



Cigna Healthcare National Preferred 5-Tier Prescription Drug List

Coverage as of July 1, 2024

For the State of California

Health Maintenance Organization (HMO), Network, Network Point of Service (POS)

View your drug list online: Cigna.com/druglist

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

View your coverage info online: [myCigna® App](#) or [myCigna.com®](#)

Last updated: 03/01/2024. This drug list is subject to change and all prior versions are no longer in effect.

Offered by: Cigna Health and Life Insurance Company, Connecticut General Life Insurance Company, or their affiliates.

975752 c CA NPF 5-Tier Split Generics 03/24 © 2024 Cigna Healthcare.





What's Inside?	Page
Information about this drug list	3
· Frequently asked questions (FAQs)	3
· Words you may need to know	11
· About this drug list	13
· How to read this drug list	13
· How to find your medication	16
List of prescription medications	19
Exclusions and limitations for coverage	235
Index of medications	236

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® App¹ 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/druglist.** Select **National Preferred 5 Tier** from the dropdown menu. Then type in your medication name or view the full list.

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 HealthcareSM ID card. We're here 24/7/365.

* Drug list created: originally created 01/01/2023

Last updated: 03/01/2024, for changes starting 07/01/2024

Next planned update: 11/01/2024, for changes starting 01/01/2025

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 1st and July 1st.
- **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. To help lower your overall health care costs, your plan doesn't cover certain high-cost brand-name medications that have lower-cost alternatives. That's because these lower-cost options work the same as, or similar to, the non-covered medication. If you're taking a medication that isn't covered and your doctor feels a different medication isn't right for you, he or she can ask Cigna Healthcare to consider approving your medication through the coverage review process.

There are also 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.

Information about this drug list

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

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

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.

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).

Information about this drug list

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

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.

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. **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 was just taken off the drug list. My doctor still wants me to take it. What do I have to do to get it covered?

A. You don't need to do anything. If your doctor continues to prescribe the medication, we'll continue to cover it. If your medication already requires prior authorization, your doctor just has to continue to request (and receive) approval from Cigna Healthcare for the medication to be covered.

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

A. If you and your doctor feel an alternative medication won't work for you, your doctor can ask 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.

Information about this drug list

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

- **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 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

Information about this drug list

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

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 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.²

Q. What's a cost-share?

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

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

A. 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.³ 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.

Information about this drug list

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

Q. Can I fill my prescription at any pharmacy in my network?

A. It depends. Some plans only allow fills at certain in-network pharmacies or through home delivery. Log in to the myCigna App or myCigna.com, or check your plan materials, to learn more about the pharmacies in your plan's network.

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

A. There are thousands of retail pharmacies in your plan's network. They include local pharmacies, grocery stores, retail chains and wholesale warehouse stores – all places where you may already shop. And some stores are open 24-hours. To find an in-network pharmacy near you, log in to the **myCigna App** or **myCigna.com**. Then click on the Prescriptions tab and choose “Find a Pharmacy” from the dropdown 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.⁴ 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

safe, and saves you trips to the pharmacy. To learn more, go to **Cigna.com/homedelivery**.

- Easily order, manage, track and pay for your medications on your phone or online
- Standard shipping at no extra cost⁵
- Automatic refills or refill reminders
- Fill up to a 90-day supply at one time⁶
- 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).⁷ 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

Information about this drug list

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

- 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 medication every day to treat diabetes. My plan requires me to fill my medication through Express Scripts® Pharmacy. How do I get started?

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

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.

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.

Information about this drug list

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

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, Tier 4 and Tier 5 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.

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.

Information about this drug list

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

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

Words you may need to know

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

Information about this drug list

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

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

Information about this drug list

About this drug list

This is a list of the most commonly prescribed medications covered on the Cigna Healthcare National Preferred 5-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 in **bold, lowercase italicized** letters next to the brand-name medication.
- If a generic equivalent for a brand-name medication is both available and covered, the generic will be listed separately from the brand-name medication in **bold, lowercase italicized** letters.
- If a generic equivalent for a brand-name medication isn't available on the market or isn't covered, the medication won't be listed separately by its generic version.
- If a generic medication is marketed under a proprietary, trademark-protected brand name, the brand-name medication will be listed in CAPITAL letters after the generic version in parentheses and regular typeface with the first letter of each word capitalized. For example: *quinapril hcl* (Accupril).

Tiers

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.

Tier 1	Preferred Generic Medications. Generics have the same strength and active ingredients as brand-name medications, but often cost much less. Preferred generic medications are covered at your plan's lowest cost-share.	\$
Tier 2	Non-Preferred Generic Medications. Non-preferred generic medications may cost more than preferred generics.	\$\$
Tier 3	Preferred Brand Medications. These medications typically have a lower-cost generic alternative available.	\$\$\$
Tier 4	Non-Preferred Brand Medications. These medications typically have a generic and/or preferred brand alternative.	\$\$\$\$
Tier 5	Brand Specialty. These medications are covered at your plan's highest cost-share. Generic specialty medications are covered on a lower tier.	\$\$\$\$\$

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

Information about this drug list

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

Letters (acronyms) 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.

PA	Prior Authorization – This medication needs approval from Cigna Healthcare before your plan will cover it. Your doctor's office will have to send us information to review to make sure the medication meets coverage requirements.
QL	Quantity Limits – 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.
ST	Step Therapy – 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.
AGE	Age Requirement – Your plan will only cover this medication if you're a certain age or within a certain age range. If you're not within the allowed age range and your doctor wants you to take this medication, your doctor's office can ask Cigna Healthcare to approve coverage.
SP	Specialty Medications 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.
HD	Home Delivery Medications – Some plans only cover certain maintenance medications if they're filled through home delivery with Express Scripts® Pharmacy. Depending on your plan, you may be able to get coverage for one, two or three fills at an in-network retail pharmacy before switching to home delivery.
PPACA	No Cost-Share Preventive Medications – 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.
CSL	Oral Cancer Medications Subject to Cost-Share Limits – State law in California limits the cost-share (or amount you pay out-of-pocket) for certain oral chemotherapy medications.

* 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 National Preferred 5-Tier Prescription Drug List.

ANALGESICS (Pain Relief and Inflammatory Disease)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ANALGESIC, NON-SALICYLATE AND BARBITURATE COMBINAT		
<i>butalbital/acetaminophen</i>	T1	
ANALGESIC, SALICYLATE, BARBITURATE, XANTHINE COMB.		
<i>butalb-aspirin-caffe 50-325-40</i>	T1	QL (6 tabs/day)
<i>butalbital-asa-caffeine cap</i> (Fiorinal)	T1	QL (6 caps/day)
FIORINAL (<i>butalbital-aspirin-caffeine</i>)	T3	QL (6 caps/day)
ANALGESIC, NON-SALICYLATE, BARBITURATE, XANTHINE COMB.		
<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)
ANALGESIC/ANTIPYRETICS, SALICYLATES		
<i>choline salicyl/mag salicylate</i>	T1	HD
<i>diflunisal</i>	T1	HD
ANTI-MIGRAINE PREPARATIONS		
AIMOVIG AUTOINJECTOR	T2	PA
AJOVY AUTOINJECTOR	T2	PA
AJOVY SYRINGE	T2	PA
<i>almotriptan malate</i>	T1	QL (12 tabs/30 days)
CAFERGOT (<i>ergotamine-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 National Preferred 5-Tier Prescription Drug List.

Information about this drug list

How to find your medication

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

Condition	Page	Condition	Page
Analgesics (Pain Relief and Inflammatory Disease)	19-24	Anti-Infectives/Miscellaneous (Infections)	52-54
Analgesics (Urinary Tract Conditions)	25	Anti-Infectives/Miscellaneous (Miscellaneous)	54
Anesthetics (Miscellaneous)	25	Anti-Infectives/Miscellaneous (Skin Conditions)	54
Anesthetics (Pain Relief and Inflammatory Disease)	25	Anti-Inflammatory Tumor Necrosis Factor Inhibiting Agents (Pain Relief and Inflammatory Disease)	54, 55
Anesthetics (Urinary Tract Conditions)	26	Anti-Neoplastics (Cancer)	55-62
Anti-Allergy (Allergy and Nasal Sprays)	26	Anti-Neoplastics (Skin Conditions)	62
Anti-Arthritics (Pain Relief and Inflammatory Disease)	26-29	Anti-Obesity Drugs (Weight Management)	62, 63
Anti-Asthmatics (Asthma/COPD/Respiratory)	29-33	Anti-Parasitics (Eye Conditions)	63
Antibiotics (Ear Medications)	33	Anti-Parasitics (Infections)	64
Antibiotics (Eye Conditions)	33-35	Anti-Parkinson's Drugs (Parkinson's Disease)	64, 65
Antibiotics (Infections)	35-41	Anti-Platelet Drugs (Blood Thinners/Anti-Clotting)	65, 66
Antibiotics (Skin Conditions)	41-43	Antivirals (AIDS/HIV)	66-69
Anti-Coagulants (Blood Thinners/Anti-Clotting)	43, 44	Antivirals (Eye Conditions)	69
Antidotes (Gastrointestinal/Heartburn)	44	Antivirals (Infections)	69, 70
Antidotes (Substance Abuse)	44	Antivirals (Skin Conditions)	70
Anti-Fungals (Eye Conditions)	44	Autonomic Drugs (Allergy/Nasal Sprays)	71
Anti-Fungals (Feminine Products)	44, 45	Autonomic Drugs (Alzheimer's Disease)	71
Anti-Fungals (Infections)	45, 46	Autonomic Drugs (Attention Deficit Hyperactivity Disorder)	71, 72
Anti-Fungals (Skin Conditions)	46, 47	Autonomic Drugs (Blood Pressure/Heart Medications)	72
Antihistamine and Decongestant Combination (Allergy/Nasal Sprays)	47	Autonomic Drugs (Urinary Tract Conditions)	72
Antihistamines (Allergy/Nasal Sprays)	47, 48	Biologicals (Allergy/Nasal Sprays)	73
Antihistamines (Eye Conditions)	48	Biologicals (Blood Pressure/Heart Medications)	73
Anti-Hyperglycemics (Diabetes)	48-52	Biologicals (Miscellaneous)	73
Anti-Infectives (Feminine Products)	52	Biologicals (Vaccines)	73-75
Anti-Infectives (Infections)	52	Blood (Blood Modifiers/Bleeding Disorders)	75, 76
Anti-Infectives/Miscellaneous (Feminine Products)	52	Blood (Blood Thinners/Anti-Clotting)	76

Information about this drug list

How to find your medication *(cont.)*

Condition	Page	Condition	Page
Cardiac Drugs (Blood Pressure/Heart Medications)	77-79	Hormones (Gastrointestinal/Heartburn)	121
Cardiovascular (Asthma/COPD/Respiratory)	79, 80	Hormones (Hormonal Agents)	121-126
Cardiovascular (Blood Pressure/Heart Medications)	80-84	Hormones (Infertility)	126
Cardiovascular (Cholesterol Medications)	84-86	Hormones (Miscellaneous)	127
CNS Drugs (Alzheimer's Disease)	86	Hormones (Osteoporosis Products)	127
CNS Drugs (Miscellaneous)	87	Immunosuppressants (Pain Relief and Inflammatory Disease)	127
CNS Drugs (Multiple Sclerosis)	87-89	Immunosuppressants (Skin Conditions)	127
CNS Drugs (Pain Relief and Inflammatory Disease)	89	Immunosuppressants (Transplant Medications)	127, 128
CNS Drugs (Seizure Disorders)	89-92	Miscellaneous Medical Supplies, Devices, Non-Drug (Diabetes)	129-149
CNS Drugs (Sleep Disorders/Sedatives)	92	Miscellaneous Medical Supplies, Devices, Non-Drug (Miscellaneous)	149-158
Colony Stimulating Factors (Blood Modifiers/Bleeding Disorders)	92	Muscle Relaxants (Pain Relief and Inflammatory Disease)	158, 159
Contraceptives (Contraception Products)	92, 93	Prenatal Vitamins (Nutritional/Dietary)	159-164
Cough/Cold Preparations (Allergy/Nasal Sprays)	94	Psychotherapeutic Drugs (Anxiety/Depression/Bipolar Disorder)	164-167
Cough/Cold Preparations (Cough/Cold Medications)	94, 95	Psychotherapeutic Drugs (Attention Deficit Hyperactivity Disorder)	167-169
Diagnostic (Diabetes)	95, 96	Psychotherapeutic Drugs (Miscellaneous)	169
Diagnostic (Miscellaneous)	96-98	Psychotherapeutic Drugs (Schizophrenia/Anti-Psychotics)	169-172
Diuretics (Diuretics)	98-100	Psychotherapeutic Drugs (Seizure Disorders)	172
EENT Preps (Allergy/Nasal Sprays)	100	Psychotherapeutic Drugs (Sleep Disorders/Sedatives)	172
EENT Preps (Ear Medications)	100	Sedative/Hypnotics (Sleep Disorders/Sedatives)	172, 173
EENT Preps (Eye Conditions)	101-105	Skin Preps (Miscellaneous)	173, 174
Elect/Caloric/H2O (Cholesterol Medications)	105	Skin Preps (Pain Relief and Inflammatory Disease)	174
Elect/Caloric/H2O (Dental Products)	105, 106	Skin Preps (Skin Conditions)	174-184
Elect/Caloric/H2O (Diabetes)	106, 107	Smoking Deterrents (Smoking Cessation)	185
Elect/Caloric/H2O (Miscellaneous)	108	Thyroid Prep (Hormonal Agents)	185
Elect/Caloric/H2O (Nutritional/Dietary)	108-114	Unclassified Drug Products (AIDS/HIV)	185
Elect/Caloric/H2O (Urinary Tract Conditions)	114	Unclassified Drug Products (Asthma/COPD/Respiratory)	185, 186
Gastrointestinal (Cholesterol Medications)	114		
Gastrointestinal (Gastrointestinal/Heartburn)	114-120		
Gastrointestinal (Pain Relief and Inflammatory Disease)	120, 121		

Information about this drug list

How to find your medication *(cont.)*

Condition	Page	Condition	Page
Unclassified Drug Products (Blood Modifiers/Bleeding Disorders)	186	Unclassified Drug Products (Pain Relief and Inflammatory Disease)	194
Unclassified Drug Products (Blood Pressure/Heart Medications)	187	Unclassified Drug Products (Seizure Disorders)	194
Unclassified Drug Products (Cancer)	187	Unclassified Drug Products (Skin Conditions)	194
Unclassified Drug Products (Dental Products)	187	Unclassified Drug Products (Substance Abuse)	194
Unclassified Drug Products (Erectile Dysfunction)	187, 188	Unclassified Drug Products (Transplant Medications)	194
Unclassified Drug Products (Eye Conditions)	188	Unclassified Drug Products (Urinary Tract Conditions)	194, 195
Unclassified Drug Products (Gastrointestinal/Heartburn)	188, 189	Unclassified Drug Products (Weight Management)	195
Unclassified Drug Products (Hormonal Agents)	189	Vitamins (Nutritional/Dietary)	195-234
Unclassified Drug Products (Miscellaneous)	189-192	Vitamins (Vitamins)	234
Unclassified Drug Products (Nutritional/Dietary)	193		
Unclassified Drug Products (Osteoporosis Products)	193		

List of Prescription Medications

ANALGESICS (Pain Relief and Inflammatory Disease)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ANALGESIC, NON-SALICYLATE AND BARBITURATE COMBINAT		
ALLZITAL	T4	PA
<i>butalbital/acetaminophen</i>	T2	
<i>butalbital/acetaminophen (Bupap)</i>	T2	
ANALGESIC, SALICYLATE, BARBITURATE, XANTHINE COMB.		
<i>butalbital/aspirin/caffeine</i>	T2	
ANALGESIC, NON-SALICYLATE, BARBITURATE, XANTHINE COMB		
<i>butalb/acetaminophen/caffeine (Esgic)</i>	T2	
<i>butalb/acetaminophen/caffeine (Fioricet)</i>	T2	
ESGIC (<i>butalb/acetaminophen/caffeine</i>)	T4	PA
FIORICET (<i>butalb/acetaminophen/caffeine</i>)	T4	PA
ANALGESIC/ANTIPYRETICS, SALICYLATES		
<i>choline salicyl/mag salicylate</i>	T2	HD
<i>diflunisal</i>	T2	HD
ANTIMIGRAINE PREPARATIONS		
AIMOVIG AUTOINJECTOR	T3	PA QL(1 auto-inj/30 days)
AJOVY 225 MG/1.5 ML AUTOINJECT	T3	PA QL(1 auto-inj/30 days)
AJOVY 225 MG/1.5 ML AUTOINJECT	T3	PA QL(3 auto-injs/90 days)
AJOVY SYRINGE	T3	PA QL(1 syringe/30 days)
<i>almotriptan malate 12.5 mg tab</i>	T2	QL(12 tabs/fill)
<i>almotriptan malate 6.25 mg tab</i>	T2	QL(6 tabs/fill)
AMERGE (<i>naratriptan hcl</i>)	T4	ST QL(9 tabs/fill)
CAFERGOT (<i>ergotamine tartrate/caffeine</i>)	T4	
CAMBIA	T4	ST QL(9 packs/fill)
<i>dihydroergotamine 1 mg/ml amp</i>	T2	
<i>dihydroergotamine 4 mg/ml spry (Migranal)</i>	T2	ST QL(8 mls/fill)
<i>eletriptan hydrobromide (Relpax)</i>	T2	QL(6 tabs/fill)
EMGALITY 120 MG/ML SYRINGE	T3	PA QL(1 syringe/30 days)
EMGALITY PEN	T3	PA QL(1 pen/30 days)
ERGOMAR	T4	
<i>ergotamine tartrate/caffeine</i>	T2	
<i>ergotamine tartrate/caffeine (Cafergot)</i>	T2	
FROVA (<i>frovatriptan succinate</i>)	T4	ST QL(9 tabs/fill)
<i>frovatriptan succinate (Frova)</i>	T2	QL(9 tabs/fill)
MIGRANAL (<i>dihydroergotamine mesylate</i>)	T4	ST QL(8 mls/fill)

T1 – Preferred Generics
 T2 – Non-Preferred Generics
 T3 – Preferred Brands
 T4 – Non-Preferred Brands

T5 – Brand Specialty
 PA – Prior Authorization
 QL – Quantity Limit

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

HD – May require home delivery pharmacy
 PPACA – No Cost-Share Preventive Medication
 CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

ANALGESICS (Pain Relief And Inflammatory Disease) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ANTIMIGRAINE PREPARATIONS (cont.)		
<i>naratriptan hcl</i> (Amerge)	T2	QL(9 tabs/fill)
NURTEC ODT	T3	PA QL(16 tabs/fill)
QULIPTA	T3	PA QL(30 tabs/30 days)
REYVOW	T4	PA QL(8 tabs/fill)
<i>rizatriptan benzoate</i> (Maxalt)	T2	QL(18 tabs/fill)
<i>sumatriptan</i> (Imitrex)	T2	QL(6 units/fill)
<i>sumatriptan 4 mg/0.5 ml cart</i> (Imitrex)	T2	QL(1 ml/fill)
<i>sumatriptan 4 mg/0.5 ml inject</i> (Imitrex)	T2	QL(2 pens/fill)
<i>sumatriptan 6 mg/0.5 ml cart</i> (Imitrex)	T2	QL(1 ml/fill)
<i>sumatriptan 6 mg/0.5 ml inject</i> (Imitrex)	T2	QL(2 pens/fill)
<i>sumatriptan 6 mg/0.5 ml vial</i>	T2	QL(2 vials/fill)
<i>sumatriptan succ 100 mg tablet</i> (Imitrex)	T2	
<i>sumatriptan succ 25 mg tablet</i> (Imitrex)	T2	
<i>sumatriptan succ 50 mg tablet</i> (Imitrex)	T2	
<i>sumatriptan succ/naproxen sod</i> (Treximet)	T2	ST QL(9 tabs/fill)
TOSYMRA	T4	ST QL(6 units/fill)
TRUDHESA	T4	ST QL(4 mls/fill)
UBRELVY	T3	PA QL(10 tabs/fill)
ZEMBRACE SYMTOUCH	T4	ST QL(4 pens/fill)
<i>zolmitriptan</i> (Zomig Zmt)	T2	QL(6 tabs/fill)
<i>zolmitriptan 2.5 mg tablet</i> (Zomig)	T2	QL(6 tabs/fill)
<i>zolmitriptan 5 mg nasal spray</i> (Zomig)	T2	ST QL(6 units/fill)
<i>zolmitriptan 5 mg tablet</i> (Zomig)	T2	QL(6 tabs/fill)
ZOMIG 2.5 MG NASAL SPRAY	T3	ST QL(6 units/fill)
ZOMIG 5 MG NASAL SPRAY (<i>zolmitriptan</i>)	T4	ST QL(6 units/fill)
NASAL NSAIDS, COX NON-SELECTIVE,SYSTEMIC ANALGESIC		
SPRIX	T4	ST QL(5 units/fill)
NSAIDS, CYCLOOXYGENASE INHIBITOR - TYPE ANALGESICS		
<i>diclofenac pot 25mg tablet</i>	T2	ST HD
<i>diclofenac pot 50 mg tablet</i>	T2	HD
<i>diclofenac pot 50 mg powdr pkt</i>	T2	HD
<i>diclofenac potassium</i>	T2	ST HD
<i>ketorolac 15 mg/ml isecure syr</i>	T2	HD
<i>ketorolac 10 mg tablet</i>	T2	QL(20 tabs/fill)

T1 – Preferred Generics
 T2 – Non-Preferred Generics
 T3 – Preferred Brands
 T4 – Non-Preferred Brands

T5 – Brand Specialty
 PA – Prior Authorization
 QL – Quantity Limit

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

HD – May require home delivery pharmacy
 PPACA – No Cost-Share Preventive Medication
 CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

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

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
NSAIDS, CYCLOOXYGENASE INHIBITOR - TYPE ANALGESICS (cont.)		
<i>ketorolac 15 mg/ml carpupject</i>	T2	HD
<i>ketorolac 15 mg/ml isecure syr</i>	T2	HD
<i>ketorolac 15 mg/ml syringe</i>	T2	HD
<i>ketorolac 15 mg/ml vial</i>	T2	HD
<i>ketorolac 30 mg/ml carpupject</i>	T2	HD
<i>ketorolac 30 mg/ml isecure syr</i>	T2	HD
<i>ketorolac 30 mg/ml syringe</i>	T2	HD
<i>ketorolac 30 mg/ml vial</i>	T2	HD
<i>ketorolac 300 mg/10 ml vial</i>	T2	HD
<i>ketorolac 60 mg/2 ml carpupject</i>	T2	HD
<i>ketorolac 60 mg/2 ml syringe</i>	T2	HD
<i>ketorolac 60 mg/2 ml vial</i>	T2	HD
<i>mefenamic acid</i>	T2	HD
OPIOID ANALGESIC AND NON-SALICYLATE ANALGESICS		
<i>acetaminophen with codeine</i>	T2	PA QL
<i>hydrocodone-acetamin 10-300 mg</i>	T2	PA QL
<i>hydrocodone-acetamin 10-325 mg</i>	T2	PA QL
<i>hydrocodone-acetamin 10-325/15</i>	T2	PA QL
HYDROCODONE-ACETAMIN 2.5-108/5	T4	PA QL
<i>hydrocodone-acetamin 2.5-108/5</i>	T2	PA QL
HYDROCODONE-ACETAMIN 5-217/10	T4	PA QL
<i>hydrocodone-acetamin 5-217/10</i>	T2	PA QL
<i>hydrocodone-acetamin 5-300 mg</i>	T2	PA QL
<i>hydrocodone-acetamin 5-325 mg</i>	T2	PA QL
<i>hydrocodone-acetamin 7.5-300</i>	T2	PA QL
<i>hydrocodone-acetamin 7.5-325</i>	T2	PA QL
<i>hydrocodone-acetamin 7.5-325/15</i>	T2	PA QL
HYDROCODONE-ACETAMIN 7.5-325/15	T4	PA QL
LORTAB	T4	PA QL
NALOCET	T4	PA QL
<i>oxycodone hcl/acetaminophen</i>	T2	PA QL
<i>oxycodone hcl/acetaminophen (Percocet)</i>	T2	PA QL
<i>prolate 10-300 mg tablet</i>	T2	PA QL

T1 – Preferred Generics
T2 – Non-Preferred Generics
T3 – Preferred Brands
T4 – Non-Preferred Brands

T5 – Brand Specialty
PA – Prior Authorization
QL – Quantity Limit

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

HD – May require home delivery pharmacy
PPACA – No Cost-Share Preventive Medication
CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

ANALGESICS (Pain Relief And Inflammatory Disease) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
OPIOID ANALGESIC AND NON-SALICYLATE ANALGESICS (cont.)		
<i>prolate 5-300 mg tablet</i>	T2	PA QL
<i>prolate 7.5-300 mg tablet</i>	T2	PA QL
<i>tramadol hcl/acetaminophen</i>	T2	PA QL(12 ds/60 days)
OPIOID ANALGESIC AND NSAID COMBINATION		
<i>hydrocodone/ibuprofen</i>	T2	PA QL
OPIOID ANALGESIC AND SALICYLATE ANALGESIC COMB		
<i>oxycodone hcl/aspirin</i>	T2	PA QL
OPIOID ANALGESIC, NON-SALICYLATE, XANTHINE COMB		
<i>acetaminophen/caff/dihydrocod</i>	T2	PA QL
TREZIX	T4	PA QL
OPIOID ANALGESICS		
ABSTRAL	T4	PA QL
ACTIQ (<i>fentanyl citrate</i>)	T4	PA QL
BELBUCA	T3	ST QL(60 films/fill)
<i>buprenorphine (Butrans)</i>	T2	ST
<i>buprenorphine 150 mcg film</i>	T2	ST QL(60 films/fill)
<i>buprenorphine 300 mcg film</i>	T2	ST QL(60 films/fill)
<i>buprenorphine 450 mcg film</i>	T2	ST QL(60 films/fill)
<i>buprenorphine 600 mcg film</i>	T2	ST QL(60 films/fill)
<i>buprenorphine 75 mcg film</i>	T2	ST QL(60 films/fill)
<i>buprenorphine 750 mcg film</i>	T2	ST QL(60 films/fill)
<i>buprenorphine 900 mcg film</i>	T2	ST QL(60 films/fill)
<i>butorphanol tartrate</i>	T2	PA QL(< 18 yo 12 ds/130 days)
<i>codeine sulfate</i>	T2	PA QL
DILAUDID (<i>hydromorphone hcl</i>)	T4	PA QL
<i>fentanyl</i>	T2	ST QL(15 patches/30 days)
<i>fentanyl cit otc 1,200 mcg (Actiq)</i>	T2	PA QL
<i>fentanyl cit otc 1,600 mcg (Actiq)</i>	T2	PA QL
<i>fentanyl citrate otc 200 mcg (Actiq)</i>	T2	PA QL
<i>fentanyl citrate otc 400 mcg (Actiq)</i>	T2	PA QL
<i>fentanyl citrate otc 600 mcg (Actiq)</i>	T2	PA QL
<i>fentanyl citrate otc 800 mcg (Actiq)</i>	T2	PA QL
<i>hydrocodone er 10 mg capsule (Zohydro Er)</i>	T2	ST QL(90 caps/30 days)

T1 – Preferred Generics
 T2 – Non-Preferred Generics
 T3 – Preferred Brands
 T4 – Non-Preferred Brands

T5 – Brand Specialty
 PA – Prior Authorization
 QL – Quantity Limit

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

HD – May require home delivery pharmacy
 PPACA – No Cost-Share Preventive Medication
 CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

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

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
OPIOID ANALGESICS (cont.)		
<i>hydrocodone er 100 mg tablet (Hysingla Er)</i>	T2	ST QL (60 tabs/30 days)
<i>hydrocodone er 120 mg tablet (Hysingla Er)</i>	T2	ST QL (60 tabs/30 days)
<i>hydrocodone er 15 mg capsule (Zohydro Er)</i>	T2	ST QL (90 caps/30 days)
<i>hydrocodone er 20 mg capsule (Zohydro Er)</i>	T2	ST QL (90 caps/30 days)
<i>hydrocodone er 20 mg tablet (Hysingla Er)</i>	T2	ST QL (60 tabs/30 days)
<i>hydrocodone er 30 mg capsule (Zohydro Er)</i>	T2	ST QL (90 caps/30 days)
<i>hydrocodone er 30 mg tablet (Hysingla Er)</i>	T2	ST QL (60 tabs/30 days)
<i>hydrocodone er 40 mg capsule (Zohydro Er)</i>	T2	ST QL (90 caps/30 days)
<i>hydrocodone er 40 mg tablet (Hysingla Er)</i>	T2	ST QL (60 tabs/30 days)
<i>hydrocodone er 50 mg capsule (Zohydro Er)</i>	T2	ST QL (90 caps/30 days)
<i>hydrocodone er 60 mg tablet (Hysingla Er)</i>	T2	ST QL (60 tabs/30 days)
<i>hydrocodone er 80 mg tablet (Hysingla Er)</i>	T2	ST QL (60 tabs/30 days)
<i>hydromorphone hcl</i>	T2	PA QL
<i>hydromorphone hcl</i>	T2	ST QL (60 tabs/30 days)
<i>hydromorphone hcl (Dilaudid)</i>	T2	PA QL
HYSINGLA ER (<i>hydrocodone bitartrate</i>)	T3	ST QL (60 tabs/30 days)
KADIAN	T4	ST QL (90 caps/30 days)
KADIAN (<i>morphine sulfate</i>)	T4	ST QL (90 caps/30 days)
LAZANDA 100 MCG NASAL SPRAY	T4	PA QL (23 units/30 days)
LAZANDA 400 MCG NASAL SPRAY	T4	PA QL (23 units/30 days)
<i>levorphanol tartrate</i>	T2	PA QL
<i>mepredine hcl</i>	T2	PA QL
<i>methadone hcl</i>	T2	ST
<i>methadone hcl</i>	T1	ST
<i>morphine sulf er 100 mg tablet (Ms Contin)</i>	T2	ST QL (120 tabs/30 days)
<i>morphine sulf er 15 mg tablet (Ms Contin)</i>	T2	ST QL (120 tabs/30 days)
<i>morphine sulf er 200 mg tablet (Ms Contin)</i>	T2	ST QL (120 tabs/30 days)
<i>morphine sulf er 30 mg tablet (Ms Contin)</i>	T2	ST QL (120 tabs/30 days)
<i>morphine sulf er 60 mg tablet (Ms Contin)</i>	T2	ST QL (120 tabs/30 days)
<i>morphine sulfate</i>	T2	
<i>morphine sulfate er 10 mg cap (Kadian)</i>	T2	ST QL (90 caps/30 days)
<i>morphine sulfate er 100 mg cap (Kadian)</i>	T2	ST QL (90 caps/30 days)
<i>morphine sulfate er 120 mg cap</i>	T2	ST QL (60 caps/30 days)
<i>morphine sulfate er 20 mg cap</i>	T2	ST QL (90 caps/30 days)

T1 – Preferred Generics
 T2 – Non-Preferred Generics
 T3 – Preferred Brands
 T4 – Non-Preferred Brands

T5 – Brand Specialty
 PA – Prior Authorization
 QL – Quantity Limit

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

HD – May require home delivery pharmacy
 PPACA – No Cost-Share Preventive Medication
 CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

ANALGESICS (Pain Relief And Inflammatory Disease) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
OPIOID ANALGESICS (cont.)		
<i>morphine sulfate er 30 mg cap</i>	T2	ST QL (60 caps/30 days)
<i>morphine sulfate er 30 mg cap</i>	T2	ST QL (90 caps/30 days)
<i>morphine sulfate er 45 mg cap</i>	T2	ST QL (60 caps/30 days)
<i>morphine sulfate er 50 mg cap (Kadian)</i>	T2	ST QL (90 caps/30 days)
<i>morphine sulfate er 60 mg cap</i>	T2	ST QL (60 caps/30 days)
<i>morphine sulfate er 60 mg cap (Kadian)</i>	T2	ST QL (90 caps/30 days)
<i>morphine sulfate er 75 mg cap</i>	T2	ST QL (60 caps/30 days)
<i>morphine sulfate er 80 mg cap (Kadian)</i>	T2	ST QL (90 caps/30 days)
<i>morphine sulfate er 90 mg cap</i>	T2	ST QL (60 caps/30 days)
MS CONTIN (<i>morphine sulfate</i>)	T4	ST QL (120 tabs/30 days)
<i>opium/belladonna alkaloids</i>	T2	PA QL
<i>oxycodone hcl</i>	T2	PA QL
<i>oxycodone hcl (Roxicodone)</i>	T2	PA QL
OXYCONTIN	T3	ST QL (90 tabs/30 days)
<i>oxymorphone hcl</i>	T2	PA QL
<i>oxymorphone hcl</i>	T2	PA QL
<i>pentazocine hcl/naloxone hcl</i>	T2	PA QL
ROXICODONE (<i>oxycodone hcl</i>)	T4	PA QL
<i>tramadol er 100 mg tablet</i>	T2	PA ST QL (30 tabs/fill)
<i>tramadol er 200 mg tablet</i>	T2	PA ST QL (30 tabs/fill)
<i>tramadol er 300 mg tablet</i>	T2	PA ST QL (30 tabs/fill)
<i>tramadol hcl 50 mg tablet</i>	T2	PA QL (240 tabs/fill)
<i>tramadol hcl 50 mg tablet</i>	T2	PA QL
<i>tramadol hcl er 100 mg tablet</i>	T2	PA ST QL (30 tabs/fill)
<i>tramadol hcl er 200 mg tablet</i>	T2	PA ST QL (30 tabs/fill)
<i>tramadol hcl er 300 mg tablet</i>	T2	PA ST QL (30 tabs/fill)
OPIOID AND SALICYLATE ANALGESICS, BARBIT, XANTHINE		
<i>codeine/butalbital/asa/caffein</i>	T2	PA QL
OPIOID, NON-SALICYL.ANALGESIC, BARBITURATE, XANTHINE		
<i>butalbit/acetamin/caff/codeine</i>	T2	PA QL
butalbit/acetamin/caff/codeine (Fioricet With Codeine)	T2	PA QL
FIORICET WITH CODEINE (<i>butalbit/acetamin/caff/codeine</i>)	T4	PA QL
SKELETAL MUSCLE RELAXANT, SALICYLAT, OPIOID ANALGESIC		
<i>carisoprodol/aspirin/codeine</i>	T2	PA QL

T1 – Preferred Generics
 T2 – Non-Preferred Generics
 T3 – Preferred Brands
 T4 – Non-Preferred Brands

T5 – Brand Specialty
 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 (Urinary Tract Conditions)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
URINARY TRACT ANALGESIC AGENTS		
ELMIRON	T3	
RIMSO-50	T4	
ANESTHETICS (Miscellaneous)		
GENERAL ANESTHETICS, INHALANT		
<i>desflurane</i>	T2	
<i>isoflurane</i>	T2	
<i>sevoflurane (Ultane)</i>	T2	
SUPRANE	T4	
ULTANE (<i>sevoflurane</i>)	T4	
ANESTHETICS (Pain Relief And Inflammatory Disease)		
LOCAL ANESTHETICS		
<i>lidocaine hcl</i>	T2	QL(60 mls/30 days)
<i>lidocaine hcl</i>	T2	
<i>lidocaine hcl 2% jel urojet ac</i>	T2	QL(60 mls/30 days)
<i>lidocaine hcl 2% jelly</i>	T2	QL(60 mls/30 days)
<i>lidocaine hcl 2% jelly uro-jet</i>	T2	QL(60 mls/30 days)
<i>lidocaine hcl 4% solution</i>	T2	
TOPICAL LOCAL ANESTHETICS		
CETACAINE ANESTHETIC	T4	
L.E.T. (LIDO-EPINEPH-TETRA)	T4	
LIDOCAN II (<i>lidocaine</i>)	T4	PA
<i>lidocaine (Lidocan li)</i>	T2	PA
<i>lidocaine 5% ointment</i>	T2	QL(50 gms/28 days)
<i>lidocaine 5% patch (Lidocan li)</i>	T2	PA
<i>lidocaine 5% patch (Lidoderm)</i>	T2	PA
<i>lidocaine hcl</i>	T2	
<i>lidocaine hcl 4% solution</i>	T2	
LIDOCAINE-EPINEPHRIN-TETRACAIN	T4	
<i>lidocaine-prilocaine cream</i>	T2	QL(30 gms/30 days)
<i>lidocaine-prilocaine cream</i>	T2	
SYNERA	T4	PA
ZTLIDO	T3	PA

T1 – Preferred Generics
 T2 – Non-Preferred Generics
 T3 – Preferred Brands
 T4 – Non-Preferred Brands

T5 – Brand Specialty
 PA – Prior Authorization
 QL – Quantity Limit

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

HD – May require home delivery pharmacy
 PPACA – No Cost-Share Preventive Medication
 CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

ANESTHETICS (Urinary Tract Conditions)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
URINARY TRACT ANESTHETIC/ANALGESIC AGNT (AZO-DYE)		
<i>phenazopyridine hcl</i> (Pyridium)	T2	
ANTIALLERGY (Allergy/Nasal Sprays)		
MAST CELL STABILIZERS		
<i>cromolyn 100 mg/5 ml oral conc</i> (Gastrocrom)	T2	
GASTROCROM (<i>cromolyn sodium</i>)	T4	
ANTIARTHRITICS (Pain Relief And Inflammatory Disease)		
ANALGESIC/ANTIPYRETICS, SALICYLATES		
DISALCID (<i>salsalate</i>)	T4	HD
<i>salsalate</i> (Disalcid)	T2	HD
ANTI-ARTHRITIC AND CHELATING AGENTS		
DEPEN (<i>penicillamine</i>)	T5	PA SP
<i>penicillamine</i> (Cuprimine)	T2	PA SP
<i>penicillamine</i> (Depen)	T2	PA SP
ANTI-ARTHRITIC, FOLATE ANTAGONIST AGENTS		
RASUVO	T3	ST
ANTI-INFLAMMATORY, PYRIMIDINE SYNTHESIS INHIBITOR		
ARAVA (<i>leflunomide</i>)	T4	QL(30 tabs/fill) HD
<i>leflunomide</i> (Arava)	T2	QL(30 tabs/fill) HD
ANTI-INFLAMMATORY, PHOSPHODIESTERASE-4(PDE4) INHIB.		
OTEZLA 28 DAY STARTER PACK	T5	PA QL(55 tabs/365 days) SP HD
OTEZLA 30 MG TABLET	T5	PA QL(60 tabs/30 days) SP HD
COLCHICINE		
<i>colchicine 0.6 mg tablet</i> (Colcrys)	T2	HD
GLOPERBA	T4	HD
MITIGARE (<i>colchicine</i>)	T3	ST HD
GOLD SALTS		
RIDAURA	T3	
HYPERURICEMIA TX - XANTHINE OXIDASE INHIBITORS		
<i>allopurinol 100 mg tablet</i> (Zyloprim)	T1	HD
<i>allopurinol 300 mg tablet</i> (Zyloprim)	T1	HD
<i>febuxostat</i> (Uloric)	T2	ST HD
ZYLOPRIM (<i>allopurinol</i>)	T4	HD

T1 – Preferred Generics
 T2 – Non-Preferred Generics
 T3 – Preferred Brands
 T4 – Non-Preferred Brands

T5 – Brand Specialty
 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

ANTIARTHRITICS (Pain Relief And Inflammatory Disease) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
JANUS KINASE (JAK) INHIBITORS		
RINVOQ ER 15 MG TABLET	T5	PA QL(30 tabs/fill) SP HD
RINVOQ ER 30 MG TABLET	T5	PA QL(30 tabs/fill) SP HD
RINVOQ ER 45 MG TABLET	T5	PA QL(56 tabs/365 days) SP HD
XELJANZ 1 MG/ML SOLUTION	T5	PA QL(300 mls/fill) SP HD
XELJANZ 10 MG TABLET	T5	PA QL(60 tabs/fill) SP HD
XELJANZ 5 MG TABLET	T5	PA QL(60 tabs/fill) SP HD
XELJANZ XR	T5	PA QL(30 tabs/fill) SP HD
NSAID AND HISTAMINE H2 RECEPTOR ANTAGONIST COMB.		
DUEXIS (<i>ibuprofen/famotidine</i>)	T4	ST HD
<i>ibuprofen/famotidine</i> (Duexis)	T2	ST HD
NSAID AND TOPICAL IRRITANT COUNTER-IRRITANT COMB.		
COMFORT PAC-IBUPROFEN	T4	
COMFORT PAC-MELOXICAM	T4	
COMFORT PAC-NAPROXEN	T4	
NSAID, COX INHIBITOR-TYPE AND PROTON-PUMP INHIBITOR		
<i>naproxen/esomeprazole mag</i> (Vimovo)	T2	ST HD
NSAIDS (COX NON-SPEC. INHIB) AND PROSTAGLANDIN ANALOG		
ARTHROTEC 50 (<i>diclofenac sodium/misoprostol</i>)	T4	ST HD
ARTHROTEC 75 (<i>diclofenac sodium/misoprostol</i>)	T4	ST HD
<i>diclofenac sodium/misoprostol</i> (Arthrotec 50)	T2	HD
<i>diclofenac sodium/misoprostol</i> (Arthrotec 75)	T2	HD
NSAIDS, CYCLOOXYGENASE INHIBITOR - TYPE ANALGESICS		
ANAPROX DS (<i>naproxen sodium</i>)	T4	ST HD
DAYPRO (<i>oxaprozin</i>)	T4	ST HD
<i>diclofenac sod dr 25 mg tab</i>	T2	HD
<i>diclofenac sod dr 50 mg tab</i>	T2	HD
<i>diclofenac sod dr 75 mg tab</i>	T2	HD
<i>diclofenac sod ec 25 mg tab</i>	T2	HD
<i>diclofenac sod ec 50 mg tab</i>	T2	HD
<i>diclofenac sod ec 75 mg tab</i>	T2	HD
<i>diclofenac sodium</i>	T2	HD
EC-NAPROSYN (<i>naproxen</i>)	T4	ST HD
<i>etodolac</i>	T2	HD
<i>etodolac</i> (Lodine)	T2	HD

T1 – Preferred Generics
T2 – Non-Preferred Generics
T3 – Preferred Brands
T4 – Non-Preferred Brands

T5 – Brand Specialty
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

ANTIARTHRITICS (Pain Relief And Inflammatory Disease) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
NSAIDS, CYCLOOXYGENASE INHIBITOR - TYPE ANALGESICS (cont.)		
FELDENE (<i>piroxicam</i>)	T4	ST HD
<i>fenoprofen 400 mg capsule</i> (Nalfon)	T2	ST HD
<i>fenoprofen 600 mg tablet</i> (Nalfon)	T2	ST HD
FENORTHO 200 MG CAPSULE	T4	ST HD
<i>flurbiprofen</i>	T2	HD
<i>ibuprofen</i>	T1	HD
<i>ibuprofen</i>	T2	HD
<i>indomethacin</i>	T2	HD
<i>indomethacin 25 mg capsule</i>	T2	HD
<i>indomethacin 50 mg capsule</i>	T2	HD
<i>indomethacin 25 mg/5 ml susp</i>	T2	HD
<i>ketoprofen</i>	T2	ST HD
<i>ketoprofen 25 mg capsule</i>	T2	ST HD
<i>ketoprofen 50 mg capsule</i>	T2	HD
<i>ketoprofen 75 mg capsule</i>	T2	HD
<i>ketoprofen er 200 mg capsule</i>	T2	ST HD
LODINE (<i>etodolac</i>)	T4	ST HD
<i>meclofenamate sodium</i>	T2	HD
<i>meloxicam 10 mg capsule</i> (Vivlodex)	T2	ST QL (30 caps/fill) HD
<i>meloxicam 5 mg capsule</i> (Vivlodex)	T2	ST QL (30 caps/fill) HD
MOBIC (<i>meloxicam</i>)	T4	ST QL (30 tabs/fill) HD
<i>nabumetone</i> (Relafen)	T2	HD
NALFON 600 MG TABLET (<i>fenoprofen calcium</i>)	T4	ST HD
NAPRELAN	T4	ST HD
NAPRELAN (<i>naproxen sodium</i>)	T4	ST HD
NAPROSYN (<i>naproxen</i>)	T4	ST HD
<i>naproxen</i> (Ec-Naprosyn)	T2	HD
<i>naproxen 125 mg/5 ml suspen</i> (Naprosyn)	T2	ST HD
<i>naproxen 250 mg tablet</i>	T1	HD
<i>naproxen 375 mg tablet</i>	T1	HD
<i>naproxen 500 mg kit</i> (Naprosyn)	T1	HD
<i>naproxen 500 mg tablet</i> (Naprosyn)	T1	HD
<i>naproxen dr 375 mg tablet</i> (Ec-Naprosyn)	T2	ST HD
<i>naproxen dr 500 mg tablet</i> (Ec-Naprosyn)	T2	HD

T1 – Preferred Generics
T2 – Non-Preferred Generics
T3 – Preferred Brands
T4 – Non-Preferred Brands

T5 – Brand Specialty
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

ANTIARTHRITICS (Pain Relief And Inflammatory Disease) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
NSAIDS, CYCLOOXYGENASE INHIBITOR - TYPE ANALGESICS (cont.)		
<i>naproxen sod er 750 mg tablet</i>	T2	ST HD
<i>naproxen sodium</i>	T2	HD
<i>naproxen sodium (Anaprox Ds)</i>	T2	HD
<i>naproxen sodium (Naprelan)</i>	T2	ST HD
<i>oxaprozin 600 mg caplet, tablet (Daypro)</i>	T2	HD
<i>piroxicam (Feldene)</i>	T2	HD
RELAFEN (<i>nabumetone</i>)	T4	ST HD
<i>sulindac</i>	T1	HD
<i>tolmetin sodium 200 mg tab</i>	T2	HD
<i>tolmetin sodium 400 mg cap</i>	T2	ST HD
<i>tolmetin sodium 600 mg tab</i>	T2	ST HD
NSAIDS, CYCLOOXYGENASE-2(COX-2) SELECTIVE INHIBITOR		
<i>celecoxib (Celebrex)</i>	T2	ST HD
URICOSURIC AGENTS		
<i>probenecid</i>	T2	HD
<i>probenecid/colchicine</i>	T2	HD
ANTIASTHMATICS (Asthma/COPD/Respiratory)		
5-LIPOXYGENASE INHIBITORS		
<i>zileuton</i>	T2	PA HD
ZYFLO	T4	PA HD
ANTICHOLINERGICS, ORALLY INHALED LONG ACTING		
LONHALA MAGNAIR REFILL	T4	QL(60 mls/fill) HD
LONHALA MAGNAIR STARTER	T4	QL(60 mls/fill) HD
SPIRIVA HANDIHALER 18 MCG CAP	T3	QL(30 caps/fill) HD
SPIRIVA HANDIHALER 18 MCG CAP	T3	QL(90 caps/fill) HD
SPIRIVA HANDIHALER 18 MCG CAP	T3	QL(5 caps/fill) HD
SPIRIVA RESPIMAT	T3	QL(1 inhaler/fill) HD
YUPELRI	T3	QL(30 vls/fill) HD
ANTICHOLINERGICS, ORALLY INHALED SHORT ACTING		
ATROVENT HFA	T4	QL(2 inhalers/fill) HD
<i>ipratropium br 0.02% soln</i>	T2	HD
BETA-ADRENERGIC AGENTS		
<i>albuterol sulf 2 mg/5 ml syrup</i>	T2	HD
<i>albuterol sulfate 2 mg tab</i>	T2	HD

T1 – Preferred Generics
 T2 – Non-Preferred Generics
 T3 – Preferred Brands
 T4 – Non-Preferred Brands

T5 – Brand Specialty
 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

ANTIASTHMATICS (Asthma/COPD/Respiratory) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
BETA-ADRENERGIC AGENTS (cont.)		
<i>albuterol sulfate 4 mg tab</i>	T2	HD
<i>albuterol sulfate er 4 mg tab</i>	T2	HD
<i>albuterol sulfate er 8 mg tab</i>	T2	HD
<i>metaproterenol sulfate</i>	T2	HD
<i>terbutaline sulfate</i>	T2	HD
BETA-ADRENERGIC AGENTS, INHALED, SHORT ACTING		
<i>albuterol 100 mg/20 ml soln</i>	T2	
<i>albuterol 2.5 mg/0.5 ml sol</i>	T2	
<i>albuterol 5 mg/ml solution</i>	T2	
<i>albuterol 15 mg/3 ml solution</i>	T2	
<i>albuterol 75 mg/15 ml soln</i>	T2	
<i>albuterol hfa 90 mcg inhaler (Proair Hfa)</i>	T2	QL(2 inhalers/fill)
<i>albuterol hfa 90 mcg inhaler (Proventil Hfa)</i>	T2	QL(2 inhalers/fill)
<i>albuterol sul 0.63 mg/3 ml sol</i>	T2	
<i>albuterol sul 1.25 mg/3 ml sol</i>	T2	
<i>albuterol sul 2.5 mg/3 ml soln</i>	T2	
<i>levalbuterol hcl (Xopenex Concentrate)</i>	T2	
<i>levalbuterol hcl (Xopenex)</i>	T2	
XOPENEX (<i>levalbuterol hcl</i>)	T4	
XOPENEX CONCENTRATE (<i>levalbuterol hcl</i>)	T4	
BETA-ADRENERGIC AGENTS, INHALED, ULTRA-LONG ACTING		
STRIVERDI RESPIMAT	T3	QL(1 inhaler/30 days) HD
BETA-ADRENERGIC AGENTS, ORALLY INHALED, LONG ACTING		
<i>arformoterol tartrate (Brovana)</i>	T2	QL(120 mls/fill) HD
BROVANA (<i>arformoterol tartrate</i>)	T4	QL(120 mls/fill) HD
<i>formoterol fumarate (Perforomist)</i>	T2	QL(120 mls/fill) HD
BETA-ADRENERGIC AND ANTICHOLINERGIC COMBO, INHALED		
ANORO ELLIPTA	T3	QL(1 inhaler/fill) HD
COMBIVENT RESPIMAT	T3	HD
<i>ipratropium/albuterol sulfate</i>	T2	
SEEBRI NEOHALER 15.6MCG INHALER	T4	
STIOLTO RESPIMAT	T3	QL(1 inhaler/fill) HD
UTIBRON NEOHALER	T4	

T1 – Preferred Generics
 T2 – Non-Preferred Generics
 T3 – Preferred Brands
 T4 – Non-Preferred Brands

T5 – Brand Specialty
 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

ANTIASTHMATICS (Asthma/COPD/Respiratory) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
BETA-ADRENERGIC AND GLUCOCORTICOID COMBO, INHALED		
ADVAIR DISKUS (<i>fluticasone propion/salmeterol</i>)	T4	PA QL(1 inhaler/fill) HD
ADVAIR HFA	T3	PA QL(1 inhaler/fill) HD
AIRDUO DIGIHALER	T4	PA QL(1 inhaler/fill) HD
AIRSUPRA	T3	HD
BREO ELLIPTA 100-25 MCG INH	T3	PA QL(60 blisters/fill) HD
BREO ELLIPTA 100-25 MCG INH	T3	PA QL(28 blisters/fill) HD
BREO ELLIPTA 200-25 MCG INH	T3	PA QL(1 inhaler/fill) HD
BREO ELLIPTA 50-25 MCG INHALER	T3	PA QL(60 blisters/fill) HD
<i>breyndra 80-4.mcg, 160-4.5 mcg inhaler</i>	T2	PA
<i>budesonide-formoterol 160-4.5, 80-4.5</i>	T2	PA QL (1 inhaler/30 days) HD
DULERA 100 MCG-5 MCG INHALER	T3	PA QL(1 inhaler/fill) HD
DULERA 200 MCG-5 MCG INHALER	T3	PA QL(1 inhaler/fill) HD
DULERA 50 MCG-5 MCG INHALER	T3	PA QL(13 gms/fill) HD
<i>fluticasone propion/salmeterol (Advair Diskus)</i>	T2	PA QL(1 inhaler/fill) HD
<i>fluticasone-salmeterol 100-50 (Advair Diskus)</i>	T2	PA QL(1 inhaler/fill) HD
<i>fluticasone-salmeterol 250-50 (Advair Diskus)</i>	T2	PA QL(1 inhaler/fill) HD
<i>fluticasone-salmeterol 500-50 (Advair Diskus)</i>	T2	PA QL(1 inhaler/fill) HD
SYMBICORT (<i>budesonide/formoterol fumarate</i>)	T4	PA QL(1 inhaler/30 days) HD
BETA-ADRENERGIC-ANTICHOLINERGIC-GLUCOCORT, INHALED		
BREZTRI AEROSPHERE	T3	QL(1 inhaler/fill)
TRELEGY ELLIPTA 100-62.5-25	T3	QL(60 blisters/fill)
TRELEGY ELLIPTA 100-62.5-25	T3	QL(28 blisters/fill)
TRELEGY ELLIPTA 200-62.5-25	T3	QL(60 blisters/fill)
TRELEGY ELLIPTA 200-62.5-25	T3	QL(28 blisters/fill)
GLUCOCORTICIDS, ORALLY INHALED		
ALVESCO 80 MCG INHALER	T4	QL(1 inhaler/fill) HD
ALVESCO 160 MCG INHALER	T4	QL(2 inhalers/fill) HD
ARNUIITY ELLIPTA 100 MCG INH	T3	QL(1 inhaler/fill) HD
ARNUIITY ELLIPTA 200 MCG INH	T3	QL(1 inhaler/fill) HD
ARNUIITY ELLIPTA 50 MCG INH	T3	QL(30 blisters/fill) HD
ASMANEX	T3	QL(1 inhaler/fill) HD
ASMANEX HFA 50 MCG INHALER	T3	QL(13 gms/fill) HD
ASMANEX HFA 100 MCG INHALER	T3	QL(1 inhaler/fill) HD
ASMANEX HFA 200 MCG INHALER	T3	QL(1 inhaler/fill) HD

T1 – Preferred Generics
 T2 – Non-Preferred Generics
 T3 – Preferred Brands
 T4 – Non-Preferred Brands

T5 – Brand Specialty
 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

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

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
GLUCOCORTICIDS, ORALLY INHALED (cont.)		
<i>budesonide 0.25 mg/2 ml susp</i> (Pulmicort)	T2	
<i>budesonide 0.5 mg/2 ml susp</i> (Pulmicort)	T2	
<i>budesonide 1 mg/2 ml inh susp</i> (Pulmicort)	T2	QL(60 mls/fill) HD
FLOVENT 50 MCG DISKUS	T3	QL(1 inhaler/fill) HD
FLOVENT 100 MCG DISKUS	T3	QL(1 inhaler/fill) HD
FLOVENT 250 MCG DISKUS	T3	QL(4 inhalers/fill) HD
FLOVENT HFA 44 MCG INHALER	T3	QL(11 gms/fill) HD
FLOVENT HFA 110 MCG INHALER	T3	QL(12 gms/fill) HD
FLOVENT HFA 220 MCG INHALER	T3	QL(24 gms/fill) HD
QVAR REDIHALER 40 MCG	T3	QL(11 gms/fill) HD
QVAR REDIHALER 80 MCG	T3	QL(22 gms/fill) HD
INTERLEUKIN-5 (IL-5) ANTAGONISTS, MAB		
NUCALA 40 MG/0.4 ML SYRINGE	T5	PA QL(1 syringe/28 days) SP HD
NUCALA 100 MG/ML AUTO-INJECTOR	T5	PA QL(1 auto-inj/28 days) SP HD
NUCALA 100 MG/ML SYRINGE	T5	PA QL(1 syringe/28 days) SP HD
INTERLEUKIN-5(IL-5) RECEPTOR ALPHA ANTAGONIST, MAB		
FASENRA PEN	T5	PA QL(1 syringe/56 days) SP HD
LEUKOTRIENE RECEPTOR ANTAGONISTS		
<i>ACCOLATE (zafirlukast)</i>	T4	HD
<i>montelukast sodium (Singulair)</i>	T2	HD
<i>zafirlukast (Accolate)</i>	T2	HD
MAST CELL STABILIZERS, ORALLY INHALED		
<i>cromolyn 20 mg/2 ml neb soln</i>	T2	HD
MONOCLONAL ANTIBODIES TO IMMUNOGLOBULIN E (IGE)		
XOLAIR 150 MG/1.2 ML POWDER VL	T5	PA QL(6 vls/28 days) SP HD
XOLAIR 150 MG/ML SYRINGE	T5	PA QL(4 syringes/28 days) SP HD
XOLAIR 75 MG/0.5 ML SYRINGE	T5	PA QL(2 syringes/28 days) SP HD
XOLAIR 300 MG/2 ML SYRINGE	T5	PA SP HD
MUCOLYTICS		
<i>acetylcysteine</i>	T2	
PHOSPHODIESTERASE-4 (PDE4) INHIBITORS		
<i>roflumilast 250 mcg tablet</i> (Daliresp)	T2	PA QL(30 tabs/fill) HD
<i>roflumilast 500 mcg tablet</i> (Daliresp)	T2	PA HD

T1 – Preferred Generics
 T2 – Non-Preferred Generics
 T3 – Preferred Brands
 T4 – Non-Preferred Brands

T5 – Brand Specialty
 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

ANTIASTHMATICS (Asthma/COPD/Respiratory) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
XANTHINES		
ELIXOPHYLLIN	T4	HD
THEO-24	T4	HD
<i>theophylline anhydrous</i>	T2	HD
ANTIBIOTICS (Ear Medications)		
EAR PREPARATIONS, ANTIBIOTICS		
<i>ciprofloxacin hcl</i>	T2	
CORTISPORIN-TC	T4	
<i>neomycin/polymyxin b/hydrocort</i>	T2	
<i>ofloxacin</i>	T2	
OTIPRIO	T4	QL(1 ml/fill)
OTIC PREPARATIONS, ANTI-INFLAMMATORY-ANTIBIOTICS		
CIPRODEX (<i>ciprofloxacin hcl/dexameth</i>)	T4	
<i>ciprofloxacin hcl/dexameth</i> (Ciprodex)	T2	
OTOVEL	T4	
ANTIBIOTICS (Eye Conditions)		
EYE ANTIBIOTIC AND GLUCOCORTICOID COMBINATIONS		
GATIFLOXACIN-DEXAMETHASONE	T4	
MAXITROL (<i>neomycin/polymyxin b/dexametha</i>)	T4	
<i>neomycin/bacit/p-myx/hydrocort</i>	T2	
<i>neomycin/polymyxin b/dexametha</i> (Maxitrol)	T2	
<i>neomycin/polymyxin b/hydrocort</i>	T2	
PRED-G	T4	
PREDNISOLONE ACET-GATIFLOXACIN	T4	
PREDNISOLONE ACET-MOXIFLOXACIN	T4	
PREDNISOLONE PHOS-GATIFLOXACIN	T4	
PREDNISOLONE PHOS-MOXIFLOXACIN	T4	
TOBRADEX	T4	
TOBRADEX (<i>tobramycin/dexamethasone</i>)	T4	
<i>tobramycin/dexamethasone</i> (Tobradex)	T2	
EYE ANTIBIOTIC, GLUCOCORTICOID AND NSAID COMB.		
PREDNISOLONE ACET-GATIFLO-BROM	T4	
PREDNISOLONE AC-MOXIFLOX-BROMF	T4	

T1 – Preferred Generics
 T2 – Non-Preferred Generics
 T3 – Preferred Brands
 T4 – Non-Preferred Brands

T5 – Brand Specialty
 PA – Prior Authorization
 QL – Quantity Limit

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

HD – May require home delivery pharmacy
 PPACA – No Cost-Share Preventive Medication
 CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

ANTIBIOTICS (Eye Conditions) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
EYE ANTIBIOTIC, GLUCOCORTICOID AND NSAID COMB.		
PREDNISOLONE AC-MOXIFLOX-NEPAF	T4	
PREDNISOLONE PHOS-GATIFLO-BROM	T4	
PREDNISOLONE PHOS-MOXIFLO-BROM	T4	
EYE SULFONAMIDES		
BLEPH-10 (<i>sulfacetamide sodium</i>)	T4	
BLEPHAMIDE S.O.P.	T4	
<i>sulfacetamide sodium</i>	T2	
<i>sulfacetamide sodium</i> (Bleph-10)	T2	
<i>sulfacetamide/prednisolone sp</i>	T2	
OPHTHALMIC ANTIBIOTICS		
AZASITE	T3	
<i>bacitracin</i>	T2	
<i>bacitracin/polymyxin b sulfate</i>	T2	
CEFUROXIME SODIUM-0.9% NACL	T4	PA
CILOXAN 0.3% EYE DROPS (<i>ciprofloxacin hcl</i>)	T4	
<i>ciprofloxacin hcl</i> (Ciloxan)	T2	
<i>erythromycin base</i>	T2	
<i>gatifloxacin</i> (Zymaxid)	T2	
<i>gentamicin 0.3% eye drop</i>	T2	
<i>gentamicin sulfate</i>	T2	
KLARITY-A(AZITHROMYCIN-CHONDR)	T4	
<i>levofloxacin</i>	T2	
<i>moxifloxacin</i>	T2	
<i>moxifloxacin</i> (Vigamox)	T2	
<i>neomycin/bacitracin/polymyxinb</i>	T2	
<i>neomycin/polymyxn b/gramicidin</i>	T2	
OCUFLOX (<i>ofloxacin</i>)	T4	
<i>ofloxacin</i> (Ocuflax)	T2	
<i>polymyxin b sulf/trimethoprim</i> (Polytrim)	T2	
POLYTRIM (<i>polymyxin b sulf/trimethoprim</i>)	T4	
<i>tobramycin 0.3% eye drop</i> (Tobrex)	T2	
TOBREX	T4	
TOBREX (<i>tobramycin</i>)	T4	

T1 – Preferred Generics
T2 – Non-Preferred Generics
T3 – Preferred Brands
T4 – Non-Preferred Brands

T5 – Brand Specialty
PA – Prior Authorization
QL – Quantity Limit

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

HD – May require home delivery pharmacy
PPACA – No Cost-Share Preventive Medication
CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

ANTIBIOTICS (Eye Conditions) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
OPHTHALMIC ANTIBIOTICS (cont.)		
VIGAMOX (<i>moxifloxacin hcl</i>)	T4	
ZYMAXID (<i>gatifloxacin</i>)	T4	
ANTIBIOTICS (Infections)		
2ND GEN. ANAEROBIC ANTIPROTOZOAL-ANTIBACTERIAL		
SOLOSEC	T3	QL(1 pack/fill)
ABSORBABLE SULFONAMIDE ANTIBACTERIAL AGENTS		
BACTRIM (<i>sulfamethoxazole/trimethoprim</i>)	T4	
BACTRIM DS (<i>sulfamethoxazole/trimethoprim</i>)	T4	
<i>sulfadiazine</i>	T2	
<i>sulfamethoxazole/trimethoprim</i>	T2	
<i>sulfamethoxazole/trimethoprim</i> (Bactrim Ds)	T1	
<i>sulfamethoxazole/trimethoprim</i> (Bactrim)	T1	
AMINOGLYCOSIDE ANTIBIOTICS		
ARIKAYCE	T5	PA SP
BETHKIS (<i>tobramycin</i>)	T5	PA QL(224 mls/fill) SP HD
<i>gentamicin 20 mg/2 ml vial</i>	T2	PA
<i>gentamicin 80 mg/2 ml vial</i>	T2	PA
<i>gentamicin 800 mg/20 ml vial</i>	T2	PA
<i>gentamicin ped 20 mg/2 ml vial</i>	T2	PA
KITABIS PAK	T5	PA QL(280 mls/fill) SP HD
<i>neomycin sulfate</i>	T2	
TOBI PODHALER	T5	PA QL(224 caps/fill) SP HD
<i>tobramycin 300 mg/4 ml ampule</i> (Bethkis)	T2	PA QL(224 mls/fill) SP HD
<i>tobramycin 300 mg/5 ml ampule</i> (Tobi)	T2	PA QL(280 mls/fill) SP HD
TOBRAMYCIN PAK 300 MG/5 ML	T5	PA QL(280 mls/fill) SP HD
<i>tobramycin sulfate</i>	T2	PA
ANAEROBIC ANTIPROTOZOAL-ANTIBACTERIAL AGENTS		
FLAGYL (<i>metronidazole</i>)	T4	
<i>metronidazole</i> (Flagyl)	T2	
ANTIBIOTIC, ANTIBACTERIAL, MISC.		
<i>fosfomycin tromethamine</i>	T2	
HIPREX (<i>methenamine hippurate</i>)	T4	
<i>meth/meblue/sod phos/psal/hyos</i>	T2	

T1 – Preferred Generics
 T2 – Non-Preferred Generics
 T3 – Preferred Brands
 T4 – Non-Preferred Brands

T5 – Brand Specialty
 PA – Prior Authorization
 QL – Quantity Limit

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

HD – May require home delivery pharmacy
 PPACA – No Cost-Share Preventive Medication
 CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

ANTIBIOTICS (Infections) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ANTIBIOTIC, ANTIBACTERIAL, MISC. (cont.)		
<i>methen/mblue/sal/sod phos/hyos</i>	T2	
<i>methenam/m.blue/salicyl/hyoscy</i> (Uribel Tabs)	T2	
<i>methenam/sod phos/mblue/hyoscy</i>	T2	
<i>methenamine hippurate</i> (Hiprex)	T2	
<i>methenamine mandelate</i>	T2	
PRIMSOL	T4	
<i>trimethoprim</i>	T2	
TRIMPEX	T4	
URELLE	T4	
URIBEL	T4	
URIBEL TABS (<i>methenam/m.blue/salicyl/hyoscy</i>)	T4	
ANTILEPROTICS		
<i>dapsone</i>	T2	
THALOMID 100 MG CAPSULE	T5	PA QL(30 caps/fill) SP HD
THALOMID 150 MG CAPSULE	T5	PA QL(60 caps/fill) SP HD
THALOMID 200 MG CAPSULE	T5	PA QL(60 caps/fill) SP HD
THALOMID 50 MG CAPSULE	T5	PA QL(30 caps/fill) SP HD
ANTI-MYCOBACTERIUM AGENTS		
<i>clindamycin hcl</i> (Cleocin Hcl)	T2	
<i>clindamycin palmitate hcl</i> (Cleocin Pediatric)	T2	
<i>ethambutol hcl</i>	T2	HD
<i>ethambutol hcl</i> (Myambutol)	T2	HD
<i>isoniazid</i>	T2	HD
MYAMBUTOL (<i>ethambutol hcl</i>)	T4	HD
MYCOBUTIN (<i>rifabutin</i>)	T4	HD
PASER	T4	HD
<i>pyrazinamide</i>	T2	HD
<i>rifabutin</i> (Mycobutin)	T2	HD
TRECTOR	T4	HD
ANTITUBERCULAR ANTIBIOTICS		
CYCLOSERINE	T4	
PRETOMANID	T4	PA
PRIFTIN	T3	

T1 – Preferred Generics
T2 – Non-Preferred Generics
T3 – Preferred Brands
T4 – Non-Preferred Brands

T5 – Brand Specialty
PA – Prior Authorization
QL – Quantity Limit

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

HD – May require home delivery pharmacy
PPACA – No Cost-Share Preventive Medication
CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

ANTIBIOTICS (Infections) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ANTITUBERCULAR ANTIBIOTICS (cont.)		
<i>rifampin</i>	T2	
SIRTURO	T5	PA SP
BETALACTAMS		
CAYSTON	T5	PA QL(84 mls/fill) SP HD
CEPHALOSPORIN ANTIBIOTICS - 1ST GENERATION		
<i>cefadroxil</i>	T2	
<i>cephalexin</i>	T2	
CEPHALOSPORIN ANTIBIOTICS - 2ND GENERATION		
<i>cefaclor</i>	T2	
<i>cefprozil</i>	T2	
<i>cefuroxime axetil</i>	T2	
CEPHALOSPORIN ANTIBIOTICS - 3RD GENERATION		
<i>cefdinir</i>	T2	
<i>cefditoren pivoxil</i>	T2	
<i>cefditoren pivoxil (Spectracef)</i>	T2	
<i>cefixime (Suprax)</i>	T2	
<i>cefpodoxime proxetil</i>	T2	
<i>ceftriaxone sodium</i>	T2	PA
SPECTRACEF (<i>cefditoren pivoxil</i>)	T4	
SUPRAX (<i>cefixime</i>)	T4	
LINCOSAMIDE ANTIBIOTICS		
CLEOCIN HCL (<i>clindamycin hcl</i>)	T4	
CLEOCIN PEDIATRIC (<i>clindamycin palmitate hcl</i>)	T4	
MACROLIDE ANTIBIOTICS		
<i>azithromycin</i>	T2	
<i>azithromycin (Zithromax Tri-Pak)</i>	T2	
<i>azithromycin (Zithromax)</i>	T2	
<i>clarithromycin</i>	T2	
DIFICID 200 MG TABLET	T4	QL(20 tabs/fill)
DIFICID 40 MG/ML SUSPENSION	T4	QL(1 bottle/fill)
E.E.S. 200 (<i>erythromycin ethylsuccinate</i>)	T4	
ERYPED 200 (<i>erythromycin ethylsuccinate</i>)	T4	
ERYPED 400 (<i>erythromycin ethylsuccinate</i>)	T4	
<i>ery-tab dr 250 mg tablet</i>	T2	

T1 – Preferred Generics
T2 – Non-Preferred Generics
T3 – Preferred Brands
T4 – Non-Preferred Brands

T5 – Brand Specialty
PA – Prior Authorization
QL – Quantity Limit

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

HD – May require home delivery pharmacy
PPACA – No Cost-Share Preventive Medication
CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

ANTIBIOTICS (Infections) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
MACROLIDE ANTIBIOTICS (cont.)		
<i>ery-tab dr 333 mg tablet</i>	T2	
ERY-TAB DR 500 MG TABLET (<i>erythromycin base</i>)	T4	
<i>erythromycin base</i>	T2	
erythromycin base (Ery-Tab)	T2	
<i>erythromycin ethylsuccinate</i>	T2	
<i>erythromycin ethylsuccinate (E.E.S. 200)</i>	T2	
<i>erythromycin ethylsuccinate (Eryped 200)</i>	T2	
<i>erythromycin ethylsuccinate (Eryped 400)</i>	T2	
<i>erythromycin stearate</i>	T2	
ZITHROMAX (<i>azithromycin</i>)	T4	
ZITHROMAX TRI-PAK (<i>azithromycin</i>)	T4	
NITROFURAN DERIVATIVES ANTIBACTERIAL AGENTS		
FURADANTIN (<i>nitrofurantoin</i>)	T4	
MACROBID (<i>nitrofurantoin monohyd/m-cryst</i>)	T4	
MACRODANTIN (<i>nitrofurantoin macrocrystal</i>)	T4	
<i>nitrofurantoin (Furadantin)</i>	T2	
<i>nitrofurantoin macrocrystal (Macrodantin)</i>	T2	
<i>nitrofurantoin monohyd/m-cryst (Macrobid)</i>	T2	
OXAZOLIDINONE ANTIBIOTICS		
<i>linezolid (Zyvox)</i>	T2	PA
ZYVOX (<i>linezolid</i>)	T4	PA
PENICILLIN ANTIBIOTICS		
<i>amoxicillin</i>	T2	
<i>amoxicillin/potassium clav</i>	T2	
<i>amoxicillin/potassium clav (Augmentin Xr)</i>	T2	
<i>amoxicillin/potassium clav (Augmentin)</i>	T2	
<i>ampicillin trihydrate</i>	T2	
AUGMENTIN 125-31.25 MG/5 ML	T3	
AUGMENTIN 250-62.5 MG/5 ML (<i>amoxicillin/potassium clav</i>)	T4	
AUGMENTIN XR (<i>amoxicillin/potassium clav</i>)	T4	
<i>dicloxacillin sodium</i>	T2	
MOXATAG	T4	
<i>penicillin v potassium</i>	T2	

T1 – Preferred Generics
 T2 – Non-Preferred Generics
 T3 – Preferred Brands
 T4 – Non-Preferred Brands

T5 – Brand Specialty
 PA – Prior Authorization
 QL – Quantity Limit

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

HD – May require home delivery pharmacy
 PPACA – No Cost-Share Preventive Medication
 CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

ANTIBIOTICS (Infections) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
PLEUROMUTILIN DERIVATIVES		
XENLETA	T4	
QUINOLONE ANTIBIOTICS		
BAXDELA	T3	QL(28 tabs/fill)
CIPRO (<i>ciprofloxacin hcl</i>)	T4	
CIPRO (<i>ciprofloxacin</i>)	T4	
<i>ciprofloxacin</i> (Cipro)	T2	
<i>ciprofloxacin hcl</i>	T1	
<i>ciprofloxacin hcl</i> (Cipro)	T1	
FACTIVE	T4	
<i>levofloxacin</i>	T2	
<i>moxifloxacin hcl</i>	T2	
<i>ofloxacin</i>	T2	
RIFAMYCINS AND RELATED DERIVATIVE ANTIBIOTICS		
AEMCOLO	T4	QL(12 tabs/fill)
XIFAXAN 200 MG TABLET	T3	QL(9 tabs/fill)
XIFAXAN 550 MG TABLET	T3	QL(60 tabs/fill)
TETRACYCLINE ANTIBIOTICS		
ACTICLATE (<i>doxycycline hyclate</i>)	T4	ST
AVIDOXY DK	T4	ST
<i>demeclocycline hcl</i>	T2	
<i>doxycycline 25 mg/5 ml susp</i> (Vibramycin)	T2	
<i>doxycycline 50 mg tablet</i> (Targadox)	T2	ST
<i>doxycycline hyc dr 100 mg tab</i>	T2	ST
<i>doxycycline hyc dr 150 mg tab</i>	T2	ST
<i>doxycycline hyc dr 200 mg tab</i> (Doryx)	T2	ST
<i>doxycycline hyc dr 50 mg tab</i> (Doryx)	T2	ST
<i>doxycycline hyc dr 75 mg tab</i>	T2	ST
<i>doxycycline hyclate 100 mg cap</i> (Vibramycin)	T2	
<i>doxycycline hyclate 100 mg tab</i> (Lymepak)	T2	
<i>doxycycline hyclate 150 mg tab</i> (Acticlate)	T2	ST
<i>doxycycline hyclate 50 mg cap</i>	T2	
<i>doxycycline hyclate 75 mg tab</i> (Acticlate)	T2	ST
<i>doxycycline mono 100 mg cap</i> (Monodox)	T2	
<i>doxycycline mono 100 mg tablet</i>	T2	

T1 – Preferred Generics
T2 – Non-Preferred Generics
T3 – Preferred Brands
T4 – Non-Preferred Brands

T5 – Brand Specialty
PA – Prior Authorization
QL – Quantity Limit

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

HD – May require home delivery pharmacy
PPACA – No Cost-Share Preventive Medication
CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

ANTIBIOTICS (Infections) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
TETRACYCLINE ANTIBIOTICS (cont.)		
<i>doxycycline mono 150 mg cap</i>	T2	ST
<i>doxycycline mono 150 mg tablet</i>	T2	
<i>doxycycline mono 50 mg cap (Monodox)</i>	T2	
<i>doxycycline mono 50 mg tablet</i>	T2	
<i>doxycycline mono 75 mg capsule (Monodox)</i>	T2	
<i>doxycycline mono 75 mg tablet</i>	T2	
<i>doxycycline monohydrate</i>	T2	
<i>doxycycline monohydrate (Monodox)</i>	T2	
LYMEPAK (<i>doxycycline hyclate</i>)	T4	
<i>minocycline hcl</i>	T2	
<i>minocycline hcl</i>	T2	ST
<i>minocycline hcl (Solodyn)</i>	T2	ST
MINOLIRA ER	T4	ST
MONODOX (<i>doxycycline monohydrate</i>)	T4	ST
<i>morgidox 100 mg capsule (Vibramycin)</i>	T2	
MORGIDOX 1X100 MG KIT	T4	ST
MORGIDOX 1X50 MG KIT	T4	ST
MORGIDOX 2X100 MG KIT	T4	ST
<i>morgidox 50 mg capsule</i>	T2	
NUZYRA	T5	QL(30 tabs/30 days) SP
SEYSARA	T4	ST
SOLODYN (<i>minocycline hcl</i>)	T4	ST
TARGADOX (<i>doxycycline hyclate</i>)	T4	ST
<i>tetracycline 250 mg capsule</i>	T2	
<i>tetracycline 250 mg tablet</i>	T2	ST
<i>tetracycline 500 mg capsule</i>	T2	
<i>tetracycline 500 mg tablet</i>	T2	ST
XACIATO	T4	
VIBRAMYCIN	T4	ST
VIBRAMYCIN (<i>doxycycline hyclate</i>)	T4	ST
VIBRAMYCIN (<i>doxycycline monohydrate</i>)	T4	ST
VAGINAL ANTIBIOTICS		
CLEOCIN	T4	
CLEOCIN (clindamycin phosphate)	T4	

T1 – Preferred Generics
T2 – Non-Preferred Generics
T3 – Preferred Brands
T4 – Non-Preferred Brands

T5 – Brand Specialty
PA – Prior Authorization
QL – Quantity Limit

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

HD – May require home delivery pharmacy
PPACA – No Cost-Share Preventive Medication
CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

ANTIBIOTICS (Infections) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
VAGINAL ANTIBIOTICS (cont.)		
<i>clindamycin 2% vaginal cream (Cleocin)</i>	T2	
CLINDESSE	T4	
METROGEL-VAGINAL (<i>metronidazole</i>)	T4	
<i>metronidazole (Metrogel-Vaginal)</i>	T2	
NUVESSA	T4	
VANCOMYCIN ANTIBIOTICS AND DERIVATIVES		
VANCOGIN HCL 125 MG CAPSULE (<i>vancomycin hcl</i>)	T4	PA QL(40 caps/fill)
VANCOGIN HCL 250 MG CAPSULE (<i>vancomycin hcl</i>)	T4	PA QL(80 caps/fill)
<i>vancomycin 250 mg/5 ml soln</i>	T2	QL(450 mls/fill)
<i>vancomycin hcl 125 mg capsule (Vancocin Hcl)</i>	T2	
<i>vancomycin hcl 250 mg capsule (Vancocin Hcl)</i>	T2	
ANTIBIOTICS (Skin Conditions)		
TOPICAL ANTIBIOTIC AND ANTI-INFLAMMATORY STEROID		
CORTISPORIN	T4	
NEO-SYNALAR	T4	
TOPICAL ANTIBIOTICS		
AKTIPAK	T4	ST
AMZEEQ	T4	ST
BENZAMYCIN (<i>erythromycin/benzoyl peroxide</i>)	T4	ST
CENTANY	T4	ST QL(30 gms/fill)
CENTANY AT	T4	ST QL(1 kit/fill)
CLEOCIN T 1% LOTION (<i>clindamycin phosphate</i>)	T4	ST QL(120 mls/30 days)
CLEOCIN T 1% PLEDGETS (<i>clindamycin phosphate</i>)	T4	ST
<i>clindacin etz 1% pledget (Cleocin T)</i>	T2	
CLINDACIN ETZ KIT	T4	ST
CLINDACIN PAC	T4	ST
<i>clindamycin ph 1% gel</i>	T2	QL(120 gms/30 days)
<i>clindamycin ph 1% solution</i>	T2	QL(120 mls/30 days)
<i>clindamycin phos 1% pledget (Cleocin T)</i>	T2	
<i>clindamycin phosp 1% lotion (Cleocin T)</i>	T2	QL(120 mls/30 days)
<i>clindamycin phosphate (Cleocin T)</i>	T2	
<i>clindamycin phosphate 1% foam (Evoclin)</i>	T2	QL(100 gms/30 days)
<i>clindamycin phosphate 1% gel (Clindagel)</i>	T2	QL(150 mls/30 days)
<i>erythromycin base in ethanol</i>	T2	

T1 – Preferred Generics
T2 – Non-Preferred Generics
T3 – Preferred Brands
T4 – Non-Preferred Brands

T5 – Brand Specialty
PA – Prior Authorization
QL – Quantity Limit

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

HD – May require home delivery pharmacy
PPACA – No Cost-Share Preventive Medication
CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

ANTIBIOTICS (Skin Conditions) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
TOPICAL ANTIBIOTICS (cont.)		
<i>erythromycin/benzoyl peroxide (Benzamycin)</i>	T2	
EVOCLIN (<i>clindamycin phosphate</i>)	T4	ST QL(100 gms/30 days)
<i>gentamicin 0.1% cream</i>	T2	QL(60 gms/fill)
<i>gentamicin 0.1% ointment</i>	T2	QL(60 gms/fill)
<i>mupirocin 2% cream</i>	T2	ST QL(30 gms/fill)
<i>mupirocin 2% ointment</i>	T2	QL (1 treatment/30 days)
<i>mupirocin 2% ointment</i>	T2	QL(30 gms/fill)
XEPI	T4	ST QL(30 gms/fill)
TOPICAL SULFONAMIDES		
AVAR LS	T4	ST
AVAR-E	T4	ST
AVAR-E GREEN	T4	ST
AVAR-E LS	T4	ST
<i>mafenide acetate (Sulfamylon)</i>	T2	
PLEXION	T4	ST
ROSULA 10%-4.5% WASH	T4	ST
<i>rosula 10%-5% cloths</i>	T2	
SILVADENE (<i>silver sulfadiazine</i>)	T4	
<i>silver sulfadiazine (Silvadene)</i>	T2	
<i>sod sulfac-sulf 9.8-4.8% clsr</i>	T2	
<i>sod sulfac-sulfur 9-4.5% wash</i>	T2	
<i>sod sulfacet-sulfr 9.8-4.8%pad</i>	T2	
<i>sod sulfacet-sulfur 10-2% clsr</i>	T2	
<i>sod sulfacet-sulfur 10-4% pad (Sumaxin)</i>	T2	
<i>sod sulfacet-sulfur 10-5% clsr</i>	T2	
<i>sod sulfac-sulfur 9.8-4.8% crm</i>	T2	
<i>sod sulfac-sulfur 9.8-4.8% lot</i>	T2	
<i>sulfacetamide sodium/sulfur</i>	T2	
<i>sulfacetamide sodium/sulfur</i>	T2	ST
<i>sulfacetamide-sulfur 10-2% crm</i>	T2	
<i>sulfacetamide-sulfur 10-5% crm</i>	T2	
<i>sulfacetamide-sulfur 10-5% lot</i>	T2	
<i>sulfacetamide-sulfur 10-5% sus</i>	T2	
<i>sulfacetamide-sulfur 8-4% susp</i>	T2	

T1 – Preferred Generics
 T2 – Non-Preferred Generics
 T3 – Preferred Brands
 T4 – Non-Preferred Brands

T5 – Brand Specialty
 PA – Prior Authorization
 QL – Quantity Limit

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

HD – May require home delivery pharmacy
 PPACA – No Cost-Share Preventive Medication
 CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

ANTIBIOTICS (Skin Conditions) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
TOPICAL SULFONAMIDES (cont.)		
<i>sulfacetamide-sulfur 9-4% clr</i>	T2	
SULFAMYLON 8.5% CREAM	T3	
SULFAMYLON POWDER PACKET (<i>mafenide acetate</i>)	T4	
SUMADAN	T4	ST
SUMADAN XLT	T4	ST
SUMAXIN	T4	ST
SUMAXIN (<i>sulfacetamide sodium/sulfur</i>)	T4	ST
SUMAXIN CP	T4	ST
SUMAXINTS	T4	ST

ANTICOAGULANTS (Blood Thinners/Anti-Clotting)

CITRATES AS ANTICOAGULANTS

ACD SOLUTION A	T3	
ACD-A	T3	
ANTICOAGULANT SODIUM CITRATE	T4	
CITRATE PHOSPHATE DEXTROSE	T3	
CRRT TRISODIUM CITRATE	T4	
SODIUM CITRATE	T4	
TRISODIUM CITRATE CRRT	T4	

DIRECT FACTOR XA INHIBITORS

ELIQUIS	T3	PA
XARELTO	T3	PA

HEPARIN AND RELATED PREPARATIONS

ARIXTRA (<i>fondaparinux sodium</i>)	T5	SP
<i>enoxaparin sodium</i> (Lovenox)	T2	SP
ARIXTRA (<i>fondaparinux sodium</i>)	T5	SP
FRAGMIN	T5	SP
<i>heparin 10,000 unit/10 ml vial</i>	T2	
<i>heparin 2,000 unit/2 ml vial</i>	T2	
<i>heparin 30,000 unit/30 ml vial</i>	T2	
<i>heparin 40,000 unit/4 ml vial</i>	T2	
<i>heparin 5,000 unit/ml carpugt</i>	T2	
<i>heparin 50,000 unit/10 ml vial</i>	T2	
<i>heparin 50,000 unit/5 ml vial</i>	T2	
<i>heparin sod 1,000 unit/ml vial</i>	T2	

T1 – Preferred Generics
 T2 – Non-Preferred Generics
 T3 – Preferred Brands
 T4 – Non-Preferred Brands

T5 – Brand Specialty
 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

ANTICOAGULANTS (Blood Thinners/Anti-Clotting) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
HEPARIN AND RELATED PREPARATIONS (cont.)		
<i>heparin sod 10,000 unit/ml v1</i>	T2	
<i>heparin sod 20,000 unit/ml v1</i>	T2	
<i>heparin sod 5,000 unit/0.5 ml</i>	T2	
HEPARIN SOD 5,000 UNIT/0.5 ML	T3	
HEPARIN SOD 5,000 UNIT/0.5 ML	T4	
<i>heparin sod 5,000 unit/ml syrg</i>	T2	
HEPARIN SOD 5,000 UNIT/ML SYRG	T4	
<i>heparin sod 5,000 unit/ml vial</i>	T2	

THROMBIN INHIBITORS, SELECTIVE, DIRECT, REVERSIBLE

<i>dabigatran etexilate mesylate</i>	T2	HD
--------------------------------------	----	----

ANTIDOTES (Gastrointestinal/Heartburn)

MU-OPIOID RECEPTOR ANTAGONISTS, PERIPHERALLY-ACTING

MOVANTIK	T3	QL(30 tabs/fill)
RELISTOR	T3	ST
SYMPROIC	T3	

ANTIDOTES (Substance Abuse)

OPIOID ANTAGONISTS

EVZIO (<i>naloxone</i>)	T4	QL(1 ml/fill)
KLOXXADO	T3	QL(2 units/fill)
<i>naloxone 0.4 mg/ml carpject</i>	T2	
<i>naloxone 0.4 mg/ml vial</i>	T2	
<i>naloxone 2 mg/2 ml syringe</i>	T2	
<i>naloxone 4 mg/10 ml vial</i>	T2	
<i>naloxone hcl 4 mg nasal spray (Narcan)</i>	T2	QL(2 units/fill)
<i>naltrexone hcl</i>	T1	
NARCAN (<i>naloxone hcl</i>)	T4	QL(2 units/30 days)

ANTIFUNGALS (Eye Conditions)

OPHTHALMIC ANTIFUNGAL AGENTS

NATACYN	T3	
---------	----	--

ANTIFUNGALS (Feminine Products)

VAGINAL ANTIFUNGALS

GYNAZOLE 1	T4	
------------	----	--

T1 – Preferred Generics
 T2 – Non-Preferred Generics
 T3 – Preferred Brands
 T4 – Non-Preferred Brands

T5 – Brand Specialty
 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

ANTIFUNGALS (Feminine Products) (cont.)

