Cigna Healthcare National Preferred 3-Tier Prescription Drug List

Coverage as of July 1, 2024

For the State of California
Exclusive Provider Organization (EPO), LocalPlus (LocalPlus IN/LocalPlus), Open Access Plus (OAPIN/OAP), Preferred Provider Organization (PPO), SureFit

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

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 This drug list is subject to change and all prior versions are no longer in effect.

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View your drug list online

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

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

Questions?

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

Information about this drug list

Frequently Asked Questions (FAQs)

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

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

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

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

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

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

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

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

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

Information about this drug list

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Your Step Therapy rights under California State law:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Information about this drug list

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

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

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

Express Scripts® Pharmacy for maintenance medications

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

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

Here are three easy ways to get started.

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

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

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

Accredo for specialty medications

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

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

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

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

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

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

Information about this drug list

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

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

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

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

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

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

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

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

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

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

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

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

Information about this drug list

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

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

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

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

Words you may need to know

- **Brand name drug:** A drug that is marketed under a proprietary, trademark-protected name. A brand name drug is listed in this formulary in all CAPITAL letters.
- **Coinsurance:** A percentage of the cost of a covered health care benefit that you pay after you have paid the deductible, if a deductible applies to the health care benefit.
- **Copayment:** A fixed dollar amount that you pay for a covered health care benefit after you have paid the deductible, if a deductible applies to the health care benefit.
- **Deductible:** The amount you pay for covered health care benefits that are subject to the

Information about this drug list

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

deductible before your health insurer begins to pay. If your health insurance policy has a deductible, it may have either one deductible or separate deductibles for medical benefits and prescription drug benefits. After you pay your deductible, you usually pay only a copayment or coinsurance for covered health care benefits. Your insurance company pays the rest.

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

Information about this drug list

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

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

About this drug list

This is a list of the most commonly prescribed medications covered on the Cigna Healthcare National Preferred 3-Tier Prescription Drug List as of July 1, 2024. Medications are listed alphabetically by their generic and brand names within their therapeutic category and class.

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

How to read this drug list

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

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

Tiers

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

Tier 1 – Typically Generics	(Lowest-cost medication)	**$**
Tier 2 – Typically Preferred Brands	(Medium-cost medication)	**$$**
Tier 3 – Typically Non-Preferred Brands	(Highest-cost medication)	**$$$**

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

Information about this drug list

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

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

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

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

Information about this drug list

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

Use the chart below to help you read this drug list. This chart is just an example. It may not show how these medications are actually covered on the Cigna Healthcare National Preferred 3-Tier Prescription Drug List.

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

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

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

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

Prescription drug name is the name of the medication

Medications are listed in **alphabetical order** within each column

Brand name medications are in all **CAPITAL** letters

Generic medications are in ***lowercase italics***

This chart is just a sample. It may not show how these medications are actually covered on the Cigna Healthcare National Preferred 3-Tier Prescription Drug List.

Information about this drug list

How to find your medication

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

Information about this drug list

How to find your medication *(cont.)*

Information about this drug list

How to find your medication *(cont.)*

List of Prescription Medications

ANALGESICS (Pain Relief and Inflammatory Disease)		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
ANALGESIC, NON-SALICYLATE AND BARBITURATE COMBINAT		
acetaminophen w/butalbital	T1	
ALLZITAL	T3	PA
tencon	T1	
ANALGESIC, SALICYLATE, BARBITURATE, XANTHINE COMB.		
butalbital-asp-caffeine (Fiorinal)	T1	
FIORINAL *(butalbital-aspirin-caffeine)*	T3	PA
ANALGESIC, NON-SALICYLATE, BARBITURATE, XANTHINE COMB.		
butalbital/apap/caffeine	T1	
butalbital/apap/caffeine (Esgic)	T1	
ESGIC *(butalbital-acetaminophen-caffe)*	T3	PA
FIORICET *(butalbital-acetaminophen-caffe)*	T3	PA
VANATOL LQ	T3	PA
VANATOL S	T3	PA
vtol lq (Vanatol Lq)	T1	
zebutal (Esgic)	T1	
ANALGESIC/ANTIPYRETICS, SALICYLATES		
aspirin	T1	HD PPACA
aspirin e.c. (Ecotrin)	T1	HD PPACA
buffered aspirin	T1	HD PPACA
bufferin	T1	HD PPACA
choline mag trisalicylate	T1	
diflunisal	T1	HD
ecotrin (Ecotrin)	T1	HD PPACA
ecpirin (Ecotrin)	T1	HD PPACA
tri-buffered aspirin	T1	HD PPACA
ANTI-MIGRAINE PREPARATIONS		
AIMOVIG AUTOINJECTOR	T2	PA QL (1 inj/23 days)
AJOVY 225 MG/1.5 ML AUTOINJECT	T2	PA QL(1 auto-inj/30 days)
AJOVY 225 MG/1.5 ML AUTOINJECT	T2	PA QL(3 auto-injs/90 days)
AJOVY SYRINGE	T2	PA QL(1 syringe/30 days)
almotriptan malate	T1	QL
AMERGE *(naratriptan hcl)*	T3	ST QL
CAFERGOT *(cafergot)*	T3	
CAMBIA	T3	ST QL

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

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

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

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

List of Prescription Medications

ANALGESICS (Pain Relief and Inflammatory Disease) (cont.)		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
ANTI-MIGRAINE PREPARATIONS (cont.)		
D.H.E.45 *(dihydroergotamine mesylate)*	T3	
diclofenac pot powder pack (CAMBIA)	T1	ST QL (9 pkts/30 days)
dihydroergotamine mesylate (D.H.E.45)	T1	
dihydroergotamine mesylate (Migranal)	T1	QL
eletriptan hbr (Relpax)	T1	QL
EMGALITY	T2	PA QL (1 unit/23 days)
EMGALITY SYRINGE	T2	PA QL (1 unit/23 days)
ERGOMAR	T3	
ergotamine-caffeine (Cafergot)	T1	
frovatriptan succinate (Frova)	T1	QL
migergot	T1	
MIGRANAL *(dihydroergotamine mesylate)*	T3	ST QL
naratriptan hcl (Amerge)	T1	QL
NURTEC ODT	T2	PA QL
QULIPTA	T2	PA QL
REYVOW 100MG TABLET	T3	PA QL (8 tabs/treatment)
rizatriptan (Maxalt)	T1	QL
sumatriptan succ 25 mg tablet (Imitrex)	T1	
sumatriptan succ 50 mg tablet (Imitrex)	T1	
sumatriptan succ 100 mg tablet (Imitrex)	T1	
sumatriptan succ-naproxen sod (Treximet)	T1	QL
TOSYMRA	T3	ST QL
TRUDHESA NASAL SPRAY	T3	ST QL (4 units (1 carton)/28 days)
UBRELVY 50MG TABLET	T2	PA QL (10 tabs/treatment)
UBRELVY 100MG TABLET	T2	PA QL (10 tabs/treatment)
ZEMBRACE SYMTOUCH	T3	ST QL
zolmitriptan odt (Zomig ZMT)	T1	QL
ZOMIG	T3	ST QL
NASAL NSAIDS, COX NON-SELECTIVE,SYSTEMIC ANALGESIC		
SPRIX	T3	ST QL
NSAIDS, CYCLOOXYGENASE INHIBITOR-TYPE ANALGESICS		
diclofenac	T1	QL HD
diclofenac	T1	
diclofenac pot 25mg tablet	T1	ST HD

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List of Prescription Medications

ANALGESICS (Pain Relief and Inflammatory Disease) (cont.)		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
NSAIDS, CYCLOOXYGENASE INHIBITOR-TYPE ANALGESICS (cont.)		
ketorolac	T1	HD
ketorolac	T1	QL HD
ketorolac	T1	
mefenamic acid	T1	HD
mefenamic acid	T1	
OPIOID ANALGESIC AND NON-SALICYLATE ANALGESICS		
acetaminophen w/codeine	T1	PA QL
endocet (Endocet)	T1	PA QL
endocet (Percocet)	T1	PA QL
hydrocodone w/acetaminophen (Norco)	T1	PA QL
lorcet (Norco)	T1	PA QL
lorcet hd (Norco)	T1	PA QL
lorcet plus (Norco)	T1	PA QL
LORTAB	T3	PA QL
NALOCET	T3	PA QL
oxycodone w/acetaminophen (Endocet)	T1	PA QL
oxycodone w/acetaminophen (Percocet)	T1	PA QL
tramadol hcl/acetaminophen	T1	PA QL(12 ds/60 days)
tramadol hcl-acetaminophen (Ultracet)	T1	PA QL
TYLENOL W/CODEINE *(acetaminophen-codeine)*	T3	PA QL
ULTRACET *(tramadol hcl-acetaminophen)*	T3	PA QL
vicodin hp	T1	PA QL
OPIOID ANALGESIC AND NSAID COMBINATION		
hydrocodone bit-ibuprofen	T1	PA QL
oxycodone hcl-ibuprofen	T1	PA QL
OPIOID ANALGESIC AND SALICYLATE ANALGESIC COMB		
oxycodone w/aspirin	T1	PA QL
OPIOID ANALGESIC AND NON-SALICYLATE XANTHINE COMB		
apap-caffeine-dihydrocodeine (Trezix)	T1	PA QL
dvorah	T1	PA QL
TREZIX	T3	PA QL
OPIOID ANALGESICS		
ACTIQ *(fentanyl)*	T3	ST QL (90 units/63 days)
ARYMO ER	T3	ST QL (120 tabs/23 days)

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List of Prescription Medications

ANALGESICS (Pain Relief and Inflammatory Disease) (cont.)		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
OPIOID ANALGESICS (cont.)		
BELBUCA	T2	ST QL
belladonna & opium	T1	PA QL
buprenorphine (Butrans)	T1	
butorphanol tartrate	T1	PA QL(< 18 yo 12 ds/130 days)
codeine	T1	PA QL
CONZIP	T3	ST QL (30 units/30 days)
DILAUDID *(hydromorphone hcl)*	T3	PA QL
diskets	T1	
DOLOPHINE HCL *(methadone hcl)*	T3	ST
fentanyl	T1	QL (15 units/23 days)
fentanyl (Actiq)	T1	QL (90 units/63 days)
fentanyl (Duragesic)	T1	QL (15 patches/23 days)
hydrocodone bitartrate (Zohydro ER)	T1	QL (90 units/23 days)
hydromorphone er	T1	QL (60 tabs/23 days)
hydromorphone hcl (Dilaudid)	T1	PA QL
HYSINGLA ER	T2	ST QL (60 units/23 days)
KADIAN (morphine er)	T3	ST QL (90 caps/23 days)
LAZANDA 100 MCG NASAL SPRAY	T3	PA QL (23 units/30 days)
LAZANDA 400 MCG NASAL SPRAY	T3	PA QL (23 units/30 days)
levorphanol tartrate	T1	PA QL
meperidine hcl	T1	
methadone hcl (Dolophine Hcl)	T1	
methadose	T1	
morphine	T1	PA QL(12 ds/60 days)
MORPHINE	T3	PA QL
morphine cr (Ms Contin)	T1	QL (120 tabs/23 days)
morphine er (Kadian)	T1	QL (90 caps/23 days)
morphine er (MS Contin)	T1	QL (120 tabs/23 days)
MS CONTIN (*morphine cr, morphine er*)	T3	ST QL (120 tabs/23 days)
MS CONTIN (*morphine er*)	T3	ST QL (120 tabs/23 days)
oxycodone hcl	T1	PA QL
oxycodone hcl (Roxicodone)	T1	PA QL
OXYCONTIN	T2	ST QL (90 tabs/23 days)
oxymorphone hcl	T1	PA QL

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List of Prescription Medications

ANALGESICS (Pain Relief and Inflammatory Disease) (cont.)		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
OPIOID ANALGESICS *(cont.)*		
oxymorphone hcl er	T1	QL (90 tabs/23 days)
pentazocine and naloxone hcl	T1	PA QL
ROXICODONE *(oxycodone hcl)*	T3	PA QL
tramadol hcl er	T1	QL (30 units/30 days)
ULTRAM *(tramadol hcl)*	T3	PA QL
OPIOID AND SALICYLATE ANALGESICS, BARBIT, XANTHINE		
asa-butalb-caff-cod (Fiorinal With Codeine #3)	T1	PA QL
ascomp with codeine (Fiorinal With Codeine #3)	T1	PA QL
butalbital compound w/codeine (Fiorinal With Codeine #3)	T1	PA QL
FIORINAL W/CODEINE *(asa-butalb-caffeine-codeine)*	T3	PA QL
OPIOID, NON-SALICYL. ANALGESIC, BARBITUATE, XANTHINE		
butalbital/caff/apap/codeine (Fioricet With Codeine)	T1	PA QL
FIORICET WITH CODEINE *(butalb-acetaminoph-caff-codein)*	T3	PA QL
SKELETAL MUSCLE RELAXANT, SALICYLAT, OPIOID ANALGES		
carisoprodol-aspirin-codeine	T1	PA QL
ANALGESICS (Urinary Tract Conditions)		
URINARY TRACT ANALGESIC AGENTS		
ELMIRON	T2	
RIMSO-50	T3	
ANESTHETICS (Miscellaneous)		
GENERAL ANESTHETICS, INHALANT		
desflurane (Suprane)	T1	
forane (Forane)	T1	
isoflurane (Forane)	T1	
sevoflurane (Ultane)	T1	
SUPRANE	T3	
terrell (Forane)	T1	
ULTANE *(sevoflurane)*	T3	
ANESTHETICS (Pain Relief and Inflammatory Disease)		
LOCAL ANESTHETICS		
glydo	T1	QL (60 ml/23 days)
lidocaine	T1	
lidocaine hcl	T1	QL (60 ml/23 days)

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

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List of Prescription Medications

ANESTHETICS (Pain Relief and Inflammatory Disease) (cont.)		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
TOPICAL LOCAL ANESTHETICS		
CETACAINE ANESTHETIC	T3	
L.E.T. (LIDO-EPINEPH-TETRA)	T3	
lidocaine (Lidocan Ii)	T1	PA
lidocaine (Lidoderm)	T1	PA
lidocaine 5% ointment	T1	QL (50 gm/21 days)
lidocaine 5% patch (Lidocan Ii)	T1	PA
lidocaine hcl	T1	
LIDOCAINE-EPINEPHRIN-TETRACAIN	T3	
lidocaine-prilocaine	T1	QL (30 gm/23 days)
LIDOCAN II *(lidocaine)*	T3	PA
SYNERA	T3	
ZTLIDO	T2	PA
ANESTHETICS (Urinary Tract Conditions)		
URINARY TRACT ANESTHETIC/ANALGESIC AGNT (AZO-DYE)		
phenazopyridine hcl (Pyridium)	T1	
PYRIDIUM *(phenazopyridine hcl)*	T3	
ANTI-ALLERGY (Allergy/Nasal Sprays)		
MAST CELL STABILIZERS		
cromolyn (Gastrocrom)	T1	
GASTROCROM *(cromolyn)*	T3	
ANTI-ARTHRITICS (Pain Relief and Inflammatory Disease)		
ANALGESIC/ANTIPYRETICS, SALICYLATES		
salsalate	T1	HD
ANTI-ARTHRITIC AND CHELATING AGENTS		
DEPEN *(penicillamine)*	T3	PA SP
penicillamine (Cuprimine)	T1	PA SP
penicillamine (Depen)	T1	PA SP
ANTI-ARTHRITIC, FOLATE ANTAGONIST AGENTS		
RASUVO	T2	ST
ANTI-INFLAMMATORY, PYRIMIDINE SYNTHESIS INHIBITOR		
ARAVA *(leflunomide)*	T3	QL (30 units/30 days) HD
leflunomide (Arava)	T1	QL (30 units/30 days) HD

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List of Prescription Medications

ANTI-ARTHRITICS (Pain Relief and Inflammatory Disease) (cont.)		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
ANTI-INFLAMMATORY, PHOSPHODIESTERASE-4(PDE4) INHIB.		
OTEZLA 28 DAY STARTER PACK	T2	PA QL (55 tabs/274 days) SP HD
OTEZLA 30 MG TABLET	T2	PA QL (60 tabs/23 days) SP HD
COLCHICINE		
colchicine (Colcrys)	T1	HD
GLOPERBA	T3	HD
MITIGARE (*colchicine)*	T2	ST HD
GOLD SALTS		
RIDAURA	T2	
allopurinol (Zyloprim)	T1	HD
febuxostat (Uloric)	T1	HD
ZYLOPRIM *(allopurinol)*	T3	HD
JANUS KINASE (JAK) INHIBITORS		
RINVOQ ER 15 MG TABLET	T2	PA QL (30 tabs/30 days) SP
RINVOQ ER 30MG TABLET	T2	PA QL (30 tabs/30 days) SP
XELJANZ	T2	PA QL SP HD
XELJANZ 1mg/ml ORAL SOLUTION	T2	QL (300ml/30 Days)
XELJANZ XR	T2	PA QL (30 units/30 days) SP HD
NSAID AND HISTAMINE H2 RECEPTOR ANTAGONIST COMB.		
DUEXIS	T3	ST HD
NSAIDS (COX NON-SPEC.INHIB) AND PROSTAGLANDIN ANALOG		
ARTHROTEC *(diclofenac -misoprostol)*	T3	ST HD
diclofenac -misoprostol (Arthrotec 50)	T1	HD
diclofenac -misoprostol (Arthrotec 75)	T1	HD
NSAIDS, CYCLOOXYGENASE INHIBITOR - TYPE ANALGESICS		
ANAPROX DS *(naproxen)*	T3	ST HD
DAYPRO *(oxaprozin)*	T3	ST HD
EC-NAPROSYN *(ec-naproxen)*	T3	ST HD
etodolac (Lodine)	T1	HD
etodolac (Lodine)	T1	
etodolac er	T1	HD
FELDENE *(piroxicam)*	T3	ST HD
FENORTHO 200 MG CAPSULE	T3	ST HD
fenoprofen	T1	HD
flurbiprofen	T1	HD

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List of Prescription Medications

ANTI-ARTHRITICS (Pain Relief and Inflammatory Disease) (cont.)		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
NSAIDS, CYCLOOXYGENASE INHIBITOR - TYPE ANALGESICS (cont.)		
ibu	T1	HD
ibuprofen	T1	HD
ibuprofen (Children'S Advil)	T1	HD
INDOCIN	T3	ST HD
indomethacin	T1	HD
indomethacin 25 mg/5 ml susp	T1	HD
ketoprofen	T1	ST HD
LODINE *(etodolac)*	T3	ST HD
meclofenamate	T1	HD
meloxicam 15mg tablet (Mobic)	T1	HD
MOBIC 7.5 MG TABLET *(meloxicam)*	T3	ST QL (30 units/30 days) HD
MOBIC 15 MG TABLET *(meloxicam)*	T3	ST QL (30 tabs/30 days) HD
nabumetone (Relafen)	T1	HD
NALFON *(fenoprofen)*	T3	ST HD
NAPRELAN *(naproxen cr)*	T3	ST HD
NAPROSYN *(naproxen)*	T3	ST HD
naproxen	T1	ST HD
naproxen er 750mg tablet (Naprelan)	T1	ST
naproxen (Anaprox DS)	T1	HD
naproxen (EC-Naprosyn)	T1	HD
naproxen (Naprosyn)	T1	HD
oxaprozin 600 mg caplet, tablet (Daypro)	T1	HD
piroxicam (Feldene)	T1	HD
QMIIZ ODT 7.5MG TABLET	T3	ST QL (30 units/30 days)
QMIIZ ODT 15 MG TABLET	T3	ST
sulindac	T1	HD
tolmetin	T1	HD
NSAIDS, CYCLOOXYGENASE-2(COX-2) SELECTIVE INHIBITOR		
celecoxib (Celebrex)	T1	HD
celecoxib	T1	HD
URICOSURIC AGENTS		
probenecid	T1	HD
probenecid w/colchicine	T1	HD

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List of Prescription Medications

ANTI-ASTHMATICS (Asthma/COPD/Respiratory)		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
5-LIPOXYGENASE INHIBITORS		
zileuton	T1	PA HD
ZYFLO	T3	PA HD
ANTICHOLINERGICS, ORALLY INHALED LONG ACTING		
INCRUSE ELLIPTA	T2	QL HD
LONHALA MAGNAIR REFILL	T3	QL HD
LONHALA MAGNAIR STARTER	T3	QL HD
SEEBRI NEOHALER	T3	QL HD
SPIRIVA	T2	QL HD
SPIRIVA RESPIMAT	T2	QL HD
YUPELRI	T2	QL (30 units/30 days) HD
ANTICHOLINERGICS, ORALLY INHALED SHORT ACTING		
ATROVENT HFA	T3	QL HD
ipratropium bromide	T1	HD
BETA-ADRENERGIC AGENTS		
albuterol	T1	HD
metaproterenol	T1	HD
terbutaline	T1	HD
BETA-ADRENERGIC AGENTS, INHALED, SHORT ACTING		
albuterol	T1	
albuterol 15 mg/3 ml solution	T1	
albuterol 75 mg/15 ml soln	T1	
albuterol hfa (Proair Hfa)	T1	QL
levalbuterol hcl (Xopenex Concentrate)	T1	
levalbuterol hcl (Xopenex)	T1	
XOPENEX *(levalbuterol concentrate)*	T3	
XOPENEX *(levalbuterol hcl)*	T3	
BETA-ADRENERGIC AGENTS, INHALED, ULTRA-LONG ACTING		
ARCAPTA NEOHALER	T3	QL (30 units/30 days) HD
STRIVERDI RESPIMAT	T2	QL(1 inhaler/30 days) HD
BETA-ADRENERGIC AGENTS, ORALLY INHALED, LONG ACTING		
BROVANA	T3	QL HD
PERFOROMIST	T3	QL HD
BETA-ADRENERGIC AND ANTICHOLINERGIC COMBO, INHALED		
ANORO ELLIPTA	T2	QL HD

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ANTI-ASTHMATICS (Asthma/COPD/Respiratory) (cont.)		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
BETA-ADRENERGIC AND ANTICHOLINERGIC COMBO, INHALED (cont.)		
COMBIVENT INHALER	T2	
COMBIVENT RESPIMAT	T2	QL HD
ipratropium/albuterol sulfate	T1	
SEEBRI NEOHALER 15.6MCG INHALER	T3	HD
STIOLTO RESPIMAT	T2	QL HD
UTIBRON NEOHALER 27.5, 15.6MCG (PS 6)	T3	HD
UTIBRON NEOHALER 27.5, 15.6 MCG (PS 60)	T3	HD
BETA-ADRENERGIC AND GLUCOCORTICOID COMBO, INHALED		
ADVAIR DISKUS *(fluticasone-salmeterol)*	T3	ST QL HD
ADVAIR HFA	T2	ST QL HD
AIRDUO DIGIHALER	T3	PA QL HD
AIRSUPRA	T2	HD
BREO ELLIPTA 50-25 MCG INHALER	T2	PA QL(60 blisters/fill) HD
BREO ELLIPTA	T2	ST QL HD
breyna 80-4.mcg, 160-4.5 mcg inhaler	T1	PA
budesonide-formoterol 160-4.5, 80-4.5	T1	PA HD QL (1 inhaler/30 days)
DULERA	T2	ST QL HD
fluticasone-salmeterol (Advair Diskus)	T1	QL HD
SYMBICORT *(budesonide/formoterol fumarate)*	T3	PA QL(1 inhaler/30 days) HD
wixela inhub (Advair Diskus)	T1	QL HD
BETA-ADRENERGIC-ANTICHOLINERGIC-GLUCOCORT, INHALED		
TRELEGY ELLIPTA	T2	QL
GLUCOCORTICOIDS, ORALLY INHALED		
ALVESCO	T3	QL HD
ARNUITY ELLIPTA	T2	QL HD
ASMANEX	T2	QL HD
ASMANEX HFA	T2	QL HD
budesonide 0.25 mg/2 ml susp (Pulmicort)	T1	
budesonide 0.5 mg/2 ml susp (Pulmicort)	T1	
FLOVENT DISKUS	T2	QL HD
FLOVENT HFA	T2	QL HD
QVAR REDIHALER	T2	QL HD
INTERLEUKIN-5(IL-5) RECEPTOR ALPHA ANTAGONIST, MAB		
FASENRA PEN	T2	PA ST QL (1 pen/56 days) SP HD

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Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
LEUKOTRIENE RECEPTOR ANTAGONISTS		
ACCOLATE *(zafirlukast)*	T3	HD
montelukast (Singulair)	T1	HD
zafirlukast (Accolate)	T1	HD
MAST CELL STABILIZERS, ORALLY INHALED		
cromolyn	T1	HD
MONOCLONAL ANTIBODIES TO IMMUNOGLOBULIN E (IGE)		
XOLAIR 75MG/0.5 ML SYRINGE	T2	PA QL (2 syr/21 days) SP HD
XOLAIR 150MG SYRINGE	T2	PA QL (4 syr/21 days) SP HD
XOLAIR 150 MG VIAL	T2	PA QL (6 vials/21 days) SP HD
XOLAIR 300 MG/2 ML SYRINGE	T2	PA SP HD
MONOCLONAL ANTIBODY - INTERLEUKIN-5 ANTAGONISTS		
NUCALA	T2	PA QL (1 unit/21 days) SP HD
MUCOLYTICS		
acetylcysteine	T1	
XANTHINES		
ELIXOPHYLLIN	T3	HD
THEO-24	T3	HD
theophylline anhydrous	T1	HD
theophylline anhydrous (Elixophyllin)	T1	HD
ANTIBIOTICS (Ear Medications)		
EAR PREPARATIONS, ANTIBIOTICS		
ciprofloxacin hcl (Cetraxal)	T1	
COLY-MYCIN S	T3	
CORTISPORIN-TC	T3	
neomycin/polymyxin/hc	T1	
ofloxacin	T1	
OTIPRIO	T3	QL
OTIC PREPARATIONS, ANTI-INFLAMMATORY-ANTIBIOTICS		
CIPRODEX	T2	
ANTIBIOTICS (Eye Conditions)		
EYE ANTIBIOTIC AND GLUCOCORTICOID COMBINATIONS		
MAXITROL *(neomycin-polymyxin-dexameth)*	T3	
neo/polymyxin/dexamethasone (Maxitrol)	T1	

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ANTIBIOTICS (Eye Conditions) (cont.)		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
EYE ANTIBIOTIC AND GLUCOCORTICOID COMBINATIONS (cont.)		
neomycin/bacitracin/poly/hc	T1	
neomycin/polymyxin/hc	T1	
neomycin-polymyxin-dexamethaso (Maxitrol)	T1	
PRED-G	T3	
PREDNISOLONE ACET-MOXIFLOXACIN	T3	
PREDNISOLONE PHOS-MOXIFLOXACIN	T3	
PREDNISOLONE-GATIFLOXACIN	T3	
TOBRADEX EYE DROPS *(tobramycin-dexamethasone)*	T3	
TOBRADEX EYE OINTMENT	T3	
tobramycin-dexamethasone (Tobradex)	T1	
EYE ANTIBIOTIC, GLUCOCORTICOID AND NSAID COMB.		
PREDNISOLONE AC-MOXIFLOX-BROMF	T3	
PREDNISOLONE AC-MOXIFLOX-NEPAF	T3	
PREDNISOLONE PHOS-MOXIFLO-BROM	T3	
PREDNISOLONE-GATIFLOX-BROMFENC	T3	
EYE SULFONAMIDES		
BLEPH-10 *(sulfacetamide)*	T3	
BLEPHAMIDE	T3	
BLEPHAMIDE S.O.P.	T3	
sulfacetamide	T1	
sulfacetamide (Bleph-10)	T1	
sulfacetamide w/prednisolone	T1	
OPHTHALMIC ANTIBIOTICS		
ak-poly-bac	T1	
AZASITE	T2	
bacitracin	T1	
bacitracin/polymyxin	T1	
CILOXAN *(ciprofloxacin hcl)*	T3	
ciprofloxacin hcl (Ciloxan)	T1	
erythromycin	T1	
gatifloxacin (Zymaxid)	T1	
gentak	T1	
gentamicin	T1	QL (300ml/30 days)
KLARITY-A (AZITHROMYCIN-CHONDR)	T3	

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ANTIBIOTICS (Eye Conditions) (cont.)		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
OPHTHALMIC ANTIBIOTICS (cont.)		
levofloxacin hemihydrate	T1	
MOXEZA *(moxifloxacin)*	T3	
moxifloxacin hcl	T1	
moxifloxacin hcl (Moxeza)	T1	
moxifloxacin hcl (Vigamox)	T1	
neomycin/bacitracin/polymyxin	T1	
neomycin/polymyxin/gramicidin	T1	
neo-polycin	T1	
OCUFLOX *(ofloxacin)*	T3	
ofloxacin (Ocuflox)	T1	
polycin	T1	
polymyxin b sul-trimethoprim (Polytrim)	T1	
POLYTRIM *(polymyxin b sul-trimethoprim)*	T3	
tobramycin (Tobrex)	T1	
TOBREX *(tobramycin)*	T3	
VIGAMOX *(moxifloxacin)*	T3	
ZYMAXID *(gatifloxacin)*	T3	
ANTIBIOTICS (Infections)		
2ND GEN. ANAEROBIC ANTIPROTOZOAL-ANTIBACTERIAL		
SOLOSEC	T2	QL
ABSORBABLE SULFONAMIDE ANTIBACTERIAL AGENTS		
BACTRIM *(sulfamethoxazole-trimethoprim)*	T3	
BACTRIM DS *(sulfamethoxazole-trimethoprim)*	T3	
sulfadiazine	T1	
sulfamethoxazole/trimethoprim (Bactrim DS)	T1	
sulfamethoxazole/trimethoprim (Bactrim)	T1	
sulfamethoxazole/trimethoprim (Sulfatrim)	T1	
sulfatrim (Sulfatrim)	T1	
AMINOGLYCOSIDE ANTIBIOTICS		
ARIKAYCE	T2	PA SP
BETHKIS	T2	PA QL SP HD
gentamicin	T1	QL (300 ml/30 days)
KITABIS PAK	T2	PA QL SP HD

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ANTIBIOTICS (Infections) (cont.)		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
AMINOGLYCOSIDE ANTIBIOTICS (cont.)		
neomycin	T1	
TOBI PODHALER	T2	PA QL
tobramycin	T1	
TOBRAMYCIN	T3	PA QL SP HD
tobramycin (Tobi)	T1	PA QL SP HD
ANAEROBIC ANTIPROTOZOAL-ANTIBACTERIAL AGENTS		
FLAGYL *(metronidazole)*	T3	
metronidazole (Flagyl)	T1	
ANTIBIOTIC, ANTIBACTERIAL, MISC.		
fosfomycin tromethamine	T1	
HIPREX *(methenamine hippurate)*	T3	
hyophen	T1	
me-naphos-mb-hyo 1 (Urogesic-Blue)	T1	
methenam/m.blue/salicyl/hyoscy (Uribel Tabs)	T1	
methenamine hippurate (Hiprex)	T1	
methenamine mandelate	T1	
MONUROL	T3	
phosphasal (Uretron D-S)	T1	
PRIMSOL	T3	
trimethoprim	T1	
URELLE	T3	
uretron d-s (Uretron D-S)	T1	
URIBEL TABS (*methenam/m.blue/salicyl/hyoscy*)	T3	
urimar-t	T1	
urin d.s. (Uretron D-S)	T1	
uro-458 (Urelle)	T1	
uroav-b (Uribel)	T1	
urogesic (Urogesic-Blue)	T1	
uro-mp (Uribel)	T1	
uryl (Urogesic-Blue)	T1	
ustell	T1	
utira-c (Uretron D-S)	T1	
vilamit mb (Uribel)	T1	
vilevev mb (Urelle)	T1	

