



# Cigna Healthcare Legacy (Standard) 4-Tier Prescription Drug List

Coverage as of July 1, 2024

For the State of California

[Cigna.com/PDL](https://Cigna.com/PDL)  
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Last updated: 03/01/2024. This drug list is subject to change and all prior versions are no longer in effect.

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### View your drug list online

This document was last updated on 03/01/2024.\* Go online to see the most up-to-date list of medications your plan covers.

- **myCigna® App<sup>1</sup> or myCigna.com®.** Click on the Prescriptions tab and select Price a Medication from the dropdown menu. Then type in your medication name.
- **Cigna.com/PDL.** Scroll down to the "California Employer Drug Lists" section. Under Cigna Legacy (Standard) Prescription Drug List, click on the pdf named **California Legacy (Standard) 4 Tier (injectable specialty medications covered on tier 4) (CDI).**

### Questions?

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

## Information about this drug list

### Frequently Asked Questions (FAQs)

Understanding your prescription medication coverage can be confusing. Here are answers to some commonly asked questions.

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

**A.** We regularly review and update your plan's drug list to make sure you're getting coverage for low-cost, safe, clinically effective medications. We make changes for many reasons – like when new medications become available or are no longer available, or when medication prices change. 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 becomes available.**  
This can happen at any time during the year.
- **Moving a medication to a higher cost tier and/or no longer covering a medication.**  
This typically happens twice a year on January 1<sup>st</sup> and July 1<sup>st</sup>.
- **Adding extra coverage requirements to a medication.**

When we make a change that affects the coverage of a medication you're taking, we let you know before it happens. This way, you have time to talk with your doctor about your options. Only you and your doctor can decide what's best for your treatment.

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

**A.** There are certain medications and products that can't be covered by your plan for any reason because they're considered to be a "plan or benefit exclusion." This means the medication or product isn't on your plan's drug list, and there's no option to ask Cigna Healthcare to consider approving it through the coverage review process. For example, your plan doesn't cover, or "excludes," medications that aren't approved by the U.S. Food and Drug Administration (FDA).

#### **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 to make sure you're receiving coverage for the right medication, at the right cost, in the right amount and for the right situation.

#### **Q. How do I know if I'm taking a medication that needs approval?**

**A.** Log in to the **myCigna App** or **myCigna.com**, or check your plan materials, to learn more about how your plan covers your medications. If your medication has a **PA** or **ST** next to it, your medication needs approval before your plan will cover it. If it has a **QL** next to it, you may need approval depending on the amount you're filling. If it has **AGE** next to it, you may need approval depending on the covered age range for the medication.

#### **Q. What types of medications typically need approval?**

**A.** Medications that:

- May be unsafe when combined with other medications
- Have lower-cost, equally effective alternatives available
- Should only be used for certain health conditions
- Are often misused or abused

## Information about this drug list

### Frequently Asked Questions (FAQs) *(cont.)*

#### **Q. What types of medications typically have quantity limits?**

**A.** Medications that are often:

- Taken in amounts larger than (or for longer than) may be appropriate
- Misused or abused

#### **Q. What types of medications require Step Therapy?**

**A.** High-cost medications that are used to treat many 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.** The FDA considers certain medication to only be clinically appropriate for people of a certain age or within a certain age range.

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

**A.** Ask your doctor's office to contact Cigna Healthcare 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 the Cigna Healthcare provider portal at [cignaforhcp.com](http://cignaforhcp.com).

Cigna Healthcare will review information your doctor sends us to make sure your medication meets coverage requirements. We'll send you and your doctor a letter with the decision and next steps. It can take 1-5 business days to hear from us. You can always check with your doctor's office to find out if a decision's been made. You can also log in to the **myCigna App** or **myCigna.com** to check the status of your approval.

If your medication isn't approved, 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 Cigna Healthcare a written request explaining why the medication should be covered.

- **For non-urgent requests**, Cigna Healthcare will 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**, Cigna Healthcare will 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 Cigna Healthcare doesn'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 from Cigna Healthcare for your plan to cover your medication, Cigna Healthcare 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, he or she can ask Cigna Healthcare to consider approving coverage of your medication. Ask your doctor's office to contact Cigna Healthcare 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 the Cigna Healthcare provider portal at [cignaforhcp.com](http://cignaforhcp.com).

Cigna Healthcare will review information your

## Information about this drug list

### Frequently Asked Questions (FAQs) *(cont.)*

doctor sends us to make sure your medication meets coverage requirements. We'll send you and your doctor a letter with the decision and next steps. It can take 1-5 business days to hear from us. You can always check with your doctor's office to find out if a decision's been made. You can also log in to the **myCigna App** or **myCigna.com** to check the status of your approval.

If your medication isn't approved, 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 Cigna Healthcare a written request explaining why the medication should be covered.

- **For non-urgent requests**, Cigna Healthcare will 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**, Cigna Healthcare will 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 Cigna Healthcare coverage requirements for the medication and/or the reviewing doctor.

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

**A.** If you and your doctor feel an alternative medication won't work for you, your doctor can ask Cigna Healthcare to consider approving coverage of your current medication. Ask your doctor's office to contact Cigna Healthcare 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 the Cigna Healthcare provider portal at

**cignaforhcp.com.**

Cigna Healthcare will review information your doctor sends us to make sure your medication meets coverage requirements. We'll send you and your doctor a letter with the decision and next steps. It can take 1-5 business days to hear from us. You can always check with your doctor's office to find out if a decision's been made. You can also log in to the **myCigna App** or **myCigna.com** to check the status of your approval.

If your medication isn't approved, 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 Cigna Healthcare a written request explaining why the medication should be covered.

- **For non-urgent requests**, Cigna Healthcare will 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**, Cigna Healthcare will 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 Cigna Healthcare doesn't respond to a completed prior authorization exception request within 72 hours of receiving a non-urgent request and 24 hours of receiving a request based on exigent circumstances, the request will be considered approved and your plan can't deny coverage of the medication.

#### **Your Step Therapy rights under California State law:**

1. A carrier may impose prior authorization requirements on prescription drug benefits.
2. When there is more than one drug that is appropriate for the treatment of a medical condition, a carrier may require step therapy.
  - a. In circumstances where an insured is changing policies, the new policy shall not require a repeat of step therapy when that insured is

## Information about this drug list

### Frequently Asked Questions (FAQs) *(cont.)*

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, he or she will see that the medication needs preapproval from Cigna Healthcare. Because you didn't get approval ahead of time, your plan won't cover the cost of your medication. You should ask your doctor to contact Cigna Healthcare to start the coverage review process. Or, you can choose to pay the medication's full cost out-of-pocket directly to the pharmacy (the cost 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 will have to contact Cigna Healthcare and ask us to approve a larger amount.

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

**A.** Yes.

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

**A.** We review all recently approved medications and products to see if they should be covered – and if so, at what cost-share (tier). It can take up to six months

from the date the FDA approved them to make a decision. These include, but are not limited to, medications, medical supplies and/or devices covered under standard pharmacy benefits. If your doctor wants you to use a recently approved medication, he or she can ask Cigna Healthcare to consider approving it through the coverage review process.

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

**A.** The Patient Protection and Affordable Care Act (PPACA), commonly referred to as "health care reform," was signed into law on March 23, 2010. Under this law, certain preventive medications (including some over-the-counter products) may be available to you at no cost-share (\$0), depending on your plan. Log in to the **myCigna App** or **myCigna.com**, or check your plan materials, to learn more about how your plan covers preventive medications. You can also view the PPACA No Cost-Share Preventive Medications drug list at **Cigna.com/PDL**. For more information about health care reform, go to **informedonreform.com** or **CignaHealthcare.com**.

#### **Q. What are preventive medications?**

**A.** Preventive medications are used to keep certain conditions from developing or from coming back. These conditions include, but are not limited to asthma, depression, diabetes, heart attack, high blood pressure, high cholesterol, osteoporosis, prenatal nutrient deficiency and stroke.

#### **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 considering the right medication for your treatment, knowing how much it costs, what lower-cost alternatives are

## Information about this drug list

### Frequently Asked Questions (FAQs) *(cont.)*

available and which pharmacies offer 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.<sup>2</sup>

#### **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.** Consider 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). You should talk with your doctor to see if one of these options may work for you.

#### **Q. What’s a generic medication?**

**A.** A generic medication is the same as its brand-name version in safety, effectiveness, quality, strength and dosage, as well as in the way it’s taken and used.<sup>3</sup> Brand-name medications are protected by patents. Patents keep other manufacturers from selling generic versions of the brand-name medication. Once a patent ends, other companies can make and sell a generic version of the brand-name medication. Generics are typically sold under their chemical or scientific name, instead of the manufacturer’s patented 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 its brand-name version.

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

**A.** The medications may look different. For example, generics may have a different shape, size or color than their brand-name versions. They may also have a different flavor, have different preservatives, come

in different packaging and/or with different labeling and may expire at different times. Generics may look different than their brand-name versions, but they’re just as safe and effective.

Generics typically cost much less than brand-name medications – in some cases, up to 85% less. Just because generics cost less, it doesn’t mean they’re lower quality.

#### **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 menu.

#### **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.<sup>4</sup> 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.

#### **Express Scripts® Pharmacy for maintenance medications**

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

## Information about this drug list

### Frequently Asked Questions (FAQs) *(cont.)*

safe, and saves you trips to the pharmacy. To learn more, go to [Cigna.com/homedelivery](https://www.cigna.com/homedelivery).

- Easily order, manage, track and pay for your medications on your phone or online
- Standard shipping at no extra cost<sup>5</sup>
- Automatic refills or refill reminders
- Fill up to a 90-day supply at one time<sup>6</sup>
- Helpful pharmacists available 24/7
- Flexible payment options

#### Here are three easy ways to get started.

- 1. Log in to the myCigna App or myCigna.com to move your prescription electronically.** Click on the Prescriptions tab and select My Medications from the dropdown menu. Then click the button next to your medication name to move your prescription(s). Or,
- 2. Call your doctor's office.** Ask them to send a 90-day prescription (with refills) electronically to Express Scripts® Home Delivery. Or,
- 3. Call Express Scripts® Pharmacy at 800.835.3784.** They'll contact your doctor's office to help transfer your prescription. Have your Cigna Healthcare ID card, doctor's contact information and medication name(s) ready when you call.

#### Accredo for specialty medications

If you're taking a specialty medication to treat a complex medical condition, Accredo's team of specialty trained pharmacists and nurses can help. They'll fill and ship your specialty medication to your home (or location of your choice).<sup>7</sup> They'll also provide you with the personalized care and support you need to manage your therapy – at no extra cost.

- 24/7 access to specialty-trained pharmacists and nurses
- Personalized care services such as training on how to administer your medication
- Help you find ways to pay for your medications
- Fast shipping at no extra cost
- Easy refills and free reminders

- Easily manage your medications online and track your orders

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. To learn more about Accredo, go to [Cigna.com/specialty](https://www.cigna.com/specialty).

#### **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 Accredo 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. Accredo has access to most specialty medications. Call 877.826.7657 for more information. Representatives are available Monday–Friday, 7:00 am–10:00 pm CST and on Saturdays, 7:00 am–4:00 pm CST.

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



## Information about this drug list

### Frequently Asked Questions (FAQs) *(cont.)*

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

**A.** Managing a complex condition isn't easy. As part of your pharmacy benefits, you have access to Accredo. Accredo's team of specialty-trained pharmacists and nurses will provide you with the personalized care and support you need to manage your complex medical condition. They'll help you work through side effects, check in with you and your doctor to see how your therapy's going, help you get your medications approved for coverage, and more.

Go to [Cigna.com/specialty](https://www.cigna.com/specialty) to learn more about Accredo or call 877.826.7657, Monday–Friday, 7:00 am–10:00 pm CST and Saturdays, 7:00 am–4:00 pm CST.

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

**A.** You can use the online tools and resources on the **myCigna App** or **myCigna.com** to help you better understand your pharmacy coverage. You can find out how much your medication costs, 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 Express Scripts® Pharmacy orders.

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

**A.** Covered medications are divided into tiers (or cost-share levels). Typically, the higher the tier, the higher the price you'll pay to fill the prescription. 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. Typically, medications that are injected or infused are covered under the medical benefit. These are given to you at a doctor's office, an infusion center or at home. Typically, medications that you take yourself and can be filled at a retail pharmacy or through home delivery are covered under the pharmacy benefit. Check your medical summary of benefits coverage to learn more about how your plan covers these medications.

#### **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).

### 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.
- **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

## Information about this drug list

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

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 Legacy (Standard) 4-Tier Prescription Drug List as of July 1, 2024. Medications are listed alphabetically by their generic and brand names within their therapeutic category and class.

**The drug list is updated often so it isn't a full list of the medications your plan covers.** Also, your specific plan may not cover all of these medications. Log in to the **myCigna App** or **myCigna.com**, or check your plan materials, to see all of the medications your plan covers.

### How to read this drug list

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

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

### Tiers

Covered medications are divided into tiers or cost-share levels. Typically, the higher the tier, the higher the price you'll pay to fill the prescription.

• <b>Tier 1 – Typically Generics</b>	(Lowest-cost medication)	<b>\$</b>
• <b>Tier 2 – Typically Preferred Brands</b>	(Medium-cost medication)	<b>\$\$</b>
• <b>Tier 3 – Typically Non-Preferred Brands</b>	(Higher-cost medication)	<b>\$\$\$</b>
• <b>Tier 4 – Injectable Specialty Medications**</b>	(Highest-cost medication)	<b>\$\$\$\$</b>

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

\*\* Oral specialty medications are covered on a lower tier (tiers 1-3).

## Information about this drug list

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

#### Letters (acronyms) next to medication names

Certain medications may need approval from Cigna Healthcare before they can be covered.\* This extra step helps make sure you're getting the right coverage for the right medication. In this drug list, medications that have extra coverage requirements or limits have **letters (acronyms)** in the Coverage Requirements and Limits column. Here's what they mean.

<b>PA</b>	<b>Prior Authorization</b> – 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 the medication meets coverage requirements.
<b>QL</b>	<b>Quantity Limits</b> – Your plan will only cover a certain amount of this medication at one time. If your doctor wants you to fill more than what's allowed, your doctor's office can ask Cigna Healthcare to approve more.
<b>ST</b>	<b>Step Therapy</b> – Your plan doesn't cover this high-cost medication until you try at least one lower-cost option first (typically a generic or preferred brand) and it didn't work for you. If your doctor feels a different medication isn't right for you, your doctor's office can ask Cigna Healthcare to approve coverage of this medication.
<b>AGE</b>	<b>Age Requirement</b> – 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 take this medication, your doctor's office can ask Cigna Healthcare to approve coverage.
<b>SP</b>	<b>Specialty Medications</b> are used to treat complex medical conditions. They're typically injected or infused and may need special handling (like refrigeration). Some plans may limit coverage to a 30-day supply and/or require you to use a preferred specialty pharmacy to receive coverage.
<b>HD</b>	<b>Home Delivery Medications</b> – 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 switching to home delivery.
<b>PPACA</b>	<b>No Cost-Share Preventive Medications</b> – Health care reform under the Patient Protection and Affordable Care Act (PPACA) requires plans to cover certain preventive medications and products at 100%, or no cost-share (\$0), to you.
<b>CSL</b>	<b>Oral Cancer Medications Subject to Cost-Share Limits</b> – State law in California limits the cost-share (or amount you pay out-of-pocket) for certain oral chemotherapy medications.

\* These coverage requirements may not apply to your specific plan. Log in to the myCigna App or myCigna.com, or check your plan materials, to find out if your plan includes prior authorization, quantity limits, Step Therapy and/or age requirements.

# Information about this drug list

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

Use the chart below to help you read this drug list. This chart is just an example. It may not show how these medications are actually covered on the Cigna Healthcare Legacy (Standard) 4-Tier Prescription Drug List.

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

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

Generic medications are in **lowercase italics**

This chart is just a sample. It may not show how these medications are actually covered on the Cigna Healthcare Legacy (Standard) 4-Tier Prescription Drug List.

## Information about this drug list

### How to find your medication

Condition	Page	Condition	Page
<b>Analgesics</b> (Pain Relief and Inflammatory Disease)	18-22	<b>Anti-Infectives/Miscellaneous</b> (Feminine Products)	48
<b>Analgesics</b> (Urinary Tract Conditions)	22	<b>Anti-Infectives/Miscellaneous</b> (Infections)	48, 49
<b>Anesthetics</b> (Miscellaneous)	22, 23	<b>Anti-Infectives/Miscellaneous</b> (Miscellaneous)	49, 50
<b>Anesthetics</b> (Pain Relief and Inflammatory Disease)	23	<b>Anti-Infectives/Miscellaneous</b> (Skin Conditions)	50
<b>Anesthetics</b> (Urinary Tract Conditions)	23	<b>Anti-Inflammatory Tumor Necrosis Factor Inhibiting Agents</b> (Pain Relief and Inflammatory Disease)	50, 51
<b>Anti-Allergy</b> (Allergy and Nasal Sprays)	23	<b>Anti-Neoplastics</b> (Cancer)	51-57
<b>Anti-Arthritics</b> (Pain Relief and Inflammatory Disease)	23-26	<b>Anti-Neoplastics</b> (Skin Conditions)	57
<b>Anti-Asthmatics</b> (Asthma/COPD/Respiratory)	26-28	<b>Anti-Obesity Drugs</b> (Weight Management)	57, 58
<b>Antibiotics</b> (Allergy/Nasal Sprays)	28	<b>Anti-Parasitics</b> (Infections)	58
<b>Antibiotics</b> (Ear Medications)	29	<b>Anti-Parkinson's Drugs</b> (Parkinson's Disease)	58-60
<b>Antibiotics</b> (Eye Conditions)	29, 30	<b>Anti-Platelet Drugs</b> (Blood Thinners/Anti-Clotting)	61
<b>Antibiotics</b> (Infections)	30-37	<b>Antivirals</b> (AIDS/HIV)	61-64
<b>Antibiotics</b> (Skin Conditions)	38	<b>Antivirals</b> (Eye Conditions)	64
<b>Anti-Coagulants</b> (Blood Thinners/Anti-Clotting)	38, 39	<b>Antivirals</b> (Infections)	64-67
<b>Antidotes</b> (Gastrointestinal/Heartburn)	39	<b>Antivirals</b> (Skin Conditions)	67
<b>Antidotes</b> (Substance Abuse)	39, 40	<b>Autonomic Drugs</b> (Allergy/Nasal Sprays)	67
<b>Anti-Fungals</b> (Eye Conditions)	40	<b>Autonomic Drugs</b> (Alzheimer's Disease)	67, 68
<b>Anti-Fungals</b> (Feminine Products)	40	<b>Autonomic Drugs</b> (Attention Deficit Hyperactivity Disorder)	68, 69
<b>Anti-Fungals</b> (Infections)	40, 41	<b>Autonomic Drugs</b> (Blood Pressure/Heart Medications)	69
<b>Anti-Fungals</b> (Skin Conditions)	41, 42	<b>Autonomic Drugs</b> (Urinary Tract Conditions)	69
<b>Antihistamine and Decongestant Combination</b> (Allergy/Nasal Sprays)	42, 43	<b>Biologicals</b> (Allergy/Nasal Sprays)	69
<b>Antihistamines</b> (Allergy/Nasal Sprays)	43	<b>Biologicals</b> (Blood Pressure/Heart Medications)	70
<b>Antihistamines</b> (Eye Conditions)	43	<b>Biologicals</b> (Miscellaneous)	70
<b>Anti-Hyperglycemics</b> (Diabetes)	43-48	<b>Biologicals</b> (Vaccines)	70, 71
<b>Anti-Infectives</b> (Feminine Products)	48	<b>Blood</b> (Blood Modifiers/Bleeding Disorders)	71, 72
<b>Anti-Infectives</b> (Infections)	49, 50	<b>Blood</b> (Blood Thinners/Anti-Clotting)	73

## Information about this drug list

### How to find your medication *(cont.)*

Condition	Page	Condition	Page
<b>Cardiac Drugs</b> (Blood Pressure/Heart Medications)	73-76	<b>Gastrointestinal</b> (Pain Relief and Inflammatory Disease)	114
<b>Cardiovascular</b> (Asthma/COPD/Respiratory)	76	<b>Hormones</b> (Hormonal Agents)	115-121
<b>Cardiovascular</b> (Blood Pressure/Heart Medications)	77-82	<b>Hormones</b> (Infertility)	121
<b>Cardiovascular</b> (Cholesterol Medications)	82-86	<b>Hormones</b> (Miscellaneous)	121
<b>CNS Drugs</b> (Alzheimer's Disease)	86, 87	<b>Hormones</b> (Osteoporosis Products)	122
<b>CNS Drugs</b> (Miscellaneous)	87	<b>Immunosuppressants</b> (Pain Relief and Inflammatory Disease)	122
<b>CNS Drugs</b> (Multiple Sclerosis)	87, 88	<b>Immunosuppressants</b> (Skin Conditions)	122
<b>CNS Drugs</b> (Pain Relief and Inflammatory Disease)	88	<b>Immunosuppressants</b> (Transplant Medications)	123
<b>CNS Drugs</b> (Seizure Disorders)	89-92	<b>Miscellaneous Medical Supplies, Devices, Non-Drug</b> (Diabetes)	124-132
<b>CNS Drugs</b> (Sleep Disorders/Sedatives)	92	<b>Miscellaneous Medical Supplies, Devices, Non-Drug</b> (Miscellaneous)	132, 133
<b>Colony Stimulating Factors</b> (Blood Modifiers/Bleeding Disorders)	93	<b>Muscle Relaxants</b> (Pain Relief and Inflammatory Disease)	134
<b>Contraceptives</b> (Contraception Products)	93-95	<b>Prenatal Vitamins</b> (Nutritional/Dietary)	135
<b>Cough/Cold Preparations</b> (Allergy/Nasal Sprays)	95	<b>Psychotherapeutic Drugs</b> (Anxiety/Depression/Bipolar Disorder)	135-141
<b>Cough/Cold Preparations</b> (Cough/Cold Medications)	95, 96	<b>Psychotherapeutic Drugs</b> (Attention Deficit Hyperactivity Disorder)	141-144
<b>Diagnostic</b> (Diabetes)	96, 97	<b>Psychotherapeutic Drugs</b> (Miscellaneous)	144
<b>Diagnostic</b> (Miscellaneous)	98	<b>Psychotherapeutic Drugs</b> (Schizophrenia/Anti-Psychotics)	144-147
<b>Diuretics</b> (Diuretics)	98, 99	<b>Psychotherapeutic Drugs</b> (Sleep Disorders/Sedatives)	145-149
<b>EENT Preps</b> (Allergy/Nasal Sprays)	99	<b>Skin Preps</b> (Miscellaneous)	149
<b>EENT Preps</b> (Ear Medications)	100	<b>Skin Preps</b> (Pain Relief and Inflammatory Disease)	149, 150
<b>EENT Preps</b> (Eye Conditions)	100-104	<b>Skin Preps</b> (Skin Conditions)	150-159
<b>Elect/Caloric/H2O</b> (Cholesterol Medications)	104	<b>Smoking Deterrents</b> (Smoking Cessation)	159
<b>Elect/Caloric/H2O</b> (Dental Products)	104	<b>Thyroid Prep</b> (Hormonal Agents)	160
<b>Elect/Caloric/H2O</b> (Diabetes)	105	<b>Unclassified Drug Products</b> (AIDS/HIV)	161
<b>Elect/Caloric/H2O</b> (Miscellaneous)	105	<b>Unclassified Drug Products</b> (Asthma/COPD/Respiratory)	161
<b>Elect/Caloric/H2O</b> (Nutritional/Dietary)	105, 106	<b>Unclassified Drug Products</b> (Blood Modifiers/Bleeding Disorders)	161
<b>Elect/Caloric/H2O</b> (Urinary Tract Conditions)	106	<b>Unclassified Drug Products</b> (Blood Pressure/Heart Medications)	161, 162
<b>Gastrointestinal</b> (Cholesterol Medications)	107		
<b>Gastrointestinal</b> (Gastrointestinal/Heartburn)	108-114		



## Information about this drug list

### How to find your medication *(cont.)*

Condition	Page	Condition	Page
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Unclassified Drug Products (Erectile Dysfunction)	162, 163	Unclassified Drug Products (Substance Abuse)	167
Unclassified Drug Products (Gastrointestinal/Heartburn)	160	Unclassified Drug Products (Transplant Medications)	167
Unclassified Drug Products (Hormonal Agents)	163	Unclassified Drug Products (Urinary Tract Conditions)	167-169
Unclassified Drug Products (Miscellaneous)	164-166	Unclassified Drug Products (Weight Management)	169
Unclassified Drug Products (Nutritional/Dietary)	166	Vitamins (Nutritional/Dietary)	169
Unclassified Drug Products (Osteoporosis Products)	166		
Unclassified Drug Products (Pain Relief and Inflammatory Disease)	167		

# List of Prescription Medications

ANALGESICS (Pain Relief and Inflammatory Disease)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>ANALGESIC, NON-SALICYLATE AND BARBITURATE COMBINAT</b>		
butalbital/acetaminophen	T1	
<b>ANALGESIC, SALICYLATE, BARBITURATE, XANTHINE COMB.</b>		
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)
<b>ANALGESIC, NON-SALICYLATE, BARBITURATE, XANTHINE COMB.</b>		
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	PA QL (6 tabs/day)
ESGIC CAPSULE (zebutal)	T3	PA QL (6 caps/day)
FIORICET (phrenilin forte)	T3	PA QL (6 caps/day)
<b>ANALGESIC/ANTIPYRETICS, SALICYLATES</b>		
choline salicyl/mag salicylate	T1	HD
diflunisal	T1	HD
<b>ANTI-MIGRAINE PREPARATIONS</b>		
AIMOVIG AUTOINJECTOR	T2	PA
AJOVY AUTOINJECTOR	T2	PA
AJOVY SYRINGE	T2	PA
almotriptan malate	T1	QL (12 tabs/30 days)
CAFERGOT (ergotamine-caffeine)	T3	QL (40 tabs/28 days)
dihydroergotamine 1 mg/ml amp	T1	QL (10 amps/30 days)
eletriptan hydrobromide	T1	QL (6 tabs/30 days)
EMGALITY PEN	T2	PA
EMGALITY SYRINGE	T2	PA
ergotamine tartrate/caffeine	T1	
ergotamine tartrate/caffeine (Cafergot)	T1	QL (40 tabs/28 days)
frovatriptan succinate	T1	QL (18 tabs/30 days)
isomethept/dichlphn/acetaminop	T1	
isomethepten/caf/acetaminophen	T1	
<i>naratriptan hcl</i>	T1	QL (9 tabs/30 days)
NURTEC ODT	T2	PA QL (16 tabs/30 days)
<i>rizatriptan benzoate</i>	T1	QL (12 tabs/30 days)
<i>rizatriptan benzoate (Maxalt Mlt)</i>	T1	QL (12 tabs/30 days)
<i>rizatriptan benzoate (Maxalt)</i>	T1	QL (12 tabs/30 days)

T1 – Typically Generics

T4 – Injectable Specialty Medications

ST – Step Therapy

HD – May require home delivery pharmacy

T2 – Typically Preferred Brands

PA – Prior Authorization

AGE – Age Requirement

PPACA – No Cost-Share Preventive Medication

T3 – Typically Non-Preferred Brands

QL – Quantity Limit

SP – Specialty Medication

CSL – Oral cancer medication subject to cost-share limits

## List of Prescription Medications

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

T1 – Typically Generics

T4 – Injectable Specialty Medications

ST – Step Therapy

HD – May require home delivery pharmacy

T2 – Typically Preferred Brands

PA – Prior Authorization

AGE – Age Requirement

PPACA – No Cost-Share Preventive Medication

T3 – Typically Non-Preferred Brands

QL – Quantity Limit

SP – Specialty Medication

CSL – Oral cancer medication subject to cost-share limits

# List of Prescription Medications

ANALGESICS (Pain Relief and Inflammatory Disease)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>OPIOID ANALGESIC AND NON-SALICYLATE ANALGESICS</b>		
<i>acetaminophen-cod #4 tablet</i>	T1	PA
APADAZ	T3	
BENZHYDROCODONE-ACETAMINOPHEN	T1	
<i>hydrocodone/acetaminophen</i>	T1	PA
<i>hydrocodone/acetaminophen</i> (Hydrocodone-acetaminophen)	T1	PA
<i>hydrocodone/acetaminophen</i> (Norco)	T1	PA
HYDROCODONE-ACETAMINOPHEN	T1	PA
LORTAB	T1	PA
NALOCET	T1	PA
NORCO ( <i>lorcet hd</i> )	T3	PA
NORCO ( <i>lorcet plus</i> )	T3	PA
NORCO ( <i>lorcet</i> )	T3	PA
<i>oxycodone hcl/acetaminophen</i> (Nalocet)	T1	PA
<i>oxycodone hcl/acetaminophen</i> (Percocet)	T1	PA
<i>oxycodone hcl/acetaminophen</i> (Primlev)	T1	PA
PERCOCET ( <i>oxycodone-acetaminophen</i> )	T3	PA
PRIMLEV	T1	PA
<i>tramadol hcl/acetaminophen</i> (Ultracet)	T1	
ULTRACET ( <i>tramadol hcl-acetaminophen</i> )	T3	
<b>OPIOID ANALGESIC AND NSAID COMBINATION</b>		
<i>hydrocodone/ibuprofen</i>	T1	PA
<i>hydrocodone/ibuprofen</i> (Ibudone)	T1	PA
IBUDONE	T1	PA
<i>ibuprofen/oxycodone hcl</i>	T1	PA
<b>OPIOID ANALGESIC AND SALICYLATE ANALGESIC COMB</b>		
<i>oxycodone hcl/aspirin</i>	T1	PA
<b>OPIOID ANALGESIC AND NON-SALICYLATE XANTHINE COMB</b>		
ACETAMIN-CAFF-DIHYDROCODEINE	T1	PA
<i>acetaminophen/caff/dihydrocod</i> (Acetamin-caff-dihydrocodeine)	T1	PA
<i>acetaminophen/caff/dihydrocod</i> (Trezix)	T1	PA
TREZIX	T3	PA
<b>OPIOID ANALGESICS</b>		
ACTIQ ( <i>fentanyl citrate</i> )	T3	PA
ARYMO ER	T3	PA
BELBUCA	T2	QL (2 films/day)

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

T4 – Injectable 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)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>OPIOID ANALGESICS</b>		
<i>buprenorphine</i> (Butrans)	T1	QL (4 patches/28 days)
<i>butorphanol tartrate</i>	T1	PA QL (6 bots/30 days)
BUTRANS ( <i>buprenorphine</i> )	T3	QL (4 patches/28 days)
<i>codeine sulfate</i>	T1	PA
DILAUDID 2 MG TABLET ( <i>hydromorphone hcl</i> )	T3	PA
DILAUDID 4 MG TABLET ( <i>hydromorphone hcl</i> )	T3	PA
DILAUDID 5 MG/5 ML ORAL LIQUID ( <i>hydromorphone hcl</i> )	T3	PA
DILAUDID 8 MG TABLET ( <i>hydromorphone hcl</i> )	T3	PA
DURAGESIC ( <i>fentanyl</i> )	T3	PA
<i>fentanyl</i>	T1	PA
<i>fentanyl</i> (Duragesic)	T1	PA
FENTANYL CITRATE	T1	PA
<i>fentanyl citrate</i> (Actiq)	T1	PA
FENTORA	T3	PA
<i>hydrocodone bitartrate</i> (Hysingla Er)	T1	PA
<i>hydrocodone bitartrate</i> (Zohydro Er)	T1	PA
<i>hydromorphone hcl</i>	T1	PA
<i>hydromorphone hcl</i> (Dilaudid)	T1	PA
HYSINGLA ER ( <i>hydrocodone bitartrate er</i> )	T2	PA
KADIAN ( <i>morphine sulfate er</i> )	T3	PA
LAZANDA	T3	PA
<i>meperidine hcl</i>	T1	PA
<i>methadone hcl</i>	T1	PA
MORPHABOND ER	T2	PA
<i>morphine sulfate</i>	T1	PA
<i>morphine sulfate</i> (Kadian)	T1	PA
<i>morphine sulfate</i> (Ms Contin)	T1	PA
MS CONTIN ( <i>morphine sulfate er</i> )	T3	PA
NUCYNTA	T2	PA
NUCYNTA ER	T3	PA
<i>opium/belladonna alkaloids</i>	T1	PA
OXAYDO	T3	PA
<i>oxycodone hcl</i>	T1	PA
OXYCODONE HCL ER	T1	PA
<i>oxymorphone hcl</i>	T1	PA

T1 – Typically Generics

T4 – Injectable Specialty Medications

ST – Step Therapy

HD – May require home delivery pharmacy

T2 – Typically Preferred Brands

PA – Prior Authorization

AGE – Age Requirement

PPACA – No Cost-Share Preventive Medication

T3 – Typically Non-Preferred Brands

QL – Quantity Limit

SP – Specialty Medication

CSL – Oral cancer medication subject to cost-share limits

## List of Prescription Medications

ANALGESICS (Pain Relief and Inflammatory Disease)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>OPIOID ANALGESICS</b>		
<i>pentazocine hcl/naloxone hcl</i>	T1	PA
ROXYBOND	T3	PA
<i>tramadol er 100 mg tablet</i>	T1	QL (1 tab/day)
<i>tramadol er 200 mg tablet</i>	T1	QL (1 tab/day)
<i>tramadol er 300 mg tablet</i>	T1	QL (1 tab/day)
tramadol hcl (Ultram)	T1	QL (8 tabs/day)
TRAMADOL HCL 25 MG TABLET	T3	PA QL(>= 18 yo 4 tabs/day)
TRAMADOL HCL ER 100 MG CAPSULE	T1	QL (1 cap/day)
<i>tramadol hcl er 100 mg tablet</i>	T1	QL (1 tab/day)
TRAMADOL HCL ER 150 MG CAPSULE	T1	QL (1 cap/day)
TRAMADOL HCL ER 200 MG CAPSULE	T1	QL (1 cap/day)
<i>tramadol hcl er 200 mg tablet</i>	T1	QL (1 tab/day)
TRAMADOL HCL ER 300 MG CAPSULE	T1	QL (1 cap/day)
<i>tramadol hcl er 300 mg tablet</i>	T1	QL (1 tab/day)
ULTRAM ( <i>tramadol hcl</i> )	T3	QL (8 tabs/day)
XTAMPZA ER	T2	PA
ZOHYDRO ER ( <i>hydrocodone bitartrate er</i> )	T3	PA
<b>OPIOID AND SALICYLATE ANALGESICS, BARBIT, XANTHINE</b>		
<i>codeine/butalbital/asa/caffein</i> (Fiorinal With Codeine #3)	T1	PA
FIORINAL WITH CODEINE #3 ( <i>butalbital compound-codeine</i> )	T3	PA
<b>OPIOID, NON-SALICYL. ANALGESIC, BARBITUATE, XANTHINE</b>		
<i>butalbit/acetamin/caff/codeine</i>	T1	PA
<i>butalbit/acetamin/caff/codeine</i> (Fioricet With Codeine)	T1	PA
FIORICET WITH CODEINE ( <i>butalb-acetaminoph-caff-codein</i> )	T3	PA
<b>SKELETAL MUSCLE RELAXANT, SALICYLAT, OPIOID ANALGES</b>		
<i>carisoprodol/aspirin/codeine</i>	T1	PA
<b>ANALGESICS (Urinary Tract Conditions)</b>		
<b>URINARY TRACT ANALGESIC AGENTS</b>		
ELMIRON	T2	
RIMSO-50	T2	
<b>ANESTHETICS (Miscellaneous)</b>		
<b>GENERAL ANESTHETICS, INHALANT</b>		
<i>desflurane</i> (Suprane)	T1	
<i>isoflurane</i>	T1	

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

T4 – Injectable Specialty Medications

PA – Prior Authorization

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AGE – Age Requirement

SP – Specialty Medication

HD – 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
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#### GENERAL ANESTHETICS, INHALANT

<i>isoflurane</i>	T3	
<i>sevoflurane</i> (Ultane)	T1	
SUPRANE	T3	
ULTANE ( <i>sevoflurane</i> )	T3	
<i>lidocaine hcl</i>	T1	

### ANESTHETICS (Pain Relief and Inflammatory Disease)

#### TOPICAL LOCAL ANESTHETICS

HURRICAIN ( <i>benzocaine</i> )	T1	
L.E.T. (LIDO-EPINEPH-TETRA)	T3	
<i>lidocaine 5% ointment</i>	T1	QL (145gm/30 days)
<i>lidocaine 5% patch</i> (Lidocan II)	T1	
<i>lidocaine 5% patch</i> (Lidoderm)	T1	
<i>lidocaine hcl</i>	T1	
<i>lidocaine hcl</i>	T3	
<i>lidocaine/prilocaine</i>	T1	
<i>lidocaine</i> (Lidocan li)	T1	PA
LIDOCAN II ( <i>lidocaine</i> )	T3	PA
LIDODERM ( <i>lidocaine</i> )	T3	
PAIN EASE MEDIUM STREAM SPRAY	T3	
SYNERA	T3	PA
ZTLIDO	T2	

### ANESTHETICS (Urinary Tract Conditions)

#### URINARY TRACT ANESTHETIC/ANALGESIC AGNT (AZO-DYE)

<i>phenazopyridine hcl</i> (Pyridium)	T1	
PYRIDIUM ( <i>phenazopyridine hcl</i> )	T3	

### ANTI-ALLERGY (Allergy/Nasal Sprays)

#### MAST CELL STABILIZERS

<i>cromolyn 100 mg/5 ml oral conc</i> (Gastrocrom)	T1	
GASTROCROM ( <i>cromolyn sodium</i> )	T3	

### ANTI-ARTHRITICS (Pain Relief and Inflammatory Disease)

#### ANALGESIC/ANTIPYRETICS, SALICYLATES

DISALCID ( <i>salsalate</i> )	T3	HD
<i>salsalate</i> (Disalcid)	T1	HD

#### ANTI-ARTHRITIC AND CHELATING AGENTS

DEPEN ( <i>penicillamine</i> )	T3	PA SP
<i>penicillamine</i>	T1	PA SP

T1 – Typically Generics

T4 – Injectable Specialty Medications

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T2 – Typically Preferred Brands

PA – Prior Authorization

AGE – Age Requirement

PPACA – No Cost-Share Preventive Medication

T3 – Typically Non-Preferred Brands

QL – Quantity Limit

SP – Specialty 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
<b>ANTI-ARTHRITIC AND CHELATING AGENTS</b>		
penicillamine (Depen)	T1	PA SP
<b>ANTI-ARTHRITIC, FOLATE ANTAGONIST AGENTS</b>		
OTREXUP	T2	PA
<b>ANTI-INFLAM. INTERLEUKIN-1 RECEPTOR ANTAGONIST</b>		
KINERET	T4	PA QL (28 syringes/28 days) SP
<b>ANTI-INFLAMMATORY, PYRIMIDINE SYNTHESIS INHIBITOR</b>		
ARAVA ( <i>leflunomide</i> )	T3	HD
<i>leflunomide</i> (Arava)	T1	HD
<b>ANTI-INFLAMMATORY, PHOSPHODIESTERASE-4(PDE4) INHIB.</b>		
OTEZLA 28 DAY STARTER PACK	T2	PA QL (1 pack/180 days) SP HD
OTEZLA 30 MG TABLET	T2	PA QL (2 tabs/day) SP HD
<b>ANTI-INFLAMMATORY, SEL.COSTIM.MOD., T-CELL INHIBITOR</b>		
ORENCIA	T4	PA QL (4 syringes/28 days) SP HD
ORENCIA CLICKJECT	T4	PA QL (4 injectors/28 days) SP HD
<b>COLCHICINE</b>		
<i>colchicine</i> (Mitigare)	T1	HD
<i>colchicine</i> (Colcris)	T1	HD
COLCRYS ( <i>colchicine</i> )	T3	HD
MITIGARE ( <i>colchicine</i> )	T2	HD
<b>GOLD SALTS</b>		
RIDAURA	T2	
<b>HYPERURICEMIA TX - XANTHINE OXIDASE INHIBITORS</b>		
<i>allopurinol</i> (Zyloprim)	T1	HD
<i>febuxostat 40 mg tablet</i> (Uloric)	T1	QL (1 tab/day) HD
<i>febuxostat 80 mg tablet</i> (Uloric)	T1	HD
ULORIC 40 MG TABLET ( <i>febuxostat</i> )	T3	QL (1 tab/day) HD
ULORIC 80 MG TABLET ( <i>febuxostat</i> )	T3	HD
ZYLOPRIM ( <i>allopurinol</i> )	T3	HD
<b>JANUS KINASE (JAK) INHIBITORS</b>		
CIBINQO	T2	PA QL (30 tabs/30 days) SP
LITFULO	T3	PA QL(1 cap/day) SP HD
OLUMIANT	T3	PA QL (1 tab/day) SP HD
RINVOQ	T2	PA QL (1 tab/day) SP HD
XELJANZ 1 MG/ML SOLUTION	T2	PA QL (480ML/22 Days) SP HD
XELJANZ 10 MG TABLET	T2	PA QL (2 tabs/day) SP HD
XELJANZ 5 MG TABLET	T2	PA QL (2 tabs/day) SP HD

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

T4 – Injectable Specialty Medications

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ST – Step Therapy

AGE – Age Requirement

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# List of Prescription Medications

## ANTI-ASTHMATICS (Pain Relief and Inflammatory Disease)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
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### JANUS KINASE (JAK) INHIBITORS

XELJANZ XR	T2	PA QL (1 tab/day) SP HD
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### NSAIDS (COX NON-SPEC.INHIB) AND PROSTAGLANDIN ANALOG

ARTHROTEC 50 ( <i>diclofenac sodium-misoprostol</i> )	T3	ST HD
ARTHROTEC 75 ( <i>diclofenac sodium-misoprostol</i> )	T3	ST HD
COXANTO	T3	PA HD
<i>diclofenac sodium-misoprostol</i> (Arthrotec 50)	T1	HD
<i>diclofenac sodium-misoprostol</i> (Arthrotec 75)	T1	HD

### NSAIDS, CYCLOOXYGENASE INHIBITOR - TYPE ANALGESICS

ANAPROX DS ( <i>naproxen sodium ds</i> )	T3	ST HD
DAYPRO ( <i>oxaprozin</i> )	T3	ST HD
<i>diclofenac sod dr 25 mg tab</i>	T1	HD
<i>diclofenac sod dr 50 mg tab</i>	T1	HD
<i>diclofenac sod dr 75 mg tab</i>	T1	HD
<i>diclofenac sod ec 25 mg tab</i>	T1	HD
<i>diclofenac sod ec 50 mg tab</i>	T1	HD
<i>diclofenac sod ec 75 mg tab</i>	T1	HD
<i>diclofenac sodium</i>	T1	HD
EC-NAPROSYN ( <i>naproxen</i> )	T3	ST HD
<i>etodolac</i>	T1	HD
<i>etodolac</i> (Lodine)	T1	HD
FELDENE ( <i>piroxicam</i> )	T3	ST HD
<i>fenoprofen calcium</i> (Nalfon)	T1	HD
<i>flurbiprofen</i>	T1	HD
<i>ibuprofen</i>	T1	HD
<i>indomethacin</i>	T1	HD
<i>ketoprofen 25 mg, 75 mg capsule</i>	T1	HD
LODINE ( <i>etodolac</i> )	T3	ST HD
<i>meclufenamate sodium</i>	T1	HD
<i>meloxicam</i> (Mobic)	T1	HD
MOBIC ( <i>meloxicam</i> )	T3	ST HD
<i>nabumetone</i>	T1	HD
NALFON 600 MG TABLET ( <i>profeno</i> )	T1	ST HD
NAPROSYN TABLET ( <i>naproxen</i> )	T3	ST HD
<i>naproxen tablet</i>	T1	HD
<i>naproxen</i> (Ec-naprosyn)	T1	HD
<i>naproxen</i> (Naprosyn)	T1	HD
<i>naproxen sodium</i> (Anaprox Ds)	T1	HD

T1 – Typically Generics  
 T2 – Typically Preferred Brands  
 T3 – Typically Non-Preferred Brands  
 T4 – Injectable 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 (Pain Relief and Inflammatory Disease)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
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#### NSAIDS, CYCLOOXYGENASE INHIBITOR - TYPE ANALGESICS

<i>oxaprozin</i> (Daypro)	T1	HD
OXAPROZIN 300 MG CAPSULE	T3	PA HD
<i>piroxicam</i> (Feldene)	T1	HD
QMIIZ ODT 15 MG TABLET	T3	ST HD
QMIIZ ODT 7.5 MG TABLET	T3	QL (1 tab/day) ST HD
<i>sulindac</i>	T1	HD
<i>tolmetin sodium</i>	T1	HD

#### NSAIDS, CYCLOOXYGENASE-2(COX-2) SELECTIVE INHIBITOR

CELEBREX 100 MG CAPSULE ( <i>celecoxib</i> )	T3	QL (2 caps/day) ST HD
CELEBREX 200 MG CAPSULE ( <i>celecoxib</i> )	T3	QL (2 caps/day) ST HD
CELEBREX 400 MG CAPSULE ( <i>celecoxib</i> )	T3	QL (1 cap/day) ST HD
CELEBREX 50 MG CAPSULE ( <i>celecoxib</i> )	T3	QL (2 caps/day) ST HD
<i>celecoxib 100 mg capsule</i> (Celebrex)	T1	QL(2 caps/day) HD
<i>celecoxib 200 mg capsule</i> (Celebrex)	T1	QL (2 caps/day) HD
<i>celecoxib 400 mg capsule</i> (Celebrex)	T1	QL (1 cap/day) HD
<i>celecoxib 50 mg capsule</i> (Celebrex)	T1	QL (2 caps/day) HD

#### URICOSURIC AGENTS

<i>probenecid</i>	T1	HD
<i>probenecid/colchicine</i>	T1	HD

### ANTI-ASTHMATICS (Asthma/COPD/Respiratory)

#### 5-LIPOXYGENASE INHIBITORS

<i>zileuton</i>	T1	HD
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#### ANTICHOLINERGICS, ORALLY INHALED LONG ACTING

INCRUSE ELLIPTA	T2	HD
LONHALA MAGNAIR REFILL	T3	PA HD
LONHALA MAGNAIR STARTER	T3	PA HD
SPIRIVA RESPIMAT	T2	HD

#### ANTICHOLINERGICS, ORALLY INHALED SHORT ACTING

ATROVENT HFA	T2	HD
<i>ipratropium bromide</i>	T1	HD

#### BETA-ADRENERGIC AGENTS

<i>albuterol sulf 2 mg/5 ml syrup</i>	T1	HD
<i>albuterol sulfate 2 mg tab</i>	T1	HD
<i>albuterol sulfate 4 mg tab</i>	T1	HD
<i>albuterol sulfate er 4 mg tab</i>	T1	HD
<i>albuterol sulfate er 8 mg tab</i>	T1	HD
<i>metaproterenol sulfate</i>	T1	HD

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

T4 – Injectable Specialty Medications

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AGE – Age Requirement

SP – Specialty Medication

HD – May require home delivery pharmacy

PPACA – No Cost-Share Preventive Medication

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# List of Prescription Medications

ANTI-ASTHMATICS (Asthma/COPD/Respiratory)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>BETA-ADRENERGIC AGENTS</b>		
<i>terbutaline sulfate</i>	T1	HD
<b>BETA-ADRENERGIC AGENTS, INHALED, SHORT ACTING</b>		
<i>albuterol 100 mg/20 ml soln</i>	T1	
<i>albuterol 15 mg/3 ml solution</i>	T1	
<i>albuterol 75 mg/15 ml soln</i>	T1	
<i>albuterol 2.5 mg/0.5 ml sol</i>	T1	
<i>albuterol 5 mg/ml solution</i>	T1	
<i>albuterol sul 0.63 mg/3 ml sol</i>	T1	
<i>albuterol sul 1.25 mg/3 ml sol</i>	T1	
<i>albuterol sul 2.5 mg/3 ml soln</i>	T1	
<i>albuterol sulfate (Albuterol Sulfate Hfa)</i>	T1	QL (18gm/30 days)
ALBUTEROL SULFATE HFA	T1	QL (18gm/30 days)
<i>levalbuterol hcl (Xopenex Concentrate)</i>	T1	
<i>levalbuterol hcl (Xopenex)</i>	T1	
XOPENEX ( <i>levalbuterol hcl</i> )	T3	
XOPENEX CONCENTRATE ( <i>levalbuterol concentrate</i> )	T3	
<b>BETA-ADRENERGIC AGENTS, INHALED, ULTRA-LONG ACTING</b>		
ARCAPTA NEOHALER	T3	HD
STRIVERDI RESPIMAT	T2	QL(1 inhaler/30 days) HD
<b>BETA-ADRENERGIC AGENTS, ORALLY INHALED, LONG ACTING</b>		
SEREVENT DISKUS	T3	ST QL(1 blister/30 days) HD
<b>BETA-ADRENERGIC AND ANTICHOLINERGIC COMBO, INHALED</b>		
ANORO ELLIPTA	T2	HD
BEVESPI AEROSPHERE	T3	PA QL(1 inhaler/30 days) HD
COMBIVENT RESPIMAT	T2	HD
<i>ipratropium/albuterol sulfate</i>	T1	HD
STIOLTO RESPIMAT INHAL SPRAY	T2	HD
<b>BETA-ADRENERGIC AGENTS AND GLUCOCORTICOID COMBO, INHALED</b>		
ADVAIR HFA	T2	HD
AIRDUO DIGIHALER	T3	ST HD
AIRSUPRA	T3	PA QL(1 GM/28 DAYS) HD
BREO ELLIPTA	T2	QL(1 inhaler/30 days) HD
<i>budesonide/formoterol fumarate (Symbicort)</i>	T1	QL HD
DULERA	T2	HD
<i>fluticasone propion/salmeterol</i>	T1	HD
FLUTICASONE-SALMETEROL	T1	PA QL(1 inhaler/30 days) HD
SYMBICORT	T2	ST QL(1 inhaler/30 days) HD

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

## List of Prescription Medications

### ANTI-ASTHMATICS (Asthma/COPD/Respiratory)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>BETA-ADRENERGIC-ANTICHOLINERGIC-GLUCOCORT, INHALED</b>		
BREZTRI AEROSPHERE	T2	
TRELEGY ELLIPTA	T2	
<b>GLUCOCORTICIDS, ORALLY INHALED</b>		
ALVESCO	T2	HD
<i>budesonide</i> (Pulmicort)	T1	HD
FLOVENT DISKUS	T3	PA QL(1 inhaler/30 days) HD
FLOVENT HFA	T3	PA QL(1 inhaler/30 days) HD
FLUTICASONE PROP 100MCG DISKUS	T3	PA QL(1 inhaler/30 days) HD
FLUTICASONE PROP 250 MCG DISK	T3	PA QL(4 inhalers/30 days) HD
FLUTICASONE PROP 50 MCG DISKUS	T3	PA QL(1 inhaler/30 days) HD
PULMICORT ( <i>budesonide</i> )	T3	HD
PULMICORT FLEXHALER	T2	PA HD
QVAR REDIHALER	T2	HD
<b>INTERLEUKIN-5(IL-5) RECEPTOR ALPHA ANTAGONIST, MAB</b>		
FASENRA PEN	T4	PA SP HD
<b>LEUKOTRIENE RECEPTOR ANTAGONISTS</b>		
ACCOLATE ( <i>zafirlukast</i> )	T3	HD
<i>montelukast sodium</i> (Singulair)	T1	HD
SINGULAIR ( <i>montelukast sodium</i> )	T3	HD
<i>zafirlukast</i> (Accolate)	T1	HD
<b>MAST CELL STABILIZERS, ORALLY INHALED</b>		
<i>cromolyn 20 mg/2 ml neb soln</i>	T1	QL (480ml/30 days) HD
<b>MONOCLONAL ANTIBODIES TO IMMUNOGLOBULIN E (IGE)</b>		
XOLAIR	T4	PA SP HD
<b>MONOCLONAL ANTIBODY - INTERLEUKIN-5 ANTAGONISTS</b>		
NUCALA	T4	PA SP HD
<b>MUCOLYTICS</b>		
<i>acetylcysteine</i>	T1	
<b>PHOSPHODIESTERASE-4 (PDE4) INHIBITORS</b>		
DALIRESP 250 MCG TABLET	T3	QL (28 tabs/180 days) HD
DALIRESP 500 MCG TABLET	T3	QL (2 tabs/day) HD
<b>XANTHINES</b>		
THEO-24	T2	HD
<i>theophylline anhydrous</i>	T1	HD

### ANTIBIOTICS (Allergy/Nasal Sprays)

NOSE PREPARATIONS ANTIBIOTICS		Drug Tier	Coverage Requirements and Limits
BACTROBAN NASAL		T2	

T1 – Typically Generics  
 T2 – Typically Preferred Brands  
 T3 – Typically Non-Preferred Brands  
 T4 – Injectable Specialty Medications  
 PA – Prior Authorization  
 QL – Quantity Limit  
 ST – Step Therapy  
 AGE – Age Requirement  
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 PPACA – No Cost-Share Preventive Medication  
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# List of Prescription Medications

## ANTIBIOTICS (Ear Medications)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>EAR PREPARATIONS, ANTIBIOTICS</b>		
<i>ciprofloxacin hcl</i>	T1	
CORTISPORIN-TC	T3	
<i>neomycin/polymyxin b/hydrocort</i>	T1	
<i>ofloxacin</i>	T1	
<b>OTIC PREPARATIONS, ANTI-INFLAMMATORY-ANTIBIOTICS</b>		
CIPRO HC	T2	
CIPRODEX ( <i>ciprofloxacin-dexamethasone</i> )	T3	
<i>ciprofloxacin hcl/dexameth</i> (Ciprodex)	T1	
CIPROFLOXACIN HCL-FLUOCINOLONE	T3	
OTOVEL	T3	

## ANTIBIOTICS (Eye Conditions)

<b>EYE ANTIBIOTIC AND GLUCOCORTICOID COMBINATIONS</b>		
MAXITROL ( <i>neomycin-polymyxin-dexameth</i> )	T3	PA
<i>neomycin/bacit/p-myx/hydrocort</i>	T1	
<i>neomycin/polymyxin b/dexametha</i> (Maxitrol)	T1	
<i>neomycin/polymyxin b/hydrocort</i>	T1	
TOBRADEX EYE DROPS ( <i>tobramycin-dexamethasone</i> )	T3	
TOBRADEX EYE OINTMENT	T2	
TOBRADEX ST	T2	
<i>tobramycin/dexamethasone</i> (Tobradex)	T1	
ZYLET	T3	
<b>EYE SULFONAMIDES</b>		
BLEPH-10 ( <i>sulfacetamide sodium</i> )	T3	
BLEPHAMIDE	T2	
<i>sulfacetamide sodium</i>	T1	
<i>sulfacetamide sodium</i> (Bleph-10)	T1	
<i>sulfacetamide/prednisolone sp</i>	T1	
<b>OPHTHALMIC ANTIBIOTICS</b>		
AZASITE	T2	PA
BACIGUENT ( <i>bacitracin</i> )	T3	
<i>bacitracin</i> (Baciguent)	T1	
<i>bacitracin/polymyxin b sulfate</i>	T1	
BESIVANCE	T2	
CILOXAN	T3	
<i>erythromycin base</i>	T1	
<i>gatifloxacin</i> (Zymaxid)	T1	

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## List of Prescription Medications

### ANTIBIOTICS (Eye Conditions)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>OPHTHALMIC ANTIBIOTICS</b>		
<i>gentamicin sulfate</i>	T1	PA
<i>levofloxacin</i>	T1	
MOXEZA ( <i>moxifloxacin</i> )	T3	
<i>moxifloxacin hcl</i> (Moxeza)	T1	
<i>moxifloxacin hcl</i> (Vigamox)	T1	
<i>neomycin sulf/bacitracin/poly</i>	T1	
<i>neomycin/polymyxn b/gramicidin</i>	T1	
OCUFLOX ( <i>ofloxacin</i> )	T3	
<i>ofloxacin</i> (Ocuflox)	T1	
<i>polymyxin b sulf/trimethoprim</i>	T1	
<i>tobramycin 0.3% eye drop</i> (Tobrex)	T1	
TOBEX	T3	
VIGAMOX ( <i>moxifloxacin</i> )	T3	
ZYMAXID ( <i>gatifloxacin</i> )	T3	

### ANTIBIOTICS (Infections)

<b>2ND GEN. ANAEROBIC ANTIPROTOZOAL-ANTIBACTERIAL</b>		
SOLOSEC	T2	

<b>ABSORBABLE SULFONAMIDE ANTIBACTERIAL AGENTS</b>		
BACTRIM ( <i>sulfamethoxazole-trimethoprim</i> )	T3	PA
BACTRIM DS ( <i>sulfamethoxazole-trimethoprim</i> )	T3	
<i>sulfadiazine</i>	T1	
<i>sulfamethoxazole/trimethoprim</i>	T1	
<i>sulfamethoxazole/trimethoprim</i>	T3	
<i>sulfamethoxazole/trimethoprim</i> (Bactrim Ds)	T1	
<i>sulfamethoxazole/trimethoprim</i> (Bactrim)	T1	