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

VAGINAL ANTIFUNGALS (cont.)

<i>miconazole nitrate</i>	T2	
<i>terconazole</i>	T2	

ANTIFUNGALS (Infections)

ANTIFUNGAL AGENTS

ANCOBON (<i>flucytosine</i>)	T4	PA
<i>clotrimazole</i>	T2	
CRESEMBA	T3	PA
DIFLUCAN 10 MG/ML SUSPENSION (<i>fluconazole</i>)	T4	
DIFLUCAN 40 MG/ML SUSPENSION (<i>fluconazole</i>)	T4	
DIFLUCAN 50 MG TABLET (<i>fluconazole</i>)	T4	
DIFLUCAN 100 MG TABLET (<i>fluconazole</i>)	T4	
DIFLUCAN 150 MG TABLET (<i>fluconazole</i>)	T4	QL(2 tabs/fill)
DIFLUCAN 200 MG TABLET (<i>fluconazole</i>)	T4	
<i>fluconazole 10 mg/ml susp</i> (Diflucan)	T2	
<i>fluconazole 40 mg/ml susp</i> (Diflucan)	T2	
<i>fluconazole 50 mg tablet</i> (Diflucan)	T2	
<i>fluconazole 100 mg tablet</i> (Diflucan)	T2	
<i>fluconazole 150 mg tablet</i> (Diflucan)	T2	QL(2 tabs/fill)
<i>fluconazole 200 mg tablet</i> (Diflucan)	T2	
<i>flucytosine</i> (Ancobon)	T2	
<i>itraconazole 10 mg/ml solution</i> (Sporanox)	T2	QL(2 bottles/fill)
<i>itraconazole 100 mg capsule</i> (Sporanox)	T2	QL(30 caps/fill)
<i>itraconazole 100 mg/10 ml cup</i> (Sporanox)	T2	QL(2 bottles/fill)
<i>ketoconazole 200 mg tablet</i>	T2	
NOXAFIL 300 MG POWDERMIX SUSP	T3	PA
NOXAFIL 40 MG/ML SUSPENSION	T3	PA SP
ORAVIG	T4	
POSACONAZOLE 200 MG/5 ML SUSP	T3	PA
<i>posaconazole dr 100 mg tablet</i> (Noxafil)	T2	PA
SPORANOX 10 MG/ML SOLUTION (<i>itraconazole</i>)	T4	QL(2 bottles/fill)
SPORANOX 100 MG CAPSULE (<i>itraconazole</i>)	T4	QL(30 caps/fill)
<i>terbinafine hcl</i>	T2	
VFEND (<i>voriconazole</i>)	T4	PA

T1 – Preferred Generics
 T2 – Non-Preferred Generics
 T3 – Preferred Brands
 T4 – Non-Preferred Brands

T5 – Brand Specialty
 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

ANTIFUNGALS (Infections) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ANTIFUNGAL AGENTS (cont.)		
VIVJOA	T4	PA QL(18 caps/fill)
voriconazole (Vfend)	T2	PA

ANTIFUNGAL ANTIBIOTICS

BREXAFEMME	T4	ST QL(4 tabs/fill)
griseofulvin ultramicrosized	T2	
griseofulvin, microsize	T2	
nystatin 100,000 unit/ml susp	T2	
nystatin 500,000 unit oral tab	T2	
nystatin 500,000 unit/5 ml cup	T2	

ANTIFUNGALS (Skin Conditions)

TOPICAL ANTIFUNGAL/ANTI-INFLAMMATORY, STEROID AGENT

clotrimazole-betamethasone crm	T2	QL(90 gms/28 days)
clotrimazole-betamethasone lot	T2	QL(60 mls/28 days)

TOPICAL ANTIFUNGALS

ciclodan 0.77% cream (Loprox)	T2	QL(90 gms/28 days)
CICLODAN 0.77% CREAM KIT	T4	
ciclodan 8% solution	T2	
ciclopirox 0.77% cream (Loprox)	T2	QL(90 gms/28 days)
ciclopirox 0.77% gel	T2	QL(100 gms/28 days)
ciclopirox 0.77% topical susp (Loprox)	T2	QL(60 mls/28 days)
ciclopirox 1% shampoo	T2	QL(120 mls/28 days)
ciclopirox 8% solution	T2	
econazole nitrate	T2	QL(85 gms/28 days)
EXELDERM 1% CREAM	T4	QL(60 gms/28 days)
EXELDERM 1% SOLUTION	T4	QL(60 mls/28 days)
EXTINA (ketoconazole)	T4	ST QL(100 gms/28 days)
JUBLIA	T4	ST
ketoconazole 2% cream	T2	QL(60 gms/28 days)
ketoconazole 2% foam (Extina)	T2	ST QL(100 gms/28 days)
ketoconazole 2% shampoo	T2	QL(120 mls/28 days)
ketodan 2% foam (Extina)	T2	ST QL(100 gms/28 days)
ketodan 2% foam kit	T2	
LOPROX 0.77% CREAM (ciclopirox olamine)	T4	QL(90 gms/28 days)
LOPROX 0.77% CREAM KIT	T4	QL(544 gms/30 days)

T1 – Preferred Generics
 T2 – Non-Preferred Generics
 T3 – Preferred Brands
 T4 – Non-Preferred Brands

T5 – Brand Specialty
 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

ANTIFUNGALS (Skin Conditions) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
TOPICAL ANTIFUNGALS (cont.)		
LOPROX 0.77% SUSPENSION KIT	T4	QL(1 kit/30 days)
LOPROX 0.77% TOPICAL SUSP (<i>ciclopirox olamine</i>)	T4	QL(60 mls/28 days)
<i>naftifine hcl</i>	T2	QL(60 gms/28 days)
<i>naftifine hcl</i> (Naftin)	T2	QL(60 gms/28 days)
NAFTIN	T4	QL(60 gms/28 days)
NAFTIN (<i>naftifine hcl</i>)	T4	QL(60 gms/28 days)
<i>nystatin</i>	T2	QL(180 gms/fill)
<i>nystatin 100,000 unit/gm cream</i>	T2	QL(60 gms/28 days)
<i>nystatin 100,000 unit/gm oint</i>	T2	QL(60 gms/28 days)
<i>nystatin 100,000 unit/gm powd</i>	T2	QL(180 gms/fill)
<i>nystatin/triamcin</i>	T2	QL(60 gms/28 days)
<i>oxiconazole nitrate</i>	T2	QL(60 gms/28 days)
<i>tavaborole</i>	T2	ST

ANTIHISTAMINE AND DECONGESTANT COMBINATION (Allergy/Nasal Sprays)

1ST GEN ANTIHISTAMINE AND DECONGESTANT COMBINATION

<i>phenylephrine hcl/prometh hcl</i>	T2	
<i>phenylephrine/chlor-tan</i>	T2	

2ND GEN ANTIHISTAMINE AND DECONGESTANT COMBINATION

CLARINEX-D 12 HOUR	T4	
CLARINEX-D 24 HOUR	T4	

ANTIHISTAMINES (Allergy/Nasal Sprays)

ANTIHISTAMINES - 1ST GENERATION

<i>carbinoxamine 4 mg/5 ml liquid</i>	T2	
<i>carbinoxamine maleate 4 mg tab</i>	T2	
<i>carbinoxamine maleate 6 mg tab</i>	T2	ST
<i>clemastine fumarate</i>	T2	
<i>cyproheptadine 2 mg/5 ml soln</i>	T2	
<i>cyproheptadine 2 mg/5 ml syrup</i>	T2	
<i>cyproheptadine 4 mg tablet</i>	T2	
CYPROHEPTADINE 4 MG/10 ML SYRP	T4	
<i>dexchlorpheniramine maleate</i> (Ryclora)	T2	
<i>hydroxyzine hcl</i>	T2	
<i>hydroxyzine hcl</i>	T1	

T1 – Preferred Generics
 T2 – Non-Preferred Generics
 T3 – Preferred Brands
 T4 – Non-Preferred Brands

T5 – Brand Specialty
 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

ANTIHISTAMINES (Allergy/Nasal Sprays) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ANTIHISTAMINES - 1ST GENERATION (cont.)		
<i>hydroxyzine pamoate</i>	T1	
<i>hydroxyzine pamoate (Vistaril)</i>	T1	
KARBINAL ER	T4	ST
<i>promethazine hcl</i>	T2	
RYCLORA (<i>dexchlorpheniramine maleate</i>)	T4	
RYVENT	T4	ST
VISTARIL (<i>hydroxyzine pamoate</i>)	T4	

ANTIHISTAMINES - 2ND GENERATION

CLARINEX (<i>desloratadine</i>)	T4	QL(30 tabs/fill) HD
<i>desloratadine</i>	T2	QL(30 tabs/fill) HD
<i>desloratadine (Clarinet)</i>	T2	QL(30 tabs/fill) HD

ANTIHISTAMINES (Eye Conditions)

EYE ANTIHISTAMINES

<i>azelastine hcl 0.05% drops</i>	T2	
BEPREVE	T2	
<i>epinastine hcl</i>	T2	
LASTACFT 0.25% EYE DROPS	T4	ST

ANTIHYPERGLYCEMICS (Diabetes)

ANTIHYPERGLY,DPP-4 ENZYME INHIB.-THIAZOLIDINEDIONE

OSENI	T4	ST QL(30 tabs/fill) HD
-------	----	------------------------

ANTIHYPERGLY,INCRETIN MIMETIC(GLP-I RECEPT.AGONIST)

ADLYXIN 10-20 MCG STARTER PACK	T4	PA QL (1 kit/28 days) HD
ADLYXIN 20 MCG MAINTENANCE PK	T4	PA QL (1 kit/28 days) HD
BYDUREON BCISE	T3	PA QL(4 auto-injs/fill) HD
BYDUREON PEN	T3	PA QL(4 pens/fill) HD
BYETTA	T3	PA QL(1 pen/fill) HD
OZEMPIC	T3	PA QL(1 pen/28 days)
TRULICITY 1.5 MG/0.5 ML PEN	T3	PA QL(1 pen/fill) HD
TRULICITY 3 MG/0.5 ML PEN	T3	PA QL(2 pens/fill) HD
TRULICITY 4.5 MG/0.5 ML PEN	T3	PA QL(1 pen/fill) HD
VICTOZA 2-PAK	T3	PA QL(1 pen/fill) HD
VICTOZA 3-PAK	T3	PA QL(30 tabs/fill) HD
TRULICITY 0.75 MG/0.5 ML PEN	T3	PA QL(4 pens/fill) HD

T1 – Preferred Generics
 T2 – Non-Preferred Generics
 T3 – Preferred Brands
 T4 – Non-Preferred Brands

T5 – Brand Specialty
 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

ANTIHYPERGLYCEMICS (Diabetes) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ANTIHYPERGLY, INSULIN, LONG ACT-GLP-I RECEPT.AGONIST		
SOLIQUA 100-33	T3	QL(15 mls/fill) HD
ANTIHYPERGLYCEMIC – DOPAMINE RECEPTOR AGONISTS		
CYCLOSET	T4	HD
ANTIHYPERGLYCEMIC – INCRETIN MIMETICS COMBINATION		
MOUNJARO	T3	PA QL(4 pens/fill)
ANTIHYPERGLYCEMIC, ALPHA-GLUCOSIDASE INHIBITORS		
<i>acarbose</i> (Precose)	T2	HD
<i>miglitol</i>	T2	HD
PRECOSE (<i>acarbose</i>)	T4	HD
ANTIHYPERGLYCEMIC, AMYLIN ANALOG-TYPE		
SYMLINPEN 120	T3	PA QL(7 pens/fill) HD
SYMLINPEN 60	T3	PA QL(7 pens/fill) HD
ANTIHYPERGLYCEMIC, BIGUANIDE TYPE		
FORTAMET ER 1,000 MG TABLET (<i>metformin hcl</i>)	T4	PA QL(60 tabs/fill) HD
FORTAMET ER 500 MG TABLET (<i>metformin hcl</i>)	T4	PA QL(30 tabs/fill) HD
<i>metformin er 1,000 mg gastr-tb</i> (Glumetza)	T2	PA QL(60 tabs/fill) HD
<i>metformin er 1,000 mg osm-tab</i> (Fortamet)	T2	PA QL(60 tabs/fill) HD
<i>metformin er 500 mg gastr-tb</i> (Glumetza)	T2	PA QL(120 tabs/fill) HD
<i>metformin er 500 mg osmotic tb</i> (Fortamet)	T2	PA QL(30 tabs/fill) HD
<i>metformin hcl 1,000 mg tablet</i>	T1	HD
<i>metformin hcl 500 mg tablet</i>	T1	HD
<i>metformin hcl 500 mg/5 ml soln</i> (Riomet)	T2	ST HD
<i>metformin hcl 850 mg tablet</i>	T1	HD
<i>metformin hcl 850 mg/8.5ml cup</i> (Riomet)	T2	ST HD
<i>metformin hcl er 500 mg tablet</i>	T1	QL(120 tabs/fill) HD
<i>metformin hcl er 750 mg tablet</i>	T1	QL(60 tabs/fill) HD
RIOMET (<i>metformin hcl</i>)	T4	ST HD
RIOMET ER	T4	ST HD
ANTIHYPERGLYCEMIC, DPP-4 INHIBITORS		
JANUVIA	T3	ST QL(30 tabs/fill) HD
<i>saxagliptin</i> (Onglyza)	T2	ST QL(30 tabs/30 days) HD
ANTIHYPERGLYCEMIC, INSULIN-RELEASE STIMULANT TYPE		
AMARYL (<i>glimepiride</i>)	T4	HD
<i>glimepiride</i> (Amaryl)	T1	HD

T1 – Preferred Generics
 T2 – Non-Preferred Generics
 T3 – Preferred Brands
 T4 – Non-Preferred Brands

T5 – Brand Specialty
 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

ANTIHYPERGLYCEMICS (Diabetes) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ANTIHYPERGLYCEMIC, INSULIN-RELEASE STIMULANT TYPE (cont.)		
<i>glipizide</i>	T1	HD
<i>glipizide</i> (Glucotrol XL)	T1	HD
GLUCOTROL XL (<i>glipizide</i>)	T4	HD
<i>glyburide</i>	T2	HD
<i>glyburide, micronized</i> (Glynase)	T2	HD
GLYNASE (<i>glyburide, micronized</i>)	T4	HD
<i>nateglinide</i>	T2	HD
PRANDIN (<i>repaglinide</i>)	T4	HD
<i>repaglinide</i>	T2	HD
<i>repaglinide</i> (Prandin)	T2	HD
ANTIHYPERGLYCEMIC, SGLT-2 AND DPP-4 INHIBITOR COMB		
GLYXAMBI	T3	ST QL (30 tabs/fill) HD
ANTIHYPERGLYCEMIC, THIAZOLIDINEDIONE AND BIGUANIDE		
ACTOPLUS MET (<i>pioglitazone hcl/metformin hcl</i>)	T4	ST HD
<i>pioglitazone hcl/metformin hcl</i>	T2	QL (90 tabs/fill) HD
<i>pioglitazone hcl/metformin hcl</i> (Actoplus Met)	T2	QL (90 tabs/fill) HD
ANTIHYPERGLYCEMIC, THIAZOLIDINEDIONE-SULFONYLUREA		
DUETACT (<i>pioglitazone-glimepiride</i>)	T4	ST QL (30 tabs/fill) HD
<i>pioglitazone hcl/glimepiride</i> (Duetact)	T2	QL (30 tabs/fill) HD
ANTIHYPERGLYCEMIC, DPP-4 INHIBITOR-BIGUANIDE COMBS.		
JANUMET	T3	ST QL (60 tabs/fill) HD
JANUMET XR 100-1,000 MG TABLET	T3	ST QL (30 tabs/fill) HD
JANUMET XR 50-1,000 MG TABLET	T3	ST QL (60 tabs/fill) HD
JANUMET XR 50-500 MG TABLET	T3	ST QL (60 tabs/fill) HD
<i>saxagliptin-metformin er 5-500</i> (Kombiglyze Xr)	T2	ST QL (30 tabs/30 days) HD
<i>saxagliptin-metformin er 5-1000</i> (Kombiglyze Xr)	T2	ST QL (30 tabs/30 days) HD
<i>saxagliptin-metformin er 2.5-1000</i> (Kombiglyze Xr)	T2	ST QL (60 tabs/30 days) HD
ANTIHYPERGLYCEMIC, INSULIN-RELEASE STIM.-BIGUANIDE		
<i>glipizide/metformin hcl</i>	T1	HD
<i>glyburide/metformin hcl</i>	T2	HD
ANTIHYPERGLYCEMIC, THIAZOLIDINEDIONE (PPARG AGONIST)		
ACTOS (<i>pioglitazone hcl</i>)	T4	ST QL (30 tabs/fill) HD
ANTIHYPERGLYCEMIC-GLUCOCORTICOID RECEPTOR BLOCKER		
<i>mifepristone 300 mg tablet</i>	T2	PA SP

T1 – Preferred Generics
 T2 – Non-Preferred Generics
 T3 – Preferred Brands
 T4 – Non-Preferred Brands

T5 – Brand Specialty
 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

ANTIHYPERGLYCEMICS (Diabetes) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ANTIHYPERGLYCEMIC-SGLT2 INHIBITOR-BIGUANIDE COMBS.		
SEGLUROMET	T3	ST QL (60 tabs/fill) HD
SYNJARDY	T3	ST QL (60 tabs/fill) HD
SYNJARDY XR 10-1,000 MG TABLET	T3	ST QL (30 tabs/fill) HD
SYNJARDY XR 12.5-1,000 MG TAB	T3	ST QL (60 tabs/fill) HD
SYNJARDY XR 25-1,000 MG TABLET	T3	ST QL (30 tabs/fill) HD
SYNJARDY XR 5-1,000 MG TABLET	T3	ST QL (60 tabs/fill) HD
XIGDUO XR 10 MG-1,000 MG TAB	T3	ST QL (30 tabs/fill) HD
XIGDUO XR 10 MG-500 MG TABLET	T3	ST QL (30 tabs/fill) HD
XIGDUO XR 2.5 MG-1,000 MG TAB	T3	ST QL (60 tabs/fill) HD
XIGDUO XR 5 MG-1,000 MG TABLET	T3	ST QL (60 tabs/fill) HD
XIGDUO XR 5 MG-500 MG TABLET	T3	ST QL (30 tabs/fill) HD
ANTIHYPERGLYCEMIC-SOD/GLUC COTRANSPORT2(SGLT2) INH		
FARXIGA	T3	ST QL (30 tabs/fill) HD
JARDIANCE	T3	ST QL (30 tabs/fill) HD
STEGLATRO	T3	ST QL (30 tabs/fill) HD
ANTIHYPERGLY-SGLT-2 INHIB, DPP-4 INHIB, BIGUANIDE CB		
TRIJARDY XR	T3	ST HD
INSULINS		
BASAGLAR KWIKPEN U-100	T4	HD
HUMALOG	T3	HD
HUMALOG JUNIOR KWIKPEN	T3	HD
HUMALOG KWIKPEN U-100	T3	HD
HUMALOG KWIKPEN U-200	T3	HD
HUMALOG MIX 50-50	T3	HD
HUMALOG MIX 50-50 KWIKPEN	T3	HD
HUMALOG MIX 75-25	T3	HD
HUMALOG MIX 75-25 KWIKPEN	T3	HD
HUMULIN 70/30 KWIKPEN	T3	HD
HUMULIN 70-30	T3	HD
HUMULIN N	T3	HD
HUMULIN N KWIKPEN	T3	HD
HUMULIN R	T3	HD
HUMULIN R U-500	T3	HD
HUMULIN R U-500 KWIKPEN	T3	HD

T1 – Preferred Generics
 T2 – Non-Preferred Generics
 T3 – Preferred Brands
 T4 – Non-Preferred Brands

T5 – Brand Specialty
 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

ANTIHYPERGLYCEMICS (Diabetes) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
INSULINS (cont.)		
INSULIN LISPRO JUNIOR KWIKPEN	T3	HD
INSULIN LISPRO KWIKPEN U-100	T3	HD
INSULIN LISPRO PROTAMINE MIX	T3	HD
INSULIN LISPRO 100 UNIT/ML VIAL	T3	HD
LYUMJEV	T3	HD
LYUMJEV KWIKPEN U-100	T3	HD
LYUMJEV KWIKPEN U-200	T3	HD
MYXREDLIN	T4	HD
SEMGLEE (YFGN)	T3	HD
SEMGLEE (YFGN) PEN	T3	HD
TOUJEO MAX SOLOSTAR	T3	HD
TOUJEO SOLOSTAR	T3	HD
TRESIBA	T3	HD
TRESIBA FLEXTOUCH U-100	T3	HD
TRESIBA FLEXTOUCH U-200	T3	HD

ANTIINFECTIVES (Feminine Products)

VAGINAL SULFONAMIDES

AVC	T4	
-----	----	--

ANTIINFECTIVES (Infections)

PENICILLIN ANTIBIOTICS

<i>amoxicillin</i>	T2	
--------------------	----	--

ANTIINFECTIVES/MISCELLANEOUS (Feminine Products)

VAGINAL ANTISEPTICS

<i>acetic acid/oxyquinoline</i> (Relagard)	T2	
RELAGARD (<i>acetic acid/oxyquinoline</i>)	T4	
TRIMO-SAN	T3	

ANTIINFECTIVES/MISCELLANEOUS (Infections)

2ND GEN. ANAEROBIC ANTIPROTOZOAL-ANTIBACTERIAL

tinidazole 250 mg tablet	T2	QL(40 tabs/30 days)
tinidazole 500 mg tablet	T2	QL(20 tabs/30 days)

AMEBICIDES

HUMATIN	T4	
<i>paromomycin sulfate</i>	T2	

T1 – Preferred Generics
T2 – Non-Preferred Generics
T3 – Preferred Brands
T4 – Non-Preferred Brands

T5 – Brand Specialty
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

ANTIINFECTIVES/MISCELLANEOUS (Infections) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ANTHELMINTICS		
<i>albendazole</i> (Albenza)	T2	QL(120 tabs/30 days)
ALBENZA (<i>albendazole</i>)	T4	QL(120 tabs/30 days)
BILTRICIDE (<i>praziquantel</i>)	T4	
EMVERM	T3	QL(6 tabs/30 days)
<i>ivermectin 3 mg tablet</i> (Stromectol)	T2	PA QL(14 tabs/30 days)
<i>praziquantel</i> (Biltricide)	T2	
STROMECTOL (<i>ivermectin</i>)	T4	PA QL(14 tabs/30 days)
ANTIMALARIAL DRUGS		
ARAKODA	T4	QL(16 tabs/fill)
<i>atovaquone-proguanil 250-100</i> (Malarone)	T2	QL(60 tabs/180 days)
<i>atovaquone-proguanil 62.5-25</i> (Malarone)	T2	QL(180 tabs/180 days)
<i>chloroquine phosphate</i>	T2	
COARTEM	T3	QL(24 tabs/30 days)
DARAPRIM (<i>pyrimethamine</i>)	T5	PA SP
HYDROXYCHLOROQUINE 100 MG TAB	T4	
<i>hydroxychloroquine 200 mg tab</i> (Plaquenil)	T2	
HYDROXYCHLOROQUINE 300 MG TAB	T4	
HYDROXYCHLOROQUINE 400 MG TAB	T4	
<i>hydroxychloroquine sulfate</i> (Sovuna)	T2	
KRINTAFEL	T4	QL(2 tabs/30 days)
MALARONE 250-100 MG TABLET (<i>atovaquone/proguanil hcl</i>)	T4	QL(60 tabs/180 days)
MALARONE 62.5-25 MG PED TAB (<i>atovaquone/proguanil hcl</i>)	T4	QL(180 tabs/180 days)
<i>mefloquine hcl</i>	T2	QL(13 tabs/180 days)
PRIMAQUINE 26.3 MG TABLET	T3	QL(120 tabs/180 days)
<i>primaquine 26.3 mg tablet</i>	T2	QL(120 tabs/180 days)
<i>pyrimethamine 25 mg tablet</i> (Daraprim)	T2	PA
<i>pyrimethamine 25 mg tablet</i> (Daraprim)	T2	PA SP
QUALAQUIN (<i>quinine sulfate</i>)	T4	QL(42 caps/30 days)
<i>quinine sulfate</i> (Qalaquin)	T2	QL(42 caps/30 days)
SOVUNA	T4	
SOVUNA (<i>hydroxychloroquine sulfate</i>)	T4	
ANTIPROTOZOAL DRUGS, MISCELLANEOUS		
<i>atovaquone</i> (Mepro)	T2	
BENZNIDAZOLE	T3	QL(360 tabs/fill)

T1 – Preferred Generics
 T2 – Non-Preferred Generics
 T3 – Preferred Brands
 T4 – Non-Preferred Brands

T5 – Brand Specialty
 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

ANTIINFECTIVES/MISCELLANEOUS (Infections) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ANTIPROTOZOAL DRUGS, MISCELLANEOUS (cont.)		
IMPAVIDO	T3	PA QL (84 caps/30 days)
MEPRON (<i>atovaquone</i>)	T4	
NEBUPENT (<i>pentamidine isethionate</i>)	T4	QL (1 vL/28 days)
<i>pentamidine isethionate</i> (Nebupent)	T2	QL (1 vL/28 days)

ANTIINFECTIVES/MISCELLANEOUS (Miscellaneous)

ANTIBACTERIAL AGENTS, MISCELLANEOUS

<i>glycine urologic solution</i>	T2	
----------------------------------	----	--

ANTISEPTICS, GENERAL

ALCOHOL SWABSTICK	T4	
CVS ISOPROPYL ALCOHOL 91% SPRY	T4	
GS ISOPROPYL ALCOHOL 70% SPRAY	T4	
ISOPROPYL ALCOHOL 70% SPRAY	T4	
MEDI-FIRST ISOPROPYL ALCOHOL	T4	

TOPICAL ANTISEPTIC DRYING AGENTS

<i>formaldehyde</i>	T2	
---------------------	----	--

ANTIINFECTIVES/MISCELLANEOUS (Skin Conditions)

TOPICAL ANTIFUNGALS

CICLODAN 8% KIT	T4	ST
<i>ciclopirox 8% treatment kit</i>	T2	

ANTIINFLAM.TUMOR NECROSIS FACTOR INHIBITING AGENTS (Pain Relief And Inflammatory Disease)

ANTI-INFLAMMATORY TUMOR NECROSIS FACTOR INHIBITOR

ADALIMUMAB-ADAZ(CF)	T5	PA QL (2 syringes/28 days) SP HD
ADALIMUMAB-ADAZ(CF) PEN	T5	PA QL (2 pens/28 days) SP HD
ADALIMUMAB-ADBM(CF)	T5	PA QL (2 srnge kits/28 days) SP HD
ADALIMUMAB-ADBM(CF) PEN CROHNS	T5	PA QL (6 pens/365 days) SP HD
ADALIMUMAB-ADBM(CF) PEN PS-UV	T5	PA QL (4 pens/365 days) SP HD
ADALIMUMAB-ADBM(CF)PEN	T5	PA QL (2 kits/28 days) SP HD
CYLTEZO(CF)	T5	PA SP
ENBREL 25 MG KIT	T5	PA QL SP HD
ENBREL 25 MG/0.5 ML SYRINGE	T5	PA QL SP HD
ENBREL 25 MG/0.5 ML VIAL	T5	PA QL SP HD
ENBREL 50 MG/ML SYRINGE	T5	PA QL (2 srnge kits/28 days) SP HD
ENBREL MINI	T5	PA QL (2 kits/28 days) SP HD

T1 – Preferred Generics
T2 – Non-Preferred Generics
T3 – Preferred Brands
T4 – Non-Preferred Brands

T5 – Brand Specialty
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

ANTIINFLAM.TUMOR NECROSIS FACTOR INHIBITING AGENTS (Pain Relief And Inflammatory Disease) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ANTI-INFLAMMATORY TUMOR NECROSIS FACTOR INHIBITOR (cont.)		
ENBREL SURECLICK	T5	PA QL(6 pens/365 days) SP HD
HUMIRA	T5	PA QL(4 pens/365 days) SP HD
HUMIRA PEN	T5	PA QL(2 srnge kits/28 days) SP HD
HUMIRA PEN CROHN'S-UC-HS	T5	PA QL(2 srnge kits/365 days) SP HD
HUMIRA PEN PSOR-UVEITS-ADOL HS	T5	PA QL(3 srnge kits/365 days) SP HD
HUMIRA(CF) 10 MG/0.1 ML SYRING	T5	PA QL(2 srnge kits/28 days) SP HD
HUMIRA(CF) 20 MG/0.2 ML SYRING	T5	PA QL(2 srnge kits/28 days) SP HD
HUMIRA(CF) 40 MG/0.4 ML SYRING	T5	PA QL(2 srnge kits/28 days) SP HD
HUMIRA(CF) PEDI CROHN 80-40 MG	T5	PA QL(2 pens/28 days) SP HD
HUMIRA(CF) PEDI CROHN 80MG/0.8	T5	PA QL(3 kits/365 days) SP HD
HUMIRA(CF) PEN 40 MG/0.4 ML	T5	PA QL(4 pens/365 days) SP HD
HUMIRA(CF) PEN 80 MG/0.8 ML	T5	PA QL(3 kits/365 days) SP HD
HUMIRA(CF) PEN CROHN'S-UC-HS	T5	PA QL(1 pen/30 days) SP HD
HUMIRA(CF) PEN PEDIATRIC UC	T5	PA QL(1 syringe/30 days) SP HD
HUMIRA(CF) PEN PSOR-UV-ADOL HS	T5	PA SP HD
HYRIMOZ(CF)	T5	PA QL(2 syringes/28 days) SP HD
HYRIMOZ(CF) PEDI CROHN 80 MG	T5	PA QL(3 syringes/365 days) SP HD
HYRIMOZ(CF) PEDI CROHN 80-40MG	T5	PA QL(2 syringes/365 days) SP HD
HYRIMOZ(CF) PEN	T5	PA QL(2 pens/28 days) SP HD
HYRIMOZ(CF) PEN CROHN-UC START	T5	PA QL(3 pens/365 days) SP HD
HYRIMOZ(CF) PEN PSORIASIS	T5	PA QL(3 pens/365 days) SP HD
SIMPONI 100 MG/ML PEN INJECTOR	T5	PA QL(1 pen/30 days) SP HD
SIMPONI 100 MG/ML SYRINGE	T5	PA QL(1 syringe/30 days) SP HD
SIMPONI ARIA	T5	PA SP HD

ANTINEOPLASTICS (Cancer)

ANP - SELECTIVE RETINOID X RECEPTOR AGONISTS (RXR)

<i>bexarotene</i> (Targretin)	T2	PA SP HD CSL
-------------------------------	----	--------------

ANTINEOPLAST, HISTONE DEACETYLASE (HDAC) INHIBITORS

FARYDAK	T4	PA QL(6 caps/fill) CSL
ZOLINZA	T5	PA QL(120 caps/fill) SP HD CSL

ANTINEOPLASTIC - ALKYLATING AGENTS

ALKERAN (<i>melphalan</i>)	T5	SP CSL
<i>cyclophosphamide 25 mg capsule</i>	T2	SP HD CSL
CYCLOPHOSPHAMIDE 25 MG TABLET	T5	SP HD CSL

T1 – Preferred Generics
T2 – Non-Preferred Generics
T3 – Preferred Brands
T4 – Non-Preferred Brands

T5 – Brand Specialty
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

ANTINEOPLASTICS (Cancer) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ANTINEOPLASTIC - ALKYLATING AGENTS (cont.)		
<i>cyclophosphamide 50 mg capsule</i>	T2	SP HD CSL
CYCLOPHOSPHAMIDE 50 MG TABLET	T5	SP HD CSL
GLEOSTINE	T3	CSL
HYDREA (<i>hydroxyurea</i>)	T4	CSL
<i>hydroxyurea</i> (Hydrea)	T2	CSL
LEUKERAN	T3	CSL
<i>melphalan</i> (Alkeran)	T2	SP CSL
MYLERAN	T3	CSL
TEMODAR (<i>temozolomide</i>)	T5	PA SP HD CSL
<i>temozolomide</i>	T2	PA SP HD CSL
<i>temozolomide</i> (Temodar)	T2	PA SP HD CSL
ANTINEOPLASTIC - ANTIANDROGENIC AGENTS		
<i>abiraterone acetate 250 mg tab</i> (Zytiga)	T2	PA QL(120 tabs/fill) SP HD CSL
<i>abiraterone acetate 500 mg tab</i> (Zytiga)	T2	PA QL(60 tabs/fill) SP HD CSL
<i>bicalutamide</i> (Casodex)	T2	CSL
CASODEX (<i>bicalutamide</i>)	T4	CSL
ERLEADA	T5	PA QL(30 tabs/fill) SP HD CSL
EULEXIN (<i>flutamide</i>)	T4	CSL
<i>flutamide</i> (Eulexin)	T2	CSL
NILANDRON (<i>nilutamide</i>)	T4	PA CSL
<i>nilutamide</i> (Nilandron)	T2	PA CSL
NUBEQA	T5	PA QL(120 tabs/fill) SP HD CSL
XTANDI 40 MG CAPSULE	T5	PA QL(120 tabs/caps/fill)SP HD CSL
XTANDI 40 MG TABLET	T5	PA QL(120 tabs/caps/fill)SP HD CSL
XTANDI 80 MG TABLET	T5	PA QL(60 tabs/fill) SP HD CSL
ANTINEOPLASTIC - ANTIMETABOLITES		
<i>capecitabine 150 mg tablet</i> (Xeloda)	T2	PA QL(56 tabs/fill) SP HD CSL
<i>capecitabine 500 mg tablet</i> (Xeloda)	T2	PA QL(140 tabs/fill) SP HD CSL
LONSURF	T5	PA SP HD CSL
<i>mercaptopurine</i>	T2	CSL
<i>methotrexate 2.5 mg tablet</i>	T2	CSL
<i>methotrexate 250 mg/10 ml vial</i>	T2	
<i>methotrexate 50 mg/2 ml vial</i>	T2	
<i>methotrexate sodium/pf</i>	T2	

T1 – Preferred Generics
T2 – Non-Preferred Generics
T3 – Preferred Brands
T4 – Non-Preferred Brands

T5 – Brand Specialty
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

ANTINEOPLASTICS (Cancer) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ANTINEOPLASTIC - ANTIMETABOLITES (cont.)		
PURIXAN	T5	SP CSL
TABLOID	T4	CSL
TREXALL	T4	CSL
XELODA 150 MG TABLET (<i>capecitabine</i>)	T5	PA QL(56 tabs/fill) SP HD CSL
XELODA 500 MG TABLET (<i>capecitabine</i>)	T5	PA QL(140 tabs/fill) SP HD CSL
ANTINEOPLASTIC - AROMATASE INHIBITORS		
<i>anastrozole</i> (Arimidex)	T2	HD PPACA CSL
AROMASIN (<i>exemestane</i>)	T4	HD CSL
<i>exemestane</i> (Aromasin)	T2	HD PPACA CSL
FEMARA (<i>letrozole</i>)	T4	HD CSL
<i>letrozole</i> (Femara)	T2	HD CSL
ANTINEOPLASTIC - BRAF KINASE INHIBITORS		
TAFINLAR	T5	PA QL(120 caps/fill) SP HD CSL
TAFINLAR 10 MG TABLET FOR SUSP	T5	PA QL (840ml/30 days) SP HD CSL
ZELBORAF	T5	PA QL(240 tabs/fill) SP HD CSL
ANTINEOPLASTIC - HEDGEHOG PATHWAY INHIBITOR		
DAURISMO 25 MG TABLET	T5	PA QL(60 tabs/fill) SP HD CSL
DAURISMO 100 MG TABLET	T5	PA QL(30 tabs/fill) SP HD CSL
ERIVEDGE	T5	PA QL(30 caps/fill) SP HD CSL
ODOMZO	T5	PA QL(30 caps/fill) SP HD CSL
ANTINEOPLASTIC - JANUS KINASE (JAK) INHIBITORS		
JAKAFI	T5	PA QL(60 tabs/fill) SP HD CSL
ANTINEOPLASTIC - KRAS PROTEIN INHIBITOR		
LUMAKRAS	T5	PA SP HD CSL
ANTINEOPLASTIC - MEKI AND MEK2 KINASE INHIBITORS		
COTELLIC	T5	PA QL(63 tabs/fill) SP HD CSL
KOSELUGO	T5	PA SP CSL
MEKINIST 0.05 MG/ML SOLUTION	T5	PA QL (108ml/30 days) SP HD CSL
MEKINIST 0.5 MG TABLET	T5	PA QL(90 tabs/fill) SP HD CSL
MEKINIST 2 MG TABLET	T5	PA QL(30 tabs/fill) SP HD CSL
ANTINEOPLASTIC - MTOR KINASE INHIBITORS		
<i>everolimus 2 mg tab for susp</i> (Afinitor Disperz)	T2	PA QL(30 tabs/fill) SP CSL
<i>everolimus 2.5 mg tablet</i> (Afinitor)	T2	
<i>everolimus 3 mg tab for susp</i> (Afinitor Disperz)	T2	PA QL(30 tabs/fill) SP CSL
<i>everolimus 5 mg tab for susp</i> (Afinitor Disperz)	T2	PA QL(30 tabs/fill) SP CSL

T1 – Preferred Generics
T2 – Non-Preferred Generics
T3 – Preferred Brands
T4 – Non-Preferred Brands

T5 – Brand Specialty
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

ANTINEOPLASTICS (Cancer) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ANTINEOPLASTIC - MTOR KINASE INHIBITORS		
<i>everolimus 5 mg tablet (Afinitor)</i>	T2	
<i>everolimus 7.5 mg tablet (Afinitor)</i>	T2	
ANTINEOPLASTIC - PROTEIN METHYLTRANSFERASE INHIBIT		
TAZVERIK	T5	PA SP CSL
ANTINEOPLASTIC - TOPOISOMERASE I INHIBITORS		
HYCAMTIN	T5	PA SP HD CSL
ANTINEOPLASTIC IMMUNOMODULATOR AGENTS		
<i>lenalidomide</i>	T2	PA QL(30 caps/fill) SP HD CSL
POMALYST	T5	PA SP HD CSL
REVLIMID	T5	PA QL(30 caps/fill) SP HD CSL
ANTINEOPLASTIC LHRH(GNRH) ANTAGONIST,PITUIT.SUPPRS		
ORGOVYX	T5	PA QL(30 tabs/fill) SP CSL
ANTINEOPLASTIC SYSTEMIC ENZYME INHIBITORS		
ALECENSA	T5	PA QL(240 caps/fill) SP HD CSL
ALUNBRIG 180 MG TABLET	T5	PA QL(30 tabs/fill) SP CSL
ALUNBRIG 30 MG TABLET	T5	PA QL(60 tabs/fill) SP CSL
ALUNBRIG 90 MG TABLET	T5	PA QL(30 tabs/fill) SP CSL
ALUNBRIG 90 MG-180 MG TAB PACK	T5	PA QL(30 tabs/fill) SP CSL
AYVAKIT	T5	PA QL(30 tabs/fill) SP CSL
BALVERSA	T5	PA SP CSL
BOSULIF 50 MG CAPSULE	T5	
BOSULIF 100 MG CAPSULE	T5	PA QL(90 tabs/fill) SP HD CSL
BOSULIF 100 MG TABLET	T5	PA QL(90 tabs/fill) SP HD CSL
BOSULIF 400 MG, 500 MG TABLET	T5	PA QL(30 tabs/fill) SP HD CSL
BRUKINSA	T5	PA SP CSL
CABOMETYX	T5	
CALQUENCE	T5	PA QL(60 tabs/caps/fill)SP CSL
CAPRELSA 100 MG TABLET	T5	PA QL(60 tabs/fill) SP CSL
CAPRELSA 300 MG TABLET	T5	PA QL(30 tabs/fill) SP CSL
COMETRIQ 100 MG DAILY-DOSE PK	T5	PA QL(56 caps/fill) SP HD CSL
COMETRIQ 140 MG DAILY-DOSE PK	T5	PA QL(112 caps/fill) SP HD CSL
COMETRIQ 60 MG DAILY-DOSE PACK	T5	PA QL(84 caps/fill) SP HD CSL
COPIKTRA	T5	PA QL(56 caps/fill) SP CSL
<i>erlotinib hcl 100 mg tablet (Tarceva)</i>	T2	PA QL(30 tabs/fill) SP HD CSL

T1 – Preferred Generics
T2 – Non-Preferred Generics
T3 – Preferred Brands
T4 – Non-Preferred Brands

T5 – Brand Specialty
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

ANTINEOPLASTICS (Cancer) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ANTINEOPLASTIC SYSTEMIC ENZYME INHIBITORS (cont.)		
<i>erlotinib hcl 150 mg tablet (Tarceva)</i>	T2	PA QL(30 tabs/fill) SP HD CSL
<i>erlotinib hcl 25 mg tablet (Tarceva)</i>	T2	PA QL(60 tabs/fill) SP HD CSL
EXKIVITY	T5	PA QL(120 caps/fill) SP CSL
GAVRETO	T5	PA QL(120 caps/fill) SP HD CSL
GILOTRIF	T5	PA QL(30 tabs/fill) SP HD CSL
ICLUSIG	T5	PA QL(30 tabs/fill) SP CSL
IMBRUVICA 70 MG CAPSULE	T5	PA QL(30 caps/fill) SP CSL
IMBRUVICA 70 MG/ML SUSPENSION	T5	PA QL(3 bottles/fill) SP CSL
IMBRUVICA 140 MG CAPSULE	T5	PA QL(120 caps/fill) SP CSL
IMBRUVICA 140 MG TABLET	T5	PA QL(30 tabs/fill) SP CSL
IMBRUVICA 280 MG TABLET	T5	PA QL(30 tabs/fill) SP CSL
IMBRUVICA 420 MG TABLET	T5	PA QL(30 tabs/fill) SP CSL
IMBRUVICA 560 MG TABLET	T5	PA ST SP CSL
INLYTA 1 MG TABLET	T5	PA QL(180 tabs/fill) SP HD CSL
INLYTA 5 MG TABLET	T5	PA QL(120 tabs/fill) SP HD CSL
IRESSA (<i>gefitinib</i>)	T5	PA QL(30 tabs/30 days) SP HD CSL
IWILFIN	T5	PA SP CSL
KISQALI	T5	PA QL (1 pack/1 time) CSL SP HD
KISQALI FEMARA CO-PACK	T5	PA QL (1 pack/28 days) CSL SP HD
<i>lapatinib ditosylate (Tykerb)</i>	T2	PA QL(180 tabs/fill) SP HD CSL
LENVIMA 4 MG CAPSULE	T5	PA QL(30 caps/fill) SP HD CSL
LENVIMA 8 MG DAILY DOSE	T5	PA QL(60 caps/fill) SP HD CSL
LENVIMA 10 MG DAILY DOSE	T5	PA QL(30 caps/fill) SP HD CSL
LENVIMA 12 MG DAILY DOSE	T5	PA QL(90 caps/fill) SP HD CSL
LENVIMA 14 MG DAILY DOSE	T5	PA QL(60 caps/fill) SP HD CSL
LENVIMA 18 MG DAILY DOSE	T5	PA QL(90 caps/fill) SP HD CSL
LENVIMA 20 MG DAILY DOSE	T5	PA QL(60 caps/fill) SP HD CSL
LENVIMA 24 MG DAILY DOSE	T5	PA QL(90 caps/fill) SP HD CSL
LORBRENA 100 MG TABLET	T5	PA QL(30 tabs/fill) SP HD CSL
LORBRENA 25 MG TABLET	T5	PA QL(90 tabs/fill) SP HD CSL
LYNPARZA	T5	PA QL(120 tabs/fill) SP HD CSL
LYTGOBI	5	PA SP CSL
NERLYNX	T5	PA SP HD CSL
NEXAVAR (<i>sorafenib tosylate</i>)	T5	PA QL(120 tabs/fill) SP HD CSL

T1 – Preferred Generics
 T2 – Non-Preferred Generics
 T3 – Preferred Brands
 T4 – Non-Preferred Brands

T5 – Brand Specialty
 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

ANTINEOPLASTICS (Cancer) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ANTINEOPLASTIC SYSTEMIC ENZYME INHIBITORS (cont.)		
NINLARO	T5	PA QL(3 caps/fill) SP HD CSL
OGSIVEO	T5	PA SP CSL
<i>pazopanib hcl (Votrient)</i>	T2	PA QL(120 tabs/30 days) SP HD CSL
PEMAZYRE	T5	PA QL(28 tabs/fill) SP CSL
PIQRAY	T6	PA SP HD CSL
RETEVMO 40 MG CAPSULE	T5	PA QL(180 caps/fill) SP HD CSL
RETEVMO 80 MG CAPSULE	T5	PA QL(120 caps/fill) SP HD CSL
ROZLYTREK 100 MG CAPSULE	T5	PA QL(30 caps/fill) SP HD CSL
ROZLYTREK 200 MG CAPSULE	T5	PA QL(90 caps/fill) SP HD CSL
ROZLYTREK 50 MG PELLETT PACKET	T5	
RUBRACA	T5	PA QL(120 tabs/fill) SP CSL
RYDAPT	T5	PA QL(224 caps/fill) SP HD CSL
SCEMBLIX 20MG TABLET	6	PA SP HD QL (600 tabs/30 days) CSL
SCEMBLIX 40MG TABLET	6	PA SP HD QL (300 tabs/30 days) CSL
<i>sorafenib tosylate (Nexavar)</i>	T2	PA QL(120 tabs/fill) SP HD CSL
SPRYCEL 100 MG TABLET	T5	PA QL(30 tabs/fill) SP HD CSL
SPRYCEL 140 MG TABLET	T5	PA QL(30 tabs/fill) SP HD CSL
SPRYCEL 20 MG TABLET	T5	PA QL(90 tabs/fill) SP HD CSL
SPRYCEL 50 MG TABLET	T5	PA QL(30 tabs/fill) SP HD CSL
SPRYCEL 70 MG TABLET	T5	PA QL(60 tabs/fill) SP HD CSL
SPRYCEL 80 MG TABLET	T5	PA QL(30 tabs/fill) SP HD CSL
STIVARGA	T5	PA QL(84 tabs/fill) SP HD CSL
<i>sunitinib malate 12.5 mg cap (Sutent)</i>	T2	PA QL(90 caps/fill) SP HD CSL
<i>sunitinib malate 25 mg capsule (Sutent)</i>	T2	PA QL(30 caps/fill) SP HD CSL
<i>sunitinib malate 37.5 mg cap (Sutent)</i>	T2	PA QL(30 caps/fill) SP HD CSL
<i>sunitinib malate 50 mg capsule (Sutent)</i>	T2	PA QL(30 caps/fill) SP HD CSL
SUTENT 12.5 MG CAPSULE (<i>sunitinib malate</i>)	T5	PA QL(90 caps/fill) SP HD CSL
SUTENT 25 MG CAPSULE (<i>sunitinib malate</i>)	T5	PA QL(30 caps/fill) SP HD CSL
SUTENT 37.5 MG CAPSULE (<i>sunitinib malate</i>)	T5	PA QL(30 caps/fill) SP HD CSL
SUTENT 50 MG CAPSULE (<i>sunitinib malate</i>)	T5	PA QL(30 caps/fill) SP HD CSL
TABRECTA	T5	PA SP HD CSL
TAGRISSO	T5	PA QL(30 tabs/fill) SP HD CSL
TALZENNA	T5	PA QL(30 caps/fill) SP HD CSL
TARCEVA 100 MG TABLET (<i>erlotinib hcl</i>)	T5	PA QL(30 tabs/fill) SP HD CSL

T1 – Preferred Generics
 T2 – Non-Preferred Generics
 T3 – Preferred Brands
 T4 – Non-Preferred Brands

T5 – Brand Specialty
 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

ANTINEOPLASTICS (Cancer) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ANTINEOPLASTIC SYSTEMIC ENZYME INHIBITORS (cont.)		
TARCEVA 150 MG TABLET (<i>erlotinib hcl</i>)	T5	PA QL(30 tabs/fill) SP HD CSL
TARCEVA 25 MG TABLET (<i>erlotinib hcl</i>)	T5	PA QL(60 tabs/fill) SP HD CSL
TASIGNA 150 MG CAPSULE	T5	PA QL(112 caps/fill) SP HD CSL
TASIGNA 200 MG CAPSULE	T5	PA QL(112 caps/fill) SP HD CSL
TASIGNA 50 MG CAPSULE	T5	PA QL(120 caps/fill) SP HD CSL
TUKYSA 150 MG TABLET	T5	PA QL(120 tabs/fill) SP CSL
TUKYSA 50 MG TABLET	T5	PA QL(300 tabs/fill) SP CSL
TURALIO	T5	PA QL(120 caps/fill) SP CSL
TYKERB (<i>lapatinib ditosylate</i>)	T5	PA QL(180 tabs/fill) SP HD CSL
VERZENIO	T5	PA QL(60 tabs/fill) SP HD CSL
VITRAKVI 100 MG CAPSULE	T5	PA QL(60 caps/fill) SP HD CSL
VITRAKVI 20 MG/ML SOLUTION	T5	PA QL(300 mls/fill) SP HD CSL
VITRAKVI 25 MG CAPSULE	T5	PA QL(180 caps/fill) SP HD CSL
VIZIMPRO	T5	PA QL(30 tabs/fill) SP HD CSL
VONJO	T5	PA QL(120 caps/fill) SP CSL
VOTRIENT (<i>pazopanib hcl</i>)	T5	PA QL(120 tabs/30 days) SP HD CSL
XALKORI 200MG, 250MG CAPSULE	T5	PA QL(60 caps/30 days) SP HD CSL
XALKORI 20MG, 50MG, 150MG PELLETT	T5	PA SP HD CSL
XOSPATA	T5	PA QL(90 tabs/fill) SP CSL
ZEJULA	T5	PA QL(90 caps/fill) SP CSL
ZYDELIG	T5	PA QL(60 tabs/fill) SP HD CSL
ZYKADIA	T5	PA QL(90 tabs/caps/fill)SP HD CSL
ANTINEOPLASTIC-B CELL LYMPHOMA-2(BCL-2) INHIBITORS		
VENCLEXTA 10 MG TAB (10MG X 2)	T5	PA QL(56 tabs/fill) SP CSL
VENCLEXTA 10 MG TABLET	T5	PA QL(56 tabs/fill) SP CSL
VENCLEXTA 100 MG TABLET	T5	PA QL(180 tabs/fill) SP CSL
VENCLEXTA 50 MG TABLET	T5	PA QL(28 tabs/fill) SP CSL
VENCLEXTA STARTING PACK	T5	PA QL(42 tabs/fill) SP CSL
ANTINEOPLASTIC-HYPOXIA INDUCIBLE FACTOR (HIF) INH		
WELIREG	T5	PA SP CSL
ANTINEOPLASTIC-ISOCITRATE DEHYDROGENASE INHIBITORS		
IDHIFA	T5	PA QL(30 tabs/fill) SP HD CSL
TIBSOVO	T5	PA SP CSL

T1 – Preferred Generics
 T2 – Non-Preferred Generics
 T3 – Preferred Brands
 T4 – Non-Preferred Brands

T5 – Brand Specialty
 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

ANTINEOPLASTICS (Cancer) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ANTINEOPLASTICS, MISCELLANEOUS		
<i>etoposide</i>	T2	SP HD CSL
LYSODREN	T3	CSL
MATULANE	T5	SP CSL
<i>tretinoin 10 mg capsule</i>	T2	CSL
IMMUNOMODULATORS		
ACTIMMUNE	T5	PA SP HD
SELECTIVE ESTROGEN RECEPTOR MODULATORS (SERMS)		
FARESTON (<i>toremifene citrate</i>)	T4	HD CSL
SOLTAMOX	T4	HD PPACA CSL
<i>tamoxifen citrate</i>	T2	HD PPACA CSL
<i>toremifene citrate (Fareston)</i>	T2	HD CSL
STEROID ANTINEOPLASTICS		
EMCYT	T5	SP HD CSL
<i>megestrol 20 mg tablet</i>	T2	CSL
<i>megestrol 40 mg tablet</i>	T2	CSL
ANTINEOPLASTICS (Skin Conditions)		
PHOTOACT, TOPICAL ANTINEOPLAST, PREMALIGNANT LESIONS		
LEVULAN	T5	SP
TOPICAL ANTINEOPLASTIC PREMALIGNANT LESION AGENTS		
bexarotene 1% gel (Targretin)	T2	PA SP HD
diclofenac sodium 3% gel	T2	PA QL(100 gms/28 days)
EFUDEX (<i>fluorouracil</i>)	T4	
FLUOROPLEX	T4	
<i>fluorouracil 2% topical soln</i>	T2	
<i>fluorouracil 5% cream (Efudex)</i>	T2	
<i>fluorouracil 5% topical soln</i>	T2	
PANRETIN	T5	PA SP HD
TARGRETIN 1% GEL (<i>bexarotene</i>)	T5	PA SP HD
TOLAK	T4	
VALCHLOR	T5	PA SP HD
ANTI-OBESITY DRUGS (Weight Management)		
ANTI-OBESITY - ANOREXIC AGENTS		
ADIPEX-P (<i>phentermine hcl</i>)	T4	PA QL(30 tabs/30 days)

T1 – Preferred Generics
 T2 – Non-Preferred Generics
 T3 – Preferred Brands
 T4 – Non-Preferred Brands

T5 – Brand Specialty
 PA – Prior Authorization
 QL – Quantity Limit

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

HD – May require home delivery pharmacy
 PPACA – No Cost-Share Preventive Medication
 CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

ANTI-OBESITY DRUGS (Weight Management) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ANTI-OBESITY - ANOREXIC AGENTS (cont.)		
<i>benzphetamine hcl</i>	T2	PA QL(90 tabs/fill)
<i>diethylpropion hcl</i>	T2	PA QL(90 tabs/fill)
<i>diethylpropion hcl</i>	T2	PA QL(30 tabs/fill)
LOMAIRA	T4	PA QL(90 tabs/fill)
<i>phendimetrazine tartrate</i>	T2	PA QL(30 caps/fill)
<i>phendimetrazine tartrate</i>	T2	PA QL(180 tabs/fill)
<i>phentermine 15 mg capsule</i>	T2	PA QL(30 caps/fill)
<i>phentermine 30 mg capsule</i>	T2	PA QL(30 caps/fill)
<i>phentermine 37.5 mg capsule</i>	T2	PA QL(30 caps/30 days)
<i>phentermine 37.5 mg tablet (Adipex-P)</i>	T2	PA QL(30 tabs/fill)
QSYMIA	T4	PA QL(30 caps/fill)
ANTI-OBESITY - MELANOCORTIN 4 RECEPTOR AGONISTS		
IMCIVREE	T5	PA QL(6 mls/30 days) SP
ANTI-OBESITY GLUCAGON-LIKE PEPTIDE-1 RECEPTOR AGONIST		
SAXENDA	T4	PA QL(5 pens/fill)
WEGOVY 0.25 MG/0.5 ML PEN	T3	PA QL(8 pens/year)
WEGOVY 0.5 MG/0.5 ML PEN	T3	PA QL(8 pens/year)
WEGOVY 1 MG/0.5 ML PEN	T3	PA QL(8 pens/year)
WEGOVY 1.7 MG/0.75 ML PEN	T3	PA QL(8 pens/year)
WEGOVY 2.4 MG/0.75 ML PEN	T3	PA QL(4 pens/28 days)
ANTI-OBESITY - INCRETIN MIMETICS COMBINATION		
ZEPBOUND	T3	
ANTI-OBESITY SEROTONIN 2C RECEPTOR AGONISTS		
BELVIQ	T4	PA
BELVIQ XR	T4	PA
ANTI-OBESITY-OPIOID ANTAG-NOREPI, DOPAMINE RECEPTOR INHIB		
CONTRAVE	T4	PA QL(120 tabs/fill)
FAT ABSORPTION DECREASING AGENTS		
ORLISTAT	T4	PA QL(90 caps/fill)
XENICAL	T4	PA QL(90 caps/fill)
ANTIPARASITICS (Eye Conditions)		
OPHTHALMIC (EYE) ANTIPARASITICS		
XDEMVIY	T5	QL(10 mgs/30 days) SP

T1 – Preferred Generics
 T2 – Non-Preferred Generics
 T3 – Preferred Brands
 T4 – Non-Preferred Brands

T5 – Brand Specialty
 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

ANTIPARASITICS (Infections)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ANTIPARASITICS		
ALINIA 100 MG/5 ML SUSPENSION	T3	QL(360 mls/30 days)
<i>nitazoxanide</i> (Alinia)	T2	QL(12 tabs/30 days)
TOPICAL ANTIPARASITICS		
<i>crotamiton</i>	T2	
ELIMITE (<i>permethrin</i>)	T4	
EURAX	T4	
<i>ivermectin 0.5% lotion</i> (Sklice)	T2	
<i>permethrin</i> (Elimite)	T2	
SKLICE (<i>ivermectin</i>)	T4	
<i>spinosad</i> (Natroba)	T2	
ULESFIA	T4	
ANTIPARKINSON DRUGS (Parkinson's Disease)		
ANTIPARKINSONISM DRUGS, ANTICHOLINERGIC		
<i>benztropine mesylate</i>	T1	HD
<i>trihexphenidyl hcl</i>	T2	HD
ANTIPARKINSONISM DRUGS, OTHER		
<i>amantadine hcl</i>	T2	HD
<i>apomorphine hcl</i>	T2	PA QL(30 mls/30 days) SP
AZILECT (<i>rasagiline mesylate</i>)	T4	ST HD
<i>bromocriptine mesylate</i> (Parlodel)	T2	HD
<i>carbidopa/levodopa</i>	T2	HD
<i>carbidopa/levodopa</i> (Sinemet 10-100)	T2	HD
<i>carbidopa/levodopa</i> (Sinemet 25-100)	T2	HD
<i>carbidopa/levodopa/entacapone</i> (Stalevo 100)	T2	HD
<i>carbidopa/levodopa/entacapone</i> (Stalevo 125)	T2	HD
<i>carbidopa/levodopa/entacapone</i> (Stalevo 150)	T2	HD
<i>carbidopa/levodopa/entacapone</i> (Stalevo 200)	T2	HD
<i>carbidopa/levodopa/entacapone</i> (Stalevo 50)	T2	HD
<i>carbidopa/levodopa/entacapone</i> (Stalevo 75)	T2	HD
COMTAN (<i>entacapone</i>)	T4	HD
DUOPA	T5	PA SP HD
<i>entacapone</i> (Comtan)	T2	HD
INBRIJA	T5	PA QL(300 caps/fill) SP HD
KYNMOBI	T3	PA QL(150 films/30 days) HD

T1 – Preferred Generics
 T2 – Non-Preferred Generics
 T3 – Preferred Brands
 T4 – Non-Preferred Brands

T5 – Brand Specialty
 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

ANTIPARKINSON DRUGS (Parkinson's Disease) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ANTIPARKINSONISM DRUGS, OTHER (cont.)		
MIRAPEX ER (<i>pramipexole di-hcl</i>)	T4	HD
NEUPRO	T4	HD
NOURIANZ	T5	PA QL(30 tabs/fill) SP HD
PARLODEL (<i>bromocriptine mesylate</i>)	T4	HD
<i>pramipexole di-hcl</i>	T2	HD
<i>pramipexole di-hcl</i> (Mirapex Er)	T2	HD
<i>rasagiline mesylate</i> (Azilect)	T2	HD
<i>ropinirole hcl</i>	T2	HD
RYTARY	T4	HD
<i>selegiline hcl</i>	T2	HD
SINEMET 10-100 (<i>carbidopa/levodopa</i>)	T4	HD
SINEMET 25-100 (<i>carbidopa/levodopa</i>)	T4	HD
STALEVO 50 (<i>carbidopa/levodopa/entacapone</i>)	T4	HD
STALEVO 75 (<i>carbidopa/levodopa/entacapone</i>)	T4	HD
STALEVO 100 (<i>carbidopa/levodopa/entacapone</i>)	T4	HD
STALEVO 125 (<i>carbidopa/levodopa/entacapone</i>)	T4	HD
STALEVO 150 (<i>carbidopa/levodopa/entacapone</i>)	T4	HD
STALEVO 200 (<i>carbidopa/levodopa/entacapone</i>)	T4	HD
TASMAR (<i>tolcapone</i>)	T4	PA HD
<i>tolcapone</i> (Tasmar)	T2	PA HD
DECARBOXYLASE INHIBITORS		
<i>carbidopa</i> (Lodosyn)	T2	PA
LODOSYN (<i>carbidopa</i>)	T4	PA

ANTIPLATELET DRUGS (Blood Thinners/Anti-Clotting)

PLATELET AGGREGATION INHIBITORS

<i>aspirin/dipyridamole</i>	T2	HD
BRILINTA	T3	HD
<i>cilostazol</i>	T2	HD
<i>clopidogrel bisulfate</i>	T1	HD
<i>clopidogrel bisulfate</i> (Plavix)	T1	HD
<i>dipyridamole</i>	T2	HD
EFFIENT (<i>prasugrel hcl</i>)	T4	HD
<i>prasugrel hcl</i> (Effient)	T2	HD
ZONTIVITY	T4	PA HD

T1 – Preferred Generics
 T2 – Non-Preferred Generics
 T3 – Preferred Brands
 T4 – Non-Preferred Brands

T5 – Brand Specialty
 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

ANTIPLATELET DRUGS (Blood Thinners/Anti-Clotting)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
PLATELET REDUCING AGENTS		
AGRYLIN (<i>anagrelide hcl</i>)	T4	
<i>anagrelide hcl</i>	T2	
<i>anagrelide hcl</i> (Agrylin)	T2	
ANTIVIRALS (AIDS/HIV)		
ANTIRETROVIRAL-INTEGRASE INHIBITOR AND NNRTI COMB.		
JULUCA	T5	SP
DOVATO	T5	SP
TRIUMEQ	T5	SP
TRIUMEQ PD	T5	SP
ANTIRETROVIRAL-NUCLEOSIDE, NUCLEOTIDE, PROTEASE INH.		
SYMTUZA	T5	SP
ANTIVIRALS, HIV-SPEC, NON-PEPTIDIC PROTEASE INHIB		
APTIVUS	T5	SP
<i>darunavir</i> (Prezista)	T2	SP
PREZISTA 600MG, 800MG TABLET (<i>darunavir</i>)	T5	SP
ANTIVIRALS, HIV-SPEC, NUCLEOSIDE-NUCLEOTIDE ANALOG		
CIMDUO	T5	SP
DESCOVY	T5	SP
<i>emtricitabine-tenofv 100-150mg</i> (Truvada)	T2	SP
<i>emtricitabine-tenofv 133-200mg</i> (Truvada)	T2	SP
<i>emtricitabine-tenofv 167-250mg</i> (Truvada)	T2	SP
<i>emtricitabine-tenofv 200-300mg</i> (Truvada)	T2	SP PPACA
TEMIXYS	T5	SP
ANTIVIRALS, HIV-SPEC., NUCLEOSIDE ANALOG, RTI COMB		
<i>abacavir sulfate/lamivudine</i> (Epzicom)	T2	SP
<i>abacavir/lamivudine/zidovudine</i> (Trizivir)	T2	SP
COMBIVIR (<i>lamivudine/zidovudine</i>)	T5	SP
EPZICOM (<i>abacavir sulfate/lamivudine</i>)	T5	SP
<i>lamivudine/zidovudine</i> (Combivir)	T2	SP
TRIZIVIR (<i>abacavir/lamivudine/zidovudine</i>)	T5	SP
ANTIVIRALS, HIV-SPECIFIC, CCR5 CO-RECEPTOR ANTAG.		
<i>maraviroc</i> (Selzentry)	T2	SP
SELZENTRY 150 MG TABLET (<i>maraviroc</i>)	T5	SP
SELZENTRY 20 MG/ML ORAL SOLN	T5	SP

T1 – Preferred Generics
 T2 – Non-Preferred Generics
 T3 – Preferred Brands
 T4 – Non-Preferred Brands

T5 – Brand Specialty
 PA – Prior Authorization
 QL – Quantity Limit

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

HD – May require home delivery pharmacy
 PPACA – No Cost-Share Preventive Medication
 CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

ANTIVIRALS (AIDS/HIV) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ANTIVIRALS, HIV-SPECIFIC, CCR5 CO-RECEPTOR ANTAG. (cont.)		
SELZENTRY 25 MG TABLET	T5	SP
SELZENTRY 300 MG TABLET (<i>maraviroc</i>)	T5	SP
SELZENTRY 75 MG TABLET	T5	SP
ANTIVIRALS, HIV-SPECIFIC, FUSION INHIBITORS		
FUZEON	T5	PA SP
ANTIVIRALS, HIV-SPECIFIC, NON-NUCLEOSIDE, RTI		
EDURANT	T5	SP
<i>efavirenz</i> (Sustiva)	T2	SP
<i>etravirine</i> (Intelence)	T2	SP
INTELENCE 100 MG TABLET (<i>etravirine</i>)	T5	SP
INTELENCE 200 MG TABLET (<i>etravirine</i>)	T5	SP
INTELENCE 25 MG TABLET	T5	SP
<i>nevirapine</i>	T2	SP
<i>nevirapine</i> (Viramune Xr)	T2	SP
SUNLENCA	T5	PA SP
SUSTIVA (<i>efavirenz</i>)	T5	SP
VIRAMUNE XR (<i>nevirapine</i>)	T5	SP
ANTIVIRALS, HIV-SPECIFIC, NUCLEOSIDE ANALOG, RTI		
<i>abacavir sulfate</i> (Ziagen)	T2	SP
<i>didanosine</i>	T2	SP
<i>emtricitabine</i> (Emtriva)	T2	SP
EMTRIVA 10 MG/ML SOLUTION	T5	SP
EMTRIVA 200 MG CAPSULE (<i>emtricitabine</i>)	T5	SP
EPIVIR (<i>lamivudine</i>)	T5	SP
<i>lamivudine</i> (EpiVir)	T2	SP
RETROVIR (<i>zidovudine</i>)	T5	SP
<i>stavudine</i>	T2	SP
ZIAGEN (<i>abacavir sulfate</i>)	T5	SP
<i>zidovudine</i>	T2	SP
<i>zidovudine</i> (Retrovir)	T2	SP
<i>tenofovir disoproxil fumarate</i> (Viread)	T2	SP
VIREAD 150 MG TABLET	T5	SP
VIREAD 200 MG TABLET	T5	SP
VIREAD 250 MG TABLET	T5	SP

T1 – Preferred Generics
T2 – Non-Preferred Generics
T3 – Preferred Brands
T4 – Non-Preferred Brands

T5 – Brand Specialty
PA – Prior Authorization
QL – Quantity Limit

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

HD – May require home delivery pharmacy
PPACA – No Cost-Share Preventive Medication
CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

ANTIVIRALS (AIDS/HIV) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ANTIVIRALS, HIV-SPECIFIC, NUCLEOSIDE ANALOG, RTI (cont.)		
VIREAD 300 MG TABLET (<i>tenofovir disoproxil fumarate</i>)	T5	SP
VIREAD POWDER	T5	SP
ANTIVIRALS, HIV-SPECIFIC, PROTEASE INHIBITOR COMB		
KALETRA (<i>lopinavir/ritonavir</i>)	T5	SP
<i>lopinavir/ritonavir</i> (Kaletra)	T2	SP
ANTIVIRALS, HIV-SPECIFIC, PROTEASE INHIBITORS		
<i>atazanavir sulfate</i> (Reyataz)	T2	SP
EVOTAZ	T5	SP
<i>fosamprenavir calcium</i> (Lexiva)	T2	SP
INVIRASE	T5	SP
LEXIVA 50 MG/ML SUSPENSION	T5	SP
LEXIVA 700 MG TABLET (<i>fosamprenavir calcium</i>)	T5	SP
NORVIR 100 MG POWDER PACKET	T5	SP
NORVIR 100 MG TABLET (<i>ritonavir</i>)	T5	SP
REYATAZ 150 MG CAPSULE (<i>atazanavir sulfate</i>)	T5	SP
REYATAZ 200 MG CAPSULE (<i>atazanavir sulfate</i>)	T5	SP
REYATAZ 300 MG CAPSULE (<i>atazanavir sulfate</i>)	T5	SP
REYATAZ 50 MG POWDER PACKET	T5	SP
<i>ritonavir</i> (Norvir)	T2	SP
VIRACEPT	T5	SP
ANTIVIRALS, HIV-I INTEGRASE STRAND TRANSFER INHIBTR		
APRETUDE	T5	PA SP PPACA
ISENTRESS	T5	SP
ISENTRESS HD	T5	SP
TIVICAY	T5	SP
TIVICAY PD	T5	SP
ARTV NUCLEOSIDE, NUCLEOTIDE, NON-NUCLEOSIDE RTI COMB		
<i>efavirenz/emtricit/tenofovr df</i> (Atripla)	T2	SP
<i>efavirenz/lamivu/tenofov disop</i> (Symfi Lo)	T2	SP
<i>efavirenz/lamivu/tenofov disop</i> (Symfi)	T2	SP
ODEFSEY	T5	SP
SYMFI (<i>efavirenz/lamivu/tenofov disop</i>)	T5	SP
SYMFI LO (<i>efavirenz/lamivu/tenofov disop</i>)	T5	SP

T1 – Preferred Generics
T2 – Non-Preferred Generics
T3 – Preferred Brands
T4 – Non-Preferred Brands

T5 – Brand Specialty
PA – Prior Authorization
QL – Quantity Limit

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

HD – May require home delivery pharmacy
PPACA – No Cost-Share Preventive Medication
CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

ANTIVIRALS (AIDS/HIV) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ARV-NUCLEOSIDE, NUCLEOTIDE RTI, INTEGRASE INHIBITORS		
BIKTARVY	T5	SP
GENVOYA	T5	SP
ANTIVIRALS (Eye Conditions)		
EYE ANTIVIRALS		
trifluridine	T2	
ZIRGAN	T4	
ANTIVIRALS (Infections)		
ANTIVIRALS, GENERAL		
acyclovir 200 mg capsule	T2	
acyclovir 200 mg/5 ml susp (Zovirax)	T2	
acyclovir 400 mg tablet	T2	
acyclovir 800 mg tablet	T2	
famciclovir 125 mg tablet	T2	QL(21 tabs/fill)
famciclovir 250 mg tablet	T2	QL(60 tabs/fill)
famciclovir 500 mg tablet	T2	QL(21 tabs/fill)
FLUMADINE (rimantadine hcl)	T4	
LIVTENCITY	T5	PA QL(112 tabs/28 days) SP
oseltamivir 6 mg/ml suspension (Tamiflu)	T2	QL(180 mls/fill)
oseltamivir phos 30 mg capsule (Tamiflu)	T2	QL(20 caps/fill)
oseltamivir phos 45 mg capsule (Tamiflu)	T2	QL(10 caps/fill)
oseltamivir phos 75 mg capsule (Tamiflu)	T2	QL(10 caps/fill)
PREVYMIS	T5	QL(30 tabs/fill) SP HD
RELENZA	T4	QL(20 blisters/fill)
rimantadine hcl (Flumadine)	T2	
TAMIFLU 30 MG CAPSULE (oseltamivir phosphate)	T4	QL(20 caps/fill)
TAMIFLU 45 MG CAPSULE (oseltamivir phosphate)	T4	QL(10 caps/fill)
TAMIFLU 75 MG CAPSULE (oseltamivir phosphate)	T4	QL(10 caps/fill)
TAMIFLU 6 MG/ML SUSPENSION (oseltamivir phosphate)	T4	QL(180 mls/fill)
valacyclovir hcl (Valtrex)	T2	QL(30 tabs/fill)
VALCYTE (valganciclovir hcl)	T4	
valganciclovir hcl (Valcyte)	T2	
XOFLUZA	T4	QL(1 tab/fill)
ZOVIRAX 200 MG/5 ML SUSP (acyclovir)	T4	

T1 – Preferred Generics
 T2 – Non-Preferred Generics
 T3 – Preferred Brands
 T4 – Non-Preferred Brands

T5 – Brand Specialty
 PA – Prior Authorization
 QL – Quantity Limit

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

HD – May require home delivery pharmacy
 PPACA – No Cost-Share Preventive Medication
 CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

ANTIVIRALS (Infections) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
HEP C - NS5A, NS3/4A, NUCLEOTIDE NS5B INHIB COMBO		
VOSEVI	T5	PA QL(28 tabs/fill) SP HD
HEP C VIRUS-NS5B POLYMERASE AND NS5A INHIB. COMBO.		
EPCLUSA 150-37.5 MG PELLET PKT	T5	PA QL(28 packs/fill) SP HD
EPCLUSA 200 MG-50 MG TABLET	T5	PA QL(28 tabs/fill) SP HD
EPCLUSA 200-50 MG PELLET PACK	T5	PA QL(28 packs/fill) SP HD
EPCLUSA 400 MG-100 MG TABLET	T5	PA QL(28 tabs/fill) SP HD
HARVONI 33.75-150 MG PELLET PK	T5	PA QL(28 packs/fill) SP HD
HARVONI 45-200 MG PELLET PACKT	T5	PA QL(56 packs/fill) SP HD
HARVONI 45-200 MG TABLET	T5	PA QL(56 tabs/fill) SP HD
HARVONI 90-400 MG TABLET	T5	PA QL(>= 18 yo 28 tabs/fill) SP HD
HEPATITIS B TREATMENT AGENTS		
<i>adefovir dipivoxil</i>	T2	SP HD
BARACLUDE 0.05 MG/ML SOLUTION	T5	SP HD
<i>entecavir (Baraclude)</i>	T2	SP HD
EPIVIR HBV 100 MG TABLET (<i>lamivudine</i>)	T5	SP
EPIVIR HBV 25 MG/5 ML SOLN	T5	SP
<i>lamivudine (Epiriv Hbv)</i>	T2	SP
VEMLIDY	T5	SP HD
PEGASYS 180 MCG/0.5 ML SYRINGE	T5	SP HD
PEGASYS 180 MCG/ML VIAL	T5	SP HD
<i>ribasphere 200 mg capsule</i>	T2	ST SP HD
<i>ribasphere 600 mg tablet</i>	T2	ST SP
HEPATITIS C TREATMENT AGENTS		
<i>ribavirin</i>	T2	ST SP HD
HEPATITIS C VIRUS- NS5A AND NS3/4A INHIBITOR COMB		
ZEPATIER	T5	PA QL(28 tabs/fill) SP HD
ANTIVIRALS (Skin Conditions)		
TOPICAL ANTIVIRALS		
<i>acyclovir 5% cream (Zovirax)</i>	T2	PA QL(5 gms/fill)
<i>acyclovir 5% ointment (Zovirax)</i>	T2	PA QL(30 gms/fill)
DENAVIR	T4	
<i>penciclovir</i>	T2	
ZOVIRAX 5% CREAM (<i>acyclovir</i>)	T4	PA QL(5 gms/fill)

T1 – Preferred Generics
 T2 – Non-Preferred Generics
 T3 – Preferred Brands
 T4 – Non-Preferred Brands

T5 – Brand Specialty
 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 (Allergy/Nasal Sprays)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ANAPHYLAXIS THERAPY AGENTS		
AUVI-Q	T3	QL(2 auto-injs/30 days)
<i>epinephrine 0.15 mg auto-inject</i> (Epipen Jr 2-Pak)	T2	QL(2 auto-injs/fill)
<i>epinephrine 0.15 mg auto-inject</i> (Epipen Jr)	T2	QL(2 auto-injs/fill)
<i>epinephrine 0.3 mg auto-inject</i> (Epipen 2-Pak)	T2	QL(2 auto-injs/fill)
<i>epinephrine 0.3 mg auto-inject</i> (Epipen)	T2	QL(2 auto-injs/fill)
EPIPEN (<i>epinephrine</i>)	T3	PA QL(2 auto-injs/fill)
EPIPEN 2-PAK (<i>epinephrine</i>)	T3	PA QL(2 auto-injs/fill)
EPIPEN JR (<i>epinephrine</i>)	T3	PA QL(2 auto-injs/fill)
EPIPEN JR 2-PAK (<i>epinephrine</i>)	T3	PA QL(2 auto-injs/fill)
SYMJEPI	T3	QL(2 syringes/fill)

AUTONOMIC DRUGS (Alzheimer's Disease)

CHOLINESTERASE INHIBITORS

ADLARITY	T4	ST HD
ARICEPT (<i>donepezil hcl</i>)	T4	ST HD
<i>donepezil hcl</i>	T1	HD
<i>donepezil hcl 10 mg tablet</i> (Aricept)	T1	HD
<i>donepezil hcl 23 mg tablet</i> (Aricept)	T1	ST HD
<i>donepezil hcl 5 mg tablet</i> (Aricept)	T1	HD
EXELON (<i>rivastigmine</i>)	T4	ST HD
<i>galantamine hbr</i>	T2	HD
<i>galantamine hbr</i> (Razadyne Er)	T2	HD
<i>pyridostigmine 60 mg/5 ml soln</i> (Mestinon)	T2	HD
PYRIDOSTIGMINE BR 30 MG TABLET	T4	HD
<i>pyridostigmine br 60 mg tablet</i> (Mestinon)	T2	HD
<i>pyridostigmine bromide</i> (Mestinon)	T2	HD
RAZADYNE ER (<i>galantamine hbr</i>)	T4	ST HD
<i>rivastigmine</i> (Exelon)	T2	HD
<i>rivastigmine tartrate</i>	T2	HD

AUTONOMIC DRUGS (Attention Deficit Hyperactivity Disorder)⁸

ADRENERGICS, AROMATIC, NON-CATECHOLAMINE

ADZENYS XR-ODT	T4	ST
<i>amphetamine sulfate</i> (Evekeo)	T2	
DESOXYN (<i>methamphetamine hcl</i>)	T4	
DEXEDRINE (<i>dextroamphetamine sulfate</i>)	T4	ST

T1 – Preferred Generics
 T2 – Non-Preferred Generics
 T3 – Preferred Brands
 T4 – Non-Preferred Brands

T5 – Brand Specialty
 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)⁸

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ADRENERGICS, AROMATIC, NON-CATECHOLAMINE (cont.)		
<i>dextroamphetamine sulfate</i>	T2	
<i>dextroamphetamine sulfate (Dexedrine)</i>	T2	
<i>dextroamphetamine sulfate (Zenzedi)</i>	T2	
<i>dextroamphetamine/amphetamine (Adderall Xr)</i>	T2	
<i>dextroamphetamine/amphetamine (Adderall)</i>	T2	
<i>dextroamphetamine/amphetamine (Mydayis)</i>	T2	
EVEKEO ODT	T4	
<i>methamphetamine hcl (Desoxyn)</i>	T2	
MYDAYIS (<i>dextroamphetamine/amphetamine</i>)	T4	ST
ZENZEDI 2.5 MG TABLET	T4	
<i>zenzedi 5 mg tablet</i>	T2	
ZENZEDI 7.5 MG TABLET	T4	
<i>zenzedi 10 mg tablet</i>	T2	
ZENZEDI 15 MG TABLET (<i>dextroamphetamine sulfate</i>)	T4	
ZENZEDI 20 MG TABLET (<i>dextroamphetamine sulfate</i>)	T4	
ZENZEDI 30 MG TABLET (<i>dextroamphetamine sulfate</i>)	T4	

AUTONOMIC DRUGS (Blood Pressure/Heart Medications)

ADRENERGIC VASOPRESSOR AGENTS

<i>droxidopa (Northera)</i>	T2	PA SP HD
<i>midodrine hcl</i>	T2	
DIBENZYLIN (<i>phenoxybenzamine hcl</i>)	T4	PA HD
<i>phenoxybenzamine hcl (Dibenzylin)</i>	T2	PA HD

AUTONOMIC DRUGS (Urinary Tract Conditions)

PARASYMPATHETIC AGENTS

<i>bethanechol chloride</i>	T2	HD
<i>bethanechol chloride (Urecholine)</i>	T2	HD
<i>cevimeline hcl (Evoxac)</i>	T2	HD
EVOXAC (<i>cevimeline hcl</i>)	T4	HD
<i>pilocarpine hcl (Salagen)</i>	T2	HD
SALAGEN (<i>pilocarpine hcl</i>)	T4	HD
URECHOLINE (<i>bethanechol chloride</i>)	T4	HD

T1 – Preferred Generics
 T2 – Non-Preferred Generics
 T3 – Preferred Brands
 T4 – Non-Preferred Brands

T5 – Brand Specialty
 PA – Prior Authorization
 QL – Quantity Limit

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

HD – May require home delivery pharmacy
 PPACA – No Cost-Share Preventive Medication
 CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

BIOLOGICALS (Allergy/Nasal Sprays)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ALLERGENIC EXTRACTS, THERAPEUTIC		
GRASTEK	T3	PA
ODACTRA	T3	PA
ORALAIR	T3	PA
RAGWITEK	T3	PA

BIOLOGICALS (Blood Pressure/Heart Medications)

PLASMA KALLIKREIN INHIBITORS

TAKHZYRO	T4	PA SP HD
----------	----	----------

BIOLOGICALS (Miscellaneous)

PKU TREATMENT AGENTS - PHENYLALANINE AMMONIA LYASE

PALYNZIQ 10 MG/0.5 ML SYRINGE	T5	PA QL(30 syringes/fill) SP HD
PALYNZIQ 2.5 MG/0.5 ML SYRINGE	T5	PA QL(8 syringes/fill) SP HD
PALYNZIQ 20 MG/ML SYRINGE	T5	PA QL(60 syringes/fill) SP HD

BIOLOGICALS (Vaccines)

COVID-19 VACCINES

COMIRNATY	T3	PPACA
JANSSEN COVID-19 VACCINE (EUA)	T3	PPACA
MODERNA COVID VAC(EUA)	T3	PPACA
MODERNA COVID-19 BOOSTER (EUA)	T3	PPACA
NOVAVAX COVID-19 VACC,ADJ(EUA)	T3	PPACA
PFIZER COVID VAC(EUA)	T3	PPACA
PFIZER COVID-19 VACCINE (EUA)	T3	PPACA
SPIKEVAX COVID (18Y UP) VACC	T3	PPACA

ENTERIC VIRUS VACCINES

IPOL	T3	PPACA
ROTARIX	T4	HD PPACA
ROTATEQ	T3	PPACA

GRAM NEGATIVE COCCI VACCINES

BEXSERO	T3	PPACA
MENACTRA	T3	PPACA
MENQUADFI	T3	PPACA
MENVEO A-C-Y-W-135-DIP	T3	PPACA
PENBRAYA	T3	PPACA

T1 – Preferred Generics
 T2 – Non-Preferred Generics
 T3 – Preferred Brands
 T4 – Non-Preferred Brands

T5 – Brand Specialty
 PA – Prior Authorization
 QL – Quantity Limit

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

HD – May require home delivery pharmacy
 PPACA – No Cost-Share Preventive Medication
 CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

BIOLOGICALS (Vaccines) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
GRAM NEGATIVE COCCI VACCINES (cont.)		
PNEUMOVAX 23	T3	PPACA
PREVNAR 13	T3	PPACA
PREVNAR 20	T3	PPACA
TRUMENBA	T3	PPACA
VAXNEUVANCE	T3	PPACA
INFLUENZA VIRUS VACCINES		
AFLURIA QUAD	T3	PPACA
FLUAD	T3	PPACA
FLUAD QUAD	T3	PPACA
FLUARIX QUAD	T3	PPACA
FLUBLOK QUAD	T3	PPACA
FLUCELVAX QUAD	T3	PPACA
FLULAVAL QUAD	T3	PPACA
FLUMIST QUAD	T3	PPACA
FLUZONE HIGH-DOSE	T3	PPACA
FLUZONE HIGH-DOSE QUAD	T3	PPACA
FLUZONE QUAD	T3	PPACA
FLUZONE QUAD PEDI	T3	PPACA
NEUROTOXIC VIRUS VACCINES		
DENGVAXIA	T3	PPACA
VACCINE/TOXOID PREPARATIONS, COMBINATIONS		
ACTHIB	T3	PPACA
ADACEL TDAP	T3	PPACA
BOOSTRIX TDAP	T3	PPACA
DAPTACEL DTAP	T3	PPACA
DIPHThERIA-TETANUS TOXOIDS-PED	T3	PPACA
HIBERIX	T3	PPACA
INFANRIX DTAP	T3	PPACA
KINRIX	T3	PPACA
M-M-R II VACCINE	T3	PPACA
PEDVAXHIB	T3	PPACA
PENTACEL	T3	PPACA
PENTACEL ACTHIB COMPONENT	T3	PPACA
PRIORIX	T3	PPACA

T1 – Preferred Generics
 T2 – Non-Preferred Generics
 T3 – Preferred Brands
 T4 – Non-Preferred Brands

T5 – Brand Specialty
 PA – Prior Authorization
 QL – Quantity Limit

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

HD – May require home delivery pharmacy
 PPACA – No Cost-Share Preventive Medication
 CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

BIOLOGICALS (Vaccines) (cont.)

