Cigna Healthcare National Preferred 5-Tier Specialty 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 This drug list is subject to change and all prior versions are no longer in effect.

Offered by: Cigna Health and Life Insurance Company, Connecticut General Life Insurance Company, or their affiliates.
975746 c CA NPF 5-Tier Specialty 03/24 © 2024 Cigna Healthcare.

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 **National Preferred 5 Tier Specialty** 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 01/01/2023

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

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

Information about this drug list

Frequently Asked Questions (FAQs)

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

Q. How often is the drug list updated? How do I know if my medication coverage changed?
A. We regularly review and update your plan's drug list to make sure you're getting coverage for low-cost, safe, clinically effective medications. We make changes for many reasons – like when new medications become available or are no longer available, or when medication prices change. These changes may include:

- **Moving a medication to a lower cost tier.** This can happen at any time during the year.
- **Moving a brand medication to a higher cost tier when a generic becomes available.** This can happen at any time during the year.
- **Moving a medication to a higher cost tier and/or no longer covering a medication.** This typically happens twice a year on January 1st and July 1st.
- **Adding extra coverage requirements** to a medication.

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

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

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

Q. How do you decide which medications to cover?
A. The Cigna Healthcare Prescription Drug List is developed with the help of the Cigna Healthcare Pharmacy and Therapeutics (P&T) Committee, which is a group of practicing doctors and pharmacists, most of whom work outside of Cigna Healthcare. The group meets regularly to review medical evidence and information provided by federal agencies, drug manufacturers, medical professional associations, national organizations and peer-reviewed journals about the safety and effectiveness of medications that are newly approved by the FDA and medications already on the market. The Cigna Healthcare Health Plan Commercial Value Assessment Committee (HVAC) then looks at the results of the P&T Committee's clinical review, as well as the medication's overall value and other factors before adding it to, or removing it from, the drug list.

Q. Why do certain medications need approval before my plan will cover them?
A. The review process helps to make sure you're receiving coverage for the right medication, at the right cost, in the right amount and for the right situation.

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

Information about this drug list

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

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

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

Q. What types of medications typically have quantity limits?
A. Medications that are often:

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

Q. What types of medications require Step Therapy?
A. High-cost medications that are used to treat many conditions, such as:

- ADD/ADHD
- Allergies
- Bladder problems
- Breathing problems
- Depression
- High blood pressure
- High cholesterol
- Osteoporosis
- Pain
- Skin conditions
- Sleep disorders

Q. Why does my medication have an age requirement?
A. The FDA considers certain medication to only be clinically appropriate for people of a certain age or within a certain age range.

Q. How do I get approval (prior authorization) for my medication?
A. Ask your doctor's office to contact Cigna Healthcare to start the coverage review process. They know how the review process works and will take care of everything for you. In case the office asks, they can download a request form from the Cigna Healthcare provider portal at **cignaforhcp.com**.

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

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

- **For non-urgent requests**, Cigna Healthcare will let you and your doctor know within 72 hours of the decision. If approved, coverage will be provided until the prescription runs out (including refills).
- **For urgent requests based on exigent circumstances**, Cigna Healthcare will let you and your doctor know within 24 hours of the decision. If approved, coverage will be provided for the duration of the exigency. If Cigna Healthcare doesn't respond to a completed prior authorization exception request within 72 hours of receiving a non-urgent request and 24 hours of receiving a request based on exigent circumstances, the request will be considered approved and your plan can't deny coverage of the medication. Also, if you've already received approval from Cigna Healthcare for your plan to cover your medication, Cigna Healthcare can't limit or exclude coverage for that medication if your doctor continues to prescribe it to treat your condition (as long as the medication is appropriately prescribed and is safe and effective in treating your condition).

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

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

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

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

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

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

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

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

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

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

prior authorization exception request within 72 hours of receiving a non-urgent request and 24 hours of receiving a request based on exigent circumstances, the request will be considered approved and your plan can't deny coverage of the medication.

Your Step Therapy rights under California State law:

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

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

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

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

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

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

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

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

Q. What are preventive medications?
A. Preventive medications are used to keep certain conditions from developing or from coming back.

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

These conditions include, but are not limited to asthma, depression, diabetes, heart attack, high blood pressure, high cholesterol, osteoporosis, prenatal nutrient deficiency and stroke.

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

Q. How can I find out how much I'll pay for a specific medication?
A. When you and your doctor are considering the right medication for your treatment, knowing how much it costs, what lower-cost alternatives are available and which pharmacies offer the best prices can help you avoid surprises. Log in to the **myCigna App** or **myCigna.com** and use the Price a Medication tool to see how much your medication costs before you get to the pharmacy counter – or, even before you leave your doctor's office.[2]

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

Q. How can I save money on my prescription medications?
A. Consider using a medication that's covered on a lower tier (such as a generic or preferred brand medication) or by filling a 90-day supply (if your plan allows). You should talk with your doctor to see if one of these options may work for you.

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

Q. Do generics work the same as brand-name medications?
A. Yes. A generic medication works in the same way and provides the same clinical benefit as its brand-name version.

Q. What are the differences between generic and brand-name medications?
A. The medications may look different. For example, generics may have a different shape, size or color than their brand-name versions. They may also have a different flavor, have different preservatives, come in different packaging and/or with different labeling and may expire at different times. Generics may look different than their brand-name versions, but they're just as safe and effective.

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

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

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

Information about this drug list

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

Q. Do I have to use home delivery to fill my prescription?
A. It depends on your plan. Some plans require you to fill maintenance medications through Express Scripts® Pharmacy and/or specialty medications through Accredo® specialty pharmacy for them to be covered.[4] Log in to the **myCigna App** or **myCigna.com**, or check your plan materials, to find out what your plan requires.

Q. Can I fill my prescriptions by mail?
A. Yes, as long as your plan offers home delivery.

Express Scripts® Pharmacy for maintenance medications

Express Scripts® Pharmacy is a convenient option when you're taking a medication on a regular basis to treat an ongoing health condition. It's simple and safe, and saves you trips to the pharmacy. To learn more, go to **Cigna.com/homedelivery**.

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

Here are three easy ways to get started.

1. **Log in to the myCigna App or myCigna.com to move your prescription electronically.** Click on the Prescriptions tab and select My Medications from the dropdown menu. Then click the button next to your medication name to move your prescription(s). Or,

2. **Call your doctor's office.** Ask them to send a 90-day prescription (with refills) electronically to Express Scripts® Home Delivery. Or,

3. **Call Express Scripts® Pharmacy at 800.835.3784.** They'll contact your doctor's office to help transfer your prescription. Have your Cigna Healthcare ID card, doctor's contact information and medication name(s) ready when you call.

Accredo for specialty medications

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

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

To get started using Accredo, call 877.826.7657, Monday–Friday, 7:00 am–10:00 pm CST and Saturdays, 7:00 am–4:00 pm CST. To learn more about Accredo, go to **Cigna.com/specialty**.

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

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

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

Information about this drug list

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

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, Tier 3, Tier 4 and Tier 5 medications.
2. **Log in to the myCigna App or myCigna.com to view your pharmacy coverage information.** You can also use the Price a Medication tool to find out how much your medication may cost you at the different pharmacies in your plan's network.
3. **Check your Summary of Benefits** coverage document.

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

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

- **For copay plans:** These medications will be covered at 100%, or no cost-share ($0) to you.

Information about this drug list

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

- **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.
- **Deductible:** The amount you pay for covered health care benefits that are subject to the

Information about this drug list

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

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.

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.

Information about this drug list

About this drug list

This is a list of the most commonly prescribed medications covered on the Cigna Healthcare National Preferred 5-Tier Specialty Prescription Drug List as of July 1, 2024. Medications are listed alphabetically by their generic and brand names within their therapeutic category and class.

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

How to read this drug list

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

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

Tiers

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

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

* 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 National Preferred 5-Tier Specialty 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 National Preferred 5-Tier Specialty 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.

Information about this drug list

How to find your medication *(cont.)*

Information about this drug list

How to find your medication *(cont.)*

List of Prescription Medications

ANALGESICS (Pain Relief and Inflammatory Disease)		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
ANALGESIC, NON-SALICYLATE AND BARBITURATE COMBINAT		
ALLZITAL	T3	PA
butalbital/acetaminophen	T1	
butalbital/acetaminophen (Bupap)	T1	
ANALGESIC, SALICYLATE, BARBITURATE, XANTHINE COMB.		
butalbital/aspirin/caffeine	T1	
ANALGESIC, NON-SALICYLATE, BARBITURATE, XANTHINE COMB		
butalb/acetaminophen/caffeine (Esgic)	T1	
butalb/acetaminophen/caffeine (Fioricet)	T1	
ESGIC *(butalb/acetaminophen/caffeine)*	T3	PA
FIORICET *(butalb/acetaminophen/caffeine)*	T3	PA
ANALGESIC/ANTIPYRETICS, SALICYLATES		
choline salicyl/mag salicylate	T1	HD
diflunisal	T1	HD
ANTIMIGRAINE PREPARATIONS		
AIMOVIG AUTOINJECTOR	T2	PA QL(1 auto-inj/30 days)
AJOVY 225 MG/1.5 ML AUTOINJECT	T2	PA QL(1 auto-inj/30 days)
AJOVY 225 MG/1.5 ML AUTOINJECT	T2	PA QL(3 auto-injs/90 days)
AJOVY SYRINGE	T2	PA QL(1 syringe/30 days)
almotriptan malate 12.5 mg tab	T1	QL(12 tabs/fill)
almotriptan malate 6.25 mg tab	T1	QL(6 tabs/fill)
AMERGE *(naratriptan hcl)*	T3	ST QL(9 tabs/fill)
CAFERGOT *(ergotamine tartrate/caffeine)*	T3	
CAMBIA	T3	ST QL(9 packs/fill)
dihydroergotamine 1 mg/ml amp	T1	
dihydroergotamine 4 mg/ml spry (Migranal)	T1	ST QL(8 mls/fill)
eletriptan hydrobromide (Relpax)	T1	QL(6 tabs/fill)
EMGALITY 120 MG/ML SYRINGE	T2	PA QL(1 syringe/30 days)
EMGALITY PEN	T2	PA QL(1 pen/30 days)
ERGOMAR	T3	
ergotamine tartrate/caffeine	T1	
ergotamine tartrate/caffeine (Cafergot)	T1	
FROVA *(frovatriptan succinate)*	T3	ST QL(9 tabs/fill)
frovatriptan succinate (Frova)	T1	QL(9 tabs/fill)
MIGRANAL (*dihydroergotamine mesylate*)	T3	ST QL(8 mls/fill)

T1 – Generics
T2 – Preferred Brands
T3 – Non-Preferred Brands
T4 – Preferred Specialty
T5 – Non-Preferred Specialty
PA – Prior Authorization
QL – Quantity Limit
ST – Step Therapy
AGE – Age Requirement
SP – Specialty Medication
HD – May require home delivery pharmacy
PPACA – No Cost-Share Preventive Medication
CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

ANALGESICS (Pain Relief and Inflammatory Disease) (cont.)		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
ANTIMIGRAINE PREPARATIONS (cont.)		
naratriptan hcl (Amerge)	T1	QL(9 tabs/fill)
NURTEC ODT	T2	PA QL(16 tabs/fill)
QULIPTA	T2	PA QL(30 tabs/30 days)
REYVOW 100MG TABLET	T3	PA QL(8 tabs/treatment)
rizatriptan benzoate (Maxalt)	T1	QL(18 tabs/fill)
sumatriptan (Imitrex)	T1	QL(6 units/fill)
sumatriptan 4 mg/0.5 ml cart (Imitrex)	T1	QL(1 ml/fill)
sumatriptan 4 mg/0.5 ml inject (Imitrex)	T1	QL(2 pens/fill)
sumatriptan 6 mg/0.5 ml cart (Imitrex)	T1	QL(1 ml/fill)
sumatriptan 6 mg/0.5 ml inject (Imitrex)	T1	QL(2 pens/fill)
sumatriptan 6 mg/0.5 ml vial	T1	QL(2 vials/fill)
sumatriptan succ 100 mg tablet (Imitrex)	T1	
sumatriptan succ 25 mg tablet (Imitrex)	T1	
sumatriptan succ 50 mg tablet (Imitrex)	T1	
sumatriptan succ/naproxen sod (Treximet)	T1	ST QL(9 tabs/fill)
TOSYMRA	T3	ST QL(6 units/fill)
TRUDHESA	T3	ST QL(4 mls/fill)
UBRELVY	T2	PA QL(10 tabs/treatment)
ZEMBRACE SYMTOUCH	T3	ST QL(4 pens/fill)
zolmitriptan (Zomig Zmt)	T1	QL(6 tabs/fill)
zolmitriptan 2.5 mg tablet (Zomig)	T1	QL(6 tabs/fill)
zolmitriptan 5 mg nasal spray (Zomig)	T1	ST QL(6 units/fill)
zolmitriptan 5 mg tablet (Zomig)	T1	QL(6 tabs/fill)
ZOMIG 2.5 MG NASAL SPRAY	T2	ST QL(6 units/fill)
ZOMIG 5 MG NASAL SPRAY (*zolmitriptan*)	T3	ST QL(6 units/fill)
NASAL NSAIDS, COX NON-SELECTIVE,SYSTEMIC ANALGESIC		
SPRIX	T3	ST QL(5 units/fill)
NSAIDS, CYCLOOXYGENASE INHIBITOR - TYPE ANALGESICS		
diclofenac pot 25mg tablet	T1	ST HD
diclofenac pot 50 mg tablet	T1	HD
diclofenac pot powder pack	T1	ST QL (9 pkts/30 days)
diclofenac potassium	T1	HD
diclofenac potassium	T1	ST HD
diclofenac potassium 25 mg cap (Zipsor)	T1	HD

T1 – Generics
T2 – Preferred Brands
T3 – Non-Preferred Brands
T4 – Preferred Specialty
T5 – Non-Preferred Specialty
PA – Prior Authorization
QL – Quantity Limit
ST – Step Therapy
AGE – Age Requirement
SP – Specialty Medication
HD – May require home delivery pharmacy
PPACA – No Cost-Share Preventive Medication
CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

ANALGESICS (Pain Relief and Inflammatory Disease) (cont.)		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
NSAIDS, CYCLOOXYGENASE INHIBITOR - TYPE ANALGESICS (cont.)		
FENORTHO 200 MG CAPSULE	T3	PA QL
ketorolac 10 mg tablet	T1	QL(20 tabs/fill)
ketorolac 15 mg/ml carpuject	T1	HD
ketorolac 15 mg/ml isecure syr	T1	HD
ketorolac 15 mg/ml syringe	T1	HD
ketorolac 15 mg/ml vial	T1	HD
ketorolac 30 mg/ml carpuject	T1	HD
ketorolac 30 mg/ml isecure syr	T1	HD
ketorolac 30 mg/ml syringe	T1	HD
ketorolac 30 mg/ml vial	T1	HD
ketorolac 300 mg/10 ml vial	T1	HD
ketorolac 60 mg/2 ml carpuject	T1	HD
ketorolac 60 mg/2 ml syringe	T1	HD
ketorolac 60 mg/2 ml vial	T1	HD
mefenamic acid	T1	HD
OPIOID ANALGESIC AND NON-SALICYLATE ANALGESICS		
acetaminophen with codeine	T1	PA QL
hydrocodone-acetamin 10-300 mg	T1	PA QL
hydrocodone-acetamin 10-325 mg	T1	PA QL
hydrocodone-acetamin 10-325/15	T1	PA QL
HYDROCODONE-ACETAMIN 2.5-108/5	T3	PA QL
hydrocodone-acetamin 2.5-108/5	T1	PA QL
HYDROCODONE-ACETAMIN 5-217/10	T3	PA QL
hydrocodone-acetamin 5-217/10	T1	PA QL
hydrocodone-acetamin 5-300 mg	T1	PA QL
hydrocodone-acetamin 5-325 mg	T1	PA QL
hydrocodone-acetamin 7.5-300	T1	PA QL
hydrocodone-acetamin 7.5-325	T1	PA QL
hydrocodone-acetamin 7.5-325/15	T1	PA QL
HYDROCODONE-ACETAMIN 7.5-325/15	T3	PA QL
LORTAB	T3	PA QL
NALOCET	T3	PA QL
oxycodone hcl/acetaminophen	T1	PA QL

T1 – Generics
T2 – Preferred Brands
T3 – Non-Preferred Brands
T4 – Preferred Specialty
T5 – Non-Preferred Specialty
PA – Prior Authorization
QL – Quantity Limit
ST – Step Therapy
AGE – Age Requirement
SP – Specialty Medication
HD – May require home delivery pharmacy
PPACA – No Cost-Share Preventive Medication
CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

ANALGESICS (Pain Relief and Inflammatory Disease) (cont.)		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
OPIOID ANALGESIC AND NON-SALICYLATE ANALGESICS (cont.)		
oxycodone hcl/acetaminophen (Percocet)	T1	PA QL
prolate 10-300 mg tablet	T1	PA QL
prolate 5-300 mg tablet	T1	PA QL
prolate 7.5-300 mg tablet	T1	PA QL
tramadol hcl/acetaminophen	T1	PA QL(12 ds/60 days)
OPIOID ANALGESIC AND NSAID COMBINATION		
hydrocodone/ibuprofen	T1	PA
OPIOID ANALGESIC AND SALICYLATE ANALGESIC COMB		
oxycodone hcl/aspirin	T1	PA QL
OPIOID ANALGESIC, NON-SALICYLATE, XANTHINE COMB		
acetaminophen/caff/dihydrocod	T1	PA QL
TREZIX	T3	PA QL
OPIOID ANALGESICS		
ABSTRAL	T3	PA QL
ACTIQ (*fentanyl citrate*)	T3	PA QL
BELBUCA	T2	ST QL(60 films/fill)
buprenorphine (Butrans)	T1	ST
buprenorphine 150 mcg film	T1	ST QL(60 films/fill)
buprenorphine 300 mcg film	T1	ST QL(60 films/fill)
buprenorphine 450 mcg film	T1	ST QL(60 films/fill)
buprenorphine 600 mcg film	T1	ST QL(60 films/fill)
buprenorphine 75 mcg film	T1	ST QL(60 films/fill)
buprenorphine 750 mcg film	T1	ST QL(60 films/fill)
buprenorphine 900 mcg film	T1	ST QL(60 films/fill)
butorphanol tartrate	T1	PA QL(< 18 yo 12 ds/130 days)
codeine sulfate	T1	PA QL
DILAUDID *(hydromorphone hcl)*	T3	PA QL
fentanyl	T1	ST QL(15 patches/30 days)
fentanyl cit otfc 1,200 mcg (Actiq)	T1	PA QL
fentanyl cit otfc 1,600 mcg (Actiq)	T1	PA QL
fentanyl citrate otfc 200 mcg (Actiq)	T1	PA QL
fentanyl citrate otfc 400 mcg (Actiq)	T1	PA QL
fentanyl citrate otfc 600 mcg (Actiq)	T1	PA QL
fentanyl citrate otfc 800 mcg (Actiq)	T1	PA QL

T1 – Generics
T2 – Preferred Brands
T3 – Non-Preferred Brands
T4 – Preferred Specialty
T5 – Non-Preferred Specialty
PA – Prior Authorization
QL – Quantity Limit
ST – Step Therapy
AGE – Age Requirement
SP – Specialty Medication
HD – May require home delivery pharmacy
PPACA – No Cost-Share Preventive Medication
CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

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

T1 – Generics
T2 – Preferred Brands
T3 – Non-Preferred Brands
T4 – Preferred Specialty
T5 – Non-Preferred Specialty
PA – Prior Authorization
QL – Quantity Limit
ST – Step Therapy
AGE – Age Requirement
SP – Specialty Medication
HD – May require home delivery pharmacy
PPACA – No Cost-Share Preventive Medication
CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

ANALGESICS (Pain Relief and Inflammatory Disease) (cont.)		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
OPIOID ANALGESICS (cont.)		
morphine sulfate er 30 mg cap	T1	ST QL(60 caps/30 days)
morphine sulfate er 30 mg cap	T1	ST QL(90 caps/30 days)
morphine sulfate er 45 mg cap	T1	ST QL(60 caps/30 days)
morphine sulfate er 50 mg cap (Kadian)	T1	ST QL(90 caps/30 days)
morphine sulfate er 60 mg cap	T1	ST QL(60 caps/30 days)
morphine sulfate er 60 mg cap (Kadian)	T1	ST QL(90 caps/30 days)
morphine sulfate er 75 mg cap	T1	ST QL(60 caps/30 days)
morphine sulfate er 80 mg cap (Kadian)	T1	ST QL(90 caps/30 days)
morphine sulfate er 90 mg cap	T1	ST QL(60 caps/30 days)
MS CONTIN (*morphine sulfate*)	T3	ST QL(120 tabs/30 days)
opium/belladonna alkaloids	T1	PA QL
oxycodone hcl	T1	PA QL
oxycodone hcl (Roxicodone)	T1	PA QL
OXYCONTIN	T2	ST QL(90 tabs/30 days)
oxymorphone hcl	T1	PA QL
oxymorphone hcl	T1	ST QL
pentazocine hcl/naloxone hcl	T1	PA QL
ROXICODONE (*oxycodone hcl*)	T3	PA QL
tramadol er 100 mg tablet	T1	PA ST QL(30 tabs/fill)
tramadol er 200 mg tablet	T1	PA ST QL(30 tabs/fill)
tramadol er 300 mg tablet	T1	PA ST QL(30 tabs/fill)
tramadol hcl 50 mg tablet	T1	PA QL
tramadol hcl er 100 mg tablet	T1	PA ST QL(30 tabs/fill)
tramadol hcl er 200 mg tablet	T1	PA ST QL(30 tabs/fill)
tramadol hcl er 300 mg tablet	T1	PA ST QL(30 tabs/fill)
OPIOID AND SALICYLATE ANALGESICS, BARBIT, XANTHINE		
codeine/butalbital/asa/caffein	T1	PA QL
OPIOID, NON-SALICYL.ANALGESIC, BARBITURATE, XANTHINE		
butalbit/acetamin/caff/codeine	T1	PA QL
butalbit/acetamin/caff/codeine (Fioricet With Codeine)	T1	PA QL
FIORICET WITH CODEINE *(butalbit/acetamin/caff/codeine)*	T3	PA QL
SKELETAL MUSCLE RELAXANT, SALICYLAT, OPIOID ANALGESC		
carisoprodol/aspirin/codeine	T1	PA QL

T1 – Generics
T2 – Preferred Brands
T3 – Non-Preferred Brands
T4 – Preferred Specialty
T5 – Non-Preferred Specialty
PA – Prior Authorization
QL – Quantity Limit
ST – Step Therapy
AGE – Age Requirement
SP – Specialty Medication
HD – May require home delivery pharmacy
PPACA – No Cost-Share Preventive Medication
CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ANALGESICS (Urinary Tract Conditions)		
URINARY TRACT ANALGESIC AGENTS		
ELMIRON	T2	
RIMSO-50	T3	
ANESTHETICS (Miscellaneous)		
GENERAL ANESTHETICS, INHALANT		
desflurane	T1	
isoflurane	T1	
sevoflurane (Ultane)	T1	
SUPRANE	T3	
ULTANE (*sevoflurane*)	T3	
ANESTHETICS (Pain Relief and Inflammatory Disease)		
LOCAL ANESTHETICS		
lidocaine hcl	T1	QL(60 mls/30 days)
lidocaine hcl	T1	
lidocaine hcl 2% jel urojet ac	T1	QL(60 mls/30 days)
lidocaine hcl 2% jelly	T1	QL(60 mls/30 days)
lidocaine hcl 2% jelly uro-jet	T1	QL(60 mls/30 days)
lidocaine hcl 4% solution	T1	
TOPICAL LOCAL ANESTHETICS		
CETACAINE ANESTHETIC	T3	
L.E.T. (LIDO-EPINEPH-TETRA)	T3	
lidocaine (Lidocan Ii)	T1	PA
lidocaine 5% ointment	T1	QL(50 gms/28 days)
lidocaine 5% patch (Lidocan Ii)	T1	PA
lidocaine 5% patch (Lidoderm)	T1	PA
lidocaine hcl	T1	
lidocaine hcl 4% solution	T1	
LIDOCAINE-EPINEPHRIN-TETRACAIN	T3	
lidocaine-prilocaine cream	T1	QL(30 gms/30 days)
LIDOCAN II (*lidocaine*)	T3	PA
SYNERA	T3	PA
ZTLIDO	T2	PA
ANESTHETICS (Urinary Tract Conditions)		
URINARY TRACT ANESTHETIC/ANALGESIC AGNT (AZO-DYE)		
phenazopyridine hcl (Pyridium)	T1	

T1 – Generics
T2 – Preferred Brands
T3 – Non-Preferred Brands
T4 – Preferred Specialty
T5 – Non-Preferred Specialty
PA – Prior Authorization
QL – Quantity Limit
ST – Step Therapy
AGE – Age Requirement
SP – Specialty Medication
HD – May require home delivery pharmacy
PPACA – No Cost-Share Preventive Medication
CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

ANTIALLERGY (Allergy/Nasal Sprays)		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
MAST CELL STABILIZERS		
cromolyn 100 mg/5 ml oral conc (Gastrocrom)	T1	
GASTROCROM (*cromolyn sodium*)	T3	
ANTIARTHRITICS (Pain Relief and Inflammatory Disease)		
ANALGESIC/ANTIPYRETICS, SALICYLATES		
DISALCID (*salsalate*)	T3	HD
salsalate (Disalcid)	T1	HD
ANTI-ARTHRITIC AND CHELATING AGENTS		
DEPEN (penicillamine)	T5	PA SP
penicillamine (Cuprimine)	T1	PA SP
penicillamine (Depen)	T1	PA SP
ANTI-ARTHRITIC, FOLATE ANTAGONIST AGENTS		
RASUVO	T2	ST
ANTI-INFLAMMATORY, PYRIMIDINE SYNTHESIS INHIBITOR		
ARAVA (*leflunomide*)	T3	QL(30 tabs/fill) HD
leflunomide (Arava)	T1	QL(30 tabs/fill) HD
ANTI-INFLAMMATORY, PHOSPHODIESTERASE-4(PDE4) INHIB.		
OTEZLA 28 DAY STARTER PACK	T4	PA QL(55 tabs/365 days) SP HD
OTEZLA 30 MG TABLET	T4	PA QL(60 tabs/30 days) SP HD
COLCHICINE		
colchicine 0.6 mg tablet (Colcrys)	T1	HD
colchicine 0.6 mg tablet	T1	HD
GLOPERBA	T3	HD
MITIGARE (*colchicine*)	T2	ST HD
GOLD SALTS		
RIDAURA	T2	
HYPERURICEMIA TX - XANTHINE OXIDASE INHIBITORS		
allopurinol 100 mg tablet (Zyloprim)	T1	HD
allopurinol 300 mg tablet (Zyloprim)	T1	HD
febuxostat (Uloric)	T1	ST HD
ZYLOPRIM (*allopurinol*)	T3	HD
JANUS KINASE (JAK) INHIBITORS		
RINVOQ ER 15 MG TABLET	T4	PA QL(30 tabs/fill) SP HD
RINVOQ ER 30 MG TABLET	T4	PA QL(30 tabs/fill) SP HD
RINVOQ ER 45 MG TABLET	T4	PA QL(56 tabs/365 days) SP HD

T1 – Generics
T2 – Preferred Brands
T3 – Non-Preferred Brands
T4 – Preferred Specialty
T5 – Non-Preferred Specialty
PA – Prior Authorization
QL – Quantity Limit
ST – Step Therapy
AGE – Age Requirement
SP – Specialty Medication
HD – May require home delivery pharmacy
PPACA – No Cost-Share Preventive Medication
CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

ANTIARTHRITICS (Pain Relief and Inflammatory Disease) (cont.)		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
JANUS KINASE (JAK) INHIBITORS (cont.)		
XELJANZ 1 MG/ML SOLUTION	T4	PA QL(300 mls/fill) SP HD
XELJANZ 10 MG TABLET	T4	PA QL(60 tabs/fill) SP HD
XELJANZ 5 MG TABLET	T4	PA QL(60 tabs/fill) SP HD
XELJANZ XR	T4	PA QL(30 tabs/fill) SP HD
NSAID AND HISTAMINE H2 RECEPTOR ANTAGONIST COMB.		
DUEXIS (*ibuprofen/famotidine*)	T3	ST HD
ibuprofen/famotidine (Duexis)	T1	ST HD
NSAID AND TOPICAL IRRITANT COUNTER-IRRITANT COMB.		
COMFORT PAC-IBUPROFEN	T3	
COMFORT PAC-MELOXICAM	T3	
COMFORT PAC-NAPROXEN	T3	
NSAID,COX INHIBITOR-TYPE AND PROTON-PUMP INHIBITOR		
naproxen/esomeprazole mag (Vimovo)	T1	ST HD
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*)	T3	ST HD
DAYPRO (*oxaprozin*)	T3	ST HD
diclofenac sod dr 25 mg tab	T1	HD
diclofenac sod dr 50 mg tab	T1	HD
diclofenac sod dr 75 mg tab	T1	HD
diclofenac sod ec 25 mg tab	T1	HD
diclofenac sod ec 50 mg tab	T1	HD
diclofenac sod ec 75 mg tab	T1	HD
diclofenac sodium	T1	HD
EC-NAPROSYN (*naproxen*)	T3	ST HD
etodolac	T1	HD
etodolac (Lodine)	T1	HD
FELDENE (*piroxicam*)	T3	ST HD
fenoprofen 400 mg capsule (Nalfon)	T1	ST HD
fenoprofen 600 mg tablet (Nalfon)	T1	ST HD

T1 – Generics
T2 – Preferred Brands
T3 – Non-Preferred Brands
T4 – Preferred Specialty
T5 – Non-Preferred Specialty
PA – Prior Authorization
QL – Quantity Limit
ST – Step Therapy
AGE – Age Requirement
SP – Specialty Medication
HD – May require home delivery pharmacy
PPACA – No Cost-Share Preventive Medication
CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

ANTIARTHRITICS (Pain Relief and Inflammatory Disease) (cont.)		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
NSAIDS, CYCLOOXYGENASE INHIBITOR - TYPE ANALGESICS (cont.)		
flurbiprofen	T1	HD
ibuprofen	T1	HD
ibuprofen	T1	HD
indomethacin	T1	HD
indomethacin 25 mg, 50 mg capsule	T1	HD
indomethacin 25 mg/5 ml susp	T1	HD
ketoprofen	T1	ST HD
ketoprofen 25 mg capsule	T1	ST HD
ketoprofen 50 mg, 75 mg capsule	T1	HD
ketoprofen er 200 mg capsule	T1	ST HD
LODINE (*etodolac*)	T3	ST HD
meclofenamate sodium	T1	HD
meloxicam 10 mg capsule (Vivlodex)	T1	ST QL(30 caps/fill) HD
meloxicam 5 mg capsule (Vivlodex)	T1	ST QL(30 caps/fill) HD
MOBIC (*meloxicam*)	T3	ST QL(30 tabs/fill) HD
nabumetone (Relafen)	T1	HD
NALFON 600 MG TABLET (*fenoprofen calcium*)	T3	ST HD
NAPRELAN	T3	ST HD
NAPRELAN (*naproxen sodium*)	T3	ST HD
NAPROSYN (*naproxen*)	T3	ST HD
naproxen (Ec-Naprosyn)	T1	HD
naproxen 125 mg/5 ml suspen (Naprosyn)	T1	ST HD
naproxen 250 mg tablet	T1	HD
naproxen 375 mg tablet	T1	HD
naproxen 500 mg kit (Naprosyn)	T1	HD
naproxen 500 mg tablet (Naprosyn)	T1	HD
naproxen dr 375 mg tablet (Ec-Naprosyn)	T1	HD
naproxen dr 500 mg tablet (Ec-Naprosyn)	T1	HD
naproxen er 750 mg tablet	T1	ST
naproxen sodium	T1	ST HD
naproxen sodium	T1	HD
naproxen sodium (Anaprox Ds)	T1	HD
naproxen sodium (Naprelan)	T1	ST HD
oxaprozin 600mg caplet (Daypro)	T1	HD

T1 – Generics
T2 – Preferred Brands
T3 – Non-Preferred Brands
T4 – Preferred Specialty
T5 – Non-Preferred Specialty
PA – Prior Authorization
QL – Quantity Limit
ST – Step Therapy
AGE – Age Requirement
SP – Specialty Medication
HD – May require home delivery pharmacy
PPACA – No Cost-Share Preventive Medication
CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

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

T1 – Generics
T2 – Preferred Brands
T3 – Non-Preferred Brands
T4 – Preferred Specialty
T5 – Non-Preferred Specialty
PA – Prior Authorization
QL – Quantity Limit
ST – Step Therapy
AGE – Age Requirement
SP – Specialty Medication
HD – May require home delivery pharmacy
PPACA – No Cost-Share Preventive Medication
CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

ANTIASTHMATICS (Asthma/COPD/Respiratory) (cont.)		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
BETA-ADRENERGIC AGENTS, INHALED, SHORT ACTING		
albuterol 100 mg/20 ml soln	T1	
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 hfa 90 mcg inhaler (*Proair Hfa*)*	T1	QL(2 inhalers/fill)
*albuterol hfa 90 mcg inhaler (*Proventil Hfa*)*	T1	QL(2 inhalers/fill)
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	
*levalbuterol hcl (*Xopenex Concentrate*)*	T1	
*levalbuterol hcl (*Xopenex*)*	T1	
XOPENEX (*levalbuterol hcl*)	T3	
XOPENEX CONCENTRATE (*levalbuterol hcl*)	T3	
BETA-ADRENERGIC AGENTS, INHALED, ULTRA-LONG ACTING		
STRIVERDI RESPIMAT	T2	QL(1 inhaler/30 days) HD
BETA-ADRENERGIC AGENTS, ORALLY INHALED,LONG ACTING		
arformoterol tartrate (Brovana)	T1	QL(120 mls/fill) HD
BROVANA (*arformoterol tartrate*)	T3	QL(120 mls/fill) HD
formoterol fumarate (Perforomist)	T1	QL(120 mls/fill) HD
BETA-ADRENERGIC AND ANTICHOLINERGIC COMBO, INHALED		
ANORO ELLIPTA	T2	QL(1 inhaler/fill) HD
COMBIVENT INHALER	T2	
COMBIVENT RESPIMAT	T2	QL(2 inhalers/fill) HD
ipratropium/albuterol sulfate	T1	
SEEBRI NEOHALER 15.6MCG INHALER	T3	HD
STIOLTO RESPIMAT	T2	QL(1 inhaler/fill) HD
UTIBRON NEOHALER 27.5, 15.6MCG (PS 6)	T3	HD
UTIBRON NEOHALER 27.5, 15.6 MCG (PS 60)	T3	HD
BETA-ADRENERGIC AND GLUCOCORTICOID COMBO, INHALED		
ADVAIR DISKUS (*fluticasone propion/salmeterol*)	T3	PA QL(1 inhaler/fill) HD
ADVAIR HFA	T2	PA QL(1 inhaler/fill) HD
AIRDUO DIGIHALER	T3	PA QL(1 inhaler/fill) HD
AIRSUPRA	T2	HD

T1 – Generics
T2 – Preferred Brands
T3 – Non-Preferred Brands
T4 – Preferred Specialty
T5 – Non-Preferred Specialty
PA – Prior Authorization
QL – Quantity Limit
ST – Step Therapy
AGE – Age Requirement
SP – Specialty Medication
HD – May require home delivery pharmacy
PPACA – No Cost-Share Preventive Medication
CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

ANTIASTHMATICS (Asthma/COPD/Respiratory) (cont.)		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
BETA-ADRENERGIC AND GLUCOCORTICOID COMBO, INHALED (cont.)		
BREO ELLIPTA 50-25 MCG INHALER	T2	PA QL(60 blisters/fill) HD
BREO ELLIPTA 100-25 MCG INH	T2	PA QL(60 blisters/fill) HD
BREO ELLIPTA 100-25 MCG INH	T2	PA QL(28 blisters/fill) HD
BREO ELLIPTA 200-25 MCG INH	T2	PA QL(1 inhaler/fill) HD
breyna 80-4.mcg, 160-4.5 mcg inhaler	T1	PA
budesonide-formoterol 160-4.5, 80-4.5	T1	PA HD QL (1 inhaler/30 days)
DULERA 100 MCG-5 MCG INHALER	T2	PA QL(1 inhaler/fill) HD
DULERA 200 MCG-5 MCG INHALER	T2	PA QL(1 inhaler/fill) HD
DULERA 50 MCG-5 MCG INHALER	T2	PA QL(13 gms/fill) HD
*fluticasone propion/salmeterol (*Advair Diskus*)*	T1	PA QL(1 inhaler/fill) HD
*fluticasone-salmeterol 100-50 (*Advair Diskus*)*	T1	PA QL(1 inhaler/fill) HD
*fluticasone-salmeterol 250-50 (*Advair Diskus*)*	T1	PA QL(1 inhaler/fill) HD
fluticasone-salmeterol 500-50 (Advair Diskus)	T1	PA QL(1 inhaler/fill) HD
SYMBICORT *(budesonide/formoterol fumarate)*	T3	PA QL(1 inhaler/30 days) HD
BETA-ADRENERGIC-ANTICHOLINERGIC-GLUCOCORT, INHALED		
BREZTRI AEROSPHERE	T2	QL(1 inhaler/fill)
TRELEGY ELLIPTA 100-62.5-25	T2	QL(60 blisters/fill)
TRELEGY ELLIPTA 100-62.5-25	T2	QL(28 blisters/fill)
TRELEGY ELLIPTA 200-62.5-25	T2	QL(60 blisters/fill)
TRELEGY ELLIPTA 200-62.5-25	T2	QL(28 blisters/fill)
GLUCOCORTICOIDS, ORALLY INHALED		
ALVESCO 80 MCG INHALER	T3	QL(1 inhaler/fill) HD
ALVESCO 160 MCG INHALER	T3	QL(2 inhalers/fill) HD
ARNUITY ELLIPTA 100 MCG, 200 MCG INH	T2	QL(1 inhaler/fill) HD
ARNUITY ELLIPTA 50 MCG INH	T2	QL(30 blisters/fill) HD
ASMANEX	T2	QL(1 inhaler/fill) HD
ASMANEX HFA 50 MCG INHALER	T2	QL(13 gms/fill) HD
ASMANEX HFA 100 MCG, 200 MCG INHALER	T2	QL(1 inhaler/fill) HD
budesonide 0.25 mg/2 ml susp (Pulmicort)	T1	
budesonide 0.5 mg/2 ml susp (Pulmicort)	T1	
budesonide 1 mg/2 ml inh susp (Pulmicort)	T1	QL(60 mls/fill) HD
FLOVENT 50 MCG, 100 MCG DISKUS	T2	QL(1 inhaler/fill) HD
FLOVENT 250 MCG DISKUS	T2	QL(4 inhalers/fill) HD
FLOVENT HFA 110 MCG INHALER	T2	QL(12 gms/fill) HD

T1 – Generics
T2 – Preferred Brands
T3 – Non-Preferred Brands
T4 – Preferred Specialty
T5 – Non-Preferred Specialty
PA – Prior Authorization
QL – Quantity Limit
ST – Step Therapy
AGE – Age Requirement
SP – Specialty Medication
HD – May require home delivery pharmacy
PPACA – No Cost-Share Preventive Medication
CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

ANTIASTHMATICS (Asthma/COPD/Respiratory) (cont.)		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
GLUCOCORTICOIDS, ORALLY INHALED (cont.)		
FLOVENT HFA 220 MCG INHALER	T2	QL(24 gms/fill) HD
FLOVENT HFA 44 MCG INHALER	T2	QL(11 gms/fill) HD
QVAR REDIHALER 40 MCG	T2	QL(11 gms/fill) HD
QVAR REDIHALER 80 MCG	T2	QL(22 gms/fill) HD
INTERLEUKIN-5 (IL-5) ANTAGONISTS, MAB		
NUCALA 100 MG/ML AUTO-INJECTOR	T4	PA QL(1 AUTO-INJ/28 DAYS) SP HD
NUCALA 100 MG/ML SYRINGE	T4	PA QL(1 syringe/28 days) SP HD
NUCALA 40 MG/0.4 ML SYRINGE	T4	PA QL(1 syringe/28 days) SP HD
INTERLEUKIN-5(IL-5) RECEPTOR ALPHA ANTAGONIST, MAB		
FASENRA PEN	T4	PA QL(1 syringe/56 days) SP HD
LEUKOTRIENE RECEPTOR ANTAGONISTS		
ACCOLATE (*zafirlukast*)	T3	HD
montelukast sodium (Singulair)	T1	HD
zafirlukast (Accolate)	T1	HD
MAST CELL STABILIZERS, ORALLY INHALED		
cromolyn 20 mg/2 ml neb soln	T1	HD
MONOCLONAL ANTIBODIES TO IMMUNOGLOBULIN E (IGE)		
XOLAIR 150 MG/1.2 ML POWDER VL	T4	PA QL(6 vls/28 days) SP HD
XOLAIR 150 MG/ML SYRINGE	T4	PA QL(4 syringes/28 days) SP HD
XOLAIR 75 MG/0.5 ML SYRINGE	T4	PA QL(2 syringes/28 days) SP HD
XOLAIR 300 MG/2 ML SYRINGE	T4	PA SP HD
MUCOLYTICS		
acetylcysteine	T1	
PHOSPHODIESTERASE-4 (PDE4) INHIBITORS		
roflumilast 250 mcg tablet (Daliresp)	T1	PA QL(30 tabs/fill) HD
roflumilast 500 mcg tablet (Daliresp)	T1	PA HD
XANTHINES		
ELIXOPHYLLIN	T3	HD
THEO-24	T3	HD
theophylline anhydrous	T1	HD
ANTIBIOTICS (Ear Medications)		
EAR PREPARATIONS, ANTIBIOTICS		
ciprofloxacin hcl	T1	
CORTISPORIN-TC	T3	

T1 – Generics
T2 – Preferred Brands
T3 – Non-Preferred Brands
T4 – Preferred Specialty
T5 – Non-Preferred Specialty
PA – Prior Authorization
QL – Quantity Limit
ST – Step Therapy
AGE – Age Requirement
SP – Specialty Medication
HD – May require home delivery pharmacy
PPACA – No Cost-Share Preventive Medication
CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

ANTIBIOTICS (Ear Medications) (cont.)		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
EAR PREPARATIONS, ANTIBIOTICS (cont.)		
neomycin/polymyxin b/hydrocort	T1	
ofloxacin	T1	
OTIPRIO	T3	QL(1 ml/fill)
OTIC PREPARATIONS, ANTI-INFLAMMATORY-ANTIBIOTICS		
CIPRODEX (*ciprofloxacin hcl/dexameth*)	T3	
ciprofloxacin hcl/dexameth (Ciprodex)	T1	
OTOVEL	T3	
ANTIBIOTICS (Eye Conditions)		
EYE ANTIBIOTIC AND GLUCOCORTICOID COMBINATIONS		
GATIFLOXACIN-DEXAMETHASONE	T3	
MAXITROL *(neomycin/polymyxin b/dexametha)*	T3	
neomycin/bacit/p-myx/hydrocort	T1	
neomycin/polymyxin b/dexametha (Maxitrol)	T1	
neomycin/polymyxin b/hydrocort	T1	
PRED-G	T3	
PREDNISOLONE ACET-GATIFLOXACIN	T3	
PREDNISOLONE ACET-MOXIFLOXACIN	T3	
PREDNISOLONE PHOS-GATIFLOXACIN	T3	
PREDNISOLONE PHOS-MOXIFLOXACIN	T3	
TOBRADEX	T3	
TOBRADEX (*tobramycin/dexamethasone*)	T3	
tobramycin/dexamethasone (Tobradex)	T1	
EYE ANTIBIOTIC, GLUCOCORTICOID AND NSAID COMB.		
PREDNISOLONE ACET-GATIFLO-BROM	T3	
PREDNISOLONE AC-MOXIFLOX-BROMF	T3	
PREDNISOLONE AC-MOXIFLOX-NEPAF	T3	
PREDNISOLONE PHOS-GATIFLO-BROM	T3	
PREDNISOLONE PHOS-MOXIFLO-BROM	T3	
EYE SULFONAMIDES		
BLEPH-10 (*sulfacetamide sodium*)	T3	
BLEPHAMIDE S.O.P.	T3	
sulfacetamide sodium	T1	
sulfacetamide sodium (Bleph-10)	T1	
sulfacetamide/prednisolone sp	T1	

T1 – Generics
T2 – Preferred Brands
T3 – Non-Preferred Brands
T4 – Preferred Specialty
T5 – Non-Preferred Specialty
PA – Prior Authorization
QL – Quantity Limit
ST – Step Therapy
AGE – Age Requirement
SP – Specialty Medication
HD – May require home delivery pharmacy
PPACA – No Cost-Share Preventive Medication
CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

ANTIBIOTICS (Eye Conditions) (cont.)		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
OPHTHALMIC ANTIBIOTICS		
AZASITE	T2	
bacitracin	T1	
bacitracin/polymyxin b sulfate	T1	
CEFUROXIME SODIUM-0.9% NACL	T3	PA
CILOXAN 0.3% EYE DROPS (*ciprofloxacin hcl*)	T3	
ciprofloxacin hcl (Ciloxan)	T1	
erythromycin base	T1	
gatifloxacin (Zymaxid)	T1	
gentamicin 0.3% eye drop	T1	
gentamicin sulfate	T1	
KLARITY-A(AZITHROMYCIN-CHONDR)	T3	
levofloxacin	T1	
neomycin/bacitracin/polymyxinb	T1	
neomycin/polymyxn b/gramicidin	T1	
OCUFLOX (*ofloxacin*)	T3	
ofloxacin (Ocuflox)	T1	
polymyxin b sulf/trimethoprim (Polytrim)	T1	
POLYTRIM (*polymyxin b sulf/trimethoprim*)	T3	
tobramycin 0.3% eye drop (Tobrex)	T1	
TOBREX	T3	
TOBREX (*tobramycin*)	T3	
VIGAMOX *(moxifloxacin hcl)*	T3	
ZYMAXID *(gatifloxacin)*	T3	
ANTIBIOTICS (Infections)		
2ND GEN. ANAEROBIC ANTIPROTOZOAL-ANTIBACTERIAL		
SOLOSEC	T2	QL(1 pack/fill)
ABSORBABLE SULFONAMIDE ANTIBACTERIAL AGENTS		
BACTRIM (*sulfamethoxazole/trimethoprim*)	T3	
BACTRIM DS (*sulfamethoxazole/trimethoprim*)	T3	
sulfadiazine	T1	
sulfamethoxazole/trimethoprim	T1	
sulfamethoxazole/trimethoprim (Bactrim Ds)	T1	
sulfamethoxazole/trimethoprim (Bactrim)	T1	

T1 – Generics
T2 – Preferred Brands
T3 – Non-Preferred Brands
T4 – Preferred Specialty
T5 – Non-Preferred Specialty
PA – Prior Authorization
QL – Quantity Limit
ST – Step Therapy
AGE – Age Requirement
SP – Specialty Medication
HD – May require home delivery pharmacy
PPACA – No Cost-Share Preventive Medication
CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

ANTIBIOTICS (Infections) (cont.)		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
AMINOGLYCOSIDE ANTIBIOTICS		
ARIKAYCE	T4	PA SP
BETHKIS *(tobramycin)*	T5	PA QL(224 mls/fill) SP HD
gentamicin 20 mg/2 ml vial	T1	PA
gentamicin 80 mg/2 ml vial	T1	PA
gentamicin 800 mg/20 ml vial	T1	PA
gentamicin ped 20 mg/2 ml vial	T1	PA
KITABIS PAK	T4	PA QL(280 mls/fill) SP HD
neomycin sulfate	T1	
TOBI PODHALER	T4	PA QL(224 caps/fill) SP HD
tobramycin 300 mg/4 ml ampule (Bethkis)	T1	PA QL(224 mls/fill) SP HD
tobramycin 300 mg/5 ml ampule (Tobi)	T1	PA QL(280 mls/fill) SP HD
TOBRAMYCIN PAK 300 MG/5 ML	T5	PA QL(280 mls/fill) SP HD
tobramycin sulfate	T1	PA
ANAEROBIC ANTIPROTOZOAL-ANTIBACTERIAL AGENTS		
FLAGYL (*metronidazole*)	T3	
metronidazole (Flagyl)	T1	
ANTIBIOTIC, ANTIBACTERIAL, MISC.		
fosfomycin tromethamine	T1	
HIPREX (*methenamine hippurate*)	T3	
meth/meblue/sod phos/psal/hyos	T1	
methen/mblue/sal/sod phos/hyos	T1	
methenam/m.blue/salicyl/hyoscy (Uribel Tabs)	T1	
methenam/sod phos/mblue/hyoscy	T1	
methenamine hippurate (Hiprex)	T1	
methenamine mandelate	T1	
PRIMSOL	T3	
trimethoprim	T1	
TRIMPEX	T3	
URELLE	T3	
URIBEL	T3	
URIBEL TABS *(methenam/m.blue/salicyl/hyoscy)*	T3	
ANTILEPROTICS		
dapsone	T1	
THALOMID 100 MG CAPSULE	T4	PA QL(30 caps/fill) SP HD

T1 – Generics
T2 – Preferred Brands
T3 – Non-Preferred Brands
T4 – Preferred Specialty
T5 – Non-Preferred Specialty
PA – Prior Authorization
QL – Quantity Limit
ST – Step Therapy
AGE – Age Requirement
SP – Specialty Medication
HD – May require home delivery pharmacy
PPACA – No Cost-Share Preventive Medication
CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

ANTIBIOTICS (Infections) (cont.)		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
ANTILEPROTICS (cont.)		
THALOMID 150 MG CAPSULE	T4	PA QL(60 caps/fill) SP HD
THALOMID 200 MG CAPSULE	T4	PA QL(60 caps/fill) SP HD
THALOMID 50 MG CAPSULE	T4	PA QL(30 caps/fill) SP HD
ANTI-MYCOBACTERIUM AGENTS		
ethambutol hcl	T1	HD
ethambutol hcl (Myambutol)	T1	HD
isoniazid	T1	HD
MYAMBUTOL (*ethambutol hcl*)	T3	HD
MYCOBUTIN (*rifabutin*)	T3	HD
PASER	T3	HD
pyrazinamide	T1	HD
rifabutin (Mycobutin)	T1	HD
TRECATOR	T3	HD
ANTITUBERCULAR ANTIBIOTICS		
CYCLOSERINE	T3	
PRETOMANID	T3	PA
PRIFTIN	T2	
rifampin	T1	
SIRTURO	T4	PA SP
BETALACTAMS		
CAYSTON	T4	PA QL(84 mls/fill) SP HD
CEPHALOSPORIN ANTIBIOTICS - IST GENERATION		
cefadroxil	T1	
cephalexin	T1	
CEPHALOSPORIN ANTIBIOTICS - 2ND GENERATION		
cefaclor	T1	
cefprozil	T1	
cefuroxime axetil	T1	
CEPHALOSPORIN ANTIBIOTICS - 3RD GENERATION		
cefdinir	T1	
cefditoren pivoxil	T1	
cefditoren pivoxil (Spectracef)	T1	
cefixime (Suprax)	T1	

T1 – Generics
T2 – Preferred Brands
T3 – Non-Preferred Brands
T4 – Preferred Specialty
T5 – Non-Preferred Specialty
PA – Prior Authorization
QL – Quantity Limit
ST – Step Therapy
AGE – Age Requirement
SP – Specialty Medication
HD – May require home delivery pharmacy
PPACA – No Cost-Share Preventive Medication
CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

ANTIBIOTICS (Infections) (cont.)		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
CEPHALOSPORIN ANTIBIOTICS - 3RD GENERATION (cont.)		
cefpodoxime proxetil	T1	
ceftriaxone sodium	T1	PA
SPECTRACEF (*cefditoren pivoxil*)	T3	
SUPRAX (*cefixime*)	T3	
LINCOSAMIDE ANTIBIOTICS		
CLEOCIN HCL (*clindamycin hcl*)	T3	
CLEOCIN PEDIATRIC (*clindamycin palmitate hcl*)	T3	
clindamycin hcl (Cleocin Hcl)	T1	
clindamycin palmitate hcl (Cleocin Pediatric)	T1	
MACROLIDE ANTIBIOTICS		
azithromycin	T1	
*azithromycin (*Zithromax Tri-Pak*)*	T1	
*azithromycin (*Zithromax*)*	T1	
clarithromycin	T1	
DIFICID 200 MG TABLET	T3	QL(20 tabs/fill)
DIFICID 40 MG/ML SUSPENSION	T3	QL(1 bottle/fill)
E.E.S. 200 *(erythromycin ethylsuccinate)*	T3	
ERYPED 200 *(erythromycin ethylsuccinate)*	T3	
ERYPED 400 (erythromycin ethylsuccinate)	T3	
ery-tab dr 250 mg, 333 mg tablet	T1	
ERY-TAB DR 500 MG TABLET *(erythromycin base)*	T3	
erythromycin base	T1	
erythromycin base (Ery-Tab)	T1	
erythromycin ethylsuccinate	T1	
*erythromycin ethylsuccinate (*E.E.S. 200*)*	T1	
*erythromycin ethylsuccinate (*Eryped 200*)*	T1	
*erythromycin ethylsuccinate (*Eryped 400*)*	T1	
erythromycin stearate	T1	
ZITHROMAX *(azithromycin)*	T3	
ZITHROMAX TRI-PAK (*azithromycin*)	T3	
NITROFURAN DERIVATIVES ANTIBACTERIAL AGENTS		
FURADANTIN (*nitrofurantoin*)	T3	
MACROBID (*nitrofurantoin monohyd/m-cryst*)	T3	
MACRODANTIN (*nitrofurantoin macrocrystal*)	T3	

T1 – Generics
T2 – Preferred Brands
T3 – Non-Preferred Brands
T4 – Preferred Specialty
T5 – Non-Preferred Specialty
PA – Prior Authorization
QL – Quantity Limit
ST – Step Therapy
AGE – Age Requirement
SP – Specialty Medication
HD – May require home delivery pharmacy
PPACA – No Cost-Share Preventive Medication
CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

ANTIBIOTICS (Infections) (cont.)		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
NITROFURAN DERIVATIVES ANTIBACTERIAL AGENTS (cont.)		
nitrofurantoin (Furadantin)	T1	
nitrofurantoin macrocrystal (Macrodantin)	T1	
nitrofurantoin monohyd/m-cryst (Macrobid)	T1	
OXAZOLIDINONE ANTIBIOTICS		
linezolid (Zyvox)	T1	PA
ZYVOX (*linezolid*)	T3	PA
PENICILLIN ANTIBIOTICS		
amoxicillin	T1	
amoxicillin/potassium clav	T1	
amoxicillin/potassium clav (Augmentin Xr)	T1	
amoxicillin/potassium clav (Augmentin)	T1	
ampicillin trihydrate	T1	
AUGMENTIN 125-31.25 MG/5 ML	T2	
AUGMENTIN 250-62.5 MG/5 ML *(amoxicillin/potassium clav)*	T3	
AUGMENTIN XR *(amoxicillin/potassium clav)*	T3	
dicloxacillin sodium	T1	
MOXATAG	T3	
penicillin v potassium	T1	
PLEUROMUTILIN DERIVATIVES		
XENLETA	T3	
QUINOLONE ANTIBIOTICS		
BAXDELA	T2	QL(28 tabs/fill)
CIPRO (*ciprofloxacin hcl*)	T3	
CIPRO (*ciprofloxacin*)	T3	
ciprofloxacin (Cipro)	T1	
ciprofloxacin hcl	T1	
ciprofloxacin hcl (Cipro)	T1	
FACTIVE	T3	
levofloxacin	T1	
moxifloxacin hcl	T1	
ofloxacin	T1	
RIFAMYCINS AND RELATED DERIVATIVE ANTIBIOTICS		
AEMCOLO	T3	QL(12 tabs/fill)
XIFAXAN 200 MG TABLET	T2	QL(9 tabs/fill)
XIFAXAN 550 MG TABLET	T2	QL(60 tabs/fill)

T1 – Generics
T2 – Preferred Brands
T3 – Non-Preferred Brands
T4 – Preferred Specialty
T5 – Non-Preferred Specialty
PA – Prior Authorization
QL – Quantity Limit
ST – Step Therapy
AGE – Age Requirement
SP – Specialty Medication
HD – May require home delivery pharmacy
PPACA – No Cost-Share Preventive Medication
CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

ANTIBIOTICS (Infections) (cont.)		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
TETRACYCLINE ANTIBIOTICS		
ACTICLATE *(doxycycline hyclate)*	T3	ST
AVIDOXY DK	T3	ST
demeclocycline hcl	T1	
doxycycline 25 mg/5 ml susp (Vibramycin)	T1	
doxycycline 50 mg tablet (Targadox)	T1	ST
doxycycline hyc dr 100 mg tab	T1	ST
doxycycline hyc dr 150 mg tab	T1	ST
doxycycline hyc dr 200 mg tab (Doryx)	T1	ST
doxycycline hyc dr 50 mg tab (Doryx)	T1	ST
doxycycline hyc dr 75 mg tab	T1	ST
doxycycline hyclate 100 mg cap (Vibramycin)	T1	
doxycycline hyclate 50 mg cap	T1	
doxycycline hyclate 75 mg tab (Acticlate)	T1	ST
doxycycline hyclate 100 mg tab (Lymepak)	T1	
doxycycline hyclate 150 mg tab (Acticlate)	T1	ST
doxycycline mono 50 mg cap (Monodox)	T1	
doxycycline mono 50 mg tablet	T1	
doxycycline mono 75 mg capsule (Monodox)	T1	
doxycycline mono 75 mg tablet	T1	
doxycycline mono 100 mg cap (Monodox)	T1	
doxycycline mono 100 mg tablet	T1	
doxycycline mono 150 mg cap	T1	ST
doxycycline mono 150 mg tablet	T1	
doxycycline monohydrate	T1	
doxycycline monohydrate (Monodox)	T1	
LYMEPAK *(doxycycline hyclate)*	T3	
minocycline hcl	T1	
minocycline hcl	T1	ST
minocycline hcl (Solodyn)	T1	ST
MINOLIRA ER	T3	ST
MONODOX *(doxycycline monohydrate)*	T3	ST
morgidox 100 mg capsule (Vibramycin)	T1	
MORGIDOX 1X50 MG KIT	T3	ST
MORGIDOX 1X100 MG KIT	T3	ST

T1 – Generics
T2 – Preferred Brands
T3 – Non-Preferred Brands
T4 – Preferred Specialty
T5 – Non-Preferred Specialty
PA – Prior Authorization
QL – Quantity Limit
ST – Step Therapy
AGE – Age Requirement
SP – Specialty Medication
HD – May require home delivery pharmacy
PPACA – No Cost-Share Preventive Medication
CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

ANTIBIOTICS (Infections) (cont.)		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
TETRACYCLINE ANTIBIOTICS (cont.)		
MORGIDOX 2X100 MG KIT	T3	ST
morgidox 50 mg capsule	T1	
NUZYRA	T5	QL(30 tabs/30 days) SP
SEYSARA	T3	ST
SOLODYN *(minocycline hcl)*	T3	ST
TARGADOX *(doxycycline hyclate)*	T3	ST
tetracycline 250 mg capsule	T1	
tetracycline 250 mg tablet	T1	ST
tetracycline 500 mg capsule	T1	
tetracycline 500 mg tablet	T1	ST
VIBRAMYCIN	T3	ST
VIBRAMYCIN (*doxycycline hyclate*)	T3	ST
VIBRAMYCIN (*doxycycline monohydrate*)	T3	ST
VAGINAL ANTIBIOTICS		
CLEOCIN	T3	
CLEOCIN (clindamycin phosphate)	T3	
clindamycin 2% vaginal cream (Cleocin)	T1	
CLINDESSE	T3	
METROGEL-VAGINAL (*metronidazole*)	T3	
metronidazole (Metrogel-Vaginal)	T1	
NUVESSA	T3	
XACIATO	T3	
VANCOMYCIN ANTIBIOTICS AND DERIVATIVES		
VANCOCIN HCL 125 MG CAPSULE (*vancomycin hcl*)	T3	PA QL(40 caps/fill)
VANCOCIN HCL 250 MG CAPSULE *(vancomycin hcl)*	T3	PA QL(80 caps/fill)
vancomycin 250 mg/5 ml soln	T1	QL(450 mls/fill)
vancomycin hcl 125 mg capsule (Vancocin Hcl)	T1	
vancomycin hcl 250 mg capsule (Vancocin Hcl)	T1	
ANTIBIOTICS (Skin Conditions)		
TOPICAL ANTIBIOTIC AND ANTI-INFLAMMATORY STEROID		
CORTISPORIN	T3	
NEO-SYNALAR	T3	
TOPICAL ANTIBIOTICS		
AKTIPAK	T3	ST

T1 – Generics
T2 – Preferred Brands
T3 – Non-Preferred Brands
T4 – Preferred Specialty
T5 – Non-Preferred Specialty
PA – Prior Authorization
QL – Quantity Limit
ST – Step Therapy
AGE – Age Requirement
SP – Specialty Medication
HD – May require home delivery pharmacy
PPACA – No Cost-Share Preventive Medication
CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

ANTIBIOTICS (Skin Conditions) (cont.)		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
TOPICAL ANTIBIOTICS (cont.)		
AMZEEQ	T3	ST
BENZAMYCIN (*erythromycin/benzoyl peroxide*)	T3	ST
CENTANY	T3	ST QL(30 gms/fill)
CENTANY AT	T3	ST QL(1 kit/fill)
CLEOCIN T 1% LOTION (*clindamycin phosphate*)	T3	ST QL(120 mls/30 days)
CLEOCIN T 1% PLEDGETS *(clindamycin phosphate)*	T3	ST
*clindacin etz 1% pledget (*Cleocin T*)*	T1	
CLINDACIN ETZ KIT	T3	ST
CLINDACIN PAC	T3	ST
clindamycin ph 1% gel	T1	QL(120 gms/30 days)
clindamycin ph 1% solution	T1	QL(120 mls/30 days)
clindamycin phos 1% pledget (Cleocin T)	T1	
clindamycin phosp 1% lotion (Cleocin T)	T1	QL(120 mls/30 days)
clindamycin phosphate (Cleocin T)	T1	
clindamycin phosphate 1% foam (Evoclin)	T1	QL(100 gms/30 days)
clindamycin phosphate 1% gel (Clindagel)	T1	QL(150 mls/30 days)
erythromycin base in ethanol	T1	
*erythromycin/benzoyl peroxide (*Benzamycin*)*	T1	
EVOCLIN *(clindamycin phosphate)*	T3	ST QL(100 gms/30 days)
gentamicin 0.1% cream	T1	QL(60 gms/fill)
gentamicin 0.1% ointment	T1	QL(60 gms/fill)
mupirocin 2% cream	T1	ST QL(30 gms/fill)
mupirocin 2% ointment	T1	QL(44 gms/fill)
mupirocin 2% ointment	T1	QL(1 treatment/30days)
XEPI	T3	ST QL(30 gms/fill)
TOPICAL SULFONAMIDES		
AVAR LS	T3	ST
AVAR-E	T3	ST
AVAR-E GREEN	T3	ST
AVAR-E LS	T3	ST
mafenide acetate (Sulfamylon)	T1	
PLEXION	T3	ST
ROSULA 10%-4.5% WASH	T3	ST
rosula 10%-5% cloths	T1	

T1 – Generics
T2 – Preferred Brands
T3 – Non-Preferred Brands
T4 – Preferred Specialty
T5 – Non-Preferred Specialty
PA – Prior Authorization
QL – Quantity Limit
ST – Step Therapy
AGE – Age Requirement
SP – Specialty Medication
HD – May require home delivery pharmacy
PPACA – No Cost-Share Preventive Medication
CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

ANTIBIOTICS (Skin Conditions) (cont.)		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
TOPICAL SULFONAMIDES (cont.)		
SILVADENE *(silver sulfadiazine)*	T3	
*silver sulfadiazine (*Silvadene*)*	T1	
sod sulface-sulf 9.8-4.8% clsr	T1	
sod sulface-sulfur 9-4.5% wash	T1	
sod sulfacet-sulfr 9.8-4.8%pad	T1	
sod sulfacet-sulfur 10-2% clsr	T1	
*sod sulfacet-sulfur 10-4% pad (*Sumaxin*)*	T1	
sod sulfacet-sulfur 10-5% clsr	T1	
sod sulfac-sulfur 9.8-4.8% crm	T1	
sod sulfac-sulfur 9.8-4.8% lot	T1	
sulfacetamide sodium/sulfur	T1	
sulfacetamide sodium/sulfur	T1	ST
sulfacetamide-sulfur 10-2% crm	T1	
sulfacetamide-sulfur 10-5% crm	T1	
sulfacetamide-sulfur 10-5% lot	T1	
sulfacetamide-sulfur 10-5% sus	T1	
sulfacetamide-sulfur 8-4% susp	T1	
sulfacetamide-sulfur 9-4% clsr	T1	
SULFAMYLON 8.5% CREAM	T2	
SULFAMYLON POWDER PACKET *(mafenide acetate)*	T3	
SUMADAN	T3	ST
SUMADAN XLT	T3	ST
SUMAXIN	T3	ST
SUMAXIN *(sulfacetamide sodium/sulfur)*	T3	ST
SUMAXIN CP	T3	ST
SUMAXIN TS	T3	ST
ANTICOAGULANTS (Blood Thinners/Anti-Clotting)		
CITRATES AS ANTICOAGULANTS		
ACD-A	T2	
ACD SOLUTION A	T2	
ANTICOAGULANT SODIUM CITRATE	T3	
CITRATE PHOSPHATE DEXTROSE	T2	
CRRT TRISODIUM CITRATE	T3	

T1 – Generics
T2 – Preferred Brands
T3 – Non-Preferred Brands
T4 – Preferred Specialty
T5 – Non-Preferred Specialty
PA – Prior Authorization
QL – Quantity Limit
ST – Step Therapy
AGE – Age Requirement
SP – Specialty Medication
HD – May require home delivery pharmacy
PPACA – No Cost-Share Preventive Medication
CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

