



# Cigna Healthcare Value 4-Tier Prescription Drug List

Coverage as of July 1, 2024

**For the State of California**

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

View your drug list online: [Cigna.com/PDL](https://Cigna.com/PDL)

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

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

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 This drug list is subject to change and all prior versions are no longer in effect.

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

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What's Inside?	Page
Information about this drug list	3
· Frequently asked questions (FAQs)	3
· Words you may need to know	11
· About this drug list	13
· How to read this drug list	13
· How to find your medication	16
List of prescription medications	19
Exclusions and limitations for coverage	146
Index of medications	147

### View your drug list online

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

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

### Questions?

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

\* Drug list created: originally created 01/01/2004

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

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

## Information about this drug list

### Frequently Asked Questions (FAQs)

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

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

**A.** We regularly review and update your plan's drug list to make sure you're getting coverage for low-cost, safe, clinically effective medications. We make changes for many reasons – like when new medications become available or are no longer available, or when medication prices change. These changes may include:

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

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

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

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

There are also certain medications and products that can't be covered by your plan for any reason because they're considered to be a "plan or benefit exclusion." This means the medication or product isn't

on your plan's drug list, and there's no option to ask Cigna Healthcare to consider approving it through the coverage review process. For example, your plan doesn't cover, or "excludes:"

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

## Information about this drug list

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

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

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

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

A. Medications that:

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

#### 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

## Information about this drug list

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

prior authorization exception request within 72 hours of receiving a non-urgent request and 24 hours of receiving a request based on exigent circumstances, the request will be considered approved and your plan can't deny coverage of the medication. Also, if you've already received approval from Cigna Healthcare for your plan to cover your medication, Cigna Healthcare can't limit or exclude coverage for that medication if your doctor continues to prescribe it to treat your condition (as long as the medication is appropriately prescribed and is safe and effective in treating your condition).

**Q. My plan doesn't cover my medication. I need to take it because it's medically necessary for my treatment. How do I get approval (prior authorization) for my medication?**

**A.** If your doctor feels that your medication is necessary for your treatment and an alternative isn't right for you, he or she can ask Cigna Healthcare to consider approving coverage of your medication. Ask your doctor's office to contact Cigna Healthcare to start the coverage review process. They know how the review process works and will take care of everything for you. In case the office asks, they can download a request form from the Cigna Healthcare provider portal at [cignaforhcp.com](http://cignaforhcp.com).

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

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

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

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

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

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

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

Cigna Healthcare will review information your doctor sends us to make sure your medication meets coverage requirements. We'll send you and your doctor a letter with the decision and next steps. It can take 1-5 business days to hear from us. You can



## Information about this drug list

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

always check with your doctor's office to find out if a decision's been made. You can also log in to the **myCigna App** or **myCigna.com** to check the status of your approval.

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

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

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

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

## Information about this drug list

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

your doctor wants you to use a recently approved medication, he or she can ask Cigna Healthcare to consider approving it through the coverage review process.

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

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

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

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

#### **Q. I see several medications on this drug list that can be used to treat my condition. Will my doctor write me a prescription for all of them?**

**A.** No. Just because a medication is listed on your plan’s drug list doesn’t mean your doctor will write you a prescription for it. Your doctor will work with you to find the medication he or she feels is best for your specific treatment.

#### **Q. How can I find out how much I’ll pay for a specific medication?**

**A.** When you and your doctor are considering the right medication for your treatment, knowing how much it costs, what lower-cost alternatives are available and which pharmacies offer the best prices can help you avoid surprises. Log in to the **myCigna App** or **myCigna.com** and use the Price a Medication

tool to see how much your medication costs before you get to the pharmacy counter – or, even before you leave your doctor’s office.<sup>3</sup>

#### **Q. What’s a cost-share?**

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

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

**A.** Consider using a medication that’s covered on a lower tier (such as a generic or preferred brand medication) or by filling a 90-day supply (if your plan allows). You should talk with your doctor to see if one of these options may work for you.

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

**A.** A generic medication is the same as its brand-name version in safety, effectiveness, quality, strength and dosage, as well as in the way it’s taken and used.<sup>4</sup> Brand-name medications are protected by patents. Patents keep other manufacturers from selling generic versions of the brand-name medication. Once a patent ends, other companies can make and sell a generic version of the brand-name medication. Generics are typically sold under their chemical or scientific name, instead of the manufacturer’s patented brand name.

#### **Q. Do generics work the same as brand-name medications?**

**A.** Yes. A generic medication works in the same way and provides the same clinical benefit as its brand-name version.

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

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

## Information about this drug list

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

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

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

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

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

#### **Q. My pharmacy isn't in my plan's network. Can I continue to fill my prescriptions there?**

**A.** To get the most from your plan coverage, you should use an in-network pharmacy. If your plan offers out-of-network coverage, you'll pay your out-of-network cost-share to fill a prescription there.

#### **Q. Do I have to use home delivery to fill my prescription?**

**A.** It depends on your plan. Some plans require you to fill maintenance medications through Express Scripts® Pharmacy and/or specialty medications through Accredo® specialty pharmacy for them to be covered.<sup>5</sup> Log in to the **myCigna App** or **myCigna.com**, or check your plan materials, to find out what your plan requires.

#### **Q. Can I fill my prescriptions by mail?**

**A.** Yes, as long as your plan offers home delivery.

### Express Scripts® Pharmacy for maintenance medications

Express Scripts® Pharmacy is a convenient option when you're taking a medication on a regular basis to treat an ongoing health condition. It's simple and 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<sup>6</sup>
- Automatic refills or refill reminders
- Fill up to a 90-day supply at one time<sup>7</sup>
- Helpful pharmacists available 24/7
- Flexible payment options

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

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

### Accredo for specialty medications

If you're taking a specialty medication to treat a complex medical condition, Accredo's team of specialty trained pharmacists and nurses can help. They'll fill and ship your specialty medication to your home (or location of your choice).<sup>8</sup> They'll also provide you with the personalized care and support you need to manage your therapy – at no extra cost.

- 24/7 access to specialty-trained pharmacists and nurses
- Personalized care services such as training on how to administer your medication



## Information about this drug list

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

- Help you find ways to pay for your medications
- Fast shipping at no extra cost
- Easy refills and free reminders
- Easily manage your medications online and track your orders

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

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

**A.** Some plans allow one or more fills at a retail pharmacy before switching to home delivery. Check your plan materials to find out if your plan allows retail fills. Here are three easy ways to get started.

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

#### **Q. I take a specialty medication to treat my multiple sclerosis. My plan requires me to fill my medication through Accredo. How do I get started?**

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

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

#### **Q. I take a specialty medication that can only be filled at certain pharmacies in the United States. How do I fill my prescription?**

**A.** Talk with your doctor. He or she should be able to tell you which in-network pharmacies can fill your prescription. Once you find a pharmacy, ask your doctor to send them your prescription.

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

#### **Q. How do I fill my prescription?**

**A.** First, you'll need to get a prescription from your doctor. Then, your doctor can either:

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

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

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

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

## Information about this drug list

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

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

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

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

**A.** Covered medications are divided into tiers (or cost-share levels). Typically, the higher the tier, the higher the price you'll pay to fill the prescription. Here are three places you can go to find out how much you'll pay for your medication based on the tier it's listed in, including the maximum cost-share amount allowed:

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

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

**A.** Some medications are covered under the pharmacy benefit, some are covered under the medical benefit, and others are covered under both benefits. Typically, medications that are injected or infused are covered under the medical benefit. These are given to you at a doctor's office, an infusion center or at home. Typically, medications that you take yourself and can be filled

at a retail pharmacy or through home delivery are covered under the pharmacy benefit. Check your medical summary of benefits coverage to learn more about how your plan covers these medications.

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

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

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

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

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

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

## Information about this drug list

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

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

### Words you may need to know

- **Brand name drug:** A drug that is marketed under a proprietary, trademark-protected name. The brand name drug shall be listed in all CAPITAL letters.
- **Coinsurance:** A percentage of the cost of a covered health care benefit that an enrollee pays after the enrollee has paid the deductible, if a deductible applies to the health care benefit, such as the prescription drug benefit.
- **Copayment:** A fixed dollar amount that an enrollee pays for a covered health care benefit after the enrollee has paid the deductible, if a deductible applies to the health care benefit, such as the prescription drug benefit.
- **Deductible:** The amount an enrollee pays for covered health care benefits before the enrollee's health plan begins payment for all or part of the cost of the health care benefit under the terms of the policy.
- **Drug tier:** A group of prescription drugs that corresponds to a specified cost sharing tier in the health plan's prescription drug coverage. The tier in which a prescription drug is placed determines the enrollee's portion of the cost for the drug.
- **Enrollee:** A person enrolled in a health plan who is entitled to receive services from the plan.

## Information about this drug list

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

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



## Information about this drug list

### About this drug list

This is a list of the most commonly prescribed medications covered on the Cigna Healthcare Value 4-Tier Prescription Drug List as of July 1, 2024. Medications are listed alphabetically by their generic and brand names within their therapeutic category and class. **The drug list is updated often so it isn't a full list of the medications your plan covers.** Also, your specific plan may not cover all of these medications. Log in to the **myCigna App** or **myCigna.com**, or check your plan materials, to see all of the medications your plan covers.

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

### How to read this drug list

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

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

### Tiers

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

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

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

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

## Information about this drug list

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

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

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

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

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

## Information about this drug list

### How to find your medication

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

Condition	Page	Condition	Page
<b>Analgesics</b> (Pain Relief and Inflammatory Disease)	18-22	<b>Anti-Infectives/Miscellaneous</b> (Infections)	45, 46
<b>Analgesics</b> (Urinary Tract Conditions)	22	<b>Anti-Infectives/Miscellaneous</b> (Miscellaneous)	46
<b>Anesthetics</b> (Miscellaneous)	22, 23	<b>Anti-Infectives/Miscellaneous</b> (Skin Conditions)	46
<b>Anesthetics</b> (Pain Relief and Inflammatory Disease)	23	<b>Anti-Inflammatory Tumor Necrosis Factor Inhibiting Agents</b> (Pain Relief and Inflammatory Disease)	46, 47
<b>Anesthetics</b> (Urinary Tract Conditions)	23	<b>Anti-Neoplastics</b> (Cancer)	47-53
<b>Anti-Allergy</b> (Allergy and Nasal Sprays)	23	<b>Anti-Neoplastics</b> (Skin Conditions)	53, 54
<b>Anti-Arthritics</b> (Pain Relief and Inflammatory Disease)	23-26	<b>Anti-Obesity Drugs</b> (Weight Management)	54, 55
<b>Anti-Asthmatics</b> (Asthma/COPD/Respiratory)	26-29	<b>Anti-Parasitics</b> (Eye Conditions)	54
<b>Antibiotics</b> (Allergy/Nasal Sprays)	29	<b>Anti-Parasitics</b> (Infections)	55
<b>Antibiotics</b> (Ear Medications)	29	<b>Anti-Parkinson's Drugs</b> (Parkinson's Disease)	55-57
<b>Antibiotics</b> (Eye Conditions)	30	<b>Anti-Platelet Drugs</b> (Blood Thinners/Anti-Clotting)	57
<b>Antibiotics</b> (Infections)	31-36	<b>Antivirals</b> (AIDS/HIV)	57-60
<b>Antibiotics</b> (Skin Conditions)	36, 37	<b>Antivirals</b> (Eye Conditions)	60
<b>Anti-Coagulants</b> (Blood Thinners/Anti-Clotting)	37, 38	<b>Antivirals</b> (Infections)	61, 62
<b>Antidotes</b> (Gastrointestinal/Heartburn)	38	<b>Antivirals</b> (Skin Conditions)	62
<b>Antidotes</b> (Substance Abuse)	38, 39	<b>Autonomic Drugs</b> (Allergy/Nasal Sprays)	62
<b>Anti-Fungals</b> (Eye Conditions)	39	<b>Autonomic Drugs</b> (Alzheimer's Disease)	62, 63
<b>Anti-Fungals</b> (Feminine Products)	39	<b>Autonomic Drugs</b> (Attention Deficit Hyperactivity Disorder)	63
<b>Anti-Fungals</b> (Infections)	39, 40	<b>Autonomic Drugs</b> (Blood Pressure/Heart Medications)	64
<b>Anti-Fungals</b> (Skin Conditions)	40	<b>Autonomic Drugs</b> (Urinary Tract Conditions)	64
<b>Antihistamine and Decongestant Combination</b> (Allergy/Nasal Sprays)	40	<b>Biologicals</b> (Allergy/Nasal Sprays)	64
<b>Antihistamines</b> (Allergy/Nasal Sprays)	40	<b>Biologicals</b> (Blood Pressure/Heart Medications)	64
<b>Antihistamines</b> (Eye Conditions)	41	<b>Biologicals</b> (Miscellaneous)	64
<b>Anti-Hyperglycemics</b> (Diabetes)	41-44	<b>Biologicals</b> (Vaccines)	64-66
<b>Anti-Infectives</b> (Feminine Products)	44	<b>Blood</b> (Blood Modifiers/Bleeding Disorders)	66, 67
<b>Anti-Infectives</b> (Infections)	45	<b>Blood</b> (Blood Thinners/Anti-Clotting)	67
<b>Anti-Infectives/Miscellaneous</b> (Feminine Products)	45	<b>Cardiac Drugs</b> (Blood Pressure/Heart Medications)	67-70

## Information about this drug list

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

Condition	Page	Condition	Page
Cardiovascular (Asthma/COPD/Respiratory)	70, 71	Hormones (Infertility)	106, 107
Cardiovascular (Blood Pressure/Heart Medications)	71-75	Hormones (Miscellaneous)	107
Cardiovascular (Cholesterol Medications)	75-78	Hormones (Osteoporosis Products)	107
CNS Drugs (Alzheimer's Disease)	78	Immunosuppressants (Pain Relief and Inflammatory Disease)	107, 108
CNS Drugs (Miscellaneous)	78, 79	Immunosuppressants (Skin Conditions)	108
CNS Drugs (Multiple Sclerosis)	79	Immunosuppressants (Transplant Medications)	108
CNS Drugs (Pain Relief and Inflammatory Disease)	80	Miscellaneous Medical Supplies, Devices, Non-Drug (Diabetes)	109-III
CNS Drugs (Seizure Disorders)	80-82	Miscellaneous Medical Supplies, Devices, Non-Drug (Miscellaneous)	112-118
CNS Drugs (Sleep Disorders/Sedatives)	83	Muscle Relaxants (Pain Relief and Inflammatory Disease)	118, 119
Colony Stimulating Factors (Blood Modifiers/Bleeding Disorders)	83	Prenatal Vitamins (Nutritional/Dietary)	119
Contraceptives (Contraception Products)	83-85	Psychotherapeutic Drugs (Anxiety/Depression/Bipolar Disorder)	119-124
Cough/Cold Preparations (Allergy/Nasal Sprays)	85	Psychotherapeutic Drugs (Attention Deficit Hyperactivity Disorder)	124, 125
Cough/Cold Preparations (Cough/Cold Medications)	85, 86	Psychotherapeutic Drugs (Schizophrenia/Anti-Psychotics)	125-128
Diagnostic (Miscellaneous)	86, 87	Psychotherapeutic Drugs (Sleep Disorders/Sedatives)	127, 128
Diuretics (Diuretics)	87-89	Skin Preps (Miscellaneous)	129, 130
EENT Preps (Allergy/Nasal Sprays)	89	Skin Preps (Pain Relief and Inflammatory Disease)	130
EENT Preps (Ear Medications)	89	Skin Preps (Skin Conditions)	130-136
EENT Preps (Eye Conditions)	89-93	Smoking Deterrents (Smoking Cessation)	137
Elect/Caloric/H2O (Cholesterol Medications)	93	Thyroid Prep (Hormonal Agents)	137, 138
Elect/Caloric/H2O (Dental Products)	93	Unclassified Drug Products (AIDS/HIV)	138, 139
Elect/Caloric/H2O (Diabetes)	94	Unclassified Drug Products (Asthma/COPD/Respiratory)	139
Elect/Caloric/H2O (Miscellaneous)	94	Unclassified Drug Products (Blood Modifiers/Bleeding Disorders)	139
Elect/Caloric/H2O (Nutritional/Dietary)	94, 95	Unclassified Drug Products (Blood Pressure/Heart Medications)	139
Elect/Caloric/H2O (Urinary Tract Conditions)	95	Unclassified Drug Products (Cancer)	139
Gastrointestinal (Cholesterol Medications)	95	Unclassified Drug Products (Dental Products)	140
Gastrointestinal (Gastrointestinal/Heartburn)	95-100	Unclassified Drug Products (Erectile Dysfunction)	139
Gastrointestinal (Pain Relief and Inflammatory Disease)	100, 101		
Hormones (Hormonal Agents)	101-106		



## Information about this drug list

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

Condition	Page
<b>Unclassified Drug Products</b> (Gastrointestinal/Heartburn)	140, 141
<b>Unclassified Drug Products</b> (Hormonal Agents)	141
<b>Unclassified Drug Products</b> (Miscellaneous)	141, 142
<b>Unclassified Drug Products</b> (Nutritional/Dietary)	143
<b>Unclassified Drug Products</b> (Osteoporosis Products)	144
<b>Unclassified Drug Products</b> (Pain Relief and Inflammatory Disease)	144

Condition	Page
<b>Unclassified Drug Products</b> (Substance Abuse)	144, 145
<b>Unclassified Drug Products</b> (Transplant Medications)	145
<b>Unclassified Drug Products</b> (Urinary Tract Conditions)	145, 146
<b>Unclassified Drug Products</b> (Weight Management)	146
<b>Vitamins</b> (Nutritional/Dietary)	146, 147

# List of Prescription Medications

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

T1 – Typically Generics

T4 – Injectable Specialty Medications

ST – Step Therapy

HD – May require home delivery pharmacy

T2 – Typically Preferred Brands

PA – Prior Authorization

AGE – Age Requirement

PPACA – No Cost-Share Preventive Medication

T3 – Typically Non-Preferred Brands

QL – Quantity Limit

SP – Specialty Medication

CSL – Oral cancer medication subject to cost-share limits

# List of Prescription Medications

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

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

T1 – Typically Generics

T4 – Injectable Specialty Medications

ST – Step Therapy

HD – May require home delivery pharmacy

T2 – Typically Preferred Brands

PA – Prior Authorization

AGE – Age Requirement

PPACA – No Cost-Share Preventive Medication

T3 – Typically Non-Preferred Brands

QL – Quantity Limit

SP – Specialty Medication

CSL – Oral cancer medication subject to cost-share limits

# List of Prescription Medications

<b>ANALGESICS (Pain Relief and Inflammatory Disease) (cont.)</b>		
<b>Prescription Drug Name</b>	<b>Drug Tier</b>	<b>Coverage Requirements and Limits</b>
<b>OPIOID ANALGESIC AND NON-SALICYLATE ANALGESICS</b>		
<i>acetamin-codein 300-30 mg/12.5</i>	T1	
<i>acetaminop-codeine 120-12 mg/5</i>	T1	
<i>acetaminophen-cod #2 tablet</i>	T1	PA
<i>acetaminophen-cod #3 tablet</i>	T1	PA
<i>acetaminophen-cod #4 tablet</i>	T1	PA
APADAZ	T3	
BENZHYDROCODONE-ACETAMINOPHEN	T1	
<i>hydrocodone/acetaminophen</i>	T1	PA
<i>hydrocodone/acetaminophen (Hydrocodone-acetaminophen)</i>	T1	PA
<i>hydrocodone/acetaminophen (Norco)</i>	T1	PA
HYDROCODONE-ACETAMINOPHEN	T1	PA
LORTAB	T1	PA
NALOCET	T1	PA
NORCO ( <i>lorcet hd</i> )	T3	PA
NORCO ( <i>lorcet plus</i> )	T3	PA
NORCO ( <i>lorcet</i> )	T3	PA
<i>oxycodone hcl/acetaminophen (Nalocet)</i>	T1	PA
<i>oxycodone hcl/acetaminophen (Percocet)</i>	T1	PA
<i>oxycodone hcl/acetaminophen (Primlev)</i>	T1	PA
PERCOCET ( <i>oxycodone-acetaminophen</i> )	T3	PA
PRIMLEV	T1	PA
<i>tramadol hcl/acetaminophen (Ultracet)</i>	T1	
ULTRACET ( <i>tramadol hcl-acetaminophen</i> )	T3	
<b>OPIOID ANALGESIC AND NSAID COMBINATION</b>		
<i>hydrocodone/ibuprofen</i>	T1	PA
<i>hydrocodone/ibuprofen (Ibudone)</i>	T1	PA
IBUDONE	T1	PA
<i>ibuprofen/oxycodone hcl</i>	T1	PA
<b>OPIOID ANALGESIC AND SALICYLATE ANALGESIC COMB</b>		
<i>oxycodone hcl/aspirin</i>	T1	PA
<b>OPIOID ANALGESIC AND NON-SALICYLATE XANTHINE COMB</b>		
ACETAMIN-CAFF-DIHYDROCODEINE	T1	PA
<i>acetaminophen/caff/dihydrocod (Acetamin-caff-dihydrocodeine)</i>	T1	PA
<i>acetaminophen/caff/dihydrocod (Trexix)</i>	T1	PA
TREXIX	T3	PA

T1 – Typically Generics

T4 – Injectable Specialty Medications

ST – Step Therapy

HD – May require home delivery pharmacy

T2 – Typically Preferred Brands

PA – Prior Authorization

AGE – Age Requirement

PPACA – No Cost-Share Preventive Medication

T3 – Typically Non-Preferred Brands

QL – Quantity Limit

SP – Specialty Medication

CSL – Oral cancer medication subject to cost-share limits



## List of Prescription Medications

ANALGESICS (Pain Relief and Inflammatory Disease) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>OPIOID ANALGESICS</b>		
ACTIQ ( <i>fentanyl citrate</i> )	T3	PA
ARYMO ER	T3	PA
BELBUCA	T2	QL (2 films/day)
<i>buprenorphine</i> (Butrans)	T1	QL (4 patches/28 days)
<i>butorphanol tartrate</i>	T1	PA QL (6 bots/30 days)
BUTRANS ( <i>buprenorphine</i> )	T3	QL (4 patches/28 days)
<i>codeine sulfate</i>	T1	PA
DILAUDID ( <i>hydromorphone hcl</i> )	T3	PA
DURAGESIC ( <i>fentanyl</i> )	T3	PA
<i>fentanyl</i>	T1	PA
<i>fentanyl</i> (Duragesic)	T1	PA
FENTANYL CITRATE	T1	PA
<i>fentanyl citrate</i> (Actiq)	T1	PA
FENTORA	T3	PA
<i>hydrocodone bitartrate</i> (Hysingla Er)	T1	PA
<i>hydrocodone bitartrate</i> (Zohydro Er)	T1	PA
<i>hydromorphone hcl</i>	T1	PA
<i>hydromorphone hcl</i> (Dilaudid)	T1	PA
HYSINGLA ER ( <i>hydrocodone bitartrate er</i> )	T2	PA
KADIAN ( <i>morphine sulfate er</i> )	T3	PA
LAZANDA	T3	PA
<i>meperidine hcl</i>	T1	PA
MORPHABOND ER	T2	PA
<i>morphine sulfate</i>	T1	PA
<i>morphine sulfate</i> (Kadian)	T1	PA
<i>morphine sulfate</i> (Ms Contin)	T1	PA
MS CONTIN ( <i>morphine sulfate er</i> )	T3	PA
NUCYNTA	T2	PA
NUCYNTA ER	T3	PA
<i>opium/belladonna alkaloids</i>	T1	PA
OXAYDO	T3	PA
<i>oxycodone hcl</i>	T1	PA
OXYCODONE HCL ER	T1	PA
<i>oxymorphone hcl</i>	T1	PA

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

T4 – Injectable Specialty Medications

PA – Prior Authorization

QL – Quantity Limit

ST – Step Therapy

AGE – Age Requirement

SP – Specialty Medication

HD – May require home delivery pharmacy

PPACA – No Cost-Share Preventive Medication

CSL – Oral cancer medication subject to cost-share limits

## List of Prescription Medications

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

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

T4 – Injectable Specialty Medications

PA – Prior Authorization

QL – Quantity Limit

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AGE – Age Requirement

SP – Specialty Medication

HD – May require home delivery pharmacy

PPACA – No Cost-Share Preventive Medication

CSL – Oral cancer medication subject to cost-share limits

## List of Prescription Medications

### ANESTHETICS (Pain Relief and Inflammatory Disease)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>TOPICAL LOCAL ANESTHETICS</b>		
<i>desflurane</i> (Suprane)	T1	
<i>isoflurane</i>	T1	
<i>isoflurane</i>	T3	
<i>sevoflurane</i> (Ultane)	T1	
SUPRANE	T3	
ULTANE ( <i>sevoflurane</i> )	T3	
<i>lidocaine</i> 5% ointment	T1	QL (145gm/30 days)
<i>lidocaine</i> 5% patch ( <i>Lidocan li</i> )	T1	
<i>lidocaine</i> 5% patch ( <i>Lidoderm</i> )	T1	
<i>lidocaine</i> hcl	T1	
<i>lidocaine</i> ( <i>Lidocan li</i> )	T1	
<i>lidocaine</i> ( <i>Lidoderm</i> )	T1	
<i>lidocaine/prilocaine</i>	T1	
LIDODERM ( <i>lidocaine</i> )	T3	
PAIN EASE MEDIUM STREAM SPRAY	T3	
ZTLIDO	T2	

### ANESTHETICS (Urinary Tract Conditions)

<b>URINARY TRACT ANESTHETIC/ANALGESIC AGNT (AZO-DYE)</b>		
<i>phenazopyridine hcl</i> ( <i>Pyridium</i> )	T1	
PYRIDIUM ( <i>phenazopyridine hcl</i> )	T3	

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

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

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

<b>ANALGESIC/ANTIPYRETICS, SALICYLATES</b>		
DISALCID ( <i>salsalate</i> )	T3	HD
<i>salsalate</i> ( <i>Disalcid</i> )	T1	HD
<b>ANTI-ARTHRITIC AND CHELATING AGENTS</b>		
DEPEN ( <i>penicillamine</i> )	T3	PA SP
<i>penicillamine</i>	T1	PA SP
<i>penicillamine</i> ( <i>Depen</i> )	T1	PA SP
<b>ANTI-ARTHRITIC, FOLATE ANTAGONIST AGENTS</b>		
OTREXUP	T2	PA

T1 – Typically Generics

T2 – Typically Preferred Brands

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T4 – Injectable Specialty Medications

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## List of Prescription Medications

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

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>ANTI-INFLAMMATORY, PYRIMIDINE SYNTHESIS INHIBITOR</b>		
ARAVA ( <i>leflunomide</i> )	T3	HD
<i>leflunomide</i> (Arava)	T1	HD
<b>ANTI-INFLAMMATORY, PHOSPHODIESTERASE-4(PDE4) INHIB.</b>		
OTEZLA 28 DAY STARTER PACK	T2	PA QL (1 pack/180 days) SP HD
OTEZLA 30 MG TABLET	T2	PA QL (2 tabs/day) SP HD
<b>ANTI-INFLAMMATORY, SEL.COSTIM.MOD., T-CELL INHIBITOR</b>		
ORENCIA	T4	PA QL (4 syringes/28 days) SP HD
ORENCIA CLICKJECT	T4	PA QL (4 injectors/28 days) SP HD
<b>COLCHICINE</b>		
<i>colchicine 0.6 mg capsule</i>	T1	HD
COLCHICINE	T1	HD
<i>colchicine</i> (Mitigare)	T1	HD
<i>colchicine</i> (Colcrys)	T1	HD
COLCRYS ( <i>colchicine</i> )	T3	HD
MITIGARE	T2	HD
<b>GOLD SALTS</b>		
RIDAURA	T3	
<b>HYPERURICEMIA TX - XANTHINE OXIDASE INHIBITORS</b>		
<i>allopurinol</i> (Zyloprim)	T1	HD
<i>febuxostat 80 mg tablet</i> (Uloric)	T1	HD
ULORIC 40 MG TABLET ( <i>febuxostat</i> )	T3	QL (1 tab/day) HD
ULORIC 80 MG TABLET ( <i>febuxostat</i> )	T3	HD
ZYLOPRIM ( <i>allopurinol</i> )	T3	HD
<b>JANUS KINASE (JAK) INHIBITORS</b>		
LITFULO	T3	PA QL(1 cap/day) SP HD
OLUMIANT	T3	PA QL (1 tab/day) SP HD
RINVOQ	T2	PA QL (1 tab/day) SP HD
XELJANZ 1 MG/ML SOLUTION	T2	PA QL (480ml/22 days) SP HD
XELJANZ 10 MG TABLET	T2	PA QL (2 tabs/day) SP HD
XELJANZ 5 MG TABLET	T2	PA QL (2 tabs/day) SP HD
XELJANZ XR	T2	PA QL (1 tab/day) SP HD
<b>NSAIDS AND TOPICAL IRRITANT COUNTER-IRRITANT COMB.</b>		
COMFORT PAC-IBUPROFEN	T3	
COMFORT PAC-MELOXICAM	T3	
COMFORT PAC-NAPROXEN	T3	

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

T4 – Injectable Specialty Medications

PA – Prior Authorization

QL – Quantity Limit

ST – Step Therapy

AGE – Age Requirement

SP – Specialty Medication

HD – May require home delivery pharmacy

PPACA – No Cost-Share Preventive Medication

CSL – Oral cancer medication subject to cost-share limits



## List of Prescription Medications

ANTI-ARTHRITICS (Pain Relief and Inflammatory Disease) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>NSAIDS(COX NON-SPEC.INHIB) AND PROSTAGLANDIN ANALOG</b>		
ARTHROTEC 50 ( <i>diclofenac sodium-misoprostol</i> )	T3	ST HD
ARTHROTEC 75 ( <i>diclofenac sodium-misoprostol</i> )	T3	ST HD
<i>diclofenac sodium/misoprostol</i> (Arthrotec 50)	T1	HD
<i>diclofenac sodium/misoprostol</i> (Arthrotec 75)	T1	HD
<b>NSAIDS, CYCLOOXYGENASE INHIBITOR- TYPE ANALGESICS</b>		
ANAPROX DS ( <i>naproxen sodium ds</i> )	T3	ST HD
DAYPRO ( <i>oxaprozin</i> )	T3	ST HD
<i>diclofenac sod dr 25 mg tab</i>	T1	HD
<i>diclofenac sod dr 50 mg tab</i>	T1	HD
<i>diclofenac sod dr 75 mg tab</i>	T1	HD
<i>diclofenac sod ec 25 mg tab</i>	T1	HD
<i>diclofenac sod ec 50 mg tab</i>	T1	HD
<i>diclofenac sod ec 75 mg tab</i>	T1	HD
<i>diclofenac sodium</i>	T1	HD
EC-NAPROSYN ( <i>naproxen</i> )	T3	ST HD
<i>etodolac</i>	T1	HD
<i>etodolac</i> (Lodine)	T1	HD
FELDENE ( <i>piroxicam</i> )	T3	ST HD
<i>fenoprofen calcium</i> (Nalfon)	T1	HD
<i>flurbiprofen</i>	T1	HD
<i>ibuprofen</i>	T1	HD
<i>indomethacin</i>	T1	HD
<i>indomethacin 25 mg/5 ml susp</i>	T1	HD
LODINE ( <i>etodolac</i> )	T3	ST HD
<i>meclofenamate sodium</i>	T1	HD
<i>meloxicam 15 mg tablet</i>	T1	HD
<i>meloxicam 7.5 mg tablet</i> (Mobic)	T1	HD
<i>meloxicam</i> (Mobic)	T1	HD
MOBIC ( <i>meloxicam</i> )	T3	ST HD
<i>nabumetone</i>	T1	HD
NALFON 600 MG TABLET ( <i>profeno</i> )	T1	ST HD
NAPROSYN TABLET ( <i>naproxen</i> )	T3	ST HD
<i>naproxen dr 375 mg tablet</i> (Ec-Naprosyn)	T1	HD
<i>naproxen dr 500 mg tablet</i> (Ec-Naprosyn)	T1	HD
<i>naproxen tablet</i>	T1	HD

T1 – Typically Generics

T4 – Injectable Specialty Medications

ST – Step Therapy

HD – May require home delivery pharmacy

T2 – Typically Preferred Brands

PA – Prior Authorization

AGE – Age Requirement

PPACA – No Cost-Share Preventive Medication

T3 – Typically Non-Preferred Brands

QL – Quantity Limit

SP – Specialty Medication

CSL – Oral cancer medication subject to cost-share limits

## List of Prescription Medications

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

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>NSAIDS, CYCLOOXYGENASE INHIBITOR- TYPE ANALGESICS (cont.)</b>		
<i>naproxen</i> (Ec-naprosyn)	T1	HD
<i>naproxen</i> (Naprosyn)	T1	HD
<i>naproxen sodium</i> (Anaprox Ds)	T1	HD
<i>oxaprozin 600 mg caplet</i> (Daypro)	T1	HD
<i>oxaprozin 600 mg tablet</i> (Daypro)	T1	HD
OXAPROZIN 300 MG CAPSULE	T3	HD
<i>piroxicam</i> (Feldene)	T1	HD
QMIIZ ODT 15 MG TABLET	T3	ST HD
QMIIZ ODT 7.5 MG TABLET	T3	QL (1 tab/day) ST HD
<i>tolmetin sodium</i>	T1	HD
<b>NSAIDS, CYCLOOXYGENASE-2(COX-2) SELECTIVE INHIBITOR</b>		
CELEBREX 100 MG CAPSULE ( <i>celecoxib</i> )	T1	QL (2 caps/day) ST HD
CELEBREX 200 MG CAPSULE ( <i>celecoxib</i> )	T1	QL (2 caps/day) ST HD
CELEBREX 400 MG CAPSULE ( <i>celecoxib</i> )	T3	QL (1 cap/day) ST HD
CELEBREX 50 MG CAPSULE ( <i>celecoxib</i> )	T3	QL (2 caps/day) ST HD
<i>celecoxib 100 mg capsule</i> (Celebrex)	T1	QL (2 caps/day) HD
<i>celecoxib 200 mg capsule</i> (Celebrex)	T1	QL (2 caps/day) HD
<i>celecoxib 400 mg capsule</i> (Celebrex)	T1	QL (1 cap/day) HD
<i>celecoxib 50 mg capsule</i> (Celebrex)	T1	QL (2 caps/day) HD
<b>URICOSURIC AGENTS</b>		
<i>probenecid</i>	T1	HD
<i>probenecid/colchicine</i>	T1	HD
<b>ANTI-ASTHMATICS (Asthma/COPD/Respiratory)</b>		
<b>5-LIPOXYGENASE INHIBITORS</b>		
<i>zileuton</i>	T1	HD
<b>ANTICHOLINERGICS, ORALLY INHALED LONG ACTING</b>		
INCRUSE ELLIPTA	T2	HD
LONHALA MAGNAIR REFILL	T3	PA HD
LONHALA MAGNAIR STARTER	T3	PA HD
STRIVERDI RESPIMAT	T2	QL(1 inhaler/30 days) HD
SPIRIVA RESPIMAT	T2	HD
<b>ANTICHOLINERGICS, ORALLY INHALED SHORT ACTING</b>		
ATROVENT HFA	T2	HD
<i>ipratropium bromide</i>	T1	HD
<b>BETA-ADRENERGIC AGENTS</b>		
<i>albuterol sulf 2 mg/5 ml syrup</i>	T1	HD

T1 – Typically Generics

T4 – Injectable Specialty Medications

ST – Step Therapy

HD – May require home delivery pharmacy

T2 – Typically Preferred Brands

PA – Prior Authorization

AGE – Age Requirement

PPACA – No Cost-Share Preventive Medication

T3 – Typically Non-Preferred Brands

QL – Quantity Limit

SP – Specialty Medication

CSL – Oral cancer medication subject to cost-share limits

## List of Prescription Medications

ANTI-ASTHMATICS (Asthma/COPD/Respiratory) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>BETA-ADRENERGIC AGENTS, INHALED, SHORT ACTING</b>		
<i>albuterol 15 mg/3 ml solution</i>	T1	
<i>albuterol 75 mg/15 ml soln</i>	T1	
<i>albuterol sulfate 2 mg tab</i>	T1	HD
<i>albuterol sulfate 4 mg tab</i>	T1	HD
<i>albuterol sulfate er 8 mg tab</i>	T1	HD
<i>metaproterenol sulfate</i>	T1	HD
<i>terbutaline sulfate</i>	T1	HD
<i>albuterol 2.5 mg/0.5 ml sol</i>	T1	
<i>albuterol 5 mg/ml solution</i>	T1	
<i>albuterol sul 0.63 mg/3 ml sol</i>	T1	
<i>albuterol sul 1.25 mg/3 ml sol</i>	T1	
<i>albuterol sul 2.5 mg/3 ml soln</i>	T1	
<i>albuterol sulfate (Albuterol Sulfate Hfa)</i>	T1	QL (8.5gm/30 days)
ALBUTEROL SULFATE HFA	T1	QL (8.5gm/30 days)
<i>levalbuterol hcl (Xopenex Concentrate)</i>	T1	
<i>levalbuterol hcl (Xopenex)</i>	T1	
XOPENEX ( <i>levalbuterol hcl</i> )	T3	
XOPENEX CONCENTRATE ( <i>levalbuterol concentrate</i> )	T3	
<b>BETA-ADRENERGIC AND ANTICHOLINERGIC COMBO, INHALED</b>		
ANORO ELLIPTA	T2	HD
COMBIVENT RESPIMAT	T2	HD QL
<i>ipratropium/albuterol sulfate</i>	T2	HD
STIOLTO RESPIMAT INHAL SPRAY	T2	HD
<b>BETA-ADRENERGIC AGENTS AND GLUCOCORTICOID COMBO, INHALED</b>		
AIRDUO DIGIHALER	T3	ST HD
<i>budesonide/formoterol fumarate (Symbicort)</i>	T1	QL HD
DULERA	T2	HD
<i>fluticasone propion/salmeterol</i>	T1	HD
<i>fluticasone-salmeterol 100-50 (Advair Diskus)</i>	T1	QL(1 inhaler/30 days) HD
<i>fluticasone-salmeterol 250-50 (Advair Diskus)</i>	T1	QL(1 inhaler/30 days) HD
<i>fluticasone-salmeterol 500-50 (Advair Diskus)</i>	T1	QL(1 inhaler/30 days) HD
FLUTICASONE-SALMETEROL 113-14	T1	QL(1 inhaler/30 days) HD
FLUTICASONE-SALMETEROL 232-14	T1	QL(1 inhaler/30 days) HD
FLUTICASONE-SALMETEROL 55-14	T1	QL(1 inhaler/30 days) HD

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

T4 – Injectable Specialty Medications

PA – Prior Authorization

QL – Quantity Limit

ST – Step Therapy

AGE – Age Requirement

SP – Specialty Medication

HD – May require home delivery pharmacy

PPACA – No Cost-Share Preventive Medication

CSL – Oral cancer medication subject to cost-share limits

## List of Prescription Medications

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

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>BETA-ADRENERGIC AGENTS, ORALLY INHALED, LONG ACTING</b>		
<i>arformoterol tartrate (Brovana)</i>	T1	QL(4 mls/day) HD
<b>BETA-ADRENERGIC-ANTICHOLINERGIC-GLUCOCORT, INHALED</b>		
BREZTRI AEROSPHERE	T2	
TRELEGY ELLIPTA	T2	
<b>GLUCOCORTICIDS, ORALLY INHALED</b>		
ALVESCO	T2	QL(1 inhaler/30 days) HD
ASMANEX HFA	T3	QL(1 inhaler/30 days) HD
ASMANEX TWISTHALER	T2	QL
ASMANEX TWISTHALER 110 MCG #30	T2	QL(1 inhaler/30 days) HD
ASMANEX TWISTHALER 220 MCG #14	T2	HD
ASMANEX TWISTHALER 220 MCG #30	T2	QL(1 inhaler/30 days) HD
ASMANEX TWISTHALER 220 MCG #60	T2	QL(1 Inhaler/30 days) HD
ASMANEX TWISTHALR 220 MCG #120	T2	QL(1 Inhaler/30 days) HD
<i>budesonide (Pulmicort)</i>	T1	HD
FLOVENT DISKUS	T2	HD
FLOVENT HFA	T2	HD
FLUTICASONE PROP 100MCG DISKUS	T3	QL HD
FLUTICASONE PROP 250 MCG DISK	T3	QL HD
FLUTICASONE PROP 50 MCG DISKUS	T3	QL HD
PULMICORT ( <i>budesonide</i> )	T3	HD
QVAR REDHALER	T2	HD
<b>INTERLEUKIN-5(IL-5) RECEPTOR ALPHA ANTAGONIST, MAB</b>		
FASENRA PEN	T4	PA SP HD
<b>LEUKOTRIENE RECEPTOR ANTAGONISTS</b>		
ACCOLATE ( <i>zafirlukast</i> )	T3	HD
<i>montelukast sodium (Singulair)</i>	T1	HD
SINGULAIR ( <i>montelukast sodium</i> )	T3	HD
<i>zafirlukast (Accolate)</i>	T1	HD
<b>MAST CELL STABILIZERS, ORALLY INHALED</b>		
<i>cromolyn 20 mg/2 ml neb soln</i>	T1	QL (480ml/30 days) HD
<b>MONOCLONAL ANTIBODIES TO IMMUNOGLOBULIN E (IGE)</b>		
XOLAIR	T4	PA SP HD
<b>MONOCLONAL ANTIBODY - INTERLEUKIN-5 ANTAGONISTS</b>		
NUCALA	T4	PA SP HD
<b>MUCOLYTICS</b>		
<i>acetylcysteine</i>	T1	

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

T4 – Injectable Specialty Medications

PA – Prior Authorization

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AGE – Age Requirement

SP – Specialty Medication

HD – May require home delivery pharmacy

PPACA – No Cost-Share Preventive Medication

CSL – Oral cancer medication subject to cost-share limits

## List of Prescription Medications

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

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>PHOSPHODIESTERASE-4 (PDE4) INHIBITORS</b>		
DALIRESP 250 MCG TABLET	T3	QL (28 tabs/180 days) HD
DALIRESP 500 MCG TABLET	T3	QL (2 tabs/day) HD
<b>XANTHINES</b>		
THEO-24	T2	HD
<i>theophylline anhydrous</i>	T1	HD

### ANTIBIOTICS (Allergy/Nasal Sprays)

#### NOSE PREPARATIONS ANTIBIOTICS

BACTROBAN NASAL	T2	
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### ANTIBIOTICS (Ear Medications)

#### EAR PREPARATIONS, ANTIBIOTICS

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

#### OTIC PREPARATIONS, ANTI-INFLAMMATORY-ANTIBIOTICS

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

### ANTIBIOTICS (Eye Conditions)

#### EYE ANTIBIOTIC AND GLUCOCORTICOID COMBINATIONS

<i>neomycin/bacit/p-myx/hydrocort</i>	T1	
<i>neomycin/polymyxin b/dexametha (Maxitrol)</i>	T1	
<i>neomycin/polymyxin b/hydrocort</i>	T1	
TOBRADEX	T3	
TOBRADEX ( <i>tobramycin-dexamethasone</i> )	T3	
TOBRADEX EYE OINTMENT	T3	
TOBRADEX ST	T2	
TOBRADEX ST 0.3-0.05% DROP	T2	
<i>tobramycin/dexamethasone (Tobradex)</i>	T1	
ZYLET	T3	

#### EYE SULFONAMIDES

BLEPH-10 ( <i>sulfacetamide sodium</i> )	T3	
BLEPHAMIDE	T3	

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

T4 – Injectable Specialty Medications

PA – Prior Authorization

QL – Quantity Limit

ST – Step Therapy

AGE – Age Requirement

SP – Specialty Medication

HD – May require home delivery pharmacy

PPACA – No Cost-Share Preventive Medication

CSL – Oral cancer medication subject to cost-share limits

## List of Prescription Medications

### ANTIBIOTICS (Eye Conditions) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>EYE SULFONAMIDES (cont.)</b>		
<i>sulfacetamide sodium</i>	T1	
<i>sulfacetamide sodium</i> (Bleph-10)	T1	
<i>sulfacetamide/prednisolone sp</i>	T1	
<b>OPHTHALMIC ANTIBIOTICS</b>		
AZASITE	T2	
AZASITE 1% EYEDROPS	T2	
BACIGUENT ( <i>bacitracin</i> )	T3	
<i>bacitracin</i>	T1	
<i>bacitracin</i> (Baciguent)	T1	
<i>bacitracin/polymyxin b sulfate</i>	T1	
BESIVANCE	T2	
BESIVANCE 0.6% SUSP	T2	
<i>erythromycin base</i>	T1	
<i>gatifloxacin</i> (Zymaxid)	T1	
<i>gentamicin sulfate</i>	T1	
<i>levofloxacin</i>	T1	
MOXEZA ( <i>moxifloxacin</i> )	T3	
<i>moxifloxacin hcl</i> (Moxeza)	T1	
<i>moxifloxacin hcl</i> (Vigamox)	T1	
<i>neomycin sulf/bacitracin/poly</i>	T1	
<i>neomycin/polymyxn b/gramicidin</i>	T1	
<i>ofloxacin</i> (Ocuflox)	T1	
<i>tobramycin 0.3% eye drop</i>	T1	

### ANTIBIOTICS (Infections)

#### ABSORBABLE SULFONAMIDE ANTIBACTERIAL AGENTS

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

#### AMINOGLYCOSIDE ANTIBIOTICS

ARIKAYCE	T3	PA SP
<i>gentamicin sulfate</i>	T1	
<i>gentamicin sulfate/pf</i>	T1	

T1 – Typically Generics

T4 – Injectable Specialty Medications

ST – Step Therapy

HD – May require home delivery pharmacy

T2 – Typically Preferred Brands

PA – Prior Authorization

AGE – Age Requirement

PPACA – No Cost-Share Preventive Medication

T3 – Typically Non-Preferred Brands

QL – Quantity Limit

SP – Specialty Medication

CSL – Oral cancer medication subject to cost-share limits



## ANTIBIOTICS (Infections) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>AMINOGLYCOSIDE ANTIBIOTICS (cont)</b>		
KITABIS PAK	T3	PA QL (10ml/day) SP HD
<i>neomycin sulfate</i>	T1	
TOBI PODHALER	T2	PA QL (8 caps/day) SP HD
<i>tobramycin 1,200 mg/30 ml vial</i>	T1	
<i>tobramycin 1.2 gm vial</i>	T1	PA
<i>tobramycin 1.2 gram/30 ml vial</i>	T1	
<i>tobramycin 10 mg/ml vial</i>	T1	
<i>tobramycin 300 mg/4 ml ampule</i>	T1	QL (28ml/day) SP HD
<i>tobramycin 300 mg/5 ml ampule</i>	T1	PA QL (10ml/day) SP HD
<i>tobramycin 40 mg/ml vial</i>	T1	
<i>tobramycin 80 mg/2 ml vial</i>	T1	
TOBRAMYCIN PAK 300 MG/5 ML	T3	PA QL (10ml/day) SP HD
<b>ANAEROBIC ANTIPROTOZOAL-ANTIBACTERIAL AGENTS</b>		
FLAGYL ( <i>metronidazole</i> )	T3	
LIKMEZ	T3	PA
<i>metronidazole</i> (Flagyl)	T1	
<b>ANTIBIOTIC, ANTIBACTERIAL, MISC.</b>		
<i>fosfomycin tromethamine</i> (Monurol)	T1	
HIPREX ( <i>methenamine hippurate</i> )	T3	
<i>meth/meblue/sod phos/psal/hyos</i>	T1	
<i>meth/meblue/sod phos/psal/hyos</i>	T3	
<i>methenam/m.blue/salicyl/hyoscy</i> (Uribel Tabs)	T1	
<i>meth/meblue/sod phos/psal/hyos</i> (Uribel)	T1	
<i>methen/mblue/sal/sod phos/hyos</i>	T1	
<i>methenam/m.blue/salicyl/hyoscy</i>	T1	
<i>methenam/sod phos/mblue/hyoscy</i>	T1	
<i>methenamine hippurate</i> (Hiprex)	T1	
<i>methenamine mandelate</i>	T1	
MONUROL ( <i>fosfomycin tromethamine</i> )	T3	
PRIMSOL	T3	
<i>trimethoprim</i>	T1	
URIBEL	T3	
URIBEL TABS ( <i>methenam/m.blue/salicyl/hyoscy</i> )	T3	
UTA	T3	
<b>ANTILEPROTICS</b>		
<i>dapsone</i>	T1	
THALOMID	T2	PA SP HD

T1 – Typically Generics

T4 – Injectable Specialty Medications

ST – Step Therapy

HD – May require home delivery pharmacy

T2 – Typically Preferred Brands

PA – Prior Authorization

AGE – Age Requirement

PPACA – No Cost-Share Preventive Medication

T3 – Typically Non-Preferred Brands

QL – Quantity Limit

SP – Specialty Medication

CSL – Oral cancer medication subject to cost-share limits

# List of Prescription Medications

## ANTIBIOTICS (Infections) (cont.)

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

T1 – Typically Generics

T4 – Injectable Specialty Medications

ST – Step Therapy

HD – May require home delivery pharmacy

T2 – Typically Preferred Brands

PA – Prior Authorization

AGE – Age Requirement

PPACA – No Cost-Share Preventive Medication

T3 – Typically Non-Preferred Brands

QL – Quantity Limit

SP – Specialty Medication

CSL – Oral cancer medication subject to cost-share limits

## List of Prescription Medications

ANTIBIOTICS (Infections) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>LINCOSAMIDE ANTIBIOTICS (cont.)</b>		
<i>clindamycin hcl</i> (Cleocin Hcl)	T1	
<i>clindamycin palmitate hcl</i> (Cleocin Pediatric)	T1	
<b>MACROLIDE ANTIBIOTICS</b>		
<i>azithromycin</i> (Zithromax)	T1	
<i>azithromycin 1 gm pwd packet</i> (Zithromax)	T1	
<i>azithromycin 100 mg/5 ml susp</i> (Zithromax)	T1	
<i>azithromycin 200 mg/5 ml susp</i> (Zithromax)	T1	
<i>azithromycin 200 mg/5 ml susp</i> (Zithromax)	T1	
<i>azithromycin 250 mg tablet</i> (Zithromax)	T1	
<i>azithromycin 500 mg tablet</i> (Zithromax Tri-pak)	T1	
<i>azithromycin 600 mg tablet</i>	T1	
<i>clarithromycin</i>	T1	
DIFICID 200 MG TABLET	T3	QL (28 tabs/28 days)
DIFICID 40 MG/ML SUSPENSION	T3	QL (5ml/day)
ERYPED 200 ( <i>erythromycin ethylsuccinate</i> )	T3	
ERY-TAB ( <i>erythromycin</i> )	T3	
<i>erythromycin base</i>	T1	
<i>erythromycin base</i>	T3	
<i>erythromycin base</i> (Ery-tab)	T1	
<i>erythromycin ethylsuccinate</i>	T1	
<i>erythromycin ethylsuccinate</i>	T3	
<i>erythromycin ethylsuccinate</i> (Eryped 200)	T1	
<i>erythromycin stearate</i>	T1	
PCE	T3	
ZITHROMAX 1 GM POWDER PACKET ( <i>azithromycin</i> )	T3	
ZITHROMAX 100 MG/5 ML SUSP ( <i>azithromycin</i> )	T3	
ZITHROMAX 200 MG/5 ML SUSP ( <i>azithromycin</i> )	T3	
ZITHROMAX 200 MG/5 ML SUSP ( <i>azithromycin</i> )	T3	
ZITHROMAX 250 MG TABLET ( <i>azithromycin</i> )	T3	
ZITHROMAX 250 MG Z-PAK TABLET ( <i>azithromycin</i> )	T3	
ZITHROMAX 500 MG TABLET ( <i>azithromycin</i> )	T3	
ZITHROMAX TRI-PAK ( <i>azithromycin</i> )	T3	
<b>NITROFURAN DERIVATIVES ANTIBACTERIAL AGENTS</b>		
FURADANTIN ( <i>nitrofurantoin</i> )	T3	
MACROBID ( <i>nitrofurantoin mono-macro</i> )	T3	