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

VACCINE/TOXOID PREPARATIONS, COMBINATIONS (cont.)

PROQUAD	T3	PPACA
QUADRACEL DTAP-IPV	T3	PPACA
TDVAX	T3	PPACA
TENIVAC	T3	PPACA
VAXELIS	T3	PPACA

VIRAL/TUMORIGENIC VACCINES

ACAM2000	T3	PPACA
AREXVY VIAL KIT	T3	PPACA
ENGERIX-B ADULT	T3	PPACA
ENGERIX-B PEDIATRIC-ADOLESCENT	T3	PPACA
GARDASIL 9	T3	PPACA
HEPLISAV-B	T3	PPACA
JYNNEOS	T3	
PEDIARIX	T3	PPACA
PREHEVBRIO	T3	PPACA
RECOMBIVAX HB	T3	PPACA
SHINGRIX	T3	PPACA
TWINRIX	T3	PPACA
VARIVAX VACCINE	T3	PPACA

BLOOD (Blood Modifiers/Bleeding Disorders)

ANTIFIBRINOLYTIC AGENTS

AMICAR (<i>aminocaproic acid</i>)	T4	SP HD
<i>aminocaproic acid</i> (Amicar)	T2	SP HD
LYSTEDA (<i>tranexamic acid</i>)	T5	SP
<i>tranexamic acid</i> (Lysteda)	T2	SP

COMPLEMENT INHIBITORS

EMPAVELI	T5	PA SP
FABHALTA	T5	PA SP

HEMOPHILIA TREATMENT AGENTS, NON-FACTOR REPLACEMENT

HEMLIBRA	T5	PA SP HD
----------	----	----------

PYRUVATE KINASE ACTIVATORS

PYRUKYND 20 MG TABLET	T5	PA QL(56 tabs/28 days) SP
PYRUKYND 20-5 MG TAPER PACK	T5	PA QL(14 tabs/365 days) SP

T1 – Preferred Generics
T2 – Non-Preferred Generics
T3 – Preferred Brands
T4 – Non-Preferred Brands

T5 – Brand Specialty
PA – Prior Authorization
QL – Quantity Limit

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

HD – May require home delivery pharmacy
PPACA – No Cost-Share Preventive Medication
CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

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

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

PYRUVATE KINASE ACTIVATORS (cont.)

PYRUKYND 5 MG TABLET	T5	PA QL(56 tabs/28 days) SP
PYRUKYND 5 MG TAPER PACK	T5	PA QL(7 tabs/365 days) SP
PYRUKYND 50 MG TABLET	T5	PA QL(56 tabs/28 days) SP
PYRUKYND 50-20 MG TAPER PACK	T5	PA QL(14 tabs/365 days) SP

SICKLE CELL ANEMIA AGENTS

DROXIA	T3	
ENDARI	T4	PA

TOPICAL HEMOSTATICS

ASTRINGYN	T4	
AVITENE	T4	
ENDO-AVITENE	T4	
EVICEL	T4	
GEL-FLOW	T4	
GEL-FLOW NT	T4	
GELFOAM	T4	
GELFOAM (<i>gelatin sponge, absorb/porcine</i>)	T4	
GELFOAM COMPRESSED	T4	
GELFOAM JMI	T4	
MONSEL'S	T3	
RECOTHROM	T4	
SURGICEL	T4	
SURGIFOAM SPONGE SIZE 100	T4	
SURGIFOAM SPONGE SIZE 100C	T4	
<i>surgifoam sponge size 12-7 (Gelfoam)</i>	T2	
SYRINGE AVITENE	T4	
TACHOSIL	T4	
THROMBI-GEL (<i>thrombin/cal/cmc/gel/dress,hem</i>)	T4	
THROMBIN-JMI	T4	
THROMBI-PAD	T4	
ULTRAFOAM	T4	

BLOOD (Blood Thinners/Anti-Clotting)

HEMORRHEOLOGIC AGENTS

<i>pentoxifylline</i>	T2	HD
-----------------------	----	----

T1 – Preferred Generics
T2 – Non-Preferred Generics
T3 – Preferred Brands
T4 – Non-Preferred Brands

T5 – Brand Specialty
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
ANTIANGINAL, ANTI-ISCHEMIC AGENTS, NON-HEMODYNAMIC		
<i>ranolazine</i> (Ranexa)	T2	HD
ANTIARRHYTHMICS		
<i>amiodarone hcl</i>	T2	HD
<i>disopyramide phosphate</i> (Norpace)	T2	HD
<i>dofetilide</i> (Tikosyn)	T2	HD
<i>flecainide acetate</i>	T2	HD
<i>mexiletine hcl</i>	T2	HD
MULTAQ	T4	HD
<i>propafenone hcl</i>	T2	HD
<i>propafenone hcl</i> (Rythmol Sr)	T2	HD
<i>quinidine gluconate</i>	T2	HD
<i>quinidine sulfate</i>	T2	HD
RYTHMOL SR (<i>propafenone hcl</i>)	T4	HD
CALCIUM CHANNEL BLOCKER AND NSAID, COX-2 INHIBITOR		
CONSENSI	T4	
CALCIUM CHANNEL BLOCKING AGENTS		
<i>amlodipine besylate</i> (Norvasc)	T1	HD
CALAN SR (<i>verapamil hcl</i>)	T4	ST HD
CARDIZEM (<i>diltiazem hcl</i>)	T4	HD
CARDIZEM CD (<i>diltiazem hcl</i>)	T4	HD
CARDIZEM LA	T4	HD
CARDIZEM LA (<i>diltiazem hcl</i>)	T4	HD
<i>diltiazem hcl</i>	T2	HD
<i>diltiazem hcl</i>	T1	HD
<i>diltiazem hcl</i> (Cardizem Cd)	T1	HD
<i>diltiazem hcl</i> (Cardizem La)	T2	HD
<i>diltiazem hcl</i> (Cardizem)	T1	HD
<i>diltiazem hcl</i> (Tiazac)	T1	HD
<i>felodipine</i>	T2	HD
<i>isradipine</i>	T2	HD
<i>nicardipine hcl</i>	T2	HD
<i>nifedipine</i>	T2	HD
<i>nifedipine</i> (Procardia XI)	T2	HD
<i>nifedipine</i> (Procardia)	T2	HD

T1 – Preferred Generics
 T2 – Non-Preferred Generics
 T3 – Preferred Brands
 T4 – Non-Preferred Brands

T5 – Brand Specialty
 PA – Prior Authorization
 QL – Quantity Limit

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

HD – May require home delivery pharmacy
 PPACA – No Cost-Share Preventive Medication
 CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

CARDIAC DRUGS (Blood Pressure/Heart Medications) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
CALCIUM CHANNEL BLOCKING AGENTS (cont.)		
<i>nimodipine</i>	T2	HD
<i>nisoldipine</i>	T2	HD
<i>nisoldipine (Sular)</i>	T2	HD
NYMALIZE	T4	HD
PROCARDIA (<i>nifedipine</i>)	T4	ST HD
PROCARDIA XL (<i>nifedipine</i>)	T4	ST HD
SULAR (<i>nisoldipine</i>)	T4	ST HD
TIAZAC (<i>diltiazem hcl</i>)	T4	HD
<i>verapamil hcl</i>	T1	HD
<i>verapamil hcl (Calan Sr)</i>	T1	HD
<i>verapamil hcl (Verelan Pm)</i>	T2	HD
<i>verapamil hcl (Verelan)</i>	T2	HD
VERELAN (<i>verapamil hcl</i>)	T4	ST HD
VERELAN PM (<i>verapamil hcl</i>)	T4	ST HD
CARDIAC MYOSIN INHIBITOR		
CAMZYOS	T5	PA QL(30 caps/fill) SP HD
DIGITALIS GLYCOSIDES		
<i>digoxin</i>	T2	HD
<i>digoxin (Lanoxin)</i>	T2	HD
LANOXIN	T4	HD
LANOXIN (<i>digoxin</i>)	T4	HD
SOLUBLE GUANYLATE CYCLASE (SGC) STIMULATOR		
VERQUVO	T3	QL(30 tabs/fill)
VASODILATORS, CORONARY		
GONITRO	T4	HD
ISORDIL (<i>isosorbide dinitrate</i>)	T4	HD
ISORDIL TITRADOSE (<i>isosorbide dinitrate</i>)	T4	HD
<i>isosorbide dinitrate</i>	T2	HD
<i>isosorbide dinitrate (Isordil Titradose)</i>	T2	HD
<i>isosorbide dinitrate (Isordil)</i>	T2	HD
<i>isosorbide mononitrate</i>	T1	HD
MINITRAN	T4	HD
NITRO-DUR	T4	HD
<i>nitroglycerin</i>	T2	HD

T1 – Preferred Generics
 T2 – Non-Preferred Generics
 T3 – Preferred Brands
 T4 – Non-Preferred Brands

T5 – Brand Specialty
 PA – Prior Authorization
 QL – Quantity Limit

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

HD – May require home delivery pharmacy
 PPACA – No Cost-Share Preventive Medication
 CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

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

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
VASODILATORS, CORONARY (cont.)		
<i>nitroglycerin 0.3 mg tablet sl</i> (Nitrostat)	T2	HD
<i>nitroglycerin 0.4 mg tablet sl</i> (Nitrostat)	T2	HD
<i>nitroglycerin 0.6 mg tablet sl</i> (Nitrostat)	T2	HD
<i>nitroglycerin 400 mcg spray</i> (Nitrolingual)	T2	HD
NITROLINGUAL (<i>nitroglycerin</i>)	T4	HD
NITROMIST (<i>nitroglycerin</i>)	T4	HD
NITROSTAT (<i>nitroglycerin</i>)	T4	HD

CARDIOVASCULAR (Asthma/COPD/Respiratory)

PULM ANTI-HTN, SOLUBLE GUANYLATE CYCLASE STIMULATOR

ADEMPAS	T5	PA QL(90 tabs/fill) SP HD
PULM.ANTI-HTN, SEL.C-GMP PHOSPHODIESTERASE T5 INHIB		
REVATIO 10 MG/ML ORAL SUSP (<i>sildenafil citrate</i>)	T5	PA QL(112 mls/fill) SP HD
REVATIO 20 MG TABLET (<i>sildenafil citrate</i>)	T5	PA QL(90 tabs/fill) SP HD
<i>sildenafil 20 mg tablet</i> (Revatio)	T2	PA QL(90 tabs/fill) SP HD
<i>tadalafil</i> (Adcirca)	T2	
<i>tadalafil 20 mg tablet</i> (Adcirca)	T2	PA QL(60 tabs/fill) SP HD

PULMONARY ANTI-HTN, ENDOTHELIN RECEPTOR ANTAGONIST

<i>ambrisentan</i> (Letairis)	T2	PA QL(30 tabs/fill) SP HD
<i>bosentan</i> (Tracleer)	T2	PA QL(60 tabs/fill) SP HD
OPSUMIT	T5	PA QL(30 tabs/fill) SP HD
TRACLEER 32 MG TABLET FOR SUSP	T5	PA QL(120 tabs/fill) SP HD
TRACLEER 62.5 MG TABLET (<i>bosentan</i>)	T5	PA QL(60 tabs/fill) SP HD
TRACLEER 125 MG TABLET (<i>bosentan</i>)	T5	PA QL(60 tabs/fill) SP HD

PULMONARY ANTIHYPERTENSIVES, PROSTACYCLIN-TYPE

ORENITRAM TITRATION KT MONTH 1	T5	PA QL (168 tabs/28 days) SP
ORENITRAM TITRATION KT MONTH 2	T5	PA QL (336 tabs/28 days) SP
ORENITRAM TITRATION KT MONTH 3	T5	PA QL (252 tabs/28 days) SP
ORENITRAM ER	T5	PA QL(90 tabs/fill) SP HD
TYVASO	T5	PA SP HD
TYVASO DPI	T5	PA SP HD
TYVASO INSTITUTIONAL START KIT	T5	PA SP HD
TYVASO REFILL KIT	T5	PA SP HD
TYVASO STARTER KIT	T5	PA SP HD
UPTRAVI 200 MCG TABLET	T5	PA QL(60 tabs/fill) SP HD

T1 – Preferred Generics
 T2 – Non-Preferred Generics
 T3 – Preferred Brands
 T4 – Non-Preferred Brands

T5 – Brand Specialty
 PA – Prior Authorization
 QL – Quantity Limit

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

HD – May require home delivery pharmacy
 PPACA – No Cost-Share Preventive Medication
 CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

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

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
PULMONARY ANTIHYPERTENSIVES, PROSTACYCLIN-TYPE (cont.)		
UPTRAVI 200-800 TITRATION PACK	T5	PA QL(1 DOSE PK/FILL) SP HD
UPTRAVI 400 MCG TABLET	T5	PA QL(60 tabs/fill) SP HD
UPTRAVI 600 MCG TABLET	T5	PA QL(60 tabs/fill) SP HD
UPTRAVI 800 MCG TABLET	T5	PA QL(60 tabs/fill) SP HD
UPTRAVI 1,000 MCG TABLET	T5	PA QL(60 tabs/fill) SP HD
UPTRAVI 1,200 MCG TABLET	T5	PA QL(60 tabs/fill) SP HD
UPTRAVI 1,400 MCG TABLET	T5	PA QL(60 tabs/fill) SP HD
UPTRAVI 1,600 MCG TABLET	T5	PA QL(60 tabs/fill) SP HD
VENTAVIS	T5	PA SP HD

CARDIOVASCULAR (Blood Pressure/Heart Medications)

ACE INHIBITOR-CALCIUM CHANNEL BLOCKER COMBINATION

<i>amlodipine besylate/benazepril</i>	T1	HD
<i>amlodipine besylate/benazepril (Lotrel)</i>	T1	HD
PRESTALIA	T4	ST HD
<i>trandolapril/verapamil hcl</i>	T2	HD

ACE INHIBITOR-THIAZIDE OR THIAZIDE-LIKE DIURETIC

<i>ACCURETIC (quinapril/hydrochlorothiazide)</i>	T4	HD
<i>benazepril/hydrochlorothiazide</i>	T2	HD
<i>benazepril/hydrochlorothiazide (Lotensin Hct)</i>	T2	HD
<i>captopril/hydrochlorothiazide</i>	T2	HD
<i>enalapril/hydrochlorothiazide</i>	T1	HD
<i>enalapril/hydrochlorothiazide (Vaseretic)</i>	T1	HD
<i>fosinopril/hydrochlorothiazide</i>	T2	HD
<i>lisinopril/hydrochlorothiazide (Zestoretic)</i>	T1	HD
<i>LOTENSIN HCT (benazepril/hydrochlorothiazide)</i>	T4	HD
<i>quinapril/hydrochlorothiazide (Accuretic)</i>	T1	HD
<i>VASERETIC (enalapril/hydrochlorothiazide)</i>	T4	HD
<i>ZESTORETIC (lisinopril/hydrochlorothiazide)</i>	T4	HD

ALPHA/BETA-ADRENERGIC BLOCKING AGENTS

<i>carvedilol (Coreg)</i>	T1	HD
<i>carvedilol phosphate (Coreg Cr)</i>	T2	HD
<i>COREG CR (carvedilol phosphate)</i>	T4	ST HD
<i>labetalol hcl</i>	T2	HD

T1 – Preferred Generics
 T2 – Non-Preferred Generics
 T3 – Preferred Brands
 T4 – Non-Preferred Brands

T5 – Brand Specialty
 PA – Prior Authorization
 QL – Quantity Limit

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

HD – May require home delivery pharmacy
 PPACA – No Cost-Share Preventive Medication
 CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

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

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ALPHA-ADRENERGIC BLOCKING AGENTS		
CARDURA 1 MG TABLET (<i>doxazosin mesylate</i>)	T4	ST QL (30 tabs/fill) HD
CARDURA 2 MG TABLET (<i>doxazosin mesylate</i>)	T4	ST QL (30 tabs/fill) HD
CARDURA 4 MG TABLET (<i>doxazosin mesylate</i>)	T4	ST QL (30 tabs/fill) HD
CARDURA 8 MG TABLET (<i>doxazosin mesylate</i>)	T4	ST QL (60 tabs/fill) HD
CARDURA XL	T4	ST QL (30 tabs/fill) HD
<i>doxazosin mesylate 1 mg tab</i> (Cardura)	T1	QL (30 tabs/fill) HD
<i>doxazosin mesylate 2 mg tab</i> (Cardura)	T1	QL (30 tabs/fill) HD
<i>doxazosin mesylate 4 mg tab</i> (Cardura)	T1	QL (30 tabs/fill) HD
<i>doxazosin mesylate 8 mg tab</i> (Cardura)	T1	QL (60 tabs/fill) HD
MINIPRESS (<i>prazosin hcl</i>)	T4	HD
<i>prazosin hcl</i> (Minipress)	T2	HD
ALPHA-ADRENERGIC BLOCKING AGENTS		
<i>terazosin 1 mg capsule</i>	T1	QL (30 caps/fill) HD
<i>terazosin 10 mg capsule</i>	T1	QL (60 caps/fill) HD
<i>terazosin 2 mg capsule</i>	T1	QL (30 caps/fill) HD
<i>terazosin 5 mg capsule</i>	T1	QL (30 caps/fill) HD
ANGIOTEN.RECEPTR ANTAG-CALCIUM CHANL BLKR-THIAZIDE		
<i>amlodipine/valsartan/hcthiazid</i> (Exforge Hct)	T2	HD
<i>olmesartan/amlodipin/hcthiazid</i> (Tribenzor)	T2	HD
ANGIOTENSIN RECEPT-NEPRILYSIN INHIBITOR COMB (ARNI)		
ENTRESTO	T3	QL (60 tabs/fill) HD
ANGIOTENSIN RECEPTOR ANTAG.-THIAZIDE DIURETIC COMB		
<i>candesartan/hydrochlorothiazid</i> (Atacand Hct)	T2	HD
<i>irbesartan/hydrochlorothiazide</i> (Avalide)	T1	HD
<i>losartan/hydrochlorothiazide</i> (Hyzaar)	T1	HD
<i>olmesartan/hydrochlorothiazide</i> (Benicar Hct)	T1	HD
<i>telmisartan/hydrochlorothiazid</i> (Micardis Hct)	T2	HD
<i>valsartan/hydrochlorothiazide</i> (Diovan Hct)	T2	HD
ANGIOTENSIN RECEPTOR BLOCKR-CALCIUM CHANNEL BLOCKR		
<i>amlodipine bes/olmesartan med</i> (Azor)	T2	HD
<i>amlodipine besylate/valsartan</i> (Exforge)	T2	HD
<i>telmisartan/amlodipine</i>	T2	HD
ANTIHYPERTENSIVES, ACE INHIBITORS		
ACCUPRIL (<i>quinapril hcl</i>)	T4	HD

T1 – Preferred Generics
T2 – Non-Preferred Generics
T3 – Preferred Brands
T4 – Non-Preferred Brands

T5 – Brand Specialty
PA – Prior Authorization
QL – Quantity Limit

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

HD – May require home delivery pharmacy
PPACA – No Cost-Share Preventive Medication
CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

CARDIOVASCULAR (Blood Pressure/Heart Medications) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ANTIHYPERTENSIVES, ACE INHIBITORS (cont.)		
ALTACE (<i>ramipril</i>)	T4	HD
<i>benazepril hcl</i>	T1	HD
<i>benazepril hcl</i> (Lotensin)	T1	HD
<i>captopril</i>	T2	HD
<i>enalapril maleate</i> (Epaned)	T2	HD
<i>enalapril maleate</i> (Vasotec)	T1	HD
<i>fosinopril sodium</i>	T1	HD
<i>lisinopril</i> (Zestril)	T1	HD
LOTENSIN (<i>benazepril hcl</i>)	T4	HD
<i>moexipril hcl</i>	T2	HD
<i>perindopril erbumine</i>	T1	HD
<i>quinapril hcl</i> (Accupril)	T1	HD
<i>ramipril</i> (Altace)	T1	HD
<i>trandolapril</i>	T1	HD
VASOTEC (<i>enalapril maleate</i>)	T4	HD
ZESTRIL (<i>lisinopril</i>)	T4	HD
ANTIHYPERTENSIVES, ANGIOTENSIN RECEPTOR ANTAGONIST		
<i>candesartan cilexetil</i> (Atacand)	T2	HD
<i>eprosartan mesylate</i>	T2	HD
<i>irbesartan</i> (Avapro)	T1	HD
<i>losartan potassium</i> (Cozaar)	T1	HD
<i>olmesartan medoxomil</i> (Benicar)	T1	HD
<i>telmisartan</i> (Micardis)	T2	HD
<i>valsartan 160 mg tablet</i> (Diovan)	T1	HD
<i>valsartan 320 mg tablet</i> (Diovan)	T1	HD
<i>valsartan 40 mg tablet</i> (Diovan)	T1	HD
<i>valsartan 80 mg tablet</i> (Diovan)	T1	HD
ANTIHYPERTENSIVES, GANGLIONIC BLOCKERS		
VECAMYL	T4	PA
ANTIHYPERTENSIVES, MISCELLANEOUS		
DEMSEER (<i>metirosine</i>)	T4	PA HD
<i>metirosine</i> (Demser)	T2	PA HD
ANTIHYPERTENSIVES, SYMPATHOLYTIC		
CATAPRES (<i>clonidine hcl</i>)	T4	HD

T1 – Preferred Generics
T2 – Non-Preferred Generics
T3 – Preferred Brands
T4 – Non-Preferred Brands

T5 – Brand Specialty
PA – Prior Authorization
QL – Quantity Limit

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

HD – May require home delivery pharmacy
PPACA – No Cost-Share Preventive Medication
CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

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

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ANTIHYPERTENSIVES, SYMPATHOLYTIC (cont.)		
CATAPRES-TTS 1 (<i>clonidine</i>)	T4	QL(4 patches/28 days) HD
CATAPRES-TTS 2 (<i>clonidine</i>)	T4	QL(4 patches/28 days) HD
CATAPRES-TTS 3 (<i>clonidine</i>)	T4	QL(4 patches/28 days) HD
<i>clonidine</i> (Catapres-Tts 1)	T2	QL(4 patches/28 days) HD
<i>clonidine</i> (Catapres-Tts 2)	T2	QL(4 patches/28 days) HD
<i>clonidine</i> (Catapres-Tts 3)	T2	QL(4 patches/28 days) HD
<i>clonidine hcl</i> (Catapres)	T1	HD
<i>guanfacine hcl</i>	T2	HD
<i>methylodopa</i>	T2	HD
<i>methylodopa/hydrochlorothiazide</i>	T2	HD
ANTIHYPERTENSIVES, VASODILATORS		
<i>hydralazine hcl</i>	T2	HD
<i>minoxidil</i>	T2	HD
BETA-ADRENERGIC BLOCKING AGENTS		
<i>acebutolol hcl</i>	T2	HD
<i>atenolol</i> (Tenormin)	T1	HD
BETAPACE (<i>sotalol hcl</i>)	T4	ST HD
BETAPACE AF (<i>sotalol hcl</i>)	T4	ST HD
<i>betaxolol hcl</i>	T2	HD
<i>bisoprolol fumarate</i>	T2	HD
CORGARD (<i>nadolol</i>)	T4	ST HD
LOPRESSOR (<i>metoprolol tartrate</i>)	T4	ST HD
<i>metoprolol succinate</i> (Toprol XL)	T1	HD
<i>metoprolol tartrate</i>	T1	HD
<i>metoprolol tartrate</i> (Lopressor)	T1	HD
<i>nadolol</i> (Corgard)	T2	HD
<i>nebivolol hcl</i> (Bystolic)	T2	HD
<i>pindolol</i>	T2	HD
<i>propranolol hcl</i>	T1	HD
<i>propranolol hcl</i> (Inderal La)	T1	HD
<i>sotalol hcl</i> (Betapace Af)	T2	HD
<i>sotalol hcl</i> (Betapace)	T2	HD
SOTYLIZE	T3	HD
TENORMIN (<i>atenolol</i>)	T4	ST HD

T1 – Preferred Generics
T2 – Non-Preferred Generics
T3 – Preferred Brands
T4 – Non-Preferred Brands

T5 – Brand Specialty
PA – Prior Authorization
QL – Quantity Limit

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

HD – May require home delivery pharmacy
PPACA – No Cost-Share Preventive Medication
CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

CARDIOVASCULAR (Blood Pressure/Heart Medications) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
BETA-BLOCKERS AND THIAZIDE, THIAZIDE-LIKE DIURETICS		
<i>timolol maleate</i>	T2	HD
atenolol/chlorthalidone (Tenoretic 100)	T2	HD
atenolol/chlorthalidone (Tenoretic 50)	T2	HD
<i>bisoprolol/hydrochlorothiazide</i> (Ziac)	T1	HD
METOPROLOL SUCCINATE ER-HCTZ	T4	ST HD
<i>metoprolol/hydrochlorothiazide</i>	T2	HD
<i>propranolol/hydrochlorothiazid</i>	T2	HD
TENORETIC 100 (<i>atenolol/chlorthalidone</i>)	T4	ST HD
TENORETIC 50 (<i>atenolol/chlorthalidone</i>)	T4	ST HD
ZIAC (<i>bisoprolol/hydrochlorothiazide</i>)	T4	ST HD
RENIN INHIBITOR, DIRECT		
<i>aliskiren hemifumarate</i> (Tekturna)	T2	HD
RENIN INHIBITOR, DIRECT AND THIAZIDE DIURETIC COMB		
TEKTRUNA HCT	T3	HD
VASODILATORS, COMBINATION		
<i>isosorbide dinit/hydralazine</i> (Bidil)	T2	
VASODILATORS, PERIPHERAL		
<i>ergoloid mesylates</i>	T2	
<i>isoxsuprine hcl</i>	T2	
CARDIOVASCULAR (Cholesterol Medications)		
ANTHYPERLIP.HMG COA REDUCT INHIB-CHOLEST.AB.INHIB		
<i>ezetimibe-atorvastatin tabs</i>	T2	ST QL (30 tabs/30 days) HD
<i>ezetimibe/simvastatin</i> (Vytorin)	T2	QL(30 tabs/fill) HD
ROSZET	T4	ST QL(30 tabs/fill) HD
ANTHYPERLIPID- HMG-COA RI-CALCIUM CHANNEL BLOCKER		
<i>amlodipine/atorvastatin</i>	T2	QL(30 tabs/fill) HD
<i>amlodipine/atorvastatin</i> (Caduet)	T2	QL(30 tabs/fill) HD
CADUET (<i>amlodipine/atorvastatin</i>)	T4	ST QL(30 tabs/fill) HD
ANTHYPERLIPIDEMIC - ATP CITRATE LYASE INHIBITOR		
NEXLETOL	T3	PA
ANTHYPERLIPIDEMIC - MTP INHIBITOR		
JUXTAPID	T5	PA SP HD
ANTHYPERLIPIDEMIC - PCSK9 INHIBITORS		
REPATHA PUSHTRONEX	T3	PA

T1 – Preferred Generics
T2 – Non-Preferred Generics
T3 – Preferred Brands
T4 – Non-Preferred Brands

T5 – Brand Specialty
PA – Prior Authorization
QL – Quantity Limit

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

HD – May require home delivery pharmacy
PPACA – No Cost-Share Preventive Medication
CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

CARDIOVASCULAR (Cholesterol Medications) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ANTIHYPERTENSIVE - PCSK9 INHIBITORS (cont.)		
REPATHA SURECLICK	T3	PA
REPATHA SYRINGE	T3	PA
ANTIHYPERTENSIVE-ACLY AND CHOLESTEROL ABSORPTION INHIBITORS		
NEXLIZET	T3	PA
ANTIHYPERTENSIVE-HMGCOA REDUCTASE INHIBITORS (STATINS)		
<i>atorvastatin 10 mg tablet (Lipitor)</i>	T1	
<i>atorvastatin 20 mg tablet (Lipitor)</i>	T1	
<i>atorvastatin 40 mg tablet (Lipitor)</i>	T1	
<i>atorvastatin 80 mg tablet (Lipitor)</i>	T1	
FLOLIPIID	T4	ST QL (150 mls/fill) HD
<i>fluvastatin sodium (Lescol XL)</i>	T2	QL (30 tabs/fill) HD PPACA
<i>fluvastatin sodium 20 mg cap</i>	T2	QL (30 caps/fill) HD PPACA
<i>fluvastatin sodium 40 mg cap</i>	T2	QL (60 caps/fill) HD PPACA
LESCOL XL (<i>fluvastatin sodium</i>)	T4	ST QL (30 tabs/fill) HD
LIVALO (<i>pitavastatin calcium</i>)	T4	ST QL (30 tabs/30 days) HD
<i>lovastatin 10 mg tablet</i>	T2	QL (30 tabs/fill) HD PPACA
<i>lovastatin 20 mg tablet</i>	T2	QL (60 tabs/fill) HD PPACA
<i>lovastatin 40 mg tablet</i>	T2	QL (60 tabs/fill) HD PPACA
<i>pitavastatin calcium (Livalo)</i>	T2	QL (30 tabs/30 days) HD PPACA
<i>pravastatin sodium</i>	T2	QL (30 tabs/fill) HD PPACA
<i>simvastatin 5 mg tablet</i>	T1	QL (30 tabs/fill) HD PPACA
<i>simvastatin 10 mg tablet (Zocor)</i>	T1	QL (30 tabs/fill) HD PPACA
<i>simvastatin 20 mg tablet (Zocor)</i>	T1	QL (30 tabs/fill) HD PPACA
SIMVASTATIN 20 MG/5 ML SUSP	T4	ST QL (150 mls/fill) HD
<i>simvastatin 40 mg tablet (Zocor)</i>	T1	QL (30 tabs/fill) HD PPACA
<i>simvastatin 80 mg tablet (Zocor)</i>	T1	QL (30 tabs/fill) HD
ZYPITAMAG	T4	ST QL (30 tabs/fill) HD
BILE SALT SEQUESTRANTS		
<i>cholestyramine (with sugar) (Questran)</i>	T2	HD
<i>cholestyramine/aspartame</i>	T2	HD
<i>cholestyramine/aspartame (Questran Light)</i>	T2	HD
<i>colesevelam hcl (Welchol)</i>	T2	HD
COLESTID	T4	ST HD
COLESTID (<i>colestipol hcl</i>)	T4	ST HD

T1 – Preferred Generics
 T2 – Non-Preferred Generics
 T3 – Preferred Brands
 T4 – Non-Preferred Brands

T5 – Brand Specialty
 PA – Prior Authorization
 QL – Quantity Limit

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

HD – May require home delivery pharmacy
 PPACA – No Cost-Share Preventive Medication
 CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

CARDIOVASCULAR (Cholesterol Medications) (cont.)

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

BILE SALT SEQUESTRANTS (cont.)

<i>colestipol hcl</i> (Colestid)	T2	HD
QUESTRAN (<i>cholestyramine (with sugar)</i>)	T4	ST HD
QUESTRAN LIGHT (<i>cholestyramine/aspartame</i>)	T4	ST HD

LIPOTROPICS

<i>ezetimibe</i> (Zetia)	T2	HD
<i>fenofibrate 40 mg tablet</i> (Fenoglide)	T2	ST HD
<i>fenofibrate 43mg, 67mg, 130mg, 134mg, 200mg capsule</i>	T2	HD
<i>fenofibrate 48 mg tablet</i> (Tricor)	T2	HD
<i>fenofibrate 54mg, 160mg tablet</i>	T2	HD
<i>fenofibrate 120 mg tablet</i> (Fenoglide)	T2	ST HD
<i>fenofibrate 145 mg tablet</i> (Tricor)	T2	HD
<i>fenofibric acid (choline)</i> (Trilipix)	T2	HD
<i>fenofibric acid</i> (Fibricor)	T2	HD
FENOGLIDE (<i>fenofibrate</i>)	T4	ST HD
FIBRICOR (<i>fenofibric acid</i>)	T4	ST HD
<i>gemfibrozil</i> (Lopid)	T1	HD
LOPID (<i>gemfibrozil</i>)	T4	HD
<i>niacin</i>	T2	HD
<i>niacin 500 mg tablet</i>	T2	HD
NIACOR	T4	HD
TRILIPIX (<i>fenofibric acid (choline)</i>)	T4	ST HD

CNS DRUGS (Alzheimer's Disease)

ALZHEIMER'S THERAPY, NMDA RECEPTOR ANTAGONISTS

MEMANTINE 5-10 MG TITRATION PK	T4	HD
<i>memantine hcl</i> (Namenda Xt)	T2	HD
<i>memantine hcl 2 mg/ml solution</i>	T2	HD
<i>memantine hcl 5 mg tablet</i> (Namenda)	T2	HD
<i>memantine hcl 10 mg tablet</i> (Namenda)	T2	HD
NAMENDA 5 MG TABLET (<i>memantine hcl</i>)	T4	ST HD
NAMENDA 10 MG TABLET (<i>memantine hcl</i>)	T4	ST HD
NAMENDA 5-10 MG TITRATION PK	T4	HD
NAMENDA XR TITRATION PACK	T4	HD
NAMZARIC	T3	ST HD

T1 – Preferred Generics
 T2 – Non-Preferred Generics
 T3 – Preferred Brands
 T4 – Non-Preferred Brands

T5 – Brand Specialty
 PA – Prior Authorization
 QL – Quantity Limit

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

HD – May require home delivery pharmacy
 PPACA – No Cost-Share Preventive Medication
 CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

CNS DRUGS (Miscellaneous)

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

AMYOTROPHIC LATERAL SCLEROSIS AGENTS

EXSERVAN	T5	PA SP
RADICAVA ORS	T5	PA SP HD
RILUTEK (<i>riluzole</i>)	T5	PA SP HD
<i>riluzole</i> (Rilutek)	T2	PA SP HD
TEGLUTIK	T5	PA SP
TIGLUTIK	T5	PA SP

DRUGS TO TREAT MOVEMENT DISORDERS

AUSTEDO 6 MG TABLET	T5	PA QL(60 tabs/fill) SP HD
AUSTEDO 9MG, 12MG TABLET	T5	PA QL(120 tabs/fill) SP HD
AUSTEDO XR 12 MG TABLET	T5	PA QL (90 tabs/30 days) SP HD
AUSTEDO XR 24 MG TABLET	T5	PA QL (60 tabs/30 days) SP HD
AUSTEDO XR 6 MG TABLET	T5	PA QL (210 tabs/30 days) SP HD
AUSTEDO XR TITRATION KT(WK1-4)	T5	PA QL(42 tabs/30 days) SP HD
HORIZANT	T4	ST
INGREZZA	T5	PA QL(30 caps/fill) SP
INGREZZA INITIATION PACK	T5	PA QL(28 caps/fill) SP
<i>tetrabenazine 12.5 mg tablet</i> (Xenazine)	T2	PA QL(120 tabs/fill) SP HD
<i>tetrabenazine 25 mg tablet</i> (Xenazine)	T2	PA QL(60 tabs/fill) SP HD

PSEUDOBULBAR AFFECT (PBA) AGENTS, NMDA ANTAGONISTS

NUDEXTA	T3	PA
---------	----	----

XANTHINES

<i>caffeine citrate</i>	T2	HD
-------------------------	----	----

CNS DRUGS (Multiple Sclerosis)

AGENTS TO TREAT MULTIPLE SCLEROSIS

AVONEX	T5	PA QL(1 kit/28 days) SP HD
AVONEX PEN	T5	PA QL(4 pens/28 days) SP HD
BAFIERTAM	T5	PA QL(120 caps/fill) SP HD
BETASERON	T5	PA QL(14 kits/30 days) SP HD
COPAXONE 20 MG/ML SYRINGE (<i>glatiramer acetate</i>)	T5	PA QL(30 syringes/30 days) SP HD
COPAXONE 40 MG/ML SYRINGE (<i>glatiramer acetate</i>)	T5	PA QL(12 syringes/30 days) SP HD
<i>dimethyl fumarate</i> (Tecfidera)	T2	PA QL(60 caps/fill) SP HD
<i>fingolimod hcl</i> (Gilenya)	T2	
<i>glatiramer 20 mg/ml syringe</i> (Copaxone)	T2	PA QL(30 syringes/30 days) SP HD
<i>glatiramer 40 mg/ml syringe</i> (Copaxone)	T2	PA QL(12 syringes/30 days) SP HD

T1 – Preferred Generics
T2 – Non-Preferred Generics
T3 – Preferred Brands
T4 – Non-Preferred Brands

T5 – Brand Specialty
PA – Prior Authorization
QL – Quantity Limit

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

HD – May require home delivery pharmacy
PPACA – No Cost-Share Preventive Medication
CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

CNS DRUGS (Multiple Sclerosis) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
AGENTS TO TREAT MULTIPLE SCLEROSIS (cont.)		
<i>glatopa 20 mg/ml syringe (Copaxone)</i>	T2	PA QL(30 syringes/30 days) SP HD
<i>glatopa 40 mg/ml syringe (Copaxone)</i>	T2	PA QL(12 syringes/30 days) SP HD
KESIMPTA PEN	T5	PA QL(1 pen/28 days) SP HD
MAVENCLAD 10 MG X 10 TABLET PK	T5	PA QL(10 tabs/fill) SP HD
MAVENCLAD 10 MG X 4 TABLET PK	T5	PA QL(4 tabs/fill) SP HD
MAVENCLAD 10 MG X 5 TABLET PK	T5	PA QL(5 tabs/fill) SP HD
MAVENCLAD 10 MG X 6 TABLET PK	T5	PA QL(6 tabs/fill) SP HD
MAVENCLAD 10 MG X 7 TABLET PK	T5	PA QL(7 tabs/fill) SP HD
MAVENCLAD 10 MG X 8 TABLET PK	T5	PA QL(8 tabs/fill) SP HD
MAVENCLAD 10 MG X 9 TABLET PK	T5	PA QL(9 tabs/fill) SP HD
MAYZENT 0.25 MG TABLET	T5	PA QL(30 tabs/fill) SP HD
MAYZENT 0.25MG START-1MG MAINT	T5	PA QL(7 tabs/fill) SP HD
MAYZENT 0.25MG START-2MG MAINT	T5	PA QL(12 tabs/fill) SP HD
MAYZENT 1 MG TABLET	T5	PA QL(30 tabs/fill) SP HD
MAYZENT 2 MG TABLET	T5	PA QL(30 tabs/fill) SP HD
PLEGRIDY 125 MCG/0.5 ML PEN	T5	PA QL(1 ml/28 days) SP HD
PLEGRIDY 125 MCG/0.5 ML SYRINGE	T5	PA QL(1 ml/28 days) SP HD
PLEGRIDY PEN INJ STARTER PACK	T5	PA QL(1 ml/365 days) SP HD
PLEGRIDY SYRINGE STARTER PACK	T5	PA QL(1 ml/365 days) SP HD
PONVORY 14-DAY STARTER PACK	T5	PA QL(14 tabs/365 days) SP HD
PONVORY 20 MG TABLET	T5	PA QL(30 tabs/30 days) SP HD
REBIF 22 MCG/0.5 ML SYRINGE	T5	PA QL(6 mls/28 days) SP HD
REBIF 44 MCG/0.5 ML SYRINGE	T5	PA QL(6 mls/28 days) SP HD
REBIF REBIDOSE 22 MCG/0.5 ML	T5	PA QL(6 mls/28 days) SP HD
REBIF REBIDOSE 44 MCG/0.5 ML	T5	PA QL(6 mls/28 days) SP HD
REBIF REBIDOSE TITRATION PACK	T5	PA QL(4.2 mls/28 days) SP HD
REBIF TITRATION PACK	T5	PA QL(4.2 mls/28 days) SP HD
VUMERITY	T5	PA QL(120 caps/fill) SP HD
AGTS TX NEUROMUSC TRANSMISSION DIS, POT-CHAN BLKR		
<i>dalfampridine (Ampyra)</i>	T2	PA QL(60 tabs/fill) SP HD
FIRDAPSE	T5	PA SP
RUZURGI	T3	PA
SPHINGOSINE I-PHOSPHATE (SIP) RECEPTOR MODULATOR		
ZEPOSIA 0.23-0.46 MG START PCK	T5	PA QL(7 caps/fill) SP HD

T1 – Preferred Generics
 T2 – Non-Preferred Generics
 T3 – Preferred Brands
 T4 – Non-Preferred Brands

T5 – Brand Specialty
 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
SPHINGOSINE I-PHOSPHATE (SIP) RECEPTOR MODULATOR (cont.)		
ZEPOSIA 0.23-0.46-0.92 MG KIT	T5	PA QL(1 kit/fill) SP HD
ZEPOSIA 0.92 MG CAPSULE	T5	PA QL(30 caps/fill) SP HD
ZEPOSIA STARTER KIT (28-DAY)	T5	
CNS DRUGS (Pain Relief And Inflammatory Disease)		
CALCITONIN GENE-RELATED PEPTIDE (CGRP) INHIBITORS		
EMGALITY 100 MG/ML SYR(1 OF 3)	T3	PA QL(3 mls/30 days)
EMGALITY 300 MG (100 MG X3SYR)	T3	PA QL(3 mls/30 days)
POSTHERPETIC NEURALGIA AGENTS		
<i>gabapentin</i> (Gralise)	T2	ST
GRALISE	T4	ST
GRALISE (<i>gabapentin</i>)	T4	ST
CNS DRUGS (Seizure Disorders)		
ANTICONSULSANT - BENZODIAZEPINE TYPE		
<i>clobazam</i> (Onfi)	T2	PA HD
<i>clonazepam</i>	T2	HD
<i>clonazepam</i> (Klonopin)	T1	HD
DIASTAT (<i>diazepam</i>)	T4	HD
DIASTAT ACUDIAL (<i>diazepam</i>)	T4	HD
<i>diazepam 10 mg rectal gel syst</i> (Diastat Acudial)	T2	HD
<i>diazepam 2.5 mg rectal gel sys</i> (Diastat)	T2	HD
<i>diazepam 20 mg rectal gel syst</i>	T2	HD
NAYZILAM	T3	PA QL(2 units/fill) HD
SYMPAZAN	T4	PA HD
VALTOCO	T4	PA QL(2 units/fill) HD
ANTICONSULSANT - CANNABINOID TYPE		
EPIDIOLEX	T5	PA SP HD
ANTICONSULSANTS		
APTIOM	T4	HD
BRIVIACT	T4	ST HD
<i>carbamazepine</i>	T2	HD
<i>carbamazepine</i>	T2	HD
<i>carbamazepine</i> (Carbatrol)	T2	HD
<i>carbamazepine</i> (Tegretol Xr)	T2	HD

T1 – Preferred Generics
 T2 – Non-Preferred Generics
 T3 – Preferred Brands
 T4 – Non-Preferred Brands

T5 – Brand Specialty
 PA – Prior Authorization
 QL – Quantity Limit

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

HD – May require home delivery pharmacy
 PPACA – No Cost-Share Preventive Medication
 CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

CNS DRUGS (Seizure Disorders) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ANTICONVULSANTS (cont.)		
<i>carbamazepine</i> (Tegretol)	T4	HD
CARBATROL (<i>carbamazepine</i>)	T3	HD
CELONTIN (<i>methsuximide</i>)	T4	HD
DEPAKOTE (<i>divalproex sodium</i>)	T4	ST HD
DEPAKOTE ER (<i>divalproex sodium</i>)	T4	ST HD
DEPAKOTE SPRINKLE (<i>divalproex sodium</i>)	T4	ST HD
DIACOMIT	T5	PA SP HD
DILANTIN 100 MG CAPSULE (<i>phenytoin sodium extended</i>)	T4	HD
DILANTIN 30 MG CAPSULE	T3	HD
DILANTIN 50 MG INFATAB (<i>phenytoin</i>)	T4	HD
DILANTIN-125 (<i>phenytoin</i>)	T4	HD
<i>divalproex sodium</i> (Depakote Er)	T2	HD
<i>divalproex sodium</i> (Depakote Sprinkle)	T2	HD
<i>divalproex sodium</i> (Depakote)	T2	HD
ELEPSIA XR	T4	ST HD
<i>ethosuximide</i> (Zarontin)	T2	HD
<i>felbamate</i> (Felbatol)	T2	HD
FELBATOL (<i>felbamate</i>)	T4	HD
FYCOMPA	T3	HD
<i>gabapentin</i>	T2	HD
<i>gabapentin</i> (Neurontin)	T1	HD
<i>gabapentin</i> (Neurontin)	T2	HD
GABITRIL (<i>tiagabine hcl</i>)	T4	HD
<i>lacosamide</i> (Vimpat)	T2	HD
LAMICTAL XR (BLUE)	T4	ST HD
LAMICTAL XR (GREEN)	T4	ST HD
LAMICTAL XR (ORANGE)	T4	ST HD
<i>lamotrigine</i> (Lamictal (Blue))	T2	HD
<i>lamotrigine</i> (Lamictal (Green))	T2	HD
<i>lamotrigine</i> (Lamictal (Orange))	T2	HD
<i>lamotrigine</i> (Lamictal Odt (Blue))	T2	HD
<i>lamotrigine</i> (Lamictal Odt (Green))	T2	HD
<i>lamotrigine</i> (Lamictal Odt (Orange))	T2	HD
<i>lamotrigine</i> (Lamictal Odt)	T2	HD

T1 – Preferred Generics
 T2 – Non-Preferred Generics
 T3 – Preferred Brands
 T4 – Non-Preferred Brands

T5 – Brand Specialty
 PA – Prior Authorization
 QL – Quantity Limit

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

HD – May require home delivery pharmacy
 PPACA – No Cost-Share Preventive Medication
 CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

CNS DRUGS (Seizure Disorders) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ANTICONVULSANTS (cont.)		
<i>lamotrigine</i> (Lamictal Xr)	T2	HD
<i>lamotrigine</i> (Lamictal)	T1	HD
<i>lamotrigine</i> (Lamictal)	T2	HD
<i>levetiracetam</i>	T2	HD
<i>levetiracetam</i> (Keppra Xr)	T2	HD
<i>levetiracetam</i> (Keppra)	T2	HD
MYSOLINE (<i>primidone</i>)	T4	HD
<i>oxcarbazepine</i> (Trileptal)	T2	HD
OXTELLAR XR	T4	ST HD
PHENYTEK (<i>phenytoin sodium extended</i>)	T4	HD
<i>phenytoin</i>	T2	HD
<i>phenytoin</i> (Dilantin)	T2	HD
<i>phenytoin</i> (Dilantin-125)	T2	HD
<i>phenytoin sodium extended</i> (Dilantin)	T2	HD
<i>phenytoin sodium extended</i> (Phenytek)	T2	HD
<i>pregabalin</i> (Lyrica)	T2	HD
QUDEXY XR (<i>topiramate</i>)	T4	ST HD
<i>rufinamide</i> (Banzel)	T2	PA HD
SPRITAM	T4	ST HD
TEGRETOL (<i>carbamazepine</i>)	T4	HD
TEGRETOL XR (<i>carbamazepine</i>)	T4	HD
<i>tiagabine hcl</i> (Gabitril)	T2	HD
<i>topiramate</i> (Qudexy Xr)	T2	ST HD
<i>topiramate</i> (Topamax)	T1	HD
<i>topiramate</i> (Topamax)	T2	HD
<i>topiramate er</i> (Trokendi XR)	T2	ST HD
TROKENDI XR	T4	ST HD
<i>valproic acid</i>	T2	HD
<i>valproic acid</i> (as sodium salt)	T2	HD
<i>vigabatrin</i> (Sabril)	T2	PA QL(150 packs/30 days) SP HD
<i>vigabatrin 500 mg tablet</i> (Sabril)	T2	
VIGADRONE	T2	PA SP HD QL (150 pkts/30 days)
XCOPRI 50 MG TABLET	T4	QL(30 tabs/fill) HD
XCOPRI 50-100 MG TITRATION PAK	T4	QL(28 tabs/fill) HD

T1 – Preferred Generics
 T2 – Non-Preferred Generics
 T3 – Preferred Brands
 T4 – Non-Preferred Brands

T5 – Brand Specialty
 PA – Prior Authorization
 QL – Quantity Limit

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

HD – May require home delivery pharmacy
 PPACA – No Cost-Share Preventive Medication
 CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

CNS DRUGS (Seizure Disorders) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ANTICONVULSANTS (cont.)		
XCOPRI 100 MG TABLET	T4	QL(30 tabs/fill) HD
XCOPRI 12.5-25 MG TITRATION PK	T4	QL(28 tabs/fill) HD
XCOPRI 150 MG TABLET	T4	QL(30 tabs/fill) HD
XCOPRI 150-200 MG TITRATION PK	T4	QL(28 tabs/fill) HD
XCOPRI 200 MG TABLET	T4	QL(30 tabs/fill) HD
XCOPRI 250 MG DAILY DOSE PACK	T4	QL(56 tabs/fill) HD
XCOPRI 350 MG DAILY DOSE PACK	T4	QL(56 tabs/fill) HD
ZARONTIN (<i>ethosuximide</i>)	T4	HD
<i>zonisamide</i>	T2	HD
<i>zonisamide (Zonegran)</i>	T2	HD

CNS DRUGS (Sleep Disorders/Sedatives)

NARCOLEPSY TX-H3-RECEPT.ANTAGONIST/INVERSE AGONIST

WAKIX 4.45 MG TABLET	T5	PA QL(30 tabs/fill) SP HD
WAKIX 17.8 MG TABLET	T5	PA QL(60 tabs/fill) SP HD

COLONY STIMULATING FACTORS (Blood Modifiers/Bleeding Disorders)

LEUKOCYTE (WBC) STIMULANTS

FULPHILA	T5	PA QL(1.2 mls/30 days) SP
ZIEXTENZO	T5	PA QL(1.2 mls/30 days) SP

THROMBOPOIETIN RECEPTOR AGONISTS

DOPTELET	T5	PA QL(15 tabs/fill) SP HD
PROMACTA	T5	PA SP HD

CONTRACEPTIVES (Contraception Products)

CONTRACEPTIVES, INTRAVAGINAL, SYSTEMIC

ANNOVERA	T4	ST QL(1 ring/365 days) PPACA
<i>etonogestrel/ethinyl estradiol (Nuvaring)</i>	T2	PPACA

CONTRACEPTIVES, INJECTABLE

DEPO-PROVERA (<i>medroxyprogesterone acetate</i>)	T4	QL(1 ml/90 days) PPACA
DEPO-SUBQ PROVERA 104	T4	QL(1 ml/90 days) PPACA
<i>medroxyprogesterone 150 mg/ml (Depo-Provera)</i>	T2	QL(1 ml/90 days) PPACA

CONTRACEPTIVES, ORAL

BEYAZ (<i>drospir/eth estra/levomefol ca</i>)	T4	ST HD PPACA
<i>desog-e.estradiol/e.estradiol (Mircette)</i>	T2	HD PPACA
<i>desogestrel-ethinyl estradiol</i>	T2	HD PPACA

T1 – Preferred Generics
T2 – Non-Preferred Generics
T3 – Preferred Brands
T4 – Non-Preferred Brands

T5 – Brand Specialty
PA – Prior Authorization
QL – Quantity Limit

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

HD – May require home delivery pharmacy
PPACA – No Cost-Share Preventive Medication
CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

CONTRACEPTIVES (Contraception Products) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
CONTRACEPTIVES, ORAL (cont.)		
<i>drospir/eth estra/levomefol ca</i> (Beyaz)	T2	HD PPACA
<i>drospir/eth estra/levomefol ca</i> (Safyral)	T2	HD PPACA
ELLA	T3	QL(1 tab/fill) HD PPACA
<i>ethinyl estradiol/drospirenone</i> (Yasmin 28)	T2	HD PPACA
<i>ethinyl estradiol/drospirenone</i> (Yaz)	T2	HD PPACA
<i>ethynodiol d-ethinyl estradiol</i>	T2	HD PPACA
<i>levonorgestrel/ethin.estradiol</i>	T2	HD PPACA
<i>l-norgest/e.estradiol-e.estrad</i> (Loseasonique)	T2	HD PPACA
<i>l-norgest/e.estradiol-e.estrad</i> (Quartette)	T2	HD PPACA
<i>l-norgest/e.estradiol-e.estrad</i> (Seasonique)	T2	HD PPACA
<i>noreth-ethinyl estradiol/iron</i>	T2	HD PPACA
<i>noreth-ethinyl estradiol/iron</i> (Generess Fe)	T2	HD PPACA
<i>norethind-eth estrad 1-0.02 mg</i> (Loestrin)	T2	HD PPACA
<i>norethindrone</i>	T2	HD PPACA
<i>norethindrone ac-eth estradiol</i> (Loestrin)	T2	HD PPACA
<i>norethindrone-e.estradiol-iron</i>	T2	HD PPACA
<i>norethindrone-e.estradiol-iron</i> (Loestrin Fe)	T2	HD PPACA
<i>norethindrone-e.estradiol-iron</i> (Minastrin 24 Fe)	T2	HD PPACA
<i>norethindrone-e.estradiol-iron</i> (Taytulla)	T2	HD PPACA
<i>norethindrone-ethin. estradiol</i>	T2	HD PPACA
<i>norethin-ee 1.5-0.03 mg(21) tb</i> (Loestrin)	T2	HD PPACA
<i>norgestimate-ethinyl estradiol</i>	T2	HD PPACA
NORGESTREL-ETHINYL ESTRADIOL	T2	HD PPACA
YAZ (<i>ethinyl estradiol/drospirenone</i>)	T4	ST HD PPACA
CONTRACEPTIVES, TRANSDERMAL		
<i>norelgestromin/ethin.estradiol</i>	T2	HD PPACA
INTRA-UTERINE DEVICES (IUDS)		
KYLEENA	T5	SP PPACA
LILETTA	T5	SP PPACA
MIRENA	T5	SP PPACA
SKYLA	T5	SP PPACA

T1 – Preferred Generics
 T2 – Non-Preferred Generics
 T3 – Preferred Brands
 T4 – Non-Preferred Brands

T5 – Brand Specialty
 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 (Allergy/Nasal Sprays)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
IST GEN ANTIHIST-DECONGEST-ANTICHOLINERGIC COMB		
RESPA A.R. (<i>pseudoephed/chlor-mal/bell alk</i>)	T4	
COUGH/COLD PREPARATIONS (Cough/Cold Medications)		
ANTITUSSIVES, NON-OPIOID		
<i>benzonatate</i>	T2	
DECONGESTANT-EXPECTORANT COMBINATIONS		
<i>guaifenesin/phenylephrine hcl</i>	T2	
NON-OPIOID ANTITUS-IST GEN.ANTIHISTAMINE-DECONGEST		
BROMFED DM (<i>brompheniramine/pseudoephed/dm</i>)	T4	
<i>brompheniramine/pseudoephed/dm</i> (Bromfed Dm)	T2	
NON-OPIOID ANTITUSSIVE-IST GEN ANTIHISTAMINE COMB.		
<i>promethazine/dextromethorphan</i>	T2	
OPIOID ANTITUSSIV-IST GEN. ANTIHISTAMINE-DECONGEST		
CAPCOF	T4	
HISTEX-AC	T4	
MAXI-TUSS CD	T4	
POLY-TUSSIN AC	T4	
<i>promethazine/phenyleph/codeine</i>	T2	
ZODRYL DAC 25	T4	
ZODRYL DAC 30	T4	
ZODRYL DAC 35	T4	
ZODRYL DAC 40	T4	
ZODRYL DAC 50	T4	
OPIOID ANTITUSSIV-IST GEN. ANTIHISTAMINE-DECONGEST		
ZODRYL DAC 60	T4	
ZODRYL DAC 80	T4	
OPIOID ANTITUSSIVE-IST GENERATION ANTIHISTAMINE		
<i>hydrocodone/chlorphen p-stirex</i>	T2	
<i>promethazine hcl/codeine</i>	T2	
TUSSICAPS	T4	PA
TUXARIN ER	T4	
TUZISTRA XR	T4	PA
ZODRYL AC 25	T4	
ZODRYL AC 30	T4	
ZODRYL AC 35	T4	

T1 – Preferred Generics
T2 – Non-Preferred Generics
T3 – Preferred Brands
T4 – Non-Preferred Brands

T5 – Brand Specialty
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
OPIOID ANTITUSSIVE-1ST GENERATION ANTIHISTAMINE (cont.)		
ZODRYL AC 40	T4	
ZODRYL AC 50	T4	
ZODRYL AC 60	T4	
ZODRYL AC 80	T4	
OPIOID ANTITUSSIVE-ANTICHOLINERGIC COMBINATIONS		
HYCODAN	T4	
HYCODAN (<i>hydrocodone bit/homatrop me-br</i>)	T4	
<i>hydrocodone bit/homatrop me-br</i>	T2	
<i>hydrocodone bit/homatrop me-br</i> (Hycodan)	T2	
OPIOID ANTITUSSIVE-DECONGESTANT-EXPECTORANT COMB		
CODITUSSIN DAC	T4	
<i>pseudoephed/codeine/guaifen</i>	T2	
ZODRYL DEC 25	T4	
ZODRYL DEC 30	T4	
ZODRYL DEC 35	T4	
ZODRYL DEC 40	T4	
ZODRYL DEC 50	T4	
ZODRYL DEC 60	T4	
ZODRYL DEC 80	T4	
OPIOID ANTITUSSIVE-EXPECTORANT COMBINATION		
<i>codeine phosphate/guaifenesin</i>	T2	
CODITUSSIN AC	T4	
GUAIFEN-CODEINE 100-10 MG/5 ML	T4	
<i>guaifen-codeine 100-10 mg/5 ml</i>	T2	
GUAIFEN-CODEINE 200-20 MG/10ML	T4	
MAR-COF CG	T4	
NINJACOF-XG	T4	
OBREDON	T4	PA
DIAGNOSTIC (Diabetes)		
BLOOD SUGAR DIAGNOSTICS		
FREESTYLE INSULINX	T3	
FREESTYLE INSULINX TEST STRIPS	T3	
FREESTYLE LITE TEST STRIP	T3	
FREESTYLE TEST STRIPS	T3	

T1 – Preferred Generics
T2 – Non-Preferred Generics
T3 – Preferred Brands
T4 – Non-Preferred Brands

T5 – Brand Specialty
PA – Prior Authorization
QL – Quantity Limit

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

HD – May require home delivery pharmacy
PPACA – No Cost-Share Preventive Medication
CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

DIAGNOSTIC (Diabetes) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
BLOOD SUGAR DIAGNOSTICS (cont.)		
ONETOUCH ULTRA TEST STRIP	T3	
ONETOUCH VERIO TEST STRIP	T3	
PRECISION XTRA	T3	
URINE GLUCOSE TEST AIDS		
DIASTIX REAGENT	T3	
DIAGNOSTIC (Miscellaneous)		
BLOOD TESTING PREPARATIONS		
FORA GTEL KETONE TEST STRIP	T4	
GOJJI BLOOD KETONE TEST STRIP	T4	
NOVAMAX PLUS	T3	
PRECISION XTRA	T3	
CARDIOVASCULAR DIAGNOSTICS-RADIOPAQUE		
OMNIPAQUE	T4	
DIAGNOSTIC PREPARATIONS, MISCELLANEOUS		
ARIDOL	T4	
GLUCAGEN DIAGNOSTIC 1 MG VIAL	T3	
METHACHOLINE CHLORIDE	T4	
PROVOCHOLINE	T4	
TC 99M SULFUR COLLOID PREP	T4	
TOXICOLOGY SALIVA COLLECTION	T4	
EYE DIAGNOSTIC AGENTS		
<i>fluorescein sodium</i>	T2	
<i>ful-glo 1 mg oph strip</i>	T2	
FUL-GLO EYE STRIPS	T4	
FLUORESCENCE IMAGING AGENTS - MALIGNANT TISSUE		
GLEOLAN	T4	
GASTROINTESTINAL RADIOPAQUE DIAGNOSTICS		
<i>diatrizoate meglumine, sodium (Gastrografin)</i>	T2	
ENTERO VU	T4	
E-Z DISK	T4	
E-Z-HD	T4	
E-Z-PAQUE	T4	
E-Z-PASTE	T4	

T1 – Preferred Generics
 T2 – Non-Preferred Generics
 T3 – Preferred Brands
 T4 – Non-Preferred Brands

T5 – Brand Specialty
 PA – Prior Authorization
 QL – Quantity Limit

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

HD – May require home delivery pharmacy
 PPACA – No Cost-Share Preventive Medication
 CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

DIAGNOSTIC (Miscellaneous) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
GASTROINTESTINAL RADIOPAQUE DIAGNOSTICS (cont.)		
GASTROGRAFIN (<i>diatrizoate meglumine, sodium</i>)	T4	
GASTROMARK	T4	
LIQUID E-Z PAQUE	T4	
LIQUID POLIBAR PLUS	T4	
NEULUMEX	T4	
POLIBAR ACB	T4	
READI-CAT 2	T4	
SITZMARKS	T4	
TAGITOL	T4	
VANILLA SILQ	T4	
VARIBAR HONEY	T4	
VARIBAR NECTAR	T4	
VARIBAR PUDDING	T4	
VARIBAR THIN HONEY	T4	
VARIBAR THIN LIQUID	T4	
VOLUMEN	T4	
METABOLIC FUNCTION DIAGNOSTICS		
METOPIRON	T4	
RADIOACTIVE DIAGNOSTICS, GENERAL		
XENON XE-133	T4	
RADIOPHARMACEUTICALS ELEMENTS		
INDICLOR	T4	
URINARY TRACT RADIOPAQUE DIAGNOSTICS		
CYSTO-CONRAY II	T4	
CYSTOGRAFIN	T4	
CYSTOGRAFIN-DILUTE	T4	
URINARY TRACT RADIOPAQUE DIAGNOSTICS		
KETONE CARE TEST STRIP	T3	
KETONE TEST STRIP	T3	
KETOSTIX REAGENT	T3	
TRUEPLUS KETONE TEST STRIP	T3	
URINE GLUCOSE/ACETONE TEST AIDS,STRIPS		
KETO-DIASTIX REAGENT	T3	

T1 – Preferred Generics
 T2 – Non-Preferred Generics
 T3 – Preferred Brands
 T4 – Non-Preferred Brands

T5 – Brand Specialty
 PA – Prior Authorization
 QL – Quantity Limit

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

HD – May require home delivery pharmacy
 PPACA – No Cost-Share Preventive Medication
 CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

DIAGNOSTIC (Miscellaneous) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
URINE MULTIPLE TEST AIDS		
CHEK-STIX	T3	
CHEMSTRIP	T3	
CHEMSTRIP 10 WITH SG	T3	
CHEMSTRIP 2 GP	T3	
CHEMSTRIP 50B	T3	
CHEMSTRIP 7	T3	
CHEMSTRIP 9	T3	
COMBISTIX REAGENT	T3	
HEMA-COMBISTIX	T3	
KETO-DIASTIX REAGENT	T3	
LABSTIX REAGENT	T3	
MULTISTIX	T3	
MULTISTIX 10 SG	T3	
MULTISTIX 5	T3	
MULTISTIX 7	T3	
MULTISTIX 8 SG	T3	
MULTISTIX 9	T3	
MULTISTIX 9 SG	T3	
URISTIX 4	T3	
URISTIX REAGENT	T3	

DIURETICS (Diuretics)

ARGININE VASOPRESSIN (AVP) RECEPTOR ANTAGONISTS

<i>tolvaptan 15 mg tablet (Samsca)</i>	T2	PA QL(30 tabs/fill) SP
<i>tolvaptan 30 mg tablet (Samsca)</i>	T2	PA QL(60 tabs/fill) SP

CARBONIC ANHYDRASE INHIBITORS

<i>acetazolamide</i>	T2	HD
<i>methazolamide</i>	T2	HD

LOOP DIURETICS

<i>bumetanide</i>	T2	HD
EDECIN (<i>ethacrynic acid</i>)	T4	ST HD
<i>ethacrynic acid (Edecrin)</i>	T2	HD
<i>furosemide</i>	T1	HD
<i>furosemide (Lasix)</i>	T1	HD

T1 – Preferred Generics
T2 – Non-Preferred Generics
T3 – Preferred Brands
T4 – Non-Preferred Brands

T5 – Brand Specialty
PA – Prior Authorization
QL – Quantity Limit

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

HD – May require home delivery pharmacy
PPACA – No Cost-Share Preventive Medication
CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

DIURETICS (Diuretics) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
LOOP DIURETICS (cont.)		
LASIX (<i>furosemide</i>)	T4	ST HD
<i>torsemide</i>	T2	HD
POLYCYSTIC KIDNEY DISEASE AGENT, AVP RECEPTOR ANTAGONIST		
JYNARQUE 15 MG TABLET	T5	PA QL(120 tabs/fill) SP
JYNARQUE 15 MG-15 MG TABLET	T5	PA QL(56 tabs/fill) SP
JYNARQUE 30 MG TABLET	T5	PA QL(120 tabs/fill) SP
JYNARQUE 30 MG-15 MG TABLET	T5	PA QL(56 tabs/fill) SP
JYNARQUE 45 MG-15 MG TABLET	T5	PA QL(56 tabs/fill) SP
JYNARQUE 60 MG-30 MG TABLET	T5	PA QL(56 tabs/fill) SP
JYNARQUE 90 MG-30 MG TABLET	T5	PA QL(56 tabs/fill) SP
POTASSIUM SPARING DIURETICS		
ALDACTONE (<i>spironolactone</i>)	T4	HD
<i>amiloride hcl</i>	T2	HD
DYRENIUM (<i>triamterene</i>)	T4	HD
<i>eplerenone</i> (Inspra)	T2	HD
INSPRA (<i>eplerenone</i>)	T4	HD
KERENDIA	T3	PA QL(30 tabs/fill) HD
<i>spironolactone</i> (Carospir)	T2	HD
<i>spironolactone</i> (Aldactone)	T1	HD
<i>triamterene</i> (Dyrenium)	T2	HD
POTASSIUM SPARING DIURETICS IN COMBINATION		
ALDACTAZIDE	T4	HD
<i>amiloride/hydrochlorothiazide</i>	T2	HD
DYAZIDE (<i>triamterene/hydrochlorothiazid</i>)	T4	HD
MAXZIDE (<i>triamterene/hydrochlorothiazid</i>)	T4	HD
MAXZIDE-25 MG (<i>triamterene/hydrochlorothiazid</i>)	T4	HD
<i>spironolact/hydrochlorothiazid</i>	T2	HD
<i>triamterene/hydrochlorothiazid</i> (Dyazide)	T1	HD
<i>triamterene/hydrochlorothiazid</i> (Maxzide)	T1	HD
<i>triamterene/hydrochlorothiazid</i> (Maxzide-25 Mg)	T1	HD
THIAZIDE AND RELATED DIURETICS		
<i>chlorthalidone</i>	T2	HD
DIURIL	T4	HD
<i>hydrochlorothiazide</i>	T1	HD

T1 – Preferred Generics
T2 – Non-Preferred Generics
T3 – Preferred Brands
T4 – Non-Preferred Brands

T5 – Brand Specialty
PA – Prior Authorization
QL – Quantity Limit

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

HD – May require home delivery pharmacy
PPACA – No Cost-Share Preventive Medication
CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

DIURETICS (Diuretics) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
THIAZIDE AND RELATED DIURETICS (cont.)		
<i>indapamide</i>	T1	HD
<i>metolazone</i>	T2	HD

EENT PREPS (Allergy/Nasal Sprays)

NASAL ANTIHISTAMINE

<i>azelastine 0.1% (137 mcg) spray</i>	T2	QL(60 mls/fill) HD
<i>azelastine 0.15% nasal spray</i>	T2	HD
<i>olopatadine hcl (Patanase)</i>	T2	QL(31 gms/fill) HD
PATANASE (<i>olopatadine hcl</i>)	T4	QL(31 gms/fill) HD

NASAL ANTIHISTAMINE AND ANTI-INFLAM. STEROID COMB.

<i>azelastine/fluticasone (Dymista)</i>	T2	ST QL(23 gms/fill) HD
DYMISTA (<i>azelastine/fluticasone</i>)	T4	ST QL(23 gms/fill) HD
RYALTRIS	T4	ST QL(1 bottle/fill) HD

NASAL ANTI-INFLAMMATORY STEROIDS

<i>flunisolide</i>	T2	ST QL(50 mls/fill) HD
<i>fluticasone prop 50 mcg spray</i>	T2	QL(16 gms/fill) HD
<i>mometasone furoate 50 mcg spray (Nasonex)</i>	T2	ST QL(17 gms/fill) HD
XHANCE	T4	ST QL(32 mls/fill) HD

NOSE PREPARATIONS, MISCELLANEOUS (RX)

COCAINE HCL	T4	HD
GOPRELTO	T4	HD
<i>ipratropium 0.03% spray</i>	T2	QL(30 mls/fill) HD
<i>ipratropium 0.06% spray</i>	T2	QL(30 mls/fill) HD
NUMBRINO	T4	HD

NOSE PREPARATIONS, VASOCONSTRICTORS (RX)

ADRENALIN CHLORIDE	T4	
<i>epinephrine hcl</i>	T2	

EENT PREPS (Ear Medications)

EAR PREPARATIONS ANTI-INFLAMMATORY

DERMOTIC (<i>fluocinolone acetonide oil</i>)	T4	
<i>fluocinolone acetonide oil (Dermotic)</i>	T2	

EAR PREPARATIONS, MISC. ANTI-INFECTIVES

<i>acetic acid</i>	T2	
CORTANE-B (<i>hydrocort/pramoxine/chloroxyli</i>)	T4	
<i>hydrocortisone/acetic acid</i>	T2	

T1 – Preferred Generics
T2 – Non-Preferred Generics
T3 – Preferred Brands
T4 – Non-Preferred Brands

T5 – Brand Specialty
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
AGENTS FOR CORNEAL COLLAGEN CROSS-LINKING		
PHOTREXA CROSS-LINKING	T4	
PHOTREXA VISCOUS	T4	
ARTIFICIAL TEARS		
KLARITY (CHONDROITIN)	T4	
LACRISERT	T4	PA QL(60 inserts/fill)
MIEBO	T3	
EYE ANTI-INFECTIVES (RX ONLY)		
BETADINE	T4	
EYE ANTI-INFLAMMATORY AGENTS		
ACULAR (<i>ketorolac tromethamine</i>)	T4	ST
ACULAR LS (<i>ketorolac tromethamine</i>)	T4	ST
<i>bromfenac sodium</i>	T2	
<i>bromfenac sodium</i> (Bromsite)	T2	
<i>bromfenac sodium</i> (Prolensa)	T2	
<i>dexamethasone sodium phosphate</i>	T2	
DEXTENZA	T4	
<i>diclofenac 0.1% eye drops</i>	T2	
<i>difluprednate</i> (Durezol)	T2	
EYSUVIS	T4	PA QL(8.3 mls/fill)
<i>fluorometholone</i> (Fml)	T2	
<i>flurbiprofen sodium</i>	T2	
FML (<i>fluorometholone</i>)	T4	ST
ILEVRO	T4	
INVELTYS	T4	ST
<i>ketorolac 0.4% ophth solution</i> (Acular Ls)	T2	
<i>ketorolac 0.5% ophth solution</i> (Acular)	T2	
KLARITY-B(BETAMETHASONE-CHOND)	T4	
KLARITY-L (<i>LOTEPREDNOL-CHONDR</i>)	T4	
LOTEMAX 0.5% EYE DROPS (<i>loteprednol etabonate</i>)	T4	
LOTEMAX 0.5% EYE OINTMENT	T4	ST
LOTEMAX 0.5% OPHTHALMIC GEL (<i>loteprednol etabonate</i>)	T4	ST
LOTEMAX SM	T4	ST
<i>loteprednol etabonate</i> (Alrex)	T2	ST
<i>loteprednol etabonate</i> (Lotemax)	T2	

T1 – Preferred Generics
T2 – Non-Preferred Generics
T3 – Preferred Brands
T4 – Non-Preferred Brands

T5 – Brand Specialty
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
EYE ANTI-INFLAMMATORY AGENTS (cont.)		
PRED FORTE (<i>prednisolone acetate</i>)	T4	
<i>prednisolone ac 1% eye drop</i> (Pred Forte)	T2	
PREDNISOLONE ACET 1% EYE DROP	T4	
<i>prednisolone sodium phosphate</i>	T2	
PREDNISOLONE-BROMFENAC	T4	
PREDNISOLONE-NEPAFENAC	T4	
PROLENSA	T4	
PROLENSA (<i>bromfenac sodium</i>)	T4	
EYE LOCAL ANESTHETICS		
AKTEN	T4	
ALCAINE (<i>proparacaine hcl</i>)	T4	
ALTAFLUOR BENOX (<i>benoxinate hcl/fluorescein sod</i>)	T4	
FLUORESCEIN-BENOXINATE	T4	
<i>proparacaine hcl</i> (Alcaine)	T2	
<i>proparacaine/fluorescein sod</i>	T2	
<i>tetracaine 0.5% eye drop</i>	T2	
TETRACAINE 0.5% STERI-UNIT SOL	T4	
<i>tetracaine hcl</i>	T2	
TETRAVISC	T4	
TETRAVISC FORTE	T4	
EYE MAST CELL STABILIZERS		
cromolyn 4% eye drops	T2	
EYE MYDRIATIC AND NSAID COMBINATIONS		
MYDRIATIC4(TROP-PROP-PE-KTRLC)	T4	
EYE PREPARATIONS, MISCELLANEOUS (OTC)		
GELFILM	T4	
EYE VASOCONSTRICTORS		
<i>phenylephrine hcl</i>	T2	
MIOTICS AND OTHER INTRAOCULAR PRESSURE REDUCERS		
ALPHAGAN P	T4	ST HD
ALPHAGAN P (<i>brimonidine tartrate</i>)	T4	ST HD
<i>apraclonidine hcl</i>	T2	HD
betaxolol hcl	T2	HD
BETOPTIC S	T4	HD

T1 – Preferred Generics
 T2 – Non-Preferred Generics
 T3 – Preferred Brands
 T4 – Non-Preferred Brands

T5 – Brand Specialty
 PA – Prior Authorization
 QL – Quantity Limit

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

HD – May require home delivery pharmacy
 PPACA – No Cost-Share Preventive Medication
 CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

EENT PREPS (Eye Conditions) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
MIOTICS AND OTHER INTRAOCULAR PRESSURE REDUCERS (cont.)		
<i>bimatoprost</i>	T2	PA HD
<i>brimonidine tartrate</i>	T2	HD
<i>brimonidine tartrate</i> (Alphagan P)	T2	HD
<i>brimonidine tartrate/timolol</i> (Combigan)	T2	HD
BRIMONIDINE-DORZOLAMIDE	T4	HD
<i>brinzolamide</i> (Azopt)	T2	HD
<i>carteolol hcl</i>	T2	HD
COMBIGAN (<i>brimonidine tartrate/timolol</i>)	T4	ST HD
DORZOLAMIDE	T4	HD
<i>dorzolamide hcl</i> (Trusopt)	T2	HD
<i>dorzolamide hcl/timolol maleate</i> (Cosopt)	T2	HD
<i>dorzolamide/timolol/pf</i> (Cosopt Pf)	T2	HD
IOPIDINE	T4	ST HD
ISOPTO CARPINE (<i>pilocarpine hcl</i>)	T4	HD
LATANOPROST 0.005% EYE DROP	T4	HD
<i>latanoprost 0.005% eye drops</i> (Xalatan)	T2	PA HD
<i>levobunolol hcl</i>	T2	HD
LUMIGAN	T4	PA HD
PHOSPHOLINE IODIDE	T5	SP HD
<i>pilocarpine hcl</i>	T2	HD
<i>pilocarpine hcl</i> (Isopto Carpine)	T2	HD
SIMBRINZA	T4	HD
<i>timolol maleate</i> (Istalol)	T2	HD
<i>timolol maleate</i> (Timoptic)	T1	HD
<i>timolol maleate</i> (Timoptic-Xe)	T2	HD
<i>timolol maleate/pf</i>	T2	HD
<i>timolol maleate/pf</i> (Timoptic Ocudose)	T2	HD
TIMOLOL-BRIMONIDIN-DORZOLAMIDE	T4	HD
TIMOLOL-BRIMONI-DORZOL-LATANOP	T4	HD
TIMOLOL-DORZOLAMIDE	T4	HD
TIMOLOL-DORZOLAMIDE-LATANOPRST	T4	HD
TIMOLOL-LATANOPROST	T4	HD
TIMOPTIC (<i>timolol maleate</i>)	T4	ST HD
TIMOPTIC-XE (<i>timolol maleate</i>)	T4	ST HD

T1 – Preferred Generics
T2 – Non-Preferred Generics
T3 – Preferred Brands
T4 – Non-Preferred Brands

T5 – Brand Specialty
PA – Prior Authorization
QL – Quantity Limit

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

HD – May require home delivery pharmacy
PPACA – No Cost-Share Preventive Medication
CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

EENT PREPS (Eye Conditions) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
MIOTICS AND OTHER INTRAOCULAR PRESSURE REDUCERS (cont.)		
<i>travoprost</i> (Travatan Z)	T2	PA HD
TRUSOPT (<i>dorzolamide hcl</i>)	T4	ST HD
VYZULTA	T4	PA HD
MYDRIATICS		
<i>atropine 1% eye drops</i>	T2	HD
<i>atropine 1% eye ointment</i>	T2	HD
ATROPINE SULFATE 0.01% EYE DRP	T4	HD
ATROPINE SULFATE-0.9% NAACL	T4	HD
CYCLOGYL	T4	HD
CYCLOGYL (<i>cyclopentolate hcl</i>)	T4	HD
CYCLOMYDRIL	T4	HD
<i>cyclopentolat/tropic/phenyleph</i>	T2	HD
<i>cyclopentolate hcl (Cyclogyl)</i>	T2	HD
CYCLOPENTOLATE-TROPICAMIDE-PE	T4	HD
<i>homatropine hbr</i>	T2	HD
MYDRIACYL (<i>tropicamide</i>)	T4	HD
PAREMYD	T4	HD
<i>tropicamide</i>	T2	HD
<i>tropicamide (Mydriacyl)</i>	T2	HD
TROPICAMIDE-CYCLOPENTOLATE-PE	T4	HD
TROPICAMIDE-CYCLOPENT-PE-KTRLC	T4	HD
TROPICAMIDE-PHENYLEPHRINE	T4	HD
TROPIC-CYCLOPENT-PE-KTRLC-PROP	T4	HD
OPHTH. VEGF-A RECEPTOR ANTAG. RCMB MC ANTIBODY		
LUCENTIS	T5	PA SP
OPHTHALMIC ANTIFIBROTIC AGENTS		
MITOMYCIN	T4	
MITOSOL	T4	
OPHTHALMIC ANTI-INFLAMMATORY IMMUNOMODULATOR-TYPE		
CEQUA	T4	PA QL (60 vls/30 days) HD
<i>cyclosporine 0.05% eye emuls</i> (Restasis)	T2	PA QL (60 vials/fill) HD
CYCLOSPORINE IN KLARITY	T4	HD
RESTASIS (<i>cyclosporine</i>)	T4	PA QL (60 vials/fill) HD
RESTASIS MULTIDOSE	T3	PA QL (6 mls/fill) HD

T1 – Preferred Generics
 T2 – Non-Preferred Generics
 T3 – Preferred Brands
 T4 – Non-Preferred Brands

T5 – Brand Specialty
 PA – Prior Authorization
 QL – Quantity Limit

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

HD – May require home delivery pharmacy
 PPACA – No Cost-Share Preventive Medication
 CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

EENT PREPS (Eye Conditions) (cont.)

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

OPHTHALMIC ANTI-INFLAMMATORY IMMUNOMODULATOR-TYPE (cont.)