ANTICOAGULANTS (Blood Thinners/Anti-Clotting)		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
CITRATES AS ANTICOAGULANTS (cont.)		
SODIUM CITRATE	T3	
TRISODIUM CITRATE CRRT	T3	
DIRECT FACTOR XA INHIBITORS		
ELIQUIS	T2	PA
XARELTO	T2	PA
HEPARIN AND RELATED PREPARATIONS		
ARIXTRA (*fondaparinux sodium*)	T5	SP
enoxaparin sodium (Lovenox)	T1	SP
fondaparinux sodium (Arixtra)	T1	SP
FRAGMIN	T4	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 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	T2	
HEPARIN SOD 5,000 UNIT/0.5 ML	T3	
heparin sod 5,000 unit/ml syrg	T1	
HEPARIN SOD 5,000 UNIT/ML SYRG	T3	
heparin sod 5,000 unit/ml vial	T1	
THROMBIN INHIBITORS, SELECTIVE, DIRECT, REVERSIBLE		
dabigatran etexilate mesylate	T1	HD
ANTIDOTES (Gastrointestinal/Heartburn)		
MU-OPIOID RECEPTOR ANTAGONISTS, PERIPHERALLY-ACTING		
MOVANTIK	T2	QL(30 tabs/fill)
RELISTOR	T2	ST
SYMPROIC	T2	

T1 – Generics
T2 – Preferred Brands
T3 – Non-Preferred Brands
T4 – Preferred Specialty
T5 – Non-Preferred Specialty
PA – Prior Authorization
QL – Quantity Limit
ST – Step Therapy
AGE – Age Requirement
SP – Specialty Medication
HD – May require home delivery pharmacy
PPACA – No Cost-Share Preventive Medication
CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

ANTIDOTES (Substance Abuse)		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
OPIOID ANTAGONISTS		
KLOXXADO	T2	QL(2 units/fill)
naloxone 0.4 mg/ml carpuject	T1	
naloxone 0.4 mg/ml vial	T1	
naloxone 2 mg/2 ml syringe	T1	
naloxone 4 mg/10 ml vial	T1	
naloxone hcl 4 mg nasal spray (Narcan)	T1	QL(2 units/fill)
naltrexone hcl	T1	
NARCAN (*naloxone hcl*)	T3	QL(2 units/30 days)
ANTIFUNGALS (Eye Conditions)		
OPHTHALMIC ANTIFUNGAL AGENTS		
NATACYN	T2	
ANTIFUNGALS (Feminine Products)		
VAGINAL ANTIFUNGALS		
GYNAZOLE 1	T3	
miconazole nitrate	T1	
terconazole	T1	
ANTIFUNGALS (Infections)		
ANTIFUNGAL AGENTS		
ANCOBON (*flucytosine*)	T3	PA
clotrimazole	T1	
CRESEMBA	T2	PA
DIFLUCAN 10 MG/ML SUSPENSION *(fluconazole)*	T3	
DIFLUCAN 100 MG TABLET *(fluconazole)*	T3	
DIFLUCAN 150 MG TABLET *(fluconazole)*	T3	QL(2 tabs/episode)
DIFLUCAN 200 MG TABLET *(fluconazole)*	T3	
DIFLUCAN 40 MG/ML SUSPENSION *(fluconazole)*	T3	
DIFLUCAN 50 MG TABLET *(fluconazole)*	T3	
fluconazole 10 mg/ml susp (Diflucan)	T1	
fluconazole 40 mg/ml susp (Diflucan)	T1	
fluconazole 100 mg tablet (Diflucan)	T1	
fluconazole 150 mg tablet (Diflucan)	T1	QL(2 tabs/fill)
fluconazole 200 mg tablet (Diflucan)	T1	
fluconazole 50 mg tablet (Diflucan)	T1	

T1 – Generics
T2 – Preferred Brands
T3 – Non-Preferred Brands
T4 – Preferred Specialty
T5 – Non-Preferred Specialty
PA – Prior Authorization
QL – Quantity Limit
ST – Step Therapy
AGE – Age Requirement
SP – Specialty Medication
HD – May require home delivery pharmacy
PPACA – No Cost-Share Preventive Medication
CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

ANTIFUNGALS (Infections) (cont.)		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
ANTIFUNGAL AGENTS (cont.)		
flucytosine (Ancobon)	T1	
itraconazole 10 mg/ml solution (Sporanox)	T1	QL(2 bottles/fill)
itraconazole 100 mg capsule (Sporanox)	T1	QL(30 caps/fill)
itraconazole 100 mg/10 ml cup (Sporanox)	T1	QL(2 bottles/fill)
ketoconazole 200 mg tablet	T1	
NOXAFIL	T2	PA
NOXAFIL 300 MG POWDERMIX SUSP	T3	PA
NOXAFIL 40 MG/ML SUSPENSION	T2	PA SP
ORAVIG	T3	
POSACONAZOLE 200 MG/5 ML SUSP	T2	PA
posaconazole dr 100 mg tablet (Noxafil)	T1	PA
SPORANOX 10 MG/ML SOLUTION (*itraconazole*)	T3	QL(2 bottles/fill)
SPORANOX 100 MG CAPSULE (*itraconazole*)	T3	QL(30 caps/fill)
terbinafine hcl	T1	
VFEND *(voriconazole)*	T3	PA
VIVJOA	T3	PA QL(18 caps/fill)
voriconazole (Vfend)	T1	PA
ANTIFUNGAL ANTIBIOTICS		
BREXAFEMME	T3	ST QL(4 tabs/fill)
griseofulvin ultramicrosize	T1	
griseofulvin, microsize	T1	
nystatin 100,000 unit/ml susp	T1	
nystatin 500,000 unit oral tab	T1	
nystatin 500,000 unit/5 ml cup	T1	
ANTIFUNGALS (Skin Conditions)		
TOPICAL ANTIFUNGAL/ANTI-INFLAMMATORY, STEROID AGENT		
clotrimazole-betamethasone crm	T1	QL(90 gms/28 days)
clotrimazole-betamethasone lot	T1	QL(60 mls/28 days)
TOPICAL ANTIFUNGALS		
ciclodan 0.77% cream (Loprox)	T1	QL(90 gms/28 days)
CICLODAN 0.77% CREAM KIT	T3	
ciclodan 8% solution	T1	
ciclopirox 0.77% cream (Loprox)	T1	QL(90 gms/28 days)
ciclopirox 0.77% gel	T1	QL(100 gms/28 days)

T1 – Generics
T2 – Preferred Brands
T3 – Non-Preferred Brands
T4 – Preferred Specialty
T5 – Non-Preferred Specialty
PA – Prior Authorization
QL – Quantity Limit
ST – Step Therapy
AGE – Age Requirement
SP – Specialty Medication
HD – May require home delivery pharmacy
PPACA – No Cost-Share Preventive Medication
CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

ANTIFUNGALS (Skin Conditions) (cont.)		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
TOPICAL ANTIFUNGALS (cont.)		
ciclopirox 0.77% topical susp (Loprox)	T1	QL(60 mls/28 days)
ciclopirox 1% shampoo	T1	QL(120 mls/28 days)
ciclopirox 8% solution	T1	
econazole nitrate	T1	QL(85 gms/28 days)
EXELDERM 1% CREAM	T3	QL(60 gms/28 days)
EXELDERM 1% SOLUTION	T3	QL(60 mls/28 days)
EXTINA 2% FOAM	T3	ST QL(100 gms/28 days)
JUBLIA	T3	ST
ketoconazole 2% cream	T1	QL(60 gms/28 days)
ketoconazole 2% foam (Extina)	T1	ST QL(100 gms/28 days)
ketoconazole 2% shampoo	T1	QL(120 mls/28 days)
ketodan 2% foam (Extina)	T1	ST QL(100 gms/28 days)
ketodan 2% foam kit	T1	ST
LOPROX 0.77% CREAM (*ciclopirox olamine*)	T3	QL(90 gms/28 days)
LOPROX 0.77% CREAM KIT	T3	QL(544 gms/30 days)
LOPROX 0.77% SUSPENSION KIT	T3	QL(1 kit/30 days)
LOPROX 0.77% TOPICAL SUSP (*ciclopirox olamine*)	T3	QL(60 mls/28 days)
naftifine hcl	T1	QL(60 gms/28 days)
naftifine hcl (Naftin)	T1	QL(60 gms/28 days)
NAFTIN	T3	QL(60 gms/28 days)
NAFTIN (*naftifine hcl*)	T3	QL(60 gms/28 days)
nystatin	T1	QL(180 gms/fill)
nystatin 100,000 unit/gm cream	T1	QL(60 gms/28 days)
nystatin 100,000 unit/gm oint	T1	QL(60 gms/28 days)
nystatin 100,000 unit/gm powd	T1	QL(180 gms/fill)
nystatin/triamcin	T1	QL(60 gms/28 days)
oxiconazole nitrate	T1	QL(60 gms/28 days)
tavaborole	T1	ST
ANTIHISTAMINE AND DECONGESTANT COMBINATION (Allergy/Nasal Sprays)		
1ST GEN ANTIHISTAMINE AND DECONGESTANT COMBINATION		
phenylephrine hcl/prometh hcl	T1	
phenylephrine/chlor-tan	T1	
2ND GEN ANTIHISTAMINE AND DECONGESTANT COMBINATION		
CLARINEX-D 12 HOUR	T3	QL(60 tabs/fill)

T1 – Generics
T2 – Preferred Brands
T3 – Non-Preferred Brands
T4 – Preferred Specialty
T5 – Non-Preferred Specialty
PA – Prior Authorization
QL – Quantity Limit
ST – Step Therapy
AGE – Age Requirement
SP – Specialty Medication
HD – May require home delivery pharmacy
PPACA – No Cost-Share Preventive Medication
CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

ANTIHISTAMINES (Allergy/Nasal Sprays)		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
ANTIHISTAMINES - 1ST GENERATION		
carbinoxamine 4 mg/5 ml liquid	T1	
carbinoxamine maleate 4 mg tab	T1	
carbinoxamine maleate 6 mg tab	T1	ST
clemastine fumarate	T1	
cyproheptadine 2 mg/5 ml soln	T1	
cyproheptadine 2 mg/5 ml syrup	T1	
cyproheptadine 4 mg tablet	T1	
CYPROHEPTADINE 4 MG/10 ML SYRP	T3	
dexchlorpheniramine maleate (Ryclora)	T1	
hydroxyzine hcl	T1	
hydroxyzine hcl	T1	
hydroxyzine pamoate	T1	
*hydroxyzine pamoate (*Vistaril*)*	T1	
KARBINAL ER	T3	ST
promethazine hcl	T1	
RYCLORA *(dexchlorpheniramine maleate)*	T3	
RYVENT	T3	ST
VISTARIL (*hydroxyzine pamoate*)	T3	
ANTIHISTAMINES - 2ND GENERATION		
CLARINEX D 24 HOUR TABLET	T3	
desloratadine	T1	QL(30 tabs/fill) HD
*desloratadine (*Clarinex*)*	T1	QL(30 tabs/fill) HD
ANTIHISTAMINES (Eye Conditions)		
EYE ANTIHISTAMINES		
azelastine hcl 0.05% drops	T1	
BEPREVE	T3	
epinastine hcl	T1	
LASTACAFT 0.25% EYE DROPS	T3	ST
ANTIHYPERGLYCEMICS (Diabetes)		
ANTIHYPERGLY,DPP-4 ENZYME INHIB.-THIAZOLIDINEDIONE		
OSENI	T3	ST QL(30 tabs/fill) HD
ANTIHYPERGLY,INCRETIN MIMETIC(GLP-1 RECEP.AGONIST)		
ADLYXIN 10-20 MCG STARTER PACK	T3	PA HD QL (1 kit/28 days)
ADLYXIN 20 MCG MAINTENANCE PK	T3	PA HD QL (1 kit/28 days)

T1 – Generics
T2 – Preferred Brands
T3 – Non-Preferred Brands
T4 – Preferred Specialty
T5 – Non-Preferred Specialty
PA – Prior Authorization
QL – Quantity Limit
ST – Step Therapy
AGE – Age Requirement
SP – Specialty Medication
HD – May require home delivery pharmacy
PPACA – No Cost-Share Preventive Medication
CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

ANTIHYPERGLYCEMICS (Diabetes) (cont.)		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
ANTIHYPERGLY,INCRETIN MIMETIC(GLP-I RECEP.AGONIST) (cont.)		
BYDUREON BCISE	T2	PA QL(4 auto-injs/fill) HD
BYDUREON PEN	T2	PA QL(4 pens/fill) HD
BYETTA	T2	PA QL(1 pen/fill) HD
OZEMPIC	T2	PA QL(1 pen/28 days) HD
RYBELSUS	T2	PA QL(30 tabs/fill) HD
TRULICITY	T2	PA QL(4 pens/fill) HD
ANTIHYPERGLY, INSULIN, LONG ACT-GLP-I RECEPT.AGONIST		
SOLIQUA 100-33	T2	QL(15 mls/fill) HD
ANTIHYPERGLYCEMIC - DOPAMINE RECEPTOR AGONISTS		
CYCLOSET	T3	HD
ANTIHYPERGLYCEMIC - INCRETIN MIMETICS COMBINATION		
MOUNJARO	T2	PA QL(4 pens/fill)
ANTIHYPERGLYCEMIC, ALPHA-GLUCOSIDASE INHIBITORS		
acarbose (Precose)	T1	HD
miglitol	T1	HD
PRECOSE *(acarbose)*	T3	HD
ANTIHYPERGLYCEMIC, AMYLIN ANALOG-TYPE		
SYMLINPEN 120	T2	PA QL(7 pens/fill) HD
SYMLINPEN 60	T2	PA QL(7 pens/fill) HD
ANTIHYPERGLYCEMIC, BIGUANIDE TYPE		
FORTAMET ER 1,000 MG TABLET (*metformin hcl*)	T3	PA QL(60 tabs/fill) HD
FORTAMET ER 500 MG TABLET *(metformin hcl)*	T3	PA QL(30 tabs/fill) HD
metformin er 1,000 mg gastr-tb (Glumetza)	T1	PA QL(60 tabs/fill) HD
metformin er 1,000 mg osm-tab (Fortamet)	T1	PA QL(60 tabs/fill) HD
metformin er 500 mg gastrc-tb (Glumetza)	T1	PA QL(120 tabs/fill) HD
metformin er 500 mg osmotic tb (Fortamet)	T1	PA QL(30 tabs/fill) HD
metformin hcl 1,000 mg tablet	T1	HD
metformin hcl 500 mg tablet	T1	HD
metformin hcl 500 mg/5 ml soln (Riomet)	T1	ST HD
metformin hcl 850 mg tablet	T1	HD
metformin hcl 850 mg/8.5ml cup (Riomet)	T1	ST HD
metformin hcl er 500 mg tablet	T1	QL(120 tabs/fill) HD
metformin hcl er 750 mg tablet	T1	QL(60 tabs/fill) HD
RIOMET *(metformin hcl)*	T3	ST HD
RIOMET ER	T3	ST HD

T1 – Generics
T2 – Preferred Brands
T3 – Non-Preferred Brands
T4 – Preferred Specialty
T5 – Non-Preferred Specialty
PA – Prior Authorization
QL – Quantity Limit
ST – Step Therapy
AGE – Age Requirement
SP – Specialty Medication
HD – May require home delivery pharmacy
PPACA – No Cost-Share Preventive Medication
CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

ANTIHYPERGLYCEMICS (Diabetes) (cont.)		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
ANTIHYPERGLYCEMIC, DPP-4 INHIBITORS		
JANUVIA	T2	ST QL(30 tabs/fill) HD
saxagliptin hcl (Onglyza)	T1	ST QL(30 tabs/30 days) HD
ANTIHYPERGLYCEMIC, INSULIN-RELEASE STIMULANT TYPE		
AMARYL (*glimepiride*)	T3	HD
glimepiride (Amaryl)	T1	HD
glipizide	T1	HD
GLUCOTROL XL (*glipizide*)	T3	HD
glyburide	T1	HD
glyburide,micronized (Glynase)	T1	HD
GLYNASE (*glyburide,micronized*)	T3	HD
nateglinide	T1	HD
PRANDIN (*repaglinide*)	T3	HD
repaglinide	T1	HD
repaglinide (Prandin)	T1	HD
ANTIHYPERGLYCEMIC, SGLT-2 AND DPP-4 INHIBITOR COMB		
GLYXAMBI	T2	ST QL(30 tabs/fill) HD
ANTIHYPERGLYCEMIC, THIAZOLIDINEDIONE AND BIGUANIDE		
ACTOPLUS MET XR 30 1000MG TABLET	T3	ST
pioglitazone hcl/metformin hcl	T1	QL(90 tabs/fill) HD
pioglitazone hcl/metformin hcl (Actoplus Met)	T1	QL(90 tabs/fill) HD
ANTIHYPERGLYCEMIC, THIAZOLIDINEDIONE-SULFONYLUREA		
DUETACT (*pioglitazone-glimepiride*)	T3	HD
pioglitazone hcl/glimepiride (Duetact)	T1	HD
ANTIHYPERGLYCEMIC, DPP-4 INHIBITOR-BIGUANIDE COMBS.		
JANUMET	T2	ST QL(60 tabs/fill) HD
JANUMET XR 50-500 MG TABLET	T2	ST QL(60 tabs/fill) HD
JANUMET XR 50-1,000 MG TABLET	T2	ST QL(60 tabs/fill) HD
JANUMET XR 100-1,000 MG TABLET	T2	ST QL(30 tabs/fill) HD
saxagliptin-metformin er 5-500 (Kombiglyze Xr)	T1	ST QL(30 tabs/30 days) HD
saxagliptin-metformn er 5-1000 (Kombiglyze Xr)	T1	ST QL(30 tabs/30 days) HD
saxagliptn-metform er 2.5-1000 (Kombiglyze Xr)	T1	ST QL(60 tabs/30 days) HD
ANTIHYPERGLYCEMIC, INSULIN-RELEASE STIM.-BIGUANIDE		
glipizide/metformin hcl	T1	HD
glyburide/metformin hcl	T1	HD

T1 – Generics
T2 – Preferred Brands
T3 – Non-Preferred Brands
T4 – Preferred Specialty
T5 – Non-Preferred Specialty
PA – Prior Authorization
QL – Quantity Limit
ST – Step Therapy
AGE – Age Requirement
SP – Specialty Medication
HD – May require home delivery pharmacy
PPACA – No Cost-Share Preventive Medication
CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

ANTIHYPERGLYCEMICS (Diabetes) (cont.)		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
ANTIHYPERGLYCEMIC, THIAZOLIDINEDIONE (PPARG AGONIST)		
ACTOS *(pioglitazone hcl)*	T3	ST QL(30 tabs/fill) HD
ANTIHYPERGLYCEMIC-GLUCOCORTICOID RECEPTOR BLOCKER		
mifepristone 300 mg tablet	T1	PA SP
ANTIHYPERGLYCEMIC-SGLT2 INHIBITOR-BIGUANIDE COMBS.		
SEGLUROMET	T2	ST QL(60 tabs/fill) HD
SYNJARDY	T2	ST QL(60 tabs/fill) HD
SYNJARDY XR 10-1,000 MG TABLET	T2	ST QL(30 tabs/fill) HD
SYNJARDY XR 12.5-1,000 MG TAB	T2	ST QL(60 tabs/fill) HD
SYNJARDY XR 25-1,000 MG TABLET	T2	ST QL(30 tabs/fill) HD
SYNJARDY XR 5-1,000 MG TABLET	T2	ST QL(60 tabs/fill) HD
XIGDUO XR 2.5 MG-1,000 MG TAB	T2	ST QL(60 tabs/fill) HD
XIGDUO XR 5 MG-500 MG TABLET	T2	ST QL(30 tabs/fill) HD
XIGDUO XR 5 MG-1,000 MG TABLET	T2	ST QL(60 tabs/fill) HD
XIGDUO XR 10 MG-1,000 MG TAB	T2	ST QL(30 tabs/fill) HD
XIGDUO XR 10 MG-500 MG TABLET	T2	ST QL(30 tabs/fill) HD
ANTIHYPERGLYCEMIC-SOD/GLUC COTRANSPORT2(SGLT2) INH		
FARXIGA	T2	ST QL(30 tabs/fill) HD
JARDIANCE	T2	ST QL(30 tabs/fill) HD
STEGLATRO	T2	ST QL(30 tabs/fill) HD
ANTIHYPERGLY-SGLT-2 INHIB, DPP-4 INHIB, BIGUANIDE CB		
TRIJARDY XR	T2	ST HD
INSULINS		
BASAGLAR KWIKPEN U-100	T3	HD
HUMALOG	T2	HD
HUMALOG JUNIOR KWIKPEN	T2	HD
HUMALOG KWIKPEN U-100	T2	HD
HUMALOG KWIKPEN U-200	T2	HD
HUMALOG MIX 50-50	T2	HD
HUMALOG MIX 50-50 KWIKPEN	T2	HD
HUMALOG MIX 75-25	T2	HD
HUMALOG MIX 75-25 KWIKPEN	T2	HD
HUMULIN 70/30 KWIKPEN	T2	HD
HUMULIN 70-30	T2	HD
HUMULIN N	T2	HD

T1 – Generics
T2 – Preferred Brands
T3 – Non-Preferred Brands
T4 – Preferred Specialty
T5 – Non-Preferred Specialty
PA – Prior Authorization
QL – Quantity Limit
ST – Step Therapy
AGE – Age Requirement
SP – Specialty Medication
HD – May require home delivery pharmacy
PPACA – No Cost-Share Preventive Medication
CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

ANTIHYPERGLYCEMICS (Diabetes) (cont.)		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
INSULINS (cont.)		
HUMULIN N KWIKPEN	T2	HD
HUMULIN R	T2	HD
HUMULIN R U-500	T2	HD
HUMULIN R U-500 KWIKPEN	T2	HD
INSULIN LISPRO 100 UNIT/ML VIAL	T2	HD
INSULIN LISPRO JUNIOR KWIKPEN	T2	HD
INSULIN LISPRO KWIKPEN U-100	T2	HD
INSULIN LISPRO PROTAMINE MIX	T2	HD
LYUMJEV	T2	HD
LYUMJEV KWIKPEN U-100	T2	HD
LYUMJEV KWIKPEN U-200	T2	HD
MYXREDLIN	T3	HD
SEMGLEE (YFGN)	T2	HD
SEMGLEE (YFGN) PEN	T2	HD
TOUJEO MAX SOLOSTAR	T2	HD
TOUJEO SOLOSTAR	T2	HD
TRESIBA	T2	HD
TRESIBA FLEXTOUCH U-100, U-200	T2	HD
ANTIINFECTIVES (Feminine Products)		
VAGINAL SULFONAMIDES		
AVC	T3	
ANTIINFECTIVES (Infections)		
PENICILLIN ANTIBIOTICS		
amoxicillin	T1	
ANTIINFECTIVES/MISCELLANEOUS (Feminine Products)		
VAGINAL ANTISEPTICS		
acetic acid/oxyquinoline (Relagard)	T1	
RELAGARD *(acetic acid/oxyquinoline)*	T3	
TRIMO-SAN	T2	
ANTIINFECTIVES/MISCELLANEOUS (Infections)		
2ND GEN. ANAEROBIC ANTIPROTOZOAL-ANTIBACTERIAL		
tinidazole 250 mg tablet	T1	QL(40 tabs/30 days)
tinidazole 500 mg tablet	T1	QL(20 tabs/30 days)

T1 – Generics
T2 – Preferred Brands
T3 – Non-Preferred Brands
T4 – Preferred Specialty
T5 – Non-Preferred Specialty
PA – Prior Authorization
QL – Quantity Limit
ST – Step Therapy
AGE – Age Requirement
SP – Specialty Medication
HD – May require home delivery pharmacy
PPACA – No Cost-Share Preventive Medication
CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

ANTIINFECTIVES/MISCELLANEOUS (Infections) (cont.)		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
AMEBICIDES		
HUMATIN	T3	
paromomycin sulfate	T1	
ANTHELMINTICS		
albendazole (Albenza)	T1	QL(120 tabs/30 days)
ALBENZA (*albendazole*)	T3	QL(120 tabs/30 days)
BILTRICIDE (*praziquantel*)	T3	
EMVERM	T2	QL(6 tabs/30 days)
ivermectin 3 mg tablet (Stromectol)	T1	PA QL(14 tabs/30 days)
praziquantel (Biltricide)	T1	
STROMECTOL (*ivermectin*)	T3	PA QL(14 tabs/30 days)
ANTIMALARIAL DRUGS		
ARAKODA	T3	QL(16 tabs/fill)
atovaquone-proguanil 250-100 (Malarone)	T1	QL(60 tabs/180 days)
atovaquone-proguanil 62.5-25 (Malarone)	T1	QL(180 tabs/180 days)
chloroquine phosphate	T1	
COARTEM	T2	QL(24 tabs/30 days)
DARAPRIM *(pyrimethamine)*	T5	PA SP
HYDROXYCHLOROQUINE 100 MG TAB	T3	
hydroxychloroquine sulfate (Sovuna)	T1	
hydroxychloroquine 200 mg tab (Plaquenil)	T1	
HYDROXYCHLOROQUINE 300 MG TAB	T3	
HYDROXYCHLOROQUINE 400 MG TAB	T3	
KRINTAFEL	T3	QL(2 tabs/30 days)
MALARONE 250-100 MG TABLET *(atovaquone/proguanil hcl)*	T3	QL(60 tabs/180 days)
MALARONE 62.5-25 MG PED TAB *(atovaquone/proguanil hcl)*	T3	QL(180 tabs/180 days)
mefloquine hcl	T1	QL(13 tabs/180 days)
PRIMAQUINE 26.3 MG TABLET	T2	QL(120 tabs/180 days)
primaquine 26.3 mg tablet	T1	QL(120 tabs/180 days)
pyrimethamine 25 mg tablet (Daraprim)	T1	PA
pyrimethamine 25 mg tablet (Daraprim)	T1	PA SP
QUALAQUIN (*quinine sulfate)*	T3	QL(42 caps/30 days)
quinine sulfate (Qualaquin)	T1	QL(42 caps/30 days)
SOVUNA	T3	
SOVUNA *(hydroxychloroquine sulfate)*	T3	

T1 – Generics
T2 – Preferred Brands
T3 – Non-Preferred Brands
T4 – Preferred Specialty
T5 – Non-Preferred Specialty
PA – Prior Authorization
QL – Quantity Limit
ST – Step Therapy
AGE – Age Requirement
SP – Specialty Medication
HD – May require home delivery pharmacy
PPACA – No Cost-Share Preventive Medication
CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

ANTIINFECTIVES/MISCELLANEOUS (Infections) (cont.)		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
ANTIPROTOZOAL DRUGS, MISCELLANEOUS		
atovaquone (Mepron)	T1	
BENZNIDAZOLE	T2	QL(360 tabs/fill)
IMPAVIDO	T2	PA QL(84 caps/30 days)
MEPRON (*atovaquone*)	T3	
NEBUPENT *(pentamidine isethionate)*	T3	QL(1 vl/28 days)
pentamidine isethionate (Nebupent)	T1	QL(1 vl/28 days)
ANTIINFECTIVES/MISCELLANEOUS (Miscellaneous)		
ANTIBACTERIAL AGENTS,MISCELLANEOUS		
glycine urologic solution	T1	
ANTISEPTICS,GENERAL		
ALCOHOL SWABSTICK	T3	
CVS ISOPROPYL ALCOHOL 91% SPRY	T3	
GS ISOPROPYL ALCOHOL 70% SPRAY	T3	
ISOPROPYL ALCOHOL 70% SPRAY	T3	
MEDI-FIRST ISOPROPYL ALCOHOL	T3	
TOPICAL ANTISEPTIC DRYING AGENTS		
formaldehyde	T1	
ANTIINFECTIVES/MISCELLANEOUS (Skin Conditions)		
TOPICAL ANTIFUNGALS		
CICLODAN 8% KIT	T3	ST
ciclopirox 8% treatment kit	T1	
ANTIINFLAM.TUMOR NECROSIS FACTOR INHIBITING AGENTS (Pain Relief and Inflammatory Disease)		
ANTI-INFLAMMATORY TUMOR NECROSIS FACTOR INHIBITOR		
ADALIMUMAB-ADAZ (CF)	T4	PA QL(2 syringes/28 days) SP HD
ADALIMUMAB-ADAZ (CF) PEN	T4	PA QL(2 pens/28 days) SP HD
ADALIMUMAB-ADBM(CF)	T4	PA QL(2 srnge kits/28 days) SP HD
ADALIMUMAB-ADBM(CF) PEN CROHNS	T4	PA QL(6 pens/365 days) SP HD
ADALIMUMAB-ADBM(CF) PEN PS-UV	T4	PA QL(4 pens/365 days) SP HD
ADALIMUMAB-ADBM(CF)PEN	T4	PA QL(2 kits/28 days) SP HD
CYLTEZO(CF) 40MG/0.8ML, 20MG/0.4ML, 10MG/0.2ML SYR, PEN CRH-UC-HS 40MG, PEN PSORIASIS 40MG, PEN 40 MG/0.8 ML	T4	PA SP
ENBREL 25 MG KIT	T4	PA QL(8 vls/28 days) SP HD
ENBREL 25 MG/0.5 ML SYRINGE	T4	PA QL(8 syringes/28 days) SP HD

T1 – Generics
T2 – Preferred Brands
T3 – Non-Preferred Brands
T4 – Preferred Specialty
T5 – Non-Preferred Specialty
PA – Prior Authorization
QL – Quantity Limit
ST – Step Therapy
AGE – Age Requirement
SP – Specialty Medication
HD – May require home delivery pharmacy
PPACA – No Cost-Share Preventive Medication
CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

ANTIINFLAM.TUMOR NECROSIS FACTOR INHIBITING AGENTS (Pain Relief and Inflammatory Disease) (cont.)		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
ANTI-INFLAMMATORY TUMOR NECROSIS FACTOR INHIBITOR (cont.)		
ENBREL 25 MG/0.5 ML VIAL	T4	PA QL(8 vials/28 days) SP HD
ENBREL 50 MG/ML SYRINGE	T4	PA QL SP HD
ENBREL MINI	T4	PA QL SP HD
ENBREL SURECLICK	T4	PA QL SP HD
HUMIRA	T4	PA QL(2 srnge kits/28 days) SP HD
HUMIRA PEN	T4	PA QL(2 kits/28 days) SP HD
HUMIRA PEN CROHN'S-UC-HS	T4	PA QL(6 pens/365 days) SP HD
HUMIRA PEN PSOR-UVEITS-ADOL HS	T4	PA QL(4 pens/365 days) SP HD
HUMIRA(CF) 10 MG/0.1 ML SYRING	T4	PA QL(2 srnge kits/28 days) SP HD
HUMIRA(CF) 20 MG/0.2 ML SYRING	T4	PA QL(2 srnge kits/28 days) SP HD
HUMIRA(CF) 40 MG/0.4 ML SYRING	T4	PA QL(2 srnge kits/28 days) SP HD
HUMIRA(CF) PEDI CROHN 80-40 MG	T4	PA QL(2 srnge kits/365 days) SP HD
HUMIRA(CF) PEDI CROHN 80MG/0.8	T4	PA QL(3 srnge kits/365 days) SP HD
HUMIRA(CF) PEN 40 MG/0.4 ML	T4	PA QL(2 kits/28 days) SP HD
HUMIRA(CF) PEN 80 MG/0.8 ML	T4	PA QL(2 pens/28 days) SP HD
HUMIRA(CF) PEN CROHN'S-UC-HS	T4	PA QL(3 kits/365 days) SP HD
HUMIRA(CF) PEN PEDIATRIC UC	T4	PA QL(4 pens/365 days) SP HD
HUMIRA(CF) PEN PSOR-UV-ADOL HS	T4	PA QL(3 kits/365 days) SP HD
HYRIMOZ(CF)	T4	PA QL(2 syringes/28 days) SP HD
HYRIMOZ(CF) PEN	T4	PA QL(2 pens/28 days) SP HD
HYRIMOZ(CF) PEDI CROHN 80 MG	T4	PA QL(3 syringes/365 days) SP HD
HYRIMOZ(CF) PEDI CROHN 80-40MG	T4	PA QL(2 syringes/365 days) SP HD
HYRIMOZ(CF) PEN CROHN-UC START	T4	PA QL(3 pens/365 days) SP HD
HYRIMOZ(CF) PEN PSORIASIS	T4	PA QL(3 pens/365 days) SP HD
SIMPONI 100 MG/ML PEN INJECTOR	T4	PA QL(1 pen/30 days) SP HD
SIMPONI 100 MG/ML SYRINGE	T4	PA QL(1 syringe/30 days) SP HD
SIMPONI ARIA	T5	PA SP HD
ANTINEOPLASTICS (Cancer)		
ANP - SELECTIVE RETINOID X RECEPTOR AGONISTS (RXR)		
bexarotene (Targretin)	T1	PA SP HD CSL
ANTINEOPLAST, HISTONE DEACETYLASE (HDAC) INHIBITORS		
FARYDAK	T3	PA QL(6 caps/fill) CSL
ZOLINZA	T4	PA QL(120 caps/fill) SP HD CSL

T1 – Generics
T2 – Preferred Brands
T3 – Non-Preferred Brands
T4 – Preferred Specialty
T5 – Non-Preferred Specialty
PA – Prior Authorization
QL – Quantity Limit
ST – Step Therapy
AGE – Age Requirement
SP – Specialty Medication
HD – May require home delivery pharmacy
PPACA – No Cost-Share Preventive Medication
CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

ANTINEOPLASTICS (Cancer) (cont.)		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
ANTINEOPLASTIC - ALKYLATING AGENTS		
ALKERAN (*melphalan*)	T5	SP CSL
cyclophosphamide 25 mg capsule	T1	SP HD CSL
CYCLOPHOSPHAMIDE 25 MG TABLET	T5	SP HD CSL
cyclophosphamide 50 mg capsule	T1	SP HD CSL
CYCLOPHOSPHAMIDE 50 MG TABLET	T5	SP HD CSL
GLEOSTINE	T2	CSL
HYDREA *(hydroxyurea)*	T3	CSL
hydroxyurea (Hydrea)	T1	CSL
LEUKERAN	T2	CSL
melphalan (Alkeran)	T1	SP CSL
MYLERAN	T2	CSL
TEMODAR (*temozolomide*)	T5	PA SP HD CSL
temozolomide	T1	PA SP HD CSL
temozolomide (Temodar)	T1	PA SP HD CSL
ANTINEOPLASTIC - ANTIANDROGENIC AGENTS		
abiraterone acetate 250 mg tab (Zytiga)	T1	PA QL(120 tabs/fill) SP HD CSL
abiraterone acetate 500 mg tab (Zytiga)	T1	PA QL(60 tabs/fill) SP HD CSL
bicalutermezaamide (Casodex)	T1	CSL
CASODEX (*bicalutamide*)	T3	CSL
ERLEADA 240 MG TABLET	T4	PA SP HD QL (30 tabs/30 days) CSL
EULEXIN *(flutamide)*	T3	CSL
flutamide (Eulexin)	T1	CSL
NILANDRON *(nilutamide)*	T3	PA CSL
nilutamide (Nilandron)	T1	PA CSL
NUBEQA	T4	PA QL(120 tabs/fill) SP HD CSL
XTANDI 40 MG CAPSULE	T4	PA QL(120 tabs/caps/fill) SP HD CSL
XTANDI 40 MG TABLET	T4	PA QL(120 tabs/caps/fill) SP HD CSL
XTANDI 80 MG TABLET	T4	PA QL(60 tabs/fill) SP HD CSL
ANTINEOPLASTIC - ANTIMETABOLITES		
capecitabine 150 mg tablet (Xeloda)	T1	PA QL(56 tabs/fill) SP HD CSL
capecitabine 500 mg tablet (Xeloda)	T1	PA QL(140 tabs/fill) SP HD CSL
LONSURF	T4	PA SP HD CSL
mercaptopurine	T1	CSL
methotrexate 2.5 mg tablet	T1	CSL

T1 – Generics
T2 – Preferred Brands
T3 – Non-Preferred Brands
T4 – Preferred Specialty
T5 – Non-Preferred Specialty
PA – Prior Authorization
QL – Quantity Limit
ST – Step Therapy
AGE – Age Requirement
SP – Specialty Medication
HD – May require home delivery pharmacy
PPACA – No Cost-Share Preventive Medication
CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

ANTINEOPLASTICS (Cancer) (cont.)		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
ANTINEOPLASTIC - ANTIMETABOLITES (cont.)		
methotrexate 250 mg/10 ml vial	T1	
methotrexate 50 mg/2 ml vial	T1	
methotrexate sodium/pf	T1	
PURIXAN	T4	SP CSL
TABLOID	T3	CSL
TREXALL	T3	CSL
XELODA 150 MG TABLET (*capecitabine*)	T5	PA QL(56 tabs/30days) SP HD CSL
XELODA 500 MG TABLET (*capecitabine*)	T5	PA QL(140 tabs/30days) SP HD CSL
ANTINEOPLASTIC - AROMATASE INHIBITORS		
anastrozole (Arimidex)	T1	HD PPACA CSL
AROMASIN (*exemestane*)	T3	HD CSL
exemestane (Aromasin)	T1	HD PPACA CSL
FEMARA *(letrozole)*	T3	HD CSL
letrozole (Femara)	T1	HD CSL
ANTINEOPLASTIC - BRAF KINASE INHIBITORS		
TAFINLAR	T4	PA QL(120 caps/fill) SP HD CSL
ZELBORAF	T4	PA QL(240 tabs/fill) SP HD CSL
ANTINEOPLASTIC - HEDGEHOG PATHWAY INHIBITOR		
DAURISMO 100 MG TABLET	T5	PA QL(30 tabs/fill) SP HD CSL
DAURISMO 25 MG TABLET	T5	PA QL(60 tabs/fill) SP HD CSL
ERIVEDGE	T4	PA QL(30 caps/fill) SP HD CSL
ODOMZO	T4	PA QL(30 caps/fill) SP HD CSL
ANTINEOPLASTIC - JANUS KINASE (JAK) INHIBITORS		
JAKAFI	T4	PA QL(60 tabs/fill) SP HD CSL
ANTINEOPLASTIC - KRAS PROTEIN INHIBITOR		
LUMAKRAS	T5	PA SP HD CSL
ANTINEOPLASTIC - MEKI AND MEK2 KINASE INHIBITORS		
COTELLIC	T4	PA QL(63 tabs/fill) SP HD CSL
KOSELUGO	T5	PA SP CSL
MEKINIST 0.05 MG/ML SOLUTION	T4	PA SP HD QL (108ml/30 days) CSL
MEKINIST 0.5 MG TABLET	T4	PA QL(90 tabs/fill) SP HD CSL
MEKINIST 2 MG TABLET	T4	PA QL(30 tabs/fill) SP HD CSL
TAFINLAR 10 MG TABLET FOR SUSP	T4	SP PA HD QL (840ml/30 days) CSL

T1 – Generics
T2 – Preferred Brands
T3 – Non-Preferred Brands
T4 – Preferred Specialty
T5 – Non-Preferred Specialty
PA – Prior Authorization
QL – Quantity Limit
ST – Step Therapy
AGE – Age Requirement
SP – Specialty Medication
HD – May require home delivery pharmacy
PPACA – No Cost-Share Preventive Medication
CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

ANTINEOPLASTICS (Cancer) (cont.)		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
ANTINEOPLASTIC - MTOR KINASE INHIBITORS		
everolimus 2 mg tab for susp (Afinitor Disperz)	T1	PA QL(30 tabs/fill) SP CSL
everolimus 2.5 mg tablet (Afinitor)	T1	
everolimus 3 mg tab for susp (Afinitor Disperz)	T1	PA QL(30 tabs/fill) SP CSL
everolimus 5 mg tab for susp (Afinitor Disperz)	T1	PA QL(30 tabs/fill) SP CSL
everolimus 5 mg tablet (Afinitor)	T1	
everolimus 7.5 mg tablet (Afinitor)	T1	
ANTINEOPLASTIC - PROTEIN METHYLTRANSFERASE INHIBIT		
TAZVERIK	T5	PA SP CSL
ANTINEOPLASTIC - TOPOISOMERASE I INHIBITORS		
HYCAMTIN	T4	PA SP HD CSL
ANTINEOPLASTIC IMMUNOMODULATOR AGENTS		
lenalidomide	T1	PA QL(30 caps/fill) SP HD CSL
POMALYST	T4	PA SP HD CSL
REVLIMID	T4	PA QL(30 caps/fill) SP HD CSL
ANTINEOPLASTIC LHRH(GNRH) ANTAGONIST,PITUIT.SUPPRS		
ORGOVYX	T5	PA QL(30 tabs/fill) SP CSL
ANTINEOPLASTIC SYSTEMIC ENZYME INHIBITORS		
ALECENSA	T4	PA QL(240 caps/fill) SP HD CSL
ALUNBRIG 30 MG TABLET	T4	PA QL(60 tabs/fill) SP CSL
ALUNBRIG 90 MG, 180 MG TABLET	T4	PA QL(30 tabs/fill) SP CSL
ALUNBRIG 90 MG-180 MG TAB PACK	T4	PA QL(30 tabs/fill) SP CSL
AYVAKIT	T5	PA QL(30 tabs/fill) SP CSL
BALVERSA	T4	PA SP CSL
BOSULIF 50 MG CAPSULE	T4	
BOSULIF 100 MG CAPSULE	T4	PA QL(90 tabs/fill) SP HD CSL
BOSULIF 100 MG TABLET	T4	PA QL(90 tabs/fill) SP HD CSL
BOSULIF 400 MG, 500 MG TABLET	T4	PA QL(30 tabs/fill) SP HD CSL
BRUKINSA	T4	PA SP CSL
CABOMETYX	T4	
CALQUENCE	T4	PA QL(60 tabs/caps/fill) SP CSL
CAPRELSA 100 MG TABLET	T4	PA QL(60 tabs/fill) SP CSL
CAPRELSA 300 MG TABLET	T4	PA QL(30 tabs/fill) SP CSL
COMETRIQ 100 MG DAILY-DOSE PK	T4	PA QL(56 caps/fill) SP HD CSL
COMETRIQ 140 MG DAILY-DOSE PK	T4	PA QL(112 caps/fill) SP HD CSL

T1 – Generics
T2 – Preferred Brands
T3 – Non-Preferred Brands
T4 – Preferred Specialty
T5 – Non-Preferred Specialty
PA – Prior Authorization
QL – Quantity Limit
ST – Step Therapy
AGE – Age Requirement
SP – Specialty Medication
HD – May require home delivery pharmacy
PPACA – No Cost-Share Preventive Medication
CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

ANTINEOPLASTICS (Cancer) (cont.)		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
ANTINEOPLASTIC SYSTEMIC ENZYME INHIBITORS (cont.)		
COMETRIQ 60 MG DAILY-DOSE PACK	T4	PA QL(84 caps/fill) SP HD CSL
COPIKTRA	T5	PA QL(56 caps/fill) SP CSL
erlotinib hcl 100 mg tablet (Tarceva)	T1	PA QL(30 tabs/fill) SP HD CSL
erlotinib hcl 150 mg tablet (Tarceva)	T1	PA QL(30 tabs/fill) SP HD CSL
erlotinib hcl 25 mg tablet (Tarceva)	T1	PA QL(60 tabs/fill) SP HD CSL
EXKIVITY 40 MG CAPSULE	T5	PA QL(120 caps/fill) SP CSL
GAVRETO	T4	PA QL(120 caps/fill) SP HD CSL
GILOTRIF	T4	PA QL(30 tabs/fill) SP HD CSL
ICLUSIG	T4	PA QL(30 tabs/fill) SP CSL
IWILFIN	T4	PA SP CSL
IMBRUVICA 70 MG CAPSULE	T4	PA QL(30 caps/fill) SP CSL
IMBRUVICA 140 MG CAPSULE	T4	PA QL(120 caps/fill) SP CSL
IMBRUVICA 70 MG/ML SUSPENSION	T4	PA QL(3 bottles/fill) SP CSL
IMBRUVICA 140 MG TABLET	T4	PA QL(30 tabs/fill) SP CSL
IMBRUVICA 280 MG TABLET	T4	PA QL(30 tabs/fill) SP CSL
IMBRUVICA 420 MG TABLET	T4	PA QL(30 tabs/fill) SP CSL
IMBRUVICA 560 MG TABLET	T4	PA SP CSL
INLYTA 1 MG TABLET	T4	PA QL(180 tabs/fill) SP HD CSL
INLYTA 5 MG TABLET	T4	PA QL(120 tabs/fill) SP HD CSL
IRESSA (*gefitinib*)	T5	PA QL(30 tabs/30 days) SP HD CSL
KISQALI	T5	PA QL (1 pack/1 time) CSL
KISQALI FEMARA CO-PACK	T5	PA QL (1 PACK/28 DAYS) CSL
lapatinib ditosylate (Tykerb)	T1	PA QL(180 tabs/fill) SP HD CSL
LENVIMA 10 MG DAILY DOSE	T4	PA QL(30 caps/fill) SP HD CSL
LENVIMA 12 MG DAILY DOSE	T4	PA QL(90 caps/fill) SP HD CSL
LENVIMA 14 MG DAILY DOSE	T4	PA QL(60 caps/fill) SP HD CSL
LENVIMA 18 MG DAILY DOSE	T4	PA QL(90 caps/fill) SP HD CSL
LENVIMA 20 MG DAILY DOSE	T4	PA QL(60 caps/fill) SP HD CSL
LENVIMA 24 MG DAILY DOSE	T4	PA QL(90 caps/fill) SP HD CSL
LENVIMA 4 MG CAPSULE	T4	PA QL(30 caps/fill) SP HD CSL
LENVIMA 8 MG DAILY DOSE	T4	PA QL(60 caps/fill) SP HD CSL
LORBRENA 100 MG TABLET	T4	PA QL(30 tabs/fill) SP HD CSL
LORBRENA 25 MG TABLET	T4	PA QL(90 tabs/fill) SP HD CSL
LYNPARZA	T4	PA QL(120 tabs/fill) SP HD CSL

T1 – Generics
T2 – Preferred Brands
T3 – Non-Preferred Brands
T4 – Preferred Specialty
T5 – Non-Preferred Specialty
PA – Prior Authorization
QL – Quantity Limit
ST – Step Therapy
AGE – Age Requirement
SP – Specialty Medication
HD – May require home delivery pharmacy
PPACA – No Cost-Share Preventive Medication
CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

ANTINEOPLASTICS (Cancer) (cont.)		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
ANTINEOPLASTIC SYSTEMIC ENZYME INHIBITORS (cont.)		
LYTGOBI	T4	PA SP CSL
NERLYNX	T4	PA SP HD CSL
NEXAVAR (*sorafenib tosylate*)	T5	PA QL(120 tabs/fill) SP HD CSL
NINLARO	T4	PA QL(3 caps/fill) SP HD CSL
OGSIVEO	T5	PA SP CSL
pazopanib hcl (Votrient)	T1	PA QL(120 tabs/30 days) SP HD CSL
PEMAZYRE	T4	PA QL(28 tabs/30 days) SP CSL
PIQRAY	T5	PA SP HD CSL
RETEVMO 40 MG CAPSULE	T5	PA QL(180 caps/fill) SP HD CSL
RETEVMO 80 MG CAPSULE	T5	PA QL(120 caps/fill) SP HD CSL
ROZLYTREK 100 MG CAPSULE	T4	PA QL(30 caps/fill) SP HD CSL
ROZLYTREK 200 MG CAPSULE	T4	PA QL(90 caps/fill) SP HD CSL
ROZLYTREK 50 MG PELLET PACKET	T4	
RUBRACA	T4	PA QL(120 tabs/fill) SP CSL
RYDAPT	T4	PA QL(224 caps/fill) SP HD CSL
SCEMBLIX 20MG TABLET	T5	PA QL(600 tabs/30 days) CSL
SCEMBLIX 40MG TABLET	T5	PA QL(300 tabs/30 days) CSL
sorafenib tosylate (Nexavar)	T1	PA QL(120 tabs/fill) SP HD CSL
SPRYCEL 20 MG TABLET	T4	PA QL(90 tabs/fill) SP HD CSL
SPRYCEL 50 MG TABLET	T4	PA QL(30 tabs/fill) SP HD CSL
SPRYCEL 70 MG TABLET	T4	PA QL(60 tabs/fill) SP HD CSL
SPRYCEL 80 MG TABLET	T4	PA QL(30 tabs/fill) SP HD CSL
SPRYCEL 100 MG TABLET	T4	PA QL(30 tabs/fill) SP HD CSL
SPRYCEL 140 MG TABLET	T4	PA QL(30 tabs/fill) SP HD CSL
STIVARGA	T4	PA QL(84 tabs/fill) SP HD CSL
sunitinib malate 12.5 mg cap (Sutent)	T1	PA QL(90 caps/fill) SP HD CSL
sunitinib malate 25 mg capsule (Sutent)	T1	PA QL(30 caps/fill) SP HD CSL
sunitinib malate 37.5 mg cap (Sutent)	T1	PA QL(30 caps/fill) SP HD CSL
sunitinib malate 50 mg capsule (Sutent)	T1	PA QL(30 caps/fill) SP HD CSL
SUTENT 12.5 MG CAPSULE (*sunitinib malate*)	T5	PA QL(90 caps/fill) SP HD CSL
SUTENT 25 MG CAPSULE (*sunitinib malate*)	T5	PA QL(30 caps/fill) SP HD CSL
SUTENT 37.5 MG CAPSULE (*sunitinib malate*)	T5	PA QL(30 caps/fill) SP HD CSL
SUTENT 50 MG CAPSULE (*sunitinib malate*)	T5	PA QL(30 caps/fill) SP HD CSL
TABRECTA	T4	PA SP HD CSL

T1 – Generics
T2 – Preferred Brands
T3 – Non-Preferred Brands
T4 – Preferred Specialty
T5 – Non-Preferred Specialty
PA – Prior Authorization
QL – Quantity Limit
ST – Step Therapy
AGE – Age Requirement
SP – Specialty Medication
HD – May require home delivery pharmacy
PPACA – No Cost-Share Preventive Medication
CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

ANTINEOPLASTICS (Cancer) (cont.)		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
ANTINEOPLASTIC SYSTEMIC ENZYME INHIBITORS (cont.)		
TAGRISSO	T4	PA QL(30 tabs/fill) SP HD CSL
TALZENNA	T4	PA QL(30 caps/fill) SP HD CSL
TARCEVA 25 MG TABLET (*erlotinib hcl*)	T5	PA QL(60 tabs/fill) SP HD CSL
TARCEVA 100 MG TABLET (*erlotinib hcl*)	T5	PA QL(30 tabs/fill) SP HD CSL
TARCEVA 150 MG TABLET (*erlotinib hcl*)	T5	PA QL(30 tabs/fill) SP HD CSL
TASIGNA 50 MG CAPSULE	T4	PA QL(120 caps/fill) SP HD CSL
TASIGNA 150 MG CAPSULE	T4	PA QL(112 caps/fill) SP HD CSL
TASIGNA 200 MG CAPSULE	T4	PA QL(112 caps/fill) SP HD CSL
TUKYSA 50 MG TABLET	T5	PA QL(300 tabs/fill) SP CSL
TUKYSA 150 MG TABLET	T5	PA QL(120 tabs/fill) SP CSL
TURALIO	T5	PA QL(120 caps/fill) SP CSL
TYKERB (*lapatinib ditosylate*)	T5	PA QL(180 tabs/fill) SP HD CSL
VERZENIO	T4	PA QL(60 tabs/fill) SP HD CSL
VITRAKVI 100 MG CAPSULE	T4	PA QL(60 caps/fill) SP HD CSL
VITRAKVI 20 MG/ML SOLUTION	T4	PA QL(300 mls/fill) SP HD CSL
VITRAKVI 25 MG CAPSULE	T4	PA QL(180 caps/fill) SP HD CSL
VIZIMPRO	T4	PA QL(30 tabs/fill) SP HD CSL
VONJO	T4	PA QL(120 caps/fill) SP CSL
VOTRIENT (*pazopanib hcl*)	T5	PA QL(120 tabs/30 days) SP HD CSL
XALKORI 200MG, 250 MG CAPSULE	T4	PA QL(60 caps/30 days) SP HD CSL
XALKORI 20MG, 50MG, 150MG PELLET	T4	PA SP HD CSL
XOSPATA	T4	PA QL(90 tabs/fill) SP CSL
ZEJULA 100MG, 200MG, 300MG TABLET	T2	SP PA
ZYDELIG	T4	PA QL(60 tabs/fill) SP HD CSL
ZYKADIA	T4	PA QL(90 tabs/caps/fill) SP HD CSL
ANTINEOPLASTIC-B CELL LYMPHOMA-2(BCL-2) INHIBITORS		
VENCLEXTA 10 MG TAB (10MG X 2)	T4	PA QL(56 tabs/fill) SP CSL
VENCLEXTA 10 MG TABLET	T4	PA QL(56 tabs/fill) SP CSL
VENCLEXTA 100 MG TABLET	T4	PA QL(180 tabs/fill) SP CSL
VENCLEXTA 50 MG TABLET	T4	PA QL(28 tabs/fill) SP CSL
VENCLEXTA STARTING PACK	T4	PA QL(42 tabs/fill) SP CSL
ANTINEOPLASTIC-HYPOXIA INDUCIBLE FACTOR (HIF) INH		
WELIREG	T5	PA SP CSL

T1 – Generics
T2 – Preferred Brands
T3 – Non-Preferred Brands
T4 – Preferred Specialty
T5 – Non-Preferred Specialty
PA – Prior Authorization
QL – Quantity Limit
ST – Step Therapy
AGE – Age Requirement
SP – Specialty Medication
HD – May require home delivery pharmacy
PPACA – No Cost-Share Preventive Medication
CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

ANTINEOPLASTICS (Cancer) (cont.)		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
ANTINEOPLASTIC-ISOCITRATE DEHYDROGENASE INHIBITORS		
IDHIFA	T4	PA QL(30 tabs/fill) SP HD CSL
TIBSOVO	T4	PA SP CSL
ANTINEOPLASTICS, MISCELLANEOUS		
etoposide	T1	SP HD CSL
LYSODREN	T2	CSL
MATULANE	T4	SP CSL
tretinoin 10 mg capsule	T1	CSL
IMMUNOMODULATORS		
ACTIMMUNE	T4	PA SP HD
SELECTIVE ESTROGEN RECEPTOR MODULATORS (SERMS)		
FARESTON (*toremifene citrate*)	T3	HD CSL
SOLTAMOX	T3	HD PPACA CSL
tamoxifen citrate	T1	HD PPACA CSL
toremifene citrate (Fareston)	T1	HD CSL
STEROID ANTINEOPLASTICS		
EMCYT	T4	SP HD CSL
megestrol 20 mg tablet	T1	CSL
megestrol 40 mg tablet	T1	CSL
ANTINEOPLASTICS (Skin Conditions)		
PHOTOACT, TOPICAL ANTINEOPLAST, PREMALIGNANT LESIONS		
LEVULAN	T5	SP
TOPICAL ANTINEOPLASTIC PREMALIGNANT LESION AGENTS		
bexarotene 1% gel (Targretin)	T1	PA SP HD
diclofenac sodium 3% gel	T1	PA QL(100 gms/28 days)
EFUDEX *(fluorouracil)*	T3	
FLUOROPLEX	T3	
fluorouracil 2% topical soln	T1	
fluorouracil 5% cream (Efudex)	T1	
fluorouracil 5% topical soln	T1	
PANRETIN	T5	PA SP HD
TARGRETIN 1% GEL (*bexarotene*)	T5	PA SP HD
TOLAK	T3	
VALCHLOR	T4	PA SP HD

T1 – Generics
T2 – Preferred Brands
T3 – Non-Preferred Brands
T4 – Preferred Specialty
T5 – Non-Preferred Specialty
PA – Prior Authorization
QL – Quantity Limit
ST – Step Therapy
AGE – Age Requirement
SP – Specialty Medication
HD – May require home delivery pharmacy
PPACA – No Cost-Share Preventive Medication
CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

ANTI-OBESITY DRUGS (Weight Management)		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
ANTI-OBESITY - ANOREXIC AGENTS		
ADIPEX-P *(phentermine hcl)*	T3	PA QL(30 tabs/30 days)
benzphetamine hcl	T1	PA QL(90 tabs/fill)
diethylpropion hcl	T1	PA QL(90 tabs/fill)
diethylpropion hcl	T1	PA QL(30 tabs/fill)
LOMAIRA	T3	PA QL(90 tabs/fill)
phendimetrazine tartrate	T1	PA QL(30 caps/fill)
phendimetrazine tartrate	T1	PA QL(180 tabs/fill)
phentermine 15 mg capsule	T1	PA QL(30 caps/fill)
phentermine 30 mg capsule	T1	PA QL(30 caps/fill)
phentermine 37.5 mg capsule	T1	PA QL(30 caps/30 days)
phentermine 37.5 mg tablet (Adipex-P)	T1	PA QL(30 tabs/fill)
QSYMIA	T3	PA QL(30 caps/fill)
ANTI-OBESITY - INCRETIN MIMETICS COMBINATION		
ZEPBOUND	T2	
ANTI-OBESITY - MELANOCORTIN 4 RECEPTOR AGONISTS		
IMCIVREE	T5	PA QL(6 mls/30 days) SP
ANTI-OBESITY GLUCAGON-LIKE PEPTIDE-I RECEP AGONIST		
SAXENDA	T3	PA QL(5 pens/fill)
WEGOVY 0.25 MG/0.5 ML PEN	T2	PA QL(8 pens/year)
WEGOVY 0.5 MG/0.5 ML PEN	T2	PA QL(8 pens/year)
WEGOVY 1 MG/0.5 ML PEN	T2	PA QL(8 pens/year)
WEGOVY 1.7 MG/0.75 ML PEN	T2	PA QL(8 pens/year)
WEGOVY 2.4 MG/0.75 ML PEN	T2	PA QL(4 pens/28 days)
ANTI-OBESITY SEROTONIN 2C RECEPTOR AGONISTS		
BELVIQ	T3	PA
BELVIQ XR	T3	PA
ANTI-OBESITY-OPIOID ANTAG-NOREPI, DOPAMINE RU INHIB		
CONTRAVE	T3	PA QL(120 tabs/fill)
FAT ABSORPTION DECREASING AGENTS		
ORLISTAT	T3	PA QL(90 caps/fill)
XENICAL	T3	PA QL(90 caps/fill)
ANTIPARASITICS (Eye Conditions)		
OPHTHALMIC (EYE) ANTIPARASITICS		
XDEMVY	T4	QL(10 mgs/30 days) SP

T1 – Generics
T2 – Preferred Brands
T3 – Non-Preferred Brands
T4 – Preferred Specialty
T5 – Non-Preferred Specialty
PA – Prior Authorization
QL – Quantity Limit
ST – Step Therapy
AGE – Age Requirement
SP – Specialty Medication
HD – May require home delivery pharmacy
PPACA – No Cost-Share Preventive Medication
CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

ANTIPARASITICS (Infections)		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
ANTIPARASITICS		
ALINIA 100 MG/5 ML SUSPENSION	T2	QL(180 mls/30 days)
nitazoxanide (Alinia)	T1	QL(12 tabs/30 days)
TOPICAL ANTIPARASITICS		
crotamiton	T1	
ELIMITE (*permethrin*)	T3	
EURAX	T3	
ivermectin 0.5% lotion (Sklice)	T1	
permethrin (Elimite)	T1	
SKLICE (*ivermectin*)	T3	
spinosad (Natroba)	T1	
ULESFIA	T3	
ANTIPARKINSON DRUGS (Parkinson's Disease)		
ANTIPARKINSONISM DRUGS, ANTICHOLINERGIC		
benztropine mesylate	T1	HD
trihexyphenidyl hcl	T1	HD
ANTIPARKINSONISM DRUGS, OTHER		
amantadine hcl	T1	HD
apomorphine hcl	T1	PA QL(30 mls/30 days) SP
AZILECT (*rasagiline mesylate*)	T3	ST 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/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	T5	PA SP HD
entacapone (Comtan)	T1	HD
INBRIJA	T4	PA QL(300 caps/fill) SP HD
KYNMOBI	T2	PA QL(150 films/30 days) HD

T1 – Generics
T2 – Preferred Brands
T3 – Non-Preferred Brands
T4 – Preferred Specialty
T5 – Non-Preferred Specialty
PA – Prior Authorization
QL – Quantity Limit
ST – Step Therapy
AGE – Age Requirement
SP – Specialty Medication
HD – May require home delivery pharmacy
PPACA – No Cost-Share Preventive Medication
CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

ANTIPARKINSON DRUGS (Parkinson's Disease) (cont.)		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
ANTIPARKINSONISM DRUGS, OTHER (cont.)		
MIRAPEX ER (*pramipexole di-hcl*)	T3	HD
NEUPRO	T3	HD
NOURIANZ	T5	PA QL(30 tabs/fill) SP HD
PARLODEL (*bromocriptine mesylate*)	T3	HD
pramipexole di-hcl	T1	HD
pramipexole di-hcl (Mirapex Er)	T1	HD
rasagiline mesylate (Azilect)	T1	HD
ropinirole hcl	T1	HD
RYTARY	T3	HD
selegiline hcl	T1	HD
SINEMET 10-100 (*carbidopa/levodopa*)	T3	HD
SINEMET 25-100 (*carbidopa/levodopa*)	T3	HD
STALEVO 50 *(carbidopa/levodopa/entacapone)*	T3	HD
STALEVO 75 *(carbidopa/levodopa/entacapone)*	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
TASMAR *(tolcapone)*	T3	PA HD
tolcapone (Tasmar)	T1	PA HD
DECARBOXYLASE INHIBITORS		
carbidopa (Lodosyn)	T1	PA
LODOSYN *(carbidopa)*	T3	PA
ANTIPLATELET DRUGS (Blood Thinners/Anti-Clotting)		
PLATELET AGGREGATION INHIBITORS		
aspirin/dipyridamole	T1	HD
BRILINTA	T2	HD
cilostazol	T1	HD
clopidogrel bisulfate	T1	HD
clopidogrel bisulfate (Plavix)	T1	HD
dipyridamole	T1	HD
EFFIENT *(prasugrel hcl)*	T3	HD
prasugrel hcl (Effient)	T1	HD
ZONTIVITY	T3	PA HD

T1 – Generics
T2 – Preferred Brands
T3 – Non-Preferred Brands
T4 – Preferred Specialty
T5 – Non-Preferred Specialty
PA – Prior Authorization
QL – Quantity Limit
ST – Step Therapy
AGE – Age Requirement
SP – Specialty Medication
HD – May require home delivery pharmacy
PPACA – No Cost-Share Preventive Medication
CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

ANTIPLATELET DRUGS (Blood Thinners/Anti-Clotting) (cont.)		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
PLATELET REDUCING AGENTS		
AGRYLIN *(anagrelide hcl)*	T3	
anagrelide hcl	T1	
anagrelide hcl (Agrylin)	T1	
ANTIVIRALS (AIDS/HIV)		
ANTIRETROVIRAL - CAPSID INHIBITORS		
SUNLENCA	T5	PA SP
ANTIRETROVIRAL-INTEGRASE INHIBITOR AND NNRTI COMB.		
JULUCA	T4	SP
DOVATO	T4	SP
TRIUMEQ	T4	SP
TRIUMEQ PD	T4	SP
ANTIRETROVIRAL-NUCLEOSIDE, NUCLEOTIDE, PROTEASE INH.		
SYMTUZA	T4	SP
ANTIVIRALS, HIV-SPEC, NON-PEPTIDIC PROTEASE INHIB		
APTIVUS	T4	SP
darunavir (Prezista)	T1	SP
PREZISTA 600MG, 800MG TABLET (*darunavir*)	T5	SP
ANTIVIRALS, HIV-SPEC, NUCLEOSIDE-NUCLEOTIDE ANALOG		
CIMDUO	T4	SP
DESCOVY	T4	SP
emtricitabine-tenofv 100-150mg (Truvada)	T1	SP
emtricitabine-tenofv 133-200mg (Truvada)	T1	SP
emtricitabine-tenofv 167-250mg (Truvada)	T1	SP
emtricitabine-tenofv 200-300mg (Truvada)	T1	SP PPACA
TEMIXYS	T4	SP
ANTIVIRALS, HIV-SPEC., NUCLEOSIDE ANALOG, RTI COMB		
abacavir sulfate/lamivudine (Epzicom)	T1	SP
abacavir/lamivudine/zidovudine (Trizivir)	T1	SP
COMBIVIR *(lamivudine/zidovudine)*	T5	SP
EPZICOM *(abacavir sulfate/lamivudine)*	T5	SP
lamivudine/zidovudine (Combivir)	T1	SP
TRIZIVIR *(abacavir/lamivudine/zidovudine)*	T5	SP
ANTIVIRALS, HIV-SPECIFIC, CCR5 CO-RECEPTOR ANTAG.		
maraviroc (Selzentry)	T1	SP
SELZENTRY 20 MG/ML ORAL SOLN	T4	SP

T1 – Generics
T2 – Preferred Brands
T3 – Non-Preferred Brands
T4 – Preferred Specialty
T5 – Non-Preferred Specialty
PA – Prior Authorization
QL – Quantity Limit
ST – Step Therapy
AGE – Age Requirement
SP – Specialty Medication
HD – May require home delivery pharmacy
PPACA – No Cost-Share Preventive Medication
CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

ANTIVIRALS (AIDS/HIV) (cont.)		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
ANTIVIRALS, HIV-SPECIFIC, CCR5 CO-RECEPTOR ANTAG. (cont.)		
SELZENTRY 25 MG TABLET	T4	SP
SELZENTRY 75 MG TABLET	T4	SP
SELZENTRY 150 MG TABLET (*maraviroc*)	T5	SP
SELZENTRY 300 MG TABLET (*maraviroc*)	T5	SP
ANTIVIRALS, HIV-SPECIFIC, FUSION INHIBITORS		
FUZEON	T4	PA QL (60 vials/30 days) SP
ANTIVIRALS, HIV-SPECIFIC, NON-NUCLEOSIDE, RTI		
EDURANT	T4	SP
efavirenz (Sustiva)	T1	SP
etravirine (Intelence)	T1	SP
INTELENCE 25 MG TABLET	T4	SP
INTELENCE 100 MG TABLET *(etravirine)*	T5	SP
INTELENCE 200 MG TABLET *(etravirine)*	T5	SP
nevirapine	T1	SP
nevirapine (Viramune Xr)	T1	SP
SUSTIVA *(efavirenz)*	T5	SP
VIRAMUNE XR (*nevirapine*)	T5	SP
ANTIVIRALS, HIV-SPECIFIC, NUCLEOSIDE ANALOG, RTI		
abacavir sulfate (Ziagen)	T1	SP
didanosine	T1	SP
emtricitabine (Emtriva)	T1	SP
EMTRIVA 10 MG/ML SOLUTION	T4	SP
EMTRIVA 200 MG CAPSULE (*emtricitabine*)	T5	SP
EPIVIR (*lamivudine*)	T5	SP
lamivudine (Epivir)	T1	SP
RETROVIR (zidovudine)	T5	SP
stavudine	T1	SP
ZIAGEN *(abacavir sulfate)*	T5	SP
zidovudine	T1	SP
zidovudine (Retrovir)	T1	SP
ANTIVIRALS, HIV-SPECIFIC, NUCLEOTIDE ANALOG, RTI		
tenofovir disoproxil fumarate (Viread)	T1	SP
VIREAD 150 MG TABLET	T4	SP
VIREAD 200 MG TABLET	T4	SP