<b>AMINOGLYCOSIDE ANTIBIOTICS</b>		
ARIKAYCE	T3	PA SP
BETHKIS ( <i>tobramycin</i> )	T3	PA QL (8ml/day) SP HD
<i>gentamicin sulfate</i>	T1	
<i>gentamicin sulfate/pf</i>	T1	
KITABIS PAK	T3	PA QL (10ml/day) SP HD
<i>neomycin sulfate</i>	T1	
TOBI ( <i>tobramycin</i> )	T3	PA QL (10ml/day) SP HD
TOBI PODHALER	T2	PA QL (8 caps/day) SP HD

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# List of Prescription Medications

ANTIBIOTICS (Infections)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>AMINOGLYCOSIDE ANTIBIOTICS</b>		
<i>tobramycin 1, 200 mg/30 ml vial</i>	T1	
<i>tobramycin 1.2 gm vial</i>	T4	PA
<i>tobramycin 1.2 gram/30 ml vial</i>	T1	
<i>tobramycin 10 mg/ml vial</i>	T1	
<i>tobramycin 300 mg/4 ml ampule (Bethkis)</i>	T1	PA QL (28 Therapy/56 days) SP HD
<i>tobramycin 300 mg/5 ml ampule (Tobi)</i>	T1	PA QL (10ml/day) SP HD
<i>tobramycin 40 mg/ml vial</i>	T1	
<i>tobramycin 80 mg/2 ml vial</i>	T1	
TOBRAMYCIN PAK 300 MG/5 ML	T3	PA QL (10ml/day) SP HD
<b>ANAEROBIC ANTIPROTOZOAL-ANTIBACTERIAL AGENTS</b>		
FLAGYL ( <i>metronidazole</i> )	T3	
LIKMEZ	T3	PA
<i>metronidazole (Flagyl)</i>	T1	
<b>ANTIBIOTIC, ANTIBACTERIAL, MISC.</b>		
<i>fosfomycin tromethamine (Monurol)</i>	T1	
HIPREX ( <i>methenamine hippurate</i> )	T3	
<i>meth/meblue/sod phos/psal/hyos</i>	T1	
<i>meth/meblue/sod phos/psal/hyos</i>	T2	
<i>meth/meblue/sod phos/psal/hyos (Uribel)</i>	T1	
<i>methenam/m.blue/salicyl/hyoscy (Uribel Tabs)</i>	T1	
<i>methen/mblue/sal/sod phos/hyos</i>	T1	
<i>methenam/m.blue/salicyl/hyoscy</i>	T1	
<i>methenam/sod phos/mblue/hyoscy</i>	T1	
<i>methenam/sod phos/mblue/hyoscy</i>	T3	
<i>methenamine hippurate (Hiprex)</i>	T1	
<i>methenamine mandelate</i>	T1	
MONUROL ( <i>fosfomycin tromethamine</i> )	T3	
PRIMSOL	T2	
<i>trimethoprim</i>	T1	
URIBEL	T3	
URIBEL TABS ( <i>methenam/m.blue/salicyl/hyoscy</i> )	T3	
UTA	T3	
<b>ANTILEPTICS</b>		
<i>dapsone 100 mg tablet</i>	T1	
<i>dapsone 25 mg tablet</i>	T1	
THALOMID	T2	PA SP HD

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 T3 – Typically Non-Preferred Brands      QL – Quantity Limit      SP – Specialty Medication      CSL – Oral cancer medication subject to cost-share limits

# List of Prescription Medications

ANTIBIOTICS (Infections)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>ANTI-MYCOBACTERIUM AGENTS</b>		
<i>ethambutol hcl</i>	T1	HD
<i>ethambutol hcl</i> (Myambutol)	T1	HD
<i>isoniazid</i>	T1	HD
MYAMBUTOL ( <i>ethambutol hcl</i> )	T3	HD
MYCOBUTIN ( <i>rifabutin</i> )	T3	PA HD
PASER	T2	HD
<i>pyrazinamide</i>	T1	HD
<i>rifabutin</i> (Mycobutin)	T1	HD
TRECTOR	T2	HD
<b>ANTI-TUBERCULAR ANTIBIOTICS</b>		
CYCLOSERINE	T1	
PRETOMANID	T3	PA QL (1 tab/day)
PRIFTIN	T3	
RIFAMATE	T2	
<i>rifampin</i>	T1	
RIFATER	T2	
SIRTURO	T3	SP
<b>BETALACTAMS</b>		
CAYSTON	T3	PA QL (3ml/day) SP HD
<b>CEPHALOSPORIN ANTIBIOTICS - 1ST GENERATION</b>		
<i>cefadroxil</i>	T1	
<i>cephalexin</i>	T1	
<i>cephalexin</i> (Keflex)	T1	
DAXBIA	T3	
KEFLEX ( <i>cephalexin</i> )	T3	
<b>CEPHALOSPORIN ANTIBIOTICS - 2ND GENERATION</b>		
<i>cefaclor</i>	T1	
<i>cefprozil</i>	T1	
<i>cefuroxime axetil</i>	T1	
<b>CEPHALOSPORIN ANTIBIOTICS - 3RD GENERATION</b>		
<i>cefdinir</i>	T1	
<i>cefditoren pivoxil</i>	T1	
<i>cefditoren pivoxil</i> (Spectracef)	T1	
<i>cefixime</i> (Suprax)	T1	
<i>cefpodoxime proxetil</i>	T1	
<i>ceftriaxone sodium</i>	T1	

T1 – Typically Generics

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T2 – Typically Preferred Brands

PA – Prior Authorization

AGE – Age Requirement

PPACA – No Cost-Share Preventive Medication

T3 – Typically Non-Preferred Brands

QL – Quantity Limit

SP – Specialty Medication

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# List of Prescription Medications

ANTIBIOTICS (Infections)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>CEPHALOSPORIN ANTIBIOTICS - 3RD GENERATION (cont.)</b>		
SPECTRACEF ( <i>cefditoren pivoxil</i> )	T3	
SUPRAX	T3	
SUPRAX ( <i>cefixime</i> )	T3	
<b>LINCOSAMIDE ANTIBIOTICS</b>		
CLEOCIN HCL 150 MG CAPSULE ( <i>clindamycin hcl</i> )	T3	
CLEOCIN HCL 300 MG CAPSULE ( <i>clindamycin hcl</i> )	T3	
CLEOCIN HCL 75 MG CAPSULE ( <i>clindamycin hcl</i> )	T2	
CLEOCIN PEDIATRIC ( <i>clindamycin (pediatric)</i> )	T3	
<i>clindamycin hcl</i> (Cleocin Hcl)	T1	
<i>clindamycin palmitate hcl</i> (Cleocin Pediatric)	T1	
<b>MACROLIDE ANTIBIOTICS</b>		
<i>azithromycin 1 gm pwd packet</i> (Zithromax)	T1	
<i>azithromycin 100 mg/5 ml susp</i> (Zithromax)	T1	
<i>azithromycin 200 mg/5 ml susp</i> (Zithromax)	T1	
<i>azithromycin 200 mg/5 ml susp</i> (Zithromax)	T1	
<i>azithromycin 250 mg tablet</i> (Zithromax)	T1	
<i>azithromycin 500 mg tablet</i> (Zithromax Tri-pak)	T1	
<i>azithromycin 600 mg tablet</i>	T1	
<i>clarithromycin</i>	T1	
DIFICID 200 MG TABLET	T3	QL (28 tabs/28 days)
DIFICID 40 MG/ML SUSPENSION	T3	QL (5ML/Day)
E.E.S. 200 ( <i>erythromycin ethylsuccinate</i> )	T3	PA
ERYPED 200 ( <i>erythromycin ethylsuccinate</i> )	T3	
ERYPED 400 ( <i>erythromycin ethylsuccinate</i> )	T3	PA
<i>ery-tab dr 250 mg tablet</i>	T3	
<i>ery-tab dr 333 mg tablet</i>	T2	
ERY-TAB DR 500 MG TABLET ( <i>erythromycin</i> )	T3	
<i>erythromycin base</i>	T1	
<i>erythromycin base</i> (Ery-tab)	T1	
<i>erythromycin ethylsuccinate</i>	T1	
<i>erythromycin ethylsuccinate</i>	T2	
<i>erythromycin ethylsuccinate</i> (Eryped 200)	T1	
<i>erythromycin ethylsuccinate</i> (Eryped 400)	T1	
<i>erythromycin stearate</i>	T1	
PCE	T3	
ZITHROMAX 1 GM POWDER PACKET ( <i>azithromycin</i> )	T3	

T1 – Typically Generics

T4 – Injectable Specialty Medications

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T2 – Typically Preferred Brands

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AGE – Age Requirement

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T3 – Typically Non-Preferred Brands

QL – Quantity Limit

SP – Specialty Medication

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## List of Prescription Medications

ANTIBIOTICS (Infections)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>MACROLIDE ANTIBIOTICS</b>		
ZITHROMAX 100 MG/5 ML SUSP ( <i>azithromycin</i> )	T3	
ZITHROMAX 200 MG/5 ML SUSP ( <i>azithromycin</i> )	T3	
ZITHROMAX 200 MG/5 ML SUSP ( <i>azithromycin</i> )	T3	
ZITHROMAX 250 MG TABLET ( <i>azithromycin</i> )	T3	
ZITHROMAX 250 MG Z-PAK TABLET ( <i>azithromycin</i> )	T3	
ZITHROMAX 500 MG TABLET ( <i>azithromycin</i> )	T3	
ZITHROMAX TRI-PAK ( <i>azithromycin</i> )	T3	
<b>NITROFURAN DERIVATIVES ANTIBACTERIAL AGENTS</b>		
FURADANTIN ( <i>nitrofurantoin</i> )	T3	
MACROBID ( <i>nitrofurantoin mono-macro</i> )	T3	
MACRODANTIN ( <i>nitrofurantoin</i> )	T3	
<i>nitrofurantoin 25 mg/5 ml susp</i> (Furadantin)	T1	
<i>nitrofurantoin 25 mg/5 ml susp</i> (Furadantin)	T1	
<i>nitrofurantoin mcr 100 mg cap</i> (Macrodantin)	T1	
<i>nitrofurantoin mcr 25 mg cap</i> (Macrodantin)	T1	
<i>nitrofurantoin mcr 50 mg cap</i> (Macrodantin)	T1	
<i>nitrofurantoin monohyd/m-cryst</i> (Macrobid)	T1	
<b>OXAZOLIDINONE ANTIBIOTICS</b>		
<i>linezolid</i> (Zyvox)	T3	PA
SIVEXTRO	T3	PA
ZYVOX ( <i>linezolid</i> )	T3	PA
<b>PENICILLIN ANTIBIOTICS</b>		
<i>amoxicillin</i>	T1	
<i>amoxicillin/potassium clav</i>	T1	
<i>amoxicillin/potassium clav</i> (Augmentin Xr)	T1	
<i>amoxicillin/potassium clav</i> (Augmentin)	T1	
<i>ampicillin trihydrate</i>	T1	
AUGMENTIN 125-31.25 MG/5 ML	T2	PA
AUGMENTIN 250-62.5 MG/5 ML ( <i>amoxicillin-clavulanate potass</i> )	T3	PA
AUGMENTIN XR ( <i>amoxicillin-clavulanate pot er</i> )	T3	PA
<i>dicloxacillin sodium</i>	T1	
MOXATAG	T3	
<b>PLEUROMUTILIN DERIVATIVES</b>		
XENLETA	T3	PA QL (10 tabs/30 days)
<b>QUINOLONE ANTIBIOTICS</b>		
AVELOX ( <i>moxifloxacin hcl</i> )	T3	
BAXDELA	T3	PA

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

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# List of Prescription Medications

## ANTIBIOTICS (Infections)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
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### QUINOLONE ANTIBIOTICS

CIPRO 10% SUSPENSION ( <i>ciprofloxacin</i> )	T2	
CIPRO 250 MG TABLET ( <i>ciprofloxacin hcl</i> )	T3	
CIPRO 5% SUSPENSION ( <i>ciprofloxacin</i> )	T2	
CIPRO 500 MG TABLET ( <i>ciprofloxacin hcl</i> )	T3	
<i>ciprofloxacin</i> (Cipro)	T1	
<i>ciprofloxacin hcl</i>	T1	
<i>ciprofloxacin hcl</i> (Cipro)	T1	
<i>ciprofloxacin/ciprofloxacin hcl</i>	T1	
FACTIVE	T3	
<i>levofloxacin</i>	T1	
<i>moxifloxacin hcl</i> (Avelox)	T1	
<i>ofloxacin</i>	T1	

### RIFAMYCINS AND RELATED DERIVATIVE ANTIBIOTICS

AEMCOLO	T3	QL (12 tabs/3 days)
XIFAXAN 200 MG TABLET	T2	
XIFAXAN 550 MG TABLET	T2	QL (126 tabs/year)

### TETRACYCLINE ANTIBIOTICS

ACTICLATE ( <i>doxycycline hyclate</i> )	T3	ST
<i>coremino er 135 mg tablet</i>	T1	
<i>coremino er 45 mg tablet</i>	T1	QL (1 tab/day)
<i>coremino er 90 mg tablet</i>	T1	
<i>demeclocycline hcl</i>	T1	
DORYX	T3	PA
DORYX ( <i>doxycycline hyclate</i> )	T3	PA
DORYX MPC	T3	PA
<i>doxycycline 50 mg tablet</i> (Targadox)	T1	PA
<i>doxycycline hyc dr 100 mg tab</i>	T1	PA
<i>doxycycline hyc dr 150 mg tab</i>	T1	PA
<i>doxycycline hyc dr 200 mg tab</i> (Doryx)	T1	PA
<i>doxycycline hyc dr 50 mg tab</i> (Doryx)	T1	PA
<i>doxycycline hyc dr 75 mg tab</i>	T1	PA
DOXYCYCLINE HYC DR 80 MG TAB	T3	PA
<i>doxycycline hyclate</i>	T1	
<i>doxycycline hyclate</i> (Vibramycin)	T1	
<i>doxycycline hyclate 100 mg cap</i> (Vibramycin)	T1	
<i>doxycycline hyclate 100 mg tab</i>	T1	
<i>doxycycline hyclate 150 mg tab</i> (Acticlate)	T1	
<i>doxycycline hyclate 50 mg cap</i>	T1	

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# List of Prescription Medications

## ANTIBIOTICS (Infections)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
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### TETRACYCLINE ANTIBIOTICS

<i>doxycycline hyclate 75 mg tab</i> (Acticlate)	T1	
DOXYCYCLINE IR-DR	T1	PA
<i>doxycycline monohydrate</i>	T1	
<i>doxycycline monohydrate</i> (Monodox)	T1	
<i>doxycycline monohydrate</i> (Vibramycin)	T1	
MINOCIN ( <i>minocycline hcl</i> )	T3	PA
MINOCYCLINE ER	T3	ST
<i>minocycline er 105 mg tablet</i> (Solodyn)	T1	
<i>minocycline er 115 mg tablet</i> (Solodyn)	T1	
<i>minocycline er 135 mg tablet</i>	T1	
<i>minocycline er 45 mg tablet</i>	T1	QL (1 tab/day)
<i>minocycline er 55 mg tablet</i> (Solodyn)	T1	
<i>minocycline er 65 mg tablet</i> (Solodyn)	T1	
<i>minocycline er 80 mg tablet</i> (Solodyn)	T1	
<i>minocycline er 90 mg tablet</i>	T1	
<i>minocycline hcl</i>	T1	
<i>minocycline hcl</i> (Minocin)	T1	
MINOLIRA ER	T3	ST
MONODOX ( <i>monodoxyne nl</i> )	T3	
MONODOX ( <i>okebo</i> )	T3	
NUZYRA	T3	PA QL (30 tablets/28 days) SP
ORACEA	T3	PA
SEYSARA	T3	PA
SOLODYN ( <i>minocycline hcl er</i> )	T3	PA
SOLOXIDE	T1	PA
TARGADOX	T3	PA
<i>tetracycline 250 mg capsule</i>	T1	
<i>tetracycline 250 mg tablet</i>	T1	PA
<i>tetracycline 500 mg capsule</i>	T1	
<i>tetracycline 500 mg tablet</i>	T1	PA
VIBRAMYCIN 100 MG CAPSULE ( <i>morgidox</i> )	T3	PA
VIBRAMYCIN 25 MG/5 ML SUSP ( <i>doxycycline monohydrate</i> )	T3	
VIBRAMYCIN 50 MG/5 ML SYRUP	T2	
XIMINO	T3	ST

### VAGINAL ANTIBIOTICS

CLEOCIN ( <i>clindamycin phosphate</i> )	T3	PA
<i>clindamycin phosphate</i> (Cleocin)	T1	

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## List of Prescription Medications

### ANTIBIOTICS (Infections)

#### Prescription Drug Name

#### Drug Tier

#### Coverage Requirements and Limits

#### VAGINAL ANTIBIOTICS (con't.)

CLINDESSE	T3	
METROGEL-VAGINAL ( <i>vandazole</i> )	T3	PA
<i>metronidazole</i> (Metrogel-vaginal)	T1	
NUVESSA	T3	PA

#### VANCOMYCIN ANTIBIOTICS AND DERIVATIVES

FIRVANQ	T3	PA
FIRVANQ ( <i>vancomycin hcl</i> )	T3	PA
VANCOGIN HCL ( <i>vancomycin hcl</i> )	T3	PA
<i>vancomycin hcl</i> (Firvanq)	T1	

### ANTIBIOTICS (Skin Conditions)

#### TOPICAL ANTIBIOTIC AND ANTI-INFLAMMATORY STEROID

CORTISPORIN	T3	
NEO-SYNALAR	T3	

#### TOPICAL ANTIBIOTICS

AMZEEQ	T3	PA
BENZAMYCIN ( <i>erythromycin-benzoyl peroxide</i> )	T3	
CENTANY	T3	
CENTANY AT	T3	
CLEOCIN T ( <i>clindamycin phosphate</i> )	T3	
<i>clindacin etz 1% pledget</i> (Cleocin T)	T1	PA
CLINDACIN ETZ KIT	T3	
CLINDACIN PAC	T3	
CLINDAGEL	T3	PA
<i>clindamycin phosphate</i>	T1	
<i>clindamycin phosphate</i> (Cleocin T)	T1	
<i>clindamycin phosphate</i> (Evoclin)	T1	
<i>erythromycin base in ethanol</i>	T1	
<i>erythromycin base in ethanol</i>	T3	
<i>erythromycin/benzoyl peroxide</i> (Benzamycin)	T1	
EVOCLIN ( <i>clindamycin phosphate</i> )	T3	
<i>gentamicin sulfate</i>	T1	
<i>mupirocin</i> (Centany)	T1	PA
<i>mupirocin calcium</i>	T1	PA
XEPI	T3	
ZILXI	T3	PA

#### TOPICAL SULFONAMIDES

AVAR 9.5-5% CLEANSING PADS	T3	
<i>avar cleanser</i> (Rosanil)	T1	

T1 – Typically Generics

T4 – Injectable Specialty Medications

ST – Step Therapy

HD – May require home delivery pharmacy

T2 – Typically Preferred Brands

PA – Prior Authorization

AGE – Age Requirement

PPACA – No Cost-Share Preventive Medication

T3 – Typically Non-Preferred Brands

QL – Quantity Limit

SP – Specialty Medication

CSL – Oral cancer medication subject to cost-share limits

# List of Prescription Medications

## ANTIBIOTICS (Skin Conditions)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>TOPICAL SULFONAMIDES (cont.)</b>		
AVAR LS	T3	PA
AVAR-E	T3	PA
AVAR-E GREEN	T2	PA
<i>mafenide acetate</i>	T1	
ROSANIL ( <i>sodium sulfacetamide-sulfur</i> )	T1	
SILVADENE ( <i>ssd</i> )	T3	
<i>silver sulfadiazine</i> (Silvadene)	T1	
<i>sulfacetamide sod/sulfur/urea</i>	T1	
<i>sulfacetamide sodium/sulfur</i>	T1	
<i>sulfacetamide sodium/sulfur</i> (Avar-e Green)	T1	
<i>sulfacetamide sodium/sulfur</i> (Rosanil)	T1	
<i>sulfacetamide/sulfur/cleansr23</i>	T1	
<i>sulfact sod/sulur/avob/otn/oct</i>	T1	
SULFAMYLON	T2	

## ANTI-COAGULANTS (Blood Thinners/Anti-Clotting)

<b>ANTI-COAGULANTS, COUMARIN TYPE</b>		
<i>warfarin sodium</i>	T1	HD

<b>CITRATES AS ANTI-COAGULANTS</b>		
ACD-A	T3	
ANTICOAG SODIUM CITRATE 4% SOL	T3	
CITRATE PHOSPHATE DEXTROSE	T1	

<b>DIRECT FACTOR XA INHIBITORS</b>		
BEVYXXA	T3	QL (42 caps/42 days)
ELIQUIS	T2	PA
SAVAYSA 15 MG TABLET	T3	PA QL (1 tab/day)
SAVAYSA 30 MG TABLET	T3	PA QL (1 tab/day)
SAVAYSA 60 MG TABLET	T3	PA
XARELTO	T2	PA

<b>HEPARIN AND RELATED PREPARATIONS</b>		
ARIXTRA ( <i>fondaparinux sodium</i> )	T3	QL (1 syringe/day) SP
<i>enoxaparin 100 mg/ml syringe</i> (Lovenox)	T1	QL (2 syringes/day) SP
<i>enoxaparin 120 mg/0.8 ml syr</i> (Lovenox)	T1	QL (2 syringes/day) SP
<i>enoxaparin 150 mg/ml syringe</i> (Lovenox)	T1	QL (2 syringes/day) SP
<i>enoxaparin 30 mg/0.3 ml syr</i> (Lovenox)	T1	QL (2 syringes/day) SP
<i>enoxaparin 300 mg/3 ml vial</i> (Lovenox)	T1	QL (1 vial/day) SP
<i>enoxaparin 40 mg/0.4 ml syr</i> (Lovenox)	T1	QL (2 syringes/day) SP
<i>enoxaparin 60 mg/0.6 ml syr</i> (Lovenox)	T1	QL (2 syringes/day) SP

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

## List of Prescription Medications

### ANTI-COAGULANTS (Blood Thinners/Anti-Clotting)

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

### THROMBIN INHIBITORS, SELECTIVE, DIRECT, REVERSIBLE

<i>dabigatran etexilate mesylate</i>	T1	PA HD
PRADAXA	T3	PA HD

### ANTIDOTES (Gastrointestinal/Heartburn)

#### MU-OPIOID RECEPTOR ANTAGONISTS, PERIPHERALLY-ACTING

MOVANTIK	T3	PA
RELISTOR	T3	PA
SYMPROIC	T3	PA

### ANTIDOTES (Substance Abuse)

#### OPIOID ANTAGONISTS

EVZIO	T3	PA QL (0.8ml/day)
KLOXXADO	T2	PA QL (2 sprays/30 days)

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

T4 – Injectable 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

### ANTIDOTES (Substance Abuse) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>OPIOID ANTAGONISTS (cont.)</b>		
<i>naloxone 0.4 mg/ml carpuject</i>	T1	
<i>naloxone 0.4 mg/ml vial</i>	T1	
NALOXONE 2 MG AUTO-INJECTOR	T3	QL (0.8ml/day)
<i>naloxone 2 mg/2 ml syringe</i>	T1	
<i>naloxone 4 mg/10 ml vial</i>	T1	
<i>naltrexone</i>	T1	QL (180 tabs/30 days)
OPVEE	T3	QL
NARCAN	T3	QL (2 units/30 days)
ZIMHI	T3	QL (2 inj/month)

### ANTI-FUNGALS (Eye Conditions)

#### OPHTHALMIC ANTI-FUNGAL AGENTS

NATACYN	T2	
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### ANTI-FUNGALS (Feminine Products)

#### VAGINAL ANTI-FUNGALS

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

### ANTI-FUNGALS (Infections)

#### ANTI-FUNGAL AGENTS

ANCOBON ( <i>flucytosine</i> )	T3	
<i>clotrimazole</i>	T1	
CRESEMBA	T3	PA
DIFLUCAN ( <i>fluconazole</i> )	T3	PA
<i>fluconazole</i> (Diflucan)	T1	
<i>flucytosine</i> (Ancobon)	T1	
<i>itraconazole</i> (Sporanox)	T1	
<i>ketoconazole</i>	T1	
NOXAFIL 40 MG/ML SUSPENSION	T3	PA
NOXAFIL DR 100 MG TABLET ( <i>posaconazole</i> )	T3	PA
ORAVIG	T3	
<i>posaconazole</i> (Noxafil)	T1	
SPORANOX ( <i>itraconazole</i> )	T3	PA
<i>terbinafine hcl</i>	T1	
TOLSURA	T3	
VFEND ( <i>voriconazole</i> )	T3	PA
<i>voriconazole</i> (Vfend)	T1	PA

T1 – Typically Generics

T4 – Injectable Specialty Medications

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T2 – Typically Preferred Brands

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AGE – Age Requirement

PPACA – No Cost-Share Preventive Medication

T3 – Typically Non-Preferred Brands

QL – Quantity Limit

SP – Specialty 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
<b>ANTI-FUNGAL ANTIBIOTICS</b>		
BREXAFEMME	T3	PA
<i>griseofulvin ultramicrosize (Gris-peg)</i>	T1	
<i>griseofulvin, microsize</i>	T1	
GRIS-PEG ( <i>griseofulvin ultramicrosize</i> )	T3	
<i>nystatin</i>	T1	
<b>ANTI-FUNGALS (Skin Conditions)</b>		
<b>TOPICAL ANTI-FUNGAL/ANTI-INFLAMMATORY, STEROID AGENT</b>		
<i>clotrimazole/betamethasone dip</i>	T1	
<b>TOPICAL ANTI-FUNGALS</b>		
<i>ciclodan 0.77% cream (Loprox)</i>	T1	
CICLODAN 0.77% CREAM KIT	T3	
<i>ciclodan 8% solution</i>	T1	
<i>ciclopirox</i>	T1	
<i>ciclopirox (Loprox)</i>	T1	
<i>ciclopirox olamine (Loprox)</i>	T1	
DIFMETIOXRIME	T3	
<i>econazole nitrate</i>	T1	
ECOZA	T3	
ERTACZO	T3	PA
EXELDERM	T3	PA
EXODERM	T1	
EXTINA ( <i>ketodan</i> )	T3	PA
FLUCONAZ-IBU-ITRACONAZ-TERBINA	T3	
HEXIOUNYL	T3	
JUBLIA	T3	PA
KERYDIN	T3	PA
KERYDIN ( <i>tavaborole</i> )	T3	PA
<i>ketoconazole</i>	T1	
<i>ketoconazole (Extina)</i>	T1	
<i>ketoconazole/skin cleanser 28</i>	T1	
LOPROX 0.77% CREAM ( <i>ciclopirox</i> )	T3	PA
LOPROX 0.77% SUSPENSION KIT	T3	
LOPROX 0.77% TOPICAL SUSP ( <i>ciclopirox</i> )	T3	
LOPROX 1% SHAMPOO ( <i>ciclopirox</i> )	T3	PA
LULICONAZOLE	T1	
LUZU	T3	PA

T1 – Typically Generics

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T3 – Typically Non-Preferred Brands

QL – Quantity Limit

SP – Specialty Medication

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## List of Prescription Medications

### ANTI-FUNGALS (Skin Conditions)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>TOPICAL ANTI-FUNGALS</b>		
MICONAZOLE-ZINC OXIDE-PETROLTM	T1	PA
<i>naftifine hcl</i>	T1	
<i>naftifine hcl</i> (Naftin)	T1	
NAFTIN	T2	
NAFTIN ( <i>naftifine hcl</i> )	T2	
<i>nystatin</i>	T1	
<i>nystatin/triamcinolone acet</i>	T1	
<i>oxiconazole nitrate</i> (Oxistat)	T1	PA
OXISTAT 1% CREAM ( <i>oxiconazole nitrate</i> )	T3	PA
OXISTAT 1% LOTION	T2	PA
RIMI	T3	
SULCONAZOLE NITRATE	T3	PA
<i>tavorale</i> (Kerydin)	T1	PA
VUSION	T3	PA
XOLEGEL	T3	PA

### ANTIHISTAMINE AND DECONGESTANT COMBINATION (Allergy/Nasal Sprays)

#### 1ST GEN ANTIHISTAMINE AND DECONGESTANT COMBINATION

<i>phenylephrine hcl/prometh hcl</i>	T1	
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#### 2ND GEN ANTIHISTAMINE AND DECONGESTANT COMBINATION

CLARINEX-D 12 HOUR	T3	
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### ANTIHISTAMINES (Allergy/Nasal Sprays)

#### ANTIHISTAMINES - 1ST GENERATION

<i>carbinoxamine 4 mg/5 ml liquid</i>	T1	
<i>carbinoxamine maleate 4 mg tab</i>	T1	
<i>carbinoxamine maleate 6 mg tab</i> (Ryvent)	T1	PA
<i>clemastine fumarate</i>	T1	
<i>cyproheptadine hcl</i>	T1	
<i>cyproheptadine hcl</i> (Cyproheptadine Hcl)	T1	
<i>dexchlorpheniramine maleate</i> (Ryclora)	T1	PA
<i>hydroxyzine hcl</i>	T1	
<i>hydroxyzine pamoate</i>	T1	
<i>hydroxyzine pamoate</i> (Vistaril)	T1	
KARBINAL ER	T3	PA
<i>promethazine hcl</i>	T1	
RYCLORA ( <i>dexchlorpheniramine maleate</i> )	T3	PA

T1 – Typically Generics

T4 – Injectable Specialty Medications

ST – Step Therapy

HD – May require home delivery pharmacy

T2 – Typically Preferred Brands

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PPACA – No Cost-Share Preventive Medication

T3 – Typically Non-Preferred Brands

QL – Quantity Limit

SP – Specialty Medication

CSL – Oral cancer medication subject to cost-share limits

# List of Prescription Medications

## ANTI-HISTAMINES (Allergy/Nasal Sprays) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>ANTI-HISTAMINES - 2ND GENERATION</b>		
RYVENT	T3	PA
VISTARIL (hydroxyzine pamoate)	T3	
cetirizine hcl	T1	HD
CLARINEX (desloratadine)	T3	HD
desloratadine 2.5 mg odt	T1	QL (1 tab/day) HD
desloratadine 5 mg odt	T1	HD
desloratadine 5 mg tablet (Clarinet)	T1	HD

## ANTI-HISTAMINES (Eye Conditions)

### EYE ANTI-HISTAMINES

azelastine hcl 0.05% drops	T1	
BEPREVE	T3	PA
epinastine hcl	T1	
LASTACAFT	T3	
olopatadine hcl 0.1% eye drops	T1	
olopatadine hcl 0.2% eye drop (Pataday)	T1	
PATADAY (olopatadine hcl)	T3	
PATANOL 0.1%		
PAZEO	T2	
ZERVIATE	T2	

## ANTI-HYPERGLYCEMICS (Diabetes)

### ANTIHYPERGLY, DPP-4 ENZYME INHIB.-THIAZOLIDINEDIONE

ALOGLIPTIN-PIOGLITAZONE	T1	PA QL (1 tab/day) HD
OSENI	T3	PA QL (1 tab/day) HD

### ANTIHYPERGLY, INCRETIN MIMETIC (GLP-1 RECEPTOR AGONIST)

BYDUREON	T2	QL (4 vials/28 days) ST HD
BYDUREON BCISE	T2	QL (4 pens/28 days) ST HD
BYDUREON PEN	T2	QL (4 pens/28 days) ST HD
BYETTA	T2	QL (1 pen/30 days) ST HD
OZEMPIC 0.25-0.5 MG DOSE PEN	T2	QL (2 pens/28 days) ST HD
OZEMPIC 1 MG DOSE PEN (1.5 ML)	T2	QL (2 pens/28 days) ST HD
OZEMPIC 1 MG DOSE PEN (3 ML)	T2	QL (3ml/21 days) ST HD
REZVOGLAR KWIKPEN	T2	PA QL
RYBELSUS	T2	QL (1 tab/day) ST HD

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

T4 – Injectable Specialty Medications

PA – Prior Authorization

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HD – 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)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>ANTIHYPERGLY, INCRETIN MIMETIC (GLP-I RECEPTOR AGONIST) (cont.)</b>		
TRULICITY 0.75 MG/0.5 ML PEN	T2	QL (4 pens/28 days) ST HD
TRULICITY 1.5 MG/0.5 ML PEN	T2	QL (4 pens/28 days) ST HD
TRULICITY 3 MG/0.5 ML PEN	T2	QL (2 ML/28 Days) ST HD
TRULICITY 4.5 MG/0.5 ML PEN	T2	QL (2 ML/28 Days) ST HD
VICTOZA 2-PAK	T3	QL (3 pens/30 days) ST HD
VICTOZA 3-PAK	T3	QL (3 pens/30 days) ST HD
<b>ANTI-HYPERGLY, INSULIN, LONG ACT-GLP-I RECEPTOR AGONIST</b>		
SOLIQUA 100-33	T2	HD
XULTOPHY 100-3.6	T3	PA HD
<b>ANTI-HYPERGLYCEMIC-SODIUM/GLUCOCOTRANSPORTER 2 (SGLT2) INHIBITORS</b>		
FARXIGA	T2	QL (1 tab/day) ST HD
INPEFA 200 MG TABLET	T3	PA QL (1 tab/day) HD
INPEFA 400 MG TABLET	T3	PA QL (1 tab/day) HD
INVOKANA	T3	PA QL (1 tab/day) ST HD
JARDIANCE	T2	QL (1 tab/day) ST HD
STEGLATRO	T3	PA QL (1 tab/day) ST HD
<b>ANTI-HYPERGLYCEMIC-DOPAMINE RECEPTOR AGONISTS</b>		
CYCLOSET	T3	HD
<b>ANTI-HYPERGLYCEMIC, ALPHA-GLUCOSIDASE INHIBITORS</b>		
<i>acarbose (Precose)</i>	T1	HD
<i>GLYSET (miglitol)</i>	T3	HD
<i>miglitol (Glyset)</i>	T1	HD
<i>PRECOSE (acarbose)</i>	T3	HD
<b>ANTI-HYPERGLYCEMIC, AMYLIN ANALOG-TYPE</b>		
SYMLINPEN 120	T2	HD
SYMLINPEN 60	T2	HD
<b>ANTI-HYPERGLYCEMIC, BIGUANIDE TYPE</b>		
FORTAMET ( <i>metformin er osmotic</i> )	T3	PA HD
GLUCOPHAGE XR ( <i>metformin hcl er</i> )	T3	HD
GLUMETZA ( <i>metformin er gastric</i> )	T3	PA HD
<i>metformin hcl</i>	T1	HD
<i>metformin hcl (Fortamet)</i>	T1	PA HD
<i>metformin hcl (Glucophage Xr)</i>	T1	HD
<i>metformin hcl (Glumetza)</i>	T1	PA HD
<i>metformin hcl (Riomet)</i>	T1	HD
RIOMET ( <i>metformin hcl</i> )	T3	HD
RIOMET ER	T3	HD

T1 – Typically Generics  
 T2 – Typically Preferred Brands  
 T3 – Typically Non-Preferred Brands  
 T4 – Injectable 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)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>ANTI-HYPERGLYCEMIC, DPP-4 INHIBITORS</b>		
ALOGLIPTIN	T1	PA QL (1 tab/day) HD
JANUVIA	T2	QL (1 tab/day) ST HD
NESINA	T3	PA QL (1 tab/day) HD
ONGLYZA	T3	PA QL (1 tab/day) HD
TRADJENTA	T3	PA QL (2 tabs/day) HD
ZITUVIO	T3	PA QL(1 TAB/DAY) HD
<b>ANTI-HYPERGLYCEMIC, INSULIN-RELEASE STIMULANT TYPE</b>		
AMARYL ( <i>glimepiride</i> )	T3	HD
<i>chlorpropamide</i>	T1	HD
<i>glimepiride</i> (Amaryl)	T1	HD
GLIPIZIDE	T3	HD
<i>glipizide</i> (Glucotrol XI)	T1	HD
<i>glipizide</i> (Glucotrol)	T1	HD
GLUCOTROL ( <i>glipizide</i> )	T3	HD
GLUCOTROL XL ( <i>glipizide xl</i> )	T3	HD
<i>glyburide</i>	T1	HD
<i>glyburide, micronized</i> (Glynase)	T1	HD
GLYNASE ( <i>glyburide micronized</i> )	T3	HD
<i>nateglinide</i> (Starlix)	T1	HD
<i>repaglinide</i>	T1	HD
STARLIX ( <i>nateglinide</i> )	T3	HD
<i>tolbutamide</i>	T1	HD
<b>ANTI-HYPERGLYCEMIC, SGLT-2 AND DPP-4 INHIBITOR COMB</b>		
GLYXAMBI	T2	QL (1 tab/day) ST HD
QTERN	T3	ST QL(1 TAB/DAY) HD
STEGLUJAN	T3	QL (1 tab/day) ST HD
<b>ANTI-HYPERGLYCEMIC, THIAZOLIDINEDIONE AND BIGUANIDE</b>		
ACTOPLUS MET ( <i>pioglitazone-metformin</i> )	T3	HD
<i>pioglitazone hcl/metformin hcl</i> (Actoplus Met)	T1	HD
<b>ANTI-HYPERGLYCEMIC, THIAZOLIDINEDIONE-SULFONYLUREA</b>		
DUETACT ( <i>pioglitazone-glimepiride</i> )	T3	HD
<i>pioglitazone hcl/glimepiride</i> (Duetact)	T1	HD
<b>ANTI-HYPERGLYCEMIC, DPP-4 INHIBITOR-BIGUANIDE COMBS.</b>		
ALOGLIPTIN-METFORMIN	T1	PA QL (2 tabs/day) HD
JANUMET	T2	QL (2 tabs/day) ST HD
JANUMET XR 100-1,000 MG TABLET	T2	QL (1 tab/day) ST HD

T1 – Typically Generics

T4 – Injectable Specialty Medications

ST – Step Therapy

HD – May require home delivery pharmacy

T2 – Typically Preferred Brands

PA – Prior Authorization

AGE – Age Requirement

PPACA – No Cost-Share Preventive Medication

T3 – Typically Non-Preferred Brands

QL – Quantity Limit

SP – Specialty Medication

CSL – Oral cancer medication subject to cost-share limits

## List of Prescription Medications

ANTI-HYPERGLYCEMICS (Diabetes)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>ANTI-HYPERGLYCEMIC, DPP-4 INHIBITOR-BIGUANIDE COMBS.(cont.)</b>		
JANUMET XR 50-1,000 MG TABLET	T2	QL (2 tabs/day) ST HD
JANUMET XR 50-500 MG TABLET	T2	QL (1 tab/day) ST HD
JENTADUETO	T3	PA QL (4 tabs/day) HD
JENTADUETO XR 2.5 MG-1,000 MG	T3	PA QL (2 tabs/day) HD
JENTADUETO XR 5 MG-1,000 MG TB	T3	PA QL (1 tab/day) HD
KAZANO	T3	PA QL (2 tabs/day) HD
KOMBIGLYZE XR 2.5-1,000 MG TAB	T3	PA QL (2 tabs/day) HD
KOMBIGLYZE XR 5-1,000 MG TAB	T3	PA QL (1 tab/day) HD
KOMBIGLYZE XR 5-500 MG TABLET	T3	PA QL (1 tab/day) HD
<b>ANTI-HYPERGLYCEMIC, INSULIN-RELEASE STIM.-BIGUANIDE</b>		
<i>glipizide/metformin hcl</i>	T1	HD
<i>glyburide/metformin hcl</i>	T1	HD
<i>repaglinide/metformin hcl</i>	T1	HD
<b>ANTI-HYPERGLYCEMIC, THIAZOLIDINEDIONE (PPARG AGONIST)</b>		
<i>ACTOS (pioglitazone hcl)</i>	T3	HD
AVANDIA	T3	HD
<i>pioglitazone hcl (Actos)</i>	T1	HD
<b>ANTI-HYPERGLYCEMIC-GLUCOCORTICOID RECEPTOR BLOCKER</b>		
KORLYM	T3	PA SP
<b>ANTI-HYPERGLYCEMIC-SGLT2 INHIBITOR-BIGUANIDE COMBS.</b>		
DAPAGLIFLOZIN-METFO ER 10-1000	T3	PA QL(1 tab/day) HD
DAPAGLIFLOZIN-METFOR ER 5-1000	T3	PA QL(2 tabs/day) HD
INVOKAMET	T3	PA QL (2 tabs/day) ST HD
INVOKAMET XR	T3	PA QL (2 tabs/day) ST HD
SEGLUROMET	T3	PA QL (2 tabs/day) ST HD
SYNJARDY	T2	QL (2 tabs/day) ST HD
SYNJARDY XR 10-1,000 MG TABLET	T2	QL (2 tabs/day) ST HD
SYNJARDY XR 12.5-1,000 MG TAB	T2	QL (2 tabs/day) ST HD
SYNJARDY XR 25-1,000 MG TABLET	T2	QL (1 tab/day) ST HD
SYNJARDY XR 5-1,000 MG TABLET	T2	QL (2 tabs/day) ST HD
XIGDUO XR 10 MG-1,000 MG TAB	T2	QL (1 tab/day) ST HD
XIGDUO XR 10 MG-500 MG TABLET	T2	QL (1 tab/day) ST HD
XIGDUO XR 2.5 MG-1,000 MG TAB	T2	QL (2 tabs/day) ST HD
XIGDUO XR 5 MG-1,000 MG TABLET	T2	QL (2 tabs/day) ST HD
XIGDUO XR 5 MG-500 MG TABLET	T2	QL (1 tab/day) ST HD
<b>ANTIHYPGLY-SGLT-2 INHIB, DPP-4 INHIB, BIGUANIDE CB</b>		
TRIJARDY XR	T2	QL (1 tab/day) ST HD

T1 – Typically Generics

T4 – Injectable Specialty Medications

ST – Step Therapy

HD – May require home delivery pharmacy

T2 – Typically Preferred Brands

PA – Prior Authorization

AGE – Age Requirement

PPACA – No Cost-Share Preventive Medication

T3 – Typically Non-Preferred Brands

QL – Quantity Limit

SP – Specialty Medication

CSL – Oral cancer medication subject to cost-share limits

# List of Prescription Medications

## ANTI-HYPERGLYCEMICS (Diabetes)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>ANTIHYPENGLY-SGLT-2 INHIB, DPP-4 INHIB, BIGUANIDE CB</b>		
BRENZAVVY	T3	PA QL(1 tabs/day) HD
DAPAGLIFLOZIN	T3	PA QL(1 tab/day) HD
<b>INSULINS</b>		
ADMELOG	T3	PA QL (1.5ml/day) HD
ADMELOG SOLOSTAR	T3	QL (1.5ml/day) HD
AFREZZA 12 UNIT CARTRIDGE	T3	PA QL (12 cartridges/day) HD
AFREZZA 4 UNIT CARTRIDGE	T3	PA QL (36 cartridges/day) HD
AFREZZA 4 UNIT/8 UNIT/12 UNIT	T3	PA QL (6 cartridges/day) HD
AFREZZA 8 UNIT CARTRIDGE	T3	PA QL (18 cartridges/day) HD
AFREZZA 90-4 UNIT / 90-8 UNIT	T3	PA QL (12 cartridges/day) HD
AFREZZA 90-8 UNIT / 90-12 UNIT	T3	PA QL (6 cartridges/day) HD
APIDRA	T3	PA QL (1.5ML/DAY) HD
APIDRA SOLOSTAR	T3	PA QL (1.5ML/DAY) HD
BASAGLAR KWIKPEN U-100	T2	QL (1.5ml/day) HD
FIASP	T3	PA QL (1.5ml/day) HD
FIASP FLEXTOUCH	T3	PA QL (1.5ml/day) HD
FIASP PENFILL	T3	PA QL (1.5ml/day) HD
HUMALOG	T3	PA 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	T2	QL (1ML/DAY) HD
HUMALOG MIX 50-50 KWIKPEN	T2	QL (1ML/DAY) HD
HUMALOG MIX 75-25	T2	QL (2ml/day) HD
HUMALOG MIX 75-25 KWIKPEN	T2	QL (2ml/day) HD
HUMULIN R U-500	T2	QL (1ML/DAY) HD
HUMULIN R U-500 KWIKPEN	T2	QL (1ML/DAY) HD
INSULIN ASPART	T2	QL (1.5ml/day) HD
INSULIN ASPART FLEXPEN	T2	QL (1.5ml/day) HD
INSULIN ASPART PENFILL	T2	QL (1.5ml/day) HD
INSULIN ASPART PROT-INSULN ASP	T2	QL (2ml/day) HD
INSULIN GLARGINE MAX SOLOSTAR	T3	PA QL(1.5 mls/day) HD
INSULIN GLARGINE-YFGN U100 PEN	T3	PA QL(1.5 mls/day) HD
INSULIN GLARGINE-YFGN U100 VL	T3	PA QL(1.5 mls/day) HD
INSULIN LISPRO	T2	PA QL (1.5ml/day) HD
INSULIN LISPRO JUNIOR KWIKPEN	T2	QL (1.5ml/day) HD
INSULIN LISPRO KWIKPEN U-100	T2	QL (1.5ml/day) HD

T1 – Typically Generics

T4 – Injectable Specialty Medications

ST – Step Therapy

HD – May require home delivery pharmacy

T2 – Typically Preferred Brands

PA – Prior Authorization

AGE – Age Requirement

PPACA – No Cost-Share Preventive Medication

T3 – Typically Non-Preferred Brands

QL – Quantity Limit

SP – Specialty Medication

CSL – Oral cancer medication subject to cost-share limits

## List of Prescription Medications

### ANTI-HYPERGLYCEMICS (Diabetes)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>INSULINS</b>		
INSULIN LISPRO PROTAMINE MIX	T2	QL (2ml/day) HD
LANTUS	T3	PA QL (1.5ml/day) HD
LANTUS SOLOSTAR	T3	PA QL (1.5ml/day) HD
LEVEMIR	T3	PA QL (1.5ml/day) HD
LEVEMIR FLEXTOUCH	T3	PA QL (1.5ml/day) HD
LYUMJEV	T2	QL (1.5ML/DAY) HD
LYUMJEV KWIKPEN U-100	T2	QL (1.5ML/DAY) HD
LYUMJEV KWIKPEN U-200	T2	QL (1ML/DAY) HD
NOVOLOG	T3	PA QL (1.5ml/day) HD
NOVOLOG FLEXPEN	T2	QL (1.5ml/day) HD
NOVOLOG MIX 70-30	T2	QL (2ml/day) HD
NOVOLOG MIX 70-30 FLEXPEN	T2	QL (2ml/day) HD
SEMGLEE	T3	PA QL (1.5ML/DAY) HD
SEMGLEE (YFGN) 100 UNIT/ML VL	T3	PA QL (1.5MLS/DAY) HD
SEMGLEE PEN	T3	PA QL (1.5ML/DAY) HD
TOUJEO MAX SOLOSTAR	T3	PA QL (0.6ml/day) HD
TOUJEO SOLOSTAR	T3	PA QL (0.6ml/day) HD
TRESIBA	T2	QL (1.5ml/day) HD
TRESIBA FLEXTOUCH U-100	T2	QL (1.5ml/day) HD
TRESIBA FLEXTOUCH U-200	T2	QL (0.9ml/day) HD

### ANTI-INFECTIVES (Feminine Products)

#### VAGINAL SULFONAMIDES

AVC	T3	
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### ANTI-INFECTIVES (Infections)

#### PENICILLIN ANTIBIOTICS

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

#### VAGINAL ANTISEPTICS

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

### ANTI-INFECTIVES/MISCELLANEOUS (Infections)

#### 2ND GEN. ANAEROBIC ANTI-PROTOZOAL-ANTIBACTERIAL

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

T1 – Typically Generics

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AGE – Age Requirement

PPACA – No Cost-Share Preventive Medication

T3 – Typically Non-Preferred Brands

QL – Quantity Limit

SP – Specialty 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
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### AMEBICIDES

<i>paromomycin sulfate</i>	T1	
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### ANTHELMINTICS

<i>albendazole</i> (Albenza)	T1	
ALBENZA ( <i>albendazole</i> )	T3	
BILTRICIDE ( <i>praziquantel</i> )	T3	
EMVERM	T1	
<i>ivermectin</i> (Stromectol)	T1	PA
<i>praziquantel</i> (Biltricide)	T1	
STROMEKTOL ( <i>ivermectin</i> )	T3	PA

### ANTI-MALARIAL DRUGS

ARAKODA	T3	PA
<i>atovaquone/proguanil hcl</i> (Malarone)	T1	
<i>chloroquine ph 250 mg tablet</i>	T1	QL (56 Tabs/365 Days)
<i>chloroquine ph 500 mg tablet</i>	T1	
COARTEM	T3	PA QL (24 tabs/30 days)
DARAPRIM ( <i>pyrimethamine</i> )	T3	PA SP
<i>hydroxychloroquine sulfate</i> (Plaquenil)	T1	
<i>hydroxychloroquine sulfate</i> (Sovuna)	T1	
KRINTAFEL	T3	PA QL (2 tabs/30 days)
MALARONE ( <i>atovaquone-proguanil hcl</i> )	T3	PA
<i>mefloquine hcl</i>	T1	
PLAQUENIL ( <i>hydroxychloroquine sulfate</i> )	T3	PA QL (30 tabs/365 days)
PRIMAQUINE	T1	
<i>primaquine phosphate</i> (Primaquine)	T1	
<i>pyrimethamine 25 mg tablet</i> (Daraprim)	T1	PA
QUALAQUIN ( <i>quinine sulfate</i> )	T3	PA
<i>quinine sulfate</i> (Qulaquin)	T1	
SOVUNA	T3	PA
SOVUNA ( <i>hydroxychloroquine sulfate</i> )	T3	PA

### ANTI-PROTOZOAL DRUGS, MISCELLANEOUS

<i>atovaquone</i> (Mepron)	T1	
BENZNIDAZOLE	T3	
IMPAVIDO	T3	PA
LAMPIT	T3	
MEPRON	T3	PA
MEPRON ( <i>atovaquone</i> )	T3	PA
NEBUPENT ( <i>pentamidine isethionate</i> )	T3	
<i>pentamidine isethionate</i> (Nebupent)	T1	

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

**ANTI-INFECTIVES/MISCELLANEOUS (Miscellaneous) (cont.)**

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>ANTIBACTERIAL AGENTS, MISCELLANEOUS</b>		
<i>glycine urologic solution</i>	T3	
<b>ANTISEPTICS,GENERAL</b>		
ALCOHOL SWABSTICK	T3	
<b>TOPICAL ANTISEPTIC DRYING AGENTS</b>		
<i>formaldehyde</i>	T1	

**ANTI-INFECTIVES/MISCELLANEOUS (Skin Conditions)**
**TOPICAL ANTIANDROGENIC AGENTS**

WINLEVI	T3	PA
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**TOPICAL ANTI-FUNGALS**

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

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

ABRILADA(CF)	T4	PA QL(2 pens/syringes/28 days) SP
ADALIMUMAB-AACF(CF) PEN	T4	PA QL(2 PENS/28 DAYS) SP HD
ADALIMUMAB-ADAZ	T4	PA QL (2 pens/ 28 days) SP
ADALIMUMAB-ADBM(CF)	T4	PA QL(2 pens/syringes/28 days) SP HD
ADALIMUMAB-ADBM(CF) PEN CROHNS	T4	PA QL(1 starter kit/365 days) SP HD
ADALIMUMAB-FKJP (CF)	T4	PA QL (2 doses/ 28 days) SP
AMJEVITA SLP	T4	PA QL (2 SYRINGES/28 DAYS) SP HD
AVSOLA	T2	PA SP
CIMZIA 200 MG VIAL KIT	T4	PA QL (1 kit/28 days) SP HD
CIMZIA 2X200 MG/ML SYRINGE KIT	T4	PA QL (1 kit/28 days) SP HD
CIMZIA 2X200 MG/ML (X3) START KT	T4	PA QL (1 kit/year) SP HD
CYLTEZO(CF) PEN PSORIASIS-UV	T4	PA QL (2 doses/ 28 days) SP
ENBREL 25 MG KIT	T4	PA QL (8 vials/28 days) SP HD
ENBREL 25 MG/0.5 ML SYRINGE	T4	PA QL (8 syringes/28 days) SP HD
ENBREL 25 MG/0.5 ML VIAL	T4	PA QL (4ml/28 days) SP HD
ENBREL 50 MG/ML SYRINGE	T4	PA QL (4 syringes/28 days) SP HD
ENBREL MINI	T4	PA QL (4 cartridges/28 days) SP HD
ENBREL SURECLICK	T4	PA QL (4 syringes/28 days) SP HD
HADLIMA	T4	PA QL (2 doses/ 28 days) SP HD
HADLIMA (CF-citrate free)	T4	PA QL (2 doses/ 28 days) SP HD
HULIO(CF)	T4	PA QL(2 PENS/SYRINGES/28 DAYS) SP
HULIO(CF) PEN	T4	PA QL(2 pens/28 days) SP
HUMIRA	T4	PA QL (2 syringes/28 days) SP HD
HUMIRA PEN	T4	PA QL (2 pens/28 days) SP HD
HUMIRA PEN CROHN'S-UC-HS	T4	PA QL (1 kit/year) SP HD
HUMIRA PEN PSOR-UVEITS-ADOL HS	T4	PA QL (1 kit/year) SP HD

T1 – Typically Generics

T4 – Injectable Specialty Medications

ST – Step Therapy

HD – May require home delivery pharmacy

T2 – Typically Preferred Brands

PA – Prior Authorization

AGE – Age Requirement

PPACA – No Cost-Share Preventive Medication

T3 – Typically Non-Preferred Brands

QL – Quantity Limit

SP – Specialty Medication

CSL – Oral cancer medication subject to cost-share limits

# List of Prescription Medications

ANTI-NEOPLASTICS (Cancer)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>ANTI-INFLAMMATORY TUMOR NECROSIS FACTOR INHIBITOR (cont.)</b>		
HUMIRA (CF)	T4	PA QL (2 syringes/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 PEDIATRIC UC	T4	PA QL (4 kits/365 days) SP HD
HYRIMOZ	T4	PA QL (2 doses/ 28 days) SP
IDACIO (CF)	T4	PA QL (2 doses/ 28 days) SP
IDACIO(CF) PEN CROHN'S-UC	T4	PA QL(1 starter kit/365 days) SP HD
IDACIO(CF) PEN PSORIASIS	T4	PA QL(2 kits/365 days) SP HD
INFLECTRA	T2	PA SP HD
REMICADE	T3	PA SP HD
SIMPONI 100 MG/ML PEN INJECTOR	T4	PA QL (1 injector/28 days) SP HD
SIMPONI 100 MG/ML SYRINGE	T4	PA QL (1 syringe/28 days) SP HD
SIMPONI 50 MG/0.5 ML PEN INJEC	T4	PA QL (1 injector/28 days) SP HD
SIMPONI 50 MG/0.5 ML SYRINGE	T4	PA QL (1 syringe/28 days) SP HD
SIMPONI ARIA	T4	PA SP HD
YUFLYMA(CF) 20 MG/0.2 ML SYRNG	T4	PA QL SP
YUFLYMA(CF) 40 MG/0.4 ML SYRNG	T4	PA QL(2 pens/syringes/28 days) SP
YUSIMRY (CF)	T4	PA QL (2 doses/ 28 days) SP
ZYMFENTRA	T3	PA QL SP HD
<b>ANP - SELECTIVE RETINOID X RECEPTOR AGONISTS (RXR)</b>		
<i>bexarotene</i> (Targretin)	T1	PA SP HD
TARGRETIN 75 MG CAPSULE ( <i>bexarotene</i> )	T3	PA SP HD
<b>ANTI-NEOPLAST, HISTONE DEACETYLASE (HDAC) INHIBITORS</b>		
FARYDAK	T3	PA SP HD
ZOLINZA	T2	PA SP HD
<b>ANTINEOPLASTIC - ALKYLATING AGENTS</b>		
ALKERAN ( <i>melphalan</i> )	T3	SP
<i>cyclophosphamide 25 mg capsule</i>	T1	SP HD
CYCLOPHOSPHAMIDE 25 MG TABLET	T3	PA SP HD
<i>cyclophosphamide 50 mg capsule</i>	T1	SP HD
CYCLOPHOSPHAMIDE 50 MG TABLET	T3	PA SP HD
GLEOSTINE	T2	
HYDREA ( <i>hydroxyurea</i> )	T3	
<i>hydroxyurea</i> (Hydrea)	T1	
LEUKERAN	T2	
<i>melphalan</i> (Alkeran)	T1	SP
MYLERAN	T2	

T1 – Typically Generics

T4 – Injectable Specialty Medications

ST – Step Therapy

HD – May require home delivery pharmacy

T2 – Typically Preferred Brands

PA – Prior Authorization

AGE – Age Requirement

PPACA – No Cost-Share Preventive Medication

T3 – Typically Non-Preferred Brands

QL – Quantity Limit

SP – Specialty Medication

CSL – Oral cancer medication subject to cost-share limits

# List of Prescription Medications

## ANTI-NEOPLASTICS (Cancer)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
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### ANTINEOPLASTIC - ALKYLATING AGENTS