XIIDRA	T3	PA QL (60 vls/fill) HD
VEVYE	T4	PA HD

OPHTHALMIC CYSTINE DEPLETING AGENTS

CYSTARAN	T5	PA SP
----------	----	-------

OPHTHALMIC HUMAN NERVE GROWTH FACTOR (HNGF)

OXERVATE	T5	PA SP HD
----------	----	----------

OPHTHALMIC PREPARATIONS, MISCELLANEOUS

HEALON GV	T4	
-----------	----	--

ELECT/CALORIC/H2O (Cholesterol Medications)

ORAL LIPID SUPPLEMENTS

DOJOLVI	T5	PA SP HD
---------	----	----------

ELECT/CALORIC/H2O (Dental Products)

FLUORIDE PREPARATIONS

CLINPRO 5000	T4	
FLORIVA	T4	
fluoride (sodium)	T2	PPACA
fluoride (sodium)	T2	
fluoride (sodium) (Prevident 5000 Plus)	T2	
fluoride (sodium) (Prevident)	T2	
FLUORIDEX	T4	
FLUORIDEX SENSITIVITY RELIEF	T4	
JUSTRIGHT 5000	T4	
PREVIDENT	T4	
PREVIDENT (fluoride (sodium))	T4	
PREVIDENT 5000 DRY MOUTH	T4	
PREVIDENT 5000 ENAMEL PROTECT	T4	
PREVIDENT 5000 ORTHO DEFENSE	T4	
PREVIDENT 5000 PLUS (fluoride (sodium))	T4	
PREVIDENT 5000 SENSITIVE	T4	
sodium fluoride 0.2% rinse (Prevident)	T2	
sodium fluoride 1.1% cream (Prevident 5000 Plus)	T2	
sodium fluoride 1.1% gel (Prevident)	T2	
sodium fluoride 5000 ppm cream (Prevident 5000 Plus)	T2	

T1 – Preferred Generics
T2 – Non-Preferred Generics
T3 – Preferred Brands
T4 – Non-Preferred Brands

T5 – Brand Specialty
PA – Prior Authorization
QL – Quantity Limit

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

HD – May require home delivery pharmacy
PPACA – No Cost-Share Preventive Medication
CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

ELECT/CALORIC/H2O (Dental Products) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
FLUORIDE PREPARATIONS (cont.)		
<i>sodium fluoride 5000 ppm paste</i>	T2	
<i>sodium fluoride/potassium nit</i>	T2	
PEDIATRIC VITAMIN PREPARATIONS		
<i>fluoride (sodium)</i>	T2	PPACA
FLURA-DROPS	T4	
<i>sodium fluoride 0.25 (0.55) mg</i>	T2	PPACA
<i>sodium fluoride 0.5 mg(1.1 mg)</i>	T2	PPACA
<i>sodium fluoride 0.5 mg/ml drop</i>	T2	PPACA
<i>sodium fluoride 1 mg (2.2 mg)</i>	T2	PPACA
ELECT/CALORIC/H2O (Diabetes)		
AGENTS TO TREAT HYPOGLYCEMIA (HYPERGLYCEMICS)		
BAQSIMI	T3	
<i>cvs glucose 4 gram tablet chew (Trueplus Glucose)</i>	T2	
CVS GLUCOSE LIQUID SHOT	T4	
DEX4 GLUCOSE 15 GM GEL PACKET	T4	
<i>dex4 glucose 4 gm tablet chew (Trueplus Glucose)</i>	T2	
<i>dex4 glucose 40% gel (Glucose-15)</i>	T2	
<i>dex4 glucose 40% gel (Glucose-45)</i>	T2	
DEX4 GLUCOSE LIQUID	T4	
DEX4 GLUCOSE LIQUID BLAST	T4	
<i>dex4 glucose tab pouch pack (Trueplus Glucose)</i>	T2	
<i>dex4 quick dissolve tab chew (Trueplus Glucose)</i>	T2	
<i>dextrose</i>	T2	
<i>dextrose (Glucose-15)</i>	T2	
<i>dextrose (Glucose-45)</i>	T2	
<i>dextrose/vitamin d3</i>	T2	
<i>diazoxide (Proglycem)</i>	T2	
<i>drug mart glucose 4 gm tab chw (Trueplus Glucose)</i>	T2	
<i>glucagon 1 mg emergency kit</i>	T2	QL(2 vials/fill)
GLUCO SHOT	T4	
GLUCOSE 2 GRAM GUMMY	T4	
<i>glucose 3.75 gram tablet chew (Trueplus Glucose)</i>	T2	
<i>glucose 4 gram tablet chew (Trueplus Glucose)</i>	T2	

T1 – Preferred Generics
 T2 – Non-Preferred Generics
 T3 – Preferred Brands
 T4 – Non-Preferred Brands

T5 – Brand Specialty
 PA – Prior Authorization
 QL – Quantity Limit

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

HD – May require home delivery pharmacy
 PPACA – No Cost-Share Preventive Medication
 CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

ELECT/CALORIC/H2O (Diabetes) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
AGENTS TO TREAT HYPOGLYCEMIA (HYPERGLYCEMICS) (cont.)		
GLUCOSE LIQUID	T4	
GLUTOSE-15 (<i>dextrose</i>)	T3	
GLUTOSE-45 (<i>dextrose</i>)	T3	
<i>gnp glucose 3.75 gram tab chew</i> (Trueplus Glucose)	T2	
<i>gnp glucose 4 gram tablet chew</i> (Trueplus Glucose)	T2	
<i>gnp quick dissolve glucose tab</i> (Trueplus Glucose)	T2	
<i>gs glucose 4 gram tablet chew</i> (Trueplus Glucose)	T2	
GVOKE	T3	QL(2 vials/fill)
GVOKE HYPOPEN 1-PACK, 2-PACK	T3	QL(2 auto-injs/fill)
GVOKE PFS 1-PACK SYRINGE	T3	QL(2 syringes/fill)
GVOKE PFS 2-PACK SYRINGE	T3	QL(2 syringes/fill)
INSTA-GLUCOSE GEL	T4	
<i>insta-glucose gel</i>	T2	
<i>kro glucose 4 gram tablet chew</i> (Trueplus Glucose)	T2	
<i>croger glucose 4 gram tab chew</i> (Trueplus Glucose)	T2	
<i>leader glucose 4 gm tab chew</i> (Trueplus Glucose)	T2	
<i>leader quick dissolve gluc tab</i> (Trueplus Glucose)	T2	
<i>longs glucose 4 gram tab chew</i> (Trueplus Glucose)	T2	
<i>meijer glucose 4 gram tab chew</i> (Trueplus Glucose)	T2	
<i>ms glucose 4 gram tablet chew</i> (Trueplus Glucose)	T2	
<i>ms quick dissolve glucose tab</i> (Trueplus Glucose)	T2	
<i>preferred plus glucose tab chw</i> (Trueplus Glucose)	T2	
PROGLYCEM (<i>diazoxide</i>)	T4	
<i>pub glucose 4 gram tablet chew</i> (Trueplus Glucose)	T2	
<i>ra glucose 4 gram tablet chew</i> (Trueplus Glucose)	T2	
<i>reliion glucose 4 gram tab chew</i> (Trueplus Glucose)	T2	
<i>reli-on glucose 4 gram tab chw</i> (Trueplus Glucose)	T2	
RELION GLUCOSE LIQUID	T4	
<i>sm glucose 4 gram tab chew</i> (Trueplus Glucose)	T2	
<i>smart sense glucose 4 gram tab</i> (Trueplus Glucose)	T2	
TRUEPLUS GLUCOSE	T4	
TRUEPLUS GLUCOSE (<i>dextrose</i>)	T4	
<i>upup glucose 4 gram tab chew</i> (Trueplus Glucose)	T2	

T1 – Preferred Generics
T2 – Non-Preferred Generics
T3 – Preferred Brands
T4 – Non-Preferred Brands

T5 – Brand Specialty
PA – Prior Authorization
QL – Quantity Limit

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

HD – May require home delivery pharmacy
PPACA – No Cost-Share Preventive Medication
CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

ELECT/CALORIC/H2O (Miscellaneous)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
NUCLEIC ACID/NUCLEOTIDE SUPPLEMENTS		
XURIDEN	T5	PA SP
ELECT/CALORIC/H2O (Nutritional/Dietary)		
CARBOHYDRATES		
ENFAMIL	T3	
GLUTOL	T3	
ELECTROLYTE DEPLETERS		
AURYXIA	T4	
<i>calcium acetate 667 mg capsule</i>	T2	QL(360 caps/fill)
<i>calcium acetate 667 mg gelcap</i>	T2	QL(360 caps/fill)
<i>calcium acetate 667 mg tablet</i>	T2	QL(360 tabs/fill)
<i>lanthanum carbonate (Fosrenol)</i>	T2	QL(90 tabs/fill)
LOKELMA	T3	QL(30 packs/fill)
PHOSLYRA	T3	
REVELA 0.8 GM POWDER PACKET (<i>sevelamer carbonate</i>)	T4	QL(180 packs/fill)
REVELA 2.4 GM POWDER PACKET (<i>sevelamer carbonate</i>)	T4	QL(90 packs/fill)
REVELA 800 MG TABLET (<i>sevelamer carbonate</i>)	T4	QL(270 tabs/fill)
<i>sevelamer hcl 400 mg tablet</i>	T2	
<i>sevelamer hcl 800 mg tablet</i>	T2	
<i>sodium polystyrene sulfon/sorb</i>	T2	
<i>sodium polystyrene sulfonate</i>	T2	
VELPHORO	T3	QL(120 tabs/fill)
VELTASSA	T3	QL(30 packs/fill)
FLUORIDE PREPARATIONS		
CLINPRO 5000	T4	
<i>fluoride (sodium)</i>	T2	PPACA
<i>fluoride (sodium)</i>	T2	
<i>fluoride (sodium) (Prevident 5000 Plus)</i>	T2	
<i>fluoride (sodium) (Prevident)</i>	T2	
FLUORIDEX	T4	
JUSTRIGHT 5000	T4	
PREVIDENT	T4	
PREVIDENT (<i>fluoride (sodium)</i>)	T4	
PREVIDENT 5000 DRY MOUTH	T4	
PREVIDENT 5000 ORTHO DEFENSE	T4	

T1 – Preferred Generics
T2 – Non-Preferred Generics
T3 – Preferred Brands
T4 – Non-Preferred Brands

T5 – Brand Specialty
PA – Prior Authorization
QL – Quantity Limit

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

HD – May require home delivery pharmacy
PPACA – No Cost-Share Preventive Medication
CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

ELECT/CALORIC/H2O (Nutritional/Dietary) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
FLUORIDE PREPARATIONS (cont.)		
PREVIDENT 5000 PLUS (<i>fluoride (sodium)</i>)	T4	
<i>sodium fluoride 0.2% rinse</i> (Prevident)	T2	
<i>sodium fluoride 1.1% cream</i> (Prevident 5000 Plus)	T2	
<i>sodium fluoride 1.1% gel</i> (Prevident)	T2	
<i>sodium fluoride 5000 ppm cream</i> (Prevident 5000 Plus)	T2	
<i>sodium fluoride 5000 ppm paste</i>	T2	
IODINE CONTAINING AGENTS		
<i>potassium iodide</i>	T2	
<i>potassium iodide/iodine</i>	T2	
SSKI	T4	
IRON REPLACEMENT		
ABATRON	T4	
ABATRON AF	T4	
ACCRUFER	T4	
ACTIVE FE	T4	
APETIGEN-PLUS	T3	
BENTIVITE BX	T4	
CHROMAGEN	T4	
CITRANATAL BLOOM	T4	
CORVITE 150	T4	
CORVITE FE	T4	
<i>cvs iron 27 mg tablet</i> (Fergon)	T2	
<i>cvs iron 65 mg tablet</i>	T2	
CVS SLOW RELEASE IRON 45 MG TB	T4	
<i>cvs slow release iron 45 mg tb</i>	T2	
<i>cvs slow release iron tablet</i>	T2	
<i>eql slow release iron 45 mg tab</i>	T2	
<i>eql slow release iron 50 mg tb</i>	T2	
FEOSOL 45 MG CAPLET (<i>iron,carbonyl</i>)	T3	
<i>feosol 65 mg tablet</i>	T2	
FEOSOL BIFERA 28 MG CAPLET	T3	
FERAHEME (<i>ferumoxytol</i>)	T4	PA
FERGON 27 MG TABLET	T4	
FERGON 27 MG TABLET (<i>ferrous gluconate</i>)	T3	

T1 – Preferred Generics
T2 – Non-Preferred Generics
T3 – Preferred Brands
T4 – Non-Preferred Brands

T5 – Brand Specialty
PA – Prior Authorization
QL – Quantity Limit

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

HD – May require home delivery pharmacy
PPACA – No Cost-Share Preventive Medication
CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

ELECT/CALORIC/H2O (Nutritional/Dietary) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
IRON REPLACEMENT (cont.)		
FERGON TABLET	T4	
FER-IN-SOL (<i>ferrous sulfate</i>)	T3	
FERIVA 21-7	T4	
FERIVA FA	T4	
FERRACTIV IRON	T4	
FERRALET 90	T4	
FERRETTIS IPS 18 MG CAP	T4	
FERRETTIS IPS 40 MG/15 ML LIQ	T3	
FERRIMIN 150	T3	
FERRLECIT (<i>sodium ferric gluconat/sucrose</i>)	T4	PA
FERRO-SEQUELS	T4	
<i>ferrous fum/vit c/b12-if/folic</i>	T2	PPACA
<i>ferrous fumarate</i>	T2	
<i>ferrous fumarate</i> (Hemocyte)	T2	
FERROUS FUMARATE 29 MG TAB	T4	
<i>ferrous fumarate 324 mg tab</i> (Hemocyte)	T2	
<i>ferrous fumarate/folic acid</i> (Hemocyte-F)	T2	
<i>ferrous gluconate</i>	T2	
<i>ferrous gluconate</i> (Fergon)	T2	
<i>ferrous sulfate</i>	T2	
<i>ferrous sulfate</i> (Fer-In-Sol)	T2	
<i>ferrous sulfate/vit c/folic ac</i>	T2	PPACA
<i>ferumoxytol</i> (Feraheme)	T2	PA
FUSION	T4	
FUSION PLUS	T4	
FUSION SPRINKLES	T4	
GENTLE IRON	T4	
<i>gnp iron 45 mg tablet</i>	T2	
<i>gnp iron 65 mg tablet</i>	T2	
HEMATEX	T4	
HEMATEX (<i>iron polysaccharide complex</i>)	T4	
HEMATOGEN	T4	
HEMATRON-AF	T4	
HEMAX	T4	

T1 – Preferred Generics
 T2 – Non-Preferred Generics
 T3 – Preferred Brands
 T4 – Non-Preferred Brands

T5 – Brand Specialty
 PA – Prior Authorization
 QL – Quantity Limit

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

HD – May require home delivery pharmacy
 PPACA – No Cost-Share Preventive Medication
 CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

ELECT/CALORIC/H2O (Nutritional/Dietary) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
IRON REPLACEMENT (cont.)		
HEMOCYTE (<i>ferrous fumarate</i>)	T3	
HEMOCYTE PLUS (<i>iron fum/folic acid/mv,min 15</i>)	T4	
HEMOCYTE-F (<i>ferrous fumarate/folic acid</i>)	T4	
<i>hm iron 65 mg tablet</i>	T2	
<i>hm slow release iron tablet</i>	T2	
I.L.X. B-12	T3	
ICAR	T3	
ICAR-C (<i>iron,carbonyl/ascorbic acid</i>)	T3	
ICAR-C PLUS (<i>iron,carb/vit c/vit b12/folic</i>)	T4	
INFED	T3	PA
INJECTAFER	T4	PA
INTEGRA	T3	
INTEGRA F (<i>iron fum,ps/folic acid/vitc/b3</i>)	T4	
INTEGRA PLUS (<i>iron fum,ps/folic/bcomp,c no.9</i>)	T4	
IRON 18 MG TABLET	T4	
<i>iron 27 mg tablet</i>	T2	
<i>iron 27 mg tablet (Fergon)</i>	T2	
<i>iron 28 mg tablet</i>	T2	
<i>iron 45 mg tablet</i>	T2	
<i>iron 65 mg tablet</i>	T2	
<i>iron aspgly,ps/c/b12/fa/ca/suc</i>	T2	
<i>iron aspgly,ps/c/succinic acid</i>	T2	
<i>iron aspgly,c/b12/fa/ca-th/suc</i>	T2	
<i>iron bg,ps/vitc/b12/fa/calcium</i>	T2	
IRON BISGLYCINATE	T4	
<i>iron fm,ps no.1/folic/mv no.18 (Tandem Plus)</i>	T2	
<i>iron fum,ag/c/b12/folic/ca/suc</i>	T2	
<i>iron fum,ps/folic acid/vitc/b3 (Integra F)</i>	T2	
<i>iron fum,ps/folic/bcomp,c no.9 (Integra Plus)</i>	T2	
<i>iron fum/folic acid/mv,min 15 (Hemocyte Plus)</i>	T2	
<i>iron fumarate/vit c/vit b12/fa</i>	T2	
<i>iron polysac/iron heme/fa/b12</i>	T2	
<i>iron polysaccharide complex</i>	T2	
<i>iron polysaccharide complex (Nu-Iron 150)</i>	T2	

T1 – Preferred Generics
T2 – Non-Preferred Generics
T3 – Preferred Brands
T4 – Non-Preferred Brands

T5 – Brand Specialty
PA – Prior Authorization
QL – Quantity Limit

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

HD – May require home delivery pharmacy
PPACA – No Cost-Share Preventive Medication
CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

ELECT/CALORIC/H2O (Nutritional/Dietary) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
IRON REPLACEMENT (cont.)		
<i>iron ps complex/b12/folic acid</i>	T2	
<i>iron,carb/vit c/vit b12/folic (Icar-C Plus)</i>	T2	
<i>iron,carbonyl</i>	T2	
<i>iron,carbonyl (Feosol)</i>	T2	
<i>iron,carbonyl/ascorbic acid (Icar-C)</i>	T2	
<i>iron/c/b12/calcium/stomach conc</i>	T2	
<i>iron/c/folic acid/mv cmb11/calc</i>	T2	
<i>iron/folic acid/vit bcomp,c/min</i>	T2	
<i>iron/folic acid/b12/c/docusate</i>	T2	
<i>iron/folic acid/c/b6/b12/zinc</i>	T2	
<i>iron/vit c/fructooligosaccharid</i>	T2	
IRONUP	T4	
IRO-PLEX	T4	
IROSPAN	T4	
LYDIA PINKHAM HERBAL	T4	
MAXFE	T4	
MONOFERRIC	T4	PA
NEONATAL FE	T4	
NIFEREX	T4	
NOVAFERRUM 125 MG/5 ML LIQUID	T4	
NOVAFERRUM 15 MG/ML DROPS	T3	
NOVAFERRUM 50	T4	
NUFERA	T4	
NU-IRON 150 (<i>iron polysaccharide complex</i>)	T3	
PARVLEX	T4	
PERFECT IRON	T4	
PRO FE	T3	
PROFERRIN	T3	
PROFERRIN-FORTE	T4	
PROTECT IRON	T4	
<i>ra high potency iron 27 mg tab</i>	T2	
RA HIGH POTENCY IRON 27 MG TAB	T4	
<i>ra iron 65 mg tablet</i>	T2	
RA SLOW RELEASE IRON 45 MG TAB	T3	

T1 – Preferred Generics
T2 – Non-Preferred Generics
T3 – Preferred Brands
T4 – Non-Preferred Brands

T5 – Brand Specialty
PA – Prior Authorization
QL – Quantity Limit

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

HD – May require home delivery pharmacy
PPACA – No Cost-Share Preventive Medication
CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

ELECT/CALORIC/H2O (Nutritional/Dietary) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
IRON REPLACEMENT (cont.)		
SIDEROL	T4	
SLOW FE	T3	
<i>slow release iron 160 mg tab</i>	T2	
SLOW RELEASE IRON 45 MG TAB	T3	
SLOW RELEASE IRON 45 MG TABLET	T3	
<i>slow release iron 45 mg tablet</i>	T2	
SLOW RELEASE IRON 45 MG TABLET	T4	
<i>slow release iron tablet</i>	T2	
SLOW RELEASE IRON TABLET	T3	
<i>sm iron 160 mg tablet sa</i>	T2	
<i>sm iron 325 mg tablet</i>	T2	
<i>sm iron 65 mg tablet</i>	T2	
SM SLOW RELEASE IRON 45 MG TAB	T3	
<i>sodium ferric gluconat/sucrose (Ferrlecit)</i>	T2	PA
<i>sv iron 65 mg tablet</i>	T2	
SV SLOW RELEASE IRON 45 MG TAB	T3	
TANDEM DUAL ACTION	T3	
TANDEM PLUS (<i>iron fm,ps no.1/folic/mv no.18</i>)	T4	
TL-HEM 150	T4	
TRIFERIC	T4	
TULIVITE	T4	
VENOFER	T3	PA
VIRT-FEFA PLUS CAPSULE	T4	
<i>virt-fefa plus capsule (Integra Plus)</i>	T2	
VITABEX IRON	T4	
VITAFOL	T4	
VITRON-C	T3	
PEDIATRIC VITAMIN PREPARATIONS		
<i>fluoride (sodium)</i>	T2	PPACA
FLURA-DROPS	T4	
<i>sodium fluoride 0.25 (0.55) mg</i>	T2	PPACA
<i>sodium fluoride 0.5 mg(1.1 mg)</i>	T2	PPACA
<i>sodium fluoride 0.5 mg/ml drop</i>	T2	PPACA
<i>sodium fluoride 1 mg (2.2 mg)</i>	T2	PPACA

T1 – Preferred Generics
T2 – Non-Preferred Generics
T3 – Preferred Brands
T4 – Non-Preferred Brands

T5 – Brand Specialty
PA – Prior Authorization
QL – Quantity Limit

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

HD – May require home delivery pharmacy
PPACA – No Cost-Share Preventive Medication
CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

ELECT/CALORIC/H2O (Nutritional/Dietary) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
POTASSIUM REPLACEMENT		
EFFER-K 10 MEQ TABLET EFF	T4	
EFFER-K 20 MEQ TABLET EFF	T4	
<i>effer-k 25 meq tablet eff</i>	T2	
K-TAB ER 20 MEQ TABLET (<i>potassium chloride</i>)	T4	
<i>k-tab er 8 meq tablet</i>	T1	
<i>potassium bicarbonate/cit ac</i>	T2	
<i>potassium chloride</i>	T1	
<i>potassium chloride</i>	T2	
<i>potassium chloride (K-Tab Er)</i>	T1	
ELECT/CALORIC/H2O (Urinary Tract Conditions)		
DIALYSIS SOLUTIONS		
PRISMASOL	T4	
URINARY PH MODIFIERS		
<i>citric acid/sodium citrate</i>	T2	HD
K-PHOS NO.2	T4	HD
K-PHOS ORIGINAL	T3	HD
ORACIT	T4	HD
<i>potassium citrate (Urocit-K)</i>	T2	HD
RENACIDIN	T3	HD
UROCIT-K (<i>potassium citrate</i>)	T4	HD
UROQID-ACID NO.2	T4	HD
GASTROINTESTINAL (Cholesterol Medications)		
LIPOTROPICS		
<i>icosapent ethyl (Vascepa)</i>	T2	PA HD
<i>omega-3 acid ethyl esters (Lovaza)</i>	T2	PA HD
VASCEPA (<i>icosapent ethyl</i>)	T3	PA HD
GASTROINTESTINAL (Gastrointestinal/Heartburn)		
AMMONIA INHIBITORS		
BUPHENYL (<i>sodium phenylbutyrate</i>)	T5	PA SP HD
<i>lactulose</i>	T2	HD
<i>lactulose 10 gm/15 ml solution</i>	T2	HD
LITHOSTAT	T4	HD
OLPRUVA DOSE KIT, DOSE ENVELOPE	T5	SP PA HD

T1 – Preferred Generics
 T2 – Non-Preferred Generics
 T3 – Preferred Brands
 T4 – Non-Preferred Brands

T5 – Brand Specialty
 PA – Prior Authorization
 QL – Quantity Limit

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

HD – May require home delivery pharmacy
 PPACA – No Cost-Share Preventive Medication
 CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

GASTROINTESTINAL (Gastrointestinal/Heartburn) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
AMMONIA INHIBITORS (cont.)		
RAVICTI	T5	PA SP HD
<i>sodium phenylbutyrate</i> (Buphenyl)	T2	PA SP HD
PHEBURANE	T5	PA SP
ANTICHOLINERGICS, QUATERNARY AMMONIUM		
<i>chlordiazepoxide/clidinium br</i> (Librax)	T2	
GLYCATE	T4	
<i>glycopyrrolate</i>	T2	
<i>glycopyrrolate</i> (Cuvposa)	T2	
<i>glycopyrrolate</i> (Robinul Forte)	T2	
<i>glycopyrrolate</i> (Robinul)	T2	
ROBINUL (<i>glycopyrrolate</i>)	T4	
ROBINUL FORTE (<i>glycopyrrolate</i>)	T4	
ANTICHOLINERGICS/ANTISPASMODICS		
<i>dicyclomine hcl</i>	T2	
ANTIDIARRHEAL - TRYPTOPHAN HYDROXYLASE INHIBITOR		
XERMELO	T5	PA QL(90 tabs/fill) SP
ANTIDIARRHEALS		
<i>diphenoxylate hcl/atropine</i>	T2	
<i>diphenoxylate hcl/atropine</i> (Lomotil)	T2	
LOMOTIL (<i>diphenoxylate hcl/atropine</i>)	T4	
MOTOFEN	T4	
<i>opium tincture</i>	T2	
<i>paregoric</i>	T2	
ANTIEMETIC, CANNABINOID-TYPE		
<i>dronabinol</i> (Marinol)	T2	PA
MARINOL (<i>dronabinol</i>)	T4	PA
SYNDROS	T4	PA
ANTIEMETIC/ANTIVERTIGO AGENTS		
<i>aprepitant 125 mg capsule</i>	T2	QL(1 cap/fill)
<i>aprepitant 125-80-80 mg pack</i> (Emend)	T2	QL(3 caps/fill)
<i>aprepitant 40 mg capsule</i> (Emend)	T2	QL(1 cap/fill)
<i>aprepitant 80 mg capsule</i> (Emend)	T2	QL(2 caps/fill)
COMPAZINE (<i>prochlorperazine maleate</i>)	T4	
COMPAZINE (<i>prochlorperazine</i>)	T4	

T1 – Preferred Generics
 T2 – Non-Preferred Generics
 T3 – Preferred Brands
 T4 – Non-Preferred Brands

T5 – Brand Specialty
 PA – Prior Authorization
 QL – Quantity Limit

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

HD – May require home delivery pharmacy
 PPACA – No Cost-Share Preventive Medication
 CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

GASTROINTESTINAL (Gastrointestinal/Heartburn) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ANTIEMETIC/ANTIVERTIGO AGENTS (cont.)		
DICLEGIS (<i>doxylamine succinate/vit b6</i>)	T4	QL(120 tabs/fill)
EMEND 150 MG VIAL (<i>fosaprepitant dimeglumine</i>)	T4	
<i>fosaprepitant dimeglumine</i> (Emend)	T2	
<i>granisetron hcl 0.1 mg/ml vial</i>	T2	
<i>granisetron hcl 1 mg tablet</i>	T2	QL(6 tabs/fill)
<i>granisetron hcl 1 mg/ml vial</i>	T2	
<i>granisetron hcl 4 mg/4 ml vial</i>	T2	
<i>ondansetron</i>	T2	QL(9 tabs/fill)
<i>ondansetron 4 mg/2 ml isecure</i>	T2	
<i>ondansetron 40 mg/20 ml vial</i>	T2	
<i>ondansetron hcl 4 mg tablet</i>	T2	QL(9 tabs/fill)
<i>ondansetron hcl 4 mg/2 ml syr</i>	T2	
<i>ondansetron hcl 4 mg/2 ml vial</i>	T2	
<i>ondansetron hcl 8 mg tablet</i>	T2	QL(9 tabs/fill)
<i>prochlorperazine</i> (Compazine)	T2	
<i>prochlorperazine maleate</i> (Compazine)	T2	
<i>promethazine hcl</i>	T2	
SANCUSO	T4	QL(1 patch/fill)
<i>scopolamine</i> (Transderm-Scop)	T2	
TIGAN (<i>trimethobenzamide hcl</i>)	T4	
<i>trimethobenzamide hcl</i> (Tigan)	T2	
VARUBI	T3	QL(2 tabs/fill)
ZUPLENZ	T4	QL(10 films/fill)
ANTI-ULCER PREPARATIONS		
CYTOTEC (<i>misoprostol</i>)	T4	HD
<i>misoprostol</i> (Cytotec)	T2	HD
<i>sucralfate</i> (Carafate)	T2	HD
ANTI-ULCER-H.PYLORI AGENTS		
<i>lansoprazole/amoxiciln/clarith</i>	T2	QL(112 units/fill)
OMECLAMOX-PAK	T4	QL(80 units/fill)
TALICIA	T3	QL(168 caps/fill)
BELLADONNA ALKALOIDS		
DONNATAL	T4	HD
DONNATAL (<i>phenobarb/hyoscy/atropine/scop</i>)	T4	HD

T1 – Preferred Generics
 T2 – Non-Preferred Generics
 T3 – Preferred Brands
 T4 – Non-Preferred Brands

T5 – Brand Specialty
 PA – Prior Authorization
 QL – Quantity Limit

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

HD – May require home delivery pharmacy
 PPACA – No Cost-Share Preventive Medication
 CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

GASTROINTESTINAL (Gastrointestinal/Heartburn) (cont.)

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

BELLADONNA ALKALOIDS (cont.)

<i>hyoscyamine sulfate</i>	T2	HD
<i>hyoscyamine sulfate (Levbid)</i>	T2	HD
<i>hyoscyamine sulfate (Levsin)</i>	T2	HD
<i>hyoscyamine sulfate (Levsin-SI)</i>	T2	HD
<i>hyoscyamine sulfate (Nulev)</i>	T2	HD
LEVBIID (<i>hyoscyamine sulfate</i>)	T4	HD
LEVSIN (<i>hyoscyamine sulfate</i>)	T4	HD
LEVSIN-SL (<i>hyoscyamine sulfate</i>)	T4	HD
<i>methscopolamine bromide</i>	T2	HD
NULEV (<i>hyoscyamine sulfate</i>)	T4	HD
<i>phenobarb/hyoscy/atropine/scop</i>	T2	HD
<i>phenobarb/hyoscy/atropine/scop</i> (Donnatal)	T2	HD
<i>phenobarb/hyoscy/atropine/scop</i> (Phenobarbital-Belladonna)	T2	HD
<i>phenobarbital-belladonna elixr</i>	T2	HD
<i>phenobarbital-belladonna elixr</i> (Donnatal)	T2	HD
PHENOBARBITAL-BELLADONNA ELIXR (<i>phenobarb/hyoscy/atropine/scop</i>)	T4	HD
<i>phenobarbital-belladonna elixr</i> (Phenobarbital-Belladonna)	T2	HD
SYMAX DUOTAB	T4	HD

BILE SALTS

CHENODAL	T5	PA SP HD
CHOLBAM 250 MG CAPSULE	T5	PA SP HD
CHOLBAM 50 MG CAPSULE	T5	PA QL(120 caps/fill) SP HD
URSO (<i>ursodiol</i>)	T4	HD
URSO FORTE (<i>ursodiol</i>)	T4	HD
<i>ursodiol</i>	T2	HD
<i>ursodiol</i> (Urso Forte)	T2	HD
<i>ursodiol</i> (Urso)	T2	HD

CHRONIC INFLAM. COLON DX, 5-A-SALICYLAT, RECTAL TX

<i>mesalamine 1,000 mg supp</i> (Canasa)	T2	
<i>mesalamine 4 gm/60 ml enema</i> (Sfrowasa)	T2	
<i>mesalamine 4 gm/60 ml kit</i> (Rowasa)	T2	
ROWASA (<i>mesalamine w/cleansing wipes</i>)	T4	
SFROWASA (<i>mesalamine</i>)	T4	

T1 – Preferred Generics
 T2 – Non-Preferred Generics
 T3 – Preferred Brands
 T4 – Non-Preferred Brands

T5 – Brand Specialty
 PA – Prior Authorization
 QL – Quantity Limit

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

HD – May require home delivery pharmacy
 PPACA – No Cost-Share Preventive Medication
 CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

GASTROINTESTINAL (Gastrointestinal/Heartburn) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
DRUG TX-CHRONIC INFLAM. COLON DX, 5-AMINOSALICYLAT		
APRISO (<i>mesalamine</i>)	T4	HD
ASACOL HD (<i>mesalamine</i>)	T4	HD
AZULFIDINE (<i>sulfasalazine</i>)	T4	HD
<i>balsalazide disodium</i> (Colazal)	T2	HD
COLAZAL (<i>balsalazide disodium</i>)	T4	HD
<i>mesalamine</i> (Apriso)	T2	HD
<i>mesalamine</i> (Delzicol)	T2	HD
<i>mesalamine</i> (Pentasa)	T2	HD
<i>mesalamine 800 mg dr tablet</i> (Asacol Hd)	T2	HD
<i>mesalamine dr 1.2 gm tablet</i> (Lialda)	T2	HD
PENTASA 250 MG CAPSULE	T3	HD
PENTASA 500 MG CAPSULE (<i>mesalamine</i>)	T4	HD
<i>sulfasalazine</i> (Azulfidine)	T2	HD
FARNESOID X RECEPTOR (FXR) AGONIST, BILE AC ANALOG		
OCALIVA	T5	PA QL(30 tabs/fill) SP HD
FECAL MICROBIOTA TRANSPLANTATION (FMT)		
VOWST CAPSULE	T5	PA SP
GASTRIC ENZYMES		
SUCRAID	T5	PA SP
HISTAMINE H2-RECEPTOR INHIBITORS		
<i>cimetidine</i>	T2	HD
<i>famotidine</i>	T2	HD
<i>famotidine</i> (Pepcid)	T1	HD
<i>nizatidine</i>	T2	HD
PEPCID (<i>famotidine</i>)	T4	HD
<i>ranitidine hcl</i>	T2	HD
IBS AGENTS, MIXED OPIOID RECEPTOR AGONISTS/ANTAGONISTS		
VIBERZI	T3	HD
IBS-C/CIC AGENTS, GUANYLATE CYCLASE-C AGONIST		
LINZESS	T3	QL(30 caps/fill)
TRULANCE	T3	
ILEAL BILE ACID TRANSPORTER (IBAT) INHIBITOR		
BYLVAY 1,200 MCG CAPSULE	T5	PA QL(60 caps/fill) SP HD
BYLVAY 200 MCG PELLETT	T5	PA QL(120 pellets/fill) SP HD

T1 – Preferred Generics
 T2 – Non-Preferred Generics
 T3 – Preferred Brands
 T4 – Non-Preferred Brands

T5 – Brand Specialty
 PA – Prior Authorization
 QL – Quantity Limit

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

HD – May require home delivery pharmacy
 PPACA – No Cost-Share Preventive Medication
 CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

GASTROINTESTINAL (Gastrointestinal/Heartburn) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ILEAL BILE ACID TRANSPORTER (IBAT) INHIBITOR (cont.)		
BYLVAY 400 MCG CAPSULE	T5	PA QL(150 caps/fill) SP HD
BYLVAY 600 MCG PELLETT	T5	PA QL(30 pellets/fill) SP HD
LIVMARLI	T5	PA SP
INTESTINAL MOTILITY STIMULANTS		
<i>metoclopramide hcl</i>	T1	
<i>metoclopramide hcl (Reglan)</i>	T1	
REGLAN (<i>metoclopramide hcl</i>)	T4	
IRRITABLE BOWEL SYNDROME AGENTS, 5-HT₃ ANTAGONIST		
<i>alosetron hcl (Lotronex)</i>	T2	SP HD
LAXATIVES AND CATHARTICS		
<i>bisac/nacl/nahco3/kcl/peg 3350</i>	T2	PPACA
GIALAX	T4	PPACA
GOLYTELY (<i>peg3350/sod sulf,bicarb,cl/kcl</i>)	T4	
KRISTALOSE	T4	
<i>lactulose</i>	T2	
<i>lactulose 10 gm packet</i>	T2	
<i>lactulose 10 gm/15 ml solution</i>	T2	
<i>lactulose 20 gm/30 ml solution</i>	T2	
<i>lubiprostone</i>	T2	QL (60 caps/30 days)
NULYTELY	T4	
NULYTELY WITH FLAVOR PACKS (<i>sodium chloride/nahco3/kcl/peg</i>)	T4	
<i>peg3350/sod sul/nacl/kcl/asb/c (Moviprep)</i>	T2	PPACA
<i>peg3350/sod sulf,bicarb,cl/kcl</i>	T2	PPACA
<i>peg3350/sod sulf,bicarb,cl/kcl (Golytely)</i>	T2	PPACA
<i>sodium chloride/nahco3/kcl/peg (Nulytely With Flavor Packs)</i>	T2	PPACA
<i>sodium, potassium,mag sulfates (Suprep)</i>	T2	PPACA
LOCAL ANORECTAL NITRATE PREPARATIONS		
<i>nitroglycerin 0.4% ointment</i>	T2	
RECTIV	T3	
MU-OPIOID RECEPTOR ANTAGONISTS,PERIPHERALLY-ACTING		
<i>alvimopan</i>	T2	
ENTEREG	T4	
PANCREATIC ENZYMES		
CREON	T3	HD

T1 – Preferred Generics
 T2 – Non-Preferred Generics
 T3 – Preferred Brands
 T4 – Non-Preferred Brands

T5 – Brand Specialty
 PA – Prior Authorization
 QL – Quantity Limit

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

HD – May require home delivery pharmacy
 PPACA – No Cost-Share Preventive Medication
 CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

GASTROINTESTINAL (Gastrointestinal/Heartburn) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
PANCREATIC ENZYMES (cont.)		
PANCREAZE	T3	HD
VIOKACE	T3	HD
ZENPEP	T3	HD
POTASSIUM-COMPETITIVE ACID BLOCKERS (PCABS)		
VOQUEZNA	T4	ST
PROTON-PUMP INHIBITORS		
<i>dexlansoprazole dr 60 mg cap</i>	T2	ST HD
<i>esomeprazole dr 10 mg packet (Nexium)</i>	T2	ST QL(30 packs/fill) HD
<i>esomeprazole dr 40 mg packet (Nexium)</i>	T2	ST HD
<i>esomeprazole dr 40 mg cap (Nexium)</i>	T2	HD
ESOMEPRAZOLE DR 49.3 MG CAP (Nexium)	T4	ST HD
<i>lansoprazole dr 30 mg capsule (Prevacid)</i>	T1	HD
<i>lansoprazole odt 15 mg tablet (Prevacid)</i>	T2	ST QL(30 tabs/fill) HD
<i>lansoprazole odt 30 mg tablet (Prevacid)</i>	T2	ST HD
<i>omeprazole dr 10 mg capsule</i>	T1	QL(30 caps/fill) HD
<i>omeprazole dr 20 mg capsule</i>	T1	QL(30 caps/fill) HD
<i>omeprazole dr 40 mg capsule</i>	T1	HD
<i>omeprazole/sodium bicarbonate (Zegerid)</i>	T2	PA HD
<i>omeprazole-bicarb 20-1,680 pkt (Zegerid)</i>	T2	PA QL(30 packs/fill) HD
<i>omeprazole-bicarb 40-1,100 cap (Zegerid)</i>	T2	PA HD
<i>omeprazole-bicarb 40-1,680 pkt (Zegerid)</i>	T2	PA HD
<i>pantoprazole 40 mg suspension (Protonix)</i>	T2	ST HD
<i>pantoprazole sod dr 40 mg tab (Protonix)</i>	T1	HD
<i>rabeprazole sod dr 20 mg tab (Aciphex)</i>	T2	HD
RECTAL PREPARATIONS		
<i>hydrocortisone acetate (Anusol-Hc)</i>	T2	
<i>hydrocortisone acetate (Proctocort)</i>	T2	
PROCTOCORT (<i>hydrocortisone acetate</i>)	T4	ST
SBS - GLUCAGON-LIKE PEPTIDE-2 (GLP-2) ANALOGS		
GATTEX	T5	PA SP HD
GASTROINTESTINAL (Pain Relief And Inflammatory Disease)		
HEMORRHOID PREP, ANTI-INFLAM STEROID-LOCAL ANESTHET		
ANA-LEX	T4	

T1 – Preferred Generics
T2 – Non-Preferred Generics
T3 – Preferred Brands
T4 – Non-Preferred Brands

T5 – Brand Specialty
PA – Prior Authorization
QL – Quantity Limit

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

HD – May require home delivery pharmacy
PPACA – No Cost-Share Preventive Medication
CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

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

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
HEMORRHOID PREP, ANTI-INFLAM STEROID-LOCAL ANESTHET (cont.)		
ANALPRAM HC 1% CREAM	T4	
ANALPRAM HC 2.5%-1% CREAM (<i>hydrocortisone/pramoxine</i>)	T4	ST
ANALPRAM HC 2.5%-1% CRM SINGLE (<i>hydrocortisone/pramoxine</i>)	T4	ST
<i>hydrocort-pramoxine 1%-1% crm</i>	T2	
<i>hydrocort-pramoxine 2.5%-1% cm (Analpram Hc)</i>	T2	ST
<i>hydrocort-pramoxine 2.5-1% crm (Analpram Hc)</i>	T2	ST
<i>lidocaine-hc 2.8-0.55% gel</i>	T2	
<i>lidocaine-hc 2-2% cream kit</i>	T2	
<i>lidocaine-hc 3-0.5% cream</i>	T2	
<i>lidocaine-hc 3-0.5% cream kit</i>	T2	
<i>lidocaine-hc 3-1% cream kit</i>	T2	
<i>lidocaine-hc 3-2.5% gel kit</i>	T2	
LIDOCAINE-HYDROCORT 3-2.5% GEL	T4	
PROCORT	T4	

HORMONES (Gastrointestinal/Heartburn)

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

CORTENEMA (<i>hydrocortisone</i>)	T4	
<i>hydrocortisone</i> (Cortenema)	T2	
UCERIS 2 MG RECTAL FOAM	T3	

HORMONES (Hormonal Agents)

ANDROGENIC AGENTS

ANDRODERM	T3	PA QL(30 patches/fill)
ANDROID (<i>methyltestosterone</i>)	T4	PA
DEPO-TESTOSTERONE	T4	PA
DEPO-TESTOSTERONE (<i>testosterone cypionate</i>)	T4	PA
FORTESTA (<i>testosterone</i>)	T4	PA QL(120 gms/fill)
JATENZO 158 MG, 198 MG CAPSULE	T4	PA QL(120 caps/30 days)
METHITEST	T3	
<i>methyltestosterone</i> (Android)	T2	
<i>methyltestosterone</i> (Testred)	T2	
<i>oxandrolone</i>	T2	
<i>testosterone 1% (25mg/2.5g) pk</i> (Androgel)	T2	PA QL(75 gms/fill)
<i>testosterone 1% (50 mg/5 g) pk</i> (Androgel)	T2	PA QL(300 gms/fill)

T1 – Preferred Generics
T2 – Non-Preferred Generics
T3 – Preferred Brands
T4 – Non-Preferred Brands

T5 – Brand Specialty
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
ANDROGENIC AGENTS (cont.)		
<i>testosterone 1.62% (2.5 g) pkt (Androgel)</i>	T2	PA QL(60 packs/fill)
<i>testosterone 1.62% gel pump (Androgel)</i>	T2	PA QL(150 gms/fill)
<i>testosterone 1.62%(1.25 g) pkt (Androgel)</i>	T2	PA QL(30 packs/fill)
<i>testosterone 10 mg gel pump (Fortesta)</i>	T2	PA QL(120 gms/fill)
TESTOSTERONE 12.5 MG/1.25 GRAM	T4	PA QL(300 gms/fill)
<i>testosterone 12.5 mg/1.25 gram</i>	T2	PA QL(300 gms/fill)
<i>testosterone 30 mg/1.5 ml pump</i>	T2	PA QL(180 mls/fill)
<i>testosterone 50 mg/5 gram gel (Testim)</i>	T2	PA QL(60 tubes/fill)
<i>testosterone 50 mg/5 gram gel (Vogelxo)</i>	T2	PA QL(60 tubes/fill)
TESTOSTERONE 50 MG/5 GRAM PKT	T4	PA QL(300 gms/fill)
<i>testosterone cypionate</i>	T2	PA
<i>testosterone cypionate (Depo-Testosterone)</i>	T2	PA
<i>testosterone enanthate</i>	T2	PA
TESTRED (<i>methyltestosterone</i>)	T4	PA
VOGELXO 12.5 MG/1.25 GRAM PUMP	T4	PA QL(300 gms/fill)
VOGELXO 50 MG/5 GRAM GEL (<i>testosterone</i>)	T4	PA QL(60 tubes/fill)
VOGELXO 50 MG/5 GRAM GEL PACKET	T4	PA QL(60 packs/fill)
XYOSTED	T3	PA QL(2 mls/28 days)
ANTIDIURETIC AND VASOPRESSOR HORMONES		
DDAVP (<i>desmopressin (nonrefrigerated)</i>)	T4	
DDAVP (<i>desmopressin acetate</i>)	T4	
<i>desmopressin 0.01% solution</i>	T2	
DESMOPRESSIN 1.5 MG/ML SPRAY	T3	
<i>desmopressin 10 mcg/0.1 ml spr</i>	T2	
<i>desmopressin acetate 0.1 mg tb (Ddavp)</i>	T2	
<i>desmopressin acetate 0.2 mg tb (Ddavp)</i>	T2	
NOCDURNA	T4	PA QL(30 tabs/fill)
ESTROGEN/ANDROGEN COMBINATIONS		
<i>estrogen, ester/me-testosterone</i>	T2	HD
ESTROGENIC AGENTS		
ACTIVELLA (<i>estradiol/norethindrone acet</i>)	T4	HD
CLIMARA (<i>estradiol</i>)	T4	QL(4 patches/28 days) HD
COMBIPATCH	T3	HD
DELESTROGEN	T4	HD

T1 – Preferred Generics
 T2 – Non-Preferred Generics
 T3 – Preferred Brands
 T4 – Non-Preferred Brands

T5 – Brand Specialty
 PA – Prior Authorization
 QL – Quantity Limit

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

HD – May require home delivery pharmacy
 PPACA – No Cost-Share Preventive Medication
 CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

HORMONES (Hormonal Agents) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ESTROGENIC AGENTS (cont.)		
DELESTROGEN (<i>estradiol valerate</i>)	T4	HD
DEPO-ESTRADIOL	T3	HD
ESTRACE 0.5 MG TABLET (<i>estradiol</i>)	T4	HD
ESTRACE 1 MG TABLET (<i>estradiol</i>)	T4	HD
ESTRACE 2 MG TABLET (<i>estradiol</i>)	T4	HD
<i>estradiol</i> (Climara)	T2	QL(4 patches/28 days) HD
<i>estradiol</i> 0.1% (0.25mg) gel pk (Divigel)	T2	QL(30 packs/fill) HD
<i>estradiol</i> 0.1% (0.75mg) gel pk (Divigel)	T2	QL(30 packs/fill) HD
<i>estradiol</i> 0.1% (1 mg) gel pkt (Divigel)	T2	QL(30 packs/fill) HD
<i>estradiol</i> 0.1% (1.25mg) gel pk	T2	QL(30 packs/fill) HD
<i>estradiol</i> 0.5 mg tablet (Estrace)	T2	HD
<i>estradiol</i> 1 mg tablet (Estrace)	T2	HD
<i>estradiol</i> 2 mg tablet (Estrace)	T2	HD
<i>estradiol valerate</i> (Delestrogen)	T2	HD
<i>estradiol/norethindrone acet</i>	T2	HD
<i>estradiol/norethindrone acet</i> (Activella)	T2	HD
MENOSTAR	T4	QL(4 patches/28 days) HD
<i>norethind-eth estrad</i> 0.5-2.5	T2	HD
<i>norethindrone ac-eth estradiol</i>	T2	HD
<i>norethin-eth estrad</i> 1 mg-5 mcg	T2	HD
PREFEST	T4	HD
ESTROGEN-PROGESTIN WITH ANTIMINERALOCORTICOID COMB		
ANGELIQ	T4	HD
ESTROGEN-SELECTIVE ESTROGEN RECEPTOR MOD (SERM) COMB		
DUAVEE	T3	
GLUCOCORTICOIDS		
<i>budesonide</i>	T2	
<i>budesonide</i> (Uceris)	T2	
CORTEF (<i>hydrocortisone</i>)	T4	
<i>cortisone acetate</i>	T2	
<i>deflazacort</i> (Emflaza)	T2	PA SP HD
<i>dexamethasone</i>	T2	PA
<i>dexamethasone</i>	T2	
<i>dexamethasone</i> 0.5 mg tablet	T1	

T1 – Preferred Generics
 T2 – Non-Preferred Generics
 T3 – Preferred Brands
 T4 – Non-Preferred Brands

T5 – Brand Specialty
 PA – Prior Authorization
 QL – Quantity Limit

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

HD – May require home delivery pharmacy
 PPACA – No Cost-Share Preventive Medication
 CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

HORMONES (Hormonal Agents) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
GLUCOCORTICOIDS (cont.)		
<i>dexamethasone 0.5 mg/5 ml elx</i>	T1	
<i>dexamethasone 0.5 mg/5 ml liq</i>	T2	
<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>	T2	PA
<i>dexamethasone 13 day 1.5 mg tb</i>	T2	PA
<i>dexamethasone 2 mg tablet</i>	T1	
<i>dexamethasone 4 mg tablet</i>	T1	
<i>dexamethasone 6 day 1.5 mg tab</i>	T2	PA
<i>dexamethasone 6 mg tablet</i>	T1	
DEXONTO	T4	
DXEVO	T4	PA
<i>hydrocortisone (Cortef)</i>	T2	
MEDROL	T4	
MEDROL (<i>methylprednisolone</i>)	T4	
<i>methylprednisolone</i>	T2	
<i>methylprednisolone (Medrol)</i>	T2	
ORAPRED ODT (<i>prednisolone sodium phosphate</i>)	T4	
<i>prednisolone</i>	T2	
<i>prednisolone sodium phosphate</i>	T2	
<i>prednisolone sodium phosphate (Orapred Odt)</i>	T2	
<i>prednisone</i>	T2	
<i>prednisone</i>	T1	
RAYOS	T4	PA
TAPERDEX	T4	PA
TARPEYO	T5	PA QL(28 caps/30 days) SP
UCERIS 9 MG ER TABLET (<i>budesonide</i>)	T4	
ZCORT	T4	PA
GROWTH HORMONE RELEASING HORMONE (GHRH) AND ANALOGS		
EGRIFTA SV	T5	PA SP HD
GROWTH HORMONES		
GENOTROPIN	T5	PA SP HD
OMNITROPE	5	PA SP

T1 – Preferred Generics
T2 – Non-Preferred Generics
T3 – Preferred Brands
T4 – Non-Preferred Brands

T5 – Brand Specialty
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
GROWTH HORMONES (cont.)		
SEROSTIM	T5	PA SP HD
ZORBTIVE	T5	PA SP HD
INSULIN-LIKE GROWTH FACTOR-I (IGF-I) HORMONES		
INCRELEX	T5	PA SP HD
LHRH (GNRH) AGONIST ANALOG PITUITARY SUPPRESSANTS		
SYNAREL	T5	PA SP HD
LHRH (GNRH) ANTAGONIST, ESTROGEN AND PROGESTIN COMB		
MYFEMBREE	T3	PA
ORIAHNN	T3	PA
LHRH (GNRH) ANTAGONIST, PITUITARY SUPPRESSANT AGENTS		
<i>cetorelix acetate</i>	T2	SP
CETROTIDE	T5	SP
GANIRELIX ACET 250 MCG/0.5 ML (<i>ganirelix acetate</i>)	T5	ST SP
<i>ganirelix acet 250 mcg/0.5 ml</i> (Ganirelix Acetate)	T2	ST SP
<i>ganirelix acetate</i> (Ganirelix Acetate)	T2	SP
ORLISSA 150 MG TABLET	T3	PA QL(30 tabs/fill)
ORLISSA 200 MG TABLET	T3	PA QL(60 tabs/fill)
MINERALOCORTICIDS		
<i>fludrocortisone acetate</i>	T1	HD
OXYTOCICS		
CERVIDIL	T4	
<i>methylgonovine maleate</i>	T2	PA QL(240 tabs/fill)
PREPIDIL	T4	
PROSTIN E2 VAGINAL SUPPOSITORY	T4	
PARATHYROID HORMONES		
NATPARA	T5	PA SP HD
PITUITARY SUPPRESSIVE AGENTS		
<i>cabergoline</i>	T2	QL(8 tabs/28 days) HD
<i>danazol</i>	T2	HD
PROGESTATIONAL AGENTS		
AYGESTIN (<i>norethindrone acetate</i>)	T4	HD
<i>medroxyprogesterone 10 mg tab</i> (Provera)	T2	HD
<i>medroxyprogesterone 2.5 mg tab</i> (Provera)	T2	HD
<i>medroxyprogesterone 5 mg tab</i> (Provera)	T2	HD

T1 – Preferred Generics
T2 – Non-Preferred Generics
T3 – Preferred Brands
T4 – Non-Preferred Brands

T5 – Brand Specialty
PA – Prior Authorization
QL – Quantity Limit

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

HD – May require home delivery pharmacy
PPACA – No Cost-Share Preventive Medication
CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

HORMONES (Hormonal Agents) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
PROGESTATIONAL AGENTS (cont.)		
<i>norethindrone acetate</i> (Aygestin)	T2	HD
<i>progesterone, micronized</i> (Prometrium)	T2	HD
PROMETRIUM (<i>progesterone, micronized</i>)	T4	HD
PROVERA (<i>medroxyprogesterone acetate</i>)	T4	HD
SOMATOSTATIC AGENTS		
MYCAPSSA	T5	PA QL (56 caps/28 days) SP
VAGINAL ESTROGEN PREPARATIONS		
<i>estradiol</i> (Vagifem)	T2	HD
<i>estradiol 0.01% cream</i> (Estrace)	T2	HD
<i>estradiol 10 mcg vaginal insrt</i> (Vagifem)	T2	HD
PREMARIN VAGINAL CREAM-APPL	T3	HD
HORMONES (Infertility)		
FERTILITY STIMULATING PREPARATIONS, NON-FSH		
<i>clomiphene citrate</i>	T2	
FOLLICLE-STIMULATING AND LUTEINIZING HORMONES		
MENOPUR	T5	SP
FOLLICLE-STIMULATING HORMONE (FSH)		
FOLLISTIM AQ	T5	ST SP
GONAL-F	T5	ST SP
GONAL-F RFF	T5	ST SP
GONAL-F RFF REDI-JECT	T5	ST SP
HUMAN CHORIONIC GONADOTROPIN (HCG)		
CHORIONIC GONAD 10,000 UNIT VL	T5	ST QL (3 vials/30 days) SP
CHORIONIC GONAD 12,000 UNIT VL	T5	ST SP
CHORIONIC GONAD 50,000 UNIT VL	T5	ST SP
CHORIONIC GONAD 6,000 UNIT VL	T5	ST SP
NOVAREL	T5	QL(6 vls/30 days) SP
OVIDREL	T5	SP
PREGNYL	T5	ST QL (3 vials/fill) SP
PREGNANCY FACILITATING/MAINTAINING AGENT, HORMONAL		
CRINONE	T3	
ENDOMETRIN	T4	

T1 – Preferred Generics
T2 – Non-Preferred Generics
T3 – Preferred Brands
T4 – Non-Preferred Brands

T5 – Brand Specialty
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 (Miscellaneous)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
LEPTIN HORMONE ANALOGS		
MYALEPT	T5	PA SP HD
HORMONES (Osteoporosis Products)		
BONE FORMATION STIMULATING AGTS - PTH REL PEPTIDES		
TYMLOS	T5	PA QL(1 pen/fill) SP HD
BONE RESORPTION INHIBITORS		
<i>calcitonin, salmon, synthetic</i>	T2	HD
<i>calcitonin, salmon, synthetic (Miacalcin)</i>	T2	HD
MIACALCIN (<i>calcitonin, salmon, synthetic</i>)	T4	HD
IMMUNOSUPPRESSANTS (Pain Relief And Inflammatory Disease)		
HUMAN INTERLEUKIN 12/23 (IL-12/13) INHIBITORS, MAB		
STELARA	T5	PA QL SP HD
IL-23 RECEPTOR ANTAGONIST, MONOCLONAL ANTIBODY		
OMVOH PEN	T5	
SKYRIZI ON-BODY	T5	PA QL(1 cartridge/56 days) SP HD
INTERLEUKIN-4(IL-4) RECEPTOR ALPHA ANTAGONIST, MAB		
DUPIXENT 100 MG/0.67 ML SYRING	T5	PA QL(2 syringes/28 days) SP HD
DUPIXENT 200 MG/1.14 ML PEN	T5	PA QL(400 mgs/28 days) SP HD
DUPIXENT 200 MG/1.14 ML SYRING	T5	PA QL(400 mgs/28 days) SP HD
DUPIXENT 300 MG/2 ML PEN	T5	PA QL(600 mgs/28 days) SP HD
DUPIXENT 300 MG/2 ML SYRINGE	T5	PA QL(600 mgs/28 days) SP HD
INTERLEUKIN-6 (IL-6) RECEPTOR INHIBITORS		
ACTEMRA	T5	PA QL(3.6 mls/28 days) SP HD
ACTEMRA ACTPEN	T5	PA QL(2 pens/28 days) SP HD
ENSPRYNG	T5	PA SP HD
IMMUNOSUPPRESSANTS (Skin Conditions)		
TOPICAL IMMUNOSUPPRESSIVE AGENTS		
HYFTOR	T5	PA SP
<i>pimecrolimus (Elidel)</i>	T2	ST QL(120 gms/30 days)
PROTOPIC (<i>tacrolimus</i>)	T4	ST QL(120 gms/30 days)
<i>tacrolimus 0.03% ointment (Protopic)</i>	T2	ST QL(120 gms/30 days)
IMMUNOSUPPRESSANTS (Transplant Medications)		
IMMUNOSUPPRESSIVES		
ASTAGRAF XL	T5	PA SP HD

T1 – Preferred Generics
 T2 – Non-Preferred Generics
 T3 – Preferred Brands
 T4 – Non-Preferred Brands

T5 – Brand Specialty
 PA – Prior Authorization
 QL – Quantity Limit

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

HD – May require home delivery pharmacy
 PPACA – No Cost-Share Preventive Medication
 CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

IMMUNOSUPPRESSANTS (Transplant Medications) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
IMMUNOSUPPRESSIVES (cont.)		
AZASAN (<i>azathioprine</i>)	T5	SP HD
<i>azathioprine</i> (Azasan)	T2	SP HD
<i>azathioprine</i> (Imuran)	T2	SP HD
CELLCEPT (<i>mycophenolate mofetil</i>)	T5	SP HD
<i>cyclosporine 100 mg capsule</i> (Sandimmune)	T2	SP HD
<i>cyclosporine 25 mg capsule</i> (Sandimmune)	T2	SP HD
<i>cyclosporine, modified</i>	T2	SP HD
<i>cyclosporine, modified</i> (Neoral)	T2	SP HD
<i>everolimus 0.25 mg tablet</i> (Zortress)	T2	SP HD
<i>everolimus 0.5 mg tablet</i> (Zortress)	T2	SP HD
<i>everolimus 0.75 mg tablet</i> (Zortress)	T2	SP HD
<i>everolimus 1 mg tablet</i> (Zortress)	T2	SP HD
IMURAN (<i>azathioprine</i>)	T5	SP HD
LUPKYNIS	T5	PA QL (180 caps/30 days) SP
<i>mycophenolate mofetil</i> (Cellcept)	T2	SP HD
<i>mycophenolate sodium</i> (Myfortic)	T2	SP HD
MYFORTIC (<i>mycophenolate sodium</i>)	T5	SP HD
NEORAL (<i>cyclosporine, modified</i>)	T5	SP HD
PROGRAF 0.2 MG GRANULE PACKET	T5	SP HD
PROGRAF 0.5 MG CAPSULE (<i>tacrolimus</i>)	T5	SP HD
PROGRAF 1 MG CAPSULE (<i>tacrolimus</i>)	T5	SP HD
PROGRAF 1 MG GRANULE PACKET	T5	SP HD
PROGRAF 5 MG CAPSULE (<i>tacrolimus</i>)	T5	SP HD
RAPAMUNE (<i>sirolimus</i>)	T5	SP HD
SANDIMMUNE 100 MG CAPSULE (<i>cyclosporine</i>)	T5	SP HD
SANDIMMUNE 100 MG/ML SOLN	T5	SP HD
SANDIMMUNE 25 MG CAPSULE (<i>cyclosporine</i>)	T5	SP HD
<i>sirolimus</i> (Rapamune)	T2	SP HD
<i>tacrolimus 0.5 mg capsule (ir)</i> (Prograf)	T2	SP HD
<i>tacrolimus 1 mg capsule (ir)</i> (Prograf)	T2	SP HD
<i>tacrolimus 5 mg capsule (ir)</i> (Prograf)	T2	SP HD
ZORTRESS (<i>everolimus</i>)	T5	SP HD

T1 – Preferred Generics
 T2 – Non-Preferred Generics
 T3 – Preferred Brands
 T4 – Non-Preferred Brands

T5 – Brand Specialty
 PA – Prior Authorization
 QL – Quantity Limit

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

HD – May require home delivery pharmacy
 PPACA – No Cost-Share Preventive Medication
 CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

MISCELLANEOUS MEDICAL SUPPLIES, DEVICES, NON-DRUG (Diabetes)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
DIABETIC SUPPLIES		
ZTEK	T4	
ACCU-CHEK AVIVA SOLUTION	T4	
ACCU-CHEK COMPACT PLUS CONTROL	T4	
ACCU-CHEK FASTCLIX LANCING DEV	T3	
ACCU-CHEK GUIDE CONTROL SOLN	T4	
ACCU-CHEK MULTICLIX LANCET KIT	T3	
ACCU-CHEK SMARTVIEW CONTRL SOL	T4	
ACCU-CHEK SOFTCLIX	T3	
ACCU-TREND GLUCOSE CONTROL	T4	
ADJUSTABLE LANCING DEVICE	T3	
ADVANCED LANCING DEVICE	T3	
ADVOCATE CONTROL SOLUTION	T4	
ADVOCATE LANCING DEVICE	T3	
ADVOCATE RAPID-SAFE LANCING DV	T3	
ADVOCATE REDI-CODE+ CTRL SOLN	T4	
AGAMATRIX CONTROL	T4	
ALKALINE BATTERIES	T4	
ALTERNATE SITE LANCING DEVICE	T3	
AQUA LANCE LANCING DEVICE	T3	
ASSURE 4 CONTROL SOLUTION	T4	
ASSURE DOSE	T4	
ASSURE PRISM	T4	
AT HOME A1C	T4	
AUTOJECT 2	T3	
AUTO-LANCET MINI	T3	
AUTOLET IMPRESSION	T3	
AUTOLET LANCING DEVICE	T3	
AUTOLET PLUS	T3	
AUTOPEN	T3	
AUTOSOFT 30	T3	
AUTOSOFT 90	T3	
AUTOSOFT XC	T3	
BLOOD GLUCOSE CONTROL	T4	
BLOOD-GLUCOSE CONTROL	T4	

T1 – Preferred Generics
T2 – Non-Preferred Generics
T3 – Preferred Brands
T4 – Non-Preferred Brands

T5 – Brand Specialty
PA – Prior Authorization
QL – Quantity Limit

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

HD – May require home delivery pharmacy
PPACA – No Cost-Share Preventive Medication
CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

MISCELLANEOUS MEDICAL SUPPLIES, DEVICES, NON-DRUG (Diabetes) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
DIABETIC SUPPLIES (cont.)		
BREEZE 2	T4	
CAREONE	T3	
CARESENS	T4	
CARETOUCH CONTROL SOLUTION	T4	
CARETOUCH LANCING DEVICE	T3	
CEQUR SIMPLICITY	T3	
CEQUR SIMPLICITY INSERTER	T3	
CHEMSTRIP BG DIARY	T4	
CLEVER CHOICE CONTROL SOLUTION	T4	
COMFORT	T3	
COMFORT SHORT	T3	
CONTACT DETACH INFUSION SET	T3	
CONTOUR	T4	
CONTOUR NEXT CONTROL SOLUTION	T4	
CONTROL SOLUTION	T4	
COOL CONTROL SOLUTION	T4	
DEXCOM G6 RECEIVER	T3	
DEXCOM G6 SENSOR	T3	PA QL(3 kits/30 days)
DEXCOM G6 TRANSMITTER	T3	PA QL(1 kit/90 days)
DEXCOM G7 RECEIVER	T3	
DEXCOM G7 SENSOR	T3	PA QL(3 units/30 days)
DIATRUE	T4	
DROPLET GENTEEL LANCING DEVICE	T3	
DROPLET LANCING DEVICE	T3	
EASY MINI EJECT LANCING DEVICE	T3	
EASY PLUS II CONTROL SOLN HIGH	T4	
EASY PLUS II CONTROL SOLN LOW	T4	
EASY STEP CONTROL SOLUTION	T4	
EASY TALK CONTROL SOLN LOW	T4	
EASY TALK HIGH CONTROL SOLN	T4	
EASY TALK PLUS II HIGH CONTROL	T4	
EASY TALK PLUS II LOW CTRL SLN	T4	
EASY TOUCH BLU LINK CTRL SOLN	T4	
EASY TOUCH CONTROL SOLUTION	T4	

T1 – Preferred Generics
T2 – Non-Preferred Generics
T3 – Preferred Brands
T4 – Non-Preferred Brands

T5 – Brand Specialty
PA – Prior Authorization
QL – Quantity Limit

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

HD – May require home delivery pharmacy
PPACA – No Cost-Share Preventive Medication
CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

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

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
DIABETIC SUPPLIES (cont.)		
EASY TOUCH LANCING DEVICE	T3	
EASY TRAK CONTROL SOLN HIGH	T4	
EASY TRAK CONTROL SOLN LOW	T4	
EASY TRAK II CONTROL SOLUTION	T4	
EASYGLUCO PLUS CONTROL NORMAL	T4	
EASYMAX 15 LEVEL 2 SOLUTION	T4	
EASYMAX NORMAL CONTROL SOLN	T4	
ELEMENT COMPACT CONTROL SOLN	T4	
ELEMENT CONTROL SOLUTION	T4	
EMBRACE EVO LEVEL 1 CTRL SOLN	T4	
EMBRACE GLUC CONTROL SOLN HIGH	T4	
EMBRACE GLUCOSE CONTROL SOLN	T4	
EMBRACE LANCING DEVICE	T3	
EMBRACE PRO	T4	
EMBRACE TALK CONTROL SOLUTION	T4	
ENLITE SERTER	T4	
EVENCARE G2 CONTROL SOLUTION	T4	
EVENCARE G3 CONTROL SOLUTION	T4	
EVOLUTION CONTROL SOLUTION	T4	
FORA CONTROL SOLUTION	T4	
FORA GTEL MULTIFUNCTN MONITOR	T4	
FORA KETONE CONTROL SOLUTION	T4	
FORA LANCING DEVICE	T3	
FORA TN'G ADVANCE PRO MONITOR	T4	
FORA TN'GO ADVANCE MULTIFN MTR	T4	
FORACARE GDH	T4	
FORTISCARE	T4	
FREESTYLE CONTROL SOLUTION	T3	
FREESTYLE LIBRE 10 DAY READER	T3	PA
FREESTYLE LIBRE 10 DAY SENSOR	T3	PA
FREESTYLE LIBRE 14 DAY READER	T3	PA
FREESTYLE LIBRE 14 DAY SENSOR	T3	PA QL(2 kits/30 days)
FREESTYLE LIBRE 2 READER	T3	PA
FREESTYLE LIBRE 2 SENSOR	T3	PA QL(2 sensors/28 days)

T1 – Preferred Generics
 T2 – Non-Preferred Generics
 T3 – Preferred Brands
 T4 – Non-Preferred Brands

T5 – Brand Specialty
 PA – Prior Authorization
 QL – Quantity Limit

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

HD – May require home delivery pharmacy
 PPACA – No Cost-Share Preventive Medication
 CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

MISCELLANEOUS MEDICAL SUPPLIES, DEVICES, NON-DRUG (Diabetes) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
DIABETIC SUPPLIES (cont.)		
FREESTYLE LIBRE 3 SENSOR	T3	PA QL(2units/28 days)
FREESTYLE NAVIGATOR SENSOR KIT	T3	
GE100 CONTROL SOLUTION NORMAL	T4	
GENTEEL VACUUM LANCING DEVICE	T4	
GLUCOCARD 01 CONTROL	T4	
GLUCOCARD EXPRESSION CNTRL SLN	T4	
GLUCOCARD SHINE CONTROL SOLN	T4	
GLUCOCOM AUTOLINK	T4	
GLUCOCOM CONTROL SOLUTION	T4	
GLUCOSE CONTROL	T4	
GLUCOSE CONTROL SOLUTION	T4	
GOJJI GLUCOSE CONTROL SOLUTION	T4	
GOJJI KETONE CONTROL SOLUTION	T4	
GOJJI LANCING DEVICE	T3	
GOJJI MULTI-FUNCTIONAL METER	T4	PA QL (1 transmitter/273 days)
GUARDIAN 4 GLUCOSE SENSOR	T4	PA QL (5 sensors/30 days)
GUARDIAN 4 TRANSMITTER	T4	PA QL (1 transmitter/273 days)
GUARDIAN LINK 3 TRANSMITTER	T4	
GUARDIAN RT CHARGER	T4	
GUARDIAN RT STARTER KIT	T4	
GUARDIAN RT SYSTEM	T4	
GUARDIAN TEST PLUG	T4	
GUARDIAN TRANSMITTER TAPE	T4	
HEALTHPRO GLUCOSE CONTROL SOLN	T4	
HEALTHY ACCENTS AUTOLET	T3	
HYPOLANCE	T3	
ILET INFUSION KIT-INSET	T3	
ILET INFUSION-CONTACT DETACH	T3	
INCONTROL LANCING DEVICE	T3	
INFINITY CONTROL SOLUTION	T4	
INFINITY VOICE CONTROL SOLN	T4	
INPEN (FOR HUMALOG)	T4	
INPEN (FOR NOVOLOG OR FIASP)	T4	
INSUL-CAP	T4	

T1 – Preferred Generics
T2 – Non-Preferred Generics
T3 – Preferred Brands
T4 – Non-Preferred Brands

T5 – Brand Specialty
PA – Prior Authorization
QL – Quantity Limit

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

HD – May require home delivery pharmacy
PPACA – No Cost-Share Preventive Medication
CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

MISCELLANEOUS MEDICAL SUPPLIES, DEVICES, NON-DRUG (Diabetes) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
DIABETIC SUPPLIES (cont.)		
INSUL-EZE	T3	
LANCING DEVICE	T3	
LANCING SYSTEM	T3	
LANZO	T3	
LITE TOUCH LANCING PEN	T3	
MEDISENSE	T3	
MEDISENSE GLUCOSE KETONE	T3	
MEDISENSE GLUCOSE KETONE CONTR	T3	
MEDTRONIC EXT INFUSION SET	T3	
MEDTRONIC REMOTE CONTROL	T4	
MICRODOT HIGH-LOW CONTROL SOL	T4	
MICRODOT NORMAL CONTROL SOLUT	T3	
MICROLET 2	T3	
MICROLET NEXT LANCING DEVICE	T3	
MINI LANCING DEVICE	T2	
MINIMED	T3	
MINIMED MIO	T3	
MINIMED MIO ADVANCE	T3	
MINIMED QUICK SET	T3	
MINIMED QUICK-SERTER	T4	
MINIMED QUICK-SERTER	T3	
MINIMED SILHOUETTE	T3	
MINIMED SURE T	T3	
MULTI-LANCET	T3	
MYGLUCOHEALTH CONTROL SOLUTION	T4	
NOVA MAX PLUS GLUC-KETON METER	T4	
NOVAMAX PLUS GLU-KET	T4	
NOVOPEN 3	T3	
NOVOPEN ECHO	T4	
OMNIPOD 5 G6 INTRO KIT (GEN 5)	T3	QL(1 kit/720 days)
OMNIPOD 5 G6 PODS (GEN 5)	T3	QL(15 pods/28 days)
OMNIPOD CLASSIC PODS (GEN 3)	T3	QL(15 pods/28 days)
OMNIPOD DASH INTRO KIT (GEN 4)	T3	QL(1 kit/720 days)
OMNIPOD DASH PODS (GEN 4)	T3	QL(15 pods/28 days)

T1 – Preferred Generics
T2 – Non-Preferred Generics
T3 – Preferred Brands
T4 – Non-Preferred Brands

T5 – Brand Specialty
PA – Prior Authorization
QL – Quantity Limit

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

HD – May require home delivery pharmacy
PPACA – No Cost-Share Preventive Medication
CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

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

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
DIABETIC SUPPLIES (cont.)		
OMNIPOD GO PODS	T3	QL(10 crtgs/30 days)
ON CALL EXPRESS CONTROL SOLN	T4	
ON CALL LANCING DEVICE	T3	
ON CALL PLUS CONTROL	T4	
ON CALL PLUS LANCING DEVICE	T3	
ON CALL VIVID CONTROL	T4	
ONETOUCH DELICA	T3	
ONETOUCH DELICA PLUS LANC DEV	T3	
ONETOUCH ULTRA CONTROL SOLN	T3	
ONETOUCH VERIO HIGH CNTRL SOLN	T3	
ONETOUCH VERIO MID CNTRL SOLN	T3	
OPTUMRX GLUCOSE CONTROL SOLN	T4	
OVAL TAPE	T4	
PARADIGM REMOTE CONTROL	T4	
PIP GLUCOSE CONTROL SOLUTION	T4	
PRECISION XTRA KETONE-GLUCOSE	T3	
PRODIGY CONTROL SOLUTION	T4	
PRODIGY LANCING DEVICE	T3	
QUICK RELEASE SOFT TEFLON	T3	
REFUAH PLUS GLUCOSE CONTROL	T4	
RELIAMED MINI LANCING DEVICE	T3	
REPLACEMENT PEDIATRIC MONITOR	T4	
RIGHTEST CONTROL SOLUTION	T4	
RIGHTEST GD500	T3	
SAFE-CLIP	T3	
SEN-SERTER	T4	
SILHOUETTE	T3	
SIL-SERTER	T3	
SMARTDIABETES VANTAGE	T3	
SMARTEST	T4	
SOF-SERTER	T3	
SOF-SET	T3	
SOF-SET MICRO	T3	
SOLLUS V2 CONTROL SOLUTION	T4	

T1 – Preferred Generics
 T2 – Non-Preferred Generics
 T3 – Preferred Brands
 T4 – Non-Preferred Brands

T5 – Brand Specialty
 PA – Prior Authorization
 QL – Quantity Limit

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

HD – May require home delivery pharmacy
 PPACA – No Cost-Share Preventive Medication
 CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

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

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
DIABETIC SUPPLIES (cont.)		
SOLUS V2 LANCING DEVICE	T3	
SURE COMFORT LANCING PEN	T3	
SUREFLEX	T3	
SURE-PEN	T3	
SURE-TEST EASYPLUS MINI SOLN	T4	
T:30 INFUSION SET	T3	
T:90	T3	
T:FLEX	T3	
T:SLIM	T3	
T:SLIM G4	T3	
T:SLIM X2	T3	
TELCARE CONTROL SOLUTION	T4	
TRUE METRIX	T4	
TRUECONTROL	T4	
TRUEDRAW	T3	
TRUSTEEL INFUSION SET	T3	
ULTI-LANCE	T3	
ULTRATRAK CONTROL SOL NORMAL	T4	
ULTRATRAK CONTROL SOLUTION	T4	
ULTRATRAK ULTIMATE CNTRL SOLN	T4	
UNISTIK 2	T3	
UNISTRIP	T4	
VARISOFT INFUSION SET	T3	
V-GO 20	T3	
V-GO 30	T3	
V-GO 40	T3	
VIVAGUARD INO CONTROL SOLUTION	T4	
VIVAGUARD LANCING DEVICE	T3	
WAVESENSE CONTROL SOLUTION	T4	
DURABLE MEDICAL EQUIPMENT, MISC (GROUP I)		
1ST TIER UNILET COMFORTOUCH	T3	
2-IN-1 LANCET DEVICE	T3	
ACCU-CHEK FASTCLIX LANCET DRUM	T3	
ACCU-CHEK SAFE-T-PRO	T3	

T1 – Preferred Generics
 T2 – Non-Preferred Generics
 T3 – Preferred Brands
 T4 – Non-Preferred Brands

T5 – Brand Specialty
 PA – Prior Authorization
 QL – Quantity Limit

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

HD – May require home delivery pharmacy
 PPACA – No Cost-Share Preventive Medication
 CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

MISCELLANEOUS MEDICAL SUPPLIES, DEVICES, NON-DRUG (Diabetes) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
DURABLE MEDICAL EQUIPMENT,MISC(GROUP I) (cont.)		
ACCU-CHEK SAFE-T-PRO PLUS	T3	
ACCU-CHEK SOFTCLIX	T3	
<i>acti-lance lite 28g lancets</i>	T2	
<i>acti-lance special 17g lancets</i>	T2	
<i>acti-lance univers 23g lancets</i>	T2	
ACTI-LANCE UNIVERS 23G LANCETS	T3	
ADVANCED TRAVEL LANCETS	T3	
ADVOCATE LANCET	T3	
ADVOCATE LANCETS	T3	
ADVOCATE SAFETY LANCET	T3	
ALTERNATE SITE LANCETS	T3	
ASSURE HAEMOLANCE PLUS	T3	
ASSURE LANCE	T3	
ASSURE LANCE PLUS	T3	
BD MICROTAINER LANCETS	T3	
BLOOD LANCETS	T3	
BULLSEYE MINI SAFETY LANCETS	T3	
BUTTERFLY TOUCH LANCET	T3	
CAREONE	T3	
CARESENS LANCET	T3	
CARETOUCH SAFETY LANCETS	T3	
CARETOUCH TWIST LANCET	T3	
CLEVER CHEK LANCETS	T3	
COAGUCHEK	T3	
COLOR LANCETS	T3	
COMFORT EZ	T3	
COMFORT LANCETS	T3	
COMFORT TOUCH PLUS SAFETY LANC	T3	
COMFORT TOUCH ULT THIN LANCET	T3	
DROPLET LANCETS	T3	
EASY COMFORT LANCETS	T3	
EASY TOUCH PULL-TOP 26G LANCET	T3	
EASY TOUCH PULL-TOP 28G LANCET	T3	
EASY TOUCH PULL-TOP 30G LANCET	T3	

T1 – Preferred Generics
 T2 – Non-Preferred Generics
 T3 – Preferred Brands
 T4 – Non-Preferred Brands

T5 – Brand Specialty
 PA – Prior Authorization
 QL – Quantity Limit

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

HD – May require home delivery pharmacy
 PPACA – No Cost-Share Preventive Medication
 CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

MISCELLANEOUS MEDICAL SUPPLIES, DEVICES, NON-DRUG (Diabetes) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
DURABLE MEDICAL EQUIPMENT,MISC(GROUP I) (cont.)		
EASY TOUCH PULL-TOP 32G LANCET	T3	
EASY TOUCH SAFETY 21G LANCETS	T3	
EASY TOUCH SAFETY 23G LANCETS	T3	
EASY TOUCH SAFETY 26G LANCETS	T3	
EASY TOUCH SAFETY 28G LANCETS	T3	
EASY TOUCH SAFETY 30G LANCETS	T3	
EASY TOUCH SAFETY 32G LANCETS	T3	
EASY TOUCH TWIST 26G LANCETS	T3	
EASY TOUCH TWIST 28G LANCETS	T3	
EASY TOUCH TWIST 30G LANCETS	T3	
EASY TOUCH TWIST 32G LANCETS	T3	
EASY TOUCH TWIST 33G LANCETS	T3	
EASY TWIST & CAP LANCETS	T3	
EMBRACE 30G LANCETS	T3	
EMBRACE SAFETY LANCET	T3	
EZ SMART LANCETS	T3	
EZ-LETS	T3	
FIFTY50 SAFETY SEAL LANCETS	T3	
FINE 30 UNIVERSAL LANCETS	T3	
FINGERSTIX	T3	
FORA LANCETS	T3	
FORACARE LANCETS	T3	
FREESTYLE LANCETS	T3	
FREESTYLE UNISTIK 2	T3	
GLUCOCOM	T3	
GLUCOCOM LANCETS	T3	
GOJJI LANCETS	T3	
HEALTHY ACCENTS UNILET LANCET	T3	
INCONTROL SUPER THIN LANCETS	T3	
INCONTROL ULTRA THIN LANCETS	T3	
INJECT EASE LANCETS	T3	
INVACARE LANCETS	T3	
<i>lancets</i>	T2	
LANCETS	T3	

T1 – Preferred Generics
T2 – Non-Preferred Generics
T3 – Preferred Brands
T4 – Non-Preferred Brands

T5 – Brand Specialty
PA – Prior Authorization
QL – Quantity Limit

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

HD – May require home delivery pharmacy
PPACA – No Cost-Share Preventive Medication
CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

MISCELLANEOUS MEDICAL SUPPLIES, DEVICES, NON-DRUG (Diabetes) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
DURABLE MEDICAL EQUIPMENT,MISC(GROUP I) (cont.)		
LANCETS THIN	T3	
LANCETS ULTRA THIN	T3	
LITE TOUCH 28G LANCETS	T3	
LITE TOUCH 30G LANCETS	T3	
LITE TOUCH 33G LANCETS	T3	
MEDISENSE THIN LANCETS	T3	
<i>medlance plus 21g lancets</i>	T2	
MEDLANCE PLUS 21G LANCETS	T3	
<i>medlance plus 30g lancets</i>	T2	
MEDLANCE PLUS 30G LANCETS	T3	
MEDLANCE PLUS EXTRA 21G LANCET	T3	
<i>medlance plus lite 25g lancets</i>	T2	
MEDLANCE PLUS LITE 25G LANCETS	T3	
MICRO THIN LANCET	T3	
MICRO THIN LANCETS	T3	
MICROLET	T3	
MOBILE LANCETS	T3	
MONOLET LANCETS	T3	
MONOLET THIN LANCETS	T3	
MYGLUCOHEALTH LANCETS	T3	
NOVA SAFETY LANCETS	T3	
NOVA SUREFLEX	T3	
ON CALL LANCET	T3	
ON CALL PLUS LANCET	T3	
ONETOUCH DELICA PLUS LANCET	T3	
ONETOUCH DELICA SAFETY LANCET	T3	
ONETOUCH LANCETS	T3	
ONETOUCH SURESOFT	T3	
ONETOUCH ULTRASOFT 2 LANCET	T3	
ON-THE-GO	T3	
PIP LANCET	T3	
PRESSURE ACTIVATED LANCETS	T3	
PRO COMFORT LANCET	T3	
PRO COMFORT LANCETS	T3	

T1 – Preferred Generics
T2 – Non-Preferred Generics
T3 – Preferred Brands
T4 – Non-Preferred Brands

T5 – Brand Specialty
PA – Prior Authorization
QL – Quantity Limit

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

HD – May require home delivery pharmacy
PPACA – No Cost-Share Preventive Medication
CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

MISCELLANEOUS MEDICAL SUPPLIES, DEVICES, NON-DRUG (Diabetes) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
DURABLE MEDICAL EQUIPMENT,MISC(GROUP I) (cont.)		
PRO COMFORT SAFETY LANCET	T3	
PRODIGY LANCETS	T3	
PRODIGY TWIST TOP LANCET	T3	
PURE COMFORT LANCETS	T3	
PURE COMFORT SAFETY LANCETS	T3	
PUSH BUTTON SAFETY LANCETS	T3	
READYLANCE SAFETY LANCETS	T3	
RELIAMED	T3	
RELIAMED SAFETY SEAL LANCETS	T3	
RELION THIN	T3	
RIGHTEST GL300 LANCETS	T3	
SAFETY LANCETS	T3	
SAFETY SEAL LANCETS	T3	
SAFETY-LET	T3	
SINGLE-LET	T3	
SMART SENSE	T3	
SMART SENSE LANCETS	T3	
SMARTTEST LANCET	T3	
SOFT TOUCH	T3	
SOLUS V2	T3	
SOLUS V2 LANCETS	T3	
STERILANCE TL	T3	
STERILE LANCETS	T3	
SUPER THIN LANCETS	T3	
SURE COMFORT LANCETS	T3	
SURE-LANCE	T3	
SURE-TOUCH	T3	
TECHLITE LANCETS	T3	
TELCARE ULTRA THIN 30G LANCETS	T3	
THIN LANCETS	T3	
TOPCARE UNIVERSAL1 LANCET	T3	
TOPCARE UNIVERSAL1 THIN LANCET	T3	
TRUE COMFORT LANCET	T3	
TRUE COMFORT SAFETY LANCET	T3	

T1 – Preferred Generics
T2 – Non-Preferred Generics
T3 – Preferred Brands
T4 – Non-Preferred Brands

T5 – Brand Specialty
PA – Prior Authorization
QL – Quantity Limit

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

HD – May require home delivery pharmacy
PPACA – No Cost-Share Preventive Medication
CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

MISCELLANEOUS MEDICAL SUPPLIES, DEVICES, NON-DRUG (Diabetes) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
DURABLE MEDICAL EQUIPMENT,MISC(GROUP I) (cont.)		
TRUEPLUS LANCET	T3	
TRUEPLUS LANCETS	T3	
TWIST LANCETS	T3	
TWIST TOP LANCET	T3	
ULTILET BASIC	T3	
ULTILET CLASSIC	T3	
ULTILET LANCETS	T3	
ULTILET SAFETY	T3	
ULTRA THIN LANCET	T3	
ULTRA THIN LANCETS	T3	
ULTRA THIN PLUS	T3	
ULTRA THIN PLUS LANCETS	T3	
ULTRA-CARE LANCETS	T3	
ULTRALANCE	T3	
ULTRA-THIN II 28G LANCETS	T3	
ULTRA-THIN II 30G LANCETS	T3	
ULTRATLC LANCETS	T3	
UNILET COMFORTOUCH	T3	
UNILET EXCELITE	T3	
UNILET EXCELITE II	T3	
UNILET GP LANCET	T3	
UNILET LANCET	T3	
UNILET LANCETS	T3	
UNISTIK 2 COMFORT	T3	
UNISTIK 2 EXTRA	T3	
UNISTIK 2 NORMAL	T3	
UNISTIK 3	T3	
UNISTIK 3 COMFORT	T3	
UNISTIK 3 DUAL	T3	
UNISTIK 3 EXTRA	T3	
UNISTIK 3 NORMAL	T3	
UNISTIK COMFORT	T3	
UNISTIK CZT	T3	
UNISTIK EXTRA	T3	

T1 – Preferred Generics
T2 – Non-Preferred Generics
T3 – Preferred Brands
T4 – Non-Preferred Brands

T5 – Brand Specialty
PA – Prior Authorization
QL – Quantity Limit

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

HD – May require home delivery pharmacy
PPACA – No Cost-Share Preventive Medication
CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

MISCELLANEOUS MEDICAL SUPPLIES, DEVICES, NON-DRUG (Diabetes) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
DURABLE MEDICAL EQUIPMENT,MISC(GROUP I) (cont.)		
UNISTIK NORMAL	T3	
UNISTIK PRO	T3	
UNISTIK SAFETY	T3	
UNISTIK TOUCH	T3	
UNIVERSAL 1	T3	
VERIFINE SAFETY LANCET MINI	T3	
VERIFINE UNIVERSAL LANCET	T3	
VIVAGUARD LANCET	T3	
NEEDLES/NEEDLELESS DEVICES		
AUTOSHIELD DUO PEN NEEDLE	T3	
BD ECLIPSE NEEDLE 18G 40MM	T4	
BD ECLIPSE NEEDLE 21GX1"	T3	
BD ECLIPSE NEEDLE 22GX1"	T3	
BD ECLIPSE NEEDLE 23GX1"	T4	
BD ECLIPSE NEEDLE 25G 16MM	T4	
BD ECLIPSE NEEDLE 25G 25MM	T4	
BD ECLIPSE NEEDLE 25GX1"	T3	
BD ECLIPSE NEEDLE 25GX1.5"	T3	
BD ECLIPSE NEEDLE 25GX5/8"	T4	
BD ECLIPSE NEEDLE 27GX1/2"	T4	
BD ECLIPSE NEEDLES 21GX1.5"	T3	
BD NEEDLES 21GX1"	T3	
BD NEEDLES 21GX1.5"	T3	
BD NEEDLES 22GX1"	T3	
BD NEEDLES 25GX0.875"	T3	
BLUNT NEEDLE	T3	
CAREPOINT PRECISION NEEDLE	T4	
CARETOUCH HYPODERMIC NEEDLE	T4	
CHEMO TRANSFER PIN	T3	
EASY TOUCH FLIPLOCK NEEDLE	T4	
EASY TOUCH FLIPLOCK NEEDLES	T4	
EASY TOUCH HYPODERMIC NEEDLE	T4	
EASYPOINT NEEDLE	T4	
EXEL HUBER NEEDLE	T3	

T1 – Preferred Generics
T2 – Non-Preferred Generics
T3 – Preferred Brands
T4 – Non-Preferred Brands

T5 – Brand Specialty
PA – Prior Authorization
QL – Quantity Limit

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

HD – May require home delivery pharmacy
PPACA – No Cost-Share Preventive Medication
CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