T1 – Typically Generics

T4 – Injectable Specialty Medications

ST – Step Therapy

HD – May require home delivery pharmacy

T2 – Typically Preferred Brands

PA – Prior Authorization

AGE – Age Requirement

PPACA – No Cost-Share Preventive Medication

T3 – Typically Non-Preferred Brands

QL – Quantity Limit

SP – Specialty Medication

CSL – Oral cancer medication subject to cost-share limits

## List of Prescription Medications

### ANTIBIOTICS (Infections) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>NITROFURAN DERIVATIVES ANTIBACTERIAL AGENTS (cont.)</b>		
MACRODANTIN ( <i>nitrofurantoin</i> )	T3	
<i>nitrofurantoin 25 mg/5 ml susp</i> (Furadantin)	T1	
<i>nitrofurantoin monohyd/m-cryst</i> (Macrobid)	T1	
<i>nitrofurantoin</i> suspension	T1	
<i>nitrofurantoin macrocrystal</i> (Macrodantin)	T1	
<i>nitrofurantoin monohyd/m-cryst</i> (Macrobid)	T1	
<b>OXAZOLIDINONE ANTIBIOTICS</b>		
<i>linezolid</i> (Zyvox)	T1	PA
SIVEXTRO	T3	PA
ZYVOX ( <i>linezolid</i> )	T3	PA
<b>PENICILLIN ANTIBIOTICS</b>		
<i>amoxicillin</i>	T1	
<i>amoxicillin/potassium clav</i> (Augmentin Es-600)	T1	
<i>ampicillin trihydrate</i>	T1	
<i>dicloxacillin sodium</i>	T1	
MOXATAG	T3	
<i>penicillin v potassium</i>	T1	
<b>PLEUROMUTILIN DERIVATIVES</b>		
XENLETA	T3	PA QL (10 tabs/30 days)
<b>QUINOLONE ANTIBIOTICS</b>		
AVELOX ( <i>moxifloxacin hcl</i> )	T3	
BAXDELA	T3	PA
CIPRO ( <i>ciprofloxacin hcl</i> )	T3	
CIPRO ( <i>ciprofloxacin</i> )	T3	
<i>ciprofloxacin</i> (Cipro)	T1	
<i>ciprofloxacin hcl</i>	T1	
<i>ciprofloxacin hcl</i> (Cipro)	T1	
<i>ciprofloxacin/ciprofloxacin hcl</i>	T1	
FACTIVE	T3	
<i>levofloxacin</i>	T1	
<i>moxifloxacin hcl</i> (Avelox)	T1	
<i>ofloxacin</i>	T1	
<b>RIFAMYCINS AND RELATED DERIVATIVE ANTIBIOTICS</b>		
AEMCOLO	T3	QL (12 tabs/3 days)
XIFAXAN 200 MG TABLET	T2	
XIFAXAN 550 MG TABLET	T2	QL (126 tabs/year)

T1 – Typically Generics

T4 – Injectable Specialty Medications

ST – Step Therapy

HD – May require home delivery pharmacy

T2 – Typically Preferred Brands

PA – Prior Authorization

AGE – Age Requirement

PPACA – No Cost-Share Preventive Medication

T3 – Typically Non-Preferred Brands

QL – Quantity Limit

SP – Specialty Medication

CSL – Oral cancer medication subject to cost-share limits

## List of Prescription Medications

### ANTIBIOTICS (Infections) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>TETRACYCLINE ANTIBIOTICS</b>		
coremino er 135 mg tablet	T1	
coremino er 45 mg tablet	T1	QL (1 tab/day)
coremino er 90 mg tablet	T1	
demeclocycline hcl	T1	
doxycycline 50 mg tablet (Targadox)	T1	
doxycycline hyclate	T1	
doxycycline monohydrate	T1	
minocycline er 115 mg tablet	T1	
minocycline er 45 mg tablet	T1	QL (1 tab/day)
minocycline er 55 mg, 65 mg, 80 mg, 90mg tablet	T1	
minocycline hcl	T1	
NUZYRA	T3	PA QL (30 tablets/28 days) SP
tetracycline 250 mg capsule	T1	
tetracycline 500 mg capsule	T1	
VIBRAMYCIN	T3	
VIBRAMYCIN (doxycycline monohydrate)	T3	
<b>VAGINAL ANTIBIOTICS</b>		
CLEOCIN	T3	
CLEOCIN (clindamycin phosphate)	T3	
clindamycin phosphate (Cleocin)	T1	
metronidazole (Metrogel-vaginal)	T1	
<b>VANCOMYCIN ANTIBIOTICS AND DERIVATIVES</b>		
vancomycin 250 mg/5 ml soln	T1	
vancomycin 50 mg/ml solution	T1	
vancomycin hcl 125 mg capsule (Vancocin Hcl)	T1	
vancomycin hcl 250 mg capsule (Vancocin Hcl)	T1	
vancomycin hcl (Firvanq)	T1	
<b>ANTIBIOTICS (Skin Conditions)</b>		
<b>TOPICAL ANTIBIOTIC AND ANTI-INFLAMMATORY STEROID</b>		
CORTISPORIN	T3	
NEO-SYNALAR	T3	
<b>TOPICAL ANTIBIOTICS</b>		
BENZAMYCIN (erythromycin-benzoyl peroxide)	T3	
CENTANY	T3	
CENTANY AT	T3	

T1 – Typically Generics

T4 – Injectable Specialty Medications

ST – Step Therapy

HD – May require home delivery pharmacy

T2 – Typically Preferred Brands

PA – Prior Authorization

AGE – Age Requirement

PPACA – No Cost-Share Preventive Medication

T3 – Typically Non-Preferred Brands

QL – Quantity Limit

SP – Specialty Medication

CSL – Oral cancer medication subject to cost-share limits



## List of Prescription Medications

### ANTIBIOTICS (Skin Conditions) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>TOPICAL ANTIBIOTICS (cont.)</b>		
CLEOCIN T ( <i>clindamycin phosphate</i> )	T3	
CLINDACIN ETZ KIT	T3	
CLINDACIN PAC	T3	
<i>clindamycin phosphate</i>	T1	
<i>clindamycin phosphate</i> (Cleocin T)	T1	
<i>clindamycin phosphate</i> (Evoclin)	T1	
<i>erythromycin base in ethanol</i>	T1	
<i>erythromycin/benzoyl peroxide</i> (Benzamycin)	T1	
EVOCLIN ( <i>clindamycin phosphate</i> )	T3	
<i>gentamicin sulfate</i>	T1	
<i>mupirocin</i> (Centany)	T1	
<i>mupirocin calcium</i>	T1	
XEPI	T3	

### TOPICAL SULFONAMIDES

AVAR 9.5-5% CLEANSING PADS	T3	
<i>avar cleanser</i> (Rosanil)	T1	
AVAR LS	T3	
<i>mafenide acetate</i>	T1	
ROSANIL ( <i>sodium sulfacetamide-sulfur</i> )	T1	
SILVADENE (ssd)	T3	
<i>silver sulfadiazine</i> (Silvadene)	T1	
<i>sulfacetamide sod/sulfur/urea</i>	T1	
<i>sulfacetamide sodium/sulfur</i>	T1	
<i>sulfacetamide sodium/sulfur</i> (Avar-e Green)	T1	
<i>sulfacetamide sodium/sulfur</i> (Rosanil)	T1	
<i>sulfacetamide/sulfur/cleansr23</i>	T1	
<i>sulfact sod/sulur/avob/otn/oct</i>	T1	
SULFAMILYLON	T3	

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

#### ANTI-COAGULANTS, COUMARIN TYPE

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

ACD SOLUTION A	T3	
ACD-A SOLUTION	T3	

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

T4 – Injectable Specialty Medications

PA – Prior Authorization

QL – Quantity Limit

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AGE – Age Requirement

SP – Specialty Medication

HD – May require home delivery pharmacy

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## List of Prescription Medications

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

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
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#### CITRATES AS ANTI-COAGULANTS (cont.)

ANTICOAGULANT SODIUM CITRATE	T3	
CITRATE PHOSPHATE DEXTROSE	T1	
SODIUM CITRATE	T1	

#### DIRECT FACTOR XA INHIBITORS

BEVYXXA	T3	QL (42 caps/42 days)
ELIQUIS	T2	PA
SAVAYSA 15 MG TABLET	T3	PA QL (1 tab/day)
SAVAYSA 30 MG TABLET	T3	PA QL (1 tab/day)
SAVAYSA 60 MG TABLET	T3	PA
XARELTO	T2	PA

#### HEPARIN AND RELATED PREPARATIONS

ARIXTRA ( <i>fondaparinux sodium</i> )	T4	QL (1 syringe/day) SP
<i>enoxaparin 100 mg/ml syringe</i> (Lovenox)	T1	QL (2 syringes/day) SP
<i>enoxaparin 120 mg/0.8 ml syr</i> (Lovenox)	T1	QL (2 syringes/day) SP
<i>enoxaparin 150 mg/ml syringe</i> (Lovenox)	T1	QL (2 syringes/day) SP
<i>enoxaparin 30 mg/0.3 ml syr</i> (Lovenox)	T1	QL (2 syringes/day) SP
<i>enoxaparin 300 mg/3 ml vial</i> (Lovenox)	T4	QL (1 vial/day) SP
<i>enoxaparin 40 mg/0.4 ml syr</i> (Lovenox)	T1	QL (2 syringes/day) SP
<i>enoxaparin 60 mg/0.6 ml syr</i> (Lovenox)	T1	QL (2 syringes/day) SP
<i>enoxaparin 80 mg/0.8 ml syr</i> (Lovenox)	T1	QL (2 syringes/day) SP
<i>fondaparinux sodium</i> (Arixtra)	T4	QL (1 syringe/day) SP
FRAGMIN	T4	QL (2ml/day) SP
<i>heparin 10,000 unit/10 ml vial</i>	T1	
<i>heparin 30,000 unit/30 ml vial</i>	T1	
<i>heparin 40,000 unit/4 ml vial</i>	T1	
<i>heparin 50,000 unit/10 ml vial</i>	T1	
<i>heparin 50,000 unit/5 ml vial</i>	T1	
<i>heparin sod 1,000 unit/ml vial</i>	T1	
<i>heparin sod 10,000 unit/ml vl</i>	T1	
<i>heparin sod 20,000 unit/ml vl</i>	T1	
<i>heparin sod 2,000 unit/ml vl</i>	T1	
<i>heparin sod 5,000 unit/0.5 ml</i>	T1	
HEPARIN SOD 5,000 UNIT/0.5 ML	T1	
<i>heparin sod 5,000 unit/0.5 ml</i> (Heparin Sodium)	T1	
<i>heparin sod 5,000 unit/ml syrg</i>	T3	

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

T4 – Injectable Specialty Medications

PA – Prior Authorization

QL – Quantity Limit

ST – Step Therapy

AGE – Age Requirement

SP – Specialty Medication

HD – May require home delivery pharmacy

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CSL – Oral cancer medication subject to cost-share limits

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

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>HEPARIN AND RELATED PREPARATIONS (cont.)</b>		
<i>heparin sod 5,000 unit/ml vial</i>	T1	
LOVENOX 100 MG/ML SYRINGE ( <i>enoxaparin sodium</i> )	T4	QL (2 syringes/day) SP
LOVENOX 120 MG/0.8 ML SYRINGE ( <i>enoxaparin sodium</i> )	T4	QL (2 syringes/day) SP
LOVENOX 150 MG/ML SYRINGE ( <i>enoxaparin sodium</i> )	T4	QL (2 syringes/day) SP
LOVENOX 30 MG/0.3 ML SYRINGE ( <i>enoxaparin sodium</i> )	T4	QL (2 syringes/day) SP
LOVENOX 300 MG/3 ML VIAL ( <i>enoxaparin sodium</i> )	T4	QL (1 vial/day) SP
LOVENOX 40 MG/0.4 ML SYRINGE ( <i>enoxaparin sodium</i> )	T4	QL (2 syringes/day) SP
LOVENOX 60 MG/0.6 ML SYRINGE ( <i>enoxaparin sodium</i> )	T4	QL (2 syringes/day) SP
LOVENOX 80 MG/0.8 ML SYRINGE ( <i>enoxaparin sodium</i> )	T4	QL (2 syringes/day) SP

### THROMBIN INHIBITORS, SELECTIVE, DIRECT, REVERSIBLE

<i>dabigatran etexilate mesylate</i>	T1	PA HD
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## ANTIDOTES (Gastrointestinal/Heartburn)

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

MOVANTIK	T3	PA
RELISTOR	T3	PA
SYMPROIC	T3	PA

## ANTIDOTES (Substance Abuse)

### OPIOID ANTAGONISTS

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

### INTERLEUKIN-13 (IL-13) INHIBITORS, MAB

ADBRY	T2	PA SP HD
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## ANTI-FUNGALS (Eye Conditions)

### OPHTHALMIC ANTI-FUNGAL AGENTS

NATACYN	T3	
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## ANTI-FUNGALS (Feminine Products)

### VAGINAL ANTI-FUNGALS

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

I2 – Typically Preferred Brands

PA – Prior Authorization

AGE – Age Requirement

PFACA – No Cost-Share Preventive Medication

T3 – Typically Non-Preferred Brands

QL – Quantity Limit

SP – Specialty Medication

CSL – Oral cancer medication subject to cost-share limits

## List of Prescription Medications

ANTI-FUNGALS (Infections)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>ANTI-FUNGAL AGENTS</b>		
ANCOBON ( <i>flucytosine</i> )	T3	
<i>clotrimazole</i>	T1	
CRESEMBA	T3	PA
fluconazole	T1	
<i>flucytosine</i> (Ancobon)	T1	
<i>itraconazole</i>	T1	
<i>ketoconazole</i>	T1	
NOXAFIL	T3	
NOXAFIL 40 MG/ML SUSPENSION ( <i>posaconazole</i> )	T3	
ORAVIG	T3	
<i>posaconazole</i> (Noxafil)	T1	
<i>terbinafine hcl</i>	T1	
VFEND ( <i>voriconazole</i> )	T3	PA
VIVJOA	T3	PA
<i>voriconazole</i> (Vfend)	T1	PA
<b>ANTI-FUNGAL ANTIBIOTICS</b>		
<i>griseofulvin ultramicrosize</i> (Gris-peg)	T1	
<i>griseofulvin, microsize</i>	T1	
GRIS-PEG ( <i>griseofulvin ultramicrosize</i> )	T3	
<i>nystatin</i>	T1	
<b>ANTI-FUNGALS (Skin Conditions)</b>		
<b>TOPICAL ANTI-FUNGAL/ANTI-INFLAMMATORY, STEROID AGENT</b>		
<i>clotrimazole/betamethasone dip</i>	T1	
<b>TOPICAL ANTI-FUNGALS</b>		
<i>ciclodan 0.77% cream</i>	T1	
CICLODAN 0.77% CREAM KIT	T3	
<i>ciclodan 8% solution</i>	T1	
<i>ciclopirox</i>	T1	
<i>ciclopirox olamine</i>	T1	
<i>ciclopirox olamine</i> (Loprox)	T1	
<i>econazole nitrate</i>	T1	
ECOZA	T3	
EXODERM	T1	
<i>ketoconazole</i>	T1	

T1 – Typically Generics

T4 – Injectable Specialty Medications

ST – Step Therapy

HD – May require home delivery pharmacy

T2 – Typically Preferred Brands

PA – Prior Authorization

AGE – Age Requirement

PPACA – No Cost-Share Preventive Medication

T3 – Typically Non-Preferred Brands

QL – Quantity Limit

SP – Specialty Medication

CSL – Oral cancer medication subject to cost-share limits

## List of Prescription Medications

ANTI-FUNGALS (Skin Conditions) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>TOPICAL ANTI-FUNGALS (cont.)</b>		
<i>ketoconazole/skin cleanser 28</i>	T1	
LOPROX	T3	
LOPROX ( <i>ciclopirox</i> )	T3	
LULICONAZOLE	T1	
<i>naftifine hcl</i>	T1	
<i>naftifine hcl</i> (Naftin)	T1	
NAFTIN ( <i>naftifine hcl</i> )	T3	
<i>nystatin</i>	T1	
<i>nystatin/triamcinolone acet</i>	T1	
ANTI-HISTAMINE AND DECONGESTANT COMBINATION (Allergy/Nasal Sprays)		
<b>1ST GEN ANTI-HISTAMINE AND DECONGESTANT COMBINATION</b>		
<i>phenylephrine hcl/prometh hcl</i>	T1	
<b>2ND GEN ANTI-HISTAMINE AND DECONGESTANT COMBINATION</b>		
CLARINEX-D 12 HOUR	T3	
ANTI-HISTAMINES (Allergy/Nasal Sprays)		
<b>ANTI-HISTAMINES - 1ST GENERATION</b>		
<i>carbinoxamine maleate</i>	T1	
<i>clemastine fumarate</i>	T1	
<i>cyproheptadine hcl</i>	T1	
<i>cyproheptadine hcl</i> (Cyproheptadine Hcl)	T1	
<i>hydroxyzine hcl</i>	T1	
<i>hydroxyzine pamoate</i>	T1	
<i>hydroxyzine pamoate</i> (Vistaril)	T1	
<i>promethazine hcl</i>	T1	
VISTARIL ( <i>hydroxyzine pamoate</i> )	T3	
<b>ANTI-HISTAMINES - 2ND GENERATION</b>		
<i>cetirizine hcl</i>	T1	HD
<i>desloratadine 2.5 mg odt</i>	T1	QL (1 tab/day) HD
<i>desloratadine 5 mg odt</i>	T1	HD
<i>desloratadine 5 mg tablet</i>	T1	HD
<i>levocetirizine dihydrochloride</i>	T1	HD

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

T4 – Injectable Specialty Medications

PA – Prior Authorization

QL – Quantity Limit

ST – Step Therapy

AGE – Age Requirement

SP – Specialty Medication

HD – May require home delivery pharmacy

PPACA – No Cost-Share Preventive Medication

CSL – Oral cancer medication subject to cost-share limits

## List of Prescription Medications

### ANTI-HISTAMINES (Eye Conditions)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>EYE ANTIHISTAMINES</b>		
<i>azelastine hcl 0.05% drops</i>	T1	
<i>bepotastine besilate</i>	T1	
<i>epinastine hcl</i>	T1	
<i>olopatadine hcl 0.1% eye drops</i>	T1	
<i>olopatadine hcl 0.2% eye drop</i>	T1	

### ANTI-HYPERGLYCEMICS (Diabetes)

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

BYDUREON	T2	QL (4 vials/28 days) ST HD
BYDUREON BCISE	T2	QL (4 pens/28 days) ST HD
BYDUREON PEN	T2	QL (4 pens/28 days) ST HD
BYETTA	T2	QL (1 pen/30 days) ST HD
OZEMPIC 0.25-0.5 MG DOSE PEN	T2	QL (2 pens/28 days) ST HD
OZEMPIC 1 MG DOSE PEN (1.5 ML)	T2	QL (2 pens/28 days) ST HD
OZEMPIC 1 MG DOSE PEN (3 ML)	T2	QL (3ml/21 days) ST HD
REZVOGLAR KWIKPEN	T2	QL
RYBELSUS	T2	QL (1 tab/day) ST HD
TRULICITY 0.75 MG/0.5 ML PEN	T2	QL (4 pens/28 days) ST HD
TRULICITY 1.5 MG/0.5 ML PEN	T2	QL (4 pens/28 days) ST HD
TRULICITY 3 MG/0.5 ML PEN	T2	QL (2 ml/28 days) ST HD
TRULICITY 4.5 MG/0.5 ML PEN	T2	QL (2 ml/28 days) ST HD

#### ANTI-HYPERGLY, INSULIN, LONG ACT-GLP-I RECEPT.AGONIST

SOLIQUA 100-33	T2	HD
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#### ANTI-HYPERGLYCEMIC-SOD/GLUC COTRANSPORT2(SGLT2) INHIB

FARXIGA	T2	QL (1 tab/day) ST HD
JARDIANCE	T2	QL (1 tab/day) ST HD

#### ANTI-HYPERGLYCEMIC-DOPAMINE RECEPTOR AGONISTS

CYCLOSET	T3	HD
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#### ANTI-HYPERGLYCEMIC, ALPHA-GLUCOSIDASE INHIBITORS

<i>acarbose (Precose)</i>	T1	HD
<i>GLYSET (miglitol)</i>	T3	HD
<i>miglitol (Glyset)</i>	T1	HD
<i>PRECOSE (acarbose)</i>	T3	HD

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

T4 – Injectable Specialty Medications

PA – Prior Authorization

QL – Quantity Limit

ST – Step Therapy

AGE – Age Requirement

SP – Specialty Medication

HD – May require home delivery pharmacy

PPACA – No Cost-Share Preventive Medication

CSL – Oral cancer medication subject to cost-share limits



# List of Prescription Medications

## ANTI-HYPERGLYCEMICS (Diabetes) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>ANTI-HYPERGLYCEMIC, AMYLIN ANALOG-TYPE</b>		
SYMLINPEN 120	T2	HD
SYMLINPEN 60	T2	HD
<b>ANTI-HYPERGLYCEMIC, BIGUANIDE TYPE</b>		
GLUCOPHAGE XR ( <i>metformin hcl er</i> )	T3	HD
<i>metformin hcl 1,000 mg tablet</i>	T1	HD
<i>metformin hcl 850 mg tablet</i>	T1	HD
<i>metformin hcl</i>	T1	HD
<i>metformin hcl (Glucophage Xr)</i>	T1	HD
<i>metformin hcl (Riomet)</i>	T1	HD
RIOMET ( <i>metformin hcl</i> )	T3	HD
RIOMET ER	T3	HD
<b>ANTI-HYPERGLYCEMIC, DPP-4 INHIBITORS</b>		
JANUVIA	T2	QL (1 tab/day) ST HD
<b>ANTI-HYPERGLYCEMIC, INSULIN-RELEASE STIMULANT TYPE</b>		
AMARYL ( <i>glimepiride</i> )	T3	HD
<i>chlorpropamide</i>	T1	HD
<i>glimepiride (Amaryl)</i>	T1	HD
GLIPIZIDE 2.5 MG TABLET	T3	HD
<i>glipizide 10 mg tablet</i>	T1	HD
<i>glipizide 5 mg tablet</i>	T1	HD
<i>glipizide (Glucotrol XL)</i>	T1	HD
<i>glipizide (Glucotrol)</i>	T1	HD
GLUCOTROL ( <i>glipizide</i> )	T3	HD
GLUCOTROL XL ( <i>glipizide xl</i> )	T3	HD
<i>glyburide</i>	T1	HD
<i>glyburide, micronized (Glynase)</i>	T1	HD
GLYNASE ( <i>glyburide micronized</i> )	T3	HD
<i>nateglinide (Starlix)</i>	T1	HD
<i>repaglinide</i>	T1	HD
STARLIX ( <i>nateglinide</i> )	T3	HD
<i>tolbutamide</i>	T1	HD
<b>ANTI-HYPERGLYCEMIC, SGLT-2 AND DPP-4 INHIBITOR COMB</b>		
GLYXAMBI	T2	QL (1 tab/day) ST HD

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

T4 – Injectable Specialty Medications

PA – Prior Authorization

QL – Quantity Limit

ST – Step Therapy

AGE – Age Requirement

SP – Specialty Medication

HD – May require home delivery pharmacy

PPACA – No Cost-Share Preventive Medication

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## List of Prescription Medications

ANTI-HYPERGLYCEMICS (Diabetes) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>ANTI-HYPERGLYCEMIC, THIAZOLIDINEDIONE AND BIGUANIDE</b>		
ACTOPLUS MET ( <i>pioglitazone-metformin</i> )	T3	HD
<i>pioglitazone hcl/metformin hcl</i> (Actoplus Met)	T1	HD
<b>ANTI-HYPERGLYCEMIC, THIAZOLIDINEDIONE-SULFONYLUREA</b>		
DUETACT ( <i>pioglitazone-glimepiride</i> )	T3	HD
<i>pioglitazone hcl/glimepiride</i> (Duetact)	T1	HD
<b>ANTI-HYPERGLYCEMIC, DPP-4 INHIBITOR-BIGUANIDE COMBS.</b>		
JANUMET	T2	QL (2 tabs/day) ST HD
JANUMET XR 100-1,000 MG TABLET	T2	QL (1 tab/day) ST HD
JANUMET XR 50-1,000 MG TABLET	T2	QL (2 tabs/day) ST HD
JANUMET XR 50-500 MG TABLET	T2	QL (1 tab/day) ST HD
<b>ANTI-HYPERGLYCEMIC, INSULIN-RELEASE STIM.-BIGUANIDE</b>		
<i>glyburide/metformin hcl</i>	T1	HD
<i>repaglinide/metformin hcl</i>	T1	HD
<b>ANTI-HYPERGLYCEMIC, THIAZOLIDINEDIONE (PPARG AGONIST)</b>		
ACTOS ( <i>pioglitazone hcl</i> )	T3	HD
AVANDIA	T3	HD
<i>pioglitazone hcl</i> (Actos)	T1	HD
<b>ANTI-HYPERGLYCEMIC-GLUCOCORTICOID RECEPTOR BLOCKER</b>		
<i>mifepristone 300 mg tablet</i>	T1	PA SP
<b>ANTI-HYPERGLYCEMIC-SGLT2 INHIBITOR-BIGUANIDE COMBS.</b>		
SYNJARDY	T2	QL (2 tabs/day) ST HD
SYNJARDY XR 10-1,000 MG TABLET	T2	QL (2 tabs/day) ST HD
SYNJARDY XR 12.5-1,000 MG TAB	T2	QL (2 tabs/day) ST HD
SYNJARDY XR 25-1,000 MG TABLET	T2	QL (1 tab/day) ST HD
SYNJARDY XR 5-1,000 MG TABLET	T2	QL (2 tabs/day) ST HD
XIGDUO XR 10 MG-1,000 MG TAB	T2	QL (1 tab/day) ST HD
XIGDUO XR 10 MG-500 MG TABLET	T2	QL (1 tab/day) ST HD
XIGDUO XR 2.5 MG-1,000 MG TAB	T2	QL (2 tabs/day) ST HD
XIGDUO XR 5 MG-1,000 MG TABLET	T2	QL (2 tabs/day) ST HD
XIGDUO XR 5 MG-500 MG TABLET	T2	QL (1 tab/day) ST HD
<b>ANTIHYPERGLY-SGLT-2 INHIB, DPP-4 INHIB, BIGUANIDE CB</b>		
TRIJARDY XR	T2	QL (1 tab/day) ST HD

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

T4 – Injectable Specialty Medications

PA – Prior Authorization

QL – Quantity Limit

ST – Step Therapy

AGE – Age Requirement

SP – Specialty Medication

HD – May require home delivery pharmacy

PPACA – No Cost-Share Preventive Medication

CSL – Oral cancer medication subject to cost-share limits

## List of Prescription Medications

### ANTI-HYPERGLYCEMICS (Diabetes) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>INSULINS</b>		
BASAGLAR KWIKPEN U-100	T2	QL (1.5ml/day) HD
FIASP PENFILL	T3	QL (1.5ml/day) HD
HUMALOG	T2	QL (1.5ml/day) HD
HUMALOG JUNIOR KWIKPEN	T2	QL (1.5ml/day) HD
HUMALOG KWIKPEN U-100	T2	QL (1.5ml/day) HD
HUMALOG KWIKPEN U-200	T2	QL (1ml/day) HD
HUMALOG MIX 50-50	T2	QL (2ml/day) HD
HUMALOG MIX 50-50 KWIKPEN	T2	QL (2ml/day) HD
HUMALOG MIX 75-25	T2	QL (2ml/day) HD
HUMALOG 100 UNIT/ML CARTRIDGE	T2	QL(1.5 mls/day) HD
HUMALOG MIX 75-25 KWIKPEN	T2	QL (2ml/day) HD
HUMULIN R U-500	T2	QL (1ml/day) HD
HUMULIN R U-500 KWIKPEN	T2	QL (1ml/day) HD
LYUMJEV	T2	QL (1.5ml/day) HD
LYUMJEV KWIKPEN U-100	T2	QL (1.5ml/day) HD
LYUMJEV KWIKPEN U-100	T2	QL (1.5ml/day) HD
LYUMJEV KWIKPEN U-200	T2	QL (1ml/day) HD
TRESIBA	T2	QL (1.5ml/day) HD
TRESIBA FLEXTOUCH U-100	T2	QL (1.5ml/day) HD
TRESIBA FLEXTOUCH U-200	T2	QL (0.9ml/day) HD

### ANTI-INFECTIVES (Feminine Products)

#### VAGINAL SULFONAMIDES

AVC	T3	
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### ANTI-INFECTIVES (Infections)

#### PENICILLIN ANTIBIOTICS

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

#### VAGINAL ANTISEPTICS

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

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

T4 – Injectable Specialty Medications

PA – Prior Authorization

QL – Quantity Limit

ST – Step Therapy

AGE – Age Requirement

SP – Specialty Medication

HD – May require home delivery pharmacy

PPACA – No Cost-Share Preventive Medication

CSL – Oral cancer medication subject to cost-share limits

## List of Prescription Medications

ANTI-INFECTIVES/MISCELLANEOUS (Infections)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>2ND GEN. ANAEROBIC ANTI-PROTOZOAL-ANTIBACTERIAL</b>		
TINDAMAX ( <i>tinidazole</i> )	T3	
<i>tinidazole</i>	T1	
<i>tinidazole</i> (Tindamax)	T1	
<b>AMEBICIDES</b>		
<i>paromomycin sulfate</i>	T1	
<b>ANTHELMINTICS</b>		
<i>albendazole</i> (Albenza)	T1	
ALBENZA ( <i>albendazole</i> )	T3	
BILTRICIDE ( <i>praziquantel</i> )	T3	
EMVERM	T1	
<i>praziquantel</i> (Biltricide)	T1	
STROMECTOL ( <i>ivermectin</i> )	T3	
<b>ANTI-MALARIAL DRUGS</b>		
<i>atovaquone/proguanil hcl</i> (Malarone)	T1	
<i>chloroquine ph 250 mg tablet</i>	T1	QL (56 Tabs/365 Days)
<i>chloroquine ph 500 mg tablet</i>	T1	
COARTEM	T3	PA QL (24 tabs/30 days)
DARAPRIM ( <i>pyrimethamine</i> )	T3	PA SP
<i>hydroxychloroquine sulfate</i> (Plaquenil)	T1	
<i>hydroxychloroquine sulfate</i> (Sovuna)	T1	
KRINTAFEL	T3	PA QL (2 tabs/30 days)
MALARONE ( <i>atovaquone-proguanil hcl</i> )	T3	PA
<i>mefloquine hcl</i>	T1	
PLAQUENIL ( <i>hydroxychloroquine sulfate</i> )	T3	PA QL (30 tabs/365 days)
PRIMAQUINE ( <i>primaquine phosphate</i> )	T1	
<i>primaquine phosphate</i>	T1	
<i>pyrimethamine 25 mg tablet</i> (Daraprim)	T1	PA
<i>pyrimethamine 25 mg tablet</i> (Daraprim)	T1	PA SP
QUALAQUIN ( <i>quinine sulfate</i> )	T3	PA
<i>quinine sulfate</i> (Qualaquin)	T1	
SOVUNA 200 MG TABLET ( <i>hydroxychloroquine sulfate</i> )	T3	PA
<b>ANTI-PROTOZOAL DRUGS, MISCELLANEOUS</b>		
BENZNIDAZOLE	T3	
IMPAVIDO	T3	PA
LAMPIT	T3	
NEBUPENT ( <i>pentamidine isethionate</i> )	T3	
<i>pentamidine isethionate</i> (Nebupent)	T1	

## List of Prescription Medications

ANTI-INFECTIVES/MISCELLANEOUS (Miscellaneous)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>ANTIBACTERIAL AGENTS, MISCELLANEOUS</b>		
<i>glycine urologic solution</i>	T1	
<i>glycine urologic solution</i>	T3	
<b>ANTISEPTICS, GENERAL</b>		
ALCOHOL SWABSTICK	T3	
GS ISOPROPYL ALCOHOL 70% SPRAY	T1	
ANTI-INFECTIVES/MISCELLANEOUS (Skin Conditions)		
<b>TOPICAL ANTI-FUNGALS</b>		
CICLODAN 8% KIT	T3	
<i>ciclopirox/urea/camph/men/euc</i> (Ciclodan)	T1	
ANTI-INFLAM.TUMOR NECROSIS FACTOR INHIBITING AGENTS (Pain Relief And Inflammatory Disease)		
<b>ANTI-INFLAMMATORY TUMOR NECROSIS FACTOR INHIBITOR</b>		
ADALIMUMAB-ADAZ	T4	PA QL (2 doses/ 28 days) SP HD
ADALIMUMAB-ADBM(CF)	T4	PA QL(2 pens/syringes/28 days) SP HD
ADALIMUMAB-ADBM(CF) PEN CROHNS	T4	PA QL(1 starter kit/365 days) SP HD
ADALIMUMAB-ADBM(CF) PEN PS-UV	T4	PA QL(1 starter kit/365 days) SP HD
ADALIMUMAB-ADBM(CF)PEN	T4	PA QL(2 pens/28 days) SP HD
AVSOLA	T4	PA SP
CIMZIA 200 MG VIAL KIT	T4	PA QL (1 kit/28 days) SP HD
CIMZIA 2X200 MG/ML SYRINGE KIT	T4	PA QL (1 kit/28 days) SP HD
CIMZIA 2X200 MG/ML(X3)START KT	T4	PA QL (1 kit/year) SP HD
CYLTEZO (CF)	T4	PA QL(1 starter kit/365 days) SP
ENBREL 25 MG KIT	T4	PA QL (8 vials/28 days) SP HD
ENBREL 25 MG/0.5 ML SYRINGE	T4	PA QL (8 syringes/28 days) SP HD
ENBREL 25 MG/0.5 ML VIAL	T4	PA QL (4ml/28 days) SP HD
ENBREL 50 MG/ML SYRINGE	T4	PA QL (4 syringes/28 days) SP HD
ENBREL MINI	T4	PA QL (4 cartridges/28 days) SP HD
ENBREL SURECLICK	T4	PA QL (4 syringes/28 days) SP HD
HADLIMA,	T4	PA QL (2 doses/28 days) SP
HADLIMA (CF)	T4	PA QL (2 doses/28 days) SP
HUMIRA	T4	PA QL (2 syringes/28 days) SP HD
HUMIRA PEN	T4	PA QL (2 pens/28 days) SP HD
HUMIRA PEN CROHN'S-UC-HS	T4	PA QL (1 kit/year) SP HD
HUMIRA PEN PSOR-UVEITS-ADOL HS	T4	PA QL (1 kit/year) SP HD
HUMIRA(CF)	T4	PA QL (2 syringes/28 days) SP HD

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

T4 – Injectable Specialty Medications

PA – Prior Authorization

QL – Quantity Limit

ST – Step Therapy

AGE – Age Requirement

SP – Specialty Medication

HD – May require home delivery pharmacy

PPACA – No Cost-Share Preventive Medication

CSL – Oral cancer medication subject to cost-share limits

## List of Prescription Medications

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

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>ANTI-INFLAMMATORY TUMOR NECROSIS FACTOR INHIBITOR (cont.)</b>		
HUMIRA(CF) PEDIATRIC CROHN'S	T4	PA QL (1 kit/year) SP HD
HUMIRA(CF) PEN 40 MG/0.4 ML	T4	PA QL (2 pens/28 days) SP HD
HUMIRA(CF) PEN 80 MG/0.8 ML	T4	PA QL (1 kit/year) SP HD
HUMIRA(CF) PEN CROHN'S-UC-HS	T4	PA QL (1 kit/year) SP HD
HUMIRA(CF) PEN PEDIATRIC UC	T4	PA QL (4 kits/365 days) SP HD
HUMIRA(CF) PEN PSOR-UV-ADOL HS	T4	PA QL (1 kit/year) SP HD
HYRIMOZ	T4	PA SP
HYRIMOZ PEN	T4	PA SP
HYRIMOZ(CF)	T4	PA QL(2 syringes/28 days) SP HD
HYRIMOZ(CF) PEN	T4	PA QL(2 pens/28 days) SP HD
INFLECTRA	T2	PA SP HD
REMICADE	T4	PA SP HD
SIMPONI 100 MG/ML PEN INJECTOR	T4	PA QL (1 injector/28 days) SP HD
SIMPONI 100 MG/ML SYRINGE	T4	PA QL (1 syringe/28 days) SP HD
SIMPONI ARIA	T4	PA SP HD
ZYMFENTRA	T3	PA QL SP HD

### ANTI-NEOPLASTICS (Cancer)

#### ANP - SELECTIVE RETINOID X RECEPTOR AGONISTS (RXR)

<i>bexarotene</i> (Targretin)	T1	PA SP HD
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#### ANTI-NEOPLAST, HISTONE DEACETYLASE (HDAC) INHIBITORS

FARYDAK	T3	PA SP HD
ZOLINZA	T2	PA SP HD

#### ANTI-NEOPLASTIC - ALKYLATING AGENTS

ALKERAN ( <i>melphalan</i> )	T3	SP
<i>cyclophosphamide</i>	T1	SP HD
GLEOSTINE	T2	
HYDREA ( <i>hydroxyurea</i> )	T3	
<i>hydroxyurea</i> (Hydrea)	T1	
LEUKERAN	T2	
<i>melphalan</i> (Alkeran)	T1	SP
MYLERAN	T2	
TEMODAR ( <i>temozolomide</i> )	T3	PA SP HD
<i>temozolomide</i>	T1	PA SP HD CSL
<i>temozolomide</i> (Temodar)	T1	PA SP HD

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

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

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

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



## List of Prescription Medications

ANTI-NEOPLASTICS (Cancer) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>ANTI-NEOPLASTIC - ANTI-ANDROGENIC AGENTS</b>		
<i>abiraterone 500 mg tablet</i>	T1	SP HD
<i>abiraterone acetate 500 mg tab (Zytiga)</i>	T1	SP HD CSL
<i>abiraterone acetate 250 mg tab</i>	T1	PA SP HD
<i>bicalutamide (Casodex)</i>	T1	
CASODEX ( <i>bicalutamide</i> )	T3	
ERLEADA	T2	PA SP HD CSL
ERLEADA 240 MG TABLET	T2	PA QL(1 tab/day) SP HD CSL
ERLEADA 60 MG TABLET	T2	PA SP HD CSL
<i>flutamide</i>	T1	
<i>nilutamide</i>	T1	QL (4 tabs/day)
NUBEQA	T2	PA SP HD
XTANDI	T2	PA SP HD
<b>ANTI-NEOPLASTIC - ANTI-METABOLITES</b>		
<i>capecitabine (Xeloda)</i>	T1	PA SP HD
INQOVI	T3	PA SP HD
JYLAMVO	T3	CSL
LONSURF	T3	PA SP HD
<i>mercaptopurine</i>	T1	
<i>methotrexate sodium</i>	T1	
<i>methotrexate sodium/pf</i>	T1	
ONUREG	T3	PA QL (14 Tabs/28 Days) SP
PURIXAN	T3	SP
TABLOID	T3	
TREXALL	T2	
XATMEP	T3	
XELODA ( <i>capecitabine</i> )	T3	PA SP HD
<b>ANTI-NEOPLASTIC - AROMATASE INHIBITORS</b>		
<i>anastrozole (Arimidex)</i>	T1	HD PPACA
ARIMIDEX ( <i>anastrozole</i> )	T3	HD
AROMASIN ( <i>exemestane</i> )	T3	HD
<i>exemestane (Aromasin)</i>	T1	HD PPACA
FEMARA ( <i>letrozole</i> )	T3	HD
<i>letrozole (Femara)</i>	T1	HD CSL
<b>ANTI-NEOPLASTIC - BRAF KINASE INHIBITORS</b>		
BRAFTOVI	T3	PA SP HD

T1 – Typically Generics

T4 – Injectable Specialty Medications

ST – Step Therapy

HD – May require home delivery pharmacy

T2 – Typically Preferred Brands

PA – Prior Authorization

AGE – Age Requirement

PPACA – No Cost-Share Preventive Medication

T3 – Typically Non-Preferred Brands

QL – Quantity Limit

SP – Specialty Medication

CSL – Oral cancer medication subject to cost-share limits

## List of Prescription Medications

<b>ANTI-NEOPLASTICS (Cancer) (cont.)</b>		
<b>Prescription Drug Name</b>	<b>Drug Tier</b>	<b>Coverage Requirements and Limits</b>
<b>ANTI-NEOPLASTIC - BRAF KINASE INHIBITORS (cont.)</b>		
TAFINLAR	T2	PA SP HD
ZELBORAF	T3	PA SP HD
<b>ANTI-NEOPLASTIC - ENZYME INHIB, ANTIANDROGEN COMB.</b>		
AKEEGA	T3	PA QL(2 tabs/day) SP CSL
<b>ANTI-NEOPLASTIC - HEDGEHOG PATHWAY INHIBITOR</b>		
DAURISMO	T3	PA SP HD
ERIVEDGE	T2	PA SP HD
ODOMZO	T3	PA SP HD
<b>ANTI-NEOPLASTIC - JANUS KINASE (JAK) INHIBITORS</b>		
JAKAFI	T3	PA SP HD
<b>ANTI-NEOPLASTIC - KRAS PROTEIN INHIBITOR</b>		
LUMAKRAS 120 MG TABLET	T3	PA QL(8 tabs/day) SP HD CSL
LUMAKRAS 320 MG TABLET	T3	PA QL(3 tabs/day) SP HD CSL
<b>ANTI-NEOPLASTIC - MEKI AND MEK2 KINASE INHIBITORS</b>		
COTELLIC	T3	PA SP HD
KOSELUGO 10 MG CAPSULE	T3	PA QL (10 capsules/day) SP
KOSELUGO 25 MG CAPSULE	T3	PA QL (4 caps/day) SP
MEKINIST	T3	PA SP HD
MEKTOVI	T3	PA SP HD
<b>ANTI-NEOPLASTIC - MTOR KINASE INHIBITORS</b>		
AFINITOR 10 MG TABLET	T2	PA SP HD
AFINITOR 2.5 MG TABLET ( <i>everolimus</i> )	T3	PA SP HD
AFINITOR 5 MG TABLET ( <i>everolimus</i> )	T3	PA SP HD
AFINITOR 7.5 MG TABLET ( <i>everolimus</i> )	T3	PA SP HD
AFINITOR DISPERZ	T3	PA SP
<i>everolimus 2.5 mg tablet</i> (Afinitor)	T1	PA SP HD
<i>everolimus 5 mg tablet</i> (Afinitor)	T1	PA SP HD
<i>everolimus 7.5 mg tablet</i> (Afinitor)	T1	PA QL(1 tab/day) SP HD CSL
<i>everolimus 10 mg tablet</i> (Afinitor)	T1	PA QL(1 tab/day) SP HD CSL
<b>ANTI-NEOPLASTIC - PROTEIN METHYLTRANSFERASE INHIBIT</b>		
TAZVERIK	T3	PA SP
<b>ANTI-NEOPLASTIC - TOPOISOMERASE I INHIBITORS</b>		
HYCAMTIN	T3	PA SP HD
<b>ANTI-NEOPLASTIC COMB - KINASE AND AROMATASE INHIBIT</b>		
KISQALI FEMARA CO-PACK	T2	PA QL(1 tab/28 days) SP HD CSL

T1 – Typically Generics

T4 – Injectable Specialty Medications

ST – Step Therapy

HD – May require home delivery pharmacy

T2 – Typically Preferred Brands

PA – Prior Authorization

AGE – Age Requirement

PPACA – No Cost-Share Preventive Medication

T3 – Typically Non-Preferred Brands

QL – Quantity Limit

SP – Specialty Medication

CSL – Oral cancer medication subject to cost-share limits

## List of Prescription Medications

### ANTI-NEOPLASTICS (Cancer) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>ANTI-NEOPLASTIC EGF RECEPTOR BLOCKER MCLON ANTIBODY</b>		
PHEGO	T4	PA SP HD
<b>ANTI-NEOPLASTIC IMMUNOMODULATOR AGENTS</b>		
<i>lenalidomide</i>	T1	PA QL(1 cap/day) SP HD CSL
POMALYST	T3	PA SP HD
REVLIMID	T2	PA QL(1 tab/day) SP HD CSL
<b>ANTI-NEOPLASTIC LHRH (GNRH) AGONIST, PITUITARY SUPPR.</b>		
<i>leuprolide acetate</i>	T4	PA SP HD
LEUPROLIDE DEPOT	T4	PA SP
LUPRON DEPOT	T4	PA SP HD
ZOLADEX	T4	PA SP HD
<b>ANTI-NEOPLASTIC LHRH (GNRH) ANTAGONIST, PITUIT.SUPPRS</b>		
FIRMAGON	T4	PA SP HD
ORGOVYX	T3	PA SP
<b>ANTI-NEOPLASTIC SYSTEMIC ENZYME INHIBITORS</b>		
ALECENSA	T2	PA QL(8 tabs/day) SP HD CSL
ALUNBRIG	T3	PA SP HD
AYVAKIT	T3	PA QL (1 tab/day) SP
BALVERSA	T3	PA SP
BOSULIF	T3	PA SP HD
BOSULIF 100 MG CAPSULE	T3	PA QL(3 caps/day) SP HD CSL
BOSULIF 50 MG CAPSULE	T3	PA QL SP HD CSL
BRUKINSA	T2	PA QL (4 caps/day) SP
CABOMETYX	T3	PA SP HD
CALQUENCE	T3	PA SP
CAPRELSA	T3	PA SP
COMETRIQ	T3	PA SP HD
COPIKTRA	T3	PA SP
<i>erlotinib hcl</i>	T1	PA SP HD
EXKIVITY	T3	PA SP HD
GAVRETO	T3	PA QL (4 tabs/day) SP
<i>gefitinib</i>	T1	PA SP HD CSL
GILOTRIF	T3	PA SP HD
GLEEVEC ( <i>imatinib mesylate</i> )	T3	PA SP HD
IBRANCE 100 MG CAPSULE	T3	PA QL(21 caps/28 days) SP HD CSL
IBRANCE 100 MG TABLET	T3	PA QL(21 tabs/28 days) SP HD CSL
IBRANCE 125 MG CAPSULE	T3	PA QL(21 caps/28 days) SP HD CSL

T1 – Typically Generics

T4 – Injectable Specialty Medications

ST – Step Therapy

HD – May require home delivery pharmacy

T2 – Typically Preferred Brands

PA – Prior Authorization

AGE – Age Requirement

PPACA – No Cost-Share Preventive Medication

T3 – Typically Non-Preferred Brands

QL – Quantity Limit

SP – Specialty Medication

CSL – Oral cancer medication subject to cost-share limits

List of Prescription Medications

**ANTI-NEOPLASTICS (Cancer) (cont.)**

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>ANTI-NEOPLASTIC SYSTEMIC ENZYME INHIBITORS (cont.)</b>		
IBRANCE 125 MG TABLET	T3	PA QL(21 tabs/28 days) SP HD CSL
IBRANCE 75 MG CAPSULE	T3	PA QL(21 caps/28 days) SP HD CSL
IBRANCE 75 MG TABLET	T3	PA QL(21 tabs/28 days) SP HD CSL
<i>imatinib mesylate 100 mg tab (Gleevec)</i>	T1	QL(6 tabs/day) SP HD CSL
<i>imatinib mesylate 400 mg tab (Gleevec)</i>	T1	QL(2 tabs/day) SP HD CSL
<i>imatinib mesylate (Gleevec)</i>	T1	QL(6 tabs/day) SP HD CSL
IMBRUVICA	T2	PA SP
INLYTA	T3	PA SP HD
INREBIC	T3	PA SP HD
IRESSA	T3	PA SP HD
IWILFIN	T3	PA QL(8 tabs/day) SP CSL
KISQALI 600mg	T2	PA SP QL(63 tabs/28 days)HD CSL
KISQALI 400mg	T2	PA SP QL(42 tabs/28 days) HD CSL
KISQALI 200mg	T2	PA QL(21 tabs/28 days) SP HD CSL
<i>lapatinib ditosylate (Tykerb)</i>	T1	PA SP HD
LENVIMA	T2	PA SP HD CSL
LORBRENA	T3	PA SP HD
LYNPARZA	T2	PA SP HD
LYTGOBI 12 MG DAILY DOSE (3X 4MG TB)	T3	PA QL(3 tabs/day) SP CSL
LYTGOBI 16 MG DAILY DOSE (4X 4MG TB)	T3	PA QL(4 tabs/day) SP CSL
LYTGOBI 20 MG DAILY DOSE (5X 4MG TB)	T3	PA QL(5 tabs/day) SP CSL
NERLYNX	T3	PA SP HD
NINLARO	T3	PA SP HD
<i>pazopanib hcl (Votrient)</i>	T1	PA QL(4 tabs/day) SP HD CSL
PEMAZYRE	T3	PA QL (14 tabs/21 days) SP
PIQRAY	T3	PA SP HD
OGSIVEO	T3	PA QL(6 tabs/day) SP CSL
OJJAARA	T3	PA QL(1 tab/day) SP CSL
QINLOCK	T3	PA QL (3 tabs/day) SP
SCSEMBLIX	T3	PA QL (2 tablets/day) SP HD
TURALIO	T3	PA QL(4 caps/day) SP CSL
TURALIO 125 MG CAPSULE	T3	PA QL(4 caps/day) SP CSL
TURALIO 200 MG CAPSULE	T3	PA SP CSL
RETEVMO 40 MG CAPSULE	T3	PA QL (6 caps/day) SP HD
RETEVMO 80 MG CAPSULE	T3	PA QL (4 tabs/day) SP HD
ROZLYTREK	T3	PA SP HD