T1 – Generics
T2 – Preferred Brands
T3 – Non-Preferred Brands
T4 – Preferred Specialty
T5 – Non-Preferred Specialty
PA – Prior Authorization
QL – Quantity Limit
ST – Step Therapy
AGE – Age Requirement
SP – Specialty Medication
HD – May require home delivery pharmacy
PPACA – No Cost-Share Preventive Medication
CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

ANTIVIRALS (AIDS/HIV) (cont.)		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
ANTIVIRALS, HIV-SPECIFIC, NUCLEOTIDE ANALOG, RTI (cont.)		
VIREAD 250 MG TABLET	T4	SP
VIREAD 300 MG TABLET (*tenofovir disoproxil fumarate*)	T5	SP
VIREAD POWDER	T4	SP
ANTIVIRALS, HIV-SPECIFIC, PROTEASE INHIBITOR COMB		
KALETRA *(lopinavir/ritonavir)*	T5	SP
*lopinavir/ritonavir (*Kaletra*)*	T1	SP
ANTIVIRALS, HIV-SPECIFIC, PROTEASE INHIBITORS		
*atazanavir sulfate (*Reyataz*)*	T1	SP
EVOTAZ	T5	SP
*fosamprenavir calcium (*Lexiva*)*	T1	SP
INVIRASE	T4	SP
LEXIVA 50 MG/ML SUSPENSION	T4	SP
LEXIVA 700 MG TABLET (*fosamprenavir calcium*)	T5	SP
NORVIR 100 MG POWDER PACKET	T4	SP
NORVIR 100 MG TABLET (*ritonavir*)	T5	SP
REYATAZ 150 MG CAPSULE (*atazanavir sulfate*)	T5	SP
REYATAZ 200 MG CAPSULE (*atazanavir sulfate*)	T5	SP
REYATAZ 300 MG CAPSULE (*atazanavir sulfate*)	T5	SP
REYATAZ 50 MG POWDER PACKET	T4	SP
ritonavir (Norvir)	T1	SP
VIRACEPT	T4	SP
ANTIVIRALS, HIV-I INTEGRASE STRAND TRANSFER INHIBTR		
APRETUDE	T4	PA SP PPACA
ISENTRESS	T4	SP
ISENTRESS HD	T4	SP
TIVICAY	T4	SP
TIVICAY PD	T4	SP
ARTV NUCLEOSIDE, NUCLEOTIDE, NON-NUCLEOSIDE RTI COMB		
efavirenz/emtricit/tenofovr df (Atripla)	T1	SP
efavirenz/lamivu/tenofov disop (Symfi Lo)	T1	SP
efavirenz/lamivu/tenofov disop (Symfi)	T1	SP
ODEFSEY	T4	SP
SYMFI *(efavirenz/lamivu/tenofov disop)*	T4	SP
SYMFI LO *(efavirenz/lamivu/tenofov disop)*	T4	SP

T1 – Generics
T2 – Preferred Brands
T3 – Non-Preferred Brands
T4 – Preferred Specialty
T5 – Non-Preferred Specialty
PA – Prior Authorization
QL – Quantity Limit
ST – Step Therapy
AGE – Age Requirement
SP – Specialty Medication
HD – May require home delivery pharmacy
PPACA – No Cost-Share Preventive Medication
CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

ANTIVIRALS (AIDS/HIV) (cont.)		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
ARV-NUCLEOSIDE, NUCLEOTIDE RTI, INTEGRASE INHIBITORS		
BIKTARVY	T4	SP
GENVOYA	T4	SP
ANTIVIRALS (Eye Conditions)		
EYE ANTIVIRALS		
trifluridine	T1	
ZIRGAN	T3	
ANTIVIRALS (Infections)		
ANTIVIRALS, GENERAL		
acyclovir 200 mg capsule	T1	
acyclovir 200 mg/5 ml susp (Zovirax)	T1	
acyclovir 400 mg tablet	T1	
acyclovir 800 mg tablet	T1	
famciclovir 125 mg tablet	T1	QL(21 tabs/fill)
famciclovir 250 mg tablet	T1	QL(60 tabs/fill)
famciclovir 500 mg tablet	T1	QL(21 tabs/fill)
FLUMADINE (*rimantadine hcl*)	T3	
LIVTENCITY	T5	PA QL(112 tabs/28 days) 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	T4	QL(30 tabs/fill) SP HD
RELENZA 5MG	T3	QL(20 blisters/10 days)
rimantadine hcl (Flumadine)	T1	
TAMIFLU 30 MG CAPSULE (*oseltamivir phosphate*)	T3	QL(20 caps/fill)
TAMIFLU 45 MG CAPSULE (*oseltamivir phosphate*)	T3	QL(10 caps/fill)
TAMIFLU 75 MG CAPSULE (*oseltamivir phosphate*)	T3	QL(10 caps/fill)
TAMIFLU 6 MG/ML SUSPENSION (*oseltamivir phosphate*)	T3	QL(180 mls/fill)
valacyclovir hcl (Valtrex)	T1	QL(30 tabs/fill)
VALCYTE (*valganciclovir hcl*)	T3	
valganciclovir hcl (Valcyte)	T1	
XOFLUZA	T3	QL(1 tab/fill)
ZOVIRAX 200 MG/5 ML SUSP (*acyclovir*)	T3	

T1 – Generics
T2 – Preferred Brands
T3 – Non-Preferred Brands
T4 – Preferred Specialty
T5 – Non-Preferred Specialty
PA – Prior Authorization
QL – Quantity Limit
ST – Step Therapy
AGE – Age Requirement
SP – Specialty Medication
HD – May require home delivery pharmacy
PPACA – No Cost-Share Preventive Medication
CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

ANTIVIRALS (Infections) (cont.)		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
HEP C - NS5A, NS3/4A, NUCLEOTIDE NS5B INHIB COMBO		
VOSEVI	T4	PA QL(28 tabs/fill) SP HD
HEP C VIRUS-NS5B POLYMERASE AND NS5A INHIB. COMBO.		
EPCLUSA 150-37.5 MG PELLET PKT	T4	PA QL(28 packs/fill) SP HD
EPCLUSA 200 MG-50 MG TABLET	T4	PA QL(28 tabs/fill) SP HD
EPCLUSA 200-50 MG PELLET PACK	T4	PA QL(28 pkts/28 days) SP HD
EPCLUSA 400 MG-100 MG TABLET	T4	PA QL(28 tabs/fill) SP HD
HARVONI 33.75-150 MG PELLET PK	T4	PA QL(28 packs/fill) SP HD
HARVONI 45-200 MG PELLET PACKT	T4	PA QL(56 packs/fill) SP HD
HARVONI 45-200 MG TABLET	T4	PA QL(56 tabs/fill) SP HD
HARVONI 90-400 MG TABLET	T4	PA QL(>= 18 yo 28 tabs/fill) SP HD
HEPATITIS B TREATMENT AGENTS		
adefovir dipivoxil	T1	SP HD
BARACLUDE 0.05 MG/ML SOLUTION	T4	SP HD
entecavir (Baraclude)	T1	SP HD
EPIVIR HBV 100 MG TABLET *(lamivudine)*	T5	SP
EPIVIR HBV 25 MG/5 ML SOLN	T4	SP
lamivudine (Epivir Hbv)	T1	SP
VEMLIDY	T4	SP HD
PEGASYS 180MCG/0.5ML SYRINGE KIT	T4	SP HD
PEGASYS PROCLICK 180MCG/0.5ML	T4	SP HD
ribasphere 200 mg capsule	T1	ST SP HD
ribasphere 600 mg tablet	T1	ST SP
HEPATITIS C TREATMENT AGENTS		
ribavirin	T1	ST SP HD
HEPATITIS C VIRUS- NS5A AND NS3/4A INHIBITOR COMB		
ZEPATIER	T4	PA QL(28 tabs/fill) SP HD
ANTIVIRALS (Skin Conditions)		
TOPICAL ANTIVIRALS		
acyclovir 5% cream (Zovirax)	T1	PA QL(5 gms/fill)
acyclovir 5% ointment (Zovirax)	T1	PA QL(30 gms/fill)
DENAVIR	T3	
penciclovir	T1	
ZOVIRAX 5% CREAM (*acyclovir*)	T3	PA QL(5 gms/fill)

T1 – Generics
T2 – Preferred Brands
T3 – Non-Preferred Brands
T4 – Preferred Specialty
T5 – Non-Preferred Specialty
PA – Prior Authorization
QL – Quantity Limit
ST – Step Therapy
AGE – Age Requirement
SP – Specialty Medication
HD – May require home delivery pharmacy
PPACA – No Cost-Share Preventive Medication
CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

AUTONOMIC DRUGS (Allergy/Nasal Sprays)		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
ANAPHYLAXIS THERAPY AGENTS		
AUVI-Q	T2	QL(2 auto-injs/30 days)
epinephrine 0.15 mg auto-injct (Epipen Jr 2-Pak)	T1	QL(2 auto-injs/fill)
epinephrine 0.15 mg auto-injct (Epipen Jr)	T1	QL(2 auto-injs/fill)
epinephrine 0.3 mg auto-inject (Epipen 2-Pak)	T1	QL(2 auto-injs/fill)
epinephrine 0.3 mg auto-inject (Epipen)	T1	QL(2 auto-injs/fill)
EPIPEN (*epinephrine*)	T2	PA QL(2 auto-injs/fill)
EPIPEN 2-PAK (*epinephrine*)	T2	PA QL(2 auto-injs/fill)
EPIPEN JR (*epinephrine*)	T2	PA QL(2 auto-injs/fill)
EPIPEN JR 2-PAK (*epinephrine*)	T2	PA QL(2 auto-injs/fill)
SYMJEPI	T2	QL(2 syringes/fill)
AUTONOMIC DRUGS (Alzheimer's Disease)		
CHOLINESTERASE INHIBITORS		
ADLARITY	T3	ST HD
ARICEPT *(donepezil hcl)*	T3	ST HD
donepezil hcl	T1	HD
donepezil hcl 10 mg tablet (Aricept)	T1	HD
donepezil hcl 23 mg tablet (Aricept)	T1	ST HD
donepezil hcl 5 mg tablet (Aricept)	T1	HD
EXELON *(rivastigmine)*	T3	ST HD
galantamine hbr	T1	HD
galantamine hbr (Razadyne Er)	T1	HD
pyridostigmine 60 mg/5 ml soln (Mestinon)	T1	HD
PYRIDOSTIGMINE BR 30 MG TABLET	T3	HD
pyridostigmine br 60 mg tablet (Mestinon)	T1	HD
pyridostigmine bromide (Mestinon)	T1	HD
RAZADYNE ER (*galantamine hbr*)	T3	ST HD
rivastigmine (Exelon)	T1	HD
rivastigmine tartrate	T1	HD
AUTONOMIC DRUGS (Attention Deficit Hyperactivity Disorder)[8]		
ADRENERGICS, AROMATIC, NON-CATECHOLAMINE		
ADZENYS XR-ODT	T3	ST
amphetamine sulfate (Evekeo)	T1	
DESOXYN (*methamphetamine hcl*)	T3	

T1 – Generics
T2 – Preferred Brands
T3 – Non-Preferred Brands
T4 – Preferred Specialty
T5 – Non-Preferred Specialty
PA – Prior Authorization
QL – Quantity Limit
ST – Step Therapy
AGE – Age Requirement
SP – Specialty Medication
HD – May require home delivery pharmacy
PPACA – No Cost-Share Preventive Medication
CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

AUTONOMIC DRUGS (Attention Deficit Hyperactivity Disorder)[8]		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
ADRENERGICS, AROMATIC, NON-CATECHOLAMINE (cont.)		
DEXEDRINE (*dextroamphetamine sulfate*)	T3	ST
dextroamphetamine sulfate	T1	
dextroamphetamine sulfate (Dexedrine)	T1	
dextroamphetamine sulfate (Zenzedi)	T1	
dextroamphetamine/amphetamine (Adderall Xr)	T1	
dextroamphetamine/amphetamine (Adderall)	T1	
dextroamphetamine/amphetamine (Mydayis)	T1	
EVEKEO ODT	T3	
methamphetamine hcl (Desoxyn)	T1	
MYDAYIS (*dextroamphetamine/amphetamine*)	T3	ST
zenzedi 10 mg tablet	T1	
ZENZEDI 15 MG TABLET (*dextroamphetamine sulfate*)	T3	
ZENZEDI 2.5 MG TABLET	T3	
ZENZEDI 20 MG TABLET (*dextroamphetamine sulfate*)	T3	
ZENZEDI 30 MG TABLET (*dextroamphetamine sulfate*)	T3	
zenzedi 5 mg tablet	T1	
ZENZEDI 7.5 MG TABLET	T3	
AUTONOMIC DRUGS (Blood Pressure/Heart Medications)		
ADRENERGIC VASOPRESSOR AGENTS		
droxidopa (Northera)	T1	PA SP HD
midodrine hcl	T1	
DIBENZYLINE (*phenoxybenzamine hcl*)	T3	PA HD
phenoxybenzamine hcl (Dibenzyline)	T1	PA HD
AUTONOMIC DRUGS (Urinary Tract Conditions)		
PARASYMPATHETIC AGENTS		
bethanechol chloride	T1	HD
bethanechol chloride (Urecholine)	T1	HD
cevimeline hcl (Evoxac)	T1	HD
EVOXAC (*cevimeline hcl*)	T3	HD
pilocarpine hcl (Salagen)	T1	HD
SALAGEN (*pilocarpine hcl*)	T3	HD
URECHOLINE (*bethanechol chloride*)	T3	HD

T1 – Generics
T2 – Preferred Brands
T3 – Non-Preferred Brands
T4 – Preferred Specialty
T5 – Non-Preferred Specialty
PA – Prior Authorization
QL – Quantity Limit
ST – Step Therapy
AGE – Age Requirement
SP – Specialty Medication
HD – May require home delivery pharmacy
PPACA – No Cost-Share Preventive Medication
CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
BIOLOGICALS (Allergy/Nasal Sprays)		
ALLERGENIC EXTRACTS, THERAPEUTIC		
GRASTEK	T2	PA
ODACTRA	T2	PA
ORALAIR	T2	PA
RAGWITEK	T2	PA
BIOLOGICALS (Blood Pressure/Heart Medications)		
PLASMA KALLIKREIN INHIBITORS		
ORLADEYO 110MG CAPSULE	T5	PA QL (28 caps/28 days) SP
ORLADEYO 150MG CAPSULE	T5	PA QL (28 caps/28 days) SP
TAKHZYRO	T4	PA SP HD
TAKHZYRO 300MG/2ML	T4	PA QL (2 units/28 days) SP HD
BIOLOGICALS (Miscellaneous)		
PKU TREATMENT AGENTS - PHENYLALANINE AMMONIA LYASE		
PALYNZIQ 10 MG/0.5 ML SYRINGE	T4	PA QL(30 syringes/fill) SP HD
PALYNZIQ 2.5 MG/0.5 ML SYRINGE	T4	PA QL(8 syringes/fill) SP HD
PALYNZIQ 20 MG/ML SYRINGE	T4	PA QL(60 syringes/fill) SP HD
BIOLOGICALS (Vaccines)		
COVID-19 VACCINES		
COMIRNATY	T2	PPACA
JANSSEN COVID-19 VACCINE (EUA)	T2	PPACA
MODERNA COVID VAC(EUA)	T2	PPACA
MODERNA COVID-19 BOOSTER (EUA)	T2	PPACA
NOVAVAX COVID-19 VACC,ADJ(EUA)	T2	PPACA
PFIZER COVID VAC(EUA)	T2	PPACA
PFIZER COVID-19 VACCINE (EUA)	T2	PPACA
SPIKEVAX COVID (18Y UP) VACC	T2	PPACA
ENTERIC VIRUS VACCINES		
IPOL	T2	PPACA
ROTARIX	T2	HD PPACA
ROTATEQ	T2	PPACA
GRAM NEGATIVE COCCI VACCINES		
BEXSERO	T2	PPACA
MENACTRA	T2	PPACA
MENQUADFI	T2	PPACA

T1 – Generics
T2 – Preferred Brands
T3 – Non-Preferred Brands
T4 – Preferred Specialty
T5 – Non-Preferred Specialty
PA – Prior Authorization
QL – Quantity Limit
ST – Step Therapy
AGE – Age Requirement
SP – Specialty Medication
HD – May require home delivery pharmacy
PPACA – No Cost-Share Preventive Medication
CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

BIOLOGICALS (Vaccines) (cont.)		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
GRAM NEGATIVE COCCI VACCINES (cont.)		
MENVEO A-C-Y-W-135-DIP	T2	PPACA
PENBRAYA	T2	PPACA
TRUMENBA	T2	PPACA
GRAM POSITIVE COCCI VACCINES		
PNEUMOVAX 23	T2	PPACA
PREVNAR 13	T2	PPACA
PREVNAR 20	T2	PPACA
VAXNEUVANCE	T2	PPACA
INFLUENZA VIRUS VACCINES		
AFLURIA QUAD	T2	PPACA
FLUAD	T2	PPACA
FLUAD QUAD	T2	PPACA
FLUARIX QUAD	T2	PPACA
FLUBLOK QUAD	T2	PPACA
FLUCELVAX QUAD	T2	PPACA
FLULAVAL QUAD	T2	PPACA
FLUMIST QUAD	T3	PPACA
FLUZONE HIGH-DOSE	T2	PPACA
FLUZONE QUAD	T2	PPACA
FLUZONE QUAD PEDI	T2	PPACA
NEUROTOXIC VIRUS VACCINES		
DENGVAXIA	T2	PPACA
VACCINE/TOXOID PREPARATIONS, COMBINATIONS		
ACTHIB	T2	PPACA
ADACEL TDAP	T2	PPACA
BOOSTRIX TDAP	T2	PPACA
DAPTACEL DTAP	T2	PPACA
DIPHTHERIA-TETANUS TOXOIDS-PED	T2	PPACA
HIBERIX	T2	PPACA
INFANRIX DTAP	T2	PPACA
KINRIX	T2	PPACA
M-M-R II VACCINE	T2	PPACA
PEDVAXHIB	T2	PPACA
PENTACEL	T2	PPACA

T1 – Generics
T2 – Preferred Brands
T3 – Non-Preferred Brands
T4 – Preferred Specialty
T5 – Non-Preferred Specialty
PA – Prior Authorization
QL – Quantity Limit
ST – Step Therapy
AGE – Age Requirement
SP – Specialty Medication
HD – May require home delivery pharmacy
PPACA – No Cost-Share Preventive Medication
CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

BIOLOGICALS (Vaccines) (cont.)		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
VACCINE/TOXOID PREPARATIONS, COMBINATIONS (cont.)		
PENTACEL ACTHIB COMPONENT	T2	PPACA
PRIORIX	T2	PPACA
PROQUAD	T2	PPACA
QUADRACEL DTAP-IPV	T2	PPACA
TDVAX	T2	PPACA
TENIVAC	T2	PPACA
VAXELIS	T2	PPACA
VIRAL/TUMORIGENIC VACCINES		
ACAM2000	T2	
AREXVY VIAL KIT	T2	PPACA
ENGERIX-B ADULT	T2	PPACA
ENGERIX-B PEDIATRIC-ADOLESCENT	T2	PPACA
GARDASIL 9	T2	PPACA
HEPLISAV-B	T2	PPACA
JYNNEOS	T2	
PEDIARIX	T2	PPACA
PREHEVBRIO	T2	PPACA
RECOMBIVAX HB	T2	PPACA
SHINGRIX	T2	PPACA
TWINRIX	T2	PPACA
VARIVAX VACCINE	T2	PPACA
BLOOD (Blood Modifiers/Bleeding Disorders)		
ANTIFIBRINOLYTIC AGENTS		
AMICAR (*aminocaproic acid*)	T5	SP HD
aminocaproic acid (Amicar)	T1	SP HD
LYSTEDA (*tranexamic acid)*	T5	SP
tranexamic acid (Lysteda)	T1	SP
COMPLEMENT INHIBITORS		
EMPAVELI	T4	PA SP
FABHALTA	T4	PA SP
HEMOPHILIA TREATMENT AGENTS, NON-FACTOR REPLACEMENT		
HEMLIBRA	T4	PA SP HD
PYRUVATE KINASE ACTIVATORS		
PYRUKYND 20 MG TABLET	T5	PA QL(56 tabs/28 days) SP

T1 – Generics
T2 – Preferred Brands
T3 – Non-Preferred Brands
T4 – Preferred Specialty
T5 – Non-Preferred Specialty
PA – Prior Authorization
QL – Quantity Limit
ST – Step Therapy
AGE – Age Requirement
SP – Specialty Medication
HD – May require home delivery pharmacy
PPACA – No Cost-Share Preventive Medication
CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

BLOOD (Blood Modifiers/Bleeding Disorders) (cont.)		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
PYRUVATE KINASE ACTIVATORS (cont.)		
PYRUKYND 20-5 MG TAPER PACK	T5	PA QL(14 tabs/365 days) SP
PYRUKYND 5 MG TABLET	T5	PA QL(56 tabs/28 days) SP
PYRUKYND 5 MG TAPER PACK	T5	PA QL(7 tabs/365 days) SP
PYRUKYND 50 MG TABLET	T5	PA QL(56 tabs/28 days) SP
PYRUKYND 50-20 MG TAPER PACK	T5	PA QL(14 tabs/365 days) SP
SICKLE CELL ANEMIA AGENTS		
DROXIA	T2	
ENDARI	T3	PA
TOPICAL HEMOSTATICS		
ASTRINGYN	T3	
AVITENE	T3	
ENDO-AVITENE	T3	
EVICEL	T3	
GEL-FLOW	T3	
GEL-FLOW NT	T3	
GELFOAM	T3	
GELFOAM (*gelatin sponge,absorb/porcine*)	T3	
GELFOAM COMPRESSED	T3	
GELFOAM JMI	T3	
MONSEL'S	T2	
RECOTHROM	T3	
SURGICEL	T3	
SURGIFOAM SPONGE SIZE 100	T3	
SURGIFOAM SPONGE SIZE 100C	T3	
surgifoam sponge size 12-7 (Gelfoam)	T1	
SYRINGE AVITENE	T3	
TACHOSIL	T3	
THROMBI-GEL (*thrombin/cal/cmc/gel/dress,hem*)	T3	
THROMBIN-JMI	T3	
THROMBI-PAD	T3	
ULTRAFOAM	T3	
BLOOD (Blood Thinners/Anti-Clotting)		
HEMORRHEOLOGIC AGENTS		
pentoxifylline	T1	HD

T1 – Generics
T2 – Preferred Brands
T3 – Non-Preferred Brands
T4 – Preferred Specialty
T5 – Non-Preferred Specialty
PA – Prior Authorization
QL – Quantity Limit
ST – Step Therapy
AGE – Age Requirement
SP – Specialty Medication
HD – May require home delivery pharmacy
PPACA – No Cost-Share Preventive Medication
CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

CARDIAC DRUGS (Blood Pressure/Heart Medications)		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
ANTIANGINAL, ANTI-ISCHEMIC AGENTS, NON-HEMODYNAMIC		
ranolazine (Ranexa)	T1	HD
ANTIARRHYTHMICS		
amiodarone hcl	T1	HD
disopyramide phosphate (Norpace)	T1	HD
dofetilide (Tikosyn)	T1	HD
flecainide acetate	T1	HD
mexiletine hcl	T1	HD
MULTAQ	T3	HD
propafenone hcl	T1	HD
propafenone hcl (Rythmol Sr)	T1	HD
quinidine gluconate	T1	HD
quinidine sulfate	T1	HD
RYTHMOL SR *(propafenone hcl)*	T3	HD
CALCIUM CHANNEL BLOCKER AND NSAID, COX-2 INHIBITOR		
CONSENSI	T3	
CALCIUM CHANNEL BLOCKING AGENTS		
amlodipine besylate (Norvasc)	T1	HD
CALAN SR *(verapamil hcl)*	T3	ST HD
CARDIZEM (*diltiazem hcl)*	T3	HD
CARDIZEM CD (*diltiazem hcl*)	T3	HD
CARDIZEM LA	T3	HD
CARDIZEM LA (*diltiazem hcl*)	T3	HD
diltiazem hcl	T1	HD
diltiazem hcl	T1	HD
diltiazem hcl (Cardizem Cd)	T1	HD
diltiazem hcl (Cardizem La)	T1	HD
diltiazem hcl (Cardizem)	T1	HD
felodipine	T1	HD
isradipine	T1	HD
nicardipine hcl	T1	HD
nifedipine	T1	HD
nifedipine (Procardia XL)	T1	HD
nifedipine (Procardia)	T1	HD
nimodipine	T1	HD

T1 – Generics
T2 – Preferred Brands
T3 – Non-Preferred Brands
T4 – Preferred Specialty
T5 – Non-Preferred Specialty
PA – Prior Authorization
QL – Quantity Limit
ST – Step Therapy
AGE – Age Requirement
SP – Specialty Medication
HD – May require home delivery pharmacy
PPACA – No Cost-Share Preventive Medication
CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

CARDIAC DRUGS (Blood Pressure/Heart Medications) (cont.)		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
CALCIUM CHANNEL BLOCKING AGENTS (cont.)		
nisoldipine	T1	HD
nisoldipine (Sular)	T1	HD
NYMALIZE	T3	HD
PROCARDIA *(nifedipine)*	T3	ST HD
PROCARDIA XL *(nifedipine)*	T3	ST HD
SULAR *(nisoldipine)*	T3	ST HD
TIAZAC *(diltiazem hcl)*	T3	HD
verapamil hcl	T1	HD
verapamil hcl (Calan Sr)	T1	HD
verapamil hcl (Verelan Pm)	T1	HD
verapamil hcl (Verelan)	T1	HD
VERELAN *(verapamil hcl)*	T3	ST HD
VERELAN *PM (verapamil hcl)*	T3	ST HD
CARDIAC MYOSIN INHIBITOR		
CAMZYOS	T4	PA QL(30 caps/fill) SP HD
DIGITALIS GLYCOSIDES		
digoxin	T1	HD
digoxin (Lanoxin)	T1	HD
LANOXIN	T3	HD
LANOXIN *(digoxin)*	T3	HD
SOLUBLE GUANYLATE CYCLASE (SGC) STIMULATOR		
VERQUVO		
VASODILATORS, CORONARY		
GONITRO	T3	HD
ISORDIL *(isosorbide dinitrate)*	T3	HD
ISORDIL TITRADOSE *(isosorbide dinitrate)*	T3	HD
isosorbide dinitrate	T1	HD
isosorbide dinitrate (Isordil Titradose)	T1	HD
isosorbide dinitrate (Isordil)	T1	HD
isosorbide mononitrate	T1	HD
MINITRAN	T3	HD
NITRO-DUR	T3	HD
nitroglycerin	T1	HD
nitroglycerin 0.3 mg tablet sl (Nitrostat)	T1	HD

T1 – Generics
T2 – Preferred Brands
T3 – Non-Preferred Brands
T4 – Preferred Specialty
T5 – Non-Preferred Specialty
PA – Prior Authorization
QL – Quantity Limit
ST – Step Therapy
AGE – Age Requirement
SP – Specialty Medication
HD – May require home delivery pharmacy
PPACA – No Cost-Share Preventive Medication
CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

CARDIAC DRUGS (Blood Pressure/Heart Medications) (cont.)		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
VASODILATORS, CORONARY (cont.)		
nitroglycerin 0.4 mg tablet sl (Nitrostat)	T1	HD
nitroglycerin 0.6 mg tablet sl (Nitrostat)	T1	HD
nitroglycerin 400 mcg spray (Nitrolingual)	T1	HD
NITROLINGUAL *(nitroglycerin)*	T3	HD
NITROMIST *(nitroglycerin)*	T3	HD
NITROSTAT *(nitroglycerin)*	T3	HD
CARDIOVASCULAR (Asthma/COPD/Respiratory)		
PULM ANTI-HTN, SOLUBLE GUANYLATE CYCLASE STIMULATOR		
ADEMPAS	T4	PA QL(90 tabs/fill) SP HD
PULM.ANTI-HTN, SEL.C-GMP PHOSPHODIESTERASE T5 INHIB		
REVATIO 10 MG/ML ORAL SUSP (*sildenafil citrate*)	T5	PA QL(112 mls/fill) SP HD
REVATIO 20 MG TABLET (*sildenafil citrate*)	T5	PA QL(90 tabs/fill) SP HD
*sildenafil 20 mg tablet (*Revatio*)*	T1	PA QL(90 tabs/fill) SP HD
*tadalafil (*Adcirca*)*	T1	
*tadalafil 20 mg tablet (*Adcirca*)*	T1	PA QL(60 tabs/fill) SP HD
PULMONARY ANTI-HTN, ENDOTHELIN RECEPTOR ANTAGONIST		
*ambrisentan (*Letairis*)*	T1	PA QL(30 tabs/fill) SP HD
bosentan (Tracleer)	T1	PA QL(60 tabs/fill) SP HD
OPSUMIT	T4	PA QL(30 tabs/fill) SP HD
TRACLEER 125 MG TABLET *(bosentan)*	T5	PA QL(60 tabs/fill) SP HD
TRACLEER 32 MG TABLET FOR SUSP	T4	PA QL(120 tabs/fill) SP HD
TRACLEER 62.5 MG TABLET (*bosentan*)	T5	PA QL(60 tabs/fill) SP HD
PULMONARY ANTIHYPERTENSIVES, PROSTACYCLIN-TYPE		
ORENITRAM ER	T5	PA QL(90 tabs/fill) SP HD
ORENITRAM TITRATION KT MONTH 1	T5	PA QL (30 tabs/30 days)
ORENITRAM TITRATION KT MONTH 2	T5	PA QL (336 tabs/28 days) SP
ORENITRAM TITRATION KT MONTH 3	T5	PA QL (252 tabs/28 days) SP
TYVASO	T4	PA SP HD
TYVASO DPI	T4	PA SP HD
TYVASO INSTITUTIONAL START KIT	T4	PA SP HD
TYVASO REFILL KIT	T4	PA SP HD
TYVASO STARTER KIT	T4	PA SP HD
UPTRAVI 200 MCG TABLET	T4	PA QL(60 tabs/fill) SP HD
UPTRAVI 400 MCG TABLET	T4	PA QL(60 tabs/fill) SP HD

T1 – Generics
T2 – Preferred Brands
T3 – Non-Preferred Brands
T4 – Preferred Specialty
T5 – Non-Preferred Specialty
PA – Prior Authorization
QL – Quantity Limit
ST – Step Therapy
AGE – Age Requirement
SP – Specialty Medication
HD – May require home delivery pharmacy
PPACA – No Cost-Share Preventive Medication
CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

CARDIOVASCULAR (Asthma/COPD/Respiratory) (cont.)		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
PULMONARY ANTIHYPERTENSIVES, PROSTACYCLIN-TYPE (cont.)		
UPTRAVI 600 MCG TABLET	T4	PA QL(60 tabs/fill) SP HD
UPTRAVI 800 MCG TABLET	T4	PA QL(60 tabs/fill) SP HD
UPTRAVI 1,000 MCG TABLET	T4	PA QL(60 tabs/fill) SP HD
UPTRAVI 1,200 MCG TABLET	T4	PA QL(60 tabs/fill) SP HD
UPTRAVI 1,400 MCG TABLET	T4	PA QL(60 tabs/fill) SP HD
UPTRAVI 1,600 MCG TABLET	T4	PA QL(60 tabs/fill) SP HD
UPTRAVI 200-800 TITRATION PACK	T4	PA QL(1 dose pk/fill) SP HD
VENTAVIS	T5	PA SP HD
CARDIOVASCULAR (Blood Pressure/Heart Medications)		
ACE INHIBITOR-CALCIUM CHANNEL BLOCKER COMBINATION		
amlodipine besylate/benazepril	T1	HD
amlodipine besylate/benazepril (Lotrel)	T1	HD
PRESTALIA	T3	ST HD
trandolapril/verapamil hcl	T1	HD
ACE INHIBITOR-THIAZIDE OR THIAZIDE-LIKE DIURETIC		
ACCURETIC (*quinapril/hydrochlorothiazide*)	T3	HD
benazepril/hydrochlorothiazide	T1	HD
benazepril/hydrochlorothiazide (Lotensin Hct)	T1	HD
captopril/hydrochlorothiazide	T1	HD
enalapril/hydrochlorothiazide	T1	HD
enalapril/hydrochlorothiazide (Vaseretic)	T1	HD
fosinopril/hydrochlorothiazide	T1	HD
lisinopril/hydrochlorothiazide (Zestoretic)	T1	HD
LOTENSIN HCT *(benazepril/hydrochlorothiazide)*	T3	HD
quinapril/hydrochlorothiazide (Accuretic)	T1	HD
VASERETIC *(enalapril/hydrochlorothiazide)*	T3	HD
ZESTORETIC *(lisinopril/hydrochlorothiazide)*	T3	HD
ALPHA/BETA-ADRENERGIC BLOCKING AGENTS		
carvedilol (Coreg)	T1	HD
carvedilol phosphate (Coreg Cr)	T1	HD
COREG CR *(carvedilol phosphate)*	T3	ST HD
labetalol hcl	T1	HD
ALPHA-ADRENERGIC BLOCKING AGENTS		
CARDURA 1 MG TABLET (*doxazosin mesylate*)	T3	ST QL(30 tabs/fill) HD

T1 – Generics
T2 – Preferred Brands
T3 – Non-Preferred Brands
T4 – Preferred Specialty
T5 – Non-Preferred Specialty
PA – Prior Authorization
QL – Quantity Limit
ST – Step Therapy
AGE – Age Requirement
SP – Specialty Medication
HD – May require home delivery pharmacy
PPACA – No Cost-Share Preventive Medication
CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

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

T1 – Generics
T2 – Preferred Brands
T3 – Non-Preferred Brands
T4 – Preferred Specialty
T5 – Non-Preferred Specialty
PA – Prior Authorization
QL – Quantity Limit
ST – Step Therapy
AGE – Age Requirement
SP – Specialty Medication
HD – May require home delivery pharmacy
PPACA – No Cost-Share Preventive Medication
CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

CARDIOVASCULAR (Blood Pressure/Heart Medications) (cont.)		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
ANTIHYPERTENSIVES, ACE INHIBITORS (cont.)		
benazepril hcl (Lotensin)	T1	HD
captopril	T1	HD
enalapril maleate (Epaned)	T1	HD
enalapril maleate (Vasotec)	T1	HD
fosinopril sodium	T1	HD
lisinopril (Zestril)	T1	HD
LOTENSIN (*benazepril hcl*)	T3	HD
moexipril hcl	T1	HD
perindopril erbumine	T1	HD
quinapril hcl (Accupril)	T1	HD
ramipril (Altace)	T1	HD
trandolapril	T1	HD
VASOTEC *(enalapril maleate)*	T3	HD
ZESTRIL *(lisinopril)*	T3	HD
ANTIHYPERTENSIVES, ANGIOTENSIN RECEPTOR ANTAGONIST		
candesartan cilexetil (Atacand)	T1	HD
eprosartan mesylate	T1	HD
irbesartan (Avapro)	T1	HD
losartan potassium (Cozaar)	T1	HD
olmesartan medoxomil (Benicar)	T1	HD
telmisartan (Micardis)	T1	HD
valsartan 160 mg tablet (Diovan)	T1	HD
valsartan 320 mg tablet (Diovan)	T1	HD
valsartan 40 mg tablet (Diovan)	T1	HD
valsartan 80 mg tablet (Diovan)	T1	HD
ANTIHYPERTENSIVES, GANGLIONIC BLOCKERS		
VECAMYL	T3	PA
ANTIHYPERTENSIVES, MISCELLANEOUS		
DEMSER (*metyrosine*)	T3	PA HD
metyrosine (Demser)	T1	PA HD
ANTIHYPERTENSIVES, SYMPATHOLYTIC		
CATAPRES (*clonidine hcl*)	T3	HD
CATAPRES-TTS 1 (*clonidine*)	T3	QL(4 patches/28 days) HD

T1 – Generics
T2 – Preferred Brands
T3 – Non-Preferred Brands
T4 – Preferred Specialty
T5 – Non-Preferred Specialty
PA – Prior Authorization
QL – Quantity Limit
ST – Step Therapy
AGE – Age Requirement
SP – Specialty Medication
HD – May require home delivery pharmacy
PPACA – No Cost-Share Preventive Medication
CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

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

T1 – Generics
T2 – Preferred Brands
T3 – Non-Preferred Brands
T4 – Preferred Specialty
T5 – Non-Preferred Specialty
PA – Prior Authorization
QL – Quantity Limit
ST – Step Therapy
AGE – Age Requirement
SP – Specialty Medication
HD – May require home delivery pharmacy
PPACA – No Cost-Share Preventive Medication
CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

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

T1 – Generics
T2 – Preferred Brands
T3 – Non-Preferred Brands
T4 – Preferred Specialty
T5 – Non-Preferred Specialty
PA – Prior Authorization
QL – Quantity Limit
ST – Step Therapy
AGE – Age Requirement
SP – Specialty Medication
HD – May require home delivery pharmacy
PPACA – No Cost-Share Preventive Medication
CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

CARDIOVASCULAR (Cholesterol Medications) (cont.)		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
ANTIHYPERLIPIDEMIC - PCSK9 INHIBITORS (cont.)		
REPATHA SURECLICK	T2	PA
REPATHA SYRINGE	T2	PA
ANTIHYPERLIPIDEMIC-ACLY AND CHOLES ABSORP INHIB		
NEXLIZET	T2	PA
ANTIHYPERLIPIDEMIC-HMGCOA REDUCTASE INHIB (STATINS)		
atorvastatin 10 mg tablet (Lipitor)	T1	
atorvastatin 20 mg tablet (Lipitor)	T1	
atorvastatin 40 mg tablet (Lipitor)	T1	
atorvastatin 80 mg tablet (Lipitor)	T1	
FLOLIPID	T3	ST QL(150 mls/fill) HD
fluvastatin sodium (Lescol XL)	T1	QL(30 tabs/fill) HD PPACA
fluvastatin sodium 20 mg cap	T1	QL(30 caps/fill) HD PPACA
fluvastatin sodium 40 mg cap	T1	QL(60 caps/fill) HD PPACA
LESCOL XL *(fluvastatin sodium)*	T3	ST QL(30 tabs/fill) HD
LIVALO *(pitavastatin calcium)*	T3	ST QL(30 tabs/30 days) HD
lovastatin 10 mg tablet	T1	QL(30 tabs/fill) HD PPACA
lovastatin 20 mg tablet	T1	QL(60 tabs/fill) HD PPACA
lovastatin 40 mg tablet	T1	QL(60 tabs/fill) HD PPACA
pitavastatin calcium (Livalo)	T1	QL(30 tabs/30 days) HD PPACA
pravastatin sodium	T1	QL(30 tabs/fill) HD PPACA
simvastatin 10 mg tablet (Zocor)	T1	QL(30 tabs/fill) HD PPACA
simvastatin 20 mg tablet (Zocor)	T1	QL(30 tabs/fill) HD PPACA
SIMVASTATIN 20 MG/5 ML SUSP	T3	ST QL(150 mls/fill) HD
simvastatin 40 mg tablet (Zocor)	T1	QL(30 tabs/fill) HD PPACA
simvastatin 5 mg tablet	T1	QL(30 tabs/fill) HD PPACA
simvastatin 80 mg tablet (Zocor)	T1	QL(30 tabs/fill) HD
ZYPITAMAG	T3	ST QL(30 tabs/fill) 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	ST HD
COLESTID (*colestipol hcl)*	T3	ST HD

T1 – Generics
T2 – Preferred Brands
T3 – Non-Preferred Brands
T4 – Preferred Specialty
T5 – Non-Preferred Specialty
PA – Prior Authorization
QL – Quantity Limit
ST – Step Therapy
AGE – Age Requirement
SP – Specialty Medication
HD – May require home delivery pharmacy
PPACA – No Cost-Share Preventive Medication
CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

CARDIOVASCULAR (Cholesterol Medications) (cont.)		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
BILE SALT SEQUESTRANTS (cont.)		
colestipol hcl (Colestid)	T1	HD
QUESTRAN (*cholestyramine (with sugar)*)	T3	ST HD
QUESTRAN LIGHT (*cholestyramine/aspartame*)	T3	ST HD
LIPOTROPICS		
ezetimibe (Zetia)	T1	HD
fenofibrate 120 mg tablet (Fenoglide)	T1	ST HD
fenofibrate 130 mg capsule	T1	HD
fenofibrate 134 mg capsule	T1	HD
fenofibrate 145 mg tablet (Tricor)	T1	HD
fenofibrate 160 mg tablet	T1	HD
fenofibrate 200 mg capsule	T1	HD
fenofibrate 40 mg tablet (Fenoglide)	T1	ST HD
fenofibrate 43 mg capsule	T1	HD
fenofibrate 48 mg tablet (Tricor)	T1	HD
fenofibrate 54 mg tablet	T1	HD
fenofibrate 67 mg capsule	T1	HD
fenofibric acid (choline) (Trilipix)	T1	HD
fenofibric acid (Fibricor)	T1	HD
FENOGLIDE (*fenofibrate*)	T3	ST HD
FIBRICOR (*fenofibric acid*)	T3	ST HD
gemfibrozil (Lopid)	T1	HD
LOPID (*gemfibrozil*)	T3	HD
niacin	T1	HD
niacin 500 mg tablet	T1	HD
NIACOR	T3	HD
TRILIPIX (*fenofibric acid (choline)*)	T3	ST HD
CNS DRUGS (Alzheimer's Disease)		
ALZHEIMER'S THERAPY, NMDA RECEPTOR ANTAGONISTS		
MEMANTINE 5-10 MG TITRATION PK	T3	HD
memantine hcl (Namenda Xr)	T1	HD
memantine hcl 10 mg tablet (Namenda)	T1	HD
memantine hcl 2 mg/ml solution	T1	HD
memantine hcl 5 mg tablet (Namenda)	T1	HD

T1 – Generics
T2 – Preferred Brands
T3 – Non-Preferred Brands
T4 – Preferred Specialty
T5 – Non-Preferred Specialty
PA – Prior Authorization
QL – Quantity Limit
ST – Step Therapy
AGE – Age Requirement
SP – Specialty Medication
HD – May require home delivery pharmacy
PPACA – No Cost-Share Preventive Medication
CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

CNS DRUGS (Alzheimer's Disease) (cont.)		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
ALZHEIMER'S THERAPY, NMDA RECEPTOR ANTAGONISTSS (cont.)		
NAMENDA 10 MG TABLET (*memantine hcl*)	T3	ST HD
NAMENDA 5 MG TABLET (*memantine hcl*)	T3	ST HD
NAMENDA 5-10 MG TITRATION PK	T3	HD
NAMENDA XR TITRATION PACK	T3	HD
NAMZARIC	T2	ST HD
CNS DRUGS (Miscellaneous)		
AMYOTROPHIC LATERAL SCLEROSIS AGENTS		
EXSERVAN	T5	PA SP
RADICAVA ORS	T4	PA SP HD
RILUTEK (*riluzole*)	T5	PA SP HD
riluzole (Rilutek)	T1	PA SP HD
TEGLUTIK	T5	PA SP
TIGLUTIK	T5	PA SP
DRUGS TO TREAT MOVEMENT DISORDERS		
AUSTEDO 6 MG TABLET	T4	PA QL(60 tabs/fill) SP HD
AUSTEDO 9 MG TABLET	T4	PA QL(120 tabs/fill) SP HD
AUSTEDO 12 MG TABLET	T4	PA QL(120 tabs/fill) SP HD
AUSTEDO XR TITRATION KT(WK1-4)	T4	PA QL(42 tabs/30 days) SP HD
AUSTEDO XR 6 MG TABLET	T4	PA SP HD QL (210 tabs/30 days)
AUSTEDO XR 12 MG TABLET	T4	PA SP HD QL (90 tabs/30 days)
AUSTEDO XR 24 MG TABLET	T4	PA SP HD QL (60 tabs/30 days)
HORIZANT	T3	ST
INGREZZA	T5	PA QL(30 caps/fill) SP
INGREZZA INITIATION PACK	T5	PA QL(28 caps/fill) SP
tetrabenazine 12.5 mg tablet (Xenazine)	T1	PA QL(120 tabs/fill) SP HD
tetrabenazine 25 mg tablet (Xenazine)	T1	PA QL(60 tabs/fill) SP HD
PSEUDOBULBAR AFFECT (PBA) AGENTS, NMDA ANTAGONISTS		
NUEDEXTA	T2	PA
XANTHINES		
caffeine citrate	T1	HD
CNS DRUGS (Multiple Sclerosis)		
AGENTS TO TREAT MULTIPLE SCLEROSIS		
AVONEX	T4	PA QL(1 kit/28 days) SP HD

T1 – Generics
T2 – Preferred Brands
T3 – Non-Preferred Brands
T4 – Preferred Specialty
T5 – Non-Preferred Specialty
PA – Prior Authorization
QL – Quantity Limit
ST – Step Therapy
AGE – Age Requirement
SP – Specialty Medication
HD – May require home delivery pharmacy
PPACA – No Cost-Share Preventive Medication
CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

CNS DRUGS (Multiple Sclerosis) (cont.)		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
AGENTS TO TREAT MULTIPLE SCLEROSIS (cont.)		
AVONEX PEN	T4	PA QL(4 pens/28 days) SP HD
BAFIERTAM	T4	PA QL(120 caps/fill) SP HD
BETASERON	T4	PA QL(14 kits/30 days) SP HD
COPAXONE 20 MG/ML SYRINGE (*glatiramer acetate*)	T5	PA QL(30 syringes/30 days) SP HD
COPAXONE 40 MG/ML SYRINGE (*glatiramer acetate*)	T5	PA QL(12 syringes/30 days) SP HD
dimethyl fumarate (Tecfidera)	T1	PA QL(60 caps/fill) SP HD
fingolimod hcl (Gilenya)	T1	
glatiramer 20 mg/ml syringe (Copaxone)	T1	PA QL(30 syringes/30 days) SP HD
glatiramer 40 mg/ml syringe (Copaxone)	T1	PA QL(12 syringes/30 days) SP HD
glatopa 20 mg/ml syringe (Copaxone)	T1	PA QL(30 syringes/30 days) SP HD
glatopa 40 mg/ml syringe (Copaxone)	T1	PA QL(12 syringes/30 days) SP HD
KESIMPTA PEN	T5	PA QL(1 pen/28 days) SP HD
MAVENCLAD 10 MG X 10 TABLET PK	T5	PA QL(10 tabs/fill) SP HD
MAVENCLAD 10 MG X 4 TABLET PK	T5	PA QL(4 tabs/fill) SP HD
MAVENCLAD 10 MG X 5 TABLET PK	T5	PA QL(5 tabs/fill) SP HD
MAVENCLAD 10 MG X 6 TABLET PK	T5	PA QL(6 tabs/fill) SP HD
MAVENCLAD 10 MG X 7 TABLET PK	T5	PA QL(7 tabs/fill) SP HD
MAVENCLAD 10 MG X 8 TABLET PK	T5	PA QL(8 tabs/fill) SP HD
MAVENCLAD 10 MG X 9 TABLET PK	T5	PA QL(9 tabs/fill) SP HD
MAYZENT 0.25 MG TABLET	T4	PA QL(30 tabs/fill) SP HD
MAYZENT 0.25MG START-1MG MAINT	T4	PA QL(7 tabs/fill) SP HD
MAYZENT 0.25MG START-2MG MAINT	T4	PA QL(12 tabs/fill) SP HD
MAYZENT 1 MG TABLET	T4	PA QL(30 tabs/fill) SP HD
MAYZENT 2 MG TABLET	T4	PA QL(30 tabs/fill) SP HD
PLEGRIDY 125 MCG/0.5 ML PEN	T4	PA QL(1 ml/28 days) SP HD
PLEGRIDY 125 MCG/0.5 ML SYRING	T4	PA QL(1 ml/28 days) SP HD
PLEGRIDY PEN INJ STARTER PACK	T4	PA QL(1 ml/365 days) SP HD
PLEGRIDY SYRINGE STARTER PACK	T4	PA QL(1 ml/365 days) SP HD
PONVORY 14-DAY STARTER PACK	T4	PA QL(14 tabs/365 days) SP HD
PONVORY 20 MG TABLET	T4	PA QL(30 tabs/30 days) SP HD
REBIF 22 MCG/0.5 ML SYRINGE	T4	PA QL(6 mls/28 days) SP HD
REBIF 44 MCG/0.5 ML SYRINGE	T4	PA QL(6 mls/28 days) SP HD
REBIF REBIDOSE 22 MCG/0.5 ML	T4	PA QL(6 mls/28 days) SP HD
REBIF REBIDOSE 44 MCG/0.5 ML	T4	PA QL(6 mls/28 days) SP HD

T1 – Generics
T2 – Preferred Brands
T3 – Non-Preferred Brands
T4 – Preferred Specialty
T5 – Non-Preferred Specialty
PA – Prior Authorization
QL – Quantity Limit
ST – Step Therapy
AGE – Age Requirement
SP – Specialty Medication
HD – May require home delivery pharmacy
PPACA – No Cost-Share Preventive Medication
CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

CNS DRUGS (Multiple Sclerosis) (cont.)		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
AGENTS TO TREAT MULTIPLE SCLEROSIS (cont.)		
REBIF REBIDOSE TITRATION PACK	T4	PA QL(4.2 mls/28 days) SP HD
REBIF TITRATION PACK	T4	PA QL(4.2 mls/28 days) SP HD
VUMERITY	T4	PA QL(120 caps/fill) SP HD
AGTS TX NEUROMUSC TRANSMISSION DIS, POT-CHAN BLKR		
dalfampridine (Ampyra)	T1	PA QL(60 tabs/fill) SP HD
FIRDAPSE	T4	PA SP
RUZURGI	T2	PA
SPHINGOSINE I-PHOSPHATE (SIP) RECEPTOR MODULATOR		
ZEPOSIA 0.23-0.46 MG START PCK	T4	PA QL(7 caps/fill) SP HD
ZEPOSIA 0.23-0.46-0.92 MG KIT	T4	PA QL(37 caps/fill) SP HD
ZEPOSIA 0.92 MG CAPSULE	T4	PA QL(30 caps/fill) SP HD
ZEPOSIA STARTER KIT (28-DAY)	T4	
CNS DRUGS (Pain Relief and Inflammatory Disease)		
CALCITONIN GENE-RELATED PEPTIDE (CGRP) INHIBITORS		
EMGALITY 100 MG/ML SYR(1 OF 3)	T2	PA QL(3 mls/30 days)
EMGALITY 300 MG (100 MG X3SYR)	T2	PA QL(3 mls/30 days)
POSTHERPETIC NEURALGIA AGENTS		
gabapentin (Gralise)	T1	ST
GRALISE *(gabapentin)*	T3	ST
GRALISE	T3	ST
CNS DRUGS (Seizure Disorders)		
ANTICONVULSANT - BENZODIAZEPINE TYPE		
clobazam (Onfi)	T1	PA HD
clonazepam	T1	HD
clonazepam (Klonopin)	T1	HD
DIASTAT (*diazepam*)	T3	HD
DIASTAT ACUDIAL (*diazepam*)	T3	HD
diazepam 10 mg rectal gel syst (Diastat Acudial)	T1	HD
diazepam 2.5 mg rectal gel sys (Diastat)	T1	HD
diazepam 20 mg rectal gel syst	T1	HD
NAYZILAM	T2	PA QL(2 units/fill) HD
SYMPAZAN	T3	PA HD
VALTOCO	T3	PA QL(2 units/fill) HD

T1 – Generics
T2 – Preferred Brands
T3 – Non-Preferred Brands
T4 – Preferred Specialty
T5 – Non-Preferred Specialty
PA – Prior Authorization
QL – Quantity Limit
ST – Step Therapy
AGE – Age Requirement
SP – Specialty Medication
HD – May require home delivery pharmacy
PPACA – No Cost-Share Preventive Medication
CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

CNS DRUGS (Seizure Disorders) (cont.)		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
ANTICONVULSANT - CANNABINOID TYPE		
EPIDIOLEX	T4	PA SP HD
ANTICONVULSANTS		
APTIOM	T3	HD
BRIVIACT	T3	ST HD
carbamazepine	T1	HD
carbamazepine	T1	HD
carbamazepine (Carbatrol)	T1	HD
carbamazepine (Tegretol Xr)	T1	HD
carbamazepine (Tegretol)	T1	HD
CARBATROL (*carbamazepine*)	T3	HD
CELONTIN (*methsuximide*)	T3	HD
DEPAKOTE *(divalproex sodium)*	T3	ST HD
DEPAKOTE ER *(divalproex sodium)*	T3	ST HD
DEPAKOTE SPRINKLE *(divalproex sodium)*	T3	ST HD
DIACOMIT	T4	PA SP HD
DILANTIN 100 MG CAPSULE (*phenytoin sodium extended*)	T3	HD
DILANTIN 30 MG CAPSULE	T2	HD
DILANTIN 50 MG INFATAB (*phenytoin*)	T3	HD
DILANTIN-125 (*phenytoin*)	T3	HD
divalproex sodium (Depakote Er)	T1	HD
divalproex sodium (Depakote Sprinkle)	T1	HD
divalproex sodium (Depakote)	T1	HD
ELEPSIA XR	T3	ST HD
ethosuximide (Zarontin)	T1	HD
felbamate (Felbatol)	T1	HD
FELBATOL *(felbamate)*	T3	HD
FYCOMPA	T2	HD
gabapentin	T1	HD
gabapentin (Neurontin)	T1	HD
gabapentin (Neurontin)	T1	HD
GABITRIL (*tiagabine hcl*)	T3	HD
lacosamide (Vimpat)	T1	HD
LAMICTAL XR (BLUE)	T3	ST HD
LAMICTAL XR (GREEN)	T3	ST HD

T1 – Generics
T2 – Preferred Brands
T3 – Non-Preferred Brands
T4 – Preferred Specialty
T5 – Non-Preferred Specialty
PA – Prior Authorization
QL – Quantity Limit
ST – Step Therapy
AGE – Age Requirement
SP – Specialty Medication
HD – May require home delivery pharmacy
PPACA – No Cost-Share Preventive Medication
CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

CNS DRUGS (Seizure Disorders) (cont.)		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
ANTICONVULSANTS (cont.)		
LAMICTAL XR (ORANGE)	T3	ST HD
lamotrigine (Lamictal (Blue))	T1	HD
lamotrigine (Lamictal (Green))	T1	HD
lamotrigine (Lamictal (Orange))	T1	HD
lamotrigine (Lamictal Odt (Blue))	T1	HD
lamotrigine (Lamictal Odt (Green))	T1	HD
lamotrigine (Lamictal Odt (Orange))	T1	HD
lamotrigine (Lamictal Odt)	T1	HD
lamotrigine (Lamictal Xr)	T1	HD
lamotrigine (Lamictal)	T1	HD
lamotrigine (Lamictal)	T1	HD
levetiracetam	T1	HD
levetiracetam (Keppra Xr)	T1	HD
levetiracetam (Keppra)	T1	HD
MYSOLINE (*primidone*)	T3	HD
oxcarbazepine (Trileptal)	T1	HD
OXTELLAR XR	T3	ST HD
PHENYTEK (*phenytoin sodium extended*)	T3	HD
phenytoin	T1	HD
phenytoin (Dilantin)	T1	HD
phenytoin (Dilantin-125)	T1	HD
phenytoin sodium extended (Dilantin)	T1	HD
phenytoin sodium extended (Phenytek)	T1	HD
pregabalin (Lyrica)	T1	HD
primidone (Mysoline)	T1	HD
QUDEXY XR (*topiramate*)	T3	ST HD
rufinamide (Banzel)	T1	PA HD
SPRITAM	T3	ST HD
TEGRETOL (*carbamazepine*)	T3	HD
TEGRETOL XR (*carbamazepine*)	T3	HD
tiagabine hcl (Gabitril)	T1	HD
topiramate er 25mg (Trokendi XR)	T1	ST HD
topiramate er 50mg (Trokendi XR)	T1	ST HD
topiramate er 100mg	T1	ST HD

T1 – Generics
T2 – Preferred Brands
T3 – Non-Preferred Brands
T4 – Preferred Specialty
T5 – Non-Preferred Specialty
PA – Prior Authorization
QL – Quantity Limit
ST – Step Therapy
AGE – Age Requirement
SP – Specialty Medication
HD – May require home delivery pharmacy
PPACA – No Cost-Share Preventive Medication
CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

CNS DRUGS (Seizure Disorders) (cont.)		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
ANTICONVULSANTS (cont.)		
topiramate (Qudexy Xr)	T1	ST HD
topiramate (Topamax)	T1	HD
topiramate (Topamax)	T1	HD
TROKENDI XR	T3	ST HD
valproic acid	T1	HD
valproic acid (as sodium salt)	T1	HD
vigabatrin 500 mg tablet (Sabril)	T1	
vigabatrin (Sabril)	T1	PA QL(150 packs/30 days) SP HD
VIGADRONE	T1	PA QL (150 pkts/30 days) SP HD
XCOPRI 100 MG TABLET	T3	QL(30 tabs/fill) HD
XCOPRI 12.5-25 MG TITRATION PK	T3	QL(28 tabs/fill) HD
XCOPRI 150 MG TABLET	T3	QL(30 tabs/fill) HD
XCOPRI 150-200 MG TITRATION PK	T3	QL(28 tabs/fill) HD
XCOPRI 200 MG TABLET	T3	QL(30 tabs/fill) HD
XCOPRI 250 MG DAILY DOSE PACK	T3	QL(56 tabs/fill) HD
XCOPRI 350 MG DAILY DOSE PACK	T3	QL(56 tabs/fill) HD
XCOPRI 50 MG TABLET	T3	QL(30 tabs/fill) HD
XCOPRI 50-100 MG TITRATION PAK	T3	QL(28 tabs/fill) HD
ZARONTIN (*ethosuximide*)	T3	HD
zonisamide	T1	HD
zonisamide (Zonegran)	T1	HD
CNS DRUGS (Sleep Disorders/Sedatives)		
NARCOLEPSY TX-H3-RECEPT.ANTAGONIST/INVERSE AGONIST		
WAKIX 17.8 MG TABLET	T5	PA QL(60 tabs/fill) SP HD
WAKIX 4.45 MG TABLET	T5	PA QL(30 tabs/fill) SP HD
COLONY STIMULATING FACTORS (Blood Modifiers/Bleeding Disorders)		
LEUKOCYTE (WBC) STIMULANTS		
FULPHILA	T4	PA QL(1.2 mls/30 days) SP
ZIEXTENZO	T4	PA QL(1.2 mls/30 days) SP
THROMBOPOIETIN RECEPTOR AGONISTS		
DOPTELET	T4	PA QL(15 tabs/fill) SP HD
PROMACTA	T4	PA SP HD

T1 – Generics
T2 – Preferred Brands
T3 – Non-Preferred Brands
T4 – Preferred Specialty
T5 – Non-Preferred Specialty
PA – Prior Authorization
QL – Quantity Limit
ST – Step Therapy
AGE – Age Requirement
SP – Specialty Medication
HD – May require home delivery pharmacy
PPACA – No Cost-Share Preventive Medication
CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

CONTRACEPTIVES (Contraception Products)		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
CONTRACEPTIVES, INTRAVAGINAL, SYSTEMIC		
ANNOVERA	T3	ST QL(1 ring/365 days) PPACA
etonogestrel/ethinyl estradiol (Nuvaring)	T1	PPACA
CONTRACEPTIVES, INJECTABLE		
DEPO-PROVERA *(medroxyprogesterone acetate)*	T3	QL(1 ml/90 days) PPACA
DEPO-SUBQ PROVERA 104	T3	QL(1 ml/90 days) PPACA
medroxyprogesterone 150 mg/ml (Depo-Provera)	T1	QL(1 ml/90 days) PPACA
CONTRACEPTIVES, ORAL		
BEYAZ (*drospir/eth estra/levomefol ca*)	T3	ST HD PPACA
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	T2	QL(1 tab/fill) HD PPACA
ethinyl estradiol/drospirenone (Yasmin 28)	T1	HD PPACA
ethinyl estradiol/drospirenone (Yaz)	T1	HD PPACA
ethynodiol d-ethinyl estradiol	T1	HD PPACA
levonorgestrel/ethin.estradiol	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
noreth-ethinyl estradiol/iron	T1	HD PPACA
noreth-ethinyl estradiol/iron (Generess Fe)	T1	HD PPACA
norethind-eth estrad 1-0.02 mg (Loestrin)	T1	HD PPACA
norethindrone	T1	HD PPACA
norethindrone ac-eth estradiol (Loestrin)	T1	HD PPACA
norethindrone-e.estradiol-iron	T1	HD PPACA
norethindrone-e.estradiol-iron (Loestrin Fe)	T1	HD PPACA
norethindrone-e.estradiol-iron (Minastrin 24 Fe)	T1	HD PPACA
norethindrone-e.estradiol-iron (Taytulla)	T1	HD PPACA
norethindrone-ethin. estradiol	T1	HD PPACA
norethin-ee 1.5-0.03 mg(21) tb (Loestrin)	T1	HD PPACA
norgestimate-ethinyl estradiol	T1	HD PPACA
NORGESTREL-ETHINYL ESTRADIOL	T1	HD PPACA
YAZ *(ethinyl estradiol/drospirenone)*	T3	ST HD PPACA

T1 – Generics
T2 – Preferred Brands
T3 – Non-Preferred Brands
T4 – Preferred Specialty
T5 – Non-Preferred Specialty
PA – Prior Authorization
QL – Quantity Limit
ST – Step Therapy
AGE – Age Requirement
SP – Specialty Medication
HD – May require home delivery pharmacy
PPACA – No Cost-Share Preventive Medication
CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

CONTRACEPTIVES (Contraception Products) (cont.)		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
CONTRACEPTIVES, TRANSDERMAL		
norelgestromin/ethin.estradiol	T1	HD PPACA
INTRA-UTERINE DEVICES (IUDS)		
KYLEENA	T4	SP PPACA
LILETTA	T5	SP PPACA
MIRENA	T4	SP PPACA
SKYLA	T4	SP PPACA
COUGH/COLD PREPARATIONS (Allergy/Nasal Sprays)		
1ST GEN ANTIHIST-DECONGEST-ANTICHOLINERGIC COMB		
RESPA A.R. (*pseudoephed/chlor-mal/bell alk*)	T3	
COUGH/COLD PREPARATIONS (Cough/Cold Medications)		
ANTITUSSIVES, NON-OPIOID		
benzonatate	T1	
DECONGESTANT-EXPECTORANT COMBINATIONS		
guaifenesin/phenylephrine hcl	T1	
NON-OPIOID ANTITUS-1ST GEN.ANTIHISTAMINE-DECONGEST		
BROMFED DM (*brompheniramine/pseudoephed/dm*)	T3	
brompheniramine/pseudoephed/dm (Bromfed Dm)	T1	
NON-OPIOID ANTITUSSIVE-1ST GEN ANTIHISTAMINE COMB.		
promethazine/dextromethorphan	T1	
OPIOID ANTITUSSIV-1ST GEN. ANTIHISTAMINE-DECONGEST		
CAPCOF	T3	
HISTEX-AC	T3	
MAXI-TUSS CD	T3	
POLY-TUSSIN AC	T3	
promethazine/phenyleph/codeine	T1	
ZODRYL DAC 25	T3	
ZODRYL DAC 30	T3	
ZODRYL DAC 35	T3	
ZODRYL DAC 40	T3	
ZODRYL DAC 50	T3	
ZODRYL DAC 60	T3	
ZODRYL DAC 80	T3	

T1 – Generics
T2 – Preferred Brands
T3 – Non-Preferred Brands
T4 – Preferred Specialty
T5 – Non-Preferred Specialty
PA – Prior Authorization
QL – Quantity Limit
ST – Step Therapy
AGE – Age Requirement
SP – Specialty Medication
HD – May require home delivery pharmacy
PPACA – No Cost-Share Preventive Medication
CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

COUGH/COLD PREPARATIONS (Cough/Cold Medications) (cont.)		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
OPIOID ANTITUSSIVE-1ST GENERATION ANTIHISTAMINE		
hydrocodone/chlorphen p-stirex	T1	
promethazine hcl/codeine	T1	
TUSSICAPS	T3	PA
TUXARIN ER	T3	
TUZISTRA XR	T3	PA
ZODRYL AC 25	T3	
ZODRYL AC 30	T3	
ZODRYL AC 35	T3	
ZODRYL AC 40	T3	
ZODRYL AC 50	T3	
ZODRYL AC 60	T3	
ZODRYL AC 80	T3	
OPIOID ANTITUSSIVE-ANTICHOLINERGIC COMBINATIONS		
HYCODAN	T3	
HYCODAN *(hydrocodone bit/homatrop me-br)*	T3	
OPIOID ANTITUSSIVE-ANTICHOLINERGIC COMBINATIONS		
hydrocodone bit/homatrop me-br	T1	
hydrocodone bit/homatrop me-br (Hycodan)	T1	
OPIOID ANTITUSSIVE-DECONGESTANT-EXPECTORANT COMB		
CODITUSSIN DAC	T3	
pseudoephed/codeine/guaifen	T1	
ZODRYL DEC 25	T3	
ZODRYL DEC 30	T3	
ZODRYL DEC 35	T3	
ZODRYL DEC 40	T3	
ZODRYL DEC 50	T3	
ZODRYL DEC 60	T3	
ZODRYL DEC 80	T3	
OPIOID ANTITUSSIVE-EXPECTORANT COMBINATION		
codeine phosphate/guaifenesin	T1	
CODITUSSIN AC	T3	
GUAIFEN-CODEINE 100-10 MG/5 ML	T3	
guaifen-codeine 100-10 mg/5 ml	T1	
GUAIFEN-CODEINE 200-20 MG/10ML	T3	

T1 – Generics
T2 – Preferred Brands
T3 – Non-Preferred Brands
T4 – Preferred Specialty
T5 – Non-Preferred Specialty
PA – Prior Authorization
QL – Quantity Limit
ST – Step Therapy
AGE – Age Requirement
SP – Specialty Medication
HD – May require home delivery pharmacy
PPACA – No Cost-Share Preventive Medication
CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

