX PLUS D	T2	ST HD
BONE RESORPTION INHIBITORS		
ACTONEL (*risedronate sodium)*	T3	ST HD
alendronate sodium	T1	HD
alendronate sodium (Fosamax)	T1	HD
ATELVIA (*risedronate sodium dr*)	T3	ST HD
BINOSTO	T3	ST HD
BONIVA (*ibandronate sodium*)	T3	ST HD
EVISTA (*raloxifene hcl*)	T3	HD
FOSAMAX (*alendronate sodium*)	T3	ST HD
ibandronate sodium (Boniva)	T1	HD
raloxifene hcl (Evista)	T1	HD PPACA
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	T4	PA SP HD
ANTI-INFLAMMATORY, INTERLEUKIN-1 BETA BLOCKERS		
ILARIS	T4	PA SP HD
FIBROMYALGIA AGENTS, SEROTONIN-NOREPINEPH RU INHIB		
SAVELLA	T3	
IMMUNOMODULATOR, B-LYMPHOCYTE STIM (BLYS)-SPEC INHIB		
BENLYSTA	T4	PA SP HD
UNCLASSIFIED DRUG PRODUCTS (Skin Conditions)		
INTERLEUKIN-13 (IL-13) INHIBITORS, MAB		
ADBRY AUTOINJECTOR	T4	PA SP HD

T1 – Typically Generics
T2 – Typically Preferred Brands
T3 – Typically Non-Preferred Brands
T4 – Specialty Medications
PA – Prior Authorization
QL – Quantity Limit
ST – Step Therapy
AGE – Age Requirement
SP – Specialty Medication
HD – May require home delivery pharmacy
PPACA – No Cost-Share Preventive Medication
CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
UNCLASSIFIED DRUG PRODUCTS (Skin Conditions)		
INTERLEUKIN-13 (IL-13) INHIBITORS, MAB		
EBGLYSS PEN	T4	PA SP
WOUND HEALING AGENTS, LOCAL		
FILSUVEZ	T4	PA SP
UNCLASSIFIED DRUG PRODUCTS (Substance Abuse)		
OPIOID WITHDRAWAL THER, ALPHA-2 ADRENERGIC AGONIST		
lofexidine hcl (Lucemyra)	T1	QL(192 tabs/30 days)
LUCEMYRA (*lofexidine hcl)*	T2	QL (192 tabs/14 days)
OPIOID WITHDRAWAL THER, ALPHA-2 ADRENERGIC AGONIST		
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 (Suboxone)	T1	
SUBOXONE (*buprenorphine-naloxone*)	T3	
ZUBSOLV	T2	
UNCLASSIFIED DRUG PRODUCTS (Transplant Medications)		
RHO KINASE INHIBITOR		
REZUROCK	T4	PA SP HD
UNCLASSIFIED DRUG PRODUCTS (Urinary Tract Conditions)		
BENIGN PROSTATIC HYPERTROPHY/MICTURITION AGENTS		
alfuzosin hcl (Uroxatral)	T1	HD
dutasteride (Avodart)	T1	HD
BENIGN PROSTATIC HYPERTROPHY/MICTURITION AGENTS *(cont.)*		
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
silodosin 8 mg capsule (Rapaflo)	T1	HD
tamsulosin hcl (Flomax)	T1	HD
VANRAFIA	T4	PA QL(1 tab/day) SP

T1 – Typically Generics
T2 – Typically Preferred Brands
T3 – Typically Non-Preferred Brands
T4 – Specialty Medications
PA – Prior Authorization
QL – Quantity Limit
ST – Step Therapy
AGE – Age Requirement
SP – Specialty Medication
HD – May require home delivery pharmacy
PPACA – No Cost-Share Preventive Medication
CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

UNCLASSIFIED DRUG PRODUCTS (Urinary Tract Conditions)		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
BPH 5-ALPHA-REDUCTASE INHIB-ALPHAI-ADRENOCEP ANTAG		
dutasteride/tamsulosin hcl (Jalyn)	T1	HD
CYSTINE-DEPLETING AGENTS, NEPHROPATHIC CYSTINOSIS		
CYSTAGON	T4	SP
KIDNEY STONE AGENTS		
solifenacin 5 mg tablet	T1	QL (1 tab/day) HD
solifenacin 10 mg tablet	T1	HD
THIOLA	T4	SP
tiopronin 100 mg tablet (Thiola)	T4	SP
tiopronin dr tablet	T4	SP
OVERACTIVE BLADDER AGENTS, BETA-3 ADRENERGIC RECEP		
mirabegron er 25 mg tablet (Myrbetriq)	T1	QL(1 tab/day) HD
mirabegron er 50 mg tablet (Myrbetriq)	T1	HD
URINARY TRACT ANTI-SPASMODIC, M(3) SELECTIVE ANTAG.		
darifenacin er 15 mg tablet	T1	HD
darifenacin er 7.5 mg tablet	T1	QL (1 tab/day) HD
URINARY TRACT ANTI-SPASMODIC/ANTI-INCONTINENCE AGENT		
flavoxate hcl	T1	HD
oxybutynin 5 mg/5 ml solution	T1	HD
oxybutynin 5 mg/5 ml syrup	T1	HD
oxybutynin chloride	T1	HD
tolterodine tart er 2 mg cap	T1	QL (1 cap/day) HD
tolterodine tart er 4 mg cap	T1	HD
tolterodine tart er 2 mg cap (Detrol La)	T1	QL(1 cap/day) HD
tolterodine tart er 4 mg cap (Detrol La)	T1	HD
tolterodine tartrate	T1	HD
trospium chloride	T1	HD
UNCLASSIFIED DRUG PRODUCTS (Weight Management)		
APPETITE STIM. FOR ANOREXIA, CACHEXIA, WASTING SYND.		
megestrol acetate	T1	
VITAMINS (Nutritional/Dietary)		
FOLIC ACID PREPARATIONS		
folic acid	T1	
true folic acid 1600mcg dfe tb	T1	

T1 – Typically Generics
T2 – Typically Preferred Brands
T3 – Typically Non-Preferred Brands
T4 – Specialty Medications
PA – Prior Authorization
QL – Quantity Limit
ST – Step Therapy
AGE – Age Requirement
SP – Specialty Medication
HD – May require home delivery pharmacy
PPACA – No Cost-Share Preventive Medication
CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

VITAMINS (Nutritional/Dietary)		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
MULTIVITAMIN PREPARATIONS		
CITRANATAL MEDLEY	T3	
CONCEPT DHA CAPSULE	T3	
FOLET ONE	T3	
mvn no.53/iron/folic/dss/dha	T1	
OBSTETRIX ONE	T1	
VITAMIN BI2 PREPARATIONS		
cyanocobalamin (vitamin b-12)	T1	
cyanocobalamin (vitamin b-12) (Nascobal)	T1	
VITAMIN D PREPARATIONS		
calcitriol 0.25 mcg capsule	T1	
calcitriol 0.5 mcg capsule	T1	
calcitriol 1 mcg/ml solution (Rocaltrol)	T1	HD
ergocalciferol (vitamin d2)	T1	HD
ROCALTROL (*calcitriol*)	T3	HD
VITAMIN K PREPARATIONS		
MEPHYTON (*phytonadione*)	T3	

T1 – Typically Generics
T2 – Typically Preferred Brands
T3 – Typically Non-Preferred Brands
T4 – Specialty Medications
PA – Prior Authorization
QL – Quantity Limit
ST – Step Therapy
AGE – Age Requirement
SP – Specialty Medication
HD – May require home delivery pharmacy
PPACA – No Cost-Share Preventive Medication
CSL – Oral cancer medication subject to cost-share limits

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.

Index of Medications

Symbols

1ST TIER UNILET 115
2-IN-1 LANCET 115

A

abacavir/lamivudine/zidovudine 61
abacavir sulfate 61, 62
abacavir sulfate/lamivudine 61
abiraterone 50
ABRYSVO 69
ACAM2000 69
acamprosate calcium 147
acarbose 43, 44
ACCOLATE 30
ACCU-CHEK 115
ACCUTANE 135
ACD-A 38
ACD SOLUTION A 38
ACE AEROSOL 122
acebutolol hcl 77
ACETAMIN-CAFF-DIHYDROCODEINE 21
acetamin-codein 21
acetaminop-codeine 21
acetaminophen/caff/dihydrocod 21
acetaminophen-cod 21
acetazolamide 91
acetic acid 46, 92, 134
acetic acid/oxyquinoline 46
acetylcysteine 30
acitretin 135
ACTEMRA 112
ACTHIB 68, 69
ACTIGALL 101
ACTI-LANCE 115
ACTIMMUNE 56
ACTIQ 22
ACTIVELLA 106
ACTONEL 150
ACTOPLUS MET 45
ACTOS 45
ACULAR 93
acyclovir 63
ACZONE 135
ADACEL TDAP 68
ADALAT CC 71
ADALIMUMAB 48
ADALIMUMAB-ADAZ 48
ADALIMUMAB-ADBM 48
ADALIMUMAB-RYVK 48
adapalene 135, 142
adapalene/benzoyl peroxide 135
ADBRY 148, 150
ADDERALL 66
ADDYI 131
adefovir dipivoxil 64
ADEMPAS 73
ADIPEX-P 57
ADRENALIN CHLORIDE 92
ADVANCED DNA MEDICATED COLLECT 90
ADVANCED TRAVEL 115
ADVOCATE 115
AEMCOLO 36
AEROCHAMBER 122
AEROTRACH 122
AEROVENT 122
AFINITOR 51
AFLURIA 68
AFLURIA QUAD 68
AGAMATRIX 113
AGRYLIN 60
AIMOVIG 15, 19
AIRSUPRA 29
AJOVY 15, 19
AKEEGA 51
AKTEN 93
AKYNZEO 100
ALA-SCALP 139
albendazole 47
ALBENZA 47
albuterol 28, 29
albuterol sulf 28
albuterol sulfate 28
ALBUTEROL SULFATE HFA 28
ALCAINE 93
alclometasone dipropionate 139
ALCOHOL 48, 149
ALDACTAZIDE 91
ALECENSA 52
alendronate 150
ALEVICYN PLUS 136
alfuzosin hcl 151
ALHEMO 70
ALINIA 58
aliskiren 78
ALKERAN 49
allopurinol 25
almotriptan malate 15, 19