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

## List of Prescription Medications

### ANTI-NEOPLASTICS (Cancer) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>ANTI-NEOPLASTIC SYSTEMIC ENZYME INHIBITORS (cont.)</b>		
RUBRACA	T2	PA SP
RYDAPT	T3	PA SP HD
SPRYCEL	T2	PA SP HD
STIVARGA	T3	PA SP HD
SUTENT	T2	PA SP HD
TABRECTA	T3	PA QL (4 tabs/day) SP HD
TAGRISSO	T3	PA SP HD
TALZENNA	T3	PA SP HD
TASIGNA	T2	PA SP HD
TEPMETKO	T4	PA QL (2 tabs/day) SP
TRUQAP	T3	PA QL(64 tabs/28 days) SP CSL
TUKYSA	T3	PA SP
TYKERB ( <i>lapatinib</i> )	T3	PA SP HD
UKONIQ	T3	PA QL (4 tabs/day) SP
VANFLYTA	T3	PA QL(2 tabs/day) SP CSL
VERZENIO	T2	PA QL(2 tabs/day) SP HD CSL
VITRAKVI	T3	PA SP HD
VIZIMPRO	T3	PA SP HD
XALKORI 150 MG PELLETT	T3	PA QL(4 pellets/day) SP HD CSL
XALKORI 20 MG PELLETT	T3	PA QL(4 pellets/day) SP HD CSL
XALKORI 200 MG CAPSULE	T3	PA QL(4 caps/day) SP HD CSL
XALKORI 250 MG CAPSULE	T3	PA QL(4 caps/day) SP HD CSL
XALKORI 50 MG PELLETT	T3	PA QL(4 pellets/day) SP HD CSL
XALKORI	T3	PA SP HD
XOSPATA	T3	PA SP
ZEJULA	T2	PA SP
ZYDELIG	T3	PA SP HD
<b>ANTI-NEOPLASTIC, ANTI-PROGRAMMED DEATH-I (PD-I) MAB</b>		
OPDIVO	T4	PA SP HD
<b>ANTI-NEOPLASTIC-B CELL LYMPHOMA-2(BCL-2) INHIBITORS</b>		
VENCLEXTA	T3	PA SP
VENCLEXTA STARTING PACK	T3	PA SP

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

T4 – Injectable Specialty Medications

PA – Prior Authorization

QL – Quantity Limit

ST – Step Therapy

AGE – Age Requirement

SP – Specialty Medication

HD – May require home delivery pharmacy

PPACA – No Cost-Share Preventive Medication

CSL – Oral cancer medication subject to cost-share limits

## List of Prescription Medications

ANTI-NEOPLASTICS (Cancer) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>ANTI-NEOPLASTIC-ISOCITRATE DEHYDROGENASE INHIBITOR</b>		
IDHIFA	T3	PA SP HD
REZLIDHIA	T3	PA QL(2 caps/day) SP CSL
TIBSOVO	T3	PA SP
<b>ANTI-NEOPLASTICS ANTIBODY/ANTIBODY-DRUG COMPLEXES</b>		
ENHERTU	T4	PA SP HD
<b>ANTI-NEOPLASTICS, MISCELLANEOUS</b>		
<i>etoposide</i>	T1	SP HD
LYSODREN	T2	
MATULANE	T2	SP
<i>tretinoin 10 mg capsule</i>	T1	PA
<b>ANTI-NEOPLASTIC-SELECT INHIB OF NUCLEAR EXP (SINE)</b>		
XPOVIO	T3	PA SP
<b>CYTOTOXIC T-LYMPHOCYTE ANTIGEN (CTLA-4) RMC ANTIBODY</b>		
YERVOY	T4	PA SP HD
<b>IMMUNOMODULATORS</b>		
ACTIMMUNE	T4	PA SP HD
<b>SELECTIVE ESTROGEN RECEPTOR MODULATORS (SERMS)</b>		
FARESTON ( <i>toremifene citrate</i> )	T3	QL (2 tabs/day) HD
SOLTAMOX	T2	HD
<i>tamoxifen citrate</i>	T1	HD PPACA
<i>toremifene citrate</i> (Fareston)	T1	QL (2 tabs/day) HD
<b>STEROID ANTI-NEOPLASTICS</b>		
EMCYT	T2	SP HD
<i>megestrol acetate</i>	T3	
ANTI-NEOPLASTICS (Skin Conditions)		
<b>PHOTOACT, TOPICAL ANTI-NEOPLAST, PREMALIGNANT LESIONS</b>		
LEVULAN	T3	SP
<b>TOPICAL ANTI-NEOPLASTIC PREMALIGNANT LESION AGENTS</b>		
EFUDEX ( <i>fluorouracil</i> )	T3	
FLUOROPLEX	T2	
<i>fluorouracil</i>	T1	
<i>fluorouracil</i> (Efudex)	T1	
PANRETIN	T3	SP HD
PICATO	T3	
TARGRETIN 1% GEL	T2	SP HD

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

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

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

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



## List of Prescription Medications

### ANTI-NEOPLASTICS (Skin Conditions) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>TOPICAL ANTI-NEOPLASTIC PREMALIGNANT LESION AGENTS</b>		
TOLAK	T3	
VALCHLOR	T3	SP HD

### ANTI-OBESITY DRUGS (Weight Management)

#### ANTI-OBESITY - ANOREXIC AGENTS

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

#### ANTI-OBESITY - INCRETIN MIMETICS COMBINATION

ZEPBOUND 10 MG/0.5 ML PEN	T2	PA QL(2 mls/30 days)
ZEPBOUND 12.5 MG/0.5 ML PEN	T2	PA QL(2 mls/30 days)
ZEPBOUND 15 MG/0.5 ML PEN	T2	PA QL(2 mls/30 days)
ZEPBOUND 2.5 MG/0.5 ML PEN	T2	PA QL(2 mls/30 days)
ZEPBOUND 5 MG/0.5 ML PEN	T2	PA QL(2 mls/30 days)
ZEPBOUND 7.5 MG/0.5 ML PEN	T2	PA QL(2 mls/30 days)

#### ANTI-OBESITY - MELANOCORTIN 4 RECEPTOR AGONISTS

IMCIVREE	T4	PA QL (9 ml/22 days) SP
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#### ANTI-OBESITY GLUCAGON-LIKE PEPTIDE-I RECEPTOR AGONIST

SAXENDA	T3	PA
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#### ANTI-OBESITY SEROTONIN 2C RECEPTOR AGONISTS

BELVIQ	T3	PA
BELVIQ XR	T3	PA

#### ANTI-OBESITY - OPIOID ANTAG-NOREPI, DOPAMINE RU INHIB

CONTRAVE	T3	PA
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#### FAT ABSORPTION DECREASING AGENTS

XENICAL	T3	PA
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### ANTI-PARASITICS (Eye Conditions)

#### OPHTHALMIC (EYE) ANTIPARASITICS

XDEMVY	T2	PA QL(4 bottles/30 days) SP
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T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

T4 – Injectable Specialty Medications

PA – Prior Authorization

QL – Quantity Limit

ST – Step Therapy

AGE – Age Requirement

SP – Specialty Medication

HD – May require home delivery pharmacy

PPACA – No Cost-Share Preventive Medication

CSL – Oral cancer medication subject to cost-share limits

# List of Prescription Medications

ANTI-PARASITICS (Infections)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>ANTI-PARASITICS</b>		
ALINIA ( <i>nitazoxanide</i> )	T3	
<i>nitazoxanide</i> (Alinia)	T1	
<b>TOPICAL ANTI-PARASITICS</b>		
<i>crotamiton</i> (Eurax)	T1	
ELIMITE ( <i>permethrin</i> )	T3	
EURAX	T3	
<i>ivermectin</i> (Sklice)	T1	
NATROBA ( <i>spinosad</i> )	T3	
<i>permethrin</i> (Elimite)	T1	
SKLICE ( <i>ivermectin</i> )	T3	
<i>spinosad</i> (Natroba)	T1	
ULESFIA	T3	
ANTI-PARKINSON DRUGS (Parkinson's Disease)		
<b>ANTI-PARKINSONISM DRUGS, ANTI-CHOLINERGIC</b>		
<i>benztropine mesylate</i>	T1	HD
<i>trihexyphenidyl hcl</i>	T1	HD
<b>ANTI-PARKINSONISM DRUGS, OTHER</b>		
<i>amantadine hcl</i>	T1	HD
APOKYN	T4	PA SP HD
AZILECT 0.5 MG TABLET ( <i>rasagiline mesylate</i> )	T3	QL (1 tab/day) HD
AZILECT 1 MG TABLET ( <i>rasagiline mesylate</i> )	T3	HD
<i>bromocriptine mesylate</i> (Parlodel)	T1	HD
<i>carbidopa/levodopa</i>	T1	HD
<i>carbidopa/levodopa</i> (Sinemet 10-100)	T1	HD
<i>carbidopa/levodopa</i> (Sinemet 25-100)	T1	HD
<i>carbidopa/levodopa</i> (Sinemet 25-250)	T1	HD
<i>carbidopa/levodopa/entacapone</i> (Stalevo 100)	T1	HD
<i>carbidopa/levodopa/entacapone</i> (Stalevo 125)	T1	HD
<i>carbidopa/levodopa/entacapone</i> (Stalevo 150)	T1	HD
<i>carbidopa/levodopa/entacapone</i> (Stalevo 200)	T1	HD
<i>carbidopa/levodopa/entacapone</i> (Stalevo 50)	T1	HD
<i>carbidopa/levodopa/entacapone</i> (Stalevo 75)	T1	HD
COMTAN ( <i>entacapone</i> )	T3	HD
DUOPA	T3	SP HD

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

T4 – Injectable Specialty Medications

PA – Prior Authorization

QL – Quantity Limit

ST – Step Therapy

AGE – Age Requirement

SP – Specialty Medication

HD – May require home delivery pharmacy

PPACA – No Cost-Share Preventive Medication

CSL – Oral cancer medication subject to cost-share limits

## List of Prescription Medications

ANTI-PARKINSON DRUGS (Parkinson's Disease) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>ANTI-PARKINSONISM DRUGS, OTHER (cont.)</b>		
<i>entacapone</i> (Comtan)	T1	HD
INBRIJA	T3	PA SP HD
KYNMOBI	T2	PA HD
MIRAPEX ER 0.375 MG TABLET ( <i>pramipexole er</i> )	T3	QL (1 tab/day) HD
MIRAPEX ER 0.75 MG TABLET ( <i>pramipexole er</i> )	T3	HD
MIRAPEX ER 1.5 MG TABLET ( <i>pramipexole er</i> )	T3	QL (1 tab/day) HD
MIRAPEX ER 2.25 MG TABLET ( <i>pramipexole er</i> )	T3	QL (1 tab/day) HD
MIRAPEX ER 3 MG TABLET ( <i>pramipexole er</i> )	T3	HD
MIRAPEX ER 3.75 MG TABLET ( <i>pramipexole er</i> )	T3	HD
MIRAPEX ER 4.5 MG TABLET ( <i>pramipexole er</i> )	T3	HD
NEUPRO	T3	HD
NOURIANZ	T3	PA QL (1 tab/day) SP HD
OSMOLEX ER	T3	QL (1 tab/day) HD
OSMOLEX ER 258 MG TABLET	T3	QL (1 tab/day) HD
PARLODEL ( <i>bromocriptine mesylate</i> )	T3	HD
<i>pramipexole di-hcl</i>	T1	HD
<i>pramipexole er 0.375 mg tablet</i> (Mirapex Er)	T1	QL (1 tab/day) HD
<i>pramipexole er 0.75 mg tablet</i> (Mirapex Er)	T1	HD
<i>pramipexole er 1.5 mg tablet</i>	T1	QL(1 tab/day) HD
<i>pramipexole er 1.5 mg tablet</i> (Mirapex Er)	T1	QL (1 tab/day) HD
<i>pramipexole er 2.25 mg tablet</i> (Mirapex Er)	T1	QL (1 tab/day) HD
<i>pramipexole er 3 mg tablet</i> (Mirapex Er)	T1	HD
<i>pramipexole er 3.75 mg tablet</i> (Mirapex Er)	T1	HD
<i>pramipexole er 4.5 mg tablet</i> (Mirapex Er)	T1	HD
<i>rasagiline mesylate 0.5 mg tab</i> (Azilect)	T1	QL (1 tab/day) HD
RYTARY	T3	HD
<i>selegiline hcl</i>	T1	HD
SINEMET 10-100 ( <i>carbidopa-levodopa</i> )	T3	HD
SINEMET 25-100 ( <i>carbidopa-levodopa</i> )	T3	HD
SINEMET 25-250 ( <i>carbidopa-levodopa</i> )	T3	HD
STALEVO 100 ( <i>carbidopa-levodopa-entacapone</i> )	T3	HD
STALEVO 125 ( <i>carbidopa-levodopa-entacapone</i> )	T3	HD
STALEVO 150 ( <i>carbidopa-levodopa-entacapone</i> )	T3	HD
STALEVO 200 ( <i>carbidopa-levodopa-entacapone</i> )	T3	HD
STALEVO 50 ( <i>carbidopa-levodopa-entacapone</i> )	T3	HD

T1 – Typically Generics

T4 – Injectable Specialty Medications

ST – Step Therapy

HD – May require home delivery pharmacy

T2 – Typically Preferred Brands

PA – Prior Authorization

AGE – Age Requirement

PPACA – No Cost-Share Preventive Medication

T3 – Typically Non-Preferred Brands

QL – Quantity Limit

SP – Specialty Medication

CSL – Oral cancer medication subject to cost-share limits

## List of Prescription Medications

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

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
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#### ANTI-PARKINSONISM DRUGS, OTHER (cont.)

STALEVO 75 (carbidopa-levodopa-entacapone)	T3	HD
TASMAR (tolcapone)	T3	HD
tolcapone (Tasmar)	T1	HD
XADAGO	T3	ST HD

#### DECARBOXYLASE INHIBITORS

carbidopa	T1	
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### ANTI-PLATELET DRUGS (Blood Thinners/Anti-Clotting)

#### PLATELET AGGREGATION INHIBITORS

aspirin/dipyridamole	T1	HD
BRILINTA	T2	HD
cilostazol	T1	HD
clopidogrel bisulfate	T1	HD
clopidogrel bisulfate (Plavix)	T1	HD
dipyridamole	T1	HD
EFFIENT (prasugrel hcl)	T3	HD
PLAVIX (clopidogrel)	T3	HD
prasugrel hcl (Effient)	T1	HD
ticlopidine hcl	T1	HD

#### PLATELET REDUCING AGENTS

AGRYLIN (anagrelide hcl)	T3	
anagrelide hcl	T1	
anagrelide hcl (Agrylin)	T1	

### ANTIVIRALS (AIDS/HIV)

#### ANTI-RETROVIRAL - CAPSID INHIBITORS

SUNLENCA 4- 300 MG TABLET	T3	PA QL(5 tabs/180 days) SP
SUNLENCA 463.5 MG/1.5 ML VIAL	T3	PA SP
SUNLENCA 5- 300 MG TABLET	T3	PA QL(5 tabs/180 days) SP

#### ANTI-RETROVIRAL - INTEGRASE INHIBITOR AND NNRTI COMB.

CABENUVA	T4	PA SP
JULUCA	T2	SP

#### ANTI-RETROVIRAL - INTEGRASE INHIBITOR AND NRTI COMB.

DOVATO	T2	SP
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#### ANTI-RETROVIRAL - NRTIS AND INTEGRASE INHIBITORS COMB

TRIUMEQ	T2	SP
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T1 – Typically Generics

T4 – Injectable Specialty Medications

ST – Step Therapy

HD – May require home delivery pharmacy

T2 – Typically Preferred Brands

PA – Prior Authorization

AGE – Age Requirement

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T3 – Typically Non-Preferred Brands

QL – Quantity Limit

SP – Specialty Medication

CSL – Oral cancer medication subject to cost-share limits

## List of Prescription Medications

ANTIVIRALS (AIDS/HIV) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>ANTI-RETROVIRAL - NUCLEOSIDE, NUCLEOTIDE, PROTEASE INH.</b>		
SYM TUZA	T2	SP
<b>ANTIVIRALS - HIV-SPEC, NON-PEPTIDIC PROTEASE INHIB</b>		
APTIVUS	T2	PA SP
<i>darunavir</i> (Prezista)	T1	SP
<i>darunavir ethanolate</i> (Prezista)	T1	SP
PREZCOBIX	T3	PA SP
PREZISTA 100 MG/ML SUSPENSION	T2	SP
PREZISTA 150 MG TABLET	T2	SP
PREZISTA 75 MG TABLET	T2	SP
<b>ANTIVIRALS - HIV-SPEC, NUCLEOSIDE-NUCLEOTIDE ANALOG</b>		
CIMDUO	T3	PA SP
DESCOVY	T2	PA SP PPACA
<i>emtricitabine-tenofv 100-150mg</i>	T1	SP
<i>emtricitabine-tenofv 133-200mg</i>	T1	SP
<i>emtricitabine-tenofv 167-250mg</i>	T1	SP
<i>emtricitabine-tenofv 200-300mg</i>	T1	SP PPACA
TEMIXYS	T3	PA SP
<b>ANTIVIRALS - HIV-SPEC, NUCLEOSIDE ANALOG, RTI COMB</b>		
<i>abacavir sulfate/lamivudine</i>	T1	PA SP
<i>abacavir/lamivudine/zidovudine</i>	T1	PA SP
<i>lamivudine/zidovudine</i>	T1	SP
<b>ANTIVIRALS - HIV-SPECIFIC, CCR5 CO-RECEPTOR ANTAG.</b>		
<i>maraviroc</i> (Selzentry)	T1	PA SP
SELZENTRY 20 MG/ML ORAL SOLN	T2	PA SP
SELZENTRY 25 MG TABLET	T2	PA SP
SELZENTRY 75 MG TABLET	T2	PA SP
<b>ANTIVIRALS - HIV-SPECIFIC, CD4 ATTACHMENT INHIBITOR</b>		
RUKOBIA	T3	PA QL (2 syringe/day) SP
<b>ANTIVIRALS - HIV-SPECIFIC, FUSION INHIBITORS</b>		
FUZEON	T4	PA SP
<b>ANTIVIRALS - HIV-SPECIFIC, NON-NUCLEOSIDE, RTI</b>		
EDURANT	T3	PA SP
<i>efavirenz</i>	T1	PA SP
<i>nevirapine</i>	T1	PA SP
PIFELTRO	T3	PA SP
<b>ANTIVIRALS - HIV-SPECIFIC, NUCLEOSIDE ANALOG, RTI</b>		
<i>abacavir sulfate</i>	T1	PA SP
<i>emtricitabine</i> (Emtriva)	T1	PA SP
EMTRIVA 10 MG/ML SOLUTION	T2	PA SP

## List of Prescription Medications

### ANTIVIRALS (AIDS/HIV) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>ANTIVIRALS - HIV-SPECIFIC, NUCLEOSIDE ANALOG, RTI (cont.)</b>		
<i>lamivudine 10 mg/ml oral soln</i>	T1	SP
<i>lamivudine 150 mg tablet</i>	T1	SP
<i>lamivudine 300 mg tablet</i>	T1	PA SP
<i>zidovudine</i>	T1	SP
<i>tenofovir disoproxil fumarate</i>	T1	PA SP
VIREAD	T2	PA SP
VIREAD POWDER	T2	PA SP
<b>ANTIVIRALS - HIV-SPECIFIC, PROTEASE INHIBITOR COMB</b>		
KALETRA 100-25 MG TABLET	T2	
KALETRA 200-50 MG TABLET	T2	
KALETRA 80-20 MG SOLUTION	T2	
<i>lopinavir/ritonavir</i>	T1	
<b>ANTIVIRALS - HIV-SPECIFIC, PROTEASE INHIBITORS</b>		
<i>atazanavir sulfate</i>	T1	PA SP
EVOTAZ	T3	PA SP
<i>fosamprenavir calcium</i>	T1	PA SP
INVIRASE	T2	PA
LEXIVA	T2	PA SP
NORVIR	T2	SP
REYATAZ	T2	PA SP
<i>ritonavir</i>	T1	SP
<b>ANTIVIRALS - HIV-I INTEGRASE STRAND TRANSFER INHIBTR</b>		
APRETUDE	T3	PA SP
ISENTRESS	T2	SP
ISENTRESS HD	T2	PA SP
TIVICAY	T2	SP
TIVICAY PD	T2	SP
<b>ARTV NUCLEOSIDE, NUCLEOTIDE, NON-NUCLEOSIDE RTI COMB</b>		
COMPLERA	T3	PA SP
DELSTRIGO	T3	PA SP
<i>efavirenz/emtricit/tenofovr df (Atripla)</i>	T1	PA SP
<i>efavirenz/lamivu/tenofov disop (Symfi Lo)</i>	T1	SP
<i>efavirenz/lamivu/tenofov disop (Symfi)</i>	T1	SP
ODEFSEY	T3	PA SP

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

T4 – Injectable Specialty Medications

PA – Prior Authorization

QL – Quantity Limit

ST – Step Therapy

AGE – Age Requirement

SP – Specialty Medication

HD – May require home delivery pharmacy

PPACA – No Cost-Share Preventive Medication

CSL – Oral cancer medication subject to cost-share limits

# List of Prescription Medications

## ANTIVIRALS (AIDS/HIV) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>ARV-NUCLEOSIDE, NUCLEOTIDE RTI, INTEGRASE INHIBITORS</b>		
BIKTARVY	T2	SP
GENVOYA	T2	SP
STRIBILD	T3	PA SP

## ANTIVIRALS (Eye Conditions)

### EYE ANTIVIRALS

<i>trifluridine</i>	T1	
ZIRGAN	T3	

## ANTIVIRALS (Infections)

### ANTIVIRALS, GENERAL

<i>acyclovir</i>	T1	
<i>acyclovir 200 mg/5 ml susp</i>	T1	
<i>famciclovir</i>	T1	
FLUMADINE ( <i>rimantadine hcl</i> )	T3	
LIVTENCITY	T4	PA QL (4 tabs/day) SP
<i>oseltamivir 6 mg/ml suspension</i> (Tamiflu)	T1	QL (180ml/30 days)
<i>oseltamivir phos 30 mg capsule</i> (Tamiflu)	T1	QL (20 caps/30 days)
<i>oseltamivir phos 45 mg capsule</i> (Tamiflu)	T1	QL (10/30 days)
<i>oseltamivir phos 75 mg capsule</i> (Tamiflu)	T1	QL (10/30 days)
PREVYMIS	T3	SP HD
RELENZA	T3	QL (20/30 days)
<i>rimantadine hcl</i> (Flumadine)	T1	
TAMIFLU 30 MG CAPSULE ( <i>oseltamivir phosphate</i> )	T3	QL (20/30 days)
TAMIFLU 45 MG CAPSULE ( <i>oseltamivir phosphate</i> )	T3	QL (10/30 days)
TAMIFLU 6 MG/ML SUSPENSION ( <i>oseltamivir phosphate</i> )	T3	QL (180ml/30 days)
TAMIFLU 75 MG CAPSULE ( <i>oseltamivir phosphate</i> )	T3	QL (10/30 days)
<i>valganciclovir hcl</i>	T1	
VALTREX ( <i>valacyclovir</i> )	T3	
XOFLUZA	T3	QL (2 tabs/30 days)

### HEP C - NS5A, NS3/4A, NUCLEOTIDE NS5B INHIB COMBO

VOSEVI	T2	PA SP HD
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### HEP C VIRUS, NUCLEOTIDE ANALOG NS5B POLYMERASE INH

SOVALDI 150 MG, 200 MG PELLETT PACKET	T2	PA QL (1 tab/day) SP HD
SOVALDI 200 MG, 400 MG TABLET	T2	PA QL (1 tab/day) SP HD

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

T4 – Injectable Specialty Medications

PA – Prior Authorization

QL – Quantity Limit

ST – Step Therapy

AGE – Age Requirement

SP – Specialty Medication

HD – May require home delivery pharmacy

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CSL – Oral cancer medication subject to cost-share limits



## List of Prescription Medications

### ANTIVIRALS (Infections) (cont.)

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

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

T4 – Injectable Specialty Medications

PA – Prior Authorization

QL – Quantity Limit

ST – Step Therapy

AGE – Age Requirement

SP – Specialty Medication

HD – May require home delivery pharmacy

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CSL – Oral cancer medication subject to cost-share limits

## List of Prescription Medications

### ANTIVIRALS (Infections) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>RNA POLYMERASE INHIBITOR</b>		
LAGEVRIO (EUA)	T2	QL(1 pack/120 days)
LAGEVRIO 200 MG CAP (EUA)	T2	QL(1 pack/120 days)
MOLNUPIRAVIR	T3	QL (1 pkg/120 days)

### ANTIVIRALS (Skin Conditions)

#### TOPICAL GENITAL WART-HPV TREATMENT AGENTS

VEREGEN	T3	
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### AUTONOMIC DRUGS (Allergy/Nasal Sprays)

#### ANAPHYLAXIS THERAPY AGENTS

<i>epinephrine</i>	T1	QL (2 packs/30 days)
<i>epinephrine</i> (Epinephrine)	T1	QL (2 packs/30 days)

### AUTONOMIC DRUGS (Alzheimer's Disease)

#### CHOLINESTERASE INHIBITORS

ARICEPT ( <i>donepezil hcl</i> )	T3	HD
<i>donepezil hcl</i>	T1	HD
<i>donepezil hcl</i> (Aricept)	T1	HD
EXELON ( <i>rivastigmine</i> )	T3	HD
<i>galantamine er 16 mg capsule</i> (Razadyne Er)	T1	HD
<i>galantamine er 24 mg capsule</i> (Razadyne Er)	T1	HD
<i>galantamine er 8 mg capsule</i> (Razadyne Er)	T1	QL (1 cap/day) HD
<i>galantamine hbr</i>	T1	HD
MESTINON ( <i>pyridostigmine bromide er</i> )	T3	HD
<i>pyridostigmine bromide</i> (Mestinon)	T1	HD
RAZADYNE ER 16 MG CAPSULE ( <i>galantamine er</i> )	T3	HD
RAZADYNE ER 24 MG CAPSULE ( <i>galantamine er</i> )	T3	HD
RAZADYNE ER 8 MG CAPSULE ( <i>galantamine er</i> )	T3	QL (1 cap/day) HD
<i>rivastigmine</i> (Exelon)	T1	HD
<i>rivastigmine tartrate</i>	T1	HD

### AUTONOMIC DRUGS (Attention Deficit Hyperactivity Disorder)<sup>9</sup>

#### ADRENERGICS, AROMATIC, NON-CATECHOLAMINE

ADDERALL ( <i>dextroamphetamine-amphetamine</i> )	T3	PA ST
<i>amphetamine sulfate</i> (Evekeo)	T1	PA
<i>dextroamph-amphet er 12.5mg cp</i> (Mydayis)	T1	PA QL (1 cap/day)
<i>dextroamph-amphet er 25 mg cap</i> (Mydayis)	T1	PA QL (1 cap/day)

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

T4 – Injectable Specialty Medications

PA – Prior Authorization

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ST – Step Therapy

AGE – Age Requirement

SP – Specialty Medication

HD – May require home delivery pharmacy

PPACA – No Cost-Share Preventive Medication

CSL – Oral cancer medication subject to cost-share limits

## List of Prescription Medications

### AUTONOMIC DRUGS (Attention Deficit Hyperactivity Disorder)<sup>9</sup> (cont.)

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

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

#### ADRENERGIC VASOPRESSOR AGENTS

<i>droxidopa (Northera)</i>	T1	SP HD
<i>midodrine hcl</i>	T1	

#### ALPHA-ADRENERGIC BLOCKING AGENTS

<i>DIBENZYLINE (phenoxybenzamine hcl)</i>	T3	HD
<i>phenoxybenzamine hcl (Dibenzyline)</i>	T1	HD

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

T4 – Injectable Specialty Medications

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AGE – Age Requirement

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# List of Prescription Medications

## AUTONOMIC DRUGS (Urinary Tract Conditions)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>PARASYMPATHETIC AGENTS</b>		
<i>bethanechol chloride</i>	T1	HD
<i>cevimeline hcl</i> (Evoxac)	T1	HD
EVOXAC ( <i>cevimeline hcl</i> )	T3	HD
<i>guanidine hcl</i>	T1	HD
<i>pilocarpine hcl</i> (Salagen)	T1	HD
SALAGEN ( <i>pilocarpine hcl</i> )	T3	HD

## BIOLOGICALS (Allergy/Nasal Sprays)

### ALLERGENIC EXTRACTS, THERAPEUTIC

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

## BIOLOGICALS (Blood Pressure/Heart Medications)

### PLASMA KALLIKREIN INHIBITORS

TAKHZYRO	T4	PA SP HD
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## BIOLOGICALS (Miscellaneous)

### PKU TREATMENT AGENTS - PHENYLALANINE AMMONIA LYASE

PALYNZIQ	T4	PA SP HD
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## BIOLOGICALS (Vaccines)

### COVID-19 VACCINES

PFIZER COVID-19 VACCINE	T2	PPACA
COMIRNATY COVID-19 VACCINE	T2	PPACA
MODERNA COVID-19 VACCINE	T2	PPACA
NOVAVAX COVID-19 VACCINE	T2	PPACA
SPIKEVAX 2023-2024	T2	PPACA
JANSSEN COVID-19 VACCINE	T2	PPACA

### ENTERIC VIRUS VACCINES

IPOL	T2	PPACA
ROTARIX	T3	PPACA
ROTATEQ	T3	PPACA

### GRAM NEGATIVE COCCI VACCINES

BEXSERO	T2	PPACA
MENACTRA	T2	PPACA

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

T4 – Injectable Specialty Medications

PA – Prior Authorization

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CSL – Oral cancer medication subject to cost-share limits

# List of Prescription Medications

<b>BIOLOGICALS (Vaccines) (cont.)</b>			
<b>Prescription Drug Name</b>	<b>Drug Tier</b>	<b>Coverage Requirements and Limits</b>	
<b>GRAM NEGATIVE COCCI VACCINES (cont.)</b>			
MENQUADFI	T2	PPACA	
MENVEO A-C-Y-W-135-DIP	T2	PPACA	
PENBRAYA	T2	PPACA	
TRUMENBA	T2	PPACA	
<b>GRAM POSITIVE COCCI VACCINES</b>			
PNEUMOVAX 23	T2	PPACA	
PREVNAR 13	T2	PPACA	
<b>INFLUENZA VIRUS VACCINES</b>			
AFLURIA	T2	PPACA	
AFLURIA QUAD	T2	PPACA	
EZ FLU	T2	PPACA	
FLUAD	T2	PPACA	
FLUAD QUAD	T2	PPACA	
FLUARIX QUAD	T2	PPACA	
FLUBLOK	T2	PPACA	
FLUBLOK QUAD	T2	PPACA	
FLUCELVAX QUAD	T2	PPACA	
FLULAVAL QUAD	T2	PPACA	
FLUMIST QUAD	T3	PPACA	
FLUVIRIN	T2	PPACA	
FLUZONE	T2	PPACA	
FLUZONE	T2	PPACA	
FLUZONE HIGH-DOSE	T2	PPACA	
FLUZONE HIGH-DOSE	T2	PPACA	
FLUZONE INTRADERM QUAD	T2	PPACA	
FLUZONE QUAD	T2	PPACA	
FLUZONE QUAD PEDI	T2	PPACA	
<b>VACCINE/TOXOID PREPARATIONS, COMBINATIONS</b>			
ACTHIB	T2	PPACA	
ADACEL TDAP	T2	PPACA	
BOOSTRIX TDAP	T2	PPACA	
DAPTACEL DTAP	T2	PPACA	
DIPHThERIA-TETANUS TOXOIDS-PED	T2	PPACA	
HIBERIX	T2	PPACA	
INFANRIX DTAP	T2	PPACA	

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

## List of Prescription Medications

### BIOLOGICALS (Vaccines) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>VACCINE/TOXOID PREPARATIONS, COMBINATIONS (cont.)</b>		
KINRIX	T2	PPACA
M-M-R II VACCINE	T2	PPACA
PEDVAXHIB	T2	PPACA
PENTACEL	T2	PPACA
PENTACEL ACTHIB COMPONENT	T2	PPACA
PROQUAD	T2	PPACA
QUADRACEL DTAP-IPV	T2	PPACA
TDVAX	T2	PPACA
TENIVAC	T2	PPACA
VAXELIS	T2	PPACA
<b>VIRAL/TUMORIGENIC VACCINES</b>		
ACAM2000	T3	
ENGERIX-B ADULT	T2	PPACA
ENGERIX-B PEDIATRIC-ADOLESCENT	T2	PPACA
GARDASIL 9	T2	PPACA
HEPLISAV-B	T2	PPACA
IXCHIQ	T3	PPACA
JYNNEOS	T3	
PEDIARIX	T2	PPACA
RECOMBIVAX HB	T2	PPACA
SHINGRIX	T2	QL (2 doses/lifetime) PPACA
TWINRIX	T2	PPACA
VARIVAX VACCINE	T2	PPACA
ZOSTAVAX	T2	PPACA

### BLOOD (Blood Modifiers/Bleeding Disorders)

#### AGENTS TO TX THROMBOTIC THROMBOCYTOPENIC PURPURA

CABLIVI	T4	PA SP
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#### ANTI-FIBRINOLYTIC AGENTS

AMICAR ( <i>aminocaproic acid</i> )	T3	SP HD
<i>aminocaproic acid</i> (Amicar)	T1	SP HD
LYSTEDA ( <i>tranexamic acid</i> )	T3	SP
<i>tranexamic acid</i> (Lysteda)	T1	SP

#### ANTI-HEMOPHILIC FACTORS

ALTUVIIIQ	T4	PA SP HD
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T1 – Typically Generics

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T4 – Injectable Specialty Medications

PA – Prior Authorization

QL – Quantity Limit

ST – Step Therapy

AGE – Age Requirement

SP – Specialty Medication

HD – May require home delivery pharmacy

PPACA – No Cost-Share Preventive Medication

CSL – Oral cancer medication subject to cost-share limits

## List of Prescription Medications

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

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>COMPLEMENT INHIBITORS</b>		
FABHALTA	T2	PA QL(2 caps/day) SP
<b>HEMOPHILIA TREATMENT AGENTS, NON-FACTOR REPLACEMENT</b>		
HEMLIBRA	T4	PA SP HD
<b>SICKLE CELL ANEMIA AGENTS</b>		
DROXIA	T2	
ENDARI	T3	
SIKLOS	T3	PA
<b>TOPICAL HEMOSTATICS</b>		
ASTRINGYN	T3	
AVITENE	T3	
ENDO-AVITENE	T3	
EVICEL	T3	
<i>gelatin sponge, absorb/porcine</i> (Gelfoam)	T1	
GELFOAM	T3	
GELFOAM ( <i>surgifoam</i> )	T3	
GELFOAM COMPRESSED	T3	
MONSEL'S	T3	
RAPLIXA	T3	
RECOTHROM	T3	
SURGIFOAM	T1	
SYRINGE AVITENE	T3	
TACHOSIL	T3	
THROMBI-GEL	T3	
THROMBIN-JMI	T3	
THROMBI-PAD	T3	
ULTRAFOAM	T3	

### BLOOD (Blood Thinners/Anti-Clotting)

<b>HEMORRHOLOGIC AGENTS</b>		
<i>pentoxifylline</i>	T1	HD

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

<b>ANTI-ANGINAL, ANTI-ISCHEMIC AGENTS, NON-HEMODYNAMIC</b>		
<i>ranolazine</i> (Ranexa)	T1	QL (4 tabs/day) HD
<b>ANTI-ARRHYTHMICS</b>		
<i>amiodarone hcl</i>	T1	HD

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AGE – Age Requirement

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# List of Prescription Medications

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

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>ANTI-ARRHYTHMICS (cont.)</b>		
NORPACE ( <i>disopyramide phosphate</i> )	T3	PA HD
NORPACE CR	T3	HD
<i>pacerone 100 mg tablet</i>	T3	PA HD
<i>pacerone 200 mg tablet</i>	T1	HD
<i>pacerone 400 mg tablet</i>	T3	PA HD
<i>propafenone hcl</i>	T1	HD
<i>propafenone hcl (Rythmol Sr)</i>	T1	HD
<i>quinidine gluconate</i>	T1	HD
RYTHMOL SR ( <i>propafenone hcl er</i> )	T3	PA HD
TIKOSYN 125 MCG CAPSULE ( <i>dofetilide</i> )	T3	PA QL (8 caps/day) HD
TIKOSYN 250 MCG CAPSULE ( <i>dofetilide</i> )	T3	PA QL (4 caps/day) HD
TIKOSYN 500 MCG CAPSULE ( <i>dofetilide</i> )	T3	PA QL (2 caps/day) HD
<b>CALCIUM CHANNEL BLOCKING AGENTS</b>		
ADALAT CC ( <i>nifedipine er</i> )	T3	HD
<i>amlodipine besylate (Norvasc)</i>	T1	HD
CALAN SR ( <i>verapamil er</i> )	T3	HD
CAMZYOS	T3	PA QL (30caps/30days) SP
CARDIZEM LA 120 MG TABLET ( <i>diltiazem hcl</i> )	T3	QL (1 tab/day) HD
CARDIZEM LA 180 MG TABLET ( <i>matzim la</i> )	T3	HD
CARDIZEM LA 240 MG TABLET ( <i>matzim la</i> )	T3	HD
CARDIZEM LA 300 MG TABLET ( <i>matzim la</i> )	T3	HD
CARDIZEM LA 360 MG TABLET ( <i>matzim la</i> )	T3	HD
CARDIZEM LA 420 MG TABLET ( <i>matzim la</i> )	T3	HD
<i>diltiazem 24h er(la) 120 mg tb (Cardizem La)</i>	T1	QL(1 tab/day) HD
<i>diltiazem 24h er(la) 180 mg tb (Cardizem La)</i>	T1	HD
<i>diltiazem 24h er(la) 240 mg tb (Cardizem La)</i>	T1	HD
<i>diltiazem 24h er(la) 300 mg tb (Cardizem La)</i>	T1	HD
<i>diltiazem 24h er(la) 360 mg tb (Cardizem La)</i>	T1	HD
<i>diltiazem 24h er(la) 420 mg tb (Cardizem La)</i>	T1	HD
<i>diltiazem hcl</i>	T1	HD
<i>diltiazem hcl (Cardizem La)</i>	T1	HD
<i>diltiazem hcl (Tiazac)</i>	T1	HD
<i>felodipine</i>	T1	HD
<i>isradipine</i>	T1	HD

T1 – Typically Generics

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T3 – Typically Non-Preferred Brands

T4 – Injectable Specialty Medications

PA – Prior Authorization

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CSL – Oral cancer medication subject to cost-share limits

## List of Prescription Medications

<b>CARDIAC DRUGS (Blood Pressure/Heart Medications) (cont.)</b>		
<b>Prescription Drug Name</b>	<b>Drug Tier</b>	<b>Coverage Requirements and Limits</b>
<b>CALCIUM CHANNEL BLOCKING AGENTS (cont.)</b>		
KATERZIA	T3	QL (10ml/day) HD
<i>nicardipine hcl</i>	T1	HD
<i>nifedipine</i>	T1	HD
<i>nifedipine</i> (Adalat Cc)	T1	HD
<i>nifedipine</i> (Procardia XI)	T1	HD
<i>nifedipine</i> (Procardia)	T1	HD
<i>nisoldipine er 17 mg tablet</i> (Sular)	T1	HD
<i>nisoldipine er 20 mg tablet</i>	T1	QL (1 tab/day) HD
<i>nisoldipine er 25.5 mg tablet</i>	T1	HD
<i>nisoldipine er 30 mg tablet</i>	T1	HD
<i>nisoldipine er 34 mg tablet</i> (Sular)	T1	HD
<i>nisoldipine er 40 mg tablet</i>	T1	HD
<i>nisoldipine er 8.5 mg tablet</i> (Sular)	T1	HD
NORLIQVA	T2	PA QL(10 mls/day) HD
NORLIQVA ORAL SOLN	T2	PA QL
NORVASC ( <i>amlodipine besylate</i> )	T3	HD
NYMALIZE	T3	HD
PROCARDIA ( <i>nifedipine</i> )	T3	HD
SULAR ( <i>nisoldipine</i> )	T3	HD
TIAZAC ( <i>tiadylt er</i> )	T3	HD
<i>verapamil hcl</i>	T1	HD
<i>verapamil hcl</i> (Calan Sr)	T1	HD
<i>verapamil hcl</i> (Verelan Pm)	T1	HD
<i>verapamil hcl</i> (Verelan)	T1	HD
VERELAN ( <i>verapamil hcl</i> )	T3	HD
VERELAN ( <i>verapamil sr</i> )	T3	HD
VERELAN PM ( <i>verapamil er pm</i> )	T3	HD
<b>DIGITALIS GLYCOSIDES</b>		
<i>digoxin</i>	T1	HD
<b>HEART RATE REDUCING, SA SELECTIVE I(F) CURRENT INH.</b>		
CORLANOR	T2	PA HD
CORLANOR 5 MG TABLET	T2	PA HD
CORLANOR 7.5 MG TABLET	T2	PA HD
CORLANOR 5 MG/5 ML ORAL SOLN	T2	PA SP HD

T1 – Typically Generics

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T3 – Typically Non-Preferred Brands

T4 – Injectable Specialty Medications

PA – Prior Authorization

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## List of Prescription Medications

CARDIAC DRUGS (Blood Pressure/Heart Medications) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>VASODILATORS, CORONARY</b>		
DILATRATE-SR	T3	HD
<i>isosorbide dinitrate</i>	T1	HD
MINITRAN	T1	HD
NITRO-DUR	T3	HD
<i>nitroglycerin 0.3 mg tablet sl (Nitrostat)</i>	T1	HD
<i>nitroglycerin 0.4 mg tablet sl (Nitrostat)</i>	T1	HD
<i>nitroglycerin 0.6 mg tablet sl (Nitrostat)</i>	T1	HD
<i>nitroglycerin 400 mcg spray (Nitrolingual)</i>	T1	HD
<i>nitroglycerin (Nitro-dur)</i>	T1	HD
<i>nitroglycerin (Nitromist)</i>	T1	HD
NITROLINGUAL ( <i>nitroglycerin</i> )	T3	HD
NITROMIST ( <i>nitroglycerin</i> )	T3	HD
NITROSTAT ( <i>nitroglycerin</i> )	T3	HD
<b>CARDIOVASCULAR (Asthma/COPD/Respiratory)</b>		
<b>PULM ANTI-HTN, SOLUBLE GUANYLATE CYCLASE STIMULATOR</b>		
ADEMPAS	T2	PA SP HD
VERQUVO	T3	QL(1 tab/day)
<b>PULM.ANTI-HTN, SEL.C-GMP PHOSPHODIESTERASE T5 INHIB</b>		
<i>sildenafil 10 mg/ml oral susp (Revatio)</i>	T1	PA SP HD
<i>sildenafil 20 mg tablet (Revatio)</i>	T1	PA SP HD
<i>tadalafil (Adcirca)</i>	T1	PA SP HD
<i>tadalafil 20 mg tablet (Adcirca)</i>	T1	PA SP HD
<b>PULMONARY ANTI-HTN, ENDOTHELIN RECEPTOR ANTAGONIST</b>		
<i>ambrisentan (Letairis)</i>	T1	PA SP HD
<i>bosentan (Tracleer)</i>	T1	PA SP HD
LETAIRIS ( <i>ambrisentan</i> )	T3	PA SP HD
OPSUMIT	T2	PA SP HD
TRACLEER 125 MG TABLET ( <i>bosentan</i> )	T3	PA SP HD
TRACLEER 32 MG TABLET FOR SUSP	T2	PA SP HD
TRACLEER 62.5 MG TABLET ( <i>bosentan</i> )	T3	PA SP HD
<b>PULMONARY ANTIHYPERTENSIVES, PROSTACYCLIN-TYPE</b>		
ORENITRAM ER	T3	PA SP HD
ORENITRAM MONTH 1 TITRATION KT	T3	PA QL(168 tabs/180 days) SP HD
ORENITRAM MONTH 2 TITRATION KT	T3	PA QL(336 tabs/180 days) SP HD
ORENITRAM MONTH 3 TITRATION KT	T3	PA QL(252 tabs/180 days) SP HD
TYVASO	T3	PA SP HD
TYVASO INSTITUTIONAL START KIT	T3	PA SP HD
TYVASO REFILL KIT	T3	PA SP HD

## List of Prescription Medications

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

#### PULMONARY ANTIHYPERTENSIVES, PROSTACYCLIN-TYPE (cont.)

TYVASO STARTER KIT	T3	PA SP HD
UPTRAVI	T2	PA SP HD
VENTAVIS	T3	PA SP HD

#### SOLUBLE GUANYLATE CYCLASE (SGC) STIMULATOR

VERQUVO	T2	PA QL(1 tab/day)
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### CARDIOVASCULAR (Blood Pressure/Heart Medications)

#### ACE INHIBITOR-CALCIUM CHANNEL BLOCKER COMBINATION

<i>amlodipine besylate/benazepril</i>	T1	HD
PRESTALIA 14 MG-10 MG TABLET	T3	HD
PRESTALIA 3.5 MG-2.5 MG TABLET	T3	QL (1 tab/day) HD
PRESTALIA 7 MG-5 MG TABLET	T3	QL (1 tab/day) HD
<i>trandolapril/verapamil hcl</i>	T1	HD

#### ACE INHIBITOR-THIAZIDE OR THIAZIDE-LIKE DIURETIC

<i>benazepril/hydrochlorothiazide</i>	T1	HD
<i>captopril-hctz 25-15 mg tablet</i>	T1	QL (3 tabs/day) HD
<i>captopril-hctz 25-25 mg tablet</i>	T1	QL (2 tabs/day) HD
<i>captopril-hctz 50-15 mg tablet</i>	T1	QL (3 tabs/day) HD
<i>captopril-hctz 50-25 mg tablet</i>	T1	QL (2 tabs/day) HD
<i>enalapril/hydrochlorothiazide</i>	T1	HD
<i>fosinopril/hydrochlorothiazide</i>	T1	HD
<i>lisinopril/hydrochlorothiazide</i>	T1	HD
<i>quinapril/hydrochlorothiazide</i>	T1	HD

#### ALPHA/BETA-ADRENERGIC BLOCKING AGENTS

<i>carvedilol (Coreg)</i>	T1	HD
<i>carvedilol er 10 mg capsule (Coreg Cr)</i>	T1	QL (1 cap/day) HD
<i>carvedilol er 40 mg capsule (Coreg Cr)</i>	T1	QL (1 cap/day) HD
<i>carvedilol er 80 mg capsule (Coreg Cr)</i>	T1	HD
COREG ( <i>carvedilol</i> )	T3	ST HD
COREG CR 10 MG CAPSULE ( <i>carvedilol er</i> )	T3	QL (1 cap/day) ST HD
COREG CR 20 MG CAPSULE ( <i>carvedilol er</i> )	T3	QL (1 cap/day) ST HD
COREG CR 40 MG CAPSULE ( <i>carvedilol er</i> )	T3	QL (1 cap/day) ST HD
COREG CR 80 MG CAPSULE ( <i>carvedilol er</i> )	T3	ST HD
<i>labetalol hcl</i>	T1	HD

T1 – Typically Generics

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T4 – Injectable Specialty Medications

PA – Prior Authorization

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AGE – Age Requirement

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HD – May require home delivery pharmacy

PPACA – No Cost-Share Preventive Medication

CSL – Oral cancer medication subject to cost-share limits

# List of Prescription Medications

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

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

## List of Prescription Medications

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

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>ANTI-HYPERTENSIVES, ACE INHIBITORS (cont.)</b>		
EPANED	T3	HD
<i>fosinopril sodium</i>	T1	HD
<i>lisinopril (Zestril)</i>	T1	HD
<i>moexipril hcl</i>	T1	HD
<i>perindopril erbumine</i>	T1	HD
<i>quinapril hcl</i>	T1	HD
<i>ramipril</i>	T1	HD
<i>trandolapril</i>	T1	HD
<b>ANTI-HYPERTENSIVES, ANGIOTENSIN RECEPTOR ANTAGONIST</b>		
<i>candesartan cilexetil</i>	T1	HD
<i>eprosartan mesylate</i>	T1	HD
<i>irbesartan</i>	T1	HD
<i>losartan potassium</i>	T1	HD
<i>olmesartan medoxomil 20 mg tab (Benicar)</i>	T1	QL (1 tab/day) HD
<i>olmesartan medoxomil 40 mg tab (Benicar)</i>	T1	HD
<i>olmesartan medoxomil 5 mg tab (Benicar)</i>	T1	HD
<i>telmisartan 20 mg tablet</i>	T1	QL (1 tab/day) HD
<i>telmisartan 40 mg tablet</i>	T1	QL (1 tab/day) HD
<i>telmisartan 80 mg tablet</i>	T1	HD
<i>valsartan</i>	T1	HD
<b>ANTI-HYPERTENSIVES, GANGLIONIC BLOCKERS</b>		
VECAMEYL	T1	
<b>ANTI-HYPERTENSIVES, MISCELLANEOUS</b>		
DEMSEER ( <i>metyrosine</i> )	T3	HD
<i>metyrosine (Demser)</i>	T1	HD
<b>ANTI-HYPERTENSIVES, SYMPATHOLYTIC</b>		
CATAPRES ( <i>clonidine hcl</i> )	T3	HD
CATAPRES-TTS 1 ( <i>clonidine</i> )	T3	HD
CATAPRES-TTS 2 ( <i>clonidine</i> )	T3	HD
CATAPRES-TTS 3 ( <i>clonidine</i> )	T3	HD
<i>clonidine (Catapres-tts 1)</i>	T1	HD
<i>clonidine (Catapres-tts 2)</i>	T1	HD
<i>clonidine (Catapres-tts 3)</i>	T1	HD
<i>clonidine hcl (Catapres)</i>	T1	HD
<i>guanfacine hcl</i>	T1	HD
<i>methyl dopa</i>	T1	HD

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T3 – Typically Non-Preferred Brands

QL – Quantity Limit

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## List of Prescription Medications

CARDIOVASCULAR (Blood Pressure/Heart Medications) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>ANTI-HYPERTENSIVES, SYMPATHOLYTIC (cont.)</b>		
<i>methyldopa/hydrochlorothiazide</i>	T1	HD
<b>ANTI-HYPERTENSIVES, VASODILATORS</b>		
<i>hydralazine hcl</i>	T1	HD
<i>minoxidil</i>	T1	HD
<b>BETA-ADRENERGIC BLOCKING AGENTS</b>		
<i>acebutolol hcl</i>	T1	HD
<i>atenolol</i> (Tenormin)	T1	HD
<i>betaxolol hcl</i>	T1	HD
bisoprolol fumarate INNOPRAN XL	T1	HD
<i>metoprolol succinate</i> (Toprol XL)	T3	ST HD
<i>metoprolol tartrate</i>	T1	HD
<i>metoprolol tartrate</i> (Lopressor)	T1	HD
<i>nadolol</i>	T1	HD
<i>nadolol</i> (Corgard)	T1	HD
<i>pindolol</i>	T1	HD
<i>propranolol hcl</i>	T1	HD
<i>propranolol hcl</i> (Inderal La)	T1	HD
<i>sotalol hcl</i>	T1	HD
<i>sotalol hcl</i> (Betapace Af)	T1	HD
SOTYLIZE	T3	HD
<i>timolol maleate</i>	T1	HD
<b>BETA-BLOCKERS AND THIAZIDE, THIAZIDE-LIKE DIURETICS</b>		
<i>atenolol/chlorthalidone</i> (Tenoretic 100)	T1	HD
<i>atenolol/chlorthalidone</i> (Tenoretic 50)	T1	HD
<i>bisoprolol/hydrochlorothiazide</i> (Ziac)	T1	HD
<i>metoprolol/hydrochlorothiazide</i>	T1	HD
<i>nadolol/bendroflumethiazide</i>	T1	HD
<i>propranolol/hydrochlorothiazid</i>	T1	HD
<b>RENIN INHIBITOR, DIRECT</b>		
<i>aliskiren 150 mg tablet</i>	T1	QL (1 tab/day) HD
<i>aliskiren 300 mg tablet</i>	T1	HD
<b>VASODILATORS, COMBINATION</b>		
BIDIL	T3	QL (6 tabs/day)
BIDIL ( <i>isosorbide dinit/hydralazine</i> )	T3	QL (6 tabs/day)
<i>isosorbide-hydralazine 20-37.5</i> (Bidil)	T1	QL(6 tabs/day) HD

