Cigna Healthcare Advantage 3-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/druglist**
24/7 Customer Service: **800.Cigna24 (800.244.6224)**
View your coverage info online: **myCigna® App** or **myCigna.com®**

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 This drug list is subject to change and all prior versions are no longer in effect.

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View your drug list online

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

- **myCigna® App[1] or myCigna.com®**. Click on the Prescriptions tab and select Price a Medication from the dropdown menu. Then type in your medication name.
- **Cigna.com/druglist.** Select **Advantage 3 Tier** from the dropdown menu. Then type in your medication name or view the full list.

Questions?

- **myCigna.com**: Click to Chat - Monday-Friday, 9:00 am-8:00 pm EST.
- **By phone:** Call the toll-free number on your Cigna Healthcare℠ 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:"

- Prescription medications used to treat heartburn/stomach acid conditions (such as Nexium, Prilosec OTC and any generics) and allergies (such as Allegra, Clarinex, Xyzal and any generics). These are available over-the-counter without a prescription.
- Medications used to treat lifestyle conditions such as infertility, erectile dysfunction and smoking cessation.[2]
- 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

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

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

Q. What types of medications typically need approval?
A. Medications that:

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

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

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

limit or exclude coverage for that medication if your doctor continues to prescribe it to treat your condition (as long as the medication is appropriately prescribed and is safe and effective in treating your condition).

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

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

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

and your doctor know within 24 hours of the decision. If approved, coverage will be provided for the duration of the exigency. If Cigna Healthcare doesn't respond to a completed prior authorization exception request within 72 hours of receiving a non-urgent request and 24 hours of receiving a request based on exigent circumstances, the request will be considered approved and your plan can't deny coverage of the medication.

Your Step Therapy rights under California State law:

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

Q. What happens if I try to fill a prescription that needs approval but I don't get approval ahead of time?
A. When your pharmacist tries to fill your prescription, he or she will see that the medication needs preapproval from Cigna Healthcare. Because you didn't get approval ahead of time, your plan won't cover the cost of your medication. You should ask your doctor to contact Cigna Healthcare to start the coverage review process. Or, you can choose to pay the medication's full cost out-of-pocket directly to the pharmacy (the cost can't be applied to your annual deductible or out-of-pocket maximum).

Q. What happens if I try to fill a prescription that has a quantity limit?
A. Your pharmacist will only fill the amount your plan covers. If you want to fill more than what's allowed, your doctor's office will have to contact Cigna Healthcare and ask us to approve a larger amount.

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

Q. Does my plan cover medications that the FDA recently approved?
A. We review all recently approved medications and products to see if they should be covered – and if so, at what cost-share (tier). It can take up to six months from the date the FDA approved them to make a decision. These include, but are not limited to, medications, medical supplies and/or devices covered under standard pharmacy benefits. If your doctor wants you to use a recently approved medication, he or she can ask Cigna Healthcare to consider approving it through the coverage review process.

Q. Which medications are covered under the health care reform law?
A. The Patient Protection and Affordable Care Act (PPACA), commonly referred to as "health care reform," was signed into law on March 23, 2010. Under this law, certain preventive medications (including 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**.

Information about this drug list

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

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

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

Q. How can I find out how much I'll pay for a specific medication?
A. When you and your doctor are considering the right medication for your treatment, knowing how much it costs, what lower-cost alternatives are available and which pharmacies offer the best prices can help you avoid surprises. Log in to the **myCigna App** or **myCigna.com** and use the Price a Medication tool to see how much your medication costs before you get to the pharmacy counter – or, even before you leave your doctor's office.[3]

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

Q. How can I save money on my prescription medications?
A. 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.[4] 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

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

offers out-of-network coverage, you'll pay your out-of-network cost-share to fill a prescription there.

Q. Do I have to use home delivery to fill my prescription?
A. It depends on your plan. Some plans require you to fill maintenance medications through Express Scripts® Pharmacy and/or specialty medications through Accredo® specialty pharmacy for them to be covered.[5] 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 cost[6]
- Automatic refills or refill reminders
- Fill up to a 90-day supply at one time[7]
- 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).[8] 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.

Information about this drug list

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

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

You may also be able to use Accredo, to fill your prescription. Accredo has access to most specialty medications. Call 877.826.7657 for more information. Representatives are available Monday–Friday, 7:00 am–10:00 pm CST and on Saturdays, 7:00 am–4:00 pm CST.

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

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

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

Go to **Cigna.com/specialty** 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 and Tier 3 medications.
2. **Log in to the myCigna App or myCigna.com to view your pharmacy coverage information.** You can also use the Price a Medication tool to find out how much your medication may cost you at the different pharmacies in your plan's network.
3. **Check your Summary of Benefits** coverage document.

Q. What's the difference between medications covered under the pharmacy benefit and medical benefit?
A. Some medications are covered under the pharmacy benefit, some are covered under the medical benefit, and others are covered under both benefits. 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

Information about this drug list

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

pharmacy benefits through Cigna Healthcare, here's how certain oral cancer medications are covered:

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

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

- **Preventive care medications and products covered under the Patient Protection and Affordable Care Act (PPACA), also known as "health care reform:"**
  - **Contraceptives:** Covered at 100%, or no cost-share ($0) to you. Certain prescription contraceptives are available at their applicable cost-share.
  - **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 Advantage 3-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.

Prescription medications used to treat allergies (ex. Allegra, Clarinex, Xyzal and generics) and heartburn/stomach acid conditions (ex. Nexium, Prilosec and generics) aren't covered on this drug list. These medications are considered plan (or benefit) exclusions. You can buy these medications at the pharmacy without a prescription.

How to read this drug list

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

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

Tiers

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)	**$$**
Tier 3 – Typically Non-Preferred Brands	(Highest-cost medication)	**$$$**

* 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 mediation 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 Advantage 3-Tier Prescription Drug List.

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

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

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

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

Prescription drug name is the name of the medication

Medications are listed in **alphabetical order** 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 Advantage 3-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
Analgesics (Pain Relief and Inflammatory Disease)	18-26
Analgesics (Urinary Tract Conditions)	26
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Anesthetics (Pain Relief and Inflammatory Disease)	27-31
Anesthetics (Urinary Tract Conditions)	31
Anti-Allergy (Allergy and Nasal Sprays)	31
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Antibiotics (Ear Medications)	37
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Antihistamines (Allergy/Nasal Sprays)	55, 56
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Anti-Infectives/Miscellaneous (Miscellaneous)	61
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Antivirals (Eye Conditions)	81
Antivirals (Infections)	81-83
Antivirals (Skin Conditions)	83
Autonomic Drugs (Allergy/Nasal Sprays)	83
Autonomic Drugs (Alzheimer's Disease)	84
Autonomic Drugs (Attention Deficit Hyperactivity Disorder)	84, 85
Autonomic Drugs (Blood Pressure/Heart Medications)	85
Autonomic Drugs (Miscellaneous)	85-87
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Biologicals (Allergy/Nasal Sprays)	87
Biologicals (Blood Pressure/Heart Medications)	87
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Information about this drug list

How to find your medication *(cont.)*

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Blood (Blood Thinners/Anti-Clotting)	92
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Cardiovascular (Cholesterol Medications)	103-106
Cardiovascular (Miscellaneous)	106
CNS Drugs (Alzheimer's Disease)	106
CNS Drugs (Miscellaneous)	107, 108
CNS Drugs (Pain Relief and Inflammatory Disease)	108
CNS Drugs (Seizure Disorders)	108-112
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Colony Stimulating Factors (Cancer)	113
Contraceptives (Contraception Products)	113-115
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Diagnostic (Diabetes)	116
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EENT Preps (Allergy/Nasal Sprays)	122
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Elect/Caloric/H2O (Dental Products)	127
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Elect/Caloric/H2O (Nutritional/Dietary)	129-133

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How to find your medication *(cont.)*

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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)
ANALGESIC/ANTIPYRETICS, SALICYLATES		
choline salicyl/mag salicylate	T1	HD
diflunisal	T1	HD
ANALGESIC/ANTIPYRETICS, NON-SALICYLATES		
ACETAMINOPHEN 1000MG/100ML BAG	T3	
acetaminophen 1,000mg/100ml vl (Ofirmev)	T1	
OFIRMEV (*acetaminophen*)	T3	
ANALGESICS, NEURONAL-TYPE CALCIUM CHANNEL BLOCKERS		
PRIALT	T3	SP
ANALGESICS, NON-OPIOID		
clonidine 1, 000 mcg/10 ml vial (Duraclon)	T1	
clonidine 5, 000 mcg/10 ml vial	T1	
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)
DURACLON (*clonidine hcl*)	T3	
eletriptan hydrobromide	T1	QL (6 tabs/30 days)
EMGALITY PEN	T2	PA
EMGALITY SYRINGE	T2	PA
ergotamine tartrate/caffeine	T1	

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

PA – Prior Authorization
QL – Quantity Limit
ST – Step Therapy

AGE – Age Requirement
SP – Specialty Medication
HD – May require home delivery pharmacy

PPACA – No Cost-Share Preventive Medication
CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

ANALGESICS (Pain Relief and Inflammatory Disease) *(cont.)*		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
ANTI-MIGRAINE PREPARATIONS *(cont.)*		
ergotamine tartrate/caffeine (Cafergot)	T1	QL (40 tabs/28 days)
frovatriptan succinate	T1	QL (18 tabs/30 days)
isomethept/dichlphn/acetaminop	T1	
isomethepten/caf/acetaminophen	T1	
naratriptan hcl	T1	QL (9 tabs/30 days)
NURTEC ODT	T2	PA QL (16 tabs/30 days)
rizatriptan benzoate	T1	QL (12 tabs/30 days)
rizatriptan benzoate (Maxalt Mlt)	T1	QL(12 tabs/30 days)
rizatriptan benzoate (Maxalt)	T1	QL(12 tabs/30 days)
rizatriptan	T1	QL(12 tabs/30 days)
sumatriptan	T1	QL (2 boxes/30 days)
sumatriptan 4 mg/0.5 ml cart	T1	QL (4ml/30 days)
sumatriptan 4 mg/0.5 ml inject	T1	QL (4ml/30 days)
sumatriptan 6 mg/0.5 ml cart	T1	QL (4ml/30 days)
sumatriptan 6 mg/0.5 ml inject	T1	QL (4ml/30 days)
sumatriptan 6 mg/0.5 ml syrng	T1	QL (4ml/30 days)
sumatriptan 6 mg/0.5 ml vial	T1	QL (5ml/30 days)
sumatriptan succ 100 mg tablet	T1	QL (9 tabs/30 days)
sumatriptan succ 25 mg tablet	T1	QL (18 tabs/28 days)
sumatriptan succ/naproxen sod	T1	QL (18 tabs/30 days)
TRUDHESA	T2	PA QL (2 pkgs/30 days)
UBRELVY	T2	PA QL (0.67 tabs/day)
VYEPTI	T3	PA SP
ZAVZPRET	T2	PA QL (6 units/30 days)
zolmitriptan	T1	QL (12 tabs/30 days)
NSAIDS, CYCLOOXYGENASE INHIBITOR-TYPE ANALGESICS		
diclofenac potassium	T1	HD
ketorolac 10 mg tablet	T1	QL (20 tabs/25 days) HD
ketorolac 15 mg/ml syringe	T1	QL (40 ml/30 days) HD
ketorolac 15 mg/ml vial	T1	QL (40 ml/30 days) HD
ketorolac 30 mg/ml carpuject	T1	HD
ketorolac 30 mg/ml isecure syr	T1	QL (20ml/30 days) HD
ketorolac 30 mg/ml syringe	T1	QL (20ml/30 days) HD

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

PA – Prior Authorization
QL – Quantity Limit
ST – Step Therapy

AGE – Age Requirement
SP – Specialty Medication
HD – May require home delivery pharmacy

PPACA – No Cost-Share Preventive Medication
CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

ANALGESICS (Pain Relief and Inflammatory Disease) *(cont.)*		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
NSAIDS, CYCLOOXYGENASE INHIBITOR-TYPE ANALGESICS *(cont.)*		
ketorolac 30 mg/ml vial	T1	QL(4 ml/ days) HD
ketorolac 300 mg/10 ml vial	T1	HD
ketorolac 60 mg/2 ml carpuject	T1	QL (20ml/30 days) HD
ketorolac 60 mg/2 ml syringe	T1	QL (20ml/30 days) HD
ketorolac 60 mg/2 ml vial	T1	QL (20ml/30 days) HD
mefenamic acid	T1	HD
OPIOID ANALGESIC AND NON-SALICYLATE ANALGESICS		
acetamin-codein 300-30 mg/12.5	T1	
acetaminop-codeine 120-12 mg/5	T1	
acetaminophen-cod #2 tablet	T1	PA
acetaminophen-cod #3 tablet	T1	PA
acetaminophen-cod #4 tablet	T1	PA
APADAZ	T3	
BENZHYDROCODONE-ACETAMINOPHEN	T1	
hydrocodone/acetaminophen	T1	PA
hydrocodone/acetaminophen (Hydrocodone-acetaminophen)	T1	PA
hydrocodone/acetaminophen (Norco)	T1	PA
HYDROCODONE-ACETAMINOPHEN	T1	PA
LORTAB	T1	PA
NALOCET	T1	PA
NORCO (*lorcet hd*)	T3	PA
NORCO (*lorcet plus*)	T3	PA
NORCO (*lorcet*)	T3	PA
oxycodone hcl/acetaminophen (Nalocet)	T1	PA
oxycodone hcl/acetaminophen (Percocet)	T1	PA
oxycodone hcl/acetaminophen (Primlev)	T1	PA
PERCOCET (*oxycodone-acetaminophen*)	T3	PA
PRIMLEV	T1	PA
tramadol hcl/acetaminophen (Ultracet)	T1	
ULTRACET (*tramadol hcl-acetaminophen*)	T3	
OPIOID ANALGESIC AND NSAID COMBINATION		
hydrocodone/ibuprofen	T1	PA
hydrocodone/ibuprofen (Ibudone)	T1	PA
IBUDONE	T1	PA
ibuprofen/oxycodone hcl	T1	PA

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List of Prescription Medications

ANALGESICS (Pain Relief and Inflammatory Disease) *(cont.)*		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
OPIOID ANALGESIC AND SALICYLATE ANALGESIC COMB		
oxycodone hcl/aspirin	T1	PA
OPIOID ANALGESIC, ANESTHETIC ADJUNCT AGENTS		
alfentanil 1, 000 mcg/2 ml amp (Alfentanil Hcl)	T1	PA
alfentanil 500 mcg/ml ampul (Alfentanil Hcl)	T1	PA
ALFENTANIL 500 MCG/ML AMPULE (*alfentanil hcl*)	T3	PA
fentanyl 100 mcg/2 ml ampul	T1	
fentanyl 100 mcg/2 ml vial	T1	
FENTANYL 2, 500 MCG/50 ML BAG	T1	
fentanyl 2, 500 mcg/50 ml vial	T1	
fentanyl 250 mcg/5 ml ampul	T1	
fentanyl 250 mcg/5 ml vial	T1	
FENTANYL 5, 000 MCG/100 ML BAG	T1	
fentanyl 50 mcg/ml vial	T1	
fentanyl 500 mcg/10 ml vial	T1	
FENTANYL CITRATE-STERILE WATER	T1	
remifentanil hcl (Ultiva)	T1	PA
sufentanil citrate	T1	PA
ULTIVA (*remifentanil hcl*)	T3	PA
OPIOID ANALGESIC AND NON-SALICYLATE XANTHINE COMB		
ACETAMIN-CAFF-DIHYDROCODEINE	T1	PA
acetaminophen/caff/dihydrocod (Acetamin-caff-dihydrocodeine)	T1	PA
acetaminophen/caff/dihydrocod (Trezix)	T1	PA
TREZIX	T3	PA
OPIOID ANALGESICS		
ACTIQ (*fentanyl citrate*)	T3	PA
ARYMO ER	T3	PA
BELBUCA 150 MCG FILM	T2	QL (2 films/day)
BELBUCA 300 MCG FILM	T2	QL (2 films/day)
BELBUCA 450 MCG FILM	T2	QL (2 films/day)
BELBUCA 600 MCG FILM	T2	QL (2 films/day)
BELBUCA 75 MCG FILM	T2	QL (2 films/day)
BELBUCA 750 MCG FILM	T2	QL (60 films/30 days)
BELBUCA 900 MCG FILM	T2	QL (2 films/day)

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

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List of Prescription Medications

ANALGESICS (Pain Relief and Inflammatory Disease) *(cont.)*		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
OPIOID ANALGESICS *(cont.)*		
buprenorphine (Butrans)	T1	QL (4 patches/28 days)
buprenorphine hcl	T1	
butorphanol 1 mg/ml vial	T1	
butorphanol 10 mg/ml spray	T1	PA QL (6 bots/30 days)
butorphanol 2 mg/ml vial	T1	
butorphanol 4 mg/2 ml vial	T1	
BUTRANS (*buprenorphine*)	T3	QL (4 patches/28 days)
codeine sulfate	T1	PA
DEMEROL	T3	PA
DILAUDID 0.2 MG/ML SYRINGE	T3	PA
DILAUDID 0.5 MG/0.5 ML SYRINGE	T3	PA
DILAUDID 1 MG/ML SYRINGE	T3	PA
DILAUDID 2 MG TABLET (*hydromorphone hcl*)	T3	PA
DILAUDID 2 MG/ML SYRINGE	T3	PA
DILAUDID 4 MG TABLET (*hydromorphone hcl*)	T3	PA
DILAUDID 4 MG/ML SYRINGE	T3	
DILAUDID 5 MG/5 ML ORAL LIQUID (*hydromorphone hcl*)	T3	PA
DILAUDID 8 MG TABLET (*hydromorphone hcl*)	T3	PA
DURAGESIC (*fentanyl*)	T3	PA
fentanyl	T1	PA
fentanyl (Duragesic)	T1	PA
FENTANYL 1, 000 MCG/100 ML-NS	T3	
FENTANYL 1, 000 MCG/100 ML-NS	T1	
FENTANYL 1, 000 MCG/50-0.9% NACL	T1	
fentanyl 1, 250 mcg/250-0.9% nacl	T1	
fentanyl 10 mcg/ml-0.9% nacl	T1	
FENTANYL 100 MCG/2 ML CARPUJCT	T1	
fentanyl 100 mcg/2 ml carpujct (Fentanyl Citrate)	T1	

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List of Prescription Medications

ANALGESICS (Pain Relief and Inflammatory Disease) *(cont.)*		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
OPIOID ANALGESICS *(cont.)*		
fentanyl 100 mcg/2 ml syringe	T1	
FENTANYL 2 MCG-BUP 0.0625%-NS	T1	
FENTANYL 2 MCG-BUPIV 0.1%-NS	T1	
FENTANYL 2 MCG-BUPIV 0.125%-NS	T1	
FENTANYL 2 MCG-BUPIV 0.125%-NS	T3	
FENTANYL 2 MCG-BUPIVAC 0.1%-NS	T1	
FENTANYL 2, 000MCG/100-0.9%NACL	T1	
FENTANYL 2, 500MCG/250-0.9%NACL	T1	
FENTANYL 2, 750 MCG/55 ML SYR	T1	
FENTANYL 2.5MG/250ML-0.9% NACL	T1	
FENTANYL 25 MCG/0.5 ML SYRINGE	T3	
FENTANYL 250 MCG/5 ML SYRINGE	T1	
FENTANYL 5, 000MCG/250-0.9%NACL	T1	
FENTANYL 50 MCG/ML SYRINGE	T1	
FENTANYL 500 MCG/50ML-0.9%NACL	T1	
FENTANYL 550 MCG/55ML-0.9%NACL	T1	
FENTANYL CIT 100 MCG BUCCAL TB	T1	PA
FENTANYL CIT 200 MCG BUCCAL TB	T1	PA
FENTANYL CIT 400 MCG BUCCAL TB	T1	PA
FENTANYL CIT 600 MCG BUCCAL TB	T1	PA
FENTANYL CIT 800 MCG BUCCAL TB	T1	PA
fentanyl cit otfc 1, 200 mcg (Actiq)	T1	PA
fentanyl cit otfc 1, 600 mcg (Actiq)	T1	PA
fentanyl citrate otfc 200 mcg (Actiq)	T1	PA
fentanyl citrate otfc 400 mcg (Actiq)	T1	PA
fentanyl citrate otfc 600 mcg (Actiq)	T1	PA
fentanyl citrate otfc 800 mcg (Actiq)	T1	PA
FENTANYL-ROPIVACAINE-0.9% NACL	T1	
FENTORA	T3	PA
hydrocodone bitartrate (Hysingla Er)	T1	PA
hydrocodone bitartrate (Zohydro Er)	T1	PA
HYDROMORPHONE 0.25 MG/0.5 ML	T3	PA
HYDROMORPHONE 0.5 MG/ML-NS SYR	T1	PA
HYDROMORPHONE 1 MG/ML-NS SYRNG	T1	PA

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Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
OPIOID ANALGESICS *(cont.)*		
HYDROMORPHONE 10 MG/50 ML-NS	T1	PA
hydromorphone 10 mg/50 ml-ns (Hydromorphone Hcl-0.9% Nacl)	T1	PA
HYDROMORPHONE 100 MG/100 ML-NS	T1	PA
HYDROMORPHONE 100 MG/50 ML-NS	T1	PA
hydromorphone 15 mg/30 ml-ns	T1	PA
HYDROMORPHONE 2 MG/10 ML-NS	T1	PA
HYDROMORPHONE 2 MG/ML-NS SYRNG	T1	PA
HYDROMORPHONE 20 MG/100 ML-NS	T1	PA
HYDROMORPHONE 200 MG/100 ML-NS	T1	PA
HYDROMORPHONE 25 MG/50 ML-NS	T1	PA
HYDROMORPHONE 30 MG/30 ML-NS	T1	PA
HYDROMORPHONE 5 MG/25 ML-NS	T1	PA
HYDROMORPHONE 50 MG/50 ML-NS	T1	PA
HYDROMORPHONE 55 MG/55 ML-NS	T1	PA
HYDROMORPHONE 6 MG/30 ML-NS	T1	PA
hydromorphone hcl	T1	PA
hydromorphone hcl (Dilaudid)	T1	PA
hydromorphone hcl/pf	T1	PA
HYDROMORPHONE HCL-WATER	T1	PA
HYDROMORPH-ROPIVA-0.9% NACL	T1	PA
HYSINGLA ER (*hydrocodone bitartrate er*)	T2	PA
INFUMORPH	T3	PA
KADIAN (*morphine sulfate er*)	T3	PA
LAZANDA	T3	PA
meperidine hcl	T1	PA
meperidine hcl/pf	T1	PA
meperidine hcl/pf	T3	PA
METHADONE HCL-0.9% NACL	T3	
MITIGO	T1	PA
MORPHABOND ER	T2	PA
morphine 0.5 mg/ml-0.9% nacl	T1	PA
MORPHINE 100 MG/100 ML-NS	T3	
morphine 100mg/100ml-0.9% nacl	T1	PA
MORPHINE 2 MG/2 ML-0.9% NACL	T1	PA

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Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
OPIOID ANALGESICS *(cont.)*		
morphine 2 mg/2 ml-0.9% nacl (Morphine Sulfate-0.9% Nacl)	T1	PA
MORPHINE 2 MG/2 ML-0.9% NACL (*morphine sulfate-nacl*)	T1	PA
MORPHINE 2 MG/ML-0.9% NACL SYR	T1	PA
MORPHINE 275 MG/55 ML-0.9%NACL	T1	PA
MORPHINE 4 MG/ML-0.9% NACL SYR	T1	PA
morphine 5 mg/5 ml-0.9% nacl (Morphine Sulfate-0.9% Nacl)	T1	PA
morphine 50 mg/50 ml-0.9% nacl	T1	PA
MORPHINE 50 MG/50 ML-0.9% NACL	T1	
MORPHINE 500MG/100ML-0.9% NACL	T1	PA
MORPHINE 55 MG/55 ML-0.9% NACL	T1	PA
morphine sulfate	T1	PA
morphine sulfate (Kadian)	T1	PA
morphine sulfate (Morphine Sulfate)	T1	PA
morphine sulfate (Ms Contin)	T1	PA
morphine sulfate/0.9% nacl/pf (Morphine Sulfate-0.9% Nacl)	T1	PA
morphine sulf 1,000 mg/20 ml	T1	PA
morphine sulfate/pf	T1	PA
morphine sulfate/pf	T3	PA
MS CONTIN (*morphine sulfate er*)	T3	PA
nalbuphine hcl	T1	
NUCYNTA	T3	PA
NUCYNTA ER	T3	PA
OLINVYK	T3	PA
OPANA	T3	
opium/belladonna alkaloids	T1	PA
OXAYDO	T3	PA
oxycodone hcl	T1	PA
OXYCODONE HCL ER	T1	PA
oxymorphone hcl	T1	PA
pentazocine hcl/naloxone hcl	T1	PA
ROXYBOND	T3	PA
tramadol hcl 50 mg tablet	T1	QL (8 tabs/day)
tramadol er 100 mg tablet	T1	QL (1 tab/day)
tramadol er 200 mg tablet	T1	QL (1 tab/day)

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Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
OPIOID ANALGESICS *(cont.)*		
tramadol er 300 mg tablet	T1	QL (1 tab/day)
tramadol hcl (Ultram)	T1	QL (8 tabs/day)
TRAMADOL HCL ER 100 MG CAPSULE	T1	QL (1 cap/day)
tramadol hcl er 100 mg tablet	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)
tramadol hcl er 200 mg tablet	T1	QL (1 tab/day)
TRAMADOL HCL ER 300 MG CAPSULE	T1	QL (1 cap/day)
tramadol hcl er 300 mg tablet	T1	QL (1 tab/day)
ULTRAM (*tramadol hcl*)	T3	QL (8 tabs/day)
XTAMPZA ER	T2	PA
ZOHYDRO ER (*hydrocodone bitartrate er*)	T3	PA
OPIOID, SALICYLATE. ANALGESIC, BARBITUATE, XANTHINE		
codeine/butalbital/asa/caffein (Fiorinal With Codeine #3)	T1	PA
FIORINAL WITH CODEINE #3 (*butalbital compound-codeine*)	T3	PA
OPIOID, NON-SALICYL. ANALGESIC, BARBITUATE, XANTHINE		
butalbit/acetamin/caff/codeine	T1	PA
butalbit/acetamin/caff/codeine (Fioricet With Codeine)	T1	PA
SKELETAL MUSCLE RELAXANT, SALICYLAT, OPIOID ANALGESC		
carisoprodol/aspirin/codeine	T1	PA
ANALGESICS (Urinary Tract Conditions)		
URINARY TRACT ANALGESIC AGENTS		
ELMIRON	T3	
RIMSO-50	T3	
ANESTHETICS (Miscellaneous)		
GENERAL ANESTHETICS, INHALANT		
desflurane (Suprane)	T1	
isoflurane	T1	
GENERAL ANESTHETICS, INJECTABLE		
AMIDATE	T3	
AMIDATE (*etomidate*)	T3	
BREVITAL SODIUM	T3	
DIPRIVAN (*propofol*)	T3	
etomidate (Amidate)	T1	

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ANESTHETICS (Miscellaneous)		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
GENERAL ANESTHETICS, INJECTABLE *(cont.)*		
KETALAR	T3	
KETALAR (*ketamine hcl*)	T3	
KETAMINE HCL	T1	
ketamine hcl (Ketalar)	T1	
ketamine hcl in 0.9 % nacl	T1	
ketamine hcl in 0.9 % nacl (Ketamine Hcl-0.9% Nacl)	T1	
KETAMINE HCL-0.9% NACL	T1	
KETAMINE HCL-0.9% NACL (*ketamine hcl-0.9% nacl*)	T1	
METHOHEXITAL-STERILE WATER	T1	
PROPOFOL	T1	
GENERAL ANESTHETICS, INJECTABLE-BENZODIAZEPINE TYPE		
midazolam hcl	T1	
midazolam hcl/pf	T1	
MIDAZOLAM HCL-0.9% NACL	T1	
MIDAZOLAM HCL-D5W	T1	
MIDAZOLAM-0.9% NACL	T1	
ANESTHETICS (Pain Relief and Inflammatory Disease)		
LOCAL ANESTHETICS		
ARTICADENT DENTAL	T3	
BUFFERED LIDOCAINE	T1	
BUPIVACAINE HCL	T1	
bupivacaine hcl (Marcaine)	T1	
bupivacaine hcl (Sensorcaine)	T1	
bupivacaine hcl in dextrose/pf (Sensorcaine With Dextrose)	T1	
bupivacaine hcl/epinephrine (Marcaine-epinephrine)	T1	
bupivacaine hcl/epinephrine/pf (Sensorcaine-mpf Epinephrine)	T1	
bupivacaine hcl/pf (Marcaine)	T1	
bupivacaine hcl/pf (Sensorcaine-mpf)	T1	
bupivacaine hcl/pf (Sensorcaine-mpf)	T3	
BUPIVACAINE HCL-0.9% NACL	T1	
CARBOCAINE	T3	
CARBOCAINE (*polocaine*)	T3	

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Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
LOCAL ANESTHETICS *(cont.)*		
CARBOCAINE (*polocaine-mpf*)	T3	
chloroprocaine hcl/pf (Nesacaine-mpf)	T1	
CITANEST FORTE DENTAL	T3	
CITANEST PLAIN DENTAL	T3	
CLOROTEKAL	T3	
EXPAREL	T3	
LIDOCAINE 0.5MG INTRADERM SYST	T1	
lidocaine 100 mg/10 ml (1%) syr	T1	
LIDOCAINE 100 MG/5 ML (2%) SYR	T1	
LIDOCAINE 200 MG/10 ML (2%) SYR	T1	
LIDOCAINE 200 MG/20 ML (1%) SYR	T1	
LIDOCAINE 40 MG/2 ML (2%) SYRG	T1	
lidocaine hcl	T1	
lidocaine hcl 0.5% vial (Xylocaine)	T1	
lidocaine hcl 0.5% vial (Xylocaine-mpf)	T1	
lidocaine hcl 1% 20 mg/2 ml (Xylocaine-mpf)	T1	
lidocaine hcl 1% 20 mg/2 ml vl (Xylocaine-mpf)	T1	
lidocaine hcl 1% 100 mg/10 ml (Xylocaine-Mpf)		
lidocaine hcl 1% 300 mg/30 ml (Xylocaine-mpf)	T1	
lidocaine hcl 1% 50 mg/5 ml (Xylocaine-mpf)	T1	
lidocaine hcl 1% 50 mg/5 ml vl (Xylocaine-mpf)	T1	
lidocaine hcl 1% vial (Xylocaine)	T1	
lidocaine hcl 1.5% ampul (Xylocaine-mpf)	T1	
lidocaine hcl 10 mg/ml syringe	T1	
lidocaine hcl 100 mg/10 ml syr	T1	
lidocaine hcl 2% 100 mg/5 ml (Xylocaine-mpf)	T1	
lidocaine hcl 2% 200 mg/10 ml (Xylocaine-mpf)	T1	
lidocaine hcl 2% 40 mg/2 ml (Xylocaine-mpf)	T1	
lidocaine hcl 2% 40 mg/2 ml vl (Xylocaine-mpf)	T1	
lidocaine hcl 2% jel urojet ac	T1	
lidocaine hcl 2% jelly	T1	
lidocaine hcl 2% jelly uro-jet	T1	
lidocaine hcl 2% vial (Xylocaine)	T1	
lidocaine hcl 2% vial (Xylocaine-mpf)	T1	

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ANESTHETICS (Pain Relief and Inflammatory Disease) *(cont.)*		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
LOCAL ANESTHETICS *(cont.)*		
LIDOCAINE HCL 200 MG/10 ML SYR	T1	
LIDOCAINE HCL 30 MG/3 ML SYR	T1	
lidocaine hcl 4% ampul	T1	
lidocaine hcl 4% solution	T1	
lidocaine hcl 4% 200 mg/5 ml	T1	
lidocaine hcl/dextrose 7.5%/pf	T1	
lidocaine hcl/epinephrine (Xylocaine With Epinephrine)	T1	
lidocaine hcl/epinephrine bit (Lidocaine-epinephrine)	T3	
lidocaine hcl/epinephrine/pf (Xylocaine With Epinephrine)	T1	
lidocaine hcl/epinephrine/pf (Xylocaine-mpf With Epinephrine)	T1	
LIDOCAINE HCL-0.9% NACL	T1	
MARCAINE (*bupivacaine hcl*)	T3	
MARCAINE (*sensorcaine*)	T3	
MARCAINE (*sensorcaine-mpf*)	T3	
MARCAINE SPINAL	T3	
MARCAINE-EPINEPHRINE (*bupivacaine hcl-epinephrine*)	T3	
MARCAINE-EPINEPHRINE (*sensorcaine-epinephrine*)	T3	
mepivacaine hcl (Carbocaine)	T1	
mepivacaine hcl/pf	T1	
mepivacaine hcl/pf	T3	
mepivacaine hcl/pf (Carbocaine)	T1	
NAROPIN	T3	
NESACAINE	T3	
NESACAINE-MPF (*chloroprocaine hcl*)	T3	
ORABLOC	T3	
POLOCAINE	T1	
ropivacaine 0.2% 20 mg/10 ml (Naropin)	T1	
ropivacaine 0.2% 200 mg/100 ml (Naropin)	T1	
ropivacaine 0.2% 40 mg/20 ml (Naropin)	T1	
ropivacaine 0.2% 400 mg/200 ml (Naropin)	T1	
ROPIVACAINE 0.2% SYRINGE	T1	
ropivacaine 0.5% 100 mg/20 ml (Naropin)	T1	
ROPIVACAINE 0.5% 1000 MG/200ML	T3	
ropivacaine 0.5% 150 mg/30 ml (Naropin)	T1	

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Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
LOCAL ANESTHETICS *(cont.)*		
ROPIVACAINE 0.5% 500 MG/100 ML	T3	
ROPIVACAINE 0.5% BAG	T1	
ropivacaine 0.75% 150 mg/20 ml (Naropin)	T1	
ropivacaine 1% 100 mg/10 ml vl (Naropin)	T1	
ropivacaine 1% 200 mg/20 ml vl (Naropin)	T1	
ROPIVACAINE 50 MG/10 ML SYRNG	T1	
ROPIVACAINE HCL 0.2% ON-Q PUMP	T1	
ROPIVACAINE HCL 0.5% SYRINGE	T1	
ROPIVACAINE HCL-0.9% NACL	T1	
ROPIVACAINE HCL-NACL	T1	
SENSORC MPF 0.75%-EPI 1:200000	T3	
SENSORCAINE 0.25% VIAL (*bupivacaine hcl*)	T3	
sensorcaine 0.5% vial (Marcaine)	T1	
SENSORCAINE WITH DEXTROSE	T1	
SENSORCAINE-MPF 0.25% AMPUL (*bupivacaine hcl*)	T3	
SENSORCAINE-MPF 0.25% VIAL (*bupivacaine hcl*)	T3	
SENSORCAINE-MPF 0.5% AMPUL (*bupivacaine hcl*)	T3	
sensorcaine-mpf 0.5% vial (Marcaine)	T1	
SENSORCAINE-MPF 0.75% AMPUL (*bupivacaine hcl*)	T1	
SENSORCAINE-MPF 0.75% VIAL (*marcaine*)	T3	
SENSORC-MPF 0.25%-EPI 1:200000 (*bupivacaine hcl-epinephrine*)	T1	
SENSORCN-MPF 0.5%-EPI 1:200000 (*bupivacaine hcl-epinephrine*)	T3	
tetracaine hcl/pf	T1	
XYLOCAINE (*lidocaine hcl*)	T3	
XYLOCAINE WITH EPINEPHRINE (*lidocaine hcl-epinephrine*)	T3	
XYLOCAINE-MPF	T3	
XYLOCAINE-MPF (*lidocaine hcl*)	T3	
XYLOCAINE-MPF WITH EPINEPHRINE	T3	
XYLOCAINE-MPF WITH EPINEPHRINE (*lidocaine hcl-epinephrine*)	T3	
ZINGO	T3	
TOPICAL LOCAL ANESTHETICS		
lidocaine 5% ointment	T1	QL (145gm/30 days)
lidocaine 5% patch (Lidoderm II)	T1	
lidocaine hcl (Lidoderm)	T1	
lidocaine hcl (Lidoderm)	T3	

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Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
TOPICAL LOCAL ANESTHETICS *(cont.)*		
lidocaine hcl 4% solution	T1	
lidocaine/prilocaine	T1	
LIDODERM (*lidocaine*)	T3	
PAIN EASE MEDIUM STREAM SPRAY	T3	
ZTLIDO	T2	
ANESTHETICS (Urinary Tract Conditions)		
URINARY TRACT ANESTHETIC/ANALGESIC AGNT (AZO-DYE)		
phenazopyridine hcl (Pyridium)	T1	
PYRIDIUM (*phenazopyridine hcl*)	T3	
ANTI-ALLERGY (Allergy/Nasal Sprays)		
MAST CELL STABILIZERS		
cromolyn 100 mg/5 ml oral conc (Gastrocrom)	T1	
GASTROCROM (*cromolyn sodium*)	T3	
ANTI-ARTHRITICS (Pain Relief and Inflammatory Disease)		
ANALGESIC/ANTIPYRETICS, SALICYLATES		
DISALCID (*salsalate*)	T3	HD
salsalate (Disalcid)	T1	HD
ANTI-ARTHRITIC AND CHELATING AGENTS		
DEPEN (*penicillamine*)	T3	PA SP
penicillamine	T1	PA SP
penicillamine (Depen)	T1	PA SP
ANTI-ARTHRITIC, FOLATE ANTAGONIST AGENTS		
OTREXUP	T2	PA
ANTI-INFLAMMATORY, PYRIMIDINE SYNTHESIS INHIBITOR		
ARAVA (*leflunomide*)	T3	HD
leflunomide (Arava)	T1	HD
ANTI-INFLAMMATORY, PHOSPHODIESTERASE-4(PDE4) INHIB.		
OTEZLA 28 DAY STARTER PACK	T2	PA QL (1 pack/180 days) SP HD
OTEZLA 30 MG TABLET	T2	PA QL (2 tabs/day) SP HD
ANTI-INFLAMMATORY/ANTIARTHRITICS AGENTS, MISC.		
DUROLANE	T3	PA SP HD
EUFLEXXA	T3	PA SP HD

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ANTI-ARTHRITICS (Pain Relief and Inflammatory Disease) *(cont.)*		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
ANTI-INFLAMMATORY/ANTIARTHRITICS AGENTS, MISC. *(cont.)*		
GEL-ONE 30MG/3ML SYR	T3	PA SP HD
GELSYN-3	T3	PA SP HD
GENVISC 850 25MG/2.5ML SYR	T3	PA SP
HYALGAN	T3	PA SP HD
HYMOVIS	T3	PA SP HD
MONOVISC	T3	PA SP HD
ORTHOVISC	T3	PA SP HD
SODIUM HYALURONATE	T3	PA SP
SUPARTZ FX 25MG/2.5ML SYR	T3	PA SP HD
SYNVISC	T3	PA SP HD
SYNVISC-ONE	T3	PA SP HD
SYNOJOYNT	T3	PA SP
TRILURON	T3	PA SP HD
TRIVISC 25MG/2.5ML SYR	T3	PA SP
VISCO-3	T3	PA SP HD
ANTI-INFLAMMATORY, SEL.COSTIM.MOD., T-CELL INHIBITOR		
ORENCIA 125 MG/ML SYRINGE	T3	PA QL (4 syringes/28 days) SP HD
ORENCIA 250 MG VIAL	T3	PA SP HD
ORENCIA 50 MG/0.4 ML SYRINGE	T3	PA QL (4 syringes/28 days) SP HD
ORENCIA 87.5 MG/0.7 ML SYRINGE	T3	PA QL (4 syringes/28 days) SP HD
ORENCIA CLICKJECT	T3	PA QL (4 injectors/28 days) SP HD
COLCHICINE		
COLCHICINE	T1	HD
colchicine (Colcrys)	T1	HD
colchicine (Mitigare)	T1	HD
COLCRYS (colchicine)	T3	HD
MITIGARE	T3	HD
MITIGARE (colchicine)	T2	HD
RIDAURA	T3	
HYPERURICEMIA TX - URATE-OXIDASE ENZYME-TYPE		
ELITEK	T2	SP
KRYSTEXXA	T3	PA SP
HYPERURICEMIA TX - XANTHINE OXIDASE INHIBITORS		
allopurinol (Zyloprim)	T1	HD

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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**
HYPERURICEMIA TX - XANTHINE OXIDASE INHIBITORS *(cont.)*		
allopurinol sodium	T1	HD
allopurinol sodium	T3	HD
febuxostat 80 mg tablet (Uloric)	T1	HD
ULORIC 40 MG TABLET (*febuxostat*)	T3	QL (1 tab/day) HD
ULORIC 80 MG TABLET (*febuxostat*)	T3	HD
ZYLOPRIM (*allopurinol*)	T3	HD
JANUS KINASE (JAK) INHIBITORS		
LITFULO	T3	PA QL(1 cap/day) SP HD
OLUMIANT	T3	PA QL (1 tab/day) SP HD
RINVOQ	T2	PA QL (1 tab/day) SP HD
XELJANZ 1 MG/ML SOLUTION	T2	PA QL (480ml/22 days) SP HD
XELJANZ 10 MG TABLET	T2	PA QL (2 tabs/day) SP HD
XELJANZ 5 MG TABLET	T2	PA QL (2 tabs/day) SP HD
XELJANZ XR	T2	PA QL (1 tab/day) SP HD
NSAID ANALGESIC AND NON-SALICYLATE ANALGESIC COMB		
COMBOGESIC IV	T3	
NSAIDS (COX NON-SPEC.INHIB) AND PROSTAGLANDIN ANALOG		
ARTHROTEC 50 (*diclofenac sodium-misoprostol*)	T3	ST HD
ARTHROTEC 75 (*diclofenac sodium-misoprostol*)	T3	ST HD
diclofenac sodium/misoprostol (Arthrotec 50)	T1	HD
diclofenac sodium/misoprostol (Arthrotec 75)	T1	HD
NSAIDS, CYCLOOXYGENASE INHIBITOR - TYPE ANALGESICS		
ANAPROX DS (*naproxen sodium ds*)	T3	ST HD
ANJESO	T3	HD
CALDOLOR	T3	HD
DAYPRO (*oxaprozin*)	T3	ST HD
diclofenac sod dr 25 mg tab	T1	HD
diclofenac sod dr 50 mg tab	T1	HD
diclofenac sod dr 75 mg tab	T1	HD
diclofenac sod ec 25 mg tab	T1	HD
diclofenac sod ec 50 mg tab	T1	HD
diclofenac sod ec 75 mg tab	T1	HD
diclofenac sodium	T1	HD
EC-NAPROSYN (*naproxen*)	T3	ST HD
etodolac	T1	HD

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Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
NSAIDS, CYCLOOXYGENASE INHIBITOR - TYPE ANALGESICS *(cont.)*		
etodolac (Lodine)	T1	HD
FELDENE (*piroxicam*)	T3	ST HD
fenoprofen calcium (Nalfon)	T1	HD
flurbiprofen	T1	HD
ibuprofen	T1	HD
indomethacin	T1	HD
indomethacin 25 mg capsule	T1	HD
indomethacin 50 mg capsule	T1	HD
ketoprofen 25 mg. 75 mg capsule	T1	HD
LODINE (*etodolac*)	T3	ST HD
meclofenamate sodium	T1	HD
meloxicam	T1	HD
MOBIC (*meloxicam*)	T3	ST HD
nabumetone	T1	HD
NALFON 600 MG TABLET (*profeno*)	T1	ST HD
NAPROSYN TABLET (*naproxen*)	T3	ST HD
naproxen	T1	HD
naproxen (Ec-naprosyn)	T1	HD
naproxen (Naprosyn)	T1	HD
naproxen sodium	T1	HD
naproxen sodium (Anaprox Ds)	T1	HD
OXAPROZIN 300 MG CAPSULE	T3	HD
oxaprozin 600 mg caplet (Daypro)	T1	HD
oxaprozin 600 mg tablet (Daypro)	T1	HD
piroxicam (Feldene)	T1	HD
QMIIZ ODT 15 MG TABLET	T3	ST HD
QMIIZ ODT 7.5 MG TABLET	T3	QL (1 tab/day) ST HD
tolmetin sodium	T1	HD
NSAIDS, CYCLOOXYGENASE-2(COX-2) SELECTIVE INHIBITOR		
CELEBREX 100 MG CAPSULE (*celecoxib*)	T3	QL (2 caps/day) ST HD
CELEBREX 200 MG CAPSULE (*celecoxib*)	T3	QL (2 caps/day) ST HD
CELEBREX 400 MG CAPSULE (*celecoxib*)	T3	QL (1 cap/day) ST HD
CELEBREX 50 MG CAPSULE (*celecoxib*)	T3	QL (2 caps/day) ST HD
celecoxib 100 mg capsule (Celebrex)	T1	QL (2 caps/day) HD
celecoxib 200 mg capsule (Celebrex)	T1	QL (2 caps/day) HD

