



Cigna Healthcare Performance 4-Tier Prescription Drug List

Coverage as of July 1, 2024

For the State of California

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

View your drug list online: Cigna.com/PDL

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

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

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 This drug list is subject to change and all prior versions are no longer in effect.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

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View your drug list online

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

- **myCigna® 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/PDL.** Scroll down to the "California Employer Drug Lists" section. Under Cigna Performance Prescription Drug List, click on the pdf named **California Performance 4 Tier (all specialty medications covered on tier 4).**

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 01/01/2004

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

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

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

If your medication isn't approved, your doctor can send us more information to review, using the same process as before. We're happy to review the request again. Depending on what your doctor sends this time, we may be able to approve coverage. Or, you and your doctor can appeal the decision by sending Cigna Healthcare a written request explaining why the medication should be covered.

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

Information about this drug list

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

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 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,

Information about this drug list

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

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.

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

Information about this drug list

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

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
- 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**.

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.

Information about this drug list

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

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** to learn more about Accredo or call 877.826.7657, Monday–Friday, 7:00 am–10:00 pm CST and Saturdays, 7:00 am–4:00 pm CST.

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

A. You can use the online tools and resources on the **myCigna App** or **myCigna.com** to help you better understand your pharmacy coverage. You can find out how much your medication costs, see which medications your plan covers, find an in-network pharmacy, ask a pharmacist a question, see your pharmacy claims and coverage details and more. You can also manage your Express Scripts® Pharmacy orders.

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

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

are three places you can go to find out how much you'll pay for your medication based on the tier it's listed in, including the maximum cost-share amount allowed:

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

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

A. Some medications are covered under the pharmacy benefit, some are covered under the medical benefit, and others are covered under both benefits. Typically, medications that are injected or infused are covered under the medical benefit. These are given to you at a doctor's office, an infusion center or at home. Typically, medications that you take yourself and can be filled at a retail pharmacy or through home delivery are covered under the pharmacy benefit. Check your medical summary of benefits coverage to learn more about how your plan covers these medications.

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

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

- **For copay plans:** These medications will be covered at 100%, or no cost-share (\$0) to you.
- **For high deductible health plans (HDHPs) that include a Health Savings Account (HSA) or qualified HDHPs:** You'll pay your plan deductible first. After that, these medications will be covered at 100%, or no cost-share (\$0) to you.

Information about this drug list

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

This is because of a federal HSA requirement.

- **For plans with a combined deductible [including Health Reimbursements Accounts (HRAs) with a combined deductible]:** You'll pay your plan deductible first. After that, these medications will be covered at 100%, or no cost-share (\$0) to you.
- **For plans with a split deductible [including Health Reimbursements Accounts (HRAs) with a split deductible]:** These medications will be covered at 100%, or no cost-share (\$0) to you.

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

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

- **Preventive care medications and products covered under the Patient Protection and Affordable Care Act (PPACA), also known as “health care reform:”**
 - **Contraceptives:** Covered at 100%, or no cost-share (\$0) to you. Certain prescription contraceptives are available at their applicable cost-share.
 - **Tobacco cessation products:** Up to two (2) 90-day courses of treatment per plan year are covered at 100%, or no cost-share (\$0) to you. Certain prescription tobacco cessation products are available at their applicable cost-share.
 - **Certain vitamins:** Covered at 100%, or no cost-share (\$0) to you. All other prescription vitamins are available at their applicable cost-share and deductible (if applicable).

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

Words you may need to know

- **Brand name drug:** A drug that is marketed under a proprietary, trademark-protected name. A brand name drug is listed in this formulary in all CAPITAL letters.
- **Coinsurance:** A percentage of the cost of a covered health care benefit that you pay after

you have paid the deductible, if a deductible applies to the health care benefit.

- **Copayment:** A fixed dollar amount that you pay for a covered health care benefit after you have paid the deductible, if a deductible applies to the health care benefit.

Information about this drug list

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

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

Information about this drug list

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

- **Age Requirements:** For certain medications, you must be within a specific age range for your plan to cover them. This is because some medications aren't considered clinically appropriate for individuals who aren't within that age range.

About this drug list

This is a list of the most commonly prescribed medications covered on the Cigna Healthcare Performance 4-Tier Prescription Drug List as of July 1, 2024. Medications are listed alphabetically by their generic and brand names within their therapeutic category and class.

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

How to read this drug list

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

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

Tiers

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

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

* 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 Performance 4-Tier Prescription Drug List.

ANALGESICS (Pain Relief and Inflammatory Disease)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ANALGESIC, NON-SALICYLATE AND BARBITURATE COMBINAT		
<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 Performance 4-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)	18-22	Anti-Infectives/Miscellaneous (Feminine Products)	45
Analgesics (Urinary Tract Conditions)	22	Anti-Infectives/Miscellaneous (Infections)	45, 46
Anesthetics (Miscellaneous)	23	Anti-Infectives/Miscellaneous (Miscellaneous)	46
Anesthetics (Pain Relief and Inflammatory Disease)	23	Anti-Infectives/Miscellaneous (Skin Conditions)	46
Anesthetics (Urinary Tract Conditions)	23	Anti-Inflammatory Tumor Necrosis Factor Inhibiting Agents (Pain Relief and Inflammatory Disease)	47
Anti-Allergy (Allergy and Nasal Sprays)	23	Anti-Neoplastics (Cancer)	48-54
Anti-Arthritics (Pain Relief and Inflammatory Disease)	24, 25	Anti-Neoplastics (Skin Conditions)	54
Anti-Asthmatics (Asthma/COPD/Respiratory)	25-29	Anti-Obesity Drugs (Weight Management)	54, 55
Antibiotics (Allergy/Nasal Sprays)	29	Anti-Parasitics (Infections)	55
Antibiotics (Ear Medications)	30	Anti-Parkinson's Drugs (Parkinson's Disease)	55-57
Antibiotics (Eye Conditions)	30, 31	Anti-Platelet Drugs (Blood Thinners/Anti-Clotting)	57
Antibiotics (Infections)	31-36	Antivirals (AIDS/HIV)	57-59
Antibiotics (Skin Conditions)	36, 37	Antivirals (Eye Conditions)	60
Anti-Coagulants (Blood Thinners/Anti-Clotting)	37-39	Antivirals (Infections)	60, 61
Antidotes (Gastrointestinal/Heartburn)	39	Antivirals (Skin Conditions)	62
Antidotes (Substance Abuse)	39	Autonomic Drugs (Allergy/Nasal Sprays)	62
Anti-Fungals (Eye Conditions)	39	Autonomic Drugs (Alzheimer's Disease)	62
Anti-Fungals (Feminine Products)	39	Autonomic Drugs (Attention Deficit Hyperactivity Disorder)	62, 63
Anti-Fungals (Infections)	40	Autonomic Drugs (Blood Pressure/Heart Medications)	64
Anti-Fungals (Skin Conditions)	40, 41	Autonomic Drugs (Urinary Tract Conditions)	64
Antihistamine and Decongestant Combination (Allergy/Nasal Sprays)	41	Biologicals (Allergy/Nasal Sprays)	634
Antihistamines (Allergy/Nasal Sprays)	41	Biologicals (Blood Pressure/Heart Medications)	64
Antihistamines (Eye Conditions)	41	Biologicals (Miscellaneous)	64
Anti-Hyperglycemics (Diabetes)	42-45	Biologicals (Vaccines)	65, 66
Anti-Infectives (Feminine Products)	45	Blood (Blood Modifiers/Bleeding Disorders)	66-68
Anti-Infectives (Infections)	45	Blood (Blood Thinners/Anti-Clotting)	68

Information about this drug list

How to find your medication *(cont.)*

Condition	Page	Condition	Page
Cardiac Drugs (Blood Pressure/Heart Medications)	68-70	Gastrointestinal (Pain Relief and Inflammatory Disease)	103
Cardiovascular (Allergy/Nasal Sprays)	71	Hormones (Hormonal Agents)	103-108
Cardiovascular (Asthma/COPD/Respiratory)	71	Hormones (Infertility)	108, 109
Cardiovascular (Blood Pressure/Heart Medications)	71-77	Hormones (Miscellaneous)	109
Cardiovascular (Cholesterol Medications)	77-80	Hormones (Osteoporosis Products)	109
Cardiovascular (Miscellaneous)	80	Immunosuppressants (Pain Relief and Inflammatory Disease)	109, 110
CNS Drugs (Alzheimer's Disease)	80	Immunosuppressants (Skin Conditions)	110
CNS Drugs (Miscellaneous)	81	Immunosuppressants (Transplant Medications)	110, 111
CNS Drugs (Multiple Sclerosis)	81, 82	Miscellaneous Medical Supplies, Devices, Non-Drug (Diabetes)	111, 122
CNS Drugs (Pain Relief and Inflammatory Disease)	82	Miscellaneous Medical Supplies, Devices, Non-Drug (Miscellaneous)	123-127
CNS Drugs (Seizure Disorders)	82-85	Muscle Relaxants (Pain Relief and Inflammatory Disease)	127
CNS Drugs (Sleep Disorders/Sedatives)	85	Prenatal Vitamins (Nutritional/Dietary)	128
Colony Stimulating Factors (Blood Modifiers/Bleeding Disorders)	85	Psychotherapeutic Drugs (Anxiety/Depression/Bipolar Disorder)	128-132
Colony Stimulating Factors (Cancer)	86	Psychotherapeutic Drugs (Attention Deficit Hyperactivity Disorder)	132-134
Contraceptives (Contraception Products)	86-88	Psychotherapeutic Drugs (Miscellaneous)	121
Cough/Cold Preparations (Allergy/Nasal Sprays)	88	Psychotherapeutic Drugs (Schizophrenia/Anti-Psychotics)	134-137
Cough/Cold Preparations (Cough/Cold Medications)	88	Psychotherapeutic Drugs (Sleep Disorders/Sedatives)	137, 138
Diagnostic (Miscellaneous)	89, 90	Skin Preps (Miscellaneous)	138
Diuretics (Diuretics)	90, 91	Skin Preps (Pain Relief and Inflammatory Disease)	139
EENT Preps (Allergy/Nasal Sprays)	91	Skin Preps (Skin Conditions)	140-145
EENT Preps (Ear Medications)	92	Smoking Deterrents (Smoking Cessation)	146
EENT Preps (Eye Conditions)	92-95	Thyroid Prep (Hormonal Agents)	146
Elect/Caloric/H2O (Cholesterol Medications)	95	Unclassified Drug Products (AIDS/HIV)	146
Elect/Caloric/H2O (Dental Products)	95	Unclassified Drug Products (Asthma/COPD/Respiratory)	147
Elect/Caloric/H2O (Diabetes)	95	Unclassified Drug Products (Blood Modifiers/Bleeding Disorders)	147
Elect/Caloric/H2O (Miscellaneous)	95	Unclassified Drug Products (Blood Pressure/Heart Medications)	147, 148
Elect/Caloric/H2O (Nutritional/Dietary)	96, 97		
Gastrointestinal (Cholesterol Medications)	97		
Gastrointestinal (Gastrointestinal/Heartburn)	97-103		

Information about this drug list

How to find your medication *(cont.)*

Condition	Page	Condition	Page
Unclassified Drug Products (Cancer)	148	Unclassified Drug Products (Pain Relief and Inflammatory Disease)	152
Unclassified Drug Products (Dental Products)	148	Unclassified Drug Products (Substance Abuse)	153
Unclassified Drug Products (Erectile Dysfunction)	148, 149	Unclassified Drug Products (Transplant Medications)	153
Unclassified Drug Products (Gastrointestinal/Heartburn)	150	Unclassified Drug Products (Urinary Tract Conditions)	153, 154
Unclassified Drug Products (Hormonal Agents)	149	Unclassified Drug Products (Weight Management)	154
Unclassified Drug Products (Miscellaneous)	149-152	Vitamins (Nutritional/Dietary)	154, 155
Unclassified Drug Products (Osteoporosis Products)	152		

List of Prescription Medications

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

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

T4 – Specialty Medications
 PA – Prior Authorization
 QL – Quantity Limit

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

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

List of Prescription Medications

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

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

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

T4 – Specialty Medications

PA – Prior Authorization

QL – Quantity Limit

ST – Step Therapy

AGE – Age Requirement

SP – Specialty Medication

HD – May require home delivery pharmacy

PPACA – No Cost-Share Preventive Medication

CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

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

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
OPIOID ANALGESIC AND NON-SALICYLATE ANALGESICS (cont.)		
<i>acetaminop-codeine 120-12 mg/5</i>	T1	
<i>acetaminophen-cod #2 tablet</i>	T1	PA
<i>acetaminophen-cod #3 tablet</i>	T1	PA
<i>acetaminophen-cod #4 tablet</i>	T1	PA
APADAZ	T3	
BENZHYDROCODONE-ACETAMINOPHEN	T1	
<i>hydrocodone/acetaminophen</i>	T1	PA
<i>hydrocodone/acetaminophen (Hydrocodone-acetaminophen)</i>	T1	PA
<i>hydrocodone/acetaminophen (Norco)</i>	T1	PA
HYDROCODONE-ACETAMINOPHEN	T1	PA
LORTAB	T1	PA
NALOCET	T1	PA
NORCO (<i>lorcet hd</i>)	T3	PA
NORCO (<i>lorcet plus</i>)	T3	PA
NORCO (<i>lorcet</i>)	T3	PA
<i>oxycodone hcl/acetaminophen (Nalocet)</i>	T1	PA
<i>oxycodone hcl/acetaminophen (Percocet)</i>	T1	PA
<i>oxycodone hcl/acetaminophen (Primlev)</i>	T1	PA
PERCOCET (<i>oxycodone-acetaminophen</i>)	T3	PA
PRIMLEV	T1	PA
<i>tramadol hcl/acetaminophen (Ultracet)</i>	T1	
ULTRACET (<i>tramadol hcl-acetaminophen</i>)	T3	
OPIOID ANALGESIC AND NSAID COMBINATION		
<i>hydrocodone/ibuprofen</i>	T1	PA
<i>hydrocodone/ibuprofen (Ibudone)</i>	T1	PA
IBUDONE	T1	PA
<i>ibuprofen/oxycodone hcl</i>	T1	PA
OPIOID ANALGESIC AND SALICYLATE ANALGESIC COMB		
<i>oxycodone hcl/aspirin</i>	T1	PA
OPIOID ANALGESIC AND NON-SALICYLATE XANTHINE COMB		
ACETAMIN-CAFF-DIHYDROCODEINE	T1	PA
<i>acetaminophen/caff/dihydrocod (Acetamin-caff-dihydrocodeine)</i>	T1	PA
<i>acetaminophen/caff/dihydrocod (Trezix)</i>	T1	PA
TREZIX	T3	PA
OPIOID ANALGESICS		
ACTIQ (<i>fentanyl citrate</i>)	T3	PA

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

T4 – Specialty Medications
PA – Prior Authorization
QL – Quantity Limit

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

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

List of Prescription Medications

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

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
OPIOID ANALGESICS (cont.)		
ARYMO ER	T3	PA
BELBUCA	T2	QL (2 films/day)
<i>buprenorphine</i> (Butrans)	T1	QL (4 patches/28 days)
<i>butorphanol tartrate</i>	T1	PA QL (6 bots/30 days)
BUTRANS (buprenorphine)	T3	QL (4 patches/28 days)
<i>codeine sulfate</i>	T1	PA
DILAUDID 2 MG TABLET (<i>hydromorphone hcl</i>)	T3	PA
DILAUDID 4 MG TABLET (<i>hydromorphone hcl</i>)	T3	PA
DILAUDID 5 MG/5 ML ORAL LIQUID (<i>hydromorphone hcl</i>)	T3	PA
DILAUDID 8 MG TABLET (<i>hydromorphone hcl</i>)	T3	PA
DURAGESIC (<i>fentanyl</i>)	T3	PA
<i>fentanyl</i>	T1	PA
<i>fentanyl</i> (Duragesic)	T1	PA
FENTANYL 25 MCG/0.5 ML SYRINGE	T3	PA
<i>fentanyl 1,000mcg/50-0.9% nacl</i>	T1	
FENTANYL CITRATE	T1	PA
<i>fentanyl citrate</i> (Actiq)	T1	PA
FENTORA	T3	PA
<i>hydrocodone bitartrate</i> (Hysingla Er)	T1	PA
<i>hydrocodone bitartrate</i> (Zohydro Er)	T1	PA
HYDROMORPHONE 0.25 MG/0.5 ML	T3	PA
<i>hydromorphone hcl</i>	T1	PA
<i>hydromorphone hcl</i> (Dilaudid)	T1	PA
HYSINGLA ER (<i>hydrocodone bitartrate er</i>)	T2	PA
KADIAN (<i>morphine sulfate er</i>)	T3	PA
LAZANDA	T3	PA
<i>meperidine hcl</i>	T1	PA
<i>methadone hcl</i>	T1	PA
MORPHABOND ER	T2	PA
<i>morphine sulfate</i>	T1	PA
<i>morphine sulf 1,000 mg/20 ml</i>	T1	PA
<i>morphine sulfate</i> (Kadian)	T1	PA
<i>morphine sulfate</i> (Ms Contin)	T1	PA
MS CONTIN (<i>morphine sulfate er</i>)	T3	PA
NUCYNTA	T2	PA

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

T4 – Specialty Medications
 PA – Prior Authorization
 QL – Quantity Limit

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

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

List of Prescription Medications

ANALGESICS (Pain Relief and Inflammatory Disease) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
OPIOID ANALGESICS (cont.)		
NUCYNTA	T2	PA
NUCYNTA ER	T3	PA
<i>opium/belladonna alkaloids</i>	T1	PA
OXAYDO	T3	PA
<i>oxycodone hcl</i>	T1	PA
OXYCODONE HCL ER	T1	PA
<i>oxymorphone hcl</i>	T1	PA
<i>pentazocine hcl/naloxone hcl</i>	T1	PA
ROXYBOND	T3	PA
<i>tramadol er 100 mg tablet</i>	T1	QL (1 tab/day)
<i>tramadol er 200 mg tablet</i>	T1	QL (1 tab/day)
<i>tramadol er 300 mg tablet</i>	T1	QL (1 tab/day)
tramadol hcl (Ultram)	T1	QL (8 tabs/day)
TRAMADOL HCL ER 100 MG CAPSULE	T1	QL (1 cap/day)
<i>tramadol hcl er 100 mg tablet</i>	T1	QL (1 tab/day)
TRAMADOL HCL ER 150 MG CAPSULE	T1	QL (1 cap/day)
TRAMADOL HCL ER 200 MG CAPSULE	T1	QL (1 cap/day)
<i>tramadol hcl er 200 mg tablet</i>	T1	QL (1 tab/day)
TRAMADOL HCL ER 300 MG CAPSULE	T1	QL (1 cap/day)
<i>tramadol hcl er 300 mg tablet</i>	T1	QL (1 tab/day)
ULTRAM (<i>tramadol hcl</i>)	T3	QL (8 tabs/day)
XTAMPZA ER	T2	PA
ZOXYDOL ER (<i>hydrocodone bitartrate er</i>)	T3	PA
OPIOID AND SALICYLATE ANALGESICS, BARBIT, XANTHINE		
<i>codeine/butalbital/asa/caffeine</i> (Fiorinal With Codeine #3)	T1	PA
FIORINAL WITH CODEINE #3 (<i>butalbital compound-codeine</i>)	T3	PA
OPIOID, NON-SALICYL. ANALGESIC, BARBITUATE, XANTHINE		
<i>butalbital/acetamin/caff/codeine</i>	T1	PA
<i>butalbital/acetamin/caff/codeine</i> (Fioricet With Codeine)	T1	PA
FIORICET WITH CODEINE (<i>butalb-<i>acetaminoph-caff-codein</i></i>)	T3	PA
SKELETAL MUSCLE RELAXANT, SALICYLATE, OPIOID ANALGESICS		
<i>carisoprodol/aspirin/codeine</i>	T1	PA
ANALGESICS (Urinary Tract Conditions)		
URINARY TRACT ANALGESIC AGENTS		
ELMIRON	T2	
RIMSO-50	T2	
T1 – Typically Generics	T4 – Specialty Medications	ST – Step Therapy
T2 – Typically Preferred Brands	PA – Prior Authorization	AGE – Age Requirement
T3 – Typically Non-Preferred Brands	QL – Quantity Limit	SP – Specialty Medication
		HD – May require home delivery pharmacy
		PPACA – No Cost-Share Preventive Medication
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List of Prescription Medications

ANESTHETICS (Miscellaneous)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
GENERAL ANESTHETICS, INHALANT		
<i>desflurane</i> (Suprane)	T1	
<i>isoflurane</i>	T1	
<i>isoflurane</i>	T3	
<i>sevoflurane</i> (Ultane)	T1	
SUPRANE	T3	
ULTANE (<i>sevoflurane</i>)	T3	
<i>lidocaine</i> (Lidocan li)	T1	
<i>lidocaine</i> (Lidoderm)	T1	
<i>lidocaine hcl</i>	T1	
ANESTHETICS (Pain Relief and Inflammatory Disease)		
LOCAL ANESTHETICS		
<i>lidocaine hcl</i> 2% 200 mg/10 ml (Xylocaine-Mpf)	T1	
<i>lidocaine hcl</i> 4% 200 mg/5 ml	T1	
TOPICAL LOCAL ANESTHETICS		
L.E.T. (LIDO-EPINEPH-TETRA)	T3	
<i>lidocaine</i> 5% ointment	T1	QL (145gm/30 days)
<i>lidocaine</i> 5% patch (Lidocan li)	T1	
<i>lidocaine</i> 5% patch (Lidoderm)	T1	
<i>lidocaine hcl</i>	T1	
<i>lidocaine hcl</i>	T3	
<i>lidocaine/prilocaine</i>	T1	
LIDODERM (<i>lidocaine</i>)	T3	
PAIN EASE MEDIUM STREAM SPRAY	T3	
SYNERA	T3	
ZTLIDO	T2	
ANESTHETICS (Urinary Tract Conditions)		
URINARY TRACT ANESTHETIC/ANALGESIC AGNT (AZO-DYE)		
<i>phenazopyridine hcl</i> (Pyridium)	T1	
PYRIDIUM (<i>phenazopyridine hcl</i>)	T3	
ANTI-ALLERGY (Allergy/Nasal Sprays)		
MAST CELL STABILIZERS		
<i>cromolyn</i> 100 mg/5 ml oral conc (Gastrocrom)	T1	
GASTROCROM (<i>cromolyn sodium</i>)	T3	

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

T4 – Specialty Medications
 PA – Prior Authorization
 QL – Quantity Limit

ST – Step Therapy
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List of Prescription Medications

ANTI-ARTHRITICS (Pain Relief and Inflammatory Disease) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ANALGESIC/ANTIPIRETICS, SALICYLATES		
DISALCID (<i>salsalate</i>)	T3	HD
<i>salsalate</i> (Disalcid)	T1	HD
ANTI-ARTHRITIC AND CHELATING AGENTS		
DEPEN (<i>penicillamine</i>)	T4	PA SP
<i>penicillamine</i>	T4	PA SP
penicillamine (Depen)	T4	PA SP
ANTI-ARTHRITIC, FOLATE ANTAGONIST AGENTS		
OTREXUP	T2	PA
ANTI-INFLAM. INTERLEUKIN-I RECEPTOR ANTAGONIST		
KINERET	T4	PA QL (28 syringes/28 days) SP
ANTI-INFLAMMATORY/ANTIARTHRITICS AGENTS, MISC.		
GEL-ONE	T4	PA SP HD
GENVISC 850	T4	PA SP
SUPARTZ FX	T4	PA SP HD
TRIVISC	T4	PA SP
VISCO-3	T4	PA SP HD
ANTI-INFLAMMATORY, PYRIMIDINE SYNTHESIS INHIBITOR		
ARAVA (<i>leflunomide</i>)	T3	HD
<i>leflunomide</i> (Arava)	T1	HD
ANTI-INFLAMMATORY, PHOSPHODIESTERASE-4(PDE4) INHIB.		
OTEZLA 28 DAY STARTER PACK	T4	PA QL (1 pack/180 days) SP HD
OTEZLA 30 MG TABLET	T4	PA QL (2 tabs/day) SP HD
ANTI-INFLAMMATORY, SEL.COSTIM.MOD., T-CELL INHIBITOR		
ORENCIA	T4	PA QL (4 syringes/28 days) SP HD
ORENCIA CLICKJECT	T4	PA QL (4 injectors/28 days) SP HD
COLCHICINE		
<i>colchicine 0.6 mg capsule</i>	T1	HD
<i>colchicine</i> (Colcrys)	T1	HD
COLCRYS (<i>colchicine</i>)	T3	HD
MITIGARE	T3	HD
MITIGARE (<i>colchicine</i>)	T2	HD
GOLD SALTS		
RIDAURA	T2	

T1 – Typically Generics
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List of Prescription Medications

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

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
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HYPERURICEMIA TX - XANTHINE OXIDASE INHIBITORS

<i>allopurinol</i> (Zyloprim)	T1	HD
<i>febuxostat 40 mg tablet</i> (Uloric)	T1	QL (1 tab/day) HD
<i>febuxostat 80 mg tablet</i> (Uloric)	T1	HD
ULORIC 40 MG TABLET (<i>febuxostat</i>)	T3	QL (1 tab/day) HD
ULORIC 80 MG TABLET (<i>febuxostat</i>)	T3	HD
ZYLOPRIM (<i>allopurinol</i>)	T3	HD

JANUS KINASE (JAK) INHIBITORS

CIBINQO	T4	PA QL (30 tabs/30 days) SP
LITFULO	T4	PA QL(1 cap/day) SP HD
OLUMIANT	T4	PA QL (1 tab/day) SP HD
RINVOQ	T4	PA QL (1 tab/day) SP HD
XELJANZ 1 MG/ML SOLUTION	T4	PA QL (480ml/22 days) SP HD
XELJANZ 10 MG TABLET	T4	PA QL (2 tabs/day) SP HD
XELJANZ 5 MG TABLET	T4	PA QL (2 tabs/day) SP HD
XELJANZ XR	T4	PA QL (1 tab/day) SP HD

ANTI-ASTHMATICS (Asthma/COPD/Respiratory)

NSAIDS (COX NON-SPEC.INHIB) AND PROSTAGLANDIN ANALOG

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

NSAIDS, CYCLOOXYGENASE INHIBITOR - TYPE ANALGESICS

ANAPROX DS (<i>naproxen sodium ds</i>)	T3	ST HD
DAYPRO (<i>oxaprozin</i>)	T3	ST HD
<i>diclofenac sod dr 25 mg tab</i>	T1	HD
<i>diclofenac sod dr 50 mg tab</i>	T1	HD
<i>diclofenac sod dr 75 mg tab</i>	T1	HD
<i>diclofenac sod ec 25 mg tab</i>	T1	HD
<i>diclofenac sod ec 50 mg tab</i>	T1	HD
<i>diclofenac sod ec 75 mg tab</i>	T1	HD
<i>diclofenac sodium</i>	T1	HD
EC-NAPROSYN (<i>naproxen</i>)	T3	ST HD
<i>etodolac</i>	T1	HD
<i>etodolac</i> (Lodine)	T1	HD
FELDENE (<i>piroxicam</i>)	T3	ST HD
<i>fenoprofen calcium</i> (Nalfon)	T1	HD

T1 – Typically Generics
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T4 – Specialty Medications
 PA – Prior Authorization
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 AGE – Age Requirement
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HD – May require home delivery pharmacy
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List of Prescription Medications

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

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
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NSAIDS, CYCLOOXYGENASE INHIBITOR - TYPE ANALGESICS (cont.)

<i>flurbiprofen</i>	T1	HD
<i>ibuprofen</i>	T1	HD
<i>indomethacin</i>	T1	HD
<i>ketoprofen 25 mg, 75 mg capsule</i>	T1	HD
LODINE (<i>etodolac</i>)	T3	ST HD
<i>meclofenamate sodium</i>	T1	HD
<i>meloxicam</i> (Mobic)	T1	HD
MOBIC (<i>meloxicam</i>)	T3	ST HD
<i>nabumetone</i>	T1	HD
NALFON 600 MG TABLET (<i>profeno</i>)	T1	ST HD
NAPROSYN TABLET (<i>naproxen</i>)	T3	ST HD
<i>naproxen tablet</i>	T1	HD
<i>naproxen</i> (Ec-naprosyn)	T1	HD
<i>naproxen</i> (Naprosyn)	T1	HD
<i>naproxen sodium</i> (Anaprox Ds)	T1	HD
<i>oxaprozin 600 mg caplet</i> (Daypro)	T1	HD
<i>oxaprozin 600 mg tablet</i> (Daypro)	T1	HD
OXAPROZIN 300 MG CAPSULE	T3	HD
<i>piroxicam</i> (Feldene)	T1	HD
QMIIZ ODT 15 MG TABLET	T3	ST HD
QMIIZ ODT 7.5 MG TABLET	T3	QL (1 tab/day) ST HD
<i>sulindac</i>	T1	HD
<i>tolmetin sodium</i>	T1	HD

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

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

URICOSURIC AGENTS

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

5-LIPOXYGENASE INHIBITORS

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

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

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ANTICHOLINERGICS, ORALLY INHALED LONG ACTING		
INCRUSE ELLIPTA	T2	HD
LONHALA MAGNAIR REFILL	T3	PA HD
LONHALA MAGNAIR STARTER	T3	PA HD
SPIRIVA RESPIMAT	T2	HD
ANTICHOLINERGICS, ORALLY INHALED SHORT ACTING		
ATROVENT HFA	T2	HD
<i>ipratropium bromide</i>	T1	HD
BETA-ADRENERGIC AGENTS		
<i>albuterol sulf 2 mg/5 ml syrup</i>	T1	HD
<i>albuterol sulfate 2 mg tab</i>	T1	HD
<i>albuterol sulfate 4 mg tab</i>	T1	HD
<i>albuterol sulfate er 4 mg tab</i>	T1	HD
<i>albuterol sulfate er 8 mg tab</i>	T1	HD
<i>metaproterenol sulfate</i>	T1	HD
<i>terbutaline sulfate</i>	T1	HD
BETA-ADRENERGIC AGENTS, INHALED, SHORT ACTING		
<i>albuterol 15 mg/3 ml solution</i>	T1	
<i>albuterol 75 mg/15 ml soln</i>	T1	
<i>albuterol 100 mg/20 ml soln</i>	T1	
<i>albuterol 2.5 mg/0.5 ml sol</i>	T1	
<i>albuterol 5 mg/ml solution</i>	T1	
<i>albuterol sul 0.63 mg/3 ml sol</i>	T1	
<i>albuterol sul 1.25 mg/3 ml sol</i>	T1	
<i>albuterol sul 2.5 mg/3 ml soln</i>	T1	
<i>albuterol sulfate (Albuterol Sulfate Hfa)</i>	T1	QL (18gm/30 days)
ALBUTEROL SULFATE HFA	T1	QL (18gm/30 days)
<i>levalbuterol hcl (Xopenex Concentrate)</i>	T1	
<i>levalbuterol hcl (Xopenex)</i>	T1	
XOPENEX (<i>levalbuterol hcl</i>)	T3	
XOPENEX CONCENTRATE (<i>levalbuterol concentrate</i>)	T3	
BETA-ADRENERGIC AGENTS, INHALED, ULTRA-LONG ACTING		
ARCAPTA NEOHALER	T3	HD
STRIVERDI RESPIMAT	T2	QL(1 inhaler/30 days) HD
BETA-ADRENERGIC AGENTS, ORALLY INHALED, LONG ACTING		
SEREVENT DISKUS	T2	HD

T1 – Typically Generics
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T4 – Specialty Medications
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 AGE – Age Requirement
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List of Prescription Medications

ANTI-ASTHMATICS (Asthma/COPD/Respiratory) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
BETA-ADRENERGIC AND ANTICHOLINERGIC COMBO, INHALED		
ANORO ELLIPTA	T2	HD
BEVESPI AEROSPHERE	T2	HD
COMBIVENT RESPIMAT	T2	HD
<i>ipratropium/albuterol sulfate</i>	T1	HD
STIOLTO RESPIMAT INHAL SPRAY	T2	HD
BETA-ADRENERGIC AGENTS AND GLUCOCORTICOID COMBO, INHALED		
ADVAIR HFA	T2	HD
AIRDUO DIGIHALER	T3	ST HD
BETA-ADRENERGIC AGENTS AND GLUCOCORTICOID COMBO, INHALED (cont.)		
BREO ELLIPTA 100-25 MCG INHALR	T2	HD
BREO ELLIPTA 100-25 MCG INHALR	T2	QL(1 inhaler/30 days) HD
BREO ELLIPTA 200-25 MCG INHALR	T2	HD
BREO ELLIPTA 200-25 MCG INHALR	T2	QL(1 inhaler/30 days) HD
BREO ELLIPTA 50-25 MCG INHALER	T2	QL(1 inhaler/30 days) HD
<i>budesonide/formoterol fumarate (Symbicort)</i>	T1	QL HD
DULERA	T2	HD
<i>fluticasone propion/salmeterol</i>	T1	HD
<i>fluticasone-salmeterol 100-50 (Advair Diskus)</i>	T1	QL(1 inhaler/30 days) HD
<i>fluticasone-salmeterol 250-50 (Advair Diskus)</i>	T1	QL(1 Inhaler/30 days) HD
<i>fluticasone-salmeterol 500-50 (Advair Diskus)</i>	T1	QL(1 inhaler/30 days) HD
FLUTICASONE-SALMETEROL 113-14	T1	QL(1 inhaler/30 days) HD
FLUTICASONE-SALMETEROL 232-14	T1	QL(1 inhaler/30 days) HD
FLUTICASONE-SALMETEROL 55-14	T1	QL(1 inhaler/30 days) HD
SYMBICORT	T2	HD
BETA-ADRENERGIC-ANTICHOLINERGIC-GLUCOCORT, INHALED		
BREZTRI AEROSPHERE	T2	
TRELEGY ELLIPTA	T2	
GLUCOCORTICIDS, ORALLY INHALED		
ALVESCO	T2	HD
ASMANEX HFA	T2	QL(1 Inhaler/30 days) HD
ASMANEX TWISTHALER 110 MCG #30	T2	QL(1 inhaler/30 days) HD
ASMANEX TWISTHALER 220 MCG #14	T2	HD
ASMANEX TWISTHALER 220 MCG #30	T2	QL(1 inhaler/30 days) HD
ASMANEX TWISTHALER 220 MCG #60	T2	QL(1 inhaler/30 days) HD
ASMANEX TWISTHALER 220 MCG #120	T2	QL(1 inhaler/30 days) HD

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List of Prescription Medications

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

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

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List of Prescription Medications

ANTIBIOTICS (Ear Medications)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
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EAR PREPARATIONS, ANTIBIOTICS

<i>ciprofloxacin hcl</i>	T1	
CORTISPORIN-TC	T3	
<i>neomycin/polymyxin b/hydrocort</i>	T1	
<i>ofloxacin</i>	T1	

OTIC PREPARATIONS, ANTI-INFLAMMATORY-ANTIBIOTICS

CIPRO HC	T2	
<i>ciprofloxacin hcl/dexameth (Ciprodex)</i>	T1	
CIPROFLOXACIN HCL-FLUOCINOLONE	T3	
OTOVEL	T3	

ANTIBIOTICS (Eye Conditions)

EYE ANTIBIOTIC AND GLUCOCORTICOID COMBINATIONS

MAXITROL (<i>neomycin-polymyxin-dexameth</i>)	T3	
<i>neomycin/bacit/p-myx/hydrocort</i>	T1	
<i>neomycin/polymyxin b/dexametha (Maxitrol)</i>	T1	
<i>neomycin/polymyxin b/hydrocort</i>	T1	
TOBRADEX EYE DROPS (<i>tobramycin-dexamethasone</i>)	T3	
TOBRADEX EYE OINTMENT	T2	
TOBRADEX ST	T2	
<i>tobramycin/dexamethasone (Tobradex)</i>	T1	
ZYLET	T3	

EYE SULFONAMIDES

BLEPH-10 (<i>sulfacetamide sodium</i>)	T3	
BLEPHAMIDE	T2	
<i>sulfacetamide sodium</i>	T1	
<i>sulfacetamide sodium (Bleph-10)</i>	T1	
<i>sulfacetamide/prednisolone sp</i>	T1	

OPHTHALMIC ANTIBIOTICS

AZASITE	T2	
BACIGUENT (<i>bacitracin</i>)	T3	
<i>bacitracin (Baciguent)</i>	T1	
<i>bacitracin/polymyxin b sulfate</i>	T1	
BESIVANCE	T2	
CILOXAN	T2	
<i>erythromycin base</i>	T1	

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

T4 – Specialty Medications
 PA – Prior Authorization
 QL – Quantity Limit

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

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

List of Prescription Medications

ANTIBIOTICS (Eye Conditions) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
OPHTHALMIC ANTIBIOTICS (cont.)		
<i>gatifloxacin</i> (Zymaxid)	T1	
<i>gentamicin sulfate</i>	T1	
<i>levofloxacin</i>	T1	
MOXEZA (<i>moxifloxacin</i>)	T3	
<i>moxifloxacin hcl</i> (Moxeza)	T1	
<i>moxifloxacin hcl</i> (Vigamox)	T1	
<i>neomycin sulf/bacitracin/poly</i>	T1	
<i>neomycin/polymyxn b/gramicidin</i>	T1	
OCUFLOX (<i>ofloxacin</i>)	T3	
<i>ofloxacin</i> (Ocuflox)	T1	
<i>polymyxin b sulf/trimethoprim</i>	T1	
<i>tobramycin 0.3% eye drop</i> (Tobrex)	T1	
TOBEX	T2	
VIGAMOX (<i>moxifloxacin</i>)	T3	
ZYMAXID (<i>gatifloxacin</i>)	T3	

ANTIBIOTICS (Infections)

2ND GEN. ANAEROBIC ANTIPROTOZOAL-ANTIBACTERIAL

SOLOSEC	T2	
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ABSORBABLE SULFONAMIDE ANTIBACTERIAL AGENTS

BACTRIM (<i>sulfamethoxazole-trimethoprim</i>)	T3	
BACTRIM DS (<i>sulfamethoxazole-trimethoprim</i>)	T3	

ABSORBABLE SULFONAMIDE ANTIBACTERIAL AGENTS

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

AMINOGLYCOSIDE ANTIBIOTICS

ARIKAYCE	T4	PA SP
<i>gentamicin sulfate</i>	T1	
<i>gentamicin sulfate/pf</i>	T1	
KITABIS PAK	T4	PA QL (10ml/day) SP HD
<i>neomycin sulfate</i>	T1	
TOBI PODHALER	T4	PA QL (28 days therapy/56 days) SP HD
<i>tobramycin 1,200 mg/30 ml vial</i>	T1	

T1 – Typically Generics
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 T4 – Specialty Medications
 PA – Prior Authorization
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 AGE – Age Requirement
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List of Prescription Medications

ANTIBIOTICS (Infections) (cont.)			
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits	
AMINOGLYCOSIDE ANTIBIOTICS (cont.)			
tobramycin 1.2 gm vial	T1	PA	
tobramycin 1.2 gram/30 ml vial	T1		
tobramycin 10 mg/ml vial	T1		
tobramycin 300 mg/4 ml ampule	T4	QL (8 ml/day) SP HD	
tobramycin 300 mg/5 ml ampule	T4	PA QL (10ml/day) SP HD	
tobramycin 40 mg/ml vial	T1		
tobramycin 80 mg/2 ml vial	T1		
TOBRAMYCIN PAK 300 MG/5 ML	T4	PA QL (10ml/day) SP HD	
ANAEROBIC ANTIPROTOZOAL-ANTIBACTERIAL AGENTS			
FLAGYL (metronidazole)	T3		
LIKMEZ			
metronidazole (Flagyl)	T1		
ANTIBIOTIC, ANTIBACTERIAL, MISC.			
fosfomycin tromethamine (Monurol)	T1		
HIPREX (methenamine hippurate)	T3		
meth/meblue/sod phos/psal/hyos	T1		
meth/meblue/sod phos/psal/hyos (Uribel)	T1		
methenam/m.blue/salicyl/hyoscy (Uribel Tabs)	T1		
methen/mblue/sal/sod phos/hyos	T1		
methenam/m.blue/salicyl/hyoscy	T1		
methenam/sod phos/mblue/hyoscy	T1		
methenamine hippurate (Hiprex)	T1		
methenamine mandelate	T1		
MONUROL (fosfomycin tromethamine)	T3		
PRIMSOL	T2		
trimethoprim	T1		
URIBEL	T3		
URIBEL TABS (methenam/m.blue/salicyl/hyoscy)	T3		
UTA	T3		
ANTILEPTOTICS			
dapsone	T1		
THALOMID	T4	PA SP HD	
ANTI-MYCOBACTERIUM AGENTS			
ethambutol hcl	T1	HD	
ethambutol hcl (Myambutol)	T1	HD	
isoniazid	T1	HD	
MYAMBUTOL (ethambutol hcl)	T3	HD	

I 1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

I4 – Specialty Medications

PA – Prior Authorization

QL – Quantity Limit

S1 – Step Therapy

AGE – Age Requirement

SP – Specialty Medication

HD – May require home delivery pharmacy

PPACA – No Cost-Share Preventive Medication

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List of Prescription Medications