T1 – Typically Generics

T4 – Injectable Specialty Medications

ST – Step Therapy

HD – May require home delivery pharmacy

T2 – Typically Preferred Brands

PA – Prior Authorization

AGE – Age Requirement

PPACA – No Cost-Share Preventive Medication

T3 – Typically Non-Preferred Brands

QL – Quantity Limit

SP – Specialty Medication

CSL – Oral cancer medication subject to cost-share limits



## List of Prescription Medications

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

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
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#### VASODILATORS, PERIPHERAL

<i>ergoloid mesylates</i>	T1	
<i>isoxsuprine hcl</i>	T1	

### CARDIOVASCULAR (Cholesterol Medications)

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

<i>ezetimibe/simvastatin</i>	T1	HD
ROSZET	T3	HD

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

<i>amlodipine-atorvast 10-40 mg (Caduet)</i>	T1	HD
<i>amlodipine-atorvast 10-80 mg (Caduet)</i>	T1	HD
<i>amlodipine-atorvast 2.5-10 mg</i>	T1	HD
<i>amlodipine-atorvast 2.5-20 mg</i>	T1	QL (1 tab/day) HD
<i>amlodipine-atorvast 2.5-40 mg</i>	T1	QL (1 tab/day) HD
<i>amlodipine-atorvast 5-10 mg (Caduet)</i>	T1	HD
<i>amlodipine-atorvast 5-20 mg (Caduet)</i>	T1	QL (1 tab/day) HD
<i>amlodipine-atorvast 5-40 mg (Caduet)</i>	T1	QL (1 tab/day) HD
<i>amlodipine-atorvast 5-80 mg (Caduet)</i>	T1	HD
CADUET 10 MG-10 MG TABLET ( <i>amlodipine-atorvastatin</i> )	T3	HD
CADUET 10 MG-20 MG TABLET ( <i>amlodipine-atorvastatin</i> )	T3	HD
CADUET 10 MG-40 MG TABLET ( <i>amlodipine-atorvastatin</i> )	T3	HD
CADUET 10 MG-80 MG TABLET ( <i>amlodipine-atorvastatin</i> )	T3	HD
CADUET 5 MG-10 MG TABLET ( <i>amlodipine-atorvastatin</i> )	T3	HD
CADUET 5 MG-20 MG TABLET ( <i>amlodipine-atorvastatin</i> )	T3	QL (1 tab/day) HD
CADUET 5 MG-40 MG TABLET ( <i>amlodipine-atorvastatin</i> )	T3	QL (1 tab/day) HD
CADUET 5 MG-80 MG TABLET ( <i>amlodipine-atorvastatin</i> )	T3	HD

#### ANTI-HYPERLIPIDEMIC - APO B-100 SYNTHESIS INHIBITOR

KYNAMRO	T4	PA SP
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#### ANTI-HYPERLIPIDEMIC - PCSK9 INHIBITORS

REPATHA PUSHTRONEX	T2	PA
REPATHA SURECLICK	T2	PA
REPATHA SYRINGE	T2	PA

#### ANTI-HYPERLIPIDEMIC-HMGCOA REDUCTASE INHIB (Statins)

<i>atorvastatin 10 mg tablet</i>	T1	HD PPACA
<i>atorvastatin 20 mg tablet</i>	T1	HD PPACA
<i>atorvastatin 40 mg tablet</i>	T1	HD
<i>atorvastatin 80 mg tablet</i>	T1	HD
<i>fluvastatin sodium</i>	T1	HD PPACA

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

PA – Prior Authorization  
QL – Quantity Limit

AGE – Age Requirement  
SP – Specialty Medication

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

## List of Prescription Medications

### CARDIOVASCULAR (Cholesterol Medications) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>ANTI-HYPERLIPIDEMIC-HMGCOA REDUCTASE INHIB (Statins) (cont.)</b>		
<i>lovastatin 10 mg tablet</i>	T1	HD
<i>lovastatin 20 mg tablet</i>	T1	HD PPACA
<i>lovastatin 40 mg tablet</i>	T1	HD PPACA
<i>pitavastatin 1 mg tablet</i>	T1	QL(1 tab/day) HD PPACA
<i>pitavastatin 2 mg tablet</i>	T1	QL(1 tab/day) HD PPACA
<i>pitavastatin 4 mg tablet</i>	T1	HD PPACA
<i>pravastatin sodium</i>	T1	HD PPACA
<i>rosuvastatin calcium 20 mg tab (Crestor)</i>	T1	QL(1 tab/day) HD
<i>rosuvastatin calcium 40 mg tab (Crestor)</i>	T1	HD
<i>rosuvastatin calcium 10 mg tab</i>	T1	QL (1 tab/day) HD PPACA
<i>rosuvastatin calcium 20 mg tab</i>	T1	QL (1 tab/day) HD
<i>rosuvastatin calcium 40 mg tab</i>	T1	HD
<i>rosuvastatin calcium 5 mg tab</i>	T1	QL (1 tab/day) HD PPACA
<i>simvastatin 10 mg tablet</i>	T1	HD PPACA
<i>simvastatin 20 mg tablet</i>	T1	HD PPACA
<i>amlodipine-atorvast 2.5-10 mg</i>	T1	HD
<i>amlodipine-atorvast 2.5-20 mg</i>	T1	QL (1 tab/day) HD
<i>amlodipine-atorvast 2.5-40 mg</i>	T1	QL (1 tab/day) HD
<i>amlodipine-atorvast 5-10 mg (Caduet)</i>	T1	HD
<i>amlodipine-atorvast 5-20 mg (Caduet)</i>	T1	QL (1 tab/day) HD
<i>amlodipine-atorvast 5-40 mg (Caduet)</i>	T1	QL (1 tab/day) HD
<i>amlodipine-atorvast 5-80 mg (Caduet)</i>	T1	HD
CADUET 10 MG-10 MG TABLET ( <i>amlodipine-atorvastatin</i> )	T3	HD
CADUET 10 MG-20 MG TABLET ( <i>amlodipine-atorvastatin</i> )	T3	HD
CADUET 10 MG-40 MG TABLET ( <i>amlodipine-atorvastatin</i> )	T3	HD
CADUET 10 MG-80 MG TABLET ( <i>amlodipine-atorvastatin</i> )	T3	HD
CADUET 5 MG-10 MG TABLET ( <i>amlodipine-atorvastatin</i> )	T3	HD
CADUET 5 MG-20 MG TABLET ( <i>amlodipine-atorvastatin</i> )	T3	QL (1 tab/day) HD
CADUET 5 MG-40 MG TABLET ( <i>amlodipine-atorvastatin</i> )	T3	QL (1 tab/day) HD
CADUET 5 MG-80 MG TABLET ( <i>amlodipine-atorvastatin</i> )	T3	HD
CADUET 10 MG-40 MG TABLET ( <i>amlodipine-atorvastatin</i> )	T3	HD
CADUET 10 MG-80 MG TABLET ( <i>amlodipine-atorvastatin</i> )	T3	HD
CADUET 5 MG-10 MG TABLET ( <i>amlodipine-atorvastatin</i> )	T3	HD
CADUET 5 MG-20 MG TABLET ( <i>amlodipine-atorvastatin</i> )	T3	QL (1 tab/day) HD

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

T4 – Injectable Specialty Medications

PA – Prior Authorization

QL – Quantity Limit

ST – Step Therapy

AGE – Age Requirement

SP – Specialty Medication

HD – May require home delivery pharmacy

PPACA – No Cost-Share Preventive Medication

CSL – Oral cancer medication subject to cost-share limits

## List of Prescription Medications

### CARDIOVASCULAR (Cholesterol Medications) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>ANTI-HYPERLIPIDEMIC-HMGCOA REDUCTASE INHIB (Statins) (cont.)</b>		
CADUET 5 MG-40 MG TABLET ( <i>amlodipine-atorvastatin</i> )	T3	QL (1 tab/day) HD
CADUET 5 MG-80 MG TABLET ( <i>amlodipine-atorvastatin</i> )	T3	HD
<i>simvastatin 40 mg tablet</i>	T1	HD PPACA
<i>simvastatin 5 mg tablet</i>	T1	HD
<i>simvastatin 80 mg tablet</i>	T1	QL (1 tab/day) HD
<b>BILE SALT SEQUESTRANTS</b>		
<i>cholestyramine (with sugar) (Questran)</i>	T1	HD
<i>cholestyramine/aspartame</i>	T1	HD
<i>cholestyramine/aspartame (Questran Light)</i>	T1	HD
<i>colesevelam hcl (Welchol)</i>	T1	HD
COLESTID	T3	HD
COLESTID ( <i>colestipol hcl</i> )	T3	HD
<i>colestipol hcl (Colestid)</i>	T1	HD
QUESTRAN ( <i>cholestyramine</i> )	T3	HD
QUESTRAN LIGHT ( <i>prevalite</i> )	T3	HD
<b>LIPOTROPICS</b>		
<i>ezetimibe (Zetia)</i>	T1	HD
<i>ezetimibe (Zetia)</i>	T1	HD
<i>fenofibrate 120 mg tablet (Fenoglide)</i>	T1	HD
<i>fenofibrate 40 mg tablet (Fenoglide)</i>	T1	HD
<i>fenofibrate</i>	T1	HD
<i>fenofibrate nanocrystallized (Tricor)</i>	T1	HD
<i>fenofibrate, micronized</i>	T1	HD
<i>fenofibric acid (choline) (Trilipix)</i>	T1	HD
<i>fenofibric acid (Fibricor)</i>	T1	HD
FIBRICOR ( <i>fenofibric acid</i> )	T3	ST HD
<i>gemfibrozil (Lopid)</i>	T1	HD
LIPOFEN	T3	ST HD
LOPID ( <i>gemfibrozil</i> )	T3	HD
<i>niacin (Niaspan)</i>	T1	HD
NIASPAN ( <i>niacin er</i> )	T3	HD
TRICOR ( <i>fenofibrate</i> )	T3	ST HD
TRIGLIDE	T3	ST HD
TRILIPIX ( <i>fenofibric acid</i> )	T3	ST HD
ZETIA ( <i>ezetimibe</i> )	T3	HD

T1 – Typically Generics

T4 – Injectable Specialty Medications

ST – Step Therapy

HD – May require home delivery pharmacy

T2 – Typically Preferred Brands

PA – Prior Authorization

AGE – Age Requirement

PPACA – No Cost-Share Preventive Medication

T3 – Typically Non-Preferred Brands

QL – Quantity Limit

SP – Specialty Medication

CSL – Oral cancer medication subject to cost-share limits

## List of Prescription Medications

CNS DRUGS (Alzheimer's Disease)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>ALZHEIMER'S THERAPY, NMDA RECEPTOR ANTAGONISTS</b>		
<i>memantine hcl</i>	T1	HD
<i>memantine hcl</i> (Namenda)	T1	HD
<i>memantine hcl er 14 mg capsule</i> (Namenda Xr)	T1	QL (1 cap/day) HD
<i>memantine hcl er 28 mg capsule</i> (Namenda Xr)	T1	HD
NAMENDA	T3	HD
NAMENDA ( <i>memantine hcl</i> )	T3	HD
NAMENDA XR 14 MG CAPSULE ( <i>memantine hcl er</i> )	T3	QL (1 cap/day) HD
NAMENDA XR 21 MG CAPSULE ( <i>memantine hcl er</i> )	T3	HD
NAMENDA XR 28 MG CAPSULE ( <i>memantine hcl er</i> )	T3	HD
NAMENDA XR 7 MG CAPSULE ( <i>memantine hcl er</i> )	T3	QL (1 cap/day) HD
NAMENDA XR TITRATION PACK	T3	QL (112/365 days) HD
<b>ALZHEIMER'S THX, NMDA RECEPTOR ANTAG-CHOLINES INHIB</b>		
NAMZARIC 14 MG-10 MG CAPSULE	T3	QL (2 caps/day) HD
NAMZARIC 21 MG-10 MG CAPSULE	T3	QL (2 caps/day) HD
NAMZARIC 28 MG-10 MG CAPSULE	T3	QL (2 caps/day) HD
NAMZARIC 7 MG-10 MG CAPSULE	T3	QL (2 caps/day) HD
NAMZARIC TITRATION PACK	T3	QL (112/365 days) HD
<b>CNS DRUGS (Miscellaneous)</b>		
<b>AMYOTROPHIC LATERAL SCLEROSIS AGENTS</b>		
RILUTEK ( <i>riluzole</i> )	T3	SP HD
RADICAVA ORS	T3	PA QL (50ml/28days) SP
<i>riluzole</i> (Rilutek)	T1	SP HD
TIGLUTIK	T3	PA SP
<b>DRUGS TO TREAT MOVEMENT DISORDERS</b>		
AUSTEDO	T3	PA SP HD
AUSTEDO XR 6MG	T3	PA QL(3 tabs/day) SP HD
AUSTEDO XR 12MG	T3	PA QL(1 tab/day) SP HD
AUSTEDO XR 24MG	T3	PA QL(2 tabs/day) SP HD
AUSTEDO XR TITRATION KIT(WK1-4)	T3	PA QL(1 kit/180 days) SP HD
INGREZZA	T3	PA SP HD
<i>tetrabenazine</i>	T1	PA SP HD
<b>PSEUDOBULBAR AFFECT (PBA) AGENTS, NMDA ANTAGONISTS</b>		
NUEDEXTA	T3	QL (4 caps/day)
<b>XANTHINES</b>		
<i>caffeine citrate</i>	T1	HD

T1 – Typically Generics

T4 – Injectable Specialty Medications

ST – Step Therapy

HD – May require home delivery pharmacy

T2 – Typically Preferred Brands

PA – Prior Authorization

AGE – Age Requirement

PPACA – No Cost-Share Preventive Medication

T3 – Typically Non-Preferred Brands

QL – Quantity Limit

SP – Specialty Medication

CSL – Oral cancer medication subject to cost-share limits

## List of Prescription Medications

CNS DRUGS (Multiple Sclerosis)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>AGENTS TO TREAT MULTIPLE SCLEROSIS</b>		
AVONEX	T4	PA SP HD
AVONEX PEN	T4	PA SP HD
BAFIERTAM	T2	PA SP HD
BETASERON	T4	PA SP HD
<i>dimethyl fumarate</i>	T1	HD
<i>glatiramer</i>	T1	HD
<i>glatiramer acetate</i>	T4	PA SP HD
<i>glatopa</i>	T1	HD
KESIMPTA PEN	T4	PA SP HD
MAVENCLAD	T3	PA SP HD
MAYZENT	T2	PA SP HD
PLEGRIDY	T4	PA SP HD
PLEGRIDY PEN	T4	PA SP HD
REBIF	T4	PA SP HD
REBIF REBIDOSE	T4	PA SP HD
<i>teriflunomide (Aubagio)</i>	T1	SP HD
VUMERITY	T2	PA SP HD
<b>AGTS TX NEUROMUSC TRANSMISSION DIS, POT-CHAN BLKR</b>		
<i>dalfampridine</i>	T1	PA SP HD
FIRDAPSE	T3	PA QL (8 tabs/day) SP
RUZURGI	T3	PA SP
<b>CNS DRUGS (Pain Relief And Inflammatory Disease)</b>		
<b>CALCITONIN GENE-RELATED PEPTIDE (CGRP) INHIBITORS</b>		
EMGALITY SYRINGE	T2	PA
<b>SPHINGOSINE I-PHOSPHATE (SIP) RECEPTOR MODULATOR</b>		
ZEPOSIA	T2	PA SP HD
<b>POSTHERPETIC NEURALGIA AGENTS</b>		
<i>gabapentin (Gralise)</i>	T1	
<b>CNS DRUGS (Seizure Disorders)</b>		
<b>ANTI-CONVULSANT - BENZODIAZEPINE TYPE</b>		
<i>clobazam (Onfi)</i>	T1	HD
<i>clonazepam</i>	T1	HD
<i>clonazepam (Klonopin)</i>	T1	HD
DIASTAT ( <i>diazepam</i> )	T3	PA HD
DIASTAT ACUDIAL ( <i>diazepam</i> )	T3	PA HD

T1 – Typically Generics

T4 – Injectable Specialty Medications

ST – Step Therapy

HD – May require home delivery pharmacy

T2 – Typically Preferred Brands

PA – Prior Authorization

AGE – Age Requirement

PPACA – No Cost-Share Preventive Medication

T3 – Typically Non-Preferred Brands

QL – Quantity Limit

SP – Specialty Medication

CSL – Oral cancer medication subject to cost-share limits

## List of Prescription Medications

### CNS DRUGS (Seizure Disorders) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>ANTI-CONVULSANT - BENZODIAZEPINE TYPE (cont)</b>		
<i>diazepam 10 mg rectal gel syst</i> (Diastat Acudial)	T1	HD
<i>diazepam 2.5 mg rectal gel sys</i> (Diastat)	T1	HD
<i>diazepam 20 mg rectal gel syst</i>	T1	HD
KLONOPIN ( <i>clonazepam</i> )	T3	PA HD
NAYZILAM	T2	PA QL (5 kits/30 days) HD
ONFI ( <i>clobazam</i> )	T3	PA HD
VALTOCO	T3	PA QL (10 packs/22 days) HD
<b>ANTI-CONVULSANT - CANNABINOID TYPE</b>		
EPIDIOLEX	T3	PA SP HD
<b>ANTI-CONVULSANTS</b>		
APTIOM 200 MG, 400 MG TABLET	T3	PA QL (1 tab/day) HD
APTIOM 600 MG, 800 MG TABLET	T3	PA HD
BANZEL 200 MG TABLET	T3	PA QL (16 tabs/day) HD
BANZEL 400 MG TABLET	T3	PA QL (8 tabs/day) HD
BRIVIACT	T3	PA HD
<i>carbamazepine</i>	T1	HD
<i>carbamazepine</i> (Carbatrol)	T1	HD
<i>carbamazepine</i> (Tegretol Xr)	T1	HD
<i>carbamazepine</i> (Tegretol)	T1	HD
CARBATROL ( <i>carbamazepine er</i> )	T3	PA HD
CELONTIN	T2	HD
DIACOMIT	T3	PA SP HD
DILANTIN 100 MG CAPSULE ( <i>phenytoin sodium extended</i> )	T3	PA HD
DILANTIN 30 MG CAPSULE	T2	PA HD
DILANTIN 50 MG INFATAB ( <i>phenytoin</i> )	T3	PA HD
DILANTIN-125 ( <i>phenytoin</i> )	T3	PA HD
<i>divalproex sodium</i> (Depakote Er)	T1	HD
<i>divalproex sodium</i> (Depakote Sprinkle)	T1	HD
<i>divalproex sodium</i> (Depakote)	T1	HD
<i>ethosuximide</i> (Zarontin)	T1	HD
<i>felbamate</i>	T1	HD
FINTEPLA	T3	PA SP HD
<i>rufinamide 200 mg tablet</i> (Banzel)	T1	PA QL(16 tabs/day) HD

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

T4 – Injectable Specialty Medications

PA – Prior Authorization

QL – Quantity Limit

ST – Step Therapy

AGE – Age Requirement

SP – Specialty Medication

HD – May require home delivery pharmacy

PPACA – No Cost-Share Preventive Medication

CSL – Oral cancer medication subject to cost-share limits

## List of Prescription Medications

### CNS DRUGS (Seizure Disorders) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>ANTI-CONVULSANTS (cont.)</b>		
<i>rufinamide 400 mg tablet</i> (Banzel)	T1	PA QL(8 tabs/day) HD
FYCOMPA 0.5 MG/ML ORAL SUSP	T2	PA HD
FYCOMPA 10 MG, 12 MG, 2 MG, 4MG TABLET	T2	PA HD
FYCOMPA 6 MG TABLET	T2	PA QL (1 tab/day) HD
FYCOMPA 8 MG TABLET	T2	PA HD
<i>gabapentin</i>	T1	HD
<i>gabapentin</i> (Neurontin)	T1	HD
GABITRIL 12 MG TABLET ( <i>tiagabine hcl</i> )	T3	PA QL (8 tabs/day) HD
GABITRIL 16 MG TABLET ( <i>tiagabine hcl</i> )	T3	PA QL (6 tabs/day) HD
GABITRIL 2 MG TABLET ( <i>tiagabine hcl</i> )	T3	PA HD
GABITRIL 4 MG TABLET ( <i>tiagabine hcl</i> )	T3	PA HD
<i>lamotrigine</i>	T1	HD
LYRICA ( <i>pregabalin</i> )	T3	PA HD
NEURONTIN ( <i>gabapentin</i> )	T3	PA HD
<i>oxcarbazepine</i>	T1	HD
OXTELLAR XR	T3	PA HD
PEGANONE	T2	HD
PHENYTEK ( <i>phenytoin sodium extended</i> )	T3	PA HD
<i>phenytoin</i>	T1	HD
<i>phenytoin</i> (Dilantin)	T1	HD
<i>phenytoin</i> (Dilantin-125)	T1	HD
<i>phenytoin sodium extended</i> (Dilantin)	T1	HD
<i>phenytoin sodium extended</i> (Phenytek)	T1	HD
<i>pregabalin</i>	T1	HD
<i>pregabalin</i> (Lyrica)	T1	HD
<i>primidone</i>	T1	HD
<i>primidone 250 mg tablet</i> (Mysoline)	T1	HD
<i>primidone 50 mg tablet</i> (Mysoline)	T1	HD
<i>rufinamide</i> (Banzel)	T1	PA QL (80ml/day) HD
SPRITAM	T3	PA HD
TEGRETOL ( <i>carbamazepine</i> )	T3	PA HD
TEGRETOL ( <i>epitol</i> )	T3	PA HD
TEGRETOL XR ( <i>carbamazepine er</i> )	T3	PA HD
<i>tiagabine hcl 12 mg tablet</i> (Gabitril)	T1	QL (8 tabs/day) HD

T1 – Typically Generics

T4 – Injectable Specialty Medications

ST – Step Therapy

HD – May require home delivery pharmacy

T2 – Typically Preferred Brands

PA – Prior Authorization

AGE – Age Requirement

PPACA – No Cost-Share Preventive Medication

T3 – Typically Non-Preferred Brands

QL – Quantity Limit

SP – Specialty Medication

CSL – Oral cancer medication subject to cost-share limits

## List of Prescription Medications

CNS DRUGS (Seizure Disorders) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>ANTI-CONVULSANTS (cont.)</b>		
<i>tiagabine hcl 16 mg tablet (Gabitril)</i>	T1	QL (6 tabs/day) HD
<i>tiagabine hcl 2 mg tablet (Gabitril)</i>	T1	HD
<i>tiagabine hcl 4 mg tablet (Gabitril)</i>	T1	HD
<i>topiramate</i>	T1	HD
<i>topiramate er 200 mg capsule (Trokendi Xr)</i>	T1	HD
<i>topiramate er 100 mg capsule (Trokendi Xr)</i>	T1	QL(1 cap/day) HD
<i>topiramate er 50 mg capsule (Trokendi Xr)</i>	T1	HD
<i>topiramate er 25 mg capsule (Trokendi Xr)</i>	T1	QL(1 cap/day) HD
<i>valproic acid</i>	T1	HD
<i>valproic acid (as sodium salt)</i>	T1	HD
<i>vigabatrin</i>	T1	SP HD
VIMPAT	T2	PA HD
XCOPRI 100 MG TABLET	T3	PA QL (1 tab/day) HD
XCOPRI 12.5-25 MG TITRATION PK	T3	PA QL (1/28 Days) HD
XCOPRI 150 MG TABLET	T3	PA QL (1/Day) HD
XCOPRI 150-200 MG TITRATION PK	T3	PA QL (1/28 Days) HD
XCOPRI 200 MG TABLET	T3	PA QL (2/Day) HD
XCOPRI 250 MG DAILY DOSE PACK	T3	PA QL (1/28 Days) HD
XCOPRI 350 MG DAILY DOSE PACK	T3	PA QL (1/28 Days) HD
XCOPRI 50 MG TABLET	T3	PA QL (1/Day) HD
XCOPRI 50-100 MG TITRATION PAK	T3	PA QL (1/28 Days) HD
ZARONTIN ( <i>ethosuximide</i> )	T3	PA HD
<i>zonisamide</i>	T1	HD
<b>CNS DRUGS (Sleep Disorders/Sedatives)</b>		
<b>NARCOLEPSY TX-H3-RECEPT.ANTAGONIST/INVERSE AGONIST</b>		
WAKIX	T3	PA QL (2 tabs/day) SP HD
<b>COLONY STIMULATING FACTORS (Blood Modifiers/Bleeding Disorders)</b>		
<b>ERYTHROPOIESIS-STIMULATING AGENTS</b>		
PROCRIIT	T4	PA SP
RETACRIIT	T4	PA SP
<b>LEUKOCYTE (WBC) STIMULANTS</b>		
FULPHILA	T4	PA SP
GRANIX	T4	PA SP

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

T4 – Injectable Specialty Medications

PA – Prior Authorization

QL – Quantity Limit

ST – Step Therapy

AGE – Age Requirement

SP – Specialty Medication

HD – May require home delivery pharmacy

PPACA – No Cost-Share Preventive Medication

CSL – Oral cancer medication subject to cost-share limits



## List of Prescription Medications

### COLONY STIMULATING FACTORS (Blood Modifiers/Bleeding Disorders) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
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#### LEUKOCYTE (WBC) STIMULANTS (cont.)

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

#### THROMBOPOIETIN RECEPTOR AGONISTS

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

### CONTRACEPTIVES (Contraception Products)

#### CONTRACEPTIVES, INTRAVAGINAL, SYSTEMIC

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

#### CONTRACEPTIVES, IMPLANTABLE

NEXPLANON	T4	SP PPACA
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#### CONTRACEPTIVES, INJECTABLE

DEPO-PROVERA ( <i>medroxyprogesterone acetate</i> )	T3	
DEPO-PROVERA 150 MG/ML SYRINGE ( <i>medroxyprogesterone acetate</i> )	T3	
DEPO-PROVERA 150 MG/ML VIAL ( <i>medroxyprogesterone acetate</i> )	T3	
DEPO-SUBQ PROVERA 104	T2	

#### CONTRACEPTIVES, ORAL

<i>desogestrel-ethinyl estradiol</i>	T1	HD PPACA
<i>drospir/eth estra/levomefol ca</i> (Beyaz)	T1	HD PPACA
ELLA	T3	HD PPACA
ESTROSTEP FE ( <i>tri-legest fe</i> )	T3	HD
<i>ethinyl estradiol/drospirenone</i> (Yasmin 28)	T1	HD PPACA
<i>drospir/eth estra/levomefol ca</i> (Safyral)	T1	HD PPACA

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

T4 – Injectable Specialty Medications

PA – Prior Authorization

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ST – Step Therapy

AGE – Age Requirement

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## List of Prescription Medications

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

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

T4 – Injectable Specialty Medications

PA – Prior Authorization

QL – Quantity Limit

ST – Step Therapy

AGE – Age Requirement

SP – Specialty Medication

HD – May require home delivery pharmacy

PPACA – No Cost-Share Preventive Medication

CSL – Oral cancer medication subject to cost-share limits

## List of Prescription Medications

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

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

T4 – Injectable Specialty Medications

PA – Prior Authorization

QL – Quantity Limit

ST – Step Therapy

AGE – Age Requirement

SP – Specialty Medication

HD – May require home delivery pharmacy

PPACA – No Cost-Share Preventive Medication

CSL – Oral cancer medication subject to cost-share limits

## List of Prescription Medications

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

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>OPIOID ANTI-TUSSIVE-1ST GENERATION ANTIHISTAMINE</b>		
<i>hydrocodone/chlorphen p-stirex</i>	T1	PA
<i>promethazine-codeine solution</i>	T1	PA QL (480ml/22 days)
<i>promethazine-codeine syrup</i>	T1	PA QL (480ml/30 days)
TUXARIN ER	T3	PA QL (2 tabs/day)
TUZISTRA XR	T3	PA QL (960ml/30 days)
<b>OPIOID ANTI-TUSSIVE-ANTI-CHOLINERGIC COMBINATIONS</b>		
HYCODAN (hydromet)	T3	PA QL (480ml/22 days)
<i>hydrocodone bit/homatrop me-br</i> (Hycodan)	T1	PA QL (480ml/22 days)
<i>hydrocodone-homatropine 5-1.5</i>	T1	PA QL (180 tabs/30 days)
<i>hydrocodone-homatropine soln</i> (Hycodan)	T1	PA QL (480ml/30 days)
HYDROCODONE-HOMATROPINE SYRUP	T1	PA QL (480ml/30 days)
<b>OPIOID ANTI-TUSSIVE-EXPECTORANT COMBINATION</b>		
HYDROCODONE-GUAIFENESIN	T1	PA QL (960ml/30 days)
OBREDON	T3	PA QL (960ml/30 days)
<b>DIAGNOSTIC (Miscellaneous)</b>		
<b>DIAGNOSTIC PREPARATIONS, MISCELLANEOUS</b>		
ADVANCED DNA MEDICATED COLLECT	T3	
ARIDOL	T3	
GLUCAGEN	T2	
<i>lidocaine hcl/glycerin</i> (Advanced Dna Medicated Collect)	T1	
PROVOCHOLINE	T3	
TC99M SULFUR COLLOID PREP	T1	
<b>EYE DIAGNOSTIC AGENTS</b>		
<i>fluorescein sodium</i>	T1	
<i>ful-glo 1 mg oph strip</i>	T1	
FUL-GLO EYE STRIPS	T3	
<i>lissamine green</i>	T1	
<b>GASTROINTESTINAL RADIOPAQUE DIAGNOSTICS</b>		
ENTERO VU	T3	
E-Z DISK	T3	
E-Z-HD	T3	
E-Z-PAQUE	T3	
E-Z-PASTE	T3	

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

T4 – Injectable Specialty Medications

PA – Prior Authorization

QL – Quantity Limit

ST – Step Therapy

AGE – Age Requirement

SP – Specialty Medication

HD – May require home delivery pharmacy

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## List of Prescription Medications

DIAGNOSTIC (Miscellaneous) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>GASTROINTESTINAL RADIOPAQUE DIAGNOSTICS (cont.)</b>		
GASTROMARK	T3	
LIQUID E-Z PAQUE	T3	
LIQUID POLIBAR PLUS	T3	
NEULUMEX	T3	
POLIBAR ACB	T3	
READI-CAT 2	T3	
SITZMARKS	T3	
TAGITOL V	T3	
VARIBAR HONEY	T3	
VARIBAR NECTAR	T3	
VARIBAR PUDDING	T3	
VARIBAR THIN HONEY	T3	
VARIBAR THIN LIQUID	T3	
<b>METABOLIC FUNCTION DIAGNOSTICS</b>		
METOPIRONE	T3	
<b>RADIOPHARMACEUTICALS ELEMENTS</b>		
INDICLOR	T3	
<b>URINARY TRACT RADIOPAQUE DIAGNOSTICS</b>		
CYSTO-CONRAY II	T3	
CYSTOGRAFIN	T3	
CYSTOGRAFIN-DILUTE	T3	
<i>diatrizoate meglumine, sodium</i> (Gastrografin)	T1	
GASTROGRAFIN ( <i>md-gastroview</i> )	T3	
<b>DIURETICS (Diuretics)</b>		
<b>ARGININE VASOPRESSIN (AVP) RECEPTOR ANTAGONISTS</b>		
TOLVAPTAN 15 MG TABLET	T3	SP
<i>tolvaptan 30 mg tablet</i> (Samsca)	T1	SP
<b>CARBONIC ANHYDRASE INHIBITORS</b>		
<i>acetazolamide</i>	T1	HD
<i>methazolamide</i>	T1	HD
<b>LOOP DIURETICS</b>		
<i>bumetanide</i>	T1	HD
FUROSCIX	T3	QL(2 kits/30 days) HD
<i>furosemide</i>	T1	HD
<i>furosemide</i> (Lasix)	T1	HD
<i>torseamide</i>	T1	HD

T2 – Typically Preferred Brands PA – Prior Authorization  
T3 – Typically Non-Preferred Brands QL – Quantity Limit

AGE – Age Requirement  
SP – Specialty Medication

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

## List of Prescription Medications

### DIURETICS (Diuretics) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>POLYCYSTIC KIDNEY DISEASE AGENT, AVP RECEPT. ANTAG</b>		
JYNARQUE 15 MG TABLET	T3	SP
JYNARQUE 15 MG-15 MG TABLET	T3	PA SP
JYNARQUE 30 MG TABLET	T3	SP
JYNARQUE 30 MG-15 MG TABLET	T3	PA SP
JYNARQUE 60 MG-30 MG TABLET	T3	PA SP
JYNARQUE 90 MG-30 MG TABLET	T3	PA SP
<b>POTASSIUM SPARING DIURETICS</b>		
<i>amiloride hcl</i>	T1	HD
CAROSPIR SUSP	T2	PA HD
CAROSPIR ( <i>spironolactone</i> )	T2	PA HD
<i>eplerenone</i> (Inspra)	T1	HD
INSPRA ( <i>eplerenone</i> )	T3	HD
KERENDIA	T2	PA QL (30 tabs/30 days)
<i>spironolactone</i> (Carospir)	T1	HD
<i>spironolactone</i> (Aldactone)	T1	HD
<i>spironolact/hydrochlorothiazid</i>	T1	HD
<i>triamterene</i> (Dyrenium)	T1	HD
<b>POTASSIUM SPARING DIURETICS IN COMBINATION</b>		
ALDACTAZIDE	T3	HD
ALDACTAZIDE ( <i>spironolactone-hctz</i> )	T3	HD
<i>amiloride/hydrochlorothiazide</i>	T1	HD
DYAZIDE ( <i>triamterene-hydrochlorothiazid</i> )	T3	HD
MAXZIDE ( <i>triamterene-hydrochlorothiazid</i> )	T3	HD
MAXZIDE-25 MG ( <i>triamterene-hydrochlorothiazid</i> )	T3	HD
<b>POTASSIUM SPARING DIURETICS IN COMBINATION</b>		
<i>spironolact/hydrochlorothiazid</i> (Aldactazide)	T1	HD
<i>triamterene/hydrochlorothiazid</i> (Dyazide)	T1	HD
<i>triamterene/hydrochlorothiazid</i> (Maxzide)	T1	HD
<i>triamterene/hydrochlorothiazid</i> (Maxzide-25 Mg)	T1	HD
<b>THIAZIDE AND RELATED DIURETICS</b>		
<i>chlorthalidone</i>	T1	HD
DIURIL	T3	HD
<i>hydrochlorothiazide</i>	T1	HD
<i>indapamide</i>	T1	HD
<i>metolazone</i>	T1	HD

T1 – Typically Generics

T4 – Injectable Specialty Medications

ST – Step Therapy

HD – May require home delivery pharmacy

T2 – Typically Preferred Brands

PA – Prior Authorization

AGE – Age Requirement

PPACA – No Cost-Share Preventive Medication

T3 – Typically Non-Preferred Brands

QL – Quantity Limit

SP – Specialty Medication

CSL – Oral cancer medication subject to cost-share limits

## List of Prescription Medications

EENT PREPS (Allergy/Nasal Sprays)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>NASAL ANTIHISTAMINE</b>		
<i>azelastine 0.1% (137 mcg) spray</i>	T1	HD
<i>azelastine 0.15% nasal spray</i>	T1	HD
<i>olopatadine 665 mcg nasal spray (Patanase)</i>	T1	HD
PATANASE ( <i>olopatadine hcl</i> )	T3	HD
<b>NASAL ANTIHISTAMINE AND ANTI-INFLAM. STEROID COMB.</b>		
<i>azelastine/fluticasone</i>	T1	HD
<b>NASAL ANTI-INFLAMMATORY STEROIDS</b>		
<i>flunisolide</i>	T1	HD
<i>fluticasone prop 50 mcg spray</i>	T1	HD
<i>mometasone furoate 50 mcg spray</i>	T1	QL (4 bots/30 days) HD
<b>NOSE PREPARATIONS, MISCELLANEOUS (RX)</b>		
<i>ipratropium bromide</i>	T1	HD
<b>NOSE PREPARATIONS, VASOCONSTRICTORS (RX)</b>		
ADRENALIN CHLORIDE	T3	
<i>epinephrine hcl (Adrenalin Chloride)</i>	T1	
<b>EENT PREPS (Ear Medications)</b>		
<b>EAR PREPARATIONS ANTI-INFLAMMATORY</b>		
DERMOTIC ( <i>fluocinolone acetonide oil</i> )	T3	
<i>fluocinolone acetonide oil (Dermotic)</i>	T1	
<b>EAR PREPARATIONS, MISC. ANTI-INFECTIVES</b>		
<i>hydrocortisone/acetic acid</i>	T1	
<b>EENT PREPS (Eye Conditions)</b>		
<b>ARTIFICIAL TEARS</b>		
LACRISERT	T3	
<b>EYE ANTI-INFECTIVES (RX ONLY)</b>		
BETADINE	T3	
<b>EYE ANTI-INFLAMMATORY AGENTS</b>		
ACULAR ( <i>ketorolac tromethamine</i> )	T3	
ACULAR LS ( <i>ketorolac tromethamine</i> )	T3	
ACUVAIL	T3	
ALREX	T3	
ALREX ( <i>loteprednol etabonate</i> )	T3	
<i>bromfenac sodium</i>	T1	
<i>bromfenac sodium (Bromsite)</i>	T1	

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

T4 – Injectable Specialty Medications

PA – Prior Authorization

QL – Quantity Limit

ST – Step Therapy

AGE – Age Requirement

SP – Specialty Medication

HD – May require home delivery pharmacy

PPACA – No Cost-Share Preventive Medication

CSL – Oral cancer medication subject to cost-share limits

## List of Prescription Medications

EENT PREPS (Eye Conditions) (cont.)			
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits	
<b>EYE ANTI-INFLAMMATORY AGENTS (cont.)</b>			
BROMSITE ( <i>bromfenac sodium</i> )	T2		
BROMSITE .075%	T2		
<i>dexamethasone sodium phosphate</i>	T1		
<i>diclofenac 0.1% eye drops</i>	T1		
EYSUVIS	T2	QL (8.3ml/14 days)	
FLAREX	T2		
<i>fluorometholone (Fml)</i>	T1		
<i>flurbiprofen sodium</i>	T1		
ILEVRO	T3		
INVELTYS 1% EYE DROP	T2		
<i>ketorolac 0.4% ophth solution (Acular Ls)</i>	T1		
<i>ketorolac 0.5% ophth solution (Acular)</i>	T1		
<i>loteprednol etabonate (Alrex)</i>	T1		
LOTEMAX SM 0.38% OPHTH GEL	T2		
<i>loteprednol etabonate (Lotemax)</i>	T1		
OMNIPRED ( <i>prednisolone acetate</i> )	T3		
<i>prednisolone acetate (Pred Forte)</i>	T1		
<i>prednisolone sodium phosphate</i>	T1		
PROLENSA	T3		
<b>EYE LOCAL ANESTHETICS</b>			
AKTEN	T3		
ALCAINE ( <i>proparacaine hcl</i> )	T3		
ALTAFLUOR BENOX ( <i>flurox</i> )	T3		
<i>benoxinate hcl/fluorescein sod (Altafluor Benox)</i>	T1		
<i>benoxinate hcl/fluorescein sod (Altafluor Benox)</i>	T3		
<i>proparacaine hcl (Alcaine)</i>	T1		
<i>proparacaine/fluorescein sod</i>	T1		
<i>proparacaine/fluorescein sod</i>	T3		
<i>tetracaine hcl</i>	T1		
TETRAVISC	T3		
TETRAVISC FORTE	T3		
<b>EYE MAST CELL STABILIZERS</b>			
<i>cromolyn 4% eye drops</i>	T1		
<b>EYE PREPARATIONS, MISCELLANEOUS (OTC)</b>			
GELFILM	T3		

T1 – Typically Generics

T4 – Injectable Specialty Medications

ST – Step Therapy

HD – May require home delivery pharmacy

T2 – Typically Preferred Brands

PA – Prior Authorization

AGE – Age Requirement

PPACA – No Cost-Share Preventive Medication

T3 – Typically Non-Preferred Brands

QL – Quantity Limit

SP – Specialty Medication

CSL – Oral cancer medication subject to cost-share limits



## List of Prescription Medications

EENT PREPS (Eye Conditions) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>EYE VASOCONSTRICTORS</b>		
<i>phenylephrine hcl</i>	T1	
<b>MIOTICS AND OTHER INTRAOCULAR PRESSURE REDUCERS</b>		
<i>apraclonidine hcl</i> (Iopidine)	T1	HD
<i>betaxolol hcl</i>	T1	HD
BETIMOL	T3	HD
BETOPTIC S	T2	HD
BETOPTIC S 0.25% DROPS	T2	HD
<i>bimatoprost</i>	T1	QL (10 gm/30 days) HD
<i>bimatoprost 0.03% eye drops</i>	T1	QL(10 mls/30 days) HD
<i>brimonidine tartrate</i>	T1	HD
<i>brimonidine tartrate</i> (Alphagan P)	T1	HD
<i>brimonidine tartrate/timolol</i> (Combigan)	T1	HD
<i>brinzolamide</i> (Azopt)	T1	HD
<i>carteolol hcl</i>	T1	HD
COMBIGAN	T2	HD
<i>dorzolamide hcl</i> (Trusopt)	T1	HD
<i>dorzolamide hcl/timolol maleat</i> (Cosopt)	T1	HD
<i>dorzolamide/timolol/pf</i> (Cosopt Pf)	T1	HD
IOPIDINE	T3	HD
ISOPTO CARPINE ( <i>pilocarpine hcl</i> )	T3	HD
<i>latanoprost</i>	T1	HD
<i>levobunolol hcl</i>	T1	HD
PHOSPHOLINE IODIDE	T3	HD
<i>pilocarpine hcl</i> (Isopto Carpine)	T1	HD
RHOPRESSA	T3	HD
ROCKLATAN	T3	HD
SIMBRINZA	T2	HD
<i>timolol maleate</i> (Istalol)	T1	HD
<i>timolol maleate</i> (Timoptic)	T1	HD
<i>timolol maleate</i> (Timoptic-xe)	T1	HD
<i>timolol maleate/pf</i> (Timoptic Ocudose)	T1	HD
<i>travoprost</i>	T1	HD
<b>MYDRIATICS</b>		
<i>atropine sulfate</i>	T1	HD
<i>atropine sulfate</i> (Isopto Atropine)	T1	HD

T1 – Typically Generics

T4 – Injectable Specialty Medications

ST – Step Therapy

HD – May require home delivery pharmacy

T2 – Typically Preferred Brands

PA – Prior Authorization

AGE – Age Requirement

PPACA – No Cost-Share Preventive Medication

T3 – Typically Non-Preferred Brands

QL – Quantity Limit

SP – Specialty Medication

CSL – Oral cancer medication subject to cost-share limits

## List of Prescription Medications

EENT PREPS (Eye Conditions) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>MYDRIATICS (cont.)</b>		
CYCLOGYL	T3	HD
CYCLOGYL (cyclopentolate hcl)	T3	HD
CYCLOMYDRIL	T3	HD
cyclopentolate hcl (Cyclogyl)	T1	HD
homatropine hbr	T1	HD
MYDRIACYL (tropicamide)	T3	HD
PAREMYD	T3	HD
tropicamide	T1	HD
tropicamide (Mydriacyl)	T1	HD
<b>OPHTHALMIC ANTI-FIBROTIC AGENTS</b>		
MITOSOL	T3	
<b>OPHTHALMIC ANTI-INFLAMMATORY IMMUNOMODULATOR-TYPE</b>		
RESTASIS	T2	HD
VEVYE	T3	QL HD
<b>OPHTHALMIC CYSTINE DEPLETING AGENTS</b>		
CYSTADROPS	T3	PA QL (20ml/21 days) SP
CYSTARAN	T3	PA QL (120ml/28 days) SP
<b>OPHTHALMIC HUMAN NERVE GROWTH FACTOR (HNGF)</b>		
OXERVATE	T3	PA SP HD
ELECT/CALORIC/H2O (Cholesterol Medications)		
<b>ORAL LIPID SUPPLEMENTS</b>		
DOJOLVI	T3	PA SP HD
ELECT/CALORIC/H2O (Dental Products)		
<b>FLUORIDE PREPARATIONS</b>		
FLUORIDEX	T1	
FLUORIDEX SENSITIVITY RELIEF	T3	
PREVIDENT	T3	
PREVIDENT (sodium fluoride)	T3	
PREVIDENT 5000	T3	
PREVIDENT 5000 ENAMEL PROTECT	T3	
PREVIDENT 5000 ORTHO DEFENSE	T3	
PREVIDENT 5000 PLUS (sodium fluoride 5000 plus)	T3	
PREVIDENT 5000 SENSITIVE	T3	
sodium fluoride/potassium nit (Prevident 5000 Sensitive)	T1	

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

T4 – Injectable Specialty Medications

PA – Prior Authorization

QL – Quantity Limit

ST – Step Therapy

AGE – Age Requirement

SP – Specialty Medication

HD – May require home delivery pharmacy

PPACA – No Cost-Share Preventive Medication

CSL – Oral cancer medication subject to cost-share limits

## List of Prescription Medications

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

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>AGENTS TO TREAT HYPOGLYCEMIA (HYPERGLYCEMICS)</b>		
BAQSIMI 3 MG SPRAY ONE PACK	T2	QL (2 units/30 days)
BAQSIMI 3 MG SPRAY TWO PACK	T2	QL (2 units/30 days)
<i>diazoxide</i> (Proglycem)	T1	
<i>glucagon 1 mg emergency kit</i>	T1	QL (2 pens/30 days)
GLUCAGON 1 MG EMERGENCY KIT	T3	QL (2 pens/30 days)
PROGLYCEM ( <i>diazoxide</i> )	T3	
BAQSIMI	T2	QL (2/30 days)
<i>diazoxide</i> (Proglycem)	T1	
<i>glucagon 1 mg emergency kit</i>	T1	QL (2 pens/30 days)
GLUCAGON 1 MG EMERGENCY KIT	T3	QL (2 pens/30 days)
PROGLYCEM ( <i>diazoxide</i> )	T3	
BAQSIMI	T2	QL (2/30 days)
<i>diazoxide</i> (Proglycem)	T1	
<i>glucagon 1 mg emergency kit</i>	T1	QL (2 pens/30 days)
GLUCAGON 1 MG EMERGENCY KIT	T3	QL (2 pens/30 days)
PROGLYCEM ( <i>diazoxide</i> )	T3	
BAQSIMI	T2	QL (2/30 days)
<i>diazoxide</i> (Proglycem)	T1	
<i>glucagon 1 mg emergency kit</i>	T1	QL (2 pens/30 days)
GLUCAGON 1 MG EMERGENCY KIT	T3	QL (2 pens/30 days)
PROGLYCEM ( <i>diazoxide</i> )	T3	
BAQSIMI	T2	QL (2/30 days)
<i>diazoxide</i> (Proglycem)	T1	
<i>glucagon 1 mg emergency kit</i>	T1	QL (2 pens/30 days)
GLUCAGON 1 MG EMERGENCY KIT	T3	QL (2 pens/30 days)
PROGLYCEM ( <i>diazoxide</i> )	T3	

### ELECT/CALORIC/H2O (Miscellaneous)

#### NUCLEIC ACID/NUCLEOTIDE SUPPLEMENTS

XURIDEN	T3	PA SP
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### ELECT/CALORIC/H2O (Nutritional/Dietary)

#### ELECTROLYTE DEPLETERS

AURYXIA	T3	QL (12 tabs/day)
<i>calcium acetate</i>	T1	
<i>lanthanum carbonate</i> (Fosrenol)	T1	
LOKELMA	T2	
PHOSLYRA	T3	
<i>sevelamer carbonate</i> (Renvela)	T1	
<i>sevelamer hcl</i>	T1	
<i>sevelamer hcl</i> (Renagel)	T1	

T1 – Typically Generics

T4 – Injectable Specialty Medications

ST – Step Therapy

HD – May require home delivery pharmacy

T2 – Typically Preferred Brands

PA – Prior Authorization

AGE – Age Requirement

PPACA – No Cost-Share Preventive Medication

T3 – Typically Non-Preferred Brands

QL – Quantity Limit

SP – Specialty Medication

CSL – Oral cancer medication subject to cost-share limits

# List of Prescription Medications

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

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>ELECTROLYTE DEPLETERS (cont.)</b>		
<i>sodium polystyrene sulfon/sorb</i>	T1	
<i>sodium polystyrene sulfonate</i>	T1	
<i>sps 15 gm/60 ml suspension</i>	T1	
<i>sps 30 gm/120 ml enema susp</i>	T3	
VELPHORO	T2	
VELTASSA	T2	
PHOSLYRA	T3	
<i>sevelamer carbonate (Renvela)</i>	T1	
<i>sevelamer hcl</i>	T1	
<i>sevelamer hcl (Renagel)</i>	T1	
<i>sodium polystyrene sulfon/sorb</i>	T1	
<i>sodium polystyrene sulfonate</i>	T1	
<i>sps 15 gm/60 ml suspension</i>	T1	
<i>sps 30 gm/120 ml enema susp</i>	T3	
VELPHORO	T2	
VELTASSA	T2	
<b>IODINE CONTAINING AGENTS</b>		
<i>potassium iodide/iodine</i>	T1	
SSKI	T1	
<b>IRON REPLACEMENT</b>		
<i>mv-mins no.73/iron fum/folic (Hemocyte Plus)</i>	T1	
CITRANATAL BLOOM	T3	
<b>POTASSIUM REPLACEMENT</b>		
EFFER-K 10 MEQ TABLET EFF	T3	
EFFER-K 20 MEQ TABLET EFF	T3	
<i>effe-r-k 25 meq tablet eff</i>	T1	
<i>klor-con 10 meq tablet (K-tab Er)</i>	T1	
<i>klor-con 10 meq tablet (K-tab Er)</i>	T3	
<i>klor-con 8 meq tablet</i>	T1	
<i>klor-con 8 meq tablet</i>	T3	
K-TAB ER ( <i>potassium chloride</i> )	T3	
<i>potassium bicarbonate/cit ac</i>	T1	
<i>potassium chloride</i>	T1	
<i>potassium chloride (K-tab Er)</i>	T1	