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Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
NSAIDS, CYCLOOXYGENASE-2(COX-2) SELECTIVE INHIBITOR *(con't.)*		
CELEBREX 400 MG CAPSULE *(celecoxib)*	T3	QL (1 cap/day) HD
CELEBREX 50 MG CAPSULE *(celecoxib)*	T3	QL (2 caps/day) HD
URICOSURIC AGENTS		
probenecid/colchicine	T1	HD
ANTIASTHMATICS (Asthma/COPD/Respiratory)		
5-LIPOXYGENASE INHIBITORS		
zileuton	T1	HD
ANTICHOLINERGICS, ORALLY INHALED LONG ACTING		
INCRUSE ELLIPTA	T2	HD
LONHALA MAGNAIR REFILL	T3	PA HD
LONHALA MAGNAIR STARTER	T3	PA HD
SPIRIVA RESPIMAT	T2	HD
ANTICHOLINERGICS, ORALLY INHALED SHORT ACTING		
ATROVENT HFA	T2	HD
ipratropium bromide	T1	HD
BETA-ADRENERGIC AGENTS		
albuterol sulf 2 mg/5 ml syrup	T1	HD
albuterol sulfate 2 mg tab	T1	HD
albuterol sulfate 4 mg tab	T1	HD
albuterol sulfate er 4 mg tab	T1	HD
albuterol sulfate er 8 mg tab	T1	HD
metaproterenol sulfate	T1	HD
terbutaline sulfate	T1	HD
BETA-ADRENERGIC AGENTS, INHALED, SHORT ACTING		
albuterol 2.5 mg/0.5 ml sol	T1	
albuterol 5 mg/ml solution	T1	
albuterol 15 mg/3 ml solution	T1	
albuterol 75 mg/15 ml soln	T1	
albuterol sul 0.63 mg/3 ml sol	T1	
albuterol sul 1.25 mg/3 ml sol	T1	
albuterol sul 2.5 mg/3 ml soln	T1	
albuterol sulfate (Albuterol Sulfate Hfa)	T1	QL (8.5gm/30 days)
ALBUTEROL SULFATE HFA	T1	QL (8.5gm/30 days)
arformoterol tartrate (Brovana)	T1	QL (4 ml/day) HD

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ANTIASTHMATICS (Asthma/COPD/Respiratory) *(cont.)*		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
BETA-ADRENERGIC AGENTS, INHALED, SHORT ACTING		
levalbuterol hcl (Xopenex / Xopenex Concentrate)	T1	
XOPENEX (*levalbuterol hcl*)	T3	
XOPENEX CONCENTRATE (*levalbuterol concentrate*)	T3	
BETA-ADRENERGIC AND ANTICHOLINERGIC COMBO, INHALED		
ANORO ELLIPTA	T2	HD
COMBIVENT RESPIMAT	T2	HD
ipratropium/albuterol sulfate	T1	HD
DULERA	T2	HD
fluticasone propion/salmeterol	T1	HD
STIOLTO RESPIMAT INHAL SPRAY	T2	HD
STRIVERDI RESPIMAT	T2	QL
BREZTRI AEROSPHERE	T2	
TRELEGY ELLIPTA	T2	
BETA-ADRENERGIC AND GLUCOCORTICOID COMBO, INHALED		
AIRDUO DIGIHALER	T3	ST HD
budesonide/formoterol fumarate (Symbicort)	T1	QL HD
FLUTICASONE-SALMETEROL	T1	QL(1 inhaler/30 days) HD
fluticasone-salmeterol (Advair Diskus)	T1	QL(1 inhaler/30 days) HD
GLUCOCORTICOIDS, ORALLY INHALED		
ALVESCO	T2	
ASMANEX HFA	T2	QL (1 inhaler/30days)
ASMANEX TWISTHALER	T2	QL (1 inhaler/30days)
budesonide (Pulmicort)	T1	HD
FLUTICASONE PROP	T3	QL HD
PULMICORT (*budesonide*)	T3	HD
QVAR REDIHALER	T2	HD
INTERLEUKIN-5 (IL-5) RECEPTOR ALPHA ANTAGONIST, MAB		
FASENRA	T2	PA SP HD
FASENRA PEN	T2	PA SP HD
LEUKOTRIENE RECEPTOR ANTAGONISTS		
ACCOLATE (*zafirlukast*)	T3	HD
montelukast sodium (Singulair)	T1	HD
SINGULAIR (*montelukast sodium*)	T3	HD
zafirlukast (Accolate)	T1	HD
MAST CELL STABILIZERS, ORALLY INHALED		
cromolyn 20 mg/2 ml neb soln	T1	QL (480ml/30 days) HD

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ANTIASTHMATICS (Asthma/COPD/Respiratory) *(cont.)*		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
MONOCLONAL ANTIBODIES TO IMMUNOGLOBULIN E (IGE)		
XOLAIR	T2	PA SP HD
MONOCLONAL ANTIBODY - INTERLEUKIN-5 ANTAGONISTS		
CINQAIR	T3	PA SP
NUCALA	T2	PA SP HD
MUCOLYTICS		
acetylcysteine	T1	
PHOSPHODIESTERASE-4 (PDE4) INHIBITORS		
DALIRESP 250 MCG TABLET	T3	QL (28 tabs/180 days) HD
DALIRESP 500 MCG TABLET	T3	QL (2 tabs/day) HD
XANTHINES		
aminophylline	T1	HD
THEO-24	T3	HD
theophylline anhydrous	T1	HD
theophylline in dextrose 5 %	T1	HD
ANTIBIOTICS (Allergy/Nasal Sprays)		
NOSE PREPARATIONS ANTIBIOTICS		
BACTROBAN NASAL	T3	
ANTIBIOTICS (Ear Medications)		
EAR PREPARATIONS, ANTIBIOTICS		
ciprofloxacin hcl	T1	
CORTISPORIN-TC	T3	
neomycin/polymyxin b/hydrocort	T1	
ofloxacin	T1	
OTIC PREPARATIONS, ANTI-INFLAMMATORY-ANTIBIOTICS		
CIPRO HC	T3	
ciprofloxacin hcl/dexameth (Ciprodex)	T1	
CIPROFLOXACIN HCL-FLUOCINOLONE	T3	
OTOVEL	T3	
ANTIBIOTICS (Eye Conditions)		
EYE ANTIBIOTIC AND GLUCOCORTICOID COMBINATIONS		
neomycin/bacit/p-myx/hydrocort	T1	
neomycin/polymyxin b/dexametha (Maxitrol)	T1	

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List of Prescription Medications

ANTIBIOTICS (Eye Conditions) *(cont.)*

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
EYE ANTIBIOTIC AND GLUCOCORTICOID COMBINATIONS		
neomycin/polymyxin b/hydrocort	T1	
tobramycin/dexamethasone (Tobradex)	T1	
TOBRADEX EYE OINTMENT	T2	
TOBRADEX ST	T3	
ZYLET	T3	
EYE SULFONAMIDES		
BLEPH-10 (*sulfacetamide sodium*)	T3	
BLEPHAMIDE	T3	
sulfacetamide sodium	T1	
sulfacetamide sodium (Bleph-10)	T1	
sulfacetamide/prednisolone sp	T1	
OPHTHALMIC ANTIBIOTICS		
AZASITE 1% EYE DROPS	T3	
bacitracin (Baciguent)	T1	
bacitracin/polymyxin b sulfate	T1	
BESIVANCE 0.6% SUSP	T2	
erythromycin base	T1	
gatifloxacin (Zymaxid)	T1	
gentamicin sulfate	T1	
levofloxacin	T1	
MOXEZA (*moxifloxacin*)	T3	
moxifloxacin hcl (Moxeza)	T1	
moxifloxacin hcl (Vigamox)	T1	
MOXIFLOXACIN HCL-BSS	T1	
MOXIFLOXACIN HCL-NACL	T1	
neomycin sulf/bacitracin/poly	T1	
neomycin/polymyxn b/gramicidin	T1	
ofloxacin (Ocuflox)	T1	
tobramycin 0.3% eye drop	T1	

ANTIBIOTICS (Infections)

ABSORBABLE SULFONAMIDE ANTIBACTERIAL AGENTS		
BACTRIM (*sulfamethoxazole-trimethoprim*)	T3	
BACTRIM DS (*sulfamethoxazole-trimethoprim*)	T3	
sulfadiazine	T1	
sulfamethoxazole/trimethoprim	T1	

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ANTIBIOTICS (Infections) *(cont.)*		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
ABSORBABLE SULFONAMIDE ANTIBACTERIAL AGENTS		
sulfamethoxazole/trimethoprim	T3	
sulfamethoxazole/trimethoprim (Bactrim Ds)	T1	
sulfamethoxazole/trimethoprim (Bactrim)	T1	
AMINOGLYCOSIDE ANTIBIOTICS		
amikacin sulfate	T1	
ARIKAYCE	T3	PA SP
gentamicin in nacl, iso-osm	T1	
gentamicin sulfate	T1	
GENTAMICIN SULFATE IN NS	T1	
gentamicin sulfate/pf	T1	
KITABIS PAK	T3	PA QL (10ml/day) SP HD
neomycin sulfate	T1	
STREPTOMYCIN SULFATE	T1	
TOBI PODHALER	T2	PA QL (8 caps/day) SP HD
tobramycin 300 mg/4 ml ampule	T1	PA QL (8ml/day) SP HD
tobramycin 300 mg/5 ml ampule	T1	PA QL (10ml/day) SP HD
TOBRAMYCIN PAK 300 MG/5 ML	T3	PA QL (10ml/day) SP HD
AMINOGLYCOSIDE ANTIBIOTICS		
tobramycin sulfate	T1	
tobramycin/sodium chloride	T1	
ZEMDRI	T3	
ANAEROBIC ANTIPROTOZOAL-ANTIBACTERIAL AGENTS		
FLAGYL (*metronidazole*)	T3	
LIKMEZ	T3	PA
metronidazole (Flagyl)	T1	
metronidazole/sodium chloride	T1	
metronidazole/sodium chloride	T3	
ANTIBIOTIC, ANTIBACTERIAL, MISC.		
fosfomycin tromethamine	T1	
fosfomycin tromethamine (Monurol)	T1	
HIPREX (*methenamine hippurate*)	T3	
meth/m.blue/salicyl/hyoscy (Uribel Tabs)	T1	
meth/meblue/sod phos/psal/hyos	T1	
meth/meblue/sod phos/psal/hyos	T3	
meth/meblue/sod phos/psal/hyos (Uribel)	T1	

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Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
ANTIBIOTIC, ANTIBACTERIAL, MISC *(cont.)*.		
methen/mblue/sal/sod phos/hyos	T1	
methenam/m.blue/salicyl/hyoscy	T1	
methenam/sod phos/mblue/hyoscy	T1	
methenam/sod phos/mblue/hyoscy	T3	
methenamine hippurate (Hiprex)	T1	
methenamine mandelate	T1	
MONUROL (*fosfomycin tromethamine*)	T3	
PRIMSOL	T3	
trimethoprim	T1	
URIBEL	T3	
URIBEL TABS (methenam/m.blue/salicyl/hyoscy)	T3	
UTA	T3	
ANTIBIOTICS, MISCELLANEOUS, OTHER		
bacitracin	T1	
ANTILEPROTICS		
dapsone	T1	
THALOMID	T2	PA SP HD
ANTI-MYCOBACTERIUM AGENTS		
ethambutol hcl	T1	HD
ethambutol hcl (Myambutol)	T1	HD
isoniazid	T1	HD
ANTI-MYCOBACTERIUM AGENTS		
MYAMBUTOL (*ethambutol hcl*)	T3	HD
PASER	T3	HD
pyrazinamide	T1	HD
rifabutin	T1	HD
TRECATOR	T3	HD
ANTITUBERCULAR ANTIBIOTICS		
CAPASTAT SULFATE	T3	
CYCLOSERINE	T1	
cycloserine	T1	
PRETOMANID	T3	PA QL (1 tab/day)
PRIFTIN	T3	
RIFADIN (*rifampin*)	T3	

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Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
ANTITUBERCULAR ANTIBIOTICS *(cont.)*		
RIFAMATE	T3	
rifampin	T1	
rifampin (Rifadin)	T1	
RIFATER	T3	
SIRTURO	T3	SP
BETALACTAMS		
AZACTAM (*aztreonam*)	T3	
aztreonam (Azactam)	T1	
CAYSTON	T3	PA QL (3ml/day) SP HD
CARBAPENEM ANTIBIOTICS (THIENAMYCINS)		
ertapenem sodium (Invanz)	T1	
imipenem/cilastatin sodium	T1	
imipenem/cilastatin sodium (Primaxin)	T1	
INVANZ (*ertapenem*)	T3	
meropenem	T1	
meropenem (Merrem)	T1	
MEROPENEM	T3	
MEROPENEM-0.9% NACL	T1	
MERREM (*meropenem*)	T3	
PRIMAXIN (*imipenem-cilastatin sodium*)	T3	
RECARBRIO	T3	
VABOMERE	T3	
CEPHALOSPORIN ANTIBIOTICS - IST GENERATION		
cefadroxil	T1	
cefazolin sodium	T1	
CEFAZOLIN 2 GM VIAL	T3	
CEFAZOLIN 3 GM VIAL	T3	
cefazolin sodium/dextrose, iso	T1	
CEFAZOLIN SODIUM-0.9% NACL	T1	
CEFAZOLIN SODIUM-D5W	T1	
CEFAZOLIN SODIUM-DEXTROSE	T1	
CEFAZOLIN SODIUM-STERILE WATER	T1	
cephalexin	T1	
cephalexin (Keflex)	T1	
DAXBIA	T3	

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ANTIBIOTICS (Infections) *(cont.)*		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
CEPHALOSPORIN ANTIBIOTICS - IST GENERATION *(cont.)*		
KEFLEX (*cephalexin*)	T3	
CEPHALOSPORIN ANTIBIOTICS - 2ND GENERATION		
cefaclor	T1	
CEFOTAN	T3	
CEFOTETAN DEXTROSE	T1	
cefotetan disodium	T1	
cefotetan disodium (Cefotan)	T1	
cefoxitin sodium	T1	
cefoxitin sodium/dextrose, iso	T1	
cefprozil	T1	
cefuroxime axetil	T1	
cefuroxime sodium (Zinacef)	T1	
ZINACEF	T3	
ZINACEF (*cefuroxime sodium*)	T3	
CEPHALOSPORIN ANTIBIOTICS - 3RD GENERATION		
AVYCAZ	T3	
cefditoren pivoxil	T1	
cefixime (Suprax)	T1	
cefpodoxime proxetil	T1	
ceftazidime	T1	
ceftazidime (Fortaz)	T1	
CEFTRIAXONE	T1	
ceftriaxone in is-osm dextrose	T1	
ceftriaxone sodium	T1	
CLAFORAN	T3	
FORTAZ	T3	
FORTAZ (*tazicef*)	T3	
FORTAZ IN ISO-OSMOTIC DEXTROSE	T3	
ZERBAXA	T3	
CEPHALOSPORIN ANTIBIOTICS - 4TH GENERATION		
CEFEPIME HCL	T1	
cefepime hcl (Maxipime)	T1	
cefepime in iso-osm dextrose	T1	
CEFEPIME-DEXTROSE	T1	

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ANTIBIOTICS (Infections) *(cont.)*		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
CEPHALOSPORIN ANTIBIOTICS - 4TH GENERATION *(cont.)*		
MAXIPIME	T3	
MAXIPIME (*cefepime hcl*)	T3	
CEPHALOSPORIN ANTIBIOTICS - SIDEROPHORE		
FETROJA	T3	
CEPHALOSPORINS - 5TH GENERATION		
TEFLARO	T3	
CHLORAMPHENICOL ANTIBIOTICS AND DERIVATIVES		
chloramphenicol sod succinate	T1	
GLYCYLCYCLINES		
tigecycline (Tygacil)	T1	
TYGACIL (*tigecycline*)	T3	
LINCOSAMIDE ANTIBIOTICS		
CLEOCIN HCL (*clindamycin hcl*)	T3	
CLEOCIN PEDIATRIC (*clindamycin (pediatric)*)	T3	
CLEOCIN PHOS 150 MG/ML VIAL (*clindamycin phosphate*)	T3	
CLEOCIN PHOS 300 MG/2 ML VIAL (*clindamycin phosphate*)	T3	
cleocin phos 300 mg/2ml addvan	T1	
CLEOCIN PHOS 600 MG/4 ML VIAL (*clindamycin phosphate*)	T3	
LINCOSAMIDE ANTIBIOTICS		
CLEOCIN PHOS 600 MG/4ML ADDVAN (*clindamycin phosphate*)	T3	
CLEOCIN PHOS 9 G/60 ML VIAL (*clindamycin phosphate*)	T3	
CLEOCIN PHOS 900 MG/6 ML VIAL (*clindamycin phosphate*)	T3	
CLEOCIN PHOS 900 MG/6ML ADDVAN (*clindamycin phosphate*)	T3	
CLIN SINGLE USE	T3	
clindamycin hcl (Cleocin Hcl)	T1	
clindamycin palmitate hcl (Cleocin Pediatric)	T1	
clindamycin phosphate	T1	
clindamycin phosphate (Cleocin Phosphate)	T1	
clindamycin phosphate/d5w	T1	
CLINDAMYCIN-0.9% NACL	T1	
LINCOCIN	T3	
lincomycin hcl (Lincocin)	T1	

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List of Prescription Medications

ANTIBIOTICS (Infections) *(cont.)*		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
LIPOGLYCOPEPTIDE ANTIBIOTICS		
DALVANCE	T3	
ORBACTIV	T3	
VIBATIV	T3	
MACROLIDE ANTIBIOTICS		
azithromycin (Zithromax)	T1	
azithromycin 1 gm pwd packet (Zithromax)	T1	
azithromycin 100 mg/5 ml susp (Zithromax)	T1	
azithromycin 200 mg/5 ml susp (Zithromax)	T1	
azithromycin 200 mg/5 ml susp (Zithromax)	T1	
azithromycin 250 mg tablet (Zithromax)	T1	
azithromycin 500 mg add-van vl	T1	
azithromycin 500 mg tablet (Zithromax Tri-pak)	T1	
azithromycin 600 mg tablet	T1	
azithromycin i.v. 500 mg vial (Zithromax)	T1	
clarithromycin	T1	
DIFICID 200 MG TABLET	T3	QL (28 tabs/28 days)
DIFICID 40 MG/ML SUSPENSION	T3	QL (5ml/day)
ERYPED 200 (*erythromycin ethylsuccinate*)	T3	
ERY-TAB (*erythromycin*)	T3	
ERYTHROCIN LACTOBIONATE	T3	
erythromycin base	T1	
erythromycin base	T3	
erythromycin base (Ery-tab)	T1	
erythromycin ethylsuccinate	T1	
erythromycin ethylsuccinate	T3	
erythromycin ethylsuccinate (Eryped 200)	T1	
erythromycin stearate	T1	
PCE	T3	
ZITHROMAX 1 GM POWDER PACKET (*azithromycin*)	T3	
ZITHROMAX 100 MG/5 ML SUSP (*azithromycin*)	T3	
ZITHROMAX 200 MG/5 ML SUSP (*azithromycin*)	T3	
ZITHROMAX 200 MG/5 ML SUSP (*azithromycin*)	T3	
ZITHROMAX 250 MG TABLET (*azithromycin*)	T3	

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ANTIBIOTICS (Infections) *(cont.)*		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
MACROLIDE ANTIBIOTICS *(cont.)*		
ZITHROMAX 250 MG Z-PAK TABLET (*azithromycin*)	T3	
ZITHROMAX 500 MG TABLET (*azithromycin*)	T3	
ZITHROMAX I.V. 500 MG VIAL (*azithromycin*)	T3	
ZITHROMAX TRI-PAK (*azithromycin*)	T3	
NITROFURAN DERIVATIVES ANTIBACTERIAL AGENTS		
FURADANTIN (*nitrofurantoin*)	T3	
MACROBID (*nitrofurantoin mono-macro*)	T3	
MACRODANTIN (*nitrofurantoin*)	T3	
nitrofurantoin (Furadantin)	T1	
nitrofurantoin macrocrystal (Macrodantin)	T1	
nitrofurantoin monohyd/m-cryst (Macrobid)	T1	
OXAZOLIDINONE ANTIBIOTICS		
linezolid (Zyvox)	T1	PA
linezolid in 0.9% sodium chlor	T1	
linezolid in dextrose 5% (Zyvox)	T1	
SIVEXTRO 200 MG TABLET	T3	PA
SIVEXTRO 200 MG VIAL	T3	
ZYVOX 100 MG/5 ML SUSPENSION (*linezolid*)	T3	PA
ZYVOX 200 MG/100 ML-D5W	T3	
ZYVOX 600 MG TABLET (*linezolid*)	T3	PA
ZYVOX 600 MG/300 ML-D5W	T3	
PENICILLIN ANTIBIOTICS		
amoxicillin	T1	
amoxicillin/potassium clav (Augmentin Es-600)	T1	
ampicillin sodium	T1	
ampicillin sodium/sulbactam na	T1	
ampicillin trihydrate	T1	
BICILLIN C-R	T3	
BICILLIN L-A	T3	
dicloxacillin sodium	T1	
MOXATAG	T3	
nafcillin in dextrose, iso-osm	T1	
nafcillin sodium	T1	

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PENICILLIN ANTIBIOTICS *(cont.)*		
oxacillin in dextrose (iso-osm)	T1	
oxacillin sodium	T1	
penicillin g potassium	T1	
penicillin g sodium	T1	
PENICILLIN GK-ISO-OSM DEXTROSE	T1	
penicillin v potassium	T1	
piperacillin sodium/tazobactam	T1	
piperacillin sodium/tazobactam (Piperacillin-tazobactam)	T1	
piperacillin sodium/tazobactam (Zosyn)	T1	
PIPERACILLIN-TAZOBACTAM	T1	
UNASYN (*ampicillin-sulbactam*)	T3	
ZOSYN	T3	
ZOSYN (*piperacillin-tazobactam*)	T3	
PLEUROMUTILIN DERIVATIVES		
XENLETA 150 MG/15 ML VIAL	T3	
XENLETA 600 MG TABLET	T3	PA QL (10 tabs/30 days)
POLYMYXIN ANTIBIOTICS AND DERIVATIVES		
colistin (colistimethate na) (Coly-mycin M Parenteral)	T1	
COLY-MYCIN M PARENTERAL (*colistimethate*)	T3	
polymyxin b sulfate	T1	
QUINOLONE ANTIBIOTICS		
AVELOX (*moxifloxacin hcl*)	T3	
AVELOX IV (*moxifloxacin*)	T3	
BAXDELA 300 MG VIAL	T3	
BAXDELA 450 MG TABLET	T3	PA
CIPRO (*ciprofloxacin hcl*)	T3	
CIPRO (*ciprofloxacin*)	T3	
CIPRO I.V. (*ciprofloxacin-d5w*)	T3	
ciprofloxacin (Cipro)	T1	
ciprofloxacin hcl	T1	
ciprofloxacin hcl (Cipro)	T1	

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ANTIBIOTICS (Infections) *(cont.)*		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
QUINOLONE ANTIBIOTICS *(cont.)*		
ciprofloxacin in 5 % dextrose	T1	
ciprofloxacin in 5 % dextrose (Cipro I.v.)	T1	
ciprofloxacin lactate	T1	
ciprofloxacin/ciprofloxa hcl	T1	
FACTIVE	T3	
levofloxacin	T1	
levofloxacin in dextrose 5 %	T1	
MOXIFLOXACIN	T1	
moxifloxacin hcl (Avelox)	T1	
moxifloxacin-sod.chloride (iso) (Avelox Iv)	T1	
ofloxacin	T1	
RIFAMYCINS AND RELATED DERIVATIVE ANTIBIOTICS		
AEMCOLO	T3	QL (12 tabs/3 days)
XIFAXAN 200 MG TABLET	T2	
XIFAXAN 550 MG TABLET	T2	QL (42 tabs/14 days)
STREPTOGRAMIN ANTIBIOTICS		
SYNERCID	T3	
TETRACYCLINE ANTIBIOTICS		
coremino er 135 mg tablet	T1	
coremino er 45 mg tablet	T1	QL (1 tab/day)
TETRACYCLINE ANTIBIOTICS		
coremino er 90 mg tablet	T1	
demeclocycline hcl (Targadox)	T1	
doxycycline hyclate	T1	
doxycycline monohydrate	T1	
doxycycline monohydrate (Vibramycin)	T1	
MINOCIN	T3	
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	

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ANTIBIOTICS (Infections) *(cont.)*		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
TETRACYCLINE ANTIBIOTICS *(cont.)*		
minocycline hcl	T1	
NUZYRA 100 MG VIAL	T3	SP
NUZYRA 150 MG TABLET	T3	QL (30 tablets/28 days) SP
tetracycline hcl	T1	
VIBRAMYCIN	T3	
XERAVA	T3	
VAGINAL ANTIBIOTICS		
clindamycin phosphate (Cleocin)	T1	
metronidazole (Metrogel-vaginal)	T1	
NUVESSA	T3	
VANCOMYCIN ANTIBIOTICS AND DERIVATIVES		
VANCOMYCIN	T1	
vancomycin 50 mg/ml solution	T1	
vancomycin 1 gm add-van vial	T1	
vancomycin 1 gm vial	T1	
VANCOMYCIN 1 GRAM/200 ML BAG	T3	
VANCOMYCIN 1.25 GM/250 ML BAG	T3	
VANCOMYCIN 1.5 GRAM/300 ML BAG	T3	
VANCOMYCIN 1.75 GM/350 ML BAG	T3	
VANCOMYCIN 2 GRAM/400 ML BAG	T3	
vancomycin 250 mg/5 ml soln (Firvanq)	T1	
vancomycin 500 mg add-van vial	T1	
vancomycin 500 mg vial	T1	
VANCOMYCIN 500 MG/100 ML BAG	T3	
VANCOMYCIN 750 MG ADD-VAN VIAL	T1	
VANCOMYCIN 750 MG/150 ML BAG	T3	
VANCOMYCIN HCL 1.25 GRAM VIAL	T1	
VANCOMYCIN HCL 1.5 GRAM VIAL	T1	
vancomycin hcl 10 gm vial	T1	
vancomycin hcl 125 mg capsule	T1	
VANCOMYCIN HCL 1G/200 ML BAG	T1	
vancomycin hcl 250 mg capsule	T1	

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ANTIBIOTICS (Infections) *(cont.)*		
VANCOMYCIN ANTIBIOTICS AND DERIVATIVES *(cont.)*		
VANCOMYCIN HCL 250 MG VIAL	T1	
vancomycin hcl 5 gm vial	T1	
vancomycin hcl 750 mg vial	T1	
VANCOMYCIN HCL-0.9% NACL	T1	
VANCOMYCIN HCL-D5W	T1	
ANTIBIOTICS (Miscellaneous)		
CYCLIC LIPOPEPTIDES		
CUBICIN (*daptomycin*)	T3	
CUBICIN RF (*daptomycin*)	T3	
DAPTOMYCIN	T1	
DAPTOMYCIN-0.9% NACL	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	
CLEOCIN T (*clindamycin phosphate*)	T3	
CLINDACIN ETZ KIT	T3	
CLINDACIN PAC	T3	
clindamycin phosphate	T1	
clindamycin phosphate (Cleocin T)	T1	
clindamycin phosphate (Evoclin)	T1	
erythromycin base in ethanol	T1	
erythromycin base in ethanol	T3	
erythromycin/benzoyl peroxide (Benzamycin)	T1	
EVOCLIN (*clindamycin phosphate*)	T3	
gentamicin sulfate	T1	
mupirocin (Centany)	T1	
mupirocin calcium	T1	
XEPI	T3	

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List of Prescription Medications

ANTIBIOTICS (Skin Conditions) *(cont.)*		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
TOPICAL SULFONAMIDES		
AVAR 9.5-5% CLEANSING PADS	T3	
avar cleanser (Rosanil)	T1	
AVAR LS	T3	
mafenide acetate	T1	
ROSANIL (*sodium sulfacetamide-sulfur*)	T1	
SILVADENE (*ssd*)	T3	
silver sulfadiazine (Silvadene)	T1	
sulfacetamide sod/sulfur/urea	T1	
sulfacetamide sodium/sulfur	T1	
sulfacetamide sodium/sulfur (Avar-e Green)	T1	
sulfacetamide sodium/sulfur (Rosanil)	T1	
sulfacetamide/sulfur/cleansr23	T1	
sulfact sod/sulur/avob/otn/oct	T1	
SULFAMYLON	T3	
ANTICOAGULANTS (Blood Thinners/Anti-Clotting)		
ANTICOAGULANTS, COUMARIN TYPE		
warfarin sodium	T1	HD
CITRATES AS ANTICOAGULANTS		
ACD SOLUTION A	T3	
ACD-A	T3	
ANTICOAG SODIUM CITRATE 4% SOL	T3	
CITRATE PHOSPHATE DEXTROSE	T1	
TRICITRASOL	T3	
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 (*fondaparinux sodium*)	T3	QL (1 syringe/day) SP

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ANTICOAGULANTS (Blood Thinners/Anti-Clotting) *(cont.)*		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
HEPARIN AND RELATED PREPARATIONS *(cont.)*		
enoxaparin 100 mg/ml syringe (Lovenox)	T1	QL (2 syringes/day) SP
enoxaparin 120 mg/0.8 ml syr (Lovenox)	T1	QL (2 syringes/day) SP
enoxaparin 150 mg/ml syringe (Lovenox)	T1	QL (2 syringes/day) SP
enoxaparin 30 mg/0.3 ml syr (Lovenox)	T1	QL (2 syringes/day) SP
enoxaparin 300 mg/3 ml vial (Lovenox)	T1	QL (1 vial/day) SP
enoxaparin 40 mg/0.4 ml syr (Lovenox)	T1	QL (2 syringes/day) SP
enoxaparin 60 mg/0.6 ml syr (Lovenox)	T1	QL (2 syringes/day) SP
enoxaparin 80 mg/0.8 ml syr (Lovenox)	T1	QL (2 syringes/day) SP
fondaparinux sodium (Arixtra)	T1	QL (1 syringe/day) SP
FRAGMIN	T3	QL (2ml/day) SP
heparin 10, 000 unit/10 ml vial	T1	
heparin 2, 000 unit/2 ml vial	T1	
heparin 30, 000 unit/30 ml vial	T1	
heparin 40, 000 unit/4 ml vial	T1	
heparin 5, 000 unit/ml carpujct	T1	
heparin 50, 000 unit/10 ml vial	T1	
heparin 50, 000 unit/5 ml vial	T1	
heparin 1,000 unit/500 ml-ns	T1	
HEPARIN 2,000 UNIT/1,000 ML-NS *(heparin sodium,porcine/ns/pf)*	T3	
heparin 2,000 unit/1,000 ml-ns (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	
heparin sod 1, 000 unit/ml vial	T1	
heparin sod 10, 000 unit/ml vl	T1	
heparin sod 20, 000 unit/ml vl	T1	
heparin sod 5, 000 unit/0.5 ml	T1	
HEPARIN SOD 5, 000 UNIT/0.5 ML	T3	
heparin sod 5, 000 unit/0.5 ml (Heparin Sodium)	T1	
heparin sod 5, 000 unit/ml syrg	T1	
heparin sod 5, 000 unit/ml vial	T1	
heparin sod, porcine/0.9 % nacl	T1	

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ANTICOAGULANTS (Blood Thinners/Anti-Clotting) *(cont.)*		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
HEPARIN AND RELATED PREPARATIONS *(cont.)*		
heparin sod, pork in 0.45% nacl	T1	
heparin sodium, porcine	T1	
heparin sodium, porcine/pf	T1	
HEPARIN SODIUM-0.45% NACL	T1	
LOVENOX 100 MG/ML SYRINGE (*enoxaparin sodium*)	T3	QL (2 syringes/day) SP
LOVENOX 120 MG/0.8 ML SYRINGE (*enoxaparin sodium*)	T3	QL (2 syringes/day) SP
LOVENOX 150 MG/ML SYRINGE (*enoxaparin sodium*)	T3	QL (2 syringes/day) SP
LOVENOX 30 MG/0.3 ML SYRINGE (*enoxaparin sodium*)	T3	QL (2 syringes/day) SP
LOVENOX 300 MG/3 ML VIAL (*enoxaparin sodium*)	T2	QL (1 vial/day) SP
LOVENOX 40 MG/0.4 ML SYRINGE (*enoxaparin sodium*)	T3	QL (2 syringes/day) SP
LOVENOX 60 MG/0.6 ML SYRINGE (*enoxaparin sodium*)	T3	QL (2 syringes/day) SP
LOVENOX 80 MG/0.8 ML SYRINGE (*enoxaparin sodium*)	T3	QL (2 syringes/day) SP
THROMBIN INHIBITORS, SELECTIVE, DIRECT, REVERSIBLE		
ARGATROBAN	T1	SP HD
ARGATROBAN 250MG/2.5ML VIAL	T3	SP
ARGATROBAN-0.9% NACL	T1	SP HD
ARGATROBAN-SODIUM CHLORIDE	T1	HD
dabigatran etexilate mesylate	T1	PA HD
PRADAXA	T3	PA HD
THROMBIN INHIBITORS, SEL, DIRECT, REVERS-HIRUDIN TYPE		
ANGIOMAX (*bivalirudin*)	T3	
BIVALIRUDIN 250 MG ADD-VANT VL	T1	
bivalirudin 250 mg vial (Angiomax)	T1	
BIVALIRUDIN RTU 250 MG/50 ML	T3	
BIVALIRUDIN-0.9% NACL	T1	
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)

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ANTIDOTES (Substance Abuse) *(cont.)*		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
OPIOID ANTAGONISTS *(cont.)*		
naloxone 0.4 mg/ml carpuject	T1	
naloxone 0.4 mg/ml vial	T1	
NALOXONE 2 MG AUTO-INJECTOR	T3	QL (0.8ml/day)
naloxone 2 mg/2 ml syringe	T1	
naloxone 4 mg/10 ml vial	T1	
naltrexone hcl	T1	QL (180 tabs/30 days)
NARCAN	T2	QL (2 units/30 days)
OPVEE	T2	QL (2 units/30 days)
ZIMHI	T3	QL (2 inj/month)
ANTIFUNGALS (Eye Conditions)		
OPHTHALMIC ANTIFUNGAL AGENTS		
NATACYN	T3	
ANTIFUNGALS (Feminine Products)		
VAGINAL ANTIFUNGALS		
GYNAZOLE 1	T1	
miconazole nitrate	T1	
terconazole	T1	
ANTIFUNGALS (Infections)		
ANTIFUNGAL AGENTS		
ANCOBON (*flucytosine*)	T3	
clotrimazole	T1	
CRESEMBA 74.5 MG CAPSULE	T3	PA
CRESEMBA 186 MG CAPSULE	T3	PA
CRESEMBA 372 MG VIAL	T3	
fluconazole	T1	
fluconazole in dextrose, iso-os	T1	
flucytosine (Ancobon)	T1	
itraconazole	T1	
ketoconazole	T1	
ORAVIG	T3	
posaconazole (*Noxafil*)	T1	
terbinafine hcl	T1	
VFEND (*voriconazole*)	T3	PA

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ANTIFUNGALS (Infections) *(cont.)*		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
ANTIFUNGAL AGENTS *(cont.)*		
VFEND IV (*voriconazole*)	T3	
VIVJOA	T3	PA
voriconazole 200 mg tablet (Vfend)	T1	PA
voriconazole 200 mg vial (Vfend Iv)	T1	
voriconazole 40 mg/ml susp (Vfend)	T1	PA
voriconazole 50 mg tablet (Vfend)	T1	PA
ANTIFUNGAL ANTIBIOTICS		
ABELCET	T3	
AMBISOME	T3	
amphotericin b	T1	
CANCIDAS (*caspofungin acetate*)	T3	
caspofungin acetate (*Cancidas*)	T1	
ERAXIS	T3	
griseofulvin ultramicrosize (Gris-peg)	T1	
griseofulvin, microsize	T1	
GRIS-PEG (*griseofulvin ultramicrosize*)	T3	
micafungin sodium (Mycamine)	T1	
MYCAMINE (*micafungin*)	T3	
nystatin	T1	
ANTIFUNGALS (Skin Conditions)		
TOPICAL ANTIFUNGAL/ANTI-INFLAMMATORY, STEROID AGENT		
clotrimazole/betamethasone dip	T1	
TOPICAL ANTIFUNGAILS		
ciclodan 0.77% cream	T1	
CICLODAN 0.77% CREAM KIT	T3	
ciclodan 8% solution	T1	
ciclopirox	T1	
ciclopirox olamine	T1	
ciclopirox olamine (Loprox)	T1	
econazole nitrate	T1	
ECOZA	T3	
EXODERM	T1	

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

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

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List of Prescription Medications

ANTIHISTAMINES (Allergy/Nasal Sprays) *(cont.)*		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
ANTIHISTAMINES - 2ND GENERATION *(cont.)*		
desloratadine 5 mg tablet	T1	HD
levocetirizine dihydrochloride	T1	HD
ANTIHISTAMINES (Eye Conditions)		
EYE ANTIHISTAMINES		
azelastine hcl 0.05% drops	T1	
bepotastine besilate	T1	
epinastine hcl	T1	
olopatadine hcl 0.1% eye drops	T1	
olopatadine hcl 0.2% eye drop	T1	
ANTIHYPERGLYCEMICS (Diabetes)		
ANTIHYPERGLY, INCRETIN MIMETIC (GLP-1 RECEP.AGONIST)		
BYDUREON	T2	QL (4 vials/28 days) ST HD
BYDUREON BCISE	T2	QL (4 pens/28 days) ST HD
BYDUREON PEN	T2	QL (4 pens/28 days) ST HD
BYETTA	T2	QL (1 pen/30 days) ST HD
OZEMPIC 0.25-0.5 MG DOSE PEN	T2	QL (2 pens/28 days) ST HD
OZEMPIC 1 MG DOSE PEN (1.5 ML)	T2	QL (2 pens/28 days) ST HD
OZEMPIC 1 MG DOSE PEN (3 ML)	T2	QL (3ml/21 days) ST HD
REZVOGLAR KWIKPEN	T2	QL
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 (2 ml/28 days) ST HD
TRULICITY 4.5 MG/0.5 ML PEN	T2	QL (2 ml/28 days) ST HD
ANTIHYPERGLY, INSULIN, LONG ACT-GLP-1 RECEPT.AGONIST		
SOLIQUA 100-33	T2	HD
ANTIHYPERGLYCEMC-SOD/GLUC COTRANSPORT2 (SGLT2) INHIB		
FARXIGA	T2	QL (1 tab/day) ST HD
JARDIANCE	T2	QL (1 tab/day) ST HD
ANTIHYPERGLYCEMIC - DOPAMINE RECEPTOR AGONISTS		
CYCLOSET	T3	HD

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List of Prescription Medications

ANTIHYPERGLYCEMICS (Diabetes) *(cont.)*		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
ANTIHYPERGLYCEMIC, ALPHA-GLUCOSIDASE INHIBITORS		
acarbose (Precose)	T1	HD
GLYSET (*miglitol*)	T3	HD
miglitol (Glyset)	T1	HD
PRECOSE (*acarbose*)	T3	HD
ANTIHYPERGLYCEMIC, AMYLIN ANALOG-TYPE		
SYMLINPEN 120	T2	HD
SYMLINPEN 60	T2	HD
ANTIHYPERGLYCEMIC, BIGUANIDE TYPE		
GLUCOPHAGE XR (*metformin hcl er*)	T3	HD
metformin hcl	T1	HD
metformin hcl (Glucophage Xr)	T1	HD
metformin hcl (Riomet)	T1	HD
RIOMET (*metformin hcl*)	T3	HD
RIOMET ER	T3	HD
ANTIHYPERGLYCEMIC, DPP-4 INHIBITORS		
JANUVIA	T2	QL (1 tab/day) ST HD
ANTIHYPERGLYCEMIC, INSULIN-RELEASE STIMULANT TYPE		
AMARYL (*glimepiride*)	T3	HD
chlorpropamide	T1	HD
glimepiride (Amaryl)	T1	HD
glipizide (Glucotrol Xl)	T1	HD
glipizide (Glucotrol)	T1	HD
GLIPIZIDE 2.5 MG TABLET	T3	HD
GLUCOTROL (*glipizide*)	T3	HD
GLUCOTROL XL (*glipizide xl*)	T3	HD
glyburide	T1	HD
glyburide, micronized (Glynase)	T1	HD
GLYNASE (*glyburide micronized*)	T3	HD
repaglinide	T1	HD
STARLIX (*nateglinide*)	T3	HD
tolbutamide	T1	HD
ANTIHYPERGLYCEMIC, SGLT-2 AND DPP-4 INHIBITOR COMB		
GLYXAMBI	T2	QL (1 tab/day) ST HD

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List of Prescription Medications

ANTIHYPERGLYCEMICS (Diabetes) *(cont.)*		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
ANTIHYPERGLYCEMIC, THIAZOLIDINEDIONE AND BIGUANIDE		
ACTOPLUS MET (*pioglitazone-metformin*)	T3	HD
pioglitazone hcl/metformin hcl (Actoplus Met)	T1	HD
ANTIHYPERGLYCEMIC, THIAZOLIDINEDIONE-SULFONYLUREA		
DUETACT (*pioglitazone-glimepiride*)	T3	HD
pioglitazone hcl/glimepiride (Duetact)	T1	HD
ANTIHYPERGLYCEMIC, DPP-4 INHIBITOR-BIGUANIDE COMBS.		
JANUMET	T2	QL (2 tabs/day) ST HD
JANUMET XR 100-1, 000 MG TABLET	T2	QL (1 tab/day) ST HD
JANUMET XR 50-1, 000 MG TABLET	T2	QL (2 tabs/day) ST HD
JANUMET XR 50-500 MG TABLET	T2	QL (1 tab/day) ST HD
ANTIHYPERGLYCEMIC, INSULIN-RELEASE STIM.-BIGUANIDE		
glipizide/metformin hcl	T1	HD
glyburide/metformin hcl	T1	HD
repaglinide/metformin hcl	T1	HD
ANTIHYPERGLYCEMIC, THIAZOLIDINEDIONE (PPARG AGONIST)		
ACTOS (*pioglitazone hcl*)	T3	HD
AVANDIA	T3	HD
pioglitazone hcl (Actos)	T1	HD
ANTIHYPERGLYCEMIC-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

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List of Prescription Medications

ANTIHYPERGLYCEMICS (Diabetes) *(cont.)*		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
INSULINS		
BASAGLAR KWIKPEN U-100	T2	QL (1.5ml/day) HD
FIASP PENFILL	T3	QL (1.5ml/day) HD
HUMALOG 100 UNIT/ML CARTRIDGE	T2	QL(1.5 mls/day) HD
HUMALOG KWIKPEN U-200	T2	QL (1ml/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 (1ml/day)HD
HUMULIN R U-500 KWIKPEN	T2	QL (1ml/day)HD
LYUMJEV	T2	QL (1.5ml/day) HD
LYUMJEV KWIKPEN U-100	T2	QL (1.5ml/day) HD
LYUMJEV KWIKPEN U-200	T2	QL (1ml/day)HD
TRESIBA	T2	QL (1.5ml/day) HD
TRESIBA FLEXTOUCH U-100	T2	QL (1.5ml/day) HD
TRESIBA FLEXTOUCH U-200	T2	QL (0.9ml/day) HD
ANTIINFECTIVES (Feminine Products)		
VAGINAL SULFONAMIDES		
AVC	T3	
ANTIINFECTIVES (INFECTIONS)		
PENICILLIN ANTIBIOTICS		
amoxicillin	T1	
ampicillin sodium	T1	
nafcillin sodium	T1	
ANTIINFECTIVES/MISCELLANEOUS (Feminine Products)		
VAGINAL ANTISEPTICS		
acetic acid/oxyquinoline (Relagard)	T1	
RELAGARD (*fem ph*)	T3	
TRIMO-SAN	T3	
ANTIINFECTIVES/MISCELLANEOUS (Infections)		
2ND GEN. ANAEROBIC ANTIPROTOZOAL-ANTIBACTERIAL		
TINDAMAX (*tinidazole*)	T3	
tinidazole	T1	
tinidazole (Tindamax)	T1	

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List of Prescription Medications

ANTIINFECTIVES/MISCELLANEOUS (Infections) *(cont.)*		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
AMEBICIDES		
paromomycin sulfate	T1	
ANTHELMINTICS		
albendazole (Albenza)	T1	
ALBENZA (*albendazole*)	T3	
BILTRICIDE (*praziquantel*)	T3	
EMVERM	T1	
ivermectin (Stromectol)	T1	PA
praziquantel (Biltricide)	T1	
STROMECTOL (*ivermectin*)	T3	PA
ANTIMALARIAL DRUGS		
atovaquone/proguanil hcl (Malarone)	T1	
chloroquine ph 250 mg tablet	T1	QL (56 Tabs/365 Days)
chloroquine ph 500 mg tablet	T1	
COARTEM	T3	PA QL (24 tabs/30 days)
DARAPRIM (*pyrimethamine*)	T3	PA SP
hydroxychloroquine sulfate (Plaquenil)	T1	
hydroxychloroquine sulfate (Sovuna)	T1	
KRINTAFEL	T3	PA QL (2 tabs/30 days)
MALARONE (*atovaquone-proguanil hcl*)	T3	PA
mefloquine hcl	T1	
PLAQUENIL (*hydroxychloroquine sulfate*)	T3	
PRIMAQUINE (primaquine phosphate)	T1	
primaquine phosphate (Primaquine)	T1	
pyrimethamine 25 mg tablet (Daraprim)	T1	PA
pyrimethamine 25 mg tablet (Daraprim)	T1	PA SP
QUALAQUIN (*quinine sulfate*)	T3	PA
quinine sulfate (Qualaquin)	T1	
SOVUNA 200 MG TABLET *(hydroxychloroquine sulfate)*	T3	PA
ANTIPROTOZOAL DRUGS, MISCELLANEOUS		
atovaquone	T1	
BENZNIDAZOLE	T3	
IMPAVIDO	T3	PA
LAMPIT	T3	
NEBUPENT (*pentamidine isethionate*)	T3	
PENTAM 300 (*pentamidine isethionate*)	T3	