TEMODAR ( <i>temozolomide</i> )	T3	PA SP HD
<i>temozolomide</i> (Temodar)	T1	PA SP HD

### ANTI-NEOPLASTIC - ANTI-ANDROGENIC AGENTS

CASODEX ( <i>bicalutamide</i> )	T3	
ERLEADA	T2	PA SP HD CSL
<i>flutamide</i>	T1	
NILANDRON ( <i>nilutamide</i> )	T3	PA QL (4 tabs/day)
<i>nilutamide</i> (Nilandron)	T1	QL (4 tabs/day)
NUBEQA	T2	PA SP HD
XTANDI	T2	PA SP HD
YONSA	T3	PA SP HD
ZYTIGA ( <i>abiraterone acetate</i> )	T3	PA SP HD

### ANTI-NEOPLASTIC - ANTI-METABOLITES

<i>capecitabine</i> (Xeloda)	T1	PA SP HD
INQOVI	T3	PA SP HD
JYLAMVO	T3	CSL
LONSURF	T3	PA SP HD
<i>mercaptopurine</i>	T1	
<i>methotrexate sodium</i>	T1	
<i>methotrexate sodium/pf</i>	T1	
ONUREG	T3	PA QL (14 Tabs/28 Days) SP
PURIXAN	T3	SP
TABLOID	T3	
TREXALL	T2	
XATMEP	T3	
XELODA ( <i>capecitabine</i> )	T3	PA SP HD

### ANTI-NEOPLASTIC - AROMATASE INHIBITORS

<i>anastrozole</i> (Arimidex)	T1	HD PPACA
ARIMIDEX ( <i>anastrozole</i> )	T3	HD
AROMASIN ( <i>exemestane</i> )	T3	HD
<i>exemestane</i> (Aromasin)	T1	HD PPACA
FEMARA ( <i>letrozole</i> )	T3	HD
<i>letrozole</i> (Femara)	T1	HD

### ANTI-NEOPLASTIC - BRAF KINASE INHIBITORS

BRAFTOVI	T3	PA SP HD
TAFINLAR	T3	PA SP HD
ZELBORAF	T3	PA SP HD

T1 – Typically Generics  
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 T4 – Injectable Specialty Medications  
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 SP – Specialty Medication  
 HD – May require home delivery pharmacy  
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# List of Prescription Medications

ANTI-NEOPLASTICS (Cancer)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>ANTI-NEOPLASTIC - ENZYME INHIB, ANTIANDROGEN COMB.</b>		
AKEEGA	T3	PA QL(2 Tabs/Day) SP CSL
<b>ANTI-NEOPLASTIC - HEDGEHOG PATHWAY INHIBITOR</b>		
DAURISMO	T3	PA SP HD
ERIVEDGE	T2	PA SP HD
ODOMZO	T3	PA SP HD
<b>ANTI-NEOPLASTIC - JANUS KINASE (JAK) INHIBITORS</b>		
JAKAFI	T3	PA SP HD
<b>ANTI-NEOPLASTIC - KRAS PROTEIN INHIBITOR</b>		
KRAZATI	T3	PA QL(6 TABS/DAY) SP CSL
LUMAKRAS	T3	PA SP QL (8 tabs per day) HD
<b>ANTI-NEOPLASTIC - MEKI AND MEK2 KINASE INHIBITORS</b>		
COTELLIC	T3	PA SP HD
KOSELUGO 10 MG CAPSULE	T3	PA QL (10 capsules/day) SP
KOSELUGO 25 MG CAPSULE	T3	PA QL (4 caps/day) SP
MEKINIST	T3	PA SP HD
MEKTOVI	T3	PA SP HD
<b>ANTI-NEOPLASTIC - MTOR KINASE INHIBITORS</b>		
AFINITOR	T3	PA SP HD
AFINITOR ( <i>everolimus</i> )	T3	PA SP HD
AFINITOR DISPERZ	T3	PA SP
<i>everolimus 2.5 mg tablet (Afinitor)</i>	T1	PA SP HD
<i>everolimus 5 mg tablet (Afinitor)</i>	T1	PA SP HD
<i>everolimus 7.5 mg tablet (Afinitor)</i>	T1	PA SP HD
<b>ANTI-NEOPLASTIC - PROTEIN METHYLTRANSFERASE INHIBIT</b>		
TAZVERIK	T3	PA SP
<b>ANTI-NEOPLASTIC - TOPOISOMERASE I INHIBITORS</b>		
HYCAMTIN	T3	PA SP HD
<b>ANTI-NEOPLASTIC COMB - KINASE AND AROMATASE INHIBIT</b>		
KISQALI 200 MG	T2	PA QL (21 per 28 days) SP HD
KISQALI 400 MG	T2	PA QL (42 per 28 days) SP HD
KISQALI 800 MG	T2	PA QL (63 per 28 days) SP HD
KISQALI FEMARA CO-PACK	T2	PA QL (1 pack per 28 days) SP HD CSL
<b>ANTI-NEOPLASTIC EGF RECEPTOR BLOCKER MCLON ANTIBODY</b>		
PHESGO	T3	PA SP HD
<b>ANTI-NEOPLASTIC IMMUNOMODULATOR AGENTS</b>		
lenalidomide	T1	PA QL(1 TAB/DAY) SP HD CSL
POMALYST	T3	PA SP HD
REVLIMID	T2	PA QL(1 TAB/DAY) SP HD CSL

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

T4 – Injectable Specialty Medications  
PA – Prior Authorization  
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AGE – Age Requirement  
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HD – May require home delivery pharmacy  
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CSL – Oral cancer medication subject to cost-share limits

## List of Prescription Medications

ANTI-NEOPLASTICS (Cancer)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>ANTI-NEOPLASTIC LHRH (GNRH) AGONIST, PITUITARY SUPPR.</b>		
<i>leuprolide acetate</i>	T1	PA SP HD
LEUPROLIDE DEPOT	T4	PA SP
LUPRON DEPOT	T2	PA SP HD
ZOLADEX	T2	PA SP HD
<b>ANTI-NEOPLASTIC LHRH (GNRH) ANTAGONIST, PITUIT.SUPPRS</b>		
FIRMAGON	T3	PA SP HD
ORGOVYX	T3	PA SP
<b>ANTI-NEOPLASTIC SYSTEMIC ENZYME INHIBITORS</b>		
ALECENSA	T2	PA QL(8 tabs/day) SP HD CSL
ALUNBRIG	T3	PA SP HD
AUGTYRO	T3	PA QL(8 caps/day) SP HD CSL
AYVAKIT	T3	PA QL (1 tab/day) SP
BALVERSA	T3	PA SP
BOSULIF	T3	PA QL (3 caps/day) SP HD CSL
CABOMETYX	T3	PA SP HD
CALQUENCE	T3	PA SP
CAPRELSA	T3	PA SP
COMETRIQ	T3	PA SP HD
COPIKTRA	T3	PA SP
<i>erlotinib hcl (Tarceva)</i>	T1	PA SP HD
EXKIVITY	T3	PA SP HD
FOTIVDA	T3	PA QL (30 caps/30 days) SP HD
FRUZAQLA 1 MG CAPSULE	T3	PA QL(84 CAPS/28 DAYS) SP CSL
FRUZAQLA 5 MG CAPSULE	T3	PA QL(21 CAPS/28 DAYS) SP CSL
GAVRETO	T3	PA QL (4 Tabs/Day) SP
GILOTRIF	T3	PA SP HD
GLEEVEC ( <i>imatinib mesylate</i> )	T3	PA SP HD
IBRANCE	T3	PA QL (21 caps/28 days) SP HD
ICLUSIG	T3	PA SP
<i>imatinib mesylate (Gleevec)</i>	T1	PA SP HD
IMBRUVICA	T2	PA SP
INLYTA	T3	PA SP HD
INREBIC	T3	PA SP HD
IRESSA	T3	PA SP HD
IWILFIN	T3	PA QL(8 TABS/DAY) SP CSL
<i>lapatinib ditosylate (Tykerb)</i>	T1	PA SP HD
LENVIMA	T2	PA SP HD

T1 – Typically Generics

T4 – Injectable Specialty Medications

ST – Step Therapy

HD – May require home delivery pharmacy

T2 – Typically Preferred Brands

PA – Prior Authorization

AGE – Age Requirement

PPACA – No Cost-Share Preventive Medication

T3 – Typically Non-Preferred Brands

QL – Quantity Limit

SP – Specialty Medication

CSL – Oral cancer medication subject to cost-share limits

# List of Prescription Medications

ANTI-NEOPLASTICS (Cancer)			
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits	
<b>ANTI-NEOPLASTIC SYSTEMIC ENZYME INHIBITORS</b>			
LORBRENA	T3	PA SP HD	
LYNPARZA	T2	PA SP HD	
LYTGOBI 12 MG DAILY DOSE PACK	T3	PA QL (3 TABS/DAY) SP CSL	
LYTGOBI 16 MG DAILY DOSE PACK	T3	PA QL (4 TABS/DAY) SP CSL	
LYTGOBI 20 MG DAILY DOSE PACK	T3	PA QL (5 TABS/DAY) SP CSL	
NERLYNX	T3	PA SP HD	
NEXAVAR	T3	PA SP HD	
NINLARO	T3	PA SP HD	
OGSIVEO	T3	PA QL (6 TABS/DAY) SP CSL	
OJJAARA	T3	PA QL (1 TAB/DAY) SP CSL	
<i>pazopanib (Votrient)</i>	T1	PA QL SP HD CSL	
PEMAZYRE	T3	PA QL (14 tabs/21 days) SP	
PIQRAY	T3	PA SP HD	
QINLOCK	T3	PA QL (3 tabs/day) SP	
RETEVMO 40 MG CAPSULE	T3	PA QL (6 caps/day) SP HD	
RETEVMO 80 MG CAPSULE	T3	PA QL (4 tabs/day) SP HD	
ROZLYTREK	T3	PA SP HD	
RUBRACA	T2	PA SP	
RYDAPT	T3	PA SP HD	
SCSEMBLIX	T3	PA QL (2 tablets/day) SP HD	
SPRYCEL	T2	PA SP HD	
STIVARGA	T3	PA SP HD	
SUTENT	T2	PA SP HD	
TABRECTA	T3	PA QL (4 tabs/day) SP HD	
TAGRISO	T3	PA SP HD	
TALZENNA	T3	PA SP HD	
TARCEVA ( <i>erlotinib hcl</i> )	T3	PA SP HD	
TASIGNA	T2	PA SP HD	
TEPMETKO	T3	PA QL (2 tabs/day) SP	
TRUQAP	T3	PA QL (64 tabs/28 days) SP CSL	
TUKYSA	T3	PA SP	
TURALIO 125 MG CAPSULE	T3	PA QL (4 CAPS/DAY) SP CSL	
TURALIO 200 MG CAPSULE	T3	PA QL (4 CAPS/DAY) SP CSL	
TYKERB ( <i>lapatinib</i> )	T3	PA SP HD	
UKONIQ	T3	PA QL (4 tabs/day) SP	
VANFLYTA	T3	PA QL (2 tabs/day) SP CSL	
VERZENIO	T2	PA QL (120mg/day) SP HD	

T1 – Typically Generics

T4 – Injectable Specialty Medications

ST – Step Therapy

HD – May require home delivery pharmacy

T2 – Typically Preferred Brands

PA – Prior Authorization

AGE – Age Requirement

PPACA – No Cost-Share Preventive Medication

T3 – Typically Non-Preferred Brands

QL – Quantity Limit

SP – Specialty Medication

CSL – Oral cancer medication subject to cost-share limits

# List of Prescription Medications

## ANTI-NEOPLASTICS (Cancer)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>ANTI-NEOPLASTIC SYSTEMIC ENZYME INHIBITORS</b>		
VITRAKVI	T3	PA SP HD
VIZIMPRO	T3	PA SP HD
VOTRIENT ( <i>pazopanib hcl</i> )	T3	PA SP HD
XALKORI 150 MG PELLETT	T3	PA QL(4 pellets/day) SP HD CSL
XALKORI 20 MG PELLETT	T3	PA QL(4 pellets/day) SP HD CSL
XALKORI 200 MG, 250 MG CAPSULE	T3	PA QL(4 caps/day) SP HD CSL
XALKORI 50 MG PELLETT	T3	PA QL(4 pellets/day) SP HD CSL
XOSPATA	T3	PA SP
ZEJULA	T2	PA SP
ZYDELIG	T3	PA SP HD
ZYKADIA	T3	PA SP HD
<b>ANTI-NEOPLASTIC, ANTI-PROGRAMMED DEATH-I (PD-I) MAB</b>		
OPDIVO	T3	PA SP HD
<b>ANTI-NEOPLASTIC-B CELL LYMPHOMA-2(BCL-2) INHIBITORS</b>		
VENCLEXTA	T3	PA SP
VENCLEXTA STARTING PACK	T3	PA SP
<b>ANTI-NEOPLASTIC-ISOCITRATE DEHYDROGENASE INHIBITOR</b>		
IDHIFA	T3	PA SP HD
REZLIDHIA	T3	PA QL(2 CAPS/DAY) SP CSL
TIBSOVO	T3	PA SP
<b>ANTI-NEOPLASTICS ANTIBODY/ANTIBODY-DRUG COMPLEXES</b>		
ENHERTU	T3	PA SP HD
<b>ANTI-NEOPLASTICS, MISCELLANEOUS</b>		
<i>etoposide</i>	T1	SP HD
LYSODREN	T2	
MATULANE	T2	SP
<i>tretinoin 10 mg capsule</i>	T1	PA
<b>ANTI-NEOPLASTIC-SELECT INHIB OF NUCLEAR EXP (SINE)</b>		
XPOVIO	T3	PA SP
<b>CYTOTOXIC T-LYMPHOCYTE ANTIGEN (CTLA-4) RMC ANTIBODY</b>		
YERVOY	T3	PA SP HD
<b>IMMUNOMODULATORS</b>		
ACTIMMUNE	T4	PA SP HD
BESREMI	T4	PA QL (2 syringes/28 days) SP
<b>SELECTIVE ESTROGEN RECEPTOR MODULATORS (SERMS)</b>		
FARESTON ( <i>toremifene citrate</i> )	T3	QL (2 tabs/day) HD
SOLTAMOX	T3	HD
<i>tamoxifen citrate</i>	T1	HD PPACA

T1 – Typically Generics

T4 – Injectable Specialty Medications

ST – Step Therapy

HD – May require home delivery pharmacy

T2 – Typically Preferred Brands

PA – Prior Authorization

AGE – Age Requirement

PPACA – No Cost-Share Preventive Medication

T3 – Typically Non-Preferred Brands

QL – Quantity Limit

SP – Specialty Medication

CSL – Oral cancer medication subject to cost-share limits



## List of Prescription Medications

### ANTI-NEOPLASTICS (Cancer)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
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#### SELECTIVE ESTROGEN RECEPTOR MODULATORS (SERMS) *cont.*

<i>toremifene citrate</i> (Fareston)	T1	QL (2 tabs/day) HD
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#### STEROID ANTI-NEOPLASTICS

EMCYT	T2	SP HD
<i>megestrol acetate</i>	T1	

### ANTI-NEOPLASTICS (Skin Conditions)

#### PHOTOACT, TOPICAL ANTI-NEOPLAST, PREMALIGNANT LESIONS

LEVULAN	T3	SP
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#### TOPICAL ANTI-NEOPLASTIC PREMALIGNANT LESION AGENTS

CARAC	T3	PA
<i>diclofenac sodium 3% gel</i>	T1	PA
EFUDEX ( <i>fluorouracil</i> )	T3	
FLUOROPLEX	T2	
<i>fluorouracil</i>	T1	
<i>fluorouracil</i> (Efudex)	T1	
KLISYRI	T3	PA QL (5 packs/30 Days)
PANRETIN	T3	SP HD
PICATO	T2	
TARGRETIN 1% GEL ( <i>bexarotene</i> )	T3	PA SP HD
TOLAK	T3	
VALCHLOR	T3	SP HD

### ANTI-OBESITY DRUGS (Weight Management)

#### ANTI-OBESITY - ANOREXIC AGENTS

ADIPEX-P ( <i>phentermine hcl</i> )	T3	PA
<i>benzphetamine hcl</i>	T1	
<i>benzphetamine hcl</i> (Regimex)	T1	
<i>diethylpropion hcl</i>	T1	
LOMAIRA	T1	
<i>phendimetrazine tartrate</i>	T1	
<i>phentermine hcl</i>	T1	
<i>phentermine hcl</i> (Adipex-p)	T1	
QSYMIA	T3	PA
REGIMEX ( <i>benzphetamine hcl</i> )	T3	

#### ANTI-OBESITY - INCRETIN MIMETICS COMBINATION

ZEPBOUND 10 MG/0.5 ML PEN	T2	PA QL(2 mls/30 days)
ZEPBOUND 12.5 MG/0.5 ML PEN	T2	PA QL(2 mls/30 days)
ZEPBOUND 15 MG/0.5 ML PEN	T2	PA QL(2 mls/30 days)

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

T4 – Injectable 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

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## List of Prescription Medications

ANTI-OBESITY DRUGS (Weight Management) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>ANTI-OBESITY - INCRETIN MIMETICS COMBINATION (cont.)</b>		
ZEPBOUND 2.5 MG/0.5 ML PEN	T2	PA QL(2 mls/365 days)
ZEPBOUND 5 MG/0.5 ML PEN	T2	PA QL(2 mls/30 days)
ZEPBOUND 7.5 MG/0.5 ML PEN	T2	PA QL(2 mls/30 days)
<b>ANTI-OBESITY - MELANOCORTIN 4 RECEPTOR AGONISTS</b>		
IMCIVREE	T3	PA QL (9 ml/22 days) SP
<b>ANTI-OBESITY GLUCAGON-LIKE PEPTIDE-I RECEPTOR AGONIST</b>		
SAXENDA	T3	PA
WEGOVY	T2	PA QL (1 BOX/MONTH)
<b>ANTI-OBESITY SEROTONIN 2C RECEPTOR AGONISTS</b>		
BELVIQ	T3	PA
BELVIQ XR	T3	PA
<b>ANTI-OBESITY - OPIOID ANTAG-NOREPI, DOPAMINE RECEPTOR INHIB</b>		
CONTRAVE	T3	PA
<b>FAT ABSORPTION DECREASING AGENTS</b>		
XENICAL	T3	PA
ANTI-PARASITICS (Infections)		
<b>ANTI-PARASITICS</b>		
ALINIA	T3	
ALINIA ( <i>nitazoxanide</i> )	T3	
<i>nitazoxanide</i> (Alinia)	T1	
<b>OPHTHALMIC (EYE) ANTIPARASITICS</b>		
XDEMVY	T2	PA QL(4 bottles/30 days) SP
<b>TOPICAL ANTI-PARASITICS</b>		
<i>crotamiton</i> (Eurax)	T1	
ELIMITE ( <i>permethrin</i> )	T3	
EURAX 10% CREAM	T2	
EURAX 10% LOTION	T3	
<i>ivermectin</i> (Sklice)	T1	
NATROBA ( <i>spinosad</i> )	T3	
<i>permethrin</i> (Elimite)	T1	
SKLICE ( <i>ivermectin</i> )	T3	
<i>spinosad</i> (Natroba)	T1	
ULESFIA	T3	

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

T4 – Injectable Specialty Medications

PA – Prior Authorization

QL – Quantity Limit

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PPACA – No Cost-Share Preventive Medication

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## List of Prescription Medications

ANTI-PARKINSON DRUGS (Parkinson's Disease)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>ANTI-PARKINSONISM DRUGS, ANTI-CHOLINERGIC</b>		
<i>benztropine mesylate</i>	T1	HD
<i>trihexyphenidyl hcl</i>	T1	HD
<b>ANTI-PARKINSONISM DRUGS, OTHER</b>		
<i>amantadine hcl</i>	T1	HD
APOKYN	T4	PA SP HD
AZILECT 0.5 MG TABLET ( <i>rasagiline mesylate</i> )	T3	QL (1 tab/day) HD
AZILECT 1 MG TABLET ( <i>rasagiline mesylate</i> )	T3	HD
<i>bromocriptine mesylate</i> (Parlodel)	T1	HD
<i>carbidopa/levodopa</i>	T1	HD
<i>carbidopa/levodopa</i> (Sinemet 10-100)	T1	HD
<i>carbidopa/levodopa</i> (Sinemet 25-100)	T1	HD
<i>carbidopa/levodopa</i> (Sinemet 25-250)	T1	HD
<i>carbidopa/levodopa/entacapone</i> (Stalevo 100)	T1	HD
<i>carbidopa/levodopa/entacapone</i> (Stalevo 125)	T1	HD
<i>carbidopa/levodopa/entacapone</i> (Stalevo 150)	T1	HD
<i>carbidopa/levodopa/entacapone</i> (Stalevo 200)	T1	HD
<i>carbidopa/levodopa/entacapone</i> (Stalevo 50)	T1	HD
<i>carbidopa/levodopa/entacapone</i> (Stalevo 75)	T1	HD
COMTAN ( <i>entacapone</i> )	T3	HD
DHIVY	T3	PA
DUOPA	T3	SP HD
<i>entacapone</i> (Comtan)	T1	HD
GOCOVRI	T3	HD
INBRIJA	T3	PA SP HD
KYNMOBI	T2	PA HD
MIRAPEX ER 0.375 MG TABLET ( <i>pramipexole er</i> )	T3	QL (1 tab/day) HD
MIRAPEX ER 0.75 MG TABLET ( <i>pramipexole er</i> )	T3	HD
MIRAPEX ER 1.5 MG TABLET ( <i>pramipexole er</i> )	T3	QL (1 tab/day) HD
MIRAPEX ER 2.25 MG TABLET ( <i>pramipexole er</i> )	T3	QL (1 tab/day) HD
MIRAPEX ER 3 MG TABLET ( <i>pramipexole er</i> )	T3	HD
MIRAPEX ER 3.75 MG TABLET ( <i>pramipexole er</i> )	T3	HD
MIRAPEX ER 4.5 MG TABLET ( <i>pramipexole er</i> )	T3	HD
NEUPRO	T3	HD
NOURIANZ	T3	PA QL (1 tab/day) SP HD
ONGENTYS	T3	PA QL (1 CAPS/DAY) HD
OSMOLEX ER 129 MG TABLET	T3	QL (1 tab/day) HD

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

T4 – Injectable Specialty Medications

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QL – Quantity Limit

ST – Step Therapy

AGE – Age Requirement

SP – Specialty Medication

HD – May require home delivery pharmacy

PPACA – No Cost-Share Preventive Medication

CSL – Oral cancer medication subject to cost-share limits

# List of Prescription Medications

ANTI-PARKINSON DRUGS (Parkinson's Disease)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>ANTI-PARKINSONISM DRUGS, OTHER</b>		
OSMOLEX ER 193 MG TABLET	T3	QL (1 tab/day) HD
OSMOLEX ER 258 MG TABLET	T3	QL (1 tab/day) HD
OSMOLEX ER 322 MG DAILY DOSE	T3	QL (2 tabs/day) HD
PARLODEL ( <i>bromocriptine mesylate</i> )	T3	HD
<i>pramipexole di-hcl</i>	T1	HD
<i>pramipexole er 0.375 mg tablet</i> (Mirapex Er)	T1	QL (1 tab/day) HD
<i>pramipexole er 0.75 mg tablet</i> (Mirapex Er)	T1	HD
<i>pramipexole er 1.5 mg tablet</i>	T1	QL(1 tab/day) HD
<i>pramipexole er 1.5 mg tablet</i> (Mirapex Er)	T1	QL (1 tab/day) HD
<i>pramipexole er 2.25 mg tablet</i> (Mirapex Er)	T1	QL (1 tab/day) HD
<i>pramipexole er 3 mg tablet</i> (Mirapex Er)	T1	HD
<i>pramipexole er 3.75 mg tablet</i> (Mirapex Er)	T1	HD
<i>pramipexole er 4.5 mg tablet</i> (Mirapex Er)	T1	HD
<i>rasagiline mesylate 0.5 mg tab</i> (Azilect)	T1	QL (1 tab/day) HD
<i>rasagiline mesylate 1 mg tab</i> (Azilect)	T1	HD
<i>ropinirole hcl</i>	T1	HD
RYTARY	T3	HD
<i>selegiline hcl</i>	T1	HD
SINEMET 10-100 ( <i>carbidopa-levodopa</i> )	T3	HD
SINEMET 25-100 ( <i>carbidopa-levodopa</i> )	T3	HD
SINEMET 25-250 ( <i>carbidopa-levodopa</i> )	T3	HD
STALEVO 100 ( <i>carbidopa-levodopa-entacapone</i> )	T3	HD
STALEVO 125 ( <i>carbidopa-levodopa-entacapone</i> )	T3	HD
STALEVO 150 ( <i>carbidopa-levodopa-entacapone</i> )	T3	HD
STALEVO 200 ( <i>carbidopa-levodopa-entacapone</i> )	T3	HD
STALEVO 50 ( <i>carbidopa-levodopa-entacapone</i> )	T3	HD
STALEVO 75 ( <i>carbidopa-levodopa-entacapone</i> )	T3	HD
TASMAR ( <i>tolcapone</i> )	T3	HD
<i>tolcapone</i> (Tasmar)	T1	HD
XADAGO	T3	ST HD
ZELAPAR	T3	PA HD
<b>DECARBOXYLASE INHIBITORS</b>		
<i>carbidopa</i> (Lodosyn)	T1	
LODOSYN ( <i>carbidopa</i> )	T3	PA

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

T4 – Injectable 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-PLATELET DRUGS (Blood Thinners/Anti-Clotting)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>PLATELET AGGREGATION INHIBITORS</b>		
<i>aspirin/dipyridamole</i>	T1	HD
ASPIRIN-OMEPRAZOLE	T3	PA HD
BRILINTA	T2	HD
<i>cilostazol</i>	T1	HD
<i>clopidogrel bisulfate</i>	T1	HD
<i>clopidogrel bisulfate</i> (Plavix)	T1	HD
<i>dipyridamole</i>	T1	HD
EFFIENT ( <i>prasugrel hcl</i> )	T3	HD
PLAVIX ( <i>clopidogrel</i> )	T3	HD
<i>prasugrel hcl</i> (Effient)	T1	HD
<i>ticlopidine hcl</i>	T1	HD
YOSPRALA	T3	PA HD
ZONTIVITY	T3	HD
<b>PLATELET REDUCING AGENTS</b>		
AGRYLIN ( <i>anagrelide hcl</i> )	T3	
<i>anagrelide hcl</i>	T1	
<i>anagrelide hcl</i> (Agyrin)	T1	
<b>ANTIVIRALS (AIDS/HIV)</b>		
<b>ANTI-RETROVIRAL - CAPSID INHIBITORS</b>		
SUNLENCA 4- 300 MG TABLET	T3	PA QL(5 TABS/180 DAYS) SP
SUNLENCA 463.5 MG/1.5 ML VIAL	T4	PA SP
SUNLENCA 5- 300 MG TABLET	T3	PA QL(5 TABS/180 DAYS) SP
<b>ANTI-RETROVIRAL - INTEGRASE INHIBITOR AND NNRTI COMB.</b>		
CABENUVA	T3	PA SP
JULUCA	T2	SP
<b>ANTI-RETROVIRAL - INTEGRASE INHIBITOR AND NRTI COMB.</b>		
DOVATO	T2	SP
<b>ANTI-RETROVIRAL - NRTIS AND INTEGRASE INHIBITORS COMB</b>		
TRIUMEQ	T2	SP
<b>ANTI-RETROVIRAL - NUCLEOSIDE, NUCLEOTIDE, PROTEASE INH.</b>		
SYMITUZA	T2	SP
<b>ANTIVIRALS - HIV-SPEC, NON-PEPTIDIC PROTEASE INHIB</b>		
APTIVUS	T2	PA SP
<i>darunavir ethanolate</i> (Prezista)	T1	PA SP
PREZCOBIX	T3	PA SP
PREZISTA 100 MG/ML SUSPENSION	T2	SP
PREZISTA 150 MG TABLET	T2	SP
PREZISTA 600 MG TABLET (darunavir)	T3	PA SP
PREZISTA 75 MG TABLET	T2	SP
PREZISTA 800 MG TABLET (darunavir)	T3	PA SP

# List of Prescription Medications

ANTIVIRALS (AIDS/HIV)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>ANTIVIRALS - HIV-SPEC, NUCLEOSIDE-NUCLEOTIDE ANALOG</b>		
CIMDUO	T3	PA SP
DESCOVY	T2	PA SP PPACA
<i>emtricitabine-tenofv 100-150mg (Truvada)</i>	T1	SP
<i>emtricitabine-tenofv 133-200mg (Truvada)</i>	T1	SP
<i>emtricitabine-tenofv 167-250mg (Truvada)</i>	T1	SP
<i>emtricitabine-tenofv 200-300mg (Truvada)</i>	T1	SP PPACA
TEMIXYS	T3	PA SP
TRUVADA ( <i>emtricitabine-tenofovir disop</i> )	T3	PA SP
<b>ANTIVIRALS - HIV-SPEC, NUCLEOSIDE ANALOG, RTI COMB</b>		
<i>abacavir sulfate/lamivudine (Epzicom)</i>	T1	PA SP
<i>abacavir/lamivudine/zidovudine (Trizivir)</i>	T1	PA SP
COMBIVIR ( <i>lamivudine-zidovudine</i> )	T3	PA SP
EPZICOM ( <i>abacavir-lamivudine</i> )	T3	PA SP
<i>lamivudine/zidovudine (Combivir)</i>	T1	SP
TRIZIVIR ( <i>abacavir-lamivudine-zidovudine</i> )	T3	PA SP
<b>ANTIVIRALS - HIV-SPECIFIC, CCR5 CO-RECEPTOR ANTAG.</b>		
AGRYLIN ( <i>anagrelide hcl</i> )	T3	
SELZENTRY 150 MG TABLET ( <i>maraviroc</i> )	T3	PA SP
SELZENTRY 20 MG/ML ORAL SOLN	T2	PA SP
SELZENTRY 25 MG TABLET	T2	PA SP
SELZENTRY 300 MG TABLET ( <i>maraviroc</i> )	T3	PA SP
SELZENTRY 75 MG TABLET	T2	PA SP
<b>ANTIVIRALS - HIV-SPECIFIC, CD4 ATTACHMENT INHIBITOR</b>		
RUKOBIA	T3	PA QL (2 SYRINGE/DAY)
<b>ANTIVIRALS - HIV-SPECIFIC, FUSION INHIBITORS</b>		
FUZEON	T4	PA SP
<b>ANTIVIRALS - HIV-SPECIFIC, NON-NUCLEOSIDE, RTI</b>		
EDURANT	T3	PA SP
INTELENCE	T3	PA SP
<i>nevirapine</i>	T1	PA SP
<i>nevirapine (Viramune Xr)</i>	T1	PA SP
<i>nevirapine (Viramune)</i>	T1	PA SP
PIFELTRO	T3	PA SP
VIRAMUNE ( <i>nevirapine</i> )	T3	PA SP
VIRAMUNE XR ( <i>nevirapine er</i> )	T3	PA SP
<i>abacavir sulfate (Ziagen)</i>	T1	PA SP
<i>didanosine (Videx Ec)</i>	T1	PA SP

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

# List of Prescription Medications

ANTIVIRALS (AIDS/HIV)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>ANTIVIRALS - HIV-SPECIFIC, NON-NUCLEOSIDE, RTI (cont.)</b>		
<i>emtricitabine</i> (Emtriva)	T1	PA SP
EMTRIVA 10 MG/ML SOLUTION	T2	PA SP
EMTRIVA 200 MG CAPSULE ( <i>emtricitabine</i> )	T3	PA SP
EPIVIR ( <i>lamivudine</i> )	T3	PA SP
<i>lamivudine 10 mg/ml oral soln</i> (EpiVir)	T1	SP
<i>lamivudine 150 mg tablet</i> (EpiVir)	T1	SP
<i>lamivudine 300 mg tablet</i> (EpiVir)	T1	PA SP
RETROVIR ( <i>zidovudine</i> )	T3	PA SP
<i>stavudine</i>	T1	PA SP
VIDEX EC	T3	PA SP
VIDEX EC ( <i>didanosine</i> )	T3	PA SP
ZIAGEN ( <i>abacavir</i> )	T3	PA SP
<i>zidovudine</i>	T1	SP
<i>zidovudine</i> (Retrovir)	T1	SP
<i>tenofovir disoproxil fumarate</i> (Viread)	T1	PA SP
VIREAD 150 MG TABLET	T2	PA SP
VIREAD 200 MG TABLET	T2	PA SP
VIREAD 250 MG TABLET	T2	PA SP
VIREAD 300 MG TABLET ( <i>tenofovir disoproxil fumarate</i> )	T3	PA SP
VIREAD POWDER	T2	PA SP
<b>ANTIVIRALS - HIV-SPECIFIC, PROTEASE INHIBITOR COMB</b>		
KALETRA 100-25 MG TABLET	T3	PA SP
KALETRA 200-50 MG TABLET	T3	PA SP
KALETRA 80 MG-20 MG/ML SOLN ( <i>lopinavir-ritonavir</i> )	T3	PA SP
<i>lopinavir/ritonavir</i> (Kaletra)	T1	
<b>ANTIVIRALS - HIV-SPECIFIC, PROTEASE INHIBITORS</b>		
<i>atazanavir sulfate</i> (Reyataz)	T1	PA SP
CRIXIVAN	T2	PA SP
EVOTAZ	T3	PA SP
<i>fosamprenavir calcium</i> (Lexiva)	T1	PA SP
INVIRASE	T2	PA SP
LEXIVA 50 MG/ML SUSPENSION	T2	PA SP
LEXIVA 700 MG TABLET ( <i>fosamprenavir calcium</i> )	T3	PA SP
NORVIR 100 MG POWDER PACKET	T2	SP
NORVIR 100 MG TABLET ( <i>ritonavir</i> )	T3	PA SP

T1 – Typically Generics

T4 – Injectable Specialty Medications

ST – Step Therapy

HD – May require home delivery pharmacy

T2 – Typically Preferred Brands

PA – Prior Authorization

AGE – Age Requirement

PPACA – No Cost-Share Preventive Medication

T3 – Typically Non-Preferred Brands

QL – Quantity Limit

SP – Specialty Medication

CSL – Oral cancer medication subject to cost-share limits

# List of Prescription Medications

ANTIVIRALS (AIDS/HIV)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>ANTIVIRALS - HIV-SPECIFIC, PROTEASE INHIBITORS</b>		
REYATAZ 150 MG CAPSULE ( <i>atazanavir sulfate</i> )	T3	PA SP
REYATAZ 200 MG CAPSULE ( <i>atazanavir sulfate</i> )	T3	PA SP
REYATAZ 300 MG CAPSULE ( <i>atazanavir sulfate</i> )	T3	PA SP
REYATAZ 50 MG POWDER PACKET	T2	PA SP
<i>ritonavir</i> (Norvir)	T1	SP
VIRACEPT	T2	PA SP
<b>ANTIVIRALS - HIV-I INTEGRASE STRAND TRANSFER INHIBITR</b>		
APRETUDE	T3	PA SP
ISENTRESS	T2	SP
ISENTRESS HD	T2	PA SP
TIVICAY	T2	SP
TIVICAY PD	T2	SP
<b>ARTV NUCLEOSIDE, NUCLEOTIDE, NON-NUCLEOSIDE RTI COMB</b>		
ATRIPLA ( <i>efavirenz-emtricit-tenofovir disop</i> )	T3	PA SP
COMPLERA	T3	PA SP
DELSTRIGO	T3	PA SP
<i>efavirenz/emtricit/tenofovir df</i> (Atripla)	T1	PA SP
<i>efavirenz/lamivudine/tenofovir disop</i> (Symfi Lo)	T1	SP
<i>efavirenz/lamivudine/tenofovir disop</i> (Symfi)	T1	SP
ODEFSEY	T3	PA SP
SYMFI ( <i>efavirenz-lamivudine-tenofovir disop</i> )	T3	PA SP
SYMFI LO ( <i>efavirenz-lamivudine-tenofovir disop</i> )	T3	PA SP
<b>ARV-NUCLEOSIDE, NUCLEOTIDE RTI, INTEGRASE INHIBITORS</b>		
BIKTARVY	T2	SP
GENVOYA	T2	SP
STRIBILD	T3	PA SP
<b>ANTIVIRALS (Eye Conditions)</b>		
<b>EYE ANTIVIRALS</b>		
<i>trifluridine</i>	T1	
ZIRGAN	T3	
<b>ANTIVIRALS (Infections)</b>		
<b>ANTIVIRALS, GENERAL</b>		
<i>acyclovir 200 mg capsule</i>	T1	

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

T4 – Injectable Specialty Medications

PA – Prior Authorization

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ST – Step Therapy

AGE – Age Requirement

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HD – May require home delivery pharmacy

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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
<b>ANTIVIRALS, GENERAL (cont.)</b>		
<i>acyclovir 200 mg/5 ml susp (Zovirax)</i>	T1	
<i>acyclovir 400 mg tablet</i>	T1	
<i>acyclovir 800 mg tablet</i>	T1	
<i>famciclovir</i>	T1	
FLUMADINE ( <i>rimantadine hcl</i> )	T3	
LIVTENCITY	T3	PA QL (4 tabs/day) SP
<i>oseltamivir 6 mg/ml suspension (Tamiflu)</i>	T1	QL (180ml/30 days)
<i>oseltamivir phos 30 mg capsule (Tamiflu)</i>	T1	QL (20/30 days)
<i>oseltamivir phos 45 mg capsule (Tamiflu)</i>	T1	QL (10/30 days)
<i>oseltamivir phos 75 mg capsule (Tamiflu)</i>	T1	QL (10 caps/30 days)
PREVYMIS	T3	SP HD
RELENZA	T3	QL (20/30 days)
<i>rimantadine hcl (Flumadine)</i>	T1	
SITAVIG	T3	PA QL (2 tabs/Rx)
TAMIFLU 30 MG CAPSULE ( <i>oseltamivir phosphate</i> )	T3	QL (20/30 days)
TAMIFLU 45 MG CAPSULE ( <i>oseltamivir phosphate</i> )	T3	QL (10/30 days)
TAMIFLU 6 MG/ML SUSPENSION ( <i>oseltamivir phosphate</i> )	T3	QL (180ml/30 days)
TAMIFLU 75 MG CAPSULE ( <i>oseltamivir phosphate</i> )	T3	QL (10/30 days)
<i>valacyclovir hcl (Valtrex)</i>	T1	
VALCYTE ( <i>valganciclovir hcl</i> )	T3	PA
<i>valganciclovir hcl (Valcyte)</i>	T1	
VALTrex ( <i>valacyclovir</i> )	T3	
XOFLUZA	T3	QL (2 tabs/30 days)
ZOVIRAX 200 MG/5 ML SUSP ( <i>acyclovir</i> )	T3	PA
<b>HEP C - NS5A, NS3/4A, NUCLEOTIDE NS5B INHIB COMBO</b>		
VOSEVI	T2	PA SP HD
<b>HEP C VIRUS, NUCLEOTIDE ANALOG NS5B POLYMERASE INH</b>		
SOVALDI 150 MG PELLETT PACKET	T2	PA QL (1 tab/day) SP HD
SOVALDI 200 MG PELLETT PACKET	T2	PA QL (1 tab/day) SP HD
SOVALDI 200 MG TABLET	T2	PA QL (1 tab/day) SP HD
SOVALDI 400 MG TABLET	T2	PA SP HD

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

T4 – Injectable Specialty Medications

PA – Prior Authorization

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SP – Specialty Medication

HD – May require home delivery pharmacy

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# List of Prescription Medications

ANTIVIRALS (Infections)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>HEP C VIRUS-NS5B POLYMERASE AND NS5A INHIB. COMBO.</b>		
EPCLUSA 200 MG-50 MG TABLET	T2	PA QL (1 tab/Day) SP HD
EPCLUSA 400 MG-100 MG TABLET	T2	PA SP HD
HARVONI 33.75-150 MG PELLETT PK	T2	PA QL (1 tab/day) SP HD
HARVONI 45-200 MG PELLETT PACKET	T2	PA QL (1 tab/day) SP HD
HARVONI 45-200 MG TABLET	T2	PA QL (1 tab/day) SP HD
HARVONI 90-400 MG TABLET	T2	PA SP HD
LEDIPASVIR-SOFOSBUVIR	T3	PA QL(1 tab/day) SP HD
SOFOSBUVIR-VELPATASVIR	T3	PA QL(1 tab/day) SP HD
<b>HEPATITIS B TREATMENT AGENTS</b>		
<i>adefovir dipivoxil</i>	T1	SP HD
BARACLUDE 0.05 MG/ML SOLUTION	T2	SP HD
BARACLUDE 0.5 MG TABLET ( <i>entecavir</i> )	T3	PA QL (1 tab/day) SP HD
BARACLUDE 1 MG TABLET ( <i>entecavir</i> )	T3	PA SP HD
<i>entecavir 0.5 mg tablet</i> (Baraclude)	T1	QL (1 tab/day) SP HD
<i>entecavir 1 mg tablet</i> (Baraclude)	T1	SP HD
EPIVIR HBV 100 MG TABLET ( <i>lamivudine hbv</i> )	T3	SP
EPIVIR HBV 25 MG/5 ML SOLN	T2	SP
HEPSERA ( <i>adefovir dipivoxil</i> )	T3	SP HD
<i>lamivudine</i> (EpiVir Hbv)	T1	SP
VEMLIDY	T2	SP HD
<b>HEPATITIS C TREATMENT AGENTS</b>		
PEGASYS	T4	PA SP HD
PEGINTRON	T2	PA SP HD
<i>ribasphere 200 mg capsule</i>	T1	SP HD
<i>ribasphere 200 mg tablet</i>	T1	SP HD
<i>ribasphere 400 mg tablet</i>	T1	SP
<i>ribasphere 600 mg tablet</i>	T1	SP
<i>ribasphere ribapak 200-400 mg</i>	T1	SP HD
<i>ribasphere ribapak 400-400 mg</i>	T1	SP HD
<i>ribasphere ribapak 400-400 mg</i>	T1	SP HD
<i>ribasphere ribapak 600-400 mg</i>	T1	SP HD
<i>ribasphere ribapak 600-400 mg</i>	T1	SP HD
<i>ribasphere ribapak 600-600 mg</i>	T1	SP HD
<i>ribasphere ribapak 600-600 mg</i>	T1	SP HD
<b>HEPATITIS C VIRUS- NS5A AND NS3/4A INHIBITOR COMB</b>		
MAVYRET 100-40 MG TABLET	T3	PA QL(3 tabs/day) SP HD
MAVYRET 50-20 MG PELLETT PACKET	T3	PA QL(5 packs/day) SP HD

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

## List of Prescription Medications

ANTIVIRALS (Infections)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>HEPATITIS C VIRUS- NS5A AND NS3/4A INHIBITOR COMB</b>		
ZEPATIER	T3	PA SP HD
<b>MAIN PROTEASE (MPRO) INHIBITOR</b>		
LAGEVRIO (EUA)	T2	QL(1 pack/120 days)
<b>RNA POLYMERASE INHIBITOR</b>		
MOLNUPIRAVIR	T3	QL (1 pkg/120 days)
ANTIVIRALS (Skin Conditions)		
<b>TOPICAL ANTIVIRAL AND ANTI-INFLAMMATORY STEROID</b>		
XERESE	T3	PA QL (5gm/30 days)
<b>TOPICAL ANTIVIRALS</b>		
<i>acyclovir 5% cream (Zovirax)</i>	T1	PA QL (5gm/30 days)
<i>acyclovir 5% ointment (Zovirax)</i>	T1	PA QL (15gm/30 days)
<b>TOPICAL ANTIVIRALS</b>		
DENAVIR	T3	QL (10 gm/30 days)
ZOVIRAX 5% CREAM ( <i>acyclovir</i> )	T3	PA QL (10 gm/30 days)
ZOVIRAX 5% OINTMENT ( <i>acyclovir</i> )	T3	PA QL (15gm/30 days)
<b>TOPICAL GENITAL WART-HPV TREATMENT AGENTS</b>		
VEREGEN	T3	PA
AUTONOMIC DRUGS (Allergy/Nasal Sprays)		
<b>ANAPHYLAXIS THERAPY AGENTS</b>		
AUVI-Q	T3	PA QL (2 packs/30 days)
EPINEPHRINE	T1	QL (2 packs/30 days)
<i>epinephrine (AUVI-Q)</i>	T3	PA QL (2 packs/30 days)
<i>epinephrine (Epipen 2-pak)</i>	T1	QL (2 packs/30 days)
<i>epinephrine (Epipen Jr 2-pak)</i>	T1	QL (2 packs/30 days)
EPIPEN ( <i>epinephrine</i> )	T3	PA QL (4 pens/22 days)
EPIPEN 2-PAK ( <i>epinephrine</i> )	T3	PA QL (2 packs/30 days)
EPIPEN JR ( <i>epinephrine</i> )	T3	PA QL (4 pens/22 days)
EPIPEN JR 2-PAK ( <i>epinephrine</i> )	T3	PA QL (2 packs/30 days)
SYMJEPI	T3	PA QL (4 syringes/30 days)
AUTONOMIC DRUGS (Alzheimer's Disease)		
<b>CHOLINESTERASE INHIBITORS</b>		
ARICEPT ( <i>donepezil hcl</i> )	T3	HD
<i>donepezil hcl</i>	T1	HD
<i>donepezil hcl (Aricept)</i>	T1	HD
EXELON ( <i>rivastigmine</i> )	T3	HD

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

T4 – Injectable 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

### AUTONOMIC DRUGS (Alzheimer's Disease) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>CHOLINESTERASE INHIBITORS (cont.)</b>		
<i>galantamine er 16 mg capsule</i> (Razadyne Er)	T1	HD
<i>galantamine er 24 mg capsule</i> (Razadyne Er)	T1	HD
<i>galantamine er 8 mg capsule</i> (Razadyne Er)	T1	QL (1 cap/day) HD
<i>galantamine hbr</i>	T1	HD
MESTINON ( <i>pyridostigmine bromide</i> )	T3	PA HD
<i>pyridostigmine 60 mg/5 ml soln</i> (Mestinon)	T1	HD
PYRIDOSTIGMINE BR 30 MG TABLET	T3	PA QL (20 tabs/day) HD
<i>pyridostigmine br 60 mg tablet</i> (Mestinon)	T1	HD
<i>pyridostigmine bromide</i> (Mestinon)	T1	HD
RAZADYNE ER 16 MG CAPSULE ( <i>galantamine er</i> )	T3	HD
RAZADYNE ER 24 MG CAPSULE ( <i>galantamine er</i> )	T3	HD
RAZADYNE ER 8 MG CAPSULE ( <i>galantamine er</i> )	T3	QL (1 cap/day) HD
<i>rivastigmine</i> (Exelon)	T1	HD
<i>rivastigmine tartrate</i>	T1	HD

### AUTONOMIC DRUGS (Attention Deficit Hyperactivity Disorder)<sup>8</sup>

#### ADRENERGICS, AROMATIC, NON-CATECHOLAMINE

ADDERALL ( <i>dextroamphetamine-amphetamine</i> )	T3	PA ST
ADDERALL XR ( <i>dextroamphetamine-amphet er</i> )	T3	PA QL (1 cap/day) ST
ADZENYS ER	T3	PA QL (15ml/day)
ADZENYS XR-ODT	T3	PA QL (1 tab/day)
AMPHETAMINE	T3	PA QL (15ml/day)
<i>amphetamine sulfate</i> (Evekeo)	T1	PA
DESOXYN	T3	PA QL (5 TABS/DAY)
DEXEDRINE SPANSULE 10 MG ( <i>dextroamphetamine sulfate er</i> )	T3	PA QL (1 cap/day)
DEXEDRINE SPANSULE 15 MG ( <i>dextroamphetamine sulfate er</i> )	T3	PA QL (3 caps/day)
DEXEDRINE SPANSULE 5 MG ( <i>dextroamphetamine sulfate er</i> )	T3	PA QL (1 cap/day)
<i>dextroamp-amphet er 10 mg cap</i> (Adderall Xr)	T1	PA QL (1 per day)
<i>dextroamp-amphet er 15 mg cap</i> (Adderall Xr)	T1	PA QL (1 per day)
<i>dextroamp-amphet er 20 mg cap</i> (Adderall Xr)	T1	PA QL (1 cap/day)
<i>dextroamp-amphet er 25 mg cap</i> (Adderall Xr)	T1	PA QL (1 cap/day)
<i>dextroamp-amphet er 30 mg cap</i> (Adderall Xr)	T1	PA QL (1 per day)
<i>dextroamp-amphet er 5 mg cap</i> (Adderall Xr)	T1	PA QL (1 per day)
<i>dextroamphetamine er 10 mg cap</i> (Dexedrine)	T1	PA QL (1 cap/day)
<i>dextroamphetamine er 15 mg cap</i> (Dexedrine)	T1	PA QL (3 caps/day)
<i>dextroamphetamine er 5 mg cap</i> (Dexedrine)	T1	PA QL (1 cap/day)

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

T4 – Injectable 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

### AUTONOMIC DRUGS (Attention Deficit Hyperactivity Disorder)<sup>8</sup>

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>ADRENERGICS, AROMATIC, NON-CATECHOLAMINE</b>		
<i>dextroamph-amphet er 12.5mg cp</i> (Mydayis)	T1	PA QL
<i>dextroamph-amphet er 25 mg cap</i> (Mydayis)	T1	PA QL
<i>dextroamph-amphet er 37.5mg cp</i> (Mydayis)	T1	PA QL
<i>dextroamphetamine sulfate</i>	T1	PA
<i>dextroamphetamine sulfate</i>	T3	PA ST
<i>dextroamphetamine/amphetamine</i> (Adderall XR)	T1	PA QL(1 cap/day)
<i>dextroamphetamine/amphetamine</i> (Mydayis)	T1	PA QL(1 cap/day)
DYANAVEL XR	T3	PA QL (8ml/day)
EVEKEO ( <i>amphetamine sulfate</i> )	T3	PA ST
EVEKEO ODT	T3	PA
MYDAYIS ( <i>dextroamphetamine/amphetamine</i> )	T3	PA QL(1 cap/day)
<i>methamphetamine hcl</i> (Desoxyn)	T1	PA
XELSTRYM	T3	PA QL(1 PATCH/DAY)
ZENZEDI	T3	PA ST

### AUTONOMIC DRUGS (Blood Pressure/Heart Medications)

#### ADRENERGIC VASOPRESSOR AGENTS

<i>droxidopa</i> (Nothera)	T1	SP HD
<i>midodrine hcl</i>	T1	
NOTHERA ( <i>droxidopa</i> )	T3	PA SP HD

#### ALPHA-ADRENERGIC BLOCKING AGENTS

DIBENZYLIN ( <i>phenoxybenzamine hcl</i> )	T3	HD
<i>phenoxybenzamine hcl</i> (Dibenzylin)	T1	HD

### AUTONOMIC DRUGS (Urinary Tract Conditions)

#### PARASYMPATHETIC AGENTS

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

### BIOLOGICALS (Allergy/Nasal Sprays)

#### ALLERGENIC EXTRACTS, THERAPEUTIC

GRASTEK	T3	PA QL (1 tab/day)
ODACTRA	T3	PA QL (1 tab/day)
ORALAIR	T3	PA QL (1 tab/day)
PALFORZIA	T3	PA SP

T1 – Typically Generics

T4 – Injectable Specialty Medications

ST – Step Therapy

HD – May require home delivery pharmacy

T2 – Typically Preferred Brands

PA – Prior Authorization

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PPACA – No Cost-Share Preventive Medication

T3 – Typically Non-Preferred Brands

QL – Quantity Limit

SP – Specialty Medication

CSL – Oral cancer medication subject to cost-share limits

## List of Prescription Medications

### BIOLOGICALS (Blood Pressure/Heart Medications)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>ALLERGENIC EXTRACTS, THERAPEUTIC .</b>		
RAGWITEK	T3	PA QL (1 tab/day)
<b>PLASMA KALLIKREIN INHIBITORS</b>		
TAKHZYRO	T4	PA SP HD

### BIOLOGICALS (Miscellaneous)

<b>PKU TREATMENT AGENTS - PHENYLALANINE AMMONIA LYASE</b>		
PALYNZIQ	T4	PA SP HD

### BIOLOGICALS (Vaccines)

#### COVID-19 VACCINES

COMIRNATY	T2	PPACA
JANSSEN COVID-19 VACCINE (EUA)	T2	PPACA
NOVAVAX COVID	T2	PPACA
MODERNA COVID-19 VACCINE (EUA)	T2	PPACA
PFIZER COVID-19 VACCINE (EUA)	T2	PPACA
SPIKEVAX	T2	PPACA

#### ENTERIC VIRUS VACCINES

IPOD	T2	PPACA
ROTARIX	T3	PPACA
ROTATEQ	T3	PPACA

#### GRAM NEGATIVE COCCI VACCINES

BEXSERO	T2	PPACA
MENACTRA	T2	PPACA
MENQUADFI	T2	PPACA
MENVEO A-C-Y-W-135-DIP	T2	PPACA
PENBRAYA	T2	PPACA
TRUMENBA	T2	PPACA

#### GRAM POSITIVE COCCI VACCINES

PNEUMOVAX 23	T2	PPACA
PREVNAR 13	T2	PPACA

#### INFLUENZA VIRUS VACCINES

AFLURIA QUAD 2	T2	PPACA
EZ FLU (FLUCELVAX)	T2	PPACA
FLUAD	T2	PPACA
FLUAD QUAD	T2	PPACA
FLUARIX QUAD	T2	PPACA
FLUBLOK QUAD	T2	PPACA
FLUCELVAX QUAD	T2	PPACA

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QL – Quantity Limit

SP – Specialty Medication

CSL – Oral cancer medication subject to cost-share limits

## List of Prescription Medications

BIOLOGICALS (Vaccines)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>INFLUENZA VIRUS VACCINES</b>		
FLULAVAL QUAD	T2	PPACA
FLUMIST QUAD	T3	PPACA
FLUZONE HIGH-DOSE QUAD	T2	PPACA
FLUZONE QUAD	T2	PPACA
<b>VACCINE/TOXOID PREPARATIONS, COMBINATIONS</b>		
ACTHIB	T2	PPACA
ADACEL TDAP	T2	PPACA
BOOSTRIX TDAP	T2	PPACA
DAPTACEL DTAP	T2	PPACA
DIPHTHERIA-TETANUS TOXOIDS-PED	T2	PPACA
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
<b>VIRAL/TUMORIGENIC VACCINES</b>		
ENGERIX-B ADULT	T2	PPACA
ENGERIX-B PEDIATRIC-ADOLESCENT	T2	PPACA
GARDASIL 9	T2	PPACA
HEPLISAV-B	T2	PPACA
IXCHIQ	T3	PPACA
JYNNEOS	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

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

T4 – Injectable 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)			
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits	
<b>AGENTS TO TX THROMBOTIC THROMBOCYTOPENIC PURPURA</b>			
CABLIVI	T3	PA SP	
<b>ANTI-FIBRINOLYTIC AGENTS</b>			
AMICAR ( <i>aminocaproic acid</i> )	T3	SP HD	
<b>AGENTS TO TX THROMBOTIC THROMBOCYTOPENIC PURPURA</b>			
<i>aminocaproic acid</i> (Amicar)	T1	SP HD	
LYSTEDA ( <i>tranexamic acid</i> )	T3	SP	
<i>tranexamic acid</i> (Lysteda)	T1	SP	
<b>ANTI-HEMOPHILIC FACTORS</b>			
ALTUVIII0	T3	PA SP HD	
<b>COMPLEMENT (C3) INHIBITORS</b>			
EMPAVELI	T4	PA SP	
FABHALTA	T2	PA QL(2 CAPS/DAY) SP	
<b>COMPLEMENT(C5) INHIBITOR</b>			
TAVNEOS	T3	PA QL (6 caps/day)SP HD	
<b>HEMOPHILIA TREATMENT AGENTS, NON-FACTOR REPLACEMENT</b>			
HEMLIBRA	T4	PA SP HD	
<b>SICKLE CELL ANEMIA AGENTS</b>			
DROXIA	T2		
OXBRYTA	T3	PA QL (5 tabs/day) SP HD	
SIKLOS	T3	PA	
<b>TOPICAL HEMOSTATICS</b>			
ASTRINGYN	T3		
AVITENE	T3		
ENDO-AVITENE	T3		
EVICEL	T3		
<i>gelatin sponge, absorb/porcine</i> (Gelfoam)	T1		
GELFOAM ( <i>surgifoam</i> )	T3		
GELFOAM COMPRESSED	T3		
MONSEL's	T3		
RAPLIXA	T3		
RECOTHROM	T3		
SURGIFOAM	T1		
SYRINGE AVITENE	T3		
TACHOSIL	T3		
THROMBI-GEL	T3		
THROMBIN-JMI	T3		
THROMBI-PAD	T3		
ULTRAFOAM	T3		