Index of Medications

ALORA 106
alosetron hcl 102
alprazolam 125
ALTABAX 139
ALTAFLUOR BENOX 93
ALTERNATE SITE 115
ALTUVIIIO 70
ALUNBRIG 52
ALVESCO 29
ALYFTREK 144
amantadine 58
AMARYL 44
ambrisentan 73
amcinonide 139
AMICAR 70
amiloride hcl 91
amiloride/hydrochlorothiazide 91
aminocaproic acid 70
amitriptyline/chlordiazepoxide 128
amitriptyline hcl 128
amlodipine-atorvast 78, 79, 80
amlodipine besylate 71, 74, 76
amlodipine-olmesartan 76
amlodipine/valsartan/hcthiazid 75
ammonium lactate 136
AMNESTEEM 135
amoxapine 128
amoxicillin 36, 46
amphetamine sulfate 66
ampicillin trihydrate 36
ANADROL-50 105
anagrelide hcl 60
ANA-LEX 104
ANALPRAM HC 104, 141
ANAPROX DS 26
anastrozole 50
ANCOBON 41
ANGELIQ 107
ANTABUSE 147
anthralin 136
ANTICOAGULANT SODIUM 38
ANZEMET 100
APADAZ 21
APOKYN 58
apraclonidine hcl 94
aprepitant 100
APRETUDE 62
APRISO 102
APTIOM 84
APTIVUS 61
AQNEURSA 98
AQUA GLYCOLIC HC 139
ARAVA 25
ARCALYST 150
ARICEPT 65
ARIDOL 90
ARIKAYCE 32
ARIMIDEX 50
aripiprazole 132
ARIXTRA 39
armodafinil 133
ARMOUR THYROID 143
AROMASIN 50
ARTHROTEC 26
ARTISS 138
ARYMO ER 22
asenapine maleate 131
ASMANEX 29
ASMANEX HFA/TWISTHALER 29
aspirin/dipyridamole 60
ASSURE 115, 124
ASTAGRAF XL 112
ASTRINGYN 70
ATABEX EC 124
atazanavir sulfate 62
ATELVIA 150
atenolol 77, 78
atomoxetine hcl 130
ATOPICLAIR 137
atorvastatin 78, 79, 80
atovaquone/proguanil 47
atropine sulfate 95
ATROVENT HFA 28
ATTRUBY 149
AURYXIA 97
AUSTEDO 82
AUTOLET 113
AUTOSHIELD 120
avanafil 145
AVANDIA 45
avar 38
AVAR 38
AVC 46
AVELOX 36
AVITENE 70
AVMAPKI 56
AVONEX 82
AVSOLA 48

Index of Medications

AYVAKIT 53
AZASAN 112
AZASITE 31
azathioprine 112
azelaic acid 138
azelastine 43, 92
azelastine hcl 43
azithromycin 34, 35

B

BACIGUENT 31
bacitracin 31, 32
bacitracin/polymyxin b sulfate 31
baclofen 123
BACTRIM 32
BAFIERTAM 82
balsalazide disodium 102
BALVERSA 53
BANZEL 84
BAQSIMI 96, 97
BARACLUDE 64
BASAGLAR 46
BAXDELA 36
BCG 68
BD 115, 120, 121
BELBUCA 22
BELVIQ 57
BELVIQ XR 57
benazepril hcl 76
benazepril/hydrochlorothiazide 74
BENLYSTA 150
benoxinate hcl/fluorescein sod 93
BENZAMYCIN 37
BENZEFOAM 137
BENZEPRO 137
BENZHYDROCODONE-ACETAMINOPHEN 21
BENZNIDAZOLE 47
benzonatate 89
benzoyl peroxide 37, 135, 137
benzphetamine 57
benztropine mesylate 58
bepotastine 43
BERINERT 145
BESIVANCE 31, 32
BETADINE 93
betaine 149
betamethasone dipropionate 139
betamethasone/propylene glyc 139
betamethasone valerate 139, 141
BETASERON 82
betaxolol hcl 77, 94
bethanechol chloride 66
BETIMOL 94
BETOPTIC S 94
BEVYXXA 38
bexarotene 49
BEXSERO 67
bicalutamide 50
BIJUVA 106
BIKTARVY 63
BILTRICIDE 47
bimatoprost 94
BIMZELX 135
BINOSTO 150
BIONECT 138
bisac/nacl/nahco3/kcl/peg 3350 103
bismuth/metronid/tetracycline 101
bisoprolol/hydrochlorothiazide 78
BLEPH-10 31
BLEPHAMIDE 31
BLOOD LANCETS 115
BLUNT 120
BONIVA 150
BONJESTA 100
BOOSTRIX TDAP 68
bosentan 73
BOSULIF 53
BREATHERITE 122
BREZTRI AEROSPHERE 29
brimonidine tartrate 94
brinzolamide 94
BRIVIACT 84
bromfenac sodium 93
bromocriptine mesylate 58, 59
brompheniramine/pseudoephed/dm 89
BROMSITE 93
BRONCHITOL 144
BRUKINSA 53
BRYHALI 139
budesonide 29, 104, 107, 108
BULLSEYE MINI 115
bumetanide 91
BUNAVAIL 151
buprenorphine 22, 151
bupropion 126, 142
bupropion hcl sr 126, 142
buspirone 125
butalb-acetamin-caff 19
butalb-acetamin-caff 50-300-40 15

Index of Medications

butalb-acetamin-caff 50-325-40 15
butalb/acetaminophen/caffeine 15, 19
butalb-aspirin-caffe 19
butalb-aspirin-caffe 50-325-40 15
butalbit/acetamin/caff/codeine 23
butalbital/acetaminophen 15, 19
butalbital-asa-caffeine 19
butalbital-asa-caffeine cap (Fiorinal) 15
butorphanol 22
BUTRANS 22
BUTTERFLY TOUCH 115
BYDUREON 43

C

CABENUVA 60
cabergoline 109
CABLIVI 69
CABOMETYX 53
CADUET 78, 79, 80
CAFERGOT 15, 19
caffeine citrate 82
CALAN SR 71
calcipotriene 136, 142
CALCIPOTRIENE 136
calcipotriene/betamethasone 142
calcitonin, salmon, synthetic 111
calcitriol 136, 153
calcium acetate 97
CALQUENCE 53
CAMZYOS 71
candesartan cilexetil 76
candesartan/hydrochlorothiazid 75
capecitabine 50
CAPEX 139
CAPLYTA 131
CAPRELSA 53
captopril 74, 76
captopril-hctz 74
CAPVAXIVE 67
CARBAGLU 147
carbamazepine 84, 85
CARBAMAZEPINE 84
CARBATROL 84
carbidopa 58, 59, 60
carbidopa/levodopa 58
carbidopa/levodopa/entacapone 58
carbinoxamine maleate 42
CARDIZEM LA 71
CARDURA 75
CARDURA XL 75
CAREONE 115
CAREPOINT 120
CARESENS 113, 115
CARETOUCH 113, 116
carisoprodol 23, 123
carisoprodol/aspirin 23, 123
carisoprodol/aspirin/codeine 23
carteolol hcl 94
carvedilol 75
carvedilol er 75
CASODEX 50
CATAPRES 77
CATAPRES-TTS 77
CAVERJECT 145
CAYA CONTOURED 88
CAYSTON 34
cefaclor 34
cefadroxil 34
cefixime 34
cefpodoxime proxetil 34
cefprozil 34
cefuroxime axetil 34
celecoxib 27
CELONTIN 84
CENTANY 37
cephalexin 34
CEQUA 95
CEQUR 113
CERDELGA 148
CERVIDIL 109
cetirizine hcl 42
CETROTIDE 109
CETYLEV 147
cevimeline hcl 66
CHANTIX 142
CHEMET 148
CHENODAL 101
chlordiazepoxide/clidinium br 99
chlordiazepoxide hcl 125
chlorhexidine gluconate 145
chloroquine ph 47
chlorpromazine hcl 132
chlorpropamide 44
chlorthalidone 78, 92
chlorzoxazone 123
CHOLBAM 101
cholestyramine 80
cholestyramine/aspartame 80
choline salicyl/mag salicylate 15, 19