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List of Prescription Medications

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ANTIINFECTIVES/MISCELLANEOUS (Miscellaneous)		
ANTIPROTOZOAL DRUGS, MISCELLANEOUS (con't.)		
pentamidine isethionate (Nebupent)	T1	
pentamidine isethionate (Pentam 300)	T1	
ANTIBACTERIAL AGENTS, MISCELLANEOUS		
glycine urologic solution	T1	
glycine urologic solution	T3	
TOPICAL ANTISEPTIC DRYING AGENTS		
formaldehyde	T1	
ANTIINFECTIVES/MISCELLANEOUS (SKIN CONDITIONS)		
TOPICAL ANTIFUNGALS		
CICLODAN 8% KIT	T3	
ciclopirox/urea/camph/men/euc (Ciclodan)	T1	
ANTIINFLAM.TUMOR NECROSIS FACTOR INHIBITING AGENTS (Pain Relief And Inflammatory Disease)		
ANTI-INFLAMMATORY TUMOR NECROSIS FACTOR INHIBITOR		
ADALIMUMAB-ADAZ	T2	PA QL (2 doses/28 days) SP
ADALIMUMAB-ADBM(CF) PEN CROHNS	T2	PA QL(1 starter kit/365 days) SP HD
ADALIMUMAB-ADBM(CF)PEN	T2	PA QL(2 pens/syringes/28 days) SP HD
AMJEVITA(CF)	T2	PA QL(2 syringes/28 days) SP HD
AMJEVITA(CF) AUTOINJECTOR	T2	PA QL(2 auto-injs/28 days) SP HD
AVSOLA	T2	PA SP
CIMZIA 200 MG VIAL KIT	T2	PA QL (1 kit/28 days) SP HD
CIMZIA 2X200 MG/ML SYRINGE KIT	T2	PA QL (1 kit/28 days) SP HD
CIMZIA 2X200 MG/ML (X3) START KT	T2	PA QL (1 kit/year) SP HD
CYLTEZO(CF) PEN PSORIASIS-UV	T2	PA QL(1 starter kit/365 days) SP
ENBREL 25 MG KIT	T2	PA QL (8 vials/28 days) SP HD
ENBREL 25 MG/0.5 ML SYRINGE	T2	PA QL (8 syringes/28 days) SP HD
ENBREL 25 MG/0.5 ML VIAL	T2	PA QL (4ml/28 days) SP HD
ENBREL 50 MG/ML SYRINGE	T2	PA QL (4 syringes/28 days) SP HD
ENBREL MINI	T2	PA QL (4 cartridges/28 days) SP HD
ENBREL SURECLICK	T2	PA QL (4 syringes/28 days) SP HD
HADLIMA	T2	PA QL (2 doses/28 days) SP
HADLIMA (CF-citrate free)	T2	PA QL (2 doses/28 days) SP
HUMIRA	T2	PA QL (2 syrings/28 days) SP HD
HUMIRA PEN	T2	PA QL (2 pens/28 days) SP HD
HUMIRA PEN CROHN'S-UC-HS	T2	PA QL (1 kit/year) SP HD
HUMIRA PEN PSOR-UVEITS-ADOL HS	T2	PA QL (1 kit/year) SP HD

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List of Prescription Medications

ANTIINFLAM.TUMOR NECROSIS FACTOR INHIBITING AGENTS (Pain Relief And Inflammatory Disease) *(cont.)*		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
ANTI-INFLAMMATORY TUMOR NECROSIS FACTOR INHIBITOR *(cont.)*		
HUMIRA (CF)	T2	PA QL (2 syrings/28 days) SP HD
HUMIRA (CF) PEDIATRIC CROHN'S	T2	PA QL (1 kit/year) SP HD
HUMIRA (CF) PEN 40 MG/0.4 ML	T2	PA QL (2 pens/28 days) SP HD
HUMIRA (CF) PEN 80 MG/0.8 ML	T2	PA QL (1 kit/year) SP HD
HUMIRA (CF) PEN CROHN'S-UC-HS	T2	PA QL (1 kit/year) SP HD
HUMIRA (CF) PEN PEDIATRIC UC	T2	PA QL (4 KITS/365 DAYS) SP HD
HUMIRA (CF) PEN PSOR-UV-ADOL HS	T2	PA QL (1 kit/year) SP HD
HYRIMOZ / HYRIMOZ PEN	T2	PA SP
HYRIMOZ(CF)	T2	PA QL (2 syringe/28 days) SP HD
HYRIMOZ(CF) PEN	T2	PA QL (2 pens/28 days) SP HD
IBRANCE	T3	PA QL SP
INFLECTRA	T2	PA SP HD
RENFLEXIS	T3	PA SP HD
SIMPONI 100 MG/ML PEN INJECTOR	T2	PA QL (1 injector/28 days) SP HD
SIMPONI 100 MG/ML SYRINGE	T2	PA QL (1 syringe/28 days) SP HD
SIMPONI ARIA	T2	PA SP HD
ANTINEOPLASTICS (Cancer)		
ANP - SELECTIVE RETINOID X RECEPTOR AGONISTS (RXR)		
bexarotene (Targretin)	T1	PA SP HD
ANTIBIOTIC ANTINEOPLASTICS		
adriamycin 10 mg vial	T1	PA SP
adriamycin 10 mg/5 ml vial	T1	PA SP
adriamycin 20 mg/10 ml vial	T1	PA SP
ADRIAMYCIN (*doxorubicin hcl)*	T3	PA SP
bleomycin sulfate	T1	PA SP
COSMEGEN	T2	PA SP
dactinomycin (Cosmegen)	T1	PA SP
daunorubicin hcl	T1	PA SP
DOXIL (*lipodox 50*)	T3	PA SP
doxorubicin hcl	T1	PA SP
doxorubicin hcl (Adriamycin)	T1	PA SP
doxorubicin hcl peg-liposomal (Doxil)	T1	PA SP
ELLENCE	T3	PA SP
ELLENCE (*epirubicin hcl*)	T3	PA SP

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ANTINEOPLASTICS (Cancer) *(cont.)*		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
ANTIBIOTIC ANTINEOPLASTICS *(cont.)*		
epirubicin 200 mg/100 ml vial (Ellence)	T1	PA SP
epirubicin 50 mg/25 ml vial (Ellence)	T1	PA SP
epirubicin hcl 200 mg vial	T1	SP
IDAMYCIN PFS (*idarubicin hcl*)	T3	PA SP
idarubicin hcl (Idamycin Pfs)	T1	PA SP
mitomycin (Mutamycin)	T1	PA SP
MUTAMYCIN (*mitomycin*)	T3	PA SP
valrubicin (Valstar)	T1	SP
VALSTAR (*valrubicin*)	T2	SP
ZANOSAR	T2	PA SP
ANTINEOPLASTICS ANTIBODY/ANTIBODY-DRUG COMPLEXES		
LUNSUMIO	T3	PA SP
ANTINEOPLASTIC,ANTI-PROGRAMMED DEATH-I (PD-I) MAB		
ZYNYZ	T3	PA SP
ANTI-CD20 (B LYMPHOCYTE) MONOCLONAL ANTIBODY		
GAZYVA	T3	PA SP
RIABNI	T2	PA SP
RITUXAN	T2	PA SP
RITUXAN HYCELA	T2	PA SP
RUXIENCE	T2	PA SP
TRUXIMA	T2	PA SP
ANTINEOPLAST HUM VEGF INHIBITOR RECOMB MC ANTIBODY		
AVASTIN	T2	PA SP
MVASI	T2	PA SP
VEGZELMA	T3	PA SP
ZIRABEV	T2	PA SP
ANTINEOPLAST, HISTONE DEACETYLASE (HDAC) INHIBITORS		
BELEODAQ	T3	PA SP
FARYDAK	T3	PA SP HD
ISTODAX	T3	PA SP
ROMIDEPSIN 10 MG KIT	T1	PA SP
ROMIDEPSIN 27.5 MG/5.5 ML VIAL	T3	PA SP
ZOLINZA	T2	PA SP HD
ANTINEOPLASTIC - ALKYLATING AGENTS		
ALKERAN 2 MG TABLET (*melphalan*)	T3	SP

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ANTINEOPLASTICS (Cancer) *(cont.)*		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
ANTINEOPLASTIC - ALKYLATING AGENTS *(cont.)*		
ALKERAN 50 MG VIAL (*melphalan hcl*)	T3	PA SP
BELRAPZO	T3	PA SP HD
bendamustine 100 mg vial	T1	PA SP
bendamustine 25 mg vial	T1	PA SP
BENDEKA	T3	PA SP HD
BICNU (*carmustine*)	T2	SP
busulfan (Busulfex)	T1	SP
carboplatin	T1	PA SP
carmustine (Bicnu)	T1	SP
CISPLATIN 50MG VIAL	T3	PA SP
cisplatin vial	T2	PA QL(2 pens/28 days) SP HD
cyclophosphamide 1 gm vial	T3	SP
CYCLOPHOSPHAMIDE 1 GM/5 ML VL	T3	SP
cyclophosphamide 2 gm vial	T3	SP
cyclophosphamide 25 mg capsule	T3	SP HD
cyclophosphamide 50 mg capsule	T3	SP HD
cyclophosphamide 500 mg vial	T3	SP
CYCLOPHOSPHAMIDE 500 MG/2.5 ML	T3	SP
EVOMELA	T3	PA SP
GLEOSTINE	T2	
GLIADEL	T3	SP
HYDREA (*hydroxyurea*)	T3	
hydroxyurea (Hydrea)	T1	
IFEX (*ifosfamide*)	T3	PA SP
ifosfamide	T1	PA SP
ifosfamide (Ifex)	T1	PA SP
LEUKERAN	T2	
melphalan (Alkeran)	T1	SP
melphalan hcl (Alkeran)	T1	PA SP
MYLERAN	T2	
oxaliplatin	T1	PA SP
PEPAXTO	T3	PA SP
TEMODAR 100 MG CAPSULE (*temozolomide*)	T3	PA SP HD
TEMODAR 100 MG VIAL	T3	PA SP

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List of Prescription Medications

ANTINEOPLASTICS (Cancer) *(cont.)*		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
ANTINEOPLASTIC - ALKYLATING AGENTS *(cont.)*		
TEMODAR 140 MG CAPSULE (*temozolomide*)	T3	PA SP HD
TEMODAR 180 MG CAPSULE (*temozolomide*)	T3	PA SP HD
TEMODAR 20 MG CAPSULE (*temozolomide*)	T3	PA SP HD
temozolomide	T1	PA SP HD CSL
temozolomide (Temodar)	T1	PA SP HD
TEPADINA	T3	PA SP
TEPADINA (*thiotepa*)	T3	PA SP
thiotepa (Tepadina)	T1	PA SP
TREANDA	T3	PA SP
YONDELIS	T3	PA SP
ZEPZELCA	T3	PA SP
ANTINEOPLASTIC - ANTIANDROGENIC AGENTS		
abiraterone 500 mg tablet	T1	SP HD
abiraterone acetate 250 mg tab	T1	PA SP HD
abiraterone acetate 500 mg tab (Zytiga)	T1	SP HD CSL
bicalutamide (Casodex)	T1	
CASODEX (*bicalutamide*)	T3	
ERLEADA 240 MG TABLET	T2	PA QL(1 tab/day) SP HD CSL
ERLEADA 60 MG TABLET	T2	PA SP HD CSL
flutamide	T1	
nilutamide	T1	QL (4 tabs/day)
NUBEQA	T2	PA SP HD
XTANDI	T2	PA SP HD
ANTINEOPLASTIC - ANTIBIOTIC AND ANTIMETABOLITE		
VYXEOS	T3	PA SP
ANTINEOPLASTIC - ANTI-CD38 MONOCLONAL ANTIBODY		
DARZALEX	T3	PA SP HD
DARZALEX FASPRO	T3	PA SP
SARCLISA	T3	PA SP
ANTINEOPLASTIC - ANTIMETABOLITES		
ALIMTA	T2	PA SP
ARRANON	T2	PA SP
capecitabine (Xeloda)	T1	PA SP HD

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ANTINEOPLASTICS (Cancer) *(cont.)*		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
ANTINEOPLASTIC - ANTIMETABOLITES *(cont.)*		
cladribine	T1	PA SP
clofarabine (Clolar)	T1	PA SP
CLOLAR (*clofarabine*)	T2	PA SP
cytarabine	T1	PA SP
cytarabine/pf	T1	PA SP
DACOGEN (*decitabine*)	T2	PA SP
floxuridine	T1	PA SP
fludarabine phosphate	T1	PA SP
fluorouracil	T1	PA SP
fluorouracil 2.5 gm/50 ml btl	T1	PA SP
fluorouracil 2.5 gm/50 ml vial	T1	PA SP
fluorouracil 5 gm/100 ml btl	T1	PA SP
fluorouracil 5 gm/100 ml vial	T1	PA SP
fluorouracil 5, 000 mg/100 ml	T1	PA SP
fluorouracil 500 mg/10 ml vial	T1	PA SP
FOLOTYN 20 MG/ML VIAL	T2	PA SP
FOLOTYN 40 MG/2 ML VIAL	T3	PA SP
gemcitabine hcl	T1	PA SP
GEMCITABINE 1GM/10ML VIAL	T3	PA SP
GEMCITABINE 1.5GM/15ML VIAL	T3	PA SP
GEMCITABINE 2GM/20ML VIAL	T3	PA SP
GEMCITABINE 200MG/2ML VIAL	T3	PA SP
INFUGEM	T3	PA SP HD
INQOVI	T3	PA SP HD
JYLAMVO	T3	CSL
LONSURF	T3	PA SP HD
mercaptopurine	T1	
methotrexate sodium	T1	
methotrexate sodium/pf	T1	
NIPENT	T3	PA SP
ONUREG	T3	PA QL (14 Tabs/28 Days) SP
PEMRYDI RTU	T3	PA SP
PURIXAN	T3	SP

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List of Prescription Medications

ANTINEOPLASTICS (Cancer) *(cont.)*		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
ANTINEOPLASTIC - ANTIMETABOLITES *(cont.)*		
TABLOID	T3	
TREXALL	T2	
VIDAZA (*azacitidine*)	T2	PA SP
XATMEP	T3	
XELODA (*capecitabine*)	T3	PA SP HD
ANTINEOPLASTIC - ANTI-SLAMF7 MONOCLONAL ANTIBODY		
EMPLICITI	T3	PA SP HD
ANTINEOPLASTIC - AROMATASE INHIBITORS		
anastrozole (Arimidex)	T1	HD PPACA
ARIMIDEX (*anastrozole*)	T3	HD
AROMASIN (*exemestane*)	T3	HD
BRAFTOVI	T3	PA SP HD
exemestane (Aromasin)	T1	HD PPACA
FEMARA (*letrozole*)	T3	HD
letrozole (Femara)	T1	HD
TAFINLAR	T3	PA SP HD
ZELBORAF	T3	PA SP HD
ANTI-NEOPLASTIC-ENZYME INHIB, ANTIANDROGEN COMB.		
AKEEGA	T3	PA QL(2 TABS/DAY) SP CSL
ANTINEOPLASTIC - CD19 (B LYMPHOCYTE) MC ANTIBODY		
MONJUVI	T3	PA SP
ANTINEOPLASTIC - EPOTHILONES AND ANALOGS		
IXEMPRA	T2	PA SP
ANTINEOPLASTIC - HEDGEHOG PATHWAY INHIBITOR		
DAURISMO	T3	PA SP HD
ERIVEDGE	T2	PA SP HD
ODOMZO	T3	PA SP HD
ANTINEOPLASTIC - IMMUNOTHERAPY, VIRUS-BASED AGENTS		
IMLYGIC	T3	PA SP
ANTINEOPLASTIC - JANUS KINASE (JAK) INHIBITORS		
JAKAFI	T3	PA SP HD
ANTINEOPLASTIC - KRAS PROTEIN INHIBITOR		
LUMAKRAS 120 MG TABLET	T3	PA QL(8 tabs/day) SP HD CSL
LUMAKRAS 320 MG TABLET	T3	PA QL(3 tabs/day) SP HD CSL

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List of Prescription Medications

ANTINEOPLASTICS (Cancer) *(cont.)*		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
ANTINEOPLASTIC - MEKI AND MEK2 KINASE INHIBITORS		
COTELLIC	T3	PA SP HD
KOSELUGO 10 MG CAPSULE	T3	PA QL (10 capsules/day) SP
KOSELUGO 25 MG CAPSULE	T3	PA QL (4 caps/day) SP
MEKINIST	T3	PA SP HD
MEKTOVI	T3	PA SP HD
ANTINEOPLASTIC - MICROTUBULE INHIBITORS		
HALAVEN	T3	PA SP
AFINITOR	T3	PA SP HD
AFINITOR (*everolimus*)	T3	PA SP HD
AFINITOR DISPERZ	T3	PA SP
everolimus 2.5 mg tablet (Afinitor)	T1	PA SP HD
everolimus 5 mg tablet (Afinitor)	T1	PA SP HD
everolimus 7.5 mg tablet (Afinitor)	T1	PA SP HD
temsirolimus (Torisel)	T1	PA SP
TORISEL (*temsirolimus*)	T2	PA SP
ANTINEOPLASTIC - MTOR KINASE INHIBITORS		
everolimus 10 mg tablet (Afinitor)	T1	PA QL(1 tab/day) SP HD CSL
everolimus 7.5 mg tablet (Afinitor)	T1	PA QL(1 tab/day) SP HD CSL
ANTINEOPLASTIC - PROTEIN METHYLTRANSFERASE INHIBIT		
TAZVERIK	T3	PA SP
ANTINEOPLASTIC - TOPOISOMERASE I INHIBITORS		
CAMPTOSAR	T3	PA SP
CAMPTOSAR (*irinotecan hcl*)	T3	PA SP
HYCAMTIN 0.25 MG CAPSULE	T3	PA SP HD
HYCAMTIN 1 MG CAPSULE	T3	PA SP HD
HYCAMTIN 4 MG VIAL (*topotecan hcl*)	T2	PA SP HD
irinotecan hcl	T1	PA SP
irinotecan hcl (Camptosar)	T1	PA SP
ONIVYDE	T3	PA SP
topotecan hcl	T1	PA SP HD
topotecan hcl (Hycamtin)	T1	PA SP HD
ANTINEOPLASTIC - VEGF-A, B AND PLGF INHIBITORS		
ZALTRAP	T3	PA SP
ANTINEOPLASTIC - VEGFR ANTAGONIST		
CYRAMZA	T3	PA SP

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ANTINEOPLASTICS (Cancer) *(cont.)*		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
ANTINEOPLASTIC - VINCA ALKALOIDS		
MARQIBO	T3	PA SP
NAVELBINE (*vinorelbine tartrate*)	T3	PA SP
vinblastine sulfate	T1	PA SP
vincristine sulfate	T1	PA SP
vinorelbine tartrate (Navelbine)	T1	PA SP
ANTINEOPLASTIC- CD22 ANTIBODY-CYTOTOXIC ANTIBIOTIC		
BESPONSA	T3	PA SP
MYLOTARG	T3	PA SP
ANTINEOPLASTIC COMB - KINASE AND AROMATASE INHIBIT		
KISQALI FEMARA CO-PACK	T2	PA QL (1 pack/28 days) SP HD CSL
ANTINEOPLASTIC EGF RECEPTOR BLOCKER MCLON ANTIBODY		
ERBITUX	T2	PA SP
HERCEPTIN	T3	PA SP
HERCEPTIN HYLECTA	T3	PA SP
HERZUMA	T3	PA SP
KANJINTI	T2	PA SP
MARGENZA	T3	PA SP
OGIVRI	T3	PA SP
ONTRUZANT	T3	PA SP
PERJETA	T3	PA SP
PHESGO	T3	PA SP HD
PORTRAZZA	T3	PA SP
TRAZIMERA	T2	PA SP
VECTIBIX	T2	PA SP
ANTINEOPLASTIC IMMUNOMODULATOR AGENTS		
lenalidomide	T1	PA QL(1 cap/day) SP HD CSL
POMALYST	T3	PA SP HD
REVLIMID	T2	PA QL(1 tab/day) SP HD CSL
ANTINEOPLASTIC LHRH (GNRH) AGONIST, PITUITARY SUPPR.		
ELIGARD	T3	SP HD
leuprolide acetate	T1	PA SP HD
LEUPROLIDE DEPOT	T3	PA SP HD
LUPRON DEPOT	T2	PA SP HD

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ANTINEOPLASTICS (Cancer) *(cont.)*		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
ANTINEOPLASTIC LHRH (GNRH) AGONIST, PITUITARY SUPPR. *(cont.)*		
TRELSTAR	T3	SP HD
ZOLADEX	T2	PA SP HD
FIRMAGON	T2	PA SP HD
ORGOVYX	T3	PA SP
ANTINEOPLASTIC SYSTEMIC ENZYME INHIBITORS		
ALECENSA	T2	PA QL(8 tabs/day) SP HD CSL
ALIQOPA	T3	PA SP
AYVAKIT	T3	PA QL (1 tab/day) SP
BALVERSA	T3	PA SP
BORTEZOMIB	T3	PA SP
BORTEZOMIB 3.5MG IV VIAL	T3	PA SP
BOSULIF	T3	PA SP HD
BRUKINSA	T2	PA QL (4 caps/day) SP
CABOMETYX	T3	PA SP HD
CALQUENCE	T3	PA SP
CAPRELSA	T3	PA SP
COMETRIQ	T3	PA SP HD
COPIKTRA	T3	PA SP
erlotinib hcl	T1	PA SP HD
EXKIVITY	T3	PA SP HD
FOTIVDA	T3	PA QL (30 caps/30 days) SP HD
GAVRETO	T3	PA QL (4 Tabs/Day) SP
gefitinib	T1	PA SP HD CSL
GILOTRIF	T3	PA SP HD
GLEEVEC (*imatinib mesylate*)	T3	PA SP HD
IBRANCE	T2	PA QL(21 caps/28 days) SP HD CSL
imatinib mesylate 100 mg tab (Gleevec)	T1	QL(6 tabs/day) SP HD CSL
imatinib mesylate 400 mg tab (Gleevec)	T1	QL(2 tabs/day) SP HD CSL
IMBRUVICA	T2	PA SP
INLYTA	T3	PA SP HD
INREBIC	T3	PA SP HD
IRESSA	T3	PA SP HD
IWILFIN	T3	PA QL(8 tabs/day) SP CSL
KISQALI 600MG	T2	PA QL (63/28days) SP HD CSL

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List of Prescription Medications

ANTINEOPLASTICS (Cancer) *(cont.)*		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
ANTINEOPLASTIC SYSTEMIC ENZYME INHIBITORS *(cont.)*		
KISQALI 400MG	T2	PA QL (42/28days) SP HD CSL
KISQALI 200MG	T2	PA QL (21/28days) SP HD CSL
KYPROLIS	T3	PA SP HD
lapatinib ditosylate (Tykerb)	T1	PA SP HD
LENVIMA	T2	PA SP HD
LORBRENA	T3	PA SP HD
LYNPARZA	T2	PA SP HD
LYTGOBI 12 MG DAILY DOSE (3X 4MG TB)	T3	PA QL(3 tabs/day) SP CSL
LYTGOBI 16 MG DAILY DOSE (4X 4MG TB)	T3	PA QL(4 tabs/day) SP CSL
LYTGOBI 20 MG DAILY DOSE (5X 4MG TB)	T3	PA QL(5 tabs/day) SP CSL
NERLYNX	T3	PA SP HD
NEXAVAR	T2	PA SP HD
NINLARO	T3	PA SP HD
OGSIVEO	T3	PA QL(6 tabs/day) SP CSL
OJJAARA	T3	PA QL(1 tab/day) SP CSL
pazopanib (Votrient)	T1	PA QL(4 tabs/day) SP HD CSL
PEMAZYRE	T3	PA QL (14 tabs/21 days) SP
PIQRAY	T3	PA SP HD
QINLOCK	T3	PA QL (3 tabs/day) SP
RETEVMO 40 MG CAPSULE	T3	PA QL (6 caps/day) SP HD
RETEVMO 80 MG CAPSULE	T3	PA QL (4 tabs/day) SP HD
ROZLYTREK	T3	PA SP HD
RUBRACA	T2	PA SP
RYDAPT	T3	PA SP HD
SPRYCEL	T2	PA SP HD
STIVARGA	T3	PA SP HD
TABRECTA	T3	PA QL (4 tabs/day) SP HD
TAGRISSO	T3	PA SP HD
TALZENNA	T3	PA SP HD
TASIGNA	T2	PA SP HD
TEPMETKO	T3	PA QL (2 tabs/day) SP
TRUQAP	T3	PA QL(64 tabs/28 days) SP CSL
TUKYSA	T3	PA SP
TURALIO 125 MG CAPSULE	T3	PA QL(4 caps/day) SP CSL
TURALIO 200 MG CAPSULE	T3	PA SP CSL

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List of Prescription Medications

TYKERB (*lapatinib*)	T3	PA SP HD
ANTINEOPLASTICS (Cancer) *(cont.)*		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
ANTINEOPLASTIC SYSTEMIC ENZYME INHIBITORS *(cont.)*		
UKONIQ	T3	PA QL (4 tabs/day) SP
VELCADE	T2	PA SP
VERZENIO	T2	PA QL (120mg/day) SP HD
VITRAKVI	T3	PA SP HD
VIZIMPRO	T3	PA SP HD
XALKORI	T3	PA SP HD
XALKORI 150 MG PELLET	T3	PA QL (4 pellets/day) SP HD CSL
XALKORI 20 MG PELLET	T3	PA QL (4 pellets/day) SP HD CSL
XALKORI 200 MG CAPSULE	T3	PA QL (4 caps/day) SP HD CSL
XALKORI 250 MG CAPSULE	T3	PA QL (4 caps/day) SP HD CSL
XALKORI 50 MG PELLET	T3	PA QL (4 pellets/day) SP HD CSL
XOSPATA	T3	PA SP
ZEJULA	T2	PA SP
ZYDELIG	T3	PA SP HD
ANTINEOPLASTIC, ANTI-PROGRAMMED DEATH-I (PD-I) MAB		
KEYTRUDA	T3	PA SP
LIBTAYO	T3	PA SP
LOQTORZI	T3	PA SP
OPDIVO	T3	PA SP HD
ZYNYZ	T3	PA SP
ANTINEOPLASTIC-B CELL LYMPHOMA-2 (BCL-2) INHIBITORS		
VENCLEXTA	T3	PA SP
VENCLEXTA STARTING PACK	T3	PA SP
ANTINEOPLASTIC-CD22 DIRECT ANTIBODY/CYTOTOXIN CONJ		
LUMOXITI	T3	PA SP
ANTINEOPLASTIC-INTERLEUKIN-6 (IL-6) INHIB, ANTIBODY		
SYLVANT	T3	PA SP
ANTINEOPLASTIC-ISOCITRATE DEHYDROGENASE INHIBITORS		
REZLIDHIA	T3	PA QL(2 caps/day) SP CSL
IDHIFA	T3	PA SP HD
TIBSOVO	T3	PA SP
ANTINEOPLASTIC-ISOCITRATE DEHYDROGENASE INHIBITORS		
ADCETRIS	T3	PA SP
BLENREP	T3	PA

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ANTINEOPLASTICS (Cancer) *(cont.)*		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
ANTINEOPLASTIC-ISOCITRATE DEHYDROGENASE INHIBITORS *(cont.)*		
BLINCYTO	T3	PA SP
ENHERTU	T3	PA SP HD
KADCYLA	T3	PA SP
PADCEV	T3	PA SP
POLIVY	T3	PA SP HD
POTELIGEO	T3	PA SP
TRODELVY	T3	PA SP
UNITUXIN	T3	PA SP
ZEVALIN	T2	PA SP
ANTINEOPLASTICS, MISCELLANEOUS		
ABRAXANE	T2	PA SP
ARSENIC TRIOXIDE	T1	PA SP
arsenic trioxide (Trisenox)	T1	PA SP
ASPARLAS	T3	SP
BCG (TICE STRAIN)	T3	SP
dacarbazine	T1	PA SP
DOCEFREZ	T3	PA SP
docetaxel 160 mg/16 ml vial	T1	PA SP
docetaxel 160 mg/8 ml vial	T1	PA SP HD
docetaxel 20 mg/2 ml vial	T1	PA SP
docetaxel 20 mg/ml vial	T1	PA SP
docetaxel 80 mg/4 ml vial (Taxotere)	T1	PA SP
docetaxel 80 mg/8 ml vial	T1	PA SP
ERWINAZE	T3	PA SP
ETOPOPHOS	T2	PA SP
etoposide	T1	PA SP
etoposide 1, 000 mg/50 ml vial	T1	PA SP
etoposide 100 mg/5 ml vial	T1	PA SP
etoposide 50 mg capsule	T1	SP HD
etoposide 500 mg/25 ml vial	T1	PA SP
JEVTANA	T3	PA SP HD
LYSODREN	T2	
MATULANE	T2	SP
mitoxantrone hcl	T1	PA SP
ONCASPAR	T2	PA SP

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ANTINEOPLASTICS (Cancer) *(cont.)*		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
ANTINEOPLASTICS, MISCELLANEOUS *(cont.)*		
paclitaxel	T1	PA SP
SYNRIBO	T3	PA SP
TAXOTERE (*docetaxel*)	T3	PA SP
TENIPOSIDE 50MG/5ML AMPULE	T3	PA SP
tretinoin 10 mg capsule	T1	PA
TRISENOX (*arsenic trioxide*)	T2	PA SP
ANTINEOPLASTIC-SELECT INHIB OF NUCLEAR EXP (SINE)		
XPOVIO	T3	PA SP
ANTI-PROGRAMMED CELL DEATH-LIGAND I (PD-LI) MAB		
BAVENCIO	T3	PA SP
IMFINZI	T3	PA SP
TECENTRIQ	T3	PA SP HD
CYTOTOXIC T-LYMPHOCYTE ANTIGEN (CTLA-4) RMC ANTIBODY		
IMJUDO	T3	PA SP HD
YERVOY	T3	PA SP HD
IMMUNOMODULATORS		
ACTIMMUNE	T2	PA SP HD
ALFERON N	T2	PA SP HD
PROLEUKIN	T2	PA SP
PHOTOACTIVATED, ANTINEOPLASTIC AGENTS (SYSTEMIC)		
PHOTOFRIN	T2	SP
UVADEX	T2	
RADIOACTIVE THERAPEUTIC AGENTS		
AZEDRA DOSIMETRIC	T3	PA SP
AZEDRA THERAPEUTIC	T3	PA SP
SELECTIVE ESTROGEN RECEPTOR MODULATORS (SERMS)		
FARESTON (*toremifene citrate*)	T3	QL (2 tabs/day) HD
FASLODEX (*fulvestrant*)	T2	PA SP HD
fulvestrant (Faslodex)	T1	PA SP HD
SOLTAMOX	T2	HD
tamoxifen citrate	T1	HD PPACA
toremifene citrate (Fareston)	T1	QL (2 tabs/day) HD
STEROID ANTINEOPLASTICS		
EMCYT	T2	SP HD
megestrol acetate	T1	

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ANTINEOPLASTICS (Skin Conditions)		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
PHOTOACT, TOPICAL ANTINEOPLAST, PREMALIGNANT LESIONS		
LEVULAN	T3	SP
TOPICAL ANTINEOPLASTIC PREMALIGNANT LESION AGENTS		
EFUDEX (*fluorouracil*)	T3	
FLUOROPLEX	T2	
FLUOROURACIL 0.5% CREAM	T1	
fluorouracil 2% topical soln	T1	
fluorouracil 5% cream (Efudex)	T1	
fluorouracil 5% topical soln	T1	
PANRETIN	T3	SP HD
PICATO	T3	
TOLAK	T3	
VALCHLOR	T3	SP HD
ANTI-OBESITY DRUGS (Weight Management)		
ANTI-OBESITY GLUCAGON-LIKE PEPTIDE-1 RECEP AGONIST		
WEGOVY	T2	PA QL (1 box/ month)
ANTIPARASITICS (Infections)		
ANTIPARASITICS		
ALINIA	T3	
ALINIA (*nitazoxanide*)	T3	
nitazoxanide (Alinia)	T1	
OPHTHALMIC (EYE) ANTIPARASITICS		
XDEMVY	T2	PA QL(4 bottles/30 days) SP
TOPICAL ANTIPARASITICS		
crotamiton (Eurax)	T1	
ELIMITE (*permethrin*)	T3	
EURAX	T3	
ivermectin (Sklice)	T1	
TOPICAL ANTIPARASITICS		
NATROBA (*spinosad*)	T3	
permethrin (Elimite)	T1	
SKLICE (*ivermectin*)	T3	
spinosad (Natroba)	T1	
ULESFIA	T3	

T1 – Typically Generics
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List of Prescription Medications

ANTIPARKINSON DRUGS (Parkinson's Disease)		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
ANTIPARKINSONISM DRUGS, ANTICHOLINERGIC		
benztropine mesylate	T1	HD
trihexyphenidyl hcl	T1	HD
ANTIPARKINSONISM DRUGS, OTHER		
amantadine hcl	T1	HD
APOKYN	T3	PA SP HD
AZILECT 0.5 MG TABLET (*rasagiline mesylate*)	T3	QL (1 tab/day) HD
AZILECT 1 MG TABLET (*rasagiline mesylate*)	T3	HD
bromocriptine mesylate (Parlodel)	T1	HD
carbidopa/levodopa	T1	HD
carbidopa/levodopa (Sinemet 10-100)	T1	HD
carbidopa/levodopa (Sinemet 25-100)	T1	HD
carbidopa/levodopa (Sinemet 25-250)	T1	HD
carbidopa/levodopa/entacapone (Stalevo 100)	T1	HD
carbidopa/levodopa/entacapone (Stalevo 125)	T1	HD
carbidopa/levodopa/entacapone (Stalevo 150)	T1	HD
carbidopa/levodopa/entacapone (Stalevo 200)	T1	HD
carbidopa/levodopa/entacapone (Stalevo 50)	T1	HD
carbidopa/levodopa/entacapone (Stalevo 75)	T1	HD
COMTAN (*entacapone*)	T3	HD
DUOPA	T3	SP HD
entacapone (Comtan)	T1	HD
INBRIJA	T3	PA SP HD
KYNMOBI	T2	PA HD
MIRAPEX ER 0.375 MG TABLET (*pramipexole er*)	T3	QL (1 tab/day) HD
MIRAPEX ER 0.75 MG TABLET (*pramipexole er*)	T3	HD
MIRAPEX ER 1.5 MG TABLET (*pramipexole er*)	T3	QL (1 tab/day) HD
MIRAPEX ER 2.25 MG TABLET (*pramipexole er*)	T3	QL (1 tab/day) HD
MIRAPEX ER 3 MG TABLET (*pramipexole er*)	T3	HD
MIRAPEX ER 3.75 MG TABLET (*pramipexole er*)	T3	HD
MIRAPEX ER 4.5 MG TABLET (*pramipexole er*)	T3	HD
NEUPRO	T3	HD
NOURIANZ	T3	PA QL (1 tab/day) SP HD
OSMOLEX ER	T3	QL(1 tab/day) HD

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List of Prescription Medications

ANTIPARKINSON DRUGS (Parkinson's Disease) *(cont.)*		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
ANTIPARKINSONISM DRUGS, OTHER *(cont.)*		
OSMOLEX ER 258 MG TABLET	T3	QL (1 tab/day) HD
PARLODEL (*bromocriptine mesylate*)	T3	HD
pramipexole di-hcl	T1	HD
pramipexole er 0.375 mg tablet (Mirapex Er)	T1	QL (1 tab/day) HD
pramipexole er 0.75 mg tablet (Mirapex Er)	T1	HD
pramipexole er 1.5 mg tablet (Mirapex Er)	T1	QL (1 tab/day) HD
pramipexole er 2.25 mg tablet (Mirapex Er)	T1	QL (1 tab/day) HD
pramipexole er 3 mg tablet (Mirapex Er)	T1	HD
pramipexole er 3.75 mg tablet (Mirapex Er)	T1	HD
pramipexole er 4.5 mg tablet (Mirapex Er)	T1	HD
rasagiline mesylate 0.5 mg tab (Azilect)	T1	QL (1 tab/day) HD
RYTARY	T3	HD
selegiline hcl	T1	HD
SINEMET 10-100 (*carbidopa-levodopa*)	T3	HD
SINEMET 25-100 (*carbidopa-levodopa*)	T3	HD
SINEMET 25-250 (*carbidopa-levodopa*)	T3	HD
STALEVO 100 (*carbidopa-levodopa-entacapone*)	T3	HD
STALEVO 125 (*carbidopa-levodopa-entacapone*)	T3	HD
STALEVO 150 (*carbidopa-levodopa-entacapone*)	T3	HD
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	
ANTIPLATELET DRUGS (Blood Thinners/Anti-Clotting)		
PLATELET AGGREGATION INHIBITORS		
AGGRASTAT	T3	HD
aspirin/dipyridamole	T1	HD

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List of Prescription Medications

ANTIPLATELET DRUGS (Blood Thinners/Anti-Clotting) *(cont.)*		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
PLATELET AGGREGATION INHIBITORS *(cont.)*		
BRILINTA	T2	HD
cilostazol	T1	HD
clopidogrel bisulfate	T1	HD
clopidogrel bisulfate (Plavix)	T1	HD
dipyridamole 25 mg tablet	T1	HD
dipyridamole 50 mg tablet	T1	HD
dipyridamole 75 mg tablet	T1	HD
EFFIENT (*prasugrel hcl*)	T3	HD
EPTIFIBATIDE	T1	HD
eptifibatide (Integrilin)	T1	HD
INTEGRILIN (*eptifibatide*)	T3	HD
PLAVIX (*clopidogrel*)	T3	HD
prasugrel hcl (Effient)	T1	HD
ticlopidine hcl	T1	HD
tirofiban-0.9% sodium chloride	T1	HD
PLATELET REDUCING AGENTS		
AGRYLIN (*anagrelide hcl*)	T3	
anagrelide hcl	T1	
anagrelide hcl (Agrylin)	T1	
ANTIVIRALS (AIDS/HIV)		
ANTIRETROVIRAL - ANTI-CD4 DOMAIN 2 MONOCLONAL AB		
TROGARZO	T3	PA SP
ANTIRETROVIRAL - CAPSID INHIBITORS		
SUNLENCA 4- 300 MG TABLET	T3	PA QL(5 tabs/180 days) SP
SUNLENCA 5- 300 MG TABLET	T3	PA QL(5 tabs/180 days) SP
SUNLENCA 463.5 MG/1.5 ML VIAL	T3	PA SP
ANTIRETROVIRAL-INTEGRASE INHIBITOR AND NNRTI COMB.		
CABENUVA	T3	PA SP
JULUCA	T2	SP
ANTIRETROVIRAL-INTEGRASE INHIBITOR AND NRTI COMB.		
DOVATO	T2	SP

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ANTIVIRALS (AIDS/HIV) *(cont.)*		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
ANTIRETROVIRAL-NRTIS AND INTEGRASE INHIBITORS COMB		
TRIUMEQ	T2	SP
ANTIRETROVIRAL-NUCLEOSIDE, NUCLEOTIDE, PROTEASE INH.		
SYMTUZA	T2	SP
ANTIVIRALS, HIV-SPEC, NON-PEPTIDIC PROTEASE INHIB		
APTIVUS	T2	PA SP
darunavir ethanolate (Prezista)	T1	SP
PREZCOBIX	T3	PA SP
PREZISTA	T2	SP
ANTIVIRALS, HIV-SPEC, NUCLEOSIDE-NUCLEOTIDE ANALOG		
CIMDUO	T3	PA SP
DESCOVY	T2	PA SP PPACA
emtricitabine-tenofv 100-150mg	T1	SP
emtricitabine-tenofv 133-200mg	T1	SP
emtricitabine-tenofv 167-250mg	T1	SP
emtricitabine-tenofv 200-300mg	T1	SP PPACA
TEMIXYS	T3	PA SP
ANTIVIRALS, HIV-SPEC., NUCLEOSIDE ANALOG, RTI COMB		
abacavir sulfate/lamivudine	T1	PA SP
abacavir/lamivudine/zidovudine	T1	PA SP
lamivudine/zidovudine	T1	SP
ANTIVIRALS, HIV-SPECIFIC, CCR5 CO-RECEPTOR ANTAG.		
maraviroc (Selzentry)	T1	PA SP
SELZENTRY	T2	PA SP
ANTIVIRALS, HIV-SPECIFIC, CD4 ATTACHMENT INHIBITOR		
RUKOBIA	T3	PA QL (2 syringe/day) SP
ANTIVIRALS, HIV-SPECIFIC, FUSION INHIBITORS		
FUZEON	T2	PA SP
ANTIVIRALS, HIV-SPECIFIC, NON-NUCLEOSIDE, RTI		
EDURANT	T3	PA SP
efavirenz	T1	PA SP
nevirapine	T1	PA SP
PIFELTRO	T3	PA SP
ANTIVIRALS, HIV-SPECIFIC, NUCLEOSIDE ANALOG, RTI		
abacavir sulfate	T1	PA SP
emtricitabine (Emtriva)	T1	PA SP
EMTRIVA 10 MG/ML SOLUTION	T2	PA SP

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List of Prescription Medications

ANTIVIRALS (AIDS/HIV) *(cont.)*		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
ANTIVIRALS, HIV-SPECIFIC, NUCLEOSIDE ANALOG, RTI *(cont.)*		
lamivudine 10 mg/ml oral soln	T1	SP
lamivudine 150 mg tablet	T1	SP
lamivudine 300 mg tablet	T1	PA SP
RETROVIR	T3	PA SP
zidovudine	T1	SP
tenofovir disoproxil fumarate	T1	PA SP
VIREAD	T2	PA SP
ANTIVIRALS, HIV-SPECIFIC, PROTEASE INHIBITOR COMB		
lopinavir/ritonavir	T1	
ANTIVIRALS, HIV-SPECIFIC, PROTEASE INHIBITORS		
atazanavir sulfate	T1	PA SP
EVOTAZ	T3	PA SP
fosamprenavir calcium	T1	PA SP
INVIRASE	T2	PA
LEXIVA	T2	PA SP
REYATAZ	T2	PA SP
ritonavir	T1	SP
ANTIVIRALS, HIV-I INTEGRASE STRAND TRANSFER INHIBTR		
APRETUDE	T3	PA SP
ISENTRESS	T2	SP
ISENTRESS HD	T2	PA SP
TIVICAY	T2	SP
TIVICAY PD	T2	SP
ARTV NUCLEOSIDE, NUCLEOTIDE, NON-NUCLEOSIDE RTI COMB		
COMPLERA	T3	PA SP
DELSTRIGO	T3	PA SP
efavirenz/emtricit/tenofovr df (Atripla)	T1	PA SP
efavirenz	T1	PA SP
efavirenz/lamivu/tenofov disop (Symfi Lo)	T1	SP
efavirenz/lamivu/tenofov disop (Symfi)	T1	SP
ODEFSEY	T3	PA SP
ARV-NUCLEOSIDE, NUCLEOTIDE RTI, INTEGRASE INHIBITORS		
BIKTARVY	T2	SP

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List of Prescription Medications

ANTIVIRALS (AIDS/HIV) *(cont.)*		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
ARV-NUCLEOSIDE, NUCLEOTIDE RTI, INTEGRASE INHIBITORS *(cont.)*		
GENVOYA	T2	SP
STRIBILD	T3	PA SP
ANTIVIRALS (Eye Conditions)		
EYE ANTIVIRALS		
trifluridine	T1	
ZIRGAN	T3	
ANTIVIRALS (Infections)		
ANTIVIRAL MONOCLONAL ANTIBODIES		
SYNAGIS	T3	PA SP HD
ANTIVIRALS, GENERAL		
acyclovir	T1	
acyclovir sodium	T1	
cidofovir	T1	SP
CYTOVENE (*ganciclovir sodium*)	T3	SP
famciclovir	T1	
FLUMADINE (*rimantadine hcl*)	T3	
foscarnet sodium (Foscavir)	T1	
FOSCAVIR	T3	
FOSCAVIR (*foscarnet sodium*)	T3	
GANCICLOVIR 500MG/250ML BAG	T3	SP
ganciclovir sodium	T1	SP
ganciclovir sodium (Cytovene)	T1	SP
LIVTENCITY	T3	PA QL (4 tabs/day) SP
oseltamivir 6 mg/ml suspension (Tamiflu)	T1	QL (180ml/30 days)
oseltamivir phos 30 mg capsule (Tamiflu)	T1	QL (20 caps/30 days)
oseltamivir phos 45 mg capsule (Tamiflu)	T1	QL (10 caps/30 days)
oseltamivir phos 75 mg capsule (Tamiflu)	T1	QL (10 caps/30 days)
PREVYMIS 240 MG TABLET	T3	SP HD
PREVYMIS 240 MG/12 ML VIAL	T3	SP
PREVYMIS 480 MG TABLET	T3	SP HD
PREVYMIS 480 MG/24 ML VIAL	T3	SP
RAPIVAB	T3	
RELENZA	T3	QL (20/30 days)