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



# List of Prescription Medications

<b>BLOOD (Blood Thinners/Anti-Clotting)</b>		
<b>Prescription Drug Name</b>	<b>Drug Tier</b>	<b>Coverage Requirements and Limits</b>
<b>HEMORRHOLOGIC AGENTS</b>		
<i>pentoxifylline</i>	T1	HD
<b>CARDIAC DRUGS (Blood Pressure/Heart Medications)</b>		
<b>ANTI-ANGINAL, ANTI-ISCHEMIC AGENTS, NON-HEMODYNAMIC</b>		
RANEXA ( <i>ranolazine er</i> )	T3	PA QL (4 tabs/day) HD
<i>ranolazine</i> (Ranexa)	T1	QL (4 tabs/day) HD
<b>ANTI-ARRHYTHMICS</b>		
<i>amiodarone hcl</i>	T1	HD
<i>disopyramide phosphate</i> (Norpace)	T1	HD
<i>dofetilide 125 mcg capsule</i> (Tikosyn)	T1	QL (8 caps/day) HD
<i>dofetilide 250 mcg capsule</i> (Tikosyn)	T1	QL (4 caps/day) HD
<i>dofetilide 500 mcg capsule</i> (Tikosyn)	T1	QL (2 caps/day) HD
<i>flecainide acetate</i>	T1	HD
<i>mexiletine hcl</i>	T1	HD
MULTAQ	T3	PA HD
NORPACE ( <i>disopyramide phosphate</i> )	T3	PA HD
NORPACE CR	T3	HD
<i>pacerone 100 mg tablet</i>	T3	PA HD
<i>pacerone 200 mg tablet</i>	T1	HD
<i>pacerone 400 mg tablet</i>	T3	PA HD
<i>propafenone hcl</i>	T1	HD
<i>propafenone hcl</i> (Rythmol Sr)	T1	HD
<i>quinidine gluconate</i>	T1	HD
<i>quinidine sulfate</i>	T1	HD
RYTHMOL SR ( <i>propafenone hcl er</i> )	T3	PA HD
TIKOSYN 125 MCG CAPSULE ( <i>dofetilide</i> )	T3	PA QL (8 caps/day) HD
TIKOSYN 250 MCG CAPSULE ( <i>dofetilide</i> )	T3	PA QL (4 caps/day) HD
TIKOSYN 500 MCG CAPSULE ( <i>dofetilide</i> )	T3	PA QL (2 caps/day) HD
<b>CALCIUM CHANNEL BLOCKER AND NSAID, COX-2 INHIBITOR</b>		
CONSENSI	T3	PA QL (1 tab/day)
<b>CALCIUM CHANNEL BLOCKING AGENTS</b>		
ADALAT CC ( <i>nifedipine er</i> )	T3	HD
<i>amlodipine besylate</i> (Norvasc)	T1	HD
CALAN SR ( <i>verapamil er</i> )	T3	HD
CARDIZEM ( <i>diltiazem hcl</i> )	T3	PA HD
CARDIZEM CD ( <i>diltiazem 24hr er (cd)</i> )	T3	PA HD

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

T4 – Injectable 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)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>CALCIUM CHANNEL BLOCKING AGENTS (cont.)</b>		
CARDIZEM LA 120 MG TABLET	T3	QL (1 tab/day) HD
CARDIZEM LA 180 MG TABLET ( <i>matzim la</i> )	T3	HD
CARDIZEM LA 240 MG TABLET ( <i>matzim la</i> )	T3	HD
CARDIZEM LA 300 MG TABLET ( <i>matzim la</i> )	T3	HD
CARDIZEM LA 360 MG TABLET ( <i>matzim la</i> )	T3	HD
CARDIZEM LA 420 MG TABLET ( <i>matzim la</i> )	T3	HD
CONJUPRI	T3	PA HD
<i>diltiazem hcl</i>	T1	HD
<i>diltiazem hcl</i> (Cardizem Cd)	T1	HD
<i>diltiazem hcl</i> (Cardizem La)	T1	HD
<i>diltiazem hcl</i> (Cardizem)	T1	HD
<i>diltiazem hcl</i> (Tiazac)	T1	HD
<i>felodipine</i>	T1	HD
<i>isradipine</i>	T1	HD
KATERZIA	T3	PA QL (10ml/day) HD
<i>nicardipine hcl</i>	T1	HD
<i>nifedipine</i>	T1	HD
<i>nifedipine</i> (Adalat Cc)	T1	HD
<i>nifedipine</i> (Procardia XI)	T1	HD
<i>nifedipine</i> (Procardia)	T1	HD
<i>nimodipine</i>	T1	HD
<i>nisoldipine er 17 mg tablet</i> (Sular)	T1	HD
<i>nisoldipine er 20 mg tablet</i>	T1	QL (1 tab/day) HD
<i>nisoldipine er 25.5 mg tablet</i>	T1	HD
<i>nisoldipine er 30 mg tablet</i>	T1	HD
<i>nisoldipine er 34 mg tablet</i> (Sular)	T1	HD
<i>nisoldipine er 40 mg tablet</i>	T1	HD
<i>nisoldipine er 8.5 mg tablet</i> (Sular)	T1	HD
NORVASC ( <i>amlodipine besylate</i> )	T3	HD
NORLIQVA	T2	PA QL (10ml/day) HD
NYMALIZE	T3	HD
PROCARDIA ( <i>nifedipine</i> )	T3	HD
PROCARDIA XL ( <i>nifedipine er</i> )	T3	PA HD
SULAR ( <i>nisoldipine</i> )	T3	HD
TIAZAC ( <i>tiadyt er</i> )	T3	HD
<i>verapamil hcl</i>	T1	HD

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

# List of Prescription Medications

## CARDIAC DRUGS (Blood Pressure/Heart Medications)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>CALCIUM CHANNEL BLOCKING AGENTS (cont.)</b>		
<i>verapamil hcl</i> (Calan Sr)	T1	HD
<i>verapamil hcl</i> (Verelan Pm)	T1	HD
CAMZYOS	T3	PA QL (30caps/30days) SP
<i>verapamil hcl</i> (Verelan)	T1	HD
VERELAN ( <i>verapamil hcl</i> )	T3	HD
VERELAN ( <i>verapamil sr</i> )	T3	HD
VERELAN PM ( <i>verapamil er pm</i> )	T3	HD
<b>DIGITALIS GLYCOSIDES</b>		
<i>digoxin</i>	T1	HD
<i>digoxin</i> (Lanoxin)	T1	HD
LANOXIN	T3	PA HD
LANOXIN ( <i>digoxin</i> )	T3	PA HD
<b>HEART RATE REDUCING, SA SELECTIVE I(F) CURRENT INH.</b>		
CORLANOR	T2	PA HD
<b>SOLUBLE GUANYLATE CYCLASE (SGC) STIMULATOR</b>		
VERQUVO	T2	PA QL (1 tab/day)
<b>VASODILATORS, CORONARY</b>		
DILATRATE-SR	T3	HD
GONITRO	T3	HD
ISORDIL ( <i>isosorbide dinitrate</i> )	T3	PA HD
ISORDIL TITRADOSE ( <i>isosorbide dinitrate</i> )	T3	PA HD
<i>isosorbide dinitrate 10 mg tab, 20 mg tab, 30 mg tab</i>	T1	HD
<i>isosorbide dinitrate 40 mg tab</i> (Isordil)	T1	PA HD
<i>isosorbide dinitrate 5 mg tab</i> (Isordil Titradose)	T1	HD
<i>isosorbide mononitrate</i>	T1	HD
MINITRAN	T1	HD
NITRO-DUR 0.1 MG/HR PATCH	T3	HD
NITRO-DUR 0.2 MG/HR PATCH	T3	HD
NITRO-DUR 0.3 MG/HR PATCH	T2	HD
NITRO-DUR 0.4 MG/HR PATCH	T3	HD
NITRO-DUR 0.6 MG/HR PATCH	T3	HD
NITRO-DUR 0.8 MG/HR PATCH	T2	HD
<i>nitroglycerin</i>	T1	HD
<i>nitroglycerin 0.3 mg tablet sl</i> (Nitrostat)	T1	HD
<i>nitroglycerin 0.4 mg tablet sl</i> (Nitrostat)	T1	HD
<i>nitroglycerin 0.6 mg tablet sl</i> (Nitrostat)	T1	HD

T1 – Typically Generics

T4 – Injectable Specialty Medications

ST – Step Therapy

HD – May require home delivery pharmacy

T2 – Typically Preferred Brands

PA – Prior Authorization

AGE – Age Requirement

PPACA – No Cost-Share Preventive Medication

T3 – Typically Non-Preferred Brands

QL – Quantity Limit

SP – Specialty Medication

CSL – Oral cancer medication subject to cost-share limits

# List of Prescription Medications

CARDIAC DRUGS (Blood Pressure/Heart Medications)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>VASODILATORS, CORONARY</b>		
<i>nitroglycerin 400 mcg spray (Nitrolingual)</i>	T1	HD
<i>nitroglycerin (Nitro-dur)</i>	T1	HD
<i>nitroglycerin (Nitromist)</i>	T1	HD
<i>nitroglycerin (Nitromist)</i>	T1	HD
<i>nitroglycerin (Nitrostat)</i>	T1	HD
NITROLINGUAL ( <i>nitroglycerin</i> )	T3	HD
NITROMIST ( <i>nitroglycerin</i> )	T3	HD
NITROSTAT ( <i>nitroglycerin</i> )	T3	HD
<b>CARDIOVASCULAR (Asthma/COPD/Respiratory)</b>		
<b>PULM ANTI-HTN, SOLUBLE GUANYLATE CYCLASE STIMULATOR</b>		
ADEMPAS	T2	PA SP HD
<b>PULM.ANTI-HTN, SEL.C-GMP PHOSPHODIESTERASE T5 INHIB</b>		
ADCIRCA ( <i>tadalafil</i> )	T3	PA SP HD
LIQREV	T3	PA SP
REVATIO ( <i>sildenafil citrate</i> )	T3	PA SP HD
<i>sildenafil 10 mg/ml oral susp (Revatio)</i>	T1	PA SP HD
<i>sildenafil 20 mg tablet (Revatio)</i>	T1	PA SP HD
<i>tadalafil (Adcirca)</i>	T1	PA SP HD
<i>tadalafil 20 mg tablet (Adcirca)</i>	T1	PA SP HD
TADLIQ	T3	PA SP HD
<b>PULMONARY ANTI-HTN, ENDOTHELIN RECEPTOR ANTAGONIST</b>		
<i>ambrisentan (Letairis)</i>	T1	PA SP HD
<i>bosentan (Tracleer)</i>	T1	PA SP HD
LETAIRIS ( <i>ambrisentan</i> )	T3	PA SP HD
OPSUMIT	T2	PA SP HD
TRACLEER 125 MG TABLET ( <i>bosentan</i> )	T3	PA SP HD
TRACLEER 32 MG TABLET FOR SUSP	T2	PA SP HD
TRACLEER 62.5 MG TABLET ( <i>bosentan</i> )	T3	PA SP HD
<b>PULMONARY ANTIHYPERTENSIVES, PROSTACYCLIN-TYPE</b>		
ORENITRAM ER	T3	PA SP HD
TYVASO	T3	PA SP HD
TYVASO INSTITUTIONAL START KIT	T3	PA SP HD
TYVASO REFILL KIT	T3	PA SP HD
TYVASO STARTER KIT	T3	PA SP HD
UPTRAVI	T2	PA SP HD
VENTAVIS	T3	PA SP HD

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

# List of Prescription Medications

CARDIOVASCULAR (Blood Pressure/Heart Medications)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>ACE INHIBITOR-CALCIUM CHANNEL BLOCKER COMBINATION</b>		
<i>amlodipine besylate/benazepril</i>	T1	HD
<i>amlodipine besylate/benazepril</i> (Lotrel)	T1	HD
LOTREL ( <i>amlodipine besylate-benazepril</i> )	T3	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
TARKA ( <i>trandolapril-verapamil er</i> )	T3	HD
<i>trandolapril/verapamil hcl</i>	T1	HD
<i>trandolapril/verapamil hcl</i> (Tarka)	T1	HD
<b>ACE INHIBITOR-THIAZIDE OR THIAZIDE-LIKE DIURETIC</b>		
ACCURETIC ( <i>quinapril-hydrochlorothiazide</i> )	T3	ST HD
<i>benazepril/hydrochlorothiazide</i>	T1	HD
<i>benazepril/hydrochlorothiazide</i> (Lotensin Hct)	T1	HD
<i>captopril-hctz 25-15 mg tablet</i>	T1	QL (3 tabs/day) HD
<i>captopril-hctz 25-25 mg tablet</i>	T1	QL (2 tabs/day) HD
<i>captopril-hctz 50-15 mg tablet</i>	T1	QL (3 tabs/day) HD
<i>captopril-hctz 50-25 mg tablet</i>	T1	QL (2 tabs/day) HD
<i>enalapril/hydrochlorothiazide</i>	T1	HD
<i>enalapril/hydrochlorothiazide</i> (Vaseretic)	T1	HD
<i>fosinopril/hydrochlorothiazide</i>	T1	HD
<i>lisinopril/hydrochlorothiazide</i> (Zestoretic)	T1	HD
LOTENSIN HCT ( <i>benazepril-hydrochlorothiazide</i> )	T3	ST HD
<i>quinapril/hydrochlorothiazide</i> (Accuretic)	T1	HD
VASERETIC ( <i>enalapril-hydrochlorothiazide</i> )	T3	ST HD
ZESTORETIC ( <i>lisinopril-hydrochlorothiazide</i> )	T3	ST HD
<b>ALPHA/BETA-ADRENERGIC BLOCKING AGENTS</b>		
<i>carvedilol</i> (Coreg)	T1	HD
<i>carvedilol er 10 mg capsule</i> (Coreg Cr)	T1	QL (1 cap/day) HD
<i>carvedilol er 20 mg capsule</i> (Coreg Cr)	T1	QL (1 cap/day) HD
<i>carvedilol er 40 mg capsule</i> (Coreg Cr)	T1	QL (1 cap/day) HD
<i>carvedilol er 80 mg capsule</i> (Coreg Cr)	T1	HD
COREG ( <i>carvedilol</i> )	T3	ST HD
COREG CR 10 MG CAPSULE ( <i>carvedilol er</i> )	T3	QL (1 cap/day) ST HD
COREG CR 20 MG CAPSULE ( <i>carvedilol er</i> )	T3	QL (1 cap/day) ST HD
COREG CR 40 MG CAPSULE ( <i>carvedilol er</i> )	T3	QL (1 cap/day) ST HD
COREG CR 80 MG CAPSULE ( <i>carvedilol er</i> )	T3	ST HD

T1 – Typically Generics

T4 – Injectable Specialty Medications

ST – Step Therapy

HD – May require home delivery pharmacy

T2 – Typically Preferred Brands

PA – Prior Authorization

AGE – Age Requirement

PPACA – No Cost-Share Preventive Medication

T3 – Typically Non-Preferred Brands

QL – Quantity Limit

SP – Specialty Medication

CSL – Oral cancer medication subject to cost-share limits

# List of Prescription Medications

CARDIOVASCULAR (Blood Pressure/Heart Medications)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>ALPHA-ADRENERGIC BLOCKING AGENTS</b>		
<i>labetalol hcl</i>	T1	HD
CARDURA ( <i>doxazosin mesylate</i> )	T3	HD
CARDURA XL	T3	HD
<i>doxazosin mesylate</i> (Cardura)	T1	HD
MINIPRESS ( <i>prazosin hcl</i> )	T3	HD
<i>prazosin hcl</i> (Minipress)	T1	HD
<i>terazosin hcl</i>	T1	HD
<b>ANGIOTEN.RECEPTR ANTAG-CALCIUM CHANL BLKR-THIAZIDE</b>		
<i>amlodipine/valsartan/hcthiazid</i> (Exforge Hct)	T1	HD
EXFORGE ( <i>amlodipine besylate/valsartan</i> )	T3	PA HD
EXFORGE HCT ( <i>amlodipine-valsartan-hctz</i> )	T3	PA HD
<i>olmesartan/amlodipin/hcthiazid</i> (Tribenzor)	T1	HD
TRIBENZOR ( <i>olmesartan-amlodipine-hctz</i> )	T3	HD
<b>ANGIOTENSIN RECEPT-NEPRILYSIN INHIBITOR COMB (ARNI)</b>		
ENTRESTO	T2	HD
<b>ANGIOTENSIN RECEPTOR ANTAG.-THIAZIDE DIURETIC COMB</b>		
ATACAND HCT ( <i>candesartan-hydrochlorothiazid</i> )	T3	ST HD
AVALIDE ( <i>irbesartan-hydrochlorothiazide</i> )	T3	ST HD
BENICAR HCT 20-12.5 MG TABLET ( <i>olmesartan-hydrochlorothiazide</i> )	T3	QL (1 tab/day) ST HD
BENICAR HCT 40-12.5 MG TABLET ( <i>olmesartan-hydrochlorothiazide</i> )	T3	ST HD
BENICAR HCT 40-25 MG TABLET ( <i>olmesartan-hydrochlorothiazide</i> )	T3	ST HD
<i>candesartan/hydrochlorothiazid</i> (Atacand Hct)	T1	HD
DIOVAN HCT ( <i>valsartan-hydrochlorothiazide</i> )	T3	ST HD
EDARBYCLOR	T3	PA HD
HYZAAR ( <i>losartan-hydrochlorothiazide</i> )	T3	ST HD
<i>irbesartan/hydrochlorothiazide</i> (Avalide)	T1	HD
<i>losartan/hydrochlorothiazide</i> (Hyzaar)	T1	HD
MICARDIS HCT 40-12.5 MG TABLET ( <i>telmisartan-hydrochlorothiazid</i> )	T3	QL (1 tab/day) ST HD
MICARDIS HCT 80-12.5 MG TABLET ( <i>telmisartan-hydrochlorothiazid</i> )	T3	ST HD
MICARDIS HCT 80-25 MG TABLET ( <i>telmisartan-hydrochlorothiazid</i> )	T3	ST HD
<i>olmesartan-hctz 20-12.5 mg tab</i> (Benicar Hct)	T1	QL (1 tab/day) HD
<i>olmesartan-hctz 40-12.5 mg tab</i> (Benicar Hct)	T1	HD
<i>olmesartan-hctz 40-25 mg tab</i> (Benicar Hct)	T1	HD
<i>telmisartan-hctz 40-12.5 mg tb</i> (Micardis Hct)	T1	QL (1 tab/day) HD
<i>telmisartan-hctz 80-12.5 mg tb</i> (Micardis Hct)	T1	HD
<i>telmisartan-hctz 80-25 mg tab</i> (Micardis Hct)	T1	HD
<i>valsartan/hydrochlorothiazide</i> (Diovan Hct)	T1	HD

I1 – Typically Generics  
 T2 – Typically Preferred Brands  
 T3 – Typically Non-Preferred Brands

I4 – Injectable Specialty Medications  
 PA – Prior Authorization  
 QL – Quantity Limit

S1 – Step Therapy  
 AGE – Age Requirement  
 SP – Specialty Medication

HD – 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)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>ANGIOTENSIN RECEPTOR BLOCKR-CALCIUM CHANNEL BLOCKR</b>		
<i>amlodipine besylate/valsartan</i> (Exforge)	T1	HD
<i>amlodipine-olmesartan 10-20 mg</i> (Azor)	T1	HD
<i>amlodipine-olmesartan 10-40 mg</i> (Azor)	T1	HD
<i>amlodipine-olmesartan 5-20 mg</i> (Azor)	T1	QL (1 tab/day) HD
<i>amlodipine-olmesartan 5-40 mg</i> (Azor)	T1	HD
AZOR 10-20 MG TABLET ( <i>amlodipine-olmesartan</i> )	T3	HD
AZOR 10-40 MG TABLET ( <i>amlodipine-olmesartan</i> )	T3	HD
AZOR 5-20 MG TABLET ( <i>amlodipine-olmesartan</i> )	T3	QL (1 tab/day) HD
AZOR 5-40 MG TABLET ( <i>amlodipine-olmesartan</i> )	T3	HD
EXFORGE ( <i>amlodipine-valsartan</i> )	T3	PA HD
<i>telmisartan-amlodipine 40-10</i>	T1	HD
<i>telmisartan-amlodipine 40-5 mg</i>	T1	QL (1 tab/day) HD
<i>telmisartan-amlodipine 80-10</i>	T1	HD
<i>telmisartan-amlodipine 80-5 mg</i>	T1	HD
<b>ANTI-HYPERTENSIVES, ACE INHIBITORS</b>		
ACCUPRIL ( <i>quinapril hcl</i> )	T3	ST HD
ALTACE ( <i>ramipril</i> )	T3	ST HD
<i>benazepril hcl</i>	T1	HD
<i>benazepril hcl</i> (Lotensin)	T1	HD
<i>captopril</i>	T1	HD
<i>enalapril maleate</i> (Vasotec)	T1	HD
EPANED	T3	HD
<i>fosinopril sodium</i>	T1	HD
<i>lisinopril</i> (Zestril)	T1	HD
LOTENSIN ( <i>benazepril hcl</i> )	T3	ST HD
<i>moexipril hcl</i>	T1	HD
<i>perindopril erbumine</i>	T1	HD
PRINIVIL ( <i>lisinopril</i> )	T3	ST HD
QBRELIS	T3	PA HD
<i>quinapril hcl</i> (Accupril)	T1	HD
<i>ramipril</i> (Altace)	T1	HD
<i>trandolapril</i>	T1	HD
VASOTEC ( <i>enalapril maleate</i> )	T3	ST HD
ZESTRIL ( <i>lisinopril</i> )	T3	ST HD

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

T4 – Injectable 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)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>ANTI-HYPERTENSIVES, ACE INHIBITORS</b>		
ATACAND ( <i>candesartan cilexetil</i> )	T3	ST HD
AVAPRO ( <i>irbesartan</i> )	T3	ST HD
BENICAR 20 MG TABLET ( <i>olmesartan medoxomil</i> )	T3	QL (1 tab/day) ST HD
BENICAR 40 MG TABLET ( <i>olmesartan medoxomil</i> )	T3	ST HD
BENICAR 5 MG TABLET ( <i>olmesartan medoxomil</i> )	T3	ST HD
<i>candesartan cilexetil</i> (Atacand)	T1	HD
COZAAR ( <i>losartan potassium</i> )	T3	ST HD
DIOVAN ( <i>valsartan</i> )	T3	ST HD
EDARBI 40 MG TABLET	T3	PA QL (1 tab/day) HD
EDARBI 80 MG TABLET	T3	PA HD
<i>eprosartan mesylate</i>	T1	HD
<i>irbesartan</i> (Avapro)	T1	HD
<i>losartan potassium</i> (Cozaar)	T1	HD
MICARDIS 20 MG TABLET ( <i>telmisartan</i> )	T3	QL (1 tab/day) ST HD
MICARDIS 40 MG TABLET ( <i>telmisartan</i> )	T3	QL (1 tab/day) ST HD
MICARDIS 80 MG TABLET ( <i>telmisartan</i> )	T3	ST HD
<i>olmesartan medoxomil 20 mg tab</i> (Benicar)	T1	QL (1 tab/day) HD
<i>olmesartan medoxomil 40 mg tab</i> (Benicar)	T1	HD
<i>olmesartan medoxomil 5 mg tab</i> (Benicar)	T1	HD
<i>telmisartan 20 mg tablet</i> (Micardis)	T1	QL (1 tab/day) HD
<i>telmisartan 40 mg tablet</i> (Micardis)	T1	QL (1 tab/day) HD
<i>telmisartan 80 mg tablet</i> (Micardis)	T1	HD
<i>valsartan</i> (Diovan)	T1	HD
<b>ANTI-HYPERTENSIVES, GANGLIONIC BLOCKERS</b>		
VECAMYL	T1	
<b>ANTI-HYPERTENSIVES, MISCELLANEOUS</b>		
DEMSER ( <i>metirosine</i> )	T3	HD
<i>metirosine</i> (Demser)	T1	HD
<b>ANTI-HYPERTENSIVES, SYMPATHOLYTIC</b>		
CATAPRES ( <i>clonidine hcl</i> )	T3	HD
CATAPRES-TTS 1 ( <i>clonidine</i> )	T3	HD
CATAPRES-TTS 2 ( <i>clonidine</i> )	T3	HD
CATAPRES-TTS 3 ( <i>clonidine</i> )	T3	HD
<i>clonidine</i> (Catapres-tts 1)	T1	HD
<i>clonidine</i> (Catapres-tts 2)	T1	HD

T1 – Typically Generics

T4 – Injectable Specialty Medications

ST – Step Therapy

HD – May require home delivery pharmacy

T2 – Typically Preferred Brands

PA – Prior Authorization

AGE – Age Requirement

PPACA – No Cost-Share Preventive Medication

T3 – Typically Non-Preferred Brands

QL – Quantity Limit

SP – Specialty Medication

CSL – Oral cancer medication subject to cost-share limits



# List of Prescription Medications

## CARDIOVASCULAR (Blood Pressure/Heart Medications)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>ANTI-HYPERTENSIVES, SYMPATHOLYTIC (cont.)</b>		
<i>clonidine</i> (Catapres-tts 3)	T1	HD
<i>clonidine hcl</i> (Catapres)	T1	HD
<i>guanfacine hcl</i> (Intuniv)	T1	HD
INTUNIV ( <i>guanfacine hcl</i> )	T3	PA HD
<i>methyldopa</i>	T1	HD
<i>methyldopa/hydrochlorothiazide</i>	T1	HD
<b>ANTI-HYPERTENSIVES, VASODILATORS</b>		
<i>hydralazine hcl</i>	T1	HD
<i>minoxidil</i>	T1	HD
<b>BETA-ADRENERGIC BLOCKING AGENTS</b>		
<i>acebutolol hcl</i>	T1	HD
<i>atenolol</i> (Tenormin)	T1	HD
BETAPACE ( <i>sotalol af</i> )	T3	PA HD
BETAPACE AF ( <i>sotalol af</i> )	T3	PA HD
<i>betaxolol hcl</i>	T1	HD
<i>bisoprolol fumarate</i>	T1	HD
BYSTOLIC 10 MG TABLET	T3	PA QL (1 tab/day) HD
BYSTOLIC 2.5 MG TABLET	T3	PA QL (1 tab/day) HD
BYSTOLIC 20 MG TABLET	T3	PA HD
BYSTOLIC 5 MG TABLET	T3	PA QL (1 tab/day) HD
CORGARD ( <i>nadolol</i> )	T3	PA HD
HEMANGEOL	T3	PA HD
INDERAL LA ( <i>propranolol hcl er</i> )	T3	PA HD
INDERAL XL	T3	PA HD
INNOPRAN XL	T3	ST HD
KAPSPARGO SPRINKLE	T3	PA HD
LOPRESSOR ( <i>metoprolol tartrate</i> )	T3	PA HD
<i>metoprolol succinate</i> (Toprol XL)	T1	HD
<i>metoprolol tartrate</i>	T1	HD
<i>metoprolol tartrate</i> (Lopressor)	T1	HD
<i>nadolol</i>	T1	HD
<i>pindolol</i>	T1	HD
<i>propranolol hcl</i>	T1	HD
<i>propranolol hcl</i> (Inderal La)	T1	HD
<i>sotalol hcl</i> (Betapace Af)	T1	HD

T1 – Typically Generics

T4 – Injectable Specialty Medications

ST – Step Therapy

HD – May require home delivery pharmacy

T2 – Typically Preferred Brands

PA – Prior Authorization

AGE – Age Requirement

PPACA – No Cost-Share Preventive Medication

T3 – Typically Non-Preferred Brands

QL – Quantity Limit

SP – Specialty Medication

CSL – Oral cancer medication subject to cost-share limits

## List of Prescription Medications

### CARDIOVASCULAR (Blood Pressure/Heart Medications)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>BETA-ADRENERGIC BLOCKING AGENTS</b>		
<i>sotalol hcl</i> (Betapace)	T1	HD
SOTYLIZE	T3	HD
TENORMIN ( <i>atenolol</i> )	T3	PA HD
<i>timolol maleate</i>	T1	HD
TOPROL XL ( <i>metoprolol succinate</i> )	T3	PA HD
<b>BETA-BLOCKERS AND THIAZIDE, THIAZIDE-LIKE DIURETICS</b>		
<i>atenolol/chlorthalidone</i> (Tenoretic 100)	T1	HD
<i>atenolol/chlorthalidone</i> (Tenoretic 50)	T1	HD
<i>bisoprolol/hydrochlorothiazide</i> (Ziac)	T1	HD
DUTOPROL	T3	PA HD
<i>metoprolol/hydrochlorothiazide</i>	T1	HD
<i>nadolol/bendroflumethiazide</i>	T1	HD
<i>propranolol/hydrochlorothiazid</i>	T1	HD
TENORETIC 100 ( <i>atenolol-chlorthalidone</i> )	T3	PA HD
TENORETIC 50 ( <i>atenolol-chlorthalidone</i> )	T3	PA HD
ZIAC ( <i>bisoprolol-hydrochlorothiazide</i> )	T3	PA HD
<b>RENIN INHIBITOR, DIRECT</b>		
<i>aliskiren 150 mg tablet</i> (Tekturna)	T1	QL (1 tab/day) HD
<i>aliskiren 300 mg tablet</i> (Tekturna)	T1	HD
TEKTURNA 150 MG TABLET ( <i>aliskiren</i> )	T3	PA QL(1 TAB/DAY) HD
TEKTURNA 300 MG TABLET ( <i>aliskiren</i> )	T3	PA HD
<b>RENIN INHIBITOR, DIRECT AND THIAZIDE DIURETIC COMB</b>		
TEKTURNA HCT	T2	HD
<b>VASODILATORS, COMBINATION</b>		
BIDIL	T3	QL (6 tabs/day)
BIDIL ( <i>isosorbide dinit/hydralazine</i> )	T3	QL(6 tabs/day) HD
<i>isosorbide-hydralazine 20-37.5</i> (Bidil)	T1	QL(6 tabs/day) HD
<b>VASODILATORS, PERIPHERAL</b>		
<i>ergoloid mesylates</i>	T1	
<i>isoxsuprine hcl</i>	T1	

### CARDIOVASCULAR (Cholesterol Medications)

#### ANTI-HYPERLIP.HMG COA REDUCT INHIB-CHOLEST.AB.INHIB

<i>ezetimibe/atorvastatin calcium</i>	T1	PA HD
<i>ezetimibe/simvastatin</i> (Vytorin)	T1	HD
ROSZET	T3	PA HD
VYTORIN ( <i>ezetimibe-simvastatin</i> )	T3	ST HD

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

T4 – Injectable 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

<b>CARDIOVASCULAR (Cholesterol Medications) (cont.)</b>		
<b>Prescription Drug Name</b>	<b>Drug Tier</b>	<b>Coverage Requirements and Limits</b>
<b>ANTI-HYPERLIPID- HMG-COA RI-CALCIUM CHANNEL BLOCKER (cont.)</b>		
<i>amlodipine-atorvast 10-10 mg (Caduet)</i>	T1	HD
<i>amlodipine-atorvast 10-20 mg (Caduet)</i>	T1	HD
<i>amlodipine-atorvast 10-40 mg (Caduet)</i>	T1	HD
<i>amlodipine-atorvast 10-80 mg (Caduet)</i>	T1	HD
<i>amlodipine-atorvast 2.5-10 mg</i>	T1	HD
<i>amlodipine-atorvast 2.5-20 mg</i>	T1	QL (1 tab/day) HD
<i>amlodipine-atorvast 2.5-40 mg</i>	T1	QL (1 tab/day) HD
<i>amlodipine-atorvast 5-10 mg (Caduet)</i>	T1	HD
<i>amlodipine-atorvast 5-20 mg (Caduet)</i>	T1	QL (1 tab/day) HD
<i>amlodipine-atorvast 5-40 mg (Caduet)</i>	T1	QL (1 tab/day) HD
<i>amlodipine-atorvast 5-80 mg (Caduet)</i>	T1	HD
CADUET 10 MG-10 MG TABLET ( <i>amlodipine-atorvastatin</i> )	T3	HD
CADUET 10 MG-20 MG TABLET ( <i>amlodipine-atorvastatin</i> )	T3	HD
CADUET 10 MG-40 MG TABLET ( <i>amlodipine-atorvastatin</i> )	T3	HD
CADUET 10 MG-80 MG TABLET ( <i>amlodipine-atorvastatin</i> )	T3	HD
CADUET 5 MG-10 MG TABLET ( <i>amlodipine-atorvastatin</i> )	T3	HD
CADUET 5 MG-20 MG TABLET ( <i>amlodipine-atorvastatin</i> )	T3	QL (1 tab/day) HD
CADUET 5 MG-40 MG TABLET ( <i>amlodipine-atorvastatin</i> )	T3	QL (1 tab/day) HD
CADUET 5 MG-80 MG TABLET ( <i>amlodipine-atorvastatin</i> )	T3	HD
LIVALO	T3	PA QL
<b>ANTI-HYPERLIPIDEMIC - APO B-100 SYNTHESIS INHIBITOR</b>		
KYNAMRO	T3	PA SP
<b>ANTI-HYPERLIPIDEMIC - ATP CITRATE LYASE INHIBITOR</b>		
NEXLETOL	T2	PA QL (1 tab/day)
<b>ANTI-HYPERLIPIDEMIC - MTP INHIBITOR</b>		
JUXTAPID	T3	PA QL SP HD
<b>ANTI-HYPERLIPIDEMIC - PCSK9 INHIBITORS</b>		
PRALUENT PEN	T3	PA
REPATHA PUSHTRONEX	T2	PA
REPATHA SURECLICK	T2	PA
REPATHA SYRINGE	T2	PA
<b>ANTI-HYPERLIPIDEMIC-ACLY AND CHOLEST ABSORP INHIB</b>		
NEXLIZET	T2	PA QL (1 SYRINGE/DAY)
<b>ANTI-HYPERLIPIDEMIC-HMGCOA REDUCTASE INHIB (Statins)</b>		
ALTOPREV 20 MG TABLET	T3	QL (1 tab/day) ST HD
ALTOPREV 40 MG TABLET	T3	ST HD

T1 – Typically Generics

T4 – Injectable Specialty Medications

ST – Step Therapy

HD – May require home delivery pharmacy

T2 – Typically Preferred Brands

PA – Prior Authorization

AGE – Age Requirement

PPACA – No Cost-Share Preventive Medication

T3 – Typically Non-Preferred Brands

QL – Quantity Limit

SP – Specialty Medication

CSL – Oral cancer medication subject to cost-share limits

# List of Prescription Medications

CARDIOVASCULAR (Cholesterol Medications)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>ANTI-HYPERLIPIDEMIC-HMGCOA REDUCTASE INHIB (Statins) (cont.)</b>		
ALTOPREV 60 MG TABLET	T3	ST HD
<i>atorvastatin 10 mg tablet (Lipitor)</i>	T1	HD PPACA
<i>atorvastatin 20 mg tablet (Lipitor)</i>	T1	HD PPACA
<i>atorvastatin 40 mg tablet (Lipitor)</i>	T1	HD
<i>atorvastatin 80 mg tablet (Lipitor)</i>	T1	HD
CRESTOR 10 MG TABLET ( <i>rosuvastatin calcium</i> )	T3	PA QL (1 tab/day) HD
CRESTOR 20 MG TABLET ( <i>rosuvastatin calcium</i> )	T3	PA QL (1 tab/day) HD
CRESTOR 40 MG TABLET ( <i>rosuvastatin calcium</i> )	T3	PA HD
CRESTOR 5 MG TABLET ( <i>rosuvastatin calcium</i> )	T3	PA QL (1 tab/day) HD
EZALLOR SPRINKLE 10 MG CAPSULE	T3	QL (1 tab/day) ST HD
EZALLOR SPRINKLE 20 MG CAPSULE	T3	QL (1 tab/day) ST HD
EZALLOR SPRINKLE 40 MG CAPSULE	T3	ST HD
EZALLOR SPRINKLE 5 MG CAPSULE	T3	QL (1 tab/day) ST HD
FLOLIPID	T3	ST HD
<i>fluvastatin sodium</i>	T1	HD PPACA
<i>fluvastatin sodium (Lescol XI)</i>	T1	HD PPACA
LESCOL XL ( <i>fluvastatin er</i> )	T3	PA HD
LIPITOR ( <i>atorvastatin calcium</i> )	T3	PA HD
LIVALO 1 MG TABLET ( <i>pitavastatin calcium</i> )	T2	QL (1 tab/day) ST HD
LIVALO 2 MG TABLET ( <i>pitavastatin calcium</i> )	T2	QL (1 tab/day) ST HD
LIVALO 4 MG TABLET ( <i>pitavastatin calcium</i> )	T2	PA HD
<i>lovastatin 10 mg tablet</i>	T1	HD
<i>lovastatin 20 mg tablet</i>	T1	HD PPACA
<i>lovastatin 40 mg tablet</i>	T1	HD PPACA
<i>pitavastatin tablet</i>	T1	QL HD PPACA
<i>pitavastatin 1 mg tablet (Livalo)</i>	T1	QL(1 tab/day) HD PPACA
<i>pitavastatin 2 mg tablet (Livalo)</i>	T1	QL(1 tab/day) HD PPACA
<i>pitavastatin 4 mg tablet (Livalo)</i>	T1	HD PPACA
PRAVACHOL ( <i>pravastatin sodium</i> )	T3	PA HD
<i>pravastatin sodium</i>	T1	HD PPACA
<i>pravastatin sodium (Pravachol)</i>	T1	HD PPACA
<i>rosuvastatin calcium 10 mg tab (Crestor)</i>	T1	QL (1 tab/day) HD PPACA
<i>rosuvastatin calcium 20 mg tab (Crestor)</i>	T1	QL (1 tab/day) HD
<i>rosuvastatin calcium 40 mg tab (Crestor)</i>	T1	HD
<i>rosuvastatin calcium 5 mg tab (Crestor)</i>	T1	QL (1 tab/day) HD PPACA

T1 – Typically Generics

T4 – Injectable Specialty Medications

ST – Step Therapy

HD – May require home delivery pharmacy

T2 – Typically Preferred Brands

PA – Prior Authorization

AGE – Age Requirement

PPACA – No Cost-Share Preventive Medication

T3 – Typically Non-Preferred Brands

QL – Quantity Limit

SP – Specialty Medication

CSL – Oral cancer medication subject to cost-share limits

# List of Prescription Medications

CARDIOVASCULAR (Cholesterol Medications)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>ANTI-HYPERLIPIDEMIC-HMGCOA REDUCTASE INHIB (Statins)</b>		
<i>simvastatin 10 mg tablet (Zocor)</i>	T1	HD PPACA
<i>simvastatin 20 mg tablet (Zocor)</i>	T1	HD PPACA
SIMVASTATIN 20 MG/5 ML SUSP	T3	ST HD
<i>simvastatin 40 mg tablet (Zocor)</i>	T1	HD PPACA
<i>simvastatin 5 mg tablet</i>	T1	HD
<i>simvastatin 80 mg tablet</i>	T1	QL (1 tab/day) HD
ZOCOR	T3	PA HD
ZYPITAMAG	T3	ST HD
<b>BILE SALT SEQUESTRANTS</b>		
<i>cholestyramine (with sugar) (Questran)</i>	T1	HD
<i>cholestyramine/aspartame</i>	T1	HD
<i>cholestyramine/aspartame (Questran Light)</i>	T1	HD
<i>colesevelam hcl (Welchol)</i>	T1	HD
COLESTID 1 GM TABLET ( <i>colestipol hcl</i> )	T3	HD
COLESTID GRANULES	T3	HD
COLESTID GRANULES ( <i>colestipol hcl</i> )	T3	HD
COLESTID GRANULES PACKET ( <i>colestipol hcl</i> )	T3	HD
<i>colestipol hcl (Colestid)</i>	T1	HD
QUESTRAN ( <i>cholestyramine</i> )	T3	HD
QUESTRAN LIGHT ( <i>prevalite</i> )	T3	HD
WELCHOL ( <i>colesevelam hcl</i> )	T3	PA HD
<b>LIPOTROPICS</b>		
ANTARA	T3	PA HD
<i>ezetimibe (Zetia)</i>	T1	HD
<i>fenofibrate 120 mg tablet (Fenoglide)</i>	T1	HD
<i>fenofibrate 130 mg capsule</i>	T1	HD
<i>fenofibrate 134 mg capsule</i>	T1	HD
<i>fenofibrate 145 mg tablet (Tricor)</i>	T1	HD
FENOFIBRATE 150 MG CAPSULE	T1	HD
<i>fenofibrate 160 mg tablet</i>	T1	HD
FENOFIBRATE 160 MG TABLET	T3	PA HD
<i>fenofibrate 200 mg capsule</i>	T1	HD
<i>fenofibrate 40 mg tablet (Fenoglide)</i>	T1	HD
<i>fenofibrate 43 mg capsule</i>	T1	HD

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

T4 – Injectable 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)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>LIPOTROPICS (cont.)</b>		
<i>fenofibrate 48 mg tablet</i> (Tricor)	T1	HD
FENOFIBRATE 50 MG CAPSULE	T1	HD
<i>fenofibrate 54 mg tablet</i>	T1	HD
<i>fenofibrate 67 mg capsule</i>	T1	HD
<i>fenofibric acid (choline)</i> (Trilipix)	T1	HD
<i>fenofibric acid</i> (Fibricor)	T1	HD
FENOGLIDE ( <i>fenofibrate</i> )	T3	PA HD
FIBRICOR ( <i>fenofibric acid</i> )	T3	ST HD
<i>gemfibrozil</i> (Lopid)	T1	HD
LIPOFEN	T3	ST HD
LOPID ( <i>gemfibrozil</i> )	T3	HD
<i>niacin</i> (Niacor)	T1	PA HD
<i>niacin</i> (Niaspan)	T1	HD
NIACOR	T3	PA HD
NIASPAN ( <i>niacin er</i> )	T3	HD
TRICOR ( <i>fenofibrate</i> )	T3	ST HD
TRIGLIDE	T3	ST HD
TRILIPIX ( <i>fenofibric acid</i> )	T3	ST HD
ZETIA ( <i>ezetimibe</i> )	T3	HD

### CNS DRUGS (Alzheimer's Disease)

#### ALZHEIMER'S THERAPY, NMDA RECEPTOR ANTAGONISTS

<i>memantine hcl</i>	T1	HD
<i>memantine hcl</i> (Namenda)	T1	HD
<i>memantine hcl er 14 mg capsule</i> (Namenda Xr)	T1	QL (1 cap/day) HD
<i>memantine hcl er 21 mg capsule</i> (Namenda Xr)	T1	HD
<i>memantine hcl er 28 mg capsule</i> (Namenda Xr)	T1	HD
<i>memantine hcl er 7 mg capsule</i> (Namenda Xr)	T1	QL (1 cap/day) HD
NAMENDA 10 MG TABLET ( <i>memantine hcl</i> )	T3	HD
NAMENDA 5 MG TABLET ( <i>memantine hcl</i> )	T3	HD
NAMENDA 5-10 MG TITRATION PK	T2	HD
NAMENDA XR 14 MG CAPSULE ( <i>memantine hcl er</i> )	T3	QL (1 cap/day) HD
NAMENDA XR 21 MG CAPSULE ( <i>memantine hcl er</i> )	T3	HD
NAMENDA XR 28 MG CAPSULE ( <i>memantine hcl er</i> )	T3	HD
NAMENDA XR 7 MG CAPSULE ( <i>memantine hcl er</i> )	T3	QL (1 cap/day) HD
NAMENDA XR TITRATION PACK	T3	QL (112/365 days) HD

T1 – Typically Generics

T4 – Injectable Specialty Medications

ST – Step Therapy

HD – May require home delivery pharmacy

T2 – Typically Preferred Brands

PA – Prior Authorization

AGE – Age Requirement

PPACA – No Cost-Share Preventive Medication

T3 – Typically Non-Preferred Brands

QL – Quantity Limit

SP – Specialty Medication

CSL – Oral cancer medication subject to cost-share limits

## List of Prescription Medications

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

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>ALZHEIMER'S THX, NMDA RECEPTOR ANTAG-CHOLINES INHIB (cont.)</b>		
NAMZARIC 14 MG-10 MG CAPSULE	T3	QL (2 caps/day) HD
NAMZARIC 21 MG-10 MG CAPSULE	T3	QL (2 caps/day) HD
NAMZARIC 28 MG-10 MG CAPSULE	T3	QL (2 caps/day) HD
NAMZARIC 7 MG-10 MG CAPSULE	T3	QL (2 caps/day) HD
NAMZARIC TITRATION PACK	T3	QL (112/365 days) HD

### CNS DRUGS (Miscellaneous)

#### AMYOTROPHIC LATERAL SCLEROSIS AGENTS

EXSERVAN	T3	PA
RADICAVA ORS	T3	PA QL (50ml/28days) SP
RELYVRIO	T3	PA QL (2 PACKS/DAY) SP HD
RILUTEK ( <i>riluzole</i> )	T3	PA SP HD
<i>riluzole</i> (Rilutek)	T1	SP HD
TIGLUTIK	T3	PA SP

#### DRUGS TO TREAT MOVEMENT DISORDERS

AUSTEDO XR 6 MG TABLET	T3	PA QL (90 tabs/30 days) SP HD
AUSTEDO XR 12 MG TABLET	T3	PA QL (30 tabs/30 days) SP HD
AUSTEDO XR 24 MG TABLET	T3	PA QL (50 tabs/30 days) SP HD
AUSTEDO XR TITRATION KIT (WK1-4)	T3	PA QL (1 KIT/180 DAYS) SP HD
HORIZANT	T3	PA
INGREZZA	T3	PA SP
INGREZZA INITIATION PACK	T3	PA QL (28 caps/year) SP
<i>tetrabenazine</i> (Xenazine)	T1	PA SP HD
XENAZINE ( <i>tetrabenazine</i> )	T3	PA SP HD

#### PSEUDOBULBAR AFFECT (PBA) AGENTS, NMDA ANTAGONISTS

NUJEXTA	T3	QL (4 caps/day)
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#### XANTHINES

<i>caffeine citrate</i>	T1	HD
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### CNS DRUGS (Multiple Sclerosis)

#### AGENTS TO TREAT MULTIPLE SCLEROSIS

AUBAGIO ( <i>teriflunomide</i> )	T3	PA SP HD
AVONEX	T4	PA SP HD
AVONEX PEN	T4	PA SP HD
BAFIERTAM	T2	PA SP HD
BETASERON	T4	PA SP HD
COPAXONE ( <i>glatopa</i> )	T4	PA SP HD

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

T4 – Injectable 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
<b>AGENTS TO TREAT MULTIPLE SCLEROSIS (cont.)</b>		
<i>dimethyl fumarate</i> (Tecfidera)	T1	HD
EXTAVIA	T4	PA SP HD
GILENYA	T3	PA SP HD
glatiramer	T4	HD
<i>glatiramer acetate</i> (Copaxone)	T1	PA SP HD
<i>glatopa</i>	T4	HD
KESIMPTA PEN	T4	PA SP HD
MAVENCLAD	T3	PA SP HD
MAYZENT	T2	PA SP HD
PLEGRIDY	T4	PA SP HD
PLEGRIDY PEN	T4	PA SP HD
PONVORY	T2	PA SP HD
REBIF	T4	PA SP HD
REBIF REBIDOSE	T4	PA SP HD
TASCENSO ODT 0.25 MG TABLET	T3	PA QL(1 TAB/DAY) SP
TECFIDERA ( <i>dimethyl fumarate</i> )	T3	PA SP HD
<i>teriflunomide</i> (Aubagio)	T1	SP HD
VUMERITY	T2	PA SP HD
ZEPOSIA	T3	PA SP HD
<b>AGTS TX NEUROMUSC TRANSMISSION DIS, POT-CHAN BLKR</b>		
AMPYRA ( <i>dalfampridine er</i> )	T3	PA SP HD
<i>dalfampridine</i> (Ampyra)	T1	PA SP HD
FIRDAPSE	T3	PA QL (8 tabs/day) SP
RUZURGI	T3	PA SP
CNS DRUGS (Pain Relief And Inflammatory Disease)		
<b>CALCITONIN GENE-RELATED PEPTIDE (CGRP) INHIBITORS</b>		
EMGALITY SYRINGE	T2	PA
<b>GLYPROMATE (GPE) ANALOGS</b>		
DAYBUE	T3	PA QL (120ml/day) SP
<b>POSTHERPETIC NEURALGIA AGENTS</b>		
<i>gabapentin</i> (Gralise)	T1	
GRALISE	T3	PA
GRALISE ( <i>gabapentin</i> )	T3	PA
<b>SPHINGOSINE I-PHOSPHATE (SIP) RECEPTOR MODULATOR</b>		
VELSIPITY	T3	PA QL(30 TABS/30 DAYS) SP HD
ZEPOSIA	T2	PA SP HD

T1 – Typically Generics

T4 – Injectable Specialty Medications

ST – Step Therapy

HD – May require home delivery pharmacy

T2 – Typically Preferred Brands

PA – Prior Authorization

AGE – Age Requirement

PPACA – No Cost-Share Preventive Medication

T3 – Typically Non-Preferred Brands

QL – Quantity Limit

SP – Specialty Medication

CSL – Oral cancer medication subject to cost-share limits



# List of Prescription Medications

CNS DRUGS (Seizure Disorders)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>ANTI-CONVULSANT - BENZODIAZEPINE TYPE</b>		
<i>clobazam</i> (Onfi)	T1	HD
<i>clonazepam</i>	T1	HD
<i>clonazepam</i> (Klonopin)	T1	HD
DIASTAT ( <i>diazepam</i> )	T3	PA HD
DIASTAT ACUDIAL ( <i>diazepam</i> )	T3	PA HD
<i>diazepam 10 mg rectal gel syst</i> (Diastat Acudial)	T1	HD
<i>diazepam 2.5 mg rectal gel sys</i> (Diastat)	T1	HD
<i>diazepam 20 mg rectal gel syst</i>	T1	HD
KLONOPIN ( <i>clonazepam</i> )	T3	PA HD
NAYZILAM	T2	PA QL (5 kits/30 days) HD
ONFI ( <i>clobazam</i> )	T3	PA HD
SYMPAZAN	T3	PA HD
VALTOCO	T3	PA QL (5 Boxes/30 Days) HD
<b>ANTI-CONVULSANT - CANNABINOID TYPE</b>		
EPIDIOLEX	T3	PA SP HD
<b>ANTI-CONVULSANTS</b>		
APTIOM 200 MG TABLET	T3	PA QL (1 tab/day) HD
APTIOM 400 MG TABLET	T3	PA QL (1 tab/day) HD
APTIOM 600 MG TABLET	T3	PA HD
APTIOM 800 MG TABLET	T3	PA HD
BANZEL 200 MG TABLET	T3	PA QL (16 tabs/day) HD
BANZEL 40 MG/ML SUSPENSION ( <i>rufinamide</i> )	T3	PA QL (80ml/day) HD
BANZEL 400 MG TABLET	T3	PA QL (8 tabs/day) HD
BRIVIACT	T3	PA HD
<i>carbamazepine</i>	T1	HD
<i>carbamazepine</i> (Carbatrol)	T1	HD
<i>carbamazepine</i> (Tegretol Xr)	T1	HD
<i>carbamazepine</i> (Tegretol)	T1	HD
CARBATROL ( <i>carbamazepine er</i> )	T3	PA HD
CELONTIN	T2	HD
DEPAKOTE ( <i>divalproex sodium</i> )	T3	PA HD
DEPAKOTE ER ( <i>divalproex sodium er</i> )	T3	PA HD
DEPAKOTE SPRINKLE ( <i>divalproex sodium</i> )	T3	PA HD
DIACOMIT	T3	PA SP HD
DILANTIN 100 MG CAPSULE ( <i>phenytoin sodium extended</i> )	T3	PA HD

T1 – Typically Generics

T4 – Injectable Specialty Medications

ST – Step Therapy

HD – May require home delivery pharmacy

T2 – Typically Preferred Brands

PA – Prior Authorization

AGE – Age Requirement

PPACA – No Cost-Share Preventive Medication

T3 – Typically Non-Preferred Brands

QL – Quantity Limit

SP – Specialty Medication

CSL – Oral cancer medication subject to cost-share limits

# List of Prescription Medications

CNS DRUGS (Seizure Disorders)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>ANTI-CONVULSANTS (cont.)</b>		
DILANTIN 30 MG CAPSULE	T2	PA HD
DILANTIN 50 MG INFATAB ( <i>phenytoin</i> )	T3	PA HD
DILANTIN-125 ( <i>phenytoin</i> )	T3	PA HD
<i>divalproex sodium</i> (Depakote Er)	T1	HD
<i>divalproex sodium</i> (Depakote Sprinkle)	T1	HD
<i>divalproex sodium</i> (Depakote)	T1	HD
ELEPSIA XR	T3	PA
EPRONTIA	T3	PA
<i>ethosuximide</i> (Zarontin)	T1	HD
<i>felbamate</i> (Felbatol)	T1	HD
FELBATOL ( <i>felbamate</i> )	T3	PA HD
FINTEPLA	T3	PA SP HD
FYCOMPA 0.5 MG/ML ORAL SUSP	T2	PA HD
FYCOMPA 10 MG TABLET	T2	PA HD
FYCOMPA 12 MG TABLET	T2	PA HD
FYCOMPA 2 MG TABLET	T2	PA HD
FYCOMPA 4 MG TABLET	T2	PA QL (1 tab/day) HD
FYCOMPA 6 MG TABLET	T2	PA QL (1 tab/day) HD
FYCOMPA 8 MG TABLET	T2	PA HD
<i>gabapentin</i>	T1	HD
<i>gabapentin</i> (Neurontin)	T1	HD
GABITRIL 12 MG TABLET ( <i>tiagabine hcl</i> )	T3	PA QL (8 tabs/day) HD
GABITRIL 16 MG TABLET ( <i>tiagabine hcl</i> )	T3	PA QL (6 tabs/day) HD
GABITRIL 2 MG TABLET ( <i>tiagabine hcl</i> )	T3	PA HD
GABITRIL 4 MG TABLET ( <i>tiagabine hcl</i> )	T3	PA HD
KEPPRA ( <i>levetiracetam</i> )	T3	PA HD
KEPPRA ( <i>roveepra</i> )	T3	PA HD
KEPPRA XR ( <i>levetiracetam er</i> )	T3	PA HD
LAMICTAL (BLUE) ( <i>subvenite (blue)</i> )	T3	PA HD
LAMICTAL (GREEN) ( <i>subvenite (green)</i> )	T3	PA HD
LAMICTAL ( <i>lamotrigine</i> )	T3	PA HD
LAMICTAL (ORANGE) ( <i>subvenite (orange)</i> )	T3	PA HD
LAMICTAL ( <i>subvenite</i> )	T3	PA HD
LAMICTAL ODT (BLUE) ( <i>lamotrigine odt (blue)</i> )	T3	PA HD
LAMICTAL ODT (GREEN) ( <i>lamotrigine odt (green)</i> )	T3	PA HD

T1 – Typically Generics

T4 – Injectable Specialty Medications

ST – Step Therapy

HD – May require home delivery pharmacy

T2 – Typically Preferred Brands

PA – Prior Authorization

AGE – Age Requirement

PPACA – No Cost-Share Preventive Medication

T3 – Typically Non-Preferred Brands

QL – Quantity Limit

SP – Specialty Medication

CSL – Oral cancer medication subject to cost-share limits

# List of Prescription Medications

CNS DRUGS (Seizure Disorders)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>ANTI-CONVULSANTS (cont.)</b>		
LAMICTAL ODT ( <i>lamotrigine odt</i> )	T3	PA HD
LAMICTAL ODT (ORANGE) ( <i>lamotrigine odt (orange)</i> )	T3	PA HD
LAMICTAL XR (BLUE)	T3	PA HD
LAMICTAL XR (GREEN)	T3	PA HD
LAMICTAL XR ( <i>lamotrigine er</i> )	T3	PA HD
LAMICTAL XR (ORANGE)	T3	PA HD
<i>lamotrigine</i> (Lamictal (blue))	T1	HD
<i>lamotrigine</i> (Lamictal (green))	T1	HD
<i>lamotrigine</i> (Lamictal (orange))	T1	HD
<i>lamotrigine</i> (Lamictal Odt (blue))	T1	HD
<i>lamotrigine</i> (Lamictal Odt (green))	T1	HD
<i>lamotrigine</i> (Lamictal Odt (orange))	T1	HD
<i>lamotrigine</i> (Lamictal Odt)	T1	HD
<i>lamotrigine</i> (Lamictal Xr)	T1	HD
<i>lamotrigine</i> (Lamictal)	T1	HD
<i>levetiracetam</i>	T1	HD
<i>levetiracetam</i> (Keppra Xr)	T1	HD
<i>levetiracetam</i> (Keppra)	T1	HD
LYRICA ( <i>pregabalin</i> )	T3	PA HD
MOTPOLY XR 100 MG CAPSULE	T3	PA QL(1 cap/day) HD
MOTPOLY XR 150 MG CAPSULE	T3	PA QL(2 caps/day) HD
MOTPOLY XR 200 MG CAPSULE	T3	PA QL(2 caps/day) HD
MYSOLINE ( <i>primidone</i> )	T3	PA HD
NEURONTIN ( <i>gabapentin</i> )	T3	PA HD
<i>oxcarbazepine</i> (Trileptal)	T1	HD
OXTELLAR XR	T3	PA HD
PEGANONE	T2	HD
PHENYTEK ( <i>phenytoin sodium extended</i> )	T3	PA HD
<i>phenytoin</i>	T1	HD
<i>phenytoin</i> (Dilantin)	T1	HD
<i>phenytoin</i> (Dilantin-125)	T1	HD
<i>phenytoin sodium extended</i> (Dilantin)	T1	HD
<i>phenytoin sodium extended</i> (Phenytek)	T1	HD
<i>pregabalin</i> (Lyrica)	T1	HD
<i>primidone</i> (Mysoline)	T1	HD