ANTIBIOTICS (Infections) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ANTI-MYCOBACTERIUM AGENTS (cont.)		
PASER	T2	HD
<i>pyrazinamide</i>	T1	HD
<i>rifabutin</i>	T1	HD
TRECATOR	T2	HD
ANTI-TUBERCULAR ANTIBIOTICS		
<i>cycloserine</i>	T1	
PRETOMANID	T3	PA QL (1 tab/day)
PRIFTIN	T3	
RIFAMATE	T2	
<i>rifampin</i>	T1	
RIFATER	T2	
SIRTURO	T4	SP
BETALACTAMS		
CAYSTON	T4	PA QL (3ml/day) SP HD
CARBAPENEM ANTIBIOTICS (THIENAMYCINS)		
<i>meropenem iv 1 gm vial</i>	T1	
<i>meropenem iv 500 mg vial (Merrem)</i>	T1	
<i>meropenem</i>	T1	
CEPHALOSPORIN ANTIBIOTICS - 1ST GENERATION		
<i>cefadroxil</i>	T1	
CEFAZOLIN 3 GM VIAL	T3	
<i>cephalexin</i>	T1	
<i>cephalexin (Keflex)</i>	T1	
DAXBIA	T3	
KEFLEX (<i>cephalexin</i>)	T3	
CEPHALOSPORIN ANTIBIOTICS - 2ND GENERATION		
<i>cefaclor</i>	T1	
<i>cefprozil</i>	T1	
<i>cefuroxime axetil</i>	T1	
CEPHALOSPORIN ANTIBIOTICS - 3RD GENERATION		
<i>cefdinir</i>	T1	
<i>cefditoren pivoxil</i>	T1	
<i>cefixime</i>	T1	
<i>cefixime (Suprax)</i>	T1	
<i>cefpodoxime proxetil</i>	T1	
<i>ceftriaxone sodium</i>	T1	
SUPRAX (<i>cefixime</i>)	T3	

T1 – Typically Generics

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T4 – Specialty Medications

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AGE – Age Requirement

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List of Prescription Medications

ANTIBIOTICS (Infections) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
CEPHALOSPORIN ANTIBIOTICS - 4TH GENERATION		
<i>cefepime hcl</i>	T1	
CEPHALOSPORIN ANTIBIOTICS - 5TH GENERATION		
ZERBAXA	T3	
LINCOSAMIDE ANTIBIOTICS		
CLEOCIN HCL 150 MG CAPSULE (<i>clindamycin hcl</i>)	T3	
CLEOCIN HCL 300 MG CAPSULE (<i>clindamycin hcl</i>)	T3	
CLEOCIN HCL 75 MG CAPSULE (<i>clindamycin hcl</i>)	T2	
CLEOCIN PEDIATRIC (<i>clindamycin (pediatric)</i>)	T3	
<i>clindamycin hcl</i> (Cleocin Hcl)	T1	
<i>clindamycin palmitate hcl</i> (Cleocin Pediatric)	T1	
MACROLIDE ANTIBIOTICS		
<i>azithromycin 1 gm pwd packet</i> (Zithromax)	T1	
<i>azithromycin 100 mg/5 ml susp</i> (Zithromax)	T1	
<i>azithromycin 200 mg/5 ml susp</i> (Zithromax)	T1	
<i>azithromycin 250 mg tablet</i> (Zithromax)	T1	
<i>azithromycin 500 mg tablet</i> (Zithromax Tri-pak)	T1	
<i>azithromycin 600 mg tablet</i>	T1	
<i>clarithromycin</i>	T1	
DIFICID 200 MG TABLET	T3	QL (28 tabs/28 days)
DIFICID 40 MG/ML SUSPENSION	T3	QL (5ml/day)
ERYPED 200 (<i>erythromycin ethylsuccinate</i>)	T3	
<i>ery-tab dr 250 mg tablet</i>	T3	
<i>ery-tab dr 333 mg tablet</i>	T2	
ERY-TAB DR 500 MG TABLET (<i>erythromycin</i>)	T3	
<i>erythromycin base</i> (Ery-tab)	T1	
<i>erythromycin ethylsuccinate</i>	T1	
<i>erythromycin ethylsuccinate</i> (Eryped 200)	T1	
<i>erythromycin stearate</i>	T1	
PCE	T3	
ZITHROMAX 1 GM POWDER PACKET (<i>azithromycin</i>)	T3	
ZITHROMAX 100 MG/5 ML SUSP (<i>azithromycin</i>)	T3	
ZITHROMAX 200 MG/5 ML SUSP (<i>azithromycin</i>)	T3	
ZITHROMAX 200 MG/5 ML SUSP (<i>azithromycin</i>)	T3	
ZITHROMAX 250 MG TABLET (<i>azithromycin</i>)	T3	
ZITHROMAX 250 MG Z-PAK TABLET (<i>azithromycin</i>)	T3	
ZITHROMAX 500 MG TABLET (<i>azithromycin</i>)	T3	
ZITHROMAX TRI-PAK (<i>azithromycin</i>)	T3	

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

T4 – Specialty Medications

PA – Prior Authorization

QL – Quantity Limit

ST – Step Therapy

AGE – Age Requirement

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List of Prescription Medications

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

T1 – Typically Generics
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List of Prescription Medications

ANTIBIOTICS (Infections) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
TETRACYCLINE ANTIBIOTICS		
coremino er 135 mg tablet	T1	
coremino er 45 mg tablet	T1	QL (1 tab/day)
coremino er 90 mg tablet	T1	
demeclocycline hcl	T1	
doxycycline hyclate	T1	
doxycycline monohydrate	T1	
minocycline er 115 mg tablet	T1	
minocycline er 45 mg tablet	T1	QL (1 tab/day)
minocycline er 55 mg tablet	T1	
minocycline er 65 mg tablet	T1	
minocycline er 80 mg tablet	T1	
minocycline er 90 mg tablet	T1	
minocycline hcl	T1	
NUZYRA	T4	PA QL (30 tablets/28 days) SP
tetracycline hcl	T1	
VIBRAMYCIN 50 MG/5 ML SYRUP	T2	
VAGINAL ANTIBIOTICS		
clindamycin phosphate (Cleocin)	T1	
metronidazole (Metrogel-vaginal)	T1	
VANCOMYCIN ANTIBIOTICS AND DERIVATIVES		
vancomycin 50 mg/ml solution	T1	
vancomycin 250 mg/5ml oral sol (Firvanq)	T1	
vancomycin hcl	T1	
vancomycin hcl 125 mg capsule	T1	
vancomycin hcl 250 mg capsule	T1	
vancomycin hcl (Firvanq)	T1	
ANTIBIOTICS (Skin Conditions)		
TOPICAL ANTIBIOTIC AND ANTI-INFLAMMATORY STEROID		
CORTISPORIN	T3	
NEO-SYNALAR	T3	
TOPICAL ANTIBIOTICS		
BENZAMYCIN (erythromycin-benzoyl peroxide)	T3	
CENTANY	T3	
CENTANY AT	T3	
CLEOCINT (clindamycin phosphate)	T3	
CLINDACIN ETZ KIT	T3	

T1 – Typically Generics
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 T3 – Typically Non-Preferred Brands

T4 – Specialty Medications
 PA – Prior Authorization
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ST – Step Therapy
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List of Prescription Medications

ANTIBIOTICS (Skin Conditions) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
TOPICAL ANTIBIOTICS (cont.)		
CLINDACIN PAC	T3	
<i>clindamycin phosphate</i>	T1	
<i>clindamycin phosphate</i> (Cleocin T)	T1	
<i>clindamycin phosphate</i> (Evoclin)	T1	
<i>erythromycin base in ethanol</i>	T1	
<i>erythromycin/benzoyl peroxide</i> (Benzamycin)	T1	
EVOCLIN (<i>clindamycin phosphate</i>)	T3	
<i>gentamicin sulfate</i>	T1	
<i>mupirocin</i> (Centany)	T1	
<i>mupirocin calcium</i>	T1	
XEPI	T3	
TOPICAL SULFONAMIDES		
AVAR 9.5-5% CLEANSING PADS	T3	
<i>avar cleanser</i> (Rosanil)	T1	
AVAR LS	T3	
<i>mafenide acetate</i>	T1	
ROSANIL (<i>sodium sulfacetamide-sulfur</i>)	T1	
SILVADENE (<i>ssd</i>)	T3	
<i>silver sulfadiazine</i> (Silvadene)	T1	
<i>sulfacetamide sod/sulfur/urea</i>	T1	
<i>sulfacetamide sodium/sulfur</i>	T1	
<i>sulfacetamide sodium/sulfur</i> (Avar-e Green)	T1	
<i>sulfacetamide sodium/sulfur</i> (Rosanil)	T1	
<i>sulfacetamide/sulfur/cleansr23</i>	T1	
<i>sulfact sod/sulur/avob/otn/oct</i>	T1	
SULFAMYLON 8.5% CREAM	T2	
SULFAMYLON POWDER PACKET (<i>mafenide acetate</i>)	T3	

ANTI-COAGULANTS (Blood Thinners/Anti-Clotting)

ANTI-COAGULANTS, COUMARIN TYPE

<i>warfarin sodium</i>	T1	HD
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CITRATES AS ANTI-COAGULANTS

ACD SOLUTION A	T3	
ACD-A	T3	
ANTICOAG SODIUM CITRATE 4% SOL	T3	
CITRATE PHOSPHATE DEXTROSE	T1	
SODIUM CITRATE	T1	

T1 – Typically Generics

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List of Prescription Medications

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

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
DIRECT FACTOR XA INHIBITORS		
BEVYXXA	T3	QL (42 caps/42 days)
ELIQUIS	T2	PA
SAVAYSA 15 MG TABLET	T3	PA QL (1 tab/day)
SAVAYSA 30 MG TABLET	T3	PA QL (1 tab/day)
SAVAYSA 60 MG TABLET	T3	PA
XARELTO	T2	PA
HEPARIN AND RELATED PREPARATIONS		
ARIXTRA (<i>fondaparinux sodium</i>)	T4	QL (1 syringe/day) SP
<i>enoxaparin 100 mg/ml syringe</i> (Lovenox)	T4	QL (2 syringes/day) SP
<i>enoxaparin 120 mg/0.8 ml syr</i> (Lovenox)	T4	QL (2 syringes/day) SP
<i>enoxaparin 30 mg/0.3 ml syr</i> (Lovenox)	T4	QL (2 syringes/day) SP
<i>enoxaparin 300 mg/3 ml vial</i> (Lovenox)	T4	QL (1 vial/day) SP
<i>enoxaparin 40 mg/0.4 ml syr</i> (Lovenox)	T4	QL (2 syringes/day) SP
<i>enoxaparin 60 mg/0.6 ml syr</i> (Lovenox)	T4	QL (2 syringes/day) SP
<i>enoxaparin 80 mg/0.8 ml syr</i> (Lovenox)	T4	QL (2 syringes/day) SP
<i>fondaparinux sodium</i> (Arixtra)	T4	QL (1 syringe/day) SP
FRAGMIN	T4	QL (2 ml/day) SP
<i>heparin 10,000 unit/10 ml vial</i>	T1	
<i>heparin 30,000 unit/30 ml vial</i>	T1	
<i>heparin 40,000 unit/4 ml vial</i>	T1	
<i>heparin 50,000 unit/10 ml vial</i>	T1	
<i>heparin 1,000 unit/500 ml-ns</i>	T1	
HEPARIN 2,000 UNIT/1,000 ML-NS (<i>heparin sodium, porcine/ns/pf</i>)	T3	
<i>heparin 2,000 unit/1,000 ml-ns</i> (Heparin Sodium-0.9% Nacl)	T1	
HEPARIN 2,500 UNIT/500 ML-NS	T1	
HEPARIN 30,000 UNIT/1,000-NS	T1	
HEPARIN 5,000 UNIT/1,000 ML-NS	T1	
HEPARIN 5,000 UNIT/500 ML-NS	T1	
<i>heparin 50,000 unit/5 ml vial</i>	T1	
<i>heparin sod 1,000 unit/ml vial</i>	T1	
<i>heparin sod 10,000 unit/ml vl</i>	T1	
<i>heparin sod 20,000 unit/ml vl</i>	T1	
<i>heparin sod 2,000 unit/ml vl</i>	T1	
<i>heparin sod 5,000 unit/0.5 ml</i>	T1	
HEPARIN SOD 5,000 UNIT/0.5 ML	T1	
<i>heparin sod 5,000 unit/0.5 ml</i> (Heparin Sodium)	T1	
<i>heparin sod 5,000 unit/ml syrg</i>	T3	

T1 – Typically Generics
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List of Prescription Medications

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

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
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HEPARIN AND RELATED PREPARATIONS

<i>heparin sod 5,000 unit/ml vial</i>	T1	
LOVENOX 100 MG/ML SYRINGE (<i>enoxaparin sodium</i>)	T4	QL (2 syringes/day) SP
LOVENOX 120 MG/0.8 ML SYRINGE (<i>enoxaparin sodium</i>)	T4	QL (2 syringes/day) SP
LOVENOX 150 MG/ML SYRINGE (<i>enoxaparin sodium</i>)	T4	QL (2 syringes/day) SP
LOVENOX 30 MG/0.3 ML SYRINGE (<i>enoxaparin sodium</i>)	T4	QL (2 syringes/day) SP
LOVENOX 300 MG/3 ML VIAL (<i>enoxaparin sodium</i>)	T4	QL (1 vial/day) SP
LOVENOX 40 MG/0.4 ML SYRINGE (<i>enoxaparin sodium</i>)	T4	QL (2 syringes/day) SP
LOVENOX 60 MG/0.6 ML SYRINGE (<i>enoxaparin sodium</i>)	T4	QL (2 syringes/day) SP
LOVENOX 80 MG/0.8 ML SYRINGE (<i>enoxaparin sodium</i>)	T4	QL (2 syringes/day) SP

THROMBIN INHIBITORS, SELECTIVE, DIRECT, REVERSIBLE

ARGATROBAN 250MG/2.5ML VIAL	T3	
<i>dabigatran etexilate mesylate</i>	T1	PA HD

ANTIDOTES (Gastrointestinal/Heartburn)

MU-OPIOID RECEPTOR ANTAGONISTS, PERIPHERALLY-ACTING

MOVANTIK	T3	PA
RELISTOR	T3	PA
SYMPROIC	T3	PA

ANTIDOTES (Substance Abuse)

OPIOID ANTAGONISTS

KLOXXADO	T2	PA QL (2 sprays/30 days)
<i>naloxone 0.4 mg/ml carpject, vial</i>	T1	
NALOXONE 2 MG AUTO-INJECTOR	T3	QL (0.8ml/day)
<i>naloxone 2 mg/2 ml syringe</i>	T1	
<i>naloxone 4 mg/10 ml vial</i>	T1	
<i>naltrexone 50 mg tablet</i>	T1	QL(180 tabs/30 days)
OPVEE	T3	QL(2 units/30 days)
NARCAN	T2	QL (2 units/30 days)
ZIMHI	T3	QL (2 inj/day)

ANTI-FUNGALS (Eye Conditions)

OPHTHALMIC ANTI-FUNGAL AGENTS

NATACYN	T2	
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ANTI-FUNGALS (Feminine Products)

VAGINAL ANTI-FUNGALS

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

I2 – Typically Preferred Brands

PA – Prior Authorization

AGL – Age Requirement

PPACA – No Cost-Share Preventive Medication

T3 – Typically Non-Preferred Brands

QL – Quantity Limit

SP – Specialty Medication

CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

ANTI-FUNGALS (Infections)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ANTI-FUNGAL AGENTS		
ANCOBON (<i>flucytosine</i>)	T3	
<i>clotrimazole</i>	T1	
CRESEMBA	T3	PA
CRESEMBA 74.5 MG CAPSULE	T3	PA
<i>fluconazole</i>	T1	
<i>flucytosine</i> (Ancobon)	T1	
<i>itraconazole</i>	T1	
<i>ketoconazole</i>	T1	
NOXAFIL 300 MG/16.7 ML VIAL	T3	
ORAVIG	T3	
<i>terbinafine hcl</i>	T1	
VFEND (<i>voriconazole</i>)	T3	PA
<i>voriconazole</i> (Vfend)	T1	PA
ANTI-FUNGAL ANTIBIOTICS		
<i>griseofulvin ultramicrosize</i> (Gris-peg)	T1	
<i>griseofulvin, microsize</i>	T1	
GRIS-PEG (<i>griseofulvin ultramicrosize</i>)	T3	
<i>nystatin</i>	T1	
ANTI-FUNGALS (Skin Conditions)		
TOPICAL ANTI-FUNGAL/ANTI-INFLAMMATORY, STEROID AGENT		
<i>clotrimazole/betamethasone dip</i>	T1	
TOPICAL ANTI-FUNGALS		
<i>ciclodan 0.77% cream</i>	T1	
CICLODAN 0.77% CREAM KIT	T3	
<i>ciclodan 8% solution</i>	T1	
<i>ciclopirox</i>	T1	
<i>ciclopirox olamine</i>	T1	
<i>ciclopirox olamine</i> (Loprox)	T1	
<i>econazole nitrate</i>	T1	
ECOZA	T3	
EXODERM	T1	
<i>ketoconazole</i>	T1	
<i>ketoconazole/skin cleanser 28</i>	T1	
LOPROX	T3	
LOPROX (<i>ciclopirox</i>)	T3	
LULICONAZOLE	T1	

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

T4 – Specialty Medications
PA – Prior Authorization
QL – Quantity Limit

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

HD – May require home delivery pharmacy
PPACA – No Cost-Share Preventive Medication
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List of Prescription Medications

ANTI-FUNGALS (Skin Conditions) (con't.)

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

ANTIHISTAMINE AND DECONGESTANT COMBINATION (Allergy/Nasal Sprays)

1ST GEN ANTIHISTAMINE AND DECONGESTANT COMBINATION

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

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

ANTIHISTAMINES - 1ST GENERATION

<i>carbinoxamine maleate</i>	T1	
<i>clemastine fumarate</i>	T1	
<i>hydroxyzine hcl</i>	T1	
<i>hydroxyzine pamoate</i>	T1	
<i>hydroxyzine pamoate</i> (Vistaril)	T1	
<i>promethazine hcl</i>	T1	
VISTARIL (<i>hydroxyzine pamoate</i>)	T3	

ANTIHISTAMINES - 2ND GENERATION

<i>cetirizine hcl</i>	T1	HD
CLARINEX (<i>desloratadine</i>)	T3	HD
<i>desloratadine 2.5 mg odt</i>	T1	QL (1 tab/day) HD
<i>desloratadine 5 mg odt</i>	T1	HD
<i>desloratadine 5 mg tablet</i> (Clarinet)	T1	HD

ANTIHISTAMINES (Eye Conditions)

EYE ANTIHISTAMINES

<i>azelastine hcl 0.05% drops</i>	T1	
BEPREVE	T3	
<i>epinastine hcl</i>	T1	
LASTACRAFT	T3	
<i>olopatadine hcl 0.1% eye drops</i>	T1	
<i>olopatadine hcl 0.2% eye drop</i> (Pataday)	T1	
PATADAY (<i>olopatadine hcl</i>)	T3	
PAZEO	T2	
ZERVIATE	T2	

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

T4 – Specialty Medications

PA – Prior Authorization

QL – Quantity Limit

ST – Step Therapy

AGE – Age Requirement

SP – Specialty Medication

HD – May require home delivery pharmacy

PPACA – No Cost-Share Preventive Medication

CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

ANTI-HYPERGLYCEMICS (Diabetes)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ANTIHYPERGLY, INCRETIN MIMETIC (GLP-I RECEPTOR AGONIST)		
BYDUREON	T2	QL (4 vials/28 days) ST HD
BYDUREON BCISE	T2	QL (4 pens/28 days) ST HD
BYDUREON PEN	T2	QL (4 pens/28 days) ST HD
BYETTA	T2	QL (1 pen/30 days) ST HD
OZEMPIC 0.25-0.5 MG DOSE PEN	T2	QL (2 pens/28 days) ST HD
OZEMPIC 1 MG DOSE PEN (1.5 ML)	T2	QL (2 pens/28 days) ST HD
OZEMPIC 1 MG DOSE PEN (3 ML)	T2	QL (3ml/21 days) ST HD
RYBELSUS	T2	QL (1 tab/day) ST HD
TRULICITY 0.75 MG/0.5 ML PEN	T2	QL (4 pens/28 days) ST HD
TRULICITY 1.5 MG/0.5 ML PEN	T2	QL (4 pens/28 days) ST HD
TRULICITY 3 MG/0.5 ML PEN	T2	QL (2ML/28 Days) ST HD
TRULICITY 4.5 MG/0.5 ML PEN	T2	QL (2ML/28 Days) ST HD
ANTI-HYPERGLY, INSULIN, LONG ACT-GLP-I RECEPTOR AGONIST		
SOLIQUA 100-33	T2	HD
ANTIHYPERGLYCEMIC-GLUCOCORTICOID RECEPTOR BLOCKER		
<i>mifepristone 300 mg tablet</i>	T2	HD
ANTI-HYPERGLYCEMIC-SODIUM/GLUCOCOTRANSPORT2(SGLT2) INHIB		
FARXIGA	T2	QL (1 tab/day) ST HD
JARDIANCE	T2	QL (1 tab/day) ST HD
ANTI-HYPERGLYCEMIC-DOPAMINE RECEPTOR AGONISTS		
CYCLOSET	T3	HD
ANTI-HYPERGLYCEMIC, ALPHA-GLUCOSIDASE INHIBITORS		
<i>acarbose (Precose)</i>	T1	HD
<i>GLYSET (miglitol)</i>	T3	HD
<i>miglitol (Glyset)</i>	T1	HD
<i>PRECOSE (acarbose)</i>	T3	HD
ANTI-HYPERGLYCEMIC, AMYLIN ANALOG-TYPE		
SYMLINPEN 120	T2	HD
SYMLINPEN 60	T2	HD
ANTI-HYPERGLYCEMIC, BIGUANIDE TYPE		
GLUCOPHAGE XR (<i>metformin hcl er</i>)	T3	HD
<i>metformin hcl</i>	T1	HD
<i>metformin hcl (Glucophage Xr)</i>	T1	HD
<i>metformin hcl (Riomet)</i>	T1	HD
RIOMET (<i>metformin hcl</i>)	T3	HD
RIOMET ER	T3	HD

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AGE – Age Requirement
SP – Specialty Medication

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List of Prescription Medications

ANTI-HYPERGLYCEMICS (Diabetes) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ANTI-HYPERGLYCEMIC, DPP-4 INHIBITORS		
JANUVIA	T2	QL (1 tab/day) ST HD
ANTI-HYPERGLYCEMIC, INSULIN-RELEASE STIMULANT TYPE		
AMARYL (<i>glimepiride</i>)	T3	HD
<i>chlorpropamide</i>	T1	HD
<i>glimepiride</i> (Amaryl)	T1	HD
<i>glipizide 10 mg tablet</i>	T1	HD
<i>glipizide 5 mg tablet</i>	T1	HD
GLIPIZIDE 2.5 MG TABLET	T3	HD
GLUCOTROL (<i>glipizide</i>)	T3	HD
GLUCOTROL XL (<i>glipizide xl</i>)	T3	HD
<i>glyburide</i>	T1	HD
<i>glyburide, micronized</i> (Glynase)	T1	HD
GLYNASE (<i>glyburide micronized</i>)	T3	HD
<i>nateglinide</i> (Starlix)	T1	HD
<i>repaglinide</i>	T1	HD
STARLIX (<i>nateglinide</i>)	T3	HD
<i>tolbutamide</i>	T1	HD
ANTI-HYPERGLYCEMIC, SGLT-2 AND DPP-4 INHIBITOR COMB		
GLYXAMBI	T2	QL (1 tab/day) ST HD
ANTI-HYPERGLYCEMIC, THIAZOLIDINEDIONE AND BIGUANIDE		
ACTOPLUS MET (<i>pioglitazone-metformin</i>)	T3	HD
<i>pioglitazone hcl/metformin hcl</i> (Actoplus Met)	T1	HD
ANTI-HYPERGLYCEMIC, THIAZOLIDINEDIONE-SULFONYLUREA		
DUETACT (<i>pioglitazone-glimepiride</i>)	T3	HD
<i>pioglitazone hcl/glimepiride</i> (Duetact)	T1	HD
ANTI-HYPERGLYCEMIC, DPP-4 INHIBITOR-BIGUANIDE COMBS.		
JANUMET	T2	QL (2 tabs/day) ST HD
JANUMET XR 100-1,000 MG TABLET	T2	QL (1 tab/day) ST HD
JANUMET XR 50-1,000 MG TABLET	T2	QL (2 tabs/day) ST HD
JANUMET XR 50-500 MG TABLET	T2	QL (1 tab/day) ST HD
ANTI-HYPERGLYCEMIC, INSULIN-RELEASE STIM.-BIGUANIDE		
<i>glipizide/metformin hcl</i>	T1	HD
<i>glyburide/metformin hcl</i>	T1	HD
<i>repaglinide/metformin hcl</i>	T1	HD

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List of Prescription Medications

ANTI-HYPERGLYCEMICS (Diabetes) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ANTI-HYPERGLYCEMIC, THIAZOLIDINEDIONE (PPARG AGONIST)		
ACTOS (<i>pioglitazone hcl</i>)	T3	HD
AVANDIA	T3	HD
<i>pioglitazone hcl</i> (Actos)	T1	HD
ANTI-HYPERGLYCEMIC-SGLT2 INHIBITOR-BIGUANIDE COMBS.		
SYNJARDY	T2	QL (2 tabs/day) ST HD
SYNJARDY XR 10-1,000 MG TABLET	T2	QL (2 tabs/day) ST HD
SYNJARDY XR 12.5-1,000 MG TAB	T2	QL (2 tabs/day) ST HD
SYNJARDY XR 25-1,000 MG TABLET	T2	QL (1 tab/day) ST HD
SYNJARDY XR 5-1,000 MG TABLET	T2	QL (2 tabs/day) ST HD
XIGDUO XR 10 MG-1,000 MG TAB	T2	QL (1 tab/day) ST HD
XIGDUO XR 10 MG-500 MG TABLET	T2	QL (1 tab/day) ST HD
XIGDUO XR 2.5 MG-1,000 MG TAB	T2	QL (2 tabs/day) ST HD
XIGDUO XR 5 MG-1,000 MG TABLET	T2	QL (2 tabs/day) ST HD
XIGDUO XR 5 MG-500 MG TABLET	T2	QL (1 tab/day) ST HD
ANTIHYPERGLY-SGLT-2 INHIB, DPP-4 INHIB, BIGUANIDE CB		
TRIJARDY XR	T2	QL (1 tab/day) ST HD
INSULINS		
BASAGLAR KWIKPEN U-100	T2	QL (1.5ml/day) HD
HUMALOG 100 UNIT/ML CARTRIDGE	T2	QL (1.5ml/day) HD
HUMALOG 100 UNIT/ML VIAL	T2	QL (1.5ml/day) HD
HUMALOG JUNIOR KWIKPEN	T2	QL (1.5ml/day) HD
HUMALOG KWIKPEN U-100	T2	QL (1.5 ml/day) HD
HUMALOG KWIKPEN U-200	T2	QL (1 ml/day) HD
HUMALOG MIX 50-50	T2	QL (2ml/day) HD
HUMALOG MIX 50-50 KWIKPEN	T2	QL (2ml/day) HD
HUMALOG MIX 75-25	T2	QL (2ml/day) HD
HUMALOG MIX 75-25 KWIKPEN	T2	QL (2ml/day) HD
HUMULIN R U-500	T2	QL (1 ml/day) HD
HUMULIN R U-500 KWIKPEN	T2	QL (1 ml/day) HD
INSULIN ASPART	T2	QL (1.5ml/day) HD
INSULIN ASPART FLEXPEN	T2	QL (1.5ml/day) HD
INSULIN ASPART PENFILL	T2	QL (1.5ml/day) HD
INSULIN ASPART PROT-INSULN ASP	T2	QL (2 ml/day) HD
INSULIN GLARGINE-YFGN	T3	QL(1.5 mls/day) HD
INSULIN LISPRO	T3	QL(1.5 mls/day) HD

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List of Prescription Medications

ANTI-HYPERGLYCEMICS (Diabetes) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
INSULINS (cont.)		
INSULIN LISPRO JUNIOR KWIKPEN	T3	QL(1.5 mls/day) HD
INSULIN LISPRO KWIKPEN U-100	T3	QL(1.5 mls/day) HD
INSULIN LISPRO PROTAMINE MIX	T3	QL(2 mls/day) HD
LEVEMIR	T2	QL (1.5ml/day) HD
LEVEMIR FLEXTOUCH	T2	QL (1.5ml/day) HD
LYUMJEV	T2	QL (1.5ml/day) HD
LYUMJEV KWIKPEN U-100	T2	QL (1.5ml/day) HD
LYUMJEV KWIKPEN U-200	T2	QL (1 ml/day) HD
SEMGLEE (YFGN) 100 UNIT/ML PEN, VIAL	T2	PA QL(1.5 mls/day) HD
TRESIBA	T2	QL (1.5ml/day) HD
TRESIBA FLEXTOUCH U-100	T2	QL (1.5ml/day) HD
TRESIBA FLEXTOUCH U-200	T2	QL (0.9ml/day) HD

ANTI-INFECTIVES (Feminine Products)

VAGINAL SULFONAMIDES

AVC	T3	
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VAGINAL ANTISEPTICS

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

ANTI-INFECTIVES (Infections)

PENICILLIN ANTIBIOTICS

<i>amoxicillin</i>	T1	
<i>amoxicillin/potassium clav</i> (Augmentin Es-600)	T1	

ANTI-INFECTIVES/MISCELLANEOUS (Infections)

2ND GEN. ANAEROBIC ANTI-PROTOZOAL-ANTIBACTERIAL

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

AMEBICIDES

<i>paromomycin sulfate</i>	T1	
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ANTHELMINTICS

<i>albendazole</i> (Albenza)	T1	
ALBENZA (<i>albendazole</i>)	T3	
BILTRICIDE (<i>praziquantel</i>)	T3	
EMVERM	T1	

T1 – Typically Generics
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List of Prescription Medications

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

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

ANTI-PROTOZOAL DRUGS, MISCELLANEOUS

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

ANTI-INFECTIVES/MISCELLANEOUS (Miscellaneous)

ANTIBACTERIAL AGENTS, MISCELLANEOUS

<i>glycine urologic solution</i>	T1	
<i>glycine urologic solution</i>	T3	

TOPICAL ANTISEPTIC DRYING AGENTS

<i>formaldehyde</i>	T1	
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ANTI-INFECTIVES/MISCELLANEOUS (Skin Conditions)

TOPICAL ANTI-FUNGALS

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

T1 – Typically Generics
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List of Prescription Medications

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

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ANTI-INFLAMMATORY TUMOR NECROSIS FACTOR INHIBITOR		
ADALIMUMAB-ADBM(CF)	T4	PA QL(2 pens/syringes/28 days) SP HD
ADALIMUMAB-ADBM(CF) PEN CROHNS	T4	PA QL(1 starter kit/365 days) SP HD
AMJEVITA(CF)	T4	PA QL(2 Syringes/28 days) SP HD
AMJEVITA(CF) AUTOINJECTOR	T4	PA QL(2 auto-injs/28 days) SP HD
AVSOLA	T4	PA SP
CIMZIA 200 MG VIAL KIT	T4	PA QL (1 kit/28 days) SP HD
CIMZIA 2X200 MG/ML SYRINGE KIT	T4	PA QL (1 kit/28 days) SP HD
CIMZIA 2X200 MG/ML(X3) START KT	T4	PA QL (1 kit/year) SP HD
CYLTEZO (CF)	T4	PA QL(1 starter kit/365 days) SP
ENBREL 25 MG KIT	T4	PA QL (8 vials/28 days) SP HD
ENBREL 25 MG/0.5 ML SYRINGE	T4	PA QL (8 syringes/28 days) SP HD
ENBREL 25 MG/0.5 ML VIAL	T4	PA QL (4 ml/28 days) SP HD
ENBREL 50 MG/ML SYRINGE	T4	PA QL (4 syringes/28 days) SP HD
ENBREL MINI	T4	PA QL (4 cartridges/28 days) SP HD
ENBREL SURECLICK	T4	PA QL (4 syringes/28 days) SP HD
HUMIRA	T4	PA QL (2 syringes/28 days) SP HD
HUMIRA PEN	T4	PA QL (2 pens/28 days) SP HD
HUMIRA PEN CROHN'S-UC-HS	T4	PA QL (1 kit/year) SP HD
HUMIRA PEN PSOR-UVEITS-ADOL HS	T4	PA QL (1 kit/year) SP HD
HUMIRA(CF)	T4	PA QL (2 syringes/28 days) SP HD
HUMIRA(CF) PEDIATRIC CROHN'S	T4	PA QL (1 kit/year) SP HD
HUMIRA(CF) PEN 40 MG/0.4 ML	T4	PA QL (2 pens/28 days) SP HD
HUMIRA(CF) PEN 80 MG/0.8 ML	T4	PA QL (1 kit/year) SP HD
HUMIRA(CF) PEN CROHN'S-UC-HS	T4	PA QL (1 kit/year) SP HD
HUMIRA(CF) PEN PEDIATRIC UC	T4	PA QL (4 kits/365 dayS) SP HD
HUMIRA(CF) PEN PSOR-UV-ADOL HS	T4	PA QL (1 kit/year) SP HD
HYRIMOZ	T4	PA QL(2 doses/28 days) SP
INFLECTRA	T4	PA SP HD
REMICADE	T4	PA SP HD
SIMPONI 100 MG/ML PEN INJECTOR	T4	PA QL (1 injector/28 days) SP HD
SIMPONI 100 MG/ML SYRINGE	T4	PA QL (1 syringe/28 days) SP HD
SIMPONI 50 MG/0.5 ML PEN INJEC	T4	PA QL (1 injector/28 days) SP HD
SIMPONI 50 MG/0.5 ML SYRINGE	T4	PA QL (1 syringe/28 days) SP HD
SIMPONI ARIA	T4	PA SP HD
ANP - SELECTIVE RETINOID X RECEPTOR AGONISTS (RXR)		
<i>bexarotene</i> (Targretin)	T4	PA SP HD

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List of Prescription Medications

ANTI-NEOPLASTICS (Cancer)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ANTIBIOTIC ANTINEOPLASTICS		
ADRIAMYCIN (<i>doxorubicin hcl</i>)	T4	PA SP
ANTI-NEOPLAST, HISTONE DEACETYLASE (HDAC) INHIBITORS		
FARYDAK	T4	PA SP HD
ZOLINZA	T4	PA SP HD
ANTINEOPLAST HUM VEGF INHIBITOR RECOMB MC ANTIBODY		
VEGZELMA	T4	PA SP
ANTI-NEOPLASTIC - ALKYLATING AGENTS (cont.)		
ALKERAN (<i>melphalan</i>)	T4	SP
<i>bendamustine 100 mg vial (Treanda)</i>	T4	PA SP
<i>bendamustine 25 mg vial (Treanda)</i>	T4	PA SP
BENDAMUSTINE 100 MG/4 ML VIAL	T3	PA HD
<i>cisplatin</i>	T4	PA SP
CISPLATIN 50MG VIAL	T4	PA SP
CYCLOPHOSPHAMIDE 1GM/5ML	T3	
CYCLOPHOSPHAMIDE 2GM/10ML	T3	
CYCLOPHOSPHAMIDE 500MG/2.5MG VIAL	T3	
<i>cyclophosphamide</i>	T4	SP HD
GLEOSTINE	T3	
HYDREA (<i>hydroxyurea</i>)	T3	
<i>hydroxyurea (Hydrea)</i>	T1	
LEUKERAN	T2	
<i>melphalan (Alkeran)</i>	T4	SP
MYLERAN	T2	
<i>temozolomide</i>	T4	PA SP HD
<i>temozolomide (Temodar)</i>	T4	PA SP HD
VIVIMUSTA	T4	PA SP
ANTI-NEOPLASTIC - ANTI-ANDROGENIC AGENTS		
<i>abiraterone acetate</i>	T4	PA SP HD
<i>bicalutamide (Casodex)</i>	T1	
CASODEX (<i>bicalutamide</i>)	T3	
ERLEADA 240MG TABLET	T4	PA SP HD
ERLEADA 60MG TABLET	T4	PA SP HD CSL
<i>flutamide</i>	T1	
<i>nilutamide</i>	T1	QL (4 tabs/day)
NUBEQA	T4	PA SP HD
TREANDA (<i>bendamustine hcl</i>)	T4	PA SP
XTANDI	T4	PA SP HD

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

T4 – Specialty Medications
PA – Prior Authorization
QL – Quantity Limit

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

HD – May require home delivery pharmacy
PPACA – No Cost-Share Preventive Medication
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List of Prescription Medications

ANTI-NEOPLASTICS (Cancer) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ANTI-NEOPLASTIC - ANTI-METABOLITES		
<i>capecitabine</i> (Xeloda)	T4	PA SP HD
DACOGEN 50 MG VIAL	T4	PA SP
<i>gemcitabine</i>	T4	PA SP
GEMCITABINE 1MG/10ML	T4	PA SP
GEMCITABINE 1.5MG/15ML	T4	PA SP
GEMCITABINE 2MG/20ML	T4	PA SP
GEMCITABINE 200MG/2ML VIAL	T4	PA SP
INQOVI	T4	PA SP HD
JYLAMVO	T3	CSL
LONSURF	T4	PA SP HD
<i>mercaptopurine</i>	T1	
<i>methotrexate sodium</i>	T1	
ONUREG	T4	PA QL (14 tabs/28 Days) SP
PEMRYDI RTU	T4	PA SP
PURIXAN	T4	SP
TABLOID	T3	
TREXALL	T2	
VIDAZA	T3	PA
XATMEP	T3	
XELODA (<i>capecitabine</i>)	T4	PA SP HD
ANTI-NEOPLASTIC, ANTI PROGRAMMED DEATH-I (PD-I) MAB		
LOQTORZI	T4	SP
ZYNYZ	T4	PA SP
ANTI-NEOPLASTIC - AROMATASE INHIBITORS		
<i>anastrozole</i> (Arimidex)	T1	HD PPACA
ARIMIDEX (<i>anastrozole</i>)	T3	HD
AROMASIN (<i>exemestane</i>)	T3	HD
<i>exemestane</i> (Aromasin)	T1	HD PPACA
FEMARA (<i>letrozole</i>)	T3	HD
<i>letrozole</i> (Femara)	T1	HD
ANTI-NEOPLASTIC - BRAF KINASE INHIBITORS		
BRAFTOVI	T4	PA SP HD
TAFINLAR	T4	PA SP HD
ZELBORAF	T4	PA SP HD
ANTI-NEOPLASTIC-ENZYME INHIB, ANTIANDROGEN COMB.		
AKEEGA	T4	PA QL(2 TABS/DAY) SP CSL

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List of Prescription Medications

ANTI-NEOPLASTICS (Cancer) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ANTI-NEOPLASTIC - HEDGEHOG PATHWAY INHIBITOR		
DAURISMO	T4	PA SP HD
ERIVEDGE	T4	PA SP HD
ODOMZO	T4	PA SP HD
ANTI-NEOPLASTIC - JANUS KINASE (JAK) INHIBITORS		
JAKAFI	T4	PA SP HD
ANTI-NEOPLASTIC - KRAS PROTEIN INHIBITOR		
LUMAKRAS 120 MG TABLET	T4	PA QL (8 tabs/day) SP HD CSL
LUMAKRAS 320 MG TABLET	T4	PA QL (3 tabs/day) SP HD CSL
ANTI-NEOPLASTIC - MEKI AND MEK2 KINASE INHIBITORS		
COTELLIC	T4	PA SP HD
KOSELUGO 10 MG CAPSULE	T4	PA QL (10 capsules/day) SP
KOSELUGO 25 MG CAPSULE	T4	PA QL (4 caps/day) SP
MEKINIST	T4	PA SP HD
MEKTOVI	T4	PA SP HD
ANTI-NEOPLASTIC - MTOR KINASE INHIBITORS		
AFINITOR	T4	PA SP HD
AFINITOR (everolimus)	T4	PA SP HD
AFINITOR DISPERZ	T4	PA SP
everolimus 2.5 mg tablet (Afinitor)	T4	PA SP HD
everolimus 5 mg tablet (Afinitor)	T4	PA SP HD
everolimus 7.5 mg tablet (Afinitor)	T4	PA SP HD
ANTI-NEOPLASTIC - PROTEIN METHYLTRANSFERASE INHIBIT		
TAZVERIK	T4	PA SP
ANTI-NEOPLASTIC - TOPOISOMERASE I INHIBITORS		
HYCAMTIN	T4	PA SP HD
ANTI-NEOPLASTIC COMB - KINASE AND AROMATASE INHIBIT		
KISQALI FEMARA CO-PACK	T4	PA QL (1 pack/28 days) SP HD CSL
KISQALI 600MG	T4	PA QL (63/28 days) SP HD CSL
KISQALI 400MG	T4	PA QL (42/28 days) SP HD CSL
KISQALI 200MG	T4	PA QL (21/28 days) SP HD CSL
ANTI-NEOPLASTIC EGF RECEPTOR BLOCKER MCLON ANTIBODY		
OGIVRI	T4	PA SP
PHESGO	T4	PA SP HD
ANTI-NEOPLASTIC IMMUNOMODULATOR AGENTS		
lenalidomide	T1	PA QL (1 cap/day) SP HD CSL
POMALYST	T4	PA SP HD
REVLIMID	T4	PA SP HD