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

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
NEEDLES/NEEDLELESS DEVICES (cont.)		
EXEL HYPODERMIC NEEDLE	T3	
EXEL MTI DRAWING NEEDLE	T3	
FILTER ASPIRATOR NEEDLE	T3	
FILTER NEEDLE	T3	
FLOW-EZE	T3	
HURRICANE LUER-LOCK	T3	
HYPODERMIC NEEDLE	T3	
INTEGRA NEEDLE	T3	
INTEGRA PRECISIONGLIDE NEEDLE	T4	
LIFESHIELD BLUNT CANNULA	T3	
MINI TRANSFER PIN	T3	
MONOJECT BLOOD COLLECTION	T3	
MONOJECT FILTER NEEDLE	T4	
NANO 2ND GEN PEN NEEDLE	T3	
NEEDLE	T3	
needles,safety huber,disposabl	T2	
NOKOR ADMIX NEEDLE	T3	
NOKOR NEEDLE	T3	
PEN NEEDLE 30G X 8MM	T4	
PHASEAL PROTECTOR	T4	
POLY HUB NEEDLE	T3	
PRECISIONGLIDE	T3	
QUINCE SPINAL NEEDLE	T3	
RAYA SURE PEN NEEDLE 29G 12MM	T4	
RAYA SURE PEN NEEDLE 31G 5MM	T4	
RAYA SURE PEN NEEDLE 31G 6MM	T4	
REGULAR BEVEL NEEDLES	T3	
SAFETYGLIDE NEEDLE	T3	
SHORT BEVEL NEEDLES	T3	
SPECIALTY USE NEEDLES	T3	
TERUMO SURGUARD2	T3	
THIN WALL NEEDLES	T3	
TRANSFER NEEDLE	T3	
TRANSFER PIN	T3	

T1 – Preferred Generics
T2 – Non-Preferred Generics
T3 – Preferred Brands
T4 – Non-Preferred Brands

T5 – Brand Specialty
PA – Prior Authorization
QL – Quantity Limit

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

HD – May require home delivery pharmacy
PPACA – No Cost-Share Preventive Medication
CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

MISCELLANEOUS MEDICAL SUPPLIES, DEVICES, NON-DRUG (Diabetes) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
NEEDLES/NEEDLELESS DEVICES (cont.)		
ULTRA-FINE MICRO PEN NEEDLE	T3	
ULTRA-FINE MINI PEN NEEDLE	T3	
ULTRA-FINE NANO PEN NEEDLE	T3	
ULTRA-FINE ORIGINAL PEN NEEDLE	T3	
ULTRA-FINE SHORT PEN NEEDLE	T3	
YALE NEEDLE	T3	
YALE NEEDLES	T3	
SYRINGES AND ACCESSORIES		
ALLERGIST TRAY	T4	
ALLERGIST TRAY SYR-DETACH NDL	T3	
ALLERGIST TRAY SYR-PERM NEEDLE	T3	
ALLERGY SYRINGE 1 ML 27GX1/2"	T4	
ALLERGY SYRINGE 1 ML 27GX3/8"	T4	
BD ALLERGY SYRINGE-NEEDLE 1 ML	T3	
BD ECLIPSE LUER-LOK SYR 1 ML	T3	
BD ECLIPSE LUER-LOK SYR 3 ML	T3	
BD ECLIPSE SYR 3 ML 22GX1-1/2"	T4	
BD INS SYR 0.3 ML 8MMX31G(1/2)	T3	
BD INS SYR UF 0.3ML 12.7MMX30G	T3	
BD INS SYR UF 0.5ML 12.7MMX30G	T3	
BD INS SYRN UF 1 ML 12.7MMX30G	T3	
BD INS SYRNG 0.3 ML 29GX12.7MM	T3	
BD INS SYRNG 0.5 ML 29GX12.7MM	T3	
BD INS SYRNG UF 0.3 ML 8MMX31G	T3	
BD INS SYRNG UF 0.5 ML 8MMX31G	T3	
BD INSULIN SYR 0.5 ML 28GX1/2"	T3	
BD INSULIN SYR 0.5 ML 29GX1/2"	T3	
BD INSULIN SYR 1 ML 25GX1"	T3	
BD INSULIN SYR 1 ML 25GX5/8"	T3	
BD INSULIN SYR 1 ML 26GX1/2"	T3	
BD INSULIN SYR 1 ML 27GX12.7MM	T3	
BD INSULIN SYR 1 ML 27GX5/8"	T3	
BD INSULIN SYR 1 ML 28GX1/2"	T3	
BD INSULIN SYR 1 ML 29GX1/2"	T3	

T1 – Preferred Generics
 T2 – Non-Preferred Generics
 T3 – Preferred Brands
 T4 – Non-Preferred Brands

T5 – Brand Specialty
 PA – Prior Authorization
 QL – Quantity Limit

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

HD – May require home delivery pharmacy
 PPACA – No Cost-Share Preventive Medication
 CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

MISCELLANEOUS MEDICAL SUPPLIES, DEVICES, NON-DRUG (Diabetes) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
SYRINGES AND ACCESSORIES (cont.)		
BD INSULIN SYR 1 ML 29GX12.7MM	T3	
BD INSULIN SYR UF 1 ML 8MMX31G	T3	
BD INSULIN SYRINGE 1 ML	T3	
BD SAFETYGLIDE 3 ML SYRINGE	T3	
BD SAFETYGLIDE SYR 22GX1.5"	T3	
BD SAFETYGLIDE SYR 3 ML 25GX1"	T4	
BD SAFETYGLIDE SYRINGE 27GX5/8	T3	
BD SYRINGE-SAFETY GLIDE	T3	
BD UF INS SYR 1 ML 30GX1/2"	T3	
BULK SYRINGE	T3	
CANNULA	T3	
CAREPOINT LL SYR 3 ML 20GX1.5"	T3	
CAREPOINT LL SYR 3 ML 21GX1"	T3	
CAREPOINT LL SYR 3 ML 21GX1.5"	T3	
CAREPOINT LL SYR 3 ML 22G 38MM	T3	
CAREPOINT LL SYR 3 ML 22GX1"	T3	
CAREPOINT LL SYR 3 ML 23GX1"	T3	
CAREPOINT LL SYR 3 ML 23GX1.5"	T3	
CAREPOINT LL SYR 3 ML 25G X 1"	T3	
CAREPOINT LL SYR 3 ML 25GX5/8"	T3	
CAREPOINT LUER LOCK SYR 3 ML	T4	
CAREPOINT LUER SLIP SYRINGE	T4	
CAREPOINT LUER SLIP SYRING-NDL	T4	
CARETOUCH LUER LOCK	T3	
CARETOUCH LUER LOCK SYRINGE	T4	
CARETOUCH LUER SLIP SYRINGE	T4	
CORNWALL SYRINGE TIP CONNECTOR	T3	
DAVOL IRRIGATION SYRINGE	T3	
DOVER BULB SYRINGE	T4	
EASY GLIDE CATHETER TIP SYRING	T4	
EASY GLIDE LUER LOCK SYRINGE	T4	
EASY GLIDE LUER SLIP TB SYRING	T4	
EASY TOUCH FLIPLK 10ML 20GX1.5	T4	
EASY TOUCH FLIPLK 10ML 21GX1.5	T4	

T1 – Preferred Generics
 T2 – Non-Preferred Generics
 T3 – Preferred Brands
 T4 – Non-Preferred Brands

T5 – Brand Specialty
 PA – Prior Authorization
 QL – Quantity Limit

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

HD – May require home delivery pharmacy
 PPACA – No Cost-Share Preventive Medication
 CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

MISCELLANEOUS MEDICAL SUPPLIES, DEVICES, NON-DRUG (Diabetes) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
SYRINGES AND ACCESSORIES (cont.)		
EASY TOUCH FLIPLK 10ML 22GX1.5	T4	
EASY TOUCH FLIPLK 5 ML 20GX1.5	T4	
EASY TOUCH FLIPLK 5 ML 21GX1.5	T4	
EASY TOUCH FLIPLK 5 ML 22GX1.5	T4	
EASY TOUCH FLIPLCK	T4	
EASY TOUCH FLIPLCK 1 ML 25GX1	T3	
EASY TOUCH FLIPLCK 10ML 21GX1	T4	
EASY TOUCH FLIPLCK 3 ML 18GX1	T4	
EASY TOUCH FLIPLCK 3 ML 20GX1	T4	
EASY TOUCH FLIPLCK 3 ML 21GX1	T4	
EASY TOUCH FLIPLCK 5 ML 18GX1	T4	
EASY TOUCH FLIPLCK 5 ML 21GX1	T4	
EASY TOUCH FLIPLCK SYRINGE	T4	
EASY TOUCH FLIPLCK 10 ML 20GX1	T4	
EASY TOUCH FLIPLCK 10 ML 25GX1	T4	
EASY TOUCH FLIPLCK 1ML 26GX3/8	T3	
EASY TOUCH FLIPLCK 1ML 27GX0.5	T3	
EASY TOUCH FLIPLCK 3ML 18GX1.5	T4	
EASY TOUCH FLIPLCK 3ML 20GX1.5	T4	
EASY TOUCH FLIPLCK 3ML 21GX1.5	T4	
EASY TOUCH FLURINGE	T3	
EASY TOUCH FLURINGE FLIPLCK	T3	
EASY TOUCH FLURINGE FLU TRAY	T4	
EASY TOUCH FLURINGE SHEATHLOCK	T3	
EASY TOUCH LUER LOCK INSULIN	T4	
EASY TOUCH LUER LOCK SYRINGE	T4	
EASY TOUCH SHEATHLOCK SYRG-NDL	T4	
EASY TOUCH SHEATHLOCK SYRINGE	T4	
EASY TOUCH SYR 1 ML 25GX5/8"	T3	
EASY TOUCH SYR 3 ML 22GX1-1/2"	T3	
EASY TOUCH SYR 3 ML 25GX5/8"	T3	
EASY TOUCH SYR ALLERGY TRAY	T4	
EASY TOUCH SYRINGE 1 ML 25GX1"	T3	
EASY TOUCH SYRINGE 3 ML 20GX1"	T3	

T1 – Preferred Generics
 T2 – Non-Preferred Generics
 T3 – Preferred Brands
 T4 – Non-Preferred Brands

T5 – Brand Specialty
 PA – Prior Authorization
 QL – Quantity Limit

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

HD – May require home delivery pharmacy
 PPACA – No Cost-Share Preventive Medication
 CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

MISCELLANEOUS MEDICAL SUPPLIES, DEVICES, NON-DRUG (Diabetes) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
SYRINGES AND ACCESSORIES (cont.)		
EASY TOUCH SYRINGE 3 ML 21GX1"	T3	
EASY TOUCH SYRINGE 3 ML 22GX1"	T3	
EASY TOUCH SYRINGE 3 ML 23GX1"	T3	
EASY TOUCH SYRINGE 3 ML 25GX1"	T3	
EASY TOUCH TUBERCULIN FLIPLock	T3	
EASY TOUCH TUBERCULIN SHEATHLK	T3	
EASY TOUCH UNI-SLIP	T4	
ECLIPSE SYRINGE	T3	
ECLIPSE SYRINGE-NEEDLE	T3	
EXEL SYRINGE	T3	
EXEL TB WITH NEEDLE	T3	
EXEL TUBERCULIN SYRINGE	T3	
EXTENDED RESERVOIR	T4	
FILTER, MILLEX-OR SYRINGE	T4	
FINGER GRIP EXTENDER	T4	
INJECT-EASE	T3	
INSULIN CARTRIDGE	T3	
INSULIN SYRINGE U-500	T3	
INTEGRA SYRINGE	T3	
INTERLINK SYRINGE	T3	
INTERLINK SYRINGE W-CANNULA	T4	
KENDALL DISINFECTANT CAP	T4	
LEVER LOCK CANNULA	T4	
LIFESHIELD BLUNT CANNULA	T3	
LUER LOCK SYRINGE	T3	
LUER SLIP TIP SYRINGE TRAY	T4	
LUER TIP CAP TRAY	T4	
LUER-LOK SYRINGE	T3	
LUER-LOK SYRINGE-NEEDLE	T3	
LUER-LOK TIP SYRINGE	T3	
LUERSLIP SYRINGE	T3	
MAGELLAN SAFETY SYRINGE	T3	
MAGELLAN TB SAFETY SYRINGE	T3	
MAGELLAN TUBERCULIN SYRINGE	T3	

T1 – Preferred Generics
T2 – Non-Preferred Generics
T3 – Preferred Brands
T4 – Non-Preferred Brands

T5 – Brand Specialty
PA – Prior Authorization
QL – Quantity Limit

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

HD – May require home delivery pharmacy
PPACA – No Cost-Share Preventive Medication
CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

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

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
SYRINGES AND ACCESSORIES (cont.)		
MINIMED RESERVOIR 1.8 ML	T4	
MINIMED RESERVOIR 3 ML	T3	
MONOJECT 3 ML SYRINGE 25GX1"	T3	
MONOJECT 6CC SAFETY SYRINGE	T3	
MONOJECT ALLERGY TRAY-NEEDLE	T3	
MONOJECT CONTROL SYRINGE	T3	
MONOJECT ENFIT SYRINGE	T4	
MONOJECT ENFIT SYRINGE CAP	T4	
MONOJECT LUER LOCK TB SYRINGE	T3	
MONOJECT MAGELLAN	T3	
MONOJECT PHARMACY TRAY	T3	
MONOJECT SAFETY SYR TIP CAP	T4	
MONOJECT SAFETY SYRINGE	T3	
MONOJECT SMARTIP CANNULA	T4	
MONOJECT SYRINGE	T3	
MONOJECT SYRINGE 140 ML	T4	
MONOJECT SYRINGE 35 ML	T3	
MONOJECT SYRINGE PHARMACY TRAY	T3	
MONOJECT TB	T3	
MONOJECT TB SYRINGE	T3	
MONOJECT TUBERCULIN SAFETY SYR	T3	
MONOJECT TUBERCULIN SYRINGE	T3	
NORM-JECT SYRINGE	T4	
NORM-JECT TUBERKULIN SYRINGE	T4	
PARADIGM	T3	
PISTON ENFIT SYRINGE	T4	
PRECISIONGLIDE	T3	
PRODIGY COUNT-A-DOSE	T3	
SAFESNAP ALLERGY SYRINGE	T4	
SAFESNAP SYRINGE 10 ML	T3	
SAFESNAP SYRINGE 10 ML	T4	
SAFESNAP SYRINGE 3 ML	T3	
SAFESNAP SYRINGE 5 ML	T3	
SAFESNAP SYRINGE 5 ML	T4	

T1 – Preferred Generics
T2 – Non-Preferred Generics
T3 – Preferred Brands
T4 – Non-Preferred Brands

T5 – Brand Specialty
PA – Prior Authorization
QL – Quantity Limit

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

HD – May require home delivery pharmacy
PPACA – No Cost-Share Preventive Medication
CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

MISCELLANEOUS MEDICAL SUPPLIES, DEVICES, NON-DRUG (Diabetes) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
SYRINGES AND ACCESSORIES (cont.)		
SAFESNAP TUBERCULIN SYRINGE	T4	
SAFETY SYRINGE WITH SHIELD	T3	
SAFETY SYRINGE-NEEDLE	T4	
SAFETYGLIDE ALLERGY	T3	
SAFETYGLIDE ALLERGY SYRINGE	T4	
SAFETYGLIDE INSULIN SYRINGE	T3	
SAFETYGLIDE TB SYRINGE	T3	
SAFETY-LOK SAFETY SYRINGE	T3	
SAFETY-LOK SAFETY SYRINGES	T3	
SAFETY-LOK SYRINGES	T3	
SLIP-TIP SYRINGE	T4	
SUPOR	T4	
SYRINGE	T3	
SYRINGE BULK	T3	
SYRINGE CATHETER TIP	T3	
SYRINGE CATHETER TIP NON-STER	T3	
SYRINGE FILTER, MILLEX-GP	T4	
SYRINGE FILTER, MILLEX-GS	T4	
SYRINGE LUER-LOK	T3	
SYRINGE LUER-LOK NON-STERILE	T3	
SYRINGE LUER-LOK STERILE	T3	
SYRINGE SLIP TIP NON-STERILE	T3	
SYRINGE STORAGE BIN	T4	
SYRINGE TIP CAP	T3	
SYRINGE WITH NEEDLE DISP	T3	
SYRINGE WITHOUT NEEDLE	T3	
SYRINGE-LUER TIP CAP	T3	
SYRINGE-NEEDLE	T3	
SYRINGE-PRECISIONGLIDE NEEDLE	T3	
TB SYRINGE	T3	
TERUMO ALLERGY SYRINGE	T3	
TERUMO HYPODERMIC NEEDLE-SYRIN	T3	
TERUMO SURGUARD2	T3	
TERUMO SYRINGE	T3	

T1 – Preferred Generics
T2 – Non-Preferred Generics
T3 – Preferred Brands
T4 – Non-Preferred Brands

T5 – Brand Specialty
PA – Prior Authorization
QL – Quantity Limit

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

HD – May require home delivery pharmacy
PPACA – No Cost-Share Preventive Medication
CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

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

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
SYRINGES AND ACCESSORIES (cont.)		
TOOMEY SYRINGE	T3	
TUBERCULIN SYRINGE	T3	
TUBERCULIN SYRINGE-NEEDLE	T3	
TWINPAK DUAL CANNULA	T3	
ULTICARE LDS SYR 1 ML 22G 1.5"	T4	
ULTICARE LDS SYR 3 ML 22GX1.5"	T3	
ULTICARE SAFETY SYRINGE	T4	
ULTICARE SYRINGE	T4	
ULTICARE TB SAFETY 1 ML 25GX1"	T3	
ULTICARE TB SAFETY 1ML 25GX5/8	T3	
ULTICARE TB SAFETY SYRINGE	T3	
ULTIGUARD SAFE 1ML 30G 12.7MM	T4	
ULTIGUARD SAFEPACK 1ML 31G 8MM	T4	
UNIVERSAL SYRINGE TIP ADAPTOR	T4	
VANISHPOINT 1 ML TB SYR 25X5/8	T3	
VANISHPOINT 1 ML TB SYR 27X1/2	T3	
VANISHPOINT 20GX1" 3 ML SYRING	T3	
VANISHPOINT 21GX1" 5 ML SYRING	T3	
VANISHPOINT 21GX1.5" 3 ML SYR	T3	
VANISHPOINT 22GX1" 3 ML SYR	T3	
VANISHPOINT 22GX1-1/2" 5 ML SY	T3	
VANISHPOINT 23GX1" 3 ML SYRING	T3	
VANISHPOINT 23GX1-1/2 3 ML SYR	T3	
VANISHPOINT 25GX1" 3 ML SYRING	T3	
VANISHPOINT 25GX5/8" 3 ML SYR	T3	
VANISHPOINT 3 ML 21GX1" SYRING	T3	
VANISHPOINT 3 ML 22GX1.5" SYRG	T3	
VANISHPOINT SYRINGE	T4	
VANISHPOINT SYRINGE 1 ML 25X1"	T3	
VEO INSULIN SYRINGE	T3	

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

BANDAGES AND RELATED SUPPLIES

ARGLAES FILM	T4	
CONFORMANT 2	T4	

T1 – Preferred Generics
 T2 – Non-Preferred Generics
 T3 – Preferred Brands
 T4 – Non-Preferred Brands

T5 – Brand Specialty
 PA – Prior Authorization
 QL – Quantity Limit

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

HD – May require home delivery pharmacy
 PPACA – No Cost-Share Preventive Medication
 CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

MISCELLANEOUS MEDICAL SUPPLIES, DEVICES, NON-DRUG (Miscellaneous) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
BANDAGES AND RELATED SUPPLIES (cont.)		
DERMAVIEW	T3	
DERMAVIEW II	T3	
IV 3000	T3	
IV3000 FRAME DELIVERY	T4	
KENDALL	T3	
NEXCARE TEGADERM 2.375"X2.75"	T4	
NEXCARE TEGADERM DRESSING	T3	
OPSITE	T4	
OPSITE IV 3000	T3	
POLYSKIN II	T3	
SURESITE MATRIX	T3	
SURESITE WINDOW	T3	
TEGADERM 1.75X1.75" DRSSNG	T4	
TEGADERM 2"X2.75" DRESSING	T3	
TEGADERM 2.375"X2.75" DRESSING	T3	
TEGADERM 2.375"X4" DRESSING	T3	
TEGADERM 2.375X2.75" DRSSNG	T3	
TEGADERM 3.5" X 4" DRESSING	T3	
TEGADERM 3.5"X 10" DRESSING	T4	
TEGADERM 3.5"X 6" DRESSING	T4	
TEGADERM 3.5"X13.75" DRESS	T4	
TEGADERM 3.5"X4.125" DRESS	T3	
TEGADERM 3.5"X8" DRESSING	T4	
TEGADERM 4" X 10" DRESSING	T3	
TEGADERM 4" X 4-3/4" DRESSING	T3	
TEGADERM 4"X4.75" DRESSING	T3	
TEGADERM 6" X 8" DRESSING	T3	
TEGADERM 8" X 12" DRESSING	T3	
TEGADERM ABSORBENT	T4	
TEGADERM HP 4" X 4.5" DRSSN	T3	
TEGADERM HP 4.5"X4.75" DRSS	T3	
TEGADERM HP DRESSING	T3	
TEGADERM HP DRESSING	T4	
TEGADERM I.V.	T4	

T1 – Preferred Generics
 T2 – Non-Preferred Generics
 T3 – Preferred Brands
 T4 – Non-Preferred Brands

T5 – Brand Specialty
 PA – Prior Authorization
 QL – Quantity Limit

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

HD – May require home delivery pharmacy
 PPACA – No Cost-Share Preventive Medication
 CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

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

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
BANDAGES AND RELATED SUPPLIES (cont.)		
TEGADERM I.V. 2.5"X2.75" DRSSN	T4	
TEGADERM I.V. 4"X4.75" DRSSN	T3	
TRANSPARENT DRESSING	T4	
TRANSPARENT FILM DRESSING	T4	
TRANSPARENT I.V. SITE DRESSING	T3	
TRANSPARENT MEPITEL FILM DRESS	T4	
TRANSPARENT THIN FILM DRESSING	T3	
WINDOW BANDAGES	T4	
DURABLE MEDICAL EQUIPMENT,MISC(GROUP I)		
1ST TIER UNILET COMFORTOUCH	T3	
2-IN-1 LANCET DEVICE	T3	
ACCU-CHEK FASTCLIX LANCET DRUM	T3	
ACCU-CHEK SAFE-T-PRO	T3	
ACCU-CHEK SAFE-T-PRO PLUS	T3	
ACCU-CHEK SOFTCLIX	T3	
<i>acti-lance lite 28g lancets</i>	T2	
<i>acti-lance special 17g lancets</i>	T2	
ACTI-LANCE UNIVERS 23G LANCETS	T3	
<i>acti-lance univers 23g lancets</i>	T2	
ADVANCED TRAVEL LANCETS	T3	
ADVOCATE LANCET	T3	
ADVOCATE LANCETS	T3	
ADVOCATE SAFETY LANCET	T3	
ALTERNATE SITE LANCETS	T3	
ASSURE HAEMOLANCE PLUS	T3	
ASSURE LANCE	T3	
ASSURE LANCE PLUS	T3	
BD MICROTAINER LANCETS	T3	
BLOOD LANCETS	T3	
BULLSEYE MINI SAFETY LANCETS	T3	
BUTTERFLY TOUCH LANCET	T3	
CAREONE	T3	
CARESENS LANCET	T3	
CARETOUCH SAFETY LANCETS	T3	

T1 – Preferred Generics

T2 – Non-Preferred Generics

T3 – Preferred Brands

T4 – Non-Preferred Brands

T5 – Brand Specialty

PA – Prior Authorization

QL – Quantity Limit

ST – Step Therapy

AGE – Age Requirement

SP – Specialty Medication

HD – May require home delivery pharmacy

PPACA – No Cost-Share Preventive Medication

CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

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

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
DURABLE MEDICAL EQUIPMENT,MISC(GROUP I) (cont.)		
CARETOUCH TWIST LANCET	T3	
CLEVER CHEK LANCETS	T3	
COAGUCHEK	T3	
COLOR LANCETS	T3	
COMFORT EZ	T3	
COMFORT LANCETS	T3	
DROPLET LANCETS	T3	
EASY COMFORT LANCETS	T3	
EASY TOUCH BUTTON 30G LANCETS	T3	
EASY TOUCH PULL-TOP 26G LANCET	T3	
EASY TOUCH PULL-TOP 28G LANCET	T3	
EASY TOUCH PULL-TOP 30G LANCET	T3	
EASY TOUCH PULL-TOP 32G LANCET	T3	
EASY TOUCH SAFETY 21G LANCETS	T3	
EASY TOUCH SAFETY 23G LANCETS	T3	
EASY TOUCH SAFETY 26G LANCETS	T3	
EASY TOUCH SAFETY 28G LANCETS	T3	
EASY TOUCH SAFETY 30G LANCETS	T3	
EASY TOUCH SAFETY 32G LANCETS	T3	
EASY TOUCH TWIST 26G LANCETS	T3	
EASY TOUCH TWIST 28G LANCETS	T3	
EASY TOUCH TWIST 30G LANCETS	T3	
EASY TOUCH TWIST 32G LANCETS	T3	
EASY TOUCH TWIST 33G LANCETS	T3	
EASY TWIST CAP LANCETS	T3	
EMBRACE 30G LANCETS	T3	
EMBRACE SAFETY LANCET	T3	
EZ SMART LANCETS	T3	
EZ-LETS	T3	
FIFTY50 SAFETY SEAL LANCETS	T3	
FINE 30 UNIVERSAL LANCETS	T3	
FINGERSTIX	T3	
FORA LANCETS	T3	
FORACARE LANCETS	T3	

T1 – Preferred Generics
T2 – Non-Preferred Generics
T3 – Preferred Brands
T4 – Non-Preferred Brands

T5 – Brand Specialty
PA – Prior Authorization
QL – Quantity Limit

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

HD – May require home delivery pharmacy
PPACA – No Cost-Share Preventive Medication
CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

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

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
DURABLE MEDICAL EQUIPMENT,MISC(GROUP I) (cont.)		
FREESTYLE LANCETS	T3	
FREESTYLE UNISTIK 2	T3	
GLUCOCOM	T3	
GLUCOCOM LANCETS	T3	
GOJJI LANCETS	T3	
HEALTHY ACCENTS UNILET LANCET	T3	
INCONTROL SUPER THIN LANCETS	T3	
INCONTROL ULTRA THIN LANCETS	T3	
INJECT EASE LANCETS	T3	
INVACARE LANCETS	T3	
<i>lancets</i>	T2	
LANCETS	T3	
LANCETS THIN	T3	
LANCETS ULTRA THIN	T3	
LITE TOUCH 28G LANCETS	T3	
LITE TOUCH 30G LANCETS	T3	
LITE TOUCH 33G LANCETS	T3	
MEDISENSE THIN LANCETS	T3	
MEDLANCE PLUS 21G LANCETS	T3	
<i>medlance plus 21g lancets</i>	T2	
MEDLANCE PLUS 30G LANCETS	T3	
<i>medlance plus 30g lancets</i>	T2	
MEDLANCE PLUS EXTRA 21G LANCET	T3	
MEDLANCE PLUS LITE 25G LANCETS	T3	
<i>medlance plus lite 25g lancets</i>	T2	
MEDLANCE PLUS SPECIAL BLADE	T3	
MICRO THIN LANCET	T3	
MICRO THIN LANCETS	T3	
MICROLET	T3	
MICROTAINER LANCETS	T3	
MONOLET LANCETS	T3	
MONOLET THIN LANCETS	T3	
MYGLUCOHEALTH LANCETS	T3	

T1 – Preferred Generics
 T2 – Non-Preferred Generics
 T3 – Preferred Brands
 T4 – Non-Preferred Brands

T5 – Brand Specialty
 PA – Prior Authorization
 QL – Quantity Limit

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

HD – May require home delivery pharmacy
 PPACA – No Cost-Share Preventive Medication
 CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

MISCELLANEOUS MEDICAL SUPPLIES, DEVICES, NON-DRUG (Miscellaneous) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
DURABLE MEDICAL EQUIPMENT,MISC(GROUP I) (cont.)		
NOVA SAFETY LANCETS	T3	
NOVA SUREFLEX	T3	
ON CALL LANCET	T3	
ON CALL PLUS LANCET	T3	
ONETOUCH DELICA	T3	
ONETOUCH DELICA PLUS LANCET	T3	
ONETOUCH DELICA SAFETY LANCET	T3	
ONETOUCH LANCETS	T3	
ONETOUCH SURESOFT	T3	
ON-THE-GO	T3	
PIP LANCET	T3	
PRESSURE ACTIVATED LANCETS	T3	
PRO COMFORT LANCET	T3	
PRO COMFORT LANCETS	T3	
PRODIGY LANCETS	T3	
PRODIGY TWIST TOP LANCET	T3	
PURE COMFORT LANCETS	T3	
PURE COMFORT SAFETY LANCETS	T3	
PUSH BUTTON SAFETY LANCETS	T3	
READYLANCE SAFETY LANCETS	T3	
RELIAMED	T3	
RELIAMED SAFETY SEAL LANCETS	T3	
RELION THIN	T3	
RIGHTEST GL300 LANCETS	T3	
SAFETY LANCETS	T3	
SAFETY SEAL LANCETS	T3	
SAFETY-LET	T3	
SINGLE-LET	T3	
SMART SENSE	T3	
SMART SENSE LANCETS	T3	
SMARTEST LANCET	T3	
SOFT TOUCH	T3	
SOLUS V2	T3	
SOLUS V2 LANCETS	T3	

T1 – Preferred Generics
T2 – Non-Preferred Generics
T3 – Preferred Brands
T4 – Non-Preferred Brands

T5 – Brand Specialty
PA – Prior Authorization
QL – Quantity Limit

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

HD – May require home delivery pharmacy
PPACA – No Cost-Share Preventive Medication
CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

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

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
DURABLE MEDICAL EQUIPMENT,MISC(GROUP I) (cont.)		
STERILANCE TL	T3	
STERILE LANCETS	T3	
SUPER THIN LANCETS	T3	
SURE COMFORT LANCETS	T3	
SURE-LANCE	T3	
SURE-TOUCH	T3	
TECHLITE LANCETS	T3	
TELCARE ULTRA THIN 30G LANCETS	T3	
THIN LANCETS	T3	
TOPCARE UNIVERSAL1 LANCET	T3	
TOPCARE UNIVERSAL1 THIN LANCET	T3	
TRUE COMFORT LANCET	T3	
TRUEPLUS LANCET	T3	
TRUEPLUS LANCETS	T3	
TWIST LANCETS	T3	
TWIST TOP LANCET	T3	
ULTILET BASIC	T3	
ULTILET CLASSIC	T3	
ULTILET LANCETS	T3	
ULTILET SAFETY	T3	
ULTRA THIN LANCET	T3	
ULTRA THIN LANCETS	T3	
ULTRA THIN PLUS	T3	
ULTRA THIN PLUS LANCETS	T3	
ULTRA-CARE LANCETS	T3	
ULTRALANCE	T3	
ULTRA-THIN II 28G LANCETS	T3	
ULTRA-THIN II 30G LANCETS	T3	
ULTRATLC LANCETS	T3	
UNILET COMFORTOUCH	T3	
UNILET EXCELITE	T3	
UNILET EXCELITE II	T3	
UNILET GP LANCET	T3	
UNILET LANCET	T3	

T1 – Preferred Generics
 T2 – Non-Preferred Generics
 T3 – Preferred Brands
 T4 – Non-Preferred Brands

T5 – Brand Specialty
 PA – Prior Authorization
 QL – Quantity Limit

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

HD – May require home delivery pharmacy
 PPACA – No Cost-Share Preventive Medication
 CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

MISCELLANEOUS MEDICAL SUPPLIES, DEVICES, NON-DRUG (Miscellaneous) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
DURABLE MEDICAL EQUIPMENT,MISC(GROUP I) (cont.)		
UNILET LANCETS	T3	
UNISTIK 2 COMFORT	T3	
UNISTIK 2 EXTRA	T3	
UNISTIK 2 NORMAL	T3	
UNISTIK 3	T3	
UNISTIK 3 COMFORT	T3	
UNISTIK 3 DUAL	T3	
UNISTIK 3 EXTRA	T3	
UNISTIK COMFORT	T3	
UNISTIK CZT	T3	
UNISTIK EXTRA	T3	
UNISTIK NORMAL	T3	
UNISTIK PRO	T3	
UNISTIK SAFETY	T3	
UNISTIK TOUCH	T3	
UNIVERSAL 1	T3	
VIVAGUARD LANCET	T3	
MEDICAL SUPPLIES,MISCELLANEOUS		
ALCOH-GLOVE	T4	
ALCOH-WIPE	T4	
PARENTERAL ADMINISTRATION SETS		
1.5 VOLT BATTERIES #357	T3	
ACCU-CHEK LINKASSIST	T4	
ACCU-CHEK RAPID D 10-100	T4	
ACCU-CHEK RAPID D 10-50	T4	
ACCU-CHEK RAPID D 10-70	T3	
ACCU-CHEK RAPID D 6-100	T4	
ACCU-CHEK RAPID D 6-50	T3	
ACCU-CHEK RAPID D 6-70	T4	
ACCU-CHEK RAPID D 8-100	T4	
ACCU-CHEK RAPID D 8-50	T3	
ACCU-CHEK RAPID D 8-70	T3	
ACCU-CHEK SPIRIT	T3	
ACCU-CHEK TENDER	T3	

T1 – Preferred Generics
T2 – Non-Preferred Generics
T3 – Preferred Brands
T4 – Non-Preferred Brands

T5 – Brand Specialty
PA – Prior Authorization
QL – Quantity Limit

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

HD – May require home delivery pharmacy
PPACA – No Cost-Share Preventive Medication
CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

MISCELLANEOUS MEDICAL SUPPLIES, DEVICES, NON-DRUG (Miscellaneous) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
PARENTERAL ADMINISTRATION SETS (cont.)		
ACCU-CHEK ULTRAFLEX	T3	
DELTEC COZMO CLEO INFUSION SET	T3	
INSET 30 TUBING	T3	
IV ADMINISTRATION SET	T3	
NERIA	T4	
PARADIGM INFUSION	T3	
PARADIGM SILHOUETTE	T3	
POLYFIN QR	T3	
PSV SET	T4	
Q-SYTE	T3	
SILHOUETTE	T3	
SURE-T	T3	
RESPIRATORY AIDS, DEVICES, EQUIPMENT		
ACE AEROSOL CLOUD ENHANCER	T3	
AEROCHAMBER MINI	T3	
AEROCHAMBER MV	T3	
AEROCHAMBER PLUS FLOW-VU	T3	
AEROCHAMBER Z-STAT PLUS	T3	
AEROTRACH PLUS	T3	
AEROVENT PLUS	T3	
BREATHERITE	T3	
BREATHERITE SPACER-ADULT MASK	T3	
BREATHERITE SPACER-INFANT MASK	T3	
BREATHERITE SPACER-LG CHLD MSK	T3	
BREATHERITE SPACER-NEONATE MSK	T3	
BREATHERITE SPACER-SM CHLD MSK	T3	
BREATHRITE	T3	
CLEVER CHOICE HOLDING CHAMBER	T3	
COMFORTSEAL	T3	
COMPACT SPACE CHAMBER	T3	
EASIVENT	T3	
FLEXICHAMBER	T3	
FLEXICHAMBER MASK	T3	
INSPIRACHAMBER	T3	

T1 – Preferred Generics
 T2 – Non-Preferred Generics
 T3 – Preferred Brands
 T4 – Non-Preferred Brands

T5 – Brand Specialty
 PA – Prior Authorization
 QL – Quantity Limit

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

HD – May require home delivery pharmacy
 PPACA – No Cost-Share Preventive Medication
 CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

MISCELLANEOUS MEDICAL SUPPLIES, DEVICES, NON-DRUG (Miscellaneous) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
RESPIRATORY AIDS, DEVICES, EQUIPMENT (cont.)		
LITEAIRE	T3	
LITETOUCH	T3	
MICROCHAMBER	T3	
MICROSPACER	T3	
MOUTHPIECE	T3	
ONE WAY MOUTHPIECE	T3	
OPTICHAMBER	T3	
OPTICHAMBER DIAMOND	T3	
PANDA MASK	T3	
PEDIATRIC MASK	T3	
PEDIATRIC PANDA MASK	T3	
POCKET CHAMBER	T3	
PRIMEAIRE	T3	
PRO COMFORT SPACER-ADULT MASK	T3	
PRO COMFORT SPACER-CHILD MASK	T4	
PRO COMFORT SPACER-INFANT MASK	T4	
PROCARE SPACER WITH ADULT MASK	T3	
PROCARE SPACER WITH CHILD MASK	T3	
PROCHAMBER	T3	
PURE COMFORT SPACER WITH MASK	T4	
RITEFLO	T3	
SIDESTREAM PEDIATRIC	T3	
SILICONE MASK	T3	
SPACE CHAMBER	T3	
SPACE CHAMBER-LARGE MASK	T3	
SPACE CHAMBER-MEDIUM MASK	T3	
SPACE CHAMBER-SMALL MASK	T3	
VORTEX	T3	
VORTEX VHC FROG MASK	T3	
VORTEX VHC LADYBUG MASK	T3	
MUSCLE RELAXANTS (Pain Relief And Inflammatory Disease)		
SKELETAL MUSCLE RELAX.-TOP. IRRITANT COUNTER-IRRIT		
COMFORT PAC-CYCLOBENZAPRINE	T4	
COMFORT PAC-TIZANIDINE	T4	

T1 – Preferred Generics
T2 – Non-Preferred Generics
T3 – Preferred Brands
T4 – Non-Preferred Brands

T5 – Brand Specialty
PA – Prior Authorization
QL – Quantity Limit

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

HD – May require home delivery pharmacy
PPACA – No Cost-Share Preventive Medication
CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

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

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
SKELETAL MUSCLE RELAXANTS		
<i>baclofen 10 mg tablet</i>	T2	
<i>baclofen 20 mg tablet</i>	T2	
<i>baclofen 5 mg tablet</i>	T2	
<i>baclofen baclofen 25 mg/5 ml suspension (Fleqsuvy)</i>	T2	
<i>carisoprodol (Soma)</i>	T2	
<i>carisoprodol/aspirin</i>	T2	
<i>chlorzoxazone</i>	T2	
<i>chlorzoxazone (Lorzone)</i>	T2	
<i>cyclobenzaprine hcl</i>	T2	
<i>cyclobenzaprine hcl (Amrix)</i>	T2	PA
<i>cyclobenzaprine hcl (Fexmid)</i>	T2	
<i>DANTRIUM (dantrolene sodium)</i>	T4	
<i>dantrolene sodium</i>	T2	
<i>dantrolene sodium (Dantrium)</i>	T2	
<i>FEXMID (cyclobenzaprine hcl)</i>	T4	PA
<i>LORZONE (chlorzoxazone)</i>	T4	PA
<i>metaxalone</i>	T2	
<i>methocarbamol 500 mg tablet</i>	T2	
<i>methocarbamol 750 mg tablet</i>	T2	
<i>NORGESIC (orphenadrine/aspirin/caffeine)</i>	T4	
<i>NORGESIC FORTE (orphenadrine/aspirin/caffeine)</i>	T4	
<i>orphenadrine citrate</i>	T2	
<i>orphenadrine/aspirin/caffeine (Norgesic Forte)</i>	T2	
<i>orphenadrine/aspirin/caffeine (Norgesic)</i>	T2	
<i>SOMA (carisoprodol)</i>	T4	
<i>tizanidine hcl</i>	T2	
<i>tizanidine hcl (Zanaflex)</i>	T2	
<i>ZANAFLEX (tizanidine hcl)</i>	T4	

PRE-NATAL VITAMINS (Nutritional/Dietary)

PRENATAL VITAMIN PREPARATIONS

BAL-CARE DHA ESSENTIAL	T4	
BRAINSTRONG PRENATAL	T4	
CADEAU DHA	T4	

T1 – Preferred Generics
 T2 – Non-Preferred Generics
 T3 – Preferred Brands
 T4 – Non-Preferred Brands

T5 – Brand Specialty
 PA – Prior Authorization
 QL – Quantity Limit

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

HD – May require home delivery pharmacy
 PPACA – No Cost-Share Preventive Medication
 CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

PRE-NATAL VITAMINS (Nutritional/Dietary) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
PRENATAL VITAMIN PREPARATIONS (cont.)		
CITRANATAL 90 DHA	T4	
CITRANATAL ASSURE	T4	
CITRANATAL B-CALM	T4	
CITRANATAL DHA	T4	
CITRANATAL HARMONY	T4	
CITRANATAL RX	T4	
CVS PRENATAL GUMMY VITAMINS	T4	
<i>cvs prenatal multi-dha softgel</i>	T2	PPACA
<i>cvs prenatal vitamins tablet</i>	T2	PPACA
DUET DHA 400	T4	
DUET DHA BALANCED	T4	
EXPECTA PRENATAL	T3	
<i>gnp prenatal vitamins tablet</i>	T2	PPACA
GS PRENATAL VITAMINS TABLET	T4	
HM ONE DAILY PRENATAL COMBO PK	T3	
<i>hm prenatal tablet</i>	T2	PPACA
KOSHER PRENATAL PLUS IRON	T4	
KPN PRENATAL TABLET	T3	
<i>kpn tablet</i>	T2	PPACA
MARNATAL-F	T4	
MINI PRENATAL	T4	
MTERYTI	T4	
MTERYTI FOLIC 5	T4	
NATACHEW	T4	
NEONATAL COMPLETE	T4	
NEONATAL PLUS	T4	
NEONATAL-DHA	T4	
NESTABS	T4	
NESTABS ABC	T4	
NESTABS DHA	T4	
OB COMPLETE ONE	T4	
OB COMPLETE PETITE	T4	
OB COMPLETE PREMIER	T4	
OB COMPLETE WITH DHA	T4	

T1 – Preferred Generics
T2 – Non-Preferred Generics
T3 – Preferred Brands
T4 – Non-Preferred Brands

T5 – Brand Specialty
PA – Prior Authorization
QL – Quantity Limit

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

HD – May require home delivery pharmacy
PPACA – No Cost-Share Preventive Medication
CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

PRE-NATAL VITAMINS (Nutritional/Dietary) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
PRENATAL VITAMIN PREPARATIONS (cont.)		
OBSTETRIX EC	T4	
OBTREX DHA	T4	
ONE A DAY WOMEN'S PRENATAL DHA	T4	
ONE-A-DAY PRENATAL-1	T4	
<i>pnv 11/iron fum/folic acid/om3</i>	T2	
<i>pnv 119/iron fum/folic acid</i>	T2	
<i>pnv 66/iron/folic/docusate/dha</i>	T2	
<i>pnv 69/iron/folic/docusate/dha</i>	T2	
<i>pnv 80/iron fum/folic/dss/dha</i>	T2	
<i>pnv cmb 52/iron/fa/omega-3/dha</i>	T2	
<i>pnv no.118/iron fumarate/fa</i>	T2	
<i>pnv,calcium 72/iron,carb/folic</i>	T2	
<i>pnv,calcium 72/iron/folic acid</i>	T2	
<i>pnv/iron,carb/docusat/folic ac</i>	T2	
<i>pnv19/iron bg,s.p/folic ac/om3</i>	T2	
<i>pnv81/iron edta,ps/folic/omeg3</i>	T2	
PRENATA	T4	
<i>prenatal 105/iron/folic ac/dha</i>	T2	
<i>prenatal 12/iron/folic/dss/om3</i>	T2	
PRENATAL 19 CHEWABLE TABLET	T4	
<i>prenatal 19 chewable tablet</i>	T2	
PRENATAL 19 TABLET	T4	
<i>prenatal 19 tablet</i>	T2	
<i>prenatal 21/iron fu/folic acid</i>	T2	PPACA
<i>prenatal 53/iron/folic ac/omg3</i>	T2	
<i>prenatal 54/iron/folic ac/omg3</i>	T2	
<i>prenatal 93/iron/folate 9/dha</i>	T2	
<i>prenatal caplet</i>	T2	PPACA
<i>prenatal comb no.42/folic acid (Vitamedmd Redichew Rx)</i>	T2	
PRENATAL FORMULA	T3	
PRENATAL FORMULA-DHA (<i>prenatal vit116/iron/folic/dha</i>)	T4	
PRENATAL GUMMIES	T4	
PRENATAL MULTI	T4	
<i>prenatal multi-dha softgel</i>	T2	PPACA

T1 – Preferred Generics
 T2 – Non-Preferred Generics
 T3 – Preferred Brands
 T4 – Non-Preferred Brands

T5 – Brand Specialty
 PA – Prior Authorization
 QL – Quantity Limit

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

HD – May require home delivery pharmacy
 PPACA – No Cost-Share Preventive Medication
 CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

PRE-NATAL VITAMINS (Nutritional/Dietary) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
PRENATAL VITAMIN PREPARATIONS (cont.)		
PRENATAL MULTI-DHA SOFTGEL	T3	
PRENATAL MULTI-DHA SOFTGEL	T4	
<i>prenatal multivitamin tablet</i>	T2	PPACA
PRENATAL MULTIVITAMIN TABLET	T4	
PRENATAL MULTIVITAMIN-DHA	T3	
PRENATAL PLUS VITAMIN-MINERAL	T4	
PRENATAL PLUS-DHA	T4	
<i>prenatal tablet</i>	T2	PPACA
PRENATAL TABLET	T4	
<i>prenatal vit 14/iron fum/folic</i>	T2	
<i>prenatal vit 55/iron/folic/om3</i>	T2	
<i>prenatal vit 91/iron/folic/dha</i>	T2	
<i>prenatal vit no.126/iron/folic</i>	T2	PPACA
<i>prenatal vit no.129/iron/folic</i>	T2	PPACA
<i>prenatal vit,cal 73/iron/folic</i>	T2	
<i>prenatal vit,calc76/iron/folic</i>	T2	
<i>prenatal vit,calc78/iron/folic</i>	T2	
<i>prenatal vit/iron fum/folic ac</i>	T2	
<i>prenatal vit27,calcium/iron/fa</i>	T2	
<i>prenatal vit86/iron/folic acid</i>	T2	
PRENATAL VITAMIN + DHA	T3	
<i>prenatal vitamin tablet</i>	T2	PPACA
PRENATAL VITAMIN TABLET (<i>prenatal vit no.124/iron/folic</i>)	T4	
<i>prenatal vitamins tablet</i>	T2	PPACA
<i>prenatal vits calc.36/iron/fa</i>	T2	PPACA
<i>prenatal,calc.40/iron/folate 1</i>	T2	
<i>prenatal71/iron/folic acid/dha</i>	T2	
PRENATE DHA	T4	
PRENATE ELITE	T4	
PRENATE ENHANCE	T4	
PRENATE MINI	T4	
PRENATE PIXIE	T4	
PRENATE RESTORE	T4	
PRENATE STAR	T4	

T1 – Preferred Generics
 T2 – Non-Preferred Generics
 T3 – Preferred Brands
 T4 – Non-Preferred Brands

T5 – Brand Specialty
 PA – Prior Authorization
 QL – Quantity Limit

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

HD – May require home delivery pharmacy
 PPACA – No Cost-Share Preventive Medication
 CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

PRE-NATAL VITAMINS (Nutritional/Dietary) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
PRENATAL VITAMIN PREPARATIONS (cont.)		
PRIMACARE	T4	
PROVIDA OB	T4	
<i>qc prenatal tablet</i>	T2	PPACA
<i>ra one daily prenatal dha pack</i>	T2	PPACA
<i>ra prenatal tablet</i>	T2	PPACA
R-NATAL OB	T4	
SELECT-OB	T4	
SELECT-OB (<i>prenatal vit128/iron/folic acid</i>)	T4	
SELECT-OB + DHA	T4	
SIMILAC PRENATAL	T4	
<i>sm prenatal vitamins tablet</i>	T2	PPACA
STUART ONE (<i>pnv no.63/iron,carb/folic/dha</i>)	T4	
<i>sv prenatal tablet</i>	T2	PPACA
SV PRENATAL VITAMINS TABLET	T4	
THERANATAL	T4	
THERANATAL COMPLETE	T4	
THERANATAL ONE	T4	
THERANATAL OVAVITE	T4	
THERANATAL PLUS	T4	
THRIVITE RX	T4	
TRICARE	T4	
TRICARE PRENATAL DHA ONE	T4	
TRISTART DHA	T4	
ULTRA PRENATAL PLUS DHA	T4	
VITAFOL FE PLUS	T4	
VITAFOL GUMMIES	T4	
VITAFOL NANO	T4	
VITAFOL ULTRA	T4	
VITAFOL-OB	T4	
VITAFOL-OB+DHA	T4	
VITAFOL-ONE	T4	
VITAMEDMD ONE RX	T4	
VITAMEDMD REDICHEW RX (<i>prenatal comb no.42/folic acid</i>)	T4	
VITAPEARL	T4	

T1 – Preferred Generics
T2 – Non-Preferred Generics
T3 – Preferred Brands
T4 – Non-Preferred Brands

T5 – Brand Specialty
PA – Prior Authorization
QL – Quantity Limit

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

HD – May require home delivery pharmacy
PPACA – No Cost-Share Preventive Medication
CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

PRE-NATAL VITAMINS (Nutritional/Dietary) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
PRENATAL VITAMIN PREPARATIONS (cont.)		
VITATRUE	T4	
VP-PNV-DHA	T4	
WOMEN'S PRENATAL PLUS DHA	T3	
PRENATAL VITAMINS WITH LOW OR NO IRON		
CVS PRENATAL GUMMIES	T4	
PRENATAL GUMMIES	T4	
TRINAZ	T4	
PSYCHOTHERAPEUTIC DRUGS (Anxiety/Depression/Bipolar Disorder) ⁸		
ALPHA-2 RECEPTOR ANTAGONIST ANTIDEPRESSANTS		
<i>mirtazapine</i>	T1	HD
<i>mirtazapine (Remeron)</i>	T1	HD
REMERON (<i>mirtazapine</i>)	T4	HD
ANTI-ANXIETY - BENZODIAZEPINES		
<i>alprazolam</i>	T2	
<i>alprazolam (Xanax Xr)</i>	T1	
<i>alprazolam (Xanax)</i>	T1	
ATIVAN (<i>lorazepam</i>)	T4	
<i>chlordiazepoxide hcl</i>	T2	
<i>clorazepate dipotassium</i>	T2	
<i>diazepam 10 mg tablet (Valium)</i>	T2	
<i>diazepam 2 mg tablet (Valium)</i>	T2	
<i>diazepam 25 mg/5 ml oral conc</i>	T2	
<i>diazepam 5 mg tablet (Valium)</i>	T2	
<i>diazepam 5 mg/5 ml oral soln</i>	T2	
<i>diazepam 5 mg/5 ml solution</i>	T2	
<i>diazepam 5 mg/ml oral conc</i>	T2	
<i>lorazepam</i>	T2	
<i>lorazepam (Ativan)</i>	T1	
<i>oxazepam</i>	T2	
ANTI-ANXIETY DRUGS		
<i>buspirone hcl</i>	T1	
<i>meprobamate</i>	T2	
ANTIDEPRESSANT - POSTPARTUM DEPRESSION (PPD)		
ZURZUVAE	T5	

T1 – Preferred Generics
 T2 – Non-Preferred Generics
 T3 – Preferred Brands
 T4 – Non-Preferred Brands

T5 – Brand Specialty
 PA – Prior Authorization
 QL – Quantity Limit

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

HD – May require home delivery pharmacy
 PPACA – No Cost-Share Preventive Medication
 CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

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

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
BIPOLAR DISORDER DRUGS		
EQUETRO	T4	HD
<i>lithium carbonate</i>	T1	HD
<i>lithium carbonate</i> (Lithobid)	T1	HD
LITHOBID (<i>lithium carbonate</i>)	T4	HD
MAOIS -NON-SELECTIVE, IRREVERSIBLE ANTIDEPRESSANTS		
MARPLAN	T4	
NARDIL (<i>phenelzine sulfate</i>)	T4	
PARNATE (<i>tranylcypromine sulfate</i>)	T4	
<i>phenelzine sulfate</i> (Nardil)	T2	
<i>tranylcypromine sulfate</i> (Parnate)	T2	
MONOAMINE OXIDASE (MAO) INHIBITOR ANTIDEPRESSANTS		
EMSAM	T4	
NOREPINEPHRINE AND DOPAMINE REUPTAKE INHIB (NDRIS)		
<i>bupropion hcl</i>	T1	HD
<i>bupropion hcl xl 150 mg tablet</i> (Wellbutrin XL)	T2	
<i>bupropion hcl xl 300 mg tablet</i> (Wellbutrin XL)	T2	
SELECTIVE SEROTONIN 5-HT_{2A} INVERSE AGONISTS (SSIA)		
NUPLAZID 10 MG TABLET	T5	PA QL(30 tabs/fill) SP HD
NUPLAZID 34 MG CAPSULE	T5	PA QL(30 caps/fill) SP HD
SELECTIVE SEROTONIN REUPTAKE INHIBITOR (SSRIS)		
<i>citalopram hbr 10 mg/5 ml soln</i>	T2	HD
<i>escitalopram 10 mg tablet</i> (Lexapro)	T1	
<i>escitalopram 20 mg tablet</i> (Lexapro)	T1	
<i>escitalopram 5 mg tablet</i> (Lexapro)	T1	
<i>escitalopram oxalate 5 mg/5 ml</i>	T1	ST HD
<i>fluoxetine 20 mg/5 ml solution</i>	T2	HD
<i>fluoxetine hcl</i>	T2	ST QL(4 caps/fill) HD
<i>fluoxetine hcl 10 mg tablet</i>	T2	ST QL(30 tabs/fill) HD
<i>fluoxetine hcl 20 mg capsule</i> (Prozac)	T1	HD
<i>fluoxetine hcl 20 mg tablet</i>	T2	ST HD
<i>fluoxetine hcl 60 mg tablet</i>	T2	ST HD
<i>fluvoxamine maleate</i>	T2	ST QL(60 caps/fill) HD
<i>fluvoxamine maleate 100 mg tab</i>	T2	QL(90 tabs/fill) HD
<i>fluvoxamine maleate 25 mg tab</i>	T2	QL(30 tabs/fill) HD
<i>fluvoxamine maleate 50 mg tab</i>	T2	QL(60 tabs/fill) HD

T1 – Preferred Generics
T2 – Non-Preferred Generics
T3 – Preferred Brands
T4 – Non-Preferred Brands

T5 – Brand Specialty
PA – Prior Authorization
QL – Quantity Limit

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

HD – May require home delivery pharmacy
PPACA – No Cost-Share Preventive Medication
CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

PSYCHOTHERAPEUTIC DRUGS (Anxiety/Depression/Bipolar Disorder)⁸ (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
SELECTIVE SEROTONIN REUPTAKE INHIBITOR (SSRIS) (cont.)		
<i>paroxetine hcl</i> (Paxil Cr)	T2	ST QL (60 tabs/fill) HD
<i>paroxetine hcl 10 mg tablet</i> (Paxil)	T1	QL(30 tabs/fill) HD
<i>paroxetine hcl 10 mg/5 ml susp</i> (Paxil)	T2	ST HD
<i>paroxetine hcl 20 mg tablet</i> (Paxil)	T1	QL(60 tabs/fill) HD
<i>paroxetine hcl 30 mg tablet</i> (Paxil)	T1	QL(60 tabs/fill) HD
<i>paroxetine hcl 40 mg tablet</i> (Paxil)	T1	QL(30 tabs/fill) HD
PAXIL 10 MG TABLET (<i>paroxetine hcl</i>)	T4	ST QL (30 tabs/fill) HD
PAXIL 10 MG/5 ML SUSPENSION (<i>paroxetine hcl</i>)	T4	ST HD
PAXIL 20 MG TABLET (<i>paroxetine hcl</i>)	T4	ST QL(60 tabs/fill) HD
PAXIL 30 MG TABLET (<i>paroxetine hcl</i>)	T4	ST QL(60 tabs/fill) HD
PAXIL 40 MG TABLET (<i>paroxetine hcl</i>)	T4	ST QL (30 tabs/fill) HD
PAXIL CR (<i>paroxetine hcl</i>)	T4	ST QL(60 tabs/fill) HD
<i>sertraline 20 mg/ml oral conc</i> (Zoloft)	T2	HD
<i>sertraline hcl 25 mg tablet</i> (Zoloft)	T1	QL(45 tabs/fill) HD
SEROTONIN-2 ANTAGONIST/REUPTAKE INHIBITORS (SARIS)		
<i>nefazodone hcl</i>	T2	HD
<i>trazodone hcl</i>	T1	HD
SEROTONIN-NOREPINEPHRINE REUPTAKE-INHIB (SNRIS)		
DESVENLAFAXINE ER	T4	ST QL(30 tabs/fill) HD
<i>duloxetine hcl dr 20 mg cap</i> (Cymbalta)	T1	QL(60 caps/fill) HD
<i>duloxetine hcl dr 30 mg cap</i> (Cymbalta)	T1	QL(30 caps/fill) HD
<i>duloxetine hcl dr 40 mg cap</i>	T1	ST QL(30 caps/fill) HD
<i>duloxetine hcl dr 60 mg cap</i> (Cymbalta)	T1	QL(60 caps/fill) HD
FETZIMA 20-40 MG TITRATION PAK	T3	ST QL(28 caps/fill) HD
FETZIMA ER 120 MG CAPSULE	T3	ST QL(30 caps/fill) HD
FETZIMA ER 20 MG CAPSULE	T3	ST QL(30 caps/fill) HD
FETZIMA ER 40 MG CAPSULE	T3	ST QL(30 caps/fill) HD
FETZIMA ER 80 MG CAPSULE	T3	ST QL(30 caps/fill) HD
<i>venlafaxine hcl</i>	T1	QL(90 tabs/fill) HD
<i>venlafaxine hcl er 150 mg tab</i>	T2	ST QL(30 tabs/fill) HD
<i>venlafaxine hcl er 225 mg tab</i>	T2	ST QL(30 tabs/fill) HD
<i>venlafaxine hcl er 37.5 mg tab</i>	T2	ST QL(30 tabs/fill) HD
<i>venlafaxine hcl er 75 mg tab</i>	T2	ST QL(30 tabs/fill) HD

T1 – Preferred Generics
 T2 – Non-Preferred Generics
 T3 – Preferred Brands
 T4 – Non-Preferred Brands

T5 – Brand Specialty
 PA – Prior Authorization
 QL – Quantity Limit

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

HD – May require home delivery pharmacy
 PPACA – No Cost-Share Preventive Medication
 CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

PSYCHOTHERAPEUTIC DRUGS (Anxiety/Depression/Bipolar Disorder) ⁸ (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
SEROTONIN-NOREPINEPHRINE REUPTAKE-INHIB (SNRIS) (cont.)		
<i>venlafaxine hcl er 150 mg cap (Effexor Xr)</i>	T1	
<i>venlafaxine hcl er 37.5 mg cap (Effexor Xr)</i>	T1	
<i>venlafaxine hcl er 75 mg cap (Effexor Xr)</i>	T1	
SSRI, SEROTONIN RECEPTOR MODULATOR ANTIDEPRESSANTS		
TRINTELLIX 10 MG TABLET	T4	ST QL(30 tabs/fill) HD
TRICYCLIC ANTIDEPRESSANT-BENZODIAZEPINE COMBINATNS		
<i>amitriptyline/chlordiazepoxide</i>	T2	HD
<i>perphenazine/amitriptyline hcl</i>	T2	HD
TRICYCLIC ANTIDEPRESSANTS, REL.NON-SEL.REUPT-INHIB		
<i>amitriptyline hcl</i>	T1	HD
<i>amoxapine</i>	T2	HD
ANAFRANIL (<i>clomipramine hcl</i>)	T4	HD
<i>clomipramine hcl (Anafranil)</i>	T2	HD
<i>desipramine hcl</i>	T2	HD
<i>desipramine hcl (Norpramin)</i>	T2	HD
<i>doxepin 10 mg capsule</i>	T2	HD
<i>doxepin 10 mg/ml oral conc</i>	T2	HD
<i>doxepin 25 mg capsule</i>	T2	HD
<i>doxepin 50 mg capsule</i>	T2	HD
<i>doxepin 75 mg capsule</i>	T2	HD
<i>doxepin 100 mg capsule</i>	T2	HD
<i>doxepin 150 mg capsule</i>	T2	HD
<i>imipramine hcl (Tofranil)</i>	T1	HD
<i>imipramine pamoate</i>	T2	HD
<i>maprotiline hcl</i>	T2	HD
NORPRAMIN (<i>desipramine hcl</i>)	T4	HD
<i>nortriptyline hcl</i>	T2	HD
<i>nortriptyline hcl (Pamelor)</i>	T1	HD
PAMELOR (<i>nortriptyline hcl</i>)	T4	HD
<i>protriptyline hcl</i>	T2	HD
SURMONTIL (<i>trimipramine maleate</i>)	T4	HD
TOFRANIL (<i>imipramine hcl</i>)	T4	HD
<i>trimipramine maleate (Surmontil)</i>	T2	HD

T1 – Preferred Generics
T2 – Non-Preferred Generics
T3 – Preferred Brands
T4 – Non-Preferred Brands

T5 – Brand Specialty
PA – Prior Authorization
QL – Quantity Limit

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

HD – May require home delivery pharmacy
PPACA – No Cost-Share Preventive Medication
CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

PSYCHOTHERAPEUTIC DRUGS (Attention Deficit Hyperactivity Disorder)⁸

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ADRENERGICS, AROMATIC, NON-CATECHOLAMINE		
<i>lisdexamfetamine 10 mg capsule (Vyvanse)</i>	T2	
<i>lisdexamfetamine 10 mg tb chew</i>	T2	ST
<i>lisdexamfetamine 20 mg capsule (Vyvanse)</i>	T2	
<i>lisdexamfetamine 20 mg tb chew</i>	T2	ST
<i>lisdexamfetamine 30 mg capsule (Vyvanse)</i>	T2	
<i>lisdexamfetamine 30 mg tb chew</i>	T2	ST
<i>lisdexamfetamine 40 mg capsule (Vyvanse)</i>	T2	
<i>lisdexamfetamine 40 mg tb chew</i>	T2	ST
<i>lisdexamfetamine 50 mg capsule (Vyvanse)</i>	T2	
<i>lisdexamfetamine 50 mg tb chew</i>	T2	ST
<i>lisdexamfetamine 60 mg capsule (Vyvanse)</i>	T2	
<i>lisdexamfetamine 60 mg tb chew</i>	T2	ST
<i>lisdexamfetamine 70 mg capsule (Vyvanse)</i>	T2	
VYVANSE	T3	ST
TX FOR ADHD - SELECTIVE ALPHA-2 RECEPTOR AGONIST		
<i>clonidine hcl er 0.1 mg tablet (Kapvay)</i>	T2	
<i>guanfacine hcl (Intuniv)</i>	T2	
KAPVAY (<i>clonidine hcl</i>)	T4	ST
TX FOR ATTENTION DEFICIT-HYPERACT (ADHD)/NARCOLEPSY		
APTENSIO XR (<i>methylphenidate hcl</i>)	T4	ST
AZSTARYS	T4	ST
COTEMPLA XR-ODT	T4	ST
DAYTRANA (<i>methylphenidate</i>)	T4	ST
<i>dexmethylphenidate hcl (Focalin Xr)</i>	T2	
<i>dexmethylphenidate hcl (Focalin)</i>	T1	
JORNAY PM	T4	ST
METHYLIN (<i>methylphenidate hcl</i>)	T4	
<i>methylphenidate</i>	T2	ST
<i>methylphenidate er 10 mg cap (Aptensio Xr)</i>	T2	ST
<i>methylphenidate er 10 mg tab</i>	T2	
<i>methylphenidate er 15 mg cap (Aptensio Xr)</i>	T2	ST
<i>methylphenidate er 18 mg tab (Concerta)</i>	T2	
<i>methylphenidate er 18 mg tab (Relexxii)</i>	T2	
<i>methylphenidate er 20 mg cap (Aptensio Xr)</i>	T2	ST

T1 – Preferred Generics
 T2 – Non-Preferred Generics
 T3 – Preferred Brands
 T4 – Non-Preferred Brands

T5 – Brand Specialty
 PA – Prior Authorization
 QL – Quantity Limit

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

HD – May require home delivery pharmacy
 PPACA – No Cost-Share Preventive Medication
 CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

PSYCHOTHERAPEUTIC DRUGS (Attention Deficit Hyperactivity Disorder)⁸ (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
TX FOR ATTENTION DEFICIT-HYPERACT (ADHD)/NARCOLEPSY (cont.)		
<i>methylphenidate er 20 mg tab</i>	T2	
<i>methylphenidate er 27 mg tab (Concerta)</i>	T2	
<i>methylphenidate er 27 mg tab (Relexxii)</i>	T2	
<i>methylphenidate er 30 mg cap (Aptensio Xr)</i>	T2	ST
<i>methylphenidate er 36 mg tab (Concerta)</i>	T2	
<i>methylphenidate er 36 mg tab (Relexxii)</i>	T2	
<i>methylphenidate er 40 mg cap (Aptensio Xr)</i>	T2	ST
<i>methylphenidate er 50 mg cap (Aptensio Xr)</i>	T2	ST
<i>methylphenidate er 54 mg tab (Concerta)</i>	T2	
<i>methylphenidate er 54 mg tab (Relexxii)</i>	T2	
<i>methylphenidate er 60 mg cap (Aptensio Xr)</i>	T2	ST
METHYLPHENIDATE ER 72 MG TAB	T4	ST
<i>methylphenidate hcl</i>	T2	
<i>methylphenidate hcl (Metadate Cd)</i>	T2	
<i>methylphenidate hcl (Methylin)</i>	T2	
<i>methylphenidate hcl (Ritalin La)</i>	T2	
<i>methylphenidate hcl (Ritalin)</i>	T2	
QELBREE ER	T4	ST
RELEXXII ER 72 MG TABLET	T4	ST
<i>atomoxetine hcl (Strattera)</i>	T2	HD

PSYCHOTHERAPEUTIC DRUGS (Miscellaneous)

HYPOACTIVE SEXUAL DESIRE DISORDER (HSDD) TX AGENTS

ADDYI	T4	PA
VYLEESI	T5	PA QL(8 auto-injs/fill) SP

PSYCHOTHERAPEUTIC DRUGS (Schizophrenia/Anti-Psychotics)⁸

ANTIPSYCH, DOPAMINE ANTAG., DIPHENYLBUTYLPIPERIDINES

<i>pimozide</i>	T2	
-----------------	----	--

ANTIPSYCHOTIC, ATYPICAL, DOPAMINE, SEROTONIN ANTAGNST

<i>asenapine maleate (Saphris)</i>	T2	QL(60 tabs/fill)
CAPLYTA	T4	QL(30 caps/fill)
<i>clozapine</i>	T2	
<i>clozapine (Clozaril)</i>	T2	
CLOZARIL (<i>clozapine</i>)	T4	

T1 – Preferred Generics
 T2 – Non-Preferred Generics
 T3 – Preferred Brands
 T4 – Non-Preferred Brands

T5 – Brand Specialty
 PA – Prior Authorization
 QL – Quantity Limit

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

HD – May require home delivery pharmacy
 PPACA – No Cost-Share Preventive Medication
 CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

PSYCHOTHERAPEUTIC DRUGS (Schizophrenia/Anti-Psychotics)⁸ (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ANTIPSYCHOTIC, ATYPICAL, DOPAMINE, SEROTONIN ANTAGNIST (cont.)		
FANAPT 1 MG TABLET	T4	QL(60 tabs/fill)
FANAPT 10 MG TABLET	T4	QL(60 tabs/fill)
FANAPT 12 MG TABLET	T4	QL(60 tabs/fill)
FANAPT 2 MG TABLET	T4	QL(60 tabs/fill)
FANAPT 4 MG TABLET	T4	QL(60 tabs/fill)
FANAPT 6 MG TABLET	T4	QL(60 tabs/fill)
FANAPT 8 MG TABLET	T4	QL(60 tabs/fill)
FANAPT TITRATION PACK	T4	QL(8 tabs/fill)
GEODON (<i>ziprasidone hcl</i>)	T4	QL(60 caps/fill)
INVEGA ER 3 MG TABLET (<i>paliperidone</i>)	T4	QL(30 tabs/fill)
INVEGA ER 6 MG TABLET (<i>paliperidone</i>)	T4	QL(60 tabs/fill)
INVEGA ER 9 MG TABLET (<i>paliperidone</i>)	T4	QL(30 tabs/fill)
<i>olanzapine (Zyprexa Zydis)</i>	T2	QL(30 tabs/fill)
<i>quetiapine er 200 mg tablet (Seroquel Xr)</i>	T2	QL(30 tabs/fill)
<i>quetiapine er 300 mg tablet (Seroquel Xr)</i>	T2	QL(60 tabs/fill)
<i>quetiapine er 400 mg tablet (Seroquel Xr)</i>	T2	QL(60 tabs/fill)
<i>quetiapine er 50 mg tablet (Seroquel Xr)</i>	T2	QL(60 tabs/fill)
<i>quetiapine fumarate 100 mg tab (Seroquel)</i>	T1	
<i>quetiapine fumarate 200 mg tab (Seroquel)</i>	T1	QL(90 tabs/fill)
<i>quetiapine fumarate 25 mg tab (Seroquel)</i>	T1	
<i>quetiapine fumarate 300 mg tab (Seroquel)</i>	T1	QL(60 tabs/fill)
<i>quetiapine fumarate 400 mg tab (Seroquel)</i>	T1	
<i>quetiapine fumarate 50 mg tab (Seroquel)</i>	T1	
RISPERDAL 0.5 MG TABLET (<i>risperidone</i>)	T4	QL(60 tabs/fill)
RISPERDAL 1 MG TABLET (<i>risperidone</i>)	T4	QL(60 tabs/fill)
RISPERDAL 1 MG/ML SOLUTION (<i>risperidone</i>)	T4	
RISPERDAL 2 MG TABLET (<i>risperidone</i>)	T4	QL(60 tabs/fill)
RISPERDAL 3 MG TABLET (<i>risperidone</i>)	T4	QL(60 tabs/fill)
RISPERDAL 4 MG TABLET (<i>risperidone</i>)	T4	QL(60 tabs/fill)
<i>risperidone</i>	T2	QL(60 tabs/fill)
<i>risperidone 0.5 mg tablet (Risperdal)</i>	T1	QL(60 tabs/fill)
<i>risperidone 1 mg tablet (Risperdal)</i>	T1	QL(60 tabs/fill)
<i>risperidone 1 mg/ml solution (Risperdal)</i>	T2	
<i>risperidone 2 mg tablet (Risperdal)</i>	T1	QL(60 tabs/fill)

T1 – Preferred Generics
 T2 – Non-Preferred Generics
 T3 – Preferred Brands
 T4 – Non-Preferred Brands

T5 – Brand Specialty
 PA – Prior Authorization
 QL – Quantity Limit

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

HD – May require home delivery pharmacy
 PPACA – No Cost-Share Preventive Medication
 CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

PSYCHOTHERAPEUTIC DRUGS (Schizophrenia/Anti-Psychotics) ⁸ (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ANTIPSYCHOTIC, ATYPICAL, DOPAMINE, SEROTONIN ANTAGONIST (cont.)		
<i>risperidone 3 mg tablet</i> (Risperdal)	T1	QL(60 tabs/fill)
<i>risperidone 4 mg tablet</i> (Risperdal)	T1	QL(60 tabs/fill)
SECUADO	T4	QL(30 patches/fill)
VERSACLOZ	T4	
<i>ziprasidone hcl</i> (Geodon)	T2	QL(60 caps/fill)
ZYPREXA (<i>olanzapine</i>)	T4	QL(30 tabs/fill)
ZYPREXA ZYDIS (<i>olanzapine</i>)	T4	QL(30 tabs/fill)
ANTIPSYCHOTIC-ATYPICAL, D3/D2 PARTIAL AG-5HT MIXED		
VRAYLAR 1.5 MG CAPSULE	T4	QL(30 caps/fill)
VRAYLAR 1.5 MG-3 MG PACK	T4	QL(7 caps/fill)
VRAYLAR 3 MG CAPSULE	T4	QL(30 caps/fill)
VRAYLAR 4.5 MG CAPSULE	T4	QL(30 caps/fill)
VRAYLAR 6 MG CAPSULE	T4	QL(30 caps/fill)
ANTIPSYCHOTICS, ATYP, D2 PARTIAL AGONIST/5HT MIXED		
ABILIFY ASIMTUFI	T4	
ABILIFY MYCITE	T4	QL(30 tabs/fill)
<i>aripiprazole</i>	T2	QL(60 tabs/fill)
<i>aripiprazole 1 mg/ml solution</i>	T2	
<i>aripiprazole 2 mg tablet</i> (Abilify)	T1	QL(30 tabs/fill)
<i>aripiprazole 10 mg tablet</i> (Abilify)	T1	QL(30 tabs/fill)
<i>aripiprazole 15 mg tablet</i> (Abilify)	T1	
<i>aripiprazole 20 mg tablet</i> (Abilify)	T1	QL(30 tabs/fill)
<i>aripiprazole 30 mg tablet</i> (Abilify)	T1	QL(30 tabs/fill)
REXULTI	T4	QL(30 tabs/fill)
ANTIPSYCHOTICS, DOPAMINE AND SEROTONIN ANTAGONISTS		
<i>loxapine succinate</i>	T2	
ANTIPSYCHOTICS, DOPAMINE ANTAGONISTS, THIOXANTHENES		
<i>thiothixene</i>	T2	
ANTIPSYCHOTICS, DOPAMINE ANTAGONISTS, BUTYROPHENONES		
<i>haloperidol</i>	T1	
<i>haloperidol lactate</i>	T2	
ANTIPSYCHOTICS, DOPAMINE ANTAGONIST, DIHYDROINDOLONES		
<i>molindone hcl</i>	T2	

T1 – Preferred Generics
T2 – Non-Preferred Generics
T3 – Preferred Brands
T4 – Non-Preferred Brands

T5 – Brand Specialty
PA – Prior Authorization
QL – Quantity Limit

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

HD – May require home delivery pharmacy
PPACA – No Cost-Share Preventive Medication
CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

PSYCHOTHERAPEUTIC DRUGS (Schizophrenia/Anti-Psychotics)⁸ (cont.)

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

ANTIPSYCHOTICS, PHENOTHIAZINES

<i>chlorpromazine hcl</i>	T2	
<i>fluphenazine hcl</i>	T2	
<i>perphenazine</i>	T2	
<i>thioridazine hcl</i>	T2	
<i>trifluoperazine hcl</i>	T2	

SSRI-ANTIPSYCH, ATYPICAL, DOPAMINE, SEROTONIN ANTAG

<i>olanzapine/fluoxetine hcl</i>	T2	
<i>olanzapine/fluoxetine hcl (Symbyax)</i>	T2	
SYMBYAX (<i>olanzapine/fluoxetine hcl</i>)	T4	

PSYCHOTHERAPEUTIC DRUGS (Seizure Disorders)

NEUROACTIVE STEROID GABA-A RECEPTOR MODULATOR

ZTALMY	T5	PA SP
--------	----	-------

PSYCHOTHERAPEUTIC DRUGS (Sleep Disorders/Sedatives)

NARCOLEPSY AND SLEEP DISORDER THERAPY AGENTS

<i>armodafinil</i> (Nuvigil)	T2	PA QL (30 tabs/fill)
<i>modafinil 100 mg tablet</i> (Provigil)	T2	PA QL (30 tabs/fill)
SUNOSI	T3	PA QL (30 tabs/fill)

SEDATIVE/HYPNOTICS (Sleep Disorders/Sedatives)

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

LUMRYZ ER	T5	PA QL (30 packets/30 days) SP HD
SODIUM OXYBATE	T5	PA QL (540ml/30 days) SP HD
XYREM	T5	PA QL (540 mls/fill) SP HD
XYWAV	T5	PA QL (540 mls/fill) SP HD

BARBITURATES

<i>phenobarbital</i>	T2	
<i>secobarbital sodium</i>	T2	QL (30 caps/fill)

HYPNOTICS, MELATONIN MT1/MT2 RECEPTOR AGONISTS

HETLIOZ	T5	PA QL (30 caps/fill) SP HD
HETLIOZ LQ	T5	PA QL (158 mls/fill) SP HD
<i>ramelteon</i> (Rozerem)	T2	QL (30 tabs/fill)

SEDATIVE-HYPNOTICS - BENZODIAZEPINES

estazolam	T2	
<i>flurazepam hcl</i>	T2	

T1 – Preferred Generics
T2 – Non-Preferred Generics
T3 – Preferred Brands
T4 – Non-Preferred Brands

T5 – Brand Specialty
PA – Prior Authorization
QL – Quantity Limit

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

HD – May require home delivery pharmacy
PPACA – No Cost-Share Preventive Medication
CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

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

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

SEDATIVE-HYPNOTICS - BENZODIAZEPINES (cont.)