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ANTIBIOTICS (Infections) (cont.)		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
ANTILEPROTICS		
dapsone	T1	
THALOMID 50mg, 100mg CAPSULES	T2	PA QL(30 caps/30 day) SP HD
THALOMID 150mg, 200mg CAPSULES	T2	PA QL(60 caps/30 day) SP HD
ANTI-MYCOBACTERIUM AGENTS		
ethambutol hcl (Myambutol)	T1	HD
isoniazid	T1	HD
MYAMBUTOL *(ethambutol hcl)*	T3	HD
MYCOBUTIN *(rifabutin)*	T3	HD
PASER	T3	HD
pyrazinamide	T1	HD
rifabutin (Mycobutin)	T1	HD
TRECATOR	T3	HD
ANTI-TUBERCULAR ANTIBIOTICS		
CYCLOSERINE	T3	
PRETOMANID	T3	PA
PRIFTIN	T2	
RIFADIN *(rifadin)*	T3	
RIFADIN *(rifampin)*	T3	
rifampin (Rifadin)	T1	
SIRTURO	T2	PA SP
BETALACTAMS		
CAYSTON	T2	QL SP HD
CEPHALOSPORIN ANTIBIOTICS - IST GENERATION		
cefadroxil	T1	
CEPHALOSPORIN ANTIBIOTICS - 2ND GENERATION		
cefaclor	T1	
cefaclor er	T1	
cefprozil	T1	
cefuroxime axetil	T1	
CEPHALOSPORIN ANTIBIOTICS - 3RD GENERATION		
cefdinir	T1	
cefditoren pivoxil	T1	
cefixime (Suprax)	T1	

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Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
CEPHALOSPORIN ANTIBIOTICS - 3RD GENERATION (cont.)		
cefpodoxime proxetil	T1	
ceftriaxone	T1	
SPECTRACEF	T3	
LINCOSAMIDE ANTIBIOTICS		
CLEOCIN HCL *(clindamycin hcl)*	T3	
CLEOCIN PALMITATE *(clindamycin (pediatric))*	T3	
clindamycin hcl (Cleocin Hcl)	T1	
clindamycin palmitate hcl (Cleocin Pediatric)	T1	
clindamycin pediatric (Cleocin Pediatric)	T1	
MACROLIDE ANTIBIOTICS		
azithromycin 100mg/5 ml suspension (Zithromax)	T1	QL (195 ml/68 days)
azithromycin 1gm powder packet (Zithromax)	T1	QL (2 packets/68 days)
azithromycin 200mg/5 ml suspension (Zithromax)	T1	QL (120 ml/68 days)
azithromycin 250mg, 500mg tablet (Zithromax)	T1	QL (15 tabs/ 68 days)
azithromycin 600mg tablet	T1	QL (24 tabs/68 days)
clarithromycin	T1	
clarithromycin er	T1	
DIFICID	T3	QL (60 caps/30 days)
e.e.s.	T1	
E.E.S. *(erythromycin ethyl)*	T3	
ERYPED *(erythromycin ethyl)*	T3	
ery-tab	T1	
erythrocin stearate	T1	
erythromycin	T1	
erythromycin (Ery-Tab)	T1	
erythromycin ethylsuccinate	T1	
erythromycin ethylsuccinate (E.E.S. 200)	T1	
erythromycin ethylsuccinate (Eryped 400)	T1	
erythromycin stearate	T1	
ZITHROMAX 1 GM POWDER PACKET *(azithromycin)*	T3	QL (2 packets/68 days)
ZITHROMAX 100MG/5 ML SUSPENSION *(azithromycin)*	T3	QL (195 ml/68 days)
ZITHROMAX 200 MG/5 ML SUSPENSION *(azithromycin)*	T3	QL (120 ml/68 days)
ZITHROMAX 250MG, 500MG TABLET *(azithromycin)*	T3	QL (15 tabs/ 68 days)

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ANTIBIOTICS (Infections) (cont.)		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
NITROFURAN DERIVATIVES ANTIBACTERIAL AGENTS		
MACROBID *(nitrofurantoin mono-macro)*	T3	
MACRODANTIN *(nitrofurantoin)*	T3	
nitrofurantoin (Macrodantin)	T1	
nitrofurantoin macrocrystal (Macrobid)	T1	
OXAZOLIDINONE ANTIBIOTICS		
linezolid (Zyvox)	T1	PA
ZYVOX *(linezolid)*	T3	PA
PENICILLIN ANTIBIOTICS		
amoxicillin	T1	
amoxicillin-clavulanate pot er	T1	
amoxicillin-clavulanate potass	T1	
amoxicillin-clavulanate potass (Augmentin ES-600)	T1	
amoxicillin-clavulanate potass (Augmentin)	T1	
ampicillin trihydrate	T1	
AUGMENTIN 125-31.25 MG/5ML	T2	
AUGMENTIN 250-62.5 MG/ML SUSP, 500 MG TAB (*amoxicillin-clavulanate potass)*	T3	
dicloxacillin	T1	
penicillin V	T1	
PLEUROMUTILIN DERIVATIVES		
XENLETA	T3	
QUINOLONE ANTIBIOTICS		
BAXDELA	T2	QL
CIPRO *(ciprofloxacin)*	T3	
ciprofloxacin hcl (Cipro)	T1	
LEVAQUIN *(levofloxacin)*	T3	
levofloxacin hemihydrate	T1	
moxifloxacin hcl	T1	
ofloxacin	T1	
RIFAMYCINS AND RELATED DERIVATIVE ANTIBIOTICS		
AEMCOLO	T3	QL
XIFAXAN	T2	QL
TETRACYCLINE ANTIBIOTICS		
ACTICLATE *(doxycycline hyclate)*	T3	ST
avidoxy	T1	

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Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
TETRACYCLINE ANTIBIOTICS (cont.)		
AVIDOXY DK	T3	ST
coremino	T1	
demeclocycline hcl	T1	
doxycycline hyclate (Acticlate)	T1	
doxycycline hyclate (Doryx)	T1	
doxycycline 50 mg tablet (Targadox)	T1	ST
doxycycline hyclate (Vibramycin)	T1	
doxycycline monohydrate (Vibramycin)	T1	
MINOCIN *(minocycline hcl)*	T3	ST
minocycline hcl	T1	
minocycline hcl er	T1	
minocycline hcl er (Solodyn)	T1	
MINOLIRA ER	T3	ST
mondoxyne nl	T1	
morgidox	T1	
MORGIDOX	T3	ST
morgidox (Vibramycin)	T1	
NUZYRA	T3	QL(30 tabs/30 days) SP
okebo	T1	
ORACEA	T3	ST
SEYSARA	T3	ST
SOLODYN *(minocycline hcl er)*	T3	ST
TARGADOX *(doxycycline hyclate)*	T3	ST
tetracycline 250 mg capsule	T1	
tetracycline 250 mg tablet	T1	ST
tetracycline 500 mg capsule	T1	
tetracycline 500 mg tablet	T1	ST
VIBRAMYCIN *(doxycycline hyclate)*	T3	ST
VIBRAMYCIN *(doxycycline monohydrate)*	T3	
VAGINAL ANTIBIOTICS		
CLEOCIN PHOSPHATE *(clindamycin phosphate)*	T3	
clindamycin phosphate (Cleocin)	T1	
CLINDESSE	T3	
metronidazole	T1	

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ANTIBIOTICS (Infections) (cont.)		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
VAGINAL ANTIBIOTICS (cont.)		
NUVESSA	T3	
vandazole	T1	
XACIATO	T3	
VANCOMYCIN ANTIBIOTICS AND DERIVATIVES		
VANCOCIN HCL *(vancomycin hcl)*	T3	QL
vancomycin 125mg capsule	T1	PA QL (40 caps/30 days)
vancomycin 250mg capsule	T1	PA QL (80 caps/30 days)
vancomycin hcl (Firvanq)	T1	QL
vancomycin hcl 125 mg capsule (Vancocin Hcl)	T1	
vancomycin hcl 250 mg capsule (Vancocin Hcl)	T1	
ANTIBIOTICS (Skin Conditions)		
TOPICAL ANTIBIOTIC AND ANTI-INFLAMMATORY STEROID		
CORTISPORIN	T3	
NEO-SYNALAR	T3	
TOPICAL ANTIBIOTICS		
AMZEEQ	T3	ST
BENZAMYCIN *(erythromycin-benzoyl peroxide)*	T3	ST
CENTANY	T3	ST QL (30 units/30 days)
CENTANY AT	T3	ST QL
CLEOCIN T *(clindamycin phosphate)*	T3	ST QL (120 gm/23 days)
CLEOCIN T *(clindamycin phosphate)*	T3	ST QL (120 ml/23 days)
CLINDACIN ETZ	T3	ST
clindacin etz	T1	
clindacin p	T1	
CLINDACIN PAC	T3	ST
clindamycin 1% foam (Evoclin)	T1	QL (100 gm/23 days)
clindamycin 1% gel	T1	
clindamycin 1% lotion (Cleocin T)	T1	QL (120 ml/23 days)
clindamycin 1% solution	T1	QL (120 ml/23 days)
clindamycin capsule	T1	
ery	T1	
erygel (Erygel)	T1	
erythromycin	T1	

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ANTIBIOTICS (Skin Conditions) (cont.)		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
TOPICAL ANTIBIOTICS (cont.)		
erythromycin (Erygel)	T1	
erythromycin-benzoyl peroxide (Benzamycin)	T1	
EVOCLIN *(clindamycin phosphate)*	T3	ST QL (100 gm/23 days)
gentamicin	T1	QL (300 ml/30 days)
mupirocin 2% oint.	T1	QL (1 treatment/30 days)
mupirocin (Centany)	T1	QL
XEPI	T3	ST QL (30 units/30 days)
TOPICAL SULFONAMIDES		
avar	T1	
AVAR LS	T3	ST
AVAR-E	T3	ST
AVAR-E LS CREAM	T3	ST
mafenide acetate (Sulfamylon)	T1	
PLEXION	T3	ST
SILVADENE *(silver sulfadiazine)*	T3	
silver sulfadiazine (Silvadene)	T1	
ss 10-2 (Avar Ls)	T1	
ssd (Silvadene)	T1	
sss 10-5	T1	
sulfacetamide -sulfur	T1	
sulfacetamide/sulfur (Avar LS)	T1	
sulfacetamide/sulfur (Avar-E LS)	T1	
sulfacetamide/sulfur (Plexion)	T1	
sulfacetamide/sulfur (Sumadan)	T1	
sulfacetamide/sulfur (Sumaxin)	T1	
sulfacleanse 8/4	T1	
SULFAMYLON 8.5% CREAM	T2	
SULFAMYLON POWDER PACKET *(mafenide)*	T3	
SUMADAN	T3	ST
SUMADAN XLT	T3	ST
SUMAXIN *(sulfacetamide-sulfur)*	T3	ST
SUMAXIN CP	T3	ST

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

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List of Prescription Medications

ANTI-COAGULANTS (Blood Thinners/Anti-Clotting)		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
ANTI-COAGULANTS, COUMARIN TYPE		
COUMADIN *(jantoven)*	T3	
COUMADIN *(warfarin)*	T3	
jantoven	T1	HD
CITRATES AS ANTI-COAGULANTS		
ACD	T2	
ACD-A	T2	
ANTICOAGULANT SODIUM CITRATE	T3	
CRRT TRISODIUM CITRATE	T3	
SODIUM CITRATE	T3	
TRISODIUM CITRATE CRRT	T3	
DIRECT FACTOR XA INHIBITORS		
BEVYXXA	T3	
ELIQUIS	T2	PA
XARELTO	T2	PA
HEPARIN AND RELATED PREPARATIONS		
ARIXTRA *(fondaparinux)*	T3	SP
enoxaparin (Lovenox)	T1	
fondaparinux (Arixtra)	T1	SP
FRAGMIN	T2	SP
heparin	T1	
THROMBIN INHIBITORS, SELECTIVE, DIRECT, REVERSIBLE		
dabigatran etexilate mesylate	T1	HD
ANTIDOTES (Gastrointestinal/Heartburn)		
MU-OPIOID RECEPTOR ANTAGONISTS, PERIPHERALLY-ACTING		
MOVANTIK	T2	QL (30 units/30 days)
RELISTOR	T2	ST
SYMPROIC	T2	
ANTIDOTES (Substance Abuse)		
OPIOID ANTAGONISTS		
naloxone	T1	
naltrexone	T1	
NARCAN *(naloxone hcl)*	T3	QL (2 units/30 days)

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List of Prescription Medications

ANTI-FUNGALS (Eye Conditions)		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
OPHTHALMIC ANTI-FUNGAL AGENTS		
NATACYN	T2	
ANTI-FUNGALS (Feminine Products)		
VAGINAL ANTI-FUNGALS		
GYNAZOLE-1	T3	
miconazole 3	T1	
terconazole	T1	
ANTI-FUNGALS (Infections)		
ANTI-FUNGAL AGENTS		
ANCOBON *(flucytosine)*	T3	PA
clotrimazole	T1	QL (60 ml/28 days)
CRESEMBA	T2	PA
DIFLUCAN *(fluconazole)*	T3	
DIFLUCAN 150MG TABLET *(fluconazole)*	T3	QL (2 tabs/episode)
fluconazole (Diflucan)	T1	
fluconazole 150mg tablet (Diflucan)	T1	QL
flucytosine (Ancobon)	T1	
itraconazole 100mg capsule (Sporanox)	T1	QL (30 units/30 days)
itraconazole 10mg/ml solution (Sporanox)	T1	
ketoconazole	T1	
NOXAFIL	T2	PA
NOXAFIL 40MG/ML SUSP	T2	PA SP
ORAVIG	T3	
posaconazole (Noxafil)	T1	PA
SPORANOX 100MG CAPSULE *(itraconazole)*	T3	QL (300 ml/1 treatment)
SPORANOX 10MG/ML SOLUTION *(itraconazole)*	T3	
terbinafine	T1	
VFEND *(voriconazole)*	T3	PA
VIVJOA	T3	PA
voriconazole (Vfend)	T1	PA
ANTI-FUNGAL ANTIBIOTICS		
BREXAFEMME 150 MG TABLET	T3	ST QL (4 tabs/treatment)
griseofulvin	T1	
griseofulvin ultramicrosize	T1	

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List of Prescription Medications

ANTI-FUNGALS (Infections) (cont.)		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
ANTI-FUNGAL ANTIBIOTICS (cont.)		
nystatin	T1	QL (60 grams/28 days)
TOPICAL ANTI-FUNGAL/ANTI-INFLAMMATORY, STEROID AGENT		
clotrimazole/betamethasone	T1	QL (45 gm/21 days)
clotrimazole/betamethasone	T1	QL (60 ml/21 days)
ANTI-FUNGALS (Skin Conditions)		
TOPICAL ANTI-FUNGALS		
ciclodan	T1	
ciclopirox 0.77% cream (Loprox)	T1	QL (90 gm/21 days)
ciclopirox 0.77% gel	T1	QL (100 grams/30 days)
ciclopirox 0.77% topical solution (Loprox)	T1	QL (60 ml/21 days)
ciclopirox 1% shampoo	T1	QL(120 mls/28 days)
ciclopirox 8% solution, treatmint kit	T1	
econazole nitrate	T1	QL (85 gm/21 days)
ERTACZO	T3	QL (60 gm/21 days)
EXELDERM	T3	QL (60 units/21 days)
EXTINA *(ketoconazole)*	T3	ST QL (100 gm/21 days)
JUBLIA	T3	ST
ketoconazole 2% cream	T1	QL (60 gm/21 days)
ketoconazole 2% foam (Extina)	T1	ST QL (100 gm/21 days)
ketoconazole 2% shampoo	T1	QL (120 ml/21 days)
ketodan (Extina)	T1	ST QL (100 gm/21 days)
ketodan (Ketodan)	T1	
LOPROX 0.77% CREAM *(ciclopirox)*	T3	QL (90 gm/21 days)
LOPROX 0.77% CREAM KIT	T3	QL (544 gm/23 days)
LOPROX 0.77% SUSPENSION KIT	T3	QL (1 kit/23 days)
LOPROX 0.77% TOPICAL SOLUTION *(ciclopirox)*	T3	QL (60 ml/21 days)
LOPROX 1% SHAMPOO *(ciclopirox)*	T3	QL (120 ml/21 days)
LOTRISONE CREAM	T3	QL (90 grams/28 days)
MICONAZOLE-ZINC OXIDE-PETROLTM	T3	QL (50 gm/21 days)
naftifine hcl (Naftin)	T1	QL (60 gm/21 days)
NAFTIN (naftifine hcl)	T3	QL (90 grams/28 days)
NIZORAL *(ketoconazole)*	T3	QL (120 ml/21 days)
nyamyc	T1	QL

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ANTI-FUNGALS (Skin Conditions) (cont.)		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
TOPICAL ANTI-FUNGALS (cont.)		
nystatin	T1	QL
nystatin w/triamcinolone	T1	QL
nystatin/triamcinolone	T1	QL
nystop	T1	QL
oxiconazole nitrate (Oxistat)	T1	QL (60 units/21 days)
OXISTAT	T3	QL (90 grams/28 days)
VUSION	T3	QL (100 grams/28 days)
ANTIHISTAMINE AND DECONGESTANT COMBINATION (Allergy/Nasal Sprays)		
1ST GEN ANTIHISTAMINE AND DECONGESTANT COMBINATION		
promethazine vc	T1	
2ND GEN ANTIHISTAMINE AND DECONGESTANT COMBINATION		
CLARINEX-D 12 HOUR	T3	QL
SEMPREX-D	T3	
ANTIHISTAMINES (Allergy/Nasal Sprays)		
ANTIHISTAMINES - 1ST GENERATION		
carbinoxamine	T1	
carbinoxamine (Ryvent)	T1	
clemastine fumarate	T1	
cyproheptadine hcl	T1	
dexchlorpheniramine maleate (Ryclora)	T1	
hydroxyzine hcl	T1	
hydroxyzine pamoate (Vistaril)	T1	
KARBINAL ER	T3	ST
promethazine hcl	T1	
RYCLORA *(dexchlorpheniramine maleate)*	T3	
RYVENT	T3	ST
VISTARIL *(hydroxyzine pamoate)*	T3	
ANTIHISTAMINES - 2ND GENERATION		
CLARINEX D 24 HOUR TABLET	T3	
desloratadine (Clarinex)	T1	QL (30 units/30 days) HD
ANTIHISTAMINES (Eye Conditions)		
EYE ANTIHISTAMINES		
azelastine hcl	T1	

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ANTIHISTAMINES (Eye Conditions) (cont.)		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
EYE ANTIHISTAMINES (cont.)		
epinastine hcl	T1	
LASTACAFT 0.25% EYE DROPS	T3	ST
ANTI-HYPERGLYCEMICS (Diabetes)		
ANTIHYPERGLY,DPP-4 ENZYME INHIB.-THIAZOLIDINEDIONE		
OSENI	T3	QL (30 units/30 days) HD
ANTIHYPERGLY, INCRETIN MIMETIC (GLP-1 RECEP.AGONIST)		
ADLYXIN 10-20 MCG STARTER PACK	T3	PA HD QL (1 kit/28 days)
ADLYXIN 20 MCG MAINTENANCE PK	T3	PA HD QL (1 kit/28 days)
BYDUREON BCISE	T2	PA QL HD
BYDUREON PEN	T2	PA QL HD
BYETTA	T2	PA QL HD
MOUNJARO	T2	PA QL
OZEMPIC	T2	PA QL(1 pen/28 days)
RYBELSUS	T2	PA QL(30 tabs/30 days) HD
TRULICITY	T2	PA QL HD
ANTI-HYPERGLY, INSULIN, LONG ACT-GLP-1 RECEPT.AGONIST		
SOLIQUA 100-33	T2	QL HD
ANTI-HYPERGLYCEMIC-SOD/GLUC COTRANSPORT2(SGLT2) INHIB		
FARXIGA	T2	ST QL (30 units/30 days) HD
JARDIANCE	T2	ST QL (30 units/30 days) HD
STEGLATRO	T2	ST QL (30 units/30 days) HD
ANTI-HYPERGLYCEMIC-DOPAMINE RECEPTOR AGONISTS		
CYCLOSET	T3	HD
ANTI-HYPERGLYCEMIC, ALPHA-GLUCOSIDASE INHIBITORS		
acarbose (Precose)	T1	HD
GLYSET *(miglitol)*	T3	HD
miglitol (Glyset)	T1	HD
PRECOSE *(acarbose)*	T3	HD
ANTI-HYPERGLYCEMIC, AMYLIN ANALOG-TYPE		
SYMLINPEN 120	T2	PA QL HD
SYMLINPEN 60	T2	PA QL HD
ANTI-HYPERGLYCEMIC, BIGUANIDE TYPE		
FORTAMET *(metformin er osmotic)*	T3	PA QL HD

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ANTI-HYPERGLYCEMICS (Diabetes) (cont.)		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
ANTI-HYPERGLYCEMIC, BIGUANIDE TYPE (cont.)		
metformin hcl	T1	HD
metformin hcl er	T1	QL HD
metformin hcl er (Fortamet)	T1	PA QL HD
metformin hcl er (Glumetza)	T1	PA QL
RIOMET *(metformin hcl)*	T3	ST HD
RIOMET ER	T3	ST HD
ANTI-HYPERGLYCEMIC, DPP-4 INHIBITORS		
JANUVIA	T2	QL (30 units/30 days) HD
saxagliptin hcl (Onglyza)	T1	ST QL(30 tabs/30 days) HD
ANTI-HYPERGLYCEMIC, INSULIN-RELEASE STIMULANT TYPE		
AMARYL *(glimepiride)*	T3	HD
glimepiride (Amaryl)	T1	HD
glipizide (Glucotrol)	T1	HD
glipizide er (Glucotrol XI)	T1	HD
glipizide xl (Glucotrol XI)	T1	HD
GLUCOTROL *(glipizide)*	T3	HD
GLUCOTROL XL *(glipizide er)*	T3	HD
glyburide	T1	HD
glyburide micronized (Glynase)	T1	HD
GLYNASE *(glyburide micronized)*	T3	HD
nateglinide (Starlix)	T1	HD
repaglinide	T1	HD
STARLIX *(nateglinide)*	T3	HD
ANTI-HYPERGLYCEMIC, SGLT-2 AND DPP-4 INHIBITOR COMB		
GLYXAMBI	T2	ST QL (30 units/30 days) HD
ANTI-HYPERGLYCEMIC, THIAZOLIDINEDIONE AND BIGUANIDE		
ACTOPLUS MET XR 30 1000MG TABLET	T3	ST
pioglitazone-metformin (Actoplus Met)	T1	QL HD
ANTI-HYPERGLYCEMIC, THIAZOLIDINEDIONE-SULFONYLUREA		
DUETACT *(pioglitazone-glimepiride)*	T3	ST QL (30 units/30 days) HD
pioglitazone-glimepiride (Duetact)	T1	QL (30 units/30 days) HD
ANTI-HYPERGLYCEMIC, DPP-4 INHIBITOR-BIGUANIDE COMBS.		
JANUMET	T2	QL HD
JANUMET XR	T2	QL HD

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ANTI-HYPERGLYCEMICS (Diabetes) (cont.)		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
ANTI-HYPERGLYCEMIC, DPP-4 INHIBITOR-BIGUANIDE COMBS. (cont.)		
*saxagliptn-metform er 2.5-1000 (*Kombiglyze Xr*)*	T1	ST QL(60 tabs/30 days) HD
*saxagliptin-metformin er 5-500 (*Kombiglyze Xr)	T1	ST QL(30 tabs/30 days) HD
saxagliptin-metformn er 5-1000 (Kombiglyze Xr)	T1	ST QL(30 tabs/30 days) HD
ANTI-HYPERGLYCEMIC, INSULIN-RELEASE STIM.-BIGUANIDE		
glipizide-metformin	T1	HD
glyburide-metformin hcl	T1	HD
ANTI-HYPERGLYCEMIC, THIAZOLIDINEDIONE (PPARG AGONIST)		
ACTOS *(pioglitazone hcl)*	T3	ST QL (30 units/30 days) HD
AVANDIA	T3	ST QL HD
ANTIHYPERGLYCEMIC-GLUCOCORTICOID RECEPTOR BLOCKER		
mifepristone 300 mg tablet	T1	PA SP
ANTI-HYPERGLYCEMIC-SGLT2 INHIBITOR-BIGUANIDE COMBS.		
INVOKAMET	T2	ST QL HD
SEGLUROMET	T2	ST QL HD
SYNJARDY	T2	ST QL (30 tabs/30 days) HD
SYNJARDY XR	T2	ST QL HD
XIGDUO XR	T2	ST QL HD
INSULINS		
BASAGLAR KWIKPEN U-100	T3	HD
HUMALOG	T2	HD
HUMALOG JUNIOR KWIKPEN	T2	HD
HUMALOG MIX 50-50	T2	HD
HUMALOG MIX 75-25	T2	HD
HUMULIN 70/30 KWIKPEN	T2	HD
HUMULIN 70-30	T2	HD
HUMULIN N	T2	HD
HUMULIN N KWIKPEN	T2	HD
HUMULIN R	T2	HD
HUMULIN R U-500 KWIKPEN	T2	HD
INSULIN LISPRO 100 UNIT/ML VIAL	T2	HD
INSULIN LISPRO JUNIOR KWIKPEN	T2	HD
INSULIN LISPRO KWIKPEN U-100	T2	HD
INSULIN LISPRO PROTAMINE MIX	T2	HD
LANTUS SOLOSTAR	T2	HD

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ANTI-HYPERGLYCEMICS (Diabetes) (cont.)		
INSULINS (cont.)		
MYXREDLIN	T3	HD
SEMGLEE	T2	HD
TOUJEO MAX SOLOSTAR	T2	HD
TOUJEO SOLOSTAR	T2	HD
TRESIBA	T2	HD
TRESIBA FLEXTOUCH U-100, U-200	T2	HD
ANTI-INFECTIVES (Infections)		
PENICILLIN ANTIBIOTICS		
amoxicillin	T1	
ANTI-INFECTIVES/MISCELLANEOUS (Feminine Products)		
VAGINAL ANTISEPTICS		
fem ph	T1	
ANTI-INFECTIVES/MISCELLANEOUS (Infections)		
2ND GEN. ANAEROBIC ANTI-PROTOZOAL-ANTIBACTERIAL		
tinidazole	T1	QL (20 tabs/23 days)
tinidazole	T1	QL (40 tabs/23 days)
AMEBICIDES		
paromomycin	T1	
ANTHELMINTICS		
albendazole (Albenza)	T1	QL (120 tabs/23 days)
ALBENZA *(albendazole)*	T3	QL (120 tabs/23 days)
BILTRICIDE *(praziquantel)*	T3	
EMVERM	T2	QL (6 tabs/23 days)
ivermectin (Stromectol)	T1	PA QL (20 tabs/23 days)
praziquantel (Biltricide)	T1	
STROMECTOL *(ivermectin)*	T3	QL (20 tabs/23 days)
ANTI-MALARIAL DRUGS		
ARAKODA	T3	QL (20 tabs/365 days)
ARAKODA 100mg tablets	T3	QL (32 tabs/180 days)
atovaquone-proguanil 250-100mg tablet (Malarone)	T1	QL (60 tabs/180 days)
atovaquone-proguanil 62.5-25mg tablet (Malarone)	T1	QL (180 tabs/180 days)
chloroquine 250mg tablet	T1	QL (56 tabs/274 days)
chloroquine 500mg tablet	T1	QL (28 tabs/274 days)

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ANTI-INFECTIVES/MISCELLANEOUS (Infections) (cont.)		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
ANTI-MALARIAL DRUGS (cont.)		
COARTEM	T2	QL (24 tabs/23 days)
DARAPRIM *(pyrimethamine)*	T3	PA SP
hydroxychloroquine (Plaquenil)	T1	QL
hydroxychloroquine sulfate (Sovuna)	T1	
KRINTAFEL	T3	QL (2 tabs/23 days)
MALARONE 250-100MG TABLET *(atovaquone-proguanil hcl)*	T3	QL (60 tabs/180 days)
MALARONE 62.5-25MG TABLET *(atovaquone-proguanil hcl)*	T3	QL (180 tabs/180 days)
mefloquine hcl	T1	QL (13 tabs/180 days)
PRIMAQUINE BRAND	T2	QL (120 tabs/180 days)
primaquine generic	T1	QL (120 tabs/180 days)
QUALAQUIN (quinine)	T3	QL (42 caps/23 days)
quinine (Qualaquin)	T1	QL (42 caps/23 days)
SOVUNA	T3	
SOVUNA *(hydroxychloroquine sulfate)*	T3	
ANTI-PROTOZOAL DRUGS, MISCELLANEOUS		
atovaquone (Mepron)	T1	
BENZNIDAZOLE	T2	QL (720 tabs/365 days)
IMPAVIDO	T2	QL (84 caps/23 days)
MEPRON *(atovaquone)*	T3	
NEBUPENT	T3	QL (1 vial/21 days)
pentamidine isethionate (Nebupent)	T1	QL (1 vial/21 days)
ANTI-INFECTIVES/MISCELLANEOUS (Miscellaneous)		
ANTIBACTERIAL AGENTS, MISCELLANEOUS		
aminoacetic acid (Aminoacetic Acid)	T1	
glycine (Aminoacetic Acid)	T1	
ANTISEPTICS,GENERAL		
ALCOHOL SWABSTICK	T3	
GS ISOPROPYL ALCOHOL 70% SPRAY	T3	
ISOPROPYL ALCOHOL	T3	
ANTI-INFECTIVES/MISCELLANEOUS (Skin Conditions)		
TOPICAL ANTI-FUNGALS		
CICLODAN	T3	ST
ciclopirox	T1	

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ANTI-INFLAM.TUMOR NECROSIS FACTOR INHIBITING AGENTS (Pain Relief And Inflammatory Disease)		
ANTI-INFLAMMATORY TUMOR NECROSIS FACTOR INHIBITOR		
ADALIMUMAB-ADAZ (CF)	T2	PA QL(2 syringes/28 days) SP HD
ADALIMUMAB-ADAZ(CF) PEN	T2	PA QL(2 pens/28 days) SP HD
ADALIMUMAB-ADBM(CF)	T2	PA QL(2 srnge kits/28 days) SP HD
ADALIMUMAB-ADBM(CF) PEN CROHNS	T2	PA QL(6 pens/365 days) SP HD
ADALIMUMAB-ADBM(CF) PEN PS-UV	T2	PA QL(4 pens/365 days) SP HD
ADALIMUMAB-ADBM(CF)PEN	T2	PA QL(2 kits/28 days) SP HD
CYLTEZO(CF) 40MG/0.8ML, 20MG/0.4ML, 10MG/0.2ML SYR, PEN CRH-UC-HS 40MG, PEN PSORIASIS 40MG, PEN 40 MG/0.8 ML	T2	PA SP
ENBREL	T2	PA QL SP HD
HUMIRA	T2	PA QL(2 pens/28 days) SP HD
HUMIRA 80MG/0.8ML PENS - PEDIATRIC ULCERATIVE COLITIS STARTER PACK	T2	PA QL (4 pens/365 days) SP HD
HUMIRA(CF) 10 MG/0.1 ML SYRING	T2	PA QL(2 srnge kits/28 days) SP HD
HUMIRA(CF) 20 MG/0.2 ML SYRING	T2	PA QL(2 srnge kits/28 days) SP HD
HUMIRA(CF) 40 MG/0.4 ML SYRING	T2	PA QL(2 srnge kits/28 days) SP HD
HUMIRA PEDIATRIC	T2	PA QL SP HD
HYRIMOZ(CF)	T2	PA QL(2 syringes/28 days) SP HD
HYRIMOZ(CF) PEDI CROHN 80 MG	T2	PA QL(3 syringes/365 days) SP HD
HYRIMOZ(CF) PEDI CROHN 80-40MG	T2	PA QL(2 syringes/365 days) SP HD
HYRIMOZ(CF) PEN	T2	PA QL(2 pens/28 days) SP HD
HYRIMOZ(CF) PEN CROHN-UC START	T2	PA QL(3 pens/365 days) SP HD
HYRIMOZ(CF) PEN PSORIASIS	T2	PA QL(3 pens/365 days) SP HD
SIMPONI	T2	PA QL SP HD
SIMPONI ARIA	T3	PA SP HD
ANTI-NEOPLASTICS (Cancer)		
ANP - SELECTIVE RETINOID X RECEPTOR AGONISTS (RXR)		
bexarotene (Targretin)	T1	PA SP HD CSL
ANTI-NEOPLAST, HISTONE DEACETYLASE (HDAC) INHIBITORS		
FARYDAK 10mg, 20mg CAPSULE	T3	PA QL SP HD CSL
FARYDAK 5mg CAPSULE	T3	PA QL
ZOLINZA	T2	PA SP HD CSL
ANTI-NEOPLASTIC - ALKYLATING AGENTS		
ALKERAN *(melphalan)*	T3	SP CSL
cyclophosphamide	T3	SP HD CSL
GLEOSTINE	T2	CSL