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List of Prescription Medications

ANTI-NEOPLASTICS (Cancer) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ANTI-NEOPLASTIC LHRH (GNRH) AGONIST, PITUITARY SUPPR.		
<i>leuprolide acetate</i>	T4	PA SP HD
LUPRON DEPOT	T4	PA SP HD
ZOLADEX	T4	PA SP HD
ANTI-NEOPLASTIC LHRH (GNRH) ANTAGONIST, PITUIT.SUPPRS		
FIRMAGON	T4	PA SP HD
ORGOVYX	T4	PA SP
ANTI-NEOPLASTIC SYSTEMIC ENZYME INHIBITORS		
ALECENSA	T4	PA QL (8 tabs/day) SP HD CSL
AYVAKIT	T4	PA QL (1 tab/day) SP
BALVERSA	T4	PA SP
BOSULIF	T4	PA QL (3 caps/day) SP HD CSL
BORTEZOMIB 3.5MG IV VIAL	T4	PA SP
BRUKINSA	T4	PA QL (4 caps/day) SP
CABOMETYX	T4	PA SP HD
CALQUENCE	T4	PA SP
CAPRELSA	T4	PA SP
COMETRIQ	T4	PA SP HD
COPIKTRA	T4	PA SP
<i>erlotinib hcl</i>	T4	PA SP HD
EXKIVITY	T4	PA SP HD
FOTIVDA	T4	PA QL (30 caps/30 days) SP HD
GAVRETO	T4	PA QL (4 tabs/Day) SP HD
<i>gefitinib</i>	T4	PA SP HD CSL
GILOTRIF	T4	PA SP HD
GLEEVEC (<i>imatinib mesylate</i>)	T4	PA SP HD
IBRANCE	T4	PA QL (21 caps/28 days) SP HD
<i>imatinib mesylate</i> (Gleevec)	T4	SP HD
IMBRUVICA	T4	PA SP
INLYTA	T4	PA SP HD
INREBIC	T4	PA SP HD
IRESSA	T4	PA SP HD
IWILFIN	T4	PA QL (8 tabs/day) SP CSL
KISQALI 200 MG DAILY DOSE	T4	PA QL (21 tabs/28 days) SP HD CSL
KISQALI 400 MG DAILY DOSE	T4	PA QL (42 tabs/28 days) SP HD CSL
KISQALI 600 MG DAILY DOSE	T4	PA QL (63 tabs/28 days) SP HD CSL
<i>lapatinib ditosylate</i> (Tykerb)	T4	PA SP HD
LENVIMA	T4	PA SP HD

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List of Prescription Medications

ANTI-NEOPLASTICS (Cancer) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ANTI-NEOPLASTIC SYSTEMIC ENZYME INHIBITORS (cont.)		
LORBRENA	T4	PA SP HD
LYNPARZA	T4	PA SP HD
LYTGOBI 12 MG DAILY DOSE (3X 4MG TB)	T4	PA QL(3 tabs/day) SP CSL
LYTGOBI 16 MG DAILY DOSE (4X 4MG TB)	T4	PA QL(4 tabs/day) SP CSL
LYTGOBI 20 MG DAILY DOSE (5X 4MG TB)	T4	PA QL(5 tabs/day) SP CSL
NERLYNX	T4	PA SP HD
NINLARO	T4	PA SP HD
OGSIVEO	T4	PA QL(6 tabs/day) SP CSL
OJJAARA	T4	PA QL(1 tab/day) SP CSL
<i>pazopanib hcl (Votrient)</i>	T4	PA QL(4 tabs/day) SP HD CSL
PEMAZYRE	T4	PA QL (14 tabs/21 days) SP
PIQRAY	T4	PA SP HD
QINLOCK	T4	PA QL (3 tabs/day) SP
RETEVMO 40 MG CAPSULE	T4	PA QL (6 caps/day) SP HD
RETEVMO 80 MG CAPSULE	T4	PA QL (4 tabs/day) SP HD
ROZLYTREK	T4	PA SP HD
RUBRACA	T4	PA SP
RYDAPT	T4	PA SP HD
SPRYCEL	T4	PA SP HD
STIVARGA	T4	PA SP HD
SUTENT	T4	PA SP HD
TALZENNA	T4	PA SP HD
TABRECTA	T4	PA QL (4 tabs/day) SP HD
TAGRISSO	T4	PA SP HD
TURALIO 125 MG CAPSULE	T4	PA QL(4 caps/day) SP CSL
TURALIO 200 MG CAPSULE	T4	PA SP CSL
TASIGNA	T4	PA SP HD
TEPMETKO	T4	PA QL (2 tabs/day) SP
TRUQAP	T4	PA QL(64 tabs/28 days) SP CSL
TUKYSA	T4	PA SP
TYKERB (<i>lapatinib</i>)	T4	PA SP HD
UKONIQ	T4	PA QL (4 tabs/day) SP
VANFLYTA	T4	PA QL(2 tabs/day) SP CSL
VERZENIO	T4	PA QL (2 tabs/day) SP HD
VITRAKVI	T4	PA SP HD
VIZIMPRO	T4	PA SP HD
XALKORI	T4	PA SP HD

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List of Prescription Medications

ANTI-NEOPLASTICS (Cancer) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ANTI-NEOPLASTIC SYSTEMIC ENZYME INHIBITORS (cont.)		
XALKORI 150 MG PELLETT	T4	PA QL(4 pellets/day) SP HD CSL
XALKORI 20 MG PELLETT	T4	PA QL(4 pellets/day) SP HD CSL
XALKORI 200 MG CAPSULE	T4	PA QL(4 caps/day) SP HD CSL
XALKORI 250 MG CAPSULE	T4	PA QL(4 caps/day) SP HD CSL
XALKORI 50 MG PELLETT	T4	PA QL(4 pellets/day) SP HD CSL
XOSPATA	T4	PA SP
ZEJULA	T4	PA SP
ZYDELIG	T4	PA SP HD
ANTI-NEOPLASTIC, ANTI-PROGRAMMED DEATH-I (PD-I) MAB		
LOQTORZI	T4	PA SP
OPDIVO	T4	PA SP HD
ANTI-NEOPLASTIC-B CELL LYMPHOMA-2(BCL-2) INHIBITORS		
VENCLEXTA	T4	PA SP
VENCLEXTA STARTING PACK	T4	PA SP
ANTI-NEOPLASTIC-ISOCITRATE DEHYDROGENASE INHIBITOR		
IDHIFA	T4	PA SP HD
REZLIDHIA	T4	PA QL(2 CAPS/DAY) SP CSL
TIBSOVO	T4	PA SP
ANTI-NEOPLASTICS ANTIBODY/ANTIBODY-DRUG COMPLEXES		
ENHERTU	T4	PA SP HD
ANTI-NEOPLASTICS, MISCELLANEOUS		
MATULANE	T4	SP
TENIPOSIDE	T4	PA SP
<i>retinoin 10 mg capsule</i>	T4	PA
ANTI-NEOPLASTIC-SELECT INHIB OF NUCLEAR EXP (SINE)		
XPOVIO	T4	PA SP
CYTOTOXIC T-LYMPHOCYTE ANTIGEN (CTLA-4) RMC ANTIBODY		
IMJUDO	T4	PA SP HD
YERVOY	T4	PA SP HD
IMMUNOMODULATORS		
ACTIMMUNE	T4	PA SP HD
INTRON A	T4	PA SP HD
SELECTIVE ESTROGEN RECEPTOR MODULATORS (SERMS)		
FARESTON (<i>toremifene citrate</i>)	T4	QL (2 tabs/day) HD
SOLTAMOX	T4	HD
<i>tamoxifen citrate</i>	T4	HD PPACA
<i>toremifene citrate (Fareston)</i>	T4	QL (2 tabs/day) HD

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List of Prescription Medications

ANTI-NEOPLASTICS (Skin Conditions)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
STEROID ANTI-NEOPLASTICS		
EMCYT	T4	SP HD
<i>megestrol acetate</i>	T1	
PHOTOACT, TOPICAL ANTI-NEOPLAST, PREMALIGNANT LESIONS		
LEVULAN	T4	SP
TOPICAL ANTI-NEOPLASTIC PREMALIGNANT LESION AGENTS		
EFUDEX (<i>fluorouracil</i>)	T3	
FLUOROPLEX	T2	
<i>fluorouracil</i>	T1	
TOPICAL ANTI-NEOPLASTIC PREMALIGNANT LESION AGENTS		
<i>fluorouracil</i> (Efudex)	T1	
PANRETIN	T4	SP HD
PICATO	T2	
TOLAK	T3	
VALCHLOR	T4	SP HD

ANTI-OBESITY DRUGS (Weight Management)

ANTI-OBESITY - ANOREXIC AGENTS		
ADIPEX-P (<i>phentermine hcl</i>)	T3	PA
<i>benzphetamine hcl</i>	T1	
<i>benzphetamine hcl</i> (Regimex)	T1	
<i>diethylpropion hcl</i>	T1	
LOMAIRA	T1	
<i>phendimetrazine tartrate</i>	T1	
<i>phentermine hcl</i>	T1	
<i>phentermine hcl</i> (Adipex-p)	T1	
QSYMIA	T3	PA
REGIMEX (<i>benzphetamine hcl</i>)	T3	
ANTI-OBESITY - MELANOCORTIN 4 RECEPTOR AGONISTS		
IMCIVREE	T4	PA QL (9 ml/22 days) SP
ANTI-OBESITY GLUCAGON-LIKE PEPTIDE-I RECEPTOR AGONIST		
SAXENDA	T3	PA
WEGOVY	T2	PA QL (1 box/month)
ANTI-OBESITY SEROTONIN 2C RECEPTOR AGONISTS		
BELVIQ	T3	PA
BELVIQ XR	T3	PA
ANTI-OBESITY - OPIOID ANTAG-NOREPI, DOPAMINE RECEPTOR INHIB		
CONTRAVE	T3	PA

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List of Prescription Medications

ANTI-OBESITY DRUGS (Weight Management) (con't.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
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FAT ABSORPTION DECREASING AGENTS

XENICAL	T3	PA
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ANTI-PARASITICS (Infections)

ANTI-PARASITICS

ALINIA	T3	
ALINIA (<i>nitazoxanide</i>)	T3	
<i>nitazoxanide</i> (Alinia)	T1	

OPHTHALMIC (EYE) ANTIPARASITICS

XDEMVY	T4	PA QL(4 bottles/30 days) SP
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TOPICAL ANTI-PARASITICS

<i>crotamiton</i> (Eurax)	T1	
ELIMITE (<i>permethrin</i>)	T3	
EURAX 10% CREAM	T2	
EURAX 10% LOTION	T3	
<i>ivermectin</i> (Sklice)	T1	
NATROBA (<i>spinosad</i>)	T3	
<i>permethrin</i> (Elimite)	T1	
SKLICE (<i>ivermectin</i>)	T3	
<i>spinosad</i> (Natroba)	T1	
ULESFIA	T3	

ANTI-PARKINSON DRUGS (Parkinson's Disease)

ANTI-PARKINSONISM DRUGS, ANTI-CHOLINERGIC

<i>benztropine mesylate</i>	T1	HD
<i>trihexphenidyl hcl</i>	T1	HD

ANTI-PARKINSONISM DRUGS, OTHER

<i>amantadine hcl</i>	T1	HD
APOKYN	T4	PA SP HD
AZILECT 0.5 MG TABLET (<i>rasagiline mesylate</i>)	T3	QL (1 tab/day) HD
AZILECT 1 MG TABLET (<i>rasagiline mesylate</i>)	T3	HD
<i>bromocriptine mesylate</i> (Parlodel)	T1	HD
<i>carbidopa/levodopa</i>	T1	HD
<i>carbidopa/levodopa</i> (Sinemet 10-100)	T1	HD
<i>carbidopa/levodopa</i> (Sinemet 25-100)	T1	HD
<i>carbidopa/levodopa</i> (Sinemet 25-250)	T1	HD
<i>carbidopa/levodopa/entacapone</i> (Stalevo 100)	T1	HD
<i>carbidopa/levodopa/entacapone</i> (Stalevo 125)	T1	HD
<i>carbidopa/levodopa/entacapone</i> (Stalevo 150)	T1	HD
<i>carbidopa/levodopa/entacapone</i> (Stalevo 200)	T1	HD

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T4 – Specialty Medications

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QL – Quantity Limit

S1 – Step Therapy

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List of Prescription Medications

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

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ANTI-PARKINSONISM DRUGS, OTHER (cont.)		
<i>carbidopa/levodopa/entacapone</i> (Stalevo 50)	T1	HD
<i>carbidopa/levodopa/entacapone</i> (Stalevo 75)	T1	HD
COMTAN (<i>entacapone</i>)	T3	HD
DUOPA	T4	SP HD
<i>entacapone</i> (Comtan)	T1	HD
INBRIJA	T4	PA SP HD
KYNMOBI	T2	PA HD
MIRAPEX ER 0.375 MG TABLET (<i>pramipexole er</i>)	T3	QL (1 tab/day) HD
MIRAPEX ER 0.75 MG TABLET (<i>pramipexole er</i>)	T3	HD
MIRAPEX ER 1.5 MG TABLET (<i>pramipexole er</i>)	T3	QL (1 tab/day) HD
MIRAPEX ER 2.25 MG TABLET (<i>pramipexole er</i>)	T3	QL (1 tab/day) HD
MIRAPEX ER 3 MG TABLET (<i>pramipexole er</i>)	T3	HD
MIRAPEX ER 3.75 MG TABLET (<i>pramipexole er</i>)	T3	HD
MIRAPEX ER 4.5 MG TABLET (<i>pramipexole er</i>)	T3	HD
NEUPRO	T3	HD
NOURIANZ	T4	PA QL (1 tab/day) SP HD
OSMOLEX ER	T3	QL (1 tab/day) HD
PARLODEL (<i>bromocriptine mesylate</i>)	T3	HD
<i>pramipexole di-hcl</i>	T1	HD
<i>pramipexole er 0.375 mg tablet</i> (Mirapex Er)	T1	QL (1 tab/day) HD
<i>pramipexole er 0.75 mg tablet</i> (Mirapex Er)	T1	HD
<i>pramipexole er 1.5 mg tablet</i> (Mirapex Er)	T1	QL (1 tab/day) HD
<i>pramipexole er 2.25 mg tablet</i> (Mirapex Er)	T1	QL (1 tab/day) HD
<i>pramipexole er 3 mg tablet</i> (Mirapex Er)	T1	HD
<i>pramipexole er 3.75 mg tablet</i> (Mirapex Er)	T1	HD
<i>pramipexole er 4.5 mg tablet</i> (Mirapex Er)	T1	HD
<i>rasagiline mesylate 0.5 mg tab</i> (Azilect)	T1	QL (1 tab/day) HD
<i>rasagiline mesylate 1 mg tab</i> (Azilect)	T1	HD
<i>ropinirole hcl</i>	T1	HD
RYTARY	T3	HD
<i>selegiline hcl</i>	T1	HD
SINEMET 10-100 (<i>carbidopa-levodopa</i>)	T3	HD
SINEMET 25-100 (<i>carbidopa-levodopa</i>)	T3	HD
SINEMET 25-250 (<i>carbidopa-levodopa</i>)	T3	HD
STALEVO 100 (<i>carbidopa-levodopa-entacapone</i>)	T3	HD
STALEVO 125 (<i>carbidopa-levodopa-entacapone</i>)	T3	HD
STALEVO 150 (<i>carbidopa-levodopa-entacapone</i>)	T3	HD

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

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ANTI-PARKINSONISM DRUGS, OTHER (cont.)		
STALEVO 200 (carbidopa-levodopa-entacapone)	T3	HD
STALEVO 50 (carbidopa-levodopa-entacapone)	T3	HD
STALEVO 75 (carbidopa-levodopa-entacapone)	T3	HD
TASMAR (tolcapone)	T3	HD
tolcapone (Tasmar)	T1	HD
XADAGO	T3	ST HD
DECARBOXYLASE INHIBITORS		
carbidopa	T1	

ANTI-PLATELET DRUGS (Blood Thinners/Anti-Clotting)

PLATELET AGGREGATION INHIBITORS		
aspirin/dipyridamole	T1	HD
BRILINTA	T2	HD
cilostazol	T1	HD
clopidogrel bisulfate	T1	HD
clopidogrel bisulfate (Plavix)	T1	HD
dipyridamole	T1	HD
EFFIENT (prasugrel hcl)	T3	HD
PLAVIX (clopidogrel)	T3	HD
prasugrel hcl (Effient)	T1	HD
ticlopidine hcl	T1	HD
ZONTIVITY	T3	HD
PLATELET REDUCING AGENTS		
AGRYLIN (anagrelide hcl)	T3	
anagrelide hcl	T1	
anagrelide hcl (Agraylin)	T1	

ANTIVIRALS (AIDS/HIV)

ANTI-RETROVIRAL - CAPSID INHIBITORS		
SUNLENCA 463.5 MG/1.5 ML VIAL	T4	PA SP
SUNLENCA 4- 300 MG TABLET	T4	PA QL(5 tabs/180 days) SP
SUNLENCA 5- 300 MG TABLET	T4	PA QL(5 tabs/180 days) SP
ANTI-RETROVIRAL - INTEGRASE INHIBITOR AND NNRTI COMB.		
CABENUVA	T4	PA SP
JULUCA	T4	SP
ANTI-RETROVIRAL - INTEGRASE INHIBITOR AND NRTI COMB.		
DOVATO	T4	SP
ANTI-RETROVIRAL - NRTIS AND INTEGRASE INHIBITORS COMB		
TRIUMEQ	T4	SP

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

T4 – Specialty Medications

PA – Prior Authorization

QL – Quantity Limit

ST – Step Therapy

AGE – Age Requirement

SP – Specialty Medication

HD – May require home delivery pharmacy

PPACA – No Cost-Share Preventive Medication

CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

ANTIVIRALS (AIDS/HIV) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ANTI-RETROVIRAL - NUCLEOSIDE, NUCLEOTIDE, PROTEASE INH.		
SYMITUZA	T4	SP
ANTIVIRALS - HIV-SPEC, NON-PEPTIDIC PROTEASE INHIB		
APTIVUS	T4	PA SP
<i>darunavir (Prezista)</i>	T4	PA SP
PREZCOBIX	T4	PA SP
PREZISTA	T4	SP
ANTIVIRALS - HIV-SPEC, NUCLEOSIDE-NUCLEOTIDE ANALOG		
CIMDUO	T4	PA SP
DESCOVY	T4	PA SP PPACA
<i>emtricitabine-tenofv 100-150mg</i>	T4	SP
<i>emtricitabine-tenofv 133-200mg</i>	T4	SP
<i>emtricitabine-tenofv 167-250mg</i>	T4	SP
<i>emtricitabine-tenofv 200-300mg</i>	T4	SP PPACA
TEMIXYS	T4	PA SP
ANTIVIRALS - HIV-SPEC, NUCLEOSIDE ANALOG, RTI COMB		
<i>abacavir sulfate/lamivudine</i>	T4	PA SP
<i>abacavir/lamivudine/zidovudine</i>	T4	PA SP
<i>lamivudine/zidovudine</i>	T4	SP
ANTIVIRALS - HIV-SPECIFIC, CCR5 CO-RECEPTOR ANTAG.		
SELZENTRY	T4	PA SP
ANTIVIRALS - HIV-SPECIFIC, CD4 ATTACHMENT INHIBITOR		
RUKOBIA	T4	PA QL (2 syringe/day) SP
ANTIVIRALS - HIV-SPECIFIC, FUSION INHIBITORS		
FUZEON	T4	PA SP
ANTIVIRALS - HIV-SPECIFIC, NON-NUCLEOSIDE, RTI		
EDURANT	T4	PA SP
<i>efavirenz</i>	T4	PA SP
<i>nevirapine</i>	T4	PA SP
PIFELTRO	T4	PA SP
ANTIVIRALS - HIV-SPECIFIC, NUCLEOSIDE ANALOG, RTI		
<i>abacavir sulfate</i>	T4	PA SP
<i>emtricitabine (Emtriva)</i>	T4	PA SP
EMTRIVA 10 MG/ML SOLUTION	T4	PA SP
<i>lamivudine 10 mg/ml oral soln</i>	T4	SP
<i>lamivudine tablet</i>	T4	PA SP
<i>zidovudine</i>	T4	SP

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

T4 – Specialty Medications
 PA – Prior Authorization
 QL – Quantity Limit

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

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

List of Prescription Medications

ANTIVIRALS (AIDS/HIV) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ANTIVIRALS - HIV-SPECIFIC, NUCLEOTIDE ANALOG, RTI		
<i>tenofovir disoproxil fumarate</i>	T4	PA SP
VIREAD	T4	PA SP
VIREAD POWDER	T4	PA SP
ANTIVIRALS - HIV-SPECIFIC, PROTEASE INHIBITOR COMB		
<i>lopinavir/ritonavir</i>	T1	
ANTIVIRALS - HIV-SPECIFIC, PROTEASE INHIBITORS		
<i>atazanavir sulfate</i>	T4	PA SP
EVOTAZ	T4	PA SP
<i>fosamprenavir calcium</i>	T4	PA SP
INVIRASE	T3	PA
LEXIVA	T4	PA SP
NORVIR	T4	SP
NORVIR 80 MG/ML SOLUTION	T4	SP
APRETUDE	T4	PA SP
REYATAZ	T4	PA SP
<i>ritonavir</i>	T4	SP
ANTIVIRALS - HIV-I INTEGRASE STRAND TRANSFER INHIBTR		
ISENTRESS	T4	SP
ISENTRESS HD	T4	PA SP
TIVICAY	T4	SP
TIVICAY PD	T4	SP
ANTIVIRAL - RNA POLYMERASE INHIBITOR		
LAGEVRIO 200 MG CAP (EUA)	T2	QL(1 pack/120 days)
ARTV NUCLEOSIDE, NUCLEOTIDE, NON-NUCLEOSIDE RTI COMB		
COMPLERA	T4	PA SP
DELSTRIGO	T4	PA SP
<i>efavirenz/emtricit/tenofovr df (Atripla)</i>	T4	PA SP
<i>efavirenz/lamivu/tenofov disop (Symfi Lo)</i>	T4	SP
<i>efavirenz/lamivu/tenofov disop (Symfi)</i>	T4	SP
ODEFSEY	T4	PA SP
ARV-NUCLEOSIDE, NUCLEOTIDE RTI, INTEGRASE INHIBITORS		
BIKTARVY	T4	SP
GENVOYA	T4	SP
STRIBILD	T4	PA SP

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

T4 – Specialty Medications
PA – Prior Authorization
QL – Quantity Limit

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

HD – May require home delivery pharmacy
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List of Prescription Medications

ANTIVIRALS (Eye Conditions)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
EYE ANTIVIRALS		
<i>trifluridine</i>	T1	
ZIRGAN	T3	
ANTIVIRALS (Infections)		
ANTIVIRALS, GENERAL		
<i>acyclovir</i>	T1	
<i>famciclovir</i>	T1	
FLUMADINE (<i>rimantadine hcl</i>)	T3	
GANCICLOVIR	T4	SP
LIVTENCITY	T4	PA QL (4 tabs/day) SP
<i>oseltamivir 6 mg/ml suspension</i> (Tamiflu)	T1	QL (180ml/30 days)
<i>oseltamivir phos 30 mg capsule</i> (Tamiflu)	T1	QL (20/30 days)
<i>oseltamivir phos 45 mg capsule</i> (Tamiflu)	T1	QL (10 caps/30 days)
<i>oseltamivir phos 75 mg capsule</i> (Tamiflu)	T1	QL (10/30 days)
PREVYMIS	T3	SP HD
RELENZA	T3	QL (20/30 days)
<i>ribavirin</i> (Virazole)	T4	SP HD
<i>rimantadine hcl</i> (Flumadine)	T1	
TAMIFLU 30 MG CAPSULE (<i>oseltamivir phosphate</i>)	T3	QL (20/30 days)
TAMIFLU 45 MG CAPSULE (<i>oseltamivir phosphate</i>)	T3	QL (10/30 days)
TAMIFLU 6 MG/ML SUSPENSION (<i>oseltamivir phosphate</i>)	T3	QL (180ml/30 days)
TAMIFLU 75 MG CAPSULE (<i>oseltamivir phosphate</i>)	T3	QL (10/30 days)
<i>valacyclovir hcl</i> (Valtrex)	T1	
<i>valganciclovir hcl</i>	T1	
VALTrex (<i>valacyclovir</i>)	T3	
VIRAZOLE	T4	SP HD
XOFLUZA	T3	QL (2 tabs/30 days)
HEP C - NS5A, NS3/4A, NUCLEOTIDE NS5B INHIB COMBO		
VOSEVI	T4	PA SP HD
HEP C VIRUS, NUCLEOTIDE ANALOG NS5B POLYMERASE INH		
SOVALDI 150 MG PELLETT PACKET	T4	PA QL (1 tab/day) SP HD
SOVALDI 200 MG PELLETT PACKET	T4	PA QL (1 tab/day) SP HD
SOVALDI 200 MG TABLET	T4	PA QL (1 tab/day) SP HD
SOVALDI 400 MG TABLET	T4	PA SP HD
HEP C VIRUS-NS5B POLYMERASE AND NS5A INHIB. COMBO.		
EPCLUSA 200 MG-50 MG TABLET	T4	PA QL (1 tab/Day) SP HD
EPCLUSA 400 MG-100 MG TABLET	T4	PA SP HD
HARVONI 33.75-150 MG PELLETT PK	T4	PA QL (1 tab/day) SP HD

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

T4 – Specialty Medications

PA – Prior Authorization

QL – Quantity Limit

ST – Step Therapy

AGE – Age Requirement

SP – Specialty Medication

HD – May require home delivery pharmacy

PPACA – No Cost-Share Preventive Medication

CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

ANTIVIRALS (Infections) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
HEP C VIRUS-NS5B POLYMERASE AND NS5A INHIB. COMBO. (cont.)		
HARVONI 45-200 MG PELLETT PACKT	T4	PA QL (1 tab/day) SP HD
HARVONI 45-200 MG TABLET	T4	PA QL (1 tab/day) SP HD
HARVONI 90-400 MG TABLET	T4	PA SP HD
LEDIPASVIR-SOFOSBUVIR	T4	PA SP HD
HEPATITIS B TREATMENT AGENTS		
<i>adefovir dipivoxil</i>	T4	SP HD
BARACLUDE	T4	SP HD
<i>entecavir 0.5 mg tablet</i>	T4	QL (1 tab/day) SP HD
<i>entecavir 1 mg tablet</i>	T4	SP HD
EPIVIR HBV 100 MG TABLET (<i>lamivudine hbv</i>)	T4	SP
EPIVIR HBV 25 MG/5 ML SOLN	T4	SP
<i>lamivudine (Epiriv Hbv)</i>	T4	SP
VEMLIDY	T4	SP HD
HEPATITIS C TREATMENT AGENTS		
PEGASYS	T4	PA SP HD
PEGINTRON	T4	PA SP HD
<i>ribasphere 200 mg capsule</i>	T4	SP HD
<i>ribasphere 200 mg tablet</i>	T4	SP HD
<i>ribasphere 400 mg tablet</i>	T4	SP
<i>ribasphere 600 mg tablet</i>	T4	SP
<i>ribasphere ribapak 200-400 mg</i>	T4	SP HD
<i>ribasphere ribapak 400-400 mg</i>	T4	SP HD
<i>ribasphere ribapak 400-400 mg</i>	T4	SP HD
<i>ribasphere ribapak 600-400 mg</i>	T4	SP HD
<i>ribasphere ribapak 600-400 mg</i>	T4	SP HD
<i>ribasphere ribapak 600-600 mg</i>	T4	SP HD
<i>ribasphere ribapak 600-600 mg</i>	T4	SP HD
RIBASPHERE RIBAPAK	T4	
<i>ribavirin</i>	T4	SP HD
HEPATITIS C VIRUS- NS5A AND NS3/4A INHIBITOR COMB		
ZEPATIER	T4	PA SP HD
MAIN PROTEASE (MPRO) INHIBITOR		
PAXLOVID	T2	QL (1 pkg/120 days)
RNA POLYMERASE INHIBITOR		
MOLNUPIRAVIR	T3	QL (1 pkg/120 days)

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

T4 – Specialty Medications
 PA – Prior Authorization
 QL – Quantity Limit

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

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

List of Prescription Medications

ANTIVIRALS (Skin Conditions)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
TOPICAL GENITAL WART-HPV TREATMENT AGENTS		
VEREGEN	T3	
AUTONOMIC DRUGS (Allergy/Nasal Sprays)		
ANAPHYLAXIS THERAPY AGENTS		
<i>epinephrine</i>	T1	QL (2 packs/30 days)
<i>epinephrine</i> (Epinephrine)	T1	QL (2 packs/30 days)
AUTONOMIC DRUGS (Alzheimer's Disease)		
CHOLINESTERASE INHIBITORS		
<i>ARICEPT (donepezil hcl)</i>	T3	HD
<i>donepezil hcl</i>	T1	HD
<i>donepezil hcl</i> (Aricept)	T1	HD
<i>EXELON (rivastigmine)</i>	T3	HD
<i>galantamine er 16 mg capsule</i> (Razadyne Er)	T1	HD
<i>galantamine er 24 mg capsule</i> (Razadyne Er)	T1	HD
<i>galantamine er 8 mg capsule</i> (Razadyne Er)	T1	QL (1 cap/day) HD
<i>galantamine hbr</i>	T1	HD
<i>pyridostigmine bromide</i> (Mestinon)	T1	HD
RAZADYNE ER 16 MG CAPSULE (<i>galantamine er</i>)	T3	HD
RAZADYNE ER 24 MG CAPSULE (<i>galantamine er</i>)	T3	HD
RAZADYNE ER 8 MG CAPSULE (<i>galantamine er</i>)	T3	QL (1 cap/day) HD
<i>rivastigmine</i> (Exelon)	T1	HD
<i>rivastigmine tartrate</i>	T1	HD
AUTONOMIC DRUGS (Attention Deficit Hyperactivity Disorder)⁸		
ADRENERGICS, AROMATIC, NON-CATECHOLAMINE		
<i>ADDERALL (dextroamphetamine-amphetamine)</i>	T3	PA ST
ADZENYS ER	T3	PA QL (15ml/day)
ADZENYS XR-ODT	T3	PA QL (1 tab/day)
AMPHETAMINE	T3	PA QL (15ml/day)
<i>amphetamine sulfate</i> (Evekeo)	T1	PA
<i>dextroamp-amphet er 10 mg cap</i>	T1	PA QL (1 cap/ day)
<i>dextroamp-amphet er 15 mg cap</i>	T1	PA QL (1 cap/day)
<i>dextroamp-amphet er 20 mg cap</i>	T1	PA QL (1 cap/day)
<i>dextroamp-amphet er 25 mg cap</i>	T1	PA QL (1 per day)
<i>dextroamp-amphet er 30 mg cap</i>	T1	PA QL (1 cap/day)

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

T4 – Specialty Medications
 PA – Prior Authorization
 QL – Quantity Limit

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

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

List of Prescription Medications

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

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ADRENERGICS, AROMATIC, NON-CATECHOLAMINE (cont.)		
<i>dextroamp-amphet er 5 mg cap</i>	T1	PA QL (1 cap/day)
<i>dextroamp-amphet er 12.5mg cp (Mydayis)</i>	T1	PA QL
<i>dextroamp-amphet er 25 mg cap (Mydayis)</i>	T1	PA QL
<i>dextroamp-amphet er 37.5mg cp (Mydayis)</i>	T1	PA QL
<i>dextroamp-amphet er 50 mg cap (Mydayis)</i>	T1	PA QL
<i>dextroamphetamine er 10 mg cap</i>	T1	PA QL (1 cap/day)
<i>dextroamphetamine er 15 mg cap</i>	T1	PA QL (3/day)
<i>dextroamphetamine er 5 mg cap</i>	T1	PA QL (1 cap/day)
<i>dextroamphetamine sulfate</i>	T1	PA
<i>dextroamphetamine sulfate</i>	T3	PA ST
<i>dextroamphetamine/amphetamine (Adderall Xr)</i>	T1	PA QL(1 cap/day)
<i>dextroamphetamine/amphetamine (Adderall)</i>	T1	PA
<i>dextroamphetamine/amphetamine (Mydayis)</i>	T1	PA QL(1 cap/day)
DYANAVEL XR	T3	PA QL (8ml/day)
EVEKEO (<i>amphetamine sulfate</i>)	T3	PA ST
EVEKEO ODT	T3	PA
<i>lisdexamfetamine 10 mg capsule (Vyvanse)</i>	T1	PA QL(1 cap/day)
<i>lisdexamfetamine 20 mg capsule (Vyvanse)</i>	T1	PA QL(1 cap/day)
<i>lisdexamfetamine 30 mg capsule (Vyvanse)</i>	T1	PA QL(1 cap/day)
<i>lisdexamfetamine 40 mg capsule (Vyvanse)</i>	T1	PA QL(1 cap/day)
<i>lisdexamfetamine 50 mg capsule (Vyvanse)</i>	T1	PA QL(1 cap/day)
<i>lisdexamfetamine 60 mg capsule (Vyvanse)</i>	T1	PA QL(1 cap/day)
<i>lisdexamfetamine 70 mg capsule (Vyvanse)</i>	T1	PA QL(1 cap/day)
<i>methamphetamine hcl</i>	T1	PA
MYDAYIS (<i>dextroamphetamine/amphetamine</i>)	T3	PA QL(1 cap/day)
VYVANSE 10 MG CAPSULE (<i>lisdexamfetamine dimesylate</i>)	T2	PA QL(1 cap/day)
VYVANSE 20 MG CAPSULE (<i>lisdexamfetamine dimesylate</i>)	T2	PA QL(1 cap/day)
VYVANSE 30 MG CAPSULE (<i>lisdexamfetamine dimesylate</i>)	T2	PA QL(1 cap/day)
VYVANSE 40 MG CAPSULE (<i>lisdexamfetamine dimesylate</i>)	T2	PA QL(1 cap/day)
VYVANSE 50 MG CAPSULE (<i>lisdexamfetamine dimesylate</i>)	T2	PA QL(1 cap/day)
VYVANSE 60 MG CAPSULE (<i>lisdexamfetamine dimesylate</i>)	T2	PA QL(1 cap/day)
VYVANSE 70 MG CAPSULE (<i>lisdexamfetamine dimesylate</i>)	T2	PA QL(1 cap/day)
XELSTRYM	T3	PA QL(1 patch/day)
ZENZEDI	T3	PA ST

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

T4 – Specialty Medications
 PA – Prior Authorization
 QL – Quantity Limit

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

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

List of Prescription Medications

AUTONOMIC DRUGS (Blood Pressure/Heart Medications)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ADRENERGIC VASOPRESSOR AGENTS		
<i>droxidopa</i> (Northera)	T4	SP HD
<i>midodrine hcl</i>	T1	
ADRENERGIC AGENTS, CATECHOLAMINES		
<i>epinephrine 1 mg/10 ml luerjet</i>	T1	
ALPHA-ADRENERGIC BLOCKING AGENTS		
DIBENZYLIN (phenoxybenzamine hcl)	T3	HD
<i>phenoxybenzamine hcl</i> (Dibenzylin)	T1	HD
AUTONOMIC DRUGS (Miscellaneous)		
NEUROMUSCULAR BLOCKING AGENTS		
DAXXIFY	T4	PA SP
MYOBLOC	T4	PA SP HD
AUTONOMIC DRUGS (Urinary Tract Conditions)		
PARASYMPATHETIC AGENTS		
<i>bethanechol chloride</i>	T1	HD
<i>cevimeline hcl</i> (Evoxac)	T1	HD
EVOXAC (<i>cevimeline hcl</i>)	T3	HD
<i>guanidine hcl</i>	T1	HD
<i>pilocarpine hcl</i> (Salagen)	T1	HD
SALAGEN (<i>pilocarpine hcl</i>)	T3	HD
URECHOLINE (<i>bethanechol chloride</i>)	T3	HD
BIOLOGICALS (Allergy/Nasal Sprays)		
ALLERGENIC EXTRACTS, THERAPEUTIC		
GRASTEK	T3	PA QL (1 tab/day)
ODACTRA	T3	PA QL (1 tab/day)
ORALAIR	T3	PA QL (1 tab/day)
RAGWITEK	T3	PA QL (1 tab/day)
BIOLOGICALS (Blood Pressure/Heart Medications)		
PLASMA KALLIKREIN INHIBITORS		
TAKHZYRO	T4	PA SP HD
BIOLOGICALS (Miscellaneous)		
PKU TREATMENT AGENTS - PHENYLALANINE AMMONIA LYASE		
PALYNZIQ	T4	PA SP HD

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

T4 – Specialty Medications
 PA – Prior Authorization
 QL – Quantity Limit

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

HD – May require home delivery pharmacy
 PPACA – No Cost-Share Preventive Medication
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List of Prescription Medications

BIOLOGICALS (Vaccines)			
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits	
COVID-19 VACCINES			
COMIRNATY 2023-2024	T3	PPACA	
JANSSEN	T2	PPACA	
MODERNA	T2	PPACA	
NOVAVAX	T3	PPACA	
PFIZER	T2	PPACA	
SPIKEVAX	T3	PPACA	
ENTERIC VIRUS VACCINES			
IPOL	T2	PPACA	
ROTARIX	T3	PPACA	
ROTATEQ	T3	PPACA	
GRAM NEGATIVE COCCI VACCINES			
BEXSERO	T2	PPACA	
MENACTRA	T2	PPACA	
MENQUADFI	T2	PPACA	
MENVEO A-C-Y-W-135-DIP	T2	PPACA	
PENBRAYA	T3	PPACA	
TRUMENBA	T2	PPACA	
GRAM POSITIVE COCCI VACCINES			
PNEUMOVAX 23	T2	PPACA	
PREVNAR 13	T2	PPACA	
INFLUENZA VIRUS VACCINES			
AFLURIA	T2	PPACA	
AFLURIA QUAD	T2	PPACA	
EZ FLU 2	T2	PPACA	
FLUAD	T2	PPACA	
FLUAD QUAD	T2	PPACA	
FLUARIX	T2	PPACA	
FLUBLOK	T2	PPACA	
FLUBLOK QUAD	T2	PPACA	
FLUCELVAX QUAD	T2	PPACA	
FLULAVAL QUAD	T2	PPACA	
FLUMIST QUAD	T3	PPACA	
FLUVIRIN	T2	PPACA	
FLUZONE HIGH-DOSE	T2	PPACA	
FLUZONE INTRADERM QUAD	T2	PPACA	
FLUZONE QUAD	T2	PPACA	
FLUZONE QUAD PEDI	T2	PPACA	

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

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

S1 – Step 1 therapy
AGE – Age Requirement
SP – Specialty Medication

HD – 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		
ACTHIB	T2	PPACA
ADACEL TDAP	T2	PPACA
BOOSTRIX TDAP	T2	PPACA
DAPTACEL DTAP	T2	PPACA
DIPHTHERIA-TETANUS TOXOIDS-PED	T2	PPACA
HIBERIX	T2	PPACA
INFANRIX DTAP	T2	PPACA
KINRIX	T2	PPACA
M-M-R II VACCINE	T2	PPACA
PEDVAXHIB	T2	PPACA
PENTACEL	T2	PPACA
PENTACEL ACTHIB COMPONENT	T2	PPACA
PROQUAD	T2	PPACA
QUADRACEL DTAP-IPV	T2	PPACA
TDVAX	T2	PPACA
TENIVAC	T2	PPACA
VAXELIS	T2	PPACA
VIRAL/TUMORIGENIC VACCINES		
ACAM2000	T3	
ENGERIX-B ADULT	T2	PPACA
ENGERIX-B PEDIATRIC-ADOLESCENT	T2	PPACA
GARDASIL 9	T2	PPACA
HEPLISAV-B	T2	PPACA
IXCHIQ	T3	PPACA
JYNNEOS	T3	
PEDIARIX	T2	PPACA
RECOMBIVAX HB	T2	PPACA
SHINGRIX	T2	QL (2 doses/lifetime) PPACA
TWINRIX	T2	PPACA
VARIVAX VACCINE	T2	PPACA
ZOSTAVAX	T2	PPACA
BLOOD (Blood Modifiers/Bleeding Disorders)		
AGENTS TO TX THROMBOTIC THROMBOCYTOPENIC PURPURA		
ADZYNMA	T4	PA SP
CABLIVI	T4	PA SP

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

T4 – Specialty Medications
 PA – Prior Authorization
 QL – Quantity Limit

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

HD – May require home delivery pharmacy
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List of Prescription Medications