T1 – Typically Generics

T4 – Injectable Specialty Medications

ST – Step Therapy

HD – May require home delivery pharmacy

T2 – Typically Preferred Brands

PA – Prior Authorization

AGE – Age Requirement

PPACA – No Cost-Share Preventive Medication

T3 – Typically Non-Preferred Brands

QL – Quantity Limit

SP – Specialty Medication

CSL – Oral cancer medication subject to cost-share limits

## List of Prescription Medications

CNS DRUGS (Seizure Disorders)			
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits	
<b>ANTI-CONVULSANTS (cont.)</b>			
QUDEXY XR ( <i>topiramate er</i> )	T3	PA HD	
<i>rufinamide</i> (Banzel)	T1	PA QL (80ML/DAY) HD	
SABRIL ( <i>vigabatrin</i> )	T3	PA SP HD	
SABRIL (vigadrone)	T3	PA SP HD	
SPRITAM	T3	PA HD	
TEGRETOL (carbamazepine)	T3	PA HD	
TEGRETOL (epitol)	T3	PA HD	
TEGRETOL XR (carbamazepine er)	T3	PA HD	
<i>tiagabine hcl 12 mg tablet</i> (Gabitril)	T1	QL (8 tabs/day) HD	
<i>tiagabine hcl 16 mg tablet</i> (Gabitril)	T1	QL (6 tabs/day) HD	
<i>tiagabine hcl 2 mg tablet</i> (Gabitril)	T1	HD	
<i>tiagabine hcl 4 mg tablet</i> (Gabitril)	T1	HD	
TOPAMAX (topiramate)	T3	PA HD	
topiramate (Qudexy Xr)	T1	HD	
topiramate (Topamax)	T1	HD	
topiramate er (Trokendi Xr)	T1	QL(1 CAP/DAY) HD	
TRILEPTAL (oxcarbazepine)	T3	PA HD	
TROKENDI XR 100 MG, 25MG, 50 MG CAPSULE (topiramate)	T3	PA QL(1 CAP/DAY) HD	
valproic acid	T1	HD	
valproic acid (as sodium salt)	T1	HD	
vigabatrin (Sabril)	T1	SP HD	
VIMPAT	T2	PA HD	
XCOPRI 100 MG TABLET	T3	PA QL (1 tab/day) HD	
XCOPRI 12.5-25 MG TITRATION PK	T3	PA QL (1/28 Days) HD	
XCOPRI 150 MG TABLET	T3	PA QL (1/Day) HD	
XCOPRI 150-200 MG TITRATION PK	T3	PA QL (1/28 Days) HD	
XCOPRI 200 MG TABLET	T3	PA QL (2/Day) HD	
XCOPRI 250 MG DAILY DOSE PACK	T3	PA QL (1/28 Days) HD	
XCOPRI 350 MG DAILY DOSE PACK	T3	PA QL (1/28 Days) HD	
XCOPRI 50 MG TABLET	T3	PA QL (1/Day) HD	
XCOPRI 50-100 MG TITRATION PAK	T3	PA QL (1/28 Days) HD	
ZARONTIN (ethosuximide)	T3	PA HD	
ZONEGRAN (zonisamide)	T3	PA HD	
zonisamide	T1	HD	
zonisamide (Zonegran)	T1	HD	
ZONISADE	T3	PA QL(6 bottles/30 days)	

T1 – Typically Generics

T4 – Injectable Specialty Medications

ST – Step Therapy

HD – May require home delivery pharmacy

T2 – Typically Preferred Brands

PA – Prior Authorization

AGE – Age Requirement

PPACA – No Cost-Share Preventive Medication

T3 – Typically Non-Preferred Brands

QL – Quantity Limit

SP – Specialty Medication

CSL – Oral cancer medication subject to cost-share limits

## List of Prescription Medications

### CNS DRUGS (Sleep Disorders/Sedatives)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
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#### NARCOLEPSY TX-H3-RECEPT.ANTAGONIST/INVERSE AGONIST

WAKIX	T3	PA QL (2 tabs/day) SP HD
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### COLONY STIMULATING FACTORS (Blood Modifiers/Bleeding Disorders)

#### ERYTHROPOIESIS-STIMULATING AGENTS

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

#### LEUKOCYTE (WBC) STIMULANTS

FULPHILA	T4	PA SP
GRANIX	T3	PA SP
LEUKINE	T2	SP
NEULASTA	T4	PA SP
NEULASTA ONPRO	T4	PA SP HD
NEUPOGEN	T3	PA SP
NIVESTYM	T4	PA SP
NYVEPRIA	T4	PA SP
STIMUFEND	T4	PA SP
UDENYCA	T4	PA SP
ZARXIO	T2	SP HD
ZIEXTENZO	T4	PA SP

#### THROMBOPOIETIN RECEPTOR AGONISTS

DOPTELET	T3	PA SP HD
MULPLETA	T3	PA SP HD
PROMACTA	T3	PA SP HD

### CONTRACEPTIVES (Contraception Products)

#### CONTRACEPTIVES, INTRAVAGINAL, SYSTEMIC

ANNOVERA	T3	
<i>etonogestrel/ethinyl estradiol (Nuvaring)</i>	T1	PPACA
NUVARING ( <i>etonogestrel-ethinyl estradiol</i> )	T3	

#### CONTRACEPTIVES, IMPLANTABLE

NEXPLANON	T2	SP PPACA
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#### CONTRACEPTIVES, INJECTABLE

DEPO-PROVERA 150 MG/ML SYRINGE ( <i>medroxyprogesterone acetate</i> )	T3	
DEPO-PROVERA 150 MG/ML VIAL ( <i>medroxyprogesterone acetate</i> )	T3	
DEPO-SUBQ PROVERA 104	T2	
<i>medroxyprogesterone 150 mg/ml (Depo-provera)</i>	T1	PPACA

T1 – Typically Generics

T4 – Injectable Specialty Medications

ST – Step Therapy

HD – May require home delivery pharmacy

T2 – Typically Preferred Brands

PA – Prior Authorization

AGE – Age Requirement

PPACA – No Cost-Share Preventive Medication

T3 – Typically Non-Preferred Brands

QL – Quantity Limit

SP – Specialty Medication

CSL – Oral cancer medication subject to cost-share limits

# List of Prescription Medications

CONTRACEPTIVES (Contraception Products)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>CONTRACEPTIVES, INTRAVAGINAL</b>		
PHEXXI	T3	PA PPACA
<b>CONTRACEPTIVES, ORAL</b>		
BALCOLTRA	T3	HD
BEYAZ ( <i>rajani</i> )	T3	HD
<i>desog-e.estradiol/e.estradiol</i> (Mircette)	T1	HD PPACA
<i>desogestrel-ethinyl estradiol</i>	T1	HD PPACA
<i>drospir/eth estra/levomefol ca</i> (Beyaz)	T1	HD PPACA
<i>drospir/eth estra/levomefol ca</i> (Safyral)	T1	HD PPACA
ELLA	T3	HD PPACA
ESTROSTEP FE ( <i>tri-legest fe</i> )	T3	HD
<i>ethinyl estradiol/drospirenone</i> (Yasmin 28)	T1	HD PPACA
<i>ethinyl estradiol/drospirenone</i> (Yaz)	T1	HD PPACA
<i>ethynodiol d-ethinyl estradiol</i>	T1	HD PPACA
<i>levonorgestrel/ethin.estradiol</i>	T1	HD PPACA
<i>levonorgest/eth.estradiol/iron</i> (Balcoltra)	T1	HD PPACA
<i>l-norgest/e.estradiol-e.estrad</i> (Loseasonique)	T1	HD PPACA
<i>l-norgest/e.estradiol-e.estrad</i> (Quartette)	T1	HD PPACA
<i>l-norgest/e.estradiol-e.estrad</i> (Seasonique)	T1	HD PPACA
LO LOESTRIN FE	T2	HD
LOESTRIN ( <i>norethindron-ethinyl estradiol</i> )	T3	HD
LOESTRIN FE ( <i>norethindrone-eth estradiol-fe</i> )	T3	HD
LOESTRIN FE ( <i>tarina fe 1-20 eq</i> )	T3	HD
LOSEASONIQUE ( <i>lojaimiess</i> )	T3	HD
MICROGESTIN 24 FE ( <i>tarina 24 fe</i> )	T3	HD
MINASTRIN 24 FE ( <i>norethin-eth estra-ferrous fum</i> )	T3	HD
MIRCETTE ( <i>volnea</i> )	T3	HD
NATAZIA	T3	HD
NEXTSTELLIS	T3	HD
<i>noreth-ethinyl estradiol/iron</i>	T1	HD PPACA
<i>norethind-eth estrad 1-0.02 mg</i> (Loestrin)	T1	HD PPACA
<i>norethindrone</i> (Ortho Micronor)	T1	HD PPACA
<i>norethindrone ac-eth estradiol</i> (Loestrin)	T1	HD PPACA
<i>norethindrone-e.estradiol-iron</i> (Estrostep Fe)	T1	HD PPACA
<i>norethindrone-e.estradiol-iron</i> (Loestrin Fe)	T1	HD PPACA

T1 – Typically Generics

T4 – Injectable Specialty Medications

ST – Step Therapy

HD – May require home delivery pharmacy

T2 – Typically Preferred Brands

PA – Prior Authorization

AGE – Age Requirement

PPACA – No Cost-Share Preventive Medication

T3 – Typically Non-Preferred Brands

QL – Quantity Limit

SP – Specialty Medication

CSL – Oral cancer medication subject to cost-share limits

## List of Prescription Medications

### CONTRACEPTIVES (Contraception Products)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
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#### CONTRACEPTIVES, ORAL

<i>norethindrone-e.estradiol-iron</i> (Microgestin 24 Fe)	T1	HD PPACA
<i>norethindrone-e.estradiol-iron</i> (Minastrin 24 Fe)	T1	HD PPACA
<i>norethindrone-e.estradiol-iron</i> (Taytulla)	T1	HD PPACA
<i>norethindrone-ethin. estradiol</i>	T1	HD PPACA
<i>norethin-ee 1.5-0.03 mg (21) tb</i> (Loestrin)	T1	HD PPACA
<i>norgestimate-ethinyl estradiol</i>	T1	HD PPACA
<i>norgestrel-ethinyl estradiol</i>	T1	HD PPACA
ORTHO MICRONOR ( <i>tulana</i> )	T3	HD
QUARTETTE ( <i>rivelsa</i> )	T3	HD
SAFYRAL ( <i>tydemy</i> )	T3	HD
SEASONIQUE ( <i>simpesse</i> )	T3	HD
SLYND	T3	HD
TAYTULLA ( <i>norethin-eth estra-ferrous fum</i> )	T3	HD
TYBLUME	T3	HD
YASMIN 28 ( <i>zumandimine</i> )	T3	HD
YAZ ( <i>vestura</i> )	T3	HD

#### CONTRACEPTIVES, TRANSDERMAL

<i>norelgestromin/ethin.estradiol</i>	T1	HD PPACA
TWIRLA	T3	HD PPACA

#### DIAPHRAGMS/CERVICAL CAP

CAYA CONTOURED	T1	PPACA
FEMCAP	T1	PPACA
WIDE SEAL DIAPHRAGM	T1	PPACA

#### INTRA-UTERINE DEVICES (IUDS)

KYLEENA	T3	SP PPACA
LILETTA	T3	SP PPACA
MIRENA	T3	SP PPACA
PARAGARD T 380-A	T3	SP PPACA
SKYLA	T3	SP PPACA

### COUGH/COLD PREPARATIONS (Allergy/Nasal Sprays)

#### 1ST GEN ANTIHIST-DECONGEST-ANTICHOLINERGIC COMB

RESPA A.R.	T3	
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### COUGH/COLD PREPARATIONS (Cough/Cold Medications)

#### ANTI-TUSSIVES, NON-OPIOID

<i>benzonatate 100 mg capsule</i> (Tessalon Perle)	T1	
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T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

T4 – Injectable 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

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

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>ANTI-TUSSIVES, NON-OPIOID (cont.)</b>		
<i>benzonatate 150 mg capsule</i>	T1	PA
<i>benzonatate 200 mg capsule</i>	T1	
<b>NON-OPIOID ANTI-TUS-IST GEN.ANTIHISTAMINE-DECONGEST</b>		
<i>benzonatate perle 100 mg cap (Tessalon Perle)</i>	T1	
TESSALON PERLE ( <i>benzonatate</i> )	T3	
<b>NON-OPIOID ANTITUS-IST GEN.ANTIHISTAMINE-DECONGEST</b>		
BROMFED DM ( <i>brompheniramine-pseudoephed-dm</i> )	T3	PA
<i>brompheniramine/pseudoephed/dm (Bromfed Dm)</i>	T1	
<b>NON-OPIOID ANTI-TUSSIVE-IST GEN ANTIHISTAMINE COMB.</b>		
<i>promethazine/dextromethorphan</i>	T1	
<i>hydrocodone/cpm/pseudoephed</i>	T1	PA
<i>promethazine/phenyleph/codeine</i>	T1	PA QL (480ml/22 days)
<i>promethazine/phenyleph/codeine</i>	T1	PA QL (480ml/30 days)
<b>OPIOID ANTI-TUSSIVE-IST GENERATION ANTIHISTAMINE</b>		
<i>hydrocodone/chlorphen p-stirex</i>	T1	PA
<i>promethazine-codeine solution</i>	T1	PA QL (480ML/22 Days)
<i>promethazine-codeine syrup</i>	T1	PA QL (480ml/30 days)
TUSSICAPS	T2	PA
TUXARIN ER	T3	PA QL (2 tabs/day)
TUZISTRA XR	T3	PA QL (960ml/30 days)
<b>OPIOID ANTI-TUSSIVE-ANTI-CHOLINERGIC COMBINATIONS</b>		
HYCODAN ( <i>hydromet</i> )	T3	PA QL (480ml/22 days)
<i>hydrocodone bit/homatrop me-br (Hycodan)</i>	T1	PA QL (480ml/22 days)
<i>hydrocodone-homatropine 5-1.5</i>	T1	PA QL (180 tabs/30 days)
<i>hydrocodone-homatropine soln (Hycodan)</i>	T1	PA QL (480ml/30 days)
HYDROCODONE-HOMATROPINE SYRUP	T1	PA QL (480ml/30 days)
<b>OPIOID ANTI-TUSSIVE-EXPECTORANT COMBINATION</b>		
HYDROCODONE-GUAIFENESIN	T1	PA QL (960ml/30 days)
OBREDON	T3	PA QL (960ml/30 days)
<b>DIAGNOSTIC (Diabetes)</b>		
<b>BLOOD SUGAR DIAGNOSTICS</b>		
FORA 6CONN-GTEL-TN'G ADV STRIP	T3	
GE333 BLOOD GLUCOSE TEST STRIP	T3	

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

T4 – Injectable 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)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>DIAGNOSTIC PREPARATIONS, MISCELLANEOUS</b>		
ADVANCED DNA MEDICATED COLLECT	T3	
ARIDOL	T3	
GLUCAGEN DIAGNOSTIC 1 MG VIAL	T2	
<i>lidocaine hcl/glycerin</i> (Advanced Dna Medicated Collect)	T1	
PROVOCHOLINE	T3	
TC99M SULFUR COLLOID PREP	T1	
<b>EYE DIAGNOSTIC AGENTS</b>		
<i>fluorescein sodium</i>	T1	
<i>ful-glo 1 mg oph strip</i>	T1	
FUL-GLO EYE STRIPS	T3	
<i>lissamine green</i>	T1	
<b>GASTROINTESTINAL RADIOPAQUE DIAGNOSTICS</b>		
ENTERO VU	T3	
E-Z DISK	T3	
E-Z-HD	T3	
E-Z-PAQUE	T3	
E-Z-PASTE	T3	
GASTROMARK	T3	
LIQUID E-Z PAQUE	T3	
LIQUID POLIBAR PLUS	T3	
NEULUMEX	T3	
POLIBAR ACB	T3	
READI-CAT 2	T3	
SITZMARKS	T3	
TAGITOL	T3	
VARIBAR HONEY	T3	
VARIBAR NECTAR	T3	
VARIBAR PUDDING	T3	
VARIBAR THIN HONEY	T3	
VARIBAR THIN LIQUID	T3	
<b>METABOLIC FUNCTION DIAGNOSTICS</b>		
METOPIRONE	T2	
<b>RADIOPHARMACEUTICALS ELEMENTS</b>		
INDICLOR	T3	
<b>URINARY TRACT RADIOPAQUE DIAGNOSTICS</b>		
CYSTO-CONRAY II	T3	

T1 – Typically Generics

T4 – Injectable Specialty Medications

ST – Step Therapy

HD – May require home delivery pharmacy

T2 – Typically Preferred Brands

PA – Prior Authorization

AGE – Age Requirement

PPACA – No Cost-Share Preventive Medication

T3 – Typically Non-Preferred Brands

QL – Quantity Limit

SP – Specialty Medication

CSL – Oral cancer medication subject to cost-share limits

# List of Prescription Medications

DIAGNOSTIC (Miscellaneous)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>URINARY TRACT RADIOPAQUE DIAGNOSTICS (cont.)</b>		
CYSTOGRAFIN	T3	
CYSTOGRAFIN-DILUTE	T3	
<i>diatrizoate meglumine, sodium</i> (Gastrografin)	T1	
GASTROGRAFIN ( <i>md-gastroview</i> )	T3	
<b>DIURETICS (Diuretics)</b>		
<b>ARGININE VASOPRESSIN (AVP) RECEPTOR ANTAGONISTS</b>		
SAMSCA	T3	PA SP
SAMSCA ( <i>tolvaptan</i> )	T3	PA SP
TOLVAPTAN 15 MG TABLET	T3	SP
<i>tolvaptan 30 mg tablet</i> (Samsca)	T1	SP
<b>CARBONIC ANHYDRASE INHIBITORS</b>		
<i>acetazolamide</i>	T1	HD
<i>methazolamide</i>	T1	HD
<b>LOOP DIURETICS</b>		
<i>bumetanide</i>	T1	HD
EDECIN ( <i>ethacrynic acid</i> )	T3	PA HD
<i>ethacrynic acid</i> (Edecrin)	T1	PA HD
FUROSCIX	T3	PA QL(2 KITS/30 DAYS) HD
<i>furosemide</i>	T1	HD
<i>furosemide</i> (Lasix)	T1	HD
LASIX ( <i>furosemide</i> )	T3	PA HD
<i>torseamide</i>	T1	HD
<b>POLYCYSTIC KIDNEY DISEASE AGENT, AVP RECEPTOR ANTAGONIST</b>		
JYNARQUE 15 MG TABLET	T3	SP
JYNARQUE 15 MG-15 MG TABLET	T3	PA SP
JYNARQUE 30 MG TABLET	T3	SP
JYNARQUE 30 MG-15 MG TABLET	T3	PA SP
JYNARQUE 45 MG-15 MG TABLET	T3	PA SP
JYNARQUE 60 MG-30 MG TABLET	T3	PA SP
JYNARQUE 90 MG-30 MG TABLET	T3	PA SP
<b>POTASSIUM SPARING DIURETICS</b>		
ALDACTONE ( <i>spironolactone</i> )	T3	PA HD
<i>amiloride hcl</i>	T1	HD
CAROSPIR ( <i>spironolactone</i> )	T2	PA HD
DYRENIUM ( <i>triamterene</i> )	T3	PA HD

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

T4 – Injectable 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)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>POTASSIUM SPARING DIURETICS IN COMBINATION</b>		
ALDACTAZIDE	T3	HD
ALDACTAZIDE ( <i>spironolactone-hctz</i> )	T3	HD
<i>amiloride/hydrochlorothiazide</i>	T1	HD
DYAZIDE ( <i>triamterene-hydrochlorothiazid</i> )	T3	HD
MAXZIDE ( <i>triamterene-hydrochlorothiazid</i> )	T3	HD
MAXZIDE-25 MG ( <i>triamterene-hydrochlorothiazid</i> )	T3	HD
<i>spironolact/hydrochlorothiazid</i>	T1	HD
<i>spironolactone</i> (Carospir)	T1	HD
<i>spironolact/hydrochlorothiazid</i> (Aldactazide)	T1	HD
<i>triamterene/hydrochlorothiazid</i> (Dyazide)	T1	HD
<i>triamterene/hydrochlorothiazid</i> (Maxzide)	T1	HD
<i>triamterene/hydrochlorothiazid</i> (Maxzide-25 Mg)	T1	HD
<b>THIAZIDE AND RELATED DIURETICS</b>		
<i>chlorthalidone</i>	T1	HD
DIURIL	T2	HD
<i>hydrochlorothiazide</i>	T1	HD
<i>indapamide</i>	T1	HD
<i>metolazone</i>	T1	HD
THALITONE	T3	PA HD
<b>EENT PREPS (Allergy/Nasal Sprays)</b>		
<b>NASAL ANTIHISTAMINE</b>		
<i>azelastine 0.1% (137 mcg) spray</i>	T1	HD
<i>azelastine 0.15% nasal spray</i>	T1	HD
<i>olopatadine 665 mcg nasal spray</i> (Patanase)	T1	HD
PATANASE ( <i>olopatadine hcl</i> )	T3	HD
<b>NASAL ANTIHISTAMINE AND ANTI-INFLAM. STEROID COMB.</b>		
<i>azelastine/fluticasone</i> (Dymista)	T1	HD
DYMISTA ( <i>azelastine-fluticasone</i> )	T3	ST HD
RYALTRIS	T3	PA QL (1 GM/30 DAYS) HD
<b>NASAL ANTI-INFLAMMATORY STEROIDS</b>		
BECONASE AQ	T3	ST HD
<i>flunisolide</i>	T1	HD
<i>fluticasone prop 50 mcg spray</i>	T1	HD
<i>mometasone furoate 50 mcg spray</i> (Nasonex)	T1	QL (4 bots/30 days) HD
NASONEX ( <i>mometasone furoate</i> )	T3	QL (4 bots/30 days) ST HD

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

T4 – Injectable 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 (Allergy/Nasal Sprays) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>NASAL ANTI-INFLAMMATORY STEROIDS (cont.)</b>		
OMNARIS	T3	ST HD
QNASL	T3	ST HD
QNASL CHILDREN	T3	HD
XHANCE	T3	ST HD
ZETONNA	T3	ST HD
<b>NOSE PREPARATIONS, MISCELLANEOUS (RX)</b>		
<i>ipratropium bromide</i>	T1	HD
<b>NOSE PREPARATIONS, VASOCONSTRICTORS (RX)</b>		
ADRENALIN CHLORIDE	T3	
<i>epinephrine hcl</i> (Adrenalin Chloride)	T1	

### EENT PREPS (Ear Medications)

#### EAR PREPARATIONS ANTI-INFLAMMATORY

DERMOTIC ( <i>fluocinolone acetonide oil</i> )	T3	
<i>fluocinolone acetonide oil</i> (Dermotic)	T1	

#### EAR PREPARATIONS, MISC. ANTI-INFECTIVES

<i>acetic acid</i>	T1	
<i>hydrocortisone/acetic acid</i>	T1	

### EENT PREPS (Eye Conditions)

#### ARTIFICIAL TEARS

LACRISERT	T3	
MIEBO	T3	PA QL(4 bottles/22 days)

#### EYE ANTI-INFECTIVES (RX ONLY)

BETADINE	T2	
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#### EYE ANTI-INFLAMMATORY AGENTS

ACULAR ( <i>ketorolac tromethamine</i> )	T3	PA
ACULAR LS ( <i>ketorolac tromethamine</i> )	T3	PA
ACUVAIL	T3	
ALREX	T3	
ALREX ( <i>loteprednol etabonate</i> )	T3	
<i>bromfenac sodium</i> (Bromsite)	T1	
<i>bromfenac sodium</i>	T1	
BROMSITE( <i> bromfenac sodium</i> )	T2	
<i>dexamethasone sodium phosphate</i>	T1	
<i>diclofenac 0.1% eye drops</i>	T1	
DUREZOL	T3	PA
EYSUVIS	T2	QL (8.3ML/14 DAYS)
FLAREX	T2	

T1 – Typically Generics

T4 – Injectable Specialty Medications

ST – Step Therapy

HD – May require home delivery pharmacy

T2 – Typically Preferred Brands

PA – Prior Authorization

AGE – Age Requirement

PPACA – No Cost-Share Preventive Medication

T3 – Typically Non-Preferred Brands

QL – Quantity Limit

SP – Specialty 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
<b>EYE ANTI-INFLAMMATORY AGENTS</b>		
<i>fluorometholone</i> (Fml)	T1	
<i>flurbiprofen sodium</i>	T1	
FML ( <i>fluorometholone</i> )	T3	PA
FML FORTE	T3	PA
ILEVRO	T3	
INVELTYS	T2	
<i>ketorolac 0.4% ophth solution</i> (Acular Ls)	T1	
<i>ketorolac 0.5% ophth solution</i> (Acular)	T1	
LOTEMAX 0.5% EYE DROPS	T3	PA
LOTEMAX OINTMENT ( <i>loteprednol etabonate</i> )	T3	PA
LOTEMAX SM	T3	PA
<i>loteprednol etabonate</i> (Lotemax)	T1	
MAXIDEX	T3	PA
NEVANAC	T3	PA
OMNIPRED ( <i>prednisolone acetate</i> )	T3	
PRED FORTE ( <i>prednisolone acetate</i> )	T3	PA
PRED MILD	T3	PA
<i>prednisolone acetate</i> (Pred Forte)	T1	
<i>prednisolone sodium phosphate</i>	T1	
PROLENSA	T3	
<b>EYE LOCAL ANESTHETICS</b>		
AKTEN	T3	
ALCAINE ( <i>proparacaine hcl</i> )	T3	
ALTAFLUOR BENOX ( <i>flurox</i> )	T3	
<i>benoxinate hcl/fluorescein sod</i> (Altafluor Benox)	T1	
<i>benoxinate hcl/fluorescein sod</i> (Altafluor Benox)	T3	
<i>proparacaine hcl</i> (Alcaine)	T1	
<i>proparacaine/fluorescein sod</i>	T1	
<i>proparacaine/fluorescein sod</i>	T2	
<i>tetracaine hcl</i>	T1	
TETRAVISC	T2	
TETRAVISC FORTE	T2	
<b>EYE MAST CELL STABILIZERS</b>		
ALOCRIAL	T3	PA
ALOMIDE	T3	PA
<i>cromolyn 4% eye drops</i>	T1	

T1 – Typically Generics

T4 – Injectable Specialty Medications

ST – Step Therapy

HD – May require home delivery pharmacy

T2 – Typically Preferred Brands

PA – Prior Authorization

AGE – Age Requirement

PPACA – No Cost-Share Preventive Medication

T3 – Typically Non-Preferred Brands

QL – Quantity Limit

SP – Specialty 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
<b>EYE PREPARATIONS, MISCELLANEOUS (OTC)</b>		
GELFILM	T3	
<b>EYE VASOCONSTRICTORS</b>		
<i>phenylephrine hcl</i>	T1	
UPNEEQ	T3	PA
<b>MIOTICS AND OTHER INTRAOCULAR PRESSURE REDUCERS</b>		
ALPHAGAN P ( <i>brimonidine tartrate</i> )	T3	HD
<i>apraclonidine hcl</i> (Iopidine)	T1	HD
AZOPT ( <i>brinzolamide</i> )	T3	PA HD
<i>betaxolol hcl</i>	T1	HD
BETIMOL	T3	PA HD
BETOPTIC S	T2	HD
<i>bimatoprost</i>	T1	QL (10ml/30 days) HD
<i>brimonidine tartrate</i>	T1	HD
<i>brimonidine tartrate</i> (Alphagan P)	T1	HD
<i>brinzolamide</i> (Azopt)	T1	HD
<i>carteolol hcl</i>	T1	HD
COMBIGAN	T3	PA HD
COSOPT ( <i>dorzolamide-timolol</i> )	T3	PA HD
COSOPT PF ( <i>dorzolamide-timolol</i> )	T3	PA HD
<i>dorzolamide hcl</i> (Trusopt)	T1	HD
<i>dorzolamide hcl/timolol maleate</i> (Cosopt)	T1	HD
<i>dorzolamide/timolol/pf</i> (Cosopt Pf)	T1	HD
IOPIDINE ( <i>apraclonidine hcl</i> )	T3	HD
ISOPTO CARPINE ( <i>pilocarpine hcl</i> )	T3	HD
ISTALOL ( <i>timolol maleate</i> )	T3	PA HD
IYUZEH	T3	PA QL (30 vials/30 days) HD
<i>latanoprost</i> (Xalatan)	T1	HD
<i>levobunolol hcl</i>	T1	HD
LUMIGAN	T3	PA HD
PHOSPHOLINE IODIDE	T2	HD
<i>pilocarpine hcl</i> (Isopto Carpine)	T1	HD
RHOPRESSA	T3	HD
ROCKLATAN	T3	HD
SIMBRINZA	T2	HD
<i>timolol maleate</i> (Istalol)	T1	HD

T1 – Typically Generics

T4 – Injectable Specialty Medications

ST – Step Therapy

HD – May require home delivery pharmacy

T2 – Typically Preferred Brands

PA – Prior Authorization

AGE – Age Requirement

PPACA – No Cost-Share Preventive Medication

T3 – Typically Non-Preferred Brands

QL – Quantity Limit

SP – Specialty 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
<b>MIOTICS AND OTHER INTRAOCULAR PRESSURE REDUCERS (cont.)</b>		
<i>timolol maleate</i> (Timoptic)	T1	HD
<i>timolol maleate</i> (Timoptic-xe)	T1	HD
<i>timolol maleate/pf</i> (Timoptic Ocudose)	T1	HD
TIMOPTIC ( <i>timolol maleate</i> )	T3	PA HD
TIMOPTIC OCUDOSE	T3	PA HD
TIMOPTIC OCUDOSE ( <i>timolol maleate</i> )	T3	PA HD
TIMOPTIC-XE ( <i>timolol maleate</i> )	T3	PA HD
TRAVATAN Z ( <i>travoprost</i> )	T3	PA HD
<i>travoprost</i> (Travatan Z)	T1	HD
TRUSOPT ( <i>dorzolamide hcl</i> )	T3	PA HD
VUITY	T3	PA
VYZULTA	T3	PA HD
XALATAN ( <i>latanoprost</i> )	T3	PA HD
XELPROS	T3	PA HD
ZIOPTAN 0.0015% EYE DROP ( <i>tafluprost/pf</i> )	T3	PA QL(60 DROPPERS/30 DAYS) HD
ZIOPTAN 0.0015% EYE DROPS ( <i>tafluprost/pf</i> )	T3	PA QL(60 DROPPERS/30 DAYS) HD
<b>MYDRIATICS</b>		
<i>atropine sulfate</i>	T1	HD
<i>atropine 1% eye drops</i>	T1	HD
CYCLOGYL 0.5% EYE DROPS ( <i>cyclopentolate hcl</i> )	T3	HD
CYCLOGYL 1% EYE DROPS	T3	HD
CYCLOGYL 1% EYE DROPS ( <i>cyclopentolate hcl</i> )	T3	HD
CYCLOGYL 2% EYE DROPS ( <i>cyclopentolate hcl</i> )	T2	HD
CYCLOMYDRIL	T2	HD
<i>cyclopentolate hcl</i> (Cyclogyl)	T1	HD
<i>homatropine hbr</i>	T1	HD
ISOPTO ATROPINE ( <i>atropine sulfate</i> )	T3	HD
MYDRIACYL ( <i>tropicamide</i> )	T3	HD
PAREMYD	T3	HD
<i>tropicamide</i>	T1	HD
<i>tropicamide</i> (Mydriacyl)	T1	HD
TROPICAMIDE-CYCLOPENTOLATE-PE	T3	HD
<b>OPHTHALMIC ANTI-FIBROTIC AGENTS</b>		
MITOSOL	T3	

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

T4 – Injectable 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
<b>OPHTHALMIC ANTI-INFLAMMATORY IMMUNOMODULATOR-TYPE (cont.)</b>		
CEQUA	T3	HD
RESTASIS	T2	HD
RESTASIS MULTIDOSE	T2	HD
VERKAZIA	T3	PA QL (1 box/month)
VEVYE	T3	PA HD
XIIDRA	T2	HD
<b>OPHTHALMIC CYSTINE DEPLETING AGENTS</b>		
CYSTADROPS	T3	PA QL (20ML/21 DAYS) SP
CYSTARAN	T3	PA QL (120ml/28 days) SP
<b>OPHTHALMIC HUMAN NERVE GROWTH FACTOR (HNGF)</b>		
OXERVATE	T3	PA SP HD
ELECT/CALORIC/H2O (Cholesterol Medications)		
<b>ORAL LIPID SUPPLEMENTS</b>		
DOJOLVI	T3	PA SP HD
ELECT/CALORIC/H2O (Dental Products)		
<b>FLUORIDE PREPARATIONS</b>		
CLINPRO 5000	T3	
<i>fluoride (sodium)</i> (Prevident 5000 Ortho Defense)	T1	
<i>fluoride (sodium)</i> (Prevident 5000 Plus)	T1	
<i>fluoride (sodium)</i> (Prevident 5000)	T1	
<i>fluoride (sodium)</i> (Prevident)	T1	
FLUORIDEX	T1	
FLUORIDEX SENSITIVITY RELIEF	T3	
PREVIDENT 0.2% RINSE	T2	
PREVIDENT 1.1% GEL ( <i>sodium fluoride</i> )	T3	
PREVIDENT 5000	T3	
PREVIDENT 5000 BOOSTER PLUS	T3	
PREVIDENT 5000 ENAMEL PROTECT	T3	
PREVIDENT 5000 ORTHO DEFENSE	T3	
PREVIDENT 5000 PLUS ( <i>sodium fluoride 5000 plus</i> )	T3	
PREVIDENT 5000 SENSITIVE	T3	
PREVIDENT DENTAL RINSE	T2	
<i>sodium fluoride/potassium nit</i> (Prevident 5000 Sensitive)	T1	

T1 – Typically Generics

T4 – Injectable Specialty Medications

ST – Step Therapy

HD – May require home delivery pharmacy

T2 – Typically Preferred Brands

PA – Prior Authorization

AGE – Age Requirement

PPACA – No Cost-Share Preventive Medication

T3 – Typically Non-Preferred Brands

QL – Quantity Limit

SP – Specialty Medication

CSL – Oral cancer medication subject to cost-share limits



## List of Prescription Medications

### ELECT/CALORIC/H2O (Diabetes)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>AGENTS TO TREAT HYPOGLYCEMIA (HYPERGLYCEMICS)</b>		
BAQSIMI 3 MG SPRAY ONE PACK	T2	QL(2 units/30 days)
BAQSIMI 3 MG SPRAY TWO PACK	T2	QL(2 units/30 days)
<i>diazoxide</i> (Proglycem)	T1	
GLUCAGEN 1 MG HYPOKIT	T2	QL (2 pens/30 days)
GLUCAGON 1 MG EMERGENCY KIT	T3	QL (2 pens/30 days)
<i>glucagon 1 mg emergency kit</i> (Glucagon Emergency Kit)	T1	QL (2 pens/30 days)
GVOKE HYPOPEN 1-PACK	T3	QL (2 packs/22 days)
GVOKE HYPOPEN 2-PACK	T3	QL (2 packs/22 days)
GVOKE PFS 1-PACK SYRINGE	T3	QL (2 syringes/30 days)
GVOKE PFS 2-PACK SYRINGE	T3	QL (2 syringes/30 days)
PROGLYCEM ( <i>diazoxide</i> )	T3	
ZEGALOGUE	T2	QL (2 units/23 days)

### ELECT/CALORIC/H2O (Miscellaneous)

<b>NUCLEIC ACID/NUCLEOTIDE SUPPLEMENTS</b>		
XURIDEN	T3	PA SP

### ELECT/CALORIC/H2O (Nutritional/Dietary)

<b>ELECTROLYTE DEPLETERS</b>		
AURYXIA	T3	QL (12 tabs/day)
<i>calcium acetate</i>	T1	
FOSRENOL 1,000 MG POWDER PACK	T2	PA
FOSRENOL 1,000 MG TABLET CHEW ( <i>lanthanum carbonate</i> )	T3	
FOSRENOL 500 MG TABLET CHEW ( <i>lanthanum carbonate</i> )	T3	
FOSRENOL 750 MG POWDER PACKET	T2	
FOSRENOL 750 MG TABLET CHEW ( <i>lanthanum carbonate</i> )	T3	
<i>lanthanum carbonate</i> (Fosrenol)	T1	
LOKELMA	T2	
PHOSLYRA	T3	
RENAGEL ( <i>sevelamer hcl</i> )	T3	PA
REVELA ( <i>sevelamer carbonate</i> )	T3	PA
<i>sevelamer carbonate</i> (Renvela)	T1	
<i>sevelamer hcl</i>	T1	
<i>sevelamer hcl</i> (Renagel)	T1	
<i>sodium polystyrene sulfon/sorb</i>	T1	
<i>sodium polystyrene sulfonate</i>	T1	
<i>sps 15 gm/60 ml suspension</i>	T1	
<i>sps 30 gm/120 ml enema susp</i>	T3	
XPHOZAH	T3	PA

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

## List of Prescription Medications

ELECT/CALORIC/H2O (Nutritional/Dietary)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>IODINE CONTAINING AGENTS</b>		
VELPHORO	T2	
VELTASSA	T2	
<i>potassium iodide/iodine</i>	T1	
SSKI	T1	
<b>IRON REPLACEMENT</b>		
CITRANATAL BLOOM	T3	
HEMOCYTE PLUS (mv-mins no.73/iron fum/folic)	T1	
mv-mins no.73/iron fum/folic (HemocYTE Plus)	T1	
<b>POTASSIUM REPLACEMENT</b>		
EFFER-K 10 MEQ TABLET EFF	T3	
EFFER-K 20 MEQ TABLET EFF	T3	
<i>effeR-k 25 meq tablet eff</i>	T1	
<i>klor-con 10 meq tablet (K-tab Er)</i>	T1	
<i>klor-con 10 meq tablet (K-tab Er)</i>	T3	
<i>klor-con 8 meq tablet</i>	T1	
<i>klor-con 8 meq tablet</i>	T3	
K-TAB ER ( <i>potassium chloride</i> )	T3	
POKONZA	T3	PA
<i>potassium bicarbonate/cit ac</i>	T1	
<i>potassium chloride</i>	T1	
<i>potassium chloride</i>	T2	
<i>potassium chloride</i>	T3	
<i>potassium chloride (K-tab Er)</i>	T1	
<b>Elect/Caloric/H2O (Urinary Tract Conditions)</b>		
<b>DIALYSIS SOLUTIONS</b>		
PRISMASOL	T3	
<b>URINARY PH MODIFIERS</b>		
K-PHOS NO.2	T2	HD
K-PHOS ORIGINAL	T2	HD
ORACIT	T3	HD
<i>potassium citrate (Urocit-k)</i>	T1	HD
<i>potassium citrate/citric acid</i>	T1	HD
RENACIDIN	T3	HD
UROCID-K ( <i>potassium citrate er</i> )	T3	HD
UROQID-ACID NO.2	T2	HD

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

T4 – Injectable Specialty Medications

PA – Prior Authorization

QL – Quantity Limit

ST – Step Therapy

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HD – May require home delivery pharmacy

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CSL – Oral cancer medication subject to cost-share limits

## List of Prescription Medications

GASTROINTESTINAL (Cholesterol Medications)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>LIPOTROPICS</b>		
<i>icosapent ethyl</i> (Vascepa)	T1	HD
LOVAZA ( <i>triklo</i> )	T3	PA HD
<i>omega-3 acid ethyl esters</i> (Lovaza)	T1	HD
VASCEPA	T2	PA HD
GASTROINTESTINAL (Gastrointestinal/Heartburn)		
<b>AMMONIA INHIBITORS</b>		
BUPHENYL ( <i>sodium phenylbutyrate</i> )	T3	PA SP HD
<i>lactulose</i>	T1	HD
<i>lactulose 10 gm/15 ml solution</i>	T1	HD
LITHOSTAT	T2	HD
OLPRUVA	T3	PA SP HD
PHEBURANE	T2	PA QL(8 Bottles/30 Days) SP HD
RAVICTI	T3	PA SP HD
<i>sodium phenylbutyrate</i> (Buphenyl)	T1	SP HD
<b>ANTI-CHOLINERGICS, QUATERNARY AMMONIUM</b>		
<i>chlordiazepoxide/clidinium br</i> (Librax)	T1	
CUVPOSA	T3	
DARTISLA	T3	PA
GLYCATE	T3	
<i>glycopyrrolate</i> (Glycate)	T1	PA
<i>glycopyrrolate</i> (Robinul Forte)	T1	
<i>glycopyrrolate</i> (Robinul)	T1	
LIBRAX ( <i>chlordiazepoxide-clidinium</i> )	T3	PA
<i>propantheline bromide</i>	T1	
ROBINUL ( <i>glycopyrrolate</i> )	T3	
ROBINUL FORTE ( <i>glycopyrrolate</i> )	T3	
<b>ANTI-CHOLINERGICS/ANTI-SPASMODICS</b>		
<i>dicyclomine hcl</i>	T1	
<b>ANTI-DIARRHEAL - G.I. CHLORIDE CHANNEL INHIBITORS</b>		
MYTESI	T3	
<b>ANTI-DIARRHEAL - TRYPTOPHAN HYDROXYLASE INHIBITOR</b>		
XERMELO	T3	PA SP

T1 – Typically Generics

T2 – Typically Preferred Brands

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T4 – Injectable Specialty Medications

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# List of Prescription Medications

GASTROINTESTINAL (Gastrointestinal/Heartburn)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>ANTI-DIARRHEALS</b>		
<i>diphenoxylate hcl/atropine</i>	T1	
<i>diphenoxylate hcl/atropine</i> (Lomotil)	T1	
LOMOTIL ( <i>diphenoxylate-atropine</i> )	T3	
<i>loperamide hcl</i>	T1	
MOTOFEN	T3	
<i>opium tincture</i>	T1	PA
<i>paregoric</i>	T1	
<b>ANTI-EMETIC, CANNABINOID-TYPE</b>		
<i>dronabinol</i> (Marinol)	T1	
MARINOL ( <i>dronabinol</i> )	T3	PA
SYNDROS	T3	PA
<b>ANTI-EMETIC/ANTI-VERTIGO AGENTS</b>		
AKYNZEO	T3	PA QL (4 caps/28 days)
ANZEMET	T3	PA QL (5 tabs/30 days) SP
<i>aprepitant 125 mg capsule</i>	T1	QL (4 caps/28 days)
<i>aprepitant 125-80-80 mg pack</i> (Emend)	T1	QL (12 caps/28 days)
<i>aprepitant 40 mg capsule</i>	T1	QL (1 cap/28 days)
<i>aprepitant 80 mg capsule</i> (Emend)	T1	QL (8 caps/28 days)
BONJESTA	T3	
COMPAZINE ( <i>prochlorperazine maleate</i> )	T3	
COMPAZINE ( <i>prochlorperazine</i> )	T3	
DICLEGIS ( <i>doxylamine succ-pyridoxine hcl</i> )	T3	
<i>doxylamine succinate/vit b6</i> (Diclegis)	T1	
EMEND 125 MG POWDER PACKET	T3	PA QL (12 caps/28 days)
EMEND 150 MG VIAL ( <i>fosaprepitant dimeglumine</i> )	T3	PA
EMEND 80 MG CAPSULE ( <i>aprepitant</i> )	T3	PA QL (8 caps/28 days)
EMEND TRIPACK ( <i>aprepitant</i> )	T3	PA QL (12 caps/28 days)
<i>fosaprepitant dimeglumine</i> (Emend)	T1	PA
<i>granisetron hcl</i>	T1	
<i>granisetron hcl/pf</i>	T1	
<i>ondansetron</i>	T1	
<i>ondansetron hcl</i>	T1	
<i>ondansetron hcl</i> (Zofran)	T1	
<i>ondansetron hcl/pf</i>	T1	
<i>prochlorperazine</i> (Compazine)	T1	

T1 – Typically Generics

T4 – Injectable Specialty Medications

ST – Step Therapy

HD – May require home delivery pharmacy

T2 – Typically Preferred Brands

PA – Prior Authorization

AGE – Age Requirement

PPACA – No Cost-Share Preventive Medication

T3 – Typically Non-Preferred Brands

QL – Quantity Limit

SP – Specialty Medication

CSL – Oral cancer medication subject to cost-share limits

# List of Prescription Medications

GASTROINTESTINAL (Gastrointestinal/Heartburn)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>ANTI-EMETIC/ANTI-VERTIGO AGENTS</b>		
<i>prochlorperazine maleate</i> (Compazine)	T1	
<i>promethazine hcl</i>	T1	
<i>promethazine hcl</i>	T3	
SANCUSO	T3	PA QL (4 patches/30 days)
<i>scopolamine</i> (Transderm-scop)	T1	
TIGAN ( <i>trimethobenzamide hcl</i> )	T3	
TRANSDERM-SCOP ( <i>scopolamine</i> )	T3	
<i>trimethobenzamide hcl</i> (Tigan)	T1	
VARUBI	T3	PA QL (4 tabs/28 days)
ZOFRAN 2 MG/ML VIAL ( <i>ondansetron hcl</i> )	T3	
ZOFRAN 4 MG TABLET ( <i>ondansetron hcl</i> )	T3	PA
ZOFRAN 8 MG TABLET ( <i>ondansetron hcl</i> )	T3	PA
ZUPLENZ	T3	PA QL (24 films/30 days)
<b>ANTI-ULCER PREPARATIONS</b>		
CARAFATE ( <i>sucralfate</i> )	T3	HD
CYTOTEC ( <i>misoprostol</i> )	T3	HD
<i>misoprostol</i> (Cytotec)	T1	HD
<i>sucralfate</i> (Carafate)	T1	HD
<b>ANTI-ULCER-H.PYLORI AGENTS</b>		
HELIDAC	T3	PA
<i>lansoprazole/amoxicilin/clarith</i>	T1	
OMECLAMOX-PAK	T3	PA
PYLERA	T3	PA
TALICIA	T3	PA
VOQUEZNA TRIPLE PAK	T3	PA
VOQUEZNA DUAL PAK	T3	PA
<b>BELLADONNA ALKALOIDS</b>		
DONNATAL	T3	HD
DONNATAL ( <i>phenohydro</i> )	T3	HD
<i>hyoscyamine sulfate</i>	T1	HD
<i>hyoscyamine sulfate</i> (Levbid)	T1	HD
<i>hyoscyamine sulfate</i> (Levsin)	T1	HD
<i>hyoscyamine sulfate</i> (Levsin-sl)	T1	HD
<i>hyoscyamine sulfate</i> (Nulev)	T1	HD
<i>hyoscyamine sulfate</i> (Nulev)	T3	HD

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

T4 – Injectable Specialty Medications

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# List of Prescription Medications

GASTROINTESTINAL (Gastrointestinal/Heartburn)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>BELLADONNA ALKALOIDS</b>		
LEVBIID ( <i>symax-sr</i> )	T3	HD
LEVSIN ( <i>oscimin</i> )	T3	HD
LEVSIN-SL ( <i>symax-sl</i> )	T3	HD
<i>methscopolamine bromide</i>	T1	HD
NULEV ( <i>symax</i> )	T1	HD
<i>phenobarb/hyoscy/atropine/scop</i> (Donnatal)	T1	HD
<i>phenobarb/hyoscy/atropine/scop</i> (Phenobarbital-belladonna)	T1	HD
<i>phenobarbital-belladonna elixr</i> (Donnatal)	T1	HD
<i>phenobarbital-belladonna elixr</i> (Phenobarbital-belladonna)	T1	HD
PHENOBARBITAL-BELLADONNA ELIXR ( <i>phenohytr</i> )	T3	HD
SYMAX DUOTAB	T2	HD
<b>BILE SALTS</b>		
ACTIGALL ( <i>ursodiol</i> )	T3	HD
CHENODAL	T3	SP HD
CHOLBAM	T3	PA SP HD
RELTONE	T3	PA HD
URSO ( <i>ursodiol</i> )	T3	HD
URSO FORTE ( <i>ursodiol</i> )	T3	HD
<i>ursodiol</i> (Actigall)	T1	HD
<i>ursodiol</i> (Urso Forte)	T1	HD
<i>ursodiol</i> (Urso)	T1	HD
<b>CHRONIC INFLAM. COLON DX, 5-A-SALICYLAT, RECTAL TX</b>		
CANASA ( <i>mesalamine</i> )	T3	PA
<i>mesalamine 1,000 mg supp</i> (Canasa)	T1	
<i>mesalamine 4 gm/60 ml enema</i> (Sfrowasa)	T1	
<i>mesalamine 4 gm/60 ml kit</i> (Rowasa)	T1	
ROWASA ( <i>mesalamine</i> )	T3	PA
SFROWASA ( <i>mesalamine</i> )	T3	
<b>DRUG TX-CHRONIC INFLAM. COLON DX, 5-AMINOSALICYLAT</b>		
APRISO ( <i>mesalamine er</i> )	T3	ST HD
ASACOL HD ( <i>mesalamine</i> )	T3	ST HD
AZULFIDINE ( <i>sulfasalazine dr</i> )	T3	PA HD
AZULFIDINE ( <i>sulfasalazine</i> )	T3	HD
<i>balsalazide disodium</i> (Colazal)	T1	HD
COLAZAL ( <i>balsalazide disodium</i> )	T3	ST HD
DELZICOL ( <i>mesalamine dr</i> )	T3	ST HD

T1 – Typically Generics

T4 – Injectable Specialty Medications

ST – Step Therapy

HD – May require home delivery pharmacy

T2 – Typically Preferred Brands

PA – Prior Authorization

AGE – Age Requirement

PPACA – No Cost-Share Preventive Medication

T3 – Typically Non-Preferred Brands

QL – Quantity Limit

SP – Specialty Medication

CSL – Oral cancer medication subject to cost-share limits

# List of Prescription Medications

GASTROINTESTINAL (Gastrointestinal/Heartburn)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>DRUG TX-CHRONIC INFLAM. COLON DX, 5-AMINOSALICYLAT (cont.)</b>		
DIPENTUM	T3	ST HD
LIALDA ( <i>mesalamine</i> )	T3	ST HD
<i>mesalamine</i> (Apriso)	T1	HD
<i>mesalamine</i> (Delzicol)	T1	HD
<i>mesalamine 800 mg dr tablet</i> (Asacol Hd)	T1	HD
<i>mesalamine dr 1.2 gm tablet</i> (Lialda)	T1	HD
PENTASA	T3	HD
<i>sulfasalazine</i> (Azulfidine)	T1	HD
<b>FARNESOID X RECEPTOR (FXR) AGONIST, BILE AC ANALOG</b>		
OCALIVA	T3	PA SP HD
<b>FECAL MICROBIOTA TRANSPLANTATION (FMT)</b>		
VOWST	T3	PA QL (12 caps/56 days) SP HD
<b>GASTRIC ENZYMES</b>		
SUCRAID	T3	PA SP
<b>HISTAMINE H2-RECEPTOR INHIBITORS</b>		
<i>cimetidine hcl</i>	T1	HD
<i>famotidine</i>	T1	HD
<i>famotidine</i> (Pepcid)	T1	HD
<i>nizatidine</i>	T1	HD
PEPCID ( <i>famotidine</i> )	T1	PA HD
<i>ranitidine hcl</i>	T1	HD
<b>IBS AGENTS, MIXED OPIOID RECEPTOR AGONISTS/ANTAGONISTS</b>		
VIBERZI	T2	HD
<b>IBS-C/CIC AGENTS, GUANYLATE CYCLASE-C AGONIST</b>		
LINZESS	T2	
TRULANCE	T2	
<b>ILEAL BILE ACID TRANSPORTER (IBAT) INHIBITOR</b>		
BYLVAY	T3	PA SP HD
LIVMARLI	T3	PA SP HD
<b>INTEGRIN RECEPTOR ANTAGONIST, MONOCLONAL ANTIBODY</b>		
ENTYVIO	T2	PA SP HD
ENTYVIO PEN	T4	PA QL(2 PENS/30 DAYS) SP HD
<b>INTESTINAL MOTILITY STIMULANTS</b>		
GIMOTI	T3	PA SP
<i>metoclopramide hcl</i>	T1	
<i>metoclopramide hcl</i> (Reglan)	T1	
MOTEGRITY	T3	PA
REGLAN ( <i>metoclopramide hcl</i> )	T3	

T1 – Typically Preferred Brands  
 T2 – Typically Preferred Brands  
 T3 – Typically Non-Preferred Brands  
 T4 – Injectable Specialty Medications  
 PA – Prior Authorization  
 QL – Quantity Limit  
 ST – Step Therapy  
 AGE – Age Requirement  
 SP – Specialty Medication  
 HD – May require home delivery pharmacy  
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# List of Prescription Medications

GASTROINTESTINAL (Gastrointestinal/Heartburn)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>IRRITABLE BOWEL SYND. AGENT, 5-HT4 PARTIAL AGONIST</b>		
ZELNORM	T3	PA
<b>IRRITABLE BOWEL SYNDROME AGENTS, 5-HT3 ANTAGONIST</b>		
<i>alosetron hcl</i> (Lotronex)	T1	SP HD
LOTROXEX ( <i>alosetron hcl</i> )	T3	PA SP HD
<b>LAXATIVES AND CATHARTICS</b>		
AMITIZA ( <i>lubiprostone</i> )	T3	PA
<i>bisac/nac/na/co3/kcl/peg 3350</i>	T1	PPACA
CLENPIQ	T2	PPACA
COLYTE WITH FLAVOR PACKETS ( <i>peg 3350-electrolyte</i> )	T3	PPACA
GOLYTELY ( <i>peg-3350 and electrolytes</i> )	T3	PA PPACA
KRISTALOSE	T3	PA
<i>lactulose</i>	T1	
<i>lactulose 10 gm packet</i> (Kristalose)	T1	PA
<i>lactulose 10 gm/15 ml solution</i>	T1	
<i>lactulose 20 gm/30 ml solution</i>	T1	
<i>lubiprostone</i> (Amitiza)	T1	
MOVIPREP ( <i>peg3350-sod sul-nacl-kcl-asb-c</i> )	T3	PA PPACA
NULYTELY	T3	PA PPACA
NULYTELY WITH FLAVOR PACKS ( <i>trilyte with flavor packets</i> )	T3	PA PPACA
OSMOPREP	T3	PA PPACA
<i>peg3350/sod sul/nacl/kcl/asb/c</i> (Moviprep)	T1	PPACA
<i>peg3350/sod sulf, bicarb, cl/kcl</i> (Colyte With Flavor Packets)	T1	PPACA
<i>peg3350/sod sulf, bicarb, cl/kcl</i> (Golytely)	T1	PPACA
PLENVU	T3	PA PPACA
PREPOPIK	T2	PPACA
<i>sodium chloride/na/co3/kcl/peg</i>	T1	PPACA
SUFLAVE	T2	PPACA
SUPREP	T3	PPACA
SUTAB	T2	PPACA
<b>LOCAL ANORECTAL NITRATE PREPARATIONS</b>		
<i>nitroglycerin 0.4% ointment</i>	T1	
RECTIV	T3	
<b>PANCREATIC ENZYMES</b>		
CREON	T3	PA HD
PANCREAZE	T2	HD
PERTZYE	T3	PA HD
VIOKACE	T3	HD
ZENPEP	T3	PA HD

11 – Typically Generics      14 – Injectable Specialty Medications      51 – Step Therapy      HD – may require home delivery pharmacy  
 T2 – Typically Preferred Brands      PA – Prior Authorization      AGE – Age Requirement      PPACA – No Cost-Share Preventive Medication  
 T3 – Typically Non-Preferred Brands      QL – Quantity Limit      SP – Specialty Medication      CSL – Oral cancer medication subject to cost-share limits