Index of Medications

CHORIONIC GONAD....111
CHORIONIC GONADOTROPIN....111
CHOSEN....113, 116
CIALIS....145
CIBINQO....137
ciclodan....41
CICLODAN....41, 48
ciclopirox....41, 42, 48
cilostazol....60
CIMDUO....61
cimetidine hcl....102
CIMZIA....159
cinacalcet hcl....146
CINRYZE....145
CIPRO....36
ciprofloxacin....30, 31, 36
ciprofloxacin hcl....30, 31
citalopram....126
citalopram hbr....126
CITRANATAL....98, 124
CITRANATAL BLOOM....98
CITRANATAL MEDLEY....153
CITRATE PHOSPHATE DEXTROSE....38
CLARAVIS....135
CLARINEX-D....42
clarithromycin....34
clemastine fumarate....42
CLEOCIN....34, 37
CLEVER CHEK....116
CLEVER CHOICE....122
CLIMARA....106
CLINDACIN....37
clindamycin hcl....34
clindamycin palmitate hcl....34
clindamycin phos/benzoyl perox....136
clindamycin phosphate....37, 38
clindamycin/tretinoin....136
clobazam....83
clobetasol....139, 140, 141
clobetasol propionate....140, 141
CLOCORTOLONE PIVALATE....140
clodan....140
CLODAN....140
CLODERM....140
clomiphene citrate....110
clomipramine hcl....128
clonazepam....83
clonidine....77, 129
clopidogrel bisulfate....60
clorazepate dipotassium....125
clotrimazole....41
clotrimazole/betamethasone dip....41
clozapine....131
CLOZAPINE ODT....131
CLOZARIL....131
COAGUCHEK....116
COARTEM....47
codeine/butalbital/asa/caffein....23
codeine sulfate....22
colchicine....25, 28
COLCHICINE....25
COLCRYS....25
colesevelam hcl....80
COLESTID....80
colestipol hcl....80
COLOR LANCETS....116
COMBIGAN....94
COMBIPATCH....106
COMBIVENT RESPIMAT....29
COMETRIQ....53
COMFORT....26, 115, 116, 117, 118, 119, 120, 123
COMFORT PAC....26, 123
COMFORT PAC-IBUPROFEN....26
COMFORT PAC-MELOXICAM....26
COMFORT PAC-NAPROXEN....26
COMFORTSEAL....122
COMIRNATY....67
COMPACT SPACE CHAMBER....122
COMPAZINE....100
CONCEPT....153
CONCEPT DHA CAPSULE....153
CONTRAVE....57
COPIKTRA....53
COREG....75
COREG CR....75
coremino er....36
CORLANOR....72, 73
CORTENEMA....104
cortisone acetate....107
CORTISPORIN....30
COSENTYX....135
COTELLIC....51
CRENESSITY....109
CRESEMBA....41
CRINONE....109, 111
cromolyn....24, 30, 94

Index of Medications

crotamiton....58
CTEXLI....101
CUROSURF....144
CUVPOSA....99
cyanocobalamin....153
cyclobenzaprine hcl....123
CYCLOGYL....95
CYCLOMYDRIL....95
cyclopentolate hcl....95
cyclophosphamide....49
cycloserine....33
CYCLOSERINE....33
CYCLOSET....43
cyclosporine....112, 113
CYLTEZO....48
cyproheptadine....42
CYSTADANE....149
CYSTADROPS....95
CYSTAGON....152
CYSTARAN....95
CYSTO-CONRAY II....91
CYSTOGRAFIN....91
CYTOMEL....143
CYTOTEC....101

D

dabigatran....39
dalfampridine....83
DALIRESP....30
danazol....109
DANTRIUM....123
dantrolene sodium....123
DANZITEN....53
dapsone....33, 136
DAPSONE....136
DAPTACEL DTAP....68
darifenacin....152
darunavir....61
dasatinib....53
DAURISMO....51
DAXBIA....34
DAYPRO....26
DAYTRANA....129
DAYVIGO....134
deferasirox....148
deferiprone....148
deflazacort....107, 108
DELSTRIGO....63
demeclocycline....36
DEMSER....77
DEPEN....25
DEPO-ESTRADIOL....106
DEPO-PROVERA....87, 109
DEPO-SUBQ PROVERA....87
DEPO-TESTOSTERONE....105
DERMA-SMOOTHE-FS....140
DERMATOP....140
dermazene....141
DERMAZENE....141
DERMOTIC....92
DESCOVY....61
desflurane....24
desipramine hcl....129
desloratadine....42
desmopressin....105, 106
desog-e.estradiol....87
desogestrel-ethinyl estradiol....87
desonide....140
DESOWEN....140
desoximetasone....140, 141
desvenlafaxine succnt er....127
dexamethasone....31, 93, 108
dexamethasone sodium phosphate....93
DEXCOM....113
DEXCOM G7....113
dexlansoprazole....103
dexmethylphenidate er....129
dexmethylphenidate hcl....129
dextroamphetamine....66
dextroamphetamine er....66
dextroamphetamine sulfate....66
DIACOMIT....84
DIASTAT....83
diatrizoate meglumine....91
diazepam....83, 125
diazoxide....96, 97
DIBENZYLINE....66
dichlorphenamide....147
DICLAREAL....135
DICLEGIS....100
diclofenac....20, 26, 93, 135
dicloxacillin sodium....36
dicyclomine hcl....100
diethylpropion....57
DIFICID....35
diflunisal....15, 19
digoxin....72
dihydroergotamine....15, 19
DILANTIN....84

Index of Medications

DILATRATE-SR 73
diltiazem 71, 72
diltiazem hcl 72
dimethyl fumarate 82
dimethyl sulfoxide 147
diphenoxylate hcl/atropine 100
DIPHTHERIA-TETANUS TOXOIDS-PED 68
DIPROLENE 140
dipyridamole 60
DISALCID 25
disopyramide phosphate 71
disulfiram 147
DIURIL 92
divalproex sodium 84
DIVIGEL 106
dofetilide 71
DOJOLVI 96
donepezil hcl 65
DOPTELET 87
DORAL 133
dorzolamide hcl 94
dorzolamide hcl/timolol maleat 94
dorzolamide/timolol/pf 94
DOVATO 60
doxazosin mesylate 75
doxepin 129, 134
doxercalciferol 147
doxycycline 36, 37, 145
doxycycline hyclate 36, 145
doxylamine succinate/vit b6 100
dronabinol 100
DROPLET 116, 121
DROPSAFE 120
drospir/eth estra/levomefol ca 87
DROXIA 70
droxidopa 66
DRYSOL 136
DUAVEE 107
DUETACT 45
DULERA 29
duloxetine hcl dr 127
DUOPA 59
DUPIXENT 111
DURAGESIC 22
dutasteride 151, 152
DYAZIDE 91

E

EASIVENT 122
EASY 113, 116
EASY COMFORT 121
EASY TOUCH 113, 116
EASY TRAK 113
EASY TWIST 116
EBGLYSS 151
ECLIPSE 120
EC-NAPROSYN 26
econazole nitrate 42
ECOZA 42
EDEX 145
EDURANT 61
efavirenz 62, 63
effer-k 98
EFFER-K 98
EFFIENT 60
EFUDEX 57
EGRIFTA 108
ELESTRIN 106
eletriptan hydrobromide 15, 19
ELIDEL 112
ELIMITE 58
ELIQUIS 38
ELLA 87
ELMIRON 23
EMBRACE 116, 120
EMCYT 56
EMEND 100
EMGALITY 15, 19, 83
emollient combination 137
EMSAM 126
emtricita 63
emtricitabine 61, 62
emtricitabine-tenofv 61
EMTRIVA 62
EMVERM 47
enalapril/hydrochlorothiazide 74
enalapril maleate 76
ENBREL 48, 49
ENDARI 70
ENDO-AVITENE 70
ENDOMETRIN 111
ENGERIX-B ADULT 69
ENGERIX-B PEDIATRIC-ADOLESCENT 69
ENHERTU 56
ENLITE SERTER 113
enoxaparin 39, 40
ENSACOVE 53
ENSPRYNG 112