BLOOD (Blood Modifiers/Bleeding Disorders) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ANTI-FIBRINOLYTIC AGENTS		
AMICAR (<i>aminocaproic acid</i>)	T4	SP HD
<i>aminocaproic acid</i> (Amicar)	T4	SP HD
LYSTEDA (<i>tranexamic acid</i>)	T4	SP
<i>tranexamic acid</i> (Lysteda)	T4	SP
<i>tranexamic acid</i> 1,000 mg/100ml-nacl	T4	SP
<i>tranexamic acid in nacl,iso-os</i>	T4	SP
TRANEXAMIC ACID-NACL	T4	SP
TRANEXAMIC 1,000 MG/100ML-NACL	T4	SP
ANTI-HEMOPHILIC FACTORS		
ALTUVILLO	T4	PA SP HD
COMPLEMENT (C3) INHIBITORS		
EMPAVELI	T4	PA SP
FABHALTA	T4	PA QL(2 caps/day) SP
VEOPOZ	T4	SP
HEMOPHILIA TREATMENT AGENTS, NON-FACTOR REPLACEMENT		
HEMLIBRA	T4	PA SP HD
SICKLE CELL ANEMIA AGENTS		
DROXIA	T3	
OXBRYTA 300MG TAB for SUSP	T4	QL (5 tabs/day) SP
SIKLOS	T3	PA
TOPICAL HEMOSTATICS		
ASTRINGYN	T3	
AVITENE	T3	
ENDO-AVITENE	T3	
EVICEL	T3	
<i>gelatin sponge, absorb/porcine</i> (Gelfoam)	T1	
GELFOAM	T3	
GELFOAM (<i>surgifoam</i>)	T3	
GELFOAM COMPRESSED	T3	
MONSEL'S	T3	
RAPLIXA	T3	
RECOTHROM	T3	
SURGIFOAM	T1	
SYRINGE AVITENE	T3	
TACHOSIL	T3	

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

T4 – Specialty Medications
 PA – Prior Authorization
 QL – Quantity Limit

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

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

List of Prescription Medications

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

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
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TOPICAL HEMOSTATICS

THROMBI-GEL	T3	
THROMBIN-JMI	T3	
THROMBI-PAD	T3	
ULTRAFOAM	T3	

BLOOD (Blood Thinners/Anti-Clotting)

HEMORRHEOLOGIC AGENTS

<i>pentoxifylline</i>	T1	HD
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BLOOD (Miscellaneous)

CELL/GENE THERAPY AGENTS - HEMATOPOIETIC

OMISIRGE	T3	
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CARDIAC DRUGS (Blood Pressure/Heart Medications)

ANTI-ANGINAL, ANTI-ISCHEMIC AGENTS, NON-HEMODYNAMIC

<i>ranolazine</i> (Ranexa)	T1	QL (4 tabs/day) HD
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ANTI-ARRHYTHMICS

<i>amiodarone hcl</i>	T1	HD
<i>disopyramide phosphate</i> (Norpace)	T1	HD
<i>dofetilide 125 mcg capsule</i> (Tikosyn)	T1	QL (8 caps/day) HD
<i>dofetilide 250 mcg capsule</i> (Tikosyn)	T1	QL (4 caps/day) HD
<i>dofetilide 500 mcg capsule</i> (Tikosyn)	T1	QL (2 caps/day) HD
<i>flecainide acetate</i>	T1	HD
<i>mexiletine hcl</i>	T1	HD
NORPACE (<i>disopyramide phosphate</i>)	T3	PA HD
NORPACE CR	T3	HD
<i>pacerone 100 mg tablet</i>	T3	PA HD
<i>pacerone 200 mg tablet</i>	T1	HD
<i>pacerone 400 mg tablet</i>	T3	PA HD
<i>propafenone hcl</i>	T1	HD
<i>propafenone hcl</i> (Rythmol Sr)	T1	HD
<i>quinidine gluconate</i>	T1	HD
<i>quinidine sulfate</i>	T1	HD
RYTHMOL SR (<i>propafenone hcl er</i>)	T3	PA HD
TIKOSYN 125 MCG CAPSULE (<i>dofetilide</i>)	T3	PA QL (8 caps/day) HD
TIKOSYN 250 MCG CAPSULE (<i>dofetilide</i>)	T3	PA QL (4 caps/day) HD
TIKOSYN 500 MCG CAPSULE (<i>dofetilide</i>)	T3	PA QL (2 caps/day) HD

T1 – Typically Generics
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T4 – Specialty Medications
 PA – Prior Authorization
 QL – Quantity Limit

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

HD – May require home delivery pharmacy
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List of Prescription Medications

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

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
CALCIUM CHANNEL BLOCKING AGENTS (cont.)		
ADALAT CC (<i>nifedipine er</i>)	T3	HD
<i>amlodipine besylate</i> (Norvasc)	T1	HD
CALAN SR (<i>verapamil er</i>)	T3	HD
CAMZYOS	T4	PA QL (30 caps/30 days) SP
CARDIZEM LA 120 MG TABLET (<i>diltiazem hcl</i>)	T3	QL (1 tab/day) HD
CARDIZEM LA 180 MG TABLET (<i>matzim la</i>)	T3	HD
CARDIZEM LA 240 MG TABLET (<i>matzim la</i>)	T3	HD
CARDIZEM LA 300 MG TABLET (<i>matzim la</i>)	T3	HD
CARDIZEM LA 360 MG TABLET (<i>matzim la</i>)	T3	HD
CARDIZEM LA 420 MG TABLET (<i>matzim la</i>)	T3	HD
<i>diltiazem hcl</i>	T1	HD
<i>diltiazem 24h er(la) 120 mg tb</i> (Cardizem La)	T1	QL(1 tab/day) HD
<i>diltiazem 24h er(la) 180 mg tb</i> (Cardizem La)	T1	HD
<i>diltiazem 24h er(la) 240 mg tb</i> (Cardizem La)	T1	HD
<i>diltiazem 24h er(la) 300 mg tb</i> (Cardizem La)	T1	HD
<i>diltiazem 24h er(la) 360 mg tb</i> (Cardizem La)	T1	HD
<i>diltiazem 24h er(la) 420 mg tb</i> (Cardizem La)	T1	HD
<i>diltiazem hcl</i> (Cardizem La)	T1	HD
<i>diltiazem hcl</i> (Tiazac)	T1	HD
<i>felodipine</i>	T1	HD
<i>isradipine</i>	T1	HD
<i>nicardipine hcl</i>	T1	HD
<i>nifedipine</i>	T1	HD
<i>nifedipine</i> (Adalat Cc)	T1	HD
<i>nifedipine</i> (Procardia XI)	T1	HD
<i>nifedipine</i> (Procardia)	T1	HD
<i>nimodipine</i>	T1	HD
<i>nisoldipine er 17 mg tablet</i> (Sular)	T1	HD
<i>nisoldipine er 20 mg tablet</i>	T1	QL (1 tab/day) HD
<i>nisoldipine er 25.5 mg tablet</i>	T1	HD
<i>nisoldipine er 30 mg tablet</i>	T1	HD
<i>nisoldipine er 34 mg tablet</i> (Sular)	T1	HD
<i>nisoldipine er 40 mg tablet</i>	T1	HD
<i>nisoldipine er 8.5 mg tablet</i> (Sular)	T1	HD
NORLIQVA	T3	QL(10 mls/day) HD
NORLIQVA ORAL SOLN	T2	PA QL
NORVASC (<i>amlodipine besylate</i>)	T3	HD

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

T4 – Specialty Medications

PA – Prior Authorization

QL – Quantity Limit

ST – Step Therapy

AGE – Age Requirement

SP – Specialty Medication

HD – May require home delivery pharmacy

PPACA – No Cost-Share Preventive Medication

CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

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

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
CALCIUM CHANNEL BLOCKING AGENTS (cont.)		
NYMALIZE	T3	HD
PROCARDIA (<i>nifedipine</i>)	T3	HD
SULAR (<i>nisoldipine</i>)	T3	HD
TIAZAC (<i>tiadylt er</i>)	T3	HD
<i>verapamil hcl</i>	T1	HD
<i>verapamil hcl</i> (Calan Sr)	T1	HD
<i>verapamil hcl</i> (Verelan Pm)	T1	HD
<i>verapamil hcl</i> (Verelan)	T1	HD
VERELAN (<i>verapamil hcl</i>)	T3	HD
VERELAN (<i>verapamil sr</i>)	T3	HD
VERELAN PM (<i>verapamil er pm</i>)	T3	HD
DIGITALIS GLYCOSIDES		
<i>digoxin</i>	T1	HD
HEART RATE REDUCING, SA SELECTIVE I(F) CURRENT INH.		
CORLANOR 5 MG TABLET	T2	PA HD
CORLANOR 5 MG/5 ML ORAL SOLN	T4	PA SP HD
CORLANOR 7.5 MG TABLET	T2	PA HD
SOLUBLE GUANYLATE CYCLASE (SGC) STIMULATOR		
VERQUVO	T2	QL(1 tab/day)
VASODILATORS, CORONARY		
DILATRATE-SR	T3	HD
<i>isosorbide dinitrate 5mg tab</i>	T1	HD
<i>isosorbide mononitrate</i>	T1	HD
MINITRAN	T1	HD
NITRO-DUR 0.1 MG/HR PATCH	T3	HD
NITRO-DUR 0.2 MG/HR PATCH	T3	HD
NITRO-DUR 0.3 MG/HR PATCH	T2	HD
NITRO-DUR 0.4 MG/HR PATCH	T3	HD
NITRO-DUR 0.6 MG/HR PATCH	T3	HD
NITRO-DUR 0.8 MG/HR PATCH	T2	HD
<i>nitroglycerin</i> (Nitrostat)	T1	HD
<i>nitroglycerin</i> (Nitro-dur)	T1	HD
<i>nitroglycerin</i> (Nitromist)	T1	HD
<i>nitroglycerin 400 mcg spray</i> (Nitrolingual)	T1	HD
NITROLINGUAL	T3	HD
NITROMIST	T3	HD
NITROSTAT	T3	HD

T1 – Typically Generics

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T4 – Specialty Medications

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List of Prescription Medications

CARDIOVASCULAR (Allergy/Nasal Spray)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
SYMPATHOMIMETIC AGENTS		
IMMPHENTIV	T3	
REZIPRES	T3	

CARDIOVASCULAR (Asthma/COPD/Respiratory)

PULM ANTI-HTN, SOLUBLE GUANYLATE CYCLASE STIMULATOR		
ADEMPAS	T4	PA SP HD

PULM.ANTI-HTN, SEL.C-GMP PHOSPHODIESTERASE T5 INHIB		
<i>sildenafil 10 mg/ml oral susp (Revatio)</i>	T4	PA SP HD
<i>sildenafil 20 mg tablet (Revatio)</i>	T4	PA SP HD
REVATIO 10 MG/12.5 ML VIAL	T4	PA SP HD
<i>tadalafil (Adcirca)</i>	T4	PA SP HD
<i>tadalafil 20 mg tablet (Adcirca)</i>	T4	PA SP HD

PULMONARY ANTI-HTN, ENDOTHELIN RECEPTOR ANTAGONIST		
<i>ambrisentan (Letairis)</i>	T4	PA SP HD
<i>bosentan (Tracleer)</i>	T4	PA SP HD
LETAIRIS (<i>ambrisentan</i>)	T4	PA SP HD
OPSUMIT	T4	PA SP HD
TRACLEER 125 MG TABLET (<i>bosentan</i>)	T4	PA SP HD
TRACLEER 32 MG TABLET FOR SUSP	T4	PA SP HD
TRACLEER 62.5 MG TABLET (<i>bosentan</i>)	T4	PA SP HD

PULMONARY ANTIHYPERTENSIVES, PROSTACYCLIN-TYPE		
ORENITRAM ER	T4	PA SP HD
ORENITRAM MONTH 1 TITRATION KT	T4	PA QL(168 tabs/180 days) SP HD
ORENITRAM MONTH 2 TITRATION KT	T4	PA QL(336 tabs/180 days) SP HD
ORENITRAM MONTH 3 TITRATION KT	T4	PA QL(252 tabs/180 days) SP HD
TYVASO	T4	PA SP HD
TYVASO INSTITUTIONAL START KIT	T4	PA SP HD
TYVASO REFILL KIT	T4	PA SP HD
TYVASO STARTER KIT	T4	PA SP HD
UPTRAVI	T4	PA SP HD
VELETRI VIAL	T4	PA SP
VENTAVIS	T4	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
LOTREL (<i>amlodipine besylate-benazepril</i>)	T3	HD

T1 – Typically Generics
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 T3 – Typically Non-Preferred Brands
 T4 – Specialty Medications
 PA – Prior Authorization
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 AGE – Age Requirement
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List of Prescription Medications

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

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ACE INHIBITOR-CALCIUM CHANNEL BLOCKER COMBINATION (cont.)		
PRESTALIA 14 MG-10 MG TABLET	T3	HD
PRESTALIA 3.5 MG-2.5 MG TABLET	T3	QL (1 tab/day) HD
PRESTALIA 7 MG-5 MG TABLET	T3	QL (1 tab/day) HD
TARKA (trandolapril-verapamil er)	T3	HD
trandolapril/verapamil hcl	T1	HD
trandolapril/verapamil hcl (Tarka)	T1	HD
ACE INHIBITOR-THIAZIDE OR THIAZIDE-LIKE DIURETIC		
ACCURETIC (quinapril-hydrochlorothiazide)	T3	ST HD
benazepril/hydrochlorothiazide	T1	HD
benazepril/hydrochlorothiazide (Lotensin Hct)	T1	HD
captopril-hctz 25-15 mg tablet	T1	QL (3 tabs/day) HD
captopril-hctz 25-25 mg tablet	T1	QL (2 tabs/day) HD
captopril-hctz 50-15 mg tablet	T1	QL (3 tabs/day) HD
captopril-hctz 50-25 mg tablet	T1	QL (2 tabs/day) HD
enalapril/hydrochlorothiazide	T1	HD
enalapril/hydrochlorothiazide (Vaseretic)	T1	HD
fosinopril/hydrochlorothiazide	T1	HD
lisinopril/hydrochlorothiazide (Zestoretic)	T1	HD
LOTENSIN HCT (benazepril-hydrochlorothiazide)	T3	ST HD
quinapril/hydrochlorothiazide (Accuretic)	T1	HD
VASERETIC (enalapril-hydrochlorothiazide)	T3	ST HD
ZESTORETIC (lisinopril-hydrochlorothiazide)	T3	ST HD
ALPHA/BETA-ADRENERGIC BLOCKING AGENTS		
carvedilol (Coreg)	T1	HD
carvedilol er 10 mg capsule (Coreg Cr)	T1	QL (1 cap/day) HD
carvedilol er 20 mg capsule (Coreg Cr)	T1	QL (1 cap/day) HD
carvedilol er 40 mg capsule (Coreg Cr)	T1	QL (1 cap/day) HD
carvedilol er 80 mg capsule (Coreg Cr)	T1	HD
COREG (carvedilol)	T3	ST HD
COREG CR 10 MG CAPSULE (carvedilol er)	T3	QL (1 cap/day) ST HD
COREG CR 20 MG CAPSULE (carvedilol er)	T3	QL (1 cap/day) ST HD
COREG CR 40 MG CAPSULE (carvedilol er)	T3	QL (1 cap/day) ST HD
COREG CR 80 MG CAPSULE (carvedilol er)	T3	ST HD
ALPHA-ADRENERGIC BLOCKING AGENTS		
CARDURA (doxazosin mesylate)	T3	HD
CARDURA XL	T3	HD

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

T4 – Specialty Medications
PA – Prior Authorization
QL – Quantity Limit

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

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List of Prescription Medications

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

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ALPHA-ADRENERGIC BLOCKING AGENTS (cont.)		
<i>doxazosin mesylate (Cardura)</i>	T1	HD
LABELALOL HCL 10 MG/2 ML SYRNG	T3	HD
<i>labetalol hcl 100 mg tablet</i>	T1	HD
<i>labetalol hcl 100 mg/20 ml vl</i>	T1	HD
<i>labetalol hcl 20 mg/4 ml crpjt</i>	T1	HD
<i>labetalol hcl 20 mg/4 ml syrng</i>	T1	HD
<i>labetalol hcl 20 mg/4 ml vial</i>	T1	HD
<i>labetalol hcl 200 mg tablet</i>	T1	HD
<i>labetalol hcl 200 mg/40 ml vl</i>	T1	HD
<i>labetalol hcl 300 mg tablet</i>	T1	HD
MINIPRESS (<i>prazosin hcl</i>)	T3	HD
<i>prazosin hcl (Minipress)</i>	T1	HD
<i>terazosin hcl</i>	T1	HD
ANGIOTEN.RECEPTR ANTAG-CALCIUM CHANL BLKR-THIAZIDE		
<i>amlodipine/valsartan/hcthiazid (Exforge Hct)</i>	T1	HD
EXFORGE HCT (<i>amlodipine-valsartan-hctz</i>)	T3	HD
<i>olmesartan/amlodipin/hcthiazid (Tribenzor)</i>	T1	HD
TRIBENZOR (<i>olmesartan-amlodipine-hctz</i>)	T3	HD
ANGIOTENSIN RECEPT-NEPRILYSIN INHIBITOR COMB (ARNI)		
ENTRESTO	T2	HD
ANGIOTENSIN RECEPTOR ANTAG.-THIAZIDE DIURETIC COMB		
ATACAND HCT (<i>candesartan-hydrochlorothiazid</i>)	T3	ST HD
AVALIDE (<i>irbesartan-hydrochlorothiazide</i>)	T3	ST HD
BENICAR HCT 20-12.5 MG TABLET (<i>olmesartan-hydrochlorothiazide</i>)	T3	QL (1 tab/day) ST HD
BENICAR HCT 40-12.5 MG TABLET (<i>olmesartan-hydrochlorothiazide</i>)	T3	ST HD
BENICAR HCT 40-25 MG TABLET (<i>olmesartan-hydrochlorothiazide</i>)	T3	ST HD
<i>candesartan/hydrochlorothiazid (Atacand Hct)</i>	T1	HD
DIOVAN HCT (<i>valsartan-hydrochlorothiazide</i>)	T3	ST HD
HYZAAR (<i>losartan-hydrochlorothiazide</i>)	T3	ST HD
<i>irbesartan/hydrochlorothiazide (Avalide)</i>	T1	HD
<i>losartan/hydrochlorothiazide (Hyzaar)</i>	T1	HD
MICARDIS HCT 40-12.5 MG TABLET (<i>telmisartan-hydrochlorothiazid</i>)	T3	QL (1 tab/day) ST HD
MICARDIS HCT 80-12.5 MG TABLET (<i>telmisartan-hydrochlorothiazid</i>)	T3	ST HD
MICARDIS HCT 80-25 MG TABLET (<i>telmisartan-hydrochlorothiazid</i>)	T3	ST HD
<i>olmesartan-hctz 20-12.5 mg tab (Benicar Hct)</i>	T1	QL (1 tab/day) HD
<i>olmesartan-hctz 40-12.5 mg tab (Benicar Hct)</i>	T1	HD

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

T4 – Specialty Medications

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AGE – Age Requirement

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List of Prescription Medications

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

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ANGIOTENSIN RECEPTOR ANTAG.-THIAZIDE DIURETIC COMB (cont.)		
<i>olmesartan-hctz 40-25 mg tab</i> (Benicar Hct)	T1	HD
<i>telmisartan-hctz 40-12.5 mg tb</i> (Micardis Hct)	T1	QL (1 tab/day) HD
<i>telmisartan-hctz 80-12.5 mg tb</i> (Micardis Hct)	T1	HD
<i>telmisartan-hctz 80-25 mg tab</i> (Micardis Hct)	T1	HD
<i>valsartan/hydrochlorothiazide</i> (Diovan Hct)	T1	HD
ANGIOTENSIN RECEPTOR BLOCKR-CALCIUM CHANNEL BLOCKR		
<i>amlodipine besylate/valsartan</i> (Exforge)	T1	HD
<i>amlodipine-olmesartan 10-20 mg</i> (Azor)	T1	HD
<i>amlodipine-olmesartan 10-40 mg</i> (Azor)	T1	HD
<i>amlodipine-olmesartan 5-20 mg</i> (Azor)	T1	QL (1 tab/day) HD
<i>amlodipine-olmesartan 5-40 mg</i> (Azor)	T1	HD
AZOR 10-20 MG TABLET (<i>amlodipine-olmesartan</i>)	T3	HD
AZOR 10-40 MG TABLET (<i>amlodipine-olmesartan</i>)	T3	HD
AZOR 5-20 MG TABLET (<i>amlodipine-olmesartan</i>)	T3	QL (1 tab/day) HD
AZOR 5-40 MG TABLET (<i>amlodipine-olmesartan</i>)	T3	HD
EXFORGE (<i>amlodipine-valsartan</i>)	T3	HD
<i>telmisartan-amlodipine 40-10</i>	T1	HD
<i>telmisartan-amlodipine 40-5 mg</i>	T1	QL (1 tab/day) HD
<i>telmisartan-amlodipine 80-10</i>	T1	HD
<i>telmisartan-amlodipine 80-5 mg</i>	T1	HD
ANTI-HYPERTENSIVES, ACE INHIBITORS		
ACCUPRIL (<i>quinapril hcl</i>)	T3	ST HD
ALTACE (<i>ramipril</i>)	T3	ST HD
<i>benazepril hcl</i>	T1	HD
<i>benazepril hcl</i> (Lotensin)	T1	HD
<i>captopril</i>	T1	HD
<i>enalapril maleate</i> (Vasotec)	T1	HD
EPANED	T3	HD
<i>fosinopril sodium</i>	T1	HD
<i>lisinopril</i> (Zestril)	T1	HD
LOTENSIN (<i>benazepril hcl</i>)	T3	ST HD
<i>moexipril hcl</i>	T1	HD
<i>perindopril erbumine</i>	T1	HD
PRINIVIL (<i>lisinopril</i>)	T3	ST HD
<i>quinapril hcl</i> (Accupril)	T1	HD
<i>ramipril</i> (Altace)	T1	HD

T1 – Typically Generics
T2 – Typically Preferred Brands
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T4 – Specialty Medications
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AGE – Age Requirement
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List of Prescription Medications

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

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ANTI-HYPERTENSIVES, ACE INHIBITORS (cont.)		
<i>trandolapril</i>	T1	HD
VASOTEC (<i>enalapril maleate</i>)	T3	ST HD
ZESTRIL (<i>lisinopril</i>)	T3	ST HD
ANTI-HYPERTENSIVES, ANGIOTENSIN RECEPTOR ANTAGONIST		
ATACAND (<i>candesartan cilexetil</i>)	T3	ST HD
AVAPRO (<i>irbesartan</i>)	T3	ST HD
BENICAR 20 MG TABLET (<i>olmesartan medoxomil</i>)	T3	QL (1 tab/day) ST HD
BENICAR 40 MG TABLET (<i>olmesartan medoxomil</i>)	T3	ST HD
BENICAR 5 MG TABLET (<i>olmesartan medoxomil</i>)	T3	ST HD
<i>candesartan cilexetil</i> (Atacand)	T1	HD
COZAAR (<i>losartan potassium</i>)	T3	ST HD
DIOVAN (<i>valsartan</i>)	T3	ST HD
EDARBI 80 MG TABLET	T3	ST HD
<i>eprosartan mesylate</i>	T1	HD
<i>irbesartan</i> (Avapro)	T1	HD
<i>losartan potassium</i> (Cozaar)	T1	HD
MICARDIS 20 MG TABLET (<i>telmisartan</i>)	T3	QL (1 tab/day) ST HD
MICARDIS 40 MG TABLET (<i>telmisartan</i>)	T3	QL (1 tab/day) ST HD
MICARDIS 80 MG TABLET (<i>telmisartan</i>)	T3	ST HD
<i>olmesartan medoxomil 20 mg tab</i> (Benicar)	T1	QL (1 tab/day) HD
<i>olmesartan medoxomil 40 mg tab</i> (Benicar)	T1	HD
<i>olmesartan medoxomil 5 mg tab</i> (Benicar)	T1	HD
<i>telmisartan 20 mg tablet</i> (Micardis)	T1	QL (1 tab/day) HD
<i>telmisartan 40 mg tablet</i> (Micardis)	T1	QL (1 tab/day) HD
<i>telmisartan 80 mg tablet</i> (Micardis)	T1	HD
<i>valsartan</i> (Diovan)	T1	HD
VALSARTAN 20 MG/5 ML SOLUTION	T3	ST HD
ANTI-HYPERTENSIVES, GANGLIONIC BLOCKERS		
VECAMYL	T1	
ANTI-HYPERTENSIVES, MISCELLANEOUS		
DEMSEER (<i>metirosine</i>)	T3	HD
<i>metirosine</i> (Demser)	T1	HD
ANTI-HYPERTENSIVES, SYMPATHOLYTIC		
CATAPRES (<i>clonidine hcl</i>)	T3	HD
CATAPRES-TTS 1 (<i>clonidine</i>)	T3	HD
CATAPRES-TTS 2 (<i>clonidine</i>)	T3	HD
CATAPRES-TTS 3 (<i>clonidine</i>)	T3	HD

T1 – Typically Generics
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T3 – Typically Non-Preferred Brands

T4 – Specialty Medications
PA – Prior Authorization
QL – Quantity Limit

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

HD – May require home delivery pharmacy
PPACA – No Cost-Share Preventive Medication
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List of Prescription Medications

CARDIOVASCULAR (Blood Pressure/Heart Medications) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ANTI-HYPERTENSIVES, SYMPATHOLYTIC (cont.)		
<i>clonidine (Catapres-tts 1)</i>	T1	HD
<i>clonidine (Catapres-tts 2)</i>	T1	HD
<i>clonidine (Catapres-tts 3)</i>	T1	HD
<i>clonidine hcl (Catapres)</i>	T1	HD
<i>guanfacine hcl</i>	T1	HD
<i>methyldopa</i>	T1	HD
<i>methyldopa/hydrochlorothiazide</i>	T1	HD
ANTI-HYPERTENSIVES, VASODILATORS		
<i>hydralazine hcl</i>	T1	HD
<i>minoxidil</i>	T1	HD
BETA-ADRENERGIC BLOCKING AGENTS		
<i>acebutolol hcl</i>	T1	HD
<i>atenolol (Tenormin)</i>	T1	HD
<i>betaxolol hcl</i>	T1	HD
<i>acebutolol hcl</i>	T1	HD
<i>atenolol (Tenormin)</i>	T1	HD
<i>betaxolol hcl</i>	T1	HD
<i>bisoprolol fumarate</i>	T1	HD
BYSTOLIC 10 MG TABLET	T2	QL (1 tab/day) ST HD
BYSTOLIC 2.5 MG TABLET	T2	QL (1 tab/day) ST HD
BYSTOLIC 20 MG TABLET	T2	ST HD
BYSTOLIC 5 MG TABLET	T2	QL (1 tab/day) ST HD
INNOPRAN XL	T3	ST HD
<i>metoprolol succinate (Toprol XL)</i>	T1	HD
<i>metoprolol tartrate</i>	T1	HD
<i>metoprolol tartrate (Lopressor)</i>	T1	HD
<i>nadolol (Corgard)</i>	T1	HD
<i>pindolol</i>	T1	HD
<i>propranolol hcl</i>	T1	HD
<i>propranolol hcl (Inderal La)</i>	T1	HD
<i>sotalol hcl</i>	T1	HD
<i>sotalol hcl (Betapace Af)</i>	T1	HD
SOTYLIZE	T3	HD
<i>timolol maleate</i>	T1	HD

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List of Prescription Medications

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

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
BETA-BLOCKERS AND THIAZIDE, THIAZIDE-LIKE DIURETICS		
<i>atenolol/chlorthalidone</i> (Tenoretic 100)	T1	HD
<i>atenolol/chlorthalidone</i> (Tenoretic 50)	T1	HD
<i>bisoprolol/hydrochlorothiazide</i> (Ziac)	T1	HD
<i>metoprolol/hydrochlorothiazide</i>	T1	HD
<i>nadolol/bendroflumethiazide</i>	T1	HD
<i>propranolol/hydrochlorothiazid</i>	T1	HD
RENIN INHIBITOR, DIRECT		
<i>aliskiren 150 mg tablet</i> (Tekturna)	T1	QL (1 tab/day) HD
<i>aliskiren 300 mg tablet</i> (Tekturna)	T1	HD
RENIN INHIBITOR, DIRECT AND THIAZIDE DIURETIC COMB		
TEKTRUNA HCT	T2	HD
VASODILATORS, COMBINATION		
<i>isosorbide dinit/hydralazine</i>	T1	QL (6 tabs/day) HD
BIDIL	T3	QL (6 tabs/day) HD
VASODILATORS, PERIPHERAL		
<i>ergoloid mesylates</i>	T1	
<i>isoxsuprine hcl</i>	T1	

CARDIOVASCULAR (Cholesterol Medications)

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

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

ANTI-HYPERLIPID- HMG-COA RI-CALCIUM CHANNEL BLOCKER

<i>amlodipine-atorvast 10-10 mg</i> (Caduet)	T1	HD
<i>amlodipine-atorvast 10-20 mg</i> (Caduet)	T1	HD
<i>amlodipine-atorvast 10-40 mg</i> (Caduet)	T1	HD
<i>amlodipine-atorvast 10-80 mg</i> (Caduet)	T1	HD
<i>amlodipine-atorvast 2.5-10 mg</i>	T1	HD
<i>amlodipine-atorvast 2.5-20 mg</i>	T1	QL (1 tab/day) HD
<i>amlodipine-atorvast 2.5-40 mg</i>	T1	QL (1 tab/day) HD

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List of Prescription Medications

CARDIOVASCULAR (Cholesterol Medications) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ANTI-HYPERLIPID- HMG-COA RI-CALCIUM CHANNEL BLOCKER (cont.)		
<i>amlodipine-atorvast 5-10 mg (Caduet)</i>	T1	HD
<i>amlodipine-atorvast 5-20 mg (Caduet)</i>	T1	QL (1 tab/day) HD
<i>amlodipine-atorvast 5-40 mg (Caduet)</i>	T1	QL (1 tab/day) HD
<i>amlodipine-atorvast 5-80 mg (Caduet)</i>	T1	HD
CADUET 10 MG-10 MG TABLET (<i>amlodipine-atorvastatin</i>)	T3	HD
CADUET 10 MG-20 MG TABLET (<i>amlodipine-atorvastatin</i>)	T3	HD
CADUET 10 MG-40 MG TABLET (<i>amlodipine-atorvastatin</i>)	T3	HD
CADUET 10 MG-80 MG TABLET (<i>amlodipine-atorvastatin</i>)	T3	HD
CADUET 5 MG-10 MG TABLET (<i>amlodipine-atorvastatin</i>)	T3	HD
CADUET 5 MG-20 MG TABLET (<i>amlodipine-atorvastatin</i>)	T3	QL (1 tab/day) HD
CADUET 5 MG-40 MG TABLET (<i>amlodipine-atorvastatin</i>)	T3	QL (1 tab/day) HD
CADUET 5 MG-80 MG TABLET (<i>amlodipine-atorvastatin</i>)	T3	HD
ANTI-HYPERLIPIDEMIC - APO B-100 SYNTHESIS INHIBITOR		
KYNAMRO	T4	PA SP
ANTI-HYPERLIPIDEMIC - ATP CITRATE LYASE INHIBITOR		
NEXLETOL	T2	PA QL (1 tab/day)
ANTI-HYPERLIPIDEMIC - MTP INHIBITOR		
JUXTAPID	T4	PA SP HD
ANTI-HYPERLIPIDEMIC - PCSK9 INHIBITORS		
REPATHA PUSHTRONEX	T2	PA
REPATHA SURECLICK	T2	PA
REPATHA SYRINGE	T2	PA
ANTI-HYPERLIPIDEMIC-ACLY AND CHOLESTEROL ABSORPTION INHIBITORS		
NEXLIZET	T2	PA QL (1 SYRINGE/DAY)
ANTI-HYPERLIPIDEMIC-HMGCOA REDUCTASE INHIBITORS (Statins)		
<i>atorvastatin 20 mg tablet</i>	T1	HD PPACA
<i>atorvastatin 40 mg tablet</i>	T1	HD
<i>atorvastatin 80 mg tablet</i>	T1	HD
<i>fluvastatin sodium</i>	T1	HD PPACA
<i>fluvastatin sodium (Lescol XI)</i>	T1	HD PPACA
LIVALO	T2	PA QL ST
LIVALO 1 MG TABLET (<i>pitavastatin calcium</i>)	T2	ST QL (1 tab/day) HD
LIVALO 2 MG TABLET (<i>pitavastatin calcium</i>)	T2	ST QL (1 tab/day) HD
LIVALO 4 MG TABLET (<i>pitavastatin calcium</i>)	T2	ST HD
<i>lovastatin 10 mg tablet</i>	T1	HD
<i>lovastatin 20 mg tablet</i>	T1	HD PPACA

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List of Prescription Medications

CARDIOVASCULAR (Cholesterol Medications) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ANTI-HYPERLIPIDEMIC-HMGCOA REDUCTASE INHIB (Statins) (cont.)		
<i>lovastatin 40 mg tablet</i>	T1	HD PPACA
<i>pitavastatin 1 mg tablet</i>	T1	QL HD PPACA
<i>pitavastatin 2 mg tablet</i>	T1	QL HD PPACA
<i>pitavastatin 4 mg tablet (Livalo)</i>	T1	HD PPACA
<i>pitavastatin 1 mg tablet (Livalo)</i>	T1	QL(1 tab/day) HD PPACA
<i>pitavastatin 2 mg tablet (Livalo)</i>	T1	QL(1 tab/day) HD PPACA
<i>pitavastatin 4 mg tablet</i>	T1	HD PPACA
<i>pravastatin sodium</i>	T1	HD PPACA
<i>pravastatin sodium (Pravachol)</i>	T1	HD PPACA
<i>rosuvastatin calcium 10 mg tab (Crestor)</i>	T1	QL (1 tab/day) HD PPACA
<i>rosuvastatin calcium 20 mg tab (Crestor)</i>	T1	QL (1 tab/day) HD
<i>rosuvastatin calcium 40 mg tab (Crestor)</i>	T1	HD
<i>rosuvastatin calcium 5 mg tab (Crestor)</i>	T1	QL (1 tab/day) HD PPACA
<i>simvastatin 10 mg tablet (Zocor)</i>	T1	HD PPACA
<i>simvastatin 20 mg tablet (Zocor)</i>	T1	HD PPACA
<i>simvastatin 40 mg tablet (Zocor)</i>	T1	HD PPACA
<i>simvastatin 5 mg tablet</i>	T1	HD
<i>simvastatin 80 mg tablet</i>	T1	QL (1 tab/day) HD
BILE SALT SEQUESTRANTS		
<i>cholestyramine (with sugar) (Questran)</i>	T1	HD
<i>cholestyramine/aspartame</i>	T1	HD
<i>cholestyramine/aspartame (Questran Light)</i>	T1	HD
<i>colesevelam hcl (Welchol)</i>	T1	HD
COLESTID 1 GM TABLET (<i>colestipol hcl</i>)	T3	HD
COLESTID FLAVORED GRANULES	T2	HD
COLESTID FLAVORED GRANULES	T3	HD
COLESTID GRANULES	T3	HD
COLESTID GRANULES (<i>colestipol hcl</i>)	T3	HD
COLESTID GRANULES PACKET (<i>colestipol hcl</i>)	T3	HD
<i>colestipol hcl (Colestid)</i>	T1	HD
QUESTRAN (<i>cholestyramine</i>)	T3	HD
QUESTRAN LIGHT (<i>prevalite</i>)	T3	HD
LIPOTROPICS		
<i>ezetimibe (Zetia)</i>	T1	HD
<i>fenofibrate</i>	T1	HD
<i>fenofibrate nanocrystallized (Tricor)</i>	T1	HD
<i>fenofibrate, micronized</i>	T1	HD

T1 – Typically Generics

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List of Prescription Medications

CARDIOVASCULAR (Cholesterol Medications) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
LIPOTROPICS (cont.)		
<i>fenofibric acid</i> (choline) (Trilipix)	T1	HD
<i>fenofibric acid</i> (Fibricor)	T1	HD
FIBRICOR (<i>fenofibric acid</i>)	T3	ST HD
<i>gemfibrozil</i> (Lopid)	T1	HD
LIPOFEN	T3	ST HD
LOPID (<i>gemfibrozil</i>)	T3	HD
<i>niacin</i> (Niaspan)	T1	HD
NIASPAN (<i>niacin er</i>)	T3	HD
TRICOR (<i>fenofibrate</i>)	T3	ST HD
TRIGLIDE	T3	ST HD
TRILIPIX (<i>fenofibric acid</i>)	T3	ST HD
ZETIA (<i>ezetimibe</i>)	T3	HD

CARDIOVASCULAR (Miscellaneous)

VENOSCLEROSING AGENTS

sodium tetradecyl sulfate

T1

CNS DRUGS (Alzheimer's Disease)

ALZHEIMER'S THERAPY, NMDA RECEPTOR ANTAGONISTS

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

ALZHEIMER'S THX, NMDA RECEPTOR ANTAG-CHOLINES INHIB

NAMZARIC 14 MG-10 MG CAPSULE	T3	QL (2 caps/day) HD
NAMZARIC 21 MG-10 MG CAPSULE	T3	QL (2 caps/day) HD
NAMZARIC 28 MG-10 MG CAPSULE	T3	QL (2 caps/day) HD
NAMZARIC 7 MG-10 MG CAPSULE	T3	QL (2 caps/day) HD
NAMZARIC TITRATION PACK	T3	QL (112/365 days) HD

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List of Prescription Medications

CNS DRUGS (Miscellaneous)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
AMYOTROPHIC LATERAL SCLEROSIS AGENTS		
QALSODY	T3	
RADICAVA ORS	T4	PA QL (50ml/28days) SP
RILUTEK (<i>riluzole</i>)	T4	SP HD
<i>riluzole</i> (Rilutek)	T4	SP HD
TIGLUTIK	T4	PA SP
DRUGS TO TREAT MOVEMENT DISORDERS		
AUSTEDO	T4	PA SP HD
AUSTEDO XR 12 MG TABLET	T4	PA QL(1 tab/day) SP HD
AUSTEDO XR 24 MG TABLET	T4	PA QL(2 tabs/day) SP HD
AUSTEDO XR 6 MG TABLET	T4	PA QL(3 tabs/day) SP HD
AUSTEDO XR TITRATION KT(WK1-4)	T4	PA QL(1 kit/180 days) SP HD
INGREZZA	T4	PA SP HD
<i>tetrabenazine</i>	T4	PA SP HD
PSEUDOBULBAR AFFECT (PBA) AGENTS, NMDA ANTAGONISTS		
NUDEXTA	T3	QL (4 caps/day)

CNS DRUGS (Multiple Sclerosis)

XANTHINES		
<i>caffeine citrate</i>	T1	HD
AGENTS TO TREAT MULTIPLE SCLEROSIS		
AVONEX	T4	PA SP HD
AVONEX PEN	T4	PA SP HD
BAFIERTAM	T4	PA SP HD
BETASERON	T4	PA SP HD
BRIUMVI	T4	PA SP
<i>dimethyl fumarate</i>	T1	HD
GILENYA	T4	PA SP HD
<i>glatopa</i>	T1	HD
<i>glatiramer</i>	T1	HD
<i>glatiramer acetate</i>	T4	PA SP HD
KESIMPTA PEN	T4	PA SP HD
MAVENCLAD	T4	PA SP HD
MAYZENT	T4	PA SP HD
OCREVUS	T4	PA SP
PLEGRIDY	T4	PA SP HD
PLEGRIDY PEN	T4	PA SP HD
PONVORY	T4	PA SP HD
REBIF	T4	PA SP HD

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List of Prescription Medications

CNS DRUGS (Multiple Sclerosis) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
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AGENTS TO TREAT MULTIPLE SCLEROSIS

REBIF REBIDOSE	T4	PA SP HD
<i>teriflunomide</i> (Aubagio)	T1	
VUMERITY	T4	PA SP HD

AGTS TX NEUROMUSC TRANSMISSION DIS, POT-CHAN BLKR

<i>dalfampridine</i>	T4	PA SP HD
FIRDAPSE	T4	PA QL (8 tabs/day) SP
RUZURGI	T4	PA SP

CNS DRUGS (Pain Relief And Inflammatory Disease)

CALCITONIN GENE-RELATED PEPTIDE (CGRP) INHIBITORS

EMGALITY SYRINGE	T2	PA
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POSTHERPETIC NEURALGIA AGENTS

<i>gabapentin</i> (Gralise)	T4	PA SP HD
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SPHINGOSINE I-PHOSPHATE (SIP) RECEPTOR MODULATOR

ZEPOSIA	T4	PA SP HD
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CNS DRUGS (Seizure Disorders)

ANTI-CONVULSANT - BENZODIAZEPINE TYPE

<i>clobazam</i> (Onfi)	T1	HD
<i>clonazepam</i>	T1	HD
<i>clonazepam</i> (Klonopin)	T1	HD
DIASTAT (<i>diazepam</i>)	T3	PA HD
DIASTAT ACUDIAL (<i>diazepam</i>)	T3	PA HD
<i>diazepam 10 mg rectal gel syst</i> (Diastat Acudial)	T1	HD
<i>diazepam 2.5 mg rectal gel sys</i> (Diastat)	T1	HD
<i>diazepam 20 mg rectal gel syst</i>	T1	HD
KLONOPIN (<i>clonazepam</i>)	T3	PA HD
NAYZILAM	T2	PA QL (5 kits/30 days) HD
ONFI (<i>clobazam</i>)	T3	PA HD
VALTOCO	T3	PA QL (5 boxes/30 Days) HD

ANTI-CONVULSANT - CANNABINOID TYPE

EPIDIOLEX	T4	PA SP HD
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ANTI-CONVULSANTS

APTIOM 200 MG TABLET	T3	PA QL (1 tab/day) HD
APTIOM 400 MG TABLET	T3	PA QL (1 tab/day) HD
APTIOM 600 MG TABLET	T3	PA HD
APTIOM 800 MG TABLET	T3	PA HD
BRIVIACT	T3	PA HD

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List of Prescription Medications

CNS DRUGS (Seizure Disorders) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ANTI-CONVULSANTS (cont.)		
<i>carbamazepine</i>	T1	HD
<i>carbamazepine</i> (Carbatrol)	T1	HD
<i>carbamazepine</i> (Tegretol Xr)	T1	HD
<i>carbamazepine</i> (Tegretol)	T1	HD
CARBATROL (<i>carbamazepine er</i>)	T3	PA HD
CELONTIN	T2	HD
DIACOMIT	T4	PA SP HD
DILANTIN 100 MG CAPSULE (<i>phenytoin sodium extended</i>)	T3	PA HD
DILANTIN 30 MG CAPSULE	T2	PA HD
DILANTIN 50 MG INFATAB (<i>phenytoin</i>)	T3	PA HD
DILANTIN-125 (<i>phenytoin</i>)	T3	PA HD
<i>divalproex sodium</i> (Depakote Er)	T1	HD
<i>divalproex sodium</i> (Depakote Sprinkle)	T1	HD
<i>divalproex sodium</i> (Depakote)	T1	HD
<i>ethosuximide</i> (Zarontin)	T1	HD
<i>felbamate</i>	T1	HD
FINTEPLA	T4	PA SP HD
FYCOMPA 0.5 MG/ML ORAL SUSP	T2	PA HD
FYCOMPA 10 MG TABLET	T2	PA HD
FYCOMPA 12 MG TABLET	T2	PA HD
FYCOMPA 2 MG TABLET	T2	PA HD
FYCOMPA 4 MG TABLET	T2	PA QL (1 tab/day) HD
FYCOMPA 6 MG TABLET	T2	PA QL (1 tab/day) HD
FYCOMPA 8 MG TABLET	T2	PA HD
<i>gabapentin</i>	T1	HD
<i>gabapentin</i> (Neurontin)	T1	HD
GABITRIL 12 MG TABLET (<i>tiagabine hcl</i>)	T3	PA QL (8 tabs/day) HD
GABITRIL 16 MG TABLET (<i>tiagabine hcl</i>)	T3	PA QL (6 tabs/day) HD
GABITRIL 2 MG TABLET (<i>tiagabine hcl</i>)	T3	PA HD
GABITRIL 4 MG TABLET (<i>tiagabine hcl</i>)	T3	PA HD
KEPPRA 500 MG/5 ML VIAL	T3	
<i>lamotrigine</i>	T1	HD
<i>levetiracetam</i>	T1	HD
LYRICA (<i>pregabalin</i>)	T3	PA HD

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List of Prescription Medications

CNS DRUGS (Seizure Disorders) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ANTI-CONVULSANTS (cont.)		
NEURONTIN (<i>gabapentin</i>)	T3	PA HD
<i>oxcarbazepine</i>	T1	HD
OXTELLAR XR	T3	PA HD
PEGANONE	T2	HD
PHENYTEK (<i>phenytoin sodium extended</i>)	T3	PA HD
<i>phenytoin</i>	T1	HD
<i>phenytoin</i> (Dilantin)	T1	HD
<i>phenytoin</i> (Dilantin-125)	T1	HD
<i>phenytoin sodium extended</i> (Dilantin)	T1	HD
<i>phenytoin sodium extended</i> (Phenytek)	T1	HD
<i>pregabalin</i>	T1	HD
<i>pregabalin</i> (Lyrica)	T1	HD
<i>primidone 250 mg tablet</i> (Mysoline)	T1	HD
<i>primidone 50 mg tablet</i> (Mysoline)	T1	HD
<i>primidone</i>	T1	HD
<i>rufinamide</i> (Banzel)	T1	PA QL (80ml/day HD)
SPRITAM	T3	PA HD
TEGRETOL (<i>carbamazepine</i>)	T3	PA HD
TEGRETOL (<i>epitol</i>)	T3	PA HD
TEGRETOL XR (<i>carbamazepine er</i>)	T3	PA HD
<i>tiagabine hcl 12 mg tablet</i> (Gabitril)	T1	QL (8 tabs/day) HD
<i>tiagabine hcl 16 mg tablet</i> (Gabitril)	T1	QL (6 tabs/day) HD
<i>tiagabine hcl 2 mg tablet</i> (Gabitril)	T1	HD
<i>tiagabine hcl 4 mg tablet</i> (Gabitril)	T1	HD
<i>topiramate er 25mg capsule</i> (Trokendi XR)	T1	QL(1 cap/day) HD
<i>topiramate er 50mg capsule</i> (Trokendi XR)	T1	HD
<i>topiramate er 100mg capsule</i> (Trokendi XR)	T1	QL(1 cap/day) HD
<i>topiramate er 200 mg capsule</i> (Trokendi XR)	T1	HD
<i>valproic acid</i>	T1	HD
<i>valproic acid</i> (as sodium salt)	T1	HD
<i>vigabatrin</i>	T4	SP HD
VIMPAT	T2	PA HD
XCOPRI 100 MG TABLET	T3	PA QL (1 tab/day) HD
XCOPRI 12.5-25 MG TITRATION PK	T3	PA QL (1/28 Days) HD
XCOPRI 150 MG TABLET	T3	PA QL (1/Day) HD
XCOPRI 150-200 MG TITRATION PK	T3	PA QL (1/28 Days) HD

T1 – Typically Generics
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T4 – Specialty Medications
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ST – Step Therapy
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List of Prescription Medications

CNS DRUGS (Seizure Disorders) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
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ANTI-CONVULSANTS (cont.)