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List of Prescription Medications

ANTI-NEOPLASTICS (Cancer) (cont.)		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
ANTI-NEOPLASTIC - ALKYLATING AGENTS (cont.)		
HYDREA *(hydroxyurea)*	T3	CSL
hydroxyurea (Hydrea)	T1	CSL
LEUKERAN	T2	CSL
melphalan hcl (Alkeran)	T1	SP CSL
MYLERAN	T2	CSL
TEMODAR *(temozolomide)*	T3	PA SP HD CSL
temozolomide (Temodar)	T1	PA SP HD CSL
ANTI-NEOPLASTIC - ANTI-ANDROGENIC AGENTS		
abiraterone acetate (Zytiga)	T1	PA QL SP HD CSL
bicalutamide (Casodex)	T1	CSL
CASODEX *(bicalutamide)*	T3	CSL
ERLEADA 240 MG TABLET	T2	PA SP HD QL (30 tabs/30 days) CSL
flutamide	T1	CSL
NILANDRON *(nilutamide)*	T3	PA CSL
nilutamide (Nilandron)	T1	PA CSL
NUBEQA	T2	PA QL SP HD CSL
XTANDI	T2	PA QL SP HD CSL
ANTI-NEOPLASTIC - ANTI-METABOLITES		
ARRANON	T3	
capecitabine (Xeloda)	T1	SP HD CSL
LONSURF	T2	PA SP HD CSL
mercaptopurine	T1	CSL
methotrexate	T1	
methotrexate	T1	CSL
PURIXAN	T2	SP CSL
TABLOID	T3	CSL
TREXALL	T3	CSL
XELODA (capecitabine)	T3	PA QL ST SP HD CSL
XELODA 150MG tablets	T3	PA SP HD QL (56 tabs/30 days) CSL
XELODA 500MG tablets	T3	PA SP HD QL (140 tabs/30 days) CSL
ANTI-NEOPLASTIC - AROMATASE INHIBITORS		
anastrozole (Arimidex)	T1	HD PPACA CSL
AROMASIN *(exemestane)*	T3	HD CSL
exemestane (Aromasin)	T1	HD PPACA CSL

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ANTI-NEOPLASTIC - AROMATASE INHIBITORS (cont.)		
FEMARA *(letrozole)*	T3	HD CSL
letrozole (Femara)	T1	HD CSL
ANTI-NEOPLASTIC - BRAF KINASE INHIBITORS		
TAFINLAR 10 MG TABLET FOR SUSP	T2	SP PA HD QL (840 ml/30 days) CSL
ZELBORAF	T2	PA QL SP HD CSL
ANTI-NEOPLASTIC - CAR-T CELL IMMUNOTHERAPY		
BREYANZI	T3	PA
ANTI-NEOPLASTIC - HEDGEHOG PATHWAY INHIBITOR		
DAURISMO	T3	PA QL SP HD CSL
ERIVEDGE	T2	PA QL (30 units/30 days) SP HD CSL
ODOMZO	T2	PA QL (30 units/30 days) SP HD CSL
ANTI-NEOPLASTIC - JANUS KINASE (JAK) INHIBITORS		
JAKAFI	T2	PA QL SP HD CSL
ANTI-NEOPLASTIC - KRAS PROTEIN INHIBITOR		
LUMAKRAS	T3	PA SP QL (8 tabs per day) HD
ANTI-NEOPLASTIC - MEKI AND MEK2 KINASE INHIBITORS		
COTELLIC	T2	PA QL SP HD CSL
MEKINIST 0.05 MG/ML SOLUTION	T2	PA SP HD QL (108ml/30 days) CSL
ANTI-NEOPLASTIC - MTOR KINASE INHIBITORS		
AFINITOR 10MG TABLET	T2	PA QL(30 tabs/30 days) ST SP HD CSL
AFINITOR DISPERZ 2 MG, 3 MG, 5MG TABLET	T3	PA QL ST SP
AFINITOR 2.5MG, 5MG, 7.5MG TABLET *(everolimus)*	T3	PA QL(30 tabs/30 days) ST SP HD CSL
AFINITOR DISPERZ	T2	PA QL(30 tabs/30 days) ST SP CSL
everolimus 2.5 mg tablet (Afinitor)	T1	
everolimus 5 mg tablet (Afinitor)	T1	
everolimus 7.5 mg tablet (Afinitor)	T1	
ANTI-NEOPLASTIC - PROTEIN METHYLTRANSFERASE INHIBIT		
TAZVERIK	T3	PA SP CSL
ANTI-NEOPLASTIC - TOPOISOMERASE I INHIBITORS		
HYCAMTIN	T2	PA SP HD CSL
ANTI-NEOPLASTIC IMMUNOMODULATOR AGENTS		
POMALYST	T2	PA SP HD CSL
REVLIMID	T2	PA QL (30 caps/30 days)SP HD CSL
SYLATRON	T2	PA

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Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
ANTI-NEOPLASTIC LHRH (GNRH) AGONIST, PITUITARY SUPPR.		
leuprolide acetate	T1	PA SP HD
LUPRON DEPOT	T3	PA SP HD
ZOLADEX	T2	SP HD
ANTI-NEOPLASTIC LHRH (GNRH) ANTAGONIST, PITUIT.SUPPRS		
FIRMAGON	T2	PA SP HD
ANTI-NEOPLASTIC SYSTEMIC ENZYME INHIBITORS		
ALECENSA	T2	PA QL SP HD CSL
ALUNBRIG	T2	PA QL SP HD CSL
AYVAKIT	T3	PA QL (30 tabs/30 days) SP CSL
BALVERSA	T2	PA SP CSL
BOSULIF	T2	PA QL SP HD CSL
BOSULIF 50 MG CAPSULE	T2	
BOSULIF 100 MG CAPSULE	T2	PA QL(90 tabs/fill) SP HD CSL
BRUKINSA	T2	PA SP CSL
CABOMETYX	T2	
CALQUENCE	T2	SP
CAPRELSA	T2	PA QL SP CSL
COMETRIQ	T2	PA SP HD CSL
COPIKTRA	T3	PA QL (56 caps/28 days) SP CSL
erlotinib hcl (Tarceva)	T1	PA QL SP HD CSL
EXKIVITY 40MG CAPSULE	T3	PA QL (120 tabs/30 days)
GAVRETO	T2	PA QL (120 tabs/30 days) SP
GILOTRIF	T2	PA QL (30 units/30 days) SP HD CSL
ICLUSIG	T2	PA QL SP CSL
IMBRUVICA 560MG TABS	T2	PA SP CSL
INLYTA	T2	PA QL SP HD CSL
IRESSA (*gefitinib*)	T3	PA QL(30 tabs/30 days) SP HD CSL
IWILFIN	T2	PA SP CSL
KISQALI	T3	PA SP HD QL (1 pack/1 time) CSL
KISQALI FEMARA CO-PACK	T3	PA SP HD QL (1 pack/28 days) CSL
LENVIMA 4MG (five 4 mg capsules per card)	T2	PA QL (30 caps/30 days) SP HD CSL
LENVIMA 8MG (ten 4 mg capsules per card)	T2	PA QL (60 caps/30 days) SP HD CSL
LENVIMA 10MG (five 10 mg capsules per card)	T2	PA QL (30 caps/30 days) SP HD CSL
LENVIMA 12MG (fifteen 4 mg capsules per card)	T2	PA QL (90 caps/30 days) SP HD CSL

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Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
ANTI-NEOPLASTIC SYSTEMIC ENZYME INHIBITORS (cont.)		
LENVIMA 14MG (five 10 mg capsules and five 4 mg capsules per card)	T2	PA QL (60 caps/30 days) SP HD CSL
LENVIMA 18MG (five 10 mg capsules and five 4 mg capsules per card)	T2	PA QL (90 caps/30 days) SP HD CSL
LENVIMA 20MG	T2	PA QL (60 caps/30 days) SP HD CSL
LENVIMA 24MG	T2	PA QL (90 caps/30 days) SP HD
LORBRENA	T2	PA QL SP HD CSL
LYNPARZA	T2	PA QL SP HD CSL
LYTGOBI	T2	PA SP CSL
NERLYNX	T2	PA SP HD CSL
NEXAVAR	T3	PA QL(120 tabs/30 days) SP HD CSL
NINLARO	T2	PA QL SP HD CSL
OGSIVEO	T3	PA SP CSL
pazopanib (Votrient)	T1	PA QL(120 tabs/30 days)SP HD CSL
PEMAZYRE 4.5MG, 9MG, 13.5MG TAB	T2	PA QL(28 tabs/30 days) SP
PIQRAY	T3	PA SP HD CSL
ROZLYTREK	T2	PA QL SP HD CSL
ROZLYTREK 50 MG PELLET PACKET	T2	
RUBRACA	T2	PA QL SP CSL
RYDAPT	T2	PA QL(224 caps/30 days) SP HD CSL
SCEMBLIX 20MG TABLET	T3	PA SP HD QL (600 tabs/30 days) CSL
SCEMBLIX 40MG TABLET	T3	PA SP HD QL (300 tabs/30 days) CSL
SPRYCEL	T2	QL SP HD CSL
STIVARGA	T2	PA QL SP HD CSL
SUTENT	T3	PA QL SP CSL
TABRECTA	T2	PA SP
TAGRISSO	T2	PA QL (30 units/30 days) SP HD CSL
TALZENNA	T2	PA QL(30 caps/30 days) SP HD CSL
TARCEVA *(erlotinib hcl)*	T3	PA QL SP HD CSL
TASIGNA	T2	PA QL SP HD CSL
TURALIO	T3	PA QL SP CSL
TYKERB	T2	PA QL SP HD CSL
UKONIQ	T3	SP
VERZENIO	T2	PA QL SP HD CSL
VIKTRAKVI 100 MG CAPSULE	T2	PA QL (60 caps/30 days) SP HD CSL
VIKTRAKVI 20 MG/ML SOLUTION	T2	PA QL (300ml/30 days) SP HD CSL

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Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
ANTI-NEOPLASTIC SYSTEMIC ENZYME INHIBITORS (cont.)		
VIKTRAKVI 25 MG CAPSULE	T2	PA QL (180 caps/30 days) SP HD CSL
VIZIMPRO	T2	PA QL (30 units/30 days) SP HD CSL
VOTRIENT *(pazopanib hcl)*	T3	PA QL(120 tabs/30 days)SP HD CSL
XOSPATA	T2	PA SP CSL
XALKORI 200MG, 250MG CAPSULE	T2	PA QL(60 caps/30 days) SP HD CSL
XALKORI 20MG, 50MG, 150MG PELLET	T2	PA SP HD CSL
ZEJULA 100MG, 200MG, 300MG TABLET	T2	SP PA
ZYDELIG	T2	PA QL SP HD CSL
ZYKADIA	T2	PA QL (90 tabs-caps/30 days) SP HD CSL
ANTI-NEOPLASTIC, ANTI-PROGRAMMED DEATH-I (PD-I) MAB		
JEMPERLI 500 MG/10 ML VIAL	T3	PA SP HD
OPDIVO	T2	PA SP HD
ANTI-NEOPLASTIC-B CELL LYMPHOMA-2(BCL-2) INHIBITORS		
VENCLEXTA	T2	PA SP CSL
VENCLEXTA STARTING PACK	T2	PA QL SP CSL
ANTI-NEOPLASTIC-ISOCITRATE DEHYDROGENASE INHIBITOR		
IDHIFA	T2	PA QL (30 units/30 days) SP HD CSL
TIBSOVO	T2	PA SP CSL
ANTI-NEOPLASTICS ANTIBODY/ANTIBODY-DRUG COMPLEXES		
ENHERTU	T3	PA SP HD
ANTI-NEOPLASTICS, MISCELLANEOUS		
etoposide	T1	SP HD CSL
LYSODREN	T2	CSL
MATULANE	T2	SP CSL
RYLAZE 10 MG/0.5 ML VIAL	T3	PA SP
tretinoin	T1	CSL
CYTOTOXIC T-LYMPHOCYTE ANTIGEN (CTLA-4) RMC ANTIBODY		
YERVOY	T2	PA SP HD
IMMUNOMODULATORS		
ACTIMMUNE	T2	SP HD
INTRON A	T2	SP HD
SELECTIVE ESTROGEN RECEPTOR MODULATORS (SERMS)		
FARESTON *(toremifene)*	T3	HD CSL
SOLTAMOX	T3	HD CSL

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ANTI-NEOPLASTICS (Cancer) (cont.)		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
SELECTIVE ESTROGEN RECEPTOR MODULATORS (SERMS) (cont.)		
tamoxifen	T1	HD PPACA CSL
toremifene (Fareston)	T1	HD CSL
STEROID ANTI-NEOPLASTICS		
EMCYT	T2	SP HD CSL
megestrol acetate	T1	CSL
ANTI-NEOPLASTICS (Skin Conditions)		
PHOTOACT, TOPICAL ANTI-NEOPLAST, PREMALIGNANT LESIONS		
LEVULAN	T3	SP
TOPICAL ANTI-NEOPLASTIC PREMALIGNANT LESION AGENTS		
PANRETIN	T3	PA SP HD
PICATO	T2	
TARGRETIN	T2	PA SP HD
TOLAK	T3	
VALCHLOR	T2	PA SP HD
ANTI-OBESITY DRUGS (Weight Management)		
ANTI-OBESITY - ANOREXIC AGENTS		
ADIPEX-P (*phentermine hcl*)	T3	PA QL(30 tabs/30 days)
benzphetamine hcl	T1	PA QL (90 tabs/30 days)
diethylpropion 25 mg tablets	T1	PA QL (90 tabs/30 days)
diethylpropion 75 mg tablets	T1	PA QL (30 tabs/30 days)
LOMAIRA	T1	PA QL (90 tabs/30 days)
phendimetrazine tartrate	T1	PA QL (180 tabs/30 days)
phentermine 37.5 mg capsule	T1	PA QL(30 caps/30 days)
QSYMIA	T3	PA QL (30 caps/30 days)
REGIMEX (*benzphetamine hcl*)	T3	PA QL (90 tabs/30 days)
ANTI-OBESITY GLUCAGON-LIKE PEPTIDE-I RECEP AGONIST		
SAXENDA	T3	PA QL (5 pens (15 ml)/30 days)
WEGOVY	T2	PA
ANTI-OBESITY - INCRETIN MIMETICS COMBINATION		
ZEPBOUND	T2	
ANTI-OBESITY - OPIOID ANTAG-NOREPI, DOPAMINE RU INHIB		
CONTRAVE	T3	PA QL (120 tabs/30 days)

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ANTI-OBESITY DRUGS (Weight Management) (cont.)		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
FAT ABSORPTION DECREASING AGENTS		
XENICAL	T3	PA QL (90 tabs/30 days)
ANTI-PARASITICS (Eye Conditions)		
OPHTHALMIC (EYE) ANTIPARASITICS		
XDEMVY	T2	QL(10 mgs/30 days) SP
ANTI-PARASITICS (Infections)		
ANTI-PARASITICS		
ALINIA 100MG/5ML SUSP	T2	QL (180 ml/30 days)
TOPICAL ANTI-PARASITICS		
crotan	T1	
ELIMITE *(permethrin)*	T3	
permethrin (Elimite)	T1	
SKLICE	T3	
spinosad (Natroba)	T1	
ULESFIA	T3	
ANTI-PARKINSON DRUGS (Parkinson's Disease)		
ANTI-PARKINSONISM DRUGS, ANTI-CHOLINERGIC		
benztropine mesylate	T1	HD
trihexyphenidyl hcl	T1	HD
ANTI-PARKINSONISM DRUGS, OTHER		
carbidopa/levodopa (Sinemet 25-100)	T1	HD
carbidopa/levodopa (Sinemet 25-250)	T1	HD
carbidopa-levodopa er	T1	HD
carbidopa-levodopa-entacapone (Stalevo 100)	T1	HD
carbidopa-levodopa-entacapone (Stalevo 125)	T1	HD
carbidopa-levodopa-entacapone (Stalevo 150)	T1	HD
carbidopa-levodopa-entacapone (Stalevo 200)	T1	HD
carbidopa-levodopa-entacapone (Stalevo 50)	T1	HD
carbidopa-levodopa-entacapone (Stalevo 75)	T1	HD
COMTAN *(entacapone)*	T3	HD
DUOPA	T3	SP HD
entacapone (Comtan)	T1	HD
INBRIJA	T2	PA QL (300 caps/30 days) SP HD
MIRAPEX ER *(pramipexole er)*	T3	HD

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ANTI-PARKINSON DRUGS (Parkinson's Disease) (cont.)		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
ANTI-PARKINSONISM DRUGS, OTHER (cont.)		
NEUPRO	T3	HD
NOURIANZ	T3	PA QL (30 units/30 days) SP HD
PARLODEL *(bromocriptine mesylate)*	T3	HD
pramipexole di-hcl	T1	HD
pramipexole di-hcl (Mirapex)	T1	HD
pramipexole er (Mirapex ER)	T1	HD
rasagiline mesylate (Azilect)	T1	HD
REQUIP XL *(ropinirole er)*	T3	HD
ropinirole hcl	T1	HD
ropinirole hcl (Requip XL)	T1	HD
RYTARY	T3	HD
selegiline hcl	T1	HD
SINEMET *(carbidopa-levodopa)*	T3	HD
STALEVO *(carbidopa-levodopa-entacapone)*	T3	HD
TASMAR *(tolcapone)*	T3	HD
tolcapone (Tasmar)	T1	HD
DECARBOXYLASE INHIBITORS		
carbidopa (Lodosyn)	T1	
LODOSYN *(carbidopa)*	T3	
ANTI-PLATELET DRUGS (Blood Thinners/Anti-Clotting)		
PLATELET AGGREGATION INHIBITORS		
aspirin e.c.	T1	HD PPACA
aspirin-dipyridamole er (Aggrenox)	T1	HD
BRILINTA	T2	HD
children's aspirin (Bayer Chewable Aspirin)	T1	HD PPACA
cilostazol	T1	HD
clopidogrel (Plavix)	T1	HD
dipyridamole	T1	HD
ecotrin	T1	HD PPACA
EFFIENT *(prasugrel hcl)*	T3	HD
enteric coated aspirin	T1	HD PPACA
low dose aspirin	T1	HD PPACA
prasugrel hcl (Effient)	T1	HD

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ANTI-PLATELET DRUGS (Blood Thinners/Anti-Clotting) (cont.)		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
PLATELET AGGREGATION INHIBITORS (cont.)		
st. joseph aspirin	T1	HD PPACA
ZONTIVITY	T3	PA HD
PLATELET REDUCING AGENTS		
AGRYLIN *(anagrelide hcl)*	T3	
anagrelide hydrochloride (Agrylin)	T1	
ANTIVIRALS (AIDS/HIV)		
ANTI-RETROVIRAL - CAPSID INHIBITORS		
SUNLENCA	T3	PA SP
ANTIRETROVIRAL-INTEGRASE INHIBITOR AND NNRTI COMB		
JULUCA	T2	SP
ANTIRETROVIRAL-INTEGRASE INHIBITOR AND NRTI COMB		
DOVATO	T2	SP
ANTIRETROVIRAL-NRTIS AND INTEGRASE INHIBITORS COMB		
TRIUMEQ	T2	SP
TRIUMEQ PD 60-5-30 MG TAB SUSP	T2	SP
ANTI-RETROVIRAL - NUCLEOSIDE, NUCLEOTIDE, PROTEASE INH.		
SYMTUZA	T2	SP
ANTIVIRALS - HIV-SPEC, NON-PEPTIDIC PROTEASE INHIB		
APTIVUS	T2	SP
darunavir 600mg, 800mg tablet	T1	SP
darunavir (Prezista)	T1	SP
PREZISTA 600MG, 800MG TABLET	T2	SP
PREZISTA 600MG, 800MG TABLET *(darunavir)*	T3	SP
ANTIVIRALS - HIV-SPEC, NUCLEOSIDE-NUCLEOTIDE ANALOG		
CIMDUO	T2	SP
DESCOVY	T2	SP PPACA
TEMIXYS	T2	SP
ANTIVIRALS - HIV-SPEC, NUCLEOSIDE ANALOG, RTI COMB		
abacavir-lamivudine (Epzicom)	T1	SP
abacavir-lamivudine-zidovudine (Trizivir)	T1	SP
COMBIVIR *(lamivudine-zidovudine)*	T3	SP
EPZICOM *(abacavir-lamivudine)*	T3	SP
lamivudine-zidovudine (Combivir)	T1	SP
TRIZIVIR *(abacavir-lamivudine-zidovudine)*	T3	SP

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ANTIVIRALS (AIDS/HIV) (cont.)		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
ANTIVIRALS - HIV-SPECIFIC, CCR5 CO-RECEPTOR ANTAG.		
SELZENTRY	T3	SP
ANTIVIRALS - HIV-SPECIFIC, FUSION INHIBITORS		
FUZEON	T2	SP QL (60 vials/30 days)
ANTIVIRALS - HIV-SPECIFIC, NON-NUCLEOSIDE, RTI		
EDURANT	T2	SP
efavirenz (Sustiva)	T1	SP
INTELENCE	T3	SP
nevirapine (Viramune)	T1	SP
nevirapine er	T1	SP
nevirapine er (Viramune XR)	T1	SP
SUSTIVA *(efavirenz)*	T3	SP
VIRAMUNE *(nevirapine)*	T3	SP
VIRAMUNE XR *(nevirapine er)*	T3	SP
ANTIVIRALS - HIV-SPECIFIC, NUCLEOSIDE ANALOG, RTI		
abacavir (Ziagen)	T1	SP
didanosine	T1	SP
EMTRIVA	T2	SP
EPIVIR *(lamivudine)*	T3	SP
lamivudine (Epivir)	T1	SP
RETROVIR *(zidovudine)*	T3	SP
stavudine (Zerit)	T1	SP
ZIAGEN *(abacavir)*	T3	SP
ANTIVIRALS - HIV-SPECIFIC, NUCLEOTIDE ANALOG, RTI		
tenofovir disoproxil fumarate (Viread)	T1	SP
VIREAD 150MG, 200MG, 250MG TABLET	T2	SP
VIREAD POWDER	T2	SP
VIREAD 300 MG TABLET *(tenofovir disoproxil fumarate)*	T3	SP
ANTIVIRALS - HIV-SPECIFIC, PROTEASE INHIBITORS		
atazanavir (Reyataz)	T1	SP
CRIXIVAN	T2	SP
EVOTAZ	T3	SP
fosamprenavir (Lexiva)	T1	SP
INVIRASE	T2	SP
KALETRA 100-25 MG TABLET	T3	QL (2 tabs/day) SP

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List of Prescription Medications

ANTIVIRALS (AIDS/HIV) (cont.)		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
ANTIVIRALS - HIV-SPECIFIC, PROTEASE INHIBITORS (cont.)		
KALETRA 200-50 MG TABLET	T3	QL (56 tabs/274 days) SP
KALETRA 80-20MG/ML SOLUTION *(lopinavir-ritonavir)*	T3	QL (2ml/day) SP
LEXIVA 50 MG/ML SUSPENSION	T2	SP
LEXIVA 700 MG TABLET *(fosamprenavir)*	T3	SP
lopinavir-ritonavir (Kaletra)	T1	QL (2ml/day) SP
NORVIR 100 MG TABLET *(ritonavir)*	T3	SP
NORVIR 100 MG POWDER PACKET	T2	SP
REYATAZ CAPSULES (atazanavir)	T3	SP
REYATAZ POWDER PACKET	T2	SP
ritonavir (Norvir)	T1	SP
VIRACEPT	T2	SP
ANTIVIRALS - HIV-I INTEGRASE STRAND TRANSFER INHIBTR		
APRETUDE ER 600MG/3ML VIAL	T2	PA SP PPACA
ISENTRESS	T2	SP
ISENTRESS HD	T2	SP
TIVICAY	T2	SP
ARTV NUCLEOSIDE, NUCLEOTIDE, NON-NUCLEOSIDE RTI		
ODEFSEY	T2	SP
SYMFI	T2	SP
SYMFI LO	T2	SP
ARV-NUCLEOSIDE, NUCLEOTIDE RTI, INTEGRASE INHIB		
BIKTARVY	T2	SP
GENVOYA	T2	SP
ANTIVIRALS (Eye Conditions)		
EYE ANTIVIRALS		
trifluridine	T1	
ZIRGAN	T3	
ANTIVIRALS (Infections)		
ANTIVIRALS, GENERAL		
acyclovir (Zovirax)	T1	
famciclovir	T1	QL
LIVTENCITY 200 MG TABLET	T3	PA SP
oseltamivir phosphate (Tamiflu)	T1	QL

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ANTIVIRALS (Infections) (cont.)		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
ANTIVIRALS, GENERAL (cont.)		
OSELTAMIVIR 6MG/ML SUSPENSION	T3	QL (180 ml/30 days)
oseltamivir 30mg capsule	T1	QL (20 caps/30 days)
oseltamivir 45mg capsule	T1	QL (10 caps/30 days)
oseltamivir 75mg capsule	T1	QL (10 caps/30 days)
PREVYMIS	T2	QL (112 tabs/30 days) SP HD
RELENZA 5 MG	T3	QL (20 blisters/10 days)
ribavirin (Virazole)	T1	SP HD
rimantadine hcl	T1	
TAMIFLU *(oseltamivir phosphate)*	T3	QL
valacyclovir (Valtrex)	T1	QL (30 units/30 days)
VALCYTE *(valganciclovir hcl)*	T3	
valganciclovir hcl (Valcyte)	T1	
XOFLUZA	T3	QL
ZOVIRAX *(acyclovir)*	T3	
HEP C - NS5A, NS3/4A, NUCLEOTIDE NS5B INHIB COMBO		
VOSEVI	T2	PA QL (84 tabs/365 days) SP HD
HEP C VIRUS-NS5B POLYMERASE AND NS5A INHIB. COMBO.		
EPCLUSA 200MG/50MG ORAL PELLET PACKET	T2	PA SP HD QL (28 pkts/28 days)
EPCLUSA	T2	PA QL (84 packets/365 days) ST SP HD
HARVONI 45-200 MG TABLET	T2	PA QL (56 tabs/dispense) SP HD
HARVONI 90-400 MG TABLET	T2	PA QL (84 tabs/365 days) SP HD
HEPATITIS B TREATMENT AGENTS		
adefovir dipivoxil	T1	SP HD
BARACLUDE	T2	SP HD
entecavir (Baraclude)	T1	SP HD
EPIVIR HBV 25 MG/5 ML SOLUTION	T2	SP
EPIVIR HBV TABLETS *(lamivudine hbv)*	T3	SP
lamivudine (Epivir Hbv)	T1	SP
VEMLIDY	T2	SP HD
HEPATITIS C TREATMENT AGENTS		
PEGASYS 180MCG/0.5ML SYRINGE KIT	T2	SP HD
PEGASYS PROCLICK 180MCG/0.5ML	T2	SP HD
PEGASYS SYRINGE	T2	QL (2ml/21 days) SP HD
PEGASYS VIAL	T2	QL (4ml/21 days) SP HD

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ANTIVIRALS (Infections) (cont.)		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
HEPATITIS C TREATMENT AGENTS (cont.)		
PEG-INTRON	T3	QL (4 kits/21 days) SP HD
ribavirin	T1	ST SP HD
HEPATITIS C VIRUS- NS5A AND NS3/4A INHIBITOR COMB		
ZEPATIER	T2	PA QL (84 tabs/365 days) SP HD
RNA POLYMERASE INHIBITOR		
MOLNUPIRAVIR	T2	
ANTIVIRALS (Skin Conditions)		
TOPICAL ANTIVIRALS		
acyclovir (Zovirax)	T1	PA QL
DENAVIR	T3	
penciclovir	T1	
ZOVIRAX *(acyclovir)*	T3	PA QL
TOPICAL GENITAL WART-HPV TREATMENT AGENTS		
VEREGEN	T3	PA QL(30 grams/treatment)
AUTONOMIC DRUGS (Allergy/Nasal Sprays)		
ANAPHYLAXIS THERAPY AGENTS		
AUVI-Q	T2	QL(2 auto-injs/30 days)
epinephrine (Auvi-Q)	T1	QL
epinephrine (Epipen Jr 2-Pak)	T1	QL
EPIPEN *(epinephrine)*	T2	QL
EPIPEN JR. *(epinephrine)*	T2	QL
SYMJEPI	T2	QL
AUTONOMIC DRUGS (Alzheimer's Disease)		
CHOLINESTERASE INHIBITORS		
ARICEPT *(donepezil hcl)*	T3	ST HD
donepezil hcl (Aricept)	T1	HD
EXELON *(rivastigmine)*	T3	ST HD
galantamine	T1	HD
galantamine er (Razadyne ER)	T1	HD
pyridostigmine bromide (Mestinon)	T1	HD
pyridostigmine bromide er (Mestinon)	T1	HD
RAZADYNE *(galantamine hbr)*	T3	ST
RAZADYNE ER *(galantamine er)*	T3	ST HD

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AUTONOMIC DRUGS (Alzheimer's Disease) (cont.)		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
CHOLINESTERASE INHIBITORS (cont.)		
rivastigmine	T1	HD
rivastigmine (Exelon)	T1	HD
AUTONOMIC DRUGS (Attention Deficit Hyperactivity Disorder)[8]		
ADRENERGICS, AROMATIC, NON-CATECHOLAMINE		
ADZENYS ER	T3	ST
ADZENYS XR-ODT	T3	ST
amphetamine (Evekeo)	T1	
AMPHETAMINE ER 1.25 MG/ML SUSP	T3	ST
DESOXYN *(methamphetamine hcl)*	T3	
DEXEDRINE (dextroamphetamine er)	T3	ST
dextroamphetamine	T1	
dextroamphetamine (Zenzedi)	T1	
dextroamphetamine er (Dexedrine)	T1	
dextroamphetamine-amphet er (Adderall XR)	T1	
dextroamphetamine-amphetamine (Adderall)	T1	
dextroamphetamine/amphetamine (Mydayis)	T1	
EVEKEO (amphetamine)	T3	
EVEKEO ODT	T3	
methamphetamine hcl (Desoxyn)	T1	
MYDAYIS (dextroamphetamine/amphetamine)	T3	ST
procentra	T1	
ZENZEDI	T3	
zenzedi (Zenzedi)	T1	
AUTONOMIC DRUGS (Blood Pressure/Heart Medications)		
ADRENERGIC VASOPRESSOR AGENTS		
midodrine hcl	T1	
ALPHA-ADRENERGIC BLOCKING AGENTS		
DIBENZYLINE *(phenoxybenzamine hcl)*	T3	PA HD
phenoxybenzamine hcl (Dibenzyline)	T1	PA HD
AUTONOMIC DRUGS (Urinary Tract Conditions)		
PARASYMPATHETIC AGENTS		
bethanechol chloride	T1	HD
cevimeline hcl (Evoxac)	T1	HD

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AUTONOMIC DRUGS (Urinary Tract Conditions) (cont.)		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
PARASYMPATHETIC AGENTS (cont.)		
EVOXAC *(cevimeline hcl)*	T3	HD
guanidine hcl	T1	HD
pilocarpine hcl (Salagen)	T1	HD
SALAGEN *(pilocarpine hcl)*	T3	HD
URECHOLINE *(bethanechol chloride)*	T3	
BIOLOGICALS (Allergy/Nasal Sprays)		
ALLERGENIC EXTRACTS, THERAPEUTIC		
GRASTEK	T2	PA
ODACTRA	T2	PA
ORALAIR	T2	PA
RAGWITEK	T2	PA
BIOLOGICALS (Blood Pressure/Heart Medications)		
PLASMA KALLIKREIN INHIBITORS		
ORLADEYO	T3	PA SP
TAKHZYRO	T2	PA SP ST HD
BIOLOGICALS (Miscellaneous)		
PKU TREATMENT AGENTS - PHENYLALANINE AMMONIA LYASE		
PALYNZIQ	T2	PA QL (8 syringes/30 days) SP HD
BIOLOGICALS (Vaccines)		
ENTERIC VIRUS VACCINES		
IPOL	T2	PPACA
ROTARIX	T2	HD PPACA
ROTATEQ	T2	PPACA
GRAM (-) BACILLI (NON-ENTERIC) VACCINES		
VIVOTIF	T2	
GRAM NEGATIVE COCCI VACCINES		
BEXSERO	T2	PPACA
MENACTRA	T2	PPACA
MENVEO A-C-Y-W-135-DIP	T3	PPACA
MENQUADFI	T2	PPACA
PENBRAYA	T2	PPACA
TRUMENBA	T2	PPACA