HALCION (<i>triazolam</i>)	T4	
MIDAZOLAM HCL 10 MG/5 ML SYRUP	T4	
<i>midazolam hcl 2 mg/ml syrup</i>	T2	
MIDAZOLAM HCL 5 MG/2.5 ML SYRUP	T4	
RESTORIL (<i>temazepam</i>)	T4	
<i>temazepam (Restoril)</i>	T2	
<i>triazolam</i>	T2	
<i>triazolam (Halcion)</i>	T2	

SEDATIVE-HYPNOTICS, NON-BARBITURATE

BELSOMRA	T4	ST QL (30 tabs/fill)
DAYVIGO	T4	ST
<i>doxepin hcl 3 mg tablet (Silenor)</i>	T2	ST QL (30 tabs/fill)
<i>doxepin hcl 6 mg tablet (Silenor)</i>	T2	ST QL (30 tabs/fill)
EDLUAR	T4	ST QL (30 tabs/fill)
<i>eszopiclone (Lunesta)</i>	T2	QL (30 tabs/fill)
IGALMI	T4	
KETAMINE HCL	T4	
MKO (MIDAZOLAM-KETAMINE-ONDAN)	T4	
QUVIVIQ	T4	ST
<i>SILENOR (doxepin hcl)</i>	T4	ST QL (30 tabs/fill)
<i>zaleplon 10 mg capsule</i>	T2	QL (60 caps/fill)
<i>zaleplon 5 mg capsule</i>	T2	QL (30 caps/fill)
<i>zolpidem tartrate</i>	T2	QL (30 tabs/fill)
<i>zolpidem tartrate (Ambien Cr)</i>	T2	QL (30 tabs/fill)
<i>zolpidem tartrate (Ambien)</i>	T2	QL (30 tabs/fill)

SKIN PREPS (Miscellaneous)

IRRIGANTS

<i>acetic acid</i>	T2	
<i>neomycin sulf/polymyxin b sulf</i>	T2	
PHYSIOLYTE (<i>physiological irrig soln no. 1</i>)	T4	
PHYSIOSOL (<i>physiological irrig soln no. 1</i>)	T4	
<i>ringer's solution</i>	T2	
<i>ringer's solution, lactated</i>	T2	

T1 – Preferred Generics
 T2 – Non-Preferred Generics
 T3 – Preferred Brands
 T4 – Non-Preferred Brands

T5 – Brand Specialty
 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 (Miscellaneous) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
IRRIGANTS (cont.)		
<i>sod,pot chlor/mag/sod,pot phos</i>	T2	
<i>sodium chloride irrig solution</i>	T2	
SORBITOL	T4	
SORBITOL-MANNITOL	T4	
water for irrigation,sterile	T2	
OXIDIZING AGENTS		
<i>hydrogen peroxide</i>	T2	
PRESERVATIVES		
<i>formaldehyde</i>	T2	
SKIN PREPS (Pain Relief And Inflammatory Disease)		
ANTIPSORIATIC AGENTS, SYSTEMIC		
<i>acitretin</i>	T2	
<i>methoxsalen</i>	T2	
SKYRIZI	T5	PA QL(150mg/84 days) SP HD
SKYRIZI (2 SYRINGES) KIT	T5	PA QL(150mg/84 days) SP HD
SKYRIZI PEN	T5	PA QL(150mg/84 days) SP HD
TALTZ AUTOINJECTOR	T5	PA QL(1 ml/28 days) SP HD
TALTZ AUTOINJECTOR (2 PACK)	T5	PA QL(1 ml/28 days) SP HD
TALTZ AUTOINJECTOR (3 PACK)	T5	PA QL(1 ml/28 days) SP HD
TALTZ SYRINGE	T5	PA QL(1 ml/28 days) SP HD
TREMFYA	T5	PA QL SP HD
TOPICAL ANTI-INFLAMMATORY, NSAIDS		
<i>diclofenac 2% solution pump (Pennsaid)</i>	T2	
<i>diclofenac sodium 1% gel</i>	T2	ST QL(500 gms/28 days) HD
FLECTOR	T3	ST QL(60 patches/fill) HD
LICART	T3	ST QL(30 patches/fill) HD
SKIN PREPS (Skin Conditions)		
ACNE AGENTS, SYSTEMIC		
ABSORICA (isotretinoin)	T4	ST
isotretinoin (Absorica)	T2	
ACZONE (<i>dapsone</i>)	T4	ST
<i>adapalene/benzoyl peroxide</i>	T2	
<i>adapalene/benzoyl peroxide (Epiduo Forte)</i>	T2	

T1 – Preferred Generics
T2 – Non-Preferred Generics
T3 – Preferred Brands
T4 – Non-Preferred Brands

T5 – Brand Specialty
PA – Prior Authorization
QL – Quantity Limit

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

HD – May require home delivery pharmacy
PPACA – No Cost-Share Preventive Medication
CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

SKIN PREPS (Skin Conditions) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ANTIPSORIATICS AGENTS (cont.)		
AZELEX	T4	ST
<i>clindamycin phos/benzoyl perox</i>	T2	
<i>clindamycin phos/benzoyl perox (Acanya)</i>	T2	
<i>clindamycin/tretinoin (Ziana)</i>	T2	PA
<i>dapsone (Aczone)</i>	T2	
EPIDUO FORTE	T4	ST
EPIDUO FORTE (<i>adapalene/benzoyl peroxide</i>)	T4	ST
KLARON (<i>sulfacetamide sodium</i>)	T4	ST
NEUAC 1.2-5% KIT	T4	ST
<i>neuac gel</i>	T2	
ONEXTON	T3	ST
<i>sulfacetamide sodium (Klaron)</i>	T2	
ACNE AGENTS, TOPICAL		
<i>clindamycin/tretinoin (Veltin)</i>	T2	
ONEXTON (<i>clindamycin phos/benzoyl perox</i>)	T4	ST
ANTIPRURITICS, TOPICAL		
<i>doxepin 5% cream (Zonalon)</i>	T2	ST QL (90 gms/30 days)
<i>doxepin hcl (Zonalon)</i>	T2	ST QL (90 gms/30 days)
ZONALON	T4	ST QL (90 gms/30 days)
ZONALON (<i>doxepin hcl</i>)	T4	ST QL (90 gms/30 days)
ANTIPSORIATICS AGENTS		
<i>calcipotriene 0.005% cream (Dovonex)</i>	T2	QL (120 gms/30 days)
<i>calcipotriene 0.005% ointment, solution</i>	T2	QL (120 gms/30 days)
<i>calcitriol 3 mcg/g ointment (Vectical)</i>	T2	
DOVONEX (<i>calcipotriene</i>)	T4	ST QL (120 gms/30 days)
DUOBRII	T4	ST QL (200 gms/30 days)
<i>tazarotene 0.05% gel (Tazorac)</i>	T2	PA
<i>tazarotene 0.1% cream (Tazorac)</i>	T2	PA
<i>tazarotene 0.1% gel (Tazorac)</i>	T2	PA
TWYNEO	T4	PA ST
VECTICAL (<i>calcitriol</i>)	T4	
VTAMA	4	PA ST QL (1 tube/28 days)
ZIANA (<i>clindamycin/tretinoin</i>)	T4	PA ST
ZORYVE	T4	PA ST QL (60 gms/28 days)

T1 – Preferred Generics
 T2 – Non-Preferred Generics
 T3 – Preferred Brands
 T4 – Non-Preferred Brands

T5 – Brand Specialty
 PA – Prior Authorization
 QL – Quantity Limit

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

HD – May require home delivery pharmacy
 PPACA – No Cost-Share Preventive Medication
 CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

SKIN PREPS (Skin Conditions) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ANTISEBORRHEIC AGENTS		
ESKATA	T4	
OVACE (<i>sulfacetamide sodium</i>)	T4	
OVACE PLUS	T4	
OVACE PLUS WASH	T4	
PLEXION NS	T4	
<i>selenium sulfide</i>	T2	
SELRX	T4	
<i>sod sulfacetam 10% clnsng gel</i>	T2	
<i>sod sulfacetamide 10% shampoo</i>	T2	
<i>sod sulfacetamide 9.8% shampoo</i>	T2	
SODIUM SULFACETAMIDE 10% WASH	T4	
<i>sodium sulfacetamide 10% wash (Ovace)</i>	T2	
TERSI FOAM	T4	
ANTISEPTICS, GENERAL		
ADVOCATE ALCOHOL 70% PREP PADS	T3	
ALCOHOL 70% PREP PADS	T3	
<i>alcohol 70% swabs</i>	T2	
ALCOHOL 70% WIPES	T3	
<i>alcohol antiseptic pads</i>	T2	
<i>alcohol prep pads</i>	T2	
<i>alcohol swabs</i>	T2	
CARETOUCH ALCOHOL PREP PAD	T3	
CURITY ALCOHOL PREPS	T3	
CVS ALCOHOL 70% PREP PADS	T3	
<i>cvs isopropyl alcohol 70% wipe</i>	T2	
DROPSAFE PREP PADS	T3	
EASY COMFORT ALCOHOL PAD	T3	
EASY TOUCH ALCOHOL PREP PADS	T3	
<i>fifty50 alcohol prep pads</i>	T2	
HM ALCOHOL 70% PREP PADS	T3	
INCONTROL ALCOHOL PADS	T3	
PHARM CHOICE ALCOHOL PREP PADS	T3	
<i>pharm choice alcohol prep pads</i>	T2	
PRO COMFORT ALCOHOL PADS	T3	

T1 – Preferred Generics
 T2 – Non-Preferred Generics
 T3 – Preferred Brands
 T4 – Non-Preferred Brands

T5 – Brand Specialty
 PA – Prior Authorization
 QL – Quantity Limit

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

HD – May require home delivery pharmacy
 PPACA – No Cost-Share Preventive Medication
 CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

SKIN PREPS (Skin Conditions) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ANTISEPTICS,GENERAL (cont.)		
PURE COMFORT ALCOHOL PAD	T3	
<i>qc alcohol 70% swabs</i>	T2	
<i>ra alcohol swabs</i>	T2	
RA ISOPROPYL ALCOHOL 70% WIPES	T3	
RELION ALCOHOL 70% SWABS	T3	
SAPS ALCOHOL 70% PREP PADS	T3	
SINGLE USE SWAB	T3	
SM ALCOHOL 70% PREP PADS	T3	
<i>sm alcohol prep pads</i>	T2	
SURE COMFORT ALCOHOL	T3	
SURE-PREP ALCOHOL PREP PADS	T3	
TRUE COMFORT ALCOHOL PADS	T3	
TRUE COMFORT PRO ALCOHOL PADS	T3	
ULTILET ALCOHOL SWAB	T3	
<i>v-r alcohol prep pads</i>	T2	
WEBCOL	T3	
ANTISEPTICS,MISCELLANEOUS		
GUAIACOL	T3	
DIABETIC ULCER PREPARATIONS, TOPICAL		
REGRANEX	T3	QL(15 gms/fill)
IMMUNOMODULATORS		
<i>imiquimod</i>	T2	
<i>imiquimod (Zyclara)</i>	T2	
IRRITANTS/COUNTER-IRRITANTS		
CANTHARIDIN-ACETONE	T4	
<i>methyl salicylate</i>	T2	
JANUS KINASE (JAK) INHIBITORS		
CIBINQO	T5	PA QL(30 tabs/30 days) SP
KERATOLYTIC-GLUCOCORTICOID COMBINATIONS		
VANOXIDE-HC	T4	ST
KERATOLYTICS		
<i>benzepro 6% foaming cloths</i>	T2	
BENZEPRO 7% CREAMY WASH (<i>benzoyl peroxide microspheres</i>)	T4	ST
<i>benzoyl peroxide</i>	T2	

T1 – Preferred Generics
T2 – Non-Preferred Generics
T3 – Preferred Brands
T4 – Non-Preferred Brands

T5 – Brand Specialty
PA – Prior Authorization
QL – Quantity Limit

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

HD – May require home delivery pharmacy
PPACA – No Cost-Share Preventive Medication
CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

SKIN PREPS (Skin Conditions) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ANTISEPTICS, GENERAL (cont.)		
<i>benzoyl peroxide (Pacnex)</i>	T2	
ENZOCLEAR	T4	ST
INOVA	T4	ST
INOVA 4-1	T4	ST
INOVA 8-2	T4	ST
PACNEX (<i>benzoyl peroxide</i>)	T4	ST
<i>podofilox 0.5% gel</i>	T2	ST QL (7 gms/30 days)
<i>podofilox 0.5% topical soln</i>	T2	
PR BENZOYL PEROXIDE (<i>benzoyl peroxide microspheres</i>)	T4	ST
PROTECTIVES		
PHARMABASE BARRIER (<i>zinc oxide</i>)	T4	
<i>zinc oxide 20% ointment</i>	T2	
ZINC OXIDE PASTE	T3	
ROSACEA AGENTS, TOPICAL		
<i>azelaic acid (Finacea)</i>	T2	
EPSOLAY	T4	ST
FINACEA 15% FOAM	T3	ST
FINACEA 15% GEL (<i>azelaic acid</i>)	T4	ST
<i>ivermectin 1% cream (Soolantra)</i>	T2	QL(45 gms/30 days)
METROCREAM (<i>metronidazole</i>)	T4	ST
METROGEL (<i>metronidazole</i>)	T4	ST
<i>metronidazole</i>	T2	
<i>metronidazole (Metrocream)</i>	T2	
<i>metronidazole (Metrogel)</i>	T2	
MIRVASO	T3	PA
RHOFADE	T4	PA
<i>rosadan 0.75% cream (Metrocream)</i>	T2	
ROSADAN 0.75% CREAM KIT	T4	ST
<i>rosadan 0.75% gel</i>	T2	
ROSADAN 0.75% GEL KIT	T4	ST
SOOLANTRA (<i>ivermectin</i>)	T4	ST QL (60 gms/30 days)
TISSUE/WOUND ADHESIVES		
ARTISS	T4	
SURGISEAL STYLUS	T4	

T1 – Preferred Generics
T2 – Non-Preferred Generics
T3 – Preferred Brands
T4 – Non-Preferred Brands

T5 – Brand Specialty
PA – Prior Authorization
QL – Quantity Limit

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

HD – May require home delivery pharmacy
PPACA – No Cost-Share Preventive Medication
CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

SKIN PREPS (Skin Conditions) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
TISSUE/WOUND ADHESIVES (cont.)		
SURGISEAL TEARDROP	T4	
SURGISEAL TWIST	T4	
TISSEEL VHSD	T4	
TOP. ANTI-INFLAM., PHOSPHODIESTERASE-4 (PDE4) INHIB		
EUCRISA	T3	ST QL(120 gms/30 days)
ZORYVE	T4	
TOPICAL ACNE AGENT,RETINOIC ACID RECEPTOR AGONIST		
AKLIEF	T4	PA ST
ARAZLO	T4	PA
TOPICAL AGENTS, MISCELLANEOUS		
MEDIHONEY	T4	
<i>trichloroacetic acid</i>	T2	
TRICHLOROACETIC ACID 100% (<i>trichloroacetic acid</i>)	T4	
TRICHLOROACETIC ACID 20% (<i>trichloroacetic acid</i>)	T3	
TRICHLOROACETIC ACID 25%	T4	
TRICHLOROACETIC ACID 30%	T3	
TRICHLOROACETIC ACID 35%	T3	
TRICHLOROACETIC ACID 40%	T3	
TRICHLOROACETIC ACID 50%	T3	
TRICHLOROACETIC ACID 75%	T4	
TRICHLOROACETIC ACID 80%	T3	
TRICHLOROACETIC ACID 85%	T3	
TRICHLOROACETIC ACID 90%	T3	
TOPICAL ANTIBIOTIC PLEUROMUTILIN DERIVATIVES		
ALTABAX	T4	ST QL(30 gms/fill)
TOPICAL ANTI-INFLAMMATORY STEROIDAL		
ALA-SCALP (<i>hydrocortisone</i>)	T4	ST
<i>alclometasone dipropionate</i>	T2	
<i>amcinonide</i>	T2	ST
<i>betamethasone dipropionate</i>	T2	
<i>betamethasone va 0.1% cream</i>	T2	
<i>betamethasone va 0.1% lotion</i>	T2	
<i>betamethasone valer 0.1% ointm</i>	T2	
<i>betamethasone valer 0.12% foam</i>	T2	ST

T1 – Preferred Generics
T2 – Non-Preferred Generics
T3 – Preferred Brands
T4 – Non-Preferred Brands

T5 – Brand Specialty
PA – Prior Authorization
QL – Quantity Limit

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

HD – May require home delivery pharmacy
PPACA – No Cost-Share Preventive Medication
CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

SKIN PREPS (Skin Conditions) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
TOPICAL ANTI-INFLAMMATORY STEROIDAL (cont.)		
<i>betamethasone/propylene glyc</i>	T2	
betamethasone/propylene glyc (Diprolene)	T2	
BRYHALI	T4	ST
CAPEX SHAMPOO	T4	ST
<i>clobetasol 0.05% cream (Temovate)</i>	T2	QL(120 gms/30 days)
<i>clobetasol 0.05% gel</i>	T2	QL(120 gms/30 days)
<i>clobetasol 0.05% ointment (Temovate)</i>	T2	QL(120 gms/30 days)
<i>clobetasol 0.05% shampoo (Clobex)</i>	T2	ST QL(236 mls/30 days)
<i>clobetasol 0.05% solution</i>	T2	QL(100 mls/30 days)
<i>clobetasol 0.05% topical lotn</i>	T2	ST QL(118 mls/30 days)
<i>clobetasol emollient 0.05% crm</i>	T2	QL(120 gms/30 days)
<i>clobetasol emollnt 0.05% foam</i>	T2	ST QL(100 gms/30 days)
<i>clobetasol prop 0.05% foam (Olux)</i>	T2	ST QL(100 gms/30 days)
<i>clobetasol prop 0.05% spray (Clobex)</i>	T2	ST QL(125 mls/30 days)
<i>clobetasol propionate/emoll</i>	T2	ST QL(100 gms/30 days)
CLOBEX 0.05% SHAMPOO (<i>clobetasol propionate</i>)	T4	ST QL(236 mls/30 days)
CLOBEX 0.05% SPRAY (<i>clobetasol propionate</i>)	T4	ST QL(125 mls/30 days)
<i>clocortolone pivalate (Cloderm)</i>	T2	
CLODAN 0.05% KIT	T4	ST QL(2 kits/28 days)
<i>clodan 0.05% shampoo (Clobex)</i>	T2	ST QL(236 mls/30 days)
CLODERM	T4	ST
CLODERM (<i>clocortolone pivalate</i>)	T4	ST
CORDRAN 0.025% CREAM	T4	ST QL(120 gms/30 days)
CORDRAN 0.05% CREAM (<i>flurandrenolide</i>)	T4	ST QL(120 gms/30 days)
CORDRAN 0.05% LOTION (<i>flurandrenolide</i>)	T4	ST QL(120 mls/30 days)
CORDRAN 0.05% OINTMENT (<i>flurandrenolide</i>)	T4	ST QL(120 gms/30 days)
CORDRAN 4 MCG/SQ CM TAPE LARGE	T4	ST
CUTIVATE (<i>fluticasone propionate</i>)	T4	ST
DERMA-SMOOTHIE-FS (<i>fluocinolone acetonide</i>)	T4	ST
DERMA-SMOOTHIE-FS (<i>fluocinolone/shower cap</i>)	T4	ST
DERMASORB HC	T4	ST
DERMASORB TA	T4	ST
DERMATOP (<i>prednicarbate</i>)	T4	ST
DESONATE (<i>desonide</i>)	T4	ST

T1 – Preferred Generics
 T2 – Non-Preferred Generics
 T3 – Preferred Brands
 T4 – Non-Preferred Brands

T5 – Brand Specialty
 PA – Prior Authorization
 QL – Quantity Limit

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

HD – May require home delivery pharmacy
 PPACA – No Cost-Share Preventive Medication
 CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

SKIN PREPS (Skin Conditions) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
TOPICAL ANTI-INFLAMMATORY STEROIDAL (cont.)		
<i>desonide</i> (Desonate)	T2	ST
<i>desonide 0.05% cream</i> (Tridesilon)	T2	
<i>desonide 0.05% gel</i> (Desonate)	T2	ST
<i>desonide 0.05% lotion</i>	T2	ST
<i>desonide 0.05% ointment</i>	T2	
<i>desoximetasone</i> (Topicort)	T2	ST
<i>diflorasone diacet/emollient</i>	T2	ST
<i>diflorasone diacetate</i>	T2	ST QL(120 gms/30 days)
DIPROLENE (<i>betamethasone/propylene glyc</i>)	T4	ST
<i>fluocinolone acetonide</i>	T2	
<i>fluocinolone acetonide</i> (Derma-Smoothe-Fs)	T2	
<i>fluocinolone acetonide</i> (Synalar)	T2	
<i>fluocinolone/shower cap</i> (Derma-Smoothe-Fs)	T2	
<i>fluocinonide 0.05% cream</i>	T2	QL(120 gms/30 days)
<i>fluocinonide 0.05% gel</i>	T2	QL(120 gms/30 days)
<i>fluocinonide 0.05% ointment</i>	T2	QL(120 gms/30 days)
<i>fluocinonide 0.05% solution</i>	T2	QL(120 gms/30 days)
<i>fluocinonide 0.1% cream</i> (Vanos)	T2	ST QL(120 gms/30 days)
<i>fluocinonide/emollient base</i>	T2	QL(120 gms/30 days)
<i>flurandrenolide 0.05% cream</i> (Cordran)	T2	ST QL(120 gms/30 days)
<i>flurandrenolide 0.05% lotion</i> (Cordran)	T2	ST QL(120 mls/30 days)
<i>flurandrenolide 0.05% ointment</i> (Cordran)	T2	ST QL(120 gms/30 days)
<i>fluticasone prop 0.005% oint</i>	T2	
<i>fluticasone prop 0.05% cream</i> (Cutivate)	T2	
<i>fluticasone prop 0.05% lotion</i> (Cutivate)	T2	ST
<i>fluticasone propionate</i> (Cutivate)	T2	ST
<i>halcinonide</i> (Halog)	T2	ST
<i>halobetasol prop 0.05% cream</i> (Ultravate)	T2	
<i>halobetasol prop 0.05% ointmnt</i> (Ultravate)	T2	
<i>halobetasol prop 0.05% cream</i>	T2	
<i>halobetasol prop 0.05% foam</i>	T2	ST
<i>halobetasol prop 0.05% ointmnt</i>	T2	
HALOG	T4	ST
HALOG (<i>halcinonide</i>)	T4	ST

T1 – Preferred Generics
 T2 – Non-Preferred Generics
 T3 – Preferred Brands
 T4 – Non-Preferred Brands

T5 – Brand Specialty
 PA – Prior Authorization
 QL – Quantity Limit

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

HD – May require home delivery pharmacy
 PPACA – No Cost-Share Preventive Medication
 CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

SKIN PREPS (Skin Conditions) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
TOPICAL ANTI-INFLAMMATORY STEROIDAL (cont.)		
<i>hydrocort buty 0.1% lipid crm (Locoid Lipocream)</i>	T2	QL(120 gms/30 days)
<i>hydrocort buty 0.1% lipo cream (Locoid Lipocream)</i>	T2	QL(120 gms/30 days)
<i>hydrocort/min oil/petrolat,wht</i>	T2	
<i>hydrocortisone</i>	T2	
<i>hydrocortisone (Ala-Scalp)</i>	T2	
<i>hydrocortisone (Anusol-Hc)</i>	T2	
<i>hydrocortisone buty 0.1% cream</i>	T2	QL(120 gms/30 days)
<i>hydrocortisone butyr 0.1% lotn (Locoid)</i>	T2	ST QL(118 mls/30 days)
<i>hydrocortisone butyr 0.1% oint</i>	T2	ST QL (10gm/28 days)
<i>hydrocortisone butyr 0.1% soln</i>	T2	ST QL(120 mls/30 days)
<i>hydrocortisone valerate</i>	T2	
IMPEKLO	T4	ST QL(136 gms/28 days)
KENALOG 0.147 MG/GRAM SPRAY (<i>triamcinolone acetonide</i>)	T4	ST QL(100 gms/30 days)
KENALOG 0.147 MG/GRAM SPRAY (<i>triamcinolone acetonide</i>)	T4	ST QL(126 gms/30 days)
<i>mometasone furoate 0.1% cream</i>	T2	
<i>mometasone furoate 0.1% oint</i>	T2	
<i>mometasone furoate 0.1% soln</i>	T2	
<i>nolix 0.05% cream (Cordran)</i>	T2	ST QL(120 gms/30 days)
<i>nolix 0.05% lotion (Cordran)</i>	T2	ST QL(120 mls/30 days)
NUCORT	T4	ST
OLUX (<i>clobetasol propionate</i>)	T4	ST QL(100 gms/30 days)
PANDEL	T4	ST
<i>prednicarbate</i>	T2	
<i>prednicarbate (Dermatop)</i>	T2	
SCALACORT DK	T4	ST
SYNALAR	T4	ST
SYNALAR (<i>fluocinolone acetonide</i>)	T4	ST
SYNALAR TS	T4	ST
TEMOVATE (<i>clobetasol propionate</i>)	T4	ST QL(120 gms/30 days)
TEXACORT	T4	ST
TOPICORT 0.05% CREAM (<i>desoximetasone</i>)	T4	ST
TOPICORT 0.05% GEL (<i>desoximetasone</i>)	T4	ST
TOPICORT 0.05% OINTMENT (<i>desoximetasone</i>)	T4	ST
TOPICORT 0.25% CREAM (<i>desoximetasone</i>)	T4	ST

T1 – Preferred Generics
 T2 – Non-Preferred Generics
 T3 – Preferred Brands
 T4 – Non-Preferred Brands

T5 – Brand Specialty
 PA – Prior Authorization
 QL – Quantity Limit

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

HD – May require home delivery pharmacy
 PPACA – No Cost-Share Preventive Medication
 CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

SKIN PREPS (Skin Conditions) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
TOPICAL ANTI-INFLAMMATORY STEROIDAL (cont.)		
TOPICORT 0.25% OINTMENT (<i>desoximetasone</i>)	T4	ST
<i>triamcinolone 0.025% cream</i>	T2	
<i>triamcinolone 0.025% lotion</i>	T2	
<i>triamcinolone 0.025% oint</i>	T2	
<i>triamcinolone 0.05% ointment</i>	T2	ST
<i>triamcinolone 0.1% cream</i>	T2	
<i>triamcinolone 0.1% lotion</i>	T2	
<i>triamcinolone 0.1% ointment</i>	T2	
<i>triamcinolone 0.147 mg/g spray (Kenalog)</i>	T2	ST QL(126 gms/30 days)
<i>triamcinolone 0.147 mg/g spray (Kenalog)</i>	T2	ST QL(100 gms/30 days)
<i>triamcinolone 0.5% cream, ointment</i>	T2	
<i>triamcinolone acetonide</i>	T2	ST
<i>triderm 0.1% cream</i>	T2	
<i>triderm 0.5% cream</i>	T2	ST
TRIDESILON (<i>desonide</i>)	T4	ST
ULTRAVATE X	T4	ST
TOPICAL ANTI-INFLAMMATORY STEROID-LOCAL ANESTHETIC		
ANALPRAM HC 2.5%-1% LOTION (<i>hydrocortisone/pramoxine</i>)	T4	ST
EPIFOAM	T4	ST
<i>hydrocort-pramoxine 2.5-1% cm</i>	T2	ST
<i>lidocaine/hydrocortisone ac</i>	T2	
<i>lidocaine-hc 3-0.5% cream</i>	T2	
PRAMOSONE	T4	ST
TOPICAL ANTIPARASITICS		
<i>lindane</i>	T2	
<i>malathion (Ovide)</i>	T2	
OVIDE (<i>malathion</i>)	T4	
TOPICAL JANUS KINASE (JAK) INHIBITORS		
OPZELURA	T4	PA QL(240 gms/28 days)
TOPICAL PREPARATIONS, ANTIBACTERIALS		
<i>iodine/potassium iodide</i>	T2	
<i>iodine/sodium iodide</i>	T2	
IODOFLEX	T4	
IODOSORB	T4	

T1 – Preferred Generics
 T2 – Non-Preferred Generics
 T3 – Preferred Brands
 T4 – Non-Preferred Brands

T5 – Brand Specialty
 PA – Prior Authorization
 QL – Quantity Limit

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

HD – May require home delivery pharmacy
 PPACA – No Cost-Share Preventive Medication
 CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

SKIN PREPS (Skin Conditions) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
TOPICAL VIT D ANALOG/ANTI-INFLAMMATORY STEROID		
<i>calcipotriene/betamethasone</i> (Taclonex)	T2	ST QL (60 gms/30 days)
<i>calcipotriene/betamethasone</i> (Taclonex)	T2	QL(60 gms/30 days)
ENSTILAR	T3	ST QL (60 gms/30 days)
TACLONEX 0.005%-0.064% SUSPENS (<i>calcipotriene/betamethasone</i>)	T4	QL(60 gms/30 days)
TACLONEX OINTMENT (<i>calcipotriene/betamethasone</i>)	T4	ST QL (60 gms/30 days)
WYNZORA	T4	ST QL(60 gms/30 days)
TOPICAL/MUCOUS MEMBR./SUBCUT. ENZYMES		
SANTYL	T3	QL(180 gms/fill)
VITAMIN A DERIVATIVES		
<i>adapalene 0.1% cream</i> (Differin)	T2	
ADAPALENE 0.1% LOTION	T4	ST
<i>adapalene 0.1% solution</i>	T2	
<i>adapalene 0.1% swab</i>	T2	ST
<i>adapalene 0.3% gel</i>	T2	
<i>adapalene 0.3% gel pump</i> (Differin)	T2	
ALTRENO	T4	PA
<i>avita 0.025% cream</i> (Retin-A)	T2	PA
AVITA 0.025% GEL	T4	PA
DIFFERIN	T4	ST
DIFFERIN (<i>adapalene</i>)	T4	ST
RETIN-A (<i>tretinoin</i>)	T4	PA
RETIN-A MICRO PUMP 0.06% GEL	T4	PA
RETIN-A MICRO PUMP 0.08% GEL	T4	PA
<i>tretinoin 0.01% gel</i> (Retin-A)	T2	PA
<i>tretinoin 0.025% cream</i> (Retin-A)	T2	PA
<i>tretinoin 0.025% gel</i> (Retin-A)	T2	PA
<i>tretinoin 0.05% cream</i> (Retin-A)	T2	PA
<i>tretinoin 0.05% gel</i> (Atralin)	T2	PA
<i>tretinoin 0.1% cream</i> (Retin-A)	T2	PA
<i>tretinoin microspheres</i> (Retin-A Micro Pump)	T2	PA
<i>tretinoin microspheres</i> (Retin-A Micro)	T2	PA
TRETIN-X	T4	PA

T1 – Preferred Generics
 T2 – Non-Preferred Generics
 T3 – Preferred Brands
 T4 – Non-Preferred Brands

T5 – Brand Specialty
 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

SMOKING DETERRENTS (Smoking Cessation)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
SMOKING DETERRENT AGENTS (GANGLIONIC STIM, OTHERS)		
NICOTROL	T4	QL(180 ds/365 days) PPACA
NICOTROL NS	T4	QL(180 ds/365 days) PPACA
SMOKING DETERRENT-NICOTINIC RECEPT.PARTIAL AGONIST		
APO-VARENICLINE 0.5 MG TABLET	T3	QL(180 ds/365 days) PPACA
APO-VARENICLINE 1 MG TABLET	T3	QL(180 ds/365 days) PPACA
CHANTIX	T4	QL(180 ds/365 days) PPACA
<i>varenicline starting month box</i>	T2	
SMOKING DETERRENTS, OTHER		
<i>bupropion hcl sr 150 mg tablet</i>	T2	QL(180 ds/365 days) PPACA
THYROID PREPS (Hormonal Agents)		
ANTITHYROID PREPARATIONS		
<i>methimazole (Tapazole)</i>	T1	HD
<i>propylthiouracil</i>	T2	HD
TAPAZOLE (<i>methimazole</i>)	T4	HD
THYROID HORMONES		
<i>adthyza 15 mg tablet</i>	T2	HD
<i>adthyza 30 mg tablet</i>	T2	HD
<i>adthyza 60 mg tablet</i>	T2	HD
<i>adthyza 90 mg tablet</i>	T2	HD
<i>adthyza 120 mg tablet</i>	T2	HD
ARMOUR THYROID	T3	HD
ERMEZA	T4	ST HD
<i>levothyroxine sodium (Synthroid)</i>	T1	HD
<i>liothyronine sodium (Cytomel)</i>	T2	HD
<i>thyroid,pork</i>	T2	HD
UNCLASSIFIED DRUG PRODUCTS (AIDS/HIV)		
CYTOCHROME P450 INHIBITORS		
TYBOST	T5	SP
UNCLASSIFIED DRUG PRODUCTS (Asthma/COPD/Respiratory)		
CYSTIC FIBROSIS - INHALED OSMOTIC AGENTS		
BRONCHITOL	T5	PA SP HD
CYSTIC FIBROSIS-CFTR POTENTIATOR-CORRECTOR COMBIN.		
ORKAMBI 100 MG-125 MG TABLET	T5	PA QL(112 tabs/fill) SP HD

T1 – Preferred Generics
 T2 – Non-Preferred Generics
 T3 – Preferred Brands
 T4 – Non-Preferred Brands

T5 – Brand Specialty
 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 (Asthma/COPD/Respiratory) (cont.)

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

CYSTIC FIBROSIS-CFTR POTENTIATOR-CORRECTOR COMBIN. (cont.)

ORKAMBI 100-125 MG GRANULE PKT	T5	PA QL(56 packs/fill) SP HD
ORKAMBI 150-188 MG GRANULE PKT	T5	PA QL(56 packs/fill) SP HD
ORKAMBI 200 MG-125 MG TABLET	T5	PA QL(112 tabs/fill) SP HD
ORKAMBI 75-94 MG GRANULE PKT	T5	PA QL(56 packs/fill) SP HD
SYMDEKO	T5	PA QL(56 tabs/fill) SP HD
TRIKAFTA	T5	PA QL(84 tabs/fill) SP HD
TRIKAFTA GRANULE PKT	T5	PA QL(84 pkts/fill) SP HD

CYSTIC FIB-TRANSMEMB CONDUCT.REG.(CFTR) POTENTIATOR

KALYDECO 5.8 MG GRANULES PKT	T5	PA QL(56 packs/fill) SP HD
KALYDECO GRANULES PACKET	T5	PA QL(56 packs/fill) SP HD
KALYDECO 150 MG TABLET	T5	PA QL(56 tabs/fill) SP HD

LUNG SURFACTANTS

CUROSURF	T4	
INFASURF	T4	
SURFAXIN	T4	
SURVANTA	T4	

MUCOLYTICS

PULMOZYME	T5	PA SP HD
-----------	----	----------

PULMONARY FIBROSIS - SYSTEMIC ENZYME INHIBITORS

OFEV	T5	PA QL(60 caps/fill) SP HD
------	----	---------------------------

SYSTEMIC ENZYME INHIBITORS

JOENJA 70 MG TABLET	T5	PA QL (60 tabs/30 days) SP
VIJOICE 125 MG TABLET	T5	PA QL(28 tabs/28 days) SP
VIJOICE 250 MG DAILY DOSE PACK	T5	PA QL(56 tabs/28 days) SP
VIJOICE 50 MG TABLET	T5	PA QL(28 tabs/28 days) SP
ZOKINVY	T5	PA QL(120 caps/fill) SP

SYSTEMIC ENZYME INHIBITORS

TEZSPIRE 210 MG/1.91 ML PEN	T5	PA QL (1 pen/28 days) SP HD
TEZSPIRE 210 MG/1.91 ML SYRING	T5	PA QL (1 syg/28 days) SP HD

UNCLASSIFIED DRUG PRODUCTS (Blood Modifiers/Bleeding Disorders)

SPLEEN TYROSINE KINASE INHIBITORS

TAVALISSE	T5	PA QL(60 tabs/fill) SP
-----------	----	------------------------

T1 – Preferred Generics
T2 – Non-Preferred Generics
T3 – Preferred Brands
T4 – Non-Preferred Brands

T5 – Brand Specialty
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 (Blood Pressure/Heart Medications)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
BRADYKININ B2 RECEPTOR ANTAGONISTS		
<i>icatibant acetate (Firazyr)</i>	T2	PA SP HD
<i>icatibant acetate (Firazyr)</i>	T2	PA SP
PLASMA KALLIKREIN INHIBITORS		
ORLADEYO	T5	PA QL (28 caps/28 days) SP
TAKHZYRO 300MG/2ML	T5	PA QL (2units/28 days) SP HD

UNCLASSIFIED DRUG PRODUCTS (Cancer)

CHEMOTHERAPY RESCUE/ANTIDOTE AGENTS

<i>leucovorin calcium</i>	T2	CSL
MESNEX	T5	SP CSL
VISTOGARD	T5	PA QL(20 packs/fill) SP CSL

RADIOACTIVE THERAPEUTIC AGENTS

SODIUM IODIDE I-123	T4	CSL
---------------------	----	-----

UNCLASSIFIED DRUG PRODUCTS (Dental Products)

DENTAL AIDS AND PREPARATIONS

<i>chlorhexidine gluconate (Peridex)</i>	T1	
PERIDEX (<i>chlorhexidine gluconate</i>)	T4	
<i>triamcinolone 0.1% paste</i>	T2	
<i>triamcinolone acetonide</i>	T2	

PERIODONTAL COLLAGENASE INHIBITORS

<i>doxycycline hyclate 20 mg tab</i>	T2	
--------------------------------------	----	--

UNCLASSIFIED DRUG PRODUCTS (Erectile Dysfunction)

DRUGS TO TREAT ERECTILE DYSFUNCTION (ED)

CAVERJECT 20 MCG VIAL	T2	PA QL(12 vials/fill)
CAVERJECT 40 MCG VIAL	T2	PA QL(12 vials/fill)
CAVERJECT IMPULSE 10 MCG KIT	T2	PA QL(12 kits/fill)
CAVERJECT IMPULSE 10 MCG SYRNG	T2	PA QL(12 syringes/fill)
CAVERJECT IMPULSE 20 MCG KIT	T2	PA QL(12 kits/fill)
CAVERJECT IMPULSE 20 MCG SYRNG	T2	PA QL(12 syringes/fill)
CIALIS (<i>tadalafil</i>)	T4	PA QL(8 tabs/30 days)
EDEX 10 MCG CARTRIDGE 2-PK KIT	T3	PA QL(6 kits/fill)
EDEX 10 MCG CARTRIDGE 6-PK KIT	T3	PA QL(2 kits/fill)
EDEX 20 MCG CARTRIDGE 2-PK KIT	T3	PA QL(6 kits/fill)
EDEX 20 MCG CARTRIDGE 6-PK KIT	T3	PA QL(2 kits/fill)

T1 – Preferred Generics
T2 – Non-Preferred Generics
T3 – Preferred Brands
T4 – Non-Preferred Brands

T5 – Brand Specialty
PA – Prior Authorization
QL – Quantity Limit

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

HD – May require home delivery pharmacy
PPACA – No Cost-Share Preventive Medication
CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

UNCLASSIFIED DRUG PRODUCTS (Erectile Dysfunction) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
DRUGS TO TREAT ERECTILE DYSFUNCTION (ED) (cont.)		
EDEX 40 MCG CARTRIDGE 2-PK KIT	T3	PA QL (6 kits/fill)
EDEX 40 MCG CARTRIDGE 6-PK KIT	T3	PA QL (2 kits/fill)
IFE-BIMIX 30/1	T3	
LEVITRA (<i>ildenafil hcl</i>)	T3	PA QL (8 tabs/fill)
MUSE	T2	PA QL (12 supps/fill)
PAPAVERINE-PHENTOLAMINE	T3	
PAPAVERINE-PHENTOLMN-ALPROSTD	T3	
STENDRA	T3	PA QL (8 tabs/fill)
<i>tadalafil 2.5 mg tablet</i>	T2	PA QL (30 tabs/30 days)
<i>tadalafil 5 mg tablet (Cialis)</i>	T2	
<i>tadalafil 10 mg tablet (Cialis)</i>	T2	
<i>tadalafil 20 mg tablet (Cialis)</i>	T2	
TRI-MIX (PAPVRN-PHNTLMN-PGE1)	T3	
<i>ildenafil hcl</i>	T2	PA QL (8 tabs/fill)
<i>ildenafil hcl (Levitra)</i>	T2	PA QL (8 tabs/fill)
VIAGRA (<i>sildenafil citrate</i>)	T4	PA QL (8 tabs/fill)

UNCLASSIFIED DRUG PRODUCTS (Eye Conditions)

NICOTINIC RECEPT.PARTIAL AGONIST, ALPHA4BETA2 SPEC

TYRVAYA	T4	PA
---------	----	----

UNCLASSIFIED DRUG PRODUCTS (Gastrointestinal/Heartburn)

AGENTS FOR STOMATOLOGICAL USE

PROTHELIAL	T4	
SILATRIX	T4	

COMPOUNDING KIT

FIRST-MOUTHWASH BLM	T4	
---------------------	----	--

ORAL MUCOSITIS/STOMATITIS AGENTS

GELCLAIR	T4	
GELX	T4	
ORAMAGICRX	T4	

ORAL MUCOSITIS/STOMATITIS ANTI-INFLAMMATORY AGENT

EPISIL	T4	
--------	----	--

SALIVA STIMULANT AGENTS

NUMOISYN	T4	
----------	----	--

T1 – Preferred Generics
T2 – Non-Preferred Generics
T3 – Preferred Brands
T4 – Non-Preferred Brands

T5 – Brand Specialty
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 (Gastrointestinal/Heartburn) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
SALIVA SUBSTITUTE AGENTS		
AQUORAL	T4	
BOCASAL	T4	
CAPHOSOL	T4	
MUCOSITISRX	T4	
NEUTRASAL	T4	
NUMOISYN	T4	
SALIVAMAX	T4	
UNCLASSIFIED DRUG PRODUCTS (Hormonal Agents)		
GROWTH HORMONE RECEPTOR ANTAGONISTS		
SOMAVERT	T5	PA SP HD
HYPERPARATHYROID TX AGENTS - VITAMIN D ANALOG-TYPE		
<i>doxercalciferol</i>	T2	ST
<i>paricalcitol</i>	T2	ST SP HD
<i>paricalcitol (Zemplar)</i>	T2	ST SP HD
RAYALDEE	T4	ST
ZEMPLAR (<i>paricalcitol</i>)	T5	ST SP HD
UNCLASSIFIED DRUG PRODUCTS (Miscellaneous)		
ABORTIFACIENT-PROGESTERONE RECEPTOR ANTAGONISTS		
MIFEPREX	T4	
<i>mifepristone 200 mg tablet</i>	T2	
AMMONIA INHIBITORS		
CARBAGLU	T5	PA SP HD
<i>carglumic acid</i>	T2	PA SP HD
AMYLOIDOSIS AGENTS-TRANSTHYRETIN (TTR) SUPPRESSION		
TEGSEDI	T5	PA QL (4 SYR/28 DAYS) SP HD
ANTI-ALCOHOLIC PREPARATIONS		
<i>acamprosate calcium</i>	T2	
<i>disulfiram</i>	T2	
ANTIFIBROTIC THERAPY - PYRIDONE ANALOGS		
<i>pirfenidone 267 mg tablet (Esbriet)</i>	T2	
<i>pirfenidone 801 mg tablet (Esbriet)</i>	T2	
CI ESTERASE INHIBITORS		
HAEGARDA 2,000UNIT VIAL	6	PA QL (24 vials/28 days) SP HD
HAEGARDA 3,000UNIT VIAL	6	PA QL (16 vials/28 days) SP HD

T1 – Preferred Generics
T2 – Non-Preferred Generics
T3 – Preferred Brands
T4 – Non-Preferred Brands

T5 – Brand Specialty
PA – Prior Authorization
QL – Quantity Limit

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

HD – May require home delivery pharmacy
PPACA – No Cost-Share Preventive Medication
CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

UNCLASSIFIED DRUG PRODUCTS (Miscellaneous) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
CALCIMIMETIC, PARATHYROID CALCIUM ENHANCER		
<i>cinacalcet hcl</i> (Sensipar)	T2	PA SP
COMPOUNDING KIT		
FIRST-MOUTHWASH BLM	T4	
CRYOPRESERVATIVE AGENTS		
<i>dimethyl sulfoxide</i>	T2	
DRUGS TO TREAT HEREDITARY TYROSINEMIA		
<i>nitisinone</i> (Orfadin)	T2	PA SP HD
NITYR	T5	PA SP
ORFADIN	T5	PA SP
ORFADIN (<i>nitisinone</i>)	T5	PA SP
DRUGS TO TX GAUCHER DX-TYPE I, SUBSTRATE REDUCING		
CERDELGA	T5	PA QL (56 caps/28 days) SP HD
ENVIRONMENT ALLERGENS AND IRRITANTS, OTHER		
T.R.U.E. TEST	T4	
GENERAL INHALATION AGENTS		
HYPER-SAL	T4	
<i>nebusal 3% vial</i>	T2	
NEBUSAL 6% VIAL	T4	
<i>sodium chloride for inhalation</i>	T2	
GENETIC D/O TX - SMN PROTEIN DEFICIENCY TREATMENT		
EVRYSDI	T5	PA QL (240 mls/fill) SP HD
GLUCOSYLCERAMIDE SYNTHASE (GCS) INHIBITOR		
<i>miglustat</i> (Zavesca)	T2	PA QL (90 caps/30 days) SP
OPFOLDA	T5	PA QL (8 caps/fill) SP HD
HOMEOPATHIC DRUGS		
VERTIGOHEEL	T4	
MENOPAUSAL SYMPTOMS SUPPRESSANT-NK3 RECEPTOR ANTAG		
VEOZAH	T4	
MENOPAUSAL SYMPTOMS SUPPRESSANT - SSRIS		
paroxetine mesylate (Brisdelle)	T2	ST QL (30 caps/fill) HD
METABOLIC DISEASE ENZYME REPLACE, HYPOPHOSPHATASIA		
STRENSIQ	T5	PA SP
METALLIC POISON, AGENTS TO TREAT		
CHEMET	T3	PA
<i>deferasirox</i> (Exjade)	T2	PA SP HD

T1 – Preferred Generics
 T2 – Non-Preferred Generics
 T3 – Preferred Brands
 T4 – Non-Preferred Brands

T5 – Brand Specialty
 PA – Prior Authorization
 QL – Quantity Limit

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

HD – May require home delivery pharmacy
 PPACA – No Cost-Share Preventive Medication
 CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

UNCLASSIFIED DRUG PRODUCTS (Miscellaneous) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
METALLIC POISON, AGENTS TO TREAT (cont.)		
<i>deferasirox</i> (Jadenu Sprinkle)	T2	PA SP HD
<i>deferasirox</i> (Jadenu)	T2	PA SP HD
<i>deferiprone</i> (Ferriprox (3 Times A Day))	T2	PA SP HD
<i>deferiprone</i> (Ferriprox)	T2	PA SP HD
FERRIPROX (2 TIMES A DAY)	T5	PA SP
FERRIPROX (3 TIMES A DAY) (<i>deferiprone</i>)	T5	PA SP
FERRIPROX 1,000 MG TABLET (<i>deferiprone</i>)	T5	PA SP
FERRIPROX 100 MG/ML SOLUTION	T5	PA SP
FERRIPROX 500 MG TABLET (<i>deferiprone</i>)	T5	PA SP
GALZIN	T4	
RADIOGARDASE	T4	
SYPRINE (<i>trientine hcl</i>)	T5	PA SP HD
<i>trientine hcl</i> (Syprine)	T2	PA SP HD
NATRIURETIC PEPTIDES		
VOXZOGO	T5	PA SP HD
PHARMACOLOGICAL CHAPERONE-ALPHA-GALACTOSID.A STABZ		
GALAFOLD	T5	PA QL(15 caps/fill) SP HD
PKU TX AGENT-COFACTOR OF PHENYLALANINE HYDROXYLASE		
<i>sapropterin dihydrochloride</i> (Kuvan)	T2	PA SP
<i>sapropterin dihydrochloride</i> (Kuvan)	T2	PA SP HD
PROTEIN STABILIZERS		
VYNDAMAX	T5	PA SP HD
VYNDAQEL	T5	PA SP HD
RETINOIC ACID RECEPTOR (RAR) AGONISTS		
SOHONOS 1 MG CAPSULE	T5	PA QL(112 caps/fill) SP
SOHONOS 1.5 MG CAPSULE	T5	PA QL(112 caps/fill) SP
SOHONOS 10 MG CAPSULE	T5	PA QL(56 caps/fill) SP
SOHONOS 2.5 MG CAPSULE	T5	PA QL(140 caps/fill) SP
SOHONOS 5 MG CAPSULE	T5	PA QL(84 caps/fill) SP
SOLVENTS		
CVS ISOPROPYL ALCOHOL 91%	T4	
<i>cvs isopropyl alcohol 91%</i>	T2	
CVS ISOPROPYL RUB ALCOHOL 70%	T4	
<i>cvs isopropyl rub alcohol 70%</i>	T2	

T1 – Preferred Generics
T2 – Non-Preferred Generics
T3 – Preferred Brands
T4 – Non-Preferred Brands

T5 – Brand Specialty
PA – Prior Authorization
QL – Quantity Limit

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

HD – May require home delivery pharmacy
PPACA – No Cost-Share Preventive Medication
CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

UNCLASSIFIED DRUG PRODUCTS (Miscellaneous) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
SOLVENTS(cont.)		
<i>eql isopropyl alcohol 91%</i>	T2	
<i>eql isopropyl rub alcohol 70%</i>	T2	
FT ISOPROPYL ALCOHOL 91%	T4	
FT ISOPROPYL RUB ALCOHOL 70%	T4	
<i>gnp isopropyl alcohol 99%</i>	T2	
<i>hm isopropyl alcohol 70%</i>	T2	
<i>hm isopropyl alcohol 91%</i>	T2	
INSTACLEAN	T3	
ISOPROPANOL	T3	
<i>isopropyl 70% alcohol</i>	T2	
<i>isopropyl alcohol</i>	T2	
<i>isopropyl alcohol 70%</i>	T2	
<i>isopropyl alcohol 91%</i>	T2	
<i>isopropyl alcohol 99%</i>	T2	
<i>isopropyl rubbing alcohol 70%</i>	T2	
ISOPROPYL RUBBING ALCOHOL 70%	T4	
ISOPROPYL RUBBING ALCOHOL 91%	T4	
<i>kro isopropyl alcohol 91%</i>	T2	
MURI-LUBE MINERAL OIL	T3	
<i>polyethylene glycol</i>	T2	
<i>qc isopropyl alcohol 91%</i>	T2	
<i>qc isopropyl rubbing alcohol</i>	T2	
<i>ra isopropyl alcohol 70%</i>	T2	
<i>ra isopropyl alcohol 91%</i>	T2	
<i>sm isopropyl alcohol 70%</i>	T2	
SM ISOPROPYL ALCOHOL 91%	T4	
<i>sm isopropyl alcohol 91%</i>	T2	
<i>sm isopropyl alcohol 99%</i>	T2	
<i>swan isopropyl alcohol 70%</i>	T2	
SUSPENDING AGENTS		
GELFILM	T4	
HYDROXYPROPYLCELLULOSE	T3	
HYPROMELLOSE	T3	

T1 – Preferred Generics
T2 – Non-Preferred Generics
T3 – Preferred Brands
T4 – Non-Preferred Brands

T5 – Brand Specialty
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 (Nutritional/Dietary)

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

METABOLIC DEFICIENCY AGENTS

<i>betaine</i> (Cystadane)	T2	PA SP HD
CARNITOR (<i>levocarnitine (with sugar)</i>)	T4	
CARNITOR (<i>levocarnitine</i>)	T4	
CARNITOR SF (<i>levocarnitine</i>)	T4	
<i>levocarnitine</i> (Carnitor Sf)	T2	
<i>levocarnitine</i> (Carnitor)	T2	
<i>levocarnitine (with sugar)</i> (Carnitor)	T2	

UNCLASSIFIED DRUG PRODUCTS (Osteoporosis Products)

BONE FORMATION STIM. AGENTS - PARATHYROID HORMONE

FORTEO (<i>teriparatide</i>)	T5	PA QL (1 pens/28 days) SP HD
<i>teriparatide 600 mcg/2.4ml pen</i> (Forteo)	T2	PA QL (1 pen/28 days) SP HD
TERIPARATIDE 620 MCG/2.48 ML	T5	PA QL (1 pen/28 days) SP HD

BONE RESORPTION INHIBITOR AND VITAMIN D COMBS.

FOSAMAX PLUS D	T4	ST QL (4 tabs/28 days) HD
----------------	----	---------------------------

BONE RESORPTION INHIBITORS

ACTONEL 150 MG TABLET (<i>risedronate sodium</i>)	T4	ST QL (1 TAB/30 DAYS) HD
ACTONEL 35 MG TABLET (<i>risedronate sodium</i>)	T4	ST QL (4 tabs/28 days) HD
<i>alendronate sod 70 mg/75 ml</i>	T2	QL (300 mls/28 days) HD
<i>alendronate sodium 10 mg tab</i>	T1	QL (30 tabs/fill) HD
<i>alendronate sodium 35 mg tab</i>	T1	QL (4 tabs/28 days) HD
<i>alendronate sodium 40 mg tab</i>	T1	HD
<i>alendronate sodium 5 mg tablet</i>	T1	QL (30 tabs/fill) HD
<i>alendronate sodium 70 mg tab</i> (Fosamax)	T1	QL (4 tabs/28 days) HD
AELVIA (<i>risedronate sodium</i>)	T4	ST QL (4 tabs/28 days) HD
BINOSTO	T4	ST QL (4 tabs/28 days) HD
EVISTA (<i>raloxifene hcl</i>)	T4	HD
FOSAMAX (<i>alendronate sodium</i>)	T4	ST QL (4 tabs/28 days) HD
<i>ibandronate sodium</i>	T2	QL (1 tab/30 days) HD
<i>raloxifene hcl</i> (Evista)	T2	HD PPACA
<i>risedronate sodium</i> (Atelvia)	T2	QL (4 tabs/28 days) HD
<i>risedronate sodium 150 mg tab</i> (Actonel)	T2	QL (1 tab/30 days) HD
<i>risedronate sodium 30 mg tab</i>	T2	QL (30 tabs/fill) HD
<i>risedronate sodium 35 mg tab</i> (Actonel)	T2	QL (4 tabs/28 days) HD
<i>risedronate sodium 5 mg tablet</i>	T2	QL (30 tabs/fill) HD

T1 – Preferred Generics
 T2 – Non-Preferred Generics
 T3 – Preferred Brands
 T4 – Non-Preferred Brands

T5 – Brand Specialty
 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 (Pain Relief And Inflammatory Disease)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ANTI-INFLAM. INTERLEUKIN-I RECEPTOR ANTAGONIST		
ARCALYST	T5	PA QL(4 vls/28 days) SP HD
FIBROMYALGIA AGENTS, SEROTONIN-NOREPINEPH RU INHIB		
SAVELLA 100 MG TABLET	T3	ST QL(60 tabs/fill) HD
SAVELLA 12.5 MG TABLET	T3	ST QL(60 tabs/fill) HD
SAVELLA 25 MG TABLET	T3	ST QL(60 tabs/fill) HD
SAVELLA 50 MG TABLET	T3	ST QL(60 tabs/fill) HD
SAVELLA TITRATION PACK	T3	ST QL(55 tabs/fill) HD
IMMUNOMODULATOR, B-LYMPHOCYTE STIM (BLYS)-SPEC INHIB		
BENLYSTA	T5	PA QL(4 mls/28 days) SP HD

UNCLASSIFIED DRUG PRODUCTS (Seizure Disorders)

NEUROPATHIC AGENTS		
<i>pregabalin</i> (Lyrica Cr)	T2	PA HD

UNCLASSIFIED DRUG PRODUCTS (Skin Conditions)

INTERLEUKIN-13 (IL-13) INHIBITORS, MAB		
ADBRY	T5	PA QL(4 syringes/28 days) SP HD
JANUS KINASE (JAK) INHIBITORS		
LITFULO	T5	PA QL(28 caps/28 days) SP HD
WOUND HEALING AGENTS, LOCAL		
FILSUIVEZ	T5	SP

UNCLASSIFIED DRUG PRODUCTS (Substance Abuse)

OPIOID WITHDRAWAL THERAPY AGENTS, OPIOID-TYPE		
<i>buprenorphine 2 mg tablet sl</i>	T2	
<i>buprenorphine 8 mg tablet sl</i>	T2	
<i>buprenorphine hcl/naloxone hcl</i>	T2	
<i>buprenorphine hcl/naloxone hcl</i> (Suboxone)	T2	
ZUBSOLV	T3	

UNCLASSIFIED DRUG PRODUCTS (Transplant Medications)

RHO KINASE INHIBITOR		
REZUROCK	T5	PA QL(30 tabs/fill) SP

UNCLASSIFIED DRUG PRODUCTS (Urinary Tract Conditions)

BENIGN PROSTATIC HYPERTROPHY/MICTURITION AGENTS		
<i>alfuzosin hcl</i> (Uroxatral)	T2	HD
<i>dutasteride</i> (Avodart)	T2	ST HD

T1 – Preferred Generics
 T2 – Non-Preferred Generics
 T3 – Preferred Brands
 T4 – Non-Preferred Brands

T5 – Brand Specialty
 PA – Prior Authorization
 QL – Quantity Limit

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

HD – May require home delivery pharmacy
 PPACA – No Cost-Share Preventive Medication
 CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

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

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

BENIGN PROSTATIC HYPERTROPHY/MICTURITION AGENTS (cont.)

<i>finasteride</i> (Proscar)	T2	HD
FLOMAX (<i>tamsulosin hcl</i>)	T4	ST HD
PROSCAR (<i>finasteride</i>)	T4	ST HD
<i>silodosin</i> (Rapaflo)	T2	HD
<i>tamsulosin hcl</i> (Flomax)	T1	HD

BPH 5-ALPHA-REDUCTASE INHIB-ALPHA1-ADRENOCEP ANTAG

<i>dutasteride/tamsulosin hcl</i> (Jalyn)	T2	ST HD
-------------------------------------------	----	-------

BPH 5-ALPHA-REDUCTASE INHIB-ALPHA1-ADRENOCEP ANTAG

JALYN (<i>dutasteride/tamsulosin hcl</i>)	T4	ST HD
---------------------------------------------	----	-------

CYSTINE-DEPLETING AGENTS, NEPHROPATHIC CYSTINOSIS

CYSTAGON	T5	SP
----------	----	----

KIDNEY STONE AGENTS

THIOLA EC	T5	PA SP
<i>tiopronin</i>	T2	PA SP
<i>tiopronin</i> (Thiola)	T2	PA SP

OVERACTIVE BLADDER AGENTS, BETA-3 ADRENERGIC RECEPTOR

GEMTESA	T4	HD
MYRBETRIQ	T3	HD

URINARY TRACT ANTISPASMODIC, M(3) SELECTIVE ANTAG.

<i>darifenacin hydrobromide</i>	T2	HD
<i>solifenacin succinate</i> (Vesicare)	T2	HD

URINARY TRACT ANTISPASMODIC/ANTIINCONTINENCE AGENT

<i>fesoterodine fumarate</i> (Toviaz)	T2	HD
<i>flavoxate hcl</i>	T2	HD
GELNIQUE	T3	QL(30 packs/fill) HD
<i>oxybutynin chloride</i>	T2	HD
OXYTROL	T4	ST QL (8 patches/28 days) HD
<i>tolterodine tartrate</i> (Detrol La)	T2	HD
<i>tolterodine tartrate</i> (Detrol)	T2	HD
<i>trospium chloride</i>	T2	HD

UNCLASSIFIED DRUG PRODUCTS (Weight Management)

APPETITE STIM. FOR ANOREXIA, CACHEXIA, WASTING SYND.

<i>megestrol 625 mg/5 ml susp</i>	T2	
<i>megestrol acet 40 mg/ml susp</i>	T2	
<i>megestrol acet 400 mg/10 ml</i>	T2	

T1 – Preferred Generics
T2 – Non-Preferred Generics
T3 – Preferred Brands
T4 – Non-Preferred Brands

T5 – Brand Specialty
PA – Prior Authorization
QL – Quantity Limit

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

HD – May require home delivery pharmacy
PPACA – No Cost-Share Preventive Medication
CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

VITAMINS (Nutritional/Dietary)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ANTIOXIDANT MULTIVITAMIN COMBINATIONS		
50 PLUS ADULT EYE HEALTH	T4	
<i>a/c/e/zinc ox/cupric ox/lutein</i>	T2	
ADULT 50 PLUS EYE HEALTH	T4	
ANTIOXIDANT FORMULA	T4	
EQ VISION FORMULA TABLET	T3	
<i>eq eye health plus lutein tab</i>	T2	
EYE HEALTH AND LUTEIN	T4	
EYE HEALTH PLUS LUTEIN TABLET	T4	
EYE MULTIVITAMIN	T3	
EYE MULTIVITAMIN WITH LUTEIN	T4	
EYEPROTECT	T4	
<i>gnp healthy eyes tablet</i>	T2	
HEALTHY EYES TABLET	T3	
<i>healthy eyes tablet</i>	T2	
I-CAPS	T3	
ICAPS AREDS FORMULA DR TABLET	T4	
ICAPS AREDS2	T4	
LIPOTRIAD	T4	
LIPOTRIAD VISIONARY	T4	
MACULAR BENEFITS	T4	
MACULAR HEALTH FORMULA	T4	
MACUVEX	T4	
MACUZIN	T4	
MULTI-BETIC	T3	
OCULAR VITAMINS	T4	
OCUVEL	T4	
OCUVITE ADULT 50 PLUS	T3	
OCUVITE WITH LUTEIN	T3	
PRESERVISION AREDS	T3	
PRESERVISION LUTEIN	T3	
VISION FORMULA TABLET	T4	
VISION FORMULA WITH LUTEIN	T4	
VISION OPTIMIZER	T4	
VISTA ADVANCED AREDS2	T4	

T1 – Preferred Generics
T2 – Non-Preferred Generics
T3 – Preferred Brands
T4 – Non-Preferred Brands

T5 – Brand Specialty
PA – Prior Authorization
QL – Quantity Limit

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

HD – May require home delivery pharmacy
PPACA – No Cost-Share Preventive Medication
CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

VITAMINS (Nutritional/Dietary) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ANTIOXIDANT MULTIVITAMIN COMBINATIONS (cont.)		
<i>vit a/vit c/vit e/zinc/copper</i>	T2	
<i>vits a,c,e/lutein/minerals</i>	T2	
BIOFLAVONOIDS		
<i>bioflav,lemon/vit bcomp,c</i>	T2	
<i>bioflav,lemon/vit bcomp,c (Lipo-Flavonoid Plus)</i>	T2	
CITRUS BIOFLAVONOIDS	T4	
EAR HEALTH PLUS CAPLET	T4	
<i>ear health plus caplet (Lipo-Flavonoid Plus)</i>	T2	
FLOGEN	T4	
INNER EAR PLUS	T4	
LIPO FLAVONOID	T4	
LIPO-FLAVONOID PLUS (<i>bioflav,lemon/vit bcomp,c</i>)	T3	
QUERCETIN	T4	
<i>rutin</i>	T2	
VASCULERA	T4	
VASOFLEX D1	T4	
VENALIV	T4	
FOLIC ACID PREPARATIONS		
<i>cvs folic acid 800 mcg tablet</i>	T2	PPACA
DENOVO	T4	
DEPLIN-ALGAL OIL (<i>levomefolate/algal oil</i>)	T4	
ENLYTE	T4	
FA-8	T4	
<i>folic acid 0.4 mg, 0.8 mg tablet</i>	T2	PPACA
<i>folic acid 1 mg tablet</i>	T2	
<i>folic acid 1,000 mcg tablet</i>	T2	
FOLIC ACID 20 MG CAPSULE	T4	
<i>folic acid 400 mcg tablet</i>	T2	PPACA
FOLIC ACID 5 MG CAPSULE	T4	
<i>folic acid 5 mg/ml vial</i>	T2	
<i>folic acid 50 mg/10 ml vial</i>	T2	
FOLIC ACID 800 MCG CAPSULE	T4	
<i>folic acid 800 mcg tablet</i>	T2	PPACA
<i>folic acid/b6/ca phos/ginger</i>	T2	

T1 – Preferred Generics
T2 – Non-Preferred Generics
T3 – Preferred Brands
T4 – Non-Preferred Brands

T5 – Brand Specialty
PA – Prior Authorization
QL – Quantity Limit

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

HD – May require home delivery pharmacy
PPACA – No Cost-Share Preventive Medication
CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

VITAMINS (Nutritional/Dietary) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
FOLIC ACID PREPARATIONS (cont.)		
FOLIKA-V	T4	
FOLITE	T4	
GENICIN VITA-Q	T4	
<i>gnp folic acid 400 mcg tablet</i>	T2	PPACA
<i>hm folic acid 400 mcg tablet</i>	T2	PPACA
HYLAZINC	T4	
<i>levomefolate calcium</i>	T2	
<i>levomefolate/algae oil (Deplin-Algal Oil)</i>	T2	
METHYLFOLATE	T4	
<i>ra folic acid 0.4 mg tablet</i>	T2	PPACA
<i>ra folic acid 800 mcg tablet</i>	T2	PPACA
<i>sm folic acid 0.4 mg tablet</i>	T2	PPACA
<i>sm folic acid 400 mcg tablet</i>	T2	PPACA
<i>sv folic acid 800 mcg tablet</i>	T2	PPACA
<i>true folic acid 1600mcg dfe tb</i>	T2	
<i>true folic acid 667 mcg dfe tb</i>	T2	PPACA
XAQUIL XR	T4	
GERIATRIC VITAMIN PREPARATIONS		
<i>a thru z advanced formula tab (Vision Plus Lutein)</i>	T2	
<i>a thru z select tablet (Vision Plus Lutein)</i>	T2	
CENTRUM SILVER CHEWABLE TABLET	T3	
<i>eldertonic elixir</i>	T2	
ELDERTONIC LIQUID	T4	
GERITOL COMPLETE	T3	
GERITOL TONIC	T3	
<i>multivit with iron, minerals</i>	T2	
<i>multivit with minerals/lutein (Vision Plus Lutein)</i>	T2	
REQ49+	T4	
SPECTRAVITE ADULT 50+	T4	
VISION PLUS LUTEIN (<i>multivit with minerals/lutein</i>)	T3	
MULTIVITAMIN PREPARATIONS		
<i>a thru z advanced formula tab</i>	T2	
A THRU Z MEN'S ULTIMATE TABLET	T3	
A THRU Z SELECT MEN 50+ TABLET	T4	

T1 – Preferred Generics
 T2 – Non-Preferred Generics
 T3 – Preferred Brands
 T4 – Non-Preferred Brands

T5 – Brand Specialty
 PA – Prior Authorization
 QL – Quantity Limit

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

HD – May require home delivery pharmacy
 PPACA – No Cost-Share Preventive Medication
 CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

VITAMINS (Nutritional/Dietary) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
MULTIVITAMIN PREPARATIONS (cont.)		
<i>a thru z select multivit tab</i>	T2	
<i>a thru z select multivit tab</i> (Centrum Silver)	T2	
<i>a thru z select multivit tab</i> (Certavite Senior)	T2	
<i>a thru z select tablet</i> (Centrum Silver)	T2	
<i>a thru z select tablet</i> (Certavite Senior)	T2	
<i>a thru z select women's tablet</i>	T2	
<i>a/c/e/zinc/sod selenate/copper</i>	T2	
ABC COMPLETE SENIOR WOMEN'S	T4	
ACTIVNUTRIENTS	T4	
ADEK GUMMIES PLUS ZINC	T4	
ADULT MULTI GUMMIES	T4	
ADULT MULTIVITAMIN GUMMIES	T4	
ADULT ONE DAILY GUMMIES	T4	
ADULTS' DAILY FORMULA	T4	
ADULTS MULTIVITAMIN	T4	
ADVANCED MULTI EA	T4	
ALIVE DAILY SUPPORT PRENATAL	T4	
ALIVE MAX POTENCY	T4	
ALIVE MEN'S 50 PLUS GUMMY	T4	
ALIVE MEN'S ENERGY	T4	
ALIVE MEN'S GUMMY	T4	
ALIVE PREMIUM PRENATAL	T4	
ALIVE WOMEN'S 50 PLUS	T4	
ALIVE WOMEN'S 50 PLUS ULTRA	T4	
ALIVE WOMEN'S ENERGY	T4	
ALIVE WOMEN'S GUMMY VITAMIN	T4	
ALIVE WOMEN'S ULTRA POTENCY	T4	
<i>amino acids/mv,tx,iron,mineral</i>	T2	
AMLADEX	T4	
ANIMI-3	T4	
AQUADEKS	T3	
BACMIN	T4	
BARIATRIC MULTIVITAMINS	T4	
<i>b-complex plus vitamin c cplt</i>	T2	

T1 – Preferred Generics
T2 – Non-Preferred Generics
T3 – Preferred Brands
T4 – Non-Preferred Brands

T5 – Brand Specialty
PA – Prior Authorization
QL – Quantity Limit

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

HD – May require home delivery pharmacy
PPACA – No Cost-Share Preventive Medication
CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

VITAMINS (Nutritional/Dietary) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
MULTIVITAMIN PREPARATIONS (cont.)		
<i>b-complex with vitamin c</i>	T2	
<i>b-complex with vitamin c (Support-500)</i>	T2	
<i>b-complex w-vitamin c caplet</i>	T2	
BEROCCA	T4	
<i>beta-carotene(a)-vits c,e/mins</i>	T2	
BIO-35	T4	
BLADDER 2.2	T3	
BODY, HAIR, SKIN AND NAILS	T4	
CENTRAL-VITE	T4	
CENTRAL-VITE WOMEN'S MATURE (<i>multivit-min/iron/folic/lutein</i>)	T4	
CENTRAVITES ADULTS	T4	
CENTRUM	T3	
CENTRUM ADULT 50 FRESH-FRUITY	T4	
CENTRUM ADULT 50 PLUS	T4	
CENTRUM CHEWABLES ADULTS TAB	T3	
CENTRUM CHEWABLES ADULTS TAB	T4	
CENTRUM COMPLETE	T3	
CENTRUM FLAVOR BURST ADULT	T4	
CENTRUM MEN	T3	
CENTRUM MULTIGUMMIES	T4	
CENTRUM SILVER MEN	T4	
CENTRUM SILVER TABLET (<i>multivit-min/fa/lycopen/lutein</i>)	T4	
CENTRUM SILVER ULTRA MEN'S (<i>multivit-min/fa/lycopen/lutein</i>)	T3	
CENTRUM SILVER WOMEN (<i>multivit-min/iron/folic/lutein</i>)	T4	
CENTRUM SPECIALIST ENERGY	T4	
CENTRUM SPECIALIST HEART	T3	
CENTRUM ULTRA MEN'S	T3	
CENTURY MEN'S	T4	
<i>certavite senior tablet (Centrum Silver)</i>	T2	
<i>certavite senior tablet (Certavite Senior)</i>	T2	
CERTAVITE SENIOR TABLET (<i>multivit-min/fa/lycopen/lutein</i>)	T4	
<i>certavite-antioxidant tablet (Certavite-Antioxidant)</i>	T2	
CERTAVITE-ANTIOXIDANT TABLET (<i>multivitamin/iron/folic acid</i>)	T4	
<i>certavite-antioxidant tablet (Tab-A-Vite Multivit With Iron)</i>	T2	

T1 – Preferred Generics
T2 – Non-Preferred Generics
T3 – Preferred Brands
T4 – Non-Preferred Brands

T5 – Brand Specialty
PA – Prior Authorization
QL – Quantity Limit

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

HD – May require home delivery pharmacy
PPACA – No Cost-Share Preventive Medication
CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

VITAMINS (Nutritional/Dietary) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
MULTIVITAMIN PREPARATIONS (cont.)		
COMPLETE MEN	T3	
COMPLETE MEN 50 PLUS	T4	
COMPLETE MULTIVITAMIN-MINERAL	T4	
CONCEPT DHA (<i>mvn-min75/iron/iron ps/om3/dha</i>)	T4	
CONCEPT OB (<i>mvn-min 74/iron fum/iron/fa</i>)	T4	
CORVITE	T4	
CULTURELLE PROBIOTIC-MULTIVIT	T4	
<i>cvs b-complex-vit c caplet</i>	T2	
CVS DAILY MULTIPLE TABLET	T3	
<i>cvs daily multiple tablet (One-A-Day)</i>	T2	
<i>cvs hair, skin and nails cplt</i>	T2	
<i>cvs one daily essential tablet (Daily-Vite)</i>	T2	
DAILY GUMMIES	T4	
DAILY MULTIVITAMIN	T4	
<i>daily-vite tablet (Daily-Vite)</i>	T2	
DAILY-VITE TABLET (<i>multivitamin with folic acid</i>)	T4	
DAYAVITE	T4	
DECUBI VITE	T4	
DEKAS BARIATRIC	T4	
DEKAS ESSENTIAL	T4	
DEKAS PLUS	T4	
DERMACINRX FOLIFLEX	T4	
DERMACINRX FOLITIN-Z	T4	
DERMACINRX MULTITAM	T4	
DERMACINRX RIBOTIN-E	T4	
DERMACINRX VENEXA	T4	
DERMACINRX VENEXA FE	T4	
DERMACINRX VENTRIXYL	T4	
DERMACINRX VENTRIXYL FE	T4	
DERMACINRX VITRAMYN	T4	
DERMACINRX VITRANOL	T4	
DERMACINRX VITRANOL FE	T4	
DERMACINRX VITREXATE	T4	
DERMACINRX VITREXATE FE	T4	

T1 – Preferred Generics
 T2 – Non-Preferred Generics
 T3 – Preferred Brands
 T4 – Non-Preferred Brands

T5 – Brand Specialty
 PA – Prior Authorization
 QL – Quantity Limit

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

HD – May require home delivery pharmacy
 PPACA – No Cost-Share Preventive Medication
 CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

VITAMINS (Nutritional/Dietary) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
MULTIVITAMIN PREPARATIONS (cont.)		
DERMACINRX ZINTREXYL-C	T4	
DIABETES HEALTH FORMULA	T4	
DIABETIC VITAMIN	T4	
DIALYVITE 800 WITH IRON	T4	
ELON MATRIX 5000 COMPLETE	T4	
ENBRACE HR	T4	
ENDUR-VM IRON-FREE	T4	
ENDUR-VM WITH IRON	T4	
EQ ONE DAILY WOMEN'S HEALTH TB	T4	
EQ ONE DAILY WOMEN'S TABLET	T3	
<i>eq1 one daily men's tablet</i>	T2	
ESSENTIAL MAN	T4	
ESSENTIAL MAN 50+	T4	
ESSENTIAL WOMAN 50+	T4	
ESTROVEN MENOPAUSE	T4	
<i>fa/mv,ca,iron,min/lycopene/lut</i>	T2	
FATIGUE RELIEF COMPLEX (<i>bcomp,c/st,jhn wrt/s.ginsg/pgn</i>)	T4	
FOLAGENT DHA	T4	
FOLAMAX	T4	
FOLAMED DHA	T4	
<i>folic acid/multivit,iron,miner</i>	T2	
<i>folic acid/mv,iron,min/lutein</i>	T2	
FOLIC ACID-VIT B-6-VIT B-12	T4	
<i>folic/mvi ther-min/lycop/lut</i>	T2	
FOLIKA-CI	T4	
FOLIKA-MG	T4	
FORTAVIT	T4	
FREEDAVITE	T4	
GENADEK STEP 1	T4	
GENADEK STEP 2	T4	
GERBER GS PRENATAL NOURISH PLS	T4	
GNP B-COMPLEX PLUS VIT C TAB	T4	
<i>gnp one daily tablet</i>	T2	
HAIR FORMULA	T4	

T1 – Preferred Generics
 T2 – Non-Preferred Generics
 T3 – Preferred Brands
 T4 – Non-Preferred Brands

T5 – Brand Specialty
 PA – Prior Authorization
 QL – Quantity Limit

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

HD – May require home delivery pharmacy
 PPACA – No Cost-Share Preventive Medication
 CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

VITAMINS (Nutritional/Dietary) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
MULTIVITAMIN PREPARATIONS (cont.)		
HAIR, SKIN AND NAILS CAPLET	T4	
HAIR, SKIN AND NAILS SOFTGEL	T4	
HAIR, SKIN AND NAILS TABLET (<i>multivitamin/folic acid/biotin</i>)	T4	
HEARTBURN ACID REFLUX	T4	
<i>high potency multivitamin tab</i>	T2	
HIGH POTENCY MULTIVITAMIN TAB	T4	
<i>high potency multivitamin tab</i> (Certavite-Antioxidant)	T2	
<i>high potency multivitamin tab</i> (Tab-A-Vite Multivit With Iron)	T2	
HM HAIR, SKIN AND NAILS TABLET	T4	
HM MEN'S ONE DAILY TABLET	T3	
ICAPS MV	T3	
ICAPS TABLET	T3	
IMMUNERX	T4	
INFUVITE ADULT	T4	
K-PAX IMMUNE SUPPORT	T3	
<i>lecithin/pyridoxine/kelp</i>	T2	
<i>lmeolate/b3/copp/zn/sel/chrom</i>	T2	
MAXIMIN	T4	
MEBOLIC	T4	
MEN 50 PLUS ADVANCED ONE DAILY	T4	
MEN 50 PLUS MULTIVITAMIN	T4	
MEN'S 50 PLUS DAILY FORMULA	T4	
MEN'S 50 PLUS MULTIVITAMIN	T4	
MEN'S DAILY FORMULA	T4	
MEN'S DAILY GUMMIES	T4	
MEN'S DAILY PACK	T4	
MEN'S MULTIVITAMIN	T4	
MONOCAPS	T4	
MULTI FOR HER 50 PLUS	T4	
MULTI FOR HER SOFTGEL	T4	
<i>multi for her tablet</i>	T2	
MULTI PRO	T4	
MULTI-DAY PLUS MINERALS	T4	
MULTILEX TABLET	T4	

T1 – Preferred Generics
T2 – Non-Preferred Generics
T3 – Preferred Brands
T4 – Non-Preferred Brands

T5 – Brand Specialty
PA – Prior Authorization
QL – Quantity Limit

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

HD – May require home delivery pharmacy
PPACA – No Cost-Share Preventive Medication
CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

VITAMINS (Nutritional/Dietary) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
MULTIVITAMIN PREPARATIONS (cont.)		
<i>multilex tablet</i>	T2	
MULTILEX T-M	T4	
<i>multivit 47/iron/folate 1/dha</i>	T2	
<i>multivit infusn,adult 1,vit k</i>	T2	
<i>multivit no.51/iron/folic acid</i>	T2	
<i>multivit with calcium,iron,min</i>	T2	
<i>multivit with iron,minerals</i>	T2	
<i>multivit,calc,mins/iron/folic</i>	T2	
<i>multivit,iron,minerals/lutein</i>	T2	
<i>multivit,stress formula/zinc (Stress Formula With Zinc)</i>	T2	
<i>multivit/iron/folic acid</i>	T2	
<i>multivit/iron/folic acid/hb179</i>	T2	
<i>multivitamin</i>	T2	
MULTI-VITAMIN	T4	
<i>multivitamin combination no.55</i>	T2	
<i>multivitamin combination no.56</i>	T2	
MULTIVITAMIN GUMMIES	T4	
MULTIVITAMIN LIQUID	T4	
<i>multivitamin tablet</i>	T2	
<i>multivitamin with folic acid (Daily-Vite)</i>	T2	
<i>multivitamin with iron</i>	T2	
MULTIVITAMIN WITH MINERALS	T4	
<i>multivitamin with minerals</i>	T2	
<i>multivitamin,stress formula</i>	T2	
<i>multivitamin,ther and minerals</i>	T2	
<i>multivitamin,therapeutic</i>	T2	
<i>multivitamin,therapeutic (Oncovite)</i>	T2	
<i>multivitamin/ferrous gluconate</i>	T2	
<i>multivitamin/iron/folic acid (Certavite-Antioxidant)</i>	T2	
<i>multivitamin/iron/folic acid (Tab-A-Vite Multivit With Iron)</i>	T2	
MULTI-VITE	T4	
<i>multivit-min/fa/lycopen/lutein</i>	T2	
<i>multivit-min/fa/lycopen/lutein (Centrum Silver)</i>	T2	
<i>multivit-min/fa/lycopen/lutein (Certavite Senior)</i>	T2	

T1 – Preferred Generics
 T2 – Non-Preferred Generics
 T3 – Preferred Brands
 T4 – Non-Preferred Brands

T5 – Brand Specialty
 PA – Prior Authorization
 QL – Quantity Limit

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

HD – May require home delivery pharmacy
 PPACA – No Cost-Share Preventive Medication
 CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

VITAMINS (Nutritional/Dietary) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
MULTIVITAMIN PREPARATIONS (cont.)		
<i>multivit-min/ferrous gluconate</i>	T2	
<i>multivit-min/folic acid/biotin</i>	T2	
<i>multivit-min/iron fum/folic ac</i>	T2	
<i>multivit-min/iron/folic acid</i>	T2	
<i>multivit-min/iron/folic/lutein</i> (Central-Vite Women'S Mature)	T2	
<i>multivit-min/iron/folic/lutein</i> (Centrum Silver Women)	T2	
<i>multivit-min69/iron/folic acid</i>	T2	
<i>multivit-minerals/fa/lycopene</i>	T2	
<i>multivit-minerals/folic acid</i> (One-A-Day)	T2	
<i>multivit-minerals/folic/ginkgo</i>	T2	
<i>multivit-mins no.7/folic acid</i>	T2	
<i>multivit-mins/iron/folic/lycop</i>	T2	
<i>mv, min 59/iron/folic/docusate</i>	T2	
<i>mv,cal,min/iron/folic acid/lut</i>	T2	
<i>mv,iron,min/ginkgo/pan.ginseng</i>	T2	
<i>mv-min/iron/folic ac/vit k/lut</i>	T2	
<i>mv-mins 71/iron/folic no.1/dha</i>	T2	
<i>mv-mins/folic/lycopene/ginkgo</i>	T2	
<i>mv-mn/folic acid/lutein/hrb178</i>	T2	
<i>mvn no.53/iron/folic/dss/dha</i>	T2	
<i>mvn-min 74/iron fum/iron/fa</i> (Concept Ob)	T2	
<i>mvn-min75/iron/iron ps/om3/dha</i> (Concept Dha)	T2	
MVW MODULATR FORM MINI MULTIVT	T4	
NEEVODHA	T4	
NEOVITE	T4	
NESTABS ONE	T4	
NICOMIDE	T4	
NIVA-PLUS (<i>multivit-mins60/iron fum/folic</i>)	T4	
NUTRIVIT	T3	
OB COMPLETE	T4	
OBSTETRIX ONE	T4	
O-CAL FA	T4	
OCUVITE EYE PLUS MULTI	T4	

T1 – Preferred Generics
 T2 – Non-Preferred Generics
 T3 – Preferred Brands
 T4 – Non-Preferred Brands

T5 – Brand Specialty
 PA – Prior Authorization
 QL – Quantity Limit

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

HD – May require home delivery pharmacy
 PPACA – No Cost-Share Preventive Medication
 CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

VITAMINS (Nutritional/Dietary) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
MULTIVITAMIN PREPARATIONS (cont.)		
<i>om-3/dha/epa/b12/fa/b6/phytost</i>	T2	
OMNIVEX	T4	
ONCOVITE (<i>multivitamin,therapeutic</i>)	T3	
ONE DAILY ESSENTIAL TABLET	T4	
<i>one daily essential tablet</i>	T2	
<i>one daily essential tablet (Daily-Vite)</i>	T2	
ONE DAILY HEALTHY WEIGHT	T4	
ONE DAILY MEN'S	T3	
ONE DAILY MEN'S 50 PLUS	T4	
ONE DAILY MEN'S 50 PLUS D3	T4	
ONE DAILY MEN'S HEALTH	T4	
ONE DAILY MEN'S MULTIVITAMIN	T4	
<i>one daily multivit-mineral tab</i>	T2	
ONE DAILY MULTIVIT-MINERAL TAB	T4	
<i>one daily multivitamin tab</i>	T2	
ONE DAILY MULTIVITAMIN TABLET	T4	
<i>one daily multivitamin tablet (Daily-Vite)</i>	T2	
<i>one daily tablet</i>	T2	
ONE DAILY WOMEN 50 PLUS TAB	T4	
ONE DAILY WOMEN'S 50 PLUS ADV	T4	
ONE DAILY WOMEN'S 50+	T3	
ONE DAILY WOMEN'S FORMULA	T4	
<i>one daily women's health tab</i>	T2	
ONE DAILY WOMEN'S MULTIVITAMIN	T4	
ONE-A-DAY (<i>multivit-minerals/folic acid</i>)	T4	
ONE-A-DAY ENERGY	T4	
ONE-A-DAY MEN VITACRAVES	T4	
ONE-A-DAY MENOPAUSE FORMULA	T4	
ONE-A-DAY MEN'S	T3	
ONE-A-DAY MEN'S 50 PLUS	T3	
ONE-A-DAY MEN'S 50 PLUS (<i>mv-mins/folic/lycopene/ginkgo</i>)	T3	
ONE-A-DAY MEN'S COMPLETE	T4	
ONE-A-DAY PROACTIVE 65 PLUS	T4	
ONE-A-DAY VITACRAVES	T4	

T1 – Preferred Generics
 T2 – Non-Preferred Generics
 T3 – Preferred Brands
 T4 – Non-Preferred Brands

T5 – Brand Specialty
 PA – Prior Authorization
 QL – Quantity Limit

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

HD – May require home delivery pharmacy
 PPACA – No Cost-Share Preventive Medication
 CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

VITAMINS (Nutritional/Dietary) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
MULTIVITAMIN PREPARATIONS (cont.)		
ONE-A-DAY VITACRAVES IMMUNITY	T4	
ONE-A-DAY VITACRAVES OMEGA-3	T4	
ONE-A-DAY VITACRAVES SOUR	T4	
ONE-A-DAY WEIGHTSMART	T3	
ONE-A-DAY WOMEN VITACRAVES	T4	
ONE-A-DAY WOMEN'S 50 PLUS	T4	
ONE-A-DAY WOMEN'S COMPLETE	T3	
ONE-A-DAY WOMEN'S HEALTHY SKIN	T4	
ONE-A-DAY WOMEN'S PETITES	T4	
ONE-A-DAY WOMEN'S TABLET	T3	
ONE-A-DAY WOMEN'S TABLET	T4	
ONE-DAILY MULTI	T4	
ONE-DAILY MULTI-VIT POWDER PKT	T4	
<i>one-daily multi-vitamin tab</i>	T2	
ONE-DAILY MULTI-VITAMIN-IRON	T4	
ONE-DAILY MULTIVITAMIN-MINERAL	T4	
ONEVITE	T4	
OPTIFAST	T4	
OPTISOURCE	T4	
OPURITY MULTIVITAMIN	T4	
POLY VITAMIN-IRON	T4	
PRENATE AM	T4	
PRENATE CHEWABLE	T4	
PRENATE ESSENTIAL	T4	
PROCERV HP	T4	
PROFOLA	T4	
PRORENAL QD	T3	
PROTECT CARDIO AF	T4	
PROTECT IRON	T4	
PROTECT PLUS SO	T4	
PUREFE OB PLUS	T4	
PUREFE PLUS	T4	
QUINTABS	T4	
QUINTABS-M	T4	

T1 – Preferred Generics
T2 – Non-Preferred Generics
T3 – Preferred Brands
T4 – Non-Preferred Brands

T5 – Brand Specialty
PA – Prior Authorization
QL – Quantity Limit

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

HD – May require home delivery pharmacy
PPACA – No Cost-Share Preventive Medication
CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

VITAMINS (Nutritional/Dietary) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
MULTIVITAMIN PREPARATIONS (cont.)		
RA MEN'S ONE DAILY TABLET	T3	
<i>ra one daily essential tablet (One-A-Day)</i>	T2	
<i>ra one daily women's tablet</i>	T2	
REMEDIENT	T4	
<i>sm b complex with vit c tablet</i>	T2	
<i>sm super b complex-c caplet</i>	T2	
SOLO	T4	
SPECTRAVITE MEN 50 PLUS	T4	
SPECTRAVITE ULTRA MEN 50+	T4	
SPECTRAVITE ULTRA MEN'S	T4	
STRESS B-COMPLEX	T4	
<i>stress formula tablet</i>	T2	
STRESS FORMULA WITH ZINC TAB (<i>multivit, stress formula/zinc</i>)	T4	
<i>stress formula with zinc tab (Stress Formula With Zinc)</i>	T2	
<i>stress-c with zinc tablet (Stress Formula With Zinc)</i>	T2	
STROVITE FORTE (<i>multivit, iron, min 5/folic acid</i>)	T4	
STROVITE ONE	T4	
SUPER GINSENG MULTIVITAMIN	T4	
SUPER MULTIPLE-LOW IRON	T4	
SUPPORT-500 (<i>b-complex with vitamin c</i>)	T4	
SV HAIR, SKIN AND NAILS CAPLET	T4	
TAB-A-VITE MULTIVIT WITH IRON	T4	
<i>tab-a-vite multivit with iron</i>	T2	
TAB-A-VITE MULTIVIT WITH IRON (<i>multivitamin/iron/folic acid</i>)	T4	
THERAGRAN-M PREMIER 50 PLUS	T4	
<i>thera-m caplet</i>	T2	
<i>thera-m tablet</i>	T2	
THERA-M CAPLET	T4	
THERAMILL FORTE	T4	
THERANATAL LACTATION SUPPORT	T4	
THEREMS-H	T3	
TOBAKIENT	T4	
TRUE MULTIVITAMIN	T4	
TRUEPLUS MULTIVITAMIN (<i>multivit-min/folic acid/vit k1</i>)	T4	

T1 – Preferred Generics

T2 – Non-Preferred Generics

T3 – Preferred Brands

T4 – Non-Preferred Brands

T5 – Brand Specialty

PA – Prior Authorization

QL – Quantity Limit

ST – Step Therapy

AGE – Age Requirement

SP – Specialty Medication

HD – May require home delivery pharmacy

PPACA – No Cost-Share Preventive Medication

CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

VITAMINS (Nutritional/Dietary) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
MULTIVITAMIN PREPARATIONS (cont.)		
UDAMIN SP	T4	
ULTRA FREEDA	T4	
VITABEX PLUS	T4	
VITAJOY ADULT MULTI	T4	
<i>vitamin b complex-vit c cap (Support-500)</i>	T2	
<i>vitamin b complex-vit c caplet</i>	T2	
<i>vitamin b complex-vitamin c tb</i>	T2	
VITAMIN D3-ALOE	T4	
<i>vitamins a and d</i>	T2	
VITAMINS A-D-E	T4	
VITREXYL	T4	
VITREXYL PLUS IRON	T4	
VITRUM 50 PLUS SENIOR	T3	
WELLESSE MULTI VITAMIN PLUS	T4	
WOMEN 50 PLUS MULTIVIT ADVANCE	T4	
WOMEN'S 50 PLUS ADVANCED	T4	
WOMEN'S 50 PLUS DAILY FORMULA	T4	
<i>women's daily formula caplet</i>	T2	
WOMEN'S DAILY FORMULA CAPLET	T3	
WOMEN'S DAILY FORMULA TABLET	T4	
WOMENS DAILY GUMMIES	T4	
WOMEN'S DAILY PACK	T4	
WOMEN'S MULTIVITAMIN	T4	
WOMEN'S MULTIVITAMIN W-BIOTIN	T4	
XYZBAC	T4	
ZYVANA	T4	
ZYVIT	T4	
NIACIN PREPARATIONS		
<i>cvs niacin 400 mg capsule</i>	T2	
<i>cvs niacin flush free 500 mg</i>	T2	
ENDUR-AMIDE	T4	
ENDUR-THINE	T4	
<i>gnp niacin 250 mg tablet</i>	T2	
<i>gnp niacin 400 mg capsule</i>	T2	

T1 – Preferred Generics
T2 – Non-Preferred Generics
T3 – Preferred Brands
T4 – Non-Preferred Brands

T5 – Brand Specialty
PA – Prior Authorization
QL – Quantity Limit

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

HD – May require home delivery pharmacy
PPACA – No Cost-Share Preventive Medication
CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

VITAMINS (Nutritional/Dietary) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
NIACIN PREPARATIONS (cont.)		
<i>hm niacin tr 250 mg tablet (Slo-Niacin)</i>	T2	
<i>niacin</i>	T2	
<i>niacin (inositol niacinate)</i>	T2	
<i>niacin (Slo-Niacin)</i>	T2	
<i>niacin 50 mg tablet</i>	T2	
<i>niacin 100 mg tablet</i>	T2	
<i>niacin 250 mg tablet</i>	T2	
<i>niacin 500 mg capsule</i>	T2	
<i>niacin 500 mg capsule sa</i>	T2	
NIACIN 500 MG SOFTGEL	T3	
<i>niacin 500 mg tablet</i>	T2	
<i>niacin 750 mg tablet sa (Slo-Niacin)</i>	T2	
NIACIN ER 1,000 MG TABLET	T3	
<i>niacin er 250 mg tablet (Slo-Niacin)</i>	T2	
<i>niacin er 500 mg caplet</i>	T2	
<i>niacin er 500 mg capsule</i>	T2	
<i>niacin er 500 mg tablet</i>	T2	
<i>niacin flush free 500 mg cap</i>	T2	
NIACIN FLUSH FREE 750 MG CAP	T3	
<i>niacin sa 250 mg capsule</i>	T2	
<i>niacin tr 250 mg capsule</i>	T2	
<i>niacin tr 250 mg tablet (Slo-Niacin)</i>	T2	
<i>niacin tr 500 mg caplet</i>	T2	
<i>niacin tr 500 mg tablet</i>	T2	
<i>niacinamide 500 mg tablet</i>	T2	
NIACINAMIDE ER 500 MG TABLET	T4	
NO FLUSH NIACIN	T4	
<i>ra niacin 100 mg tablet</i>	T2	
RA NIACIN 500 MG TABLET	T4	
<i>ra niacin 500 mg tablet</i>	T2	
SLO-NIACIN 250 MG TABLET (<i>niacin</i>)	T3	
<i>slo-niacin 500 mg tablet</i>	T2	
SLO-NIACIN 750 MG TABLET (<i>niacin</i>)	T3	
<i>sv niacin flush free 500 mg</i>	T2	