T1 – Typically Generics

T4 – Injectable Specialty Medications

ST – Step Therapy

HD – May require home delivery pharmacy

T2 – Typically Preferred Brands

PA – Prior Authorization

AGE – Age Requirement

PPACA – No Cost-Share Preventive Medication

T3 – Typically Non-Preferred Brands

QL – Quantity Limit

SP – Specialty Medication

CSL – Oral cancer medication subject to cost-share limits

## List of Prescription Medications

ELECT/CALORIC/H2O (Urinary Tract Conditions)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>DIALYSIS SOLUTIONS</b>		
PRISMASOL	T3	
<b>URINARY PH MODIFIERS</b>		
K-PHOS NO.2	T3	HD
K-PHOS ORIGINAL	T3	HD
ORACIT	T3	HD
<i>potassium citrate</i> (Urocit-k)	T1	HD
<i>potassium citrate/citric acid</i>	T1	HD
RENACIDIN	T3	HD
UROCI-K ( <i>potassium citrate er</i> )	T3	HD
UROQID-ACID NO.2	T3	HD
<b>GASTROINTESTINAL (Cholesterol Medications)</b>		
<b>LIPOTROPICS</b>		
<i>icosapent ethyl</i> (Vascepa)	T1	HD
<i>omega-3 acid ethyl esters</i> (Lovaza)	T1	HD
VASCEPA	T2	PA HD
<b>GASTROINTESTINAL (Gastrointestinal/Heartburn)</b>		
<b>AMMONIA INHIBITORS</b>		
<i>lactulose</i>	T1	HD
<i>lactulose 10 gm/15 ml solution</i>	T1	HD
LITHOSTAT	T3	HD
<i>sodium phenylbutyrate</i> (Buphenyl)	T1	SP HD
<b>ANTI-CHOLINERGICS, QUATERNARY AMMONIUM</b>		
<i>chlordiazepoxide/clidinium br</i>	T1	
CUVPOSA	T3	
GLYCATE	T3	
<i>glycopyrrolate</i> (Glycate)	T1	
<i>glycopyrrolate</i> (Robinul Forte)	T1	
<i>glycopyrrolate</i> (Robinul)	T1	
PHEBURANE	T2	PA QL(8 Bottles/30 Days) SP HD
<i>propantheline bromide</i>	T1	
ROBINUL ( <i>glycopyrrolate</i> )	T3	
ROBINUL FORTE ( <i>glycopyrrolate</i> )	T3	
OLPRUVA	T3	PA SP HD

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

T4 – Injectable Specialty Medications

PA – Prior Authorization

QL – Quantity Limit

ST – Step Therapy

AGE – Age Requirement

SP – Specialty Medication

HD – May require home delivery pharmacy

PPACA – No Cost-Share Preventive Medication

CSL – Oral cancer medication subject to cost-share limits

## List of Prescription Medications

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

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

T4 – Injectable Specialty Medications

PA – Prior Authorization

QL – Quantity Limit

ST – Step Therapy

AGE – Age Requirement

SP – Specialty Medication

HD – May require home delivery pharmacy

PPACA – No Cost-Share Preventive Medication

CSL – Oral cancer medication subject to cost-share limits

## List of Prescription Medications

GASTROINTESTINAL (Gastrointestinal/Heartburn) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>ANTI-EMETIC/ANTI-VERTIGO AGENTS (cont.)</b>		
<i>ondansetron</i>	T1	
<i>ondansetron hcl</i>	T1	
<i>ondansetron hcl/pf</i>	T1	
<i>prochlorperazine (Compazine)</i>	T1	
<i>prochlorperazine maleate (Compazine)</i>	T1	
<i>promethazine hcl</i>	T1	
<i>promethazine hcl</i>	T3	
SANCUSO	T3	PA QL (4 patches/30 days)
<i>scopolamine (Transderm-scop)</i>	T1	
TIGAN ( <i>trimethobenzamide hcl</i> )	T3	
TRANSDERM-SCOP ( <i>scopolamine</i> )	T3	
<i>trimethobenzamide hcl (Tigan)</i>	T1	
VARUBI	T3	PA QL (4 tabs/28 days)
<b>ANTI-ULCER PREPARATIONS</b>		
CARAFATE ( <i>sucralfate</i> )	T3	HD
CYTOTEC ( <i>misoprostol</i> )	T3	HD
<i>misoprostol (Cytotec)</i>	T1	HD
<i>sucralfate (Carafate)</i>	T1	HD
<b>ANTI-ULCER-H.PYLORI AGENTS</b>		
<i>bismuth/metronid/tetracycline (Pylera)</i>	T1	
<i>lansoprazole/amoxicilin/clarith</i>	T1	
<b>BELLADONNA ALKALOIDS</b>		
<i>methscopolamine bromide</i>	T1	HD
NULEV ( <i>symax</i> )	T1	HD
<i>phenobarb/hyoscy/atropine/scop (Donnatal)</i>	T1	HD
<i>phenobarb/hyoscy/atropine/scop (Phenobarbital-belladonna)</i>	T1	HD
<i>phenobarbital-belladonna elixr (Donnatal)</i>	T1	HD
<i>phenobarbital-belladonna elixr (Phenobarbital-belladonna)</i>	T1	HD
PHENOBARBITAL-BELLADONNA ELIXR ( <i>phenohytr</i> )	T3	HD
SYMAX DUOTAB	T3	HD

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

T4 – Injectable Specialty Medications

PA – Prior Authorization

QL – Quantity Limit

ST – Step Therapy

AGE – Age Requirement

SP – Specialty Medication

HD – May require home delivery pharmacy

PPACA – No Cost-Share Preventive Medication

CSL – Oral cancer medication subject to cost-share limits

# List of Prescription Medications

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

T1 – Typically Generics

T4 – Injectable Specialty Medications

ST – Step Therapy

HD – May require home delivery pharmacy

T2 – Typically Preferred Brands

PA – Prior Authorization

AGE – Age Requirement

PPACA – No Cost-Share Preventive Medication

T3 – Typically Non-Preferred Brands

QL – Quantity Limit

SP – Specialty Medication

CSL – Oral cancer medication subject to cost-share limits



## List of Prescription Medications

### GASTROINTESTINAL (Gastrointestinal/Heartburn) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>IBS-C/CIC AGENTS, GUANYLATE CYCLASE-C AGONIST</b>		
TRULANCE	T2	
<b>INTEGRIN RECEPTOR ANTAGONIST, MONOCLONAL ANTIBODY</b>		
ENTYVIO	T4	PA SP HD
ENTYVIO PEN	T4	PA QL(2 pens/30 days) SP HD
<b>INTESTINAL MOTILITY STIMULANTS</b>		
<i>metoclopramide hcl</i>	T1	
<i>metoclopramide hcl (Reglan)</i>	T1	
REGLAN ( <i>metoclopramide hcl</i> )	T3	
<b>IRRITABLE BOWEL SYNDROME AGENTS, 5-HT<sub>3</sub> ANTAGONIST</b>		
<i>alosetron hcl</i>	T1	SP HD
<b>LAXATIVES AND CATHARTICS</b>		
bisac/nacl/nahco <sub>3</sub> /kcl/peg 3350	T1	PPACA
CLENPIQ	T2	PPACA
<i>lactulose</i>	T1	
<i>lactulose 10 gm/15 ml solution</i>	T1	
<i>lactulose 20 gm/30 ml solution</i>	T1	
<i>lubiprostone (Amitiza)</i>	T1	
NULYTELY	T3	PPACA
<i>peg3350/sod sul/nacl/kcl/asb/c</i>	T1	PPACA
<i>peg3350/sod sulf, bicarb, cl/kcl</i>	T1	PPACA
PREPOIK	T2	PPACA
<i>sodium chloride/nahco<sub>3</sub>/kcl/peg</i>	T1	PPACA
SUFLAVE	T2	PPACA
SUTAB	T2	PPACA
<b>LOCAL ANORECTAL NITRATE PREPARATIONS</b>		
<i>nitroglycerin 0.4% ointment</i>	T1	
RECTIV	T3	
<b>PANCREATIC ENZYMES</b>		
PANCREAZE	T2	HD
VIOKACE	T3	HD
<b>POTASSIUM-COMPETITIVE ACID BLOCKERS (PCABS)</b>		
VOQUEZNA	T3	PA QL(1 tab/day)
<b>PROTON-PUMP INHIBITORS</b>		
<i>dexlansoprazole dr 30 mg cap</i>	T1	QL(2 caps/day) HD
<i>dexlansoprazole dr 60 mg cap</i>	T1	QL(1 cap/day) HD
<i>esomeprazole dr 10 mg packet</i>	T1	QL (4 packets/day) HD

T1 – Typically Generics

T4 – Injectable Specialty Medications

ST – Step Therapy

HD – May require home delivery pharmacy

T2 – Typically Preferred Brands

PA – Prior Authorization

AGE – Age Requirement

PPACA – No Cost-Share Preventive Medication

T3 – Typically Non-Preferred Brands

QL – Quantity Limit

SP – Specialty Medication

CSL – Oral cancer medication subject to cost-share limits

## List of Prescription Medications

### GASTROINTESTINAL (Gastrointestinal/Heartburn) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>PROTON-PUMP INHIBITORS (cont.)</b>		
<i>esomeprazole dr 20 mg packet</i>	T1	QL (2 packs/day) HD
<i>esomeprazole dr 40 mg packet</i>	T1	QL (1 packet/day) HD
<i>esomeprazole dr 20 mg packet (Nexium)</i>	T1	QL(2 packs/day) HD
<i>esomeprazole dr 40 mg packet (Nexium)</i>	T1	QL(1 pack/day) HD
<i>esomeprazole mag dr 20 mg cap</i>	T1	QL(2 caps/day) HD
<i>esomeprazole mag dr 40 mg cap</i>	T1	QL(1 cap/day) HD
<i>esomeprazole sodium</i>	T1	HD
<i>lansoprazole dr 15 mg capsule</i>	T1	QL (2 caps/day) HD
<i>lansoprazole dr 30 mg capsule</i>	T1	QL (1 cap/day) HD
<i>lansoprazole odt 15 mg tablet</i>	T1	QL (2 tabs/day) HD
<i>lansoprazole odt 30 mg tablet</i>	T1	QL (30 tabs/30 days) HD
NEXIUM DR 2.5 MG PACKET	T2	QL (480 packs/30 days) HD
NEXIUM DR 5 MG PACKET	T2	QL (240 packs/30 days) HD
<i>omeppi 20 mg-1, 100 mg capsule</i>	T1	PA QL (60 caps/30 days) HD
<i>omeppi 40 mg-1, 100 mg capsule</i>	T1	PA QL (30 caps/30 days) HD
<i>omeprazole dr 10 mg capsule</i>	T1	QL (120 caps/30 days) HD
<i>omeprazole dr 20 mg capsule</i>	T1	QL (60 caps/30 days) HD
<i>omeprazole dr 40 mg capsule</i>	T1	QL (30 caps/30 days) HD
<i>omeprazole-bicarb 20-1, 100 cap</i>	T1	PA QL (60 caps/30 days) HD
<i>omeprazole-bicarb 20-1, 680 pkt</i>	T1	PA QL (60 packs/30 days) HD
<i>omeprazole-bicarb 40-1, 100 cap</i>	T1	PA QL (1 cap/day) HD
<i>omeprazole-bicarb 40-1, 680 pkt</i>	T1	PA QL (30 packs/30 days) HD
<i>pantoprazole 40 mg suspension</i>	T1	QL (1 dose/day) HD
<i>pantoprazole sod dr 20 mg tab</i>	T1	QL (2 tabs/day) HD
<i>pantoprazole sod dr 40 mg tab</i>	T1	QL (1 tab/day) HD
<i>pantoprazole sodium 40 mg vial</i>	T1	HD
<i>rabeprazole sodium</i>	T1	QL (30 tabs/30 days) HD

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

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

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

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

## List of Prescription Medications

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

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>RECTAL/LOWER BOWEL PREP., GLUCOCORT. (NON-HEMORR)</b>		
<i>budesonide 2 mg rectal foam</i>	T1	QL(2 kits/180 days)
CORTENEMA ( <i>hydrocortisone</i> )	T3	
<i>hydrocortisone</i> (Cortenema)	T1	

### HORMONES (Hormonal Agents)

#### ADRENAL STEROID INHIBITORS

ISTURISA	T3	PA QL (2 tabs/day) SP
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#### ANDROGEN/ESTROGEN PREPS FOR FEMALE SEXUAL DYSFUNC

INTRAROSA	T3	
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#### ANDROGENIC AGENTS

ANADROL-50	T3	PA
ANDRODERM	T3	PA QL (1 patch/day)
ANDROGEL 1% (25 MG/2.5 G) PKT ( <i>testosterone</i> )	T3	PA QL (150gm/30 days)
ANDROGEL 1% (50 MG/5 G) PKT ( <i>testosterone</i> )	T3	PA QL (2 packs/day)
ANDROGEL 1.62% GEL PUMP ( <i>testosterone</i> )	T3	PA QL (150gm/30 days)
ANDROGEL 1.62%(1.25G) GEL PCKT ( <i>testosterone</i> )	T3	PA QL (2 packs/day)
ANDROID ( <i>methyltestosterone</i> )	T3	
DEPO-TESTOSTERONE	T3	
DEPO-TESTOSTERONE ( <i>testosterone cypionate</i> )	T3	
METHITEST	T1	
<i>methyltestosterone</i> (Testred)	T1	
<i>oxandrolone</i>	T1	PA
<i>testosterone 1% (25mg/2.5g) pk</i> (Androgel)	T1	PA QL (150gm/30 days)
<i>testosterone 1% (50 mg/5 g) pk</i> (Testosterone)	T1	PA QL (2 packs/day)
<i>testosterone 1.62% (2.5 g) pkt</i> (Androgel)	T1	PA QL (150gm/30 days)
<i>testosterone 1.62%(1.25 g) pkt</i> (Androgel)	T1	PA QL (2 packs/day)
<i>testosterone 10 mg gel pump</i>	T1	PA QL (120 gm/30 days)
TESTOSTERONE 12.5 MG/1.25 GRAM	T1	PA QL (150gm/30 days)
<i>testosterone 12.5 mg/1.25 gram</i> (Testosterone)	T1	PA QL (150gm/30 days)
<i>testosterone 30 mg/1.5 ml pump</i>	T1	PA QL (180ml/30 days)
<i>testosterone 50 mg/5 gram gel</i>	T1	PA QL (2 tubes/day)
TESTOSTERONE 50 MG/5 GRAM PKT	T1	PA QL (2 packs/day)
<i>testosterone cypionate</i> (Depo-testosterone)	T1	
<i>testosterone enanthate</i>	T1	
TESTRED ( <i>methyltestosterone</i> )	T3	
XYOSTED	T3	PA QL(2 ml/28 days)

T1 – Typically Generics

T4 – Injectable Specialty Medications

ST – Step Therapy

HD – May require home delivery pharmacy

T2 – Typically Preferred Brands

PA – Prior Authorization

AGE – Age Requirement

PPACA – No Cost-Share Preventive Medication

T3 – Typically Non-Preferred Brands

QL – Quantity Limit

SP – Specialty Medication

CSL – Oral cancer medication subject to cost-share limits

## List of Prescription Medications

<b>HORMONES (Hormonal Agents) (cont.)</b>			
<b>Prescription Drug Name</b>	<b>Drug Tier</b>	<b>Coverage Requirements and Limits</b>	
<b>ANTI-DIURETIC AND VASOPRESSOR HORMONES</b>			
<i>desmopressin 0.01% solution</i>	T1	HD	
<i>desmopressin 10 mcg/0.1 ml spr</i>	T1	HD	
<i>desmopressin (nonrefrigerated)</i>	T1		
<i>desmopressin 0.01% solution (Ddavp)</i>	T1		
<i>desmopressin 10 mcg/0.1 ml spr (Ddavp)</i>	T1		
<i>desmopressin 40 mcg/10 ml vial (Ddavp)</i>	T1	SP	
<i>desmopressin ac 4 mcg/ml ampul (Ddavp)</i>	T1	SP	
<i>desmopressin ac 4 mcg/ml vial (Ddavp)</i>	T1	SP	
<i>desmopressin acetate</i>	T1		
<i>desmopressin acetate 0.1 mg tb (Ddavp)</i>	T1	HD	
<i>desmopressin acetate 0.2 mg tb (Ddavp)</i>	T1	HD	
NOCTIVA	T3	PA	
STIMATE	T3	SP	
<b>ESTROGEN AND PROGESTIN COMBINATIONS</b>			
BIJUVA	T3		
<b>ESTROGEN/ANDROGEN COMBINATIONS</b>			
<i>estrogen, ester/me-testosterone</i>	T1	HD	
<b>ESTROGENIC AGENTS</b>			
ACTIVELLA ( <i>mimvey lo</i> )	T3	HD	
ACTIVELLA ( <i>mimvey</i> )	T3	HD	
ALORA	T3	QL (16 patches/28 days)	HD
CLIMARA ( <i>estradiol (once weekly)</i> )	T3	HD	
CLIMARA PRO	T3	HD	
COMBIPATCH	T3	HD	
DEPO-ESTRADIOL	T3	HD	
DIVIGEL	T3	HD	
ELESTRIN	T3	HD	
ESTRACE ( <i>estradiol</i> )	T3	HD	
<i>estradiol (Climara)</i>	T1	HD	
<i>estradiol (Vivelle-dot)</i>	T1	QL (8 patches/21 days)	HD
<i>estradiol (Vivelle-dot)</i>	T1	QL (8 patches/21 days)	HD
<i>estradiol 0.5 mg tablet (Estrace)</i>	T1	HD	
<i>estradiol 1 mg tablet (Estrace)</i>	T1	HD	
<i>estradiol 2 mg tablet (Estrace)</i>	T1	HD	
<i>estradiol 0.025 mg patch(2/wk) (Minivelle)</i>	T1	QL(16 patches/28 days)	HD
T1 – Typically Generics	T4 – Injectable Specialty Medications	ST – Step Therapy	HD – May require home delivery pharmacy
T2 – Typically Preferred Brands	PA – Prior Authorization	AGE – Age Requirement	PPACA – No Cost-Share Preventive Medication
T3 – Typically Non-Preferred Brands	QL – Quantity Limit	SP – Specialty Medication	CSL – Oral cancer medication subject to cost-share limits

# List of Prescription Medications

## HORMONES (Hormonal Agents) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>ESTROGENIC AGENTS (cont.)</b>		
<i>estradiol 0.025 mg patch(2/wk)</i> (Vivelle-Dot)	T1	QL(16 patches/28 days) HD
<i>estradiol 0.0375mg patch(2/wk)</i> (Minivelle)	T1	QL(16 patches/28 days) HD
<i>estradiol 0.0375mg patch(2/wk)</i> (Vivelle-Dot)	T1	QL(16 patches/28 days) HD
<i>estradiol 0.05 mg patch (2/wk)</i> (Minivelle)	T1	QL(16 patches/28 days) HD
<i>estradiol 0.05 mg patch (2/wk)</i> (Vivelle-Dot)	T1	QL(16 patches/28 days) HD
<i>estradiol 0.075 mg patch(2/wk)</i> (Minivelle)	T1	QL(16 patches/28 days) HD
<i>estradiol 0.075 mg patch(2/wk)</i> (Vivelle-Dot)	T1	QL(16 patches/28 days) HD
<i>estradiol 0.1 mg patch (2/wk)</i> (Minivelle)	T1	QL(16 patches/28 days) HD
<i>estradiol 0.1 mg patch (2/wk)</i> (Vivelle-Dot)	T1	QL(16 patches/28 days) HD
<i>estradiol 0.1% (0.5mg) gel pkt</i> (Divigel)	T1	HD
<i>estradiol valerate</i> (Delestrogen)	T1	HD
<i>estradiol/norethindrone acet</i>	T1	HD
<i>estradiol/norethindrone acet</i> (Activella)	T1	HD
ESTROGEL	T3	HD
EVAMIST	T3	HD
FEMHRT ( <i>norethindron-ethinyl estradiol</i> )	T3	HD
MENEST	T3	HD
MENOSTAR	T3	QL (8 patches/28 days) HD
MINIVELLE ( <i>Jyllana</i> )	T3	QL (16 patches/28 days) HD
<i>norethind-eth estrad 0.5-2.5</i> (Femhrt)	T1	HD
<i>norethindrone ac-eth estradiol</i>	T1	HD
<i>norethindrone ac-eth estradiol</i> (Femhrt)	T1	HD
<i>norethin-eth estrad 1 mg-5 mcg</i>	T1	HD
PREFEST	T3	HD
PREMARIN	T2	HD
PREMPHASE	T2	HD
PREMPRO	T2	HD
VIVELLE-DOT ( <i>Jyllana</i> )	T3	QL (16 patches/28 days) HD
<b>ESTROGEN-PROGESTIN WITH ANTI-MINERALOCORTICOID COMB</b>		
ANGELIQ	T3	HD
<b>ESTROGEN-SELECTIVE ESTROGEN RECEPTOR MOD (SERM) COMB</b>		
DUAVEE	T2	
<b>GLUCOCORTICOIDS</b>		
<i>budesonide</i>	T1	PA QL (1 tab/day)

T1 – Typically Generics

T4 – Injectable Specialty Medications

ST – Step Therapy

HD – May require home delivery pharmacy

T2 – Typically Preferred Brands

PA – Prior Authorization

AGE – Age Requirement

PPACA – No Cost-Share Preventive Medication

T3 – Typically Non-Preferred Brands

QL – Quantity Limit

SP – Specialty Medication

CSL – Oral cancer medication subject to cost-share limits

## List of Prescription Medications

### HORMONES (Hormonal Agents) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>GLUCOCORTICOIDS (cont.)</b>		
<i>budesonide</i> (Entocort Ec)	T1	
CORTEF ( <i>hydrocortisone</i> )	T3	
<i>cortisone acetate</i>	T1	
<i>deflazacort</i> (Emflaza)	T1	PA SP HD
<i>dexamethasone</i>	T1	
<i>dexamethasone 1.5 mg tablet</i>	T1	
<i>dexamethasone 2 mg tablet</i>	T1	
<i>dexamethasone 4 mg tablet</i>	T1	
<i>dexamethasone 6 mg tablet</i>	T1	
EMFLAZA	T3	PA SP HD
EMFLAZA ( <i>deflazacort</i> )	T3	PA SP HD
ENTOCORT EC ( <i>budesonide ec</i> )	T3	
<i>hydrocortisone</i> (Cortef)	T1	
LOCORT	T1	
MEDROL	T3	
MEDROL ( <i>methylprednisolone</i> )	T3	
<i>methylprednisolone</i> (Medrol)	T1	
MILLIPRED 10 MG/5 ML SOLUTION ( <i>prednisolone sodium phosphate</i> )	T3	
<i>millipred 5 mg tablet</i>	T1	
ORAPRED ODT ( <i>prednisolone sodium phos odt</i> )	T3	
<i>prednisolone</i>	T1	
<i>prednisolone sodium phosphate</i>	T1	
<i>prednisolone sodium phosphate</i> (Millipred)	T1	
<i>prednisolone sodium phosphate</i> (Orapred Odt)	T1	
<i>prednisone</i>	T1	
<b>GROWTH HORMONE RELEASING HORMONE (GHRH) AND ANALOGS</b>		
EGRIFTA	T4	PA SP HD
EGRIFTA SV	T4	PA SP HD
<b>GROWTH HORMONES</b>		
GENOTROPIN	T4	PA SP HD
NORDITROPIN FLEXPRO	T4	PA SP HD
NGENLA	T4	PA SP
OMNITROPE	T4	PA SP HD
SEROSTIM	T4	PA SP HD
SKYTROFA	T4	PA SP HD
SOGROYA	T4	PA SP

T1 – Typically Generics

T4 – Injectable Specialty Medications

ST – Step Therapy

HD – May require home delivery pharmacy

T2 – Typically Preferred Brands

PA – Prior Authorization

AGE – Age Requirement

PPACA – No Cost-Share Preventive Medication

T3 – Typically Non-Preferred Brands

QL – Quantity Limit

SP – Specialty Medication

CSL – Oral cancer medication subject to cost-share limits

## List of Prescription Medications

<b>HORMONES (Hormonal Agents) (cont.)</b>			
<b>Prescription Drug Name</b>	<b>Drug Tier</b>	<b>Coverage Requirements and Limits</b>	
<b>INSULIN-LIKE GROWTH FACTOR-I (IGF-I) HORMONES</b>			
INCRELEX	T4	PA SP HD	
<b>LHRH (GNRH) AGONIST ANALOG AND PROGESTIN COMB</b>			
LUPANETA PACK	T3	PA SP HD	
<b>LHRH (GNRH) AGONIST ANALOG PITUITARY SUPPRESSANTS</b>			
LUPRON DEPOT	T4	PA SP HD	
SYNAREL	T3	PA SP HD	
<b>LHRH (GNRH) ANTAGONIST, ESTROGEN AND PROGESTIN COMB</b>			
ORIAHNN	T2	PA QL (2 capsules/day)	
<b>LHRH (GNRH) ANTAGONIST, PITUITARY SUPPRESSANT AGENTS</b>			
CETROTIDE	T4	PA SP	
<i>ganirelix acet 250 mcg/0.5 ml</i> (Ganirelix Acetate)	T4	PA SP	
GANIRELIX ACET 250 MCG/0.5 ML ( <i>ganirelix acetate</i> )	T4	PA SP	
ORILISSA 150 MG TABLET	T2	PA QL (1 tab/day)	
ORILISSA 200 MG TABLET	T2	PA QL (2 tabs/day)	
<b>LHRH (GNRH) AGNST PIT.SUP-CENTRAL PRECOCIOUS PUBERTY</b>			
FENSOLVI	T4	PA SP	
LUPRON DEPOT-PED	T4	PA SP HD	
<b>MINERALOCORTICOIDS</b>			
<i>fludrocortisone acetate</i>	T1	HD	
<b>OXYTOCICS</b>			
CERVIDIL	T3		
<i>methylergonovine maleate</i>	T1		
PREPIDIL	T3		
PROSTIN E2 VAGINAL SUPPOSITORY	T3		
<b>PITUITARY SUPPRESSIVE AGENTS</b>			
<i>cabergoline</i>	T1	QL (16 tabs/28 days) HD	
<i>danazol</i>	T1	HD	
<b>PROGESTATIONAL AGENTS</b>			
AYGESTIN ( <i>norethindrone acetate</i> )	T3	HD	
CRINONE 4% GEL	T3	PA HD	
DEPO-PROVERA 400 MG/ML VIAL	T3	HD	
<i>medroxyprogesterone 10 mg tab</i> (Provera)	T1	HD	
<i>medroxyprogesterone 2.5 mg tab</i> (Provera)	T1	HD	
<i>medroxyprogesterone 5 mg tab</i> (Provera)	T1	HD	
<i>norethindrone acetate</i> (Aygestin)	T1	HD	
<i>progesterone, micronized</i> (Prometrium)	T1	HD	

T1 – Typically Generics

T4 – Injectable Specialty Medications

ST – Step Therapy

HD – May require home delivery pharmacy

T2 – Typically Preferred Brands

PA – Prior Authorization

AGE – Age Requirement

PPACA – No Cost-Share Preventive Medication

T3 – Typically Non-Preferred Brands

QL – Quantity Limit

SP – Specialty Medication

CSL – Oral cancer medication subject to cost-share limits

## List of Prescription Medications

### HORMONES (Hormonal Agents) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>PROGESTATIONAL AGENTS (cont.)</b>		
PROMETRIUM ( <i>progesterone</i> )	T3	HD
PROVERA ( <i>medroxyprogesterone acetate</i> )	T3	HD
<b>SOMATOSTATIC AGENTS</b>		
BYNFEZIA	T4	PA SP
<i>octreotide acetate</i>	T4	PA SP HD
<i>octreotide acetate</i> (Sandostatin)	T4	PA SP HD
SANDOSTATIN ( <i>octreotide acetate</i> )	T4	PA SP HD
SANDOSTATIN LAR DEPOT	T4	PA SP
SIGNIFOR	T4	PA SP
SIGNIFOR LAR	T4	PA SP
SOMATULINE DEPOT	T4	PA SP HD
<b>VAGINAL ESTROGEN FOR SEXUAL DYSFUNCTION</b>		
IMVEXXY 10 MCG MAINTENANCE PAK	T3	QL (16/28 days) HD
IMVEXXY 10 MCG STARTER PACK	T3	QL (36/28 days) HD
IMVEXXY 4 MCG MAINTENANCE PAK	T3	QL (16/28 days) HD
IMVEXXY 4 MCG STARTER PACK	T3	QL (36/28 days) HD
<b>VAGINAL ESTROGEN PREPARATIONS</b>		
ESTRACE ( <i>estradiol</i> )	T3	HD
<i>estradiol</i> (Vagifem)	T1	QL (36 tabs/28 days) HD
<i>estradiol 0.01% cream</i> (Estrace)	T1	HD
<i>estradiol 10 mcg vaginal insrt</i> (Vagifem)	T1	QL (36 tabs/28 days) HD
ESTRING	T3	QL (2 rings/90 days) HD
FEMRING	T3	HD
PREMARIN	T2	HD
VAGIFEM ( <i>yuvaferm</i> )	T3	QL (36 tabs/28 days) HD
<b>HORMONES (Infertility)</b>		
<b>FERTILITY STIMULATING PREPARATIONS, NON-FSH</b>		
<i>clomiphene citrate</i>	T1	
<b>FOLLICLE-STIMULATING AND LUTEINIZING HORMONES</b>		
MENOPUR	T4	PA SP
<b>FOLLICLE-STIMULATING HORMONE (FSH)</b>		
FOLLISTIM AQ	T4	PA SP
GONAL-F	T4	PA SP
GONAL-F RFF	T4	PA SP
GONAL-F RFF REDI-JECT	T4	PA SP

T1 – Typically Generics

T4 – Injectable Specialty Medications

ST – Step Therapy

HD – May require home delivery pharmacy

T2 – Typically Preferred Brands

PA – Prior Authorization

AGE – Age Requirement

PPACA – No Cost-Share Preventive Medication

T3 – Typically Non-Preferred Brands

QL – Quantity Limit

SP – Specialty Medication

CSL – Oral cancer medication subject to cost-share limits



## List of Prescription Medications

<b>HORMONES (Infertility) (cont.)</b>		
<b>Prescription Drug Name</b>	<b>Drug Tier</b>	<b>Coverage Requirements and Limits</b>
<b>HUMAN CHORIONIC GONADOTROPIN (HCG)</b>		
CHORIONIC GONADOTROPIN	T3	PA SP
CHORIONIC GONAD 10,000 UNIT VL	T4	PA SP
CHORIONIC GONAD 12,000 UNIT VL	T4	SP
CHORIONIC GONAD 6,000 UNIT VL	T4	SP
NOVAREL	T4	PA SP
OVIDREL	T4	PA SP
PREGNYL	T2	PA SP
<b>PREGNANCY FACILITATING/MAINTAINING AGENT, HORMONAL</b>		
CRINONE 8% GEL	T2	
ENDOMETRIN	T2	
<b>HORMONES (Miscellaneous)</b>		
<b>LEPTIN HORMONE ANALOGS</b>		
MYALEPT	T4	PA SP HD
<b>HORMONES (Osteoporosis Products)</b>		
<b>BONE FORMATION STIM. AGENTS - PARATHYROID HORMONE</b>		
<i>teriparatide 600 mcg/2.4ml pen</i>	T1	PA QL(0.09 mls/day) SP HD
TERIPARATIDE 620 MCG/2.48 ML	T3	PA QL(0.09 mls/day) SP HD
<b>BONE RESORPTION INHIBITORS</b>		
<i>calcitonin, salmon, synthetic</i>	T1	HD
<i>ibandronate sodium</i>	T1	HD
MIACALCIN	T2	HD
<b>IMMUNOSUPPRESSANTS (Pain Relief And Inflammatory Disease)</b>		
<b>IL-23 RECEPTOR ANTAGONIST, MONOCLONAL ANTIBODY</b>		
OMVOH PEN	T4	PA QL(2 pens/28 days) SP HD
<b>INTERLEUKIN-4(IL-4) RECEPTOR ALPHA ANTAGONIST, MAB</b>		
DUPIXENT PEN	T2	PA SP HD
DUPIXENT SYRINGE	T2	PA SP HD
<b>INTERLEUKIN-6 (IL-6) RECEPTOR INHIBITORS</b>		
ACTEMRA	T4	PA QL (4 syringes/28 days) SP HD
ACTEMRA ACTPEN	T4	PA QL (4 pens/28 days) SP HD
ENSPRYNG	T4	PA SP HD
KEVZARA 150 MG/1.14 ML PEN INJ	T4	PA QL (2 pens/28 days) SP HD

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

T4 – Injectable Specialty Medications

PA – Prior Authorization

QL – Quantity Limit

ST – Step Therapy

AGE – Age Requirement

SP – Specialty Medication

HD – May require home delivery pharmacy

PPACA – No Cost-Share Preventive Medication

CSL – Oral cancer medication subject to cost-share limits

## List of Prescription Medications

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

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
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#### INTERLEUKIN-6 (IL-6) RECEPTOR INHIBITORS (cont.)

KEVZARA 150 MG/1.14 ML SYRINGE	T4	PA QL (2 syringes/28 days) SP HD
KEVZARA 200 MG/1.14 ML PEN INJ	T4	PA QL (2 pens/28 days) SP HD
KEVZARA 200 MG/1.14 ML SYRINGE	T4	PA QL (2 syringes/28 days) SP HD
KEVZARA 150 MG/1.14 ML PEN INJ	T4	PA QL (2 pens/28 days) SP HD
KEVZARA 150 MG/1.14 ML SYRINGE	T4	PA QL (2 syringes/28 days) SP HD
KEVZARA 200 MG/1.14 ML PEN INJ	T4	PA QL (2 pens/28 days) SP HD
KEVZARA 200 MG/1.14 ML SYRINGE	T4	PA QL (2 syringes/28 days) SP HD

#### MONOCLONAL ANTIBODY-HUMAN INTERLEUKIN I2/23 INHIB

STELARA 45 MG/0.5 ML SYRINGE	T4	PA QL (1 syringe/84 days) SP HD
STELARA 45 MG/0.5 ML VIAL	T4	PA QL (1 vial/84 days) SP HD
STELARA 90 MG/ML SYRINGE	T4	PA QL (1 syringe/84 days) SP HD

### IMMUNOSUPPRESSANTS (Skin Conditions)

#### TOPICAL IMMUNOSUPPRESSIVE AGENTS

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

### IMMUNOSUPPRESSANTS (Transplant Medications)

#### IMMUNOSUPPRESSIVES

ASTAGRAF XL	T3	SP HD
AZASAN	T2	SP HD
<i>azathioprine</i> (Imuran)	T1	SP HD
CELLCEPT ( <i>mycophenolate mofetil</i> )	T3	SP HD
<i>cyclosporine</i> (Sandimmune)	T1	SP HD
<i>cyclosporine, modified</i>	T1	SP HD
<i>cyclosporine, modified</i> (Neoral)	T1	SP HD
ENVARUSUS XR	T3	SP HD
<i>everolimus</i> 0.25 mg tablet (Zortress)	T1	SP HD
<i>everolimus</i> 0.5 mg tablet (Zortress)	T1	SP HD
<i>everolimus</i> 0.75 mg tablet (Zortress)	T1	SP HD
IMURAN ( <i>azathioprine</i> )	T3	SP HD
LUPKYNIS	T3	PA QL(6 caps/day) SP
<i>mycophenolate mofetil</i> (Cellcept)	T1	SP HD

T1 – Typically Generics

T4 – Injectable Specialty Medications

ST – Step Therapy

HD – May require home delivery pharmacy

T2 – Typically Preferred Brands

PA – Prior Authorization

AGE – Age Requirement

PPACA – No Cost-Share Preventive Medication

T3 – Typically Non-Preferred Brands

QL – Quantity Limit

SP – Specialty Medication

CSL – Oral cancer medication subject to cost-share limits

## List of Prescription Medications

### IMMUNOSUPPRESSANTS (Transplant Medications) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>IMMUNOSUPPRESSIVES (cont.)</b>		
MYFORTIC ( <i>mycophenolic acid</i> )	T3	SP HD
PROGRAF	T3	SP HD
PROGRAF ( <i>tacrolimus</i> )	T3	SP HD
RAPAMUNE ( <i>sirolimus</i> )	T3	SP HD
<i>sirolimus</i> (Rapamune)	T1	SP HD
<i>tacrolimus 0.5 mg capsule</i> (ir) (Prograf)	T1	SP HD
<i>tacrolimus 1 mg capsule</i> (ir) (Prograf)	T1	SP HD
<i>tacrolimus 5 mg capsule</i> (ir) (Prograf)	T1	SP HD
ZORTRESS	T3	SP HD
ZORTRESS ( <i>everolimus</i> )	T3	SP HD

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

#### DIABETIC SUPPLIES

CARESENS	T1	
CARETOUCH CONTROL SOLUTION	T1	
CEQR SIMPLICITY	T2	
CEQR SIMPLICITY INSERTER	T2	
DEXCOM G6 RECEIVER	T2	PA QL (1 syringe/365 days)
DEXCOM G6 SENSOR	T2	PA QL (3/30 days)
DEXCOM G6 TRANSMITTER	T2	PA QL (1 syringe/67 days)
DEXCOM G7 RECIEVER	T2	PA QL(1 unit/365 days)
DEXCOM G7 SENSOR	T2	PA QL(3 sensors/30 days)
EASY TOUCH BLU LINK CTRL SOLN	T1	
EASY TRAK II CONTROL SOLUTION	T1	
ENLITE SERTER	T1	
FREESTYLE LIBRE 10 DAY READER	T2	PA QL (1 reader/day)
FREESTYLE LIBRE 10 DAY SENSOR	T2	PA QL (3/30 days)
FREESTYLE LIBRE 14 DAY READER	T2	PA QL (1 reader/day)
FREESTYLE LIBRE 14 DAY SENSOR	T2	PA QL (2/28 days)
FREESTYLE LIBRE 3 READER	T2	PA QL(1 unit/720 days)
FREESTYLE LIBRE 2 READER	T2	PA QL (1 reader/day)
FREESTYLE LIBRE 2 SENSOR	T2	PA QL(2 sensors/21 days)
GLUCOCOM AUTOLINK	T1	
GUARDIAN RT CHARGER	T1	
GUARDIAN RT STARTER KIT	T1	
GUARDIAN RT SYSTEM	T1	

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

T4 – Injectable Specialty Medications

PA – Prior Authorization

QL – Quantity Limit

ST – Step Therapy

AGE – Age Requirement

SP – Specialty Medication

HD – May require home delivery pharmacy

PPACA – No Cost-Share Preventive Medication

CSL – Oral cancer medication subject to cost-share limits

## List of Prescription Medications

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

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>DIABETIC SUPPLIES (cont.)</b>		
GUARDIAN TEST PLUG	T1	
FORA TN'GO ADVANCE MULTIFN MTR	T3	
HUMAPEN LUXURA HD	T1	
INPEN (FOR HUMALOG)	T1	
INPEN (FOR NOVOLOG OR FIASP)	T1	
LITE TOUCH LANCING PEN	T1	
MOBILE LANCETS	T1	
NOVOPEN ECHO	T1	
OMNIPOD 5 (GEN 5) KIT	T2	QL (1 kit/365 days)
OMNIPOD 5 (GEN 5) PODS	T2	QL (30 pods/30 days)
OMNIPOD 5 G6-G7 INTRO KT(GEN5)	T2	QL
OMNIPOD 5 G6-G7 PODS (GEN 5)	T2	QL
OMNIPOD CLASSIC (GEN 3) KIT	T2	QL (1 kit/365 days)
OMNIPOD CLASSIC (GEN 4) KIT	T2	QL (1 kit/365 days)
OMNIPOD CLASSIC (GEN 3) PODS	T2	QL (30 pods/30 days)
OMNIPOD CLASSIC (GEN 4) PODS	T2	QL (30 pods/30 days)
OMNIPOD DASH 5 PACK POD	T2	PA QL (6 boxes/30 days)
ONETOUCH DELICA PLUS LANCET	T1	
ONETOUCH DELICA PLUS LANC DEV	T1	
ONETOUCH ULTRA CONTROL SOLN	T1	
ONETOUCH ULTRA TEST STRIP	T2	
ONETOUCH ULTRASOFT 2 LANCET	T1	
ONETOUCH VERIO HIGH CNTRL SOLN	T1	
ONETOUCH VERIO MID CNTRL SOLN	T1	
ONETOUCH VERIO TEST STRIP	T2	
PRO COMFORT SAFETY LANCET	T1	
REPLACEMENT PEDIATRIC MONITOR	T1	
SEN-SERTER	T1	
UNIFINE SAFECONTROL	T1	
V-GO 20	T2	
V-GO 30	T2	
V-GO 40	T2	
<b>DURABLE MEDICAL EQUIPMENT, MISC (GROUP I)</b>		
1ST TIER UNILET COMFORTOUCH	T1	
2-IN-1 LANCET DEVICE	T1	

T1 – Typically Generics

T4 – Injectable Specialty Medications

ST – Step Therapy

HD – May require home delivery pharmacy

T2 – Typically Preferred Brands

PA – Prior Authorization

AGE – Age Requirement

PPACA – No Cost-Share Preventive Medication

T3 – Typically Non-Preferred Brands

QL – Quantity Limit

SP – Specialty Medication

CSL – Oral cancer medication subject to cost-share limits

## List of Prescription Medications

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

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

T1 – Typically Generics

T4 – Injectable Specialty Medications

ST – Step Therapy

HD – May require home delivery pharmacy

T2 – Typically Preferred Brands

PA – Prior Authorization

AGE – Age Requirement

PPACA – No Cost-Share Preventive Medication

T3 – Typically Non-Preferred Brands

QL – Quantity Limit

SP – Specialty Medication

CSL – Oral cancer medication subject to cost-share limits

## List of Prescription Medications

EMBRACE SAFETY LANCET	T1	
EZ SMART LANCETS	T1	
EZ-LETS	T1	
FIFTY50 SAFETY SEAL LANCETS	T1	

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

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
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### DURABLE MEDICAL EQUIPMENT, MISC (GROUP I) (cont.)

FINE 30 UNIVERSAL LANCETS	T1	
FINGERSTIX	T1	
FORA LANCETS	T1	
FORACARE LANCETS	T1	
FREESTYLE LANCETS	T1	
FREESTYLE UNISTIK 2	T1	
GLUCOCOM	T1	
GLUCOCOM LANCETS	T1	
GOJJI LANCETS	T1	
HEALTHY ACCENTS UNILET LANCET	T1	
INCONTROL SUPER THIN LANCETS	T1	
INCONTROL ULTRA THIN LANCETS	T1	
INJECT EASE LANCETS	T1	
INVACARE LANCETS	T1	
LANCETS	T1	
LANCETS THIN	T1	
LANCETS ULTRA THIN	T1	
LITE TOUCH	T1	
LITE TOUCH 28G LANCETS	T1	
LITE TOUCH 30G LANCETS	T1	
LITE TOUCH 33G LANCETS	T1	
MEDISENSE THIN LANCETS	T1	
MEDLANCE PLUS	T1	
MICRO THIN LANCET	T1	
MICRO THIN LANCETS	T1	
MICROLET	T1	
MOBILE LANCETS	T1	
MONOLET LANCETS	T1	
MONOLET THIN LANCETS	T1	
MYGLUCOHEALTH LANCETS	T1	

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

T4 – Injectable Specialty Medications

PA – Prior Authorization

QL – Quantity Limit

ST – Step Therapy

AGE – Age Requirement

SP – Specialty Medication

HD – May require home delivery pharmacy

PPACA – No Cost-Share Preventive Medication

CSL – Oral cancer medication subject to cost-share limits

## List of Prescription Medications

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

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>DURABLE MEDICAL EQUIPMENT, MISC (GROUP I) (cont.)</b>		
NOVA SAFETY LANCETS	T1	
NOVA SUREFLEX	T1	
ON CALL LANCET	T1	
ON CALL PLUS LANCET	T1	
ONETOUCH DELICA PLUS LANCET	T1	
ONETOUCH DELICA SAFETY LANCET	T1	
ONETOUCH LANCETS	T1	
ONETOUCH SURESOFT	T1	
ONETOUCH ULTRASOFT 2 LANCET	T1	
ON-THE-GO	T1	
PIP LANCET	T1	
PRESSURE ACTIVATED LANCETS	T1	
PRO COMFORT LANCET	T1	
PRO COMFORT LANCETS	T1	
PRO COMFORT SAFETY LANCET	T1	
PRODIGY LANCETS	T1	
PRODIGY TWIST TOP LANCET	T1	
PURE COMFORT LANCETS	T1	
PURE COMFORT SAFETY LANCETS	T1	
PUSH BUTTON SAFETY LANCETS	T1	
READYLANCE SAFETY LANCETS	T1	
RELIAMED	T1	
RELIAMED SAFETY SEAL LANCETS	T1	
RELION THIN	T1	
RIGHTEST GL300 LANCETS	T1	
SAFETY LANCETS	T1	
SAFETY SEAL LANCETS	T1	
SAFETY-LET	T1	
SINGLE-LET	T1	
SMART SENSE	T1	
SMART SENSE LANCETS	T1	
SMARTTEST LANCET	T1	
SOFT TOUCH	T1	
SOLUS V2	T1	

T1 – Typically Generics

T4 – Injectable Specialty Medications

ST – Step Therapy

HD – May require home delivery pharmacy

T2 – Typically Preferred Brands

PA – Prior Authorization

AGE – Age Requirement

PPACA – No Cost-Share Preventive Medication

T3 – Typically Non-Preferred Brands

QL – Quantity Limit

SP – Specialty Medication

CSL – Oral cancer medication subject to cost-share limits

## List of Prescription Medications

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

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>DURABLE MEDICAL EQUIPMENT, MISC (GROUP I) (cont.)</b>		
SOLUS V2 LANCETS	T1	
STERILANCE TL	T1	
STERILE LANCETS	T1	
SUPER THIN LANCETS	T1	
SURE COMFORT LANCETS	T1	
SURE-LANCE	T1	
SURE-TOUCH	T1	
TECHLITE LANCETS	T1	
TELCARE ULTRA THIN 30G LANCETS	T1	
THIN LANCETS	T1	
TOPCARE UNIVERSAL 1 LANCET	T1	
TOPCARE UNIVERSAL 1 THIN LANCET	T1	
TRUE COMFORT LANCET	T1	
TRUE COMFORT SAFETY LANCET	T1	
TRUEPLUS LANCET	T1	
TRUEPLUS LANCETS	T1	
TWIST LANCETS	T1	
TWIST TOP LANCET	T1	
ULTILET BASIC	T1	
ULTILET CLASSIC	T1	
ULTILET LANCETS	T1	
ULTILET SAFETY	T1	
ULTRA-THIN II 28G LANCETS	T1	
ULTRA-THIN II 30G LANCETS	T1	
ULTRA THIN LANCETS	T1	
ULTRA THIN PLUS	T1	
ULTRA THIN PLUS LANCETS	T1	
ULTRA-CARE LANCETS	T1	
ULTRALANCE	T1	
ULTRA-THIN II	T1	
ULTRATLC LANCETS	T1	
UNILET COMFORTOUCH	T1	
UNILET EXCELITE	T1	
UNILET EXCELITE II	T1	

T1 – Typically Generics

T4 – Injectable Specialty Medications

ST – Step Therapy

HD – May require home delivery pharmacy

T2 – Typically Preferred Brands

PA – Prior Authorization

AGE – Age Requirement

PPACA – No Cost-Share Preventive Medication

T3 – Typically Non-Preferred Brands

QL – Quantity Limit

SP – Specialty Medication

CSL – Oral cancer medication subject to cost-share limits



## List of Prescription Medications

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

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>DURABLE MEDICAL EQUIPMENT, MISC (GROUP I) (cont.)</b>		
UNILET GP LANCET	T1	
UNILET LANCET	T1	
UNILET LANCETS	T1	
UNISTIK 2 COMFORT	T1	
UNISTIK 2 EXTRA	T1	
UNISTIK 2 NORMAL	T1	
UNISTIK 3	T1	
UNISTIK 3 COMFORT	T1	
UNISTIK 3 DUAL	T1	
UNISTIK 3 EXTRA	T1	
UNISTIK 3 NORMAL	T1	
UNISTIK COMFORT	T1	
UNISTIK CZT	T1	
UNISTIK EXTRA	T1	
UNISTIK NORMAL	T1	
UNISTIK PRO	T1	
UNISTIK SAFETY	T1	
UNISTIK TOUCH	T1	
UNIVERSAL 1	T1	
VERIFINE SAFETY LANCET MINI	T1	
VERIFINE UNIVERSAL LANCET	T1	
VIVAGUARD LANCET	T1	
UNISTIK 2 COMFORT	T1	
UNISTIK 2 EXTRA	T1	
UNISTIK 2 NORMAL	T1	
UNISTIK 3 COMFORT	T1	
UNISTIK 3 DUAL	T1	
<b>NEEDLES/NEEDLELESS DEVICES</b>		
BD NEEDLES 21GX1"	T1	
BD NEEDLES 21GX1.5"	T1	
BD NEEDLES 22GX1"	T1	
BD NEEDLES 25GX0.875"	T1	
BLUNT NEEDLE	T1	
CAREPOINT PRECISION NEEDLE	T1	
ECLIPSE NEEDLE	T1	
EMBRACE PEN NEEDLE	T1	

T1 – Typically Generics  
T2 – Typically Preferred Brands  
T3 – Typically Non-Preferred Brands  
T4 – Injectable Specialty Medications  
PA – Prior Authorization  
QL – Quantity Limit

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

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

## List of Prescription Medications

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

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>DURABLE MEDICAL EQUIPMENT, MISC (GROUP I) (cont.)</b>		
FILTER NEEDLE	T1	
HYPODERMIC NEEDLE	T1	
INSUPEN PEN NEEDLE	T1	
MONOJECT BLOOD COLLECTION NEEDLE	T1	
PEN NEEDLE	T1	
PHASEAL PROTECTOR	T1	
TERUMO SURGUARD2	T1	
VERIFINE PEN NEEDLE	T1	
<b>SYRINGES AND ACCESSORIES</b>		
ASSURE ID INSULIN SAFETY	T1	
EASY COMFORT INSULIN SYRINGE	T1	
INSULIN SYRINGE	T1	
INSULIN SYRINGE U-500	T1	
LITE TOUCH INSULIN 0.5 ML SYR	T1	
LITE TOUCH INSULIN 1 ML SYR	T1	
LITE TOUCH INSULIN SYR 0.3 ML	T1	
MAGELLAN INSULIN SAFETY SYRNG	T1	
MAGELLAN INSULIN SYRINGE	T1	
MINIMED RESERVOIR	T1	
MONOJECT	T1	
MONOJECT INSULIN SYRINGE	T1	
PARADIGM	T1	
SECURESAFE INSULIN SYRINGE	T1	
SURE COMFORT 0.3 ML SYRINGE	T1	
SURE COMFORT 0.5 ML SYRINGE	T1	
SURE COMFORT 1 ML SYRINGE	T1	
SURE COMFORT 3/10 ML SYRINGE	T1	
ULTRA-THIN II 1 ML 31GX5/16"	T1	
ULTRA-THIN II INS 0.3 ML 30G	T1	
ULTRA-THIN II INS 0.3 ML 31G	T1	
ULTRA-THIN II INS 0.5 ML 29G	T1	
ULTRA-THIN II INS 0.5 ML 30G	T1	
ULTRA-THIN II INS 0.5 ML 31G	T1	
ULTRA-THIN II INS SYR 1 ML 29G	T1	
ULTRA-THIN II INS SYR 1 ML 30G	T1	
VERIFINE INSULIN SYRINGE	T1	

LS — Typically Non-Preferred Brands QL — Quantity Limit

SP — Specialty Medication

CSL — Oral cancer medication subject to cost-share limits

# List of Prescription Medications

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

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

T1 – Typically Generics

T4 – Injectable Specialty Medications

ST – Step Therapy

HD – May require home delivery pharmacy

T2 – Typically Preferred Brands

PA – Prior Authorization

AGE – Age Requirement

PPACA – No Cost-Share Preventive Medication

T3 – Typically Non-Preferred Brands

QL – Quantity Limit

SP – Specialty Medication

CSL – Oral cancer medication subject to cost-share limits

## List of Prescription Medications

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

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>RESPIRATORY AIDS, DEVICES, EQUIPMENT (cont.)</b>		
RITEFLO	T2	QL (1 unit/year)
SILICONE MASK	T2	QL (1 unit/year)
SPACE CHAMBER	T2	QL (1 unit/year)
SPACE CHAMBER-LARGE MASK	T2	QL (1 unit/year)
SPACE CHAMBER-MEDIUM MASK	T2	QL (1 unit/year)
SPACE CHAMBER-SMALL MASK	T2	QL (1 unit/year)
UNISTIK 3 NORMAL	T1	
VORTEX	T2	QL (1 unit/year)
VORTEX HOLDING CHAMBER-CHILD	T2	QL (1 unit/year)
VORTEX HOLDING CHAMBER-TODDLER	T2	QL (1 unit/year)
VORTEX VHC FROG MASK	T2	QL (1 unit/year)
VORTEX VHC LADYBUG MASK	T2	QL (1 unit/year)

### 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

<i>baclofen 10 mg tablet</i>	T1	HD
<i>baclofen 20 mg tablet</i>	T1	HD
<i>baclofen 5 mg tablet</i>	T1	HD
<i>carisoprodol/aspirin</i>	T1	
<i>chlorzoxazone</i>	T1	
<i>cyclobenzaprine hcl</i>	T1	
<i>cyclobenzaprine hcl (Fexmid)</i>	T1	
DANTRIUM ( <i>dantrolene sodium</i> )	T3	
<i>dantrolene sodium</i>	T1	
<i>dantrolene sodium (Dantrium)</i>	T1	
FEXMID ( <i>cyclobenzaprine hcl</i> )	T3	
FLEQSUVY ( <i>baclofen</i> )	T3	HD
<i>metaxalone</i>	T1	
<i>metaxalone (Skelaxin)</i>	T1	
<i>methocarbamol</i>	T1	
<i>methocarbamol (Robaxin-750)</i>	T1	
<i>orphenadrine citrate</i>	T1	

T1 – Typically Generics

T4 – Injectable Specialty Medications

ST – Step Therapy

HD – May require home delivery pharmacy

T2 – Typically Preferred Brands

PA – Prior Authorization

AGE – Age Requirement

PPACA – No Cost-Share Preventive Medication

T3 – Typically Non-Preferred Brands

QL – Quantity Limit

SP – Specialty Medication

CSL – Oral cancer medication subject to cost-share limits

## List of Prescription Medications

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

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
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#### SKELLETAL MUSCLE RELAXANTS (cont.)