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BIOLOGICALS (Vaccines) (cont.)		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
GRAM POSITIVE COCCI VACCINES		
PNEUMOVAX 23	T2	PPACA
PREVNAR 13	T2	PPACA
INFLUENZA VIRUS VACCINES		
AFLURIA QUAD	T2	PPACA
FLUAD	T2	PPACA
FLUARIX	T2	PPACA
FLUBLOK QUAD	T2	PPACA
FLUCELVAX QUAD	T2	PPACA
FLULAVAL	T2	PPACA
FLUMIST	T2	PPACA
FLUZONE HIGH-DOSE	T2	PPACA
FLUZONE QUAD	T2	PPACA
FLUZONE QUAD PEDI	T2	PPACA
TOXIN-PRODUCING BACILLI VACCINES/TOXOIDS		
VAXCHORA VACCINE	T2	
VACCINE/TOXOID PREPARATIONS, COMBINATIONS		
ACTHIB	T2	PPACA
ADACEL	T2	PPACA
BOOSTRIX	T2	PPACA
DAPTACEL	T2	PPACA
DIPHTHERIA-TETANUS TOXOIDS-PED	T2	PPACA
HIBERIX	T2	PPACA
INFANRIX	T2	PPACA
KINRIX	T2	PPACA
M-M-R II VACCINE W/DILUENT	T2	PPACA
PRIORIX VIAL	T2	PPACA
PEDVAXHIB	T2	PPACA
PENTACEL	T2	PPACA
PROQUAD	T2	PPACA
QUADRACEL DTAP-IPV	T2	PPACA
TENIVAC	T2	PPACA
TETANUS DIPHTHERIA TOXOIDS	T2	PPACA
VAXELIS	T2	PPACA

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BIOLOGICALS (Vaccines) (cont.)		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
VIRAL/TUMORIGENIC VACCINES		
ACAM2000	T2	
AREXVY VIAL KIT	T2	PPACA
ENGERIX-B	T2	PPACA
GARDASIL 9	T2	PPACA
HAVRIX	T2	PPACA
HEPLISAV-B	T2	PPACA
JYNNEOS	T2	
PEDIARIX	T2	PPACA
RECOMBIVAX HB	T2	PPACA
SHINGRIX	T2	PPACA
TWINRIX	T2	PPACA
VAQTA	T3	PPACA
VARIVAX VACCINE	T2	PPACA
BLOOD (Blood Modifiers/Bleeding Disorders)		
AGENTS TO TX THROMBOTIC THROMBOCYTOPENIC PURPURA		
CABLIVI	T2	PA SP
ANTI-FIBRINOLYTIC AGENTS		
AMICAR *(aminocaproic acid)*	T3	SP HD
aminocaproic acid (Amicar)	T1	SP HD
LYSTEDA *(tranexamic acid)*	T3	SP
tranexamic acid (Lysteda)	T1	SP
COMPLEMENT INHIBITORS		
EMPAVELI	T2	PA SP
FABHALTA	T2	PA SP
HEMOPHILIA TREATMENT AGENTS, NON-FACTOR REPLACEMENT		
HEMLIBRA	T2	PA SP HD
SICKLE CELL ANEMIA AGENTS		
DROXIA	T2	
TOPICAL HEMOSTATICS		
AVITENE	T3	
ENDO-AVITENE	T3	
GEL-FLOW	T3	
GELFOAM	T3	
GELFOAM JMI	T3	

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List of Prescription Medications

BLOOD (Blood Modifiers/Bleeding Disorders) (cont.)		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
TOPICAL HEMOSTATICS (cont.)		
MONSEL'S	T2	
RECOTHROM	T3	
SYRINGE AVITENE	T3	
TACHOSIL	T3	
THROMBI-GEL	T3	
THROMBIN-JMI	T3	
THROMBI-PAD	T3	
ULTRAFOAM	T3	
BLOOD (Blood Thinners/Anti-Clotting)		
HEMORRHEOLOGIC AGENTS		
pentoxifylline	T1	HD
CARDIAC DRUGS (Blood Pressure/Heart Medications)		
ANTI-ANGINAL, ANTI-ISCHEMIC AGENTS, NON-HEMODYNAMIC		
ranolazine er (Ranexa)	T1	HD
ANTI-ARRHYTHMICS		
amiodarone hcl	T1	HD
amiodarone hcl (Pacerone)	T1	HD
disopyramide phosphate (Norpace)	T1	HD
dofetilide (Tikosyn)	T1	HD
flecainide acetate	T1	HD
mexiletine hcl	T1	HD
MULTAQ	T3	HD
NORPACE *(disopyramide phosphate)*	T3	HD
NORPACE CR	T3	HD
pacerone	T1	HD
propafenone hcl	T1	HD
propafenone hcl er (Rythmol SR)	T1	HD
quinidine	T1	HD
quinidine gluconate	T1	HD
RYTHMOL SR *(propafenone hcl er)*	T3	HD
CALCIUM CHANNEL BLOCKER AND NSAID, COX-2 INHIBITOR		
CONSENSI	T3	

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CARDIAC DRUGS (Blood Pressure/Heart Medications) (cont.)		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
CALCIUM CHANNEL BLOCKING AGENTS		
ADALAT CC *(nifedipine er)*	T3	
amlodipine besylate (Norvasc)	T1	
CALAN SR *(verapamil er)*	T3	HD
CAMZYOS	T3	PA QL (30 caps/30 days) SP
CARDIZEM *(diltiazem hcl)*	T3	HD
CARDIZEM CD *(cartia xt)*	T3	HD
CARDIZEM CD *(diltiazem 24hr er (cd))*	T3	HD
CARDIZEM LA	T3	HD
CARDIZEM LA *(diltiazem 24hr er (la))*	T3	HD
CARDIZEM LA *(matzim la)*	T3	HD
cartia xt (Cardizem CD)	T1	HD
diltiazem 24hr er (cd) (Cardizem CD)	T1	HD
diltiazem 24hr er (la) (Cardizem La)	T1	HD
diltiazem 24hr er (xr)	T1	HD
diltiazem er	T1	HD
diltiazem er (Tiazac)	T1	HD
diltiazem hcl (Cardizem)	T1	HD
dilt-xr	T1	HD
felodipine er	T1	HD
isradipine	T1	HD
matzim la (Cardizem La)	T1	HD
nicardipine hcl	T1	HD
nifedipine	T1	HD
nifedipine (Procardia)	T1	HD
nifedipine er	T1	HD
nifedipine er (Procardia XI)	T1	HD
nimodipine	T1	HD
nisoldipine	T1	HD
nisoldipine (Sular)	T1	HD
NYMALIZE	T3	
PROCARDIA *(nifedipine)*	T3	HD
PROCARDIA XL *(nifedipine er)*	T3	HD
SULAR *(nisoldipine)*	T3	HD
taztia xt (Tiazac)	T1	HD

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CARDIAC DRUGS (Blood Pressure/Heart Medications) (cont.)		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
CALCIUM CHANNEL BLOCKING AGENTS (cont.)		
tiadylt er (Tiazac)	T1	HD
TIAZAC *(diltiazem 24hr er)*	T3	HD
verapamil er (Calan SR)	T1	HD
verapamil er (Verelan)	T1	HD
verapamil er pm (Verelan PM)	T1	HD
verapamil hcl	T1	HD
verapamil hcl (Verelan)	T1	HD
VERELAN *(verapamil er)*	T3	HD
VERELAN *(verapamil hcl)*	T3	HD
VERELAN PM *(verapamil er pm)*	T3	HD
CARDIOPLEGIC SOLUTIONS		
cardioplegic (Plegisol)	T1	
DIGITALIS GLYCOSIDES		
digitek (Lanoxin)	T1	HD
digoxin (Lanoxin)	T1	HD
LANOXIN	T3	HD
LANOXIN *(digitek)*	T3	HD
SOLUBLE GUANYLATE CYCLASE (SGC) STIMULATOR		
VERQUVO	T2	QL (max 30 tabs/30 days)
VASODILATORS, CORONARY		
DILATRATE-SR	T2	HD
GONITRO	T3	
ISORDIL *(isosorbide dinitrate)*	T3	HD
isosorbide dinitrate	T1	HD
isosorbide dinitrate (Isordil Titradose)	T1	HD
isosorbide dinitrate (Isordil)	T1	HD
isosorbide mononitrate	T1	HD
MINITRAN	T3	HD
nitro-bid	T1	HD
NITRO-DUR	T3	HD
nitroglycerin	T1	HD
nitroglycerin (Nitro-Dur)	T1	HD
nitroglycerin 400 mcg spray (Nitrolingual)	T1	HD
nitroglycerin 0.3 mg tablet sl (Nitrostat)	T1	HD

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CARDIAC DRUGS (Blood Pressure/Heart Medications) (cont.)		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
VASODILATORS, CORONARY (cont.)		
nitroglycerin 0.4 mg tablet sl (Nitrostat)	T1	HD
nitroglycerin 0.6 mg tablet sl (Nitrostat)	T1	HD
NITROLINGUAL *(nitroglycerin)*	T3	
NITROMIST *(nitroglycerin)*	T3	HD
NITROSTAT *(nitroglycerin)*	T3	HD
nitro-time	T1	HD
CARDIOVASCULAR (Asthma/COPD/Respiratory)		
PULM ANTI-HTN, SOLUBLE GUANYLATE CYCLASE STIMULATOR		
ADEMPAS	T2	PA QL (90 tabs/30 days) SP HD
PULM.ANTI-HTN, SEL.C-GMP PHOSPHODIESTERASE T5 INHIB		
REVATIO *(sildenafil)*	T3	PA QL SP HD
sildenafil (Revatio)	T1	PA QL SP HD
tadalafil (Adcirca)	T1	
PULMONARY ANTI-HTN, ENDOTHELIN RECEPTOR ANTAGONIST		
ambrisentan (Letairis)	T1	PA SP HD
bosentan (Tracleer)	T1	PA SP HD
bosentan (Tracleer)	T1	PA
OPSUMIT	T2	PA QL (30 tabs/30 days) SP HD
TRACLEER 32 MG TABLET FOR SUSPENSION	T2	PA ST QL (120 tabs/30 days) SP HD
TRACLEER 62.5 MG, 125 MG TABLET *(bosentan)*	T3	PA QL (60 tabs/30 days) SP HD
PULMONARY ANTIHYPERTENSIVES, PROSTACYCLIN-TYPE		
ORENITRAM ER	T3	PA QL (90 tabs/30 days) SP HD
ORENITRAM TITRATION KT MONTH 1	T3	PA SP QL (168 tabs/28 days)
ORENITRAM TITRATION KT MONTH 2	T3	PA SP QL (336 tabs/28 days)
ORENITRAM TITRATION KT MONTH 3	T3	PA SP QL (252 tabs/28 days)
TYVASO	T2	PA ST SP HD
UPTRAVI	T2	PA QL (60 tabs/30 days) SP HD
UPTRAVI TITRATION PACK	T2	PA QL (1 pack/1 time use) SP HD
VENTAVIS	T3	PA SP HD
CARDIOVASCULAR (Blood Pressure/Heart Medications)		
ACE INHIBITOR-CALCIUM CHANNEL BLOCKER COMBINATION		
amlodipine besylate-benazepril	T1	HD
amlodipine besylate-benazepril (Lotrel)	T1	HD

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CARDIOVASCULAR (Blood Pressure/Heart Medications) (cont.)		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
ACE INHIBITOR-CALCIUM CHANNEL BLOCKER COMBINATION (cont.)		
PRESTALIA	T3	HD
TARKA *(trandolapril-verapamil er)*	T3	HD
trandolapril-verapamil	T1	HD
trandolapril-verapamil (Tarka)	T1	HD
ACE INHIBITOR-THIAZIDE OR THIAZIDE-LIKE DIURETIC		
ACCURETIC *(quinapril-hydrochlorothiazide)*	T3	HD
benazepril hcl-hctz (Lotensin HCT)	T1	HD
captopril/hydrochlorothiazide	T1	HD
enalapril maleate/hctz (Vaseretic)	T1	HD
fosinopril-hydrochlorothiazide	T1	HD
lisinopril-hctz (Zestoretic)	T1	HD
LOTENSIN HCT *(benazepril-hydrochlorothiazide)*	T3	HD
quinapril-hydrochlorothiazide (Accuretic)	T1	HD
VASERETIC *(enalapril-hydrochlorothiazide)*	T3	HD
ZESTORETIC *(lisinopril-hydrochlorothiazide)*	T3	HD
ALPHA/BETA-ADRENERGIC BLOCKING AGENTS		
CARDURA *(doxazosin mesylate)*	T3	QL HD
CARDURA XL	T3	QL (30 units/30 days) HD
doxazosin mesylate (Cardura)	T1	QL HD
MINIPRESS *(prazosin hcl)*	T3	HD
prazosin hcl (Minipress)	T1	HD
terazosin hcl	T1	QL (30 caps/30 days) HD
ANGIOTEN.RECEPTR ANTAG-CALCIUM CHANL BLKR-THIAZIDE		
amlodipine-valsartan-hctz (Exforge HCT)	T1	HD
olmesartan-amlodipine-hctz (Tribenzor)	T1	HD
ANGIOTENSIN RECEPT-NEPRILYSIN INHIBITOR COMB (ARNI)		
ENTRESTO	T2	QL HD
ANGIOTENSIN RECEPTOR ANTAG.-THIAZIDE DIURETIC COMB		
candesartan-hydrochlorothiazid (Atacand Hct)	T1	HD
irbesartan-hydrochlorothiazide (Avalide)	T1	HD
losartan-hydrochlorothiazide (Hyzaar)	T1	HD
losartan-hydrochlorothiazide (Hyzaar)	T1	
olmesartan-hydrochlorothiazide (Benicar HCT)	T1	HD
telmisartan-hydrochlorothiazid (Micardis HCT)	T1	HD

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List of Prescription Medications

CARDIOVASCULAR (Blood Pressure/Heart Medications) (cont.)		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
ANGIOTENSIN RECEPTOR ANTAG.-THIAZIDE DIURETIC COMB (cont.)		
valsartan-hydrochlorothiazide (Diovan HCT)	T1	HD
ANGIOTENSIN RECEPTOR BLOCKR-CALCIUM CHANNEL BLOCKR		
amlodipine-olmesartan (Azor)	T1	HD
amlodipine-valsartan (Exforge)	T1	HD
telmisartan-amlodipine (Twynsta)	T1	HD
ANTI-HYPERTENSIVES, ACE INHIBITORS		
ACCUPRIL *(quinapril hcl)*	T3	HD
ALTACE *(ramipril)*	T3	HD
benazepril hcl (Lotensin)	T1	HD
captopril	T1	HD
enalapril maleate (Vasotec)	T1	HD
fosinopril	T1	HD
lisinopril (Prinivil)	T1	HD
lisinopril (Zestril)	T1	HD
LOTENSIN *(benazepril hcl)*	T3	HD
moexipril hcl	T1	HD
perindopril erbumine	T1	HD
PRINIVIL *(lisinopril)*	T3	HD
quinapril (Accupril)	T1	HD
ramipril (Altace)	T1	HD
trandolapril	T1	HD
VASOTEC *(enalapril maleate)*	T3	HD
ZESTRIL *(lisinopril)*	T3	HD
ANTI-HYPERTENSIVES, ANGIOTENSIN RECEPTOR ANTAGONIST		
candesartan cilexetil (Atacand)	T1	HD
eprosartan mesylate	T1	
irbesartan (Avapro)	T1	HD
losartan (Cozaar)	T1	HD
olmesartan medoxomil (Benicar)	T1	HD
telmisartan (Micardis)	T1	HD
valsartan (Diovan)	T1	HD
ANTI-HYPERTENSIVES, GANGLIONIC BLOCKERS		
VECAMYL	T3	

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CARDIOVASCULAR (Blood Pressure/Heart Medications) (cont.)		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
ANTI-HYPERTENSIVES, MISCELLANEOUS		
DEMSER	T3	PA HD
ANTI-HYPERTENSIVES, SYMPATHOLYTIC		
CATAPRES *(clonidine hcl)*	T3	HD
CATAPRES-TTS *(clonidine)*	T3	QL (4 patches/21 days) HD
clonidine hcl (Catapres)	T1	HD
clonidine hcl (Catapres)	T1	
clonidine hcl (Catapres-TTS 1)	T1	QL (4 patches/21 days) HD
clonidine hcl (Catapres-TTS 2)	T1	QL (4 patches/21 days) HD
clonidine hcl (Catapres-TTS 3)	T1	QL (4 patches/21 days) HD
guanfacine hcl	T1	HD
methyldopa	T1	HD
methyldopa/hydrochlorothiazide	T1	HD
ANTI-HYPERTENSIVES, VASODILATORS		
hydralazine hcl	T1	HD
minoxidil	T1	HD
BETA-ADRENERGIC BLOCKING AGENTS		
acebutolol hcl	T1	HD
atenolol (Tenormin)	T1	HD
BETAPACE *(sorine)*	T3	HD
BETAPACE AF *(sorine)*	T3	HD
betaxolol hcl	T1	HD
bisoprolol fumarate	T1	HD
CORGARD *(nadolol)*	T3	HD
HEMANGEOL	T3	HD
LOPRESSOR *(metoprolol tartrate)*	T3	HD
metoprolol succinate (Toprol XL)	T1	HD
metoprolol tartrate	T1	HD
metoprolol tartrate (Lopressor)	T1	HD
nadolol (Corgard)	T1	HD
pindolol	T1	HD
propranolol hcl	T1	HD
propranolol hcl er (Inderal La)	T1	HD
sorine	T1	HD
sorine (Betapace)	T1	HD

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Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
BETA-ADRENERGIC BLOCKING AGENTS (cont.)		
sotalol	T1	HD
sotalol (Betapace)	T1	HD
sotalol af (Betapace)	T1	HD
SOTYLIZE	T2	HD
TENORMIN *(atenolol)*	T3	HD
timolol maleate	T1	HD
BETA-BLOCKERS AND THIAZIDE, THIAZIDE-LIKE DIURETICS		
atenolol w/chlorthalidone (Tenoretic 100)	T1	HD
atenolol w/chlorthalidone (Tenoretic 50)	T1	
atenolol w/chlorthalidone (Tenoretic 50)	T1	HD
bisoprolol fumarate/hctz (Ziac)	T1	HD
metoprolol-hydrochlorothiazide	T1	HD
metoprolol-hydrochlorothiazide (Lopressor HCT)	T1	HD
propranolol hcl-hctz	T1	HD
TENORETIC *(atenolol-chlorthalidone)*	T3	HD
ZIAC *(bisoprolol-hydrochlorothiazide)*	T3	HD
RENIN INHIBITOR, DIRECT		
aliskiren (Tekturna)	T1	HD
RENIN INHIBITOR, DIRECT AND THIAZIDE DIURETIC COMB		
TEKTURNA HCT	T2	HD
VASODILATORS, PERIPHERAL		
ergoloid mesylates	T1	
isoxsuprine hcl	T1	
CARDIOVASCULAR (Cholesterol Medications)		
ANTI-HYPERLIP.HMG COA REDUCT INHIB-CHOLEST.AB.INHIB		
ezetimibe-atorvastatin tabs	T1	ST HD QL (30 tabs/30 days)
ezetimibe-simvastatin (Vytorin)	T1	QL (30 units/30 days) HD
ANTI-HYPERLIPID- HMG-COA RI-CALCIUM CHANNEL BLOCKER		
amlodipine-atorvastatin (Caduet)	T1	QL (30 units/30 days) HD
CADUET *(amlodipine-atorvastatin)*	T3	ST QL (30 units/30 days) HD
ANTI-HYPERLIPIDEMIC - ANGIOPOIETIN-LIKE 3 INHIBITOR		
EVKEEZA	T3	PA
ANTI-HYPERLIPIDEMIC - MTP INHIBITOR		
JUXTAPID	T2	SP HD

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CARDIOVASCULAR (Cholesterol Medications) (cont.)		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
ANTI-HYPERLIPIDEMIC - PCSK9 INHIBITORS		
REPATHA	T2	
ANTI-HYPERLIPIDEMIC-HMGCOA REDUCTASE INHIB (STATINS)		
atorvastatin 10 mg tablet (Lipitor)	T1	
atorvastatin 20 mg tablet (Lipitor)	T1	
atorvastatin 40 mg tablet (Lipitor)	T1	
atorvastatin 80 mg tablet (Lipitor)	T1	
FLOLIPID	T3	ST QL HD
fluvastatin	T1	QL HD PPACA
fluvastatin	T1	QL (30 units/30 days) HD PPACA
fluvastatin er (Lescol XL)	T1	QL (30 units/30 days) HD PPACA
LESCOL XL *(fluvastatin er)*	T3	ST QL (30 units/30 days) HD
LIVALO (*pitavastatin calcium*)	T3	ST QL(30 tabs/30 days) HD
lovastatin	T1	QL HD PPACA
pitavastatin calcium (Livalo)	T1	QL(30 tabs/30 days) HD PPACA
pravastatin (Pravachol)	T1	QL (30 units/30 days) HD PPACA
simvastatin	T1	QL (30 units/30 days) HD
simvastatin (Zocor)	T1	QL (30 units/30 days) HD PPACA
ZYPITAMAG	T3	ST QL (30 units/30 days) HD
BILE SALT SEQUESTRANTS		
cholestyramine (Questran)	T1	HD
cholestyramine light (Questran Light)	T1	HD
colesevelam hcl (Welchol)	T1	HD
COLESTID *(colestipol hcl)*	T3	HD
colestipol hcl (Colestid)	T1	HD
prevalite	T1	HD
prevalite (Questran Light)	T1	HD
QUESTRAN *(cholestyramine)*	T3	HD
QUESTRAN LIGHT *(cholestyramine light)*	T3	HD
LIPOTROPICS		
ANTARA	T3	ST HD
ezetimibe (Zetia)	T1	HD
fenofibrate	T1	HD
fenofibrate (Fenoglide)	T1	HD
fenofibrate (Tricor)	T1	HD

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CARDIOVASCULAR (Cholesterol Medications) (cont.)		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
LIPOTROPICS (cont.)		
fenofibric acid (Fibricor)	T1	HD
fenofibric acid (Trilipix)	T1	HD
FENOGLIDE *(fenofibrate)*	T3	ST HD
FIBRICOR *(fenofibric acid)*	T3	ST HD
gemfibrozil (Lopid)	T1	HD
LIPOFEN	T2	HD
LOPID *(gemfibrozil)*	T3	HD
niacin	T1	HD
niacin er (Niaspan)	T1	HD
NIACOR	T3	HD
NIASPAN *(niacin er)*	T3	HD
rosuvastatin 5mg, 10mg, 20mg, 40mg tab (Crestor)	T1	
TRIGLIDE	T3	ST
TRILIPIX *(fenofibric acid)*	T3	ST HD
CNS DRUGS (Alzheimer's Disease)		
ALZHEIMER'S THERAPY, NMDA RECEPTOR ANTAGONISTS		
memantine hcl (Namenda)	T1	HD
memantine hcl (Namenda)	T1	
memantine hcl er (Namenda XR)	T1	HD
NAMENDA	T3	HD
NAMENDA *(memantine hcl)*	T3	ST HD
NAMENDA XR	T3	HD
ALZHEIMER'S THX, NMDA RECEPTOR ANTAG-CHOLINES INHIB		
NAMZARIC	T2	ST HD
CNS DRUGS (Miscellaneous)		
AMYOTROPHIC LATERAL SCLEROSIS AGENTS		
EXSERVAN 50 MG FILM	T3	
RILUTEK *(riluzole)*	T3	PA SP HD
riluzole (Rilutek)	T1	PA SP HD
TEGLUTIK	T3	PA SP
TIGLUTIK	T3	PA SP
DRUGS TO TREAT MOVEMENT DISORDERS		
AUSTEDO XR 6 MG TABLET	T2	PA SP HD QL (210 tabs/30 days)

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List of Prescription Medications

CNS DRUGS (Miscellaneous) (cont.)		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
DRUGS TO TREAT MOVEMENT DISORDERS (cont.)		
AUSTEDO XR 12 MG TABLET	T2	PA SP HD QL (90 tabs/30 days)
AUSTEDO XR 24 MG TABLET	T2	PA SP HD QL (60 tabs/30 days)
AUSTEDO XR TITRATION KT(WK1-4)	T2	PA QL(42 tabs/30 days) SP HD
HORIZANT	T3	ST
INGREZZA CAPSULES	T3	PA ST QL (1 cap/1 day) SP HD
INGREZZA INITIATION PACK	T3	PA ST QL (28 caps/84 days)
tetrabenazine (Xenazine)	T1	PA QL SP HD
XANTHINES		
caffeine d	T1	HD
CNS DRUGS (Multiple Sclerosis)		
AGENTS TO TREAT MULTIPLE SCLEROSIS		
AUBAGIO	T3	PA SP HD QL (30 tabs/30 days)
AVONEX ADMINISTRATION PACK	T2	PA QL (1 kit/21 days) SP HD
AVONEX PEN	T2	PA QL (1 box/21 days) SP HD
BAFIERTAM	T2	PA ST (120 caps/30 days) SP HD
BETASERON	T2	PA QL (14 kits/23 days) SP HD
COPAXONE 20 MG/ML SYRINGE *(glatiramer)*	T3	PA QL (30 syr/23 days) SP HD
COPAXONE 40 MG/ML SYRINGE *(glatiramer)*	T3	PA QL (12 ml/23 days) SP HD
fingolimod	T1	PA ST QL (30 caps/30 days) SP HD
fingolimod hcl (Gilenya)	T1	
glatiramer acetate 20 mg/ml syringe (Copaxone)	T1	QL (30 syr/23 days) SP HD
glatiramer acetate 40 mg/ml syringe (Copaxone)	T1	QL (12 ml/23 days) SP HD
glatopa 20 mg/ml syringe (Copaxone)	T1	PA QL (30 syr/23 days) SP HD
glatopa 40 mg/ml syringe (Copaxone)	T1	PA QL (12 ml/23 days) SP HD
KESIMPTA PEN	T2	PA ST QL (1 pen/28 days)SP HD
MAVENCLAD 10 MG X 10 TABLET PACK	T3	PA QL (10 tabs/dispense) SP HD
MAVENCLAD 10 MG X 4 TABLET PACK	T3	PA QL (4 tabs/dispense) SP HD
MAVENCLAD 10 MG X 5 TABLET PACK	T3	PA QL (5 tabs/dispense) SP HD
MAVENCLAD 10 MG X 6 TABLET PACK	T3	PA QL (6 tabs/dispense) SP HD
MAVENCLAD 10 MG X 7 TABLET PACK	T3	PA QL (7 tabs/dispense) SP HD
MAVENCLAD 10 MG X 8 TABLET PACK	T3	PA QL (8 tabs/dispense) SP HD
MAVENCLAD 10 MG X 9 TABLET PACK	T3	PA QL (9 tabs/dispense) SP HD
MAYZENT	T2	PA QL (30 units/30 days) SP HD

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List of Prescription Medications

CNS DRUGS (Multiple Sclerosis) (cont.)		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
AGENTS TO TREAT MULTIPLE SCLEROSIS (cont.)		
PLEGRIDY PEN/SYRINGE	T2	PA QL (1 ml/21 days) SP HD
PLEGRIDY STARTER PACK	T2	PA QL (1 pack/365 days) SP HD
PONVORY	T2	PA ST QL (30 tabs/30 days) SP
PONVORY 14-DAY STARTER PACK	T2	PA ST QL (14 tabs/use)
PONVORY 20 MG TABLET	T2	PA ST QL (30 tabs/30 days) SP
REBIF REBIDOSE SYRINGES	T2	PA ST QL (1 pack/28 days) SP HD
REBIF REBIDOSE TITRATION PACK	T2	PA ST QL (1 pack/28 days) SP HD
REBIF SYRINGES	T2	PA QL (6 ml/21 days) SP HD
REBIF TITRATION PACK	T2	PA QL (5 ml/21 c) SP HD
VUMERITY STARTER PACK	T2	PA QL (106 c/30 days)SP HD
VUMERITY	T2	PA QL (120 caps/30 days)SP HD
ZEPOSIA	T2	PA QL SP HD
ZEPOSIA 0.23-0.46 MG START PCK	T2	PA QL (37 v/30 days) SP HD
ZEPOSIA 0.23-0.46-0.92 MG KIT	T2	PA QL (7 v/7 days) SP HD
ZEPOSIA 0.92 MG CAPSULE	T2	PA QL (30 caps/30 Days) SP HD
AGTS TX NEUROMUSC TRANSMISSION DIS, POT-CHAN BLKR		
AMPYRA ER 10 MG TABLET	T3	PA QL (30 caps/30 days) SP HD
dalfampridine er (Ampyra)	T1	PA SP HD
FIRDAPSE	T2	PA SP
RUZURGI	T2	PA SP
SPHINGOSINE I-PHOSPHATE (SIP) RECEPTOR MODULATOR		
ZEPOSIA STARTER KIT (28-DAY)	T2	
CNS DRUGS (Pain Relief And Inflammatory Disease)		
CALCITONIN GENE-RELATED PEPTIDE (CGRP) INHIBITORS		
EMGALITY SYRINGE	T2	PA QL (1 syr/23 days)
POSTHERPETIC NEURALGIA AGENTS		
gabapentin (Gralise)	T1	ST
GRALISE	T3	ST
GRALISE *(gabapentin)*	T3	ST
CNS DRUGS (Seizure Disorders)		
ANTI-CONVULSANT - BENZODIAZEPINE TYPE		
clobazam (Onfi)	T1	PA HD
clonazepam (Klonopin)	T1	HD

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CNS DRUGS (Seizure Disorders) (cont.)		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
ANTI-CONVULSANT - BENZODIAZEPINE TYPE (cont.)		
DIASTAT *(diazepam)*	T3	HD
DIASTAT ACUDIAL *(diazepam)*	T3	HD
diazepam (Diastat)	T1	HD
diazepam 20 mg rectal gel syst	T1	HD
KLONOPIN *(clonazepam)*	T3	HD
NAYZILAM	T2	PA QL HD
ONFI *(clobazam)*	T3	PA HD
SYMPAZAN	T3	PA HD
VALTOCO	T3	PA QL HD
ANTI-CONVULSANT - CANNABINOID TYPE		
EPIDIOLEX	T2	PA SP HD
ANTI-CONVULSANTS		
APTIOM	T3	HD
BANZEL	T3	PA HD
BRIVIACT	T3	ST HD
carbamazepine (Tegretol)	T1	HD
carbamazepine er (Carbatrol)	T1	HD
carbamazepine er (Tegretol XR)	T1	HD
CARBATROL *(carbamazepine er)*	T3	HD
CELONTIN (*methsuximide*)	T3	HD
DEPAKOTE *(divalproex)*	T3	ST HD
DEPAKOTE ER *(divalproex er)*	T3	ST HD
DEPAKOTE SPRINKLE *(divalproex)*	T3	ST HD
DIACOMIT	T2	PA SP HD
DILANTIN *(phenytoin)*	T3	HD
DILANTIN 30 MG CAPSULE	T2	HD
divalproex er (Depakote ER)	T1	HD
divalproex (Depakote Sprinkle)	T1	HD
divalproex (Depakote)	T1	HD
epitol (Tegretol)	T1	HD
ELEPSIA XR	T3	ST HD
ethosuximide (Zarontin)	T1	HD
felbamate (Felbatol)	T1	HD
FELBATOL *(felbamate)*	T3	HD