Index of Medications

entacapone 58, 59
entecavir 64
ENTERO 90
ENTOCORT EC 108
ENTRESTO 75
ENVARSUS 113
ENZOCLEAR 137
EPANED 76
EPCLUSA 64
EPIDIOLEX 84
EPIFOAM 141
epinastine hcl 43
epinephrine 65, 92
EPIVIR HBV 64
eplerenone 91
eprosartan mesylate 76
EQUETRO 125
ergocalciferol 153
ergoloid mesylates 78
ergotamine tartrate/caffeine 15, 19
ERIVEDGE 51
ERLEADA 50
erlotinib 53
ERVEBO 69
ERYPED 35
ERY-TAB 35
erythromycin 32, 35, 37
escitalopram 126
ESGIC 15, 19
eslicarbazepine 84
esomeprazole 103
esomeprazole dr 103
esomeprazole mag dr 103
esomeprazole sodium 103
estazolam 133
ESTRACE 106, 110
estradiol 87, 88, 106, 107, 110
ESTROGEL 107
estrogen, ester/me-testosterone 106
ESTROSTEP FE 87
eszopiclone 134
ethambutol hcl 33
ethinyl estradiol/drospirenone 87
ethosuximide 84, 86
ethynodiol d-ethinyl estradiol 87
etodolac 26, 27
etonogestrel/ethinyl estradiol 87
etoposide 56
EURAX 58
EVAMIST 107
EVEKEO 66
everolimus 51, 52, 113
EVICEL 70
EVISTA 150
EVOCLIN 38
EVOTAZ 62
EVRYSDI 148
EXELON 65
exemestane 50
exenatide 43
EXJADE 148
EXKIVITY 53
EXODERM 42
EYSUVIS 93
E-Z 90, 122
ezetimibe 78, 80
ezetimibe/simvastatin 78
EZ FLU 68
EZ-LETS 116
EZ SMART 116

F

FABHALTA 70
FACTIVE 36
famciclovir 63
famotidine 102
FARESTON 56
FARXIGA 43
FARYDAK 49
febuxostat 25
felbamate 84
FELDENE 26
felodipine 72
FEMARA 52
FEMCAP 88
FEMHRT 107
FEMRING 110
fenofibrate 80, 81
fenofibric acid 81
fenoprofen 26
FENSOLVI 109
fentanyl 22
FENTANYL 22
FERRIPROX 148
FETZIMA 127, 128
FEXMID 123
FIASP 46, 114
FIBRICOR 81
FIFTY50 116

Index of Medications

FILSPARI 81
FILSUVEZ 151
FILTER 120
finasteride 151
FINE 30 116
FINGERSTIX 116
FINTEPLA 84
FIORICET 15, 23
FIORINAL 15, 19, 23
FIORINAL WITH CODEINE #3 23
FIRDAPSE 83
FIRMAGON 52
FLAGYL 33
flavoxate hcl 152
FLEXICHAMBER 122
FLOVENT 29
FLOVENT DISKUS 29
FLUAD 68
FLUAD QUAD 68
FLUARIX QUAD 68
FLUBLOK 68
FLUBLOK QUAD 68
FLUCELVAX QUAD 68
fluconazole 41
flucytosine 41
fludrocortisone acetate 109
FLULAVAL QUAD 68
FLUMADINE 63
FLUMIST QUAD 68
flunisolide 92
fluocinolone 92, 140, 141, 163
fluocinolone acetonide 92, 140, 141
fluocinolone/shower cap 140
fluocinonide 140
fluorescein sodium 90
FLUORIDEX 96
fluorometholone 93
FLUOROPLEX 57
fluorouracil 57
fluoxetine 126, 127, 133
fluphenazine hcl 132
flurazepam 133
flurbiprofen 26, 93
flutamide 50
fluticasone 29, 92, 140
FLUTICASONE 30
fluticasone propion/salmeterol 29
fluticasone-salmeterol 29
FLUTICASONE-SALMETEROL 29
fluvastatin sodium 79
FLUVIRIN 68
fluvoxamine er 127
fluvoxamine maleate 127
FLUZONE 68
FLUZONE QUAD 68
FOCALIN 129
FOLET ONE 153
folic acid 152
FOLLISTIM AQ 111
fondaparinux 39
FORACARE 116
FORA LANCETS 116
FORA TN'GO 114
formoterol 29
FORTEO 146
FOSAMAX 150
FOSAMAX PLUS D 150
fosamprenavir calcium 62
fosaprepitant 100
fosaprepitant dimeglumine 100
fosfomycin tromethamine 33
fosinopril/hydrochlorothiazide 74
fosinopril sodium 76
FRAGMIN 39
FRAICHE 96
FREESTYLE 89, 90, 113, 114, 116
FREESTYLE LANCETS 116
FREESTYLE LIBRE 114
frovatriptan succinate 19
FRUZAQLA 53
FT 149
ful-glo 90
FUL-GLO 90
FULPHILA 86
FURADANTIN 35
furosemide 91
FUZEON 61
FYCOMPA 84

G

gabapentin 83, 84
GALAFOLD 149
galantamine er 65
galantamine hbr 65
GALZIN 149
ganirelix acet 109
GANIRELIX ACET 109
GARDASIL 9 69
GASTROGRAFIN 91

Index of Medications

GASTROMARK....90
gatifloxacin....32
GATTEX....104
GAVRETO....53
gelatin sponge, absorb/porcine....70
GELCLAIR....146
GELFILM....94
GELFOAM....70
gemfibrozil....81
GENERESS FE....87
GENOTROPIN....108
gentamicin....32, 38
GENVOYA....63
GILOTRIF....53
glatiramer....82
glatiramer acetate....82
glatopa....82
GLEEVEC....53
GLEOSTINE....49
glimepiride....44, 45
GLIMEPIRIDE....44
glipizide....44
GLIPIZIDE....44
glucagon....96, 97
GLUCAGON....96, 97
GLUCOCOM....114, 116
GLUCOCOM AUTOLINK....114
GLUCOPHAGE XR....44
GLUCOTROL....44
GLUCOTROL XL....44
glyburide....44, 45
GLYCATE....99
glycine urologic solution....48
glycopyrrolate....99
GLYNASE....44
GLYSET....43
GLYXAMBI....45
GOJJI....116
GOMEKLI....51
GONAL-F....111
GORDON'S UREA....139
granisetron hcl....100
GRANIX....86
GRASTEK....66
griseofulvin....41
GRIS-PEG....41
GS ISOPROPYL....48, 149
GUAIACOL....136
guanfacine hcl....77, 129
guanidine hcl....66
GUARDIAN....114
GUARDIAN RT....114
GYNAZOLE 1....40

H

HAEGARDA....145
halcinonide....140
HALCION....133
halobetasol....140, 141
halobetasol propionate....140, 141
haloperidol....132
HALUCORT....137
HARVONI....64
HEALTHY ACCENTS....116
HEMICLOR....92
HEMLIBRA....70
heparin....39
HEPARIN....39, 40
HEPLISAV-B....69
HETLIOZ....133
HIBERIX....69
homatropine hbr....95
HPR PLUS-MB HYDROGEL....137
HUMALOG....46, 114
HUMAPEN....114
HUMIRA....49
HUMULIN....46
HUMULIN R....46
HYCAMTIN....52
HYCODAN....89
hydralazine hcl....77
HYDREA....49
HYDRO 35....137
HYDRO 40....137
hydrochlorothiazide....74, 75, 77, 78, 91, 92
hydrocodone/acetaminophen....21
HYDROCODONE-ACETAMINOPHEN....21
hydrocodone bitartrate....22, 23
hydrocodone bit/homatrop me-br....89
hydrocodone/chlorphen p-stirex....89
hydrocodone/cpm/pseudoephed....89
HYDROCODONE-GUAIFENESIN....89
hydrocodone-homatropine....89
HYDROCODONE-HOMATROPINE....89
hydrocodone/ibuprofen....21
hydrocortisone....92, 104, 108, 140, 141, 142
hydrocortisone/acetic acid....92
hydrocortisone/lidocaine/aloe....104
hydrocortisone/pramoxine....104, 141

Index of Medications

hydrogen peroxide....134
hydromorphone....22
hydroxychloroquine sulfate....47
hydroxyurea....49
hydroxyzine hcl....42
hydroxyzine pamoate....42
HYFTOR....139
HYMPAVZI....70
HYPER-SAL....148
HYPODERMIC....120
HYRIMOZ....49
HYSINGLA ER....22

I

ibandronate....111, 150
ibandronate sodium....150
IBRANCE....53
IBUDONE....21
ibuprofen....21, 26
ibuprofen/oxycodone....21
icatibant acetate....145
icosapent ethyl....99
IDHIFA....56
IFE....146
IHEALTH....114
ILARIS....150
ILEVRO....93
ILUMYA....135
imatinib....53, 54
imatinib mesylate....53, 54
IMCIVREE....57
imipramine pamoate....129
imiquimod....137
IMKELDI....54
IMPAVIDO....47
IMVEXXY....110
INBRIJA....59
INCONTROL....116
INCRELEX....109
INCRUSE ELLIPTA....28
indapamide....92
INDICLOR....91
indomethacin....27
INFANRIX DTAP....69
INFASURF....144
INFLECTRA....49
INGREZZA....82
INJECT EASE....116
INLYTA....54
INNOPRAN XL....77
INOVA....137
INPEN....114
INQOVI....50
INREBIC....54
INSPIRACHAMBER....122
INSPRA....91
INSULIN....121
INSULIN SYRINGE....121
INSUPEN....120
INTRAROSA....105
INVACARE....117
INVEGA ER....131
iodine/potassium iodide....142
iodine/sodium iodide....142
IODOFLEX....142
IODOSORB....142
IPOL....67
ipratropium....28, 29, 92
ipratropium bromide....28, 92
irbesartan....75, 76
irbesartan/hydrochlorothiazide....75
IRESSA....54
ISENTRESS....62
isoflurane....24
isomethept/dichlphn/acetaminop....19
isomethepten/caf/acetaminophen....19
isoniazid....33
isopropyl alcohol....149
ISOPTO CARPINE....94
isosorbide....73, 78
isosorbide dinitrate....73
isosorbide-hydralazine....78
isotretinoin....135
isoxsuprine hcl....78
isradipine....72
ISTURISA....105
ITOVEBI....54
itraconazole....41
ivabradine....72, 73
ivermectin....47, 58, 138
IWILFIN....54
IXCHIQ....69