XCOPRI 200 MG TABLET	T3	PA QL (2/Day) HD
XCOPRI 250 MG DAILY DOSE PACK	T3	PA QL (1/28 Days) HD
XCOPRI 350 MG DAILY DOSE PACK	T3	PA QL (1/28 Days) HD
XCOPRI 50 MG TABLET	T3	PA QL (1/Day) HD
XCOPRI 50-100 MG TITRATION PAK	T3	PA QL (1/28 Days) HD
ZARONTIN (<i>ethosuximide</i>)	T3	PA HD
<i>zonisamide</i>	T1	HD

CNS DRUGS (Sleep Disorders/Sedatives)

NARCOLEPSY TX-H3-RECEPT.ANTAGONIST/INVERSE AGONIST

WAKIX	T4	PA QL (2 tabs/day) SP HD
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COLONY STIMULATING FACTORS (Blood Modifiers/Bleeding Disorders)

ERYTHROPOIESIS-STIMULATING AGENTS

ARANESP	T4	PA SP
EPOGEN	T4	PA SP
MIRCERA	T4	PA SP
PROCRIT	T4	PA SP
RETACRIT	T4	PA SP

LEUKOCYTE (WBC) STIMULANTS

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

THROMBOPOIETIN RECEPTOR AGONISTS

DOPTELET	T4	PA SP HD
MULPLETA	T4	PA SP HD
PROMACTA	T4	PA SP HD

T1 – Typically Generics
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List of Prescription Medications

CONTRACEPTIVES (Contraception Products)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
CONTRACEPTIVES (Contraception Products)		
CONTRACEPTIVES, INTRAVAGINAL, SYSTEMIC		
ANNOVERA	T3	
<i>etonogestrel/ethinyl estradiol</i> (Nuvaring)	T1	PPACA
NUVARING (<i>etonogestrel-ethinyl estradiol</i>)	T3	
CONTRACEPTIVES, IMPLANTABLE		
NEXPLANON	T3	SP PPACA
CONTRACEPTIVES, INJECTABLE		
DEPO-PROVERA 150 MG/ML SYRINGE (<i>medroxyprogesterone acetate</i>)	T3	
DEPO-PROVERA 150 MG/ML VIAL (<i>medroxyprogesterone acetate</i>)	T3	
DEPO-SUBQ PROVERA 104	T2	
<i>medroxyprogesterone 150 mg/ml</i> (Depo-provera)	T1	PPACA
CONTRACEPTIVES, ORAL		
BALCOLTRA (<i>levonorgest/eth.estradiol/iron</i>)	T3	HD
BEYAZ (<i>rajani</i>)	T3	HD
<i>desog-e.estradiol/e.estradiol</i> (Mircette)	T1	HD PPACA
<i>desogestrel-ethinyl estradiol</i>	T1	HD PPACA
<i>drospir/eth estra/levomefol ca</i> (Beyaz)	T1	HD PPACA
<i>drospir/eth estra/levomefol ca</i> (Safyral)	T1	HD PPACA
ELLA	T3	HD PPACA
ESTROSTEP FE (<i>tri-legest fe</i>)	T3	HD
<i>ethinyl estradiol/drospirenone</i> (Yasmin 28)	T1	HD PPACA
<i>ethinyl estradiol/drospirenone</i> (Yaz)	T1	HD PPACA
<i>ethynodiol d-ethinyl estradiol</i>	T1	HD PPACA
GENERESS FE (<i>norethin-eth estra-ferrous fum</i>)	T3	HD
<i>levonorgestrel/ethin.estradiol</i>	T1	HD PPACA
<i>levonorgest/eth.estradiol/iron</i> (Balcoltra)	T1	HD PPACA
<i>l-norgest/e.estradiol-e.estrad</i> (Loseasonique)	T1	HD PPACA
<i>l-norgest/e.estradiol-e.estrad</i> (Quartette)	T1	HD PPACA
<i>l-norgest/e.estradiol-e.estrad</i> (Seasonique)	T1	HD PPACA
LO LOESTRIN FE	T2	HD
LOESTRIN (<i>norethindron-ethinyl estradiol</i>)	T3	HD
LOESTRIN FE (<i>norethindrone-eth estradiol-fe</i>)	T3	HD
LOESTRIN FE (<i>tarina fe 1-20 eq</i>)	T3	HD
LOSEASONIQUE (<i>lojaimiess</i>)	T3	HD

CONTRACEPTIVES (Contraception Products) (cont.)

T1 – Typically Generics
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 T3 – Typically Non-Preferred Brands

T4 – Specialty Medications
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List of Prescription Medications

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
CONTRACEPTIVES, ORAL (cont.)		
MICROGESTIN 24 FE (<i>tarina 24 fe</i>)	T3	HD
MINASTRIN 24 FE (<i>norethin-eth estra-ferrous fum</i>)	T3	HD
MIRCETTE (<i>volnea</i>)	T3	HD
NATAZIA	T3	HD
NEXTSTELLIS	T3	HD
<i>noreth-ethinyl estradiol/iron</i>	T1	HD PPACA
<i>noreth-ethinyl estradiol/iron</i> (Generess Fe)	T1	HD PPACA
<i>noreth-ethinyl estradiol/iron</i> (Generess Fe)	T3	HD PPACA
<i>norethind-eth estrad 1-0.02 mg</i> (Loestrin)	T1	HD PPACA
<i>norethindrone</i> (Ortho Micronor)	T1	HD PPACA
<i>norethindrone ac-eth estradiol</i> (Loestrin)	T1	HD PPACA
<i>norethindrone-e.estradiol-iron</i> (Estrostep Fe)	T1	HD PPACA
<i>norethindrone-e.estradiol-iron</i> (Loestrin Fe)	T1	HD PPACA
<i>norethindrone-e.estradiol-iron</i> (Microgestin 24 Fe)	T1	HD PPACA
<i>norethindrone-e.estradiol-iron</i> (Minastrin 24 Fe)	T1	HD PPACA
<i>norethindrone-e.estradiol-iron</i> (Taytulla)	T1	HD PPACA
<i>norethindrone-ethin. estradiol</i>	T1	HD PPACA
<i>norethin-ee 1.5-0.03 mg(21) tb</i> (Loestrin)	T1	HD PPACA
<i>norgestrel-ethinyl estradiol</i>	T1	HD PPACA
ORTHO MICRONOR (<i>tulana</i>)	T3	HD
QUARTETTE (<i>rivelsa</i>)	T3	HD
SAFYRAL (<i>tydemy</i>)	T3	HD
SEASONIQUE (<i>simpesse</i>)	T3	HD
SLYND	T3	HD
TAYTULLA (<i>norethin-eth estra-ferrous fum</i>)	T3	HD
TYBLUME	T3	HD
YASMIN 28 (<i>zumandimine</i>)	T3	HD
YAZ (<i>vestura</i>)	T3	HD
CONTRACEPTIVES, TRANSDERMAL		
<i>norelgestromin/ethin.estradiol</i>	T1	HD PPACA
TWIRLA	T3	HD PPACA
DIAPHRAGMS/CERVICAL CAP		
CAYA CONTOURED	T1	PPACA
FEMCAP	T1	PPACA
WIDE SEAL DIAPHRAGM	T1	PPACA

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List of Prescription Medications

CONTRACEPTIVES (Contraception Products) (cont.)			
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits	
INTRA-UTERINE DEVICES (IUDS)			
KYLEENA	T4	SP PPACA	
LILETTA	T4	SP PPACA	
MIRENA	T4	SP PPACA	
PARAGARD T 380-A	T4	SP PPACA	
SKYLA	T4	SP PPACA	
COUGH/COLD PREPARATIONS (Allergy/Nasal Sprays)			
1ST GEN ANTIHIST-DECONGEST-ANTICHOLINERGIC COMB			
RESPA A.R.	T3		
COUGH/COLD PREPARATIONS (Cough/Cold Medications)			
ANTI-TUSSIVES, NON-OPIOID			
<i>benzonatate</i>	T1		
<i>benzonatate</i> (Tessalon Perle)	T1		
TESSALON PERLE (<i>benzonatate</i>)	T3		
NON-OPIOID ANTI-TUS-1ST GEN.ANTIHISTAMINE-DECONGEST			
<i>brompheniramine/pseudoephed/dm</i> (Bromfed Dm)	T1		
NON-OPIOID ANTI-TUSSIVE-1ST GEN ANTIHISTAMINE COMB.			
<i>promethazine/dextromethorphan</i>	T1		
OPIOID ANTI-TUSSIV-1ST GEN. ANTIHISTAMINE-DECONGEST			
<i>hydrocodone/cpm/pseudoephed</i>	T1	PA	
<i>promethazine/phenyleph/codeine</i>	T1	PA QL (480ml/22 days)	
<i>promethazine/phenyleph/codeine</i>	T1	PA QL (480ml/30 days)	
OPIOID ANTI-TUSSIVE-1ST GENERATION ANTIHISTAMINE			
<i>hydrocodone/chlorphen p-stirex</i>	T1	PA	
<i>promethazine-codeine solution</i>	T1	PA QL (480ML/22 Days)	
<i>promethazine-codeine syrup</i>	T1	PA QL (480ml/30 days)	
TUXARIN ER	T3	PA QL (2 tabs/day)	
TUZISTRA XR	T3	PA QL (960ml/30 days)	
OPIOID ANTI-TUSSIVE-ANTI-CHOLINERGIC COMBINATIONS			
HYCODAN (<i>hydromet</i>)	T3	PA QL (480ml/22 days)	
<i>hydrocodone bit/homatrop me-br</i> (Hycodan)	T1	PA QL (480ml/22 days)	
<i>hydrocodone-homatropine 5-1.5</i>	T1	PA QL (180 tabs/30 days)	
<i>hydrocodone-homatropine soln</i> (Hycodan)	T1	PA QL (480ml/30 days)	
HYDROCODONE-HOMATROPINE SYRUP	T1	PA QL (480ml/30 days)	
OPIOID ANTI-TUSSIVE-EXPECTORANT COMBINATION			
HYDROCODONE-GUAIFENESIN	T1	PA QL (960ml/30 days)	
OBREDON	T3	PA QL (960ml/30 days)	

T1 – Typically Preferred Brands
T2 – Typically Preferred Brands
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List of Prescription Medications

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

T1 – Typically Generics
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T4 – Specialty Medications
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List of Prescription Medications

DIAGNOSTIC (Miscellaneous) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
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URINARY TRACT RADIOPAQUE DIAGNOSTICS

CYSTO-CONRAY II	T3	
CYSTOGRAFIN	T3	
CYSTOGRAFIN-DILUTE	T3	
<i>diatrizoate meglumine, sodium (Gastrografin)</i>	T1	
GASTROGRAFIN (<i>md-gastroview</i>)	T3	

DIURETICS (Diuretics)

ARGININE VASOPRESSIN (AVP) RECEPTOR ANTAGONISTS

TOLVAPTAN 15 MG TABLET	T4	SP
<i>tolvaptan 30 mg tablet (Samsca)</i>	T4	SP

CARBONIC ANHYDRASE INHIBITORS

<i>acetazolamide</i>	T1	HD
<i>methazolamide</i>	T1	HD
<i>bumetanide</i>	T1	HD
<i>furosemide</i>	T1	HD
<i>furosemide (Lasix)</i>	T1	HD
<i>torsemide</i>	T1	HD

LOOP DIURETICS

FUROSCIX	T3	QL(2 kits/30 days) HD
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OSMOTIC DIURETICS

<i>osmitrol 20% (100 gm/500 ml)</i>	T2	
<i>osmitrol 20% (50 gm/250 ml)</i>	T2	
OSMITROL 10% (50 GM/500 ML) (<i>mannitol</i>)	T3	
OSMITROL 5% (50 GM/1,000 ML) (<i>mannitol</i>)	T3	

POLYCYSTIC KIDNEY DISEASE AGENT, AVP RECEPTOR ANTAGONIST

JYNARQUE 15 MG TABLET	T4	SP
JYNARQUE 15 MG-15 MG TABLET	T4	PA SP
JYNARQUE 30 MG TABLET	T4	SP
JYNARQUE 30 MG-15 MG TABLET	T4	PA SP
JYNARQUE 45 MG-15 MG TABLET	T4	PA SP
JYNARQUE 60 MG-30 MG TABLET	T4	PA SP
JYNARQUE 90 MG-30 MG TABLET	T4	PA SP

POTASSIUM SPARING DIURETICS

<i>amiloride hcl</i>	T1	HD
CAROSPIR (<i>Spirolactone</i>)	T2	HD
<i>eplerenone (Inspra)</i>	T1	HD
INSPRA (<i>eplerenone</i>)	T3	HD
KERENDIA	T4	PA QL (30 tabs/30 days) SP HD

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List of Prescription Medications

DIURETICS (Diuretics) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
POTASSIUM SPARING DIURETICS (cont.)		
<i>spironolactone</i> (Aldactone)	T1	HD
<i>triamterene</i> (Dyrenium)	T1	HD
POTASSIUM SPARING DIURETICS IN COMBINATION		
ALDACTAZIDE (<i>spironolactone-hctz</i>)	T3	HD
<i>amiloride/hydrochlorothiazide</i>	T1	HD
CAROSPIR SUSP	T2	PA
DYAZIDE (<i>triamterene-hydrochlorothiazid</i>)	T3	HD
THIAZIDE AND RELATED DIURETICS		
MAXZIDE (<i>triamterene-hydrochlorothiazid</i>)	T3	HD
MAXZIDE-25 MG (<i>triamterene-hydrochlorothiazid</i>)	T3	HD
<i>spironolact/hydrochlorothiazid</i> (Aldactazide)	T1	HD
<i>triamterene/hydrochlorothiazid</i> (Dyazide)	T1	HD
<i>triamterene/hydrochlorothiazid</i> (Maxzide)	T1	HD
<i>triamterene/hydrochlorothiazid</i> (Maxzide-25 Mg)	T1	HD
<i>chlorthalidone</i>	T1	HD
DIURIL	T2	HD
<i>hydrochlorothiazide</i>	T1	HD
<i>indapamide</i>	T1	HD
<i>metolazone</i>	T1	HD
EENT PREPS (Allergy/Nasal Sprays)		
NASAL ANTIHISTAMINE		
<i>azelastine 0.1% (137 mcg) spray</i>	T1	HD
<i>azelastine 0.15% nasal spray</i>	T1	HD
<i>olopatadine 665 mcg nasal spray</i> (Patanase)	T1	HD
PATANASE (<i>olopatadine hcl</i>)	T3	HD
NASAL ANTIHISTAMINE AND ANTI-INFLAM. STEROID COMB.		
<i>azelastine/fluticasone</i>	T1	HD
NASAL ANTI-INFLAMMATORY STEROIDS		
<i>flunisolide</i>	T1	HD
<i>fluticasone prop 50 mcg spray</i>	T1	HD
<i>mometasone furoate 50 mcg spray</i>	T1	QL (4 bots/30 days) HD
NOSE PREPARATIONS, MISCELLANEOUS (RX)		
<i>ipratropium bromide</i>	T1	HD
NOSE PREPARATIONS, VASOCONSTRICTORS (RX)		
ADRENALIN CHLORIDE	T3	
<i>epinephrine hcl</i> (Adrenalin Chloride)	T1	

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List of Prescription Medications

EENT PREPS (Ear Medications)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
EAR PREPARATIONS ANTI-INFLAMMATORY		
DERMOTIC (<i>fluocinolone acetonide oil</i>)	T3	
<i>fluocinolone acetonide oil</i> (Dermotic)	T1	
EAR PREPARATIONS, MISC. ANTI-INFECTIVES		
<i>acetic acid</i>	T1	
<i>hydrocortisone/acetic acid</i>	T1	
EENT PREPS (Eye Conditions)		
ARTIFICIAL TEARS		
LACRISERT	T2	
EYE ANTI-INFECTIVES (RX ONLY)		
BETADINE	T2	
EYE ANTI-INFLAMMATORY AGENTS		
ACUVAIL	T3	
ALREX	T3	
<i>bromfenac sodium</i>	T1	
BROMSITE (<i>bromfenac sodium</i>)	T2	
<i>dexamethasone sodium phosphate</i>	T1	
<i>diclofenac 0.1% eye drops</i>	T1	
EYSUVIS	T2	QL (8.3ml/14 days)
FLAREX	T2	
<i>fluorometholone</i> (Fml)	T1	
<i>flurbiprofen sodium</i>	T1	
FML (<i>fluorometholone</i>)	T3	
FML FORTE	T2	
ILEVRO	T3	
INVELTYS	T2	
<i>ketorolac 0.4% ophth solution</i> (Acular Ls)	T1	
<i>ketorolac 0.5% ophth solution</i> (Acular)	T1	
LOTEMAX 0.5% EYE OINT	T2	
LOTEMAX SM	T2	
<i>loteprednol etabonate</i> (Alrex)		
<i>loteprednol etabonate</i> (Lotemax)	T1	
MAXIDEX	T2	
OMNIPRED (<i>prednisolone acetate</i>)	T3	
PRED MILD	T2	
<i>prednisolone acetate</i> (Pred Forte)	T1	
<i>prednisolone sodium phosphate</i>	T1	

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List of Prescription Medications

EENT PREPS (Eye Conditions) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
EYE ANTI-INFLAMMATORY AGENTS (cont.)		
PROLENSA	T3	
AKTEN	T3	
ALCAINE (<i>proparacaine hcl</i>)	T3	
EYE LOCAL ANESTHETICS		
AKTEN	T3	
ALCAINE (<i>proparacaine hcl</i>)	T3	
ALTAFLUOR BENOX (<i>flurox</i>)	T3	
<i>benoxinate hcl/fluorescein sod</i> (Altafluor Benox)	T1	
<i>benoxinate hcl/fluorescein sod</i> (Altafluor Benox)	T3	
<i>proparacaine hcl</i> (Alcaine)	T1	
<i>proparacaine/fluorescein sod</i>	T1	
<i>proparacaine/fluorescein sod</i>	T2	
<i>tetracaine hcl</i>	T1	
TETRAVISC	T2	
TETRAVISC FORTE	T2	
EYE MAST CELL STABILIZERS		
ALOCRIIL	T3	
ALOMIDE	T2	
<i>cromolyn 4% eye drops</i>	T1	
EYE PREPARATIONS, MISCELLANEOUS (OTC)		
GELFILM	T3	
EYE VASOCONSTRICTORS		
<i>phenylephrine hcl</i>	T1	
MIOTICS AND OTHER INTRAOCULAR PRESSURE REDUCERS		
<i>apraclonidine hcl</i> (Iopidine)	T1	HD
<i>betaxolol hcl</i>	T1	HD
BETIMOL	T2	HD
BETOPTIC S	T2	HD
<i>bimatoprost</i>	T1	QL (10 gm/30 days) HD
<i>brimonidine tartrate</i>	T1	HD
<i>brimonidine tartrate</i> (Alphagan P)	T1	HD
<i>brinzolamide</i> (Azopt)	T1	HD
<i>carteolol hcl</i>	T1	HD
<i>dorzolamide hcl</i> (Trusopt)	T1	HD
<i>dorzolamide hcl/timolol maleat</i> (Cosopt)	T1	HD
<i>dorzolamide/timolol/pf</i> (Cosopt Pf)	T1	HD

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EENT PREPS (Eye Conditions) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
MIOTICS AND OTHER INTRAOCULAR PRESSURE REDUCERS (cont.)		
IOPIDINE 0.5% EYE DROPS (<i>apraclonidine hcl</i>)	T3	HD
IOPIDINE 1% EYE DROPS	T2	HD
ISOPTO CARPINE (<i>pilocarpine hcl</i>)	T3	HD
<i>latanoprost</i>	T1	HD
<i>levobunolol hcl</i>	T1	HD
PHOSPHOLINE IODIDE	T2	HD
<i>pilocarpine hcl</i> (Isopto Carpine)	T1	HD
RHOPRESSA	T3	HD
ROCKLATAN	T3	HD
SIMBRINZA	T2	HD
<i>timolol maleate</i> (Istalol)	T1	HD
<i>timolol maleate</i> (Timoptic-xe)	T1	HD
<i>timolol maleate/pf</i> (Timoptic Ocudose)	T1	HD
<i>travoprost</i>	T1	HD
MYDRIATICS		
<i>atropine 1% eye drops</i>	T1	HD
<i>atropine sulfate</i>	T1	HD
<i>atropine sulfate</i> (Isopto Atropine)	T1	HD
ATROPINE SULFATE-0.9% NAACL	T3	HD
CYCLOGYL 0.5% EYE DROPS (<i>cyclopentolate hcl</i>)	T3	HD
CYCLOGYL 1% EYE DROPS (<i>cyclopentolate hcl</i>)	T3	HD
CYCLOGYL 2% EYE DROPS (<i>cyclopentolate hcl</i>)	T2	HD
CYCLOMYDRIL	T2	HD
<i>cyclopentolate hcl</i> (Cyclogyl)	T1	HD
<i>homatropine hbr</i>	T1	HD
MYDRIACYL (<i>tropicamide</i>)	T3	HD
PAREMYD	T3	HD
<i>tropicamide</i>	T1	HD
<i>tropicamide</i> (Mydracyl)	T1	HD
OPHTHALMIC ANTI-FIBROTIC AGENTS		
MITOSOL	T3	
OPHTHALMIC ANTI-INFLAMMATORY IMMUNOMODULATOR-TYPE		
CEQUA	T3	HD
RESTASIS	T2	HD
RESTASIS MULTIDOSE	T2	HD
VEVYE	T3	QL HD
XIIDRA	T2	HD

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List of Prescription Medications

EENT PREPS (Eye Conditions) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
OPHTHALMIC CYSTINE DEPLETING AGENTS		
CYSTADROPS	T4	PA QL (20ml/21 days) SP
CYSTARAN	T4	PA QL (120ml/28 days) SP
OPHTHALMIC PREPARATIONS, MISCELLANEOUS		
PROVISC	T4	SP
TOTALVISC	T4	SP
OPHTHALMIC HUMAN NERVE GROWTH FACTOR (HNGF)		
OXERVATE	T4	PA SP HD

ELECT/CALORIC/H2O (Cholesterol Medications)

ORAL LIPID SUPPLEMENTS

DOJOLVI	T4	PA SP HD
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ELECT/CALORIC/H2O (Dental Products)

FLUORIDE PREPARATIONS

PREVIDENT 1.1% GEL (<i>sodium fluoride</i>)	T3	
PREVIDENT 5000	T3	
PREVIDENT 5000 BOOSTER PLUS	T3	
PREVIDENT 5000 ENAMEL PROTECT	T3	
PREVIDENT 5000 ORTHO DEFENSE	T3	
PREVIDENT 5000 PLUS (<i>sodium fluoride 5000 plus</i>)	T3	
PREVIDENT 5000 SENSITIVE	T3	
PREVIDENT DENTAL RINSE	T2	
<i>sodium fluoride/potassium nit</i> (Prevident 5000 Sensitive)	T1	

ELECT/CALORIC/H2O (Diabetes)

AGENTS TO TREAT HYPOGLYCEMIA (HYPERGLYCEMICS)

BAQSIMI	T2	QL (2/30 days)
<i>diazoxide</i> (Proglycem)	T1	
GLUCAGEN 1 MG HYPOKIT	T2	QL (2 pens/30 days)
GLUCAGON 1 MG EMERGENCY KIT	T3	QL (2 pens/30 days)
<i>glucagon 1 mg emergency kit</i> (Glucagon Emergency Kit)	T1	QL (2 pens/30 days)
GVOKE HYPOPEN 1-PACK	T3	QL (2 PACKS/22 DAYS)
GVOKE HYPOPEN 2-PACK	T3	QL (2 PACKS/22 DAYS)
GVOKE PFS 1-PACK SYRINGE	T3	QL (2 syringes/30 days)
GVOKE PFS 2-PACK SYRINGE	T3	QL (2 syringes/30 days)
PROGLYCEM (<i>diazoxide</i>)	T3	
ZEGALOGUE	T2	QL (2 units/23 days)

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List of Prescription Medications

ELECT/CALORIC/H2O (Miscellaneous)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
NUCLEIC ACID/NUCLEOTIDE SUPPLEMENTS		
XURIDEN	T4	PA SP
ELECT/CALORIC/H2O (Nutritional/Dietary)		
CALCIUM REPLACEMENT		
<i>calcium gluc 2,000mg/100ml-nacl</i>	T1	
<i>calcium gluc 1,000mg/50ml-nacl</i>	T1	
ELECTROLYTE DEPLETERS		
AURYXIA	T3	QL (12 tabs/day)
<i>calcium acetate</i>	T1	
<i>lanthanum carbonate (Fosrenol)</i>	T1	
LOKELMA	T2	
PHOSLYRA	T3	
<i>sevelamer carbonate (Renvela)</i>	T1	
<i>sevelamer hcl (Renagel)</i>	T1	
<i>sodium polystyrene sulfon/sorb</i>	T1	
<i>sodium polystyrene sulfonate</i>	T1	
<i>sps 15 gm/60 ml suspension</i>	T1	
<i>sps 30 gm/120 ml enema susp</i>	T3	
VELPHORO	T2	
VELTASSA	T2	
IODINE CONTAINING AGENTS		
<i>potassium iodide/iodine</i>	T1	
SSKI	T1	
IRON REPLACEMENT		
CITRANATAL BLOOM	T3	
FERAHEME	T3	PA
HEMOCYTE PLUS (mv-mins no.73/iron fum/folic)	T3	
INJECTAFER	T3	PA
MONOFERRIC	T3	PA
<i>mv-mins no.73/iron fum/folic (Hemocyte Plus)</i>	T1	
PARENTERAL AMINO ACID SOLUTIONS AND COMBINATIONS		
AA 3%-D10W-CALCIUM-HEPARIN	T3	
POTASSIUM REPLACEMENT		
EFFER-K 10 MEQ TABLET EFF	T3	
EFFER-K 20 MEQ TABLET EFF	T3	
<i>effer-k 25 meq tablet eff</i>	T1	
<i>klor-con 10 meq tablet (K-tab Er)</i>	T1	

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List of Prescription Medications

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

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
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POTASSIUM REPLACEMENT (cont.)

<i>klor-con 10 meq tablet (K-tab Er)</i>	T3	
<i>klor-con 8 meq tablet</i>	T1	
<i>klor-con 8 meq tablet</i>	T3	
<i>potassium bicarbonate/cit ac</i>	T1	
<i>potassium chloride</i>	T1	
<i>potassium chloride</i>	T2	
<i>potassium chloride</i>	T3	
<i>potassium chloride (K-tab Er)</i>	T1	

DIALYSIS SOLUTIONS

PRISMASOL	T3	
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URINARY PH MODIFIERS

K-PHOS NO.2	T2	HD
K-PHOS ORIGINAL	T2	HD
ORACIT	T3	HD
<i>potassium citrate (Urocit-k)</i>	T1	HD
<i>potassium citrate/citric acid</i>	T1	HD
RENACIDIN	T3	HD
UROCI-K (<i>potassium citrate er</i>)	T3	HD
UROQID-ACID NO.2	T2	HD

ZINC REPLACEMENT

<i>zinc sulfate</i>	T1	HD
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GASTROINTESTINAL (Cholesterol Medications)

LIPOTROPICS

<i>icosapent ethyl (Vascepa)</i>	T1	HD
LOVAZA (<i>triklo</i>)	T3	HD
<i>omega-3 acid ethyl esters (Lovaza)</i>	T1	HD
VASCEPA	T2	PA HD

GASTROINTESTINAL (Gastrointestinal/Heartburn)

AMMONIA INHIBITORS

<i>lactulose 10 gm/15 ml solution</i>	T1	
LITHOSTAT	T2	HD
OLPRUVA	T3	PA SP HD
PHEBURANE		
RAVICTI		

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List of Prescription Medications

GASTROINTESTINAL (Gastrointestinal/Heartburn) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
AMMONIA INHIBITORS (cont.)		
RAVICTI	T4	PA SP HD
<i>sodium phenylbutyrate</i> (Buphenyl)	T4	SP HD
ANTI-CHOLINERGICS, QUATERNARY AMMONIUM		
<i>chlordiazepoxide/clidinium br</i>	T1	
CUVPOSA	T3	
GLYCATE	T3	
<i>glycopyrrolate</i> (Glycate)	T1	
<i>glycopyrrolate</i> (Robinul Forte)	T1	
<i>glycopyrrolate</i> (Robinul)	T1	
<i>propantheline bromide</i>	T1	
ROBINUL (<i>glycopyrrolate</i>)	T3	
ROBINUL FORTE (<i>glycopyrrolate</i>)	T3	
ANTI-CHOLINERGICS/ANTI-SPASMODICS		
<i>dicyclomine hcl</i>	T1	
ANTI-DIARRHEAL - G.I. CHLORIDE CHANNEL INHIBITORS		
MYTESI	T3	
ANTI-DIARRHEAL - TRYPTOPHAN HYDROXYLASE INHIBITOR		
XERMELO	T4	PA SP
ANTI-DIARRHEALS		
<i>diphenoxylate hcl/atropine</i>	T1	
<i>diphenoxylate hcl/atropine</i> (Lomotil)	T1	
LOMOTIL (<i>diphenoxylate-atropine</i>)	T3	
<i>loperamide hcl</i>	T1	
MOTOFEN	T3	
<i>opium tincture</i>	T1	PA
<i>paregoric</i>	T1	
ANTI-EMETIC, CANNABINOID-TYPE		
<i>dronabinol</i>	T1	
ANTI-EMETIC/ANTI-VERTIGO AGENTS		
AKYNZEO	T3	PA QL (4 caps/28 days)
ANZEMET	T4	PA QL (5 tabs/30 days) SP
<i>aprepitant 125 mg capsule</i>	T1	QL (4 caps/28 days)
<i>aprepitant 125-80-80 mg pack</i> (Emend)	T1	QL (12 caps/28 days)
<i>aprepitant 40 mg capsule</i>	T1	QL (1 cap/28 days)
<i>aprepitant 80 mg capsule</i> (Emend)	T1	QL (8 caps/28 days)
BONJESTA	T3	
COMPAZINE (<i>prochlorperazine maleate</i>)	T3	

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List of Prescription Medications

GASTROINTESTINAL (Gastrointestinal/Heartburn) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ANTI-EMETIC/ANTI-VERTIGO AGENTS		
COMPAZINE (<i>prochlorperazine</i>)	T3	
DICLEGIS (<i>doxylamine succ-pyridoxine hcl</i>)	T3	
<i>doxylamine succinate/vit b6</i> (Diclegis)	T1	
EMEND 125 MG POWDER PACKET	T3	PA QL (12 caps/28 days)
EMEND 150 MG VIAL (<i>fosaprepitant dimeglumine</i>)	T3	PA
EMEND 80 MG CAPSULE (<i>aprepitant</i>)	T3	PA QL (8 caps/28 days)
EMEND TRIPACK (<i>aprepitant</i>)	T3	PA QL (12 caps/28 days)
<i>fosaprepitant dimeglumine</i> (Emend)	T1	PA
<i>granisetron hcl</i>	T1	
<i>granisetron hcl/pf</i>	T1	
<i>ondansetron</i>	T1	
<i>ondansetron hcl</i>	T1	
<i>ondansetron hcl/pf</i>	T1	
<i>prochlorperazine</i> (Compazine)	T1	
<i>prochlorperazine maleate</i> (Compazine)	T1	
<i>promethazine hcl</i>	T1	
<i>promethazine hcl</i>	T3	
SANCUSO	T3	PA QL (4 patches/30 days)
<i>scopolamine</i> (Transderm-scop)	T1	
TIGAN (<i>trimethobenzamide hcl</i>)	T3	
TRANSDERM-SCOP (<i>scopolamine</i>)	T3	
<i>trimethobenzamide hcl</i> (Tigan)	T1	
VARUBI	T3	PA QL (4 tabs/28 days)
ANTI-ULCER PREPARATIONS		
CARAFATE (<i>sucralfate</i>)	T3	HD
CYTOTEC (<i>misoprostol</i>)	T3	HD
<i>misoprostol</i> (Cytotec)	T1	HD
<i>sucralfate</i> (Carafate)	T1	HD
ANTI-ULCER-H.PYLORI AGENTS		
<i>bismuth/metronid/tetracycline</i> (Pylera)	T1	
<i>lansoprazole/amoxiciln/clarith</i>	T1	
BELLADONNA ALKALOIDS		
ATROPINE 0.25 MG/5 ML SYRINGE	T3	HD
<i>atropine 0.25 mg/5 ml syringe</i>	T1	HD
DONNATAL	T3	HD
DONNATAL (<i>phenohydro</i>)	T3	HD

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List of Prescription Medications

GASTROINTESTINAL (Gastrointestinal/Heartburn) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
BELLADONNA ALKALOIDS (cont.)		
<i>hyoscyamine sulfate</i>	T1	HD
<i>hyoscyamine sulfate</i> (Levbid)	T1	HD
<i>hyoscyamine sulfate</i> (Levsin)	T1	HD
<i>hyoscyamine sulfate</i> (Levsin-sl)	T1	HD
<i>hyoscyamine sulfate</i> (Nulev)	T1	HD
<i>hyoscyamine sulfate</i> (Nulev)	T3	HD
LEVBIID (<i>symax-sr</i>)	T3	HD
LEVSIN (<i>oscimin</i>)	T3	HD
LEVSIN-SL (<i>symax-sl</i>)	T3	HD
<i>methscopolamine bromide</i>	T1	HD
NULEV (<i>symax</i>)	T1	HD
<i>phenobarb/hyoscy/atropine/scop</i> (Donnatal)	T1	HD
<i>phenobarb/hyoscy/atropine/scop</i> (Phenobarbital-belladonna)	T1	HD
<i>phenobarbital-belladonna elixr</i> (Donnatal)	T1	HD
<i>phenobarbital-belladonna elixr</i> (Phenobarbital-belladonna)	T1	HD
PHENOBARBITAL-BELLADONNA ELIXR (<i>phenohytr</i>)	T3	HD
SYMAX DUOTAB	T2	HD
BILE SALTS		
ACTIGALL (<i>ursodiol</i>)	T3	HD
CHENODAL	T4	SP HD
CHOLBAM	T4	PA SP HD
URSO (<i>ursodiol</i>)	T3	HD
URSO FORTE (<i>ursodiol</i>)	T3	HD
<i>ursodiol</i> (Actigall)	T1	HD
<i>ursodiol</i> (Urso Forte)	T1	HD
<i>ursodiol</i> (Urso)	T1	HD
CHRONIC INFLAM. COLON DX, 5-A-SALICYLAT, RECTAL TX		
<i>mesalamine 1,000 mg supp</i> (Canasa)	T1	
<i>mesalamine 4 gm/60 ml enema</i> (Sfrowasa)	T1	
<i>mesalamine 4 gm/60 ml kit</i>	T1	
SFROWASA (<i>mesalamine</i>)	T3	
DRUG TX-CHRONIC INFLAM. COLON DX, 5-AMINOSALICYLAT		
APRISO (<i>mesalamine er</i>)	T3	HD
<i>balsalazide disodium</i>	T1	HD
<i>mesalamine</i>	T1	HD
<i>mesalamine</i> (Apriso)	T1	HD

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GASTROINTESTINAL (Gastrointestinal/Heartburn) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
DRUG TX-CHRONIC INFLAM. COLON DX, 5-AMINOSALICYLAT		
<i>mesalamine 800 mg dr tablet</i>	T1	HD
<i>mesalamine dr 1.2 gm tablet (Lialda)</i>	T1	HD
<i>sulfasalazine (Azulfidine)</i>	T1	HD
FARNESOID X RECEPTOR (FXR) AGONIST, BILE AC ANALOG		
OCALIVA	T4	PA SP HD
FECAL MICROBIOTA TRANSPLANTATION (FMT)		
VOWST	T4	PA QL(12 caps/56 days) SP
GASTRIC ENZYMES		
SUCRAID	T4	PA SP
HISTAMINE H2-RECEPTOR INHIBITORS		
<i>cimetidine</i>	T1	HD
<i>cimetidine hcl</i>	T1	HD
<i>famotidine</i>	T1	HD
<i>nizatidine</i>	T1	HD
<i>ranitidine hcl</i>	T1	HD
IBS AGENTS, MIXED OPIOID RECEPTOR AGONISTS/ANTAGONISTS		
VIBERZI	T2	HD
IBS-C/CIC AGENTS, GUANYLATE CYCLASE-C AGONIST		
LINZESS	T2	
TRULANCE	T2	
INTEGRIN RECEPTOR ANTAGONIST, MONOCLONAL ANTIBODY		
ENTYVIO	T4	PA SP HD
INTESTINAL MOTILITY STIMULANTS		
<i>metoclopramide hcl</i>	T1	
<i>metoclopramide hcl (Reglan)</i>	T1	
REGLAN (<i>metoclopramide hcl</i>)	T3	
IRRITABLE BOWEL SYNDROME AGENTS, 5-HT3 ANTAGONIST		
<i>alosetron hcl</i>	T4	SP HD
LAXATIVES AND CATHARTICS		
<i>bisac/nac/na/co3/kcl/peg 3350</i>	T1	PPACA
CLENPIQ	T2	PPACA
<i>lactulose</i>	T1	
<i>lactulose 10 gm/15 ml solution</i>	T1	
<i>lactulose 20 gm/30 ml solution</i>	T1	
<i>lubiprostone (Amitiza)</i>	T1	
NULYTELY	T3	PPACA
<i>peg3350/sod sul/nacl/kcl/asb/c</i>	T1	PPACA

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GASTROINTESTINAL (Gastrointestinal/Heartburn) (cont.)