COUGH/COLD PREPARATIONS (Cough/Cold Medications) (cont.)		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
OPIOID ANTITUSSIVE-EXPECTORANT COMBINATION (cont.)		
MAR-COF CG	T3	
NINJACOF-XG	T3	
OBREDON	T3	PA
DIAGNOSTIC (Diabetes)		
BLOOD SUGAR DIAGNOSTICS		
FREESTYLE INSULINX	T2	
FREESTYLE INSULINX TEST STRIPS	T2	
FREESTYLE LITE TEST STRIP	T2	
FREESTYLE TEST STRIPS	T2	
ONETOUCH ULTRA TEST STRIP	T2	
ONETOUCH VERIO TEST STRIP	T2	
PRECISION XTRA	T2	
URINE GLUCOSE TEST AIDS		
DIASTIX REAGENT	T2	
DIAGNOSTIC (Miscellaneous)		
BLOOD TESTING PREPARATIONS		
FORA GTEL KETONE TEST STRIP	T3	
GOJJI BLOOD KETONE TEST STRIP	T3	
NOVAMAX PLUS	T2	
PRECISION XTRA	T2	
CARDIOVASCULAR DIAGNOSTICS-RADIOPAQUE		
OMNIPAQUE	T3	
DIAGNOSTIC PREPARATIONS, MISCELLANEOUS		
ARIDOL	T3	
GLUCAGEN DIAGNOSTIC 1 MG VIAL	T2	
METHACHOLINE CHLORIDE	T3	
PROVOCHOLINE	T3	
TC 99M SULFUR COLLOID PREP	T3	
TOXICOLOGY SALIVA COLLECTION	T3	
EYE DIAGNOSTIC AGENTS		
fluorescein sodium	T1	
ful-glo 1 mg opth strip	T1	
FUL-GLO EYE STRIPS	T3	

T1 – Generics
T2 – Preferred Brands
T3 – Non-Preferred Brands
T4 – Preferred Specialty
T5 – Non-Preferred Specialty
PA – Prior Authorization
QL – Quantity Limit
ST – Step Therapy
AGE – Age Requirement
SP – Specialty Medication
HD – May require home delivery pharmacy
PPACA – No Cost-Share Preventive Medication
CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

DIAGNOSTIC (Miscellaneous) (cont.)		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
FLUORESCENCE IMAGING AGENTS - MALIGNANT TISSUE		
GLEOLAN	T3	
GASTROINTESTINAL RADIOPAQUE DIAGNOSTICS		
diatrizoate meglumine, sodium (Gastrografin)	T1	
ENTERO VU	T3	
E-Z DISK	T3	
E-Z-HD	T3	
E-Z-PAQUE	T3	
E-Z-PASTE	T3	
GASTROGRAFIN (*diatrizoate meglumine, sodium*)	T3	
GASTROMARK	T3	
LIQUID E-Z PAQUE	T3	
LIQUID POLIBAR PLUS	T3	
NEULUMEX	T3	
POLIBAR ACB	T3	
READI-CAT 2	T3	
SITZMARKS	T3	
TAGITOL	T3	
VANILLA SILQ	T3	
VARIBAR HONEY	T3	
VARIBAR NECTAR	T3	
VARIBAR PUDDING	T3	
VARIBAR THIN HONEY	T3	
VARIBAR THIN LIQUID	T3	
VOLUMEN	T3	
METABOLIC FUNCTION DIAGNOSTICS		
METOPIRONE	T3	
RADIOACTIVE DIAGNOSTICS, GENERAL		
XENON XE-133	T3	
RADIOPHARMACEUTICALS ELEMENTS		
INDICLOR	T3	
URINARY TRACT RADIOPAQUE DIAGNOSTICS		
CYSTO-CONRAY II	T3	
CYSTOGRAFIN	T3	
CYSTOGRAFIN-DILUTE	T3	

T1 – Generics
T2 – Preferred Brands
T3 – Non-Preferred Brands
T4 – Preferred Specialty
T5 – Non-Preferred Specialty
PA – Prior Authorization
QL – Quantity Limit
ST – Step Therapy
AGE – Age Requirement
SP – Specialty Medication
HD – May require home delivery pharmacy
PPACA – No Cost-Share Preventive Medication
CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

DIAGNOSTIC (Miscellaneous) (cont.)		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
URINARY TRACT RADIOPAQUE DIAGNOSTICS (cont.)		
KETONE CARE TEST STRIP	T2	
KETONE TEST STRIP	T2	
KETOSTIX REAGENT	T2	
TRUEPLUS KETONE TEST STRIP	T2	
URINE GLUCOSE/ACETONE TEST AIDS,STRIPS		
KETO-DIASTIX REAGENT	T2	
URINE MULTIPLE TEST AIDS		
CHEK-STIX	T2	
CHEMSTRIP	T2	
CHEMSTRIP 10 WITH SG	T2	
CHEMSTRIP 2 GP	T2	
CHEMSTRIP 50B	T2	
CHEMSTRIP 7	T2	
CHEMSTRIP 9	T2	
COMBISTIX REAGENT	T2	
HEMA-COMBISTIX	T2	
KETO-DIASTIX REAGENT	T2	
LABSTIX REAGENT	T2	
MULTISTIX	T2	
MULTISTIX 10 SG	T2	
MULTISTIX 5	T2	
MULTISTIX 7	T2	
MULTISTIX 8 SG	T2	
MULTISTIX 9	T2	
MULTISTIX 9 SG	T2	
URISTIX 4	T2	
URISTIX REAGENT	T2	
DIURETICS (Diuretics)		
ARGININE VASOPRESSIN (AVP) RECEPTOR ANTAGONISTS		
tolvaptan 15 mg tablet (Samsca)	T1	PA QL(30 tabs/fill) SP
tolvaptan 30 mg tablet (Samsca)	T1	PA QL(60 tabs/fill) SP
CARBONIC ANHYDRASE INHIBITORS		
acetazolamide	T1	HD
methazolamide	T1	HD

T1 – Generics
T2 – Preferred Brands
T3 – Non-Preferred Brands
T4 – Preferred Specialty
T5 – Non-Preferred Specialty
PA – Prior Authorization
QL – Quantity Limit
ST – Step Therapy
AGE – Age Requirement
SP – Specialty Medication
HD – May require home delivery pharmacy
PPACA – No Cost-Share Preventive Medication
CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

DIURETICS (Diuretics) (cont.)		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
LOOP DIURETICS		
bumetanide	T1	HD
EDECRIN *(ethacrynic acid)*	T3	ST HD
ethacrynic acid (Edecrin)	T1	HD
furosemide	T1	HD
POLYCYSTIC KIDNEY DISEASE AGENT, AVP RECEP. ANTAG		
furosemide (Lasix)	T1	HD
LASIX (*furosemide*)	T3	ST HD
torsemide	T1	HD
JYNARQUE 15 MG TABLET	T5	PA QL(120 tabs/fill) SP
JYNARQUE 15 MG-15 MG TABLET	T5	PA QL(56 tabs/fill) SP
JYNARQUE 30 MG TABLET	T5	PA QL(120 tabs/fill) SP
JYNARQUE 30 MG-15 MG TABLET	T5	PA QL(56 tabs/fill) SP
JYNARQUE 45 MG-15 MG TABLET	T5	PA QL(56 tabs/fill) SP
JYNARQUE 60 MG-30 MG TABLET	T5	PA QL(56 tabs/fill) SP
JYNARQUE 90 MG-30 MG TABLET	T5	PA QL(56 tabs/fill) SP
POTASSIUM SPARING DIURETICS		
ALDACTONE (*spironolactone*)	T3	HD
amiloride hcl	T1	HD
DYRENIUM (*triamterene*)	T3	HD
eplerenone (Inspra)	T1	HD
INSPRA *(eplerenone)*	T3	HD
KERENDIA	T2	PA QL(30 tabs/fill) HD
spironolactone (Aldactone)	T1	HD
spironolactone (Carospir)	T1	HD
triamterene (Dyrenium)	T1	HD
POTASSIUM SPARING DIURETICS IN COMBINATION		
ALDACTAZIDE	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	T1	HD
triamterene/hydrochlorothiazid (Dyazide)	T1	HD

T1 – Generics
T2 – Preferred Brands
T3 – Non-Preferred Brands
T4 – Preferred Specialty
T5 – Non-Preferred Specialty
PA – Prior Authorization
QL – Quantity Limit
ST – Step Therapy
AGE – Age Requirement
SP – Specialty Medication
HD – May require home delivery pharmacy
PPACA – No Cost-Share Preventive Medication
CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

DIURETICS (Diuretics) (cont.)		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
POTASSIUM SPARING DIURETICS IN COMBINATION (cont.)		
triamterene/hydrochlorothiazid (Maxzide)	T1	HD
triamterene/hydrochlorothiazid (Maxzide-25 Mg)	T1	HD
THIAZIDE AND RELATED DIURETICS		
chlorthalidone	T1	HD
DIURIL	T3	HD
hydrochlorothiazide	T1	HD
indapamide	T1	HD
metolazone	T1	HD
EENT PREPS (Allergy/Nasal Sprays)		
NASAL ANTIHISTAMINE		
azelastine 0.1% (137 mcg) spry	T1	QL(60 mls/fill) HD
azelastine 0.15% nasal spray	T1	HD
olopatadine hcl (Patanase)	T1	QL(31 gms/fill) HD
PATANASE (*olopatadine hcl*)	T3	QL(31 gms/fill) HD
NASAL ANTIHISTAMINE AND ANTI-INFLAM. STEROID COMB.		
azelastine/fluticasone (Dymista)	T1	ST QL(23 gms/fill) HD
DYMISTA (*azelastine/fluticasone*)	T3	ST QL(23 gms/fill) HD
RYALTRIS	T3	ST QL(1 bottle/fill) HD
NASAL ANTI-INFLAMMATORY STEROIDS		
flunisolide	T1	ST QL(50 mls/fill) HD
fluticasone prop 50 mcg spray	T1	QL(16 gms/fill) HD
mometasone furoate 50 mcg spry (Nasonex)	T1	ST QL(17 gms/fill) HD
XHANCE	T3	ST QL(32 mls/fill) HD
NOSE PREPARATIONS, MISCELLANEOUS (RX)		
COCAINE HCL	T3	HD
GOPRELTO	T3	HD
ipratropium 0.03% spray	T1	QL(30 mls/fill) HD
ipratropium 0.06% spray	T1	QL(30 mls/fill) HD
NUMBRINO	T3	HD
NOSE PREPARATIONS, VASOCONSTRICTORS (RX)		
ADRENALIN CHLORIDE	T3	
epinephrine hcl	T1	

T1 – Generics
T2 – Preferred Brands
T3 – Non-Preferred Brands
T4 – Preferred Specialty
T5 – Non-Preferred Specialty
PA – Prior Authorization
QL – Quantity Limit
ST – Step Therapy
AGE – Age Requirement
SP – Specialty Medication
HD – May require home delivery pharmacy
PPACA – No Cost-Share Preventive Medication
CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

EENT PREPS (Ear Medications)		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
EAR PREPARATIONS ANTI-INFLAMMATORY		
DERMOTIC (*fluocinolone acetonide oil*)	T3	
fluocinolone acetonide oil (Dermotic)	T1	
EAR PREPARATIONS, MISC. ANTI-INFECTIVES		
acetic acid	T1	
CORTANE-B *(hydrocort/pramoxine/chloroxyl)*	T3	
hydrocortisone/acetic acid	T1	
EENT PREPS (Eye Conditions)		
AGENTS FOR CORNEAL COLLAGEN CROSS-LINKING		
PHOTREXA CROSS-LINKING	T3	
PHOTREXA VISCOUS	T3	
ARTIFICIAL TEARS		
KLARITY (CHONDROITIN)	T3	
LACRISERT	T3	PA QL(60 inserts/fill)
MIEBO	T2	
EYE ANTI-INFECTIVES (RX ONLY)		
BETADINE	T3	
EYE ANTI-INFLAMMATORY AGENTS		
ACULAR (*ketorolac tromethamine*)	T3	ST
ACULAR LS (*ketorolac tromethamine*)	T3	ST
bromfenac sodium	T1	
bromfenac sodium (Bromsite)	T1	
bromfenac sodium (Prolensa)	T1	
dexamethasone sodium phosphate	T1	
DEXTENZA	T3	
diclofenac 0.1% eye drops	T1	
difluprednate (Durezol)	T1	
EYSUVIS	T3	PA QL(8.3 mls/fill)
fluorometholone (FmI)	T1	
flurbiprofen sodium	T1	
FML *(fluorometholone)*	T3	ST
ILEVRO	T3	
INVELTYS	T3	ST
ketorolac 0.4% ophth solution (Acular Ls)	T1	
ketorolac 0.5% ophth solution (Acular)	T1	

T1 – Generics
T2 – Preferred Brands
T3 – Non-Preferred Brands
T4 – Preferred Specialty
T5 – Non-Preferred Specialty
PA – Prior Authorization
QL – Quantity Limit
ST – Step Therapy
AGE – Age Requirement
SP – Specialty Medication
HD – May require home delivery pharmacy
PPACA – No Cost-Share Preventive Medication
CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

EENT PREPS (Eye Conditions) (cont.)		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
EYE ANTI-INFLAMMATORY AGENTS (cont.)		
KLARITY-B(BETAMETHASONE-CHOND)	T3	
KLARITY-L (LOTEPREDNOL-CHONDR)	T3	
LOTEMAX 0.5% EYE DROPS *(loteprednol etabonate)*	T3	
LOTEMAX 0.5% EYE OINTMENT	T3	ST
LOTEMAX 0.5% OPHTHALMIC GEL (*loteprednol etabonate*)	T3	ST
LOTEMAX SM	T3	ST
loteprednol etabonate (Alrex)	T1	ST
loteprednol etabonate (Lotemax)	T1	
PRED FORTE (*prednisolone acetate*)	T3	
prednisolone ac 1% eye drop (Pred Forte)	T1	
PREDNISOLONE ACET 1% EYE DROP	T3	
prednisolone sodium phosphate	T1	
PREDNISOLONE-BROMFENAC	T3	
PREDNISOLONE-NEPAFENAC	T3	
PROLENSA *(bromfenac sodium)*	T3	
EYE LOCAL ANESTHETICS		
AKTEN	T3	
ALCAINE (*proparacaine hcl*)	T3	
ALTAFLUOR BENOX (*benoxinate hcl/fluorescein sod*)	T3	
FLUORESCEIN-BENOXINATE	T3	
proparacaine hcl (Alcaine)	T1	
proparacaine/fluorescein sod	T1	
tetracaine 0.5% eye drop	T1	
TETRACAINE 0.5% STERI-UNIT SOL	T3	
tetracaine hcl	T1	
TETRAVISC	T3	
TETRAVISC FORTE	T3	
EYE MAST CELL STABILIZERS		
cromolyn 4% eye drops	T1	
EYE MYDRIATIC AND NSAID COMBINATIONS		
MYDRIATIC4(TROP-PROP-PE-KTRLC)	T3	
EYE PREPARATIONS, MISCELLANEOUS (OTC)		
GELFILM	T3	

T1 – Generics
T2 – Preferred Brands
T3 – Non-Preferred Brands
T4 – Preferred Specialty
T5 – Non-Preferred Specialty
PA – Prior Authorization
QL – Quantity Limit
ST – Step Therapy
AGE – Age Requirement
SP – Specialty Medication
HD – May require home delivery pharmacy
PPACA – No Cost-Share Preventive Medication
CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

EENT PREPS (Eye Conditions) (cont.)		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
EYE VASOCONSTRICTORS		
phenylephrine hcl	T1	
MIOTICS AND OTHER INTRAOCULAR PRESSURE REDUCERS		
ALPHAGAN P	T3	ST HD
ALPHAGAN P (*brimonidine tartrate*)	T3	ST HD
apraclonidine hcl	T1	HD
betaxolol hcl	T1	HD
BETOPTIC S	T3	HD
bimatoprost	T1	PA HD
brimonidine tartrate	T1	HD
brimonidine tartrate (Alphagan P)	T1	HD
brimonidine tartrate/timolol (Combigan)	T1	HD
BRIMONIDINE-DORZOLAMIDE	T3	HD
brinzolamide (Azopt)	T1	HD
carteolol hcl	T1	HD
COMBIGAN *(brimonidine tartrate/timolol)*	T3	ST HD
DORZOLAMIDE	T3	HD
dorzolamide hcl (Trusopt)	T1	HD
dorzolamide hcl/timolol maleat (Cosopt)	T1	*HD*
dorzolamide/timolol/pf (Cosopt Pf)	T1	HD
IOPIDINE	T3	ST HD
ISOPTO CARPINE *(pilocarpine hcl)*	T3	HD
LATANOPROST 0.005% EYE DROP	T3	HD
latanoprost 0.005% eye drops (Xalatan)	T1	PA HD
levobunolol hcl	T1	HD
LUMIGAN	T3	PA HD
PHOSPHOLINE IODIDE	T4	SP HD
pilocarpine hcl	T1	HD
pilocarpine hcl (Isopto Carpine)	T1	HD
SIMBRINZA	T3	HD
timolol maleate (Istalol)	T1	HD
timolol maleate (Timoptic)	T1	HD
timolol maleate (Timoptic-Xe)	T1	HD
timolol maleate/pf	T1	HD
timolol maleate/pf (Timoptic Ocudose)	T1	HD

T1 – Generics
T2 – Preferred Brands
T3 – Non-Preferred Brands
T4 – Preferred Specialty
T5 – Non-Preferred Specialty
PA – Prior Authorization
QL – Quantity Limit
ST – Step Therapy
AGE – Age Requirement
SP – Specialty Medication
HD – May require home delivery pharmacy
PPACA – No Cost-Share Preventive Medication
CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

EENT PREPS (Eye Conditions) (cont.)		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
MIOTICS AND OTHER INTRAOCULAR PRESSURE REDUCERS (cont.)		
TIMOLOL-BRIMONIDIN-DORZOLAMIDE	T3	HD
TIMOLOL-BRIMONI-DORZOL-LATANOP	T3	HD
TIMOLOL-DORZOLAMIDE	T3	HD
TIMOLOL-DORZOLAMIDE-LATANOPRST	T3	HD
TIMOLOL-LATANOPROST	T3	HD
TIMOPTIC (*timolol maleate*)	T3	ST HD
TIMOPTIC-XE (*timolol maleate*)	T3	ST HD
travoprost (Travatan Z)	T1	PA HD
TRUSOPT *(dorzolamide hcl)*	T3	ST HD
VYZULTA	T3	PA HD
MYDRIATICS		
atropine 1% eye drops	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
cyclopentolat/tropic/phenyleph	T1	HD
cyclopentolate hcl (Cyclogyl)	T1	HD
CYCLOPENTOLATE-TROPICAMIDE-PE	T3	HD
homatropine hbr	T1	HD
MYDRIACYL (*tropicamide*)	T3	HD
PAREMYD	T3	HD
tropicamide	T1	HD
tropicamide (Mydriacyl)	T1	HD
TROPICAMIDE-CYCLOPENTOLATE-PE	T3	HD
TROPICAMIDE-CYCLOPENT-PE-KTRLC	T3	HD
TROPICAMIDE-PHENYLEPHRINE	T3	HD
TROPIC-CYCLOPENT-PE-KTRLC-PROP	T3	HD
OPHTH. VEGF-A RECEPTOR ANTAG. RCMB MC ANTIBODY		
LUCENTIS	T5	PA SP
OPHTHALMIC ANTIFIBROTIC AGENTS		
MITOMYCIN	T3	
MITOSOL	T3	

T1 – Generics
T2 – Preferred Brands
T3 – Non-Preferred Brands
T4 – Preferred Specialty
T5 – Non-Preferred Specialty
PA – Prior Authorization
QL – Quantity Limit
ST – Step Therapy
AGE – Age Requirement
SP – Specialty Medication
HD – May require home delivery pharmacy
PPACA – No Cost-Share Preventive Medication
CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

EENT PREPS (Eye Conditions) (cont.)		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
OPHTHALMIC ANTI-INFLAMMATORY IMMUNOMODULATOR-TYPE		
CEQUA	T3	PA QL(60 vls/30 days) HD
cyclosporine 0.05% eye emuls (Restasis)	T1	PA QL(60 vials/fill) HD
CYCLOSPORINE IN KLARITY	T3	HD
RESTASIS (*cyclosporine*)	T3	PA QL(60 vials/fill) HD
RESTASIS MULTIDOSE	T2	PA QL(6 mls/fill) HD
XIIDRA	T2	PA QL(60 vls/fill) HD
VEVYE	T3	PA HD
OPHTHALMIC CYSTINE DEPLETING AGENTS		
CYSTARAN	T4	PA SP
OPHTHALMIC HUMAN NERVE GROWTH FACTOR (HNGF)		
OXERVATE	T4	PA SP HD
OPHTHALMIC PREPARATIONS, MISCELLANEOUS		
HEALON GV	T3	
ELECT/CALORIC/H2O (Cholesterol Medications)		
ORAL LIPID SUPPLEMENTS		
DOJOLVI	T5	PA SP HD
ELECT/CALORIC/H2O (Dental Products)		
FLUORIDE PREPARATIONS		
CLINPRO 5000	T3	
FLORIVA	T3	
fluoride (sodium)	T1	PPACA
fluoride (sodium)	T1	
fluoride (sodium) (Prevident 5000 Plus)	T1	
fluoride (sodium) (Prevident)	T1	
FLUORIDEX	T3	
FLUORIDEX SENSITIVITY RELIEF	T3	
JUSTRIGHT 5000	T3	
PREVIDENT	T3	
PREVIDENT (*fluoride (sodium)*)	T3	
PREVIDENT 5000 DRY MOUTH	T3	
PREVIDENT 5000 ENAMEL PROTECT	T3	
PREVIDENT 5000 ORTHO DEFENSE	T3	
PREVIDENT 5000 PLUS (*fluoride (sodium)*)	T3	

T1 – Generics
T2 – Preferred Brands
T3 – Non-Preferred Brands
T4 – Preferred Specialty
T5 – Non-Preferred Specialty
PA – Prior Authorization
QL – Quantity Limit
ST – Step Therapy
AGE – Age Requirement
SP – Specialty Medication
HD – May require home delivery pharmacy
PPACA – No Cost-Share Preventive Medication
CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

ELECT/CALORIC/H2O (Dental Products) (cont.)		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
FLUORIDE PREPARATIONS (cont.)		
PREVIDENT 5000 SENSITIVE	T3	
sodium fluoride 0.2% rinse (Prevident)	T1	
sodium fluoride 1.1% cream (Prevident 5000 Plus)	T1	
sodium fluoride 1.1% gel (Prevident)	T1	
sodium fluoride 5000 ppm cream (Prevident 5000 Plus)	T1	
sodium fluoride 5000 ppm paste	T1	
sodium fluoride/potassium nit	T1	
PEDIATRIC VITAMIN PREPARATIONS		
fluoride (sodium)	T1	PPACA
FLURA-DROPS	*T3*	
sodium fluoride 0.25 (0.55) mg	T1	PPACA
sodium fluoride 0.5 mg(1.1 mg)	T1	PPACA
sodium fluoride 0.5 mg/ml drop	T1	PPACA
sodium fluoride 1 mg (2.2 mg)	T1	PPACA
ELECT/CALORIC/H2O (Diabetes)		
AGENTS TO TREAT HYPOGLYCEMIA (HYPERGLYCEMICS)		
BAQSIMI	T2	
cvs glucose 4 gram tablet chew (Trueplus Glucose)	T1	
CVS GLUCOSE LIQUID SHOT	T3	
DEX4 GLUCOSE 15 GM GEL PACKET	T3	
dex4 glucose 4 gm tablet chew (Trueplus Glucose)	T1	
dex4 glucose 40% gel (Glutose-15)	T1	
dex4 glucose 40% gel (Glutose-45)	T1	
DEX4 GLUCOSE LIQUID	T3	
DEX4 GLUCOSE LIQUID BLAST	T3	
dex4 glucose tab pouch pack (Trueplus Glucose)	T1	
dex4 quick dissolve tab chew (Trueplus Glucose)	T1	
dextrose	T1	
dextrose (Glutose-15)	T1	
dextrose (Glutose-45)	T1	
dextrose/vitamin d3	T1	
diazoxide (Proglycem)	T1	
drug mart glucose 4 gm tab chw (Trueplus Glucose)	T1	
glucagon 1 mg emergency kit	T1	QL(2 vials/fill)

T1 – Generics
T2 – Preferred Brands
T3 – Non-Preferred Brands
T4 – Preferred Specialty
T5 – Non-Preferred Specialty
PA – Prior Authorization
QL – Quantity Limit
ST – Step Therapy
AGE – Age Requirement
SP – Specialty Medication
HD – May require home delivery pharmacy
PPACA – No Cost-Share Preventive Medication
CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

ELECT/CALORIC/H2O (Diabetes) (cont.)		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
AGENTS TO TREAT HYPOGLYCEMIA (HYPERGLYCEMICS) (cont.)		
GLUCO SHOT	T3	
GLUCOSE 2 GM GUMMY	T3	
glucose 3.75 gram tablet chew (Trueplus Glucose)	T1	
glucose 4 gram tablet chew (Trueplus Glucose)	T1	
GLUCOSE LIQUID	T3	
GLUTOSE-15 (*dextrose*)	T2	
GLUTOSE-45 (*dextrose*)	T2	
gnp glucose 3.75 gram tab chew (Trueplus Glucose)	T1	
gnp glucose 4 gram tablet chew (Trueplus Glucose)	T1	
gnp quick dissolve glucose tab (Trueplus Glucose)	T1	
gs glucose 4 gram tablet chew (Trueplus Glucose)	T1	
GVOKE	T2	QL(2 vials/fill)
GVOKE HYPOPEN 1-PACK, 2-PACK	T2	QL(2 auto-injs/fill)
GVOKE PFS 1-PACK, 2-PACK SYRINGE	T2	QL(2 syringes/fill)
INSTA-GLUCOSE GEL	T3	
insta-glucose gel	T1	
kro glucose 4 gram tablet chew (Trueplus Glucose)	T1	
kroger glucose 4 gram tab chew (Trueplus Glucose)	T1	
leader glucose 4 gm tab chew (Trueplus Glucose)	T1	
leader quick dissolve gluc tab (Trueplus Glucose)	T1	
longs glucose 4 gram tab chew (Trueplus Glucose)	T1	
meijer glucose 4 gram tab chew (Trueplus Glucose)	T1	
ms glucose 4 gram tablet chew (Trueplus Glucose)	T1	
ms quick dissolve glucose tab (Trueplus Glucose)	T1	
preferred plus glucose tab chw (Trueplus Glucose)	T1	
PROGLYCEM (*diazoxide*)	T3	
pub glucose 4 gram tablet chew (Trueplus Glucose)	T1	
ra glucose 4 gram tablet chew (Trueplus Glucose)	T1	
relion glucose 4 gram tab chew (Trueplus Glucose)	T1	
reli-on glucose 4 gram tab chw (Trueplus Glucose)	T1	
RELION GLUCOSE LIQUID	T3	
sm glucose 4 gram tab chew (Trueplus Glucose)	T1	
smart sense glucose 4 gram tab (Trueplus Glucose)	T1	
TRUEPLUS GLUCOSE	T3	

T1 – Generics
T2 – Preferred Brands
T3 – Non-Preferred Brands
T4 – Preferred Specialty
T5 – Non-Preferred Specialty
PA – Prior Authorization
QL – Quantity Limit
ST – Step Therapy
AGE – Age Requirement
SP – Specialty Medication
HD – May require home delivery pharmacy
PPACA – No Cost-Share Preventive Medication
CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

ELECT/CALORIC/H2O (Diabetes) (cont.)		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
AGENTS TO TREAT HYPOGLYCEMIA (HYPERGLYCEMICS) (cont.)		
TRUEPLUS GLUCOSE (*dextrose*)	T3	
upup glucose 4 gram tab chew (Trueplus Glucose)	T1	
ELECT/CALORIC/H2O (Miscellaneous)		
NUCLEIC ACID/NUCLEOTIDE SUPPLEMENTS		
XURIDEN	T4	PA SP
ELECT/CALORIC/H2O (Nutritional/Dietary)		
CARBOHYDRATES		
ENFAMIL	T2	
GLUTOL	T2	
ELECTROLYTE DEPLETERS		
AURYXIA	T3	
calcium acetate 667 mg capsule	T1	QL(360 caps/fill)
calcium acetate 667 mg gelcap	T1	QL(360 caps/fill)
calcium acetate 667 mg tablet	T1	QL(360 tabs/fill)
lanthanum carbonate (Fosrenol)	T1	QL(90 tabs/fill)
LOKELMA	T2	QL(30 packs/fill)
PHOSLYRA	T2	
RENVELA 0.8 GM POWDER PACKET (*sevelamer carbonate*)	T3	QL(180 packs/fill)
RENVELA 2.4 GM POWDER PACKET (*sevelamer carbonate*)	T3	QL(90 packs/fill)
RENVELA 800 MG TABLET (sevelamer carbonate)	T3	QL(270 tabs/fill)
sevelamer hcl 400 mg tablet	T1	
sevelamer hcl 800 mg tablet	T1	
sodium polystyrene sulfon/sorb	T1	
sodium polystyrene sulfonate	T1	
VELPHORO	T2	QL(120 tabs/fill)
VELTASSA	T2	QL(30 packs/fill)
FLUORIDE PREPARATIONS		
CLINPRO 5000	T3	
fluoride (sodium)	T1	PPACA
fluoride (sodium)	T1	
fluoride (sodium) (Prevident 5000 Plus)	T1	
fluoride (sodium) (Prevident)	T1	
FLUORIDEX	T3	

T1 – Generics
T2 – Preferred Brands
T3 – Non-Preferred Brands
T4 – Preferred Specialty
T5 – Non-Preferred Specialty
PA – Prior Authorization
QL – Quantity Limit
ST – Step Therapy
AGE – Age Requirement
SP – Specialty Medication
HD – May require home delivery pharmacy
PPACA – No Cost-Share Preventive Medication
CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

ELECT/CALORIC/H2O (Nutritional/Dietary) (cont.)		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
ELECTROLYTE DEPLETERS (cont.)		
JUSTRIGHT 5000	T3	
PREVIDENT	T3	
PREVIDENT *(fluoride (sodium))*	T3	
PREVIDENT 5000 DRY MOUTH	T3	
PREVIDENT 5000 ORTHO DEFENSE	T3	
PREVIDENT 5000 PLUS *(fluoride (sodium))*	T3	
sodium fluoride 0.2% rinse (Prevident)	T1	
sodium fluoride 1.1% cream (Prevident 5000 Plus)	T1	
sodium fluoride 1.1% gel (Prevident)	T1	
sodium fluoride 5000 ppm cream (Prevident 5000 Plus)	T1	
sodium fluoride 5000 ppm paste	T1	
IODINE CONTAINING AGENTS		
potassium iodide	T1	
potassium iodide/iodine	T1	
SSKI	T3	
IRON REPLACEMENT		
ABATRON	T3	
ABATRON AF	T3	
ACCRUFER	T3	
ACTIVE FE	T3	
APETIGEN-PLUS	T2	
BENTIVITE BX	T3	
CHROMAGEN	T3	
CITRANATAL BLOOM	T3	
CORVITE 150	T3	
CORVITE FE	T3	
cvs iron 27 mg tablet (Fergon)	T1	
cvs iron 65 mg tablet	T1	
CVS SLOW RELEASE IRON 45 MG TB	T3	
cvs slow release iron 45 mg tb	T1	
cvs slow release iron tablet	T1	
eql slow release iron 45 mg tab	T1	
eql slow release iron 50 mg tb	T1	
FEOSOL 45 MG CAPLET (*iron,carbonyl*)	T2	

T1 – Generics
T2 – Preferred Brands
T3 – Non-Preferred Brands
T4 – Preferred Specialty
T5 – Non-Preferred Specialty
PA – Prior Authorization
QL – Quantity Limit
ST – Step Therapy
AGE – Age Requirement
SP – Specialty Medication
HD – May require home delivery pharmacy
PPACA – No Cost-Share Preventive Medication
CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

ELECT/CALORIC/H2O (Nutritional/Dietary) (cont.)		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
IRON REPLACEMENT (cont.)		
feosol 65 mg tablet	T1	
FEOSOL BIFERA 28 MG CAPLET	T2	
FERAHEME (*ferumoxytol*)	T3	PA
FERGON 27 MG TABLET	T3	
FERGON 27 MG TABLET (*ferrous gluconate*)	T2	
FERGON TABLET	T3	
FER-IN-SOL (*ferrous sulfate*)	T2	
FERIVA 21-7	T3	
FERIVA FA	T3	
FERRACTIV IRON	T3	
FERRALET 90	T3	
FERRETTS IPS 18 MG CAP	T3	
FERRETTS IPS 40 MG/15 ML LIQ	T2	
FERRIMIN 150	T2	
FERRLECIT (*sodium ferric gluconat/sucrose*)	T3	PA
FERRO-SEQUELS	T3	
ferrous fum/vit c/b12-if/folic	T1	PPACA
ferrous fumarate	T1	
ferrous fumarate (Hemocyte)	T1	
FERROUS FUMARATE 29 MG TAB	T3	
ferrous fumarate 324 mg tab (Hemocyte)	T1	
ferrous fumarate/folic acid (Hemocyte-F)	T1	
ferrous gluconate	T1	
ferrous gluconate (Fergon)	T1	
ferrous sulfate	T1	
ferrous sulfate (Fer-In-Sol)	T1	
ferrous sulfate/vit c/folic ac	T1	PPACA
ferumoxytol (Feraheme)	T1	PA
FUSION	T3	
FUSION PLUS	T3	
FUSION SPRINKLES	T3	
GENTLE IRON	T3	
gnp iron 45 mg tablet	T1	
gnp iron 65 mg tablet	T1	

T1 – Generics
T2 – Preferred Brands
T3 – Non-Preferred Brands
T4 – Preferred Specialty
T5 – Non-Preferred Specialty
PA – Prior Authorization
QL – Quantity Limit
ST – Step Therapy
AGE – Age Requirement
SP – Specialty Medication
HD – May require home delivery pharmacy
PPACA – No Cost-Share Preventive Medication
CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

ELECT/CALORIC/H2O (Nutritional/Dietary) (cont.)		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
IRON REPLACEMENT(cont.)		
HEMATEX	T3	
HEMATEX (*iron polysaccharide complex*)	T3	
HEMATOGEN	T3	
HEMATRON-AF	T3	
HEMAX	T3	
HEMOCYTE (*ferrous fumarate*)	T2	
HEMOCYTE PLUS (*iron fum/folic acid/mv,min 15*)	T3	
HEMOCYTE-F (*ferrous fumarate/folic acid*)	T3	
hm iron 65 mg tablet	T1	
hm slow release iron tablet	T1	
I.L.X. B-12	T2	
ICAR	T2	
ICAR-C (*iron,carbonyl/ascorbic acid*)	T2	
ICAR-C PLUS (*iron,carb/vit c/vit b12/folic*)	T3	
INFED	T2	PA
INJECTAFER	T3	PA
INTEGRA	T2	
INTEGRA F (*iron fum,ps/folic acid/vitc/b3*)	T3	
INTEGRA PLUS (*iron fum,ps/folic/bcomp,c no.9*)	T3	
IRON 18 MG TABLET	T3	
iron 27 mg tablet	T1	
iron 27 mg tablet (Fergon)	T1	
iron 28 mg tablet	T1	
iron 45 mg tablet	T1	
iron 65 mg tablet	T1	
iron aspgly,ps/c/b12/fa/ca/suc	T1	
iron aspgly,ps/c/succinic acid	T1	
iron aspgly/c/b12/fa/ca-th/suc	T1	
iron bg,ps/vitc/b12/fa/calcium	T1	
IRON BISGLYCINATE	T3	
iron fm,ps no.1/folic/mv no.18 (Tandem Plus)	T1	
iron fum,ag/c/b12/folic/ca/suc	T1	
iron fum,ps/folic acid/vitc/b3 (Integra F)	T1	
iron fum,ps/folic/bcomp,c no.9 (Integra Plus)	T1	

T1 – Generics
T2 – Preferred Brands
T3 – Non-Preferred Brands
T4 – Preferred Specialty
T5 – Non-Preferred Specialty
PA – Prior Authorization
QL – Quantity Limit
ST – Step Therapy
AGE – Age Requirement
SP – Specialty Medication
HD – May require home delivery pharmacy
PPACA – No Cost-Share Preventive Medication
CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

ELECT/CALORIC/H2O (Nutritional/Dietary) (cont.)		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
IRON REPLACEMENT (cont.)		
iron fum/folic acid/mv,min 15 (Hemocyte Plus)	T1	
iron fumarate/vit c/vit b12/fa	T1	
iron polysac/iron heme/fa/b12	T1	
iron polysaccharide complex	T1	
iron polysaccharide complex (Nu-Iron 150)	T1	
iron ps complex/b12/folic acid	T1	
iron,carb/vit c/vit b12/folic (Icar-C Plus)	T1	
iron,carbonyl	T1	
iron,carbonyl (Feosol)	T1	
iron,carbonyl/ascorbic acid (Icar-C)	T1	
iron/c/b12/calciu/stomach conc	T1	
iron/c/folic acd/mv cmb11/calc	T1	
iron/folic ac/vit bcomp,c/min	T1	
iron/folic acid/b12/c/docusate	T1	
iron/folic acid/c/b6/b12/zinc	T1	
iron/vit c/fructooligosacchard	T1	
IRONUP	T3	
IRO-PLEX	T3	
IROSPAN	T3	
LYDIA PINKHAM HERBAL	T3	
MAXFE	T3	
MONOFERRIC	T3	PA
NEONATAL FE	T3	
NIFEREX	T3	
NOVAFERRUM 125 MG/5 ML LIQUID	T3	
NOVAFERRUM 15 MG/ML DROPS	T2	
NOVAFERRUM 50	T3	
NUFERA	T3	
NU-IRON 150 (*iron polysaccharide complex*)	T2	
PARVLEX	T3	
PERFECT IRON	T3	
PRO FE	T2	
PROFERRIN	T2	
PROFERRIN-FORTE	T3	

T1 – Generics
T2 – Preferred Brands
T3 – Non-Preferred Brands
T4 – Preferred Specialty
T5 – Non-Preferred Specialty
PA – Prior Authorization
QL – Quantity Limit
ST – Step Therapy
AGE – Age Requirement
SP – Specialty Medication
HD – May require home delivery pharmacy
PPACA – No Cost-Share Preventive Medication
CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

ELECT/CALORIC/H2O (Nutritional/Dietary) (cont.)		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
IRON REPLACEMENT(cont.)		
PROTECT IRON	T3	
ra high potency iron 27 mg tab	T1	
RA HIGH POTENCY IRON 27 MG TAB	T3	
ra iron 65 mg tablet	T1	
RA SLOW RELEASE IRON 45 MG TAB	T2	
SIDEROL	T3	
SLOW FE	T2	
slow release iron 160 mg tab	T1	
SLOW RELEASE IRON 45 MG TAB	T2	
SLOW RELEASE IRON 45 MG TABLET	T2	
slow release iron 45 mg tablet	T1	
SLOW RELEASE IRON 45 MG TABLET	T3	
slow release iron tablet	T1	
SLOW RELEASE IRON TABLET	T2	
sm iron 160 mg tablet sa	T1	
sm iron 325 mg tablet	T1	
sm iron 65 mg tablet	T1	
SM SLOW RELEASE IRON 45 MG TAB	T2	
sodium ferric gluconat/sucrose (Ferrlecit)	T1	PA
sv iron 65 mg tablet	T1	
SV SLOW RELEASE IRON 45 MG TAB	T2	
TANDEM DUAL ACTION	T2	
TANDEM PLUS (*iron fm,ps no.1/folic/mv no.18*)	T3	
TL-HEM 150	T3	
TRIFERIC	T3	
TULIVITE	T3	
VENOFER	T2	PA
VIRT-FEFA PLUS CAPSULE	T3	
virt-fefa plus capsule (Integra Plus)	T1	
VITABEX IRON	T3	
VITAFOL	T3	
VITRON-C	T2	
PEDIATRIC VITAMIN PREPARATIONS		
fluoride (sodium)	T1	PPACA

T1 – Generics
T2 – Preferred Brands
T3 – Non-Preferred Brands
T4 – Preferred Specialty
T5 – Non-Preferred Specialty
PA – Prior Authorization
QL – Quantity Limit
ST – Step Therapy
AGE – Age Requirement
SP – Specialty Medication
HD – May require home delivery pharmacy
PPACA – No Cost-Share Preventive Medication
CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

ELECT/CALORIC/H2O (Nutritional/Dietary) (cont.)		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
PEDIATRIC VITAMIN PREPARATIONS(cont.)		
FLURA-DROPS	T3	
sodium fluoride 0.25 (0.55) mg	T1	PPACA
sodium fluoride 0.5 mg(1.1 mg)	T1	PPACA
sodium fluoride 0.5 mg/ml drop	T1	PPACA
sodium fluoride 1 mg (2.2 mg)	T1	PPACA
POTASSIUM REPLACEMENT		
EFFER-K 10 MEQ TABLET EFF	T3	
EFFER-K 20 MEQ TABLET EFF	T3	
effer-k 25 meq tablet eff	T1	
K-TAB ER 20 MEQ TABLET (*potassium chloride*)	T3	
k-tab er 8 meq tablet	T1	
potassium bicarbonate/cit ac	T1	
potassium chloride	T1	
potassium chloride	T1	
potassium chloride (K-Tab Er)	T1	
ELECT/CALORIC/H2O (Urinary Tract Conditions)		
DIALYSIS SOLUTIONS		
PRISMASOL	T3	
URINARY PH MODIFIERS		
citric acid/sodium citrate	T1	HD
K-PHOS NO.2	T3	HD
K-PHOS ORIGINAL	T2	HD
ORACIT	T3	HD
potassium citrate (Urocit-K)	T1	HD
RENACIDIN	T2	HD
UROCIT-K (*potassium citrate*)	T3	HD
UROQID-ACID NO.2	T3	HD
GASTROINTESTINAL (Cholesterol Medications)		
LIPOTROPICS		
icosapent ethyl (Vascepa)	T1	PA HD
omega-3 acid ethyl esters (Lovaza)	T1	PA HD
VASCEPA *(icosapent ethyl)*	T2	PA HD

T1 – Generics
T2 – Preferred Brands
T3 – Non-Preferred Brands
T4 – Preferred Specialty
T5 – Non-Preferred Specialty
PA – Prior Authorization
QL – Quantity Limit
ST – Step Therapy
AGE – Age Requirement
SP – Specialty Medication
HD – May require home delivery pharmacy
PPACA – No Cost-Share Preventive Medication
CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

GASTROINTESTINAL (Gastrointestinal/Heartburn)		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
AMMONIA INHIBITORS		
BUPHENYL (*sodium phenylbutyrate*)	T5	PA SP HD
lactulose	T1	HD
lactulose 10 gm/15 ml solution	T1	HD
LITHOSTAT	T3	HD
OLPRUVA DOSE KIT, DOSE ENVELOPE	T5	SP PA HD
PHEBURANE	T4	PA SP
RAVICTI	T4	PA SP HD
sodium phenylbutyrate (Buphenyl)	T1	PA SP HD
ANTICHOLINERGICS, QUATERNARY AMMONIUM		
chlordiazepoxide/clidinium br (Librax)	T1	
GLYCATE	T3	
glycopyrrolate	T1	
glycopyrrolate (Cuvposa)	T1	
glycopyrrolate (Robinul Forte)	T1	
glycopyrrolate (Robinul)	T1	
ROBINUL *(glycopyrrolate)*	T3	
ROBINUL FORTE *(glycopyrrolate)*	T3	
dicyclomine hcl	T1	
ANTIDIARRHEAL - TRYPTOPHAN HYDROXYLASE INHIBITOR		
XERMELO	T4	PA QL(84 tabs/28 days) SP
ANTIDIARRHEALS		
diphenoxylate hcl/atropine	T1	
diphenoxylate hcl/atropine (Lomotil)	T1	
LOMOTIL (*diphenoxylate hcl/atropine*)	T3	
MOTOFEN	T3	
opium tincture	T1	
paregoric	T1	
ANTIEMETIC, CANNABINOID-TYPE		
dronabinol (Marinol)	T1	PA
MARINOL *(dronabinol)*	T3	PA
SYNDROS	T3	PA
ANTIEMETIC/ANTIVERTIGO AGENTS		
aprepitant 125 mg capsule	T1	QL(1 cap/fill)
aprepitant 125-80-80 mg pack (Emend)	T1	QL(3 caps/fill)

T1 – Generics
T2 – Preferred Brands
T3 – Non-Preferred Brands
T4 – Preferred Specialty
T5 – Non-Preferred Specialty
PA – Prior Authorization
QL – Quantity Limit
ST – Step Therapy
AGE – Age Requirement
SP – Specialty Medication
HD – May require home delivery pharmacy
PPACA – No Cost-Share Preventive Medication
CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

GASTROINTESTINAL (Gastrointestinal/Heartburn) (cont.)		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
ANTIEMETIC/ANTIVERTIGO AGENTS (cont.)		
aprepitant 40 mg capsule (Emend)	T1	QL(1 cap/fill)
aprepitant 80 mg capsule (Emend)	T1	QL(2 caps/fill)
COMPAZINE *(prochlorperazine maleate)*	T3	
COMPAZINE *(prochlorperazine)*	T3	
DICLEGIS (*doxylamine succinate/vit b6*)	T3	QL(120 tabs/fill)
EMEND 150 MG VIAL *(fosaprepitant dimeglumine)*	T3	
fosaprepitant dimeglumine (Emend)	T1	
granisetron hcl 0.1 mg/ml vial	T1	
granisetron hcl 1 mg tablet	T1	QL(6 tabs/fill)
granisetron hcl 1 mg/ml vial	T1	
granisetron hcl 4 mg/4 ml vial	T1	
ondansetron	T1	QL(9 tabs/fill)
ondansetron 4 mg/2 ml isecure	T1	
ondansetron 40 mg/20 ml vial	T1	
ondansetron hcl 4 mg tablet	T1	QL(9 tabs/fill)
ondansetron hcl 4 mg/2 ml syr	T1	
ondansetron hcl 4 mg/2 ml vial	T1	
ondansetron hcl 8 mg tablet	T1	QL(9 tabs/fill)
prochlorperazine (Compazine)	T1	
prochlorperazine maleate (Compazine)	T1	
promethazine hcl	T1	
SANCUSO	T3	QL(1 patch/fill)
scopolamine (Transderm-Scop)	T1	
TIGAN (*trimethobenzamide hcl*)	T3	
trimethobenzamide hcl (Tigan)	T1	
VARUBI	T2	QL(2 tabs/fill)
ZUPLENZ	T3	QL(10 films/fill)
ANTI-ULCER PREPARATIONS		
CYTOTEC (*misoprostol*)	T3	HD
misoprostol (Cytotec)	T1	HD
sucralfate (Carafate)	T1	HD
ANTI-ULCER-H.PYLORI AGENTS		
lansoprazole/amoxiciln/clarith	T1	QL(112 units/fill)
OMECLAMOX-PAK	T3	QL(80 units/fill)

T1 – Generics
T2 – Preferred Brands
T3 – Non-Preferred Brands
T4 – Preferred Specialty
T5 – Non-Preferred Specialty
PA – Prior Authorization
QL – Quantity Limit
ST – Step Therapy
AGE – Age Requirement
SP – Specialty Medication
HD – May require home delivery pharmacy
PPACA – No Cost-Share Preventive Medication
CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

GASTROINTESTINAL (Gastrointestinal/Heartburn) (cont.)		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
ANTI-ULCER-H.PYLORI AGENTS (cont.)		
TALICIA	T2	QL(168 caps/fill)
BELLADONNA ALKALOIDS		
DONNATAL	T3	HD
DONNATAL (*phenobarb/hyoscy/atropine/scop*)	T3	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
LEVBID (*hyoscyamine sulfate*)	T3	HD
LEVSIN (*hyoscyamine sulfate*)	T3	HD
LEVSIN-SL (*hyoscyamine sulfate*)	T3	HD
methscopolamine bromide	T1	HD
NULEV (*hyoscyamine sulfate*)	T3	HD
phenobarb/hyoscy/atropine/scop	T1	HD
phenobarb/hyoscy/atropine/scop (Donnatal)	T1	HD
phenobarb/hyoscy/atropine/scop (Phenobarbital-Belladonna)	T1	HD
phenobarbital-belladonna elixr	T1	HD
phenobarbital-belladonna elixr (Donnatal)	T1	HD
PHENOBARBITAL-BELLADONNA ELIXR (*phenobarb/hyoscy/atropine/scop*)	T3	HD
phenobarbital-belladonna elixr (Phenobarbital-Belladonna)	T1	HD
SYMAX DUOTAB	T3	HD
BILE SALTS		
CHENODAL	T4	PA SP HD
CHOLBAM 50 MG CAPSULE	T4	PA QL(120 caps/fill) SP HD
CHOLBAM 250 MG CAPSULE	T4	PA SP HD
URSO (*ursodiol*)	T3	HD
URSO FORTE (*ursodiol*)	T3	HD
ursodiol	T1	HD
ursodiol (Urso Forte)	T1	HD
ursodiol (Urso)	T1	HD
CHRONIC INFLAM. COLON DX, 5-A-SALICYLAT, RECTAL TX		
mesalamine 1,000 mg supp (Canasa)	T1	
mesalamine 4 gm/60 ml enema (Sfrowasa)	T1	

T1 – Generics
T2 – Preferred Brands
T3 – Non-Preferred Brands
T4 – Preferred Specialty
T5 – Non-Preferred Specialty
PA – Prior Authorization
QL – Quantity Limit
ST – Step Therapy
AGE – Age Requirement
SP – Specialty Medication
HD – May require home delivery pharmacy
PPACA – No Cost-Share Preventive Medication
CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

GASTROINTESTINAL (Gastrointestinal/Heartburn) (cont.)		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
CHRONIC INFLAM. COLON DX, 5-A-SALICYLAT, RECTAL TX (cont.)		
mesalamine 4 gm/60 ml kit (Rowasa)	T1	
ROWASA *(mesalamine w/cleansing wipes)*	T3	
SFROWASA (*mesalamine*)	T3	
DRUG TX-CHRONIC INFLAM. COLON DX, 5-AMINOSALICYLAT		
APRISO (*mesalamine*)	T3	HD
ASACOL HD (*mesalamine*)	T3	HD
AZULFIDINE (*sulfasalazine*)	T3	HD
balsalazide disodium (Colazal)	T1	HD
COLAZAL *(balsalazide disodium)*	T3	HD
mesalamine (Apriso)	T1	HD
mesalamine (Delzicol)	T1	HD
mesalamine (Pentasa)	T1	HD
mesalamine 800 mg dr tablet (Asacol Hd)	T1	HD
mesalamine dr 1.2 gm tablet (Lialda)	T1	HD
PENTASA 250 MG CAPSULE	T2	HD
PENTASA 500 MG CAPSULE (*mesalamine*)	T3	HD
sulfasalazine (Azulfidine)	T1	HD
FARNESOID X RECEPTOR (FXR) AGONIST, BILE AC ANALOG		
OCALIVA	T4	PA QL(30 tabs/fill) SP HD
FECAL MICROBIOTA TRANSPLANTATION (FMT)		
VOWST CAPSULE	T5	SP
GASTRIC ENZYMES		
SUCRAID	T4	PA SP
HISTAMINE H2-RECEPTOR INHIBITORS		
cimetidine	T1	HD
cimetidine hcl	T1	HD
famotidine	T1	HD
famotidine (Pepcid)	T1	HD
nizatidine	T1	HD
PEPCID *(famotidine)*	T3	HD
ranitidine hcl	T1	HD
IBS AGENTS, MIXED OPIOID RECEP AGONISTS/ANTAGONISTS		
VIBERZI	T2	HD

T1 – Generics
T2 – Preferred Brands
T3 – Non-Preferred Brands
T4 – Preferred Specialty
T5 – Non-Preferred Specialty
PA – Prior Authorization
QL – Quantity Limit
ST – Step Therapy
AGE – Age Requirement
SP – Specialty Medication
HD – May require home delivery pharmacy
PPACA – No Cost-Share Preventive Medication
CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

GASTROINTESTINAL (Gastrointestinal/Heartburn) (cont.)		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
IBS-C/CIC AGENTS, GUANYLATE CYCLASE-C AGONIST		
LINZESS	T2	QL(30 caps/fill)
TRULANCE	T2	
ILEAL BILE ACID TRANSPORTER (IBAT) INHIBITOR		
BYLVAY 1,200 MCG CAPSULE	T5	PA QL(60 caps/fill) SP HD
BYLVAY 200 MCG PELLET	T5	PA QL(120 pellets/fill) SP HD
BYLVAY 400 MCG CAPSULE	T5	PA QL(150 caps/fill) SP HD
BYLVAY 600 MCG PELLET	T5	PA QL(30 pellets/fill) SP HD
LIVMARLI	T5	PA SP
INTESTINAL MOTILITY STIMULANTS		
metoclopramide hcl	T1	
metoclopramide hcl (Reglan)	T1	
REGLAN (*metoclopramide hcl*)	T3	
IRRITABLE BOWEL SYNDROME AGENTS, 5-HT3 ANTAGONIST		
alosetron hcl (Lotronex)	T1	SP HD
LAXATIVES AND CATHARTICS		
bisac/nacl/nahco3/kcl/peg 3350	T1	PPACA
GIALAX	T3	PPACA
GOLYTELY *(peg3350/sod sulf,bicarb,cl/kcl)*	T3	
KRISTALOSE	T3	
lactulose	T1	
lactulose 10 gm packet	T1	
lactulose 10 gm/15 ml solution	T1	
lactulose 20 gm/30 ml solution	T1	
lubiprostone	T1	QL (60 caps/30 days)
NULYTELY	T3	
NULYTELY WITH FLAVOR PACKS *(sodium chloride/nahco3/kcl/peg)*	T3	
peg3350/sod sul/nacl/kcl/asb/c (Moviprep)	T1	PPACA
peg3350/sod sulf,bicarb,cl/kcl	T1	PPACA
peg3350/sod sulf,bicarb,cl/kcl (Golytely)	T1	PPACA
sodium chloride/nahco3/kcl/peg (Nulytely With Flavor Packs)	T1	PPACA
sodium, potassium,mag sulfates (Suprep)	T1	PPACA
LOCAL ANORECTAL NITRATE PREPARATIONS		
RECTIV	T2	
nitroglycerin 0.4% ointment	T1	

T1 – Generics
T2 – Preferred Brands
T3 – Non-Preferred Brands
T4 – Preferred Specialty
T5 – Non-Preferred Specialty
PA – Prior Authorization
QL – Quantity Limit
ST – Step Therapy
AGE – Age Requirement
SP – Specialty Medication
HD – May require home delivery pharmacy
PPACA – No Cost-Share Preventive Medication
CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

GASTROINTESTINAL (Gastrointestinal/Heartburn) (cont.)		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
MU-OPIOID RECEPTOR ANTAGONISTS,PERIPHERALLY-ACTING		
alvimopan	T1	
ENTEREG	T3	
PANCREATIC ENZYMES		
CREON	T2	HD
PANCREAZE	T2	HD
VIOKACE	T2	HD
ZENPEP	T2	HD
POTASSIUM-COMPETITIVE ACID BLOCKERS (PCABS)		
VOQUEZNA	T3	ST
PROTON-PUMP INHIBITORS		
dexlansoprazole dr 30 mg cap	T1	ST QL
dexlansoprazole dr 60 mg cap	T1	ST HD
*esomeprazole dr 10 mg packet (*Nexium*)*	T1	ST QL(30 packs/fill) HD
*esomeprazole dr 40 mg packet (*Nexium*)*	T1	ST HD
ESOMEPRAZOLE DR 49.3 MG CAP	T3	ST HD
*esomeprazole mag dr 40 mg cap (*Nexium*)*	T1	HD
*lansoprazole dr 30 mg capsule (*Prevacid*)*	T1	HD
*lansoprazole odt 15 mg tablet (*Prevacid*)*	T1	ST QL(30 tabs/fill) HD
*lansoprazole odt 30 mg tablet (*Prevacid*)*	T1	ST HD
omeprazole dr 10 mg, 20 mg capsule	T1	QL(30 caps/fill) HD
omeprazole dr 40 mg capsule	T1	HD
*omeprazole/sodium bicarbonate (*Zegerid*)*	T1	PA HD
*omeprazole-bicarb 20-1,680 pkt (*Zegerid*)*	T1	PA QL(30 packs/fill) HD
*omeprazole-bicarb 40-1,100 cap (*Zegerid*)*	T1	PA HD
omeprazole-bicarb 40-1,680 pkt (Zegerid)	T1	PA HD
pantoprazole 40 mg suspension (Protonix)	T1	ST HD
*pantoprazole sod dr 40 mg tab (*Protonix*)*	T1	HD
*rabeprazole sod dr 20 mg tab (*Aciphex*)*	T1	HD
RECTAL PREPARATIONS		
*hydrocortisone acetate (*Anusol-Hc*)*	T1	
*hydrocortisone acetate (*Proctocort*)*	T1	
PROCTOCORT *(hydrocortisone acetate)*	T3	ST
SBS - GLUCAGON-LIKE PEPTIDE-2 (GLP-2) ANALOGS		
GATTEX	T5	PA SP HD

T1 – Generics
T2 – Preferred Brands
T3 – Non-Preferred Brands
T4 – Preferred Specialty
T5 – Non-Preferred Specialty
PA – Prior Authorization
QL – Quantity Limit
ST – Step Therapy
AGE – Age Requirement
SP – Specialty Medication
HD – May require home delivery pharmacy
PPACA – No Cost-Share Preventive Medication
CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

GASTROINTESTINAL (Pain Relief and Inflammatory Disease)		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
HEMORRHOID PREP, ANTI-INFLAM STEROID-LOCAL ANESTHET		
ANA-LEX	T3	
ANALPRAM HC 1% CREAM	T3	
ANALPRAM HC 2.5%-1% CREAM (*hydrocortisone/pramoxine)*	T3	ST
ANALPRAM HC 2.5%-1% CRM SINGLE *(hydrocortisone/pramoxine)*	T3	ST
hydrocort-pramoxine 1%-1% crm	T1	
*hydrocort-pramoxine 2.5%-1% cm (*Analpram Hc*)*	T1	ST
hydrocort-pramoxine 2.5-1% crm (Analpram Hc)	T1	ST
lidocaine-hc 2.8-0.55% gel	T1	
lidocaine-hc 2-2% cream kit	T1	
lidocaine-hc 3-0.5% cream	T1	
lidocaine-hc 3-0.5% cream kit	T1	
lidocaine-hc 3-1% cream kit	T1	
lidocaine-hc 3-2.5% gel kit	T1	
LIDOCAINE-HYDROCORT 3-2.5% GEL	T3	
PROCORT	T3	
HORMONES (Gastrointestinal/Heartburn)		
RECTAL/LOWER BOWEL PREP.,GLUCOCORT. (NON-HEMORR)		
CORTENEMA (*hydrocortisone*)	T3	
hydrocortisone (Cortenema)	T1	
UCERIS 2 MG RECTAL FOAM	T2	
HORMONES (Hormonal Agents)		
ANDROGENIC AGENTS		
ANDRODERM	T2	PA QL(30 patches/fill)
ANDROID (*methyltestosterone*)	T3	PA
DEPO-TESTOSTERONE	T3	PA
DEPO-TESTOSTERONE (*testosterone cypionate)*	T3	PA
FORTESTA *(testosterone)*	T3	PA QL(120 gms/fill)
JATENZO 158 MG, 198 MG CAPSULE	T3	PA QL(120 caps/30 days)
METHITEST	T2	
methyltestosterone (Android)	T1	
methyltestosterone (Testred*)*	T1	
oxandrolone	T1	
testosterone 1% (25mg/2.5g) pk (Androgel)	T1	PA QL(75 gms/fill)

T1 – Generics
T2 – Preferred Brands
T3 – Non-Preferred Brands
T4 – Preferred Specialty
T5 – Non-Preferred Specialty
PA – Prior Authorization
QL – Quantity Limit
ST – Step Therapy
AGE – Age Requirement
SP – Specialty Medication
HD – May require home delivery pharmacy
PPACA – No Cost-Share Preventive Medication
CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

HORMONES (Hormonal Agents) (cont.)		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
ANDROGENIC AGENTS (cont.)		
testosterone 1% (50 mg/5 g) pk (Androgel)	T1	PA QL(300 gms/fill)
testosterone 1.62% (2.5 g) pkt (Androgel)	T1	PA QL(60 packs/fill)
*testosterone 1.62% gel pump (*Androgel*)*	T1	PA QL(150 gms/fill)
testosterone 1.62%(1.25 g) pkt (Androgel)	T1	PA QL(30 packs/fill)
*testosterone 10 mg gel pump (*Fortesta*)*	T1	PA QL(120 gms/fill)
TESTOSTERONE 12.5 MG/1.25 GRAM	T3	PA QL(300 gms/fill)
testosterone 12.5 mg/1.25 gram	T1	PA QL(300 gms/fill)
testosterone 30 mg/1.5 ml pump	T1	PA QL(180 mls/fill)
*testosterone 50 mg/5 gram gel (*Testim*)*	T1	PA QL(60 tubes/fill)
*testosterone 50 mg/5 gram gel (*Vogelxo*)*	T1	PA QL(60 tubes/fill)
TESTOSTERONE 50 MG/5 GRAM PKT	T3	PA QL(300 gms/fill)
testosterone cypionate	T1	PA
*testosterone cypionate (*Depo-Testosterone*)*	T1	PA
testosterone enanthate	T1	PA
TESTRED (*methyltestosterone*)	T3	PA
VOGELXO 12.5 MG/1.25 GRAM PUMP	T3	PA QL(300 gms/fill)
VOGELXO 50 MG/5 GRAM GEL (*testosterone*)	T3	PA QL(60 tubes/fill)
VOGELXO 50 MG/5 GRAM GEL PACKT	T3	PA QL(60 packs/fill)
XYOSTED	T2	QL(2 mls/28 days)
ANTIDIURETIC AND VASOPRESSOR HORMONES		
DDAVP (*desmopressin (nonrefrigerated)*)	T3	
DDAVP (*desmopressin acetate*)	T3	
desmopressin 0.01% solution	T1	
DESMOPRESSIN 1.5 MG/ML SPRAY	T2	
desmopressin 10 mcg/0.1 ml spr	T1	
*desmopressin acetate 0.1 mg tb (*Ddavp*)*	T1	
*desmopressin acetate 0.2 mg tb (*Ddavp*)*	T1	
NOCDURNA	T3	PA QL(30 tabs/fill)
ESTROGEN/ANDROGEN COMBINATIONS		
estrogen,ester/me-testosterone	T1	HD
ESTROGENIC AGENTS		
ACTIVELLA (*estradiol/norethindrone acet*)	T3	HD
CLIMARA (*estradiol*)	T3	QL(4 patches/28 days) HD

T1 – Generics
T2 – Preferred Brands
T3 – Non-Preferred Brands
T4 – Preferred Specialty
T5 – Non-Preferred Specialty
PA – Prior Authorization
QL – Quantity Limit
ST – Step Therapy
AGE – Age Requirement
SP – Specialty Medication
HD – May require home delivery pharmacy
PPACA – No Cost-Share Preventive Medication
CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

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

T1 – Generics
T2 – Preferred Brands
T3 – Non-Preferred Brands
T4 – Preferred Specialty
T5 – Non-Preferred Specialty
PA – Prior Authorization
QL – Quantity Limit
ST – Step Therapy
AGE – Age Requirement
SP – Specialty Medication
HD – May require home delivery pharmacy
PPACA – No Cost-Share Preventive Medication
CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

HORMONES (Hormonal Agents) (cont.)		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
GLUCOCORTICOIDS (cont.)		
dexamethasone	T1	
dexamethasone 0.5 mg tablet	T1	
dexamethasone 0.5 mg/5 ml elx	T1	
dexamethasone 0.5 mg/5 ml liq	T1	
dexamethasone 0.75 mg tablet	T1	
dexamethasone 1 mg tablet	T1	
dexamethasone 1.5 mg tablet	T1	
dexamethasone 6 day 1.5 mg tab	T1	PA
dexamethasone 10 day 1.5 mg tb	T1	PA
dexamethasone 13 day 1.5 mg tb	T1	PA
dexamethasone 2 mg tablet	T1	
dexamethasone 4 mg tablet	T1	
dexamethasone 6 mg tablet	T1	
DEXONTO	T3	
DXEVO	T3	PA
hydrocortisone (Cortef)	T1	
MEDROL	T3	
MEDROL (*methylprednisolone)*	T3	
methylprednisolone	T1	
methylprednisolone (Medrol)	T1	
ORAPRED ODT (*prednisolone sodium phosphate*)	T3	
prednisolone	T1	
prednisolone sodium phosphate	T1	
*prednisolone sodium phosphate (*Orapred Odt*)*	T1	
prednisone	T1	
prednisone	T1	
RAYOS	T3	PA
TAPERDEX	T3	PA
TARPEYO	T5	PA QL(28 caps/30 days) SP
UCERIS 9 MG ER TABLET *(budesonide)*	T3	
ZCORT	T3	PA
GROWTH HORMONE RELEASING HORMONE (GHRH) AND ANALOGS		
EGRIFTA SV	T4	PA SP HD

T1 – Generics
T2 – Preferred Brands
T3 – Non-Preferred Brands
T4 – Preferred Specialty
T5 – Non-Preferred Specialty
PA – Prior Authorization
QL – Quantity Limit
ST – Step Therapy
AGE – Age Requirement
SP – Specialty Medication
HD – May require home delivery pharmacy
PPACA – No Cost-Share Preventive Medication
CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