J

JAKAFI....51
JANSSEN COVID-19 VACCINE....67
JANUMET....45
JANUMET XR....45
JANUVIA....44
JARDIANCE....43

Index of Medications

javygtor 149
JOENJA 144
JULUCA 60
JYLAMVO 50
JYNNEOS 69

K

KADIAN 22
KALBITOR 145
KALETRA 62
KALYDECO 144
KATERZIA 72
KEFLEX 34
KERAFOAM 137
keralyt 137
KERALYT 137
KERENDIA 91
KESIMPTA 82
ketoconazole 41, 42
ketorolac 20, 93
KEVZARA 112
KINRIX 69
KISQALI 52, 54
KITABIS 32
KLARON 136
KLONOPIN 83
klor-con 98
KOSELUGO 51
K-PHOS 99
KRINTAFEL 47
K-TAB ER 98
KYLEENA 88
KYNAMRO 79
KYNMOBI 59

L

labetalol hcl 75
LACRISERT 93
lactulose 99, 103
LAGEVRIO 65
lamivudine 61, 62, 64
lamivudine/zidovudine 61
lamotrigine 84
LAMPIT 47
LANCETS 114, 115, 116, 117, 118, 119
lanreotide 110
LANREOTIDE 110
lansoprazole/amoxiciln/clarith 101
lansoprazole dr 103
lansoprazole odt 103
lanthanum carbonate 97
lapatinib ditosylate 54
latanoprost 94
LAZANDA 22
leflunomide 25
lenalidomide 52
LENVIMA 54
LEQSELVI 25
letrozole 50
leucovorin calcium 145
LEUKERAN 49
LEUKINE 86
leuprolide acetate 52
LEUPROLIDE DEPOT 52
levalbuterol 28
LEVITRA 146
levobunolol hcl 94
levocarnitine 150
levocetirizine dihydrochloride 42
levofloxacin 32, 36
levonorgest 87
levonorgestrel/ethin.estradiol 87
levothyroxine 143
LEVOTHYROXINE 143
levothyroxine sodium 143
LEVULAN 56
LIBERVANT 83
lidocaine 24, 90, 104, 141
lidocaine hcl 24, 90
lidocaine hcl/glycerin 90
LIDOCAINE-HYDROCORTISONE 104
LIDODERM 24
LIKMEZ 33
LILETTA 88
lindane 141
linezolid 35
liothyronine sodium 143
LIPOFEN 81
LIQUID E-Z PAQUE 90
LIQUID POLIBAR PLUS 90
lisdexamfetamine 66
lisinopril 74, 76
lisinopril/hydrochlorothiazide 74
lissamine 90
LITEAIRE 122
LITE TOUCH 114, 117
LITETOUCH 122
LITFULO 26
lithium carbonate 125
lithium citrate 125

Index of Medications

LITHOSTAT 99
LIVTENCITY 63
L-MESITRAN SOFT 139
l-norgest/e.estradiol-e.estrad 87
LOCORT 108
LODINE 27
LOESTRIN 87, 88
LOESTRIN FE 88
lofexidine 151
LOKELMA 97
LOMAIRA 57
LONHALA MAGNAIR 28
LONSURF 50
loperamide hcl 100
LOPID 81
lopinavir/ritonavir 62
LOPROX 42
lorazepam 125
LORBRENA 54
LORTAB 21
losartan/hydrochlorothiazide 75
losartan potassium 76
LOSEASONIQUE 88
loteprednol 93
loteprednol etabonate 93
lovastatin 79
LOVENOX 39, 40
loxapine succinate 132
lubiprostone 103
LUCEMYRA 151
LULICONAZOLE 42
LUMAKRAS 51
LUMRYZ 133
LUPANETA 109
LUPKYNIS 113
LUPRON 52, 109
LUPRON DEPOT 109
lurasidone 131
LUXIQ 141
LYNPARZA 54
LYRICA 84
LYSODREN 56
LYSTEDA 70
LYTGOBI 54
LYUMJEV 46

M

MACROBID 35
mafenide 38
maprotiline hcl 129
maraviroc 61
MARPLAN 125
MATULANE 56
MAVENCLAD 82
MAYZENT 83
meclofenamate 27
MEDIHONEY 139
MEDISENSE 117
MEDLANCE 117
MEDROL 108
medroxyprogesterone 87, 109, 110
mefenamic acid 20
mefloquine hcl 47
megestrol acetate 56, 152
MEKINIST 51
meloxicam 27
melphalan 49
memantine hcl 81
memantine hcl er 81
MENACTRA 67
MENEST 107
MENOPUR 110
MENOSTAR 107
MENQUADFI 67
MENVEO A-C-Y-W-135-DIP 67
meperidine 22
MEPHYTON 153
meprobamate 125
mercaptopurine 50
mesalamine 102
mesna 145
MESNEX 145
MESTINON 65
metaproterenol 28
metaxalone 123, 124
metformin 44, 45
metformin hcl 44, 45
methamphetamine hcl 66
methazolamide 91
methenamine hippurate 33
methenamine mandelate 33
methenam/m.blue/salicyl/hyoscy 33
methen/mblue/sal/sod phos/hyos 33
methimazole 143
METHITEST 105
methocarbamol 124
methotrexate sodium 50
methoxsalen 135
methscopolamine bromide 101

Index of Medications

methyldopa....77
methyldopa/hydrochlorothiazide....77
methylergonovine maleate....109
METHYLIN....129
methylphenidate....129, 130
methylphenidate er....130
methylphenidate hcl....129, 130
methylphenidate la....130
methylprednisolone....108
methyl salicylate....137
methyltestosterone....105
metoclopramide hcl....102
metolazone....92
METOPIRONE....91
metoprolol/hydrochlorothiazide....78
metoprolol succinate....77
metoprolol tartrate....77
metronidazole....32, 33, 37, 138
metyrosine....77
MEZPAROX-HC....141
MIACALCIN....111
miconazole nitrate....40
MICROCHAMBER....123
MICROGESTIN 24 FE....88
MICROLET....117
MICROSPACER....123
MICRO THIN....117
midazolam hcl....133
midodrine hcl....66
MIEBO....93
MIFEPREX....147
mifepristone....147
miglitol....43
miglustat....148
millipred....108
MILLIPRED....108
MIMYX....137
MINIMED RESERVOIR....121
MINIPRESS....75
MINITRAN....73
MINIVELLE....107
minocycline....36, 37
minocycline er....36, 37
minoxidil....77
mirabegron....152
MIRAPEX ER....59
MIRENA....88
mirtazapine....125
misoprostol....26, 101
MITIGARE....25
MITOSOL....95
MIUDELLA....88
M-M-R II VACCINE....69
MOBIC....27
MOBILE....114, 117
MOBILE LANCETS....114
modafinil....133
MODERNA....67
moexipril hcl....76
molindone hcl....132
MOLNUPIRAVIR....65
MOMETACURE....141
mometasone furoate....92, 141
MONOJECT....120
MONOLET....117
MONSEL'S....70
montelukast sodium....30
MONUROL....33
MORPHABOND ER....22
morphine sulfate....22
MOTOFEN....100
MOVANTIK....40
MOXATAG....36
MOXEZA....32
moxifloxacin....32, 36
MRESVIA....69
MS CONTIN....22
MUGARD....146
MULPLETA....87
MULTAQ....71
mupirocin....38
MURI-LUBE....149
MUSE....146
mvn no.53/iron/folic/dss/dha....153
MYALEPT....111
mycophenolate mofetil....113
MYDRIACYL....95
MYGLUCOHEALTH....117
MYLERAN....49
MYORISAN....135
MYTESI....100

N

nabumetone....27
nadolol....77, 78
nadolol/bendroflumethiazide....78
naftifine....42
NAFTIN....42
NALFON....27