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

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

T4 – Specialty Medications

PA – Prior Authorization

QL – Quantity Limit

ST – Step Therapy

AGE – Age Requirement

SP – Specialty Medication

HD – May require home delivery pharmacy

PPACA – No Cost-Share Preventive Medication

CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

GASTROINTESTINAL (Gastrointestinal/Heartburn) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
PROTON-PUMP INHIBITORS (cont.)		
<i>pantoprazole sod dr 20 mg tab</i> (Protonix)	T1	QL (2 tabs/day) HD
<i>pantoprazole sod dr 40 mg tab</i> (Protonix)	T1	QL (1 tab/day) HD
PREVACID DR 15 MG CAPSULE (<i>lansoprazole</i>)	T3	QL (60 caps/30 days) ST HD
PREVACID DR 30 MG CAPSULE (<i>lansoprazole</i>)	T3	QL (30 caps/30 days) ST HD
PRILOSEC DR 10 MG SUSPENSION	T3	QL (120 packs/30 days) HD
PRILOSEC DR 2.5 MG SUSPENSION	T3	QL (480 packs/30 days) HD
PROTONIX 40 MG SUSPENSION (<i>pantoprazole sodium</i>)	T3	QL (30 packs/30 days) ST HD
PROTONIX DR 20 MG TABLET (<i>pantoprazole sodium</i>)	T3	QL (60 tabs/30 days) ST HD
PROTONIX DR 40 MG TABLET (<i>pantoprazole sodium</i>)	T3	QL (30 tabs/30 days) ST HD
<i>rabeprazole sodium</i> (Aciphex)	T1	QL (30 tabs/30 days) HD
RECTAL PREPARATIONS		
<i>hydrocortisone acetate</i>	T1	
SBS - GLUCAGON-LIKE PEPTIDE-2 (GLP-2) ANALOGS		
GATTEX	T4	PA SP HD

GASTROINTESTINAL (Pain Relief And Inflammatory Disease)

HEMORRHOID PREP, ANTI-INFLAM STEROID-LOCAL ANESTHET

ANA-LEX	T1	
ANALPRAM HC 1% CREAM	T3	
<i>hydrocortisone/lidocaine/aloe</i>	T1	
<i>hydrocortisone/pramoxine</i> (Analpram Hc)	T1	
<i>lidocaine/hydrocortisone ac</i>	T1	
LIDOCAINE-HYDROCORTISONE	T1	
PROCORT	T3	
PROCTOFOAM-HC	T2	

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

<i>budesonide 2 mg rectal foam</i>	T1	QL(2 KITS/180 DAYS)
CORTENEMA (<i>hydrocortisone</i>)	T3	
<i>hydrocortisone</i> (Cortenema)	T1	

HORMONES (Hormonal Agents)

ANDROGEN/ESTROGEN PREPS FOR FEMALE SEXUAL DYSFUNC

INTRAROSA	T3	
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ANDROGENIC AGENTS

ANADROL-50	T2	PA
ANDRODERM	T2	PA QL (1 patch/day)
ANDROGEL 1% (25 MG/2.5 G) PKT (<i>testosterone</i>)	T3	PA QL (150gm/30 days)
ANDROGEL 1% (50 MG/5 G) PKT (<i>testosterone</i>)	T3	PA QL (2 packs/day)

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

T4 – Specialty Medications

PA – Prior Authorization

QL – Quantity Limit

ST – Step Therapy

AGE – Age Requirement

SP – Specialty Medication

HD – May require home delivery pharmacy

PPACA – No Cost-Share Preventive Medication

CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

HORMONES (Hormonal Agents) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ANDROGENIC AGENTS (cont.)		
ANDROGEL 1.62% GEL PUMP (testosterone)	T3	PA QL (150gm/30 days)
ANDROGEL 1.62%(1.25G) GEL PCKT (testosterone)	T3	PA QL (2 packs/day)
ANDROGEL 1.62%(2.5G) GEL PCKT (testosterone)	T3	PA QL (150gm/30 days)
ANDROID (methyltestosterone)	T3	
DEPO-TESTOSTERONE	T3	
DEPO-TESTOSTERONE (testosterone cypionate)	T3	
METHITEST	T1	
methyltestosterone (Testred)	T1	
oxandrolone	T1	PA
testosterone 1% (50 mg/5 g) pk (Testosterone)	T1	PA QL (2 packs/day)
testosterone 1% (25mg/2.5g) pk (Androgel)	T1	PA QL (150gm/30 days)
testosterone 1.62% (2.5 g) pkt (Androgel)	T1	PA QL (150gm/30 days)
testosterone 1.62% gel pump (Androgel)	T1	PA QL (150gm/30 days)
testosterone 1.62%(1.25 g) pkt (Androgel)	T1	PA QL (2 packs/day)
testosterone 10 mg gel pump	T1	PA QL (120 gm/30 days)
TESTOSTERONE 12.5 MG/1.25 GRAM	T1	PA QL (150gm/30 days)
testosterone 12.5 mg/1.25 gram (Testosterone)	T1	PA QL (150gm/30 days)
testosterone 30 mg/1.5 ml pump	T1	PA QL (180ml/30 days)
testosterone 50 mg/5 gram gel	T1	PA QL (2 tubes/day)
TESTOSTERONE 50 MG/5 GRAM PKT	T1	PA QL (2 packs/day)
testosterone cypionate (Depo-testosterone)	T1	
testosterone enanthate	T1	
TESTRED (methyltestosterone)	T3	
ANTI-DIURETIC AND VASOPRESSOR HORMONES		
desmopressin (nonrefrigerated)	T1	HD
desmopressin acetate	T1	HD
NOCTIVA	T3	PA
STIMATE	T4	SP
ESTROGEN AND PROGESTIN COMBINATIONS		
BIJUVA	T3	
ESTROGEN/ANDROGEN COMBINATIONS		
estrogen, ester/me-testosterone	T1	HD
ESTROGENIC AGENTS		
ACTIVELLA (mimvey lo)	T3	HD
ACTIVELLA (mimvey)	T3	HD
ALORA	T3	QL (16 patches/28 days) HD

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

T4 – Specialty Medications
 PA – Prior Authorization
 QL – Quantity Limit

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

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

List of Prescription Medications

HORMONES (Hormonal Agents) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ESTROGENIC AGENTS (cont.)		
CLIMARA (estradiol (once weekly))	T3	HD
CLIMARA PRO	T3	HD
COMBIPATCH	T3	HD
DEPO-ESTRADIOL	T3	HD
DIVIGEL	T2	HD
ELESTRIN	T3	HD
ESTRACE (estradiol)	T3	HD
estradiol (Climara)	T1	HD
estradiol (Vivelle-dot)	T1	QL (8 patches/21) days HD
estradiol (Vivelle-dot)	T1	QL (16 patches/28 days) HD
estradiol 0.025 mg patch(2/wk) (Minivelle)	T1	QL(16 patches/28 days) HD
estradiol 0.025 mg patch(2/wk) (Vivelle-Dot)	T1	QL(16 patches/28 days) HD
estradiol 0.0375mg patch(2/wk) (Minivelle)	T1	QL(16 patches/28 days) HD
estradiol 0.0375mg patch(2/wk) (Vivelle-Dot)	T1	QL(16 patches/28 days) HD
estradiol 0.05 mg patch (2/wk) (Minivelle)	T1	QL(16 patches/28 days) HD
estradiol 0.05 mg patch (2/wk) (Vivelle-Dot)	T1	QL(16 patches/28 days) HD
estradiol 0.075 mg patch(2/wk) (Minivelle)	T1	QL(16 patches/28 days) HD
estradiol 0.075 mg patch(2/wk) (Vivelle-Dot)	T1	QL(16 patches/28 days) HD
estradiol 0.1 mg patch (2/wk) (Minivelle)	T1	QL(16 patches/28 days) HD
estradiol 0.1 mg patch (2/wk) (Vivelle-Dot)	T1	QL(16 patches/28 days) HD
estradiol 0.5 mg tablet (Estrace)	T1	HD
estradiol 1 mg tablet (Estrace)	T1	HD
estradiol 2 mg tablet (Estrace)	T1	HD
estradiol valerate (Delestrogen)	T1	HD
estradiol/norethindrone acet (Activella)	T1	HD
ESTROGEL	T3	HD
EVAMIST	T3	HD
FEMHRT (norethindron-ethinyl estradiol)	T3	HD
MENEST	T3	HD
MENOSTAR	T3	QL (8 patches/28 days) HD
MINIVELLE (Iyllana)	T3	QL (16 patches/28 days) HD
norethind-eth estrad 0.5-2.5 (Femhrt)	T1	HD
norethindrone ac-eth estradiol	T1	HD
norethindrone ac-eth estradiol (Femhrt)	T1	HD
norethin-eth estrad 1 mg-5 mcg	T1	HD
PREFEST	T3	HD
PREMARIN	T2	HD

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

T4 – Specialty Medications
PA – Prior Authorization
QL – Quantity Limit

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

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

List of Prescription Medications

HORMONES (Hormonal Agents) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ESTROGENIC AGENTS (cont.)		
PREMPHASE	T2	HD
PREMPRO	T2	HD
VIVELLE-DOT (<i>lyllana</i>)	T3	QL (16 patches/28 days) HD
ESTROGEN-PROGESTIN WITH ANTI-MINERALOCORTICOID COMB		
ANGELIQ	T3	HD
ESTROGEN-SELECTIVE ESTROGEN RECEPTOR MOD (SERM) COMB		
DUAVEE	T2	
GLUCOCORTICOIDS		
<i>budesonide</i>	T1	PA QL (56 tabs/180 days)
<i>budesonide</i> (Entocort Ec)	T1	
CORTEF (<i>hydrocortisone</i>)	T3	
<i>cortisone acetate</i>	T1	
<i>deflazacort</i> (Emflaza)	T4	PA SP HD
<i>dexamethasone</i>	T1	
<i>dexamethasone sodium phosp/pf</i>	T1	
EMFLAZA	T4	PA SP HD
ENTOCORT EC (<i>budesonide ec</i>)	T3	
<i>hydrocortisone</i> (Cortef)	T1	
LOCORT	T1	
MEDROL 16 MG TABLET (<i>methylprednisolone</i>)	T3	
MEDROL 2 MG TABLET	T2	
MEDROL 32 MG TABLET (<i>methylprednisolone</i>)	T3	
MEDROL 4 MG DOSEPAK (<i>methylprednisolone</i>)	T3	
MEDROL 4 MG TABLET (<i>methylprednisolone</i>)	T3	
MEDROL 8 MG TABLET (<i>methylprednisolone</i>)	T3	
<i>methylprednisolone</i> (Medrol)	T1	
MILLIPRED 10 MG/5 ML SOLUTION (<i>prednisolone sodium phosphate</i>)	T3	
<i>millipred 5 mg tablet</i>	T1	
ORAPRED ODT (<i>prednisolone sodium phos odt</i>)	T3	
<i>prednisolone</i>	T1	
<i>prednisolone sodium phosphate</i>	T1	
<i>prednisolone sodium phosphate</i> (Millipred)	T1	
<i>prednisolone sodium phosphate</i> (Orapred Odt)	T1	
<i>prednisone</i>	T1	
GROWTH HORMONE RELEASING HORMONE (GHRH) AND ANALOGS		
EGRIFTA	T4	PA SP HD
EGRIFTA SV	T4	PA SP HD

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

T4 – Specialty Medications
 PA – Prior Authorization
 QL – Quantity Limit

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

HD – May require home delivery pharmacy
 PPACA – No Cost-Share Preventive Medication
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List of Prescription Medications

HORMONES (Hormonal Agents) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
GROWTH HORMONES		
GENOTROPIN	T4	PA SP HD
NGENLA	T4	PA SP
NORDITROPIN FLEXPRO	T4	PA SP HD
OMNITROPE	T4	PA SP HD
SEROSTIM	T4	PA SP
SKYTROFA	T4	SP HD
SOGROYA	T4	PA SP
INSULIN-LIKE GROWTH FACTOR-I (IGF-I) HORMONES		
INCRELEX	T4	PA SP HD
LHRH (GNRH) AGONIST ANALOG AND PROGESTIN COMB		
LUPANETA PACK	T4	PA SP HD
LHRH (GNRH) AGONIST ANALOG PITUITARY SUPPRESSANTS		
LUPRON DEPOT	T4	PA SP HD
TRIPTODUR	T4	PA SP
SYNAREL	T4	PA SP HD
LHRH (GNRH) ANTAGONIST, ESTROGEN AND PROGESTIN COMB		
MYFEMBREE	T2	PA QL (24 MONTH THERAPY)
ORIAHNN	T2	PA QL (2 CAPSULES/DAY)
LHRH (GNRH) ANTAGONIST, PITUITARY SUPPRESSANT AGENTS		
CETROTIDE	T4	PA SP
<i>ganirelix acet 250 mcg/0.5 ml (Ganirelix Acetate)</i>	T4	PA SP
GANIRELIX ACET 250 MCG/0.5 ML (<i>ganirelix acetate</i>)	T4	PA SP
ORLISSA 150 MG TABLET	T2	PA QL (1 tab/day)
ORLISSA 200 MG TABLET	T2	PA QL (6 months therapy/lifetime)
LHRH (GNRH) AGNST PIT.SUP-CENTRAL PRECOCIOUS PUBERTY		
FENSOLVI	T4	PA SP
LUPRON DEPOT-PED	T4	PA SP HD
MINERALOCORTICIDS		
<i>fludrocortisone acetate</i>	T1	HD
OXYTOCICS		
carboprost 250 mcg/ml ampul (Hemabate)	T1	
CARBOPROST 250 MCG/ML SYRINGE	T3	
CERVIDIL	T3	
<i>methylergonovine maleate</i>	T1	
PREPIDIL	T3	
PROSTIN E2 VAGINAL SUPPOSITORY	T3	

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

T4 – Specialty Medications
 PA – Prior Authorization
 QL – Quantity Limit

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

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

List of Prescription Medications

HORMONES (Hormonal Agents) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
PITUITARY SUPPRESSIVE AGENTS		
<i>cabergoline</i>	T1	QL (16 tabs/28 days) HD
<i>danazol</i>	T1	HD
PROGESTATIONAL AGENTS		
AYGESTIN (<i>norethindrone acetate</i>)	T3	HD
CRINONE 4% GEL	T3	PA HD
DEPO-PROVERA 400 MG/ML VIAL	T3	HD
<i>hydroxyprogesterone 1.25 g/5ml</i>	T1	HD
<i>medroxyprogesterone 10 mg tab</i> (Provera)	T1	HD
<i>medroxyprogesterone 2.5 mg tab</i> (Provera)	T1	HD
<i>medroxyprogesterone 5 mg tab</i> (Provera)	T1	HD
<i>norethindrone acetate</i> (Aygestin)	T1	HD
<i>progesterone, micronized</i> (Prometrium)	T1	HD
PROVERA (<i>medroxyprogesterone acetate</i>)	T3	HD
SOMATOSTATIC AGENTS		
BYNFEZIA	T4	PA SP
<i>octreotide acetate</i>	T4	PA SP HD
<i>octreotide acetate</i> (Sandostatin)	T4	PA SP HD
SANDOSTATIN (<i>octreotide acetate</i>)	T4	PA SP HD
SANDOSTATIN LAR DEPOT	T4	PA SP
SIGNIFOR	T4	PA SP
SIGNIFOR LAR	T4	PA SP
SOMATULINE DEPOT	T4	PA SP HD
VAGINAL ESTROGEN FOR SEXUAL DYSFUNCTION		
IMVEXXY 10 MCG MAINTENANCE PAK	T3	QL (16/28 days) HD
IMVEXXY 10 MCG STARTER PACK	T3	QL (36/28 days) HD
IMVEXXY 4 MCG MAINTENANCE PAK	T3	QL (16/28 days) HD
IMVEXXY 4 MCG STARTER PACK	T3	QL (36/28 days) HD
VAGINAL ESTROGEN PREPARATIONS		
ESTRACE (<i>estradiol</i>)	T3	HD
<i>estradiol</i>	T1	QL (36 tabs/28 days) HD
<i>estradiol 0.01% cream</i>	T1	HD
<i>estradiol 10 mcg vaginal insrt</i>	T1	QL (36 tabs/28 days) HD
ESTRING	T2	QL (2 rings/90 days) HD
FEMRING	T3	HD
PREMARIN	T2	HD
VAGIFEM (<i>yuvafem</i>)	T3	QL (36 tabs/28 days) HD

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

T4 – Specialty Medications
 PA – Prior Authorization
 QL – Quantity Limit

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

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

List of Prescription Medications

HORMONES (Infertility)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
FERTILITY STIMULATING PREPARATIONS, NON-FSH		
<i>clomiphene citrate</i>	T1	
FOLLICLE-STIMULATING AND LUTEINIZING HORMONES		
MENOPUR	T4	PA SP
FOLLICLE-STIMULATING HORMONE (FSH)		
FOLLISTIM AQ	T4	PA SP
GONAL-F	T4	PA SP
GONAL-F RFF	T4	PA SP
GONAL-F RFF REDI-JECT	T4	PA SP
HUMAN CHORIONIC GONADOTROPIN (HCG)		
CHORIONIC GONAD 10,000 UNIT VL	T4	PA SP
CHORIONIC GONAD 12,000 UNIT VL	T4	SP
NOVAREL	T4	PA SP
PREGNYL	T4	PA SP
PREGNANCY FACILITATING/MAINTAINING AGENT, HORMONAL		
CRINONE 8% GEL	T2	
ENDOMETRIN	T3	
<i>hydroxyprogesterone 1,250 mg/5 ml</i>	T1	PA
<i>hydroxyprogesterone 250 mg/ml vial</i>	T1	PA
MAKENA	T3	PA
HORMONES (Miscellaneous)		
LEPTIN HORMONE ANALOGS		
MYALEPT	T4	PA SP HD
HORMONES (Osteoporosis Products)		
BONE FORMATION STIMULATING AGENTS - PTH RELATED PEPTIDES		
<i>teriparatide 600 mcg/2.4ml pen</i>	T4	PA QL(0.09 mls/day) SP HD
TERIPARATIDE 620 MCG/2.48 ML	T4	PA QL(0.09 mls/day) SP HD
BONE RESORPTION INHIBITORS		
<i>calcitonin, salmon, synthetic</i>	T1	HD
RECLAST 5 MG/100 ML SOLUTION	T3	
MIACALCIN	T2	HD
<i>zoledronic acid 4 mg vial</i>		
ZOLEDRONIC ACID 4MG/100ML	T3	
IMMUNOSUPPRESSANTS (Pain Relief And Inflammatory Disease)		
IL-23 RECEPTOR ANTAGONIST, MONOCLONAL ANTIBODY		
OMVOH	T4	SP HD

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

T4 – Specialty Medications
 PA – Prior Authorization
 QL – Quantity Limit

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

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

List of Prescription Medications

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

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
INTERLEUKIN-4(IL-4) RECEPTOR ALPHA ANTAGONIST, MAB		
DUPIXENT PEN	T4	PA SP HD
DUPIXENT SYRINGE	T4	PA SP HD
INTERLEUKIN-6 (IL-6) RECEPTOR INHIBITORS		
ACTEMRA	T4	PA QL (4 syringes/28 days) SP HD
ACTEMRA ACTPEN	T4	PA QL (4 pens/28 days) SP HD
ENSPRYNG	T4	PA SP HD
KEVZARA 150 MG/1.14 ML PEN INJ	T4	PA QL (2 pens/28 days) SP HD
KEVZARA 150 MG/1.14 ML SYRINGE	T4	PA QL (2 syringes/28 days) SP HD
KEVZARA 200 MG/1.14 ML PEN INJ	T4	PA QL (2 pens/28 days) SP HD
KEVZARA 200 MG/1.14 ML SYRINGE	T4	PA QL (2 syringes/28 days) SP HD
MONOCLONAL ANTIBODY-HUMAN INTERLEUKIN I2/23 INHIB		
STELARA 45 MG/0.5 ML SYRINGE	T4	PA QL (1 syringe/84 days) SP HD
STELARA 45 MG/0.5 ML VIAL	T4	PA QL (1 vial/84 days) SP HD
STELARA 90 MG/ML SYRINGE	T4	PA QL (1 syringe/84 days) SP HD

IMMUNOSUPPRESSANTS (Skin Conditions)

TOPICAL IMMUNOSUPPRESSIVE AGENTS

ELIDEL (<i>pimecrolimus</i>)	T3	
<i>pimecrolimus</i> (Elidel)	T1	
PROTOPIC (<i>tacrolimus</i>)	T3	
<i>tacrolimus</i> 0.03% ointment (Protopic)	T1	
<i>tacrolimus</i> 0.1% ointment (Protopic)	T1	

IMMUNOSUPPRESSANTS (Transplant Medications)

IMMUNOSUPPRESSIVES

ASTAGRAF XL	T4	SP HD
AZASAN	T4	SP HD
<i>azathioprine</i> (Imuran)	T4	SP HD
CELLCEPT (<i>mycophenolate mofetil</i>)	T4	SP HD
<i>cyclosporine</i> (Sandimmune)	T4	SP HD
<i>cyclosporine, modified</i> (Neoral)	T4	SP HD
ENVARUSUS XR	T4	SP HD
<i>everolimus</i> 0.25 mg tablet (Zortress)	T4	SP HD
<i>everolimus</i> 0.5 mg tablet (Zortress)	T4	SP HD
<i>everolimus</i> 0.75 mg tablet (Zortress)	T4	SP HD
IMURAN (<i>azathioprine</i>)	T4	SP HD
LUPKYNIS	T4	PA QL (6 CAPS/DAY) SP
<i>mycophenolate mofetil</i> (Cellcept)	T4	SP HD

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

T4 – Specialty Medications

PA – Prior Authorization

QL – Quantity Limit

ST – Step Therapy

AGE – Age Requirement

SP – Specialty Medication

HD – May require home delivery pharmacy

PPACA – No Cost-Share Preventive Medication

CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

IMMUNOSUPPRESSANTS (Transplant Medications) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
IMMUNOSUPPRESSIVES (cont.)		
<i>mycophenolate sodium</i> (Myfortic)	T4	SP HD
MYFORTIC (<i>mycophenolic acid</i>)	T4	SP HD
PROGRAF	T4	SP HD
PROGRAF (<i>tacrolimus</i>)	T4	SP HD
RAPAMUNE (<i>sirolimus</i>)	T4	SP HD
<i>sirolimus</i> (Rapamune)	T4	SP HD
<i>tacrolimus 0.5 mg capsule</i> (ir) (Prograf)	T4	SP HD
<i>tacrolimus 1 mg capsule</i> (ir) (Prograf)	T4	SP HD
<i>tacrolimus 5 mg capsule</i> (ir) (Prograf)	T4	SP HD
ZORTRESS	T4	SP HD
ZORTRESS (<i>everolimus</i>)	T4	SP HD

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

DIABETIC SUPPLIES

2TEK CONTROL SOLUTION	T1	
2TEK GLUCOSE-WRIST MONITOR KIT	T3	
ACCU-CHEK	T1	
ACCU-CHEK FASTCLIX LANCING DEV	T1	
ACCU-CHEK GUIDE CONTROL SOLN	T1	
ACCU-CHEK SMARTVIEW CONTRL SOL	T1	
ACCU-CHEK SOFTCLIX	T1	
ACCUTREND GLUCOSE CONTROL	T1	
ADJUSTABLE LANCING DEVICE	T1	
ADVANCED LANCING DEVICE	T1	
ADVOCATE CONTROL SOLUTION	T1	
ADVOCATE LANCING DEVICE	T1	
ADVOCATE RAPID-SAFE LANCING DV	T1	
ADVOCATE REDI-CODE+ CTRL SOLN	T1	
AGAMATRIX CONTROL	T1	
ALKALINE BATTERIES	T1	
ALTERNATE SITE LANCING DEVICE	T1	
AQUA LANCE LANCING DEVICE	T1	
ASSURE 4 CONTROL SOLUTION	T1	
ASSURE DOSE	T1	
ASSURE PRISM	T1	
AT HOME A1C	T1	
AUTOJECT 2	T1	
AUTO-LANCET MINI	T1	

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

T4 – Specialty Medications

PA – Prior Authorization

QL – Quantity Limit

ST – Step Therapy

AGE – Age Requirement

SP – Specialty Medication

HD – May require home delivery pharmacy

PPACA – No Cost-Share Preventive Medication

CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

MISCELLANEOUS MEDICAL SUPPLIES, DEVICES, NON-DRUG (Diabetes) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
DIABETIC SUPPLIES (cont.)		
AUTOLET IMPRESSION	T1	
AUTOLET LANCING DEVICE	T1	
AUTOLET PLUS	T1	
AUTOPEN	T1	
BLOOD GLUCOSE CONTROL	T1	
BLU LINK DIABETIC TEST BUNDLE	T3	
BLU LINK GLUCOSE MONITOR SYST	T3	
BREEZE 2	T1	
CAREONE	T1	
CARESENS	T1	
CARETOUCH CONTROL SOLUTION	T1	
CARETOUCH LANCING DEVICE	T1	
CEQUR SIMPLICITY	T2	
CEQUR SIMPLICITY INSERTER	T2	
CHEMSTRIP BG DIARY	T1	
CLEVER CHOICE CONTROL SOLUTION	T1	
CONTOUR METER	T3	
CONTOUR NEXT CONTROL SOLUTION	T1	
CONTOUR SOLUTION	T1	
COOL CONTROL SOLUTION	T1	
DEXCOM G6 RECEIVER	T2	PA QL (1 syringe/365 days)
DEXCOM G6 SENSOR	T2	PA QL (3/30 days)
DEXCOM G6 TRANSMITTER	T2	PA QL (1 syringe/67 days)
DEXCOM G7 RECEIVER	T2	PA QL(1 unit/365 days)
DEXCOM G7 SENSOR	T2	PA QL(3 sensors/30 days)
DIATRUE	T1	
DROPLET GENTEEL LANCING DEVICE	T1	
DROPLET LANCING DEVICE	T1	
EASY MINI EJECT LANCING DEVICE	T1	
EASY PLUS II CONTROL SOLN HIGH	T1	
EASY PLUS II CONTROL SOLN LOW	T1	
EASY STEP CONTROL SOLUTION	T1	
EASY TALK CONTROL SOLN LOW	T1	
EASY TALK HIGH CONTROL SOLN	T1	
EASY TALK PLUS II HIGH CONTROL	T1	
EASY TALK PLUS II LOW CTRL SLN	T1	

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

T4 – Specialty Medications

PA – Prior Authorization

QL – Quantity Limit

ST – Step Therapy

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SP – Specialty Medication

HD – May require home delivery pharmacy

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List of Prescription Medications

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

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
DIABETIC SUPPLIES (cont.)		
EASY TOUCH BLU LINK CTRL SOLN	T1	
EASY TOUCH CONTROL SOLUTION	T1	
EASY TOUCH LANCING DEVICE	T1	
EASY TRAK CONTROL SOLN HIGH	T1	
EASY TRAK CONTROL SOLN LOW	T1	
EASY TRAK II CONTROL SOLUTION	T1	
EASYGLUCO PLUS CONTROL NORMAL	T1	
EASYMAX 15 LEVEL 2 SOLUTION	T1	
EASYMAX NORMAL CONTROL SOLN	T1	
ELEMENT COMPACT CONTROL SOLN	T1	
ELEMENT CONTROL SOLUTION	T1	
EMBRACE EVO LEVEL 1 CTRL SOLN	T1	
EMBRACE GLUC CONTROL SOLN HIGH	T1	
EMBRACE GLUCOSE CONTROL SOLN	T1	
EMBRACE LANCING DEVICE	T1	
EMBRACE PRO	T1	
EMBRACE TALK CONTROL SOLUTION	T1	
EMBRACE WAVE PLUS GLUCOSE MTR	T3	
ENLITE SERTER	T1	
EVENCARE G2 CONTROL SOLUTION	T1	
EVENCARE G3 CONTROL SOLUTION	T1	
EVOLUTION CONTROL SOLUTION	T1	
EZ-VAC	T1	
FORA CONTROL SOLUTION	T1	
FORA LANCING DEVICE	T1	
FORA TN'GO ADVANCE MULTIFN MTR	T3	
FORACARE GDH	T1	
FORTISCARE	T1	
FREESTYLE CONTROL SOLUTION	T1	
FREESTYLE LIBRE 10 DAY READER	T2	PA QL (1 reader/day)
FREESTYLE LIBRE 10 DAY SENSOR	T2	PA QL (3/30 days)
FREESTYLE LIBRE 14 DAY READER	T2	PA QL (1 reader/day)
FREESTYLE LIBRE 14 DAY SENSOR	T2	PA QL (2/28 days)
FREESTYLE LIBRE 2 READER	T2	PA QL (1 reader/day)
FREESTYLE LIBRE 2 SENSOR	T2	PA QL (2 sensors/21 days)
GE100 CONTROL SOLUTION NORMAL	T1	

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

T4 – Specialty Medications

PA – Prior Authorization

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List of Prescription Medications

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

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
DIABETIC SUPPLIES (cont.)		
GE333 BLOOD GLUCOSE SYSTEM	T3	
GENTEEL VACUUM LANCING DEVICE	T1	
GLUCOCARD 01 CONTROL	T1	
GLUCOCARD EXPRESSION CNTRL SLN	T1	
GLUCOCARD SHINE CONTROL SOLN	T1	
GLUCOCOM AUTOLINK	T1	
GLUCOCOM CONTROL SOLUTION	T1	
GLUCOSE CONTROL	T1	
GOJJI GLUCOSE CONTROL SOLUTION	T1	
GOJJI LANCING DEVICE	T1	
GUARDIAN RT CHARGER	T1	
GUARDIAN RT STARTER KIT	T1	
GUARDIAN RT SYSTEM	T1	
GUARDIAN TEST PLUG	T1	
GUARDIAN TRANSMITTER TAPE	T1	
HEALTHPRO GLUCOSE CONTROL SOLN	T1	
HEALTHY ACCENTS AUTOLET	T1	
HUMAPEN LUXURA HD	T1	
HYPOLANCE	T1	
INCONTROL LANCING DEVICE	T1	
INFINITY CONTROL SOLUTION	T1	
INFINITY VOICE CONTROL SOLN	T1	
INPEN (FOR HUMALOG)	T1	
INPEN (FOR NOVOLOG OR FIASP)	T1	
INSUL-CAP	T1	
INSUL-EZE	T1	
LANCING DEVICE	T1	
LANCING SYSTEM	T1	
LANZO	T1	
LITE TOUCH	T1	
MAGNI-GUIDE MAGNIFIER	T1	
MEDISENSE	T1	
MEDISENSE GLUCOSE KETONE	T1	
MEDISENSE GLUCOSE KETONE CONTR	T1	
MEDTRONIC REMOTE CONTROL	T1	
MICRODOT HIGH-LOW CONTROL SOL	T1	

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

T4 – Specialty Medications

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List of Prescription Medications

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

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
DIABETIC SUPPLIES (cont.)		
MICRODOT NORMAL CONTROL SOLUT	T1	
MICROLET 2	T1	
MICROLET NEXT LANCING DEVICE	T1	
MINI LANCING DEVICE	T1	
MINIMED QUICK-SERTER	T1	
MOBILE LANCETS	T2	
MULTI-LANCET	T1	
MYGLUCOHEALTH CONTROL SOLUTION	T1	
NOVAMAX PLUS GLU-KET	T1	
NOVOPEN ECHO	T1	
OMNIPOD 5 G6-G7 INTRO KT(GEN5)	T2	QL
OMNIPOD 5 G6-G7 PODS (GEN 5)	T2	QL
OMNIPOD DASH 5 PACK POD	T2	PA QL (6 boxes/30 days)
ON CALL EXPRESS CONTROL SOLN	T1	
ON CALL LANCING DEVICE	T1	
ON CALL PLUS CONTROL	T1	
ON CALL PLUS LANCING DEVICE	T1	
ON CALL VIVID CONTROL	T1	
ONETOUCH DELICA PLUS LANC DEV	T1	
ONETOUCH ULTRA CONTROL SOLN	T1	
ONETOUCH ULTRASOFT 2 LANCET	T2	
ONETOUCH VERIO HIGH CNTRL SOLN	T1	
ONETOUCH VERIO MID CNTRL SOLN	T1	
OPTUMRX GLUCOSE CONTROL SOLN	T1	
OVAL TAPE	T1	
PARADIGM REMOTE CONTROL	T1	
PIP GLUCOSE CONTROL SOLUTION	T1	
PRO COMFORT SAFETY LANCET	T2	
PRODIGY CONTROL SOLUTION	T1	
PRODIGY LANCING DEVICE	T1	
REFUAH PLUS GLUCOSE CONTROL	T1	
RELIAMED MINI LANCING DEVICE	T1	
REPLACEMENT PEDIATRIC MONITOR	T1	
RIGHTEST CONTROL SOLUTION	T1	
RIGHTEST GD500	T1	
SAFE-CLIP	T1	

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

T4 – Specialty Medications

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List of Prescription Medications

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

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
DIABETIC SUPPLIES (cont.)		
SEN-SERTER	T1	
SIL-SERTER	T1	
SMARTDIABETES VANTAGE	T1	
SMARTEST	T1	
SOLUS V2 CONTROL SOLUTION	T1	
SOLUS V2 LANCING DEVICE	T1	
SURE COMFORT LANCING PEN	T1	
SUREFLEX	T1	
SURE-PEN	T1	
SURE-TEST EASYPLUS MINI SOLN	T1	
TELCARE CONTROL SOLUTION	T1	
TRUE METRIX	T1	
TRUECONTROL	T1	
TRUEDRAW	T1	
ULTI-LANCE	T1	
ULTRATRAK CONTROL SOL NORMAL	T1	
ULTRATRAK CONTROL SOLUTION	T1	
ULTRATRAK ULTIMATE CNTRL SOLN	T1	
UNISTIK 2	T1	
UNISTIK 2 NORMAL	T1	
UNISTIK 3	T1	
UNISTIK 3 COMFORT	T1	
UNISTIK 3 NEONATAL	T1	
UNISTRIP	T1	
VERASENS CONTROL SOLUTION	T1	
V-GO 20	T2	
V-GO 30	T2	
V-GO 40	T2	
VIVAGUARD INO CONTROL SOLUTION	T1	
VIVAGUARD LANCING DEVICE	T1	
WAVESENSE CONTROL SOLUTION	T1	
NEEDLES/NEEDLELESS DEVICES		
1ST TIER UNIFINE PENTIPS	T1	
1ST TIER UNIFINE PENTIPS PLUS	T1	
ABOUTIME PEN NEEDLE	T1	
ADVOCATE PEN NEEDLES	T1	

T1 – Typically Generics

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List of Prescription Medications

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

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
NEEDLES/NEEDLELESS DEVICES (cont.)		
AQINJECT PEN NEEDLE	T1	
ASSURE ID PEN NEEDLE	T1	
AUTOSHIELD DUO PEN NEEDLE	T1	
BLUNT NEEDLE	T1	
CAREFINE PEN NEEDLE	T1	
CARETOUCH HYPODERMIC NEEDLE	T1	
CARETOUCH PEN NEEDLE	T1	
CLICKFINE	T1	
COMFORT EZ PEN NEEDLE	T1	
COMFORT EZ PRO SAFETY PEN ND	T1	
COMFORT TOUCH PEN NEEDLE	T1	
DROPLET MICRON PEN NEEDLE	T1	
DROPLET PEN NEEDLE	T1	
DROPSAFE PEN NEEDLE	T1	
EASY COMFORT PEN NEEDLE	T1	
EASY COMFORT PEN NEEDLES	T1	
EASY GLIDE PEN NEEDLE	T1	
EASY TOUCH FLIPLock NEEDLE	T1	
EASY TOUCH FLIPLock NEEDLES	T1	
EASY TOUCH HYPODERMIC NEEDLE	T1	
EASY TOUCH PEN NEEDLE	T1	
EASY TOUCH SAFETY PEN NEEDLE	T1	
EASYPPOINT NEEDLE	T1	
ECLIPSE NEEDLE	T1	
EMBRACE PEN NEEDLE	T1	
EXEL HUBER NEEDLE	T1	
EXEL HYPODERMIC NEEDLE	T1	
FILTER ASPIRATOR NEEDLE	T1	
FILTER NEEDLE	T1	
FLOW-EZE	T1	
HEALTHWISE PEN NEEDLE	T1	
HEALTHY ACCENTS UNIFINE PENTIP	T1	
HYPODERMIC NEEDLE	T1	
INCONTROL PEN NEEDLE	T1	
INSULIN PEN NEEDLE	T1	
INSUPEN	T1	

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

T4 – Specialty Medications
PA – Prior Authorization
QL – Quantity Limit

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

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

List of Prescription Medications

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

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
NEEDLES/NEEDLELESS DEVICES (cont.)		
INSUPEN PEN NEEDLE	T1	
INTEGRA NEEDLE	T1	
INTEGRA PRECISIONGLIDE NEEDLE	T1	
LIFESHIELD BLUNT CANNULA	T1	
LITE TOUCH	T1	
MAXICOMFORT II PEN NEEDLE	T1	
MAXICOMFORT SAFETY PEN NEEDLE	T1	
MICRODOT INSULIN PEN NEEDLE	T1	
MINI PEN NEEDLE	T1	
MINI ULTRA-THIN II	T1	
MONOJECT BLOOD COLLECTION	T1	
MONOJECT FILTER NEEDLE	T1	
NANO 2ND GEN PEN NEEDLE	T1	
NEEDLES	T1	
needles,safety huber,disposable	T1	
NOKOR ADMIX NEEDLE	T1	
NOKOR NEEDLE	T1	
NOVOFINE 32	T1	
NOVOFINE AUTOCOVER	T1	
NOVOFINE PLUS	T1	
NOVOTWIST	T1	
PEN NEEDLES	T1	
PENTIPS	T1	
PHASEAL PROTECTOR	T1	
PIP PEN NEEDLE	T1	
POLY HUB NEEDLE	T1	
PRECISIONGLIDE	T1	
PREVENT DROPSAFE PEN NEEDLE	T1	
PRO COMFORT PEN NEEDLE	T1	
PURE COMFORT PEN NEEDLE	T1	
PURE COMFORT SAFETY PEN NEEDLE	T1	
RAYA SURE PEN NEEDLE	T1	
REGULAR BEVEL NEEDLES	T1	
RELION PEN NEEDLES	T1	
SAFETY PEN NEEDLE	T1	
SAFETYGLIDE NEEDLE	T1	

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

T4 – Specialty Medications
PA – Prior Authorization
QL – Quantity Limit

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

HD – May require home delivery pharmacy
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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.)		
SECURESAFE PEN NEEDLE	T1	
SHORT BEVEL NEEDLES	T1	
SKY SAFETY PEN NEEDLE	T1	
SPECIALTY USE NEEDLES	T1	
SURE COMFORT	T1	
SURE COMFORT PEN NEEDLE	T1	
SURE COMFORT SAFETY PEN NEEDLE	T1	
SURE-FINE PEN NEEDLES	T1	
TECHLITE PEN NEEDLE	T1	
TERUMO SURGUARD2	T1	
TERUMO SURGUARD2	T1	
THIN WALL NEEDLES	T1	
TOPCARE CLICKFINE	T1	
TRANSFER NEEDLE	T1	
TRUE COMFORT PEN NEEDLE	T1	
TRUE COMFORT PRO PEN NEEDLE	T1	
TRUE COMFORT SAFETY PEN NEEDLE	T1	
TRUEPLUS PEN NEEDLE	T1	
ULTICARE PEN NEEDLE	T1	
ULTICARE SAFETY PEN NEEDLE	T1	
ULTIGUARD SAFEPACK-PEN NEEDLE	T1	
ULTILET PEN NEEDLE	T1	
ULTRA FLO PEN NEEDLE	T1	
ULTRA THIN	T1	
ULTRACARE PEN NEEDLE	T1	
ULTRA-FINE MICRO PEN NEEDLE	T1	
ULTRA-FINE MINI PEN NEEDLE	T1	
ULTRA-FINE NANO PEN NEEDLE	T1	
ULTRA-FINE ORIGINAL PEN NEEDLE	T1	
ULTRA-FINE SHORT PEN NEEDLE	T1	
ULTRA-THIN II	T1	
UNIFINE PEN NEEDLE	T1	
UNIFINE PENTIPS	T1	
UNIFINE PENTIPS PLUS	T1	
UNIFINE PENTIPS PLUS MAXFLOW	T1	
UNIFINE SAFECONTROL	T1	
UNIFINE ULTRA PEN NEEDLE	T1	