HORMONES (Hormonal Agents) (cont.)		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
GROWTH HORMONES		
GENOTROPIN	T4	PA SP HD
OMNITROPE	T4	PA SP
SEROSTIM	T4	PA SP HD
ZORBTIVE	T5	PA SP HD
INSULIN-LIKE GROWTH FACTOR-I (IGF-I) HORMONES		
INCRELEX	T4	PA SP HD
LHRH (GNRH) AGONIST ANALOG PITUITARY SUPPRESSANTS		
SYNAREL	T4	PA SP HD
LHRH (GNRH) ANTAGONIST, ESTROGEN AND PROGESTIN COMB		
MYFEMBREE	T2	PA
ORIAHNN	T2	PA
LHRH (GNRH) ANTAGONIST, PITUITARY SUPPRESSANT AGENTS		
cetrorelix acetate	T1	SP
CETROTIDE	T4	SP
GANIRELIX ACET 250 MCG/0.5 ML (*ganirelix acetate*)	T5	ST SP
ganirelix acet 250 mcg/0.5 ml (Ganirelix Acetate)	T1	ST SP
ganirelix acetate (Ganirelix Acetate)	T1	SP
ORILISSA 150 MG TABLET	T2	PA QL(30 tabs/fill)
ORILISSA 200 MG TABLET	T2	PA QL(60 tabs/fill)
MINERALOCORTICOIDS		
fludrocortisone acetate	T1	HD
OXYTOCICS		
CERVIDIL	T3	
methylergonovine maleate	T1	PA QL(240 tabs/fill)
PREPIDIL	T3	
PROSTIN E2 VAGINAL SUPPOSITORY	T3	
PARATHYROID HORMONES		
NATPARA	T4	PA SP HD
PITUITARY SUPPRESSIVE AGENTS		
cabergoline	T1	QL(8 tabs/28 days) HD
danazol	T1	HD
PROGESTATIONAL AGENTS		
AYGESTIN (*norethindrone acetate*)	T3	HD
CRINONE 8% GEL	T2	

T1 – Generics
T2 – Preferred Brands
T3 – Non-Preferred Brands
T4 – Preferred Specialty
T5 – Non-Preferred Specialty
PA – Prior Authorization
QL – Quantity Limit
ST – Step Therapy
AGE – Age Requirement
SP – Specialty Medication
HD – May require home delivery pharmacy
PPACA – No Cost-Share Preventive Medication
CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

HORMONES (Hormonal Agents) (cont.)		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
PROGESTATIONAL AGENTS (cont.)		
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, micronized (Prometrium)	T1	HD
PROMETRIUM *(progesterone, micronized)*	T3	HD
PROVERA (*medroxyprogesterone acetate*)	T3	HD
SOMATOSTATIC AGENTS		
MYCAPSSA	T5	PA SP
MYCAPSSA DR 20MG CAPSULE	T5	PA QL (56 caps/28 days) SP
SIGNIFOR	T4	PA SP
VAGINAL ESTROGEN PREPARATIONS		
estradiol (Vagifem)	T1	HD
estradiol 0.01% cream (Estrace)	T1	HD
estradiol 10 mcg vaginal insrt (Vagifem)	T1	HD
PREMARIN VAGINAL CREAM-APPL	T2	HD
HORMONES (Infertility)		
FERTILITY STIMULATING PREPARATIONS, NON-FSH		
clomiphene citrate	T1	
FOLLICLE-STIMULATING AND LUTEINIZING HORMONES		
MENOPUR	T4	SP
FOLLICLE-STIMULATING HORMONE (FSH)		
FOLLISTIM AQ	T5	ST SP
GONAL-F	T4	ST SP
GONAL-F RFF	T4	ST SP
GONAL-F RFF REDI-JECT	T4	ST SP
HUMAN CHORIONIC GONADOTROPIN (HCG)		
CHORIONIC GONAD 10,000 UNIT VL	T5	ST QL(3 vials/30 days) SP
CHORIONIC GONAD 12,000 UNIT VL	T5	ST SP
CHORIONIC GONAD 50,000 UNIT VL	T5	ST SP
CHORIONIC GONAD 6,000 UNIT VL	T5	ST SP
NOVAREL	T4	QL(6 vls/30 days) SP
OVIDREL	T4	SP
PREGNYL	T5	ST QL(3 vials/fill) SP

T1 – Generics
T2 – Preferred Brands
T3 – Non-Preferred Brands
T4 – Preferred Specialty
T5 – Non-Preferred Specialty
PA – Prior Authorization
QL – Quantity Limit
ST – Step Therapy
AGE – Age Requirement
SP – Specialty Medication
HD – May require home delivery pharmacy
PPACA – No Cost-Share Preventive Medication
CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

HORMONES (Infertility) (cont.)		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
PREGNANCY FACILITATING/MAINTAINING AGENT, HORMONAL		
CRINONE	T3	
ENDOMETRIN	T3	
HORMONES (Miscellaneous)		
LEPTIN HORMONE ANALOGS		
MYALEPT	T4	PA SP HD
HORMONES (Osteoporosis Products)		
BONE FORMATION STIMULATING AGTS - PTH REL PEPTIDES		
TYMLOS	T4	PA QL(1 pen/fill) SP HD
BONE RESORPTION INHIBITORS		
calcitonin,salmon,synthetic	T1	HD
calcitonin,salmon,synthetic (Miacalcin)	T1	HD
MIACALCIN (*calcitonin,salmon,synthetic*)	T3	HD
IMMUNOSUPPRESSANTS (Pain Relief and Inflammatory Disease)		
HUMAN INTERLEUKIN 12/23 (IL-12/13) INHIBITORS, MAB		
STELARA	T4	PA QL SP HD
IL-23 RECEPTOR ANTAGONIST, MONOCLONAL ANTIBODY		
OMVOH PEN	T4	
SKYRIZI ON-BODY	T4	PA QL(1 cartridge/56 days) SP HD
INTERLEUKIN-4(IL-4) RECEPTOR ALPHA ANTAGONIST, MAB		
DUPIXENT 100 MG/0.67 ML SYRING	T4	PA QL(2 syringes/28 days) SP HD
DUPIXENT 200 MG/1.14 ML PEN	T4	PA QL(400 mgs/28 days) SP HD
DUPIXENT 200 MG/1.14 ML SYRING	T4	PA QL(400 mgs/28 days) SP HD
INTERLEUKIN-4(IL-4) RECEPTOR ALPHA ANTAGONIST, MAB		
DUPIXENT 300 MG/2 ML PEN	T4	PA QL(600 mgs/28 days) SP HD
DUPIXENT 300 MG/2 ML SYRINGE	T4	PA QL(600 mgs/28 days) SP HD
INTERLEUKIN-6 (IL-6) RECEPTOR INHIBITORS		
ACTEMRA	T4	PA QL(3.6 mls/28 days) SP HD
ACTEMRA ACTPEN	T4	PA QL(2 pens/28 days) SP HD
ENSPRYNG	T4	PA SP HD
IMMUNOSUPPRESSANTS (Skin Conditions)		
TOPICAL IMMUNOSUPPRESSIVE AGENTS		
HYFTOR	T5	PA SP

T1 – Generics
T2 – Preferred Brands
T3 – Non-Preferred Brands
T4 – Preferred Specialty
T5 – Non-Preferred Specialty
PA – Prior Authorization
QL – Quantity Limit
ST – Step Therapy
AGE – Age Requirement
SP – Specialty Medication
HD – May require home delivery pharmacy
PPACA – No Cost-Share Preventive Medication
CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

IMMUNOSUPPRESSANTS (Skin Conditions) (cont.)		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
TOPICAL IMMUNOSUPPRESSIVE AGENTS (cont.)		
pimecrolimus (Elidel)	T1	ST QL(120 gms/30 days)
PROTOPIC (*tacrolimus*)	T3	ST QL(120 gms/30 days)
tacrolimus 0.03% ointment (Protopic)	T1	ST QL(120 gms/30 days)
IMMUNOSUPPRESSANTS (Transplant Medications)		
IMMUNOSUPPRESSIVES		
ASTAGRAF XL	T5	PA SP HD
AZASAN (*azathioprine*)	T5	SP HD
azathioprine (Azasan)	T1	SP HD
azathioprine (Imuran)	T1	SP HD
CELLCEPT (*mycophenolate mofetil*)	T5	SP HD
cyclosporine 100 mg capsule (Sandimmune)	T1	SP HD
cyclosporine 25 mg capsule (Sandimmune)	T1	SP HD
cyclosporine, modified	T1	SP HD
cyclosporine, modified (Neoral)	T1	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
everolimus 1 mg tablet (Zortress)	T1	SP HD
IMURAN (*azathioprine*)	T5	SP HD
LUPKYNIS	T5	PA QL (180 caps/30 days) SP
mycophenolate mofetil (Cellcept)	T1	SP HD
mycophenolate sodium (Myfortic)	T1	SP HD
MYFORTIC (*mycophenolate sodium*)	T5	SP HD
NEORAL (*cyclosporine, modified*)	T5	SP HD
PROGRAF 0.2 MG GRANULE PACKET	T4	SP HD
PROGRAF 0.5 MG CAPSULE (*tacrolimus*)	T5	SP HD
PROGRAF 1 MG CAPSULE (*tacrolimus*)	T5	SP HD
PROGRAF 1 MG GRANULE PACKET	T4	SP HD
PROGRAF 5 MG CAPSULE (*tacrolimus*)	T5	SP HD
RAPAMUNE (*sirolimus*)	T5	SP HD
SANDIMMUNE 100 MG CAPSULE (*cyclosporine*)	T5	SP HD
SANDIMMUNE 100 MG/ML SOLN	T4	SP HD
SANDIMMUNE 25 MG CAPSULE (*cyclosporine*)	T5	SP HD

T1 – Generics
T2 – Preferred Brands
T3 – Non-Preferred Brands
T4 – Preferred Specialty
T5 – Non-Preferred Specialty
PA – Prior Authorization
QL – Quantity Limit
ST – Step Therapy
AGE – Age Requirement
SP – Specialty Medication
HD – May require home delivery pharmacy
PPACA – No Cost-Share Preventive Medication
CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

IMMUNOSUPPRESSANTS (Transplant Medications) (cont.)		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
IMMUNOSUPPRESSIVES (cont.)		
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 (*everolimus*)	T5	SP HD
MISCELLANEOUS MEDICAL SUPPLIES, DEVICES, NON-DRUG (Diabetes)		
DIABETIC SUPPLIES		
2TEK	T3	
ACCU-CHEK AVIVA SOLUTION	T3	
ACCU-CHEK COMPACT PLUS CONTROL	T3	
ACCU-CHEK FASTCLIX LANCING DEV	T2	
ACCU-CHEK GUIDE CONTROL SOLN	T3	
ACCU-CHEK MULTICLIX LANCET KIT	T2	
ACCU-CHEK SMARTVIEW CONTRL SOL	T3	
ACCU-CHEK SOFTCLIX	T2	
ACCUTREND GLUCOSE CONTROL	T3	
ADJUSTABLE LANCING DEVICE	T2	
ADVANCED LANCING DEVICE	T2	
ADVOCATE CONTROL SOLUTION	T3	
ADVOCATE LANCING DEVICE	T2	
ADVOCATE RAPID-SAFE LANCING DV	T2	
ADVOCATE REDI-CODE+ CTRL SOLN	T3	
AGAMATRIX CONTROL	T3	
ALKALINE BATTERIES	T3	
ALTERNATE SITE LANCING DEVICE	T2	
AQUA LANCE LANCING DEVICE	T2	
ASSURE 4 CONTROL SOLUTION	T3	
ASSURE DOSE	T3	
ASSURE PRISM	T3	
AT HOME A1C	T3	
AUTOJECT 2	T2	
AUTO-LANCET MINI	T2	
AUTOLET IMPRESSION	T2	

T1 – Generics
T2 – Preferred Brands
T3 – Non-Preferred Brands
T4 – Preferred Specialty
T5 – Non-Preferred Specialty
PA – Prior Authorization
QL – Quantity Limit
ST – Step Therapy
AGE – Age Requirement
SP – Specialty Medication
HD – May require home delivery pharmacy
PPACA – No Cost-Share Preventive Medication
CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

MISCELLANEOUS MEDICAL SUPPLIES, DEVICES, NON-DRUG (Diabetes) (cont.)		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
DIABETIC SUPPLIES (cont.)		
AUTOLET LANCING DEVICE	T2	
AUTOLET PLUS	T2	
AUTOPEN	T2	
AUTOSOFT 30	T2	
AUTOSOFT 90	T2	
AUTOSOFT XC	T2	
BLOOD GLUCOSE CONTROL	T3	
BLOOD-GLUCOSE CONTROL	T3	
BREEZE 2	T3	
CAREONE	T2	
CARESENS	T3	
CARETOUCH CONTROL SOLUTION	T3	
CARETOUCH LANCING DEVICE	T2	
CEQUR SIMPLICITY	T2	
CEQUR SIMPLICITY INSERTER	T2	
CHEMSTRIP BG DIARY	T3	
CLEVER CHOICE CONTROL SOLUTION	T3	
COMFORT	T2	
COMFORT SHORT	T2	
CONTACT DETACH INFUSION SET	T2	
CONTOUR	T3	
CONTOUR NEXT CONTROL SOLUTION	T3	
CONTROL SOLUTION	T3	
COOL CONTROL SOLUTION	T3	
DEXCOM G6 RECEIVER	T2	
DEXCOM G6 SENSOR	T2	PA QL(3 kits/30 days)
DEXCOM G6 TRANSMITTER	T2	PA QL(1 kit/90 days)
DEXCOM G7 RECEIVER	T2	
DEXCOM G7 SENSOR	T2	PA QL(3 units/30 days)
DIATRUE	T3	
DROPLET GENTEEL LANCING DEVICE	T2	
DROPLET LANCING DEVICE	T2	
EASY MINI EJECT LANCING DEVICE	T2	
EASY PLUS II CONTROL SOLN HIGH	T3	

T1 – Generics
T2 – Preferred Brands
T3 – Non-Preferred Brands
T4 – Preferred Specialty
T5 – Non-Preferred Specialty
PA – Prior Authorization
QL – Quantity Limit
ST – Step Therapy
AGE – Age Requirement
SP – Specialty Medication
HD – May require home delivery pharmacy
PPACA – No Cost-Share Preventive Medication
CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

MISCELLANEOUS MEDICAL SUPPLIES, DEVICES, NON-DRUG (Diabetes) (cont.)		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
DIABETIC SUPPLIES (cont.)		
EASY PLUS II CONTROL SOLN LOW	T3	
EASY STEP CONTROL SOLUTION	T3	
EASY TALK CONTROL SOLN LOW	T3	
EASY TALK HIGH CONTROL SOLN	T3	
EASY TALK PLUS II HIGH CONTROL	T3	
EASY TALK PLUS II LOW CTRL SLN	T3	
EASY TOUCH BLU LINK CTRL SOLN	T3	
EASY TOUCH CONTROL SOLUTION	T3	
EASY TOUCH LANCING DEVICE	T2	
EASY TRAK CONTROL SOLN HIGH	T3	
EASY TRAK CONTROL SOLN LOW	T3	
EASY TRAK II CONTROL SOLUTION	T3	
EASYGLUCO PLUS CONTROL NORMAL	T3	
EASYMAX 15 LEVEL 2 SOLUTION	T3	
EASYMAX NORMAL CONTROL SOLN	T3	
ELEMENT COMPACT CONTROL SOLN	T3	
ELEMENT CONTROL SOLUTION	T3	
EMBRACE EVO LEVEL 1 CTRL SOLN	T3	
EMBRACE GLUC CONTROL SOLN HIGH	T3	
EMBRACE GLUCOSE CONTROL SOLN	T3	
EMBRACE LANCING DEVICE	T2	
EMBRACE PRO	T3	
EMBRACE TALK CONTROL SOLUTION	T3	
ENLITE SERTER	T3	
EVENCARE G2 CONTROL SOLUTION	T3	
EVENCARE G3 CONTROL SOLUTION	T3	
EVOLUTION CONTROL SOLUTION	T3	
FORA CONTROL SOLUTION	T3	
FORA GTEL MULTIFUNCTN MONITOR	T3	
FORA KETONE CONTROL SOLUTION	T3	
FORA LANCING DEVICE	T2	
FORA TN'GO ADVANCE MULTIFN MTR	T3	
FORA TN'G ADVANCE PRO MONITOR	T3	
FORACARE GDH	T3	

T1 – Generics
T2 – Preferred Brands
T3 – Non-Preferred Brands
T4 – Preferred Specialty
T5 – Non-Preferred Specialty
PA – Prior Authorization
QL – Quantity Limit
ST – Step Therapy
AGE – Age Requirement
SP – Specialty Medication
HD – May require home delivery pharmacy
PPACA – No Cost-Share Preventive Medication
CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

MISCELLANEOUS MEDICAL SUPPLIES, DEVICES, NON-DRUG (Diabetes) (cont.)		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
DIABETIC SUPPLIES (cont.)		
FORTISCARE	T3	
FREESTYLE CONTROL SOLUTION	T2	
FREESTYLE LIBRE 10 DAY READER	T2	PA
FREESTYLE LIBRE 10 DAY SENSOR	T2	PA
FREESTYLE LIBRE 14 DAY READER	T2	PA
FREESTYLE LIBRE 14 DAY SENSOR	T2	PA QL(2 kits/30 days)
FREESTYLE LIBRE 2 READER	T2	PA
FREESTYLE LIBRE 2 SENSOR	T2	PA QL(2 sensors/28 days)
FREESTYLE LIBRE 3 SENSOR	T2	PA QL(2 units/28 days)
FREESTYLE NAVIGATOR SENSOR KIT	T2	
GE100 CONTROL SOLUTION NORMAL	T3	
GENTEEL VACUUM LANCING DEVICE	T3	
GLUCOCARD 01 CONTROL	T3	
GLUCOCARD EXPRESSION CNTRL SLN	T3	
GLUCOCARD SHINE CONTROL SOLN	T3	
GLUCOCOM AUTOLINK	T3	
GLUCOCOM CONTROL SOLUTION	T3	
GLUCOSE CONTROL	T3	
GLUCOSE CONTROL SOLUTION	T3	
GOJJI GLUCOSE CONTROL SOLUTION	T3	
GOJJI KETONE CONTROL SOLUTION	T3	
GOJJI LANCING DEVICE	T2	
GOJJI MULTI-FUNCTIONAL METER	T3	
GUARDIAN 4 GLUCOSE SENSOR	T3	PA QL (5 sensors/30 days)
GUARDIAN 4 TRANSMITTER	T3	PA QL (1 transmitter/273 days)
GUARDIAN LINK 3 TRANSMITTER	T3	PA QL (1 transmitter/273 days)
GUARDIAN RT CHARGER	T3	
GUARDIAN RT STARTER KIT	T3	
GUARDIAN RT SYSTEM	T3	
GUARDIAN TEST PLUG	T3	
GUARDIAN TRANSMITTER TAPE	T3	
HEALTHPRO GLUCOSE CONTROL SOLN	T3	
HEALTHY ACCENTS AUTOLET	T2	
HYPOLANCE	T2	

T1 – Generics
T2 – Preferred Brands
T3 – Non-Preferred Brands
T4 – Preferred Specialty
T5 – Non-Preferred Specialty
PA – Prior Authorization
QL – Quantity Limit
ST – Step Therapy
AGE – Age Requirement
SP – Specialty Medication
HD – May require home delivery pharmacy
PPACA – No Cost-Share Preventive Medication
CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

MISCELLANEOUS MEDICAL SUPPLIES, DEVICES, NON-DRUG (Diabetes) (cont.)		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
DIABETIC SUPPLIES (cont.)		
ILET INFUSION KIT-INSET	T2	
ILET INFUSION-CONTACT DETACH	T2	
INCONTROL LANCING DEVICE	T2	
INFINITY CONTROL SOLUTION	T3	
INFINITY VOICE CONTROL SOLN	T3	
INPEN (FOR HUMALOG)	T3	
INPEN (FOR NOVOLOG OR FIASP)	T3	
INSUL-CAP	T3	
INSUL-EZE	T3	
LANCING DEVICE	T2	
LANCING SYSTEM	T2	
LANZO	T2	
LITE TOUCH LANCING PEN	T2	
MEDISENSE	T2	
MEDISENSE GLUCOSE KETONE	T2	
MEDISENSE GLUCOSE KETONE CONTR	T2	
MEDTRONIC EXT INFUSION SET	T2	
MEDTRONIC REMOTE CONTROL	T2	
MICRODOT HIGH-LOW CONTROL SOL	T3	
MICRODOT NORMAL CONTROL SOLUT	T3	
MICROLET 2	T2	
MICROLET NEXT LANCING DEVICE	T2	
MINI LANCING DEVICE	T2	
MINIMED	T2	
MINIMED MIO	T2	
MINIMED MIO ADVANCE	T2	
MINIMED QUICK SET	T2	
MINIMED QUICK-SERTER	T3	
MINIMED QUICK-SERTER	T2	
MINIMED SILHOUETTE	T2	
MINIMED SURE T	T2	
MULTI-LANCET	T2	
MYGLUCOHEALTH CONTROL SOLUTION	T3	
NOVA MAX PLUS GLUC-KETON METER	T3	

T1 – Generics
T2 – Preferred Brands
T3 – Non-Preferred Brands
T4 – Preferred Specialty
T5 – Non-Preferred Specialty
PA – Prior Authorization
QL – Quantity Limit
ST – Step Therapy
AGE – Age Requirement
SP – Specialty Medication
HD – May require home delivery pharmacy
PPACA – No Cost-Share Preventive Medication
CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

MISCELLANEOUS MEDICAL SUPPLIES, DEVICES, NON-DRUG (Diabetes) (cont.)		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
DIABETIC SUPPLIES (cont.)		
NOVAMAX PLUS GLU-KET	T3	
NOVOPEN 3	T2	
NOVOPEN ECHO	T3	
OMNIPOD 5 G6 INTRO KIT (GEN 5)	T2	QL(1 kit/720 days)
OMNIPOD 5 G6 PODS (GEN 5)	T2	QL(15 pods/28 days)
OMNIPOD CLASSIC PODS (GEN 3)	T2	QL(15 pods/28 days)
OMNIPOD DASH INTRO KIT (GEN 4)	T2	QL(1 kit/720 days)
OMNIPOD DASH PODS (GEN 4)	T2	QL(15 pods/28 days)
OMNIPOD GO PODS	T2	QL(10 crtgs/30 days)
ON CALL EXPRESS CONTROL SOLN	T3	
ON CALL LANCING DEVICE	T2	
ON CALL PLUS CONTROL	T3	
ON CALL PLUS LANCING DEVICE	T2	
ON CALL VIVID CONTROL	T3	
ONETOUCH DELICA	T2	
ONETOUCH DELICA PLUS LANC DEV	T2	
ONETOUCH ULTRA CONTROL SOLN	T2	
ONETOUCH VERIO HIGH CNTRL SOLN	T2	
ONETOUCH VERIO MID CNTRL SOLN	T2	
OPTUMRX GLUCOSE CONTROL SOLN	T3	
OVAL TAPE	T3	
PARADIGM REMOTE CONTROL	T3	
PIP GLUCOSE CONTROL SOLUTION	T3	
PRECISION XTRA KETONE-GLUCOSE	T2	
PRODIGY CONTROL SOLUTION	T3	
PRODIGY LANCING DEVICE	T2	
QUICK RELEASE SOFT TEFLON	T2	
REFUAH PLUS GLUCOSE CONTROL	T3	
RELIAMED MINI LANCING DEVICE	T2	
REPLACEMENT PEDIATRIC MONITOR	T3	
RIGHTEST CONTROL SOLUTION	T3	
RIGHTEST GD500	T2	
SAFE-CLIP	T2	
SEN-SERTER	T3	

T1 – Generics
T2 – Preferred Brands
T3 – Non-Preferred Brands
T4 – Preferred Specialty
T5 – Non-Preferred Specialty
PA – Prior Authorization
QL – Quantity Limit
ST – Step Therapy
AGE – Age Requirement
SP – Specialty Medication
HD – May require home delivery pharmacy
PPACA – No Cost-Share Preventive Medication
CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

MISCELLANEOUS MEDICAL SUPPLIES, DEVICES, NON-DRUG (Diabetes) (cont.)		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
DIABETIC SUPPLIES (cont.)		
SILHOUETTE	T2	
SIL-SERTER	T2	
SMARTDIABETES VANTAGE	T2	
SMARTEST	T3	
SOF-SERTER	T2	
SOF-SET	T2	
SOF-SET MICRO	T2	
SOLUS V2 CONTROL SOLUTION	T3	
SOLUS V2 LANCING DEVICE	T2	
SURE COMFORT LANCING PEN	T2	
SUREFLEX	T2	
SURE-PEN	T2	
SURE-TEST EASYPLUS MINI SOLN	T3	
T:30 INFUSION SET	T2	
T:90	T2	
T:FLEX	T2	
T:SLIM	T2	
T:SLIM G4	T2	
T:SLIM X2	T2	
TELCARE CONTROL SOLUTION	T3	
TRUE METRIX	T3	
TRUECONTROL	T3	
TRUEDRAW	T2	
TRUSTEEL INFUSION SET	T2	
ULTI-LANCE	T2	
ULTRATRAK CONTROL SOL NORMAL	T3	
ULTRATRAK CONTROL SOLUTION	T3	
ULTRATRAK ULTIMATE CNTRL SOLN	T3	
UNISTIK 2	T2	
UNISTRIP	T3	
VARISOFT INFUSION SET	T2	
V-GO 20	T2	
V-GO 30	T2	
V-GO 40	T2	

T1 – Generics
T2 – Preferred Brands
T3 – Non-Preferred Brands
T4 – Preferred Specialty
T5 – Non-Preferred Specialty
PA – Prior Authorization
QL – Quantity Limit
ST – Step Therapy
AGE – Age Requirement
SP – Specialty Medication
HD – May require home delivery pharmacy
PPACA – No Cost-Share Preventive Medication
CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

MISCELLANEOUS MEDICAL SUPPLIES, DEVICES, NON-DRUG (Diabetes) (cont.)		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
DIABETIC SUPPLIES (cont.)		
VIVAGUARD INO CONTROL SOLUTION	T3	
VIVAGUARD LANCING DEVICE	T2	
WAVESENSE CONTROL SOLUTION	T3	
DURABLE MEDICAL EQUIPMENT,MISC(GROUP I)		
1ST TIER UNILET COMFORTOUCH	T2	
2-IN-1 LANCET DEVICE	T2	
ACCU-CHEK FASTCLIX LANCET DRUM	T2	
ACCU-CHEK SAFE-T-PRO	T2	
ACCU-CHEK SAFE-T-PRO PLUS	T2	
ACCU-CHEK SOFTCLIX	T2	
acti-lance lite 28g lancets	T1	
acti-lance special 17g lancets	T1	
acti-lance univers 23g lancets	T1	
ACTI-LANCE UNIVERS 23G LANCETS	T2	
ADVANCED TRAVEL LANCETS	T2	
ADVOCATE LANCET	T2	
ADVOCATE LANCETS	T2	
ADVOCATE SAFETY LANCET	T2	
ALTERNATE SITE LANCETS	T2	
ASSURE HAEMOLANCE PLUS	T2	
ASSURE LANCE	T2	
ASSURE LANCE PLUS	T2	
BD MICROTAINER LANCETS	T2	
BLOOD LANCETS	T2	
BULLSEYE MINI SAFETY LANCETS	T2	
BUTTERFLY TOUCH LANCET	T2	
CAREONE	T2	
CARESENS LANCET	T2	
CARETOUCH SAFETY LANCETS	T2	
CARETOUCH TWIST LANCET	T2	
CLEVER CHEK LANCETS	T2	
COAGUCHEK	T2	
COLOR LANCETS	T2	
COMFORT EZ	T2	

T1 – Generics
T2 – Preferred Brands
T3 – Non-Preferred Brands
T4 – Preferred Specialty
T5 – Non-Preferred Specialty
PA – Prior Authorization
QL – Quantity Limit
ST – Step Therapy
AGE – Age Requirement
SP – Specialty Medication
HD – May require home delivery pharmacy
PPACA – No Cost-Share Preventive Medication
CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

MISCELLANEOUS MEDICAL SUPPLIES, DEVICES, NON-DRUG (Diabetes) (cont.)		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
DURABLE MEDICAL EQUIPMENT,MISC(GROUP I) (cont.)		
COMFORT LANCETS	T2	
COMFORT TOUCH PLUS SAFETY LANC	T2	
COMFORT TOUCH ULT THIN LANCET	T2	
DROPLET LANCETS	T2	
EASY COMFORT LANCETS	T2	
EASY TOUCH PULL-TOP 26G LANCET	T2	
EASY TOUCH PULL-TOP 28G LANCET	T2	
EASY TOUCH PULL-TOP 30G LANCET	T2	
EASY TOUCH PULL-TOP 32G LANCET	T2	
EASY TOUCH SAFETY 21G LANCETS	T2	
EASY TOUCH SAFETY 23G LANCETS	T2	
EASY TOUCH SAFETY 26G LANCETS	T2	
EASY TOUCH SAFETY 28G LANCETS	T2	
EASY TOUCH SAFETY 30G LANCETS	T2	
EASY TOUCH SAFETY 32G LANCETS	T2	
EASY TOUCH TWIST 26G LANCETS	T2	
EASY TOUCH TWIST 28G LANCETS	T2	
EASY TOUCH TWIST 30G LANCETS	T2	
EASY TOUCH TWIST 32G LANCETS	T2	
EASY TOUCH TWIST 33G LANCETS	T2	
EASY TWIST & CAP LANCETS	T2	
EMBRACE 30G LANCETS	T2	
EMBRACE SAFETY LANCET	T2	
EZ SMART LANCETS	T2	
EZ-LETS	T2	
FIFTY50 SAFETY SEAL LANCETS	T2	
FINE 30 UNIVERSAL LANCETS	T2	
FINGERSTIX	T2	
FORA LANCETS	T2	
FORACARE LANCETS	T2	
FREESTYLE LANCETS	T2	
FREESTYLE UNISTIK 2	T2	
GLUCOCOM	T2	
GLUCOCOM LANCETS	T2	

T1 – Generics
T2 – Preferred Brands
T3 – Non-Preferred Brands
T4 – Preferred Specialty
T5 – Non-Preferred Specialty
PA – Prior Authorization
QL – Quantity Limit
ST – Step Therapy
AGE – Age Requirement
SP – Specialty Medication
HD – May require home delivery pharmacy
PPACA – No Cost-Share Preventive Medication
CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

MISCELLANEOUS MEDICAL SUPPLIES, DEVICES, NON-DRUG (Diabetes) (cont.)		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
DURABLE MEDICAL EQUIPMENT,MISC(GROUP I) (cont.)		
GOJJI LANCETS	T2	
HEALTHY ACCENTS UNILET LANCET	T2	
INCONTROL SUPER THIN LANCETS	T2	
INCONTROL ULTRA THIN LANCETS	T2	
INJECT EASE LANCETS	T2	
INVACARE LANCETS	T2	
lancets	T1	
LANCETS	T2	
LANCETS THIN	T2	
LANCETS ULTRA THIN	T2	
LITE TOUCH 28G LANCETS	T2	
LITE TOUCH 30G LANCETS	T2	
LITE TOUCH 33G LANCETS	T2	
MEDISENSE THIN LANCETS	T2	
medlance plus 21g lancets	T1	
MEDLANCE PLUS 21G LANCETS	T2	
medlance plus 30g lancets	T1	
MEDLANCE PLUS 30G LANCETS	T2	
MEDLANCE PLUS EXTRA 21G LANCET	T2	
medlance plus lite 25g lancets	T1	
MEDLANCE PLUS LITE 25G LANCETS	T2	
MICRO THIN LANCET	T2	
MICRO THIN LANCETS	T2	
MICROLET	T2	
MOBILE LANCETS	T2	
MONOLET LANCETS	T2	
MONOLET THIN LANCETS	T2	
MYGLUCOHEALTH LANCETS	T2	
NOVA SAFETY LANCETS	T2	
NOVA SUREFLEX	T2	
ON CALL LANCET	T2	
ON CALL PLUS LANCET	T2	
ONETOUCH DELICA PLUS LANCET	T2	
ONETOUCH DELICA SAFETY LANCET	T2	

T1 – Generics
T2 – Preferred Brands
T3 – Non-Preferred Brands
T4 – Preferred Specialty
T5 – Non-Preferred Specialty
PA – Prior Authorization
QL – Quantity Limit
ST – Step Therapy
AGE – Age Requirement
SP – Specialty Medication
HD – May require home delivery pharmacy
PPACA – No Cost-Share Preventive Medication
CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

MISCELLANEOUS MEDICAL SUPPLIES, DEVICES, NON-DRUG (Diabetes) (cont.)		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
DURABLE MEDICAL EQUIPMENT,MISC(GROUP I) (cont.)		
ONETOUCH LANCETS	T2	
ONETOUCH SURESOFT	T2	
ONETOUCH ULTRASOFT 2 LANCET	T2	
ON-THE-GO	T2	
PIP LANCET	T2	
PRESSURE ACTIVATED LANCETS	T2	
PRO COMFORT LANCET	T2	
PRO COMFORT LANCETS	T2	
PRO COMFORT SAFETY LANCET	T2	
PRODIGY LANCETS	T2	
PRODIGY TWIST TOP LANCET	T2	
PURE COMFORT LANCETS	T2	
PURE COMFORT SAFETY LANCETS	T2	
PUSH BUTTON SAFETY LANCETS	T2	
READYLANCE SAFETY LANCETS	T2	
RELIAMED	T2	
RELIAMED SAFETY SEAL LANCETS	T2	
RELION THIN	T2	
RIGHTEST GL300 LANCETS	T2	
SAFETY LANCETS	T2	
SAFETY SEAL LANCETS	T2	
SAFETY-LET	T2	
SINGLE-LET	T2	
SMART SENSE	T2	
SMART SENSE LANCETS	T2	
SMARTEST LANCET	T2	
SOFT TOUCH	T2	
SOLUS V2	T2	
SOLUS V2 LANCETS	T2	
STERILANCE TL	T2	
STERILE LANCETS	T2	
SUPER THIN LANCETS	T2	
SURE COMFORT LANCETS	T2	
SURE-LANCE	T2	

T1 – Generics
T2 – Preferred Brands
T3 – Non-Preferred Brands
T4 – Preferred Specialty
T5 – Non-Preferred Specialty
PA – Prior Authorization
QL – Quantity Limit
ST – Step Therapy
AGE – Age Requirement
SP – Specialty Medication
HD – May require home delivery pharmacy
PPACA – No Cost-Share Preventive Medication
CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

MISCELLANEOUS MEDICAL SUPPLIES, DEVICES, NON-DRUG (Diabetes) (cont.)		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
DURABLE MEDICAL EQUIPMENT,MISC(GROUP I) (cont.)		
SURE-TOUCH	T2	
TECHLITE LANCETS	T2	
TELCARE ULTRA THIN 30G LANCETS	T2	
THIN LANCETS	T2	
TOPCARE UNIVERSAL1 LANCET	T2	
TOPCARE UNIVERSAL1 THIN LANCET	T2	
TRUE COMFORT LANCET	T2	
TRUE COMFORT SAFETY LANCET	T2	
TRUEPLUS LANCET	T2	
TRUEPLUS LANCETS	T2	
TWIST LANCETS	T2	
TWIST TOP LANCET	T2	
ULTILET BASIC	T2	
ULTILET CLASSIC	T2	
ULTILET LANCETS	T2	
ULTILET SAFETY	T2	
ULTRA THIN LANCET	T2	
ULTRA THIN LANCETS	T2	
ULTRA THIN PLUS	T2	
ULTRA THIN PLUS LANCETS	T2	
ULTRA-CARE LANCETS	T2	
ULTRALANCE	T2	
ULTRA-THIN II 28G LANCETS	T2	
ULTRA-THIN II 30G LANCETS	T2	
ULTRATLC LANCETS	T2	
UNILET COMFORTOUCH	T2	
UNILET EXCELITE	T2	
UNILET EXCELITE II	T2	
UNILET GP LANCET	T2	
UNILET LANCET	T2	
UNILET LANCETS	T2	
UNISTIK 2 COMFORT	T2	
UNISTIK 2 EXTRA	T2	
UNISTIK 2 NORMAL	T2	

T1 – Generics
T2 – Preferred Brands
T3 – Non-Preferred Brands
T4 – Preferred Specialty
T5 – Non-Preferred Specialty
PA – Prior Authorization
QL – Quantity Limit
ST – Step Therapy
AGE – Age Requirement
SP – Specialty Medication
HD – May require home delivery pharmacy
PPACA – No Cost-Share Preventive Medication
CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

MISCELLANEOUS MEDICAL SUPPLIES, DEVICES, NON-DRUG (Diabetes) (cont.)		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
DURABLE MEDICAL EQUIPMENT,MISC(GROUP I) (cont.)		
UNISTIK 3	T2	
UNISTIK 3 COMFORT	T2	
UNISTIK 3 DUAL	T2	
UNISTIK 3 EXTRA	T2	
UNISTIK 3 NORMAL	T2	
UNISTIK COMFORT	T2	
UNISTIK CZT	T2	
UNISTIK EXTRA	T2	
UNISTIK NORMAL	T2	
UNISTIK PRO	T2	
UNISTIK SAFETY	T2	
UNISTIK TOUCH	T2	
UNIVERSAL 1	T2	
VERIFINE SAFETY LANCET MINI	T2	
VERIFINE UNIVERSAL LANCET	T2	
VIVAGUARD LANCET	T2	
NEEDLES/NEEDLELESS DEVICES		
AUTOSHIELD DUO PEN NEEDLE	T2	
BD ECLIPSE NEEDLE 18G 40MM	T3	
BD ECLIPSE NEEDLE 21GX1"	T2	
BD ECLIPSE NEEDLE 22GX1"	T2	
BD ECLIPSE NEEDLE 23GX1"	T3	
BD ECLIPSE NEEDLE 25G 16MM	T3	
BD ECLIPSE NEEDLE 25G 25MM	T3	
BD ECLIPSE NEEDLE 25GX1"	T2	
BD ECLIPSE NEEDLE 25GX1.5"	T2	
BD ECLIPSE NEEDLE 25GX5/8"	T3	
BD ECLIPSE NEEDLE 27GX1/2"	T3	
BD ECLIPSE NEEDLES 21GX1.5"	T2	
BD NEEDLES 21GX1"	T2	
BD NEEDLES 21GX1.5"	T2	
BD NEEDLES 22GX1"	T2	
BD NEEDLES 25GX0.875"	T2	
BLUNT NEEDLE	T2	

T1 – Generics
T2 – Preferred Brands
T3 – Non-Preferred Brands
T4 – Preferred Specialty
T5 – Non-Preferred Specialty
PA – Prior Authorization
QL – Quantity Limit
ST – Step Therapy
AGE – Age Requirement
SP – Specialty Medication
HD – May require home delivery pharmacy
PPACA – No Cost-Share Preventive Medication
CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

MISCELLANEOUS MEDICAL SUPPLIES, DEVICES, NON-DRUG (Diabetes) (cont.)		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
NEEDLES/NEEDLELESS DEVICES (cont.)		
CAREPOINT PRECISION NEEDLE	T3	
CARETOUCH HYPODERMIC NEEDLE	T3	
CHEMO TRANSFER PIN	T2	
EASY TOUCH FLIPLOCK NEEDLE	T3	
EASY TOUCH FLIPLOCK NEEDLES	T3	
EASY TOUCH HYPODERMIC NEEDLE	T3	
EASYPOINT NEEDLE	T3	
EXEL HUBER NEEDLE	T2	
EXEL HYPODERMIC NEEDLE	T2	
EXEL MTI DRAWING NEEDLE	T2	
FILTER ASPIRATOR NEEDLE	T2	
FILTER NEEDLE	T2	
FLOW-EZE	T2	
HURRICAINE LUER-LOCK	T2	
HYPODERMIC NEEDLE	T2	
INTEGRA NEEDLE	T2	
INTEGRA PRECISIONGLIDE NEEDLE	T3	
LIFESHIELD BLUNT CANNULA	T2	
MINI TRANSFER PIN	T2	
MONOJECT BLOOD COLLECTION	T2	
MONOJECT FILTER NEEDLE	T3	
NANO 2ND GEN PEN NEEDLE	T2	
NEEDLE	T2	
needles,safety huber,disposabl	T1	
NOKOR ADMIX NEEDLE	T2	
NOKOR NEEDLE	T2	
PEN NEEDLE 30G X 8MM	T3	
PHASEAL PROTECTOR	T3	
POLY HUB NEEDLE	T2	
PRECISIONGLIDE	T2	
QUINCE SPINAL NEEDLE	T2	
RAYA SURE PEN NEEDLE 29G 12MM	T3	
RAYA SURE PEN NEEDLE 31G 5MM	T3	
RAYA SURE PEN NEEDLE 31G 6MM	T3	

T1 – Generics
T2 – Preferred Brands
T3 – Non-Preferred Brands
T4 – Preferred Specialty
T5 – Non-Preferred Specialty
PA – Prior Authorization
QL – Quantity Limit
ST – Step Therapy
AGE – Age Requirement
SP – Specialty Medication
HD – May require home delivery pharmacy
PPACA – No Cost-Share Preventive Medication
CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

MISCELLANEOUS MEDICAL SUPPLIES, DEVICES, NON-DRUG (Diabetes) (cont.)		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
NEEDLES/NEEDLELESS DEVICES (cont.)		
REGULAR BEVEL NEEDLES	T2	
SAFETYGLIDE NEEDLE	T2	
SHORT BEVEL NEEDLES	T2	
SPECIALTY USE NEEDLES	T2	
TERUMO SURGUARD2	T2	
THIN WALL NEEDLES	T2	
TRANSFER NEEDLE	T2	
TRANSFER PIN	T2	
ULTRA-FINE MICRO PEN NEEDLE	T2	
ULTRA-FINE MINI PEN NEEDLE	T2	
ULTRA-FINE NANO PEN NEEDLE	T2	
ULTRA-FINE ORIGINAL PEN NEEDLE	T2	
ULTRA-FINE SHORT PEN NEEDLE	T2	
YALE NEEDLE	T2	
YALE NEEDLES	T2	
SYRINGES AND ACCESSORIES		
ALLERGIST TRAY	T3	
ALLERGIST TRAY SYR-DETACH NDL	T2	
ALLERGIST TRAY SYR-PERM NEEDLE	T2	
ALLERGY SYRINGE 1 ML 27GX1/2"	T3	
ALLERGY SYRINGE 1 ML 27GX3/8"	T3	
BD ALLERGY SYRINGE-NEEDLE 1 ML	T2	
BD ECLIPSE LUER-LOK SYR 1 ML	T2	
BD ECLIPSE LUER-LOK SYR 3 ML	T2	
BD ECLIPSE SYR 3 ML 22GX1-1/2"	T3	
BD INS SYR 0.3 ML 8MMX31G(1/2)	T2	
BD INS SYR UF 0.3ML 12.7MMX30G	T2	
BD INS SYR UF 0.5ML 12.7MMX30G	T2	
BD INS SYRN UF 1 ML 12.7MMX30G	T2	
BD INS SYRNG 0.3 ML 29GX12.7MM	T2	
BD INS SYRNG 0.5 ML 29GX12.7MM	T2	
BD INS SYRNG UF 0.3 ML 8MMX31G	T2	
BD INS SYRNG UF 0.5 ML 8MMX31G	T2	
BD INSULIN SYR 0.5 ML 28GX1/2"	T2	

T1 – Generics
T2 – Preferred Brands
T3 – Non-Preferred Brands
T4 – Preferred Specialty
T5 – Non-Preferred Specialty
PA – Prior Authorization
QL – Quantity Limit
ST – Step Therapy
AGE – Age Requirement
SP – Specialty Medication
HD – May require home delivery pharmacy
PPACA – No Cost-Share Preventive Medication
CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

MISCELLANEOUS MEDICAL SUPPLIES, DEVICES, NON-DRUG (Diabetes) (cont.)		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
SYRINGES AND ACCESSORIES (cont.)		
BD INSULIN SYR 0.5 ML 29GX1/2"	T2	
BD INSULIN SYR 1 ML 25GX1"	T2	
BD INSULIN SYR 1 ML 25GX5/8"	T2	
BD INSULIN SYR 1 ML 26GX1/2"	T2	
BD INSULIN SYR 1 ML 27GX12.7MM	T2	
BD INSULIN SYR 1 ML 27GX5/8"	T2	
BD INSULIN SYR 1 ML 28GX1/2"	T2	
BD INSULIN SYR 1 ML 29GX1/2"	T2	
BD INSULIN SYR 1 ML 29GX12.7MM	T2	
BD INSULIN SYR UF 1 ML 8MMX31G	T2	
BD INSULIN SYRINGE 1 ML	T2	
BD SAFETYGLIDE 3 ML SYRINGE	T2	
BD SAFETYGLIDE SYR 22GX1.5"	T2	
BD SAFETYGLIDE SYR 3 ML 25GX1"	T3	
BD SAFETYGLIDE SYRINGE 27GX5/8	T2	
BD SYRINGE-SAFETY GLIDE	T2	
BD UF INS SYR 1 ML 30GX1/2"	T2	
BULK SYRINGE	T2	
CANNULA	T2	
CAREPOINT LL SYR 3 ML 20GX1.5"	T2	
CAREPOINT LL SYR 3 ML 21GX1"	T2	
CAREPOINT LL SYR 3 ML 21GX1.5"	T2	
CAREPOINT LL SYR 3 ML 22G 38MM	T2	
CAREPOINT LL SYR 3 ML 22GX1"	T2	
CAREPOINT LL SYR 3 ML 23GX1"	T2	
CAREPOINT LL SYR 3 ML 23GX1.5"	T2	
CAREPOINT LL SYR 3 ML 25G X 1"	T2	
CAREPOINT LL SYR 3 ML 25GX5/8"	T2	
CAREPOINT LUER LOCK SYR 3 ML	T3	
CAREPOINT LUER SLIP SYRINGE	T3	
CAREPOINT LUER SLIP SYRING-NDL	T3	
CARETOUCH LUER LOCK	T2	
CARETOUCH LUER LOCK SYRINGE	T3	
CARETOUCH LUER SLIP SYRINGE	T3	

T1 – Generics
T2 – Preferred Brands
T3 – Non-Preferred Brands
T4 – Preferred Specialty
T5 – Non-Preferred Specialty
PA – Prior Authorization
QL – Quantity Limit
ST – Step Therapy
AGE – Age Requirement
SP – Specialty Medication
HD – May require home delivery pharmacy
PPACA – No Cost-Share Preventive Medication
CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

MISCELLANEOUS MEDICAL SUPPLIES, DEVICES, NON-DRUG (Diabetes) (cont.)		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
SYRINGES AND ACCESSORIES (cont.)		
CORNWALL SYRINGE TIP CONNECTOR	T2	
DAVOL IRRIGATION SYRINGE	T2	
DOVER BULB SYRINGE	T3	
EASY GLIDE CATHETER TIP SYRING	T3	
EASY GLIDE LUER LOCK SYRINGE	T3	
EASY GLIDE LUER SLIP TB SYRING	T3	
EASY TOUCH FLIPLK 10ML 20GX1.5	T3	
EASY TOUCH FLIPLK 10ML 21GX1.5	T3	
EASY TOUCH FLIPLK 10ML 22GX1.5	T3	
EASY TOUCH FLIPLK 5 ML 20GX1.5	T3	
EASY TOUCH FLIPLK 5 ML 21GX1.5	T3	
EASY TOUCH FLIPLK 5 ML 22GX1.5	T3	
EASY TOUCH FLIPLOCK	T3	
EASY TOUCH FLIPLOCK 1 ML 25GX1	T2	
EASY TOUCH FLIPLOCK 10ML 21GX1	T3	
EASY TOUCH FLIPLOCK 3 ML 18GX1	T3	
EASY TOUCH FLIPLOCK 3 ML 20GX1	T3	
EASY TOUCH FLIPLOCK 3 ML 21GX1	T3	
EASY TOUCH FLIPLOCK 5 ML 18GX1	T3	
EASY TOUCH FLIPLOCK 5 ML 21GX1	T3	
EASY TOUCH FLIPLOCK SYRINGE	T3	
EASY TOUCH FLIPLOK 10 ML 20GX1	T3	
EASY TOUCH FLIPLOK 10 ML 25GX1	T3	
EASY TOUCH FLIPLOK 1ML 26GX3/8	T2	
EASY TOUCH FLIPLOK 1ML 27GX0.5	T2	
EASY TOUCH FLIPLOK 3ML 18GX1.5	T3	
EASY TOUCH FLIPLOK 3ML 20GX1.5	T3	
EASY TOUCH FLIPLOK 3ML 21GX1.5	T3	
EASY TOUCH FLURINGE	T2	
EASY TOUCH FLURINGE FLIPLOCK	T2	
EASY TOUCH FLURINGE FLU TRAY	T3	
EASY TOUCH FLURINGE SHEATHLOCK	T2	
EASY TOUCH LUER LOCK INSULIN	T3	
EASY TOUCH LUER LOCK SYRINGE	T3	

T1 – Generics
T2 – Preferred Brands
T3 – Non-Preferred Brands
T4 – Preferred Specialty
T5 – Non-Preferred Specialty
PA – Prior Authorization
QL – Quantity Limit
ST – Step Therapy
AGE – Age Requirement
SP – Specialty Medication
HD – May require home delivery pharmacy
PPACA – No Cost-Share Preventive Medication
CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

MISCELLANEOUS MEDICAL SUPPLIES, DEVICES, NON-DRUG (Diabetes) (cont.)		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
SYRINGES AND ACCESSORIES (cont.)		
EASY TOUCH SHEATHLOCK SYRG-NDL	T3	
EASY TOUCH SHEATHLOCK SYRINGE	T3	
EASY TOUCH SYR 1 ML 25GX5/8"	T2	
EASY TOUCH SYR 3 ML 22GX1-1/2"	T2	
EASY TOUCH SYR 3 ML 25GX5/8"	T2	
EASY TOUCH SYR ALLERGY TRAY	T3	
EASY TOUCH SYRINGE 1 ML 25GX1"	T2	
EASY TOUCH SYRINGE 3 ML 20GX1"	T2	
EASY TOUCH SYRINGE 3 ML 21GX1"	T2	
EASY TOUCH SYRINGE 3 ML 22GX1"	T2	
EASY TOUCH SYRINGE 3 ML 23GX1"	T2	
EASY TOUCH SYRINGE 3 ML 25GX1"	T2	
EASY TOUCH TUBERCULIN FLIPLOCK	T2	
EASY TOUCH TUBERCULIN SHEATHLK	T2	
EASY TOUCH UNI-SLIP	T3	
ECLIPSE SYRINGE	T2	
ECLIPSE SYRINGE-NEEDLE	T2	
EXEL SYRINGE	T2	
EXEL TB WITH NEEDLE	T2	
EXEL TUBERCULIN SYRINGE	T2	
EXTENDED RESERVOIR	T3	
FILTER, MILLEX-OR SYRINGE	T3	
FINGER GRIP EXTENDER	T3	
INJECT-EASE	T2	
INSULIN CARTRIDGE	T2	
INSULIN SYRINGE U-500	T2	
INTEGRA SYRINGE	T2	
INTERLINK SYRINGE	T2	
INTERLINK SYRINGE W-CANNULA	T3	
KENDALL DISINFECTANT CAP	T3	
LEVER LOCK CANNULA	T3	
LIFESHIELD BLUNT CANNULA	T2	
LUER LOCK SYRINGE	T2	
LUER SLIP TIP SYRINGE TRAY	T3	

T1 – Generics
T2 – Preferred Brands
T3 – Non-Preferred Brands
T4 – Preferred Specialty
T5 – Non-Preferred Specialty
PA – Prior Authorization
QL – Quantity Limit
ST – Step Therapy
AGE – Age Requirement
SP – Specialty Medication
HD – May require home delivery pharmacy
PPACA – No Cost-Share Preventive Medication
CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

MISCELLANEOUS MEDICAL SUPPLIES, DEVICES, NON-DRUG (Diabetes) (cont.)		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
SYRINGES AND ACCESSORIES (cont.)		
LUER TIP CAP TRAY	T3	
LUER-LOK SYRINGE	T2	
LUER-LOK SYRINGE-NEEDLE	T2	
LUER-LOK TIP SYRINGE	T2	
LUERSLIP SYRINGE	T2	
MAGELLAN SAFETY SYRINGE	T2	
MAGELLAN TB SAFETY SYRINGE	T2	
MAGELLAN TUBERCULIN SYRINGE	T2	
MINIMED RESERVOIR 1.8 ML	T3	
MINIMED RESERVOIR 3 ML	T2	
MONOJECT 3 ML SYRINGE 25GX1"	T2	
MONOJECT 6CC SAFETY SYRINGE	T2	
MONOJECT ALLERGY TRAY-NEEDLE	T2	
MONOJECT CONTROL SYRINGE	T2	
MONOJECT ENFIT SYRINGE	T3	
MONOJECT ENFIT SYRINGE CAP	T3	
MONOJECT LUER LOCK TB SYRINGE	T2	
MONOJECT MAGELLAN	T2	
MONOJECT PHARMACY TRAY	T2	
MONOJECT SAFETY SYR TIP CAP	T3	
MONOJECT SAFETY SYRINGE	T2	
MONOJECT SMARTIP CANNULA	T3	
MONOJECT SYRINGE	T2	
MONOJECT SYRINGE 140 ML	T3	
MONOJECT SYRINGE 35 ML	T2	
MONOJECT SYRINGE PHARMACY TRAY	T2	
MONOJECT TB	T2	
MONOJECT TB SYRINGE	T2	
MONOJECT TUBERCULIN SAFETY SYR	T2	
MONOJECT TUBERCULIN SYRINGE	T2	
NORM-JECT SYRINGE	T3	
NORM-JECT TUBERKULIN SYRINGE	T3	
PARADIGM	T2	
PISTON ENFIT SYRINGE	T3	

T1 – Generics
T2 – Preferred Brands
T3 – Non-Preferred Brands
T4 – Preferred Specialty
T5 – Non-Preferred Specialty
PA – Prior Authorization
QL – Quantity Limit
ST – Step Therapy
AGE – Age Requirement
SP – Specialty Medication
HD – May require home delivery pharmacy
PPACA – No Cost-Share Preventive Medication
CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

MISCELLANEOUS MEDICAL SUPPLIES, DEVICES, NON-DRUG (Diabetes) (cont.)		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
SYRINGES AND ACCESSORIES (cont.)		
PRECISIONGLIDE	T2	
PRODIGY COUNT-A-DwOSE	T2	
SAFESNAP ALLERGY SYRINGE	T3	
SAFESNAP SYRINGE 10 ML	T2	
SAFESNAP SYRINGE 10 ML	T3	
SAFESNAP SYRINGE 3 ML	T2	
SAFESNAP SYRINGE 5 ML	T2	
SAFESNAP SYRINGE 5 ML	T3	
SAFESNAP TUBERCULIN SYRINGE	T3	
SAFETY SYRINGE WITH SHIELD	T2	
SAFETY SYRINGE-NEEDLE	T3	
SAFETYGLIDE ALLERGY	T2	
SAFETYGLIDE ALLERGY SYRINGE	T3	
SAFETYGLIDE INSULIN SYRINGE	T2	
SAFETYGLIDE TB SYRINGE	T2	
SAFETY-LOK SAFETY SYRINGE	T2	
SAFETY-LOK SAFETY SYRINGES	T2	
SAFETY-LOK SYRINGES	T2	
SLIP-TIP SYRINGE	T3	
SUPOR	T3	
SYRINGE	T2	
SYRINGE BULK	T2	
SYRINGE CATHETER TIP	T2	
SYRINGE CATHETER TIP NON-STER	T2	
SYRINGE FILTER, MILLEX-GP	T3	
SYRINGE FILTER, MILLEX-GS	T3	
SYRINGE LUER-LOK	T2	
SYRINGE LUER-LOK NON-STERILE	T2	
SYRINGE LUER-LOK STERILE	T2	
SYRINGE SLIP TIP NON-STERILE	T2	
SYRINGE STORAGE BIN	T3	
SYRINGE TIP CAP	T2	
SYRINGE WITH NEEDLE DISP	T2	
SYRINGE WITHOUT NEEDLE	T2	

T1 – Generics
T2 – Preferred Brands
T3 – Non-Preferred Brands
T4 – Preferred Specialty
T5 – Non-Preferred Specialty
PA – Prior Authorization
QL – Quantity Limit
ST – Step Therapy
AGE – Age Requirement
SP – Specialty Medication
HD – May require home delivery pharmacy
PPACA – No Cost-Share Preventive Medication
CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

MISCELLANEOUS MEDICAL SUPPLIES, DEVICES, NON-DRUG (Diabetes) (cont.)		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
SYRINGES AND ACCESSORIES (cont.)		
SYRINGE-LUER TIP CAP	T2	
SYRINGE-NEEDLE	T2	
SYRINGE-PRECISIONGLIDE NEEDLE	T2	
TB SYRINGE	T2	
TERUMO ALLERGY SYRINGE	T2	
TERUMO HYPODERMIC NEEDLE-SYRIN	T2	
TERUMO SURGUARD2	T2	
TERUMO SYRINGE	T2	
TOOMEY SYRINGE	T2	
TUBERCULIN SYRINGE	T2	
TUBERCULIN SYRINGE-NEEDLE	T2	
TWINPAK DUAL CANNULA	T2	
ULTICARE LDS SYR 1 ML 22G 1.5"	T3	
ULTICARE LDS SYR 3 ML 22GX1.5"	T2	
ULTICARE SAFETY SYRINGE	T3	
ULTICARE SYRINGE	T3	
ULTICARE TB SAFETY 1 ML 25GX1"	T2	
ULTICARE TB SAFETY 1ML 25GX5/8	T2	
ULTICARE TB SAFETY SYRINGE	T2	
ULTIGUARD SAFE 1ML 30G 12.7MM	T3	
ULTIGUARD SAFEPACK 1ML 31G 8MM	T3	
UNIVERSAL SYRINGE TIP ADAPTOR	T3	
VANISHPOINT 1 ML TB SYR 25X5/8	T2	
VANISHPOINT 1 ML TB SYR 27X1/2	T2	
VANISHPOINT 20GX1" 3 ML SYRING	T2	
VANISHPOINT 21GX1" 5 ML SYRING	T2	
VANISHPOINT 21GX1.5" 3 ML SYR	T2	
VANISHPOINT 22GX1" 3 ML SYR	T2	
VANISHPOINT 22GX1-1/2" 5 ML SY	T2	
VANISHPOINT 23GX1" 3 ML SYRING	T2	
VANISHPOINT 23GX1-1/2 3 ML SYR	T2	
VANISHPOINT 25GX1" 3 ML SYRING	T2	
VANISHPOINT 25GX5/8" 3 ML SYR	T2	
VANISHPOINT 3 ML 21GX1" SYRING	T2	

T1 – Generics
T2 – Preferred Brands
T3 – Non-Preferred Brands
T4 – Preferred Specialty
T5 – Non-Preferred Specialty
PA – Prior Authorization
QL – Quantity Limit
ST – Step Therapy
AGE – Age Requirement
SP – Specialty Medication
HD – May require home delivery pharmacy
PPACA – No Cost-Share Preventive Medication
CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

MISCELLANEOUS MEDICAL SUPPLIES, DEVICES, NON-DRUG (Diabetes) (cont.)		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
SYRINGES AND ACCESSORIES (cont.)		
VANISHPOINT 3 ML 22GX1.5" SYRG	T2	
VANISHPOINT SYRINGE	T3	
VANISHPOINT SYRINGE 1 ML 25X1"	T2	
VEO INSULIN SYRINGE	T2	
MISCELLANEOUS MEDICAL SUPPLIES, DEVICES, NON-DRUG (Miscellaneous)		
BANDAGES AND RELATED SUPPLIES		
ARGLAES FILM	T3	
CONFORMANT 2	T3	
DERMAVIEW	T2	
DERMAVIEW II	T2	
IV 3000	T2	
IV3000 FRAME DELIVERY	T3	
KENDALL	T2	
NEXCARE TEGADERM 2.375"X2.75"	T3	
NEXCARE TEGADERM DRESSING	T2	
OPSITE	T3	
OPSITE IV 3000	T2	
POLYSKIN II	T2	
SURESITE MATRIX	T2	
SURESITE WINDOW	T2	
TEGADERM 1.75X1.75" DRSSNG	T3	
TEGADERM 2"X2.75" DRESSING	T2	
TEGADERM 2.375"X2.75" DRESSING	T2	
TEGADERM 2.375"X4" DRESSING	T2	
TEGADERM 2.375X2.75" DRSSNG	T2	
TEGADERM 3.5" X 4" DRESSING	T2	
TEGADERM 3.5"X 10" DRESSING	T3	
TEGADERM 3.5"X 6" DRESSING	T3	
TEGADERM 3.5"X13.75" DRESS	T3	
TEGADERM 3.5"X4.125" DRESS	T2	
TEGADERM 3.5"X8" DRESSING	T3	
TEGADERM 4" X 10" DRESSING	T2	
TEGADERM 4" X 4-3/4" DRESSING	T2	

T1 – Generics
T2 – Preferred Brands
T3 – Non-Preferred Brands
T4 – Preferred Specialty
T5 – Non-Preferred Specialty
PA – Prior Authorization
QL – Quantity Limit
ST – Step Therapy
AGE – Age Requirement
SP – Specialty Medication
HD – May require home delivery pharmacy
PPACA – No Cost-Share Preventive Medication
CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

MISCELLANEOUS MEDICAL SUPPLIES, DEVICES, NON-DRUG (Miscellaneous) (cont.)		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
BANDAGES AND RELATED SUPPLIES (cont.)		
TEGADERM 4"X4.75" DRESSING	T2	
TEGADERM 6" X 8" DRESSING	T2	
TEGADERM 8" X 12" DRESSING	T2	
TEGADERM ABSORBENT	T3	
TEGADERM HP 4" X 4.5 " DRSSN	T2	
TEGADERM HP 4.5"X4.75" DRSS	T2	
TEGADERM HP DRESSING	T2	
TEGADERM HP DRESSING	T3	
TEGADERM I.V.	T3	
TEGADERM I.V. 2.5"X2.75" DRSSN	T3	
TEGADERM I.V. 4"X4.75" DRSSN	T2	
TRANSPARENT DRESSING	T3	
TRANSPARENT FILM DRESSING	T3	
TRANSPARENT I.V. SITE DRESSING	T2	
TRANSPARENT MEPITEL FILM DRESS	T3	
TRANSPARENT THIN FILM DRESSING	T2	
WINDOW BANDAGES	T3	
DURABLE MEDICAL EQUIPMENT,MISC(GROUP I)		
1ST TIER UNILET COMFORTOUCH	T2	
2-IN-1 LANCET DEVICE	T2	
ACCU-CHEK FASTCLIX LANCET DRUM	T2	
ACCU-CHEK SAFE-T-PRO	T2	
ACCU-CHEK SAFE-T-PRO PLUS	T2	
ACCU-CHEK SOFTCLIX	T2	
acti-lance lite 28g lancets	T1	
acti-lance special 17g lancets	T1	
ACTI-LANCE UNIVERS 23G LANCETS	T2	
acti-lance univers 23g lancets	T1	
ADVANCED TRAVEL LANCETS	T2	
ADVOCATE LANCET	T2	
ADVOCATE LANCETS	T2	
ADVOCATE SAFETY LANCET	T2	
ALTERNATE SITE LANCETS	T2	
ASSURE HAEMOLANCE PLUS	T2	

T1 – Generics
T2 – Preferred Brands
T3 – Non-Preferred Brands
T4 – Preferred Specialty
T5 – Non-Preferred Specialty
PA – Prior Authorization
QL – Quantity Limit
ST – Step Therapy
AGE – Age Requirement
SP – Specialty Medication
HD – May require home delivery pharmacy
PPACA – No Cost-Share Preventive Medication
CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

MISCELLANEOUS MEDICAL SUPPLIES, DEVICES, NON-DRUG (Miscellaneous) (cont.)		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
DURABLE MEDICAL EQUIPMENT,MISC(GROUP I) (cont.)		
ASSURE LANCE	T2	
ASSURE LANCE PLUS	T2	
BD MICROTAINER LANCETS	T2	
BD ULTRA-FINE	T2	
BD ULTRA-FINE II	T2	
BLOOD LANCETS	T2	
BULLSEYE MINI SAFETY LANCETS	T2	
BUTTERFLY TOUCH LANCET	T2	
CAREONE	T2	
CARESENS LANCET	T2	
CARETOUCH SAFETY LANCETS	T2	
CARETOUCH TWIST LANCET	T2	
CLEVER CHEK LANCETS	T2	
COAGUCHEK	T2	
COLOR LANCETS	T2	
COMFORT EZ	T2	
COMFORT LANCETS	T2	
DROPLET LANCETS	T2	
EASY COMFORT LANCETS	T2	
EASY TOUCH BUTTON 30G LANCETS	T2	
EASY TOUCH PULL-TOP 26G LANCET	T2	
EASY TOUCH PULL-TOP 28G LANCET	T2	
EASY TOUCH PULL-TOP 30G LANCET	T2	
EASY TOUCH PULL-TOP 32G LANCET	T2	
EASY TOUCH SAFETY 21G LANCETS	T2	
EASY TOUCH SAFETY 23G LANCETS	T2	
EASY TOUCH SAFETY 26G LANCETS	T2	
EASY TOUCH SAFETY 28G LANCETS	T2	
EASY TOUCH SAFETY 30G LANCETS	T2	
EASY TOUCH SAFETY 32G LANCETS	T2	
EASY TOUCH TWIST 26G LANCETS	T2	
EASY TOUCH TWIST 28G LANCETS	T2	
EASY TOUCH TWIST 30G LANCETS	T2	
EASY TOUCH TWIST 32G LANCETS	T2	

T1 – Generics
T2 – Preferred Brands
T3 – Non-Preferred Brands
T4 – Preferred Specialty
T5 – Non-Preferred Specialty
PA – Prior Authorization
QL – Quantity Limit
ST – Step Therapy
AGE – Age Requirement
SP – Specialty Medication
HD – May require home delivery pharmacy
PPACA – No Cost-Share Preventive Medication
CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

MISCELLANEOUS MEDICAL SUPPLIES, DEVICES, NON-DRUG (Miscellaneous) (cont.)		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
DURABLE MEDICAL EQUIPMENT,MISC(GROUP I) (cont.)		
EASY TOUCH TWIST 33G LANCETS	T2	
EASY TWIST CAP LANCETS	T2	
EMBRACE 30G LANCETS	T2	
EMBRACE SAFETY LANCET	T2	
EZ SMART LANCETS	T2	
EZ-LETS	T2	
FIFTY50 SAFETY SEAL LANCETS	T2	
FINE 30 UNIVERSAL LANCETS	T2	
FINGERSTIX	T2	
FORA LANCETS	T2	
FORACARE LANCETS	T2	
FREESTYLE LANCETS	T2	
FREESTYLE UNISTIK 2	T2	
GLUCOCOM	T2	
GLUCOCOM LANCETS	T2	
GOJJI LANCETS	T2	
HEALTHY ACCENTS UNILET LANCET	T2	
INCONTROL SUPER THIN LANCETS	T2	
INCONTROL ULTRA THIN LANCETS	T2	
INJECT EASE LANCETS	T2	
INVACARE LANCETS	T2	
lancets	T1	
LANCETS	T2	
LANCETS THIN	T2	
LANCETS ULTRA THIN	T2	
LITE TOUCH 28G LANCETS	T2	
LITE TOUCH 30G LANCETS	T2	
LITE TOUCH 33G LANCETS	T2	
MEDISENSE THIN LANCETS	T2	
MEDLANCE PLUS 21G LANCETS	T2	
medlance plus 21g lancets	T1	
MEDLANCE PLUS 30G LANCETS	T2	
medlance plus 30g lancets	T1	
MEDLANCE PLUS EXTRA 21G LANCET	T2	