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CNS DRUGS (Seizure Disorders) (cont.)		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
ANTI-CONVULSANTS (cont.)		
FYCOMPA	T2	HD
gabapentin (Neurontin)	T1	HD
GABITRIL *(tiagabine hcl)*	T3	HD
LAMICTAL XR	T3	ST HD
lamotrigine (blue) (Lamictal (Blue)	T1	HD
lamotrigine (green) (Lamictal (Green)	T1	HD
lamotrigine (Lamictal XR)	T1	HD
lamotrigine (Lamictal)	T1	HD
lamotrigine (orange) (Lamictal (Orange)	T1	HD
lamotrigine odt (Lamictal ODT)	T1	HD
levetiracetam	T1	HD
levetiracetam (Keppra XR)	T1	HD
levetiracetam (Keppra)	T1	HD
MYSOLINE *(primidone)*	T3	HD
oxcarbazepine (Trileptal)	T1	HD
OXTELLAR XR	T3	ST HD
PEGANONE	T2	HD
PHENYTEK *(phenytoin extended)*	T3	HD
phenytoin	T1	HD
phenytoin (Dilantin)	T1	HD
phenytoin (Dilantin-125)	T1	HD
phenytoin (Phenytek)	T1	HD
pregabalin (Lyrica)	T1	HD
primidone (Mysoline)	T1	HD
QUDEXY XR	T2	ST HD
roweepra (Keppra)	T1	HD
SABRIL *(vigabatrin)*	T3	PA SP HD
SPRITAM	T3	ST HD
subvenite (Lamictal (Blue)	T1	HD
subvenite (Lamictal (Green)	T1	HD
subvenite (Lamictal (Orange)	T1	HD
subvenite (Lamictal)	T1	HD
TEGRETOL *(carbamazepine)*	T3	HD
TEGRETOL XR *(carbamazepine er)*	T3	HD
tiagabine hcl (Gabitril)	T1	HD

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
CNS DRUGS (Seizure Disorders) (cont.)		
ANTI-CONVULSANTS (cont.)		
topiramate (Topamax)	T1	HD
topiramate er 25mg, 50mg, 100mg capsule (Trokendi XR)	T1	ST
TROKENDI XR	T3	ST HD
valproic acid	T1	HD
vigabatrin 500 mg tablet (Sabril)	T1	
VIGADRONE	T1	PA SP HD QL (150 pkts/30 days)
vigadrone (Sabril)	T1	PA SP HD
VIMPAT	T2	HD
ZARONTIN *(ethosuximide)*	T3	HD
zonisamide	T1	HD
zonisamide (Zonegran)	T1	HD
ZTALMY 50 MG/ML SUSPENSION	T2	SP
CNS DRUGS (Sleep Disorders/Sedatives)		
NARCOLEPSY TX-H3-RECEPT.ANTAGONIST/INVERSE AGONIST		
WAKIX	T3	PA QL SP HD
COLONY STIMULATING FACTORS (Blood Modifiers/Bleeding Disorders)		
ERYTHROPOIESIS-STIMULATING AGENTS		
PROCRIT	T2	PA SP
RETACRIT	T2	PA SP
LEUKOCYTE (WBC) STIMULANTS		
FULPHILA	T2	PA QL (2 syr/23 days) SP
LEUKINE	T2	SP
NIVESTYM	T2	PA SP
ZARXIO	T2	PA SP HD
ZIEXTENZO	T2	PA ST QL (2 syr/30 days) SP
THROMBOPOIETIN RECEPTOR AGONISTS		
DOPTELET	T2	PA QL SP HD
PROMACTA	T2	PA SP HD
CONTRACEPTIVES (Contraception Products)		
CONTRACEPTIVES, INTRAVAGINAL, SYSTEMIC		
ANNOVERA VAGINAL RING	T3	QL (1 ring)
eluryng (Nuvaring)	T1	PPACA
etonogestrel-ethinyl estradiol (Nuvaring)	T1	PPACA
NUVARING *(eluryng)*	T3	

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List of Prescription Medications

CONTRACEPTIVES (Contraception Products) (cont.)		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
CONTRACEPTIVES, IMPLANTABLE		
NEXPLANON	T2	SP
CONTRACEPTIVES, INJECTABLE		
DEPO-PROVERA *(medroxyprogesterone acetate)*	T3	QL (1 ml/90 days) PPACA
DEPO-SUBQ PROVERA	T3	QL (1 ml/68 days)
medroxyprogesterone acetate (Depo-Provera)	T1	QL (1 ml/68 days) PPACA
CONTRACEPTIVES, INTRAVAGINAL		
gynol ii	T1	PPACA
TODAY CONTRACEPTIVE SPONGE	T2	PPACA
vcf	T1	PPACA
CONTRACEPTIVES, ORAL		
afirmelle	T1	HD PPACA
AFTERA *(aftera)*	T3	QL HD PPACA
altavera	T1	HD PPACA
alyacen	T1	HD PPACA
amethia (Seasonique)	T1	HD PPACA
amethia lo (Loseasonique)	T1	HD PPACA
amethyst	T1	HD PPACA
apri	T1	HD PPACA
aranelle	T1	HD PPACA
ashlyna (Seasonique)	T1	HD PPACA
aubra	T1	HD PPACA
aubra eq	T1	HD PPACA
aurovela (Loestrin)	T1	HD PPACA
aurovela 24 fe	T1	HD PPACA
aurovela fe (Loestrin Fe)	T1	HD PPACA
aviane	T1	HD PPACA
ayuna	T1	HD PPACA
azurette (Mircette)	T1	HD PPACA
balziva	T1	HD PPACA
bekyree (Mircette)	T1	HD PPACA
BEYAZ *(drospirenone-eth estra-levomef)*	T3	HD
blisovi 24 fe	T1	HD PPACA
blisovi fe (Loestrin Fe)	T1	HD PPACA
briellyn	T1	HD PPACA

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CONTRACEPTIVES, ORAL (cont.)		
camila	T1	HD PPACA
camrese (Seasonique)	T1	HD PPACA
camrese lo (Loseasonique)	T1	HD PPACA
caziant	T1	HD PPACA
chateal	T1	HD PPACA
chateal eq	T1	HD PPACA
cryselle	T1	HD PPACA
cyclafem	T1	HD PPACA
cyred	T1	HD PPACA
cyred eq	T1	HD PPACA
dasetta	T1	HD PPACA
daysee (Seasonique)	T1	HD PPACA
deblitane	T1	HD PPACA
desogestrel-ethinyl estradiol	T1	
desogestr-eth estrad eth estra (Mircette)	T1	HD PPACA
drospirenone-eth estra-levomef (Beyaz)	T1	HD PPACA
drospirenone-eth estra-levomef (Safyral)	T1	HD PPACA
drospirenone-ethinyl estradiol (Yasmin 28)	T1	HD PPACA
drospirenone-ethinyl estradiol (Yaz)	T1	HD PPACA
econtra ez (Plan B One-Step)	T1	QL HD PPACA
econtra one-step (Plan B One-Step)	T1	QL HD PPACA
elinest	T1	HD PPACA
ELLA	T2	QL HD PPACA
emoquette	T1	HD PPACA
enpresse	T1	HD PPACA
enskyce	T1	HD PPACA
errin	T1	HD PPACA
estarylla	T1	HD PPACA
ethynodiol-ethinyl estradiol	T1	HD PPACA
falmina	T1	HD PPACA
fayosim (Quartette)	T1	HD PPACA
femynor	T1	HD PPACA
gianvi (Yaz)	T1	HD PPACA
hailey (Loestrin)	T1	HD PPACA

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CONTRACEPTIVES, ORAL (cont.)		
hailey 24 fe	T1	HD PPACA
heather	T1	HD PPACA
incassia	T1	HD PPACA
introvale	T1	HD PPACA
isibloom	T1	HD PPACA
jasmiel (Yaz)	T1	HD PPACA
jencycla	T1	
jolessa	T1	HD PPACA
juleber	T1	HD PPACA
junel (Loestrin)	T1	HD PPACA
junel fe	T1	HD PPACA
junel fe (Loestrin Fe)	T1	HD PPACA
kaitlib fe (Generess Fe)	T1	HD PPACA
kalliga	T1	HD PPACA
kariva (Mircette)	T1	HD PPACA
kelnor 1-35	T1	HD PPACA
kelnor 1-50	T1	HD PPACA
larin (Loestrin)	T1	HD PPACA
larin fe	T1	HD PPACA
larin fe (Loestrin Fe)	T1	HD PPACA
larissia	T1	HD PPACA
layolis fe (Generess Fe)	T1	HD
leena	T1	HD PPACA
lessina	T1	HD PPACA
levonest	T1	HD PPACA
levonorgestrel (Plan B One-Step)	T1	QL HD PPACA
levonorgestrel-eth estradiol	T1	HD PPACA
levonorgestrel-eth estradiol	T1	
levonorg-eth estrad eth estrad (Loseasonique)	T1	HD PPACA
levonorg-eth estrad eth estrad (Quartette)	T1	HD PPACA
levonorg-eth estrad eth estrad (Seasonique)	T1	HD PPACA
levora	T1	HD PPACA
lillow	T1	HD PPACA
loryna (Yaz)	T1	HD PPACA

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CONTRACEPTIVES, ORAL (cont.)		
low-ogestrel	T1	HD PPACA
lo-zumandimine (Yaz)	T1	HD PPACA
lutera	T1	HD PPACA
lyza	T1	HD PPACA
marlissa	T1	HD PPACA
melodetta 24 fe (Minastrin 24 Fe)	T1	HD PPACA
microgestin (Loestrin)	T1	HD PPACA
microgestin fe (Loestrin Fe)	T1	HD PPACA
mili	T1	HD PPACA
mono-linyah	T1	HD PPACA
my choice (Plan B One-Step)	T1	QL HD PPACA
my way (Plan B One-Step)	T1	QL HD PPACA
necon	T1	HD PPACA
new day (Plan B One-Step)	T1	QL HD PPACA
nikki (Yaz)	T1	HD PPACA
nora-be	T1	HD PPACA
norethindrone acetate	T1	HD PPACA
norethindrone-ethin estradiol (Loestrin)	T1	HD PPACA
norethin-eth estra ferrous fum (Generess Fe)	T1	HD PPACA
norethin-eth estra ferrous fum (Loestrin Fe)	T1	HD PPACA
norethin-eth estra ferrous fum (Minastrin 24 Fe)	T1	HD PPACA
norethin-eth estra ferrous fum (Minastrin 24 Fe)	T1	
norgestimate-ethinyl estradiol	T1	HD PPACA
norgestimate-ethinyl estradiol	T1	
norgestrel-ethiny estra	T1	
norlyda	T1	HD PPACA
nortrel	T1	HD PPACA
ocella (Yasmin 28)	T1	HD PPACA
ogestrel	T1	
opcicon one-step (Plan B One-Step)	T1	QL HD PPACA
option 2 (Plan B One-Step)	T1	QL HD PPACA
orsythia	T1	HD PPACA
ORTHO-NOVUM *(alyacen)*	T3	
philith	T1	HD PPACA

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CONTRACEPTIVES (Contraception Products) (cont.)		
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CONTRACEPTIVES, ORAL (cont.)		
pimtrea (Mircette)	T1	HD PPACA
pirmella	T1	HD PPACA
PLAN B ONE-STEP *(aftera)*	T2	QL HD PPACA
portia	T1	HD PPACA
previfem	T1	HD PPACA
reclipsen	T1	HD PPACA
rivelsa (Quartette)	T1	HD PPACA
setlakin	T1	HD PPACA
sharobel	T1	HD PPACA
simliya (Mircette)	T1	HD PPACA
simpesse (Seasonique)	T1	HD PPACA
sprintec	T1	HD PPACA
sronyx	T1	HD PPACA
syeda (Yasmin 28)	T1	HD PPACA
TAKE ACTION *(aftera)*	T3	QL HD PPACA
tarina fe	T1	HD PPACA
tarina fe (Loestrin Fe)	T1	HD PPACA
tilia fe (Estrostep Fe)	T1	HD PPACA
tri femynor	T1	HD PPACA
tri-estarylla	T1	HD PPACA
tri-legest fe (Estrostep Fe)	T1	HD PPACA
tri-linyah	T1	HD PPACA
tri-lo-estarylla	T1	HD PPACA
tri-lo-marzia	T1	HD PPACA
tri-lo-mili	T1	HD PPACA
tri-lo-sprintec	T1	HD PPACA
tri-mili	T1	HD PPACA
tri-previfem	T1	HD PPACA
tri-sprintec	T1	HD PPACA
trivora	T1	HD PPACA
tri-vylibra	T1	HD PPACA
tulana	T1	HD PPACA
tydemy (Safyral)	T1	HD PPACA
velivet	T1	HD PPACA

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CONTRACEPTIVES (Contraception Products) (cont.)		
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CONTRACEPTIVES, ORAL (cont.)		
vienva	T1	HD PPACA
viorele (Mircette)	T1	HD PPACA
vyfemla	T1	HD PPACA
vylibra	T1	HD PPACA
wera	T1	HD PPACA
wymzya fe	T1	HD PPACA
YAZ *(drospirenone-ethinyl estradiol)*	T3	HD
zarah (Yasmin 28)	T1	HD PPACA
zovia	T1	HD PPACA
zumandimine (Yasmin 28)	T1	HD PPACA
CONTRACEPTIVES, TRANSDERMAL		
xulane	T1	HD PPACA
DIAPHRAGMS/CERVICAL CAP		
CAYA CONTOURED	T3	PPACA
FEMCAP	T2	PPACA
WIDE SEAL DIAPHRAGM	T3	PPACA
INTRA-UTERINE DEVICES (IUDS)		
KYLEENA	T2	SP
LILETTA	T3	SP
MIRENA	T2	SP
PARAGARD T 380-A	T3	SP
SKYLA	T2	SP
CONTRACEPTIVES (Miscellaneous)		
CONDOMS		
FC2 FEMALE CONDOM	T2	PPACA
COUGH/COLD PREPARATIONS (Cough/Cold Medications)		
ANTI-TUSSIVES, NON-OPIOID		
benzonatate (Tessalon Perle)	T1	
TESSALON PERLE *(benzonatate)*	T3	
NON-OPIOID ANTI-TUS-IST GEN.ANTIHISTAMINE-DECONGEST		
BROMFED-DM *(bromfed dm)*	T3	
bromipheniramin-pseudoephed-dm	T1	
brompheniramine w/pseudoephed	T1	

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List of Prescription Medications

COUGH/COLD PREPARATIONS (Cough/Cold Medications) (cont.)		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
NON-OPIOID ANTI-TUSSIVE-IST GEN ANTIHISTAMINE COMB.		
promethazine w/dm	T1	
OPIOID ANTI-TUSSIV-IST GEN. ANTIHISTAMINE-DECONGEST		
CAPCOF	T3	
HISTEX-AC	T3	
MAXI-TUSS CD	T3	
POLY-TUSSIN AC	T3	
promethazine vc w/codeine	T1	
OPIOID ANTI-TUSSIVE-IST GENERATION ANTIHISTAMINE		
hydrocodone-chlorpheniramine	T1	
promethazine w/codeine	T1	
TUSSICAPS	T3	PA
TUXARIN ER	T3	
TUZISTRA XR	T3	PA
Z-TUSS AC	T3	
OPIOID ANTI-TUSSIVE-ANTI-CHOLINERGIC COMBINATIONS		
hydrocodone compound	T1	
hydrocodone/homatropine	T1	
hydromet	T1	
OPIOID ANTITUSSIVE-DECONGESTANT-EXPECTORANT COMB		
CODITUSSIN DAC	T3	
guaifenesin dac	T1	
lortuss ex	T1	
virtussin dac	T1	
OPIOID ANTI-TUSSIVE-EXPECTORANT COMBINATION		
CODITUSSIN AC	T3	
g tussin ac (Virtussin Ac)	T1	
guaifenesin ac (Virtussin Ac)	T1	
guaifenesin with codeine (Virtussin Ac)	T1	
guiatussin ac (Virtussin Ac)	T1	
MAR-COF CG	T3	
m-clear wc	T1	
NINJACOF-XG	T3	
virtussin ac (Virtussin Ac)	T1	

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List of Prescription Medications

DIAGNOSTIC (Diabetes)		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
BLOOD SUGAR DIAGNOSTICS		
FREESTYLE TEST STRIPS	T2	
ONE TOUCH ULTRA TEST STRIPS	T2	
ONE TOUCH VERIO	T2	
PRECISION XTRA	T2	
URINE GLUCOSE TEST AIDS		
DIASTIX REAGENT	T2	
DIAGNOSTIC (Miscellaneous)		
BLOOD TESTING PREPARATIONS		
FORA GTEL KETONE TEST STRIP	T3	
NOVAMAX PLUS	T2	
PRECISION XTRA	T2	
CARDIOVASCULAR DIAGNOSTICS-RADIOPAQUE		
OMNIPAQUE	T3	
DIAGNOSTIC PREPARATIONS, MISCELLANEOUS		
ARIDOL	T3	
GLUCAGEN	T2	
PROVOCHOLINE	T3	
TC 99M SULFUR COLLOID PREP	T3	
TOXICOLOGY SALIVA COLLECTION	T3	
DIAGNOSTIC TEST DEVICES AND SUPPLIES		
BD VERITOR SYSTEM SARS-COV[1]2	T2	
BINAXNOW COVD AG CARD HOME TST	T2	
BINAXNOW COVID-19 AG CARD	T2	
BINAXNOW COVID-19 AG SELF TEST	T2	
COVID19 SPECIMEN COLLECT NCPDP	T2	
CVS COVID19 TEST BY PHARMACIST	T2	
ELLUME COVID-19 HOME TEST	T2	
FLOWFLEX COVID-19 AG HOME TEST	T2	
INTELISWAB COVID-19 RAPID TEST	T2	
QUICKVUE AT-HOME COVID-19 TEST	T2	
QUICKVUE SARS ANTIGEN TEST	T2	
RAPID RESPONSE COVID-19 TEST	T2	
SOFIA SARS ANTIGEN FIA TEST	T2	
SOFIA2 FLU-SARS ANTIGEN FIA	T2	

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DIAGNOSTIC (Miscellaneous) (cont.)		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
DIAGNOSTIC TEST DEVICES AND SUPPLIES (cont.)		
VERITOR SARS-COV-2 AND FLU A-B	T2	
EYE DIAGNOSTIC AGENTS		
bio glo (Fluor-I-Strip At)	T1	
ful-glo (Fluor-I-Strip At)	T1	
glostrips (Fluor-I-Strip At)	T1	
DIURETICS (Diuretics)		
ARGININE VASOPRESSIN (AVP) RECEPTOR ANTAGONISTS		
JYNARQUE	T3	PA QL SP
SAMSCA 15 MG TABLET	T2	PA QL (30 units/30 days) SP
SAMSCA 30 MG TABLET	T3	PA QL SP
CARBONIC ANHYDRASE INHIBITORS		
acetazolamide	T1	HD
methazolamide	T1	HD
LOOP DIURETICS		
bumetanide	T1	HD
EDECRIN *(ethacrynic acid)*	T3	HD
ethacrynic acid (Edecrin)	T1	HD
furosemide	T1	HD
FUROSEMIDE	T3	HD
furosemide (Lasix)	T1	HD
LASIX *(furosemide)*	T3	HD
torsemide	T1	HD
torsemide	T1	
OSMOTIC DIURETICS		
RESECTISOL	T2	
POLYCYSTIC KIDNEY DISEASE AGENT, AVP RECEP. ANTAG		
JYNARQUE 15mg tablets	T3	PA QL (120 tabs/30 days) SP
JYNARQUE 30mg tablets	T3	PA QL (120 tabs/30 days) SP
JYNARQUE 15-15mg tablets (7-day blister packs)	T3	PA QL (56 tabs/28 days) SP
JYNARQUE 30-15mg tablets (7-day blister packs)	T3	PA QL (56 tabs/28 days) SP
POTASSIUM SPARING DIURETICS		
ALDACTONE *(spironolactone)*	T3	HD
amiloride hcl	T1	HD
CAROSPIR	T3	PA HD

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DIURETICS (Diuretics) (cont.)		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
POTASSIUM SPARING DIURETICS (cont.)		
DYRENIUM *(triamterene)*	T3	HD
eplerenone (Inspra)	T1	HD
INSPRA *(eplerenone)*	T3	HD
spironolactone	T1	HD
spironolactone (Aldactone)	T1	HD
*spironolactone (*Carospir*)*	T1	HD
triamterene (Dyrenium)	T1	HD
POTASSIUM SPARING DIURETICS IN COMBINATION		
ALDACTAZIDE	T3	HD
amiloride hcl w/hctz	T1	HD
DYAZIDE *(triamterene-hydrochlorothiazid)*	T3	HD
MAXZIDE *(triamterene-hydrochlorothiazid)*	T3	HD
JYNARQUE 45-15mg tablets	T3	PA QL (56 tabs/30 days) SP
JYNARQUE 60-30mg tablets	T3	PA QL (56 tabs/30 days) SP
JYNARQUE 90-30mg tablets	T3	PA QL (56 tabs/30 days) SP
spironolact/hctz	T1	HD
spironolactone w/hctz (Aldactazide)	T1	HD
triamterene w/hctz (Dyazide)	T1	HD
triamterene w/hctz (Maxzide)	T1	HD
triamterene w/hctz (Maxzide-25 Mg)	T1	HD
THIAZIDE AND RELATED DIURETICS		
chlorthalidone	T1	HD
DIURIL	T3	HD
hydrochlorothiazide	T1	HD
indapamide	T1	HD
metolazone	T1	HD
EENT PREPS (Allergy/Nasal Sprays)		
NASAL ANTIHISTAMINE		
azelastine hcl	T1	QL HD
olopatadine hcl (Patanase)	T1	QL HD
PATANASE *(olopatadine hcl)*	T3	QL HD
NASAL ANTIHISTAMINE AND ANTI-INFLAM. STEROID COMB.		
DYMISTA *(azelastine-fluticasone)*	T2	ST QL HD
RYALTRIS 665-25MCG SPRAY	T3	ST QL HD

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EENT PREPS (Allergy/Nasal Sprays) (cont.)		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
NASAL ANTI-INFLAMMATORY STEROIDS		
FLONASE ALLERGY RELIEF 50mcg NASAL SPRAY (15.8 PS)	T3	
FLONASE ALLERGY RELIEF 50mcg NASAL SPRAY (9.9 PS)	T2	
FLONASE SENSIMIST 27.5mcg (5.9, 9.9)	T2	
FLONASE SENSIMIST 27.5mcg (9.1, 15.8)	T2	
flunisolide	T1	QL HD
fluticasone propionate	T1	QL HD
mometasone (Nasonex)	T1	QL HD
NASACORT ALLERGY 24 hour SPRAY (10.8 PS)	T2	
NASACORT ALLERGY 24 hour SPRAY (16.9 PS)	T2	
NASONEX	T3	ST SP
RHINOCORT ALLERGY RELIEF 50mcg NASAL SPRAY	T2	
RHINOCORT AQUA NASAL SPRAY	T2	
XHANCE	T3	ST QL HD
NOSE PREPARATIONS, MISCELLANEOUS (RX)		
COCAINE HCL	T3	HD
GOPRELTO	T3	HD
ipratropium bromide	T1	QL (30 units/30 days) HD
NUMBRINO	T3	HD
NOSE PREPARATIONS, VASOCONSTRICTORS (RX)		
ADRENALIN CHLORIDE	T3	
EENT PREPS (Ear Medications)		
EAR PREPARATIONS ANTI-INFLAMMATORY		
DERMOTIC *(flac otic oil)*	T3	
flac otic oil (Dermotic)	T1	
fluocinolone acetonide oil (Dermotic)	T1	
EAR PREPARATIONS, MISC. ANTI-INFECTIVES		
acetic acid	T1	
acetic acid/hydrocortisone	T1	
CORTANE-B *(hc pramoxine)*	T3	
EENT PREPS (Eye Conditions)		
AGENTS FOR CORNEAL COLLAGEN CROSS-LINKING		
PHOTREXA CROSS-LINKING	T3	
PHOTREXA VISCOUS	T3	

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EENT PREPS (Eye Conditions) (cont.)		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
ARTIFICIAL TEARS		
KLARITY (CHONDROITIN)	T3	
LACRISERT	T3	PA
MIEBO	T2	
EYE ANTI-INFECTIVES (RX ONLY)		
BETADINE	T3	
EYE ANTI-INFLAMMATORY AGENTS		
bromfenac sodium (Bromsite)	T1	
bromfenac sodium (Prolensa)	T1	
DEXTENZA	T3	
DUREZOL	T3	ST
EYSUVIS	T3	PA QL (max 8.3ml/14 days)
fluorometholone (Fml)	T1	
flurbiprofen	T1	
FML *(fluorometholone)*	T3	
ILEVRO	T3	
INVELTYS	T3	ST
ketorolac (Acular LS)	T1	
ketorolac (Acular)	T1	
KLARITY-B (BETAMETHASONE-CHOND)	T3	
KLARITY-L (LOTEPREDNOL-CHONDR)	T3	
LOTEMAX DROPS *(loteprednol etabonate)*	T3	
LOTEMAX GEL, OINTMENT	T3	ST
LOTEMAX SM	T3	ST
loteprednol etabonate (Alrex)	T1	ST
loteprednol etabonate (Lotemax)	T1	
PRED FORTE *(prednisolone)*	T3	
prednisolone phosphate	T1	
prednisolone acetate (Pred Forte)	T1	
PREDNISOLONE-NEPAFENAC	T3	
PROLENSA *(bromfenac sodium)*	T3	
EYE IRRIGATIONS		
balanced salt (BSS)	T1	
EYE LOCAL ANESTHETICS		
AKTEN	T3	

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List of Prescription Medications

EENT PREPS (Eye Conditions) (cont.)		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
EYE LOCAL ANESTHETICS (cont.)		
ALCAINE *(proparacaine hcl)*	T3	
altacaine	T1	
ALTAFLUOR BENOX	T3	
proparacaine hcl (Alcaine)	T1	
proparacaine-fluorescein	T1	
tetracaine hcl	T1	
EYE MAST CELL STABILIZERS		
cromolyn	T1	
pilocarpine hcl (Isopto Carpine)	T1	HD
SIMBRINZA	T3	HD
timolol maleate (Istalol)	T1	HD
timolol maleate (Timoptic)	T1	HD
timolol maleate (Timoptic-XE)	T1	HD
TIMOLOL-BRIMONIDIN-DORZOLAMIDE	T3	HD
TIMOLOL-BRIMONI-DORZOL-LATANOP	T3	HD
TIMOLOL-DORZOLAMIDE-LATANOPRST	T3	HD
TIMOLOL-LATANOPROST	T3	HD
TIMOPTIC *(timolol maleate)*	T3	ST HD
TIMOPTIC-XE *(timolol maleate)*	T3	ST HD
travoprost (Travatan Z)	T1	HD
TRUSOPT *(dorzolamide hcl)*	T3	ST HD
VYZULTA	T3	ST HD
EYE MYDRIATIC AND NSAID COMBINATIONS		
MYDRIATIC4 (TROP-PROP-PE-KTRLC)	T3	
EYE PREPARATIONS, MISCELLANEOUS (OTC)		
GELFILM	T3	
EYE VASOCONSTRICTORS		
phenylephrine hcl	T1	
MIOTICS AND OTHER INTRAOCULAR PRESSURE REDUCERS		
ALPHAGAN P 0.1% DROPS	T3	ST HD
ALPHAGAN P 0.15% DROPS *(brimonidine tartrate)*	T3	HD
apraclonidine hcl	T1	HD
betaxolol hcl	T1	HD
BETOPTIC S	T3	HD

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MIOTICS AND OTHER INTRAOCULAR PRESSURE REDUCERS (cont.)		
bimatoprost	T1	HD
brimonidine tartrate (Alphagan P)	T1	HD
BRIMONIDINE-DORZOLAMIDE	T3	HD
carteolol hcl	T1	HD
COMBIGAN	T3	HD
DORZOLAMIDE HCL	T3	HD
dorzolamide hcl (Trusopt)	T1	HD
DORZOLAMIDE-TIMOLOL	T3	HD
dorzolamide-timolol (Cosopt PF)	T1	HD
dorzolamide-timolol (Cosopt)	T1	HD
IOPIDINE	T3	ST HD
ISOPTO CARPINE *(pilocarpine hcl)*	T3	HD
LATANOPROST	T3	HD
latanoprost (Xalatan)	T1	HD
levobunolol hcl	T1	HD
LUMIGAN	T3	PA HD
miostat (Miostat)	T1	HD
PHOSPHOLINE IODIDE	T2	HD
MYDRIATICS		
atropine	T1	HD
atropine 1% eye drops	T1	HD
CYCLOGYL *(cyclopentolate hcl)*	T3	HD
CYCLOMYDRIL	T3	HD
cyclopentolate hcl (Cyclogyl)	T1	HD
CYCLOPENTOLATE-TROPICAMIDE-PE	T3	HD
homatropaire	T1	HD
MYDRIACYL *(tropicamide)*	T3	HD
PAREMYD	T3	HD
tropicamide	T1	HD
tropicamide (Mydriacyl)	T1	HD
TROPICAMIDE-CYCLOPENTOLATE-PE	T3	HD
TROPICAMIDE-PHENYLEPHRINE	T3	HD
OPHTH VASC. ENDOTHELIAL GROWTH FACTOR ANTAGONISTS		
MACUGEN	T3	PA

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EENT PREPS (Eye Conditions) (cont.)		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
OPHTH. VEGF-A RECEPTOR ANTAG. RCMB MC ANTIBODY		
LUCENTIS	T3	PA SP
OPHTHALMIC ANTI-FIBROTIC AGENTS		
MITOSOL	T3	
OPHTHALMIC ANTI-INFLAMMATORY IMMUNOMODULATOR-TYPE		
CEQUA	T3	
CYCLOSPORINE IN KLARITY	T3	HD
RESTASIS	T3	PA QL HD
RESTASIS MULTIDOSE	T2	PA QL HD
XIIDRA	T2	PA QL
VEVYE	T3	PA HD
OPHTHALMIC CYSTINE DEPLETING AGENTS		
CYSTARAN	T2	SP
OPHTHALMIC HUMAN NERVE GROWTH FACTOR (HNGF)		
OXERVATE	T2	PA SP HD
OPHTHALMIC PREPARATIONS, MISCELLANEOUS		
biolon	T1	SP
OPHTHALMIC PROTEOLYTIC ENZYME AGENTS		
JETREA	T2	
OPHTHALMIC SURGICAL AIDS		
ocucoat (Cellugel)	T1	
ELECT/CALORIC/H2O (Dental Products)		
FLUORIDE PREPARATIONS		
CLINPRO 5000	T3	
denta 5000 plus	T1	
dentagel	T1	
FLUORIDEX DAILY DEFENSE	T3	
FLUORIDEX SENSITIVITY RELIEF	T3	
fluoritab	T1	PPACA
PREVIDENT	T3	
PREVIDENT 5000 ENAMEL PROTECT	T3	
PREVIDENT 5000 ORTHO DEFENSE	T3	
PREVIDENT 5000 SENSITIVE	T3	
sf	T1	
sf 5000 plus	T1	

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ELECT/CALORIC/H2O (Dental Products) (cont.)		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
FLUORIDE PREPARATIONS (cont.)		
sodium fluoride	T1	
sodium fluoride 5000 plus	T1	
sodium fluoride enamel protect	T1	
sodium fluoride sensitive	T1	
IRON REPLACEMENT		
ACCRUFER 30 MG CAPSULE	T3	
FERAHEME 510 MG/17 ML VIAL	T3	PA
ELECT/CALORIC/H2O (Diabetes)		
AGENTS TO TREAT HYPOGLYCEMIA (HYPERGLYCEMICS)		
BAQSIMI	T2	
dex4 glucose	T1	
GLUCAGEN	T2	QL
GLUCAGON EMERGENCY KIT	T2	QL
gluco burst	T1	
GLUCO SHOT	T3	
glucose	T1	
GLUCOSE 2 GRAM GUMMY	T3	
GLUCOSE	T3	
glucose bits	T1	
glucose gel	T1	
glutose	T1	
GLUTOSE *(gluco burst)*	T2	
GVOKE	T2	
GVOKE SYRINGE	T2	QL
GLUCOSE 2 GRAM GUMMY	T3	
PROGLYCEM *(diazoxide)*	T3	
relion	T1	
TRUEPLUS	T3	
TRUEPLUS *(dex4 glucose)*	T3	
ELECT/CALORIC/H2O (Miscellaneous)		
NUCLEIC ACID/NUCLEOTIDE SUPPLEMENTS		
XURIDEN	T2	SP