# List of Prescription Medications

## GASTROINTESTINAL (Gastrointestinal/Heartburn)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>PROTON-PUMP INHIBITORS</b>		
ACIPHEX ( <i>rabeprazole sodium</i> )	T3	QL (30 tabs/30 days) ST HD
ACIPHEX SPRINKLE DR 10 MG CAP	T3	QL (60 caps/30 days) HD
ACIPHEX SPRINKLE DR 5 MG CAP	T3	QL (120 caps/30 days) HD
DEXILANT DR 30 MG CAPSULE	T3	QL (2 caps/day) HD
DEXILANT DR 60 MG CAPSULE	T3	PA QL (30 caps/30 days) HD
<i>dexlansoprazole dr 30 mg cap</i>	T1	QL (2 CAPS/DAY) HD
<i>esomeprazole dr 10 mg packet</i> (Nexium)	T1	QL (4 packets/day) HD
<i>esomeprazole dr 20 mg packet</i> (Nexium)	T1	QL (2 packs/day) HD
<i>esomeprazole dr 40 mg packet</i> (Nexium)	T1	QL (1 packet/day) HD
<i>esomeprazole mag dr 20 mg cap</i> (Nexium)	T1	QL (2/day) HD
<i>esomeprazole mag dr 40 mg cap</i> (Nexium)	T1	QL (30 caps/30 days) HD
ESOMEPRAZOLE STRONTIUM	T3	QL (30 caps/30 days) HD
<i>lansoprazole dr 15 mg capsule</i> (Prevacid)	T1	QL (2 caps/day) HD
<i>lansoprazole dr 30 mg capsule</i> (Prevacid)	T1	QL (30 caps/30 days) HD
<i>lansoprazole odt 15 mg tablet</i> (Prevacid)	T1	QL (2 tabs/day) HD
<i>lansoprazole odt 30 mg tablet</i> (Prevacid)	T1	QL (30 tabs/30 days) HD
NEXIUM DR 10 MG PACKET ( <i>esomeprazole magnesium</i> )	T3	PA QL (120 packs/30 days) HD
NEXIUM DR 2.5 MG PACKET	T2	QL (480 packs/30 days) HD
NEXIUM DR 20 MG CAPSULE ( <i>esomeprazole magnesium</i> )	T3	PA QL (2 caps/day) HD
NEXIUM DR 20 MG PACKET ( <i>esomeprazole magnesium</i> )	T3	PA QL (2 packs/day) HD
NEXIUM DR 40 MG CAPSULE ( <i>esomeprazole magnesium</i> )	T3	PA QL (30 caps/30 days) HD
NEXIUM DR 40 MG PACKET ( <i>esomeprazole magnesium</i> )	T3	PA QL (30 packs/30 days) HD
NEXIUM DR 5 MG PACKET	T2	QL (240 packs/30 days) HD
<i>omeppi 20 mg-1, 100 mg capsule</i> (Zegerid)	T3	PA QL (60 caps/30 days) HD
<i>omeppi 40 mg-1, 100 mg capsule</i> (Zegerid)	T3	PA QL (30 caps/30 days) HD
<i>omeprazole dr 10 mg capsule</i>	T1	QL (4 caps/day) HD
<i>omeprazole dr 20 mg capsule</i>	T1	QL (60 caps/30 days) HD
<i>omeprazole dr 40 mg capsule</i>	T1	QL (1 cap/day) HD
<i>omeprazole-bicarb 20-1, 100 cap</i> (Zegerid)	T1	PA QL (2 caps/day) HD
<i>omeprazole-bicarb 20-1, 680 pkt</i> (Zegerid)	T1	PA QL (60 packs/30 days) HD
<i>omeprazole-bicarb 40-1, 100 cap</i> (Zegerid)	T1	PA QL (30 caps/30 days) HD
<i>omeprazole-bicarb 40-1, 680 pkt</i> (Zegerid)	T1	PA QL (30 packs/30 days) HD
<i>pantoprazole 40 mg suspension</i> (Protonix)	T1	QL (1 dose/day) HD
<i>pantoprazole sod dr 20 mg tab</i> (Protonix)	T1	QL (60 tabs/30 days) HD
<i>pantoprazole sod dr 40 mg tab</i> (Protonix)	T1	QL (1 tab/day) HD
PREVACID 15 MG SOLUTAB ( <i>lansoprazole</i> )	T3	PA QL (2 tabs/day) HD

T1 – Typically Generics

T4 – Injectable Specialty Medications

ST – Step Therapy

HD – May require home delivery pharmacy

T2 – Typically Preferred Brands

PA – Prior Authorization

AGE – Age Requirement

PPACA – No Cost-Share Preventive Medication

T3 – Typically Non-Preferred Brands

QL – Quantity Limit

SP – Specialty Medication

CSL – Oral cancer medication subject to cost-share limits

## List of Prescription Medications

### GASTROINTESTINAL (Gastrointestinal/Heartburn)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>PROTON-PUMP INHIBITORS</b>		
PREVACID 30 MG SOLUTAB ( <i>lansoprazole</i> )	T3	PA QL (30 tabs/30 days) HD
PREVACID DR 15 MG CAPSULE ( <i>lansoprazole</i> )	T3	QL (60 caps/30 days) ST HD
PREVACID DR 30 MG CAPSULE ( <i>lansoprazole</i> )	T3	QL (30 caps/30 days) ST HD
PRILOSEC DR 10 MG SUSPENSION	T3	QL (120 packs/30 days) HD
PRILOSEC DR 2.5 MG SUSPENSION	T3	QL (480 packs/30 days) HD
PROTONIX 40 MG SUSPENSION ( <i>pantoprazole sodium</i> )	T3	QL (30 packs/30 days) ST HD
PROTONIX DR 20 MG TABLET ( <i>pantoprazole sodium</i> )	T3	QL (60 tabs/30 days) ST HD
PROTONIX DR 40 MG TABLET ( <i>pantoprazole sodium</i> )	T3	QL (30 tabs/30 days) ST HD
RABEPRAZOLE DR 10 MG SPRNKL CP	T3	QL (2 caps/day) HD
<i>rabeprazole sod dr 20 mg tab</i> (Aciphex)	T1	QL (30 tabs/30 days) HD
ZEGERID 20 MG CAPSULE ( <i>omeprazole-sodium bicarbonate</i> )	T3	PA QL (60 caps/30 days) HD
ZEGERID 20 MG PACKET ( <i>omeprazole-sodium bicarbonate</i> )	T3	PA QL (60 packs/30 days) HD
ZEGERID 40 MG CAPSULE ( <i>omeprazole-sodium bicarbonate</i> )	T3	PA QL (30 caps/30 days) HD
ZEGERID 40 MG PACKET ( <i>omeprazole-sodium bicarbonate</i> )	T3	PA QL (30 packs/30 days) HD

### POTASSIUM-COMPETITIVE ACID BLOCKERS (PCABS)

VOQUEZNA	T3	PA QL(1 TAB/DAY)
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### RECTAL PREPARATIONS

ANUSOL-HC 25 MG SUPPOSITORY ( <i>hydrocortisone acetate</i> )	T3	PA
<i>hydrocortisone acetate</i>	T1	
<i>hydrocortisone acetate</i> (Anusol-hc)	T1	

### SBS - GLUCAGON-LIKE PEPTIDE-2 (GLP-2) ANALOGS

GATTEX	T4	PA SP HD
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### GASTROINTESTINAL (Pain Relief And Inflammatory Disease)

#### HEMORRHOID PREP, ANTI-INFLAM STEROID-LOCAL ANESTHET

ANA-LEX	T1	
ANALPRAM HC	T3	
ANALPRAM HC ( <i>hydrocortisone-pramoxine</i> )	T3	PA
<i>hydrocortisone/lidocaine/aloe</i>	T1	
<i>hydrocortisone/pramoxine</i> (Analpram Hc)	T1	
<i>lidocaine/hydrocortisone ac</i>	T1	
LIDOCAINE-HYDROCORTISONE	T1	
PROCORT	T3	
PROCTOFOAM-HC	T2	

#### RECTAL/LOWER BOWEL PREP., GLUCOCORT. (NON-HEMORR)

CORTENEMA ( <i>hydrocortisone</i> )	T3	
CORTIFOAM	T3	PA
<i>hydrocortisone</i> (Cortenema)	T1	
UCERIS 2 MG RECTAL FOAM	T3	PA QL (2 kits/180 days)

T1 – Typically Generics

T4 – Injectable Specialty Medications

T2 – Typically Preferred Brands

PA – Prior Authorization

AGE – Age Requirement

T3 – Typically Non-Preferred Brands

QL – Quantity Limit

SP – Specialty Medication

HD – may require home delivery pharmacy

PPACA – No Cost-Share Preventive Medication

CSL – Oral cancer medication subject to cost-share limits

# List of Prescription Medications

## HEMATOPOIETIC GROWTH FACTORS (Miscellaneous)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>HYPOXIA INDUCIBLE FACTOR PROLYL HYDROXYLASE INH.</b>		
JESDUVROQ 1 MG TABLET	T3	PA QL(1 TAB/DAY)
JESDUVROQ 2 MG TABLET	T3	PA QL(1 TAB/DAY)
JESDUVROQ 4 MG TABLET	T3	PA QL(1 TAB/DAY)
JESDUVROQ 6 MG TABLET	T3	PA QL(2 TABS/DAY)
JESDUVROQ 8 MG TABLET	T3	PA QL(3 TABS/DAY)

## HORMONES (Hormonal Agents)

### ADRENAL STEROID INHIBITORS

ISTURISA	T3	PA QL (2 TABS/DAY) SP
RECORLEV	T3	PA QL (8 tabs/day) SP

### ANDROGEN/ESTROGEN PREPS FOR FEMALE SEXUAL DYSFUNC

INTRAROSA	T3	
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### ANDROGENIC AGENTS

ANADROL-50	T2	PA
ANDRODERM	T2	PA QL (1 patch/day)
ANDROGEL 1% (25 MG/2.5 G) PKT ( <i>testosterone</i> )	T3	PA QL (150gm/30 days)
ANDROGEL 1% (50 MG/5 G) PKT ( <i>testosterone</i> )	T3	PA QL (2 packs/day)
ANDROGEL 1.62% GEL PUMP ( <i>testosterone</i> )	T3	PA QL (150gm/30 days)
ANDROGEL 1.62% (1.25G) GEL PCKT ( <i>testosterone</i> )	T3	PA QL (2 packs/day)
ANDROGEL 1.62% (2.5G) GEL PCKT ( <i>testosterone</i> )	T3	PA QL (150gm/30 days)
ANDROID ( <i>methyltestosterone</i> )	T3	
DEPO-TESTOSTERONE	T3	
DEPO-TESTOSTERONE ( <i>testosterone cypionate</i> )	T3	
FORTESTA ( <i>testosterone</i> )	T3	PA QL (120 gm/30 days)
JATENZO 158 MG CAPSULE	T3	PA QL (4 caps/day)
JATENZO 198 MG CAPSULE	T3	PA QL (4 caps/day)
JATENZO 237 MG CAPSULE	T3	PA QL (2 caps/day)
KYZATREX	T3	PA QL(2 caps/day)
METHITEST	T1	
TLANDO	T3	PA QL (4/day)
<i>methyltestosterone</i> (Testred)	T1	
NATESTO	T3	PA QL (3 bots/30 days)
<i>oxandrolone</i>	T1	PA
TESTIM ( <i>testosterone</i> )	T3	PA QL (2 tubes/day)
<i>testosterone 1% (25mg/2.5g) pk</i> (Androgel)	T1	PA QL (150gm/30 days)
<i>testosterone 1% (50 mg/5 g) pk</i> (Vogelxo)	T1	PA QL (2 packs/day)
<i>testosterone 1.62% (2.5 g) pkt</i> (Androgel)	T1	PA QL (150gm/30 days)
<i>testosterone 1.62% gel pump</i> (Androgel)	T1	PA QL (150gm/30 days)

T1 – Typically Generics

T4 – Injectable Specialty Medications

ST – Step Therapy

HD – May require home delivery pharmacy

T2 – Typically Preferred Brands

PA – Prior Authorization

AGE – Age Requirement

PPACA – No Cost-Share Preventive Medication

T3 – Typically Non-Preferred Brands

QL – Quantity Limit

SP – Specialty 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
<b>ANDROGENIC AGENTS</b>		
<i>testosterone 1.62% (1.25 g) pkt</i> (Androgel)	T1	PA QL (2 packs/day)
<i>testosterone 10 mg gel pump</i> (Fortesta)	T1	PA QL (120 gm/30 days)
TESTOSTERONE 12.5 MG/1.25 GRAM	T1	PA QL (150gm/30 days)
<i>testosterone 12.5 mg/1.25 gram</i> (Vogelxo)	T1	PA QL (150gm/30 days)
<i>testosterone 30 mg/1.5 ml pump</i>	T1	PA QL (180ml/30 days)
<i>testosterone 50 mg/5 gram gel</i> (Vogelxo)	T1	PA QL (2 tubes/day)
TESTOSTERONE 50 MG/5 GRAM PKT	T1	PA QL (2 packs/day)
TESTRED ( <i>methyltestosterone</i> )	T3	
VOGELXO 12.5 MG/1.25 GRAM PUMP	T3	PA QL (150gm/30 days)
VOGELXO 50 MG/5 GRAM GEL ( <i>testosterone</i> )	T3	PA QL (2 tubes/day)
VOGELXO 50 MG/5 GRAM GEL PACKET	T3	PA QL (2 packs/day)
XYOSTED	T3	PA QL (4 injectors/28 days)
<b>ANTI-DIURETIC AND VASOPRESSOR HORMONES</b>		
DDAVP 0.1 MG TABLET ( <i>desmopressin acetate</i> )	T3	PA HD
DDAVP 0.2 MG TABLET ( <i>desmopressin acetate</i> )	T3	PA HD
DDAVP ( <i>desmopressin acetate</i> )	T3	PA
<i>desmopressin (nonrefrigerated)</i> (Ddavp)	T1	
<i>desmopressin 0.01% solution</i>	T1	HD
<i>desmopressin 10 mcg/0.1 ml spr</i>	T1	HD
<i>desmopressin acetate 0.1 mg tb</i> (Ddavp)	T1	HD
<i>desmopressin acetate 0.2 mg tb</i> (Ddavp)	T1	HD
<i>desmopressin acetate</i> (Ddavp)	T1	
NOC DURNA	T3	PA
NOCTIVA	T3	PA
STIMATE	T2	SP
<b>ESTROGEN AND PROGESTIN COMBINATIONS</b>		
BIJUVA	T3	
<b>ESTROGEN/ANDROGEN COMBINATIONS</b>		
<i>estrogen, ester/me-testosterone</i>	T1	HD
<b>ESTROGENIC AGENTS</b>		
ACTIVELLA ( <i>mimvey lo</i> )	T3	HD
ACTIVELLA ( <i>mimvey</i> )	T3	HD
ALORA	T3	QL (16 patches/28 days) HD
CLIMARA ( <i>estradiol (once weekly)</i> )	T3	HD
CLIMARA PRO	T3	HD

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

T4 – Injectable 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

<b>HORMONES (Hormonal Agents) (cont.)</b>		
<b>Prescription Drug Name</b>	<b>Drug Tier</b>	<b>Coverage Requirements and Limits</b>
<b>ESTROGENIC AGENTS (cont.)</b>		
COMBIPATCH	T3	HD
DELESTROGEN	T3	PA HD
DELESTROGEN ( <i>estradiol valerate</i> )	T3	HD
DEPO-ESTRADIOL	T3	HD
DIVIGEL	T2	HD
ELESTRIN	T3	HD
ESTRACE ( <i>estradiol</i> )	T3	HD
<i>estradiol</i> (Climara)	T1	HD
<i>estradiol</i> (Vivelle-dot)	T1	QL (8 PATCHES/21 DAYS) HD
<i>estradiol</i> (Vivelle-dot)	T1	QL (16 patches/28 days) HD
<i>estradiol 0.5 mg tablet</i> (Estrace)	T1	HD
<i>estradiol 1 mg tablet</i> (Estrace)	T1	HD
<i>estradiol 2 mg tablet</i> (Estrace)	T1	HD
<i>estradiol valerate</i> (Delestrogen)	T1	HD
<i>estradiol/norethindrone acet</i> (Activella)	T1	HD
ESTROGEL	T3	HD
EVAMIST	T3	HD
FEMHRT ( <i>norethindron-ethinyl estradiol</i> )	T3	HD
MENEST	T3	HD
MENOSTAR	T3	QL (8 patches/28 days) HD
MINIVELLE ( <i>Jyllana</i> )	T3	QL (16 patches/28 days) HD
<i>norethind-eth estrad 0.5-2.5</i> (Femhrt)	T1	HD
<i>norethindrone ac-eth estradiol</i>	T1	HD
<i>norethindrone ac-eth estradiol</i> (Femhrt)	T1	HD
<i>norethin-eth estrad 1 mg-5 mcg</i>	T1	HD
PREFEST	T3	HD
PREMARIN	T2	HD
PREMPHASE	T2	HD
PREMPRO	T2	HD
VIVELLE-DOT ( <i>Jyllana</i> )	T3	QL (16 patches/28 days) HD
<b>ESTROGEN-PROGESTIN WITH ANTI-MINERALOCORTICOID COMB</b>		
ANGELIQ	T3	HD
<b>ESTROGEN-SELECTIVE ESTROGEN RECEPTOR MOD (SERM) COMB</b>		
DUAVEE	T2	
<b>GLUCOCORTICOIDS</b>		

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

T4 – Injectable 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
<b>GLUCOCORTICOIDS (cont)</b>		
ALKINDI SPRINKLE	T3	PA
<i>budesonide</i> (Entocort Ec)	T1	
<i>budesonide</i> (Uceris)	T1	PA QL (56 tabs/180 days)
CORTEF ( <i>hydrocortisone</i> )	T3	
<i>cortisone acetate</i>	T1	
<i>deflazacort</i> (Emflaza)	T1	PA SP HD
<i>dexamethasone</i>	T1	
<i>dexamethasone</i> (Dxevo)	T1	
<i>dexamethasone</i> (Taperdex)	T1	PA
<i>dexamethasone 0.5 mg tablet</i>	T1	
<i>dexamethasone 0.5 mg/5 ml elx</i>	T1	
<i>dexamethasone 0.5 mg/5 ml liq</i>	T1	
<i>dexamethasone 0.75 mg tablet</i>	T1	
<i>dexamethasone 1 mg tablet</i>	T1	
<i>dexamethasone 1.5 mg tablet</i>	T1	
<i>dexamethasone 10 day 1.5 mg tb</i>	T1	PA
<i>dexamethasone 13 day 1.5 mg tb</i>	T1	PA
<i>dexamethasone 2 mg tablet</i>	T1	
<i>dexamethasone 4 mg tablet</i>	T1	
<i>dexamethasone 6 day 1.5 mg tab</i> (Taperdex)	T1	PA
<i>dexamethasone 6 mg tablet</i>	T1	
DXEVO	T3	
EMFLAZA	T3	PA SP HD
EMFLAZA ( <i>deflazacort</i> )	T3	PA SP HD
ENTOCORT EC ( <i>budesonide ec</i> )	T3	
HEMADY	T3	
<i>hydrocortisone</i> (Cortef)	T1	
LOCORT	T1	
MEDROL 16 MG TABLET ( <i>methylprednisolone</i> )	T3	
MEDROL 2 MG TABLET	T2	
MEDROL 32 MG TABLET ( <i>methylprednisolone</i> )	T3	
MEDROL 4 MG DOSEPAK ( <i>methylprednisolone</i> )	T3	
MEDROL 4 MG TABLET ( <i>methylprednisolone</i> )	T3	
MEDROL 8 MG TABLET ( <i>methylprednisolone</i> )	T3	
<i>methylprednisolone</i> (Medrol)	T1	
MILLIPRED 10 MG/5 ML SOLUTION ( <i>prednisolone sodium phosphate</i> )	T3	
<i>millipred 5 mg tablet</i>	T1	

T1 – Typically Generics

T4 – Injectable Specialty Medications

ST – Step Therapy

HD – May require home delivery pharmacy

T2 – Typically Preferred Brands

PA – Prior Authorization

AGE – Age Requirement

PPACA – No Cost-Share Preventive Medication

T3 – Typically Non-Preferred Brands

QL – Quantity Limit

SP – Specialty Medication

CSL – Oral cancer medication subject to cost-share limits

# List of Prescription Medications

<b>HORMONES (Hormonal Agents)</b>		
<b>Prescription Drug Name</b>	<b>Drug Tier</b>	<b>Coverage Requirements and Limits</b>
<b>GLUCOCORTICOIDS (cont)</b>		
ORAPRED ODT ( <i>prednisolone sodium phos odt</i> )	T3	
<i>prednisolone</i>	T1	
<i>prednisolone sodium phosphate</i>	T1	
<i>prednisolone sodium phosphate</i> (Millipred)	T1	
<i>prednisolone sodium phosphate</i> (Orapred Odt)	T1	
<i>prednisone</i>	T1	
RAYOS	T3	PA
TAPERDEX	T1	PA
TARPEYO	T3	PA QL (4 caps/day) SP
UCERIS 9 MG ER TABLET ( <i>budesonide er</i> )	T3	PA QL (1 tab/day)
ZCORT	T3	PA
ZONACORT	T3	
<b>GROWTH HORMONE RELEASING HORMONE (GHRH) AND ANALOGS</b>		
EGRIFTA	T4	PA SP HD
EGRIFTA SV	T4	PA SP HD
<b>GROWTH HORMONES</b>		
GENOTROPIN	T4	PA SP HD
HUMATROPE	T4	PA SP HD
NGENLA	T3	PA SP
NORDITROPIN FLEXPRO	T4	PA SP HD
NUTROPIN AQ NUSPIN	T4	PA SP HD
OMNITROPE	T4	PA SP HD
SAIZEN	T4	PA SP HD
SAIZEN-SAIZENPREP	T4	PA SP HD
SEROSTIM	T4	PA SP HD
SKYTROFA	T4	PA SP HD
SOGROYA	T3	PA SP HD
ZOMACTON	T4	PA SP HD
<b>INSULIN-LIKE GROWTH FACTOR-I (IGF-I) HORMONES</b>		
INCRELEX	T4	PA SP HD
<b>LHRH (GNRH) AGONIST ANALOG AND PROGESTIN COMB</b>		
LUPANETA PACK	T3	PA SP HD
<b>LHRH (GNRH) AGONIST ANALOG PITUITARY SUPPRESSANTS</b>		
LUPRON DEPOT	T2	PA SP HD
SYNAREL	T3	PA SP HD
<b>LHRH (GNRH) ANTAGONIST, ESTROGEN AND PROGESTIN COMB</b>		
MYFEMBREE	T2	PA QL (24 MONTH THERAPY)
ORIAHNN	T2	PA QL (2 CAPSULES/DAY)

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

T4 – Injectable 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

<b>HORMONES (Hormonal Agents)</b>		
<b>Prescription Drug Name</b>	<b>Drug Tier</b>	<b>Coverage Requirements and Limits</b>
<b>LHRH (GNRH) ANTAGONIST, PITUITARY SUPPRESSANT AGENTS</b>		
CETROTIDE	T2	PA SP
<i>ganirelix acet 250 mcg/0.5 ml</i> (Ganirelix Acetate)	T1	PA SP
GANIRELIX ACET 250 MCG/0.5 ML ( <i>ganirelix acetate</i> )	T2	PA SP
ORILISSA 150 MG TABLET	T2	PA QL (1 tab/day)
ORILISSA 200 MG TABLET	T2	PA QL (2 tabs/day)
<b>LHRH (GNRH) AGNST PIT.SUP-CENTRAL PRECOCIOUS PUBERTY</b>		
FENSOLVI	T3	PA SP
LUPRON DEPOT-PED	T2	PA SP HD
<b>MINERALOCORTICIDS</b>		
<i>fludrocortisone acetate</i>	T1	HD
<b>OXYTOCICS</b>		
CERVIDIL	T3	
<i>methylgonovine maleate</i>	T1	
PREPIDIL	T3	
PROSTIN E2 VAGINAL SUPPOSITORY	T3	
<b>PITUITARY SUPPRESSIVE AGENTS</b>		
<i>cabergoline</i>	T1	QL (16 tabs/28 days) HD
<i>danazol</i>	T1	HD
<b>PROGESTATIONAL AGENTS</b>		
AYGESTIN ( <i>norethindrone acetate</i> )	T3	HD
CRINONE 4% GEL	T2	PA HD
DEPO-PROVERA 400 MG/ML VIAL	T3	HD
<b>PROGESTATIONAL AGENTS</b>		
<i>medroxyprogesterone 10 mg tab</i> (Provera)	T1	HD
<i>medroxyprogesterone 2.5 mg tab</i> (Provera)	T1	HD
<i>medroxyprogesterone 5 mg tab</i> (Provera)	T1	HD
<i>norethindrone acetate</i> (Aygestin)	T1	HD
<i>progesterone, micronized</i> (Prometrium)	T1	HD
PROMETRIUM ( <i>progesterone</i> )	T3	PA HD
PROVERA ( <i>medroxyprogesterone acetate</i> )	T3	HD
<b>SOMATOSTATIC AGENTS</b>		
BYNFEZIA	T4	PA SP
MYCAPSSA	T3	PA QL (4 CAPS/DAY) SP
<i>octreotide acetate</i>	T1	PA SP HD
<i>octreotide acetate</i> (Sandostatin)	T1	PA SP HD
SANDOSTATIN ( <i>octreotide acetate</i> )	T3	PA SP HD
SANDOSTATIN LAR DEPOT	T2	PA SP

T1 – Typically Generics

T4 – Injectable Specialty Medications

ST – Step Therapy

HD – May require home delivery pharmacy

T2 – Typically Preferred Brands

PA – Prior Authorization

AGE – Age Requirement

PPACA – No Cost-Share Preventive Medication

T3 – Typically Non-Preferred Brands

QL – Quantity Limit

SP – Specialty Medication

CSL – Oral cancer medication subject to cost-share limits



# List of Prescription Medications

<b>HORMONES (Hormonal Agents)</b>		
<b>Prescription Drug Name</b>	<b>Drug Tier</b>	<b>Coverage Requirements and Limits</b>
<b>SOMATOSTATIC AGENTS</b>		
SIGNIFOR	T4	PA SP
SIGNIFOR LAR	T4	PA SP
SOMATULINE DEPOT	T2	PA SP HD
<b>VAGINAL ESTROGEN FOR SEXUAL DYSFUNCTION</b>		
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 PAK	T3	QL (16/28 days) HD
IMVEXXY 4 MCG STARTER PACK	T3	QL (36/28 days) HD
<b>VAGINAL ESTROGEN PREPARATIONS</b>		
ESTRACE ( <i>estradiol</i> )	T3	HD
<i>estradiol</i> (Vagifem)	T1	QL (36 tabs/28 days) HD
<i>estradiol 0.01% cream</i> (Estrace)	T1	HD
<i>estradiol 10 mcg vaginal insrt</i> (Vagifem)	T1	QL (36 tabs/28 days) HD
ESTRING	T2	QL (2 rings/90 days) HD
FEMRING	T3	HD
PREMARIN	T2	HD
VAGIFEM ( <i>yuvafem</i> )	T3	QL (36 tabs/28 days) HD
<b>HORMONES (Infertility)</b>		
<b>FERTILITY STIMULATING PREPARATIONS, NON-FSH</b>		
<i>clomiphene citrate</i>	T1	
<b>FOLLICLE-STIMULATING AND LUTEINIZING HORMONES</b>		
MENOPUR	T2	PA SP
<b>FOLLICLE-STIMULATING HORMONE (FSH)</b>		
FOLLISTIM AQ	T2	PA SP
GONAL-F	T2	PA SP
GONAL-F RFF	T2	PA SP
GONAL-F RFF REDI-JECT	T2	PA SP
<b>HUMAN CHORIONIC GONADOTROPIN (HCG)</b>		
CHORIONIC GONAD 10,000 UNIT VL	T3	PA SP
CHORIONIC GONAD 12,000 UNIT VL	T1	SP
CHORIONIC GONAD 6,000 UNIT VL	T1	SP
NOVAREL	T2	PA SP
OVIDREL	T2	PA SP
PREGNYL	T2	PA SP

T1 – Typically Generics

T4 – Injectable Specialty Medications

ST – Step Therapy

HD – May require home delivery pharmacy

T2 – Typically Preferred Brands

PA – Prior Authorization

AGE – Age Requirement

PPACA – No Cost-Share Preventive Medication

T3 – Typically Non-Preferred Brands

QL – Quantity Limit

SP – Specialty Medication

CSL – Oral cancer medication subject to cost-share limits

# List of Prescription Medications

<b>HORMONES (Infertility)</b>		
<b>Prescription Drug Name</b>	<b>Drug Tier</b>	<b>Coverage Requirements and Limits</b>
<b>PREGNANCY FACILITATING/MAINTAINING AGENT, HORMONAL</b>		
CRINONE 8% GEL	T3	PA
ENDOMETRIN	T3	
<b>HORMONES (Miscellaneous)</b>		
<b>LEPTIN HORMONE ANALOGS</b>		
MYALEPT	T4	PA SP HD
<b>HORMONES (Osteoporosis Products)</b>		
<b>BONE FORMATION STIMULATING AGTS - PTH REL PEPTIDES</b>		
TYMLOS	T3	PA QL(1 PEN/30 DAYS) SP HD
<b>BONE RESORPTION INHIBITORS</b>		
<i>calcitonin, salmon, synthetic</i>	T1	HD
MIACALCIN	T2	HD
RECLAST 5 MG/100 ML SOLUTION	T3	
<b>IMMUNOSUPPRESSANTS (Pain Relief And Inflammatory Disease)</b>		
<b>INTERLEUKIN-4(IL-4) RECEPTOR ALPHA ANTAGONIST, MAB</b>		
DUPIXENT PEN	T4	PA SP HD
DUPIXENT SYRINGE	T4	PA SP HD
<b>INTERLEUKIN-6 (IL-6) RECEPTOR INHIBITORS</b>		
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 syringes/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 syringes/28 days) SP HD
<b>IL-23 RECEPTOR ANTAGONIST, MONOCLONAL ANTIBODY</b>		
OMVOH PEN	T4	PA QL(2 PENS/28 DAYS) SP HD
<b>MONOCLONAL ANTIBODY-HUMAN INTERLEUKIN I2/23 INHIB</b>		
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

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

T4 – Injectable 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 (Skin Conditions)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>TOPICAL IMMUNOSUPPRESSIVE AGENTS</b>		
ELIDEL ( <i>pimecrolimus</i> )	T3	
NUJO	T3	
OXIANUJI	T3	
<i>pimecrolimus</i> (Elidel)	T1	
PROTOPIC ( <i>tacrolimus</i> )	T3	
<i>tacrolimus</i> 0.03% ointment (Protopic)	T1	
<i>tacrolimus</i> 0.1% ointment (Protopic)	T1	

### IMMUNOSUPPRESSANTS (Transplant Medications)

#### IMMUNOSUPPRESSIVES

ASTAGRAF XL	T3	SP HD
AZASAN	T2	SP HD
<i>azathioprine</i> (Imuran)	T1	PA SP HD
CELLCEPT ( <i>mycophenolate mofetil</i> )	T3	SP HD
<i>cyclosporine</i> (Sandimmune)	T1	SP HD
<i>cyclosporine, modified</i>	T1	SP HD
<i>cyclosporine, modified</i> (Neoral)	T1	SP HD
ENVARUSUS XR	T3	SP HD
<i>everolimus</i> 0.25, 0.5 mg, 0.75 mg tablet (Zortress)	T1	SP HD
IMURAN ( <i>azathioprine</i> )	T3	SP HD
LUPKYNIS 7.9 MG CAPSULE	T3	PA QL (6 caps/day)
<i>mycophenolate mofetil</i> (Cellcept)	T1	SP HD
<i>mycophenolate sodium</i> (Myfortic)	T1	SP HD
MYFORTIC ( <i>mycophenolic acid</i> )	T3	SP HD
NEORAL ( <i>gengraf</i> )	T3	PA SP HD
PROGRAF	T3	SP HD
PROGRAF ( <i>tacrolimus</i> )	T3	SP HD
RAPAMUNE ( <i>sirolimus</i> )	T3	SP HD
SANDIMMUNE 100 MG CAPSULE ( <i>cyclosporine</i> )	T3	SP HD
SANDIMMUNE 100 MG/ML SOLN	T3	SP HD
SANDIMMUNE 25 MG CAPSULE ( <i>cyclosporine</i> )	T3	SP HD
<i>sirolimus</i> (Rapamune)	T1	SP HD
<i>tacrolimus</i> 0.5 mg capsule, 1 mg, 5 mg capsule (ir) (Prograf)	T1	SP HD
ZORTRESS	T3	SP HD
ZORTRESS ( <i>everolimus</i> )	T3	SP HD

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

PA – Prior Authorization  
 QL – Quantity Limit

AGE – Age Requirement  
 SP – Specialty Medication

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)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>DIABETIC SUPPLIES</b>		
CARETOUCH CONTROL SOLUTION	T1	
CEQUR SIMPLICITY	T2	
CEQUR SIMPLICITY INSERTER	T2	
DEXCOM G6 RECEIVER	T2	PA QL (1 syringe/365 days)
DEXCOM G6 SENSOR	T2	PA QL (3/30 days)
DEXCOM G6 TRANSMITTER	T2	PA QL (1 syringe/67 days)
DEXCOM G7 RECEIVER	T2	PA QL (1 UNIT/365 DAYS)
DEXCOM G7 SENSOR	T2	PA QL (3 sensors/30 days)
EASY TOUCH BLU LINK CTRL SOLN	T1	
EASY TRAK II CONTROL SOLUTION	T1	
ENLITE SERTER	T1	
FREESTYLE LIBRE 10 DAY READER	T2	PA QL (1 reader/day)
FREESTYLE LIBRE 10 DAY SENSOR	T2	PA QL (3/30 days)
FREESTYLE LIBRE 14 DAY READER	T2	PA QL (1 reader/day)
FREESTYLE LIBRE 14 DAY SENSOR	T2	PA QL (2/28 days)
FREESTYLE LIBRE 2 READER	T2	PA QL (1 reader/day)
FREESTYLE LIBRE 2 SENSOR	T2	PA QL (2 sensors/21 days)
FREESTYLE LIBRE 3 READER	T2	PA QL (1 unit/720 days)
FORA TN'GO ADVANCE MULTIFEN MTR	T3	
GLUCOCOM AUTOLINK	T1	
GUARDIAN RT CHARGER	T1	
GUARDIAN RT STARTER KIT	T1	
GUARDIAN RT SYSTEM	T1	
GUARDIAN TEST PLUG	T1	
HUMAPEN LUXURA HD	T1	
INPEN (FOR HUMALOG)	T1	
INPEN (FOR NOVOLOG OR FIASP)	T1	
NOVOPEN ECHO	T1	
MAGELLAN INSULIN SAFETY SYRNG	T1	
MAGELLAN INSULIN SYRINGE	T1	
MINIMED RESERVOIR	T1	
OMNIPOD 5 G6-G7 INTRO KT(GEN5)	T2	QL
OMNIPOD 5 G6-G7 PODS (GEN 5)	T2	QL
OMNIPOD DASH 5 PACK POD	T2	PA QL (6 boxes/30 days)
REPLACEMENT PEDIATRIC MONITOR	T1	
SEN-SERTER	T1	
V-GO 20 , V-GO 30, V-GO 40	T2	

T1 – Typically Generics

T4 – Injectable Specialty Medications

ST – Step Therapy

HD – May require home delivery pharmacy

T2 – Typically Preferred Brands

PA – Prior Authorization

AGE – Age Requirement

PPACA – No Cost-Share Preventive Medication

T3 – Typically Non-Preferred Brands

QL – Quantity Limit

SP – Specialty Medication

CSL – Oral cancer medication subject to cost-share limits

# List of Prescription Medications

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

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>DURABLE MEDICAL EQUIPMENT,MISC(GROUP I)</b>		
1ST TIER UNILET COMFORTOUCH	T1	
2-IN-1 LANCET DEVICE	T1	
ACCU-CHEK FASTCLIX LANCET DRUM	T1	
ACCU-CHEK SAFE-T-PRO	T1	
ACCU-CHEK SAFE-T-PRO PLUS	T1	
ACCU-CHEK SOFTCLIX	T1	
ACTI-LANCE	T1	
ADVANCED TRAVEL LANCETS	T1	
ADVOCATE LANCET	T1	
ADVOCATE LANCETS	T1	
ALTERNATE SITE LANCETS	T1	
ASSURE HAEMOLANCE PLUS	T1	
ASSURE LANCE	T1	
ASSURE LANCE PLUS	T1	
BD MICROTAINER LANCETS	T1	
BD ULTRA-FINE	T1	
BD ULTRA-FINE II	T1	
BLOOD LANCETS	T1	
BULLSEYE MINI SAFETY LANCETS	T1	
BUTTERFLY TOUCH LANCET	T1	
CAREONE	T1	
CARESENS LANCET	T1	
CARETOUCH	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	

T1 – Typically Generics

T4 – Injectable Specialty Medications

ST – Step Therapy

HD – May require home delivery pharmacy

T2 – Typically Preferred Brands

PA – Prior Authorization

AGE – Age Requirement

PPACA – No Cost-Share Preventive Medication

T3 – Typically Non-Preferred Brands

QL – Quantity Limit

SP – Specialty Medication

CSL – Oral cancer medication subject to cost-share limits

## List of Prescription Medications

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

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>DURABLE MEDICAL EQUIPMENT,MISC(GROUP I) (cont.)</b>		
EZ-LETS	T1	
FIFTY50 SAFETY SEAL LANCETS	T1	
FINE 30 UNIVERSAL LANCETS	T1	
FINGERSTIX	T1	
FORA LANCETS	T1	
FORACARE LANCETS	T1	
FREESTYLE LANCETS	T1	
FREESTYLE UNISTIK 2	T1	
GLUCOCOM	T1	
GLUCOCOM LANCETS	T1	
GOJJI LANCETS	T1	
HEALTHY ACCENTS UNILET LANCET	T1	
INCONTROL SUPER THIN LANCETS	T1	
INCONTROL ULTRA THIN LANCETS	T1	
INJECT EASE LANCETS	T1	
INVACARE LANCETS	T1	
<i>lancets</i>	T1	
LANCETS	T1	
LANCETS THIN	T1	
LANCETS ULTRA THIN	T1	
LITE TOUCH	T1	
MEDISENSE THIN LANCETS	T1	
MEDLANCE PLUS	T1	
MICRO THIN LANCET	T1	
MICRO THIN LANCETS	T1	
MICROLET	T1	
MOBILE LANCETS	T1	
MONOLET LANCETS	T1	
MONOLET THIN LANCETS	T1	
MYGLUCOHEALTH LANCETS	T1	
NOVA SAFETY LANCETS	T1	
NOVA SUREFLEX	T1	
ON CALL LANCET	T1	
ON CALL PLUS LANCET	T1	
ONETOUCH DELICA PLUS LANCET	T1	
ONETOUCH DELICA SAFETY LANCET	T1	
ONETOUCH LANCETS	T1	

T1 – Typically Generics

T4 – Injectable Specialty Medications

ST – Step Therapy

HD – May require home delivery pharmacy

T2 – Typically Preferred Brands

PA – Prior Authorization

AGE – Age Requirement

PPACA – No Cost-Share Preventive Medication

T3 – Typically Non-Preferred Brands

QL – Quantity Limit

SP – Specialty Medication

CSL – Oral cancer medication subject to cost-share limits

## List of Prescription Medications

MISCELLANEOUS MEDICAL SUPPLIES, DEVICES, NON-DRUG (Diabetes)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>DURABLE MEDICAL EQUIPMENT,MISC(GROUP I) (cont.)</b>		
ONETOUCH SURESOFT	T1	
ONETOUCH ULTRASOFT 2 LANCET	T1	
ON-THE-GO	T1	
PIP LANCET	T1	
PRESSURE ACTIVATED LANCETS	T1	
PRO COMFORT LANCET	T1	
PRO COMFORT LANCETS	T1	
PRO COMFORT SAFETY LANCET	T1	
PRODIGY LANCETS	T1	
PRODIGY TWIST TOP LANCET	T1	
PURE COMFORT LANCETS	T1	
PURE COMFORT SAFETY LANCETS	T1	
PUSH BUTTON SAFETY LANCETS	T1	
READYLANCER SAFETY LANCETS	T1	
RELIAMED	T1	
RELIAMED SAFETY SEAL LANCETS	T1	
RELION THIN	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	
SOFT TOUCH	T1	
SOLUS V2	T1	
SOLUS V2 LANCETS	T1	
STERILANCETL	T1	
STERILE LANCETS	T1	
SUPER THIN LANCETS	T1	
SURE COMFORT LANCETS	T1	
SURE-LANCE	T1	
SURE-TOUCH	T1	
TECHLITE LANCETS	T1	

T1 – Typically Generics

T4 – Injectable Specialty Medications

ST – Step Therapy

HD – May require home delivery pharmacy

T2 – Typically Preferred Brands

PA – Prior Authorization

AGE – Age Requirement

PPACA – No Cost-Share Preventive Medication

T3 – Typically Non-Preferred Brands

QL – Quantity Limit

SP – Specialty Medication

CSL – Oral cancer medication subject to cost-share limits

## List of Prescription Medications

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

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>DURABLE MEDICAL EQUIPMENT,MISC(GROUP I) (cont.)</b>		
TELCARE ULTRA THIN 30G LANCETS	T1	
THIN LANCETS	T1	
TOPCARE UNIVERSAL1 LANCET	T1	
TOPCARE UNIVERSAL1 THIN LANCET	T1	
TRUE COMFORT LANCET	T1	
TRUE COMFORT SAFETY LANCET	T1	
TRUEPLUS LANCET	T1	
TRUEPLUS LANCETS	T1	
TWIST LANCETS	T1	
TWIST TOP LANCET	T1	
ULTILET BASIC	T1	
ULTILET CLASSIC	T1	
ULTILET LANCETS	T1	
ULTILET SAFETY	T1	
ULTRA THIN LANCET	T1	
ULTRA THIN LANCETS	T1	
ULTRA THIN PLUS	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	

T1 – Typically Generics

T4 – Injectable Specialty Medications

ST – Step Therapy

HD – May require home delivery pharmacy

T2 – Typically Preferred Brands

PA – Prior Authorization

AGE – Age Requirement

PPACA – No Cost-Share Preventive Medication

T3 – Typically Non-Preferred Brands

QL – Quantity Limit

SP – Specialty Medication

CSL – Oral cancer medication subject to cost-share limits



# List of Prescription Medications

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

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>DURABLE MEDICAL EQUIPMENT,MISC(GROUP I) (cont.)</b>		
UNISTIK COMFORT	T1	
UNISTIK CZT	T1	
UNISTIK EXTRA	T1	
UNISTIK NORMAL	T1	
UNISTIK PRO	T1	
UNISTIK SAFETY	T1	
UNISTIK TOUCH	T1	
UNIVERSAL 1	T1	
VERIFINE SAFETY LANCET MINI	T1	
VERIFINE UNIVERSAL LANCET	T1	
VIVAGUARD LANCET	T1	
UNISTIK 2 COMFORT	T1	
UNISTIK 2 EXTRA	T1	
UNISTIK 2 NORMAL	T1	
UNISTIK 3 COMFORT	T1	
UNISTIK 3 DUAL	T1	
<b>NEEDLES/NEEDLELESS DEVICES</b>		
1ST TIER UNIFINE PENTIPS	T1	PA
1ST TIER UNIFINE PENTIPS PLUS	T1	PA
ABOUTIME PEN NEEDLE	T1	PA
ADVOCATE PEN NEEDLE	T1	PA
ADVOCATE PEN NEEDLES	T1	PA
AQINJECT PEN NEEDLE	T1	PA
ASSURE ID DUO PRO SFTY PEN NDL	T1	PA
ASSURE ID PEN NEEDLE	T1	PA
ASSURE ID PRO PEN NEEDLE	T1	PA
BD NEEDLES 21GX1"	T1	
BD NEEDLES 21GX1.5"	T1	
BD NEEDLES 22GX1"	T1	
BD NEEDLES 25GX0.875"	T1	
CAREFINE PEN NEEDLE	T1	PA
CAREPOINT PRECISION NEEDLE	T1	
CARETOUCH PEN NEEDLE	T1	PA
CLICKFINE	T1	PA
COMFORT EZ PEN NEEDLE	T1	PA

T1 – Typically Generics

T4 – Injectable Specialty Medications

ST – Step Therapy

HD – May require home delivery pharmacy

T2 – Typically Preferred Brands

PA – Prior Authorization

AGE – Age Requirement

PPACA – No Cost-Share Preventive Medication

T3 – Typically Non-Preferred Brands

QL – Quantity Limit

SP – Specialty Medication

CSL – Oral cancer medication subject to cost-share limits

## List of Prescription Medications

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

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>NEEDLES/NEEDLELESS DEVICES</b>		
COMFORT EZ PRO SAFETY PEN NDL	T1	PA
COMFORT TOUCH PEN NEEDLE	T1	PA
DROPLET MICRON PEN NEEDLE	T1	PA
DROPLET PEN NEEDLE	T1	PA
DROPSAFE PEN NEEDLE	T1	PA
EASY COMFORT PEN NEEDLE	T1	PA
EASY COMFORT PEN NEEDLES	T1	PA
EASY COMFORT SAFETY PEN NEEDLE	T1	PA
EASY GLIDE PEN NEEDLE	T1	PA
EASY TOUCH PEN NEEDLE	T1	PA
EASY TOUCH SAFETY PEN NEEDLE	T1	PA
EMBRACE PEN NEEDLE	T1	PA
HEALTHWISE PEN NEEDLE	T1	PA
HEALTHY ACCENTS UNIFINE PENTIP	T1	PA
INCONTROL PEN NEEDLE	T1	PA
INSULIN PEN NEEDLE	T1	PA
INSUPEN	T1	PA
INSUPEN PEN NEEDLE	T1	PA
LITE TOUCH 31GX1/4" PEN NEEDLE	T1	PA
LITE TOUCH PEN NEEDLE 29G	T1	PA
LITE TOUCH PEN NEEDLE 31G	T1	PA
MAXICOMFORT II PEN NEEDLE	T1	PA
MAXICOMFORT SAFETY PEN NEEDLE	T1	PA
MICRODOT INSULIN PEN NEEDLE	T1	PA
MINI PEN NEEDLE	T1	PA
MINI ULTRA-THIN II	T1	PA
NOVOFINE 32	T1	PA
NOVOFINE AUTOCOVER	T1	PA
NOVOFINE PLUS	T1	PA
NOVOTWIST	T1	PA
PEN NEEDLE	T1	PA
PEN NEEDLES	T1	PA
PENTIPS	T1	PA
PIP PEN NEEDLE	T1	PA
PREVENT DROPSAFE PEN NEEDLE	T1	PA
PRO COMFORT PEN NEEDLE	T1	PA
PURE COMFORT PEN NEEDLE	T1	PA

T1 – Typically Generics

T4 – Injectable Specialty Medications

ST – Step Therapy

HD – May require home delivery pharmacy

T2 – Typically Preferred Brands

PA – Prior Authorization

AGE – Age Requirement

PPACA – No Cost-Share Preventive Medication

T3 – Typically Non-Preferred Brands

QL – Quantity Limit

SP – Specialty Medication

CSL – Oral cancer medication subject to cost-share limits

## List of Prescription Medications

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

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>NEEDLES/NEEDLELESS DEVICES</b>		
PURE COMFORT SAFETY PEN NEEDLE	T1	PA
RAYA SURE PEN NEEDLE	T1	PA
RELI ON 31G X 1/4" NEEDLES	T1	PA
RELION PEN NEEDLES	T1	PA
SAFETY PEN NEEDLE	T1	PA
SECURESAFE PEN NEEDLE	T1	PA
SKY SAFETY PEN NEEDLE	T1	PA
SURE COMFORT 30G PEN NEEDLE	T1	PA
SURE COMFORT PEN ND 29GX1/2"	T1	PA
SURE COMFORT PEN NEEDLE	T1	PA
SURE COMFORT SAFETY PEN NEEDLE	T1	PA
SURE-FINE PEN NEEDLES	T1	PA
TECHLITE PEN NEEDLE	T1	PA
TOPCARE CLICKFINE	T1	PA
TRUE COMFORT PEN NEEDLE	T1	PA
TRUE COMFORT PRO PEN NEEDLE	T1	PA
TRUE COMFORT SAFETY PEN NEEDLE	T1	PA
TRUEPLUS PEN NEEDLE	T1	PA
ULTICARE PEN NEEDLE	T1	PA
ULTICARE SAFETY PEN NEEDLE	T1	PA
ULTIGUARD SAFEPACK-PEN NEEDLE	T1	PA
ULTILET PEN NEEDLE	T1	PA
ULTRA FLO PEN NEEDLE	T1	PA
ULTRA THIN	T1	PA
ULTRACARE PEN NEEDLE	T1	PA
ULTRA-THIN II PEN ND 29GX1/2"	T1	PA
ULTRA-THIN II PEN ND 31GX5/16	T1	PA
UNIFINE PEN NEEDLE	T1	PA
UNIFINE PENTIPS	T1	PA
UNIFINE PENTIPS MAXFLOW	T1	PA
UNIFINE PENTIPS PLUS	T1	PA
UNIFINE PENTIPS PLUS MAXFLOW	T1	PA
UNIFINE PROTECT	T1	PA
UNIFINE SAFECONTROL	T1	PA
UNIFINE ULTRA PEN NEEDLE	T1	PA
VERIFINE PEN NEEDLE	T1	PA
VERIFINE PLUS PEN NEEDLE	T1	PA
VERIFINE PLUS PEN NEEDLE-SHARP	T1	PA

T1 – Typically Generics

T4 – Injectable Specialty Medications

ST – Step Therapy

HD – May require home delivery pharmacy

T2 – Typically Preferred Brands

PA – Prior Authorization

AGE – Age Requirement

PPACA – No Cost-Share Preventive Medication

T3 – Typically Non-Preferred Brands

QL – Quantity Limit

SP – Specialty Medication

CSL – Oral cancer medication subject to cost-share limits

## List of Prescription Medications

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

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>SYRINGES AND ACCESSORIES</b>		
LITE TOUCH INSULIN 0.5 ML SYR	T1	
LITE TOUCH INSULIN 1 ML SYR	T1	
LITE TOUCH INSULIN SYR 0.3 ML	T1	
LITE TOUCH INSULIN SYR 0.5 ML	T1	
LITE TOUCH INSULIN SYR 1 ML	T1	
SURE COMFORT 0.3 ML SYRINGE	T1	
SURE COMFORT 0.5 ML SYRINGE	T1	
SURE COMFORT 1 ML SYRINGE	T1	
SURE COMFORT 3/10 ML SYRINGE	T1	
ULTRA-THIN II 1 ML 31GX5/16"	T1	
ULTRA-THIN II INS 0.3 ML 30G	T1	
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	

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

#### RESPIRATORY AIDS, DEVICES, EQUIPMENT

ACE AEROSOL CLOUD ENHANCER	T2	QL (1 unit/year)
AEROCHAMBER MINI	T2	QL (1 unit/year)
AEROCHAMBER MV	T2	QL (1 unit/year)
AEROCHAMBER PLUS FLOW-VU	T2	QL (1 unit/year)
AEROCHAMBER WITH FLOWSIGNAL	T2	QL (1 unit/year)
AEROCHAMBER Z-STAT PLUS	T2	QL (1 unit/year)
AEROTRACH PLUS	T2	QL (1 unit/year)
AEROVENT PLUS	T2	QL (1 unit/year)
BREATHERITE	T2	QL (1 unit/year)
BREATHERITE SPACER-ADULT MASK	T2	QL (1 unit/year)
BREATHERITE SPACER-INFANT MASK	T2	QL (1 unit/year)
BREATHERITE SPACER-LARGE MASK	T2	QL (1 MASK/365 DAYS)
BREATHERITE SPACER-LG CHLD MSK	T2	QL (1 unit/year)
BREATHERITE SPACER-MEDIUM MASK	T2	QL (1 MASK/365 DAYS)
BREATHERITE SPACER-NEONATE MSK	T2	QL (1 unit/year)
BREATHERITE SPACER-SM CHLD MSK	T2	QL (1 unit/year)

T1 – Typically Generics

T4 – Injectable Specialty Medications

ST – Step Therapy

HD – May require home delivery pharmacy

T2 – Typically Preferred Brands

PA – Prior Authorization

AGE – Age Requirement

PPACA – No Cost-Share Preventive Medication

T3 – Typically Non-Preferred Brands

QL – Quantity Limit

SP – Specialty 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
<b>RESPIRATORY AIDS, DEVICES, EQUIPMENT</b>		
BREATHRITE SPACER-SMALL MASK	T2	QL (1 MASK/365 DAYS)
BREATHRITE	T2	QL (1 unit/year)
CLEVER CHOICE HOLDING CHAMBER	T2	QL (1 unit/year)
COMFORTSEAL	T2	QL
COMPACT SPACE CHAMBER	T2	QL (1 unit/year)
EASIVENT	T2	QL (1 unit/year)
E-Z SPACER	T2	QL (1 unit/year)
FLEXICHAMBER	T2	QL (1 unit/year)
FLEXICHAMBER MASK	T2	QL (1 unit/year)
INSPIRACHAMBER	T2	QL (1 unit/year)
LITEAIRE	T2	QL (1 unit/year)
LITETOUCH	T2	QL (1 unit/year)
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	T2	QL (1 unit/year)
SPACE CHAMBER-LARGE MASK	T2	QL (1 unit/year)
SPACE CHAMBER-MEDIUM MASK	T2	QL (1 unit/year)
SPACE CHAMBER-SMALL MASK	T2	QL (1 unit/year)
VORTEX	T2	QL (1 unit/year)
VORTEX HOLDING CHAMBER-CHILD	T2	QL (1 unit/year)
VORTEX HOLDING CHAMBER-TODDLER	T2	QL (1 unit/year)
VORTEX VHC FROG MASK	T2	QL (1 unit/year)
VORTEX VHC LADYBUG MASK	T2	QL (1 unit/year)

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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
<b>SKELLETAL MUSCLE RELAXANTS (cont.)</b>		
AMRIX ER 15 MG CAPSULE ( <i>cyclobenzaprine hcl er</i> )	T3	PA QL (1 cap/day)
AMRIX ER 30 MG CAPSULE ( <i>cyclobenzaprine hcl er</i> )	T3	PA
<i>baclofen</i>	T1	
<i>baclofen 5 mg, 10 mg, 20 mg tablet</i>	T1	HD
<i>baclofen 25 mg/5 ml suspension (Fleqsuvy)</i>	T1	PA HD
BACLOFEN 5 MG/5 ML SOLUTION	T3	PA HD
BACLOFEN 10 MG/5 ML SOLUTION	T3	PA HD
<i>carisoprodol (Soma)</i>	T1	
<i>carisoprodol/aspirin</i>	T1	
<i>chlorzoxazone 250 mg tablet</i>	T1	PA
<i>chlorzoxazone 500 mg tablet</i>	T1	
<i>chlorzoxazone 250 mg, 375 mg, 750 mg tablet (Lorzone)</i>	T1	PA
<i>cyclobenzaprine er 15 mg cap (Amrix)</i>	T1	PA QL (1 cap/day)
<i>cyclobenzaprine er 30 mg cap (Amrix)</i>	T1	PA
<i>cyclobenzaprine hcl</i>	T1	
<i>cyclobenzaprine hcl (Fexmid)</i>	T1	
DANTRIUM ( <i>dantrolene sodium</i> )	T3	
<i>dantrolene sodium</i>	T1	
<i>dantrolene sodium (Dantrium)</i>	T1	
FEXMID ( <i>cyclobenzaprine hcl</i> )	T3	
FLEQSUVY ( <i>baclofen</i> )	T3	PA HD
LORZONE ( <i>chlorzoxazone</i> )	T3	PA
LYVISPAH	T3	PA
<i>metaxalone (Skelaxin)</i>	T1	
<i>methocarbamol</i>	T1	
<i>methocarbamol (Robaxin-750)</i>	T1	
NORGESIC FORTE	T3	PA
<i>orphenadrine citrate</i>	T1	
<i>orphenadrine/aspirin/caffeine (Norgesic Forte)</i>	T1	PA
OZOBAX	T3	PA HD
OZOBAX DS	T3	PA HD
ROBAXIN-750 ( <i>methocarbamol</i> )	T3	
SKELAXIN ( <i>metaxalone</i> )	T3	
SOMA ( <i>carisoprodol</i> )	T3	
SOMA ( <i>vanadom</i> )	T3	
<i>tizanidine hcl</i>	T1	PA
<i>tizanidine hcl (Zanaflex)</i>	T1	PA
ZANAFLEX ( <i>tizanidine hcl</i> )	T3	

13 – Typically Non-Preferred Brands QL – Quantity Limit

SP – Specialty 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
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#### SKELETAL MUSCLE RELAXANTS (cont.)