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List of Prescription Medications

ANTIVIRALS (Infections) *(cont.)*		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
ANTIVIRALS, GENERAL *(cont.)*		
rimantadine hcl (Flumadine)	T1	
TAMIFLU 30 MG CAPSULE (*oseltamivir phosphate*)	T3	QL (20/30 days)
TAMIFLU 45 MG CAPSULE (*oseltamivir phosphate*)	T3	QL (10/30 days)
TAMIFLU 6 MG/ML SUSPENSION (*oseltamivir phosphate*)	T3	QL (180ml/30 days)
TAMIFLU 75 MG CAPSULE (*oseltamivir phosphate*)	T3	QL (10/30 days)
valganciclovir hcl	T1	
VALTREX (*valacyclovir*)	T3	
XOFLUZA	T3	QL (2 tabs/30 days)
ANTIVIRAL - RNA POLYMERASE INHIBITOR		
LAGEVRIO (EUA)	T3	QL (1 pack/120 days)
HEP C - NS5A, NS3/4A, NUCLEOTIDE NS5B INHIB COMBO		
VOSEVI	T2	PA SP HD
HEP C VIRUS, NUCLEOTIDE ANALOG NS5B POLYMERASE INH		
SOVALDI 150 MG PELLET PACKET	T2	PA QL (1 tab/day) SP HD
SOVALDI 200 MG PELLET PACKET	T2	PA QL (1 tab/day) SP HD
SOVALDI 200 MG TABLET	T2	PA QL (1 tab/day) SP HD
SOVALDI 400 MG TABLET	T2	PA SP HD
HEP C VIRUS-NS5B POLYMERASE AND NS5A INHIB. COMBO.		
EPCLUSA 200 MG-50 MG TABLET	T2	PA QL (1 tab/Day) SP HD
EPCLUSA 400 MG-100 MG TABLET	T2	PA SP HD
HARVONI 33.75-150 MG PELLET PK	T2	PA QL (1 tab/day) SP HD
HARVONI 45-200 MG PELLET PACKT	T2	PA QL (1 tab/day) SP HD
HARVONI 45-200 MG TABLET	T2	PA QL (1 tab/day) SP HD
HARVONI 90-400 MG TABLET	T2	PA SP HD
HEPATITIS B TREATMENT AGENTS		
adefovir dipivoxil (Hepsera)	T1	SP HD
BARACLUDE	T2	SP HD
entecavir 0.5 mg tablet	T1	QL (1 tab/day) SP HD
entecavir 1 mg tablet	T1	SP HD
EPIVIR HBV 100 MG TABLET (*lamivudine hbv*)	T3	SP
EPIVIR HBV 25 MG/5 ML SOLN	T2	SP
lamivudine (Epivir Hbv)	T1	SP

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ANTIVIRALS (Infections) *(cont.)*		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
HEPATITIS B TREATMENT AGENTS *(cont.)*		
VEMLIDY	T2	SP HD
PEGASYS	T2	PA SP HD
PEGINTRON	T3	PA SP HD
ribasphere 200 mg capsule	T1	SP HD
ribasphere 200 mg tablet	T1	SP HD
ribasphere 400 mg tablet	T1	SP
ribasphere 600 mg tablet	T1	SP
ribasphere ribapak 200-400 mg	T3	SP HD
RIBASPHERE RIBAPAK 400-400 mg	T1	SP HD
RIBASPHERE RIBAPAK *600-400 mg*	T1	SP HD
RIBASPHERE RIBAPAK *600-600 mg*	T1	SP HD
ribavirin	T1	SP HD
HEPATITIS C VIRUS- NS5A AND NS3/4A INHIBITOR COMB		
ZEPATIER	T3	PA SP HD
RNA POLYMERASE INHIBITOR		
LAGEVRIO 200 MG CAP (EUA)	T2	QL(1 pack/120 days)
MOLNUPIRAVIR	T3	QL (1 pkg/120 days)
ANTIVIRALS (Skin Conditions)		
TOPICAL GENITAL WART-HPV TREATMENT AGENTS		
VEREGEN	T3	
AUTONOMIC DRUGS (Allergy/Nasal Sprays)		
ANAPHYLAXIS THERAPY AGENTS		
ADYPHREN	T1	
ADYPHREN AMP	T1	
epinephrine 0.15 mg auto-injct	T1	QL (2 packs/30 days)
EPINEPHRINE 0.3 MG AUTO-INJECT	T1	QL (2 packs/30 days)
epinephrine 0.3 mg auto-inject (Epinephrine)	T1	QL (2 packs/30 days)
EPINEPHRINE PROFESSIONAL EMS	T3	
EPINEPHRINE PROFESSIONAL KIT	T3	
EPINEPHRINESNAP-EMS	T3	
EPINEPHRINESNAP-V	T3	

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List of Prescription Medications

AUTONOMIC DRUGS (Alzheimer's Disease)		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
CHOLINESTERASE INHIBITORS		
ARICEPT (*donepezil hcl*)	T3	HD
BLOXIVERZ (*neostigmine methylsulfate*)	T3	HD
donepezil hcl	T1	HD
donepezil hcl (Aricept)	T1	HD
EXELON (*rivastigmine*)	T3	HD
galantamine er 16 mg capsule (Razadyne Er)	T1	HD
galantamine er 24 mg capsule (Razadyne Er)	T1	HD
galantamine er 8 mg capsule (Razadyne Er)	T1	QL (1 cap/day) HD
galantamine hbr	T1	HD
neostigmine methylsulfate (Bloxiverz)	T1	HD
neostigmine methylsulfate (Bloxiverz)	T1	HD
neostigmine methylsulfate (Neostigmine Methylsulfate)	T1	HD
NEOSTIGMINE-STERILE WATER	T1	HD
physostigmine salicylate	T1	HD
pyridostigmine bromide	T3	HD
pyridostigmine bromide (Mestinon)	T1	HD
RAZADYNE ER 16 MG CAPSULE (*galantamine er*)	T3	HD
RAZADYNE ER 24 MG CAPSULE (*galantamine er*)	T3	HD
RAZADYNE ER 8 MG CAPSULE (*galantamine er*)	T3	QL (1 cap/day) HD
rivastigmine (Exelon)	T1	HD
rivastigmine tartrate	T1	HD
AUTONOMIC DRUGS (Attention Deficit Hyperactivity Disorder)[II]		
ADRENERGICS, AROMATIC, NON-CATECHOLAMINE		
ADDERALL (*dextroamphetamine-amphetamine*)	T3	PA ST
amphetamine sulfate (Evekeo)	T1	PA
dextroamp/amphet (Adderall Xr) (Mydayis)	T1	PA QL (1 cap/day)
dextroamp-amphet er 10 mg cap (Adderall Xr)	T1	PA QL (1 cap/day)
dextroamp-amphet er 15 mg cap (Adderall Xr)	T1	PA QL (1 cap/day)
dextroamp-amphet er 20 mg cap (Adderall Xr)	T1	PA QL (1 cap/day)
dextroamp-amphet er 25 mg cap (Adderall Xr)	T1	PA QL (1 per day)
dextroamp-amphet er 30 mg cap (Adderall Xr)	T1	PA QL (1 per day)
dextroamp-amphet er 5 mg cap (Adderall Xr)	T1	PA QL (1 cap/day)

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AUTONOMIC DRUGS (Attention Deficit Hyperactivity Disorder)[11] *(cont.)*		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
ADRENERGICS, AROMATIC, NON-CATECHOLAMINE *(cont.)*		
dextroamphetamine er 10 mg cap	T1	PA QL (1 cap/day)
dextroamphetamine er 15 mg cap	T1	PA QL (3/day)
dextroamphetamine er 5 mg cap	T1	PA QL (1 cap/day)
dextroamphetamine sulfate	T1	PA
dextroamphetamine sulfate	T3	PA ST
dextroamph-amphet er cp (Mydayis)	T1	QL
EVEKEO (*amphetamine sulfate*)	T3	PA ST
methamphetamine hcl	T1	PA
XELSTRYM	T3	PA QL(1 patch/day)
ZENZEDI	T3	PA ST
AUTONOMIC DRUGS (Blood Pressure/Heart Medications)		
ADRENERGIC VASOPRESSOR AGENTS		
droxidopa (Northera)	T1	SP HD
midodrine hcl	T1	
ALPHA-ADRENERGIC BLOCKING AGENTS		
DIBENZYLINE (*phenoxybenzamine hcl*)	T3	HD
phenoxybenzamine hcl (Dibenzyline)	T1	HD
phentolamine mesylate	T1	HD
AUTONOMIC DRUGS (Miscellaneous)		
ADRENERGIC AGENTS, CATECHOLAMINES		
dopamine hcl	T1	
dopamine hcl in dextrose 5 %	T1	
epinephrine	T3	
epinephrine 0.1 mg/ml syringe	T1	
epinephrine 1 mg/10 ml luerjet	T1	
epinephrine 1 mg/10 ml abbojct	T1	
epinephrine 1 mg/ml ampul	T1	
epinephrine 30 mg/30 ml vial	T1	
epinephrine hcl in 0.9 % nacl	T1	
epinephrine hcl in 0.9 % nacl (Epinephrine Hcl-0.9% Nacl)	T1	
epinephrine hcl in dextrose 5%	T1	
epinephrine hcl in dextrose 5% (Epinephrine Hcl-d5w)	T1	

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List of Prescription Medications

AUTONOMIC DRUGS (Miscellaneous) *(cont.)*		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
ADRENERGIC AGENTS, CATECHOLAMINES *(cont.)*		
EPINEPHRINE HCL-0.9% NACL	T1	
EPINEPHRINE HCL-0.9% NACL (*epinephrine hcl-0.9% nacl*)	T1	
EPINEPHRINE HCL-D5W	T1	
EPINEPHRINE HCL-D5W (*epinephrine hcl-d5w*)	T1	
isoproterenol hcl	T1	
isoproterenol hcl (Isuprel)	T1	
ISUPREL	T3	
LEVOPHED (*norepinephrine bitartrate*)	T3	
LEVOPHED BITARTRATE (*norepinephrine bitartrate*)	T3	
norepinephrine bit/0.9 % nacl	T1	
NOREPINEPHRINE BITAR-0.9% NACL	T1	
norepinephrine bitartrate (Levophed Bitartrate)	T1	
norepinephrine bitartrate (*Levophed*)	T1	
norepinephrine bitartrate/d5w	T1	
NOREPINEPHRINE BITARTRATE-D5W	T1	
NEUROMUSCULAR BLOCKING AGENTS		
atracurium besylate	T1	
BOTOX 100 UNIT VIAL	T3	PA SP
BOTOX 200 UNIT VIAL	T3	PA SP HD
cisatracurium besylate (Nimbex)	T1	
DAXXIFY	T3	PA SP
DYSPORT	T3	PA SP HD
MIVACRON	T3	
MYOBLOC	T3	PA SP HD
NIMBEX (*cisatracurium besylate*)	T3	
pancuronium bromide	T1	
QUELICIN (*succinylcholine chloride*)	T3	
rocuronium bromide	T1	
rocuronium bromide (Rocuronium Bromide)	T1	
SUCCINYLCHOLINE CHLORIDE	T1	
succinylcholine chloride (Quelicin)	T1	
succinylcholine chloride (Quelicin)	T3	
succinylcholine chloride (Succinylcholine Chloride)	T1	
SUCCINYLCHOLINE CHLORIDE-NACL	T1	
vecuronium bromide	T1	

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List of Prescription Medications

AUTONOMIC DRUGS (Miscellaneous) *(cont.)*		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
NEUROMUSCULAR BLOCKING AGENTS *(cont.)*		
VECURONIUM BROMIDE-WATER	T1	
XEOMIN	T3	PA SP HD
AUTONOMIC DRUGS (Urinary Tract Conditions)		
PARASYMPATHETIC AGENTS		
bethanechol chloride	T1	HD
cevimeline hcl (Evoxac)	T1	HD
EVOXAC (*cevimeline hcl*)	T3	HD
guanidine hcl	T1	HD
pilocarpine hcl (Salagen)	T1	HD
SALAGEN (*pilocarpine hcl*)	T3	HD
BIOLOGICALS (Allergy/Nasal Sprays)		
ALLERGENIC EXTRACTS, THERAPEUTIC		
GRASTEK	T3	PA QL (1 tab/day)
ODACTRA	T3	PA QL (1 tab/day)
ORALAIR	T3	PA QL (1 tab/day)
RAGWITEK	T3	PA QL (1 tab/day)
BIOLOGICALS (Blood Pressure/Heart Medications)		
PLASMA KALLIKREIN INHIBITORS		
TAKHZYRO	T3	PA SP HD
BIOLOGICALS (Miscellaneous)		
ANTISERA		
HYPERRHO S-D	T3	SP
MICRHOGAM ULTRA-FILTERED PLUS	T3	SP
RHOGAM ULTRA-FILTERED PLUS	T3	SP
RHOPHYLAC	T3	SP
WINRHO SDF	T3	SP HD
PKU TREATMENT AGENTS - PHENYLALANINE AMMONIA LYASE		
PALYNZIQ	T3	PA SP HD
BIOLOGICALS (Vaccines)		
COVID-19 VACCINES		
COMIRNATY 2023-2024	T3	PPACA
MODERNA COVID EUA	T3	PPACA
PFIZER COVIDEUA	T3	PPACA
SPIKEVAX 2023-2024	T3	PPACA

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BIOLOGICALS (Vaccines) *(cont.)*		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
ENTERIC VIRUS VACCINES		
IPOL	T3	PPACA
ROTARIX	T3	PPACA
ROTATEQ	T3	PPACA
GRAM NEGATIVE COCCI VACCINES		
BEXSERO	T3	PPACA
MENACTRA	T3	PPACA
MENQUADFI	T3	PPACA
MENVEO A-C-Y-W-135-DIP	T3	PPACA
PENBRAYA	T3	PPACA
TRUMENBA	T3	PPACA
GRAM POSITIVE COCCI VACCINES		
PNEUMOVAX 23	T3	PPACA
PREVNAR 13	T3	PPACA
INFLUENZA VIRUS VACCINES		
AFLURIA 2017-2018	T3	PPACA
AFLURIA 2018-2019	T3	PPACA
AFLURIA QUAD 2017-2018	T3	PPACA
AFLURIA QUAD 2018-2019	T3	PPACA
AFLURIA QUAD 2019-20 (3YR UP)	T3	PPACA
AFLURIA QUAD 2019-20 (6-35MO)	T3	PPACA
AFLURIA QUAD 2019-2020	T3	PPACA
AFLURIA QUAD 2020-2021	T3	PPACA
AFLURIA QUAD 2020-21 (3YR UP)	T3	PPACA
AFLURIA QUAD 2020-21 (6-35MO)	T3	PPACA
EZ FLU 2018-2019 (FLUCELVAX)	T3	PPACA
FLUAD 2017-2018	T3	PPACA
FLUAD 2018-2019	T3	PPACA
FLUAD 2019-2020	T3	PPACA
FLUAD 2020-2021	T3	PPACA
FLUAD QUAD 2020-2021	T3	PPACA
FLUARIX QUAD 2017-2018	T3	PPACA
FLUARIX QUAD 2018-2019	T3	PPACA
FLUARIX QUAD 2019-2020	T3	PPACA
FLUARIX QUAD 2020-2021	T3	PPACA

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BIOLOGICALS (Vaccines) *(cont.)*		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
INFLUENZA VIRUS VACCINES *(cont.)*		
FLUBLOK QUAD 2020-2021	T3	PPACA
FLUCELVAX QUAD 2017-2018	T3	PPACA
FLUCELVAX QUAD 2018-2019	T3	PPACA
FLUCELVAX QUAD 2019-2020	T3	PPACA
FLUCELVAX QUAD 2020-2021	T3	PPACA
FLULAVAL QUAD 2017-2018	T3	PPACA
FLULAVAL QUAD 2018-2019	T3	PPACA
FLULAVAL QUAD 2019-2020	T3	PPACA
FLULAVAL QUAD 2020-2021	T3	PPACA
FLUMIST QUAD 2017-2018	T3	PPACA
FLUMIST QUAD 2018-2019	T3	PPACA
FLUMIST QUAD 2019-2020	T3	PPACA
FLUMIST QUAD 2020-2021	T3	PPACA
FLUVIRIN 2017-2018	T3	PPACA
FLUZONE HIGH-DOSE 2017-2018	T3	PPACA
FLUZONE HIGH-DOSE 2018-2019	T3	PPACA
FLUZONE HIGH-DOSE 2019-2020	T3	PPACA
FLUZONE HIGH-DOSE QUAD 2020-21	T3	PPACA
FLUZONE INTRADERM QUAD 2017-18	T3	PPACA
FLUZONE QUAD 2017-2018	T3	PPACA
FLUZONE QUAD 2018-2019	T3	PPACA
FLUZONE QUAD 2019-2020	T3	PPACA
FLUZONE QUAD 2020-2021	T3	PPACA
FLUZONE QUAD PEDI 2017-2018	T3	PPACA
FLUZONE QUAD PEDI 2018-2019	T3	PPACA
FLUZONE QUAD PEDI 2019-2020	T3	PPACA
VACCINE/TOXOID PREPARATIONS, COMBINATIONS		
ACTHIB	T3	PPACA
ADACEL TDAP	T3	PPACA
BOOSTRIX TDAP	T3	PPACA
DAPTACEL DTAP	T3	PPACA

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BIOLOGICALS (Vaccines) *(cont.)*		
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VACCINE/TOXOID PREPARATIONS, COMBINATIONS *(cont.)*		
DIPHTHERIA-TETANUS TOXOIDS-PED	T3	PPACA
HIBERIX	T3	PPACA
INFANRIX DTAP	T3	PPACA
KINRIX	T3	PPACA
M-M-R II VACCINE	T3	PPACA
PEDVAXHIB	T3	PPACA
PENTACEL	T3	PPACA
PENTACEL ACTHIB COMPONENT	T3	PPACA
PROQUAD	T3	PPACA
QUADRACEL DTAP-IPV	T3	PPACA
TDVAX	T3	PPACA
TENIVAC	T3	PPACA
VAXELIS	T3	PPACA
VIRAL/TUMORIGENIC VACCINES		
ACAM2000	T3	PPACA
ENGERIX-B ADULT	T3	PPACA
ENGERIX-B PEDIATRIC-ADOLESCENT	T3	PPACA
GARDASIL 9	T3	PPACA
HEPLISAV-B	T3	PPACA
IXCHIQ	T3	PPACA
JYNNEOS	T3	PPACA
PEDIARIX	T3	PPACA
RECOMBIVAX HB	T3	PPACA
SHINGRIX	T3	PPACA
TWINRIX	T3	PPACA
VARIVAX VACCINE	T3	PPACA
ZOSTAVAX	T3	PPACA
BLOOD (Blood Modifiers/Bleeding Disorders)		
AGENTS TO TX THROMBOTIC THROMBOCYTOPENIC PURPURA		
ADZYNMA	T3	PA SP
CABLIVI	T3	PA SP
ANTIFIBRINOLYTIC AGENTS		
AMICAR (*aminocaproic acid*)	T3	SP HD
aminocaproic acid	T1	SP HD

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BLOOD (Blood Modifiers/Bleeding Disorders) *(cont.)*		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
ANTIFIBRINOLYTIC AGENTS *(cont.)*		
aminocaproic acid (Amicar)	T1	SP HD
CYKLOKAPRON (*tranexamic acid*)	T3	SP
FIBRYGA	T3	PA SP
LYSTEDA (*tranexamic acid*)	T3	SP
RIASTAP	T3	PA SP
tranexamic acid (Cyklokapron)	T1	SP
tranexamic acid (Lysteda)	T1	SP
tranexamic acid in nacl,iso-os	T1	SP
TRANEXAMIC ACID-NACL	T1	SP
TRANEXAMIC 1,000 MG/100ML-NACL	T3	SP
ANTIHEMOPHILIC FACTORS		
ALTUVILLO	T2	PA SP HD
COMPLEMENT (C3) INHIBITORS		
EMPAVELI	T2	PA SP
FABHALTA	T2	PA QL(2 caps/day) SP
BLOOD FACTORS, MISCELLANEOUS		
VONVENDI	T3	SP HD
COAGULANTS		
protamine sulfate	T1	
FACTOR IX COMPLEX (PCC) PREPARATIONS		
KCENTRA	T3	SP
FACTOR X PREPARATIONS		
COAGADEX	T3	PA SP
CORIFACT	T3	PA SP
TRETTEN	T3	PA SP
HEMOPHILIA TREATMENT AGENTS, NON-FACTOR REPLACEMENT		
HEMLIBRA	T3	PA SP HD
HUMAN MONOCLONAL ANTIBODY COMPLEMENT (C5) INHIBITOR		
SOLIRIS	T2	PA SP
ULTOMIRIS	T3	PA SP HD
PROTEIN C PREPARATIONS		
CEPROTIN	T3	PA SP
SICKLE CELL ANEMIA AGENTS		
ADAKVEO	T3	PA SP
DROXIA	T2	

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BLOOD (Blood Modifiers/Bleeding Disorders) *(cont.)*		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
TOPICAL HEMOSTATICS		
OXBRYTA 300MG TAB	T3	PA QL (5 tabs/day) SP
SIKLOS	T3	PA
ASTRINGYN	T3	
AVITENE	T3	
ENDO-AVITENE	T3	
EVICEL	T3	
gelatin sponge, absorb/porcine (Gelfoam)	T1	
GELFOAM	T3	
GELFOAM (*surgifoam*)	T3	
GELFOAM COMPRESSED	T3	
MONSEL'S	T3	
RAPLIXA	T3	
RECOTHROM	T3	
SURGIFOAM	T1	
SYRINGE AVITENE	T3	
TACHOSIL	T3	
THROMBI-GEL	T3	
THROMBIN-JMI	T3	
THROMBI-PAD	T3	
ULTRAFOAM	T3	
BLOOD (Blood Thinners/Anti-Clotting)		
ANTICOAGULANT REVERSAL AGENT FOR FACTOR XA INHIB.		
ANDEXXA	T3	SP
ANTICOAGULANT REVERSAL AGENT, DIRECT THROMBIN INHIB		
PRAXBIND	T3	SP
HEMORRHEOLOGIC AGENTS		
pentoxifylline	T1	HD
THROMBOLYTIC - NUCLEOTIDE TYPE		
DEFITELIO	T3	PA SP
THROMBOLYTIC ENZYMES		
ACTIVASE	T3	
CATHFLO ACTIVASE	T3	
RETAVASE	T3	
TNKASE	T3	

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BLOOD (Miscellaneous)		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
CELL/GENE THERAPY AGENTS - HEMATOPOIETIC		
OMISIRGE	T3	
CARDIAC DRUGS (Blood Pressure/Heart Medications)		
ANTIANGINAL, ANTI-ISCHEMIC AGENTS, NON-HEMODYNAMIC		
RANEXA (*ranolazine er*)	T3	QL (4 tabs/day) HD
ranolazine (Ranexa)	T1	QL (4 tabs/day) HD
ANTIARRHYTHMICS		
adenosine 12 mg/4 ml syringe	T1	HD
adenosine 12 mg/4 ml vial	T1	HD
adenosine 6 mg/2 ml syringe	T1	HD
adenosine 6 mg/2 ml vial	T1	HD
amiodarone hcl	T1	HD
AMIODARONE HCL-D5W	T1	HD
bretylium tosylate	T1	HD
CORVERT (*ibutilide fumarate*)	T3	PA HD
disopyramide phosphate (Norpace)	T1	HD
dofetilide 125 mcg capsule (Tikosyn)	T1	QL (8 caps/day) HD
dofetilide 250 mcg capsule (Tikosyn)	T1	QL (4 caps/day) HD
dofetilide 500 mcg capsule (Tikosyn)	T1	QL (2 caps/day) HD
flecainide acetate	T1	HD
ibutilide fumarate (Corvert)	T1	HD
lidocaine hcl 1% abboject	T1	HD
lidocaine hcl 1% syringe	T1	HD
lidocaine hcl 2% abboject	T1	HD
lidocaine hcl 2% luer-jet	T1	HD
lidocaine hcl 2% syringe	T1	HD
lidocaine hcl 2% vial	T1	HD
lidocaine hcl/dextrose 5 %/pf	T1	HD
mexiletine hcl	T1	HD
NEXTERONE	T3	HD
NORPACE (*disopyramide phosphate*)	T3	PA HD
NORPACE CR	T3	HD
pacerone 100 mg tablet	T3	PA HD
pacerone 200 mg tablet	T1	HD

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CARDIAC DRUGS (Blood Pressure/Heart Medications) *(cont.)*		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
ANTIARRHYTHMICS *(cont.)*		
pacerone 400 mg tablet	T3	PA HD
procainamide hcl	T1	HD
propafenone hcl	T1	HD
propafenone hcl (Rythmol Sr)	T1	HD
quinidine gluconate	T1	HD
RYTHMOL SR (*propafenone hcl er*)	T3	PA HD
TIKOSYN 125 MCG CAPSULE (*dofetilide*)	T3	PA QL (8 caps/day) HD
TIKOSYN 250 MCG CAPSULE (*dofetilide*)	T3	PA QL (4 caps/day) HD
TIKOSYN 500 MCG CAPSULE (*dofetilide*)	T3	PA QL (2 caps/day) HD
XYLOCAINE IV	T3	HD
CALCIUM CHANNEL BLOCKING AGENTS		
ADALAT CC (*nifedipine er*)	T3	HD
amlodipine besylate (Norvasc)	T1	HD
CALAN SR (*verapamil er*)	T3	HD
CAMZYOS	T3	PA QL (30 caps/30 days) SP
CARDENE I.V.	T3	HD
CARDENE I.V. (*nicardipine hcl*)	T3	HD
CARDIZEM LA 120 MG TABLET (*diltiazem hcl*)	T3	QL (1 tab/day) HD
CARDIZEM LA 180 MG TABLET (*matzim la*)	T3	HD
CARDIZEM LA 240 MG TABLET (*matzim la*)	T3	HD
CARDIZEM LA 300 MG TABLET (*matzim la*)	T3	HD
CARDIZEM LA 360 MG TABLET (*matzim la*)	T3	HD
CARDIZEM LA 420 MG TABLET (*matzim la*)	T3	HD
CLEVIPREX	T3	HD
diltiazem 24h er(la) 120 mg tb (Cardizem La)	T1	QL(1 tab/day) HD
diltiazem 24h er(la) 180 mg tb (Cardizem La)	T1	HD
diltiazem 24h er(la) 240 mg tb (Cardizem La)	T1	HD
diltiazem 24h er(la) 300 mg tb (Cardizem La)	T1	HD
diltiazem 24h er(la) 360 mg tb (Cardizem La)	T1	HD
diltiazem 24h er(la) 420 mg tb (Cardizem La)	T1	HD
diltiazem hcl	T1	HD
diltiazem hcl (Cardizem La)	T1	HD

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CARDIAC DRUGS (Blood Pressure/Heart Medications) *(cont.)*		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
CALCIUM CHANNEL BLOCKING AGENTS *(cont.)*		
diltiazem hcl (Tiazac)	T1	HD
DILTIAZEM HCL-0.7% NACL	T3	HD
DILTIAZEM HCL-0.9% NACL	T1	HD
felodipine	T1	HD
isradipine	T1	HD
NICARDIPIN 20MG/200ML-0.9%NACL	T3	HD
NICARDIPIN 40MG/200ML-0.9%NACL	T3	HD
NICARDIPINE 1 MG/10 ML-NS SYRG	T1	HD
nicardipine hcl	T1	HD
nicardipine hcl (Cardene I.v.)	T1	HD
NICARDIPINE HCL-D5W	T1	HD
nifedipine	T1	HD
nifedipine (Adalat Cc)	T1	HD
nifedipine (Procardia XI)	T1	HD
nifedipine (Procardia)	T1	HD
nisoldipine er 17 mg tablet (Sular)	T1	HD
nisoldipine er 20 mg tablet	T1	QL (1 tab/day) HD
nisoldipine er 25.5 mg tablet	T1	HD
nisoldipine er 30 mg tablet	T1	HD
nisoldipine er 34 mg tablet (Sular)	T1	HD
nisoldipine er 40 mg tablet	T1	HD
nisoldipine er 8.5 mg tablet (Sular)	T1	HD
NORLIQVA ORAL SOLN	T2	PA QL(10 mls/day) HD
NORVASC (*amlodipine besylate*)	T3	HD
NYMALIZE	T3	HD
PROCARDIA (*nifedipine*)	T3	HD
SULAR (*nisoldipine*)	T3	HD
TIAZAC (*tiadylt er*)	T3	HD
verapamil hcl	T1	HD
verapamil hcl (Calan Sr)	T1	HD
verapamil hcl (Verelan Pm)	T1	HD

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CARDIAC DRUGS (Blood Pressure/Heart Medications) *(cont.)*		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
CALCIUM CHANNEL BLOCKING AGENTS *(cont.)*		
verapamil hcl (Verelan)	T1	HD
VERELAN (*verapamil hcl*)	T3	HD
VERELAN (*verapamil sr*)	T3	HD
VERELAN PM (*verapamil er pm*)	T3	HD
CARDIOPLEGIC SOLUTIONS		
CARDIOPLEGIA DEL NIDO FORMULA	T3	
CARDIOPLEGIA HIGH POTASSIUM	T3	
CARDIOPLEGIA IND 8:1 NON-ENRCH	T3	
CARDIOPLEGIA INDUCTION 4:1	T3	
CARDIOPLEGIA INDUCTION 8:1	T3	
CARDIOPLEGIA MAINTENANCE 4:1	T3	
CARDIOPLEGIA MAINTENANCE 8:1	T3	
CARDIOPLEGIA REPERFUSATE 4:1	T3	
cardioplegic solution no.1 (Plegisol)	T1	
PLEGISOL	T3	
DIGITALIS GLYCOSIDES		
digoxin	T1	HD
digoxin (Lanoxin)	T1	HD
LANOXIN	T3	HD
LANOXIN (*digoxin*)	T3	HD
LANOXIN PEDIATRIC	T3	HD
HEART RATE REDUCING, SA SELECTIVE I (F) CURRENT INH.		
CORLANOR 5 MG TABLET	T2	PA HD
CORLANOR 5 MG/5 ML ORAL SOLN	T2	PA SP HD
CORLANOR 7.5 MG TABLET	T2	PA HD
INOTROPIC DRUGS		
dobutamine hcl	T1	
dobutamine hcl in dextrose 5 %	T1	
milrinone lactate	T1	
milrinone lactate/d5w	T1	
VASODILATORS, CORONARY		
DILATRATE-SR	T3	HD
isosorbide dinitrate	T1	HD
MINITRAN	T1	HD
NITRO-DUR	T3	HD

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CARDIAC DRUGS (Blood Pressure/Heart Medications) *(cont.)*		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
VASODILATORS, CORONARY *(cont.)*		
nitroglycerin (Nitro-dur)	T1	HD
nitroglycerin (Nitrolingual)	T1	HD
nitroglycerin (Nitromist)	T1	HD
nitroglycerin (Nitrostat)	T1	HD
nitroglycerin 50 mg/10 ml vial	T1	HD
nitroglycerin in 5 % dextrose	T1	HD
NITROLINGUAL (*nitroglycerin*)	T3	HD
NITROMIST (*nitroglycerin*)	T3	HD
NITROSTAT (*nitroglycerin*)	T3	HD
SOLUBLE GUANYLATE CYCLASE (SGC) STIMULATOR		
VERQUVO	T2	PA QL(1 tab/day)
CARDIOVASCULAR (Allergy/Nasal Sprays)		
SYMPATHOMIMETIC AGENTS		
AKOVAZ	T3	
BIORPHEN	T3	
EPHEDRINE SULFATE	T1	
ephedrine sulfate (Akovaz)	T1	
EPHEDRINE SULFATE-0.9% NACL	T1	
EPHEDRINE SULFATE-NACL	T1	
IMMPHENTIV	T3	
phenylephrine hcl (Vazculep)	T1	
phenylephrine hcl in 0.9% nacl (Phenylephrine Hcl-0.9% Nacl)	T1	
phenylephrine hcl/dextrose 5 %	T1	
PHENYLEPHRINE HCL-0.9% NACL	T1	
PHENYLEPHRINE HCL-0.9% NACL (*phenylephrine hcl-0.9% nacl*)	T1	
PHENYLEPHRINE HCL-D5W	T1	
REZIPRES		
VAZCULEP (*phenylephrine hcl*)	T3	
CARDIOVASCULAR (Asthma/COPD/Respiratory)		
PULM ANTI-HTN, SOLUBLE GUANYLATE CYCLASE STIMULATOR		
ADEMPAS	T3	PA SP HD
PULM.ANTI-HTN, SEL.C-GMP PHOSPHODIESTERASE T5 INHIB		
REVATIO 10 MG/12.5 ML VIAL	T3	PA SP HD
sildenafil citrate (Revatio)	T1	PA SP HD

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List of Prescription Medications

CARDIOVASCULAR (Asthma/COPD/Respiratory) *(cont.)*		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
PULM.ANTI-HTN, SEL.C-GMP PHOSPHODIESTERASE T5 INHIB *(con't.)*		
tadalafil (Adcirca)	T1	PA SP HD
PULMONARY ANTI-HTN, ENDOTHELIN RECEPTOR ANTAGONIST		
ambrisentan (Letairis)	T1	PA SP HD
bosentan (Tracleer)	T1	PA SP HD
LETAIRIS (*ambrisentan*)	T3	PA SP HD
OPSUMIT	T2	PA SP HD
TRACLEER 125 MG TABLET (*bosentan*)	T3	PA SP HD
TRACLEER 32 MG TABLET FOR SUSP	T2	PA SP HD
TRACLEER 62.5 MG TABLET (*bosentan*)	T3	PA SP HD
PULMONARY ANTIHYPERTENSIVES, PROSTACYCLIN-TYPE		
epoprostenol sodium	T3	PA SP HD
epoprostenol sodium 0.5 mg vl	T1	PA SP HD
epoprostenol sodium 0.5 mg vl (Flolan)	T1	PA SP
epoprostenol sodium 1.5 mg vl	T1	PA SP HD
epoprostenol sodium 1.5 mg vl (Flolan)	T1	PA SP
FLOLAN	T3	PA SP
ORENITRAM ER	T3	PA SP HD
ORENITRAM MONTH 1 TITRATION KT	T3	PA QL(168 tabs/180 days) SP HD
ORENITRAM MONTH 2 TITRATION KT	T3	PA QL(336 tabs/180 days) SP HD
ORENITRAM MONTH 3 TITRATION KT	T3	PA QL(252 tabs/180 days) SP HD
REMODULIN (*treprostinil*)	T3	PA SP HD
treprostinil sodium (Remodulin)	T1	PA SP HD
TYVASO	T3	PA SP HD
TYVASO INSTITUTIONAL START KIT	T3	PA SP HD
TYVASO REFILL KIT	T3	PA SP HD
TYVASO STARTER KIT	T3	PA SP HD
UPTRAVI	T2	PA SP HD
VENTAVIS	T3	PA SP HD
VELETRI VIAL	T1	PA SP
CARDIOVASCULAR (Blood Pressure/Heart Medications)		
ACE INHIBITOR-CALCIUM CHANNEL BLOCKER COMBINATION		
amlodipine besylate/benazepril	T1	HD
PRESTALIA 14 MG-10 MG TABLET	T3	HD
PRESTALIA 3.5 MG-2.5 MG TABLET	T3	QL (1 tab/day) HD

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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-THIAZIDE OR THIAZIDE-LIKE DIURETIC		
PRESTALIA 7 MG-5 MG TABLET	T3	QL (1 tab/day) HD
trandolapril/verapamil hcl	T1	HD
captopril-hctz 25-15 mg tablet	T1	QL (3 tabs/day) HD
captopril-hctz 25-25 mg tablet	T1	QL (2 tabs/day) HD
captopril-hctz 50-15 mg tablet	T1	QL (3 tabs/day) HD
captopril-hctz 50-25 mg tablet	T1	QL (2 tabs/day) HD
enalapril/hydrochlorothiazide	T1	HD
fosinopril/hydrochlorothiazide	T1	HD
lisinopril/hydrochlorothiazide	T1	HD
quinapril/hydrochlorothiazide	T1	HD
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
LABETALOL HCL 10 MG/2 ML SYRNG	T3	HD
labetalol hcl 100 mg tablet	T1	HD
labetalol hcl 100 mg/20 ml vl	T1	HD
labetalol hcl 20 mg/4 ml crpjt	T1	HD
labetalol hcl 20 mg/4 ml syrng	T1	HD
labetalol hcl 20 mg/4 ml vial	T1	HD
CARDURA (*doxazosin mesylate*)	T3	HD
CARDURA XL	T3	HD
labetalol hcl 200 mg tablet	T1	HD
labetalol hcl 200 mg/40 ml vl	T1	HD
labetalol hcl 300 mg tablet	T1	HD
doxazosin mesylate (Cardura)	T1	HD
MINIPRESS (*prazosin hcl*)	T3	HD

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CARDIOVASCULAR (Blood Pressure/Heart Medications) *(cont.)*		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
ALPHA/BETA-ADRENERGIC BLOCKING AGENTS *(cont.)*		
terazosin hcl	T1	HD
ANGIOTEN.RECEPTR ANTAG-CALCIUM CHANL BLKR-THIAZIDE		
amlodipine/valsartan/hcthiazid	T1	HD
olmesartan/amlodipin/hcthiazid	T1	HD
ANGIOTENSIN RECEPT-NEPRILYSIN INHIBITOR COMB (ARNI)		
ENTRESTO	T2	HD
ANGIOTENSIN RECEPTOR ANTAG.-THIAZIDE DIURETIC COMB		
candesartan/hydrochlorothiazid	T1	HD
irbesartan/hydrochlorothiazide	T1	HD
losartan/hydrochlorothiazide	T1	HD
olmesartan-hctz 20-12.5 mg tab	T1	QL (1 tab/day) HD
olmesartan-hctz 40-12.5 mg tab	T1	HD
olmesartan-hctz 40-25 mg tab	T1	HD
telmisartan-hctz 40-12.5 mg tb	T1	QL (1 tab/day) HD
telmisartan-hctz 80-12.5 mg tb	T1	HD
telmisartan-hctz 80-25 mg tab	T1	HD
valsartan/hydrochlorothiazide (Diovan Hct)	T1	HD
ANGIOTENSIN RECEPTOR BLOCKR-CALCIUM CHANNEL BLOCKR		
amlodipine besylate/valsartan	T1	HD
amlodipine-olmesartan 10-20 mg	T1	HD
amlodipine-olmesartan 10-40 mg	T1	HD
amlodipine-olmesartan 5-20 mg	T1	QL (1 tab/day) HD
amlodipine-olmesartan 5-40 mg	T1	HD
telmisartan-amlodipine 40-10	T1	HD
telmisartan-amlodipine 40-5 mg	T1	QL (1 tab/day) HD
telmisartan-amlodipine 80-10	T1	HD
telmisartan-amlodipine 80-5 mg	T1	HD
ANTIHYPERTENSIVES, ACE INHIBITORS		
benazepril hcl	T1	HD
captopril	T1	HD
enalapril maleate (Vasotec)	T1	HD
enalaprilat dihydrate	T1	HD
EPANED	T3	HD

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Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
ANTIHYPERTENSIVES, ACE INHIBITORS *(cont.)*		
fosinopril sodium	T1	HD
lisinopril (Zestril)	T1	HD
moexipril hcl	T1	HD
perindopril erbumine	T1	HD
quinapril hcl	T1	HD
ramipril	T1	HD
trandolapril	T1	HD
ANTIHYPERTENSIVES, ANGIOTENSIN RECEPTOR ANTAGONIST		
candesartan cilexetil	T1	HD
eprosartan mesylate	T1	HD
irbesartan	T1	HD
losartan potassium	T1	HD
olmesartan medoxomil 20 mg tab	T1	QL (1 tab/day) HD
olmesartan medoxomil 40 mg tab	T1	HD
olmesartan medoxomil 5 mg tab	T1	HD
telmisartan 20 mg tablet	T1	QL (1 tab/day) HD
telmisartan 40 mg tablet	T1	QL (1 tab/day) HD
telmisartan 80 mg tablet	T1	HD
valsartan	T1	HD
ANTIHYPERTENSIVES, GANGLIONIC BLOCKERS		
VECAMYL	T1	
ANTIHYPERTENSIVES, MISCELLANEOUS		
DEMSER (*metyrosine*)	T3	HD
metyrosine (Demser)	T1	HD
NITROPRESS	T3	HD
nitroprusside sodium (Nitropress)	T1	HD
ANTIHYPERTENSIVES, SYMPATHOLYTIC		
CATAPRES (*clonidine hcl*)	T3	HD
CATAPRES-TTS 1 (*clonidine*)	T3	HD
CATAPRES-TTS 2 (*clonidine*)	T3	HD
CATAPRES-TTS 3 (*clonidine*)	T3	HD
clonidine (Catapres-tts 1)	T1	HD
clonidine (Catapres-tts 2)	T1	HD
clonidine (Catapres-tts 3)	T1	HD

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Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
ANTIHYPERTENSIVES, SYMPATHOLYTIC *(cont.)*		
clonidine hcl 0.1 mg tablet (Catapres)	T1	HD
clonidine hcl 0.2 mg tablet (Catapres)	T1	HD
clonidine hcl 0.3 mg tablet (Catapres)	T1	HD
guanfacine hcl	T1	HD
methyldopa	T1	HD
methyldopa/hydrochlorothiazide	T1	HD
methyldopate hcl	T1	HD
ANTIHYPERTENSIVES, VASODILATORS		
CORLOPAM	T3	HD
hydralazine hcl	T1	HD
minoxidil	T1	HD
BETA-ADRENERGIC BLOCKING AGENTS		
acebutolol hcl	T1	HD
atenolol (Tenormin)	T1	HD
betaxolol hcl	T1	HD
bisoprolol fumarate	T1	HD
BREVIBLOC	T3	HD
esmolol hcl	T1	HD
esmolol hcl (Brevibloc)	T1	HD
ESMOLOL HCL-WATER	T1	HD
esmolol in sodium chloride, iso (Brevibloc)	T1	HD
INNOPRAN XL	T3	ST HD
metoprolol succinate (Toprol XL)	T1	HD
metoprolol tartrate	T1	HD
metoprolol tartrate (Lopressor)	T1	HD
nadolol	T1	HD
nadolol (Corgard)	T1	HD
pindolol	T1	HD
propranolol hcl	T1	HD
propranolol hcl (Inderal La)	T1	HD
sotalol hcl	T1	HD
sotalol hcl (Betapace Af)	T1	HD

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CARDIOVASCULAR (Blood Pressure/Heart Medications) *(cont.)*		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
BETA-ADRENERGIC BLOCKING AGENTS *(cont.)*		
SOTYLIZE SOLN	T3	HD
timolol maleate	T1	HD
BETA-BLOCKERS AND THIAZIDE, THIAZIDE-LIKE DIURETICS		
atenolol/chlorthalidone (Tenoretic 100)	T1	HD
atenolol/chlorthalidone (Tenoretic 50)	T1	HD
bisoprolol/hydrochlorothiazide (Ziac)	T1	HD
metoprolol/hydrochlorothiazide	T1	HD
nadolol/bendroflumethiazide	T1	HD
propranolol/hydrochlorothiazid	T1	HD
MUSCARINIC RECEPTOR ANTAGONISTS (ANTICHOLINERGIC)		
ATROPEN	T3	
PATENT DUCTUS ARTERIOSUS TREAT. AGENTS, NSAID-TYPE		
ibuprofen lysine/pf (Neoprofen)	T1	
indomethacin 1 mg vial	T1	
NEOPROFEN (*ibuprofen lysine*)	T3	
RENIN INHIBITOR, DIRECT		
aliskiren 150 mg tablet	T1	QL (1 tab/day) HD
aliskiren 300 mg tablet	T1	HD
VASODILATORS, COMBINATION		
BIDIL	T3	QL (6 tabs/day) HD
isosorbide-hydralazine 20-37.5 (Bidil)	T1	QL(6 tabs/day) HD
VASODILATORS, MISCELLANEOUS		
alprostadil	T1	
PROSTIN VR PEDIATRIC	T3	
VASODILATORS, PERIPHERAL		
ergoloid mesylates	T1	
isoxsuprine hcl	T1	
papaverine hcl	T1	
CARDIOVASCULAR (Cholesterol Medications)		
ANTIHYPERLIP.HMG COA REDUCT INHIB-CHOLEST.AB.INHIB		
ezetimibe/simvastatin	T1	HD
ROSZET	T3	HD
ANTIHYPERLIPID- HMG-COA RI-CALCIUM CHANNEL BLOCKER		
amlodipine-atorvast 10-40 mg (Caduet)	T1	HD