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ELECT/CALORIC/H2O (Nutritional/Dietary)		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
CARBOHYDRATES		
ENFAMIL	T2	
GLUTOL	T2	
ELECTROLYTE DEPLETERS		
acetate	T1	
AURYXIA	T3	
CALCIUM 667mg	T3	QL (360 tabs/30 days)
kionex	T1	
lanthanum carbonate (Fosrenol)	T1	QL (90 tabs/30 days)
LOKELMA	T2	QL (30 units/30 days)
PHOSLYRA	T2	
polystyrene sulfonate	T1	
RENVELA *(sevelamer carbonate)*	T3	QL (270 tabs/30 days)
sevelamer hcl 400 mg tablet	T1	
sevelamer hcl 800 mg tablet	T1	
sps	T1	
VELPHORO	T2	QL (120 tabs/20 days)
VELTASSA	T2	ST QL (30 packets/30 days)
IODINE CONTAINING AGENTS		
lugol's	T1	
SSKI	T3	
strong iodine	T1	
IRON REPLACEMENT		
ferrous fum/vit c/b12-if/folic	T1	PPACA
HEMATOGEN	T3	
TULIVITE	T3	
PEDIATRIC VITAMIN PREPARATIONS		
fluoride	T1	PPACA
fluoritab	T1	PPACA
ludent fluoride	T1	PPACA
POTASSIUM REPLACEMENT		
chloride (Klor-Con 10)	T1	
chloride (Klor-Con 8)	T1	
chloride (K-Tab ER)	T1	

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ELECT/CALORIC/H2O (Nutritional/Dietary) (cont.)		
POTASSIUM REPLACEMENT (cont.)		
effer-k	T1	
klor-con	T1	
klor-con (Klor-Con 10)	T1	
klor-con (Klor-Con 8)	T1	
klor-con m	T1	
klor-con m (Klor-Con M15)	T1	
klor-con-ef	T1	
K-TAB	T3	
k-tab (Klor-Con 8)	T1	
ELECT/CALORIC/H2O (Urinary Tract Conditions)		
URINARY PH MODIFIERS		
citric acid/sodium citrate	T1	HD
er (Urocit-K)	T1	HD
K-PHOS NO.2	T3	HD
K-PHOS ORIGINAL	T2	HD
ORACIT	T3	HD
RENACIDIN	T2	HD
UROCIT-K *(potassium er)*	T3	HD
GASTROINTESTINAL (Cholesterol Medications)		
LIPOTROPICS		
LOVAZA *(omega-3 acid ethyl esters)*	T3	PA HD
omega-3 acid ethyl esters (Lovaza)	T1	PA HD
VASCEPA	T2	PA HD
GASTROINTESTINAL (Gastrointestinal/Heartburn)		
AMMONIA INHIBITORS		
BUPHENYL *(phenylbutyrate)*	T3	SP HD
enulose	T1	HD
generlac	T1	HD
lactulose	T1	HD
LITHOSTAT	T3	HD
OLPRUVA DOSE KIT, DOSE ENVELOPE	T3	SP PA HD
phenylbutyrate (Buphenyl)	T1	SP HD
PHEBURANE	T2	PA SP

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GASTROINTESTINAL (Gastrointestinal/Heartburn) (cont.)		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
AMMONIA INHIBITORS (cont.)		
RAVICTI	T2	SP HD
ANTI-CHOLINERGICS, QUATERNARY AMMONIUM		
clidinium w/chlordiazepoxide (Librax)	T1	
CUVPOSA	T3	
GLYCATE	T3	
glycopyrrolate (Glycate)	T1	
propantheline bromide	T1	
ANTI-CHOLINERGICS/ANTI-SPASMODICS		
dicyclomine hcl	T1	
ANTI-DIARRHEAL - TRYPTOPHAN HYDROXYLASE INHIBITOR		
XERMELO	T2	PA QL(84 tabs/28 days) SP
ANTI-DIARRHEALS		
diphenoxylate w/atropine (Lomotil)	T1	
LOMOTIL *(diphenoxylate-atropine)*	T3	
MOTOFEN	T3	
opium	T1	
ANTI-EMETIC, CANNABINOID-TYPE		
dronabinol (Marinol)	T1	PA
SYNDROS	T3	PA
ANTI-EMETIC/ANTI-VERTIGO AGENTS		
aprepitant	T1	QL
aprepitant (Emend)	T1	QL
BONJESTA	T3	QL (60 tabs/dispense)
compro	T1	
DICLEGIS *(doxylamine succ-pyridoxine hcl)*	T3	QL (720 tabs/365 days)
doxylamine succ-pyridoxine hcl (Diclegis)	T1	QL (720 tabs/365 days)
EMEND *(fosaprepitant dimeglumine)*	T3	
fosaprepitant dimeglumine (Emend)	T1	
granisetron hcl	T1	QL
ondansetron hcl (Zofran)	T1	QL
ondansetron odt	T1	QL
phenadoz	T1	
prochlorperazine maleate	T1	
promethazine hcl	T1	

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Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
ANTI-EMETIC/ANTI-VERTIGO AGENTS (cont.)		
promethegan	T1	
SANCUSO	T3	QL
scopolamine (Transderm-Scop)	T1	
TIGAN *(trimethobenzamide hcl)*	T3	
trimethobenzamide hcl (Tigan)	T1	
VARUBI	T2	QL
ZOFRAN *(ondansetron hcl)*	T3	QL
ZUPLENZ	T3	QL
ANTI-ULCER PREPARATIONS		
CYTOTEC *(misoprostol)*	T3	HD
misoprostol (Cytotec)	T1	HD
sucralfate (Carafate)	T1	HD
ANTI-ULCER-H.PYLORI AGENTS		
lansoprazol-amoxicil-clarithro	T1	QL
OMECLAMOX-PAK	T3	QL
TALICIA	T2	QL
BELLADONNA ALKALOIDS		
anaspaz (Anaspaz)	T1	HD
belladonna-phenobarbital (Donnatal)	T1	HD
DONNATAL *(phenohytro)*	T3	HD
ed-spaz (Anaspaz)	T1	HD
hyoscyamine	T1	HD
hyoscyamine (Anaspaz)	T1	HD
hyoscyamine (Levbid)	T1	HD
hyoscyamine (Levsin)	T1	HD
hyoscyamine (Levsin-SL)	T1	HD
hyosyne	T1	HD
LEVBID (hyoscyamine er)	T3	HD
LEVSIN (hyoscyamine)	T3	HD
LEVSIN-SL (hyoscyamine)	T3	HD
methscopolamine bromide	T1	HD
NULEV *(ed-spaz)*	T3	HD
oscimin (Levsin)	T1	HD
oscimin sl (Levsin-SL)	T1	HD

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Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
BELLADONNA ALKALOIDS (cont.)		
oscimin sr (Levbid)	T1	HD
phenohytro (Donnatal)	T1	HD
SYMAX DUOTAB	T3	HD
symax-sl (Levsin-SL)	T1	HD
symax-sr (Levbid)	T1	HD
BILE SALTS		
ACTIGALL *(ursodiol)*	T3	HD
CHENODAL	T2	PA SP HD
CHOLBAM	T2	PA QL SP HD
URSO *(ursodiol)*	T3	HD
URSO FORTE *(ursodiol)*	T3	HD
ursodiol (Actigall)	T1	HD
ursodiol (Urso Forte)	T1	HD
ursodiol (Urso)	T1	HD
CHRONIC INFLAM. COLON DX, 5-A-SALICYLAT, RECTAL TX		
mesalamine (Canasa)	T1	
mesalamine (Rowasa)	T1	
mesalamine (Sfrowasa)	T1	
ROWASA *(mesalamine)*	T3	
SFROWASA *(mesalamine)*	T3	
DRUG TX-CHRONIC INFLAM. COLON DX, 5-AMINOSALICYLAT		
APRISO *(mesalamine er)*	T3	HD
ASACOL HD (*mesalamine*)	T3	HD
AZULFIDINE *(sulfasalazine dr)*	T3	HD
AZULFIDINE *(sulfasalazine)*	T3	HD
balsalazide di (Colazal)	T1	HD
COLAZAL *(balsalazide di)*	T3	HD
mesalamine (Asacol Hd)	T1	HD
mesalamine (Lialda)	T1	HD
mesalamine dr (Delzicol)	T1	HD
mesalamine er (Apriso)	T1	HD
PENTASA	T2	HD
sulfasalazine (Azulfidine)	T1	HD

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Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
FARNESOID X RECEPTOR (FXR) AGONIST, BILE AC ANALOG		
OCALIVA	T2	PA QL (30 units/30 days) SP HD
FECAL MICROBIOTA TRANSPLANTATION (FMT)		
VOWST CAPSULE	T3	SP
GASTRIC ENZYMES		
SUCRAID	T2	SP
HISTAMINE H2-RECEPTOR INHIBITORS		
cimetidine	T1	HD
famotidine	T1	HD
nizatidine	T1	HD
PEPCID *(famotidine)*	T3	HD
IBS AGENTS, MIXED OPIOID RECEP AGONISTS/ANTAGONISTS		
VIBERZI	T2	HD
IBS-C/CIC AGENTS, GUANYLATE CYCLASE-C AGONIST		
LINZESS	T2	QL (30 units/30 days)
TRULANCE	T2	
INTEGRIN RECEPTOR ANTAGONIST, MONOCLONAL ANTIBODY		
ENTYVIO	T2	PA SP HD
INTESTINAL MOTILITY STIMULANTS		
metoclopramide hcl (Reglan)	T1	
metoclopramide hcl odt	T1	
MOTEGRITY	T3	QL (30 units/30 days)
REGLAN *(metoclopramide hcl)*	T3	
IRRITABLE BOWEL SYND. AGENT, 5-HT4 PARTIAL AGO		
ZELNORM	T3	
IRRITABLE BOWEL SYNDROME AGENTS, 5-HT3 ANTAGONIST		
alosetron hcl (Lotronex)	T1	SP HD
LAXATIVES AND CATHARTICS		
alophen pills (Dulcolax)	T1	PPACA
bisacodyl (Dulcolax)	T1	PPACA
bisa-lax (Dulcolax)	T1	PPACA
citroma (Citroma)	T1	
clearlax (Miralax)	T1	PPACA
clearlax (Miralax)	T1	
constulose	T1	

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Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
LAXATIVES AND CATHARTICS (cont.)		
ducodyl (Dulcolax)	T1	
gavilax (Miralax)	T1	PPACA
gavilyte-g (Golytely)	T1	PPACA
gavilyte-n (Nulytely)	T1	PPACA
gentle laxative (Correctol)	T1	PPACA
gentle laxative (Dulcolax)	T1	PPACA
gentlelax (Miralax)	T1	PPACA
glycolax (Miralax)	T1	PPACA
healthylax (Miralax)	T1	PPACA
KRISTALOSE	T3	
lactulose (Kristalose)	T1	
laxaclear (Miralax)	T1	PPACA
laxative (Dulcolax)	T1	PPACA
laxative peg 3350 (Miralax)	T1	PPACA
lubiprostone	T1	QL (60 caps/30 days)
magnesium (Citroma)	T1	
milk of magnesia	T1	
miralax	T1	PPACA
natura-lax (Miralax)	T1	PPACA
NULYTELY WITH FLAVOR PACKS *(gavilyte-n)*	T3	PPACA
of magnesia (Citroma)	T1	
peg 3350-electrolyte (Golytely)	T1	PPACA
peg 3350-electrolyte (Nulytely)	T1	PPACA
peg-prep	T1	PPACA
polyethylene glycol (Miralax)	T1	PPACA
powderlax (Miralax)	T1	
PREPOPIK	T2	
purelax (Miralax)	T1	PPACA
smoothlax (Miralax)	T1	PPACA
trilyte with flavor packets (Nulytely)	T1	PPACA
women's gentle laxative (Dulcolax)	T1	PPACA
women's laxative (Correctol)	T1	PPACA
women's laxative (Dulcolax)	T1	PPACA

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Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
LOCAL ANORECTAL NITRATE PREPARATIONS		
nitroglycerin 0.4% ointment	T1	
RECTIV	T2	
MU-OPIOID RECEPTOR ANTAGONISTS,PERIPHERALLY-ACTING		
ENTEREG	T3	
PANCREATIC ENZYMES		
CREON	T2	HD
VIOKACE	T2	HD
ZENPEP	T2	HD
POTASSIUM-COMPETITIVE ACID BLOCKERS (PCABS)		
VOQUEZNA	T3	ST
PROTON-PUMP INHIBITORS		
dexlansoprazole dr 30 mg cap	T1	ST QL
ESOMEPRAZOLE DR 49.3 MG CAP	T3	ST HD
esomeprazole magnesium (Nexium 24HR)	T1	QL (30 units/30 days) HD
esomeprazole magnesium (Nexium)	T1	HD
lansoprazole (Prevacid)	T1	HD
omeprazole	T1	QL (30 caps/30 days) HD
omeprazole- bicarbonate (Zegerid)	T1	PA HD
pantoprazole (Protonix)	T1	QL (30 units/30 days) HD
rabeprazole (Aciphex)	T1	HD
RECTAL PREPARATIONS		
anucort-hc (Anucort-HC)	T1	
hemmorex-hc (Anucort-HC)	T1	
hydrocortisone acetate (Anucort-HC)	T1	
hydrocortisone acetate (Proctocort)	T1	
PROCTOCORT *(hydrocortisone)*	T3	ST
SBS - GLUCAGON-LIKE PEPTIDE-2 (GLP-2) ANALOGS		
GATTEX	T3	SP HD
GASTROINTESTINAL (Pain Relief And Inflammatory Disease)		
HEMORRHOID PREP, ANTI-INFLAM STEROID-LOCAL ANESTHET		
ANA-LEX	T3	
ANALPRAM-HC *(hydrocortisone-pramoxine)*	T3	ST
hc pramoxine (Analpram HC)	T1	
lidocaine-hc	T1	

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GASTROINTESTINAL (Pain Relief And Inflammatory Disease) (cont.)		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
HEMORRHOID PREP, ANTI-INFLAM STEROID-LOCAL ANESTHET (cont.)		
pramoxine hcl w/hydrocortisone (Analpram Hc)	T1	
PROCORT	T3	
HORMONES (Gastrointestinal/Heartburn)		
RECTAL/LOWER BOWEL PREP., GLUCOCORT. (NON-HEMORR)		
colocort (Cortenema)	T1	
CORTENEMA *(hydrocortisone)*	T3	
hydrocortisone (Cortenema)	T1	
UCERIS	T2	
HORMONES (Hormonal Agents)		
ANDROGENIC AGENTS		
ANADROL-50	T3	
ANDRODERM	T2	PA QL (30 units/30 days)
DEPO-TESTOSTERONE *(testosterone cypionate)*	T3	PA
FORTESTA *(testosterone)*	T3	PA QL
METHITEST	T2	
methyltestosterone	T1	
oxandrolone	T1	
STRIANT	T3	PA QL
testosterone	T1	PA QL
TESTOSTERONE	T3	PA QL
testosterone (Androgel)	T1	PA QL
testosterone (Fortesta)	T1	PA QL
testosterone (Testim)	T1	PA QL
testosterone (Vogelxo)	T1	PA QL
testosterone cypionate (Depo-Testosterone)	T1	PA
testosterone enanthate	T1	PA
VOGELXO *(testosterone)*	T3	PA QL
XYOSTED	T2	QL(2 mls/28 days)
ANTI-DIURETIC AND VASOPRESSOR HORMONES		
DDAVP SOLUTION	T2	
DDAVP TABLET	T3	
desmopressin 0.01% solution	T1	
desmopressin 10 mcg/0.1 ml spr	T1	

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HORMONES (Hormonal Agents) (cont.)		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
ANTI-DIURETIC AND VASOPRESSOR HORMONES (cont.)		
NOCDURNA	T3	PA QL (30 Units/30 days)
STIMATE	T2	
ESTROGEN/ANDROGEN COMBINATIONS		
covaryx	T1	HD
covaryx h.s.	T1	HD
eemt	T1	HD
eemt hs	T1	HD
estrogen & methyltestosterone	T1	HD
ESTROGENIC AGENTS		
ACTIVELLA *(amabelz)*	T3	HD
ALORA	T3	QL (8 patches/21 days) HD
amabelz (Activella)	T1	HD
CLIMARA *(estradiol (once weekly))*	T3	QL (4 patches/21 days) HD
COMBIPATCH	T2	HD
DELESTROGEN *(estradiol valerate)*	T3	HD
DEPO-ESTRADIOL	T2	HD
dotti (Alora)	T1	QL (8 patches/21 days) HD
dotti (Minivelle)	T1	QL (8 patches/21 days) HD
ESTRACE *(estradiol)*	T3	HD
estradiol (Alora)	T1	QL (8 patches/21 days) HD
estradiol (Climara)	T1	QL (4 patches/21 days) HD
estradiol (Delestrogen)	T1	HD
estradiol (Estrace)	T1	HD
estradiol/norethindrone acet	T1	HD
estradiol-norethindrone acetat (Activella)	T1	HD
FEMHRT *(fyavolv)*	T3	HD
fyavolv (Femhrt)	T1	HD
jinteli	T1	HD
lopreeza (Activella)	T1	
MENOSTAR	T3	QL (4 patches/21 days) HD
mimvey (Activella)	T1	HD
norethindrone-ethin estradiol (Femhrt)	T1	HD
PREFEST	T3	HD

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HORMONES (Hormonal Agents) (cont.)		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
ESTROGEN-PROGESTIN WITH ANTI-MINERALOCORTICOID COMB		
ANGELIQ	T3	HD
ESTROGEN-SELECTIVE ESTROGEN RECEPTOR MOD (SERM) COMB		
DUAVEE	T2	
GLUCOCORTICOIDS		
budesonide ec (Entocort EC)	T1	
budesonide er (Uceris)	T1	
CORTEF *(hydrocortisone)*	T3	
cortisone acetate	T1	
decadron	T1	
deflazacort (Emflaza)	T1	PA SP HD
dexamethasone	T1	PA
dexamethasone 0.5 mg/5 ml elx	T1	
DEXONTO	T3	
DEXPAK *(dexamethasone)*	T3	PA
DXEVO	T3	PA
ENTOCORT EC *(budesonide ec)*	T3	
hidex	T1	PA
hydrocortisone (Cortef)	T1	
MEDROL *(methylpred dp)*	T3	
MEDROL *(methylprednisolone)*	T3	
methylpred dp (Medrol)	T1	
methylprednisolone (Medrol)	T1	
millipred	T1	
ORAPRED ODT *(prednisolone phos odt)*	T3	
prednisolone	T1	
prednisolone phos odt (Orapred ODT)	T1	
prednisolone phosphate	T1	
prednisolone phosphate (Pediapred)	T1	
prednisone	T1	
RAYOS	T3	PA
TAPERDEX	T3	PA
TARPEYO DR 4MG CAPSULE	T3	PA
UCERIS *(budesonide er)*	T3	

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GROWTH HORMONE RELEASING HORMONE (GHRH) AND ANALOGS		
EGRIFTA SV	T2	PA SP HD
GENOTROPIN	T2	PA SP HD
ZORBTIVE	T3	PA SP HD
GROWTH HORMONES		
OMNITROPE	T2	PA SP
SEROSTIM	T2	PA SP HD
INSULIN-LIKE GROWTH FACTOR-I (IGF-I) HORMONES		
INCRELEX	T2	PA SP HD
LHRH (GNRH) AGONIST ANALOG AND PROGESTIN COMB		
LUPANETA PACK	T2	PA SP HD
LUPRON DEPOT	T2	PA SP HD
LHRH (GNRH) AGONIST ANALOG PITUITARY SUPPRESSANTS		
SYNAREL	T2	PA SP HD
LHRH (GNRH) ANTAGONIST, PITUITARY SUPPRESSANT AGENTS		
cetrorelix acetate	T1	
fyremadel (generic to GANIRELIX)	T1	PA ST
ORILISSA 150 MG TABLET	T2	PA QL (1 tab/day)
ORILISSA 200 MG TABLET	T2	PA QL (360 tabs/365 days)
LHRH (GNRH) AGNST PIT.SUP-CENTRAL PRECOCIOUS PUBERTY		
LUPRON DEPOT-PED	T2	PA SP HD
MINERALOCORTICOIDS		
fludrocortisone acetate	T1	HD
OXYTOCICS		
CERVIDIL	T3	
methergine	T1	PA QL
methylergonovine maleate	T1	PA QL
PREPIDIL	T3	
PROSTIN E2 VAGINAL SUPPOSITORY	T3	
PARATHYROID HORMONES		
NATPARA	T2	PA SP HD
PITUITARY SUPPRESSIVE AGENTS		
cabergoline	T1	QL (8 tabs/21 days) HD
danazol	T1	HD

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Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
PROGESTATIONAL AGENTS		
AYGESTIN *(norethindrone)*	T3	HD
CRINONE 8% GEL	T2	
medroxyprogesterone acetate	T1	HD
medroxyprogesterone acetate (Provera)	T1	HD
norethindrone acetate (Aygestin)	T1	HD
progesterone (Prometrium)	T1	HD
PROMETRIUM *(progesterone)*	T3	HD
PROVERA *(medroxyprogesterone)*	T3	HD
SOMATOSTATIC AGENTS		
MYCAPSSA DR 20 MG CAPSULE	T3	PA SP QL (56 caps/28 days)
octreotide acetate	T1	SP HD
SANDOSTATIN *(octreotide)*	T3	PA ST SP HD
SIGNIFOR	T2	PA SP HD
SOMATULINE DEPOT	T2	PA SP HD
VAGINAL ESTROGEN PREPARATIONS		
estradiol (Estrace)	T1	HD
estradiol (Vagifem)	T1	HD
yuvafem (Vagifem)	T1	HD
HORMONES (Infertility)		
HUMAN CHORIONIC GONADOTROPIN (HCG)		
CHORIONIC GONAD 10, 000 UNIT VIAL	T3	ST QL(3 vials/30 days) SP
NOVAREL	T2	QL(6 vls/30 days) SP
PREGNANCY FACILITATING/MAINTAINING AGENT,HORMONAL		
ENDOMETRIN	T3	
HORMONES (Miscellaneous)		
LEPTIN HORMONE ANALOGS		
MYALEPT	T2	PA SP HD
HORMONES (Osteoporosis Products)		
BONE FORMATION STIMULATING AGTS - PTH REL PEPTIDES		
TYMLOS	T2	PA QL SP HD
BONE RESORPTION INHIBITORS		
calcitonin-salmon	T1	HD
MIACALCIN	T3	HD

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IMMUNOSUPPRESSANTS (Pain Relief And Inflammatory Disease)		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
IL-23 RECEPTOR ANTAGONIST, MONOCLONAL ANTIBODY		
OMVOH PEN	T2	
INTERLEUKIN-4(IL-4) RECEPTOR ALPHA ANTAGONIST, MAB		
DUPIXENT 100MG/0.67ML PREFILLED SYRINGE	T2	PA QL (2 pens/28 days) SP HD
DUPIXENT 200 MG/1.14 ML SYRINGE	T2	PA QL (800 mg/21 days) SP HD
DUPIXENT 300 MG2 ML SYRINGE	T2	PA QL (600 mg/21 days) SP HD
INTERLEUKIN-6 (IL-6) RECEPTOR INHIBITORS		
ACTEMRA	T2	PA QL (2 syr/21 days) SP HD
ACTEMRA ACTPEN	T2	PA QL (2 pens/21 days) SP HD
MONOCLONAL ANTIBODY-HUMAN INTERLEUKIN 12/23 INHIB		
STELARA	T2	PA QL SP HD
IMMUNOSUPPRESSANTS (Skin Conditions)		
TOPICAL IMMUNOSUPPRESSIVE AGENTS		
pimecrolimus (Elidel)	T1	QL (100 gm/23 days)
PROTOPIC *(tacrolimus)*	T3	ST QL (120 grams/30 days)
tacrolimus (Protopic)	T1	QL (100gm/23 days)
IMMUNOSUPPRESSANTS (Transplant Medications)		
IMMUNOSUPPRESSIVES		
ASTAGRAF XL	T3	PA SP HD
AZASAN	T3	SP HD
azathioprine (Imuran)	T1	SP HD
CELLCEPT *(mycophenolate mofetil)*	T3	SP HD
cyclosporine (Neoral)	T1	SP HD
cyclosporine (Sandimmune)	T1	SP HD
gengraf (Neoral)	T1	SP HD
IMURAN *(azathioprine)*	T3	SP HD
LUPKYNIS	T3	PA SP QL (180 caps/30 days)
mycophenolate mofetil (Cellcept)	T1	SP HD
mycophenolic acid (Myfortic)	T1	SP HD
MYFORTIC *(mycophenolic acid)*	T3	SP HD
NEORAL *(cyclosporine modified)*	T3	SP HD
PROGRAF CAPSULES *(tacrolimus)*	T3	SP HD
PROGRAF GRANULE PACKETS	T2	SP HD
RAPAMUNE *(sirolimus)*	T3	SP HD

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List of Prescription Medications

IMMUNOSUPPRESSANTS (Transplant Medications)(cont.)		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
IMMUNOSUPPRESSIVES (cont.)		
SANDIMMUNE CAPSULES *(cyclosporine)*	T3	SP HD
SANDIMMUNE SOLUTION	T2	SP HD
sirolimus (Rapamune)	T1	SP HD
tacrolimus (Prograf)	T1	SP HD
ZORTRESS 0.25MG, 0.5MG, 0.75 MG TABLETS (*everolimus)*	T3	SP HD
ZORTRESS 1 MG TABLET	T3	SP HD
MISCELLANEOUS MEDICAL SUPPLIES, DEVICES, NON-DRUG (Diabetes)		
DIABETIC SUPPLIES		
ACCU-CHEK	T2	
CEQUR SIMPLICITY 2 UNIT PATCH, INSERTER	T2	
CONTOUR	T3	
CONTOUR NEXT	T3	
DEXCOM G6	T2	QL (3 kits/23 days)
DEXCOM G6 RECEIVER	T2	
DEXCOM G7 RECEIVER	T2	
DEXCOM G7 SENSOR	T2	PA QL(3 units/30 days)
EASY MINI EJECT LANCING DEVICE	T2	
EASY PLUS II	T3	
EASY STEP CONTROL SOLUTION	T3	
EASY TALK	T3	
EASY TOUCH	T3	
EASY TOUCH LANCING DEVICE	T2	
EASY TRAK	T3	
EASYMAX	T3	
EASYMAX N	T3	
EMBRACE	T3	
EMBRACE EVO	T3	
EMBRACE PRO	T3	
EVENCARE G2	T3	
EVENCARE G3	T3	
EVERSENSE SENSOR-HOLDER	T3	PA QL
EVERSENSE SMART TRANSMITTER	T3	PA QL
FORA	T3	

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MISCELLANEOUS MEDICAL SUPPLIES, DEVICES, NON-DRUG (Diabetes) (cont.)		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
DIABETIC SUPPLIES (cont.)		
FORA TN'GO ADVANCE MULTIFN MTR	T3	
FORACARE	T3	
FORTISCARE	T3	
FREESTYLE	T2	
FREESTYLE LIBRE 2, 3	T2	PA QL(2 sensors/28 days)
FREESTYLE LIBRE 10 DAY SENSOR	T2	PA
FREESTYLE LIBRE 14 DAY SENSOR	T2	PA QL (2 kits/21 days)
FREESTYLE NAVIGATOR SENSOR KIT	T2	
GENTLE DRAW	T2	
GLUCOCARD	T3	
GLUCOCOM	T3	
GLUCOSE CONTROL	T3	
GLUCOSE CONTROL SOLUTION	T3	
GUARDIAN LINK 3 TRANSMITTER	T3	PA QL (1 transmitter/273 days)
GUARDIAN 4 TRANSMITTER	T3	PA QL (1 transmitter/273 days)
GUARDIAN 4 GLUCOSE SENSOR	T3	PA QL (5 sensors/30 days)
GUARDIAN RT REPLACE MONITOR	T3	
GUARDIAN SENSOR 3	T3	
HEALTHY ACCENTS AUTOLET	T2	
HYPOLANCE	T2	
INCONTROL LANCING DEVICE	T2	
INFINITY CONTROL SOLUTION	T3	
INFINITY VOICE CONTROL SOLN	T3	
ILET INFUSION KIT-INSET	T2	
ILET INFUSION-CONTACT DETACH	T2	
LITE TOUCH	T2	
MEDISENSE	T2	
MICROLET	T2	
MINI LANCING DEVICE	T2	
MINIMED	T2	
OMNIPOD	T2	
OMNIPOD DASH	T2	QL (15 pods/30 days)
OMNIPOD GO PODS	T2	QL(10 crtgs/30 days)
ONE TOUCH DELICA	T2	

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MISCELLANEOUS MEDICAL SUPPLIES, DEVICES, NON-DRUG (Diabetes) (cont.)		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
DIABETIC SUPPLIES (cont.)		
ONE TOUCH ULTRA CONTROL SOLN	T2	
ONE TOUCH VERIO	T2	
ONETOUCH DELICA PLUS LANC DEV	T2	
PRODIGY LANCING DEVICE	T2	
T:FLEX	T2	
T:SLIM	T2	
TRUE METRIX	T3	
TRUECONTROL	T3	
ULTI-LANCE	T2	
VGO 20	T2	
VGO 30	T2	
VGO 40	T2	
DURABLE MEDICAL EQUIPMENT,MISC(GROUP I)		
1ST TIER UNILET COMFORTOUCH	T2	
2-IN-1 LANCET DEVICE	T2	
ACCU-CHEK FASTCLIX LANCET DRUM	T2	
ACCU-CHEK SAFE-T-PRO	T2	
ACCU-CHEK SAFE-T-PRO PLUS	T2	
ACCU-CHEK SOFTCLIX	T2	
acti-lance lite 28g lancets	T1	
acti-lance special 17g lancets	T1	
acti-lance univers 23g lancets	T1	
ACTI-LANCE UNIVERS 23G LANCETS	T2	
ADVANCED TRAVEL LANCETS	T2	
ADVOCATE LANCET	T2	
ADVOCATE LANCETS	T2	
ADVOCATE SAFETY LANCET	T2	
ALTERNATE SITE LANCETS	T2	
ASSURE HAEMOLANCE PLUS	T2	
ASSURE LANCE	T2	
ASSURE LANCE PLUS	T2	
BD MICROTAINER LANCETS	T2	
BLOOD LANCETS	T2	
BULLSEYE MINI SAFETY LANCETS	T2	

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Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
DURABLE MEDICAL EQUIPMENT,MISC(GROUP I) (cont.)		
BUTTERFLY TOUCH LANCET	T2	
CAREONE	T2	
CARESENS LANCET	T2	
CARETOUCH SAFETY LANCETS	T2	
CARETOUCH TWIST LANCET	T2	
CLEVER CHEK LANCETS	T2	
COAGUCHEK	T2	
COLOR LANCETS	T2	
COMFORT EZ	T2	
COMFORT LANCETS	T2	
COMFORT TOUCH PLUS SAFETY LANC	T2	
COMFORT TOUCH ULT THIN LANCET	T2	
DROPLET LANCETS	T2	
EASY COMFORT LANCETS	T2	
EASY TOUCH PULL-TOP 26G LANCET	T2	
EASY TOUCH PULL-TOP 28G LANCET	T2	
EASY TOUCH PULL-TOP 30G LANCET	T2	
EASY TOUCH PULL-TOP 32G LANCET	T2	
EASY TOUCH SAFETY 21G LANCETS	T2	
EASY TOUCH SAFETY 23G LANCETS	T2	
EASY TOUCH SAFETY 26G LANCETS	T2	
EASY TOUCH SAFETY 28G LANCETS	T2	
EASY TOUCH SAFETY 30G LANCETS	T2	
EASY TOUCH SAFETY 32G LANCETS	T2	
EASY TOUCH TWIST 26G LANCETS	T2	
EASY TOUCH TWIST 28G LANCETS	T2	
EASY TOUCH TWIST 30G LANCETS	T2	
EASY TOUCH TWIST 32G LANCETS	T2	
EASY TOUCH TWIST 33G LANCETS	T2	
EASY TWIST & CAP LANCETS	T2	
EMBRACE 30G LANCETS	T2	
EMBRACE SAFETY LANCET	T2	
EZ SMART LANCETS	T2	
EZ-LETS	T2	