Index of Medications

NALOCET 21
naloxone 23, 40, 151
NALOXONE 40
naltrexone 40
NAMENDA 81
NAMENDA XR 81
NAMZARIC 81
NANO 120
NAPROSYN 26, 27
naproxen 20, 26, 27
naratriptan 19
NARCAN 40
NATACYN 40
nateglinide 44
NAYZILAM 83
NEBUPENT 47
nebusal 148
NEBUSAL 148
NEEDLE 120
NEEDLES 120
nefazodone hcl 127
neomycin 31, 32, 134
neomycin/bacit/p-myx/hydrocort 31
neomycin/polymyxin b/dexametha 31
neomycin/polymyxin b/hydrocort 31
neomycin/polymyxn b/gramicidin 32
neomycin sulfate 32
neomycin sulf/bacitracin/poly 32
neomycin sulf/polymyxin b sulf 134
NEO-SYNALAR 37
NERLYNX 54
NEULASTA 86
NEULUMEX 90
NEUPOGEN 86
NEUPRO 59
NEURONTIN 84
NEUTRASAL 146
nevirapine 62
NEXIUM DR 104
NEXPLANON 87
niacin 81
NIASPAN 81
nicardipine hcl 72
NICOTROL 142
nifedipine 71, 72
nilutamide 50
NINLARO 54
nisoldipine er 72
nitazoxanide 58
nitisinone 147, 148
NITRO-DUR 73
nitrofurantoin 35
nitroglycerin 73, 103
NITROLINGUAL 73
NITROMIST 73
NITROSTAT 73
NITYR 147
NIVESTYM 86
NOCTIVA 106
NORCO 21
NORDITROPIN FLEXPRO 108
norelgestromin/ethin.estradiol 88
noreth-ethinyl estradiol/iron 88
norethind-eth estrad 88, 107
norethindrone 87, 88, 107, 110
norethindrone ac-eth estradiol 107
norethindrone-e.estradiol-iron 88
norethin-ee 88
norethin-eth estrad 107
norgestrel-ethinyl estradiol 88
NORLIQVA 72
NORPACE 71
NORPACE CR 71
nortriptyline hcl 129
NORVIR 62
NOURIANZ 59
NOVA 117
NOVAREL 111
NOVAVAX 67
NOVOPEN 114
NOXAFIL 41
NUBEQA 50
NUCALA 30
NUCORT 141
NUCYNTA 22
NUCYNTA ER 22
NUEDEXTA 82
NULEV 101
NULIBRY 148
NULYTELY 103
NUMOISYN 146
NUPLAZID 126
NURTEC ODT 19
NUVARING 87
NUZYRA 37
NYMALIZE 72
NYPOZI 86
nystatin 41, 42

Index of Medications

NYVEPRIA....86

O

OBREDON....89
OBSTETRIX....124, 153
OBTREX DHA....124
OCALIVA....102
octreotide acetate....110
ODACTRA....67
ODEFSEY....63
ODOMZO....51
OFEV....144
ofloxacin....31, 32, 36
OGSIVEO....54
OJEMDA....51
OJJAARA....54
olanzapine....131, 133
olmesartan/amlodipin/hcthiazid....75
olmesartan-hctz....75
olmesartan medoxomil....76
olopatadine....43, 92
olopatadine hcl....43, 92
OLPRUVA....99
OLUMIANT....26
omega-3 acid ethyl esters....99
omeppi....104
omeprazole-bicarb....104
omeprazole dr....104
OMNIPOD....114
OMNIPOD 5 (GEN 5) KIT....114
OMNIPOD 5 (GEN 5) POD....114
OMNIPOD CLASSIC (GEN 3) kit....114
OMNIPOD CLASSIC (GEN 3) KIT....114
OMNIPOD CLASSIC (GEN 3) PODS....114
OMNIPOD CLASSIC (GEN 4) KIT....114
OMNIPOD CLASSIC (GEN 4) PODS....114
OMNIPRED....93
OMNITROPE....108
OMVOH....111
ON CALL....117
ondansetron....100
ONETOUCH....114, 115, 117
ONETOUCH DELICA....114, 117
ONEXTON....136
ONFI....83
ON-THE-GO....117
ONUREG....50
OPDIVO....56
OPFOLDA....148
opium....22
opium/belladonna alkaloids....22
opium tincture....100
OPSUMIT....73
OPSYNVI....74
OPTICHAMBER....123
OPVEE....40
ORACIT....99
ORALAIR....67
ORAMAGICRX....146
ORAPRED ODT....108
ORAVIG....41
ORENCIA....25
ORENITRAM....74
ORENITRAM ER....74
ORFADIN....148
ORGOVYX....52
ORIAHNN....109
ORILISSA....109
ORKAMBI....144
ORLADEYO....145
orphenadrine citrate....124
ORTHO MICRONOR....88
oseltamivir....63
OSMOLEX ER....59
OSPHENA....147
OTEZLA....25
OTOVEL....31
OTREXUP....25
OVACE....136
OVIDREL....111
oxandrolone....105
oxaprozin....26, 27
OXAPROZIN....27
OXAYDO....22
oxazepam....125
oxcarbazepine....84
OXERVATE....95
OXSORALEN-ULTRA....135
OXTELLAR XR....85
oxybutynin....152
oxybutynin chloride....152
oxycodone....21, 22, 23
oxycodone hcl....21
oxycodone hcl/acetaminophen....21
OXYCODONE HCL ER....23
oxymorphone hcl....23
OZEMPIC....43
OZOBAX DS....124

P

Index of Medications

pacerone....71
PACNEX....137
PAIN EASE....24
paliperidone er....131
PALYNZIQ....67
PANCREAZE....103
PANRETIN....57
pantoprazole....104
PAPAVERINE....146
PARADIGM....121
PARAGARD....88
paregoric....100
PAREMYD....95
paricalcitol....147
PARLODEL....59
paromomycin sulfate....47
paroxetine....127, 148
paroxetine cr....127
paroxetine er....127
PASER....33
PATANASE....92
pazopanib....54
PCE....35
PEDIARIX....69
PEDVAXHIB....69
peg3350/sod sulf, bicarb, cl/kcl....103
peg3350/sod sul/nacl/kcl/asb/c....103
PEGANONE....85
PEGASYS....64
PEGINTRON....64
PEMAZYRE....54
PENBRAYA....67
penicillamine....25
penicillin v potassium....36
PENTACEL....69
PENTACEL ACTHIB COMPONENT....69
pentamidine isethionate....47
PENTASA....102
pentazocine hcl/naloxone hcl....23
pentoxifylline....71
PERFECT....117, 120
PERIDEX....145
perindopril erbumine....76
permethrin....58
perphenazine....128, 132
perphenazine/amitriptyline hcl....128
PFIZER COVID-19 VACCINE....67
PHARMABASE BARRIER....138
PHEBURANE....99
phenazopyridine....24
phendimetrazine....57
phenelzine sulfate....125
phenobarb/hyoscy/atropine/scop....101
phenobarbital....101, 133
phenobarbital-belladonna elixr....101
PHENOBARBITAL-BELLADONNA ELIXR....101
phenoxybenzamine hcl....66
phentermine....57
PHENTOLAMINE-ALPROSTADIL....146
phenylephrine hcl....42, 94
phenylephrine hcl/prometh hcl....42
PHENYTEK....85
phenytoin....84, 85
PHESGO....52
PHOSLYRA....97
PHOSPHOLINE IODIDE....94
PHYSIOLYTE....134
PHYSIOSOL....134
phytonadione....153
PICATO....57
PIFELTRO....62
pilocarpine hcl....66, 94
pimecrolimus....112
pimozide....131
pindolol....77
pioglitazone hcl....45
pioglitazone hcl/glimepiride....45
pioglitazone hcl/metformin hcl....45
PIP....117
PIQRAY....54
pirfenidone....147
piroxicam....26, 27
pitavastatin....79
PLEGRIDY....83
PLIXDA....142
PNEUMOVAX 23....67
pnv....124
pnv 22/iron, gluc/folic/dss/dha....124
pnv 66/iron/folic/docusate/dha....124
pnv 69/iron/folic/docusate/dha....124
pnv 80/iron fum/folic/dss/dha....124
pnv/ferrous fum/docusate/folic....124
pnv/iron, carb/docusat/folic ac....124
POCKET CHAMBER....123
PODOCON-25....137
podofilox....137, 138
POLIBAR ACB....90
polydimethylsiloxanes/silicon....138