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

T4 – Specialty Medications

PA – Prior Authorization

QL – Quantity Limit

ST – Step Therapy

AGE – Age Requirement

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List of Prescription Medications

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

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
NEEDLES/NEEDLELESS DEVICES (cont.)		
VERIFINE PEN NEEDLE	T1	
VERIFINE PLUS PEN NEEDLE	T1	
YALE NEEDLES	T1	
SYRINGES AND ACCESSORIES		
ADVOCATE SYRINGES	T1	
ASSURE ID INSULIN SAFETY	T1	
CARETOUCH INSULIN SYRINGE	T1	
COMFORT EZ INSULIN SYRINGE	T1	
DROPLET INSULIN SYRINGE	T1	
DROPSAFE INSULIN SYRINGE	T1	
EASY COMFORT INSULIN SYRINGE	T1	
EASY GLIDE INSULIN SYRINGE	T1	
EASY TOUCH	T1	
EASY TOUCH FLIPLOCK INSULIN	T1	
EASY TOUCH INSULIN SAFETY	T1	
EASY TOUCH INSULIN SYRINGE	T1	
EASY TOUCH LUER LOCK INSULIN	T1	
EASY TOUCH SHEATHLOCK INSULIN	T1	
EASY TOUCH UNI-SLIP	T1	
EASY-TOUCH INSULIN SYRINGE	T1	
ECLIPSE SYRINGE	T1	
FREESTYLE PRECISION	T1	
HEALTHWISE INSULIN SYRINGE	T1	
INSULIN SYRINGE	T1	
INSULIN SYRINGE U-500	T1	
LITE TOUCH	T1	
LITETOUCH INSULIN SYRINGE	T1	
LUER-LOK SYRINGE	T1	
MAGELLAN INSULIN SAFETY SYRNG	T1	
MAGELLAN INSULIN SYRINGE	T1	
MAXI-COMFORT	T1	
MAXICOMFORT INSULIN SYRINGE	T1	
MINIMED RESERVOIR 1.8 ML	T1	
MINIMED RESERVOIR 3 ML	T3	
MONOJECT	T1	
MONOJECT INSULIN SAFETY SYRNG	T1	

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

T4 – Specialty Medications

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List of Prescription Medications

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

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
SYRINGES AND ACCESSORIES (cont.)		
MONOJECT INSULIN SYRINGE	T1	
PARADIGM RESERVOIR 1.8 ML	T1	
PARADIGM RESERVOIR 3 ML	T3	
PRO COMFORT INSULIN SYRINGE	T1	
PRODIGY INSULIN SYRINGE	T1	
SAFESNAP INSULIN SYRINGE	T1	
SAFETYGLIDE INSULIN SYRINGE	T1	
SECURESAFE INSULIN SYRINGE	T1	
SURE COMFORT	T1	
SURE COMFORT INSULIN SYRINGE	T1	
SURE-JECT INSULIN SYRINGE	T1	
<i>syringe and needle,insulin,1ml</i>	T1	
<i>syringe-needle,insulin,0.5 ml</i>	T1	
<i>syring-needl,disp,insul,0.3 ml</i>	T1	
TECHLITE INSULIN SYRINGE	T1	
TERUMO INSULIN SYRINGE	T1	
THINPRO INSULIN SYRINGE	T1	
TOPCARE ULTRA COMFORT	T1	
TRUE COMFORT INSULIN SYRINGE	T1	
TRUE COMFORT PRO INS SYRINGE	T1	
TRUEPLUS INSULIN SYRINGE	T1	
ULTICARE INSULIN SYRINGE	T1	
ULTIGUARD SAFE 1ML 30G 12.7MM	T3	
ULTIGUARD SAFE0.3ML 30G 12.7MM	T3	
ULTIGUARD SAFE0.5ML 30G 12.7MM	T1	
ULTIGUARD SAFEPACK 1ML 31G 8MM	T3	
ULTIGUARD SAFEPK 0.3ML 31G 8MM	T3	
ULTIGUARD SAFEPK 0.5ML 31G 8MM	T1	
ULTILET INSULIN SYRINGE	T1	
ULTRA COMFORT	T1	
ULTRA FLO INSULIN SYRINGE	T1	
ULTRACARE INSULIN SYRINGE	T1	
ULTRA-THIN II	T1	
VANISHPOINT	T1	
VANISHPOINT INSULIN SYRINGE	T1	
VEO INSULIN SYRINGE	T1	
VERIFINE INSULIN SYRINGE	T1	

T1 – Typically Generics
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 T4 – Specialty Medications
 PA – Prior Authorization
 QL – Quantity Limit
 ST – Step Therapy
 AGE – Age Requirement
 SP – Specialty Medication
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List of Prescription Medications

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

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
DURABLE MEDICAL EQUIPMENT,MISC(GROUP I)		
1ST TIER UNILET COMFORTOUCH	T1	
2-IN-1 LANCET DEVICE	T1	
ACCU-CHEK FASTCLIX LANCET DRUM	T1	
ACCU-CHEK SAFE-T-PRO	T1	
ACCU-CHEK SAFE-T-PRO PLUS	T1	
ACCU-CHEK SOFTCLIX	T1	
ACTI-LANCE	T1	
ADVANCED TRAVEL LANCETS	T1	
ADVOCATE LANCETS	T1	
ALTERNATE SITE LANCETS	T1	
ASSURE HAEMOLANCE PLUS	T1	
ASSURE LANCE	T1	
ASSURE LANCE PLUS	T1	
BD MICROTAINER LANCETS	T1	
BD ULTRA-FINE	T1	
BD ULTRA-FINE II	T1	
BLOOD LANCETS	T1	
BULLSEYE MINI SAFETY LANCETS	T1	
BUTTERFLY TOUCH LANCET	T1	
CAREONE	T1	
CARETOUCH TWIST LANCET	T1	
CLEVER CHEK LANCETS	T1	
COAGUCHEK	T1	
COLOR LANCETS	T1	
COMFORT EZ	T1	
COMFORT LANCETS	T1	
COMFORT TOUCH PLUS SAFETY LANC	T1	
COMFORT TOUCH ULT THIN LANCET	T1	
DROPLET LANCETS	T1	
EASY COMFORT LANCETS	T1	
EASY TOUCH	T1	
EASY TWIST & CAP LANCETS	T1	
EMBRACE 30G LANCETS	T1	
EMBRACE SAFETY LANCET	T1	
EZ SMART LANCETS	T1	
EZ-LETS	T1	

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

T4 – Specialty Medications
 PA – Prior Authorization
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ST – Step Therapy
 AGE – Age Requirement
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List of Prescription Medications

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

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

T4 – Specialty Medications

PA – Prior Authorization

QL – Quantity Limit

ST – Step Therapy

AGE – Age Requirement

SP – Specialty Medication

HD – May require home delivery pharmacy

PPACA – No Cost-Share Preventive Medication

CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

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

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
DURABLE MEDICAL EQUIPMENT,MISC(GROUP I) (cont.)		
ONETOUCH SURESOFT	T1	
ONETOUCH ULTRASOFT 2 LANCET	T1	
ON-THE-GO	T1	
PIP LANCET	T1	
PRESSURE ACTIVATED LANCETS	T1	
PRO COMFORT LANCETS	T1	
PRO COMFORT SAFETY LANCET	T1	
PRODIGY LANCETS	T1	
PRODIGY TWIST TOP LANCET	T1	
PURE COMFORT LANCETS	T1	
PURE COMFORT SAFETY LANCETS	T1	
PUSH BUTTON SAFETY LANCETS	T1	
READYLANCER SAFETY LANCETS	T1	
RELIAMED	T1	
RELIAMED SAFETY SEAL LANCETS	T1	
RELION THIN	T1	
RIGHTTEST GL300 LANCETS	T1	
SAFETY LANCETS	T1	
SAFETY SEAL LANCETS	T1	
SAFETY-LET	T1	
SINGLE-LET	T1	
SMART SENSE	T1	
SMART SENSE LANCETS	T1	
SMARTTEST LANCET	T1	
SOFT TOUCH	T1	
SOLUS V2 28G LANCETS	T1	
SOLUS V2 LANCETS	T1	
STERILANCETL	T1	
STERILE LANCETS	T1	
SUPER THIN LANCETS	T1	
SURE COMFORT LANCETS	T1	
SURE-LANCE	T1	
SURE-TOUCH	T1	
TECHLITE LANCETS	T1	
TELCARE ULTRA THIN 30G LANCETS	T1	
THIN LANCETS	T1	

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

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
DURABLE MEDICAL EQUIPMENT,MISC(GROUP I) (cont.)		
TOPCARE UNIVERSAL1 LANCET	T1	
TOPCARE UNIVERSAL1 THIN LANCET	T1	
TRUE COMFORT LANCET	T1	
TRUE COMFORT SAFETY LANCET	T1	
TRUEPLUS LANCETS	T1	
TWIST LANCETS	T1	
TWIST TOP LANCET	T1	
ULTILET BASIC	T1	
ULTILET CLASSIC	T1	
ULTILET LANCETS	T1	
ULTILET SAFETY	T1	
ULTRA THIN LANCETS	T1	
ULTRA THIN PLUS	T1	
ULTRA THIN PLUS LANCETS	T1	
ULTRA-CARE LANCETS	T1	
ULTRALANCE	T1	
ULTRA-THIN II	T1	
ULTRATLC LANCETS	T1	
UNILET COMFORTOUCH	T1	
UNILET EXCELITE	T1	
UNILET EXCELITE II	T1	
UNILET GP LANCET	T1	
UNILET LANCET	T1	
UNISTIK 3	T1	
UNISTIK 3 EXTRA	T1	
UNISTIK 3 NORMAL	T1	
UNISTIK COMFORT	T1	
UNISTIK CZT	T1	
UNISTIK EXTRA	T1	
UNISTIK NORMAL	T1	
UNISTIK PRO	T1	
UNISTIK SAFETY	T1	
UNISTIK TOUCH	T1	
UNIVERSAL 1	T1	
VERIFINE SAFETY LANCET MINI	T1	
VERIFINE UNIVERSAL LANCET	T1	
VIVAGUARD LANCET	T1	

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List of Prescription Medications

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

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
RESPIRATORY AIDS, DEVICES, EQUIPMENT		
ACE AEROSOL CLOUD ENHANCER	T2	QL (1 unit/year)
AEROCHAMBER MINI	T2	QL (1 unit/year)
AEROCHAMBER MV	T2	QL (1 unit/year)
AEROCHAMBER PLUS FLOW-VU	T2	QL (1 unit/year)
AEROCHAMBER WITH FLOWSIGNAL	T2	QL (1 unit/year)
AEROCHAMBER Z-STAT PLUS	T2	QL (1 unit/year)
AEROTRACH PLUS	T2	QL (1 unit/year)
AEROVENT PLUS	T2	QL (1 unit/year)
BREATHERITE	T2	QL (1 unit/year)
BREATHERITE SPACER-ADULT MASK	T2	QL (1 unit/year)
BREATHERITE SPACER-INFANT MASK	T2	QL (1 unit/year)
BREATHERITE SPACER-LARGE MASK	T2	QL (1 mask/365 days)
BREATHERITE SPACER-LG CHLD MSK	T2	QL (1 unit/year)
BREATHERITE SPACER-MEDIUM MASK	T2	QL (1 mask/365 days)
BREATHERITE SPACER-NEONATE MSK	T2	QL (1 unit/year)
BREATHERITE SPACER-SM CHLD MSK	T2	QL (1 unit/year)
BREATHERITE SPACER-SMALL MASK	T2	QL (1 mask/365 days)
BREATHRITE	T2	QL (1 unit/year)
CLEVER CHOICE HOLDING CHAMBER	T2	QL (1 unit/year)
COMPACT SPACE CHAMBER	T2	QL (1 unit/year)
EASIVENT	T2	QL (1 unit/year)
E-Z SPACER	T2	QL (1 unit/year)
FLEXICHAMBER	T2	QL (1 unit/year)
FLEXICHAMBER MASK	T2	QL (1 unit/year)
INSPIRACHAMBER	T2	QL (1 unit/year)
LITEAIRE	T2	QL (1 unit/year)
LITETOUCH	T2	QL (1 unit/year)
MICROCHAMBER	T2	QL (1 unit/year)
MICROSPACER	T2	QL (1 unit/year)
OPTICHAMBER	T2	QL (1 unit/year)
OPTICHAMBER DIAMOND	T2	QL (1 unit/year)
POCKET CHAMBER	T2	QL (1 unit/year)
PRIMEAIRE	T2	QL (1 unit/year)
PRO COMFORT SPACER WITH MASK	T2	QL (1 unit/year)
PROCARE SPACER WITH ADULT MASK	T2	QL (1 unit/year)
PROCARE SPACER WITH CHILD MASK	T2	QL (1 unit/year)

T1 – Typically Generics

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List of Prescription Medications

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

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
RESPIRATORY AIDS, DEVICES, EQUIPMENT (cont.)		
PROCHAMBER	T2	QL (1 unit/year)
RITEFLO	T2	QL (1 unit/year)
SILICONE MASK	T2	QL (1 unit/year)
SPACE CHAMBER MASK	T2	QL (1 unit/year)
VORTEX	T2	QL (1 unit/year)
VORTEX HOLDING CHAMBER-CHILD, TODDLER	T2	QL (1 unit/year)
VORTEX VHC FROG MASK	T2	QL (1 unit/year)
VORTEX VHC LADYBUG MASK	T2	QL (1 unit/year)
SYRINGES AND ACCESSORIES		
LITE TOUCH INSULIN SYR	T1	
SURE COMFORT SYRINGE	T1	
ULTRA-THIN II	T1	
TISSUE BULKING IMPLANTS		
BARRIGEL (hyaluronate sodium, stabilized)	T4	PA SP HD
MUSCLE RELAXANTS (Pain Relief And Inflammatory Disease)		
SKELETAL MUSCLE RELAXANTS		
<i>baclofen</i>	T1	HD
<i>carisoprodol</i> (Soma)	T1	
<i>carisoprodol/aspirin</i>	T1	
<i>chlorzoxazone</i>	T1	
<i>cyclobenzaprine hcl</i>	T1	
<i>cyclobenzaprine hcl</i> (Fexmid)	T1	
DANTRIUM (<i>dantrolene sodium</i>)	T3	
<i>dantrolene sodium</i>	T1	
<i>dantrolene sodium</i> (Dantrium)	T1	
FEXMID (<i>cyclobenzaprine hcl</i>)	T3	
FLEQSUVY (<i>baclofen</i>)	T3	HD
<i>metaxalone</i>	T1	
<i>metaxalone</i> (Skelaxin)	T1	
<i>methocarbamol</i> (Robaxin-750)	T1	
<i>orphenadrine citrate</i>	T1	
OZOBAX DS	T3	
ROBAXIN-750 (<i>methocarbamol</i>)	T3	
SKELAXIN (<i>metaxalone</i>)	T3	
SOMA (<i>carisoprodol</i>)	T3	

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List of Prescription Medications

PRE-NATAL VITAMINS (Nutritional/Dietary)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
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SKELETAL MUSCLE RELAXANTS

SOMA (<i>vanadom</i>)	T3	
<i>tizanidine hcl</i> (Zanaflex)	T1	
ZANAFLEX (<i>tizanidine hcl</i>)	T3	
ATABEX EC	T2	

PRENATAL VITAMIN PREPARATIONS

CITRANATAL 90 DHA	T2	
CITRANATAL ASSURE	T2	
CITRANATAL DHA	T2	
CITRANATAL HARMONY	T2	
CITRANATAL RX	T2	
OBSTETRIX EC	T2	

PSYCHOTHERAPEUTIC DRUGS (Anxiety/Depression/Bipolar Disorder)⁸

ALPHA-2 RECEPTOR ANTAGONIST ANTI-DEPRESSANTS

OBTREX DHA	T2	
<i>pnv 22/iron, gluc/folic/dss/dha</i>	T1	
<i>pnv 66/iron/folic/docusate/dha</i>	T1	
<i>pnv 69/iron/folic/docusate/dha</i>	T1	
<i>pnv 80/iron fum/folic/dss/dha</i>	T1	
<i>pnv/ferrous fum/docusate/folic</i>	T1	
<i>pnv/iron, carb/docusat/folic ac</i>	T1	
<i>prenatal 12/iron/folic/dss/om3</i> (Obtrex Dha)	T1	
PRENATAL 19	T1	
<i>prenatal 34/iron/folic/dss/dha</i>	T1	
<i>prenatal vits15/iron/folic/dss</i>	T1	
VITAFOL FE+	T2	
<i>mirtazapine</i>	T1	HD
<i>mirtazapine</i> (Remeron)	T1	HD

ANTI-ANXIETY - BENZODIAZEPINES

<i>alprazolam</i>	T1	
<i>alprazolam</i> (Xanax Xr)	T1	
<i>alprazolam</i> (Xanax)	T1	
<i>chlordiazepoxide hcl</i>	T1	
<i>clorazepate dipotassium</i>	T1	
<i>clorazepate dipotassium</i> (Tranxene T-tab)	T1	
<i>diazepam 10 mg tablet</i> (Valium)	T1	
<i>diazepam 2 mg tablet</i> (Valium)	T1	

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List of Prescription Medications

PSYCHOTHERAPEUTIC DRUGS (Anxiety/Depression/Bipolar Disorder) ⁸ (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ANTI-ANXIETY - BENZODIAZEPINES (cont.)		
<i>diazepam 5 mg tablet (Valium)</i>	T1	
<i>diazepam 5 mg/5 ml solution</i>	T1	
<i>diazepam 5 mg/ml oral conc</i>	T1	
<i>lorazepam</i>	T1	
<i>oxazepam</i>	T1	
TRANXENE T-TAB (<i>clorazepate dipotassium</i>)	T3	
VALIUM (<i>diazepam</i>)	T3	
XANAX (<i>alprazolam</i>)	T3	
XANAX XR (<i>alprazolam xr</i>)	T3	
ANTI-ANXIETY DRUGS		
<i>buspirone hcl</i>	T1	
<i>meprobamate</i>	T1	
ANTI-DEPRESSANT - NMDA RECEPTOR ANTAGONIST		
SPRAVATO	T4	PA SP
BIPOLAR DISORDER DRUGS		
EQUETRO	T3	HD
<i>lithium carbonate (Lithobid)</i>	T1	HD
<i>lithium citrate</i>	T1	HD
MAOIS -NON-SELECTIVE, IRREVERSIBLE ANTI-DEPRESSANTS		
MARPLAN	T3	QL (12 tabs/day)
<i>phenelzine sulfate (Nardil)</i>	T1	
<i>tranylcypromine sulfate</i>	T1	
MONOAMINE OXIDASE (MAO) INHIBITOR ANTI-DEPRESSANTS		
EMSAM 12 MG/24 HOURS PATCH	T3	QL (1 patch/day)
EMSAM 6 MG/24 HOURS PATCH	T3	QL (2 patches/day)
EMSAM 9 MG/24 HOURS PATCH	T3	QL (1 patch/day)
NOREPINEPHRINE AND DOPAMINE REUPTAKE INHIB (NDRIs)		
<i>bupropion hcl 100 mg tablet</i>	T1	QL (4 tabs/day) HD
<i>bupropion hcl 75 mg tablet</i>	T1	QL (6 tabs/day) HD
<i>bupropion hcl sr 100 mg tablet (Wellbutrin Sr)</i>	T1	QL (4 tabs/day) HD
<i>bupropion hcl sr 150 mg tablet (Wellbutrin Sr)</i>	T1	QL (2 tabs/day) HD
<i>bupropion hcl sr 200 mg tablet (Wellbutrin Sr)</i>	T1	QL (2 tabs/day) HD
<i>bupropion hcl xl 150 mg tablet</i>	T1	QL (3 tabs/day) HD
<i>bupropion hcl xl 300 mg tablet</i>	T1	QL (1 tab/day) HD
ANTIDEPRESSANT - POSTPARTUM DEPRESSION (PPD)		
ZURZUVAE 20 MG CAPSULE	T3	PA QL(28 caps/270 days) SP HD
ZURZUVAE 25 MG CAPSULE	T3	PA QL(28 caps/270 days) SP HD

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List of Prescription Medications

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

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ANTIDEPRESSANT - POSTPARTUM DEPRESSION (PPD) (cont.)		
ZURZUVAE 30 MG CAPSULE	T4	PA QL(14 caps/270 days) SP HD
SELECTIVE SEROTONIN 5-HT2A INVERSE AGONISTS (SSiAs)		
NUPLAZID	T4	PA SP HD
SELECTIVE SEROTONIN REUPTAKE INHIBITOR (SSRIs)		
<i>citalopram hbr 10 mg tablet (Celexa)</i>	T1	QL (6 tabs/day) HD
<i>citalopram hbr 10 mg/5 ml soln</i>	T1	QL (30ml/day) HD
<i>citalopram hbr 20 mg tablet (Celexa)</i>	T1	QL (3 tabs/day) HD
<i>citalopram hbr 20 mg/10 ml sol</i>	T1	QL (30ml/day) HD
<i>citalopram hbr 40 mg tablet (Celexa)</i>	T1	QL (1 tab/day) HD
<i>escitalopram 10 mg tablet</i>	T1	QL (2 tabs/day) HD
<i>escitalopram 20 mg tablet</i>	T1	QL (1 tab/day) HD
<i>escitalopram 5 mg tablet</i>	T1	QL (4 tabs/day) HD
<i>escitalopram oxalate 5 mg/5 ml</i>	T1	QL (20ml/day) HD
<i>fluoxetine 20 mg/5 ml solution</i>	T1	QL (20ml/day) HD
<i>fluoxetine hcl</i>	T1	QL (4 caps/28 days) HD
<i>fluoxetine hcl 10 mg capsule (Prozac)</i>	T1	QL (8 caps/day) HD
<i>fluoxetine hcl 20 mg capsule (Prozac)</i>	T1	QL (4 caps/day) HD
<i>fluoxetine hcl 20 mg tablet</i>	T1	HD
<i>fluoxetine hcl 40 mg capsule (Prozac)</i>	T1	QL (2 caps/day) HD
<i>fluoxetine hcl 60 mg tablet</i>	T1	QL (1 tab/day) HD
<i>fluvoxamine er 100 mg capsule</i>	T1	QL (3 caps/day) HD
<i>fluvoxamine er 150 mg capsule</i>	T1	QL (2 caps/day) HD
<i>fluvoxamine maleate 100 mg tab</i>	T1	QL (3 tabs/day) HD
<i>fluvoxamine maleate 25 mg tab</i>	T1	QL (12 tabs/day) HD
<i>fluvoxamine maleate 50 mg tab</i>	T1	QL (6 tabs/day) HD
<i>paroxetine cr 12.5 mg tablet (Paxil Cr)</i>	T1	QL (6 tabs/day) HD
<i>paroxetine cr 25 mg tablet (Paxil Cr)</i>	T1	QL (3 tabs/day) HD
<i>paroxetine cr 37.5 mg tablet (Paxil Cr)</i>	T1	QL (2 tabs/day) HD
<i>paroxetine er 12.5 mg tablet (Paxil Cr)</i>	T1	QL (1 tab/day) HD
<i>paroxetine er 25 mg tablet (Paxil Cr)</i>	T1	QL (3 tabs/day) HD
<i>paroxetine er 37.5 mg tablet (Paxil Cr)</i>	T1	QL (2 tabs/day) HD
<i>paroxetine hcl 10 mg tablet (Paxil)</i>	T1	QL (6 tabs/day) HD
<i>paroxetine hcl 20 mg tablet (Paxil)</i>	T1	QL (3 tabs/day) HD
<i>paroxetine hcl 30 mg tablet (Paxil)</i>	T1	QL (2 tabs/day) HD
<i>paroxetine hcl 40 mg tablet (Paxil)</i>	T1	QL (1 tab/day) HD
SARAFEM (<i>fluoxetine hcl</i>)	T3	ST HD

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

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
SELECTIVE SEROTONIN REUPTAKE INHIBITOR (SSRIs) (cont.)		
<i>sertraline 20 mg/ml oral conc</i> (Zoloft)	T1	QL (10ml/day) HD
<i>sertraline hcl 100 mg tablet</i> (Zoloft)	T1	QL (2 tabs/day) HD
<i>sertraline hcl 25 mg tablet</i> (Zoloft)	T1	QL (8 tabs/day) HD
<i>sertraline hcl 50 mg tablet</i> (Zoloft)	T1	QL (4 tabs/day) HD
SEROTONIN-2 ANTAGONIST/REUPTAKE INHIBITORS (SARIs)		
<i>nefazodone hcl</i>	T1	HD
<i>trazodone hcl</i>	T1	HD
SEROTONIN-NOREPINEPHRINE REUPTAKE-INHIB (SNRIs)		
<i>desvenlafaxine succnt er 100mg</i> (Pristiq)	T1	QL (4 tabs/day) HD
<i>desvenlafaxine succnt er 25 mg</i> (Pristiq)	T1	QL (16 tabs/day) HD
<i>desvenlafaxine succnt er 50 mg</i> (Pristiq)	T1	QL (1 tab/day) HD
<i>duloxetine hcl dr 20 mg cap</i>	T1	QL (6 caps/day) HD
<i>duloxetine hcl dr 30 mg cap</i>	T1	QL (4 caps/day) HD
<i>duloxetine hcl dr 40 mg cap</i>	T1	QL (3 caps/day) HD
<i>duloxetine hcl dr 60 mg cap</i>	T1	QL (2 caps/day) HD
FETZIMA 20-40 MG TITRATION PAK	T3	QL (28 caps/180 days) ST HD
FETZIMA ER 120 MG CAPSULE	T3	QL (1 cap/day) ST HD
FETZIMA ER 20 MG CAPSULE	T3	QL (6 caps/day) ST HD
FETZIMA ER 40 MG CAPSULE	T3	QL (3 caps/day) ST HD
FETZIMA ER 80 MG CAPSULE	T3	QL (1 cap/day) ST HD
PRISTIQ ER 100 MG TABLET (<i>desvenlafaxine succinate er</i>)	T3	QL (2 tabs/day) ST HD
PRISTIQ ER 25 MG TABLET (<i>desvenlafaxine succinate er</i>)	T3	QL (16 tabs/day) ST HD
PRISTIQ ER 50 MG TABLET (<i>desvenlafaxine succinate er</i>)	T3	QL (1 tab/day) ST HD
<i>venlafaxine hcl 100 mg tablet</i>	T1	QL (3 tabs/day) HD
<i>venlafaxine hcl 25 mg tablet</i>	T1	QL (15 tabs/day) HD
<i>venlafaxine hcl 37.5 mg tablet</i>	T1	QL (10 tabs/day) HD
<i>venlafaxine hcl 50 mg tablet</i>	T1	QL (7 tabs/day) HD
<i>venlafaxine hcl 75 mg tablet</i>	T1	QL (5 tabs/day) HD
<i>venlafaxine hcl er 150 mg cap</i> (Effexor Xr)	T1	QL (2 caps/day) HD
<i>venlafaxine hcl er 150 mg tab</i>	T1	QL (2 tabs/day) HD
<i>venlafaxine hcl er 225 mg tab</i>	T1	QL (1 tab/day) HD
<i>venlafaxine hcl er 37.5 mg cap</i> (Effexor Xr)	T1	QL (8 caps/day) HD
<i>venlafaxine hcl er 37.5 mg tab</i>	T1	QL (8 tabs/day) HD
<i>venlafaxine hcl er 75 mg cap</i> (Effexor Xr)	T1	QL (4 caps/day) HD
<i>venlafaxine hcl er 75 mg tab</i>	T1	QL (4 tabs/day) HD

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

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
SSRI AND 5HT1A PARTIAL AGONIST ANTI-DEPRESSANTS		
VIIBRYD 10 MG TABLET	T3	QL (1 tab/day) ST HD
VIIBRYD 10-20 MG STARTER PACK	T3	ST HD
VIIBRYD 20 MG TABLET	T3	QL (1 tab/day) ST HD
VIIBRYD 40 MG TABLET	T3	ST HD
SSRI, SEROTONIN RECEPTOR MODULATOR ANTI-DEPRESSANTS		
TRINTELLIX 10 MG TABLET	T2	QL (1 tab/day) ST HD
TRINTELLIX 20 MG TABLET	T2	ST HD
TRINTELLIX 5 MG TABLET	T2	QL (1 tab/day) ST HD
TRICYCLIC ANTI-DEPRESSANT-BENZODIAZEPINE COMBINATNS		
<i>amitriptyline/chlordiazepoxide</i>	T1	HD
TRICYCLIC ANTI-DEPRESSANT-PHENOTHIAZINE COMBINATNS		
<i>perphenazine/amitriptyline hcl</i>	T1	HD
TRICYCLIC ANTI-DEPRESSANTS, REL.NON-SEL.REUPT-INHIB		
<i>amitriptyline hcl</i>	T1	HD
<i>amoxapine</i>	T1	HD
<i>clomipramine hcl</i>	T1	HD
<i>desipramine hcl</i>	T1	HD
<i>desipramine hcl (Norpramin)</i>	T1	HD
<i>doxepin 10 mg capsule</i>	T1	HD
<i>doxepin 10 mg/ml oral conc</i>	T1	HD
<i>doxepin 100 mg capsule</i>	T1	HD
<i>doxepin 150 mg capsule</i>	T1	HD
<i>doxepin 25 mg capsule</i>	T1	HD
<i>doxepin 50 mg capsule</i>	T1	HD
<i>doxepin 75 mg capsule</i>	T1	HD
<i>imipramine hcl</i>	T1	HD
<i>imipramine pamoate</i>	T1	HD
<i>maprotiline hcl</i>	T1	HD
<i>nortriptyline hcl</i>	T1	HD
<i>protriptyline hcl</i>	T1	HD
<i>trimipramine maleate</i>	T1	HD
ADRENERGICS, AROMATIC, NON-CATECHOLAMINE		
MYDAYIS	T2	QL
VYVANSE 10 MG CAPSULE	T3	PA QL (1 cap/day)
VYVANSE 10 MG CHEWABLE TABLET	T3	PA QL (1 tab/day)
VYVANSE 20 MG CAPSULE	T3	PA QL (1 cap/day)

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

T4 – Specialty Medications
PA – Prior Authorization
QL – Quantity Limit

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

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

List of Prescription Medications

PSYCHOTHERAPEUTIC DRUGS (Attention Deficit Hyperactivity Disorder)⁸

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ADRENERGICS, AROMATIC, NON-CATECHOLAMINE		
VYVANSE 20 MG CHEWABLE TABLET	T3	PA QL (1 tab/day)
VYVANSE 30 MG CAPSULE	T3	PA QL (1 cap/day)
VYVANSE 30 MG CHEWABLE TABLET	T3	PA QL (1 tab/day)
VYVANSE 40 MG CAPSULE	T3	PA QL (1 cap/day)
VYVANSE 40 MG CHEWABLE TABLET	T3	PA QL (1 tab/day)
VYVANSE 50 MG CAPSULE	T3	PA QL (1 cap/day)
VYVANSE 50 MG CHEWABLE TABLET	T3	PA QL (1 tab/day)
VYVANSE 60 MG CAPSULE	T3	PA QL (1 cap/day)
VYVANSE 60 MG CHEWABLE TABLET	T3	PA QL (1 tab/day)
VYVANSE 70 MG CAPSULE	T3	PA QL (1 cap/day)
TX FOR ADHD - SELECTIVE ALPHA-2 RECEPTOR AGONIST		
<i>clonidine hcl</i> (Kapvay)	T1	
<i>guanfacine hcl</i> (Intuniv)	T1	HD
TX FOR ATTENTION DEFICIT-HYPERACT (ADHD)/NARCOLEPSY		
DAYTRANA (<i>methylphenidate</i>)	T3	PA QL(1 PATCH/DAY)
DAYTRANA 10 MG/9 HR PATCH	T3	PA QL (1 patch/day)
DAYTRANA 15 MG/9 HR PATCH	T3	PA QL (1 per day)
DAYTRANA 20 MG/9 HOUR PATCH	T3	PA QL (1 patch/day)
DAYTRANA 30 MG/9 HOUR PATCH	T3	PA QL (1 patch/day)
<i>dexmethylphenidate hcl</i>	T1	PA QL (1 cap/day)
<i>dexmethylphenidate hcl</i> (Focalin)	T1	PA
FOCALIN (<i>dexmethylphenidate hcl</i>)	T3	PA ST
METADATE CD (<i>methylphenidate hcl</i>)	T3	PA QL
METHYLIN (<i>methylphenidate hcl</i>)	T3	PA
<i>methylphenidate</i> (Daytrana)	T1	PA QL(1 patch/day)
<i>methylphenidate 10 mg/9hr ptch</i> (Daytrana)	T1	PA QL(1 patch/day)
<i>methylphenidate 15 mg/9hr ptch</i> (Daytrana)	T1	PA QL(1 patch/day)
<i>methylphenidate 20 mg/9hr ptch</i> (Daytrana)	T1	PA QL(1 patch/day)
<i>methylphenidate 30 mg/9hr ptch</i> (Daytrana)	T1	PA QL(1 patch/day)
<i>methylphenidate er 10 mg cap</i>	T1	QL (1 per day)
<i>methylphenidate er 10 mg tab</i>	T1	PA QL (2 tabs/day)
<i>methylphenidate er 15 mg cap</i>	T1	QL (1 per day)
<i>methylphenidate er 18 mg tab</i>	T1	PA QL (1 tab/day)
<i>methylphenidate er 18 mg tab</i> (Relexxii)	T1	PA QL(1 tab/day)
<i>methylphenidate er 20 mg cap</i>	T1	QL (1 cap/day)
<i>methylphenidate er 20 mg tab</i>	T1	PA QL (3 tabs/day)
<i>methylphenidate er 27 mg tab</i>	T1	PA QL (1 tab/day)

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List of Prescription Medications

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

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

<i>methylphenidate er 30 mg cap</i>	T1	QL (1 per day)
<i>methylphenidate er 36 mg tab</i>	T1	PA QL (2 tabs/day)
<i>methylphenidate er 40 mg cap</i>	T1	QL (1 per day)
<i>methylphenidate er 50 mg cap</i>	T1	QL (1 per day)
<i>methylphenidate er 54 mg tab</i>	T1	PA QL (1 tab/day)
<i>methylphenidate er 60 mg cap</i>	T1	QL (1 per day)
<i>methylphenidate hcl (Metadate CD)</i>	T1	PA QL (1 cap/day)
<i>methylphenidate hcl (Methylin)</i>	T1	PA
<i>methylphenidate hcl (Ritalin)</i>	T1	PA
<i>methylphenidate la 10 mg cap</i>	T1	PA QL (1 cap/day)
<i>methylphenidate la 20 mg cap</i>	T1	PA QL (1 per day)
<i>methylphenidate la 30 mg cap</i>	T1	PA QL (1 per day)
<i>methylphenidate la 40 mg cap</i>	T1	PA QL (1 per day)
<i>methylphenidate la 60 mg cap</i>	T1	PA QL (1 cap/day)
QUILLICHEW ER	T3	PA QL (1 tab/day)
QUILLIVANT XR	T3	PA QL (12ml/day)
RITALIN (<i>methylphenidate hcl</i>)	T3	PA ST

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

<i>atomoxetine hcl 10 mg capsule (Strattera)</i>	T1	HD
<i>atomoxetine hcl 100 mg capsule (Strattera)</i>	T1	HD
<i>atomoxetine hcl 18 mg capsule (Strattera)</i>	T1	HD
<i>atomoxetine hcl 25 mg capsule (Strattera)</i>	T1	HD
<i>atomoxetine hcl 40 mg capsule (Strattera)</i>	T1	QL (1 cap/day) HD
<i>atomoxetine hcl 60 mg capsule (Strattera)</i>	T1	HD
<i>atomoxetine hcl 80 mg capsule (Strattera)</i>	T1	HD
SUPARTZ FX 25MG/2.5ML SYR	T3	PA SP

PSYCHOTHERAPEUTIC DRUGS (Miscellaneous)

HYPOACTIVE SEXUAL DESIRE DISORDER (HSDD) TX AGENTS

ADDYI	T3	PA QL (1 tab/day)
VYLEESI	T4	PA QL (8 injectors/30 days) SP

PSYCHOTHERAPEUTIC DRUGS (Schizophrenia/Anti-Psychotics)⁸

ANTI-PSYCH, DOPAMINE ANTAG., DIPHENYLBUTYLPIPERIDINES

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

ABILIFY MAINTENA	T2	
<i>asenapine maleate (Saphris)</i>	T1	

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List of Prescription Medications

PSYCHOTHERAPEUTIC DRUGS (Schizophrenia/Anti-Psychotics)⁸ (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ANTI-PSYCHOTIC, ATYPICAL, DOPAMINE, SEROTONIN ANTAGONIST (cont.)		
CAPLYTA	T3	ST QL(1 tabs/caps/day)
clozapine	T1	
clozapine (Clozapine Odt)	T1	
clozapine (Clozaril)	T1	
CLOZAPINE ODT	T1	
CLOZARIL (clozapine)	T3	ST
FANAPT 1 MG TABLET	T3	QL (4 tabs/day) ST
FANAPT 10 MG TABLET	T3	QL (4 tabs/day) ST
FANAPT 12 MG TABLET	T3	ST
FANAPT 2 MG TABLET	T3	QL (4 tabs/day) ST
FANAPT 4 MG TABLET	T3	QL (4 tabs/day) ST
FANAPT 6 MG TABLET	T3	QL (4 tabs/day) ST
FANAPT 8 MG TABLET	T3	QL (4 tabs/day) ST
FANAPT TITRATION PACK	T3	QL (4 packs/year) ST
INVEGA ER 1.5 MG TABLET (<i>paliperidone er</i>)	T3	ST
INVEGA ER 3 MG TABLET (<i>paliperidone er</i>)	T3	QL (1 tab/day) ST
INVEGA ER 6 MG TABLET (<i>paliperidone er</i>)	T3	ST
INVEGA ER 9 MG TABLET (<i>paliperidone er</i>)	T3	ST
<i>lurasidone hcl 120 mg tablet (Latuda)</i>	T1	
<i>lurasidone hcl 20 mg tablet (Latuda)</i>	T1	
<i>lurasidone hcl 40 mg tablet (Latuda)</i>	T1	QL(1 tab/day)
<i>lurasidone hcl 60 mg tablet (Latuda)</i>	T1	QL(1 tab/day)
<i>lurasidone hcl 80 mg tablet (Latuda)</i>	T1	
<i>olanzapine</i>	T1	
<i>paliperidone er 1.5 mg tablet</i>	T1	
<i>paliperidone er 3 mg tablet (Invega)</i>	T1	QL (1 tab/day)
<i>paliperidone er 6 mg tablet (Invega)</i>	T1	
<i>paliperidone er 9 mg tablet (Invega)</i>	T1	
<i>quetiapine fumarate (Seroquel Xr)</i>	T1	
<i>quetiapine fumarate (Seroquel)</i>	T1	
<i>risperidone</i>	T1	
<i>risperidone microspheres</i>	T1	QL
risperidone microspheres (Risperdal Consta)	T1	QL(4 vials/28 days)
<i>risperidone (Risperdal)</i>	T1	
SAPHRIS (<i>asenapine maleate</i>)	T3	ST

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List of Prescription Medications

PSYCHOTHERAPEUTIC DRUGS (Schizophrenia/Anti-Psychotics) ⁸ (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ANTI-PSYCHOTIC, ATYPICAL, DOPAMINE, SEROTONIN ANTAGONIST (cont.)		
SECUADO	T3	ST
SEROQUEL (<i>quetiapine fumarate</i>)	T3	ST
SEROQUEL XR (<i>quetiapine fumarate er</i>)	T3	ST
<i>ziprasidone hcl</i>	T1	
ZYPREXA	T3	
ANTI-PSYCHOTIC-ATYPICAL, D3/D2 PARTIAL AG-5HT MIXED		
VRAYLAR 1.5 MG CAPSULE	T3	QL (1 cap/day) ST
VRAYLAR 1.5 MG-3 MG PACK	T3	ST
VRAYLAR 3 MG CAPSULE	T3	QL (1 cap/day) ST
VRAYLAR 4.5 MG CAPSULE	T3	ST
VRAYLAR 6 MG CAPSULE	T3	ST
ANTIPSYCHOTICS, ATYP, D2 PARTIAL AGONIST/5HT MIXED		
ABILIFY ASIMTUFI	T3	
<i>aripiprazole</i>	T1	
<i>aripiprazole 1 mg/ml solution</i>	T1	
<i>aripiprazole 10 mg tablet</i>	T1	
<i>aripiprazole 15 mg tablet</i>	T1	
<i>aripiprazole 2 mg tablet</i>	T1	
<i>aripiprazole 20 mg tablet</i>	T1	
<i>aripiprazole 30 mg tablet</i>	T1	
<i>aripiprazole 5 mg tablet</i>	T1	QL (1 tab/day)
REXULTI 0.25 MG TABLET	T3	QL (1 tab/day) ST
REXULTI 0.5 MG TABLET	T3	QL (1 tab/day) ST
REXULTI 1 MG TABLET	T3	QL (1 tab/day) ST
REXULTI 2 MG TABLET	T3	QL (1 tab/day) ST
REXULTI 3 MG TABLET	T3	ST
REXULTI 4 MG TABLET	T3	ST
ANTI-PSYCHOTICS, DOPAMINE AND SEROTONIN ANTAGONISTS		
<i>loxapine succinate</i>	T1	
ANTI-PSYCHOTICS, DOPAMINE ANTAGONISTS, THIOXANTHENES		
<i>thiothixene</i>	T1	

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List of Prescription Medications

PSYCHOTHERAPEUTIC DRUGS (Schizophrenia/Anti-Psychotics)⁸ (cont.)