<i>tizanidine hcl</i> (Zanaflex)	T1	PA
ZANAFLEX ( <i>tizanidine hcl</i> )	T3	

### PRE-NATAL VITAMINS (Nutritional/Dietary)

#### PRENATAL VITAMIN PREPARATIONS

ATABEX EC	T2	
CITRANATAL 90 DHA	T2	
CITRANATAL ASSURE	T2	
CITRANATAL DHA	T2	
CITRANATAL HARMONY	T2	
CITRANATAL RX	T2	
OBSTETRIX EC	T2	
OBTREX DHA	T2	
<i>pnv 22/iron, gluc/folic/dss/dha</i>	T1	
<i>pnv 66/iron/folic/docusate/dha</i>	T1	
<i>pnv 69/iron/folic/docusate/dha</i>	T1	
<i>pnv 80/iron fum/folic/dss/dha</i>	T1	
<i>pnv/ferrous fum/docusate/folic</i>	T1	
<i>pnv/iron, carb/docusat/folic ac</i>	T1	
<i>prenatal 12/iron/folic/dss/om3</i> (Obtrex Dha)	T1	
PRENATAL 19	T1	
<i>prenatal 34/iron/folic/dss/dha</i>	T1	
<i>prenatal vits 15/iron/folic/dss</i>	T1	
VITAFOL FE+	T2	

### PSYCHOTHERAPEUTIC DRUGS (Anxiety/Depression/Bipolar Disorder)<sup>8</sup>

#### ALPHA-2 RECEPTOR ANTAGONIST ANTI-DEPRESSANTS

<i>mirtazapine</i>	T1	HD
<i>mirtazapine</i> (Remeron)	T1	HD
QELBREE	T3	PA QL
REMERON ( <i>mirtazapine</i> )	T3	PA HD

#### ANTI-ANXIETY - BENZODIAZEPINES

<i>alprazolam</i>	T1	
<i>alprazolam</i> (Xanax Xr)	T1	
<i>alprazolam</i> (Xanax)	T1	
ATIVAN ( <i>lorazepam</i> )	T3	PA
<i>chlordiazepoxide hcl</i>	T1	
<i>clorazepate dipotassium</i>	T1	
<i>clorazepate dipotassium</i> (Tranxene T-tab)	T1	
<i>diazepam 10 mg tablet</i> (Valium)	T1	

T3 – Typically Non-Preferred Brands QL – Quantity Limit

SP – Specialty Medication

CSL – Oral cancer medication subject to cost-share limits

## List of Prescription Medications

PSYCHOTHERAPEUTIC DRUGS (Anxiety/Depression/Bipolar Disorder) <sup>8</sup>		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>ANTI-ANXIETY - BENZODIAZEPINES (con't.)</b>		
<i>diazepam 2 mg tablet (Valium)</i>	T1	
<i>diazepam 5 mg tablet (Valium)</i>	T1	
<i>diazepam 5 mg/5 ml solution</i>	T1	
<i>diazepam 5 mg/ml oral conc</i>	T1	
<i>lorazepam</i>	T1	
<i>lorazepam (Ativan)</i>	T1	
LOREEV XR	T3	PA QL (30 tabs/30 days) SP
<i>oxazepam</i>	T1	
TRANXENE T-TAB ( <i>clorazepate dipotassium</i> )	T3	PA
VALIUM ( <i>diazepam</i> )	T3	
XANAX ( <i>alprazolam</i> )	T3	
XANAX XR ( <i>alprazolam xr</i> )	T3	
<b>ANTI-ANXIETY DRUGS</b>		
<i>bupirone hcl 10 mg tablet</i>	T1	HD
<i>bupirone hcl 15 mg tablet</i>	T1	
<i>bupirone hcl 15 mg tablet</i>	T1	HD
<i>bupirone hcl 30 mg tablet</i>	T1	HD
<i>bupirone hcl 5 mg tablet</i>	T1	HD
<i>bupirone hcl 7.5 mg tablet</i>	T1	HD
<i>meprobamate</i>	T1	
SPRAVATO	T3	PA SP
<b>ANTIDEPRESSANT- POSTPARTUM DEPRESSION (PPD)</b>		
ZURZUVAE 20 MG CAPSULE	T3	PA QL(28 caps/270 days) SP HD
ZURZUVAE 25 MG CAPSULE	T3	PA QL(28 caps/270 days) SP HD
ZURZUVAE 30 MG CAPSULE	T3	PA QL(14 caps/270 days) SP HD
<b>BIPOLAR DISORDER DRUGS</b>		
EQUETRO	T3	HD
<i>lithium carbonate</i>	T1	HD
<i>lithium carbonate (Lithobid)</i>	T1	HD
<i>lithium citrate</i>	T1	HD
LITHOBID ( <i>lithium carbonate er</i> )	T3	PA HD
<b>MAOIS -NON-SELECTIVE, IRREVERSIBLE ANTI-DEPRESSANTS</b>		
MARPLAN	T3	QL (12 tabs/day)
NARDIL ( <i>phenelzine sulfate</i> )	T3	PA
PARNATE ( <i>tranylcypromine sulfate</i> )	T3	PA
<i>phenelzine sulfate (Nardil)</i>	T1	
<i>tranylcypromine sulfate (Parnate)</i>	T1	

T1 – Typically Generics

T4 – Injectable Specialty Medications

ST – Step Therapy

HD – May require home delivery pharmacy

T2 – Typically Preferred Brands

PA – Prior Authorization

AGE – Age Requirement

PPACA – No Cost-Share Preventive Medication

T3 – Typically Non-Preferred Brands

QL – Quantity Limit

SP – Specialty Medication

CSL – Oral cancer medication subject to cost-share limits



# List of Prescription Medications

## PSYCHOTHERAPEUTIC DRUGS (Anxiety/Depression/Bipolar Disorder)<sup>8</sup>

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>MONOAMINE OXIDASE (MAO) INHIBITOR ANTI-DEPRESSANTS</b>		
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)
<b>NDMA RECEPTOR ANTAGONIST AND NDRI COMB</b>		
AUVELITY	T3	PA QL(60 tabs/30 days)
<b>NOREPINEPHRINE AND DOPAMINE REUPTAKE INHIB (NDRIs)</b>		
APLENZIN ER 174 MG TABLET	T3	PA QL (3 tabs/day) HD
APLENZIN ER 348 MG TABLET	T3	PA QL (1 tab/day) HD
APLENZIN ER 522 MG TABLET	T3	PA QL (1 tab/day) HD
<i>bupropion hcl 100 mg tablet</i>	T1	QL (4 tabs/day) HD
<i>bupropion hcl 75 mg tablet</i>	T1	QL (6 tabs/day) HD
<i>bupropion hcl sr 100 mg tablet (Wellbutrin Sr)</i>	T1	QL (4 tabs/day) HD
<i>bupropion hcl sr 150 mg tablet (Wellbutrin Sr)</i>	T1	QL (2 tabs/day) HD
<i>bupropion hcl sr 200 mg tablet (Wellbutrin Sr)</i>	T1	QL (2 tabs/day) HD
<i>bupropion hcl xl 150 mg tablet (Wellbutrin XL)</i>	T1	QL (3 tabs/day) HD
<i>bupropion hcl xl 300 mg tablet (Wellbutrin XL)</i>	T1	QL (1 tab/day) HD
BUPROPION HCL XL 450 MG TABLET	T3	PA QL (1 tab/day) HD
FORFIVO XL	T3	PA QL (1 tab/day) HD
WELLBUTRIN SR 100 MG TABLET ( <i>bupropion hcl sr</i> )	T3	PA QL (4 tabs/day) HD
WELLBUTRIN SR 150 MG TABLET ( <i>bupropion hcl sr</i> )	T3	PA QL (2 tabs/day) HD
WELLBUTRIN SR 200 MG TABLET ( <i>bupropion hcl sr</i> )	T3	PA QL (2 tabs/day) HD
WELLBUTRIN XL 150 MG TABLET ( <i>bupropion xl</i> )	T3	PA QL (3 tabs/day) HD
WELLBUTRIN XL 300 MG TABLET ( <i>bupropion xl</i> )	T3	PA QL (1 tab/day) HD
<b>SELECTIVE SEROTONIN 5-HT<sub>2A</sub> INVERSE AGONISTS (SSiAs)</b>		
NUPLAZID	T3	PA SP HD
<b>SELECTIVE SEROTONIN REUPTAKE INHIBITOR (SSRIs)</b>		
CELEXA 10 MG TABLET ( <i>citalopram hbr</i> )	T3	PA QL (6 tabs/day) HD
CELEXA 20 MG TABLET ( <i>citalopram hbr</i> )	T3	PA QL (3 tabs/day) HD
CELEXA 40 MG TABLET ( <i>citalopram hbr</i> )	T3	PA QL (1 tab/day) HD
<i>citalopram hbr 10 mg tablet (Celexa)</i>	T1	QL (6 tabs/day) HD
<i>citalopram hbr 10 mg/5 ml soln</i>	T1	QL (30ml/day) HD
<i>citalopram hbr 20 mg tablet (Celexa)</i>	T1	QL (3 tabs/day) HD
<i>citalopram hbr 20 mg/10 ml sol</i>	T1	QL (30ml/day) HD
<i>citalopram hbr 40 mg tablet (Celexa)</i>	T1	QL (1 tab/day) HD
<i>escitalopram 10 mg tablet (Lexapro)</i>	T1	QL (2 tabs/day) HD
<i>escitalopram 20 mg tablet (Lexapro)</i>	T1	QL (1 tab/day) HD
<i>escitalopram 5 mg tablet (Lexapro)</i>	T1	QL (4 tabs/day) HD
<i>escitalopram oxalate 5 mg/5 ml</i>	T1	QL (20ml/day) HD

T1 – Typically Generics

T4 – Injectable Specialty Medications

ST – Step Therapy

HD – May require home delivery pharmacy

T2 – Typically Preferred Brands

PA – Prior Authorization

AGE – Age Requirement

PPACA – No Cost-Share Preventive Medication

T3 – Typically Non-Preferred Brands

QL – Quantity Limit

SP – Specialty Medication

CSL – Oral cancer medication subject to cost-share limits

## List of Prescription Medications

PSYCHOTHERAPEUTIC DRUGS (Anxiety/Depression/Bipolar Disorder) <sup>8</sup>		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>SELECTIVE SEROTONIN REUPTAKE INHIBITOR (SSRIs)</b>		
<i>fluoxetine 20 mg/5 ml solution</i>	T1	QL (20ml/day) HD
<i>fluoxetine hcl</i>	T1	QL (4 caps/28 days) HD
<i>fluoxetine hcl 10 mg capsule (Prozac)</i>	T1	QL (8 caps/day) HD
<i>fluoxetine hcl 10 mg tablet (Sarafem)</i>	T1	HD
<i>fluoxetine hcl 20 mg capsule (Prozac)</i>	T1	QL (4 caps/day) HD
<i>fluoxetine hcl 20 mg tablet</i>	T1	HD
<i>fluoxetine hcl 40 mg capsule (Prozac)</i>	T1	QL (2 caps/day) HD
<i>fluoxetine hcl 60 mg tablet</i>	T1	QL (1 tab/day) HD
<i>fluvoxamine er 100 mg capsule</i>	T1	QL (3 caps/day) HD
<i>fluvoxamine er 150 mg capsule</i>	T1	QL (2 caps/day) HD
<i>fluvoxamine maleate 100 mg tab</i>	T1	QL (3 tabs/day) HD
<i>fluvoxamine maleate 25 mg tab</i>	T1	QL (12 tabs/day) HD
<i>fluvoxamine maleate 50 mg tab</i>	T1	QL (6 tabs/day) HD
LEXAPRO 10 MG TABLET ( <i>escitalopram oxalate</i> )	T3	PA QL (2 tabs/day) HD
LEXAPRO 20 MG TABLET ( <i>escitalopram oxalate</i> )	T3	PA QL (1 tab/day) HD
LEXAPRO 5 MG TABLET ( <i>escitalopram oxalate</i> )	T3	PA QL (4 tabs/day) HD
<i>paroxetine cr 12.5 mg tablet (Paxil Cr)</i>	T1	QL (1 tab/day) HD
<i>paroxetine cr 25 mg tablet (Paxil Cr)</i>	T1	QL (3 tabs/day) HD
<i>paroxetine cr 37.5 mg tablet (Paxil Cr)</i>	T1	QL (2 tabs/day) HD
<i>paroxetine er 12.5 mg tablet (Paxil Cr)</i>	T1	QL (1 tab/day) HD
<i>paroxetine er 25 mg tablet (Paxil Cr)</i>	T1	QL (3 tabs/day) HD
<i>paroxetine er 37.5 mg tablet (Paxil Cr)</i>	T1	QL (2 tabs/day) HD
<i>paroxetine hcl 10 mg tablet (Paxil)</i>	T1	QL (6 tabs/day) HD
<i>paroxetine hcl 20 mg tablet (Paxil)</i>	T1	QL (3 tabs/day) HD
<i>paroxetine hcl 30 mg tablet (Paxil)</i>	T1	QL (2 tabs/day) HD
<i>paroxetine hcl 40 mg tablet (Paxil)</i>	T1	QL (1 tab/day) HD
PAXIL 10 MG TABLET ( <i>paroxetine hcl</i> )	T3	PA QL (6 tabs/day) HD
PAXIL 10 MG/5 ML SUSPENSION	T3	PA QL (30ml/day) HD
PAXIL 20 MG TABLET ( <i>paroxetine hcl</i> )	T3	PA QL (3 tabs/day) HD
PAXIL 30 MG TABLET ( <i>paroxetine hcl</i> )	T3	PA QL (2 tabs/day) HD
PAXIL 40 MG TABLET ( <i>paroxetine hcl</i> )	T3	PA QL (1 tab/day) HD
PAXIL CR 12.5 MG TABLET ( <i>paroxetine er</i> )	T3	PA QL (1 tab/day) HD
PAXIL CR 25 MG TABLET ( <i>paroxetine er</i> )	T3	PA QL (3 tabs/day) HD
PAXIL CR 37.5 MG TABLET ( <i>paroxetine er</i> )	T3	PA QL (2 tabs/day) HD
PEXEVA 10 MG TABLET	T3	PA QL (6 tabs/day) HD
PEXEVA 20 MG TABLET	T3	PA QL (3 tabs/day) HD

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# List of Prescription Medications

PSYCHOTHERAPEUTIC DRUGS (Anxiety/Depression/Bipolar Disorder) <sup>8</sup>		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>SELECTIVE SEROTONIN REUPTAKE INHIBITOR (SSRIs)</b>		
PEXEVA 30 MG TABLET	T3	PA QL (2 tabs/day) HD
PEXEVA 40 MG TABLET	T3	PA QL (1 tab/day) HD
PROZAC 10 MG PULVULE ( <i>fluoxetine hcl</i> )	T3	PA QL (8 caps/day) HD
PROZAC 20 MG PULVULE ( <i>fluoxetine hcl</i> )	T3	PA QL (4 caps/day) HD
PROZAC 40 MG PULVULE ( <i>fluoxetine hcl</i> )	T3	QL (2 caps/day) ST HD
SARAFEM ( <i>fluoxetine hcl</i> )	T3	ST HD
<i>sertraline 20 mg/ml oral conc</i> (Zoloft)	T1	QL (10ml/day) HD
<i>sertraline hcl 100 mg tablet</i> (Zoloft)	T1	QL (2 tabs/day) HD
<i>sertraline hcl 25 mg tablet</i> (Zoloft)	T1	QL (8 tabs/day) HD
<i>sertraline hcl 50 mg tablet</i> (Zoloft)	T1	QL (4 tabs/day) HD
ZOLOFT 100 MG TABLET ( <i>sertraline hcl</i> )	T3	PA QL (2 tabs/day) HD
ZOLOFT 20 MG/ML ORAL CONC ( <i>sertraline hcl</i> )	T3	PA QL (10ml/day) HD
ZOLOFT 25 MG TABLET ( <i>sertraline hcl</i> )	T3	PA QL (8 tabs/day) HD
ZOLOFT 50 MG TABLET ( <i>sertraline hcl</i> )	T3	PA QL (4 tabs/day) HD
<b>SEROTONIN-2 ANTAGONIST/REUPTAKE INHIBITORS (SARIs)</b>		
<i>nefazodone hcl</i>	T1	HD
<i>trazodone hcl</i>	T1	HD
<b>SEROTONIN-NOREPINEPHRINE REUPTAKE-INHIB (SNRIs)</b>		
CYMBALTA 20 MG CAPSULE ( <i>duloxetine hcl</i> )	T3	PA QL (6 caps/day) HD
CYMBALTA 30 MG CAPSULE ( <i>duloxetine hcl</i> )	T3	PA QL (4 caps/day) HD
CYMBALTA 60 MG CAPSULE ( <i>duloxetine hcl</i> )	T3	PA QL (2 caps/day) HD
DESVENLAFAXINE ER 100 MG TAB	T3	PA QL (4 tabs/day) HD
DESVENLAFAXINE ER 50 MG TAB	T3	PA QL (8 tabs/day) HD
<i>desvenlafaxine succnt er 100mg</i> (Pristiq)	T1	QL (4 tabs/day) HD
<i>desvenlafaxine succnt er 25 mg</i> (Pristiq)	T1	QL (16 tabs/day) HD
<i>desvenlafaxine succnt er 50 mg</i> (Pristiq)	T1	QL (1 tab/day) HD
DRIZALMA SPRINKLE DR 20 MG CAP	T3	QL (1 cap/day) ST HD
DRIZALMA SPRINKLE DR 30 MG CAP	T3	QL (1 cap/day) ST HD
DRIZALMA SPRINKLE DR 40 MG CAP	T3	QL (1 cap/day) ST HD
DRIZALMA SPRINKLE DR 60 MG CAP	T3	QL (2 caps/day) ST HD
<i>duloxetine hcl dr 20 mg cap</i> (Cymbalta)	T1	QL (6 caps/day) HD
<i>duloxetine hcl dr 30 mg cap</i> (Cymbalta)	T1	QL (4 caps/day) HD
<i>duloxetine hcl dr 40 mg cap</i>	T1	QL (3 caps/day) HD
<i>duloxetine hcl dr 60 mg cap</i> (Cymbalta)	T1	PA QL (2 caps/day) HD
EFFEXOR XR 150 MG CAPSULE ( <i>venlafaxine hcl er</i> )	T3	PA QL (2 caps/day) HD
EFFEXOR XR 37.5 MG CAPSULE ( <i>venlafaxine hcl er</i> )	T3	PA QL (8 caps/day) HD

T1 – Typically Generics

T4 – Injectable Specialty Medications

ST – Step Therapy

HD – May require home delivery pharmacy

T2 – Typically Preferred Brands

PA – Prior Authorization

AGE – Age Requirement

PPACA – No Cost-Share Preventive Medication

T3 – Typically Non-Preferred Brands

QL – Quantity Limit

SP – Specialty Medication

CSL – Oral cancer medication subject to cost-share limits

## List of Prescription Medications

### PSYCHOTHERAPEUTIC DRUGS (Anxiety/Depression/Bipolar Disorder)<sup>8</sup>

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>SEROTONIN-NOREPINEPHRINE REUPTAKE-INHIB (SNRIs)</b>		
EFFEXOR XR 75 MG CAPSULE ( <i>venlafaxine hcl er</i> )	T3	QL (4 caps/day) ST HD
FETZIMA 20-40 MG TITRATION PAK	T3	QL (28 caps/180 days) ST HD
FETZIMA ER 120 MG CAPSULE	T3	QL (1 cap/day) ST HD
FETZIMA ER 20 MG CAPSULE	T3	QL (6 caps/day) ST HD
FETZIMA ER 40 MG CAPSULE	T3	QL (3 caps/day) ST HD
FETZIMA ER 80 MG CAPSULE	T3	QL (1 cap/day) ST HD
PRISTIQ ER 100 MG TABLET ( <i>desvenlafaxine succinate er</i> )	T3	PA QL (4 tabs/day) HD
PRISTIQ ER 25 MG TABLET ( <i>desvenlafaxine succinate er</i> )	T3	PA QL (16 tabs/day) HD
PRISTIQ ER 50 MG TABLET ( <i>desvenlafaxine succinate er</i> )	T3	PA QL (1 tab/day) HD
<i>venlafaxine hcl 100 mg tablet</i>	T1	QL (3 tabs/day) HD
<i>venlafaxine hcl 25 mg tablet</i>	T1	QL (15 tabs/day) HD
<i>venlafaxine hcl 37.5 mg tablet</i>	T1	QL (10 tabs/day) HD
<i>venlafaxine hcl 50 mg tablet</i>	T1	QL (7 tabs/day) HD
<i>venlafaxine hcl 75 mg tablet</i>	T1	QL (5 tabs/day) HD
<i>venlafaxine hcl er 150 mg cap (Effexor Xr)</i>	T1	QL (2 caps/day) HD
<i>venlafaxine hcl er 150 mg tab</i>	T1	QL (2 tabs/day) HD
<i>venlafaxine hcl er 225 mg tab</i>	T1	QL (1 tab/day) HD
<i>venlafaxine hcl er 37.5 mg cap (Effexor Xr)</i>	T1	QL (8 caps/day) HD
<i>venlafaxine hcl er 37.5 mg tab</i>	T1	QL (8 tabs/day) HD
<i>venlafaxine hcl er 75 mg cap (Effexor Xr)</i>	T1	QL (4 caps/day) HD
<i>venlafaxine hcl er 75 mg tab</i>	T1	QL (4 tabs/day) HD
<b>SSRI AND 5HT1A PARTIAL AGONIST ANTI-DEPRESSANTS</b>		
VIIBRYD 10 MG TABLET	T3	QL (1 tab/day) PA HD
VIIBRYD 20 MG TABLET	T3	PA QL (1 tab/day) HD
VIIBRYD 40 MG TABLET	T3	PA HD
<b>SSRI, SEROTONIN RECEPTOR MODULATOR ANTI-DEPRESSANTS</b>		
TRINTELLIX 10 MG TABLET	T2	QL(1 TAB/DAY) HD
TRINTELLIX 20 MG TABLET	T2	HD
TRINTELLIX 5 MG TABLET	T2	QL(1 TAB/DAY) HD
<b>TRICYCLIC ANTI-DEPRESSANT-BENZODIAZEPINE COMBINATNS</b>		
<i>amitriptyline/chlordiazepoxide</i>	T1	HD
<b>TRICYCLIC ANTI-DEPRESSANT-PHENOTHIAZINE COMBINATNS</b>		
<i>perphenazine/amitriptyline hcl</i>	T1	HD
<b>TRICYCLIC ANTI-DEPRESSANTS, REL.NON-SEL.REUPT-INHIB</b>		
<i>amitriptyline hcl</i>	T1	HD
<i>amoxapine</i>	T1	HD
ANAFRANIL ( <i>clomipramine hcl</i> )	T3	PA HD
<i>clomipramine hcl (Anafranil)</i>	T1	HD

T1 – Typically Generics

T4 – Injectable Specialty Medications

ST – Step Therapy

HD – May require home delivery pharmacy

T2 – Typically Preferred Brands

PA – Prior Authorization

AGE – Age Requirement

PPACA – No Cost-Share Preventive Medication

T3 – Typically Non-Preferred Brands

QL – Quantity Limit

SP – Specialty Medication

CSL – Oral cancer medication subject to cost-share limits

## List of Prescription Medications

### PSYCHOTHERAPEUTIC DRUGS (Anxiety/Depression/Bipolar Disorder)<sup>8</sup>

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>TRICYCLIC ANTI-DEPRESSANTS, REL.NON-SEL.REUPT-INHIB</b>		
<i>desipramine hcl</i>	T1	HD
<i>desipramine hcl</i> (Norpramin)	T1	HD
<i>doxepin 10 mg capsule</i>	T1	HD
<i>doxepin 10 mg/ml oral conc</i>	T1	HD
<i>doxepin 100 mg capsule</i>	T1	HD
<i>doxepin 150 mg capsule</i>	T1	HD
<i>doxepin 25 mg capsule</i>	T1	HD
<i>doxepin 50 mg capsule</i>	T1	HD
<i>doxepin 75 mg capsule</i>	T1	HD
<i>imipramine pamoate</i>	T1	HD
<i>imipramine hcl</i>	T1	HD
<i>maprotiline hcl</i>	T1	HD
NORPRAMIN ( <i>desipramine hcl</i> )	T3	PA HD
<i>nortriptyline hcl</i>	T1	HD
<i>nortriptyline hcl</i> (Pamelor)	T1	HD
PAMELOR ( <i>nortriptyline hcl</i> )	T3	PA HD
<i>protriptyline hcl</i>	T1	HD
<i>trimipramine maleate</i>	T1	HD

### PSYCHOTHERAPEUTIC DRUGS (Attention Deficit Hyperactivity Disorder)<sup>8</sup>

#### ADRENERGICS, AROMATIC, NON-CATECHOLAMINE

<i>lisdexamfetamine 10 mg capsule</i> (Vyvanse)	T1	PA QL (1 cap/day)
<i>lisdexamfetamine 20 mg capsule</i> (Vyvanse)	T1	PA QL (1 tab/day)
<i>lisdexamfetamine 30 mg capsule</i> (Vyvanse)	T1	PA QL (1 per day)
<i>lisdexamfetamine 40 mg capsule</i> (Vyvanse)	T1	PA QL (1 cap/day)
<i>lisdexamfetamine 40 mg capsule</i> (Vyvanse)	T1	PA QL (1 tab/day)
<i>lisdexamfetamine 60 mg capsule</i> (Vyvanse)	T1	PA QL (1 per day)
<i>lisdexamfetamine 70 mg capsule</i> (Vyvanse)	T1	PA QL (1 tab/day)
VYVANSE 10 MG CAPSULE ( <i>lisdexamfetamine dimesylate</i> )	T3	PA QL(1 cap/day)
VYVANSE 10 MG CHEWABLE TABLET	T3	PA QL (1 tab/day)
VYVANSE 20 MG CAPSULE ( <i>lisdexamfetamine dimesylate</i> )	T3	PA QL (1 cap/day)
VYVANSE 20 MG CHEWABLE TABLET	T3	PA QL (1 tab/day)
VYVANSE 30 MG CAPSULE ( <i>lisdexamfetamine dimesylate</i> )	T3	PA QL (1 per day)
VYVANSE 30 MG CHEWABLE TABLET	T3	PA QL (1 tab/day)
VYVANSE 40 MG CAPSULE ( <i>lisdexamfetamine dimesylate</i> )	T3	PA QL (1 cap/day)
VYVANSE 40 MG CHEWABLE TABLET	T3	PA QL (1 tab/day)
VYVANSE 50 MG CAPSULE ( <i>lisdexamfetamine dimesylate</i> )	T3	PA QL (1 per day)
VYVANSE 50 MG CHEWABLE TABLET	T3	PA QL (1 tab/day)

T2 – Typically Preferred Brands PA – Prior Authorization

T3 – Typically Non-Preferred Brands QL – Quantity Limit

AGE – Age Requirement

SP – Specialty Medication

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)<sup>8</sup>

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>ADRENERGICS, AROMATIC, NON-CATECHOLAMINE</b>		
VYVANSE 60 MG CAPSULE	T3	PA QL (1 cap/day)
VYVANSE 60 MG CHEWABLE TABLET	T3	PA QL (1 tab/day)
VYVANSE 70 MG CAPSULE	T3	PA QL (1 per day)
<b>TX FOR ADHD - SELECTIVE ALPHA-2 RECEPTOR AGONIST</b>		
<i>clonidine hcl</i> (Kapvay)	T1	
<i>guanfacine hcl</i> (Intuniv)	T1	
INTUNIV ( <i>guanfacine hcl er</i> )	T3	PA
KAPVAY ( <i>clonidine hcl er</i> )	T3	PA
<b>TX FOR ATTENTION DEFICIT-HYPERACT (ADHD)/NARCOLEPSY</b>		
ADHANSIA XR	T3	PA QL (1 cap/day) ST
APTENSIO XR ( <i>methylphenidate er</i> )	T3	PA QL (1 cap/day) ST
CONCERTA ( <i>methylphenidate er</i> )	T3	PA QL (1 tab/day) ST
COTEMPLA XR-ODT 17.3 MG TABLET	T3	PA QL (1 tab/day)
COTEMPLA XR-ODT 25.9 MG TABLET	T3	PA QL (2 tabs/day)
COTEMPLA XR-ODT 8.6 MG TABLET	T3	PA QL (1 tab/day)
DAYTRANA ( <i>methylphenidate</i> ) 10 MG/9 HR PATCH	T3	PA QL (1 patch/day)
DAYTRANA ( <i>methylphenidate</i> ) 15 MG/9 HR PATCH	T3	PA QL (1 per day)
DAYTRANA ( <i>methylphenidate</i> ) 20 MG/9 HOUR PATCH	T3	PA QL (1 patch/day)
DAYTRANA ( <i>methylphenidate</i> ) 30 MG/9 HOUR PATCH	T3	PA QL (1 patch/day)
<i>dexmethylphenidate er 10 mg cp</i> (Focalin Xr)	T1	PA QL (1 cap/day)
<i>dexmethylphenidate er 15 mg cp</i> (Focalin Xr)	T1	PA QL (1 per day)
<i>dexmethylphenidate er 20 mg cp</i> (Focalin Xr)	T1	PA QL (1 cap/day)
<i>dexmethylphenidate er 25 mg cp</i> (Focalin Xr)	T1	PA QL (1 cap/day)
<i>dexmethylphenidate er 30 mg cp</i> (Focalin Xr)	T1	PA QL (1 cap/day)
<i>dexmethylphenidate er 35 mg cp</i> (Focalin Xr)	T1	PA QL (1 cap/day)
<i>dexmethylphenidate er 40 mg cp</i> (Focalin Xr)	T1	PA QL (1 cap/day)
<i>dexmethylphenidate er 5 mg cap</i> (Focalin Xr)	T1	PA QL (1 cap/day)
<i>dexmethylphenidate hcl</i> (Focalin)	T1	PA
FOCALIN ( <i>dexmethylphenidate hcl</i> )	T3	PA ST
FOCALIN XR 10 MG CAPSULE ( <i>dexmethylphenidate hcl er</i> )	T3	PA QL (1 cap/day) ST
FOCALIN XR 15 MG CAPSULE ( <i>dexmethylphenidate hcl er</i> )	T3	PA QL (1 cap/day) ST
FOCALIN XR 20 MG CAPSULE ( <i>dexmethylphenidate hcl er</i> )	T3	PA QL (1 per day) ST
FOCALIN XR 25 MG CAPSULE ( <i>dexmethylphenidate hcl er</i> )	T3	PA QL (1 cap/day) ST

T1 – Typically Generics

T4 – Injectable Specialty Medications

ST – Step Therapy

HD – May require home delivery pharmacy

T2 – Typically Preferred Brands

PA – Prior Authorization

AGE – Age Requirement

PPACA – No Cost-Share Preventive Medication

T3 – Typically Non-Preferred Brands

QL – Quantity Limit

SP – Specialty Medication

CSL – Oral cancer medication subject to cost-share limits

# List of Prescription Medications

## PSYCHOTHERAPEUTIC DRUGS (Attention Deficit Hyperactivity Disorder)<sup>8</sup>

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>TX FOR ATTENTION DEFICIT-HYPERACT (ADHD)/NARCOLEPSY</b>		
FOCALIN XR 30 MG CAPSULE ( <i>dexmethylphenidate hcl er</i> )	T3	PA QL (1 cap/day) ST
FOCALIN XR 35 MG CAPSULE ( <i>dexmethylphenidate hcl er</i> )	T3	PA QL (1 cap/day) ST
FOCALIN XR 40 MG CAPSULE ( <i>dexmethylphenidate hcl er</i> )	T3	PA QL (1 cap/day) ST
FOCALIN XR 5 MG CAPSULE ( <i>dexmethylphenidate hcl er</i> )	T3	PA QL (1 cap/day) ST
JORNAY PM	T3	PA QL (1 cap/day) ST
METADATE CD ( <i>methylphenidate hcl</i> )	T3	PA QL
METHYLIN ( <i>methylphenidate hcl</i> )	T3	PA
<i>methylphenidate</i> (Daytrana)	T1	PA QL(1 patch/day)
<i>methylphenidate er 10 mg cap</i> (Aptensio Xr)	T1	PA QL (1 per day)
<i>methylphenidate er 10 mg tab</i>	T1	PA QL (2/day)
<i>methylphenidate er 15 mg cap</i> (Aptensio Xr)	T1	PA QL (1 per day)
<i>methylphenidate er 18 mg tab</i> (Relexxii)	T1	PA QL(1 tab/day)
<i>methylphenidate er 18 mg tab</i> (Concerta)	T1	PA QL (1 tab/day)
<i>methylphenidate er 20 mg cap</i> (Aptensio Xr)	T1	PA QL (1 per day)
<i>methylphenidate er 20 mg tab</i>	T1	PA QL (3 tabs/day)
<i>methylphenidate er 18 mg tab</i> (Relexxii)	T1	PA QL(1 tab/day)
<i>methylphenidate er 27 mg tab</i> (Concerta)	T1	PA QL (1 per day)
<i>methylphenidate er 27 mg tab</i> (Concerta)	T1	PA QL (1 per day)
<i>methylphenidate er 30 mg cap</i> (Aptensio Xr)	T1	PA QL (1 per day)
<i>methylphenidate er 36 mg tab</i> (Concerta)	T1	PA QL (1 per day)
<i>methylphenidate er 36 mg tab</i> (Relexxii)	T1	PA QL(2 tabs/day)
<i>methylphenidate er 40 mg cap</i> (Aptensio Xr)	T1	PA QL (1 per day)
<i>methylphenidate er 50 mg cap</i> (Aptensio Xr)	T1	PA QL (1 per day)
<i>methylphenidate er 54 mg tab</i> (Concerta)	T1	PA QL (1 per day)
<i>methylphenidate er 54 mg tab</i> (Relexxii)	T1	PA QL(1 tab/day)
<i>methylphenidate er 60 mg cap</i> (Aptensio Xr)	T1	PA QL (1 per day)
METHYLPHENIDATE ER 72 MG TAB	T3	PA QL (1 tab/day)
<i>methylphenidate hcl</i> (Metadate Cd)	T1	PA QL(1 cap/day)
<i>methylphenidate hcl</i> (Methylin)	T1	PA
<i>methylphenidate hcl</i> (Ritalin La)	T1	PA QL (1 cap/day)
<i>methylphenidate hcl</i> (Ritalin)	T1	PA
<i>methylphenidate la 10 mg cap</i> (Ritalin La)	T1	PA QL (1 cap/day)
<i>methylphenidate la 20 mg cap</i> (Ritalin La)	T1	PA QL (1 cap/day)
<i>methylphenidate la 30 mg cap</i> (Ritalin La)	T1	PA QL (1 per day)
<i>methylphenidate la 40 mg cap</i> (Ritalin La)	T1	PA QL (1 cap/day)
<i>methylphenidate la 60 mg cap</i>	T1	PA QL (1 cap/day)

T1 – Typically Generics

T4 – Injectable Specialty Medications

ST – Step Therapy

HD – May require home delivery pharmacy

T2 – Typically Preferred Brands

PA – Prior Authorization

AGE – Age Requirement

PPACA – No Cost-Share Preventive Medication

T3 – Typically Non-Preferred Brands

QL – Quantity Limit

SP – Specialty Medication

CSL – Oral cancer medication subject to cost-share limits

# List of Prescription Medications

## PSYCHOTHERAPEUTIC DRUGS (Attention Deficit Hyperactivity Disorder)<sup>8</sup>

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
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### TX FOR ATTENTION DEFICIT-HYPERACT (ADHD)/NARCOLEPSY

<i>methylphenidate ptch (Daytrana)</i>	T1	PA QL(1 patch/day)
QUILLICHEW ER	T3	PA QL (1 tab/day)
QUILLIVANT XR	T3	PA QL (12ml/day)
RELEXXII	T3	PA QL (1 tab/day)
RELEXXII ER 18 MG TABLET ( <i>methylphenidate hcl</i> )	T3	PA QL(1 tab/day)
RELEXXII ER 27 MG TABLET( <i>methylphenidate hcl</i> )	T3	PA QL(1 tab/day)
RELEXXII ER 36 MG TABLET <i>methylphenidate hcl</i> )	T3	PA QL(2 tabs/day)
RELEXXII ER 45 MG TABLET	T3	PA QL(1 tab/day)
RELEXXII ER 54 MG TABLET( <i>methylphenidate hcl</i> )	T3	PA QL(1 tab/day)
RELEXXII ER 63 MG TABLET	T3	PA QL(1 tab/day)
RELEXXII ER 72 MG TABLET	T3	PA QL(1 tab/day)
RITALIN ( <i>methylphenidate hcl</i> )	T3	PA ST
RITALIN LA ( <i>methylphenidate la</i> )	T3	PA QL (1 cap/day) ST

### TX FOR ATTENTION DEFICIT-HYPERACT.(ADHD), NRI-TYPE

<i>atomoxetine hcl 10 mg capsule (Strattera)</i>	T1	HD
<i>atomoxetine hcl 100 mg capsule (Strattera)</i>	T1	HD
<i>atomoxetine hcl 18 mg capsule (Strattera)</i>	T1	HD
<i>atomoxetine hcl 25 mg capsule (Strattera)</i>	T1	HD
<i>atomoxetine hcl 40 mg capsule (Strattera)</i>	T1	QL (1 cap/day) HD
STRATTERA 100 MG CAPSULE ( <i>atomoxetine hcl</i> )	T3	PA QL HD
STRATTERA 18 MG CAPSULE ( <i>atomoxetine hcl</i> )	T3	PA QL HD
STRATTERA 25 MG CAPSULE ( <i>atomoxetine hcl</i> )	T3	PA QL HD
STRATTERA 40 MG CAPSULE ( <i>atomoxetine hcl</i> )	T3	PA QL (1 cap/day) HD
STRATTERA 60 MG CAPSULE ( <i>atomoxetine hcl</i> )	T3	PA QL HD
STRATTERA 80 MG CAPSULE ( <i>atomoxetine hcl</i> )	T3	PA QL HD

## PSYCHOTHERAPEUTIC DRUGS (Miscellaneous)

### HYPOACTIVE SEXUAL DESIRE DISORDER (HSDD) TX AGENTS

ADDYI	T3	PA QL (1 tab/day)
VYLEESI	T3	PA QL (8 injectors/30 days) SP

## PSYCHOTHERAPEUTIC DRUGS (Schizophrenia/Anti-Psychotics)<sup>8</sup>

### ANTI-PSYCH, DOPAMINE ANTAG., DIPHENYLBUTYLPIPERIDINES

<i>pimozide</i>	T1	
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### ANTI-PSYCHOTIC,ATYPICAL,DOPAMINE,SEROTONIN ANTAGNST

<i>asenapine maleate (Saphris)</i>	T1	
CAPLYTA	T3	QL (1 CAPS/DAY) ST

T1 – Typically Generics

T4 – Injectable Specialty Medications

ST – Step Therapy

HD – May require home delivery pharmacy

T2 – Typically Preferred Brands

PA – Prior Authorization

AGE – Age Requirement

PPACA – No Cost-Share Preventive Medication

T3 – Typically Non-Preferred Brands

QL – Quantity Limit

SP – Specialty Medication

CSL – Oral cancer medication subject to cost-share limits



# List of Prescription Medications

## PSYCHOTHERAPEUTIC DRUGS (Schizophrenia/Anti-Psychotics)<sup>8</sup>

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>ANTI-PSYCHOTIC, ATYPICAL, DOPAMINE, SEROTONIN ANTAGONIST</b>		
<i>clozapine</i>	T1	
<i>clozapine</i> (Clozapine Odt)	T1	
<i>clozapine</i> (Clozaril)	T1	
<i>clozapine</i> (Fazacllo)	T1	
CLOZAPINE ODT	T1	
CLOZARIL ( <i>clozapine</i> )	T3	PA
FANAPT 1 MG TABLET	T3	QL (4 tabs/day) ST
FANAPT 10 MG TABLET	T3	QL (4 tabs/day) ST
FANAPT 12 MG TABLET	T3	ST
FANAPT 2 MG TABLET	T3	QL (4 tabs/day) ST
FANAPT 4 MG TABLET	T3	QL (4 tabs/day) ST
FANAPT 6 MG TABLET	T3	QL (4 tabs/day) ST
FANAPT 8 MG TABLET	T3	QL (4 tabs/day) ST
FANAPT TITRATION PACK	T3	QL (4 packs/year) ST
FAZACLO ( <i>clozapine odt</i> )	T3	PA
GEODON ( <i>ziprasidone hcl</i> )	T3	PA
INVEGA ER 1.5 MG TABLET ( <i>paliperidone er</i> )	T3	ST
INVEGA ER 3 MG TABLET ( <i>paliperidone er</i> )	T3	QL (1 tab/day) ST
INVEGA ER 6 MG TABLET ( <i>paliperidone er</i> )	T3	ST
INVEGA ER 9 MG TABLET ( <i>paliperidone er</i> )	T3	ST
LATUDA 120 MG TABLET	T3	
LATUDA 20 MG TABLET	T2	
LATUDA 40 MG TABLET	T2	QL (1 tab/day)
LATUDA 60 MG TABLET	T2	QL (1 tab/day)
LATUDA 80 MG TABLET	T2	
<i>olanzapine</i> (Zyprexa Zydis)	T1	
<i>olanzapine</i> (Zyprexa)	T1	
<i>paliperidone er 1.5 mg tablet</i>	T1	
<i>paliperidone er 1.5 mg tablet</i> (Invega)	T1	
<i>paliperidone er 3 mg tablet</i> (Invega)	T1	QL (1 tab/day)
<i>paliperidone er 6 mg tablet</i> (Invega)	T1	
<i>paliperidone er 9 mg tablet</i> (Invega)	T1	
<i>quetiapine fumarate</i> (Seroquel Xr)	T1	
<i>quetiapine fumarate</i> (Seroquel)	T1	
RISPERDAL ( <i>risperidone</i> )	T3	PA
<i>risperidone</i>	T1	

T1 – Typically Generics

T4 – Injectable Specialty Medications

ST – Step Therapy

HD – May require home delivery pharmacy

T2 – Typically Preferred Brands

PA – Prior Authorization

AGE – Age Requirement

PPACA – No Cost-Share Preventive Medication

T3 – Typically Non-Preferred Brands

QL – Quantity Limit

SP – Specialty Medication

CSL – Oral cancer medication subject to cost-share limits

## List of Prescription Medications

### PSYCHOTHERAPEUTIC DRUGS (Schizophrenia/Anti-Psychotics)<sup>8</sup>

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>ANTI-PSYCHOTIC, ATYPICAL, DOPAMINE, SEROTONIN ANTAGONIST</b>		
<i>risperidone</i> (Risperdal)	T1	
SAPHRIS ( <i>asenapine maleate</i> )	T3	ST
SECUADO	T3	ST
SEROQUEL ( <i>quetiapine fumarate</i> )	T3	ST
SEROQUEL XR ( <i>quetiapine fumarate er</i> )	T3	ST
VERSACLOZ	T3	PA
<i>ziprasidone hcl</i> (Geodon)	T1	
ZYPREXA ( <i>olanzapine</i> )	T3	PA
ZYPREXA ZYDIS ( <i>olanzapine odt</i> )	T3	PA
<b>ANTI-PSYCHOTIC-ATYPICAL, D3/D2 PARTIAL AG-5HT MIXED</b>		
VRAYLAR 1.5 MG CAPSULE	T3	QL (1 cap/day) ST
VRAYLAR 1.5 MG-3 MG PACK	T3	ST
VRAYLAR 3 MG CAPSULE	T3	QL (1 cap/day) ST
VRAYLAR 4.5 MG CAPSULE	T3	ST
VRAYLAR 6 MG CAPSULE	T3	ST
<b>ANTIPSYCHOTICS, ATYP, D2 PARTIAL AGONIST/5HT MIXED</b>		
ABILIFY 10 MG TABLET ( <i>aripiprazole</i> )	T3	ST
ABILIFY 15 MG TABLET ( <i>aripiprazole</i> )	T3	ST
ABILIFY 2 MG TABLET ( <i>aripiprazole</i> )	T3	ST
ABILIFY 20 MG TABLET ( <i>aripiprazole</i> )	T3	ST
ABILIFY 30 MG TABLET ( <i>aripiprazole</i> )	T3	ST
ABILIFY 5 MG TABLET ( <i>aripiprazole</i> )	T3	QL (1 tab/day) ST
ABILIFY MYCITE	T3	PA
<i>aripiprazole</i>	T1	
<i>aripiprazole 1 mg/ml solution</i>	T1	
<i>aripiprazole 10 mg tablet</i> (Abilify)	T1	
<i>aripiprazole 15 mg tablet</i> (Abilify)	T1	
<i>aripiprazole 2 mg tablet</i> (Abilify)	T1	
<i>aripiprazole 20 mg tablet</i> (Abilify)	T1	
<i>aripiprazole 30 mg tablet</i> (Abilify)	T1	
<i>aripiprazole 5 mg tablet</i> (Abilify)	T1	QL (1 tab/day)
REXULTI 0.25 MG TABLET	T3	QL (1 tab/day) ST
REXULTI 0.5 MG TABLET	T3	QL (1 tab/day) ST
REXULTI 1 MG TABLET	T3	QL (1 tab/day) ST
REXULTI 2 MG TABLET	T3	QL (1 tab/day) ST
REXULTI 3 MG TABLET	T3	ST
REXULTI 4 MG TABLET	T3	ST

T1 – Typically Generics

T4 – Injectable Specialty Medications

ST – Step Therapy

HD – May require home delivery pharmacy

T2 – Typically Preferred Brands

PA – Prior Authorization

AGE – Age Requirement

PPACA – No Cost-Share Preventive Medication

T3 – Typically Non-Preferred Brands

QL – Quantity Limit

SP – Specialty Medication

CSL – Oral cancer medication subject to cost-share limits

## List of Prescription Medications

### PSYCHOTHERAPEUTIC DRUGS (Schizophrenia/Anti-Psychotics)<sup>8</sup>

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>ANTI-PSYCHOTICS, DOPAMINE AND SEROTONIN ANTAGONISTS</b>		
<i>loxapine succinate</i>	T1	
<i>lurasidone hcl</i>	T1	
<b>ANTI-PSYCHOTICS, DOPAMINE ANTAGONISTS, THIOXANTHENES</b>		
<i>thiothixene</i>	T1	
<b>ANTI-PSYCHOTICS, DOPAMINE ANTAGONISTS, BUTYROPHENONES</b>		
<i>haloperidol</i>	T1	
<i>haloperidol lactate</i>	T1	
<b>ANTI-PSYCHOTICS, DOPAMINE ANTAGONST, DIHYDROINDOLONES</b>		
<i>molindone hcl</i>	T1	
<b>ANTI-PSYCHOTICS, PHENOTHIAZINES</b>		
<i>chlorpromazine hcl</i>	T1	
<i>fluphenazine hcl</i>	T1	
<i>perphenazine</i>	T1	
<i>thioridazine hcl</i>	T1	
<i>trifluoperazine hcl</i>	T1	
<b>SSRI-ANTI-PSYCH, ATYPICAL, DOPAMINE, SEROTONIN ANTAG</b>		
<i>olanzapine/fluoxetine hcl</i>	T1	
<i>olanzapine/fluoxetine hcl (Symbyax)</i>	T1	
<i>SYMBYAX (olanzapine-fluoxetine hcl)</i>	T3	PA

### PSYCHOTHERAPEUTIC DRUGS (Sleep Disorders/Sedatives)

#### NARCOLEPSY AND SLEEP DISORDER THERAPY AGENTS

<i>armodafinil (Nuvigil)</i>	T1	PA
<i>modafinil (Provigil)</i>	T1	PA
NUVIGIL ( <i>armodafinil</i> )	T3	PA
PROVIGIL ( <i>modafinil</i> )	T3	PA
SUNOSI	T2	PA QL (1 tab/day)

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

LUMRYZ	T3	PA QL(1 pack/day) SP HD
XYREM	T3	PA SP HD
XYWAV	T3	PA SP HD

#### BARBITURATES

<i>phenobarbital</i>	T1	
<i>secobarbital sodium</i>	T3	PA

#### HYPNOTICS, MELATONIN MT1/MT2 RECEPTOR AGONISTS

HETLIOZ	T3	PA SP HD
HETLIOZ LQ	T3	PA SP HD

T1 – Typically Generics

T4 – Injectable Specialty Medications

ST – Step Therapy

HD – May require home delivery pharmacy

T2 – Typically Preferred Brands

PA – Prior Authorization

AGE – Age Requirement

PPACA – No Cost-Share Preventive Medication

T3 – Typically Non-Preferred Brands

QL – Quantity Limit

SP – Specialty Medication

CSL – Oral cancer medication subject to cost-share limits

# List of Prescription Medications

PSYCHOTHERAPEUTIC DRUGS (Sleep Disorders/Sedatives)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>HYPNOTICS, MELATONIN MT1/MT2 RECEPTOR AGONISTS</b>		
<i>ramelteon</i> (Rozerem)	T1	QL (1 tab/day)
ROZEREM ( <i>ramelteon</i> )	T3	PA QL (1 tab/day)
DORAL	T3	
<i>estazolam</i>	T1	
HALCION ( <i>triazolam</i> )	T3	
<i>midazolam hcl</i>	T1	
QUAZEPAM	T1	
<i>quazepam</i> (Quazepam)	T1	
RESTORIL ( <i>temazepam</i> )	T3	PA
<b>NARCOLEPSY AND SLEEP DISORDER THERAPY AGENTS</b>		
<i>armodafinil</i> (Nuvigil)	T1	PA
<i>modafinil</i> (Provigil)	T1	PA
NUVIGIL ( <i>armodafinil</i> )	T3	PA
PROVIGIL ( <i>modafinil</i> )	T3	PA
SUNOSI	T2	PA QL (1 tab/day)
<b>SEDATIVE-HYPNOTICS - BENZODIAZEPINES</b>		
<i>flurazepam hcl</i>	T1	
<i>temazepam</i> (Restoril)	T1	
<i>triazolam</i>	T1	
<i>triazolam</i> (Halcion)	T1	
<b>SEDATIVE-HYPNOTICS, NON-BARBITURATE</b>		
AMBIEN ( <i>zolpidem tartrate</i> )	T3	PA
AMBIEN CR 12.5 MG TABLET ( <i>zolpidem tartrate er</i> )	T3	PA
AMBIEN CR 6.25 MG TABLET ( <i>zolpidem tartrate er</i> )	T3	PA QL (1 tab/day)
BELSOMRA	T3	PA
DAYVIGO	T2	QL (1 tab/day) ST
<i>doxepin hcl 3 mg tablet</i> (Silenor)	T1	QL (1 tab/day)
<i>doxepin hcl 6 mg tablet</i> (Silenor)	T1	
EDLUAR 10 MG SL TABLET	T3	PA
EDLUAR 5 MG SL TABLET	T3	PA QL (1 tab/day)
<i>eszopiclone</i> (Lunesta)	T1	
LUNESTA ( <i>eszopiclone</i> )	T3	PA
QUVIVQ	T3	PA QL (1 day)
SILENOR 3 MG TABLET ( <i>doxepin hcl</i> )	T3	PA QL (1 tab/day)
SILENOR 6 MG TABLET ( <i>doxepin hcl</i> )	T3	PA
<i>zaleplon</i>	T1	

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

T4 – Injectable 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 (Sleep Disorders/Sedatives)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>SEDATIVE-HYPNOTICS, NON-BARBITURATE</b>		
<i>zolpidem tart er 12.5 mg tab (Ambien Cr)</i>	T1	
<i>zolpidem tart er 6.25 mg tab (Ambien Cr)</i>	T1	QL (1 tab/day)
<i>zolpidem tartrate</i>	T1	
<i>zolpidem tartrate (Ambien)</i>	T1	
ZOLPIMIST	T3	PA

### SKIN PREPS (Miscellaneous)

#### IRRIGANTS

<i>acetic acid</i>	T1	
<i>neomycin sulf/polymyxin b sulf</i>	T1	
PHYSIOLYTE	T3	
PHYSIOSOL	T3	
<i>ringer's solution</i>	T1	
<i>ringer's solution, lactated</i>	T1	
<i>sod, pot chlor/mag/sod, pot phos</i>	T3	
<i>sodium chloride irrig solution</i>	T1	
SORBITOL	T1	
SORBITOL-MANNITOL	T1	
VASHE WOUND	T3	
VASHE WOUND THERAPY	T3	
<i>water for irrigation, sterile</i>	T1	

#### OXIDIZING AGENTS

<i>hydrogen peroxide</i>	T1	
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### SKIN PREPS (Pain Relief And Inflammatory Disease)

#### ANTI-PSORIATIC AGENTS, SYSTEMIC

<i>acitretin</i>	T1	
<i>acitretin (Soriatane)</i>	T1	
BIMZELX	T4	PA QL(10 MLS/365 DAYS) SP HD
BIMZELX AUTOINJECTOR	T4	PA QL(10 MLS/365 DAYS) SP HD
COSENTYX (2 SYRINGES)	T4	PA QL (2 syringes/28 days) SP HD
COSENTYX PEN	T4	PA QL (1 pen/28 days) SP HD
COSENTYX PEN (2 PENS)	T4	PA QL (2 pens/28 days) SP HD
COSENTYX SYRINGE	T4	PA QL (1 syringe/28 days) SP HD
ILUMYA	T4	PA QL (1 syringe/84 days) SP HD
<i>methoxsalen (Oxsoralen-ultra)</i>	T1	
OXSORALEN-ULTRA ( <i>methoxsalen</i> )	T3	
SILIQ	T4	PA QL (2 syringes/28 days) SP HD
SKYRIZI (2 SYRINGES) KIT	T4	PA QL (1 kit/84 days) SP HD

T1 – Typically Generics

T4 – Injectable Specialty Medications

ST – Step Therapy

HD – May require home delivery pharmacy

T2 – Typically Preferred Brands

PA – Prior Authorization

AGE – Age Requirement

PPACA – No Cost-Share Preventive Medication

T3 – Typically Non-Preferred Brands

QL – Quantity Limit

SP – Specialty 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
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### ANTI-PSORIATIC AGENTS, SYSTEMIC (cont.)