Index of Medications

POMALYST....52
posaconazole....41
potassium....20, 36, 76, 96, 98, 99, 142
POTASSIUM....91, 92, 98, 103
potassium bicarbonate/cit ac....98
potassium chloride....98
potassium citrate....99
potassium iodide/iodine....98
pramipexole....59
pramipexole di-hcl....59
pramipexole er....59
PRAMOSONE....141
prasugrel....60
pravastatin sodium....79
praziquantel....47
prazosin....75
prazosin hcl....75
PR BENZOYL PEROXIDE....138
PRECISION....90
PRECISIONGLIDE....120
PRECOSE....44
prednicarbate....140, 141
prednisolone....31, 93, 108
prednisolone acetate....93
prednisolone sodium....93, 108
prednisone....108
pregabalin....84, 85
PREGNYL....111
PREMARIN....107, 110
PREMPHASE....107
PREMPRO....107
prenatal 12/iron/folic/dss/om3....124
PRENATAL 19....124
prenatal 34/iron/folic/dss/dha....124
prenatal vits15/iron/folic/dss....124
PREPIDIL....109
PREPOPIK....103
PRESSURE....94, 95, 117
PRESTALIA....74
PRETOMANID....33
PREVIDENT....96
PREVNAR 13....67
PREVYMIS....63
PREZCOBIX....61
PREZISTA....61
PRIFTIN....33
PRIMAQUINE....47
primaquine phosphate....47
PRIMEAIRE....123
primidone....85
PRIMLEV....21
PRIMSOL....33
PRISMASOL....99
probenecid....28
PROCARDIA....72
PROCARE....123
PROCHAMBER....123
prochlorperazine....100, 101
PRO COMFORT....115, 117, 123
PROCORT....104
PROCRIT....86
PROCTOFOAM-HC....104
PRODIGY....117, 118
progesterone, micronized....110
PROGLYCEM....96, 97
PROGRAF....113
PROLENSA....93
promethazine-codeine....89
promethazine/dextromethorphan....89
promethazine hcl....42, 101
promethazine/phenyleph/codeine....89
PROMETRIUM....110
propafenone hcl....71
propantheline bromide....99
proparacaine/fluorescein sod....94
proparacaine hcl....93
propranolol hcl....77
propranolol/hydrochlorothiazid....78
propylthiouracil....143
PROQUAD....69
PROSCAR....151
PROSTIN....109
protectives2/ceramide....138
PROTOPIC....112
protriptyline hcl....129
PROVERA....87, 109
PROVOCHOLINE....90
PULMOZYME....144
PURE COMFORT....118
PURIXAN....50
PUSH BUTTON....118
pyrazinamide....33
pyridostigmine bromide....65
pyrimethamine....47

Q

QBREXZA....141
QINLOCK....54
QMIIZ ODT....27

Index of Medications

QSYMIA 57
QUADRACEL DTAP-IPV 69
QUALAQUIN 47
QUARTETTE 88
quazepam 134
QUAZEPAM 133
QUESTRAN 80
quetiapine fumarate 131, 132
QUILLIVANT XR 130
quinapril hcl 76
quinapril/hydrochlorothiazide 74
quinidine gluconate 71
quinine sulfate 47
QUTENZA 137
QVAR REDIHALER 30

R

rabeprazole sodium 104
RADIAGEL 149
RADIAPLEXRX 138
RADICAVA ORS 82
RADIOGARDASE 149
RAGWITEK 67
raloxifene hcl 150
ramelteon 133
ramipril 76
ranitidine hcl 102
ranolazine 71
RAPAFLO 151
RAPLIXA 70
rasagiline mesylate 59
RAYALDEE 147
RAZADYNE ER 65
READI-CAT 2 90
READYLANCE 118
REBIF 83
RECOMBIVAX HB 69
RECOTHROM 70
RECTIV 103
REGIMEX 57
REGLAN 102
REGRANEX 136
RELAGARD 46
RELENZA 63
RELIAMED 118
RELION 90
RELISTOR 40
REMICADE 49
RENACIDIN 99
repaglinide 44, 45
REPATHA 79
REPLACEMENT PEDIATRIC MONITOR 115
RESPA A.R. 89
RESTASIS 95
RESTIZAN 137
RETACRIT 86
RETEVMO 55
REVLIMID 52
REVUFORJ 55
REXTOVY 40
REXULTI 132
REYATAZ 62
REZDIFFRA 146
REZLIDHIA 56
REZUROCK 151
REZVOGLAR KWIKPEN 43
RHOPRESSA 95
ribasphere 64, 65
ribasphere ribapak 64, 65
RIDAURA 25
rifabutin 33
RIFAMATE 34
rifampin 34
RIFATER 34
RIGHTEST 118
RILUTEK 82
riluzole 82
rimantadine hcl 63
RIMSO-50 23
ringer's 134
RINVOQ 26
RIOMET 44
RIOMET ER 44
risedronate sodium 150
risperidone 131
RITALIN 130
RITEFLO 123
ritonavir 62
rivaroxaban 38
rivastigmine 65
rizatriptan 19, 20, 173
rizatriptan benzoate 20
ROBAXIN-750 124
ROBINUL 99
ROCALTROL 153
ROCKLATAN 95
roflumilast 30
ROLVEDON 86
ROSANIL 38

Index of Medications

rosuvastatin....79
rosuvastatin calcium....79
ROTARIX....67
ROTATEQ....67
ROXYBOND....23
ROZLYTREK....55
RUBRACA....55
RUCONEST....145
rufinamide....85
RUKOBIA....61
RUZURGI....83
RYBELSUS....43
RYDAPT....55
RYTARY....59
RYTHMOL SR....71

S

sacubitril....75
SAF-CLENS AF....139
SAFETY....115, 116, 117, 118, 119, 120
SAFETY LANCET....115, 116, 117, 118, 120
SALAGEN....66
salicylic acid....137, 138
SALIMEZ FORTE....138
SALKERA....138
salsalate....25
SALVAX DUO PLUS....138
SANCUSO....101
SANDOSTATIN....110
SANTYL....142
SAPHRIS....131
sapropterin dihydrochloride....149
SARAFEM....127
SAVELLA....150
SCALACORT DK....141
SCEMBLIX....54
scopolamine....101
secobarbital sodium....133
SECUADO....132
SELARSDI....112
selegiline hcl....59
selenium sulfide....136
SELZENTRY....61
SEN-SERTER....115
SEROQUEL....132
SEROQUEL XR....132
SEROSTIM....108
sertraline....127
sevelamer....97
sevoflurane....24
SFROWASA....102
SHINGRIX....69
SIGNIFOR....110
SIKLOS....70
sildenafil....73, 146
SILICONE....123
SILIQ....135
silodosin....151
SILVADENE....38
silver nitrate....138, 142
silver sulfadiazine....38
SIMBRINZA....95
SIMLANDI....49
SIMPONI....49
simvastatin....78, 79, 80
SINEMET....59
SINGLE-LET....118
sirolimus....113
SIRTURO....34
SITZMARKS....90
SIVEXTRO....35
SKELAXIN....124
SKYLA....88
SKYRIZI....135
SKYTROFA....108
SMARTEST....118
SMART SENSE....118
sodium chloride for inhalation....148
sodium chloride irrig solution....134
sodium chloride/nahco3/kcl/peg....103
SODIUM CITRATE....38
sodium fluoride/potassium nit....96
SODIUM OXYBATE....133
sodium phenylbutyrate....99
sodium polystyrene sulfon/sorb....97
sod, pot chlor/mag/sod, pot phos....134
SOFT....139
SOGROYA....108
solifenacin....152
SOLIQUA....43
SOLTAMOX....56
SOLUS....118
SOMA....124
SOMATULINE DEPOT....110
SOMAVERT....147
SOOLANTRA....138
SORBITOL....134
sotalol hcl....77
SOTYKTU....135

Index of Medications

SOTYLIZE 77
SOVALDI 64
SPACE CHAMBER 122, 123
SPEVIGO 135
SPIKEVAX 67
spinosad 58
SPIRIVA RESPIMAT 28
spironolact/hydrochlorothiazid 92
spironolactone 91
SPRITAM 85
sps 97
SSKI 98
STALEVO 59
STARLIX 44
STELARA 112
STENDRA 146
STERILANCE 118
STERILE LANCETS 118
STIMATE 106
STIMUFEND 86
STIOLTO RESPIMAT 29
STIVARGA 55
STRENSIQ 148
STRIBILD 63
STRIVERDI RESPIMAT 28
STROMECTOL 47
SUBOXONE 151
SUCRAID 102
sucralfate 101
SULAR 72
sulfacetamide 31
sulfacetamide sodium 38, 136
sulfacetamide sod/sulfur/urea 38
sulfacetamide/sulfur/cleansr23 38
sulfact sod/sulur/avob/otn/oct 38
sulfadiazine 32, 38
sulfamethoxazole/trimethoprim 32
SULFAMYLON 38
sulfasalazine 102
sumatriptan 20
SUNLENCA 60
SUNOSI 133
SUPER THIN 116, 118
SUPRANE 24
SURE COMFORT 118
SURE-LANCE 118
SURE-TOUCH 118
SURGIFOAM 70
SURGISEAL 138, 139
SURVANTA 144
SUTENT 55
SYMAX DUOTAB 101
SYMDEKO 144
SYMLINPEN 44
SYMPROIC 40
SYMTUZA 61
SYNALAR 37, 141
SYNAREL 109
SYNJARDY 45
SYNJARDY XR 45
SYNTHROID 143
SYRINGE 79

T

TABLOID 50
TABRECTA 55
tacrolimus 112, 113
tadalafil 73, 145, 146
TAFINLAR 51
TAGITOL 90
TAGRISSO 55
TAKHZYRO 67
TALTZ 135
TALZENNA 55
TAMIFLU 63
tamoxifen 56
tamsulosin hcl 151, 152
TAPAZOLE 143
TARGRETIN 57
TASMAR 60
TAVALISSE 145
TAVNEOS 70
tazarotene 136
TAZVERIK 52
TC99M 90
TDVAX 69
TECHLITE 118
TEGRETOL 85
TEGSEDI 147
TELCARE 118
telmisartan 75, 76
telmisartan-amlodipine 76
telmisartan-hctz 75
temazepam 134
TEMIXYS 61
TEMOVATE 141
temozolomide 49
TENIVAC 69
tenofovir disoproxil fumarate 62