OZOBAX DS	T3	
ROBAXIN-750 (methocarbamol)	T3	
SKELAXIN (metaxalone)	T3	
SOMA (carisoprodol)	T3	
SOMA (vanadom)	T3	
tizanidine hcl	T1	
tizanidine hcl (Zanaflex)	T1	
ZANAFLEX (tizanidine hcl)	T3	

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

#### PRENATAL VITAMIN PREPARATIONS

ATABEX EC	T3	
CITRANATAL 90 DHA	T3	
CITRANATAL ASSURE	T3	
CITRANATAL DHA	T3	
CITRANATAL HARMONY	T3	
CITRANATAL RX	T3	
OBSTETRIX EC	T3	
OBTREX DHA	T3	
pnv 22/iron, gluc/folic/dss/dha	T1	
pnv 66/iron/folic/docusate/dha	T1	
pnv 69/iron/folic/docusate/dha	T1	
pnv 80/iron fum/folic/dss/dha	T1	
pnv/ferrous fum/docusate/folic	T1	
pnv/iron, carb/docusat/folic ac	T1	
prenatal 12/iron/folic/dss/om3 (Obtrex Dha)	T1	
PRENATAL 19	T1	
prenatal 34/iron/folic/dss/dha	T1	
prenatal vits 15/iron/folic/dss	T1	
VITAFOL FE+	T3	

### PSYCHOTHERAPEUTIC DRUGS (Anxiety/Depression/Bipolar Disorder)<sup>9</sup>

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

mirtazapine	T1	HD
mirtazapine (Remeron)	T1	HD

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

T4 – Injectable Specialty Medications

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AGE – Age Requirement

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PPACA – No Cost-Share Preventive Medication

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## List of Prescription Medications

### PSYCHOTHERAPEUTIC DRUGS (Anxiety/Depression/Bipolar Disorder)<sup>9</sup> (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>ANTIDEPRESSANT - POSTPARTUM DEPRESSION (PPD)</b>		
ZURZUVAE 20 MG CAPSULE	T3	PA QL(28 caps/270 days) SP HD
ZURZUVAE 25 MG CAPSULE	T3	PA QL(28 caps/270 days) SP HD
ZURZUVAE 30 MG CAPSULE	T3	PA QL(14 caps/270 days) SP HD
<b>ANTI-ANXIETY - BENZODIAZEPINES</b>		
<i>alprazolam</i>	T1	
<i>alprazolam (Xanax Xr)</i>	T1	
<i>alprazolam (Xanax)</i>	T1	
<i>chlordiazepoxide hcl</i>	T1	
<i>clorazepate dipotassium</i>	T1	
<i>clorazepate dipotassium (Tranxene T-tab)</i>	T1	
<i>diazepam 10 mg tablet (Valium)</i>	T1	
<i>diazepam 2 mg tablet (Valium)</i>	T1	
<i>diazepam 5 mg tablet (Valium)</i>	T1	
<i>diazepam 5 mg/5 ml solution</i>	T1	
<i>diazepam 5 mg/ml oral conc</i>	T1	
<i>lorazepam</i>	T1	
<i>oxazepam</i>	T1	
TRANXENET-TAB ( <i>clorazepate dipotassium</i> )	T3	
VALIUM ( <i>diazepam</i> )	T3	
XANAX ( <i>alprazolam</i> )	T3	
XANAX XR ( <i>alprazolam xr</i> )	T3	
<b>ANTI-ANXIETY DRUGS</b>		
<i>bupirone hcl 10 mg tablet</i>	T1	HD
<i>bupirone hcl 15 mg tablet</i>	T1	
<i>bupirone hcl 15 mg tablet</i>	T1	HD
<i>bupirone hcl 30 mg tablet</i>	T1	HD
<i>bupirone hcl 5 mg tablet</i>	T1	HD
<i>bupirone hcl 7.5 mg tablet</i>	T1	HD
<i>meprobamate</i>	T1	
<b>ANTIDEPRESSANT - NMDA RECEPTOR ANTAGONIST</b>		
SPRAVATO	T3	PA SP
<b>BIPOLAR DISORDER DRUGS</b>		
EQUETRO	T3	HD
<i>lithium carbonate</i>	T1	HD
<i>lithium carbonate (Lithobid)</i>	T1	HD
<i>lithium citrate</i>	T1	HD

T1 – Typically Generics

T4 – Injectable Specialty Medications

ST – Step Therapy

HD – May require home delivery pharmacy

T2 – Typically Preferred Brands

PA – Prior Authorization

AGE – Age Requirement

PPACA – No Cost-Share Preventive Medication

T3 – Typically Non-Preferred Brands

QL – Quantity Limit

SP – Specialty Medication

CSL – Oral cancer medication subject to cost-share limits

## List of Prescription Medications

PSYCHOTHERAPEUTIC DRUGS (Anxiety/Depression/Bipolar Disorder) <sup>9</sup> (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>MAOIS -NON-SELECTIVE, IRREVERSIBLE ANTI-DEPRESSANTS</b>		
MARPLAN	T3	QL (12 tabs/day)
<i>phenelzine sulfate</i> (Nardil)	T1	
<i>tranylcypromine sulfate</i>	T1	
<b>MONOAMINE OXIDASE (MAO) INHIBITOR ANTI-DEPRESSANTS</b>		
EMSAM 12 MG/24 HOURS PATCH	T3	QL (1 patch/day)
EMSAM 6 MG/24 HOURS PATCH	T3	QL (2 patches/day)
EMSAM 9 MG/24 HOURS PATCH	T3	QL (1 patch/day)
<b>NOREPINEPHRINE AND DOPAMINE REUPTAKE INHIB (NDRIs)</b>		
<i>bupropion hcl 100 mg tablet</i>	T1	QL (4 tabs/day) HD
<i>bupropion hcl 75 mg tablet</i>	T1	QL (6 tabs/day) HD
<i>bupropion hcl sr 100 mg tablet</i> (Wellbutrin Sr)	T1	QL (4 tabs/day) HD
<i>bupropion hcl sr 150 mg tablet</i> (Wellbutrin Sr)	T1	QL (2 tabs/day) HD
<i>bupropion hcl sr 200 mg tablet</i> (Wellbutrin Sr)	T1	QL (2 tabs/day) HD
<i>bupropion hcl xl 150 mg tablet</i>	T1	QL (3 tabs/day) HD
<i>bupropion hcl xl 300 mg tablet</i>	T1	QL (1 tab/day) HD
<i>bupropion hcl xl 150 mg tablet</i> (Wellbutrin XI)	T1	QL(3 tabs/day) HD
<i>bupropion hcl xl 300 mg tablet</i> (Wellbutrin XI)	T1	QL(1 tab/day) HD
WELLBUTRIN SR 100 MG TABLET ( <i>bupropion hcl sr</i> )	T3	QL (4 tabs/day) ST HD
WELLBUTRIN SR 150 MG TABLET ( <i>bupropion hcl sr</i> )	T3	QL (2 tabs/day) ST HD
WELLBUTRIN SR 200 MG TABLET ( <i>bupropion hcl sr</i> )	T3	QL (2 tabs/day) ST HD
<b>SELECTIVE SEROTONIN 5-HT<sub>2A</sub> INVERSE AGONISTS (SSiAs)</b>		
NUPLAZID	T3	PA SP HD
<b>SELECTIVE SEROTONIN REUPTAKE INHIBITOR (SSRIs)</b>		
<i>citalopram hbr 10 mg tablet</i> (Celexa)	T1	QL(6 tabs/day) HD
<i>citalopram hbr 20 mg tablet</i> (Celexa)	T1	QL(3 tabs/day) HD
<i>citalopram hbr 40 mg tablet</i> (Celexa)	T1	QL (1 tab/day) HD
<i>escitalopram 10 mg tablet</i>	T1	QL (2 tabs/day) HD
<i>escitalopram 20 mg tablet</i>	T1	QL (1 tab/day) HD
<i>escitalopram 5 mg tablet</i>	T1	QL (4 tabs/day) HD
<i>escitalopram oxalate 5 mg/5 ml</i>	T1	QL (20ml/day) HD
<i>fluoxetine 20 mg/5 ml solution</i>	T1	QL (20ml/day) HD
<i>fluoxetine hcl</i>	T1	QL (4 caps/28 days) HD
<i>fluoxetine hcl 10 mg capsule</i> (Prozac)	T1	QL (8 caps/day) HD
<i>fluoxetine hcl 10 mg tablet</i> (Sarafem)	T1	HD
<i>fluoxetine hcl 20 mg capsule</i> (Prozac)	T1	QL (4 caps/day) HD

T1 – Typically Generics

T4 – Injectable Specialty Medications

ST – Step Therapy

HD – May require home delivery pharmacy

T2 – Typically Preferred Brands

PA – Prior Authorization

AGE – Age Requirement

PPACA – No Cost-Share Preventive Medication

T3 – Typically Non-Preferred Brands

QL – Quantity Limit

SP – Specialty Medication

CSL – Oral cancer medication subject to cost-share limits

# List of Prescription Medications

## PSYCHOTHERAPEUTIC DRUGS (Anxiety/Depression/Bipolar Disorder)<sup>9</sup> (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>SELECTIVE SEROTONIN REUPTAKE INHIBITOR (SSRIs) (cont.)</b>		
<i>fluoxetine hcl 20 mg tablet</i>	T1	HD
<i>fluoxetine hcl 40 mg capsule (Prozac)</i>	T1	QL (2 caps/day) HD
<i>fluoxetine hcl 60 mg tablet</i>	T1	QL (1 tab/day) HD
<i>fluvoxamine er 100 mg capsule</i>	T1	QL (3 caps/day) HD
<i>fluvoxamine er 150 mg capsule</i>	T1	QL (2 caps/day) HD
<i>fluvoxamine maleate 100 mg tab</i>	T1	QL (3 tabs/day) HD
<i>fluvoxamine maleate 25 mg tab</i>	T1	QL (12 tabs/day) HD
<i>fluvoxamine maleate 50 mg tab</i>	T1	QL (6 tabs/day) HD
<i>paroxetine cr 12.5 mg tablet (Paxil Cr)</i>	T1	QL (1 tab/day) HD
<i>paroxetine cr 25 mg tablet (Paxil Cr)</i>	T1	QL (3 tabs/day) HD
<i>paroxetine cr 37.5 mg tablet (Paxil Cr)</i>	T1	QL (2 tabs/day) HD
<i>paroxetine er 12.5 mg tablet (Paxil Cr)</i>	T1	QL (1 tab/day) HD
<i>paroxetine er 25 mg tablet (Paxil Cr)</i>	T1	QL (3 tabs/day) HD
<i>paroxetine er 37.5 mg tablet (Paxil Cr)</i>	T1	QL (2 tabs/day) HD
<i>paroxetine hcl 10 mg tablet (Paxil)</i>	T1	QL (6 tabs/day) HD
<i>paroxetine hcl 20 mg tablet (Paxil)</i>	T1	QL (3 tabs/day) HD
<i>paroxetine hcl 30 mg tablet (Paxil)</i>	T1	QL (2 tabs/day) HD
<i>paroxetine hcl 40 mg tablet (Paxil)</i>	T1	QL (1 tab/day) HD
SARAFEM ( <i>fluoxetine hcl</i> )	T3	ST HD
<i>sertraline 20 mg/ml oral conc (Zoloft)</i>	T1	QL (10ml/day) HD
<i>sertraline hcl 100 mg tablet (Zoloft)</i>	T1	QL (2 tabs/day) HD
<i>sertraline hcl 25 mg tablet (Zoloft)</i>	T1	QL (8 tabs/day) HD
<i>sertraline hcl 50 mg tablet (Zoloft)</i>	T1	QL (4 tabs/day) HD
<b>SEROTONIN-2 ANTAGONIST/REUPTAKE INHIBITORS (SARIs)</b>		
<i>nefazodone hcl</i>	T1	HD
<i>trazodone hcl</i>	T1	HD
<b>SEROTONIN-NOREPINEPHRINE REUPTAKE-INHIB (SNRIs)</b>		
<i>desvenlafaxine succnt er 100mg</i>	T1	QL (4 tabs/day) HD
<i>desvenlafaxine succnt er 25 mg</i>	T1	QL (16 tabs/day) HD
<i>desvenlafaxine succnt er 50 mg</i>	T1	QL (1 tab/day) HD
<i>duloxetine hcl dr 20 mg cap</i>	T1	QL (6 caps/day) HD
<i>duloxetine hcl dr 30 mg cap</i>	T1	QL (4 caps/day) HD
<i>duloxetine hcl dr 40 mg cap</i>	T1	QL (3 caps/day) HD
<i>duloxetine hcl dr 60 mg cap</i>	T1	QL (2 caps/day) HD
FETZIMA 20-40 MG TITRATION PAK	T3	QL (28 caps/180 days) ST HD

T1 – Typically Generics

T4 – Injectable Specialty Medications

ST – Step Therapy

HD – May require home delivery pharmacy

T2 – Typically Preferred Brands

PA – Prior Authorization

AGE – Age Requirement

PPACA – No Cost-Share Preventive Medication

T3 – Typically Non-Preferred Brands

QL – Quantity Limit

SP – Specialty Medication

CSL – Oral cancer medication subject to cost-share limits



## List of Prescription Medications

PSYCHOTHERAPEUTIC DRUGS (Anxiety/Depression/Bipolar Disorder) <sup>9</sup> (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>SEROTONIN-NOREPINEPHRINE REUPTAKE-INHIB (SNRIs) (cont.)</b>		
FETZIMA ER 120 MG CAPSULE	T3	QL (1 cap/day) ST HD
FETZIMA ER 20 MG CAPSULE	T3	QL (6 caps/day) ST HD
FETZIMA ER 40 MG CAPSULE	T3	QL (3 caps/day) ST HD
FETZIMA ER 80 MG CAPSULE	T3	QL (1 cap/day) ST HD
venlafaxine hcl 100 mg tablet	T1	QL (3 tabs/day) HD
venlafaxine hcl 25 mg tablet	T1	QL (15 tabs/day) HD
venlafaxine hcl 37.5 mg tablet	T1	QL (10 tabs/day) HD
venlafaxine hcl 50 mg tablet	T1	QL (7 tabs/day) HD
venlafaxine hcl 75 mg tablet	T1	QL (5 tabs/day) HD
venlafaxine hcl er 150 mg cap (Effexor Xr)	T1	QL (2 caps/day) HD
venlafaxine hcl er 150 mg tab	T1	QL (2 tabs/day) HD
venlafaxine hcl er 225 mg tab	T1	QL (1 tab/day) HD
venlafaxine hcl er 37.5 mg cap (Effexor Xr)	T1	QL (8 caps/day) HD
venlafaxine hcl er 37.5 mg tab	T1	QL (8 tabs/day) HD
venlafaxine hcl er 75 mg cap (Effexor Xr)	T1	QL (4 caps/day) HD
venlafaxine hcl er 75 mg tab	T1	QL (4 tabs/day) HD
<b>SSRI AND 5HT1A PARTIAL AGONIST ANTI-DEPRESSANTS</b>		
vilazodone hcl 10 mg tablet (Viibryd)	T1	QL(1 tab/day) HD
vilazodone hcl 20 mg tablet (Viibryd)	T1	QL(1 tab/day) HD
vilazodone hcl 40 mg tablet (Viibryd)	T1	HD
VIIBRYD 10 MG TABLET	T3	QL (1 tab/day) ST HD
VIIBRYD 10-20 MG STARTER PACK	T3	ST HD
VIIBRYD 20 MG TABLET	T3	QL (1 tab/day) ST HD
VIIBRYD 40 MG TABLET	T3	ST HD
<b>SSRI, SEROTONIN RECEPTOR MODULATOR ANTI-DEPRESSANTS</b>		
TRINTELLIX 10 MG TABLET	T2	QL(1 TAB/DAY) HD
TRINTELLIX 20 MG TABLET	T2	HD
TRINTELLIX 5 MG TABLET	T2	QL(1 TAB/DAY) HD
<b>TRICYCLIC ANTI-DEPRESSANT-BENZODIAZEPINE COMBINATNS</b>		
amitriptyline/chlordiazepoxide	T1	HD
<b>TRICYCLIC ANTI-DEPRESSANT-PHENOTHIAZINE COMBINATNS</b>		
perphenazine/amitriptyline hcl	T1	HD
<b>TRICYCLIC ANTI-DEPRESSANTS, REL.NON-SEL.REUPT-INHIB</b>		
amoxapine	T1	HD
clomipramine hcl	T1	HD

T1 – Typically Generics

T4 – Injectable Specialty Medications

ST – Step Therapy

HD – May require home delivery pharmacy

T2 – Typically Preferred Brands

PA – Prior Authorization

AGE – Age Requirement

PPACA – No Cost-Share Preventive Medication

T3 – Typically Non-Preferred Brands

QL – Quantity Limit

SP – Specialty Medication

CSL – Oral cancer medication subject to cost-share limits

## List of Prescription Medications

### PSYCHOTHERAPEUTIC DRUGS (Anxiety/Depression/Bipolar Disorder)<sup>9</sup> (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
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#### TRICYCLIC ANTI-DEPRESSANTS, REL.NON-SEL.REUPT-INHIB (cont.)

<i>desipramine hcl</i>	T1	HD
<i>desipramine hcl</i> (Norpramin)	T1	HD
<i>doxepin 10 mg capsule</i>	T1	HD
<i>doxepin 10 mg/ml oral conc</i>	T1	HD
<i>doxepin 100 mg, 150 mg capsule</i>	T1	HD
<i>doxepin 25 mg capsule</i>	T1	HD
<i>doxepin 50 mg capsule</i>	T1	HD
<i>doxepin 75 mg capsule</i>	T1	HD
<i>imipramine hcl</i>	T1	HD
<i>imipramine pamoate</i>	T1	HD
<i>maprotiline hcl</i>	T1	HD
<i>nortriptyline hcl</i>	T1	HD
<i>protriptyline hcl</i>	T1	HD
<i>trimipramine maleate</i>	T1	HD

### PSYCHOTHERAPEUTIC DRUGS (Attention Deficit Hyperactivity Disorder)<sup>9</sup>

#### TX FOR ADHD - SELECTIVE ALPHA-2 RECEPTOR AGONIST

<i>clonidine hcl</i> (Kapvay)	T1	
<i>guanfacine hcl</i> (Intuniv)	T1	HD

#### TX FOR ATTENTION DEFICIT-HYPERACT (ADHD)/NARCOLEPSY

DAYTRANA	T3	PA QL (1 patch/day)
<i>dexmethylphenidate er 10 mg cp</i>	T1	PA QL (1 cap/day)
<i>dexmethylphenidate er 15 mg cp</i>	T1	PA QL (1 per day)
<i>dexmethylphenidate er 20 mg cp</i>	T1	PA QL (1 cap/day)
<i>dexmethylphenidate er 25 mg cp</i>	T1	PA QL (1 cap/day)
<i>dexmethylphenidate er 30 mg cp</i>	T1	PA QL (1 cap/day)
<i>dexmethylphenidate er 35 mg cp</i>	T1	PA QL (1 cap/day)
<i>dexmethylphenidate er 40 mg cp</i>	T1	PA QL (1 cap/day)
<i>dexmethylphenidate hcl</i> (Focalin)	T1	PA
FOCALIN ( <i>dexmethylphenidate hcl</i> )	T3	PA ST
METADATE CD ( <i>methylphenidate hcl</i> )	T3	PA QL
METHYLIN ( <i>methylphenidate hcl</i> )	T3	PA
<i>methylphenidate hcl</i> (Metadate Cd)	T1	PA QL(1 cap/day)
<i>methylphenidate</i> (Daytrana)	T1	PA QL(1 patch/day)
<i>methylphenidate 10 mg/9hr ptch</i> (Daytrana)	T1	PA QL(1 patch/day)
<i>methylphenidate 15 mg/9hr ptch</i> (Daytrana)	T1	PA QL(1 patch/day)

T1 – Typically Generics

T4 – Injectable Specialty Medications

ST – Step Therapy

HD – May require home delivery pharmacy

T2 – Typically Preferred Brands

PA – Prior Authorization

AGE – Age Requirement

PPACA – No Cost-Share Preventive Medication

T3 – Typically Non-Preferred Brands

QL – Quantity Limit

SP – Specialty Medication

CSL – Oral cancer medication subject to cost-share limits

**PSYCHOTHERAPEUTIC DRUGS (Attention Deficit Hyperactivity Disorder)<sup>9</sup> (cont.)**

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

<i>methylphenidate 20 mg/9hr ptch</i> (Daytrana)	T1	PA QL(1 patch/day)
<i>methylphenidate 30 mg/9hr ptch</i> (Daytrana)	T1	PA QL(1 patch/day)
<i>methylphenidate er 10 mg tab</i>	T1	PA QL (2 tabs/day)
<i>methylphenidate er 18 mg tab</i>	T1	PA QL (1 tab/day)
<i>methylphenidate er 18 mg tab</i> (Relexxii)	T1	PA QL (1 tab/day)
<i>methylphenidate er 10, 15, 20 mg cap</i>	T1	QL (1 per day)
<i>methylphenidate er 20 mg tab</i>	T1	PA QL (3/day)
<i>methylphenidate er 27 mg tab</i>	T1	PA QL (1 tab/day)
<i>methylphenidate er 27 mg tab</i> (Relexxii)	T1	PA QL(1 tab/day)
<i>methylphenidate er 30 mg cap</i>	T1	QL (1 per day)
<i>methylphenidate er 36 mg tab</i>	T1	PA QL (2 tabs/day)
<i>methylphenidate er 36 mg tab</i> (Relexxii)	T1	PA QL (2 tabs/day)
<i>methylphenidate er 40 mg cap</i>	T1	QL (1 per day)
<i>methylphenidate er 50 mg cap</i>	T1	QL (1 per day)
<i>methylphenidate er 54 mg tab</i>	T1	PA QL (1 per day)
<i>methylphenidate er 54 mg tab</i> (Relexxii)	T1	PA QL(1 tab/day)
<i>methylphenidate er 60 mg cap</i>	T1	QL (1 per day)
<i>methylphenidate hcl</i>	T1	PA QL (1 cap/day)
<i>methylphenidate hcl</i> (Methylin)	T1	PA
<i>methylphenidate hcl</i> (Ritalin)	T1	PA
<i>methylphenidate la 10 mg cap</i>	T1	PA QL (1 cap/day)
<i>methylphenidate la 20 mg cap</i>	T1	PA QL (1 per day)
<i>methylphenidate la 30 mg cap</i>	T1	PA QL (1 per day)
<i>methylphenidate la 40 mg cap</i>	T1	PA QL (1 cap/day)
<i>methylphenidate la 60 mg cap</i>	T1	PA QL (1 cap/day)
QUILLIVANT XR	T3	PA QL (12ml/day)
RITALIN ( <i>methylphenidate hcl</i> )	T3	PA ST

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

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

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

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

T3 – Typically Non-Preferred Brands QL – Quantity Limit

SP – Specialty Medication

CSL – Oral cancer medication subject to cost-share limits

## List of Prescription Medications

### PSYCHOTHERAPEUTIC DRUGS (Schizophrenia/Anti-Psychotics)<sup>9</sup>

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>ANTI-PSYCH, DOPAMINE ANTAG., DIPHENYLBUTYLPIPERIDINES</b>		
<i>pimozide</i>	T1	
<b>ANTI-PSYCHOTIC, ATYPICAL, DOPAMINE, SEROTONIN ANTAGONIST</b>		
<i>asenapine maleate</i> (Saphris)	T1	
CAPLYTA	T3	ST QL(1 tabs/caps/day)
<i>clozapine</i>	T1	
<i>clozapine</i> (Clozapine Odt)	T1	
<i>clozapine</i> (Clozaril)	T1	
CLOZAPINE ODT	T1	
CLOZARIL ( <i>clozapine</i> )	T3	ST
FANAPT 1 MG TABLET	T3	QL (4 tabs/day) ST
FANAPT 10 MG TABLET	T3	QL (4 tabs/day) ST
FANAPT 12 MG TABLET	T3	ST
FANAPT 2 MG TABLET	T3	QL (4 tabs/day) ST
FANAPT 4 MG TABLET	T3	QL (4 tabs/day) ST
FANAPT 6 MG TABLET	T3	QL (4 tabs/day) ST
FANAPT 8 MG TABLET	T3	QL (4 tabs/day) ST
FANAPT TITRATION PACK	T3	QL (4 packs/year) ST
INVEGA ER 1.5 MG TABLET ( <i>paliperidone er</i> )	T3	ST
INVEGA ER 3 MG TABLET ( <i>paliperidone er</i> )	T3	QL (1 tab/day) ST
INVEGA ER 6 MG TABLET ( <i>paliperidone er</i> )	T3	ST
INVEGA ER 9 MG TABLET ( <i>paliperidone er</i> )	T3	ST
<i>lurasidone hcl 120 mg tablet</i> (Latuda)	T1	
<i>lurasidone hcl 20 mg tablet</i> (Latuda)	T1	
<i>lurasidone hcl 40 mg tablet</i> (Latuda)	T1	QL(1 tab/day)
<i>lurasidone hcl 60 mg tablet</i> (Latuda)	T1	QL(1 tab/day)
<i>lurasidone hcl 80 mg tablet</i> (Latuda)	T1	
<i>olanzapine</i>	T1	
<i>olanzapine</i> (Zyprexa)	T1	
<i>paliperidone er 1.5 mg tablet</i>	T1	
<i>paliperidone er 3 mg tablet</i> (Invega)	T1	QL (1 tab/day)
<i>paliperidone er 9 mg tablet</i> (Invega)	T1	
<i>quetiapine fumarate</i> (Seroquel Xr)	T1	
<i>quetiapine fumarate 400 mg tab</i> (Seroquel)	T1	
<i>quetiapine fumarate</i> (Seroquel)	T1	

T1 – Typically Generics

T4 – Injectable Specialty Medications

ST – Step Therapy

HD – May require home delivery pharmacy

T2 – Typically Preferred Brands

PA – Prior Authorization

AGE – Age Requirement

PPACA – No Cost-Share Preventive Medication

T3 – Typically Non-Preferred Brands

QL – Quantity Limit

SP – Specialty Medication

CSL – Oral cancer medication subject to cost-share limits

## List of Prescription Medications

PSYCHOTHERAPEUTIC DRUGS (Schizophrenia/Anti-Psychotics) <sup>9</sup> (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>ANTI-PSYCHOTIC, ATYPICAL, DOPAMINE, SEROTONIN ANTAGONIST (cont.)</b>		
<i>risperidone</i>	T1	
<i>risperidone</i> (Risperdal)	T1	
SAPHRIS ( <i>asenapine maleate</i> )	T3	ST
SECUADO	T3	ST
SEROQUEL ( <i>quetiapine fumarate</i> )	T3	ST
SEROQUEL XR ( <i>quetiapine fumarate er</i> )	T3	ST
<i>ziprasidone hcl</i>	T1	
<b>ANTI-PSYCHOTIC-ATYPICAL, D3/D2 PARTIAL AG-5HT MIXED</b>		
VRAYLAR 1.5 MG CAPSULE	T3	QL (1 cap/day) ST
VRAYLAR 1.5 MG-3 MG PACK	T3	ST
VRAYLAR 3 MG CAPSULE	T3	QL (1 cap/day) ST
VRAYLAR 4.5 MG CAPSULE	T3	ST
VRAYLAR 6 MG CAPSULE	T3	ST
<b>ANTIPSYCHOTICS, ATYP, D2 PARTIAL AGONIST/5HT MIXED</b>		
<i>aripiprazole</i>	T1	
<i>aripiprazole 1 mg/ml solution</i>	T1	
<i>aripiprazole 10 mg tablet</i>	T1	
<i>aripiprazole 15 mg tablet</i>	T1	
<i>aripiprazole 2 mg tablet</i>	T1	
<i>aripiprazole 20 mg tablet</i>	T1	
<i>aripiprazole 30 mg tablet</i>	T1	
<i>aripiprazole 5 mg tablet</i>	T1	QL (1 tab/day)
REXULTI 0.25 MG TABLET	T3	QL (1 tab/day) ST
REXULTI 0.5 MG TABLET	T3	QL (1 tab/day) ST
REXULTI 1 MG TABLET	T3	QL (1 tab/day) ST
REXULTI 2 MG TABLET	T3	QL (1 tab/day) ST
REXULTI 3 MG, 4 MG TABLET	T3	ST
<b>ANTI-PSYCHOTICS, DOPAMINE AND SEROTONIN ANTAGONISTS</b>		
<i>loxapine succinate</i>	T1	
<b>ANTI-PSYCHOTICS, DOPAMINE ANTAGONISTS, BUTYROPHENONES</b>		
<i>haloperidol</i>	T1	
<i>haloperidol lactate</i>	T1	
<b>ANTI-PSYCHOTICS, DOPAMINE ANTAGONIST, DIHYDROINDOLONES</b>		
<i>molindone hcl</i>	T1	

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

T4 – Injectable Specialty Medications

PA – Prior Authorization

QL – Quantity Limit

ST – Step Therapy

AGE – Age Requirement

SP – Specialty Medication

HD – May require home delivery pharmacy

PPACA – No Cost-Share Preventive Medication

CSL – Oral cancer medication subject to cost-share limits

## List of Prescription Medications

### PSYCHOTHERAPEUTIC DRUGS (Schizophrenia/Anti-Psychotics)<sup>9</sup> (cont.)

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

### PSYCHOTHERAPEUTIC DRUGS (Sleep Disorders/Sedatives)

#### NARCOLEPSY AND SLEEP DISORDER THERAPY AGENTS

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

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

LUMRYZ	T3	PA QL(1 pack/day) SP HD
SODIUM OXYBATE 0.5 G/ML SOLN	T3	PA QL(18 mls/day) SP HD
XYWAV	T3	PA SP HD

#### BARBITURATES

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

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

HETLIOZ	T3	PA SP HD
HETLIOZ LQ	T3	PA SP HD
<i>ramelteon (Rozerem)</i>	T1	QL (1 tab/day)
<i>tasimelteon</i>	T1	PA SP

#### SEDATIVE-HYPNOTICS - BENZODIAZEPINES

DORAL	T3	
<i>estazolam</i>	T1	
<i>flurazepam hcl</i>	T1	
HALCION ( <i>triazolam</i> )	T3	
<i>midazolam hcl</i>	T1	
QUAZEPAM	T1	
<i>quazepam (Quazepam)</i>	T1	

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

T4 – Injectable Specialty Medications

PA – Prior Authorization

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PPACA – No Cost-Share Preventive Medication

CSL – Oral cancer medication subject to cost-share limits

## List of Prescription Medications

PSYCHOTHERAPEUTIC DRUGS (Sleep Disorders/Sedatives)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>SEDATIVE-HYPNOTICS - BENZODIAZEPINES</b>		
<i>temazepam</i>	T1	
<i>triazolam</i>	T1	
<i>triazolam</i> (Halcion)	T1	
<b>SEDATIVE-HYPNOTICS, NON-BARBITURATE</b>		
DAYVIGO	T2	QL (1 tab/day) ST
<i>doxepin hcl 3 mg tablet</i> (Silenor)	T1	QL (1 tab/day)
<i>doxepin hcl 6 mg tablet</i> (Silenor)	T1	
<i>eszopiclone</i> (Lunesta)	T1	
DAYVIGO	T2	QL (1 tab/day) ST
<i>doxepin hcl 3 mg tablet</i> (Silenor)	T1	QL (1 tab/day)
<i>doxepin hcl 6 mg tablet</i> (Silenor)	T1	
<i>zaleplon</i>	T1	
<i>zolpidem tart er 12.5 mg tab</i>	T1	
<i>zolpidem tart er 6.25 mg tab</i>	T1	QL (1 tab/day)
<i>zolpidem tartrate 10 mg tablet</i> (Ambien)	T1	
<i>zolpidem tartrate 5 mg tablet</i> (Ambien)	T1	
<i>zolpidem tartrate</i>	T1	
<b>SKIN PREPS (Miscellaneous)</b>		
<b>IRRIGANTS</b>		
<i>acetic acid</i>	T1	
<i>neomycin sulf/polymyxin b sulf</i>	T1	
PHYSIOLYTE	T3	
PHYSIOSOL	T3	
<i>ringer's solution</i>	T1	
<i>ringer's solution, lactated</i>	T1	
<i>sod, pot chlor/mag/sod, pot phos</i>	T3	
<i>sodium chloride irrig solution</i>	T1	
SORBITOL	T1	
SORBITOL-MANNITOL	T1	
VASHE WOUND	T3	
VASHE WOUND THERAPY	T3	
<i>water for irrigation, sterile</i>	T1	
<b>OXIDIZING AGENTS</b>		
<i>hydrogen peroxide</i>	T1	

T1 – Typically Generics

T4 – Injectable Specialty Medications

ST – Step Therapy

HD – May require home delivery pharmacy

T2 – Typically Preferred Brands

PA – Prior Authorization

AGE – Age Requirement

PPACA – No Cost-Share Preventive Medication

T3 – Typically Non-Preferred Brands

QL – Quantity Limit

SP – Specialty Medication

CSL – Oral cancer medication subject to cost-share limits

## List of Prescription Medications

### SKIN PREPS (Pain Relief And Inflammatory Disease)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
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#### ANTI-PSORIATIC AGENTS, SYSTEMIC

<i>acitretin</i>	T1	
BIMZELX	T4	PA QL(10 mls/365 days) SP HD
BIMZELX AUTOINJECTOR	T4	PA QL(10 mls/365 days) SP HD
COSENTYX	T3	PA QL SP
ILUMYA	T4	PA QL (1 syringe/84 days) SP HD
SILIQ	T4	PA QL SP
<i>methoxsalen</i> (Oxsoralen-ultra)	T1	
OXSORALEN-ULTRA ( <i>methoxsalen</i> )	T3	
SKYRIZI (2 SYRINGES) KIT	T4	PA QL (1 kit/84 days) SP HD
SOTYKTU	T3	PA QL (1 tab/day) SP HD
TALTZ AUTOINJECTOR	T4	PA QL (1 injector/28 days) SP HD
TALTZ AUTOINJECTOR (2 PACK)	T4	PA QL (1 injector/28 days) SP HD
TALTZ AUTOINJECTOR (3 PACK)	T4	PA QL (1 injector/28 days) SP HD
TALTZ SYRINGE	T4	PA QL (1 syringe/28 days) SP HD
TREMFYA 100 MG/ML INJECTOR	T4	PA QL (1 injector/56 days) SP HD
TREMFYA 100 MG/ML SYRINGE	T4	PA QL (1 syringe/56 days) SP HD

#### TOPICAL ANTI-INFLAMMATORY, NSAIDS

DICLAREAL	T3	HD
<i>diclofenac sodium 1% gel</i>	T1	QL (1000gm/30 days) HD

### SKIN PREPS (Skin Conditions)

#### ACNE AGENTS, SYSTEMIC

ABSORICA (isotretinoin)	T3	
ACUTANE	T1	
AMNESTEEM	T1	
CLARAVIS	T1	
<i>isotretinoin</i>	T1	
<i>isotretinoin (Absorica)</i>	T1	
MYORISAN	T1	
ZENATANE	T1	

#### ACNE AGENTS, TOPICAL

ACZONE 7.5% GEL PUMP ( <i>dapsone</i> )	T3	
<i>adapalene/benzoyl peroxide</i>	T1	
<i>clindamycin phos/benzoyl perox</i>	T1	
<i>clindamycin-benzoyl perox 1-5% pmp</i>	T1	
<i>clindamycin/tretinoin</i> (Veltin)	T1	
<i>clindamycin/tretinoin</i>	T1	

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

PA – Prior Authorization  
 QL – Quantity Limit

AGE – Age Requirement  
 SP – Specialty Medication

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



## List of Prescription Medications

SKIN PREPS (Skin Conditions) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>ACNE AGENTS, TOPICAL</b>		
<i>dapsone</i>	T1	
<i>dapsone</i> (Aczone)	T1	
KLARON ( <i>sulfacetamide sodium</i> )	T3	
<i>sulfacetamide sodium</i> (Klaron)	T1	
<b>ANTI-PERSPIRANTS</b>		
DRYSOL	T3	
<b>ANTI-PRURITICS, TOPICAL</b>		
ALEVICYN PLUS	T3	
<b>ANTI-PSORIATICS AGENTS</b>		
<i>anthralin</i>	T1	
<i>calcipotriene</i>	T1	
<i>calcipotriene 0.005% cream</i>	T1	
CALCIPOTRIENE 0.005% FOAM	T3	
<i>calcipotriene 0.005% ointment</i>	T1	
<i>calcipotriene 0.005% solution</i>	T1	
<i>calcitriol 3 mcg/g ointment</i>	T1	QL (800gm/30 days)
<i>tazarotene</i>	T1	
<i>tazarotene 0.05% gel</i> (Tazorac)	T1	
<i>tazarotene 0.1% gel</i> (Tazorac)	T1	
<b>ANTI-SEBORRHEIC AGENTS</b>		
OVACE PLUS	T3	
<i>selenium sulfide</i>	T1	
<i>sulfacetamide sodium</i>	T1	
TERSI FOAM	T3	
<b>ANTISEPTICS, MISCELLANEOUS</b>		
GUAIACOL	T1	
<b>DIABETIC ULCER PREPARATIONS, TOPICAL</b>		
REGRANEX	T3	PA QL (2 tubs/30 days)
<b>EMOLLIENTS</b>		
<i>ammonium lactate</i>	T1	
ATOPICLAIR	T3	
<i>emollient combination no.35</i> (Mimyx)	T1	
<i>emollient combination no.60</i> (Restizan)	T1	
<i>emollient combination no.60</i> (Restizan)	T3	
HALUCORT	T3	

T1 – Typically Generics

T4 – Injectable Specialty Medications

ST – Step Therapy

HD – May require home delivery pharmacy

T2 – Typically Preferred Brands

PA – Prior Authorization

AGE – Age Requirement

PPACA – No Cost-Share Preventive Medication

T3 – Typically Non-Preferred Brands

QL – Quantity Limit

SP – Specialty Medication

CSL – Oral cancer medication subject to cost-share limits

## List of Prescription Medications

SKIN PREPS (Skin Conditions) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>EMOLLIENTS</b>		
HPR PLUS-MB HYDROGEL	T1	
MIMYX ( <i>prumyx</i> )	T3	
RESTIZAN	T1	
<i>vite ac/grape/hyaluronic acid</i> (Atopiclair)	T1	
XCLAIR	T3	
<b>IMMUNOMODULATORS</b>		
<i>imiquimod</i>	T1	
<b>IRRITANTS/COUNTER-IRRITANTS</b>		
<i>methyl salicylate</i>	T1	
QUTENZA	T3	
<b>JANUS KINASE (JAK) INHIBITORS</b>		
CIBINQO	T2	PA QL(30 tabs/30 days) SP
<b>KERATOLYTICS</b>		
BENZEFOAM	T3	
BENZEPRO	T1	
<i>benzoyl peroxide</i>	T1	
<i>benzoyl peroxide</i> (Enzoclear)	T1	
<i>benzoyl peroxide</i> (Pacnex)	T1	
ENZOCLEAR	T3	
HYDRO 35	T3	
HYDRO 40 ( <i>umecta</i> )	T3	
INOVA	T3	
KERAFOAM	T3	
KERALYT 6% GEL ( <i>salicylic acid</i> )	T3	
<i>keralyt 6% shampoo</i>	T1	
KERALYT SCALP	T3	
KERALYT SCALP ( <i>salicylic acid</i> )	T3	
PACNEX ( <i>benzoyl peroxide</i> )	T3	
PODOCON-25	T1	
<i>podofilox</i>	T1	
PR BENZOYL PEROXIDE	T1	
SALICATE	T3	
<i>salicylic acid</i>	T3	
<i>salicylic acid</i> (Keralyt Scalp)	T1	
<i>salicylic acid/ceramide comb 1</i>	T1	

T1 – Typically Generics

T4 – Injectable Specialty Medications

ST – Step Therapy

HD – May require home delivery pharmacy

T2 – Typically Preferred Brands

PA – Prior Authorization

AGE – Age Requirement

PPACA – No Cost-Share Preventive Medication

T3 – Typically Non-Preferred Brands

QL – Quantity Limit

SP – Specialty Medication

CSL – Oral cancer medication subject to cost-share limits

## List of Prescription Medications

SKIN PREPS (Skin Conditions) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>KERATOLYTICS</b>		
SALIMEZ FORTE	T1	
SALKERA	T3	
SALVAX DUO PLUS	T3	
<i>silver nitrate</i>	T1	
<i>silver nitrate applicator</i>	T1	
URAMAXIN	T3	
URAMAXIN ( <i>urea</i> )	T3	
<i>urea</i>	T1	
<i>urea</i> (Hydro 35)	T1	
<i>urea</i> (Hydro 40)	T3	
<i>urea</i> (Uramaxin)	T1	
<i>urea</i> (Xurea)	T1	
XUREA	T3	
<b>PROTECTIVES</b>		
BIONECT	T3	
PHARMABASE BARRIER	T1	
<i>polydimethylsiloxanes/silicon</i>	T1	
<i>protectives2/ceramide 1, 3, 6-ii</i>	T1	
RADIAPLEXRX	T3	
<i>zinc oxide</i>	T1	
<b>ROSACEA AGENTS, TOPICAL</b>		
<i>azelaic acid</i>	T1	
<i>ivermectin</i>	T1	
<i>metronidazole</i>	T1	
<b>TISSUE/WOUND ADHESIVES</b>		
ARTISS	T3	
SURGISEAL STYLUS	T3	
SURGISEAL TEARDROP	T3	
SURGISEAL TWIST	T3	
TISSEEL VHSD	T3	
<b>TOP. ANTI-INFLAM., PHOSPHODIESTERASE-4 (PDE4) INHIB</b>		
EUCRISA	T2	
<b>TOPICAL AGENTS, MISCELLANEOUS</b>		
GORDON'S UREA	T3	
HYFTOR	T3	PA SP

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

T4 – Injectable Specialty Medications

PA – Prior Authorization

QL – Quantity Limit

ST – Step Therapy

AGE – Age Requirement

SP – Specialty Medication

HD – May require home delivery pharmacy

PPACA – No Cost-Share Preventive Medication

CSL – Oral cancer medication subject to cost-share limits

## List of Prescription Medications

SKIN PREPS (Skin Conditions) <i>(cont.)</i>		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>TOPICAL AGENTS, MISCELLANEOUS</b>		
L-MESITRAN SOFT	T3	
MEDIHONEY	T3	
SAF-CLENS AF	T1	
trichloroacetic acid	T3	
TRICHLOROACETIC ACID	T1	
urea	T1	
<b>TOPICAL ANTIBIOTIC PLEUROMUTILIN DERIVATIVES</b>		
ALTABAX	T3	
<b>TOPICAL ANTI-INFLAMMATORY STEROIDAL</b>		
ALA-SCALP ( <i>scalacort</i> )	T3	ST
<i>alclometasone dipropionate</i>	T1	
<i>amcinonide 0.1% cream</i>	T1	
<i>amcinonide 0.1% lotion</i>	T1	
<i>amcinonide</i>	T1	
AQUA GLYCOLIC HC	T3	
<i>betamethasone dipropionate</i>	T1	
<i>betamethasone valerate</i>	T1	
<i>betamethasone valerate (Luxiq)</i>	T1	
<i>betamethasone/propylene glyc</i>	T1	
<i>betamethasone/propylene glyc (Diprolene)</i>	T1	
BRYHALI	T3	ST
CAPEX SHAMPOO	T3	ST
<i>clobetasol propionate</i>	T1	
<i>clobetasol propionate (Temovate)</i>	T1	
<i>clobetasol propionate/emoll</i>	T1	
CLOCORTOLONE PIVALATE	T1	
CLODAN 0.05% KIT	T3	ST
<i>clodan 0.05% shampoo</i>	T1	
CLODERM	T3	ST
DERMA-SMOOTHIE-FS ( <i>fluocinolone acetonide</i> )	T3	ST
DERMATOP ( <i>prednicarbate</i> )	T3	ST
<i>desonide</i>	T1	
<i>desonide (Desowen)</i>	T1	
DESOWEN ( <i>desonide</i> )	T3	ST
<i>desoximetasone (Topicort)</i>	T1	

T1 – Typically Generics

T4 – Injectable Specialty Medications

ST – Step Therapy

HD – May require home delivery pharmacy

T2 – Typically Preferred Brands

PA – Prior Authorization

AGE – Age Requirement

PPACA – No Cost-Share Preventive Medication

T3 – Typically Non-Preferred Brands

QL – Quantity Limit

SP – Specialty Medication

CSL – Oral cancer medication subject to cost-share limits

## List of Prescription Medications

SKIN PREPS (Skin Conditions) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>TOPICAL ANTI-INFLAMMATORY STEROIDAL (cont.)</b>		
DIPROLENE (betamethasone diprop augmented)	T3	ST
fluocinolone acetonide (Derma-Smoothe-Fs)	T1	
fluocinolone/shower cap (Derma-Smoothe-Fs)	T1	
fluocinolone acetonide	T1	
fluocinolone acetonide (Derma-smoothe-fs)	T1	
fluocinolone acetonide (Synalar)	T1	
fluocinolone/shower cap (Derma-smoothe-fs)	T1	
fluocinonide	T1	
fluocinonide/emollient base	T1	
fluticasone prop 0.005% oint	T1	
fluticasone prop 0.05% cream	T1	
fluticasone prop 0.05% lotion	T1	
fluticasone propionate	T1	
halobetasol prop 0.05% cream	T1	
halobetasol prop 0.05% foam	T1	
halobetasol prop 0.05% ointmnt	T1	
halobetasol propionate	T1	
halobetasol propionate (Ultravate)	T1	
hydrocortisone	T1	
hydrocortisone (Ala-scalp)	T1	
hydrocortisone butyrate	T1	
hydrocortisone valerate	T1	
LUXIQ (betamethasone valerate)	T3	ST
MOMETACURE	T3	
mometasone furoate 0.1% cream	T1	
mometasone furoate 0.1% oint	T1	
mometasone furoate 0.1% soln	T1	
NUCORT	T3	ST
prednicarbate (Dermatop)	T1	
SCALACORT DK	T3	ST
SYNALAR	T3	ST
SYNALAR (fluocinolone acetonide)	T3	ST
SYNALARTS	T3	ST
TEMOVATE (clobetasol propionate)	T3	ST

T1 – Typically Generics

T4 – Injectable Specialty Medications

ST – Step Therapy

HD – May require home delivery pharmacy

T2 – Typically Preferred Brands

PA – Prior Authorization

AGE – Age Requirement

PPACA – No Cost-Share Preventive Medication

T3 – Typically Non-Preferred Brands

QL – Quantity Limit

SP – Specialty Medication

CSL – Oral cancer medication subject to cost-share limits

## List of Prescription Medications

SKIN PREPS (Skin Conditions) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>TOPICAL ANTI-INFLAMMATORY STEROIDAL (cont.)</b>		
TEXACORT	T3	ST
TOPICORT ( <i>desoximetasone</i> )	T3	ST
ULTRAVATE ( <i>halobetasol propionate</i> )	T3	ST
<b>TOPICAL ANTI-INFLAMMATORY STEROID-LOCAL ANESTHETIC</b>		
ANALPRAM HC	T3	
ANALPRAM HC 1% CREAM	T3	
EPIFOAM	T2	
<b>TOPICAL ANTI-INFLAMMATORY STEROID-LOCAL ANESTHETIC (cont.)</b>		
<i>hydrocortisone/pramoxine</i> (Pramosone)	T1	
<i>lidocaine/hydrocortisone ac</i>	T1	
MEZPAROX-HC	T1	
PRAMOSONE	T3	
<b>TOPICAL ANTI-CHOLINERGIC HYPERHIDROSIS TX AGENTS</b>		
QBREXZA	T3	PA
<b>TOPICAL ANTI-PARASITICS</b>		
<i>lindane</i>	T1	
<i>malathion</i> (Ovide)	T1	
OVIDE ( <i>malathion</i> )	T3	
<b>TOPICAL PREPARATIONS, ANTIBACTERIALS</b>		
<i>dermazene cream</i>	T1	
DERMAZENE CREAM PACKET	T3	
<i>hydrocortisone/iodoquinol</i>	T1	
<i>hydrocortisone/iodoquinol/aloe</i>	T1	
<i>iodine/potassium iodide</i>	T1	
<i>iodine/sodium iodide</i>	T1	
IODOFLEX	T3	
IODOSORB	T3	
<i>silver nitrate</i>	T1	
<b>TOPICAL VIT D ANALOG/ANTI-INFLAMMATORY STEROID</b>		
TACLONEX 0.005%-0.064% SUSPENS ( <i>calcipotriene/betamethasone</i> )	T3	
<i>calcipotriene/betamethasone</i>	T1	
<b>TOPICAL/MUCOUS MEMBR./SUBCUT. ENZYMES</b>		
SANTYL	T3	QL (60gm/30 days)
<b>VITAMIN A DERIVATIVES</b>		
<i>adapalene</i> (Plixda)	T1	PA
PLIXDA	T1	PA