SORIATANE ( <i>acitretin</i> )	T3	PA
SOTYKTU	T3	PA QL (1/day) SP
TALTZ AUTOINJECTOR	T4	PA QL (1 injector/28 days) SP HD
TALTZ AUTOINJECTOR (2 PACK)	T4	PA QL (1 injector/28 days) SP HD
TALTZ AUTOINJECTOR (3 PACK)	T4	PA QL (1 injector/28 days) SP HD
TALTZ SYRINGE	T4	PA QL (1 syringe/28 days) SP HD
TREMFYA 100 MG/ML INJECTOR	T4	PA QL (1 injector/56 days) SP HD
TREMFYA 100 MG/ML SYRINGE	T4	PA QL (1 syringe/56 days) SP HD

### TOPICAL ANTI-INFLAMMATORY, NSAIDS

DICLAREAL	T3	HD
<i>diclofenac 1.5% topical soln</i>	T1	PA HD
DICLOFENAC EPOLAMINE	T3	PA QL (2 patches/day) HD
<i>diclofenac sodium 1% gel (Voltaren)</i>	T1	QL (1000gm/30 days) HD
FLECTOR	T2	PA QL (2 patches/day) HD
LICART	T2	PA QL (1 patch/day) HD
PENNSAID	T3	PA HD
VOLTAREN ( <i>diclofenac sodium</i> )	T3	PA QL (1000gm/30 days) HD

## SKIN PREPS (Skin Conditions)

### ACNE AGENTS, SYSTEMIC

ABSORICA	T3	QL (150 days therapy/210 days) ST
ABSORICA (isotretinoin)	T3	
ABSORICA LD	T3	ST
ACUTANE	T1	
AMNESTEEM	T1	
CLARAVIS	T1	
<i>isotretinoin (Absorica)</i>	T1	
MYORISAN	T1	
ZENATANE	T1	
ACANYA ( <i>clindamycin phos-benzoyl perox</i> )	T3	
ACZONE 5% GEL ( <i>dapsone</i> )	T3	
ACZONE 7.5% GEL PUMP	T2	
<i>adapalene/benzoyl peroxide</i>	T1	
AZELEX	T2	
BENZACLIN ( <i>clindamycin-benzoyl peroxide</i> )	T3	PA
<i>clindamycin phos/benzoyl perox (Onexton)</i>	T1	
<i>clindamycin phos/benzoyl perox (Acanya)</i>	T1	

T1 – Typically Generics

T4 – Injectable Specialty Medications

ST – Step Therapy

HD – May require home delivery pharmacy

T2 – Typically Preferred Brands

PA – Prior Authorization

AGE – Age Requirement

PPACA – No Cost-Share Preventive Medication

T3 – Typically Non-Preferred Brands

QL – Quantity Limit

SP – Specialty 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
<b>ACNE AGENTS, SYSTEMIC (cont.)</b>		
<i>clindamycin phos/benzoyl perox</i> (Benzaclin)	T1	
<i>clindamycin/tretinoin</i> (Ziana)	T1	
<i>clindamycin/tretinoin</i> (Veltin)	T1	
<i>dapsone 5% gel</i> (Aczone)	T1	
DAPSONE 7.5% GEL PUMP	T3	PA
<i>dapsone 7.5% gel pump</i> (Dapsone)	T1	
EPIDUO FORTE	T2	
KLARON ( <i>sulfacetamide sodium</i> )	T3	
NEUAC 1.2-5% KIT	T3	
<i>neuac gel</i>	T1	
ONEXTON ( <i>clindamycin phos/benzoyl perox</i> )	T3	
<i>sulfacetamide sodium</i> (Klaron)	T1	
VELTIN	T3	PA
ZIANA ( <i>clindamycin phos-tretinoin</i> )	T3	PA
<b>ACNE AGENTS, TOPICAL</b>		
CABTREO	T3	PA
<i>clindamyc-bnz perox 1.2-3.75%</i> (Onexton)	T1	PA
<i>clindamycin-benzoyl perox 1-5%</i>	T1	
<i>clindamycin-bnz perox 1-5% pmp</i>	T1	
<b>ANTI-PERSPIRANTS</b>		
DRYSOL	T2	
<b>ANTI-PRURITICS, TOPICAL</b>		
ALEVICYN PLUS	T3	
<i>doxepin 5% cream</i> (Zonalon)	T1	PA QL (90gm/30 days)
<i>doxepin hcl</i> (Zonalon)	T3	PA QL (90gm/30 days)
ZONALON	T3	PA QL (90gm/30 days)
ZONALON ( <i>prudoxin</i> )	T3	PA QL (90gm/30 days)
<b>ANTI-PSORIATICS AGENTS</b>		
<i>anthralin</i>	T1	
<i>calcipotriene 0.005% cream</i> (Dovonex)	T1	
CALCIPOTRIENE 0.005% FOAM	T3	PA
<i>calcipotriene 0.005% ointment</i>	T1	
<i>calcipotriene 0.005% solution</i>	T1	
<i>calcitriol 3 mcg/g ointment</i> (Vectical)	T1	QL (800gm/30 days)
DOVONEX ( <i>calcipotriene</i> )	T3	
DUOBRII	T3	

T1 – Typically Generics

T4 – Injectable Specialty Medications

ST – Step Therapy

HD – May require home delivery pharmacy

T2 – Typically Preferred Brands

PA – Prior Authorization

AGE – Age Requirement

PPACA – No Cost-Share Preventive Medication

T3 – Typically Non-Preferred Brands

QL – Quantity Limit

SP – Specialty 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
<b>ANTI-PSORIATICS AGENTS (cont.)</b>		
RYALTRIS	T3	PA QL (1 tube/30/days)
SORILUX	T3	PA
<i>tazarotene 0.1% cream (Tazorac)</i>	T1	
TAZORAC 0.05% CREAM	T2	
TAZORAC 0.05% GEL	T2	
TAZORAC 0.1% CREAM ( <i>tazarotene</i> )	T3	
TAZORAC 0.1% GEL	T2	
VECTICAL ( <i>calcitriol</i> )	T3	QL (800gm/30 days)
ZORYVE 0.3% CREAM	T3	PA QL(1 gm/30 days)
<b>ANTI-SEBORRHEIC AGENTS</b>		
OVACE PLUS	T3	
<i>selenium sulfide</i>	T1	
<i>sulfacetamide sodium</i>	T1	
TERSI FOAM	T3	
<b>ANTISEPTICS, MISCELLANEOUS</b>		
GUAIACOL	T1	
<b>DIABETIC ULCER PREPARATIONS, TOPICAL</b>		
REGRANEX	T3	PA QL (2 tubs/30 days)
<b>EMOLLIENTS</b>		
ATOPICLAIR	T3	
<i>emollient combination no.35 (Mimyx)</i>	T1	
<i>emollient combination no.60 (Restizan)</i>	T1	
<i>emollient combination no.60 (Restizan)</i>	T3	
HALUCORT	T3	
MIMYX ( <i>prumyx</i> )	T3	
RESTIZAN	T1	
<i>vite ac/grape/hyaluronic acid (Atopiclair)</i>	T1	
XCLAIR	T3	
<b>IMMUNOMODULATORS</b>		
ALDARA ( <i>imiquimod</i> )	T3	PA
<i>imiquimod 3.75% cream (Zyclara)</i>	T1	PA QL(112 PACKETS/67 DAYS)
IMIQUIMOD 3.75% CREAM PUMP	T1	PA
<i>imiquimod 5% cream packet (Aldara)</i>	T1	
ZYCLARA 2.5% CREAM PUMP	T3	PA QL (4 bots/30 days)
ZYCLARA 3.75% CREAM ( <i>imiquimod</i> )	T3	PA QL (112 packs/30 days)
ZYCLARA 3.75% CREAM PUMP	T3	PA
<b>IRRITANTS/COUNTER-IRRITANTS</b>		
<i>methyl salicylate</i>	T1	
QUTENZA	T3	

T3 – Typically Non-Preferred Brands    QL – Quantity Limit

SP – Specialty 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	
<b>KERATOLYTICS</b>			
BENSAL HP	T1	PA	
BENZEFOAM	T3		
BENZEPRO	T1		
<i>benzoyl peroxide</i> (Enzoclear)	T1		
<i>benzoyl peroxide</i> (Pacnex)	T1		
CONDYLOX	T3	PA	
ENZOCLEAR	T3		
HYDRO 35	T3		
HYDRO 40 ( <i>umecta</i> )	T3		
INOVA	T3		
KERAFOAM	T3		
KERALYT 6% GEL ( <i>salicylic acid</i> )	T3		
<i>keralyt 6% shampoo</i>	T1		
KERALYT SCALP	T3		
KERALYT SCALP ( <i>salicylic acid</i> )	T3		
PACNEX ( <i>benzoyl peroxide</i> )	T3		
PODOCON-25	T1		
<i>podofilox</i>	T1		
PR BENZOYL PEROXIDE	T1		
PRONAL	T3		
RAYASAL	T3		
SALICATE	T3		
<i>salicylic acid</i>	T1		
<i>salicylic acid</i> (Keralyt Scalp)	T1		
<i>salicylic acid/ceramide comb 1</i>	T1		
SALIMEZ FORTE	T1		
SALKERA	T3		
SALVAX DUO PLUS	T3		
<i>silver nitrate</i>	T1		
<i>silver nitrate applicator</i>	T1		
URAMAXIN	T3		
URAMAXIN ( <i>urea</i> )	T3		
<i>urea</i>	T1		
<i>urea</i> (Hydro 35)	T1		
<i>urea</i> (Hydro 40)	T3		
<i>urea</i> (Uramaxin)	T1		
<i>urea</i> (Xurea)	T1		
XUREA	T3		

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

PA – Prior Authorization  
 QL – Quantity Limit

AGE – Age Requirement  
 SP – Specialty Medication

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
<b>PROTECTIVES</b>		
PHARMABASE BARRIER	T1	
<i>polydimethylsiloxanes/silicon</i>	T1	
<i>protectives2/ceramide 1, 3, 6-ii</i>	T1	
RADIAPLEXRX	T3	
<i>zinc oxide</i>	T1	
<b>ROSACEA AGENTS, TOPICAL</b>		
<i>azelaic acid (Finacea)</i>	T1	
FINACEA	T3	PA
FINACEA ( <i>azelaic acid</i> )	T3	PA
IDAOXIA	T3	
<i>ivermectin (Soolantra)</i>	T1	
METROCREAM ( <i>rosadan</i> )	T3	PA
METROGEL ( <i>metronidazole</i> )	T3	PA
<i>metronidazole</i>	T1	
<i>metronidazole (Metrocream)</i>	T1	
<i>metronidazole (Metrogel)</i>	T1	
NORITATE	T3	PA
SOOLANTRA	T3	PA
SOOLANTRA ( <i>ivermectin</i> )	T3	PA
<b>TISSUE/WOUND ADHESIVES</b>		
ARTISS	T3	
SURGISEAL STYLUS	T3	
SURGISEAL TEARDROP	T3	
SURGISEAL TWIST	T3	
TISSEEL VHSD	T3	
<b>TOP. ANTI-INFLAM., PHOSPHODIESTERASE-4 (PDE4) INHIB</b>		
EUCRISA	T2	
<b>TOPICAL AGENTS, MISCELLANEOUS</b>		
L-MESITRAN SOFT	T3	
MEDIHONEY	T3	
SAF-CLENS AF	T1	
<i>trichloroacetic acid</i>	T3	
TRICHLOROACETIC ACID	T1	
<i>urea</i>	T1	
<b>TOPICAL ANTIBIOTIC PLEUROMUTILIN DERIVATIVES</b>		
ALTABAX	T3	

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

T4 – Injectable 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	
<b>TOPICAL ANTICHOLINERGIC HYPERHIDROSIS TX AGENTS</b>			
QBREXZA	T3		
<b>TOPICAL ANTI-INFLAMMATORY STEROIDAL</b>			
ACIOXIA	T3		
ALA-SCALP ( <i>scalacort</i> )	T3	ST	
<i>alclometasone dipropionate</i>	T1		
<i>amcinonide 0.1%</i>	T1		
ANUSOL-HC 2.5% CREAM ( <i>proctozone-hc</i> )	T1	PA	
AQUA GLYCOLIC HC	T3		
<i>betamethasone dipropionate</i>	T1		
<i>betamethasone valerate</i>	T1		
<i>betamethasone valerate (Luxiq)</i>	T1		
<i>betamethasone/propylene glyc</i>	T1		
<i>betamethasone/propylene glyc (Diprolene)</i>	T1		
BRYHALI	T3	ST	
CAPEX SHAMPOO	T3	ST	
<i>clobetasol propionate</i>	T1		
<i>clobetasol propionate (Clobex)</i>	T1		
<i>clobetasol propionate (Olux)</i>	T1		
<i>clobetasol propionate (Temovate)</i>	T1		
<i>clobetasol propionate/emoll</i>	T1		
<i>clobetasol propionate/emoll (Olux-e)</i>	T1		
CLOBEX ( <i>clobetasol propionate</i> )	T3	PA	
CLOBEX ( <i>clodan</i> )	T3	PA	
CLOCORTOLONE PIVALATE	T1		
CLODAN 0.05% KIT	T3	ST	
<i>clodan 0.05% shampoo (Clobex)</i>	T1		
CLODERM	T3	ST	
CORDRAN	T3	PA	
CORDRAN ( <i>flurandrenolide</i> )	T3	PA	
CORDRAN ( <i>nolix</i> )	T3	PA	
CUTIVATE 0.05% CREAM ( <i>fluticasone propionate</i> )	T3	ST	
CUTIVATE 0.05% LOTION ( <i>fluticasone propionate</i> )	T3	PA	
DERMA-SMOOTHIE-FS ( <i>fluocinolone acetonide</i> )	T3	ST	
DERMATOP ( <i>prednicarbate</i> )	T3	ST	
<i>desonide</i>	T1		
<i>desonide (Desowen)</i>	T1		
<i>desonide (Tridesilon)</i>	T1		

T1 – Typically Generics      T4 – Injectable Specialty Medications      ST – Step Therapy      HD – May require home delivery pharmacy  
 T2 – Typically Preferred Brands      PA – Prior Authorization      AGE – Age Requirement      PPACA – No Cost-Share Preventive Medication  
 T3 – Typically Non-Preferred Brands      QL – Quantity Limit      SP – Specialty 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
<b>TOPICAL ANTI-INFLAMMATORY STEROIDAL</b>		
DESOWEN ( <i>desonide</i> )	T3	ST
<i>desoximetasone</i> (Topicort)	T1	
<i>diflorasone diacetate</i>	T1	PA
<i>diflorasone diacetate</i> (Psorcon)	T1	PA
<i>diflorasone diacetate/emoll</i>	T1	PA
DIPROLENE ( <i>betamethasone diprop augmented</i> )	T3	ST
<i>fluocinolone acetonide</i>	T1	
<i>fluocinolone acetonide</i> (Derma-smoothe-fs)	T1	
<i>fluocinolone acetonide</i> (Synalar)	T1	
<i>fluocinolone/shower cap</i> (Derma-smoothe-fs)	T1	
<i>fluocinonide</i>	T1	
<i>fluocinonide</i> (Vanos)	T1	
<i>fluocinonide/emollient base</i>	T1	
<i>flurandrenolide</i> (Cordran)	T1	PA
<i>fluticasone prop 0.005% oint</i>	T1	
<i>fluticasone prop 0.05% cream</i> (Cutivate)	T1	
<i>fluticasone prop 0.05% lotion</i> (Cutivate)	T1	
<i>fluticasone propionate</i> (Cutivate)	T1	
<i>halcinonide</i> (Halog)	T1	PA
<i>halobetasol prop 0.05% foam</i>	T1	
HALOBETASOL PROPIONATE	T3	PA
HALOG 0.1% CREAM ( <i>halcinonide</i> )	T3	PA
HALOG 0.1% OINTMENT	T3	PA
HALOG 0.1% SOLUTION	T3	ST
<i>hydrocort buty 0.1% lipid crm</i> (Locoid Lipocream)	T1	PA
<i>hydrocort buty 0.1% lipo cream</i> (Locoid Lipocream)	T1	PA
<i>hydrocortisone</i>	T1	
<i>hydrocortisone</i> (Ala-scalp)	T1	
<i>hydrocortisone</i> (Anusol-hc)	T1	
<i>hydrocortisone buty 0.1% cream</i>	T1	
<i>hydrocortisone butyr 0.1% lotn</i> (Locoid)	T1	PA
<i>hydrocortisone butyr 0.1% oint</i> (Locoid)	T1	
<i>hydrocortisone butyr 0.1% soln</i>	T1	
<i>hydrocortisone valerate</i>	T1	
IMPEKLO	T3	PA
IMPOYZ	T3	PA

T1 – Typically Generics

T4 – Injectable Specialty Medications

ST – Step Therapy

HD – May require home delivery pharmacy

T2 – Typically Preferred Brands

PA – Prior Authorization

AGE – Age Requirement

PPACA – No Cost-Share Preventive Medication

T3 – Typically Non-Preferred Brands

QL – Quantity Limit

SP – Specialty 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
<b>TOPICAL ANTI-INFLAMMATORY STEROIDAL</b>		
KENALOG ( <i>triamcinolone acetonide</i> )	T3	PA
LEXETTE	T3	PA
LOCOID 0.1% LOTION ( <i>hydrocortisone butyrate</i> )	T3	PA
LOCOID 0.1% OINTMENT ( <i>hydrocortisone butyrate</i> )	T3	
LOCOID LIPOCREAM	T3	PA
LOCOID LIPOCREAM ( <i>hydrocortisone butyrate</i> )	T3	PA
LUXIQ ( <i>betamethasone valerate</i> )	T3	ST
MOMETACURE	T3	
<i>mometasone furoate 0.1% cream</i>	T1	
<i>mometasone furoate 0.1% oint</i>	T1	
<i>mometasone furoate 0.1% soln</i>	T1	
NUCORT	T3	ST
OLUX ( <i>clobetasol propionate</i> )	T3	PA
OLUX-E ( <i>tovet emollient</i> )	T3	PA
PANDEL	T3	PA
<i>prednicarbate</i> (Dermatop)	T1	
PSORCON ( <i>diflorasone diacetate</i> )	T3	PA
SCALACORT DK	T3	ST
SERNIVO	T3	PA
SYNALAR	T3	ST
SYNALAR ( <i>fluocinolone acetonide</i> )	T3	ST
SYNALARTS	T3	ST
TEMOVATE ( <i>clobetasol propionate</i> )	T3	ST
TEXACORT	T3	ST
TOPICORT ( <i>desoximetasone</i> )	T3	ST
<i>triamcinolone acetonide</i>	T1	
<i>triamcinolone acetonide</i>	T1	PA
<i>triamcinolone acetonide</i> (Kenalog)	T1	PA
TRIDESILON ( <i>desonide</i> )	T3	PA
VANOS ( <i>fluocinonide</i> )	T3	PA
VERDESO	T3	PA

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

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# List of Prescription Medications

## SKIN PREPS (Skin Conditions)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
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### TOPICAL ANTI-INFLAMMATORY STEROID-LOCAL ANESTHETIC

ANALPRAM HC	T3	PA
EPIFOAM	T3	
<i>hydrocortisone/pramoxine</i> (Pramosone)	T1	
<i>lidocaine/hydrocortisone ac</i>	T1	
MEZPAROX-HC	T1	
PRAMOSONE 1% LOTION	T2	
PRAMOSONE 1%-1% CREAM	T2	
PRAMOSONE 1%-1% OINTMENT	T2	
PRAMOSONE 2.5%-1% CREAM	T3	
PRAMOSONE 2.5%-1% LOTION	T3	
PRAMOSONE 2.5%-1% OINTMENT	T2	

### TOPICAL ANTI-PARASITICS

<i>malathion</i> (Ovide)	T1	
OVIDE ( <i>malathion</i> )	T3	

### TOPICAL PREPARATIONS, ANTIBACTERIALS

<i>dermazene cream</i>	T1	
DERMAZENE CREAM PACKET	T3	
<i>hydrocortisone/iodoquinol</i>	T1	
<i>hydrocortisone/iodoquinol/aloe</i>	T1	
<i>iodine/potassium iodide</i>	T1	
<i>iodine/sodium iodide</i>	T1	
IODOFLEX	T3	
IODOSORB	T3	
<i>silver nitrate</i>	T1	

### TOPICAL VIT D ANALOG/ANTI-INFLAMMATORY STEROID

<i>calcipotriene/betamethasone</i> (Taclonex)	T1	
ENSTILAR	T3	PA
TACLONEX 0.005%-0.064% SUSPENS ( <i>calcipotriene/betamethasone</i> )	T3	
TACLONEX OINTMENT ( <i>calcipotriene/betamethasone</i> )	T3	PA
WYNZORA	T3	PA

### TOPICAL/MUCOUS MEMBR./SUBCUT. ENZYMES

SANTYL	T2	QL (60gm/30 days)
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### VITAMIN A DERIVATIVES

<i>adapalene</i>	T1	PA
<i>adapalene</i> (Differin)	T1	PA
<i>adapalene</i> (Plixda)	T1	PA
AKLIEF	T3	

T1 – Typically Generics

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# List of Prescription Medications

SKIN PREPS (Skin Conditions)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>VITAMIN A DERIVATIVES (con't.)</b>		
ALTRENO	T3	PA
ATRALIN ( <i>tretinoin</i> )	T3	PA
<i>avita 0.025% cream (Retin-a)</i>	T3	PA
AVITA 0.025% GEL	T3	
DIFFERIN	T3	PA
DIFFERIN ( <i>adapalene</i> )	T3	PA
PLIXDA	T1	PA
RETIN-A 0.01% GEL ( <i>tretinoin</i> )	T3	
RETIN-A 0.025% CREAM ( <i>tretinoin</i> )	T3	PA
RETIN-A 0.025% GEL ( <i>tretinoin</i> )	T3	
RETIN-A 0.05% CREAM ( <i>tretinoin</i> )	T3	PA
RETIN-A 0.1% CREAM ( <i>tretinoin</i> )	T3	PA
RETIN-A MICRO ( <i>tretinoin microsphere</i> )	T3	PA
RETIN-A MICRO PUMP	T3	PA
RETIN-A MICRO PUMP ( <i>tretinoin microsphere</i> )	T3	PA
<i>tretinoin 0.01% gel (Retin-a)</i>	T1	
<i>tretinoin 0.025% cream (Retin-a)</i>	T1	PA
<i>tretinoin 0.025% gel (Retin-a)</i>	T1	
<i>tretinoin 0.05% cream (Retin-a)</i>	T1	PA
<i>tretinoin 0.05% gel (Atralin)</i>	T1	PA
<i>tretinoin 0.1% cream (Retin-a)</i>	T1	PA
<i>tretinoin microspheres (Retin-a Micro Pump)</i>	T1	PA
<i>tretinoin microspheres (Retin-a Micro)</i>	T1	PA
TRETIN-X	T3	PA
<b>VITAMIN A DERIVATIVES, TOPICAL ACNE AGENTS</b>		
ARAZLO	T2	
FABIOR	T3	
TAZAROTENE 0.1% FOAM	T3	
<b>SMOKING DETERRENTS (Smoking Cessation)<sup>8</sup></b>		
<b>SMOKING DETERRENT AGENTS (GANGLIONIC STIM, OTHERS)</b>		
NICOTROL	T2	PPACA
NICOTROL NS	T2	PPACA
<b>SMOKING DETERRENT-NICOTINIC RECEPT.PARTIAL AGONIST</b>		
CHANTIX	T2	
<i>varenicline 1 mg cont month bx</i>	T1	PPACA
<b>SMOKING DETERRENTS, OTHER</b>		
<i>bupropion hcl sr 150 mg tablet</i>	T1	PPACA

T1 – Typically Generics      T4 – Injectable Specialty Medications      ST – Step Therapy      HD – May require home delivery pharmacy  
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## List of Prescription Medications

THYROID PREPS (Hormonal Agents)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>ANTI-THYROID PREPARATIONS</b>		
<i>methimazole</i> (Tapazole)	T1	HD
<i>propylthiouracil</i>	T1	HD
TAPAZOLE ( <i>methimazole</i> )	T3	HD
<b>THYROID HORMONES</b>		
<i>adthyza 120 mg tablet</i>	T1	PA HD
ADTHYZA 130 MG TABLET	T3	PA HD
<i>adthyza 15 mg tablet</i>	T1	PA HD
ADTHYZA 16.25 MG TABLET	T3	PA HD
<i>adthyza 30 mg tablet</i>	T1	PA HD
ADTHYZA 32.5 MG TABLET	T3	PA HD
<i>adthyza 60 mg tablet</i>	T1	PA HD
ADTHYZA 65 MG TABLET	T3	PA HD
ADTHYZA 97.5 MG TABLET	T3	PA HD
ARMOUR THYROID	T3	HD
CYTOMEL ( <i>liothyronine sodium</i> )	T3	HD
LEVOTHYROXINE	T3	HD
<i>levothyroxine sodium</i> (Synthroid)	T1	HD
<i>levothyroxine sodium</i> (Synthroid)	T3	HD
<i>liothyronine sodium</i> (Cytomel)	T1	HD
SYNTHROID ( <i>unithroid</i> )	T3	HD
THYQUIDITY	T3	PA HD
<i>thyroid, pork</i>	T1	HD
<i>thyroid, pork</i> (Armour Thyroid)	T1	HD
<i>thyroid, pork</i> (Wp Thyroid)	T1	HD
THYROLAR-1	T2	HD
THYROLAR-1/2	T2	HD
THYROLAR-1/4	T2	HD
THYROLAR-2	T2	HD
THYROLAR-3	T2	HD
TIROSINT	T3	HD
TIROSINT-SOL	T3	HD
WP THYROID	T1	HD
WP THYROID ( <i>nature-throid</i> )	T1	HD
WP THYROID ( <i>westhroid</i> )	T1	HD

T1 – Typically Generics

T4 – Injectable Specialty Medications

ST – Step Therapy

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## List of Prescription Medications

### UNCLASSIFIED DRUG PRODUCTS (AIDS/HIV)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>CYTOCHROME P450 INHIBITORS</b>		
TYBOST	T3	SP

### UNCLASSIFIED DRUG PRODUCTS (Asthma/COPD/Respiratory)

<b>CYSTIC FIBROSIS-CFTR POTENTIATOR-CORRECTOR COMBIN.</b>		
BRONCHITOL 40 MG INHALE CAP	T3	PA SP
ORKAMBI 100 MG-125 MG TABLET	T3	PA QL (4 tabs/day) SP HD
ORKAMBI 100-125 MG GRANULE PKT	T3	PA QL (2 packs/day) SP HD
ORKAMBI 150-188 MG GRANULE PKT	T3	PA QL (2 packs/day) SP HD
ORKAMBI 200 MG-125 MG TABLET	T3	PA QL (4 tabs/day) SP HD
SYMDEKO	T3	PA QL (2 tabs/day) SP HD
TRIKAFTA	T3	PA QL (3 tabs/day) SP HD

<b>CYSTIC FIB-TRANSMEMB CONDUCT.REG.(CFTR) POTENTIATOR</b>		
KALYDECO 5.8 MG TABLET	T3	PA QL (2 tabs/day) SP HD
KALYDECO 150 MG TABLET	T3	PA QL (2 tabs/day) SP HD
KALYDECO 25 MG GRANULES PACKET	T3	PA QL (2 packs/day) SP HD
KALYDECO 50 MG GRANULES PACKET	T3	PA QL (2 packs/day) SP HD
KALYDECO 75 MG GRANULES PACKET	T3	PA QL (2 packs/day) SP HD

<b>LUNG SURFACTANTS</b>		
CUROSURF	T3	
INFASURF	T3	
SURVANTA	T3	

<b>MUCOLYTICS</b>		
PULMOZYME	T2	PA SP HD

<b>PULMONARY FIBROSIS - SYSTEMIC ENZYME INHIBITORS</b>		
OFEV	T2	PA SP HD

<b>SYSTEMIC ENZYME INHIBITORS</b>		
JOENJA	T3	PA QL SP
VIJOICE 125mg,50 mg	T3	PA QL(PA QL (30tabs/30days) SP
VIJOICE 250mg dose pack	T3	PA QL (2 tabs/30 days)
ZOKINVY	T3	PA QL (4 CAPS/DAY) SP

### UNCLASSIFIED DRUG PRODUCTS (Blood Modifiers/Bleeding Disorders)

<b>SPLEEN TYROSINE KINASE INHIBITORS</b>		
TAVALISSE	T3	PA SP

### UNCLASSIFIED DRUG PRODUCTS (Blood Pressure/Heart Medications)

<b>ANTI-INFLAMMATORY-ANTIMITOTICS</b>		
LODOCO	T3	PA

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

T4 – Injectable Specialty Medications

PA – Prior Authorization

QL – Quantity Limit

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AGE – Age Requirement

SP – Specialty Medication

HD – 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 (Blood Pressure/Heart Medications) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>BRADYKININ B2 RECEPTOR ANTAGONISTS</b>		
FIRAZYR ( <i>icatibant</i> )	T4	PA SP HD
<i>icatibant acetate</i> (Firazyr)	T4	PA SP HD
<b>CI ESTERASE INHIBITORS</b>		
BERINERT	T3	PA SP HD
CINRYZE	T3	PA SP HD
HAEGARDA	T4	PA SP HD
RUCONEST	T3	PA SP HD
<b>PLASMA KALLIKREIN INHIBITORS</b>		
KALBITOR	T3	PA SP HD
ORLADEYO	T3	PA QL (1 CAPS/DAY) SP

### UNCLASSIFIED DRUG PRODUCTS (Cancer)

#### CHEMOTHERAPY RESCUE/ANTIDOTE AGENTS

<i>leucovorin calcium</i>	T1	
MESNEX	T3	SP
VISTOGARD	T3	SP

### UNCLASSIFIED DRUG PRODUCTS (Dental Products)

#### DENTAL AIDS AND PREPARATIONS

<i>chlorhexidine gluconate</i> (Peridex)	T1	
PERIDEX ( <i>perio gard</i> )	T1	
<i>triamcinolone acetonide</i>	T1	

#### PERIODONTAL COLLAGENASE INHIBITORS

<i>doxycycline hyclate 20 mg tab</i>	T1	
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### UNCLASSIFIED DRUG PRODUCTS (Diabetes)

#### PERIODONTAL COLLAGENASE INHIBITORS

INPEFA	T3	PA QL(1 tab/day) HD
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### UNCLASSIFIED DRUG PRODUCTS (Erectile Dysfunction)

#### DRUGS TO TREAT ERECTILE DYSFUNCTION (ED)

CAVERJECT	T3	PA QL (6 injectors/30 days)
CIALIS 10 MG TABLET ( <i>tadalafil</i> )	T3	QL (8 tabs/30 days) ST
CIALIS 20 MG TABLET ( <i>tadalafil</i> )	T3	ST QL(8 tabs/30 days) HD
CIALIS 5 MG TABLET ( <i>tadalafil</i> )	T3	ST QL(1 tab/day) HD
EDEX	T3	PA QL (6 injectors/30 days)
IFE-BIMIX 30/1	T2	
IFE-PG20	T2	
LEVITRA ( <i>ardenafil hcl</i> )	T3	QL (10 tabs/30 days) ST
MUSE	T2	PA QL (6/30 days)

T1 – Typically Generics

T4 – Injectable Specialty Medications

ST – Step Therapy

HD – May require home delivery pharmacy

T2 – Typically Preferred Brands

PA – Prior Authorization

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T3 – Typically Non-Preferred Brands

QL – Quantity Limit

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## UNCLASSIFIED DRUG PRODUCTS (Erectile Dysfunction) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>DRUGS TO TREAT ERECTILE DYSFUNCTION (ED) (cont.)</b>		
PAPAVERINE-ALPROSTADIL	T1	
PHENTOLAMINE-ALPROSTADIL	T1	
<i>sildenafil 100 mg tablet (Viagra)</i>	T1	QL(8 TABS/30 DAYS) HD
<i>sildenafil 25 mg tablet (Viagra)</i>	T1	QL(8 TABS/30 DAYS) HD
<i>sildenafil 50 mg tablet (Viagra)</i>	T1	QL(8 TABS/30 DAYS) HD
STENDRA	T3	QL (8 tabs/30 days) ST
<i>tadalafil 10 mg tablet (Cialis)</i>	T1	QL(8 TABS/30 DAYS) HD
<i>tadalafil 2.5 mg tablet</i>	T1	QL(1 TAB/DAY) HD
<i>tadalafil 20 mg tablet (Cialis)</i>	T1	QL(8 TABS/30 DAYS) HD
<i>tadalafil 5 mg tablet (Cialis)</i>	T1	QL(1 TAB/DAY) HD
<i>vardenafil hcl</i>	T1	QL (10 tabs/30 days)
<i>vardenafil hcl (Levitra)</i>	T1	QL (10 tabs/30 days)
VIAGRA ( <i>sildenafil citrate</i> )	T3	ST QL(8 tabs/30 days) HD

## UNCLASSIFIED DRUG PRODUCTS (Gastrointestinal/Heartburn)

### CALCIMIMETIC, PARATHYROID CALCIUM ENHANCER

<i>cinacalcet hcl (Sensipar)</i>	T1	SP
SENSIPAR ( <i>cinacalcet hcl</i> )	T3	PA SP

### ORAL MUCOSITIS/STOMATITIS AGENTS

ORAMAGICRX	T3	
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### SALIVA STIMULANT AGENTS

NUMOISYN	T3	
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## UNCLASSIFIED DRUG PRODUCTS (Hormonal Agents)

### BONE FORMATION STIM. AGENTS - PARATHYROID HORMONE

FORTEO	T2	PA QL (3ML/21 DAYS) SP HD
FORTEO ( <i>teriparatide</i> )	T3	PA QL(0.09 MLS/DAY) SP HD
<i>teriparatide 600 mcg/2.4ml pen</i>	T1	PA QL(0.09 mls/day) SP HD
TERIPARATIDE 620 MCG/2.48 ML	T3	PA QL(0.09 mls/day) SP HD
TERIPARATIDE	T3	PA QL (1 pen/28 days) SP HD

### GROWTH HORMONE RECEPTOR ANTAGONISTS

SOMAVERT	T4	PA SP HD
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### HYPERPARATHYROID TX AGENTS - VITAMIN D ANALOG-TYPE

<i>doxercalciferol</i>	T1	
<i>paricalcitol</i>	T1	SP HD
<i>paricalcitol (Zemplar)</i>	T1	SP HD
RAYALDEE	T3	
ZEMPLAR ( <i>paricalcitol</i> )	T3	SP HD

### MENOPAUSAL SYMPT SUPP-SEL ESTROGEN RECEP MODULATOR

OSPHENA	T3	HD
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I1 – Typically Generics

I4 – Injectable Specialty Medications

S1 – Step Therapy

HD – May require home delivery pharmacy

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T3 – Typically Non-Preferred Brands

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# List of Prescription Medications

UNCLASSIFIED DRUG PRODUCTS (Miscellaneous)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>ABORTIFACIENT-PROGESTERONE RECEPTOR ANTAGONISTS</b>		
MIFEPREX	T3	
<i>mifepristone (Mifeprex)</i>	T1	
<b>AGENTS TO TX PERIODIC PARALYSIS - CARBON ANHYD INH</b>		
<i>dichlorphenamide</i>	T1	PA SP
KEVEYIS	T3	SP
<b>AMMONIA INHIBITORS</b>		
CARBAGLU	T3	SP HD
<b>AMYLOIDOSIS AGENTS-TRANSTHYRETIN (TTR) SUPPRESSION</b>		
TEGSEDI	T3	PA SP HD
<b>ANTI-ALCOHOLIC PREPARATIONS</b>		
<i>acamprosate calcium</i>	T1	
ANTABUSE ( <i>disulfiram</i> )	T3	
<i>disulfiram (Antabuse)</i>	T1	
<b>ANTIDOTES, MISCELLANEOUS</b>		
CETYLEV	T3	
<b>ANTI-FIBROTIC THERAPY - PYRIDONE ANALOGS</b>		
ESBRIET	T3	PA SP HD
<i>pirfenidone 267 mg capsule</i>	T1	PA SP HD
<b>CRYOPRESERVATIVE AGENTS</b>		
<i>dimethyl sulfoxide</i>	T1	
<b>DRUGS TO TREAT HEREDITARY TYROSINEMIA</b>		
<i>nitisinone (Orfadin)</i>	T1	PA SP HD
NITYR	T2	PA SP
ORFADIN	T3	PA SP
ORFADIN ( <i>nitisinone</i> )	T3	PA SP
<b>GENERAL INHALATION AGENTS</b>		
HYPER-SAL	T3	
<i>nebusal 3% vial</i>	T1	
NEBUSAL 6% VIAL	T3	
<i>sodium chloride for inhalation</i>	T1	
<i>sodium chloride for inhalation (Hyper-sal)</i>	T1	
<b>GENETIC D/O TX - SMN PROTEIN DEFICIENCY TREATMENT</b>		
EVRYSDI	T3	PA SP HD
<b>GLUCOSYLCERAMIDE SYNTHASE (GCS) INHIBITOR</b>		
CERDELGA	T2	PA SP HD
OPFOLDA	T3	PA QL(8 CAPS/30 DAYS) SP HD

T1 – Typically Generics      T4 – Injectable Specialty Medications      ST – Step Therapy      HD – May require home delivery pharmacy  
 T2 – Typically Preferred Brands      PA – Prior Authorization      AGE – Age Requirement      PPACA – No Cost-Share Preventive Medication  
 T3 – Typically Non-Preferred Brands      QL – Quantity Limit      SP – Specialty 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
<b>GLUCOSYLCERAMIDE SYNTHASE (GCS) INHIBITOR</b>		
<i>miglustat (Zavesca)</i>	T1	PA SP
ZAVESCA ( <i>miglustat</i> )	T3	PA SP HD
<b>MENOPAUSAL SYMPTOMS SUPPRESSANT-NK3 RECEPTOR ANTAG</b>		
VEOZAH	T3	QL(1 tab/day)
<b>MENOPAUSAL SYMPTOMS SUPPRESSANT - SSRIs</b>		
paroxetine mesylate	T1	QL(1 CAP/DAY) HD
<b>METABOLIC DISEASE ENZYME REPLACE, HYPOPHOSPHATASIA</b>		
STRENSIQ	T4	PA SP
<b>METABOLIC DISEASE ENZYME REPLACEMENT, MOCD</b>		
NULIBRY	T3	PA SP
<b>METALLIC POISON, AGENTS TO TREAT</b>		
CHEMET	T3	
CUVRIOR	T3	PA SP
<i>deferasirox (Exjade)</i>	T1	SP HD
<i>deferasirox (Jadenu Sprinkle)</i>	T1	SP HD
<i>deferasirox (Jadenu)</i>	T1	SP HD
<i>deferiprone (Ferriprox)</i>	T1	PA SP
EXJADE ( <i>deferasirox</i> )	T3	PA SP HD
FERRIPROX	T3	PA SP
FERRIPROX (2 TIMES A DAY)	T3	PA SP
GALZIN	T3	
JADENU ( <i>deferasirox</i> )	T3	PA SP HD
JADENU SPRINKLE ( <i>deferasirox</i> )	T3	PA SP HD
RADIOGARDASE	T3	
SYPRINE ( <i>trientine hcl</i> )	T3	PA SP HD
<i>trientine hcl (Syprine)</i>	T1	PA SP HD
<b>NATRIURETIC PEPTIDES</b>		
VOXZOGO	T4	PA SP HD
<b>NICOTINIC RECEPT.PARTIAL AGONIST, ALPHA4BETA2 SPEC</b>		
TYRVAYA	T3	PA QL (2/month) HD
<b>NUCLEAR FACTOR ERYTHROID 2-REL. FACTOR 2 ACTIVATOR</b>		
SKYCLARYS	T1	
<b>OINTMENT/CREAM BASES</b>		
RADIAGEL	T1	
<b>PHARMACOLOGICAL CHAPERONE-ALPHA-GALACTOSID.A STABZ</b>		
GALAFOLD	T3	PA SP HD

T1 – Typically Generics  
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 S1 – Step Therapy  
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 SP – Specialty Medication  
 HD – may require home delivery pharmacy  
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## List of Prescription Medications

UNCLASSIFIED DRUG PRODUCTS (Miscellaneous)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>PKU TX AGENT-COFACTOR OF PHENYLALANINE HYDROXYLASE</b>		
KUVAN ( <i>sapropterin dihydrochloride</i> )	T3	PA SP HD
<i>sapropterin dihydrochloride</i> (Kuvan)	T1	PA SP HD
<b>PROTEIN STABILIZERS</b>		
VYNDAMAX	T3	PA QL (1 cap/day) SP HD
VYNDAQEL	T3	PA QL (4 caps/day) SP HD
<b>RETINOIC ACID RECEPTOR (RAR) AGONISTS</b>		
SOHONOS	T3	PA SP
<b>SOLVENTS</b>		
FT ISOPROPYL ALCOHOL 91%	T1	
FT ISOPROPYL RUB ALCOHOL 70%	T3	
<i>isopropyl alcohol</i>	T1	
MURI-LUBE MINERAL OIL	T1	
<b>THYMIC STROMAL LYMPHOPOIETIN (TSLP) INHIBITORS</b>		
TEZSPIRE	T4	PA SP
UNCLASSIFIED DRUG PRODUCTS (Nutritional/Dietary)		
<b>METABOLIC DEFICIENCY AGENTS</b>		
CARNITOR 1 GM/5 ML VIAL	T3	PA
CARNITOR 100 MG/ML ORAL SOLN ( <i>levocarnitine</i> )	T3	PA
CARNITOR 330 MG TABLET ( <i>levocarnitine</i> )	T3	PA
CARNITOR SF ( <i>levocarnitine sf</i> )	T3	PA
CYSTADANE	T2	SP
<i>levocarnitine</i> (Carnitor Sf)	T1	
<i>levocarnitine</i> (Carnitor)	T1	
<i>levocarnitine (with sugar)</i> (Carnitor)	T1	
UNCLASSIFIED DRUG PRODUCTS (Osteoporosis Products)		
<b>BONE RESORPTION INHIBITOR AND VITAMIN D COMBS.</b>		
FOSAMAX PLUS D	T3	ST HD
<b>BONE RESORPTION INHIBITORS</b>		
ACTONEL ( <i>risedronate sodium</i> )	T3	ST HD
<i>alendronate sodium</i>	T1	HD
<i>alendronate sodium</i> (Fosamax)	T1	HD
AELVIA ( <i>risedronate sodium dr</i> )	T3	ST HD
BINOSTO	T3	ST HD
BONIVA ( <i>ibandronate sodium</i> )	T3	ST HD
EVISTA ( <i>raloxifene hcl</i> )	T3	HD
FOSAMAX ( <i>alendronate sodium</i> )	T3	ST HD
<i>ibandronate sodium</i>	T1	HD

T1 – Typically Generics  
T2 – Typically Preferred Brands  
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T4 – Injectable 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 (Osteoporosis Products)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>BONE RESORPTION INHIBITORS</b>		
<i>raloxifene hcl</i> (Evista)	T1	HD PPACA
<i>risedronate sodium</i>	T1	HD
<i>risedronate sodium</i> (Actonel)	T1	HD
<i>risedronate sodium</i> (Atelvia)	T1	HD
<b>UNCLASSIFIED DRUG PRODUCTS (Pain Relief And Inflammatory Disease)</b>		
<b>ANTI-INFLAM. INTERLEUKIN-1 RECEPTOR ANTAGONIST</b>		
ARCALYST	T4	PA SP HD
<b>ANTI-INFLAMMATORY, INTERLEUKIN-1 BETA BLOCKERS</b>		
ILARIS	T3	PA SP HD
<b>UNCLASSIFIED DRUG PRODUCTS (Pain Relief And Inflammatory Disease) (cont.)</b>		
<b>FIBROMYALGIA AGENTS, SEROTONIN-NOREPINEPH RU INHIB</b>		
SAVELLA	T2	HD
<b>IMMUNOMODULATOR, B-LYMPHOCYTE STIM (BLYS)-SPEC INHIB</b>		
BENLYSTA	T4	PA SP HD
<b>UNCLASSIFIED DRUG PRODUCTS (Seizure Disorders)</b>		
<b>NEUROPATHIC AGENTS</b>		
LYRICA CR	T3	HD
<b>UNCLASSIFIED DRUG PRODUCTS (Skin Conditions)</b>		
<b>INTERLEUKIN-13 (IL-13) INHIBITORS, MAB</b>		
ADBRY	T4	PA SP HD
<b>UNCLASSIFIED DRUG PRODUCTS (Substance Abuse)</b>		
<b>OPIOID WITHDRAWAL THER, ALPHA-2 ADRENERGIC AGONIST</b>		
LUCEMYRA	T2	QL (168 tabs/14 days)
<b>OPIOID WITHDRAWAL THERAPY AGENTS, OPIOID-TYPE</b>		
BUNAVAIL	T3	
<i>buprenorphine hcl</i>	T1	
<i>buprenorphine hcl/naloxone hcl</i>	T1	
<i>buprenorphine hcl/naloxone hcl</i> (Suboxone)	T1	
SUBOXONE ( <i>buprenorphine-naloxone</i> )	T3	
ZUBSOLV	T2	
<b>UNCLASSIFIED DRUG PRODUCTS (Transplant Medications)</b>		
<b>RHO KINASE INHIBITOR</b>		
REZUROCK	T3	PA SP HD

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# List of Prescription Medications

## UNCLASSIFIED DRUG PRODUCTS (Urinary Tract Conditions)

### BENIGN PROSTATIC HYPERTROPHY/MICTURITION AGENTS

<i>alfuzosin hcl</i> (Uroxatral)	T1	HD
AVODART ( <i>dutasteride</i> )	T3	PA HD
<i>dutasteride</i> (Avodart)	T1	HD
<i>finasteride</i> (Proscar)	T1	HD
FLOMAX ( <i>tamsulosin hcl</i> )	T3	HD
PROSCAR ( <i>finasteride</i> )	T3	HD
RAPAFLO 4 MG CAPSULE ( <i>silodosin</i> )	T3	QL (1 cap/day) HD
RAPAFLO 8 MG CAPSULE ( <i>silodosin</i> )	T3	HD
<i>silodosin 4 mg capsule</i> (Rapaflo)	T1	QL (1 cap/day) HD
<i>silodosin 8 mg capsule</i> (Rapaflo)	T1	HD
<i>tamsulosin hcl</i> (Flomax)	T1	HD
UROXATRAL ( <i>alfuzosin hcl er</i> )	T3	HD

### BPH AGENT-5-ALPHA-REDUCTASE INH AND PDE5 INH COMB

ENTADFI	T3	PA QL (30caps/30days)
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### BPH 5-ALPHA-REDUCTASE INHIB-ALPHA1-ADRENOCEP ANTAG

<i>dutasteride/tamsulosin hcl</i> (Jalyn)	T1	HD
JALYN ( <i>dutasteride-tamsulosin</i> )	T3	PA HD

### CYSTINE-DEPLETING AGENTS, NEPHROPATHIC CYSTINOSIS

CYSTAGON	T2	SP
PROCYSBI	T3	PA SP HD

### KIDNEY STONE AGENTS

THIOLA	T3	PA SP
THIOLA EC	T3	PA SP
<i>tiopronin</i>	T1	SP

### OVERACTIVE BLADDER AGENTS, BETA-3 ADRENERGIC RECEPTOR

GEMTESA	T3	QL (1 tab/Day) ST HD
MYRBETRIQ ER 25 MG TABLET	T3	QL (1 tab/day) ST HD
MYRBETRIQ ER 50 MG TABLET	T3	ST HD

### URINARY TRACT ANTI-SPASMODIC, M(3) SELECTIVE ANTAG.

<i>darifenacin er 15 mg tablet</i>	T1	HD
<i>darifenacin er 7.5 mg tablet</i> (Enablex)	T1	QL (1 tab/day) HD
ENABLEX ( <i>darifenacin er</i> )	T3	QL (1 tab/day) ST HD
<i>solifenacin 10 mg tablet</i> (Vesicare)	T1	HD
<i>solifenacin 5 mg tablet</i> (Vesicare)	T1	QL (1 tab/day) HD
VESICARE 10 MG TABLET ( <i>solifenacin succinate</i> )	T3	ST HD
VESICARE 5 MG TABLET ( <i>solifenacin succinate</i> )	T3	QL (1 tab/day) ST HD
VESICARE LS	T3	ST HD

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## List of Prescription Medications

UNCLASSIFIED DRUG PRODUCTS (Urinary Tract Conditions)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>URINARY TRACT ANTI-SPASMODIC/ANTI-INCONTINENCE AGENT</b>		
DETROL ( <i>tolterodine tartrate</i> )	T3	ST HD
DETROL LA 2 MG CAPSULE ( <i>tolterodine tartrate er</i> )	T3	QL (1 cap/day) ST HD
DETROL LA 4 MG CAPSULE ( <i>tolterodine tartrate er</i> )	T3	ST HD
DITROPAN XL ( <i>oxybutynin chloride er</i> )	T3	ST HD
<i>flavoxate hcl</i>	T1	HD
GELNIQUE	T3	ST HD
<i>oxybutynin chloride</i>	T1	HD
<i>oxybutynin chloride</i> (Ditropan XL)	T1	HD
OXYTROL	T3	ST HD
<i>tolterodine tart er 2 mg cap</i> (Detrol La)	T1	QL (1 cap/day) HD
<i>tolterodine tart er 4 mg cap</i> (Detrol La)	T1	HD
<i>tolterodine tartrate</i> (Detrol)	T1	HD
TOVIAZ ER 4 MG TABLET	T2	QL (1 tab/day) HD
TOVIAZ ER 8 MG TABLET	T2	HD
<i>tropium chloride</i>	T1	HD
<b>UNCLASSIFIED DRUG PRODUCTS (Weight Management)</b>		
<b>APPETITE STIM. FOR ANOREXIA, CACHEXIA, WASTING SYND.</b>		
<i>megestrol acetate</i>	T1	
<b>VITAMINS (Nutritional/Dietary)</b>		
<b>FOLIC ACID PREPARATIONS</b>		
<i>folic acid</i>	T1	
<i>true folic acid 1600mcg dfe tb</i>	T1	
<b>MULTIVITAMIN PREPARATIONS</b>		
CONCEPT DHA CAPSULE	T3	
FOLET ONE	T2	
<i>mvn no.53/iron/folic/dss/dha</i>	T1	
OBSTETRIX ONE	T1	
<b>VITAMIN B PREPARATIONS</b>		
POTABA	T2	HD
<b>VITAMIN B12 PREPARATIONS</b>		
<i>cyanocobalamin (vitamin b-12)</i>	T1	
NASCOBAL	T3	PA
<b>VITAMIN D PREPARATIONS</b>		
<i>calcitriol 0.25 mcg capsule</i> (Rocaltrol)	T1	HD
<i>calcitriol 0.5 mcg capsule</i> (Rocaltrol)	T1	HD
<i>calcitriol 1 mcg/ml solution</i> (Rocaltrol)	T1	HD

T1 – Typically Generics

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## List of Prescription Medications

VITAMINS (Nutritional/Dietary)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>VITAMIN D PREPARATIONS</b>		
DRISDOL ( <i>vitamin d2</i> )	T2	HD
<i>ergocalciferol (vitamin d2)</i> (Drisdol)	T1	HD
ROCALTROL ( <i>calcitriol</i> )	T3	HD
<b>VITAMIN K PREPARATIONS</b>		
MEPHYTON ( <i>phytonadione</i> )	T3	
<i>phytonadione (vit k1)</i> (Mephyton)	T1	

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

T4 – Injectable Specialty Medications

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## Exclusions and limitations for coverage

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

Plans generally do not provide coverage for the following under the pharmacy benefit, except as required by state or federal law, or by the terms of your specific plan:<sup>9</sup>

- 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,<sup>10</sup> sexual dysfunction, cosmetic purposes, weight loss, smoking cessation,<sup>10</sup> or athletic enhancement.
- Prescription vitamins (other than prenatal vitamins) or dietary supplements unless state or federal law requires coverage of such products.
- Immunization agents, biological products for allergy immunization, biological sera, blood, blood plasma and other blood products or fractions and medications used for travel prophylaxis.
- Replacement of prescription medications and related supplies due to loss or theft.
- Medications which are to be taken by or administered to a covered person while they are a patient in a licensed hospital, skilled nursing facility, rest home or similar institution which operates on its premises or allows to be operated on its premises a facility for dispensing pharmaceuticals.
- Prescriptions more than one year from the date of issue.
- Coverage for prescription medication products for the amount dispensed (days' supply) which is more than the applicable supply limit, or is less than any applicable supply minimum set forth in The Schedule, or which is more than the quantity limit(s) or dosage limit(s) set by the P&T Committee.
- More than one prescription order or refill for a given prescription supply period for the same prescription medication product prescribed by one or more doctors and dispensed by one or more pharmacies.
- Prescription medication products dispensed outside the jurisdiction of the United States, except as required for emergency or urgent care treatment.

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

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1. App/online store terms and mobile phone carrier/data charges apply. Customers under age 13 (and/or their parent/guardian) will not be able to register at myCigna.com.
2. Prices shown on myCigna are not guaranteed and coverage is subject to your plan terms and conditions. Visit myCigna for more information.
3. U.S. Food and Drug Administration (FDA) website, "Generic Drugs: Questions and Answers." Last updated 03/16/21. [fda.gov/drugs/questions-answers/generic-drugs-questions-answers](https://www.fda.gov/drugs/questions-answers/generic-drugs-questions-answers).
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6. Some medications aren't available in a 90-day supply and may only be packaged in lesser amounts. For example, three packages of oral contraceptives equal an 84-day supply. Even though it's not a "90-day supply," it's still considered a 90-day prescription.
7. As allowable by law. For medications administered by a health care provider, Accredo will ship the medication directly to your doctor's office.
8. **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 plan covers these medications, log in to the myCigna App or myCigna.com, or call Customer Service using the number on your ID card.
9. 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.
10. **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.**

Product availability may vary by location and plan type and is subject to change. All group health insurance policies and health benefit plans contain exclusions and limitations. For costs and details of coverage, review your plan documents or contact a Cigna Healthcare representative.

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

# DISCRIMINATION IS AGAINST THE LAW

## Medical coverage

Cigna complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Cigna does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

Cigna:

- Provides free aids and services to people with disabilities 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 services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, contact customer service at the toll-free number shown on your ID card, and ask a Customer Service Associate for assistance.

If you believe that Cigna has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance by sending an email to [ACAGrievance@Cigna.com](mailto:ACAGrievance@Cigna.com) or by writing to the following address:

Cigna  
Nondiscrimination Complaint Coordinator  
PO Box 188016  
Chattanooga, TN 37422

If you need assistance filing a written grievance, please call the number on the back of your ID card or send an email to [ACAGrievance@Cigna.com](mailto:ACAGrievance@Cigna.com). 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  
<http://www.hhs.gov/ocr/office/file/index.html>.



All Cigna products and services are provided exclusively by or through operating subsidiaries of Cigna Corporation, including Cigna Health and Life Insurance Company, Connecticut General Life Insurance Company, Evernorth Care Solutions, Inc., Evernorth Behavioral Health, Inc., Cigna Health Management, Inc., and HMO or service company subsidiaries of Cigna Health Corporation and Cigna Dental Health, Inc. The Cigna name, logos, and other Cigna marks are owned by Cigna Intellectual Property, Inc. ATTENTION: If you speak languages other than English, language assistance services, free of charge are available to you. For current Cigna customers, call the number on the back of your ID card. Otherwise, call 1.800.244.6224 (TTY: Dial 711). ATENCIÓN: Si usted habla un idioma que no sea inglés, tiene a su disposición servicios gratuitos de asistencia lingüística. Si es un cliente actual de Cigna, llame al número que figura en el reverso de su tarjeta de identificación. Si no lo es, llame al 1.800.244.6224 (los usuarios de TTY deben llamar al 711).

## Proficiency of Language Assistance Services

**English** – ATTENTION: Language assistance services, free of charge, are available to you. For current Cigna customers, call the number on the back of your ID card. Otherwise, call 1.800.244.6224 (TTY: Dial 711).

**Spanish** – ATENCIÓN: Hay servicios de asistencia de idiomas, sin cargo, a su disposición. Si es un cliente actual de Cigna, llame al número que figura en el reverso de su tarjeta de identificación. Si no lo es, llame al 1.800.244.6224 (los usuarios de TTY deben llamar al 711).

**Chinese** – 注意：我們可為您免費提供語言協助服務。對於 Cigna 的現有客戶，請致電您的 ID 卡背面的號碼。其他客戶請致電 1.800.244.6224（聽障專線：請撥 711）。

**Vietnamese** – XIN LỜI Ý: Quý vị được cấp dịch vụ trợ giúp về ngôn ngữ miễn phí. Dành cho khách hàng hiện tại của Cigna, vui lòng gọi số ở mặt sau thẻ Hội viên. Các trường hợp khác xin gọi số 1.800.244.6224 (TTY: Quay số 711).

**Korean** – 주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 현재 Cigna 가입자님들께서는 ID 카드 뒷면에 있는 전화번호로 연락해주시십시오. 기타 다른 경우에는 1.800.244.6224 (TTY: 다이얼 711)번으로 전화해주시십시오.

**Tagalog** – PAUNAWA: Makakakuha ka ng mga serbisyo sa tulong sa wika nang libre. Para sa mga kasalukuyang customer ng Cigna, tawagan ang numero sa likuran ng iyong ID card. O kaya, tumawag sa 1.800.244.6224 (TTY: I-dial ang 711).

**Russian** – ВНИМАНИЕ: вам могут предоставить бесплатные услуги перевода. Если вы уже участвуете в плане Cigna, позвоните по номеру, указанному на обратной стороне вашей идентификационной карточки участника плана. Если вы не являетесь участником одного из наших планов, позвоните по номеру 1.800.244.6224 (TTY: 711).

**Arabic** – برجاء الانتباه خدمات الترجمة المجانية متاحة لكم. لعملاء Cigna الحاليين برجاء الاتصال بالرقم المدون علي ظهر بطاقتكم الشخصية. او اتصل ب 1.800.244.6224 (TTY: اتصل ب 711).

**French Creole** – ATANSYON: Gen sèvis èd nan lang ki disponib gratis pou ou. Pou kliyan Cigna yo, rele nimewo ki dèyè kat ID ou. Sinon, rele nimewo 1.800.244.6224 (TTY: Rele 711).

**French** – ATTENTION: Des services d'aide linguistique vous sont proposés gratuitement. Si vous êtes un client actuel de Cigna, veuillez appeler le numéro indiqué au verso de votre carte d'identité. Sinon, veuillez appeler le numéro 1.800.244.6224 (ATS : composez le numéro 711).

**Portuguese** – ATENÇÃO: Tem ao seu dispor serviços de assistência linguística, totalmente gratuitos. Para clientes Cigna atuais, ligue para o número que se encontra no verso do seu cartão de identificação. Caso contrário, ligue para 1.800.244.6224 (Dispositivos TTY: marque 711).

**Polish** – UWAGA: w celu skorzystania z dostępnej, bezpłatnej pomocy językowej, obecni klienci firmy Cigna mogą dzwonić pod numer podany na odwrocie karty identyfikacyjnej. Wszystkie inne osoby prosimy o skorzystanie z numeru 1 800 244 6224 (TTY: wybierz 711).

**Japanese** – 注意事項: 日本語を話される場合、無料の言語支援サービスをご利用いただけます。現在のCignaのお客様は、IDカード裏面の電話番号まで、お電話にてご連絡ください。その他の方は、1.800.244.6224 (TTY: 711)まで、お電話にてご連絡ください。

**Italian** – ATTENZIONE: Sono disponibili servizi di assistenza linguistica gratuiti. Per i clienti Cigna attuali, chiamare il numero sul retro della tessera di identificazione. In caso contrario, chiamare il numero 1.800.244.6224 (utenti TTY: chiamare il numero 711).

**German** – ACHTUNG: Die Leistungen der Sprachunterstützung stehen Ihnen kostenlos zur Verfügung. Wenn Sie gegenwärtiger Cigna-Kunde sind, rufen Sie bitte die Nummer auf der Rückseite Ihrer Krankenversicherungskarte an. Andernfalls rufen Sie 1.800.244.6224 an (TTY: Wählen Sie 711).

**Persian (Farsi)** – توجه: خدمات کمک زبانی، به صورت رایگان به شما ارائه می‌شود. برای مشتریان فعلی Cigna، لطفاً با شماره‌ای که در پشت کارت شناسایی شماست تماس بگیرید. در غیر اینصورت با شماره 1.800.244.6224 تماس بگیرید (شماره تلفن ویژه ناشنوايان: شماره 711 را شماره‌گیری کنید).