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CARDIOVASCULAR (Cholesterol Medications) *(cont.)*		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
ANTIHYPERLIPID- HMG-COA RI-CALCIUM CHANNEL BLOCKER *(cont.)*		
amlodipine-atorvast 10-80 mg (Caduet)	T1	HD
amlodipine-atorvast 2.5-10 mg	T1	HD
amlodipine-atorvast 2.5-20 mg	T1	QL (1 tab/day) HD
amlodipine-atorvast 2.5-40 mg	T1	QL (1 tab/day) HD
amlodipine-atorvast 5-10 mg (Caduet)	T1	HD
amlodipine-atorvast 5-20 mg (Caduet)	T1	QL (1 tab/day) HD
amlodipine-atorvast 5-40 mg (Caduet)	T1	QL (1 tab/day) HD
amlodipine-atorvast 5-80 mg (Caduet)	T1	HD
CADUET 10 MG-10 MG TABLET (*amlodipine-atorvastatin*)	T3	HD
CADUET 10 MG-20 MG TABLET (*amlodipine-atorvastatin*)	T3	HD
CADUET 10 MG-40 MG TABLET (*amlodipine-atorvastatin*)	T3	HD
CADUET 10 MG-80 MG TABLET (*amlodipine-atorvastatin*)	T3	HD
CADUET 5 MG-10 MG TABLET (*amlodipine-atorvastatin*)	T3	HD
CADUET 5 MG-20 MG TABLET (*amlodipine-atorvastatin*)	T3	QL (1 tab/day) HD
CADUET 5 MG-40 MG TABLET (*amlodipine-atorvastatin*)	T3	QL (1 tab/day) HD
CADUET 5 MG-80 MG TABLET (*amlodipine-atorvastatin*)	T3	HD
ANTIHYPERLIPIDEMIC - ANGIOPOIETIN-LIKE 3 INHIBITOR		
EVKEEZA	T3	PA SP
ANTIHYPERLIPIDEMIC - APO B-100 SYNTHESIS INHIBITOR		
KYNAMRO	T3	PA SP
ANTIHYPERLIPIDEMIC - PCSK9 INHIBITORS		
REPATHA PUSHTRONEX	T2	PA
REPATHA SURECLICK	T2	PA
REPATHA SYRINGE	T2	PA
ANTIHYPERLIPIDEMIC-HMGCOA REDUCTASE INHIB (STATINS)		
atorvastatin 10 mg tablet	T1	HD PPACA
atorvastatin 20 mg tablet	T1	HD PPACA
atorvastatin 40 mg tablet	T1	HD
atorvastatin 80 mg tablet	T1	HD
fluvastatin sodium	T1	HD PPACA
lovastatin 10 mg tablet	T1	HD
lovastatin 20 mg tablet	T1	HD PPACA
lovastatin 40 mg tablet	T1	HD PPACA
pitavastatin 1 mg tablet (Livalo)	T1	QL (1 tab/day) HD PPACA
pitavastatin 2 mg tablet (Livalo)	T1	QL (1 tab/day) HD PPACA

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List of Prescription Medications

CARDIOVASCULAR (Cholesterol Medications) *(cont.)*		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
ANTIHYPERLIPIDEMIC-HMGCOA REDUCTASE INHIB (STATINS) *(cont.)*		
pitavastatin 4 mg tablet (Livalo)	T1	HD PPACA
pravastatin sodium	T1	HD PPACA
rosuvastatin calcium 10 mg tab	T1	QL (1 tab/day) HD PPACA
rosuvastatin calcium 20 mg tab (Crestor)	T1	QL (1 tab/day) HD
rosuvastatin calcium 40 mg tab (Crestor)	T1	HD
rosuvastatin calcium 5 mg tab	T1	QL (1 tab/day) HD PPACA
simvastatin 10 mg tablet	T1	HD PPACA
simvastatin 20 mg tablet	T1	HD PPACA
simvastatin 40 mg tablet	T1	HD PPACA
simvastatin 5 mg tablet	T1	HD
BILE SALT SEQUESTRANTS		
cholestyramine (with sugar) (Questran)	T1	HD
cholestyramine/aspartame	T1	HD
cholestyramine/aspartame (Questran Light)	T1	HD
colesevelam hcl (Welchol)	T1	HD
COLESTID	T3	HD
COLESTID (*colestipol hcl*)	T3	HD
colestipol hcl (Colestid)	T1	HD
QUESTRAN (*cholestyramine*)	T3	HD
QUESTRAN LIGHT (*prevalite*)	T3	HD
LIPOTROPICS		
ezetimibe (Zetia)	T1	HD
fenofibrate	T1	HD
fenofibrate nanocrystallized (Tricor)	T1	HD
fenofibrate, micronized	T1	HD
fenofibrate 120 mg tablet (Fenoglide)	T1	HD
fenofibrate 40 mg tablet (Fenoglide)	T1	HD
fenofibric acid (choline) (Trilipix)	T1	HD
fenofibric acid (Fibricor)	T1	HD
FIBRICOR (*fenofibric acid*)	T3	ST HD
gemfibrozil (Lopid)	T1	HD
LIPOFEN	T3	ST HD
LOPID (*gemfibrozil*)	T3	HD

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CARDIOVASCULAR (Cholesterol Medications) *(cont.)*		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
LIPOTROPICS *(cont.)*		
niacin (Niaspan)	T1	HD
NIASPAN (*niacin er*)	T3	HD
TRICOR (*fenofibrate*)	T3	ST HD
TRIGLIDE	T3	ST HD
TRILIPIX (*fenofibric acid*)	T3	ST HD
ZETIA (*ezetimibe*)	T3	HD
CARDIOVASCULAR (Miscellaneous)		
VENOSCLEROSING AGENTS		
ASCLERA	T3	PA SP
ETHAMOLIN	T3	
sodium tetradecyl sulfate (Sotradecol)	T1	
SOTRADECOL	T3	
SOTRADECOL (*sodium tetradecyl sulfate*)	T3	
CNS DRUGS (Alzheimer's Disease)		
ALZHEIMER'S THERAPY, NMDA RECEPTOR ANTAGONISTS		
memantine hcl	T1	HD
memantine hcl (Namenda)	T1	HD
memantine hcl er 14 mg capsule (Namenda Xr)	T1	QL (1 cap/day) HD
memantine hcl er 28 mg capsule (Namenda Xr)	T1	HD
NAMENDA	T3	HD
NAMENDA (*memantine hcl*)	T3	HD
NAMENDA XR 14 MG CAPSULE (*memantine hcl er*)	T3	QL (1 cap/day) HD
NAMENDA XR 21 MG CAPSULE (*memantine hcl er*)	T3	HD
NAMENDA XR 28 MG CAPSULE (*memantine hcl er*)	T3	HD
NAMENDA XR 7 MG CAPSULE (*memantine hcl er*)	T3	QL (1 cap/day) HD
NAMENDA XR TITRATION PACK	T3	QL (112/365 days) HD
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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CNS DRUGS (Miscellaneous)		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
ALCOHOL, SYSTEMIC USE		
ALCOHOL, DEHYDRATED	T1	
ethyl alcohol	T1	
AMYOTROPHIC LATERAL SCLEROSIS AGENTS		
QALSODY	T3	
RADICAVA ORS	T3	PA SP QL(50ml/28days)
RADICAVA	T3	PA SP
RILUTEK (*riluzole*)	T3	SP HD
riluzole (Rilutek)	T1	SP HD
TIGLUTIK	T3	PA SP
CENTRAL NERVOUS SYSTEM STIMULANTS		
DOPRAM	T3	
doxapram hcl (Dopram)	T1	
DRUGS TO TREAT MOVEMENT DISORDERS		
AUSTEDO	T3	PA SP HD
AUSTEDO XR 6 MG TABLET	T3	PA QL (90 tabs/30 days) SP HD
AUSTEDO XR 12 MG TABLET	T3	PA QL (30 tabs/30 days) SP HD
AUSTEDO XR 24 MG TABLET	T3	PA QL (60 tabs/30 days) SP HD
AUSTEDO XR TITRATION KT(WK1-4)	T3	PA QL (1 kit/180 days) SP HD
INGREZZA	T4	PA SP
INGREZZA INITIATION PACK	T4	PA QL (28 caps/year) SP
tetrabenazine	T1	PA SP HD
PSEUDOBULBAR AFFECT (PBA) AGENTS, NMDA ANTAGONISTS		
NUEDEXTA	T3	QL (4 caps/day)
XANTHINES		
CAFCIT (*caffeine citrate*)	T3	HD
CAFFEINE AND SODIUM BENZOATE	T1	HD
caffeine citrate	T1	HD
caffeine citrate (Cafcit)	T1	HD
caffeine/sodium benzoate (Caffeine And Sodium Benzoate)	T1	HD
AGENTS TO TREAT MULTIPLE SCLEROSIS		
AVONEX	T2	PA SP HD
AVONEX PEN	T2	PA SP HD
BAFIERTAM	T2	PA SP HD
BETASERON	T2	PA SP HD

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CNS DRUGS (Miscellaneous) *(cont.)*		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
AGENTS TO TREAT MULTIPLE SCLEROSIS *(cont.)*		
BRIUMVI	T3	PA SP
dimethyl fumarate	T1	HD
glatopa	T1	HD
glatiramer	T1	HD
glatiramer acetate	T1	PA SP HD
KESIMPTA PEN	T2	PA SP HD
LEMTRADA	T3	PA SP HD
MAVENCLAD	T3	PA SP HD
MAYZENT	T2	PA SP HD
OCREVUS	T3	PA SP HD
PLEGRIDY	T2	PA SP HD
PLEGRIDY PEN	T2	PA SP HD
PONVORY	T2	PA SP HD
REBIF	T2	PA SP HD
REBIF REBIDOSE	T2	PA SP HD
teriflunomide (Aubagio)	T1	SP HD
VUMERITY	T2	PA SP HD
AGTS TX NEUROMUSC TRANSMISSION DIS, POT-CHAN BLKR		
dalfampridine	T1	PA SP HD
FIRDAPSE	T3	PA QL (8 tabs/day) SP
RUZURGI	T3	PA SP
CNS DRUGS (Pain Relief And Inflammatory Disease)		
CALCITONIN GENE-RELATED PEPTIDE (CGRP) INHIBITORS		
EMGALITY SYRINGE	T2	PA
CNS DRUGS (Seizure Disorders)		
ANTICONVULSANT - BENZODIAZEPINE TYPE		
clobazam (Onfi)	T1	HD
clonazepam	T1	HD
clonazepam (Klonopin)	T1	HD
DIASTAT (*diazepam*)	T3	PA HD
DIASTAT ACUDIAL (*diazepam*)	T3	PA HD
diazepam 10 mg rectal gel syst (Diastat Acudial)	T1	HD
diazepam 2.5 mg rectal gel sys (Diastat)	T1	HD

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List of Prescription Medications

CNS DRUGS (Seizure Disorders) *(con.t)*		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
ANTICONVULSANT - BENZODIAZEPINE TYPE *(cont.)*		
diazepam 20 mg rectal gel syst	T1	HD
KLONOPIN (*clonazepam*)	T3	PA HD
NAYZILAM	T2	PA QL (5 kits/30 days) HD
ONFI (*clobazam*)	T3	PA HD
VALTOCO	T3	PA QL (5 boxes/30 Days) HD
ANTICONVULSANT - CANNABINOID TYPE		
EPIDIOLEX	T3	PA SP HD
ANTICONVULSANTS		
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 10 MG TABLET	T3	PA HD
BRIVIACT 10 MG/ML ORAL SOLN	T3	PA HD
BRIVIACT 100 MG TABLET	T3	PA HD
BRIVIACT 25 MG TABLET	T3	PA HD
BRIVIACT 50 MG TABLET	T3	PA HD
BRIVIACT 50 MG/5 ML VIAL	T3	HD
BRIVIACT 75 MG TABLET	T3	PA HD
carbamazepine	T1	HD
carbamazepine (Carbatrol)	T1	HD
carbamazepine (Tegretol Xr)	T1	HD
carbamazepine (Tegretol)	T1	HD
CARBATROL (*carbamazepine er*)	T3	PA HD
CELONTIN	T2	HD
CEREBYX (*fosphenytoin sodium*)	T3	HD
DIACOMIT	T3	PA SP HD

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CNS DRUGS (Seizure Disorders) *(con.t)*		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
ANTICONVULSANTS *(cont.)*		
DILANTIN 100 MG CAPSULE (*phenytoin sodium extended*)	T3	PA HD
DILANTIN 30 MG CAPSULE	T2	PA HD
DILANTIN 50 MG INFATAB (*phenytoin*)	T3	PA HD
DILANTIN-125 (*phenytoin*)	T3	PA HD
divalproex sodium (Depakote Er)	T1	HD
divalproex sodium (Depakote Sprinkle)	T1	HD
divalproex sodium (Depakote)	T1	HD
ethosuximide (Zarontin)	T1	HD
felbamate	T1	HD
FINTEPLA	T3	PA SP HD
FYCOMPA 0.5 MG/ML ORAL SUSP	T2	PA HD
FYCOMPA 10 MG TABLET	T2	PA HD
FYCOMPA 12 MG TABLET	T2	PA HD
FYCOMPA 2 MG TABLET	T2	PA HD
FYCOMPA 4 MG TABLET	T2	PA QL (1 tab/day) HD
FYCOMPA 6 MG TABLET	T2	PA QL (1 tab/day) HD
FYCOMPA 8 MG TABLET	T2	PA HD
gabapentin (Gralise)	T1	HD
gabapentin (Neurontin)	T1	HD
GABITRIL 12 MG TABLET (*tiagabine hcl*)	T3	PA QL (8 tabs/day) HD
GABITRIL 16 MG TABLET (*tiagabine hcl*)	T3	PA QL (6 tabs/day) HD
GABITRIL 2 MG TABLET (*tiagabine hcl*)	T3	PA HD
GABITRIL 4 MG TABLET (*tiagabine hcl*)	T3	PA HD
KEPPRA (*levetiracetam*)	T3	HD
lacosamide (Vimpat)	T1	HD
lamotrigine	T1	HD
levetiracetam (Keppra)	T1	HD
levetiracetam in nacl (iso-os)	T1	HD
LYRICA (*pregabalin*)	T3	PA HD
NEURONTIN (*gabapentin*)	T3	PA HD
oxcarbazepine	T1	HD
OXTELLAR XR	T3	PA HD

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CNS DRUGS (Seizure Disorders) *(con.t)*		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
ANTICONVULSANTS *(cont.)*		
PEGANONE	T2	HD
PHENYTEK (*phenytoin sodium extended*)	T3	PA HD
phenytoin	T1	HD
phenytoin (Dilantin)	T1	HD
phenytoin (Dilantin-125)	T1	HD
phenytoin sodium	T1	HD
phenytoin sodium extended (Dilantin)	T1	HD
phenytoin sodium extended (Phenytek)	T1	HD
pregabalin	T1	HD
pregabalin (Lyrica)	T1	HD
primidone	T1	HD
primidone 250 mg tablet (Mysoline)	T1	HD
primidone 50 mg tablet (Mysoline)	T1	HD
rufinamide 200 mg tablet (Banzel)	T1	PA QL (16 tabs/day) HD
rufinamide 400 mg tablet (Banzel)	T1	PA QL (8 tabs/day) HD
SPRITAM	T3	PA HD
TEGRETOL (*carbamazepine*)	T3	PA HD
TEGRETOL (*epitol*)	T3	PA HD
TEGRETOL XR (*carbamazepine er*)	T3	PA HD
tiagabine hcl 12 mg tablet (Gabitril)	T1	QL (8 tabs/day) HD
tiagabine hcl 16 mg tablet (Gabitril)	T1	QL (6 tabs/day) HD
tiagabine hcl 2 mg tablet (Gabitril)	T1	HD
tiagabine hcl 4 mg tablet (Gabitril)	T1	HD
topiramate er 200 mg capsule (Trokendi Xr)	T1	HD
topiramate er 100 mg capsule (Trokendi Xr)	T1	QL(1 cap/day) HD
topiramate er 25 mg capsule (Trokendi Xr)	T1	QL(1 cap/day) HD
topiramate er 50 mg capsule (Trokendi Xr)	T1	HD
topiramate	T1	HD
valproic acid	T1	HD
valproic acid (as sodium salt)	T1	HD
vigabatrin	T1	SP HD
VIMPAT 10 MG/ML SOLUTION	T2	PA HD
VIMPAT 100 MG TABLET	T2	PA HD
VIMPAT 150 MG TABLET	T2	PA HD

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CNS DRUGS (Seizure Disorders) *(con.t)*		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
ANTICONVULSANTS *(cont.)*		
VIMPAT 200 MG TABLET	T2	PA HD
VIMPAT 200 MG/20 ML VIAL	T3	HD
VIMPAT 50 MG TABLET	T2	PA HD
XCOPRI 100 MG TABLET	T3	PA QL (1 tab/day) HD
XCOPRI 12.5-25 MG TITRATION PK	T3	PA QL (1/28 days) HD
XCOPRI 150 MG TABLET	T3	PA QL (1/day) HD
XCOPRI 150-200 MG TITRATION PK	T3	PA QL (1/28 days) HD
XCOPRI 200 MG TABLET	T3	PA QL (2/day) HD
XCOPRI 250 MG DAILY DOSE PACK	T3	PA QL (1/28 days) HD
XCOPRI 350 MG DAILY DOSE PACK	T3	PA QL (1/28 days) HD
XCOPRI 50 MG TABLET	T3	PA QL (1/day) HD
XCOPRI 50-100 MG TITRATION PAK	T3	PA QL (1/28 days) HD
ZARONTIN (*ethosuximide*)	T3	PA HD
zonisamide	T1	HD
CNS DRUGS (Sleep Disorders/Sedatives)		
NARCOLEPSY TX-H3-RECEPT.ANTAGONIST/INVERSE AGONIST		
WAKIX	T3	PA QL (2 tabs/day) SP HD
COLONY STIMULATING FACTORS (Blood Modifiers/Bleeding Disorders)		
ERYTHROPOIESIS-STIMULATING AGENTS		
ARANESP	T2	PA SP
EPOGEN	T2	PA SP
MIRCERA	T3	PA SP
PROCRIT	T2	PA SP
RETACRIT	T2	PA SP
LEUKOCYTE (WBC) STIMULANTS		
FULPHILA	T3	PA SP
GRANIX	T3	PA SP
LEUKINE	T2	SP
NEULASTA	T2	PA SP
NEULASTA ONPRO	T2	PA SP HD
NEUPOGEN	T3	PA SP
NIVESTYM	T2	SP
NYVEPRIA	T2	PA SP

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COLONY STIMULATING FACTORS (Blood Modifiers/Bleeding Disorders) *(cont.)*		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
LEUKOCYTE (WBC) STIMULANTS *(cont.)*		
STIMUFEND	T3	PA SP
UDENYCA	T2	PA SP
ZARXIO	T2	SP HD
ZIEXTENZO	T3	PA SP
THROMBOPOIETIN RECEPTOR AGONISTS		
DOPTELET	T3	PA SP HD
MULPLETA	T3	PA SP HD
NPLATE	T3	PA SP
PROMACTA	T3	PA SP HD
COLONY STIMULATING FACTORS (Cancer)		
CXCR4 CHEMOKINE RECEPTOR ANTAGONIST		
MOZOBIL	T3	PA SP
CONTRACEPTIVES (Contraception Products)		
CONTRACEPTIVES, INTRAVAGINAL, SYSTEMIC		
ANNOVERA	T3	
etonogestrel/ethinyl estradiol (Nuvaring)	T1	PPACA
NUVARING (*etonogestrel-ethinyl estradiol*)	T3	
CONTRACEPTIVES, IMPLANTABLE		
NEXPLANON	T3	SP PPACA
CONTRACEPTIVES, INJECTABLE		
DEPO-PROVERA 150 MG/ML SYRINGE (*medroxyprogesterone acetate*)	T3	
DEPO-PROVERA 150 MG/ML VIAL (*medroxyprogesterone acetate*)	T3	
DEPO-SUBQ PROVERA 104	T3	
CONTRACEPTIVES, ORAL		
BEYAZ (*rajani*)	T3	HD
desog-e.estradiol/e.estradiol (Mircette)	T1	HD PPACA
desogestrel-ethinyl estradiol	T1	HD PPACA
drospir/eth estra/levomefol ca (Beyaz)	T1	HD PPACA
drospir/eth estra/levomefol ca (Safyral)	T1	HD PPACA
ELLA	T3	HD PPACA
ESTROSTEP FE (*tri-legest fe*)	T3	HD
ethinyl estradiol/drospirenone (Yasmin 28)	T1	HD PPACA

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List of Prescription Medications

CONTRACEPTIVES (Contraception Products) *(cont.)*		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
CONTRACEPTIVES, ORAL *(cont.)*		
ethinyl estradiol/drospirenone (Yaz)	T1	HD PPACA
ethynodiol d-ethinyl estradiol	T1	HD PPACA
levonorgest/eth.estradiol/iron (Balcoltra)	T1	HD PPACA
l-norgest/e.estradiol-e.estrad (Loseasonique)	T1	HD PPACA
l-norgest/e.estradiol-e.estrad (Quartette)	T1	HD PPACA
l-norgest/e.estradiol-e.estrad (Seasonique)	T1	HD PPACA
LO LOESTRIN FE	T2	HD
LOESTRIN (*norethindron-ethinyl estradiol*)	T3	HD
LOESTRIN FE (*norethindrone-eth estradiol-fe*)	T3	HD
LOESTRIN FE (*tarina fe 1-20 eq*)	T3	HD
LOSEASONIQUE (*lojaimiess*)	T3	HD
MICROGESTIN 24 FE (*tarina 24 fe*)	T3	HD
MINASTRIN 24 FE (*norethin-eth estra-ferrous fum*)	T3	HD
MIRCETTE (*volnea*)	T3	HD
noreth-ethinyl estradiol/iron	T1	HD PPACA
noreth-ethinyl estradiol/iron (Generess Fe)	T1	HD PPACA
noreth-ethinyl estradiol/iron (Generess Fe)	T3	HD PPACA
norethind-eth estrad 1-0.02 mg (Loestrin)	T1	HD PPACA
norethindrone (Ortho Micronor)	T1	HD PPACA
norethindrone ac-eth estradiol (Loestrin)	T1	HD PPACA
norethindrone-e.estradiol-iron	T1	HD PPACA
norethindrone-e.estradiol-iron (Estrostep Fe)	T1	HD PPACA
norethindrone-e.estradiol-iron (Loestrin Fe)	T1	HD PPACA
norethindrone-e.estradiol-iron (Microgestin 24 Fe)	T1	HD PPACA
norethindrone-e.estradiol-iron (Minastrin 24 Fe)	T1	HD PPACA
norethindrone-ethin. estradiol	T1	HD PPACA
norethin-ee 1.5-0.03 mg (21) tb (Loestrin)	T1	HD PPACA
norgestrel-ethinyl estradiol	T1	HD PPACA
ORTHO MICRONOR (*tulana*)	T3	HD
QUARTETTE (*rivelsa*)	T3	HD
SAFYRAL (*tydemy*)	T3	HD
SEASONIQUE (*simpesse*)	T3	HD

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List of Prescription Medications

CONTRACEPTIVES (Contraception Products) *(cont.)*		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
CONTRACEPTIVES, ORAL *(cont.)*		
TYBLUME	T3	HD
YASMIN 28 (*zumandimine*)	T3	HD
YAZ (*vestura*)	T3	HD
CONTRACEPTIVES, TRANSDERMAL		
norelgestromin/ethin.estradiol	T1	HD PPACA
DIAPHRAGMS/CERVICAL CAP		
CAYA CONTOURED	T3	PPACA
FEMCAP	T3	PPACA
WIDE SEAL DIAPHRAGM	T3	PPACA
INTRA-UTERINE DEVICES (IUDS)		
KYLEENA	T3	SP PPACA
LILETTA	T3	SP PPACA
MIRENA	T3	SP PPACA
PARAGARD T 380-A	T3	SP PPACA
SKYLA	T3	SP PPACA
COUGH/COLD PREPARATIONS (Allergy/Nasal Sprays)		
IST GEN ANTIHIST-DECONGEST-ANTICHOLINERGIC COMB		
RESPA A.R.	T3	
COUGH/COLD PREPARATIONS (Cough/Cold Medications)		
ANTITUSSIVES, NON-OPIOID		
benzonatate	T1	
benzonatate (Tessalon Perle)	T1	
TESSALON PERLE (*benzonatate*)	T3	
NON-OPIOID ANTITUS-IST GEN.ANTIHISTAMINE-DECONGEST		
brompheniramine/pseudoephed/dm (Bromfed Dm)	T1	
NON-OPIOID ANTITUSSIVE-IST GEN ANTIHISTAMINE COMB.		
promethazine/dextromethorphan	T1	
OPIOID ANTITUSSIV-IST GEN. ANTIHISTAMINE-DECONGEST		
hydrocodone/cpm/pseudoephed	T1	PA
promethazine/phenyleph/codeine	T1	PA QL (480ml/22 days)
promethazine/phenyleph/codeine	T1	PA QL (480ml/30 days)
OPIOID ANTITUSSIVE-IST GENERATION ANTIHISTAMINE		
hydrocodone/chlorphen p-stirex	T1	PA
promethazine-codeine solution	T1	PA QL (480ml/22 days)
promethazine-codeine syrup	T1	PA QL (480ml/30 days)

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COUGH/COLD PREPARATIONS (Cough/Cold Medications) *(cont.)*		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
OPIOID ANTITUSSIVE-1ST GENERATION ANTIHISTAMINE *(cont.)*		
TUXARIN ER	T3	PA QL (2 tabs/day)
TUZISTRA XR	T3	PA QL (960ml/30 days)
OPIOID ANTITUSSIVE-ANTICHOLINERGIC COMBINATIONS		
HYCODAN (*hydromet*)	T3	PA QL (480ml/22 days)
hydrocodone bit/homatrop me-br (Hycodan)	T1	PA QL (480ml/22 days)
hydrocodone-homatropine 5-1.5	T1	PA QL (180 tabs/30 days)
hydrocodone-homatropine soln (Hycodan)	T1	PA QL (480ml/30 days)
HYDROCODONE-HOMATROPINE SYRUP	T1	PA QL (480ml/30 days)
OPIOID ANTITUSSIVE-EXPECTORANT COMBINATION		
HYDROCODONE-GUAIFENESIN	T1	PA QL (960ml/30 days)
OBREDON	T3	PA QL (960ml/30 days)
DIAGNOSTIC (Diabetes)		
BLOOD SUGAR DIAGNOSTICS		
ONETOUCH ULTRA TEST STRIP	T2	
ONETOUCH VERIO TEST STRIP	T2	
DIAGNOSTIC (Miscellaneous)		
ADRENAL RADIOACTIVE DIAGNOSTICS		
ADREVIEW	T3	
BILIARY DIAGNOSTICS		
CHOLETEC	T3	
TC99M MEBROFENIN PREP	T1	
BILIARY DIAGNOSTICS, RADIOPAQUE		
indocyanine green	T1	
SINOGRAFIN	T3	
CARDIOVASCULAR DIAGNOSTICS - RADIOACTIVE		
AMMONIA N-13	T3	
MYOVIEW	T3	
TC99M PYROPHOSPHATE PREP	T1	
TC99M SESTAMIBI PREP	T1	
THALLOUS CHLORIDE TL-201	T1	
CARDIOVASCULAR DIAGNOSTICS, NON-RADIOPAQUE AGENTS		
adenosine 60 mg/20 ml vial	T1	
adenosine 90 mg/30 ml vial	T1	
DEFINITY	T3	

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DIAGNOSTIC (Miscellaneous) *(cont.)*		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
CARDIOVASCULAR DIAGNOSTICS, NON-RADIOPAQUE AGENTS *(cont.)*		
dipyridamole 5 mg/ml vial	T1	
LEXISCAN	T3	
OPTISON	T3	
regadenoson 0.4 mg/5 ml syring	T1	
CARDIOVASCULAR DIAGNOSTICS-RADIOPAQUE		
ISOVUE-200	T3	
ISOVUE-250	T3	
ISOVUE-300	T3	
CARDIOVASCULAR DIAGNOSTICS-RADIOPAQUE		
ISOVUE-370	T3	
ISOVUE-M 200	T3	
ISOVUE-M 300	T3	
OMNIPAQUE	T3	
OPTIRAY 240	T3	
OPTIRAY 300	T3	
OPTIRAY 320	T3	
OPTIRAY 350	T3	
ULTRAVIST	T3	
VISIPAQUE	T3	
CEREBRAL SPINAL RADIOACTIVE DIAGNOSTICS		
CERETEC	T3	
INDIUM IN-111 DTPA	T3	
DOTAREM	T3	
gadoterate meglumine (Dotarem)	T1	
MAGNEVIST	T3	
MULTIHANCE	T3	
MULTIHANCE MULTIPACK	T3	
OMNISCAN	T3	
OMNISCAN PREFILL PLUS	T3	
OPTIMARK	T3	
PROHANCE	T3	
PROHANCE MULTIPACK	T3	
DIAGNOSTIC PREPARATIONS, MISCELLANEOUS		
ADVANCED DNA MEDICATED COLLECT	T3	

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DIAGNOSTIC (Miscellaneous) *(cont.)*		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
DIAGNOSTIC PREPARATIONS, MISCELLANEOUS *(cont.)*		
ARIDOL	T3	
DMSA	T3	
DRAXIMAGE DTPA	T3	
GADAVIST	T3	
gadobutrol	T1	
GLUCAGEN	T3	
GLUCAGON HCL	T1	
isosulfan blue (Lymphazurin)	T1	
lidocaine hcl/glycerin (Advanced Dna Medicated Collect)	T1	
LIPIODOL	T3	
LUMASON	T3	
LYMPHAZURIN	T3	
NETSPOT	T3	
PROVOCHOLINE	T3	
TC99M MEDRONATE PREP	T1	
TC99M SULFUR COLLOID PREP	T1	
DIAGNOSTIC RADIOPHARM - AMYLOID/TAU IMAGING		
AMYVID	T3	
VIZAMYL	T3	PA
DIAGNOSTIC RADIOPHARM - DOPAMINE TRANSPORTER (DAT)		
DATSCAN	T3	
EYE DIAGNOSTIC AGENTS		
AK-FLUOR	T3	
AK-FLUOR (*fluorescite*)	T3	
fluorescein sodium	T1	
fluorescein sodium (Ak-fluor)	T1	
ful-glo 1 mg opth strip	T1	
FUL-GLO EYE STRIPS	T3	
lissamine green	T1	
FLUORESCENCE CYSTOSCOPY/OPTICAL IMAGING AGENTS		
CYSVIEW	T3	
GASTROINTESTINAL RADIOPAQUE DIAGNOSTICS		
ENTERO VU	T3	
E-Z DISK	T3	

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DIAGNOSTIC (Miscellaneous) *(cont.)*		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
GASTROINTESTINAL RADIOPAQUE DIAGNOSTICS *(cont.)*		
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	T3	
VARIBAR NECTAR	T3	
VARIBAR PUDDING	T3	
VARIBAR THIN HONEY	T3	
VARIBAR THIN LIQUID	T3	
HEPATIC DIAGNOSTICS		
EOVIST	T3	
HISTAMINE PREPARATIONS		
HISTATROL INTRADERMAL	T3	
HISTATROL PERCUTANEOUS	T3	
METABOLIC FUNCTION DIAGNOSTICS		
CHIRHOSTIM	T3	
METOPIRONE	T3	
R-GENE 10	T3	
NEOPLASM MONOCLONAL DIAGNOSTIC AGENTS		
PROSTASCINT	T3	
RADIOACTIVE DIAGNOSTICS, GENERAL		
OCTREOSCAN	T3	
RADIOACTIVE DX RADIOLABEL OF AUTOLOGOUS LEUKOCYTES		
INDIUM IN-111 OXYQUINOLINE	T1	
RADIOACTIVE DX RADIOLABEL OF SYNTHETIC AMINO ACIDS		
AXUMIN	T3	

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List of Prescription Medications

DIAGNOSTIC (Miscellaneous) *(cont.)*		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
RADIOACTIVE METABOLIC FUNCTION DIAGNOSTICS		
FLUDEOXYGLUCOSE F-18	T3	
RADIOPHARMACEUTICALS ELEMENTS		
GA 68 DOTATOC	T3	
INDICLOR	T3	
RENAL FUNCTION DIAGNOSTICS AGENTS		
indigotindisulfonate sodium	T3	
URINARY TRACT RADIOPAQUE DIAGNOSTICS		
CONRAY	T3	
CONRAY-30	T3	
URINARY TRACT RADIOPAQUE DIAGNOSTICS		
CONRAY-43	T3	
CYSTO-CONRAY II	T3	
CYSTOGRAFIN	T3	
CYSTOGRAFIN-DILUTE	T3	
diatrizoate meglumine, sodium	T3	
diatrizoate meglumine, sodium (Gastrografin)	T1	
GASTROGRAFIN (*md-gastroview*)	T3	
DIURETICS (Diuretics)		
ARGININE VASOPRESSIN (AVP) RECEPTOR ANTAGONISTS		
TOLVAPTAN 15 MG TABLET	T3	SP
tolvaptan 30 mg tablet (Samsca)	T1	SP
VAPRISOL-5% DEXTROSE	T3	
CARBONIC ANHYDRASE INHIBITORS		
acetazolamide	T1	HD
acetazolamide sodium	T1	HD
methazolamide	T1	HD
LOOP DIURETICS		
bumetanide	T1	HD
FUROSCIX	T3	QL(2 kits/30 days) HD
furosemide	T1	HD
furosemide (Lasix)	T1	HD
FUROSEMIDE-0.9% NACL	T1	HD
SODIUM EDECRIN (*ethacrynate sodium*)	T3	HD
torsemide	T1	HD

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DIURETICS (Diuretics) *(cont.)*		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
OSMOTIC DIURETICS		
mannitol	T3	
mannitol (Osmitrol)	T1	
OSMITROL (*mannitol*)	T3	
POLYCYSTIC KIDNEY DISEASE AGENT, AVP RECEP. ANTAG		
JYNARQUE 15 MG TABLET	T3	SP
JYNARQUE 15 MG-15 MG TABLET	T3	PA SP
POLYCYSTIC KIDNEY DISEASE AGENT, AVP RECEP. ANTAG		
JYNARQUE 30 MG TABLET	T3	SP
JYNARQUE 30 MG-15 MG TABLET	T3	PA SP
JYNARQUE 45 MG-15 MG TABLET	T3	PA SP
JYNARQUE 60 MG-30 MG TABLET	T3	PA SP
JYNARQUE 90 MG-30 MG TABLET	T3	PA SP
POTASSIUM SPARING DIURETICS		
amiloride hcl	T1	HD
CAROSPIR SUSP	T2	PA HD
CAROSPIR *(spironolactone)*	T1	HD
eplerenone (Inspra)	T1	HD
INSPRA (*eplerenone*)	T3	HD
KERENDIA	T2	PA QL (30 tabs/30 days) HD
spironolactone	T1	HD
spironolactone (Aldactone) (Carospir)	T1	HD
triamterene (Dyrenium)	T1	HD
POTASSIUM SPARING DIURETICS IN COMBINATION		
ALDACTAZIDE	T3	HD
ALDACTAZIDE (*spironolactone-hctz*)	T3	HD
amiloride/hydrochlorothiazide	T1	HD
DYAZIDE (*triamterene-hydrochlorothiazid*)	T3	HD
MAXZIDE (*triamterene-hydrochlorothiazid*)	T3	HD
MAXZIDE-25 MG (*triamterene-hydrochlorothiazid*)	T3	HD
spironolact/hydrochlorothiazid (Aldactazide)	T1	HD
triamterene/hydrochlorothiazid (Dyazide)	T1	HD
triamterene/hydrochlorothiazid (Maxzide)	T1	HD
triamterene/hydrochlorothiazid (Maxzide-25 Mg)	T1	HD

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DIURETICS (Diuretics) *(cont.)*		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
THIAZIDE AND RELATED DIURETICS		
chlorothiazide sodium (Sodium Diuril)	T1	HD
chlorthalidone	T1	HD
DIURIL	T3	HD
hydrochlorothiazide	T1	HD
indapamide	T1	HD
metolazone	T1	HD
SODIUM DIURIL (*chlorothiazide sodium*)	T3	HD
EENT PREPS (Allergy/Nasal Sprays)		
NASAL ANTIHISTAMINE		
azelastine 0.1% (137 mcg) spry	T1	HD
azelastine 0.15% nasal spray	T1	HD
olopatadine 665 mcg nasal spry (Patanase)	T1	HD
PATANASE (*olopatadine hcl*)	T3	HD
NASAL ANTIHISTAMINE AND ANTI-INFLAM. STEROID COMB.		
azelastine/fluticasone	T1	HD
NASAL ANTI-INFLAMMATORY STEROIDS		
flunisolide	T1	HD
fluticasone prop 50 mcg spray	T1	HD
mometasone furoate 50 mcg spry	T1	QL (4 bots/30 days) HD
NOSE PREPARATIONS, MISCELLANEOUS (RX)		
ipratropium bromide	T1	HD
NOSE PREPARATIONS, VASOCONSTRICTORS (RX)		
ADRENALIN CHLORIDE	T3	
epinephrine hcl (Adrenalin Chloride)	T1	
EENT PREPS (Ear Medications)		
EAR PREPARATIONS ANTI-INFLAMMATORY		
DERMOTIC (*fluocinolone acetonide oil*)	T3	
fluocinolone acetonide oil (Dermotic)	T1	
EAR PREPARATIONS, MISC. ANTI-INFECTIVES		
hydrocortisone/acetic acid	T1	
EENT PREPS (Eye Conditions)		
ARTIFICIAL TEARS		
LACRISERT	T3	

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EENT PREPS (Eye Conditions) *(cont.)*		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
EYE ANTI-INFECTIVES (RX ONLY)		
BETADINE	T3	
EYE ANTI-INFLAMMATORY AGENTS		
ACUVAIL	T3	
ALREX	T3	
bromfenac sodium (Bromsite)	T1	
EYE ANTI-INFLAMMATORY AGENTS *(con't.)*		
BROMSITE .*(bromfenac sodium)*	T2	
dexamethasone 0.1% eye drop	T1	
diclofenac 0.1% eye drops	T1	
EYSUVIS	T2	QL (8.3ml/14 days)
FLAREX 0.1% EYE DROPS	T2	
fluorometholone (Fml)	T1	
flurbiprofen sodium	T1	
ILEVRO	T3	
ILUVIEN	T3	SP
INVELTYS 1% EYE DROP	T2	
ketorolac 0.4% ophth solution (Acular Ls)	T1	
ketorolac 0.5% ophth solution (Acular)	T1	
LOTEMAX 0.5% EYE OINTMENT	T2	
LOTEMAX (*loteprednol etabonate*)	T3	
LOTEMAX SM 0.38% OPHTH GEL	T2	
loteprednol etabonate (Lotemax)	T1	
OMNIPRED (*prednisolone acetate*)	T3	
OZURDEX	T3	SP
prednisolone acetate (Pred Forte)	T1	
prednisolone sodium phosphate	T1	
PROLENSA	T3	
TRIESENCE	T3	
EYE IRRIGATIONS		
balanced salt irrig soln no.2	T1	
balanced salt irrig soln no.2	T3	
BSS PLUS	T3	

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EENT PREPS (Eye Conditions) *(cont.)*		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
EYE LOCAL ANESTHETICS		
AKTEN	T3	
ALCAINE (*proparacaine hcl*)	T3	
ALTAFLUOR BENOX (*flurox*)	T3	
benoxinate hcl/fluorescein sod (Altafluor Benox)	T1	
benoxinate hcl/fluorescein sod (Altafluor Benox)	T3	
proparacaine hcl (Alcaine)	T1	
proparacaine/fluorescein sod	T1	
proparacaine/fluorescein sod	T3	
tetracaine hcl	T1	
TETRAVISC	T3	
TETRAVISC FORTE	T3	
EYE MAST CELL STABILIZERS		
cromolyn 4% eye drops	T1	
EYE MYDRIATIC AND NSAID COMBINATIONS		
OMIDRIA	T3	
EYE PREPARATIONS, MISCELLANEOUS (OTC)		
GELFILM	T3	
EYE VASOCONSTRICTORS		
phenylephrine hcl	T1	
MIOTICS AND OTHER INTRAOCULAR PRESSURE REDUCERS		
apraclonidine hcl (Iopidine)	T1	HD
AZOPT (*brinzolamide*)	T3	HD
betaxolol hcl	T1	HD
BETOPTIC S 0.25% DROPS	T2	HD
bimatoprost	T1	QL (10 gm/30 days) HD
brimonidine tartrate	T1	HD
brimonidine tartrate (Alphagan P)	T1	HD
brimonidine tartrate/timolol (Combigan)	T1	HD
brinzolamide (Azopt)	T1	HD
carbachol	T3	HD
carteolol hcl	T1	HD
COMBIGAN	T2	HD
dorzolamide hcl (Trusopt)	T1	HD

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Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
MIOTICS AND OTHER INTRAOCULAR PRESSURE REDUCERS *(cont.)*		
dorzolamide hcl/timolol maleat (Cosopt)	T1	HD
dorzolamide/timolol/pf (Cosopt Pf)	T1	HD
DURYSTA	T3	PA SP HD
IOPIDINE	T3	HD
IOPIDINE (*apraclonidine hcl*)	T3	HD
ISOPTO CARPINE (*pilocarpine hcl*)	T3	HD
latanoprost	T1	HD
levobunolol hcl	T1	HD
MIOCHOL-E	T3	HD
PHOSPHOLINE IODIDE	T3	HD
pilocarpine hcl (Isopto Carpine)	T1	HD
RHOPRESSA	T3	HD
ROCKLATAN	T3	HD
SIMBRINZA	T2	HD
timolol maleate (Istalol)	T1	HD
timolol maleate (Timoptic)	T1	HD
timolol maleate (Timoptic-xe)	T1	HD
timolol maleate/pf (Timoptic Ocudose)	T1	HD
travoprost	T1	HD
MYDRIATICS		
atropine 1% eye drops (Isopto Atropine)	T1	HD
atropine 1% eye ointment	T1	HD
ATROPINE SULFATE-0.9% NACL	T3	HD
CYCLOGYL	T3	HD
CYCLOGYL (*cyclopentolate hcl*)	T3	HD
CYCLOMYDRIL	T3	HD
cyclopentolate hcl (Cyclogyl)	T1	HD
homatropine hbr	T1	HD
MYDRIACYL (*tropicamide*)	T3	HD
PAREMYD	T3	HD
tropicamide	T1	HD
tropicamide (Mydriacyl)	T1	HD

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EENT PREPS (Eye Conditions) *(cont.)*		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
OPHTH VASC. ENDOTHELIAL GROWTH FACTOR ANTAGONISTS		
EYLEA	T3	PA SP
OPHTH. VEGF-A RECEPTOR ANTAG. RCMB MC ANTIBODY		
BEOVU	T3	PA SP
LUCENTIS	T3	PA SP
OPHTHALMIC ANTIFIBROTIC AGENTS		
MITOSOL	T3	
OPHTHALMIC ANTI-INFLAMMATORY IMMUNOMODULATOR-TYPE		
CEQUA	T3	HD
RESTASIS	T2	HD
VEVYE		
XIIDRA	T2	HD
OPHTHALMIC COMPLEMENT INHIBITORS		
SYFOVRE	T3	PA SP HD
OPHTHALMIC CYSTINE DEPLETING AGENTS		
CYSTADROPS	T3	PA QL (20ml/21 days) SP
CYSTARAN	T3	PA QL (120ml/28 days) SP
OPHTHALMIC HUMAN NERVE GROWTH FACTOR (HNGF)		
OXERVATE	T3	PA SP HD
OPHTHALMIC PREPARATIONS, MISCELLANEOUS		
AMVISC	T3	SP
AMVISC PLUS	T3	SP
DISCOVISC	T3	
DUOVISC	T3	
HEALON (*biolon*)	T3	SP
HEALON5	T3	
hyaluronate sodium (Provisc)	T1	SP
PROVISC 10MG/ML DISP SYR	T3	SP
TOTALVISC	T3	SP
VISCOAT	T3	
OPHTHALMIC SURGICAL AIDS		
CELLUGEL	T3	
hypromellose (Cellugel)	T1	
MEMBRANEBLUE	T3	
VISIONBLUE	T3	

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ELECT/CALORIC/H2O (Cholesterol Medications)		
ORAL LIPID SUPPLEMENTS		
DOJOLVI	T3	PA SP HD
ELECT/CALORIC/H2O (Dental Products)		
FLUORIDE PREPARATIONS		
CLINPRO 5000	T3	
fluoride (sodium) (Prevident 5000 Ortho Defense)	T1	
fluoride (sodium) (Prevident 5000 Plus)	T1	
fluoride (sodium) (Prevident 5000)	T1	
fluoride (sodium) (Prevident)	T1	
FLUORIDEX	T1	
FLUORIDEX SENSITIVITY RELIEF	T3	
PREVIDENT	T3	
PREVIDENT (*sodium fluoride*)	T3	
PREVIDENT 5000	T3	
PREVIDENT 5000 ENAMEL PROTECT	T3	
PREVIDENT 5000 ORTHO DEFENSE	T3	
PREVIDENT 5000 PLUS (*sodium fluoride 5000 plus*)	T3	
PREVIDENT 5000 SENSITIVE	T3	
sodium fluoride/potassium nit (Prevident 5000 Sensitive)	T1	
ELECT/CALORIC/H2O (Diabetes)		
AGENTS TO TREAT HYPOGLYCEMIA (HYPERGLYCEMICS)		
BAQSIMI	T2	QL (2/30 days)
diazoxide (Proglycem)	T1	
glucagon 1 mg emergency kit	T1	QL (2 pens/30 days)
GLUCAGON 1 MG EMERGENCY KIT	T3	QL (2 pens/30 days)
PROGLYCEM (*diazoxide*)	T3	
ZEGALOGUE	T2	QL (2 units/23 days)
ELECT/CALORIC/H2O (Miscellaneous)		
BICARBONATE PRODUCING/CONTAINING AGENTS		
sodium acetate	T1	
sodium bicarbonate	T1	
sodium bicarbonate in d5w	T1	
DRUGS USED TO TREAT ACIDOSIS		
THAM	T3	