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

PSYCHOTHERAPEUTIC DRUGS (Sleep Disorders/Sedatives)

NARCOLEPSY AND SLEEP DISORDER THERAPY AGENTS

<i>armodafinil</i>	T1	PA
<i>modafinil</i>	T1	PA
SUNOSI	T2	PA QL (1 tab/day)

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

LUMRYZ	T4	PA QL (1 pack/day) SP HD
SODIUM OXYBATE 0.5 G/ML SOLN	T4	PA QL(18 mls/day) SP HD
XYWAV	T4	PA SP HD

BARBITURATES

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

HYPNOTICS, MELATONIN MT1/MT2 RECEPTOR AGONISTS

HETLIOZ	T4	PA SP HD
HETLIOZ LQ	T4	PA SP HD
<i>ramelteon (Rozerem)</i>	T3	QL (1 tab/day)
<i>tasimelteon</i>	T4	PA SP

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List of Prescription Medications

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

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
SEDATIVE-HYPNOTICS – BENZODIAZEPINES		
DORAL	T3	
<i>estazolam</i>	T1	
HALCION (<i>triazolam</i>)	T3	
<i>midazolam hcl</i>	T1	
QUAZEPAM	T1	
<i>quazepam</i> (Quazepam)	T1	
<i>temazepam</i>	T1	
<i>triazolam</i>	T1	
<i>triazolam</i> (Halcion)	T1	
SEDATIVE-HYPNOTICS, NON-BARBITURATE		
DAYVIGO	T2	QL (1 tab/day) ST
<i>doxepin hcl 3 mg tablet</i> (Silenor)	T1	QL (1 tab/day)
<i>doxepin hcl 6 mg tablet</i> (Silenor)	T1	
<i>eszopiclone</i> (Lunesta)	T1	
<i>flurazepam hcl</i>	T1	
<i>zaleplon</i>	T1	
<i>zolpidem tart er 12.5 mg tab</i>	T1	
<i>zolpidem tart er 6.25 mg tab</i>	T1	QL (1 tab/day)
<i>zolpidem tartrate</i>	T1	
<i>acetic acid</i>	T1	
<i>neomycin sulf/polymyxin b sulf</i>	T1	
PHYSIOLYTE	T3	
SKIN PREPS (Miscellaneous)		
IRRIGANTS		
PHYSIOSOL	T3	
<i>ringer's solution</i>	T1	
<i>ringer's solution, lactated</i>	T1	
<i>sod, pot chlor/mag/sod, pot phos</i>	T3	
<i>sodium chloride irrig solution</i>	T1	
SORBITOL	T1	
SORBITOL-MANNITOL	T1	
VASHE WOUND	T3	
VASHE WOUND THERAPY	T3	
<i>water for irrigation, sterile</i>	T1	
OXIDIZING AGENTS		
SORBITOL	T1	

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List of Prescription Medications

SKIN PREPS (Pain Relief and Inflammatory Disease)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ANTIPSORIATICS AGENTS, SYSTEMIC		
<i>acitretin</i>	T1	
COSENTYX	T4	PA SP
ILUMYA	T4	PA QL (1 syringe/84 days) SP HD
<i>methoxsalen (Oxsoralen-ultra)</i>	T1	
OXSORALEN-ULTRA (<i>methoxsalen</i>)	T3	
SKYRIZI (2 SYRINGES) KIT	T4	PA QL (1 kit/84 days) SP HD
SILIQ	T4	PA QL (2 inj/15 days) SP HD
SOTYKTU	T4	PA QL (1 tab/day) SP HD
TALTZ AUTOINJECTOR	T4	PA QL (1 injector/28 days) SP HD
TALTZ AUTOINJECTOR (2 PACK)	T4	PA QL (1 injector/28 days) SP HD
TALTZ AUTOINJECTOR (3 PACK)	T4	PA QL (1 injector/28 days) SP HD
TALTZ SYRINGE	T4	PA QL (1 syringe/28 days) SP HD
TREMFYA 100 MG/ML INJECTOR	T4	PA QL (1 injector/56 days) SP HD
TREMFYA 100 MG/ML SYRINGE	T4	PA QL (1 syringe/56 days) SP HD

TOPICAL ANTI-INFLAMMATORY, NSAIDS

DICLAREAL	T3	HD
DICLOFENAC EPOLAMINE	T3	PA QL (2 patches/day) HD
<i>diclofenac sodium 1% gel (Voltaren)</i>	T1	QL (1000gm/30 days) HD
FLECTOR	T2	PA QL (2 patches/day) HD
LICART 1.3% PATCH	T2	PA QL (1 patch/day) HD
VOLTAREN (<i>diclofenac sodium</i>)	T3	PA QL (1000gm/30 days) HD

SKIN PREPS (Skin Conditions)

ACNE AGENTS, SYSTEMIC

ACUTANE	T1	
AMNESTEEM	T1	
CLARAVIS	T1	
isotretinoin	T1	
MYORISAN	T1	
ZENATANE	T1	

ACNE AGENTS, TOPICAL

ACZONE 7.5% GEL PUMP (<i>dapsone</i>)	T3	
<i>adapalene/benzoyl peroxide</i>	T1	
<i>clindamycin phos/benzoyl perox</i> (Onexton)	T1	
<i>clindamycin phos/benzoyl perox</i>	T1	
<i>clindamycin/tretinoin</i>	T1	
<i>dapsone</i>	T1	

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List of Prescription Medications

SKIN PREPS (Skin Conditions) <i>(cont.)</i>		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ACNE AGENTS, TOPICAL <i>(cont.)</i>		
KLARON (<i>sulfacetamide sodium</i>)	T3	
<i>sulfacetamide sodium</i> (Klaron)	T1	
ANTI-PERSPIRANTS		
DRYSOL	T2	
ANTI-PRURITICS, TOPICAL		
ALEVICYN PLUS	T3	
ANTI-PSORIATICS AGENTS		
<i>anthralin</i>	T1	
BIMZELX	T4	PA QL(10 mls/365 days) SP HD
BIMZELX AUTOINJECTOR	T4	PA QL(10 mls/365 days) SP HD
<i>calcipotriene</i>	T1	
<i>calcipotriene 0.005% cream</i> (Dovonex)	T1	
CALCIPOTRIENE 0.005% FOAM	T3	
<i>calcipotriene 0.005% ointment</i>	T1	
<i>calcipotriene 0.005% solution</i>	T1	
<i>calcitriol 3 mcg/g ointment</i> (Vectical)	T1	QL (800gm/30 days)
COSENTYX	T4	SP HD
DOVONEX (<i>calcipotriene</i>)	T3	
ANTISEPTICS, GENERAL		
ALCOHOL SWAB	T1	
CURITY ALCOHOL PREPS	T1	
DROPSAFE PREP PADS	T1	
EASY COMFORT ALCOHOL PAD	T1	
INCONTROL ALCOHOL PADS	T1	
PRO COMFORT ALCOHOL PADS	T1	
PURE COMFORT ALCOHOL PAD	T1	
SINGLE USE SWAB	T1	
SURE COMFORT ALCOHOL	T1	
TRUE COMFORT ALCOHOL PADS	T1	
TRUE COMFORT PRO ALCOHOL PADS	T1	
ULTILET ALCOHOL SWAB	T1	
ALCOHOL WIPES	T1	
SURE-PREP ALCOHOL PREP PADS	T1	
WEBCOL	T1	
CARETOUCH ALCOHOL PREP PAD	T1	
EASY TOUCH ALCOHOL PREP PADS	T1	

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PA – Prior Authorization

QL – Quantity Limit

ST – Step Therapy

AGE – Age Requirement

SP – Specialty Medication

HD – 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
ALCOHOL PREP PADS		
ALCOHOL SWABS	T1	
alcohol antiseptic pads	T1	
GUAIACOL	T1	
ANTISEBORRHEIC AGENTS		
<i>tazarotene</i>	T1	
VECTICAL (<i>calcitriol</i>)	T3	QL (800gm/30 days)
OVACE PLUS	T3	
<i>selenium sulfide</i>	T1	
<i>sulfacetamide sodium</i>	T1	
TERSI FOAM	T3	
DIABETIC ULCER PREPARATIONS, TOPICAL		
REGRANEX	T3	PA QL (2 tubs/30 days)
EMOLLIENTS		
<i>emollient combination no.60</i> (Restizan)	T3	
HALUCORT	T3	
MIMYX (<i>prumyx</i>)	T3	
RESTIZAN	T1	
<i>vite ac/grape/hyaluronic acid</i> (Atopiclair)	T1	
XCLAIR	T3	
IMMUNOMODULATORS		
<i>imiquimod</i>	T1	
IRRITANTS/COUNTER-IRRITANTS		
<i>methyl salicylate</i>	T1	
QUTENZA	T3	
KERATOLYTICS		
BENZEFOAM	T3	
BENZEPRO	T1	
<i>benzoyl peroxide</i>	T1	
<i>benzoyl peroxide</i> (Enzoclear)	T1	
<i>benzoyl peroxide</i> (Pacnex)	T1	
ENZOCLEAR	T3	
HYDRO 35	T3	
HYDRO 40 (<i>umecta</i>)	T3	
INOVA	T3	
KERAFOAM	T3	
KERALYT 6% GEL (<i>salicylic acid</i>)	T3	

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

T4 – Specialty Medications
 PA – Prior Authorization
 QL – Quantity Limit

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

HD – May require home delivery pharmacy
 PPACA – No Cost-Share Preventive Medication
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List of Prescription Medications

SKIN PREPS (Skin Conditions) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
KERATOLYTICS (cont.)		
<i>keralyt 6% shampoo</i>	T1	
KERALYT SCALP	T3	
KERALYT SCALP (<i>salicylic acid</i>)	T3	
PACNEX (<i>benzoyl peroxide</i>)	T3	
PODOCON-25	T1	
<i>podofilox</i>	T1	
PR BENZOYL PEROXIDE	T1	
<i>salicylic acid</i>	T1	
<i>salicylic acid</i>	T3	
<i>salicylic acid</i> (Keralyt Scalp)	T1	
<i>salicylic acid/ceramide comb 1</i>	T1	
SALIMEZ FORTE	T1	
SALICATE	T3	
SALKERA	T3	
SALVAX DUO PLUS	T3	
<i>silver nitrate</i>	T1	
<i>silver nitrate applicator</i>	T1	
URAMAXIN	T3	
URAMAXIN (<i>urea</i>)	T3	
<i>urea</i>	T1	
<i>urea</i> (Hydro 35)	T1	
<i>urea</i> (Hydro 40)	T3	
<i>urea</i> (Uramaxin)	T1	
<i>urea</i> (Xurea)	T1	
XUREA	T3	
PROTECTIVES		
PHARMABASE BARRIER	T1	
<i>polydimethylsiloxanes/silicon</i>	T1	
<i>protectives2/ceramide 1,3,6-ii</i>	T1	
RADIAPLEXRX	T3	
<i>zinc oxide</i>	T1	
ROSACEA AGENTS, TOPICAL		
<i>azelaic acid</i>	T1	
<i>ivermectin</i>	T1	
<i>metronidazole</i>	T1	
TISSUE/WOUND ADHESIVES		
ARTISS	T3	

T1 – Typically Generics

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List of Prescription Medications

SKIN PREPS (Skin Conditions) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
TISSUE/WOUND ADHESIVES (cont.)		
SURGISEAL STYLUS	T3	
SURGISEAL TEARDROP	T3	
SURGISEAL TWIST	T3	
TISSEEL VHSD	T3	
TOP. ANTI-INFLAM., PHOSPHODIESTERASE-4 (PDE4) INHIB		
EUCRISA	T2	
TOPICAL AGENTS, MISCELLANEOUS		
GORDON'S UREA	T3	
MEDIHONEY	T3	
L-MESITRAN SOFT	T3	
SAF-CLENS AF	T1	
<i>trichloroacetic acid</i>	T3	
TRICHLOROACETIC ACID	T1	
TOPICAL ANTIBIOTIC PLEUROMUTILIN DERIVATIVES		
ALTABAX	T3	
TOPICAL ANTI-INFLAMMATORY STEROIDAL		
ALA-SCALP (<i>scalacort</i>)	T3	ST
<i>alclometasone dipropionate</i>	T1	
<i>amcinonide 0.1% cream</i>	T1	
<i>amcinonide 0.1% lotion</i>	T1	
AQUA GLYCOLIC HC	T3	
<i>betamethasone dipropionate</i>	T1	
<i>betamethasone valerate</i>	T1	
<i>betamethasone valerate (Luxiq)</i>	T1	
<i>betamethasone/propylene glycol</i>	T1	
<i>betamethasone/propylene glycol (Diprolene)</i>	T1	
BRYHALI	T3	ST
CAPEX SHAMPOO	T3	ST
<i>clobetasol propionate</i>	T1	
<i>clobetasol propionate (Temovate)</i>	T1	
<i>clobetasol propionate/emoll</i>	T1	
CLOCORTOLONE PIVALATE	T1	
CLODAN 0.05% KIT	T3	ST
<i>clodan 0.05% shampoo</i>	T1	
CLODERM	T3	ST
DERMA-SMOOTHIE-FS (<i>fluocinolone acetonide</i>)	T3	ST
DERMATOP (<i>prednicarbate</i>)	T3	ST

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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> (Desowen)	T1	
DESOWEN (<i>desonide</i>)	T3	ST
<i>desoximetasone</i> (Topicort)	T1	
DIPROLENE (<i>betamethasone diprop augmented</i>)	T3	ST
<i>fluocinolone acetonide</i>	T1	
<i>fluocinolone acetonide</i> (Derma-smoothe-fs)	T1	
<i>fluocinolone acetonide</i> (Synalar)	T1	
<i>fluocinolone/shower cap</i> (Derma-smoothe-fs)	T1	
<i>fluocinonide</i>	T1	
<i>fluocinonide/emollient base</i>	T1	
<i>fluticasone prop 0.005% oint</i>	T1	
<i>fluticasone prop 0.05% cream</i>	T1	
<i>fluticasone prop 0.05% lotion</i>	T1	
<i>halobetasol prop 0.05% foam</i>	T1	
<i>halobetasol propionate</i> (Ultravate)	T1	
<i>hydrocortisone</i>	T1	
<i>hydrocortisone</i> (Ala-scalp)	T1	
<i>hydrocortisone butyrate</i>	T1	
<i>hydrocortisone valerate</i>	T1	
LUXIQ (<i>betamethasone valerate</i>)	T3	ST
MOMETACURE	T3	
<i>mometasone furoate 0.1% cream</i>	T1	
<i>mometasone furoate 0.1% oint</i>	T1	
<i>mometasone furoate 0.1% soln</i>	T1	
NUCORT	T3	ST
<i>prednicarbate</i> (Dermatop)	T1	
SCALACORT DK	T3	ST
SYNALAR	T3	ST
SYNALAR (<i>fluocinolone acetonide</i>)	T3	ST
SYNALAR TS	T3	ST
TEMOVATE (<i>clobetasol propionate</i>)	T3	ST
TEXACORT	T3	ST
TOPICORT (<i>desoximetasone</i>)	T3	ST
ULTRAVATE (<i>halobetasol propionate</i>)	T3	ST
TOPICAL ANTI-INFLAMMATORY STEROID-LOCAL ANESTHETIC		
ANALPRAM HC	T3	
EPIFOAM	T3	

T1 – Typically Generics

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List of Prescription Medications

SKIN PREPS (Skin Conditions) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
TOPICAL ANTI-INFLAMMATORY STEROID-LOCAL ANESTHETIC (cont.)		
<i>hydrocortisone/pramoxine</i> (Pramosone)	T1	
<i>lidocaine/hydrocortisone ac</i>	T1	
MEZPAROX-HC	T1	
PRAMOSONE 1% LOTION	T2	
PRAMOSONE 1%-1% CREAM	T2	
PRAMOSONE 1%-1% OINTMENT	T2	
PRAMOSONE 2.5%-1% CREAM	T3	
PRAMOSONE 2.5%-1% LOTION	T3	
PRAMOSONE 2.5%-1% OINTMENT	T2	
TOPICAL ANTI-PARASITICS		
<i>malathion</i> (Ovide)	T1	
OVIDE (<i>malathion</i>)	T3	
TOPICAL PREPARATIONS, ANTIBACTERIALS		
<i>dermazene cream</i>	T1	
DERMAZENE CREAM PACKET	T3	
<i>hydrocortisone/iodoquinol</i>	T1	
<i>hydrocortisone/iodoquinol/aloe</i>	T1	
<i>iodine/potassium iodide</i>	T1	
<i>iodine/sodium iodide</i>	T1	
IODOFLEX	T3	
IODOSORB	T3	
<i>silver nitrate</i>	T1	
TOPICAL VIT D ANALOG/ANTI-INFLAMMATORY STEROID		
<i>calcipotriene/betamethasone</i>	T1	
TACLONEX 0.005%-0.064% SUSPENS (<i>calcipotriene/betamethasone</i>)	T3	
TOPICAL/MUCOUS MEMBR./SUBCUT. ENZYMES		
SANTYL	T2	QL (60gm/30 days)
VITAMIN A DERIVATIVES		
<i>adapalene 0.1% cream</i>	T1	PA
<i>adapalene 0.3% gel pump</i>	T1	PA
PLIXDA	T1	PA
<i>tretinoin 0.01% gel</i>	T1	
<i>tretinoin 0.025% cream</i>	T1	PA
<i>tretinoin 0.025% gel</i>	T1	
<i>tretinoin 0.05% cream</i>	T1	PA
<i>tretinoin 0.05% gel</i>	T1	PA
<i>tretinoin 0.1% cream</i>	T1	PA

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List of Prescription Medications

SMOKING DETERRENTS (Smoking Cessation)⁸

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
SMOKING DETERRENT AGENTS (GANGLIONIC STIM, OTHERS)		
NICOTROL	T2	PPACA
NICOTROL NS	T2	PPACA
SMOKING DETERRENT-NICOTINIC RECEPT.PARTIAL AGONIST		
CHANTIX	T2	
varenicline 1 mg cont month bx	T1	PPACA
SMOKING DETERRENTS, OTHER		
bupropion hcl sr 150 mg tablet	T1	PPACA

THYROID PREPS (Hormonal Agents)

ANTI-THYROID PREPARATIONS		
methimazole (Tapazole)	T1	HD
propylthiouracil	T1	HD
TAPAZOLE (methimazole)	T3	HD
THYROID HORMONES		
ARMOUR THYROID	T3	HD
CYTOMEL (liothyronine sodium)	T3	HD
LEVOTHYROXINE	T3	HD
levothyroxine sodium (Synthroid)	T1	HD
levothyroxine sodium (Synthroid)	T3	HD
liothyronine sodium (Cytomel)	T1	HD
SYNTHROID (unithroid)	T3	HD
thyroid, pork	T1	HD
thyroid, pork (Armour Thyroid)	T1	HD
thyroid, pork (Wp Thyroid)	T1	HD
THYROLAR-1	T2	HD
THYROLAR-1/2	T2	HD
THYROLAR-1/4	T2	HD
THYROLAR-2	T2	HD
THYROLAR-3	T2	HD
TIROSINT	T3	HD
TIROSINT-SOL	T3	HD
WP THYROID	T1	HD
WP THYROID (nature-throid)	T1	HD
WP THYROID (westhroid)	T1	HD

UNCLASSIFIED DRUG PRODUCTS (AIDS/HIV)

CYTOCHROME P450 INHIBITORS		
TYBOST	T4	SP

T1 – Typically Generics PA – Prior Authorization SP – Specialty Medication Requirement
 T2 – Typically Preferred Brands QL – Quantity Limit HD – May require Specialty Pharmacy
 T3 – Typically Non-Preferred Brands ST – Step Therapy HD – May require Specialty Pharmacy
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List of Prescription Medications

UNCLASSIFIED DRUG PRODUCTS (Asthma/COPD/Respiratory)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
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CYSTIC FIBROSIS-CFTR POTENTIATOR-CORRECTOR COMBIN.

BRONCHITOL 40 MG INHALE CAPSULE	T4	PA SP
ORKAMBI 100 MG-125 MG TABLET	T4	PA QL (4 tabs/day) SP HD
ORKAMBI 100-125 MG GRANULE PKT	T4	PA QL (2 packs/day) SP HD
ORKAMBI 150-188 MG GRANULE PKT	T4	PA QL (2 packs/day) SP HD
ORKAMBI 200 MG-125 MG TABLET	T4	PA QL (4 tabs/day) SP HD
SYMDEKO	T4	PA QL (2 tabs/day) SP HD
TRIKAFTA 100-50-75 MG/150 MG	T4	PA QL (3 tabs/day) SP HD
TRIKAFTA 100-50-75 MG/75MG PKT	T4	PA QL (3 tabs/day) HD
TRIKAFTA 50-25-37.5 MG/75 MG	T4	PA QL (3 tabs/day) SP HD
TRIKAFTA 80-40-60MG/59.5MG PKT	T4	PA QL (3 tabs/day) HD

CYSTICFIB-TRANSMEMB CONDUCT.REG. (CFTR) POTENTIATOR

KALYDECO 5.8 MG GRANULES PKT	T4	PA QL SP HD
KALYDECO 150 MG TABLET	T4	PA QL (2 tabs/day) SP HD
KALYDECO 25 MG GRANULES PACKET	T4	PA QL (2 packs/day) SP HD
KALYDECO 50 MG GRANULES PACKET	T4	PA QL (2 packs/day) SP HD
KALYDECO 75 MG GRANULES PACKET	T4	PA QL (2 packs/day) SP HD

LUNG SURFACTANTS

CUROSURF	T3	
INFASURF	T3	
SURVANTA	T3	

MUCOLYTICS

PULMOZYME	T4	PA SP HD
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PULMONARY FIBROSIS - SYSTEMIC ENZYME INHIBITORS

OFEV	T4	PA SP HD
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SYSTEMIC ENZYME INHIBITORS

JOENJA	T4	PA QL (2 tabs/day) SP
VIJOICE 125mg, 50mg	T4	PA QL (30 tabs/30 days) SP
VIJOICE 250mg	T4	PA QL (2 tabs/30 days) SP
ZEMAIRA	T4	PA SP
ZOKINVY	T4	PA QL (4 caps/day) SP

UNCLASSIFIED DRUG PRODUCTS (Blood Modifiers/Bleeding Disorders)

SPLEEN TYROSINE KINASE INHIBITORS

TAVALISSE	T4	PA SP
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UNCLASSIFIED DRUG PRODUCTS (Blood Pressure/Heart Medications)

BRADYKININ B2 RECEPTOR ANTAGONISTS

<i>icatibant acetate</i>	T4	PA SP HD
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T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

T4 – Specialty Medications

PA – Prior Authorization

QL – Quantity Limit

ST – Step Therapy

AGE – Age Requirement

SP – Specialty Medication

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PPACA – No Cost-Share Preventive Medication

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List of Prescription Medications

UNCLASSIFIED DRUG PRODUCTS (Blood Pressure/Heart Medications) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
CI ESTERASE INHIBITORS		
BERINERT	T4	PA SP HD
CINRYZE	T4	PA SP HD
HAEGARDA	T4	PA SP HD
RUCONEST	T4	PA SP HD
PLASMA KALLIKREIN INHIBITORS		
KALBITOR	T4	PA SP HD
ORLADEYO	T4	PA QL (1 caps/day) SP

UNCLASSIFIED DRUG PRODUCTS (Cancer)

CHEMOTHERAPY RESCUE/ANTIDOTE AGENTS

<i>leucovorin calcium</i>	T1	
MESNEX	T4	SP
VISTOGARD	T4	SP

UNCLASSIFIED DRUG PRODUCTS (Dental Products)

DENTAL AIDS AND PREPARATIONS

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

PERIODONTAL COLLAGENASE INHIBITORS

<i>doxycycline hyclate</i>	T1	
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UNCLASSIFIED DRUG PRODUCTS (Erectile Dysfunction)

DRUGS TO TREAT ERECTILE DYSFUNCTION (ED)

CAVERJECT	T3	PA QL (6 injectors/30 days)
CIALIS 10 MG TABLET (<i>tadalafil</i>)	T3	QL (6 tabs/30 days) ST HD
CIALIS 20 MG TABLET (<i>tadalafil</i>)	T3	QL (6 tabs/30 days) ST HD
CIALIS 5 MG TABLET (<i>tadalafil</i>)	T3	QL (8 tabs/30 days) ST HD
EDEX	T3	PA QL (6 injectors/30 days)
IFE-BIMIX 30/1	T2	
IFE-PG20	T2	
LEVITRA (<i>ardenafil hcl</i>)	T3	QL (10 tabs/30 days) ST
MUSE	T2	PA QL (6/30 days)
PAPAVERINE-ALPROSTADIL	T1	
PAPAVERINE-PHENTOLAMINE	T1	
PAPAVERINE-PHENTOLMN-ALPROSTDIL	T1	
PHENTOLAMINE-ALPROSTADIL	T1	

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List of Prescription Medications

UNCLASSIFIED DRUG PRODUCTS (Erectile Dysfunction)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
DRUGS TO TREAT ERECTILE DYSFUNCTION (ED) (cont.)		
<i>sildenafil 100 mg tablet (Viagra)</i>	T1	QL (10 tabs/30 days) HD
<i>sildenafil 25 mg tablet (Viagra)</i>	T1	QL (6 tabs/30 days) HD
<i>sildenafil 50 mg tablet (Viagra)</i>	T1	QL (6 tabs/30 days) HD
STENDRA	T3	QL (8 tabs/30 days) ST
<i>tadalafil 10 mg tablet (Cialis)</i>	T1	QL (10 tabs/30 days) HD
<i>tadalafil 20 mg tablet (Cialis)</i>	T1	PA QL (10 tabs/30 days) HD
<i>tadalafil 5 mg tablet (Cialis)</i>	T1	QL (8 tabs/30 days) HD
TRI-MIX (PAPVRN-PHNTLMN-PGE1)	T3	
<i>varденаfil hcl</i>	T1	QL (10 tabs/30 days)
<i>varденаfil hcl (Levitra)</i>	T1	QL (10 tabs/30 days)
VIAGRA (<i>sildenafil citrate</i>)	T3	QL (6 tabs/30 days) ST HD
UNCLASSIFIED DRUG PRODUCTS (Gastrointestinal/Heartburn)		
CALCIMIMETIC, PARATHYROID CALCIUM ENHANCER		
<i>cinacalcet hcl</i>	T4	SP
ORAL MUCOSITIS/STOMATITIS AGENTS		
ORAMAGICRX	T3	
SALIVA STIMULANT AGENTS		
NUMOISYN	T3	
UNCLASSIFIED DRUG PRODUCTS (Hormonal Agents)		
BONE FORMATION STIM. AGENTS - PARATHYROID HORMONE		
<i>teriparatide 600 mcg/2.4ml pen (Forteo)</i>	T4	PA QL(0.09 mls/day) SP HD
GROWTH HORMONE RECEPTOR ANTAGONISTS		
SOMAVERT	T4	PA SP HD
HYPERPARATHYROID TX AGENTS - VITAMIN D ANALOG-TYPE		
<i>doxercalciferol</i>	T1	
PARICALCITOL 10MCG/2ML	T4	SP
PARICALCITOL 2MCG/ML VIAL	T4	SP
PARICALCITOL 5MCG/ML VIAL	T4	SP
RAYALDEE	T3	
ZEMPLAR (<i>paricalcitol</i>)	T4	SP HD
MENOPAUSAL SYMPT SUPP-SEL ESTROGEN RECEPTOR MODULATOR		
OSPHENA	T3	HD

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List of Prescription Medications

UNCLASSIFIED DRUG PRODUCTS (Miscellaneous)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ABORTIFACIENT-PROGESTERONE RECEPTOR ANTAGONISTS		
MIFEPREX	T3	
<i>mifepristone</i> (Mifeprex)	T1	
ACID AND ALKALI POISON ANTIDOTES		
METHYLENE BLUE 1%	T3	
methylene blue 1%	T1	
AGENTS TO TX PERIODIC PARALYSIS - CARBON ANHYD INH		
<i>dichlorphenamide</i> (Keveysis)	T4	PA SP
AMMONIA INHIBITORS		
CARBAGLU	T4	SP HD
AMYLOIDOSIS AGENTS-TRANSTHYRETIN (TTR) SUPPRESSION		
TEGSEDI	T4	PA SP HD
ANTI-ALCOHOLIC PREPARATIONS		
<i>acamprosate calcium</i>	T1	
ANTABUSE (<i>disulfiram</i>)	T3	
<i>disulfiram</i> (Antabuse)	T1	
ANTIDOTES, MISCELLANEOUS		
CETYLEV	T3	
ANTI-FIBROTIC THERAPY - PYRIDONE ANALOGS		
<i>pirfenidone 267 mg capsule</i> (Esbriet)	T4	PA SP HD
CATHETER LOCK SOLUTIONS		
DEFENCATH	T3	
CRYOPRESERVATIVE AGENTS		
<i>dimethyl sulfoxide</i>	T1	
DRUGS TO TREAT HEREDITARY TYROSINEMIA		
<i>nitisinone</i> (Orfadin)	T4	PA SP HD
NITYR	T4	PA SP
ORFADIN	T4	PA SP
ORFADIN (<i>nitisinone</i>)	T4	PA SP
GENERAL INHALATION AGENTS		
HYPER-SAL	T3	
<i>nebusal 3% vial</i>	T1	
NEBUSAL 6% VIAL	T3	
<i>sodium chloride for inhalation</i> (Hyper-sal)	T1	
GENETIC D/O TX - SMN PROTEIN DEFICIENCY TREATMENT		
EVRYSDI	T4	PA SP HD
GLUCOSYLCERAMIDE SYNTHASE INHIBITOR		
<i>miglustat</i> (Zavesca)	T4	PA SP

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AGE – Age Requirement
SP – Specialty Medication

HD – May require home delivery pharmacy
PPACA – No Cost-Share Preventive Medication
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List of Prescription Medications

UNCLASSIFIED DRUG PRODUCTS (Miscellaneous) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
GLUCOSYLCERAMIDE SYNTHASE INHIBITOR		
CERDELGA	T4	PA SP HD
OPFOLDA	T4	PA QL(8 caps/30 days) SP HD
INTERLEUKIN-13 (IL-13) INHIBITORS, MAB		
ADBRY	T4	PA SP
MENOPAUSAL SYMPTOMS SUPPRESSANT-NK3 RECEPTOR ANTAG		
VEOZAH	T3	QL(1 tab/day)
MENOPAUSAL SYMPTOMS SUPPRESSANT - SSRIs		
<i>paroxetine mesylate</i>	T1	QL(1 cap/day) HD
METABOLIC DX ENZYME REPLACEMENT, ALPHA-MANNOSIDOSIS		
LAMZEDE	T4	PA SP
METABOLIC DISEASE ENZYME REPLACE, HYPOPHOSPHATASIA		
STRENSIQ	T4	PA SP
METABOLIC DISEASE ENZYME REPLACEMENT, MOCD		
NULIBRY	T4	PA SP
METABOLIC DISEASE ENZYME REPLACEMENT, POMPE DISEASE		
ELFABRIO	T4	PA SP
POMBILITI	T4	PA SP HD
METALLIC POISON, AGENTS TO TREAT		
CHEMET	T3	
<i>deferasirox (Exjade)</i>	T4	SP HD
<i>deferasirox (Jadenu Sprinkle)</i>	T4	SP HD
<i>deferasirox (Jadenu)</i>	T4	SP HD
<i>deferiprone (Ferriprox)</i>	T4	PA SP
EXJADE (<i>deferasirox</i>)	T4	PA SP HD
FERRIPROX	T4	PA SP
FERRIPROX (2 TIMES A DAY)	T4	PA SP
GALZIN	T3	
JADENU (<i>deferasirox</i>)	T4	PA SP HD
JADENU SPRINKLE (<i>deferasirox</i>)	T4	PA SP HD
RADIOGARDASE	T3	
<i>trientine hcl</i>	T4	PA SP HD
<i>trientine hcl 250 mg capsule (Syprine)</i>	T4	PA SP HD
TRIENTINE HCL 500 MG CAPSULE	T4	PA SP HD
NATRIURETIC PEPTIDES		
VOXZOGO	T4	PA SP HD
OINTMENT/CREAM BASES		
RADIAGEL	T1	

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

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List of Prescription Medications

UNCLASSIFIED DRUG PRODUCTS (Miscellaneous) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
PHARMACOLOGICAL CHAPERONE-ALPHA-GALACTOSID.A STABZ		
GALAFOLD	T4	PA SP HD
PKU TX AGENT-COFACTOR OF PHENYLALANINE HYDROXYLASE		
<i>javygtor 100 mg powder packet (Kuvan)</i>	T4	PA SP
<i>javygtor 100 mg tablet (Kuvan)</i>	T4	PA SP HD
<i>javygtor 500 mg powder packet (Kuvan)</i>	T4	PA SP
<i>sapropterin dihydrochloride</i>	T4	PA SP HD
PROTEIN STABILIZERS		
VYNDAMAX	T4	PA QL (1 cap/day) SP HD
VYNDAQEL	T4	PA QL (4 caps/day) SP HD
SOLVENTS		
<i>isopropyl alcohol</i>	T1	
MURI-LUBE MINERAL OIL	T1	
THYMIC STROMAL LYMPHOPOIETIN (TSLP) INHIBITORS		
TEZSPIRE 210 MG/1.91 ML PEN	T4	PA QL (1 pen/28 days) SP HD
TEZSPIRE 210 MG/1.91 ML SYRING	T4	PA SP HD

UNCLASSIFIED DRUG PRODUCTS (Osteoporosis Products)

BONE RESORPTION INHIBITOR AND VITAMIN D COMBS.		
FOSAMAX PLUS D	T3	ST HD
BONE RESORPTION INHIBITORS		
ACTONEL (<i>risedronate sodium</i>)	T3	ST HD
<i>alendronate sodium</i> (FOSAMAX)	T1	HD
<i>alendronate sodium</i>	T1	HD
ADELVIA (<i>risedronate sodium dr</i>)	T3	ST HD
BINOSTO	T3	ST HD
BONIVA (<i>ibandronate sodium</i>)	T3	ST HD
EVISTA (<i>raloxifene hcl</i>)	T3	HD
FOSAMAX (<i>alendronate sodium</i>)	T3	ST HD
<i>ibandronate sodium</i> (Boniva)	T1	HD
<i>ibandronate sodium 150 mg tab</i>	T1	HD
<i>raloxifene hcl</i> (Evista)	T1	HD PPACA
<i>risedronate sodium</i> (Actonel)	T1	HD
<i>risedronate sodium</i> (Atelvia)	T1	HD

UNCLASSIFIED DRUG PRODUCTS (Pain Relief And Inflammatory Disease)

ANTI-INFLAM. INTERLEUKIN-I RECEPTOR ANTAGONIST		
ARCALYST	T4	PA SP HD

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

T4 – Specialty Medications
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List of Prescription Medications

UNCLASSIFIED DRUG PRODUCTS (Pain Relief And Inflammatory Disease)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ANTI-INFLAMMATORY, INTERLEUKIN-1 BETA BLOCKERS		
ILARIS	T4	PA SP HD
FIBROMYALGIA AGENTS, SEROTONIN-NOREPINEPHRU INHIB		
SAVELLA	T2	HD
IMMUNOMODULATOR, B-LYMPHOCYTE STIM (BLYS)-SPEC INHIB		
BENLYSTA	T4	PA SP HD
UNCLASSIFIED DRUG PRODUCTS (Substance Abuse)		
OPIOID WITHDRAWAL THER, ALPHA-2 ADRENERGIC AGONIST		
LUCEMYRA	T2	QL (168 tabs/14 days)
OPIOID WITHDRAWAL THERAPY AGENTS, OPIOID-TYPE		
BUNAVAIL	T3	
<i>buprenorphine hcl</i>	T1	
<i>buprenorphine hcl/naloxone hcl</i>	T1	
<i>buprenorphine hcl/naloxone hcl (Suboxone)</i>	T1	
SUBOXONE (<i>buprenorphine-naloxone</i>)	T3	
ZUBSOLV	T2	
UNCLASSIFIED DRUG PRODUCTS (Transplant Medications)		
RHO KINASE INHIBITOR		
REZUROCK	T4	PA SP HD
UNCLASSIFIED DRUG PRODUCTS (Urinary Tract Conditions)		
BENIGN PROSTATIC HYPERTROPHY/MICTURITION AGENTS		
<i>alfuzosin hcl (Uroxatral)</i>	T1	HD
<i>dutasteride (Avodart)</i>	T1	HD
<i>finasteride (Proscar)</i>	T1	HD
FLOMAX (<i>tamsulosin hcl</i>)	T3	HD
PROSCAR (<i>finasteride</i>)	T3	HD
RAPAFLO 4 MG CAPSULE (<i>silodosin</i>)	T3	QL (1 cap/day) HD
RAPAFLO 8 MG CAPSULE (<i>silodosin</i>)	T3	HD
<i>silodosin 4 mg capsule (Rapaflo)</i>	T1	QL (1 cap/day) HD
<i>silodosin 8 mg capsule (Rapaflo)</i>	T1	HD
<i>tamsulosin hcl (Flomax)</i>	T1	HD
UROXATRAL (<i>alfuzosin hcl er</i>)	T3	HD
BPH 5-ALPHA-REDUCTASE INHIB-ALPHA1-ADRENOCEP ANTAG		
<i>dutasteride/tamsulosin hcl (Jalyn)</i>	T1	HD
CYSTINE-DEPLETING AGENTS, NEPHROPATHIC CYSTINOSIS		
CYSTAGON	T4	SP

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

T4 – Specialty Medications
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List of Prescription Medications

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

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
KIDNEY STONE AGENTS		
<i>tiopronin</i>	T4	SP
URINARY TRACT ANTI-SPASMODIC, M(3) SELECTIVE ANTAG.		
<i>darifenacin er 15 mg tablet</i>	T1	HD
<i>darifenacin er 7.5 mg tablet</i>	T1	QL (1 tab/day) HD
<i>solifenacin 10 mg tablet</i>	T1	HD
<i>solifenacin 5 mg tablet</i>	T1	QL (1 tab/day) HD
URINARY TRACT ANTI-SPASMODIC/ANTI-INCONTINENCE AGENT		
<i>flavoxate hcl</i>	T1	HD
<i>oxybutynin 5 mg tablet</i>	T1	HD
<i>oxybutynin 5 mg/5 ml solution</i>	T1	HD
<i>oxybutynin 5 mg/5 ml syrup</i>	T1	HD
<i>oxybutynin chloride</i>	T1	HD
<i>tolterodine tart er 2 mg cap</i>	T1	QL (1 cap/day) HD
<i>tolterodine tart er 4 mg cap</i>	T1	HD
<i>tolterodine tartrate</i>	T1	HD
<i>tropium chloride</i>	T1	HD

UNCLASSIFIED DRUG PRODUCTS (Weight Management)

APPETITE STIM. FOR ANOREXIA, CACHEXIA, WASTING SYND.

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

FOLIC ACID PREPARATIONS

<i>folic acid</i>	T1	
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MULTIVITAMIN PREPARATIONS

CITRANATAL MEDLEY	T3	
FOLET ONE	T2	
<i>mvn no.53/iron/folic/dss/dha</i>	T1	
OBSTETRIX ONE	T1	
VITLIPID N ADULT	T3	

PEDIATRIC VITAMIN PREPARATIONS

VITLIPID N INFANT	T3	
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VITAMIN B PREPARATIONS

POTABA	T2	HD
NIVA-FOL	T1	HD

VITAMIN B12 PREPARATIONS

<i>cyanocobalamin (vitamin b-12) (Nascobal)</i>	T1	
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T1 – Typically Generics
T2 – Typically Preferred Brands
T3 – Typically Non-Preferred Brands

T4 – Specialty Medications
PA – Prior Authorization
QL – Quantity Limit

ST – Step Therapy
AGE – Age Requirement
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List of Prescription Medications

VITAMINS (Nutritional/Dietary) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
VITAMIN D PREPARATIONS		
<i>calcitriol 0.25 mcg capsule</i>	T1	HD
<i>calcitriol 0.5 mcg capsule</i>	T1	HD
<i>calcitriol 1 mcg/ml solution</i>	T1	HD
<i>calcitriol 1 mcg/ml vial</i>	T1	HD
DRISDOL	T3	HD
<i>ergocalciferol (vitamin d2)</i>	T1	HD
ROCALTROL	T3	HD
VITAMIN K PREPARATIONS		
MEPHYTON	T3	
<i>phytonadione 5mg tablet</i>	T1	

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

T4 – Specialty Medications
 PA – Prior Authorization
 QL – Quantity Limit

ST – Step Therapy
 AGE – Age Requirement
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Exclusions and limitations for coverage

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

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

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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.

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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>.



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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).