T1 – Generics
T2 – Preferred Brands
T3 – Non-Preferred Brands
T4 – Preferred Specialty
T5 – Non-Preferred Specialty
PA – Prior Authorization
QL – Quantity Limit
ST – Step Therapy
AGE – Age Requirement
SP – Specialty Medication
HD – May require home delivery pharmacy
PPACA – No Cost-Share Preventive Medication
CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

MISCELLANEOUS MEDICAL SUPPLIES, DEVICES, NON-DRUG (Miscellaneous) (cont.)		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
DURABLE MEDICAL EQUIPMENT,MISC(GROUP I) (cont.)		
MEDLANCE PLUS LITE 25G LANCETS	T2	
medlance plus lite 25g lancets	T1	
MEDLANCE PLUS SPECIAL BLADE	T2	
MICRO THIN LANCET	T2	
MICRO THIN LANCETS	T2	
MICROLET	T2	
MICROTAINER LANCETS	T2	
MONOLET LANCETS	T2	
MONOLET THIN LANCETS	T2	
MYGLUCOHEALTH LANCETS	T2	
NOVA SAFETY LANCETS	T2	
NOVA SUREFLEX	T2	
ON CALL LANCET	T2	
ON CALL PLUS LANCET	T2	
ONETOUCH DELICA	T2	
ONETOUCH DELICA PLUS LANCET	T2	
ONETOUCH DELICA SAFETY LANCET	T2	
ONETOUCH LANCETS	T2	
ONETOUCH SURESOFT	T2	
ON-THE-GO	T2	
PIP LANCET	T2	
PRESSURE ACTIVATED LANCETS	T2	
PRO COMFORT LANCET	T2	
PRO COMFORT LANCETS	T2	
PRODIGY LANCETS	T2	
PRODIGY TWIST TOP LANCET	T2	
PURE COMFORT LANCETS	T2	
PURE COMFORT SAFETY LANCETS	T2	
PUSH BUTTON SAFETY LANCETS	T2	
READYLANCE SAFETY LANCETS	T2	
RELIAMED	T2	
RELIAMED SAFETY SEAL LANCETS	T2	
RELION THIN	T2	
RIGHTEST GL300 LANCETS	T2	

T1 – Generics
T2 – Preferred Brands
T3 – Non-Preferred Brands
T4 – Preferred Specialty
T5 – Non-Preferred Specialty
PA – Prior Authorization
QL – Quantity Limit
ST – Step Therapy
AGE – Age Requirement
SP – Specialty Medication
HD – May require home delivery pharmacy
PPACA – No Cost-Share Preventive Medication
CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

MISCELLANEOUS MEDICAL SUPPLIES, DEVICES, NON-DRUG (Miscellaneous) (cont.)		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
DURABLE MEDICAL EQUIPMENT,MISC(GROUP I) (cont.)		
SAFETY LANCETS	T2	
SAFETY SEAL LANCETS	T2	
SAFETY-LET	T2	
SINGLE-LET	T2	
SMART SENSE	T2	
SMART SENSE LANCETS	T2	
SMARTEST LANCET	T2	
SOFT TOUCH	T2	
SOLUS V2	T2	
SOLUS V2 LANCETS	T2	
STERILANCE TL	T2	
STERILE LANCETS	T2	
SUPER THIN LANCETS	T2	
SURE COMFORT LANCETS	T2	
SURE-LANCE	T2	
SURE-TOUCH	T2	
TECHLITE LANCETS	T2	
TELCARE ULTRA THIN 30G LANCETS	T2	
THIN LANCETS	T2	
TOPCARE UNIVERSAL1 LANCET	T2	
TOPCARE UNIVERSAL1 THIN LANCET	T2	
TRUE COMFORT LANCET	T2	
TRUEPLUS LANCET	T2	
TRUEPLUS LANCETS	T2	
TWIST LANCETS	T2	
TWIST TOP LANCET	T2	
ULTILET BASIC	T2	
ULTILET CLASSIC	T2	
ULTILET LANCETS	T2	
ULTILET SAFETY	T2	
ULTRA THIN LANCET	T2	
ULTRA THIN LANCETS	T2	
ULTRA THIN PLUS	T2	
ULTRA THIN PLUS LANCETS	T2	

T1 – Generics
T2 – Preferred Brands
T3 – Non-Preferred Brands
T4 – Preferred Specialty
T5 – Non-Preferred Specialty
PA – Prior Authorization
QL – Quantity Limit
ST – Step Therapy
AGE – Age Requirement
SP – Specialty Medication
HD – May require home delivery pharmacy
PPACA – No Cost-Share Preventive Medication
CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

MISCELLANEOUS MEDICAL SUPPLIES, DEVICES, NON-DRUG (Miscellaneous) (cont.)		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
DURABLE MEDICAL EQUIPMENT,MISC(GROUP I) (cont.)		
ULTRA-CARE LANCETS	T2	
ULTRALANCE	T2	
ULTRA-THIN II 28G LANCETS	T2	
ULTRA-THIN II 30G LANCETS	T2	
ULTRATLC LANCETS	T2	
UNILET COMFORTOUCH	T2	
UNILET EXCELITE	T2	
UNILET EXCELITE II	T2	
UNILET GP LANCET	T2	
UNILET LANCET	T2	
UNILET LANCETS	T2	
UNISTIK 2 COMFORT	T2	
UNISTIK 2 EXTRA	T2	
UNISTIK 2 NORMAL	T2	
UNISTIK 3	T2	
UNISTIK 3 COMFORT	T2	
UNISTIK 3 DUAL	T2	
UNISTIK 3 EXTRA	T2	
UNISTIK COMFORT	T2	
UNISTIK CZT	T2	
UNISTIK EXTRA	T2	
UNISTIK NORMAL	T2	
UNISTIK PRO	T2	
UNISTIK SAFETY	T2	
UNISTIK TOUCH	T2	
UNIVERSAL 1	T2	
VIVAGUARD LANCET	T2	
MEDICAL SUPPLIES,MISCELLANEOUS		
ALCOH-GLOVE	T3	
ALCOH-WIPE	T3	
PARENTERAL ADMINISTRATION SETS		
1.5 VOLT BATTERIES #357	T2	
ACCU-CHEK LINKASSIST	T3	
ACCU-CHEK RAPID D 10-100	T3	

T1 – Generics
T2 – Preferred Brands
T3 – Non-Preferred Brands
T4 – Preferred Specialty
T5 – Non-Preferred Specialty
PA – Prior Authorization
QL – Quantity Limit
ST – Step Therapy
AGE – Age Requirement
SP – Specialty Medication
HD – May require home delivery pharmacy
PPACA – No Cost-Share Preventive Medication
CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

MISCELLANEOUS MEDICAL SUPPLIES, DEVICES, NON-DRUG (Miscellaneous) (cont.)		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
PARENTERAL ADMINISTRATION SETS (cont.)		
ACCU-CHEK RAPID D 10-50	T3	
ACCU-CHEK RAPID D 10-70	T2	
ACCU-CHEK RAPID D 6-100	T3	
ACCU-CHEK RAPID D 6-50	T2	
ACCU-CHEK RAPID D 6-70	T3	
ACCU-CHEK RAPID D 8-100	T3	
ACCU-CHEK RAPID D 8-50	T2	
ACCU-CHEK RAPID D 8-70	T2	
ACCU-CHEK SPIRIT	T2	
ACCU-CHEK TENDER	T2	
ACCU-CHEK ULTRAFLEX	T2	
DELTEC COZMO CLEO INFUSION SET	T2	
INSET 30 TUBING	T2	
IV ADMINISTRATION SET	T2	
NERIA	T3	
PARADIGM INFUSION	T2	
PARADIGM SILHOUETTE	T2	
POLYFIN QR	T2	
PSV SET	T3	
Q-SYTE	T2	
SILHOUETTE	T2	
SURE-T	T2	
RESPIRATORY AIDS,DEVICES,EQUIPMENT		
ACE AEROSOL CLOUD ENHANCER	T2	
AEROCHAMBER MINI	T2	
AEROCHAMBER MV	T2	
AEROCHAMBER PLUS FLOW-VU	T2	
AEROCHAMBER Z-STAT PLUS	T2	
AEROTRACH PLUS	T2	
AEROVENT PLUS	T2	
BREATHERITE	T2	
BREATHERITE SPACER-ADULT MASK	T2	
BREATHERITE SPACER-INFANT MASK	T2	
BREATHERITE SPACER-LG CHLD MSK	T2	

T1 – Generics
T2 – Preferred Brands
T3 – Non-Preferred Brands
T4 – Preferred Specialty
T5 – Non-Preferred Specialty
PA – Prior Authorization
QL – Quantity Limit
ST – Step Therapy
AGE – Age Requirement
SP – Specialty Medication
HD – May require home delivery pharmacy
PPACA – No Cost-Share Preventive Medication
CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

MISCELLANEOUS MEDICAL SUPPLIES, DEVICES, NON-DRUG (Miscellaneous) (cont.)		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
RESPIRATORY AIDS,DEVICES,EQUIPMENT (cont.)		
BREATHERITE SPACER-NEONATE MSK	T2	
BREATHERITE SPACER-SM CHLD MSK	T2	
BREATHRITE	T2	
CLEVER CHOICE HOLDING CHAMBER	T2	
COMFORTSEAL	T2	
COMPACT SPACE CHAMBER	T2	
EASIVENT	T2	
FLEXICHAMBER	T2	
FLEXICHAMBER MASK	T2	
INSPIRACHAMBER	T2	
LITEAIRE	T2	
LITETOUCH	T2	
MICROCHAMBER	T2	
MICROSPACER	T2	
MOUTHPIECE	T2	
ONE WAY MOUTHPIECE	T2	
OPTICHAMBER	T2	
OPTICHAMBER DIAMOND	T2	
PANDA MASK	T2	
PEDIATRIC MASK	T2	
PEDIATRIC PANDA MASK	T2	
POCKET CHAMBER	T2	
PRIMEAIRE	T2	
PRO COMFORT SPACER-ADULT MASK	T2	
PRO COMFORT SPACER-CHILD MASK	T3	
PRO COMFORT SPACER-INFANT MASK	T3	
PROCARE SPACER WITH ADULT MASK	T2	
PROCARE SPACER WITH CHILD MASK	T2	
PROCHAMBER	T2	
PURE COMFORT SPACER WITH MASK	T3	
RITEFLO	T2	
SIDESTREAM PEDIATRIC	T2	
SILICONE MASK	T2	
SPACE CHAMBER	T2	

T1 – Generics
T2 – Preferred Brands
T3 – Non-Preferred Brands
T4 – Preferred Specialty
T5 – Non-Preferred Specialty
PA – Prior Authorization
QL – Quantity Limit
ST – Step Therapy
AGE – Age Requirement
SP – Specialty Medication
HD – May require home delivery pharmacy
PPACA – No Cost-Share Preventive Medication
CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

MISCELLANEOUS MEDICAL SUPPLIES, DEVICES, NON-DRUG (Miscellaneous) (cont.)		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
RESPIRATORY AIDS,DEVICES,EQUIPMENT (cont.)		
SPACE CHAMBER-LARGE MASK	T2	
SPACE CHAMBER-MEDIUM MASK	T2	
SPACE CHAMBER-SMALL MASK	T2	
VORTEX	T2	
VORTEX VHC FROG MASK	T2	
VORTEX VHC LADYBUG MASK	T2	
MUSCLE RELAXANTS (Pain Relief and Inflammatory Disease)		
SKELETAL MUSCLE RELAX.-TOP. IRRITANT COUNTER-IRRIT		
COMFORT PAC-CYCLOBENZAPRINE	T3	
COMFORT PAC-TIZANIDINE	T3	
SKELETAL MUSCLE RELAXANTS		
baclofen 5 mg tablet	T1	
baclofen 10 mg tablet	T1	
baclofen 20 mg tablet	T1	
baclofen 25mg/5ml suspension (Fleqsuvy)	T1	
carisoprodol (Soma)	T1	
carisoprodol/aspirin	T1	
chlorzoxazone	T1	
chlorzoxazone (Lorzone)	T1	
cyclobenzaprine hcl	T1	
cyclobenzaprine hcl (Amrix)	T1	PA
cyclobenzaprine hcl (Fexmid)	T1	
DANTRIUM *(dantrolene sodium)*	T3	
dantrolene sodium	T1	
dantrolene sodium (Dantrium)	T1	
FEXMID *(cyclobenzaprine hcl)*	T3	PA
LORZONE *(chlorzoxazone)*	T3	PA
metaxalone	T1	
methocarbamol 500 mg tablet	T1	
methocarbamol 750 mg tablet	T1	
NORGESIC (*orphenadrine/aspirin/caffeine)*	T3	
NORGESIC FORTE (*orphenadrine/aspirin/caffeine*)	T3	
orphenadrine citrate	T1	

T1 – Generics
T2 – Preferred Brands
T3 – Non-Preferred Brands
T4 – Preferred Specialty
T5 – Non-Preferred Specialty
PA – Prior Authorization
QL – Quantity Limit
ST – Step Therapy
AGE – Age Requirement
SP – Specialty Medication
HD – May require home delivery pharmacy
PPACA – No Cost-Share Preventive Medication
CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

MUSCLE RELAXANTS (Pain Relief and Inflammatory Disease) (cont.)		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
SKELETAL MUSCLE RELAXANTS (cont.)		
orphenadrine/aspirin/caffeine (Norgesic Forte)	T1	
orphenadrine/aspirin/caffeine (Norgesic)	T1	
SOMA (*carisoprodol*)	T3	
tizanidine hcl	T1	
tizanidine hcl (Zanaflex)	T1	
ZANAFLEX (*tizanidine hcl*)	T3	
PRE-NATAL VITAMINS (Nutritional/Dietary)		
PRENATAL VITAMIN PREPARATIONS		
BAL-CARE DHA ESSENTIAL	T3	
BRAINSTRONG PRENATAL	T3	
CADEAU DHA	T3	
CITRANATAL 90 DHA	T3	
CITRANATAL ASSURE	T3	
CITRANATAL B-CALM	T3	
CITRANATAL DHA	T3	
CITRANATAL HARMONY	T3	
CITRANATAL RX	T3	
CVS PRENATAL GUMMY VITAMINS	T3	
cvs prenatal multi-dha softgel	T1	PPACA
cvs prenatal vitamins tablet	T1	PPACA
DUET DHA 400	T3	
DUET DHA BALANCED	T3	
EXPECTA PRENATAL	T2	
gnp prenatal vitamins tablet	T1	PPACA
GS PRENATAL VITAMINS TABLET	T3	
HM ONE DAILY PRENATAL COMBO PK	T2	
hm prenatal tablet	T1	PPACA
KOSHER PRENATAL PLUS IRON	T3	
KPN PRENATAL TABLET	T2	
kpn tablet	T1	PPACA
MARNATAL-F	T3	
MINI PRENATAL	T3	
MTERYTI	T3	

T1 – Generics
T2 – Preferred Brands
T3 – Non-Preferred Brands
T4 – Preferred Specialty
T5 – Non-Preferred Specialty
PA – Prior Authorization
QL – Quantity Limit
ST – Step Therapy
AGE – Age Requirement
SP – Specialty Medication
HD – May require home delivery pharmacy
PPACA – No Cost-Share Preventive Medication
CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

PRE-NATAL VITAMINS (Nutritional/Dietary) (cont.)		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
PRENATAL VITAMIN PREPARATIONS (cont.)		
MTERYTI FOLIC 5	T3	
NATACHEW	T3	
NEONATAL COMPLETE	T3	
NEONATAL PLUS	T3	
NEONATAL-DHA	T3	
NESTABS	T3	
NESTABS ABC	T3	
NESTABS DHA	T3	
OB COMPLETE ONE	T3	
OB COMPLETE PETITE	T3	
OB COMPLETE PREMIER	T3	
OB COMPLETE WITH DHA	T3	
OBSTETRIX EC	T3	
OBTREX DHA	T3	
ONE A DAY WOMEN'S PRENATAL DHA	T3	
ONE-A-DAY PRENATAL-1	T3	
pnv 11/iron fum/folic acid/om3	T1	
pnv 119/iron fum/folic acid	T1	
pnv 66/iron/folic/docusate/dha	T1	
pnv 69/iron/folic/docusate/dha	T1	
pnv 80/iron fum/folic/dss/dha	T1	
pnv cmb 52/iron/fa/omega-3/dha	T1	
pnv no.118/iron fumarate/fa	T1	
pnv,calcium 72/iron,carb/folic	T1	
pnv,calcium 72/iron/folic acid	T1	
pnv/iron,carb/docusat/folic ac	T1	
pnv19/iron bg,s.p/folic ac/om3	T1	
pnv81/iron edta,ps/folic/omeg3	T1	
PRENATA	T3	
prenatal 105/iron/folic ac/dha	T1	
prenatal 12/iron/folic/dss/om3	T1	
PRENATAL 19 CHEWABLE TABLET	T3	
prenatal 19 chewable tablet	T1	
PRENATAL 19 TABLET	T3	

T1 – Generics
T2 – Preferred Brands
T3 – Non-Preferred Brands
T4 – Preferred Specialty
T5 – Non-Preferred Specialty
PA – Prior Authorization
QL – Quantity Limit
ST – Step Therapy
AGE – Age Requirement
SP – Specialty Medication
HD – May require home delivery pharmacy
PPACA – No Cost-Share Preventive Medication
CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

PRE-NATAL VITAMINS (Nutritional/Dietary) (cont.)		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
PRENATAL VITAMIN PREPARATIONS (cont.)		
prenatal 19 tablet	T1	
prenatal 21/iron fu/folic acid	T1	PPACA
prenatal 53/iron/folic ac/omg3	T1	
prenatal 54/iron/folic ac/omg3	T1	
prenatal 93/iron/folate 9/dha	T1	
prenatal caplet	T1	PPACA
prenatal comb no.42/folic acid (Vitamedmd Redichew Rx)	T1	
PRENATAL FORMULA	T2	
PRENATAL FORMULA-DHA *(prenatal vit116/iron/folic/dha)*	T3	
PRENATAL GUMMIES	T3	
PRENATAL MULTI	T3	
prenatal multi-dha softgel	T1	PPACA
PRENATAL MULTI-DHA SOFTGEL	T2	
PRENATAL MULTI-DHA SOFTGEL	T3	
prenatal multivitamin tablet	T1	PPACA
PRENATAL MULTIVITAMIN TABLET	T3	
PRENATAL MULTIVITAMIN-DHA	T2	
PRENATAL PLUS VITAMIN-MINERAL	T3	
PRENATAL PLUS-DHA	T3	
prenatal tablet	T1	PPACA
PRENATAL TABLET	T3	
prenatal vit 14/iron fum/folic	T1	
prenatal vit 55/iron/folic/om3	T1	
prenatal vit 91/iron/folic/dha	T1	
prenatal vit no.126/iron/folic	T1	PPACA
prenatal vit no.129/iron/folic	T1	PPACA
prenatal vit,cal 73/iron/folic	T1	
prenatal vit,calc76/iron/folic	T1	
prenatal vit,calc78/iron/folic	T1	
prenatal vit/iron fum/folic ac	T1	
prenatal vit27,calcium/iron/fa	T1	
prenatal vit86/iron/folic acid	T1	
PRENATAL VITAMIN + DHA	T2	
prenatal vitamin tablet	T1	PPACA

T1 – Generics
T2 – Preferred Brands
T3 – Non-Preferred Brands
T4 – Preferred Specialty
T5 – Non-Preferred Specialty
PA – Prior Authorization
QL – Quantity Limit
ST – Step Therapy
AGE – Age Requirement
SP – Specialty Medication
HD – May require home delivery pharmacy
PPACA – No Cost-Share Preventive Medication
CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

PRE-NATAL VITAMINS (Nutritional/Dietary) (cont.)		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
PRENATAL VITAMIN PREPARATIONS (cont.)		
PRENATAL VITAMIN TABLET *(prenatal vit no.124/iron/folic)*	T3	
prenatal vitamins tablet	T1	PPACA
prenatal vits calc.36/iron/fa	T1	PPACA
prenatal,calc.40/iron/folate 1	T1	
prenatal71/iron/folic acid/dha	T1	
PRENATE DHA	T3	
PRENATE ELITE	T3	
PRENATE ENHANCE	T3	
PRENATE MINI	T3	
PRENATE PIXIE	T3	
PRENATE RESTORE	T3	
PRENATE STAR	T3	
PRIMACARE	T3	
PROVIDA OB	T3	
qc prenatal tablet	T1	PPACA
ra one daily prenatal dha pack	T1	PPACA
ra prenatal tablet	T1	PPACA
R-NATAL OB	T3	
SELECT-OB	T3	
SELECT-OB *(prenatal vit128/iron/folic acd)*	T3	
SELECT-OB + DHA	T3	
SIMILAC PRENATAL	T3	
sm prenatal vitamins tablet	T1	PPACA
STUART ONE *(pnv no.63/iron,carb/folic/dha)*	T3	
sv prenatal tablet	T1	PPACA
SV PRENATAL VITAMINS TABLET	T3	
THERANATAL	T3	
THERANATAL COMPLETE	T3	
THERANATAL ONE, OVAVITE	T3	
THERANATAL PLUS	T3	
THRIVITE RX	T3	
TRICARE	T3	
TRICARE PRENATAL DHA ONE	T3	
TRISTART DHA	T3	

T1 – Generics
T2 – Preferred Brands
T3 – Non-Preferred Brands
T4 – Preferred Specialty
T5 – Non-Preferred Specialty
PA – Prior Authorization
QL – Quantity Limit
ST – Step Therapy
AGE – Age Requirement
SP – Specialty Medication
HD – May require home delivery pharmacy
PPACA – No Cost-Share Preventive Medication
CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

PRE-NATAL VITAMINS (Nutritional/Dietary) (cont.)		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
PRENATAL VITAMIN PREPARATIONS (cont.)		
ULTRA PRENATAL PLUS DHA	T3	
VITAFOL FE PLUS	T3	
VITAFOL GUMMIES	T3	
VITAFOL NANO	T3	
VITAFOL ULTRA	T3	
VITAFOL-OB	T3	
VITAFOL-OB+DHA	T3	
VITAFOL-ONE	T3	
VITAMEDMD ONE RX	T3	
VITAMEDMD REDICHEW RX (*prenatal comb no.42/folic acid*)	T3	
VITAPEARL	T3	
VITATRUE	T3	
VP-PNV-DHA	T3	
WOMEN'S PRENATAL PLUS DHA	T2	
PRENATAL VITAMINS WITH LOW OR NO IRON		
CVS PRENATAL GUMMIES	T3	
PRENATAL GUMMIES	T3	
TRINAZ	T3	
PSYCHOTHERAPEUTIC DRUGS (Anxiety/Depression/Bipolar Disorder)[8]		
ALPHA-2 RECEPTOR ANTAGONIST ANTIDEPRESSANTS		
mirtazapine	T1	HD
mirtazapine (Remeron)	T1	HD
REMERON *(mirtazapine)*	T3	HD
ANTI-ANXIETY - BENZODIAZEPINES		
alprazolam	T1	
alprazolam (Xanax Xr)	T1	
alprazolam (Xanax)	T1	
ATIVAN *(lorazepam)*	T3	
chlordiazepoxide hcl	T1	
clorazepate dipotassium	T1	
diazepam 10 mg tablet (Valium)	T1	
diazepam 2 mg tablet (Valium)	T1	
diazepam 25 mg/5 ml oral conc	T1	

T1 – Generics
T2 – Preferred Brands
T3 – Non-Preferred Brands
T4 – Preferred Specialty
T5 – Non-Preferred Specialty
PA – Prior Authorization
QL – Quantity Limit
ST – Step Therapy
AGE – Age Requirement
SP – Specialty Medication
HD – May require home delivery pharmacy
PPACA – No Cost-Share Preventive Medication
CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

PSYCHOTHERAPEUTIC DRUGS (Anxiety/Depression/Bipolar Disorder)[8] (cont.)		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
ANTI-ANXIETY - BENZODIAZEPINES (cont.)		
diazepam 5 mg tablet (Valium)	T1	
diazepam 5 mg/5 ml oral soln	T1	
diazepam 5 mg/5 ml solution	T1	
diazepam 5 mg/ml oral conc	T1	
lorazepam	T1	
lorazepam (Ativan)	T1	
oxazepam	T1	
ANTI-ANXIETY DRUGS		
buspirone hcl	T1	
meprobamate	T1	
ANTIDEPRESSANT - POSTPARTUM DEPRESSION (PPD)		
ZURZUVAE	T4	
BIPOLAR DISORDER DRUGS		
EQUETRO	T3	HD
lithium carbonate	T1	HD
lithium carbonate (Lithobid)	T1	HD
LITHOBID *(lithium carbonate)*	T3	HD
MAOIS -NON-SELECTIVE, IRREVERSIBLE ANTIDEPRESSANTS		
MARPLAN	T3	
NARDIL (*phenelzine sulfate*)	T3	
PARNATE (*tranylcypromine sulfate*)	T3	
phenelzine sulfate (Nardil)	T1	
tranylcypromine sulfate (Parnate)	T1	
MONOAMINE OXIDASE (MAO) INHIBITOR ANTIDEPRESSANTS		
EMSAM	T3	
NOREPINEPHRINE AND DOPAMINE REUPTAKE INHIB (NDRIS)		
bupropion hcl	T1	HD
bupropion hcl xl 150 mg tablet (Wellbutrin XI)	T1	
bupropion hcl xl 300 mg tablet (Wellbutrin XI)	T1	
SELECTIVE SEROTONIN 5-HT2A INVERSE AGONISTS (SSIA)		
NUPLAZID 10 MG TABLET	T5	PA QL(30 tabs/fill) SP HD
NUPLAZID 34 MG CAPSULE	T5	PA QL(30 caps/fill) SP HD
SELECTIVE SEROTONIN REUPTAKE INHIBITOR (SSRIS)		
citalopram hbr 10 mg/5 ml soln	T1	HD

T1 – Generics
T2 – Preferred Brands
T3 – Non-Preferred Brands
T4 – Preferred Specialty
T5 – Non-Preferred Specialty
PA – Prior Authorization
QL – Quantity Limit
ST – Step Therapy
AGE – Age Requirement
SP – Specialty Medication
HD – May require home delivery pharmacy
PPACA – No Cost-Share Preventive Medication
CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

PSYCHOTHERAPEUTIC DRUGS (Anxiety/Depression/Bipolar Disorder)[8] (cont.)		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
SELECTIVE SEROTONIN REUPTAKE INHIBITOR (SSRIS) (cont.)		
escitalopram 10 mg tablet (Lexapro)	T1	
escitalopram 20 mg tablet (Lexapro)	T1	
escitalopram 5 mg tablet (Lexapro)	T1	
escitalopram oxalate 5 mg/5 ml	T1	ST HD
fluoxetine 20 mg/5 ml solution	T1	HD
fluoxetine hcl	T1	ST QL(4 caps/fill) HD
fluoxetine hcl 10 mg tablet	T1	ST QL(30 tabs/fill) HD
fluoxetine hcl 20 mg capsule (Prozac)	T1	HD
fluoxetine hcl 20 mg tablet	T1	ST HD
fluoxetine hcl 60 mg tablet	T1	ST HD
fluvoxamine maleate	T1	ST QL(60 caps/fill) HD
fluvoxamine maleate 100 mg tab	T1	QL(90 tabs/fill) HD
fluvoxamine maleate 25 mg tab	T1	QL(30 tabs/fill) HD
fluvoxamine maleate 50 mg tab	T1	QL(60 tabs/fill) HD
paroxetine hcl (Paxil Cr)	T1	ST QL(60 tabs/fill) HD
paroxetine hcl 10 mg tablet (Paxil)	T1	QL(30 tabs/fill) HD
paroxetine hcl 10 mg/5 ml susp (Paxil)	T1	ST HD
paroxetine hcl 20 mg tablet (Paxil)	T1	QL(60 tabs/fill) HD
paroxetine hcl 30 mg tablet (Paxil)	T1	QL(60 tabs/fill) HD
paroxetine hcl 40 mg tablet (Paxil)	T1	QL(30 tabs/fill) HD
PAXIL 10 MG TABLET *(paroxetine hcl)*	T3	ST QL(30 tabs/fill) HD
PAXIL 10 MG/5 ML SUSPENSION *(paroxetine hcl)*	T3	ST HD
PAXIL 20 MG TABLET *(paroxetine hcl)*	T3	ST QL(60 tabs/fill) HD
PAXIL 30 MG TABLET *(paroxetine hcl)*	T3	ST QL(60 tabs/fill) HD
PAXIL 40 MG TABLET *(paroxetine hcl)*	T3	ST QL(30 tabs/fill) HD
PAXIL CR (*paroxetine hcl)*	T3	ST QL(60 tabs/fill) HD
sertraline 20 mg/ml oral conc (Zoloft)	T1	HD
sertraline hcl 25 mg tablet (Zoloft)	T1	QL(45 tabs/fill) HD
SEROTONIN-2 ANTAGONIST/REUPTAKE INHIBITORS (SARIS)		
nefazodone hcl	T1	HD
trazodone hcl	T1	HD
SEROTONIN-NOREPINEPHRINE REUPTAKE-INHIB (SNRIS)		
DESVENLAFAXINE ER	T3	ST QL(30 tabs/fill) HD
duloxetine hcl dr 20 mg cap (Cymbalta)	T1	QL(60 caps/fill) HD

T1 – Generics
T2 – Preferred Brands
T3 – Non-Preferred Brands
T4 – Preferred Specialty
T5 – Non-Preferred Specialty
PA – Prior Authorization
QL – Quantity Limit
ST – Step Therapy
AGE – Age Requirement
SP – Specialty Medication
HD – May require home delivery pharmacy
PPACA – No Cost-Share Preventive Medication
CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

PSYCHOTHERAPEUTIC DRUGS (Anxiety/Depression/Bipolar Disorder)[8] (cont.)		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
SEROTONIN-NOREPINEPHRINE REUPTAKE-INHIB (SNRIS) (cont.)		
duloxetine hcl dr 30 mg cap (Cymbalta)	T1	QL(30 caps/fill) HD
duloxetine hcl dr 40 mg cap	T1	ST QL(30 caps/fill) HD
duloxetine hcl dr 60 mg cap (Cymbalta)	T1	QL(60 caps/fill) HD
FETZIMA 20-40 MG TITRATION PAK	T2	ST QL(28 caps/fill) HD
FETZIMA ER 20 MG CAPSULE	T2	ST QL(30 caps/fill) HD
FETZIMA ER 40 MG CAPSULE	T2	ST QL(30 caps/fill) HD
FETZIMA ER 80 MG CAPSULE	T2	ST QL(30 caps/fill) HD
FETZIMA ER 120 MG CAPSULE	T2	ST QL(30 caps/fill) HD
venlafaxine hcl	T1	QL(90 tabs/fill) HD
venlafaxine hcl er 150 mg tab	T1	ST QL(30 tabs/fill) HD
venlafaxine hcl er 225 mg tab	T1	ST QL(30 tabs/fill) HD
venlafaxine hcl er 37.5 mg tab	T1	ST QL(30 tabs/fill) HD
venlafaxine hcl er 75 mg tab	T1	ST QL(30 tabs/fill) HD
venlafaxine hcl er 150 mg cap (Effexor Xr)	T1	
venlafaxine hcl er 37.5 mg cap (Effexor Xr)	T1	
venlafaxine hcl er 75 mg cap (Effexor Xr)	T1	
SSRI, SEROTONIN RECEPTOR MODULATOR ANTIDEPRESSANTS		
TRINTELLIX 10 MG TABLET	T3	QL (1 tab/day) ST HD
TRICYCLIC ANTIDEPRESSANT-BENZODIAZEPINE COMBINATNS		
amitriptyline/chlordiazepoxide	T1	HD
perphenazine/amitriptyline hcl	T1	HD
TRICYCLIC ANTIDEPRESSANTS, REL.NON-SEL.REUPT-INHIB		
amitriptyline hcl	T1	HD
amoxapine	T1	HD
ANAFRANIL *(clomipramine hcl)*	T3	HD
clomipramine hcl (Anafranil)	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 25 mg capsule	T1	HD
doxepin 50 mg capsule	T1	HD
doxepin 75 mg capsule	T1	HD
doxepin 100 mg capsule	T1	HD

T1 – Generics
T2 – Preferred Brands
T3 – Non-Preferred Brands
T4 – Preferred Specialty
T5 – Non-Preferred Specialty
PA – Prior Authorization
QL – Quantity Limit
ST – Step Therapy
AGE – Age Requirement
SP – Specialty Medication
HD – May require home delivery pharmacy
PPACA – No Cost-Share Preventive Medication
CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

PSYCHOTHERAPEUTIC DRUGS (Anxiety/Depression/Bipolar Disorder)[8] (cont.)		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
TRICYCLIC ANTIDEPRESSANTS, REL.NON-SEL.REUPT-INHIB (cont.)		
doxepin 150 mg capsule	T1	HD
imipramine hcl (Tofranil)	T1	HD
imipramine pamoate	T1	HD
maprotiline hcl	T1	HD
NORPRAMIN *(desipramine hcl)*	T3	HD
nortriptyline hcl	T1	HD
nortriptyline hcl (Pamelor)	T1	HD
PAMELOR *(nortriptyline hcl)*	T3	HD
protriptyline hcl	T1	HD
SURMONTIL *(trimipramine maleate)*	T3	HD
TOFRANIL (*imipramine hcl*)	T3	HD
trimipramine maleate (Surmontil)	T1	HD
PSYCHOTHERAPEUTIC DRUGS (Attention Deficit Hyperactivity Disorder)[8]		
ADRENERGICS, AROMATIC, NON-CATECHOLAMINE		
lisdexamfetamine 10 mg capsule (Vyvanse)	T1	
lisdexamfetamine 10 mg tb chew	T1	ST
lisdexamfetamine 20 mg capsule (Vyvanse)	T1	
lisdexamfetamine 20 mg tb chew	T1	ST
lisdexamfetamine 30 mg capsule (Vyvanse)	T1	
lisdexamfetamine 30 mg tb chew	T1	ST
lisdexamfetamine 40 mg capsule (Vyvanse)	T1	
lisdexamfetamine 40 mg tb chew	T1	ST
lisdexamfetamine 50 mg capsule (Vyvanse)	T1	
lisdexamfetamine 50 mg tb chew	T1	ST
lisdexamfetamine 60 mg capsule (Vyvanse)	T1	
lisdexamfetamine 60 mg tb chew	T1	ST
lisdexamfetamine 70 mg capsule (Vyvanse)	T1	
VYVANSE	T2	ST
TX FOR ADHD - SELECTIVE ALPHA-2 RECEPTOR AGONIST		
clonidine hcl er 0.1 mg tablet (Kapvay)	T1	
guanfacine hcl (Intuniv)	T1	
KAPVAY (*clonidine hcl*)	T3	ST

T1 – Generics
T2 – Preferred Brands
T3 – Non-Preferred Brands
T4 – Preferred Specialty
T5 – Non-Preferred Specialty
PA – Prior Authorization
QL – Quantity Limit
ST – Step Therapy
AGE – Age Requirement
SP – Specialty Medication
HD – May require home delivery pharmacy
PPACA – No Cost-Share Preventive Medication
CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

PSYCHOTHERAPEUTIC DRUGS (Attention Deficit Hyperactivity Disorder)[8] (cont.)		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
TX FOR ATTENTION DEFICIT-HYPERACT (ADHD)/NARCOLEPSY		
APTENSIO XR (*methylphenidate hcl*)	T3	ST
AZSTARYS	T3	ST
COTEMPLA XR-ODT	T3	ST
DAYTRANA	T3	ST
dexmethylphenidate hcl (Focalin Xr)	T1	
dexmethylphenidate hcl (Focalin)	T1	
JORNAY PM	T3	ST
METHYLIN *(methylphenidate hcl)*	T3	
methylphenidate	T1	ST
methylphenidate er 10 mg cap (Aptensio Xr)	T1	ST
methylphenidate er 10 mg, 20 mg tab	T1	
methylphenidate er 15 mg cap (Aptensio Xr)	T1	ST
methylphenidate er 18 mg tab (Relexxii)	T1	
methylphenidate er 18 mg tab (Concerta)	T1	
methylphenidate er 20 mg cap (Aptensio Xr)	T1	ST
methylphenidate er 27 mg tab (Relexxii)	T1	
methylphenidate er 27 mg tab (Concerta)	T1	
methylphenidate er 30 mg cap (Aptensio Xr)	T1	ST
methylphenidate er 36 mg tab (Relexxii)	T1	
methylphenidate er 36 mg tab (Concerta)	T1	
methylphenidate er 40 mg cap (Aptensio Xr)	T1	ST
methylphenidate er 50 mg cap (Aptensio Xr)	T1	ST
methylphenidate er 54 mg tab (Relexxii)	T1	
methylphenidate er 54 mg tab (Concerta)	T1	
methylphenidate er 60 mg cap (Aptensio Xr)	T1	ST
METHYLPHENIDATE ER 72 MG TAB	T3	ST
methylphenidate hcl	T1	
methylphenidate hcl ((Metadate Cd)	T1	
methylphenidate hcl (Methylin)	T1	
methylphenidate hcl (Ritalin La)	T1	
methylphenidate hcl (Ritalin)	T1	
QUELBREE ER	T3	ST
RELEXXII ER 72 MG TABLET	T3	ST
atomoxetine hcl (Strattera)	T1	HD

T1 – Generics
T2 – Preferred Brands
T3 – Non-Preferred Brands
T4 – Preferred Specialty
T5 – Non-Preferred Specialty
PA – Prior Authorization
QL – Quantity Limit
ST – Step Therapy
AGE – Age Requirement
SP – Specialty Medication
HD – May require home delivery pharmacy
PPACA – No Cost-Share Preventive Medication
CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

PSYCHOTHERAPEUTIC DRUGS (Miscellaneous)		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
HYPOACTIVE SEXUAL DESIRE DISORDER (HSDD) TX AGENTS		
ADDYI	T3	PA
VYLEESI	T5	PA QL(8 auto-injs/fill) SP
PSYCHOTHERAPEUTIC DRUGS (Schizophrenia/Anti-Psychotics)[8]		
ANTIPSYCH, DOPAMINE ANTAG., DIPHENYLBUTYLPIPERIDINES		
pimozide	T1	
ANTIPSYCHOTIC, ATYPICAL, DOPAMINE, SEROTONIN ANTAGNST		
asenapine maleate (Saphris)	T1	QL(60 tabs/fill)
CAPLYTA	T3	QL(30 caps/fill)
clozapine	T1	
clozapine (Clozaril)	T1	
CLOZARIL (*clozapine*)	T3	
FANAPT 1 MG TABLET	T3	QL(60 tabs/fill)
FANAPT 2 MG TABLET	T3	QL(60 tabs/fill)
FANAPT 4 MG TABLET	T3	QL(60 tabs/fill)
FANAPT 6 MG TABLET	T3	QL(60 tabs/fill)
FANAPT 8 MG TABLET	T3	QL(60 tabs/fill)
FANAPT 10 MG TABLET	T3	QL(60 tabs/fill)
FANAPT 12 MG TABLET	T3	QL(60 tabs/fill)
FANAPT TITRATION PACK	T3	QL(8 tabs/fill)
GEODON (*ziprasidone hcl*)	T3	QL(60 caps/fill)
INVEGA ER 3 MG TABLET (*paliperidone*)	T3	QL(30 tabs/fill)
INVEGA ER 6 MG TABLET (*paliperidone*)	T3	QL(60 tabs/fill)
INVEGA ER 9 MG TABLET (*paliperidone*)	T3	QL(30 tabs/fill)
olanzapine (Zyprexa Zydis)	T1	QL(30 tabs/fill)
quetiapine er 50 mg tablet (Seroquel Xr)	T1	QL(60 tabs/fill)
quetiapine er 200 mg tablet (Seroquel Xr)	T1	QL(30 tabs/fill)
quetiapine er 300 mg tablet (Seroquel Xr)	T1	QL(60 tabs/fill)
quetiapine er 400 mg tablet (Seroquel Xr)	T1	QL(60 tabs/fill)
quetiapine fumarate 25 mg tab (Seroquel)	T1	
quetiapine fumarate 50 mg tab (Seroquel)	T1	
quetiapine fumarate 100 mg tab (Seroquel)	T1	
quetiapine fumarate 200 mg tab (Seroquel)	T1	QL(90 tabs/fill)
quetiapine fumarate 300 mg tab (Seroquel)	T1	QL(60 tabs/fill)

T1 – Generics
T2 – Preferred Brands
T3 – Non-Preferred Brands
T4 – Preferred Specialty
T5 – Non-Preferred Specialty
PA – Prior Authorization
QL – Quantity Limit
ST – Step Therapy
AGE – Age Requirement
SP – Specialty Medication
HD – May require home delivery pharmacy
PPACA – No Cost-Share Preventive Medication
CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

PSYCHOTHERAPEUTIC DRUGS (Schizophrenia/Anti-Psychotics)[8]		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
ANTIPSYCHOTIC, ATYPICAL, DOPAMINE, SEROTONIN ANTAGNST (cont.)		
quetiapine fumarate 400 mg tab (Seroquel)	T1	
RISPERDAL 0.5 MG TABLET (*risperidone*)	T3	QL(60 tabs/fill)
RISPERDAL 1 MG TABLET (*risperidone*)	T3	QL(60 tabs/fill)
RISPERDAL 1 MG/ML SOLUTION (*risperidone*)	T3	
RISPERDAL 2 MG TABLET (*risperidone*)	T3	QL(60 tabs/fill)
RISPERDAL 3 MG TABLET (*risperidone*)	T3	QL(60 tabs/fill)
RISPERDAL 4 MG TABLET (*risperidone*)	T3	QL(60 tabs/fill)
risperidone	T1	QL(60 tabs/fill)
risperidone 0.5 mg tablet (Risperdal)	T1	QL(60 tabs/fill)
risperidone 1 mg tablet (Risperdal)	T1	QL(60 tabs/fill)
risperidone 1 mg/ml solution (Risperdal)	T1	
risperidone 2 mg tablet (Risperdal)	T1	QL(60 tabs/fill)
risperidone 3 mg tablet (Risperdal)	T1	QL(60 tabs/fill)
risperidone 4 mg tablet (Risperdal)	T1	QL(60 tabs/fill)
SECUADO	T3	QL(30 patches/fill)
VERSACLOZ	T3	
ziprasidone hcl (Geodon)	T1	QL(60 caps/fill)
ZYPREXA (*olanzapine*)	T3	QL(30 tabs/fill)
ZYPREXA ZYDIS (*olanzapine*)	T3	QL(30 tabs/fill)
ANTIPSYCHOTIC-ATYPICAL, D3/D2 PARTIAL AG-5HT MIXED		
VRAYLAR 1.5 MG CAPSULE	T3	QL(30 caps/fill)
VRAYLAR 1.5 MG-3 MG PACK	T3	QL(7 caps/fill)
VRAYLAR 3 MG CAPSULE	T3	QL(30 caps/fill)
VRAYLAR 4.5 MG CAPSULE	T3	QL(30 caps/fill)
VRAYLAR 6 MG CAPSULE	T3	QL(30 caps/fill)
ANTIPSYCHOTICS, ATYP, D2 PARTIAL AGONIST/5HT MIXED		
ABILIFY ASIMTUFII 720MG/2.4ML, 960MG/3.2ML	T3	
ABILIFY MYCITE	T3	QL(30 tabs/fill)
aripiprazole	T1	QL(60 tabs/fill)
aripiprazole 1 mg/ml solution	T1	
aripiprazole 2 mg tablet (Abilify)	T1	QL(30 tabs/fill)
aripiprazole 10 mg tablet (Abilify)	T1	QL(30 tabs/fill)
aripiprazole 15 mg tablet (Abilify)	T1	
aripiprazole 20 mg tablet (Abilify)	T1	QL(30 tabs/fill)

T1 – Generics
T2 – Preferred Brands
T3 – Non-Preferred Brands
T4 – Preferred Specialty
T5 – Non-Preferred Specialty
PA – Prior Authorization
QL – Quantity Limit
ST – Step Therapy
AGE – Age Requirement
SP – Specialty Medication
HD – May require home delivery pharmacy
PPACA – No Cost-Share Preventive Medication
CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

PSYCHOTHERAPEUTIC DRUGS (Schizophrenia/Anti-Psychotics)[8]		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
ANTIPSYCHOTICS, ATYP, D2 PARTIAL AGONIST/5HT MIXED (cont.)		
aripiprazole 30 mg tablet (Abilify)	T1	QL(30 tabs/fill)
REXULTI	T3	QL(30 tabs/fill)
ANTIPSYCHOTICS, DOPAMINE AND SEROTONIN ANTAGONISTS		
loxapine succinate	T1	
ANTIPSYCHOTICS, DOPAMINE ANTAGONISTS, THIOXANTHENES		
thiothixene	T1	
ANTIPSYCHOTICS, DOPAMINE ANTAGONISTS, BUTYROPHENONES		
haloperidol	T1	
haloperidol lactate	T1	
ANTIPSYCHOTICS, DOPAMINE ANTAGONST, DIHYDROINDOLONES		
molindone hcl	T1	
ANTIPSYCHOTICS, PHENOTHIAZINES		
chlorpromazine hcl	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	
SYMBYAX (*olanzapine/fluoxetine hcl)*	T3	
PSYCHOTHERAPEUTIC DRUGS (Seizure Disorders)		
NEUROACTIVE STEROID GABA-A RECEPTOR MODULATOR		
ZTALMY	T4	PA SP
PSYCHOTHERAPEUTIC DRUGS (Sleep Disorders/Sedatives)		
NARCOLEPSY AND SLEEP DISORDER THERAPY AGENTS		
armodafinil (Nuvigil)	T1	PA QL(30 tabs/fill)
modafinil 100 mg tablet (Provigil)	T1	PA QL(30 tabs/fill)
SUNOSI	T2	PA QL(30 tabs/fill)
SEDATIVE/HYPNOTICS (Sleep Disorders/Sedatives)		
ANTI-NARCOLEPSY, ANTI-CATAPLEXY, SEDATIVE-TYPE AGENT		
LUMRYZ ER	T5	PA SP HD QL (30 packets/30 days)
SODIUM OXYBATE	T4	PA QL (540 mls/30 days)

T1 – Generics
T2 – Preferred Brands
T3 – Non-Preferred Brands
T4 – Preferred Specialty
T5 – Non-Preferred Specialty
PA – Prior Authorization
QL – Quantity Limit
ST – Step Therapy
AGE – Age Requirement
SP – Specialty Medication
HD – May require home delivery pharmacy
PPACA – No Cost-Share Preventive Medication
CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

SEDATIVE/HYPNOTICS (Sleep Disorders/Sedatives) (cont.)		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
ANTI-NARCOLEPSY, ANTI-CATAPLEXY, SEDATIVE-TYPE AGENT (cont.)		
XYREM	T4	PA QL(540 mls/fill) SP HD
XYWAV	T4	PA QL(540 mls/fill) SP HD
BARBITURATES		
phenobarbital	T1	
secobarbital sodium	T1	QL(30 caps/fill)
HYPNOTICS, MELATONIN MT1/MT2 RECEPTOR AGONISTS		
HETLIOZ	T5	PA QL(30 caps/fill) SP HD
HETLIOZ LQ	T5	PA QL(158 mls/fill) SP HD
ramelteon (Rozerem)	T1	QL(30 tabs/fill)
SEDATIVE-HYPNOTICS - BENZODIAZEPINES		
estazolam	T1	
flurazepam hcl	T1	
HALCION *(triazolam)*	T3	
MIDAZOLAM HCL 10 MG/5 ML SYRUP	T3	
midazolam hcl 2 mg/ml syrup	T1	
MIDAZOLAM HCL 5 MG/2.5 ML SYRP	T3	
RESTORIL *(temazepam)*	T3	
temazepam (Restoril)	T1	
triazolam	T1	
triazolam (Halcion)	T1	
SEDATIVE-HYPNOTICS, NON-BARBITURATE		
BELSOMRA	T3	ST QL(30 tabs/fill)
DAYVIGO	T3	ST
doxepin hcl 3 mg tablet (Silenor)	T1	ST QL(30 tabs/fill)
doxepin hcl 6 mg tablet (Silenor)	T1	ST QL(30 tabs/fill)
EDLUAR	T3	ST QL(30 tabs/fill)
eszopiclone (Lunesta)	T1	QL(30 tabs/fill)
IGALMI	T3	
KETAMINE HCL	T3	
MKO (MIDAZOLAM-KETAMINE-ONDAN)	T3	
QUVIVIQ	T3	ST
SILENOR (*doxepin hcl*)	T3	ST QL(30 tabs/fill)
zaleplon 10 mg capsule	T1	QL(60 caps/fill)

T1 – Generics
T2 – Preferred Brands
T3 – Non-Preferred Brands
T4 – Preferred Specialty
T5 – Non-Preferred Specialty
PA – Prior Authorization
QL – Quantity Limit
ST – Step Therapy
AGE – Age Requirement
SP – Specialty Medication
HD – May require home delivery pharmacy
PPACA – No Cost-Share Preventive Medication
CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

SEDATIVE/HYPNOTICS (Sleep Disorders/Sedatives) (cont.)		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
SEDATIVE-HYPNOTICS, NON-BARBITURATE(cont.)		
zaleplon 5 mg capsule	T1	QL(30 caps/fill)
zolpidem tartrate	T1	QL(30 tabs/fill)
zolpidem tartrate (Ambien Cr)	T1	QL(30 tabs/fill)
zolpidem tartrate (Ambien)	T1	QL(30 tabs/fill)
SKIN PREPS (Miscellaneous)		
IRRIGANTS		
acetic acid	T1	
neomycin sulf/polymyxin b sulf	T1	
PHYSIOLYTE (*physiological irrig soln no.1*)	T3	
PHYSIOSOL (*physiological irrig soln no.1*)	T3	
ringer's solution	T1	
ringer's solution,lactated	T1	
sod,pot chlor/mag/sod,pot phos	T1	
sodium chloride irrig solution	T1	
SORBITOL	T3	
SORBITOL-MANNITOL	T3	
water for irrigation,sterile	T1	
OXIDIZING AGENTS		
hydrogen peroxide	T1	
PRESERVATIVES		
formaldehyde	T1	
SKIN PREPS (Pain Relief and Inflammatory Disease)		
ANTIPSORIATIC AGENTS, SYSTEMIC		
acitretin	T1	
methoxsalen	T1	
SKYRIZI	T4	PA QL(150 mg/84 days) SP HD
SKYRIZI (2 SYRINGES) KIT	T4	PA QL(150 mg/84 days) SP HD
SKYRIZI PEN	T4	PA QL(150 mg/84 days) SP HD
TALTZ AUTOINJECTOR	T4	PA QL(1 ml/28 days) SP HD
TALTZ AUTOINJECTOR (2 PACK)	T4	PA QL(1 ml/28 days) SP HD
TALTZ AUTOINJECTOR (3 PACK)	T4	PA QL(1 ml/28 days) SP HD
TALTZ SYRINGE	T4	PA QL(1 ml/28 days) SP HD
TREMFYA	T4	PA QL SP HD

T1 – Generics
T2 – Preferred Brands
T3 – Non-Preferred Brands
T4 – Preferred Specialty
T5 – Non-Preferred Specialty
PA – Prior Authorization
QL – Quantity Limit
ST – Step Therapy
AGE – Age Requirement
SP – Specialty Medication
HD – May require home delivery pharmacy
PPACA – No Cost-Share Preventive Medication
CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

SKIN PREPS (Pain Relief and Inflammatory Disease) (cont.)		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
TOPICAL ANTI-INFLAMMATORY, NSAIDS		
diclofenac 2% solution pump (Pennsaid)	T1	
diclofenac sodium 1% gel	T1	ST QL(500 gms/28 days) HD
FLECTOR	T2	ST QL(60 patches/fill) HD
LICART	T2	ST QL(30 patches/fill) HD
SKIN PREPS (Skin Conditions)		
ACNE AGENTS, SYSTEMIC		
ABSORICA (isotretinoin)	T3	ST
isotretinoin (Absorica)	T1	
ACZONE *(dapsone)*	T3	ST
adapalene/benzoyl peroxide	T1	
adapalene/benzoyl peroxide (Epiduo Forte)	T1	
AZELEX	T3	ST
clindamycin phos/benzoyl perox	T1	
clindamycin phos/benzoyl perox (Acanya)	T1	
clindamycin/tretinoin (Ziana)	T1	PA
dapsone (Aczone)	T1	
EPIDUO FORTE	T3	ST
EPIDUO FORTE *(adapalene/benzoyl peroxide)*	T3	ST
KLARON *(sulfacetamide sodium)*	T3	ST
NEUAC 1.2-5% KIT	T3	ST
neuac gel	T1	
ONEXTON	T2	ST
sulfacetamide sodium (Klaron)	T1	
ACNE AGENTS, TOPICAL		
clindamycin/tretinoin (Veltin)	T1	
ONEXTON (*clindamycin phos/benzoyl perox)*	T3	ST
ANTIPRURITICS, TOPICAL		
doxepin 5% cream (Zonalon)	T1	ST QL(90 gms/30 days)
doxepin hcl (Zonalon)	T1	ST QL(90 gms/30 days)
ZONALON	T3	ST QL(90 gms/30 days)
ZONALON (*doxepin hcl*)	T3	ST QL(90 gms/30 days)
ANTIPSORIATICS AGENTS		
calcipotriene 0.005% cream (Dovonex)	T1	QL(120 gms/30 days)
calcipotriene 0.005% ointment	T1	QL(120 gms/30 days)

T1 – Generics
T2 – Preferred Brands
T3 – Non-Preferred Brands
T4 – Preferred Specialty
T5 – Non-Preferred Specialty
PA – Prior Authorization
QL – Quantity Limit
ST – Step Therapy
AGE – Age Requirement
SP – Specialty Medication
HD – May require home delivery pharmacy
PPACA – No Cost-Share Preventive Medication
CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

SKIN PREPS (Skin Conditions) (cont.)		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
ANTIPSORIATICS AGENTS (cont.)		
calcipotriene 0.005% solution	T1	QL(120 mls/30 days)
calcitriol 3 mcg/g ointment (Vectical)	T1	
DOVONEX (*calcipotriene*)	T3	ST QL(120 gms/30 days)
DUOBRII	T3	ST QL(200 gms/30 days)
tazarotene 0.05% gel (Tazorac)	T1	PA
tazarotene 0.1% cream (Tazorac)	T1	PA
tazarotene 0.1% gel (Tazorac)	T1	PA
TWYNEO	T3	PA ST
VECTICAL (*calcitriol*)	T3	
VTAMA	T3	PA ST QL (1 tube/28 days)
ZIANA *(clindamycin/tretinoin)*	T3	PA ST
ZORYVE	T3	PA ST QL(60 gms/28 days)
ANTISEBORRHEIC AGENTS		
ESKATA	T3	
OVACE (*sulfacetamide sodium*)	T3	
OVACE PLUS	T3	
OVACE PLUS WASH	T3	
PLEXION NS	T3	
selenium sulfide	T1	
SELRX	T3	
sod sulfacetam 10% clnsng gel	T1	
sod sulfacetamide 10% shampoo	T1	
sod sulfacetamide 9.8% shampoo	T1	
SODIUM SULFACETAMIDE 10% WASH	T3	
sodium sulfacetamide 10% wash (Ovace)	T1	
TERSI FOAM	T3	
ANTISEPTICS, GENERAL		
ADVOCATE ALCOHOL 70% PREP PADS	T2	
ALCOHOL 70% PREP PADS	T2	
ALCOHOL 70% SWABS	T2	
alcohol 70% swabs	T1	
ALCOHOL 70% WIPES	T2	
alcohol antiseptic pads	T1	
alcohol prep pads	T1	

T1 – Generics
T2 – Preferred Brands
T3 – Non-Preferred Brands
T4 – Preferred Specialty
T5 – Non-Preferred Specialty
PA – Prior Authorization
QL – Quantity Limit
ST – Step Therapy
AGE – Age Requirement
SP – Specialty Medication
HD – May require home delivery pharmacy
PPACA – No Cost-Share Preventive Medication
CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

SKIN PREPS (Skin Conditions) (cont.)		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
ANTISEPTICS, GENERAL (cont.)		
alcohol swabs	T1	
CARETOUCH ALCOHOL PREP PAD	T2	
CURITY ALCOHOL PREPS	T2	
CVS ALCOHOL 70% PREP PADS	T2	
cvs isopropyl alcohol 70% wipe	T1	
DROPSAFE PREP PADS	T2	
EASY COMFORT ALCOHOL PAD	T2	
EASY TOUCH ALCOHOL PREP PADS	T2	
fifty50 alcohol prep pads	T1	
HM ALCOHOL 70% PREP PADS	T2	
INCONTROL ALCOHOL PADS	T2	
PHARM CHOICE ALCOHOL PREP PADS	T2	
pharm choice alcohol prep pads	T1	
PRO COMFORT ALCOHOL PADS	T2	
PURE COMFORT ALCOHOL PAD	T2	
qc alcohol 70% swabs	T1	
ra alcohol swabs	T1	
RA ISOPROPYL ALCOHOL 70% WIPES	T2	
RELION ALCOHOL 70% SWABS	T2	
SAPS ALCOHOL 70% PREP PADS	T2	
SINGLE USE SWAB	T2	
SM ALCOHOL 70% PREP PADS	T2	
sm alcohol prep pads	T1	
SURE COMFORT ALCOHOL	T2	
SURE-PREP ALCOHOL PREP PADS	T2	
TRUE COMFORT ALCOHOL PADS	T2	
TRUE COMFORT PRO ALCOHOL PADS	T2	
ULTILET ALCOHOL SWAB	T2	
v-r alcohol prep pads	T1	
WEBCOL	T2	
ANTISEPTICS,MISCELLANEOUS		
GUAIACOL	T2	
DIABETIC ULCER PREPARATIONS, TOPICAL		
REGRANEX	T2	QL(15 gms/fill)

T1 – Generics
T2 – Preferred Brands
T3 – Non-Preferred Brands
T4 – Preferred Specialty
T5 – Non-Preferred Specialty
PA – Prior Authorization
QL – Quantity Limit
ST – Step Therapy
AGE – Age Requirement
SP – Specialty Medication
HD – May require home delivery pharmacy
PPACA – No Cost-Share Preventive Medication
CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

SKIN PREPS (Skin Conditions) (cont.)		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
IMMUNOMODULATORS		
imiquimod	T1	
imiquimod (Zyclara)	T1	
IRRITANTS/COUNTER-IRRITANTS		
CANTHARIDIN-ACETONE	T3	
IRRITANTS/COUNTER-IRRITANTS		
methyl salicylate	T1	
JANUS KINASE (JAK) INHIBITORS		
CIBINQO	T4	PA QL(30 tabs/30 days) SP
KERATOLYTIC-GLUCOCORTICOID COMBINATIONS		
VANOXIDE-HC	T3	ST
KERATOLYTICS		
benzepro 6% foaming cloths	T1	
BENZEPRO 7% CREAMY WASH (*benzoyl peroxide microspheres*)	T3	ST
benzoyl peroxide	T1	
benzoyl peroxide (Pacnex)	T1	
ENZOCLEAR	T3	ST
INOVA	T3	ST
INOVA 4-1	T3	ST
INOVA 8-2	T3	ST
PACNEX (*benzoyl peroxide*)	T3	ST
podofilox 0.5% gel	T1	ST QL(7 gms/30 days)
podofilox 0.5% topical soln	T1	
PR BENZOYL PEROXIDE (*benzoyl peroxide microspheres*)	T3	ST
PROTECTIVES		
PHARMABASE BARRIER (*zinc oxide*)	T3	
zinc oxide 20% ointment	T1	
ZINC OXIDE PASTE	T2	
ROSACEA AGENTS, TOPICAL		
azelaic acid (Finacea)	T1	
EPSOLAY	T3	ST
FINACEA 15% FOAM	T2	ST
FINACEA 15% GEL *(azelaic acid)*	T3	ST
ivermectin 1% cream (Soolantra)	T1	QL(45 gms/30 days)
METROCREAM *(metronidazole)*	T3	ST

T1 – Generics
T2 – Preferred Brands
T3 – Non-Preferred Brands
T4 – Preferred Specialty
T5 – Non-Preferred Specialty
PA – Prior Authorization
QL – Quantity Limit
ST – Step Therapy
AGE – Age Requirement
SP – Specialty Medication
HD – May require home delivery pharmacy
PPACA – No Cost-Share Preventive Medication
CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

SKIN PREPS (Skin Conditions) (cont.)		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
ROSACEA AGENTS, TOPICAL (cont.)		
METROGEL *(metronidazole)*	T3	ST
metronidazole	T1	
metronidazole (Metrocream)	T1	
metronidazole (Metrogel)	T1	
MIRVASO	T2	PA
RHOFADE	T3	PA
rosadan 0.75% cream (Metrocream)	T1	
ROSADAN 0.75% CREAM KIT	T3	ST
rosadan 0.75% gel	T1	
ROSADAN 0.75% GEL KIT	T3	ST
SOOLANTRA (*ivermectin*)	T3	ST QL(60 gms/30 days)
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	ST QL(120 gms/30 days)
ZORYVE	T3	
TOPICAL ACNE AGENT,RETINOIC ACID RECEPTOR AGONIST		
AKLIEF	T3	PA ST
ARAZLO	T3	PA
TOPICAL AGENTS, MISCELLANEOUS		
MEDIHONEY	T3	
trichloroacetic acid	T1	
TRICHLOROACETIC ACID 100% (*trichloroacetic acid*)	T3	
TRICHLOROACETIC ACID 20% (*trichloroacetic acid*)	T2	
TRICHLOROACETIC ACID 25%	T3	
TRICHLOROACETIC ACID 30%	T2	
TRICHLOROACETIC ACID 35%	T2	
TRICHLOROACETIC ACID 40%	T2	
TRICHLOROACETIC ACID 50%	T2	
TRICHLOROACETIC ACID 75%	T3	

T1 – Generics
T2 – Preferred Brands
T3 – Non-Preferred Brands
T4 – Preferred Specialty
T5 – Non-Preferred Specialty
PA – Prior Authorization
QL – Quantity Limit
ST – Step Therapy
AGE – Age Requirement
SP – Specialty Medication
HD – May require home delivery pharmacy
PPACA – No Cost-Share Preventive Medication
CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

SKIN PREPS (Skin Conditions) (cont.)		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
TOPICAL AGENTS, MISCELLANEOUS (cont.)		
TRICHLOROACETIC ACID 80%	T2	
TRICHLOROACETIC ACID 85%	T2	
TRICHLOROACETIC ACID 90%	T2	
TOPICAL ANTIBIOTIC PLEUROMUTILIN DERIVATIVES		
ALTABAX	T3	ST QL(30 gms/fill)
TOPICAL ANTI-INFLAMMATORY STEROIDAL		
ALA-SCALP (*hydrocortisone*)	T3	ST
alclometasone dipropionate	T1	
amcinonide	T1	ST
betamethasone dipropionate	T1	
betamethasone va 0.1% cream	T1	
betamethasone va 0.1% lotion	T1	
betamethasone valer 0.1% ointm	T1	
betamethasone valer 0.12% foam	T1	ST
betamethasone/propylene glyc	T1	
betamethasone/propylene glyc (Diprolene)	T1	
BRYHALI	T3	ST
CAPEX SHAMPOO	T3	ST
clobetasol 0.05% cream (Temovate)	T1	QL(120 gms/30 days)
clobetasol 0.05% gel	T1	QL(120 gms/30 days)
clobetasol 0.05% ointment (Temovate)	T1	QL(120 gms/30 days)
clobetasol 0.05% shampoo (Clobex)	T1	ST QL(236 mls/30 days)
clobetasol 0.05% solution	T1	QL(100 mls/30 days)
clobetasol 0.05% topical lotn	T1	ST QL(118 mls/30 days)
clobetasol emollient 0.05% crm	T1	QL(120 gms/30 days)
clobetasol emollnt 0.05% foam	T1	ST QL(100 gms/30 days)
clobetasol prop 0.05% foam (Olux)	T1	ST QL(100 gms/30 days)
clobetasol prop 0.05% spray (Clobex)	T1	ST QL(125 mls/30 days)
clobetasol propionate/emoll	T1	ST QL(100 gms/30 days)
CLOBEX 0.05% SHAMPOO *(clobetasol propionate)*	T3	ST QL(236 mls/30 days)
CLOBEX 0.05% SPRAY (*clobetasol propionate*)	T3	ST QL(125 mls/30 days)
clocortolone pivalate (Cloderm)	T1	
CLODAN 0.05% KIT	T3	ST QL(2 kits/28 days)
clodan 0.05% shampoo (Clobex)	T1	ST QL(236 mls/30 days)

T1 – Generics
T2 – Preferred Brands
T3 – Non-Preferred Brands
T4 – Preferred Specialty
T5 – Non-Preferred Specialty
PA – Prior Authorization
QL – Quantity Limit
ST – Step Therapy
AGE – Age Requirement
SP – Specialty Medication
HD – May require home delivery pharmacy
PPACA – No Cost-Share Preventive Medication
CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