Index of Medications

TEPMETKO....55
terazosin hcl....75
terbinafine....41
terbutaline....28
terconazole....40
teriflunomide....83
teriparatide....111, 146
TERIPARATIDE....111
TERSI....136
TESSALON PERLE....89
testosterone....105, 106
TESTOSTERONE....105
tetrabenazine....82
tetracaine hcl....94
tetracycline....37, 101
TETRAVISC....94
TEXACORT....141
TEZSPIRE....150
THALOMID....33
THEO-24....30
theophylline....30
THIOLA....152
thioridazine hcl....132
THROMBI-GEL....70
THROMBIN-JMI....70
THROMBI-PAD....70
thyroid....143
THYROLAR....143
tiagabine....85
TIAZAC....72
TIBSOVO....56
ticagrelor....60
ticlopidine....60
TIGLUTIK....82
TIKOSYN....71
timolol maleate....77, 95
TINDAMAX....47
tinidazole....47
tiopronin....152
TIROSINT....143
TIROSINT-SOL....143
TISSEEL....139
TIVICAY....62
tizanidine hcl....124
TOBI....32
TOBRADEX....31
tobramycin....31, 32, 33
TOBRAMYCIN....33
tobramycin/dexamethasone....31
TOLAK....57
tolbutamide....45
tolcapone....60
tolmetin....27
tolterodine....152
tolvaptan....91
TOLVAPTAN....91
TOPCARE....118
TOPICORT....141
topiramate....85
toremifene....56
torsemide....91
TRACLEER....73
tramadol....23
TRAMADOL....23
tramadol er....23
tramadol hcl....21, 23
tramadol hcl/acetaminophen....21
TRAMADOL HCL ER....23
trandolapril....74, 76
trandolapril/verapamil hcl....74
tranexamic acid....70
TRANSDERM-SCOP....101
TRANXENE T-TAB....125
tranylcypromine sulfate....125
travoprost....95
trazodone hcl....127
TRECATOR....33
TRELEGY ELLIPTA....29
TREMFYA....135
TRESIBA....46
tretinoin....56, 136, 142
TREXALL....50
TREZIX....21
triamcinolone acetonide....145
triamterene....91, 92
triazolam....133, 134
trichloroacetic acid....139
TRICHLOROACETIC ACID....139
TRICOR....81
trientine....149
TRIENTINE....149
trientine hcl....149
trifluoperazine hcl....133
trifluridine....63
TRIGLIDE....81
trihexyphenidyl....58
TRIJARDY XR....46

Index of Medications

TRIKAFTA....144
TRILIPIX....81
trimethobenzamide....101
trimethoprim....32, 33
trimipramine....129
TRIMO-SAN....46
TRINTELLIX....128
TRIUMEQ....61
TROKENDI....85
tropicamide....95
trospium chloride....152
true....152
TRUE....118, 121
TRUE METRIX....90
TRUEPLUS....118
TRULANCE....102
TRULICITY....43
TRUMENBA....67
TRUQAP....55
TRUSOPT....95
TRYNGOLZA....79
TUKYSA....55
TURALIO....54, 55
TUXARIN ER....89
TUZISTRA XR....89
TWINRIX....69
TWIST....116, 118, 139
TWIST TOP....118
TYBOST....144
TYENNE....112
TYKERB....55
TYRVAYA....149
TYVASO....74

U

UBRELVY....20
UCERIS....108
UDENYCA....86
UKONIQ....55
ULESFIA....58
ULORIC....25
ULTANE....24
ULTILET....119
ULTRA....120
ULTRA-CARE....119
ULTRACET....21
ULTRA-FINE....120
ULTRAFOAM....71
ULTRALANCE....119
ULTRAM....23
ULTRA THIN....116, 117, 118, 119
ULTRA-THIN II....119, 121, 122
ULTRATLC....119
ULTRAVATE....141
UNIFINE....115
UNILET....115, 116, 119
UNISTIK....116, 119, 120, 123
UNIVERSAL 1....119
UPTRAVI....74
URAMAXIN....138
urea....38, 48, 138, 139
UROCIT-K....99
UROQID....99
URSO....101
ursodiol....101
USTEKINUMAB....112
UTA....33

V

VAGIFEM....110
VALCHLOR....57
valganciclovir hcl....63
valproic acid....85
valsartan....75, 76
valsartan/hydrochlorothiazide....75
VALTOCO....83
VALTREX....64
vancomycin....37
VANFLYTA....55
VANRAFIA....151
vardenafil hcl....146
VARIBAR....90
VARUBI....101
VASCEPA....99
VASHE....134
VAXELIS....69
VECAMYL....77
VELPHORO....97, 98
VELSIPITY....83
VELTASSA....97, 98
VEMLIDY....64
VENCLEXTA....56
venlafaxine hcl....128
VENTAVIS....74
verapamil hcl....72, 74
VEREGEN....65
VERELAN....72
VERIFINE....120, 122
VERQUVO....73, 74

Index of Medications

VERZENIO 55
VEVYE 95
VFEND 41
V-GO 115
VIAGRA 146
VIBERZI 102
VIBRAMYCIN 37
vigabatrin 85
VIIBRYD 128
VIJOICE 144
vilazodone 128
VIMPAT 85
VIOKACE 103
VIREAD 62
VISTARIL 42
VISTOGARD 145
VITAFOL FE 124
vite ac/grape/hyaluronic acid 137
VITRAKVI 55
VIVAGUARD 120
VIVELLE-DOT 107
VIVJOA 41
VIZIMPRO 55
VOQUEZNA 103
voriconazole 41
VORTEX 123
VOSEVI 64
VOWST 102
VOXZOGO 149
VOYDEYA 70
VRAYLAR 132
VUMERITY 83
VYKAT 57
VYLEESI 131
VYNDAMAX 149
VYNDAQEL 149
VYVGART 149

W

WAKIX 86
warfarin 38
water for irrigation, sterile 134
WELLBUTRIN SR 126
WIDE SEAL DIAPHRAGM 88
WINREVAIR 74
WP THYROID 143

X

XADAGO 60
XALKORI 55
XANAX 125
XARELTO 39
XATMEP 50
XCLAIR 137
XCOPRI 86
XDEMVY 57
XELJANZ 26
XELODA 50
XELSTRYM 66
XENICAL 57
XENLETA 36
XEPI 38
XERMELO 100
XIFAXAN 36
XIGDUO XR 45
XOFLUZA 64
XOLAIR 30
XOLREMDI 86
XOPENEX 28
XOSPATA 55
XPOVIO 56
XTAMPZA ER 23
XTANDI 50
XUREA 138
XURIDEN 97
XYOSTED 105
XYWAV 133

Y

YERVOY 56
YESINTEK 112

Z

zafirlukast 30
zaleplon 134
ZANAFLEX 124
ZARONTIN 86
ZARXIO 87
ZAVESCA 148
ZAVZPRET 20
ZEJULA 55
ZELBORAF 51
ZEMPLAR 147
ZENATANE 135
ZENPEP 103
ZENZEDI 66
ZEPATIER 65
ZEPOSIA 83
zidovudine 61, 62
ZIEXTENZO 87
zileuton 28
ZIMHI 40

Index of Medications

zinc oxide 138
ziprasidone hcl 132
ZIRGAN 63
ZITHROMAX 35
ZOHYDRO ER 23
ZOKINVY 144
ZOLADEX 52
ZOLINZA 49
zolmitriptan 20
zolpidem 134
zolpidem tart er 134
zolpidem tartrate 134
zonisamide 86
ZORTRESS 113
ZORYVE 139
ZTLIDO 24
ZUBSOLV 151
ZURZUVAE 125
ZYDELIG 55
ZYLET 31
ZYLOPRIM 25
ZYVOX 35

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

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

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

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

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

938071 n CA Value 4-Tier Specialty 08/25

Discrimination is against the law

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

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

Cigna Healthcare:

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

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

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

ACAGrievance@CignaHealthcare.com

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

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

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

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

Proficiency of Language Assistance Services

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

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

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

Vietnamese – XIN LƯU Ý: Nếu bạn nói tiếng Viet, dịch vụ hỗ trợ ngôn ngữ miễn phí có sẵn cho bạn. Các thiết bị và dịch vụ hỗ trợ phù hợp để cung cấp thông tin ở định dạng có thể tiếp cận cũng có sẵn miễn phí. Gọi số 1-800-244-6224 (TTY: Gọi 711) hoặc nói chuyện với nhà cung cấp của bạn).

Korean – 주의: 한국어를 사용하시는 경우, 무료 언어 지원 서비스가 제공됩니다. 접근 가능한 형식으로 정보를 제공하기 위한 적절한 보조 기기 및 서비스도 무료로 제공됩니다. 1-800-244-6224 (TTY: 711 로 전화) 로 전화하시거나 제공자에게 문의하십 시오.

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

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

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

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

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

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

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

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

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

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

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