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Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
DURABLE MEDICAL EQUIPMENT,MISC(GROUP I) (cont.)		
FIFTY50 SAFETY SEAL LANCETS	T2	
FINE 30 UNIVERSAL LANCETS	T2	
FINGERSTIX	T2	
FORA LANCETS	T2	
FORACARE LANCETS	T2	
FREESTYLE LANCETS	T2	
FREESTYLE UNISTIK 2	T2	
GLUCOCOM	T2	
GLUCOCOM LANCETS	T2	
GOJJI LANCETS	T2	
HEALTHY ACCENTS UNILET LANCET	T2	
INCONTROL SUPER THIN LANCETS	T2	
INCONTROL ULTRA THIN LANCETS	T2	
INJECT EASE LANCETS	T2	
INVACARE LANCETS	T2	
lancets	T1	
LANCETS	T2	
LANCETS THIN	T2	
LANCETS ULTRA THIN	T2	
LITE TOUCH 28G LANCETS	T2	
LITE TOUCH 30G LANCETS	T2	
LITE TOUCH 33G LANCETS	T2	
MEDISENSE THIN LANCETS	T2	
medlance plus 21g lancets	T1	
MEDLANCE PLUS 21G LANCETS	T2	
medlance plus 30g lancets	T1	
MEDLANCE PLUS 30G LANCETS	T2	
MEDLANCE PLUS EXTRA 21G LANCET	T2	
medlance plus lite 25g lancets	T1	
MEDLANCE PLUS LITE 25G LANCETS	T2	
MICRO THIN LANCET	T2	
MICRO THIN LANCETS	T2	
MICROLET	T2	
MOBILE LANCETS	T2	

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MISCELLANEOUS MEDICAL SUPPLIES, DEVICES, NON-DRUG (Diabetes) (cont.)		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
DURABLE MEDICAL EQUIPMENT,MISC(GROUP I) (cont.)		
MONOLET LANCETS	T2	
MONOLET THIN LANCETS	T2	
MYGLUCOHEALTH LANCETS	T2	
NOVA SAFETY LANCETS	T2	
NOVA SUREFLEX	T2	
ON CALL LANCET	T2	
ON CALL PLUS LANCET	T2	
ONETOUCH DELICA PLUS LANCET	T2	
ONETOUCH DELICA SAFETY LANCET	T2	
ONETOUCH LANCETS	T2	
ONETOUCH SURESOFT	T2	
ONETOUCH ULTRASOFT 2 LANCET	T2	
ON-THE-GO	T2	
PIP LANCET	T2	
PRESSURE ACTIVATED LANCETS	T2	
PRO COMFORT LANCET	T2	
PRO COMFORT LANCETS	T2	
PRO COMFORT SAFETY LANCET	T2	
PRODIGY LANCETS	T2	
PRODIGY TWIST TOP LANCET	T2	
PURE COMFORT LANCETS	T2	
PURE COMFORT SAFETY LANCETS	T2	
PUSH BUTTON SAFETY LANCETS	T2	
READYLANCE SAFETY LANCETS	T2	
RELIAMED	T2	
RELIAMED SAFETY SEAL LANCETS	T2	
RELION THIN	T2	
RIGHTEST GL300 LANCETS	T2	
SAFETY LANCETS	T2	
SAFETY SEAL LANCETS	T2	
SAFETY-LET	T2	
SINGLE-LET	T2	
SMART SENSE	T2	
SMART SENSE LANCETS	T2	

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

MISCELLANEOUS MEDICAL SUPPLIES, DEVICES, NON-DRUG (Diabetes) (cont.)		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
DURABLE MEDICAL EQUIPMENT,MISC(GROUP I) (cont.)		
SMARTEST LANCET	T2	
SOFT TOUCH	T2	
SOLUS V2	T2	
SOLUS V2 LANCETS	T2	
STERILANCE TL	T2	
STERILE LANCETS	T2	
SUPER THIN LANCETS	T2	
SURE COMFORT LANCETS	T2	
SURE-LANCE	T2	
SURE-TOUCH	T2	
TECHLITE LANCETS	T2	
TELCARE ULTRA THIN 30G LANCETS	T2	
THIN LANCETS	T2	
TOPCARE UNIVERSAL1 LANCET	T2	
TOPCARE UNIVERSAL1 THIN LANCET	T2	
TRUE COMFORT LANCET	T2	
TRUE COMFORT SAFETY LANCET	T2	
TRUEPLUS LANCET	T2	
TRUEPLUS LANCETS	T2	
TWIST LANCETS	T2	
TWIST TOP LANCET	T2	
ULTILET BASIC	T2	
ULTILET CLASSIC	T2	
ULTILET LANCETS	T2	
ULTILET SAFETY	T2	
ULTRA THIN LANCET	T2	
ULTRA THIN LANCETS	T2	
ULTRA THIN PLUS	T2	
ULTRA THIN PLUS LANCETS	T2	
ULTRA-CARE LANCETS	T2	
ULTRALANCE	T2	
ULTRA-THIN II 28G LANCETS	T2	
ULTRA-THIN II 30G LANCETS	T2	
ULTRATLC LANCETS	T2	

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Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
DURABLE MEDICAL EQUIPMENT,MISC(GROUP I) (cont.)		
UNILET COMFORTOUCH	T2	
UNILET EXCELITE	T2	
UNILET EXCELITE II	T2	
UNILET GP LANCET	T2	
UNILET LANCET	T2	
UNILET LANCETS	T2	
UNISTIK 2 COMFORT	T2	
UNISTIK 2 EXTRA	T2	
UNISTIK 2 NORMAL	T2	
UNISTIK 3	T2	
UNISTIK 3 COMFORT	T2	
UNISTIK 3 DUAL	T2	
UNISTIK 3 EXTRA	T2	
UNISTIK 3 NORMAL	T2	
UNISTIK COMFORT	T2	
UNISTIK CZT	T2	
UNISTIK EXTRA	T2	
UNISTIK NORMAL	T2	
UNISTIK PRO	T2	
UNISTIK SAFETY	T2	
UNISTIK TOUCH	T2	
UNIVERSAL 1	T2	
VERIFINE SAFETY LANCET MINI	T2	
VERIFINE UNIVERSAL LANCET	T2	
VIVAGUARD LANCET	T2	
NEEDLES/NEEDLELESS DEVICES		
BD NEEDLES	T2	
BD ECLIPSE NEEDLE 18G 40MM	T3	
CAREPOINT PRECISION NEEDLE	T3	
EXEL HUBER NEEDLE	T2	
exel huber needle (V-Go 20)	T1	
EXEL HYPODERMIC NEEDLE	T2	
EXEL MTI DRAWING NEEDLE	T2	
FILTER NEEDLE	T2	

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Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
NEEDLES/NEEDLELESS DEVICES (cont.)		
FLOW-EZE	T2	
HEALTHWISE PEN NEEDLE	T3	
HEALTHY ACCENTS UNIFINE PENTIP	T3	
HURRICAINE LUER-LOCK	T2	
LITE TOUCH	T3	
MINI TRANSFER PIN	T2	
NOVOFINE	T2	
NOVOTWIST	T2	
MISCELLANEOUS MEDICAL SUPPLIES, DEVICES, NON-DRUG (Miscellaneous)		
DURABLE MEDICAL EQUIPMENT,MISC(GROUP I)		
ADVOCATE SAFETY LANCET	T2	
CARESENS LANCET	T2	
CARETOUCH SAFETY LANCETS	T2	
RESPIRATORY AIDS, DEVICES, EQUIPMENT		
ACE AEROSOL CLOUD ENHANCER	T2	
AEROCHAMBER	T2	
AEROCHAMBER PLUS	T2	
AEROCHAMBER Z-STAT PLUS	T2	
AEROTRACH PLUS	T2	
AEROVENT PLUS	T2	
CLEVER CHOICE HOLDING CHAMBER	T2	
COMFORTSEAL	T2	
COMPACT SPACE CHAMBER	T2	
EASIVENT	T2	
FLEXICHAMBER	T2	
INSPIRACHAMBER	T2	
LITEAIRE	T2	
LITwETOUCH	T2	
MASK	T2	
MICROCHAMBER	T2	
MICROSPACER	T2	
MOUTHPIECE	T2	
ONE WAY MOUTHPIECE	T2	

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MISCELLANEOUS MEDICAL SUPPLIES, DEVICES, NON-DRUG (Miscellaneous) (cont.)		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
RESPIRATORY AIDS, DEVICES, EQUIPMENT (cont.)		
OPTICHAMBER	T2	
OPTICHAMBER DIAMOND	T2	
PANDA MASK	T2	
PEDIATRIC PANDA MASK	T2	
POCKET CHAMBER	T2	
PRIMEAIRE	T2	
PRO COMFORT SPACER WITH MASK	T2	
PROCHAMBER	T2	
RITEFLO	T2	
SIDESTREAM PEDIATRIC	T2	
SILICONE MASK	T2	
UNISTIK 2 COMFORT	T2	
UNISTIK 2 EXTRA	T2	
UNISTIK 2 NORMAL	T2	
UNISTIK 3 COMFORT	T2	
UNISTIK 3 DUAL	T2	
VORTEX	T2	
MUSCLE RELAXANTS (Pain Relief And Inflammatory Disease)		
SKELETAL MUSCLE RELAXANTS		
baclofen	T1	
baclofen 25 mg/5 ml suspension (Fleqsuvy)	T1	
carisoprodol (Soma)	T1	
carisoprodol-aspirin	T1	
chlorzoxazone (Lorzone)	T1	
CYCLOBENZAPRINE ER	T1	ST
cyclobenzaprine hcl	T1	
cyclobenzaprine hcl (Amrix)	T1	
cyclobenzaprine hcl (Fexmid)	T1	
DANTRIUM *(dantrolene)*	T3	
dantrolene (Dantrium)	T1	
FEXMID *(cyclobenzaprine hcl)*	T3	PA
LORZONE *(chlorzoxazone)*	T3	PA
metaxalone (Skelaxin)	T1	
methocarbamol	T1	

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MUSCLE RELAXANTS (Pain Relief And Inflammatory Disease) (cont.)		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
SKELETAL MUSCLE RELAXANTS (cont.)		
NORGESIC FORTE	T3	
orphenadrine	T1	
orphenadrine-aspirin-caffeine (Norgesic Forte)	T1	
orphengesic forte (Norgesic Forte)	T1	
ROBAXIN *(methocarbamol)*	T3	
SKELAXIN *(metaxalone)*	T3	
SOMA *(carisoprodol)*	T3	
tizanidine hcl (Zanaflex)	T1	
ZANAFLEX *(tizanidine hcl)*	T3	
PRE-NATAL VITAMINS (Nutritional/Dietary)		
PRENATAL VITAMIN PREPARATIONS		
daily prenatal	T1	PPACA
perry prenatal tablet (Perry Prenatal)	T1	PPACA
prenatal	T1	PPACA
prenatal complete	T1	PPACA
prenatal formula	T1	PPACA
prenatal multi + dha	T1	PPACA
prenatal vitamin	T1	PPACA
prenavite (Classic Prenatal)	T1	PPACA
PSYCHOTHERAPEUTIC DRUGS (Anxiety/Depression/Bipolar Disorder)[8]		
ALPHA-2 RECEPTOR ANTAGONIST ANTI-DEPRESSANTS		
alprazolam (Xanax)	T1	
alprazolam er (Xanax XR)	T1	
alprazolam intensol	T1	
mirtazapine	T1	HD
mirtazapine (Remeron)	T1	HD
REMERON *(mirtazapine)*	T3	HD
ANTI-ANXIETY - BENZODIAZEPINES		
alprazolam odt	T1	
alprazolam xr (Xanax XR)	T1	
ATIVAN *(lorazepam)*	T3	
chlordiazepoxide hcl	T1	
clorazepate di (Tranxene T-Tab)	T1	

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PSYCHOTHERAPEUTIC DRUGS (Anxiety/Depression/Bipolar Disorder)[8] (cont.)		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
ANTI-ANXIETY - BENZODIAZEPINES (cont.)		
diazepam (Valium)	T1	
lorazepam (Ativan)	T1	
lorazepam intensol	T1	
oxazepam	T1	
TRANXENE T-TAB *(clorazepate dipotassium)*	T3	
ANTI-ANXIETY DRUGS		
buspirone hcl	T1	
meprobamate	T1	
ANTIDEPRESSANT - POSTPARTUM DEPRESSION (PPD)		
ZURZUVAE	T2	
BIPOLAR DISORDER DRUGS		
EQUETRO	T3	HD
lithium	T1	HD
lithium carbonate (Lithobid)	T1	HD
LITHOBID *(lithium carbonate er)*	T3	HD
MAOIS -NON-SELECTIVE, IRREVERSIBLE ANTI-DEPRESSANTS		
MARPLAN	T3	
NARDIL (phenelzine)	T3	
PARNATE (tranylcypromine)	T3	
phenelzine (Nardil)	T1	
tranylcypromine (Parnate)	T1	
MONOAMINE OXIDASE (MAO) INHIBITOR ANTI-DEPRESSANTS		
EMSAM	T3	
NOREPINEPHRINE AND DOPAMINE REUPTAKE INHIB (NDRIs)		
bupropion hcl	T1	HD
bupropion hcl er (Wellbutrin SR)	T1	QL HD
bupropion hcl xl 300 mg tablet (Wellbutrin SR)	T1	QL(30 tabs/30 days) HD
bupropion hcl xl 150 mg tablet (Wellbutrin XI)	T1	
bupropion hcl xl 300 mg tablet (Wellbutrin XI)	T1	
BUPROPION HCL XL	T3	ST QL (30 units/30 days) HD
FORFIVO XL	T3	ST QL (30 units/30 days) HD
SELECTIVE SEROTONIN 5-HT2A INVERSE AGONISTS (SSIAs)		
NUPLAZID	T3	PA QL SP HD

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PSYCHOTHERAPEUTIC DRUGS (Anxiety/Depression/Bipolar Disorder)[8] (cont.)		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
SELECTIVE SEROTONIN REUPTAKE INHIBITOR (SSRIs)		
escitalopram 5 mg tablet (Lexapro)	T1	
escitalopram 10 mg tablet (Lexapro)	T1	
escitalopram 20 mg tablet (Lexapro)	T1	
fluoxetine dr	T1	QL ST HD
fluoxetine hcl (Sarafem)	T1	HD
fluvoxamine maleate	T1	QL HD
paroxetine er (Paxil CR)	T1	QL HD
paroxetine hcl (Paxil)	T1	ST HD
PAXIL *(paroxetine hcl)*	T3	ST QL HD
PAXIL CR *(paroxetine cr)*	T3	ST QL HD
SARAFEM *(fluoxetine hcl)*	T3	ST QL (30 units/30 days) HD
vilazodone-hctz tablets	T1	QL ST
SEROTONIN-2 ANTAGONIST/REUPTAKE INHIBITORS (SARIs)		
nefazodone hcl	T1	HD
trazodone hcl	T1	HD
SEROTONIN-NOREPINEPHRINE REUPTAKE-INHIB (SNRIs)		
desvenlafaxine succinate er (Pristiq)	T1	QL (30 units/30 days) HD
duloxetine hcl	T1	QL (30 units/30 days) HD
duloxetine hcl (Cymbalta)	T1	QL HD
FETZIMA ER TITRATION PACK	T2	ST QL(1 pack/30 days) HD
venlafaxine hcl	T1	QL HD
venlafaxine hcl er	T1	QL (30 units/30 days) HD
venlafaxine hcl er 150 mg cap (Effexor Xr)	T1	
venlafaxine hcl er 37.5 mg cap (Effexor Xr)	T1	
venlafaxine hcl er 75 mg cap (Effexor Xr)	T1	
SSRI, SEROTONIN RECEPTOR MODULATOR ANTI-DEPRESSANTS		
TRINTELLIX	T3	ST QL (30 units/30 days) HD
TRICYCLIC ANTI-DEPRESSANT-BENZODIAZEPINE COMBINATNS		
amitriptyline/chlordiazepoxide	T1	HD
amitriptyline-perphenazine	T1	HD
TRICYCLIC ANTI-DEPRESSANTS, REL.NON-SEL.REUPT-INHIB		
amitriptyline hcl	T1	HD
amoxapine	T1	HD

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

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PSYCHOTHERAPEUTIC DRUGS (Attention Deficit Hyperactivity Disorder)[8] (cont.)		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
TX FOR ATTENTION DEFICIT-HYPERACT (ADHD)/NARCOLEPSY		
APTENSIO XR	T3	ST
COTEMPLA XR-ODT	T3	ST
DAYTRANA	T2	ST
dexmethylphenidate hcl (Focalin)	T1	
dexmethylphenidate hcl er (Focalin XR)	T1	
JORNAY PM	T3	ST
METHYLIN *(methylphenidate hcl)*	T3	
methylphenidate er	T1	
methylphenidate er (Concerta)	T1	
methylphenidate er 18 mg tab (Relexxii)	T1	
methylphenidate er 27 mg tab (Relexxii)	T1	
methylphenidate er 36 mg tab (Relexxii)	T1	
methylphenidate er 54 mg tab (Relexxii)	T1	
methylphenidate er (Ritalin LA)	T1	
methylphenidate hcl	T1	
methylphenidate hcl (Metadate Cd)	T1	
methylphenidate hcl (Methylin)	T1	
methylphenidate hcl (Ritalin)	T1	
methylphenidate hcl cd	T1	
methylphenidate la	T1	
methylphenidate la (Ritalin La)	T1	
QELBREE ER	T3	ST
RITALIN *(methylphenidate hcl)*	T3	
RITALIN LA *(methylphenidate er (la))*	T3	ST
TX FOR ATTENTION DEFICIT-HYPERACT.(ADHD), NRI-TYPE		
atomoxetine hcl (Strattera)	T1	HD
PSYCHOTHERAPEUTIC DRUGS (Schizophrenia/Anti-Psychotics)[8]		
ANTI-PSYCH, DOPAMINE ANTAG., DIPHENYLBUTYLPIPERIDINES		
pimozide	T1	
ANTI-PSYCHOTIC,ATYPICAL,DOPAMINE,SEROTONIN ANTAGNST		
clozapine (Clozaril)	T1	
clozapine odt	T1	
CLOZAPINE ODT	T3	

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Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
ANTI-PSYCHOTIC,ATYPICAL,DOPAMINE,SEROTONIN ANTAGNST (cont.)		
CLOZARIL *(clozapine)*	T3	
FANAPT	T3	QL (1 pack/1 time use)
GEODON *(ziprasidone hcl)*	T3	QL
INVEGA *(paliperidone er)*	T3	QL
olanzapine odt (Zyprexa Zydis)	T1	QL (30 units/30 days)
quetiapine fumarate 100 mg tab (Seroquel)	T1	
quetiapine fumarate 25 mg tab (Seroquel)	T1	
quetiapine fumarate 400 mg tab (Seroquel)	T1	
quetiapine fumarate 50 mg tab (Seroquel)	T1	
quetiapine fumarate er (Seroquel XR)	T1	QL
RISPERDAL *(risperidone)*	T3	QL
risperidone (Risperdal)	T1	QL
risperidone odt	T1	QL
SECUADO	T3	QL
VERSACLOZ	T3	
ziprasidone hcl (Geodon)	T1	QL
ZYPREXA *(olanzapine)*	T3	QL (30 units/30 days)
ZYPREXA ZYDIS *(olanzapine odt)*	T3	QL (30 units/30 days)
ANTI-PSYCHOTIC-ATYPICAL, D3/D2 PARTIAL AG-5HT MIXED		
CAPLYTA 10.5MG, 21MG CAPSULE	T3	QL (30 caps/30 days)
VRAYLAR	T3	QL (7 caps/1 time use)
ANTIPSYCHOTICS, ATYP, D2 PARTIAL AGONIST/5HT MIXED		
ABILIFY ASIMTUFII 720MG/2.4ML, 960MG/3.2ML	T3	
ABILIFY MYCITE	T3	QL (30 units/30 days)
aripiprazole	T1	
aripiprazole (Abilify)	T1	QL (30 units/30 days)
aripiprazole 15 mg tablet (Abilify)	T1	
aripiprazole odt	T1	QL
REXULTI	T3	QL (30 units/30 days)
ANTI-PSYCHOTICS, DOPAMINE AND SEROTONIN ANTAGONISTS		
ADASUVE	T3	
loxapine succinate	T1	
ANTI-PSYCHOTICS, DOPAMINE ANTAGONISTS, THIOXANTHENES		
thiothixene	T1	

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Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
ANTI-PSYCHOTICS, DOPAMINE ANTAGONISTS, BUTYROPHENONES		
haloperidol	T1	
haloperidol lactate	T1	
ANTI-PSYCHOTICS, DOPAMINE ANTAGONST, DIHYDROINDOLONES		
molindone hcl	T1	
ANTI-PSYCHOTICS, PHENOTHIAZINES		
chlorpromazine hcl	T1	
fluphenazine hcl	T1	
perphenazine	T1	
thioridazine hcl	T1	
trifluoperazine hcl	T1	
SSRI-ANTI-PSYCH, ATYPICAL, DOPAMINE, SEROTONIN ANTAG		
olanzapine-fluoxetine hcl (Symbyax)	T1	
SYMBYAX *(olanzapine-fluoxetine hcl)*	T3	
PSYCHOTHERAPEUTIC DRUGS (Sleep Disorders/Sedatives)		
NARCOLEPSY AND SLEEP DISORDER THERAPY AGENTS		
armodafinil (Nuvigil)	T1	PA QL (30 units/30 days)
SUNOSI	T2	PA QL (30 units/30 days)
ANTI-NARCOLEPSY, ANTI-CATAPLEXY, SEDATIVE-TYPE AGENT		
LUMRYZ ER	T3	PA SP HD QL (30 packets/30 days)
SODIUM OXYBATE	T2	PA SP HD QL (540 ml/30 days)
XYREM	T2	QL (540 ml/ 30 days) SP HD
XYWAV	T2	QL (540 ml/ 30 days)
BARBITURATES		
phenobarbital	T1	
seconal (Seconal Sodium)	T1	QL (30 units/30 days)
HYPNOTICS, MELATONIN MT1/MT2 RECEPTOR AGONISTS		
HETLIOZ	T3	PA QL (30 units/30 days) SP HD
ramelteon (Rozerem)	T1	QL (30 units/30 days)
SEDATIVE-HYPNOTICS - BENZODIAZEPINES		
estazolam	T1	
flurazepam hcl	T1	
HALCION *(triazolam)*	T3	
midazolam hcl	T1	
RESTORIL *(temazepam)*	T3	

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List of Prescription Medications

PSYCHOTHERAPEUTIC DRUGS (Sleep Disorders/Sedatives) (cont.)		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
SEDATIVE-HYPNOTICS - BENZODIAZEPINES (cont.)		
temazepam (Restoril)	T1	
triazolam (Halcion)	T1	
SEDATIVE-HYPNOTICS, NON-BARBITURATE		
BELSOMRA	T3	ST QL (30 units/30 days)
doxepin hcl (Silenor)	T1	QL (30 units/30 days)
EDLUAR	T3	ST QL (30 units/30 days)
eszopiclone (Lunesta)	T1	QL (30 units/30 days)
INTERMEZZO *(zolpidem tartrate)*	T3	ST QL (30 units/30 days)
KETAMINE HCL	T3	
MKO (MIDAZOLAM-KETAMINE-ONDAN)	T3	
QUVIVIQ	T3	ST
SILENOR *(doxepin hcl)*	T3	ST QL (30 units/30 days)
zaleplon	T1	QL
zolpidem tartrate	T1	QL (30 units/30 days)
zolpidem tartrate (Ambien)	T1	QL (30 units/30 days)
zolpidem tartrate (Intermezzo)	T1	QL (30 units/30 days)
zolpidem tartrate er (Ambien CR)	T1	QL (30 units/30 days)
ZOLPIMIST	T3	ST QL
SKIN PREPS (Miscellaneous)		
IRRIGANTS		
acetic acid	T1	
neomycin-polymyxin b	T1	
PHYSIOLYTE	T3	
PHYSIOSOL	T3	
OXIDIZING AGENTS		
hydrogen peroxide	T1	
SKIN PREPS (Pain Relief And Inflammatory Disease)		
ANTI-PSORIATIC AGENTS, SYSTEMIC		
acitretin	T1	
methoxsalen (Oxsoralen-Ultra)	T1	
OXSORALEN-ULTRA *(methoxsalen)*	T3	
SKYRIZI (2 SYRINGES) KIT	T2	PA QL (1 kit/30 days) SP HD
SORIATANE *(acitretin)*	T3	

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List of Prescription Medications

SKIN PREPS (Pain Relief And Inflammatory Disease) (cont.)		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
ANTI-PSORIATIC AGENTS, SYSTEMIC (cont.)		
TALTZ	T2	PA QL (1ml/21 days) SP HD
TREMFYA	T2	PA QL SP HD
TOPICAL ANTI-INFLAMMATORY, NSAIDS		
diclofenac	T1	QL ST HD
diclofenac 2% solution pump (Pennsaid)	T1	
FLECTOR	T2	ST QL
VOLTAREN *(arthritis pain)*	T3	ST QL (500gm/21 days) HD
SKIN PREPS (Skin Conditions)		
ACNE AGENTS, SYSTEMIC		
ABSORICA	T2	ST
ABSORICA LD	T3	
amnesteem (Absorica)	T1	
claravis (Absorica)	T1	
isotretinoin (Absorica)	T1	
isotretinoin authorized generics by Sun pharmaceuticals	T1	ST
myorisan (Absorica)	T1	
zenatane (Absorica)	T1	
ACNE AGENTS, TOPICAL		
ACZONE *(dapsone)*	T3	ST
adapalene-benzoyl peroxide (Epiduo)	T1	
AZELEX	T3	ST
BENZACLIN *(clindamycin-benzoyl peroxide)*	T3	ST
clindamycin phos-tretinoin (Veltin)	T1	PA
clindamycin-benzoyl peroxide	T1	
clindamycin-benzoyl peroxide (Acanya)	T1	
clindamycin-benzoyl peroxide (Benzaclin)	T1	
clindamycin/tretinoin (Veltin)	T1	
dapsone (Aczone)	T1	
EPIDUO FORTE GEL PUMP	T3	ST
KLARON *(sulfacetamide)*	T3	ST
neuac	T1	
ONEXTON *(clindamycin phos/benzoyl perox)*	T3	ST
ONEXTON	T2	ST

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SKIN PREPS (Skin Conditions) (cont.)		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
ACNE AGENTS, TOPICAL (cont.)		
sulfacetamide (Klaron)	T1	
ZIANA *(clindamycin phos-tretinoin)*	T3	PA ST
ANTI-PRURITICS, TOPICAL		
doxepin hcl (Prudoxin)	T1	QL (45 gm/23 days)
prudoxin (Prudoxin)	T1	QL (45 gm/23 days)
ZONALON *(doxepin hcl)*	T3	ST QL (90 grams/30 days)
ANTI-PSORIATICS AGENTS		
calcipotriene (Dovonex)	T1	QL (120/23 days)
calcitriol (Vectical)	T1	
DOVONEX *(calcipotriene)*	T3	QL (120/23 days)
DUOBRII	T3	ST QL (200 gm/23 days)
tazarotene cream (Tazorac)	T1	PA
TAZORAC	T2	PA
VECTICAL *(calcitriol)*	T3	
VTAMA	T3	PA ST QL (1 tube/28 days)
ZORYVE	T3	PA ST QL(60 gms/28 days)
ANTI-SEBORRHEIC AGENTS		
ESKATA	T3	
OVACE *(sulfacetamide)*	T3	
OVACE PLUS	T3	
selenium sulfide (Selrx)	T1	
SELRX	T3	
sulfacetamide (Ovace Plus Wash)	T1	
sulfacetamide (Ovace Plus)	T1	
sulfacetamide (Ovace)	T1	
VTAMA	T3	PA QL
ZORYVE	T3	PA QL (60 grams/21 days)
DIABETIC ULCER PREPARATIONS, TOPICAL		
REGRANEX	T2	QL
IMMUNOMODULATORS		
ALDARA *(imiquimod)*	T3	
imiquimod (Aldara)	T1	
KERATOLYTICS		
benzepro	T1	

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KERATOLYTICS (cont.)		
BENZEPRO *(benzepro)*	T3	ST
benzoyl peroxide	T1	
CONDYLOX	T3	ST QL (7 grams/30 days)
ENZOCLEAR	T3	ST
INOVA	T3	ST
INOVA 4-1	T3	ST
INOVA 8-2	T3	ST
podofilox 0.5% gel	T1	ST QL(7 gms/30 days)
podofilox 0.5% topical soln	T1	
PR BENZOYL PEROXIDE *(benzepro)*	T3	ST
PROTECTIVES		
PHARMABASE *(pharmabase barrier)*	T3	
zinc oxide	T1	
ROSACEA AGENTS, TOPICAL		
azelaic acid (Finacea)	T1	
EPSOLAY	T3	
FINACEA *(azelaic acid)*	T3	ST
ivermectin 1% cream (Soolantra)	T1	QL(45 gms/30 days)
METROCREAM *(metronidazole)*	T3	ST
METROGEL *(metronidazole)*	T3	ST
METROLOTION *(metronidazole)*	T3	ST
metronidazole	T1	
metronidazole (Metrocream)	T1	
metronidazole (Metrogel)	T1	
metronidazole (Metrolotion)	T1	
MIRVASO	T2	PA
NORITATE	T3	ST
RHOFADE	T3	PA
ROSADAN	T3	ST
rosadan (Metrocream)	T1	
TISSUE/WOUND ADHESIVES		
ARTISS	T3	
TISSEEL VHSD	T3	

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SKIN PREPS (Skin Conditions) (cont.)		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
TOP. ANTI-INFLAM., PHOSPHODIESTERASE-4 (PDE4) INHIB		
EUCRISA	T2	ST QL(120 gms/30 days)
ZORYVE	T3	
TOPICAL AGENTS, MISCELLANEOUS		
HYFTOR 0.2% GEL	T3	PA
TOPICAL ANTIBIOTIC PLEUROMUTILIN DERIVATIVES		
ALTABAX	T3	ST QL (30 units/30 days)
TOPICAL ANTICHOLINERGIC HYPERHIDROSIS TX AGENTS		
QBREXZA	T3	PA
TOPICAL ANTI-INFLAMMATORY STEROIDAL		
ALA-SCALP HP *(hydrocortisone)*	T3	ST
alclometasone dipropionate	T1	
amcinonide	T1	
apexicon e	T1	
beser (Cutivate)	T1	
betamethasone	T1	
betamethasone dipropionate	T1	
betamethasone valer 0.12% foam	T1	ST
BRYHALI	T3	ST
CAPEX SHAMPOO	T3	ST
clobetasol e	T1	QL (120gm/23 days)
clobetasol emollnt 0.05% foam	T1	ST QL(100 gms/30 days)
clobetasol propionate/emoll	T1	ST QL(100 gms/30 days)
clobetasol emulsion (Olux-E)	T1	QL (100 units/23 days)
clobetasol propionate	T1	QL
CLOBEX SHAMPOO *(clobetasol propionate)*	T3	ST QL (263ml/23 days)
CLOBEX SPRAY *(clobetasol propionate)*	T3	ST QL (125ml/23 days)
CLOBEX TOPICAL LOTION *(clobetasol propionate)*	T3	ST QL (118ml/23 days)
clocortolone (Cloderm)	T1	QL
CLODAN	T3	ST
clodan (Clobex)	T1	QL (263ml/23 days)
CLODERM	T3	ST
CORDRAN	T3	ST QL
CUTIVATE *(beser)*	T3	ST
DERMA-SMOOTHE-FS *(fluocinolone acetonide)*	T3	ST