T1 – Preferred Generics
 T2 – Non-Preferred Generics
 T3 – Preferred Brands
 T4 – Non-Preferred Brands

T5 – Brand Specialty
 PA – Prior Authorization
 QL – Quantity Limit

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

HD – May require home delivery pharmacy
 PPACA – No Cost-Share Preventive Medication
 CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

VITAMINS (Nutritional/Dietary) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
PANTHENOL PREPARATIONS		
CALCIUM PANTOTHENATE	T4	
PANTETHINE	T4	
PEDIATRIC VITAMIN PREPARATIONS		
ABDEK MULTIVITAMIN	T4	
ANIMAL SHAPES COMPLETE	T4	
AQUADEKS	T3	
CENTRUM KIDS	T4	
CHILD CHEWABLE VITAMN COMPLETE	T4	
CHILD COMPLETE CHEWABLE VITAMN	T4	
CHILD COMPLETE MULTIVITAMIN	T4	
CHILD MULTIVITAMIN PLUS IRON	T4	
CHILDREN MULTIVITAMIN	T4	
<i>children multivitamin chew tab</i>	T2	
CHILDREN MULTIVITAMIN GUMMIES	T4	
CHILDREN MULTIVITAMIN GUMMIES (<i>pediatric multivitamin no.120</i>)	T4	
CHILDREN'S CHEW MULTIVIT-IRON (<i>pedi multivit no.91/iron fum</i>)	T4	
<i>childrens chew vitamin tab</i> (Flintstones With Extra C)	T2	
<i>childrens chew vitamin tab</i> (Flintstones)	T2	
CHILDREN'S CHEWABLE	T4	
CHILDREN'S MULTI-VIT GUMMIES	T4	
CHILDREN'S MULTIVITAMIN GUMMY	T4	
CHILD'S CHEWABLE VITAMIN TAB	T4	
CHILD'S OMEGA-3 DHA MULTIVITAM	T4	
CULTURELLE KIDS PROBIOTIC-MV	T4	
CULTURELLE KIDS PRO-MV-LUTEIN	T4	
CVS CHILD GUMMY DINOS GUMMIES	T4	
<i>cvs gummy dinos vitamin</i>	T4	
DEKAS PLUS	T2	
EMERGEN-C KIDZ	T4	
EQ CHILD MULTIVITAMIN GUMMIES	T4	
FLINTSTONES COMPLETE GUMMIES	T3	
FLINTSTONES COMPLETE TABLET (<i>multivit with iron,minerals</i>)	T4	
FLINTSTONES EXTRA C GUMMIES	T3	
FLINTSTONES EXTRA C TAB CHEW (<i>multivitamin</i>)	T4	

T1 – Preferred Generics
T2 – Non-Preferred Generics
T3 – Preferred Brands
T4 – Non-Preferred Brands

T5 – Brand Specialty
PA – Prior Authorization
QL – Quantity Limit

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

HD – May require home delivery pharmacy
PPACA – No Cost-Share Preventive Medication
CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

VITAMINS (Nutritional/Dietary) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
PEDIATRIC VITAMIN PREPARATIONS (cont.)		
FLINTSTONES GUMMIES	T3	
FLINTSTONES GUMMIES CHEW TAB	T3	
FLINTSTONES IMMUNITY SUPPORT	T4	
FLINTSTONES MULTIVIT CHEW TAB (<i>pedi multivit no.25/folic acid</i>)	T4	
FLINTSTONES MULTI-VIT GUMMIES	T4	
FLINTSTONES PLUS CALCIUM	T3	
FLINTSTONES SOUR-GUM CHEW TAB	T3	
FLINTSTONES TAB CHEW	T4	
FLINTSTONES TABLET CHEWABLE (multivitamin)	T3	
FLINTSTONES WITH IRON	T4	
FLORIVA	T3	
FLORIVA PLUS	T4	
GENADEK	T4	
GERBER GROW MIGHTY	T4	
GERBER LIL BRAINIES	T4	
GUMMIES CHILDREN MULTIVITAMIN	T4	
GUMMY	T4	
INFANT-TODDLER MULTIVITAMIN	T4	
INFANT-TODDLER MULTIVIT-IRON	T4	
infant-toddler multivit-iron	T2	
INFANT-TODDLER TRI-VITAMIN	T4	
INFUVITE PEDIATRIC	T3	
JUST 4 KIDZ MULTIVIT-PROBIOTIC	T4	
KIDS COD LIVER OIL +D	T4	
KIDS MULTIVITAMIN-MINERALS	T3	
LITTLE ANIMALS PLUS IRON	T4	
LIVITA FOR CHILDREN	T4	
M.V.I. PEDIATRIC	T3	
<i>multivit with iron,minerals</i>	T2	
<i>multivit with iron,minerals (Flintstones Complete)</i>	T2	
<i>multivit with iron,minerals (Scooby-Doo)</i>	T2	
<i>multivitamin (Flintstones With Extra C)</i>	T2	
<i>multivitamin (Flintstones)</i>	T2	
<i>multivitamin with iron</i>	T2	

T1 – Preferred Generics
T2 – Non-Preferred Generics
T3 – Preferred Brands
T4 – Non-Preferred Brands

T5 – Brand Specialty
PA – Prior Authorization
QL – Quantity Limit

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

HD – May require home delivery pharmacy
PPACA – No Cost-Share Preventive Medication
CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

VITAMINS (Nutritional/Dietary) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
PEDIATRIC VITAMIN PREPARATIONS (cont.)		
MULTI-VIT-FLOR	T4	
MULTIVIT-FLUOR 0.25 MG TAB CHW	T4	
<i>multivit-fluor 0.25 mg tab chw</i>	T2	PPACA
<i>multivit-fluor 0.25 mg/ml drop</i>	T2	PPACA
<i>multivit-fluor 0.5 mg tab chew</i>	T2	PPACA
MULTIVIT-FLUOR 0.5 MG TAB CHEW	T4	
<i>multivit-fluor 0.5 mg/ml drop</i>	T2	PPACA
<i>multivit-fluoride 1 mg tab chw</i>	T2	PPACA
MULTIVIT-FLUORIDE 1 MG TAB CHW	T4	
MVW COMPLETE FORMLTN PEDIATRIC	T4	
MVW COMPLETE FORMULATION D3000	T4	
MVW COMPLETE FORMULATION D5000	T4	
MVW COMPLETE FORMULTN MULTIVIT	T4	
MVW MODULATR FORMLTN PEDIATRIC	T4	
NANO VM 1-3	T3	
NANO VM 4-8	T3	
NANOVM 9-18	T4	
NANOVM T-F	T4	
NOVAFERRUM PEDIATRIC MV-IRON	T4	
NOVAMV	T4	
ONE-A-DAY KID'S	T4	
ONE-A-DAY TEEN HER VITACRAVES	T4	
ONE-A-DAY TEEN HIM VITACRAVES	T4	
<i>ped mvit a,c,d3 no.21/fluoride</i>	T2	PPACA
<i>pedi multivit 158/iron/vit k1</i>	T2	
<i>pedi multivit 45/fluoride/iron</i>	T2	
<i>pedi multivit no. 12 w-fluoride</i>	T2	PPACA
<i>pedi multivit no. 159/iron sulf</i>	T2	
<i>pedi multivit no.23/folic acid</i>	T2	
<i>pedi multivit no.25/folic acid (Flintstones)</i>	T2	
PEDIA POLY-VITE	T4	
<i>pedia poly-vite iron 5mg/0.5ml</i>	T2	
PEDIA POLY-VITE WITH IRON DROP	T4	
PEDIA TRI-VITE	T4	

T1 – Preferred Generics
T2 – Non-Preferred Generics
T3 – Preferred Brands
T4 – Non-Preferred Brands

T5 – Brand Specialty
PA – Prior Authorization
QL – Quantity Limit

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

HD – May require home delivery pharmacy
PPACA – No Cost-Share Preventive Medication
CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

VITAMINS (Nutritional/Dietary) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
PEDIATRIC VITAMIN PREPARATIONS (cont.)		
<i>pediatric multivit no.36/iron</i>	T2	
<i>pediatric multivitamin no.17</i>	T2	
PEDIATRIC POLY-VITAMIN	T4	
PEDIATRIC POLY-VITAMIN-IRON	T4	
PEDIATRIC POLY-VITE	T4	
PEDIATRIC POLY-VITE WITH IRON	T4	
PEDIATRIC TRI-VITAMIN	T4	
PEDIATRIC TRI-VITE	T4	
POLY-VI-FLOR	T4	
POLY-VI-FLOR WITH IRON	T4	
poly-vi-sol 0.5 ml oral syring	T2	
POLY-VI-SOL 1 ML ENFIT SYRINGE	T4	
POLY-VI-SOL 250MCG-50MG/ML DRP	T4	
POLY-VI-SOL WITH IRON	T4	
POLY-VITA	T4	
POLY-VITA WITH IRON	T4	
QUFLORA	T4	
QUFLORA FE	T4	
SCOOBY-DOO ONE A DAY GUMMIES	T4	
SCOOBY-DOO ONE A DAY TABLET (<i>multivit with iron,minerals</i>)	T3	
TRI-VI-FLOR	T4	
TRI-VI-SOL	T4	
TROPICAL LIQUID NUTRITION (<i>pediatric multivitamin no.118</i>)	T4	
<i>vit a palmitate/vit c/vit d3</i>	T2	
ZOO FRIENDS	T4	
ZOO FRIENDS COMPLETE	T4	
VITAMIN A AND D PREPARATIONS		
cod liver oil softgel	T2	
gnp norwegian cod liver oil	T2	
SV COD LIVER OIL SOFTGEL	T4	
VITAMIN A PREPARATIONS		
A-25	T4	
AQUASOL A	T3	
<i>beta-carotene</i>	T2	

T1 – Preferred Generics
 T2 – Non-Preferred Generics
 T3 – Preferred Brands
 T4 – Non-Preferred Brands

T5 – Brand Specialty
 PA – Prior Authorization
 QL – Quantity Limit

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

HD – May require home delivery pharmacy
 PPACA – No Cost-Share Preventive Medication
 CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

VITAMINS (Nutritional/Dietary) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
VITAMIN A PREPARATIONS (cont.)		
<i>cvs vitamin a 2,400 mcg sftgl</i>	T2	
<i>gnp vitamin a 10,000 unit sfgl</i>	T2	
NORWEGIAN COD LIVER OIL SFGL	T4	
PREVENT	T3	
<i>ra vitamin a 10,000 unit sftgl</i>	T2	
VITAMIN A BETA CAROTENE	T4	
<i>vitamin a 10,000 unit capsule</i>	T2	
<i>vitamin a 10,000 unit softgel</i>	T2	
VITAMIN A 10,000 UNIT SOFTGEL	T4	
<i>vitamin a 3,000 mcg softgel</i>	T2	
<i>vitamin a 8,000 unit capsule</i>	T2	
<i>vitamin a 8,000 unit softgel</i>	T2	
VITAMIN A PALMITATE	T4	
<i>vitamin a/vit c/zinc/propolis</i>	T2	
VITAMINS A D	T4	
VITAMIN B PREPARATIONS		
5-MTHF PLUS B12	T4	HD
<i>acetyl/cyst/methylb12/levomefol</i>	T2	HD
ALBA-LYBE	T3	HD
APETEX (<i>vitamin b complex/lysine</i>)	T3	HD
APETIGEN (<i>vitamin b complex/lysine</i>)	T3	HD
ARKALIOX	T4	HD
B ACTIV	T4	HD
<i>b comp no3/folic/c/biotin/zinc</i>	T2	HD
<i>b comp/ferrous gluc/lysin/znox</i>	T2	HD
<i>b complex 11/folic/c/biot/zinc</i>	T2	HD
<i>b complex c no.10/folic acid</i>	T2	HD
<i>b complex capsule</i>	T2	HD
<i>b complex tablet</i>	T2	HD
<i>b complex w-c no.20/folic acid (Nirt-Caps)</i>	T2	HD
B COMPLEX WITH B-12	T4	HD
B COMPLEX WITH VITAMIN C	T4	HD
B COMPLEX-FOLIC ACID (<i>cyanocobalamin/folic ac/vit b6</i>)	T4	HD
<i>b12/levomefolate calcium/b-6</i>	T2	HD

T1 – Preferred Generics
T2 – Non-Preferred Generics
T3 – Preferred Brands
T4 – Non-Preferred Brands

T5 – Brand Specialty
PA – Prior Authorization
QL – Quantity Limit

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

HD – May require home delivery pharmacy
PPACA – No Cost-Share Preventive Medication
CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

VITAMINS (Nutritional/Dietary) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
VITAMIN B PREPARATIONS (cont.)		
B-50 COMPLEX	T4	HD
<i>balanced b-100 complex tab sa</i>	T2	HD
<i>b-complex 100 injection</i>	T2	HD
<i>b-complex injection vial</i>	T2	HD
<i>b-complex plus vitamin c cplt (Vita-Bee With C)</i>	T2	HD PPACA
<i>b-complex tablet</i>	T2	HD PPACA
B-COMPLEX FAST DISSOLVE TABLET	T4	HD
B-COMPLEX WITH B-12	T4	HD
<i>b-complex with b12 tablet</i>	T2	HD
<i>b-complex with vit c caplet (Vita-Bee With C)</i>	T2	HD PPACA
<i>b-complex with vit c tablet (Vita-Bee With C)</i>	T2	HD PPACA
B-COMPLEX-VITAMIN C TR TABLET	T3	HD
BIOTIN 1,000 MCG GUMMIES	T4	HD
<i>biotin 1,000 mcg tablet</i>	T2	HD
BIOTIN 10 MG TABLET	T3	HD
BIOTIN 10,000 MCG SOFTGEL	T4	HD
BIOTIN 10,000 MCG TABLET	T3	HD
<i>biotin 2,500 mcg softgel (Hard Nails)</i>	T2	HD
<i>biotin 300 mcg tablet</i>	T2	HD
BIOTIN 5 MG TABLET	T4	HD
<i>biotin 5,000 mcg capsule (Meribin)</i>	T2	HD
BIOTIN 5,000 MCG FAST DISSOLVE	T4	HD
BIOTIN 5,000 MCG QUICK DISSOLV	T4	HD
<i>biotin 5,000 mcg softgel (Meribin)</i>	T2	HD
BIOTIN 5,000 MCG TABLET	T4	HD
<i>biotin 800 mcg tablet</i>	T2	HD
BIOTIN FORTE 3 MG TABLET	T4	HD
BIOTIN FORTE 5 MG TABLET	T3	HD
BREWER'S YEAST	T4	HD
B-STRESS	T4	HD
CARDIOTEK-RX	T4	HD
CEREFOLIN (<i>vit b12/levomefolate/vit b6/b2</i>)	T4	HD
CEREFOLIN NAC	T4	HD
COMPLEX B-100 ER CAPLET	T4	HD

T1 – Preferred Generics
 T2 – Non-Preferred Generics
 T3 – Preferred Brands
 T4 – Non-Preferred Brands

T5 – Brand Specialty
 PA – Prior Authorization
 QL – Quantity Limit

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

HD – May require home delivery pharmacy
 PPACA – No Cost-Share Preventive Medication
 CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

VITAMINS (Nutritional/Dietary) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
VITAMIN B PREPARATIONS (cont.)		
<i>complex b-100 tablet sa</i>	T2	HD
COMPLEX B-50	T4	HD
CVS BALANCED B-100 TR CAPLET	T4	HD
<i>cvs biotin 1,000 mcg tablet</i>	T2	HD
CVS BIOTIN 10,000 MCG SOFTGEL	T4	HD
<i>cvs super b-complex-vit c cplt (Vita-Bee With C)</i>	T2	HD PPACA
<i>cyanocobalamin/folic ac/vit b6</i>	T2	HD
<i>cyanocobalamin/folic ac/vit b6</i>	T2	HD PPACA
<i>cyanocobalamin/folic ac/vit b6 (Niva-Fol)</i>	T2	HD
CYTO B7	T4	HD
DIALYVITE 3000	T4	HD
DIALYVITE 5000	T4	HD
DIALYVITE 800 CHEWABLE WAFER	T4	HD
DIALYVITE 800 PLUS D	T4	HD
<i>dialyvite 800 tablet</i>	T2	HD PPACA
DIALYVITE 800 WITH ZINC	T4	HD
DIALYVITE 800-ULTRA D	T3	HD
DIALYVITE SUPREME D	T4	HD
ELFOLATE PLUS	T4	HD
ENDUR-B COMPLEX	T4	HD
<i>eql b complex 50 tablet</i>	T2	HD
<i>folic acid/b complex c no.17</i>	T2	HD
<i>folic acid/vit b complex and c</i>	T2	HD PPACA
<i>folic acid/vit b complex and c</i>	T2	HD
<i>folic acid/vit b complex and c (Hylavite)</i>	T2	HD
<i>folic acid/vit b complex and c (Vita-Bee With C)</i>	T2	HD PPACA
<i>folic acid/vit bcomp,c/cu/zinc</i>	T2	HD
FOLIKA-BC	T4	HD
FOLIKA-NC	T4	HD
FOLIKA-T	T4	HD
FOLINIC-PLUS	T4	HD
FOLTX	T4	HD
GENICIN VITA-S	T4	HD
<i>gnp biotin 5,000 mcg capsule (Meribin)</i>	T2	HD

T1 – Preferred Generics
 T2 – Non-Preferred Generics
 T3 – Preferred Brands
 T4 – Non-Preferred Brands

T5 – Brand Specialty
 PA – Prior Authorization
 QL – Quantity Limit

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

HD – May require home delivery pharmacy
 PPACA – No Cost-Share Preventive Medication
 CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

VITAMINS (Nutritional/Dietary) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
VITAMIN B PREPARATIONS (cont.)		
HAIR-SKIN-NAILS	T4	HD
HARD NAILS (<i>biotin</i>)	T4	HD
HM BIOTIN 10,000 MCG TABLET	T4	HD
<i>hm biotin 5,000 mcg capsule</i> (Meribin)	T2	HD
HOMOCYSTEINE FORMULA	T4	HD
HYLAVITE (<i>folic acid/vit b complex and c</i>)	T4	HD
<i>levomefolate/b6/b12/algal oil</i>	T2	HD
LEVOMEFOLATE-NAC-MECOBAL-ALGAL	T4	HD
LEVOMEFOL-PYRIDOXAL-MEC-ALGAL	T4	HD
<i>l-mefol/a-cyst/meb12/algal oil</i>	T2	HD
L-METHYLFOL-ALGAL-NAC-ME-CBL	T4	HD
L-METHYLFOL-ALGAL-P5P-ME-CBL	T4	HD
LORID	T4	HD
LORMATE	T4	HD
<i>mecobal/levomefolat ca/b6 phos</i>	T2	HD
MEDTYCHOLL-B COMPLEX W-LIVER	T4	HD
MEGA BIOTIN	T4	HD
MERIBIN (<i>biotin</i>)	T3	HD
METANX	T4	HD
METHAVER	T4	HD
METHYL PROTECT	T4	HD
MULTIVITAMIN-ZINC-STRESS	T4	HD
NEPHRON FA	T4	HD
NEPHRO-VITE	T3	HD
NIVA-FOL (<i>cyanocobalamin/folic ac/vit b6</i>)	T4	HD
NUFOLA	T4	HD
PODIAPN	T4	HD
POTABA	T4	HD
PRORENAL	T3	HD
QUIN B STRONG	T4	HD
<i>ra balanced b-100 tablet</i>	T2	HD PPACA
<i>ra b-complex-vitamin b-12 tab</i>	T2	HD
<i>ra biotin 2,500 mcg capsule</i> (Hard Nails)	T2	HD
RENAL VITAMIN	T4	HD

T1 – Preferred Generics
T2 – Non-Preferred Generics
T3 – Preferred Brands
T4 – Non-Preferred Brands

T5 – Brand Specialty
PA – Prior Authorization
QL – Quantity Limit

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

HD – May require home delivery pharmacy
PPACA – No Cost-Share Preventive Medication
CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

VITAMINS (Nutritional/Dietary) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
VITAMIN B PREPARATIONS (cont.)		
RENAL-VITE	T4	HD
RENAPLEX	T4	HD
RENAPLEX-D	T4	HD
RIBOZEL	T4	HD
<i>sm biotin 5,000 mcg capsule (Meribin)</i>	T2	HD
SM BIOTIN 5,000 MCG TABLET	T4	HD
<i>sm stress formula+zinc tablet</i>	T2	HD
<i>super b complex-vit c caplet (Vita-Bee With C)</i>	T2	HD PPACA
<i>super b-50 complex capsule</i>	T2	HD
<i>super b-50 complex capsule</i>	T2	HD PPACA
<i>super quints b-50 tablet</i>	T2	HD PPACA
<i>super quints b-50 tablets</i>	T2	HD
SV BIOTIN 1,000 MCG SOFTGEL	T4	HD
<i>sv biotin 5,000 mcg softgel (Meribin)</i>	T2	HD
TRONVITE	T4	HD
ULTRA B-100 COMPLEX TABLET	T4	HD
<i>ultra b-100 complex tablet</i>	T2	HD
VB7 MAX	T4	HD
VIRT-CAPS (<i>b complex w-c no.20/folic acid</i>)	T4	HD
<i>vit b comp c 19/folic acid/d3</i>	T2	HD PPACA
<i>vit b comp no.3/folic/c/biotin</i>	T2	HD
<i>vit b comp/c/fa/iron sulf/vite</i>	T2	HD PPACA
<i>vit b comp/c/folic/iron/vit e</i>	T2	HD PPACA
<i>vit b complex 100 combo no.2</i>	T2	HD
<i>vit b 12/levomefolate/vit b6/b2 (Cerefolin)</i>	T2	HD
VITA-BEE WITH C (<i>folic acid/vit b complex and c</i>)	T4	HD
VITAL-D RX	T4	HD
VITAJOY BIOTIN	T4	HD
<i>vitamin b complex</i>	T2	HD
<i>vitamin b complex capsule</i>	T2	HD
<i>vitamin b complex softgel</i>	T2	HD
<i>vitamin b complex tablet</i>	T2	HD PPACA
<i>vitamin b complex tablet</i>	T2	HD
<i>vitamin b complex/folic acid</i>	T2	HD PPACA

T1 – Preferred Generics
T2 – Non-Preferred Generics
T3 – Preferred Brands
T4 – Non-Preferred Brands

T5 – Brand Specialty
PA – Prior Authorization
QL – Quantity Limit

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

HD – May require home delivery pharmacy
PPACA – No Cost-Share Preventive Medication
CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

VITAMINS (Nutritional/Dietary) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
VITAMIN B PREPARATIONS (cont.)		
<i>vitamin b complex/lysine (Apetex)</i>	T2	HD
<i>vitamin b complex/lysine (Apetigen)</i>	T2	HD
<i>vitamin b complex-vitamin c tb (Vita-Bee With C)</i>	T2	HD PPACA
<i>vitamin b-complex c caplet</i>	T2	HD PPACA
VITA-RESPA	T4	HD
VITASURE	T4	HD
WEST-VITE WITH FOLIC ACID	T4	HD
XVITE	T4	HD
ZELDANA	T4	HD
VITAMIN B1 PREPARATIONS		
CYTO B-1	T4	
<i>thiamine 100 mg tablet</i>	T2	
<i>thiamine 200 mg/2 ml vial</i>	T2	
<i>thiamine 250 mg tablet</i>	T2	
THIAMINE 500 MG TABLET	T4	
<i>thiamine hcl</i>	T2	
<i>thiamine mononitrate (vit b1)</i>	T2	
VITAMIN B1	T4	
VITAMIN B12 PREPARATIONS		
ABANEU-SL	T4	
APATATE	T3	
B-12 1,000 MCG FAST DISSOLVE	T4	
B-12 1,000 MCG LOZENGE	T4	
B-12 1,000 MCG QUICK DISSOLVE	T4	
<i>b-12 1,000 mcg tablet</i>	T2	
B-12 1,000 MCG/15 ML LIQUID	T3	
<i>b-12 1,000 mcg/15 ml liquid</i>	T2	
<i>b-12 2,500 mcg microlozenge</i>	T2	
<i>b12 2,500 mcg tablet sl</i>	T2	
<i>b-12 2,500 mcg tablet sl</i>	T2	
B-12 3,000 MCG TABLET SL	T4	
<i>b-12 3,000 mcg/ml subling liq</i>	T2	
B-12 5,000 MCG FAST DISSOLVE	T4	
B12 5,000 MCG MICROLOZENGE	T4	

T1 – Preferred Generics
 T2 – Non-Preferred Generics
 T3 – Preferred Brands
 T4 – Non-Preferred Brands

T5 – Brand Specialty
 PA – Prior Authorization
 QL – Quantity Limit

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

HD – May require home delivery pharmacy
 PPACA – No Cost-Share Preventive Medication
 CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

VITAMINS (Nutritional/Dietary) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
VITAMIN B12 PREPARATIONS (cont.)		
B-12 5,000 MCG MICROLOZENGE	T3	
B-12 5,000 MCG ODT	T4	
B-12 5,000 MCG QUICK DISSOLVE	T4	
B-12 5,000 MCG SUBLINGUAL TAB	T4	
B-12 5,000 MCG/ML SUBLING LIQ	T4	
B-12 500 MCG QUICK DISSOLVE TB	T4	
<i>b-12 500 mcg tablet</i>	T2	
B12 ACTIVE	T4	
B-12 DUAL SPECTRUM	T4	
<i>b-12 er 1,000 mcg tab</i>	T2	
B-12 WITH FOLIC ACID	T4	
CVS VIT B12 2,500 MCG SOFT CHW	T4	
<i>cvs b-12 1,000 mcg tablet</i>	T2	
CVS B-12 5,000 MCG MICROLOZENG	T4	
CVS B-12 5,000 MCG MICROLOZENG	T3	
CVS VIT B-12 500 MCG LOZENGE	T3	
<i>cvs vit b-12 500 mcg lozenge</i>	T2	
<i>cvs vit b-12 tr 1,000 mcg tab</i>	T2	
<i>cvs vit b-12 tr 2,000 mcg tab</i>	T2	
CVS VITAMIN B-12 500 MCG GUMMY	T4	
CVS VITAMIN B12 5,000 MCG TAB	T4	
<i>cvs vitamin b-12 500 mcg tab</i>	T2	
<i>cyanocobalamin (vitamin b-12) (Nascobal)</i>	T2	ST QL(4 units/30 days)
<i>eql vitamin b-12 500 mcg tab</i>	T2	
<i>fn vitamin b-12 1,000 mcg tab</i>	T2	
FOLTRATE	T4	
<i>gnp b12 2,500 mcg tablet sl</i>	T2	
<i>gnp vit b-12 er 1,000 mcg tab</i>	T2	
<i>gnp vitamin b-12 500 mcg tab</i>	T2	
<i>hm vit b-12 tr 1,000 mcg tab</i>	T2	
<i>hm vitamin b-12 500 mcg tablet</i>	T2	
<i>hydroxocobalamin</i>	T2	
INTRINSI B12-FOLATE	T4	
METHYL B-12	T4	

T1 – Preferred Generics
 T2 – Non-Preferred Generics
 T3 – Preferred Brands
 T4 – Non-Preferred Brands

T5 – Brand Specialty
 PA – Prior Authorization
 QL – Quantity Limit

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

HD – May require home delivery pharmacy
 PPACA – No Cost-Share Preventive Medication
 CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

VITAMINS (Nutritional/Dietary) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
VITAMIN B12 PREPARATIONS (cont.)		
METHYLCOBALAMIN	T4	
METHYLCOBALAMIN 5,000 MCG TAB	T4	
MTX SUPPORT	T4	
NASCOBAL (<i>cyanocobalamin (vitamin b-12)</i>)	T3	ST QL (4 units/30 days)
NEURIN-SL	T4	
OPURITY	T4	
<i>ra vit b12 1,000 mcg tab sa</i>	T2	
RA VIT B-12 1,000 MCG/ML LIQ	T4	
<i>ra vitamin b-12 100 mcg tablet</i>	T2	
<i>ra vitamin b12 er 2,000 mcg tb</i>	T2	
RAPID B-12 ENERGY	T4	
<i>sm vitamin b12 1,000 mcg tab</i>	T2	
<i>sm vitamin b-12 100 mcg tablet</i>	T2	
<i>sm vitamin b-12 500 mcg tablet</i>	T2	
<i>sv b-12 2,500 mcg microlozenge</i>	T2	
SV B-12 5,000 MCG MICROLOZENGE	T3	
SV VIT B-12 500 MCG LOZENGE	T3	
<i>sv vitamin b-12 500 mcg tablet</i>	T2	
<i>sv vitamin b12 tr 1,000 mcg tb</i>	T2	
<i>true vitamin b-12 1000 mcg tab</i>	T2	
<i>true vitamin b-12 500 mcg tab</i>	T2	
VIT B-12 500 MCG SUBLING TAB	T4	
VITAMIN B-12 1,000 MCG SOFTGEL	T4	
<i>vitamin b-12 1,000 mcg tab sl</i>	T2	
<i>vitamin b-12 1,000 mcg tablet</i>	T2	
<i>vitamin b-12 100 mcg tablet</i>	T2	
<i>vitamin b-12 2,000 mcg tab sa</i>	T2	
VITAMIN B-12 2,000 MCG TABLET	T4	
<i>vitamin b-12 2,500 mcg tab sl</i>	T2	
VITAMIN B-12 250 MCG LOZENGE	T4	
<i>vitamin b-12 250 mcg tablet</i>	T2	
VITAMIN B-12 3,000 MCG SL LOZ	T4	
VITAMIN B-12 3,000 MCG SOFTGEL	T4	
VITAMIN B-12 3,000 MCG TAB SL	T4	

T1 – Preferred Generics
T2 – Non-Preferred Generics
T3 – Preferred Brands
T4 – Non-Preferred Brands

T5 – Brand Specialty
PA – Prior Authorization
QL – Quantity Limit

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

HD – May require home delivery pharmacy
PPACA – No Cost-Share Preventive Medication
CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

VITAMINS (Nutritional/Dietary) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
VITAMIN B12 PREPARATIONS (cont.)		
VITAMIN B-12 5,000 MCG ODT	T4	
VITAMIN B-12 5,000 MCG SOFTGEL	T4	
VITAMIN B-12 5,000 MCG TAB SL	T3	
<i>vitamin b-12 5,000 mcg tab sl</i>	T2	
VITAMIN B-12 5,000 MCG TAB SL	T4	
VITAMIN B-12 5,000 MCG TABLET	T4	
VITAMIN B-12 50 MCG LOZENGE	T4	
<i>vitamin b12 50 mcg tablet</i>	T2	
<i>vitamin b-12 50 mcg tablet</i>	T2	
VITAMIN B-12 500 MCG LOZENGE	T3	
<i>vitamin b12 500 mcg tablet</i>	T2	
<i>vitamin b-12 500 mcg tablet</i>	T2	
<i>vitamin b-12 tr 1,000 mcg tab</i>	T2	
<i>vitamin b-12 tr 2,000 mcg tab</i>	T2	
VITAMIN B12-FOLIC ACID	T4	
VITAMIN B2 PREPARATIONS		
CYTO B-2	T4	
<i>riboflavin (vitamin b2)</i>	T2	
<i>riboflavin 100 mg tablet</i>	T2	
RIBOFLAVIN 400 MG TABLET	T4	
<i>riboflavin 50 mg tablet</i>	T2	
VITAMIN B6 PREPARATIONS		
CHROMIUM PICOLINATE KLB6	T4	
<i>cvs vitamin b-6 100 mg tablet</i>	T2	
<i>eql vitamin b-6 100 mg tablet</i>	T2	
<i>gnp vitamin b-6 100 mg tablet</i>	T2	
<i>pyridoxine 100 mg/ml vial</i>	T2	
<i>pyridoxine 25 mg tablet</i>	T2	
<i>pyridoxine 250 mg tablet</i>	T2	
PYRIDOXINE 50 MG TABLET (<i>pyridoxine hcl (vitamin b6)</i>)	T3	
<i>pyridoxine 50 mg tablet (Pyridoxine Hcl)</i>	T2	
PYRIDOXINE 500 MG TABLET (<i>pyridoxine hcl (vitamin b6)</i>)	T4	
<i>pyridoxine hcl (vitamin b6)</i>	T2	
<i>pyridoxine hcl (vitamin b6) (Pyridoxine Hcl)</i>	T2	

T1 – Preferred Generics
T2 – Non-Preferred Generics
T3 – Preferred Brands
T4 – Non-Preferred Brands

T5 – Brand Specialty
PA – Prior Authorization
QL – Quantity Limit

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

HD – May require home delivery pharmacy
PPACA – No Cost-Share Preventive Medication
CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

VITAMINS (Nutritional/Dietary) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
VITAMIN B6 PREPARATIONS (cont.)		
<i>ra vitamin b-6 100 mg tablet</i>	T2	
<i>ra vitamin b-6 50 mg tablet</i>	T2	
<i>sm vitamin b-6 100 mg tablet</i>	T2	
<i>sv vitamin b-6 100 mg tablet</i>	T2	
<i>true vitamin b-6 100 mg tablet</i>	T2	
<i>true vitamin b-6 25 mg tablet</i>	T2	
<i>true vitamin b-6 50 mg tablet</i>	T2	
TRUE VITAMIN B-6 10 MG TABLET	T4	
VB6 PSP	T4	
<i>vitamin b-6 100 mg tablet</i>	T2	
<i>vitamin b-6 25 mg tablet</i>	T2	
<i>vitamin b-6 250 mg tablet</i>	T2	
<i>vitamin b-6 50 mg tablet</i>	T2	
VITAMIN C PREPARATIONS		
ASCOR	T4	
<i>ascorbate calcium</i>	T2	
<i>ascorbic acid</i>	T2	
<i>ascorbic acid 500 mg tablet</i>	T2	
<i>ascorbic acid 500 mg/ml vial</i>	T2	
ASCORBIC ACID GRANULES	T3	
<i>ascorbic acid/ascorbate sodium</i>	T2	
BIO C 1:1	T4	
<i>c-1,000 mg tablet sa</i>	T2	
<i>cod liver oil tab chewable</i>	T2	
<i>cvs vit c-rose hip 1,000 mg tb</i>	T2	
<i>cvs vit c-rose hip 500 mg chew</i>	T2	
<i>cvs vit c-rose hips 500 mg tab</i>	T2	
<i>cvs vitamin c 1,000 mg caplet</i>	T2	
CVS VITAMIN C 1,000 MG POWDER	T4	
<i>cvs vitamin c 250 mg tablet</i>	T2	
<i>cvs vitamin c 500 mg caplet</i>	T2	
<i>cvs vitamin c 500 mg tablet</i>	T2	
CYTO C	T4	
EMERGEN-C	T4	

T1 – Preferred Generics
 T2 – Non-Preferred Generics
 T3 – Preferred Brands
 T4 – Non-Preferred Brands

T5 – Brand Specialty
 PA – Prior Authorization
 QL – Quantity Limit

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

HD – May require home delivery pharmacy
 PPACA – No Cost-Share Preventive Medication
 CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

VITAMINS (Nutritional/Dietary) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
VITAMIN C PREPARATIONS (cont.)		
EMERGEN-C IMMUNE PLUS	T4	
EMERGEN-C MSM LITE	T4	
<i>eql vitamin c 1,000 mg tablet</i>	T2	
ESSENCE C	T4	
ESTER-C 1,000 MG TABLET	T4	
ESTER-C 500 MG TABLET	T3	
FLEVOXIN	T4	
FRUIT C-100 TABLET CHEWABLE	T4	
<i>fruit c-100 tablet chewable</i>	T2	
FRUIT C-200	T4	
<i>gnp vit c-rose hips 500 mg tab</i>	T2	
<i>gnp vitamin c 1,000 mg tablet</i>	T2	
<i>gnp vitamin c 250 mg tablet</i>	T2	
<i>gnp vitamin c 500 mg tab chew</i>	T2	
<i>gnp vitamin c 500 mg tablet</i>	T2	
<i>gnp vitamin c er 500 mg tablet</i>	T2	
<i>hm vit c-rose hip 1,000 mg tab</i>	T2	
<i>hm vit c-rose hips 500 mg cplt</i>	T2	
<i>hm vitamin c 500 mg tab chew</i>	T2	
LIQUID C	T4	
PAN-C 500	T4	
PERIDIN-C	T3	
<i>ra vit c-rose hips 500 mg tab</i>	T2	
<i>ra vitamin c 1,000 mg tab sa</i>	T2	
<i>ra vitamin c 1,000 mg tablet</i>	T2	
<i>ra vitamin c 250 mg tablet</i>	T2	
<i>ra vitamin c 500 mg chew tab</i>	T2	
<i>ra vitamin c 500 mg tab chew</i>	T2	
<i>ra vitamin c 500 mg tablet</i>	T2	
RA VITAMIN C 53 MG DROP	T4	
<i>ra vitamin c tr 500 mg caplet</i>	T2	
<i>sm vit c-rose hips 500 mg tab</i>	T2	
<i>sm vitamin c 1,000 mg tablet</i>	T2	
<i>sm vitamin c 250 mg tablet</i>	T2	

T1 – Preferred Generics
 T2 – Non-Preferred Generics
 T3 – Preferred Brands
 T4 – Non-Preferred Brands

T5 – Brand Specialty
 PA – Prior Authorization
 QL – Quantity Limit

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

HD – May require home delivery pharmacy
 PPACA – No Cost-Share Preventive Medication
 CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

VITAMINS (Nutritional/Dietary) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
VITAMIN C PREPARATIONS (cont.)		
<i>sm vitamin c 500 mg chew tab</i>	T2	
<i>sm vitamin c 500 mg tab chew</i>	T2	
<i>sm vitamin c 500 mg tablet</i>	T2	
<i>sm vitamin c with rose hips</i>	T2	
SPAN C	T4	
<i>sv vit c-rose hip 1,000 mg tab</i>	T2	
<i>sv vit c-rose hips 1,000 mg tb</i>	T2	
<i>sv vit c-rose hips 500 mg tab</i>	T2	
<i>sv vitamin c 500 mg tab chew</i>	T2	
<i>sv vitamin c tr 1,000 mg tab</i>	T2	
<i>true vitamin c 1,000 mg tablet</i>	T2	
<i>true vitamin c 250 mg tablet</i>	T2	
<i>true vitamin c 500 mg tablet</i>	T2	
<i>vit c-rose hip 1,000 mg caplet</i>	T2	
<i>vit c-rose hips 1,000 mg cplt</i>	T2	
<i>vit c-rose hips 1,000 mg tab</i>	T2	
VIT C-ROSE HIPS 500 MG CHEW TB	T4	
<i>vit c-rose hips 500 mg tablet</i>	T2	
<i>vit c-rose hips tr 1,000 mg</i>	T2	
<i>vit c-rose hips tr 500 mg cplt</i>	T2	
<i>vit c-rose hips tr 500 mg tab</i>	T2	
VITAJLOY DAILY C	T4	
<i>vitamin c 1,000 mg caplet</i>	T2	
<i>vitamin c 1,000 mg tablet</i>	T2	
<i>vitamin c 1,500 mg tablet sa</i>	T2	
<i>vitamin c 100 mg tablet</i>	T2	
VITAMIN C 125 MG GUMMIES	T4	
<i>vitamin c 250 mg tablet</i>	T2	
VITAMIN C 250 MG TABLET CHEW	T4	
<i>vitamin c 250 mg tablet chew</i>	T2	
<i>vitamin c 500 mg capsule sa</i>	T2	
<i>vitamin c 500 mg chew tablet</i>	T2	
VITAMIN C 500 MG POWDER PACKET	T4	
VITAMIN C 500 MG SOFTGEL	T4	

T1 – Preferred Generics
 T2 – Non-Preferred Generics
 T3 – Preferred Brands
 T4 – Non-Preferred Brands

T5 – Brand Specialty
 PA – Prior Authorization
 QL – Quantity Limit

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

HD – May require home delivery pharmacy
 PPACA – No Cost-Share Preventive Medication
 CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

VITAMINS (Nutritional/Dietary) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
VITAMIN C PREPARATIONS (cont.)		
<i>vitamin c 500 mg tablet</i>	T2	
<i>vitamin c 500 mg tablet chew</i>	T2	
VITAMIN C 500 MG WAFER	T4	
VITAMIN C 500 MG/15 ML LIQUID	T4	
<i>vitamin c 500 mg/5 ml liquid</i>	T2	
<i>vitamin c drops</i>	T2	
<i>vitamin c er 500 mg capsule</i>	T2	
VITAMIN C FIZZY DRINK	T4	
VITAMIN C POWDER	T4	
<i>vitamin c powder</i>	T2	
<i>vitamin c tr 1,000 mg tablet</i>	T2	
<i>vitamin c tr 500 mg caplet</i>	T2	
<i>vitamin c tr 500 mg tablet</i>	T2	
<i>vitamin c-500 mg tablet</i>	T2	
<i>vitamin c-500 mg tr capsule</i>	T2	
VITAMIN C-BIOFLAVINOIDS-RH	T4	
<i>vitamin c-rose hip 1,000 mg tb</i>	T2	
<i>v-r vitamin c 1,000 mg tablet</i>	T2	
<i>v-r vitamin c 250 mg tab chew</i>	T2	
<i>v-r vitamin c 500 mg tab chew</i>	T2	
XCELLENT C	T4	
ZINC PLUS	T4	
ZINC-VITAMIN C	T4	
VITAMIN D PREPARATIONS		
AQUA-D CONCENTRATE	T4	HD
BABY DDROPS	T4	HD
BABY VITAMIN D3	T4	HD
BABY'S SUPER DAILY D3	T4	HD
BIO-D-MULSION	T4	HD
BIO-D-MULSION FORTE	T4	HD
<i>calcitriol 0.25 mcg capsule (Rocaltrol)</i>	T2	HD
<i>calcitriol 0.5 mcg capsule (Rocaltrol)</i>	T2	HD
<i>calcitriol 1 mcg/ml ampul</i>	T2	HD
<i>calcitriol 1 mcg/ml solution (Rocaltrol)</i>	T2	HD

T1 – Preferred Generics
 T2 – Non-Preferred Generics
 T3 – Preferred Brands
 T4 – Non-Preferred Brands

T5 – Brand Specialty
 PA – Prior Authorization
 QL – Quantity Limit

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

HD – May require home delivery pharmacy
 PPACA – No Cost-Share Preventive Medication
 CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

VITAMINS (Nutritional/Dietary) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
VITAMIN D PREPARATIONS (cont.)		
CHOLECAL DF	T4	HD
<i>cholecalciferol</i> (vitamin d3)	T2	HD
<i>cod liver oil</i>	T2	HD
<i>cod liver oil capsule</i>	T2	HD
<i>cod liver oil softgel</i>	T2	HD
<i>cvs vit d3 1,000 unit gummies</i>	T2	HD
<i>cvs vitamin d3 25 mcg gummies</i>	T2	HD
<i>cvs vitamin d3 400 unit sftgl</i>	T2	HD
<i>cvs vitamin d3 1,000 unit sftgl</i>	T2	HD
<i>cvs vitamin d3 2,000 unit sftgl</i>	T2	HD
<i>cvs vitamin d3 5,000 unit sftgl</i>	T2	HD
<i>cvs vit d3 250 mcg softgel</i>	T2	HD
<i>cvs vitamin d3 10 mcg softgel</i>	T2	HD
<i>cvs vitamin d3 25 mcg softgel</i>	T2	HD
<i>cvs vitamin d3 50 mcg softgel</i>	T2	HD
<i>cvs vitamin d3 125 mcg softgel</i>	T2	HD
CVS VITAMIN D3 250 MCG SOFTGEL	T4	HD
CYFOLEX	T4	HD
D3 LIQUID	T4	HD
D3 PLUS K2 DOTS	T4	HD
D3-50	T3	HD
DDROPS	T4	HD
<i>decara 10,000 unit softgel</i>	T2	HD
DECARA 25,000 UNIT VEGICAP	T3	HD
<i>decara 50,000 unit softgel</i>	T2	HD
DECARA K	T4	HD
DERMACINRX DOTREMIN	T4	HD
DERMACINRX FOLDITAM	T4	HD
DERMACINRX FOLIXAPURE	T4	HD
DERMACINRX FOLTAMIN	T4	HD
DERMACINRX FOLTREXYL	T4	HD
DERMACINRX PUREFOLIX	T4	HD
DIALYVITE VITAMIN D3 MAX	T4	HD
DOSOKAP	T4	HD

T1 – Preferred Generics
T2 – Non-Preferred Generics
T3 – Preferred Brands
T4 – Non-Preferred Brands

T5 – Brand Specialty
PA – Prior Authorization
QL – Quantity Limit

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

HD – May require home delivery pharmacy
PPACA – No Cost-Share Preventive Medication
CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

VITAMINS (Nutritional/Dietary) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
VITAMIN D PREPARATIONS (cont.)		
DOSOQUIN	T4	HD
DRISDOL (<i>ergocalciferol (vitamin d2)</i>)	T4	HD
<i>eql vitamin d3 2,000 unit sftgl</i>	T2	HD
<i>eql vitamin d3 400 unit sftgl</i>	T2	HD
ERGOCAL	T4	HD
<i>ergocalciferol (vitamin d2)</i>	T2	HD
FOLIC D3	T4	HD
FOLIKA-D	T4	HD
FOLIXAPURE	T4	HD
FOLVITE-D	T4	HD
<i>ft vitamin d3 25 mcg softgel</i>	T2	HD
<i>ft vitamin d3 50 mcg softgel</i>	T2	HD
GENICIN VITA-D	T4	HD
<i>gnp vit d3 10mcg(400 unit) chw</i>	T2	HD
<i>gnp vitamin d3 1,000 unit tab</i>	T2	HD
<i>gnp vitamin d3 10 mcg tablet</i>	T2	HD
<i>gnp vitamin d3 2,000 unit tab</i>	T2	HD
<i>gnp vitamin d3 25 mcg tablet</i>	T2	HD
<i>gnp vitamin d3 25mcg(1000 unt)</i>	T2	HD
<i>gnp vitamin d3 5,000 unit tab</i>	T2	HD
<i>hm vitamin d3 1,000 unit tab</i>	T2	HD
<i>hm vitamin d3 2,000 unit sftgl</i>	T2	HD
HM VITAMIN D3 4,000 UNIT SFTGL	T4	HD
IS-D-10,000	T4	HD
K2 PLUS D3	T4	HD
K2-D3 10,000	T4	HD
K2-D3 5000	T4	HD
MAXIMUM D3	T3	HD
NOXIFOL-D3	T4	HD
OPTIMAL D3 M	T4	HD
ORTHO DF	T4	HD
OSTACHOL	T4	HD
<i>qc cod liver oil</i>	T2	HD
<i>ra cod liver oil</i>	T2	HD

T1 – Preferred Generics
 T2 – Non-Preferred Generics
 T3 – Preferred Brands
 T4 – Non-Preferred Brands

T5 – Brand Specialty
 PA – Prior Authorization
 QL – Quantity Limit

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

HD – May require home delivery pharmacy
 PPACA – No Cost-Share Preventive Medication
 CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

VITAMINS (Nutritional/Dietary) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
VITAMIN D PREPARATIONS (cont.)		
<i>ra cod liver oil softgel</i>	T2	HD
<i>ra vitamin d3 1,000 unit tab</i>	T2	HD
<i>ra vitamin d3 2,000 unit sfgl</i>	T2	HD
<i>ra vitamin d3 2,000 unit sftgl</i>	T2	HD
<i>ra vitamin d3 5,000 unit sftgl</i>	T2	HD
REPLESTA NX	T3	HD
REVESTA	T4	HD
ROCALTROL (<i>calcitriol</i>)	T4	ST HD
ROXIFOL-D	T4	HD
<i>sm vitamin d3 1,000 unit tab</i>	T2	HD
<i>sm vitamin d3 2,000 unit sftgl</i>	T2	HD
<i>sm vitamin d3 25 mcg tablet</i>	T2	HD
<i>sm vitamin d3 50 mcg softgel</i>	T2	HD
SUPER DAILY D3	T4	HD
<i>sv vitamin d3 1,000 unit gummy</i>	T2	HD
<i>sv vitamin d3 1,000 unit sftgl</i>	T2	HD
<i>sv vitamin d3 2,000 unit sftgl</i>	T2	HD
<i>sv vitamin d3 25mcg(1000 unit)</i>	T2	HD
<i>sv vitamin d3 400 unit softgel</i>	T2	HD
<i>sv vitamin d3 5,000 unit sftgl</i>	T2	HD
<i>thera-d 2000 tablet</i>	T2	HD
THERA-D 4000 TABLET	T4	HD
<i>thera-d rapid repletion tablet</i>	T2	HD
<i>thera-d sport 2,000 unit tab</i>	T2	HD
<i>true vitamin d3 1,250 mcg tab</i>	T2	HD
<i>true vitamin d3 10 mcg capsule</i>	T2	HD
<i>true vitamin d3 10 mcg tablet</i>	T2	HD
<i>true vitamin d3 125 mcg cap</i>	T2	HD
<i>true vitamin d3 125 mcg tablet</i>	T2	HD
<i>true vitamin d3 25 mcg capsule</i>	T2	HD
<i>true vitamin d3 25 mcg tablet</i>	T2	HD
TRUE VITAMIN D3 1,250 MCG CAP	T4	HD
TRUE VITAMIN D3 250 MCG CAP	T4	HD
TRUE VITAMIN D3 250 MCG TABLET	T4	HD

T1 – Preferred Generics
 T2 – Non-Preferred Generics
 T3 – Preferred Brands
 T4 – Non-Preferred Brands

T5 – Brand Specialty
 PA – Prior Authorization
 QL – Quantity Limit

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

HD – May require home delivery pharmacy
 PPACA – No Cost-Share Preventive Medication
 CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

VITAMINS (Nutritional/Dietary) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
VITAMIN D PREPARATIONS (cont.)		
<i>vit d3 125 mcg (5000 unit) tab</i>	T2	HD
VIT D3 5,000 UNIT FAST DISSOLV	T4	HD
<i>vitamin d2 1.25mg(50,000 unit) (Drisdol)</i>	T2	HD
VITAMIN D2 2,000 UNIT TABLET	T3	HD
<i>vitamin d2 400 unit tablet</i>	T2	HD
VITAMIN D2 50 MCG (2,000 UNIT)	T4	HD
VITAMIN D3 50 MCG DISSOLVE TAB	T4	HD
<i>vitamin d3 1,000 unit gummies</i>	T2	HD
<i>vitamin d3 1,000 unit gummy</i>	T2	HD
<i>vitamin d3 1,000 unit softgel</i>	T2	HD
VITAMIN D3 62.5 MCG SOFTGEL	T4	HD
VITAMIN D3 1,000 UNIT SPRAY	T4	HD
<i>vitamin d3 1,000 unit tab chew</i>	T2	HD
<i>vitamin d3 1,000 unit tablet</i>	T2	HD
VITAMIN D3 1,000 UNIT/10 ML LQ	T4	HD
<i>vitamin d3 1,250 mcg capsule</i>	T2	HD
<i>vitamin d3 1.25 mg softgel</i>	T2	HD
<i>vitamin d3 10 mcg tablet</i>	T2	HD
<i>vitamin d3 10 mcg(400 unit)/ml</i>	T2	HD
<i>vitamin d3 10 mcg/ml drop</i>	T2	HD
<i>vitamin d3 10 mcg/ml liquid</i>	T2	HD
VITAMIN D3 10,000 UNIT CAPSULE	T4	HD
<i>vitamin d3 10,000 unit softgel</i>	T2	HD
VITAMIN D3 10,000 UNIT TABLET	T4	HD
<i>vitamin d3 125 mcg (5000 unit)</i>	T2	HD
<i>vitamin d3 125 mcg capsule</i>	T2	HD
<i>vitamin d3 125 mcg softgel</i>	T2	HD
<i>vitamin d3 125 mcg tablet</i>	T2	HD
VITAMIN D3 125 MCG/0.5 ML DROP	T4	HD
<i>vitamin d3 2,000 unit softgel</i>	T2	HD
VITAMIN D3 2,000 UNIT TAB CHEW	T4	HD
<i>vitamin d3 2,000 unit tablet</i>	T2	HD
<i>vitamin d3 25 mcg (1,000 unit)</i>	T2	HD
<i>vitamin d3 25 mcg gummy</i>	T2	HD

T1 – Preferred Generics
 T2 – Non-Preferred Generics
 T3 – Preferred Brands
 T4 – Non-Preferred Brands

T5 – Brand Specialty
 PA – Prior Authorization
 QL – Quantity Limit

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

HD – May require home delivery pharmacy
 PPACA – No Cost-Share Preventive Medication
 CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

VITAMINS (Nutritional/Dietary) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
VITAMIN D PREPARATIONS (cont.)		
<i>vitamin d3 25 mcg softgel</i>	T2	HD
<i>vitamin d3 25 mcg tablet</i>	T2	HD
VITAMIN D3 250 MCG TABLET	T4	HD
VITAMIN D3 3,000 UNIT TABLET	T4	HD
<i>vitamin d3 400 unit softgel</i>	T2	HD
<i>vitamin d3 400 unit tab chew</i>	T2	HD
<i>vitamin d3 400 unit tablet</i>	T2	HD
VITAMIN D3 400 UNIT/5 ML LIQ	T4	HD
<i>vitamin d3 400 unit/ml liquid</i>	T2	HD
<i>vitamin d3 5,000 unit capsule</i>	T2	HD
<i>vitamin d3 5,000 unit softgel</i>	T2	HD
<i>vitamin d3 5,000 unit tablet</i>	T2	HD
<i>vitamin d3 5,000 unit/ml drops</i>	T2	HD
<i>vitamin d3 50 mcg (2,000 unit)</i>	T2	HD
<i>vitamin d3 50 mcg capsule</i>	T2	HD
<i>vitamin d3 50 mcg softgel</i>	T2	HD
<i>vitamin d3 50 mcg tablet</i>	T2	HD
<i>vitamin d3 50,000 unit capsule</i>	T2	HD
<i>vitamin d3/folic acid</i>	T2	HD
<i>v-r cod liver oil capsule</i>	T2	HD
VITAMIN E PREPARATIONS		
AQUA-E	T3	
AQUA-E CONCENTRATE	T4	
<i>cvs vitamin e 180 mg softgel</i>	T2	
<i>cvs vitamin e 200 unit softgel</i>	T2	
<i>cvs vitamin e 268 mg softgel</i>	T2	
CVS VITAMIN E 450 MG SOFTGEL	T4	
<i>cvs vitamin e 90 mg softgel</i>	T2	
<i>eql vitamin e 1,000 unit sftgl</i>	T2	
<i>eql vitamin e 180 mg softgel</i>	T2	
<i>gnp vitamin e 180 mg softgel</i>	T2	
<i>gnp vitamin e 400 unit softgel</i>	T2	
GNP VITAMIN E 450 MG SOFTGEL	T4	
<i>gnp vitamin e 90 mg softgel</i>	T2	

T1 – Preferred Generics
 T2 – Non-Preferred Generics
 T3 – Preferred Brands
 T4 – Non-Preferred Brands

T5 – Brand Specialty
 PA – Prior Authorization
 QL – Quantity Limit

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

HD – May require home delivery pharmacy
 PPACA – No Cost-Share Preventive Medication
 CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

VITAMINS (Nutritional/Dietary) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
VITAMIN E PREPARATIONS (cont.)		
<i>hm vitamin e 180 mg softgel</i>	T2	
<i>hm vitamin e 200 unit softgel</i>	T2	
<i>hm vitamin e 400 unit softgel</i>	T2	
MIXED TOCOTRIENOLS	T4	
<i>ra vitamin e 268 mg softgel</i>	T2	
SOLUVITA-E	T4	
<i>sv vitamin e 180 mg softgel</i>	T2	
<i>sv vitamin e 400 unit softgel</i>	T2	
<i>sv vitamin e 450 mg softgel</i>	T2	
<i>sv vitamin e 670 mg softgel</i>	T2	
<i>true vitamin e 180 mg capsule</i>	T2	
<i>true vitamin e 90 mg capsule</i>	T2	
TRUE VITAMIN E 450 MG CAPSULE	T4	
<i>vitamin e (dl,tocopheryl acet)</i>	T2	
<i>vitamin e 1,000 unit capsule</i>	T2	
<i>vitamin e 1,000 unit softgel</i>	T2	
VITAMIN E 1,000 UNIT SOFTGEL	T4	
<i>vitamin e 100 unit softgel</i>	T2	
VITAMIN E 100 UNIT TABLET	T4	
VITAMIN E 15 UNIT/0.3 ML DROP	T4	
<i>vitamin e 15 unit/0.3 ml drop</i>	T2	
<i>vitamin e 180 mg softgel</i>	T2	
<i>vitamin e 180mg(400 unit) sfgl</i>	T2	
<i>vitamin e 200 unit capsule</i>	T2	
<i>vitamin e 200 unit softgel</i>	T2	
<i>vitamin e 268 mg softgel</i>	T2	
<i>vitamin e 400 unit capsule</i>	T2	
<i>vitamin e 400 unit softgel</i>	T2	
<i>vitamin e 45 mg softgel</i>	T2	
VITAMIN E 450 MG SOFTGEL	T4	
<i>vitamin e 450 mg softgel</i>	T2	
<i>vitamin e 600 unit capsule</i>	T2	
<i>vitamin e 90 mg capsule</i>	T2	
<i>vitamin e 90 mg softgel</i>	T2	

T1 – Preferred Generics
 T2 – Non-Preferred Generics
 T3 – Preferred Brands
 T4 – Non-Preferred Brands

T5 – Brand Specialty
 PA – Prior Authorization
 QL – Quantity Limit

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

HD – May require home delivery pharmacy
 PPACA – No Cost-Share Preventive Medication
 CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

VITAMINS (Nutritional/Dietary) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
VITAMIN E PREPARATIONS (cont.)		
VITAMIN E NATURAL OIL DROPS	T3	
VITAMIN E OIL	T4	
VITAMIN E OIL DROPS	T3	
VITAMIN E OIL DROPS	T4	
VITAMIN E-OIL	T3	
WHEAT GERM OIL	T3	
XCELLENT E	T4	
VITAMIN K PREPARATIONS		
AQUA-K CONCENTRATE	T4	
K1-1000	T4	
K2 LIQUID	T4	
K2-45	T4	
MEPHYTON (<i>phytonadione (vit k1)</i>)	T4	QL(10 tabs/fill)
<i>phytonadione (vit k1)</i>	T2	
PHYTONADIONE 1 MG/0.5 ML SYR	T3	
PHYTONADIONE 1 MG/0.5 ML VIAL	T3	
<i>phytonadione 10 mg/ml ampul</i>	T2	
<i>phytonadione 10 mg/ml vial</i>	T2	
VITAMIN K	T3	
VITAMIN K-1	T3	
VITAMIN K2	T4	
VITAMIN K2 (MENAQUINONE-4)	T4	
VITAMINS (Vitamins)		
MULTIVITAMIN PREPARATIONS		
CENTRUM ADULTS 50 PLUS MINIS	T4	
CENTRUM MEN 50 PLUS MINIS	T4	
DAVIMET-M	T4	
PEDIATRIC VITAMIN PREPARATIONS		
CHILDREN'S MULTI	T4	

T1 – Preferred Generics
T2 – Non-Preferred Generics
T3 – Preferred Brands
T4 – Non-Preferred Brands

T5 – Brand Specialty
PA – Prior Authorization
QL – Quantity Limit

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

HD – May require home delivery pharmacy
PPACA – No Cost-Share Preventive Medication
CSL – Oral cancer medication subject to cost-share limits

Exclusions and limitations for coverage

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

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

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

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

Index of Medications

Symbols

1.5 VOLT BATTERIES	156
1ST TIER	135, 151
1ST TIER UNILET COMFORTOUCH.....	151
2-IN-1	135, 151
2-IN-1 LANCET DEVICE	151
2TEK.....	129
5-MTHF.....	215
50 PLUS ADULT EYE.....	196

A

A-25	214
abacavir	66, 67
abacavir/lamivudine/zidovudine	66
abacavir sulfate/lamivudine	66
ABANEU-SL.....	220
ABATRON.....	109
ABC COMPLETE	199
ABDEK.....	211
ABILIFY.....	171
abiraterone.....	56
ABSORICA.....	174
ABSTRAL	22
acamprosate.....	189
acarbose	49
ACCOLATE	32
ACCRUFER.....	109
ACCU-CHEK.....	129, 135, 136, 151, 156, 157
ACCUPRIL.....	81
ACCURETIC.....	80
ACCUTREND.....	129
ACD-A.....	43
ACD SOLUTION A	43
ACE.....	80, 81, 82
ACE AEROSOL.....	157
acebutolol.....	83
acetaminophen/caff/dihydrocod.....	22
acetaminophen with codeine.....	21
acetazolamide.....	98
acetic acid	52, 100, 173
acetic acid/oxyquinoline	52
acetylcysteine	32
acetylcyst/methylbl2/levomefol	215
a/c/e/zinc ox/cupric ox/lutein.....	196
a/c/e/zinc/sod selenate/copper	199
acitretin	174
ACTEMRA.....	127
ACTHIB.....	74
ACTICLATE	39

acti-lance	136, 151
ACTI-LANCE	136, 151
acti-lance lite.....	151
acti-lance univers.....	151
ACTI-LANCE UNIVERS	151
ACTIMMUNE.....	62
ACTIQ	22
ACTIVE FE	109
ACTIVELLA.....	122
ACTIVNUTRIENTS	199
ACTONEL	193
ACTOPLUS MET	50
ACTOS	50
ACULAR	101
acyclovir.....	69, 70
ACZONE.....	174
ADACEL TDAP	74
ADALIMUMAB-ADAZ	54
ADALIMUMAB-ADBIM	54
adapalene.....	174, 175, 184
ADAPALENE	184
adapalene/benzoyl peroxide.....	174, 175
ADBRY	194
ADDYI	169
adefovir	70
ADEK GUMMIES	199
ADEMPAS	79
ADIPEX-P	62
ADJUSTABLE LANCING DEVICE	129
ADLARITY.....	71
ADLYXIN.....	48
ADRENALIN CHLORIDE	100
adthyza	185
ADULT 50 PLUS EYE HEALTH.....	196
ADULT MULTI.....	199
ADULT ONE DAILY.....	199
ADULTS' DAILY FORMULA.....	199
ADULTS MULTIVITAMIN	199
ADVAIR DISKUS	31
ADVAIR HFA.....	31
ADVANCED	129, 136, 151, 196, 199, 203, 209
ADVANCED LANCING DEVICE	129
ADVANCED MULTI EA.....	199
ADVANCED TRAVEL LANCETS.....	151
ADVOCATE.....	129, 136, 151, 176
ADVOCATE CONTROL SOLUTION.....	129
ADVOCATE LANCET	151

Index of Medications

ADVOCATE LANCETS	151	almotriptan.....	19
ADVOCATE LANCING DEVICE.....	129	almotriptan malate.....	15
ADVOCATE RAPID-SAFE LANCING DV.....	129	alosetron.....	119
ADVOCATE REDI-CODE+ CTRL SOLN.....	129	ALPHAGAN P.....	102
ADZENYS.....	71	alprazolam.....	164
AEMCOLO.....	39	ALTABAX.....	179
AEROCHAMBER.....	157	ALTACE.....	82
AEROTRACH.....	157	ALTAFLUOR BENOX.....	102
AEROVENT.....	157	ALTERNATE.....	129, 136, 151
AFLURIA QUAD.....	74	ALTERNATE SITE LANCETS.....	151
AGAMATRIX CONTROL.....	129	ALTERNATE SITE LANCING DEVICE.....	129
AGRYLIN.....	66	ALTRENO.....	184
AIMOVIG.....	15	ALUNBRIG.....	58
AIMOVIG AUTOINJECTOR.....	19	ALVESCO.....	31
AIRDUO DIGIHALER.....	31	alvimopan.....	119
AIRSUPRA.....	31	amantadine.....	64
AJOVY.....	15, 19	AMARYL.....	49
AKLIEF.....	179	ambrisentan.....	79
AKTEN.....	102	amcinonide.....	179
AKTIPAK.....	41	AMERGE.....	19
ALA-SCALP.....	179	AMICAR.....	75
ALBA-LYBE.....	215	amiloride.....	99
albendazole.....	53	amino acids/mv,tx,iron,mineral.....	199
ALBENZA.....	53	aminocaproic.....	75
albuterol.....	29, 30	amiodarone.....	77
ALCAINE.....	102	amitriptyline.....	167
alclometasone.....	179	amitriptyline/chlordiazepoxide.....	167
ALCOH-GLOVE.....	156	AMLADEx.....	199
alcohol.....	176, 177, 191, 192	amlodipine.....	77, 80, 81, 84
ALCOHOL.....	54, 176, 177, 191, 192	amoxapine.....	167
ALCOH-WIPE.....	156	amoxicillin.....	38, 52
ALDACTAZIDE.....	99	amphetamine.....	71, 72
ALDACTONE.....	99	ampicillin.....	38
ALECENSA.....	58	AMZEEQ.....	41
alendronate.....	193	ANAFRANIL.....	167
alfuzosin.....	194	anagrelide.....	66
ALINIA.....	64	ANA-LEX.....	120
aliskiren hemifumarate.....	84	ANALPRAM.....	121, 183
ALIVE.....	199	ANAPROX DS.....	27
ALIVE DAILY.....	199	anastrozole.....	57
ALIVE PREMIUM.....	199	ANCOBON.....	45
ALIVE WOMEN'S.....	199	ANDRODERM.....	121
ALKALINE BATTERIES.....	129	ANDROID.....	121
ALKERAN.....	55	ANGELIQ.....	123
ALLERGIST TRAY.....	143	ANIMAL SHAPES COMPLETE.....	211
ALLERGY SYRINGE.....	143, 147, 148	ANIMI-3.....	199
allopurinol.....	26	ANNOVERA.....	92
ALLZITAL.....	19	ANORO ELLIPTA.....	30

Index of Medications

ANTICOAGULANT SODIUM CITRATE	43	ASMANEX	31
ANTIOXIDANT FORMULA	196	aspirin/dipyridamole.....	65
APATATE	220	ASSURE.....	129, 136, 151, 160
APETEX.....	215	ASSURE 4 CONTROL SOLUTION.....	129
APETIGEN.....	109, 215	ASSURE DOSE	129
APETIGEN-PLUS.....	109	ASSURE HAEMOLANCE PLUS.....	151
apomorphine	64	ASSURE LANCE	151
APO-VARENICLINE.....	185	ASSURE PRISM.....	129
apraclonidine.....	102	ASTAGRAF	127
aprepitant.....	115	ASTRINGYN	76
APRETUDE.....	68	atazanavir	68
APRISO	118	ATELVIA	193
APTENSIO	168	atenolol	83, 84
APTIOM.....	89	AT HOME AIC	129
APTIVUS.....	66	a thru z.....	198, 199
AQUA-D.....	227	A THRU Z MEN'S ULTIMATE	198
AQUADEKS	199, 211	A THRU Z SELECT	198
AQUA-E.....	232	ATIVAN.....	164
AQUA-K.....	234	atomoxetine	169
AQUA LANCE LANCING DEVICE.....	129	atorvastatin.....	84, 85
AQUASOL A.....	214	atovaquone	53, 54
AQUORAL	189	atovaquone-proguanil.....	53
ARAKODA.....	53	atropine	104, 115, 116, 117
ARAVA.....	26	ATROPINE.....	104
ARAZLO.....	179	ATROVENT HFA.....	29
ARCALYST.....	194	AUGMENTIN	38
AREXVY.....	75	AURYXIA.....	108
arformoterol.....	30	AUSTEDO.....	87
ARGLAES FILM.....	149	AUTOJECT.....	129
ARICEPT	71	AUTO-LANCET	129
ARIDOL	96	AUTOLET	129
ARIKAYCE	35	AUTOPEN	129
aripiprazole.....	171	AUTOSHIELD DUO	141
ARIXTRA.....	43	AUTOSOFT	129
ARKALIOX.....	215	AUVI-Q.....	71
armodafinil.....	172	AVAR-E.....	42
ARMOUR THYROID.....	185	AVAR LS.....	42
ARNUIITY ELLIPTA.....	31	AVC	52
AROMASIN	57	AVIDOXY.....	39
ARTHROTEC 50.....	27	avita	184
ARTHROTEC 75.....	27	AVITA.....	184
ARTISS.....	178	AVITENE	76
ASACOL.....	118	AVONEX.....	87
ASCOR.....	224	AYGESTIN	125
ascorbate.....	224	AYVAKIT	58
ascorbic.....	111, 112, 224	AZASAN.....	128
ASCORBIC ACID.....	224	AZASITE.....	34
asenapine	169	azathioprine.....	128

Index of Medications

azelaic acid	178	BELVIQ.....	63
azelastine.....	48, 100	benazepril.....	80, 82
AZELEX	175	benazepril/hydrochlorothiazide.....	80
AZILECT	64	BENLYSTA.....	194
azithromycin.....	37, 38	BENTIVITE BX.....	109
AZSTARYS.....	168	BENZAMYCIN.....	41
AZULFIDINE	118	benzepro	177
B		BENZEPRO	177
BI	220	BENZNIDAZOLE.....	53
b-12.....	218, 220, 221, 222, 223	benzonatate.....	94
bi2.....	110, 111, 112, 206, 215, 216, 218, 219, 220, 221, 222, 223	benzoyl peroxide.....	41, 42, 174, 175, 177, 178
B-12.....	111, 202, 215, 216, 220, 221, 222, 223	benzphetamine.....	63
BI2.....	215, 220, 221, 223	benztropine	64
BI2 ACTIVE.....	221	BEPREVE	48
b-12 er.....	221	BEROCCA.....	200
bi2/levomefolate calcium/b-6.....	215	beta-carotene	200, 214
B-50 COMPLEX	216	BETADINE	101
BABY DDROPS.....	227	betaine	193
BABY'S SUPER DAILY D3	227	betamethasone	46, 179, 180, 181, 184
BABY VITAMIN D3	227	BETAPACE.....	83
bacitracin.....	34	BETASERON.....	87
baclofen.....	159	betaxolol.....	83, 102
BACLOFEN	159	bethanechol	72
BACMIN.....	199	BETHKIS.....	35
B ACTIV	215	BETOPTIC S	102
BACTRIM.....	35	bexarotene.....	55, 62
BAFIERTAM.....	87	BEXSERO.....	73
BALANCED B-100	217	BEYAZ	92
balanced b-100 complex tab sa	216	bicalutamide.....	56
BAL-CARE DHA	159	BIKTARVY	69
balsalazide.....	118	BILTRICIDE.....	53
BALVERSA.....	58	bimatoprost	103
BAQSIMI.....	106	BINOSTO	193
BARACLUDGE.....	70	BIO-35	200
BARIATRIC MULTIVITAMINS.....	199	BIO C.....	224
BASAGLAR KWIKPEN.....	51	BIO-D-MULSION	227
BAXDELA.....	39	bioflav,lemon/vit bcomp,c	197
b comp	215, 219	biotin.....	203, 205, 215, 216, 217, 218, 219
b complex.....	208, 209, 215, 217, 218, 219, 220	BIOTIN.....	209, 216, 217, 218, 219
b-complex	199, 200, 201, 208, 216, 217, 218, 220	bisac/nacl/nahco3/kcl/peg 3350	119
B COMPLEX	215, 217, 218	bisoprolol.....	83, 84
B-COMPLEX	202, 208, 216	BLADDER 2.2	200
B-COMPLEX-VITAMIN C	216	BLEPH-IO	34
B-COMPLEX WITH B-12.....	216	BLEPHAMIDE S.O.P.....	34
BD.....	136, 141, 143, 144, 151	BLOOD.....	75, 76, 95, 96, 129, 136, 142, 151
BD ECLIPSE.....	141, 143	BLOOD GLUCOSE CONTROL.....	129
BELBUCA.....	22	BLOOD-GLUCOSE CONTROL.....	129
BELSOMRA	173	BLOOD LANCETS	151

Index of Medications

BLUNT	141, 142, 146	BUTTERFLY TOUCH LANCET	151
BOCASAL	189	BYDUREON BCISE.....	48
BODY, HAIR, SKIN AND NAILS.....	200	BYDUREON PEN.....	48
BOOSTRIX TDAP	74	BYETTA	48
bosentan.....	79	BYLVAY	118, 119
BOSULIF	58	C	
BRAINSTRONG	159	c-1,000	224
BREATHERITE.....	157	cabergoline.....	125
BREATHRITE.....	157	CABOMETYX.....	58
BREEZE 2	130	CADEAU DHA	159
BREO ELLIPTA.....	31	CADUET	84
BREWER'S YEAST	216	CAFERGOT	15, 19
BREXAFEMME.....	46	caffeine.....	19, 87, 159
breyana.....	31	CALAN	77
BREZTRI AEROSPHERE.....	31	calcipotriene.....	175, 184
BRILINTA.....	65	calcitonin,salmon,synthetic.....	127
brimonidine	102, 103	calcitriol.....	175, 227, 230
BRIMONIDINE-DORZOLAMIDE.....	103	calcium acetate.....	108
brinzolamide.....	103	CALCIUM PANTOTHENATE.....	211
BRIVIACT	89	CALQUENCE	58
BROMFED DM	94	CAMBIA	19
bromfenac.....	101	CAMZYOS.....	78
bromocriptine.....	64, 65	candesartan cilexetil.....	82
brompheniramine/pseudoephed/dm	94	candesartan/hydrochlorothiazid.....	81
BRONCHITOL.....	185	CANNULA.....	142, 144, 146, 147, 149
BROVANA.....	30	CANTHARIDIN-ACETONE.....	177
BRUKINSA.....	58	CAPCOF	94
BRYHALI.....	180	capecitabine.....	56, 57
B-STRESS	216	CAPEX.....	180
budesonide	31, 32, 123, 124	CAPHOSOL.....	189
BULK SYRINGE.....	144	CAPLYTA.....	169
BULLSEYE	136, 151	CAPRELSA	58
BULLSEYE MINI SAFETY LANCETS.....	151	captopril	80, 82
bumetanide.....	98	captopril/hydrochlorothiazide.....	80
BUPHENYL.....	114	CARBAGLU	189
buprenorphine	22, 194	carbamazepine.....	89, 90, 91
bupropion	165, 185	CARBATROL.....	90
bupirone	164	carbidopa.....	64, 65
butalb-acetamin-caff 50-300-40.....	15	carbidopa/levodopa	64, 65
butalb-acetamin-caff 50-325-40	15	carbinoxamine	47
butalb/acetaminophen/caffeine.....	15, 19	CARDIOTEK-RX	216
butalb-aspirin-caffe 50-325-40	15	CARDIZEM.....	77
butalbit/acetamin/caff/codeine	24	CARDURA	81
butalbital/acetaminophen.....	15, 19	CAREONE.....	130, 136, 151
butalbital-asa-caffeine cap (Fiorinal).....	15	CAREPOINT.....	141, 144
butalbital/aspirin/caffeine	19	CARESENS.....	130, 136, 151
butorphanol.....	22	CARETOUCH.....	130, 136, 141, 144, 151, 152, 176
BUTTERFLY	136, 151	carglumic	189

Index of Medications

carisoprodol.....	24, 159	CHILD COMPLETE	211
carisoprodol/aspirin/codeine	24	CHILD MULTIVITAMIN PLUS IRON.....	211
CARNITOR.....	193	children multivitamin.....	211
carteolol.....	103	CHILDREN MULTIVITAMIN	211, 212
carvedilol.....	80	CHILDREN'S.....	211, 234
CASODEX.....	56	CHILDREN'S CHEWABLE	211
CATAPRES.....	82, 83	CHILDREN'S CHEW MULTIVIT-IRON	211
CAVERJECT	187	childrens chew vitamin	211
CAYSTON.....	37	CHILDREN'S MULTI-VIT	211
cefaclor.....	37	CHILDREN'S MULTIVITAMIN GUMMY	211
cefadroxil.....	37	CHILD'S CHEWABLE.....	211
cefdinir	37	CHILD'S OMEGA-3.....	211
cefditoren pivoxil	37	chlordiazepoxide.....	115, 164
cefixime.....	37	chlordiazepoxide/clidinium br	115
cefpodoxime proxetil.....	37	chlorhexidine	187
cefprozil.....	37	chloroquine	53
ceftriaxone	37	chlorpromazine.....	172
cefuroxime axetil.....	37	chlorthalidone	84, 99
CEFUROXIME SODIUM-0.9% NACL.....	34	chlorzoxazone.....	159
celecoxib	29	CHOLBAM.....	117
CELLCEPT	128	cholecalciferol.....	228
CELONTIN.....	90	CHOLECAL DF	228
CENTANY.....	41	cholestyramine	85, 86
CENTRAL-VITE.....	200	choline salicyl/mag salicylate	15, 19
CENTRAVITES.....	200	CHORIONIC	126
CENTRUM.....	198, 200, 211, 234	CHORIONIC GONAD.....	126
CENTRUM KIDS	211	CHROMAGEN.....	109
CENTRUM SILVER	198, 200	CHROMIUM PICOLINATE.....	223
CENTURY	200	CIALIS	187
cephalexin.....	37	CIBINQO.....	177
CEQUA	104	ciclodan.....	46
CEQR SIMPLICITY	130	CICLODAN.....	46, 54
CERDELGA.....	190	ciclopirox.....	46, 47
CEREFOLIN	216	ciclopirox 8% treatment kit.....	54
certavite	200	cilostazol	65
CERTAVITE.....	200	CILOXAN	34
CERVIDIL.....	125	CIMDUO.....	66
CETACAINE ANESTHETIC.....	25	cimetidine.....	118
cetorelix.....	125	cinacalcet.....	190
CETROTIDE	125	CIPRO.....	39
cevimeline.....	72	CIPRODEX	33
CHANTIX.....	185	ciprofloxacin.....	33, 34, 39
CHEK-STIX.....	98	citalopram.....	165
CHEMET	190	CITRANATAL	109, 160
CHEMO TRANSFER PIN	141	CITRANATAL BLOOM	109
CHEMSTRIP.....	98, 130	CITRATE PHOSPHATE DEXTROSE.....	43
CHENODAL	117	citric.....	114
CHILD CHEWABLE VITAMN	211	CITRUS BIOFLAVONOIDS.....	197

Index of Medications

CLARINEX	47, 48	COMBIPATCH	122
CLARINEX-D.....	47	COMBISTIX REAGENT	98
clarithromycin.....	37	COMBIVENT RESPIMAT	30
clemastine.....	47	COMBIVIR.....	66
CLEO.....	157	COMETRIQ.....	58
CLEOCIN	37, 40, 41	COMFORT .. 27, 130, 135, 136, 138, 139, 140, 152, 154, 155, 156, 158, 176, 177	
CLEVER.....	130, 136, 152, 157	COMFORT PAC-IBUPROFEN.....	27
CLEVER CHEK LANCETS.....	152	COMFORT PAC-MELOXICAM.....	27
CLEVER CHOICE.....	157	COMFORT PAC-NAPROXEN.....	27
CLEVER CHOICE CONTROL SOLUTION	130	COMFORTSEAL	157
CLIMARA.....	122	COMIRNATY.....	73
clindacin.....	41	COMPACT SPACE CHAMBER.....	157
CLINDACIN	41	COMPAZINE.....	115
clindamycin.....	36, 37, 40, 41, 42, 175	COMPLEX B-50	217
CLINDESSE.....	41	complex b-100	217
CLINPRO 5000	105, 108	COMPLEX B-100.....	216
clobazam.....	89	COMTAN.....	64
clobetasol.....	180, 182	CONCEPT	201
CLOBEX	180	CONFORMANT 2	149
clocortolone.....	180	CONSENSI.....	77
clodan	180	CONTACT DETACH INFUSION SET	130
CLODAN	180	CONTOUR.....	130
CLODERM.....	180	CONTRAVE.....	63
clomiphene.....	126	CONTROL SOLUTION	129, 130, 131, 132, 133, 134, 135
clomipramine.....	167	COOL CONTROL SOLUTION	130
clonazepam.....	89	COPAXONE	87
clonidine.....	82, 83, 168	COPIKTRA	58
clopidogrel	65	CORDRAN	180
clorazepate.....	164	COREG	80
clotrimazole.....	45, 46	CORGARD	83
clozapine.....	169	CORNWALL SYRINGE TIP CONNECTOR.....	144
CLOZARIL.....	169	CORTANE-B.....	100
COAGUCHEK.....	136, 152	CORTEF	123
COARTEM	53	CORTENEMA	121
COCAINE.....	100	cortisone.....	123
codeine.....	21, 22, 24, 94, 95	CORTISPORIN.....	33, 41
CODITUSSIN AC	95	CORVITE.....	109, 201
CODITUSSIN DAC.....	95	CORVITE I50.....	109
cod liver oil.....	214, 224, 228, 229, 230, 232	CORVITE FE.....	109
COLAZAL	118	COTELLIC	57
colchicine	26, 29	COTEMPLA	168
COLCHICINE.....	26	CREON.....	119
colesevelam.....	85	CRESEMBA	45
COLESTID.....	85	CRINONE	126
colestipol	85, 86	cromolyn	26, 32, 102
COLOR.....	136, 152	crotamiton.....	64
COLOR LANCETS.....	152	CRRT TRISODIUM CITRATE.....	43
COMBIGAN.....	103		

Index of Medications

CULTURELLE.....	201, 211	CYSTOGRAFIN-DILUTE.....	97
CULTURELLE KIDS.....	211	CYTO B-1.....	220
CURITY ALCOHOL PREPS.....	176	CYTO B-2.....	223
CUROSURF.....	186	CYTO B7.....	217
CUTIVATE.....	180	CYTO C.....	224
cvs106, 109, 160, 176, 191, 197, 201, 209, 211, 215, 217, 221, 223, 224, 228, 232		CYTOTEC.....	116
CVS.....	106, 109, 160, 164, 176, 191, 201, 211, 217, 221, 224, 232	D	
CVS ALCOHOL 70% PREP PADS.....	176	D3.....	171, 206, 209, 227, 228, 229, 230, 231, 232
CVS CHILD GUMMY.....	211	dabigatran.....	44
cvs glucose.....	106	daily-vite.....	201
CVS GLUCOSE LIQUID.....	106	dalfampridine.....	88
cvs iron.....	109	danazol.....	125
cvs isopropyl alcohol 70% wipe.....	176	DANTRIUM.....	159
CVS ISOPROPYL ALCOHOL 91% SPRY.....	54	dantrolene.....	159
cvs prenatal.....	160	dapsone.....	36, 174, 175
CVS PRENATAL.....	160, 164	DAPTACEL DTAP.....	74
cvs slow release iron.....	109	DARAPRIM.....	53
CVS SLOW RELEASE IRON.....	109	darifenacin.....	195
CVS VITAMIN.....	221, 224, 232	darunavir.....	66
cvs vitamin a.....	215	DAURISMO.....	57
cvs vitamin b-12.....	221	DAVIMET-M.....	234
cvs vitamin c.....	224	DAVOL IRRIGATION SYRINGE.....	144
cvs vitamin d3.....	228	DAYAVITE.....	201
cvs vitamin e.....	232	DAYPRO.....	27
cvs vit c.....	224	DAYTRANA.....	168
cvs vit d3.....	228	DAYVIGO.....	173
cyanocobalamin.....	215, 217, 218, 221	DDAVP.....	122
cyclobenzaprine.....	159	DDROPS.....	227, 228
CYCLOGYL.....	104	decara.....	228
CYCLOMYDRIL.....	104	DECARA.....	228
cyclopentolate.....	104	DECUBI.....	201
CYCLOPENTOLATE-TROPICAMIDE-PE.....	104	deferasirox.....	190, 191
cyclopentolat/tropic/phenyleph.....	104	deferiprone.....	191
cyclophosphamide.....	55, 56	deflazacort.....	123
CYCLOPHOSPHAMIDE.....	55, 56	DEKAS.....	201, 211
CYCLOSERINE.....	36	DEKAS PLUS.....	201, 211
CYCLOSET.....	49	DELESTROGEN.....	122, 123
cyclosporine.....	104, 128	DELTEC COZMO CLEO.....	157
CYCLOSPORINE.....	104	demeclocycline.....	39
CYFOLEX.....	228	DEMSEER.....	82
CYLTEZO.....	54	DENAVIR.....	70
cyproheptadine.....	47	DENGVAXIA.....	74
CYPROHEPTADINE.....	47	DENOVO.....	197
CYSTAGON.....	195	DEPAKOTE.....	90
CYSTARAN.....	105	DEPEN.....	26
CYSTO-CONRAY II.....	97	DEPLIN-ALGAL OIL.....	197
CYSTOGRAFIN.....	97	DEPO-ESTRADIOL.....	123
		DEPO-PROVERA.....	92