SKIN PREPS (Skin Conditions) (cont.)		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
TOPICAL ANTI-INFLAMMATORY STEROIDAL (cont.)		
CLODERM	T3	ST
CLODERM (*clocortolone pivalate*)	T3	ST
CORDRAN 0.025% CREAM	T3	ST QL(120 gms/30 days)
CORDRAN 0.05% CREAM *(flurandrenolide)*	T3	ST QL(120 gms/30 days)
CORDRAN 0.05% LOTION *(flurandrenolide)*	T3	ST QL(120 mls/30 days)
CORDRAN 0.05% OINTMENT (flurandrenolide)	T3	ST QL(120 gms/30 days)
CORDRAN 4 MCG/SQ CM TAPE LARGE	T3	ST
CUTIVATE (*fluticasone propionate*)	T3	ST
DERMA-SMOOTHE-FS *(fluocinolone acetonide)*	T3	ST
DERMA-SMOOTHE-FS *(fluocinolone/shower cap)*	T3	ST
DERMASORB HC	T3	ST
DERMASORB TA	T3	ST
DERMATOP *(prednicarbate)*	T3	ST
DESONATE *(desonide)*	T3	ST
desonide (Desonate)	T1	ST
desonide 0.05% cream (Tridesilon)	T1	
desonide 0.05% gel (Desonate)	T1	ST
desonide 0.05% lotion	T1	ST
desonide 0.05% ointment	T1	
desoximetasone (Topicort)	T1	ST
diflorasone diacet/emollient	T1	ST
diflorasone diacetate	T1	ST QL(120 gms/30 days)
DIPROLENE *(betamethasone/propylene glyc)*	T3	ST
fluocinolone acetonide	T1	
fluocinolone acetonide (Derma-Smoothe-Fs)	T1	
fluocinolone acetonide (Synalar)	T1	
fluocinolone/shower cap (Derma-Smoothe-Fs)	T1	
fluocinonide 0.05% cream	T1	QL(120 gms/30 days)
fluocinonide 0.05% gel	T1	QL(120 gms/30 days)
fluocinonide 0.05% ointment	T1	QL(120 gms/30 days)
fluocinonide 0.05% solution	T1	QL(120 gms/30 days)
fluocinonide 0.1% cream (Vanos)	T1	ST QL(120 gms/30 days)
fluocinonide/emollient base	T1	QL(120 gms/30 days)
flurandrenolide 0.05% cream (Cordran)	T1	ST QL(120 gms/30 days)

T1 – Generics
T2 – Preferred Brands
T3 – Non-Preferred Brands
T4 – Preferred Specialty
T5 – Non-Preferred Specialty
PA – Prior Authorization
QL – Quantity Limit
ST – Step Therapy
AGE – Age Requirement
SP – Specialty Medication
HD – May require home delivery pharmacy
PPACA – No Cost-Share Preventive Medication
CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

SKIN PREPS (Skin Conditions) (cont.)		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
TOPICAL ANTI-INFLAMMATORY STEROIDAL (cont.)		
flurandrenolide 0.05% lotion (Cordran)	T1	ST QL(120 mls/30 days)
flurandrenolide 0.05% ointment (Cordran)	T1	ST QL(120 gms/30 days)
fluticasone prop 0.005% oint	T1	
fluticasone prop 0.05% cream (Cutivate)	T1	
fluticasone prop 0.05% lotion (Cutivate)	T1	ST
fluticasone propionate (Cutivate)	T1	ST
halcinonide (Halog)	T1	ST
halobetasol prop 0.05% cream	T1	
halobetasol prop 0.05% foam	T1	ST
halobetasol prop 0.05% ointmnt	T1	
halobetasol prop 0.05% cream (Ultravate)	T1	
halobetasol prop 0.05% ointmnt (Ultravate)	T1	
HALOG	T3	ST
HALOG (*halcinonide*)	T3	ST
hydrocort buty 0.1% lipid crm (Locoid Lipocream)	T1	QL(120 gms/30 days)
hydrocort buty 0.1% lipo cream (Locoid Lipocream)	T1	QL(120 gms/30 days)
hydrocort/min oil/petrolat,wht	T1	
hydrocortisone	T1	
hydrocortisone (Ala-Scalp)	T1	
hydrocortisone (Anusol-Hc)	T1	
hydrocortisone buty 0.1% cream	T1	QL(120 gms/30 days)
hydrocortisone butyr 0.1% lotn (Locoid)	T1	ST QL(118 mls/30 days)
hydrocortisone butyr 0.1% oint	T1	ST QL (10 gm/28 days)
hydrocortisone butyr 0.1% soln	T1	ST QL(120 mls/30 days)
hydrocortisone valerate	T1	
IMPEKLO	T3	ST QL(136 gms/28 days)
KENALOG 0.147 MG/GRAM SPRAY (*triamcinolone acetonide*)	T3	ST QL(100 gms/30 days)
KENALOG 0.147 MG/GRAM SPRAY (*triamcinolone acetonide*)	T3	ST QL(126 gms/30 days)
mometasone furoate 0.1% cream	T1	
mometasone furoate 0.1% oint	T1	
mometasone furoate 0.1% soln	T1	
nolix 0.05% cream (Cordran)	T1	ST QL(120 gms/30 days)
nolix 0.05% lotion (Cordran)	T1	ST QL(120 mls/30 days)
NUCORT	T3	ST

T1 – Generics
T2 – Preferred Brands
T3 – Non-Preferred Brands
T4 – Preferred Specialty
T5 – Non-Preferred Specialty
PA – Prior Authorization
QL – Quantity Limit
ST – Step Therapy
AGE – Age Requirement
SP – Specialty Medication
HD – May require home delivery pharmacy
PPACA – No Cost-Share Preventive Medication
CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

SKIN PREPS (Skin Conditions) (cont.)		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
TOPICAL ANTI-INFLAMMATORY STEROIDAL (cont.)		
OLUX (*clobetasol propionate*)	T3	ST QL(100 gms/30 days)
PANDEL	T3	ST
prednicarbate	T1	
prednicarbate (Dermatop)	T1	
SCALACORT DK	T3	ST
SYNALAR	T3	ST
SYNALAR (*fluocinolone acetonide*)	T3	ST
SYNALAR TS	T3	ST
TEMOVATE (*clobetasol propionate*)	T3	ST QL(120 gms/30 days)
TEXACORT	T3	ST
TOPICORT 0.25% CREAM (*desoximetasone*)	T3	ST
TOPICORT 0.25% OINTMENT (*desoximetasone*)	T3	ST
TOPICORT 0.05% CREAM (*desoximetasone*)	T3	ST
TOPICORT 0.05% GEL (*desoximetasone*)	T3	ST
TOPICORT 0.05% OINTMENT (*desoximetasone*)	T3	ST
triamcinolone 0.025% cream	T1	
triamcinolone 0.025% lotion	T1	
triamcinolone 0.025% oint	T1	
triamcinolone 0.5% cream	T1	
triamcinolone 0.05% ointment	T1	ST
triamcinolone 0.1% cream	T1	
triamcinolone 0.1% lotion	T1	
triamcinolone 0.1% ointment	T1	
*triamcinolone 0.147 mg/g spray (*Kenalog*)*	T1	ST QL(126 gms/30 days)
*triamcinolone 0.147 mg/g spray (*Kenalog*)*	T1	ST QL(100 gms/30 days)
triamcinolone 0.5% ointment	T1	
triamcinolone acetonide	T1	ST
triderm 0.1% cream	T1	
triderm 0.5% cream	T1	ST
TRIDESILON (*desonide*)	T3	ST
ULTRAVATE X	T3	ST
TOPICAL ANTI-INFLAMMATORY STEROID-LOCAL ANESTHETIC		
ANALPRAM HC 2.5%-1% LOTION (*hydrocortisone/pramoxine*)	T3	ST
EPIFOAM	T3	ST

T1 – Generics
T2 – Preferred Brands
T3 – Non-Preferred Brands
T4 – Preferred Specialty
T5 – Non-Preferred Specialty
PA – Prior Authorization
QL – Quantity Limit
ST – Step Therapy
AGE – Age Requirement
SP – Specialty Medication
HD – May require home delivery pharmacy
PPACA – No Cost-Share Preventive Medication
CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

SKIN PREPS (Skin Conditions) (cont.)		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
TOPICAL ANTI-INFLAMMATORY STEROID-LOCAL ANESTHETIC (cont.)		
hydrocort-pramoxine 2.5-1% crm	T1	ST
lidocaine/hydrocortisone ac	T1	
lidocaine-hc 3-0.5% cream	T1	
PRAMOSONE	T3	ST
TOPICAL ANTIPARASITICS		
lindane	T1	
malathion (Ovide)	T1	
OVIDE (*malathion*)	T3	
TOPICAL JANUS KINASE (JAK) INHIBITORS		
OPZELURA	T3	PA QL(240 gms/28 days)
TOPICAL PREPARATIONS, ANTIBACTERIALS		
iodine/potassium iodide	T1	
iodine/sodium iodide	T1	
IODOFLEX	T3	
IODOSORB	T3	
TOPICAL VIT D ANALOG/ANTI-INFLAMMATORY STEROID		
calcipotriene/betamethasone (Taclonex)	T1	ST QL(60 gms/30 days)
calcipotriene/betamethasone (Taclonex)	T1	QL(60 gms/30 days)
ENSTILAR	T2	ST QL(60 gms/30 days)
TACLONEX 0.005%-0.064% SUSPENS *(calcipotriene/betamethasone)*	T3	QL(60 gms/30 days)
TACLONEX OINTMENT *(calcipotriene/betamethasone)*	T3	ST QL(60 gms/30 days)
WYNZORA	T3	ST QL(60 gms/30 days)
TOPICAL/MUCOUS MEMBR./SUBCUT. ENZYMES		
SANTYL	T2	QL(180 gms/fill)
VITAMIN A DERIVATIVES		
adapalene 0.1% cream (Differin)	T1	
ADAPALENE 0.1% LOTION	T3	ST
adapalene 0.1% solution	T1	
adapalene 0.1% swab	T1	ST
adapalene 0.3% gel	T1	
adapalene 0.3% gel pump (Differin)	T1	
ALTRENO	T3	PA
avita 0.025% cream (Retin-A)	T1	PA
AVITA 0.025% GEL	T3	PA
DIFFERIN	T3	ST

T1 – Generics
T2 – Preferred Brands
T3 – Non-Preferred Brands
T4 – Preferred Specialty
T5 – Non-Preferred Specialty
PA – Prior Authorization
QL – Quantity Limit
ST – Step Therapy
AGE – Age Requirement
SP – Specialty Medication
HD – May require home delivery pharmacy
PPACA – No Cost-Share Preventive Medication
CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

SKIN PREPS (Skin Conditions) (cont.)		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
VITAMIN A DERIVATIVES (cont.)		
DIFFERIN *(adapalene)*	T3	ST
RETIN-A *(tretinoin)*	T3	PA
RETIN-A MICRO PUMP 0.06% GEL	T3	PA
RETIN-A MICRO PUMP 0.08% GEL	T3	PA
tretinoin 0.01% gel (Retin-A)	T1	PA
tretinoin 0.025% cream (Retin-A)	T1	PA
tretinoin 0.025% gel (Retin-A)	T1	PA
tretinoin 0.05% cream (Retin-A)	T1	PA
tretinoin 0.05% gel (Atralin)	T1	PA
tretinoin 0.1% cream (Retin-A)	T1	PA
tretinoin microspheres (Retin-A Micro Pump)	T1	PA
tretinoin microspheres (Retin-A Micro)	T1	PA
TRETIN-X	T3	PA
SMOKING DETERRENTS (Smoking Cessation)		
SMOKING DETERRENT AGENTS (GANGLIONIC STIM, OTHERS)		
NICOTROL	T3	QL(180 ds/365 days)PPACA
NICOTROL NS	T3	QL(180 ds/365 days)PPACA
SMOKING DETERRENT-NICOTINIC RECEPT.PARTIAL AGONIST		
APO-VARENICLINE 0.5 MG TABLET	T2	QL(180 ds/365 days)PPACA
APO-VARENICLINE 1 MG TABLET	T2	QL(180 ds/365 days)PPACA
CHANTIX	T3	QL(180 ds/365 days)PPACA
varenicline starting month box	T1	
SMOKING DETERRENTS, OTHER		
bupropion hcl sr 150 mg tablet	T1	QL(180 ds/365 days)PPACA
THYROID PREPS (Hormonal Agents)		
ANTITHYROID PREPARATIONS		
methimazole (Tapazole)	T1	HD
propylthiouracil	T1	HD
TAPAZOLE (*methimazole*)	T3	HD
THYROID HORMONES		
adthyza 15 mg tablet	T1	HD
adthyza 30 mg tablet	T1	HD
adthyza 60 mg tablet	T1	HD

T1 – Generics
T2 – Preferred Brands
T3 – Non-Preferred Brands
T4 – Preferred Specialty
T5 – Non-Preferred Specialty
PA – Prior Authorization
QL – Quantity Limit
ST – Step Therapy
AGE – Age Requirement
SP – Specialty Medication
HD – May require home delivery pharmacy
PPACA – No Cost-Share Preventive Medication
CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

THYROID PREPS (Hormonal Agents) (cont.)		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
THYROID HORMONES (cont.)		
adthyza 90 mg tablet	T1	HD
adthyza 120 mg tablet	T1	HD
ARMOUR THYROID	T2	HD
ERMEZA SOLUTION	T3	ST HD
levothyroxine sodium (Synthroid)	T1	HD
liothyronine sodium (Cytomel)	T1	HD
thyroid,pork	T1	HD
UNCLASSIFIED DRUG PRODUCTS (AIDS/HIV)		
CYTOCHROME P450 INHIBITORS		
TYBOST	T5	SP
UNCLASSIFIED DRUG PRODUCTS (Asthma/COPD/Respiratory)		
CYSTIC FIBROSIS - INHALED OSMOTIC AGENTS		
BRONCHITOL	T5	PA SP HD
CYSTIC FIBROSIS-CFTR POTENTIATOR-CORRECTOR COMBIN.		
ORKAMBI 100 MG-125 MG TABLET	T4	PA QL(112 tabs/fill) SP HD
ORKAMBI 100-125 MG GRANULE PKT	T4	PA QL(56 packs/fill) SP HD
ORKAMBI 150-188 MG GRANULE PKT	T4	PA QL(56 packs/fill) SP HD
ORKAMBI 200 MG-125 MG TABLET	T4	PA QL(112 tabs/fill) SP HD
ORKAMBI 75-94 MG GRANULE PKT	T4	PA QL(56 packs/fill) SP HD
SYMDEKO	T4	PA QL(56 tabs/fill) SP HD
TRIKAFTA 100-50-75 MG/75MG PKT	T4	SP PA HD QL (56 packets/28 days)
TRIKAFTA 80-40-60MG/59.5MG PKT	T4	SP PA HD QL (56 packets/28 days)
CYSTIC FIB-TRANSMEMB CONDUCT.REG.(CFTR) POTENTIATOR		
KALYDECO 150 MG TABLET	T4	PA QL(56 tabs/fill) SP HD
KALYDECO 5.8 MG GRANULES PKT	T4	PA QL(56 packs/fill) SP HD
KALYDECO 13.4MG GRANULES PKT	T4	PA SP QIL (56 packets/28 days)
KALYDECO 25 MG GRANULES PACKET	T4	PA QL(56 packs/fill) SP HD
KALYDECO 50 MG GRANULES PACKET	T4	PA QL(56 packs/fill) SP HD
KALYDECO 75 MG GRANULES PACKET	T4	PA QL(56 packs/fill) SP HD
LUNG SURFACTANTS		
CUROSURF	T3	
INFASURF	T3	
SURFAXIN	T3	
SURVANTA	T3	

T1 – Generics
T2 – Preferred Brands
T3 – Non-Preferred Brands
T4 – Preferred Specialty
T5 – Non-Preferred Specialty
PA – Prior Authorization
QL – Quantity Limit
ST – Step Therapy
AGE – Age Requirement
SP – Specialty Medication
HD – May require home delivery pharmacy
PPACA – No Cost-Share Preventive Medication
CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

UNCLASSIFIED DRUG PRODUCTS (Asthma/COPD/Respiratory) (cont.)		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
MUCOLYTICS		
PULMOZYME	T4	PA SP HD
PULMONARY FIBROSIS - SYSTEMIC ENZYME INHIBITORS		
OFEV	T4	PA QL(60 caps/fill) SP HD
SYSTEMIC ENZYME INHIBITORS		
JOENJA 70 MG TABLET	T5	PA SP QL (60 tabs/30 days)
VIJOICE 125 MG TABLET	T4	PA QL(28 tabs/28 days) SP
VIJOICE 250 MG DAILY DOSE PACK	T4	PA QL(56 tabs/28 days) SP
VIJOICE 50 MG TABLET	T4	PA QL(28 tabs/28 days) SP
ZOKINVY	T5	PA QL(120 caps/fill) SP
THYMIC STROMAL LYMPHOPOIETIN (TSLP) INHIBITORS		
TEZSPIRE 210 MG/1.91 ML PEN	T4	SP PA HD QL (1 pen/28 days)
TEZSPIRE 210 MG/1.91 ML SYRING	T4	SP PA HD QL (1 syringe/28 days)
UNCLASSIFIED DRUG PRODUCTS (Blood Modifiers/Bleeding Disorders)		
SPLEEN TYROSINE KINASE INHIBITORS		
TAVALISSE	T4	PA QL(60 tabs/fill) SP
UNCLASSIFIED DRUG PRODUCTS (Blood Pressure/Heart Medications)		
BRADYKININ B2 RECEPTOR ANTAGONISTS		
icatibant acetate (Firazyr)	T1	PA SP HD
icatibant acetate (Firazyr)	T1	PA SP
PLASMA KALLIKREIN INHIBITORS		
ORLADEYO	T5	PA SP
UNCLASSIFIED DRUG PRODUCTS (Cancer)		
CHEMOTHERAPY RESCUE/ANTIDOTE AGENTS		
leucovorin calcium	T1	CSL
MESNEX	T4	SP CSL
VISTOGARD	T4	PA QL(20 packs/30 days) SP CSL
RADIOACTIVE THERAPEUTIC AGENTS		
SODIUM IODIDE I-123	T3	CSL
UNCLASSIFIED DRUG PRODUCTS (Dental Products)		
DENTAL AIDS AND PREPARATIONS		
chlorhexidine gluconate (Peridex)	T1	
PERIDEX (*chlorhexidine gluconate*)	T3	
triamcinolone 0.1% paste	T1	

T1 – Generics
T2 – Preferred Brands
T3 – Non-Preferred Brands
T4 – Preferred Specialty
T5 – Non-Preferred Specialty
PA – Prior Authorization
QL – Quantity Limit
ST – Step Therapy
AGE – Age Requirement
SP – Specialty Medication
HD – May require home delivery pharmacy
PPACA – No Cost-Share Preventive Medication
CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

UNCLASSIFIED DRUG PRODUCTS (Dental Products) (cont.)		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
DENTAL AIDS AND PREPARATIONS (cont.)		
triamcinolone acetonide	T1	
PERIODONTAL COLLAGENASE INHIBITORS		
doxycycline hyclate 20 mg tab	T1	
UNCLASSIFIED DRUG PRODUCTS (Erectile Dysfunction)		
DRUGS TO TREAT ERECTILE DYSFUNCTION (ED)		
CAVERJECT 20 MCG VIAL	T2	PA QL(12 vials/fill)
CAVERJECT 40 MCG VIAL	T2	PA QL(12 vials/fill)
CAVERJECT IMPULSE 10 MCG KIT	T2	PA QL(12 kits/fill)
CAVERJECT IMPULSE 10 MCG SYRNG	T2	PA QL(12 syringes/fill)
CAVERJECT IMPULSE 20 MCG KIT	T2	PA QL(12 kits/fill)
CAVERJECT IMPULSE 20 MCG SYRNG	T2	PA QL(12 syringes/fill)
CIALIS (*tadalafil*)	T3	PA QL(8 tabs/30 days)
EDEX 10 MCG CARTRIDGE 2-PK KIT	T3	PA QL(6 kits/fill)
EDEX 10 MCG CARTRIDGE 6-PK KIT	T3	PA QL(2 kits/fill)
EDEX 20 MCG CARTRIDGE 2-PK KIT	T3	PA QL(6 kits/fill)
EDEX 20 MCG CARTRIDGE 6-PK KIT	T3	PA QL(2 kits/fill)
EDEX 40 MCG CARTRIDGE 2-PK KIT	T3	PA QL(6 kits/fill)
EDEX 40 MCG CARTRIDGE 6-PK KIT	T3	PA QL(2 kits/fill)
IFE-BIMIX 30/1	T3	
LEVITRA *(vardenafil hcl)*	T3	PA QL(8 tabs/fill)
MUSE	T2	PA QL(12 supps/fill)
PAPAVERINE-PHENTOLAMINE	T3	
PAPAVERINE-PHENTOLMN-ALPROSTDL	T3	
STENDRA	T3	PA QL(8 tabs/fill)
tadalafil 2.5 mg tablet	T1	PA QL(30 tabs/30 days)
tadalafil 5 mg tablet (Cialis)	T1	
tadalafil 10 mg tablet (Cialis)	T1	
tadalafil 20 mg tablet (Cialis)	T1	
TRI-MIX (PAPVRN-PHNTLMN-PGE1)	T3	
vardenafil hcl	T1	PA QL(8 tabs/fill)
vardenafil hcl (Levitra)	T1	PA QL(8 tabs/fill)
VIAGRA (*sildenafil citrate*)	T3	PA QL(8 tabs/fill)

T1 – Generics
T2 – Preferred Brands
T3 – Non-Preferred Brands
T4 – Preferred Specialty
T5 – Non-Preferred Specialty
PA – Prior Authorization
QL – Quantity Limit
ST – Step Therapy
AGE – Age Requirement
SP – Specialty Medication
HD – May require home delivery pharmacy
PPACA – No Cost-Share Preventive Medication
CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

UNCLASSIFIED DRUG PRODUCTS (Eye Conditions)		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
NICOTINIC RECEPT.PARTIAL AGONIST, ALPHA4BETA2 SPEC		
TYRVAYA	T3	PA
UNCLASSIFIED DRUG PRODUCTS (Gastrointestinal/Heartburn)		
AGENTS FOR STOMATOLOGICAL USE		
PROTHELIAL	T3	
SILATRIX	T3	
COMPOUNDING KIT		
FIRST-MOUTHWASH BLM	T3	
ORAL MUCOSITIS/STOMATITIS AGENTS		
GELCLAIR	T3	
GELX	T3	
ORAMAGICRX	T3	
ORAL MUCOSITIS/STOMATITIS ANTI-INFLAMMATORY AGENT		
EPISIL	T3	
SALIVA STIMULANT AGENTS		
NUMOISYN	T3	
SALIVA SUBSTITUTE AGENTS		
AQUORAL	T3	
BOCASAL	T3	
CAPHOSOL	T3	
MUCOSITISRX	T3	
NEUTRASAL	T3	
NUMOISYN	T3	
SALIVAMAX	T3	
UNCLASSIFIED DRUG PRODUCTS (Hormonal Agents)		
GROWTH HORMONE RECEPTOR ANTAGONISTS		
SOMAVERT	T4	PA SP HD
HYPERPARATHYROID TX AGENTS - VITAMIN D ANALOG-TYPE		
doxercalciferol	T1	ST
paricalcitol	T1	ST SP HD
paricalcitol (Zemplar)	T1	ST SP HD
RAYALDEE	T3	ST
ZEMPLAR (*paricalcitol*)	T5	ST SP HD

T1 – Generics
T2 – Preferred Brands
T3 – Non-Preferred Brands
T4 – Preferred Specialty
T5 – Non-Preferred Specialty
PA – Prior Authorization
QL – Quantity Limit
ST – Step Therapy
AGE – Age Requirement
SP – Specialty Medication
HD – May require home delivery pharmacy
PPACA – No Cost-Share Preventive Medication
CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

UNCLASSIFIED DRUG PRODUCTS (Miscellaneous)		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
ABORTIFACIENT-PROGESTERONE RECEPTOR ANTAGONISTS		
MIFEPREX	T3	
mifepristone 200 mg tablet	T1	
AMMONIA INHIBITORS		
CARBAGLU	T4	PA SP HD
carglumic acid	T1	PA SP HD
AMYLOIDOSIS AGENTS-TRANSTHYRETIN (TTR) SUPPRESSION		
TEGSEDI	T4	PA QL (SP HD
ANTI-ALCOHOLIC PREPARATIONS		
acamprosate calcium	T1	
disulfiram	T1	
ANTIFIBROTIC THERAPY - PYRIDONE ANALOGS		
pirfenidone 267 mg capsules	T1	PA QL(270 caps/30 days) SP HD
pirfenidone 267 mg tablet (Esbriet)	T1	
pirfenidone 801 mg tablet (Esbriet)	T1	
CI ESTERASE INHIBITORS		
HAEGARDA	T5	PA SP HD
HAEGARDA 2,000UNIT VIAL	T5	PA QL (24 vials/28 days) SP HD
HAEGARDA 3,000UNIT VIAL	T5	PA QL (16 vials/28 days) SP HD
CALCIMIMETIC,PARATHYROID CALCIUM ENHANCER		
cinacalcet hcl (Sensipar)	T1	PA SP
COMPOUNDING KIT		
FIRST-MOUTHWASH BLM	T3	
CRYOPRESERVATIVE AGENTS		
dimethyl sulfoxide	T1	
DRUGS TO TREAT HEREDITARY TYROSINEMIA		
nitisinone (Orfadin)	T1	PA SP HD
NITYR	T4	PA SP
ORFADIN	T5	PA SP
ORFADIN (*nitisinone*)	T5	PA SP
DRUGS TO TX GAUCHER DX-TYPE I, SUBSTRATE REDUCING		
CERDELGA	T4	PA QL (56 caps/28 days) SP HD
miglustat (Zavesca)	T1	PA SP HD
ENVIRONMENT ALLERGENS AND IRRITANTS, OTHER		
T.R.U.E. TEST	T3	

T1 – Generics
T2 – Preferred Brands
T3 – Non-Preferred Brands
T4 – Preferred Specialty
T5 – Non-Preferred Specialty
PA – Prior Authorization
QL – Quantity Limit
ST – Step Therapy
AGE – Age Requirement
SP – Specialty Medication
HD – May require home delivery pharmacy
PPACA – No Cost-Share Preventive Medication
CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

UNCLASSIFIED DRUG PRODUCTS (Miscellaneous) (cont.)		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
GENERAL INHALATION AGENTS		
HYPER-SAL	T3	
nebusal 3% vial	T1	
NEBUSAL 6% VIAL	T3	
sodium chloride for inhalation	T1	
GLUCOSYLCERAMIDE SYNTHASE (GCS) INHIBITOR		
miglustat (Zavesca)	T1	PA QL(90 caps/30 days) SP
OPFOLDA	T5	PA QL(8 caps/fill) SP HD
HOMEOPATHIC DRUGS		
VERTIGOHEEL	T3	
MENOPAUSAL SYMPTOMS SUPPRESSANT-NK3 RECEPTOR ANTAG		
VEOZAH	T3	
MENOPAUSAL SYMPTOMS SUPPRESSANT - SSRIS		
paroxetine mesylate (Brisdelle)	T1	ST QL(30 caps/fill) HD
METABOLIC DISEASE ENZYME REPLACE, HYPOPHOSPHATASIA		
STRENSIQ	T4	PA SP
METALLIC POISON, AGENTS TO TREAT		
CHEMET	T2	PA
*deferasirox (*Exjade*)*	T1	PA SP HD
*deferasirox (*Jadenu Sprinkle*)*	T1	PA SP HD
*deferasirox (*Jadenu*)*	T1	PA SP HD
*deferiprone (*Ferriprox (3 Times A Day))	T1	PA SP HD
deferiprone (Ferriprox)	T1	PA SP HD
FERRIPROX	T5	PA SP
FERRIPROX (2 TIMES A DAY)	T4	PA SP
FERRIPROX (3 TIMES A DAY) (*deferiprone*)	T4	PA SP
FERRIPROX 1,000 MG TABLET (*deferiprone*)	T4	PA SP
FERRIPROX 100 MG/ML SOLUTION	T4	PA SP
FERRIPROX 500 MG TABLET (*deferiprone*)	T5	PA SP
GALZIN	T3	
RADIOGARDASE	T3	
SYPRINE (*trientine hcl*)	T5	PA SP HD
trientine hcl (Syprine)	T1	PA SP HD
NATRIURETIC PEPTIDES		
VOXZOGO	T5	PA SP HD

T1 – Generics
T2 – Preferred Brands
T3 – Non-Preferred Brands
T4 – Preferred Specialty
T5 – Non-Preferred Specialty
PA – Prior Authorization
QL – Quantity Limit
ST – Step Therapy
AGE – Age Requirement
SP – Specialty Medication
HD – May require home delivery pharmacy
PPACA – No Cost-Share Preventive Medication
CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

UNCLASSIFIED DRUG PRODUCTS (Miscellaneous) (cont.)		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
PHARMACOLOGICAL CHAPERONE-ALPHA-GALACTOSID.A STABZ		
GALAFOLD	T5	PA QL(15 caps/fill) SP HD
PKU TX AGENT-COFACTOR OF PHENYLALANINE HYDROXYLASE		
sapropterin dihydrochloride (Kuvan)	T1	PA SP
sapropterin dihydrochloride (Kuvan)	T1	PA SP HD
PROTEIN STABILIZERS		
VYNDAMAX	T4	PA SP HD
VYNDAQEL	T4	PA SP HD
RETINOIC ACID RECEPTOR (RAR) AGONISTS		
SOHONOS 1 MG CAPSULE	T5	PA QL(112 caps/fill) SP
SOHONOS 1.5 MG CAPSULE	T5	PA QL(112 caps/fill) SP
SOHONOS 10 MG CAPSULE	T5	PA QL(56 caps/fill) SP
SOHONOS 2.5 MG CAPSULE	T5	PA QL(140 caps/fill) SP
SOHONOS 5 MG CAPSULE	T5	PA QL(84 caps/fill) SP
SOLVENTS		
CVS ISOPROPYL ALCOHOL 91%	T3	
cvs isopropyl alcohol 91%	T1	
CVS ISOPROPYL RUB ALCOHOL 70%	T3	
cvs isopropyl rub alcohol 70%	T1	
eql isopropyl alcohol 91%	T1	
eql isopropyl rub alcohol 70%	T1	
FT ISOPROPYL ALCOHOL 91%	T3	
FT ISOPROPYL RUB ALCOHOL 70%	T3	
gnp isopropyl alcohol 99%	T1	
hm isopropyl alcohol 70%	T1	
hm isopropyl alcohol 91%	T1	
INSTACLEAN	T2	
ISOPROPANOL	T2	
isopropyl 70% alcohol	T1	
isopropyl alcohol	T1	
isopropyl alcohol 70%	T1	
isopropyl alcohol 91%	T1	
isopropyl alcohol 99%	T1	
isopropyl rubbing alcohol 70%	T1	

T1 – Generics
T2 – Preferred Brands
T3 – Non-Preferred Brands
T4 – Preferred Specialty
T5 – Non-Preferred Specialty
PA – Prior Authorization
QL – Quantity Limit
ST – Step Therapy
AGE – Age Requirement
SP – Specialty Medication
HD – May require home delivery pharmacy
PPACA – No Cost-Share Preventive Medication
CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

UNCLASSIFIED DRUG PRODUCTS (Miscellaneous) (cont.)		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
SOLVENTS (cont.)		
ISOPROPYL RUBBING ALCOHOL 70%	T3	
ISOPROPYL RUBBING ALCOHOL 91%	T3	
kro isopropyl alcohol 91%	T1	
MURI-LUBE MINERAL OIL	T2	
polyethylene glycol	T1	
qc isopropyl alcohol 91%	T1	
qc isopropyl rubbing alcohol	T1	
ra isopropyl alcohol 70%	T1	
ra isopropyl alcohol 91%	T1	
sm isopropyl alcohol 70%	T1	
SM ISOPROPYL ALCOHOL 91%	T3	
sm isopropyl alcohol 91%	T1	
sm isopropyl alcohol 99%	T1	
swan isopropyl alcohol 70%	T1	
SUSPENDING AGENTS		
GELFILM	T3	
HYDROXYPROPYLCELLULOSE	T2	
HYPROMELLOSE	T2	
UNCLASSIFIED DRUG PRODUCTS (Nutritional/Dietary)		
METABOLIC DEFICIENCY AGENTS		
betaine (Cystadane)	T1	PA SP HD
CARNITOR (*levocarnitine (with sugar)*)	T3	
CARNITOR (*levocarnitine*)	T3	
CARNITOR SF (*levocarnitine*)	T3	
levocarnitine 4 gm/20 ml vial	T1	
levocarnitine (Carnitor Sf)	T1	
levocarnitine (Carnitor)	T1	
levocarnitine (with sugar) (Carnitor)	T1	
UNCLASSIFIED DRUG PRODUCTS (Osteoporosis Products)		
BONE FORMATION STIM. AGENTS - PARATHYROID HORMONE		
FORTEO *(teriparatide)*	T4	PA QL(1 pens/28 days) SP HD
teriparatide 600 mcg/2.4ml pen (Forteo)	T1	PA QL(1 pen/28 days) SP HD
TERIPARATIDE 620 MCG/2.48 ML	T5	PA QL(1 pen/28 days) SP HD

T1 – Generics
T2 – Preferred Brands
T3 – Non-Preferred Brands
T4 – Preferred Specialty
T5 – Non-Preferred Specialty
PA – Prior Authorization
QL – Quantity Limit
ST – Step Therapy
AGE – Age Requirement
SP – Specialty Medication
HD – May require home delivery pharmacy
PPACA – No Cost-Share Preventive Medication
CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

UNCLASSIFIED DRUG PRODUCTS (Osteoporosis Products) (cont.)		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
BONE RESORPTION INHIBITOR AND VITAMIN D COMBS.		
FOSAMAX PLUS D	T3	ST QL(4 tabs/28 days) HD
BONE RESORPTION INHIBITORS		
ACTONEL 35 MG TABLET *(risedronate sodium)*	T3	ST QL(4 tabs/28 days) HD
ACTONEL 150 MG TABLET (*risedronate sodium*)	T3	ST QL(1 tab/30 days) HD
alendronate sod 70 mg/75 ml	T1	QL(300 mls/28 days) HD
alendronate sodium 5mg, 10mg tablet	T1	QL(30 tabs/fill) HD
alendronate sodium 35 mg tab	T1	QL(4 tabs/28 days) HD
alendronate sodium 40 mg tab	T1	HD
alendronate sodium 70 mg tab (Fosamax)	T1	QL(4 tabs/28 days) HD
ATELVIA *(risedronate sodium)*	T3	ST QL(4 tabs/28 days) HD
BINOSTO	T3	ST QL(4 tabs/28 days) HD
EVISTA (*raloxifene hcl)*	T3	HD
FOSAMAX (*alendronate sodium*)	T3	ST QL(4 tabs/28 days) HD
ibandronate sodium	T1	QL(1 tab/30 days) HD
raloxifene hcl (Evista)	T1	HD PPACA
risedronate sodium (Atelvia)	T1	QL(4 tabs/28 days) HD
risedronate sodium 5 mg tablet	T1	QL(30 tabs/fill) HD
risedronate sodium 30 mg tab	T1	QL(30 tabs/fill) HD
risedronate sodium 35 mg tab (Actonel)	T1	QL(4 tabs/28 days) HD
risedronate sodium 150 mg tab (Actonel)	T1	QL(1 tab/30 days) HD
UNCLASSIFIED DRUG PRODUCTS (Pain Relief and Inflammatory Disease)		
ANTI-INFLAM. INTERLEUKIN-I RECEPTOR ANTAGONIST		
ARCALYST	T5	PA QL(4 vls/28 days) SP HD
FIBROMYALGIA AGENTS, SEROTONIN-NOREPINEPH RU INHIB		
SAVELLA 12.5MG, 25MG, 50MG, 100MG TABLET	T2	ST QL(60 tabs/fill) HD
SAVELLA TITRATION PACK	T2	ST QL(1 pack/retailL) HD
IMMUNOMODULATOR, B-LYMPHOCYTE STIM (BLYS)-SPEC INHIB		
BENLYSTA	T4	PA QL(4 mls/28 days) SP HD
UNCLASSIFIED DRUG PRODUCTS (Seizure Disorders)		
NEUROPATHIC AGENTS		
pregabalin (Lyrica Cr)	T1	PA HD

T1 – Generics
T2 – Preferred Brands
T3 – Non-Preferred Brands
T4 – Preferred Specialty
T5 – Non-Preferred Specialty
PA – Prior Authorization
QL – Quantity Limit
ST – Step Therapy
AGE – Age Requirement
SP – Specialty Medication
HD – May require home delivery pharmacy
PPACA – No Cost-Share Preventive Medication
CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
UNCLASSIFIED DRUG PRODUCTS (Skin Conditions)		
INTERLEUKIN-13 (IL-13) INHIBITORS, MAB		
ADBRY	T4	PA QL(4 syringes/28 days) SP HD
JANUS KINASE (JAK) INHIBITORS		
LITFULO	T5	PA QL(28 caps/28 days) SP HD
WOUND HEALING AGENTS, LOCAL		
FILSUVEZ	T5	SP
UNCLASSIFIED DRUG PRODUCTS (Substance Abuse)		
OPIOID WITHDRAWAL THERAPY AGENTS, OPIOID-TYPE		
buprenorphine 2 mg tablet sl	T1	
buprenorphine 8 mg tablet sl	T1	
buprenorphine hcl/naloxone hcl	T1	
buprenorphine hcl/naloxone hcl (Suboxone)	T1	
ZUBSOLV	T2	
UNCLASSIFIED DRUG PRODUCTS (Transplant Medications)		
RHO KINASE INHIBITOR		
REZUROCK	T5	PA QL(30 tabs/fill) SP
UNCLASSIFIED DRUG PRODUCTS (Urinary Tract Conditions)		
BENIGN PROSTATIC HYPERTROPHY/MICTURITION AGENTS		
alfuzosin hcl (Uroxatral)	T1	HD
dutasteride (Avodart)	T1	ST HD
finasteride (Proscar)	T1	HD
FLOMAX (*tamsulosin hcl*)	T3	ST HD
PROSCAR (*finasteride*)	T3	ST HD
silodosin (Rapaflo)	T1	HD
BENIGN PROSTATIC HYPERTROPHY/MICTURITION AGENTS (cont.)		
tamsulosin hcl (Flomax)	T1	HD
BPH 5-ALPHA-REDUCTASE INHIB-ALPHAI-ADRENOCEP ANTAG		
dutasteride/tamsulosin hcl (Jalyn)	T1	ST HD
JALYN (*dutasteride/tamsulosin hcl*)	T3	ST HD
CYSTINE-DEPLETING AGENTS, NEPHROPATHIC CYSTINOSIS		
CYSTAGON	T4	SP
KIDNEY STONE AGENTS		
THIOLA EC	T5	PA SP
tiopronin	T1	PA SP
tiopronin (Thiola)	T1	PA SP

T1 – Generics
T2 – Preferred Brands
T3 – Non-Preferred Brands
T4 – Preferred Specialty
T5 – Non-Preferred Specialty
PA – Prior Authorization
QL – Quantity Limit
ST – Step Therapy
AGE – Age Requirement
SP – Specialty Medication
HD – May require home delivery pharmacy
PPACA – No Cost-Share Preventive Medication
CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

UNCLASSIFIED DRUG PRODUCTS (Urinary Tract Conditions) (cont.)		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
OVERACTIVE BLADDER AGENTS, BETA-3 ADRENERGIC RECEP		
GEMTESA	T3	HD
MYRBETRIQ	T2	HD
URINARY TRACT ANTISPASMODIC, M(3) SELECTIVE ANTAG.		
darifenacin hydrobromide	T1	HD
solifenacin succinate (Vesicare)	T1	HD
URINARY TRACT ANTISPASMODIC/ANTIINCONTINENCE AGENT		
fesoterodine fumarate (Toviaz)	T1	HD
flavoxate hcl	T1	HD
GELNIQUE	T2	QL(30 packs/fill) HD
oxybutynin chloride	T1	HD
OXYTROL	T3	ST QL(8 patches/28 days) HD
tolterodine tartrate (Detrol La)	T1	HD
tolterodine tartrate (Detrol)	T1	HD
trospium chloride	T1	HD
UNCLASSIFIED DRUG PRODUCTS (Weight Management)		
APPETITE STIM. FOR ANOREXIA, CACHEXIA, WASTING SYND.		
megestrol 625 mg/5 ml susp	T1	
megestrol acet 40 mg/ml susp	T1	
megestrol acet 400 mg/10 ml	T1	
VITAMINS (Nutritional/Dietary)		
ANTIOXIDANT MULTIVITAMIN COMBINATIONS		
50 PLUS ADULT EYE HEALTH	T3	
a/c/e/zinc ox/cupric ox/lutein	T1	
ADULT 50 PLUS EYE HEALTH	T3	
ANTIOXIDANT FORMULA	T3	
EQ VISION FORMULA TABLET	T2	
eql eye health plus lutein tab	T1	
EYE HEALTH AND LUTEIN	T3	
EYE HEALTH PLUS LUTEIN TABLET	T3	
EYE MULTIVITAMIN	T2	
EYE MULTIVITAMIN WITH LUTEIN	T3	
EYEPROTECT	T3	
gnp healthy eyes tablet	T1	

T1 – Generics
T2 – Preferred Brands
T3 – Non-Preferred Brands
T4 – Preferred Specialty
T5 – Non-Preferred Specialty
PA – Prior Authorization
QL – Quantity Limit
ST – Step Therapy
AGE – Age Requirement
SP – Specialty Medication
HD – May require home delivery pharmacy
PPACA – No Cost-Share Preventive Medication
CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

VITAMINS (Nutritional/Dietary) (cont.)		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
ANTIOXIDANT MULTIVITAMIN COMBINATIONS (cont.)		
HEALTHY EYES TABLET	T2	
healthy eyes tablet	T1	
I-CAPS	T2	
ICAPS AREDS FORMULA DR TABLET	T3	
ICAPS AREDS2	T3	
LIPOTRIAD	T3	
LIPOTRIAD VISIONARY	T3	
MACULAR BENEFITS	T3	
MACULAR HEALTH FORMULA	T3	
MACUVEX	T3	
MACUZIN	T3	
MULTI-BETIC	T2	
OCULAR VITAMINS	T3	
OCUVEL	T3	
OCUVITE ADULT 50 PLUS	T2	
OCUVITE WITH LUTEIN	T2	
PRESERVISION AREDS	T2	
PRESERVISION LUTEIN	T2	
VISION FORMULA TABLET	T3	
VISION FORMULA WITH LUTEIN	T3	
VISION OPTIMIZER	T3	
VISTA ADVANCED AREDS2	T3	
vit a/vit c/vit e/zinc/copper	T1	
vits a,c,e/lutein/minerals	T1	
BIOFLAVONOIDS		
bioflav,lemon/vit bcomp,c	T1	
bioflav,lemon/vit bcomp,c (Lipo-Flavonoid Plus)	T1	
CITRUS BIOFLAVONOIDS	T3	
EAR HEALTH PLUS CAPLET	T3	
ear health plus caplet (Lipo-Flavonoid Plus)	T1	
FLOGEN	T3	
INNER EAR PLUS	T3	
LIPO FLAVONOID	T3	
LIPO-FLAVONOID PLUS (*bioflav,lemon/vit bcomp,c*)	T2	

T1 – Generics
T2 – Preferred Brands
T3 – Non-Preferred Brands
T4 – Preferred Specialty
T5 – Non-Preferred Specialty
PA – Prior Authorization
QL – Quantity Limit
ST – Step Therapy
AGE – Age Requirement
SP – Specialty Medication
HD – May require home delivery pharmacy
PPACA – No Cost-Share Preventive Medication
CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

VITAMINS (Nutritional/Dietary) (cont.)		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
BIOFLAVONOIDS (cont.)		
QUERCETIN	T3	
rutin	T1	
VASCULERA	T3	
VASOFLEX D1	T3	
VENALIV	T3	
FOLIC ACID PREPARATIONS		
cvs folic acid 800 mcg tablet	T1	PPACA
DENOVO	T3	
DEPLIN-ALGAL OIL *(levomefolate/algal oil)*	T3	
ENLYTE	T3	
FA-8	T3	
folic acid 0.4 mg tablet	T1	PPACA
folic acid 0.8 mg tablet	T1	PPACA
folic acid 1 mg tablet	T1	
folic acid 1,000 mcg tablet	T1	
FOLIC ACID 20 MG CAPSULE	T3	
folic acid 400 mcg tablet	T1	PPACA
FOLIC ACID 5 MG CAPSULE	T3	
folic acid 5 mg/ml vial	T1	
folic acid 50 mg/10 ml vial	T1	
FOLIC ACID 800 MCG CAPSULE	T3	
folic acid 800 mcg tablet	T1	PPACA
folic acid/b6/ca phos/ginger	T1	
FOLIKA-V	T3	
FOLITE	T3	
GENICIN VITA-Q	T3	
gnp folic acid 400 mcg tablet	T1	PPACA
hm folic acid 400 mcg tablet	T1	PPACA
HYLAZINC	T3	
levomefolate calcium	T1	
levomefolate/algal oil (Deplin-Algal Oil)	T1	
METHYLFOLATE	T3	
ra folic acid 0.4 mg tablet	T1	PPACA
ra folic acid 800 mcg tablet	T1	PPACA

T1 – Generics
T2 – Preferred Brands
T3 – Non-Preferred Brands
T4 – Preferred Specialty
T5 – Non-Preferred Specialty
PA – Prior Authorization
QL – Quantity Limit
ST – Step Therapy
AGE – Age Requirement
SP – Specialty Medication
HD – May require home delivery pharmacy
PPACA – No Cost-Share Preventive Medication
CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

VITAMINS (Nutritional/Dietary) (cont.)		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
FOLIC ACID PREPARATIONS (cont.)		
sm folic acid 0.4 mg tablet	T1	PPACA
sm folic acid 400 mcg tablet	T1	PPACA
sv folic acid 800 mcg tablet	T1	PPACA
true folic acid 667 mcg dfe tb	T1	PPACA
true folic acid 1600mcg dfe tb	T1	
XAQUIL XR	T3	
GERIATRIC VITAMIN PREPARATIONS		
a thru z advanced formula tab (Vision Plus Lutein)	T1	
a thru z select tablet (Vision Plus Lutein)	T1	
CENTRUM SILVER CHEWABLE TABLET	T2	
eldertonic elixir	T1	
ELDERTONIC LIQUID	T3	
GERITOL COMPLETE	T2	
GERITOL TONIC	T2	
multivit with iron,minerals	T1	
multivit with minerals/lutein (Vision Plus Lutein)	T1	
REQ49+	T3	
SPECTRAVITE ADULT 50+	T3	
VISION PLUS LUTEIN (*multivit with minerals/lutein*)	T2	
MULTIVITAMIN PREPARATIONS		
a thru z advanced formula tab	T1	
A THRU Z MEN'S ULTIMATE TABLET	T2	
A THRU Z SELECT MEN 50+ TABLET	T3	
a thru z select multivit tab	T1	
a thru z select multivit tab (Centrum Silver)	T1	
a thru z select multivit tab (Certavite Senior)	T1	
a thru z select tablet (Centrum Silver)	T1	
a thru z select tablet (Certavite Senior)	T1	
a thru z select women's tablet	T1	
a/c/e/zinc/sod selenate/copper	T1	
ABC COMPLETE SENIOR WOMEN'S	T3	
ACTIVNUTRIENTS	T3	
ADEK GUMMIES PLUS ZINC	T3	
ADULT MULTI GUMMIES	T3	

T1 – Generics
T2 – Preferred Brands
T3 – Non-Preferred Brands
T4 – Preferred Specialty
T5 – Non-Preferred Specialty
PA – Prior Authorization
QL – Quantity Limit
ST – Step Therapy
AGE – Age Requirement
SP – Specialty Medication
HD – May require home delivery pharmacy
PPACA – No Cost-Share Preventive Medication
CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

VITAMINS (Nutritional/Dietary) (cont.)		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
MULTIVITAMIN PREPARATIONS (cont.)		
ADULT MULTIVITAMIN GUMMIES	T3	
ADULT ONE DAILY GUMMIES	T3	
ADULTS' DAILY FORMULA	T3	
ADULTS MULTIVITAMIN	T3	
ADVANCED MULTI EA	T3	
ALIVE DAILY SUPPORT PRENATAL	T3	
ALIVE MAX POTENCY	T3	
ALIVE MEN'S 50 PLUS GUMMY	T3	
ALIVE MEN'S ENERGY	T3	
ALIVE MEN'S GUMMY	T3	
ALIVE PREMIUM PRENATAL	T3	
ALIVE WOMEN'S 50 PLUS	T3	
ALIVE WOMEN'S 50 PLUS ULTRA	T3	
ALIVE WOMEN'S ENERGY	T3	
ALIVE WOMEN'S GUMMY VITAMIN	T3	
ALIVE WOMEN'S ULTRA POTENCY	T3	
amino acids/mv,tx,iron,mineral	T1	
AMLADEX	T3	
ANIMI-3	T3	
AQUADEKS	T2	
BACMIN	T3	
BARIATRIC MULTIVITAMINS	T3	
b-complex plus vitamin c cplt	T1	
b-complex with vitamin c	T1	
b-complex with vitamin c (Support-500)	T1	
b-complex w-vitamin c caplet	T1	
BEROCCA	T3	
beta-carotene(a)-vits c,e/mins	T1	
BIO-35	T3	
BLADDER 2.2	T2	
BODY, HAIR, SKIN AND NAILS	T3	
CENTRAL-VITE	T3	
CENTRAL-VITE WOMEN'S MATURE (*multivit-min/iron/folic/lutein*)	T3	
CENTRAVITES ADULTS	T3	

T1 – Generics
T2 – Preferred Brands
T3 – Non-Preferred Brands
T4 – Preferred Specialty
T5 – Non-Preferred Specialty
PA – Prior Authorization
QL – Quantity Limit
ST – Step Therapy
AGE – Age Requirement
SP – Specialty Medication
HD – May require home delivery pharmacy
PPACA – No Cost-Share Preventive Medication
CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

VITAMINS (Nutritional/Dietary) (cont.)		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
MULTIVITAMIN PREPARATIONS (cont.)		
CENTRUM	T2	
CENTRUM ADULT 50 PLUS	T3	
CENTRUM ADULT 50 FRESH-FRUITY	T3	
CENTRUM CHEWABLES ADULTS TAB	T2	
CENTRUM CHEWABLES ADULTS TAB	T3	
CENTRUM COMPLETE	T2	
CENTRUM FLAVOR BURST ADULT	T3	
CENTRUM MEN	T2	
CENTRUM MULTIGUMMIES	T3	
CENTRUM SILVER MEN	T3	
CENTRUM SILVER TABLET (*multivit-min/fa/lycopen/lutein*)	T3	
CENTRUM SILVER ULTRA MEN'S (*multivit-min/fa/lycopen/lutein*)	T2	
CENTRUM SILVER WOMEN (*multivit-min/iron/folic/lutein*)	T3	
CENTRUM SPECIALIST ENERGY	T3	
CENTRUM SPECIALIST HEART	T2	
CENTRUM ULTRA MEN'S	T2	
CENTURY MEN'S	T3	
certavite senior tablet (Centrum Silver)	T1	
certavite senior tablet (Certavite Senior)	T1	
CERTAVITE SENIOR TABLET (*multivit-min/fa/lycopen/lutein*)	T3	
certavite-antioxidant tablet (Certavite-Antioxidant)	T1	
CERTAVITE-ANTIOXIDANT TABLET (*multivitamin/iron/folic acid*)	T3	
certavite-antioxidant tablet (Tab-A-Vite Multivit With Iron)	T1	
COMPLETE MEN	T2	
COMPLETE MEN 50 PLUS	T3	
COMPLETE MULTIVITAMIN-MINERAL	T3	
CONCEPT DHA (*mvn-min75/iron/iron ps/om3/dha*)	T3	
CONCEPT OB (m*vn-min 74/iron fum/iron/fa*)	T3	
CORVITE	T3	
CULTURELLE PROBIOTIC-MULTIVIT	T3	
cvs b-complex-vit c caplet	T1	
CVS DAILY MULTIPLE TABLET	T2	
cvs daily multiple tablet (One-A-Day)	T1	
cvs hair, skin and nails cplt	T1	

T1 – Generics
T2 – Preferred Brands
T3 – Non-Preferred Brands
T4 – Preferred Specialty
T5 – Non-Preferred Specialty
PA – Prior Authorization
QL – Quantity Limit
ST – Step Therapy
AGE – Age Requirement
SP – Specialty Medication
HD – May require home delivery pharmacy
PPACA – No Cost-Share Preventive Medication
CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

VITAMINS (Nutritional/Dietary) (cont.)		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
MULTIVITAMIN PREPARATIONS (cont.)		
cvs one daily essential tablet (Daily-Vite)	T1	
DAILY GUMMIES	T3	
DAILY MULTIVITAMIN	T3	
daily-vite tablet (Daily-Vite)	T1	
DAILY-VITE TABLET (*multivitamin with folic acid*)	T3	
DAYAVITE	T3	
DECUBI VITE	T3	
DEKAS BARIATRIC	T3	
DEKAS ESSENTIAL	T3	
DEKAS PLUS	T3	
DERMACINRX FOLIFLEX	T3	
DERMACINRX FOLITIN-Z	T3	
DERMACINRX MULTITAM	T3	
DERMACINRX RIBOTIN-E	T3	
DERMACINRX VENEXA	T3	
DERMACINRX VENEXA FE	T3	
DERMACINRX VENTRIXYL	T3	
DERMACINRX VENTRIXYL FE	T3	
DERMACINRX VITRAMYN	T3	
DERMACINRX VITRANOL	T3	
DERMACINRX VITRANOL FE	T3	
DERMACINRX VITREXATE	T3	
DERMACINRX VITREXATE FE	T3	
DERMACINRX ZINTREXYL-C	T3	
DIABETES HEALTH FORMULA	T3	
DIABETIC VITAMIN	T3	
DIALYVITE 800 WITH IRON	T3	
ELON MATRIX 5000 COMPLETE	T3	
ENBRACE HR	T3	
ENDUR-VM IRON-FREE	T3	
ENDUR-VM WITH IRON	T3	
EQ ONE DAILY WOMEN'S HEALTH TB	T3	
EQ ONE DAILY WOMEN'S TABLET	T2	
eql one daily men's tablet	T1	

T1 – Generics
T2 – Preferred Brands
T3 – Non-Preferred Brands
T4 – Preferred Specialty
T5 – Non-Preferred Specialty
PA – Prior Authorization
QL – Quantity Limit
ST – Step Therapy
AGE – Age Requirement
SP – Specialty Medication
HD – May require home delivery pharmacy
PPACA – No Cost-Share Preventive Medication
CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

VITAMINS (Nutritional/Dietary) (cont.)		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
MULTIVITAMIN PREPARATIONS (cont.)		
ESSENTIAL MAN	T3	
ESSENTIAL MAN 50+	T3	
ESSENTIAL WOMAN 50+	T3	
ESTROVEN MENOPAUSE	T3	
fa/mv,ca,iron,min/lycopene/lut	T1	
FATIGUE RELIEF COMPLEX (*bcomp,c/st.jhn wrt/s.ginsg/pgn*)	T3	
FOLAGENT DHA	T3	
FOLAMAX	T3	
FOLAMED DHA	T3	
folic acid/multivit,iron,miner	T1	
folic acid/mv,iron,min/lutein	T1	
FOLIC ACID-VIT B-6-VIT B-12	T3	
folic/mvi ther-min/lycop/lut	T1	
FOLIKA-CI	T3	
FOLIKA-MG	T3	
FORTAVIT	T3	
FREEDAVITE	T3	
GENADEK STEP 1	T3	
GENADEK STEP 2	T3	
GERBER GS PRENATAL NOURISH PLS	T3	
GNP B-COMPLEX PLUS VIT C TAB	T3	
gnp one daily tablet	T1	
HAIR FORMULA	T3	
HAIR, SKIN AND NAILS CAPLET	T3	
HAIR, SKIN AND NAILS SOFTGEL	T3	
HAIR, SKIN AND NAILS TABLET (*multivitamin/folic acid/biotin*)	T3	
HEARTBURN ACID REFLUX	T3	
high potency multivitamin tab	T1	
HIGH POTENCY MULTIVITAMIN TAB	T3	
high potency multivitamin tab (Certavite-Antioxidant)	T1	
high potency multivitamin tab (Tab-A-Vite Multivit With Iron)	T1	
HM HAIR, SKIN AND NAILS TABLET	T3	
HM MEN'S ONE DAILY TABLET	T2	
ICAPS MV	T2	

T1 – Generics
T2 – Preferred Brands
T3 – Non-Preferred Brands
T4 – Preferred Specialty
T5 – Non-Preferred Specialty
PA – Prior Authorization
QL – Quantity Limit
ST – Step Therapy
AGE – Age Requirement
SP – Specialty Medication
HD – May require home delivery pharmacy
PPACA – No Cost-Share Preventive Medication
CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

VITAMINS (Nutritional/Dietary) (cont.)		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
MULTIVITAMIN PREPARATIONS (cont.)		
ICAPS TABLET	T2	
IMMUNERX	T3	
INFUVITE ADULT	T3	
K-PAX IMMUNE SUPPORT	T2	
lecithin/pyridoxine/kelp	T1	
lmefolate/b3/copp/zn/sel/chrom	T1	
MAXIMIN	T3	
MEBOLIC	T3	
MEN 50 PLUS ADVANCED ONE DAILY	T3	
MEN 50 PLUS MULTIVITAMIN	T3	
MEN'S 50 PLUS DAILY FORMULA	T3	
MEN'S 50 PLUS MULTIVITAMIN	T3	
MEN'S DAILY FORMULA	T3	
MEN'S DAILY GUMMIES	T3	
MEN'S DAILY PACK	T3	
MEN'S MULTIVITAMIN	T3	
MONOCAPS	T3	
MULTI FOR HER 50 PLUS	T3	
MULTI FOR HER SOFTGEL	T3	
multi for her tablet	T1	
MULTI PRO	T3	
MULTI-DAY PLUS MINERALS	T3	
MULTILEX TABLET	T3	
multilex tablet	T1	
MULTILEX T-M	T3	
multivit 47/iron/folate 1/dha	T1	
multivit infusn,adult 1,vit k	T1	
multivit no.51/iron/folic acid	T1	
multivit with calcium,iron,min	T1	
multivit with iron,minerals	T1	
multivit,calc,mins/iron/folic	T1	
multivit,iron,minerals/lutein	T1	
multivit,stress formula/zinc (Stress Formula With Zinc)	T1	
multivit/iron/folic acid/hb179	T1	

T1 – Generics
T2 – Preferred Brands
T3 – Non-Preferred Brands
T4 – Preferred Specialty
T5 – Non-Preferred Specialty
PA – Prior Authorization
QL – Quantity Limit
ST – Step Therapy
AGE – Age Requirement
SP – Specialty Medication
HD – May require home delivery pharmacy
PPACA – No Cost-Share Preventive Medication
CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

VITAMINS (Nutritional/Dietary) (cont.)		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
MULTIVITAMIN PREPARATIONS (cont.)		
multivitamin	T1	
MULTI-VITAMIN	T3	
multivitamin combination no.55	T1	
multivitamin combination no.56	T1	
MULTIVITAMIN GUMMIES	T3	
MULTIVITAMIN LIQUID	T3	
multivitamin tablet	T1	
multivitamin with folic acid (Daily-Vite)	T1	
multivitamin with iron	T1	
MULTIVITAMIN WITH MINERALS	T3	
multivitamin with minerals	T1	
multivitamin,stress formula	T1	
multivitamin,ther and minerals	T1	
multivitamin,therapeutic	T1	
multivitamin,therapeutic (Oncovite)	T1	
multivitamin/ferrous gluconate	T1	
multivitamin/iron/folic acid (Certavite-Antioxidant)	T1	
multivitamin/iron/folic acid (Tab-A-Vite Multivit With Iron)	T1	
MULTI-VITE	T3	
multivit-min/fa/lycopen/lutein	T1	
*multivit-min/fa/lycopen/lutein (*Centrum Silver*)*	T1	
*multivit-min/fa/lycopen/lutein (*Certavite Senior*)*	T1	
multivit-min/ferrous gluconate	T1	
multivit-min/folic acid/biotin	T1	
multivit-min/iron fum/folic ac	T1	
multivit-min/iron/folic/lutein (Central-Vite Women'S Mature)	T1	
multivit-min/iron/folic/lutein (Centrum Silver Women)	T1	
multivit-min69/iron/folic acid	T1	
multivit-minerals/fa/lycopene	T1	
multivit-minerals/folic acid (One-A-Day)	T1	
multivit-minerals/folic/ginkgo	T1	
multivit-mins no.7/folic acid	T1	
multivit-mins/iron/folic/lycop	T1	
mv, min 59/iron/folic/docusate	T1	

T1 – Generics
T2 – Preferred Brands
T3 – Non-Preferred Brands
T4 – Preferred Specialty
T5 – Non-Preferred Specialty
PA – Prior Authorization
QL – Quantity Limit
ST – Step Therapy
AGE – Age Requirement
SP – Specialty Medication
HD – May require home delivery pharmacy
PPACA – No Cost-Share Preventive Medication
CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

VITAMINS (Nutritional/Dietary) (cont.)		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
MULTIVITAMIN PREPARATIONS (cont.)		
mv,cal,min/iron/folic acid/lut	T1	
mv,iron,min/ginkgo/pan.ginseng	T1	
mv-min/iron/folic ac/vit k/lut	T1	
mv-mins 71/iron/folic no.1/dha	T1	
mv-mins/folic/lycopene/ginkgo	T1	
mv-mn/folic acid/lutein/hrb178	T1	
mvn no.53/iron/folic/dss/dha	T1	
mvn-min 74/iron fum/iron/fa (Concept Ob)	T1	
mvn-min75/iron/iron ps/om3/dha (Concept Dha)	T1	
MVW MODULATR FORM MINI MULTIVT	T3	
NEEVODHA	T3	
NEOVITE	T3	
NESTABS ONE	T3	
NICOMIDE	T3	
NIVA-PLUS (*multivit-mins60/iron fum/folic*)	T3	
NUTRIVIT	T2	
OB COMPLETE	T3	
OBSTETRIX ONE	T3	
O-CAL FA	T3	
OCUVITE EYE PLUS MULTI	T3	
om-3/dha/epa/b12/fa/b6/phytost	T1	
OMNIVEX	T3	
ONCOVITE (*multivitamin,therapeutic*)	T2	
ONE DAILY ESSENTIAL TABLET	T3	
one daily essential tablet	T1	
one daily essential tablet (Daily-Vite)	T1	
ONE DAILY HEALTHY WEIGHT	T3	
ONE DAILY MEN'S	T2	
ONE DAILY MEN'S 50 PLUS	T3	
ONE DAILY MEN'S 50 PLUS D3	T3	
ONE DAILY MEN'S HEALTH	T3	
ONE DAILY MEN'S MULTIVITAMIN	T3	
one daily multivitamin tab	T1	

T1 – Generics
T2 – Preferred Brands
T3 – Non-Preferred Brands
T4 – Preferred Specialty
T5 – Non-Preferred Specialty
PA – Prior Authorization
QL – Quantity Limit
ST – Step Therapy
AGE – Age Requirement
SP – Specialty Medication
HD – May require home delivery pharmacy
PPACA – No Cost-Share Preventive Medication
CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

VITAMINS (Nutritional/Dietary) (cont.)		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
MULTIVITAMIN PREPARATIONS (cont.)		
one daily multivitamin tab	T1	
ONE DAILY MULTIVITAMIN TABLET	T3	
one daily multivitamin tablet (Daily-Vite)	T1	
one daily tablet	T1	
ONE DAILY WOMEN 50 PLUS TAB	T3	
ONE DAILY WOMEN'S 50 PLUS ADV	T3	
ONE DAILY WOMEN'S 50+	T2	
ONE DAILY WOMEN'S FORMULA	T3	
one daily women's health tab	T1	
ONE DAILY WOMEN'S MULTIVITAMIN	T3	
ONE-A-DAY (*multivit-minerals/folic acid*)	T3	
ONE-A-DAY ENERGY	T3	
ONE-A-DAY MEN VITACRAVES	T3	
ONE-A-DAY MENOPAUSE FORMULA	T3	
ONE-A-DAY MEN'S	T2	
ONE-A-DAY MEN'S 50 PLUS	T2	
ONE-A-DAY MEN'S 50 PLUS (*mv-mins/folic/lycopene/ginkgo*)	T2	
ONE-A-DAY MEN'S COMPLETE	T3	
ONE-A-DAY PROACTIVE 65 PLUS	T3	
ONE-A-DAY VITACRAVES	T3	
ONE-A-DAY VITACRAVES IMMUNITY	T3	
ONE-A-DAY VITACRAVES OMEGA-3	T3	
ONE-A-DAY VITACRAVES SOUR	T3	
ONE-A-DAY WEIGHTSMART	T2	
ONE-A-DAY WOMEN VITACRAVES	T3	
ONE-A-DAY WOMEN'S 50 PLUS	T3	
ONE-A-DAY WOMEN'S COMPLETE	T2	
ONE-A-DAY WOMEN'S HEALTHY SKIN	T3	
ONE-A-DAY WOMEN'S PETITES	T3	
ONE-A-DAY WOMEN'S TABLET	T2	
ONE-A-DAY WOMEN'S TABLET	T3	
ONE-DAILY MULTI	T3	
ONE-DAILY MULTI-VIT POWDER PKT	T3	
one daily multivit-mineral tab	T1	

T1 – Generics
T2 – Preferred Brands
T3 – Non-Preferred Brands
T4 – Preferred Specialty
T5 – Non-Preferred Specialty
PA – Prior Authorization
QL – Quantity Limit
ST – Step Therapy
AGE – Age Requirement
SP – Specialty Medication
HD – May require home delivery pharmacy
PPACA – No Cost-Share Preventive Medication
CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

VITAMINS (Nutritional/Dietary) (cont.)		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
MULTIVITAMIN PREPARATIONS (cont.)		
ONE DAILY MULTIVIT-MINERAL TAB	T3	
one-daily multi-vitamin tab	T1	
ONE-DAILY MULTI-VITAMIN-IRON	T3	
ONE-DAILY MULTIVITAMIN-MINERAL	T3	
ONEVITE	T3	
OPTIFAST	T3	
OPTISOURCE	T3	
OPURITY MULTIVITAMIN	T3	
POLY VITAMIN-IRON	T3	
PRENATE AM	T3	
PRENATE CHEWABLE	T3	
PRENATE ESSENTIAL	T3	
PROCERV HP	T3	
PROFOLA	T3	
PRORENAL QD	T2	
PROTECT CARDIO AF	T3	
PROTECT IRON	T3	
PROTECT PLUS SO	T3	
PUREFE OB PLUS	T3	
PUREFE PLUS	T3	
QUINTABS	T3	
QUINTABS-M	T3	
RA MEN'S ONE DAILY TABLET	T2	
ra one daily essential tablet (One-A-Day)	T1	
ra one daily women's tablet	T1	
REMEDIENT	T3	
sm b complex with vit c tablet	T1	
sm super b complex-c caplet	T1	
SOLO	T3	
SPECTRAVITE MEN 50 PLUS	T3	
SPECTRAVITE ULTRA MEN 50+	T3	
SPECTRAVITE ULTRA MEN'S	T3	
STRESS B-COMPLEX	T3	
stress formula tablet	T1	