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SKIN PREPS (Skin Conditions) (cont.)		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
TOPICAL ANTI-INFLAMMATORY STEROIDAL (cont.)		
DESONATE	T3	ST
desonide (Desowen)	T1	
DESOWEN *(desonide)*	T3	ST
desoximetasone (Topicort)	T1	
diflorasone diacetate	T1	QL (120gm/23 days)
DIPROLENE *(betamethasone diprop augmented)*	T3	ST
fluocinolone acetonide	T1	
fluocinonide	T1	QL
fluocinonide-e	T1	QL (120 gm/23 days)
flurandrenolide (Cordran)	T1	QL
fluticasone propionate	T1	
halcinonide (Halog)	T1	
halobetasol prop 0.05% cream	T1	
halobetasol prop 0.05% foam	T1	ST
halobetasol prop 0.05% ointmnt	T1	
HALOG *(halcinonide)*	T3	ST
hydrocortisone	T1	
hydrocortisone butyrate	T1	ST QL (10gm/28 days)
hydrocortisone butyrate (Locoid Lipocream)	T1	QL (120gm/23 days)
hydrocortisone butyrate (Locoid)	T1	QL (118ml/23 days)
IMPEKLO	T3	ST QL (136 gm/28 days)
IMPOYZ	T3	ST QL (120 gm/23 days)
KENALOG *(triamcinolone acetonide)*	T3	ST QL
LEXETTE	T3	ST
mometasone	T1	
nolix (Cordran)	T1	QL
NUCORT	T3	ST
OLUX *(clobetasol propionate)*	T3	ST QL (100 units/23 days)
PANDEL	T3	ST
prednicarbate	T1	
procto-med hc	T1	
procto-pak	T1	
proctosol-hc	T1	
proctozone-hc	T1	

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SKIN PREPS (Skin Conditions) (cont.)		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
TOPICAL ANTI-INFLAMMATORY STEROIDAL (cont.)		
PSORCON *(diflorasone di)*	T3	ST QL (120gm/23 days)
SCALACORT DK	T3	ST
SERNIVO	T3	ST
SYNALAR *(fluocinolone acetonide)*	T3	ST
SYNALAR TS	T3	ST
TEMOVATE *(clobetasol propionate)*	T3	ST QL (120 gm/23 days)
TEXACORT	T3	ST
TOPICORT *(desoximetasone)*	T3	ST
tovet emollient (Olux-E)	T1	QL (100 units/23 days)
triamcinolone acetonide	T1	
triamcinolone acetonide (Kenalog)	T1	QL
trianex	T1	
triderm	T1	
TRIDESILON *(desonide)*	T3	ST
ULTRAVATE	T3	ST
TOPICAL ANTI-INFLAMMATORY STEROID-LOCAL ANESTHETIC		
ANALPRAM-HC *(hc pramoxine)*	T3	ST
EPIFOAM	T3	ST
hc pramoxine (Pramosone)	T1	
lidocaine-hc	T1	
PRAMOSONE	T3	ST
TOPICAL ANTI-PARASITICS		
lindane	T1	
malathion (Ovide)	T1	
OVIDE *(malathion)*	T3	
TOPICAL PREPARATIONS, ANTIBACTERIALS		
iodine	T1	
iodine (Lugol'S)	T1	
IODOFLEX	T3	
IODOSORB	T3	
TOPICAL VIT D ANALOG/ANTI-INFLAMMATORY STEROID		
calcipotriene-betamethasone (Taclonex)	T1	QL (60 gm/23 days)
calcipotriene-betamethasone dp (Taclonex)	T1	QL (60 gm/23 days)
ENSTILAR	T2	QL (60 gm/23 days)

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SKIN PREPS (Skin Conditions) (cont.)		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
TOPICAL VIT D ANALOG/ANTI-INFLAMMATORY STEROID (cont.)		
ENSTILAR FOAM	T2	QL ST
TACLONEX *(calcipotriene-betamethasone dp)*	T3	QL
TOPICAL/MUCOUS MEMBR./SUBCUT. ENZYMES		
SANTYL	T2	QL
VITAMIN A DERIVATIVES		
adapalene (Differin)	T1	
AKLIEF	T3	PA ST
ALTRENO	T3	PA
AVITA	T3	PA
avita (Avita)	T1	PA
DIFFERIN *(adapalene)*	T3	ST
RETIN-A *(tretinoin)*	T3	PA
tretinoin	T1	
tretinoin (Atralin)	T1	PA
tretinoin (Avita)	T1	PA
tretinoin microsphere (Retin-A Micro Pump)	T1	PA
tretinoin microsphere (Retin-A Micro)	T1	PA
VITAMIN A DERIVATIVES, TOPICAL ACNE AGENTS		
FABIOR	T3	PA
SMOKING DETERRENTS (Smoking Cessation)[8]		
SMOKING DETERRENT AGENTS (GANGLIONIC STIM, OTHERS)		
NICODERM CQ *(nicoderm cq)*	T2	QL (180 days supply/365 days) PPACA
NICODERM CQ *(nicotine patch)*	T2	QL (180 days supply/365 days) PPACA
nicorelief (Nicorette)	T1	QL (180 days supply/365 days) PPACA
NICORETTE	T2	QL (180 days supply/365 days) PPACA
NICORETTE *(nicorelief)*	T2	QL (180 days supply/365 days) PPACA
NICORETTE *(nicotine gum)*	T2	QL (180 days supply/365 days) PPACA
nicotine	T1	QL (180 days supply/365 days) PPACA
nicotine (Nicoderm CQ)	T1	QL (180 days supply/365 days) PPACA
nicotine (Nicorette)	T1	QL (180 days supply/365 days) PPACA
nicotine gum (Nicorette)	T1	QL (180 days supply/365 days) PPACA
NICOTROL	T3	QL (180 days supply/365 days)
NICOTROL NS	T3	QL (180 days supply/365 days)
quit 2 (Nicorette)	T1	QL (180 days supply/365 days) PPACA

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SMOKING DETERRENTS (Smoking Cessation)[8] (cont.)		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
SMOKING DETERRENT AGENTS (GANGLIONIC STIM, OTHERS) (cont.)		
quit 4 (Nicorette)	T1	QL (180 days supply/365 days) PPACA
stop smoking aid (Nicorette)	T1	QL (180 days supply/365 days) PPACA
SMOKING DETERRENT-NICOTINIC RECEPT.PARTIAL AGONIST		
CHANTIX	T3	QL (180 Days Supply/365 Days)
varenicline starting month box	T1	
SMOKING DETERRENTS, OTHER		
bupropion sr	T1	QL (180 days supply/365 days) PPACA
THYROID PREPS (Hormonal Agents)		
ANTI-THYROID PREPARATIONS		
methimazole (Tapazole)	T1	HD
propylthiouracil	T1	HD
TAPAZOLE *(methimazole)*	T3	HD
THYROID HORMONES		
adthyza 15 mg tablet	T1	HD
adthyza 30 mg tablet	T1	HD
adthyza 60 mg tablet	T1	HD
adthyza 90 mg tablet	T1	HD
adthyza 120 mg tablet	T1	HD
ERMEZA SOLUTION	T3	ST HD
EUTHYROX (Euthyroxlevothyroxine)	T1	HD
LEVO-T (Euthyroxlevothyroxine)	T1	HD
LEVO-T (Levo-Tlevothyroxine)	T1	HD
levothyroxine	T1	HD
levoxyl (Euthyrox)	T1	HD
liothyronine (Cytomel)	T1	HD
nature-throid	T1	
np thyroid (Armour Thyroid)	T1	HD
thyroid (Armour Thyroid)	T1	
unithroid (Euthyrox)	T1	HD
unithroid (Levo-T)	T1	HD
westhroid	T1	HD

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UNCLASSIFIED DRUG PRODUCTS (AIDS/HIV)		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
CYTOCHROME P450 INHIBITORS		
TYBOST	T3	SP
UNCLASSIFIED DRUG PRODUCTS (Asthma/COPD/Respiratory)		
CYSTIC FIBROSIS-CFTR POTENTIATOR-CORRECTOR COMBIN.		
BRONCHITOL 40 MG INHALE CAPSULE	T3	PA SP
ORKAMBI	T2	PA QL (56 packets/28 days) SP HD
SYMDEKO	T2	PA QL SP HD
TRIKAFTA 80-40-60MG/59.5MG PKT	T2	SP PA HD QL (56 packets/28 days)
TRIKAFTA 100-50-75 MG/75MG PKT	T2	SP PA HD QL (56 packets/28 days)
CYSTIC FIB-TRANSMEMB CONDUCT.REG.(CFTR) POTENTIATOR		
KALYDECO 5.8 MG GRANULES PKT	T2	PA QL(56 packs/fill) SP HD
KALYDECO 13.4MG GRANULES PKT	T2	PA SP QL (56 packets/28 days)
LUNG SURFACTANTS		
CUROSURF	T3	
INFASURF	T3	
SURVANTA	T3	
MUCOLYTICS		
PULMOZYME	T2	SP HD
PULMONARY FIBROSIS - SYSTEMIC ENZYME INHIBITORS		
OFEV	T2	PA QL SP HD
SYSTEMIC ENZYME INHIBITORS		
JOENJA 70 MG TABLET	T3	PA SP QL (60 tabs/30 days)
VIJOICE	T2	SP PA QL (28 tabs/30 days)
ZOKINVY	T3	PA QL (max 120 caps/30 days)
THYMIC STROMAL LYMPHOPOIETIN (TSLP) INHIBITORS		
TEZSPIRE 210 MG/1.91 ML PEN	T2	SP PA HD QL (1 pen/28 days)
TEZSPIRE 210 MG/1.91 ML SYRING	T2	SP PA HD QL (1 syringe/28 days)
UNCLASSIFIED DRUG PRODUCTS (Blood Pressure/Heart Medications)		
BRADYKININ B2 RECEPTOR ANTAGONISTS		
icatibant (Firazyr)	T1	PA SP HD
CI ESTERASE INHIBITORS		
CINRYZE	T2	PA SP HD
HAEGARDA 2,000UNIT VIAL	T3	PA SP HD QL (24 vials/28 days)
HAEGARDA 3,000UNIT VIAL	T3	PA SP HD QL (16 vials/28 days)
RUCONEST	T2	PA SP HD

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UNCLASSIFIED DRUG PRODUCTS (Blood Pressure/Heart Medications) (cont.)		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
PLASMA KALLIKREIN INHIBITORS		
KALBITOR	T3	PA SP HD
ORLADEYO 110MG, 150MG CAPSULE	T3	PA SP QL (28 caps/28 days)
TAKHZYRO 300MG/2ML	T2	PA SP HD QL (2 units/28 days)
UNCLASSIFIED DRUG PRODUCTS (Cancer)		
ANTINEOPLASTIC - ANTIMETABOLITES		
FLUOROURACIL	T2	
CHEMOTHERAPY RESCUE/ANTIDOTE AGENTS		
leucovorin	T1	
MESNEX	T2	SP
VISTOGARD 10GM PKT	T2	PA QL(20 pkts/30days) SP
UNCLASSIFIED DRUG PRODUCTS (Dental Products)		
DENTAL AIDS AND PREPARATIONS		
chlorhexidine gluconate	T1	
oralone	T1	
PERIDEX *(chlorhexidine gluconate)*	T3	
periogard	T1	
triamcinolone acetonide	T1	
PERIODONTAL COLLAGENASE INHIBITORS		
doxycycline hyclate	T1	
UNCLASSIFIED DRUG PRODUCTS (Erectile Dysfunction)		
DRUGS TO TREAT ERECTILE DYSFUNCTION (ED)		
CIALIS *(tadalafil)*	T3	
tadalafil 2.5 mg tablet	T1	PA QL(8 tabs/30 days)
tadalafil 5 mg tablet (Cialis)	T1	
tadalafil 10 mg tablet (Cialis)	T1	
tadalafil 20 mg tablet (Cialis)	T1	
UNCLASSIFIED DRUG PRODUCTS (Eye Conditions)		
NICOTINIC RECEPT.PARTIAL AGONIST, ALPHA4BETA2 SPEC		
TYRVAYA 0.03 MG NASAL SPRAY	T3	PA
UNCLASSIFIED DRUG PRODUCTS (Gastrointestinal/Heartburn)		
AGENTS FOR STOMATOLOGICAL USE		
PROTHELIAL	T3	

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List of Prescription Medications

UNCLASSIFIED DRUG PRODUCTS (Gastrointestinal/Heartburn) (cont.)		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
CALCIMIMETIC, PARATHYROID CALCIUM ENHANCER		
cinacalcet hcl (Sensipar)	T1	SP
ORAL MUCOSITIS/STOMATITIS AGENTS		
GELCLAIR	T3	
ORAMAGICRX	T3	
ORAL MUCOSITIS/STOMATITIS ANTI-INFLAMMATORY AGENT		
EPISIL	T3	
SALIVA STIMULANT AGENTS		
NUMOISYN	T3	
SALIVA SUBSTITUTE AGENTS		
AQUORAL	T3	
BOCASAL	T3	
CAPHOSOL	T3	
MUCOSITISRX	T3	
NEUTRASAL	T3	
NUMOISYN	T3	
SALIVAMAX	T3	
UNCLASSIFIED DRUG PRODUCTS (Hormonal Agents)		
BONE FORMATION STIM. AGENTS - PARATHYROID HORMONE		
FORTEO	T2	PA QL (1 pen/21 days) SP HD
teriparatide 600 mcg/2.4ml pen	T1	PA QL(1 pen/28 days) SP HD
TERIPARATIDE 620 MCG/2.48 ML	T3	PA QL(1 pen/28 days) SP HD
BONE RESORPTION INHIBITORS		
ibandronate	T1	QL(1 tab/30 days) HD
GROWTH HORMONE RECEPTOR ANTAGONISTS		
SOMAVERT	T2	SP HD
HYPERPARATHYROID TX AGENTS - VITAMIN D ANALOG-TYPE		
doxercalciferol	T1	
paricalcitol	T1	SP HD
paricalcitol (Zemplar)	T1	SP HD
RAYALDEE	T3	
ZEMPLAR *(paricalcitol)*	T3	SP HD

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List of Prescription Medications

UNCLASSIFIED DRUG PRODUCTS (Miscellaneous)		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
ABORTIFACIENT-PROGESTERONE RECEPTOR ANTAGONISTS		
MIFEPREX	T3	
mifepristone 200 mg tablet	T1	
mifepristone (Mifeprex)	T1	
AMMONIA INHIBITORS		
CARBAGLU	T2	SP HD
AMYLOIDOSIS AGENTS-TRANSTHYRETIN (TTR) SUPPRESSION		
TEGSEDI	T2	PA SP HD QL (4 syr/28 days)
ANTI-ALCOHOLIC PREPARATIONS		
acamprosate	T1	
ANTABUSE *(disulfiram)*	T3	
disulfiram (Antabuse)	T1	
ANTI-FIBROTIC THERAPY - PYRIDONE ANALOGS		
ESBRIET	T3	PA QL(90 tabs/30 days) SP ST HD
pirfenidone 267mg capsules	T1	PA SP HD QL (270 caps/30 days)
pirfenidone 267 mg tablet (Esbriet)	T1	
pirfenidone 801 mg tablet (Esbriet)	T1	
CRYOPRESERVATIVE AGENTS		
cryoserv	T1	
DRUGS TO TREAT HEREDITARY TYROSINEMIA		
nitisinone (Orfadin)	T1	PA SP HD
NITYR	T2	PA SP
ORFADIN *(nitisinone)*	T3	PA SP
DRUGS TO TX GAUCHER DX-TYPE I, SUBSTRATE REDUCING		
CERDELGA	T2	PA SP HD QL (56 caps/28 days)
GENERAL INHALATION AGENTS		
chloride	T1	
HYPER-SAL	T3	
nebusal	T1	
NEBUSAL	T3	
pulmosal	T1	
GLUCOSYLCERAMIDE SYNTHASE (GCS) INHIBITOR		
miglustat (Zavesca)	T1	PA QL(90 caps/30 days) SP
OPFOLDA	T3	PA QL(8 caps/fill) SP HD

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UNCLASSIFIED DRUG PRODUCTS (Miscellaneous) (cont.)		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
MENOPAUSAL SYMPTOMS SUPPRESSANT-NK3 RECEPTOR ANTAG		
VEOZAH	T2	
MENOPAUSAL SYMPTOMS SUPPRESSANT - SSRIs		
paroxetine mesylate (Brisdelle)	T1	QL (30 units/30 days) HD
METABOLIC DISEASE ENZYME REPLACE, HYPOPHOSPHATASIA		
STRENSIQ	T2	PA SP
METABOLIC DISEASE ENZYME REPLACEMENT, MOCD		
NULIBRY 9.5 MG VIAL	T3	PA
METABOLIC DISEASE ENZYME REPLACEMENT, POMPE DISEASE		
NEXVIAZYME 100 MG VIAL	T3	PA
METALLIC POISON, AGENTS TO TREAT		
CHEMET	T2	PA
clovique (Syprine)	T1	PA SP HD
deferasirox (Exjade)	T1	PA SP HD
deferasirox (Jadenu)	T1	PA SP HD
deferiprone (Ferriprox)	T1	PA SP HD
*deferiprone (*Ferriprox (3 Times A Day)	T1	PA SP HD
FERRIPROX	T3	PA SP
GALZIN	T3	
RADIOGARDASE	T3	
SYPRINE *(clovique)*	T3	PA SP HD
trientine hcl (Syprine)	T1	PA SP HD
NATRIURETIC PEPTIDES		
VOXZOGO 0.4 MG VIAL	T3	PA SP
PHARMACOLOGICAL CHAPERONE-ALPHA-GALACTOSID.A STABZ		
GALAFOLD	T3	PA QL SP HD
PROTEIN STABILIZERS		
VYNDAMAX	T2	PA SP HD
VYNDAQEL	T2	PA SP HD
RETINOIC ACID RECEPTOR (RAR) AGONISTS		
SOHONOS 1 MG CAPSULE	T3	PA QL(112 caps/fill) SP
SOHONOS 1.5 MG CAPSULE	T3	PA QL(112 caps/fill) SP
SOHONOS 2.5 MG CAPSULE	T3	PA QL(140 caps/fill) SP
SOHONOS 5 MG CAPSULE	T3	PA QL(84 caps/fill) SP
SOHONOS 10 MG CAPSULE	T3	PA QL(56 caps/fill) SP

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UNCLASSIFIED DRUG PRODUCTS (Miscellaneous) (cont.)		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
SOLVENTS		
dy-o-derm	T1	
FT ISOPROPYL ALCOHOL 91%	T3	
FT ISOPROPYL RUB ALCOHOL 70%	T3	
INSTACLEAN	T2	
ISOPROPANOL	T2	
isopropyl alcohol	T1	
ISOPROPYL ALCOHOL	T3	
MURI-LUBE MINERAL OIL	T2	
SUSPENDING AGENTS		
GELFILM	T3	
HYDROXYPROPYLCELLULOSE	T2	
HYPROMELLOSE	T2	
UNCLASSIFIED DRUG PRODUCTS (Multiple Sclerosis)		
LEUKOCYTE ADHESION INHIB,ALPHA4-MEDIAT IGG4K MC AB		
TYSABRI 300 MG/15 ML VIAL	T2	PA QL (15 mL/30 days) HD
UNCLASSIFIED DRUG PRODUCTS (Nutritional/Dietary)		
METABOLIC DEFICIENCY AGENTS		
CARNITOR *(levocarnitine)*	T3	
CARNITOR SF *(levocarnitine sf)*	T3	
CYSTADANE	T2	PA ST SP
levocarnitine (Carnitor)	T1	
levocarnitine sf (Carnitor SF)	T1	
levocarnitine 4 gm/20 ml vial	T1	
UNCLASSIFIED DRUG PRODUCTS (Osteoporosis Products)		
BONE FORMATION STIM. AGENTS - PARATHYROID HORMONE		
teriparatide 600 mcg/2.4ml pen (Forteo)	T1	PA QL(1 pen/28 days) SP HD
FORTEO (teriparatide)	T2	PA QL(1 pens/28 days) SP HD
BONE RESORPTION INHIBITOR AND VITAMIN D COMBS.		
FOSAMAX PLUS D	T3	ST QL (4 tabs/21 days) HD
BONE RESORPTION INHIBITORS		
ACTONEL 150 MG TABLET *(risedronate)*	T3	ST QL (1 tab/23 days) HD
ACTONEL 35 MG TABLET *(risedronate)*	T3	ST QL (4 tabs/21 days) HD
ACTONEL 5 MG TABLET *(risedronate)*	T3	ST QL (30 units/30 days)

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UNCLASSIFIED DRUG PRODUCTS (Osteoporosis Products) (cont.)		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
BONE RESORPTION INHIBITORS (cont.)		
alendronate 10mg tablet	T1	QL (30 units/30 days) HD
alendronate sodium 40mg tablet	T1	HD
alendronate 35mg, 70mg tablets (Fosamax)	T1	QL (4 tabs/ 21 days) HD
alendronate 70 mg/75 ml	T1	QL (4 bottles/21 days) HD
ATELVIA *(risedronate dr)*	T3	ST QL (4 tabs/21 days) HD
BINOSTO	T3	ST QL (4 tabs/21 days) HD
EVISTA *(raloxifene hcl)*	T3	HD
FOSAMAX *(alendronate)*	T3	ST QL (4 tabs/21 days) HD
raloxifene hcl (Evista)	T1	HD PPACA
risedronate	T1	QL HD
risedronate dr (Atelvia)	T1	QL (4 tabs/21 days) HD
UNCLASSIFIED DRUG PRODUCTS (Pain Relief And Inflammatory Disease)		
ANTI-INFLAM. INTERLEUKIN-I RECEPTOR ANTAGONIST		
ARCALYST	T3	PA SP HD
ANTI-INFLAMMATORY, INTERLEUKIN-I BETA BLOCKERS		
ILARIS	T2	PA SP HD
FIBROMYALGIA AGENTS, SEROTONIN-NOREPINEPH RU INHIB		
SAVELLA TITRATION PACK	T2	ST QL (1 pack/30 days) HD
IMMUNOMODULATOR, B-LYMPHOCYTE STIM (BLYS)-SPEC INHIB		
BENLYSTA	T2	PA QL (4ml/28 days) SP HD
UNCLASSIFIED DRUG PRODUCTS (Skin Conditions)		
INTERLEUKIN-13 (IL-13) INHIBITORS, MAB		
ADBRY 150MG/ML SYRINGE	T2	PA SP
JANUS KINASE (JAK) INHIBITORS		
LITFULO	T3	PA QL(28 caps/28 days) SP HD
WOUND HEALING AGENTS, LOCAL		
FILSUVEZ	T3	SP
UNCLASSIFIED DRUG PRODUCTS (Substance Abuse)		
OPIOID WITHDRAWAL THERAPY AGENTS, OPIOID-TYPE		
buprenorphine hydrochloride	T1	
buprenorphine-naloxone (Suboxone)	T1	QL
PROBUPHINE	T3	
SUBOXONE *(buprenorphine-naloxone)*	T3	QL
ZUBSOLV	T2	QL

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UNCLASSIFIED DRUG PRODUCTS (Transplant Medications)		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
RHO KINASE INHIBITOR		
REZUROCK 200 MG TABLET	T3	PA QL (30 tabs/30 days)
UNCLASSIFIED DRUG PRODUCTS (Urinary Tract Conditions)		
BENIGN PROSTATIC HYPERTROPHY/MICTURITION AGENTS		
alfuzosin hcl er (Uroxatral)	T1	HD
dutasteride (Avodart)	T1	HD
finasteride (Proscar)	T1	HD
FLOMAX *(tamsulosin hcl)*	T3	HD
PROSCAR *(finasteride)*	T3	ST HD
silodosin (Rapaflo)	T1	HD
tamsulosin hcl (Flomax)	T1	HD
BPH 5-ALPHA-REDUCTASE INHIB-ALPHA1-ADRENOCEP ANTAG		
dutasteride-tamsulosin (Jalyn)	T1	HD
JALYN *(dutasteride-tamsulosin)*	T3	ST HD
CYSTINE-DEPLETING AGENTS, NEPHROPATHIC CYSTINOSIS		
CYSTAGON	T2	SP
KIDNEY STONE AGENTS		
THIOLA	T3	SP
THIOLA EC	T3	SP
tiopronin	T1	PA SP
OVERACTIVE BLADDER AGENTS, BETA-3 ADRENERGIC RECEP		
GEMTESA	T3	
MYRBETRIQ	T2	HD
URINARY TRACT ANTI-SPASMODIC, M(3) SELECTIVE ANTAG.		
darifenacin er	T1	HD
ENABLEX *(darifenacin er)*	T3	ST
fesoterodine er tablets (generic)	T1	ST
solifenacin succinate (Vesicare)	T1	HD
URINARY TRACT ANTI-SPASMODIC/ANTI-INCONTINENCE AGENT		
DITROPAN XL *(oxybutynin chloride er)*	T3	ST HD
flavoxate hcl	T1	HD
GELNIQUE	T2	QL (30 units/30 days) HD
oxybutynin	T1	HD
oxybutynin chloride er (Ditropan XL)	T1	HD

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
UNCLASSIFIED DRUG PRODUCTS (Urinary Tract Conditions) (cont.)		
URINARY TRACT ANTI-SPASMODIC/ANTI-INCONTINENCE AGENT (cont)		
OXYTROL	T3	ST QL (8 patches/21 days) HD
tolterodine tartrate (Detrol)	T1	HD
tolterodine tartrate er (Detrol LA)	T1	HD
TOVIAZ	T3	ST HD
TOVIAZ ER	T3	HD
trospium chloride	T1	HD
UNCLASSIFIED DRUG PRODUCTS (Weight Management)		
APPETITE STIM. FOR ANOREXIA, CACHEXIA, WASTING SYND.		
megestrol acetate	T1	
VITAMINS (Nutritional/Dietary)		
ANTIOXIDANT MULTIVITAMIN COMBINATIONS		
VISION OPTIMIZER	T3	
BIOFLAVONOIDS		
LIPO FLAVONOID	T3	
FOLIC ACID PREPARATIONS		
folic acid	T1	PPACA
true folic acid 667 mcg dfe tb	T1	PPACA
true folic acid 1600mcg dfe tb	T1	
MULTIVITAMIN PREPARATIONS		
ALIVE MEN'S 50 PLUS GUMMY	T3	
ALIVE MEN'S ENERGY	T3	
ALIVE MEN'S GUMMY	T3	
b complex w-vitamin c	T1	PPACA
CENTRUM ADULT 50 PLUS	T3	
one daily multivit-mineral tab	T1	
ONE DAILY MULTIVIT-MINERAL TAB	T3	
MVW MODULATR FORM MINI MULTIVT	T3	
super b-complex w/vitamin c	T1	PPACA
thera-m caplet	T1	
thera-m tablet	T1	
THERA-M CAPLET	T3	
TRUE MULTIVITAMIN	T3	
VITAJOY ADULT MULTI	T3	
vitamin b complex with c	T1	HD PPACA

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VITAMINS (Nutritional/Dietary) (cont.)		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
PEDIATRIC VITAMIN PREPARATIONS		
FLINTSTONES IMMUNITY SUPPORT	T3	
LIVITA FOR CHILDREN	T3	
MVW MODULATR FORMLTN PEDIATRIC	T3	
MULTIVIT-FLUOR 0.5 MG TAB CHEW	T3	
MULTIVIT-FLUORIDE 1 MG TAB CHW	T3	
multivitamin with fluoride	T1	PPACA
mvc-fluoride	T1	PPACA
tri-vitamin with fluoride	T1	PPACA
vitamins a, c, d & fluoride	T1	PPACA
VITAMIN B PREPARATIONS		
b complex	T1	HD PPACA
b complex w-vitamin c	T1	HD PPACA
B-COMPLEX FAST DISSOLVE TABLET	T3	HD
balance b	T1	HD PPACA
balanced b-complex	T1	HD PPACA
dialyvite 800 (Nephro-Vite)	T1	HD PPACA
FOLIKA-BC	T3	HD
foltabs 800	T1	HD PPACA
full spectrum b (Nephro-Vite)	T1	HD PPACA
rena-vite (Nephro-Vite)	T1	HD PPACA
super b complex	T1	HD PPACA
super b complex-vitamin c	T1	HD PPACA
vitamin b complex	T1	HD PPACA
vitamin b-complex & c	T1	HD PPACA
super b-50 complex capsule	T1	HD
super b-50 complex capsule	T1	HD PPACA
vit b comp c 19/folic acid/d3	T1	HD PPACA
VITAJOY BIOTIN	T3	HD
VITAMIN B1 PREPARATIONS		
VITAMIN B1	T3	
VITAMIN B12 PREPARATIONS		
CVS VIT B12 2,500 MCG SOFT CHW	T3	
CVS VITAMIN B12 5,000 MCG TAB	T3	

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VITAMINS (Nutritional/Dietary) (cont.)		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
VITAMIN B12 PREPARATIONS (cont.)		
cyanocobalamin	T1	
cyanocobalamin (vitamin b-12) (Nascobal)	T1	ST QL(4 units/30 days)
hydroxocobalamin	T1	
NASCOBAL *(cyanocobalamin (vitamin b-12))*	T2	ST QL(4 units/30 days)
true vitamin b-12 1000 mcg tab	T1	
true vitamin b-12 500 mcg tab	T1	
VITAMIN B12 2,500 MCG TABLET	T3	
VITAMIN B6 PREPARATIONS		
cvs vitamin b-6 100 mg tablet	T1	
eql vitamin b-6 100 mg tablet	T1	
gnp vitamin b-6 100 mg tablet	T1	
ra vitamin b-6 100 mg tablet	T1	
ra vitamin b-6 50 mg tablet	T1	
sm vitamin b-6 100 mg tablet	T1	
sv vitamin b-6 100 mg tablet	T1	
true vitamin b-6 100 mg tablet	T1	
true vitamin b-6 25 mg tablet	T1	
true vitamin b-6 50 mg tablet	T1	
vitamin b-6 100 mg tablet	T1	
vitamin b-6 25 mg tablet	T1	
vitamin b-6 250 mg tablet	T1	
vitamin b-6 50 mg tablet	T1	
TRUE VITAMIN B-6 10 MG TABLET	T3	
VITAMIN C PREPARATIONS		
FLEVOXIN	T3	
true vitamin c 1,000 mg tablet	T1	
true vitamin c 250 mg tablet	T1	
true vitamin c 500 mg tablet	T1	
VITAMIN D PREPARATIONS		
calcitriol (Rocaltrol)	T1	HD
CVS VITAMIN D3 250 MCG SOFTGEL	T3	HD
DRISDOL *(vitamin d2)*	T3	HD
ft vitamin d3 25 mcg softgel	T1	HD
ft vitamin d3 50 mcg softgel	T1	HD

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VITAMINS (Nutritional/Dietary) (cont.)		
Prescription Drug Name	**Drug Tier**	**Coverage Requirements and Limits**
VITAMIN D PREPARATIONS (cont.)		
ROCALTROL (calcitriol)	T3	HD
true vitamin d3 1,250 mcg tab	T1	HD
true vitamin d3 10 mcg capsule	T1	HD
true vitamin d3 10 mcg tablet	T1	HD
true vitamin d3 125 mcg cap	T1	HD
true vitamin d3 125 mcg tablet	T1	HD
true vitamin d3 25 mcg capsule	T1	HD
true vitamin d3 25 mcg tablet	T1	HD
TRUE VITAMIN D3 1,250 MCG CAP	T3	HD
TRUE VITAMIN D3 250 MCG CAP	T3	HD
TRUE VITAMIN D3 250 MCG TABLET	T3	HD
vitamin d2 (Drisdol)	T1	HD
VITAMIN D3 50 MCG DISSOLVE TAB	T3	HD
VITAMIN D3 62.5 MCG SOFTGEL	T3	HD
VITAMIN E PREPARATIONS		
true vitamin e 180 mg capsule	T1	
true vitamin e 90 mg capsule	T1	
TRUE VITAMIN E 450 MG CAPSULE	T3	
VITAMIN K PREPARATIONS		
MEPHYTON *(phytonadione)*	T3	QL
phytonadione	T1	
vitamin k	T1	
VITAMINS (Vitamins)		
MULTIVITAMIN PREPARATIONS		
CENTRUM ADULTS 50 PLUS MINIS	T3	
CENTRUM MEN 50 PLUS MINIS	T3	
DAVIMET-M	T3	
PEDIATRIC VITAMIN PREPARATIONS		
CHILDREN'S MULTI	T3	

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Exclusions and limitations for coverage

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

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

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

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

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

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

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

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

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

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

DISCRIMINATION IS AGAINST THE LAW

Medical coverage

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

Cigna:

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

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

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

Cigna
Nondiscrimination Complaint Coordinator
PO Box 188016
Chattanooga, TN 37422

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

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

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Proficiency of Language Assistance Services

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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