T1 – Typically Generics

T4 – Injectable Specialty Medications

ST – Step Therapy

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T2 – Typically Preferred Brands

PA – Prior Authorization

AGE – Age Requirement

PPACA – No Cost-Share Preventive Medication

T3 – Typically Non-Preferred Brands

QL – Quantity Limit

SP – Specialty Medication

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## List of Prescription Medications

SKIN PREPS (Skin Conditions) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>tretinoin 0.01% gel</i>	T1	
<i>tretinoin 0.025% cream</i>	T1	PA
<i>tretinoin 0.025% gel</i>	T1	
<i>tretinoin 0.05% cream</i>	T1	PA
<i>tretinoin 0.05% gel</i>	T1	PA
<i>tretinoin 0.1% cream</i>	T1	PA
<i>tretinoin microspheres</i>	T1	PA
SMOKING DETERRENTS (Smoking Cessation) <sup>9</sup>		
SMOKING DETERRENT AGENTS (GANGLIONIC STIM, OTHERS)		
NICOTROL	T3	PPACA
NICOTROL NS	T3	PPACA
SMOKING DETERRENT-NICOTINIC RECEPT.PARTIAL AGONIST		
CHANTIX	T3	
<i>varenicline 0.5 mg tablet</i>	T1	PPACA
<i>varenicline 1 mg cont month bx</i>	T1	PPACA
<i>varenicline 1 mg tablet</i>	T1	PPACA
<i>varenicline starting month box</i>	T1	PPACA
SMOKING DETERRENTS, OTHER		
<i>bupropion hcl sr 150 mg tablet</i>	T1	PPACA
THYROID PREPS (Hormonal Agents)		
ANTI-THYROID PREPARATIONS		
<i>methimazole (Tapazole)</i>	T1	HD
<i>propylthiouracil</i>	T1	HD
TAPAZOLE ( <i>methimazole</i> )	T3	HD
THYROID HORMONES		
ARMOUR THYROID	T3	HD
CYTOMEL ( <i>liothyronine sodium</i> )	T3	HD
LEVOTHYROXINE	T3	PA HD
<i>levothyroxine 100 mcg tablet (Synthroid)</i>	T1	HD
<i>levothyroxine 112 mcg tablet (Synthroid)</i>	T1	HD
<i>levothyroxine 125 mcg tablet (Synthroid)</i>	T1	HD
<i>levothyroxine 137 mcg tablet (Synthroid)</i>	T1	HD
<i>levothyroxine 150 mcg tablet (Synthroid)</i>	T1	HD
<i>levothyroxine 175 mcg tablet (Synthroid)</i>	T1	HD
<i>levothyroxine 200 mcg tablet (Synthroid)</i>	T1	HD
<i>levothyroxine 25 mcg tablet (Synthroid)</i>	T1	HD

T1 – Typically Generics

T4 – Injectable Specialty Medications

ST – Step Therapy

HD – May require home delivery pharmacy

T2 – Typically Preferred Brands

PA – Prior Authorization

AGE – Age Requirement

PPACA – No Cost-Share Preventive Medication

T3 – Typically Non-Preferred Brands

QL – Quantity Limit

SP – Specialty Medication

CSL – Oral cancer medication subject to cost-share limits

## List of Prescription Medications

### THYROID PREPS (Hormonal Agents) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>THYROID HORMONES (cont.)</b>		
levothyroxine 300 mcg tablet (Synthroid)	T1	HD
levothyroxine 50 mcg tablet (Synthroid)	T1	HD
levothyroxine 75 mcg tablet (Synthroid)	T1	HD
levothyroxine 88 mcg tablet (Synthroid)	T1	HD
levothyroxine sodium (Synthroid)	T1	HD
liothyronine sodium (Cytomel)	T1	HD
SYNTHROID (unithroid)	T3	HD
thyroid, pork	T1	HD
thyroid, pork (Armour Thyroid)	T1	HD
thyroid, pork (Wp Thyroid)	T1	HD
THYROLAR-1	T3	HD
THYROLAR-1/2	T3	HD
THYROLAR-1/4	T3	HD
THYROLAR-2	T3	HD
THYROLAR-3	T3	HD
TIROSINT	T3	PA HD
TIROSINT-SOL	T3	PA HD
WP THYROID	T1	HD
WP THYROID (nature-throid)	T1	HD
WP THYROID (westhroid)	T1	HD

### UNCLASSIFIED DRUG PRODUCTS (AIDS/HIV)

#### CYTOCHROME P450 INHIBITORS

TYBOST	T3	SP
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### UNCLASSIFIED DRUG PRODUCTS (Asthma/COPD/Respiratory)

#### CYSTIC FIBROSIS-CFTR POTENTIATOR-CORRECTOR COMBIN.

BRONCHITOL 40 MG INHALE CAP	T3	PA SP
ORKAMBI 100 MG-125 MG TABLET	T3	PA QL (4 tabs/day) SP HD
ORKAMBI 100-125 MG GRANULE PKT	T3	PA QL (2 packs/day) SP HD
ORKAMBI 150-188 MG GRANULE PKT	T3	PA QL (2 packs/day) SP HD
ORKAMBI 200 MG-125 MG TABLET	T3	PA QL (4 tabs/day) SP HD
SYMDEKO	T3	PA QL (2 tabs/day) SP HD
TRIKAFTA 100-50-75 MG/150 MG	T3	PA QL (3 tabs/day) SP HD
TRIKAFTA 100-50-75 MG/75MG PKT	T3	PA QL(3 tabs/day) SP HD
TRIKAFTA 50-25-37.5 MG/75 MG	T3	PA QL(3 tabs/day) HD
TRIKAFTA 80-40-60MG/59.5MG PKT	T3	PA QL(3 tabs/day) SP HD

T1 – Typically Generics

T4 – Injectable Specialty Medications

ST – Step Therapy

HD – May require home delivery pharmacy

T2 – Typically Preferred Brands

PA – Prior Authorization

AGE – Age Requirement

PPACA – No Cost-Share Preventive Medication

T3 – Typically Non-Preferred Brands

QL – Quantity Limit

SP – Specialty Medication

CSL – Oral cancer medication subject to cost-share limits



## List of Prescription Medications

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

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>CYSTIC FIB-TRANSMEMB CONDUCT.REG.(CFTR) POTENTIATOR</b>		
KALYDECO 5.8 MG GRANULES PKT	T3	PA QL SP HD
KALYDECO 150 MG TABLET	T3	PA QL (2 tabs/day) SP HD
KALYDECO 25 MG GRANULES PACKET	T3	PA QL (2 packs/day) SP HD
KALYDECO 50 MG GRANULES PACKET	T3	PA QL (2 packs/day) SP HD
KALYDECO 75 MG GRANULES PACKET	T3	PA QL (2 packs/day) SP HD
<b>LUNG SURFACTANTS</b>		
CUROSURF	T3	
INFASURF	T3	
SURVANTA	T3	
<b>MUCOLYTICS</b>		
PULMOZYME	T3	PA SP HD
<b>PULMONARY FIBROSIS - SYSTEMIC ENZYME INHIBITORS</b>		
OFEV	T2	PA SP HD
<b>SYSTEMIC ENZYME INHIBITORS</b>		
JOENJA	T3	PA QL(2 tabs/day) SP
VIJOICE 125mg,50mg	T3	PA QL (30tabs/30days) SP
VIJOICE 250mg dose pack	T3	PA QL (2 tabs/30days) SP
ZOKINVY	T3	PA QL (4 caps/day) SP
<b>UNCLASSIFIED DRUG PRODUCTS (Blood Modifiers/Bleeding Disorders)</b>		
<b>SPLEEN TYROSINE KINASE INHIBITORS</b>		
TAVALISSE	T3	PA SP
<b>UNCLASSIFIED DRUG PRODUCTS (Blood Pressure/Heart Medications)</b>		
<b>BRADYKININ B2 RECEPTOR ANTAGONISTS</b>		
<i>icatibant acetate</i>	T4	PA SP HD
<b>CI ESTERASE INHIBITORS</b>		
BERINERT	T4	PA SP HD
CINRYZE	T4	PA SP HD
HAEGARDA	T4	PA SP HD
RUCONEST	T4	PA SP HD
<b>PLASMA KALLIKREIN INHIBITORS</b>		
KALBITOR	T4	PA SP HD
ORLADEYO	T4	PA QL (1 caps/day) SP

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

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

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

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

## List of Prescription Medications

### UNCLASSIFIED DRUG PRODUCTS (Cancer)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>CHEMOTHERAPY RESCUE/ANTIDOTE AGENTS</b>		
<i>leucovorin calcium</i>	T1	
MESNEX	T3	SP
VISTOGARD	T3	SP

### UNCLASSIFIED DRUG PRODUCTS (Dental Products)

#### DENTAL AIDS AND PREPARATIONS

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

#### PERIODONTAL COLLAGENASE INHIBITORS

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

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

CAVERJECT	T3	PA QL (6 injectors/30 days)
CIALIS 10 MG TABLET ( <i>tadalafil</i> )	T3	QL (8 tabs/30 days) ST HD
CIALIS 20 MG TABLET ( <i>tadalafil</i> )	T3	QL (8 tabs/30 days) ST HD
CIALIS 5 MG TABLET ( <i>tadalafil</i> )	T3	QL (1 tabs/30 days) ST HD
EDEX	T3	PA QL (6 injectors/30 days)
IFE-BIMIX 30/1	T2	
IFE-PG20	T2	
LEVITRA ( <i>varденаfil hcl</i> )	T3	QL (10 tabs/30 days) ST
MUSE	T3	PA QL (6/30 days)
PAPAVERINE-ALPROSTADIL	T1	
PHENTOLAMINE-ALPROSTADIL	T1	
<i>sildenafil 100 mg tablet</i> (Viagra)	T1	QL(8 tabs/30 days) HD
<i>sildenafil 25 mg tablet</i> (Viagra)	T1	QL(8 tabs/30 days) HD
<i>sildenafil 50 mg tablet</i> (Viagra)	T1	QL(8 tabs/30 days) HD
STENDRA	T3	QL (8 tabs/30 days) ST
<i>tadalafil 10 mg tablet</i> (Cialis)	T1	QL(8 Tabs/30 days) HD
<i>tadalafil 2.5 mg tablet</i>	T1	QL(1 tab/day) HD
<i>tadalafil 20 mg tablet</i> (Cialis)	T1	QL(8 tabs/30 days) HD
<i>tadalafil 5 mg tablet</i> (Cialis)	T1	QL(1 tab/day) HD
<i>varденаfil hcl</i>	T1	QL (10 tabs/30 days)
<i>varденаfil hcl</i> (Levitra)	T1	QL (10 tabs/30 days)
VIAGRA ( <i>sildenafil citrate</i> )	T3	ST QL(8 tabs/30 days) HD

T1 – Typically Generics

T4 – Injectable Specialty Medications

ST – Step Therapy

HD – May require home delivery pharmacy

T2 – Typically Preferred Brands

PA – Prior Authorization

AGE – Age Requirement

PPACA – No Cost-Share Preventive Medication

T3 – Typically Non-Preferred Brands

QL – Quantity Limit

SP – Specialty Medication

CSL – Oral cancer medication subject to cost-share limits

## List of Prescription Medications

UNCLASSIFIED DRUG PRODUCTS (Gastrointestinal/Heartburn)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>CALCIMIMETIC, PARATHYROID CALCIUM ENHANCER</b>		
<i>cinacalcet hcl</i>	T1	SP
<b>ORAL MUCOSITIS/STOMATITIS AGENTS</b>		
MUGARD	T3	
ORAMAGICRX	T3	
<b>SALIVA STIMULANT AGENTS</b>		
NUMOISYN	T3	
<b>SALIVA SUBSTITUTE AGENTS</b>		
NEUTRASAL	T3	
NUMOISYN	T3	
UNCLASSIFIED DRUG PRODUCTS (Hormonal Agents)		
<b>BONE FORMATION STIM. AGENTS - PARATHYROID HORMONE</b>		
FORTEO	T4	PA QL (3ml/21 days) SP HD
<i>teriparatide 600 mcg/2.4ml pen (Forteo)</i>	T1	PA QL(0.09 ml/day) SP HD
<b>GROWTH HORMONE RECEPTOR ANTAGONISTS</b>		
SOMAVERT	T4	PA SP HD
<b>HYPERPARATHYROID TX AGENTS - VITAMIN D ANALOG-TYPE</b>		
<i>doxercalciferol</i>	T1	
<i>paricalcitol</i>	T1	SP HD
<i>paricalcitol (Zemplar)</i>	T1	SP HD
RAYALDEE	T3	
ZEMPLAR ( <i>paricalcitol</i> )	T3	SP HD
<b>MENOPAUSAL SYMPT SUPP-SEL ESTROGEN RECEPTOR MODULATOR</b>		
OSPHENA	T3	QL(30 tabs/30 days) HD
UNCLASSIFIED DRUG PRODUCTS (Miscellaneous)		
<b>ABORTIFACIENT-PROGESTERONE RECEPTOR ANTAGONISTS</b>		
MIFEPREX	T3	
<i>mifepristone (Mifeprex)</i>	T1	
<i>mifepristone 200 mg tablet</i>	T1	
<b>AGENTS TO TREAT PERIODIC PARALYSIS - CARBON ANHYDRASE INHIBITORS</b>		
<i>dichlorphenamide (Keveyis)</i>	T1	PA SP
<b>AMMONIA INHIBITORS</b>		
CARBAGLU	T3	SP HD
<b>AMYLOIDOSIS AGENTS-TRANSTHYRETIN (TTR) SUPPRESSION</b>		
TEGSEDI	T4	PA SP HD

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

T4 – Injectable Specialty Medications

PA – Prior Authorization

QL – Quantity Limit

ST – Step Therapy

AGE – Age Requirement

SP – Specialty Medication

HD – May require home delivery pharmacy

PPACA – No Cost-Share Preventive Medication

CSL – Oral cancer medication subject to cost-share limits

## List of Prescription Medications

UNCLASSIFIED DRUG PRODUCTS (Miscellaneous) (cont.)			
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits	
<b>ANTI-ALCOHOLIC PREPARATIONS</b>			
<i>acamprosate calcium</i>	T1		
ANTABUSE ( <i>disulfiram</i> )	T3		
<i>disulfiram</i> (Antabuse)	T1		
<b>ANTIDOTES, MISCELLANEOUS</b>			
CETYLEV	T3		
<b>ANTI-FIBROTIC THERAPY - PYRIDONE ANALOGS</b>			
<i>pirfenidone 267 mg capsule</i> (Esbriet)	T1	PA	SP HD
<i>pirfenidone 801 mg capsule</i> (Esbriet)	T1	PA	SP HD
<b>CRYOPRESERVATIVE AGENTS</b>			
<i>dimethyl sulfoxide</i>	T1		
<b>DRUGS TO TREAT HEREDITARY TYROSINEMIA</b>			
<i>nitisinone</i> (Orfadin)	T1	PA	SP HD
NITYR	T2	PA	SP
ORFADIN	T3	PA	SP
ORFADIN ( <i>nitisinone</i> )	T3	PA	SP
<b>DRUGS TO TX GAUCHER DX-TYPE I, SUBSTRATE REDUCING</b>			
CERDELGA	T2	PA	SP HD
<i>miglustat</i> (Zavesca)	T1	PA	SP
ZAVESCA ( <i>miglustat</i> )	T3	PA	SP HD
<b>GENERAL INHALATION AGENTS</b>			
HYPER-SAL	T3		
nebusal 3% vial	T1		
NEBUSAL 6% VIAL	T3		
<i>sodium chloride for inhalation</i>	T1		
<i>sodium chloride for inhalation</i> (Hyper-sal)	T1		
<b>GENETIC D/O TX - SMN PROTEIN DEFICIENCY TREATMENT</b>			
EVRYSDI	T3	PA	SP HD
<b>GLUCOSYLCERAMIDE SYNTHASE (GCS) INHIBITOR</b>			
<i>miglustat</i> (Zavesca)	T1	PA	SP HD
OPFOLDA	T3	PA	QL(8 caps/30 days) SP HD
<b>MENOPAUSAL SYMPTOMS SUPPRESSANT - SSRIs</b>			
<i>paroxetine mesylate</i>	T1	QL(1 cap/day)	HD
<b>METABOLIC DISEASE ENZYME REPLACE, HYPOPHOSPHATASIA</b>			
STRENSIQ	T4	PA	SP
<b>METABOLIC DISEASE ENZYME REPLACEMENT, MOCD</b>			
NULIBRY	T3	PA	SP

T1 – Typically Generics

T4 – Injectable Specialty Medications

ST – Step Therapy

HD – May require home delivery pharmacy

T2 – Typically Preferred Brands

PA – Prior Authorization

AGE – Age Requirement

PPACA – No Cost-Share Preventive Medication

T3 – Typically Non-Preferred Brands

QL – Quantity Limit

SP – Specialty Medication

CSL – Oral cancer medication subject to cost-share limits

## List of Prescription Medications

UNCLASSIFIED DRUG PRODUCTS (Miscellaneous) (cont.)			
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits	
<b>METALLIC POISON, AGENTS TO TREAT</b>			
CHEMET	T3		
<i>deferasirox</i> (Exjade)	T1	SP	HD
<i>deferasirox</i> (Jadenu Sprinkle)	T1	SP	HD
<i>deferasirox</i> (Jadenu)	T1	SP	HD
<i>deferiprone</i> (Ferriprox)	T1	PA	SP HD
<i>deferiprone</i> (Ferriprox 3 Times A Day)	T1	PA	SP HD
EXJADE ( <i>deferasirox</i> )	T3	PA	SP HD
FERRIPROX	T3	PA	SP
FERRIPROX (2 TIMES A DAY)	T3	PA	SP
GALZIN	T3		
JADENU ( <i>deferasirox</i> )	T3	PA	SP HD
JADENU SPRINKLE ( <i>deferasirox</i> )	T3	PA	SP HD
RADIOGARDASE	T3		
TRIENTINE HCL 500 MG CAPSULE	T3	PA	SP HD
<i>trientine hcl 250 mg capsule</i> (Syprine)	T1	PA	SP HD
<i>trientine hcl</i>	T1	PA	SP HD
<b>NATRIURETIC PEPTIDES</b>			
VOXZOGO	T4	PA	SP HD
<b>OINTMENT/CREAM BASES</b>			
RADIAGEL	T1		
<b>PHARMACOLOGICAL CHAPERONE-ALPHA-GALACTOSID.A STABZ</b>			
GALAFOLD	T3	PA	SP HD
<b>PKU TX AGENT-COFACTOR OF PHENYLALANINE HYDROXYLASE</b>			
<i>javygtor 100 mg powder packet</i> (Kuvan)	T1	PA	SP
<i>javygtor 100 mg tablet</i> (Kuvan)	T1	PA	SP HD
<i>javygtor 500 mg powder packet</i> (Kuvan)	T1	PA	SP
<i>sapropterin dihydrochloride</i>	T1	PA	SP HD
<b>PROTEIN STABILIZERS</b>			
VYNDAMAX	T3	PA	QL (1 cap/day) SP HD
VYNDAQEL	T3	PA	QL (4 caps/day) SP HD
<b>SOLVENTS</b>			
FT ISOPROPYL ALCOHOL 91%	T1		
FT ISOPROPYL RUB ALCOHOL 70%	T3		
GS ISOPROPYL ALCOHOL 70%	T3		
<i>isopropyl alcohol</i>	T1		
MURI-LUBE MINERAL OIL	T1		

T1 – Typically Generics

T4 – Injectable Specialty Medications

ST – Step Therapy

HD – May require home delivery pharmacy

T2 – Typically Preferred Brands

PA – Prior Authorization

AGE – Age Requirement

PPACA – No Cost-Share Preventive Medication

T3 – Typically Non-Preferred Brands

QL – Quantity Limit

SP – Specialty Medication

CSL – Oral cancer medication subject to cost-share limits

## List of Prescription Medications

UNCLASSIFIED DRUG PRODUCTS (Nutritional/Dietary)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>METABOLIC DEFICIENCY AGENTS</b>		
CYSTADANE	T3	SP
<i>levocarnitine</i> (Carnitor Sf)	T1	
<i>levocarnitine</i> (Carnitor)	T1	
<i>levocarnitine</i> (with sugar) (Carnitor)	T1	
<b>THYMIC STROMAL LYMPHOPOIETIN (TSLP) INHIBITORS</b>		
TEZSPIRE 210 MG/1.91 ML PEN	T4	PA QL(1 pen/28 days) SP HD
TEZSPIRE 210 MG/1.91 ML SYRING	T4	PA SP HD
UNCLASSIFIED DRUG PRODUCTS (Osteoporosis Products)		
<b>BONE RESORPTION INHIBITOR AND VITAMIN D COMBS.</b>		
FOSAMAX PLUS D	T2	ST HD
<b>BONE RESORPTION INHIBITORS</b>		
ACTONEL ( <i>risedronate sodium</i> )	T3	ST HD
<i>alendronate sodium</i>	T1	HD
<i>alendronate sodium</i> (Fosamax)	T1	HD
ADELVIA ( <i>risedronate sodium dr</i> )	T3	ST HD
BINOSTO	T3	ST HD
BONIVA ( <i>ibandronate sodium</i> )	T3	ST HD
EVISTA ( <i>raloxifene hcl</i> )	T3	HD
FOSAMAX ( <i>alendronate sodium</i> )	T3	ST HD
<i>ibandronate sodium</i> (Boniva)	T1	HD
<i>raloxifene hcl</i> (Evista)	T1	HD PPACA
<i>risedronate sodium</i>	T1	HD
<i>risedronate sodium</i> (Actonel)	T1	HD
<i>risedronate sodium</i> (Atelvia)	T1	HD
UNCLASSIFIED DRUG PRODUCTS (Pain Relief And Inflammatory Disease)		
<b>ANTI-INFLAM. INTERLEUKIN-1 RECEPTOR ANTAGONIST</b>		
ARCALYST	T4	PA SP HD
<b>ANTI-INFLAMMATORY, INTERLEUKIN-1 BETA BLOCKERS</b>		
ILARIS	T4	PA SP HD
<b>FIBROMYALGIA AGENTS, SEROTONIN-NOREPINEPH RU INHIB</b>		
SAVELLA	T3	HD
<b>IMMUNOMODULATOR, B-LYMPHOCYTE STIM (BLYS)-SPEC INHIB</b>		
BENLYSTA	T4	PA SP HD

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

T4 – Injectable Specialty Medications

PA – Prior Authorization

QL – Quantity Limit

ST – Step Therapy

AGE – Age Requirement

SP – Specialty Medication

HD – May require home delivery pharmacy

PPACA – No Cost-Share Preventive Medication

CSL – Oral cancer medication subject to cost-share limits

## List of Prescription Medications

### UNCLASSIFIED DRUG PRODUCTS (Substance Abuse)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>OPIOID WITHDRAWAL THER, ALPHA-2 ADRENERGIC AGONIST</b>		
LUCEMYRA	T2	QL (168 tabs/14 days)
<b>OPIOID WITHDRAWAL THERAPY AGENTS, OPIOID-TYPE</b>		
BUNAVAIL	T3	
<i>buprenorphine 2 mg tablet sl</i>	T1	
<i>buprenorphine 8 mg tablet sl</i>	T1	
<i>buprenorphine hcl</i>	T1	
<i>buprenorphine hcl/naloxone hcl</i>	T1	
<i>buprenorphine hcl/naloxone hcl (Suboxone)</i>	T1	
SUBOXONE ( <i>buprenorphine-naloxone</i> )	T3	
ZUBSOLV	T2	

### UNCLASSIFIED DRUG PRODUCTS (Transplant Medications)

<b>RHO KINASE INHIBITOR</b>		
REZUROCK	T3	PA SP HD

### UNCLASSIFIED DRUG PRODUCTS (Urinary Tract Conditions)

<b>BENIGN PROSTATIC HYPERTROPHY/MICTURITION AGENTS</b>		
<i>alfuzosin hcl (Uroxatral)</i>	T1	HD
<i>dutasteride (Avodart)</i>	T1	HD
<i>finasteride (Proscar)</i>	T1	HD
FLOMAX ( <i>tamsulosin hcl</i> )	T3	HD
PROSCAR ( <i>finasteride</i> )	T3	HD
RAPAFLO 4 MG CAPSULE ( <i>silodosin</i> )	T3	QL (1 cap/day) HD
RAPAFLO 8 MG CAPSULE ( <i>silodosin</i> )	T3	HD
<i>silodosin 4 mg capsule (Rapaflo)</i>	T1	QL (1 cap/day) HD
<i>silodosin 8 mg capsule (Rapaflo)</i>	T1	HD
<i>tamsulosin hcl (Flomax)</i>	T1	HD
UROXATRAL ( <i>alfuzosin hcl er</i> )	T3	HD
<b>BPH 5-ALPHA-REDUCTASE INHIB-ALPHA1-ADRENOCEP ANTAG</b>		
<i>dutasteride/tamsulosin hcl (Jalyn)</i>	T1	HD
<b>CYSTINE-DEPLETING AGENTS, NEPHROPATHIC CYSTINOSIS</b>		
CYSTAGON	T2	SP
<b>KIDNEY STONE AGENTS</b>		
<i>solifenacin 10 mg tablet</i>	T1	HD
<i>solifenacin 5 mg tablet</i>	T1	QL (1 tab/day) HD

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

T4 – Injectable Specialty Medications

PA – Prior Authorization

QL – Quantity Limit

ST – Step Therapy

AGE – Age Requirement

SP – Specialty Medication

HD – May require home delivery pharmacy

PPACA – No Cost-Share Preventive Medication

CSL – Oral cancer medication subject to cost-share limits

## List of Prescription Medications

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

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>KIDNEY STONE AGENTS</b>		
THIOLA	T3	SP
THIOLA EC	T3	SP
<i>tiopronin</i>	T1	SP
<b>URINARY TRACT ANTI-SPASMODIC, M(3) SELECTIVE ANTAG.</b>		
<i>darifenacin er 15 mg tablet</i>	T1	HD
<i>darifenacin er 7.5 mg tablet</i>	T1	QL (1 tab/day) HD
<b>URINARY TRACT ANTI-SPASMODIC/ANTI-INCONTINENCE AGENT</b>		
<i>flavoxate hcl</i>	T1	HD
<i>oxybutynin 5 mg/5 ml solution</i>	T1	HD
<i>oxybutynin 5 mg/5 ml syrup</i>	T1	HD
<i>oxybutynin chloride</i>	T1	HD
<i>tolterodine tart er 2 mg cap</i>	T1	QL (1 cap/day) HD
<i>tolterodine tart er 4 mg cap</i>	T1	HD
<i>tolterodine tart er 2 mg cap (Detrol La)</i>	T1	QL(1 cap/day) HD
<i>tolterodine tart er 4 mg cap (Detrol La)</i>	T1	HD
<i>tolterodine tartrate</i>	T1	HD
<i>tropium chloride</i>	T1	HD
<b>UNCLASSIFIED DRUG PRODUCTS (Weight Management)</b>		
<b>APPETITE STIM. FOR ANOREXIA, CACHEXIA, WASTING SYND.</b>		
<i>megestrol acetate</i>	T1	
<b>VITAMINS (Nutritional/Dietary)</b>		
<b>FOLIC ACID PREPARATIONS</b>		
<i>folic acid</i>	T1	
<i>true folic acid 1600mcg dfe tb</i>	T1	
<b>MULTIVITAMIN PREPARATIONS</b>		
CITRANATAL MEDLEY	T3	
CONCEPT DHA CAPSULE	T3	
FOLET ONE	T3	
<i>mvn no.53/iron/folic/dss/dha</i>	T1	
OBSTETRIX ONE	T1	
<b>VITAMIN B PREPARATIONS</b>		
POTABA	T2	HD
<b>VITAMIN B12 PREPARATIONS</b>		
<i>cyanocobalamin (vitamin b-12)</i>	T1	
<i>cyanocobalamin (vitamin b-12) (Nascobal)</i>	T1	

T1 – Typically Generics

T4 – Injectable Specialty Medications

ST – Step Therapy

HD – May require home delivery pharmacy

T2 – Typically Preferred Brands

PA – Prior Authorization

AGE – Age Requirement

PPACA – No Cost-Share Preventive Medication

T3 – Typically Non-Preferred Brands

QL – Quantity Limit

SP – Specialty Medication

CSL – Oral cancer medication subject to cost-share limits



## List of Prescription Medications

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

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

T4 – Injectable Specialty Medications

PA – Prior Authorization

QL – Quantity Limit

ST – Step Therapy

AGE – Age Requirement

SP – Specialty Medication

HD – May require home delivery pharmacy

PPACA – No Cost-Share Preventive Medication

CSL – Oral cancer medication subject to cost-share limits

## Exclusions of Medications for coverage

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

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

- Over-the-counter (OTC) medicines (those that do not require a prescription) except insulin unless state or federal law requires coverage of such medicines.
  - Prescription medications or supplies for which there is a prescription or OTC therapeutic equivalent or therapeutic alternative.
  - Doctor-administered injectable medications covered under the Plan's medical benefit, unless otherwise covered under the Plan's prescription drug list or approved by Cigna Healthcare.
  - Implantable contraceptive devices covered under the Plan's medical benefit.
  - Medications that are not medically necessary.
  - Experimental or investigational medications, including U.S. Food and Drug Administration (FDA)-approved medications used for purposes other than those approved by the FDA unless the medication is recognized for the treatment of the particular indication.
  - Medications that are not approved by the FDA.
  - Prescription and non-prescription devices, supplies, and appliances other than those supplies specifically listed as covered.
  - Medications used for fertility,<sup>11</sup> sexual dysfunction, cosmetic purposes, weight loss, smoking cessation,<sup>12</sup> or athletic enhancement.
  - Prescription vitamins (other than prenatal vitamins) or dietary supplements unless state or federal law requires coverage of such products.
  - Immunization agents, biological products for allergy immunization, biological sera, blood, blood plasma and other blood products or fractions and medications used for travel prophylaxis.
  - Replacement of prescription medications and related supplies due to loss or theft.
  - Medications which are to be taken by or administered to a covered person while they are a patient in a licensed hospital, skilled nursing facility, rest home or similar institution which operates on its premises or allows to be operated on its premises a facility for dispensing pharmaceuticals.
  - Prescriptions more than one year from the date of issue.
  - Coverage for prescription medication products for the amount dispensed (days' supply) which is more than the applicable supply limit, or is less than any applicable supply minimum set forth in The Schedule, or which is more than the quantity limit(s) or dosage limit(s) set by the P&T Committee.
  - More than one prescription order or refill for a given prescription supply period for the same prescription medication product prescribed by one or more doctors and dispensed by one or more pharmacies.
  - Prescription medication products dispensed outside the jurisdiction of the United States, except as required for emergency or urgent care treatment.
- In addition to the plan's standard pharmacy exclusions, certain new FDA-approved medication products (including, but not limited to, medications, medical supplies or devices that are covered under standard pharmacy benefit plans) may not be covered for the first six months of market availability unless approved by Cigna Healthcare as medically necessary.

# Index of Medications

## Symbols

1ST TIER UNILET .....	111
2-IN-1 LANCET.....	111

## A

abacavir/lamivudine/zidovudine.....	58
abacavir sulfate.....	58, 59
abacavir sulfate/lamivudine.....	58
abiraterone.....	48
ABSORICA.....	131
ACAM2000.....	66
acamprosate calcium.....	142
acarbose.....	41
ACCOLATE.....	28
ACCU-CHEK.....	111
AC CUTANE.....	131
ACD-A.....	36
ACD SOLUTION A.....	36
ACE AEROSOL.....	117
acebutolol hcl.....	74
ACETAMIN-CAFF-DIHYDROCODEINE.....	20
acetamin-codein.....	20
acetaminop-codeine.....	20
acetaminophen/caff/dihydrocod.....	20
acetaminophen-cod.....	20
acetazolamide.....	87
acetic acid.....	44, 89, 130
acetic acid/oxyquinoline.....	44
acetylcysteine.....	28
acitretin.....	130
ACTEMRA.....	108
ACTHIB.....	65, 66
ACTIGALL.....	98
ACTI-LANCE.....	111
ACTIMMUNE.....	53
ACTIQ.....	21
ACTIVELLA.....	102
ACTONEL.....	145
ACTOPLUS MET.....	43
ACTOS.....	43
ACULAR.....	89
ACUVAIL.....	89
acyclovir.....	60
ACZONE.....	131
ADACEL TDAP.....	65
ADALAT CC.....	68
ADALIMUMAB.....	46
ADALIMUMAB-ADAZ.....	46
adapalene.....	131, 137

adapalene/benzoyl peroxide.....	131
ADBRY.....	38
ADDERALL.....	62
ADDYI.....	126
adefovir dipivoxil.....	61
ADEMPAS.....	70
ADIPEX-P.....	54
ADRENALIN CHLORIDE.....	89
ADVANCED DNA MEDICATED COLLECT.....	86
ADVANCED TRAVEL.....	111
ADVOCATE.....	111
AEMCOLO.....	34
AEROCHAMBER.....	117
AEROTRACH.....	117
AEROVENT.....	117
AFINITOR.....	49
AFLURIA.....	65
AFLURIA QUAD.....	65
AGRYLIN.....	57
AIMOVIG.....	14, 18
AJOVY.....	14, 18
AKEEGA.....	49
AKTEN.....	90
AKYNZEO.....	96
ALA-SCALP.....	134
albendazole.....	45
ALBENZA.....	45
albuterol.....	26, 27
albuterol sulf.....	26
albuterol sulfate.....	27
ALBUTEROL SULFATE HFA.....	27
ALCAINE.....	90
alclometasone dipropionate.....	134
ALCOHOL.....	46, 144
ALDACTAZIDE.....	88
ALECENSA.....	50
alendronate.....	145
ALEVICYN PLUS.....	131
alfuzosin hcl.....	146
ALINIA.....	55
aliskiren.....	74, 75
ALKERAN.....	47
allopurinol.....	24
almotriptan malate.....	14, 18
ALORA.....	102
alosetron hcl.....	99
alprazolam.....	120, 121
ALREX.....	89

## Index of Medications

ALTABAX.....	134	APTIVUS.....	58
ALTAFLUOR BENOX.....	90	AQUA GLYCOLIC HC.....	135
ALTERNATE SITE.....	111	ARAVA.....	24
ALTUVIIIO.....	67	ARCALYST.....	145
ALUNBRIG.....	50	ARICEPT.....	62
ALVESCO.....	28	ARIDOL.....	86
amantadine.....	55	ARIKAYCE.....	30
AMARYL.....	42	ARIMIDEX.....	48
ambrisentan.....	70	aripiprazole.....	128
amcinonide.....	134, 135	ARIXTRA.....	37
AMICAR.....	66	armodafinil.....	129
amiloride hcl.....	88	ARMOUR THYROID.....	138
amiloride/hydrochlorothiazide.....	88	AROMASIN.....	48
aminocaproic acid.....	66	ARTHROTEC.....	25
amitriptyline/chlordiazepoxide.....	124	ARTISS.....	134
amitriptyline hcl.....	124	ARYMO ER.....	21
amlodipine-atorvast.....	75, 76	asenapine maleate.....	126, 127
amlodipine besylate.....	68, 69, 71, 72	ASMANEX.....	28
amlodipine-olmesartan.....	72	ASMANEX HFA/TWISTHALER.....	28
amlodipine/valsartan/hcthiazid.....	72	aspirin/dipyridamole.....	57
ammonium lactate.....	132	ASSURE.....	111, 116, 119
AMNESTEEM.....	131	ASSURE ID INSULIN SAFETY.....	116
amoxapine.....	124	ASTAGRAF XL.....	108
amoxicillin.....	34, 44	ASTRINGYN.....	67
amphetamine sulfate.....	63	ATABEX EC.....	119
ampicillin trihydrate.....	34	atazanavir sulfate.....	59
ANADROL-50.....	101	ATELVIA.....	145
anagrelide hcl.....	57	atenolol.....	74
ANA-LEX.....	100	atomoxetine hcl.....	126
ANALPRAM HC.....	100, 136	ATOPICLAIR.....	132
ANAPROX DS.....	25	atorvastatin.....	75, 76, 77
anastrozole.....	48	atovaquone/proguanil.....	45
ANCOBON.....	39	atropine sulfate.....	92
ANDRODERM.....	101	ATROVENT HFA.....	26
ANDROGEL.....	101	AURYXIA.....	93
ANDROID.....	101	AUSTEDO.....	78
ANGELIQ.....	104	AVANDIA.....	43
ANNOVERA.....	83	avar.....	36
ANTABUSE.....	142	AVAR.....	36
anthralin.....	131	AVC.....	44
ANTICOAGULANT SODIUM.....	37	AVELOX.....	34
ANZEMET.....	96	AVITENE.....	67
APADAZ.....	20	AVONEX.....	79
APOKYN.....	55	AVSOLA.....	46
apraclonidine hcl.....	91	AYGESTIN.....	106
aprepitant.....	96, 97	AYVAKIT.....	50
APRETUDE.....	59	AZASAN.....	108
APRISO.....	98	AZASITE.....	30
APTIOM.....	80	azathioprine.....	108, 109

## Index of Medications

azelaic acid.....	134	BEXSERO.....	64
azelastine.....	41, 89	bicalutamide.....	48
azelastine hcl.....	41	BIDIL.....	75
AZILECT.....	55	BIJUVA.....	102
azithromycin.....	33	BIKTARVY.....	60
<b>B</b>		BILTRICIDE.....	45
BACIGUENT.....	30	bimatoprost.....	91
bacitracin.....	30	BIMZELX.....	130
bacitracin/polymyxin b sulfate.....	30	BINOSTO.....	145
baclofen.....	118, 152	BIONECT.....	134
BACTRIM.....	30	bisac/nacl/nahco3/kcl/peg 3350.....	99
BAFIERTAM.....	79	bismuth/metronid/tetracycline.....	97
balsalazide disodium.....	98	bisoprolol fumarate.....	74
BALVERSA.....	50	bisoprolol/hydrochlorothiazide.....	74
BANZEL.....	80	BLEPH-10.....	29
BAQSIMI.....	93, 152	BLEPHAMIDE.....	29
BARACLUDE.....	61	BLOOD LANCETS.....	111
BASAGLAR.....	44	BONIVA.....	145
BAXDELA.....	34	BONJESTA.....	96
BD.....	111, 116	BOOSTRIX TDAP.....	65
BELBUCA.....	21	bosentan.....	70
BELVIQ.....	54	BOSULIF.....	50, 152
BELVIQ XR.....	54	BRAFTOVI.....	48
benazepril hcl.....	73	BREATHERITE.....	117
benazepril/hydrochlorothiazide.....	71	BREZTRI AEROSPHERE.....	28
BENLYSTA.....	145	BRILINTA.....	57
benoxinate hcl/fluorescein sod.....	90	brimonidine tartrate.....	91
BENZAMYCIN.....	35	brinzolamide.....	91
BENZEFOAM.....	133	BRIVIACT.....	80
BENZEPRO.....	133	bromfenac sodium.....	89
BENZHYDROCODONE-ACETAMINOPHEN.....	20	bromocriptine mesylate.....	55, 56
BENZNIDAZOLE.....	45	brompheniramine/pseudoephed/dm.....	85
benzonatate.....	85	BROMSITE.....	90, 152
benzoyl peroxide.....	35, 36, 131, 133	BRONCHITOL.....	139
benzphetamine.....	54	BRUKINSA.....	50
benztropine mesylate.....	55	BRYHALI.....	135
BERINERT.....	140	budesonide.....	27, 28, 101, 104
BESIVANCE.....	30	BULLSEYE MINI.....	111
BETADINE.....	89	bumetanide.....	87
betamethasone dipropionate.....	135	BUNAVAIL.....	145
betamethasone/propylene glyc.....	135	buprenorphine.....	21, 146
betamethasone valerate.....	135, 136	bupropion.....	121, 122, 138
BETASERON.....	79	bupropion hcl sr.....	121, 122, 138
betaxolol hcl.....	74, 91	buspirone.....	121, 152
bethanechol chloride.....	64	butalb-acetamin-caff.....	18
BETIMOL.....	91	butalb-acetamin-caff 50-300-40.....	14
BETOPTIC S.....	91	butalb-acetamin-caff 50-325-40.....	14
BEVYXXA.....	37	butalb/acetaminophen/caffeine.....	14, 18
bexarotene.....	47	butalb-aspirin-caffe.....	18

## Index of Medications

butalb-aspirin-caffè 50-325-40 .....	14	CARESENS .....	109, 111
butalbit/acetamin/caff/codeine .....	22	CARETOUCH .....	109, 111
butalbital/acetaminophen .....	14, 18	carisoprodol .....	22, 118, 119
butalbital-asa-caffeine .....	18	carisoprodol/aspirin .....	22, 118
butalbital-asa-caffeine cap (Fiorinal) .....	14	carisoprodol/aspirin/codeine .....	22
butorphanol .....	21	CAROSPIR .....	88
BUTRANS .....	21	carteolol hcl .....	91
BUTTERFLY TOUCH .....	111	carvedilol .....	71, 72
BYDUREON .....	41	carvedilol er .....	71, 72
BYETTA .....	41	CASODEX .....	48
BYNFEZIA .....	106	CATAPRES .....	73
<b>C</b>		CATAPRES-TTS .....	73
CABENUVA .....	57	CAVERJECT .....	141
cabergoline .....	105	CAYA CONTOURED .....	85
CABLIVI .....	66	CAYSTON .....	32
CABOMETYX .....	50	cefaclor .....	32
CADUET .....	75, 76, 77	cefadroxil .....	32
CAFERGOT .....	14, 18	cefditoren pivoxil .....	32
caffeine citrate .....	79	cefixime .....	32
CALAN SR .....	68	cefepodoxime proxetil .....	32
calcipotriene .....	131, 132, 137, 153	cefprozil .....	32
CALCIPOTRIENE .....	132	cefuroxime axetil .....	32
calcipotriene/betamethasone .....	137	CELEBREX .....	26
calcitonin, salmon, synthetic .....	107	celecoxib .....	26
calcitriol .....	132, 147, 148	CELLCEPT .....	108
calcium acetate .....	93	CELONTIN .....	80
CALQUENCE .....	50	CENTANY .....	35
CAMZYOS .....	68	cephalexin .....	32
candesartan cilexetil .....	73	CEQR .....	109
candesartan/hydrochlorothiazid .....	72	CERDELGA .....	143
capecitabine .....	48	CERVIDIL .....	105
CAPEX .....	135	cetirizine hcl .....	40
CAPLYTA .....	126	CETROTIDE .....	105
CAPRELSA .....	50	CETYLEV .....	142
captopril .....	71, 73	cevimeline hcl .....	64
captopril-hctz .....	71	CHANTIX .....	137
CARAFATE .....	97	CHEMET .....	143
CARBAGLU .....	142	CHENODAL .....	98
carbamazepine .....	80, 81, 82	chlordiazepoxide/clidinium br .....	95
CARBATROL .....	80	chlordiazepoxide hcl .....	120
carbidopa .....	55, 56, 57	chlorhexidine gluconate .....	140
carbidopa/levodopa .....	55	chloroquine ph .....	45
carbidopa/levodopa/entacapone .....	55	chlorpromazine hcl .....	128
carbinoxamine maleate .....	40	chlorpropamide .....	42
CARDIZEM LA .....	68	chlorthalidone .....	74, 88
CARDURA .....	72	chlorzoxazone .....	118
CARDURA XL .....	72	CHOLBAM .....	98
CAREONE .....	111	cholestyramine .....	77
CAREPOINT .....	116	cholestyramine/aspartame .....	77

## Index of Medications

choline salicyl/mag salicylate .....	14, 18	clopidogrel bisulfate .....	57
CHORIONIC GONAD.....	107	clorazepate dipotassium.....	120
CHORIONIC GONADOTROPIN .....	107	clotrimazole .....	39
CIALIS .....	141	clotrimazole/betamethasone dip.....	39
CIBINQO.....	132	clozapine .....	126
ciclodan.....	39	CLOZAPINE ODT.....	126
CICLODAN .....	39, 46	CLOZARIL.....	127
ciclopirox.....	39, 40, 46	COAGUCHEK.....	111
cilostazol .....	57	COARTEM .....	45
CIMDUO.....	58	codeine/butalbital/asa/caffein .....	22
cimetidine hcl .....	98	codeine sulfate.....	21
CIMZIA.....	46	colchicine .....	24, 26
cinacalcet hcl.....	141	COLCHICINE .....	24
CINRYZE.....	140	COLCRYS .....	24
CIPRO.....	34	colesevelam hcl .....	77
ciprofloxacin.....	29, 34	COLESTID .....	77
ciprofloxacin hcl.....	29	colestipol hcl .....	77
CIPROFLOXACIN HCL-FLUOCINOLONE .....	29	COMBIGAN .....	91
citalopram hbr .....	122	COMBIPATCH .....	102
CITRANATAL .....	94, 119	COMBIVENT RESPIMAT .....	27
CITRANATAL BLOOM .....	94	COMETRIQ .....	50
CITRANATAL MEDLEY .....	147	COMFORT .....	24, 110, 111, 112, 113, 114, 115, 116, 118
CITRATE PHOSPHATE DEXTROSE .....	37	COMFORT PAC .....	24, 118
CLARAVIS .....	131	COMFORT PAC-IBUPROFEN.....	24
CLARINEX-D.....	40	COMFORT PAC-MELOXICAM .....	24
clarithromycin .....	33	COMFORT PAC-NAPROXEN.....	24
clemastine fumarate.....	40	COMFORTSEAL .....	117
CLENPIQ .....	99	COMPACT SPACE CHAMBER.....	117
CLEOCIN .....	32, 35, 36	COMPAZINE .....	96
CLEVER CHEK .....	111	COMPLERA.....	60
CLEVER CHOICE.....	117	COMTAN .....	56
CLIMARA .....	102	CONCEPT .....	147
CLINDACIN.....	36	CONCEPT DHA CAPSULE.....	147
clindamycin hcl.....	33	CONTRAVE.....	54
clindamycin palmitate hcl.....	33	COPIKTRA .....	50
clindamycin phos/benzoyl perox .....	131, 154	COREG.....	71, 72
clindamycin phosphate .....	35, 36	COREG CR .....	71, 72
clindamycin/tretinoin.....	131	coremino er.....	35
clobazam.....	80	CORLANOR .....	69
clobetasol propionate.....	135, 136	CORTEF .....	104
CLOCORTOLONE PIVALATE.....	135	CORTENEMA.....	101
clodan .....	135	cortisone acetate.....	104
CLODAN .....	135	CORTISPORIN.....	35
CLODERM .....	135	COSENTYX.....	130
clomiphene citrate.....	107	COTELLIC .....	49
clomipramine hcl.....	124	CRESEMBA .....	39
clonazepam.....	80	CRINONE.....	106, 107
clonidine .....	73, 74, 124	cromolyn .....	23, 28, 90

## Index of Medications

crotamiton.....	55	DEPO-SUBQ PROVERA.....	83
CUROSURF.....	140	DEPO-TESTOSTERONE.....	101
CUVPOSA.....	95	DERMA-SMOOTHIE-FS.....	135
cyanocobalamin.....	147	DERMATOP.....	135
cyclobenzaprine hcl.....	119	dermazene.....	137
CYCLOGYL.....	92	DERMAZENE.....	137
CYCLOMYDRIL.....	92	DERMOTIC.....	89
cyclopentolate hcl.....	92	DESCOVY.....	58
cyclophosphamide.....	47	desflurane.....	22, 23
cycloserine.....	32	desipramine hcl.....	124
CYCLOSERINE.....	32	desloratadine.....	40
CYCLOSET.....	41	desmopressin.....	102, 155
cyclosporine.....	108, 109	desogestrel-ethinyl estradiol.....	83
CYLTEZO.....	46	desonide.....	135
cyproheptadine.....	40	DESOWEN.....	135
CYSTADANE.....	144	desoximetasone.....	135, 136
CYSTADROPS.....	92	desvenlafaxine succnt er.....	123
CYSTAGON.....	146	dexamethasone.....	29, 90, 104
CYSTARAN.....	92	dexamethasone sodium phosphate.....	90
CYSTO-CONRAY II.....	87	DEXCOM.....	109
CYSTOGRAFIN.....	87	DEXCOM G7.....	109
CYTOMEL.....	138	dexlansoprazole.....	99, 100
CYTOTEC.....	97	dexmethylphenidate er.....	125
<b>D</b>		dexmethylphenidate hcl.....	125
dabigatran.....	38	dextroamp-amphet er.....	63
dalfampridine.....	79	dextroamph.....	63
DALIRESP.....	29	dextroamphetamine.....	62, 63
danazol.....	105	dextroamphetamine er.....	63
DANTRIUM.....	119	dextroamphetamine sulfate.....	63
dantrolene sodium.....	119	DIACOMIT.....	80
dapsone.....	31, 131, 155	DIASTAT.....	80
DAPTACEL DTAP.....	65	diatrizoate meglumine.....	87
DARAPRIM.....	45	diazepam.....	80, 120
darifenacin.....	147	diazoxide.....	93
darunavir.....	58	DIBENZYLINE.....	63
DAURISMO.....	49	dichlorphenamide.....	142
DAXBIA.....	32	DICLAREAL.....	131
DAYPRO.....	25	DICLEGIS.....	96
DAYTRANA.....	125	diclofenac.....	19, 25, 90, 131
DAYVIGO.....	129	dicloxacillin sodium.....	34
deferasirox.....	143, 144	dicyclomine hcl.....	96
deferiprone.....	144	diethylpropion.....	54
deflazacort.....	104	DIFICID.....	33
DELSTRIGO.....	60	diflunisal.....	14, 18
demeclocycline.....	35	digoxin.....	69
DEMSEK.....	73	dihydroergotamine.....	14, 18
DEPEN.....	23	DILANTIN.....	80
DEPO-ESTRADIOL.....	102	DILATRATE-SR.....	70
DEPO-PROVERA.....	83, 106	DILAUDID.....	21



## Index of Medications

diltiazem .....	68	EASY TRAK .....	109
diltiazem hcl .....	68	EASY TWIST.....	112
dimethyl fumarate.....	79	EC-NAPROSYN.....	25
dimethyl sulfoxide.....	143	econazole nitrate.....	39
diphenoxylate hcl/atropine.....	96	ECOZA.....	39
DIPHThERIA-TETANUS TOXOIDS-PED.....	65	EDEX.....	141
DIPROLENE.....	135	EDURANT.....	58
dipyridamole.....	57	efavirenz.....	58, 60
DISALCID.....	23	effer-k.....	94
disopyramide phosphate.....	68	EFFER-K.....	94
disulfiram.....	142	EFFIENT.....	57
DIURIL.....	88	EFUDEX.....	53
divalproex sodium.....	80	EGRIFTA.....	104
DIVIGEL.....	102	ELESTRIN.....	102
dofetilide.....	68	eletriptan hydrobromide.....	14, 18
DOJOLVI.....	92	ELIDEL.....	108
donepezil hcl.....	62	ELIMITE.....	55
DOPTELET.....	83	ELIQUIS.....	37
DORAL.....	129	ELLA.....	83
dorzolamide hcl.....	91	ELMIRON.....	22
dorzolamide hcl/timolol maleat.....	91	EMBRACE.....	112, 116
dorzolamide/timolol/pf.....	91	EMCYT.....	53
DOVATO.....	57	EMEND.....	96, 97
doxazosin mesylate.....	72	EMFLAZA.....	104, 156
doxepin.....	124, 129	EMGALITY.....	14, 18, 79
doxercalciferol.....	142	emollient combination.....	132
doxycycline.....	35, 141	EMSAM.....	121
doxycycline hyclate.....	35, 141	emtricitabine.....	58, 59
doxylamine succinate/vit b6.....	96	emtricitabine-tenofv.....	58
DRISDOL.....	148	EMTRIVA.....	59
dronabinol.....	96	EMVERM.....	45
DROPLET.....	112	enalapril/hydrochlorothiazide.....	71
drospir/eth estra/levomefol ca.....	83, 84	enalapril maleate.....	73
DROXIA.....	67	ENBREL.....	46
droxidopa.....	63	ENDARI.....	67
DRYSOL.....	131	ENDO-AVITENE.....	67
DUAVEE.....	104	ENDOMETRIN.....	107
DUETACT.....	43	ENGERIX-B ADULT.....	66
DULERA.....	27	ENGERIX-B PEDIATRIC-ADOLESCENT.....	66
duloxetine hcl dr.....	123	ENHERTU.....	53
DUOPA.....	56	ENLITE SERTER.....	109
DUPIXENT.....	108	enoxaparin.....	37, 38
DURAGESIC.....	21	ENSPRYNG.....	108
dutasteride.....	146	entacapone.....	55, 56, 57
DYAZIDE.....	88	entecavir.....	61
<b>E</b>		ENTERO.....	86
EASIVENT.....	117	ENTOCORT EC.....	104
EASY COMFORT.....	116	ENTRESTO.....	72
EASY TOUCH.....	109, 112	ENTYVIO.....	99