T1 – Generics
T2 – Preferred Brands
T3 – Non-Preferred Brands
T4 – Preferred Specialty
T5 – Non-Preferred Specialty
PA – Prior Authorization
QL – Quantity Limit
ST – Step Therapy
AGE – Age Requirement
SP – Specialty Medication
HD – May require home delivery pharmacy
PPACA – No Cost-Share Preventive Medication
CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

VITAMINS (Nutritional/Dietary) (cont.)		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
MULTIVITAMIN PREPARATIONS (cont.)		
STRESS FORMULA WITH ZINC TAB (*multivit,stress formula/zinc*)	T3	
stress formula with zinc tab (Stress Formula With Zinc)	T1	
stress-c with zinc tablet (Stress Formula With Zinc)	T1	
STROVITE FORTE (*multivit,iron,min 5/folic acid*)	T3	
STROVITE ONE	T3	
SUPER GINSENG MULTIVITAMIN	T3	
SUPER MULTIPLE-LOW IRON	T3	
SUPPORT-500 (*b-complex with vitamin c*)	T3	
SV HAIR, SKIN AND NAILS CAPLET	T3	
TAB-A-VITE MULTIVIT WITH IRON	T3	
tab-a-vite multivit with iron	T1	
TAB-A-VITE MULTIVIT WITH IRON (*multivitamin/iron/folic acid)*	T3	
THERAGRAN-M PREMIER 50 PLUS	T3	
thera-m caplet	T1	
thera-m tablet	T1	
THERA-M CAPLET	T3	
THERAMILL FORTE	T3	
THERANATAL LACTATION SUPPORT	T3	
THEREMS-H	T2	
TOBAKIENT	T3	
TRUE MULTIVITAMIN	T3	
TRUEPLUS MULTIVITAMIN (*multivit-min/folic acid/vit k1)*	T3	
UDAMIN SP	T3	
ULTRA FREEDA	T3	
VITABEX PLUS	T3	
VITAJOY ADULT MULTI	T3	
vitamin b complex-vit c cap (Support-500)	T1	
vitamin b complex-vit c caplet	T1	
vitamin b complex-vitamin c tb	T1	
VITAMIN D3-ALOE	T3	
vitamins a and d	T1	
VITAMINS A-D-E	T3	
VITREXYL	T3	

T1 – Generics
T2 – Preferred Brands
T3 – Non-Preferred Brands
T4 – Preferred Specialty
T5 – Non-Preferred Specialty
PA – Prior Authorization
QL – Quantity Limit
ST – Step Therapy
AGE – Age Requirement
SP – Specialty Medication
HD – May require home delivery pharmacy
PPACA – No Cost-Share Preventive Medication
CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

VITAMINS (Nutritional/Dietary) (cont.)		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
MULTIVITAMIN PREPARATIONS (cont.)		
VITREXYL PLUS IRON	T3	
VITRUM 50 PLUS SENIOR	T2	
WELLESSE MULTI VITAMIN PLUS	T3	
WOMEN 50 PLUS MULTIVIT ADVANCE	T3	
WOMEN'S 50 PLUS ADVANCED	T3	
WOMEN'S 50 PLUS DAILY FORMULA	T3	
women's daily formula caplet	T1	
WOMEN'S DAILY FORMULA CAPLET	T2	
WOMEN'S DAILY FORMULA TABLET	T3	
WOMENS DAILY GUMMIES	T3	
WOMEN'S DAILY PACK	T3	
WOMEN'S MULTIVITAMIN	T3	
WOMEN'S MULTIVITAMIN W-BIOTIN	T3	
XYZBAC	T3	
ZYVANA	T3	
ZYVIT	T3	
NIACIN PREPARATIONS		
cvs niacin 400 mg capsule	T1	
cvs niacin flush free 500 mg	T1	
ENDUR-AMIDE	T3	
ENDUR-THINE	T3	
gnp niacin 250 mg tablet	T1	
gnp niacin 400 mg capsule	T1	
hm niacin tr 250 mg tablet (Slo-Niacin)	T1	
niacin	T1	
niacin (inositol niacinate)	T1	
niacin (Slo-Niacin)	T1	
niacin 100 mg tablet	T1	
niacin 250 mg tablet	T1	
niacin 50 mg tablet	T1	
niacin 500 mg capsule	T1	
niacin 500 mg capsule sa	T1	
NIACIN 500 MG SOFTGEL	T2	

T1 – Generics
T2 – Preferred Brands
T3 – Non-Preferred Brands
T4 – Preferred Specialty
T5 – Non-Preferred Specialty
PA – Prior Authorization
QL – Quantity Limit
ST – Step Therapy
AGE – Age Requirement
SP – Specialty Medication
HD – May require home delivery pharmacy
PPACA – No Cost-Share Preventive Medication
CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

VITAMINS (Nutritional/Dietary) (cont.)		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
NIACIN PREPARATIONS (cont.)		
niacin 500 mg tablet	T1	
niacin 750 mg tablet sa (Slo-Niacin)	T1	
NIACIN ER 1,000 MG TABLET	T2	
niacin er 250 mg tablet (Slo-Niacin)	T1	
niacin er 500 mg caplet	T1	
niacin er 500 mg capsule	T1	
niacin er 500 mg tablet	T1	
niacin flush free 500 mg cap	T1	
NIACIN FLUSH FREE 750 MG CAP	T2	
niacin sa 250 mg capsule	T1	
niacin tr 250 mg capsule	T1	
niacin tr 250 mg tablet (Slo-Niacin)	T1	
niacin tr 500 mg caplet	T1	
niacin tr 500 mg tablet	T1	
niacinamide 500 mg tablet	T1	
NIACINAMIDE ER 500 MG TABLET	T3	
NO FLUSH NIACIN	T3	
ra niacin 100 mg tablet	T1	
RA NIACIN 500 MG TABLET	T3	
ra niacin 500 mg tablet	T1	
SLO-NIACIN 250 MG TABLET (*niacin*)	T2	
slo-niacin 500 mg tablet	T1	
SLO-NIACIN 750 MG TABLET (*niacin*)	T2	
sv niacin flush free 500 mg	T1	
PANTHENOL PREPARATIONS		
CALCIUM PANTOTHENATE	T3	
PANTETHINE	T3	
PEDIATRIC VITAMIN PREPARATIONS		
ABDEK MULTIVITAMIN	T3	
ANIMAL SHAPES COMPLETE	T3	
AQUADEKS	T2	
CENTRUM KIDS	T3	
CHILD CHEWABLE VITAMN COMPLETE	T3	
CHILD COMPLETE CHEWABLE VITAMN	T3	

T1 – Generics
T2 – Preferred Brands
T3 – Non-Preferred Brands
T4 – Preferred Specialty
T5 – Non-Preferred Specialty
PA – Prior Authorization
QL – Quantity Limit
ST – Step Therapy
AGE – Age Requirement
SP – Specialty Medication
HD – May require home delivery pharmacy
PPACA – No Cost-Share Preventive Medication
CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

VITAMINS (Nutritional/Dietary) (cont.)		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
PEDIATRIC VITAMIN PREPARATIONS (cont.)		
CHILD COMPLETE MULTIVITAMIN	T3	
CHILD MULTIVITAMIN PLUS IRON	T3	
CHILDREN MULTIVITAMIN	T3	
children multivitamin chew tab	T1	
CHILDREN MULTIVITAMIN GUMMIES	T3	
CHILDREN MULTIVITAMIN GUMMIES (*pediatric multivitamin no.120*)	T3	
CHILDREN'S CHEW MULTIVIT-IRON (*pedi multivit no.91/iron fum*)	T3	
childrens chew vitamin tab (Flintstones With Extra C)	T1	
childrens chew vitamin tab (Flintstones)	T1	
CHILDREN'S CHEWABLE	T3	
CHILDREN'S MULTI-VIT GUMMIES	T3	
CHILDREN'S MULTIVITAMIN GUMMY	T3	
CHILD'S CHEWABLE VITAMIN TAB	T3	
CHILD'S OMEGA-3 DHA MULTIVITAM	T3	
CULTURELLE KIDS PROBIOTIC-MV	T3	
CULTURELLE KIDS PRO-MV-LUTEIN	T3	
CVS CHILD GUMMY DINOS GUMMIES	T3	
cvs gummy dinos vitamin	T1	
DEKAS PLUS	T3	
EMERGEN-C KIDZ	T3	
EQ CHILD MULTIVITAMIN GUMMIES	T3	
FLINTSTONES COMPLETE GUMMIES	T3	
FLINTSTONES COMPLETE TABLET (*multivit with iron,minerals*)	T2	
FLINTSTONES EXTRA C GUMMIES	T3	
FLINTSTONES EXTRA C TAB CHEW (*multivitamin*)	T2	
FLINTSTONES GUMMIES	T2	
FLINTSTONES GUMMIES CHEW TAB	T3	
FLINTSTONES IMMUNITY SUPPORT	T3	
FLINTSTONES MULTIVIT CHEW TAB (*pedi multivit no.25/folic acid*)	T3	
FLINTSTONES MULTI-VIT GUMMIES	T2	
FLINTSTONES PLUS CALCIUM	T2	
FLINTSTONES SOUR-GUM CHEW TAB	T3	
FLINTSTONES TAB CHEW	T2	
FLINTSTONES TABLET CHEWABLE (multivitamin)	T2	

T1 – Generics
T2 – Preferred Brands
T3 – Non-Preferred Brands
T4 – Preferred Specialty
T5 – Non-Preferred Specialty
PA – Prior Authorization
QL – Quantity Limit
ST – Step Therapy
AGE – Age Requirement
SP – Specialty Medication
HD – May require home delivery pharmacy
PPACA – No Cost-Share Preventive Medication
CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

VITAMINS (Nutritional/Dietary) (cont.)		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
PEDIATRIC VITAMIN PREPARATIONS (cont.)		
FLINTSTONES WITH IRON	T3	
FLORIVA	T3	
FLORIVA PLUS	T3	
GENADEK	T3	
GERBER GROW MIGHTY	T3	
GERBER LIL BRAINIES	T3	
GUMMIES CHILDREN MULTIVITAMIN	T3	
GUMMY	T3	
INFANT-TODDLER MULTIVITAMIN	T3	
INFANT-TODDLER MULTIVIT-IRON	T3	
infant-toddler multivit-iron	T1	
INFANT-TODDLER TRI-VITAMIN	T3	
INFUVITE PEDIATRIC	T2	
JUST 4 KIDZ MULTIVIT-PROBIOTIC	T3	
KIDS COD LIVER OIL +D	T3	
KIDS MULTIVITAMIN-MINERALS	T2	
LITTLE ANIMALS PLUS IRON	T3	
LIVITA FOR CHILDREN	T3	
M.V.I. PEDIATRIC	T2	
multivit with iron,minerals	T1	
multivit with iron,minerals (Flintstones Complete)	T1	
multivit with iron,minerals (Scooby-Doo)	T1	
multivitamin (Flintstones With Extra C)	T1	
multivitamin (Flintstones)	T1	
multivitamin with iron	T1	
MULTI-VIT-FLOR	T3	
MULTIVIT-FLUOR 0.25 MG TAB CHW	T3	
multivit-fluor 0.25 mg tab chw	T1	PPACA
multivit-fluor 0.25 mg/ml drop	T1	PPACA
multivit-fluor 0.5 mg tab chew	T1	PPACA
MULTIVIT-FLUOR 0.5 MG TAB CHEW	T3	
multivit-fluor 0.5 mg/ml drop	T1	PPACA
multivit-fluoride 1 mg tab chw	T1	PPACA
MULTIVIT-FLUORIDE 1 MG TAB CHW	T3	

T1 – Generics
T2 – Preferred Brands
T3 – Non-Preferred Brands
T4 – Preferred Specialty
T5 – Non-Preferred Specialty
PA – Prior Authorization
QL – Quantity Limit
ST – Step Therapy
AGE – Age Requirement
SP – Specialty Medication
HD – May require home delivery pharmacy
PPACA – No Cost-Share Preventive Medication
CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

VITAMINS (Nutritional/Dietary) (cont.)		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
PEDIATRIC VITAMIN PREPARATIONS (cont.)		
MVW COMPLETE FORMLTN PEDIATRIC	T3	
MVW COMPLETE FORMULATION D3000	T3	
MVW COMPLETE FORMULATION D5000	T3	
MVW COMPLETE FORMULTN MULTIVIT	T3	
MVW MODULATR FORMLTN PEDIATRIC	T3	
NANO VM 1-3	T2	
NANO VM 4-8	T2	
NANOVM 9-18	T3	
NANOVM T-F	T3	
NOVAFERRUM PEDIATRIC MV-IRON	T3	
NOVAMV	T3	
ONE-A-DAY KID'S	T3	
ONE-A-DAY TEEN HER VITACRAVES	T3	
ONE-A-DAY TEEN HIM VITACRAVES	T3	
ped mvit a,c,d3 no.21/fluoride	T1	PPACA
pedi multivit 158/iron/vit k1	T1	
pedi multivit 45/fluoride/iron	T1	
pedi multivit no.12 w-fluoride	T1	PPACA
pedi multivit no.159/iron sulf	T1	
pedi multivit no.23/folic acid	T1	
pedi multivit no.25/folic acid (Flintstones)	T1	
PEDIA POLY-VITE	T3	
pedia poly-vite iron 5mg/0.5ml	T1	
PEDIA POLY-VITE WITH IRON DROP	T3	
PEDIA TRI-VITE	T3	
pediatric multivit no.36/iron	T1	
pediatric multivitamin no.17	T1	
PEDIATRIC POLY-VITAMIN	T3	
PEDIATRIC POLY-VITAMIN-IRON	T3	
PEDIATRIC POLY-VITE	T3	
PEDIATRIC POLY-VITE WITH IRON	T3	
PEDIATRIC TRI-VITAMIN	T3	
PEDIATRIC TRI-VITE	T3	
POLY-VI-FLOR	T3	

T1 – Generics
T2 – Preferred Brands
T3 – Non-Preferred Brands
T4 – Preferred Specialty
T5 – Non-Preferred Specialty
PA – Prior Authorization
QL – Quantity Limit
ST – Step Therapy
AGE – Age Requirement
SP – Specialty Medication
HD – May require home delivery pharmacy
PPACA – No Cost-Share Preventive Medication
CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

VITAMINS (Nutritional/Dietary) (cont.)		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
PEDIATRIC VITAMIN PREPARATIONS (cont.)		
POLY-VI-FLOR WITH IRON	T3	
poly-vi-sol 0.5 ml oral syring	T1	
POLY-VI-SOL 1 ML ENFIT SYRINGE	T3	
POLY-VI-SOL 250MCG-50MG/ML DRP	T3	
POLY-VI-SOL WITH IRON	T3	
POLY-VITA	T3	
POLY-VITA WITH IRON	T3	
QUFLORA	T3	
QUFLORA FE	T3	
SCOOBY-DOO ONE A DAY GUMMIES	T3	
SCOOBY-DOO ONE A DAY TABLET (*multivit with iron,minerals*)	T2	
TRI-VI-FLOR	T3	
TRI-VI-SOL	T3	
TROPICAL LIQUID NUTRITION (*pediatric multivitamin no.118*)	T3	
vit a palmitate/vit c/vit d3	T1	
ZOO FRIENDS	T3	
ZOO FRIENDS COMPLETE	T3	
VITAMIN A AND D PREPARATIONS		
cod liver oil softgel	T1	
gnp norwegian cod liver oil	T1	
SV COD LIVER OIL SOFTGEL	T3	
VITAMIN A PREPARATIONS		
A-25	T3	
AQUASOL A	T2	
beta-carotene	T1	
cvs vitamin a 2,400 mcg sftgl	T1	
gnp vitamin a 10,000 unit sfgl	T1	
NORWEGIAN COD LIVER OIL SFGL	T3	
PREVENT	T2	
ra vitamin a 10,000 unit sftgl	T1	
VITAMIN A BETA CAROTENE	T3	
vitamin a 10,000 unit capsule	T1	
vitamin a 10,000 unit softgel	T1	
VITAMIN A 10,000 UNIT SOFTGEL	T3	

T1 – Generics
T2 – Preferred Brands
T3 – Non-Preferred Brands
T4 – Preferred Specialty
T5 – Non-Preferred Specialty
PA – Prior Authorization
QL – Quantity Limit
ST – Step Therapy
AGE – Age Requirement
SP – Specialty Medication
HD – May require home delivery pharmacy
PPACA – No Cost-Share Preventive Medication
CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

VITAMINS (Nutritional/Dietary) (cont.)		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
VITAMIN A PREPARATIONS (cont.)		
vitamin a 3,000 mcg softgel	T1	
vitamin a 8,000 unit capsule	T1	
vitamin a 8,000 unit softgel	T1	
VITAMIN A PALMITATE	T3	
vitamin a/vit c/zinc/propolis	T1	
VITAMINS A D	T3	
VITAMIN B PREPARATIONS		
5-MTHF PLUS B12	T3	HD
acetylcyst/methylb12/levomefol	T1	HD
ALBA-LYBE	T2	HD
APETEX (*vitamin b complex/lysine*)	T2	HD
APETIGEN (*vitamin b complex/lysine*)	T2	HD
ARKALIOX	T3	HD
B ACTIV	T3	HD
b comp no3/folic/c/biotin/zinc	T1	HD
b comp/ferrous gluc/lysin/znox	T1	HD
b complex 11/folic/c/biot/zinc	T1	HD
b complex c no.10/folic acid	T1	HD
b complex capsule	T1	HD
b complex tablet	T1	HD
b complex w-c no.20/folic acid (Virt-Caps)	T1	HD
B COMPLEX WITH B-12	T3	HD
B COMPLEX WITH VITAMIN C	T3	HD
B COMPLEX-FOLIC ACID *(cyanocobalamin/folic ac/vit b6)*	T3	HD
b12/levomefolate calcium/b-6	T1	HD
B-50 COMPLEX	T3	HD
balanced b-100 complex tab sa	T1	HD
b-complex 100 injection	T1	HD
B COMPLEX FAST DISSOLVE TABLET	T3	HD
b-complex injection vial	T1	HD
b-complex plus vitamin c cplt (Vita-Bee With C)	T1	HD PPACA
b-complex tablet	T1	HD PPACA
B-COMPLEX WITH B-12	T3	HD
b-complex with b12 tablet	T1	HD

T1 – Generics
T2 – Preferred Brands
T3 – Non-Preferred Brands
T4 – Preferred Specialty
T5 – Non-Preferred Specialty
PA – Prior Authorization
QL – Quantity Limit
ST – Step Therapy
AGE – Age Requirement
SP – Specialty Medication
HD – May require home delivery pharmacy
PPACA – No Cost-Share Preventive Medication
CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

VITAMINS (Nutritional/Dietary) (cont.)		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
VITAMIN B PREPARATIONS (cont.)		
b-complex with vit c caplet (Vita-Bee With C)	T1	HD PPACA
b-complex with vit c tablet (Vita-Bee With C)	T1	HD PPACA
B-COMPLEX-VITAMIN C TR TABLET	T2	HD
BIOTIN 1,000 MCG GUMMIES	T3	HD
biotin 1,000 mcg tablet	T1	HD
BIOTIN 10 MG TABLET	T2	HD
BIOTIN 10,000 MCG SOFTGEL	T3	HD
BIOTIN 10,000 MCG TABLET	T2	HD
biotin 2,500 mcg softgel (Hard Nails)	T1	HD
biotin 300 mcg tablet	T1	HD
BIOTIN 5 MG TABLET	T3	HD
biotin 5,000 mcg capsule (Meribin)	T1	HD
BIOTIN 5,000 MCG FAST DISSOLVE	T3	HD
BIOTIN 5,000 MCG QUICK DISSOLV	T3	HD
biotin 5,000 mcg softgel (Meribin)	T1	HD
BIOTIN 5,000 MCG TABLET	T3	HD
biotin 800 mcg tablet	T1	HD
BIOTIN FORTE 3 MG TABLET	T3	HD
BIOTIN FORTE 5 MG TABLET	T2	HD
BREWER'S YEAST	T3	HD
B-STRESS	T3	HD
CARDIOTEK-RX	T3	HD
CEREFOLIN *(vit b12/levomefolate/vit b6/b2)*	T3	HD
CEREFOLIN NAC	T3	HD
COMPLEX B-100 ER CAPLET	T3	HD
complex b-100 tablet sa	T1	HD
COMPLEX B-50	T3	HD
CVS BALANCED B-100 TR CAPLET	T3	HD
cvs biotin 1,000 mcg tablet	T1	HD
CVS BIOTIN 10,000 MCG SOFTGEL	T3	HD
cvs super b-complex-vit c cplt (Vita-Bee With C)	T1	HD PPACA
cyanocobalamin/folic ac/vit b6	T1	HD
cyanocobalamin/folic ac/vit b6	T1	HD PPACA
cyanocobalamin/folic ac/vit b6 (Niva-Fol)	T1	HD

T1 – Generics
T2 – Preferred Brands
T3 – Non-Preferred Brands
T4 – Preferred Specialty
T5 – Non-Preferred Specialty
PA – Prior Authorization
QL – Quantity Limit
ST – Step Therapy
AGE – Age Requirement
SP – Specialty Medication
HD – May require home delivery pharmacy
PPACA – No Cost-Share Preventive Medication
CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

VITAMINS (Nutritional/Dietary) (cont.)		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
VITAMIN B PREPARATIONS (cont.)		
CYTO B7	T3	HD
DIALYVITE 3000	T3	HD
DIALYVITE 5000	T3	HD
DIALYVITE 800 CHEWABLE WAFER	T3	HD
DIALYVITE 800 PLUS D	T3	HD
dialyvite 800 tablet	T1	HD PPACA
DIALYVITE 800 WITH ZINC	T3	HD
DIALYVITE 800-ULTRA D	T2	HD
DIALYVITE SUPREME D	T3	HD
ELFOLATE PLUS	T3	HD
ENDUR-B COMPLEX	T3	HD
eql b complex 50 tablet	T1	HD
folic acid/b complex c no.17	T1	HD
folic acid/vit b complex and c	T1	HD PPACA
folic acid/vit b complex and c	T1	HD
folic acid/vit b complex and c (Hylavite)	T1	HD
folic acid/vit b complex and c (Vita-Bee With C)	T1	HD PPACA
folic acid/vit bcomp,c/cu/zinc	T1	HD
FOLIKA-BC	T3	HD
FOLIKA-NC	T3	HD
FOLIKA-T	T3	HD
FOLINIC-PLUS	T3	HD
FOLTX	T3	HD
GENICIN VITA-S	T3	HD
gnp biotin 5,000 mcg capsule (Meribin)	T1	HD
HAIR-SKIN-NAILS	T3	HD
HARD NAILS (*biotin*)	T3	HD
HM BIOTIN 10,000 MCG TABLET	T3	HD
hm biotin 5,000 mcg capsule (Meribin)	T1	HD
HOMOCYSTEINE FORMULA	T3	HD
HYLAVITE (*folic acid/vit b complex and c*)	T3	HD
levomefolate/b6/b12/algal oil	T1	HD
LEVOMEFOLATE-NAC-MECOBAL-ALGAL	T3	HD
LEVOMEFOL-PYRIDOXAL-MEC-ALGAL	T3	HD

T1 – Generics
T2 – Preferred Brands
T3 – Non-Preferred Brands
T4 – Preferred Specialty
T5 – Non-Preferred Specialty
PA – Prior Authorization
QL – Quantity Limit
ST – Step Therapy
AGE – Age Requirement
SP – Specialty Medication
HD – May require home delivery pharmacy
PPACA – No Cost-Share Preventive Medication
CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

VITAMINS (Nutritional/Dietary) (cont.)		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
VITAMIN B PREPARATIONS (cont.)		
l-mefol/a-cyst/meb12/algal oil	T1	HD
L-METHYLFOL-ALGAL-NAC-ME-CBL	T3	HD
L-METHYLFOL-ALGAL-P5P-ME-CBL	T3	HD
LORID	T3	HD
LORMATE	T3	HD
mecobal/levomefolat ca/b6 phos	T1	HD
MEDTYCHOLL-B COMPLEX W-LIVER	T3	HD
MEGA BIOTIN	T3	HD
MERIBIN (*biotin*)	T2	HD
METANX	T3	HD
METHAVER	T3	HD
METHYL PROTECT	T3	HD
MULTIVITAMIN-ZINC-STRESS	T3	HD
NEPHRON FA	T3	HD
NEPHRO-VITE	T2	HD
NIVA-FOL (*cyanocobalamin/folic ac/vit b6*)	T3	HD
NUFOLA	T3	HD
PODIAPN	T3	HD
POTABA	T3	HD
PRORENAL	T2	HD
QUIN B STRONG	T3	HD
ra balanced b-100 tablet	T1	HD PPACA
ra b-complex-vitamin b-12 tab	T1	HD
ra biotin 2,500 mcg capsule (Hard Nails)	T1	HD
RENAL VITAMIN	T3	HD
RENAL-VITE	T3	HD
RENAPLEX	T3	HD
RENAPLEX-D	T3	HD
RIBOZEL	T3	HD
sm biotin 5,000 mcg capsule (Meribin)	T1	HD
SM BIOTIN 5,000 MCG TABLET	T3	HD
sm stress formula+zinc tablet	T1	HD
super b-50 complex capsule	T1	HD
super b-50 complex capsule	T1	HD PPACA

T1 – Generics
T2 – Preferred Brands
T3 – Non-Preferred Brands
T4 – Preferred Specialty
T5 – Non-Preferred Specialty
PA – Prior Authorization
QL – Quantity Limit
ST – Step Therapy
AGE – Age Requirement
SP – Specialty Medication
HD – May require home delivery pharmacy
PPACA – No Cost-Share Preventive Medication
CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

VITAMINS (Nutritional/Dietary) (cont.)		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
VITAMIN B PREPARATIONS (cont.)		
super b complex-vit c caplet (Vita-Bee With C)	T1	HD PPACA
super quints b-50 tablet	T1	HD PPACA
super quints b-50 tablets	T1	HD
SV BIOTIN 1,000 MCG SOFTGEL	T3	HD
sv biotin 5,000 mcg softgel (Meribin)	T1	HD
TRONVITE	T3	HD
ULTRA B-100 COMPLEX TABLET	T3	HD
ultra b-100 complex tablet	T1	HD
VB7 MAX	T3	HD
VIRT-CAPS (*b complex w-c no.20/folic acid*)	T3	HD
vit b comp c 19/folic acid/d3	T1	HD PPACA
vit b comp no.3/folic/c/biotin	T1	HD
vit b comp/c/fa/iron sulf/vite	T1	HD PPACA
vit b comp/c/folic/iron/vit e	T1	HD PPACA
vit b complex 100 combo no.2	T1	HD
vit b12/levomefolate/vit b6/b2 (Cerefolin)	T1	HD
VITA-BEE WITH C (*folic acid/vit b complex and c*)	T3	HD
VITAL-D RX	T3	HD
VITAJOY BIOTIN	T3	HD
vitamin b complex	T1	HD
vitamin b complex capsule	T1	HD
vitamin b complex softgel	T1	HD
vitamin b complex tablet	T1	HD PPACA
vitamin b complex tablet	T1	HD
vitamin b complex/folic acid	T1	HD PPACA
vitamin b complex/lysine (Apetex)	T1	HD
vitamin b complex/lysine (Apetigen)	T1	HD
vitamin b complex-vitamin c tb (Vita-Bee With C)	T1	HD PPACA
vitamin b-complex c caplet	T1	HD PPACA
VITA-RESPA	T3	HD
VITASURE	T3	HD
WEST-VITE WITH FOLIC ACID	T3	HD
XVITE	T3	HD
ZELDANA	T3	HD

T1 – Generics
T2 – Preferred Brands
T3 – Non-Preferred Brands
T4 – Preferred Specialty
T5 – Non-Preferred Specialty
PA – Prior Authorization
QL – Quantity Limit
ST – Step Therapy
AGE – Age Requirement
SP – Specialty Medication
HD – May require home delivery pharmacy
PPACA – No Cost-Share Preventive Medication
CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

VITAMINS (Nutritional/Dietary) (cont.)		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
VITAMIN BI PREPARATIONS		
CYTO B-1	T3	
thiamine 100 mg tablet	T1	
thiamine 200 mg/2 ml vial	T1	
thiamine 250 mg tablet	T1	
THIAMINE 500 MG TABLET	T3	
thiamine hcl	T1	
thiamine mononitrate (vit b1)	T1	
VITAMIN B1	T3	
VITAMIN BI2 PREPARATIONS		
ABANEU-SL	T3	
APATATE	T2	
B-12 1,000 MCG FAST DISSOLVE	T3	
B-12 1,000 MCG LOZENGE	T3	
B-12 1,000 MCG QUICK DISSOLVE	T3	
b-12 1,000 mcg tablet	T1	
B-12 1,000 MCG/15 ML LIQUID	T2	
b-12 1,000 mcg/15 ml liquid	T1	
b-12 2,500 mcg microlozenge	T1	
b12 2,500 mcg tablet sl	T1	
b-12 2,500 mcg tablet sl	T1	
B-12 3,000 MCG TABLET SL	T3	
b-12 3,000 mcg/ml subling liq	T1	
B-12 5,000 MCG FAST DISSOLVE	T3	
B12 5,000 MCG MICROLOZENGE	T3	
B-12 5,000 MCG MICROLOZENGE	T2	
B-12 5,000 MCG ODT	T3	
B-12 5,000 MCG QUICK DISSOLVE	T3	
B-12 5,000 MCG SUBLINGUAL TAB	T3	
B-12 5,000 MCG/ML SUBLING LIQ	T3	
B-12 500 MCG QUICK DISSOLVE TB	T3	
b-12 500 mcg tablet	T1	
B12 ACTIVE	T3	
B-12 DUAL SPECTRUM	T3	
b-12 er 1,000 mcg tab	T1	

T1 – Generics
T2 – Preferred Brands
T3 – Non-Preferred Brands
T4 – Preferred Specialty
T5 – Non-Preferred Specialty
PA – Prior Authorization
QL – Quantity Limit
ST – Step Therapy
AGE – Age Requirement
SP – Specialty Medication
HD – May require home delivery pharmacy
PPACA – No Cost-Share Preventive Medication
CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

VITAMINS (Nutritional/Dietary) (cont.)		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
VITAMIN B12 PREPARATIONS (cont.)		
B-12 WITH FOLIC ACID	T3	
cvs b-12 1,000 mcg tablet	T1	
CVS B-12 5,000 MCG MICROLOZENG	T3	
CVS B-12 5,000 MCG MICROLOZENG	T2	
CVS VIT B-12 500 MCG LOZENGE	T2	
cvs vit b-12 500 mcg lozenge	T1	
cvs vit b-12 tr 1,000 mcg tab	T1	
cvs vit b-12 tr 2,000 mcg tab	T1	
CVS VIT B12 2,500 MCG SOFT CHW	T3	
CVS VITAMIN B12 5,000 MCG TAB	T3	
CVS VITAMIN B-12 500 MCG GUMMY	T3	
cvs vitamin b-12 500 mcg tab	T1	
cyanocobalamin (vitamin b-12) (Nascobal)	T1	ST QL(4 units/30 days)
eql vitamin b-12 500 mcg tab	T1	
fn vitamin b-12 1,000 mcg tab	T1	
FOLTRATE	T3	
gnp b12 2,500 mcg tablet sl	T1	
gnp vit b-12 er 1,000 mcg tab	T1	
gnp vitamin b-12 500 mcg tab	T1	
hm vit b-12 tr 1,000 mcg tab	T1	
hm vitamin b-12 500 mcg tablet	T1	
hydroxocobalamin	T1	
INTRINSI B12-FOLATE	T3	
METHYL B-12	T3	
METHYLCOBALAMIN	T3	
METHYLCOBALAMIN 5,000 MCG TAB	T3	
MTX SUPPORT	T3	
NASCOBAL *(cyanocobalamin (vitamin b-12))*	T2	ST QL(4 units/30 days)
NEURIN-SL	T3	
OPURITY	T3	
ra vit b12 1,000 mcg tab sa	T1	
RA VIT B-12 1,000 MCG/ML LIQ	T3	
ra vitamin b-12 100 mcg tablet	T1	
ra vitamin b12 er 2,000 mcg tb	T1	

T1 – Generics
T2 – Preferred Brands
T3 – Non-Preferred Brands
T4 – Preferred Specialty
T5 – Non-Preferred Specialty
PA – Prior Authorization
QL – Quantity Limit
ST – Step Therapy
AGE – Age Requirement
SP – Specialty Medication
HD – May require home delivery pharmacy
PPACA – No Cost-Share Preventive Medication
CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

VITAMINS (Nutritional/Dietary) (cont.)		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
VITAMIN B12 PREPARATIONS (cont.)		
RAPID B-12 ENERGY	T3	
sm vitamin b12 1,000 mcg tab	T1	
sm vitamin b-12 100 mcg tablet	T1	
sm vitamin b-12 500 mcg tablet	T1	
sv b-12 2,500 mcg microlozenge	T1	
SV B-12 5,000 MCG MICROLOZENGE	T2	
SV VIT B-12 500 MCG LOZENGE	T2	
sv vitamin b-12 500 mcg tablet	T1	
sv vitamin b12 tr 1,000 mcg tb	T1	
true vitamin b-12 1000 mcg tab	T1	
true vitamin b-12 500 mcg tab	T1	
VIT B-12 500 MCG SUBLING TAB	T3	
VITAMIN B12 2,500 MCG TABLET	T3	
VITAMIN B-12 1,000 MCG SOFTGEL	T3	
vitamin b-12 1,000 mcg tab sl	T1	
vitamin b-12 1,000 mcg tablet	T1	
vitamin b-12 100 mcg tablet	T1	
vitamin b-12 2,000 mcg tab sa	T1	
VITAMIN B-12 2,000 MCG TABLET	T3	
vitamin b-12 2,500 mcg tab sl	T1	
VITAMIN B-12 250 MCG LOZENGE	T3	
vitamin b-12 250 mcg tablet	T1	
VITAMIN B-12 3,000 MCG SL LOZ	T3	
VITAMIN B-12 3,000 MCG SOFTGEL	T3	
VITAMIN B-12 3,000 MCG TAB SL	T3	
VITAMIN B-12 5,000 MCG ODT	T3	
VITAMIN B-12 5,000 MCG SOFTGEL	T3	
VITAMIN B-12 5,000 MCG TAB SL	T2	
vitamin b-12 5,000 mcg tab sl	T1	
VITAMIN B-12 5,000 MCG TAB SL	T3	
VITAMIN B-12 5,000 MCG TABLET	T3	
VITAMIN B-12 50 MCG LOZENGE	T3	
vitamin b12 50 mcg tablet	T1	
vitamin b-12 50 mcg tablet	T1	

T1 – Generics
T2 – Preferred Brands
T3 – Non-Preferred Brands
T4 – Preferred Specialty
T5 – Non-Preferred Specialty
PA – Prior Authorization
QL – Quantity Limit
ST – Step Therapy
AGE – Age Requirement
SP – Specialty Medication
HD – May require home delivery pharmacy
PPACA – No Cost-Share Preventive Medication
CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

VITAMINS (Nutritional/Dietary) (cont.)		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
VITAMIN B12 PREPARATIONS (cont.)		
VITAMIN B-12 500 MCG LOZENGE	T2	
vitamin b12 500 mcg tablet	T1	
vitamin b-12 500 mcg tablet	T1	
vitamin b-12 tr 1,000 mcg tab	T1	
vitamin b-12 tr 2,000 mcg tab	T1	
VITAMIN B12-FOLIC ACID	T3	
VITAMIN B2 PREPARATIONS		
CYTO B-2	T3	
riboflavin (vitamin b2)	T1	
riboflavin 100 mg tablet	T1	
RIBOFLAVIN 400 MG TABLET	T3	
riboflavin 50 mg tablet	T1	
VITAMIN B6 PREPARATIONS		
CHROMIUM PICOLINATE KLB6	T3	
cvs vitamin b-6 100 mg tablet	T1	
eql vitamin b-6 100 mg tablet	T1	
gnp vitamin b-6 100 mg tablet	T1	
pyridoxine 100 mg/ml vial	T1	
pyridoxine 25 mg tablet	T1	
pyridoxine 250 mg tablet	T1	
PYRIDOXINE 50 MG TABLET (*pyridoxine hcl (vitamin b6)*)	T2	
pyridoxine 50 mg tablet (Pyridoxine Hcl)	T1	
PYRIDOXINE 500 MG TABLET (*pyridoxine hcl (vitamin b6)*)	T3	
pyridoxine hcl (vitamin b6)	T1	
pyridoxine hcl (vitamin b6) (Pyridoxine Hcl)	T1	
ra vitamin b-6 100 mg tablet	T1	
ra vitamin b-6 50 mg tablet	T1	
sm vitamin b-6 100 mg tablet	T1	
sv vitamin b-6 100 mg tablet	T1	
true vitamin b-6 100 mg tablet	T1	
true vitamin b-6 25 mg tablet	T1	
true vitamin b-6 50 mg tablet	T1	
vitamin b-6 100 mg tablet	T1	
vitamin b-6 25 mg tablet	T1	

T1 – Generics
T2 – Preferred Brands
T3 – Non-Preferred Brands
T4 – Preferred Specialty
T5 – Non-Preferred Specialty
PA – Prior Authorization
QL – Quantity Limit
ST – Step Therapy
AGE – Age Requirement
SP – Specialty Medication
HD – May require home delivery pharmacy
PPACA – No Cost-Share Preventive Medication
CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

VITAMINS (Nutritional/Dietary) (cont.)		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
VITAMIN B6 PREPARATIONS (cont.)		
vitamin b-6 250 mg tablet	T1	
vitamin b-6 50 mg tablet	T1	
TRUE VITAMIN B-6 10 MG TABLET	T3	
VB6 P5P	T3	
VITAMIN C PREPARATIONS		
ASCOR	T3	
ascorbate calcium	T1	
ascorbic acid	T1	
ascorbic acid 500 mg tablet	T1	
ascorbic acid 500 mg/ml vial	T1	
ASCORBIC ACID GRANULES	T2	
ascorbic acid/ascorbate sodium	T1	
BIO C 1:1	T3	
c-1,000 mg tablet sa	T1	
cod liver oil tab chewable	T1	
cvs vit c-rose hip 1,000 mg tb	T1	
cvs vit c-rose hip 500 mg chew	T1	
cvs vit c-rose hips 500 mg tab	T1	
cvs vitamin c 1,000 mg caplet	T1	
CVS VITAMIN C 1,000 MG POWDER	T3	
cvs vitamin c 250 mg tablet	T1	
cvs vitamin c 500 mg caplet	T1	
cvs vitamin c 500 mg tablet	T1	
CYTO C	T3	
EMERGEN-C	T3	
EMERGEN-C IMMUNE PLUS	T3	
EMERGEN-C MSM LITE	T3	
eql vitamin c 1,000 mg tablet	T1	
ESSENCE C	T3	
ESTER-C 1,000 MG TABLET	T3	
ESTER-C 500 MG TABLET	T2	
FLEVOXIN	T3	
FRUIT C-100 TABLET CHEWABLE	T3	
fruit c-100 tablet chewable	T1	

T1 – Generics
T2 – Preferred Brands
T3 – Non-Preferred Brands
T4 – Preferred Specialty
T5 – Non-Preferred Specialty
PA – Prior Authorization
QL – Quantity Limit
ST – Step Therapy
AGE – Age Requirement
SP – Specialty Medication
HD – May require home delivery pharmacy
PPACA – No Cost-Share Preventive Medication
CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

VITAMINS (Nutritional/Dietary) (cont.)		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
VITAMIN C PREPARATIONS (cont.)		
FRUIT C-200	T3	
gnp vit c-rose hips 500 mg tab	T1	
gnp vitamin c 1,000 mg tablet	T1	
gnp vitamin c 250 mg tablet	T1	
gnp vitamin c 500 mg tab chew	T1	
gnp vitamin c 500 mg tablet	T1	
gnp vitamin c er 500 mg tablet	T1	
hm vit c-rose hip 1,000 mg tab	T1	
hm vit c-rose hips 500 mg cplt	T1	
hm vitamin c 500 mg tab chew	T1	
LIQUID C	T3	
PAN-C 500	T3	
PERIDIN-C	T2	
ra vit c-rose hips 500 mg tab	T1	
ra vitamin c 1,000 mg tab sa	T1	
ra vitamin c 1,000 mg tablet	T1	
ra vitamin c 250 mg tablet	T1	
ra vitamin c 500 mg chew tab	T1	
ra vitamin c 500 mg tab chew	T1	
ra vitamin c 500 mg tablet	T1	
RA VITAMIN C 53 MG DROP	T3	
ra vitamin c tr 500 mg caplet	T1	
sm vit c-rose hips 500 mg tab	T1	
sm vitamin c 1,000 mg tablet	T1	
sm vitamin c 250 mg tablet	T1	
sm vitamin c 500 mg chew tab	T1	
sm vitamin c 500 mg tab chew	T1	
sm vitamin c 500 mg tablet	T1	
sm vitamin c with rose hips	T1	
SPAN C	T3	
sv vit c-rose hip 1,000 mg tab	T1	
sv vit c-rose hips 1,000 mg tb	T1	
sv vit c-rose hips 500 mg tab	T1	
sv vitamin c 500 mg tab chew	T1	

T1 – Generics
T2 – Preferred Brands
T3 – Non-Preferred Brands
T4 – Preferred Specialty
T5 – Non-Preferred Specialty
PA – Prior Authorization
QL – Quantity Limit
ST – Step Therapy
AGE – Age Requirement
SP – Specialty Medication
HD – May require home delivery pharmacy
PPACA – No Cost-Share Preventive Medication
CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

VITAMINS (Nutritional/Dietary) (cont.)		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
VITAMIN C PREPARATIONS (cont.)		
sv vitamin c tr 1,000 mg tab	T1	
true vitamin c 250 mg tablet	T1	
true vitamin c 500 mg tablet	T1	
true vitamin c 1,000 mg tablet	T1	
vit c-rose hip 1,000 mg caplet	T1	
vit c-rose hips 1,000 mg cplt	T1	
vit c-rose hips 1,000 mg tab	T1	
VIT C-ROSE HIPS 500 MG CHEW TB	T3	
vit c-rose hips 500 mg tablet	T1	
vit c-rose hips tr 1,000 mg	T1	
vit c-rose hips tr 500 mg cplt	T1	
vit c-rose hips tr 500 mg tab	T1	
VITAJOY DAILY C	T3	
vitamin c 1,000 mg caplet	T1	
vitamin c 1,000 mg tablet	T1	
vitamin c 1,500 mg tablet sa	T1	
vitamin c 100 mg tablet	T1	
VITAMIN C 125 MG GUMMIES	T3	
vitamin c 250 mg tablet	T1	
VITAMIN C 250 MG TABLET CHEW	T3	
vitamin c 250 mg tablet chew	T1	
vitamin c 500 mg capsule sa	T1	
vitamin c 500 mg chew tablet	T1	
VITAMIN C 500 MG POWDER PACKET	T3	
VITAMIN C 500 MG SOFTGEL	T3	
vitamin c 500 mg tablet	T1	
vitamin c 500 mg tablet chew	T1	
VITAMIN C 500 MG WAFER	T3	
VITAMIN C 500 MG/15 ML LIQUID	T3	
vitamin c 500 mg/5 ml liquid	T1	
vitamin c drops	T1	
vitamin c er 500 mg capsule	T1	
VITAMIN C FIZZY DRINK	T3	
VITAMIN C POWDER	T3	

T1 – Generics
T2 – Preferred Brands
T3 – Non-Preferred Brands
T4 – Preferred Specialty
T5 – Non-Preferred Specialty
PA – Prior Authorization
QL – Quantity Limit
ST – Step Therapy
AGE – Age Requirement
SP – Specialty Medication
HD – May require home delivery pharmacy
PPACA – No Cost-Share Preventive Medication
CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

VITAMINS (Nutritional/Dietary) (cont.)		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
VITAMIN C PREPARATIONS (cont.)		
vitamin c powder	T1	
vitamin c tr 1,000 mg tablet	T1	
vitamin c tr 500 mg caplet	T1	
vitamin c tr 500 mg tablet	T1	
vitamin c-500 mg tablet	T1	
vitamin c-500 mg tr capsule	T1	
VITAMIN C-BIOFLAVINOIDS-RH	T3	
vitamin c-rose hip 1,000 mg tb	T1	
v-r vitamin c 1,000 mg tablet	T1	
v-r vitamin c 250 mg tab chew	T1	
v-r vitamin c 500 mg tab chew	T1	
XCELLENT C	T3	
ZINC PLUS	T3	
ZINC-VITAMIN C	T3	
VITAMIN D PREPARATIONS		
AQUA-D CONCENTRATE	T3	HD
BABY DDROPS	T3	HD
BABY VITAMIN D3	T3	HD
BABY'S SUPER DAILY D3	T3	HD
BIO-D-MULSION	T3	HD
BIO-D-MULSION FORTE	T3	HD
calcitriol 0.25 mcg capsule (Rocaltrol)	T1	HD
calcitriol 0.5 mcg capsule (Rocaltrol)	T1	HD
calcitriol 1 mcg/ml ampul	T1	HD
calcitriol 1 mcg/ml solution (Rocaltrol)	T1	HD
CHOLECAL DF	T3	HD
cholecalciferol (vitamin d3)	T1	HD
cod liver oil	T1	HD
cod liver oil capsule	T1	HD
cod liver oil softgel	T1	HD
cvs vit d3 1,000 unit gummies	T1	HD
cvs vit d3 250 mcg softgel	T1	HD
cvs vitamin d3 1,000 unit sfgl	T1	HD
cvs vitamin d3 10 mcg softgel	T1	HD

T1 – Generics
T2 – Preferred Brands
T3 – Non-Preferred Brands
T4 – Preferred Specialty
T5 – Non-Preferred Specialty
PA – Prior Authorization
QL – Quantity Limit
ST – Step Therapy
AGE – Age Requirement
SP – Specialty Medication
HD – May require home delivery pharmacy
PPACA – No Cost-Share Preventive Medication
CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

VITAMINS (Nutritional/Dietary) (cont.)		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
VITAMIN D PREPARATIONS (cont.)		
cvs vitamin d3 125 mcg softgel	T1	HD
CVS VITAMIN D3 250 MCG SOFTGEL	T3	HD
cvs vitamin d3 2,000 unit sfgl	T1	HD
cvs vitamin d3 25 mcg gummies	T1	HD
cvs vitamin d3 25 mcg softgel	T1	HD
cvs vitamin d3 400 unit sftgl	T1	HD
cvs vitamin d3 5,000 unit sfgl	T1	HD
cvs vitamin d3 50 mcg softgel	T1	HD
CYFOLEX	T3	HD
D3 LIQUID	T3	HD
D3 PLUS K2 DOTS	T3	HD
D3-50	T2	HD
DDROPS	T3	HD
decara 10,000 unit softgel	T1	HD
DECARA 25,000 UNIT VEGICAP	T2	HD
decara 50,000 unit softgel	T1	HD
DECARA K	T3	HD
DERMACINRX DOTREMIN	T3	HD
DERMACINRX FOLDITAM	T3	HD
DERMACINRX FOLIXAPURE	T3	HD
DERMACINRX FOLTAMIN	T3	HD
DERMACINRX FOLTREXYL	T3	HD
DERMACINRX PUREFOLIX	T3	HD
DIALYVITE VITAMIN D3 MAX	T3	HD
DOSOKAP	T3	HD
DOSOQUIN	T3	HD
DRISDOL (*ergocalciferol (vitamin d2)*)	T3	HD
eql vitamin d3 2,000 unit sfgl	T1	HD
eql vitamin d3 400 unit sftgl	T1	HD
ERGOCAL	T3	HD
ergocalciferol (vitamin d2)	T1	HD
FOLIC D3	T3	HD
FOLIKA-D	T3	HD
FOLIXAPURE	T3	HD

T1 – Generics
T2 – Preferred Brands
T3 – Non-Preferred Brands
T4 – Preferred Specialty
T5 – Non-Preferred Specialty
PA – Prior Authorization
QL – Quantity Limit
ST – Step Therapy
AGE – Age Requirement
SP – Specialty Medication
HD – May require home delivery pharmacy
PPACA – No Cost-Share Preventive Medication
CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

VITAMINS (Nutritional/Dietary) (cont.)		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
VITAMIN D PREPARATIONS (cont.)		
FOLVITE-D	T3	HD
ft vitamin d3 25 mcg softgel	T1	HD
ft vitamin d3 50 mcg softgel	T1	HD
GENICIN VITA-D	T3	HD
gnp vit d3 10mcg(400 unit) chw	T1	HD
gnp vitamin d3 1,000 unit tab	T1	HD
gnp vitamin d3 10 mcg tablet	T1	HD
gnp vitamin d3 2,000 unit tab	T1	HD
gnp vitamin d3 25 mcg tablet	T1	HD
gnp vitamin d3 25mcg(1000 unt)	T1	HD
gnp vitamin d3 5,000 unit tab	T1	HD
hm vitamin d3 1,000 unit tab	T1	HD
hm vitamin d3 2,000 unit sftgl	T1	HD
HM VITAMIN D3 4,000 UNIT SFTGL	T3	HD
IS-D-10,000	T3	HD
K2 PLUS D3	T3	HD
K2-D3 10,000	T3	HD
K2-D3 5000	T3	HD
MAXIMUM D3	T2	HD
NOXIFOL-D3	T3	HD
OPTIMAL D3 M	T3	HD
ORTHO DF	T3	HD
OSTACHOL	T3	HD
qc cod liver oil	T1	HD
ra cod liver oil	T1	HD
ra cod liver oil softgel	T1	HD
ra vitamin d3 1,000 unit tab	T1	HD
ra vitamin d3 2,000 unit sfgl	T1	HD
ra vitamin d3 2,000 unit sftgl	T1	HD
ra vitamin d3 5,000 unit sftgl	T1	HD
REPLESTA NX	T2	HD
REVESTA	T3	HD
ROCALTROL (*calcitriol*)	T3	ST HD
ROXIFOL-D	T3	HD

T1 – Generics
T2 – Preferred Brands
T3 – Non-Preferred Brands
T4 – Preferred Specialty
T5 – Non-Preferred Specialty
PA – Prior Authorization
QL – Quantity Limit
ST – Step Therapy
AGE – Age Requirement
SP – Specialty Medication
HD – May require home delivery pharmacy
PPACA – No Cost-Share Preventive Medication
CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

VITAMINS (Nutritional/Dietary) (cont.)		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
VITAMIN D PREPARATIONS (cont.)		
sm vitamin d3 1,000 unit tab	T1	HD
sm vitamin d3 2,000 unit sftgl	T1	HD
sm vitamin d3 25 mcg tablet	T1	HD
sm vitamin d3 50 mcg softgel	T1	HD
SUPER DAILY D3	T3	HD
sv vitamin d3 1,000 unit gummy	T1	HD
sv vitamin d3 1,000 unit sftgl	T1	HD
sv vitamin d3 2,000 unit sftgl	T1	HD
sv vitamin d3 25mcg(1000 unit)	T1	HD
sv vitamin d3 400 unit softgel	T1	HD
sv vitamin d3 5,000 unit sftgl	T1	HD
thera-d 2000 tablet	T1	HD
THERA-D 4000 TABLET	T3	HD
thera-d rapid repletion tablet	T1	HD
thera-d sport 2,000 unit tab	T1	HD
true vitamin d3 1,250 mcg tab	T1	HD
true vitamin d3 10 mcg capsule	T1	HD
true vitamin d3 10 mcg tablet	T1	HD
true vitamin d3 125 mcg cap	T1	HD
true vitamin d3 125 mcg tablet	T1	HD
true vitamin d3 25 mcg capsule	T1	HD
true vitamin d3 25 mcg tablet	T1	HD
TRUE VITAMIN D3 1,250 MCG CAP	T1	HD
TRUE VITAMIN D3 250 MCG CAP	T1	HD
TRUE VITAMIN D3 250 MCG TABLET	T1	HD
vit d3 125 mcg (5000 unit) tab	T1	HD
VIT D3 5,000 UNIT FAST DISSOLV	T3	HD
vitamin d2 1.25mg(50,000 unit) (Drisdol)	T1	HD
VITAMIN D2 2,000 UNIT TABLET	T2	HD
vitamin d2 400 unit tablet	T1	HD
VITAMIN D2 50 MCG (2,000 UNIT)	T3	HD
vitamin d3 1,000 unit gummies	T1	HD
vitamin d3 1,000 unit gummy	T1	HD
vitamin d3 1,000 unit softgel	T1	HD

T1 – Generics
T2 – Preferred Brands
T3 – Non-Preferred Brands
T4 – Preferred Specialty
T5 – Non-Preferred Specialty
PA – Prior Authorization
QL – Quantity Limit
ST – Step Therapy
AGE – Age Requirement
SP – Specialty Medication
HD – May require home delivery pharmacy
PPACA – No Cost-Share Preventive Medication
CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

VITAMINS (Nutritional/Dietary) (cont.)		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
VITAMIN D PREPARATIONS (cont.)		
VITAMIN D3 1,000 UNIT SPRAY	T3	HD
vitamin d3 1,000 unit tab chew	T1	HD
vitamin d3 1,000 unit tablet	T1	HD
VITAMIN D3 1,000 UNIT/10 ML LQ	T3	HD
vitamin d3 1,250 mcg capsule	T1	HD
vitamin d3 1.25 mg softgel	T1	HD
vitamin d3 10 mcg tablet	T1	HD
vitamin d3 10 mcg(400 unit)/ml	T1	HD
vitamin d3 10 mcg/ml drop	T1	HD
vitamin d3 10 mcg/ml liquid	T1	HD
VITAMIN D3 10,000 UNIT CAPSULE	T3	HD
vitamin d3 10,000 unit softgel	T1	HD
VITAMIN D3 10,000 UNIT TABLET	T3	HD
vitamin d3 125 mcg (5000 unit)	T1	HD
vitamin d3 125 mcg capsule	T1	HD
vitamin d3 125 mcg softgel	T1	HD
vitamin d3 125 mcg tablet	T1	HD
VITAMIN D3 125 MCG/0.5 ML DROP	T3	HD
vitamin d3 2,000 unit softgel	T1	HD
VITAMIN D3 2,000 UNIT TAB CHEW	T3	HD
vitamin d3 2,000 unit tablet	T1	HD
vitamin d3 25 mcg (1,000 unit)	T1	HD
vitamin d3 25 mcg gummy	T1	HD
vitamin d3 25 mcg softgel	T1	HD
vitamin d3 25 mcg tablet	T1	HD
VITAMIN D3 62.5 MCG SOFTGEL	T3	HD
VITAMIN D3 250 MCG TABLET	T3	HD
VITAMIN D3 3,000 UNIT TABLET	T3	HD
vitamin d3 400 unit softgel	T1	HD
vitamin d3 400 unit tab chew	T1	HD
vitamin d3 400 unit tablet	T1	HD
VITAMIN D3 400 UNIT/5 ML LIQ	T3	HD
vitamin d3 400 unit/ml liquid	T1	HD
vitamin d3 5,000 unit capsule	T1	HD

T1 – Generics
T2 – Preferred Brands
T3 – Non-Preferred Brands
T4 – Preferred Specialty
T5 – Non-Preferred Specialty
PA – Prior Authorization
QL – Quantity Limit
ST – Step Therapy
AGE – Age Requirement
SP – Specialty Medication
HD – May require home delivery pharmacy
PPACA – No Cost-Share Preventive Medication
CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

VITAMINS (Nutritional/Dietary) (cont.)		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
VITAMIN D PREPARATIONS (cont.)		
vitamin d3 5,000 unit softgel	T1	HD
vitamin d3 5,000 unit tablet	T1	HD
vitamin d3 5,000 unit/ml drops	T1	HD
vitamin d3 50 mcg (2,000 unit)	T1	HD
vitamin d3 50 mcg capsule	T1	HD
vitamin d3 50 mcg softgel	T1	HD
vitamin d3 50 mcg tablet	T1	HD
VITAMIN D3 50 MCG DISSOLVE TAB	T3	HD
vitamin d3 50,000 unit capsule	T1	HD
vitamin d3/folic acid	T1	HD
v-r cod liver oil capsule	T1	HD
VITAMIN E PREPARATIONS		
AQUA-E	T2	
AQUA-E CONCENTRATE	T3	
cvs vitamin e 180 mg softgel	T1	
cvs vitamin e 200 unit softgel	T1	
cvs vitamin e 268 mg softgel	T1	
CVS VITAMIN E 450 MG SOFTGEL	T3	
cvs vitamin e 90 mg softgel	T1	
eql vitamin e 1,000 unit sftgl	T1	
eql vitamin e 180 mg softgel	T1	
gnp vitamin e 180 mg softgel	T1	
gnp vitamin e 400 unit softgel	T1	
GNP VITAMIN E 450 MG SOFTGEL	T3	
gnp vitamin e 90 mg softgel	T1	
hm vitamin e 180 mg softgel	T1	
hm vitamin e 200 unit softgel	T1	
hm vitamin e 400 unit softgel	T1	
MIXED TOCOTRIENOLS	T3	
ra vitamin e 268 mg softgel	T1	
SOLUVITA-E	T3	
sv vitamin e 180 mg softgel	T1	
sv vitamin e 400 unit softgel	T1	
sv vitamin e 450 mg softgel	T1	

T1 – Generics
T2 – Preferred Brands
T3 – Non-Preferred Brands
T4 – Preferred Specialty
T5 – Non-Preferred Specialty
PA – Prior Authorization
QL – Quantity Limit
ST – Step Therapy
AGE – Age Requirement
SP – Specialty Medication
HD – May require home delivery pharmacy
PPACA – No Cost-Share Preventive Medication
CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

VITAMINS (Nutritional/Dietary) (cont.)		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
VITAMIN E PREPARATIONS (cont.)		
sv vitamin e 670 mg softgel	T1	
true vitamin e 180 mg capsule	T1	
true vitamin e 90 mg capsule	T1	
TRUE VITAMIN E 450 MG CAPSULE	T1	
vitamin e (dl,tocopheryl acet)	T1	
vitamin e 1,000 unit capsule	T1	
vitamin e 1,000 unit softgel	T1	
VITAMIN E 1,000 UNIT SOFTGEL	T3	
vitamin e 100 unit softgel	T1	
VITAMIN E 100 UNIT TABLET	T3	
VITAMIN E 15 UNIT/0.3 ML DROP	T3	
vitamin e 15 unit/0.3 ml drop	T1	
vitamin e 180 mg softgel	T1	
vitamin e 180mg(400 unit) sfgl	T1	
vitamin e 200 unit capsule	T1	
vitamin e 200 unit softgel	T1	
vitamin e 268 mg softgel	T1	
vitamin e 400 unit capsule	T1	
vitamin e 400 unit softgel	T1	
vitamin e 45 mg softgel	T1	
VITAMIN E 450 MG SOFTGEL	T3	
vitamin e 450 mg softgel	T1	
vitamin e 600 unit capsule	T1	
vitamin e 90 mg capsule	T1	
vitamin e 90 mg softgel	T1	
VITAMIN E NATURAL OIL DROPS	T2	
VITAMIN E OIL	T3	
VITAMIN E OIL DROPS	T2	
VITAMIN E OIL DROPS	T3	
VITAMIN E-OIL	T2	
WHEAT GERM OIL	T2	
XCELLENT E	T3	
VITAMIN K PREPARATIONS		
AQUA-K CONCENTRATE	T3	

T1 – Generics
T2 – Preferred Brands
T3 – Non-Preferred Brands
T4 – Preferred Specialty
T5 – Non-Preferred Specialty
PA – Prior Authorization
QL – Quantity Limit
ST – Step Therapy
AGE – Age Requirement
SP – Specialty Medication
HD – May require home delivery pharmacy
PPACA – No Cost-Share Preventive Medication
CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

VITAMINS (Nutritional/Dietary) (cont.)		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
VITAMIN K PREPARATIONS (cont.)		
K1-1000	T3	
K2 LIQUID	T3	
K2-45	T3	
MEPHYTON (*phytonadione (vit k1)*)	T3	QL(10 tabs/fill)
phytonadione (*vit k1*)	T1	
PHYTONADIONE 1 MG/0.5 ML SYR	T2	
PHYTONADIONE 1 MG/0.5 ML VIAL	T2	
phytonadione 10 mg/ml ampul	T1	
phytonadione 10 mg/ml vial	T1	
VITAMIN K	T2	
VITAMIN K-1	T2	
VITAMIN K2	T3	
VITAMIN K2 (MENAQUINONE-4)	T3	
VITAMINS (Vitamins)		
MULTIVITAMIN PREPARATIONS		
CENTRUM ADULTS 50 PLUS MINIS	T3	
CENTRUM MEN 50 PLUS MINIS	T3	
DAVIMET-M	T3	
PEDIATRIC VITAMIN PREPARATIONS		
CHILDREN'S MULTI	T3	

T1 – Generics
T2 – Preferred Brands
T3 – Non-Preferred Brands
T4 – Preferred Specialty
T5 – Non-Preferred Specialty
PA – Prior Authorization
QL – Quantity Limit
ST – Step Therapy
AGE – Age Requirement
SP – Specialty Medication
HD – May require home delivery pharmacy
PPACA – No Cost-Share Preventive Medication
CSL – Oral cancer medication subject to cost-share limits

Exclusions and limitations for coverage

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

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

- Over-the-counter (OTC) medicines (those that do not require a prescription) except insulin unless state or federal law requires coverage of such medicines.
- Prescription medications or supplies for which there is a prescription or OTC therapeutic equivalent or therapeutic alternative.
- Doctor-administered injectable medications covered under the Plan's medical benefit, unless otherwise covered under the Plan's prescription drug list or approved by Cigna Healthcare.
- Implantable contraceptive devices covered under the Plan's medical benefit.
- Medications that are not medically necessary.
- Experimental or investigational medications, including U.S. Food and Drug Administration (FDA)-approved medications used for purposes other than those approved by the FDA unless the medication is recognized for the treatment of the particular indication.
- Medications that are not approved by the FDA.
- Prescription and non-prescription devices, supplies, and appliances other than those supplies specifically listed as covered.
- Medications used for fertility,[10] sexual dysfunction, cosmetic purposes, weight loss, smoking cessation,[10] or athletic enhancement.
- Prescription vitamins (other than prenatal vitamins) or dietary supplements unless state or federal law requires coverage of such products.
- Immunization agents, biological products for allergy immunization, biological sera, blood, blood plasma and other blood products or fractions and medications used for travel prophylaxis.
- Replacement of prescription medications and related supplies due to loss or theft.
- Medications which are to be taken by or administered to a covered person while they are a patient in a licensed hospital, skilled nursing facility, rest home or similar institution which operates on its premises or allows to be operated on its premises a facility for dispensing pharmaceuticals.
- Prescriptions more than one year from the date of issue.
- Coverage for prescription medication products for the amount dispensed (days' supply) which is more than the applicable supply limit, or is less than any applicable supply minimum set forth in The Schedule, or which is more than the quantity limit(s) or dosage limit(s) set by the P&T Committee.
- More than one prescription order or refill for a given prescription supply period for the same prescription medication product prescribed by one or more doctors and dispensed by one or more pharmacies.
- Prescription medication products dispensed outside the jurisdiction of the United States, except as required for emergency or urgent care treatment.

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

Index of Medications

Symbols

A

Index of Medications

Index of Medications

Index of Medications

B

Index of Medications

C

Index of Medications

Index of Medications

Index of Medications

D

Index of Medications

Index of Medications

E

Index of Medications

Index of Medications

Index of Medications

G

Index of Medications

H

Index of Medications

Index of Medications

J

Index of Medications

Index of Medications

M

Index of Medications

Index of Medications

Index of Medications

N

Index of Medications

O

Index of Medications

P

Index of Medications

Index of Medications

Index of Medications

Q

R

Index of Medications

Index of Medications

Index of Medications

Index of Medications

T

Index of Medications

Index of Medications

Index of Medications

Index of Medications

Index of Medications

Index of Medications

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

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

1. App/online store terms and mobile phone carrier/data charges apply. Customers under age 13 (and/or their parent/guardian) will not be able to register at myCigna.com.
2. Prices shown on myCigna are not guaranteed and coverage is subject to your plan terms and conditions. Visit myCigna for more information.
3. U.S. Food and Drug Administration (FDA) website, "Generic Drugs: Questions and Answers." Last updated 03/16/21. fda.gov/drugs/questions-answers/generic-drugs-questions-answers.
4. Not all plans offer Express Scripts® Pharmacy and Accredo as covered pharmacy options. Log in to the myCigna App or myCigna.com, or check your plan materials, to learn more about the pharmacies in your plan's network. Cigna Healthcare maintains an ownership interest in Express Scripts® Pharmacy's home delivery services and Accredo's specialty pharmacy services. However, you have the right to fill prescriptions at any pharmacy in your plan's network. You won't be penalizStandard shipping costs are included as part of your prescription plan.
5. Standard shipping costs are included as part of your prescription plan.
6. Some medications aren't available in a 90-day supply and may only be packaged in lesser amounts. For example, three packages of oral contraceptives equal an 84-day supply. Even though it's not a "90-day supply," it's still considered a 90-day prescription.
7. As allowable by law. For medications administered by a health care provider, Accredo will ship the medication directly to your doctor's office.
8. **For insured plans that must follow Delaware's state insurance laws:** Brand-name antidepressants, smoking cessation, attention deficit hyperactivity disorder (ADHD) and anti-psychotic medications that don't have a generic equivalent available will be covered as Tier 2 (preferred brand). This is true even if the medication is listed as Tier 3 (non-preferred brand) on your plan's drug list. To find out how your specific plans covers these medications, log in to the myCigna App or myCigna.com, or call Customer Service using the number on your ID card.
9. Costs and complete details of the plan's prescription drug coverage are set forth in the plan documents. If there are any differences between the information provided here and the plan documents, the information in the plan documents takes complete precedence.
10. **For plans that must follow state insurance laws, such as Delaware:** Your plan may provide coverage for infertility medications and smoking cessation medications even if this drug list states that your plan may not cover them. To find out if your specific plan covers these medications, log in to the myCigna App or myCigna.com, or check your plan materials.

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

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

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

DISCRIMINATION IS AGAINST THE LAW

Medical coverage

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

Cigna:

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

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

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

Cigna
Nondiscrimination Complaint Coordinator
PO Box 188016
Chattanooga, TN 37422

If you need assistance filing a written grievance, please call the number on the back of your ID card or send an email to ACAGrievance@Cigna.com. You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, DC 20201
1.800.368.1019, 800.537.7697 (TDD)
Complaint forms are available at
http://www.hhs.gov/ocr/office/file/index.html.

896375b 05/21

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).