Index of Medications

DEPO-SUBQ PROVERA.....	92	diclofenac.....	20, 27, 62, 101, 174
DEPO-TESTOSTERONE.....	121	dicloxacillin.....	38
DERMACINRX.....	201, 202, 228	dicyclomine.....	115
DERMA-SMOOTH-ES.....	180	didanosine.....	67
DERMASORB.....	180	diethylpropion.....	63
DERMATOP.....	180	DIFFERIN.....	184
DERMAVIEW.....	150	DIFICID.....	37
DERMOTIC.....	100	diflorasone.....	181
DESCOVY.....	66	DIFLUCAN.....	45
desflurane.....	25	diflunisal.....	15, 19
desipramine.....	167	difluprednate.....	101
desloratadine.....	48	digoxin.....	78
desmopressin.....	122	dihydroergotamine.....	15, 19
DESMOPRESSIN.....	122	DILANTIN.....	90
desog-e.estradiol/e.estradiol.....	92	DILAUDID.....	22
desogestrel-ethinyl estradiol.....	92	diltiazem.....	77
DESONATE.....	180	dimethyl.....	87, 190
desonide.....	180, 181, 183	dimethyl fumarate.....	87
desoximetasone.....	181, 182, 183	diphenoxylate hcl/atropine.....	115
DESOXYN.....	71	DIPHThERIA-TETANUS TOXOIDS-PED.....	74
DESVENLAFAXINE.....	166	DIPROLENE.....	181
dex4 glucose.....	106	dipyridamole.....	65
DEX4 GLUCOSE.....	106	DISALCID.....	26
dex4 quick dissolve tab chew.....	106	disopyramide.....	77
dexamethasone.....	33, 101, 123, 124	disulfiram.....	189
dexchlorpheniramine.....	47, 48	DIURIL.....	99
DEXCOM.....	130	divalproex.....	90
DEXCOM G6.....	130	dofetilide.....	77
DEXEDRINE.....	71	DOJOLVI.....	105
dexlansoprazole.....	120	donepezil.....	71
dexmethylphenidate.....	168	DONNATAL.....	116
DEXONTO.....	124	DOPTLET.....	92
DEXTENZA.....	101	dorzolamide.....	103, 104
dextroamphetamine.....	71, 72	DORZOLAMIDE.....	103
dextrose.....	106, 107	DOSOKAP.....	228
DIABETES HEALTH.....	202	DOSOQUIN.....	229
DIABETIC VITAMIN.....	202	DOVATO.....	66
DIACOMIT.....	90	DOVER BULB SYRINGE.....	144
dialyvite.....	217	DOVONEX.....	175
DIALYVITE.....	202, 217, 228	doxazosin.....	81
DIASTAT.....	89	doxepin.....	167, 173, 175
DIASTIX REAGENT.....	96, 97, 98	doxercalciferol.....	189
diatrizoate meglumine.....	96, 97	doxycycline.....	39, 40, 187
DIATRUE.....	130	doxylamine succinate/vit b6.....	116
diazepam.....	89, 164	DRISDOL.....	229
diazoxide.....	106, 107	dronabinol.....	115
DIBENZYLINE.....	72	DROPLET.....	130, 136, 152
DICLEGIS.....	116	DROPLET GENTEEL LANCING DEVICE.....	130

Index of Medications

DROPLET LANCETS.....	152	EDURANT.....	67
DROPLET LANCING DEVICE.....	130	E.E.S. 200.....	37, 38
DROPSAFE PREP PADS.....	176	efavirenz.....	67, 68
drosipir/eth estra/levomefol.....	92, 93	effer-k.....	114
DROXIA.....	76	EFFER-K.....	114
droxidopa.....	72	EFFIENT.....	65
drug mart glucose.....	106	EFUDEX.....	62
DUAVEE.....	123	EGRIFTA.....	124
DUETACT.....	50	eldertonic.....	198
DUET DHA.....	160	ELDERTONIC LIQUID.....	198
DUEXIS.....	27	ELEMENT COMPACT.....	131
DULERA.....	31	ELEMENT CONTROL.....	131
duloxetine.....	166	ELEPSIA.....	90
DUOBRII.....	175	eletriptan hydrobromide.....	15, 19
DUOPA.....	64	ELFOLATE.....	217
DUPIXENT.....	127	ELIMITE.....	64
dutasteride.....	194, 195	ELIQUIS.....	43
DXEVO.....	124	ELIXOPHYLLIN.....	33
DYAZIDE.....	99	ELLA.....	93
DYMISTA.....	100	ELMIRON.....	25
DYRENIUM.....	99	ELON.....	202
E		EMBRACE.....	131, 137, 152
EAR HEALTH PLUS.....	197	EMBRACE EVO LEVEL I.....	131
ear health plus caplet.....	197	EMBRACE GLUC CONTROL SOLN.....	131
EASIVENT.....	157	EMBRACE LANCING DEVICE.....	131
EASY.....	130, 131, 136, 137, 141, 144, 145, 146, 152, 176	EMBRACE PRO.....	131
EASY COMFORT ALCOHOL PAD.....	176	EMBRACE TALK CONTROL.....	131
EASY COMFORT LANCETS.....	152	EMCYT.....	62
EASY GLIDE CATHETER.....	144	EMEND.....	116
EASY GLIDE LUER.....	144	EMERGEN-C.....	211, 224, 225
EASYGLUCO PLUS.....	131	EMERGEN-C KIDZ.....	211
EASYMAX I5.....	131	EMGALITY.....	15, 19, 89
EASYMAX NORMAL.....	131	EMGALITY PEN.....	19
EASY MINI EJECT.....	130	EMPAVELI.....	75
EASY PLUS II.....	130	EMSAM.....	165
EASYPOINT.....	141	emtricitabine.....	66, 67
EASY STEP.....	130	emtricitabine-tenofv.....	66
EASY TALK.....	130	EMTRIVA.....	67
EASY TOUCH.....	130, 131, 141, 144, 145, 146, 152, 176	EMVERM.....	53
EASY TOUCH FLIPLock.....	141, 145	enalapril.....	80, 82
EASY TRAK.....	131	enalapril/hydrochlorothiazide.....	80
EASY TWIST CAP LANCETS.....	152	ENBRACE.....	202
ECLIPSE SYRINGE.....	146	ENBREL.....	54, 55
EC-NAPROSYN.....	27	ENDARI.....	76
econazole.....	46	ENDO-AVITENE.....	76
EDECIN.....	98	ENDOMETRIN.....	126
EDEX.....	187, 188	ENDUR-AMIDE.....	209
EDLUAR.....	173	ENDUR-THINE.....	209

Index of Medications

ENDUR-VM.....	202	ESGIC.....	15, 19
ENFAMIL.....	108	ESKATA.....	176
ENGERIX-B.....	75	esomeprazole.....	27, 120
ENLITE SERTER.....	131	ESOMEPRAZOLE.....	120
ENLYTE.....	197	ESSENCE C.....	225
enoxaparin.....	43	ESSENTIAL.....	159, 201, 202, 206, 207
ENSPRYNG.....	127	estazolam.....	172
ENSTILAR.....	184	ESTER-C.....	225
entacapone.....	64, 65	ESTRACE.....	123
entecavir.....	70	estradiol.....	92, 93, 122, 123, 126
ENTEREG.....	119	estrogen,ester/me-testosterone.....	122
ENTERO VU.....	96	ESTROVEN.....	202
ENTRESTO.....	81	eszopiclone.....	173
ENZOCLEAR.....	178	ethacrynic.....	98
EPCLUSA.....	70	ethambutol.....	36
EPIDIOLEX.....	89	ethinyl estradiol/drospirenone.....	93
EPIDUO FORTE.....	175	ethosuximide.....	90, 92
EPIFOAM.....	183	ethynodiol d-ethinyl estradiol.....	93
epinastine.....	48	etodolac.....	27, 28
epinephrine.....	71, 100	etonogestrel/ethinyl estradiol.....	92
EPIPEN.....	71	etoposide.....	62
EPISIL.....	188	etravirine.....	67
EPIVIR.....	67, 70	EUCRISA.....	179
eplerenone.....	99	EULEXIN.....	56
eprosartan.....	82	EURAX.....	64
EPSOLAY.....	178	EVEKEO.....	72
EPZICOM.....	66	EVENCARE.....	131
EQ.....	196, 202, 211	everolimus.....	57, 58, 128
EQ CHILD.....	211	EVICEL.....	76
eql.....	109, 192, 196, 202, 217, 221, 223, 225, 229, 232	EVISTA.....	193
eql slow release iron.....	109	EVOCLIN.....	42
eql vitamin.....	221, 225, 229, 232	EVOLUTION.....	131
EQUETRO.....	165	EVOTAZ.....	68
EQ VISION.....	196	EVOXAC.....	72
ERGOCAL.....	229	EVRYSDI.....	190
ergocalciferol.....	229	EVZIO.....	44
ergoloid.....	84	EXEL.....	141, 142, 146
ERGOMAR.....	19	EXELDERM.....	46
ergotamine tartrate/caffeine.....	15, 19	EXEL HUBER.....	141
ERIVEDGE.....	57	EXELON.....	71
ERLEADA.....	56	exemestane.....	57
erlotinib.....	58, 59, 60, 61	EXKIVITY.....	59
ERMEZA.....	185	EXPECTA PRENATAL.....	160
ERYPED.....	37	EXSERVAN.....	87
ERY-TAB.....	38	EXTENDED RESERVOIR.....	146
ery-tab dr.....	37, 38	EXTINA.....	46
erythromycin.....	34, 37, 38, 41, 42	EYE HEALTH AND LUTEIN.....	196
escitalopram.....	165	EYE HEALTH PLUS LUTEIN TABLET.....	196

Index of Medications

EYE MULTIVITAMIN	196	FERRIPROX	191
EYEPROTECT	196	FERRLECIT	110
EYSUVIS	101	FERRO-SEQUELS	110
EZ	136, 137, 152	ferrous fumarate	110, 111
E-Z DISK	96	FERROUS FUMARATE	110
ezetimibe	84, 86	ferrous fum/vit c/b12-if/folic	110
ezetimibe/simvastatin	84	ferrous gluconate	109, 110, 204, 205
E-Z-HD	96	ferrous sulfate	110
EZ-LETS	152	ferumoxytol	109, 110
E-Z-PAQUE	96	fesoterodine	195
E-Z-PASTE	96	FETZIMA	166
EZ SMART LANCETS	152	FEXMID	159
F		FIBRICOR	86
FA-8	197	FIFTY50	137, 152
FABHALTA	75	fifty50 alcohol prep pads	176
FACTIVE	39	FIFTY50 SAFETY SEAL LANCETS	152
famciclovir	69	FILSUVEZ	194
famotidine	27, 118	FILTER	142, 146, 148
fa/mv,ca,iron,min/lycopene/lut	202	FILTER ASPIRATOR	142
FANAPT	170	FINACEA	178
FARESTON	62	finasteride	195
FARXIGA	51	FINE	137, 143, 152
FARYDAK	55	FINE 30 UNIVERSAL LANCETS	152
FASENRA	32	FINGER GRIP	146
FATIGUE RELIEF COMPLEX	202	FINGERSTIX	137, 152
febuxostat	26	fingolimod	87
felbamate	90	FIORICET	15, 19, 24
FELBATOL	90	FIORINAL	15
FELDENE	28	FIRDAPSE	88
felodipine	77	FIRST-MOUTHWASH BLM	188, 190
FEMARA	57	FLAGYL	35
fenofibrate	86	flavoxate	195
fenofibric	86	flecainide	77
FENOGLIDE	86	FLECTOR	174
fenopfen	28	FLEVOXIN	225
FENORTHO	28	FLEXICHAMBER	157
fentanyl	22	FLINTSTONES	211, 212
feosol	109	FLOGEN	197
FEOSOL	109	FLOLIPID	85
FERAHEME	109	FLOMAX	195
FERGON	109, 110	FLORIVA	105, 212
FER-IN-SOL	110	FLOVENT	32
FERIVA 2I-7	110	FLOW-EZE	142
FERIVA FA	110	FLUAD	74
FERRACTIV IRON	110	FLUAD QUAD	74
FERRALET	110	FLUARIX QUAD	74
FERRETT'S IPS	110	FLUBLOK QUAD	74
FERRIMIN	110	FLUCELVAX QUAD	74

Index of Medications

fluconazole.....	45	FOLITE.....	198
flucytosine.....	45	FOLIXAPURE.....	228, 229
fludrocortisone.....	125	FOLLISTIM AQ.....	126
FLULAVAL QUAD.....	74	FOLTRATE.....	221
FLUMADINE.....	69	FOLTIX.....	217
FLUMIST QUAD.....	74	FOLVITE-D.....	229
flunisolide.....	100	fondaparinux.....	43
fluocinolone.....	100, 180, 181, 182	FORA.....	96, 131, 137, 152
fluocinonide.....	181	FORACARE.....	131, 137, 152
fluorescein.....	96, 102	FORACARE LANCETS.....	152
FLUORESCEIN-BENOXINATE.....	102	FORA GTEL.....	96, 131
fluoride.....	105, 106, 108, 109, 113, 213	FORA LANCETS.....	152
FLUORIDEX.....	105, 108	formaldehyde.....	54, 174
fluorometholone.....	101	formoterol.....	30
FLUOROPLEX.....	62	FORTAMET.....	49
fluorouracil.....	62	FORTAVIT.....	202
fluoxetine.....	165, 172	FORTEO.....	193
fluphenazine.....	172	FORTESTA.....	121
FLURA-DROPS.....	106, 113	FORTISCARE.....	131
flurandrenolide.....	180, 181	FOSAMAX.....	193
flurazepam.....	172	FOSAMAX PLUS D.....	193
flurbiprofen.....	28, 101	fosamprenavir.....	68
flutamide.....	56	fosaprepitant.....	116
fluticasone.....	31, 100, 180, 181	fosfomycin tromethamine.....	35
fluticasone propion/salmeterol.....	31	fosinopril.....	80, 82
fluticasone-salmeterol.....	31	fosinopril/hydrochlorothiazide.....	80
fluticasone-salmeterol 100-50.....	31	FRAGMIN.....	43
fluvastatin.....	85	FREEDAVITE.....	202
fluvoxamine.....	165	FREESTYLE.....	95, 131, 132, 137, 153
FLUZONE HIGH-DOSE.....	74	FREESTYLE INSULINX.....	95
FLUZONE HIGH-DOSE QUAD.....	74	FREESTYLE LITE.....	95
FLUZONE QUAD.....	74	FROVA.....	19
FML.....	101	frovatriptan succinate.....	19
fn vitamin.....	221	FRUIT C.....	225
FOLAGENT.....	202	fruit c-100.....	225
FOLAMAX.....	202	FRUIT C-100.....	225
FOLAMED.....	202	ft.....	229
FOLIC.....	160, 197, 198, 202, 215, 220, 221, 223, 229	FT.....	192
folic acid.....	110, 111, 112, 161, 162, 163, 197, 198, 200, 201, 202, 203, 204, 205, 206, 208, 212, 213, 215, 217, 218, 219, 232	ful-glo.....	96
folic/mvi ther-min/lycop/lut.....	202	FUL-GLO.....	96
FOLIKA.....	198, 202, 217, 229	FULPHILA.....	92
FOLIKA-BC.....	217	FURADANTIN.....	38
FOLIKA-D.....	229	furosemide.....	98, 99
FOLIKA-NC.....	217	FUSION.....	67, 110
FOLIKA-T.....	217	FUZEON.....	67
FOLIKA-V.....	198	FYCOMPA.....	90
FOLINIC-PLUS.....	217	G	
		gabapentin.....	89, 90

Index of Medications

GABITRIL	90	GLUCAGON.....	63, 120
GALAFOLD.....	191	GLUCO	106
galantamine.....	71	GLUCOCARD.....	132
GALZIN.....	191	GLUCOCOM.....	132, 137, 153
ganirelix.....	125	glucose.....	106, 107
GANIRELIX.....	125	GLUCOSE.....	106
GARDASIL 9	75	GLUCOSE CONTROL	129, 131, 132, 134
GASTROCROM.....	26	GLUCOSE LIQUID.....	106, 107
GASTROGRAFIN.....	97	GLUCOTROL	50
GASTROMARK.....	97	GLUTOL.....	108
gatifloxacin.....	34, 35	GLUTOSE-15.....	107
GATIFLOXACIN-DEXAMETHASONE	33	GLUTOSE-45	107
GATTEX	120	glyburide	50
GAVRETO	59	GLYCATE.....	115
GEIOO.....	132	glycine urologic solution.....	54
GELCLAIR.....	188	glycopyrrolate.....	115
GELFILM.....	102, 192	GLYNASE.....	50
GEL-FLOW	76	GLYXAMBI.....	50
GELFOAM.....	76	gnp...107, 110, 160, 192, 196, 198, 202, 209, 214, 215, 217, 221, 223, 225, 229, 232	
GELNIQUE	195	GNP B-COMPLEX PLUS VIT C TAB.....	202
GELX.....	188	gnp glucose.....	107
gemfibrozil	86	GNP VITAMIN E	232
GEMTESA	195	GOJJI	96, 132, 137, 153
GENADEK	202, 212	GOLYTELY	119
GENICIN	198, 217, 229	GONAL-F	126
GENICIN VITA-Q	198	GONITRO.....	78
GENICIN VITA-S.....	217	GOPRELTO	100
GENOTROPIN.....	124	GRALISE.....	89
gentamicin	34, 35, 42	granisetron.....	116
GENTEEL	130, 132	GRASTEK	73
GENTLE IRON.....	110	griseofulvin.....	46
GENVOYA.....	69	gs.....	107
GEODON.....	170	GS	54, 148, 160, 202
GERBER	202, 212	GS PRENATAL	160, 202
GERBER GROW MIGHTY	212	GUAIACOL.....	177
GERBER LIL BRAINIES.....	212	guaifen-codeine	95
GERITOL	198	GUAIFEN-CODEINE.....	95
GIALAX	119	guaifenesin/phenylephrine.....	94
GILOTRIF	59	guanfacine.....	83, 168
glatiramer	87	GUARDIAN.....	132
glatopa.....	88	GUMMIES CHILDREN MULTIVITAMIN	212
GLEOLAN.....	96	GUMMY.....	160, 199, 211, 212, 221
GLEOSTINE.....	56	GVOKE.....	107
glimepiride.....	49, 50	GYNAZOLE	44
glipizide	50	H	
GLOPERBA	26	HAIR FORMULA	202
GLUCAGEN	96	HAIR, SKIN AND NAILS.....	200, 203, 208
glucagon.....	106		

Index of Medications

HAIR-SKIN-NAILS.....	218	HUMALOG	51
halcinonide.....	181	HUMATIN.....	52
HALCION.....	173	HUMIRA.....	55
halobetasol.....	181	HUMULIN.....	51
HALOG.....	181	HURRICAIN LUER-LOCK	142
haloperidol.....	171	HYCAMTIN.....	58
HARD NAILS.....	218	HYCODAN.....	95
HARVONI.....	70	hydralazine.....	83, 84
HEALON GV.....	105	HYDREA.....	56
HEALTHPRO GLUCOSE CONTROL SOLN.....	132	hydrochlorothiazide.....	80, 81, 83, 84, 99
HEALTHY.....	132, 137, 153, 196, 206, 207	hydrocodone.....	21, 22, 23, 94, 95
HEALTHY ACCENTS AUTOLET	132	hydrocodone-acetamin.....	21
HEALTHY ACCENTS UNILET LANCET	153	HYDROCODONE-ACETAMIN.....	21
healthy eyes tablet.....	196	hydrocodone/ibuprofen.....	22
HEALTHY EYES TABLET	196	hydrocort.....	33, 100, 121, 182, 183
HEARTBURN ACID REFLUX.....	203	hydrocortisone.....	100, 120, 121, 123, 124, 179, 182, 183
HEMA-COMBISTIX.....	98	hydrocortisone/acetic acid.....	100
HEMATEX	110	hydrocort-pramoxine.....	121, 183
HEMATOGEN.....	110	hydrogen peroxide.....	174
HEMATRON-AF	110	hydromorphone.....	22, 23
HEMAX.....	110	hydroxocobalamin.....	221
HEMLIBRA	75	hydroxychloroquine.....	53
HEMOCYTE.....	III	HYDROXYCHLOROQUINE.....	53
heparin.....	43, 44	HYDROXYPROPYLCELLULOSE	192
HEPARIN.....	43, 44	hydroxyurea.....	56
HEPLISAV-B.....	75	hydroxyzine.....	47, 48
HETLIOZ.....	172	HYFTOR.....	127
HIBERIX.....	74	HYLAVITE.....	218
high potency multivitamin tab.....	203	HYLAZINC.....	198
HIGH POTENCY MULTIVITAMIN TAB	203	hyoscyamine.....	117
HIPREX	35	HYPER-SAL	190
HISTEX-AC.....	94	HYPODERMIC NEEDLE.....	141, 142, 148
hm.....	III, 160, 192, 198, 210, 218, 221, 225, 229, 233	HYPOLANCE.....	132
HM ALCOHOL 70% PREP PADS.....	176	HYPROMELLOSE	192
HM BIOTIN.....	218	HYRIMOZ.....	55
HM HAIR, SKIN AND NAILS TABLET	203	HYSINGLA.....	23
hm iron.....	III	I	
HM MEN'S ONE DAILY TABLET	203	ibandronate.....	193
HM ONE DAILY PRENATAL	160	ibuprofen.....	22, 27, 28
hm prenatal.....	160	ibuprofen/famotidine.....	27
hm slow release iron.....	III	I-CAPS.....	196
hm vit.....	221, 225	ICAPS.....	196, 203
hm vitamin.....	221, 225, 229, 233	ICAPS AREDS2.....	196
HM VITAMIN.....	229	ICAR.....	III
homatropine.....	104	icatibant.....	187
HOMOCYSTEINE.....	218	ICLUSIG.....	59
HORIZANT.....	87	icosapent.....	114
HORMONES.....	121, 122, 123, 124, 125, 126, 127, 185	IDHIFA.....	61

Index of Medications

IFE-BIMIX.....	188	INSUL-EZE.....	133
IGALMI.....	173	INSULIN.....	49, 50, 52, 125, 143, 144, 145, 146, 148, 149
ILET.....	132	INSULIN CARTRIDGE.....	146
ILEVRO.....	101	INSULIN LISPRO.....	52
I.L.X. B-12.....	III	INSULIN SYRINGE U-500.....	146
IMBRUVICA.....	59	INTEGRA.....	III, 142, 146
IMCIVREE.....	63	INTELENCE.....	67
imipramine.....	167	INTERLINK.....	146
imiquimod.....	177	INTRINSI.....	221
IMMUNERX.....	203	INVACARE.....	137, 153
IMPAVIDO.....	54	INVEGA.....	170
IMPEKLO.....	182	INVELTYS.....	101
IMURAN.....	128	INVIRASE.....	68
INBRIJA.....	64	iodine/potassium iodide.....	183
INCONTROL.....	132, 137, 153, 176	iodine/sodium iodide.....	183
INCONTROL LANCING DEVICE.....	132	IODOFLEX.....	183
INCRELEX.....	125	IODOSORB.....	183
indapamide.....	100	IOPIDINE.....	103
INDICLOR.....	97	IPOL.....	73
indomethacin.....	28	ipratropium.....	29, 30, 100
INFANRIX DTAP.....	74	irbesartan.....	81, 82
INFANT-TODDLER MULTIVITAMIN.....	212	irbesartan/hydrochlorothiazide.....	81
infant-toddler multivit-iron.....	212	IRESSA.....	59
INFANT-TODDLER MULTIVIT-IRON.....	212	IRON.....	109, 110, III, 112, 113, 160, 164, 202, 207, 208, 209, 211, 212, 213, 214
INFANT-TODDLER TRI-VITAMIN.....	212	iron bg.....	III, 161
INFASURF.....	186	IRON BISGLYCINATE.....	III
INFED.....	III	iron/c.....	112
INFINITY.....	132	iron,carbonyl.....	109, III, 112
INFUSION SET.....	130, 133, 135, 157	iron fm.....	III, 113
INFUVITE.....	203, 212	iron/folic.....	112, 161, 162, 163, 200, 204, 205, 208
INGREZZA.....	87	iron fum.....	III, 161, 162, 201, 205, 211
INJECT.....	137, 146, 153	iron fumarate.....	III, 161
INJECTAFER.....	III	iron polysac.....	III
INJECT EASE.....	153	iron polysaccharide.....	110, III, 112
INJECT-EASE.....	146	IRONUP.....	112
INLYTA.....	59	IRO-PLEX.....	112
INNER EAR PLUS.....	197	IROSPAN.....	112
INOVA.....	178	IS-D.....	229
INPEN.....	132	ISENTRESS.....	68
INSET.....	157	isoflurane.....	25
INSET 30.....	157	isoniazid.....	36
INSET 30 TUBING.....	157	ISOPROPANOL.....	192
INSPIRACHAMBER.....	157	isopropyl.....	176, 191, 192
INSPRA.....	99	isopropyl alcohol.....	176, 191, 192
INSTACLEAN.....	192	ISOPROPYL ALCOHOL.....	177, 191, 192
INSTA-GLUCOSE.....	107	ISOPROPYL ALCOHOL 70% SPRAY.....	54
insta-glucose gel.....	107	isopropyl rubbing alcohol.....	192
INSUL-CAP.....	132		

Index of Medications

ISOPROPYL RUBBING ALCOHOL.....	192	ketorolac.....	20, 21, 101
ISOPTO CARPINE.....	103	KETOSTIX REAGENT	97
ISORDIL.....	78	KIDS COD LIVER OIL.....	212
isosorbide.....	78, 84	KIDS MULTIVITAMIN.....	212
isotretinoin.....	174	KINRIX.....	74
isoxsuprine	84	KISQALI.....	59
isradipine.....	77	KITABIS PAK.....	35
itraconazole.....	45	KLARITY.....	34, 101, 104
IV 3000.....	150	KLARITY-A(AZITHROMYCIN-CHONDR).....	34
IV3000.....	150	KLARON.....	175
IV ADMINISTRATION SET.....	157	KLOXXADO.....	44
ivermectin.....	53, 64, 178	KOSELUGO.....	57
IWILFIN.....	59	KOSHER PRENATAL.....	160
J		K-PAX.....	203
JAKAFI.....	57	K-PHOS.....	114
JALYN.....	195	KPN PRENATAL.....	160
JANSSEN COVID-19 VACCINE.....	73	kpn tablet.....	160
JANUMET.....	50	KRINTAFEL.....	53
JANUVIA.....	49	KRISTALOSE.....	119
JARDIANCE.....	51	croger glucose.....	107
JOENJA 70 MG TABLET.....	186	kro glucose.....	107
JORNAY.....	168	kro isopropyl alcohol 91%.....	192
JUBLIA.....	46	k-tab.....	114
JULUCA.....	66	K-TAB.....	114
JUST 4 KIDZ MULTIVIT-PROBIOTIC.....	212	KYLEENA.....	93
JUSTRIGHT 5000.....	105, 108	KYNMOBI.....	64
JUXTAPID.....	84	L	
JYNARQUE.....	99	labetalol.....	80
K		LABSTIX REAGENT.....	98
KI-1000.....	234	lacosamide.....	90
K2.....	228, 229, 234	LACRISERT.....	101
KADIAN.....	23	lactulose.....	114, 119
KALETRA.....	68	LAMICTAL.....	90
KALYDECO.....	186	lamivudine.....	66, 67, 70
KAPVAY.....	168	lamivudine/zidovudine.....	66
KARBINAL.....	48	lamotrigine.....	90, 91
KENALOG.....	182	lancets.....	136, 137, 138, 151, 153
KENDALL.....	146, 150	LANCETS.....	136, 137, 138, 139, 140, 151, 152, 153, 154, 155, 156
KENDALL DISINFECTANT CAP.....	146	LANCETS THIN.....	153
KERENDIA.....	99	LANCETS ULTRA THIN.....	153
KESIMPTA.....	88	LANCING DEVICE.....	129, 130, 131, 132, 133, 134, 135
KETAMINE.....	173	LANCING SYSTEM.....	133
ketoconazole.....	45, 46	LANOXIN.....	78
ketodan.....	46	lansoprazole.....	116, 120
KETO-DIASTIX REAGENT.....	97, 98	lansoprazole/amoxicilin/clarith.....	116
KETONE CARE TEST STRIP.....	97	lanthanum carbonate.....	108
KETONE TEST STRIP.....	96, 97	LANZO.....	133
ketoprofen.....	28	lapatinib ditosylate.....	59, 61

Index of Medications

LASIX.....	99	LIQUID E-Z PAQUE.....	97
LASTACAPT.....	48	LIQUID POLIBAR PLUS.....	97
latanoprost.....	103	lisinopril.....	80, 82
LATANOPROST.....	103	lisinopril/hydrochlorothiazide.....	80
LAZANDA.....	23	LITE.....	95, 133, 138, 153, 225
leader glucose.....	107	LITEAIRE.....	158
leader quick dissolve gluc.....	107	LITE TOUCH.....	133, 153
lecithin/pyridoxine/kelp.....	203	LITETOUCH.....	158
leflunomide.....	26	LITFULO.....	194
lenalidomide.....	58	lithium.....	165
LENVIMA.....	59	LITHOBID.....	165
LESCOL.....	85	LITHOSTAT.....	114
L.E.T.....	25	LITTLE ANIMALS.....	212
letrozole.....	57	LIVALO.....	85
leucovorin.....	187	LIVITA.....	212
LEUKERAN.....	56	LIVMARLI.....	119
levabuterol.....	30	LIVTENCITY.....	69
LEVBID.....	117	l-mefol/a-cyst/mebl2/algol oil.....	218
LEVER LOCK CANNULA.....	146	lmefolate/b3/copp/zp/sel/chrom.....	203
levetiracetam.....	91	L-METHYLFOL.....	218
LEVITRA.....	188	l-norgest/e.estradiol-e.estrad.....	93
levobunolol.....	103	LODINE.....	28
levocarnitine.....	193	LODOSYN.....	65
levofloxacin.....	34, 39	LOKELMA.....	108
LEVOMEFOL.....	218	LOMAIRA.....	63
levomefolate.....	197, 198, 215, 216, 218, 219	LOMOTIL.....	115
LEVOMEFOLATE.....	218	longs glucose.....	107
levonorgestrel/ethin.estradiol.....	93	LONHALA MAGNAIR.....	29
levorphanol.....	23	LONSURF.....	56
levothyroxine.....	185	LOPID.....	86
LEVSIN.....	117	lopinavir/ritonavir.....	68
LEVULAN.....	62	LOPRESSOR.....	83
LEXIVA.....	68	LOPROX.....	46, 47
LICART.....	174	lorazepam.....	164
lidocaine.....	25, 121, 183	LORBRENA.....	59
LIDOCAINE-EPINEPHRIN-TETRACAIN.....	25	LORID.....	218
LIDOCAINE-HYDROCORT.....	121	LORMATE.....	218
LIDOCAN.....	25	LORTAB.....	21
LIFESHIELD BLUNT CANNULA.....	142, 146	LORZONE.....	159
LILETTA.....	93	losartan/hydrochlorothiazide.....	81
lindane.....	183	losartan potassium.....	82
linezolid.....	38	LOTEMAX.....	101
LINZESS.....	118	LOTENSIN.....	80, 82
liothyronine.....	185	LOTENSIN HCT.....	80
LIPO.....	197	loteprednol etabonate.....	101
LIPO-FLAVONOID PLUS.....	197	lovastatin.....	85
LIPOTRIAD.....	196	loxapine.....	171
LIQUID C.....	225	lubiprostone.....	119

Index of Medications

LUCENTIS	104	medlance	138, 153
LUER LOCK	144, 145, 146, 147	MEDLANCE	138, 153
LUER-LOK	143, 146, 148	medlance plus	153
LUERSLIP	146	MEDLANCE PLUS	153
LUER SLIP TIP	146	MEDROL	124
LUER TIP CAP	146, 148	medroxyprogesterone	92, 125, 126
LUMAKRAS	57	MEDTRONIC	133
LUMIGAN	103	MEDTYCHOLL-B	218
LUMRYZ	172	mefenamic	21
LUPKYNIS	128	mefloquine	53
LYDIA PINKHAM HERBAL	112	MEGA BIOTIN	218
LYMEPAK	40	megestrol	62, 195
LYNPARZA	59	meijer glucose	107
LYSODREN	62	MEKINIST	57
LYSTEDA	75	meloxicam	28
LYTGOBI	59	melphalan	55, 56
LYUMJEV	52	memantine	86
M		MEMANTINE	86
MACROBID	38	MEN 50	198, 201, 203, 208
MACRODANTIN	38	MENACTRA	73
MACULAR BENEFITS	196	MENOPUR	126
MACUVEX	196	MENOSTAR	123
MACUZIN	196	MENQUADFI	73
mafenide	42, 43	MEN'S 50 PLUS	203, 206
MAGELLAN	146, 147	MEN'S DAILY	203
MALARONE	53	MEN'S MULTIVITAMIN	203, 206
malathion	183	MENVEO	73
maprotiline	167	meperidine	23
maraviroc	66, 67	MEPHYTON	234
MAR-COF CG	95	meprobamate	164
MARINOL	115	MEPRON	54
MARNATAL-F	160	mercaptopurine	56
MARPLAN	165	MERIBIN	218
MATULANE	62	mesalamine	117, 118
MAVENCLAD	88	MESNEX	187
MAXFE	112	METANX	218
MAXIMIN	203	metaproterenol	30
MAXIMUM D3	229	metaxalone	159
MAXITROL	33	metformin	49, 50
MAXI-TUSS CD	94	METHACHOLINE	96
MAXZIDE	99	methadone	23
MAYZENT	88	methamphetamine	71, 72
MEBOLIC	203	METHAVER	218
meclofenamate	28	methazolamide	98
mecobal/levomefolat ca/b6 phos	218	methenamine hippurate	35, 36
MEDI-FIRST ISOPROPYL ALCOHOL	54	methenamine mandelate	36
MEDIHONEY	179	methenam/m.blue/salicyl/hyoscy	36
MEDISENSE	133, 138, 153	methenam/sod phos/mblue/hyoscy	36


Index of Medications

methen/mblue/sal/sod phos/hyos.....	36	miglustat.....	190
methimazole.....	185	MIGRANAL.....	19
METHITEST.....	121	MINI LANCING DEVICE.....	133, 134
meth/meblue/sod phos/psal/hyos.....	35	MINIMED.....	133, 147
methocarbamol.....	159	MINIMED RESERVOIR.....	147
methotrexate.....	56	MINI PRENATAL.....	160
methoxsalen.....	174	MINIPRESS.....	81
methscopolamine.....	117	MINITRAN.....	78
METHYL B-12.....	221	minocycline.....	40
METHYLCOBALAMIN.....	222	MINOLIRA.....	40
methyldopa.....	83	minoxidil.....	83
methylergonovine.....	125	MIRAPEX.....	65
METHYLFOLATE.....	198	MIRENA.....	93
METHYLIN.....	168	mirtazapine.....	164
methylphenidate.....	168, 169	MIRVASO.....	178
METHYLPHENIDATE.....	169	misoprostol.....	27, 116
methylprednisolone.....	124	MITIGARE.....	26
METHYL PROTECT.....	218	MITOMYCIN.....	104
methyl salicylate.....	177	MITOSOL.....	104
methyltestosterone.....	121, 122	MIXED TOCOTRIENOLS.....	233
metoclopramide.....	119	MKO.....	173
metolazone.....	100	M-M-R II VACCINE.....	74
METOPIRONE.....	97	MOBIC.....	28
metoprolol.....	83, 84	MOBILE.....	138
METOPROLOL SUCCINATE ER-HCTZ.....	84	modafinil.....	172
METROCREAM.....	178	MODERNA COVID.....	73
METROGEL.....	41, 178	MODERNA COVID-19 BOOSTER.....	73
METROGEL-VAGINAL.....	41	moexipril.....	82
metronidazole.....	35, 41, 178	molindone.....	171
metyrosine.....	82	mometasone.....	100, 182
mexiletine.....	77	MONOCAPS.....	203
MIACALCIN.....	127	MONODOX.....	40
miconazole.....	45	MONOFERRIC.....	112
MICRO.....	134, 138, 143, 153, 184	MONOJECT.....	142, 147
MICROCHAMBER.....	158	MONOLET.....	138, 153
MICRODOT.....	133	MONSEL'S.....	76
MICROLET.....	133, 138, 153	montelukast.....	32
MICROSPACER.....	158	morgidox.....	40
MICROTAINER.....	151, 153	MORGIDOX.....	40
MICRO THIN LANCET.....	153	morphine.....	23, 24
MICRO THIN LANCETS.....	153	MOTOFEN.....	115
midazolam.....	173	MOUNJARO.....	49
MIDAZOLAM.....	173	MOUTHPIECE.....	158
midodrine.....	72	MOVANTIK.....	44
MIEBO.....	101	MOXATAG.....	38
MIFEPREX.....	189	moxifloxacin.....	34, 35, 39
mifepristone.....	50, 189	MOXIFLOXACIN.....	33
miglitol.....	49	MS CONTIN.....	24

Index of Medications

ms glucose.....	107	nadolol.....	83
ms quick dissolve glucose.....	107	naftifine.....	47
MTERYTI.....	160	NAFTIN.....	47
MTX.....	222	NALFON.....	28
MUCOSITISRX.....	189	NALOCET.....	21
MULTAQ.....	77	naloxone.....	24, 44, 194
MULTI-BETIC.....	196	naltrexone.....	44
MULTI-DAY PLUS MINERALS.....	203	NAMENDA.....	86
multi for her.....	203	NAMZARIC.....	86
MULTI FOR HER.....	203	NANO.....	142, 143, 163, 213
MULTI-LANCET.....	133	NANO 2ND GEN.....	142
multilex.....	204	NANOVM.....	213
MULTILEX.....	203, 204	NAPRELAN.....	28
MULTI PRO.....	203	NAPROSYN.....	27, 28
MULTISTIX.....	98	naproxen.....	20, 27, 28, 29
multivit198, 199, 200, 202, 204, 205, 206, 208, 211, 212, 213, 214		naproxen/esomeprazole mag.....	27
multivitamin.....	162, 200, 201, 203, 204, 206, 208, 211, 212, 214	naratriptan.....	19, 20
MULTIVITAMIN 162, 196, 197, 198, 199, 200, 201, 202, 203, 204, 205, 206, 207, 208, 209, 211, 212, 218		NARCAN.....	44
MULTI-VITE.....	204	NARDIL.....	165
MULTI-VIT-FLOR.....	213	NASCOBAL.....	222
MULTIVIT-FLUOR.....	213	NATACHEW.....	160
multivit-min/fa/lycopen/lutein.....	200, 204	NATACYN.....	44
mupirocin.....	42	nateglinide.....	50
MURI-LUBE.....	192	NATPARA.....	125
MUSE.....	188	NAYZILAM.....	89
mv.....	III, 112, 113, 199, 202, 205, 206	nebivolol.....	83
M.V.I. PEDIATRIC.....	212	NEBUPENT.....	54
mvn.....	201, 205	nebusal.....	190
MVW.....	205, 213	NEBUSAL.....	190
MVW COMPLETE.....	213	NEEDLE.....	141, 142, 143, 146, 147, 148, 149
MYALEPT.....	127	needles,safety huber,disposabl.....	142
MYAMBUTOL.....	36	NEEVODHA.....	205
MYCAPSSA.....	126	nefazodone.....	166
MYCOBUTIN.....	36	neomycin.....	33, 34, 35, 173
mycophenolate.....	128	neomycin/bacit/p-myx/hydrocort.....	33
MYDAYIS.....	72	neomycin/bacitracin/polymyxinb.....	34
MYDRIACYL.....	104	neomycin/polymyxin b/dexametha.....	33
MYDRIATIC4.....	102	neomycin/polymyxin b/hydrocort.....	33
MYFEMBREE.....	125	neomycin/polymyxn b/gramicidin.....	34
MYFORTIC.....	128	neomycin sulfate.....	35
MYGLUCOHEALTH.....	133, 138, 153	NEONATAL.....	112, 160
MYLERAN.....	56	NEONATAL FE.....	112
MYRBETRIQ.....	195	NEORAL.....	128
MYSOLINE.....	91	NEO-SYNALAR.....	41
MYXREDLIN.....	52	NEOVITE.....	205
N		NEPHRON FA.....	218
nabumetone.....	28, 29	NEPHRO-VITE.....	218
		NERIA.....	157

Index of Medications

NERLYNX.....	59	norethindrone.....	93, 122, 123, 125, 126
NESTABS.....	160, 205	norethin-ee.....	93
NEUAC.....	175	norethin-eth estrad.....	123
neuac gel.....	175	NORGESIC.....	159
NEULUMEX.....	97	norgestimate-ethinyl estradiol.....	93
NEUPRO.....	65	norgestrel-ethinyl estradiol.....	93
NEURIN-SL.....	222	NORM-JECT.....	147
NEUTRASAL.....	189	NORPRAMIN.....	167
nevirapine.....	67	nortriptyline.....	167
NEXAVAR.....	59	NORVIR.....	68
NEXCARE TEGADERM.....	150	NORWEGIAN COD LIVER OIL.....	215
NEXLETOL.....	84	NOURIANZ.....	65
NEXLIZET.....	85	NOVA.....	133, 138, 154
niacin.....	86, 209, 210	NOVAFERRUM.....	112, 213
NIACIN.....	209, 210	NOVAMAX PLUS.....	96, 133
niacinamide.....	210	NOVAMV.....	213
NIACINAMIDE.....	210	NOVAREL.....	126
NIACOR.....	86	NOVAVAX COVID-19 VACC,ADJ.....	73
nicardipine.....	77	NOVOPEN 3.....	133
NICOMIDE.....	205	NOVOPEN ECHO.....	133
NICOTROL.....	185	NOXAFIL.....	45
nifedipine.....	77, 78	NOXIFOL-D3.....	229
NIFEREX.....	112	NUBEQA.....	56
NILANDRON.....	56	NUCALA.....	32
nilutamide.....	56	NUCORT.....	182
nimodipine.....	78	NUDEXTA.....	87
NINJACOF-XG.....	95	NUFERA.....	112
NINLARO.....	60	NUFOLA.....	218
nisoldipine.....	78	NU-IRON.....	112
nitazoxanide.....	64	NULEV.....	117
nitisinone.....	190	NULYTELY.....	119
NITRO-DUR.....	78	NUMBRINO.....	100
nitrofurantoin.....	38	NUMOISYN.....	188, 189
nitroglycerin.....	78, 79, 119	NUPLAZID.....	165
NITROLINGUAL.....	79	NURTEC ODT.....	20
NITROMIST.....	79	NUTRIVIT.....	205
NITROSTAT.....	79	NUVESSA.....	41
NITYR.....	190	NUZYRA.....	40
NIVA-FOL.....	218	NYMALIZE.....	78
NIVA-PLUS.....	205	nystatin.....	46, 47
nizatidine.....	118		
NOCDURNA.....	122	OB COMPLETE.....	160, 205
NO FLUSH NIACIN.....	210	OBREDON.....	95
NOKOR.....	142	OBSTETRIX EC.....	161
nolix.....	182	OBSTETRIX ONE.....	205
norelgestromin/ethin.estradiol.....	93	OBTREX DHA.....	161
noreth-ethinyl estradiol/iron.....	93	O-CAL FA.....	205
norethind-eth estrad.....	93, 123	OCALIVA.....	118

Index of Medications

OCUFLOX.....	34	opium tincture.....	115
OCULAR VITAMINS.....	196	OPSITE.....	150
OCUVEL.....	196	OPSUMIT.....	79
OCUVITE.....	196, 205	OPTICHAMBER.....	158
ODACTRA.....	73	OPTIFAST.....	207
ODEFSEY.....	68	OPTIMAL D3 M.....	229
ODOMZO.....	57	OPTISOURCE.....	207
OFEV.....	186	OPTUMRX.....	134
ofloxacin.....	33, 34, 39	OPURITY.....	207, 222
OGSIVEO.....	60	OPZELURA.....	183
olanzapine.....	170, 171, 172	ORACIT.....	114
olmesartan/amlodipin/hcthiazid.....	81	ORALAIR.....	73
olmesartan/hydrochlorothiazide.....	81	ORAMAGICRX.....	188
olmesartan medoxomil.....	82	ORAPRED ODT.....	124
olopatadine.....	100	ORAVIG.....	45
OLPRUVA.....	114	ORENITRAM.....	79
OLUX.....	182	ORFADIN.....	190
om-3.....	206	ORGOVYX.....	58
OMECLAMOX-PAK.....	116	ORIAHNN.....	125
omega-3 acid.....	114	ORLISSA.....	125
omeprazole.....	120	ORKAMBI.....	185, 186
OMNIPAQUE.....	96	ORLADEYO.....	187
OMNIPOD.....	133, 134	ORLISTAT.....	63
OMNITROPE.....	124	orphenadrine.....	159
OMNIVEX.....	206	ORTHO DF.....	229
OMVOH.....	127	oseltamivir.....	69
ON CALL.....	134, 138, 154	OSENI.....	48
ONCOVITE.....	206	OSTACHOL.....	229
ondansetron.....	116	OTEZLA.....	26
one.....	5, 6, 7, 8, 9, 12, 14, 163, 201, 202, 206, 207, 208, 235	OTIPRIO.....	33
ONE.....	158, 160, 161, 163, 199, 202, 203, 205, 206, 207, 208, 213, 214	OTOVEL.....	33
ONE A DAY.....	161, 214	OVACE.....	176
ONE-A-DAY.....	161, 206, 207, 213	OVAL TAPE.....	134
one daily.....	163, 201, 202, 206, 208	OVIDE.....	183
one-daily.....	207	OVIDREL.....	126
ONE DAILY.....	160, 199, 202, 203, 206, 208	oxandrolone.....	121
ONE-DAILY.....	207	oxaprozin.....	27, 29
ONETOUCH.....	96, 134, 138, 154	oxazepam.....	164
ONETOUCH DELICA.....	134, 154	oxcarbazepine.....	91
ONETOUCH ULTRA.....	96, 134	OXERVATE.....	105
ONETOUCH VERIO.....	96, 134	oxiconazole.....	47
ONEVITE.....	207	OXTELLAR.....	91
ONE WAY MOUTHPIECE.....	158	oxybutynin.....	195
ONEXTON.....	175	oxycodone.....	21, 22, 24
ON-THE-GO.....	138, 154	oxycodone hcl/acetaminophen.....	21
OPFOLDA.....	190	OXYCONTIN.....	24
opium/belladonna.....	24	oxymorphone.....	24
		OXYTROL.....	195

Index of Medications

OZEMPIC.....	48	penciclovir.....	70
P		penicillamine.....	26
PACNEX.....	178	penicillin.....	38
paliperidone.....	170	PENTACEL.....	74
PALYNZIQ.....	73	pentamidine.....	54
PAMELOR.....	167	PENTASA.....	118
PAN-C.....	225	pentazocine.....	24
PANCREAZE.....	120	pentoxifylline.....	76
PANDA.....	158	PEPCID.....	118
PANDEL.....	182	PERFECT IRON.....	112
PANRETIN.....	62	PERIDEX.....	187
PANTETHINE.....	211	PERIDIN-C.....	225
pantoprazole.....	120	perindopril erbumine.....	82
PAPAVERINE-PHENTOLAMINE.....	188	permethrin.....	64
PAPAVERINE-PHENTOLMN-ALPROSTDL.....	188	perphenazine.....	172
PARADIGM.....	134, 147, 157	perphenazine/amitriptyline hcl.....	167
paregoric.....	115	PFIZER COVID.....	73
PAREMYD.....	104	PHARMABASE BARRIER.....	178
paricalcitol.....	189	pharm choice alcohol prep pads.....	176
PARLODEL.....	65	PHARM CHOICE ALCOHOL PREP PADS.....	176
PARNATE.....	165	PHASEAL.....	142
paromomycin.....	52	PHEBURANE.....	115
paroxetine.....	166, 190	phenazopyridine.....	26
PARVLEX.....	112	phendimetrazine.....	63
PASER.....	36	phenelzine.....	165
PATANASE.....	100	phenobarb/hyoscy/atropine/scop.....	116, 117
PAXIL.....	166	phenobarbital.....	117, 172
pazopanib.....	60	phenobarbital-belladonna elixr.....	117
PEDIA POLY-VITE.....	213	PHENOBARBITAL-BELLADONNA ELIXR.....	117
pedia poly-vite iron.....	213	phenoxybenzamine.....	72
PEDIARIX.....	75	phentermine.....	62, 63
PEDIATRIC MASK.....	158	phenylephrine.....	47, 94, 102
PEDIATRIC MONITOR.....	134	PHENYTEK.....	91
pediatric multivit.....	214	phenytoin.....	90, 91
pediatric multivitamin.....	211, 214	PHOSLYRA.....	108
PEDIATRIC PANDA MASK.....	158	PHOSPHOLINE IODIDE.....	103
PEDIATRIC POLY-VITAMIN.....	214	PHOTREXA.....	101
PEDIATRIC POLY-VITE.....	214	PHYSIOLYTE.....	173
PEDIATRIC TRI-VITAMIN.....	214	PHYSIOSOL.....	173
PEDIATRIC TRI-VITE.....	214	phytonadione.....	234
PEDIA TRI-VITE.....	213	PHYTONADIONE.....	234
pedi multivit.....	211, 212, 213	pilocarpine.....	72, 103
ped mvit.....	213	pimecrolimus.....	127
PEDVAXHIB.....	74	pimozide.....	169
peg3350/sod sulf,bicarb,cl/kcl.....	119	pindolol.....	83
peg3350/sod sul/nacl/kcl/asb/c.....	119	pioglitazone.....	50
PEGASYS.....	70	PIP.....	134, 138, 154
PEMAZYRE.....	60	PIP GLUCOSE CONTROL SOLUTION.....	134
PENBRAYA.....	73	PIP LANCET.....	154

Index of Medications

PIQRAY	60	prednicarbate	180, 182
pirfenidone	189	prednisolone	34, 102, 124
piroxicam	28, 29	PREDNISOLONE	33, 34, 102
PISTON ENFIT	147	PREDNISOLONE ACET-GATIFLO-BROM	33
PLEGRIDY	88	PREDNISOLONE ACET-GATIFLOXACIN	33
PLEXION	42, 176	PREDNISOLONE ACET-MOXIFLOXACIN	33
PNEUMOVAX 23	74	PREDNISOLONE AC-MOXIFLOX-BROMF	33
pnv	161, 163	PREDNISOLONE AC-MOXIFLOX-NEPAF	34
pnv8l	161	PREDNISOLONE PHOS-GATIFLO-BROM	34
POCKET CHAMBER	158	PREDNISOLONE PHOS-GATIFLOXACIN	33
PODIAPN	218	PREDNISOLONE PHOS-MOXIFLO-BROM	34
podofilox	178	PREDNISOLONE PHOS-MOXIFLOXACIN	33
POLIBAR ACB	97	prednisone	124
polyethylene	192	preferred plus glucose	107
POLY HUB	142	PREFEST	123
polymyxin b sulf/trimethoprim	34	pregabalin	91, 194
POLYSKIN II	150	PREGNYL	126
POLYTRIM	34	PREHEVBRIO	75
POLY-TUSSIN AC	94	PREMARIN	126
POLY-VI-FLOR	214	PRENATA	161
poly-vi-sol	214	prenatal	160, 161, 162, 163
POLY-VI-SOL	214	PRENATAL	159, 160, 161, 162, 163, 164, 199, 202
POLY-VITA	214	prenatal7l	162
POLY VITAMIN-IRON	207	PRENATE	162, 207
POLY-VITE	213, 214	PREPIDIL	125
POMALYST	58	PRESERVISION	196
PONVORY	88	PRESSURE	102, 103, 104, 138, 154
POSACONAZOLE	45	PRESSURE ACTIVATED LANCETS	154
posaconazole dr	45	PRESTALIA	80
POTABA	218	PRETOMANID	36
potassium bicarbonate/cit ac	114	PREVENT	215
potassium chloride	114	PREVIDENT	105, 108, 109
potassium citrate	114	PREVNAR 13	74
potassium iodide	109, 183	PREVNAR 20	74
potassium iodide/iodine	109	PREVYMIS	69
pramipexole	65	PREZISTA	66
PRAMOSONE	183	PRIFTIN	36
PRANDIN	50	PRIMACARE	163
prasugrel	65	primaquine	53
pravastatin	85	PRIMAQUINE	53
praziquantel	53	PRIMEAIRE	158
prazosin	81	primidone	91
PR BENZOYL PEROXIDE	178	PRIMSOL	36
PRECISIONGLIDE	142, 147, 148	PRIORIX	74
PRECISION XTRA	96, 134	PRISMASOL	114
PRECOSE	49	probenecid	29
PRED FORTE	102	PROCARDIA	78
PRED-G	33	PROCARE SPACER	158

Index of Medications

PROCERV HP.....	207	PYRIDOXINE.....	223
PROCHAMBER.....	158	pyrimethamine.....	53
prochlorperazine.....	115, 116	PYRUKYND.....	75, 76
PRO COMFORT.....	138, 139, 154, 158, 176	Q	
PROCORT.....	121	qc.....	163, 177, 192, 229
PROCTOCORT.....	120	qc alcohol 70% swabs.....	177
PRODIGY.....	134, 139, 147, 154	qc prenatal tablet.....	163
PRODIGY COUNT-A-DOSE.....	147	QELBREE.....	169
PRO FE.....	112	QSYMIA.....	63
PROFERRIN.....	112	Q-SYTE.....	157
PROFOLA.....	207	QUADRACEL DTAP-IPV.....	75
progesterone.....	126	QUALAQUIN.....	53
PROGLYCEM.....	107	QUDEXY.....	91
PROGRAF.....	128	QUERCETIN.....	197
prolate.....	21, 22	QUESTRAN.....	86
PROLENSA.....	102	quetiapine.....	170
PROMACTA.....	92	QUFLORA.....	214
promethazine.....	48, 94, 116	QUICK RELEASE SOFT TEFLON.....	134
PROMETRIUM.....	126	quinapril.....	80, 81, 82
propafenone.....	77	quinapril/hydrochlorothiazide.....	80
proparacaine.....	102	QUIN B STRONG.....	218
propranolol.....	83, 84	QUINCE SPINAL.....	142
propylthiouracil.....	185	quinidine.....	77
PROQUAD.....	75	quinine.....	53
PRORENAL.....	207, 218	QUINTABS.....	207
PROSCAR.....	195	QULIPTA.....	20
PROSTIN E2.....	125	QUVIVIQ.....	173
PROTECT.....	105, 112, 207, 218	QVAR REDIHALER.....	32
PROTECT IRON.....	112, 207	R	
PROTHELIAL.....	188	ra.....	107, 112, 163, 177, 192, 198, 208, 210, 215, 218, 222, 224, 225, 229, 230, 233
PROTOPIC.....	127	ra alcohol swabs.....	177
protriptyline.....	167	ra balanced.....	218
PROVERA.....	92, 126	rabeprazole.....	120
PROVIDA OB.....	163	RADICAVA ORS.....	87
PROVOCHOLINE.....	96	RADIOGARDASE.....	191
pseudoephed/codeine/guaifen.....	95	ra glucose.....	107
PSV SET.....	157	RAGWITEK.....	73
pub glucose.....	107	ra high potency iron.....	112
PULMOZYME.....	186	RA HIGH POTENCY IRON.....	112
PURE.....	139, 154, 158, 177	ra iron.....	112
PURE COMFORT.....	154, 158, 177	ra isopropyl alcohol 70%.....	192
PUREFE.....	207	RA ISOPROPYL ALCOHOL 70% WIPES.....	177
PURIXAN.....	57	ra isopropyl alcohol 91%.....	192
PUSH.....	139, 154	raloxifene.....	193
PUSH BUTTON.....	154	ramelteon.....	172
pyrazinamide.....	36	RA MEN'S.....	208
pyridostigmine.....	71	ramipril.....	82
PYRIDOSTIGMINE.....	71	RA NIACIN.....	210
pyridoxine.....	203, 223		

Index of Medications

ranitidine.....	118	REPLESTA	230
ranolazine.....	77	REQ49+	198
ra one daily prenatal dha pack	163	RESPA A.R.....	94
RAPAMUNE.....	128	RESTASIS.....	104
RAPID B-12 ENERGY	222	RESTORIL.....	173
ra prenatal tablet.....	163	RETEVMO	60
rasagiline.....	64, 65	RETIN-A.....	184
RASUVO.....	26	RETROVIR.....	67
RAVICTI	115	REVATIO	79
ra vit.....	222, 225	REVESTA	230
RA VIT	222	REVLIMID	58
ra vitamin.....	215, 222, 225, 230, 233	REXULTI	171
ra vitamin a.....	215	REYATAZ.....	68
RA VITAMIN C	225	REYVOW.....	20
RAYALDEE	189	REZUROCK	194
RAYA SURE.....	142	RHOFADE	178
RAYOS.....	124	ribasphere	70
RAZADYNE.....	71	ribavirin	70
READI-CAT 2	97	riboflavin.....	223
READYLANCE.....	139, 154	RIBOFLAVIN.....	223
REBIF.....	88	RIBOZEL.....	219
RECOMBIVAX HB.....	75	RIDAURA.....	26
RECOTHROM.....	76	rifabutin.....	36
RECTIV	119	rifampin	37
REFUAH	134	RIGHTEST.....	134, 139, 154
REGLAN	119	RILUTEK.....	87
REGRANEX.....	177	riluzole.....	87
REGULAR BEVEL	142	rimantadine.....	69
RELAFEN.....	29	RIMSO-50.....	25
RELAGARD.....	52	ringer's solution.....	173
RELENZA	69	RINVOQ	27
RELEXXII.....	169	RIOMET	49
RELIAMED	134, 139, 154	risedronate.....	193
RELION.....	107, 139, 154, 177	RISPERDAL	170
reli-on glucose	107	risperidone.....	170, 171
relion glucose	107	RITEFLO	158
RELION GLUCOSE	107	ritonavir.....	68
RELISTOR.....	44	rivastigmine.....	71
REMEDIENT.....	208	rizatriptan.....	20
REMERON	164	R-NATAL.....	163
RENACIDIN.....	114	ROBINUL.....	115
RENAL VITAMIN.....	218	ROCALTROL	230
RENAL-VITE.....	219	roflumilast.....	32
RENAPLEX.....	219	ropinirole	65
RENVELA.....	108	rosadan.....	178
repaglinide.....	50	ROSADAN.....	178
REPATHA	84, 85	rosula.....	42
REPLACEMENT	75, 109, 110, 111, 112, 113	ROSULA	42
REPLACEMENT PEDIATRIC MONITOR.....	134	ROSZET	84

Index of Medications

ROTARIX	73	SELECT-OB.....	163
ROTATEQ	73	selegiline	65
ROWASA	117	selenium.....	176
ROXICODONE	24	SELRX	176
ROXIFOL.....	230	SELZENTRY	66, 67
ROZLYTREK	60	SEMGLEE.....	52
RUBRACA	60	SEN-SERTER.....	134
rufinamide.....	91	SEROSTIM	125
rutin	197	sertraline	166
RUZURGI	88	sevelamer	108
RYALTRIS.....	100	sevoflurane.....	25
RYCLORA.....	48	SEYSARA.....	40
RYDAPT	60	SFROWASA	117
RYTARY	65	SHINGRIX.....	75
RYTHMOL	77	SHORT BEVEL	142
RYVENT	48	SIDEROL	113
S		SIDESTREAM	158
SAFE-CLIP.....	134	SILATRIX	188
SAFESNAP.....	147, 148	sildenafil.....	79, 188
SAFETY ...136, 137, 138, 139, 140, 141, 144, 146, 147, 148, 149, 151, 152, 154, 155, 156		SILENOR	173
SAFETYGLIDE.....	142, 144, 148	SILHOUETTE	133, 134, 157
SAFETY LANCETS	151, 154	SILICONE MASK.....	158
SAFETY-LET.....	154	silodosin.....	195
SAFETY-LOK	148	SIL-SERTER.....	134
SAFETY SEAL LANCETS.....	152, 154	SILVADENE	42
SAFETY SYRINGE	146, 147, 148, 149	silver sulfadiazine.....	42
SALAGEN	72	SIMBRINZA	103
SALIVAMAX.....	189	SIMILAC PRENATAL.....	163
salsalate.....	26	SIMPONI	55
SANCUSO	116	simvastatin.....	84, 85
SANDIMMUNE.....	128	SIMVASTATIN.....	85
SANTYL.....	184	SINEMET	65
sapropterin.....	191	SINGLE-LET.....	139, 154
SAPS ALCOHOL 70% PREP PADS	177	SINGLE USE SWAB	177
SAVELLA.....	194	sirolimus	128
saxagliptin.....	49	SIRTURO	37
saxagliptin-metformin	50	SITZMARKS.....	97
saxagliptin-metformn	50	SKLICE	64
saxagliptn-metform	50	SKYLA	93
SAXENDA.....	63	SKYRIZI	127, 174
SCALACORT	182	SLIP-TIP.....	148
SCEMBLIX.....	60	slo-niacin.....	210
SCOOBY-DOO ONE A DAY	214	SLO-NIACIN	210
scopolamine.....	116	SLOW FE.....	113
secobarbital.....	172	slow release iron.....	109, 111, 113
SECUADO	171	SLOW RELEASE IRON.....	109, 112, 113
SEEBRI	30	sm... 107, 113, 163, 177, 192, 198, 208, 219, 222, 224, 225, 226, 230	
SEGLUROMET	51	SM ALCOHOL 70% PREP PADS.....	177
		sm alcohol prep pads	177

Index of Medications

SMART	137, 139, 152, 154	SOMA	159
SMARTDIABETES VANTAGE	134	SOMAVERT	189
SMARTEST	134, 139, 154	SOOLANTRA	178
smart sense	107	sorafenib tosylate	59, 60
SMART SENSE	154	SORBITOL	174
SM BIOTIN	219	sotalol	83
sm iron	113	SOTYLIZE	83
sm isopropyl alcohol 70%	192	SOVUNA	53
sm isopropyl alcohol 91%	192	SPACE CHAMBER	157, 158
SM ISOPROPYL ALCOHOL 91%	192	SPAN C	226
sm prenatal vitamins tablet	163	SPECIALTY USE NEEDLES	142
SM SLOW RELEASE IRON 45 MG TAB	113	SPECTRACEF	37
sm vitamin	222, 225, 226, 230	SPECTRAVITE	198, 208
sodium chloride	119, 174, 190	SPIKEVAX COVID	73
sodium chloride/nahco3/kcl/peg	119	spinosad	64
SODIUM CITRATE	43	SPIRIVA HANDIHALER	29
sodium ferric gluconat/sucrose	110, 113	SPIRIVA RESPIMAT	29
sodium fluoride	105, 106, 109, 113	spironolact/hydrochlorothiazid	99
SODIUM IODIDE I-123	187	spironolactone	99
SODIUM OXYBATE	172	SPORANOX	45
sodium phenylbutyrate	114, 115	SPRITAM	91
sodium polystyrene sulfonate	108	SPRIX	20
sodium polystyrene sulfon/sorb	108	SPRYCEL	60
sodium, potassium, mag sulfates	119	SSKI	109
sodium sulfacetamide	176	STALEVO	65
SODIUM SULFACETAMIDE 10% WASH	176	stavudine	67
sod,pot chlor/mag/sod,pot phos	174	STEGLATRO	51
sod sulface-sulf	42	STELARA	127
sod sulface-sulfur	42	STENDRA	188
sod sulfacetam 10% clnsng gel	176	STERILANCE	139, 155
sod sulfacetamide 9.8% shampoo	176	STERILANCE TL	155
sod sulfacetamide 10% shampoo	176	STERILE	139, 148, 155
sod sulfacet-sulfr	42	STERILE LANCETS	155
sod sulfacet-sulfur	42	STIOLTO RESPIMAT	30
sod sulfac-sulfur	42	STIVARGA	60
SOF-SERTER	134	STRENSIQ	190
SOF-SET	134	STRESS B-COMPLEX	208
SOFT	134, 139, 154	stress-c	208
SOFT TOUCH	154	stress formula	204, 208, 219
SOHONOS	191	STRESS FORMULA	208
solifenacin	195	STRIVERDI	30
SOLQUA	49	STROMECTOL	53
SOLO	208	STROVITE	208
SOLODYN	40	STUART ONE	163
SOLOSEC	35	SUCRAID	118
SOLTAMOX	62	sucalfate	116
SOLUS	134, 135, 139, 154	SULAR	78
SOLUS V2	134, 135, 154	sulfacetamide	34, 42, 43, 175, 176
SOLUVITA-E	233	sulfadiazine	35, 42

Index of Medications

sulfamethoxazole/trimethoprim	35	sv prenatal tablet	163
SULFAMYLON	43	SV PRENATAL VITAMINS TABLET	163
sulfasalazine	118	SV SLOW RELEASE IRON 45 MG TAB	113
sulindac	29	sv vitamin	222, 226, 230, 233
SUMADAN	43	sv vitamin b-12	222
sumatriptan	20	sv vitamin c	226
SUMAXIN	43	SV VIT B	222
sunitinib malate	60	sv vit c	226
SUNLENCA	67	SYMAX DUOTAB	117
SUNOSI	172	SYMBICORT	31
super	208, 217, 219	SYMBYAX	172
SUPER	137, 139, 153, 155, 208, 227, 230	SYMDEKO	186
super b complex-vit c	219	SYMFI	68
SUPER DAILY D3	227, 230	SYMJEPI	71
SUPER GINSENG	208	SYMLINPEN	49
super quints	219	SYMPAZAN	89
SUPER THIN LANCETS	153, 155	SYMPROIC	44
SUPOR	148	SYMTUZA	66
SUPPORT-500	208	SYNALAR	41, 182
SUPRANE	25	SYNAREL	125
SUPRAX	37	SYNDROS	115
SURE	133, 135, 139, 142, 155, 157, 177	SYNERA	25
SURE COMFORT	135, 155, 177	SYNJARDY	51
SUREFLEX	135, 154	SYPRINE	191
SURE-LANCE	155	SYRINGE	19, 32, 54, 55, 70, 73, 76, 85, 87, 88, 107, 127, 143, 144, 145, 146, 147, 148, 149, 174, 214
SURE-PEN	135	SYRINGE AVITENE	76
SURE-PREP ALCOHOL PREP PADS	177	SYRINGE BULK	148
SURESITE	150	SYRINGE CATHETER	148
SURE-T	157	SYRINGE FILTER	148
SURE-TEST EASYPLUS	135	SYRINGE SLIP TIP	148
SURE-TOUCH	155	SYRINGE STORAGE BIN	148
SURFAXIN	186	SYRINGE TIP CAP	148
SURGICEL	76	SYRINGE WITH NEEDLE DISP	148
surgifoam	76	SYRINGE WITHOUT NEEDLE	148
SURGIFOAM	76	T	
SURGISEAL	178, 179	T:30	135
SURMONTIL	167	T:90	135
SURVANTA	186	tab-a-vite	208
SUSTIVA	67	TAB-A-VITE	208
SUTENT	60	TABLOID	57
sv	113, 163, 198, 210, 219, 222, 224, 226, 230, 233	TABRECTA	60
sv b-12	222	TACHOSIL	76
sv biotin	219	TACLONEX	184
SV BIOTIN	219	tacrolimus	127, 128
SV COD LIVER OIL	214	tadalafil	79, 187, 188
sv folic acid	198	TAFINLAR	57
SV HAIR, SKIN AND NAILS	208	TAGITOL	97
sv iron	113	TAGRISSO	60
sv niacin	210		

Index of Medications

TAKHZYRO.....	73, 187	teriparatide	193
TALICIA	116	TERIPARATIDE.....	193
TALTZ	174	TERSI FOAM.....	176
TALZENNA.....	60	TERUMO.....	142, 148
TAMIFLU.....	69	TERUMO SURGUARD2.....	142, 148
tamoxifen.....	62	TERUMO SYRINGE.....	148
tamsulosin	195	testosterone.....	121, 122
TANDEM DUAL ACTION.....	113	TESTOSTERONE.....	121, 122
TANDEM PLUS.....	113	TESTRED.....	122
TAPAZOLE	185	tetrabenazine.....	87
TAPERDEX.....	124	tetracaine.....	102
TARCEVA.....	60, 61	TETRACAINE	102
TARGADOX.....	40	tetracycline.....	40
TARGRETIN	62	TETRAVISC.....	102
TARPEYO.....	124	TEXACORT	182
TASIGNA.....	61	T:FLEX	135
TASMAR.....	65	THALOMID	36
tavaborole.....	47	THEO-24.....	33
TAVALISSE.....	186	theophylline anhydrous.....	33
tazarotene.....	175	thera-d.....	230
TAZVERIK	58	THERA-D.....	230
TB SYRINGE.....	147, 148	THERAGRAN	208
TC 99M.....	96	thera-m.....	208
TDVAX.....	75	THERA-M.....	208
TECHLITE.....	139, 155	THERAMILL FORTE	208
TEGADERM.....	150, 151	THERANATAL.....	163, 208
TEGLUTIK	87	THEREMS-H.....	208
TEGRETOL	91	thiamine.....	220
TEGSEDI	189	THIAMINE.....	220
TEKTRUNA HCT	84	THIN.....	97, 136, 137, 138, 139, 140, 142, 151, 153, 154, 155
TELCARE.....	135, 139, 155	THIN LANCETS.....	153, 155
TELCARE CONTROL SOLUTION.....	135	THIN WALL NEEDLES.....	142
TELCARE ULTRA THIN.....	155	THIOLA EC	195
telmisartan.....	81, 82	thioridazine.....	172
telmisartan/amlodipine	81	thiothixene.....	171
telmisartan/hydrochlorothiazid	81	THRIVITE.....	163
temazepam	173	THROMBI-GEL.....	76
TEMIXYS.....	66	THROMBIN.....	44
TEMODAR.....	56	THROMBIN-JMI.....	76
TEMOVATE.....	182	THROMBI-PAD	76
temozolomide.....	56	thyroid,pork.....	185
TENIVAC.....	75	tiagabine	90, 91
tenofovir.....	67, 68	TIAZAC	78
TENORETIC.....	84	TIBSOVO	61
TENORMIN	83	TIGAN.....	116
terazosin	81	TIGLUTIK.....	87
terbinafine	45	timolol.....	84, 103
terbutaline.....	30	TIMOLOL-BRIMONIDIN-DORZOLAMIDE.....	103
terconazole	45	TIMOLOL-BRIMONI-DORZOL-LATANOP	103

Index of Medications

TIMOLOL-DORZOLAMIDE.....	103	triamcinolone	182, 183, 187
TIMOLOL-LATANOPROST	103	triamterene	99
TIMOPTIC.....	103	triamterene/hydrochlorothiazid	99
tinidazole.....	52	triazolam.....	173
tiopronin.....	195	TRICARE.....	163
TISSEEL VHSD	179	trichloroacetic acid.....	179
TIVICAY	68	TRICHLOROACETIC ACID	179
tizanidine	159	triderm.....	183
TL-HEM 150.....	113	TRIDESILON.....	183
TOBAKIENT.....	208	trientine.....	191
TOBI PODHALER.....	35	TRIFERIC.....	113
TOBRADEX.....	33	trifluoperazine.....	172
tobramycin.....	33, 34, 35	trifluridine.....	69
tobramycin/dexamethasone	33	trihexyphenidyl.....	64
TOBRAMYCIN PAK.....	35	TRIJARDY	51
TOBREX.....	34	TRIKAFTA.....	186
TOFRANIL	167	TRILIPIX	86
TOLAK	62	trimethobenzamide	116
tolcapone.....	65	trimethoprim.....	34, 35, 36
tolmetin.....	29	trimipramine.....	167
tolterodine.....	195	TRI-MIX.....	188
tolvaptan.....	98	TRIMO-SAN.....	52
TOOMEY SYRINGE.....	149	TRIMPEX.....	36
TOPCARE.....	139, 155	TRINAZ	164
TOPICORT	182, 183	TRINTELLIX.....	167
topiramate.....	91	TRISODIUM CITRATE CRRT.....	43
toremifene.....	62	TRISTART	163
toremide.....	99	TRIUMEQ.....	66
TOSYMRA	20	TRI-VI-FLOR.....	214
TOUJEO.....	52	TRI-VI-SOL.....	214
TOXICOLOGY SALIVA COLLECTION.....	96	TRIZIVIR.....	66
TRACLEER.....	79	TROKENDI	91
tramadol.....	22, 24	TRONVITE	219
trandolapril.....	80, 82	TROPICAL LIQUID.....	214
trandolapril/verapamil.....	80	tropicamide.....	104
tranexamic	75	TROPICAMIDE-CYCLOPENTOLATE-PE	104
TRANSFER.....	68, 141, 142	TROPICAMIDE-CYCLOPENT-PE-KTRLC	104
TRANSPARENT	151	TROPICAMIDE-PHENYLEPHRINE	104
tranlycypromine.....	165	TROPIC-CYCLOPENT-PE-KTRLC-PROP	104
travoprost.....	104	tropium	195
trazodone	166	TRUDHESA	20
TRECTOR	36	true.....	198, 222, 224, 226, 230, 233
TRELEGY ELLIPTA.....	31	TRUE.....	135, 139, 155, 177, 208, 224, 230, 233
TREMFYA.....	174	TRUE COMFORT	155, 177
TRESIBA.....	52	TRUECONTROL.....	135
tretinoin.....	62, 175, 184	TRUEDRAW	135
TRETIN-X.....	184	TRUE METRIX	135
TREXALL.....	57	TRUEPLUS.....	97, 107, 140, 155, 208
TREZIX.....	22	TRUEPLUS GLUCOSE.....	107

Index of Medications

TRUEPLUS KETONE TEST STRIP.....	97	ULTRA FREEDA.....	209
T.R.U.E. TEST.....	190	ULTRALANCE.....	140, 155
TRULANCE.....	118	ULTRA PRENATAL PLUS DHA.....	163
TRULICITY.....	48	ULTRA THIN.....	153, 155
TRUMENBA.....	74	ULTRA-THIN II.....	155
TRUSOPT.....	104	ULTRA THIN PLUS.....	155
TRUSTEEL INFUSION SET.....	135	ULTRATLC.....	140, 155
T:SLIM.....	135	ULTRATRAK CONTROL.....	135
TUBERCULIN SYRINGE.....	146, 147, 148, 149	ULTRATRAK ULTIMATE.....	135
TUKYSA.....	61	ULTRAVATE X.....	183
TULIVITE.....	113	UNILET.....	135, 137, 140, 151, 153, 155, 156
TURALIO.....	61	UNISTIK.....	135, 137, 140, 141, 153, 156
TUSSICAPS.....	94	UNISTRIP.....	135
TUXARIN.....	94	UNIVERSAL.....	137, 141, 149, 152, 156
TUZISTRA.....	94	UNIVERSAL I.....	156
TWINPAK DUAL CANNULA.....	149	UNIVERSAL SYRINGE.....	149
TWINRIX.....	75	UPTRAVI.....	79, 80
TWIST.....	136, 137, 139, 140, 152, 154, 155, 179	upup.....	107
TWYNEO.....	175	URECHOLINE.....	72
TYBOST.....	185	URELLE.....	36
TYKERB.....	61	URIBEL.....	36
TYMLOS.....	127	URISTIX.....	98
TYRVAYA.....	188	UROCID-K.....	114
TYVASO.....	79	UROQID-ACID.....	114
U		URSO.....	117
UBRELVY.....	20	ursodiol.....	117
UCERIS.....	121, 124	UTIBRON NEOHALER.....	30
UDAMIN SP.....	209	V	
ULESFIA.....	64	valacyclovir.....	69
ULTANE.....	25	VALCHLOR.....	62
ULTICARE LDS SYR.....	149	VALCYTE.....	69
ULTICARE SAFETY SYRINGE.....	149	valganciclovir.....	69
ULTICARE SYRINGE.....	149	valproic.....	91
ULTICARE TB SAFETY.....	149	valsartan.....	81, 82
ULTIGUARD SAFE.....	149	valsartan/hydrochlorothiazide.....	81
ULTIGUARD SAFEPACK.....	149	VALTOCO.....	89
ULTI-LANCE.....	135	VANOCOCIN.....	41
ULTILET.....	140, 155, 177	vancomycin.....	41
ULTRA96, 134, 137, 138, 139, 140, 143, 153, 155, 163, 199, 200, 208, 209, 217, 219		VANILLA SILQ.....	97
ultra b-100.....	219	VANISHPOINT.....	149
ULTRA B-100 COMPLEX.....	219	VANOXIDE-HC.....	177
ULTRA-CARE.....	155	vardenafil.....	188
ULTRA-FINE MICRO.....	143	varenicline.....	185
ULTRA-FINE MINI.....	143	VARIBAR.....	97
ULTRA-FINE NANO.....	143	VARISOFT.....	135
ULTRA-FINE ORIGINAL.....	143	VARIVAX VACCINE.....	75
ULTRA-FINE SHORT.....	143	VARUBI.....	116
ULTRAFOAM.....	76	VASCEPA.....	114
		VASCULERA.....	197

Index of Medications

VASERETIC.....	80	vit a.....	197, 214
VASOFLEX.....	197	VITA-BEE.....	219
VASOTEC.....	82	VITABEX.....	113, 209
VAXELIS.....	75	VITAFOL.....	113, 163
VAXNEUVANCE.....	74	VITAJOY.....	209, 219, 226
VB6 P5P.....	224	VITAL-D.....	219
VB7 MAX.....	219	VITAMEDMD.....	163
VECAMYL.....	82	vitamin a.....	215
VECTICAL.....	175	VITAMIN A.....	184, 214, 215, 216, 217, 218, 219, 220, 221, 222, 223, 224, 225, 226, 227, 228, 229, 230, 231, 232, 233, 234
VELPHORO.....	108	vitamin b-12.....	218, 221, 222, 223
VELTASSA.....	108	vitamin b12.....	222, 223
VEMLIDY.....	70	VITAMIN B-12.....	221, 222, 223
VENALIV.....	197	VITAMIN B12.....	220, 223
VENCLEXTA.....	61	vitamin b complex.....	209, 215, 219, 220
venlafaxine.....	166, 167	vitamin b-complex.....	220
VENOFER.....	113	vitamin c.....	199, 200, 208, 209, 216, 220, 224, 225, 226, 227
VENTAVIS.....	80	VITAMIN C.....	215, 216, 224, 225, 226, 227
VEO INSULIN SYRINGE.....	149	vitamin d2.....	229, 231
VEOZAH.....	190	VITAMIN D2.....	231
verapamil.....	77, 78, 80	vitamin d3.....	106, 228, 229, 230, 231, 232
VERELAN.....	78	VITAMIN D3.....	209, 227, 228, 229, 231, 232
VERIFINE.....	141	VITAMIN D3-ALOE.....	209
VERQUVO.....	78	vitamin e.....	232, 233
VERSACLOZ.....	171	VITAMIN E.....	232, 233, 234
VERTIGOHEEL.....	190	VITAMIN K.....	234
VERZENIO.....	61	VITAMIN K2.....	234
VEVYE.....	105	vitamins a and d.....	209
VFEND.....	45	VITAMINS A D.....	215
V-GO.....	135	VITAMINS A-D-E.....	209
VIAGRA.....	188	VITAPEARL.....	163
VIBERZI.....	118	VITA-RESPA.....	220
VIBRAMYCIN.....	40	VITASURE.....	220
VICTOZA.....	48	VITATRUE.....	164
vigabatrin.....	91	vit a/vit c/vit e/zinc/copper.....	197
VIGADRONE.....	91	vit b.....	217, 218, 219, 221
VIGAMOX.....	35	VIT B-12.....	202, 221, 222
VIJOICE.....	186	vit b12/levomefolate/vit b6/b2.....	216, 219
VIOKACE.....	120	vit c-rose hip.....	224, 225, 226
VIRACEPT.....	68	vit c-rose hips.....	224, 225, 226
VIRAMUNE.....	67	VIT C-ROSE HIPS.....	226
VIREAD.....	67, 68	vit d3.....	214, 228, 229, 231
VIRT-CAPS.....	219	VIT D3 5,000 UNIT FAST DISSOLV.....	231
virt-fefa plus.....	113	VITRAKVI.....	61
VIRT-FEFA PLUS.....	113	VITREXYL.....	209
VISION FORMULA.....	196	VITRON-C.....	113
VISION PLUS.....	198	VITRUM 50.....	209
VISTA ADVANCED AREDS2.....	196	vits a,c,e/lutein/minerals.....	197
VISTARIL.....	48	VIVAGUARD.....	135, 141, 156
VISTOGARD.....	187		

Index of Medications

VIVJOA.....	46	XCELLENT.....	227, 234
VIZIMPRO.....	61	XCELLENT C.....	227
VOGELXO.....	122	XCOPRI.....	91, 92
VOLUMEN.....	97	XDEMVI.....	63
VONJO.....	61	XELJANZ.....	27
VOQUEZNA.....	120	XELODA.....	57
voriconazole.....	45, 46	XENICAL.....	63
VORTEX.....	158	XENLETA.....	39
VOSEVI.....	70	XENON XE-I33.....	97
VOTRIENT.....	61	XEPI.....	42
VOWST.....	118	XERMELO.....	115
VOXZOGO.....	191	XHANCE.....	100
VP-PNV-DHA.....	164	XIFAXAN.....	39
v-r alcohol prep pads.....	177	XIGDUO.....	51
VRAYLAR.....	171	XIIDRA.....	105
VRAYLAR 1.5 MG CAPSULE.....	171	XOFLUZA.....	69
v-r cod liver oil capsule.....	232	XOLAIR.....	32
v-r vitamin c.....	227	XOPENEX.....	30
VTAMA.....	175	XOSPATA.....	61
VUMERITY.....	88	XTANDI.....	56
VYLEESI.....	169	XURIDEN.....	108
VYNDAMAX.....	191	XVITE.....	220
VYNDAQEL.....	191	XYOSTED.....	122
VYVANSE.....	168	XYREM.....	172
VYZULTA.....	104	XYWAV.....	172
W		XYZBAC.....	209
WAKIX.....	92	Y	
water.....	174	YALE.....	143
WAVESENSE.....	135	YAZ.....	93
WEBCOL.....	177	YUPELRI.....	29
WEGOVI.....	63	Z	
WELIREG.....	61	zafirlukast.....	32
WELLESSE.....	209	zaleplon.....	173
WEST-VITE.....	220	ZANAFLEX.....	159
WHEAT GERM.....	234	ZARONTIN.....	92
WINDOW BANDAGES.....	151	ZCORT.....	124
WOMEN 50 PLUS MULTIVIT ADVANCE.....	209	ZEJULA.....	61
WOMEN'S 50.....	199, 206, 207, 209	ZELBORAF.....	57
women's daily.....	209	ZELDANA.....	220
WOMEN'S DAILY.....	209	ZEMBRACE SYMTOUCH.....	20
WOMENS DAILY GUMMIES.....	209	ZEMPLAR.....	189
WOMEN'S MULTIVITAMIN.....	206, 209	ZENPEP.....	120
WOMEN'S PRENATAL PLUS DHA.....	164	zenzedi.....	72
WYNZORA.....	184	ZENZEDI.....	72
X		ZEPATIER.....	70
XACIATO.....	40	ZEPBOUND.....	63
XALKORI.....	61	ZEPOSIA.....	88, 89
XAQUIL.....	198	ZESTORETIC.....	80
XARELTO.....	43	ZESTRIL.....	82

Index of Medications

ZIAC.....	84	ZONTIVITY.....	65
ZIAGEN.....	67	ZOO FRIENDS.....	214
ZIANA.....	175	ZORBTIVE.....	125
zidovudine.....	66, 67	ZORTRESS.....	128
ZIEXTENZO.....	92	ZORYVE.....	175, 179
zileuton.....	29	ZOVIRAX.....	69, 70
zinc oxide.....	178	ZTALMY.....	172
ZINC OXIDE PASTE.....	178	ZTLIDO.....	25
ZINC PLUS.....	227	ZUBSOLV.....	194
ziprasidone.....	170, 171	ZUPLENZ.....	116
ZIRGAN.....	69	ZURZUVAE.....	164
ZITHROMAX.....	38	ZYDELIG.....	61
ZODRYL AC.....	94, 95	ZYFLO.....	29
ZODRYL DAC.....	94	ZYKADIA.....	61
ZODRYL DEC.....	95	ZYLOPRIM.....	26
ZOKINVY.....	186	ZYMAXID.....	35
ZOLINZA.....	55	ZYPITAMAG.....	85
zolmitriptan.....	20	ZYPREXA.....	171
zolpidem.....	173	ZYVANA.....	209
ZOMIG.....	20	ZYVIT.....	209
ZONALON.....	175	ZYVOX.....	38
zonisamide.....	92		

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

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



1. App/online store terms and mobile phone carrier/data charges apply. Customers under age 13 (and/or their parent/guardian) will not be able to register at myCigna.com.
2. Prices shown on myCigna are not guaranteed and coverage is subject to your plan terms and conditions. Visit myCigna for more information.
3. U.S. Food and Drug Administration (FDA) website, "Generic 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).
4. Not all plans offer Express Scripts® Pharmacy and Accredo as covered pharmacy options. Log in to the myCigna App or myCigna.com, or check your plan materials, to learn more about the pharmacies in your plan's network. Cigna Healthcare maintains an ownership interest in Express Scripts® Pharmacy's home delivery services and Accredo's specialty pharmacy services. However, you have the right to fill prescriptions at any pharmacy in your plan's network. You won't be penalized. Standard shipping costs are included as part of your prescription plan.
5. Standard shipping costs are included as part of your prescription plan.
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 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. 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).