## Index of Medications

ENVARBUS	109	EVOXAC	64
ENZOCLEAR	133	EVRYSDI	143
EPANED	73	EXELON	62
EPCLUSA	61	exemestane	48
EPIDIOLEX	80	EXJADE	144
EPIFOAM	136	EXKIVITY	50
epinastine hcl	41	EXODERM	39
epinephrine	62, 89	EYSUVIS	90
EPIVIR HBV	61	E-Z	86, 87, 117
eplerenone	88	ezetimibe	75, 77, 78
eprosartan mesylate	73	ezetimibe/simvastatin	75
EQUETRO	121	EZ FLU	65
ergocalciferol	148	EZ-LETS	112
ergoloid mesylates	75	EZ SMART	112
ergotamine tartrate/caffeine	14, 18	<b>F</b>	
ERIVEDGE	49	FABHALTA	67
ERLEADA	48	FACTIVE	34
erlotinib	50	famciclovir	60
ERYPED	33	famotidine	98
ERY-TAB	33	FANAPT	127
erythromycin	30, 33, 35, 36	FARESTON	53
escitalopram	122	FARXIGA	41
ESGIC	14, 18	FARYDAK	47
esomeprazole dr	100	febuxostat	24
esomeprazole mag dr	100	felbamate	81
esomeprazole sodium	100	FELDENE	25
estazolam	129	felodipine	68
ESTRACE	102, 106	FEMARA	48, 49
estradiol	83, 84, 85, 102, 103, 106	FEMCAP	85
ESTRING	106	FEMHRT	103
ESTROGEL	103	FEMRING	106
estrogen, ester/me-testosterone	102	fenofibrate	77, 78
ESTROSTEP FE	83	fenofibric acid	77, 78
eszopiclone	129	fenoprofen	25
ethambutol hcl	32	FENSOLVI	105
ethinyl estradiol/drospirenone	84	fentanyl	21
ethosuximide	80, 82	FENTANYL	21
ethynodiol d-ethinyl estradiol	84	FERRIPROX	144
etodolac	25	FETZIMA	123
etonogestrel/ethinyl estradiol	83	FEXMID	119
etoposide	53	FIASP	44, 110
EURAX	55	FIBRICOR	77
EVAMIST	103	FIFTY50	112
EVEKEO	63	finasteride	146
everolimus	49, 109	FINE 30	112
EVICEL	67	FINGERSTIX	112
EVISTA	145	FINTEPLA	81
EVOCLIN	36	FIORICET	14, 22
EVOTAZ	59	FIORINAL	14, 18, 22

## Index of Medications

FIORINAL WITH CODEINE #3.....	22	folic acid.....	147
FIRDAPSE.....	79	FOLLISTIM AQ.....	107
FIRMAGON.....	50	fondaparinux.....	37
FLAGYL.....	31	FORACARE.....	112
FLAREX.....	90	FORA LANCETS.....	112
flavoxate hcl.....	147	FORA TN'GO.....	110
FLEQSUVY.....	119	FORTEO.....	142
FLEXICHAMBER.....	117	FOSAMAX.....	145
FLOMAX.....	146	FOSAMAX PLUS D.....	145
FLOVENT.....	28	fosamprenavir calcium.....	59
FLOVENT DISKUS.....	28	fosaprepitant dimeglumine.....	96
FLUAD.....	65	fosfomycin tromethamine.....	31
FLUAD QUAD.....	65	fosinopril/hydrochlorothiazide.....	71
FLUARIX QUAD.....	65	fosinopril sodium.....	73
FLUBLOK.....	65	FRAGMIN.....	37
FLUBLOK QUAD.....	65	FREESTYLE LANCETS.....	112
FLUCELVAX QUAD.....	65	FREESTYLE LIBRE.....	109, 110
fluconazole.....	39	frovatriptan succinate.....	18
flucytosine.....	39	FT.....	144
fludrocortisone acetate.....	105	ful-glo.....	86
FLULAVAL QUAD.....	65	FUL-GLO.....	86
FLUMADINE.....	60	FULPHILA.....	83
FLUMIST QUAD.....	65	FURADANTIN.....	33
flunisolide.....	89	FUROSCIX.....	87
fluocinolone acetonide.....	89, 135, 136	furosemide.....	87
fluocinolone/shower cap.....	135	FUZEON.....	58
fluocinonide.....	135	FYCOMPA.....	81
fluorescein sodium.....	86	<b>G</b>	
FLUORIDEX.....	92	gabapentin.....	79, 81
fluorometholone.....	90	GABITRIL.....	81
FLUOROPLEX.....	53	GALAFOLD.....	144
fluorouracil.....	53	galantamine er.....	62
fluoxetine.....	122, 128	galantamine hbr.....	62
fluphenazine hcl.....	128	GALZIN.....	144
flurazepam.....	129	ganirelix acet.....	105
flurbiprofen.....	25, 90	GANIRELIX ACET.....	105
flutamide.....	48	GARDASIL 9.....	66
fluticasone.....	27, 89, 135, 136	GASTROCROM.....	23
FLUTICASONE.....	28	GASTROGRAFIN.....	87
fluticasone propion/salmeterol.....	27	GASTROMARK.....	87
FLUTICASONE-SALMETEROL.....	27	gatifloxacin.....	30
fluvastatin sodium.....	76	GATTEX.....	100
FLUVIRIN.....	65	GAVRETO.....	50
fluvoxamine er.....	122	gelatin sponge, absorb/porcine.....	67
fluvoxamine maleate.....	122	GELFILM.....	91
FLUZONE.....	65	GELFOAM.....	67
FLUZONE QUAD.....	65	gemfibrozil.....	77
FOCALIN.....	125	GENERESS FE.....	84
FOLET ONE.....	147	GENOTROPIN.....	105

## Index of Medications

gentamicin.....	30, 36	HEALTHY ACCENTS.....	112
GENVOYA.....	60	HEMLIBRA.....	67
GILOTRIF.....	50	heparin.....	37, 38
glatiramer.....	79	HEPARIN.....	37, 38
glatiramer acetate.....	79	HEPLISAV-B.....	66
glatopa.....	79	HETLIOZ.....	129
GLEEVEC.....	50	HIBERIX.....	65
GLEOSTINE.....	47	HIPREX.....	31
glimepiride.....	42, 43	homatropine hbr.....	92
glipizide.....	42	HPR PLUS-MB HYDROGEL.....	132
GLUCAGEN.....	86	HUMALOG.....	44, 110
glucagon.....	93	HUMAPEN.....	110
GLUCAGON.....	93	HUMIRA.....	46, 47
GLUCOCOM.....	110, 112	HUMULIN R.....	44
GLUCOCOM AUTOLINK.....	110	HYCAMTIN.....	49
GLUCOPHAGE XR.....	42	HYCODAN.....	86
GLUCOTROL.....	42	hydralazine hcl.....	74
GLUCOTROL XL.....	42	HYDREA.....	47
glyburide.....	42, 43	HYDRO 35.....	133
GLYCAT.....	95	HYDRO 40.....	133
glycine urologic solution.....	46	hydrochlorothiazide.....	71, 72, 74, 88
glycopyrrolate.....	95, 96	hydrocodone/acetaminophen.....	20
GLYNASE.....	42	HYDROCODONE-ACETAMINOPHEN.....	20
GLYSET.....	41	hydrocodone bitartrate.....	21, 22
GLYXAMBI.....	42	hydrocodone bit/homatrop me-br.....	86
GOJJI.....	112	hydrocodone/chlorphen p-stirex.....	86
GONAL-F.....	107	hydrocodone/cpm/pseudoephed.....	85
GORDON'S UREA.....	134	HYDROCODONE-GUAIFENESIN.....	86
granisetron hcl.....	97	hydrocodone-homatropine.....	86
GRANIX.....	83	HYDROCODONE-HOMATROPINE.....	86
GRASTEK.....	64	hydrocodone/ibuprofen.....	20
griseofulvin.....	39	hydrocortisone.....	89, 100, 101, 104, 136, 137
GRIS-PEG.....	39	hydrocortisone/acetic acid.....	89
GS ISOPROPYL.....	46, 144	hydrocortisone/lidocaine/aloe.....	100
GUAIACOL.....	132	hydrocortisone/pramoxine.....	101, 136
guanfacine hcl.....	74, 124	hydrogen peroxide.....	130
guanidine hcl.....	64	hydromorphone.....	21
GUARDIAN.....	110	hydroxychloroquine sulfate.....	45
GUARDIAN RT.....	110	hydroxyurea.....	47
GYNAZOLE 1.....	38	hydroxyzine hcl.....	40
<b>H</b>		hydroxyzine pamoate.....	40
HADLIMA.....	46	HYFTOR.....	134
HAEGARDA.....	140	HYPER-SAL.....	143
HALCION.....	129	HYRIMOZ.....	47
halobetasol.....	136	HYSINGLA ER.....	21
halobetasol propionate.....	136	<b>I</b>	
haloperidol.....	128	ibandronate.....	107, 145
HALUCORT.....	132	ibandronate sodium.....	145
HARVONI.....	61	IBRANCE.....	50, 51, 159

## Index of Medications

IBUDONE .....	20	IPOLE .....	64
ibuprofen.....	20, 25	ipratropium bromide .....	26, 89
ibuprofen/oxycodone .....	20	irbesartan.....	72, 73
icatibant acetate.....	140	irbesartan/hydrochlorothiazide .....	72
icosapent ethyl.....	95	IRESSA .....	51
IDHIFA.....	53	ISENTRESS.....	59
IFE.....	141	isoflurane .....	22, 23
ILARIS .....	145	isomethept/dichlphn/acetaminop .....	18
ILEVRO.....	90	isomethepten/caf/acetaminophen.....	18
ILUMYA.....	130	isoniazid.....	32
imatinib mesylate.....	50, 51	isopropyl alcohol.....	144
IMBRUVICA .....	51	ISOPTO CARPINE .....	91
IMCIVREE.....	54	isosorbide dinitrate .....	70
imipramine pamoate.....	124	isosorbide-hydralazine .....	75
imiquimod .....	132	isotretinoin.....	131, 160
IMPAVIDO.....	45	isoxsuprine hcl .....	75
IMURAN .....	109	isradipine.....	69
IMVEXXY .....	106	ISTURISA .....	101
INBRIJA.....	56	itraconazole.....	39
INCONTROL .....	112	ivermectin.....	45, 55, 134
INCRELEX.....	105	IWILFIN.....	51
INCRUSE ELLIPTA .....	26	IXCHIQ .....	66
indapamide.....	88	<b>J</b>	
INDICLOR .....	87	JADENU .....	144
indomethacin.....	25	JAKAFI .....	49
INFANRIX DTAP.....	66	JANSSEN COVID-19 VACCINE.....	64
INFASURF .....	140	JANUMET .....	43
INFLECTRA.....	47	JANUMET XR.....	43
INGREZZA.....	79	JANUVIA.....	42
INJECT EASE .....	112	JARDIANCE.....	41
INLYTA .....	51	javygtor.....	144
INNOPRAN XL.....	74	JOENJA .....	140
INOVA .....	133	JULUCA.....	57
INPEN .....	110	JYLAMVO .....	48
INQOVI.....	48	JYNARQUE.....	88
INREBIC.....	51	JYNNEOS .....	66
INSPIRACHAMBER.....	117	<b>K</b>	
INSPIRA .....	88	KADIAN .....	21
INSULIN SYRINGE.....	116	KALBITOR .....	140
INSUPEN.....	116	KALETRA .....	59
INTRAROSA .....	101	KALYDECO .....	139
INVACARE .....	112	KATERZIA .....	69
INVEGA ER.....	127	KEFLEX.....	32
INVELTYS .....	90	KERAFOAM.....	133
INVIRASE.....	59	keralyt.....	133
iodine/potassium iodide .....	137	KERALYT .....	133
iodine/sodium iodide .....	137	KERENDIA.....	88
IODOFLEX .....	137	KESIMPTA.....	79
IODOSORB .....	137	ketoconazole.....	39, 40

## Index of Medications

ketorolac.....	19, 89, 90	LEVOTHYROXINE.....	138
KEVZARA.....	108	levothyroxine sodium.....	138
KINRIX.....	66	LEVULAN.....	53
KISQALI.....	49, 51	LEXIVA.....	59
KITABIS.....	31	lidocaine.....	22, 23, 86, 100, 101, 136
KLARON.....	131	lidocaine hcl.....	22, 23, 86
KLONOPIN.....	80	lidocaine hcl/glycerin.....	86
klor-con.....	94, 95	LIDOCAINE-HYDROCORTISONE.....	101
KOSELUGO.....	49	LIDODERM.....	23
K-PHOS.....	95	LIKMEZ.....	31
KRINTAFEL.....	45	LILETTA.....	85
K-TAB ER.....	95	lindane.....	137
KYLEENA.....	85	linezolid.....	34
KYNAMRO.....	75	liothyronine sodium.....	138
KYNMOBI.....	56	LIPOFEN.....	77
<b>L</b>		LIQUID E-Z PAQUE.....	87
labetalol hcl.....	72	LIQUID POLIBAR PLUS.....	87
LACRISERT.....	89	lisdexamfetamine.....	63
lactulose.....	95, 99	lisinopril.....	71, 73
LAGEVRIO.....	62	lisinopril/hydrochlorothiazide.....	71
lamivudine.....	58, 59, 61	lissamine.....	86
lamivudine/zidovudine.....	58	LITEAIRE.....	118
lamotrigine.....	81	LITE TOUCH.....	110, 112
LAMPIT.....	45	LITETOUCH.....	118
lansoprazole/amoxicilin/clarith.....	97	LITFULO.....	24
lansoprazole dr.....	100	lithium carbonate.....	121
lansoprazole odt.....	100	lithium citrate.....	121
lanthanum carbonate.....	93	LITHOSTAT.....	95
lapatinib ditosylate.....	51	LIVTENCITY.....	60
latanoprost.....	91	L-MESITRAN SOFT.....	134
LAZANDA.....	21	l-norgest/e.estradiol-e.estrad.....	84
leflunomide.....	24	LOCORT.....	104
lenalidomide.....	50	LODINE.....	25
LENVIMA.....	51	LOESTRIN.....	84
LETAIRIS.....	70	LOESTRIN FE.....	84
letrozole.....	48	LOKELMA.....	93
leucovorin calcium.....	140	LO LOESTRIN FE.....	84
LEUKERAN.....	47	LOMAIRA.....	54
LEUKINE.....	83	LOMOTIL.....	96
leuprolide acetate.....	50	LONHALA MAGNAIR.....	26
LEUPROLIDE DEPOT.....	50	LONSURF.....	48
levabuterol.....	27	loperamide hcl.....	96
LEVITRA.....	141	LOPID.....	77
levobunolol hcl.....	91	lopinavir/ritonavir.....	59
levocarnitine.....	145	LOPROX.....	40
levocetirizine dihydrochloride.....	40	lorazepam.....	120
levofloxacin.....	30, 34	LORBRENA.....	51
levonorgestrel/ethin.estradiol.....	84	LORTAB.....	20
levothyroxine.....	138	losartan/hydrochlorothiazide.....	72

## Index of Medications

losartan potassium	73	memantine hcl	78
LOSEASONIQUE	84	memantine hcl er	78
LOTEMAX	90	MENACTRA	65
loteprednol	89, 90, 161	MENEST	103
loteprednol etabonate	90	MENOPUR	107
lovastatin	76	MENOSTAR	103
LOVENOX	38	MENQUADFI	65
loxapine succinate	128	MENVEO A-C-Y-W-135-DIP	65
lubiprostone	99	meperidine	21
LUCEMYRA	145	MEPHYTON	148
LULICONAZOLE	40	meprobamate	121
LUMAKRAS	49	mercaptapurine	48
LUMRYZ	129	mesalamine	98
LUPANETA	105	MESNEX	140
LUPKYNIS	109	MESTINON	62
LUPRON DEPOT	50, 105	METADATE	125
lurasidone	127	metaproterenol	27
LUXIQ	136	metaxalone	119
LYNPARZA	51	metformin hcl	42, 43
LYRICA	81	methamphetamine hcl	63
LYSODREN	53	methazolamide	87
LYSTEDA	66	methenamine hippurate	31
LYTGOBI	51	methenamine mandelate	31
LYUMJEV	44	methenam/m.blue/salicyl/hyoscy	31, 162
<b>M</b>		methenam/sod phos/mblue/hyoscy	31
MACROBID	33	methen/mblue/sal/sod phos/hyos	31
MACRODANTIN	34	methimazole	138
mafenide	36	METHITEST	101
MAGELLAN INSULIN	116	meth/meblue/sod phos/psal/hyos	31
malathion	137	methocarbamol	119
maprotiline hcl	124	methotrexate sodium	48
maraviroc	58	methoxsalen	130
MARPLAN	121	methscopolamine bromide	97
MATULANE	53	methyl dopa	74
MAVENCLAD	79	methyl dopa/hydrochlorothiazide	74
MAXZIDE	88	methylergonovine maleate	105
MAYZENT	79	METHYLIN	125
meclofenamate	25	methylphenidate	125, 126, 162
MEDIHONEY	134	methylphenidate er	125, 126
MEDLANCE	113	methylphenidate hcl	125, 126
MEDROL	104	methylphenidate la	126
medroxyprogesterone	83, 106	methylprednisolone	104
mefenamic acid	19	methyl salicylate	132
mefloquine hcl	45	methyltestosterone	101, 102
megestrol acetate	53, 147	metoclopramide hcl	99
MEKINIST	49	metolazone	88
MEKTOVI	49	METOPIRONE	87
meloxicam	25	metoprolol/hydrochlorothiazide	74
melphalan	47	metoprolol succinate	74

## Index of Medications

metoprolol tartrate .....	74	MORPHABOND ER.....	21
metronidazole.....	31, 35, 134	morphine sulfate.....	21
metirosine.....	73	MOTOFEN.....	96
MEZPAROX-HC.....	136	MOVANTIK.....	38
MIACALCIN.....	107	MOXATAG.....	34
miconazole nitrate.....	38	MOXEZA.....	30
MICROCHAMBER.....	118	moxifloxacin.....	30, 34
MICROGESTIN 24 FE.....	84	MS CONTIN.....	21
MICROLET.....	113	MUGARD.....	141
MICROSPACER.....	118	MULPLETA.....	83
MICRO THIN.....	113	mupirocin.....	36
midazolam hcl.....	129	MURI-LUBE.....	144
midodrine hcl.....	63	MUSE.....	141
MIFEPREX.....	142	mvn no.53/iron/folic/dss/dha.....	147
mifepristone.....	142	MYALEPT.....	107
miglitol.....	41	MYAMBUTOL.....	32
miglustat.....	143	mycophenolate mofetil.....	108, 109
millipred.....	104	MYDRIACYL.....	92
MILLIPRED.....	104	MYFORTIC.....	109
MIMYX.....	132	MYGLUCOHEALTH.....	113
MINASTRIN 24 FE.....	84	MYLERAN.....	47
MINIMED RESERVOIR.....	116	MYORISAN.....	131
MINIPRESS.....	72	MYTESI.....	96
MINITRAN.....	70	<b>N</b>	
MINIVELLE.....	103	nabumetone.....	25
minocycline.....	35	nadolol.....	74
minocycline er.....	35	nadolol/bendroflumethiazide.....	74
minoxidil.....	74	naftifine.....	40
MIRAPEX ER.....	56	NAFTIN.....	40
MIRCETTE.....	84	NALFON.....	25
MIRENA.....	85	NALOCET.....	20
mirtazapine.....	120	naloxone.....	22, 38, 146
misoprostol.....	25, 97	NALOXONE.....	38
MITIGARE.....	24	naltrexone.....	38
MITOSOL.....	92	NAMENDA.....	78
M-M-R II VACCINE.....	66	NAMENDA XR.....	78
MOBIC.....	25	NAMZARIC.....	78
MOBILE LANCETS.....	110	NAPROSYN.....	25
modafinil.....	129	naproxen.....	19, 25, 26
moexipril hcl.....	73	naratriptan.....	18
molindone hcl.....	128	NARCAN.....	38
MOLNUPIRAVIR.....	62	NATACYN.....	38
MOMETACURE.....	136	nateglinide.....	42
mometasone furoate.....	89, 136	NATROBA.....	55
MONOJECT.....	116	NAYZILAM.....	80
MONOLET.....	113	NEBUPENT.....	45
MONSEL'S.....	67	nebusal.....	143
montelukast sodium.....	28	NEBUSAL.....	143
MONUROL.....	31	NEEDLE.....	116



## Index of Medications

nefazodone hcl.....	123	norethin-eth estrad.....	103
neomycin.....	29	norgestrel-ethinyl estradiol.....	84
neomycin/bacit/p-myx/hydrocort.....	29	NORLIQVA.....	69
neomycin/polymyxin b/dexametha.....	29	NORPACE.....	68
neomycin/polymyxin b/hydrocort.....	29	NORPACE CR.....	68
neomycin/polymyxin b/gramicidin.....	30	nortriptyline hcl.....	124
neomycin sulfate.....	31	NORVASC.....	69
neomycin sulf/bacitracin/poly.....	30	NORVIR.....	59
neomycin sulf/polymyxin b sulf.....	130	NOURIANZ.....	56
NEO-SYNALAR.....	35	NOVA.....	113
NERLYNX.....	51	NOVAREL.....	107
NEULASTA.....	83	NOVOPEN.....	110
NEULUMEX.....	87	NOXAFIL.....	39
NEUPOGEN.....	83	NUBEQA.....	48
NEUPRO.....	56	NUCALA.....	28
NEURONTIN.....	81	NUCORT.....	136
NEUTRASAL.....	142	NUCYNTA.....	21
nevirapine.....	59	NUCYNTA ER.....	21
NEXIUM DR.....	100	NUDEXTA.....	79
NEXPLANON.....	83	NULEV.....	97
NGENLA.....	105	NULIBRY.....	143
niacin.....	78	NULYTELY.....	99
NIASPAN.....	78	NUMOISYN.....	142
nicardipine hcl.....	69	NUPLAZID.....	122
NICOTROL.....	137	NURTEC ODT.....	18
nifedipine.....	68, 69	NUVARING.....	83
nilutamide.....	48	NUZYRA.....	35
NINLARO.....	51	NYMALIZE.....	69
nisoldipine er.....	69	nystatin.....	39, 40
nitazoxanide.....	55	NYVEPRIA.....	83
nitisinone.....	143	<b>O</b>	
NITRO-DUR.....	70	OBREDON.....	86
nitrofurantoin.....	33, 34	OBSTETRIX.....	119, 147
nitroglycerin.....	70, 99, 164	OBTREX DHA.....	119
NITROLINGUAL.....	70	OCALIVA.....	98
NITROMIST.....	70	octreotide acetate.....	106
NITROSTAT.....	70	ODACTRA.....	64
NITYR.....	143	ODEFSEY.....	60
NIVESTYM.....	83	ODOMZO.....	49
NOCTIVA.....	102	OFEV.....	140
NORCO.....	20	ofloxacin.....	30, 34
NORDITROPIN FLEXPRO.....	105	OGSIVEO.....	51
norelgestromin/ethin.estradiol.....	85	OJJAARA.....	51
noreth-ethinyl estradiol/iron.....	84	olanzapine.....	127, 128
norethind-eth estrad.....	84, 103	olmesartan/amlodipin/hcthiazid.....	72
norethindrone.....	84, 103, 106	olmesartan-hctz.....	72
norethindrone ac-eth estradiol.....	84, 103	olmesartan medoxomil.....	73
norethindrone-e.estradiol-iron.....	84	olopatadine.....	41, 89
norethin-ee.....	84	olopatadine hcl.....	41, 89

## Index of Medications

OLPRUVA.....	96	OSMOLEX ER.....	56
OLUMIANT.....	24	OSPHENA.....	142
omega-3 acid ethyl esters.....	95	OTEZLA.....	24
omeppi.....	100	OTOVEL.....	29
omeprazole-bicarb.....	100	OTREXUP.....	23
omeprazole dr.....	100	OVACE.....	132
OMNIPOD.....	110	OVIDE.....	137
OMNIPOD 5 (GEN 5) KIT.....	110	OVIDREL.....	107
OMNIPOD 5 (GEN 5) POD.....	110	oxandrolone.....	101
OMNIPOD CLASSIC (GEN 3) kit.....	110	oxaprozin.....	25, 26
OMNIPOD CLASSIC (GEN 3) KIT.....	110	OXAPROZIN.....	26
OMNIPOD CLASSIC (GEN 3) PODS.....	110	OXAYDO.....	21
OMNIPOD CLASSIC (GEN 4) KIT.....	110	oxazepam.....	120
OMNIPOD CLASSIC (GEN 4) PODS.....	110	oxcarbazepine.....	81
OMNIPRED.....	90	OXERVATE.....	92
OMNITROPE.....	105	OXSORALEN-ULTRA.....	130
OMVOH.....	107	OXTELLAR XR.....	81
ON CALL.....	113	oxybutynin chloride.....	147
ondansetron.....	97	oxycodone hcl.....	20, 21
ONETOUCH.....	110, 113	oxycodone hcl/acetaminophen.....	20
ONETOUCH DELICA.....	110, 113	oxycodone hcl/aspirin.....	20
ONFI.....	80	OXYCODONE HCL ER.....	21
ON-THE-GO.....	113	oxymorphone hcl.....	21
ONUREG.....	48	OZEMPIC.....	41
OPDIVO.....	52	OZOBAX DS.....	119
OPFOLDA.....	143	<b>P</b>	
opium.....	21	pacerone.....	68
opium/belladonna alkaloids.....	21	PACNEX.....	133
opium tincture.....	96	PAIN EASE.....	23
OPSUMIT.....	70	paliperidone er.....	127
OPTICHAMBER.....	118	PALYNZIQ.....	64
OPVEE.....	38	PANCREAZE.....	99
ORACIT.....	95	PANRETIN.....	53
ORALAIR.....	64	pantoprazole.....	100
ORAMAGICRX.....	141	PAPAVERINE.....	141
ORAPRED ODT.....	104	PARADIGM.....	116
ORAVIG.....	39	PARAGARDT 380-A.....	85
ORENCIA.....	24	paregoric.....	96
ORENITRAM.....	70, 71	PAREMYD.....	92
ORENITRAM ER.....	70	paricalcitol.....	142
ORFADIN.....	143	PARLODEL.....	56
ORGOVYX.....	50	paromomycin sulfate.....	45
ORIAHNN.....	105	paroxetine.....	122, 143
ORILISSA.....	105	paroxetine cr.....	122
ORKAMBI.....	139	paroxetine er.....	122
ORLADEYO.....	140	PASER.....	32
orphenadrine citrate.....	119	PATANASE.....	89
ORTHO MICRONOR.....	84	pazopanib.....	51
oseltamivir.....	60	PCE.....	33

## Index of Medications

PEDIARIX .....	66	pimecrolimus .....	108
PEDVAXHIB .....	66	pimozide .....	126
peg3350/sod sulf, bicarb, cl/kcl .....	99	pindolol .....	74
peg3350/sod sul/nacl/kcl/asb/c .....	99	pioglitazone hcl .....	43
PEGANONE .....	81	pioglitazone hcl/glimepiride .....	43
PEGASYS .....	61	pioglitazone hcl/metformin hcl .....	43
PEGINTRON .....	61	PIP .....	113
PEMAZYRE .....	51	PIQRAY .....	51
PENBRAYA .....	65	pirfenidone .....	143
penicillamine .....	23	piroxicam .....	25, 26
penicillin v potassium .....	34	pitavastatin .....	76
PENTACEL .....	66	PLAQUENIL .....	45
PENTACEL ACTHIB COMPONENT .....	66	PLAVIX .....	57
pentamidine isethionate .....	45	PLEGRIDY .....	79
pentazocine hcl/naloxone hcl .....	22	PLIXDA .....	137
pentoxifylline .....	67	PNEUMOVAX 23 .....	65
PERCOCET .....	20	pnv 22/iron, gluc/folic/dss/dha .....	119
PERIDEX .....	140	pnv 66/iron/folic/docusate/dha .....	119
perindopril erbumine .....	73	pnv 69/iron/folic/docusate/dha .....	119
permethrin .....	55	pnv 80/iron fum/folic/dss/dha .....	119
perphenazine .....	124, 128	pnv/ferrous fum/docusate/folic .....	120
perphenazine/amitriptyline hcl .....	124	pnv/iron, carb/docusat/folic ac .....	120
PFIZER COVID-19 VACCINE .....	64	POCKET CHAMBER .....	118
PHARMABASE BARRIER .....	134	PODOCON-25 .....	133
PHASEAL PROTECTOR .....	116	podofilox .....	133
PHEBURANE .....	95	POLIBAR ACB .....	87
phenazopyridine .....	23	polydimethylsiloxanes/silicon .....	134
phendimetrazine .....	54	POMALYST .....	50
phenelzine sulfate .....	121	posaconazole .....	39
phenobarb/hyoscy/atropine/scop .....	97	POTABA .....	147
phenobarbital .....	97, 98, 129	potassium bicarbonate/cit ac .....	95
phenobarbital-belladonna elixr .....	97, 98	potassium chloride .....	95
PHENOBARBITAL-BELLADONNA ELIXR .....	98	potassium citrate .....	95
phenoxybenzamine hcl .....	63, 64	potassium iodide/iodine .....	94
phentermine .....	54	pramipexole di-hcl .....	56
PHENTOLAMINE-ALPROSTADIL .....	141	pramipexole er .....	56
phenylephrine hcl .....	40, 91	PRAMOSONE .....	137
phenylephrine hcl/prometh hcl .....	40	prasugrel .....	57
PHENYTEK .....	81	pravastatin sodium .....	76
phenytoin .....	80, 81	praziquantel .....	45
PHESGO .....	50	prazosin hcl .....	72
PHOSLYRA .....	94, 166	PR BENZOYL PEROXIDE .....	133
PHOSPHOLINE IODIDE .....	91	PRECOSE .....	41
PHYSIOLYTE .....	130	prednicarbate .....	135, 136
PHYSIOSOL .....	130	prednisolone .....	30, 90, 104
phytonadione .....	148	prednisolone acetate .....	90
PICATO .....	54	prednisolone sodium .....	90, 104
PIFELTRO .....	59	prednisone .....	104
pilocarpine hcl .....	64, 91	PREFEST .....	103

## Index of Medications

pregabalin.....	81	propracaine hcl .....	90
PREGNYL.....	107	propranolol hcl.....	74
PREMARIN.....	103, 106	propranolol/hydrochlorothiazid.....	74
PREMPHASE.....	103	propylthiouracil.....	138
PREMPRO.....	103	PROQUAD.....	66
prenatal 12/iron/folic/dss/om3.....	120	PROSCAR.....	146
PRENATAL 19.....	120	PROSTIN.....	105
prenatal 34/iron/folic/dss/dha.....	120	protectives2/ceramide.....	134
prenatal vits15/iron/folic/dss.....	120	PROTOPIC.....	108
PREPIDIL.....	105	protriptyline hcl.....	124
PREPOPIK.....	99	PROVERA.....	83, 106
PRESTALIA.....	71	PROVOCHOLINE.....	86
PRETOMANID.....	32	PULMICORT.....	28
PREVIDENT.....	92, 93	PULMOZYME.....	140
PREVNAR 13.....	65	PURIXAN.....	48
PREVYMIS.....	60	pyrazinamide.....	32
PREZCOBIX.....	58	PYRIDIUM.....	23
PREZISTA.....	58, 166	pyridostigmine bromide.....	62
PRIFTIN.....	32	pyrimethamine.....	45
PRIMAQUINE.....	45	<b>Q</b>	
primaquine phosphate.....	45	QBREXZA.....	137
PRIMEAIRE.....	118	QINLOCK.....	51
primidone.....	81	QMIIZ ODT.....	26
PRIMLEV.....	20	QSYMIA.....	54
PRIMSOL.....	31	QUADRACEL DTAP-IPV.....	66
PRISMASOL.....	95	QUALAQUIN.....	45
probenecid.....	26	QUARTETTE.....	84
PROCARDIA.....	69	quazepam.....	129
PROCARE.....	118	QUAZEPAM.....	129
PROCHAMBER.....	118	QUESTRAN.....	77
prochlorperazine.....	96, 97	quetiapine fumarate.....	127
PRO COMFORT.....	118	QUILLIVANT XR.....	126
PROCORT.....	101	quinapril hcl.....	73
PROCRI.....	82	quinapril/hydrochlorothiazide.....	71
PROCTOFOAM-HC.....	101	quinidine gluconate.....	68
PRODIGY.....	113	quinine sulfate.....	45
progesterone, micronized.....	106	QUTENZA.....	132
PROGLYCEM.....	93	QVAR REDIHALER.....	28
PROGRAF.....	109	<b>R</b>	
PROLENSA.....	90	rabeprazole sodium.....	100
PROMACTA.....	83	RADIAGEL.....	144
promethazine-codeine.....	86	RADIAPLEXRX.....	134
promethazine/dextromethorphan.....	85	RADICAVA ORS.....	78
promethazine hcl.....	40, 97	RADIOGARDASE.....	144
promethazine/phenyleph/codeine.....	86	RAGWITEK.....	64
PROMETRIUM.....	106	raloxifene hcl.....	145
propafenone hcl.....	68	ramelteon.....	129
propantheline bromide.....	96	ramipril.....	73
propracaine/fluorescein sod.....	90	ranitidine hcl.....	98

## Index of Medications

ranolazine	67	RIMSO-50	22
RAPAFLO	146	ringer's	130
RAPAMUNE	109	RINVOQ	24
RAPLIXA	67	RIOMET	42
rasagiline mesylate	55, 56	RIOMET ER	42
RAYALDEE	142	risedronate sodium	145
RAZADYNE ER	62	risperidone	127
READI-CAT 2	87	RITALIN	126
READYLANCE	113	RITEFLO	118
REBIF	79	ritonavir	59
RECOMBIVAX HB	66	rivastigmine	62
RECOTHROM	67	rizatriptan	18, 19
RECTIV	99	rizatriptan benzoate	19
REGIMEX	54	ROBAXIN-750	119
REGLAN	99	ROBINUL	96
REGRANEX	132	ROCALTROL	148
RELAGARD	44	ROCKLATAN	91
RELENZA	60	ROSANIL	36
RELIAMED	113	rosuvastatin calcium	76
RELION	113	ROSZET	75
RELISTOR	38	ROTARIX	64
REMICADE	47	ROTATEQ	64
RENACIDIN	95	ROXYBOND	22
repaglinide	42, 43	ROZLYTREK	52
REPATHA	75	RUBRACA	52
REPLACEMENT PEDIATRIC MONITOR	110	RUCONEST	140
RESPA A.R.	85	rufinamide	81
RESTASIS	92	RUKOBIA	58
RESTIZAN	132	RUZURGI	79
RETACRIT	82	RYBELSUS	41
RETEVMO	52	RYDAPT	52
REVLIMID	50	RYTARY	56
REXULTI	128	RYTHMOL SR	68
REYATAZ	59	<b>S</b>	
REZLIDHIA	53	SAF-CLENS AF	134
REZUROCK	146	SAFETY LANCET	110, 112, 113, 114, 115
REZVOGLAR KWIKPEN	41	SAFYRAL	85
RHOPRESSA	91	SALAGEN	64
ribasphere	61, 62	salicylic acid	133
ribasphere ribapak	61, 62	SALIMEZ FORTE	133
RIDAURA	24	SALKERA	133
rifabutin	32	salsalate	23
RIFAMATE	32	SALVAX DUO PLUS	133
rifampin	32	SANCUSO	97
RIFATER	32	SANDOSTATIN	106
RIGHTEST	113	SANTYL	137
RILUTEK	78	SAPHRIS	127
riluzole	78	sapropterin dihydrochloride	144
rimantadine hcl	60	SARAFEM	122

## Index of Medications

SAVAYSA.....	37	SODIUM CITRATE.....	37
SAVELLA.....	145	sodium fluoride/potassium nit.....	93
SAXENDA.....	54	SODIUM OXYBATE.....	129, 169
SCALACORT DK.....	136	sodium phenylbutyrate.....	95
SCEMBLIX.....	51	sodium polystyrene sulfon/sorb.....	94
scopolamine.....	97	sod, pot chlor/mag/sod, pot phos.....	130
SEASONIQUE.....	85	SOGROYA.....	105
secobarbital sodium.....	129	solifenacin.....	146
SECUADO.....	127	SOLIQUA.....	41
SECURESAFE.....	116	SOLTAMOX.....	53
selegiline hcl.....	56	SOLUS.....	114
selenium sulfide.....	132	SOMA.....	119
SELZENTRY.....	58, 168	SOMATULINE DEPOT.....	106
SEN-SERTER.....	111	SOMAVERT.....	142
SEROQUEL.....	127	SORBITOL.....	130
SEROQUEL XR.....	127	sotalol hcl.....	74
SEROSTIM.....	105	SOTYKTU.....	130
sertraline.....	123	SOTYLIZE.....	74
sevelamer.....	94	SOVALDI.....	61
sevoflurane.....	22, 23	SOVUNA.....	45
SFROWASA.....	98	SPACE CHAMBER.....	117, 118
SHINGRIX.....	66	spinosad.....	55
SIGNIFOR.....	106	SPIRIVA RESPIMAT.....	26
SIKLOS.....	67	spironolact/hydrochlorothiazid.....	88
sildenafil.....	70, 141	spironolactone.....	88
SILICONE.....	118	SPRAVATO.....	121
SILIQ.....	130	SPRITAM.....	81
silodosin.....	146	SPRYCEL.....	52
SILVADENE.....	36	sps.....	94
silver nitrate.....	133, 137	SSKI.....	94
silver sulfadiazine.....	36	STALEVO.....	56, 57
SIMBRINZA.....	91	STARLIX.....	42
SIMPONI.....	47	STELARA.....	108
simvastatin.....	75, 76, 77	STENDRA.....	141
SINEMET.....	56	STERILANCE.....	114
SINGULAIR.....	28	STIMATE.....	102
sirolimus.....	109	STIMUFEND.....	83
SIRTURO.....	32	STIOLTO RESPIMAT.....	27
SITZMARKS.....	87	STIVARGA.....	52
SIVEXTRO.....	34	STRENSIQ.....	143
SKELAXIN.....	119	STRIBILD.....	60
SKYLA.....	85	STRIVERDI RESPIMAT.....	26
SKYRIZI.....	130	STROMEKTOL.....	45
SKYTROFA.....	105	SUBOXONE.....	146
SMARTEST.....	114	SUCRAID.....	98
SMART SENSE.....	114	sucrafate.....	97
sodium chloride for inhalation.....	143	SUFLAVE.....	99
sodium chloride irrig solution.....	130	SULAR.....	69
sodium chloride/nahco3/kcl/peg.....	99	sulfacetamide.....	29, 30

## Index of Medications

sulfacetamide sodium .....	36, 131, 132	TASMAR .....	57
sulfacetamide sod/sulfur/urea .....	36	TAVALISSE .....	140
sulfacetamide/sulfur/cleansr23 .....	36	tazarotene .....	132
sulfact sod/sulur/avob/otn/oct .....	36	TAZVERIK .....	49
sulfadiazine .....	30, 36	TC99M .....	86
sulfamethoxazole/trimethoprim .....	30	TDVAX .....	66
SULFAMYLON .....	36	TECHLITE .....	114
sulfasalazine .....	98	TEGRETOL .....	81, 82
sumatriptan .....	19	TEGSEDI .....	142
SUNLENCA .....	57	TELCARE .....	114
SUNOSI .....	129	telmisartan .....	72, 73
SUPRANE .....	23	telmisartan-amlopidine .....	72
SURE COMFORT .....	114, 116, 117	telmisartan-hctz .....	72
SURE-LANCE .....	114	temazepam .....	129
SURE-TOUCH .....	114	TEMIXYS .....	58
SURGIFOAM .....	67	TEMODAR .....	47
SURGISEAL .....	134	TEMOVATE .....	136
SURVANTA .....	140	temozolomide .....	47
SUTAB .....	99	TENIVAC .....	66
SUTENT .....	52	tenofovir disoproxil fumarate .....	59
SYMAX DUOTAB .....	98	TEPMETKO .....	52
SYMDEKO .....	139	terazosin hcl .....	72
SYMLINPEN .....	42	terbinafine .....	39
SYMPROIC .....	38	terbutaline .....	27
SYMTUZA .....	58	terconazole .....	38
SYNALAR .....	35, 136	teriparatide .....	107, 142
SYNAREL .....	105	TERIPARATIDE .....	107
SYNJARDY .....	43	TERSI .....	132
SYNJARDY XR .....	43	TERUMO SURGUARD2 .....	116
SYNTHROID .....	138	TESSALON PERLE .....	85
<b>T</b>		testosterone .....	101, 102
TABLOID .....	48	TESTOSTERONE .....	101, 102
TABRECTA .....	52	TESTRED .....	102
TACHOSIL .....	67	tetrabenazine .....	79
TACLONEX .....	137	tetracaine hcl .....	90
tacrolimus .....	108, 109	tetracycline .....	35, 97, 152, 170
tadalafil .....	70, 141	TETRAVISC .....	90
TAFINLAR .....	49	TEXACORT .....	136
TAGITOL .....	87	TEZSPIRE .....	145
TAGRISSO .....	52	THALOMID .....	31
TAKHZYRO .....	64	THEO-24 .....	29
TALTZ .....	130, 131	theophylline .....	29
TALZENNA .....	52	THIOLA .....	146
TAMIFLU .....	60	thioridazine hcl .....	128
tamoxifen .....	53	THROMBI-GEL .....	67
tamsulosin hcl .....	146	THROMBIN-JMI .....	67
TAPAZOLE .....	138	THROMBI-PAD .....	67
TARGRETIN .....	54	thyroid .....	138
TASIGNA .....	52	THYROLAR .....	139

## Index of Medications

tiagabine.....	81, 82	tretinoin.....	53, 131, 137
TIAZAC.....	69	TREXALL.....	48
TIBSOVO.....	53	TREZIX.....	20
ticlopidine.....	57	triamcinolone acetoneide.....	141
TIGAN.....	97	triamterene.....	88
TIGLUTIK.....	78	triazolam.....	129
TIKOSYN.....	68	trichloroacetic acid.....	134
timolol maleate.....	74, 91	TRICHLOROACETIC ACID.....	134
TINDAMAX.....	45	TRICOR.....	78
tinidazole.....	45	trientine.....	144
TIROSINT.....	139	trientine hcl.....	144
TIROSINT-SOL.....	139	trifluoperazine hcl.....	128
TISSEEL.....	134	trifluridine.....	60
TIVICAY.....	59	TRIGLIDE.....	78
tizanidine hcl.....	119	trihexyphenidyl.....	55
TOBI.....	31	TRIJARDY XR.....	43
TOBRADEX.....	29	TRIKAFTA.....	139
tobramycin.....	29, 30, 31	TRILIPIX.....	78
TOBRAMYCIN.....	31	trimethobenzamide.....	97
tobramycin/dexamethasone.....	29	trimethoprim.....	30, 31
TOLAK.....	54	trimipramine.....	124
tolbutamide.....	42	TRIMO-SAN.....	44
tolcapone.....	57	TRINTELLIX.....	124
tolmetin.....	26	TRIUMEQ.....	58
tolterodine.....	147	tropicamide.....	92
tolvaptan.....	87	tropium chloride.....	147
TOLVAPTAN.....	87	TRUDHESA.....	19
TOPCARE.....	114	TRUEPLUS.....	114
TOPICORT.....	136	TRULANCE.....	99
topiramate.....	82	TRULICITY.....	41
toremifene.....	53	TRUMENBA.....	65
torsemide.....	88	TRUQAP.....	52
TRACLEER.....	70	TUKYSA.....	52
tramadol er.....	22	TURALIO.....	51
tramadol hcl.....	20, 22	TUXARIN ER.....	86
tramadol hcl/acetaminophen.....	20	TUZISTRA XR.....	86
TRAMADOL HCL ER.....	22	TWINRIX.....	66
trandolapril.....	71, 73	TWIST.....	111, 112, 113, 114, 134
trandolapril/verapamil hcl.....	71	TWIST TOP.....	113, 114
tranexamic acid.....	66	TYBLUME.....	85
TRANSDERM-SCOP.....	97	TYBOST.....	139
TRANXENE T-TAB.....	120	TYKERB.....	52
tranylcypromine sulfate.....	121	TYVASO.....	71
travoprost.....	91	<b>U</b>	
trazodone hcl.....	123	UBRELVY.....	19
TRECATOR.....	32	UDENYCA.....	83
TRELEGY ELLIPTA.....	28	UKONIQ.....	52
TREMFYA.....	131	ULESFIA.....	55
TRESIBA.....	44	ULORIC.....	24



## Index of Medications

ULTANE .....	22, 23	VENTAVIS.....	71
ULTILET.....	114	verapamil hcl .....	69, 71
ULTRA-CARE .....	115	VEREGEN .....	62
ULTRACET .....	20	VERELAN .....	69
ULTRAFOAM.....	67	VERIFINE.....	115, 116, 117
ULTRALANCE.....	115	VERQUVO .....	70, 71
ULTRAM.....	22	VERZENIO .....	52
ULTRA THIN .....	112, 114, 115	VEVYE.....	92
ULTRA-THIN II.....	114, 115, 117	VFEND .....	39
ULTRATLC.....	115	V-GO.....	111
ULTRAVATE .....	136	VIAGRA.....	141
UNIFINE.....	111	VIBERZI.....	99
UNILET.....	111, 112, 115	VIBRAMYCIN .....	35
UNISTIK .....	112, 115, 118	vigabatrin.....	82
UNIVERSAL 1.....	115	VIBRYD .....	124
UPTRAVI .....	71	VIJOICE .....	140
URAMAXIN.....	133	vilazodone.....	123, 124
urea .....	36, 46, 133, 134, 169, 171	VIMPAT .....	82
URIBEL.....	31	VIOKACE.....	99
UROCIT-K.....	95	VIREAD .....	59
UROQID .....	95	VISTARIL .....	40
UROXATRAL.....	146	VISTOGARD .....	140
URSO .....	98	VITAFOL FE.....	120
ursodiol .....	98	vite ac/grape/hyaluronic acid.....	132
UTA.....	31	VITRAKVI.....	52
<b>V</b>		VIVELLE-DOT.....	103
VAGIFEM.....	106	VIVJOA.....	39
VALCHLOR.....	54	VIZIMPRO.....	52
valganciclovir hcl.....	60	VOQUEZNA .....	99
VALIUM .....	120	voriconazole .....	39
valproic acid.....	82	VORTEX.....	118
valsartan .....	72, 73, 151, 172	VOSEVI .....	61
valsartan/hydrochlorothiazide .....	72	VOWST .....	98
VALTOCO.....	80	VOXZOGO .....	144
VALTRES .....	60	VRAYLAR.....	127, 128
vancomycin.....	35	VUMERITY.....	79
VANFLYTA.....	52	VYLEESI .....	126
vardenafil hcl .....	141	VYNDAMAX.....	144
VARIBAR .....	87	VYNDAQEL .....	144
VARUBI .....	97	<b>W</b>	
VASCEPA.....	95	WAKIX .....	82
VASHE.....	130	warfarin.....	36
VAXELIS.....	66	water for irrigation, sterile .....	130
VECAMYL .....	73	WELLBUTRIN SR.....	121, 122
VELPHORO.....	94	WIDE SEAL DIAPHRAGM .....	85
VELTASSA .....	94	WP THYROID .....	139
VEMLIDY .....	61	<b>X</b>	
VENCLEXTA .....	53	XADAGO .....	57
venlafaxine hcl.....	123		

## Index of Medications

XALKORI.....	52	ZIEXTENZO.....	83
XANAX.....	120, 121	zileuton.....	26
XARELTO.....	37	ZIMHI.....	38
XATMEP.....	48	zinc oxide.....	134
XCLAIR.....	132	ziprasidone hcl.....	127
XCOPRI.....	82	ZIRGAN.....	60
XDEMYVY.....	55	ZITHROMAX.....	33
XELJANZ.....	24	ZOXYDRO ER.....	22
XELODA.....	48	ZOKINVY.....	140
XELSTRYM.....	63	ZOLADEX.....	50
XENICAL.....	54	ZOLINZA.....	47
XENLETA.....	34	zolmitriptan.....	19
XEPI.....	36	zolpidem tart er.....	130
XERMELO.....	96	zolpidem tartrate.....	130
XIFAXAN.....	34	zonisamide.....	82
XIGDUO XR.....	43	ZORTRESS.....	109
XOFLUZA.....	61	ZTLIDO.....	23
XOLAIR.....	28	ZUBSOLV.....	146
XOPENEX.....	27	ZURZUVAE.....	120
XOSPATA.....	52	ZYDELIG.....	52
XPOVIO.....	53	ZYLET.....	29
XTAMPZA ER.....	22	ZYLOPRIM.....	24
XTANDI.....	48	ZYMFENTRA.....	47
XUREA.....	134	ZYVOX.....	34
XURIDEN.....	93		
XYOSTED.....	102		
XYWAV.....	129		
<b>Y</b>			
YASMIN.....	85		
YAZ.....	85		
YERVOY.....	53		
<b>Z</b>			
zafirlukast.....	28		
zaleplon.....	130		
ZANAFLEX.....	119		
ZARONTIN.....	82		
ZARXIO.....	83		
ZAVESCA.....	143		
ZAVZPRET.....	19		
ZEJULA.....	52		
ZELBORAF.....	49		
ZEMPLAR.....	142		
ZENATANE.....	131		
ZENZEDI.....	63		
ZEPATIER.....	62		
ZEPBOUND.....	54		
ZEPOSIA.....	79		
ZETIA.....	78		
zidovudine.....	58, 59		

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

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

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

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

# DISCRIMINATION IS AGAINST THE LAW

## Medical coverage

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

Cigna:

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

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

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

Cigna  
Nondiscrimination Complaint Coordinator  
PO Box 188016  
Chattanooga, TN 37422

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

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



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## Proficiency of Language Assistance Services

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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