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ELECT/CALORIC/H2O (Miscellaneous) *(cont.)*		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
IV SOLUTIONS: DEXTROSE AND LACTATED RINGERS		
dextrose 5%-lactated ringers	T1	
IV SOLUTIONS: DEXTROSE-SALINE		
dextrose 10 % and 0.2 % nacl	T1	
dextrose 10 % and 0.45 % nacl	T1	
dextrose 2.5 % and 0.45 % nacl	T1	
dextrose 5 % and 0.3 % nacl	T1	
dextrose 5 % and 0.9 % nacl	T1	
dextrose 5 %-0.2 % sod chlorid	T1	
dextrose 5 %-0.45 % sod chlord	T1	
dextrose 10 % in water	T1	
dextrose 20 % in water	T1	
dextrose 25 % in water	T1	
dextrose 30 % in water	T1	
dextrose 40 % in water	T1	
dextrose 5 % in water	T1	
dextrose 5 % in water (Glucose In Water)	T1	
dextrose 50 % in water	T1	
dextrose 70 % in water	T1	
GLUCOSE IN WATER (*dextrose in water*)	T1	
NUCLEIC ACID/NUCLEOTIDE SUPPLEMENTS		
XURIDEN	T3	PA SP
PARENTERAL AMINO ACID SOLUTIONS AND COMBINATIONS		
AA 3%-D10W-CALCIUM-HEPARIN	T3	
AMINOSYN	T3	
AMINOSYN II	T3	
AMINOSYN II WITH ELECTROLYTES	T3	
AMINOSYN M	T3	
AMINOSYN WITH ELECTROLYTES	T3	
AMINOSYN-PF	T3	
AMINOSYN-RF	T3	
CLINIMIX	T3	
CLINIMIX E	T3	
CLINISOL	T3	
HEPATAMINE	T3	

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ELECT/CALORIC/H2O (Miscellaneous) *(cont.)*		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
PARENTERAL AMINO ACID SOLUTIONS AND COMBINATIONS *(cont.)*		
KABIVEN	T3	
parenteral amino acid 10% no.4	T3	
parenteral amino acid 10% no.6	T3	
parenteral amino acid 10% no.7	T3	
PERIKABIVEN	T3	
PLENAMINE	T3	
PROCALAMINE	T3	
PROSOL	T3	
TROPHAMINE	T3	
ELECT/CALORIC/H2O (Nutritional/Dietary)		
CALCIUM REPLACEMENT		
calcium chloride	T1	
calcium gluc 1,000mg/50ml-nacl	T1	
calcium glu 2,000mg/100ml-nacl	T1	
calcium gluconate	T1	
calcium gluconate in 0.9% nacl (Calcium Gluconate-0.9% Nacl)	T1	
CALCIUM GLUCONATE-0.9% NACL	T1	
CALCIUM GLUCONATE-0.9% NACL (*calcium gluconate-0.9% nacl*)	T1	
CALCIUM GLUCONATE-D5W	T1	
ELECTROLYTE MAINTENANCE		
AURYXIA	T3	QL (12 tabs/day)
calcium acetate	T1	
electrolyte-48 solution/d5w	T1	
FOSRENOL 1, 000 MG POWDER PACK	T2	
FOSRENOL 1, 000 MG TABLET CHEW (*lanthanum carbonate*)	T3	
FOSRENOL 500 MG TABLET CHEW (*lanthanum carbonate*)	T3	
FOSRENOL 750 MG POWDER PACKET	T2	
FOSRENOL 750 MG TABLET CHEW (*lanthanum carbonate*)	T3	
IONOSOL B WITH DEXTROSE 5%	T3	
IONOSOL MB-DEXTROSE 5%	T3	
ISOLYTE P WITH DEXTROSE	T3	
ISOLYTE S	T3	
lanthanum carbonate (Fosrenol)	T1	

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ELECT/CALORIC/H2O (Nutritional/Dietary) *(cont.)*		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
ELECTROLYTE MAINTENANCE *(cont.)*		
LOKELMA	T2	
NORMOSOL-M AND DEXTROSE	T3	
NORMOSOL-R	T3	
NORMOSOL-R AND DEXTROSE	T3	
NORMOSOL-R PH 7.4	T3	
PLASMA-LYTE 148	T3	
PLASMA-LYTE A PH 7.4	T3	
ringer's solution	T1	
ringer's solution, lactated	T1	
sevelamer carbonate (Renvela)	T1	
sevelamer hcl	T1	
sevelamer hcl (Renagel)	T1	
sodium polystyrene sulfon/sorb	T1	
sodium polystyrene sulfonate	T1	
sps 15 gm/60 ml suspension	T1	
sps 30 gm/120 ml enema susp	T3	
TPN ELECTROLYTES	T3	
TPN ELECTROLYTES II	T3	
VELPHORO	T2	
VELTASSA	T2	
IODINE CONTAINING AGENTS		
IODOPEN	T3	
potassium iodide/iodine	T1	
SSKI	T1	
IRON REPLACEMENT		
CITRANATAL BLOOM	T3	
FERAHEME	T3	PA
FERRLECIT (*sod ferric gluconate complex*)	T3	
INFED	T3	
INJECTAFER	T3	PA
iron dextran complex (Infed)	T3	
MONOFERRIC	T3	PA
mv-mins no.73/iron fum/folic (Hemocyte Plus)	T1	

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ELECT/CALORIC/H2O (Nutritional/Dietary) *(cont.)*		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
IRON REPLACEMENT *(cont.)*		
sodium ferric gluconat/sucrose (Ferrlecit)	T1	
TRIFERIC	T3	
VENOFER	T3	
MAGNESIUM SALTS REPLACEMENT		
magnesium chloride	T1	
magnesium sulfate	T1	
magnesium sulfate in water	T1	
MAGNESIUM SULFATE-0.9% NACL	T1	
MAGNESIUM SULFATE-D5W	T1	
MAGNESIUM-LACTATED RINGERS	T1	
MINERAL REPLACEMENT, MISCELLANEOUS		
ADDAMEL N	T3	
chromic chloride	T1	
cupric chloride	T1	
manganese chloride	T1	
manganese sulfate	T1	
MULTITRACE-4 CONC VIAL	T1	
multitrace-4 vial	T3	
MULTITRACE-4 VIAL	T1	
MULTITRACE-5	T1	
PEDITRACE	T3	
SELENIOUS ACID	T1	
TRALEMENT	T3	
PHOSPHATE REPLACEMENT		
GLYCOPHOS	T3	
potassium phos, m-basic-d-basic	T1	
POTASSIUM PHOSPHATE-0.9% NACL	T1	
POTASSIUM PHOSPHATES	T3	
potassium phos,m-basic-d-basic	T1	
potassium cl er 15 meq tablet	T1	
sod phosphate, monobasic-dibas	T1	
SODIUM PHOSPHATE-0.9% NACL	T1	
POTASSIUM REPLACEMENT		
EFFER-K 10 MEQ TABLET EFF	T3	
EFFER-K 20 MEQ TABLET EFF	T3	

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List of Prescription Medications

ELECT/CALORIC/H2O (Nutritional/Dietary) *(cont.)*		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
POTASSIUM REPLACEMENT *(cont.)*		
effer-k 25 meq tablet eff	T1	
klor-con 10 meq tablet (K-tab Er)	T1	
klor-con 10 meq tablet (K-tab Er)	T3	
klor-con 8 meq tablet	T1	
klor-con 8 meq tablet	T3	
potassium acetate	T1	
potassium bicarbonate/cit ac	T1	
potassium chloride	T1	
potassium chloride	T3	
potassium chloride (K-tab Er)	T1	
potassium chloride in 0.9%nacl	T1	
potassium chloride in d5w	T1	
potassium chloride in lr-d5	T1	
potassium chloride in water	T1	
potassium chloride/d5-0.2%nacl	T1	
potassium chloride/d5-0.3%nacl	T1	
potassium chloride/d5-0.45nacl	T1	
potassium chloride/d5-0.9%nacl	T1	
potassium chloride-0.45% nacl	T1	
POTASSIUM CHLORIDE-0.9% NACL	T1	
potassium cl/lido/0.9 % nacl (Potassium Cl-lidocaine-ns)	T1	
POTASSIUM CL-LIDOCAINE-NS (*potassium cl-lidocaine-ns*)	T1	
SODIUM/SALINE PREPARATIONS		
0.9 % sodium chloride	T1	
KENDALL 0.9% NACL WITH CAP	T1	
sodium chloride 0.45 %	T1	
sodium chloride 0.9 % (flush)	T1	
sodium chloride 3 %	T1	
sodium chloride 5 %	T1	
SWABFLUSH	T3	

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ELECT/CALORIC/H2O (Nutritional/Dietary) *(cont.)*		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
ZINC REPLACEMENT		
zinc chloride	T1	
zinc sulfate	T1	
ELECT/CALORIC/H2O (Urinary Tract Conditions)		
DIALYSIS SOLUTIONS		
DELFLEX WITH 1.5% DEXTROSE	T3	
DELFLEX-2.5% DEXTROSE	T3	
DIANEAL PD-2 W-1.5% DEXTROSE	T3	
DIANEAL PD-2 W-2.5% DEXTROSE	T2	
DIANEAL PD-2 W-4.25% DEXTROSE	T3	
DIANEAL WITH 1.5% DEXTROSE	T3	
DIANEAL WITH 2.5% DEXTROSE	T3	
DIANEAL WITH 4.25% DEXTROSE	T3	
EXTRANEAL ICODEXTRIN DIALYSIS	T3	
perit. dialysis no.6-1.5 % dex (Dianeal With 1.5% Dextrose)	T3	
periton.dialysis 7-2.5 % dextr (Dianeal With 2.5% Dextrose)	T3	
periton.dialysis 8-4.25 % dext (Dianeal With 4.25% Dextrose)	T3	
PHOXILLUM	T3	
PRISMASOL	T3	
URINARY PH MODIFIERS		
K-PHOS NO.2	T3	HD
K-PHOS ORIGINAL	T3	HD
ORACIT	T3	HD
URINARY PH MODIFIERS		
potassium citrate (Urocit-k)	T1	HD
potassium citrate/citric acid	T1	HD
RENACIDIN	T3	HD
UROCIT-K (*potassium citrate er*)	T3	HD
UROQID-ACID NO.2	T3	HD
GASTROINTESTINAL (Cholesterol Medications)		
LIPOTROPICS		
icosapent ethyl (Vascepa)	T1	HD
LOVAZA (*triklo*)	T3	HD
omega-3 acid ethyl esters (Lovaza)	T1	HD
VASCEPA	T2	PA HD

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List of Prescription Medications

GASTROINTESTINAL (Gastrointestinal/Heartburn)		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
AMMONIA INHIBITORS		
AMMONUL (*sodium phenylacet-sod benzoate*)	T3	HD
lactulose	T1	HD
lactulose 10 gm/15 ml solution	T1	
LITHOSTAT	T3	HD
OLPRUVA	T3	PA SP HD
PHEBURANE	T2	PA QL(8 Bottles/30 Days) SP HD
sodium benzoate/sod phenylacet (Ammonul)	T1	HD
sodium phenylbutyrate (Buphenyl)	T1	SP HD
ANTICHOLINERGICS, QUATERNARY AMMONIUM		
chlordiazepoxide/clidinium br	T1	
CUVPOSA	T3	
GLYCATE	T3	
glycopyrrolate	T1	
GLYCOPYRROLATE 1 MG/5 ML SYRNG	T1	
glycopyrrolate 1 mg/5 ml vial	T1	
glycopyrrolate (Glycate)	T1	
glycopyrrolate (Robinul Forte)	T1	
glycopyrrolate (Robinul)	T1	
GLYCOPYRROLATE-WATER	T1	
propantheline bromide	T1	
ROBINUL (*glycopyrrolate*)	T3	
ROBINUL FORTE (*glycopyrrolate*)	T3	
ANTICHOLINERGICS/ANTISPASMODICS		
BENTYL	T3	
dicyclomine hcl	T1	
dicyclomine hcl (Bentyl)	T1	
ANTIDIARRHEAL - G.I. CHLORIDE CHANNEL INHIBITORS		
MYTESI	T3	
ANTIDIARRHEAL - TRYPTOPHAN HYDROXYLASE INHIBITOR		
XERMELO	T3	PA SP
ANTIDIARRHEALS		
diphenoxylate hcl/atropine	T1	
diphenoxylate hcl/atropine (Lomotil)	T1	
LOMOTIL (*diphenoxylate-atropine*)	T3	
loperamide hcl	T1	

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GASTROINTESTINAL (Gastrointestinal/Heartburn) *(cont.)*		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
ANTIDIARRHEALS *(cont.)*		
MOTOFEN	T3	
opium tincture	T1	PA
paregoric	T1	
ANTIEMETIC, CANNABINOID-TYPE		
dronabinol	T1	
ANTIEMETIC/ANTIVERTIGO AGENTS		
AKYNZEO 235-0.25 MG VIAL	T3	PA
AKYNZEO 235-0.25 MG/20 ML VIAL	T3	PA
AKYNZEO 300-0.5 MG CAPSULE	T3	PA QL (4 caps/28 days)
ALOXI (*palonosetron hcl*)	T3	PA
ANZEMET	T3	PA QL (5 tabs/30 days) SP
aprepitant 125 mg capsule	T1	QL (4 caps/28 days)
aprepitant 125-80-80 mg pack (Emend)	T1	QL (12 caps/28 days)
aprepitant 40 mg capsule	T1	QL (1 cap/28 days)
aprepitant 80 mg capsule (Emend)	T1	QL (8 caps/28 days)
BARHEMSYS	T3	
BONJESTA	T3	
CINVANTI	T3	PA
COMPAZINE (*prochlorperazine maleate*)	T3	
COMPAZINE (*prochlorperazine*)	T3	
DICLEGIS (*doxylamine succ-pyridoxine hcl*)	T3	
dimenhydrinate	T1	
doxylamine succinate/vit b6 (Diclegis)	T1	
EMEND 125 MG POWDER PACKET	T3	PA QL (12 caps/28 days)
EMEND 150 MG VIAL (*fosaprepitant dimeglumine*)	T3	PA
EMEND 80 MG CAPSULE (*aprepitant*)	T3	PA QL (8 caps/28 days)
EMEND TRIPACK (*aprepitant*)	T3	PA QL (12 caps/28 days)
granisetron hcl	T1	
granisetron hcl/pf	T1	
ondansetron	T1	
ondansetron hcl	T1	
ondansetron hcl/pf	T1	
ONDANSETRON HCL-0.9% NACL	T1	

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GASTROINTESTINAL (Gastrointestinal/Heartburn) *(cont.)*		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
ANTIEMETIC/ANTIVERTIGO AGENTS *(cont.)*		
ONDANSETRON HCL-D5W	T1	
palonosetron hcl	T1	PA
palonosetron hcl (Aloxi)	T1	PA
prochlorperazine (Compazine)	T1	
prochlorperazine edisylate	T1	
prochlorperazine maleate (Compazine)	T1	
promethazine hcl	T1	
promethazine hcl	T3	
SANCUSO	T3	PA QL (4 patches/30 days)
scopolamine (Transderm-scop)	T1	
SUSTOL	T3	PA
TIGAN	T3	
TIGAN (*trimethobenzamide hcl*)	T3	
TRANSDERM-SCOP (*scopolamine*)	T3	
trimethobenzamide hcl (Tigan)	T1	
VARUBI	T3	PA QL (4 tabs/28 days)
ANTI-ULCER PREPARATIONS		
CARAFATE (*sucralfate*)	T3	HD
CYTOTEC (*misoprostol*)	T3	HD
misoprostol (Cytotec)	T1	HD
sucralfate (Carafate)	T1	HD
ANTI-ULCER-H.PYLORI AGENTS		
bismuth/metronid/tetracycline (Pylera)	T1	
lansoprazole/amoxiciln/clarith	T1	
BELLADONNA ALKALOIDS		
ATROPINE 0.25 MG/5 ML SYRINGE	T1	HD
atropine 0.4 mg/ml vial	T1	HD
ATROPINE 0.4 MG/ML VIAL	T3	HD
ATROPINE SULFATE-0.9% NACL	T3	HD
atropine 0.5 mg/5 ml abboject	T1	HD
atropine 1 mg/10 ml abboject	T1	HD
atropine 1 mg/10 ml syringe	T1	HD
ATROPINE 1 MG/2.5 ML SYRINGE	T3	HD

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GASTROINTESTINAL (Gastrointestinal/Heartburn) *(cont.)*		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
BELLADONNA ALKALOIDS *(cont.)*		
atropine 1 mg/ml vial	T1	HD
ATROPINE 1 MG/ML VIAL	T3	HD
ATROPINE 2 MG/5 ML SYRINGE	T3	HD
atropine 8 mg/20 ml vial	T1	HD
DONNATAL	T3	HD
DONNATAL (*phenohytro*)	T3	HD
hyoscyamine 0.125 mg odt (Nulev)	T1	HD
hyoscyamine 0.125 mg tab sl (Levsin-sl)	T1	HD
hyoscyamine 0.125 mg/5 ml elix	T1	HD
hyoscyamine 0.125 mg/ml drop	T1	HD
hyoscyamine sulf 0.125 mg tab (Levsin)	T1	HD
hyoscyamine sulfate	T1	HD
hyoscyamine sulfate (Levbid)	T1	HD
hyoscyamine sulfate (Levsin)	T1	HD
hyoscyamine sulfate (Levsin-sl)	T1	HD
hyoscyamine sulfate (Nulev)	T1	HD
hyoscyamine sulfate (Nulev)	T3	HD
HYOSCYAMINE SULFATE 0.5 MG/ML	T3	HD
LEVBID (*symax-sr*)	T3	HD
LEVSIN	T3	HD
LEVSIN (*oscimin*)	T3	HD
LEVSIN-SL (*symax-sl*)	T3	HD
methscopolamine bromide	T1	HD
NULEV (*symax*)	T1	HD
phenobarb/hyoscy/atropine/scop (Donnatal)	T1	HD
phenobarb/hyoscy/atropine/scop (Phenobarbital-belladonna)	T1	HD
phenobarbital-belladonna elixr (Donnatal)	T1	HD
phenobarbital-belladonna elixr (Phenobarbital-belladonna)	T1	HD
PHENOBARBITAL-BELLADONNA ELIXR (*phenohytro*)	T3	HD
SYMAX DUOTAB	T3	HD
BILE SALTS		
ACTIGALL (*ursodiol*)	T3	HD
CHENODAL	T3	SP HD

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GASTROINTESTINAL (Gastrointestinal/Heartburn) *(cont.)*		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
BILE SALTS *(cont.)*		
CHOLBAM	T3	PA SP HD
URSO (*ursodiol*)	T3	HD
URSO FORTE (*ursodiol*)	T3	HD
ursodiol (Actigall)	T1	HD
ursodiol (Urso Forte)	T1	HD
ursodiol (Urso)	T1	HD
CHOLERETICS		
KINEVAC	T3	
CHRONIC INFLAM. COLON DX, 5-A-SALICYLAT, RECTAL TX		
mesalamine 1, 000 mg supp (Canasa)	T1	
mesalamine 4 gm/60 ml enema (Sfrowasa)	T1	
mesalamine 4 gm/60 ml kit	T1	
SFROWASA (*mesalamine*)	T3	
DRUG TX-CHRONIC INFLAM. COLON DX, 5-AMINOSALICYLAT		
APRISO (*mesalamine er*)	T3	HD
balsalazide disodium (Colazal)	T1	HD
LIALDA (*mesalamine*)	T3	HD
mesalamine	T1	HD
mesalamine (Apriso)	T1	HD
mesalamine 800 mg dr tablet	T1	HD
DRUG TX-CHRONIC INFLAM. COLON DX, 5-AMINOSALICYLAT		
mesalamine dr 1.2 gm tablet (Lialda)	T1	HD
sulfasalazine (Azulfidine)	T1	HD
FARNESOID X RECEPTOR (FXR) AGONIST, BILE AC ANALOG		
OCALIVA	T3	PA SP HD
FECAL MICROBIOTA TRANSPLANTATION (FMT)		
VOWST	T3	PA QL(12 CAPS/56 DAYS) SP
GASTRIC ENZYMES		
SUCRAID	T3	PA SP
HISTAMINE H2-RECEPTOR INHIBITORS		
cimetidine hcl	T1	HD
famotidine	T1	HD
ranitidine hcl	T1	HD
IBS AGENTS, MIXED OPIOID RECEP AGONISTS/ANTAGONISTS		
VIBERZI	T2	HD

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Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
IBS-C/CIC AGENTS, GUANYLATE CYCLASE-C AGONIST		
LINZESS	T2	
TRULANCE	T2	
INTEGRIN RECEPTOR ANTAGONIST, MONOCLONAL ANTIBODY		
ENTYVIO	T2	PA SP HD
ENTYVIO PEN	T3	PA QL(2 pens/30 days) SP HD
INTESTINAL MOTILITY STIMULANTS		
metoclopramide hcl	T1	
metoclopramide hcl (Reglan)	T1	
REGLAN (*metoclopramide hcl*)	T3	
IRRITABLE BOWEL SYNDROME AGENTS, 5-HT3 ANTAGONIST		
alosetron hcl	T1	SP HD
IV FAT EMULSIONS		
CLINOLIPID	T3	
fat emulsions (Nutrilipid)	T3	
INTRALIPID	T3	
NUTRILIPID (*intralipid*)	T3	
OMEGAVEN	T3	
SMOFLIPID	T3	
LAXATIVES AND CATHARTICS		
bisac/nacl/nahco3/kcl/peg 3350	T1	PPACA
CLENPIQ	T2	PPACA
lactulose	T1	
lactulose 10 gm/15 ml solution	T1	
lactulose 20 gm/30 ml solution	T1	
lubiprostone (Amitiza)	T1	
NULYTELY	T3	PPACA
peg3350/sod sul/nacl/kcl/asb/c	T1	PPACA
peg3350/sod sulf, bicarb, cl/kcl	T1	PPACA
PREPOPIK	T2	PPACA
sodium chloride/nahco3/kcl/peg	T2	PPACA
SUFLAVE	T2	PPACA
SUPREP	T2	PPACA
SUTAB	T2	PPACA

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GASTROINTESTINAL (Gastrointestinal/Heartburn) *(cont.)*		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
LOCAL ANORECTAL NITRATE PREPARATIONS		
nitroglycerin 0.4% ointment	T1	
RECTIV	T3	
PANCREATIC ENZYMES		
PANCREAZE	T2	HD
VIOKACE	T3	HD
POTASSIUM-COMPETITIVE ACID BLOCKERS (PCABS)		
VOQUEZNA	T3	PA QL(1 tab/day)
PROTON-PUMP INHIBITORS		
dexlansoprazole dr 30 mg cap	T1	QL (2 caps/day) HD
dexlansoprazole dr 60 mg cap	T1	QL(1 cap/day) HD
esomeprazole dr 10 mg packet	T1	QL (4 packets/day) HD
esomeprazole dr 20 mg packet (Nexium)	T1	QL (2 packs/day) HD
esomeprazole dr 40 mg packet (Nexium)	T1	QL (1 packet/day) HD
esomeprazole mag dr 20 mg cap	T1	QL (2 caps/day) HD
esomeprazole mag dr 40 mg cap	T1	QL (1 cap/day) HD
pantoprazole sodium 40 mg vial	T1	HD
lansoprazole dr 15 mg capsule	T1	QL (2 caps/day) HD
lansoprazole dr 30 mg capsule	T1	QL (30 caps/30 days) HD
lansoprazole odt 15 mg tablet	T1	QL (2 tabs/day) HD
lansoprazole odt 30 mg tablet	T1	QL (30 tabs/30 days) HD
NEXIUM DR 2.5 MG PACKET	T2	QL (480 packs/30 days) HD
NEXIUM DR 5 MG PACKET	T2	QL (240 packs/30 days) HD
omeppi 20 mg-1, 100 mg capsule	T1	PA QL (60 caps/30 days) HD
omeppi 40 mg-1, 100 mg capsule	T1	PA QL (30 caps/30 days) HD
omeprazole dr 10 mg capsule	T1	QL (4 caps/day) HD
omeprazole dr 20 mg capsule	T1	QL (60 caps/30 days) HD
omeprazole dr 40 mg capsule	T1	QL (30 caps/30 days) HD
omeprazole-bicarb 20-1, 100 cap	T1	PA QL (60 caps/30 days) HD
omeprazole-bicarb 20-1, 680 pkt	T1	PA QL (60 packs/30 days) HD
omeprazole-bicarb 40-1, 100 cap	T1	PA QL (30 caps/30 days) HD
omeprazole-bicarb 40-1, 680 pkt	T1	PA QL (30 packs/30 days) HD
pantoprazole 40 mg suspension	T1	QL (1 dose/day) HD
pantoprazole sod dr 20 mg tab	T1	QL (2 tabs/day) HD
pantoprazole sod dr 40 mg tab	T1	QL (30 tabs/30 days) HD

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GASTROINTESTINAL (Gastrointestinal/Heartburn) *(cont.)*		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
PROTON-PUMP INHIBITORS *(con't)*		
pantoprazole sodium 40 mg vial	T1	HD
rabeprazole sodium	T1	QL (1 tab/day) HD
SBS - GLUCAGON-LIKE PEPTIDE-2 (GLP-2) ANALOGS		
GATTEX	T3	PA SP HD
GASTROINTESTINAL (Pain Relief And Inflammatory Disease)		
HEMORRHOID PREP, ANTI-INFLAM STEROID-LOCAL ANESTHET		
ANA-LEX	T1	
hydrocortisone/lidocaine/aloe	T1	
hydrocortisone/pramoxine (Analpram Hc)	T1	
lidocaine/hydrocortisone ac	T1	
LIDOCAINE-HYDROCORTISONE	T1	
PROCORT	T3	
PROCTOFOAM-HC	T3	
GASTROINTESTINAL (Skin Conditions)		
KERATINOCYTE GROWTH FACTOR (KGF)		
KEPIVANCE	T3	SP
HORMONES (Gastrointestinal/Heartburn)		
RECTAL/LOWER BOWEL PREP., GLUCOCORT. (NON-HEMORR)		
budesonide 2 mg rectal foam	T1	
CORTENEMA (*hydrocortisone*)	T3	
hydrocortisone (Cortenema)	T1	
HORMONES (Hormonal Agents)		
ADRENOCORTICOTROPHIC HORMONES		
ACTHAR	T3	PA SP HD
ACTHREL	T3	SP
cosyntropin	T1	
ANDROGEN/ESTROGEN PREPS FOR FEMALE SEXUAL DYSFUNC		
INTRAROSA	T3	
ANDROGENIC AGENTS		
ANADROL-50	T3	PA
ANDRODERM	T3	PA QL (1 patch/day)
ANDROGEL 1% (25 MG/2.5 G) PKT (*testosterone*)	T3	PA QL (150gm/30 days)
ANDROGEL 1% (50 MG/5 G) PKT (*testosterone*)	T3	PA QL (2 packs/day)

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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)
ANDROID (*methyltestosterone*)	T3	
AVEED	T3	PA SP
DEPO-TESTOSTERONE	T3	
DEPO-TESTOSTERONE (*testosterone cypionate*)	T3	
METHITEST	T1	
methyltestosterone (Testred)	T1	
oxandrolone	T1	PA
TESTOPEL	T3	PA
testosterone 1% (25mg/2.5g) pk (Androgel)	T1	PA QL (150gm/30 days)
testosterone 1% (50 mg/5 g) pk (Testosterone)	T1	PA QL (2 packs/day)
testosterone 1.62% (2.5 g) pkt (Androgel)	T1	PA QL (150gm/30 days)
testosterone 1.62% 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)
TESTRED (*methyltestosterone*)	T3	
ANTIDIURETIC AND VASOPRESSOR HORMONES		
desmopressin 0.01% solution	T1	HD
desmopressin 0.01% spray	T1	HD
desmopressin 10 mcg/0.1 ml spr	T1	HD
desmopressin 40 mcg/10 ml vial	T1	SP
desmopressin ac 4 mcg/ml ampul	T1	SP
desmopressin ac 4 mcg/ml vial	T1	SP
desmopressin acetate 0.1 mg tb	T1	
desmopressin acetate 0.2 mg tb	T1	
NOCTIVA	T3	PA

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

HORMONES (Hormonal Agents) *(cont.)*		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
ANTIDIURETIC AND VASOPRESSOR HORMONES *(cont.)*		
STIMATE	T3	SP
vasopressin	T1	
VASOPRESSIN-0.9% NACL	T1	
VASOPRESSIN-D5W	T1	
VASOSTRICT	T3	
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
CLIMARA (*estradiol (once weekly)*)	T3	HD
CLIMARA PRO	T3	HD
COMBIPATCH	T3	HD
DEPO-ESTRADIOL	T3	HD
DIVIGEL	T3	HD
ELESTRIN	T3	HD
ESTRACE (*estradiol*)	T3	HD
estradiol (Climara)	T1	HD
estradiol 0.1% (0.5mg) gel pkt (Divigel)	T1	HD
estradiol patch (Minivelle)	T1	QL (16 patches/28 days) HD
estradiol patch (Vivelle-Dot)	T1	QL (16 patches/28 days) HD
estradiol 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

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HORMONES (Hormonal Agents) *(cont.)*		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
ESTROGENIC AGENTS *(cont.)*		
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
PREMPHASE	T2	HD
PREMPRO	T2	HD
VIVELLE-DOT (*lyllana*)	T3	QL (16 patches/28 days) HD
ESTROGEN-PROGESTIN WITH ANTIMINERALOCORTICOID COMB		
ANGELIQ	T3	HD
ESTROGEN-SELECTIVE ESTROGEN RECEPTOR MOD (SERM) COMB		
DUAVEE	T2	
GLUCOCORTICOIDS		
BETA 1	T3	
betamethasone acetate, sod phos (Celestone)	T1	
BSP 0820	T3	
budesonide	T1	PA QL (56 tabs/180 days)
budesonide (Entocort Ec)	T1	
CELESTONE (*betamethasone sod phos-acetate*)	T3	
CORTEF (*hydrocortisone*)	T3	
cortisone acetate	T1	
deflazacort (Emflaza)	T1	PA SP HD
DEPO-MEDROL	T3	
dexamethasone	T1	
dexamethasone sodium phosp/pf	T1	
dexamethasone tablet	T1	
DEXAMETHASONE 10 MG/ML SYRING	T3	
dexamethasone 10 mg/ml vial	T1	
dexamethasone 100 mg/10 ml vl	T1	
dexamethasone 120 mg/30 ml vl	T1	
dexamethasone 20 mg/5 ml vial	T1	
dexamethasone 4 mg/ml syringe	T1	
dexamethasone 4 mg/ml vial	T1	
dexamethasone in 0.9 % sod chl	T1	

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List of Prescription Medications

HORMONES (Hormonal Agents) *(cont.)*		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
GLUCOCORTICOIDS *(cont.)*		
EMFLAZA	T3	PA SP HD
ENTOCORT EC (*budesonide ec*)	T3	
hydrocortisone (Cortef)	T1	
hydrocortisone sod succinate (Solu-cortef)	T1	
KENALOG-10	T3	
KENALOG-40 (*triamcinolone acetonide*)	T3	
KENALOG-80	T3	
LOCORT	T1	
MEDROL	T3	
MEDROL (*methylprednisolone*)	T3	
MEDROLOAN II SUIK	T3	
methylprednisolone (Medrol)	T1	
methylprednisolone acetate (Depo-medrol)	T1	
methylprednisolone sod succ	T1	
methylprednisolone sod succ (Solu-medrol)	T1	
MILLIPRED 10 MG/5 ML SOLUTION (*prednisolone sodium phosphate*)	T3	
millipred 5 mg tablet	T1	
ORAPRED ODT (*prednisolone sodium phos odt*)	T3	
P-CARE D80G	T1	
P-CARE K80	T1	
POD-CARE 100C	T1	
prednisolone	T1	
prednisolone sodium phosphate	T1	
prednisolone sodium phosphate (Millipred)	T1	
prednisolone sodium phosphate (Orapred Odt)	T1	
prednisone	T1	
PRO-C-DURE 5	T3	
PRO-C-DURE 6	T3	
READYSHARP BETAMETHASONE	T1	
SOLU-CORTEF	T3	
SOLU-MEDROL	T3	
ZILRETTA	T3	PA
GROWTH HORMONES		
GENOTROPIN	T2	PA SP HD

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List of Prescription Medications

HORMONES (Hormonal Agents) *(cont.)*		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
GROWTH HORMONES *(cont.)*		
NGENLA	T3	PA SP
NORDITROPIN FLEXPRO	T2	PA SP HD
OMNITROPE	T2	PA SP HD
SEROSTIM	T2	PA SP
SKYTROFA	T2	PA SP
SOGROYA	T3	PA SP
ZORBTIVE	T2	PA SP HD
LHRH (GNRH) AGONIST ANALOG AND PROGESTIN COMB		
LUPANETA PACK	T3	PA SP HD
LHRH (GNRH) AGONIST ANALOG PITUITARY SUPPRESSANTS		
LUPRON DEPOT	T2	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	T3	PA SP
ganirelix acet 250 mcg/0.5 ml (Ganirelix Acetate)	T1	PA SP
GANIRELIX ACET 250 MCG/0.5 ML (*ganirelix acetate*)	T3	PA SP
ORILISSA 150 MG TABLET	T2	PA QL (24 months of treament/lifetime)
ORILISSA 200 MG TABLET	T2	PA QL (2 tabs/day)
LHRH (GNRH) AGNST PIT.SUP-CENTRAL PRECOCIOUS PUBERTY		
FENSOLVI	T2	PA SP
LUPRON DEPOT-PED	T2	PA SP HD
SUPPRELIN LA	T3	PA SP HD
TRIPTODUR	T2	PA SP
MINERALOCORTICOIDS		
fludrocortisone acetate	T1	HD
OXYTOCICS		
CARBOPROST	T3	
carboprost tromethamine	T1	
CERVIDIL	T3	
HEMABATE	T3	
methylergonovine maleate	T1	
oxytocin (Pitocin)	T1	
OXYTOCIN-D5-LACTATED RINGERS	T1	
OXYTOCIN-D5W	T1	

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HORMONES (Hormonal Agents) *(cont.)*		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
OXYTOCICS *(cont.)*		
OXYTOCIN-LACTATED RINGERS	T1	
PITOCIN (*oxytocin*)	T3	
PREPIDIL	T3	
PROSTIN E2 VAGINAL SUPPOSITORY	T3	
PITUITARY SUPPRESSIVE AGENTS		
cabergoline	T1	QL (16 tabs/28 days) HD
danazol	T1	HD
PROGESTATIONAL AGENTS		
AYGESTIN (*norethindrone acetate*)	T3	HD
CRINONE 4% GEL	T3	PA HD
DEPO-PROVERA 400 MG/ML VIAL	T2	HD
hydroxyprogesterone 1.25 g/5ml	T1	HD
medroxyprogesterone 10 mg tab (Provera)	T1	HD
medroxyprogesterone 2.5 mg tab (Provera)	T1	HD
medroxyprogesterone 5 mg tab (Provera)	T1	HD
norethindrone acetate (Aygestin)	T1	HD
progesterone 100 mg capsule (Prometrium)	T1	HD
progesterone 200 mg capsule (Prometrium)	T1	HD
progesterone 500 mg/10 ml vial	T1	SP HD
PROVERA (*medroxyprogesterone acetate*)	T3	HD
RENIN-ANGIOTENSIN-ALDOSTERONE SYS. (RAAS) HORMONES		
GIAPREZA	T3	SP
SOMATOSTATIC AGENTS		
BYNFEZIA	T3	PA SP
octreotide acetate	T1	PA SP HD
octreotide acetate (Sandostatin)	T1	PA SP HD
SANDOSTATIN 0.05 MG/ML AMPUL (*octreotide acetate*)	T2	PA SP HD
SANDOSTATIN 0.1 MG/ML AMPUL (*octreotide acetate*)	T3	PA SP HD
SANDOSTATIN 0.5 MG/ML AMPUL (*octreotide acetate*)	T3	PA SP HD
SANDOSTATIN LAR DEPOT	T2	PA SP
SIGNIFOR	T3	PA SP
SIGNIFOR LAR	T3	PA SP
SOMATULINE DEPOT	T2	PA SP HD
VAGINAL ESTROGEN FOR SEXUAL DYSFUNCTION		
IMVEXXY 10 MCG MAINTENANCE PAK	T3	QL (16/28 days) HD

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List of Prescription Medications

HORMONES (Hormonal Agents) *(cont.)*		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
VAGINAL ESTROGEN FOR SEXUAL DYSFUNCTION		
OXYTOCIN-LACTATED RINGERS	T1	
IMVEXXY 4 MCG MAINTENANCE PACK	T3	QL (16/28 days) HD
IMVEXXY 4 MCG STARTER PACK	T3	QL (36/28 days) HD
VAGINAL ESTROGEN PREPARATIONS		
ESTRACE (*estradiol*)	T3	HD
estradiol (Vagifem)	T1	QL (36 tabs/28 days) HD
estradiol 0.01% cream (Estrace)	T1	HD
estradiol 10 mcg vaginal insrt (Vagifem)	T1	QL (36 tabs/28 days) HD
ESTRING	T3	QL (2 rings/90 days) HD
FEMRING	T3	HD
PREMARIN	T2	HD
VAGIFEM (*yuvafem*)	T3	QL (36 tabs/28 days) HD
HORMONES (Infertility)		
FERTILITY STIMULATING PREPARATIONS, NON-FSH		
clomiphene citrate	T1	
FOLLICLE-STIMULATING AND LUTEINIZING HORMONES		
MENOPUR	T3	PA SP
FOLLICLE-STIMULATING HORMONE (FSH)		
FOLLISTIM AQ	T3	PA SP
GONAL-F	T2	PA SP
GONAL-F RFF	T2	PA SP
GONAL-F RFF REDI-JECT	T2	PA SP
HUMAN CHORIONIC GONADOTROPIN (HCG)		
CHORIONIC GONAD 12, 000 UNIT VL	T1	SP
CHORIONIC GONAD 6, 000 UNIT VL	T1	SP
CHORIONIC GONADOTROPIN	T3	PA SP
NOVAREL	T2	PA SP
OVIDREL	T3	PA SP
PREGNYL	T2	PA SP
PREGNANCY FACILITATING/MAINTAINING AGENT, HORMONAL		
CRINONE 8% GEL	T2	PA
ENDOMETRIN	T2	
PREGNANCY MAINTAINING AGENT, HORMONAL		
hydroxyprogest 250 mg/ml vial (Makena)	T1	PA

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List of Prescription Medications

HORMONES (Miscellaneous)		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
PREGNANCY MAINTAINING AGENT, HORMONAL *(con't.)*		
MAKENA	T3	PA
MAKENA (*hydroxyprogesterone caproate*)	T3	PA
LEPTIN HORMONE ANALOGS		
MYALEPT	T3	PA SP HD
BONE RESORPTION INHIBITORS		
calcitonin, salmon, synthetic	T1	HD
MIACALCIN	T3	HD
IMMUNOSUPPRESSANTS (Miscellaneous)		
IMMUNOSUPPRESSANT-INTERFERON GAMMA INHIBITOR, MAB		
GAMIFANT	T3	PA SP
IMMUNOSUPPRESSANTS (Pain Relief And Inflammatory Disease)		
ANTI-CD19 (B LYMPHOCYTE) MONOCLONAL ANTIBODY		
UPLIZNA	T3	PA SP
IL-23 RECEPTOR ANTAGONIST, MONOCLONAL ANTIBODY		
OMVOH	T2	SP HD
OMVOH PEN	T2	PA QL(2 pens/28 days) SP HD
INTERLEUKIN-4 (IL-4) RECEPTOR ALPHA ANTAGONIST, MAB		
DUPIXENT PEN	T2	PA SP HD
DUPIXENT SYRINGE	T2	PA SP HD
INTERLEUKIN-6 (IL-6) RECEPTOR INHIBITORS		
ACTEMRA 162 MG/0.9 ML SYRINGE	T2	PA QL (4 syringes/28 days) SP HD
ACTEMRA 200 MG/10 ML VIAL	T2	PA SP HD
ACTEMRA 400 MG/20 ML VIAL	T2	PA SP HD
ACTEMRA 80 MG/4 ML VIAL	T2	PA SP HD
ACTEMRA ACTPEN	T2	PA QL (4 pens/28 days) SP HD
ENSPRYNG	T3	PA SP HD
KEVZARA 150 MG/1.14 ML PEN INJ	T3	PA QL (2 pens/28 days) SP HD
KEVZARA 150 MG/1.14 ML SYRINGE	T3	PA QL (2 syrings/28 days) SP HD
KEVZARA 200 MG/1.14 ML PEN INJ	T3	PA QL (2 pens/28 days) SP HD
KEVZARA 200 MG/1.14 ML SYRINGE	T3	PA QL (2 syrings/28 days) SP HD
MONOCLONAL ANTIBODY-HUMAN INTERLEUKIN 12/23 INHIB		
STELARA 130 MG/26 ML VIAL	T2	PA SP HD
STELARA 45 MG/0.5 ML SYRINGE	T2	PA QL (1 syringe/84 days) SP HD

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List of Prescription Medications

IMMUNOSUPPRESSANTS (Skin Conditions)		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
MONOCLONAL ANTIBODY-HUMAN INTERLEUKIN 12/23 INHIB *(con't.)*		
STELARA 45 MG/0.5 ML VIAL	T2	PA QL (1 vial/84 days) SP HD
STELARA 90 MG/ML SYRINGE	T2	PA QL (1 syringe/84 days) SP HD
TOPICAL IMMUNOSUPPRESSIVE AGENTS		
ELIDEL (*pimecrolimus*)	T3	
pimecrolimus (Elidel)	T1	
PROTOPIC (*tacrolimus*)	T3	
tacrolimus 0.03% ointment (Protopic)	T1	
tacrolimus 0.1% ointment (Protopic)	T1	
IMMUNOSUPPRESSANTS (Transplant Medications)		
IMMUNOSUPP - MONOCLONAL AB INHIBITING T LYMPH FXN		
SIMULECT	T2	SP
IMMUNOSUPPRESSIVES		
ASTAGRAF XL	T3	SP HD
AZASAN	T2	SP HD
azathioprine (Imuran)	T1	SP HD
azathioprine sodium	T1	
CELLCEPT 200 MG/ML ORAL SUSP (*mycophenolate mofetil*)	T3	SP HD
CELLCEPT 250 MG CAPSULE (*mycophenolate mofetil*)	T3	SP HD
CELLCEPT 500 MG TABLET (*mycophenolate mofetil*)	T3	SP HD
CELLCEPT 500 MG VIAL (*mycophenolate mofetil*)	T2	SP
cyclosporine 100 mg capsule (Sandimmune)	T1	SP HD
cyclosporine 25 mg capsule (Sandimmune)	T1	SP HD
cyclosporine 250 mg/5 ml ampul (Sandimmune)	T1	SP
cyclosporine, modified	T1	SP HD
cyclosporine, modified (Neoral)	T1	SP HD
ENVARSUS XR	T3	SP HD
everolimus 0.25 mg tablet (Zortress)	T1	SP HD
everolimus 0.5 mg tablet (Zortress)	T1	SP HD
everolimus 0.75 mg tablet (Zortress)	T1	SP HD
IMURAN (*azathioprine*)	T3	SP HD
LUPKYNIS	T3	PA QL(6 caps/day) SP
mycophenolate 200 mg/ml susp (Cellcept)	T1	SP HD
mycophenolate 250 mg capsule (Cellcept)	T1	SP HD
mycophenolate 500 mg tablet (Cellcept)	T1	SP HD

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List of Prescription Medications

IMMUNOSUPPRESSANTS (Transplant Medications) *(cont.)*		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
IMMUNOSUPPRESSIVES *(cont.)*		
mycophenolate 500 mg vial (Cellcept)	T1	SP
MYFORTIC (*mycophenolic acid*)	T3	SP HD
NULOJIX	T3	SP
PROGRAF 0.2 MG GRANULE PACKET	T3	SP HD
PROGRAF 0.5 MG CAPSULE (*tacrolimus*)	T3	SP HD
PROGRAF 1 MG CAPSULE (*tacrolimus*)	T3	SP HD
PROGRAF 1 MG GRANULE PACKET	T3	SP HD
PROGRAF 5 MG CAPSULE (*tacrolimus*)	T3	SP HD
PROGRAF 5 MG/ML AMPULE	T2	SP
RAPAMUNE (*sirolimus*)	T3	SP HD
sirolimus (Rapamune)	T1	SP HD
tacrolimus 0.5 mg capsule (ir) (Prograf)	T1	SP HD
tacrolimus 1 mg capsule (ir) (Prograf)	T1	SP HD
tacrolimus 5 mg capsule (ir) (Prograf)	T1	SP HD
ZORTRESS	T3	SP HD
ZORTRESS (*everolimus*)	T3	SP HD
MISCELLANEOUS MEDICAL SUPPLIES, DEVICES, NON-DRUG (Diabetes)		
DIABETIC SUPPLIES		
2TEK CONTROL SOLUTION	T1	
2TEK GLUCOSE-WRIST MONITOR KIT	T1	
ACCU-CHEK	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	T1	
AT HOME A1C	T1	
AUTOJECT 2	T1	

List of Prescription Medications

MISCELLANEOUS MEDICAL SUPPLIES, DEVICES, NON-DRUG (Diabetes) *(cont.)*		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
DIABETIC SUPPLIES *(cont.)*		
AUTO-LANCET MINI	T1	
AUTOLET	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	
CARESENS N FELIZ GLUCOSE METER	T3	
CARETOUCH	T1	
CEQUR SIMPLICITY	T2	
CEQUR SIMPLICITY INSERTER	T2	
CHEMSTRIP BG DIARY	T1	
CLEVER CHOICE CONTROL SOLUTION	T1	
CONTOUR SOLUTION/METER/NEXT CONTROL SOLUTION	T1	
CONTROL SOLUTION	T1	
COOL CONTROL SOLUTION	T1	
DEXCOM G7 RECEIVER	T2	PA QL(1 unit/365 days)
DEXCOM G7 SENSOR	T2	PA QL(3 sensors/30 days)
DEXCOM	T3	
DEXCOM G4	T3	
DEXCOM G5	T3	
DEXCOM G5-G4 SENSOR	T3	
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)
DIATRUE	T1	
DROPLET GENTEEL LANCING DEVICE	T1	
DROPLET LANCING DEVICE	T1	
EASY MINI EJECT LANCING DEVICE	T1	
EASY PLUS II CONTROL SOLN HIGH/ LOW	T1	
EASY STEP CONTROL SOLUTION	T1	
EASY TALK CONTROL SOLN LOW / HIGH CONTROL SOLN	T1	
EASY TALK PLUS II HIGH CONTROL/ LOW CTRL SLN	T1	

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MISCELLANEOUS MEDICAL SUPPLIES, DEVICES, NON-DRUG (Diabetes) *(cont.)*		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
DIABETIC SUPPLIES *(cont.)*		
EASY TOUCH	T1	
EASY TRAK	T1	
EASYGLUCO PLUS CONTROL NORMAL	T1	
EASYMAX	T1	
ELEMENT	T1	
EMBRACE	T1	
ENLITE	T3	
ENLITE GLUCOSE SENSOR	T3	
ENLITE SERTER	T3	
EVENCARE SOLUTION	T1	
EVERSENSE SENSOR-HOLDER	T3	
EVERSENSE SMART TRANSMITTER	T3	
EVOLUTION CONTROL SOLUTION	T1	
EZ-VAC	T1	
FORA CONTROL SOLUTION/ LANCING DEVICE	T1	
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)
FREESTYLE LIBRE 3 READER	T2	PA QL(1 unit/720 days)
FREESTYLE NAVIGATOR	T3	
GE100 CONTROL SOLUTION NORMAL	T1	
GE333 BLOOD GLUCOSE SYSTEM	T3	
GENTEEL VACUUM LANCING DEVICE	T1	
GLUCOCARD	T1	
GLUCOCOM	T1	
GLUCOSE	T1	
GOJJI GLUCOSE CONTROL SOLUTION/ LANCING DEVICE	T1	
GUARDIAN CONNECT TRANSMITTER	T3	
GUARDIAN	T3	

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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.)*		
GUARDIAN RT CHARGER	T1	
GUARDIAN RT STARTER KIT	T3	
GUARDIAN RT SYSTEM	T1	
GUARDIAN SENSOR 3	T3	
GUARDIAN TEST PLUG	T1	
GUARDIAN TRANSMITTER TAPE	T1	
HEALTHPRO GLUCOSE CONTROL SOLN	T1	
HEALTHY ACCENTS AUTOLET	T1	
HUMAPEN LUXURA HD	T3	
HYPOLANCE	T1	
INCONTROL LANCING DEVICE	T1	
INFINITY CONTROL SOLUTION / VOICE CONTROL SOLN	T1	
INPEN (FOR HUMALOG) / (FOR NOVOLOG OR FIASP)	T1	
INSUL-CAP	T1	
INSUL-EZE	T1	
LANCING DEVICE/ SYSTEM	T1	
LANZO	T1	
LITE TOUCH	T1	
MAGNI-GUIDE MAGNIFIER	T1	
MEDISENSE	T1	
MEDTRONIC REMOTE CONTROL	T1	
MICRODOT HIGH-LOW CONTROL SOL / NORMAL CONTROL SOLUT	T1	
MICROLET 2/ NEXT LANCING DEVICE	T1	
MINI LANCING DEVICE	T1	
MINILINK REAL-TIME TRANSMITTER	T2	
MINIMED QUICK-SERTER	T1	
MINIMED 630G GUARDIAN START KT	T3	
MOBILE LANCETS	T2	
MYGLUCOHEALTH CONTROL SOLUTION	T1	
MOBILE	T1	
NOVA MAX GLUCOSE CONTROL SOLN/ PLUS GLU-KET	T1	
NOVOPEN ECHO	T1	
OMNIPOD CLASSIC (GEN 3 & 4) KIT	T2	QL (1 kit/365 days)
OMNIPOD CLASSIC (GEN 3 & 4) PODS	T2	QL (30 pods/30 days)
OMNIPOD 5 (GEN 5) KIT	T2	QL (1 kit/365 days)

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Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
DIABETIC SUPPLIES *(cont.)*		
OMNIPOD 5 (GEN 5) PODS	T2	QL (30 pods/30 days)
OMNIPOD 5 G6-G7 INTRO KT(GEN5)	T2	QL
OMNIPOD 5 G6-G7 PODS (GEN 5)	T2	QL
OMNIPOD DASH 5 PACK POD	T2	QL (6 boxes/30 days)
ON CALL	T1	
ONETOUCH DELICA PLUS LANC DEV	T1	
ONETOUCH ULTRA CONTROL SOLN	T1	
ONETOUCH ULTRASOFT 2 LANCET	T2	
ONETOUCH VERIO	T1	
OPTUMRX GLUCOSE CONTROL SOLN	T1	
OVAL TAPE	T1	
PARADIGM REAL-TIME	T2	
PARADIGM REMOTE CONTROL	T1	
PIP GLUCOSE CONTROL SOLUTION	T1	
PRO COMFORT SAFETY LANCET	T2	
PRODIGY CONTROL SOLUTION / LANCING DEVICE	T1	
REFUAH PLUS GLUCOSE CONTROL	T1	
RELIAMED MINI LANCING DEVICE	T1	
REPLACEMENT PEDIATRIC MONITOR	T3	
RIGHTEST CONTROL SOLUTION/ GD500	T1	
SAFE-CLIP	T1	
SIL-SERTER	T1	
SEN-SERTER	T2	
SMARTDIABETES VANTAGE	T1	
SMARTEST	T1	
SOF-SENSOR	T2	
SOLUS V2 CONTROL SOLUTION / 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	

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Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
DIABETIC SUPPLIES *(cont.)*		
ULTI-LANCE	T1	
ULTRATRAK	T1	
UNISTIK	T1	
UNISTRIP	T1	
VERASENS CONTROL SOLUTION	T1	
V-GO 20	T2	
V-GO 30	T2	
V-GO 40	T2	
VIVAGUARD	T1	
WAVESENSE CONTROL SOLUTION	T1	
NEEDLES/NEEDLELESS DEVICES		
1ST TIER UNIFINE PENTIPS / PLUS	T1	
ABOUTTIME PEN NEEDLE	T1	
ADVOCATE PEN NEEDLES	T1	
AQINJECT PEN NEEDLE	T1	
ASSURE ID PEN NEEDLE	T1	
AUTOSHIELD DUO PEN NEEDLE	T1	
BD NEEDLES		
BLUNT NEEDLE	T1	
CAREFINE PEN NEEDLE	T1	
CARETOUCH HYPODERMIC NEEDLE / PEN NEEDLE	T1	
CAREPOINT PRECISION NEEDLE	T1	
CLICKFINE	T1	
COMFORT EZ PEN NEEDLE / EZ PRO SAFETY PEN NDL	T1	
COMFORT TOUCH PEN NEEDLE	T1	
DROPLET MICRON PEN NEEDLE / PEN NEEDLE	T1	
DROPSAFE PEN NEEDLE	T1	
EASY COMFORT PEN NEEDLES	T1	
EASY GLIDE PEN NEEDLE	T1	
EASY TOUCH	T1	
EASYPOINT NEEDLE	T1	
ECLIPSE NEEDLE	T1	
EMBRACE PEN NEEDLE	T1	
EXEL HUBER NEEDLE/ HYPODERMIC NEEDLE	T1	
FILTER NEEDLE / ASPIRATOR NEEDLE	T1	

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Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
NEEDLES/NEEDLELESS DEVICES *(cont.)*		
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	
INTEGRA	T1	
LIFESHIELD BLUNT CANNULA	T1	
LITE TOUCH	T1	
MAXICOMFORT	T1	
MICRODOT INSULIN PEN NEEDLE	T1	
MINI PEN NEEDLE/ MINI ULTRA-THIN II	T1	
MONOJECT BLOOD COLLECTION / FILTER NEEDLE	T1	
NANO 2ND GEN PEN NEEDLE	T1	
NEEDLES	T1	
needles,safety huber,disposabl	T1	
NOKOR	T1	
NOVOFINE	T1	
NOVOTWIST	T1	
PEN NEEDLES	T1	
PHASEAL PROTECTOR	T2	
PENTIPS	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 / SAFETY PEN NEEDLE	T1	
RAYA SURE PEN NEEDLE	T1	
REGULAR BEVEL NEEDLES	T1	
RELION PEN NEEDLES	T1	
SAFETY PEN NEEDLE	T1	
SAFETYGLIDE NEEDLE	T1	
SECURESAFE PEN NEEDLE	T1	

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Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
NEEDLES/NEEDLELESS DEVICES *(cont.)*		
SHORT BEVEL NEEDLES	T1	
SKY SAFETY PEN NEEDLE	T1	
SPECIALTY USE NEEDLES	T1	
SURE COMFORT	T1	
SURE-FINE PEN NEEDLES	T1	
TECHLITE PEN NEEDLE	T1	
TERUMO SURGUARD2	T1	
THIN WALL NEEDLES	T1	
TOPCARE CLICKFINE	T1	
TRANSFER NEEDLE	T1	
TRUE COMFORT	T1	
TRUEPLUS PEN NEEDLE	T1	
ULTICARE PEN NEEDLE / SAFETY PEN NEEDLE	T1	
ULTIGUARD SAFEPACK-PEN NEEDLE	T1	
ULTILET PEN NEEDLE	T1	
ULTRA FLO PEN NEEDLE	T1	
ULTRA THIN / ULTRA-THIN II	T1	
ULTRACARE PEN NEEDLE	T1	
ULTRA-FINE	T1	
UNIFINE	T1	
VERIFINE	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	
ECLIPSE SYRINGE	T1	
FREESTYLE PRECISION	T1	
HEALTHWISE INSULIN SYRINGE	T1	
INSULIN SYRINGE	T1	

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Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
SYRINGES AND ACCESSORIES *(cont.)*		
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	T1	
MONOJECT	T1	
MONOJECT INSULIN SYRINGE	T1	
PARADIGM	T1	
PRO COMFORT INSULIN SYRINGE	T1	
PRODIGY INSULIN SYRINGE	T1	
SAFESNAP INSULIN SYRINGE	T1	
SAFETYGLIDE	T1	
SECURESAFE INSULIN SYRINGE	T1	
SURE COMFORT	T1	
SURE-JECT INSULIN SYRINGE	T1	
syringe and needle,insulin,1ml	T1	
syring-needl,disp,insul	T1	
TECHLITE INSULIN SYRINGE	T1	
TERUMO INSULIN SYRINGE	T1	
THINPRO INSULIN SYRINGE	T1	
TOPCARE ULTRA COMFORT	T1	
TRUE COMFORT INSULIN SYRINGE / PRO INS SYRINGE	T1	
TRUEPLUS INSULIN SYRINGE	T1	
ULTICARE	T1	
ULTICARE INSULIN SYRINGE	T1	
ULTIGUARD SAFE	T1	
ULTILET INSULIN SYRINGE	T1	
ULTRA COMFORT / FLO INSULIN SYRINGE	T1	
ULTRACARE INSULIN SYRINGE	T1	
ULTRA-THIN II	T1	
VANISHPOINT	T1	

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Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
SYRINGES AND ACCESSORIES *(cont.)*		
VEO INSULIN SYRINGE	T1	
VERIFINE INSULIN SYRINGE	T1	
DURABLE MEDICAL EQUIPMENT,MISC(GROUP I)		
1ST TIER UNILET COMFORTOUCH	T1	
2-IN-1 LANCET DEVICE	T1	
ACCU-CHEK	T1	
DURABLE MEDICAL EQUIPMENT,MISC(GROUP I) *(cont.)*		
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 / ULT THIN LANCET	T1	
DROPLET LANCETS	T1	
EASY COMFORT LANCETS	T1	
EASY TOUCH	T1	
EASY TWIST & CAP LANCETS	T1	
EMBRACE 30G LANCETS / SAFETY LANCET	T1	
EZ SMART LANCETS	T1	
EZ-LETS	T1	

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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 LANCETS / UNISTIK 2	T1	
GLUCOCOM	T1	
GOJJI LANCETS	T1	
HEALTHY ACCENTS UNILET LANCET	T1	
INCONTROL SUPER THIN LANCETS / ULTRA THIN LANCETS	T1	
INJECT EASE LANCETS	T1	
INVACARE LANCETS	T1	
lancets	T1	
LANCETS	T1	
LITE TOUCH	T1	
MEDISENSE THIN LANCETS	T1	
MEDLANCE PLUS	T1	
MICRO THIN LANCETS	T1	
MICROLET	T1	
MICROTAINER LANCETS	T1	
MOBILE LANCETS	T1	
MONOLET LANCETS / THIN LANCETS	T1	
MYGLUCOHEALTH LANCETS	T1	
NOVA SAFETY LANCETS	T1	
NOVA SUREFLEX	T1	
ON CALL LANCET / PLUS LANCET	T1	
ONETOUCH	T1	
ON-THE-GO	T1	
PIP LANCET	T1	
PRESSURE ACTIVATED LANCETS	T1	
PRO COMFORT LANCETS / SAFETY LANCET	T1	
PRODIGY LANCETS / TWIST TOP LANCET	T1	
PURE COMFORT LANCETS / SAFETY LANCETS	T1	
PUSH BUTTON SAFETY LANCETS	T1	
READYLANCE SAFETY LANCETS	T1	

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Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
DURABLE MEDICAL EQUIPMENT,MISC(GROUP I) *(cont.)*		
RELIAMED	T1	
RELIAMED SAFETY SEAL LANCETS	T1	
RELION THIN	T1	
RIGHTEST GL300 LANCETS	T1	
SAFETY LANCETS / SEAL LANCETS	T1	
SAFETY-LET	T1	
SINGLE-LET	T1	
SMART SENSE/ SENSE LANCETS	T1	
SMARTEST LANCET	T1	
SOFT TOUCH	T1	
SOLUS V2 LANCETS / 28G LANCETS	T1	
STERILANCE TL	T1	
STERILE LANCETS	T1	
SUPER THIN LANCETS	T1	
SURE COMFORT LANCETS	T1	
SURE-LANCE	T1	
SURE-TOUCH	T1	
TECHLITE LANCETS	T1	
TELCARE ULTRA THIN 30G LANCETS	T1	
THIN LANCETS	T1	
TOPCARE UNIVERSAL1 THIN LANCET / UNIVERSAL1 LANCET	T1	
TRUE COMFORT LANCET / SAFETY LANCET	T1	
TRUEPLUS LANCETS	T1	
TWIST LANCETS / TOP LANCET	T1	
ULTILET	T1	
ULTRA THIN	T1	
ULTRA-CARE LANCETS	T1	
ULTRALANCE	T1	
ULTRA-THIN II	T1	
ULTRATLC LANCETS	T1	
UNILET	T1	
UNISTIK	T1	
UNIVERSAL 1	T1	
VERIFINE SAFETY LANCET MINI / UNIVERSAL LANCET	T1	
VIVAGUARD LANCET	T1	

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MISCELLANEOUS MEDICAL SUPPLIES, DEVICES, NON-DRUG (Diagnostic Test Devices, Supplies, And Services Miscellaneous)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
TISSUE BULKING IMPLANTS		
BARRIGEL (hyaluronate sodium, stabilized)	T1	PA SP HD
MUSCLE RELAXANTS (Pain Relief And Inflammatory Disease)		
SKELETAL MUSCLE RELAXANTS		
baclofen 5 mg tablet	T1	HD
carisoprodol/aspirin	T1	
chlorzoxazone	T1	
cyclobenzaprine hcl	T1	
cyclobenzaprine hcl (Fexmid)	T1	
DANTRIUM	T3	
DANTRIUM (*dantrolene sodium*)	T3	
dantrolene sodium	T1	
dantrolene sodium (Dantrium)	T1	
FEXMID (*cyclobenzaprine hcl*)	T3	
FLEQSUVY (baclofen)	T3	HD
GABLOFEN	T3	
GABLOFEN (*baclofen*)	T3	
LIORESAL INTRATHECAL	T3	
metaxalone	T1	
metaxalone (Skelaxin)	T1	
methocarbamol (Robaxin)	T1	
methocarbamol (Robaxin-750)	T1	
orphenadrine citrate	T1	
OZOBAX DS	T3	
ROBAXIN	T3	
ROBAXIN-750 (*methocarbamol*)	T3	
RYANODEX	T3	
SKELAXIN (*metaxalone*)	T3	
SOMA (*carisoprodol*)	T3	
SOMA (*vanadom*)	T3	
tizanidine hcl (Zanaflex)	T1	
ZANAFLEX (*tizanidine hcl*)	T3	
PRE-NATAL VITAMINS (Nutritional/Dietary)		
PRENATAL VITAMIN PREPARATIONS		
ATABEX EC	T3	

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PRE-NATAL VITAMINS (Nutritional/Dietary) *(cont.)*		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
PRENATAL VITAMIN PREPARATIONS *(cont.)*		
CITRANATAL 90 DHA	T3	
CITRANATAL ASSURE	T3	
CITRANATAL DHA	T3	
CITRANATAL HARMONY	T3	
CITRANATAL RX	T3	
OBSTETRIX EC	T3	
OBTREX DHA	T3	
pnv 22/iron, gluc/folic/dss/dha	T1	
pnv 66/iron/folic/docusate/dha	T1	
pnv 69/iron/folic/docusate/dha	T1	
pnv 80/iron fum/folic/dss/dha	T1	
pnv/ferrous fum/docusate/folic	T1	
pnv/iron, carb/docusat/folic ac	T1	
prenatal 12/iron/folic/dss/om3 (Obtrex Dha)	T1	
PRENATAL 19	T1	
prenatal 34/iron/folic/dss/dha	T1	
prenatal vits15/iron/folic/dss	T1	
VITAFOL FE+	T3	
PSYCHOTHERAPEUTIC DRUGS (Anxiety/Depression/Bipolar Disorder)[II]		
ALPHA-2 RECEPTOR ANTAGONIST ANTIDEPRESSANTS		
mirtazapine	T1	HD
mirtazapine (Remeron)	T1	HD
ANTI-ANXIETY - BENZODIAZEPINES		
alprazolam	T1	
alprazolam (Xanax Xr)	T1	
alprazolam (Xanax)	T1	
chlordiazepoxide hcl	T1	
clorazepate dipotassium	T1	
clorazepate dipotassium (Tranxene T-tab)	T1	
diazepam 10 mg tablet (Valium)	T1	
diazepam 10 mg/2 ml carpuject	T1	
diazepam 10 mg/2 ml syringe	T1	
diazepam 2 mg tablet (Valium)	T1	
diazepam 5 mg tablet (Valium)	T1	

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PSYCHOTHERAPEUTIC DRUGS (Anxiety/Depression/Bipolar Disorder)[11] *(cont.)*		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
ANTI-ANXIETY - BENZODIAZEPINES *(cont.)*		
diazepam 5 mg/5 ml solution	T1	
diazepam 5 mg/ml oral conc	T1	
diazepam 50 mg/10 ml vial	T1	
lorazepam	T1	
oxazepam	T1	
TRANXENE T-TAB (*clorazepate dipotassium*)	T3	
VALIUM (*diazepam*)	T3	
XANAX (*alprazolam*)	T3	
XANAX XR (*alprazolam xr*)	T3	
ANTI-ANXIETY DRUGS		
buspirone hcl	T1	HD
meprobamate	T1	
ANTIDEPRESSANT - NMDA RECEPTOR ANTAGONIST		
SPRAVATO	T3	PA SP
ANTIDEPRESSANT - POSTPARTUM DEPRESSION (PPD)		
ZURZUVAE 20 MG CAPSULE	T3	PA QL(28 caps/270 days) SP HD
ZURZUVAE 25 MG CAPSULE	T3	PA QL(28 caps/270 day) SP HD
ZURZUVAE 30 MG CAPSULE	T3	PA QL(14 caps/270 day) SP HD
BIPOLAR DISORDER DRUGS		
EQUETRO	T3	HD
lithium carbonate	T1	HD
lithium carbonate (Lithobid)	T1	HD
lithium citrate	T1	HD
MAOIS -NON-SELECTIVE, IRREVERSIBLE ANTIDEPRESSANTS		
MARPLAN	T3	QL (12 tabs/day)
phenelzine sulfate (Nardil)	T1	
tranylcypromine sulfate	T1	
MONOAMINE OXIDASE (MAO) INHIBITOR ANTIDEPRESSANTS		
EMSAM 12 MG/24 HOURS PATCH	T3	QL (1 patch/day)
EMSAM 6 MG/24 HOURS PATCH	T3	QL (2 patches/day)
EMSAM 9 MG/24 HOURS PATCH	T3	QL (1 patch/day)
NOREPINEPHRINE AND DOPAMINE REUPTAKE INHIB (NDRIS)		
bupropion hcl 100 mg tablet	T1	QL (4 tabs/day) HD
bupropion hcl 75 mg tablet	T1	QL (6 tabs/day) HD
bupropion hcl sr 100 mg tablet (Wellbutrin Sr)	T1	QL (4 tabs/day) HD

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List of Prescription Medications

PSYCHOTHERAPEUTIC DRUGS (Anxiety/Depression/Bipolar Disorder)[11] *(cont.)*		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
NOREPINEPHRINE AND DOPAMINE REUPTAKE INHIB (NDRIS) *(con't.)*		
bupropion hcl sr 150 mg tablet (Wellbutrin Sr)	T1	QL (2 tabs/day) HD
bupropion hcl sr 200 mg tablet (Wellbutrin Sr)	T1	QL (2 tabs/day) HD
bupropion hcl xl 150 mg tablet	T1	QL (3 tabs/day) HD
bupropion hcl xl 300 mg tablet	T1	QL (1 tab/day) HD
SELECTIVE SEROTONIN 5-HT2A INVERSE AGONISTS (SSIA)		
NUPLAZID	T3	PA SP HD
SELECTIVE SEROTONIN REUPTAKE INHIBITOR (SSRIS)		
citalopram hbr 10 mg tablet (Celexa)	T1	QL (6 tabs/day) HD
citalopram hbr 10 mg/5 ml soln	T1	QL (30ml/day) HD
citalopram hbr 20 mg tablet (Celexa)	T1	QL (3 tabs/day) HD
citalopram hbr 20 mg/10 ml sol	T1	QL (30ml/day) HD
citalopram hbr 40 mg tablet (Celexa)	T1	QL (1 tab/day) HD
escitalopram 10 mg tablet	T1	QL (2 tabs/day) HD
escitalopram 5 mg tablet	T1	QL (4 tabs/day) HD
escitalopram oxalate 5 mg/5 ml	T1	QL (20ml/day) HD
fluoxetine 20 mg/5 ml solution	T1	QL (20ml/day) HD
fluoxetine hcl	T1	QL (4 caps/28 days) HD
fluoxetine hcl 10 mg capsule (Prozac)	T1	QL (8 caps/day) HD
fluoxetine hcl 10 mg tablet (Sarafem)	T1	HD
fluoxetine hcl 20 mg capsule (Prozac)	T1	QL (4 caps/day) HD
fluoxetine hcl 20 mg tablet	T1	HD
fluoxetine hcl 40 mg capsule (Prozac)	T1	QL (2 caps/day) HD
fluoxetine hcl 60 mg tablet	T1	QL (1 tab/day) HD
fluvoxamine er 100 mg capsule	T1	QL (3 caps/day) HD
fluvoxamine er 150 mg capsule	T1	QL (2 caps/day) HD
fluvoxamine maleate 100 mg tab	T1	QL (3 tabs/day) HD
fluvoxamine maleate 25 mg tab	T1	QL (12 tabs/day) HD
fluvoxamine maleate 50 mg tab	T1	QL (6 tabs/day) HD
paroxetine cr 12.5 mg tablet (Paxil Cr)	T1	QL (1 tab/day) HD
paroxetine cr 25 mg tablet (Paxil Cr)	T1	QL (3 tabs/day) HD
paroxetine cr 37.5 mg tablet (Paxil Cr)	T1	QL (2 tabs/day) HD
paroxetine er 12.5 mg tablet (Paxil Cr)	T1	QL (1 tab/day) HD
paroxetine er 25 mg tablet (Paxil Cr)	T1	QL (3 tabs/day) HD
paroxetine er 37.5 mg tablet (Paxil Cr)	T1	QL (2 tabs/day) HD

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PSYCHOTHERAPEUTIC DRUGS (Anxiety/Depression/Bipolar Disorder)[11] *(cont.)*		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
SELECTIVE SEROTONIN REUPTAKE INHIBITOR (SSRIS) *(cont.)*		
paroxetine hcl 10 mg tablet (Paxil)	T1	QL (6 tabs/day) HD
paroxetine hcl 20 mg tablet (Paxil)	T1	QL (3 tabs/day) HD
paroxetine hcl 30 mg tablet (Paxil)	T1	QL (2 tabs/day) HD
paroxetine hcl 40 mg tablet (Paxil)	T1	QL (1 tab/day) HD
PAXIL CR 12.5 MG TABLET (*paroxetine er*)	T3	QL (1 tab/day) ST HD
PAXIL CR 25 MG TABLET (*paroxetine er*)	T3	QL (3 tabs/day) ST HD
SARAFEM (*fluoxetine hcl*)	T3	ST HD
sertraline 20 mg/ml oral conc (Zoloft)	T1	QL (10ml/day) HD
sertraline hcl 100 mg tablet (Zoloft)	T1	QL (2 tabs/day) HD
sertraline hcl 25 mg tablet (Zoloft)	T1	QL (8 tabs/day) HD
sertraline hcl 50 mg tablet (Zoloft)	T1	QL (4 tabs/day) HD
SEROTONIN-2 ANTAGONIST/REUPTAKE INHIBITORS (SARIS)		
nefazodone hcl	T1	HD
trazodone hcl	T1	HD
SEROTONIN-NOREPINEPHRINE REUPTAKE-INHIB (SNRIS)		
desvenlafaxine succnt er 100mg	T1	QL (4 tabs/day) HD
desvenlafaxine succnt er 25 mg	T1	QL (16 tabs/day) HD
desvenlafaxine succnt er 50 mg	T1	QL (1 tab/day) HD
duloxetine hcl dr 20 mg cap	T1	QL (6 caps/day) HD
duloxetine hcl dr 30 mg cap	T1	QL (4 caps/day) HD
duloxetine hcl dr 40 mg cap	T1	QL (3 caps/day) HD
duloxetine hcl dr 60 mg cap	T1	QL (2 caps/day) HD
FETZIMA 20-40 MG TITRATION PAK	T3	QL (28 caps/180 days) ST 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
venlafaxine hcl 100 mg tablet	T1	QL (3 tabs/day) HD
venlafaxine hcl 25 mg tablet	T1	QL (15 tabs/day) HD
venlafaxine hcl 37.5 mg tablet	T1	QL (10 tabs/day) HD
venlafaxine hcl 50 mg tablet	T1	QL (7 tabs/day) HD
venlafaxine hcl 75 mg tablet	T1	QL (5 tabs/day) HD
venlafaxine hcl er 150 mg cap (Effexor Xr)	T1	QL (2 caps/day) HD
venlafaxine hcl er 150 mg tab	T1	QL (2 tabs/day) HD
venlafaxine hcl er 225 mg tab	T1	QL (1 tab/day) HD

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PSYCHOTHERAPEUTIC DRUGS (Anxiety/Depression/Bipolar Disorder)[11] *(cont.)*		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
SEROTONIN-NOREPINEPHRINE REUPTAKE-INHIB (SNRIS)		
venlafaxine hcl er 37.5 mg cap (Effexor Xr)	T1	QL (8 caps/day) HD
venlafaxine hcl er 37.5 mg tab	T1	QL (8 tabs/day) HD
venlafaxine hcl er 75 mg cap (Effexor Xr)	T1	QL (4 caps/day) HD
venlafaxine hcl er 75 mg tab	T1	QL (4 tabs/day) HD
SSRI AND 5HTIA PARTIAL AGONIST ANTIDEPRESSANTS		
VIIBRYD 10-20 MG STARTER PACK	T3	ST HD
vilazodone hcl 10 mg tablet (Viibryd)	T1	QL (1 tab/day) ST HD
vilazodone hcl 20 mg tablet (Viibryd)	T1	QL (1 tab/day) ST HD
vilazodone hcl 40 mg tablet (Viibryd)	T1	HD
SSRI, SEROTONIN RECEPTOR MODULATOR ANTIDEPRESSANTS		
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 ANTIDEPRESSANT-BENZODIAZEPINE COMBINATNS		
amitriptyline/chlordiazepoxide	T1	HD
TRICYCLIC ANTIDEPRESSANT-PHENOTHIAZINE COMBINATNS		
perphenazine/amitriptyline hcl	T1	HD
TRICYCLIC ANTIDEPRESSANTS, REL.NON-SEL.REUPT-INHIB		
amitriptyline hcl	T1	HD
amoxapine	T1	HD
clomipramine hcl	T1	HD
desipramine hcl	T1	HD
desipramine hcl (Norpramin)	T1	HD
doxepin 10 mg capsule	T1	HD
doxepin 10 mg/ml oral conc	T1	HD
doxepin capsule	T1	HD
imipramine hcl	T1	HD
imipramine pamoate	T1	HD
maprotiline hcl	T1	HD
nortriptyline hcl	T1	HD
protriptyline hcl	T1	HD
trimipramine maleate	T1	HD
PSYCHOTHERAPEUTIC DRUGS (Attention Deficit Hyperactivity Disorder)[11]		
ADRENERGICS, AROMATIC, NON-CATECHOLAMINE		
lisdexamfetamine (Vyvanse)	T1	PA QL (1 cap/day)

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PSYCHOTHERAPEUTIC DRUGS (Attention Deficit Hyperactivity Disorder)[11]		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
TX FOR ADHD - SELECTIVE ALPHA-2 RECEPTOR AGONIST		
clonidine hcl (Kapvay)	T1	
guanfacine hcl (Intuniv)	T1	HD
INTUNIV (*guanfacine hcl er*)	T3	
TX FOR ATTENTION DEFICIT-HYPERACT (ADHD) /NARCOLEPSY		
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)
dexmethylphenidate er 10 mg cp	T1	PA QL (1 cap/day)
dexmethylphenidate er 15 mg cp	T1	PA QL (1 per day)
dexmethylphenidate er 20 mg cp	T1	PA QL (1 cap/day)
dexmethylphenidate er 25 mg cp	T1	PA QL (1 cap/day)
dexmethylphenidate er 30 mg cp	T1	PA QL (1 cap/day)
dexmethylphenidate er 35 mg cp	T1	PA QL (1 cap/day)
dexmethylphenidate er 40 mg cp	T1	PA QL (1 cap/day)
dexmethylphenidate er 5 mg cap	T1	PA QL (1 cap/day)
dexmethylphenidate hcl (Focalin)	T1	PA
FOCALIN (*dexmethylphenidate hcl*)	T3	PA ST
METADATE CD (methylphenidate hcl)	T3	PA QL
METHYLIN (*methylphenidate hcl*)	T3	PA
methylphenidate (Daytrana)	T1	PA QL (1 patch/day)
methylphenidate er 18, 27, 54mg cap	T1	PA QL (1 tab/day)
methylphenidate er 36mg cap	T1	PA QL (2 tab/day)
methylphenidate er 10 mg cap	T1	QL (1 per day)
methylphenidate er 10 mg tab	T1	PA QL (2/day)
methylphenidate 10 mg/9hr ptch (Daytrana)	T1	PA QL (1 patch/day)
methylphenidate er 15 mg cap	T1	QL (1 per day)
methylphenidate 15 mg/9hr ptch (Daytrana)	T1	PA QL (1 patch/day)
methylphenidate er 18 mg tab	T1	PA QL (1 per day)
methylphenidate er 20 mg cap	T1	QL (1 per day)
methylphenidate er 20 mg tab	T1	PA QL (3/day)
methylphenidate 20 mg/9hr ptch (Daytrana)	T1	PA QL (1 patch/day)
methylphenidate er 27 mg tab	T1	PA QL (1 tab/day)
methylphenidate er 30 mg cap	T1	QL (1 per day)
methylphenidate 30 mg/9hr ptch (Daytrana)	T1	PA QL (1 patch/day)

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List of Prescription Medications

PSYCHOTHERAPEUTIC DRUGS (Attention Deficit Hyperactivity Disorder)[11] *(cont.)*		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
TX FOR ATTENTION DEFICIT-HYPERACT (ADHD) /NARCOLEPSY *(cont.)*		
methylphenidate er 36 mg tab	T1	PA QL (1 per day)
methylphenidate er 40 mg cap	T1	QL (1 per day)
methylphenidate er 50 mg cap	T1	QL (1 per day)
methylphenidate er 54 mg tab	T1	PA QL (1 tab/day)
methylphenidate er 60 mg cap	T1	QL (1 per day)
methylphenidate hcl	T1	PA
methylphenidate hcl (Metadate CD)	T1	PA QL (1 cap/day)
methylphenidate hcl (Methylin)	T1	PA
methylphenidate hcl (Ritalin)	T1	PA
methylphenidate la 10 mg cap	T1	PA QL (1 cap/day)
methylphenidate la 20 mg cap	T1	PA QL (1 cap/day)
methylphenidate la 30 mg cap	T1	PA QL (1 per day)
methylphenidate la 40 mg cap	T1	PA QL (1 cap/day)
methylphenidate la 60 mg cap	T1	PA QL (1 cap/day)
QUILLIVANT XR	T3	PA QL (12ml/day)
RITALIN (*methylphenidate hcl*)	T3	PA ST
TX FOR ATTENTION DEFICIT-HYPERACT. (ADHD) , NRI-TYPE		
atomoxetine hcl 10 mg capsule (Strattera)	T1	HD
atomoxetine hcl 100 mg capsule (Strattera)	T1	HD
atomoxetine hcl 18 mg capsule (Strattera)	T1	HD
atomoxetine hcl 25 mg capsule (Strattera)	T1	HD
atomoxetine hcl 40 mg capsule (Strattera)	T1	QL (1 cap/day) HD
atomoxetine hcl 60 mg capsule (Strattera)	T1	HD
atomoxetine hcl 80 mg capsule (Strattera)	T1	HD
STRATTERA 10 MG CAPSULE (*atomoxetine hcl*)	T3	HD
STRATTERA 100 MG CAPSULE (*atomoxetine hcl*)	T3	HD
STRATTERA 18 MG CAPSULE (*atomoxetine hcl*)	T3	HD
STRATTERA 25 MG CAPSULE (*atomoxetine hcl*)	T3	HD
STRATTERA 40 MG CAPSULE (*atomoxetine hcl*)	T3	QL (1 cap/day) HD
STRATTERA 60 MG CAPSULE (*atomoxetine hcl*)	T3	HD
STRATTERA 80 MG CAPSULE (*atomoxetine hcl*)	T3	HD

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List of Prescription Medications

PSYCHOTHERAPEUTIC DRUGS (Schizophrenia/Anti-Psychotics)[11] *(cont.)*		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
ANTIPSYCH, DOPAMINE ANTAG., DIPHENYLBUTYLPIPERIDINES		
pimozide	T1	
ANTIPSYCHOTIC, ATYPICAL, DOPAMINE, SEROTONIN ANTAGNST		
asenapine maleate (Saphris)	T1	
CAPLYTA	T3	ST QL(1 tabs/caps/day)
clozapine	T1	
clozapine (Clozapine Odt)	T1	
clozapine (Clozaril)	T1	
CLOZAPINE ODT	T1	
CLOZARIL (*clozapine*)	T3	ST
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
GEODON	T3	
INVEGA ER 1.5 MG TABLET (*paliperidone er*)	T3	ST
INVEGA ER 3 MG TABLET (*paliperidone er*)	T3	QL (1 tab/day) ST
INVEGA ER 6 MG TABLET (*paliperidone er*)	T3	ST
INVEGA ER 9 MG TABLET (*paliperidone er*)	T3	ST
INVEGA SUSTENNA 117 MG/0.75 ML	T3	QL (2 syrings/28 days)
INVEGA SUSTENNA 156 MG/ML SYRG	T3	QL (1 syringe/28 days)
INVEGA SUSTENNA 234 MG/1.5 ML	T3	QL (1 syringe/28 days)
INVEGA SUSTENNA 39 MG/0.25 ML	T3	QL (2 syrings/28 days)
INVEGA SUSTENNA 78 MG/0.5 ML	T3	QL (2 syrings/28 days)
INVEGA TRINZA	T3	QL (2 injectors/90 days)
lurasidone hcl 120 mg tablet (Latuda)	T1	
lurasidone hcl 20 mg tablet (Latuda)	T1	
lurasidone hcl 40 mg tablet (Latuda)	T1	QL(1 tab/day)
lurasidone hcl 60 mg tablet (Latuda)	T1	QL(1 tab/day)
lurasidone hcl 80 mg tablet (Latuda)	T1	

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PSYCHOTHERAPEUTIC DRUGS (Schizophrenia/Anti-Psychotics)[II] *(cont.)*		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
ANTIPSYCHOTIC, ATYPICAL, DOPAMINE, SEROTONIN ANTAGNST *(cont.)*		
olanzapine	T1	
olanzapine (Zyprexa)	T1	
paliperidone er 1.5 mg tablet (Invega)	T1	
paliperidone er 3 mg tablet (Invega)	T1	QL (1 tab/day)
paliperidone er 9 mg tablet (Invega)	T1	
PERSERIS	T3	QL (1 kit/28 days)
quetiapine fumarate (Seroquel Xr)	T1	
quetiapine fumarate 400 mg tab (Seroquel)	T1	
risperidone	T1	QL
risperidone (Risperdal)	T1	
SAPHRIS (*asenapine maleate*)	T3	ST
SECUADO	T3	ST
SEROQUEL (*quetiapine fumarate*)	T3	ST
SEROQUEL XR (*quetiapine fumarate er*)	T3	ST
ziprasidone hcl	T1	
ziprasidone mesylate (Geodon)	T1	
ZYPREXA (*olanzapine*)	T2	
ZYPREXA RELPREVV 210 MG VIAL	T3	QL (4 vials/28 days)
ZYPREXA RELPREVV 210 MG VL KIT	T3	QL (4 vials/28 days)
ZYPREXA RELPREVV 300 MG VIAL	T3	QL (4 vials/28 days)
ZYPREXA RELPREVV 300 MG VL KIT	T3	QL (4 vials/28 days)
ZYPREXA RELPREVV 405 MG VIAL	T3	QL (2 vials/28 days)
ZYPREXA RELPREVV 405 MG VL KIT	T3	QL (2 vials/28 days)
ANTIPSYCHOTIC-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 ASIMTUFII	T3	

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PSYCHOTHERAPEUTIC DRUGS (Schizophrenia/Anti-Psychotics)[11] *(cont.)*		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
ANTIPSYCHOTICS, ATYP, D2 PARTIAL AGONIST/5HT MIXED *(cont.)*		
ABILIFY MAINTENA ER 300 MG SYR	T2	QL (2 injectors/30 days)
ABILIFY MAINTENA ER 300 MG VL	T2	QL (2 injectors/30 days)
ABILIFY MAINTENA ER 400 MG SYR	T2	QL (2 injectors/30 days)
ABILIFY MAINTENA ER 400 MG VL	T2	
aripiprazole	T1	
aripiprazole 10 mg tablet	T1	
aripiprazole 15 mg tablet	T1	
aripiprazole 2 mg tablet	T1	
aripiprazole 20 mg tablet	T1	
aripiprazole 30 mg tablet	T1	
aripiprazole 5 mg tablet	T1	QL (1 tab/day)
ARISTADA ER 1064 MG/3.9 ML SYR	T3	
ARISTADA ER 441 MG/1.6 ML SYRN	T3	QL (2 syrings/30 days)
ARISTADA ER 662 MG/2.4 ML SYRN	T3	QL (2 syrings/30 days)
ARISTADA ER 882 MG/3.2 ML SYRN	T3	QL (2 syrings/30 days)
ARISTADA INITIO	T3	
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
ANTIPSYCHOTICS, DOPAMINE AND SEROTONIN ANTAGONISTS		
loxapine succinate	T1	
ANTIPSYCHOTICS, DOPAMINE ANTAGONISTS, BUTYROPHENONES		
droperidol	T1	
HALDOL (*haloperidol lactate*)	T3	
HALDOL DECANOATE 100 (*haloperidol decanoate 100*)	T3	
HALDOL DECANOATE 50 (*haloperidol decanoate*)	T3	
haloperidol	T1	
haloperidol decanoate	T1	
haloperidol decanoate (Haldol Decanoate 100)	T1	

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PSYCHOTHERAPEUTIC DRUGS (Schizophrenia/Anti-Psychotics)[II] *(cont.)*		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
ANTIPSYCHOTICS, DOPAMINE ANTAGONISTS, BUTYROPHENONES *(cont.)*		
haloperidol decanoate (Haldol Decanoate 50)	T1	
haloperidol lactate	T1	
haloperidol lactate (Haldol)	T1	
ANTIPSYCHOTICS, DOPAMINE ANTAGONST, DIHYDROINDOLONES		
molindone hcl	T1	
ANTIPSYCHOTICS, PHENOTHIAZINES		
chlorpromazine hcl	T1	
fluphenazine decanoate	T1	
fluphenazine hcl	T1	
perphenazine	T1	
thioridazine hcl	T1	
trifluoperazine hcl	T1	
SSRI-ANTIPSYCH, ATYPICAL, DOPAMINE, SEROTONIN ANTAG		
olanzapine/fluoxetine hcl	T1	
olanzapine/fluoxetine hcl (Symbyax)	T1	
PSYCHOTHERAPEUTIC DRUGS (Sleep Disorders/Sedatives)		
NARCOLEPSY AND SLEEP DISORDER THERAPY AGENTS		
armodafinil	T1	PA
modafinil (Provigil)	T1	PA
SUNOSI	T2	PA QL (1 tab/day)
SEDATIVE/HYPNOTICS (Sleep Disorders/Sedatives)		
ANTI-NARCOLEPSY, ANTI-CATAPLEXY, SEDATIVE-TYPE AGENT		
LUMRYZ	T3	PA QL (1 pack/day) SP HD
SODIUM OXYBATE	T3	PA QL(18 mls/day) SP HD
BARBITURATES		
AMYTAL SODIUM	T3	
NEMBUTAL SODIUM (*pentobarbital sodium*)	T3	PA
pentobarbital sodium (Nembutal Sodium)	T1	PA
phenobarbital	T1	
phenobarbital sodium	T1	
secobarbital sodium	T3	PA

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

SEDATIVE/HYPNOTICS (Sleep Disorders/Sedatives) *(cont.)*		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
SEDATIVE-HYPNOTICS, NON-BARBITURATE *(cont.)*		
HETLIOZ	T3	PA SP HD
HETLIOZ LQ	T3	PA SP HD
ramelteon (Rozerem)	T1	QL (1 tab/day)
tasimelteon	T1	PA SP
SEDATIVE-HYPNOTICS - BENZODIAZEPINES		
DORAL	T3	
estazolam	T1	
flurazepam hcl	T1	
HALCION (*triazolam*)	T3	
lorazepam	T1	
LORAZEPAM-0.9% NACL	T1	
LORAZEPAM-D5W	T1	
QUAZEPAM	T1	
quazepam (Quazepam)	T1	
temazepam	T1	
triazolam	T1	
triazolam (Halcion)	T1	
SEDATIVE-HYPNOTICS, NON-BARBITURATE		
DAYVIGO	T2	QL (1 tab/day) ST
DEXMEDETOMIDINE HCL	T1	
dexmedetomidine hcl (Precedex)	T1	
dexmedetomidine in 0.9 % nacl	T1	
doxepin hcl 3 mg tablet (Silenor)	T1	QL (1 tab/day)
doxepin hcl 6 mg tablet (Silenor)	T1	
eszopiclone (Lunesta)	T1	
PRECEDEX	T3	
zaleplon	T1	
zolpidem tartrate 10 mg tablet (Ambien)	T1	
zolpidem tartrate 5 mg tablet (Ambien)	T1	
zolpidem tart er 12.5 mg tab	T1	
zolpidem tart er 6.25 mg tab	T1	QL (1 tab/day)
zolpidem tartrate	T1	

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List of Prescription Medications

SKIN PREPS (Miscellaneous)		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
IRRIGANTS		
acetic acid	T1	
neomycin sulf/polymyxin b sulf	T1	
PHYSIOLYTE	T3	
PHYSIOSOL	T3	
ringer's solution	T1	
ringer's solution, lactated	T1	
sod, pot chlor/mag/sod, pot phos	T3	
sodium chloride irrig solution	T1	
SORBITOL	T1	
SORBITOL-MANNITOL	T1	
water for irrigation, sterile	T1	
OXIDIZING AGENTS		
hydrogen peroxide	T1	
SKIN PREPS (Pain Relief And Inflammatory Disease)		
ANTIPSORIATIC AGENTS, SYSTEMIC		
acitretin	T1	
BIMZELX	T3	PA QL(10 mls/365 days) SP HD
BIMZELX AUTOINJECTOR	T3	PA QL(10 mls/365 days) SP HD
COSENTYX	T3	PA SP HD
ILUMYA	T3	PA QL (1 syringe/84 days) SP HD
methoxsalen (Oxsoralen-ultra)	T1	
OXSORALEN-ULTRA (*methoxsalen*)	T3	
SKYRIZI (2 SYRINGES) KIT	T2	PA QL (1 kit/84 days) SP HD
SILIQ	T3	PA QL (2 inj/15 days) SP HD
SOTYKTU	T3	PA QL (1 tab/day) SP HD
TALTZ AUTOINJECTOR	T2	PA QL (1 injector/28 days) SP HD
TALTZ AUTOINJECTOR (2 PACK)	T2	PA QL (1 injector/28 days) SP HD
TALTZ AUTOINJECTOR (3 PACK)	T2	PA QL (1 injector/28 days) SP HD
TALTZ SYRINGE	T2	PA QL (1 syringe/28 days) SP HD
TREMFYA 100 MG/ML INJECTOR	T2	PA QL (1 injector/56 days) SP HD
TREMFYA 100 MG/ML SYRINGE	T2	PA QL (1 syringe/56 days) SP HD
TOPICAL ANTI-INFLAMMATORY, NSAIDS		
DICLAREAL	T3	HD
diclofenac sodium 1% gel	T1	QL (1000gm/30 days) HD

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List of Prescription Medications

SKIN PREPS (Skin Conditions)		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
ACNE AGENTS, SYSTEMIC		
ABSORICA (isotretinoin)		
ACCUTANE	T1	
AMNESTEEM	T1	
CLARAVIS	T1	
isotretinoin (Absorica)	T1	
MYORISAN	T1	
ZENATANE	T1	
ACNE AGENTS, TOPICAL		
ABSORICA *(isotretinoin)*	T3	
ACZONE 7.5% GEL PUMP *(dapsone)*		
adapalene/benzoyl peroxide	T1	
clindamycin-benzoyl perox 1-5%	T1	
clindamycin-bnz perox 1-5% pmp		
clindamycin/tretinoin	T1	
dapsone (Aczone)	T1	
KLARON (*sulfacetamide sodium*)	T3	
sulfacetamide sodium (Klaron)	T1	
ANTIPERSPIRANTS		
DRYSOL	T3	
ANTIPSORIATICS AGENTS		
anthralin	T1	
calcipotriene	T1	
calcipotriene 0.005% cream	T1	
CALCIPOTRIENE 0.005% FOAM	T3	
calcipotriene 0.005% ointment	T1	
calcipotriene 0.005% solution	T1	
calcitriol 3 mcg/g ointment	T1	QL (800gm/30 days)
tazarotene (Tazorac)	T1	
OVACE PLUS	T3	
PROMISEB	T2	
selenium sulfide	T1	
sulfacetamide sodium	T1	
TERSI FOAM	T3	

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List of Prescription Medications

SKIN PREPS (Skin Conditions) *(cont.)*		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
ANTISEPTICS, GENERAL *(cont.)*		
alcohol antiseptic pads	T1	
ALCOHOL PREP PADS / SWABS/ WIPES	T1	
CARETOUCH ALCOHOL PREP PAD	T1	
CURITY ALCOHOL PREPS	T1	
DROPSAFE PREP PADS	T1	
EASY COMFORT ALCOHOL PAD	T1	
EASY TOUCH ALCOHOL PREP PADS	T1	
INCONTROL ALCOHOL PADS	T1	
PRO COMFORT ALCOHOL PADS	T1	
PURE COMFORT ALCOHOL PAD	T1	
SINGLE USE SWAB	T1	
SURE COMFORT ALCOHOL	T1	
SURE-PREP ALCOHOL PREP PADS	T1	
TRUE COMFORT ALCOHOL PADS / PRO ALCOHOL PADS	T1	
ULTILET ALCOHOL SWAB	T1	
WEBCOL	T1	
ANTISEPTICS, MISCELLANEOUS		
GUAIACOL	T3	
DIABETIC ULCER PREPARATIONS, TOPICAL		
REGRANEX	T3	PA QL (2 tubs/30 days)
EMOLLIENTS		
ammonium lactate	T1	
ATOPICLAIR	T3	
BIAFINE (*sonafine*)	T3	
emollient combination no.10 (Biafine)	T1	
emollient combination no.35 (Mimyx)	T1	
emollient combination no.44	T1	
HALUCORT	T3	
MIMYX (*prumyx*)	T3	
RESTIZAN	T1	
vite ac/grape/hyaluronic acid (Atopiclair)	T1	
XCLAIR	T3	
IMMUNOMODULATORS		
imiquimod	T1	

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SKIN PREPS (Skin Conditions) *(cont.)*		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
IRRITANTS/COUNTER-IRRITANTS		
methyl salicylate	T1	
QUTENZA	T3	
JANUS KINASE (JAK) INHIBITORS		
CIBINQO	T2	PA QL (30 tabs/30 days) SP
KERATOLYTICS		
BENZEFOAM	T3	
BENZEPRO	T1	
benzoyl peroxide	T1	
benzoyl peroxide (Enzoclear)	T1	
benzoyl peroxide (Pacnex)	T1	
ENZOCLEAR	T3	
HYDRO 35	T3	
HYDRO 40 (*umecta*)	T3	
INOVA	T3	
KERAFOAM	T3	
KERALYT 6% GEL (*salicylic acid*)	T3	
keralyt 6% shampoo	T1	
KERALYT SCALP	T3	
KERALYT SCALP (*salicylic acid*)	T3	
PACNEX (*benzoyl peroxide*)	T3	
PODOCON-25	T1	
podofilox	T1	
PR BENZOYL PEROXIDE	T1	
SALICATE	T3	
salicylic acid	T1	
salicylic acid (Keralyt Scalp)	T1	
salicylic acid/ceramide comb 1	T1	
SALIMEZ FORTE	T1	
SALKERA	T3	
SALVAX DUO PLUS	T3	
silver nitrate	T1	
silver nitrate applicator	T1	
URAMAXIN	T3	
URAMAXIN (*urea*)	T3	

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SKIN PREPS (Skin Conditions) *(cont.)*		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
KERATOLYTICS *(cont.)*		
urea	T1	
urea (Hydro 35)	T1	
urea (Hydro 40)	T3	
urea (Uramaxin)	T1	
urea (Xurea)	T1	
XUREA	T3	
PROTECTIVES		
BIONECT	T3	
PHARMABASE BARRIER	T1	
polydimethylsiloxanes/silicon	T1	
protectives2/ceramide 1, 3, 6-ii	T1	
RADIAPLEXRX	T3	
zinc oxide	T1	
ROSACEA AGENTS, TOPICAL		
azelaic acid	T1	
ivermectin	T1	
metronidazole	T1	
TISSUE/WOUND ADHESIVES		
ARTISS	T3	
SURGISEAL STYLUS	T3	
SURGISEAL TEARDROP	T3	
SURGISEAL TWIST	T3	
TISSEEL VHSD	T3	
TOP. ANTI-INFLAM., PHOSPHODIESTERASE-4 (PDE4) INHIB		
EUCRISA	T2	
TOPICAL AGENTS, MISCELLANEOUS		
GORDON'S UREA	T3	
HYFTOR	T3	PA SP
L-MESITRAN SOFT	T3	
MEDIHONEY	T3	
SAF-CLENS AF	T3	
trichloroacetic acid	T3	
TRICHLOROACETIC ACID	T1	

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List of Prescription Medications

SKIN PREPS (Skin Conditions) *(cont.)*		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
TOPICAL ANTIBIOTIC PLEUROMUTILIN DERIVATIVES		
ALTABAX	T3	
TOPICAL ANTI-INFLAMMATORY STEROIDAL		
ALA-SCALP (*scalacort*)	T3	ST
ACIOXIA	T3	
alclometasone dipropionate	T1	
amcinonide 0.1% cream/ lotion	T1	
AQUA GLYCOLIC HC	T3	
betamethasone dipropionate	T1	
betamethasone valerate	T1	
betamethasone valerate (Luxiq)	T1	
betamethasone/propylene glyc	T1	
betamethasone/propylene glyc (Diprolene)	T1	
BRYHALI	T3	ST
CAPEX SHAMPOO	T3	ST
clobetasol propionate	T1	
clobetasol propionate (Temovate)	T1	
clobetasol propionate/emoll	T1	
CLOCORTOLONE PIVALATE	T1	
CLODAN 0.05% KIT	T3	ST
clodan 0.05% shampoo	T1	
CLODERM	T3	ST
DERMA-SMOOTHE-FS (*fluocinolone acetonide*)	T3	ST
DERMATOP (*prednicarbate*)	T3	ST
desonide	T1	
desonide (Desowen)	T1	
DESOWEN (*desonide*)	T3	ST
desoximetasone (Topicort)	T1	
DIPROLENE (*betamethasone diprop augmented*)	T3	ST
fluocinolone acetonide	T1	
fluocinolone acetonide (Derma-smoothe-fs)	T1	
fluocinolone acetonide (Synalar)	T1	
fluocinolone/shower cap (Derma-smoothe-fs)	T1	
fluocinonide	T1	

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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.)*		
fluocinonide/emollient base	T1	
fluticasone prop 0.005% oint	T1	
fluticasone prop 0.05% cream	T1	
fluticasone prop 0.05% lotion	T1	
fluticasone propionate	T1	
halobetasol propionate (Ultravate)	T1	
halobetasol prop 0.05% cream	T1	
halobetasol prop 0.05% foam	T1	
halobetasol prop 0.05% ointmnt	T1	
hydrocortisone	T1	
hydrocortisone (Ala-scalp)	T1	
hydrocortisone butyrate	T1	
hydrocortisone valerate	T1	
LUXIQ (*betamethasone valerate*)	T3	ST
MOMETACURE	T3	
mometasone furoate 0.1% cream	T1	
mometasone furoate 0.1% oint	T1	
mometasone furoate 0.1% soln	T1	
NUCORT	T3	ST
prednicarbate (Dermatop)	T1	
SCALACORT DK	T3	ST
SYNALAR (*fluocinolone acetonide*)	T3	ST
SYNALAR TS	T3	ST
TACLONEX 0.005%-0.064% SUSPENS *(calcipotriene/betamethasone)*	T3	
TEMOVATE (*clobetasol propionate*)	T3	ST
TEXACORT	T3	ST
TOPICORT (*desoximetasone*)	T3	ST
ULTRAVATE (*halobetasol propionate*)	T3	ST
TOPICAL ANTI-INFLAMMATORY STEROID-LOCAL ANESTHETIC		
ANALPRAM HC	T3	
EPIFOAM	T2	
hydrocortisone/pramoxine (Pramosone)	T1	
lidocaine/hydrocortisone ac	T1	
MEZPAROX-HC	T1	
PRAMOSONE	T3	

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List of Prescription Medications

SKIN PREPS (Skin Conditions) *(cont.)*		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
TOPICAL ANTIPARASITICS		
lindane	T1	
malathion (Ovide)	T1	
OVIDE (*malathion*)	T3	
TOPICAL PREPARATIONS, ANTIBACTERIALS		
dermazene cream	T1	
DERMAZENE CREAM PACKET	T3	
hydrocortisone/iodoquinol	T1	
hydrocortisone/iodoquinol/aloe	T1	
iodine/potassium iodide	T1	
iodine/sodium iodide	T1	
IODOFLEX	T3	
IODOSORB	T3	
silver nitrate	T1	
TOPICAL VIT D ANALOG/ANTI-INFLAMMATORY STEROID		
calcipotriene/betamethasone	T1	
TOPICAL/MUCOUS MEMBR./SUBCUT. ENZYMES		
AMPHADASE	T3	
SANTYL	T3	QL (60gm/30 days)
VITRASE	T3	
VITAMIN A DERIVATIVES		
adapalene (Plixda)	T1	PA
PLIXDA	T1	PA
tretinoin 0.01% gel	T1	
tretinoin 0.025% cream	T1	PA
tretinoin 0.025% gel	T1	
tretinoin 0.05% cream	T1	PA
tretinoin 0.05% gel	T1	PA
tretinoin 0.1% cream	T1	PA
tretinoin microspheres	T1	PA
THYROID PREPS (Hormonal Agents)		
ANTITHYROID PREPARATIONS		
methimazole (Tapazole)	T1	HD
propylthiouracil	T1	HD
TAPAZOLE (*methimazole*)	T3	HD

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List of Prescription Medications

THYROID PREPS (Hormonal Agents)		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
THYROID FUNCTION DIAGNOSTIC AGENTS		
THYROGEN	T3	SP
THYROID HORMONES		
ARMOUR THYROID	T3	HD
CYTOMEL (*liothyronine sodium*)	T3	HD
LEVOTHYROXINE	T3	PA HD
levothyroxine sodium	T1	HD
levothyroxine sodium (Synthroid)	T1	HD
liothyronine sodium (Cytomel)	T1	HD
liothyronine sodium (Triostat)	T1	HD
SYNTHROID (*unithroid*)	T3	HD
thyroid, pork	T1	HD
thyroid, pork (Armour Thyroid)	T1	HD
thyroid, pork (Wp Thyroid)	T1	HD
THYROLAR-1	T3	HD
THYROLAR-1/2	T3	HD
THYROLAR-1/4	T3	HD
THYROLAR-2	T3	HD
THYROLAR-3	T3	HD
TIROSINT	T3	PA HD
TIROSINT-SOL	T3	PA HD
TRIOSTAT (*liothyronine sodium*)	T3	HD
WP THYROID	T1	HD
WP THYROID (*nature-throid*)	T1	HD
WP THYROID (*westhroid*)	T1	HD
UNCLASSIFIED DRUG PRODUCTS (AIDS/HIV)		
CYTOCHROME P450 INHIBITORS		
TYBOST	T3	SP
UNCLASSIFIED DRUG PRODUCTS (Asthma/COPD/Respiratory)		
CYSTIC FIBROSIS-CFTR POTENTIATOR-CORRECTOR COMBIN.		
BRONCHITOL 40 MG INHALE CAP	T3	PA SP
ORKAMBI 100 MG-125 MG TABLET	T3	PA QL (4 tabs/day) SP HD
ORKAMBI 100-125 MG GRANULE PKT	T3	PA QL (2 packs/day) SP HD
ORKAMBI 150-188 MG GRANULE PKT	T3	PA QL (2 packs/day) SP HD

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UNCLASSIFIED DRUG PRODUCTS (Asthma/COPD/Respiratory) *(cont.)*		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
CYSTIC FIBROSIS-CFTR POTENTIATOR-CORRECTOR COMBIN. *(cont.)*		
ORKAMBI 200 MG-125 MG TABLET	T3	PA QL (4 tabs/day) SP HD
SYMDEKO	T3	PA QL (2 tabs/day) SP HD
TRIKAFTA 100-50-75 MG/150 MG	T3	PA QL(3 tabs/day) SP HD
TRIKAFTA 100-50-75 MG/75MG PKT	T3	PA QL(3 tabs/day) HD
TRIKAFTA 50-25-37.5 MG/75 MG	T3	PA QL(3 tabs/day) SP HD
TRIKAFTA 80-40-60MG/59.5MG PKT	T3	PA QL(3 tabs/day) HD
CYSTIC FIB-TRANSMEMB CONDUCT.REG. (CFTR) POTENTIATOR		
KALYDECO 150 MG TABLET	T3	PA QL (2 tabs/day) SP HD
KALYDECO 5.8 MG GRANULES PACKET	T3	PA QL (2 tabs/day) SP
KALYDECO 25 MG GRANULES PACKET	T3	PA QL (2 packs/day) SP HD
KALYDECO 50 MG GRANULES PACKET	T3	PA QL (2 packs/day) SP HD
KALYDECO 75 MG GRANULES PACKET	T3	PA QL (2 packs/day) SP HD
LUNG SURFACTANTS		
CUROSURF	T3	
INFASURF	T3	
SURVANTA	T3	
MUCOLYTICS		
PULMOZYME	T3	PA SP HD
PULMONARY FIBROSIS - SYSTEMIC ENZYME INHIBITORS		
OFEV	T2	PA SP HD
SYSTEMIC ENZYME INHIBITORS		
ARALAST NP	T3	PA SP
GLASSIA	T3	PA QL(2 tabs/day) SP
JOENJA	T3	PA QL SP
PROLASTIN C	T3	PA SP
VIJOICE 125mg, 50mg	T3	PA QL (30 tabs/30 days) SP
VIJOICE 250mg dose pack	T3	PA QL (2 tabs/30 days) SP
ZEMAIRA	T3	PA SP HD
ZOKINVY	T3	PA QL (4 caps/day) SP
UNCLASSIFIED DRUG PRODUCTS (Blood Modifiers/Bleeding Disorders)		
ANTIPORPHYRIA FACTORS		
PANHEMATIN	T3	SP

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UNCLASSIFIED DRUG PRODUCTS (Blood Modifiers/Bleeding Disorders) *(cont.)*		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
ERYTHROID MATURATION AGENTS		
REBLOZYL	T3	PA SP
SPLEEN TYROSINE KINASE INHIBITORS		
TAVALISSE	T3	PA SP
BRADYKININ B2 RECEPTOR ANTAGONISTS		
icatibant acetate	T1	PA SP HD
CI ESTERASE INHIBITORS		
BERINERT	T3	PA SP HD
CINRYZE	T3	PA SP HD
HAEGARDA	T3	PA SP HD
RUCONEST	T3	PA SP HD
PLASMA KALLIKREIN INHIBITORS		
KALBITOR	T3	PA SP HD
ORLADEYO	T3	PA QL (1 caps/day) SP
UNCLASSIFIED DRUG PRODUCTS (Cancer)		
CHEMOTHERAPY RESCUE/ANTIDOTE AGENTS		
amifostine crystalline (Ethyol)	T1	SP
dexrazoxane hcl (Zinecard)	T1	SP
ETHYOL (*amifostine*)	T3	SP
CHEMOTHERAPY RESCUE/ANTIDOTE AGENTS		
KHAPZORY	T3	PA
leucovorin calcium	T1	
mesna (Mesnex)	T1	SP
MESNEX	T3	SP
MESNEX (*mesna*)	T3	SP
VISTOGARD	T3	SP
VORAXAZE	T3	PA SP
ZINECARD (*dexrazoxane*)	T3	SP
INTRAPLEURAL SCLEROSING AGENTS, ANTINEOPLAST. ADJ.		
SCLEROSOL	T3	
STERILE TALC	T1	
STERITALC	T3	
RADIOACTIVE THERAPEUTIC AGENTS		
LUTATHERA	T3	PA SP

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List of Prescription Medications

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
UNCLASSIFIED DRUG PRODUCTS (Cancer) *(cont.)*		
RADIOACTIVE THERAPEUTIC AGENTS *(cont.)*		
METASTRON	T3	PA
QUADRAMET	T3	PA
strontium-89 chloride (Metastron)	T1	PA
XOFIGO	T3	PA
TISSUE PROTECTIVE TX OF CHEMOTHERAPY EXTRAVASATION		
TOTECT	T3	
UNCLASSIFIED DRUG PRODUCTS (Dental Products)		
DENTAL AIDS AND PREPARATIONS		
chlorhexidine gluconate (Peridex)	T1	
PERIDEX (*periogard*)	T1	
triamcinolone acetonide	T1	
PERIODONTAL COLLAGENASE INHIBITORS		
doxycycline hyclate	T1	
UNCLASSIFIED DRUG PRODUCTS (Eye Conditions)		
INSULIN-LIKE GROWTH FACTOR RECEPTOR (IGF-R) INHIB		
TEPEZZA	T3	PA SP HD
OCULAR PHOTOACTIVATED VESSEL-OCCLUDING AGENTS		
VISUDYNE	T3	SP
UNCLASSIFIED DRUG PRODUCTS (Gastrointestinal/Heartburn)		
CALCIMIMETIC, PARATHYROID CALCIUM ENHANCER		
cinacalcet hcl	T1	SP
PARSABIV	T3	PA SP
ORAL MUCOSITIS/STOMATITIS AGENTS		
ORAMAGICRX	T3	
SALIVA STIMULANT AGENTS		
NUMOISYN	T3	
teriparatide 600 mcg/2.4ml pen	T1	PA QL (0.09 mls/day) SP HD
TERIPARATIDE 620 MCG/2.48 ML	T3	PA QL (0.09 mls/day) SP HD
GROWTH HORMONE RECEPTOR ANTAGONISTS		
SOMAVERT	T3	PA SP HD
HYPERPARATHYROID TX AGENTS - VITAMIN D ANALOG-TYPE		
doxercalciferol	T1	

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List of Prescription Medications

UNCLASSIFIED DRUG PRODUCTS (Gastrointestinal/Heartburn) *(cont.)*		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
HYPERPARATHYROID TX AGENTS - VITAMIN D ANALOG-TYPE *(cont.)*		
paricalcitol 1 mcg capsule (Zemplar)	T1	SP HD
PARICALCITOL 10 MCG/2 ML VIAL	T3	SP
PARICALCITOL 2MCG/ML VIAL	T3	SP
PARICALCITOL 5MCG/ML VIAL	T3	SP
paricalcitol 10 mcg/2 ml vial (Zemplar)	T1	SP
paricalcitol 2 mcg capsule (Zemplar)	T1	SP HD
PARICALCITOL 2 MCG/ML VIAL	T1	SP
paricalcitol 2 mcg/ml vial (Zemplar)	T1	SP
paricalcitol 4 mcg capsule	T1	SP HD
PARICALCITOL 5 MCG/ML VIAL	T1	SP
paricalcitol 5 mcg/ml vial (Zemplar)	T1	SP
RAYALDEE	T3	
ZEMPLAR 1 MCG CAPSULE (*paricalcitol*)	T3	SP HD
ZEMPLAR 10 MCG/2 ML VIAL (*paricalcitol*)	T3	SP
ZEMPLAR 2 MCG CAPSULE (*paricalcitol*)	T3	SP HD
ZEMPLAR 2 MCG/ML VIAL (*paricalcitol*)	T3	SP
ZEMPLAR 5 MCG/ML VIAL (*paricalcitol*)	T3	SP
MENOPAUSAL SYMPT SUPP-SEL ESTROGEN RECEP MODULATOR		
OSPHENA	T3	QL(30 tabs/30 days) HD
UNCLASSIFIED DRUG PRODUCTS (Miscellaneous)		
ABORTIFACIENT-PROGESTERONE RECEPTOR ANTAGONISTS		
MIFEPREX	T3	
mifepristone (Mifeprex)	T1	
ACID AND ALKALI POISON ANTIDOTES		
methylene blue (antidotes)	T1	
PROVAYBLUE	T3	
AGENTS TO TX PERIODIC PARALYSIS - CARBON ANHYD INH		
dichlorphenamide (Keveyis))	T1	PA SP
AMMONIA INHIBITORS		
CARBAGLU	T3	SP HD
AMYLOIDOSIS AGENTS-TRANSTHYRETIN (TTR) SUPPRESSION		
ONPATTRO	T3	PA SP
TEGSEDI	T3	PA SP HD

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UNCLASSIFIED DRUG PRODUCTS (Miscellaneous) *(cont.)*		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
ANTI-ALCOHOLIC PREPARATIONS		
acamprosate calcium	T1	
ANTABUSE (*disulfiram*)	T3	
disulfiram (Antabuse)	T1	
VIVITROL	T3	SP HD
ANTIDOTES, MISCELLANEOUS		
ACETADOTE (*acetylcysteine*)	T3	
acetylcysteine (Acetadote)	T1	
CETYLEV	T3	
CYANOKIT	T3	
DIGIFAB	T3	
fomepizole	T1	
SODIUM NITRITE	T1	
ANTIFIBROTIC THERAPY - PYRIDONE ANALOGS		
pirfenidone 267 mg capsule (Esbriet)	T1	PA SP HD
pirfenidone 801 mg capsule (Esbriet)	T1	PA SP HD
BENZODIAZEPINE ANTAGONISTS		
flumazenil	T1	
CATHETER LOCK SOLUTIONS		
DEFENCATH	T3	
CHOLINESTERASE REACTIVAT.-MUSCARINIC ANTG.ANTIDOTE		
DUODOTE	T3	
PRALIDOXIME CHLORIDE	T1	
PROTOPAM CHLORIDE	T3	
COMPLEMENT INHIBITORS		
VEOPOZ	T3	SP
CRYOPRESERVATIVE AGENTS		
dimethyl sulfoxide	T3	
DILUENT SOLUTIONS		
diluent for epoprostenol (glyc)	T1	
DILUENT FOR REMODULIN	T3	
diluent for treprostinil (gly) (Diluent For Remodulin)	T1	
ELLIOTTS B	T3	
PH 12 DILUENT FOR FLOLAN	T3	
DRUGS TO TREAT ACUTE HEPATIC PORPHYRIA (AHP)		
GIVLAARI	T3	PA SP HD

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UNCLASSIFIED DRUG PRODUCTS (Miscellaneous) *(cont.)*		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
DRUGS TO TREAT HEREDITARY TYROSINEMIA		
nitisinone (Orfadin)	T1	PA SP HD
NITYR	T2	PA SP
ORFADIN	T3	PA SP
ORFADIN (*nitisinone*)	T3	PA SP
DRUGS TO TX GAUCHER DX-TYPE I, SUBSTRATE REDUCING		
CERDELGA	T2	PA SP HD
miglustat (Zavesca)	T1	PA SP HD
ZAVESCA (*miglustat*)	T3	PA SP HD
GENERAL INHALATION AGENTS		
HYPER-SAL	T3	
nebusal 3% vial	T1	
NEBUSAL 6% VIAL	T3	
sodium chloride for inhalation (Hyper-sal)	T1	
GENETIC D/O TX - SMN PROTEIN DEFICIENCY TREATMENT		
EVRYSDI	T3	PA SP HD
SPINRAZA	T3	PA SP HD
GENETIC D/O TX-EXON SKIPPING ANTISENSE OLIGONUCLEO		
AMONDYS-45	T3	PA SP
EXONDYS-51	T3	PA SP
VILTEPSO	T3	PA SP
VYONDYS-53	T3	PA SP
GLUCOSYLCERAMIDE SYNTHASE (GCS) INHIBITOR		
miglustat (Zavesca)	T1	PA SP
OPFOLDA	T3	PA QL(8 CAPS/30 DAYS) SP HD
LEAD POISONING, AGENTS TO TREAT (CHELATING-TYPE)		
CALCIUM DISODIUM VERSENATE	T1	PA
MENOPAUSAL SYMPTOMS SUPPRESSANT - SSRIS		
paroxetine mesylate	T1	QL (1 cap/day) HD
METABOLIC DX ENZYME REPLACEMENT,ALPHA-MANNOSIDOSIS		
LAMZEDE	T3	PA SP
METABOLIC DISEASE ENZYME REPLACE, HYPOPHOSPHATASIA		
STRENSIQ	T2	PA SP
BRINEURA	T3	PA SP
METABOLIC DISEASE ENZYME REPLACEMENT, FABRY'S DX		
ELFABRIO	T3	PA SP
FABRAZYME	T3	PA SP HD

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UNCLASSIFIED DRUG PRODUCTS (Miscellaneous) *(cont.)*		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
METABOLIC DISEASE ENZYME REPLACEMENT, GAUCHER'S DX		
CEREZYME	T3	PA SP HD
ELELYSO	T3	PA SP
VPRIV	T3	PA SP HD
METABOLIC DISEASE ENZYME REPLACEMENT, MOCD		
NULIBRY	T3	PA SP
METABOLIC DISEASE ENZYME REPLACEMENT, POMPE DISEASE		
POMBILITI	T3	PA SP HD
METABOLIC DX ENZYME REPLACE, MUCOPOLYSACCHARIDOSIS		
ALDURAZYME	T3	PA SP HD
ELAPRASE	T2	PA SP
MEPSEVII	T3	PA SP
NAGLAZYME	T3	PA SP
VIMIZIM	T3	PA SP
METABOLIC DX ENZYME REPLACEMENT, LYSO.ACID LIP.DEF.		
KANUMA	T3	PA SP
METABOLIC DX ENZYME REPLACEMT, SEV.COMB.IMMUNE DEF.		
ADAGEN	T3	PA SP
REVCOVI	T3	PA SP
METALLIC POISON, AGENTS TO TREAT		
BAL IN OIL	T3	PA
CHEMET	T3	
deferasirox (Exjade)	T1	SP HD
deferasirox (Jadenu Sprinkle)	T1	SP HD
deferasirox (Jadenu)	T1	SP HD
deferiprone (Ferriprox)	T1	PA SP
deferoxamine mesylate	T1	
deferoxamine mesylate (Desferal Mesylate)	T1	
DESFERAL MESYLATE (*deferoxamine mesylate*)	T3	
EXJADE (*deferasirox*)	T3	PA SP HD
FERRIPROX	T3	PA SP
FERRIPROX (2 TIMES A DAY)	T3	PA SP
GALZIN	T3	
JADENU (*deferasirox*)	T3	PA SP HD

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UNCLASSIFIED DRUG PRODUCTS (Miscellaneous) *(cont.)*		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
METALLIC POISON, AGENTS TO TREAT *(cont.)*		
JADENU SPRINKLE (*deferasirox*)	T3	PA SP HD
NITHIODOTE	T3	
PENTETATE CALCIUM TRISODIUM	T1	
PENTETATE ZINC TRISODIUM	T1	
RADIOGARDASE	T3	
sodium thiosulf (poison treat)	T1	
trientine hcl 250 mg capsule (Syprine)	T1	PA SP HD
TRIENTINE HCL 500 MG CAPSULE	T3	PA SP HD
MISCELLANEOUS AGENTS		
NEXAVIR	T3	SP
NATRIURETIC PEPTIDES		
VOXZOGO	T3	PA SP HD
OINTMENT/CREAM BASES		
RADIAGEL	T3	
PHARMACOLOGICAL CHAPERONE-ALPHA-GALACTOSID.A STABZ		
GALAFOLD	T3	PA SP HD
PKU TX AGENT-COFACTOR OF PHENYLALANINE HYDROXYLASE		
javygtor 100 mg powder packet (Kuvan)	T1	PA SP
javygtor 100 mg tablet (Kuvan)	T1	PA SP HD
javygtor 500 mg powder packet (Kuvan)	T1	PA SP
PROTEIN STABILIZERS		
VYNDAMAX	T3	PA QL (1 cap/day) SP HD
VYNDAQEL	T3	PA QL (4 caps/day) SP HD
RADIOPHARMACEUTICALS ELEMENTS		
TECHNELITE TC-99M GENERATOR	T3	
RETINOIC ACID RECEPTOR (RAR) AGONISTS		
SOHONOS	T3	PA SP
SODIUM/SALINE PREPARATIONS		
bacteriostatic sodium chloride	T1	
SOLVENTS		
ISOPROPYL ALCOHOL	T3	
MURI-LUBE MINERAL OIL	T3	
SUSPENDING AGENTS		
GELFILM	T3	
HYDROXYPROPYLCELLULOSE	T3	

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List of Prescription Medications

UNCLASSIFIED DRUG PRODUCTS (Multiple Sclerosis)		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
SUSPENDING AGENTS *(cont.)*		
HYPROMELLOSE	T3	
LEUKOCYTE ADHESION INHIB, ALPHA4-MEDIAT IGG4K MC AB		
TYSABRI	T3	PA SP HD
UNCLASSIFIED DRUG PRODUCTS (Nutritional/Dietary)		
METABOLIC DEFICIENCY AGENTS		
CYSTADANE	T3	SP
levocarnitine (Carnitor Sf)	T1	
levocarnitine (Carnitor)	T1	
levocarnitine (with sugar) (Carnitor)	T1	
BONE FORMATION AGENTS - SCLEROSTIN INHIBITOR, MONO		
EVENITY	T3	PA QL (2 syrings/month) SP
EVENITY (2 SYRINGES)	T3	PA QL (2 syrings/month) SP
BONE RESORPTION INHIBITOR AND VITAMIN D COMBS.		
FOSAMAX PLUS D	T3	ST HD
BONE RESORPTION INHIBITORS		
ACTONEL (*risedronate sodium*)	T3	ST HD
alendronate sodium	T1	HD
alendronate sodium (FOSAMAX)	T1	HD
ATELVIA (*risedronate sodium dr*)	T3	ST HD
BINOSTO	T3	ST HD
BONIVA 150 MG TABLET (*ibandronate sodium*)	T3	ST HD
BONIVA 3 MG/3 ML SYRINGE (*ibandronate sodium*)	T3	SP HD
EVISTA (*raloxifene hcl*)	T3	HD
FOSAMAX (*alendronate sodium*)	T3	ST HD
ibandronate 3 mg/3 ml syringe (Boniva)	T1	SP HD
ibandronate 3 mg/3 ml vial	T1	SP HD
ibandronate sodium 150 mg tab (Boniva)	T1	HD
pamidronate disodium	T1	SP HD
PROLIA	T3	PA SP HD
raloxifene hcl (Evista)	T1	HD PPACA
RECLAST (*zoledronic acid*)	T3	SP HD
risedronate sodium	T1	HD
risedronate sodium (Actonel)	T1	HD
risedronate sodium (Atelvia)	T1	HD

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UNCLASSIFIED DRUG PRODUCTS (Nutritional/Dietary) *(cont.)*		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
BONE RESORPTION INHIBITORS *(cont.)*		
XGEVA	T3	PA SP HD
ZOLEDRONIC ACID 4MG/100ML	T3	SP HD
zoledronic acid/mannitol-water	T1	SP HD
zoledronic acid/mannitol-water (Reclast)	T1	SP HD
UNCLASSIFIED DRUG PRODUCTS (Osteoporosis Products)		
THYMIC STROMAL LYMPHOPOIETIN (TSLP) INHIBITORS		
TEZSPIRE 210 MG/1.91 ML PEN	T2	PA QL(1 pen/28 days) SP HD
TEZSPIRE 210 MG/1.91 ML SYRING	T2	PA SP HD
TOPICAL/MUCOUS MEMBR./SUBCUT. ENZYMES		
HYLENEX	T3	SP HD
WATER		
water for inj., bacteriostatic	T1	
water for injection, sterile	T1	
water/me-paraben/propylparaben	T1	
UNCLASSIFIED DRUG PRODUCTS (Pain Relief And Inflammatory Disease)		
ANTI-INFLAM. INTERLEUKIN-I RECEPTOR ANTAGONIST		
ARCALYST	T3	PA SP HD
ANTI-INFLAMMATORY, INTERLEUKIN-I BETA BLOCKERS		
ILARIS	T3	PA SP HD
FIBROMYALGIA AGENTS, SEROTONIN-NOREPINEPH RU INHIB		
SAVELLA	T3	HD
IMMUNOMODULATOR, B-LYMPHOCYTE STIM (BLYS) -SPEC INHIB		
BENLYSTA 120 MG VIAL	T3	PA SP
BENLYSTA 200 MG/ML AUTOINJECT	T3	PA SP HD
BENLYSTA 200 MG/ML SYRINGE	T3	PA SP HD
BENLYSTA 400 MG VIAL	T3	PA SP
JOINT CONTRACTURE THERAPY, COLLAGENASE ENZYME		
XIAFLEX	T3	PA SP

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List of Prescription Medications

UNCLASSIFIED DRUG PRODUCTS (Skin Conditions)		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
iNTERLEUKIN-13 (IL-13) INHIBITORS, MAB		
ADBRY	T2	PA SP
WOUND HEALING AGENTS, LOCAL		
balsam peru/castor oil (Venelex)	T1	
BALSAM PERU-CASTOR OIL	T1	
DERMULCERA	T1	
VENELEX	T3	
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	
buprenorphine 2 mg tablet sl	T1	
buprenorphine 8 mg tablet sl	T1	
buprenorphine hcl	T1	
buprenorphine hcl/naloxone hcl	T1	
buprenorphine hcl/naloxone hcl (Suboxone)	T1	
PROBUPHINE	T3	
SUBLOCADE	T3	SP
SUBOXONE (*buprenorphine-naloxone*)	T3	
ZUBSOLV	T2	
UNCLASSIFIED DRUG PRODUCTS (Transplant Medications)		
ORGAN TRANSPLANTATION PRESERVATION SOLUTIONS		
VIASPAN BELZER-UW	T3	
RHO KINASE INHIBITOR		
REZUROCK	T3	PA SP HD
UNCLASSIFIED DRUG PRODUCTS (Urinary Tract Conditions)		
BENIGN PROSTATIC HYPERTROPHY/MICTURITION AGENTS		
alfuzosin hcl (Uroxatral)	T1	HD
dutasteride (Avodart)	T1	HD
finasteride (Proscar)	T1	HD
FLOMAX (*tamsulosin hcl*)	T3	HD
PROSCAR (*finasteride*)	T3	HD

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UNCLASSIFIED DRUG PRODUCTS (Urinary Tract Conditions) *(cont.)*		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
BENIGN PROSTATIC HYPERTROPHY/MICTURITION AGENTS *(cont.)*		
RAPAFLO 4 MG CAPSULE (*silodosin*)	T3	QL (1 cap/day) HD
RAPAFLO 8 MG CAPSULE (*silodosin*)	T3	HD
silodosin 4 mg capsule (Rapaflo)	T1	QL (1 cap/day) HD
silodosin 8 mg capsule (Rapaflo)	T1	HD
tamsulosin hcl (Flomax)	T1	HD
UROXATRAL (*alfuzosin hcl er*)	T3	HD
BPH 5-ALPHA-REDUCTASE INHIB-ALPHAI-ADRENOCEP ANTAG		
dutasteride/tamsulosin hcl (Jalyn)	T1	HD
CYSTINE-DEPLETING AGENTS, NEPHROPATHIC CYSTINOSIS		
CYSTAGON	T2	SP
KIDNEY STONE AGENTS		
tiopronin	T1	SP
URINARY TRACT ANTISPASMODIC, M (3) SELECTIVE ANTAG.		
darifenacin er 15 mg tablet	T1	HD
darifenacin er 7.5 mg tablet	T1	QL (1 tab/day) HD
solifenacin 10 mg tablet	T1	HD
solifenacin 5 mg tablet	T1	QL (1 tab/day) HD
URINARY TRACT ANTISPASMODIC/ANTIINCONTINENCE AGENT		
flavoxate hcl	T1	HD
oxybutynin 5 mg/5 ml solution	T1	HD
oxybutynin 5 mg/5 ml syrup	T1	HD
oxybutynin chloride	T1	HD
tolterodine tart er 2 mg cap	T1	QL (1 cap/day) HD
tolterodine tart er 4 mg cap	T1	HD
tolterodine tartrate	T1	HD
trospium chloride	T1	HD
UNCLASSIFIED DRUG PRODUCTS (Weight Management)		
APPETITE STIM. FOR ANOREXIA, CACHEXIA, WASTING SYND.		
megestrol acetate	T1	
VACCINES (Vaccines)		
COVID-19 VACCINES		
JANSSEN COVID-19 VACCINE (EUA)	T3	PPACA
MODERNA COVID-19 VACCINE (EUA)	T3	PPACA
PFIZER COVID-19 VACCINE (EUA)	T3	PPACA

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List of Prescription Medications

VITAMINS (Nutritional/Dietary)		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
FOLIC ACID PREPARATIONS		
folic acid	T1	
MULTIVITAMIN PREPARATIONS		
CITRANATAL MEDLEY	T3	
FOLET ONE	T3	
INFUVITE ADULT	T3	
multivit infusn, adult 1, vit k	T3	
mvn no.53/iron/folic/dss/dha	T1	
OBSTETRIX ONE	T1	
PEDIATRIC VITAMIN PREPARATIONS		
INFUVITE PEDIATRIC	T3	
M.V.I. PEDIATRIC	T3	
VITALIPID N INFANT	T3	
VITLIPID N INFANT	T3	
VITAMIN A PREPARATIONS		
AQUASOL A	T3	
VITAMIN B PREPARATIONS		
vitamins b1, b2, b3, b5, and b6	T1	HD
VITAMIN BI PREPARATIONS		
thiamine hcl	T1	
VITAMIN BI2 PREPARATIONS		
B-12 COMPLIANCE	T1	
cyanocobalamin (vitamin b-12) (Nascobal)	T1	
hydroxocobalamin	T1	
PHYSICIANS EZ USE B-12	T3	
VITAMIN B6 PREPARATIONS		
pyridoxine hcl (vitamin b6)	T1	
VITAMIN C PREPARATIONS		
ASCOR	T3	
ascorbic acid	T1	
VITAMIN D PREPARATIONS		
calcitriol 0.25 mcg capsule (Rocaltrol)	T1	HD
calcitriol 1 mcg/ml vial	T1	HD

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VITAMINS (Nutritional/Dietary) *(cont.)*		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
VITAMIN D PREPARATIONS *(cont.)*		
calcitriol 0.5 mcg capsule (Rocaltrol)	T1	HD
calcitriol 1 mcg/ml ampul	T1	HD
calcitriol 1 mcg/ml solution (Rocaltrol)	T1	HD
DRISDOL (*vitamin d2*)	T3	HD
ergocalciferol (vitamin d2) (Drisdol)	T1	HD
ROCALTROL (*calcitriol*)	T3	HD
VITAMIN K PREPARATIONS		
MEPHYTON (*phytonadione*)	T3	
PHYTONADIONE	T1	
phytonadione (vit k1)	T1	
phytonadione (vit k1) (Mephyton)	T1	
VITAMINS (Vitamins)		
MULTIVITAMIN PREPARATIONS		
VITLIPID N ADULT	T3	

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

PA – Prior Authorization
QL – Quantity Limit
ST – Step Therapy

AGE – Age Requirement
SP – Specialty Medication
HD – May require home delivery pharmacy

PPACA – No Cost-Share Preventive Medication
CSL – Oral cancer medication subject to cost-share limits

Exclusions and limitations for coverage

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

Plans generally do not provide coverage for the following under the pharmacy benefit, except as required by state or federal law, or by the terms of your specific plan:[10]

- 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,[11] sexual dysfunction, cosmetic purposes, weight loss, smoking cessation,[11] 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.

cigna healthcare

1. App/online store terms and mobile phone carrier/data charges apply. Customers under age 13 (and/or their parent/guardian) will not be able to register at myCigna.com.
2. Smoking cessation medications are not typically covered under the plan, except as required by law or by the terms of your specific plan. Costs and complete details of the plan's prescription drug coverage, including a full list of exclusions and limitations, are set forth in the plan documents. If there are any differences between the information provided here and the plan documents, the information in the plan documents takes complete precedence.
3. Prices shown on myCigna are not guaranteed and coverage is subject to your plan terms and conditions. Visit myCigna for more information.
4. U.S. Food and Drug Administration (FDA) website, "Generic Drugs: Questions and Answers." Last updated 03/16/21. fda.gov/drugs/questions-answers/generic-drugs-questions-answers.
5. 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 penalizStandard shipping costs are included as part of your prescription plan.
6. Standard shipping costs are included as part of your prescription plan.
7. 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.
8. As allowable by law. For medications administered by a health care provider, Accredo will ship the medication directly to your doctor's office.
9. **For insured plans that must follow Delaware's state insurance laws:** Brand-name antidepressants, smoking cessation, attention deficit hyperactivity disorder (ADHD) and anti-psychotic medications that don't have a generic equivalent available will be covered as Tier 2 (preferred brand). This is true even if the medication is listed as Tier 3 (non-preferred brand) on your plan's drug list. To find out how your specific plans covers these medications, log in to the myCigna App or myCigna.com, or call Customer Service using the number on your ID card.
10. 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.
11. **For plans that must follow state insurance laws, such as Delaware:** Your plan may provide coverage for infertility medications and smoking cessation medications even if this drug list states that your plan may not cover them. To find out if your specific plan covers these medications, log in to the myCigna App or myCigna.com, or check your plan materials.

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

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

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

927840 k CA Advantage 3-Tier 03/24

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 LƯU 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 연락해주십시오. 기타 다른 경우에는 1.800.244.6224 (TTY: 다이얼 711)번으로 전화해주십시오.

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 ناشنوایان: شماره 711 را شماره‌گیری کنید).